

MUTUALITY AND SOLIDARITY IN HEALTHCARE IN SOUTH AFRICA

By HD McLeod

ABSTRACT

This paper uses Wilkie's definitions of mutuality and solidarity to review the history of private healthcare in South Africa. The vision for a future unified national healthcare system is given and the phases of reform are outlined. The first phase of reforms has been completed and these are contextualised in terms of a return to solidarity principles. The elements of a planned social health-insurance system are described and it is shown how income cross-subsidies will further entrench the principles of solidarity. In the past, healthcare actuaries largely supported mutuality principles. The implications for the actuarial profession are suggested.

KEYWORDS

Healthcare; medical schemes; social solidarity; community rating; minimum benefits; social health insurance; risk equalisation

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1. INTRODUCTION

1.1 David Wilkie, in a few sentences in a talk at a conference at the Royal Society in 1996 (Wilkie, 1997), introduced the terms 'mutuality' and 'solidarity' to English actuarial literature. Actuaries are steeped in mutuality principles in their training and working lives but have little exposure to the existence of solidarity principles. Wilkie's simple exposition of the two concepts became pegs on which to hang other literature and provided an understanding of the conflict that arose several times in the decade of the 1990s between South African healthcare actuaries and policy-makers.

1.2 The South African healthcare system has been undergoing substantial transformation since 1994. Actuaries may not always be fully aware of the broader issues and the social-security thinking that lies behind that transformation, nor are many familiar with the framework for social health insurance (SHI). This paper uses the pegs of mutuality and solidarity to explain the regulatory changes of the 1990s and to describe the elements that still need to be implemented for an SHI system in South Africa.

1.3 The paper begins with Wilkie's description of the two concepts and a paper by Moultrie and Thomas on similar themes. An introduction to healthcare in South Africa in

section 3 highlights the disparities inherited in 1994 between the public and private provision of healthcare. The rationale and constitutional imperatives to create a single unified healthcare system are described.

1.4 Section 4 considers a brief history of the medical-scheme environment in terms of philosophical shifts between mutuality and solidarity. The section also outlines the conflicts that occurred in the return to solidarity principles.

1.5 Section 5 outlines the phases of reform and the social-security context for the future healthcare system envisaged for South Africa. The first phase of reforms is dealt with in detail in section 6 and the SHI reforms in section 7. Concluding remarks are then made on the implications for the actuarial profession in South Africa and the future role of healthcare actuaries.

2. ACTUARIAL THINKING ON MUTUALITY AND SOLIDARITY

2.1 WILKIE ON MUTUALITY AND SOLIDARITY

2.1.1 Wilkie (1997) describes the words ‘mutuality’ and ‘solidarity’ as being probably unfamiliar in this context of the assessment of risks and the sharing of losses, even to British actuaries, although the words are, he says, familiar terms in the Romance languages.

2.1.2 Wilkie (op. cit.) describes ‘mutuality’ as:

“the normal form of commercial insurance, whether or not it is run by a mutual insurance company or one owned by shareholders. Applicants contribute to the pool through a premium that relates to their particular risk at the time of the application, perceived as well as it can be at that time on the basis of all the facts that are available and relevant, ... The pooled funds then pay those insured who suffer losses in accordance with the scale of their losses for things like fire, household and marine insurance, or in accordance with the agreed sum assured for life insurance.”

2.1.3 He says that:

“‘Solidarity’ is a concept that has some similarity to mutuality, but also a profound difference. The similarity is that losses are paid according to need, and the difference is that contributions are made not in accordance with the risks that each applicant brings in with him, but perhaps according to ability to pay, or just equally. Solidarity is the basis of what goes under a variety of names, such as social security, social insurance or national insurance. The word insurance is often borrowed, but in each case it is modified by a word like social or national, which implies some measure of universality and some measure of compulsion.”

2.1.4 He cautions that:

“it is important not to get the concepts of mutuality and solidarity mixed up. Both involve the sharing of losses, but only mutuality involves the assessment of risks. Solidarity

requires comprehensiveness or compulsion; a private commercial insurance market requires mutuality.”

2.2 MOULTRIE AND THOMAS ON THE RIGHT TO UNDERWRITE

2.2.1 In South Africa, Moultrie & Thomas (1996) argue that:

“insurance underwriting, like all business practices, operates in a social context. Insurance has a number of features which distinguish it from most other products and which give it some of the features of a merit good (that is, a good which society considers should be available even to those who do not have the resources to purchase it in a private market transaction) and of a social good (that is, a good the supply of which generates positive externalities). The importance of these features depends on the extent to which social needs are met by private insurance.”

2.2.2 Moultrie & Thomas (op. cit.) argue that:

“if the industry wants an increasing social role for private insurance and the associated opportunities for profit, it must accept that society will take a greater interest in the social legitimacy of risk classification procedures. The alternative is for the industry to decline this increased social role, and retreat into a more limited position in which its risk classification procedures will be of less concern to society.”

2.2.3 They conclude that:

“[the profession] should recognize that the actuarial perspective on fairness in insurance classification has its limitations, and that we are not the only arbiters of fairness. The acceptability of underwriting procedures is societally determined, and a profession which fails to recognise and make allowances for this courts the risk of being ostracised and increasingly ignored.”

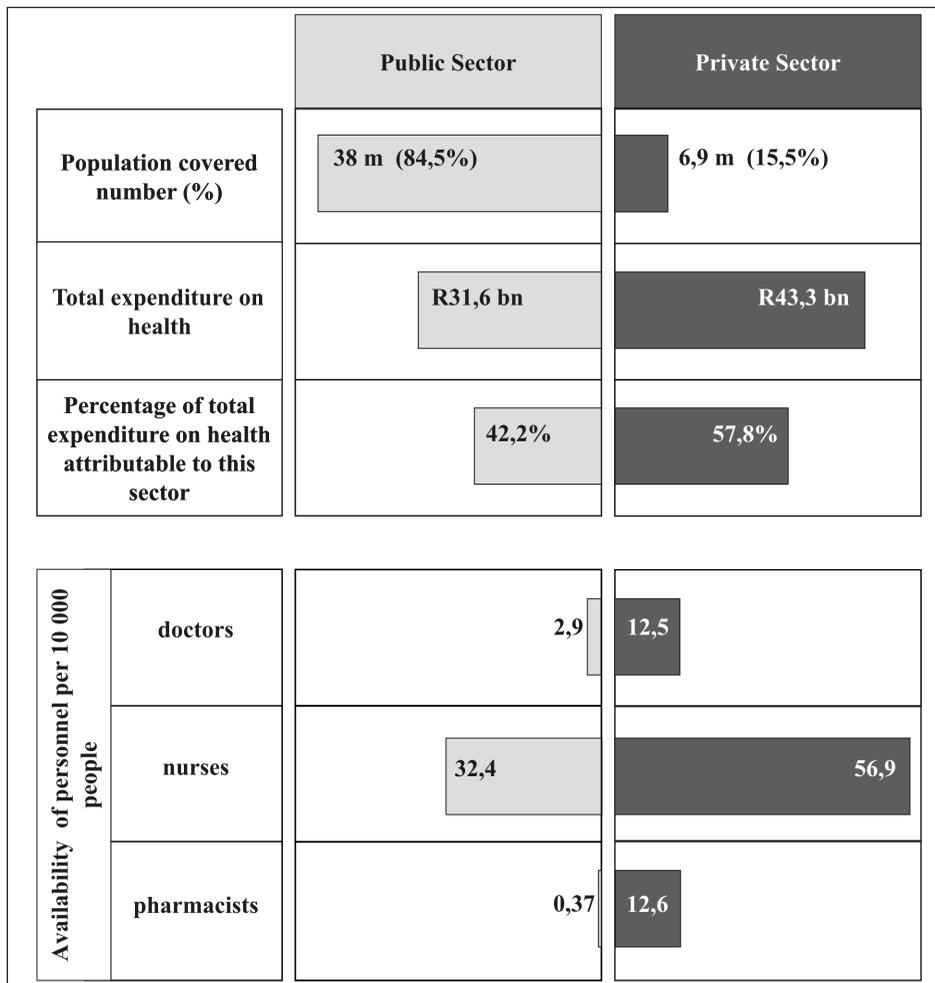
3. INTRODUCTION TO HEALTHCARE IN SOUTH AFRICA

3.1 INEQUALITIES BETWEEN PUBLIC AND PRIVATE SECTOR

3.1.1 Public and private healthcare in South Africa had evolved separately in the apartheid era. The Department of Health (unpublished) summarises this history as follows:

“Until 1994 the health system was splitting markedly into a public sector focused exclusively on the indigent or those without medical scheme cover and private sector focused on the young and healthy employed population.”

3.1.2 Figure 1 illustrates the inequalities that persisted in health expenditure and resources between the public and private sectors in South Africa in 2003, despite attempts since 1994 to ensure ‘healthcare for all’, as the Department of Health slogan exhorts.

Figure 1. South African healthcare inequalities 2003¹

3.2 TOWARDS A NATIONAL HEALTHCARE SYSTEM

3.2.1 Since the advent of a democratic government in 1994, there have been strong moves to reintegrate the two parts into a single healthcare system from a planning perspective, affecting both the financing and delivery of healthcare.

3.2.2 The extent of the work to reintegrate the public and private sectors into an efficient single system is immense. In a review of the performance of health systems, the World Health Organisation (unpublished), ranked South Africa at number 175 out of 191

1 Source: ABSA Healthcare.

member countries. The eight measures used included fairness of contribution, responsiveness and health level achieved and the overall measure relates health-system achievement to health-system expenditure.

