

16 Concluding Remarks

A pivotal recommendation of this Report is that the reform direction and approach developed and proposed in the 1995 NHI Report remains valid and should continue to be the basis for further reforms. In the long-term this requires that South Africa move toward a National Health Insurance system over time making use of multiple funds in the form of regulated medical schemes, coupled to and compatible with a universal contributory system.

It is a finding of the report that the Medical Schemes reforms initiated in 1998 (Medical Schemes Act No.131 of 1998), based on the 1995 NHI Report, are an essential component of a stable health system. These reforms prevented the large-scale removal of high-risk groups from cover and have been instrumental in starting the drive toward lower cost medical service models in the private sector.

The reform process has to take into account the need to look at a phased approach whereby key enabling measures are implemented and the base established for the longer-term reforms. This Report has grouped the reforms into four phases:

Phase 1: Development of the enabling environment:

- (a) Reform of the public hospital system:
 - a. Decentralise public hospital management;
 - b. Centralise key aspects of the public health budget;
 - c. Implement a coherent uniform policy with respect to enhanced amenities;
 - d. Investigate the possibility of a financial injection to enhance public sector amenities;
 - e. Establish a process to develop and implement minimum service requirements for the public system;
 - f. Revise the human resource environment as it relates to health personnel to improve management and incentives to perform.

- (b) Consolidation of Medical Scheme reforms to remove any residual risk-selection and to increase coverage:
 - a. Expand prescribed minimum benefits to include chronic conditions and other essential services;
 - b. Phase out benefit options or, alternatively limit the degree to which they can be differentiated;
 - c. Phase out medical savings accounts from medical schemes;

- d. Refine the late-joiner penalties;
 - e. Require all civil servants to become members of a medical scheme; and
 - f. Significantly improve the regulatory environment for intermediaries.
- (c) Development of an effective policy process on defining and implementing Basic Essential Services: Ultimately both the public and private sectors will need to ensure coverage for an equivalent 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.
- (d) Development of an Integrated Subsidy System:
- a. This process needs to focus on rectifying structural deficiencies within and between the existing risk-pooling mechanisms (i.e. medical schemes and any part of the system funded from general taxes). These should include dealing with:
 - i. Inequity in the allocation of public health services;
 - ii. The tax subsidy to medical schemes;
 - iii. Risk-equalisation between medical schemes; and
 - iv. Unfair penalties applied within the medical schemes environment.
 - b. The public sector budget system needs to be revised to ensure that the regional allocation of health services is equitable. Furthermore, the subsidy provided to the private sector should at no time exceed that provided to people covered through the public sector.
 - c. It is essential that a system of risk-equalisation between medical schemes be introduced. This fund would also serve the function of allocating any appropriately structured risk-adjusted subsidy to medical schemes provided by Government.
 - d. The tax subsidy currently runs counter to the achievement of health policy objectives and must be reformed. It is recommended that it be converted into an explicit income- and risk-adjusted subsidy. This subsidy could ultimately be funded from an earmarked tax, although initially it should be funded from general tax revenue.
- (e) Measures to contain private sector cost increases need to be more explicitly targeted by Government policy. These should include the use of:
- a. Direct controls on the supply of services;
 - b. Various market-related measures; and
 - c. Improved regulation of competition.

Phase 2: *Implement preparatory reforms which include:*

- (a) A risk-equalisation fund.
- (b) A risk-adjusted subsidy to medical schemes;
- (c) A state-sponsored medical scheme; and
- (d) A mandatory environment for civil servants.

Phase 3: *Implement initial mandates and develop voluntary low-cost contributory options for low-income groups:*

- (a) Mandate medical scheme membership for higher income groups; and
- (b) A voluntary contributory environment for low-income groups outside of the medical schemes environment.

Phase 4: *Implementation of National Health Insurance:*

- (a) Implement a universal contributory system which would be offset from general taxes.
- (b) Establish a Central Equity Fund which would have the following functions:
 - The collection of income-based contributions from the public;
 - Alternatively, a formula-based allocation funded from general taxes could be considered;
 - The management of a contributor database and membership information;
 - The distribution of funds to:
 - The public sector basic amenity service for non-contributors;
 - The public sector enhanced amenity for contributors;
 - The private sector medical schemes;
 - The fund distributions will be based on an equity formula which would incorporate both income- and risk-based cross-subsidies.
- (c) Establish a Public Sector Contributory Fund to manage the reimbursement of provincial health departments. This authority would not deviate from the equity allocation distributions established by the Central Equity Fund. This fund would however take into account the regional distribution of public health services and attempt to achieve equity.
- (d) All residents of South Africa should become entitled to a subsidy equivalent to the risk-adjusted per capita average of all contributions and revenue received into the CEF. This subsidy system should evolve from the reforms in phases 1 through 3.