

## **15 Integrated Strategy for Health Systems Reform**

### **15.1 Overview**

The reform strategy outlined in this section integrates the information from previous reform processes and the analyses of earlier sections in this report and encapsulates it within a rational reform path. To a large extent reforms recommended in earlier processes remain intact. This section provides a prioritisation of those reforms pivotal to the achievement of fundamental health systems reform.

Elements of the reform process which need to be prioritised in the short- to medium-term are identified and divided into four phases. The achievement of the final phase is seen as a fairly long-term objective which will not be fully realised within the next ten years. It is important however to reflect this final phase here to provide clarity on the ultimate direction of the health system.

Government policy is clearly complicated by the peculiarities of the health market which necessitates intervention if health goals are to be achieved. Further complicating Government policy is the fact that no clear formula exists to achieving its goals. The level of economic development and the maturity of existing institutions affect the available options and opportunities. There is therefore an ongoing obligation on Government to carefully assess policies on their merits.

Although the level of economic development and existing institutions influence reform options, they need not undermine the achievement of policy goals that address the underlying obligations of Government.

Within this section various institutional arrangements are suggested. These are given suggested names consistent with their function. Ultimately, if accepted, these functions could be arranged quite differently from an institutional point of view. This would however not diminish the need for the functions themselves.

### **15.2 Principles**

Applying some of the key principles identified thus far the following obligations on the state can be identified with respect to social security (which includes health care) and health care in particular:

- (a) *Basic necessities*: All people living in South Africa are entitled to the basic necessities of life.
- (b) *Comprehensive and co-ordinated social security programme*: The State must adopt a comprehensive and co-ordinated social security programme in which responsibilities and tasks are clearly allocated to the different spheres of government, and appropriate financial and human resources are available for its implementation;
- (c) *Responsibility*: The national government and not merely a single department or authority has the overall responsibility of co-ordinating a social security programme and for co-ordinating and managing the health system.
- (d) *Equity*: Public sector resources must be allocated on an equitable basis. Within the context of health care, an equitable distribution of health services is also required.
- (e) *Finance*: Overall revenue allocated to the health system must involve a fair share of the overall resources of the country.
- (f) *Implementation*: Policies and programmes must be reasonable both in their conception and their implementation for them to be regarded as compliant with the qualification of progressive realisation provided for in the Constitution.
- (g) *Prioritisation for those in desperate need*: Government must identify those in desperate need within the context of health service provision and ensure that it has a valid programme in place to cater for this need.
- (h) *Emergency Medical Care*: The right of access to emergency treatment is not subject to the qualification of progressive realisation. However, the Constitution does not make provision for this right to be free of charge. The State is therefore obligated to provide an environment in which the exercise of this right can occur in a manner that does not undermine the sustainability of the health system, and minimises the financial distress of all concerned.
- (i) *Children*: Children have special rights provided for in the Constitution. The importance of children within the life-cycle, within families, and broadly in their relationship to effective social development is a clear underlying value of society. Families with children in distress also have a first call on state resources. The State is therefore obligated to ensure that access to basic health care services is unrestricted for children and related services where children may be affected.

### 15.3 Goals

Access to a basic set of services must be guaranteed to all and not be based on the ability of any individual or group to pay.

Although access to a basic set of services will be guaranteed for all, those able to contribute, whether in the form of taxes or mandatory contributions, should be required to contribute. As far as possible contributions need to be made over in a pre-paid form and, where essential basic services are concerned, with user fees and co-payments eliminated.

The central objectives of a final system are clearly those underpinning all of health policy. The objectives underlying the desired structure and institutional framework may be more specific and should include:

#### Financing:

- (a) Achieve the integration of the existing voluntary contributory system with mandatory contributions and tax-based finance;
- (b) Broaden the risk-pooling and thereby lower the costs of accessing the health system for all residents;
- (c) Eliminate all co-payments (user-fees) at point-of-service for all public facilities, and private facilities where these involve basic essential services;
- (d) Ensure that all those able to contribute on a pre-paid basis do so.

#### Service provision:

- (a) Ensure the existence of a strong public sector owned and controlled service as a provider of last resort for all residents;
- (b) Ensure an equitable distribution of public health services for the entire non-contributing population;
- (c) Provide the flexibility for public sector services to be available to medical schemes on a full cost-recovery basis;
- (d) Provide flexibility for medical, nursing and auxiliary staff to be able to contract for work in both the public and private sectors;
- (e) Provide a regulatory framework that ensures that private sector providers cannot abuse their potential monopoly power to increase fees, costs and utilisation in excess of socially desirable levels.

#### Institutional framework:

- (a) Responsibility for health policy should reside with the national Department of Health;
- (b) The administration key public sector services and functions, such as hospital services and district management, should be fully decentralised with improved financial accountability and governance;
- (c) Where national priorities must be met by a lower tier of government, as far as appropriate, allocations should be conditionally allocated by the national Department of Health.

### 15.4 Reform Strategy

*It is the recommendation of this Report that in the medium- to long-term South Africa move toward a National Health Insurance system compatible with multiple funds and a public sector contributory environment as defined in the 1995 NHI Committee Report. Initially the environment should continue to be strictly differentiated between a private contributory environment and a general tax funded public sector environment. Over time this strict differentiation can diminish with a broader contributory environment emerging, replacing general taxes as a revenue source. The ultimate elimination of general taxes as a key revenue source is unlikely for a fairly long time, and may in fact not even be desirable as policy objective.*

Four phases are envisaged defining important linked reform measures. The phases guide the evolution of health system toward the achievement of a universal contributory system.

