LIMS Revisited

Roseanne da Silva

7 May 2015

The South African landscape

- Healthcare expenditure at approx 8.5% of GDP
- Approx 42% is public expenditure
- Approx 18% of population has access to private health insurance through medical schemes (mutual funds)
- Private health insurance plays a small role (less regulated)
- Public health service faces delivery challenges
- Great political pressure for National Health Insurance
- Small tax base (2.8m)

The need for extending access

- Encourage those who can pay to make self provision
- Pre-payment principle
- Poverty trap associated with health events (dual loss)

Challenges in SA health insurance

- Disease prevalence
- Technology costs
- Specialist and hospital billing arrangements and control
- Medicine regulation
- Prescribed minimum benefits
- Anti-selection
- Income disparities

The Process so Far

- LIMS study in 2006
  - CMS requested, industry funded
- Some PMB exemptions
  - Restricted and Bargaining Council Schemes
- Circular 9 or 2015
- Workshop on 12 March
  - Industry input
- ITAP discussions
- CMS feedback to follow….

LIMS Terms of Reference

- Ministerial Task Team on Social Health Insurance and CMS
- Investigate barriers to low income participation in medical schemes
- Attempt to identify consensus

The LIMS Project

- Large scale national household survey
- Detailed literature review
- Demand model for take up
- Capacity model for the supply side

- Open and transparent process

Findings: Attitudes to Medical Scheme Coverage

- Strong interest in belonging to a medical scheme
  - 72%-80% indicated willingness to risk pool for health care
- Strong preference for out of hospital relative to private hospital cover, although private hospital cover also seen as important
- Willingess to Pay: Results of Discrete Choice Experiment
  - PHC package (GP + Dental + Medicines+ Optometry): R74.61
  - PHC package plus specialists: R89.97
  - Private hospital cover: R61.64
  - Consistent pattern in all income bands

LIMS Target Population: R2500-R6000

	LIMS household survey 2005
Number of households (millions)	2.6
Number of individuals (millions)	11.5
% under the age of 16 years	26%
% over the age of 65 years	4%
Number of households with medical aid (millions)	0.505
Number of individuals with medical aid (millions)	1.37

Barriers to entry

	No household member working	One/more members working in formal sector	One/more members working in informal sector	Total
A: Value Proposition	**79.2%**	**46.2%**	**62.0%**	**57.0%**
B: Access Related	**15.9%**	**42.5%**	**29.5%**	**33.9%**
C: Choice	**4.9%**	**10.5%**	**8.3%**	**8.8%**
D: Other	**7.2%**	**17.5%**	**14.5%**	**14.6%**

Finscope cross tabulations

	Number with Medical Insurance	% of Medical Insurance with Product	% of Product with Medical Insurance
Bank	2,711,902	98%	17%
Funeral Insurance	1,971,967	71%	16%
Retirement	1,904,837	69%	60%
Asset Insurance	1,852,525	67%	64%
Life Insurance	1,742,062	63%	55%
Retail	1,624,677	58%	26%
Home loan	1,229,654	44%	54%
Loans	1,143,624	41%	35%
Investments	987,567	36%	69%
Savings	141,748	5%	7%

Utilisation levels

3 months prior to survey

Service	Medical Aid	No Medical Aid
Private GP	34%	7%
Public clinic	6%	15%
Workplace clinic	2%	0.5%
Specialists	5%	0.5%
Traditional healers		1%
Hospital admissions	6.1%	3.5%
% public sector admissions	17.5%	98.5%

Financial Diaries Project

- Average medical spending on doctors, traditional healers and medication is 1.6% of gross income.
- Rural households tend to spend a slightly higher proportion of income on medical items, as do poorer households.
- Only 1/10 of households have medical insurance, as opposed to 1/6 of households with at least one form of funeral insurance and often two.
- Those few households with higher medical expenses often do so for chronic illness.
- Several comment that community services do not provide adequate care, forcing them to seek expensive private care

