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.

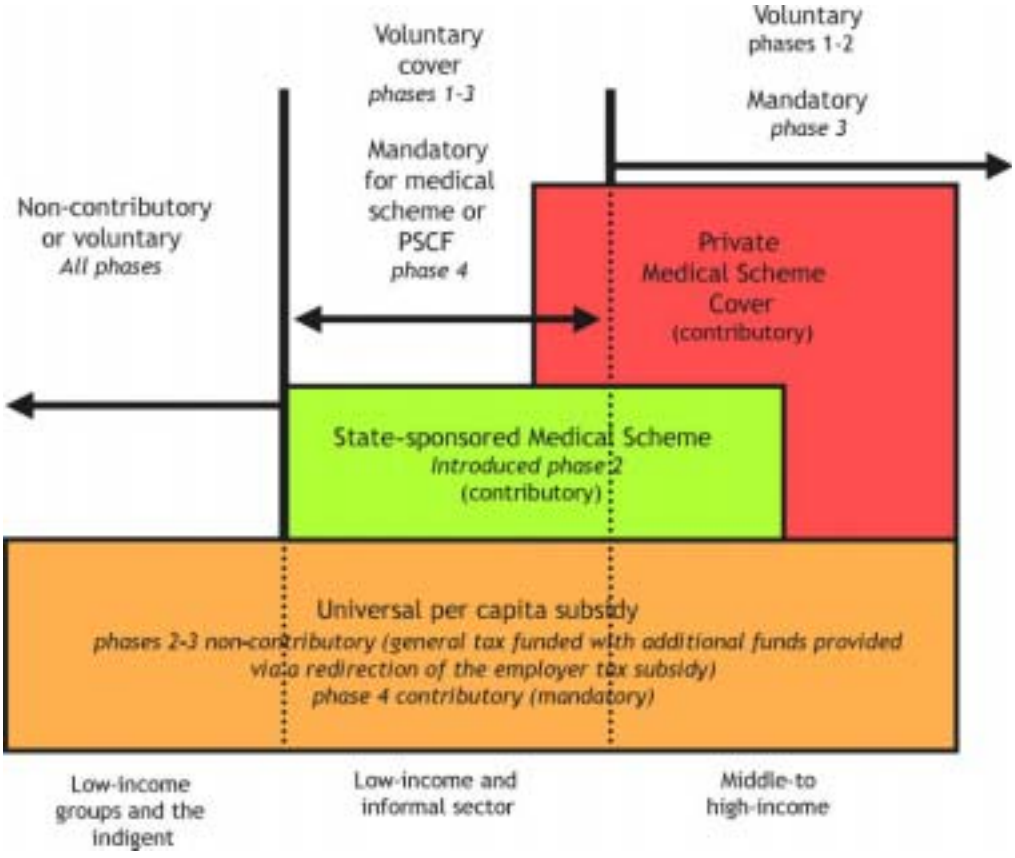

Table 9
Summary of coverage by broad income category

	Phase 1	Phase 2	Phase 3	Phase 4
Poor	o Public sector: basic amenity (free)	o Public sector: basic amenity (free)	o Public sector: basic amenity (free)	o Public sector: basic amenity (free)
Low-income	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)
Middle-income	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)
High-income	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.