#### *Phase 1: Development of the enabling environment for greater integration:*

The current health system is incompatible with the introduction of or integration with contributory environments. The overall system of cross-subsidies is fragmented and not structured in accordance with strategic policy goals. Furthermore, the strict partitioning between the public and private sector spheres negatively affects the operational effectiveness of both environments.

The priorities within phase 1 therefore need to focus on putting in place an enabling environment for more substantive and far reaching policy reforms.

#### *Phase 2: Implement preparatory reforms:*

In conjunction with the establishment of the enabling environment, a number of reforms of strategic importance should be implemented. These need to focus on the creation of regulated risk pools, and major enhancements to the regulation and subsidisation of the medical schemes

environment. The objective is to improve the quality and cost-effectiveness of cover within the voluntary contributory environment (medical schemes).

The phase 2 reforms serve to enhance the voluntary contributory environment in order to facilitate the establishment of a mandatory environment emphasised in phases 3 and 4. The greater the degree of cover, and the acceptability of the contributory environment, the less the disruption involved in establishing any future mandatory environment.

*Phase 3: Implementation of the initial mandates:*

Once the preparatory reforms of phase 2 are in place, the groundwork would have been established for the implementation of the first statutory mandates. Given the income distribution in South Africa, the mandates should begin with higher income groups. Where lower income groups are concerned, this phase should focus on further development of the voluntary contributory environment.

Phase 2 would have seen the initiation of a state-sponsored medical scheme. Phase 3 should focus on the development of a contributory scheme for *non-medical scheme members*. This will help to establish the institutions in government that would ultimately manage a public sector contributory scheme within a National Health Insurance framework. Thus two contributory mechanisms will exist: the first based on medical schemes; and the second a dedicated public sector contributory fund.

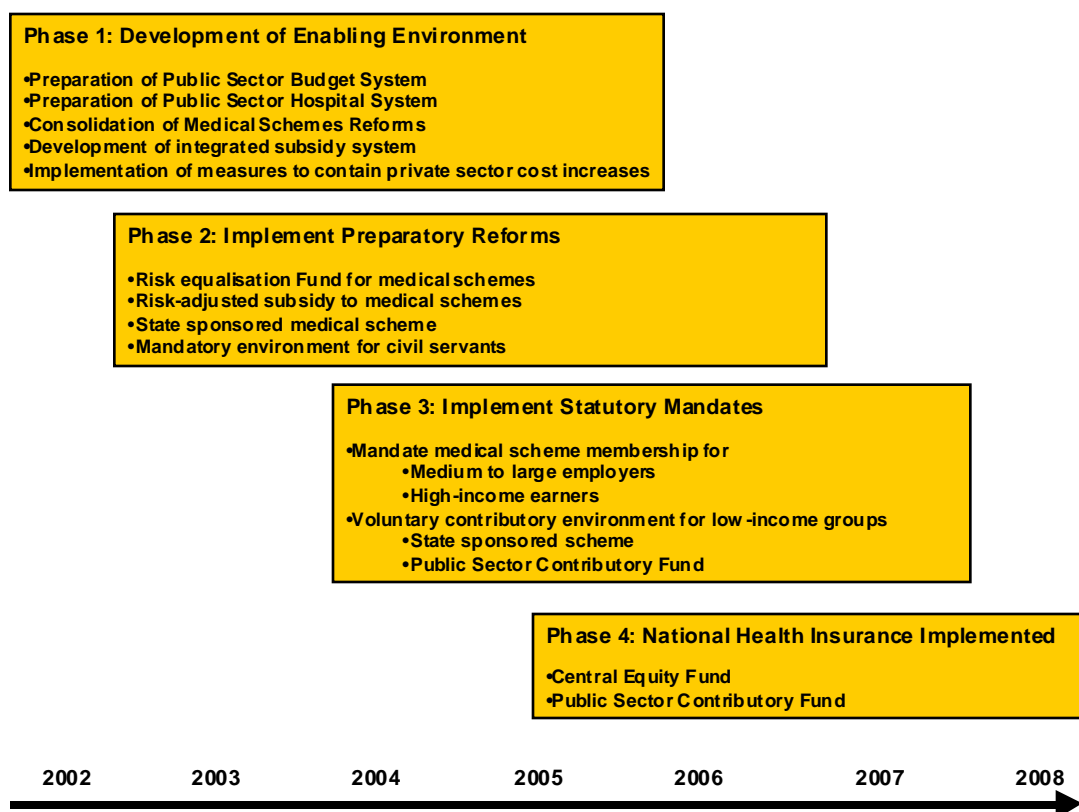
*Phase 4: Implementation of National Health Insurance:*

The last phase envisages the implementation of a universal contributory system which would to a substantial degree replace general tax funding as a source of revenue. General tax as a supplementary source of revenue may nevertheless prove desirable. The final phase essentially envisages the establishment of a contributory environment for all groups and individuals assessed to be in a position to contribute toward the health system. These contributions would not replace medical scheme contributions, but rather fund a proposed subsidy provided to medical schemes. All contributions and general tax allocations should ultimately be made directly to a Central Equity Fund (CEF) which would in turn allocate them to the public sector and medical schemes based on a risk-adjusted equity formula.