LIMS: Cover Preferences

- Preference analysis (linked to costs)
- 20% - 25% indicated GP requirement
- 15% indicated private hospital requirement
- 14% indicated comprehensive requirement
- Proposed plan
  - GP consultations
  - Basic radiology and pathology
  - Dental and Optometry
  - Formulary medications
  - Emergency transport
  - Maternity care and specialists optional
  - *No private hospital coverage*

LIMS: Impact of Tax Subsidies

- Assumptions
  - Affordability is 8% of household income
  - Direct subsidy of R50 per month
  - 50% employer subsidy
  - Premium R150 per beneficiary per month
- Increase in coverage: R3.6m lives

Additional lives covered ('000s)

	Premium = R200 per month			Premium = R150 per month		
	NT subsidy R0	**NT subsidy R25**	**NT subsidy R50**	**NT subsidy R0**	**NT subsidy R25**	**NT subsidy R50**
5%	1,549	1,601	1,848	1,848	1,848	3,166
8%	1,848	3,166	3,265	3,266	3,589	3,589
12%	3,265	3,589	3,589	3,589	5,136	5,252

LIMS Recommendations

- Modification of medical scheme environment
- Differentiated minimum benefit package
- Protection of existing risk pool
- Buy-ups encouraged
- Urgent investigation required into legislative obstacles to emergence of cost effective integrated delivery models
    - HPCSA rules, guidelines, regulations
    - Scope of practice of various professions
- Engagement with trades unions and organised business on role in distribution

Recommended benefits

- LIMS schemes/options must offer a LIMS Minimum Package:
  - Defined minimum numbers of GP and dental visits
    - M0 = 3 visits, up to family maximum of 12
    - 2 dental visits per life
  - Formularies for acute and chronic medicines, radiology and pathology
  - Defined optometry benefit
  - Additional GP visits and formulary for CDL conditions
  - Emergency transport to hospital

- LIMS schemes/options can offer additional benefits above the LMP, but cannot offer any hospital cover

Recommendations on risk management

- LIMS schemes must be substantially differentiated from current schemes in terms of benefits, in order to prevent inappropriate buy-downs from current environment
  - Exclusion of private hospital cover is key to this benefit differentiation
  - Key buy down risks are young and healthy in current environment, who will buy down if can obtain private hospital cover in LIMS schemes
  - Income threshold not tight enough to prevent buy down risk alone
- Exclusion of hospital cover goes along with recommendation to eliminate user fees at public hospitals for all individuals earning below the proposed LIMS threshold
- 3 month and 12 month waiting periods as for current schemes
- Specific provisions for later buy-ups from LIMS to current schemes

Current exemptions

- Sapphire
  - Only public hospitals
- Moto Healthcare
  - 2 options
- BCIMA
  - Some private hospital cover
- Bargaining Council
  - Fishmed
  - Golden Arrow

