

REFORMING FINANCING OF PRIVATE HEALTH CARE IN SOUTH AFRICA: THE QUEST FOR GREATER ACCESS AND EFFICIENCY

A DRAFT POLICY DOCUMENT

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DEPARTMENT OF HEALTH



FOREWORD

In my budget speech during April 1997, I signalled the Ministry's intentions to seek measures that will improve the affordability of, and access to private health care through medical schemes. I announced at the time that an important element of these reforms would be to reinforce the requirement of community rating within medical schemes. The core of a community rated system that I proposed was that people should not be discriminated against in obtaining medical schemes cover on the basis of their health risk.

A great deal of policy work has been done since then, and this document gives effect to those objectives. The document builds on many of the policy frameworks contained in the report entitled ***Restructuring the National Health System For Universal Primary Health Care*** issued by the Ministry during April 1996. The current proposals have benefited greatly from discussions with a wide range of people and organisations, including the Council for Medical Schemes and its chairperson, the Honourable Mr Justice D.A. Melamet; Representative Association of Medical Schemes; Concerned Medical Schemes Group; Life Offices Association; Financial Services Board; South African Institute of Chartered Accountants; a number of medical schemes and administrators; Medical Association of South Africa, South African Medical and Dental Practitioners; Congress of South African Trade Unions; National Congress of Trade Unions; National Progressive Primary Health Care Network and many other organisations that are represented on the National Consultative Health Forum. These consultations have achieved a substantial consensus on the way forward, and I am very grateful for the quality of these discussions. There are nonetheless areas where consensus has been elusive. The Department hopes to continue discussions on any of the unresolved issues. However, the Department will also be proceeding speedily towards making changes to the ***Medical Schemes Act (No: 72 of 1967)*** to reflect the new policy imperatives.

Dr. NC Dlamini-Zuma, Minister of Health



1. THE CASE FOR CHANGE

Private sources of funding account for nearly 62% of total health expenditure in South Africa, and provides care for 23% of the population on a regular basis. Medical schemes are the principal financial intermediaries in the private sector, accounting for almost two-third of total private spending on health services. The private health sector is therefore a significant part of the national health system: it plays an essential complementary role to the public health system. However, the private health sector faces a number of acute problems and challenges to its long term sustainability.

Costs in the private sector, particularly those within medical schemes, have increased more rapidly than the rate of inflation, and make up an ever increasing proportion of the average salary. In 1980 the average contribution was approximately 7% of average salary. By 1996 contributions had spiralled to 17,3%. Due to this escalation many people can no longer afford adequate medical aid cover. As a result many of these people have to rely on the public health sector for health care without paying for these services through medical schemes.

The proliferation of non-indemnity medical insurance has led to substantial 'cream-skimming', and many young and healthy members have opted out of traditional medical aid schemes, preferring only to obtain catastrophic health care cover. Thus risk pools of medical schemes have been systematically denuded of the young and healthy members. The impact has been to reduce or eliminate cross-subsidisation within medical schemes. To avert possible collapse, schemes are forced to charge even higher premiums to those who remain (especially the old and sickly) at the time when they can hardly afford it. Most of these people inevitably fall back onto the public sector.

The increasing tendency within medical aid schemes to take into account individual risk profile (age, gender, claims pattern, health status) rather than that of the group in which the person belongs deprives cover to many who would otherwise qualify. This occurs through high premiums and largely unaffordable benefit options that some groups face because they are sick and/or old.

Many medical schemes have varying benefit packages, some of which provide inadequate cover. Many people with these unrealistically low options exhaust their medical aid cover very quickly and are transferred to public hospitals, a 'dumping phenomenon' that is becoming increasingly common. Demand pressure is consequently increasing on the public hospital system at the time when there is not adequate capacity to provide services to additional people.

Some schemes have introduced individualised medical savings plans. These plans might encourage people to opt out of insurance type medical schemes, thus threatening cross subsidisation. In addition such savings accounts can create perverse incentives that discourage use of preventive health care. They can also create opportunities for tax avoidance. Lastly, low income persons and those who left employment frequently may be grossly underfunded under a savings accounts regime, as they would be able to save less and to meet fewer of their health care needs.

Other challenges within medical schemes relate to inappropriate governance systems and inadequate financial administration of funds of schemes.

Management committees of many medical schemes often lack adequate and sufficiently skilled member representation. In many cases the interests of members and those of intermediaries of medical schemes are not properly aligned. This results in potential conflict of interest. In addition, there are few incentives to manage the funds of medical schemes in a judicious manner the current environment.