A Public Sector Contributory Fund (PSCF) should be considered to become the national funding authority for the public health system. This would enable the consolidated allocation of all funds directly allocated by the national Department of Health. Phases 1 through 3 would have seen the centralisation of key components of the health budget (including the establishment of a

contributory system dedicated to funding public sector services), and the establishment of capacity to fund provinces via improvements in the capacity to manage the conditional grant system. The end phase of these enhancements should see the creation of the PSCF to take responsibility for and manage the allocation of funds from general tax revenues and contributions allocated through the CEF.

**Figure 15.1 Reform Strategy and Approximate Timeline**



## 15.5 Phase 1: Enabling Environment

### 15.5.1 Objectives

Public sector reform pre-requisites for the introduction of a contributory component to funding public sector services require the:

- Centralisation of the health budget;
- Creation of a dedicated unit to manage the system of conditional grants;
- Implementation of differential amenities; and

- (d) Decentralisation of hospital management.

Private sector funding reforms required as pre-requisites for the introduction of a mandatory environment for medical scheme membership are the:

- (a) Revision of the subsidy system for medical schemes;
- (b) Implementation of a risk-equalisation fund;
- (c) Availability of contracting options for public sector services; and
- (d) Mandating of medical scheme membership for all public sector employees as a pilot.

Complementary measures to the above would include:

- (a) Developing an ongoing policy with respect to defining and implementing a basic essential package of services compatible with both the public and private sector approaches to service reimbursement and provision.

### **15.5.2 Preparation of the Public Sector Budget System**

*Centralisation (ring-fencing) of the key components of the Health budget:*

Centralising the allocation of the health budget creates a coherent link between national policy objectives and provincial service delivery. It also establishes a required direct relationship between the budget allocation process and any future contributory system dedicated to using public health services. This could be phased in over a number of years as the capacity of the national Department of Health is improved to revise the current allocation system.

If no central ring-fencing of the health budget occurs the viability of any future social health insurance option dedicated to funding public health services will experience difficulties for the following reasons:

- o The creation of a social health insurance institution will require a parallel administration system resulting in inefficient duplication when the conventional budget system could be adapted instead.
- o Ensuring that funding levels for public hospital services will be compatible with the entitlements to those services for both contributors and non-contributors.
- o Ensuring compatibility between the funding of hospital and district level services will prove difficult.

*However, it should be noted that the use of matching conditional grants in conjunction with minimum norms and standards could achieve many of the objectives without the full ring-fencing of the public health budget. This less onerous approach could therefore be considered in the short- to medium-term if full centralisation is perceived as too risky. Irrespective of which option is*

*adopted, the establishment of a dedicated unit with the required expertise to allocated current and future conditional grants should nevertheless be established.*

*Establish an expert unit to manage the conditional grant system*

Ensuring the achievement of an equitable distribution of physical health services requires careful management of the conditional grant system. Both allocation criteria and conditions need to be established centrally. This role should not extend to the micro-management of provincial administrations, but should instead attempt to achieve designated broad service targets within a coherent national framework with mutual consent. This unit should ultimately be incorporated into the proposed PSCF.

### **15.5.3 Preparation of the Public Sector Hospital System**

*Decentralisation of public hospital management:*

The current inflexible regulation of public hospitals affects both their management of revenue sourced from general taxes and their ability to access the private sector contributory (medical scheme) environment. Hospital decentralisation needs to extend to their having strong boards, a CEO as the accounting officer, and the holding of their own bank accounts. Hospitals need to be placed in a position to enter into and manage contracts directly, subject to the oversight of provincial health authorities and the relevant hospital board.

*Implement a coherent uniform policy with respect to enhanced amenities:*

In order to reinforce the contributory system, enhanced amenities need to be introduced into the public system. It is proposed that this focus on, but not be limited to, hospital services.

As access to particular services and amenities will depend on whether or not someone is part of the contributory environment, a smart card identification system is important, if not essential. If such a card is not produced at a public facility, however, no-one will be denied cover. *They will only be denied access to the enhanced amenity.*

Public facilities should at all times retain their public sector identity. No separate facilities offering only enhanced amenities should be created as this will impact on access and equity. Over time the system of enhanced amenities may fall away once the need for an inducement to pay ceases to be important.

Initially enhanced amenities will apply and be developed with respect to medical schemes. However, the development of a public sector contributory system for low-income groups would also develop around the enhanced amenity.

*Financial injection to enhance the public sector services:*

In order to implement a system partially reliant on voluntary contributions, basic improvements to the facilities and services are required. Otherwise contributions will not be forthcoming. These improvements must not be confined to the enhanced amenities.

*Establish a process to develop and implement minimum service requirements for the public system:*

To ensure the consistency of the conditional grants, a national policy framework for public services, integrating all levels of care, is required. As the conditional grant system is effectively the implementation arm of public health policy, this process should focus on the establishment of *service requirements* and *norms and standards*.

*Human resources:*

Staffing arrangements also need to come under tighter management, but allow for greater flexibility to serve both the public and private sectors. These contracts should be limited to scarce personnel only, and probably to specified institutions.

