WITS SCHOOL OF GOVERNANCE
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

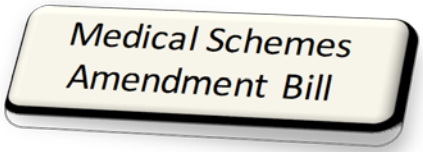
Prof Alex van den Heever
Chair in the field of Social Security
Wits School of Governance
alex.vandenheever@wits.ac.za

A CRITICAL ASSESSMENT OF SOUTH AFRICA'S HEALTH REFORM LANDSCAPE

Presentation to the Economics Roundtable of the South African Reserve Bank
17 August 2018

There is quite a lot to talk about…

- Significant structural concerns with the health system, both the public and private health sectors/systems
- Three sets of reforms have recently been tabled, two in Bill form and a third the provisional outcome of the Health Market Inquiry into the private health system
- This talk reviews the adequacy of tabled reforms against the backdrop of a health systems diagnostic - the focus is principally on the systemic features of the system influencing performance



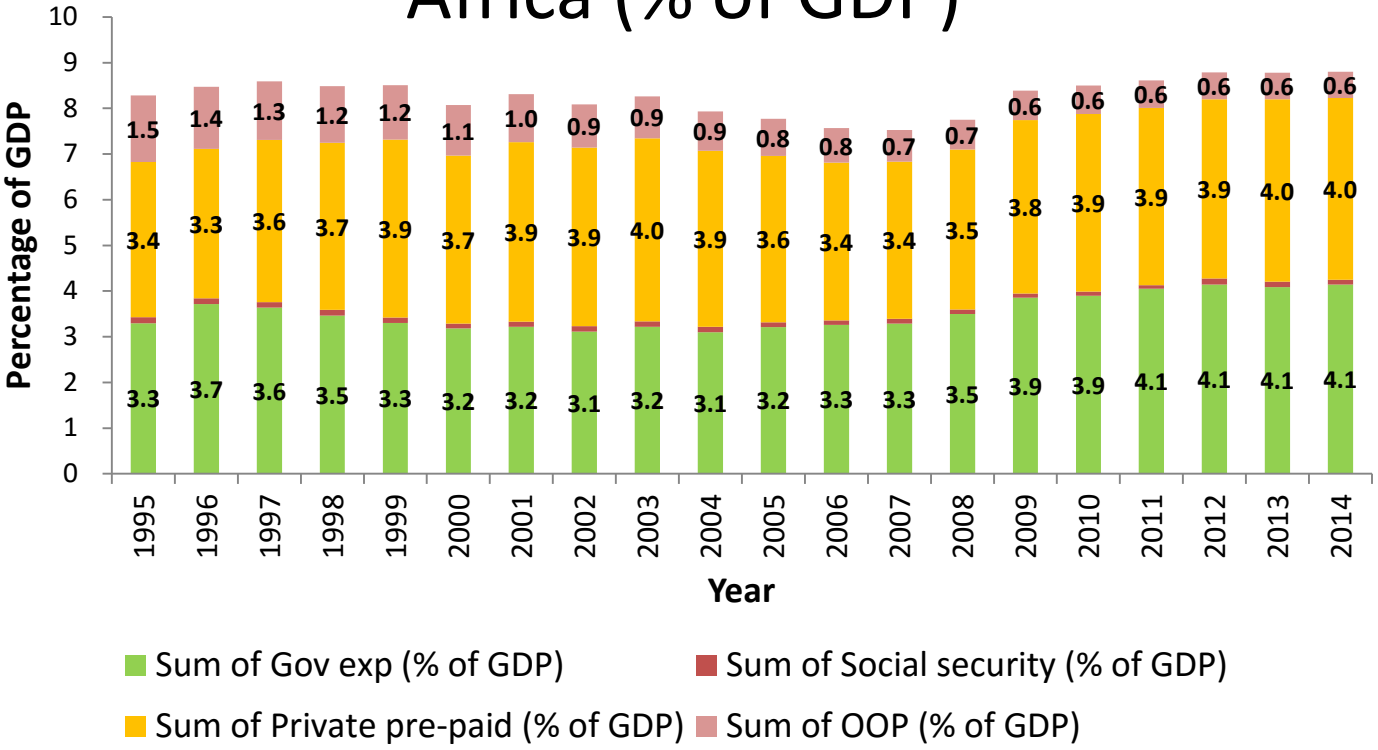
Context

Universal Health Coverage

- Is an objective of all countries
- Is achieved through many different mechanisms – with no country the same

- But note:
  - National Health Insurance is a **mechanism** and not an **objective**
  - **South Africa *has* universal health coverage** – with lapses entirely a consequences of government failure to act

National Health Accounts: South Africa (% of GDP)



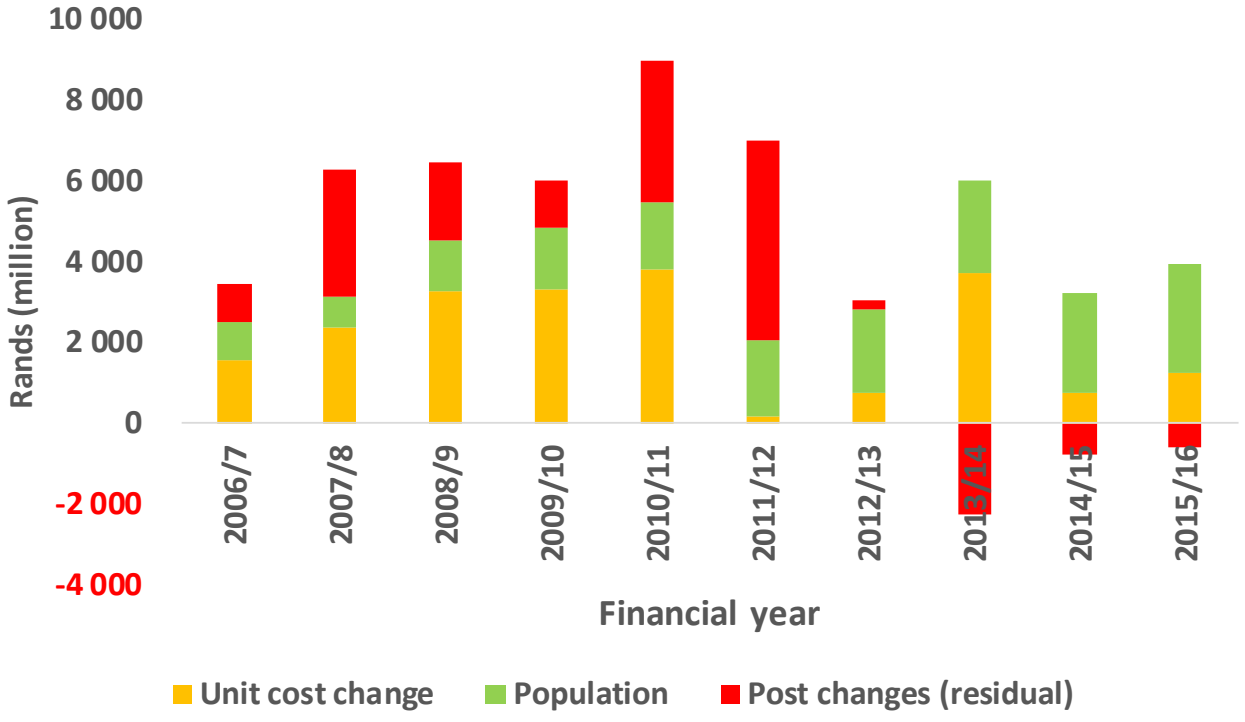
Source: World Health Organisation, National Health Accounts

Some features of the public health system

There a number of headline concerns regarding the performance of the public health system

- Contingent liabilities – medico-legal claims R35 billion (National Treasury) (Actual figure likely to be higher and increasing)
- Accruals relating to non-staff expenses – around R7 billion for Gauteng Province with an unknown level for provinces outside the Western Cape
- Quality of care indicators suggest the public health system is under-performing relative to what is feasible (i.e. performance failures are not principally a function of resources – which have in fact improved over time)

Real changes in **public health sector remuneration** broken down by **cost driver** (from 2005/6 to 2015/16) (2015/16 prices)



Quality of public health care – the Office of Health Standards Compliance

Score range	Number of hospitals	% of total	Number of beds	% of total
80%+	16	11,9%	8 377	18,8%
70-80%	25	18,5%	11 798	26,5%
60-70%	38	28,1%	13 775	30,9%
50-60%	27	20,0%	6 658	15,0%
40-50%	25	18,5%	3 521	7,9%
30-40%	2	1,5%	110	0,2%
20-30%	1	0,7%	40	0,1%
10-20%	0	0,0%	0	0,0%
0-10%	1	0,7%	240	0,5%
Total	**135**	**100,0%**	**44 519**	**100,0%**

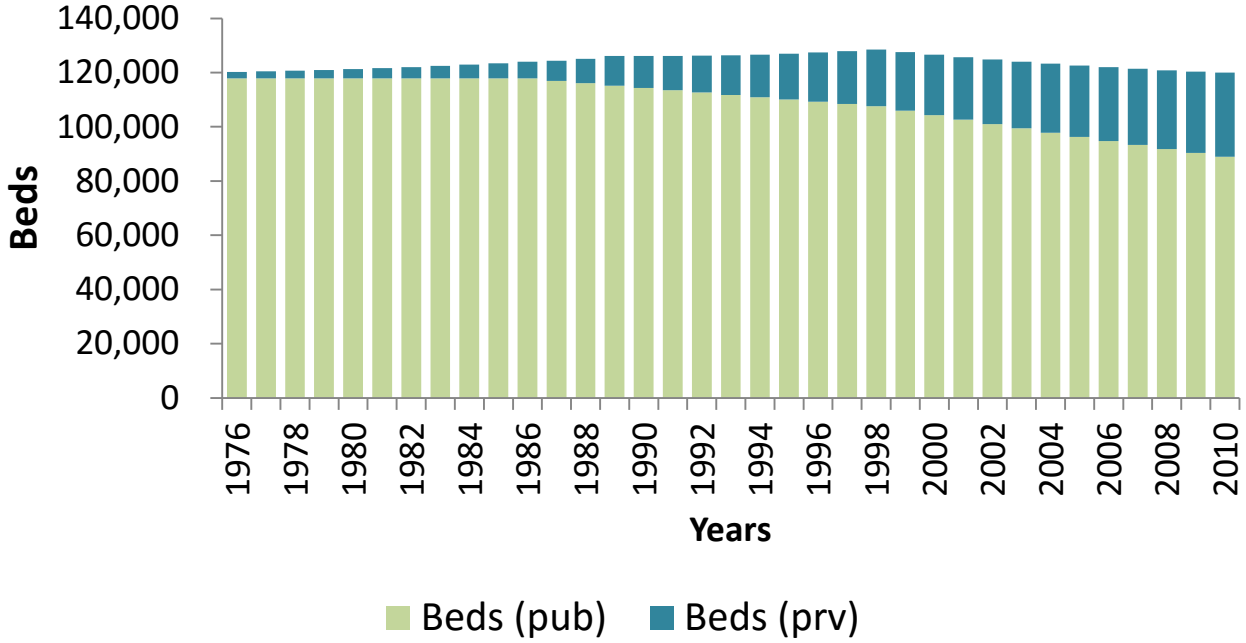
Only 11.9% of public hospitals meet the basic OHSC norm, representing only 18.8% of the beds evaluated

But the quality assurance scores don't correlate with health outcomes using facility-based MMRs

(*Facility-based MMR (maternal mortality ratio per 100,000 live births) averaged for the period 2010 to 2012)*

