



**Compiled  
for  
BHF Trustee Training Programme**

**SYNOPSIS OF THE HEALTHCARE POLICY & LEGISLATIVE  
ENVIRONMENT.**

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## Contents

<b>1.</b>	<b>Introduction</b>	<b>1</b>
<b>2.</b>	<b>National Health Policy.</b>	<b>1</b>
<b>3.</b>	<b>Legislative/ regulatory trends.</b>	<b>2</b>
<b>4.</b>	<b>The Medical Scheme Council's agenda for the next two years.</b>	<b>5</b>
<b>5</b>	<b>Key Market Drivers</b>	<b>7</b>
<b>6.</b>	<b>Issues of particular interest to employer groups during the next two years</b>	<b>7</b>
<b>7.</b>	<b>Strategic considerations for medical schemes</b>	<b>8</b>

## 1. Introduction

This resource document provides an overview of the policy and regulatory changes that will shape the private health sector during the next five years. It also identifies the short-term reform agenda of the Council of Medical Schemes.

This document has been prepared as an input document for a BHF Trustee Training Programme.

## 2. National Health Policy<sup>1</sup>

### 2.1. The goals and objectives for transforming the health sector

- To unify the fragmented health services at all levels into a comprehensive and integrated National Health System;
- To promote equity, accessibility and utilization of health services;
- To extend availability and ensure the appropriateness of health services;
- To develop health promotion activities and healthy lifestyles;
- To develop the human resources available to the health sector;
- To foster community participation and good governance across the health sector;
- To improve health sector planning and monitoring of health status and services;
- Improving the quality of care and making health care services affordable to all South Africans.

### 2.2. Priorities for 2004 – 2009

- To improve governance and management of the health system;
- To promote health and healthy lifestyles;
- To restore human dignity and improve the quality of care;
- To better manage communicable and non-communicable diseases;
- To strengthen PHC, emergency medical services and hospital services;
- To strengthen support services;
- To improve human resource planning, development and management;
- To improve planning, budgeting, monitoring and evaluation;
- To prepare and implement legislation; and
- To strengthen international relations.

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<sup>1</sup> Speech by Dr Manto Tshabalala-Misimang, the Minister of Health, on the framework for the Health Charter: Caesar's Palace – 5 August 2004.

### 3. Legislative/ regulatory trends

The Department of Health (DOH) in its response to the Taylor Report has articulated the legislative trends<sup>2</sup>. Highlights of this response are set out below to show that there is a clearly mapped out plan to implement social health insurance (compulsory contributions to medical schemes for all in employment). Currently the DOH does not believe that national health insurance (cross-subsidy between the economically active and the unemployed) is feasible:

#### 3.1. DOH's specific objectives with respect to the introduction of compulsory health insurance are to:

- Obtain pre-paid contributions from those who are able to pay for health care, increasing the amount of publicly regulated health finance
- Increase access of lower income groups to quality health care
- Increase funds available to the public health service
- Improve the equity of health care financing.

#### 3.2. State sponsored Medical Insurance Cover Risk Equalisation and Social Health Insurance

- The department supports the development of a state sponsored open medical scheme. It hopes that this can be derived from the DPSA public service medical scheme and will negotiate with DPSA to this effect. The department does not currently support the introduction of a separate Public Hospital Fund for low-income workers.
- The department supports the development of medical scheme risk equalisation.
- The department supports the process of the phased introduction of mandatory medical scheme membership for formal sector employees working in qualifying employer groups and earning above a statutorily determined level. The mandate should be applied first to higher income groups.
- The department affirms that mandatory medical scheme membership, combined with income cross subsidisation and (if possible) risk equalisation, will constitute *social health insurance* in South Africa.

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<sup>2</sup> Department of Health response to the report on the inquiry into the various social security aspects of the South African health system: Based on the Health Subcommittee Findings of the Committee of Inquiry into a Comprehensive System of Social Security (THE 'TAYLOR REPORT'), March 2003

- In this context the department accepts that out of pocket fees at the point of delivery for public hospital treatment should be abolished in the context of SHI. The exception to this might be the use of bypass fees where public primary level facilities are reasonably available.
- The department accepts that fees charged to medical schemes should include an element for reimbursement of investment costs.
- The department will negotiate a national agreement on revenue retention with the National Treasury in the context of SHI development. It will argue for full retention of revenue in the health sector.
- The department accepts that, within national guidelines, some of the operating surplus generated by public hospitals from medical schemes may be used by provincial health departments to support facilities unable to generate revenue of their own, provided the provincial policy employed and the sums of money involved are made explicit in provincial strategic plans.