**15.5.4 Consolidation of Medical Scheme Reforms***Remove residual risk-selection:*

The removal of residual risk-selection requires a number of smaller reforms in conjunction with a risk-equalisation process. The risk-equalisation mechanism is discussed further below. The other reforms required include:

- (a) *Prescribed minimum benefits*: The expansion of prescribed minimum benefits to include chronic conditions, expanded HIV/AIDS cover and other essential services;
- (b) *Benefit Options*: The phasing out of separate options in schemes, or alternatively, limiting their number and the basis upon which benefits can be differentiated;
- (c) *Medical Savings Accounts*: The phasing out of medical savings accounts; and
- (d) *Late Joiner Penalties*: The introduction of an improved system of unfunded lifetime community rating.

*Increase coverage generally:*

This can occur through a number of measures:

- (a) Mandating membership in restricted membership schemes; and
- (b) Requiring all civil servants to become members of a medical scheme.

*Effective regulatory environment for intermediaries:*

A system which ensures appropriate economic rewards for intermediaries needs to be considered. A substantially improved approach to consumer protection is also required.

### **15.5.5 Development of a Policy Process on Basic Essential Services**

The public and private sectors define their benefit entitlements differently. The public sector establishes services which provide comprehensive cover for an undefined range of conditions. The conditions covered may be qualified through the use of protocols.

The regulatory environment for private sector has moved toward the creation of positive lists of services for which cover is provided. The Medical Schemes Act No. 131 of 1998 now specifies a positive list of conditions and treatments which must be covered by schemes.

Government has to move toward defining what it regards as basic essential services which everyone must be covered for. Although these may be defined differently between the public and private sectors, there must be convergence on the approaches adopted in the two environments.

Ultimately both the public and private sectors need to provide a *minimum core set of services*. Within medical schemes these would be regulated as prescribed minimum benefits. Within the public sector a similar process would occur and be framed as *minimum norms and standards*.

### **15.5.6 Development of Integrated Subsidy System**

*Revise the subsidy system:*

The tax system is currently the most important vehicle for achieving most of the risk-pooling required to generate income-related cross-subsidies. Consideration has to be given to using the system of general taxes to achieve income-related cross-subsidies in the medical schemes environment.

The Medical Schemes Act No.131 of 1998 provided for the introduction of a limited number of risk-related cross-subsidies within the medical schemes environment. However, there are various structural deficiencies which need revision and include:

- Inequity in the allocation of public health services;
- Tax subsidy to medical schemes;
- The lack of risk-equalisation between schemes; and
- Unfair penalties.

*Revision of the Budget System:*

The budget system needs to be revised to ensure that the regional allocation of health services is equitable. Furthermore, the value of subsidies given to the private sector should not exceed that provided for people covered through the public sector.

*Tax subsidy:*

The tax subsidy currently contradicts health system objectives. A revision of the overall system along the lines begun through the Medical Schemes Act must be considered, which achieves greater risk pooling and converts the tax subsidy into an explicit risk- and income- adjusted subsidy. The achievement of these cross-subsidies will require the creation of a risk equalisation fund.

The existing tax subsidy should be phased out and an explicit on-balance sheet subsidy phased in. The subsidy would initially be funded from general taxes but could gradually be replaced by an earmarked tax. The subsidy would take the form of a risk-adjusted per capita allocation in respect of everyone in a medical scheme, or who participates in any public sector voluntary or mandatory contributory environment.

*Introduce a system of risk-equalisation:*

A system of risk-equalisation is required both to balance the uneven risk pools (i.e. schemes with above or below average proportions of older or sicker people) between medical schemes and to distribute the explicit subsidy that replaces the tax subsidy.

**15.5.7 Implementation of measures to Contain Private Sector Cost Increases**

Various measures are possible to reduce service costs within the private sector using either direct limitations on the supply of technology, or through market oriented measures such as central purchasing by the public sector for both public and private sectors.

*Supply controls:*

Currently under-utilised or not consistently utilised are a number of measures that are essential to containing the ballooning of costs on the supply-side within the private sector. Internationally there is careful management of the introduction of new technology, and the geographical distribution of services. Over-concentration leads to supply-induced demand which private sector funders find difficult to control. Government has to implement a coherent framework which aims to directly limit excessive concentrations of providers and new technology.

*Medical Scheme Administration Fees:*

Open medical schemes are experiencing significant increases in non-medical expense related costs. Consideration needs to be given to capping administration costs at reasonable levels. Annual increases should also be limited to ordinary inflation.

*Market-related measures:*

The rational use of highly specialised services or expensive diagnostic services can be encouraged through making these services available to the private sector at cost through the public sector. In certain instances, services could be provided universally free of charge where appropriate. Tuberculosis and HIV/AIDS services would be examples.

Areas that can be seriously considered for sale to medical schemes on a cost-recovery basis to the mutual advantage of both environments are:

- (a) Enhanced amenities;
- (b) Intensive Care Units;
- (c) High Care;
- (d) Highly specialised services;
- (e) Radiology;
- (f) Dialysis;
- (g) Home-based care services;
- (h) Palliative care;
- (i) Step-down facilities; and
- (j) Essential drugs.

*Removal of bottlenecks constraining the development of managed care:*

The development of improved selective contracting within the private sector requires that schemes be permitted to determine the terms and conditions of service suppliers in contracts entered into on a willing buyer and seller basis.

Medical schemes must be placed in a position where they can include volume and price in the same contract. Only in this way can appropriate risk be shared between the scheme and the service provider.