Principal Officers of many medical schemes (who usually take most decisions on the day-to-day running of schemes) are often employees of administration companies. There is therefore the potential that not all their decisions will be in the interest of schemes, especially within the context of weak member representation on management committees.

Proper supervision and oversight of medical schemes are hampered by inadequate provision of reports to the Office of the Registrar of Medical Schemes and lack of adequate capacity in the Office of the Registrar.

Lack of adequate reserve requirement on medical schemes prejudices the solvency of many medical schemes.

Many medical schemes are too small. When few people subscribe to a medical aid scheme, the benefits of economies of scale are lost. It also becomes difficult to spread the risk of illness across a larger risk pool.

There have been a number of cases of fraud reported to the Council for Medical Schemes during the last few years. Such fraudulent behaviour is a major concern and contributes to escalating costs because for every claim made for a non-health benefit or for a non-member or his/her dependent benefit, contributions have to increase to ensure that there are sufficient funds to pay for legitimate health care benefits.

PROPOSED SOLUTIONS

Many of the proposals made here are set against the Department's more general policies for the health system as a whole. These include attempts to maximise the effectiveness of the health system in the delivery of services; improve equity in the financing and delivering of health care; and promote greater efficiency in the use of resources. The next sections outline the policy proposals aimed at curbing spiralling costs and consequent unaffordability of medical schemes as well the problems of inappropriate governance and administrative systems.

1. Reinforce a community rated medical schemes' environment

The Department considers that community rating will ensure that cross-subsidisation takes root in medical schemes. Community rating will contribute towards equalising contributions for high and low risk members and will promote greater equity. Although this may involve slightly higher contributions for current younger and healthy members, international and local evidence suggest that overall system costs diminish in a risk-pooled environment (refs). The most important characteristics of the community rated system proposed by the Department would be:

Box 1: Proposed community rating system within the South African private health care system

- Avoidance of the individual's age, gender, claims patterns, experience and health risk when determining contributions;
- Residual ability to use members' incomes and/or number of dependants for determination of contribution rates.
- Membership of the scheme will define the "community" for the purposes of determining contributions.
- Anybody must be able to enter a medical scheme if they can afford to pay the average contribution, regardless of their health condition. In this regard open schemes will be required to accept all applicants while employer based schemes may accept any applicant. This provision will be subject to protections against adverse selection detailed in Box 2 below.
- Anybody must be able to stay in a medical scheme, regardless of their health condition.

The Department regards the equity and efficiency arguments for a community rated medical schemes environment as strong. System costs will decrease. In addition, the tendency to exclude high risk groups from coverage will be minimised. In this system medical schemes will rate the **community of members** it covers rather than the **individual**. The consequences of this change from risk-rating will be to protect greater cross-subsidization from the healthy to the sickly.

The Department received some submissions that argued for a system of "community rating by class" where contribution rates are based on plan type, geographic area, number of dependants and **age and sex** on entry to schemes. It has also been proposed that schemes should not be obliged to accept all applicants. This view has argued that community rating, coupled with the voluntary nature of the medical schemes market, could result in some lower risk deferring membership until they are sick. The Department has also noted the view that age rating on entry makes late subscription to a medical scheme a poor strategy. While proponents of age rating on entry concede that many elderly and sickly persons would largely be excluded from private cover under this system, they have further proposed that a separate, high risk pool be created for those who have been declined cover by traditional medical schemes.

It is the Department's view, nonetheless, that age rating would have more drawbacks than it purports to resolve:

Age rating on entry fails to resolve the problem of access for the elderly and people with higher probabilities of requiring expensive care through no fault of their own. A medical scheme operates through the use of cross-subsidisation from the healthy to the sickly. People generally do not know when they are going to need medical care. This applies irrespective of age, sex or income. When medical need occurs, these costs could, and very often do, result in an effective barrier to access to health care. Community rating as suggested by the Department consequently allows everyone, especially the sickly and elderly, and those in whom a costly episode of illness is indicated, to pay at the average cost of utilisation in any year, lowering the cost of access to health care.

The annual increases in medical costs experienced within the private health care environment is a major problem with which all third-party payers will have to come to grips over the next few years. However, a temptation that exists amongst many schemes is to offer lower premiums through allowing only low risk members to join. Although this practice is potentially profitable to some, the problem of what to do with the people who are progressively excluded from cover is left for the Government to resolve. Given that the government provides a tax deduction of approximately R5 billion to the private sector to cover these groups, it is inappropriate that such support persists while cost shifting to public hospitals continues to occur. The Department does not believe that the notion of a high risk pool for the old and the uninsurable, as proposed by some respondents, provides an effective solution.

