The funding of healthcare: NHI, medical schemes and public sector funding – whereto for South Africa?

Elsabé Klinck

1. South Africa in a global context

The World Health Statistics 2010 (based on 2009 data) lists country health outcomes in tables and includes outcomes of each of the Millennium Development Goals (MDGs).[1] It shows that, in South Africa, life expectancy has declined from 59 in 1990 to 52 in 2008 for males, and from 68 to 55 for females. By 2008, SA was reported as having 8 doctors per 10 000 population, 41 nurses per 10 000 and 3 pharmacists per 10 000. When measured against countries such as China, Mexico and Russia, South Africa is not performing well.

In terms of health expenditure, SA spent 8.5% of gross domestic product (GDP) on health in 2000, and 8.6% of GDP in 2007. Government spent 10.9% of its total budget on health in 2000, and 10,8% of its total budget on health in 2007. On a per capita basis, SA has increased its total health spend from $803 to $1148 at average exchange rate of which $290 and $375 are government per capita spend, the rest being private healthcare spend.

The World Economic Forum's Global Competitiveness Index has been released.[2] South Africa is number 54 on the overall index. In terms of the three sub-indices, South Africa, and other countries perform as set out in Table 2. The three sub-indices are comprised of the following:

- Basic requirements (institutions, infrastructure, macro-economic stability, health and primary education).
- Efficiency enhancers (higher education and training, goods market efficiency, labour market efficiency, financial market

Table 1. Country health outcomes, including South Africa[1]

	Life expectancy	Neonatal mortality per 1000	Birth by C-section	Doctors per 10 000	Expenditure of health as % GDP	Per capita government expenditure on health (PPP int. $)
China	74	11	23%	14	4.3%	$104
India	64	37	8.5%	6	4.1%	$29
Mexico	76	7	36.1%	29	5.9%	$372
Namibia	63	18	12.7%	3	7.6%*	$196
Russia	68	6	17.2%	43	5.4%	$512
South Africa	53	20	20.6%	8	8.6%*	$340

* Incl. private spend

Table 2. World Economic Forum's Global Competitiveness Index 2010[2]

Country	Basic requirements	Efficiency enhancers	Sophistication factor	Overall index
China	30	29	31	27
Spain	38	32	41	42
India	81	38	42	51
South Africa	**79**	**42**	**43**	**54**
Brazil	86	44	38	58
Russia	65	53	80	63
Mexico	66	61	69	66

Elsabé Klinck owns EKC, a healthcare consulting enterprise. She specialises in health law, health policy and ethics. She was a senior lecturer in Constitutional and Human Rights Law before entering the health sector as a legal advisor in 2001. She has also worked for a private health-sector training institution, a pharmaceutical trade association and a healthcare consulting firm. For more on her business, visit: www.ekconsulting.co.za

sophistication, technological readiness, market size).
- Sophistication factors (business sophistication, innovation).

It is clear that South Africa's performance on the "basic requirements" index has a negative influence on our overall score.

2. How are resources allocated to healthcare in South Africa?

After servicing our debt, the remainder of the South African budget (approx 70% – 75%), more or less half goes towards the National Government Departments, i.e. National Department of Health (NDOH), Sports and Recreation, Department of Trade and Industry (DTI), Education, Police, etc. Just under the other half of the remainder is provided to the provinces as part of the so-called "provincial equitable share" (PES). The PES depends on information obtained such as general population data, the General Household Survey, GDP per province (GDP-R), income and expenditure of households (IES), etc. This also means that health-specific provincial challenges are not worked into what is allocated to various provinces annually. It also means that, even if there is a small population, there would be a minimum cost relating to healthcare professionals, who are remunerated according to national scales, i.e. the costs do not decrease directly proportionally to the size of the province.

One should also bear in mind that the current PES is worked out on formulas that exclude medical scheme members from the population to be served by the health budget. The National Department of Health has proposed in Parliament that the PES should change in relation to healthcare, taking into account health demographics and work load per province/hospital. The Department's Strategic Plan 2011/12 – 2013/14 also states the unification of the health system as a priority. This background creates a better understanding as to why the NHI envisages a single, national Health Insurance Fund.

As seen from the World Health Statistics above, South Africa spends just about 10% of its government spend on healthcare. Provinces spend anything between 37% and 18% of their budgets on healthcare, depending on the specific province.

Of the PES allocated to each province, the specific province has to make allocations to healthcare from the PES. Part of the PES comprised so-called "Conditional Grants" (CGs), which are ear-marked monies provided to the provinces, for, amongst others the purposes outlined in Table 3.

3. Private sector and medical scheme funding

Medical scheme membership has increased by 2.5% in the year 2009/2010, to covering more than 8 million persons. It is estimated that a further 7 million persons occasionally use the private sector (mostly for GP care), but such persons do not benefit from the risk pooling that takes place in medical schemes.

Medical schemes paid, according to the Council for Medical Scheme's Annual Report 2009/2010,[4] on average, per beneficiary, per month, just under R300 towards hospitalisation, about R250 towards specialist care, just over R50 towards GP care and about R160 towards medicines. Open schemes, on average, paid R96 towards administration costs. Authorities are concerned about this fact (non-healthcare costs) and the upward trend lines in healthcare costs seen in Figure 1.

