Health Service Structural Changes:

- A **Direct Democracy Forum** (**DDF**) administration will regard all hospitals equally.
- Private hospitals and clinics will, as a condition of license, be required to admit and treat public health care patients, for a fee paid by a health care fund (*).
- Public hospitals and clinics will be obliged to admit and treat private health care patients, for a fee paid by a private health care insurance scheme or directly by the patient.
- Public hospitals and clinics will be run on an equity share basis so all levels of staff have a sense of ownership and share in the rewards of consistently good patient care.
    - All public hospitals and clinics will compete in an annual national competition for the best hospital and clinic in the country.
    - Private hospitals can also compete in a similar competition.
    - Patient assessments of the quality of care will be obtained from all patients in all participating institutions, the outcome of which will determine the finalists who will be judged on peer appraisals to determine the final outcome.
    - The staff of public institutions performing consistently well in the patient care assessments will receive performance bonuses and the staff of the annual competition winners will be handsomely rewarded.
    - The staff of the winners of the annual performance competition amongst private institutions will also be similarly rewarded, from public funds.
- Medication on prescriptions issued by any qualified medical doctor can be filled by any competent and qualified pharmacist. This means that a public sector prescription can be filled in a private or public sector pharmacy and will be paid for by the health fund concerned or directly by the patient.
- The schemes and funds may not discriminate between diseases. Thus all medications prescribed by an attending physician, whether for AIDS, TB or the flu will be supplied by the pharmacy of choice and be paid for by the patient's health care fund or medical insurance scheme.
- Legitimate generics can be supplied unless the prescription expressly prohibits the practice.

Funding:

The DDF envisage a number of different and complementary ways of funding, which a patient can use separately or together.

Health Care Funds:

- If a patient participates in a health care fund the patient is due the benefits of the fund or scheme without further payment, if not, the patient pays the going rate for care received from an institute or practitioner.
- Membership of a health care fund is voluntary.
- For payment to a Health Care Fund of a nominal monthly premium, a patient can receive any medically needed surgical treatment at a public or private hospital (see (*) above), for a fee paid by the fund.
- For payment to a Health Care Fund of a nominal monthly premium, a patient can receive any medical treatment required at a public or private clinic (see (*) above) or at a private practitioner, for a fee paid by the fund.
- These premiums will be determined by actuarial assessment of the lowest fee necessary, along with contributions from the state, to sustain the public health care service.
- The principle applied will be an equal sharing of risk between all the patients and the state.
- The state's contribution is justified by the belief that a healthy population will be a successful population.
- Payment by the patient to the funds will be effected by means of the national cellphone network. T
- he state will underwrite 100% of membership fees for health funds for all patients registered as indigents with no visible means of paying the fees themselves.

Medical Aid or Health Insurance Schemes:

These will essentially carry on as at present.

- For a fee negotiated between the patient and a private scheme, a patient can receive whatever benefits are due in terms of the insurance scheme, as prescribed by their attending physician, however:
    - A health insurance scheme will not be permitted to cherry-pick its members according to their health profiles but instead must manage the scheme in the manner of risk sharing by and between members.
    - Such a health insurance scheme will derive its profits from having the widest possible range and largest possible body of members and providing the most comprehensive cover so as to attract that membership.

Complementary Systems:

It is anticipated that the two systems will complement one-another. The low premiums in the public health care funds will enable wide ranged participation and economies of scale and members of private sector health insurance schemes will derive benefits from membership of the public sector health care funds as an affordable backup of an unrestricted source of medical and surgical care.

Modes of Payment:

A practitioner, clinic or hospital can opt for one of two modes of payment;

- Payment to a practitioner, clinic or hospital of a fixed monthly fee for the unlimited care of a patient registered as a contracted care patient of the practitioner, clinic or hospital **OR**
- Payment of fixed and agreed on fees for services rendered by a practitioner, clinic or hospital, on an ad hoc basis.
- In either instance the practitioner / institute bills the fund concerned directly and is paid directly by return.
- A contracted care patient may be registered at one practitioner, one 24 hour clinic and one hospital at any one time and may attend as many specialist practitioners as referred by the contracting practitioner or institute.
    - Specialist practitioners (including dental practitioners) would generally bill on an ad hoc basis.
- Payment for prescription medicines will be paid to the patient's pharmacy of choice by the relevant health care fund or insurance scheme or by the patient,
- Claims and payments are subject to historic audit and practitioners / institutes found guilty of unreliable or dishonest billing practices will be precluded from participating in the funds and may be subject to criminal proceedings if fraud is suspected.

Benefits:

- Institutions which provide professional and reliable services will attract patients and thrive where unreliable and unprofessional institutions will struggle to survive.
- Where the institutions are public institutions, struggling institutions will draw the attention of public health support services.
- If support services are unable to fix the problem and the institute is not providing benefit to their patient base, the institute will be closed and the patient base be transferred elsewhere.
- An element of competitiveness will exist between the private and public health care system and within the two systems themselves, which hopefully will stimulate improved performances in both sectors.
- The health care load will be spread more evenly between the public and private sector so patients will have greater choices.
- Public sector institutions, practitioners and staff will be positively motivated to perform better through the rewards system and practitioners will be more motivated, for the same reasons, to serve in the public sector.
- Private sector health care providers will be able to derive benefits from economies of scale and a reliable payment system for services rendered to public sector patients.
- Private sector pharmacies will be able to share in the public sector pharmaceutical business providing better choices for patients.
- When a private sector provider encounters difficulties the public sector health care funds and providers will be available to provide patient backup at affordable cost to patients. No one need be left without affordable health care services.
- The cost of public health care services will be shared by the state and the patients in an affordable and sustainable manner.

Conclusion:

The **DDF** believe there should be an element of competition between medical facilities in order to stimulate the provision of improved services and improved patient experiences and outcomes. Without changing the nature of the public health care system other than that a member of the public can attend the facility of his choice, the different institutions will be encouraged to provide better services and thus attract more patients and more revenue, from which the institutions and their staff will benefit.

In short the **DDF** will be introducing rewards for good service delivery and consequences for poor service delivery. The **DDF** believe this will benefit all the sectors of the medical profession and their patients, who at the end of every day, are the most important players in a health care system.