Exploring the different financing models for Universal Health Coverage in different countries: Lessons for South Africa

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Abstract

Introduction

Several countries have implemented various financing models to establish universal healthcare coverage (UHC). These financing models are established to ensure population coverage and financial protection, as recommended by the WHO (2020). The systems range from national health insurance (NHI), social health insurance (SHI), and voluntary health insurance (VHI). South Africa has recently introduced the NHI Act 2024, as a single-payer model, which has raised concerns as to whether the country will be able to finance such a system.

Purpose

This study examines the various models used in countries with established UHC systems. It examines the United Kingdom, Canada, Australia, and Ghana, to draw lessons for South Africa. The research explores taxation structures, mandatory contributions, and cost-sharing mechanisms as potential sources of revenue.

Method

The study uses a qualitative research design, examining empirical evidence of healthcare funding.

Results

The findings suggest that most countries incorporate incremental reforms, rather than fundamental ones. Whereby a combination of financing approaches is employed, there isn't one that is most preferred. Financing approaches include different contributing and financing mechanisms through incorporating progressive taxation, hypothecated taxes, and premiums. These may provide sustainable sources of revenue for funding the NHI in South Africa. Additionally, the research highlights the importance of incremental reforms, financial

protection mechanisms for certain groups of people, and ways to include the informal sector in health financing.

Conclusion

South Africa has an opportunity to adopt an approach that promotes equity, access, and financial protection for all by looking at adopting some of these funding models but carefully adjusting them to fit the country in an incremental manner.

Keywords

Healthcare funding, mandatory contributions, national health insurance (NHI), universal health coverage (UHC)

CHAPTER ONE

1. Introduction

1.1 Overview

The goal for universal health coverage (UHC) is to ensure that all people in a country obtain access to health care without suffering financial hardship (WHO, 2020). Several countries have considered health care reforms that will support UHC (Gabani, Mazumdar, & Suhrcke, 2023). These reforms may entail national health insurance (NHI), social health insurance (SHI) or voluntary health insurance (VHI), (WHO, 2024). The Global Health 2035 agenda proposed two progressive methods to achieving UHC, first, that the cover is universal, and secondly, that the minimum coverage is standardised across socioeconomic groups (Fenny, Yates, & Thompson, 2021). Furthermore, the World Health Report 2010 refers to UHC as all people having access to healthcare, pooling large funds for health, and alleviating financial burden (Michel, et al., 2020). South Africa is one of the countries that have recently implemented a health reform towards UHC (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022). In an attempt to close the gap in healthcare and to move closer to Universal Health Coverage (UHC), the government of South Africa has introduced the National Health Insurance (NHI) (Department of Health, 2024).

1.2 Background of Study

South Africa uses a dual health system, including both public and private health system (Rensburg, 2021). The public health system caters for all South Africans, and the private healthcare system caters to the portion of the population that is covered by a private medical scheme and out-of-pocket (OOP), (Delobelle, 2013). The majority of the population, which comprises eighty-six percent, depends on public health provided by the state, and a minority, sixteen percent, use private healthcare provided by private healthcare providers (Department of Health booklet, 2022). The disparities are a reflection of the unequal socio-economic levels in the country, and the quality of public healthcare (White Paper, 2015). This National Health Insurance will cover every South African, employed or unemployed, with low income or high income (Department of Health, 2024). The NHI is a model that is a single purchaser and single payer of healthcare services (Department of Health, 2024). The implementation of the NHI has caused concerns amongst many stakeholders, particularly around how South Africa will

afford or finance the NHI. Discovery Health's perspective on the NHI bill is that the funding remains constrained due to macro-economic conditions and other fiscal pressures on the government (Discovery, 2024). Several studies have pointed to the fact that NHI might be too expensive for South Africa at this time (Heever, 2010; Christmals & Aidam, 2020; Columbia Mailman School of Public Health, 2023).

Section 27 of the Constitution of South Africa provides every citizen with the right to healthcare (Department of Health, 2024). Regardless of having free services, income earners elect to pay out-of-pocket expenses to access day-to-day medical services (Heever, 2010). Even though eighty percent of the population makes use of public facilities, the majority of the resources are in private healthcare, servicing the sixteen percent (Department of Health booklet, 2022). Private health spending is about 57%, of which 44% is medical aid schemes and 13% is out-of-pocket (Heever, 2010). This author argues that patients on medical aid schemes regularly have to pay out-of-pocket or co-payments, pointing to how costly private healthcare can be.

Health funding is the function of the health system concerned with mobilising and allocating funds to meet people's health requirements, both individually and collectively, within a healthcare system. Some African countries have implemented government budgets, social health insurance (SHI), volunteer health insurance, and other direct payments (Fenny, Yates, & Thompson, 2021).

1.3 Motivation for the study

Research Problems

In the White Paper (2015), the cost of the NHI was initially estimated to reach 256 billion rands by 2025/2026, using 2010 prices. These projections have since changed and are estimated to be above 400 billion rands (Michel, et al., 2020). It is difficult to get the real numbers as the NHI is still in the future, and prices and demand for healthcare fluctuate regularly (White Paper, 2015). South Africa has a dual healthcare system with disproportionate share of healthcare funding, and therefore, access remains unequal. However, there are a few countries that have made great strides in implementing similar health systems and reforms, which would be beneficial to study and draw lessons from. Therefore, this research shall

investigate the different funding models used in other countries that have adopted UHC and draw lessons for South Africa in funding and implementing UHC.

1.4 Research Objectives

1. Assess how South Africa is planning to fund the NHI;
2. Assess what other health funding methods are used in countries that have adopted the NHI/UHC, and
3. Evaluate what other factors may influence the ability of a country to successfully adopt the NHI/UHC.

1.5 Significance of Study

Achieving UHC requires mobilising resources, providing quality care, and providing accessible health care to all (Fenny, Yates, & Thompson, 2021). UHC exists in a number of countries; however, some countries do not have a single-payer model (Delobelle, 2013). South Africa's NHI is a single-payer model (Department of Health, 2015). Countries like the Canada, Ghana, and Australia have adopted and made strides towards implementing UHC. The NHI has been studied and criticised; however, there are a limited number of studies that have reviewed how other countries are able to fund the UHC reforms implemented. An even fewer number have examined how South Africa can draw lessons on how these policies have been implemented and financed. This research aims to contribute to the debate on financing a healthcare system that is promising UHC. Being able to learn from other countries will enable the implementation of the NHI in South Africa for better planning and how better pooling of funds without causing financial distress is achieved.

1.6 Limitations for the study

The study did not attempt to examine an exhaustive list of countries that have a form of UHC and other health systems, because that was not the aim of the study. The objective of this study is to extract insights from the selected countries that may contribute to the formulation and implementation of (UHC) in South Africa. Consequently, the scope of the study was confined to an analysis of the healthcare financing models employed in these countries. This research does not seek to establish definitive conclusions regarding specific aspects of healthcare financing.

Below are the definitions of keywords that will be used throughout the study.

Definition of terms

Universal Health Cover (UHC): a state where "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care" (WHO, 2024).

