Neither here nor there: the South African medical scheme industry in limbo

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ABSTRACT
Medical schemes are the primary financing mechanisms for private healthcare in South Africa. They are not-for-profit entities owned by their members and are regulated on the basis of social solidarity principles. The key features of the environment are open enrolment, community rating and prescribed minimum benefits. However, social solidarity reforms were not fully implemented and the system lacks any form of income cross-subsidy, risk equalisation or mandatory membership. We argue that the system is intrinsically flawed in the absence of either fully implemented social solidarity mechanisms for risk- and income-cross-subsidies on the one hand, or managed open-market competition on the other. This uncomfortable middle ground means there is currently no incentive for innovation or growth, an administration industry which is prone to incumbency and cover that is increasingly unaffordable and unsustainable.

KEYWORDS
South Africa; medical schemes

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1. **INTRODUCTION**

In the 2010/11 fiscal year, health sector expenditure in South Africa made up 8.8% of GDP (Blecher et al., 2011). Just over half (50.4%) of this expenditure occurred in the private sector (Blecher et al., 2011), where medical schemes act as the primary financing intermediaries by collecting contributions, pooling these contributions and purchasing medical goods and services. As at the end of the first quarter of 2013 there were approximately 8.6 million beneficiaries covered by medical schemes, representing 16.6% of the population (Council for Medical Schemes, 2012; Statistics South Africa, 2012). Medical schemes are tax-exempt, not-for-profit entities owned by their members. They provide near-indemnity health insurance cover and are regulated under social-solidarity principles.

South Africa has a dual healthcare system, with publicly-funded and -provided healthcare, operating in parallel to privately-funded and -provided healthcare. South Africa has worse health outcomes than comparable upper-middle-income countries (Okorafor, 2012) and the healthcare system has been described as being both inequitable and inefficient (Mayosi et al., 2012). The inequity between public and private healthcare relates to both financial and human resources, with the private sector being considerably better resourced (Mayosi et al., 2012).

Despite the size of the industry and apparent demand for medical scheme cover, the medical scheme industry has been criticised on a number of fronts, *inter alia* the unaffordability of cover (Fish & Ramjee, 2007), a lack of innovation, passive purchasing of healthcare (McLeod & Ramjee, 2007) and a failure to curb escalating healthcare costs (McIntyre, 2010). These criticisms raise a number of questions: Is there a role for private health insurance in South Africa? To what extent is the current regulatory environment responsible for the failings of medical schemes? What strengths (if any) do medical schemes have that can be utilised in the reform of the health system?

The future of the medical scheme industry is highly uncertain given that South Africa is in the process of moving towards a system of National Health Insurance (NHI). In this paper we make the case for private healthcare funding as a key component in the South African healthcare landscape. For context, we provide a brief history of medical schemes in South Africa, and describe the rationale for the current social-solidarity principles that govern the industry. We also outline the proposed reforms and the objectives driving the changes.

We argue that there continues to be a strong rationale for the continuing existence of medical schemes, and explore the potential roles that they could play in the broader health system. The current industry is critiqued against the reasons for existence, and particular shortcomings are highlighted. We also argue that reforms critical to the success of the private sector funding be implemented – in particular exploring the potential for schemes to be demutualised. We argue for the condition necessary to ensure a future for medical schemes in South Africa and highlight the key considerations for policymakers in considering their role moving forward.
2. A BRIEF HISTORY OF MEDICAL SCHEMES

The South African healthcare system is characterised by deep inequalities in the allocation of financial and human resources – historically on the basis of race but more recently on the basis of socio-economic status (McLeod & Grobler, 2010). The first medical schemes were established in South Africa in 1889 to provide for white mine workers with coverage continuing to be reserved for the white population until the late 1970’s (Coovadia et al., 2009). Medical scheme membership is currently concentrated in the top two income quintiles of the South African population (McIntyre, 2010) and per-capita expenditure for the covered population far exceeds per-capita expenditure for the uncovered population.

Medical schemes are largely privately-funded (by employers and households, albeit with a tax-expenditure subsidy) and provide access to privately-delivered health-care. The delivery of private care in South Africa is described as being “well developed, resource intensive and highly specialised” (McLeod & Grobler, 2010).

Medical schemes have always been not-for-profit entities that are owned by their members and are managed by boards of trustees. They are however, surrounded by (and confused with) a number of for-profit entities that provide a range of services such as administration, marketing, managed care, consulting and advisory services (McLeod & Ramjee, 2007).

