Innovative Medicines South Africa

Executive Summary of NHI Policy Brief 21

Myths about Medical Schemes

The fundamental reason for these policy briefs has been to put hard evidence on issues relating to healthcare and NHI in the public domain. This policy brief deals with several pervasive myths about medical schemes that have surfaced in debates and in the NHI Green Paper.

There was s statement by COSATU in November 2011 that said the private sector "serves a minority of the population, the majority of whom are white and wealthy." The roots of the problems in the two-tier health system are also linked to race in the Green Paper. While this characterisation of the two-tier system as being black-white may be useful political rhetoric but it is simply no longer true: in 2010 Whites made up only 35.7% of medical schemes, using data from StatsSA.

Data on the historical situation is traced back to 1980 with data from the Council for Medical Schemes being combined with survey data from StatsSA from 1993 onwards. in 1980 only 7.9% of those covered by medical schemes were African/Black . This proportion grew steadily to 30.9% by 1994 and to 46.3% by 2010. In 1994, Whites were 52.0% of the medical scheme population, with the "previously-disadvantaged" being 48.0% of medical schemes. In 2010, this group has grown to be 64.3% with Whites making up only 35.7% of medical schemes.

New evidence on the taxable income levels of those using the medical schemes deduction is presented, using data from SARS and National Treasury in 2010. It was found that:

- The bands from R12,500 to R25,000 per month cover 32.6% of taxpayers using the deduction.
- Only 16.7% of taxpayers have taxable earnings over R25,000 per month.
- 50.7% of taxpayers using the deduction had taxable earnings of below R12,500 per month. Removing the tax deduction would cause substantial hardship for these families.

Mark Heywood said in 2009[a]: "For activists to participate effectively in the discussion about NHI, a number of misleading ideological assumptions about health care need to be dispensed with. One is that only rich people access private care. This is not true. Thousands of trade unionists are members of medical aid schemes. In addition, because of the terrible quality of the public health sector, its queues and unpredictability, poor people often opt to pay out of pocket for whatever health service they think they can afford."

The proportion of the South African population covered by medical schemes is often quoted in order to bolster a particular position. At times, values as low as 13.7% and as high as 20% of the population have been quoted. Using the most reliable figures available it is shown that the proportion of people on medical schemes has fluctuated between 14.5% and 17.1% over the period from 1985 to 2010. The best estimate of the proportion of people in South Africa covered by medical schemes is thus 16.2% in 2009 and 16.7% in 2010. Note that this covers only those on registered medical schemes and does not include those on bargaining council schemes.

The NHI Green Paper says: "A number of medical schemes have collapsed, been placed under curatorship or merged. They have reduced from over 180 in the year 2001 to about 102 in 2009. This was mainly due to over pricing of health care." A long-term history of the number of schemes in South Africa, using the official figures from the Council for Medical Schemes is shown. The analysis shows that the reduction in the number of schemes is a very long-term trend that has been consistent since 1974 when data was first collected. This reduction is in the interests of members as it means fewer, larger schemes: the larger the risk pool, the more stable and predictable the results.

There seems to be a misunderstanding that medical schemes are profiting from their members. The reality is that medical schemes are not-for-profit entities and are controlled by their members. They are analogous to pension and provident funds rather than insurance companies. The Green Paper fails to recognise that it is Government legislation and regulatory supervision that requires that medical schemes remain solvent at all times. The Green Paper also does not acknowledge that the regulator, the Council for Medical Schemes, has in some cases refused the increases that schemes require in order to maintain solvency. The trustees must take action to remain solvent at all times and they have thus been forced to cut benefits.

---

[a] National Health Insurance: A Step in the Health Direction: http://www.amandlapublishers.co.za

The fundamental issue in the Green Paper and also repeated by many commentators is the seeming imbalance in expenditure between the public and private sector on healthcare: R11,300 for each medical scheme member and only R1,900 for those using the public sector.

This total expenditure is misquoted to seem as if it is Government expenditure or somehow within the ability of Government to direct both the public and personal funds. What is needed is to clearly separate out expenditure on health that is made by Government from expenditure on health by people from their own pockets. Using figures from National Treasury the revised table below is provided.

Table 1: Government and Personal Expenditure on Healthcare per beneficiary per annum in 2008

Group	**Government Expenditure on Delivery and Tax Subsidies**	Personal Expenditure on Medical Schemes	Personal Out-of-Pocket Expenditure on Healthcare Providers	**Total Government and Personal Expenditure**
Users of Government primary care and hospital services	**R1,950**	-	-	**R1,950**
Users of Government hospital services, but private primary care	**R1,950**	-	R550	**R2,500**
Medical Scheme beneficiaries	**R1,600**	R8,000	R1,700	**R11,300**

The critical comparison is what Government spends on someone using public sector care (**R1,950 pbpa**) and what Government spends on someone who uses medical schemes (**R1,600 pbpa**).

Activists should also be questioning two other Government expenditures on healthcare that are in the form of subsidies paid by Government as employer to those who work in the public sector:

- **R5,220 pbpa** for employer subsidy on GEMS for public sector workers and their families.
- **R14,518 pbpa** for employer subsidy on PARMED for politicians and their families.

Summarised for IMSA by **Prof Heather McLeod**
5 January 2012

New resources on the IMSA NHI web-site

http://www.innovativemedicines.co.za/national_health_insurance.html

- The full policy brief and slides used.