National Health Insurance (NHI) is a healthcare system that is funded by means of general taxation (Asmal, Bhorat, Lochmann, Martin, & Shah, 2024).

Social Health Insurance (SHI) is a system funded by earmarked premiums mainly from people employed in the formal sector (van der Zee & Kroneman, 2007). Social health insurance is a system in which people contribute to a health fund that provides them with certain healthcare benefits, which are often created by the government. Contributions are made up of employee deductions and employer contributions.

Mandatory health contributions: usually collected as a levy on earnings from employment, from the employer and employee contributing

Out-of-Pocket payments: contributions paid at the point of receiving healthcare, e.g., co-payments

CHAPTER TWO

2. LITERATURE REVIEW

2.1 Introduction

Several nations have implemented various modifications of the Beveridge and Bismarck health insurance models (Christmals & Aidam, 2020). The Beveridge insurance model is a tax-funded system, and the Bismarck is a SHI system (Kutzin, Ibraimova, Jakab, & O'Dougherty, 2009). In the United Kingdom the National Health service (NHS) was created by the Act of 1946 based on the recommendations of the Beveridge report (Musgrove, 2000). It is one of the first health insurance systems that introduced publicly funded healthcare. Conversely, social health insurance is a system where individuals pay premiums to access healthcare benefits. However, Social health insurance is said to work best in low-income countries because coverage can span from the formal sector to the entire population (Kutzin, Ibraimova, Jakab, & O'Dougherty, 2009). The critics have argued that this model increases the disparities in access and financial protection, especially in countries with a sizeable informal sector (Gabani, Mazumdar, & Suhrcke, 2023).

2.2 Assess how South Africa is planning to fund the NHI

The NHI white paper proposes that the NHI be funded using direct tax revenue, indirect tax, payroll taxation, and premiums (White Paper, 2015). Direct tax revenue refers to mandatory taxes imposed on individuals or companies in proportion to their income, e.g., personal taxes and corporate taxes (White Paper, 2015). Indirect taxes refer to taxes levied on consumption like value-added tax, fuel levies, tobacco levies etc. Payroll taxation is tax levied on employment, the unemployment insurance fund (UIF), and worker's compensation assistance (WCA) (White Paper, 2015). Premiums will be collected from employees or individuals that earn gross income above R700 000 per annum. Other methods of raising potential revenue include a surcharge on taxable income and using the medical scheme tax credit that the government contributes as a subsidy towards medical schemes for government workers (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022).

In 2013, healthcare funding accounted for 11% of taxpayer revenue (Delobelle, 2013). Kutzin, Ibraimova, Jakab and O'Dougherty (2009) argue that in a low-income setting where there is a sizeable informal sector, payroll taxes do not pool a significant amount of money. Additionally, payroll taxes increase the cost of employment and have adverse effects on employment creation (Department of health, 2015). Increasing taxes would cause an affordability problem for South Africans, especially the low-income earners. Higher taxes are unlikely improve services, even though they would affect the affordability of health services (Discovery, 2024). Macroeconomics show that the taxable income of taxpayers accounts for about 33% of the GDP (OECD, 2024).

The administration cost of the NHI is estimated at 2.5–2.8% of the total health expenditure (THE). In South Korea, the administration budget amounts to about 4% of the total health budget. In a similar vehicle in South Africa, the South African Social Security Agency (SASSA) and Government Employees Medical Scheme (GEMS), the administration costs are about 6% each individually (Heever, 2010).

This shows that South Africa would need to be very careful in how it will use tax to raise funds for the NHI in order to not strain the taxpayers.

2.3 Assess what other health funding methods are used in countries that have adopted the NHI/UHC

Fenny, Yates, and Thompson (2021) argue that contributory revenue and tax revenue are the two main models to pool health funds. These methods differ from country to country in how the funds are collected. Governments usually charge user fees or subscription fees to raise additional funds and limit demand (Fenny, Yates, & Thompson, 2021). Middle-income countries such as Taiwan, Mexico, Thailand, Vietnam, and Colombia have implemented UHC swiftly and with great innovation (Heever, 2010).

On the other hand, the cross-subsidisation system works well in countries that have a sizeable formal sector, such as Germany and the Netherlands. Additionally, higher-income countries, such as Germany, that use SHI took over 100 years to achieve through an incremental and transformational manner (Fenny, Yates, & Thompson, 2021).

The current trend in many African countries is to adopt a combination of different approaches for health funding. The combinations include sources such as government tax funding through government budgets, SHI or VHI and other direct payments (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022).

Ghana uses a combination of sources to generate revenue for health. These sources include a portion of VAT and Social Security and National Insurance Trust (SSNIT), contributions from employees that work in the formal sector, and other sources (Christmals & Aidam, 2020). The scheme covers 95% of the burden of disease. It covers in- and out-patient services, maternity, eyecare, and oral health. Similarly to South Africa, certified healthcare providers are contracted by the scheme; they provide the services and then bill the scheme for the work done (Christmals & Aidam, 2020).

Mexico utilises sugar tax from soft drinks to raise additional funds for healthcare (Fenny, Yates, & Thompson, 2021). Australia introduced a surcharge tax in 1990's called the Medicare levy surcharge when they introduced UHC to be supplementary revenue towards healthcare (Ludlow, Fooken, Rose, & Tang, 2024). It's a levy that individuals with an income above a certain threshold and who are also without private health insurance are charged.

Ghana includes insurance premiums, payroll taxes, and earmarked value-added tax (VAT), which is about 72% of the funding (Christmals & Aidam, 2020). Countries like Japan, Colombia, and Chile spend 6.5%, 4.9%, and 4.1% of the GDP, respectively. However, more industrialised countries spend higher percentages of their GDP (WHO, 2024).

2.4 Evaluate what other factors may influence the ability of a country to successfully adopt the NHI/UHC

There are many factors that influence healthcare expenditure and the adoption of UHC (Papanicolas, Mossialos, Gundersen, Woskie, & Jha, 2019). Factors such as epidemiological trends, population, technological advancements, and economies of scale impact healthcare purchasing and funding. Fenny, Yates, and Thompson (2021) found that Ghana struggled the most with imposing mandatory contributions for their NHIS due to the fact that the mandatory contributions are regressive and favour the rich. It resulted in 33% of its members being non-payers and total membership dropping by 23%.

2.5 Analytical framework

2.5.1 Theoretical framework

The Health Policy Analysis Framework provides a structured approach to evaluating funding models for South Africa's National Health Insurance (NHI) (Jones, Gautier, & Ridde, 2021). The framework looks at policy goals (implementation and impact), problem statement, background, landscape, options and recommendations. The policy goals of the NHI include achieving (UHC) by ensuring equitable access to healthcare services, regardless of income level. The problem statement centers on the financial sustainability of the NHI, identifying challenges such as limited public sector funding, high out-of-pocket expenditures, and economic constraints. The background considers South Africa's existing healthcare financing system, which is characterized by a dual health system with significant disparities between public and private healthcare. The landscape analysis examines international case studies and the contextual factors influencing healthcare financing, including economic conditions, political will, and stakeholder interests. Various options for NHI funding, such as general taxation, payroll taxes, or social health insurance, must be assessed based on feasibility and equity. Finally, the recommendations will provide evidence-based lessons on the funding mechanisms that align with South Africa's economic and healthcare landscape while ensuring financial sustainability for the NHI.