In order to frame the history of medical scheme funding, the concepts of mutuality and solidarity need to be outlined. These concepts are related but are fundamentally different in nature. Both speak to the mechanism of pooling, but with an important difference. Mutuality relates to the pooling of risks after being assessed, where contributions are paid according to the assessed risk (typically insurance) (McLeod, 2005). Solidarity is similar to the pooling of risk, but with the important distinction that contributions are made according to some other measure – typically ability to pay (McLeod, 2005).

Reforms during the 1980s and early 1990s saw an industry based on principles of mutuality (i.e. lives were underwritten and risk-rated), with mandatory benefits removed in 1994 (van den Heever, 2012). The overall number of beneficiaries covered grew during this period (van den Heever, 2012) but there was a decline in access to cover for vulnerable lives (McLeod & Ramjee, 2007). The period was characterised by relatively weak governance, particularly for open schemes (van den Heever, 2012). Schemes saw a rapid escalation in non-healthcare costs – particularly brokerage, reinsurance and managed care (Magennis & van Zyl, 2009). There was little innovation within medical schemes themselves during this period, other than the introduction of so-called low-income products in the late 1990s (Ranchod, McLeod & Adams, 2001). However, it is unclear how market forces would have played out given enough time and stronger governance.

The current regulatory environment (applicable since 1 January 2000) re-introduced open enrolment, community rating and the provision of a prescribed package of minimum benefits. The current regulations are regarded as being incomplete in a number of ways:
— membership is voluntary not mandatory;
— there is no mechanism for income cross-subsidies and the tax-expenditure subsidy only applies to those above the tax threshold; and
— the proposed Risk Equalisation Fund (REF), which would have made monthly risk-adjusted payments to medical schemes, was never implemented.

The implications of the partial reform implementation are discussed in Section 4.

Demarcation between medical schemes and other health insurance products is a continued area of contention (Republic of South Africa, 2013). Other health insurance products are permitted to be sold on a for-profit and risk-rated basis, making clear demarcation necessary to prevent cherry-picking by insurers. This demarcation means that other health insurance products are not permitted to offer indemnity or near-indemnity cover. The key products are Hospital Plans which pay out claims based on the length of a hospital stay, and other limited top-up insurance products which purport to pay for some out-of-pocket medical expenses. Whilst medical schemes provide greater protection than health insurance products, they are also more expensive (Childs & Erasmus, 2012).

With regard to supervision, medical schemes are regulated by the Council for Medical Schemes, whilst responsibility for the oversight of the rest of the financial services industry currently lies with the Financial Services Board. South Africa is moving towards twin-peaks financial-services regulation where the Financial Services Board will maintain responsibility for market-conduct regulation whilst the South African Reserve Bank (SARB) will provide prudential regulation.

Solvency requirements for medical schemes require minimum solvency levels of 25% of gross contributions for each unique package of benefits (referred to as benefit options) (Ganz, 2012). This is at odds with a move towards risk-based capital in the rest of the financial services industry (Ganz, 2012).

There have been a number of policy proposals for mandatory health insurance since the advent of democracy in South Africa. All the proposals envisage that medical schemes would continue to play a role as financing intermediaries. The earlier vision of mandatory insurance was that cover would be provided for contributors and their dependants whilst the more recent NHI proposals have argued for universal coverage. There has been a policy shift away from the retention of the current two-tier system (where formal-sector workers access a different package of benefits to those who receive their care from tax-funded public sector health services) to the creation of a single tier (McLeod, 2009). The role for medical schemes in the most recent proposals has not been clearly articulated.

A 2011 policy paper (Department of Health, 2011) outlined the following reasons for NHI:
— **Right to Access** reflecting the South African constitutional right to access healthcare services, and government’s responsibility to facilitate the provision of those services
— **Social Solidarity** which is the requirement for cross-subsidisation between rich and poor, healthy and sick. The paper takes the further step of including consumption smoothing here i.e. “spreading of health costs over a person’s lifecycle”
— **Effectiveness** is the objective for the system to actually meet the healthcare needs of the population
— **Appropriateness** speaks to the need to recognise South Africa’s unique context in the design of delivery mechanisms – particularly for Primary Health Care.
— **Equity** the need to ensure that inequalities are removed from the system as far as possible
— **Affordability** referring more to the containment of costs, and by implication, contribution levels
— **Efficiency** the need to limit duplication of costs between different spheres of government and the private sector

There is little consideration of how these factors relate to each other, and the trade-offs between them. In addition, it is not clear how these goals will be achieved in the period before NHI is fully implemented.

