Medical Schemes

Past, Present and Future…

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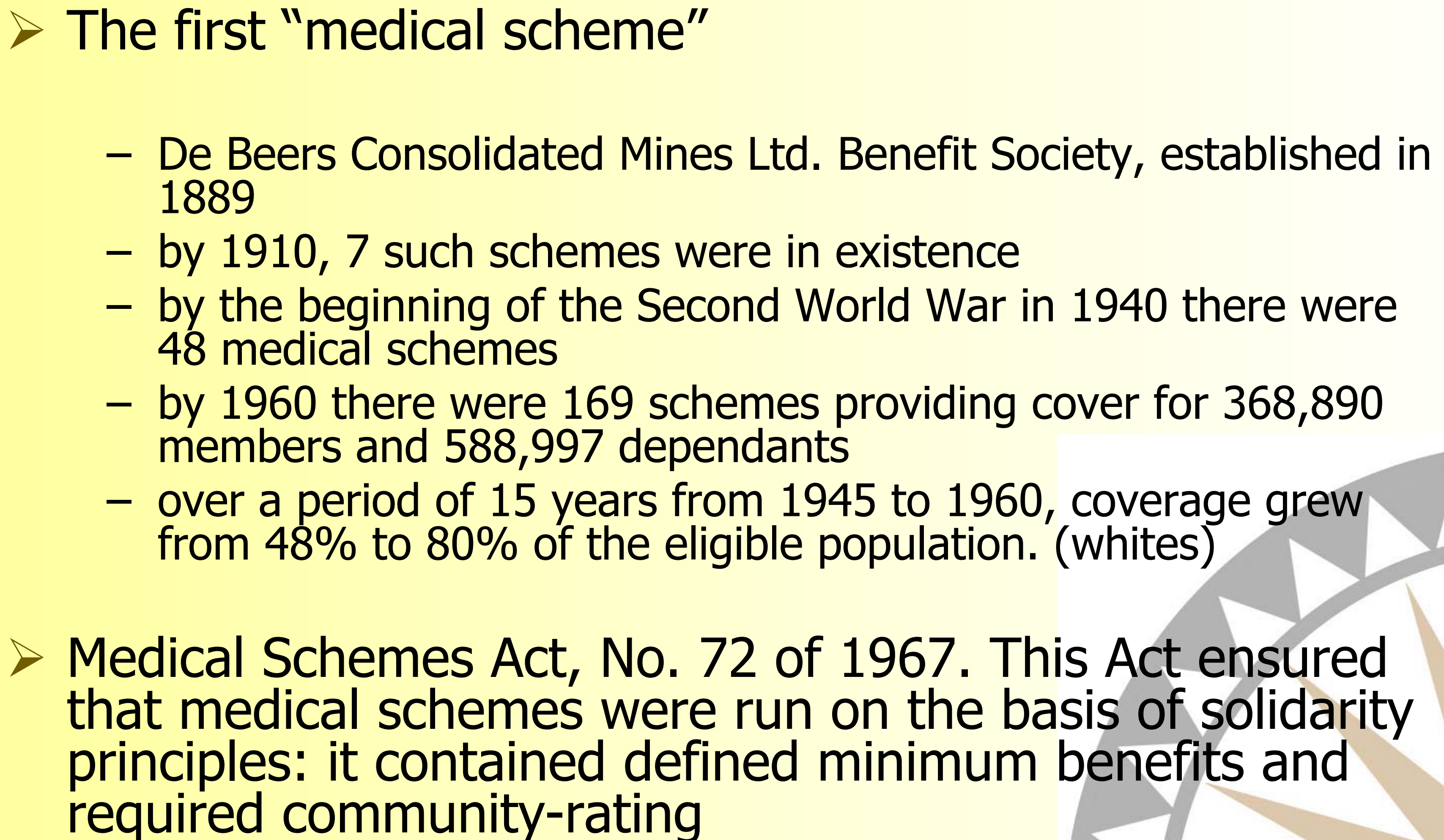
Mutuality and Solidarity defined

- 'Mutuality' a normal form of commercial insurance - contribute to the pool through a premium that relates to a particular risk at the time of the application

- 'Solidarity' similar but different - losses are paid according to need. Contributions are not made in accordance with the risks that each applicant brings

