

Financing South Africa's National Health insurance: The impact on the taxpayer

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ABSTRACT

The tax system in South Africa makes provision for every South African citizen to contribute to a greater or lesser extent to funding the National Health Insurance (NHI), either through VAT or PAYE. However, as a result of the high unemployment rate, a large gap exists between tax and non-tax contributors. The question can now be asked whether it is fair that just a small percentage of taxpayers are responsible for the total funding of the NHI. Furthermore, it could be asked whether the taxpayer is aware of the additional tax burden the NHI will impose on him/her.

The purpose of this research was to investigate three countries, namely, Brazil, Spain and Germany, where some form of NHI is in operation, in order to find a possible appropriate funding model for South Africa's NHI and, ultimately, to make conclusions and recommendations based on the outcomes.

It was subsequently found that, although the taxpayer should be more heavily taxed in order to fund the NHI, there are a few other possibilities for distributing the tax burden more evenly. However, the impact of the proposed adjustment to increase VAT could have a negative impact on the non-taxpayer and might contribute to greater poverty in South Africa.

KEYWORDS:

Financial implications, Funding, Health care for all, Increased tax burden, Increasing VAT, International Health Insurance, National Health Insurance, Payroll taxes, Tax surcharges, Universal Health Care.

OPSOMMING

Die belastingstelsel maak voorsiening dat elke Suid-Afrikaner wel in 'n mindere of meerdere mate 'n bydrae tot die Nasionale Gesondheidsorgversekering (NGV) se befondsing kan maak, hetsy deur BTW of LBS. Werkloosheid veroorsaak egter dat daar 'n groot gaping tussen die belasting- en nie-belastingbydraers bestaan. Dit kan dan nou met reg gevra word of dit regverdig sal wees dat die klein persentasie belastingbetalers vir die totale befondsing van die NGV verantwoordelik sal wees. Voorts kan gevra word of die belastingbetaler wel bewus is van hierdie addisionele belastinglas wat die NGV op hom/haar sal plaas.

Die doel van die navorsing was om drie lande naamlik, Brasilië, Spanje en Duitsland, waar 'n tipe NGV in bedryf is, te ondersoek om 'n moontlike geskikte befondsingsmodel vir Suid-Afrika se NGV te vind, en ten einde, op grond van die uitkomstes verkry, gevolgtrekkings en aanbevelings te kan maak.

Bevindinge is dat, hoewel die belastingbetaler swaarder belas moet word ten einde die NGV te befonds, daar wel 'n paar moontlikhede is om die belastinglas meer eweredig te versprei. Die impak van die voorgestelde aanpassing om BTW te verhoog sal egter die nie-belastingbetaler moontlik negatief beïnvloed en moontlik bydra tot groter armoede in Suid-Afrika.

SLEUTELWOORDE:

Befondsing, Belastingbybetalings, Finansiële implikasie, Geskikte NGV modelle, Gesondheidsorg vir alle inwoners, Internasionale gesondheidsorg, Nasionale Gesondheidsorgversekering, Toename in BTW, Toename in belastinglas, Werknemersbelasting, Universele gesondheidsorg.

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CHAPTER 1: INTRODUCTION, OBJECTIVE AND PROBLEM STATEMENT

1.1 INTRODUCTION AND BACKGROUND

According to Torrey (2008), the concept of universal healthcare or universal coverage refers to a situation where all the legal citizens of a country receive basic health services and where no one is denied access to such services, for example all the people in the state of Massachusetts, or the entire population of a country such as Canada.

The Encyclopaedia Britannica Online School Edition (2012) explores the fact that Germany instituted the first mandatory national health insurance scheme in 1883, the so called “Bismarck's law”. Health insurance developed primarily on a work-related basis as a condition for a specific occupation. This responsibility of employers towards employees led to legislative substance in societies where national markets started to develop. Consequently, employers with no responsibility to contribute to a sick fund had a competitive edge over employers that did have an obligation to contribute. At that time, the key reason for the scheme was to control socialist tendencies.

The Department of Health (2012) draws attention to the fact that the national health insurance (NHI) will be a financing system that will ensure that every South African citizen, including long-term residents, has access to vital health care, whatever their employment status or ability to contribute in rand terms to the NHI fund.

PNHP (2010a) state that information supplied by the Organisation for Economic Cooperation and Development (OECD) shows that the health care systems in various countries mainly reflect three types of programmes:

- **Single-payer national health insurance system.**

According to this system, the state administers and pays for the health insurance and the majority of medical practitioners form part of the private sector. Countries that have a single-payer system include Canada, Denmark, Norway and Sweden.

- **National health services.**

In this system the government owns and operates the hospitals and salaried medical practitioners dominate the sector. Great Britain and Spain are among the countries mentioned by the OECD as having national health services.

- **Multi-payer health insurance systems.**

This system is a highly controlled system where universal health insurance is implemented by means of sickness funds, which pay standardised negotiated rates to medical practitioners and hospitals. This system is also called the all-payer system. Germany, Brazil and France have this system in place.

On 12 August 2011, the Minister of Health, Dr. Aaron Motsoaledi, published the Green Paper on National Health Insurance in the Government Gazette, number 34523, as part of the Department of Health's process of initiating public consultation on the policy proposal for the implementation of the NHI in South Africa (NCHF, 2011).

Byl (2011) states that, according to KPMG calculations using the projected figures in the Green Paper, R10,4 billion per year, over and above current public health spending, would be needed to rollout the NHI over the next 14 years. This gives a total of R145 billion over the entire period.

According to the 2012 Budget Speech (National Treasury, 2012), the NHI will be implemented over the next 14 years starting in the fiscal year 2012 to 2013. The NHI is anticipated to give equal health exposure to the entire South African population over time. However, extra funds need to be raised over and above the current public health budgets. It was further stated in the speech that these funds could possibly be raised by an increase in the VAT rate, a payroll tax, tax surcharges on individuals or a combination of the methods. User charges would also be considered. Nevertheless, a sustainable tax system would still have to be in place as well as economic growth, job creation and savings. A White Paper on the NHI was expected in April 2012, but has not yet seen the light.

The Department of Health (2011:9) states that the World Health Organization (WHO) recommends that countries spend at least 5% of their gross domestic product (GDP) on health care.

Byl (2011) discusses the fact that South Africa may be compared to countries such as Russia and Brazil, which form part of the BRICS (Brazil, Russia, India, China and South Africa) countries, when considering public health expenditure as a percentage of GDP or of total government expenditure. Furthermore, Byl is of the opinion that South Africa does not spend enough on public health per capita. However, it is difficult to compare South Africa to countries with existing national health security systems, such as Australia and the United Kingdom. The reason for this is that there are significant challenges for South Africa when trying to deliver health care services through the public health system. For example, the GDP in relation to the population that needs to be serviced through the health care system is off balance and the non-contributing unemployed population in South Africa places additional strain on the available funding per capita. Byl (2011) also points out that if growth in the economy occurs and the employment figures rise, this could have a positive impact on the health services rendered to South Africans.

South Africa Info (2012) states that in order for the initial NHI model to be completed by 2025, public health care financing needs to rise from 4% to 6% of GDP.

The question that can now rightfully be asked is whether the individual taxpayer in South Africa is aware of the income tax effects of the NHI. As mentioned above, some consideration has to be given to the various factors that impact on the implementation of the NHI.

1.2 PROBLEM STATEMENT

The question that may now be asked is: What alternative methods are available for financing the NHI and how may these methods affect the individual taxpayer?

1.3 MOTIVATION

The core issue of this dissertation is to identify the different financing options that are available for the NHI and the possible impact they could have on the individual taxpayer in South Africa.

Four countries will be discussed in this regard, South Africa, Brazil, Spain and Germany. The latter three countries were selected for the following reasons:

- Brazil – South Africa and Brazil both form part of the BRICS group of countries.
- Spain – Spain's unemployment rate is very high and is comparable to the high unemployment rate in South Africa.
- Germany – is a developed country with a well-established health system and economy.

It should be kept in mind; however, that South Africa is a developing country, while the countries that it will be compared with in this dissertation have well-established operating health systems.

A comparative analysis will be done to compare foreign legislation to proposed local legislation and, subsequently, to identify shortcomings and to provide some suggestions for ways in which local legislation could be developed to ensure that the NHI is appropriately addressed in line with global standards.

1.4 OBJECTIVES

The primary objective of this dissertation is to explore the different financing options available for funding the NHI in South Africa and to ascertain the effect they would have on the individual South African taxpayer. This primary objective will be addressed by the following secondary objectives:

- to investigate the proposed South African NHI model and the various financing options suggested
- to investigate the different health care models that exist internationally

- to do an overview of the national health insurance models used by the three countries selected
- to compare the employee contributions to NHI in Brazil, Spain and Germany with the benefits obtained to understand what options are available
- to make suggestions to the South African government for the implementation of the NHI.

1.5 RESEARCH METHOD

1.5.1 Literature review

The research will to a great extent rely on a literature review of journal articles, internet sources, textbooks and government releases on the subject. There is an ongoing flow of research concerning the NHI proposal and various role players in the financial sector have made valuable inputs to the debate on the advantages and disadvantages of the NHI.

1.5.2 Comparative analysis

A comparative analysis of the health contributions of Brazil, Spain and Germany will be done to understand the options that are available as compared with the benefits received.

1.6 OVERVIEW

To achieve the objectives of the dissertation, the topic will be presented and discussed in the following chapters:

CHAPTER 1: INTRODUCTION, OBJECTIVE AND PROBLEM STATEMENT

In this chapter the problem is stated in terms of the various financing methods available for funding the NHI and the way in which these methods could affect the individual taxpayer. Chapter 1 also includes the introduction, motivation, problem statement, objectives and research method.

