





# Chapter 8

## Health

### 8.1 Introduction

Transformation of the health system in South Africa has been and remains an urgent priority for the democratic Government since 1994. South Africa has introduced significant policy shifts and institutional changes to deal with the underlying problems of an inequitable race based system. Through its primary healthcare approach, the Government prioritised the needs of women and children by extending free healthcare for children under the age of six and pregnant women. The free healthcare programme was thereafter extended to all South Africans using public primary healthcare facilities. At hospital level, payment for services is means tested, and indigent citizens are entitled to receive free services.

Health interventions are critical in determining how Governments address issues of capability poverty. In the design of social security reform, health indicators are used to identify the extent to which deprivation and exclusion from essential health services affect the life chances of people. This section of the report addresses the key problem areas in the current policy context, and sets out a long-term strategy to address the underlying challenges with particular emphasis on those aspects related to social protection.

Healthcare provision constitutes an essential component of a minimum package of goods and services for the development and advancement of people. Moreover, given the history of unequal allocation of resources, levels of poverty and unemployment, a central policy objective is to achieve equity in and access to the allocation of

state resources to address health needs. The relationship between public and private health provision and the roles and responsibilities that are located in these environments are examined by the Committee to ensure the sustainable, equitable use of resources in the interests of all.

An overview of developments in South Africa's health system indicates that the reform direction and approach developed and proposed in the 1995 National Health Insurance (NHI) Paper remains a valid point of departure for ongoing reform. This requires that South Africa move ultimately toward a NHI system over time that integrates the public sector and private medical schemes within the context of a universal contributory system.

### 8.2 Findings

#### 8.2.1 Problems identified with the existing strategic framework

The existing structure of the health system has certain endemic perverse cycles that need to be reversed through interventions at an institutional level. The central contributors to this negative cycle are identifiable in four areas:

- **Cover:** The public sector is faced with an increasing population, both low-income and indigent, while the private sector population is not increasing. The public sector also has to provide cover for sicker and less healthy groups traditionally covered by the private sector. This latter shift is induced through risk-selection

within and uncontrolled cost increases.

- **Burden of disease:** The public sector is facing a worsening burden of disease as a result of HIV/AIDS as well as increasing levels of diseases of poverty. The private sector is attempting to shift HIV/AIDS patients and chronic patients onto the state system, as part of the risk selection process.
- **Finance:** Despite an increasing population and disease burden, the public sector health system faces a constant or declining real budget allocation. The private sector, by contrast, increases its expenditure at roughly double the annual inflation rate on a per capita basis. As costs increase in the private sector, so does the effective tax subsidy.
- **Providers:** In the face of an increased population to cover, an increased disease burden, and a declining budget, the public sector is losing clinical personnel to the private sector. As such, the private sector effectively drains resources from the state to provide cover to a relatively healthy and younger population. The private sector effectively receives a tax subsidy of approximately R7,8 billion to reinforce this trend.

Taking account of the above, Government needs to adopt a strategic approach to reforming the health system that engages fully with both the public and private sectors. The objective would be to achieve jointly what each cannot realise alone.

### 8.2.2 Role and scope of Government involvement

The ultimate responsibility for the overall performance of a country's health system lies with Government, which in turn should involve all sectors of society. Government has the responsibility for establishing the best and most equitable health system possible with available resources. The oversight and effective regulation of the private sector has to form part of the overall Government response and must be high on the policy agenda.

#### Central objectives

- **Increased risk pooling:** Risk pooling needs to be encouraged through the use of a combination of instruments. These would

include the tax system, the creation of risk equalisation mechanisms within both public and private sectors, Government mandates, and the reinforcement of community rating.

- **Benefits:** Government policy needs to provide a framework that results in cover for a minimum level of essential benefits irrespective of whether it is provided in the public or the private sectors.
- **Efficiency:** Given the existence of perverse incentives in unregulated markets for healthcare, any regulation must pay careful attention to the incentives generated. The use of mixed systems for covering and providing healthcare combined with the correct elements of choice is the best approach to balancing healthcare objectives with the need for operational efficiency.

#### Role of the public sector

The public sector system must remain the backbone of the overall health system and should be protected from chronic under-funding.

#### Role of the private sector

The private sector can provide an effective environment for achieving increased levels of funding over and above tax-based allocations. However, as the private market for healthcare suffers from chronic market imperfections, public sector involvement is required to ensure that funding levels are socially optimal and not merely what the market will bear.

## 8.3 Recommendations

### 8.3.1 Reform strategy

*The Committee recommends that South Africa move toward a NHI system based on multiple funds and a public sector contributory environment as defined in the 1995 NHI Committee Paper.* Initially the environment would remain differentiated between a private contributory environment and a general tax funded public sector environment. Over time this strict differentiation should 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 (figure 13).

**Figure 13**  
**Reform strategy and approximate timeline.**



The reform process has to take into account the need to develop a phased approach whereby key enabling measures are implemented and the base established for the longer-term reforms.

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 (figure 13).