On the other hand, from a systems theory perspective, successful policy implementation is contingent upon the effective coordination and functioning of interconnected subsystems, including financial resources, institutional actors, and implementation mechanisms. The procurement of ongoing funding acts as a vital input into the policy system, increasing the probability of effective and sustainable implementation (Cheung, Mirzaei, & Leeder, 2010). Without consistent financial support, the implementation subsystem may be unable to transform policy goals into tangible outcomes, thereby weakening the system's overall performance. Furthermore**,** a frequent disjunction exists between policy designers and implementers**,** with policy authors typically not involved in the operational aspects of implementation (Cheung, Mirzaei, & Leeder, 2010). This disconnect disrupts the flow of information and weakens alignment between policy formulation and execution. Systems theory emphasizes the importance of feedback loops and communication channels within

and across subsystems to ensure adaptability and responsiveness (Frederickson, Smith, Larimer, & Licari, 2012). For this reason, policy formulation should include early consultation with implementation actors and mechanisms for feedback to refine and recalibrate actions during execution. When treated as an integrated system, where resources, actors, and processes are aligned and continuously evaluated, policy implementation is more likely to achieve its intended objectives (Frederickson, Smith, Larimer, & Licari, 2012).

The literature review explored contextual, economic and factors such as epidemiological trends, population dynamics and funding mechanisms. It is essential to empirically assess how these factors exist in different contexts using research methodology to systematically analyse the financing models of selected countries and their applicability to South Africa's NHI.

CHAPTER THREE

3.1 RESEARCH METHODOLOGY

3.1.2 Research Design

The study used a qualitative research design. Aspects of the level of coverage, services covered under UHC, and the pooling mechanism were studied. Articles from Google scholar, Science Direct, and PubMed that cover the terms of UHC, NHI, and health financing. The OECD website was used to access statistics and figures on the 3 OECD countries (UK, Canada, Australia) and some information on the two non-OECD countries (SA, Ghana). The review was supplemented using grey literature mainly sourced from the official Department of Health websites, Department of Health White Paper, and the WHO website. The grey literature was used to supplement the reviews on areas of medical scheme finance reports and economists that have studied universal health coverage financing.

3.1.3 Data Collection Methods

The study used secondary data collection from published reports, governmental statistics, and previous research studies. For comparison purposes, data from 2020 to present were used to compare statistical points.

3.1.4 Sampling Technique

The study used a purposeful sampling method where five specific countries—the United Kingdom (UK), Canada, Australia, South Africa, and Ghana—were reviewed. Of the five countries, three of those countries are OECD countries (UK, Canada, Australia), and two of these countries are non-OECD countries (South Africa and Ghana). The three OECD countries are high-income countries; the UK has one of the oldest UHC policies, and the OECD countries generally have widely available, high-quality, credible data that can be reviewed. Ghana was studied because it is one of the first African countries to propose a UHC policy. Even though UHC has not been achieved, it makes a good case study on their progress thus far. Ghana is also a LMIC like South Africa, which will be comparable.

3.1.5 Data Analysis

The study used a content analysis approach to analyse the healthcare financing policies of the selected countries (South Africa, the United Kingdom, Canada, Australia, and Ghana). A content analysis employs systematic, rule-based methods to examine the informational substance of textual material. (Forman & Damschroder, 2008). Metrix studied include policy on health acts, health spending as a percentage of GDP, revenue sources, tax revenue, and insurance coverage rate

3.1.6 Possible limitations and challenges

The challenges of the study are accessing data and the quality of the data from the different countries. The heterogeneity of the healthcare system as healthcare systems varies widely, and so do their funding approaches.

3.1.7 Ethical Considerations

The study ensured integrity and responsible reporting of data. This was done by ensuring that data was sourced from credible sources such as WHO, OECD, governmental reports, and peer-reviewed journals. The data was represented objectively to avoid misrepresentation.

CHAPTER 4

4.1 DATA ANALYSIS AND INTERPRETATION OF RESULTS

Three OECD countries are considered in this research paper, namely United Kingdom (UK), Canada, and Australia. Two African countries that are classified as low-middle-income countries (LMIC) were also considered: South Africa and Ghana. The selected OECD countries have a long history of universal systems that can be studied. The UK has one of the oldest Universal Health Coverage (UHC) systems called the NHS. It was adopted in 1948, following the Beveridge report. Canada and Australia each have a healthcare plan that is administered by Medicare; additionally, the countries also have a good presence of the private sector embedded in their healthcare system. Ghana is one of the first African countries to pass a universal cover policy in 2003; however, coverage of the entire population is yet to be attained (Fenny, Yates, & Thompson, 2021). South Africa has recently adopted the NHI, and this therefore is the main subject of this paper.

The NHS, being one of the oldest UHC systems, provides near-comprehensive healthcare to all UK residents; it is predominantly free of charge at the point of use (Charlesworth, et al., 2021). It is a government-funded health system through general taxation, accounting for 86% of the healthcare revenue and 11% funded through national insurance contributions. Patient charges account for 1% through prescription charges and dental fees (Charlesworth, et al., 2021). National insurance contributions are paid by employers and employees; between 3% and 10.2% are contributed depending on the income (Harker, 2012) . However, about 15% of the population is covered by private insurance as a duplicate cover to fast-track some services provided by the NHS (Papanicolas, Mossialos, Gundersen, Woskie, & Jha, 2019).

Canada has a publicly administered healthcare system through Medicare. It offers comprehensive coverage conditions and is portable across provinces. It is publicly funded and covers the entire population, therefore universal (Justice Laws Website, 2024). However, about 67% of the population in Canada has private supplementary coverage, which covers all the other health services not covered by UHC, such as vision and dental care, outpatient prescription drugs, rehabilitation services, and private hospital rooms (Justice Laws Website, 2024).

In Australia, public healthcare is administered by Medicare, which is a tax-funded public health insurance that provides full coverage for public hospitals and full sometimes partial coverage for outpatient services (Ludlow, Fooken, Rose, & Tang, 2024). Services outside of public hospitals are charged; however, a subsidy funded by Medicare applies. Therefore, private healthcare is covered by the patient as out-of-pocket or by private health insurance minus the subsidy by Medicare. Medicare provides limited coverage or no coverage for dental, optical, and physiotherapy, and therefore private health insurance or OOP covers such services. About 40% of adults are covered for private healthcare by a private health insurance (Ludlow, Fooken, Rose, & Tang, 2024). This coverage is sometimes supplementary or even duplicate cover for some healthcare services covered by Medicare.

South Africa has both a public and private-funded healthcare system. Public healthcare services account for 86% of the population and private health services for 16% of the population (Department of Health, 2024). Public healthcare is free for the entire population; however, private healthcare is accessible to those that are paying for private healthcare coverage. Therefore, the individuals covered by private healthcare have duplicate cover for the services that are accessible in public health and supplementary cover for the services that are not covered by the public healthcare system (OECD, 2015).