3. **THE ROLE OF PRIVATE HEALTHCARE FUNDING**

   Internationally, private health insurance (PHI) is often defined relative to the structure of the public healthcare system. There is an international trend for the core of the healthcare financing system to be publicly funded – either via a public pooling mechanism or through subsidised private coverage (Tapay, Colombo & OECD Secretariat, 2004). In many cases public pooling mechanisms have replaced private funding mechanisms, often instituted by employers: a shift driven by the need for broad affordability, particularly for those with higher healthcare costs such as the elderly or chronically ill (Tapay et al., 2004). In these situations PHI has had to adapt to be complementary to the public system, to be supplementary to the public system, or as a duplicate system (McLeod, 2009). Duplicate cover is where private cover is offered as an alternative to the central system on some kind of opt-out basis (Tapay et al., 2004). Supplementary insurance offers a choice of cover for either a better experience for needs covered by the public scheme (e.g. shorter waiting times, greater comfort and convenience etc.) or for benefits which are not covered by the public scheme (Tapay et al., 2004).

   The role of private health insurance can also be considered from a social security perspective. McLeod (2008) outlines the following framework for understanding the constituents of a well-formulated healthcare financing system in terms of the pillars of social security:
— **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 provide market regulation and ensure that basic consumer protection is in place.

It is important to note the differing primary objectives of pillar 1 as opposed to pillar 2 and 3. Pillar 1 mainly deals with universal access for the lifetime poor and informal sector. Pillars 2 and 3 focus on consumption smoothing and affordability for the formally employed sector.¹ In these pillars, cross subsidies do exist but with a focus on broad affordability as opposed to universal access.

The policy shift over the last decade has meant that medical schemes in South Africa have played a role in pillar 2 – with community rating, prescribed minimum benefits and an envisaged Risk Equalisation Fund. There is also an argument that schemes play a role in pillar 3 objectives given that schemes offer a multitude of benefit options for individuals. McLeod (2005) notes:

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.

A strong private healthcare funding industry is key to a responsive and efficient healthcare system. Private health insurance provides an alternative source of healthcare financing, and in this way increases health system capacity, including an increase in the overall supply of healthcare services (Tapay et al., 2004). Hospitals which operate both on private and public funding have been shown to be in a position to increase capacity (Tapay et al., 2004). Whilst the public sector in South Africa has struggled to retain healthcare professionals, other countries have been able to partner with the private sector to leverage capacity (Tapay et al., 2004).

The existence of PHI can have a positive effect on access to care, both because of the increased system capacity and because the option to purchase care is available to those who can afford it (Tapay et al., 2004). The existence of PHI introduces an alternative to potentially long waiting times and low comfort levels that can occur in public hospitals operating on non-price rationing of resources, and can alleviate

¹ The Paper “Old Age Income Support in the 21st century” deals mainly with retirement system reform, but discusses healthcare as an integral component (Holzmann & Hinz, 2004). In that paper, there are five pillars. For purposes of this paper, Pillar 1 here refers to a combination of Pillars 0 and 4 in the World Bank paper, Pillar 2 here refers to Pillar 1 in the World Bank paper and Pillar 3 here refers to a combination of Pillar 2 and 3 in the World Bank paper.
pressure on the public system – particularly important for access to elective care (Tapay et al., 2004).

A very important further benefit is that of innovation. A strong private industry has been shown to foster innovation both in improved funding structures, as well as rapid adoption of new benefits (Tapay et al., 2004). The presence of multiple purchasers (both public and private) and competition between multiple insurers can drive responsiveness and efficiency, not just of the insurers but also of healthcare providers (Helderman et al., 2005).

Helderman et al. (2005) emphasise the importance of “technical and institutional preconditions” for market reform to be effective. The potential drawbacks of PHI are primarily linked to the introduction of inequality that accompanies the “money-rationing” approach that a private system introduces (Tapay et al., 2004). Without a balancing mechanism, resources can be skewed to those who can afford to pay for it. For example, privately-funded elective surgery has been shown to take preference over publicly-funded non-elective surgery in some situations (Tapay et al., 2004). However, a formal method of allocation between the public and private sectors can help eradicate these inequalities:

Explicit rules can be set to assure equity of access to services, for example by allocating elective care on the basis of a single waiting list for both publicly and privately insured patients, or guaranteeing that all providers treat all patients in the same care settings and are subject to the same reimbursement levels. (Tapay et al., 2004).

In the South African context there is a high level of resource inequality between the private and public health sectors. Competition for resources from privately-funded care is perceived to have a negative effect on quality of care in the public system. NHI is seen as a way of reducing this inequity. It is, however, possible to employ methods to manage potential inequality in a multiple-purchaser environment:

In the Netherlands, the system is designed to channel individuals to the same level of care and choice, irrespective of insurance status, through uniform provider fees across insurance types and universal access to all providers (Tapay et al., 2004).