Regulation 8 to the Medical Schemes Act requires of medical schemes to fund the "diagnosis, treatment and care costs" of the conditions listed in the prescribed minimum benefit (PMB) list in the law, which is often blamed for cost increases of schemes. Schemes do,

Table 3. Compiled from Parliamentary Portfolio Committee on Health minutes, 2010[3]

Grant name	Purpose of grant	Basis of size of grant
HIV and AIDS	ARV treatment, prevention, VCT, PMTCT, PEP, HCBC,[9] step-down care.	Based on HIV antenatal prevalence.
Hospital revitalisation	Infrastructure, health technology, equipment & monitoring and evaluation, supports management development, total upgrades.	Based on projected cash flow figures for approved projects over MTEF period.
Forensic pathology	To assist the criminal justice system.	Based on project plan.
National Tertiary Services (NTS)	Strategic funding to enable provinces to plan, modernise and transform services in tertiary hospitals.	The cost of the specific services to be rendered (with reference to past NTS).
Health Professions Training	To be integrated into National Education? Noted that 1687 registrars' posts currently unfilled.	Being reviewed.

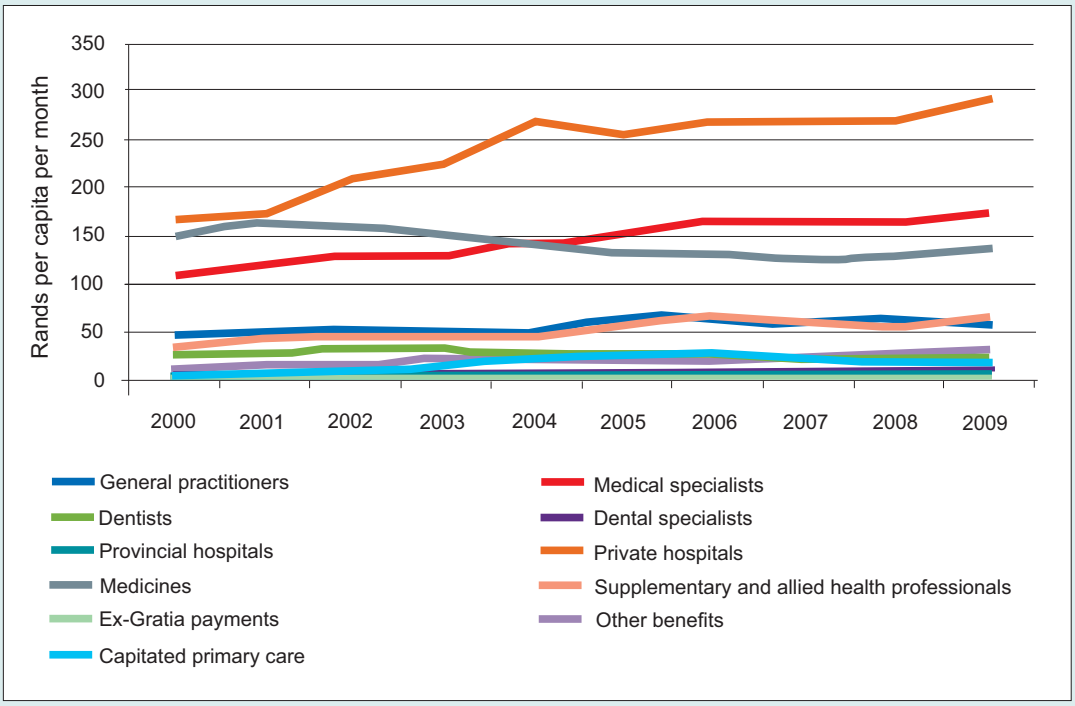

Figure 1. Private health care in costs Rands per capita per month 2000 – 2009 [4]

however, have mechanisms to manage such cost, as regulation 8 permits schemes to undertake so-called "managed care" and also to appoint Designated Service Providers (requiring of members to then co-pay if they visit non-designated service providers).

In spite of the tools awarded to schemes in terms of legislation to manage cost, a body representing medical schemes has approached the High Court to interpret regulation 8 to read "payment in full" within the framework of the scheme's rules. This means that a scheme would be able to place a cap on what it regards as sufficient payment for a particular PMB condition. This case is opposed by the Council for Medical Schemes and various health service provider groups (doctors, pharmacists and hospitals) and is likely to only be heard later in 2011.

It is therefore also not strange that the Council for Medical Schemes has seen an increase in PMB complaints from patients, from 291 in 2008, to over 1300 in 2009.

4. Whereto, then?

One of the key policy proposals to address the above situation, is the National Health Insurance plan. This plan is due to be released within the next couple of months, and would aim to address the inequities in the health system, and reorganise the funding of healthcare. It appears that medical scheme members would have to contribute to the NHI, and would then need to decide whether there would be fund left to buy additional, or alternative cover from a medical scheme. The full implementation of the NHI would, according to reports, take till 2025.

In the meantime, other proposals are set to prepare the sector for these reforms. An Office of Health Standards Compliance will be established to accredit and inspect facilities and a proposal for a Pricing Authority, under which health price negotiations would take place, was made late in 2010. For medicines, the capping of the dispensing fee has been finalised, whilst proposals to cap logistics fees are being considered. Although the NHI envisage a national fund, moves are afoot to decentralise the management of health funds at a health facility level, allowing facilities to manage all their resources to address the needs of the community it serves.

The final evaluation of these proposals will have to be as to whether it can rationally ensure better access to healthcare for more South Africans, as is envisaged in the South African Constitution of 1996.

References

1. World Health Organization. World health statistics 2010. Geneva: WHO; 2011.
2. World Economic Forum. Global Competitiveness Index 2010. Geneva: WEF; 2010.
3. Parliamentary Portfolio Committee on Health minutes. 2010.
4. Council for Medical Schemes. Annual Report 2009 – 2010. Pretoria: CMS.