Ghana established the NHIS following the NHA 2003 to provide structure in the provision of universal healthcare coverage in the country (Christmals & Aidam, 2020). Even though the NHIS has increased access to health, access is far from universal, as a pre-payment is required before accessing healthcare and therefore offers complementary coverage to those covered. About 60% of the population was covered under the NHIS in 2017 (Christmals & Aidam, 2020).

Country	Year adopted	Health Act	Type of coverage
UK	National Health Service Act 1946; National Health Service Act 2006	The Act provided for the establishment of a comprehensive health service for the UK that was free at the point of use and universally available to all.	Duplicate

Canada	Canada Health Act 1984	"The main objective of healthcare policy in Canada is to facilitate reasonable, continued access to quality healthcare to all Canadians, regardless of income or geographic location, by establishing criteria and conditions in respect of insured health services and extended health care services." (http://laws-lois.justice.gc.ca)	Supplementary
Australia	National Health Act 1956	An Act related to the supply of pharmaceutical, sickness, and hospital benefits, as well as medical and dental services.	Supplementary/duplicate
South Africa	National Health Act 2003; National Health insurance Act 2024	To provide a framework for the country's health system. The act ensures a uniform health system across the country while taking into account the rights of individuals and the responsibilities of local, provincial, and national governments.	Duplicate/ supplementary
Ghana	National Health Act 2003	which established the Ghana National Health Insurance Scheme (NHIS), providing a	Complementary

		framework for universal health insurance access to basic healthcare services for all Ghanaian residents through a system of subsidised premiums managed by the National Health Insurance Authority (NHIA)	

Assess how South Africa is planning to fund the NHI

According to WHO, health financing is one of the six building blocks for a successful healthcare system (WHO, 2007). WHO further indicates that the costs associated with the implementation of UHC reforms are influenced by many factors, including design elements and the pace of implementation (WHO , 2015). Since the inception of the NHI, there has been no structured funding strategy; the White Paper (2015) remains the sole official document proposing a funding mechanism for the NHI. Consequently, the following information is derived from the White Paper (2015).

Table 1 below illustrates the projection of the cost of NHI, which has been revised from the Green Paper. In this projection, the NHI expenditure for 2025/26 is projected to be R256 billion using 2010 prices. This projection would take the average annual percent increase from about 4% to 6.2% by 2025/26. However, these projections have changed over time, and the NHI financing requirements remain uncertain. It is therefore more important to focus on how to pool revenue and how to structure fiscal resources to support the NHI.

Mobilising fiscal resources will require major changes to the tax structure. The potential sources of revenue for the NHI are direct taxation, indirect tax, payroll tax, and premiums. Direct taxation is taxes charged on individuals or entities according to level of income or earnings, e.g., personal tax or corporate income tax. Indirect taxes are levied on transactions of goods and services, e.g., VAT, alcohol, and tobacco. A payroll tax is charged on payroll as either employer or employee contributions, e.g., contributions for NHI. Lastly, premiums are

mandatory payments or premiums from employee or informal sector, e.g., NHI mandatory contributions.

The plan is to completely eradicate out-of-pocket (OOP) fees. Without regard to the fact that this will result in a deficit because the revenue that was generated from out-of-pocket fees will have been eradicated. OOP accounts for 6% of the total health revenue (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022). Thus, other avenues to replace the revenue need to be employed. The NHI Bill proposes the mobilisation of extra revenue through mandatory payments from those that are eligible. It is further looking at scenarios of increasing VAT and imposing a surcharge tax on taxable income and the introduction of a payroll tax (Department of health, 2015).

Consideration has been given on the hypothecation of tax charged on tobacco and alcohol towards health care. Lastly, consideration has been given to using carbon tax as revenue towards healthcare.

All the scenarios described above are possible ways of raising ways to pool funds for the NHI. There is no concrete or finalised way in which revenue will be raised.

Table 1: Projection of NHI costs adapted from Green Paper

		Average annual per cent increase	Cost Projection R m (2010 prices)
Baseline public health budget:	**2010/11**		**109 769**
Projected NHI expenditure:	2015/16	4.1%	134 324
	2020/21	6.7%	185 370
	2025/26	6.7%	**255 815**
Funding shortfall in 2025/26 if baseline increases by:		2.0%	108 080
		3.5%	71 914
		5.0%	27 613

Source: National Treasury projection (2012)

Assess what other health funding methods are used in countries that have adopted the NHI/UHC

The health expenditure from general taxation in the UK has increased over the years from 3.5% of GDP in 1949 to 8.2% in 2010/11 (Harker, 2012). Although there has been a steady increase over the years, it has accelerated in the recent years (Harker, 2012). Figure 1 shows that in 2022, the UK's expenditure was spending 11.1% of GDP towards healthcare, which is

above the OECD average (OECD, 2022). Similarly, Canada and Australia spent 11.2% and 9.8%, respectively, in 2022, which are above the OECD average (OECD, 2022).
South Africa and Ghana spent 8.5% (OECD, 2022) and 1.4% (Unicef, 2022) respectively, which is below the OECD average. However, South Africa spent above the LMIC average (2.3%) and Ghana below the LMIC average.

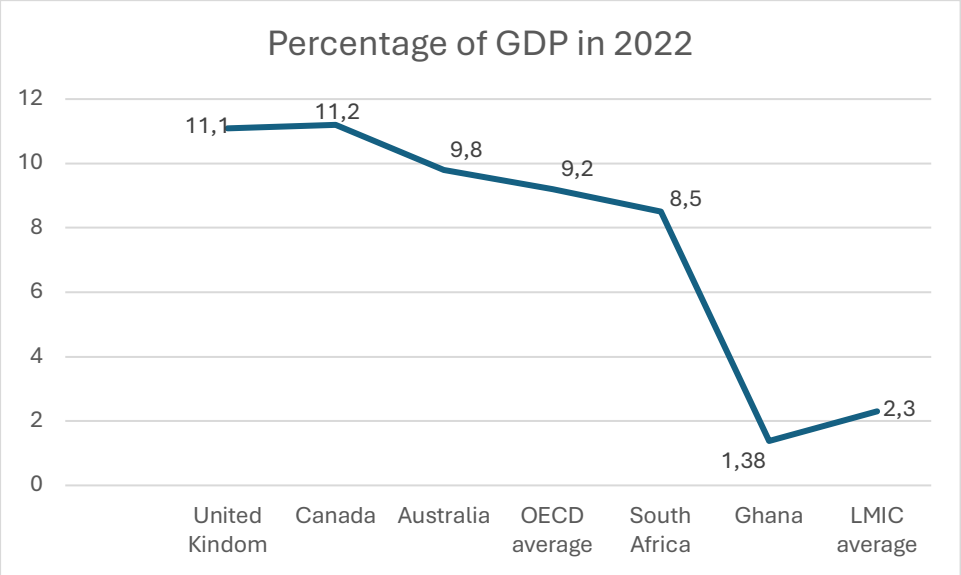

Figure 1: % of GDP for healthcare in each country. This graph illustrates the level of spending per country as a percentage of GDP. It also illustrates the OECD average and LMIC average as comparative points for the countries represented.

