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UNIVERSAL HEALTH COVERAGE V – Conclusions

Charles Simkins reviews the previous four briefs, pulling together themes and proposing how the government could affect genuinely meaningful change to South Africa's public health system.

We made the point in the first brief of this series that there is a conceptual distinction between universal health coverage and a single payer system. The second, third and fourth briefs, which considered systems in Austria, Germany, Israel, the Netherlands and Canada, show clearly that there are multiple routes to universal health care. In particular, extension of health insurance is a feasible route to UHC.

Careful consideration of the alternative routes has not been a feature of the debate about the future of health care in South Africa. It is high time for a change. If real progress is to be made, we have to take into account the resources we are likely to have over the medium term – say the next ten years – and how they can best be used. Proposals which entail a huge jump in health expenditure are, and should be, regarded with scepticism – especially as the International Monetary Fund projects low economic growth in South Africa until 2021. [1]

Part of thinking clearly about the issues involves conceptual clarity. Some people believe that the type of good that health care is can be normatively specified. That is an error. It depends on the facts of the case. Some aspects of health care are indeed public goods. To the extent that the Johannesburg metro ensures fresh air, the collection of rubbish and prevention of raw sewage running in the streets, all residents benefit. A's enjoyment of fresh air does not prevent B from enjoying it. The reduction of risk from infection from vermin and e coli for C is also a reduction for D. It is also true that some aspects of health care have positive externalities. E's inoculation against an infectious disease reduces F's chances of catching it.

But a great deal of health care is a private good. G's consumption of an aspirin to relieve a headache means that that same aspirin is not available for H to take for his headache. The medical attention and the stiches I gets after being mugged in the street are not available for J who suffers the same fate. Those are facts which cannot be defined away.

In so far as health care bears a private cost, people have to consider it the light of their expenditure as a whole. The decisions they make will depend on their

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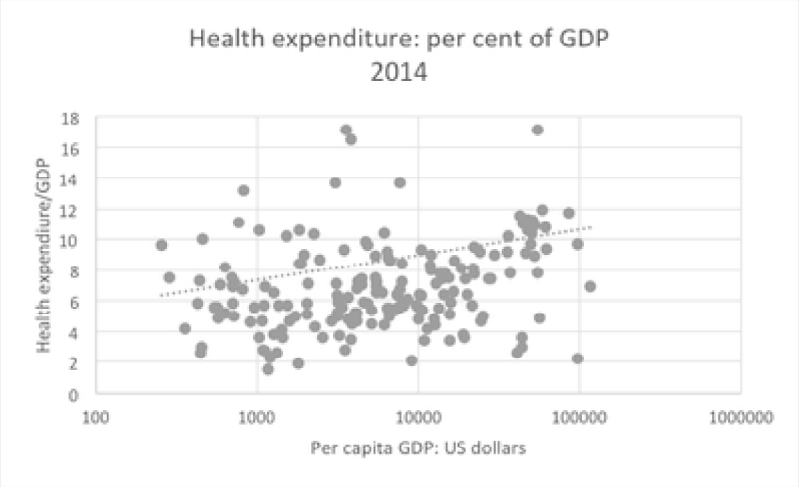
circumstances and preferences. One might for instance consider a trade off between seeing a doctor for a minor irritation and, say, a meal in a restaurant. One might trade off expensive dentistry against the type of car one drives. The fact that part of the cost of health care is borne by the government does not remove the need for trade offs. It simply relocates the decisions about them.

One important question about the demand for health care is how it varies with income. This turns out not to be so easy to measure for individuals, but a major and careful study conducted by the US Department of Agriculture in 2003 of data from 114 countries found that, without exception, health expenditure rose as a proportion of income as income rose. [2] What is true for individuals is true for countries, as the Figure below shows.



Source: World Bank, World Development Indicators.

While there is considerable variation in health expenditure as a per cent of GDP, there is also a clear trend. Up to a per capita income of US $ 10 000, the level is between 4% and 7% and hardly rises. Beyond that level of per capita income, health expenditure rises more rapidly, reaching 10% of GDP at a per capita income of US $ 100 000 per year. South Africa, with a GDP of US $ 6 484 in 2014, spent 8.8% of GDP on health, more than 2% higher than the average of countries at our level of income per capita.