A further challenge to the effectiveness of a PHI is the experience in various jurisdictions of imperfect competition, given that competition is critical to the success of a private market. International experience points to low levels of mobility between insurers, spurred by high barriers to entry for new players and product complexity which makes price comparisons difficult (Tapay et al., 2004). South Africa by contrast has relatively high levels of mobility between medical schemes driven by broker activity (McLeod & Grobler, 2010). The overall level of churn in the industry was estimated at 12.74% in 2012, although this shifts to 21.37% if Discovery Health Medical Scheme is excluded as they have a particularly low rate of 4.73%. Further analysis, however, is required to understand true broker-driven mobility given the skewing effect of Discovery.
International experts have recommended that only a limited set of standardised benefit packages be offered by medical schemes (Armstrong et al., 2004). Standardised benefit design has also been shown to improve mobility and therefore competition, however this has to be traded off against allowing providers to “innovate in response to market changes” (Tapay et al., 2004).

Furthermore, much of the innovation and competitive advantage of private industry can be linked to attracting the “right” risk pool (“cream-skimming” or “cherry-picking”), which can cause inequality (Tapay et al., 2004). Community rating together with risk equalisation can reduce the benefits to insurers of competition on the basis of cream-skimming, encouraging instead emphasis on competition on the basis of efficiency and service delivery (McLeod, 2009).

Both the ILO and OECD recognise a potential role for private health insurance. According to the OECD: “Governments in several OECD countries have used or considered using private health insurance (PHI) as a policy lever to promote certain health system goals, such as reducing financing pressures on public health systems, promoting individual choice and improving efficiency” (Tapay et al., 2004). The ILO Social Security Department (2008) suggests optimising existing forms of social health protection in order to achieve universal coverage (referred to as a pluralistic approach).

The ILO pluralistic approach ties in with the concept of “subsidiarity”. Subsidiarity need not exist separately from solidarity, as illustrated in the history of the Dutch medical funding system. To quote:

Historically, the Dutch welfare state is founded on two constituting principles. First, the principle of subsidiarity implies that what can be managed in the private sphere should not be undertaken by government. The second principle is that of social solidarity on an organised basis, actively supported by the government. Although the principle of subsidiarity resulted in a dominant role for private organisations in the formulation and implementation of health care policy, the principle of solidarity triggered an increasing amount of government regulation (Helderman et al., 2005).

The NHI green paper (Department of Health, 2011) sees the introduction of NHI as a means of introducing more social solidarity into the system, without examining the possibility that this could be delivered (at least partially) by medical schemes:

The rationale for introducing National Health Insurance is ... to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. National Health Insurance will improve access to quality healthcare services and provide financial risk protection against health-related catastrophic expenditures for the whole population. Such a system will provide a mechanism for improving cross-subsidisation in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. Moreover, by significantly reducing direct costs for health care,
families and households under National Health Insurance are less likely to face impoverishing health care costs.

It is evident that South African policymakers view subsidiarity in contrast to social solidarity, and not a mechanism by which to achieve it.

4. CRITIQUE OF THE CURRENT SYSTEM

The case for the continued existence of medical schemes rests on the ability of schemes to contribute to national social solidarity goals and on the promise of subsidiarity (i.e. that medical schemes can provide an efficient and sustainable insurance solution).

4.1 Do Medical Schemes deliver on the Promise of Social Solidarity?

The definition of solidarity presented in the NHI green paper (Department of Health, 2011) implies a high degree of risk cross subsidisation and income cross subsidisation. The principle of solidarity is supported in the regulation of the medical scheme environment via the mechanisms of open enrolment and community rating. Open enrolment ensures that prospective members of medical schemes cannot be excluded or denied cover, whilst community rating (where contributions are allowed to vary only by family size, family structure, in terms of adult and child dependants, and income, and not by risk factors such as age and health status) ensures a degree of risk cross subsidisation can occur. However, the current environment is entirely voluntary (with the exception of employer influence as far are requiring cover as a condition of employment) which undermines the achievement of solidarity because it not only permits but incentivises anti-selection.

There are currently 90 medical schemes covering approximately 8.7 million people (Council for Medical Schemes, 2013). Each of these schemes is able to offer a range of benefit options, each of which is required by regulation to be self-sustaining and separately community rated – effectively causing multiple small risk pools as opposed to one big one (McLeod & Ramjee, 2007). With a total of 323 benefit options on offer, this results in an average risk pool size of less than 30,000 people (Council for Medical Schemes, 2013). The proposed (and subsequently shelved) Risk Equalisation Fund (REF) would have enabled community rating to occur on an industry-wide basis, and would have ensured that members of a particular pool would be neither advantaged nor disadvantaged by the risk profile of that pool. Without REF, the extent of risk cross subsidisation, and hence solidarity, is limited to between members of the same (on average rather small) risk pool.