### **3.3. Reform of tax subsidies for medical scheme cover and income cross subsidisation**

- The department will investigate the feasibility of introducing income based medical scheme contributions in the mandatory environment of Social Health Insurance (SHI).
- The department agrees that the present system of tax allowances for medical scheme cover should be reformed and could be replaced by an explicit tax subsidy. The use of a tax subsidy would be informed by the decision about whether or not to apply income related scheme contributions. The department will spell out the justification for a subsidy made to private medical scheme cover.
- The department will investigate how to make a tax subsidy benefit the needy population proportionately more than the better off.
- The department agrees that a tax subsidy to medical schemes could be used to provide (in part or in whole) income cross subsidisation for SHI and eventually could be distributed via a risk equalisation fund.
- The department will decide for what purposes, and through what mechanisms, it will use any money accruing to the public health sector from reform of the present tax allowance system.

- The department will negotiate with the National Treasury to put into effect the above decisions.

**Table 1** reflects the current subsidy structure preferred by employers. This subsidy is likely to favour higher earners.

**Table 1: Employer medical scheme contributions: South Africa, 2002.**

Company contribution (%)	Percentage of respondents
40 – 49	5
50 – 59	68
60 – 69	9
70 – 79	9
80 – 89	5
100	18

Deloitte & Touché Human Capital Corporation Employer Survey: 2002.

### **3.4. Reform of public health resource allocation processes: re-centralisation of the health budget**

- Pending any government re-think of its fiscal devolution policy, the department does not support the recommendation to re-centralise the health budget by either of the two options proposed.
- The department will make any necessary representations with the National Treasury to promote more inter-provincial health service equity through the use of the equitable share formula.
- No other decision is necessary, as the work on service norms and standards and strengthening the capacity of provincial health departments to motivate for resources in the context of fiscal decentralisation is already in hand.

### **3.5. National Health Insurance versus tax financing of the public health service: Integration of different systems of cross subsidisation**

- The department finds that the case for NHI in South Africa has not been made and at this time does not support an automatic move towards an NHI system.
- The department will commission a health financing and benefit incidence study to look further into an NHI option.
- The department will investigate with other government departments the possibility of integrating cross subsidies in the health sector with those of other social interventions and the tax system. This possibility could be researched in connection with the financing and benefit incidence study.

## **4. The Medical Scheme Council's agenda for the next two years**

The Council of Medical Schemes and Registrar's office are likely to afford priority to the following issues during the next two years<sup>3</sup>:

- Medical savings accounts and routine benefits to improve equity (applicable from 2006):
  - ✓ Medical savings accounts and routine benefits must apply from "first Rand" and must be exhausted before risk benefits apply.
  - ✓ Contribution tables pertaining to an option cannot vary for that option based on selection of the level of savings chosen.
  - ✓ Options will not be approved if the only difference between them relates to level of savings.
  - ✓ Cannot have "contribution holidays" linked to level of savings.
- Employee medical benefits tax (from 1 March 2006):
  - ✓ The objective of achieving a fairer subsidy is supported by the Department of Health.
  - ✓ Treasury will release a discussion document (2005).
  - ✓ Department of Health and Treasury will liaise regarding the discussion document.
- Risk equalisation fund (REF):
  - ✓ REF will be shadow implemented (2005 and 2006).
  - ✓ In 2007, cash flows will be implemented if the system proves to work adequately.

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<sup>3</sup> Based on a telephonic conversation between Reg Magennis and Alex van der Heever, 17 March 2005.

- Regulatory revamp of benefit design to improve access to low earners:
  - ✓ To be investigated in 2005/6, possible implementation 2007.
  - ✓ Possibility of a low earner basic package is being suggested with more flexible benefit scope.
  
- Regulatory revamp of benefit design to create transparency:
  - ✓ The theory will be explored and debated during 2005/6;
  - ✓ Idea of a basic package (different to low earner basic package) plus standardised buy-up levels (modules) is being considered;
  - ✓ Once structures are approved, the changes will be phased in (likely to be after 2007/8 due to potential major impact on the market).
  