The shifting of risk onto insured members or individuals has proven to be an inferior and discredited strategy. It is only when adequate risk-sharing between funders and providers exist that genuine efficiencies can be realised.

To prevent provider collusion from preventing the development of appropriate selective contracting a legislative framework that deals with competition needs to be introduced into the Medical Schemes Act and enforced by the Council for Medical Schemes.

Establishing a consistent competition dispensation for the health system needs to be developed in conjunction with the Competition Commission.

## **15.6 Phase 2: Implement Preparatory Reforms**

### **15.6.1 Objectives**

This phase needs to expand cover within the voluntary contributory system (medical schemes) and consolidate reforms to improve the system of cross-subsidies.

### **15.6.2 Implement Risk-equalisation Fund for Medical Schemes**

The full implementation of a risk-equalisation system, begun in phase 1, is required. The risk-equalisation fund will be a statutory authority reporting to the Minister of Health. Its key functions will be two-fold:

- (a) Ensure that all medical schemes face the average demographic and health risk structure of the market as a whole; and
- (b) Distribute a risk-adjusted subsidy to medical schemes.

The risk-adjusted subsidy should replace the existing inefficient and inequitable tax subsidy provided to employers and individuals. Ultimately, the risk-equalisation fund will be expanded into the CEF implemented in phase 4.

### **15.6.3 Implement Risk-adjusted Subsidy to Medical Schemes**

The tax subsidy, currently valued at R7,8 billion will need to be replaced by a more efficient and explicit subsidy to medical scheme members. This subsidy should initially be funded from general tax revenue. In phase 4 of the reform process the revenue source could move toward a universal mandatory contributory system.

The aggregate value of the subsidy will be determined according to the value of public sector services not utilised by individuals receiving cover in the private sector. The difference in the value of the original tax subsidy and the revised subsidy will be used to improve the public sector budget. The distribution mechanism for the subsidy should be the risk-equalisation fund.

#### **15.6.4 Implement State-Sponsored Medical Schemes**

The implementation of a state-sponsored medical scheme targeted at low-income groups and the informal sector would have the following objectives:

- (i) A scheme of last resort would always be available for anyone of low-income able and willing to join a medical scheme;
- (j) A benchmark scheme will be available in the market which can generate competitive pressure on inefficiently run open schemes;
- (k) The scheme would be established as the lowest cost scheme in the market, setting a minimum benchmark price against a set of minimum essential benefits;
- (l) The cost level of the scheme would provide an indication of the income group for whom mandatory membership of a medical scheme could be set;
- (m) An opportunity will be created for establishing and taking advantage of contracts with the public hospital provider system; and
- (n) This scheme could be one of the key schemes used for public sector employees when membership of a medical scheme becomes mandated in that environment.

Not only will such a scheme create downward pressure on costs within the private market, it will assist in the development of a low-income contributory environment.

#### **15.6.5 Implement Mandatory Environment for Civil Servants**

Currently just under 50 percent of civil servants are on a medical scheme. The first phase of any move toward a mandatory contributory environment should therefore begin with moving civil servants under some form of cover. This can be achieved through an employer mandate requiring membership of one of a limited number of accredited medical schemes. Although this measure can take the form of an employer and employee bargaining process (as opposed to a statutory one) aspects of it can be reflected in legislation in accordance with a broader statutory framework.

### **15.7 Phase 3: Implement Statutory Mandates**

#### **15.7.1 Objectives**

There are two major objectives to this phase:

- (a) Establish a mandatory environment for medical scheme membership for high-income groups; and
- (b) Initiate a voluntary public sector contributory environment outside of the medical schemes movement.

The first measure represents the final phase in the reform of the medical schemes environment, while the second establishes the basis for a subsidised low-income contributory environment.

### **15.7.2 Mandate Medical Scheme Membership**

The mandatory medical scheme membership for high-income groups will reduce adverse selection and stabilise medical scheme membership. This move really only becomes socially acceptable once major efforts have been made to bring private sector cost increases under control and to ensure adequate risk-equalisation between schemes. This measure represents the final phase of the medical scheme reform process initiated through the introduction of the Medical Schemes Act No.131 of 1998.

The mandate should initially focus on groups that are largely in membership already. As such the mandate should involve limited disruption to employer costs and employee benefits. Qualifying groups for the mandate need to be based on a combination of employer size and minimum income levels.

By this phase a fairly sustainable and good quality low-income scheme environment could have evolved based on reforms introduced in phases 1 and 2. This would have been achieved through the following:

- (a) *Supply-side measures*: to limit supply-induced demand;
- (b) *Replacement of the tax subsidy with an income-based risk-adjusted per capita subsidy*, lower the cost of cover for low-income groups;
- (c) *Public sector contracts with medical schemes*: introduce effective competition with private health service suppliers; and
- (d) *State-sponsored medical scheme*: introduce competition with existing medical schemes

The lower-cost environment should provide employers with greater choices for more affordable cover for good quality services. The mandatory environment also diminishes the need for late-joiner penalties.

### **15.7.3 Implement Voluntary Contributory Environment for Low-Income Groups**

The existing system of user fees for higher income groups using public sector hospitals need to be replaced by a form of pre-payment. For individuals within a medical scheme this issue will already have been resolved. A pre-payment system exclusively for public hospital utilisation for low-income groups outside of the mandatory framework is required for those who may not wish to, or be unable to afford, medical scheme cover.