3.2.3 The preamble to the long-awaited National Health Act of 2003² gives the rationale and constitutional requirements for a unified national healthcare system:

“Recognising: the socio-economic injustices, imbalances and inequities of health services of the past; the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights; the need to improve the quality of life of all citizens and to free the potential of each person;

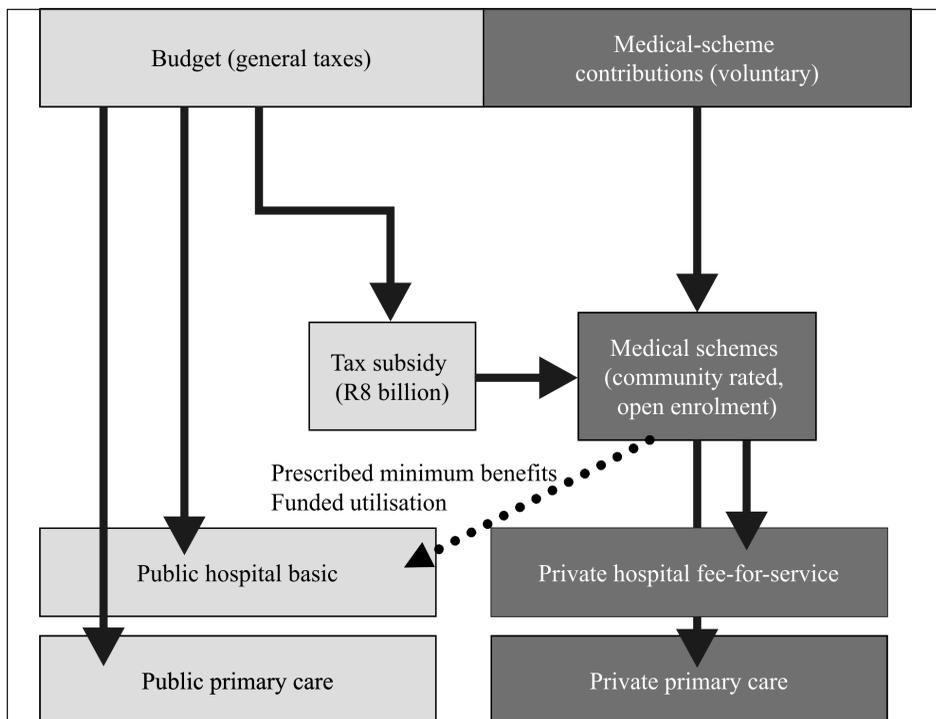
“Bearing in mind that: the State must, in compliance with section 7(2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa; in terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care; section 27(3) of the Constitution provides that no one may be refused emergency medical treatment; in terms of section 28(1)(c) of the Constitution every child has the right to basic health care services; in terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being;

“And in order to: unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa; provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards in which each province, municipality and health district must address questions of health policy and delivery of quality health care services; establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans.”

3.2.4 There are now increasing linkages between the public and private sectors on the delivery of healthcare, and the use of public–private partnerships in health is being encouraged. The delivery of healthcare is becoming increasingly blurred across the two sectors as public providers contract with the private sector for elements of their delivery and some medical schemes contract with public providers for the delivery of hospital care and chronic medicine to their members.

3.2.5 The funding of healthcare has, however, still been separate, funding for public sector beneficiaries coming from the national budget and private-sector medical schemes being funded by voluntary contributions from members and their employers. It was not widely understood that there were also hidden subsidies from government to the private sector in the form of tax concessions for medical-scheme membership.

2 Act no. 61 of 2003.

Figure 2. South African healthcare system in 2000³

3.2.6 Figure 2 outlines the relationship between the two sectors in 2000, after the first reforms. The tax expenditure subsidy to the private sector is now the subject of reform under SHI proposals, which are discussed in Section 7. Initial estimates of this subsidy were of the order of R4 billion to R6 billion, but comprehensive estimates prepared in 2004 show the amount to be R8,2 billion at 2001 prices.

3.2.7 In the framework of a unified national health system, medical schemes would be described as providing substitutive health insurance. In other words, private cover substitutes for what the state may provide directly or through regulation, as for example in Germany, Belgium and the Netherlands. Where private insurance is a top-up to some form of social or national health insurance it is known as supplementary health insurance, examples being found in the United Kingdom and Australia.

3.2.8 As South Africa moves to the implementation of a unified national health system, so medical schemes find themselves changing from being a voluntary product to becoming a mandated part of the healthcare system. The role and history of medical schemes is explored more fully below as background to the reforms for a unified national health system which the paper returns to in more depth in section 5.

3.3 PRIVATE-SECTOR HEALTHCARE FUNDING

3.3.1 There are two classes of health products on offer in the South African market:

- Medical schemes reimburse their members for actual expenditure on health. (This class is also known as ‘indemnity business’.) They are run on a not-for-profit basis and are essentially mutual societies, governed under the Medical Schemes Act of 1998⁴.
- Health insurance policies are provided by short-term insurers and life offices. These products were controversial and many of the designs used in the 1990s have become illegal. The demarcation of health insurance was redefined in the Long- and Short-term Insurance Acts of 1998⁵, together with the Medical Schemes Act of 1998. These policies may not indemnify policyholders, must offer a sum assured defined in advance of any healthcare provision and may not reimburse providers.

3.3.2 In addition, many employees are provided with occupational health services at their work-sites. This is particularly true of heavy industry and the mining industry. The system of mine hospitals linked to primary care facilities is one of the few examples of an integrated delivery system in private-sector healthcare.

3.3.3 Many countries use the term ‘health insurance’ to denote indemnity business, but the term has a particular and limited meaning in South Africa. Health insurance in South Africa covers only the products delivered by the long- and short-term insurance industries. Permissible health insurance includes disability cover and forms of dread-disease cover.

3.3.4 Medical schemes are the dominant vehicles for providing coverage for healthcare in the private sector. The national health accounts for 1998 showed that direct expenditure on medical schemes amounted to 73,0% of total private health expenditure, but this increased to 89,1% when the estimate of out-of-pocket payments by members was included. Health insurance accounted for only 1,4% of total private health expenditure. Direct expenditure by companies accounted for 1,8% and payments to the fund for workers compensation accounted for a further 1,3% of total private health expenditure.

3.3.5 The Medical Schemes Act defines the ‘business of a medical scheme’ as: “the business of undertaking liability in return for a premium or contribution in order to make provision for obtaining any ‘relevant health service’; or in order to grant assistance in defraying expenditure on a health service; or to render a relevant health service, directly or by agreement with the medical scheme.”

3.3.6 A ‘relevant health service’ is defined further as:

“any examination, diagnosis, treatment, prevention or advice; prescription or supply of medicine, appliance or apparatus; ambulance service, accommodation in hospital, maternity or nursing home; for a physical or mental defect, illness, deficiency; or pregnancy.”

4 Act no. 131 of 1998.

5 Acts nos. 52 and 53 of 1998 respectively.

3.3.7 The implication of the definition is that any arrangement which is intended to assist members in defraying the costs of medical services must satisfy the requirements of the Act. These requirements include, amongst others, being registered as a medical scheme under the jurisdiction of the Registrar of Medical Schemes. Schemes must put up financial guarantees, maintain prescribed solvency levels and have at least 6 000 members.

3.3.8 The most recent report of the Registrar of Medical Schemes⁶ gives the size of the medical scheme business in South Africa as R48,6 billion. The total size of legitimate health insurance in 1999 was estimated to be R0,5 billion and this is unlikely to have increased.

4. SOLIDARITY TO MUTUALITY TO SOLIDARITY

A history of medical schemes in South Africa was set out in a discussion document by the Department of Health (unpublished) in May 2002 as part of a review of healthcare for the Taylor Committee process. The summary below is drawn largely from that document.

4.1 EARLY HISTORY AND THE FIRST MEDICAL SCHEMES ACT

4.1.1 The first 'medical scheme' in South Africa was the De Beers Consolidated Mines Ltd. Benefit Society, established in 1889. By 1910 seven such schemes were in existence and by 1940 there were 48 medical schemes. The Friendly Societies Act⁷ was the first legislation used to govern these arrangements. The controls applied by this Act were primarily financial in nature.

4.1.2 By 1960 there were 169 schemes providing cover for 368 890 members and 588 997 dependants. The Department of Health (op. cit.) states:

"These schemes served the needs of the white middle class, especially those in urban areas. The importance of this type of scheme can be seen in the rapid growth in coverage that this form of scheme provided for the predominantly middle class white population. For whites, over a period of 15 years from 1945 to 1960, coverage grew from 48 percent to 80 percent of the eligible population."

4.1.3 The Snyman Commission, which incorporated the recommendations of the Reinach Committee, reported in 1962. These recommendations, and subsequent debate, resulted in the Medical Schemes Act of 1967⁸. This act ensured that medical schemes were run on the basis of solidarity principles: it contained defined minimum benefits and required community-rating.

6 Council for Medical Schemes. Report of the Registrar of Medical Schemes 2003/2004. Available on <http://www.medicalschemes.com>.

7 Act no. 25 of 1956.

8 Act no. 72 of 1967.

4.2 THE ARGUMENTS FOR FREE-MARKET REFORMS

4.2.1 The Department of Health (*op. cit.*) states that by 1980 it began to be recognised that there were too many medical schemes, with a consequent inadequate spread of risk. Rather than dealing with the issue of too many too small risk pools, pressure began to build to allow even more flexibility and less regulation:

“The prevention of a ‘socialised health system’ became a recurrent theme in many parliamentary debates over amendments to the Act toward the end of the 1970s and for most of the 1980s.”

4.2.2 The Browne Commission, which reported in 1986, “developed a free-market theme where it saw the public interest served through the gradual privatisation of the public health service.” The White Paper on the Commission largely accepted the recommendations and resulted in the Medical Schemes Amendment Act of 1988.

4.2.3 It stated that:

“The government rejected proposals that compulsory minimum benefits be removed on the grounds that ‘otherwise those members who do not have minimum cover would simply turn to the State for assistance.’”