Critically, “the intention of the REF is that funds will no longer compete on the basis of risk selection but on the basis of effective delivery of healthcare.” (McLeod & Grobler, 2010). There is a strong incentive in the current system to use benefit design, marketing and distribution to “cream skim” healthy members – a clear undermining of social solidarity principles (McLeod & Ramjee, 2007). To ensure their sustainability,
schemes predominantly compete on their ability to attract the right risk profile of members. This imperative for schemes has become the predominant factor driving their strategy, with the consequent negative implications for the vulnerable members the legislation is intended to protect.

Medical scheme cover is unaffordable for the vast majority of South Africa (Eighty20, 2009) and the rising cost of cover has been put forward in numerous forums as part of the motivation for the introduction of National Health Insurance (McIntyre, 2010). From 2001 to 2011, contributions increases exceeded CPI by an average 3.9% per annum (Council for Medical Schemes, 2012).

The affordability pressure undermines solidarity in two key ways: it limits the extension of cover to a larger portion of the South African population, and it results in beneficiaries changing to lower cost benefit options or deregistering dependants (particularly children) (McLeod & Ramjee, 2007). Younger and healthier beneficiaries tend to be more price sensitive and are therefore more prone to the “buy-down phenomenon” (Council for Medical Schemes, 2012). Deregistration of dependants is evidenced by a declining dependant ratio, currently 1.3 dependants per member in open schemes as compared to a ratio of 1.6 in 2005 (Council for Medical Schemes, 2013).

The current environment offers limited income cross-subsidisation. Those earning above the tax threshold receive a tax credit to partially offset medical scheme contributions – but there is nothing in place for those earning below the tax threshold. Medical schemes are also permitted to vary contributions by income. However, this practice has declined in open schemes due to the risk of anti-selection, with approximately 20% of open schemes offering income bands in 2013.Restricted schemes are better placed for some degree of social engineering (McLeod & Ramjee, 2007). The implementation of REF would have enabled industry-wide income cross subsidies to be achieved.

The requirement that schemes offer a package of Prescribed Minimum Benefits (PMBs) is intended to protect members, and to limit the ability of schemes to use benefit design as a means of cherry-picking. There is, however, strong contention from stakeholders that PMBs increase the contribution rates for medical schemes, due to both poor benefit definitions and unregulated medical prices (Taylor et al., 2007; Theophanides, Wayburne & Padayachy, 2012). As they stand, the PMBs encourage hospitalisation through members bypassing the lower levels of treatment such as GPs and going straight to specialists. In addition, medical schemes are required to cover the full cost of treatment without limit. Claims for PMBs have increased more rapidly than for non-PMBs (Magennis & van Zyl, 2009). A revised set of minimum benefits has been proposed which would be much cheaper to provide and hence increase contribution affordability (Broomberg, 2006). The Council for Medical Schemes strongly contends that PMBs are not a cost-driver despite evidence to the contrary (Council for Medical Schemes, 2012; 2013). Despite these protective mechanisms, McIntyre (2010) contends that schemes provide insufficient financial protection for their members:
Over and above these contributions, medical scheme members also have to make substantial out-of-pocket payments in the form of co-payments, covering the costs of services not covered by schemes or paying for services once the annual benefits have been exhausted.

The ability for medical schemes to contribute effectively to social solidarity is severely hampered by the partial implementation of social health reforms. In January 2004 the Minister of Health stated there were three issues on the unfinished agenda for implementing social health insurance (SHI): risk-related cross-subsidies; income-related cross-subsidies; and mandatory cover for the families of those with incomes above a certain level. The policy shift to NHI has meant that this “unfinished agenda” is set to continue, in effect creating an industry that is a “regulatory orphan” (Raath, 2013). Ultimately, the policy environment robs schemes of a fair opportunity to demonstrate their potential to contribute more widely to social solidarity.

4.2 Do Medical Schemes justify a Subsidiarity Argument?

As discussed, a key argument for private provision rests on the promise of subsidiarity. Decentralised decision-making in theory means that decisions are made most closely to those that they affect. This in turn should engender efficiency, market responsiveness and innovation. Bernardes and Hanna (2009) define responsiveness as “a firm’s propensity to act on market knowledge to anticipate and/or rapidly address modifications in customers’ expectations.”

On the one hand, medical schemes offer products to those who can afford it that are generally valued by those covered and by employers. This is evidenced by inelasticity in the demand for medical scheme cover (Baloyi, 2013) and high levels of coverage amongst higher income groups (McIntyre, 2010). A payroll tax to finance NHI has been estimated to have a minimal impact on the demand for medical scheme cover (Okorafor, 2012).