Pre-payment would qualify individuals for access to enhanced amenities within public sector hospitals. For non-contributors access will only be permitted to basic amenities. In terms of this system, everyone will be entitled to a free state service whether or not they make a contribution. The pre-payment system merely provides a vehicle for “buying up” within the state system and thereby incentives payment.

To minimise the risk for the state system, and the sustainability of the medical schemes environment, the mandatory medical scheme membership for high-income groups needs to be implemented together with the creation of the low-income contributory system.

## **15.8 Phase 4: Final Implementation of National Health Insurance**

### **15.8.1 Objectives**

The final stages of the reform process will involve the implementation of a universal contributory environment. Despite the universality, a degree of flexibility will continue to exist between funding environments and provider choice. Choice of funding environment will become more limited the lower the income of an individual or family. However, the flexibility of the third-party purchaser (public and private) to contract with different providers will be high. This will increase price competition between providers and serve to preserve the sustainability and affordability of health care services generally.

### **15.8.2 Overall Framework**

The final phase of the reform process would seek to combine the public and private sectors under a single universal contributory system. This system would directly fund the basic public health sector service, a differentiated public service for non-medical scheme members, and subsidise members of medical schemes who would be able to top-up their subsidies with their own contributions to their medical scheme.

The proposed environment would effectively integrate the regulated multi-fund (medical schemes) and a public sector managed and controlled system. The universal contribution would be distributed via a proposed Central Equity Fund (CEF) which would evolve from the risk-equalisation fund established in phase 2.

To cater for adverse selection issues within the medical schemes environment, higher income groups will be required to join a medical scheme. They would however be free to choose their scheme. This would already have been implemented in phase three.

Lower income groups, including the informal sector, would have the option to choose between a medical scheme or access the enhanced public sector amenities via the PSCF. Contributions for the low-income formal sector workers will be mandatory where they exceed a statutorily determined level.

Both the CEF and PSCF should operate within a statutory framework established by the Minister of Health.

In this way the public and private systems become integrated within a unifying framework that permits public policy to coherently influence equity and access to health services irrespective of where they are situated (i.e. public or private sector) or their revenue source.

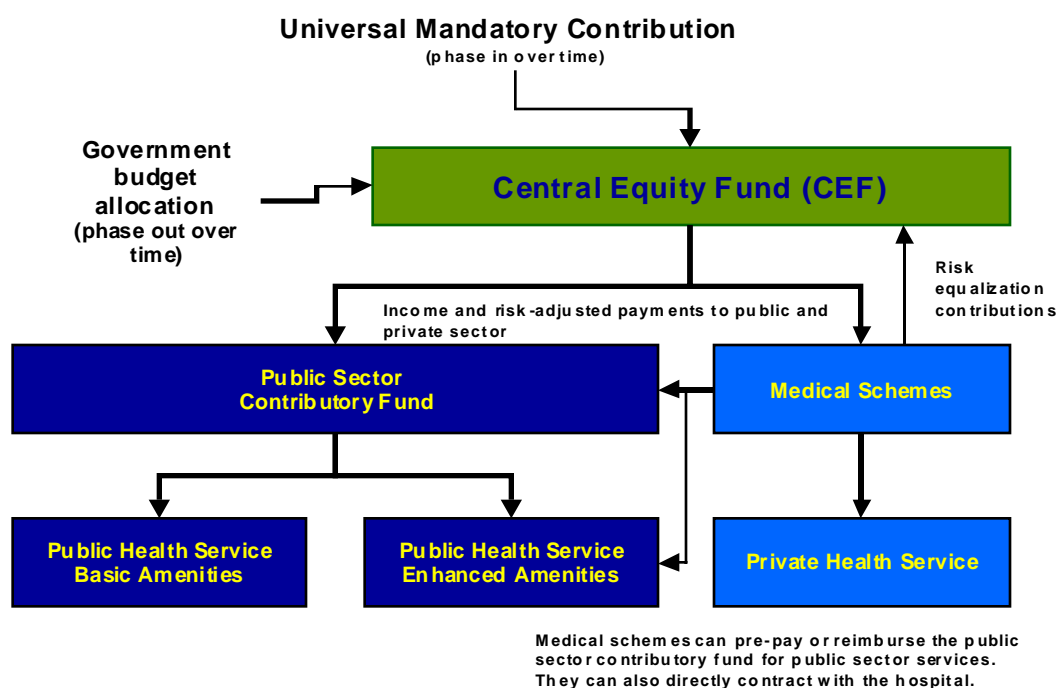
The continued existence of the medical schemes environment will be essential, as these vehicles provide an established and functioning contributory environment which, if regulated to achieve minimum equity and access guarantees, can ensure that adequate resources are available within the overall health system.

Medical scheme revenue would be derived from two sources:

- (a) A risk-adjusted subsidy based on an equitable allocation from the CEF; and
- (b) Top-up contributions (also risk-adjusted via the CEF) derived from member contributions

To prevent or contain perverse trends in the distribution of physical resources resulting from the medical schemes environment, supply-side management of any escalation or maldistribution of private sector resources needs to become an established regulatory function of national and provincial government.

