CONSULTATIVE FORUM ON RISK EQUALISATION

DATE: 10 JULY 2003
VENUE: GALLAGHER ESTATES, MIDRAND

OPENING ADDRESS BY DR AYANDA NTSALUBA, DIRECTOR-GENERAL, DEPARTMENT OF HEALTH

Let me start by thanking all the participants for coming to this very important meeting. We have chosen to call it a consultative forum, because we want to invite all of you to participate on an ongoing basis to help us finalise our policy decisions on key issues that will have a very direct impact on your business. I am very pleased to see such good representation from the private health care industry, especially the medical schemes and their administrators. I am particularly pleased to see the business sector taking such a keen interest in the health funding issues, as your input will help us to formulate workable solutions to the challenges we jointly face in trying to improve access to health care.

We in the department have spoken for a long time about the need to establish a social health insurance system in South Africa. Over the past decade, some of you have participated in various fora to discuss the issue and try to formulate a workable model for South Africa. Perhaps you have even come to doubt the seriousness of our intentions to go the mandatory route. I am therefore very pleased to inform you that we are more committed to

mandatory contributions than we have ever been in the past. The reason for this renewed commitment is two-fold:

First, we have addressed some of the key constraints that prevented us from implementing any sort of mandatory cover in the last decade. Secondly, we have won the commitment of our political principals to move towards this very significant change in the structure of health care financing in this country. I will not elaborate any further on the second reason, as most of you will have heard our President commit the department in his State of the Nation Address. The first reason requires a little more elaboration.

In the 1980's, when we started speaking about national health insurance, we were faced with a highly fragmented health care system, with great inter-provincial inequities and an unregulated private health care market contributing to extreme cost escalation in the health sector. When the ANC-led government came to power in 1994, it became clear to us that the problems we inherited would not be addressed by any magic bullet. Instead, we established two Committees of Inquiry, and later a departmental task team to advise us on how we should proceed towards our stated objective of achieving universal access to high quality health care services for all citizens. The Committees made various recommendations, but all three shared one common proposal: they proposed that we should move towards mandatory contributions for all citizens, be it national or social health insurance.

The challenge for the department in interpreting the proposals was to ensure appropriate phasing of the reforms so as to prevent unexpected shocks on the

system that could have unforeseen consequences. All of us recognised the need for certain key issues to be addressed in order for mandatory cover to be feasible: we all understood the need to improve our regulation of the private sector to control the cost escalation and ensure affordability of mandatory contributions. We had to ensure that risk-rating would not continue to undermine access for the most vulnerable groups. We also had to ensure that there was an appropriate and affordable provider environment that could be reasonably accessed by all contributors. We always held the view that the enactment of the Medical Schemes Act would be a pre-cursor to the implementation of a mandatory environment.

The Medical Schemes Act of 1998, and its accompanying Regulations was introduced as a key cornerstone to govern our regulation of the private health care industry. The objectives of the legislation were clear:

- First, we wanted to reverse the risk rating that had come to characterise the sector, and re-introduce community rating. We took the view that cross-subsidisation should be re-established as the basis for the operation of the health care market.
- Second, we introduced open enrolment, to improve access to medical schemes for people who were previously excluded
- Third, we introduced solvency and other financial and governance requirements to improve financial management and governance of schemes.

- ❖ Finally, we mandated a Prescribed Minimum Benefit Package to be funded by all schemes. This intervention was for us, fundamental to the reorientation of the private health care sector.

Our decision to re-establish community rating was informed by the view that access to adequate health care is a right that should not be subject to an individual's ability to pay. In addressing the question of who should subsidise whom, we looked not only at income, but also at the intricate relationship between health and income. Given the scarcity of funding for health care, we could not allow risk rating to continue to leave large sections of the population who have demonstrated some ability to pay, to be left without any cover. To the extent that comprehensive cover was priced out of the reach of many individuals with modest incomes, it became necessary for government to intervene.

Our motivation for developing the PMB came from past experience of some undesirable practices, which had developed within medical schemes, with negative effects on the public health care system. Such practices include dumping and failure to reimburse public hospitals for services rendered to medical scheme patients. In addition to addressing the dumping problem, we also needed to protect the interests of medical scheme members. In the absence of a PMB, members were faced with a confusing array of packages from which to select, without adequate guidance on how to select the most important combination of interventions. The inevitable result of this was that

members would discover too late that they did not have cover for some essential benefits.