CHAPTER 2: NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

This chapter will include an overview of the Green Paper that was implemented in August 2011, and will also discuss the advantages and disadvantages of the NHI in South Africa. Discussion points will include the gross domestic product % (GDP %), ways in which the NHI will be funded, the system that will be used in South Africa and the implication of the suggested methods for funding the NHI. These include an increase in value-added tax (VAT), payroll taxes and surcharges on taxable income.

CHAPTER 3: INTERNATIONAL HEALTH CARE MODELS

This chapter will include an overview of the four international health care models, that is, the Bismarck model, the Beveridge model, the national health insurance model and the out-of-pocket model.

CHAPTER 4: NATIONAL HEALTH INSURANCE IN BRAZIL

In this chapter, an overview of the Brazilian health system will be given including the advantages and challenges of the Brazilian health system. This discussion will include gross domestic product % (GDP %), how the NHI is funded in Brazil and the system in use in Brazil.

CHAPTER 5: NATIONAL HEALTH INSURANCE IN SPAIN

This chapter gives an overview of the Spanish health system. The discussion includes the advantages and challenges of the Spanish health system, the gross domestic product % (GDP %), how the NHI is funded in Spain and the system that is in use in Spain.

CHAPTER 6: NATIONAL HEALTH INSURANCE IN GERMANY

An overview of the German health system is given in this chapter. This overview includes the advantages and challenges of the German health system and the discussion will include the gross domestic product % (GDP %), how the NHI is funded in Germany and the system that is in use.

CHAPTER 7: COMPARATIVE ANALYSIS OF THE DIFFERENT HEALTH SYSTEM CONTRIBUTION OPTIONS OF THE THREE SELECTED COUNTRIES

In this chapter the various contribution options for the national health insurance policies of the three countries will be compared to project the potential effect of those policies on the South African taxpayer in order to try to determine what policy could work in the South African environment.

CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

This chapter concludes the dissertation by presenting the results that were obtained by the analysis performed in chapter 7, as well as making general conclusions about the answers obtained relating to the research question in general. The chapter also includes recommendations for improvements South Africa could make in the implementation of the NHI.

CHAPTER 2: NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

2.1 INTRODUCTION

In this chapter the background to the South African health system, the current healthcare system and the possible funding options for the NHI will be discussed.

According to the Department of Health (2011:4–5), South Africa currently has a two-tiered health care financing system. Most of the funding takes place through medical schemes, various hospital health care plans as well as out-of-pocket payments. Accordingly, only private patients with medical schemes are covered; thus, it is only the employed, including self-employed, citizens that get the benefit. The rest of the population are public sector users who are financed by the fiscus. Under this system, only private sector users are able to choose which medical providers they want to use; the rest of the population has no choice.

Furthermore, the Department of Health states that, owing to the fact that only a few have access to good health care services, there is an unjust health care system, which is unpractical and unfair to the less privileged. Hence, the introduction of a national health insurance (NHI) anticipates a reasonable and fair health care system for all South African citizens and legal residents. In terms of such a system the entire population would be covered and individual payments would be much lower than they are currently. This proposed system is referred to by the WHO (2013) as “universal coverage”.

It is therefore important for South Africa to establish an equitable health care system that will best benefit all citizens.

2.2 BACKGROUND TO SOUTH AFRICAN HEALTH CARE

The National Planning Commission (2011:295–296) states that the commitment to primary health care has come a long way in South Africa. The history of community-orientated primary care dates back to the 1940s when it comprised a network of decentralised health centres.

According to Gilson and McIntyre (2007), since 1994 the South African government has positioned equity as a priority in its health policy goals. These authors are furthermore of the opinion that large inequities in income, health status and access to health and other social services have been in place in South Africa since 1994.

2.3 CURRENT HEALTH CARE SYSTEM

The Department of Health (2011:4) states that the current healthcare system in South Africa consists of a private and public sector. However, only a small percentage of the population is a member of a medical scheme.

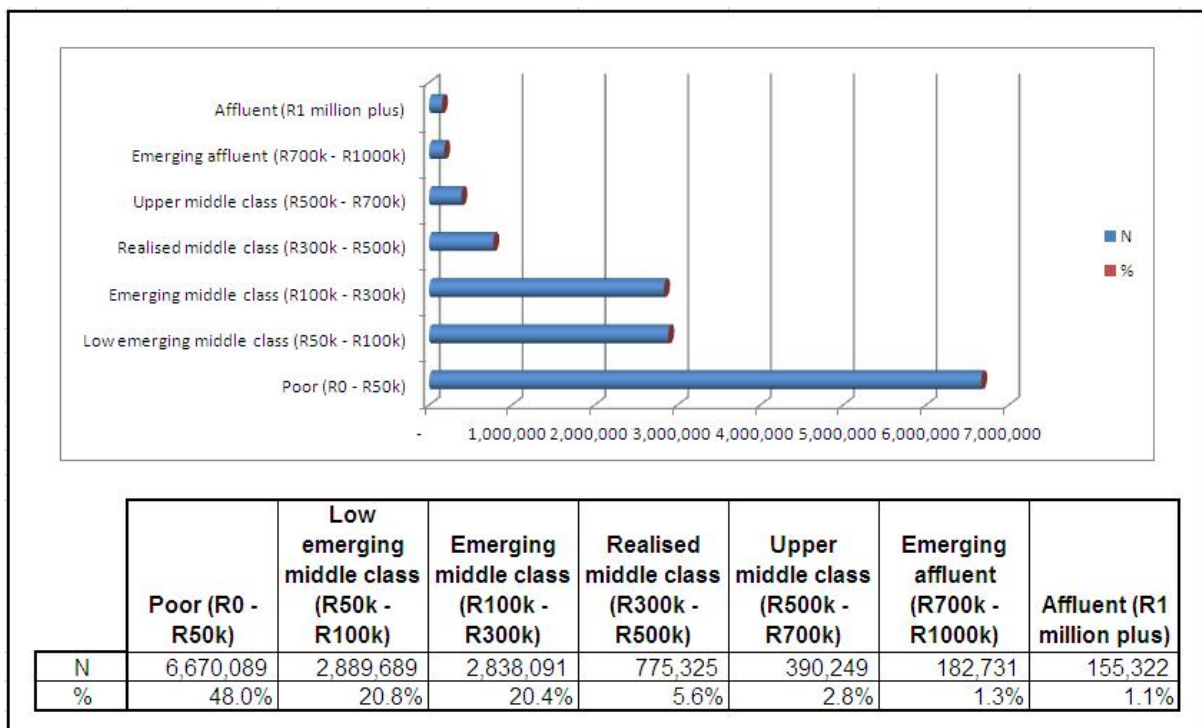


Figure 2.1: The distribution of households per annum income group in 2010

Source: Adapted from Masemola, Van Aardt and Coetzee (2010).

The low emerging middle class and the emerging middle class households are the major contributors of income in South Africa.

Gilson and McIntyre (2007) explain that the current health care system is divided into two sectors:

- **Public health sector**

The public health sector is the responsibility of the national, provincial and local government tiers. Public sector funds are generated from national taxes, with a small part being funded by local government and by user fees (charges for service).

- **Private health sector**

The private sector consists of general practitioners, specialists, pharmacies, private hospitals and traditional healers. Medical schemes and out-of-pocket payments are the main sources of funding.

Coovadia *et al.* (2009) state that the South African health sector is organised into different levels:

- National health policy is managed by the National Department of Health.
- Provincial policies are developed by the nine provincial departments.
- There are tertiary, regional and district hospitals.
- The district hospitals and community health systems include clinics which are managed by nurses.
- It is the duty of local government to improve services and have controls in place to prevent bad service.

According to the Census (2011) conducted in 2011, South Africa is a middle-income country. This is based on the GDP for a population of around 51,8 million. According to Amado *et al.* (2012:6), the WHO recommends that middle-income countries spend 5% of their GDP on health. However, although South Africa spends 8,3% on health, which is a higher proportion of its GDP, it still has a major burden of illness and unfortunate health outcomes. Public sector health spending consists of 4,2% of GDP, which supports 84% of the population (42 million individuals). By contrast, the private sector spends the rest (4,1%), which supports just 16% of the population (8,2 million individuals).

Health expenditure in the South African public and private sector is summarised in table 2.1 below.

Table 2.1: Health expenditure in the South African public and private sector

	07/08	08/09	09/10	10/11	11/12	12/13	13/14	Annual real % 07/08 13/14
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	
Public sector								
National Department of Health Care	1,210	1,436	1,645	1,736	1,784	1,864	1,961	2.2
Provincial departments of health	62,582	75,120	88,593	98,066	110,014	119,003	126,831	6.1
Defence	1,878	2,177	2,483	2,770	2,961	3,201	3,377	4.0
Correctional services	261	282	300	318	339	356	374	0.1
Local government (own revenue)	1,625	1,793	1,829	1,865	1,977	2,096	2,221	9.4
Workmen's Compensation	1,287	1,415	1,529	1,651	1,718	1,804	1,894	0.6
Road Accident Fund	764	797	740	860	980	1,029	1,080	-0.1
Education	1,833	2,134	2,350	2,503	2,653	2,812	2,981	2.2
Total public sector health	71,439	85,154	99,468	109	122,427	132	140,721	5.6
Private sector				769		165		
Medical schemes	65,468	74,089	84,863	96,482	104,008	112,120	120,866	4.4
Out of pocket	14,694	15,429	16,200	17,172	18,202	19,294	20,452	-0.3
Medical insurance	2,179	2,452	2,660	2,870	3,094	3,336	3,596	2.5
Employer private	1,041	1,172	1,271	1,372	1,479	1,594	1,718	2.5
Total private sector health	83,383	93,141	104,994	117,896	126,783	136,344	146,632	3.6
Donors or NGOs	3,835	5,212	6,319	5,787	5,308	5,574	5,852	1.2
Total	158,657	183,507	210,781	233,452	254,518	274,083	293,205	4.4
Total as % of GDP	7.6	7.9	8.6	8.8	8.7	8.6	8.3	
Public as % of GDP	3.4	3.7	4.1	4.1	4.2	4.0	4.0	
Public as % of total government expenditure (non-interest)	13.9	14.0	13.8	14.1	14.7	14.7	14.6	
Private financing as % total	52.6	50.8	49.8	50.5	49.8	49.7	50.0	
Public sector real rand per capita 10/11 prices	2,131	2,300	2,512	2,635	2,766	2,812	2,816	4.8
Public per family of four per month real 10/11 prices	710	767	837	878	922	937	939	4.8

Source: Adapted from National Planning Commission (2011:309)

The GDP forecast for 2013/2014 is 8,3%. Of this, the public sector will contribute approximately 4% and the private sector the remainder of 4,3%. In terms of funding, the Provincial Department of Health is the main contributor to the public sector and the medical schemes to the private sector.

