

This Policy Brief considers the reform path and the impact that each stage of reform will have on families and individuals. The order in which the steps are introduced is critical and there is a preferred order of implementation to avoid disastrous consequences for low income families.

McLeod & Grobler developed a methodology for demonstrating the effect of sequential reforms. As shown in Policy Brief 9 and Figure 1, medical schemes are currently unaffordable for lower-income workers and their families. The current environment has open enrolment, community rating and minimum benefits which include the treatment of chronic diseases as of 2004.

Families just below the tax threshold would currently be faced with spending 44% of income on a medical scheme. The replacement of the current tax break for medical scheme members with a per capita subsidy improves their position to 28% of income. The introduction of the Risk Equalisation Fund (REF) simultaneously with income cross-subsidies on Prescribed Minimum Benefits (PMBs) continues to reduce contributions to 22% of income for this group. All the medium and lower income groups benefit, with only minor increases for the highest income group from 6.2% of income before the tax break to 7.7% of income after REF and income cross-subsidies.

REF on its own before the per capita subsidy or any income cross-subsidy is seriously damaging to all lower income groups, putting them in a much worse position than before (not illustrated, but families just below the tax threshold would pay 52% of income). REF after the per capita subsidy but before any income cross-subsidies is almost as unaffordable as without any reform, needing 36% of income for this family. The reason is that many low income workers are on options that have a younger age profile. Those with higher incomes are often on options with comprehensive cover that attract older, less healthy members. This is why REF was never envisaged as being introduced in isolation without the accompanying income cross-subsidies.

It is shown in Figure 1 that the replacement of the tax break with the per capita subsidy has the most important effect on affordability for lower income workers. If full income cross-subsidies are implemented, then lower income workers are better off than with the per capita subsidy alone.

This does NOT mean that REF and income cross-subsidy are contributing very little to affordability. Without REF, there remain unfair differences between options or schemes where the amount paid depends on the demographics. Under REF, the price for PMBs converges on the industry community rate for all market participants.

Benefit reform to expand the benefits package is even worse for the lower income groups, due to introducing risk cross-subsidies without adequate and matching income cross-subsidies in the scheme. However, if the package is treated as an expansion of minimum benefits, such that income cross-subsidies are applied to the package over which REF is applied, then more is paid via the income cross-subsidy and thus the outcome is better for the lower income groups.

The social security contribution needed for a benefit package was estimated assuming that everyone aged 20 to 65 who earns any amount will contribute and that the beneficiaries of NHI will be the Insurable Families^a of the contributors. Contributions are reduced for low income families if risk and income cross-subsidies are for a package larger than existing PMBs. Other possible benefit packages are Extended PMBs (PMBs + all in-hospital events), Basic Benefit Package (BBPs: PMBs + all primary care) and Comprehensive Benefit Package (CBPs: PMBs + all primary care + all in-hospital events).

For income cross-subsidies for PMBs only, which were priced at R257.02 pbpm in 2007, the contribution required is estimated to be 4.1% of income. The Extended PMBs would need 10.3% of income, BBPs would need 12.1% and the CBPs would need 18.3%. If the same contributors covered everyone in the country for CBPs (not only their own families), then the social security contribution needed would be 37.2% of income – this is clearly out of the bounds of possibility.

^a Includes a member and a spouse or partner, with all their children. Children are defined as those under age 21 or those in tertiary education up to age 25.

The trade-off, which has not yet been adequately discussed by stakeholders and society: what is the extent of income cross-subsidies that the higher income groups are prepared to tolerate in setting up a NHI system? What is the extent of solidarity that could be designed into the social security system?

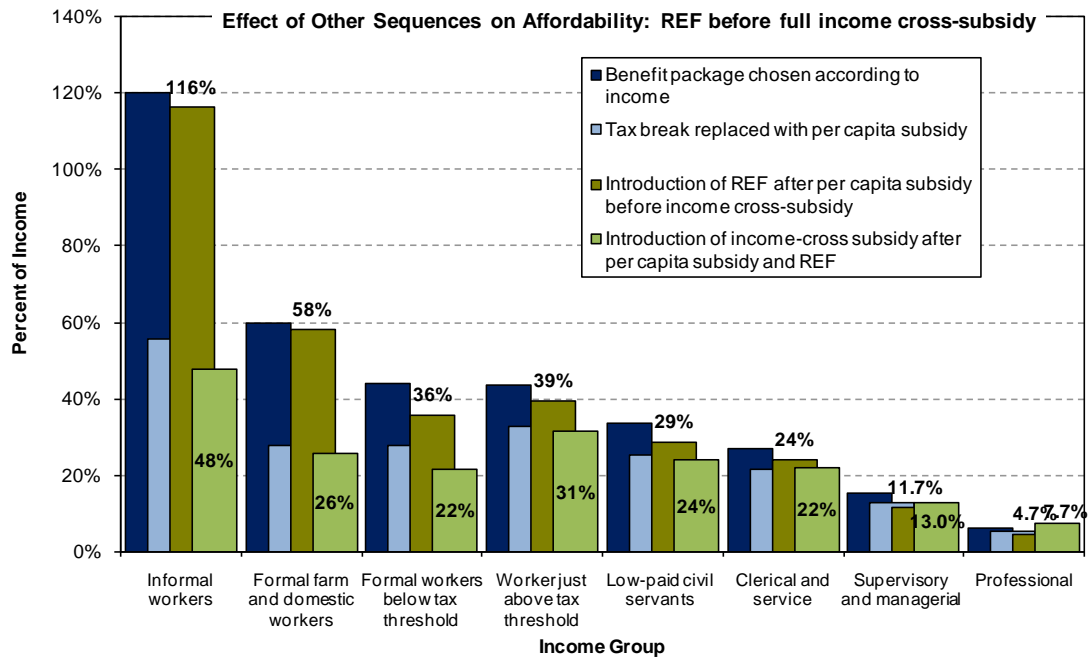


Figure 1: Impact on Affordability of the Risk Equalisation Fund with Partial and Full Income Cross-Subsidies

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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.
- A spreadsheet of the results of the affordability and sequence of reform model by McLeod & Grobler, showing the effect on affordability of each step in the reform process.

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