

Equitable Subsidy Framework

The second part of this policy brief builds on Policy Brief 16 to develop a mechanism that would link the National Health Service (NHS), private health insurance funds, LIMS funds and Bargaining Council funds in a common subsidy framework. Community-based and micro-insurance financing for health has not been a major feature but it is conceptually possible to extend the diagram to include these.

The International Labour Organization (ILO) policy on the use of multiple financing mechanisms argues for the pragmatic inclusion of all forms of healthcare financing, including tax-funded National Health Service (NHS) delivery systems; mandatory social health insurance financed by employers and workers; mandated or regulated private non-profit health insurance schemes; and mutual and community-based non-profit health insurance schemes. An important component of the plan to enhance universal coverage through a mix of these mechanisms is to determine the rules governing the financing mechanisms for each subsystem and the financial linkages between them, which includes financial risk equalisation between different subsystems.

The diagram shows taxes being raised from the population (by SARS) and becoming available as Government funding. The amount determined to be needed for healthcare could conceptually be paid to a National Health Solidarity Fund and then allocated to the various subsystems. This does not require a separate fund and could be a notional allocation exercise by National Treasury. The allocations for the provincial NHS are to be risk-adjusted by National Treasury from April 2011.

The allocations to the Risk Equalisation Fund (REF) for medical schemes and similar bodies for LIMS options (or schemes) and Bargaining Council schemes are shown. Each of these could then adopt a different approach to the risk-adjustment formula in paying to their respective funds. The envisaged formula for the REF requires extensive data on chronic disease in order to deal with the highly competitive behaviour of open medical schemes and uses the following risk factors: age; gender; numbers with the 25 Chronic Disease List (CDL) conditions; numbers with HIV/AIDS receiving anti-retroviral therapy; a factor for multiple chronic conditions; and a factor for maternity events.

The LIMS recommendations are for LIMS to have its own risk-adjustment pool due to the need to have separate benefit packages in different equalisation pools. It may also be possible to use a simpler formula for risk-adjustment which includes (say) age, gender and a single chronic-disease marker or HIV/AIDS. If all the funds were union, industry or employer-based, as with Bargaining Councils, then it is feasible to agree a much simpler approach. The funds could either be allocated on a per capita basis or on a simple risk-adjustment basis using only age and gender.

It is critical that risk-adjustment not be implemented without simultaneously introducing income cross-subsidies otherwise there will be very adverse consequences for lower income families. In Figure 1 a box for income cross-subsidisation is drawn around all three types of funds. It is likely that the lowest income workers will be better off in a single income-cross-subsidy pool. The larger the package of benefits pooled, the better off the lower income workers will be. But there comes a limit as to the extent to which income-cross-subsidies can be pushed and the extent to which middle and higher-income workers can cross-subsidise the much higher numbers of lower income workers.

The answers are not straightforward and require further technical work to be done on the degree of solidarity that it is possible to engineer into the environment. A further important issue is whether the transfers from the National Health Solidarity Fund should be made to the subsystems on the basis of a per capita allocation or whether this should be on a risk-adjusted basis.

NHI as envisaged by the ANC in September 2010²² is to be implemented perhaps in 14 years time. We cannot simply allow the current problematic healthcare financing arrangements in South Africa to continue for that length of time (or longer). In the opinion of the author we should be using the ILO framework to be looking for ways to improve universal coverage using all the subsystems we have available. While the work is still at a conceptual stage, the diagram showing the financial linkage between the multiple healthcare subsystems could provide a way forward.

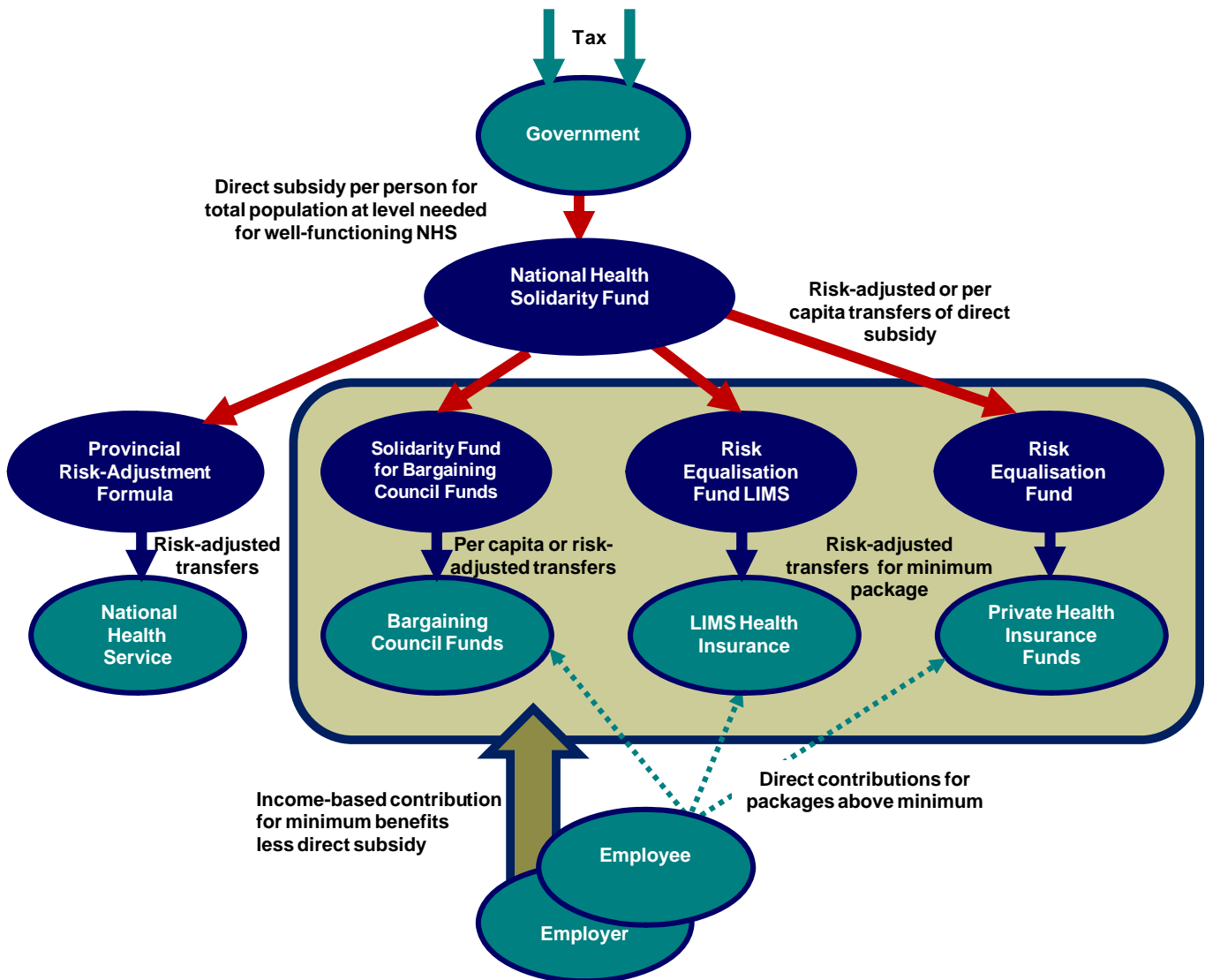


Figure 1: Financial Linkage between Multiple Healthcare Subsystems in South Africa

Summarised for IMSA by **Heather McLeod**

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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 and slides.

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