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REPORT OF THE COMMITTEE OF INQUIRY INTO A NATIONAL HEALTH INSURANCE SYSTEM

EXECUTIVE SUMMARY

1. APPOINTMENT, TERMS OF REFERENCE, MEMBERSHIP AND MODE OF OPERATION

1.1 Appointment and terms of reference

The Committee of Inquiry into a National Health Insurance System was appointed by the Minister of Health, Dr NC Dlamini Zuma, in January 1995. The terms of reference of the Committee are shown on page 1 of the main report.

1.2 Membership of the Committee

The Committee was chaired by Dr Jonathan Broomberg and Dr Olive S Shisana, and consisted of technical experts appointed from the Departments of Health and Finance and from private sector organisations, as well as four international consultants. The full list of Committee members is shown in Appendix 1.

1.3 Mode of operation of the Committee

The Committee conducted formal hearings, considered written evidence, engaged in its own research and deliberations, and consulted widely with interested stakeholders. Formal hearings were conducted in all nine provinces, and oral submissions were taken from a total of 90 groups or individuals. In addition, a total of 215 written submissions were received and analysed. Details of all evidence considered by the Committee is shown in Appendix 2.

2. ASSESSMENT OF CRITICAL PROBLEMS IN THE ORGANISATION AND DELIVERY OF PRIMARY HEALTH CARE AND OTHER HEALTH SERVICES

Many South Africans face substantial obstacles in obtaining access to adequate health services, including geographical and financial barriers, and those caused by disorganised and poor quality services that are primarily the legacy of the apartheid health care system. These problems impact profoundly on the health status of those who depend on public sector services, and particularly the poor. Addressing these problems is therefore a fundamental precondition for fulfillment of the Reconstruction

and Development Plan, and of its specific goals of providing access to adequate health care services for the entire population, and of meeting basic needs.

One of the most critical problems affecting the health care in South Africa is the weak and fragmented public sector primary health care (PHC) system. The faults of this system are attributable to a combination of problems, critical among which is maldistribution of resources (financial, physical and human) between hospitals and the primary care system, and between urban and rural areas. These problems are aggravated by a severe maldistribution of resources between the public and private health sectors. South Africa spent approximately R30 billion on health care in 1992/93, or 8.5% of GDP, of which 60.8% was accounted for by the private health sector, which provides care for only 23% of the population on a regular basis. Similarly, 59% of doctors and 93% of dentists work exclusively in the private sector. While these substantial private sector resources contribute to the high total expenditure on health care in the country, they are currently not accessible to the majority of the population on a consistent basis. In addition, inefficiency and cost escalations are rendering private health care increasingly unaffordable.

South Africa therefore faces serious problems in both the public and private sectors, as well as in the interface between them. These will become increasingly serious as the burden on the health services increases over time due to the rapidly expanding HIV/AIDS epidemic, the ageing of the population and other epidemiological shifts. Addressing these problems effectively will require a significant level of restructuring of both sectors. The Department of Health and the nine provincial health administrations have begun a process of restructuring and reprioritisation of the health services, and the recommendations of this Committee should be seen in this context.

3. INTRODUCTION TO FINDINGS OF THE COMMITTEE

Despite the focus of the terms of reference on the PHC system, it became clear during the work of the Committee that PHC services could not be considered in isolation from the rest of the health care system. With the consent of the Minister of Health, it was thus decided to extend the scope of the investigation to include consideration of both the public and private components of the national health system.

This report therefore puts forward a set of proposals aimed firstly at the achievement of substantial, visible and sustainable improvements to the accessibility, efficiency and effectiveness of *publicly funded PHC services*, as well as on the funding required to finance these changes. It is envisaged that these proposals will be implemented over a five year period, with several 'fast track' elements designed for immediate implementation. In addition, proposals aimed at improving funding and governance of the public hospital, as well as the equity and efficiency of the private sector are put forward. These proposals should be interpreted as part of a broader and continuing restructuring and transformation of the entire national health system. They are also informed by the perspective that the restructuring of the health sector must be achieved in a context of controlled global health sector expenditures, requiring more efficient and effective use of existing resources. This will in turn require redistribution of

resources between levels of care within the public sector, as well as of resources currently used only in the private sector to make them accessible to a broader section of the population.

4. THE ORGANISATION OF THE PHC DELIVERY SYSTEM

4.1 Basic Principles

The following basic principles inform the Committee's recommendations:

1. Universal Access. All permanent residents[1] of South Africa should be guaranteed access, on equal terms, to all services provided by the publicly funded PHC system. This implies that the financial, geographical and other barriers to access to PHC services, and the quality of services delivered, should be equivalent for all users of the system.

2. The publicly funded PHC system should build on and strengthen the existing public sector PHC system.

3. The PHC system should be congruent with, and should strengthen the emerging district based health care system.

4. The PHC system should be based on a comprehensive primary health care approach, and should use population based planning and delivery mechanisms.

5. The PHC delivery system should be fully integrated with, and consistent with, other levels of the health care system.

6. The PHC system should optimise the public-private mix in health care provision, and should ensure the achievement of redistribution of resources between the current private and public sectors.

7. The PHC system should preserve the choice of individuals to use private providers and to insure themselves for doing so. While the proposals laid out in this report envisage the development of a high quality, publicly funded PHC system to which all would have access, and which all taxpayers would ultimately be required to finance, these proposals nevertheless recognise the right of individuals to use private sector providers for their PHC services, and to insure themselves for the use of these services.

[1] The Committee gave some consideration to the definition of permanent residents, but recognised that this definition is a political question, which must be addressed by the Government in light of more general policies on immigration and foreign relations.

4.2 The PHC package

It is proposed that the publicly funded PHC system provide a comprehensive package of PHC services, including district hospital services, environmental health services and other preventive, promotive and monitoring services, and comprehensive personal ambulatory services, including access to essential medicines for PHC. Furthermore, the package should be defined in terms of access to defined providers serving a defined population, who will collectively provide the list of services outlined in Tables 1 and 2 of the main report. This list of services is not exhaustive, but attempts to define the margins of the package, with providers and local managers enjoying some discretion in decisions over appropriate levels of care. The actual scope of the PHC package will in practice be determined by resource constraints, and may change over time.

4.3 The PHC delivery model

The main features of the proposed delivery model for PHC services are illustrated in Figure 1 in the main report.

4.3.1 Access to the PHC system

In compliance with the basic principle of universal access to the PHC system, all permanent residents, whether or not they have private health insurance, will have the right of access to the publicly funded PHC system on equal terms. This implies that a uniform policy on user charges should be implemented throughout the country.

It is proposed that access to all personal consultation services, and all non-personal services provided by the publicly funded PHC system will be free of charge to all users of the system at the point of service. Specific exceptions to this principle may apply in the case of medicines, for which a small co-payment per script may be required. However, no-one will be denied access to medicines on the grounds of inability to pay. In addition, where patients bypass PHC facilities and present at public hospitals for outpatient services, they will be penalised by an additional user charge, except in emergencies, or where public PHC facilities are closed or not available. Finally, as part of a more general policy on user charges in public hospitals, charges will be placed on in-patient hospital care at district level.

