HASA 2022 CONFERENCE

RESILIENCE THROUGH COLLABORATION

An alternative history for health care financing in South Africa
Lessons from the past to take into the future

Barry Childs

Friendly Societies Act was first Act to govern early medical schemes

1956

First Medical Schemes Act ensured schemes were run on solidarity principles (minimum benefits and community rating)

1967

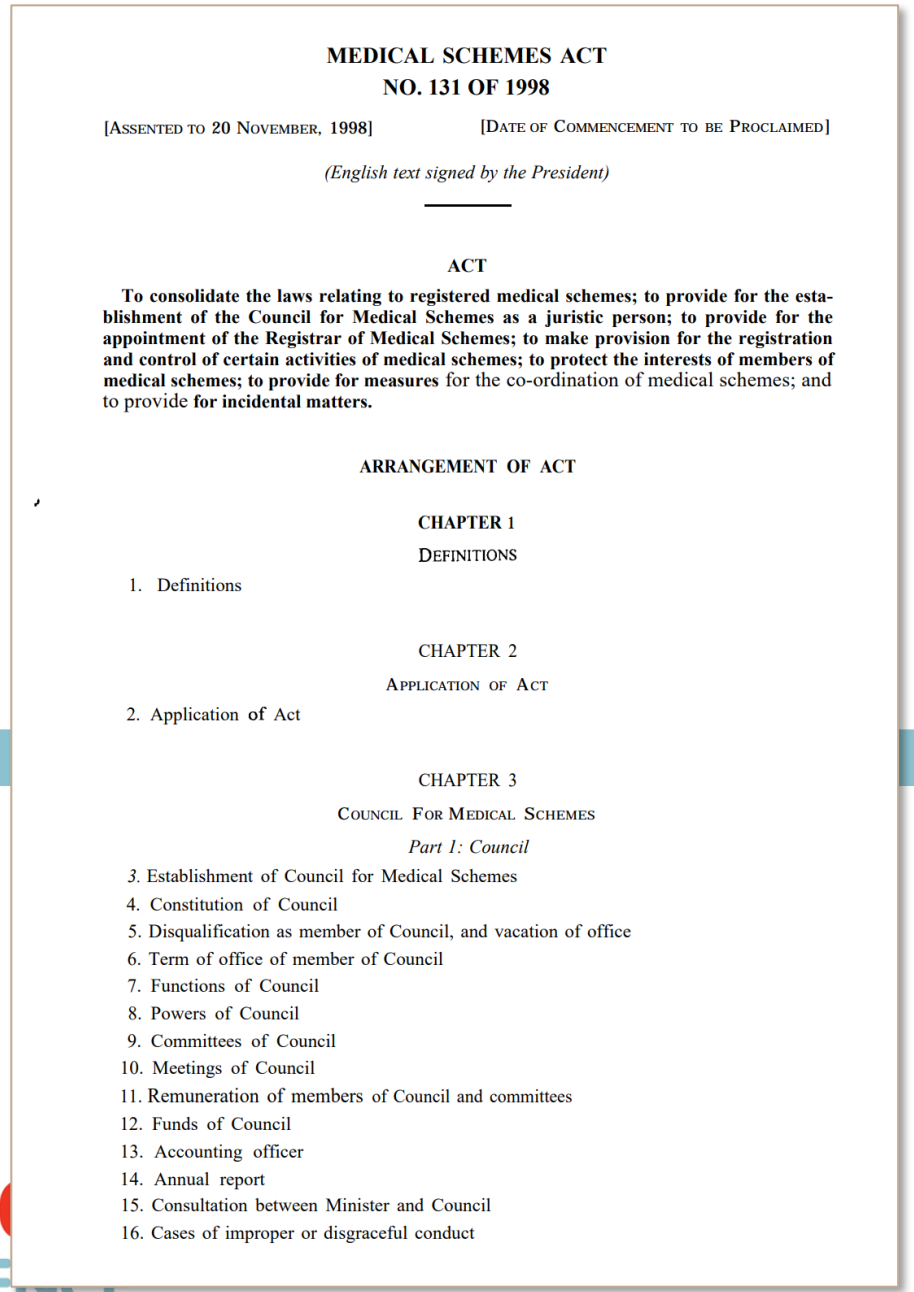
1988

Pressure to follow free market based system lead to Amendment Act of 1988, included allowance for risk rating and varying benefit levels, intended, among other things, to consolidate industry risk pools.