**Figure 15.2: Framework for a Universal Contributory System**



### 15.8.3 Central Equity Fund (CEF)

The CEF should initially start out as the institution created to manage risk-equalisation between schemes as well as allocate a risk-adjusted subsidy to medical schemes. The initial subsidy would be an explicit allocation from general taxes (as described in phase 2) replacing the existing tax deduction. This system would:

- (a) Ensure equity in the raising and allocation of health resources;
- (b) Improve the mobilisation of revenue through combining contributory (which contains a strong willingness-to-pay element) and tax-based sources of revenue; and
- (c) Ensure a consistent link is maintained between the economy's capacity to fund an acceptable health service and the funding made available.

The CEF would have the following functions:

- (a) The collection of income-based contributions from the public;
- (b) Alternatively to (a) the same effect could be achieved via a formula-based subsidy funded from general taxes;
- (c) The management of a contributor database and membership information;
- (d) The distribution of funds to:
  - o The public sector basic amenity service for non-contributors;

- o The public sector enhanced amenity services for contributors; and
  - o The private sector medical schemes.
- (e) The fund distributions will be based on an equity formula which would incorporate both income and risk-based cross-subsidies.

The health system could move entirely away from a general tax-funded system toward a universal contributory system. Within such a framework some allocations from general tax to deal with any revenue instability would initially remain. If this occurs consideration could be given to the allocation of a fixed percentage of revenue from VAT and corporate tax supplementing the contributory system.

Contributions would be required on a mandatory basis from specified income classes within qualifying employer groups. Certain employer groups may be excluded, i.e. those below a specified number of employees. For groups falling outside of the mandatory net, voluntary membership would nevertheless be possible. Non-contributors would be entitled to utilise the basic amenity service of the state free of charge. They will however not have access to enhanced amenities. Although some free-riding will occur it should not be financially significant.

The CEF would not attempt to manage provider reimbursement itself but merely fund institutions in the public and private sector that are specialised to perform this complex function. Within the public sector the responsible institution will be the national Department of Health, via the PSCF. In the private sector, medical schemes would directly fund services.

With respect to the private sector, the CEF would perform a risk-equalisation and income-cross-subsidisation function. The schemes would continue to directly manage the reimbursement of service providers. Funds involved in the risk-equalisation process would come directly from medical schemes.

#### **15.8.4 Public Sector Contributory Fund (PSCF)**

A Public Sector Contributory Fund (PSCF) should be established to manage the reimbursement of provincial health departments. This authority would not deviate from the equity allocation distributions established by the CEF, but focus on and be empowered to ensure the equitable regional distribution of *physical health services*.

The PSCF would flow from reforms initiated in phase 1 where specialised capacity in the form of a national Department of Health unit is created to manage and distribute the health allocations as conditional grants to provinces.

The PSCF would determine the allocations to provinces as *conditional grants*. It would also establish the associated *conditions* in conjunction with the national Department of Health. It would however not determine the actual provincial budgets, as these will be set by the provincial governments.

The determination of allocations to provinces would be a technical and not a policy exercise. Policy decisions would be the exclusive responsibility of the Department of Health.

The PSCF will need to take into account factors such as the *physical distribution* of health care service providers and personnel in the determination of allocations and conditions. Progressively achieving an equitable distribution of health resources would need to occur through negotiations with the provinces and the development of a consistent funding framework.

The PSCF would also need to determine the allocation of funds in respect of enhanced amenities via the conditional grant mechanism. The proposed system should form part of the existing budget system and cycles.

Medical schemes should be able to directly *contract with the public health system* where desired. They should also be in a position to pay funds directly to the PSCF in respect of pre-paid or utilised services in the public sector. Where such payments are made, the PSCF should adjust the provincial allocations and conditions accordingly.

#### **15.8.5 Subsidy to Medical Scheme Members**

All residents should be entitled to a subsidy equivalent to the risk-adjusted per capita average of all contributions received into the CEF. This subsidy should be available irrespective of whether the individuals are covered through the medical schemes environment or through the PSCF.

This subsidy system will evolve from the recommended changes to the tax subsidy system which forms part of the short- to medium-term reform process.

This approach will permit individuals to opt out of the public sector provider system without impacting on the degree of income- and risk-related (i.e. healthy to sick) cross-subsidisation underpinning the allocations of the CEF.

## 15.9 Financial Implications

The functioning of health systems are extremely sensitive to the financial framework within which they operate. Unstable revenue sources that have no relationship to changes in service demand are as problematic as revenue sources very sensitive to demand changes. To be effective health systems must operate with sustainable revenue sources, a reasonable degree of sensitivity to demand changes, and a variety of provider reimbursement mechanisms.

The South Africa public sector budget system does not provide sufficient flexibility to ensure the financial sustainability of the public health system. The current framework appears to have generated structural under-funding of the health services and their associated capital requirements. The public health system is also unable to respond to demand changes resulting from higher income groups (with and without medical scheme cover) using public hospitals due to rigidities inherent in the budgeting process.

The envisaged framework outlined in phases 1 through 4 requires that certain principles be established in implementing the reform process. The following are recommendations on a number of principles:

- (a) All revenue taken from user fees or funds received from medical schemes within public sector facilities should be retained at source and be used to cover the cost of services sold;
- (b) Allocations to public health services from the general taxes should as far as possible be determined nationally and allocated to provinces on an equitable basis;
- (c) Redistributive objectives within the public sector must be achieved with budget allocations emanating from general taxes and not from user fees and medical scheme payments;
- (d) The management of hospitals must be decentralised to permit the utilisation of more appropriate financial management approaches with respect to revenue from multiple sources;

- (e) The overall financial framework should be designed to maximise the effects of risk-pooling.

