Assessing the redistributive potential of the South African health system

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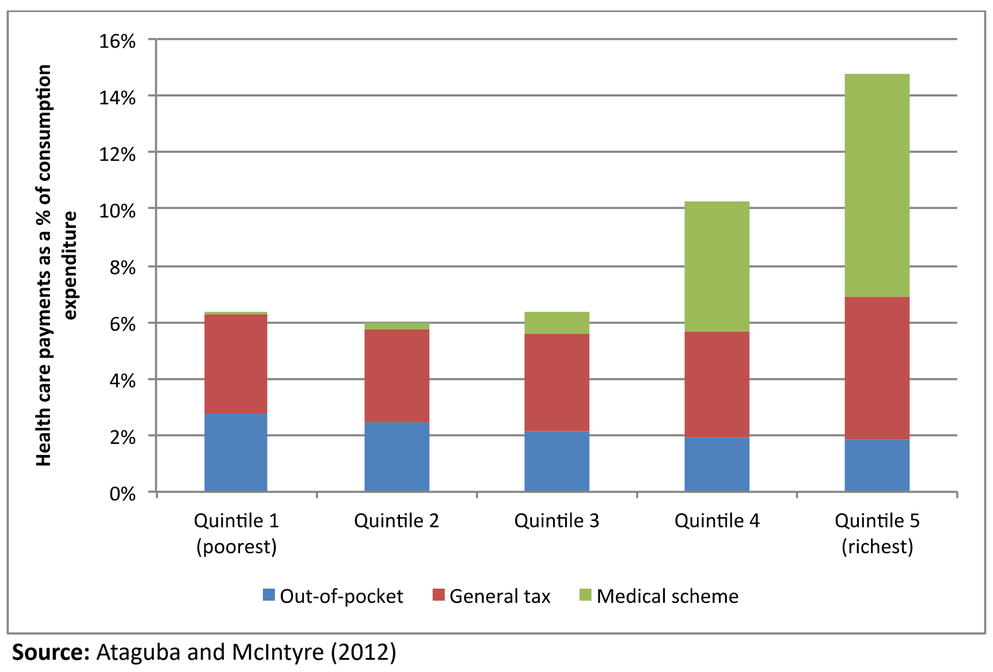
Introduction

- The policy context of this research is the proposed introduction of a National Health Insurance (NHI) system in South Africa. The NHI is in line with global efforts to move towards Universal Health Coverage (UHC), which means:
  - providing financial protection from the costs of using health services for all people,
  - enabling them to obtain the health services that they need,
  - where the services should be of sufficient quality to be effective.
- Although termed a National Health *Insurance*, the intention is that it will be tax funded.
- From a poverty and inequality (P&I) perspective, this research is of importance as the health system can contribute to redistribution, both in terms of who pays how much for funding health services and who uses and benefits from health services.
- The research assesses:
  - Changes in income redistribution associated with financing health services over time;
  - Inequality in unmet health care needs

Main research findings

- Previous research (see Figure 1) has shown that:
  - Out-of-pocket payments for health services are regressive (i.e. the poor pay a higher % of their income than the rich)
  - General tax revenue allocated to the health sector is progressive (although indirect taxes are regressive)
  - Medical scheme contributions are strongly progressive across the overall population, but are regressive across scheme members (richer scheme members pay a smaller % of their income in scheme contributions than less rich members)

Figure 1: Health care payments as % of expenditure (2005/06)



Source: Ataguba and McIntyre (2012)

- Research as part of the SARChI P&I explored changes between 2005/06 and 2010/11 and found that:
  - There has *not* been a statistically significant change in income redistribution from overall health care financing since 2005/06
  - However, indirect taxes have become more regressive over time and funding of health services through the indirect tax component of general tax revenue has contributed significantly to widening of income inequality since 2005/06
  - In contrast, medical scheme contributions have become more progressive, suggesting that medical scheme membership (16% of the population) has become even more concentrated among richer groups

Findings - continued

- Another aspect of this research explored inequalities in health care financing between and within different groups in 2010/11 (see Table 1) and found that:
  - Increases or decreases in income distribution inequalities caused by each health care payment mechanism within race and gender groups and within urban and rural areas is the dominant effect compared to changes in distribution between groups or areas
  - Consistently, out-of-pocket payments and indirect taxes have a negative redistribution effect (i.e. increase inequalities) while the direct taxes, medical scheme contributions and overall health financing has a positive redistribution effect (i.e. reduces inequalities)
  - However, the positive redistribution effect of overall health financing is not statistically significant

Table 1: Major drivers of inequality for each category of group and financing mechanism

Financing mechanism	'Race' group	Gender (Household head)	Urban/rural
Out-of-pocket payments	Inequality ***increased*** within groups by this form of payment	Inequality ***increased*** both between & within groups	Inequality ***increased*** within urban & rural areas
Direct taxes	Inequality ***reduced*** within groups by this form of payment	Inequality ***reduced*** within groups by this form of payment	Inequality ***reduced*** within areas by this form of payment
Indirect taxes	Inequality ***increased*** both between & within groups	Inequality ***increased*** both between & within groups	Inequality ***increased*** both between & within areas
Medical schemes	Inequality ***reduced*** within groups	Inequality ***reduced*** within groups	Inequality ***reduced*** within areas
Overall health care financing	Inequality ***reduced*** within groups; particularly driven by inequality impact within African group	Inequality ***reduced*** within groups; particularly driven by inequality impact within female headed households (except for schemes)	Inequality ***reduced*** within areas; particularly driven by inequality impact within rural areas

- The analysis of inequality in unmet need is yet to be completed
- However, previous research has shown that use of health services in South Africa is not in line with need for health care, suggesting that unmet need is concentrated amongst the poorest

Policy implications of findings

- Even though overall health care financing has a small positive redistributive impact at present, the full redistributive potential of the health system is not yet being realised
- In terms of current NHI debates, the key implications are:
  - Increases in indirect taxes such as VAT should be avoided as a means to fund the NHI; instead the emphasis should be placed on direct taxes if the NHI is to contribute not only to promoting equitable access to health care but also to income redistribution
  - The future role of medical schemes requires careful consideration. Although scheme contributions have positive redistributive impacts from a financing perspective, only scheme members (16% of the population) benefit from these resources, contributing to large inequalities in benefits from using health services

References

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