The Department believes that underwriting on entry is inappropriate for people who have previously been members of another registered medical scheme. People who periodically left medical schemes (eg. due to unemployment, self-employment, employment in other countries, etc.) could only return to medical

schemes at a new age rated premium. Such people would forfeit their accumulated contributions, and this will lead to perceptions of greater inequity.

The Department accepts that adverse selection can potentially result from open enrolment, especially in cases where people join schemes late in life or for a limited period and only to obtain benefits. Such opportunistic behaviour can also result in inequitable transfer from long term scheme members to those only joining late in life. There may therefore be efficiency and equity arguments for some form of anti-selection mechanisms for person joining for the first time only late in life. The Department considers that such protections should be based on a system of lifetime community rating underpinned by a gradual increases in waiting periods to deter late and 'strategic' entry into a medical scheme. Such an approach is preferred internationally as the one that provides incentives for people to join health insurance schemes while still young and healthy and that also protects equity. A system of waiting periods may well be the most effective interim way of containing the worst aspects of adverse selection, while ensuring the equity goals of the government.

The Department therefore proposes that various protections be created by limiting certain aspects of open enrolment, and that open enrolment be conditional upon the following:

Box 2: Proposed protections against adverse selection for registered medical schemes

An applicant must have been a member of another medical scheme immediately prior to applying;

Where a current member of a scheme wishes to change to another scheme, such transfer should not be prevented on the basis of any pre-existing condition(s).

If a person was not a principal or dependent member of a medical scheme immediately prior to applying for membership of another scheme, then the scheme would be permitted to limit that individual's access through a system of waiting periods. A maximum of 12 months waiting period can be imposed in this regard, with an option of waiving all or a part of the waiting period in return for paying contributions, at average rate.

Medical schemes may not deny coverage or impose pre-existing condition exclusions for more than 12 months for any condition diagnosed or treated at any time during the six months preceding the member's application. No pre-existing condition exclusions may be imposed on anyone who had continuously been a member of another medical scheme prior to applying to join a new scheme.

Waiting periods cannot exceed nine months in case of confinement for maternity; and

Three months in any other circumstances.

2. Effect proper demarcation between business of medical schemes and 'commercial' medical insurance

Costs of access to medical schemes have also gone up because risk rated, non-indemnity insurance products have been able to "cherry-pick" and attract the younger and generally healthy members out of schemes, leaving the sickly and elderly behind. Many medical schemes have therefore been forced to either increase their contribution rates or adopt similar strategic behaviour and discriminate between the classes of risk. The result has been that many high risk individuals have either lost cover or faced prohibitive costs. Many expert opinions have argued that such strategic "cream-skimming" can only be effectively attenuated through regulation of all health insurance business in a consistent manner within the ambit of a single Act. It has been argued that such consistent regulation will 'level the playing fields' between medical schemes and commercial health insurance, and that it will lead to the stabilisation of medical schemes' risk pools. There has, nonetheless been some resistance to the notion of making all health product register under a single Act in some submissions.

The debate on a single Act for all health cover is complex. Such an Act would require that various classes of health business and schemes be defined; different registration, reporting and solvency requirements be defined for each class of business; distinctions be made between for profit and non for profit status; and the tax exemption status of separate schemes be defined. While the Department remains firmly committed to the ultimate consolidation of all Acts governing private health care financing, this issue cannot be resolved in the short term.

The Department therefore proposes that the integrity of the community rated medical schemes environment be protected through proper **demarcation of the dividing line between medical schemes and commercial medical insurance policies** as defined within the proposed insurance bills. Such demarcation should be effected through a redefinition of "business of a medical scheme" within the Medical Schemes Act. Any person who operates any entity with the object of a medical scheme should be required to comply with the Act.

2.1 Proposed definition of a medical scheme

2.1(a) Current definition

A medical scheme is presently defined in the following way:

"**medical scheme**" means a scheme established with the object of making provision for -

- a. the obtaining, by members thereof and by dependants of such members, of any service;

- b. the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
- c. the rendering of a service to members thereof or to dependants of such members, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme.

A "**member**" in relation to a scheme, means a person who has been enrolled or admitted as and is still a member of the scheme, or who in terms of the rules of the scheme is a member of the scheme. "**Service**", on the other hand, means any health care treatment of any person, by a person registered in terms of any law, which treatment has as its object-

- a. the physical or mental examination of that person;
- b. the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- c. the giving of advice in relation to any such defect, illness or deficiency;
- d. the giving of advice in relation to or treatment of any condition arising out of a pregnancy;
- e. the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy;
- f. nursing or midwifery - and includes the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, provided such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy.