	Row Labels	Weighted average quality score	MMR	Benchmark MMR
?	**Western Cape**	74,5	77,1	19,0
?	**Gauteng**	72,2	141,1	19,0
	Eastern Cape	59,0	167,2	19,0
?	**North West**	73,6	179,2	19,0
	Limpopo	61,4	182,7	19,0
	Kwazulu Natal	71,2	185,2	19,0
	Mpumalanga	58,4	194,2	19,0
	Northern Cape	46,3	202,6	19,0
	Free State	63,0	209,4	19,0

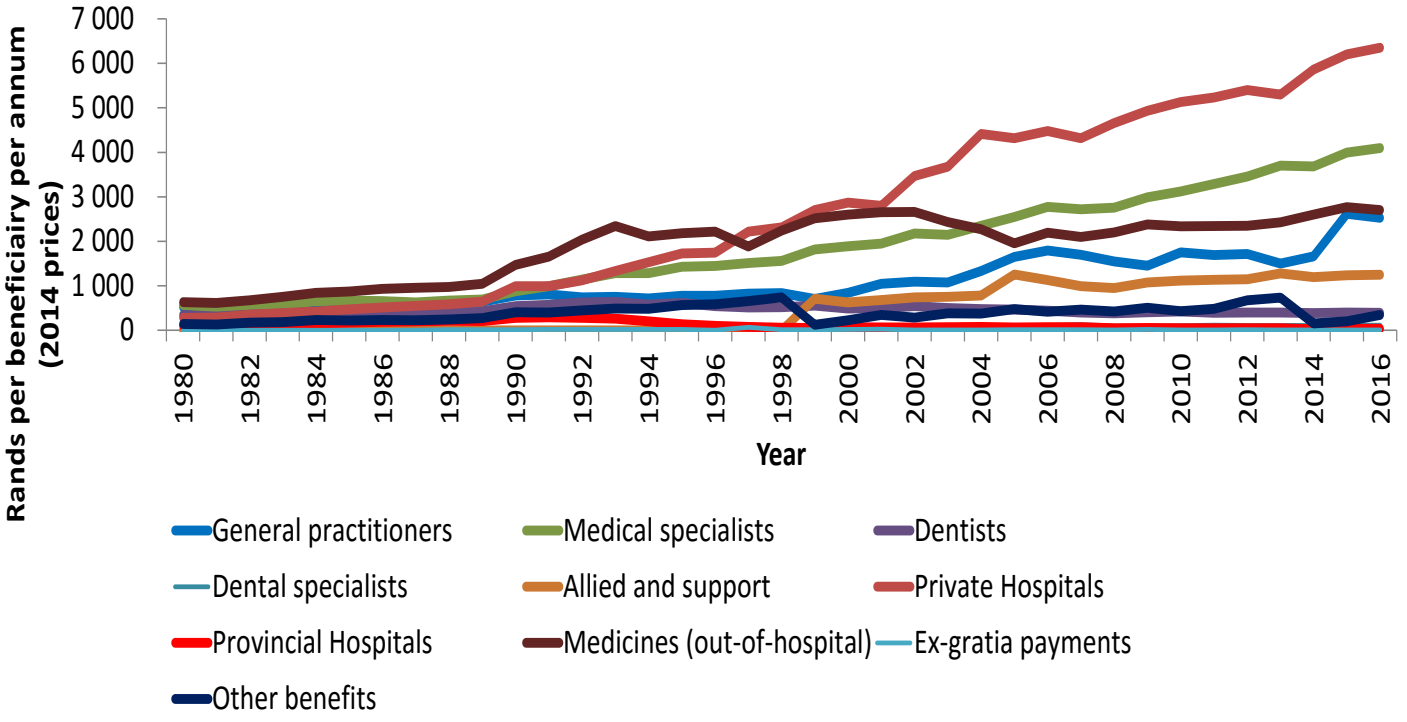
Changes in total beds in South Africa 1976 to 2010: public and private sector



Source: derived from Health Systems Trust data

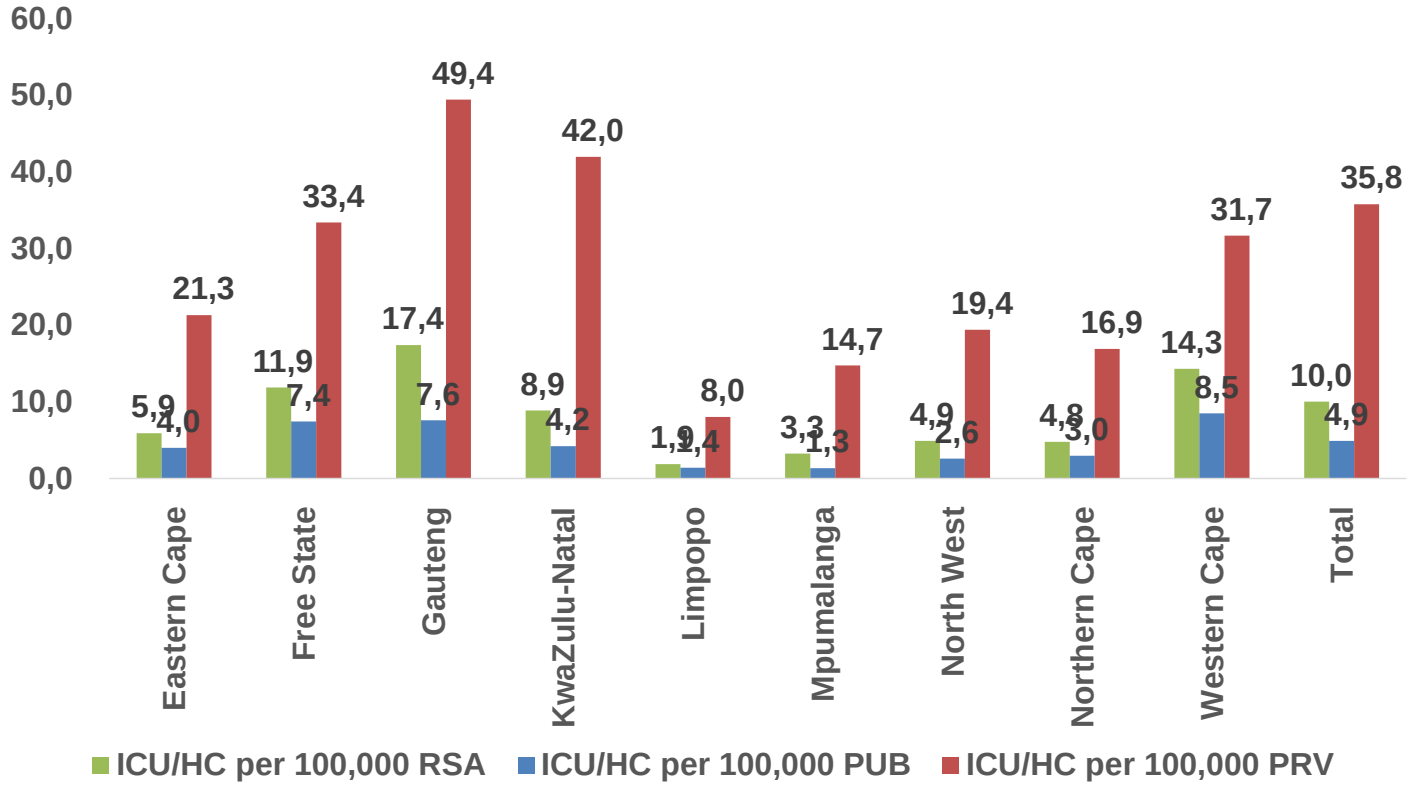
Some features of the private health system

Medical scheme real per capita claims cost changes from 1980 to 2016



Source: Annual Reports of the Council for Medical Schemes

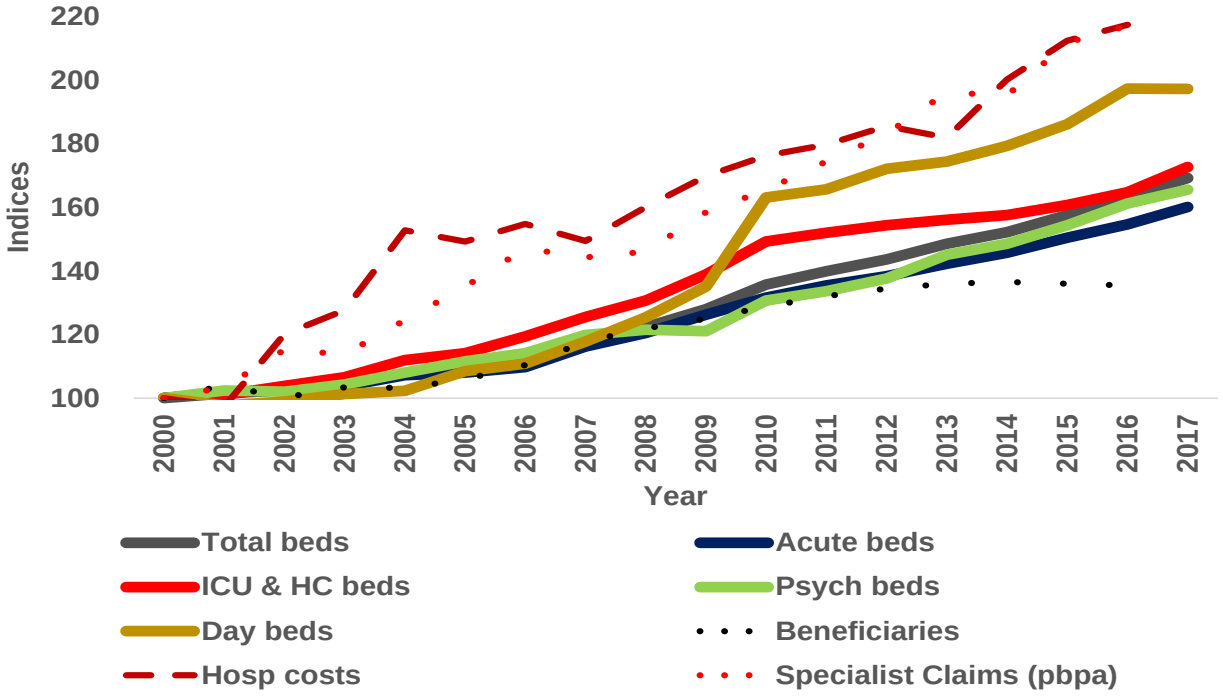
ICU/HC beds per 100,000 in South Africa (2016 estimate)



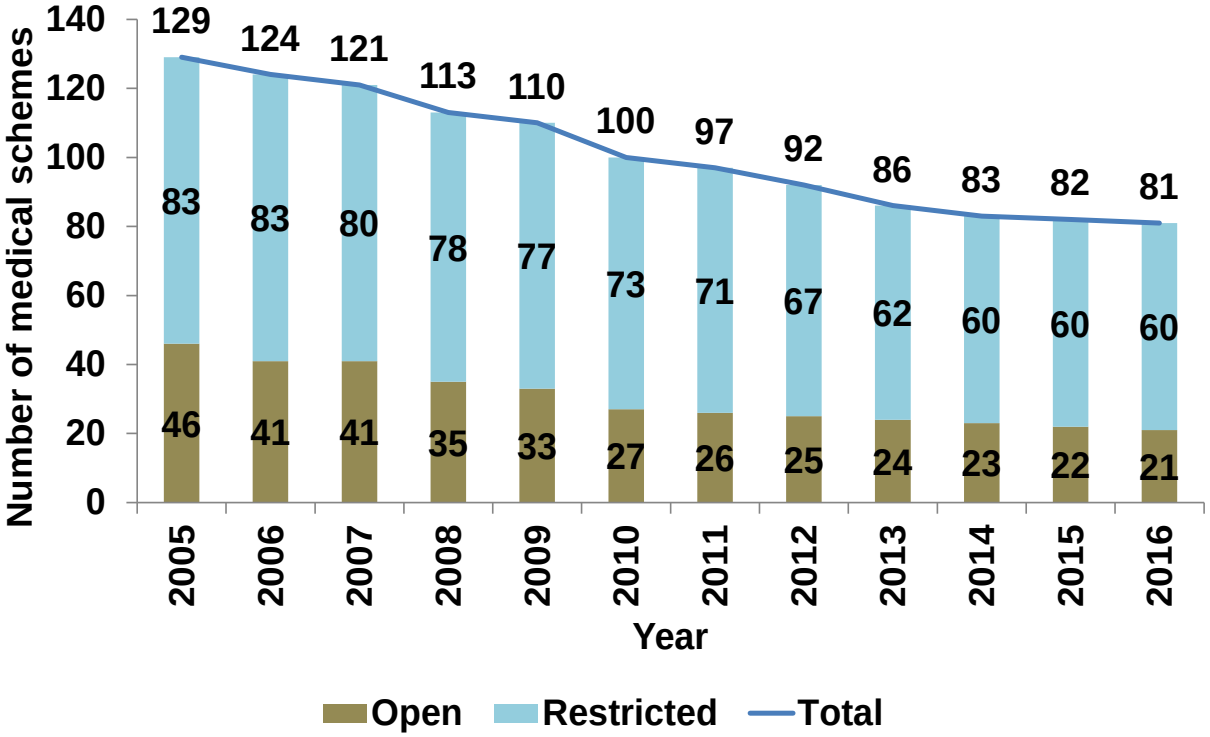
What happens elsewhere?