There is, however, some contention about whether the local industry has delivered fully on the promise of subsidiarity. There is some degree of decentralisation in that decisions are made by Boards of Trustees of each scheme. However, regulatory and other constraints on medical schemes (and other stakeholders) have meant that the effectiveness of this subsidiarity has been limited.

One of the key drivers of efficiency and innovation by medical schemes and their service providers is effective competition between them. This is on two levels: firstly, competition between schemes for members and secondly, competition between service providers for the business of medical schemes. In both instances, competition is dependent on the ability of new entrants to enter the market, as well as a level playing field on which to compete.
4.2.1 **Competition between Schemes**

Medical schemes are primarily fiduciary vehicles with no shareholders, with 50% of the board appointed by member election. This means that the board’s strategy is likely to be predominantly conservative in nature, and act in the interests of the current members as opposed to the broad population, included the currently uncovered. Unlike a profit-driven organisation, they are not specifically incentivised for growth. Actions are therefore driven by sustainability of the scheme, in particular – given community-rating regulations and the absence of risk equalisation – attracting sufficient new members of the “right” profile to ensure the continued financial wellbeing of the scheme. Innovation is skewed towards attracting the “right” profile, as opposed to improving efficiency, containing costs and responsiveness to the needs of the broad population. Attracting the “right” profile will have a vastly bigger impact on pricing than operational efficiency or clever purchasing of services (van den Heever, 2012).

Linked to this, the current solvency requirement for medical schemes is 25% of gross contributions. This formulation, in combination with the non-profit nature of medical schemes, creates disincentives for scheme growth.

Furthermore, PMBs account for a large proportion of a scheme’s actuarial liability (approximately 60%) and therefore dominate product design – further limiting the scheme’s responsiveness to the needs of various market segments. The statutory open-ended liability created by PMBs make it difficult for schemes to contain costs (Raath, 2013), placing upward pressure on claims costs. Schemes do have some tools available to them to manage costs: they can contract with designated service providers to limit price risk and they can make use of clinical protocols such as formularies and treatment plans. However, schemes cannot offer significantly reduced-premium options that offer limited coverage of PMBs (even if explicitly marketed as such). This means that members and potential members cannot make the trade-off of coverage and affordability. One detrimental effect of this is that a scheme wanting to offer a solution for medical cover to lower-income markets will struggle to find a sustainable business model. Even schemes wanting to altruistically subsidise such an option are prevented from doing so by regulation that requires each benefit option to be financially sustainable.

The presence of brokers plays a significant role in the competitive dynamic between schemes. Since brokers began to operate in the market in 1996 (and subsequently formally regulated in 2000 with capped commissions), there has been a marked increase in scheme membership. Product complexity limits the comparability of medical schemes and necessitates the involvement of brokers. van den Heever (2012), however, argues that conflicted relationships between brokers and medical schemes inhibit effective competition between schemes. Numerous commentators have argued for common benefit packages across medical schemes to facilitate transparency and competition (Armstrong et al., 2004; Mcleod, 2013; van den Heever, 2012), an outcome which would be greatly facilitated by the Risk Equalisation Fund.
In fact, the key driver of cost levels within schemes has not been size, but whether they are open or restricted. Restricted schemes are those schemes which do not compete in the open market but exist to serve certain groups, such as employee schemes (including GEMS – the government employees medical scheme). These schemes have a significantly lower cost base (on average 7.7% of contributions vs 13.6% for open schemes) principally due to the fact that they have no need for marketing and distribution, and administration is simpler.

In our analysis, the result of these factors mean that brokers will continue to add value to the extent that product complexity makes comparison difficult. The currently conflicted role that schemes play between pillar 2, where benefits are more standardised, and pillar 3 – where benefits are diverse and complex have meant that the role of brokers has been a contentious one. Separating these two aspects may help to frame the involvement of brokers in future.

The issue of purchasing is also key. Medical schemes should play a key role in acting as an intermediary between providers and members and purchasing services on their behalf. Principally this includes two roles, namely making the trade-off between cost and value for members (which is essentially product development – deciding which services should be included in which option – and that we have discussed) and secondly containing those costs.

Cost containment has been a key issue in the healthcare space globally, and the South African context is no different. While non-medical costs have consistently been below inflation since 2008, medical costs have escalated at a rate significantly higher than inflation over the same period (Cipla Consult, 2013). The possible causes of the above-inflation increases in healthcare costs are:
— changes in the risk profile of the covered population;
— changes in benefit richness;
— increased utilisation of benefits for a given risk profile and set of benefits; and
— changes in the price of medical goods and services (true medical inflation).