4.3.2 The administrative role of the District Health Authority

The Department of Health and the Provincial health administrations have decided to move rapidly towards the implementation of a district based health care system, and substantial progress has been made in this direction. The Committee is strongly supportive of this general policy direction, and believes that the district based health care system will facilitate both increased equity and efficiency in health services management, as well as increased community participation, and responsiveness to the needs of patients and communities.

It is envisaged that the district health authority (DHA) will play the key administrative role, as the lowest tier of government, within the publicly funded PHC system. Until the DHA is competent to assume its full responsibilities, the provincial and/or local authorities will play this role. The Committee recognises that the political and constitutional issues surrounding the respective roles of, and the balance of powers between, the DHA, provinces and local authorities remain to be settled.

4.3.3 The DHA as 'purchaser' of services

The improvement of public sector governance is a crucial component of the strategy of strengthening the public PHC system. It is proposed that improved governance would be achieved by the introduction, over time, of a gradual shift in the role of the DHA, from that of an integrated funder and provider of care towards a 'public purchaser' model in which the DHA will act as a purchaser of care from varying combinations of public and private providers.

In this model, all providers, whether public or private, would ultimately be contracted to the DHA, and would have to be accredited as competent to provide the defined range of services. In practice, the system will retain a substantial component of direct public sector provision of services. This is particularly the case for district hospital services, environmental health services, and other district support services, which the DHAs will continue to fund using normal budgetary mechanisms.

In the case of ambulatory personal services, there will be greater long term opportunities for the DHAs to contract with a combination of public and accredited private providers, and for the ultimate emergence of some forms of provider competition, especially in densely populated areas of the country. This approach will also address the maldistribution of resources between the present public and private sectors by making private providers accessible to the broader population.

The rapid introduction of accredited private providers poses several problems. Private providers will need to reorganise in order to obtain accreditation. The full-scale introduction of contracted providers will also require registration of the populations served by each provider. Rapid introduction also poses the risk of undermining public sector provision, as well as of opportunistic behaviour by contractors where DHAs are not competent to manage contracts. A gradual approach to the introduction of accredited private providers will therefore be essential, and it is envisaged that public providers will remain the dominant providers of PHC in most parts of the country for the first few years. Accredited private providers will therefore be introduced on a gradual and experimental basis in the first instance, with particular emphasis on currently underserved areas. These might include urban areas currently underserved by public providers, as well as rural areas. The effects of these contractual arrangements should also be carefully monitored through the introduction of pilot projects.

4.3.4 Public providers

Public providers will include all existing public facilities, such as local authority and provincial clinics, community health centres, day hospitals and district hospital outpatient departments (OPD). These providers would provide comprehensive personal services on site, including curative, preventive and promotive services. It is intended that public providers would begin as direct subsidiaries of the DHA, but would shift over time to functioning with greater autonomy. The purpose of this shift to greater autonomy is once again to create more powerful incentives for efficient behaviour by public providers.

Primary Health Care Nurses (PHCNs)[2] are envisaged as the *front-line providers* of clinical PHC services within public facilities, with referral to medical and to other allied health personnel, as appropriate. The details of the actual responsibilities and relationships between PHCNs and medical practitioners will be determined at district and at institutional level

Payments to individual health workers within public facilities will initially be based on the salary systems and frameworks currently in practice. However, it is intended that conditions of service should be substantially improved. Part of these improvements might involve a shift towards some combination of salary and capped fee-for-service type payment, or other reimbursement arrangements designed to maximise incentives for efficiency.

4.3.5 Accredited private providers

Accredited private providers are envisaged as health care teams, involving a range of personnel, including medical practitioners, PHCNs and allied health personnel. The teams would be expected to provide a defined, comprehensive range of *personal* services to a registered patient group. These private providers would need to be accredited, and would then compete for contracts from the DHA.

4.3.5.1 Organisation of accredited private providers

The ideal arrangement would be for most services to be available under one roof, and for some limited services to be sub-contracted if essential. The major mode of organisation is thus seen as the multi-disciplinary group practice, and it is not envisaged that solo general practitioners (or other health professionals) could obtain

[2] Primary health care nurses are envisaged in this report as professional nurses, with additional clinical training. The term PHCN does not necessarily refer to the specific category of nurses currently registered by the South African Nursing Council. The precise details of training and competencies of PHCNs remains to be worked out in consultation with the appropriate training and licensing bodies. It is recognised that several different categories of nurses with clinical training currently exist, and these will need to be standardised.

contracts as accredited private providers, and then sub-contract all other services. This would inconvenience patients, and most general practitioners (and other health professionals) practising alone are generally not able to offer the type of comprehensive PHC services envisaged here. It will be also inefficient and logistically difficult for the DHA to enter into and monitor large numbers of contracts with solo practitioners.

All of these arrangements should be flexible enough to cope with variations in local conditions. In some rural areas, or in some townships, it may be impossible for the DHA to find accredited private providers who meet all criteria, making it necessary to contract with solo practitioners. The DHA will be more interested in the range and quality of services offered than in the details of health personnel employed, and accredited private provider will enjoy some flexibility over staff arrangements. Constraints on flexibility will emerge from cost pressures, and from range of service requirements.

4.3.5.2 Contractual arrangements between DHAs and accredited private providers

The precise details of the contractual arrangements between DHAs and accredited private providers remain to be worked out in the planning process. Certain criteria governing these relationships have been defined at this stage. Contracts will need to spell out the contractor's responsibilities in some detail, and will also have to specify the nature and timing of reporting requirements, details of monitoring and regulation by the DHA, and mechanisms and penalties for breach of the contract. Efficient contracting also requires that the risk of the contract is distributed between the contractor and the purchaser.

Accredited private providers would not be entitled to charge any patients for their services. This would not preclude medical practitioners who operate within accredited provider practices from operating in private practice at a different location. These arrangements could not however be undertaken at the expense of patient care in the accredited provider practice.

4.3.6 The accreditation process

The specific details of the accreditation process remain to be finalised. The following general principles would however apply:

- Accreditation should occur within a national accreditation framework, under the auspices of a national accreditation body which should be set up as soon as possible. The national accreditation body might have provincial substructures, or might have representative/s within the provincial department of health.

Criteria to be included within the framework might include:
- minimum standards for numbers, range and qualifications of personnel
- provision of equipment and facilities of required standards.
- demonstrated capacity to store and handle medicines and other materials.
- fulfilment of minimum information system requirements.
- quality of services provided, evaluated in terms of process and outcome measures.

Accreditation will ultimately apply to both public and private providers. The accreditation process must begin with and sustain high levels of credibility, and be even handed in its application to both public and private providers.

4.3.7 Registration of the population

These proposals will require registration of the populations served by the DHA. This should ideally be done under the auspices of a national data base, but may have to be undertaken by the Department of Health for its own purposes. Registration issues will need to be investigated urgently.

4.3.8 Strengthening human resource capacity

The delivery of comprehensive, high quality PHC services is currently constrained by substantial gaps in both the quality and quantity of suitably trained PHCNs, doctors, other paramedical staff and managers in the public sector. The strengthening the human resources capacity of public PHC facilities is a central component of these proposals. The Committee has estimated in some detail the requirements, and consequent gaps over five years, in several key personnel categories. Details are shown in chapter 4 in the main report.