2.1(b) Proposed changes

It is proposed that the following change be made:

"medical scheme" means any organisation, institution, fund, plan, arrangement, agreement or insurance policy established with the object of enrolling members and making provision for:

- a. the obtaining, by members thereof and by dependants of such members, of any service;
- b. the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
- c. the rendering of a service to members thereof or to dependants of such members, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme;

It is further proposed that the term "**service**" be altered to "**health care service**" with the current definition of "service" applied to "health care service". The intention is to make clear the nature of services covered. In addition, it is proposed that forms of health cover such as Benefit Funds, Friendly Societies, Exempted Schemes, and other schemes that engage in the business of a medical scheme should also be required to register in terms of the Medical Schemes Act.

The intention of these alterations is to ensure that all forms of health cover **which have the object of a medical scheme** are registerable in terms of the Act. This will ensure the establishment and maintenance of viable risk pools. It will also secure proper community rating and cross-subsidisation, where the healthy and the young help to subsidise the sickly and the elderly. The changes will further afford the public adequate protection against schemes that currently do not have to report to the registrar.

3. Individualised Medical Savings Accounts

The Department supports a phasing out of individualised medical savings accounts due to the reasons outlined earlier. While the Department has taken note of assertions that savings accounts have managed to reduce the rate of medical costs increases, we remain unconvinced about the value of savings accounts in containing costs in the long run. Medical costs will begin to decline in a meaningful manner only through adoption of alternative delivery systems and payment mechanisms that can contain both unit costs and number of episodes of care. However, the Department is willing to consider the continued interim existence of savings schemes under the following conditions:

Box 3: Proposed regulation of medical savings accounts within medical schemes

- Only a maximum of 15% of annual contribution income can accumulate into an individualised savings account; the remaining 85% should be paid into a pooled fund;
- All services in the proposed prescribed minimum benefits package should form part of the pooled, community rated portion of the fund;
- Where withdrawal of benefits occurs, these should be subject to a final withholding tax, as proposed by the Katz Commission.

4. Prescribed minimum benefits

The Department considers that a prescribed set of minimum benefits should apply to all registered medical schemes to ensure that members of schemes have adequate coverage and that "dumping" onto the public health sector is minimised. There has been support for the notion of a prescribed minimum benefits from many submissions received by the Department. Many have considered that such prescribed minimum benefits are the best way of ensuring

access to appropriate level of service to the population covered. Opposition to the concept of prescribed minimum benefits has been based on concerns that such a minimum will make schemes unaffordable and would therefore inhibit growth of private sector coverage.

Many of these concerns appear to be based on a misguided interpretation of the Department's proposal. The recommendation on prescribed minimum benefits, coupled with the non-cancellability of membership, aims to protect essential cover and to prevent dumping of seriously ill patients onto public hospitals, which are already overburdened with care. Currently, many low cost medical schemes have very low limits for hospital care, requiring that for many serious illnesses, patients plead indigence at public hospitals. The proposed reforms would ensure that medical schemes continue to pay for care, as long as it is part of the prescribed benefits, at least at the public hospital level.

There has been some confusion about whether or not the reforms propose a role for the registrar of medical schemes in setting and/or negotiating fees. No such role is envisaged. The Department believes that prices should be negotiated between schemes and providers. Fixing prices would significantly inhibit the potential for managed care interventions, as well as stifle innovative provider arrangements, as was the case with the pre-1989 Medical Schemes Act. It is the benefits themselves that would be mandatory, not the price that is paid for them. In addition, it should be noted that the department proposes that where schemes do not provide the specified minimum benefits, then such schemes will have to reinsure or forward fund the expected public hospital utilisation by their members. The choice of whether to provide prescribed minimum benefits or to reinsure will be left entirely in the hands of medical schemes.

The Department proposes to convene a technical working group to review the key decisions on the definition of prescribed minimum benefits. The working group will include clinicians in the public and private sectors, medical schemes experts, academics, Council for Medical Schemes and members of the Department. The groups will review a number of ways of defining prescribed minimum benefits, including health condition-treatment pairs that have been used elsewhere; cost based caps; exclusion of some interventions, especially non-emergency ones; etc. Choice of an appropriate approach will be guided by considerations such as the extent to which the approach encourages cost-effective allocation to competing interventions, prioritising necessary over discretionary care and ensuring that cost shifting onto public hospitals is minimised. Once agreed, these benefits will be promulgated in regulation. The Registrar and Council for Medical Schemes will be responsible for making adjustments to such prescribed benefits when necessary.

5. Additional benefits

As pointed out above, medical schemes will be expected to provide a prescribed minimum set of benefits, which should be fully funded. However, it is clear that most schemes will be providing more than the prescribed minimum benefits. The Department considers that the question of co-payment for such ancillary benefits is different from that of prescribed benefits as demand for such services is largely predictable and discretionary. Co-payments for such services would not therefore have adverse equity implications.

