Board of Healthcare Funders

Discussion Document on National Health Insurance

Final draft

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BHF DISCUSSION DOCUMENT ON NATIONAL HEALTH INSURANCE

PREAMBLE

At the BHF Board meeting held on the 12th March 2009 it was resolved;

- That BHF notes that the government of the day have pledged to established a generic South African NHI model within the framework of the overall economic situation in South Africa;
- That BHF and its membership have a pragmatic approach to this far reaching development in the healthcare industry and supports the vision of government in bringing universal access to all South Africans at an affordable cost;
- That against this background BHF is charged by its membership to renew its total commitment to leaving no stone unturned to ensure that, through a collective process, Medical schemes as a major role player and asset in the private healthcare sector continue to fulfil a vital, meaningful, integral and central role in the roll out of NHI in the interest of all the citizens of our country, without at any time losing sight of the constitutional rights of medical scheme members;
- That BHF is of the conviction that in this way we would successfully rise to the challenge of a 'time for change' with a confident 'yes we can'.

1. Introduction

1.1 The Board of Healthcare Funders of Southern Africa (BHF), representing the majority of medical schemes in South Africa, Lesotho, Namibia, Zimbabwe and Botswana, recognises and embraces the intent of the South African Government to implement National Health Insurance (NHI) as one of the major mechanisms to finance the National Health System (NHS) in South Africa.

1.2 It is crucial for BHF to have an official position that has been mandated by the membership on the NHI issues. This discussion document is compiled to encapsulate the thinking and proposals of the membership in this regard. This will assist the process of constructive engagement by BHF in the NHI debates.

1.3 BHF agrees with the key objective of NHI, which, is to achieve universal coverage. The official World Health Organisation (WHO) definition of Universal coverage is: *"Health system that provides all with adequate health care at an affordable cost"*

1.4 A question of paramount importance in a majority of the world's countries is how health financing systems can provide sufficient 'financial risk protection' to all of the population against the costs of healthcare?

1.5 The presentations made by Prof Di McIntyre, Prof Steven Friedman and Dr Zweli Mkhize at the 9th Annual BHF Conference in Durban 13-16th July 2008, asserted that:

- There is no "ideal NHI model" in the world that will be appropriate for South Africa.
- South Africa must develop its own "tailor-made" model for NHI.
- This must be developed in a way that preserves what is good, utilising the available expertise, competence and resources.

1.6 The BHF Board, in its meeting of the 21st August 2008, agreed to the following:

- BHF endorses and supports the principle of the implementation of NHI.
- BHF endorses the goal of universal coverage and acknowledges that this will be achieved via an incremental process.
- Medical schemes should be an integral part of the NHI solution.
- Medical schemes will make available their resources, competencies, expertise and skills to assist the process of the implementation if NHI.
- BHF will embark on a process that will unpack how the Medical Scheme Industry can meaningfully contribute to the implementation of NHI.

1.7 At a BHF Consultative Workshop of the 12th November 2008, Emperor's Palace, Johannesburg the following was agreed to by the membership:

- We must fully understand how NHI will be structured and implemented in South Africa. For now we support it in principle.
- The National Health Act, 2003 defines the National Health System (NHS) as including the private sector; therefore medical schemes will be an integral part of the NHS.
- We must compile a detailed proposal on what our role can be. This role must be informed by our strengths, achievements and positive trends over the years.
- We must therefore indicate how we would like to see the NHI evolving and why. Nobody knows what form NHI will take in South Africa. We want to be part of the NHI process, play an integral, central and meaningful role to devise a system specific for South Africa.
- We want to make the expertise, capacity and resources available to enable a smooth implementation that takes into consideration the realities of South Africa.

2. Present Medical Schemes – their role in the Healthcare System

2.1 South Africa's medical schemes have evolved out of necessity. The administration expertise that has been built up to manage them, represent a critical asset of the South Africa's healthcare system. This includes health financing, purchasing and risk management. All of these various skills, systems and resources in the medical scheme environment will be critically required in an NHI system.

2.2 There are 122 medical schemes in South Africa (81 restricted and 41 open) with a total number of 7 478 040 beneficiaries (CMS Annual Report 2007-08). All the medical schemes in South Africa are registered with the Council for Medical Schemes (CMS) as "not for profit" entities.

2.3 Those who are able to join medical schemes have access to a standard of healthcare that is comparable to that provided by some of the best healthcare systems in the world. This is itself an important asset for the economy and the

country, and is critical in any government strategy to attract and retain scarce skills to the country, as well as to attract foreign investors.