Melamet Commission suggestions for more market freedom rejected. Return to solidarity based principles through MSA of 1998 as part of broader reforms.

1999

Quick trip through history



MEDICAL SCHEMES ACT
NO. 131 OF 1998

[ASSENTED TO 20 NOVEMBER, 1998] [DATE OF COMMENCEMENT TO BE PROCLAIMED]

(English text signed by the President)

ACT

To consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide **for incidental matters.**

ARRANGEMENT OF ACT

CHAPTER 1
DEFINITIONS
1. Definitions

CHAPTER 2
APPLICATION OF ACT
2. Application of Act

CHAPTER 3
COUNCIL FOR MEDICAL SCHEMES
Part 1: Council
3. Establishment of Council for Medical Schemes
4. Constitution of Council
5. Disqualification as member of Council, and vacation of office
6. Term of office of member of Council
7. Functions of Council
8. Powers of Council
9. Committees of Council
10. Meetings of Council
11. Remuneration of members of Council and committees
12. Funds of Council
13. Accounting officer
14. Annual report
15. Consultation between Minister and Council
16. Cases of improper or disgraceful conduct

2000

Medical Schemes Act 131 of 1998, implemented in 1999 & 2000

Return to solidarity based principles after nearly a decade of deregulation

Intended to be the start of medical scheme reform implementing open enrolment, PMBs, and community rating. Intention was to follow shortly thereafter with Risk Equalisation Fund and some form of mandatory membership.

PMBs were intended to be reviewed every 2 years. Last review was in 2003. Current review started in 2016 and is currently in limbo.

Transforming the Present - Protecting the Future

2002

Taylor Commission of Inquiry. *Protecting the Future, Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa, March 2002*

Four planned phases of reform.

1 – solidarity principles for schemes and improvement of public health facilities and management

2 – improved cover and standardisation of private cover

3 – implementation of mandates (starting with public sector medical scheme) resulting in SHI system

4 – progress towards NHI system, noting concerns at the time about affordability and that more deliberation and debate would be required. High levels of unemployment seen as a barrier to NHI implementation.