Country	ICU/HC per 100,000
France	11,6
Switzerland	11,0
Spain	9,7
United Kingdom	6,6
Netherlands	6,4
Sweden	5,8

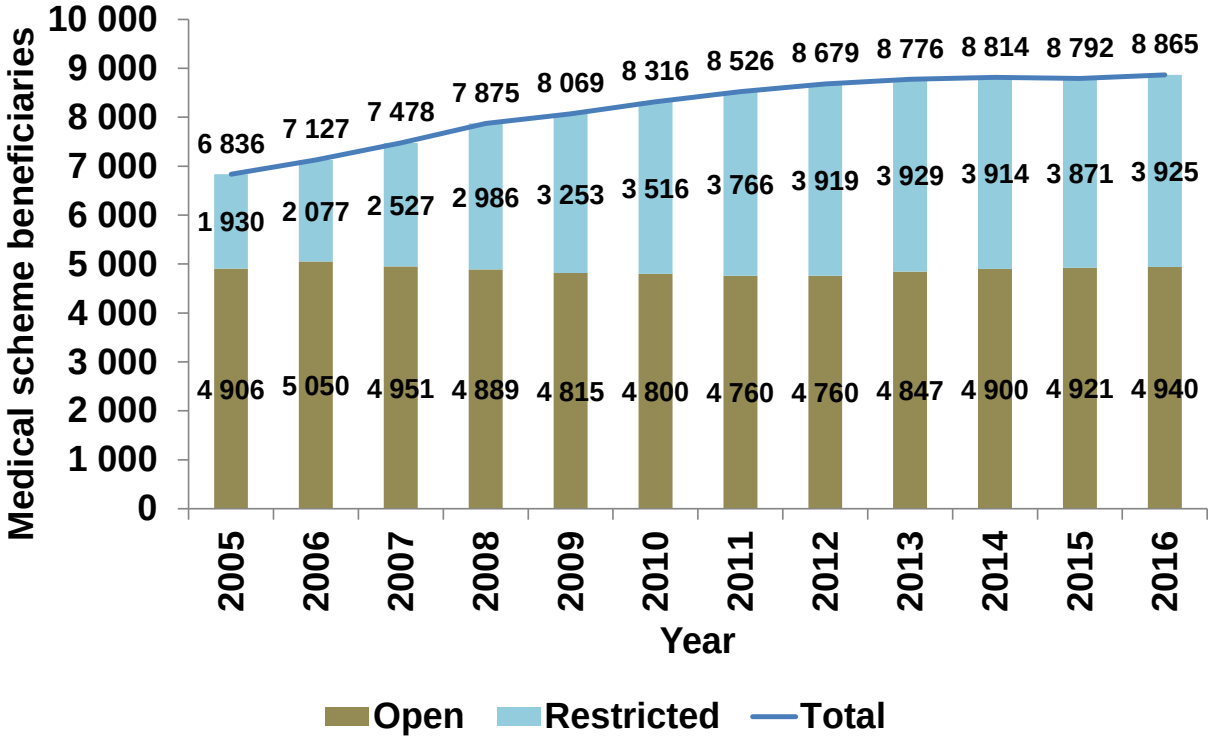
Index trends in private hospital beds compared to medical scheme claims data 2000 to 2017



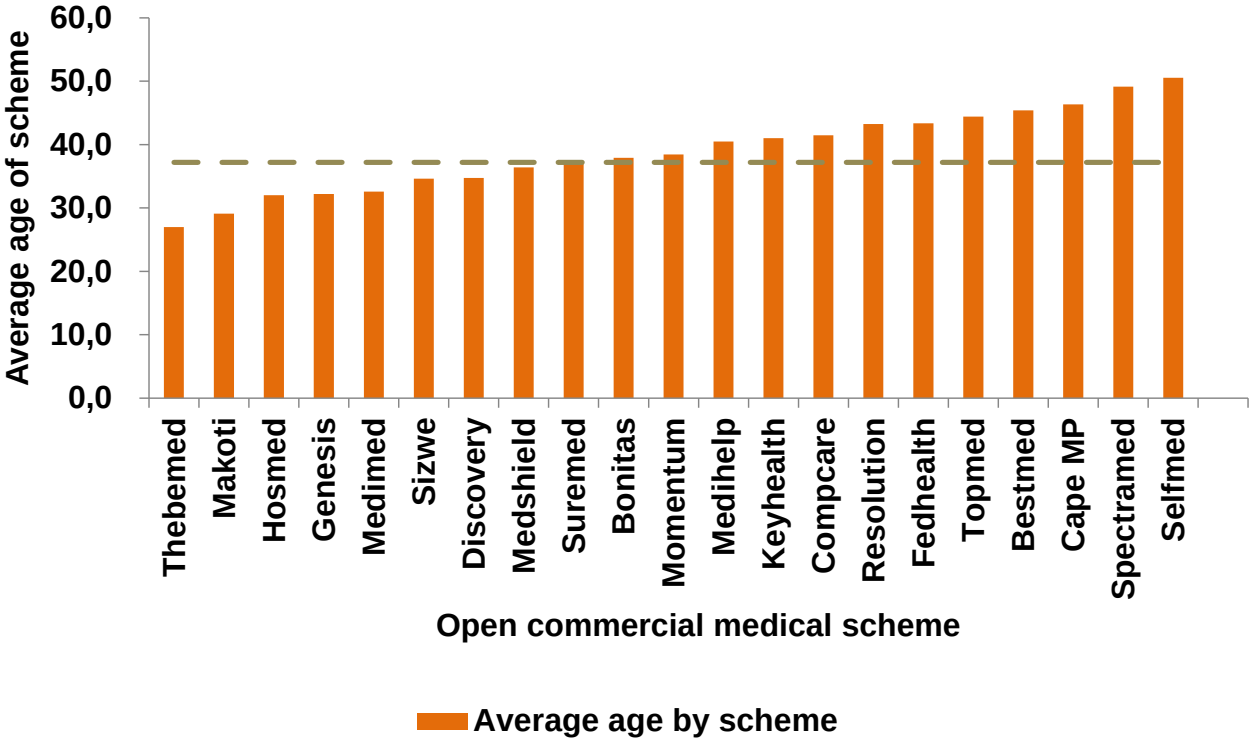
Number of medical schemes



Medical scheme beneficiaries (000)



Average age by open medical scheme (2016)



Medical scheme age structure by monthly risk contribution band (2016)

Contrib band (risk) (Rands)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
0 - 501	22	19	26	23	24	20	25	25	24	24	25	18
501 - 1001	18	16	16	15	16	15	17	17	19	20	20	18
1001 - 1501	22	22	22	24	23	23	21	20	20	21	22	21
1501 - 2001	34	35	35	35	34	30	29	29	32	33	32	31
2001 - 2501	35	39	44	43	45	40	35	37	41	37	36	38
2501 - 3001	50	45	44	41	48	53	50	43	39	42	44	47
3001 - 3501	49	57	51	50	46	48	48	50	54	53	55	53
3501 - 4001	49	54	60	63	46	46	35	53	52	55	53	56
4001 - 4501	50	69	64	61	58	62	59	49	49	56	62	70
4501 - 5001	56		64		67	58	55		58	57	58	59
5001+	26	54	58	60	49	64	63	59	59	60	49	52
Average	**32**	**32**	**31**	**32**	**32**	**32**	**32**	**32**	**32**	**32**	**33**	**33**

Underwriting results by contribution band (2016 prices) for the 2016 financial year (Discovery Health Medical Scheme)

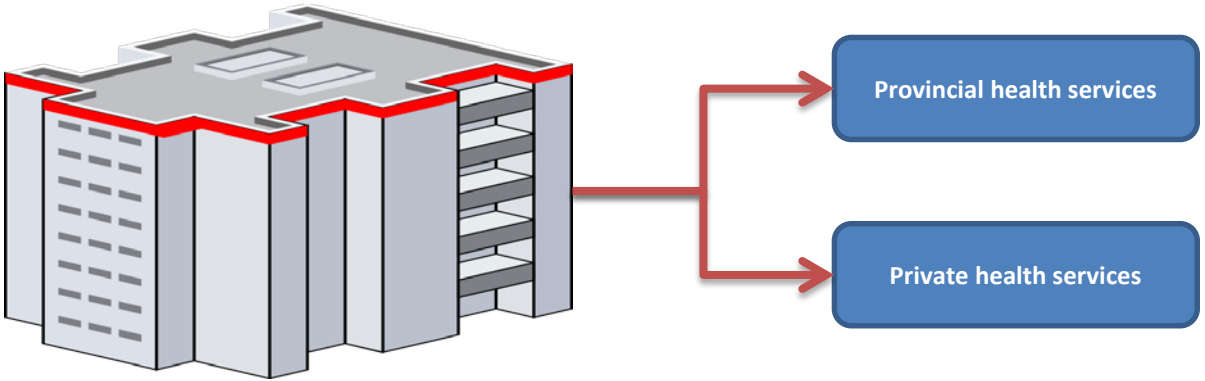
year	0 - 501	501 - 1001	1001 - 1501	1501 - 2001	2001 - 2501	2501 - 3001	3001 - 3501
2005	15 178 294	-57 951 059	255 314 737	-1 209 590 189			
2006		1 533 047	561 419 462	-1 150 736 188			
2007		399 492 263	925 530 650	-170 866 280			
2008		389 527 784	804 991 442	-434 076 759	-288 713 007		
2009		194 565 568	880 507 890	-637 713 094	-294 266 816		
2010		-23 767 937	1 056 213 575	-708 568 036	-359 894 247		
2011		-86 872 044	1 162 869 151	-805 002 624	-377 951 287		
2012		-327 685 936	1 612 581 488		-697 821 391	-344 037 109	
2013		-131 616 267	1 973 050 385	-2 226 767	-463 028 120	-314 914 766	
2014		-233 119 822	1 657 866 830	405 786 290	-623 382 462	-330 841 858	
2015		-469 663 653	1 652 357 090	365 785 600	-660 736 649	-348 639 776	
2016		-445 440 004	1 421 009 737	287 774 602	-810 367 370		-350 527 015
Grand Total	**15 178 294**	**-790 998 060**	**13 963 712 435**	**-4 059 433 445**	**-4 576 161 351**	**-1 338 433 509**	**-350 527 015**

Source: Council for Medical Schemes data from schemes audited financial statements from 2005/6 to 2016/17

National health insurance bill

Key features

- Establishes a National Health Insurance Fund
  - Functions
    - Procurement/purchasing
    - Accreditation – in conjunction with the OHSC



Rationale

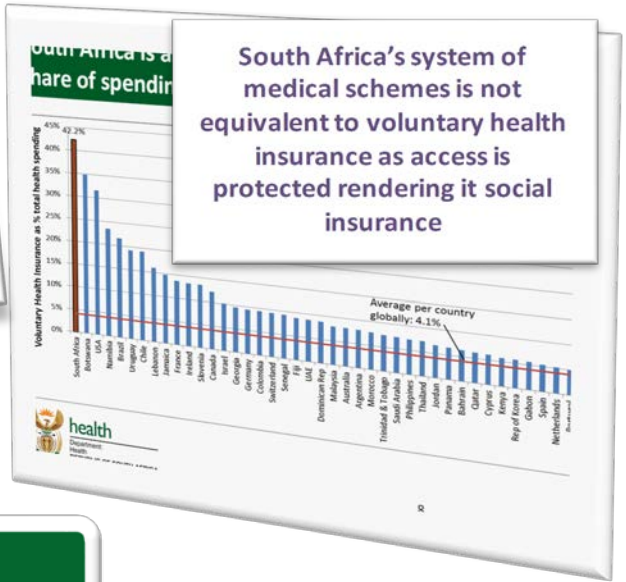
WHAT PROBLEM ARE WE SOLVING IN SOUTH AFRICA TO ACHIEVE UINVERSAL HEALTH COVERAGE?