In this coming year, we will be expanding the PMB to include chronic disease cover, which had unfortunately become a casualty of some schemes' attempts to circumvent the stated aims of the legislation.

On the provider side, we remain concerned about the continuing high cost of cover, as a result of various systemic problems within the industry. One of these is the fee-for service system, which encourages over servicing and over-utilisation. Although some schemes have introduced managed health care and other interventions to address this, alternative reimbursement mechanisms have not taken off. For our part, we recognise the need to establish the public hospital system as a contender for the provision of mandatory services under a contributory environment.

The state of our public health facilities will remain one of our key focus areas for development in the medium to long term. Some of you will be aware that we have embarked on an extensive hospital revitalisation programme, which is a multi-faceted programme to improve the planning, management and physical state of our public hospitals. We have so far invested in excess of R2 billion in this project. We are accelerating our investment on this with R717 million budgeted this year and R911 million for next year and just over R1 billion for the outer year of the Medium Term Expenditure Framework.

Move to Mandatory Contributions

Following all the reforms and interventions I have mentioned so far, we now feel that we are at a stage where we can begin to talk about the implementation of mandates. We have taken note of the proposals made by the Taylor Committee of Inquiry, which released its report in April last year. After the release of their report, we embarked on an extensive consultation process whereby we asked our stakeholders to provide us with their written comments on the proposals. We also had direct meetings with some of the stakeholders and used all these inputs to formulate a departmental response to the Taylor proposals. I must add that we received extensive comments not only from both the private funders and providers, but also from labour unions and employer representative groups. As you would very well expect, the views of different stakeholders were quite different on some of the key proposals. However, I must thank all those stakeholders who responded to our call for input. The views that the department has now formed were informed in large measure by these inputs.

The Department has now formed the view that in our current context, the pursuit of Social Health Insurance is a more achievable goal in the immediate term. Of course, this view is not shared by some of our key stakeholders, who have motivated for National Health Insurance. We will continue to engage in these discussions, with the understanding that, given the complexity of the issues we face, there are no simple solutions. Our key concern with a move to NHI is the risk of a reduction in the tax-based funding for health. We are not convinced that the NHI approach will be more

progressive than a combination of SHI and tax funding for health. We believe that for quite some time to come, we will continue to require a significant portion of our health system to be funded out of general tax revenue.

The introduction of Social Health Insurance is therefore intended to achieve four key objectives:

- To strengthen the public health care system by increasing the revenue available to it.
- To obtain pre-paid contributions from those who are able to pay for health care
- To reduce inequities in health care financing by improving income and risk-related cross-subsidies, and
- To improve access of lower income groups to quality health care.

In our unique context, we would be satisfied that we are implementing a Social Health Insurance scheme if the following components are in place:

- Government-mandated health insurance cover for specified groups.
- Income cross-subsidies among contributors
- Risk-related cross-subsidies among contributors

From an implementation point of view, we are satisfied that the cross-subsidies can be addressed even outside of any mandatory SHI. We believe that the introduction of income cross-subsidies and risk-related subsidies will

greatly enhance the stability and sustainability of the medical schemes environment.

5.2 Income cross subsidies among contributors

On income cross subsidies, the Department continues to hold the view that SHI contributions under should be based on income, to ensure that income cross-subsidies are entrenched in the mandatory environment. We in the department have been very concerned to hear that contributions are at present not income related. We would therefore wish to explore the possibility of achieving such income cross subsidies as we move into the mandatory environment.

The tax subsidy on medical scheme contribution, currently estimated at R7,8 billion, is an important reflection of government commitment to encourage people to provide for their own health care. It is intended to make medical aid cover affordable for more people by subsidising their contributions.

Because the current tax subsidy is based on the size of the medical aid contribution, it favours high-income earners belonging to high cost medical schemes, to the detriment of lower-income earners. The linking of the subsidy to medical aid contributions means that the subsidy has continued to grow in line with the inflationary trends in medical aid contributions. We need to ask uncomfortable questions about whether it is appropriate for government

to allocate more than R1000.00 per capita on medical scheme beneficiaries who spend R5000 per year on health care, while only allocating R800 per capita on public sector users.

Clearly, none of us wants to lose the subsidy. What we do want is to ensure that it is more equitably distributed so that the low-income earners receive greater subsidies than high-income earners. This in turn should make medical scheme coverage more accessible for a greater number of people. Of course our considerations must be balanced with the likely impact on labour costs, and this is the reason we have specifically invited employers to participate and give us their views on this. We would also like to hear organised labour's view on this, as this impacts directly on their employee benefits. So I would urge you to participate fully in this process, as the ultimate subsidy structure that emerges must be informed by your input into the consultative task teams we will be establishing.