Now consider a comparison which has been made often in South Africa, a version of which is contained in the National Health Insurance White Paper:

"South Africa spends 8.5% of GDP on health and 4.1% of the GDP is spent on 84% of the population, the majority utilizing the public health sector whilst 4.4 % of its GDP is spent on only 16% of the population in 2015/16." [3]

But what follows? Surely not the conclusion that part of the 4.4% can be captured for the 84% of the population. One might, with considerable coercion, prevent the 16% from spending as much on health care as they do, but, thus constrained, they would simply spend it on something else. You can affect individuals' disposable income through the pattern of taxation. You can also affect it by policies designed to reduce the (very high, in our case) level of inequality in pre-tax income. But once disposable income is determined, individuals will themselves choose how it is allocated between savings and consumption and between individual items of consumption.

Health care expenditure has one important characteristic. While most people for most of the time spend relatively little on health care, everyone is at risk of needing expensive health care at some time – so expensive that it is catastrophic for the individual concerned. This is the reason why people want health insurance. It reduces risk to a tolerable level. Like all financial services, health insurance needs regulation in the interests of consumers. It is when regulation goes beyond this point that issues start to arise.

In insurance based UHC, there is always a mandatory level of insurance. Given this level, the possibilities exist of supplementary insurance – to finance a higher level of service and/or choice – and complementary insurance – to finance services not covered by mandatory insurance. Country practices vary. Israel, for instance, allows both supplementary insurance and complementary insurance. Germany allows people earning above a certain level of income to opt out of social insurance alltogether and buy private insurance.

The issues remain similar in the case of single payer UHC systems. The United Kingdom allows both supplementary and complementary health insurance. Canada allows the latter, but actively discourages the former. But, in any event, the coverage of Canadian single payer health provision is such that there is little need for supplementary insurance. That is the advantage of being an affluent country. Canada had a per capita income of US $ 50 230 in 2014. That said, it is not clear what purpose the Canadian government's stance on private health insurance serves. Canada is unusual in that it does not prescribe the conditions to be covered under its single payer system: the federal government merely sets out criteria which provincial systems must meet.

One may assess the vulnerability of the population to risk by considering the percentage of private health expenditure which is not covered by the government or pre-paid health insurance. In South Africa, this was 6.5% in 2014. [4] Only ten countries, out of 178, had lower percentages. [5] Of course, averages hide

distributions and there may have been catastrophic payments by individuals. But the catastrophic risk can be insured against at low cost, and catastrophic costs can be simply written off if incurred in public facilities.

It is the mark of a civilised society that the minimum platform of health care available to all its members be set as high as possible. Government expenditure assigned to this task has to be weighed against competing claims year by year. Measures amounting to an earmarked tax for health expenditure have been proposed in the NHI White Paper. But experience with earmarked taxes in South Africa have not been happy, [6] and in any case, they are hard to justify as constraints on the composition of government spending.

But improvement of value for money deserves support, as does careful consideration of which interventions yield the greatest gains in health. Many of the supply side interventions outlined in the NHI White Paper are appropriate and should be implemented in priority order as funds become available. But the system is going to struggle in the next few years. The implication of the medium term projections in the 2016 Budget indicate that government expenditure per capita on primary health care will remain static in the next three years, and the government expenditure per capita on hospitals will decline slightly. A resumption of growth is needed to move forward in a substantial way.

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Bibliography

[1] International Monetary Fund, World Economic Outlook, April 2016
[2] James Seale, Anita Regmi and Jason Bernstein, International Evidence on Food Consumption Patterns, Economic Research Service, US Department of Agriculture, 2003
[3] NHI White Paper, p 17
[4] World Health Organisation, Global Health Expenditure Database
[5] These were Botswana, Brunei, France, Netherlands, Oman, Seychelles and four Pacific Island States (Samoa, Solomon Islands, Tuvalu and Vanuatu)
[6] Think of the payroll tax financing SETAs, which have not worked well, and the Unemployment Insurance Fund, which is building up large actuarial surpluses.