4.3.8.1 Filling the PHCN gap

In the case of PHCNs, extensive and rapid investments in training are required, and detailed training programmes are planned. Key features will include the development and extension of a six month training programme for nurses with a four year professional degree. It is estimated that the gap in PHCN requirements can be filled within approximately five years. Until adequately trained PHCNs are available in suitable numbers, however, services will continue to be provided largely by professional nurses without formal training in clinical practice.

4.3.8.2 Filling the medical and paramedical staff gap

The gaps in medical staff requirements would best be filled through substantial increases in the number of full-time doctors working in public facilities, and urgent steps are planned to achieve this goal. Short term measures are discussed under the

'fast track' programme below. In the longer term, the fundamental problem of poor conditions of service will have to be addressed if increased numbers of full-time medical staff are to be attracted to, and retained by, the public PHC system. Additional longer term issues to be addressed include:

- Improvements in total compensation package for medical staff

- Development of an attractive generalist career structure for non-specialist medical practitioners.

- A policy that would require new medical graduates to undergo formal training, equivalent to a registrarship, prior to being allowed to enter general practice.

- A policy requiring new medical and other health professional graduates to spend a defined period working in the public sector prior to being allowed to enter private practice. This would be in lieu of the costs of their training, and could be replaced by repayment of a sum representing the cost of that training.

- Creation of strong linkages between academic centres and the PHC system.

Despite the strong preference for full-time medical staff, it remains likely that the majority of additional medical staff requirements will be fulfilled by attracting increased numbers of part-time sessional medical staff to work in public facilities. Short term measures are discussed under the 'fast track' programme below. Longer term measures would include:

- Systematic planning of sessional post requirements.

- Measures to ensure better integration of sessional staff with full-time employees, and participation of sessional staff in functions beyond clinical consultations.

- Improvement of the contractual arrangements between DHAs and sessional employees.

- Improvements in oversight and quality control.

- Sessional posts to be integrated into, and become part of the obligations for GP training and/or a period of public service.

Note that all of the above comments refer to both medical and paramedical staff.

Where full-time and part-time practitioners are in short supply, private practitioners' services will be engaged through *referral contracts,* in which patients would be referred to the GP by a PHCN in the public facility. This amounts to a significant restructuring of the problematic district surgeon (DS) system, which will be implemented as a matter of urgency. The overall effect of these proposals is to facilitate the emergence of flexible and creative arrangements between DHAs and local practitioners so as to maximise the contribution of private practitioners to the public delivery system.

Specific proposals include:

- *Change of name from district surgeon to district family practitioner (DFP).*

- *Changes to referral system and site of practice.* Where public PHC services with PHCNs or equivalent exist, the requirement of a Magistrate's certificate of indigency should be replaced by a requirement for referral from a public PHC provider. Wherever possible, the DFP should be encouraged to see public patients in a public facility. Where no public facility exists, the requirement of referral will be dropped.

- *Disaggregation of the functions performed by DFPs and inclusion of new duties.* Certain functions currently performed by DSs may be more efficiently provided either by full time public staff, or sessional staff in certain districts. These functions include curative care for indigent patients, care for other public sector patients (e.g. prisoners), medico-legal cases and after hours duties. Additional duties might include training and support of PHCNs; provision of more detailed epidemiological data and co-ordination with preventive and promotive aspects of PHC.

- *Increasing the number of DFP posts where appropriate.*

- *Improvements to payment mechanisms and incentives.*

- *Improved monitoring of quality and cost of services.*

4.3.8.3 Filling the gap in managerial staff

The improvement of governance and service delivery within the PHC system will also require rapid and extensive investments in management training. Two basic forms of management training are proposed. Extensive in-service training will be required for nurses and other staff currently holding management positions within the public PHC system. In addition, full-time training programmes will be implemented to train new managers for the districts, and for health facilities. The ultimate goal would be for all district health managers to have approved post-graduate qualifications in public health and health services management within a five year period. In the short term, the possibility of hiring managers with private sector experience on short term contracts should be investigated. These arrangements could be combined with the creation of apprenticeship/shadow management arrangements, in which management trainees are attached to experienced private sector managers, with the aim of building management capacity in the public sector.

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4.3.8.4 Improvements in staff distribution and efficiency

Additional specific proposals aimed at improving distribution of staff, particularly to rural and undeserved areas, as well at improving general staff efficiency, include:

- Design of compensation systems to include incentives to attract health workers to underserved areas.

- The use of licensing and accreditation mechanisms to assist in efficient distribution of health professionals.

- Changes in training of health professionals which will reverse the current pattern of the majority of graduates remaining in urban areas.

- Measures to increase the flexibility and efficiency of human resources management at the DHA and institutional level.

4.3.9 Gaps in provision of physical facilities

The accessibility and quality of PHC services are also constrained by inadequate supply and inequitable distribution of physical facilities, and by poor condition of much of the existing capital stock. The Committee has undertaken research to determine the current supply, and projected requirements, and hence the gap over time, in the provision of PHC facilities. Estimated costs of filling this gap have also been assessed. While RDP and other projects are already addressing this problem, substantial additional investments will be required if the deficit is to be eliminated within a five year period. Investment plans will thus need to be developed by the provincial governments, with funding coming from a combination of existing capital works and health department budgets, as well as from incremental funding for the PHC system. Some proportion of the capital deficit may be made up through private sector investment.

4.3.10 Access to essential PHC medicines.

The Committee strongly supports the intended introduction of a national essential medicines programme for the public sector as a whole, as proposed by the Drug Policy Committee.

4.3.10.1 The Essential Drugs List concept

A national Essential Drugs List (EDL) is being developed, and will be implemented in conjunction with a national essential medicines programme (EDP). The EDL will consist of medicines critically required for use in the public sector for the prevention and management of 90%-95% of the common and important conditions in the country. These medicines should meet the highest standards of safety, efficacy and quality, and

should be available at lowest possible cost to all South Africans. The EDL will serve as the basis for the national system of medicines procurement, distribution, utilisation, review, training of health personnel, pricing, and policies governing support to the local pharmaceutical industry. The EDL will be introduced alongside comprehensive treatment guidelines for use within the public sector, and will specify the appropriate prescriber level for each drug.

4.3.10.2 Application of the EDL and EDP in the PHC system

EDL medicines will be available at all district hospitals, public providers and accredited private providers. A small co-payment for medicines may be required from patients obtaining these at public and accredited private providers.

PHC level medicines on the EDL will also be made available, at state tender costs, via retail pharmacies, with additional payment of a dispensing fee which would be retained by the dispenser. Thus, individuals who choose to use private practitioners for their PHC services would be able purchase PHC level EDL medicines at substantially lower cost than is presently the case. Note that this would apply only to those medicines on the EDL. All medicines not on the EDL would need to be purchased at full retail price. For those medicines on the EDL, pharmacists would not be allowed to mark up the costs of the medicines, and would be entitled to charge only a dispensing fee, which would represent payment for the costs of handling the medicines, plus a reasonable profit. This element of the proposal is consistent with the recommendation of the Drug Policy Committee that a system of reimbursement for costs of acquisition and storage, rather than mark-ups, should be studied. Also consistent with the proposals of the Drug Policy Committee, PHC medicines on the EDL would be made available, under the same conditions, to doctors entitled to dispense (the Drug Policy recommendation was that dispensing should be permitted primarily where there are no licensed pharmaceutical outlets within a reasonable distance).