Risk-related cross-subsidies among contributors

The Medical Schemes Act outlaws the use of health status or claims experience in the determination of contributions. This measure, together with the newly promulgated extension of the Prescribed Minimum Benefit Package to include chronic disease cover, is intended to protect the ill from risk rating. Despite these provisions, some room still exists for schemes to structure their benefits in a manner that discourages high-risk members from joining. A system of risk equalisation is therefore needed, in which a central fund

receives contributions from below average risk schemes and allocates funds to above average risk schemes. This system creates a much larger risk pool and, instead of schemes competing on the basis of risk selection, they compete on the basis of cost and the quality of health care services purchased.

The international literature we have examined suggests risk equalization is a complex exercise to undertake. We are convinced that in this country, the Risk Equalisation Fund would be an important instrument to buttress the sustainability of the contributory environment. The Department is committed to exploring its feasibility and proper implementation in this country.

By far the greatest input we received on this issue was both from medical schemes and administrators. Because of the different view expressed on this, we would like to see significant input into the task teams from the affected stakeholders. We have also received considerable input on the experiences of various countries that have taken this route, and the challenges they faced in its implementation. For this reason, we would like the stakeholders present here to provide us with a very carefully considered proposal on how to implement risk equalization in our context, taking into consideration our specific environment and requirements for success.

Government-mandated health insurance cover

On mandatory cover, we are of the view that over time, contribution to some

of health care cover should become mandatory for all those with the ability to pay. The mandates should be phased in over time, beginning with high-income earners and specific categories of employers. The mandates could then be broadened with the establishment of a state-sponsored scheme to meet the needs of lower-income people who would not be able to afford conventional medical schemes. Such a scheme would include the use of public hospital services as providers of choice, and also offer primary health care services in the private sector.

While the state-sponsored scheme could be established independently, the Department is aware of the work currently under way in the Department of Public Service and Administration to establish a civil service medical scheme. An idea we are considering in the department is the possibility of opening the membership of this scheme to non-civil servants over time, so that this becomes the state-sponsored low cost scheme. Obviously, we would need to explore this with the relevant parties.

CONCLUSION

The proposals I have put before you reflect the current thinking within the department of health. The establishment of this consultative forum is an opportunity for our key stakeholders and those directly affected by the changes we are proposing to participate in determining the final path we will follow. In the end, the success of the health system depends on the collective action of all stakeholders, and how each impacts on the other. I therefore encourage you to make all the contributions you can to this process.

Thank you

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THE CONTEXT FOR HEALTH FINANCING REFORM IN SOUTH AFRICA

PRESENTED BY BRENDA KHUNOANE, DIRECTOR: SOCIAL HEALTH INSURANCE

I would like to thank all the participants for attending this consultative forum. We would like to use this forum as a continuous platform to interact with our key stakeholders on issues that affect us all very directly in our daily business. We view this meeting as the beginning of a very intensive consultation process to help us harden our views on some very key policy areas that we must resolve this year. I am pleased to see the wide range of organizations represented here, starting from employers, medical schemes, labour organizations and even some provider groups such as HASA, SAMA and pharmaceutical companies. As the DG has already stated, we would like to finalise our recommendations on the changes to the tax subsidy and the risk equalization fund. The time frames we have set for ourselves are quite short, and I'll refer to this a bit later.

I think that before I go there, it would be useful to provide you with some contextual picture of how we have arrived at the reforms we will be discussing. Firstly, you will be aware of the transformation agenda that the health department set itself since 1994. When the Minister of Health took office in 1994, she established various committees to examine the total health system, both on the funding and provision side. The key challenge then, as it is now, was to ensure

that all available resources, both public and private, are applied efficiently for the realization of universal access.

On the Funding side, two Committees were appointed, one in 1994 and another in 1995. Both made recommendations regarding the financing of the health system, taking into account the existence of a significant private health care sector alongside a mostly tax-funded public health care system. The 1994 Finance Committee proposed three options to address the need to ensure universal access for all South Africans. The first two options proposed universal primary health care coverage, and left other levels of care to be funded out of voluntary private insurance. The third option suggested a phased approach towards universal cover, whereby the employed would be obliged to contribute to a scheme providing all levels of care. The intention was that over time, the scheme would be expanded progressively until a switch could be made to a national health insurance scheme.