McIntyre (2009) avers that South African health care is currently funded from three main sources:

- **General tax funds** – income tax, VAT, and other taxes collected by the government to raise funds.
- **Contributions to medical schemes** – individuals and employers contribute to medical aids on a monthly basis.
- **Out-of-pocket payments** – these occur when individuals pay health care providers for services that are not covered by their medical aids, as well as fees paid to hospitals in the public sector and fees paid by patients who do not belong to a medical aid.

2.4 NHI FUNDING OPTIONS

In the 2012 Budget Speech (National Treasury, 2012), the Minister of Finance, Pravin Gordhan, stated that an increase in the VAT rate, a payroll tax on employers, a surcharge on the taxable income of individuals, or some combination of these are the options under consideration for the funding of the proposed NHI. Alongside options for increased tax revenue, the role of user charges is also being investigated.

To implement an NHI successfully, it is important to consider the principles of such a system. Anon (2011) explains the three principles of NHI as follows:

- **The right to health**

In terms of Section 27 of the South African Constitution (1996), all South Africans are entitled to health care. However, the majority of citizens do not get adequate health services. Quality and cost-free health care is the main purpose of the NHI.

- **Social solidarity and universal coverage**

Everyone in South Africa will make a financial contribution to the NHI funding and everyone will be part of the same cover, receiving exactly the same health care no matter what their income is. Progressive taxation means that those who have adequate finances will carry the financial burden. The most

important issue here is that everyone should have access to quality health care.

- **Public administration**

The funds for the NHI, which will be raised through taxation and mandatory contributions, for example an extra tax on income, will be placed in a central fund. The national government will administer the funds and the Minister of Health will oversee them. To keep the intention of making profit out of health care, as well as to keep prices low, the system will be administered by the public service.

Figure 2.2 demonstrates the flow of funds and the provision of services in a fully developed NHI.

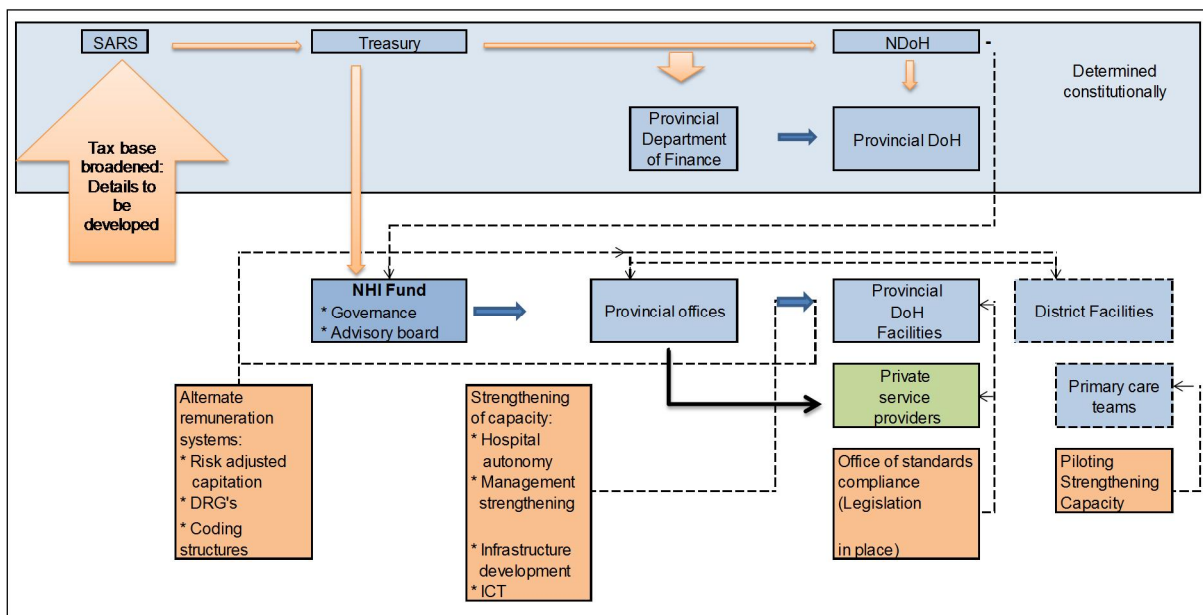


Figure 2.2: Flow of funds and provision of services in the NHI framework

Source: Adapted from CMS (2011:6).

As illustrated in figure 2.2, SARS will both collect taxes and allocate funds to the provinces through the equitable share formula and the National Department of Health. The allocation will then flow from the National Treasury to the NHI fund. The NHI structure will consist of provinces and districts, and health care services will be purchased from the private and the public sector. One of the main focus areas will be

primary care. The Macmillan English dictionary for advanced learners (2006:1118) defines primary care as “medical treatment and advice that you get in your local community from a doctor or nurse, rather than treatment from a specialist”.

Figure 2.3 illustrates the sources of the general tax revenue in South Africa.

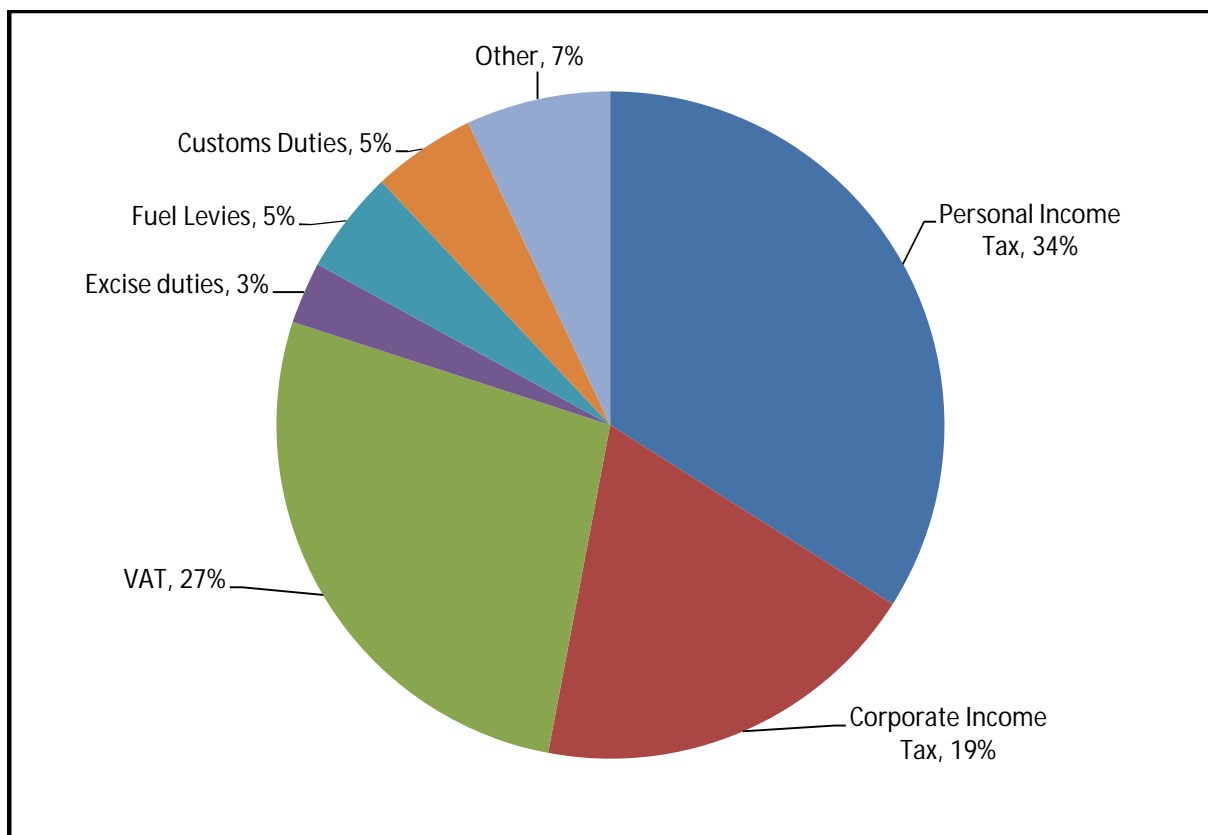


Figure 2.3: Sources of general tax revenue (2013)

Source: Adapted from National Treasury (2013).

As stated by McIntyre (2009), the whole population pays some form of tax, whether in the form of VAT on purchased goods or fuel levies (which is even built into the cost of minibus taxi fares). The emphasis is however more on personal income tax paid by employees in formal employment. According to figure 2.3 above, personal income tax accounts for more than a third of the total tax revenue in South Africa, VAT for 27% of revenue, while company taxes are the third biggest contributor to the national treasury.