DEEPLY ENTRENCHED INEQUITIES

- The World Health Organisation recomm… health.
- South Africa currently …
- The private sector spe… population.
- The public sector sper… population

Civil servants' medical scheme subsidies are employee benefits and not government subsidies

GEMS			
Civil Servants not on GE…			22%
SOEs	7.2	8.3	15%
TOTAL GOVT AS AN EMPLOYER	26.8	31.0	16%
MEDICAL TAX CREDITS AND REBATES	20.0	26.0	30%
TOTAL STATE SUBSIDY	46.8	57.0	22%



WHO/OECD view on South African private health expenditure

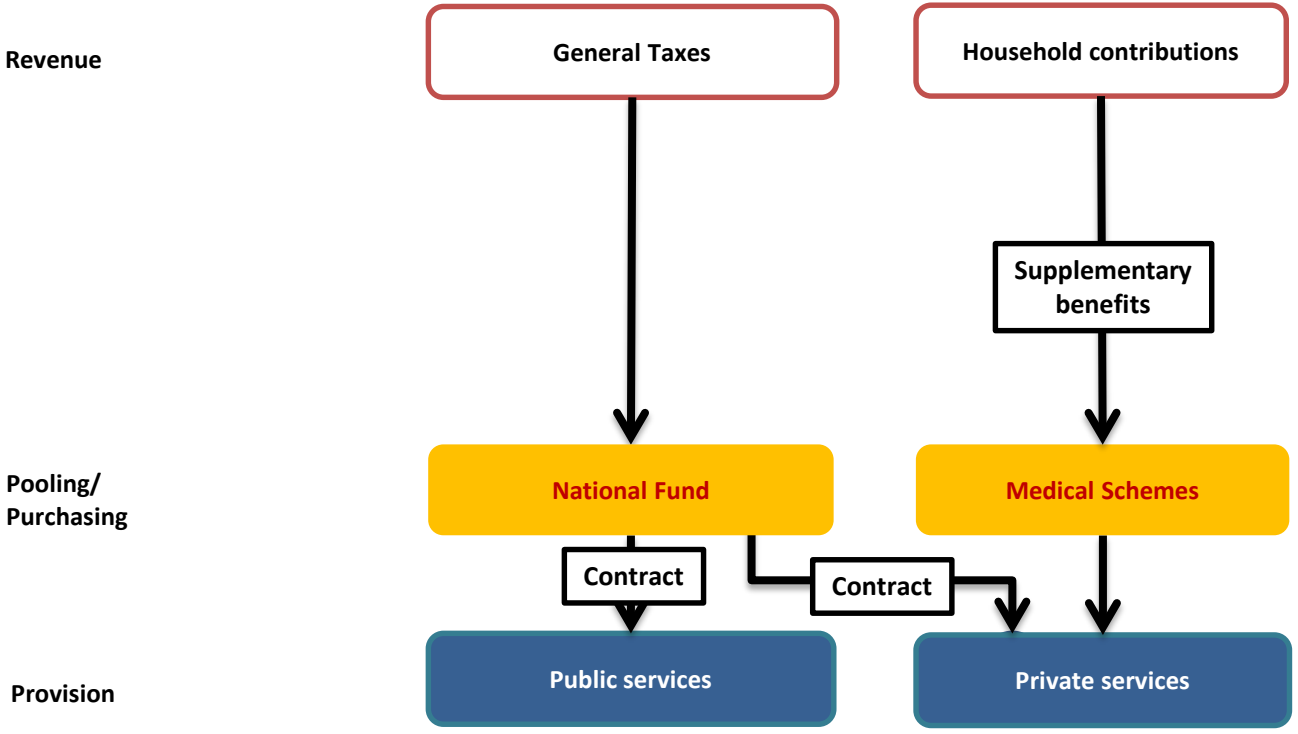
- The previous slide indicates why the WHO and the OECD, have contended that South Africa is the only country in the whole world, where so much money is spent on the health of so few people. (presentation to the Health Market Inquiry)

health
Department: Health
REPUBLIC OF SOUTH AFRICA

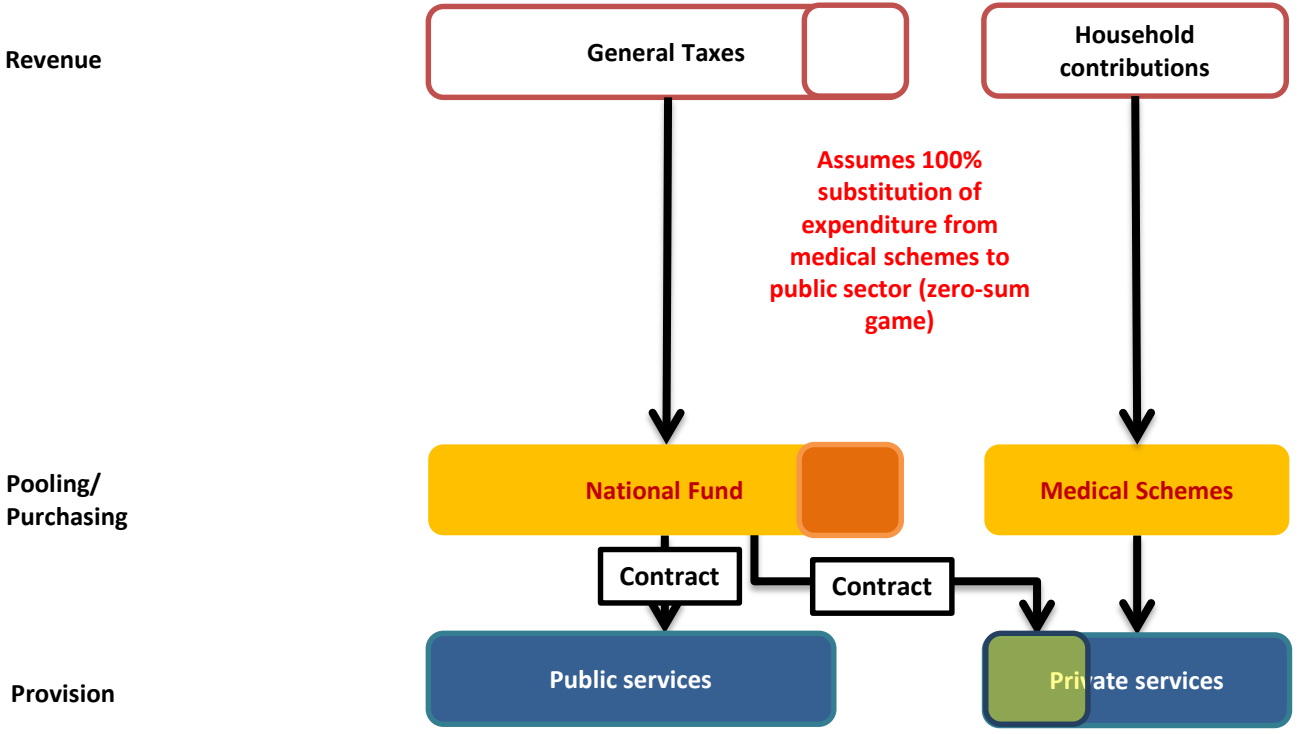
9

There is no diagnostic provided that talks to the actual **structural** problems in the health system

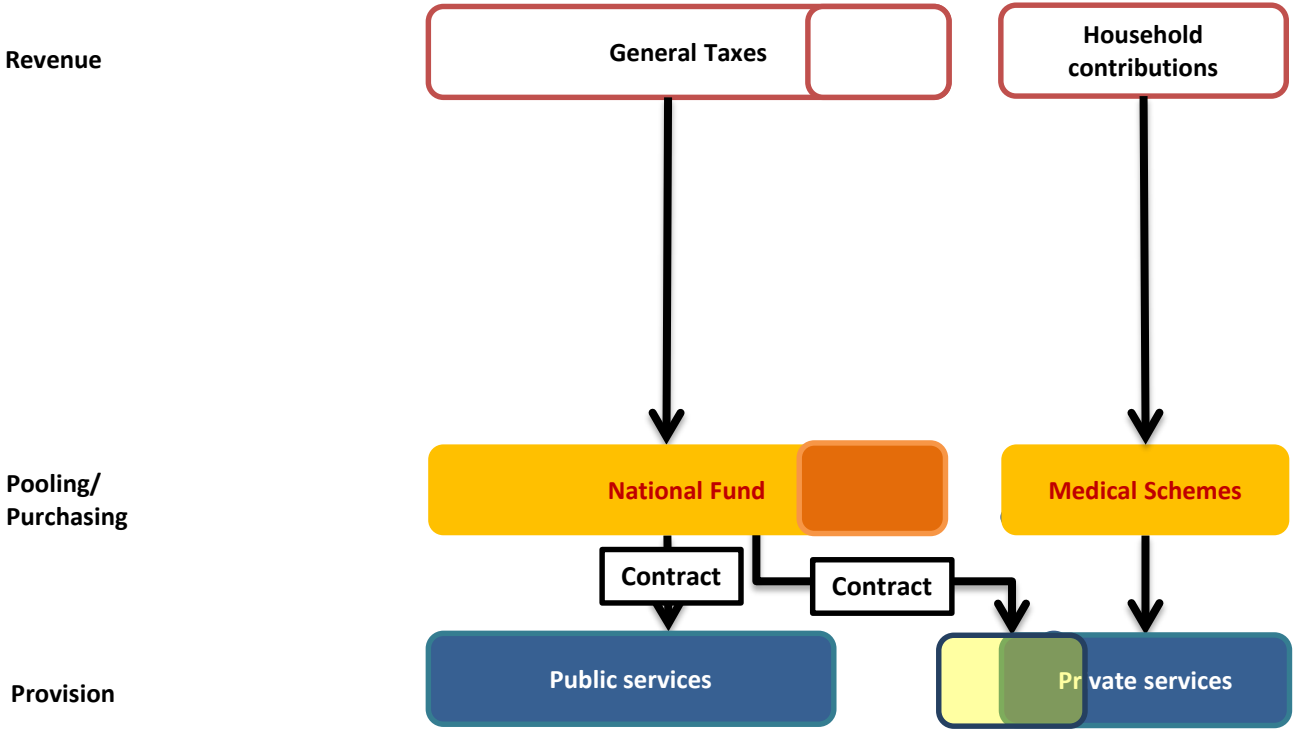
The Big Idea


Revenue
General Taxes
Household contributions
Supplementary benefits
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

The Big Idea


Revenue
General Taxes
Household contributions
Assumes 100% substitution of expenditure from medical schemes to public sector (zero-sum game)
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

The Big Idea


Revenue
General Taxes
Household contributions
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

Financing – according to the MOH

R259bn for NHI scheme was a 'thumb suck'

> **R259 billion NHI figure was a guess – we don't know what it will cost: Motsoaledi**

"We made a mistake with the figures. I then went for advice to the World Bank and the World Health Organisation and they asked why am I trying to do this, it can't be quantified by any human being because the costs are so variable." (Minister of Health)

The following are the financing issues not addressed…

- In developing countries general tax revenues cannot fund a single system for all – it will hit a limit insufficient to offer universal coverage
- Additional revenue needs to be mobilised through
  - Contributory social insurance schemes
  - Contributory regulated private health insurance – usually mandatory, risk-equalised and government subsidised with a package of services that must be guaranteed and underwritten by private actors rather than the government

The package… what is to be covered?