4.2.4 The Department of Health (*op. cit.*) quotes the Browne Commission on the arguments for risk-rating and experience-rating within medical schemes:

“Greater flexibility in contribution rate determination should be allowed, enabling schemes to charge different contribution rates for different classes of risk. Provision could also be made for allowing different levels of benefit to be chosen by groups or individuals to satisfy their needs. This will encourage merging of small schemes with larger ones, resulting in increased administrative efficiency. In some cases significant cost savings could be achieved if the member paid small claims himself [*sic*] and was only allowed to claim from the scheme after a specific amount had been paid by himself.”

4.2.5 Although the White Paper did not accept these recommendations, they were “nevertheless introduced in 1989 amendments to regulation” (Department of Health, *op. cit.*).

4.3 THE FLIRTATION WITH MUTUALITY

4.3.1 The legislative amendments of 1989 set the stage for an application of mutuality principles for the next 11 years:

“According to the modified regulation, a member’s contributions could be based on: number of dependants; income level; age; geographic area; actual claims experience; extent of cover provided; period of membership; and size of group to which member belongs.” (Department of Health, *op. cit.*)

4.3.2 The Medical Schemes Amendment Act⁹ “introduced further far-reaching

9 Act no. 23 of 1993.

changes in legislation. Statutory guaranteed minimum benefits and guaranteed payment for claims were removed from the Act. Schemes would be able to exclude or limit cover for procedures, and risk-rate to a greater extent.” This was balanced by an increasing ability for schemes to supply healthcare direct by owning clinics and hospitals and employing healthcare professionals. This aspect of the legislation was used by very few schemes.

4.3.3 The Department of Health (op. cit.) also notes the introduction in this period of further insurance principles:

“An amendment was also introduced allowing schemes to ‘provide additional cover for members by way of insurance, reinsurance or in any other manner whatsoever or, subject to the provisions of any law relating to insurance, underwrite or provide for such cover’.”

4.3.4 An analysis by the Department of Health (op. cit.) states that:

“the history of the medical schemes movement and its regulation shows a drift from solidarity principles which defined the original schemes, to individualising health cover.”

4.3.5 The report goes on to say that during the early 1990s:

“benefits declined and the older and sicker membership were excluded from cover to a greater extent. By 1999 no open scheme was permitting anyone over the age of 55 to join as an individual member. Virtually all open schemes applied life-time exclusions for pre-existing conditions, and age-rated and/or experience rated their membership without restriction. As such, by 1999 the majority of medical scheme membership was in an environment which excluded vulnerable groups from cover (e.g. the old and those with chronic conditions), where medical costs continued to rise (due to the retention of fee-for-service reimbursement) and where non-medical costs were driven up (through profit taking and hidden commission costs).”

4.4 THE RETURN TO SOLIDARITY

4.4.1 The Melamet Commission reported in the last month of the apartheid government, arguing for increased ‘freedom with disclosure’ on a number of issues. Further deregulation was recommended on the basis that insurance products represented the best way of providing health cover.

4.4.2 This was rejected by the newly elected democratic government and was replaced by a strategic direction that emerged from the 1995 National Health Insurance Committee of Inquiry. Although this report focused on a system of national health insurance, medical-scheme reform featured prominently.

4.4.3 The 1995 report found that:

“Policy directions that were supported by the analysis adhered to the following four objectives:

(a) The regulatory structure should reinforce the agency function of the third-party payer. This was seen as a fundamental requirement for empowering the consumer of health insurance and healthcare.

(b) In order to limit confusion in the market, the regulatory structure should reinforce

uniformity in the benefit structure of medical schemes. This would enable people to make effective decisions in their own favour.

(c) Schemes should operate on the basis of solidarity, i.e. that groups do not get treated differently within a scheme. This remains a structurally rational manner in which to provide coverage.

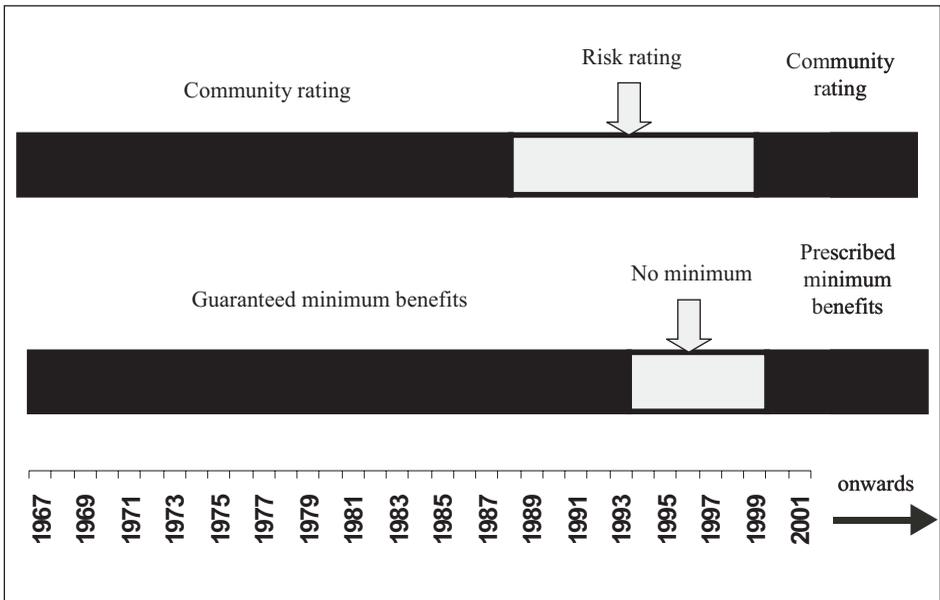
(d) The overall system should create a rational system of risk-sharing between as large a group as possible and, in the longer-term, ensure the availability of a minimum level of cover for all within the public and private sectors.”

4.4.4 Although the word ‘solidarity’ was used in the 1995 report, many of those involved in the industry, the author included, did not appreciate at the time what the implications were.

4.4.5 The recommendations flowing from the analysis of industry issues were largely incorporated in the Medical Schemes Act of 1998. This act came into effect in February 1999 and key regulations under it came into effect on 1 January 2000. It reintroduced prescribed minimum benefits as a policy instrument for defining minimum levels of medical-scheme cover. Community-rating was also reintroduced, ending an 11-year flirtation with mutuality, which had produced adverse results in terms of healthcare equity and access.

4.4.6 Figure 3 indicates by means of arrows the periods of mutuality over the history of medical-scheme regulation in South Africa.

Figure 3. History of legislation relating to medical schemes



4.4.7 The return to solidarity principles in 2000 was not accompanied immediately by compulsory membership. Wilkie's definition has compulsion as a key element and it was the lack of compulsion that was of great concern to actuaries in South Africa. There have been several calls by the profession and major employers to speed up compulsory membership in order to stabilise risk pools. The principles of solidarity, including compulsion, will be further entrenched with the implementation of SHI as described in section 7.

4.5 ATTEMPTS TO MAINTAIN MUTUALITY

4.5.1 Van den Heever & McLeod (unpublished) documented attempts by the insurance industry in South Africa to maintain principles of mutuality when the new Medical Schemes Act took effect.

4.5.2 They found that:

"the aggressive commercial schemes managed by insurance companies that had profited from 'cherry-picking' in the previous environment, were vociferous in their efforts to delay the implementation of the Medical Schemes Act."

4.5.3 In this the industry was supported by the actuarial profession:

"Once it became apparent that the Act and Regulations would come into force on 1 January 2000, they attempted to recreate the previous environment in a different form. These companies took advantage of the parallel insurance environment and the gaps in enforcement, both at the Financial Services Board (FSB) and [at] the Office of the Registrar of Medical Schemes."

4.5.4 "New Long-term and Short-term Insurance Acts were promulgated in 1998, within a month of the new Medical Schemes Act" of 1998 (*ibid.*). "The definition of a medical scheme in the Medical Schemes Act is a positive one. The insurance acts define health insurance in a negative way that excludes 'the business of a medical scheme'." (*ibid.*) There were thus no gaps in the legal definition of the products.

4.5.5 "All insurers were required to re-register under the new insurance acts, but this process had been delayed. As at December 1999, only 4 insurers had been re-registered with a further 147 waiting processing and being allowed to continue temporarily under their old licensing conditions ... The delay in re-registration of insurers exacerbated the problem and provided a gap in the regulatory environment that insurers were quick to exploit." (*ibid.*) The emergence of hybrid products occurred in October 1999, at a time when the new Office of the Registrar of Medical Schemes was not yet fully staffed.

4.5.6 "Three months prior to implementation of the Act, hybrid products were marketed which combined a small community-rated medical scheme with an age-rated insurance product created under the parallel insurance environment... The new hybrid structures were marketed without obtaining approval from either the Registrar of Medical Schemes or the FSB." (*ibid.*)

4.5.7 “A further development of the hybrid structure utilized insurance products to pay for the difference in premium of the benefit packages on offer. By over-pricing the richer medical scheme packages, the company could force potential members to apply for insurance cover that would provide the access to the richer packages as needed, triggered by the need for health services. This had the effect of ensuring age-rated and underwritten access to the medical scheme.” (ibid.)

4.5.8 “Schemes created gaps in their benefit structure that were filled by complementary insurance products. For example, a high deductible for cancer treatment was set in the medical scheme that was completely covered if the insurance product was bought simultaneously from the same group.” (ibid.)

4.5.9 A number of abuses were recorded that were encouraged by brokers or relied on their behaviour:

“[Some] schemes restricted the payment of commission to reward brokers only for new members under the age of 55 years. The powers of the Minister of Health in the Act were used to declare this an undesirable business practice and it was thus immediately made unlawful.” (ibid.)

4.5.10 The resolution of these problems was achieved by establishing ongoing communication between the Council for Medical Schemes and the Financial Services Board through a joint liaison committee to deal with matters of common interest. “Guidelines were developed for allowable health insurance products and published in September 2000. However sections of the actuarial fraternity and the insurance industry have continued to dispute this demarcation between health insurance and the business of a medical scheme.” (ibid.) This unwillingness to accept the return to solidarity was still found in isolated pockets in 2004, but gradually the Life Offices Association and key insurers recognised that the environment had changed.