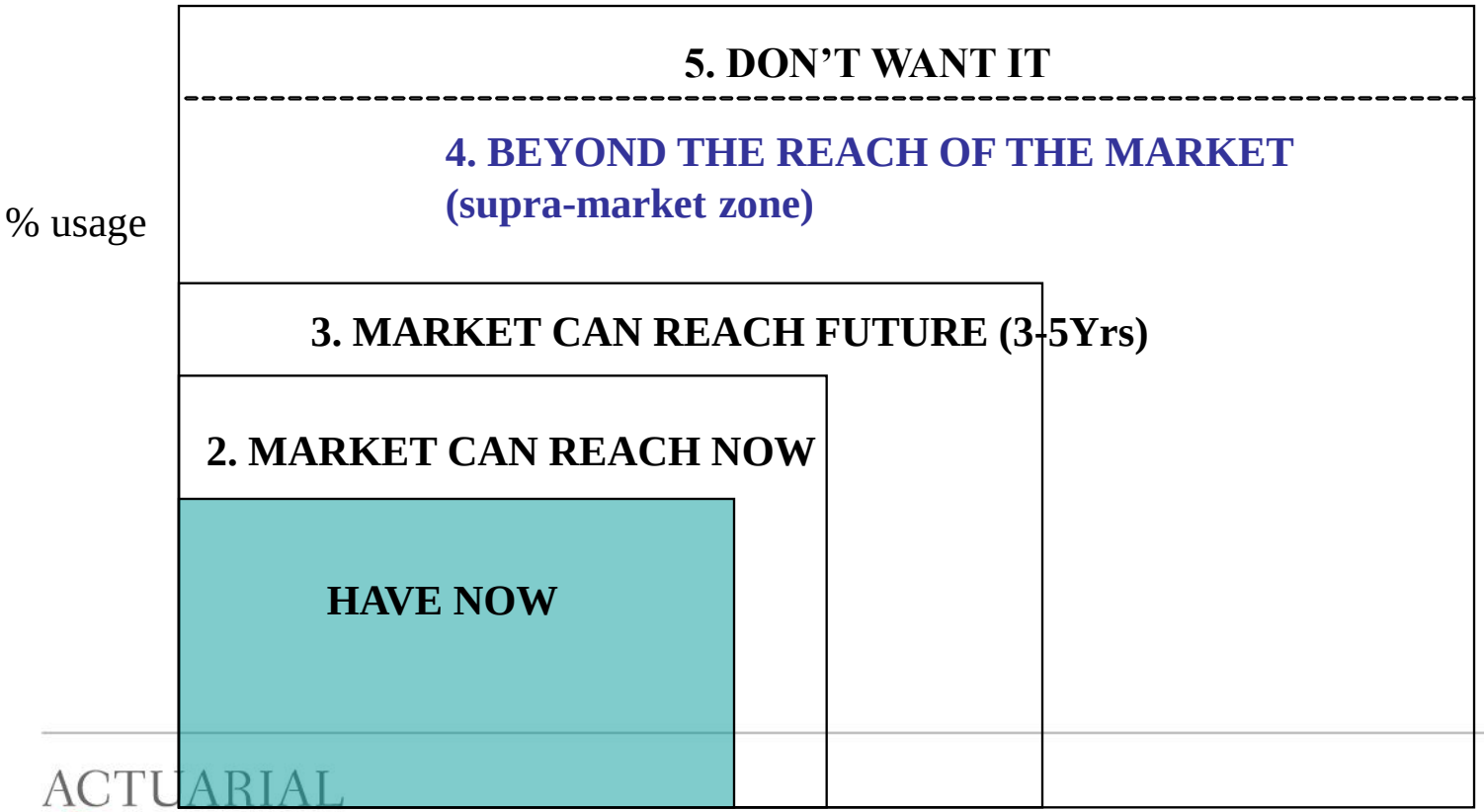
Some comments

- Key issues:
    - Meaningful benefits
    - Simplicity
    - Affordability
- Focus on primary care
- Link to demarcation regulations
- Key issue is ring fencing (nature of benefits or income level)
- Risk pool definition (mandatory, group cover)