2.4 Medical schemes promote access to healthcare in a number of ways:

- Medical schemes respond to the "healthcare" needs of 7.5million lives in South Africa. Their access has been secured by means of their personal funds (e.g. wages, salaries, pensions, savings) and their employers' funds. In addition to this the members and their employees pay general taxes which are used to finance the provision of healthcare services in the public sector, largely to the uninsured, indigent and unemployed. It is vital to understand that it is largely this same population which will be funding the NHI.
- Medical Scheme members make "voluntary contributions" to their medical schemes in order to secure a package of benefits that will make healthcare available to them when needed. It must therefore be appreciated that the spend on private healthcare comes from the voluntary contributions of the members of the private medical aid and the other stakeholders and NOT from government coffers.

- Medical schemes enable people who would ordinarily be obliged to seek medical treatment from the overburdened public health sector, to obtain that treatment in the private health sector. They therefore alleviate some of the pressure on the public health sector by channelling some patients into private health establishments. In fact the current Prescribed Minimum Benefits (PMBs) package was deliberately designed with this exact goal as stated in the introduction to the PMBs' regulations under the Medical Schemes Act , 1998;

- Medical schemes shorten the waiting lists in the public sector by enabling people who could otherwise not afford it, to receive health care services in the private sector. They therefore to some extent improve the lot, if only indirectly, of public sector patients. Furthermore some medical schemes have engaged in public private initiatives with provincial governments, for example in the Western Cape,

to upgrade public sector facilities for use by private and public patients alike. This is of direct benefit to public sector patients and could not have been achieved without the existence of the medical scheme.

- Through increasing use of managed care initiatives medical schemes scrutinize the health services rendered by providers and have made a great deal of progress in eliminating provider fraud and abuse of health care funding. This in turn ensures that more funds are available for health care services than would have been the case without such scrutiny.

- Medical schemes enable access to treatment that would be denied in the public health sector due to rationing protocols e.g. renal dialysis of people over a specified age and ventilation of neonates weighing less than 1000g. In so doing they promote the right to life and to freedom and security of the person as well as the right of access to healthcare services. This has to be pursued for everybody in South Africa.

- Medical schemes ensure that private sector providers are paid quickly and efficiently for health services rendered which in turn ensures that providers are available to render treatment to patients. Conversely, the COID fund and the Road Accident Fund – both state agencies – seem unable to pay providers timeously to such an extent that many private doctors do not want to treat workmen's compensation patients who are not on medical aid and would rather refer them to the public sector.

- Provision is made in terms of the Medical Schemes Act to designate service providers from whom their members could obtain medical care including the public health sector. Medical schemes currently support the provision of health care in both the public and the private health sectors.

- Accessibility of health care services also involves the location of health establishments, and the management and funding thereof, in close proximity, both geographically and from a governance perspective, to the communities they serve. If people who govern a purchaser of health care services are drawn from the specific population to which those services are provided they are more likely to have insight into and understanding of the key issues involved and more likely to be able to effectively address them. This principle is known as subsidiarity. Institutional subsidiarity constrains any more encompassing or super ordinate institution (or body or community) to refrain from taking for its account matters which a more particular, subordinate institution (or body or community) can appropriately dispose of irrespective of whether the latter is an organ of state or of civil society. Medical schemes are subordinate institutions that are closer to their members (and the employers of those members). In some cases members of the scheme are known to the trustees personally - they are employees of the same employer as a trustee or members of the same labour union as a trustee. The people who govern medical schemes are thus 'closer' to the problems faced by their members in obtaining health care services. The principle of subsidiarity is endorsed in the National Health Act, 2003 in its creation of district health councils to manage public sector district health facilities. As a legal principle institutional subsidiarity is well established (and readily relied on) in amongst others the law of the European Union and in German constitutional law. At least one South African legal scholar has shown that subsidiarity is an implied constitutional value "at the root of an open and democratic society"

2.5 In spite of the positives addressed above, there are difficulties in the current framework and model of the medical schemes' operations and the following can be highlighted:

- The regulatory structuring of the PMBs around diagnosis and severity as opposed to specific health interventions that are the most cost effective and epidemiologically appropriate for the promotion and maintenance of the health of insured populations. This is aggravated by the absence of a REF that would

address issues of fragmentation within the medical schemes industry and effectively create a single large risk pool of the insured persons.