5. FUTURE VISION FOR HEALTHCARE FINANCING IN SOUTH AFRICA

5.1 THE FOUR PHASES OF REFORM

5.1.1 The Department of Health is in the process of implementing a system of SHI for South Africa. The previous Director General of Health, Dr A Ntsaluba, described these reforms in July 2003 as “a very significant change in the structure of healthcare financing in this country”.

5.1.2 The future vision for the South African healthcare system was outlined in the Report of the Taylor Committee, released in May 2002¹⁰. A more detailed discussion document on healthcare was also released by the Department of Health (unpublished).

10 Transforming the Present – Protecting the Future, Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa, March 2002. Available on <http://www.welfare.gov.za>.

These reports recommended that South Africa move ultimately towards a national health insurance system that integrates the public sector and private medical schemes in a universal contributory system.

5.1.3 Under SHI, only those that contribute receive benefits. Under national health insurance the taxpayers contribute but all citizens are entitled to the same defined package of benefits. The four phases of reform of private-sector healthcare have an initial goal of an SHI system.

5.1.4 Phase 1 is the development of the enabling environment. The system of subsidies for healthcare is seen to be fragmented and not structured in accordance with strategic policy goals. Strict partitioning between public and private sectors has resulted in substantial and unsustainable private-sector cost escalations. As medical schemes become less affordable, so more people need to make use of the public sector. The escalations in private-sector healthcare also lead to the tax subsidy for healthcare escalating at a much higher rate than budgets for public-sector care.

5.1.5 Phase 1 focuses on an enabling environment for the later policy reforms. This phase has been completed and the impact on medical schemes is discussed in more detail in section 6. The public-sector goals for this phase include a focused improvement of public health facilities and their management.

5.1.6 Phase 2 is the implementation of preparatory reforms in order to improve the quality and cost-effectiveness of cover in the environment of voluntary contributory arrangements (i.e. medical schemes). The greater the degree of cover and acceptability of this environment, the less the disruption in establishing the environment of mandatory arrangements in the next phase. Phase 2 is currently in progress and sees the finalisation of the design of SHI, which is described in detail in section 7.

5.1.7 Phase 3 is the implementation of the initial mandates. By this stage it is envisaged that civil servants will already be in mandatory schemes (the new public-sector medical scheme is an important vehicle for this first mandate). Once the public sector as an employer has accepted the mandate for compulsory cover, implementation of the first statutory mandates can begin in other groups. Given the skewed income distribution in South Africa, the mandates were recommended to begin with higher-income groups. It was envisaged that, 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 an SHI System.

5.1.8 Phase 4 is the implementation of a national health insurance (NHI) system. Although preliminary structures have been outlined by the Taylor Committee process, there is still the question whether NHI would be affordable. Once the country has reached an 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.

5.2 THE SOCIAL-SECURITY CONTEXT FOR HEALTHCARE

5.2.1 In social-security systems the entitlements to benefits and the degree of risk-pooling are described in terms of pillars:

- Pillar 1 is a universally available basic benefit for all citizens and specified classes of legal resident. It is available without contributions as a fixed financial allocation, or an entitlement to a free service, or both. Funding is typically from general taxes.
- Pillar 2 is a contributory arrangement above pillar 1 or as a substitute for pillar 1. It is characterised by strong mechanisms to ensure social solidarity: income-based cross-subsidies; risk-related cross-subsidies; and mandatory participation.
- Pillar 3 is discretionary social security over and above minimum levels regarded as essential. Individuals are left to make decisions completely at their discretion. Government is, however, still required to ensure that basic consumer protection is in place.

5.2.2 SHI in South Africa is considered to be a pillar-2 intervention. However, in creating the second pillar it is also important to ensure that the first pillar fits neatly into the overall framework. The reform of the South African health system thus requires that all three pillars need to be addressed.

5.2.3 Pillar 1 of the health system needs to be reorganised. The means test will need to be adjusted so that the income test only applies to people with no possibility of obtaining medical-scheme cover. Those whose income is higher than the means test have the opportunity to be part of a risk-pool within medical schemes. The Taylor Committee argued that the means test at the point of service should be removed, as it is inefficient. The tax subsidy for medical-scheme membership needs to be revised to result in a progressive financial transfer linked to medical-scheme membership. This is discussed more fully in section 7.3.

5.2.4 The second pillar of the health system, SHI, needs to be fully implemented. This will require a mandatory comprehensive minimum benefit package and a mandatory income-based contributory environment that will substitute for a portion of the existing community-rated contribution. A full system of inter-scheme risk equalisation is needed to deal with demographic and health-risk variations between medical schemes. Once these reforms are in place, a system of mandatory cover must be introduced to limit adverse selection against the medical-schemes environment.

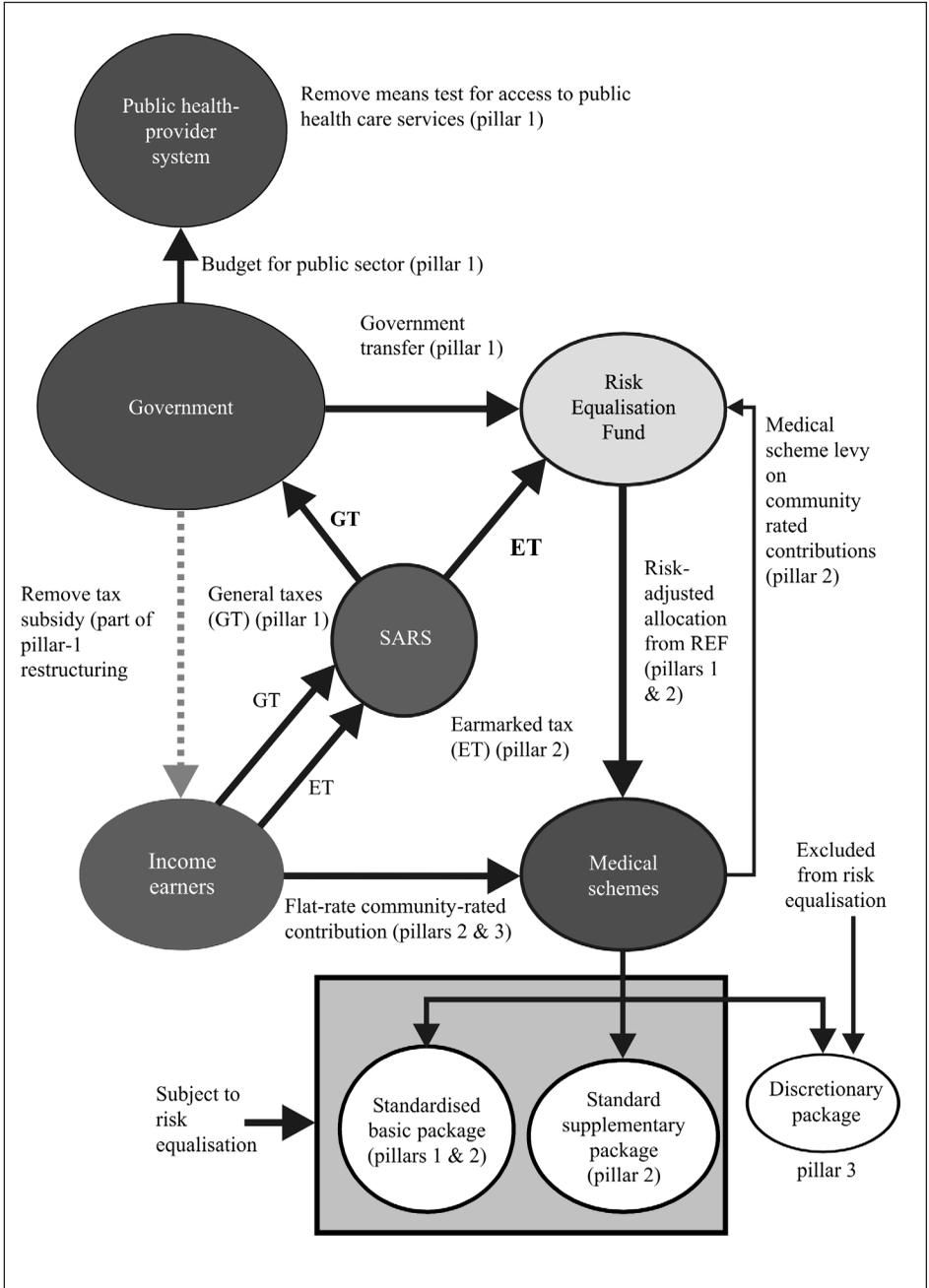
5.2.5 The first and second pillars seen together embody the principles and required outcomes of a unified national health system, as shown in Figure 4.

5.2.6 The dividing line between the second and third pillars needs to be clearly defined. Some stakeholders have begun to argue that everything above a minimum basic package should become pillar-3 benefits and thus should be capable of being offered by insurance companies. Given the history of problems with mutuality for healthcare in South Africa, this wish seems remote.

5.2.7 Some have argued that the International Review Panel (Armstrong et al., 2004) had created a space for a return to risk-rating for benefits above a basic benefit package (BBP) with the so-called standardised benefit package (SBP). However, the Panel argued that:

“Standardization will reduce product competition based on the design of numerous benefits packages (which hardly benefits the consumer) and increase price competition among the medical schemes. Standardization of the SBP should discourage medical schemes from selling benefits packages that are specially designed for risk selection.

Figure 4. A unified national health system for South Africa



“Selling the SBP under open enrolment and community rating without risk adjustment through the [Risk Equalization Fund] may give the medical schemes very strong incentives for selection (as currently is the case for the entire range of products). In order to reduce this risk selection, the open enrolment into the standardized supplementary benefits packages should be combined with contribution rate bands.

