Innovative Medicines South Africa

Executive Summary of NHI Policy Brief 17, Part A

Evaluation of LIMS Reforms

The first part of this policy brief considers the Low Income Medical Scheme (LIMS) recommendations made in 2006 in the light of subsequent evidence of the impact on low income workers. A preliminary costing was done for the LIMS report but this was not done by age and gender. More recent work, using component cost curves, has produced an estimate of the LIMS minimum package by age and gender. The LIMS package was determined using: PMBs for maternity in hospital; PMBs for chronic medicine; PMBs for related visits and tests; and capitated primary care including specialists.

The LIMS report had proposed hospitalisation other than maternity should occur in the public sector. This gives a curve which is much flatter with age than PMBs. The LIMS design effectively cuts the high tail from the standard PMB package and the extended Basic Benefit Package (BBP i.e. PMBs plus primary care). Given the shape of the LIMS curve, the LIMS pricing will thus be less sensitive to an aging profile than PMBs or other medical scheme packages. However this would be an added risk to the public National Health Service (NHS). As the LIMS population begins to age so the cost of hospitalisation in the NHS for the LIMS beneficiaries is likely to escalate faster than the cost of the LIMS package and faster than the total package of care delivered in the NHS.

If cover is made mandatory from the LIMS threshold of R2,000 per month, then mandatory health insurance might cover 14.8 million beneficiaries (30.0% of the total population). However there is an overlap between LIMS and the coverage in existing voluntary medical schemes, which had 7.9 million beneficiaries in 2009. LIMS options with a limit of R6,000 income per month in 2005 Rand terms would cover 9.7 million beneficiaries (19.7% of the population). The LIMS age profile is very different to that of medical schemes because at the outset there are only workers and their families, with no elderly members. Over time, it would thus be expected that the LIMS population would begin to have more elderly people and thus the cost of LIMS packages would begin to rise.

If LIMS is implemented this might leave perhaps only 4.4 million on voluntary medical schemes. Even if membership of medical schemes became mandatory over the tax threshold or the LIMS threshold, the total medical scheme population might only be increased by 0.7 million to a total of 5.1 million (10.3% of the population). This will have a significant impact on the price in existing medical schemes as those remaining on medical schemes will be older than the current medical scheme population.

The community rate for the LIMS package is estimated to be R301.53 pbpm in 2009, compared to the R479.46 pbpm needed to cover PMBs in voluntary medical schemes. The LIMS package thus around 63% of the cost of PMBs but this excludes the cost to the public NHS of providing hospitalisation.

If LIMS is implemented the community rate in voluntary medical schemes is expected to increase from R479.46 pbpm to R545.07 pbpm, an increase of 114% on the price. This may make cover less affordable and the younger and healthier may fall out of cover, further increasing the price to the remaining medical scheme members.

The effects of the LIMS reforms on members is examined by considering the effect on benchmark families with differing levels of income, as shown in Figure 1. LIMS achieves good results for workers just above and just below the tax threshold largely due to reduction in the direct package cost. However the results for the two lower income groups, informal workers and formal farm and domestic workers are worse than remaining on a conventional medical scheme with a per capita subsidy.

The consequences of LIMS are shown not to be straightforward and that the sequence of reform is as critical as for conventional medical schemes. It seems likely that the lowest income workers will be better off in a single income-cross-subsidy pool. The larger the package of benefits pooled, the better off the lower income workers will be. But there comes a limit as to the extent to which income-cross-subsidies can be pushed and the extent to which middle and higher-income workers can cross-subsidise the much higher numbers of lower income workers. This requires further technical work to be done on the degree of solidarity that it is possible to engineer into the environment.

However even if LIMS members are shown to benefit most from being part of a greater risk pool with a common benefit package and high income cross-subsidisation, there may still be good reasons to introduce a separately branded form of health insurance. This is analogous to the Mzansi bank account initiative or the new Zimele initiative for insurance.

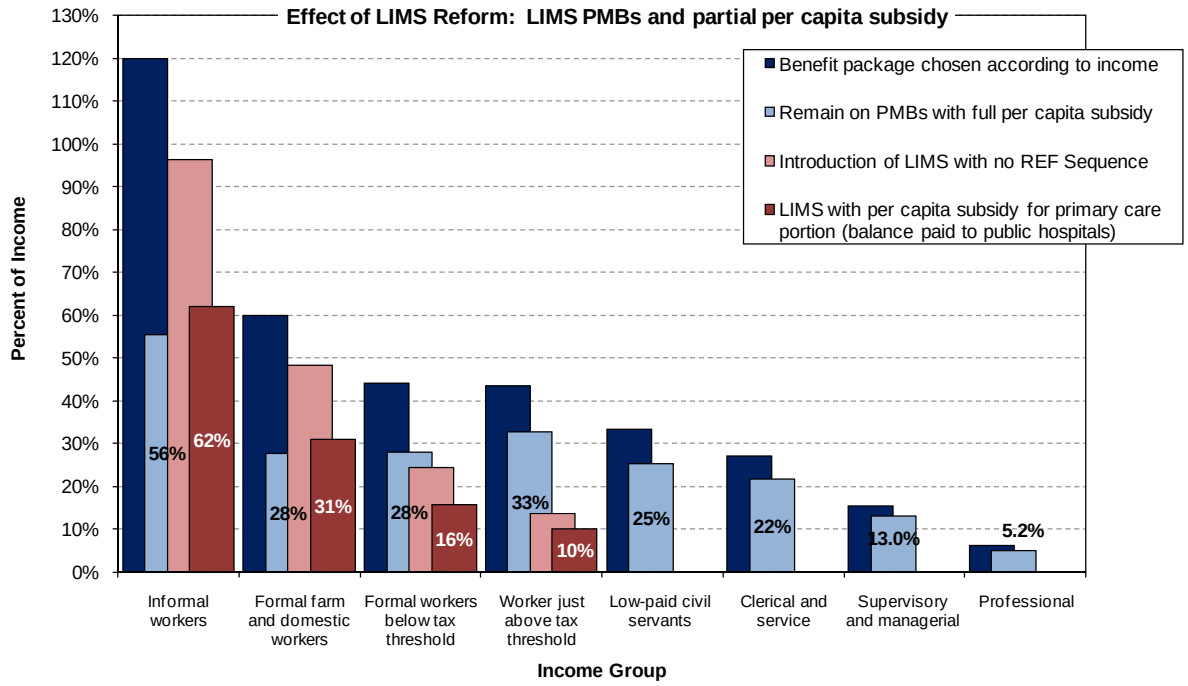

Figure 1: Impact on Affordability of LIMS Minimum Benefits compared to PMBs

Summarised for IMSA by **Heather McLeod**
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Further resources on the IMSA NHI web-site

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

- The full policy brief and slides.