Public sector - funded exclusively by general taxes

Supply-driven – what is provided is the package subject to treatment protocols and referral systems

+

Contributory/insurance - funded mainly by own contributions

Explicit positive and negative lists

=

Risks

- Prices not managed
- Service quality not transparent and not managed
- Public sector – demand exceeds supply
- Insurance systems – supplier induced demand
- Poor contracting

The system of guaranteed protection (of the package) requires constant review, which takes account of societal priorities and technical considerations – no such reviews are presently carried out and the NHI Bill does not suggest it understands the distinction between a supply-driven and an insurance package

Key proposals with systemic implications

- Governance of the NHIF and the OHSC
  - Effectively everyone appointed by the MOH
- Central hospitals to fall under the national MOH

Transitional arrangements

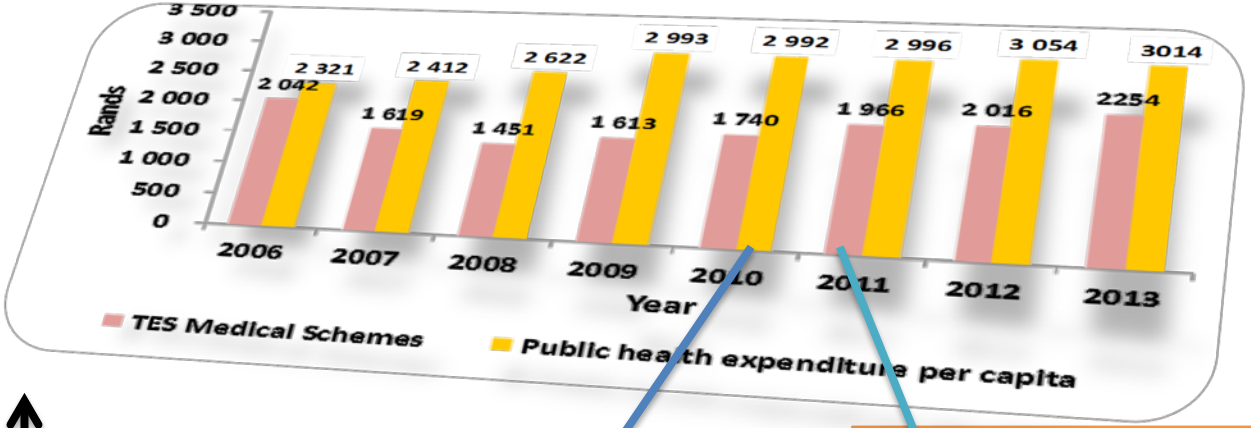
- Phase 1
  - "Phase 1 encompassed a period of five years from **2012 to 2017** and included testing of effective health system strengthening initiatives."

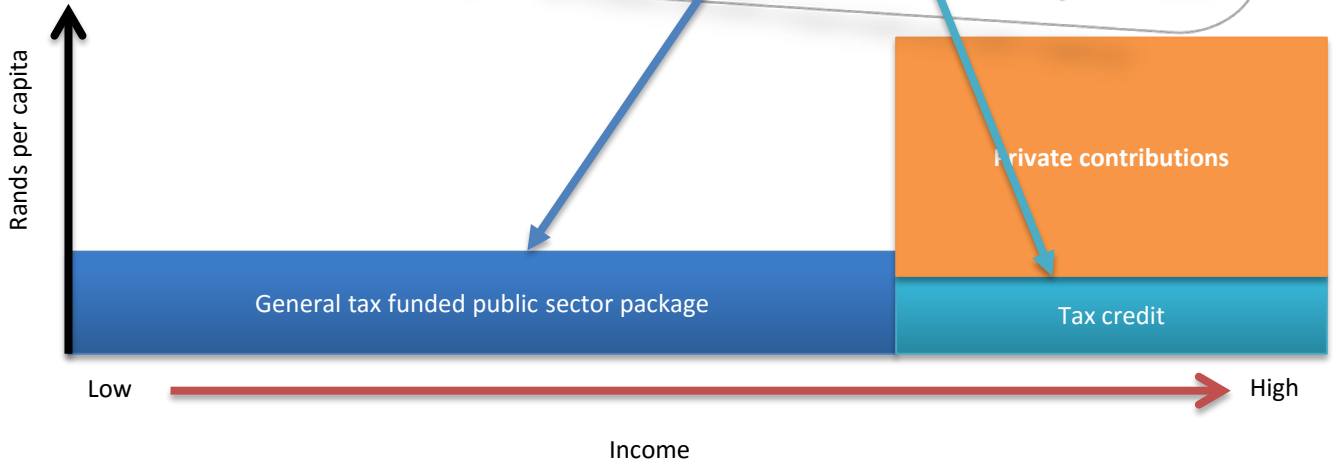
- There is no evidence of any "system strengthening initiatives"

- **Phase 2** will be for a period of five years from **2017 to 2022** and will -
  - continue with the implementation health system strengthening initiatives, including the alignment of human resources with that which will be required under the Fund
  - include the development of National Health Insurance legislation and amendments to other legislation
  - include the undertaking of Initiatives which are aimed at establishing institutions that will be the foundation for a fully functional Fund
  - will include the interim purchasing of personal healthcare services for vulnerable groups such as children, women, people with mental health disorders, people with disability and the elderly

- **Phase 3** will be for a period of four years from **2022 to 2026** and will include-
  - the continuation of Health systems strengthening activities on an ongoing basis
  - the mobilisation of additional resources as approved by Cabinet
  - the selective contracting of healthcare services from private providers

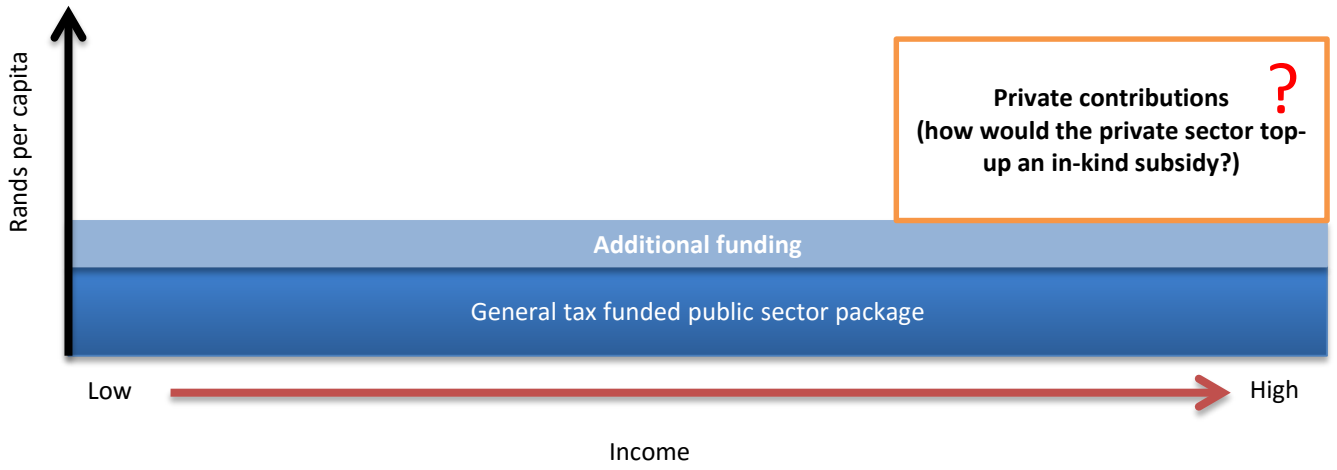
Building blocks of a costing





Building blocks of a costing approach

The enhancement of the per capita expenditure on public sector users, even if realised, is very unlikely to materially improve service quality by much while retaining a strong demand for those with adequate incomes to demand private coverage