“The Panel considers that the standardized SBP should not be included in the REF, at least not at present; and medical schemes offering these packages would not be entitled to any payment from the REF for this segment of their business. Alternatively, if it is established that SBP increase risk selection significantly, one might consider applying some form of risk equalization to (some of) these packages.”

5.2.8 It seems likely that the extent of the cover already offered by medical schemes will be allowed as standardised supplementary packages in a voluntary contributory environment with many of the consumer protections afforded to other pillar-2 benefits. Some discretionary cover, for example for cosmetic surgery or expensive-technology surgical interventions where other more cost-effective solutions exist, might become part of pillar-3 offerings. It seems unlikely that the scope of pillar-3 health-insurance products will be extended beyond those currently allowed in legislation.

6. PHASE 1 REFORMS FOR MEDICAL SCHEMES

This section shows how three of the reforms introduced by the revised Medical Schemes Act¹¹ prepared the ground for SHI. The Act came into force in February 1999, most provisions of the regulations applying from 1 January 2000. These reforms formed part of phase 1 of the overall health-system reforms.

6.1 A MINIMUM PACKAGE OF BENEFITS

6.1.1 The Medical Schemes Act of 1998 reintroduced a minimum package of benefits to be provided by all schemes. Annexure A to the regulations defined the prescribed minimum benefits (PMBs) in terms of some 270 diagnosis–treatment pairs. (For example, in the chapter on Heart and Vasculature, PMB code 26E reads: ‘Diagnosis: arterial embolism/thrombosis: abdominal aorta, thoracic aorta. Treatment: medical and surgical management’.) These PMBs have to be provided in at least one network setting, and diagnosis and treatment must be covered in full from pooled funds, without financial limits or co-payments.

6.1.2 The objective of specifying a set of minimum benefits is given in the 1999 Regulations as:

“to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals; and to encourage improved efficiency in the allocation of private and public healthcare resources.”

11 Act no. 131 of 1998.

6.1.3 The regulations of November 2002 provided substantial clarification of the PMB requirements and defined emergency procedures and the need for designated service providers. Medical schemes may make use of managed-care techniques such as pre-authorisation, the development of formularies and the use of restricted networks of providers in order to ration care. Co-payments may be levied if a member chooses to use a provider who is not the contracted designated service provider (DSP).

6.1.4 The PMBs were substantially extended from 1 January 2004 with the introduction in the regulations of a 'chronic disease list' (CDL). This defines 25 chronic conditions considered to be life-threatening, which are explicitly regulated in order to prevent late sequelae and complications. The cost of diagnosis, treatment and medication for these conditions must be covered in full by medical schemes, subject to published treatment algorithms. The treatment algorithms were developed by practitioners and are specified in regulations.

6.1.5 In order to facilitate understanding, it has been proposed that the following terminology be more commonly used. The PMBs thus consist of:

- a list of some 270 diagnosis–treatment pairs (PMB-DTP), which was introduced from 1 January 2000;
- emergency medical conditions (PMB-EMC), usually included in PMB-DTP, which were clarified and in force from 1 January 2003; and
- diagnosis, treatment and medication according to therapeutic algorithms for 25 defined chronic conditions (PMB-CDL), which were introduced from 1 January 2004.

Discussions with stakeholders have begun, as part of a focus on the needs of low income groups, on the question of the inclusion of a primary-care package in the PMBs (PMB-PHC).

6.1.6 The Council for Medical Schemes embarked on a project to define the diagnosis–treatment pairs more clearly, as there were initially no diagnosis codes (ICD-10) or procedure codes (CPT-4) in the regulations and thus medical schemes had to individually interpret the PMBs. A document was released on 30 December 2004 containing ICD-10 codes for all 14 chapters of the PMB-DTPs. The CDL algorithms have used ICD-10 coding to define the 25 covered chronic conditions since their first promulgation. Stakeholders have agreed that compulsory ICD-10 coding by healthcare providers will be implemented in the private sector during 2005.

6.1.7 The Taylor Committee recommended there be a policy process for defining and implementing basic essential healthcare services that would be available in both the public and private sectors. The report argues that both sectors need to provide a minimum core set of services: in medical schemes these are regulated as PMBs, whereas in the public sector these are framed as minimum norms and standards.

6.1.8 Benefits in respect of HIV/AIDS are a good example of the link between public norms and standards and private PMBs. Initially the PMB for HIV/AIDS covered only opportunistic infections. It was extended to cover mother-to-child transmission and rape prophylaxis once these benefits were made available in the public sector. Now that the public sector is committed to the roll-out of anti-retroviral treatment, medical schemes will include antiretroviral treatment in PMBs from January 2005. The lack of a primary healthcare package is the most glaring omission in the current private-sector PMBs.

6.1.9 Despite the PMB-DTPs being in place for over five years, few schemes or administrators track expenditure on this component, and furthermore, many healthcare practitioners are not fully aware of the rights of their patients under PMB legislation. The compulsory use of ICD-10 coding from 2005 and the increased focus on the PMB package under risk equalisation (see section 7.2) should see expenditure on PMBs being tracked more carefully in future.

6.2 OPEN ENROLMENT AND COMMUNITY RATING

6.2.1 In South Africa there are three kinds of medical schemes:

- Restricted-membership schemes are allowed to restrict who may become a member. Definitions include: employment in a particular profession, trade or industry; employment by a particular employer or class of employers; or membership of a professional association or union.
- Bargaining-council schemes were initially set up under the Labour Relations Act, 1995¹² and typically offer very limited benefits, often only primary healthcare delivered by salaried or panel doctors. They are not able to comply fully with the Medical Schemes Act and are typically granted exemptions from providing the PMBs.
- All other schemes are classified as open schemes (previously also called ‘commercial schemes’).

6.2.2 Table 1 illustrates that the open schemes are generally much larger in size. There is little uniformity in size, however, and the industry is dominated by a few very large schemes. The largest open scheme has over 1,5 million beneficiaries.

Table 1. Distribution of types of medical schemes at 31 December 2003

	Number of medical schemes	Proportion by number of medical schemes	Proportion by number of beneficiaries
Open schemes	49	32,9%	68,1%
Restricted-membership schemes	88	59,1%	28,2%
Bargaining-council schemes	12	8,0%	3,7%
All medical schemes	149	100,0%	100,0%

6.2.3 All open schemes have to accept anyone who wants to become a member, at standard rates. This is known as ‘open enrolment’.

6.2.4 Since January 2000, schemes have not been allowed to underwrite or to charge an individual according to the risk of the individual or group. Everyone must be charged the same standard rate, regardless of age or state of health. This is known as ‘community rating’, and it applies to all medical schemes. Community rating is applicable

12 Act no. 66 of 1995.

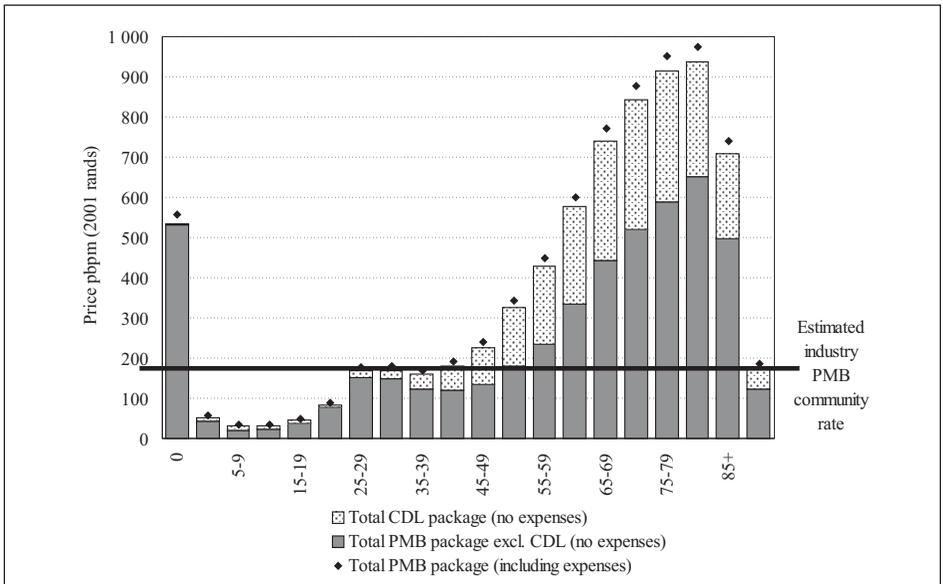
to the price of each option (separate benefit package) within a medical scheme. Legislation permits differentiation in contributions on the basis of income, family size and adult or child dependants.

6.2.5 Schemes may impose waiting periods of up to 12 months, as defined by regulation, in order to reduce anti-selection by those who do not join medical schemes until they need care. The nature and extent of underwriting is circumscribed by legislation, but members can still switch to a more comprehensive option as they need care and the waiting periods do not apply in all circumstances to the PMB package.

6.2.6 After an initial amnesty period that was extended and expired on 31 March 2001, schemes may impose age-related late-joiner penalties. People who had no medical cover were encouraged to join during the amnesty period. Once a late-joiner penalty is imposed, the consumer carries that penalty for the rest of life. These penalties (similar to those implemented in Australia) encourage people to join schemes while they are young and to remain in the system. They have the negative effect of penalising those who could not afford medical schemes in the past and their use will need to be reviewed as SHI is implemented.

6.2.7 Figure 5, from a study of PMB prices in 2001 and adapted by McLeod et al. (unpublished), illustrates the importance of age in the price of healthcare to a medical scheme, using the PMB package to illustrate the phenomenon. The price is shown per beneficiary per month (pbpm) in 2001 rands. The 'all ages' price in the figure is the estimate of the industry community rate for the PMB package. These are private-sector, fee-for-service prices for the PMB package.