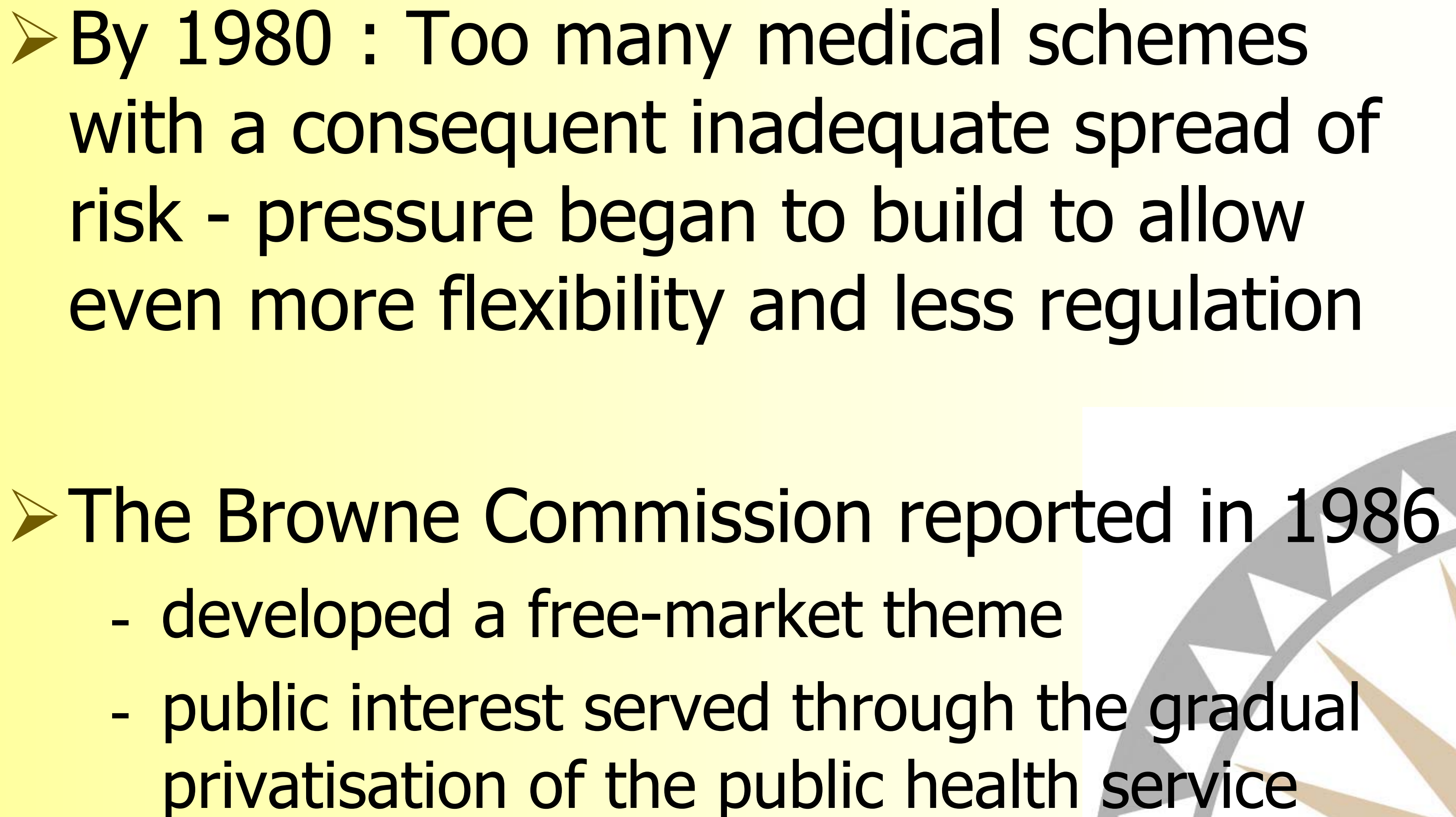
Early history : Medical Schemes Act



- The first "medical scheme"
  - De Beers Consolidated Mines Ltd. Benefit Society, established in 1889
  - by 1910, 7 such schemes were in existence
  - by the beginning of the Second World War in 1940 there were 48 medical schemes
  - by 1960 there were 169 schemes providing cover for 368,890 members and 588,997 dependants
  - over a period of 15 years from 1945 to 1960, coverage grew from 48% to 80% of the eligible population. (whites)
- Medical Schemes Act, No. 72 of 1967. This Act ensured that medical schemes were run on the basis of solidarity principles: it contained defined minimum benefits and required community-rating

Risk Rating

- By 1980 : Too many medical schemes with a consequent inadequate spread of risk - pressure began to build to allow even more flexibility and less regulation



- The Browne Commission reported in 1986
  - developed a free-market theme
  - public interest served through the gradual privatisation of the public health service

Risk rating cont…

- The Browne Commission argued for risk-rating and experience-rating within schemes: greater flexibility in contribution rate determination should be allowed, charge different contribution rates for different classes of risk. Different levels of benefit to be chosen by groups or individuals to satisfy their needs

Risk rating cntd.

- The stage was set for an application of mutuality principles for the next 11 years
- Member's contributions based on:
  - number of dependants;
  - income level;
  - age;
  - geographic area;
  - actual claims experience;
  - extent of cover provided;
  - period of membership;
  - size of group to which member belongs

Amendment Act, No. 23 of 1993

- Introduced statutory guaranteed minimum benefits and guaranteed payment for claims were removed from Act
- Schemes would be able to exclude or limit cover for procedures, and risk-rate to a greater extent, but balanced by increasing ability for schemes to directly supply healthcare by owning clinics / hospitals and employing healthcare professionals. (used by very few schemes)
- *Drift from solidarity principles*

The 1990's

- Benefits declined and the older and sicker membership were excluded from cover to a greater extent
- By mid-90s no open scheme was permitting anyone older than 55 to join as an individual member
- Virtually all open schemes applied life-time exclusions for pre-existing conditions.
- By 1999 the majority of medical scheme membership was in an environment which excluded vulnerable groups from cover
- BUT medical costs continued to rise

The return to solidarity

- The newly-elected democratic Government rejected further deregulation and replaced it with a strategic direction emerging from the 1995 NHI Committee of Inquiry

- Policy directions supported by 1995 report :

    - the regulatory structure should reinforce the agency function of the third-party payer

    - the regulatory structure should reinforce uniformity in the benefit structure of medical schemes, enabling people to make effective decisions in their own favour

The return to solidarity cont…

- schemes should operate on the basis of solidarity , i.e. that groups do not get treated differently within a scheme

- the overall system should create a rational system of risk-sharing between as large a group as possible and, ensure the availability of a minimum level of cover for all within the public and private sectors

(circular 8 of 2006!)

In a word – Solidarity

Recommendations were largely incorporated in Medical Schemes Act, No. 131 of 1998 which re-introduced prescribed minimum benefits. community-rating re-introduced ending an 11-year flirtation with mutuality

Mandatory membership

- Although mandatory membership is one of the key solidarity principal, the reforms in 2000 were not accompanied immediately by compulsory membership
- Several calls by the industry and major employers to speed up compulsory membership to stabilise risk pools

Reforms

- Since 1994, strong moves to reintegrate the two parts into a single healthcare system from a planning perspective – but thus far it has not been successful

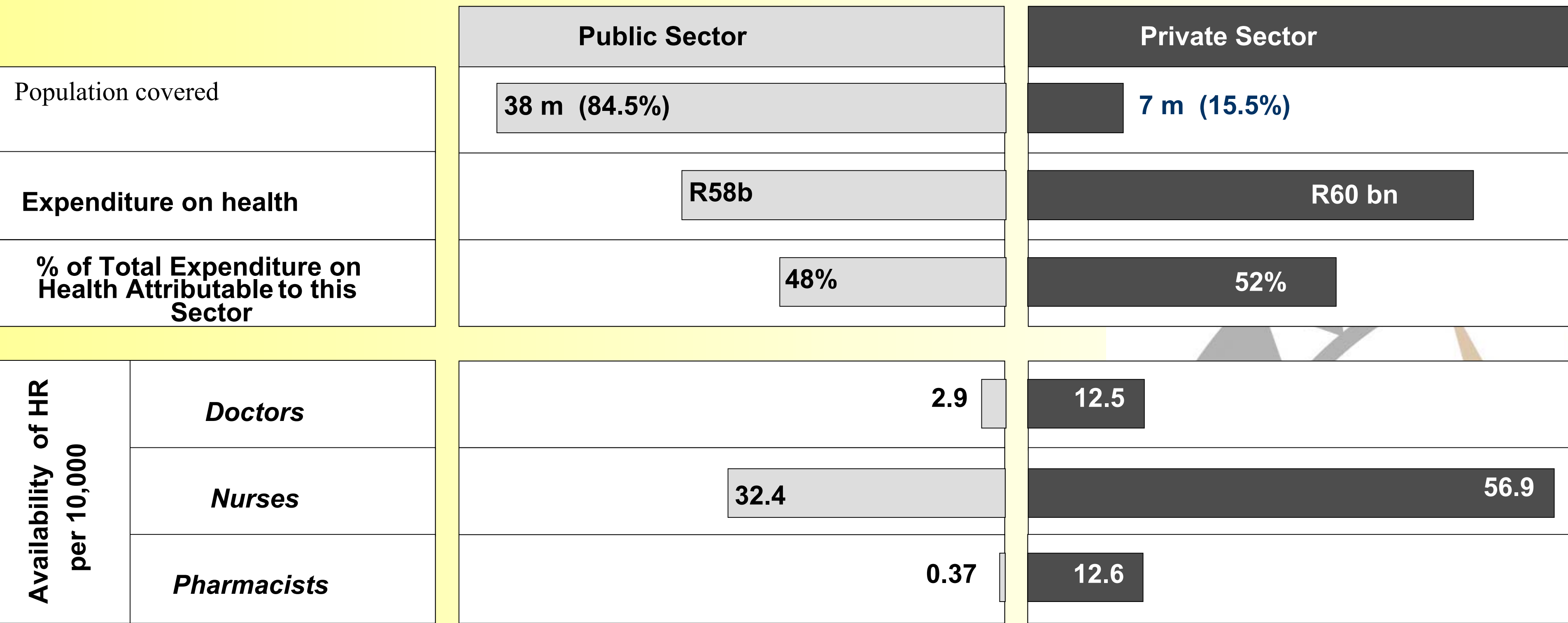
- World Health Organisation published a review. SA was ranked at number 175 out of 191 member countries. Measures included:

  - fairness of contribution
  - responsiveness
  - health level achieved
  - the overall health system achievement to health system expenditure