It is not possible to detangle these cost drivers and further research is required on this issue. Whilst medical schemes have limited control over risk profile, they can impact on the latter three through trade-offs in benefit design and effective cost management. To the extent that cost increases are not purely driven by risk profile changes, an increased cost base may be justifiable if it reflects consumer preferences. In Section 4.1 we highlight the increasing lack of affordability of medical scheme cover. The lack of consumer willingness to accept higher costs of cover is evidenced by both the buy-down phenomenon and reducing family coverage. Furthermore, claims made out of savings accounts which members themselves control increased by only 1.6%, while risk claims increased by an average of 8.2% (Cipla Consult, 2013). This would suggest that increases are not due to members increased appetite for healthcare spend. The combination of these factors may indicate a breakdown between consumer preference and medical scheme purchasing.
Schemes have also been criticised for being passive rather than strategic purchasers of services, with little in the way of selective contracting and alternative reimbursement (van den Heever, 2012). McLeod and Ramjee (2007) observed that many administrators do little other than verify the fee-for-service accounts of providers and eligibility of members. They define strategic purchasing as “continuous search for the best ways to maximise health system performance by deciding which interventions should be purchased, how, and from whom”. Again, in a theoretical competitive market, schemes would naturally gravitate to becoming strategic purchasers to gain a pricing advantage. However, given that pricing is dominated by risk profile, schemes’ management’s focus has been skewed away from purchasing. They also note:

The Medical Schemes Act of 1998 allows schemes to own clinics and hospitals and to choose to deliver health care directly. Very few schemes have made use of this legislated opportunity and the few examples are concentrated in the mining industry or remote locations.

The policy drive by the regulator is for larger schemes which are able to leverage economies of scale to reduce cost and increase effectiveness. However, there is no evidence of schemes being able to capture savings from economies of scale (Thema, 2012).

4.2.2 Competition between Administrators

Administrators and other service providers are generally for-profit organisations to which various functions of medical schemes are outsourced.

Genesis (2012) describe the administrator market as being competitive due to low barriers to entry, oversight by the Council for Medical Schemes and the ability of schemes to switch administrators. Competition between service providers for schemes’ business has driven innovation in various areas, notably in capitation services and managed healthcare. This has demonstrated that the system can produce responsiveness.

However, administrators are also constrained by the environment – particularly in their ability to start a new scheme. There are limited methods of funding the solvency and other capital requirements of a new scheme in an economically viable way (principally due to the fact that all funds in the scheme belong to members). This is reflected in the fact that the number of schemes in the market reduced from 97 to 90 in the period 2011 to 2013 (Council for Medical Schemes, 2013), with no new schemes being added in that period. This leaves administrators simply competing for the work of existing schemes – a pool which is somewhat limited.

Van den Heever (2012) differentiates between strong schemes (those where service providers must bid for business) and weak schemes (those with entrenched relationships with service providers). Current entrenched relationships between administrators and schemes are a major limitation on the ability of administrators to compete.
5. PROPOSED LANDSCAPE AND CONCLUSION

As we have discussed, there remains an important role for private health insurance in achieving key health system goals. A pluralistic approach allows for the achievement of both social solidarity and subsidiarity goals. South Africa needs a competitive and dynamic medical funding industry that achieves efficient risk smoothing and pooling, promotes social solidarity and protects broad affordability. Private healthcare funding is part of a multipronged approach, and should not be seen as a potential replacement for the proposed NHI scheme. Ideally, other forms of funding should create a safety net (Pillar 1) for the poor and unemployed.

There is a commonly held perception that a private industry cannot achieve both subsidiary and solidarity. We assert that, given an appropriate regulatory environment, private industry can both realise the promise of subsidiarity, as well as work towards social solidarity outcomes. Key to the discussion is the clarity of roles of the private sector between pillar 2 and 3. The nature of solutions for the two pillars will differ, with pillar 2 characterised by standardised benefits and community rating, and pillar 3 by a more open and complex environment.

In order to achieve subsidiarity in both pillar 2 and 3 objectives, players in the industry would need the incentive to drive both efficiency, market responsiveness and innovation across the entire value chain. The mechanism that most effectively creates these incentives would be effective competition in the industry. This includes the ability for new talent and capital to enter the market, as well as mechanisms to ensure that competition occurs on the basis of cost effective healthcare delivery that meets the consumer needs.