### **8.3.1.1 Phase 1: Development of the enabling environment**

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 is resulting in substantial and unsustainable private sector cost escalations. This occurs because private medical schemes are technically barred from officially contracting for and using public sector services.

The priorities within phase 1 therefore focus on an enabling environment for more substantive future policy reforms. Central to

this process is a focused improvement of public health facilities and their management.

- (a) Preparation of the public hospital system:
  - i. Decentralise public hospital management
  - ii. Implement a coherent uniform policy with respect to enhanced amenities
  - iii. Investigate financial injection options to enhance public sector amenities
  - iv. Establish a process to develop and implement minimum service requirements for the public system
  - v. 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:
  - i. Expand prescribed minimum benefits to include chronic

- conditions and other essential services
  - ii. Phase out benefit options or, alternatively limit the degree to which they can be differentiated
  - iii. Phase out medical savings accounts
  - iv. Refine the late-joiner penalties
  - v. Significantly improve the regulatory framework dealing with 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:
- i. A process needs to focus on rectifying structural deficiencies within and between the existing risk-pooling mechanisms. These include:
    1. Inequity in the allocation of public health services
    2. The tax subsidy to medical schemes
    3. Risk-equalisation between medical schemes
    4. Unfair penalties applied within the medical schemes environment.
  - ii. 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 must at no time exceed that provided to people covered through the public sector.
  - iii. 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.

- iv. 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.

- (e) Measures to contain private sector cost increases need to be more explicitly targeted by Government policy. These should include the use of:

- i. Direct controls on the supply of services
- ii. Various market-related measures
- iii. Improved regulation of competition.

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

These need to focus on the creation of regulated risk pools, and changes 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.

Key reform elements would include the final implementation of:

- The risk-equalisation fund (begun in phase 1)
- The risk-adjusted subsidy to medical schemes (begun in phase 1)
- The state-sponsored medical scheme
- A mandatory environment for civil servants.

#### **8.3.1.3 Phase 3: Implementation of the initial mandates**

Once the preparatory reforms of phase 2 are substantially 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 active encouragement and 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* in addition to the state-sponsored medical scheme. This will help to establish the institutions in Government that would ultimately manage a public sector contributory scheme within a NHI framework. Thus two contributory mechanisms will exist: the first based on medical schemes (including the state-sponsored medical scheme); and the second a dedicated Public Sector Contributory Fund (PSCF). The non-contributory portion of the health system would continue to be funded from general taxes.

#### 8.3.1.4 Phase 4: Implementation of an NHI

The last phase envisages the implementation of a universal contributory system that would, to a substantial degree, replace general tax funding

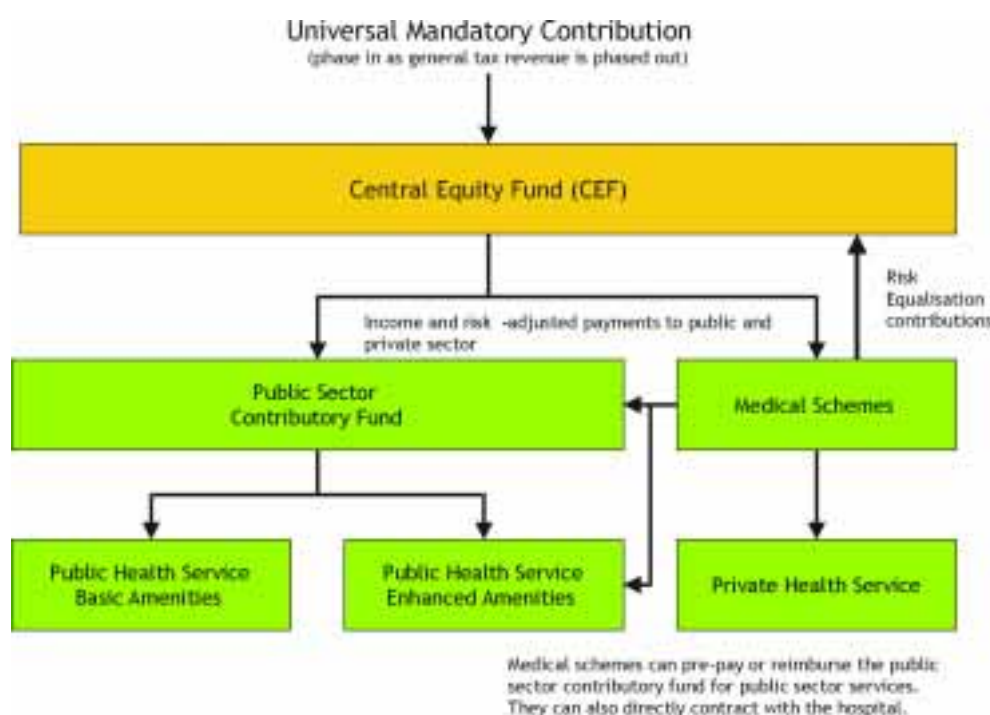
as a source of revenue (figure 14). General tax as a supplementary source of revenue may nevertheless prove desirable.