	Argentina	Brazil	Chile	Mexico	Netherlands	South Africa
2004 WHO Report	Other		BBP			
Total population	38m	176.2m	15.6m	102m	16.1m	44.8m
GDP per capita (Intl $, 2001)	11,920	7,537	11,265	8,903	29,237	7,538
Life expectancy at birth male (years):	70.8	65.7	73,4	71.7	76	48.8
Life expectancy at birth female (years):	78.1	72.3	80	77	81.1	52.6
Healthy life expectancy at birth male (years):	62.5	57.2	64.9	63.4	69.7	43.3
Healthy life expectancy at birth female(years):	68.1	62.4	69.7	67.6	72.6	45.3
Child mortality male (per 1000):	20	42	16	30	6	86
Child mortality female (per 1000):	16	34	13	24	5	81
Adult mortality male (per 1000):	177	246	134	170	94	598
Adult mortality female (per 1000):	90	136	67	97	65	482
Total health expenditure per capita (Intl $, 2001):	1,130	573	792	544	2,612	652
Total health expenditure as % of GDP (2001):	9.5	7.6	7	6.1	8.9	8.6

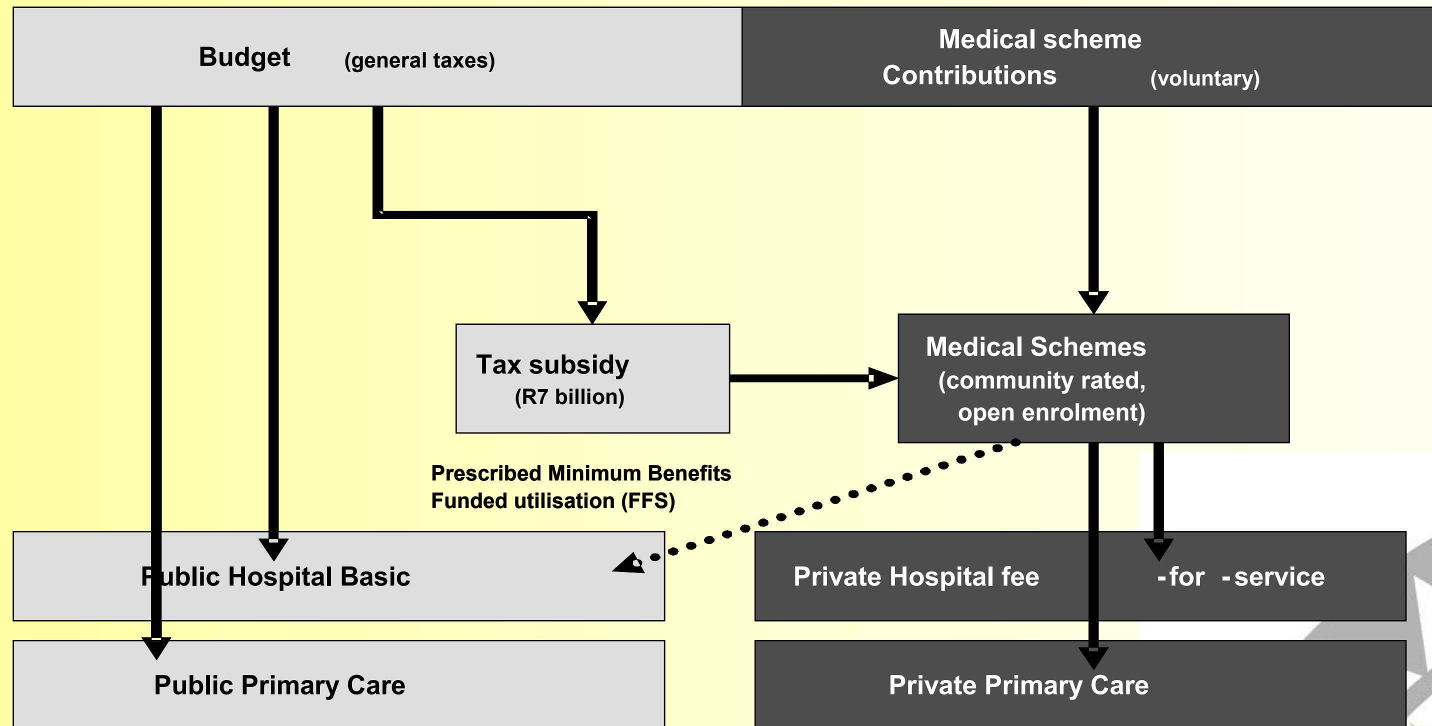
Public/private sector

- Public sector focused exclusively on
  - the indigent and those without medical scheme cover
- Private sector focused on
  - young and healthy employed population



		Public Sector	Private Sector
Population covered		38 m (84.5%)	7 m (15.5%)
Expenditure on health		R58b	R60 bn
% of Total Expenditure on Health Attributable to this Sector		48%	52%
Availability of HR per 10,000	*Doctors*	2.9	12.5
	Nurses	32.4	56.9
	Pharmacists	0.37	12.6

Funding of healthcare



Source : Taylor Committee Process. Health System in 2000.

Future vision: The four phases of reform

- The DoH is in the process of implementing a system of Social Health Insurance (SHI) as a step towards the broader objective of achieving a National Health Insurance (NHI) system

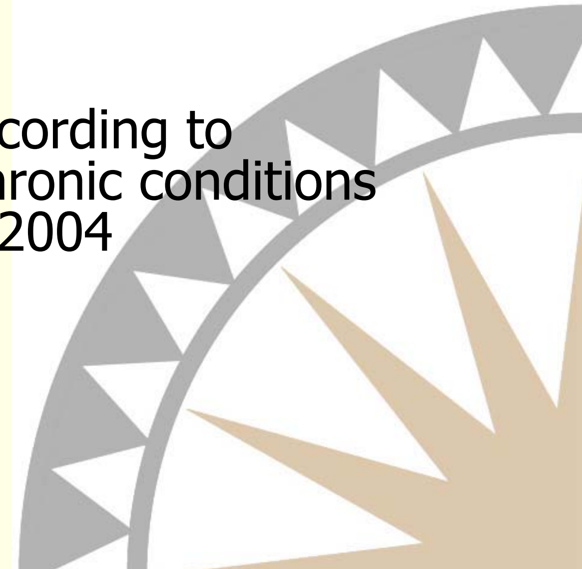
- The Difference Between SHI and NHI

  - Under SHI, those that contribute receive benefits and state provides for others

  - Under NHI taxpayers contribute but all citizens are entitled to the same defined package of benefits

Phase 1
Development of an enabling environment

- A minimum package of Benefits
  - A list of some 270 diagnosis and treatment pairs (PMB-DTP). Introduced from 1 January 2000
  - Emergency medical conditions (PMB-EMC, but usually included in PMB-DTP). Clarified and in force from 1 January 2003
  - Diagnosis, treatment and medication according to therapeutic algorithms for 25 defined chronic conditions (PMB-CDL). Introduced from 1 January 2004



Phase 1
Development of an enabling environment cont…

- ICD 10 codes to define DTP's more clearly and to track expenditure more accurately

- The Taylor Committee recommended a policy process for defining and implementing basic essential healthcare services that would be available in both the public and private sectors.

