

- 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.**