6. Multiple benefit options within schemes

Many medical schemes currently offer a differentiated set of benefits and a system of 'options' within one scheme. Such a system is predicated on the basis that it allows a medical scheme to develop niche products that some members may prefer. This has led to a number of problems, however, including lack of member information about the risks of choosing a particular benefit option; inadequate funding and oversight over many benefit options; and, within the context of a community rated environment, the tension between proliferation of benefit options and minimising cream skimming.

Though the Department is not in favour of such proliferation of options, we have nonetheless accepted the view that a flexible approach to options be adopted so as to minimise undue disruption in the industry and to offer more choice. The Department therefore proposes that any option would have to meet the following requirements:

Box 4: Proposed regulation of options within medical schemes

- All options will have to include at least the prescribed minimum benefits.
- Each option will have to be self-funding. No cross-subsidisation will be allowed between options.
- Each option will have to maintain a minimum membership requirement of 2,500. In addition, the Registrar will also be entitled to call for sufficient financial guarantees for each option.
- Options that are created for the sole purpose of hosting defined groups on an exclusive basis may not be registered.
- Movement between options will only be effected with the express permission of the Registrar.

7. Tax deductibility of contributions to registered medical schemes

The Department considers the tax subsidy on contributions to registered medical schemes as an important incentive for persons who can afford to pay for their own care to do so. However, it needs to be considered whether the crude application of the tax deduction, as at present, has unintended indirect consequences for the system as a whole and equity. With this in mind, the Department is of the view that the tax deduction should be applied exclusively where its application best serves the interests of broader health policy and the

community in general. Consequently, the Department recommends that only health cover registered under the Medical Schemes Act should continue to obtain a tax deduction on contributions. Such tax deductibility should also be extended to self-employed persons.

The Katz Commission recommendationSixth Interim Report of the Commission of Inquiry into aspects of the Tax Structure of South Africa, July 1997.Sixth Interim Report of the Commission of Inquiry into aspects of the Tax Structure of South Africa, July 1997. that would extend the tax subsidy to risk rated non indemnity medical insurance registered under the Insurance Act is therefore not supported by the Department, given the possibility of substantial cream skimming and adverse selection against medical schemes. Assertions have been made in some submissions that differential tax treatment generates distortions. However, such assertions have been challenged in many areas, including differential application of tax in the case of many parastatals and charitable organisations. In any case any distortions are likely to be too small to warrant changes that accommodate products that are simply age and risk rated and discriminate against the elderly and the chronically ill.

The Department also agrees with the recommendation that benefit funds established under paragraph (c) of the Income Tax Act should be required to migrate to the medical schemes environment (or insurance environment as appropriate). We further suggest that the Income Tax Act be amended by the deletion of paragraph (c) within a year.

8. Prefunding within medical schemes

The Department places significant emphasis on reinforcing the community rated medical schemes environment. Within this context there are a number of concerns with regard to prefunding, including diminished risk pooling due to the individualisation of accumulating funds and inevitable discrimination of high risks within this environment. The Katz Commission has recommended that existing retirement vehicles are appropriate vehicles for the pre-funding of post-retirement medical scheme contributions, a position that the Department supports.

9. Continuation membership

The Department supports the right to continuation membership (widows, widowers, and pensioners) under the Medical Schemes Act, and the current provisions will continue.

10. Cancellability of membership

It is the view of the Department that membership of schemes should continue to be non-cancellable in accordance with the rules of schemes. In proven cases of

serious transgressions (e.g. fraud) provisions in the Act with regard to disputes should be invoked before schemes can cancel membership.

11. Minimum membership requirement

Council for Medical Schemes has recommended that a scheme should have at least 2,500 principal members for it to be registered. In addition, it was recommended that the Registrar be granted the power to de-register a scheme which cannot meet these requirements. The Department supports these recommendations, except insofar as it regards the recommended minimum of 2,500 as too low to deal with problems of "fly by night" schemes and to effect adequate risk pools and would like to see this increased to 6,000 principal members. These recommendations would apply only in the case of new schemes. Any exemptions to this provision will be decided by the Council on a case by case basis, taking into account guarantees provided by scheme and its likely reserve position.

12. Governance in relation to medical schemes

12.1 General

Governance structures of many medical schemes in South Africa lack adequate member representation. For most members the decision-making processes of schemes appear remote and unresponsive. In many cases there are no proper incentives and mechanisms to monitor the affairs of schemes. Many of the current governance structures are thus characterised by lack of accountability and transparency, as well as a potential for conflicts of interest.