The distribution of PHC drugs on the EDL at cost to private sector consumers will have a dramatic effect on current private sector expenditure on drugs. A conservative estimate suggests a saving of approximately R1.2 billion per annum would be possible. This proposal would also have a significant impact on the serious problem of theft of drugs purchased by the public sector, which are then resold in the private sector.

4.3.11 Implementation

Several elements of the proposed changes to the PHC delivery system are already an integral part of the current health sector restructuring process. The Committee is of the view that a phased approach should be adopted in the implementation of the new proposals set out here. This will allow for the required discussion, consultation and negotiation which are a crucial part of the decision making process. In addition, this approach is appropriate in the context of a system which requires substantial preparation and investments prior to being ready to implement the full-scale restructuring of the system proposed here.

Initial changes will therefore take the form of a series of 'fast track' implementation steps, which are regarded as essential pre-requisites for the full operation of the national PHC delivery system. Details of the 'fast track' programme are provided in the following section. These are aimed at rapid improvements to several of the critical problems facing the public PHC system. It is recommended that all, or most of these fast track elements be implemented by the beginning of April 1996 at the latest. In addition to the 'fast track' elements, it is proposed that EDL medicines and accompanying treatment protocols will be available at all public PHC facilities by April 1996, and that there should be some progress towards the introduction of accredited private provider contracts in some areas by that time. Access to EDL medicines in the private sector should be introduced by April 1997, at which time the entire delivery system as set out here should be in operation in most parts of the country.

Fast track elements of the restructuring programme

I. Improvement of access to the PHC system

A. Eliminate user charges for consultation services at public providers. Simultaneously implement payment for medicines, and penalty charges for unreferred consultations at outpatient departments of non-district hospitals.

II. Development of the district based health care system

A. Continuation of current negotiations and planning aimed at establishment of DHAs over next two years.

B. Establish priorities for investment in administrative and management capacity at DHA level.

III. Increased autonomy and efficiency of public PHC providers

A. Investigate mechanisms for increasing managerial autonomy of public PHC providers.

B. Investigate shifts from global budgets to capped fee-for-service or other transitional payment systems.

IV. Introduction of accredited private providers

A. Begin negotiations with appropriate representative bodies and provinces on structure and functions of accredited private providers, and on nature of contractual arrangements required.

B. Investigate, at provincial level, appropriate sites for introduction of accredited private providers, and begin design of pilot projects. This should be linked to capital development planning so as to avoid duplication of facilities between the public and private sectors (see 12)

V. The accreditation process

A. Investigate establishment of a national accreditation body, and determine relationship between the national body and provincial/DHA accreditation process.

B. Begin negotiations on criteria for accreditation of providers.

C. Establish timetable for implementation of accreditation for private and public providers.

VI. Registration

A. Initiate discussions with Department of Home Affairs, RDP Office and other relevant government authorities on plans for national population database.

B. Begin planning alternative strategies for health sector registration if no national database is planned.

VII. Increasing the supply of PHCNs in public PHC facilities

A. Urgent investigations into areas of shortage of professional nurses, and transfer of some professional nurse (PRN) posts from hospitals to PHC facilities where required.

B. Begin negotiations, planning and implementation of a national PHCN training programme.

C. Planning and implementation of short-term, in-service training in clinical skills for professional nurses currently working as clinicians in the PHC system.

D. Begin negotiations and investigation into improved conditions of service for PHCNs.

E. Begin investigations into longer term changes to nursing career structures to allow for advancement to senior posts at clinic level.

VIII. Increasing the supply of medical personnel working in public PHC facilities

A. Increasing the number of full-time medical staff in public PHC facilities by:

1. Rapid identification, assessment and filling of vacant posts regarded as appropriate.

2. Rationalisation and redeployment of posts with a particular emphasis on redistribution of posts from hospitals to the PHC level,.

3. Creation of new posts where required.

4. Implementation of incentives to attract staff to work in underserved areas.

5. Begin investigations into improvements in compensation and working conditions for full-time medical staff.

B. Increasing the number of medical staff working on a sessional basis in the public PHC system, by:

1. Undertaking similar short term measures as those noted under full-time staff.

2. Begin investigation into feasibility of the various longer term proposals for improving supply of sessional staff.

C. Introduction of direct referral contracts, and changes to the district surgeon (DS) system

1. Begin urgent negotiations with appropriate representative bodies on changes to the district surgeon system.

2. Change name from district surgeon to district family practitioner (DFP).

3. Eliminate direct access to DFP on the basis of certificate of indigency from a magistrate, and replace with requirement for referral to a DFP from a public facility.

4. Where no public facilities exist, DFP to continue seeing patients in own rooms, but discriminatory practices to be abolished, and rigorously regulated.

5. Investigate incentives/regulations for DFP to see patients within public facilities.

6. Disaggregation of current DFP duties into separate contracts, with more appropriate allocation of tasks.

7. Inclusion of new duties within DFP contract, including training and support for PHCNs etc.

8. Increase number of DFP posts in areas where DFP currently overloaded, as well as in other areas, with intention of increasing competition.

9. Urgent investigation into methods and levels of remuneration of DFPs.

IX. Increasing the supply of para-medical personnel working in public PHC facilities

A. See items referring to full-time and sessional medical staff.

X. Creation of adequate numbers of effective district and facility managers

A. Planning and implementation of training programmes for health service managers. Combinations of in-service and full-time training envisaged.

B. Hiring of managers with private sector experience in short term, and creation of apprenticeship/shadow management arrangements to build capacity in the public sector.

XI. Additional measures to improve staff distribution and efficiency

A. Urgent investigations into design of incentives to attract health personnel to underserved areas.

B. Urgent investigation of licensing and accreditation mechanisms to assist in better distribution of personnel.

XII. Addressing the gap in provision of PHC facilities

A. Continuation and expansion of current clinic building programme to cover all areas currently without adequate PHC facilities. Investment priorities to be determined at provincial level.

B. Investigation of a range of short term arrangements for provision of facilities prior to construction of permanent public facilities. These might include loaning of facilities by the private sector, and by churches and schools, conversion of some hospital facilities, and the use of temporary structures in some areas.

C. Investigation of financing and other incentive arrangements to encourage provision of facilities by accredited private providers.

XIII. Provision of EDL medicines at all public PHC facilities

A. Finalisation of the national EDL, related therapeutic protocols, and other elements of the EDP.

B. Urgent investigations, and implementation of improvements in the central purchasing function carried out by COMED, and management of the medicines logistics pipeline, including warehousing, distribution and medicines management at facility level. In this regard, proposals concerning the contracting out of these functions should be urgently investigated.

C. Training of all pharmacy, medical and clinical nursing staff in the public PHC system in the principles and operations of the EDL system.

D. Begin planning to ensure availability of EDL medicines at all public PHC facilities by April 1996.

E. Begin investigation and negotiations concerning extension of EDL medicines to retail pharmacies, and where permitted, to dispensing doctors.