- Brokers:
  - ✓ Partial or substantial revision of regulations is being considered;
  - ✓ “Partial” revision is more likely than “substantial”;
  - ✓ Partial revision is likely to focus on:
    - Differences between independent and marketing brokers;
    - Mechanisms for facilitating member choice of brokers (e.g. differentiated contribution tables).
  
- Social Health Insurance (SHI):
  - ✓ Defined as compulsory income based contributions – typically implemented using a payroll tax.
  - ✓ Implementation is potentially feasible in 2008, but this depends on the success of the REF and the process of regulating for the restructuring and standardising of benefits.
  
- Risk based capital model for reserving:
  - ✓ Regarded as a low priority at this time.

## 5. Key Market Drivers

Industry leaders were surveyed over a period of two years. **Table 2**<sup>4</sup> provides an analysis of the key drivers that will shape the responses of private sector business activity over the next 5 years.

**Table 2**

<b>Key market drivers: 2005 to 2010</b>		
	<b>2005 Score Out of 8</b>	<b>2004 Score Out of 8</b>
• Affordability/ innovation for low earners	8	8
• Income cross subsidy (SHI, tax subsidy, payroll tax, compulsory contributions)	8	8
• Government Employee Medical Scheme (GEMS)	6	4
• Change/improvement/refinement of regulations	5	7
• Transformation/ BEE	5	4
• REF (health risk cross subsidy)	4	4
• Monopolies/ cartel activity/ market inefficiencies	4	6
• Quality/outcomes management/ treatment protocols	3	
• Medical scheme governance	2	
• Risk taking by providers/ doctor incentives/ networks	2	4
• Doctor training/shortage/maldistribution/pessimism	2	5

Reference should be made to the Research paper for a full interpretation of the findings.

## 6. Issues of particular interest to employer groups during the next two years

The complex and evolving healthcare environment presents a challenge for “employers of choice” to remain up to date with developments and to respond appropriately in the interest of employees and

<sup>4</sup> Magennis R. H., Mxenge. M. Opinion Survey: Major trends 2005 to 2010; Compiled for the June 2005 conference of the Board of Healthcare Funders.

the company as a whole. The following matters are particularly important to watch over the next two years:

- Employee tax policy relating to medical scheme contributions. (Reforms will take effect on 1 March 2006). This will place cost pressure on higher earners and may bring some relief to categories of lower earners.
- Benefit design requirements are under continued revision by the Department of Health. This will impact on the choices available to members.
- The introduction of the State employee medical scheme (2007) is likely to influence:
  - ✓ Healthcare service provider pricing and contracting.
  - ✓ Employer and union views regarding employee medical benefit levels and structures.
  - ✓ Consolidation in the medical scheme and medical scheme administration sector.
- The planned Risk Equalisation system may shift costs between high-risk employer groups and low risk employer groups, depending on the scheme of choice.
- The following key factors are intensifying competition between open medical schemes, which is leading to new benefit and product innovations:
  - ✓ The Competition Commission has stopped industry level collective tariff negotiation between medical schemes and healthcare service providers.
  - ✓ Regulation of brokers.

Innovations to watch for: loyalty & wellness programmes; insurance and banking services that are integrating with medical scheme services; intranet based employer and employee assistance tools.
- Court resolution of the new medicine pricing regulations may have further impact on medical scheme benefit design and pricing (areas to watch: acute, chronic and hospital benefits).

## 7. Strategic considerations for medical schemes

The following matters require careful attention within the context of regulatory and related market changes:

- **Product innovation**
  - ✓ Medical benefit design (regulations; market forces).
  - ✓ Value adding enhancements: loyalty & wellness programmes, long-term insurance, banking, real-time electronic trading.
- **Marketing innovation**
  - ✓ New avenues for broker remuneration.

- ✓ New generation sales approaches: (distribution channels, agencies, franchisees, super sales teams, direct member retrieval).
  
- **Provider cost shifting**
  - ✓ Provider tariff and alternative reimbursement.
  - ✓ Cost containment.
  - ✓ Balance of power shift to hospitals and pharmaceutical companies.
  
- **Risks of fixed administrative costs during times of membership volatility**
  - ✓ Member retention.
  - ✓ R&D costs.
  
- **Governance risks**
  - ✓ Solvency.
  - ✓ Provider risk sharing arrangements.