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 the subsidy provided to medical schemes. In other words, medical scheme contributions would be regarded as a top-up contribution to the subsidy.

All contributions and general tax allocations would 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 PSCF would become the national funding authority for the public health system. This would either operate as a dedicated unit within the national Department of Health, or exist as a separate parastatal reporting to the Minister of Health. Phases 1 through 3 would have seen the centralisation of the health budget, and the establishment of capacity to fund provinces via substantial improvements in the capacity to manage and apply the conditional grant system.

**Figure 14**  
**Institutional framework for a universal contributory system.**



The end phase of these enhancements would see the creation of the PSCF that would take responsibility for, and manage, the allocation of funds from general tax revenues and contributions allocated through the CEF.

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.

## 8.4 Strategic financial framework

Unlike retirement provision and other forms of insurance and social assistance, the health system comprises both a financial framework as well as a provider system. The proposed strategic framework involves the development of three risk-pooling systems.

The first is the universal per capita subsidy, funded from general taxes and enhanced through a redirection of the existing employer tax-subsidy. This system begins as entirely non-contributory

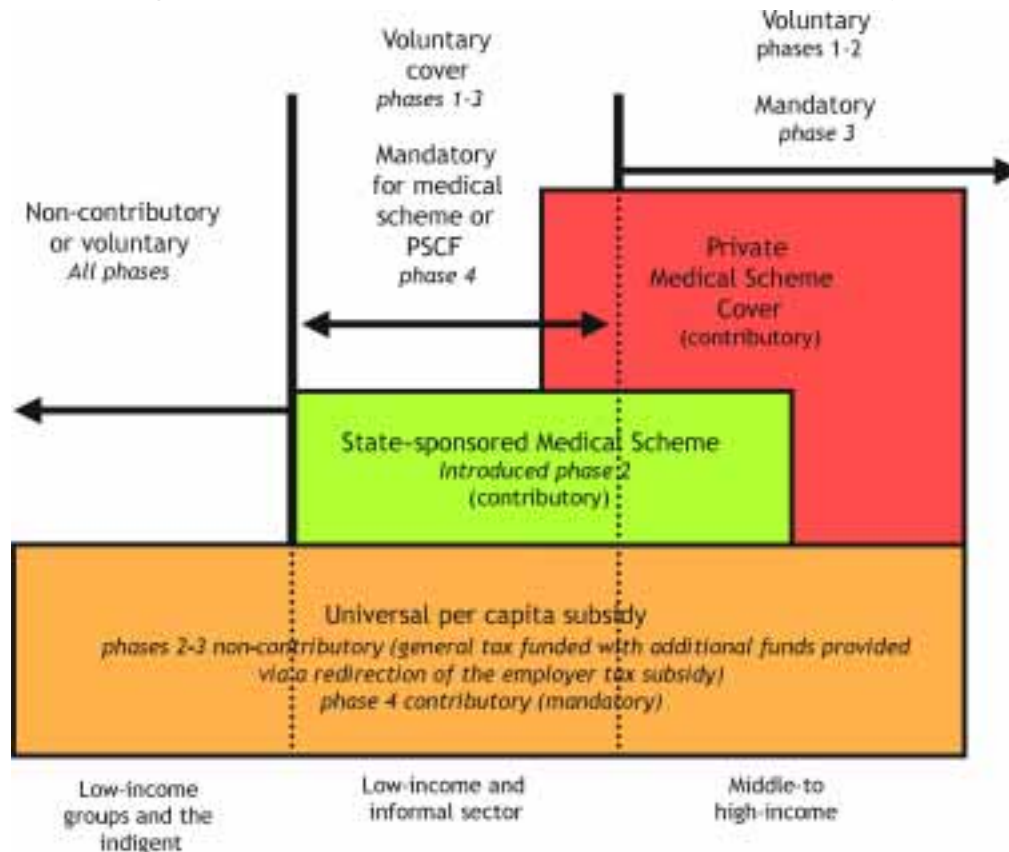
(funded from general taxes – phases 1-3) and converts to a contributory fund in phase 4. Contributors toward the universal per capita subsidy can choose to utilise this subsidy through the PSCF and obtain an enhanced public sector amenity, or to subsidise their contributions to a medical scheme. This system becomes the basis for entrenching income cross-subsidies within both the non-contributory and contributory financial systems.

The second major system is the medical schemes environment. This remains voluntary for high income groups for phases 1 and 2, after which it becomes mandatory. The third major risk pooling system involves the establishment of a state-sponsored medical scheme targeted at low-income groups, the informal sector, and middle-income groups who wish to obtain more cost-effective cover (figure 15).

## 8.5 Coverage

Coverage changes over the four general phases with the gradual expansion of the contributory system (table 9). The public sector basic amenity is the non-contributory environment offered free

**Figure 15**  
**Strategic financial framework for the South African health system.**



**Table 9**  
**Summary of coverage by broad income category**

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

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 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 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 that includes low-income groups. From that stage on, low-income contributors will access enhanced amenity services.

## 8.6 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.

It is recommended that the Department of Health engage in a consultation process to fully refine and develop this framework.