5. FUNDING REQUIREMENTS FOR THE PHC SYSTEM

5.1 Estimates of total expenditure requirements for the PHC system

Table S1 summarises the results of a detailed simulation of the costs of the proposed PHC system over a five year period, beginning April 1996. The simulation model assumes the extension of high quality services throughout the country. The nature and

resourcing of services assumed in the model are based on detailed studies carried out at existing public and NGO PHC delivery sites, with appropriate modifications to suit the package design outlined here. The model thus assumes the extrapolation to the country at large of currently existing, and well regarded PHC models. The resulting estimates of total and per capita cost have been compared with available data from a range of public and private PHC delivery sites, and the Committee is of the view that the model estimates are reasonable and reliable.

The model assumes that utilisation of personal services increases from 2.0 visits per capita per year in 1996 to 3.5 visits per capita per year in 2000. These utilisation increases, as well as underlying population growth drive the cost increases over the five year period. The population base assumes that those without medical scheme cover use the system for all of their PHC services, while those with medical scheme cover make limited use of the system (at a constant rate of 0.5 visits per capita per year, and with use of EDL drugs at 5 scripts per capita per year).

Table S1: Costs, expenditure and additional funding requirement, R billions (1995) - Base-line Scenario

	1996/97	1997/98	1998/99	1999/2000	2000/01
Projected total costs of PHC system (1)	5.52	6.28	7.12	8.09	9.22
Projected Public Expenditure on PHC	2.21	3.97	3.97	3.97	3.97
Additional allocations to PHC	0.30	0.60	0.90	1.20	1.50
Revenues from EDL sales to private sector	0.34	0.35	0.35	0.36	0.36
Total available funding for PHC (2)	3.08	4.92	5.22	5.53	5.83
PHC Funding Gap (1-2)	**n/a**	**1.36**	**1.90**	**2.56**	**3.39**

5.2 Current expenditures on PHC

The table also summarises available data on current public sector expenditure on PHC services. The combined 1995/96 budgets of the national, provincial and local authorities for PHC services amounts to R3.97 billion, which represents a substantial increase in allocations to PHC relative to previous years. The most recent data on actual PHC expenditure indicates that an estimated R1.85 billion was spent in 1992/93 (R2.21 billion in 1995/96 prices), suggesting a real increase of 32% in budgeted expenditures on PHC between 1992/93 and 1995/96. The extent of this reallocation suggests that much of the increased allocations will however not actually be spent on PHC in 1995/96, since it is likely to be tied up in hospital and other budgets, and will take some time to shift towards actual PHC expenditure. The absence of more recent data requires judgements on the extent to which the 1995/96 budgets reflect actual PHC expenditure. It is the Committee's view, that the 1995/96 budgets can in fact be regarded as a genuine indication of actual PHC expenditures for the 1997/98 year. However, it will be crucial for the Department of Health to monitor carefully the extent to which these provincial budgetary commitments to PHC are actually realised. To the extent that they remain theoretical commitments, the estimates of the PHC funding gap provided below may need to be adjusted.

The Committee is also of the view that real increases in public expenditure on PHC of approximately R300m per year over a five year period are feasible, resulting in a cumulative increase of R1.5 billion per annum by the year beginning April 2000. Major sources of this real increase in expenditure are expected to be increased health sector allocations resulting from reductions in Defence expenditure, as well as further reallocations towards PHC from within existing health sector budgets. Further savings from efficiency gains in hospital services and pharmaceuticals will be used to offset the reduced allocations to the hospital sector that have occurred as a result of reprioritisation.

As noted in the discussion on the essential drugs programme, it is envisaged that EDL drugs will be sold to the private sector at cost. The costs of this are incorporated into the total cost estimates for the PHC system. Table S1 therefore shows an estimate of revenues to be obtained from these sales (adjusted for distribution and collection costs).

5.3 Additional funding requirements for PHC

These data allow an estimation of the PHC funding gap, including both capital and recurrent requirements, over a five year period. These estimates are also shown in Table S1. The Committee has given careful consideration to the question of the timing of new funding flows for PHC. While it would be ideal to implement the proposed new funding flows from the 1996/97 year, the Committee is of the view that the PHC system will not be in a position to fully absorb the envisaged increases in funding at that stage, and that substantial investment and restructuring will be required before it is in a position to do so. The Committee is further of the view that the PHC system will be in a position to absorb the planned increases in funding by the 1997/98 year, and the gap is thus considered to be a real one from that point onwards.

The Committee therefore proposes that additional funding be sought to address the gap identified here from the 1997/98 financial year. This implies that, in 1995 prices, an additional R1.36 billion would be required in the 1997/98 financial year, and that this requirement would increase to a level of R3.39 billion in the 2000/01 financial year. If the assumed real increases in allocations to the health budget are excluded, then the requirements would be R1.96 billion in 1997/98 and 4.89 billion in 2000/01.

In the interim, funding for the fast track elements, and for other increased requirements will be sought from additional bridging funding of approximately R350 million in the 1996/97 year, as well as from within current budgets, and from local and international donor funding. The critical importance of capital investments suggests that a particular effort should be made to secure adequate funding for capital development in the 1996/97 year.

The overall approach of phasing in the new funding requirements is commensurate with the realities of the public health care system, and will increase the political acceptability of the overall restructuring programme. It will allow rapid achievement of

a series of visible improvements in the PHC system, while simultaneously allowing for a more phased, systematic development of the PHC delivery system.

6. THE FLOW OF FUNDS FOR PHC SERVICES

In considering the flow of funds for the new PHC system, the Committee defined a number of requirements which any funding mechanism would have to meet. In brief, the mechanism adopted should:

- Be consistent with the principles of strengthening the public sector, the DHA as the principle administrative authority in the delivery of PHC services, and the integration of PHC services with other levels of care.

- Promote financial equity, and equity of access, between provinces and between districts within provinces.

- Be consistent with existing financing mechanisms, and avoid adding administrative or logistical complexity to those mechanisms.

In the light of these criteria, the Committee recommends the following funding arrangements for the PHC system (see Figure 2 in main report):

A *notional fund*, perhaps to be called the "Primary Health Care Fund", should be established at national level. This Fund would comprise funding from two sources:

a. Funds allocated to PHC services from the national health budget, the provincial budgets, and relevant local authority budgets.

b. A separate national vote for primary health care, perhaps called the "National Primary Health Care Programme". This programme would obtain a direct allocation from the fiscus, and would be allocated to the provinces by the Minister of Health, using a conditional transfer mechanism.

This proposal would serve the dual functions of creating a more identifiable mechanism for funding of PHC, while retaining all funding flows on budget. It would have the further advantage of ensuring some Ministerial discretion over the allocation of PHC funds. It is envisaged that all funds within the nominal "Primary Health Care Fund" would be allocated to the provincial health authorities, who would then allocate funds to the DHAs. The proposed mechanism for allocation to the DHA is that of a capitation based formula, with appropriate adjustments to compensate for risk of utilisation of PHC services. In making this recommendation, the Committee is aware of the fact that the specific allocation formulae and mechanisms would ultimately be at the discretion of the provinces themselves. However, a formula that addresses geographic inequities should be adopted, and this approach underlies this recommendation.