- Work has now begun on a BBP which includes primary health care into the PMB's

- Within medical schemes these are regulated as Prescribed Minimum Benefits (PMBs) whereas within the public sector these are minimum norms and standards

Phase 1
Open enrolment and community-rating

- In SA there are three kinds of medical schemes:
  - Restricted membership schemes.
  - Bargaining Council schemes
  - All other schemes are classified as open schemes (previously also called "commercial schemes")
- All open schemes have to accept anyone who wants to become a member at standard rates- this is known as "open enrolment"

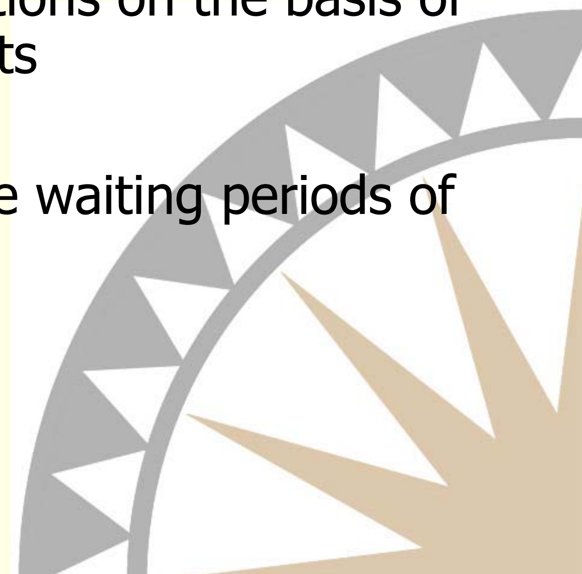
Phase 1
Open enrolment and community-rating cont…

- Everyone must be charged the same standard rate, regardless of age or state of health. Known as "community rating"

- Community rating is (currently) applicable to the price of each option within a medical scheme (This may change in the near future – Circular 8 and MS Amendment Bill)

- Legislation permits differentiation in contributions on the basis of income, family size and adult/child dependants

- To reduce anti-selection schemes may impose waiting periods of up to 12 months



Phase 1
Open enrolment and community-rating cont.

- Age-related late-joiner penalties to encourage people to join schemes while they are young and to remain in the system

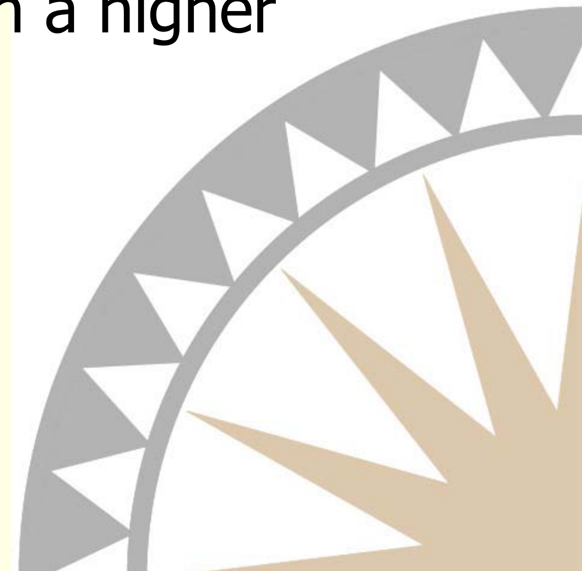
- Policy makers believe that community-rating should apply not only to the options within schemes but to the industry as a whole. This is the major rationale for the introduction of the Risk Equalisation Fund

Phase 2
Social Health Insurance

- In January 2004 the Minister of Health stated three issues on the unfinished reform agenda toward implementing Social Health Insurance:
  - risk-related cross-subsidies
  - income-related cross-subsidies
  - mandatory cover

Phase 2
Risk-related cross-subsidies

- Despite reforms of open enrolment, community-rating and Prescribed Minimum Benefits, it is still possible for some open schemes to design and market themselves in such a way that they attract younger and healthier people. This leaves other schemes with older and less healthy people and with a higher community rate for the PMB package.



The importance of age in price of care

Total CDL package (no expenses)
Total PMB Package excl. CDL (no expenses)
Total PMB Package (Including Expenses)

Price pbpm (2001 Rands)

1,000
900
800
700
600
500
400
300
200
100
0

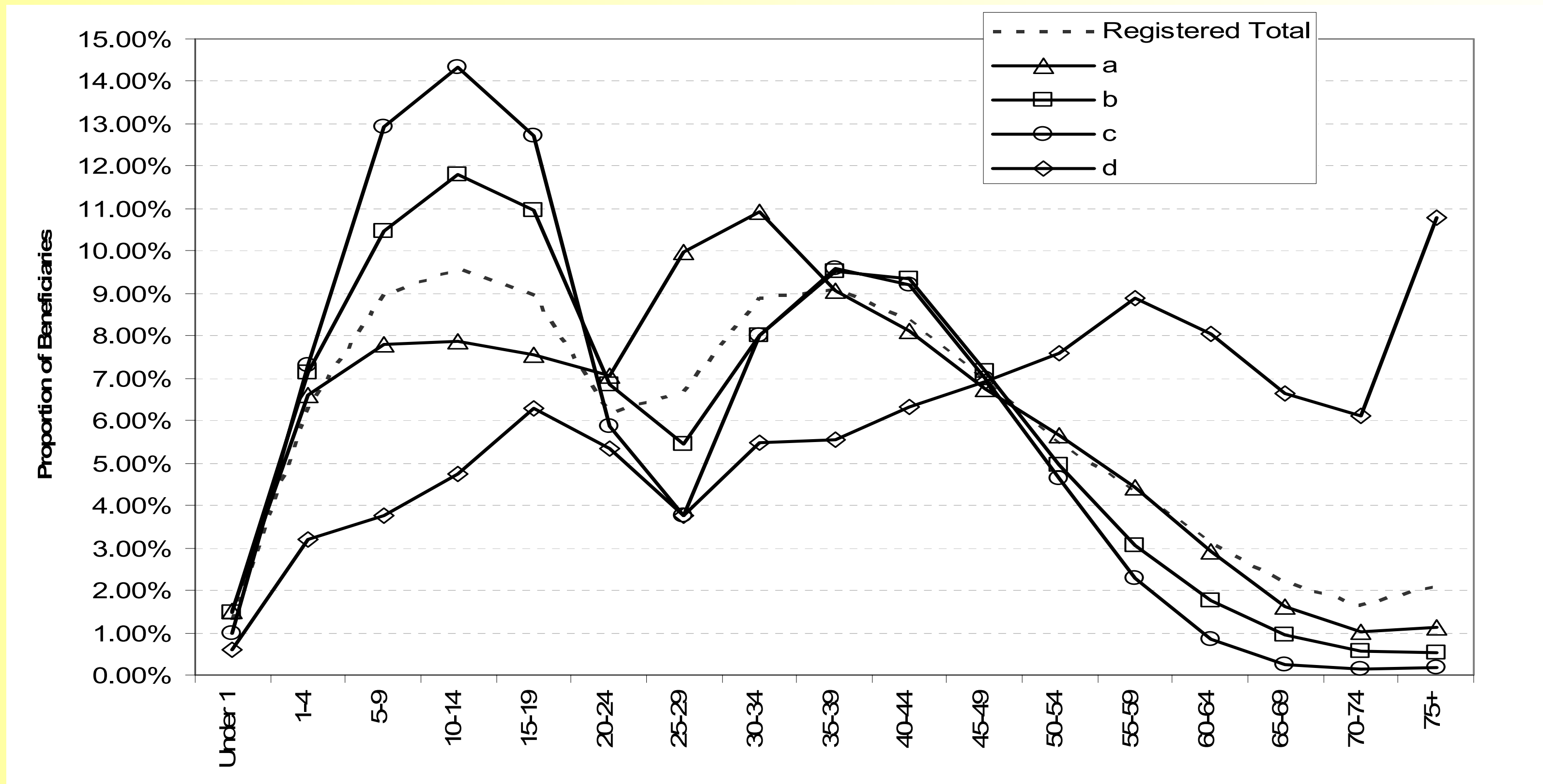
0 | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75-79 | 80-84 | 85+ | All ages

Estimated Industry PMB Community Rate

Source: Derived from PMB Studies 2002/2003, using 2001 data

Phase 2
Risk-related cross-subsidies

- The age profile shapes for the four largest open schemes in 2002.