Contributing mechanisms

This section probes into the contributing mechanisms that were used in the five countries to pool revenue for healthcare. Figure 2 below illustrates the tax structures of each country for 2022, highlighting the various types of taxes employed and their respective contributions as a percentage of total tax revenue.

The United Kingdom (UK)

In the United Kingdom, personal income tax accounted for 29% of total tax revenue; VAT contributed 21%; corporate tax represented 9%; non-VAT tax included 10%; and social contributions made up 20% (OECD, 2024). VAT and personal income tax were the two primary tax revenues. A system of taxable income brackets governs personal income tax; the tax rate

varies according to the tax bracket that the income is in (Charlesworth et al., 2021). The marginal tax rate for personal income is set progressively, with 20% being the lowest and 45% being the highest.

VAT is charged at three rates: 0%, 5%, and 20% (PWC, 2017). The standard VAT rate is 20%, with some goods zero-rated or charged at a reduced rate of 5%.

Auxiliary funding for the NHS budget comes from national insurance contributions. Employers, workers, and independent contractors are required to contribute this from their earnings. The NHS spends 18% of its budget on national insurance (Chang, Peysakhovich, Wang, & Zhu, 2024). The UK does not generate any revenue from payroll taxes (OECD, 2024).

Canada

The general tax revenue generated by personal income tax was 36%. Figure 2 depicts other taxes, including as employment-based health insurance, Canada Pension Plan payments, and provincial sales tax (PST) collected by provinces, the rate of which varies by province. The Goods and Services Tax (GST) contributed 13% of overall tax income (OECD, 2024). Some provinces combine the GST and PST into one harmonised sales tax (HST) of 15% (OECD, 2024). Some goods and services are zero-rated and consequently not subject to GST. Some provinces levy an earmarked tax or "premium" to complement health-care income (Kinyua, 2009).

Other significant taxes collected include non-VAT/GST charges on goods and services, excise duties, and fuel fees, which account for 9% (OECD, 2024). Payroll taxes totalled 2%, property taxes 10%, and business capital taxes 14% (OECD, 2024). Healthcare contributions produced 14%, a large contribution (OECD, 2024). Out-of-pocket expenses remained 15% of overall health expenditure (Gabani, Mazumdar, & Suhrcke, 2023).

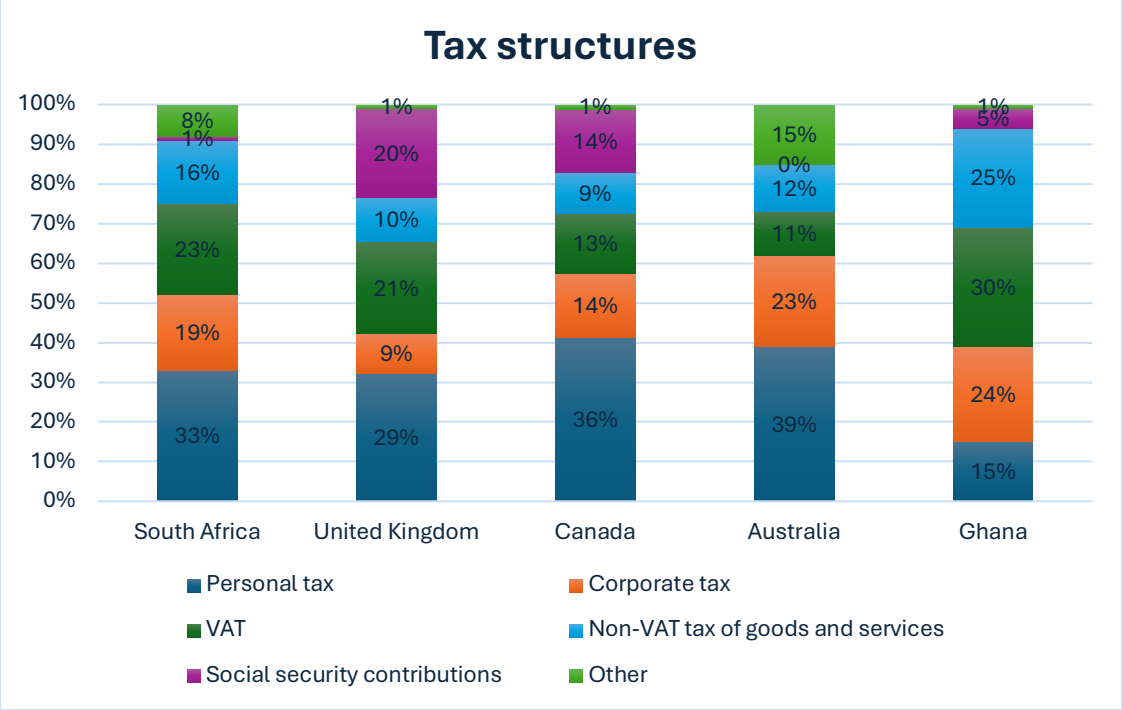

Figure 2: Tax structures for the countries. This figure illustrates different taxes and their contributions to total tax revenue in 2022.

Australia

Australia generated much higher tax revenue from personal income tax (39%), corporate tax 23% and other tax (15%). Australia generated the lowest revenue from VAT in terms of percentage of total revenue, 11%. The country did not generate any revenue from social security contributions.

South Africa

The highest share of tax revenue in South Africa in 2022 was contributed by personal income tax (33%). The second highest was derived from VAT (23%). The lowest share came from social contributions at (1%). South Africa generated non-tax revenue of 0.7% of GDP (OECD, 2024).

Ghana

Out of the 5 countries, Ghana generates the highest percentage of its revenue from VAT (30%) and non-VAT tax on goods & services (25%). The lowest percentage of revenue is generated from personal income tax compared to the other countries. Funds for NHIS are generated through five sources, which include 2.5% of the 17% Value-Added Tax (VAT), 2.5% of the 17% Social Security and National Insurance Trust (SSNIT), formal sector employees, dividends of investments by NHIA, and premiums from subscribers (Christmals & Aidam, 2020). Earmarked

premiums for NHIS are charged to individuals, these premiums are uniform, the rich and the poor pay the same amount to access the scheme.