Figure 2.4 below shows the different tax payments as a percentage of household income.

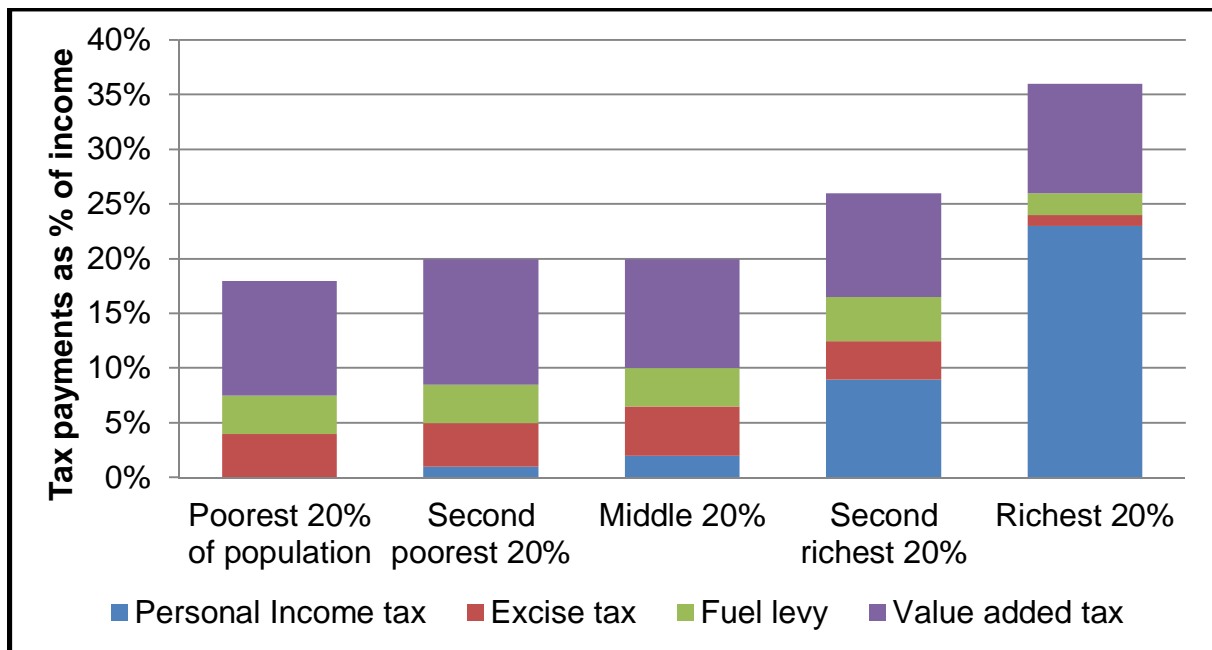


Figure 2.4: Different tax payments as a percentage of household income (2005/06)
 Source: Ataguba and McIntyre (2009)

McIntyre (2009) maintains that personal income tax is very progressive, but that the other taxes are regressive. Accordingly, higher income earning South Africans pay a higher percentage of their income towards tax than lower income groups as illustrated in figure 2.4 (above).

Joubert (2012) draws attention to the fact that 25% of the time spent at work is effectively time spent working for the state.

According to Gordhan in the 2012 Budget Speech (National Treasury, 2012), there are three possible funding options that could be considered, namely, an increase in VAT, tax surcharges and payroll tax. These three options are explored in more detail below.

2.4.1 Increase in VAT

Delfin, *et al.* (2005) states that, in September 1991, general sales tax (GST) was replaced by VAT, which was levied at 10%. This was subsequently raised to 14% in 1993. Accordingly, VAT is levied on domestic supplies and imports of goods and services. Exported goods (such as gold) and services are zero-rated, which means that VAT is levied at 0%.

According to Statistics South Africa (2013), the unemployment rate is 24,9%, which implies that a large part of the population does not have an income. Thus an increase in the VAT rate would probably have a significant impact on the day-to-day living of the poor.

Ataguba and McIntyre (2009) conclude that VAT is a regressive tax in South Africa as both wealthy and poor individuals pay the same amount of tax, levied at the same rate (currently 14%). Because less privileged households pay a larger portion of their income as VAT than wealthy households, VAT is a greater financial burden on the poor. Parker (2012) argues that if the VAT rate were to be increased the less privileged would be the most affected, therefore an increase in the VAT rate needs to be carefully considered. According to Gordhan in the 2013 Budget Speech (National Treasury, 2013), during the 2012/2013 tax year VAT represented R215 billion and was the second highest contributor to total tax revenue (27%) in South Africa. VAT is thus a fairly stable and predictable tax, but it is influenced by the state of the economy.

A possible increase in the VAT rate could contribute to a major part of the funding for the NHI; however, the impact on the poor would be severe. Therefore, any changes to the VAT rate should be carefully considered before it is made. Owing to the fact that VAT is the second highest contributor after normal income tax in South Africa a rate increase cannot be disregarded. For example, if the VAT rate were to increase by 1%, an additional R15,4 billion (R215 billion divided by 14 and multiplied by 1) would be raised.

2.4.2 Tax surcharges

The Macmillan English dictionary for advanced learners (2006:1448) defines sur-tax as “an additional tax on something that is already taxed, especially a high income”. Another definition is provided by the Oxford advanced learner’s dictionary of current English (2006:1491), which states that sur-tax is “a tax charged at a higher rate than the normal rate, on income above a particular level”.

The number of South African high-income earners and their level of income are the main factors to consider for generating tax surcharge income. Deloitte (2012) states that in the budget for 2012 it was evident that 25% of individual taxpayers (those with an annual taxable income of between R260 000 and R1 000 000) would account for 45% of revenue from personal income taxes, while 2% of individual taxpayers (those with an annual income in excess of R1 000 000) would account for 25%. According to Deloitte (2012), a surcharge on taxable income may be a good source of income as a considerable portion of the population is in the medium to higher tax bracket and they contribute almost half of the personal income tax in the country.

2.4.3 Payroll taxes

According to the Unemployment Insurance Act, No.4 of 2002 (cited by Seccombe, 2012), employers pay a minimal contribution of 1% of remuneration to the Unemployment Insurance Fund (UIF) towards the social welfare of their employees. This contribution has been capped at R148,72 from 1 October 2012 (up to 30 September 2012 it was R124,78) per month per employee. In addition, the employee also contributes 1% of his monthly remuneration to the UIF. According to the SARS (2012), the UIF fund raises R12,184 billion a year. It is therefore proposed that another 1% contribution of remuneration should be made by employers towards the National Skills Development Fund. It is the employee’s responsibility to pay for their own social benefits, such as medical aid and retirement funding, although they do get tax relief on medical aid and retirement fund contributions.

Broomberg (2009) is of the opinion that an increase in additional tax revenues for the health care system would have serious repercussions for the economy, particularly in the current economic environment. Broomberg furthermore argues that although

the new payroll tax is still vague (levels of 2–5% have been suggested), this proposed payroll tax (which would be shared between employers and employees) would have a significant impact on the employment environment and job creation.

Furthermore, Broomberg (2009) maintains it has not been made clear whether the real economic situation would allow an NHI system to make it possible for an all-inclusive package of benefits for all the citizens. South Africa has one of the highest unemployment rates in the world and the reality is that only a small number of employed taxpayers would be responsible for providing the envisaged package of healthcare benefits to the entire population. The following examples illustrate this dilemma clearly: If the NHI were to provide the current package of benefits obtained by the average member of a medical scheme to the entire population, this would cost approximately R497 billion, equivalent to 20,1% of South Africa's total GDP. Broomberg contends that the unpleasant facts are that in the current stage of economic development, an NHI system would only be able to provide a partial package of benefits through the public health care system.

McIntyre (2010) states that if government spending on health care comes from general tax revenue it should be gradually increased to 15%, because it would require an increase in additional income taxes of approximately 1% of taxable income by the second year, increasing to 3,6% in the sixth year and thereafter. The result would be a smaller increase for the lower income earners, but a major increase for higher income earners. High income earners would end up paying a maximum marginal tax rate of about 44 to 45%.

One possibility for an equitable solution that is progressively structured might be a mandatory contribution. The advantage of a mandatory contribution would be the ability to generate a considerable amount of revenue, although this would depend on the size of the formal sector and economic growth. Mandatory contributions could be used as a potential method to generate a significant amount of additional revenue for the NHI in the long term as the necessity for health care grows.

2.5 CONCLUSION

As demonstrated by the above discussion, South Africa does not currently have a fair and equal health system, as only 16% of the population is catered for by private sector health services. The rest of the population relies on the government for health care. It is thus clear that South Africa is in urgent need of an improved health care system.

The proposed NHI could be the long anticipated South African dream to provide good and efficient health care to all its citizens. However, the funding options need to be carefully considered because they will have a significant impact on the individual taxpayer. The poor pay proportionally more VAT, so an increase in the VAT rate to fund the NHI would have a great impact on the poor in South Africa. It is thus clear that the tax burden will have to be heaviest on the higher income category, no matter what funding option will be selected.

In the following chapter an in-depth discussion on the various health care models available for NHI funding will be conducted with reference to countries that have already implemented an NHI system.

CHAPTER 3: INTERNATIONAL HEALTH CARE MODELS

3.1 INTRODUCTION

Countries all over the world use different health care models, customised to the needs of the specific country. The onus is therefore on South Africa to consider which health care model will best benefit all its citizens.

There are currently four major health care models in the world, namely, the Bismarck model, the Beveridge model, the national health insurance model and the out-of-pocket model. In this chapter the four health care models will be discussed as well as the accompanying advantages and challenges of these models.