(Source: 2002 data from Registrar of Medical Schemes)

Phase 2
The REF

- Risk equalisation is a mechanism to ensure that everyone pays the same industry community rate for the common package of benefits
- Formula Consultative Task Team established in July 2003
- An International Review Panel of experts from six countries supported the findings
- The Department of Health formally adopted the REF as policy in September 2004

Phase 2
REF cont…

- Testing phase of the REF was approved by Cabinet in January 2005
- The DoH has embarked on a shadow process for REF with the intention to fully implement from 1 January 2007 , but this has been postponed.

Phase 2
REF cont…

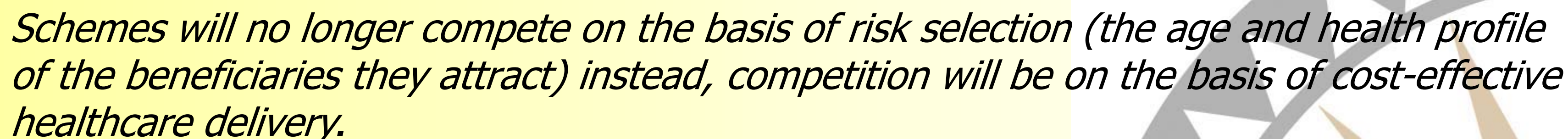
- Each medical scheme receives an amount from the REF equal to the risk-equalised amount for the basic benefit package (currently the PMB). Medical schemes that cannot contract for the delivery of the BBP within that amount will need to charge an additional amount directly to their members.

- Considerable pressure to contract with providers for efficient healthcare delivery.

The REF formula

Published in the form of a REF Contribution Table based on risk factors

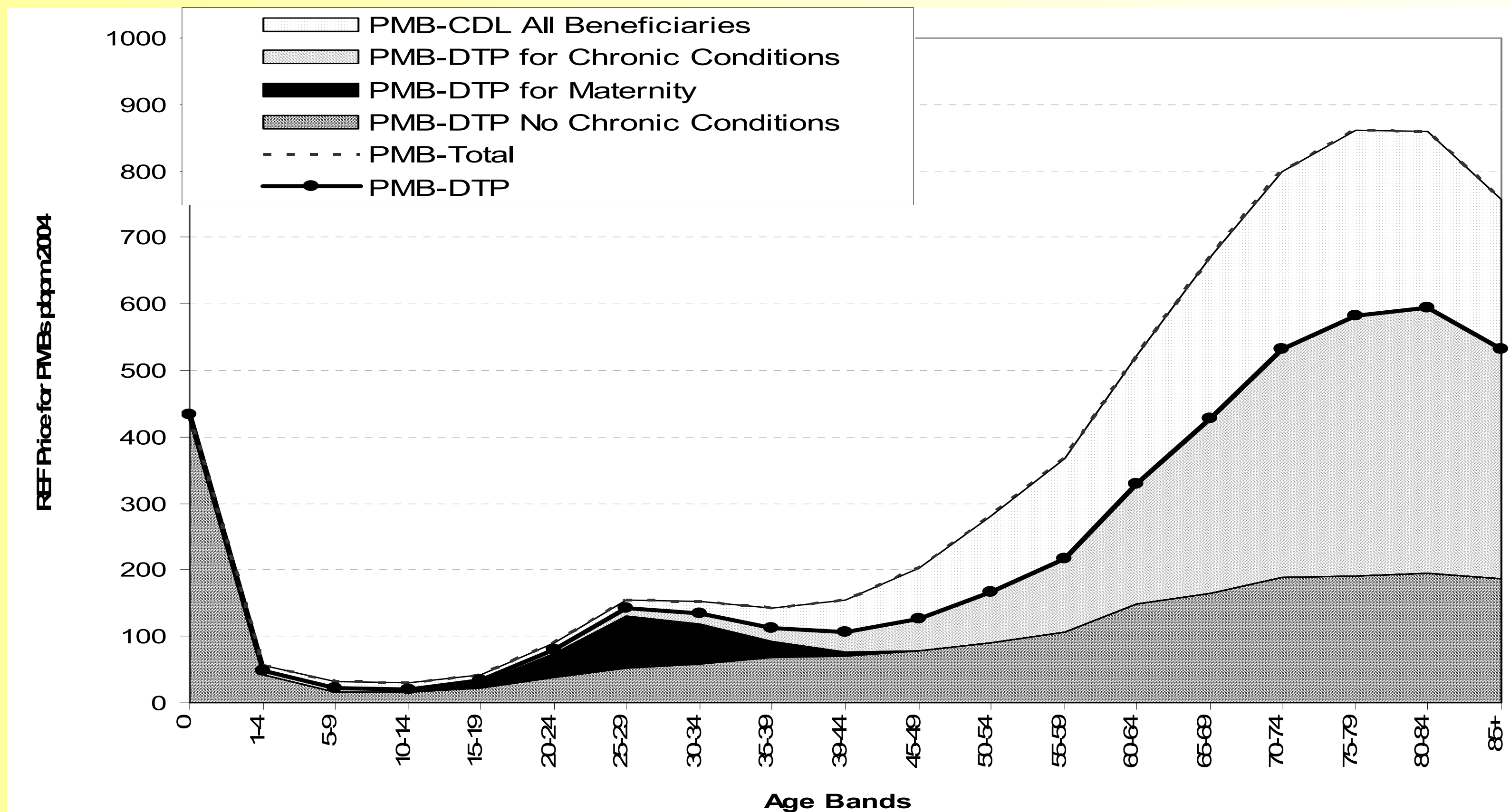
- Age . Bands Under 1, 1-4, 5-9, 10-14… 75-79, 80-84, 85+;
- The diagnosis and treatment of any of the 25 PMB–CDL conditions; Where a beneficiary has more than one CDL condition, the scheme may count the most expensive of the conditions;
- The number of multiple CDL conditions.
- The treatment of HIV/Aids provided the beneficiary is receiving or has received anti-retroviral therapy according to the PMB definition; and
- Maternity, defined as the delivery of a single/multiple foetus either stillborn or alive



Schemes will no longer compete on the basis of risk selection (the age and health profile of the beneficiaries they attract) instead, competition will be on the basis of cost-effective healthcare delivery.

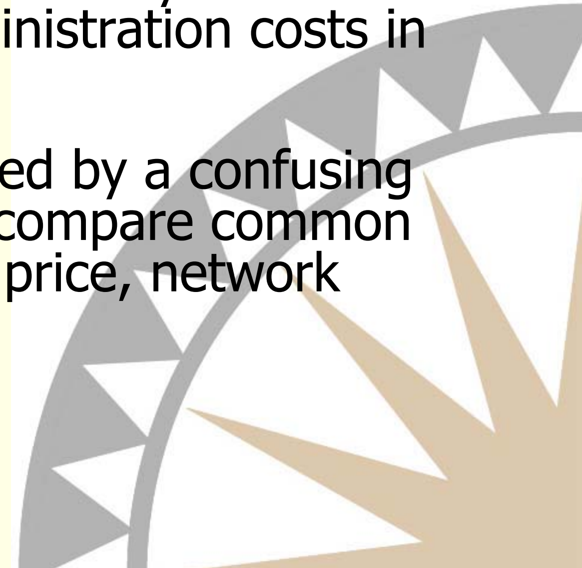
Phase 2
Price of healthcare by age

- Information from the REF Contribution Table 2004.