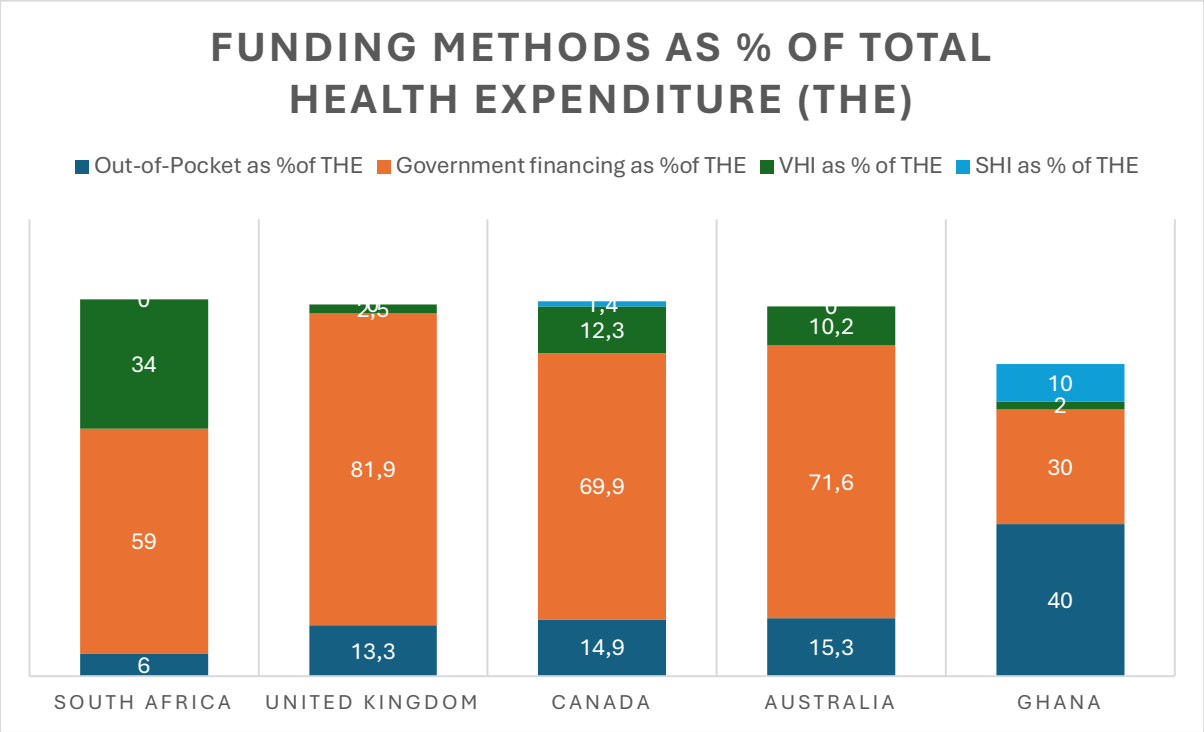

Figure 3: The different healthcare funding methods as a percentage of the total health expenditure

Figure 3 above illustrates that the United Kingdom, Canada, and Australia rely predominantly on government financing, contributing 81.9%, 69.9%, and 71.6% of THE, respectively. In contrast, South Africa and Ghana show a more diversified funding structure, with South Africa's government financing accounting for 59% of THE and Ghana's for only 30%. Notably, out-of-pocket payments form a significant share in Ghana (40%), whereas it remain below 15% in the other countries. Voluntary health insurance (VHI) plays a notable role in South Africa (34%) and Canada (12.3%) but is minimal in Ghana (2%). Additionally, SHI is prominent only in Ghana (10%) and Canada (1.4%), indicating different financing approaches among these nations

Evaluate what other factors may influence the ability of a country to successfully adopt the NHI/UHC

In the majority of the countries, the state of the wider economy plays an important role in determining the approaches of health financing (Cylus, et al., 2018). Factors like the GDP growth of the country influence how much can be spent on health care. A number of countries have had slow GDP growth post-COVID, and therefore so did the percentage of GDP spent on health care (Office for National Statistics, 2023). For instance, the UK health expenditure decreased from 12.4 in 2021 to 11.3 in 2022 because the economy was not growing fast enough (Office for National Statistics, 2023).

Concerns for sustainability of ways of funding over short-term pooling of funds play a greater role in financing decisions (Cylus, et al., 2018). Ensuring that the ability to generate stable and sufficient funds is achievable, especially when there is a broad tax base.

The study found that the influence of social, economic, and political factors plays a wide role in shaping the health reforms. Without strong government commitment to prioritise health care to make it the main goal of national policy, UHC is unlikely to succeed. Good governance and transparency in the allocation of resources, strong regulatory frameworks, and accountability help build trust and social solidarity (WHO, 2023).

The existing health system and infrastructure play a pivotal role in a country's ability to adopt UHC (WHO, 2023). WHO (2023) emphasizes that investing in health infrastructure is essential for achieving UHC, as it improves service delivery and creates public trust in the healthcare system. In countries like Canada, Australia, and the UK that already had a relatively strong health system with adequate physical infrastructure, hospitals, and healthcare providers, it is more feasible to expand coverage to the wider population. It is also easier to foster an integration of the public and private sector (WHO, 2023).

CHAPTER 5

5.1 DISCUSSION OF FINDINGS

The UK, Canada, and Australia are high-income countries and therefore have made greater strides in implementing universal health systems. As defined by WHO, UHC must cover the majority of the population and offer financial protection. Low- and middle-income countries are considering healthcare reforms to accelerate the goal towards Universal Health coverage (Gabani, Mazumdar, & Suhrcke, 2023). Ghana has a UHC policy; however, universal coverage and financial protection are yet to be achieved, with more and more people being covered by the NHIS. Financial protection for the poor has not been achieved because pre-payments are required prior to access to healthcare. Furthermore, the premiums are not charged in a progressive manner; the low-income earners and high-income earners are charged the same premium. South Africa's proposed NHI has been assented to by the president; however, changes in legislation, funding mechanisms, and purchasing of health care are yet to change to reflect UHC.

The study has found that the high-income countries offer voluntary health insurance as either duplicate cover or supplementary cover to either accelerate access or expand to healthcare services that are covered or not covered by the state. In the UK, about 15% of the population is covered by private health insurance as duplicate cover. In Australia, about 40% of the adults are covered by private health insurance as a supplementary cover. Canada has the highest number of the population (67%) covered by private health insurance as complementary cover. Canada and Australia have a number of services that are not covered by Medicare, and therefore a high percentage of the population needs private health insurance to cover those services. Services that are excluded under UHC, such as vision, dental care, outpatient prescription drugs, rehabilitation services, and private hospital rooms, are covered by complementary cover.

5.1.1 Incremental vs. Fundamental

This paper has found that more incremental changes to health financing arrangements are more common than fundamental reforms (Cylus, et al., 2018). The UK, being one of the earliest UHS, has evolved over time to improve coverage and financing reforms (Cylus, et al., 2018). The level of GDP expenditure has been progressive over time, and the cost-sharing

arrangements have evolved with time. For instance, prescription and dental charges were initially part of the NHS in England, Northern Ireland, Scotland, and Wales, then they got abolished in all four countries only to be reinstated again in England (Maynard, 1986; Harker, 2012; Chang, Peysakhovich, Wang, & Zhu, 2024). The user charges are a mechanism to limit demand and as a source of revenue, even though they do not contribute very significant revenue (0.5% of NHS budget) (Harker, 2012). The health expenditure increased over the years from 3.5% of GDP in 1949 to 8.2% in 2010/11 and 11.1% in 2022 (Harker, 2012).

Healthcare expenditure has gone from being centrally administered in the UK to regional and local district authorities overseeing some aspects of the budget (Maynard, 1986). This has allowed the country to have an efficient administration that utilizes only 5% of the total health budget (Cylus, et al., 2018).