7. SOURCES OF FINANCE FOR THE PHC FUNDING GAP

The Committee' consideration of funding for the PHC system has been informed by the government's stated fiscal policy commitments to reducing the deficit, consumption expenditure and the overall tax burden. These policies have led to some degree of circumspection in both the design of the PHC package and of the delivery system. Despite these constraints, real increases in funding will be required if genuine improvements in the accessibility and quality of publicly funded PHC services are to be realised. The Committee recognises the potential conflict between the government's fiscal policy objectives and the requirement for additional funding for PHC. For these reasons, it is crucial to examine the additional funding requirements in the context of the overall health budget, and of the general restructuring of the health sector. The process of budgetary reprioritisation is already underway at both provincial and national levels, and the requirements for additional funding for PHC need to be examined in this context. It is however the Committee's view that even the full extent of reprioritisation within existing health budgets will be insufficient to fund the full additional requirement estimated here, and that real increases in allocations to the health budget may therefore be required over time in order to allow for increased expenditure on PHC services. Also, given fiscal constraints, offsetting adjustments elsewhere in government expenditures may be necessary.

Consequently, the Committee has given careful consideration to its role in making recommendations on appropriate sources of funding for the broader health care system, and hence for PHC services. It is felt that the major role played by the Committee has been in dealing with various aspects of the restructuring of the PHC system, including the PHC package, an appropriate delivery model, and the estimation of the additional funding requirements in order to effectively implement these proposals. A further role has also been to provide motivation for additional funding for the public health sector.

It is also felt that, at least in respect of revenue, the precise mechanism or combination of mechanisms for securing additional funding are of secondary importance. Some alternative funding mechanisms may however have differential effects on dynamics within the health sector, and may enjoy more or less support from interests within and outside of the health sector. In these respects, the Committee was of the view that it could contribute to the debate through an examination of the advantages and disadvantages of alternative funding mechanisms. A detailed analysis of several funding mechanisms was undertaken, and is presented in Appendix 10. The mechanisms examined were:

1. General tax revenues
2. Dedicated funding from excise duties and/or VAT
3. Dedicated tax funding derived from reductions in tax expenditure through modification of the tax treatment of contributions to medical schemes
4. Dedicated payroll taxes
5. Imposition of a user charge on voluntary private health insurance contributions, with or without mandatory coverage for a defined hospital benefit package.

Having undertaken the analysis, the Committee decided, for the reasons set out above, that it should avoid making explicit recommendations among the various funding options, and that these decisions should be left to Cabinet, in discussion with the social partners.

8. REGULATORY REFORM OF THE PRIVATE HEALTH SECTOR

The Committee incorporated questions relating to the regulation of the private health insurance market within its deliberations for several reasons. The private health insurance system is currently facing a crisis which requires urgent responses from the government. Cost escalations in recent years have begun to undermine the viability of elements of the system, with the risk that the state will be burdened with the care of increasing numbers of people unable to afford the costs of private health care. These problems have been aggravated by certain of the recent regulatory reforms, specifically those which have undermined the principles of cross subsidisation and risk pooling within medical schemes. The need to contain private sector cost increases provides further justification for examination of these issues.

The Committee recognises that its proposals for private sector regulation have a different status to those concerning PHC services, since these issues were not included within the original terms of reference of the Committee, and as a result, the public has not had the opportunity to contribute sufficiently to the debate on some of these issues. Nevertheless, the interdependence of the proposed restructuring of the public sector and improved functioning of the private sector is clear, and several of the regulations proposed here are now urgently required. The purpose of these proposals is therefore to accelerate the debate and facilitate its rapid conclusion. It will be necessary for the government to move rapidly to a process of discussion and negotiation around these proposals, with the express aim of reaching rapid conclusions and then moving to legislation. In this context, it is recommended that the Minister of Health convene an urgent meeting of all relevant stakeholders to initiate and plan the discussion, negotiation and legislative process on these issues.

8.1 A proposal for mandatory health insurance coverage for a defined hospital benefit package

This proposal envisages that it be made mandatory for all in formal employment to obtain private health insurance coverage for at least a minimum core package of hospital benefits. *The controversial nature of this proposal, and its implications for business and workers is recognised, and it is therefore put forward as a proposal for discussion.* The Committee believes that this proposal would have multiple beneficial effects, and therefore merits serious consideration.

Under this proposal, the minimum benefit package would explicitly not specify coverage for primary care services as part of the minimum requirement, since these would be funded and provided via the publicly funded PHC. Instead, the minimum

requirements would be that all employed individuals and their families obtain coverage for *at least* the costs of their use of the *public hospital system.* This might take the form of indemnity coverage for public hospital services, with the possibility of a specified maximum limit per beneficiary per year.

All current medical scheme members would already have the minimum coverage level required. Those in formal employment without medical scheme cover would thus be obliged to obtain such cover, and would be free to negotiate with employers for packages that exceeded the minimum requirements, including packages which covered private PHC and/or hospital services. *The mandatory core benefit package would not explicitly require that those covered be treated in a public hospital, only that the costs of that treatment must be covered, should they in fact use a public hospital.* Employers and/or medical schemes would thus be free to negotiate favourable rates with private hospitals, or to make other arrangements to provide hospital care for their employees/members. Contributions would not necessarily have to go to an existing medical scheme, but might instead be channelled via a new state sponsored hospital plan, the administration of which might be undertaken either by private or state administrators.

Mandatory coverage requirements would be accompanied by regulatory reform of the private health insurance market, designed to ensure adequate risk sharing and stabilisation of the health insurance system. Preliminary estimates suggest that the statutorily defined minimum coverage for public hospital care would be generally affordable, and might approximate R400 per person per annum on average. Assuming adequate risk sharing arrangements, total costs for a family of three might amount to approximately R56 per month, which would be split equally between employers and employees. The actual amount paid would be related to income, so that those at lower income levels would pay substantially less than this estimated average amount, while higher income earners would pay more. On the assumption that total taxable income formed the base for these contributions, they would be equivalent to an average payroll tax of approximately 0.66%.

There are two main rationales for this approach. Firstly, it is consistent with a general policy of improving cost recovery within the public hospital system, to which the Department of Health and Provincial health administrations are firmly committed. This is in contrast to the present situation, in which large numbers of employed people without medical aid cover use public hospitals, but fail to pay for these services, or pay well below the actual costs incurred by the hospital system. Conservative estimates suggest that approximately 5-6 million individuals would be newly covered under this proposal, and that at least an additional R1.32 billion per annum could be generated in hospital user charges. The ability of hospitals to generate and retain substantial revenues would also have significantly positive effects on governance.

Secondly, the imposition of mandatory coverage for a core benefit package, together with regulatory reform of the related private insurance markets, would stabilise the private health insurance system through a reversal of the current trend towards fragmentation of risk pools and the exclusion of the aged and sick from affordable coverage. The entry into the market of a large number of relatively low income contributors would also generate incentives for medical schemes to design low cost,

affordable benefit packages in excess of the statutorily defined minimum, which will encourage current trends towards managed care and other cost containment measures.