Last systemic analysis of the system as a whole

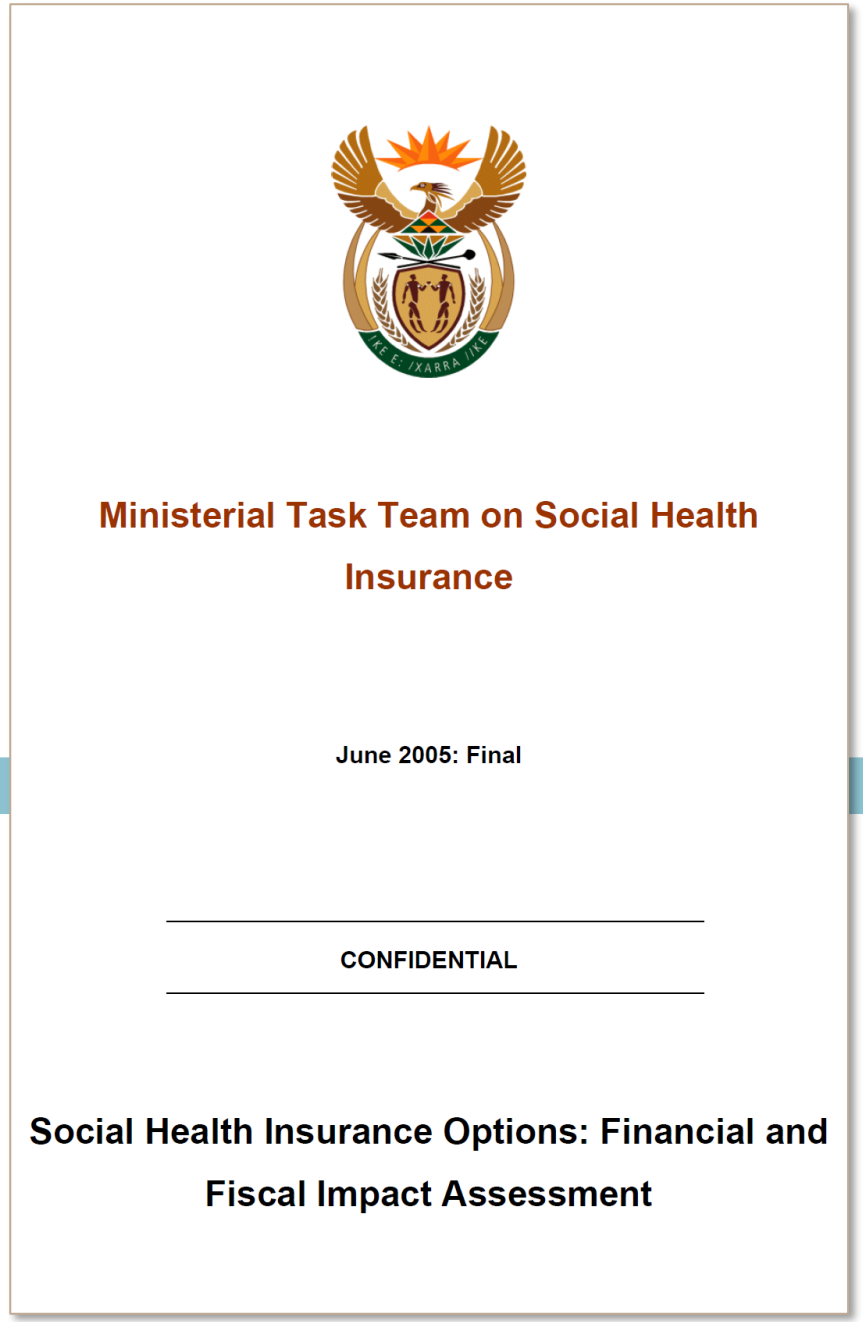
3 SHI options and 1 NHI option considered

TES removal contemplated in all scenarios

Promotes incremental phased approach to reform

2005

Shows NHI most equitable but also most costly and "unaffordable in the medium term"



"NHI will become affordable only if the level of formal employment rises coupled with significant increases in the average incomes of the formally employed population. This will only happen in the very long-term, and will depend fundamentally on the nature and extent of economic development. "