- The prohibition in the Competition Act on collective bargaining by schemes;
- Difficulties in securing contracts with public sector providers of health care services;
- Mandatory community rating without compulsory membership;
- The oligopoly in the private hospital sector permitted over the years by the Competition Commission;
- The current licensing of facilities legislation;
- The difficulty which is faced when wanting to bring in scarce skills from overseas;
- Difficulties with the Competition Act concerning mergers of schemes and the high fees charged by the Commission in respect of certain mergers;
- A strict approach to benefit design and the levying of contributions by the CMS which discourages innovation and encourages the status quo;
- Regulatory provision for “late joiner penalties” and the imposition of waiting periods on those who change medical schemes or join one for the first time later in life. These are not conducive to membership growth in those areas of society that find it difficult to afford medical scheme membership to start with or who have historically been denied the privilege of medical scheme membership due to reduced circumstances beyond their control and have only recently gained the means to acquire that membership;
- Comparative lack of regulatory control of private health care providers;

  Non standardization of procedural codes and treatment protocols due to the Competition Act and rulings of the Competition Commission in the health sector and lack of regulation in these areas by the state;
- The lack of meaningful growth due to a combination of factors the most important of these being the slow rate of employment growth in the South African economy. Medical scheme principal members correlate very closely with personal tax payer numbers. These have only started to grow over the past 3 years, and have been stagnant for the 8 years prior to that.

- High costs of private healthcare services in relation to the growth of salaries and wages. These high costs are due to a number of factors, including ongoing ageing of the medical scheme population, the high and progressively increasing rates of chronic diseases including cancer, diabetes, cardiovascular disease and HIV/AIDS, as well as the high rate of entry of new medical technology at high prices. These trends are aggravated by supply side constraints.

- From a regulatory point of view, growth has been constrained by an unfortunate co-incidence of factors and timing of regulatory implementation. These include the significant costs of providing the extensive PMBs package, which would have been mitigated by the implementation of the Risk Equalisation Fund, income cross subsidies for low income members, and exemptions to PMB requirements for low income employees. However, none of these three regulatory requirements have yet been implemented, and as a result, PMB requirements have been a factor constraining growth of medical scheme cover at the low income end of the membership spectrum. The high and rigid statutory solvency requirements to which schemes are subject, which fail to take into account scheme size and relative risk, have also played some part in increasing scheme premiums.

- The distortion of the PMBs package towards secondary and tertiary level, hospital based care;

- Utilisation problems – over servicing, fraud, lack of Health Technology Assessment.

- Medical schemes are perceived, in some circles, to be in existence solely for profit without due regard of the members' interests. The reality is that all the medical schemes in South Africa are registered "not for profit". The contributions they get for various options from the membership are controlled and approved by the Council for Medical Schemes (CMS).

- Medical schemes are perceived to be accumulating huge reserves that enrich the schemes at the expense of the membership. Firstly, it is a legal requirement for every scheme to have a minimum solvency ratio of 25%. (Presently the Industry average is 37.8% from 20.2% in 2000: CMS Annual Report 2007-08). The aim of this legal requirement is to protect the interests of the member. In addition, well funded medical schemes are also able to use their assets for the benefit of their members both by way of offsetting the effects of medical inflation in lower contribution increases and by internal cross-subsidy.

- It is perceived, at times, that medical schemes contributions are unreasonable and not affordable. Therefore people get out of schemes and few people join schemes. Accessibility is therefore not adequately addressed. The reality is that we are failing to attract more members, costs being the barrier, but also we experienced a deficit of R2.1 billion in 2006 and R992.0 million in 2007. (CMS Annual Report 2007-08).

- The Non-healthcare costs keep on increasing. The reality is that some of these costs are inherent in the administrative processes in pursuit of corporate governance and some of the legal requirements. The administrative activities are rendered by entities that are "for profit" with a huge capital outlay and resources. We submit that the medical schemes can do a lot to improve on this, given the opportunity.

- The Healthcare costs keep on rising and the Medical Scheme industry is failing to contain them. The fact is that the medical schemes have been disempowered by the Competition Commission ruling of 2003, which prevented Schemes from negotiating with healthcare providers as a collective, in order to extract reasonable tariffs and fees. The fees and tariffs of healthcare providers are not adequately regulated, and there is no meaningful competition to exert a downward pressure on costs.

- BHF and its member schemes and administrators have identified these difficulties. We have embarked on strategies to address them by working closely with the Government and CMS. We believe that these problems with the existing medical schemes environment do not, however, imply that this system should be marginalised and not be part of the proposed NHI reforms.

3. Medical Schemes (BHF members) position on NHI

3.1 This underlying demand for high quality healthcare, is clearly evident in South Africa, through the purchasing patterns of the 7.5 million medical scheme members, as well as the many millions of non scheme members who purchase primary health care and other private services on an out of pocket basis.

3.2 This underlying demand will remain, and the NHI system would need to be able to provide similar levels of access and quality of healthcare as is currently available to the members of medical schemes.

3.3 In the development and implementation of the NHI model in South Africa, careful consideration must be given to the Constitutional rights of the medical schemes members.

3.4 The NHI system should work on bringing levels of access up to those enjoyed by the currently insured population and not inadvertently reduce the levels of access of the latter.

3.5 What the medical schemes have been providing to its membership in terms of access, quality and human dignity issues - must be maintained or preferably improved on even in an NHI environment.