### 15.10 Coverage

Coverage changes over the four general phases with the gradual expansion of the contributory system. The public sector basic amenity is the non-contributory environment offered free to all below a certain income level. Higher income groups move from a voluntary contributory environment into mandatory options for both medical scheme membership and a final National Health Insurance (NHI) contribution.

By phase 3 the user fee system for public hospitals is eliminated and replaced by a combination of mandatory medical scheme membership and a voluntary contributory system for an enhanced differential amenity. Middle- and upper-income groups will largely be compelled to join a medical scheme during this phase. Public sector schemes will be able to contract for the differential (enhanced) amenity. Phase 4 creates a mandatory contributory environment which includes low-income groups. From that stage on, low-income contributors will access enhanced amenity services.

**Figure 15.3: Implications for Coverage over all Phases**

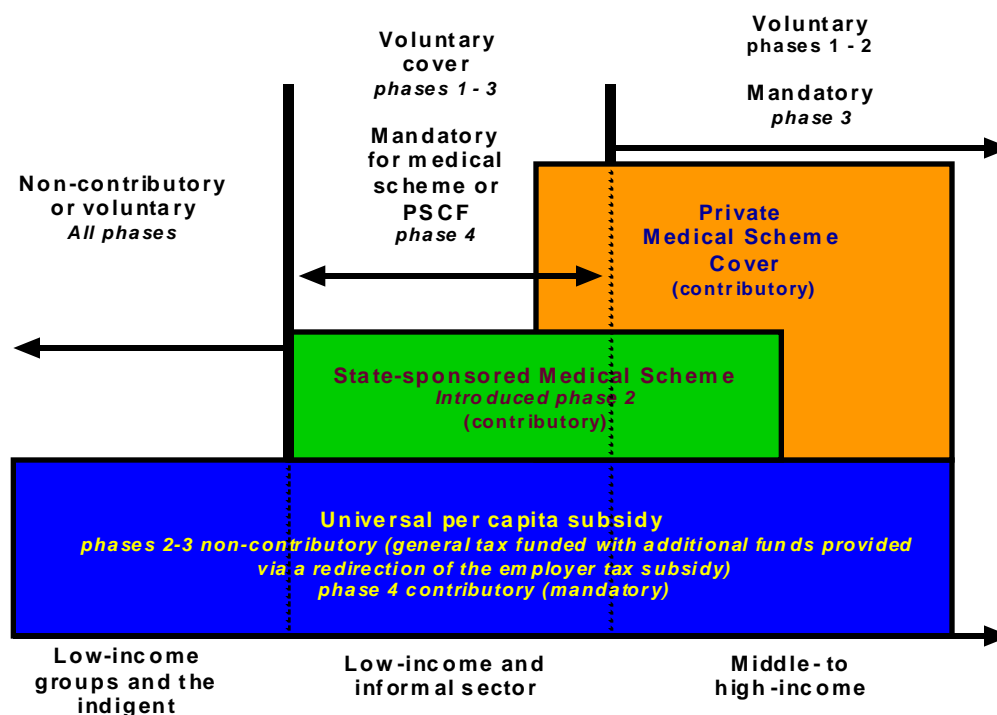


Table 15.1 Summary of coverage by broad income category

	Phase 1	Phase 2	Phase 3	Phase 4
<b>Poor</b>	Public sector: basic amenity <b>(free)</b>	o Public sector: basic amenity <b>(free)</b>	o Public sector: basic amenity <b>(free)</b>	o Public sector: basic amenity <b>(free)</b>
<b>Low-income</b>	o Public sector: basic amenity <b>(user fee)</b>	o Public sector: basic amenity <b>(user fee)</b> o Medical Scheme <b>(voluntary)</b>	o Public sector: basic amenity <b>(free)</b> o Public sector contributory fund <b>(voluntary)</b> o Medical Scheme <b>(voluntary)</b>	o Public sector: basic amenity <b>(free)</b> o Public sector contributory fund via NHI contribution <b>(mandatory)</b> o Medical Scheme <b>(voluntary)</b>
<b>Middle-income</b>	o Public sector: basic amenity <b>(user fee)</b> o Medical Scheme <b>(voluntary)</b>	o Public sector: basic amenity <b>(user fee)</b> o Medical Scheme <b>(voluntary)</b>	o Medical Scheme <b>(mandatory)</b>	o NHI contribution <b>(mandatory)</b> o Medical Scheme <b>(mandatory)</b>
<b>High-income</b>	o Public sector: basic amenity <b>(user fee)</b> o Medical Scheme <b>(voluntary)</b>	o Public sector: basic amenity <b>(user fee)</b> o Medical Scheme <b>(voluntary)</b>	o Medical Scheme <b>(mandatory)</b>	o NHI contribution <b>(mandatory)</b> o Medical Scheme <b>(mandatory)</b>

### 15.11 Concluding Remarks

The various phases outlined in this framework reflect the need for careful planning and prioritisation of interventions. The reform process is complex and multi-dimensional. Significant technical work and consultation will be required in virtually every phase and step of the process. This complexity should be recognised as inherent to health systems reform and a degree of openness and flexibility permitted to fully develop the reforms for implementation.