It is therefore evident that many incremental changes will happen as a country progresses towards UHC. Consequently, changes in the pooling mechanism of the funds that will be used for UHC become important.

5.1.2 Pooling mechanism

There is no high-income country that has private healthcare spending as the predominant financing mechanism for health care services (Charlesworth, et al., 2021). Government schemes account for a majority of the health spending in these countries, and it usually accounts for less in LMICs (WHO, 2024). As a consequence, OOP, which is an inherently inequitable form of health funding that links people's access to healthcare to their capability to pay, becomes the predominant form of funding (WHO, 2024). OOP does not offer financial protection to the poor and is a regressive form of funding healthcare (Cylus, et al., 2018). However, even though South Africa is a low-middle-income country, the predominant financing mechanism is government funding, accounting for 59% (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022). The level of OOP payments is 6%, which is the lowest out of all the countries. Ghana, on the other hand, has a much higher OOP share as the percentage of the total health expenditure (40%) (Gabani, Mazumdar, & Suhrcke, 2023) which is similar to other LMICs (WHO, 2024). Even though UHC policy and the NHIS are forms of SHI, the predominant form of funding is still OOP.

What is noteworthy is that South Africa does not embody the characteristics of universal health care coverage as defined by WHO because of the lack of financial protection for the population. Healthcare in South Africa is not free at the point of care, both in government and in private. There are out-of-pocket fees charged, both in the public sector and private sector (Department of Health, 2024). Voluntary health insurance is the highest in South Africa percentage-wise, accounting for 35% of the total health expenditure (Mametja, Semenya , Letshweni , Hattingh , & Moloabi , 2022). This indicates how fragmented the healthcare system is and how expenditure is biased towards private healthcare. South Africa spends 8.1% of the GDP towards healthcare; however, 4.2% is towards private healthcare (Department of Health, 2024).

The three main sources of tax revenue in SA are personal income tax (33%), value-added tax (23%), and corporate income tax (19%) (OECD, 2024). This is similar to the tax structure in the UK and Canada, which are high-income countries despite South Africa having a narrow tax base. A narrow tax base requires higher tax rates, while a relatively broad tax base requires lower tax rates to generate the same amount of tax revenue (Department of health, 2015). Additionally, personal and corporate income taxes are a more stable source of tax, which guarantees South Africa a more stable source of revenue to fund health. Ghana generates more revenue from VAT (30%), non-VAT tax on goods and services (25%), and corporate tax (24%). VAT and non-VAT tax on goods and services are less stable sources of revenue that depend on the buying power of consumers.

South Africa is considering a funding mix that includes increasing VAT, imposing a surcharge tax on taxable income, and an introduction of a payroll tax (Department of health, 2015). The are five different permutations of how these forms of taxation would be combined and deployed (Department of health, 2015). The increment on these taxes will be done at a rate between 0% and 4% in their different combinations.

Introducing a payroll tax will increase the cost of employment in the formal sector. It also does not look at how to pool revenue from the informal sector and very wealthy individuals who do not necessarily get salaries, inherited wealth and investments. Similarly to surcharge taxes, they will increase the overall tax on employees from the formal sector and reduce disposable income.

The increment on VAT affects both the formally employed and informally employed and the unemployment. However, it affects low-income earners the most, as it is a more regressive form of taxation. South Africa charges VAT lower than the international average of 16.4% (Department of health, 2015). Therefore, there is arguably some room to increase VAT.

There is also a notion of introducing mandatory NHI contributions that will be deducted from the salaries according to a sliding scale (Department of health, 2015). With the higher income earners having a higher premium and the low-income earners with a lower premium (Department of health, 2015). This is to create cross-subsidisation between the low- and high-income earners. The revenue generated from these contributions will be used towards revenue for health care and will form part of the NHI pool of funds to purchase health (Department of health, 2015). In Ghana, the NHIS contributions are equal for everyone (poor and rich); there is no cross-subsidisation and financial protection for the poor (Christmals & Aidam, 2020). In the UK, national insurance contributions are charged at 3-10% from the employee and/or employer depending on income, allowing for cross-subsidisation (Charlesworth, et al., 2021). There are certain exemptions made for mandatory health insurance contributions; for instance, children, pregnant women, and the elderly (above 70 years) are exempt in Ghana from paying NHIS contributions.

An important factor to consider that has not been accounted for in the NHI White Paper (2015) is that South Africa has a bigger informal sector, with about 7.5 million people participating in the informal sector (Asmal, Bhorat, Lochmann, Martin, & Shah, 2024). The informal sector contributes around 5.1% of South Africa's GDP (Masuku & Nzewi, 2021). This could be a significant contribution that needs to be considered as a source of revenue for healthcare.

The case for expanding taxation within the informal economy is supported by both revenue and equity considerations. One key argument is that, while taxing small informal firms may generate limited revenue initially, it integrates them into the tax system early on laying the foundation for improved compliance as these businesses grow and formalize over time (Makochekanwa, 2020).

The question of how may be answered by the introduction of presumptive taxation. One of the most widely adopted approaches to extending direct and indirect taxation to informal sector firms, typically at a diminished rate, is the implementation of presumptive taxation

(Dube & Casale, 2016). Presumptive taxes are not based on actual reported income, but rather on estimated or assumed income levels**,** using simplified criteria. This method is particularly useful in contexts where firms operate outside formal accounting systems and accurate income data is difficult to obtain (Dube & Casale, 2016). A common example is the taxation of public transport operators, such as minibus or taxi owners, who pay a fixed quarterly amount based on non- financial indicators like the carrying capacity of their vehicles**.** The vehicle income tax in Ghana is a notable example of this approach, where tax liabilities are calculated using proxies rather than verified income, enabling the state to widen its tax net while minimizing administrative burdens (Jansen & Calitz, 2017). South Africa has a large taxi industry, which could potentially contribute to the tax base using presumptive taxation (Etim & Daramola, 2020).

Furthermore, on taxation as a source of revenue, the White Paper 2015 considers the hypothecation of tax levied on tobacco and alcohol for healthcare funding (Department of health, 2015). This is because tobacco and alcohol consumption directly impact healthcare in one way or the other. This kind of taxation is to raise revenue while discouraging unhealthy behaviours (Cylus, et al., 2018). Many studies have been conducted on tax hypothecation, and a few countries have considered it (Cylus, et al., 2018). Ghana uses a form of soft hypothecation where 2.5% of the 17% VAT and 2.5% of the SSNIT from formal sector employees is “earmarked” for funding healthcare (Christmals & Aidam, 2020). The argument against hypothecation is that it may limit the budget when tax collected from the goods is not continuously increasing and therefore may result in instability in revenue streams (Cylus, et al., 2018).

5.1.3 Cost-sharing measures

Many countries internationally, such as the UK and Australia have looked at cost-sharing measures in health in the form of user charges. These user fees are for raising revenues and to reduce excess demand (Cylus, et al., 2018). They are usually a small amount that is charged for specific services, e.g., the NHS in England charges prescription fees and dental charges (Chang, Peysakhovich, Wang, & Zhu, 2024). User fees are sometimes not preferred because they may deter some patients, especially those with low income, from seeking necessary healthcare (Cylus, et al., 2018). User fees also contribute only a small percentage of the total

revenue; for instance, they contribute 1% of the total NHS funds (Charlesworth, et al., 2021). The main challenge with user fees is how they are likely to impact different socioeconomic groups. However, systems of exemptions to provide financial protection can be introduced, e.g., children, the elderly, and those with low income. In Australia, those who are chronically ill are exempt from paying user fees (Gabani, Mazumdar, & Suhrcke, 2023).