The Department supports the recommendations from the Council for Medical Schemes and the Registrar that the Act should be changed to make provision for appointment of a Board of Trustees consisting of member trustees and a principal executive officer. The Board will be expected to take all reasonable steps to ensure that the interests of members are protected at all times. It will also act with due care, diligence, good faith and with impartiality in respect of all members and beneficiaries.

The duties of the board shall be to -

- appoint a public principal officer;
- ensure that proper registers, books, minutes, resolutions and records of operations of the scheme are kept;
- ensure that proper control systems are employed by or on behalf of the scheme in respect of benefits, contributions paid, and other income due to the scheme;
- ensure that adequate and appropriate information on members' contributions, benefits, rights and duties in terms of the rules of the scheme is communicated

- to them;
- take all reasonable steps to ensure that contributions are paid timeously to the scheme in accordance with the Act;
- obtain expert advice on matters where board members may lack sufficient expertise; and
- ensure that the rules, operation and administration of the scheme comply with this Act and all other applicable laws.

The Department also support the proposition that certain recommendations of the **King Committee Report on Corporate Governance** should apply to Trustees. In particular, it is considered that Trustees should be subject to a "fit and proper" test as is the case in terms of **Section 28** of the **Insurance Act of 1943**. In terms of this, individuals who are proposing to become Directors or Chief Executive Officers of an insurance company, are required to fill out a personal questionnaire. This questionnaire would serve as the model for persons seeking to be appointed as Trustees of a medical scheme.

With due regard to the **King Committee Report** the Department proposes that the current Principal Officer's Report to schemes' members should be replaced with a Trustees' Report and that this report should emanate from the Chairperson of the Board of Trustees. Such Trustees' Report shall deal with all matters that impact in a meaningful manner on the affairs of the scheme and the results thereof. The report should also relevant information indicating whether or not the resources of the scheme have been used in an efficient manner. A Principal Officer would function as mandated by the Trustees, and may not exercise a vote on the Board. The Department would have preferred that the Principal Officer not be an employee of an administrator. However, we have accepted the view that the choice of Principal Officer be left to the trustees of a scheme and that they may appoint an independent person if they so wish.

12.2 Auditing requirements

The Department supports the recommendations of Council that current reporting requirements must be changed to provide for more regular and more meaningful reporting. It is proposed therefore that whilst the requirement for an annual audit stands, provision should be made for all schemes to file to the registrar interim (albeit unaudited) reports every six months in the same format as would be adopted in their annual returns. Particular emphasis should be paid to provisions for outstanding or unintimated claims, and these should be calculated in a standard and consistent format. These provisions must be monitored by the registrar on a regular basis in order to verify their accuracy. The Board of each scheme should also provide the registrar with an abridged quarterly report in a format defined by the registrar. This will allow the registrar to ascertain whether all performance criteria are being met, with particular emphasis on the scheme's solvency position. In addition, the Department supports the recommendation that

any changes to the rules, contribution rates and benefits of a scheme be certified by the Chairperson of the Board of the scheme.

The Department also accepts the recommendation by Council that a scheme's auditors should report to the Board of Trustees of each scheme, who in turn, will have an obligation to report to the scheme's members. The Department believes disclosure should be made by the auditors in compliance with generally accepted accounting practice. Furthermore, auditors should be obliged to report any irregularities, non-compliance with statutory requirements or any other untoward circumstances, directly to the registrar.

12.3 Investments by schemes

The Department is concerned that **Section 20B (d)** of the Medical Schemes Act permits the funds of a medical scheme to be used in a manner that may compromise the medical scheme's environment. It will consequently review this part of the Act with a view to achieving the following:

- Appropriate separation of investments from insurance;
- Reducing the scope in relation to insurance that can be purchased by a medical scheme; and
- insuring that medical schemes invest their funds in an appropriate manner.

13 Financial management and administration

13.1 General

According to the registrar the provision that annual financial statements be submitted within 6 months after the end of the scheme's financial year was effected at a time when such statements were prepared manually. Therefore, it is considered fair to expect such returns within 4 months given access to advanced technology. It will also be necessary for a scheme to provide information concerning any fees paid to any intermediary, and the nature of the services provided. These intermediaries would include managed care companies, pharmaceutical management companies, administrators etc.

13.2 Guarantees provided by the scheme

Council has recommended that in addition to the minimum membership requirements, new schemes wishing to register should deposit a minimum of R2.5 million in cash and furnish an additional R2.5 million in guarantees from a recognised financial institution. The registrar has proposed that these additional guarantee should be in place for as long as the scheme remains registered. The Department supports these recommendations.