In order to facilitate this, the barrier to entry would need to be reduced as well as the introduction of incentives to attract these new entrants. As discussed, the current non-profit structure of the industry works against this goal in a number of ways. For this reason, we propose a market-driven approach, and allowing for for-profit ownership structures for market players. Importantly this would reduce the barriers to entry for new entrants, who would be able to seed capital into a new company without the need to find an existing scheme and with a reasonable prospect of a return on that capital. It would also retain the current capacity built up by medical scheme administrators as they would be able to compete directly.

For pillar 2 objectives, some kind of standardised benefit set should be maintained that will drive ease of comparison and hence mobility and competition. Given the simplified benefit structure, broker involvement in this tier would need to be limited, and significant constraints on commission could be considered.

Social solidarity would be the primary purpose of the pillar 2 structure. A private industry run purely on principles of mutuality, however, would potentially reduce access for the vulnerable, and mechanisms would need to be put in place to counteract this. These include community rating, open enrolment, risk equalisation, income cross subsidies and mandatory contributions. The latter three elements are currently absent in the South African environment.
Risk equalisation would require a common benefit package, along the lines of the current PMBs, which could be implemented in the form of product level regulation. It is clear, however, that the current PMB package would need to be revisited – as is well documented.

Furthermore, alignment of the REF flows to the true actuarial risk of each provider would be critical in ensuring that providers are not incentivised to compete on risk profile. This will ensure that competitive dynamics of the market focus innovation on areas of efficiency, value proposition and price.

Competition on this basis would remove the incentive for competing narrowly on the basis of risk profile, as is currently the case and drive companies to formulate simple client value propositions that are responsive to client preferences and needs. This will drive innovation in the product development (closely linked to the purchasing function) and incentivise companies to find innovative ways of working with both private and public healthcare providers to deliver value-for-money healthcare offerings. It would also incentivise companies to invest in efficient systems and processes that will drive down the cost of administration. Alternatively, certain companies could find markets for premium service models which may drive up the cost of administration in some cases – clients willing to pay.

The issue of income-cross subsidy should also be considered here, though a solution would need to be sought that limits the potential for abuse and other unintended consequences. The design of income cross-subsidies would need to dovetail with financing arrangements for NHI.

Furthermore, to ensure that individuals cannot select against the whole system (particularly given the presence of complementary, non-community rated products), compulsory contributions should be introduced for families with an income above a low threshold. While this could be facilitated via a central collection point, such as the revenue services, the presence of complementary products could potentially mean that provider collections would be more practical. There would, however, need to be a mechanism to verify that individuals are contributing to a scheme, which could be included in the annual tax return process.

In order to achieve pillar 3 objectives and leverage off economies of scope, providers could offer complementary products which would fall outside the community rating regime, and be priced similarly to current short term and life products – according to the principle of mutuality. These would fall under the current regulatory regime of either the Short Term or Long Term insurance acts – depending on the nature of the product. Economies of scope along various elements of the value chain could be obtained by allowing providers to offer these products on the back of the same administrative, marketing and distribution capabilities as the common benefit package. Providers would be able to take an integrated approach, ultimately resulting in a more coherent and cost-effective offering to clients.

Note that these proposals do not preclude mutual companies from entering the market – as well as employer medical schemes – though they would need to comply
with the regulatory regime proposed here. Given the cost effectiveness of employer driven schemes (due to the lack of distribution costs), incentives could be given to employers to offer group medical cover to their employees.

Regulation should be aligned with the current financial services regulatory regime – by the Financial Services Board (FSB). A similar twin peaks approach to regulation is proposed, with both market conduct and solvency issues being regulated by the relevant divisions of the FSB. This will promote integration between the medical and insurance markets.

Also, the need for a more scientific approach to solvency has been well established. While the presence of the REF should negate the need for a risk based capital approach somewhat, residual risk nonetheless would remain with the provider (not to mention that of complementary products). One of the benefits of alignment with the broader financial services sector would include the implementation of a regime similar to SAM and result in a more robust and efficient use of solvency capital. Providers would also be able to gain from any diversification benefits with the rest of their business.

The current medical scheme environment faces a number of challenges: sustained cost escalations in excess of consumer inflation, a failure to extend coverage, fragmented risk pools and opaque product offerings. In terms of achieving social solidarity, amongst currently covered members, the current system is found to be severely lacking. The case for the existence of medical schemes largely rests on the promise of subsidiarity. However, the current environment offers little in terms of either efficiency or sustainability and requires significant structural reform to ensure that it lives up to its potential. By providing cover to 8.7 million beneficiaries medical schemes currently reduce the burden on the State. There is significant risk that NHI reforms will be undermined if the medical scheme environment is not recognised as a potentially significant contributor to national healthcare objectives, particularly in the period before the full implementation of NHI. There are longer-term benefits to carefully considering the potential role for private health insurance in South Africa under NHI.

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