MMW4P Concepts

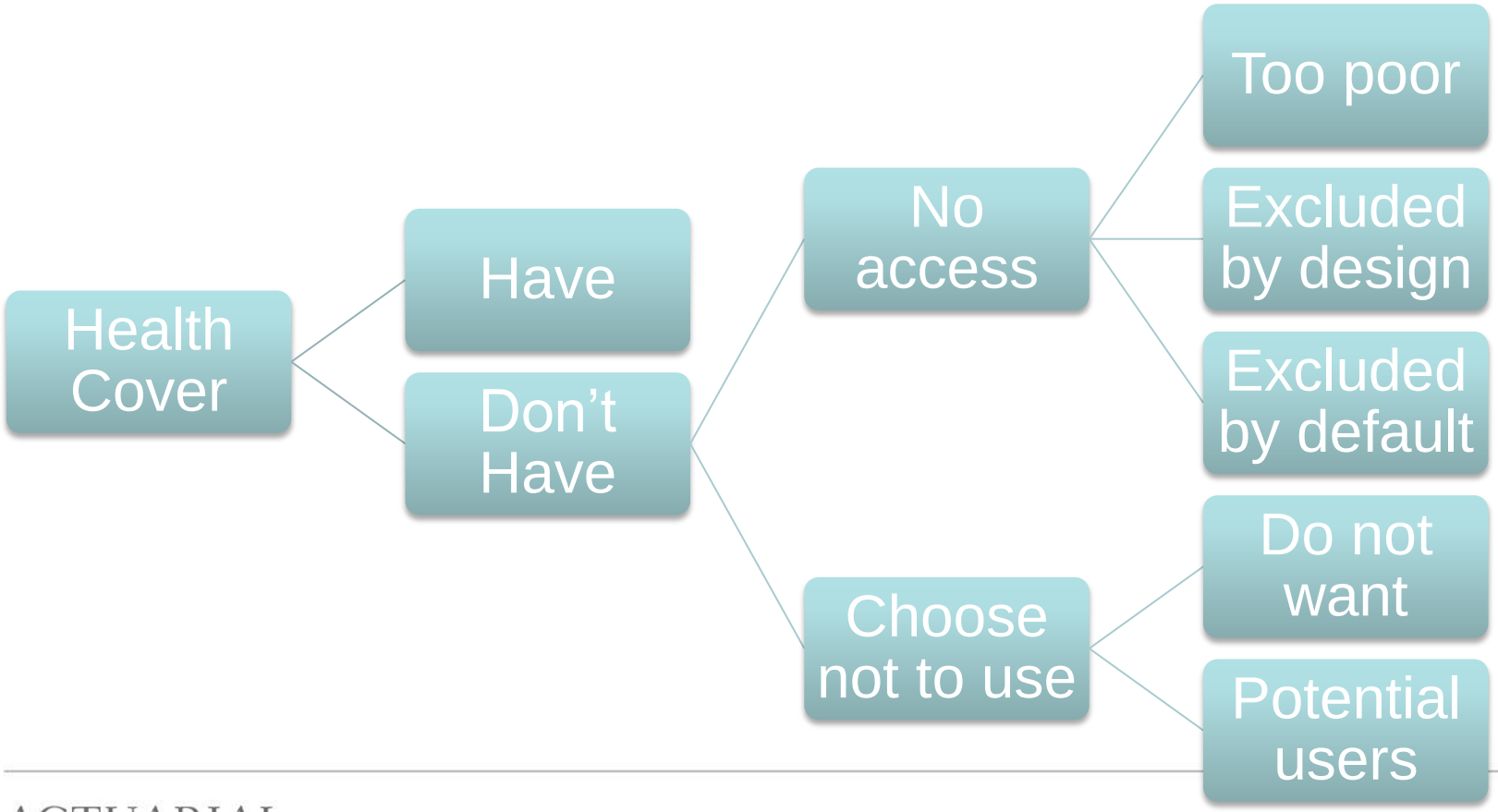
The Access Frontier:

The Access Frontier is defined as the "*maximum proportion of eligible consumers who presently have access to the product or service*".