Phase 2
The REF formula cont…

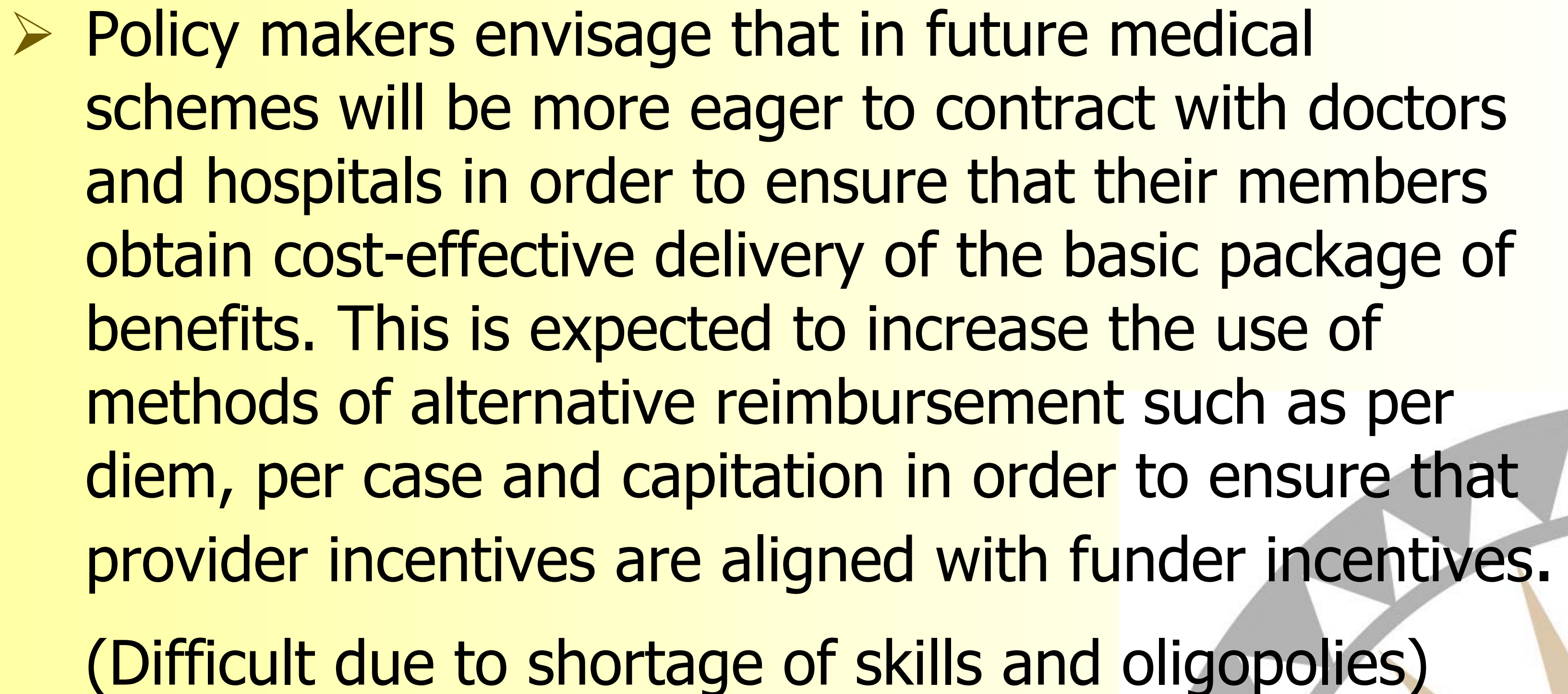
- Further recommendations by the IRP
  - stakeholders design a basic benefit package which might include the existing PMB together with primary health care.
  - medical schemes be allowed to offer only a limited standard set of benefit packages above the BBP
  - standardized benefit packages would mean a substantial reduction in the administration burden faced by practitioners and should also lower administration costs in medical schemes
  - consumers would no longer be confronted by a confusing array of options and instead be able to compare common packages and make decisions based on price, network availability and quality.



Phase 2
Use of ARM's

- Policy makers envisage that in future medical schemes will be more eager to contract with doctors and hospitals in order to ensure that their members obtain cost-effective delivery of the basic package of benefits. This is expected to increase the use of methods of alternative reimbursement such as per diem, per case and capitation in order to ensure that provider incentives are aligned with funder incentives.

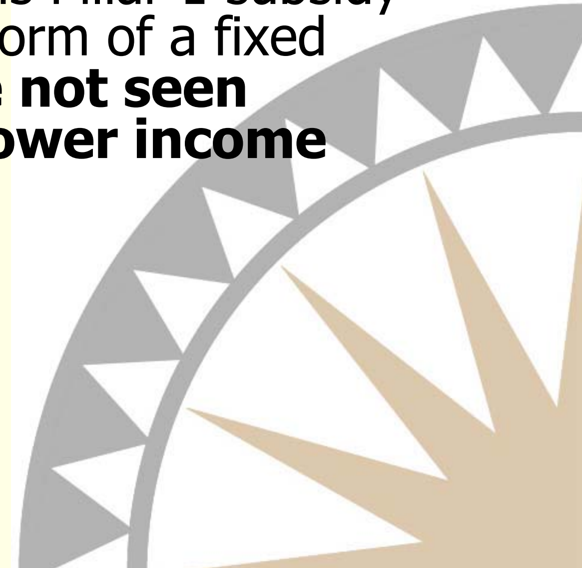
  (Difficult due to shortage of skills and oligopolies)



Phase 2
Income-related cross-subsidies

- Tax Expenditure Subsidy has begun to be more progressive. Up until 2006 it was a regressive system. The higher the income, the greater the tax deduction, the larger the contribution the greater the tax deduction - reduces the sensitivity of higher income groups to medical scheme price increases. TES increased with income. Seen as inequitable

- The groups that suffered most under the previous tax framework were the average and lower income groups. The intention behind the reforms is to equalise this Pillar 1 subsidy available to all, regardless of income, in the form of a fixed subsidy per beneficiary**. However, we have not seen membership grow substantially in the lower income groups.**



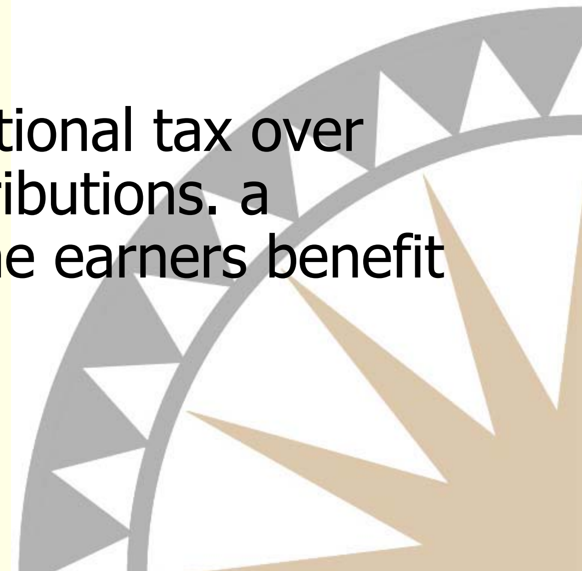
Phase 2
Income-related cross subsidies cont…

- New arrangement
  - R500 per adult beneficiary
  - R300 per child beneficiary
- Risk of option downgrading
- Risk of family splitting
- But progressive system