In considering the 1994 proposals, the Minister established the 1995 National Health Insurance Committee, to further examine the proposals around national health insurance. I will not go through all the recommended made by the 1995 Committee. Instead, I will highlight only those key elements, which were to a large extent implemented through the Medical Schemes Act:

1. That Medical schemes should community rate and cannot discriminate on the basis of health status.
2. That all open schemes must accept all applicants, subject to specified anti-selection protections.
3. That all medical schemes must offer a prescribed set of minimum benefits, and that they must cover the full cost of any prescribed minimum benefits that are obtained from public sector hospitals.
4. That all persons doing the business of a medical scheme must register in terms of the Medical Schemes Act.

5. That a mechanism of *unfunded lifetime community rating* has been introduced. The late joiner penalties are intended to achieve this by allowing a penalty surcharge to be applied for people entering the medical schemes environment for the first time late in life.
6. That the definition of a dependant be expanded to include people who are financially dependant on the principle member and to same sex partners.
7. That a new and substantially expanded regulatory authority be established which will be able to oversee the environment more effectively.
8. That a revised governance structure be introduced to ensure that medical schemes act first and foremost as agents for their members.

The recommendations from the 1995 Committee were taken up by the Department through the establishment of another Task Team in 1997. This Task Team considered various models for a future health system some of which differed from the 1995 NHI Committee proposals. Although they argued for a move towards Social Health Insurance, one of the key recommendations of the 1997 Task Team was that the Medical Schemes Act reforms should be prioritised, as they were largely compatible with any future direction towards mandatory contributions. The Taylor Committee of Inquiry, which completed its work in 2001, referred copiously to the recommendations made by the two Committees. It also drew substantially on other research work done within the Department.

RELATED PUBLIC SECTOR ISSUES

Obviously, the proposed reforms were going to have a significant impact on the funding and provision of services in the public sector. Although the reforms envisaged the reimbursement of public hospitals where people covered by a medical scheme use them, the public hospitals have not been able to adjust to benefit from the Medical Schemes Act, due to inadequate billing and the inability to retain revenue within the health sector. The revenue retention framework we had established is not being implemented in all provinces in the same way, with

the result that some provinces do not retain their revenue. The Department will therefore explore the possible use of legislation, and engage the National Treasury to ensure that the national revenue retention framework is implemented in all provinces. This is a key area of work that we will complete during this year.

We believe that the public hospitals can play a major role in reducing the cost of hospital care faced by the medical schemes industry. Clearly, significant quality and management improvements would have to be effected to enable public hospitals to meet the challenge. In this regard, the DG has already referred to the hospital revitalization project to improve the management and physical condition of public hospitals.

Further impetus is provided by the new regulations in terms of the Medical Schemes Act, which require all medical schemes to contract with specific service providers for the provision of prescribed Minimum Benefits. In order to encourage medical schemes to designate public hospitals as their preferred providers, the department is piloting 20 hospitals to act as designated service providers for selected medical schemes, in preparation for January 2004 when the regulations must be implemented. The intention is to increase the number of participating hospitals and schemes over time, so that public hospitals can act as a network of preferred providers for various medical schemes. Such schemes should in future include the civil service scheme and the state-sponsored low-cost scheme.

Now, following the implementation of the Medical Schemes Act, we have re-examined the other aspects of the proposals made by the 1995 Committee and echoed by the 1997 Task Team. The central thrust of all these provisions was to ensure that the private sector could play a complementary role to the public sector. We wanted to enable those who could afford to pay to access the sector

without facing risk-related discrimination. We also wanted to reduce the burden on the state services, so that our limited resources could be appropriately focused on those who could not afford to pay.

We have explored many other avenues to address the cost escalation in the private sector. Some of these are included in existing legislation, and others are supply-side interventions contained in our National Health Bill. We expect these interventions to, amongst other things, put significant downward pressure on the cost of pharmaceuticals, and reduce the oversupply of providers in certain areas.

We have also explored public-private partnerships in an attempt to create a cheaper provider platform for medical schemes. The designated provider contracts will provide additional impetus to this extension of public provider networks for use by medical scheme members. For us, these interventions are key if we are to make any significant impact on the cost of hospital inpatient care faced by medical schemes.