3.6 The wording of section 27(3) of the Constitution states that the government must "within *its* available resources", take reasonable legislative and other

measures to ensure the *"progressive"* realization of the right of access to health care services. It will not be progressive to increase the access of one sector of the population by reducing that of another.

3.7 The financial reserves of medical schemes belong to the scheme and its members.

3.8 The current medical scheme system is a precious asset that is highly valued by its current membership, and should be a very valuable and critical component of any proposed NHI system.

3.9 BHF strongly supports the objectives of NHI defined as the provision of universal access to a defined range of healthcare services for all South Africans at an affordable cost.

3.10 The achievement of an NHI system is a process and not an event. The policy framework for achieving an NHI must therefore be a progressive and incremental one, which is based on the realities of the South African economy, and the South African healthcare system. This process should build on and expand the existing assets of both the public and private South African healthcare systems.

3.11 We strongly support increased allocation of government funds to the public health sector so that it becomes a substantial and major backbone for rendering health services in an NHI environment.

3.12 The NHI system should be built by integrating the existing public and medical scheme financing mechanisms into a workable system that achieves the goals of the NHI. This approach is fully consistent with that adopted in the progressive development of NHI systems in the vast majority of both developed and middle income countries.

3.13 Definitions must not compromise creating a "South African version of NHI" that takes into consideration the realities that exist. This pragmatic approach must not be disregarded because it is not aligned with certain definitions.

3.14 The competencies, expertise and resources presently available in medical schemes and their administrators must be utilised in various ways for the general implementation of NHI.

4. Medical Scheme Members and the Constitution

- Medical schemes promote the constitutional rights to freedom and security of the person and human dignity by ensuring that their beneficiaries obtain high quality and timely health care services.
- Medical schemes enable the delivery of emergency medical treatment which is a constitutional right, at the nearest health establishment to the patient. Medical schemes are entirely consistent with the Constitutional mandate to government to take reasonable legislative and other measures to achieve the progressive realization of the right to health care services.
- The Medical Schemes Act was promulgated in 1998 and was drafted so as to include principles of community rating and open enrolment to ensure "social solidarity" and "cross subsidization" of the old and ailing by the young and healthy in the private health sector. This supports the constitutional mandate of the state as outlined in Section 27 of the Constitution.
- The constitutional right of access to health care services is about far more than just the health care services that are rendered. Access to health care also involves rights to privacy, freedom and security of the person, bodily and psychological integrity and dignity. These human rights together, with access to healthcare, must be upheld. Medical schemes promote this in the private sector for their members. It is therefore important not to lose sight of this in the implementation of a NHI system.
- Human dignity can be affected by the manner in which a health system deals with people – the way it "processes" people. Having to wait for long periods of time in order to access health care services, can have a severe negative impact

on human dignity and prolongs human suffering. Having to pay cash up front for badly needed health services and financially unable to do so impacts negatively on human dignity. Having to stand in long queues whilst ill or injured without rest or refreshment in order to obtain health services impacts negatively on human dignity. Being treated with disrespect by administrative and health workers in health establishments, and being verbally or even physically abused by such workers infringes the constitutional right to human dignity. Waiting all day for medicines only to be told to come back tomorrow impacts negatively on human dignity. Having to beg administrative and health workers for their attention is not conducive to human dignity. Medical schemes' ability to independently fund providers attempts to minimize all of the above for their members.

5 Proposals on how Medical Schemes (BHF members) should be an integral part of the evolving process and implementation.

5.1 Come up with helpful documents that highlight the "tenets" of administering healthcare finances, purchasing of healthcare services and the nature of systems and processes to be in place.

5.2 Compile a document that intelligently interprets the transactions of the 7.5million lives to provide helpful information that will assist the modelling of NHI for South Africa.

5.3 Provide useful information on how an "appropriate balance" between providers of healthcare and funding can be achieved in a way that will contain healthcare costs.

5.4 Engage in partnership projects that will facilitate the implementation of a workable NHI system

6 CONCLUDING REMARKS

Economic Context

6.1 This intent is shaped by the Macro-Economic Context of South Africa that has been driven by the introduction of Growth Employment and Redistribution (GEAR) policy in June 1996, the South African Constitution (1994) and related social development imperatives.

6.2 While it is recognised that GEAR did have successes, it is also unfortunate that there has not been significant redistribution. Inequalities have widened and funding of the Public Health System on real per capita expenditure basis declined from 1996 to 2000. The increase that has been seen over the last couple of years puts us where we were in 1996.

6.3 The medical schemes industry on the other hand, with all its positive attributes, has not managed to increase the membership, and put a downward pressure on healthcare costs. It is therefore unfortunate that the medical schemes have not achieved universal coverage at an affordable cost.