The Committee has received a surprisingly wide range of submissions supporting the general principle of mandatory contributions by the formally employed for a defined benefit package. Some stakeholders have argued that coverage of this kind should be negotiated rather than mandated, in line with a more general principle that control of health expenditures should be retained within the ambit of private choice.

8.2 Regulations applying to the core benefit package under a mandatory coverage scenario

In the event that mandatory coverage for a core benefit package is introduced, a series of accompanying regulations will be required, in order to ensure scheme efficiency, as well as efficient and equitable distribution of risk. Proposed regulations in this respect are set out in the following sections. Section 8.3 sets out regulations, with a similar set of aims, which should be applied to all medical scheme benefit packages, irrespective of whether or not mandatory coverage is introduced.

8.2.1 A national, standard core package of benefits will be defined. At a minimum, this will cover hospital care in the public sector.

8.2.2 Contribution rates for the mandatory package must be set in relation to income. This will allow an equitable distribution of financing burden across income levels for the same core benefits (to achieve cross subsidisation of low income members). Contributions for the core package could be weighted for the number of dependants covered.

8.2.3 All medical schemes should participate in an equalisation fund that receives money from some schemes and redistributes it to others according to the risk profile of each scheme's members relative to the average for all schemes. The contributions to, and risk adjusted capitation payments out of the equalisation fund cover only the core package. The simultaneous imposition of the above regulations creates a situation in which some schemes have more high risk members while others have younger and healthier members. Yet if the schemes with higher average risk, and hence expenditure, are not allowed to raise additional income, they will not be able to afford the same benefits as other schemes with fewer high risk members. This can be dealt with by transferring funds from schemes with relatively healthy members to those with higher risk members and from schemes with higher than average incomes to those with low income members.

8.3 Regulations applying to the full benefit package offered by medical schemes

The following set of regulatory mechanisms are required to reverse the instability, increasing costs, and reducing coverage which have resulted from a some of the recent

regulatory reforms to the private health insurance market. These proposed new regulations are designed primarily to increase risk pooling and cross subsidisation from sick to healthy, and from young to old, and would apply to the full benefit package offered by medical schemes, and not only to the core benefit package under a mandatory coverage scenario.

8.3.1 Schemes may not exclude any individual on the basis of his/her health risk. There should be open enrolment, guaranteed renewal, and transferability of membership between schemes. In some cases, qualifications to this general principle may be required, so that in certain circumstances to be defined, schemes may exclude some benefits or some conditions from cover.

8.3.2 Schemes are obliged to continue providing health benefits to continuation members (i.e. pensioners, widows, widowers), and for a limited period after becoming unemployed.

8.3.3 Medical scheme contributions must be based on community or group rating for all members of a given fund. In other words, an individual's contributions may not be related to his/her health risk or claiming patterns. This is necessary in order to ensure that individuals are not excluded on the basis of poor health status or age by increasing their contributions above what they can afford. Some qualifications to this general principle may be required (see page 79 of main report).

8.3.4 Mechanisms to guarantee funding for continuation members must be investigated. This is required to deal with problems faced by schemes with ageing demographic profiles, in which the funding burden on younger scheme members is becoming unsustainable. Fair competition between schemes can only occur if they face equal prefunding requirements, which will have to be nationally regulated.

8.3.5 Schemes should be allowed to limit cover for people who only start contributing to any scheme for the first time close to retiring. This may be necessary to avoid adverse risk selection once medical schemes are obliged to accept all potential members without adjusting contributions according to health risk. Otherwise people would avoid membership while young and only join just before retiring. This would not apply to the core benefits in a mandatory coverage scenario.

8.3.6 A legal requirement that employers and employees extend medical scheme cover to dependants should be investigated. This practice is already a well accepted norm in most schemes, and could be easily regulated. The definition of "dependant" will need attention as it is easily open to abuse, to the disadvantage of the fund.

8.4 Further regulations to enhance the efficiency of the health insurance market

8.4.1 All health insurance products, medical schemes, benefit funds, and medical savings accounts should be brought under the ambit of a single Act. The Act should provide for clear differentiation between medical schemes (which must comply with all the conditions specified above) and other health insurance products.

8.4.2 Regulations aimed at increasing competition between schemes should be investigated. Examples of this type of regulation might include an obligation on employers to offer a choice of medical schemes to employees. An alternative would be that employers may not force employees to join a particular scheme, but must allow employees an individual choice of scheme. The Committee recognises the potential problems of this proposal. Many schemes depend on the group membership nature of their membership structure for financial viability, and allowing members to leave a scheme could create serious problems for that scheme. Exceptions to the regulation would therefore probably have to be made for in-house schemes and employer provided services. However, the principle could probably be applied relatively easily within the context of the mandatory core package with an equalisation fund.

8.4.3 Regulations aimed at increasing efficiency of scheme management should be investigated. These should align more closely the interests and incentives of medical schemes and their administrators - e.g. by linking payment to administrators to achievement of reduced spending targets. As a general goal, smaller schemes should be encouraged to merge either structurally or functionally so that they can achieve economies of scale as purchasers, users of information systems and managerial expertise. This may occur automatically if schemes are subject to competitive pressure from other schemes and from regulations requiring the provision of the mandatory package within a capped per capita budget. In addition, the recommendations noted here would go some way towards strengthening the capacity of schemes to manage costs.

8.4.4 Regulations aimed at improved monitoring of medical schemes. The Melamet Commission made several recommendations about strengthening oversight through strengthening the authority and capacity of the Office of the Registrar of Medical Schemes, links and transfer of some responsibility to the Financial Services Board, and reporting requirements of schemes. The detail of some of these specific proposals might change in the light of the proposals in this report. However, the principles underlying these recommendations are supported by the Committee, and their implementation should be investigated.

8.5 Regulations aimed at containing costs in private sector

Hospitals

8.5.1 Provincial authorities should be responsible for authorising the construction of new private hospitals and regulating supply of expensive technology in both the public and private sectors. In addition to statutory control of the supply side, the Committee recommends that the state intervene in the market for hospital services by providing guidance on cost-effective interventions and pricing mechanisms through including them selectively in the mandatory benefits package. This might include the collection and publication of standard performance data. Statutory purchasing funds such as Workmen's Compensation Fund and Motor Vehicle Accident Fund could be required to limit payments to public hospital rates, or to enter into preferred provider contracts with public hospitals.

Pharmacy related regulation

8.5.2 Pharmacies may be owned by any legal persona, but control over all issues related to dispensing must be the responsibility of a registered pharmacist (who may be employed or contracted by the pharmacy owners). This proposal is motivated principally by the need to promote the emergence of managed care structures, including health maintenance organisations and group practices, which rely on the dispensing of medicines by pharmacists rather than by dispensing doctors. A second motivation is to improve prices through bulk purchasing by health plans.

8.5.3 Remuneration of pharmacies and dispensing doctors should be based on a professional fee and costs, but not related to the cost of the items dispensed. This should apply to prescription and over-the-counter medicines. Currently, most income from dispensing is based on a mark-up basis, which creates incentives for selecting more expensive items to prescribe and dispense. Removing the link between the price of the item and the income of the clinician will lead to more cost-effective use of medicines.