Figure 5. Price by age for the complete PMB package (2001 rands)



6.2.8 In the graph it is clear that children under the age of 1 year and all beneficiaries over age 40 are more expensive to a medical scheme than the industry community rate. Open schemes thus have a strong incentive to attract a younger age profile and thereby reduce their community rate to the market. Given the highly competitive market in South Africa and the actions of brokers in switching members aggressively each year, the medical schemes that can attract a younger and healthier profile have a substantial competitive advantage. This practice is known as ‘cream-skimming’ or ‘cherry-picking’.

6.2.9 Policy-makers believe that community rating should apply not only to the options within schemes but to the industry as a whole. Members should be facing a common community-rated price for the PMB package and not a price determined by each scheme according to its own age and health profile. This is the major rationale for the introduction of the Risk Equalisation Fund, discussed in section 7.2.

7. SOCIAL HEALTH INSURANCE

In January 2004 the Minister of Health stated there were three issues on the unfinished reform agenda toward implementing SHI: risk-related cross-subsidies; income-related cross-subsidies; and mandatory cover.

7.1 RISK-RELATED CROSS-SUBSIDIES

7.1.1 During the 1990s it was demonstrated by N. Söderlund that there had been extensive cherry-picking by commercial medical schemes. By the Alexander Forbes Survey of 1998, of five large medical schemes with pensioner ratios of less than 1,5%, four were associated with life offices. Some restricted schemes were left with pensioner ratios exceeding 30%. The very low pensioner ratios began to increase in the Alexander Forbes Survey of 1999 as schemes prepared for the introduction of open enrolment.

7.1.2 Despite the reforms of open enrolment, community rating and PMBs, which came into effect from 1 January 2000, 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. This is neither fair nor equitable.

7.1.3 Figure 6 below illustrates the extent to which the age profiles in medical schemes can differ. The figure shows the age profiles for the four largest open schemes in 2002.

7.1.4 The price of PMBs in 2001 (excluding expenses) was used together with the age profiles in order to determine the effect of the age profile on the price of PMBs in each scheme. This is contrasted with the scheme’s total community rate per beneficiary, as determined from the contributions reported to the Registrar of Medical Schemes. The results are shown in the Figure 7.

Figure 6. Age profiles of the largest open schemes¹³

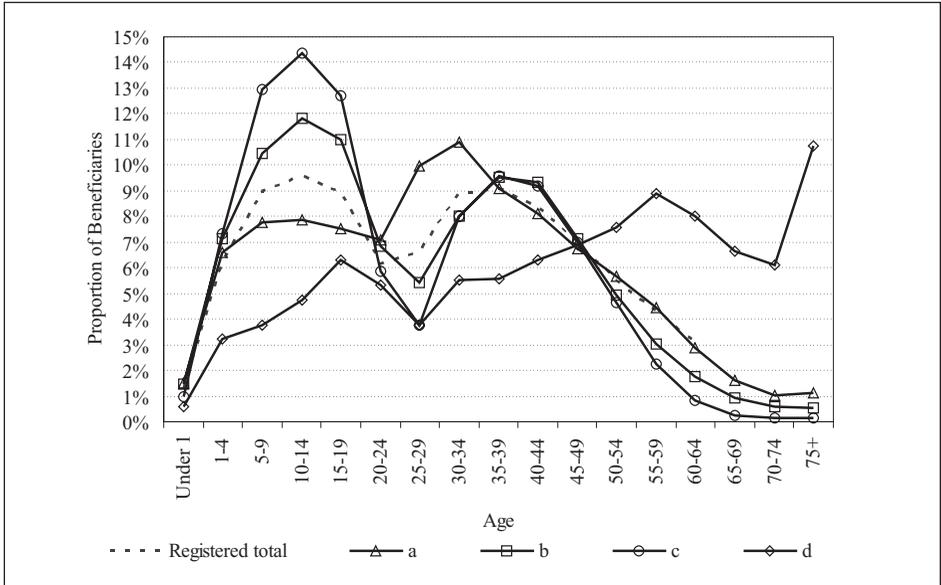
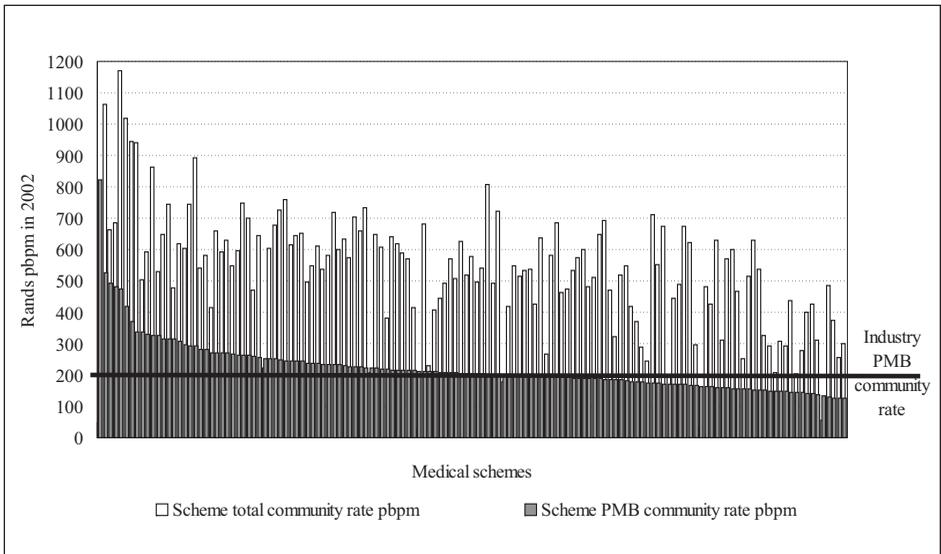


Figure 7. Estimated community rates for each registered scheme



13 Source: 2002 data from the Registrar of Medical Schemes.

7.1.5 It was determined that the industry community rate for PMBs was R199–69 pbpm. In the graph above, the highest community rate for PMBs was R821–50 pbpm in a very small restricted scheme, with the most expensive open scheme at R482–94 in the fourth highest position. The lowest community rate for PMBs in an open scheme was calculated to be R124–65 pbpm.

7.1.6 Thus PMBs in one open scheme were 38% cheaper than the industry community rate, while in another they were 142% more expensive than the industry rate, based on the difference in age profile alone. The cost difference between the two schemes is some 180% of the industry community rate, based only on the difference in age profile. There are 66 medical schemes in which people pay less than the industry PMB community rate and 76 in which people pay more than that rate.

7.1.7 Risk equalisation is a mechanism to ensure that everyone pays the same industry community rate for the common package of benefits, not the rate determined by the age and health profile of the medical scheme they have chosen to join.

7.1.8 In Ireland, legislation in 1994 provided for the Irish Minister of Health to choose to implement risk equalisation if the market became distorted by up to 2% of the claims costs. When the distortion exceeds 10% the Minister is required to implement risk equalisation. The market in South Africa shows a range of 180% for PMB costs based on age differences alone. The need for a risk-equalisation mechanism in South Africa is thus overwhelming.

7.1.9 South Africa is unusual in having open enrolment and community rating without risk equalisation. This was not a policy oversight, but a question of timing, and the South African Department of Health considers that the environment is now ready for the introduction of a Risk Equalisation Fund (REF).

7.1.10 A Formula Consultative Task Team was established in July 2003 and reported on the issue to government in January 2004. An International Review Panel (Armstrong et al., 2004) of experts from six countries supported the findings. The Department of Health formally adopted the REF as policy in September 2004 and the testing phase of the REF was approved by Cabinet in January 2005. The Department of Health has embarked on a shadow process for the REF (no money changing hands) during 2005 with the intention to fully implement from 1 January 2007.

7.1.11 The REF formula is published in the form of an REF contribution table, which indicates the amount to be received by the medical scheme for each person in each risk group. The risk factors agreed by the industry for use by the REF are:

- age last birthday on 1 January, summarised into the age bands under 1, 1 to 4, 5 to 9, 10 to 14, ... 75 to 79, 80 to 84, 85 and over;
- 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, allowance being made for 2, 3, and 4 or more simultaneous 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 or multiple foetus either stillborn or alive.

7.1.12 As a result of the REF, 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. Schemes that are successful at reducing the cost of delivery will retain that benefit for their members and will thus be able to lower their contributions for the basic package.

7.1.13 The International Review Panel made further recommendations to change the way in which medical schemes would compete in the future. They recommended that stakeholders design a BBP, which might include the existing PMBs together with primary health care. They recommended that medical schemes be allowed to offer only a limited standard set of benefit packages above the BBP. These SBPs 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. (There were some 450 options in the market in 2003.) Consumers will instead be able to compare common packages and make decisions based on price, network availability and quality.

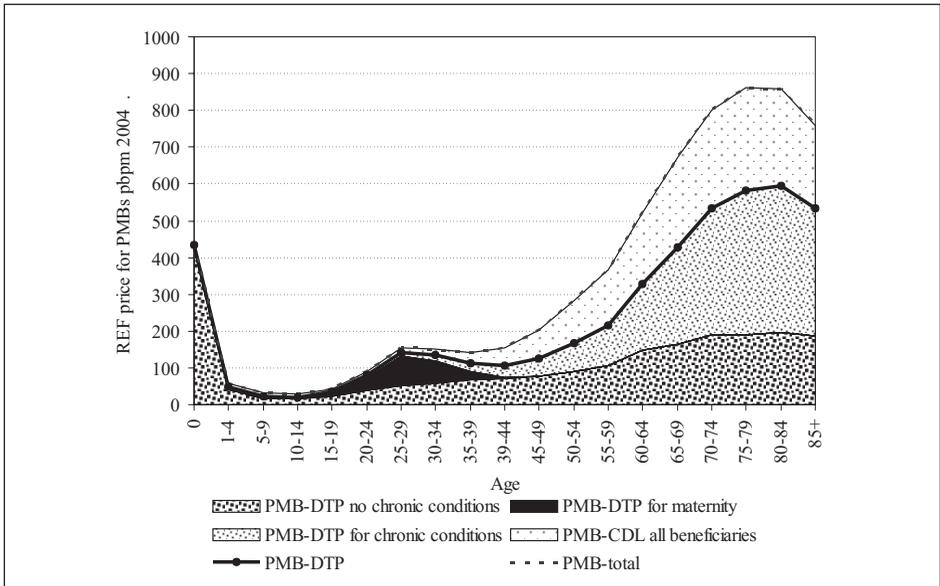
7.1.14 Discussions on the design of the BBP and SBP should begin with stakeholders in 2005. Consultants and administrators are less in favour of these reforms, as product differentiation has been their competitive edge. The role of brokers would also be less important in a standardised environment. The consultations are likely to be intense, and while it may be feasible to introduce the BBP relatively quickly, it seems unlikely that an SBP could be implemented before 2007 at the earliest.