Health market inquiry

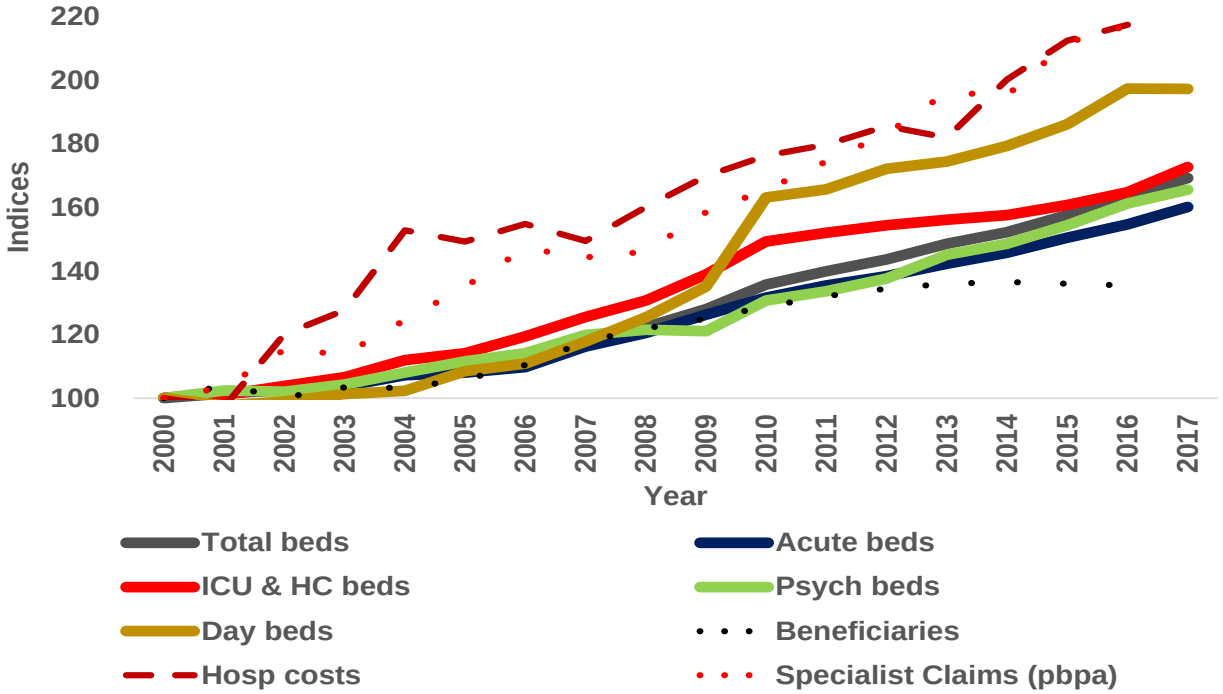
Key findings

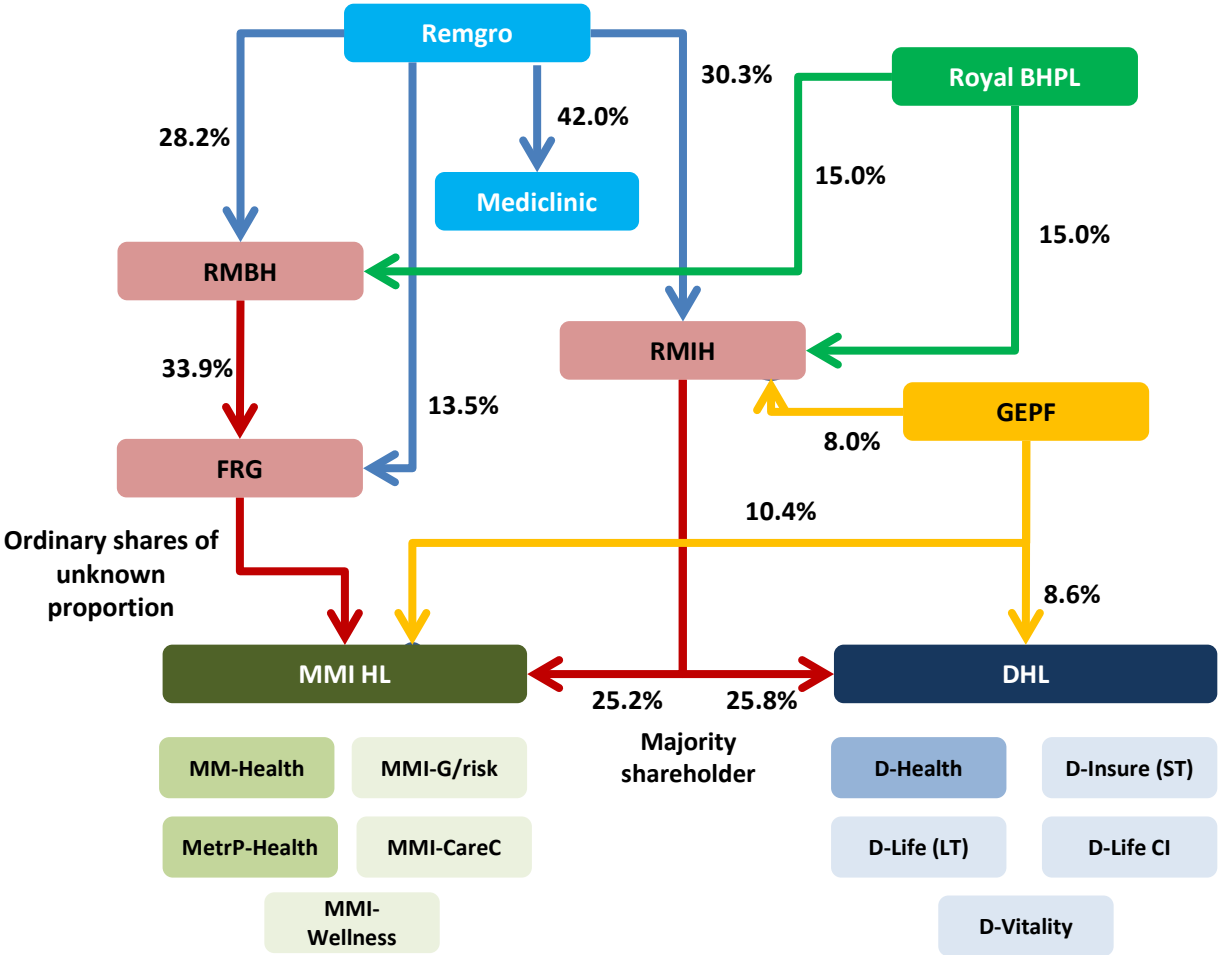
- Substantial market failure on both the funder and provider sides of the system
- Significant market concentration
  - Medical schemes
  - Medical scheme administrators and related corporate groups
  - Hospital groups

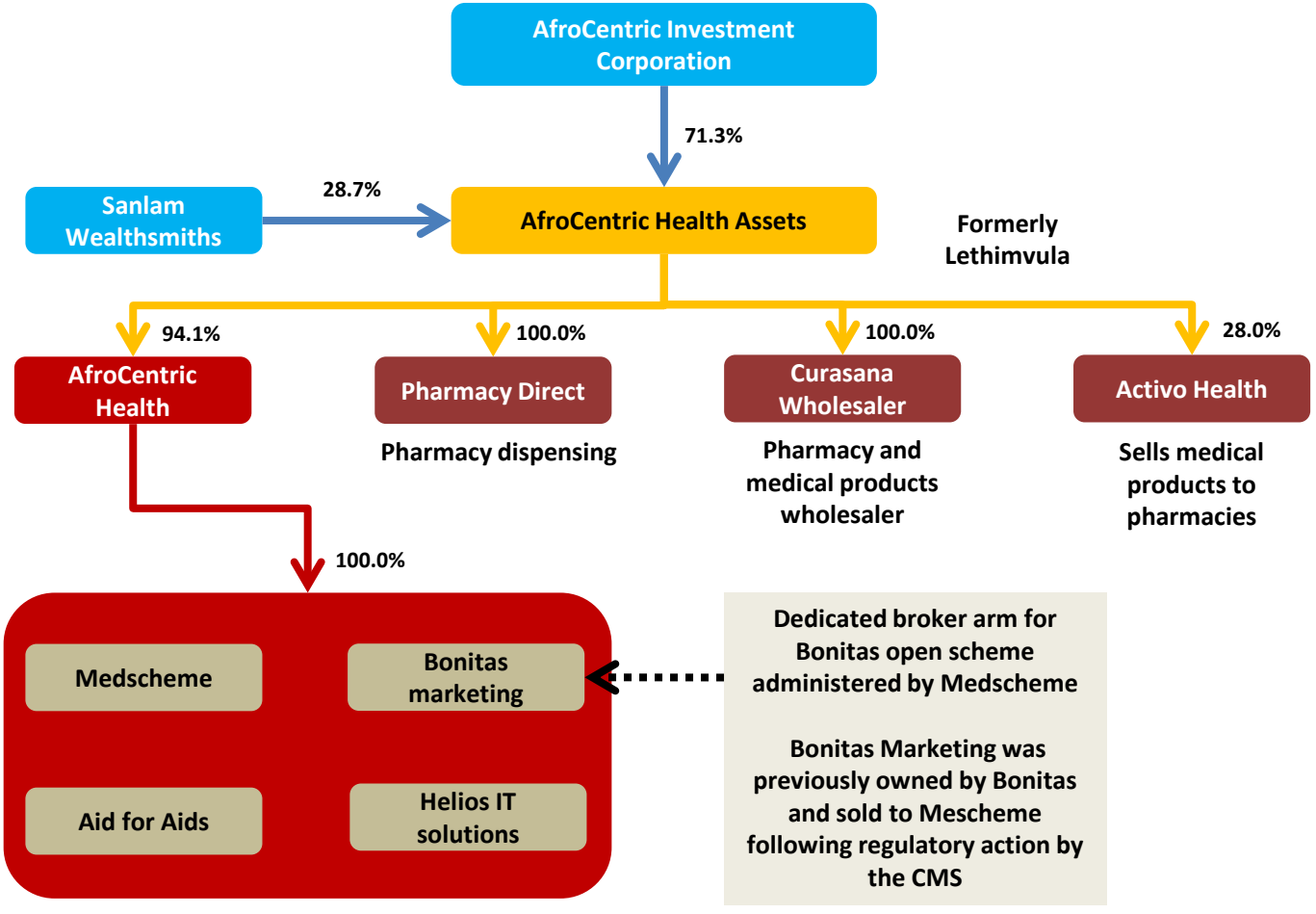
- Funder (administrator) profitability
  - Sustained high profit margins
  - Discovery at “multiples” of other administrators!
- No disruptive market innovation despite high costs and sustained high profits
- Supplier induced demand significant, with funders showing little interest in addressing the problem (retaining ffs)
- Providers and funders don’t compete on features that matter to consumers (such as costs and quality)

- Market lacks transparency for consumers
  - Scheme benefits complex
  - No information on health provider quality
  - Brokers not incentivised to properly advise members
- HPCSA ethical rules represent a barrier to innovation

Index trends in private hospital beds compared to medical scheme claims data 2000 to 2017




Remgro
Royal BHPL
Mediclinic
RMBH
RMIH
GEPF
FRG
MMI HL
DHL
28.2%
42.0%
30.3%
15.0%
15.0%
33.9%
13.5%
8.0%
10.4%
8.6%
25.2%
25.8%
Ordinary shares of unknown proportion
Majority shareholder
MM-Health
MMI-G/risk
MetrP-Health
MMI-CareC
MMI-Wellness
D-Health
D-Insure (ST)
D-Life (LT)
D-Life CI
D-Vitality


AfroCentric Investment Corporation
71.3%
Sanlam Wealthsmiths
28.7%
AfroCentric Health Assets
Formerly Lethimvula
94.1%
100.0%
100.0%
28.0%
AfroCentric Health
Pharmacy Direct
Curasana Wholesaler
Activo Health
Pharmacy dispensing
Pharmacy and medical products wholesaler
Sells medical products to pharmacies
100.0%
Medscheme
Bonitas marketing
Aid for Aids
Helios IT solutions
Dedicated broker arm for Bonitas open scheme administered by Medscheme
Bonitas Marketing was previously owned by Bonitas and sold to Mescheme following regulatory action by the CMS

Recommendations

- Proposals take the form of a package and partial implementation not supported
  - Risk adjustment mechanism on basic benefits
  - Basic and supplementary benefits – to achieve easy to understand standardised benefits
  - Reinsurance (social) for start-up schemes
  - Efficiency discounts
  - Contribution subsidy – for income subsidy (converted from tax credit)

- Brokers
  - Opt-in system (annual)
  - Explicit contracts with members
  - Members free to choose their broker
  - Only pay if a broker is chosen
  - Tied brokers earn less
  - Schemes must be able to deal directly with members if members so choose – without an additional fee

