

This policy brief deals with considerations of the role of private health insurance (PHI) alongside a public health system or public health insurance system. This has critical relevance to the future role of medical schemes under a National Health Insurance (NHI) system in South Africa.

The June 2009 NHI proposal from the African National Congress (ANC) task team envisages that medical schemes will continue but on a voluntary basis. It is proposed that members will pay for NHI AND for any medical scheme they join. The contribution to NHI will be via general tax, supplemented by a progressive mandatory, payroll-related contribution shared between employers and employees. Everyone earning above the income tax threshold will have to make this NHI contribution (i.e. no one may 'opt-out'). The amount of the mandatory contribution was not determined in that report.

The current income tax subsidy for private healthcare is inequitable since it benefits those in the high income tax brackets the most. Low-income earners who get a small tax subsidy are still unable to afford adequate coverage, leaving them with modest benefits and high cost sharing. The core problem with a tax subsidy, no matter how it is structured is that if you are not paying income tax, then there is no subsidy. This means that individuals below the tax threshold^a get no subsidy at all if they are members of medical schemes. McIntyre, McLeod and Thiede argued instead for a direct per capita subsidy to improve affordability of healthcare for lower-income workers. This subsidy would be set to cover the full costs of a basic benefits package at public sector costs, and not be subject to the uncontrolled cost spiral of the private sector. This would also be neutral to the fiscus in future as the subsidy would be linked to the amount spent per head in the public sector.

Social security systems are commonly grouped into tiers, defined by the way individuals contribute to and draw benefits from each tier. In a single tier system there is only one system for everyone; this is typical of industrialised developed countries. In developing countries, multi-tier systems are common. For example a public health system as Tier 1, a mandatory contributory fund or funds for those employed as Tier 2, and purely private insurance and out-of-pocket spend in Tier 3.

Universal coverage does not necessarily mean a single tier system. Universal coverage can be achieved through a combination of funding methods (i.e. a multi-tiered system). The WHO urged Governments in Africa to develop plans for universal protection against cost-of-illness that might include a combination of tax-based financing, mandatory social health insurance and private insurance in a multi-tier system.

For example, a national public health service funded from general taxation might form Tier 1. All employed, including public sector workers, might make mandatory contributions to Tier 2 with significant income cross-subsidies. This could include medical schemes, bargaining council schemes and other forms of workplace-based healthcare. Tier 3 would be private cover and be provided, for example, by medical schemes or insurance companies or paid by individuals out-of-pocket.

The possible roles of PHI are shown in Figure 1. The 2009 ANC proposals on NHI effectively relegate medical schemes to a "duplicate PHI" role, i.e. cover already included under public insurance. It does not exempt individuals from contributing to public health insurance, but can offer access to different providers or levels of service. This will make medical schemes more unaffordable than at present and the decline in membership could be very rapid – initial and preliminary research suggests the numbers could decline from nearly 8 million lives to less than 1 million.

The principles described in the ANC Health Plan of 1994, however, suggest that a "substitutive" role for medical schemes was envisaged under NHI: the majority of that document is focussed on the creation of a National Health Service, not a National Health Insurance system. "A single comprehensive, equitable and integrated National Health System (NHS) must be created."

^a The tax threshold is the level at which people begin to pay income tax. This is at R54,200 per annum or R4,517 per month for those under age 65 in the tax year 2009/10. For those older than 65, the tax threshold is higher at R84,200 per annum or R7,017 per month.

NHI (as opposed to NHS) merits less than 1 page of that 77 page document. Thus what was envisaged initially seems to be a multi-tier system: a public National Health Service, alongside of which is a mandatory contributory National Health Insurance environment for formal sector workers. This early thinking needs to be revisited in the NHI debate in 2010.

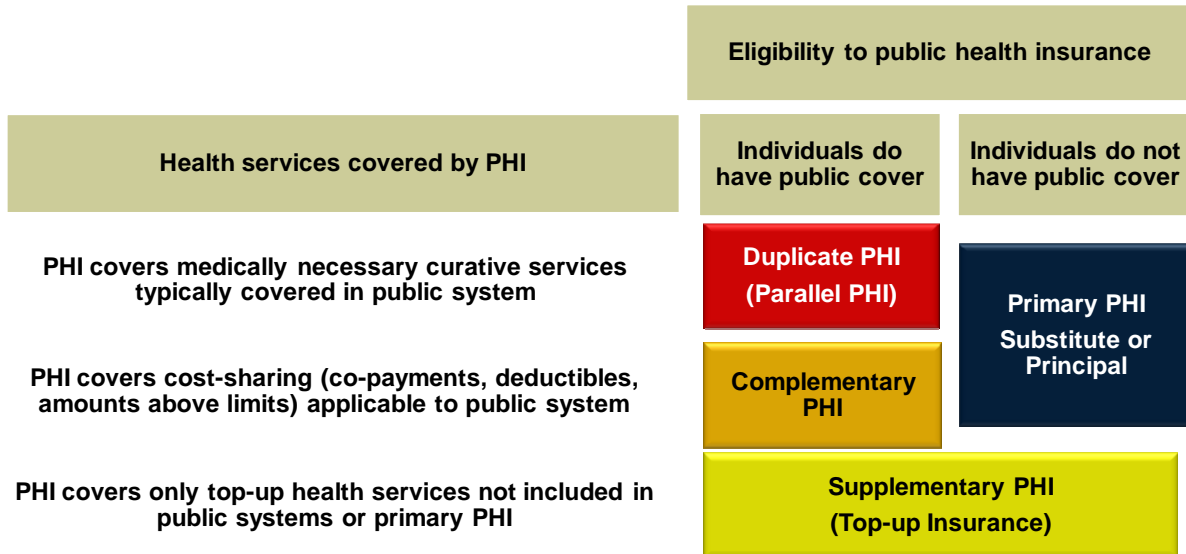


Figure 1: Possible Roles for Private Health Insurance

Source: Organization for Economic Co-operation and Development, 2004

Summarised for IMSA by **Jessica Nurick and Shivani Ramjee**

8 March 2010

Further resources on the IMSA NHI web-site

http://www.innovativemedicines.co.za/national_health_insurance.html

- The full policy brief, as well as the slides and tables used.
- The ANC Health Plan on 1994.

All material produced for the IMSA web-site may be freely used, provided the source is acknowledged. It is produced under a Creative Commons Attribution-Noncommercial-Share Alike licence. <http://creativecommons.org/licenses/by-nc-sa/2.5/za/>