Private doctors

Reforms to financing should be combined with policies to ensure an adequate public/private mix of providers. The government may need to intervene on both the supply and demand sides. The following proposals will impact on the supply side:

8.5.4 The ability of medical and other health care practitioners trained at public expense to work in the private sector should be restricted, until they have completed a certain number of years of work in the public sector. An alternative of paying off training costs should be investigated.

8.5.5 To ensure adequate geographical distribution, the introduction of certification/licensing procedures should be introduced to control access to private practice in oversubscribed areas, and to encourage practice in underserved areas.

8.6 Reform to current tax treatment of medical scheme contributions

Employer's contribution to medical schemes

The Committee recognises the inequity and distortions from present tax policies regarding medical scheme contributions. These disproportionately reduce the price of high-cost packages, encouraging inefficient use and allocation of medical resources. In addition, if mandatory cover is extended to all employees, the current tax treatment of contributions would result in decreases in employees' after tax income, and would affect disproportionately impact on the self-employed.

The Committee therefore proposes the following measures aimed at restructuring the tax concessions on medical expenses:

8.6.1 All contributions, whether by employer or employee should be considered part of an employee's taxable income. This will eliminate the tax avoidance schemes currently engaged in by employers and employees in manipulating the proportion of contributions being paid by each. It also levels the playing fields for the self-employed, part-time and contract workers. Thirdly, it establishes the principle that the employer's contribution, while a legitimate production cost for the employer, is a fringe benefit constituting part of an employee's taxable income.

8.6.2 A fixed amount of all medical expenditure, including contributions to approved medical schemes, should be allowed as a deduction from taxable income before tax. A number of criteria could be applied for setting the ceiling on tax deductible contributions. For example, the cost of core package under a mandatory coverage scenario, or the amount spent by the state on individuals in public sector. Alternatively, it could be linked to level of income, or could be set at some fixed percentage of the total contribution.

8.6.3 Consideration should be given to increasing the current threshold above which medical expenses are tax deductible. Presently, the portion of total medical expenses that exceeds 5% of income is deductible before tax. This is to provide disaster relief for households hit by an unexpected catastrophe. Rapid escalations in costs of medical care in the private sector mean that this threshold may be too low, and that many taxpayers are claiming this deduction for routine, rather than for catastrophic expenditures. Increasing this threshold would restore this arrangement to its original purpose.

9. THE WAY FORWARD

9.1 The decision making process

The Committee's terms of reference envisaged that its report be subject to public discussion and consultation prior to finalisation of the proposals. In this regard, it is recommended that the Minister establish and announce a formal process of public consultation on the proposals contained in this report. This should include a two month time limit for public reaction, and could include the submission of written and possibly oral evidence. During this process, efforts should be made to obtain inputs from key stakeholders, including relevant health sector stakeholders, the social partners in NEDLAC, and others. This consultation process would be best managed by a small group drawn from the Committee, which should include representation from the Departments of Health and Finance. It is further recommended that once the consultation process is completed, the Minister move directly to the legislation drafting stage, during which the results of the consultation process would be appropriately incorporated.

9.2 Management of the implementation process

The implementation process should be managed by a dedicated group, comprising officials of the Department of Health and outside consultants, who would work closely with the Provincial Health Restructuring Committee, and with the relevant line functions in the National Department of Health and the Provincial health administrations. The objectives of this dedicated group would be to provide the impetus to drive the restructuring process forward, as well as to ensure integration across provinces and across line functions. The outside consultants should ideally be drawn from members of the Committee, and should include one or more of the international consultants on the Committee. It may also be necessary to draw on additional consultants, from outside of the Committee, where particular skills, experience or expertise are required.

10. COMPLIANCE WITH THE TERMS OF REFERENCE

The integrated set of proposals contained in this report lay the groundwork for the development of a restructured, publicly funded national health system, and a more efficient and equitable private health sector, which together are capable of meeting the four policy objectives contained in the terms of reference of the Committee. The Committee has also fulfilled its mandate in terms of items A and B in the specific terms of reference. With regard to item C, it is recommended that the Ministry of Health, rather than the Committee, incorporate the results of the further consultation process into the legislation drafting process. Item D has not been addressed, since further consultation and refinement of the proposals are required prior to the drafting of legislation.

PRESS STATEMENT BY MINISTER OF HEALTH, DR. NC DLAMINI ZUMA ON 23 JANUARY 1995, CAPE TOWN

PROBLEMS

There are many problems in South Africa's health care system. Many people have little or no access to needed health services. Health services are inequitably distributed, depending on income, residence, race and gender. Our public hospitals are overcrowded, partly because people who only require primary care are seeking services in hospitals. The shortage of primary care services forces many people to forego the services they need altogether. Many people cannot afford to pay directly for health services.

The problems are not only limited to public health services. Medical schemes are limited to few people, i.e. 19% of the population, leaving the majority of black people without coverage; the contributions to medical schemes are unaffordable to most people and rising faster than the inflation rate. Increasingly, older South Africans, the most vulnerable members of our society, find that they cannot get cover because they cannot afford the premiums. Medicines are too expensive, aggravating the already critical situation.

In order effectively to rectify these problems, in the shortest possible time, substantial health care reform is necessary. The core of any successful health care system is strong primary care, i.e. a basic health service for all South Africans. Most health problems can be handled at the primary care level for a small portion of the total health care cost.

I have therefore established a Committee of Enquiry into a National Health Insurance System which will fund and organize primary health care for all South Africans.

POLICY OBJECTIVES

The Committee has been given the following policy framework within which to operate. The policy objectives are:

1. Universal and non-discriminatory access to quality primary health care for all South Africans, regardless of race, gender, income, and place of residence;

2. affordability and sustainability of the system;

3. efficiency and cost control;

4. consistency with the objectives of the Reconstruction and Development Programme (RDP).

I have asked the committee to report to me by the end of April 1995 with a preliminary plan that can achieve the above objectives.

4. SPECIFIC TERMS OF REFERENCE OF THE COMMITTEE

A. To prepare a detailed and costed plan for the introduction of a national health insurance system, or a publicly supported alternative, with the express aim of ensuring access to primary health care services for all South Africans. The work of the committee should be based on the necessary investigation and consultation, and must address at least the following issues:

- the overall economic feasibility of the proposed system of funding;
- the level of funding required and sources of that funding;

- the availability and distribution of the required service providers, facilities and supplies;
- mechanisms and levels of payment to suppliers and providers of products and services;
- administration and management resources, systems and infrastructure;
- interface with other components of the public and private health care systems; and
- mechanisms and timetables for implementation.

B. To consult with interested parties and the public in developing a plan addressing the policy objectives.

C. After the preliminary report, and the Government's consideration of it, the committee may continue to improve and refine the plan based on feedback arising out of consultation.

D. To recommend what legislation might be required for the introduction of the system proposed by the committee.

PUBLIC CONSULTATION

In addition to the Committee's consultations to fulfil its terms of reference, the Ministry of Health and the MEC's for Health will undertake public consultation in all provinces. Both written and oral consultations will be sought. The process of consultation will be announced shortly.

CONSTITUTION OF THE COMMITTEE

The committee will include National and International Experts in health care financing and delivery and representatives from the Department of Health and Department of Finance. The final composition of the Committee is still to be finalized to ensure appropriate race and gender representation.

END

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