3.2 BISMARCK MODEL

Fincham (2011) states that, the Prussian Chancellor Otto von Bismarck, who unified Germany in the 19th century, was the founder of the Bismarck model. This model comprises health care structure, health care financing and health care delivery. Today, the model, also called the “sickness fund”, is primarily funded by employer and employee contributions through a payroll deduction. The Bismarck model consists of employer-sponsored health insurance coverage that is a benefit for the employee. Sickness funds are non-profit organisations. Kutzin (2011) emphasises that in terms of the Bismarck model, all workers have a right to health care, which in turn increases productivity. According to Saha (2011), both the health care providers and the payers are private and everyone is covered. Further, within the Bismarck model, medical services and fees are strictly regulated.

Schnackenberg (2011) refers to the Bismarck model as a multi-payer system that consists of three parts, namely:

- *Population.* Every employed person has to contribute depending on their working conditions. Other parties, for example students, pensioners and the unemployed, are also covered by the system. Therefore the Bismarck model complies with the concept of universal coverage.
- *Providers.* There are both public and private sector providers.

- *Contribution collectors*. Defined by Schnackenberg (2011) as “statutory third party payers that have decentralized sovereignty over revenue and work independantly from health care providers”.

Schnackenberg (2011) holds the view that contributions are not health related but rather wage- and community-related per capita premiums or additional income from taxes.

Gottret and Schieber (2006) explain that there are advantages and challenges for every model. The advantages of the Bismarck model are the following:

- Extra funds are gathered from employers.
- Funds are earmarked for health and are isolated from the annual budget.
- The part of the population that is covered supports the system.
- The model is progressive.

On the other hand, the challenges include:

- Only workers in the formal sector are covered.
- If taxes were to be capped they would be less progressive.
- As a result of an increasing payroll contribution, unemployment could rise.
- It is a complex model.
- People may leave the formal sector to avoid payroll taxes.

Other countries that have implemented the Bismarck model are, for example, France, Japan, Switzerland and Belgium.

3.3 BEVERIDGE MODEL

According to Schnackenberg (2011), the Beveridge model of health care funding, also known as the “socialised medicine model”, was established by the British economist William Henry Beveridge, who published a report focusing on social insurance and allied services in 1942. After the Second World War, the Labour government applied the social reforms covered in this report.

Saha (2011) states that, according to this model, the government pays for and provides health care through tax contributions by citizens. Medical services are a public service to all without medical charges. The government controls the cost of medical expenses as it is the only payer (single payer).

In Kutzin's (2011) view, when the Beveridge model is followed, the entire population is covered. It is also noted that the Beveridge model has tended to be implemented by high income countries. The World Bank (2013a) explains that a high income country is defined on the basis of its gross national income (GNI) per capita, with national economies being classified as low income, middle income (subdivided into lower middle and upper middle) or high income.

Gottret and Schieber (2006) state that the advantages of the Beveridge model are the following:

- The whole population is covered.
- Funds can be raised in various ways.
- Revenue is collected progressively.
- Administration of the service is simple and cheap.

By contrast, the challenges of the Beveridge model are:

- Funding depends on available tax revenue as well as political power.
- As the health system is provided by the government, there is no competition between providers, which can affect the quality of services.

Countries that have implemented the Beveridge model include Brazil, Australia, Italy, Spain, Denmark and Ireland.

3.4 NATIONAL HEALTH INSURANCE MODEL

PNHP (2010b) states that the national health insurance model is a combination of the Bismarck and the Beveridge models. In an NHI model, private sector providers are used but funding comes from a government-run insurance programme to which all citizens contribute.

Saha (2011) states that the national insurance model is financed through monthly premiums to pay their creditors. This model has an advantage over the other models in that administration is cheaper and easier. However, citizens are limited to certain medical services and patients need to wait to be treated to control medical costs.

According to Lee *et al.* (2008:109), a national health insurance model is a single-payer insurance system. As a single-payer system, it forms an integrated financing system for collecting and allocating monies. In such systems all citizens have access to health care services.

The advantages and challenges of the national health insurance model as proposed by Gottret and Schieber (2006) are the following:

- Low income groups and informal sector workers are covered.
- Government or donor funding is facilitated to subsidise premiums for the targeted population.
- It complements other financing mechanisms, for example user fees.
- The administration is for all practical purposes more feasible.

The concomitant challenges are:

- The poorest people need to be subsidised.
- The difficulties that community-based health insurance schemes are confronted with prevent them from being effective and sustainable in fulfilling the purpose for which they were established in the first place.
- Financial protection is limited due to a small revenue base and benefit packages.
- The risk pool is low therefore benefits are limited.

Countries that have implemented the national health insurance model include Canada, South Korea and Taiwan.

3.5 OUT-OF-POCKET MODEL

The World Bank (2011) states that, an out-of-pocket (OOP) model is one where patients pay directly for medical care with no reimbursement by insurers or third parties. Accordingly, patients pay user fees for doctor appointments, prescribed medicines or any other expenses that are not included in the health services.

PNHP (2010b) believes that the majority of countries in the world experience poverty and are unable to provide public health services. Consequently, wealthy citizens are able to provide for medical care but the less privileged get sick and die.

According to Saha (2011), in terms of the OOP model, there is no insurance or government plan. For this reason such countries that implement this model are also known as “no-system” countries. According to this model, all medical expenses are for the patient’s own account.

The advantages and challenges of an OOP model, as stated by Gottret and Schieber (2006), are the following:

- The high income sector of the population has financial protection.
- Such patients can choose their own provider.

However, the challenges of the model are:

- No universal coverage.
- The government is not involved.
- There is limited domestic resource mobilisation.

Countries that have an out-of-pocket model include India, China and Cambodia.

3.6 CONCLUSION

The South African government has to be very careful and use good judgement when selecting a health care model. It is important to remember in this regard that all of these health care models have been uniquely customised for the specific country in which they are implemented.

A summarised version of the health care models discussed in this chapter is given in table 3.1:

Table 3.1: Summary of health care models

Model	Public	Private	Mixed public and private	Multi/single payer
Bismarck			X	Multi payer
Beveridge	X			Single payer
National health insurance		X		Single payer
OOP		X		Single payer

Three countries were selected for the comparative analysis, as discussed in section 1.3. The following factors were considered in the selection of the countries used for the comparative analysis:

- unemployment rate
- member of BRICS countries
- well-structured health care system

After giving careful consideration to the above-mentioned factors, the following countries were selected:

- Spain
- Brazil
- Germany

The health care systems of these countries will be discussed in detail in the next three chapters.

CHAPTER 4: NATIONAL HEALTH INSURANCE IN BRAZIL

4.1 INTRODUCTION

South Africa forms part of the BRICS (Brazil, Russia, India, China and South Africa) group of countries. It is therefore relevant to compare Brazil's health care system to the proposed South African national health insurance (NHI) scheme.

The State University – Education Encyclopaedia (2013) states that Brazil is ranked as the fifth most inhabited country in the world and is also one of the most dynamic countries globally due to its significant number of natural and mineral resources. IBGE (2013) states that the average unemployment rate in Brazil for 2012 was 5,5%.

According to Qobo (2010), Jim O'Neill of Goldman Sachs developed the BRIC concept in 2003, by identifying the fastest growing economies with globular middle classes, promising markets and the potential to overtake the G7 (the United States of America, the United Kingdom, France, Italy, Canada, Germany and Japan) as top performing economies by 2040. In December 2010, South Africa was invited to form part of the BRIC nations and consequently the existing BRICS countries were formed (Global Sherpa, 2013).

4.2 AN OVERVIEW OF THE BRAZILIAN HEALTH SYSTEM

In terms of Article 196 of the Brazilian Constitution (1996), health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for health promotion, protection and recovery.

Johnson (2009) explains that the current health system in Brazil was constituted in 1988 and is managed by the government and financed through federal taxes. The WHO (2008) reports that there are approximately 190 million people in the country and that 70% receive care from the health care system, also called the "Sistema Único de Saúde" (SUS).

The Brazilian Ministry of Health (2010) states that the Brazilian population falls into three groups with regard to access to health care:

- Citizens who can afford private health care services.
- Registered workers who have access to public health care secured by social security.
- People with limited rights.

The WHO (2008) refers to the three levels of government that form part of the health system in Brazil, namely:

- federal;
- state and
- Municipal.

The OECD (2012a) confirms that current health spending in Brazil is 9% of GDP. This is, however, lower than the average of 9,5% in OECD countries. In 2010, average health spending per capita in Brazil was USD1 028. This is much lower than the OECD average of USD3 268. Average spending on health care funded by public sources in OECD countries is 72,2%, whereas Brazil's public funding amounts to only 47%. Moreover, the numbers of physicians, nurses and hospital beds are below the norm set by the OECD.

The Council on Foreign Relations (2012) emphasises that most of the BRICS countries struggle with public health matters, including universal coverage, technologies, medicines, diseases and increasing costs.

4.3 HEALTH SYSTEM FINANCING IN BRAZIL

Ernst & Young (2012) states that every citizen who earns an income from a Brazilian source, is subject to a social security tax that is withheld by the employer.

The IGP (2011) highlights the fact that these social security contributions include a number of benefits, namely:

- health care services
- retirement benefits (pension)
- death benefits
- disability benefits
- family allowances.

Joint Learning Network (2013) states that the SUS services include:

- women and child health, hypertension, diabetes, tuberculosis, leprosy, HIV, oral health and health promotion
- disease prevention
- medical specialists
- complex care with highly sophisticated technology and equipment.

The employer's and employee's social security contribution rates are summarised below in tables 4.1 and 4.2.

Table 4.1: Social security contribution rates for employers

Type of worker	%
Total payroll	20
Total payroll – employers in financial sector	22,5
Earnings – work cooperatives	15
Payroll – domestic workers	12
Earnings – rural employees	2,7

Source: Adapted from IGP (2011).