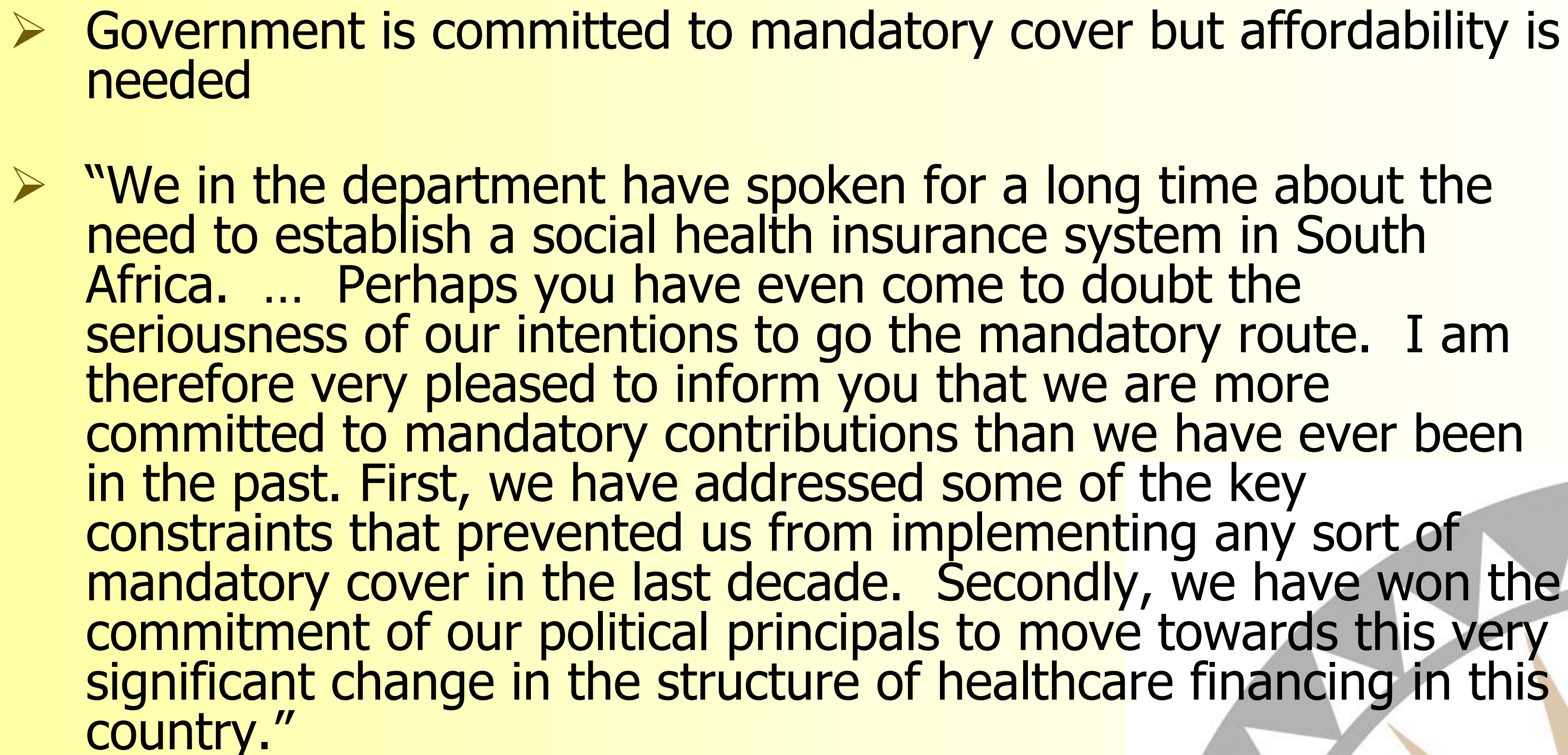
Phase 2
Earmarked tax?

- Possible scenario would be to introduce an earmarked Social Health Insurance contribution for all those earning above the tax threshold which might be collected by SARS. Early indications are that the SHI Contribution may be of the order of 4.5% of income to cover the full cost of a basic benefit package for some 10 million people under the first phase of SHI

- The SHI contribution may not be an additional tax over and above existing medical scheme contributions. a fundamental principle is that lower income earners benefit substantially

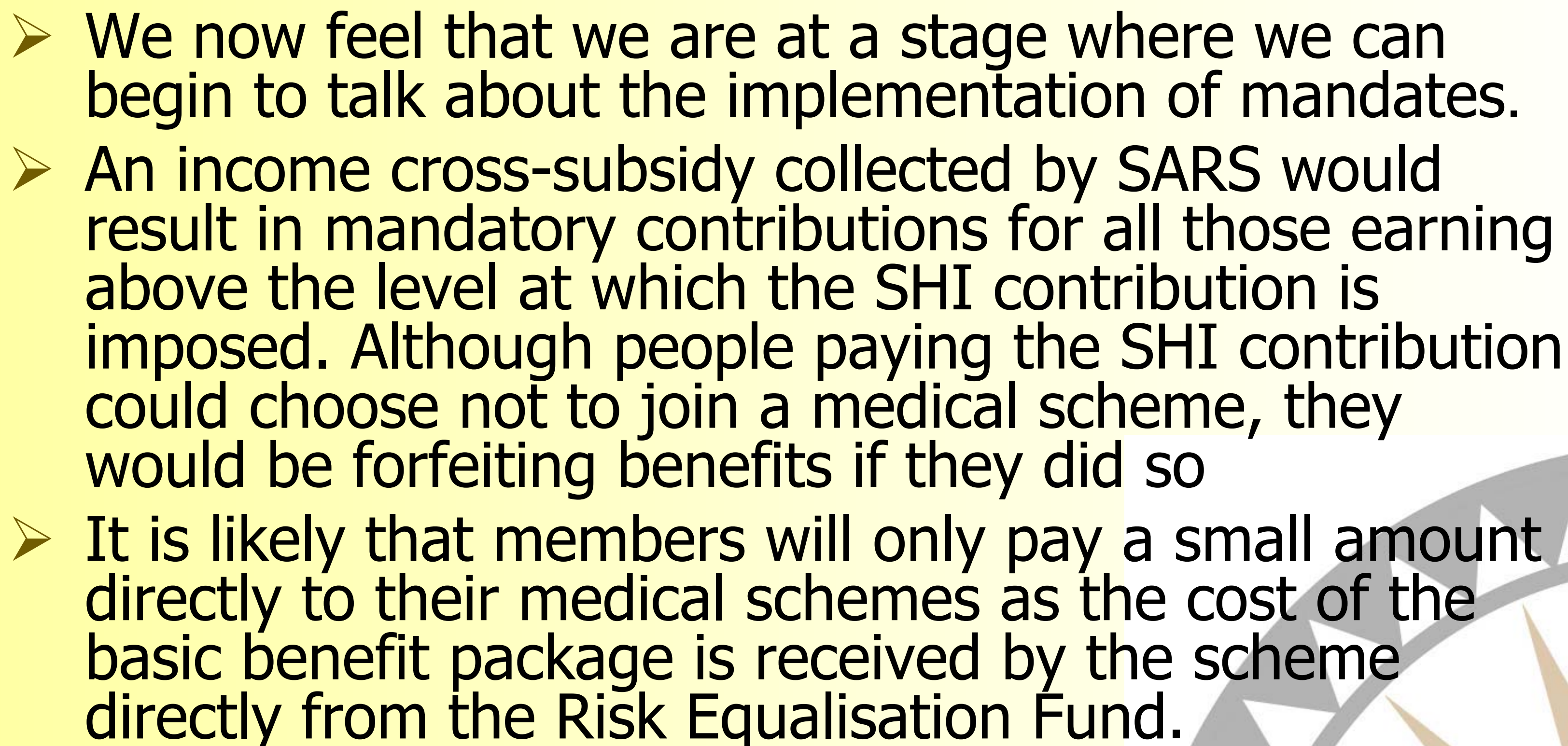


Phase 3
Mandatory contributions and mandatory cover



- Government is committed to mandatory cover but affordability is needed
- "We in the department have spoken for a long time about the need to establish a social health insurance system in South Africa. … Perhaps you have even come to doubt the seriousness of our intentions to go the mandatory route. I am therefore very pleased to inform you that we are more committed to mandatory contributions than we have ever been in the past. First, we have addressed some of the key constraints that prevented us from implementing any sort of mandatory cover in the last decade. Secondly, we have won the commitment of our political principals to move towards this very significant change in the structure of healthcare financing in this country."