7.1.15 In future, medical schemes should be more eager to contract with doctors and hospitals in order to ensure that their members obtain cost-effective delivery of the BBP. This is expected to increase the use of methods of reimbursement, such as per diem, per case and capitation, in order to ensure that provider incentives are aligned with funder incentives. Fee-for-service reimbursement is likely to become less common and eventually might be used only for highly specialised services.

7.1.16 Figure 8 illustrates the price of healthcare by age, using the information from the REF contribution table for 2004 and the prevalences of chronic diseases in medical schemes.

7.1.17 Note the shape and height of the PMB-DTP component for those without any of the 25 CDL conditions. The shape of the price for maternity benefits is also distinctive—the so-called ‘pregnancy bump’. Of particular interest to funders and healthcare practitioners should be the very high price by age for those with chronic conditions when the two components, PMB-DTP (chronic) and PMB-CDL are added together. At older ages the high price of healthcare delivery is largely due to those with chronic conditions (and often multiple chronic conditions). This argues for the use of programmes that target these high-cost patients rather than more general disease-specific management programmes.

Figure 8. Price of healthcare by age in medical schemes, using the REF contribution table for 2004



7.2 INCOME-RELATED CROSS-SUBSIDIES

7.2.1 A further important policy issue is the subsidy framework for medical schemes. Government currently provides a tax expenditure subsidy (TES) to private-sector healthcare in the form of a tax deduction on medical-scheme contributions by both employer and individual taxpayers.

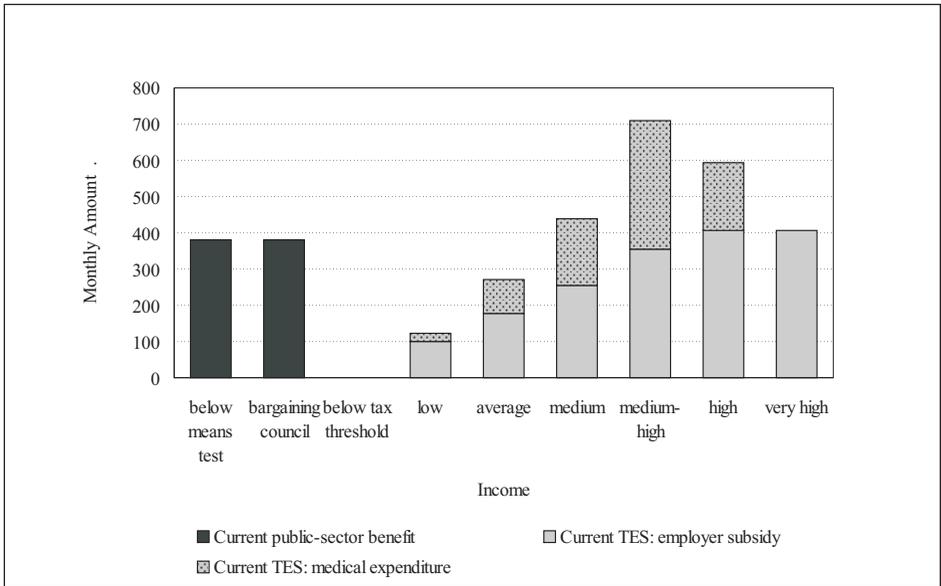
7.2.2 It is estimated that the TES is R8,2 billion when expressed in 2001 prices. The TES for medical scheme members is R7,5 billion and is made up of two components: the TES for medical scheme contributions by employees and out-of-pocket expenditure by employees of R2,9 billion; and the TES for employer contribution to medical schemes of R4,6 billion. The TES for income earners who obtain healthcare in the public sector but can deduct out-of-pocket expenditure is R0,7 billion. In 2005 rand terms, the TES now exceeds R10 billion.

7.2.3 Figure 9 shows an estimate of the TES at different levels of income for a family of four. Note the darker bars on the left, which represent the current subsidy to the same family structure for those who can only afford public sector healthcare.

7.2.4 For the highest income groups, the higher the income, the greater the tax deduction. In addition, the larger the contribution to a medical scheme, the greater the tax deduction. This reduces the sensitivity of higher income groups to medical-scheme price increases and thus does not act as a brake on increases in excess of general inflation.

7.2.5 The TES of R10 billion for the nearly 7 million medical-scheme beneficiaries is more than the government spends per head on people in the public sector.

Figure 9. Current subsidy of private-sector healthcare through the tax structure



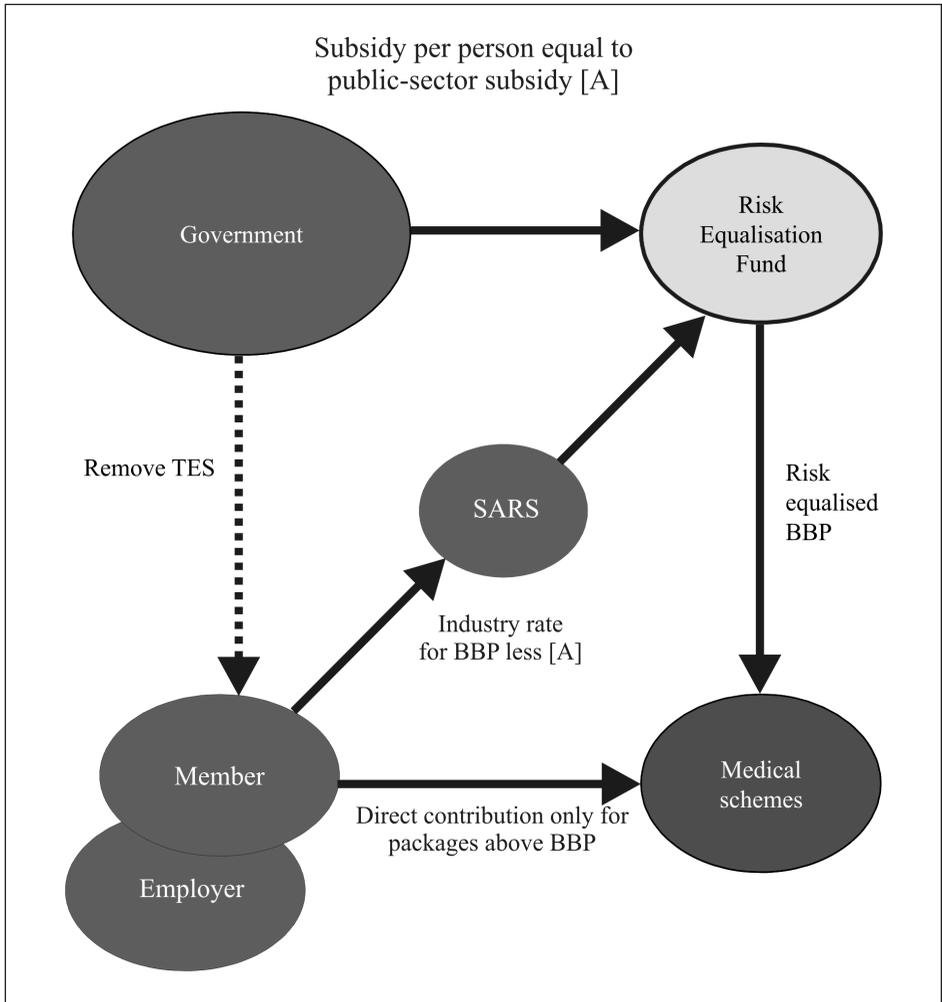
The graph shows how strongly the TES increases with income. It is seen as inequitable that the subsidy to those with the highest incomes in the private sector is greater than that to each person in the public sector.

7.2.6 Individual taxpayers with no or very low income currently receive an in-kind subsidy for public-sector healthcare. In using public hospitals, a means test is applied. Healthcare is subsidised only for those earning less than the means test (the amount currently differs by province) and everyone else must pay the full cost of healthcare received in the public sector. The poor state of billing and debt recovery by some provinces has meant that employees are not fully aware that they will need to pay for healthcare in public hospitals.

7.2.7 The groups that suffer most under the current tax framework are the average- and lower-income groups. For individuals in those groups, the means test requires that, on visiting a public hospital, they pay for services; hence their in-kind subsidy is reduced. Yet their incomes are too low to be able to afford medical-scheme membership in large numbers, and thus the tax deduction does not apply to them. Those earning below the tax threshold get no benefit at all from the tax subsidy.

7.2.8 The intention is to equalise this pillar-1 subsidy available to all, regardless of income, in the form of a fixed subsidy per beneficiary. This would mean the elimination of the TES for individual taxpayers, to be replaced by a per-capita universal subsidy to all medical-scheme members and their dependants. The medical schemes will use that subsidy towards the purchase of the BBP for their members. They will thus reduce the contributions members need to pay direct to their schemes.

Figure 10. Flow of funds to medical schemes under SHI



7.2.9 Figure 10 expands a part of Figure 4 in order to focus on the impact on medical schemes of the changes in the tax subsidy. The income-related contribution, which could be collected by the South African Revenue Service (SARS), is also illustrated.