Table 4.2: Social security contribution rates for employees

Earnings (monthly)	%
0–BRL1 107,52	8
BRL1 107,53–BRL1 845,87	9
BRL1 845,88–BRL3 691,74	11

Source: Adapted from IGP (2011).

According to the Brazilian Ministry of Planning, Budget and Management (2012), the allocation towards health is USD48,5 billion. When this is compared to total social security expenditure in the budget of USD191,4 billion, it is evident that approximately 25,3% of the total social security contribution relates to health care. In this dissertation it is assumed that the total contribution for employees and employers could be multiplied by 25,3% to determine an approximate amount that relates to health care.

4.4 ADVANTAGES AND CHALLENGES OF THE SUS IN BRAZIL

4.1.1 Advantages

Binge (2010) concludes that the advantages of the SUS are the following:

- Health care is available to the entire population at no additional cost.
- The health system covers all treatment – from precautionary to more complex treatment.
- The federal, state and municipal services are decentralised and are jointly responsible for funds and health care services.

4.1.2 Challenges

Kay and Matijascic (2010) state that, in Brazil, less than 30% of the population has the finances to pay for private health care and education. While De Moraes and Carrara (2007) explain that the main challenges Brazil faces in terms of its health care system are the following:

- The population is still required to make out-of-pocket payments for prescription medicine and dental care. This is approximately 25% of Brazil's health care costs.
- Unfair treatment is experienced in terms of access to health care between the different social classes in the country and the different regions.
- The health care administration experiences challenges in providing fair universal coverage for all.

4.5 CONCLUSION

Brazil is densely populated with nearly 190 million people in comparison with South Africa which has a total population of 51,8 million. Due to the fact that South Africa forms part of the BRICS countries, which represent the major developing economies in the world, a comparative analysis of the health taxes payable in the two countries is relevant.

However, Brazil is still facing many challenges in its health care system although the necessary infrastructure is in place. Its social security contribution could be a possible funding option for the proposed NHI in South Africa.

CHAPTER 5: NATIONAL HEALTH INSURANCE IN SPAIN

5.1 INTRODUCTION

South Africa is currently one of the countries with the highest unemployment rates in the world. Statistics South Africa (2013) states that the unemployment rate for 2012 was 24,9%. In comparison, the OECD (2012b) confirms that Spain, at 25,1%, has the largest unemployment rate of all the OECD countries. After considering these statistics it is accepted that it could be meaningful to look at a country that is comparable to South Africa in terms of the levels of unemployment.

According to Garcia-Armesto, *et al.* (2010:1), Spain is the third biggest country in Western Europe. The two Canary Islands off West Africa, namely, Ceuta and Melilla and the Balearic Islands in the Mediterranean also form part of Spanish territory. The country consists of 17 independent communities (autonomous regions) and two independent cities in West Africa.

In this chapter an overview will be given of the Spanish health care system.

5.2 AN OVERVIEW OF THE SPANISH HEALTH CARE SYSTEM

In terms of Section 43 of the Spanish Constitution (1978):

- The right to health protection is recognised.
- It is incumbent upon the public authorities to organise and safeguard public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all concerned in this respect.
- The public authorities shall foster health education, physical education and sports. Likewise, they shall encourage the proper use of leisure time.

According to Patxot *et al.* (2012), the current health system in Spain was transformed in 1984 to a Beveridge model health system. Since 2002 every autonomous region has responsibility for the health in its own region.

In an OECD (2013a) report it was reported that there were 46 070 970 people in Spain and 99,2% (OECD, 2011) are covered by the Spanish National Health Service, called “Sistema Nacional de la Salud” (SNS).

In an OECD (2013b) briefing note it was stated that current health spending in Spain is 9,6% of GDP. This is higher than the average of 9,5% in the OECD countries. The average health spending per capita in Spain was USD3 079 in 2009, which is lower than the OECD average of USD3 268. The average spending on health care that was funded by public sources in the OECD countries is 72,2%, whereas Spain’s public funding amounts to 73,6% of total health care expenditure. Physicians, nurses and hospital beds are above the norm set by the OECD.

Peralta (2006) maintains that the Spanish national health system is controlled by the state and autonomous community health departments, which are responsible for all the services and functions that are legally expected from the public authorities.

In a report by the European Union (2011), it was stated that the social security system in Spain consists of two parts:

- The contributory system
 - General scheme: employees not covered by any special scheme, including selected civil servants.
 - Three special schemes: self-employed, coal miners and sea workers.
 - Students are covered by a special protection plan.
- The non-contributory system
 - Citizens with need or with income below the stipulated threshold are entitled to non-contributory benefits, even people who have never contributed to social security before may have access to non-contributory benefits.

The Ministry of Social Security (2013) reveals that pensioners, citizens who receive any other periodic social security benefits, including unemployment benefits, and

people who are currently unemployed and have used all their unemployment benefits are covered by social security.

Angloinfo (2013) states that the social security contribution entitles the contributor to a number of benefits:

- illness
- non work-related injuries
- work-related injuries and occupational illnesses
- retirement
- maternity and paternity leave
- overtime
- unemployment
- the Wage Guarantee Fund
- occupational training.

The Spanish Ministry of Health and Social Policy (2010) and Peralta (2006) are in agreement that the services included in Spanish public health care include:

- precautionary care
- diagnostic and therapeutic techniques
- rehabilitation
- health promotion and maintenance
- child, youth, woman, adult and geriatric care
- mental health
- dental care
- care for the terminally ill
- specialist care
- emergency care
- pharmaceutical services
- orthopaedic and prosthetic care
- nutritional goods
- transport of the sick.

5.3 HEALTH SYSTEM FINANCING IN SPAIN

The European Union (2011) explains that when any person in Spain starts working social security contributions become compulsory.

Garcia-Armesto *et al.* (2010:xxii) state that the SNS provides universal coverage, including immigrants, in the public sector, which is funded by taxes. Citizens under the age of 65 need to contribute 40% out-of-pocket for prescribed medicine. Garcia-Armesto *et al.* (2010:xxiii) continues, indicating that Spanish health expenditure consists of

- 71% from the public sector (from taxes)
- 5,5% private insurance
- 22,4% out-of-pocket payments. Out-of-pocket payments are payable on adult dental care, optical products and prescriptions.

According to the Social Security Administration (2012), the total social security contribution of the employee's wage in Spain is 28,3%, of which employees contribute 4,7% and the employer 23,6%. Minimum monthly earnings are EUR748,20 and maximum earnings are EUR3 262,40. Self-employed workers contribute between 26,5% and 29,8% of their earnings towards the social security system.

The Ministry of Economy and Finance (2011) allocates EUR4 255 million towards health care. When comparing this to the total social security expenses in the budget of EUR183 308 million, it is concluded that approximately 2,3% of the total social security contribution relates to health care. In this dissertation it is assumed that the total contribution to the social security system for employees and employers can be multiplied by 2,3% to determine an approximate amount that could be apportioned to health care.

5.4 ADVANTAGES AND CHALLENGES OF THE SNS IN SPAIN

5.4.1 Advantages

Garcia-Armesto *et al.* (2010:75,248) state that the advantage of the SNS system is that health care is generally accessible to the Spanish population and, consequently, that Spain is at the forefront in all health care statistics, for example fifth in life expectancy at birth.

Angloinfo (2013) confirms that pensioners have free access to health care provided that the necessary documentation is in place.

5.4.2 Challenges

According to Patxot *et al.* (2012), the following challenges relate to the SNS system:

- The recent financial difficulties experienced by Spain have led to a reduction in health care spending, for example staff numbers have been reduced and pharmaceutical costs cut.
- A number of challenges relate to the different income levels and access to health care in different regions.

Garcia-Armesto *et al.* (2010:14, 70) highlight the fact that Spain has one of the highest ageing populations worldwide. Moreover, there have been complaints from discontented patients relating to the long waiting periods for medical treatment.

5.5 CONCLUSION

There is a definite parallel between Spain's and South Africa's unemployment statistics and this provides a basis for comparison. In both countries it is compulsory to register at the revenue services as soon as a person enters the workforce. Unemployed workers in Spain are entitled to health care even if they are not contributing to the social security fund. In Spain, social security, including health care, is funded by payroll taxes and the autonomous communities are responsible for the administration of the health care system. South Africa could consider this social security model.

CHAPTER 6: NATIONAL HEALTH INSURANCE IN GERMANY

6.1 INTRODUCTION

The Bismarck model originated in Germany as discussed in chapter 3. The European Observatory on Health Care Systems (2000) states that Germany was the first country to implement a national social security system. This took place in 1883, more than 130 years ago.

Germany's health care system is well developed and well established; consequently, this will provide South Africa with a good model to consult when developing an NHI system.

6.2 AN OVERVIEW OF THE GERMAN HEALTH SYSTEM

According to Diederichs, *et al.* (2008), a large part of the German population became poor in the 19th century as a result of industrialisation. The pressure on the workforce led to the emergence of the first national health insurance.

The World Bank (2013b) reports that there are approximately 81,8 million people in Germany and, according to Stolpe (2011), approximately 90% of the population receive care from the public health care system, also called social health insurance (SHI).

The OECD (2012c) states that current health spending in Germany is 11,6% of GDP. This is higher than the average of 9,5% in the OECD countries. In 2010 the average health spending per capita in Germany was USD4338, which is higher than the OECD average of USD3268. The average spending on health care that was funded by public sources in the OECD countries is 72,2%, whereas Germany's public funding is 76,8% of the total expenditure on health care. Moreover, physicians, nurses and hospital beds are above the norm set by the OECD.

Klusen (2010) explains that the population contributes to the SHI according to their income received. When employees receive more than the set threshold, they can decide whether they want to contribute towards the SHI or to private health

insurance (PHI). The SHI-insured population has a choice of which providers they want to use.