13.3 Reserve requirements

Many medical schemes currently operate without provision for adequate reserves. The Department believes that it is financially prudent to keep a level of reserve because premium income may at times not be adequate to cover benefits - due to increases in medical costs and variations in claims. Presently it is merely a recommendation that medical schemes maintain accumulated funds equivalent to 25 percent of their annual contribution income. Council has recommended this requirement be made mandatory.

Many arguments have been advanced that the proposed reserve requirement is arbitrary and that such requirement should be linked with number of members and guarantees made available by schemes. The Department accepts the view that an optimal level of reserves will be influenced by a number of factors including the size of a scheme's membership, provision for outstanding claims, bad debts, the rate of medical inflation, etc. Sufficient reserves are nonetheless critical to deal with volatility of claims, and twenty five percent represents only three months of average claims. The Department therefore proposes that new schemes should have business plans that make provision for the required level of solvency margins before they can be registered. Existing schemes should be given three years in which to comply or face deregistration. The Department further proposes the establishment of a two trigger system similar to the one that has been proposed in Australia to ensure effective implementation of the solvency margin:

Box 5: Proposed mechanism for implementing solvency margins within registered medical schemes

■ The first trigger - the registrar would signal to a scheme when a warning reserve level (less than three months but more than two months of contribution income) has been breached. The scheme would then have to undertake measures, approved by the registrar to build up its' level of reserves. This could occur at any time during the year or at the time of the half yearly (albeit unaudited) report.

■ the second trigger - should a schemes' reserves fall below a critical level (two months of contribution income) the registrar would indicate to a scheme that this gives cause for further action such appointment of a judicial manager to administer the scheme, deregistration of the schemes, and/or a compulsory merger with another scheme.

The Department is of the view this system will meet the overriding concern of protecting the interests of members, and not those of inefficient medical schemes.

13.4 Measures to curb fraud

The Department is keen to investigate the feasibility of measures aimed at preventing fraud (eg. the use of high security cards in combination with identity documents to ensure that only eligible members are provided services). The

Department will also assess the feasibility of authorising schemes to withdraw the practise numbers for health care providers if schemes prove that the medical aid card was used by either someone not-eligible or it paid for non-health cover. In proven cases of fraud, members could also be charged and removed from schemes.

13.5 Penalties

The Department supports the recommendation made by Council and the registrar that some contraventions of the Act should be dealt with through administrative penalties. Such infractions will include failure to submit to the registrar such statistical or other information, or returns, reports, annual financial statements or any other document requested by the registrar.

14. MEDICAL SCHEME INTERMEDIARIES

14.1 Central concerns

The Department of Health is concerned that current behaviour of some intermediaries may often be against the interests of members of medical schemes. Presently no system of accreditation exists for intermediaries, and they cannot be held accountable for improper conduct in the management of, or their dealing with, a scheme. The Department therefore supports recommendations by the registrar that provision be made within the Act concerning undesirable business practices that are becoming apparent within the private health care financing environment. Because new practises are emerging all the time within this market, the registrar has proposed that the amendment of **Section 39** should read:

"39C Business practices declared undesirable -

"Notwithstanding the provisions of any other law, Council may, after consultation with medical schemes, by notice in the Gazette, declare a particular business practice as undesirable for -

"all or a particular category of medical schemes; or all or a particular category of persons who render administration and intermediary services in respect of health care cover."

Such declaration shall only be made after the registrar has given schemes a notice of at least 60 days of the intention to make the declaration, and has invited interested parties to make written representations in this regard.

14.2 Administrators of medical schemes

The registrar has proposed that organisations that intend to act as administrators of registered medical schemes need to conform to predetermined and objective standards of competence before embarking on such administration, and should

be accredited by the Office of the Registrar. These proposals have received wide support. The Department further proposes that objective minimum criteria for accreditation be developed jointly by Council and representatives of the medical schemes industry. These minimum criteria will be updated regularly to account for new developments and changes in technology. The status of an administrator will consequently be re-assessed on a regular basis. Failure to conform to the agreed standards may be a cause for withdrawal of accreditation.

14.3 Managed health care

The introduction of managed health care in South Africa raises a number of issues, including the ability of managed care to contain costs without hurting access and quality of care; the need to ensure solvency of managed care plans; fairness in contracting with providers and the need to develop appropriate standards for resolution of potential disputes among the contracting parties. Some of the proposals made in this document will also apply to managed care organisations. In addition, the Department has established a consultative forum on managed health care. Theme committees on patient protection; standards for contracting; financial regulation and industry concentration have been set up to provide the Department with recommendations and possible regulatory frameworks. The Department will then be responsible for evaluating these recommendations and developing appropriate policy guidelines on managed health care.