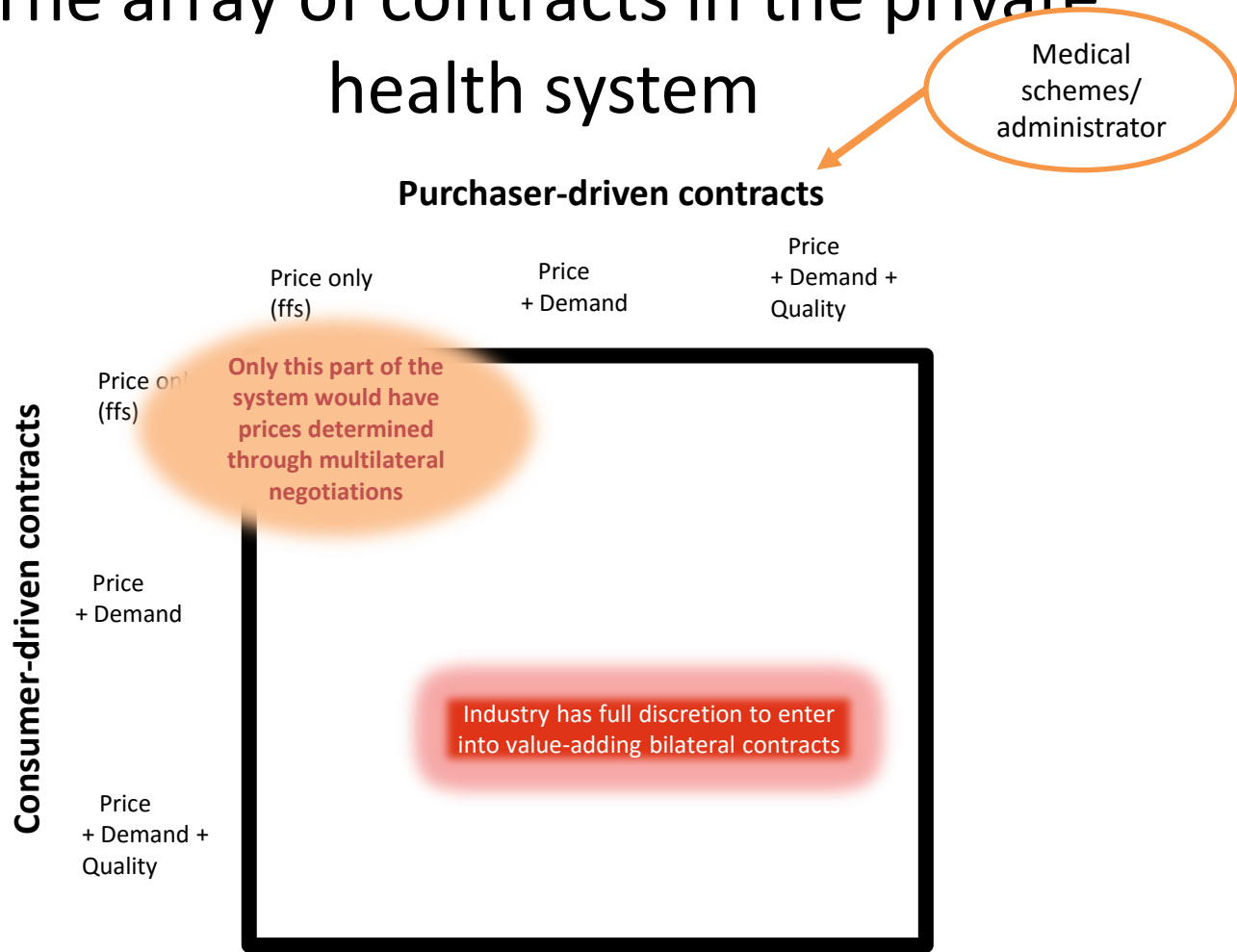
Supply side regulator for healthcare (SSRH)

- Supply side regulator for healthcare (SSRH)
  - Licensing unit
  - Economic value assessment unit
  - Health services monitoring unit
  - Health services pricing unit

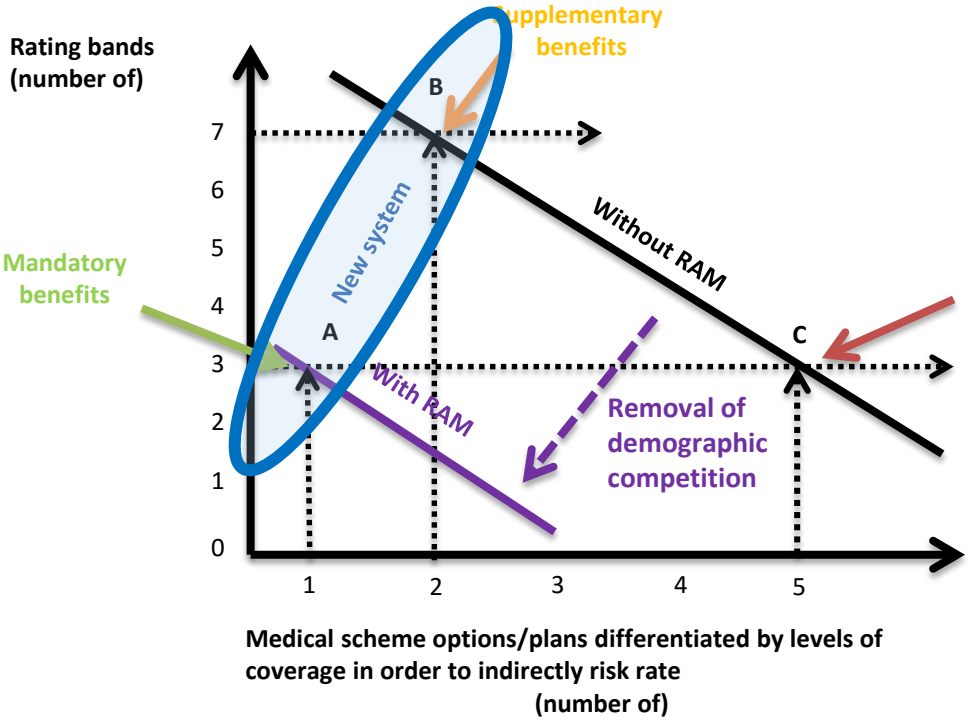
- Outcomes measurement and reporting
  - Outcomes Measurement and Reporting Organisation (OMRO)
  - To be functional within 6 years
  - OMRO must be **strictly independent from government**

- Tariff setting – for fee-for-service tariffs
  - Regulated prices with meaningful consultation
  - Multilateral negotiations
  - (Coding systems public domain and determined by the SSR)
- Bilateral negotiations (non-ffs)

The array of contracts in the private health system



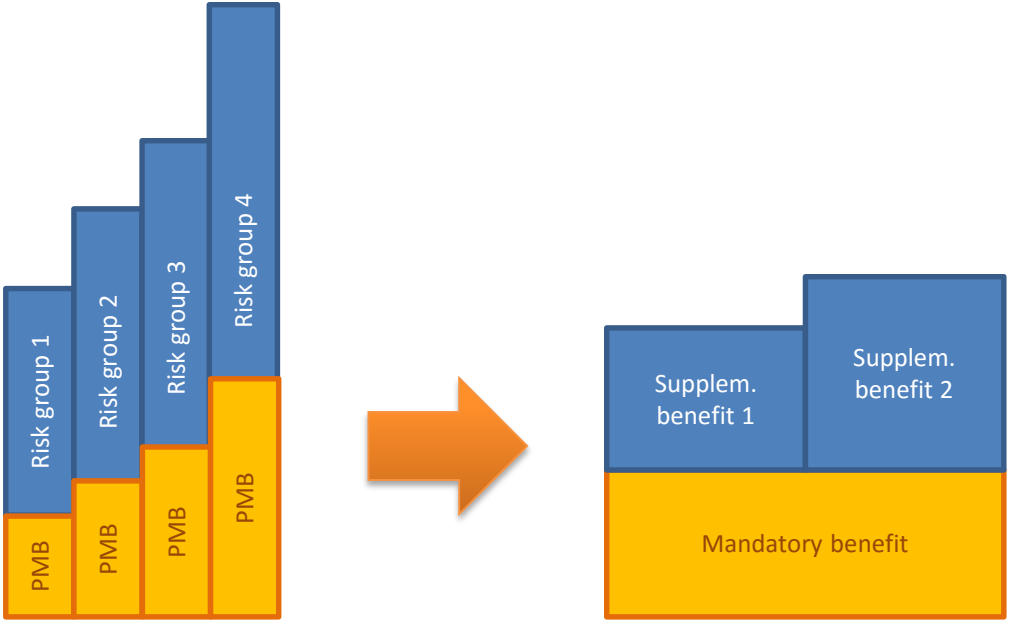
Impact of the Risk Adjustment Mechanism



Current system, with proliferation of options at varying levels of coverage

A, B, and C reflect stable "equilibrium" points that fully accommodate for risk differentials between schemes

Change in organisation of medical schemes benefits – heightening productive competition



Non-transparent (current)

Transparent (with revised regulatory framework)

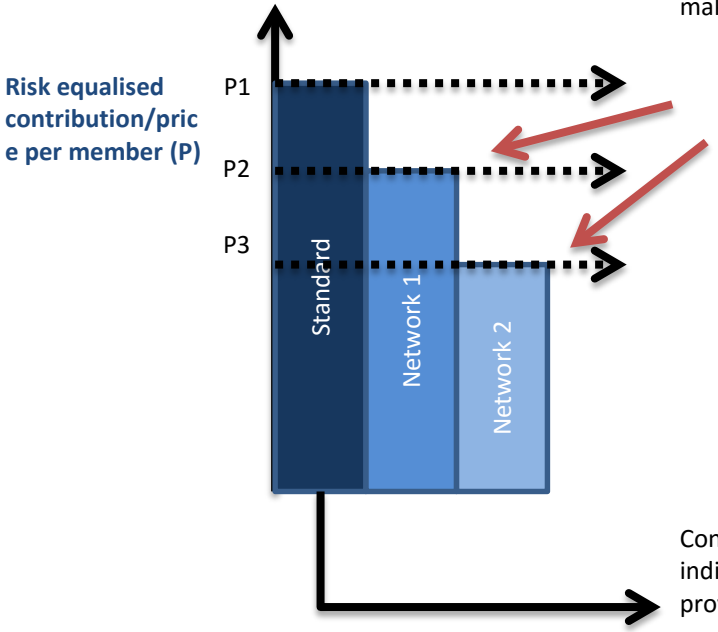
A complete framework – not in recommendations

Mandatory reinsurance – system pooling – increasing opportunities for market entry of small insurers without sacrificing opportunities for purchasing at scale

- **Mandatory reinsurance**
  - **Retrospective reimbursement for relevant catastrophic claims up to a fixed value, where incidence for a diagnostic category exceeds what is predicted by the REF**

Mandatory package – can be differentiated based on efficiencies, with cost savings available to consumers (in MSAB not HMI)

Medical scheme chooses the providers – but information on provider quality must be made explicit (i.e. scheme must make value-based choices to attract membership)



Competition generated between networks, network arrangements and free consumer choice)

Consumers choose providers based on transparent indicators of value (cost and quality) (providers can provide cash rebates/discounts to attract consumers

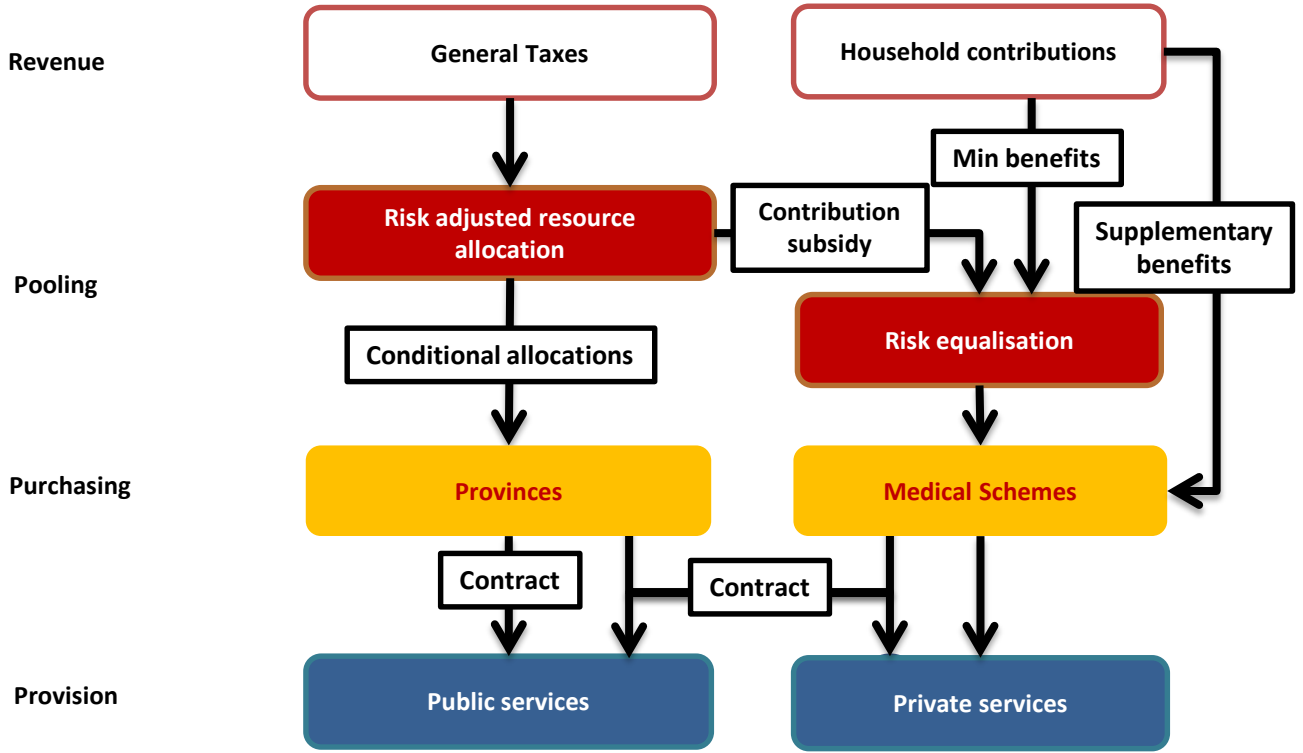
Strategic way forward?