Initiated by the MTT on SHI of 2005

The last comprehensive collaboration on system reform discussions

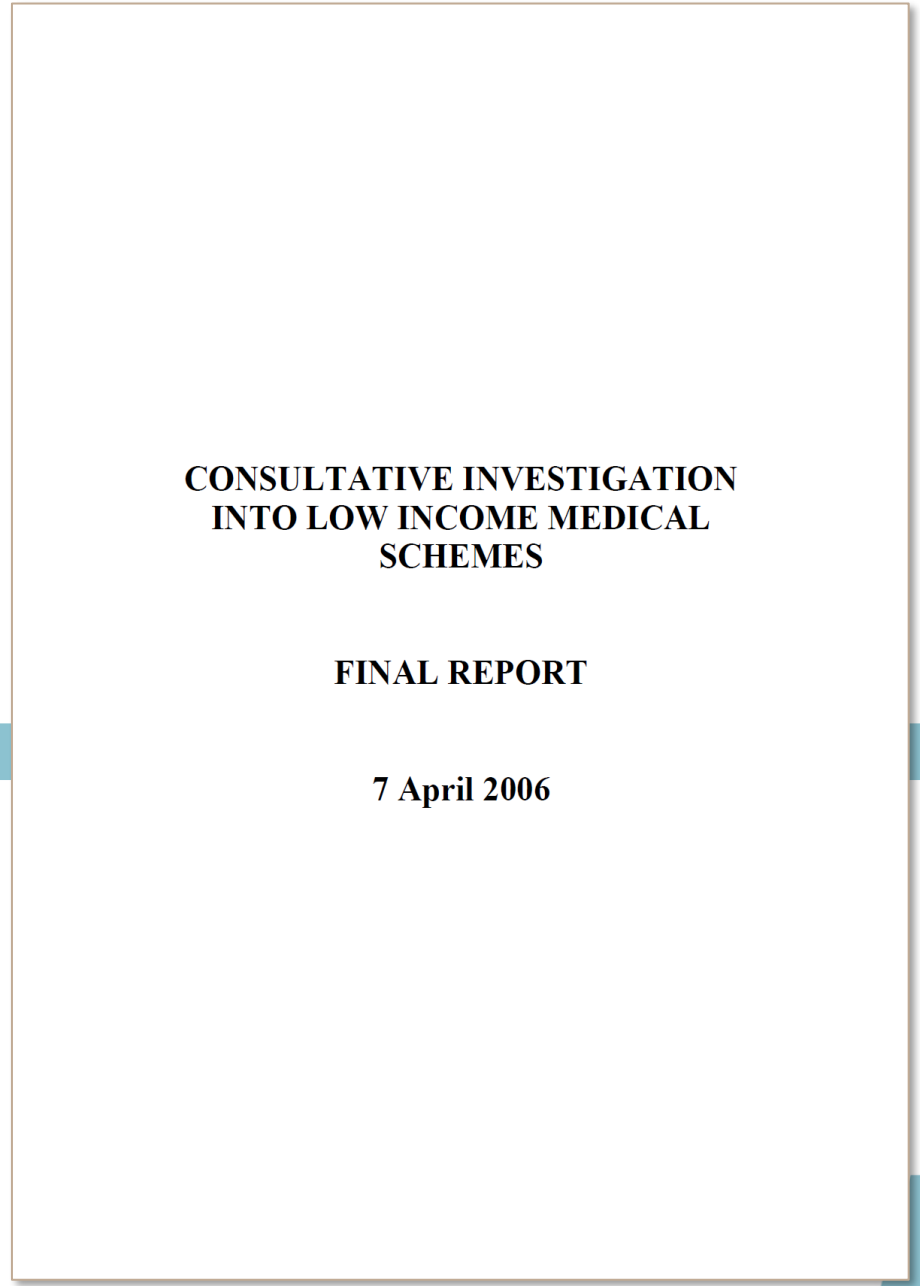
Low income South Africans would pay for pooled private primary care.

Halted until false restart in 2015 (first LCBO CMS circular)

April 2006

Revived again in 2019 as unregulated products began to proliferate

Protracted discussion…


CONSULTATIVE INVESTIGATION
INTO LOW INCOME MEDICAL
SCHEMES

FINAL REPORT

7 April 2006

Friendly Societies

MSA, Solidarity, 1967-1988

MSA, Free market, 1989-2000

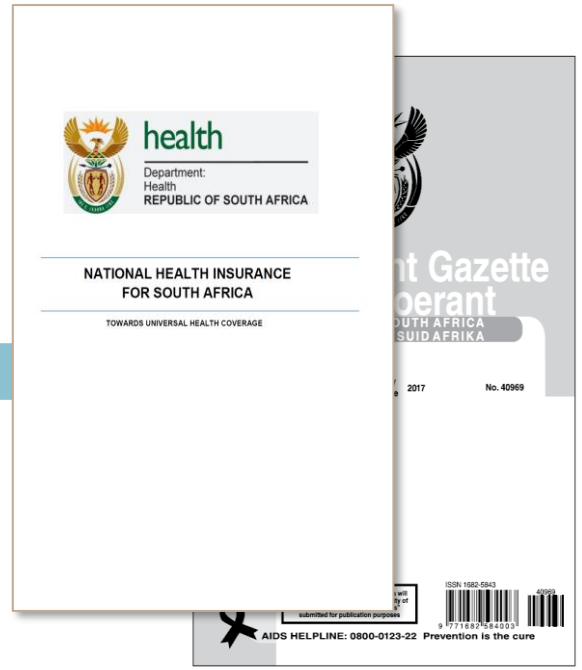
Taylor Commission, SHI, 2002

MTT on SHI, 2005

LIMS, 2006

2007

Focus of DOH reforms since Polokwane 2007 has been NHI, leaving medical scheme reform largely in limbo for the last 15 years.