Phase 3
Mandatory cover cont…

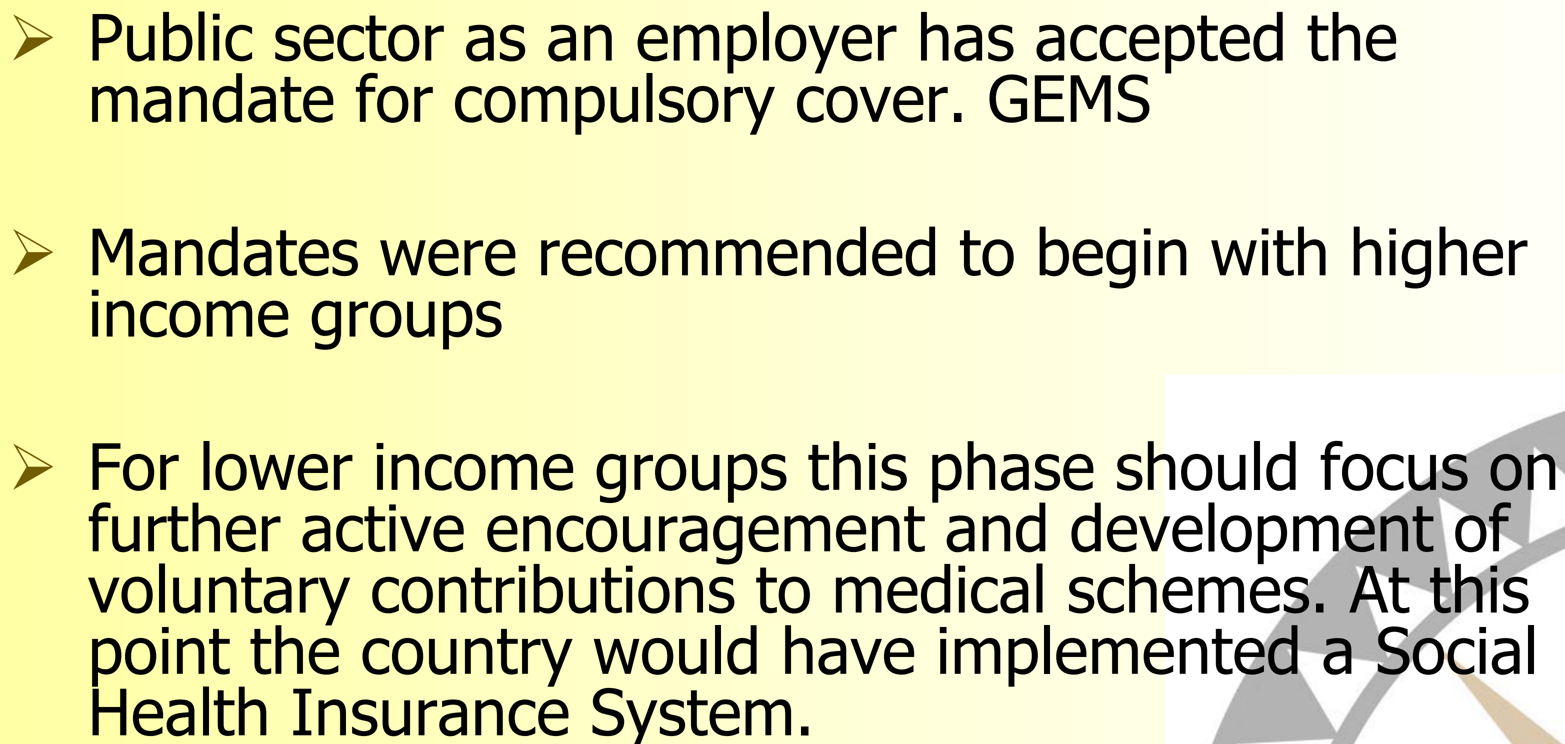


- We now feel that we are at a stage where we can begin to talk about the implementation of mandates.
- An income cross-subsidy collected by SARS would result in mandatory contributions for all those earning above the level at which the SHI contribution is imposed. Although people paying the SHI contribution could choose not to join a medical scheme, they would be forfeiting benefits if they did so
- It is likely that members will only pay a small amount directly to their medical schemes as the cost of the basic benefit package is received by the scheme directly from the Risk Equalisation Fund.

Phase 3
Mandatory cover cont…

- Once the Risk Equalisation Fund is in operation with the risk-related and income-related cross-subsidies, it is planned that mandatory cover be introduced for certain groups

Phase 3
Implementation of the initial mandates

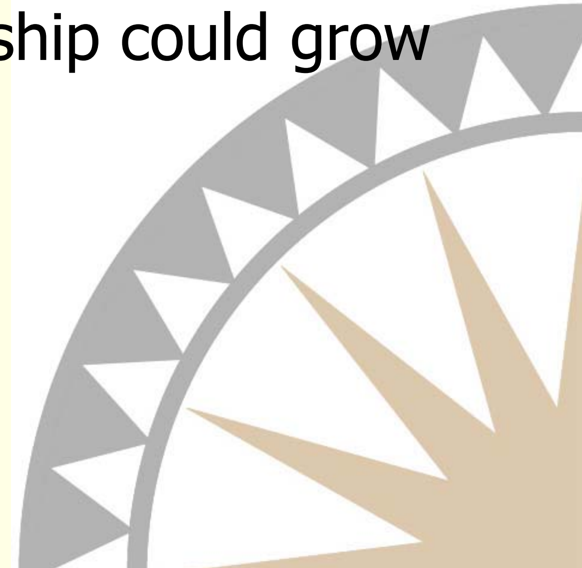


- Public sector as an employer has accepted the mandate for compulsory cover. GEMS
- Mandates were recommended to begin with higher income groups
- For lower income groups this phase should focus on further active encouragement and development of voluntary contributions to medical schemes. At this point the country would have implemented a Social Health Insurance System.

Phase 3
Healthcare financing under SHI

- Approximately 16% of the population are beneficiaries of medical schemes.

- If appropriate lower-cost products are developed and the tax reforms assist lower-income workers to join the system, medical scheme membership could grow to 15 million people under SHI



Healthcare delivery under SHI

- Mix of public sector second-tier (i.e. private beds in public hospitals) and private sector hospitals, together with private primary care.

- Increasing use of public-private partnerships, including centres of excellence.

Phase 4
Implementation of NHI

- Still the question of whether NHI would be affordable. Once the country has reached SHI system the question of its extension to NHI will require much further deliberation and debate

- The high levels of unemployment are a barrier to the direct implementation of NHI

Questions?