7.2.10 A further intention is to introduce an earmarked SHI contribution for all those earning above the tax threshold (R32 222 a year or R2 685 a month in the 2004–5 tax year). This SHI contribution might be collected by SARS. The amount is set so that the SHI contribution together with the universal subsidy provides the amount needed for the BBP. Early indications are that the SHI contribution may be of the order of 4,5% of

income to cover the full cost of the BBP for some 10 million people under the first phase of SHI.

7.2.11 It is very important to realise that the SHI contribution is not an additional tax over and above existing medical-scheme contributions. Direct contributions to medical schemes are reduced by the universal subsidy and the amounts collected from the SHI contribution.

7.2.12 Each medical scheme receives an amount from the REF equal to the risk-equalised amount for the BBP. Medical schemes that cannot contract for the delivery of the BBP within that amount will need to charge an additional amount direct to their members. Medical schemes will thus be under considerable pressure to contract with providers for efficient healthcare delivery.

7.2.13 The introduction of an income-based contribution in the form of an earmarked SHI contribution was supported by stakeholders in private healthcare in the recommendations of the Subsidy Consultative Task Team, which reported in January 2004. The analysis of the impact on individual employees is complex, but a fundamental principle is that lower-income earners benefit substantially.

7.2.14 The SHI contribution could ultimately be incorporated into the envisaged social security tax once retirement contributions are also made mandatory, as recommended by the Taylor Committee.

7.3 MANDATORY CONTRIBUTIONS AND MANDATORY COVER

7.3.1 Dr A Ntsaluba, the previous Director General of Health, speaking on 10 July 2003, said¹⁴:

“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.

“We now feel that we are at a stage where we can begin to talk about the implementation of mandates. We are of the view that over time, contribution to health care cover should become mandatory for all those with the ability to pay.”

7.3.2 He went on to discuss the possibility of a state-sponsored medical scheme. The model proposed for the state-sponsored scheme would use private beds in public hospitals, together with private primary healthcare. The state-sponsored scheme

14 Opening Address to the Consultative Forum On Risk Equalisation by Dr Ayanda Ntsaluba, Director-General, Department of Health. Midrand, 10 July 2003.

Available on <http://www.medicalschemes.com>

should not be confused with the restricted-membership scheme for state employees, which is a completely separate initiative. If the private healthcare industry aggressively develops suitable lower-cost options within existing medical schemes, there might be no need to develop a separate state-sponsored medical scheme.

7.3.3 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.

7.3.4 It is likely that members will only pay a small amount direct to their medical schemes, as the cost of the BBP is received by the scheme direct from the REF. Medical schemes that cannot contract for efficient delivery of the BBP within this amount will need to charge an additional contribution direct to their members. Thus members will have a much clearer understanding of the price of healthcare and the trade-offs of network availability, cost and quality.

7.3.5 A member of a medical scheme who is not paying the SHI contribution (for some reason is not registered with SARS) would need to make a higher direct contribution to the medical scheme to compensate the scheme for the loss of subsidy from the REF. In order to track and validate those who have paid the SHI contribution, a registry of people entitled to the REF subsidy is envisaged.

7.3.6 It is planned that, once the REF is in operation with the risk-related and income-related cross-subsidies, mandatory cover will be introduced; i.e. that medical-scheme membership will eventually become mandatory for certain groups. It is possible that mandatory cover will only be rolled out from 2008. As mandatory contributions would already have been in place for some time, most people paying the SHI contribution should have already enrolled with a medical scheme. Thus the mandate to be a member of a medical scheme should have relatively little impact.

7.3.7 In summary, mandatory contributions (the SHI contribution) could be phased in from 2007 over a period of perhaps four years. Mandatory membership is likely to be considered only several years later, but anyone paying mandatory contributions would be entitled to the BBP from the medical scheme of their choice.

7.3.8 The lower-income groups (earning roughly between R2 000 and R3 000 a month) may remain in a voluntary environment for some time into the future. There remain issues to be finalised on the level at which the SHI contribution becomes compulsory. Research confirms that it would be advantageous for the lower-income groups to contribute to healthcare by way of an income-based cross-subsidy, rather than pay a voluntary amount for membership of a medical scheme. These issues are still the subject of discussions with government, labour and business stakeholders.

7.3.9 Figure 4 shows the South African healthcare system once SHI has been implemented.

7.4 HEALTHCARE FINANCING UNDER SHI

7.4.1 Data from the October Household Survey 1999 (OHS99) have been used to develop estimates of the numbers of people who are currently covered in medical

schemes and those who could become members of medical schemes under SHI. This section considers the financing arrangements under SHI, while section 7.5 deals with the impact on the delivery of healthcare.

7.4.2 The OHS99 figures show that 7,025 million people are already beneficiaries of medical schemes, which represents 16,2% of the population of 43,325 million.

7.4.3 At the fullest extent of SHI, a further 8,127 million could potentially become beneficiaries of medical schemes. The initial phase could see 3,233 million new beneficiaries, making a total medical-scheme membership of 10,259 million people. If appropriate lower-cost products are developed and the tax reforms assist lower-income workers to join the system, a further 4,893 million people could become beneficiaries of medical schemes, making 15,152 million people under SHI (35,0% of the total population).

7.4.4 The lowest-income groups and those without income are expected to remain in the publicly funded system. This amounts to 28,173 million people in the public sector.

7.5 HEALTHCARE DELIVERY UNDER SHI

7.5.1 The same figures can be used to illustrate future healthcare delivery under SHI. At present, the 7,025 million medical-scheme beneficiaries largely use private-sector hospitals and private primary care. The public sector provides public-sector hospital services and public-sector primary care to 36,300 million people.

7.5.2 At the fullest extent of SHI there could be 15,152 million beneficiaries covered by medical schemes. They will use a mix of public-sector second-tier (i.e. private beds in public hospitals) and private-sector hospitals, together with private primary care. In the initial phase this is expected to be the delivery mechanism for 10,259 million beneficiaries.

7.5.3 Under SHI proposals, 28,173 million people will remain in public-sector basic hospitals (i.e. public beds in public hospitals) and will use largely public-sector primary care. Some primary care may be obtained on a self-funded basis as out-of-pocket expenditure on private primary care.

7.5.4 There is expected to be increasing use of public-private partnerships, including centres of excellence. Medical schemes are expected to make more use of public-sector radiology and pathology, public-sector chronic-disease management and the provision of chronic medication by the public sector utilising the essential drugs list.

8. IMPLICATIONS FOR THE ACTUARIAL PROFESSION

8.1 The classic education of actuaries prepares them for a world of mutuality, not solidarity. Yet the environment in which healthcare actuaries will need to contribute in the years to come is one founded on solidarity.

8.2 Slattery (unpublished) used the phrase 'Adapt or die'. In describing the actuarial contribution to healthcare he states:

“Actuaries will need to decide how they view their public role in this field. This is a critical issue for the future of actuaries in healthcare in South Africa.”

8.3 He goes on to state:

“To date most actuaries have approached the field of healthcare from the perspective of health insurance. Viewing healthcare in this way may mean that actuaries are not attuned to the needs of the majority of people in South Africa.”

8.4 Since 1994 the South African healthcare system has been on a trajectory of moving away from the principles of mutuality to those of solidarity. Actuaries have not been at the forefront of this important shift, which has largely been led by healthcare economists.

8.5 Society has now determined that healthcare in South Africa in the foreseeable future will be organised on solidarity principles. To paraphrase Moultrie & Thomas (1996): [A] profession which fails to recognise and make allowances for this courts the risk of being ostracised and increasingly ignored.

8.6 It is possible that some actuaries saw the regulatory changes in the late 1990s in a more limited context and did not fully appreciate the fundamental shift in thinking and the change in social legitimacy that occurred after 1994. A respected colleague, on reading an earlier summary, asked when these issues would be debated. It was necessary to point out that the policy documents and debates had all been in the public domain over the last ten years, albeit not in our traditional actuarial literature.

8.7 There are, however, very encouraging signs. Over the past three years a nucleus of experienced actuaries have become deeply involved in processes such as the REF and have contributed much time to making the environment of solidarity a success. In turn, they are training a new generation of actuaries in a different way of addressing the problems.

8.8 Slattery (*op. cit.*) states:

“Actuaries have not always been mindful of the fact that they don’t have exclusive rights to say what is best in the area (of healthcare) and that society may have a different view of things.”

In healthcare, where the actuary is a relatively new member of the team, actuaries need to listen to and learn from our colleagues in economics and social security. There is a wealth of literature in health-economics journals on issues like co-payments, benefit structuring, risk adjustment, incentives and social solidarity.

8.9 Actuaries need to remind themselves of their professional responsibility to society at large and not only to the narrow world of private products in South Africa. This issue is

also becoming more relevant for retirement-fund actuaries as they begin to deal with the Taylor Committee recommendations on mandatory social insurance for retirement.

8.10 As described in this paper, future competition in healthcare in South Africa will no longer be based on risk selection but on the cost-effective delivery of healthcare. In order to contribute to delivery issues, actuaries will need to enter into partnership with healthcare providers like hospital managers and doctors. The efficiency gains inherent in risk-sharing arrangements in managed care are a good example of an area where actuaries could add considerable value.

8.11 The trustees of medical schemes are beginning to undergo the shift from simply designing benefits and managing payments, to engaging in the buying of healthcare and managing the quality of healthcare delivery. Organised labour is beginning to play a role in setting up clinics and employing healthcare providers to deliver care direct to their members.

8.12 Actuaries are called on to turn away from the view of healthcare as merely another financial service and to engage fully with the delivery of healthcare. The future clients for healthcare actuaries are not only medical schemes or employers but increasingly healthcare providers.

8.13 This paper sets the overall context for the nature of the actuary needed for the continued transformation of the South African healthcare system. As the first South African healthcare exams are prepared, it needs to be ensured that actuaries will be produced who will thrive in a solidarity environment.

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