Competition Commission price ruling

\+ Guardrisk ruling

RETAP

Draft MSA amendment bill

Abandonment of remaining scheme reform pillars

Ignoring of Health Market Inquiry recommendations

Protracted PMB reform

Stop & Start, drawn out LIMS / LCBO reforms

What if ?

Risk Equalisation Fund

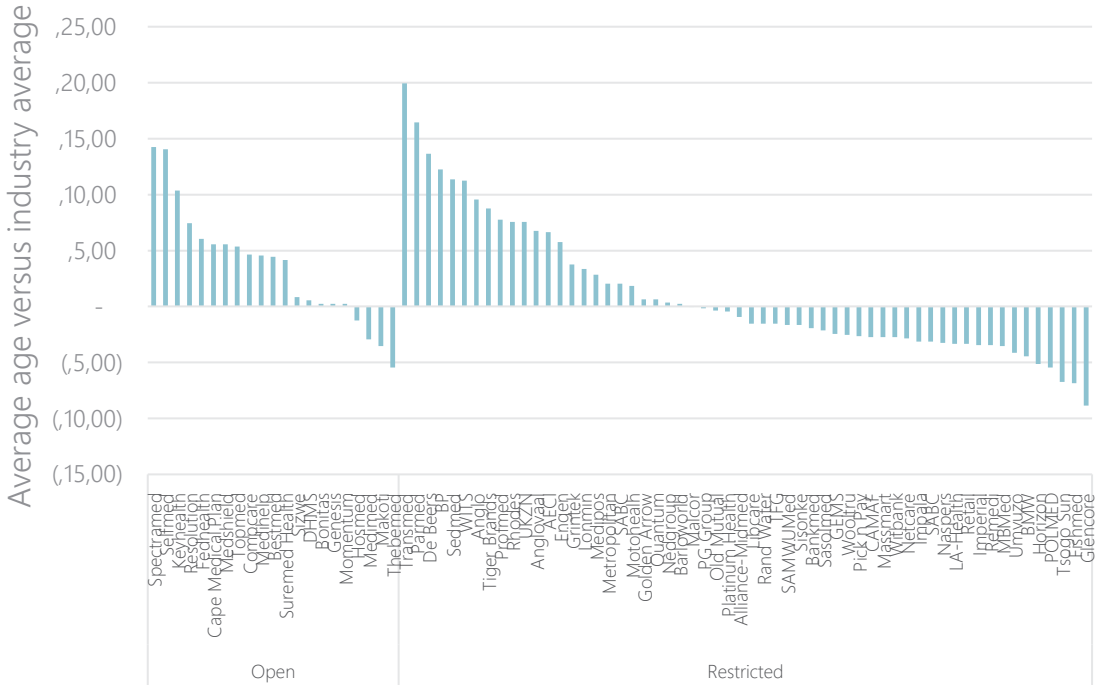
Had REF been implemented, medical scheme contributions would have better reflected efficiency instead of selection.