Although the currently proposed NHI is a notional option, it cannot achieve any meaningful health systems objectives in the foreseeable future

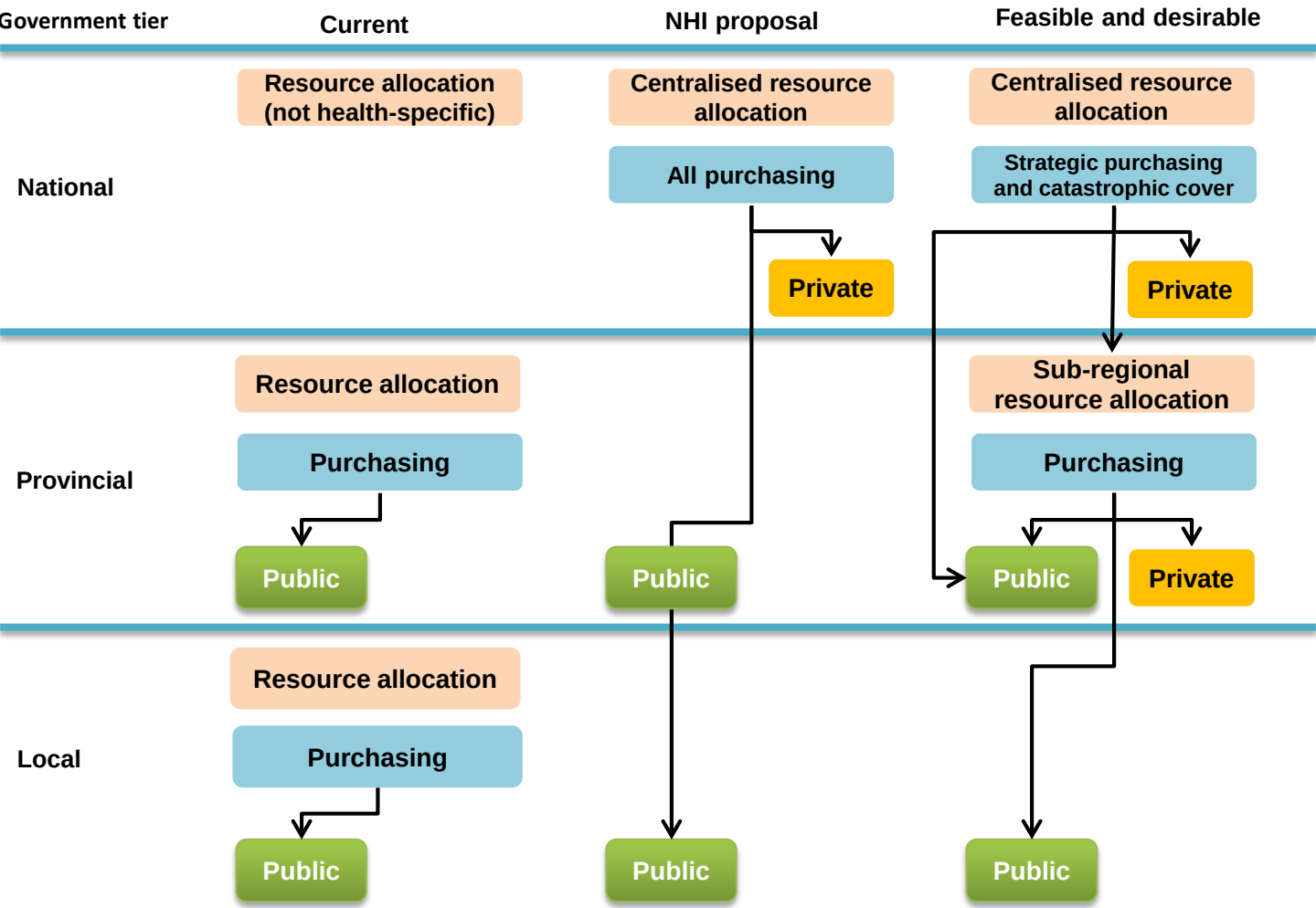
For arguments sake lets say there are two options

- Option 1 – the NHI as proposed model for universal health coverage
  - Consolidates and centralises the pooling (vertical and horizontal) and purchasing/procurement for the basic package of services for the entire population (does not address structural failures of the public and private systems; centralises functions that should be decentralised; fails to address governance framework)
- Option 2 – the hybrid NHI model for universal health coverage
  - Strategic pooling at the national level
  - Decentralised purchasing through
    - Provinces – but with enhanced governance
    - Medical schemes – as proposed by the Health Market Inquiry
  - Structural reforms targeted at systems weaknesses (governance for decentralisation in the public sector; in the private sector removal of competition on unproductive market features + enhanced competition on productive market features)

Option 2 – NHI designed on uniformity of the subsidy regime



Public health system architecture



Discussion

Medical schemes amendment bill

This is provided as additional material as it is too long for the talk. It can be referred to if questions arise. In large part the Health Market Inquiry supersedes what is contained in the disjointed MSAB. It is however noteworthy that the Minister's briefing was at odds with the actual content of the MSAB – raising serious questions about the quality of the policy process

Medical Schemes Amendment Bill – what the Minister said

- **"The first amendment is to abolish what has come to be known as co-payments…"**
  - Furthermore, the data at our disposal shows that medical schemes are holding reserves of close to R60 billion that are not being used.
  - Granted, there is a statutory requirement that medical schemes should have 25% of their income in reserve. This is to cater for emergencies. But presently the R60 billion is equivalent to 33% reserves, which means unnecessary accumulation at the expense of patients.
  - These huge reserves were accumulated partly through high premiums but also by introducing the co-payments such that medical schemes avoid having to pay or even dip into the reserves if the situation demands.
  - Furthermore the Council for Medical Schemes (CMS) is busy reviewing this statutory requirement of 25% with a view to releasing enough money for patients rather than holding a lot of reserves while patients suffer the hardships.

- The MOH fails to understand the nature of a reserve relative to a current liability – such as a benefit payment

- **“The second amendment is to abolish the practice of using brokers within the medical scheme environment”**
  - “*We are aware that most of the work supposedly done by brokers is actually done by the Council for Medical Schemes - the statutory body*.” (MOH)
  - “*We believe that brokers play an important role in advising members but that their interests should be aligned more closely to those of applicants/members*.” (HMI)

- Brokers are not abolished in the MSAB!

- **“The third amendment is to abolish the practice of Prescribed Minimum Benefits (PMBs) and replace it with comprehensive service benefits.”**
  - “To address the lack of comparability across scheme options and inability of consumers to compare the value of these options, the HMI proposes that a standardised benefit package be developed that must be offered by all schemes (the obligatory ‘base benefit option’).” (HMI)

- **“The fourth amendment deals with the various unequal and even unfair benefit options which medical schemes are subjecting their members to.”**
  - “The amendment prevents any medical scheme from implementing any benefit option unless approved by the Registrar of the Council for Medical Schemes and in doing this the Registrar will have to determine first that such an option is in the best interest of the member.”

- This is already in the MSA – via the approval of amendments to rules in section 31(1)(a) and (b)

- **“The fifth amendment is to declare the carrying on of the business of a medical scheme by a person not registered as a medical scheme to be a specific offence.”**

- This is already in the Medical Schemes Act

- **“The sixth amendment is the creation of a central beneficiary and provider registry and the management thereof by the Registrar of the Council for Medical Schemes.”**
  - Was provided for in the MSAB of 2008 which was allowed to lapse because it related to the REF
  - “Risk adjustment would be of little use if it is not applied to a standard basket of benefits. In the absence of a standard package, it would be impossible to measure the risk across schemes fairly. Therefore, as indicated above, the HMI proposes that a risk adjustment mechanism be implemented for the base benefit package to be offered by all schemes.” (HMI)

- "The seventh amendment is to introduce income cross-subsidisation model"
  - "*The essence of NHI which must start now even with the present medical aid schemes is that the rich must subsidise the poor, the young must subsidise the old and the healthy must subsidise the sick. The present contribution table charges the same rate for a lower income earner and a high income earner for the same benefits. This practice completely negates the principles of income cross-subsidisation*." (MOH)
  - "*To address the needs of low-income scheme members, it is recommended that the current tax credit regime be reconstituted to take the form of a contribution subsidy administered through the RAM rather than though the South African Revenue Services. In this way the RAM would be able to integrate both a risk and income adjusted subsidy in a manner consistent with similar arrangements around the world." (HMI)*

- *Income cross-subsides can only be introduced through government subsidies. There is no way that open medical schemes can assess incomes as a basis differentiating contributions*

DOH consultation report of 2002

- *"Income-based cross-subsidies are generally achieved through the tax system, or mandating insurance in a manner that closely follows normal tax principles. In essence people pay according to their means, but receive benefits according to their needs. The following instruments are important within the South African context:*
  - *The level of general tax funding for public services;*
  - *Subsidies to the private sector (tax subsidies versus on-balance sheet per capita subsidies);*
  - *Contributions to medical schemes (flat-rate versus income-based); and*
  - *Mandating contributions to either social health insurance or medical schemes.*
- ***The redesign of the income tax subsidy represents the only viable short- to medium-term measure for achieving minimum required income-based cross-subsidies across the entire health system, both public and private."***

- The eighth amendment is to compel medical aid schemes to pass back savings if a member uses a designated service provider according to the rules of the scheme.
  - Presently medical aid schemes compel members to use designated service providers in order to save money.
  - This is a good practice to be encouraged but however the problem is that these savings are taken over by the scheme or the administrator instead of being passed on to the member in the form of premium reduction.

- I can't find this in the MSAB

- **“The ninth amendment deals with the cancellation of membership and waiting periods between joining a scheme and accessing benefits.”**
  - “This is because under NHI there will be no penalty related to late joining or age. This is further to protect the interest of living spouses after the passing of the principal member or after retirement prior to payment of their benefits.” (MOH)
  - Waiting periods are retained in the MSAB – although some provisions are not clear
  - The HMI retains waiting periods and looks for additional measures to attract membership for adults under the age of 30

- “The tenth amendment is Governance of medical schemes.”
  - “This amendment for minimum educational requirement and expertise to be a member of a Board of Trustees or a CEO of a Medical Aid Scheme.”

- Ahem… The MSAB goes far further than this

- Provides for minimum and maximum board size (no smaller than 5 and no more than 10)
- Fit and proper requirements
- Requirement for a scheme CEO
- The CEO is allocated specific responsibilities in terms of the Act (but no requirement for a CFO ?)
- Establish parameters for BOT remuneration
- Removal of a CEO by the BOT – including appropriate disclosure to the Registrar
- Ability to publish norms for good governance (as guidance)

Not mentioned by the Minister

Section 34 of the principal Act is hereby amended by the addition of the following subsection:

"(3) The registrar may, after consultation with the Minister, restrict the extent of benefits offered by medical schemes, having regards to the benefit and services coverage under the Fund thereby eliminating duplicative costs for the same benefit."