Reinhardt (2011) states that, as from 2004, when contributing to a payroll tax Germans had a choice of more than 200 public sickness funds. These funds cover the employee and his or her spouse if they are not working. However, the federal government pays for children's sickness funds and pensioners contribute 50% out of pocket towards the sickness fund and the rest is covered by their pension fund. The unemployment insurance fund pays out to unemployed citizens. The OECD (2012b) confirms that the German unemployment rate is 5,5%.

According to Leffmann (2009), the public health care system in Germany is administered by the sixteen federal states, with these states assuming responsibility for financing hospitals and controlling patient ratios.

Green and Irvine (2013) state that the SHI services include:

- precautionary treatment that can prevent cancer or other severe illnesses
- general practitioners
- hospital care
- rehabilitation
- psychological health care
- dental care
- prescribed medicine
- reimbursement for sick leave
- home nursing.

6.3 HEALTH SYSTEM FINANCING IN GERMANY

Fang *et al.* (2012) state, that it is compulsory for all German residents to have a minimum of hospital and out-patient medical treatment insurance. Accordingly, citizens contribute to either the SHI or PHI. Employees that earn less than €50 850 per annum have to belong to the SHI. An employee who earns more than €50 850 or who is self-employed has the option to either contribute to the SHI or take out PHI.

The employer's and employee's health insurance contributions are summarised in table 6.1 below.

Table 6.1: Health insurance contribution rates for employers and employees

Contributor	% of gross wage
Employer	7,3
Employee	8,2

Source: Adapted from Germany Trade & Invest (2012).

The health insurance contribution is limited to €287,44 for employers and €322,87 for employees, as stated by KPMG (2013).

According to the Federal Ministry of Finance (2013), Germany's health care expenditure forms part of the environment, sport and recreation pool. The estimated expenditure of the total federal budget for the health pool is €1 740 000, which is 0,6% of the total budget.

6.4 ADVANTAGES AND CHALLENGES OF THE SHI IN GERMANY

6.4.1 Advantages

According to Klusen (2010) the advantages of the SHI are the following:

- Most of the population is covered.
- Medical services are of outstanding quality and very accessible.
- Control of costs has been partially successful.

Reinhardt (2011) states that the government has effective controls in place at both the state and the federal level.

6.4.2 Challenges

Stolpe (2011) states that the increase in life expectancy of the German population is a challenge but it can be positively applied for future public and health investments. Klusen (2010) meanwhile explains that the constant update of the SHI regulations has led to more competition with PHI. In the end, increased numbers of PHI users will result in less SHI income.

Leffmann (2009) highlights the fact that improvements in health care technologies and cost increases in treatment and pharmaceuticals are a challenge for Germany's health care system.

6.5 CONCLUSION

Germany is a First World country with well-established health infrastructure. The number of citizens who are contributors to the SHI and who are not obliged to be members to the state health system is a very good indicator of a functional and successful public health system.

The German public health system model could be considered as a good example of how to structure a health system that would be suitable for all South African citizens, taking into consideration South Africa's specific challenges. Furthermore, the financing method used by the public health system in Germany comprises payroll taxes. Therefore, as administration seems to be working well in the German system, it might be beneficial for South Africa to consider this payroll tax method for funding the NHI.

CHAPTER 7: COMPARATIVE ANALYSIS OF THE DIFFERENT HEALTH SYSTEM CONTRIBUTION OPTIONS OF THE THREE SELECTED COUNTRIES

7.1 INTRODUCTION

The objective of this study is to draw a comparison between the different options for health care contributions in a practical situation to evaluate the implications thereof for the individual South African taxpayer. A comparative analysis of the health contributions of Brazil, Spain and Germany will be done to achieve the objective as stated in section 1.4 (p.4). In conclusion, a comparison of the three selected countries, as discussed in chapters 4 to 6, will be given in table 7.1, where after the findings will be applied in a comparative analysis of the individual South African taxpayer.

7.2 RESEARCH METHODOLOGY

In section 1.6 reference was made to the research methods used in this study, namely, a literature review and a comparative analysis of the contributions of the different health systems in the selected countries. These methods are discussed below.

7.2.1 Literature review

The purpose of the literature review was to present the way in which the different health systems in South Africa, Brazil, Spain and Germany operate. The information gathered in the previous chapters is summarised in table 7.1 below in section 7.3.

7.2.2 Comparative analysis

The summarised information relating to the advantages and challenges of the health care systems of Brazil, Spain and Germany in section 7.3 is applied to South Africa in section 7.4.

7.3 SUMMARY OF THE HEALTH SYSTEM CONTRIBUTIONS OF THE SELECTED COUNTRIES

In chapters 4 to 6, the health systems and the sources for financing the health systems in Brazil, Spain and Germany were discussed. The data collected on the three countries is summarised in the following table.

Table 7.1: Summary of the health care systems of South Africa, Brazil, Spain and Germany

	South Africa	Brazil	Spain	Germany
Name of health system	NHI – not yet in place	SUS (section 4.2)	SNS (section 5.2)	SHI (section 6.2)
Population	51,8 million (section 2.3)	190 million (section 4.2)	46 million (section 5.2)	81,8 million (section 5.2)
% making use of public health care	84% (section 2.3)	70% (section 4.2)	99,2% (section 5.2)	90% (section 5.2)
Health spending as % of GDP	8,3% (section 2.3)	9% (section 4.2)	9,6% (section 5.2)	11,6% (section 5.2)
Spending per capita	N/A	USD1 028 (section 4.2)	USD3 079 (section 5.2)	USD 4 338 (section 5.2)
Public health funding	N/A	47% (section 4.2)	73,6% (section 5.2)	76,8% (section 5.2)
Unemployment	24,9% (section 5.1)	4,6% (section 4.1)	25,1% (section 5.1)	5,5% (section 6.2)
Contribution per employer	N/A	(2,7 to 22.5%) x 25,3% (section 4.3)	(23,6%) x 2,3% (section 5.3)	7,3% (section 6.3)
Contribution per employee	N/A	(8 to 11%) x 25,3% (section 4.3)	(4,7%) x 2,3% (section 5.3)	8,2% (section 6.3)
Services rendered by public health system	N/A	<ul style="list-style-type: none"> • Women and child health, hypertension, diabetes, tuberculosis, 	<ul style="list-style-type: none"> • Precautionary care • Diagnostic and therapeutic techniques • Rehabilitation 	<ul style="list-style-type: none"> • Precautious treatment that can prevent cancer or other severe illnesses.

		<p>leprosy, HIV, oral health and health promotion</p> <ul style="list-style-type: none"> • Disease prevention • Medical specialists • Complex care with highly sophisticated technology and equipment (section 4.3) 	<ul style="list-style-type: none"> • Health promotion and maintenance • Child, youth, woman, adult and old age people care. • Dental health • Mental care • Care for the terminally ill • Specialist care • Emergency care • Pharmaceutical services • Orthopaedic and prosthetic care • Nutritional goods • Transport of the sick (section 5.2) 	<ul style="list-style-type: none"> • General practitioners • Hospital care • Rehabilitation • Psychological health care • Dental care • Prescribed medicine • Reimbursement for sick leave • Home nursing (section 6.2)
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7.4 COMPARATIVE ANALYSIS

In order to conduct a comparative analysis of the various countries' health system options, the following advantages and challenges have been applied to South Africa.

7.4.1 Applying the advantages and challenges of the Brazilian health care system to the proposed South African NHI

7.4.1.1 Advantages of the Brazilian health system

As indicated in chapter 4, the advantages of the Brazilian health system are the following:

- Health care is available to the entire population at no additional cost.
- The health system covers all treatment – from precautionary to more complex.
- The federal, state and municipal services are decentralised and are jointly responsible for funds and health care services.

To apply these advantages to the proposed NHI in South Africa it is important to consider the current situation in South Africa:

- Currently more than 84% of the South African population depends on public health; however, the public health services are not of a high standard.
- Various public health services are rendered to South Africans, but their lack of availability and long waiting lists can make it difficult.
- South Africa has national government, provincial and municipal structures in place that are at present responsible for different aspects of health. Currently, funds that are distributed are misused; consequently controls need to be in place to channel these funds to the right places and the particular needs so as to ultimately provide the best health care.

7.4.1.2 Challenges of the Brazilian health system

In chapter 4 the challenges in the Brazilian health system were stated as follows:

- Less than 30% of the population have the finances to pay for private health care and education.
- The population is still required to make out-of-pocket payments for prescription medicine and dental care. This forms approximately 25% of Brazil's health care costs.
- Unfair treatment with regard to social classes, different regions and access to health care in the country.
- Administration experiences challenges in terms of equity and universal coverage for all.

Precautions should be taken not to repeat the challenges of Brazil in the proposed NHI in South Africa. It is important to look at the current situation in South Africa:

- Only 16% of the population can afford private health care, which increases the burden on public health care considerably.
- Currently South Africans also pay out-of-pocket payments which put a strain on the poor.
- There is unfair medical treatment in South Africa, especially in the rural areas as there is limited access to health care.
- Currently, health administration in South Africa is challenging and it is mismanaged.

7.4.2 Applying the advantages and challenges of the Spanish health care system to the proposed South African NHI

7.4.2.1 Advantages of the Spanish health system

In chapter 5 the advantages in the Spanish health system were recorded as follows:

- Health care is generally accessible to the Spanish population and Spain is at the forefront in all health care statistics, for example fifth in terms of life expectancy at birth.
- Pensioners have free access to health care provided that the necessary documentation is in place.