5.2 LESSONS AND RECOMMENDATIONS FOR SOUTH AFRICA

South Africa already uses a progressive income tax system where the people pay according to their tax bracket. South Africa also gets the majority of its general revenue from direct taxation, which is a stable source of revenue. This is similar to how the UK, Canada, and Australia are funding their UHC systems. Therefore, the recommendation from this paper is that South Africa continue to apply a progressive income tax without any increases in the tax tables. This is to avoid putting added pressure on the taxpayers. However, South Africa can consider prioritising health by increasing the percentage of GDP dedicated to health expenditure. The increase can be incremental rather than fundamental and aims to achieve around 9.2% of GDP by 2026—to the level of the OECD average. This will continue to increase incrementally as there is increased demand for the NHI. This will allow South Africa to dedicate more revenue towards health to ensure that the NHI is supported by adequate health expenditure.

This paper did not find sufficient evidence for the introduction of payroll taxes and surcharge taxes when looking at the countries that were studied. Payroll taxes only generated 2% of revenue in Canada; however, none of the other countries generated much revenue from payroll taxes. Payroll taxes and surcharge taxes increase the cost of employment and put additional pressure on taxpayers.

VAT is the second biggest source of revenue in South Africa and the UK, and it is the biggest source of revenue in Ghana. Ghana and the UK charge a much higher VAT than South Africa; in fact, South Africa charges a lower VAT than the international average (16.4%). Therefore, VAT in South Africa also has the potential to be increased gradually and can generate an additional source of revenue for the NHI. VAT is unfortunately a more regressive form of

taxation where the low-income earners are most affected and therefore might be a challenge to impose increases.

While VAT is often criticised for its regressive nature, several features within its design and application can mitigate its impact on lower-income households. Firstly, VAT systems apply zero- rating or exemptions on basic goods and services such as staple foods, healthcare, and education (Makochekanwa, 2020). This policy design significantly reduces the effective VAT burden on poorer households, who allocate a larger share of their consumption to these necessities. Secondly, although low- income households may pay a higher proportion of their income in VAT, wealthier households typically spend far more in absolute terms, particularly on discretionary and luxury goods, and consequently contribute more total VAT revenue (Jansen & Calitz, 2017). To address this imbalance, tax systems often adopt a multi-rate VAT structure (Jansen & Calitz, 2017)**.** While zero-rating or reduced rates on essential goods provide some relief to poorer households, the introduction of a higher VAT rate or excise taxes on luxury items enhances equity without distorting the VAT's function as a broad-based, efficient revenue generator.

Excise taxes on luxury goods**,** predominantly consumed by higher-income groups, play a vital role in offsetting the regressiveness of VAT. These taxes act as a redistributive mechanism**,** signalling a policy intent to ensure that those who can afford to pay more do so without compromising the neutrality and efficiency of the VAT system (Jansen & Calitz, 2017).

Furthermore, VAT is a broad-based, efficient, and relatively hard-to-evade tax due to its multi-stage collection process, ensuring compliance across the formal economy (Makochekanwa, 2020). This makes VAT a reliable revenue source, especially in countries with large informal sectors. Crucially, the revenues generated from VAT can be used to finance redistributive public spending, such as social grants, healthcare, and education subsidies. In this way, VAT can support equity indirectly, as the progressivity of government expenditure may more than compensate for any regressivity in the tax itself (Makochekanwa, 2020).

A more progressive way of collecting revenue is through mandatory health insurance contributions, which is one of the most common ways of raising revenue in several countries with UHC. Mandatory contributions from the employer and the employees can also be charged at a progressive sliding scale, where the high-income earners contribute more and the low-income earners contribute less. Mandatory health insurance contributions in the UK are charged from 3% to 10% depending on the income. A similar arrangement can be applied in South Africa to raise revenue for healthcare.

Additionally, a significant segment of South Africa's workforce is in the informal sector, and therefore mechanisms to include the informal sector in the funding model, either through some form of taxation or contribution mechanism, are important.

Furthermore, South Africa can consider the use of cost-sharing methods as a source of revenue in the initial phases. Cost-sharing methods look at charging user fees to some health services. User fees can be charged while offering some form of mechanism to protect the income of some population groups. For instance, in Australia, the chronically ill are exempt from paying user fees; children, pregnant women, and elderly (> 70 years old) in Ghana are also exempt. The UK (more England) and Canada use a threshold that is calculated per year as a mechanism to guide the charging of user fees. User charges are also a way to control demand; cost sharing may be attractive for countries that would like to reduce demand (Cylus, et al., 2018).

Lastly, there is a role that hypothecation of taxes can play in channelling and pooling funding for the NHI. Soft hypothecation of tobacco and alcohol can be used towards healthcare funding. Moreover, the hypothecation of the medical scheme fees tax credit can be used to generate revenue for healthcare.

Many countries have made a commitment to achieving UHC by implementing policies that point towards UHC. The commitment was supported through the adopted healthcare funding models, therefore, South Africa can make small incremental changes towards UHC by following the lessons from other countries.

CHAPTER 6

6.1 CONCLUSION

In conclusion, universal health care has be implemented by countries by adopting different funding methods to support it. Countries like South Africa can draw on international cases of healthcare reform to achieve UHC that can be funded appropriately. South Africa has an opportunity to tailor a funding model that promotes equity, financial protection, and accessibility. This study has found that there are no “pure” healthcare financing models that countries adopt; several countries tend to employ mixed financing methods. These models include the use of public funds, an element of direct mandatory contributions, and cost-sharing. Private healthcare remains a feature of the healthcare system in terms of out-of-pocket payments, and private health insurance, however, is not the predominant funding method for healthcare. This ensures financial protection for the entire population while having access to healthcare. Some countries have utilized cost-sharing methods as a form of revenue and also to limit demand. Consequently, when employing cost-sharing methods, countries often have to consider ways to protect the financially disadvantaged by putting financial protection measures in place.

Most countries reviewed fund health care using primarily public sources such as general taxation, mandatory health insurance, and some elements of cost-sharing. Health funding reforms tend to employ an incremental rather than fundamental approach. Countries have taken diverse approaches that have been adapted over time to suit the funding needs of that country. Elements like GDP growth remain a vital macroeconomic factor, as do the sustainability of the funding methods and the political commitment to support UHC. Therefore, South Africa will need to establish a unique funding method that will suit the needs of the country while ensuring financial protection using lessons from other countries.

Future considerations

There is a general lack of reliable data from low- and middle-income countries that can be studied for topics like UHC. Therefore, studies that compare and investigate data from low- and middle- income countries are necessary so that it can be seen how these countries can implement UHC more suitable for their context.

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