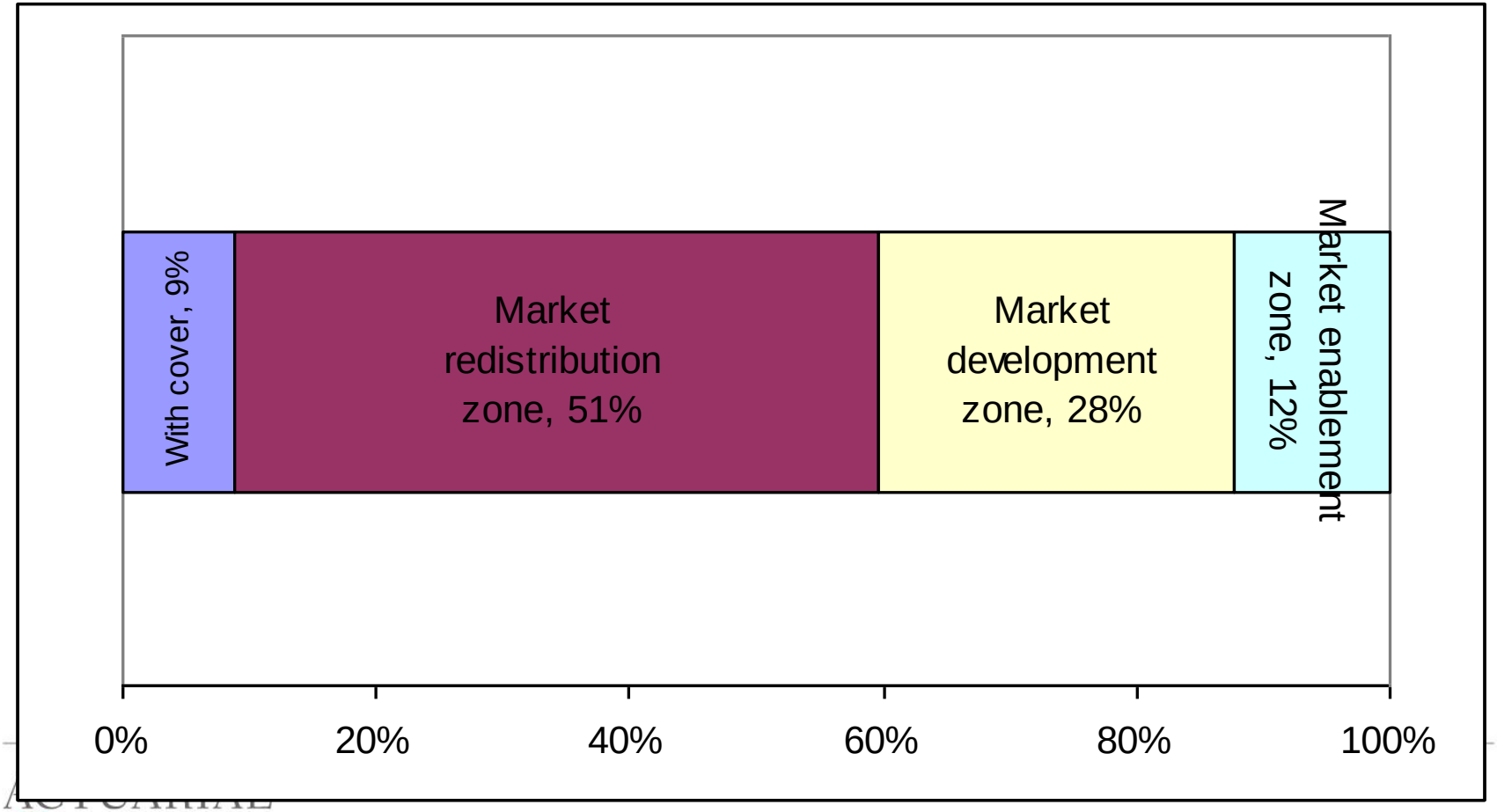


Source: Porteous 2004 & 2005 mimeo

Access Frontier



The Access Frontier



MMW4P

- Government's role:
  - Provision of service
  - Pay others to provide service
  - Transfer to consumers the means to buy service
  - Require existing providers to cross subsidise extension of service
  - *Create enabling environment*

Enabling environment

- Appropriate vehicles for delivery
  - Mutual vs. for profit
  - Specialised vehicles (Alive+)
- Role of competition
  - Service providers
  - Funders
- Public/private partnerships
  - Existing points of access
  - Competition for hospitals
  - Additional revenue sources

Research Topics

- Supply of healthcare services
- Willingness to pay
- Funding of benefits
- Appropriate product design
- Funding vehicles
- Distribution mechanisms

What is the way forward?

- Consider regulatory role and structure

- Open architecture
  - Removes massive barriers to entry (eg does lack of reinsurance prevents new entrants?)
  - Facilitates rivalry, innovation and market expansion
  - BUT may be less stable AND
  - Requires a different role for state:
    - Leadership, coordination, facilitation, supervision