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Improving Equity in the Subsidies for Healthcare in South Africa

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Background

In May 2005 the World Health Assembly endorsed a resolution¹ calling on member states to work towards universal coverage and pre-payment for healthcare services. Countries were called on to share experiences on different methods of health financing, including the development of social health insurance schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system. A report in 2006 on the status of healthcare funding in Africa² concluded that countries need a comprehensive health financing strategic plan with a clear roadmap of how to transit to universal coverage.

The South African health system has long been characterised by extreme inequalities in the allocation of financial and human resources. The delivery system is a mix of robust private sector, struggling public sector and some non-governmental not-for-profit organisations. Private health insurance has been in existence since 1889 but remains voluntary and serves only the 14.8% of the population with higher incomes. There is a tax subsidy for private healthcare which favours the highest income but gives no subsidy to those using private insurance that earn below the tax threshold. Out-of-pocket payments account for almost a quarter of private health care financing, partly due to the use of personal individual medical savings accounts in many health insurance funds.

South Africa intends to implement major reforms in the collection and pooling of financing for healthcare. Free market reforms in private health insurance in the late

¹ World Health Organization (2005b) *Sustainable Health Financing, Universal Coverage and Social Health Insurance. Resolution*. Fifty-Eighth World Health Assembly WHA58.33, Agenda item 13.16, 25 May 2005. Available on <http://www.who.int>

² Kirigia J.M., Preker A., Carrin G., Mwikisa C., Diarra-Nama A.J. (2006) *An overview of health financing patterns and the way forward in the WHO African Region*. East African Medical Journal, September 2006 (Supplement). Available on <http://www.who.int>

1980s and early 1990s had produced adverse results in terms of health care equity and access, with the elderly and those with chronic disease being most vulnerable.

The new democratic government in 1994 began a process of re-regulation, with the re-introduction of open enrolment, community-rating and minimum benefits from January 2000. A system of national health insurance with income cross-subsidies, risk-adjusted payments and mandatory membership was envisaged in policy papers from 1994 onwards³. Subsequent work has seen the design of a Risk Equalisation Fund (REF) that will operate between competing private health insurance funds. The REF is also envisaged as the vehicle to distribute the government subsidy for healthcare. The diagram below indicates the steps that are envisaged in moving to a mandatory health system⁴.

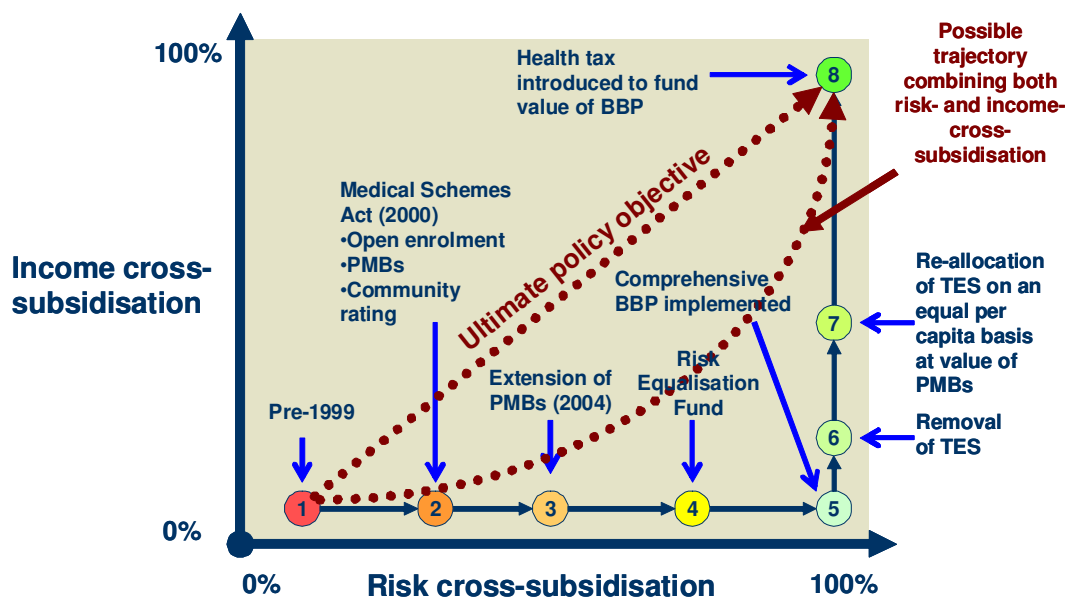


Figure 1: Policy trajectory for the implementation of mandatory health insurance
Source: Ministerial Task Team on Social Health Insurance, July 2005

This presentation will focus on steps 6 and 7 in Figure 1. A critique of the system of subsidies for private health insurance was prepared initially⁵ using data adjusted to

³ McIntyre D., van den Heever A. (2007) Social or National Health Insurance. In: Harrison S., Bhana R., Ntuli A., editors. *South African Health Review 2007*. Durban: Health Systems Trust; 2007. URL: <http://www.hst.org.za/publications/711>

⁴ The "Removal of TES" refers to the removal of the tax expenditure subsidy created by the tax subsidy for private health insurance. "PMBs" are the prescribed minimum benefits that must be offered by all health insurance funds. "BBP" is an expanded set of minimum benefits.

⁵ McIntyre D., McLeod H. and Thiede M. (2005) *Comments on the National Treasury Discussion Document on the Proposed Tax Reforms Relating to Medical Scheme Contributions and Medical Expenses*. Unpublished report from Health Economics Unit and

calendar 2005. The subsequent tax reforms of 2006 did not substantially change the shape of the subsidies or ease the problem that those earning below the tax threshold do not benefit from any subsidy. The level of the subsidy for private healthcare is also not linked in any way to the funding of public sector care. With very high healthcare inflation in the private sector, the subsidy for private health insurance is growing faster than public sector funding.

The technical work on evaluating the subsidy would be updated to 2008 and the revised tax tables for 2008 used in the model. The lack of equity in the subsidy for private insurance would be demonstrated using model families and particularly low income families. An approach which would equalise the subsidies and link them to public sector expenditure per person would be demonstrated. This would substantially improve the equity in the subsidy structure.

The difficulty of sequential implementation of complex reforms will be raised as a concern in the implementation of a mandatory health insurance system. Problems associated with implementing step 4, the Risk Equalisation Fund, before implementing the change in subsidy in step 7 will be considered. The adverse impact of risk equalization on low income workers in the absence of income cross-subsidies and mandatory membership will be demonstrated. Risk equalization is a critical component in moving towards a system of social or national health insurance in competitive markets, but its implementation in isolation while the market remains voluntary could be damaging.

This material is critical for the debate needed in South Africa on the rapid implementation of a mandatory health insurance system. The material should be of interest to researchers from other African countries in high-lighting obstacles to avoid in moving from voluntary to mandatory health insurance.