The Department accepted the view that the re-regulation of the private health care sector should be prioritized ahead of any move towards mandatory contributions. Three years since its introduction, the Medical Schemes Act has laid the groundwork for the move towards mandatory contributions. However, there are still significant challenges for us to address:

1. Medical schemes are predominantly high cost and dependant on fee-for-service reimbursement. Although evolving in response to the introduction of the Medical Schemes Act, the low-cost environment has not yet reached a sufficient maturity to mandate membership for low-income groups. The creation of a low-cost state-sponsored scheme is currently receiving attention in the department, as the DG has already stated.

2. The original reform proposals recommended a mandatory hospital-based package of services to be offered by all medical schemes. This was implemented in 2000 but shown to be inadequate. Although we are introducing an extension of the PMB as from 2004, we need to explore the possibility of ensuring that a comprehensive package of both in- and out-of-hospital services are prescribed for all insured persons.
3. The approach recommended in 1995 required the development of income-based contributions to medical schemes. Currently the open scheme market is largely based on flat rate contributions. It will therefore be necessary to examine how we can achieve the necessary income-related cross-subsidy as we go forward. This work needs to be considered as part of the work we are inviting you to do as we review the tax subsidies on medical aid contributions.
4. Risk-equalisation was recommended as a means for balancing adverse risk pools within the medical schemes environment. It was intended as the vehicle for achieving inter-scheme income- and risk-related cross-subsidies. We think that this reform is still feasible within the voluntary environment.

The consultative Forum we are having today is aimed at addressing the last two issues, while the first two will be addressed via other departmental processes.

Risk Equalization Fund Task Group

The Department of Health has established a Risk Equalization Task Group, to finalize the department's views on the establishment of a Risk Equalization Fund. This Task Team comprises officials from the Department and from the Office of the Registrar of Medical Schemes. In addition, the task team has formed a joint working group with National Treasury, and will interact with individuals contracted to do some technical work to support the process.

Today's Consultative Forum has been organized by the REF Task Group to inform stakeholders of the current departmental position, the research and information collated to date, and announce the establishment of two technical task teams.

REF Consultative Task Team

Prof Heather McLeod, who has technical expertise in the area of health care, actuarial science and statistics, will chair the REF Consultative Task Team.

The terms of reference of the FCTT are to:

- Develop the REF formula, and make recommendations in this respect;
- Consult directly with external stakeholders and affected parties and to co-ordinate their inputs into the process;
- Identify any benefits and risks that may result from any proposed formula;

Their output will be a final Report to the REFTG advising on the formula and the required implementation requirements for a REF.

Subsidy Framework Consultative Task Team

Mr Anton Roux, who has direct experience at a senior level within the medical schemes industry, will chair the Subsidy Framework Consultative Task Team.
The terms of reference of the SFCTT will be to:

- Develop a revised subsidy framework for medical schemes which achieves an equitable redistribution of income between both public and private sector health system users;
- Assess various options for revising the subsidy to address horizontal and vertical equity goals of the Department.
- Revise the tax rebate framework to ensure appropriate employer participation in the provision of medical scheme cover;

- Examine the fiscal implications and requirements associated with alternative subsidy configurations;
- Consult directly with affected stakeholders and parties to co-ordinate their inputs into the process; and

Their output will be a final Report to the REF Task Group advising on the appropriate subsidy framework that achieves the objectives of national health policy.

TIME FRAMES

The Task Group has six months from today to make its final recommendations to the National Department of Health. The intention is that at the end six months, the Department will receive final report from the Task Group, based on the input of the two technical task teams. The Department will then make its final policy decisions and implementation plans based on this final report.

So next year should be spent preparing the necessary policy and legislative changes, for implementation of the Risk Equalisation Fund with revised tax subsidies as from January 2005.

STAKEHOLDER PARTICIPATION

In the morning you will hear presentations on Risk Equalisation and the Subsidy Framework. Here we will provide some indication of how far the work has gone to date, and identify some of the gaps and questions that we still need to answer. One key gap we are aware of is the absence of input from the key stakeholders represented here on first, your concerns, and secondly any work that you have already conducted or are planning to conduct on the same issues. Obviously, we would be very keen for you to come forward with this input.

In the afternoon after lunch, we will introduce the chairs of the two technical task teams, who will describe the work they will be conducting and give you an

indication of how you can participate.

CONCLUSION

Given the tight time frames we are faced with, I'll conclude by inviting as many of the stakeholders as possible to participate in the technical task teams. Your input will be fed directly into the policy direction that the department will ultimately take. For our part, we look forward to a very busy six months, during which we hope to benefit from as much interest and support as you have displayed in attending today's meeting.

Thank you.