14.4 Brokers

The Department has received a number of recommendations that payment by medical schemes to brokers is not in the interest of members. It has been argued that brokers do not add any value in health care and that their behaviour is virtually impossible to monitor. It has further been argued that if brokers wish to operate, the fee should be charged directly and obtained explicitly from the member. Others have argued that such a system would be impractical.

The Department's view is that brokers should be regulated in a consistent manner across all industries, including pension funds, etc. The Department therefore supports the notion of a functional regulation of brokers, to be administered by the FSB. Such a regime should deregulate brokers' fees and emphasise appropriate disclosure. Administrators and schemes will be required to comply with these regulations or face withdrawal of their accreditation.

An additional problem is the tendency of brokers and other intermediaries to receive contributions from members and to hold it for various periods of time before paying it over. The Department therefore considers it necessary to amend the Act to read:

"No person shall receive, hold or in any manner deal with the subscription or contribution which is payable to a registered

scheme by or on behalf of a member of such scheme. Such subscription or contribution shall be payable directly to the scheme concerned within three days of payment thereof becoming due."

15. OVERSIGHT OF MEDICAL SCHEMES

15.1 Office of the Registrar

Various options concerning the future of the Office of the Registrar are under consideration. These options are discussed fully in the attached document entitled ***Prospects for strengthening the Office of the Registrar and funding the Office through a levy on medical schemes***. The Department has decided that while the recommendations made in this document are under review, the Office of the Registrar will be upgraded to a directorate as soon as possible and that additional expertise will be brought in to assist the registrar.

16. CONCLUSION

The reforms proposed in this document have been prompted by concerns over rising costs of private medical cover; increasing cream-skimming by non-indemnity products and resultant risk rating by medical schemes; and concerns that adequate access to medical schemes cover should be available at prices which do not exclude high risk groups (who are progressively "dumped" onto public hospitals). The Department considers that these problems can be best resolved by reinforcing a system of lifetime community rating that relies on the application of longer waiting periods for people entering medical schemes only late in life. In addition the Department believes that a prescribed minimum package of benefits will afford members of schemes meaningful benefits, and attenuate the tendency to shift costs of some members to the public sector. The Department is also convinced that the proposed governance structures for medical schemes contribute to improved management and accountability. The agency function of medical schemes will be reinforced and proper financial administration of medical schemes should become the norm rather than the exception.

Many persons and organisations have been consulted in the development of these proposals, and the Department is grateful for the quality of these discussions. It is the view of the Department that substantial consensus has been achieved in the development of these proposals. There are nonetheless issues that still require further consultation prior to final decisions and implementation. The Department remains committed to further consultations on such issues. However, the Department will also be moving speedily towards making changes to the Medical Schemes Act to reflect those policy imperatives on which consensus has already been achieved.



APPENDIX: SUBMISSIONS AND COMMENTS RECEIVED BY THE DEPARTMENT OF HEALTH

Chartered Accountants Medical Aid Fund (1997). Response to Department's policy proposal to regulate private sector health care funding.

Concerned Medical Schemes Group (1997). Savings accounts: controlling health care costs, providing comprehensive cover.

Concerned Medical Schemes Group (1997). Contrasting high risk pools and guaranteed issue in South Africa.

Concerned Medical Schemes Group (1997). Mechanisms for the protection of high risk individuals within an environment of age-based community rating.

Council for Medical Schemes (1996). Report of Council for Medical Schemes to the Minister of Health.

Council for Medical Schemes (1996). Minutes of the Council meeting held on 14-15 November 1996.

Life Offices Association (1997). The Life Offices Association's submission on financing of health care to the Department of Health.

Local Authorities Medical Aid Fund (1997) Comments and viewpoints on the draft discussion document pertaining to proposals concerning the financing of the private health industry in South Africa.

Medical Association of South Africa (1997). Response on draft discussion document pertaining to proposals concerning the financing of the private health industry in South Africa.

National Association of IPAs (1997). Comments on draft document concerning the financing of the private health care industry in South Africa.

ProSano Medical Aid Scheme (1997). Comments on the draft discussion document pertaining to proposals concerning the financing of the private health industry in South Africa.

Representative Association of Medical Schemes (1997). Response of the RAMS Council to the Department of Health in respect of the discussion document on the financing of the private health care system.

South African Chamber of Business (1997). Comments on the draft document pertaining to proposals concerning the financing of the private health industry in South Africa.

South African Medical And Dental Practitioners (1997). Comments on the proposed regulation of medical schemes.

Southern Healthcare JV (1997). Response to the Department of Health's proposed regulatory framework for the financing of private health care in South Africa.



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