To apply these advantages to the proposed NHI in South Africa it is important to consider the current situation in South Africa:

- South Africa does not have good health statistics, especially with regard to the high HIV/AIDS rate and tuberculosis. Health care services are not up to standard.
- Most of the pensioners in South Africa depend on public health care; this places a great burden on the public health care sector.

7.4.2.2 Challenges of the Spanish health system

In chapter 5 the challenges in the Spanish health system were indicated as being the following:

- The recent financial difficulties in Spain have led to a reduction in health care spending, for example personnel have been reduced and pharmaceutical costs cut.
- There are a few challenges resulting from the different income levels and health access in different regions.
- Spain has one of the highest ageing populations worldwide. Another challenge is discontented patients complaining about long waiting periods for medical treatment.

Precautions should be taken not to repeat the challenges in Spain in the proposed NHI in South Africa. It is important to consider the current situation in South Africa:

- South Africa is also in a very difficult financial position; currently there is not enough staff to serve the public health sector.

- Only a small percentage of the population earns more than the annual threshold, which means only a few contribute to taxes in South Africa.
- South Africa currently does not have very high life expectancy and the poor health conditions do not improve these figures.

7.4.3 Applying the advantages and challenges of the German health care system to the proposed South African NHI

7.4.3.1 Advantages of the German health system

In chapter 6 the advantages in the German health system were recorded as being the following:

- Most of the population is covered.
- Medical services are of outstanding quality and very accessible.
- Costs have been to a large extent controlled.
- The government has good controls in place at both state and federal level.

To apply these advantages to the proposed NHI in South Africa it is important to consider the current situation in South Africa:

- If the majority of the population is to be covered by the NHI, it is essential that the best funding option is chosen. In Germany payroll taxes are used to fund the system. However, the unemployment rate in Germany is 5,5%, compared with 24,9% in South Africa. Thus only a small percentage of the South African population earns more than the annual threshold, which implies that the NHI will be funded by comparatively few individuals.
- Currently, public hospitals in South Africa are not up to standard. For the NHI to be successful, hospitals and medical facilities will have to be upgraded.
- Corruption is a big problem in South Africa; therefore funds need to be controlled properly.
- The nine provinces in South Africa can be used to administer the NHI; the government needs to have effective systems in place to be able to render services.

7.4.3.2 Challenges of the German health system

In chapter 6 the challenges experienced by the German health system were listed as:

- The increase in the life expectancy of the German population is a challenge but it can be positively applied for future public and health investments.
- The constant update of regulations on the SHI leads to more competition with the PHI. More PHI users will result in less SHI income.
- The improvement in health care technologies and the cost increases in treatment and pharmaceuticals are a challenge for Germany's health care system.

Precautions should be taken not to repeat the challenges in Germany when implementing the proposed NHI in South Africa. It is important to consider the current situation in South Africa:

- In South Africa life expectancy is currently low; this could be improved by the NHI.
- Currently, only 16% of the South African population belongs to a private medical scheme. The competition between the public health system and the private sector will most likely not put the NHI at risk at this stage.
- For the NHI to be effective, price controls need to be in place.

CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

8.1 INTRODUCTION

In conclusion, with reference to the problem statement in section 1.2, the question can now be asked, what are the alternative methods for financing the NHI and how will these methods affect the taxpayer? For the purpose of this research, three countries were used to investigate a possible funding option for the South African NHI.

The main objective in section 1.4 of this study was stated as to compare the preliminary NHI in South Africa with the NHI in Brazil, Spain and Germany, especially considering the effect funding options will have on the individual taxpayer and to make suggestions on how the South African government can implement the NHI.

In chapter 7 a summary of the literature review in chapters 4 to 6 was given in table 7.1, where after the advantages and challenges of the different countries were applied to South Africa.

In this chapter a conclusion will be given and a number of recommendations will be made with regard to financing options for the NHI in South Africa.

8.2 CONCLUSION

The research conducted for this study, which had the intention of identifying a possible NHI option for South Africa, investigated three countries: Brazil, Spain and Germany, as well as four international health care models, namely: the Bismarck, the Beveridge, the national health insurance and the out-of-pocket models.

Accordingly, the three funding options for the NHI in South Africa are proposed as being an increase in VAT, payroll taxes, tax surcharges or a combination of the these three methods.

The only possible financing method that would involve every citizen in South Africa in making contributions to the NHI would be by increasing the VAT percentage,

because everyone in South Africa pays VAT, but only a small percentage of the population pays personal income tax. Accordingly, the infrastructure for levying and collecting VAT is already in place and thus an increase in the VAT percentage as a contribution for the NHI would be a definite possibility, without having to incur any substantial additional costs for the levying and collection thereof. However, critics of this proposed financing option are of the opinion that an increase in VAT could have a significant negative impact on the poor in South Africa.

A structure for the levying and collection of employee tax through the Pay-As-You-Earn (PAYE) system is also well established in South Africa; therefore to implement an additional payroll tax to collect a contribution for the NHI could easily be done. The main criticism to this financing option, however, is the ratio between those who contribute through PAYE and those who do not, as it is only a small percentage of South African residents that does actually pay tax through this system and, therefore, if this proposed financing option is indeed selected, it would impact negatively on these contributors only, as they would be responsible for contributing to the benefit of all citizens.

Payroll taxes, in the form of Unemployment Insurance Fund (UIF) contributions, have an impact on the employer as well as on the employee. As mentioned earlier, UIF raises about R12,184 billion a year through the levy of a 1% contribution from the employer's payroll as well as 1% from the employee's salary. If the same marginal rate of 1% per employer and 1% per employee were to be applied to collect NHI contributions, the R10,4 billion per year needed for financing the NHI could be raised using the same collection method.

The South African Revenue Service (SARS) has a effective system in place for collecting revenue from individual taxpayers. Therefore, a tax surcharge would be a possibility as a financing option for the NHI, but as with the payroll tax option, only a few citizens pay taxes in South Africa, which means tax surcharges would only have an impact on the taxpaying citizens, who are already the only contributors to national revenue.

The three countries discussed in chapters 4 to 6 use payroll taxes to fund their health system. Accordingly, it would seem that a universal health care system

should be reasonable and fair. However, would an additional payroll tax be fair in South Africa, bearing in mind that only a small percentage of the total population would fund the NHI even though all would benefit?

A combination of an increase in VAT and the application of payroll taxes could be a possible answer to this imbalance between taxpayer and non-taxpayer.

In spite of a number of challenges, Brazil, Spain and Germany have managed to provide adequate primary health care for all their people. On paper, the NHI model in combination with the three other models seems to be the long-awaited solution to the problem of better health care for all the citizens of South Africa.

However, the grim reality is that the South African government, and in particular the Department of Health, is unable to deliver proper health care services. The existing state hospitals and clinic facilities are in very poor condition and are equipped with just the bare necessities.

Moreover, as a result of corruption and incompetence, accounts are not settled on time; medical equipment is not regularly serviced; critically ill patients are dying on hospital floors because of a lack of available beds; bed linen and blankets do not exist in stock registers; patients have to take their own bedding when they are admitted to a state hospital; and medicine and syringes are stolen or unavailable when urgently needed.

This is only the tip of the iceberg. The current collapse of the health system must be addressed before any NHI model can be chosen. Moreover, the upgrading of buildings and equipment will cost millions of rands. Currently, there are more questions than answers for the proposed NHI, for example:

- Will the current medical aid contributors be able to pay their monthly contributions with the proposed NHI funding option, for example payroll taxes?
- What would happen with the additional R10,4 billion budget for the NHI if the existing budget were misused?
- Who will control the distribution of these funds?

- How will the government finance the repairs to medical facilities?

The answers of the above questions will only be answered through trial and error and, ultimately learning from, for example, the mistakes made by the three countries mentioned in this study.

My personal view is that if the government of South Africa plans carefully and controls the funds, the NHI could be rolled out in due course. However, if the vast gap between taxpayer and non-taxpayer is not bridged with the proper financing option it will come at a great cost to the taxpayer.

On the basis of the comparative analysis conducted in chapter 7, the following recommendations are made for the implementation of the NHI system in South Africa.

8.3 RECOMMENDATIONS

- The public health services in South Africa need a complete overhaul in order to make the NHI a success.
- Corruption must be rooted out and the culprits brought to justice.
- Health services should be more readily available and waiting times should be decreased at hospitals and clinics to implement a more sufficient system.
- The funds for the NHI have to be used carefully and a very strict system of controls needs to be implemented to ensure that the funds are spent wisely.
- Out-of-pocket payments should be reduced, especially for the poor.
- Improvements to medical services in rural areas are of the utmost importance in order to give equal access to health for all citizens.
- The administration of the NHI has to be properly managed to provide the greatest benefits for the new system, especially in terms of the maintenance of equipment and control of medicine.
- Pensioners should be treated with extra care; this could improve their life expectancy.
- More properly trained medical personnel should be employed.

- The proper funding of the NHI should be carefully considered as only a small percentage of the population earn more than the annual threshold in South Africa.
- The current infrastructure of the nine provinces together with that of municipalities in South Africa could be put to good use to administer the NHI; effective systems must be in place for the rendering of proper services of a high quality and standard.
- Price regulation needs to be in place to restrict overspending on fees.
- The government should put a plan in place to reduce the high unemployment rate. The purpose of this is to reduce other citizens' contributions to the NHI.

This study has contributed to a better understanding of the information available on the NHI. The research contributed to more in-depth knowledge of the NHI, and is an indication to taxpayers of the impact that the different financing options for the NHI will have on them. Furthermore, the research highlighted those aspects which should be focused on when the NHI is implemented.

The findings of this study could be extended through further research on the following aspects:

- Impact on the employer when a health payroll tax is implemented.
- The impact of an increase in VAT on the individual as well as on the private sector.
- An analysis of the impact on the individual when contributing to private and public health funds.

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