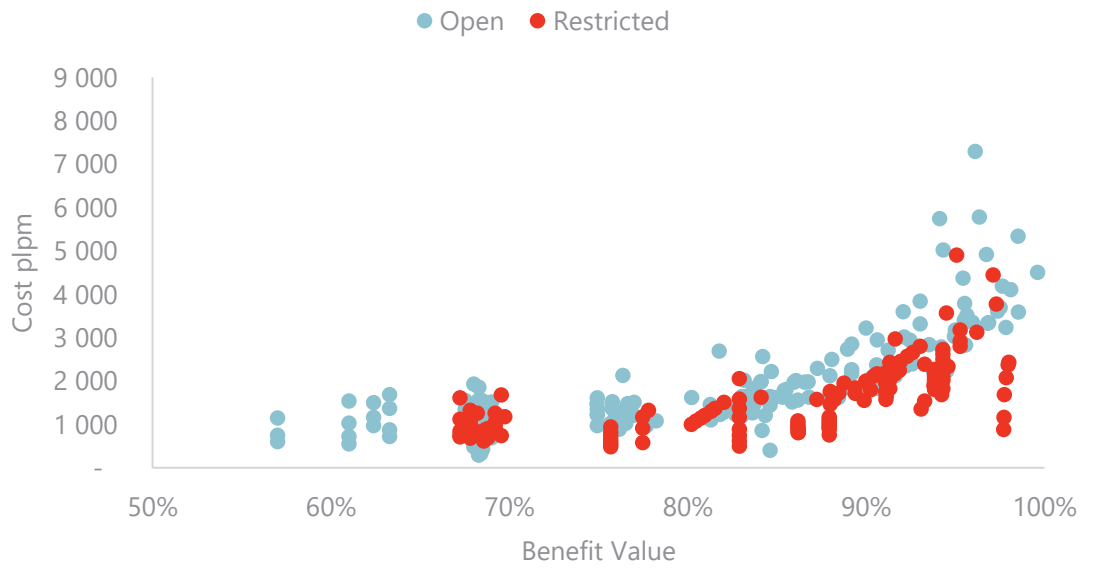
Schemes would have consolidated, as inefficient schemes would have been forced out of the market.

Wealthier members would have paid more for cover, and contributions on the low end of the market would have decreased, improving access and progressivity and set the laid the ground work for an earmarked portable tax.

Costs would come down as (real) competition improved and more opportunities for efficiency were sought.

Useful to note that the REF was further proposed in the HMI recommendations referred to as a ‘Risk Adjustment Mechanism’





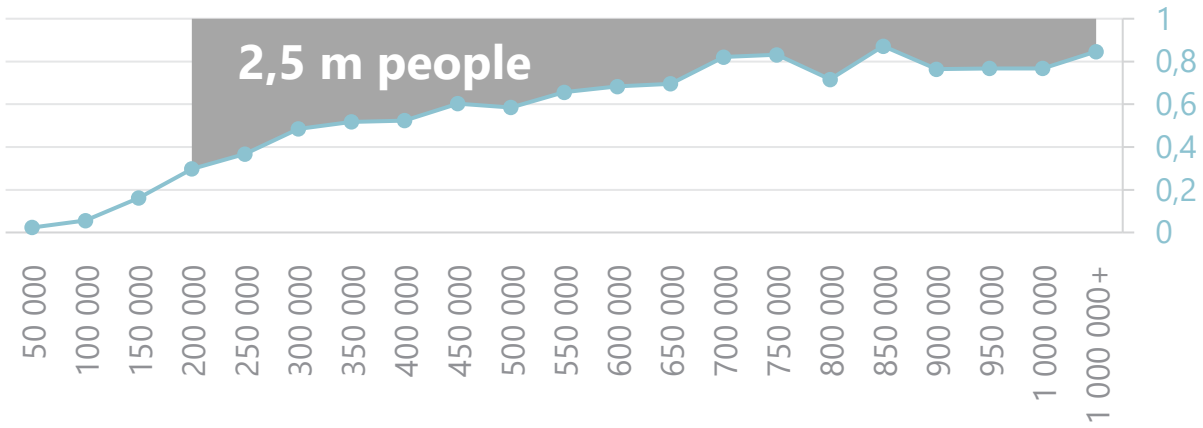
Mandatory membership

Notably not considered in the 2005 SHI paper which was based on an earmarked tax subsidy that would be directed to medical schemes **OR** the public sector

Also not recommended by the HMI until efficiency of the market is improved.

Mandatory earmarked tax

Improved fiscal participation of those not contributing to schemes, or ‘enough’ to the tax pool for health.



Could expand to 4.5m people with income cross subsidy

PMBs, modified to be closer to a BBP including primary care, would amount to circa R1000 plpm or 6% of taxable income for medical scheme members. This is roughly 2.6x the public health budget per capita.

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Mandatory earmarked tax

Improved fiscal participation of those not contributing to schemes, or ‘enough’ to the tax pool for health.

Retains choice of where to obtain services noting that additional contributions would be required for private sector services.

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LIMS / LCBO / PH Insurance

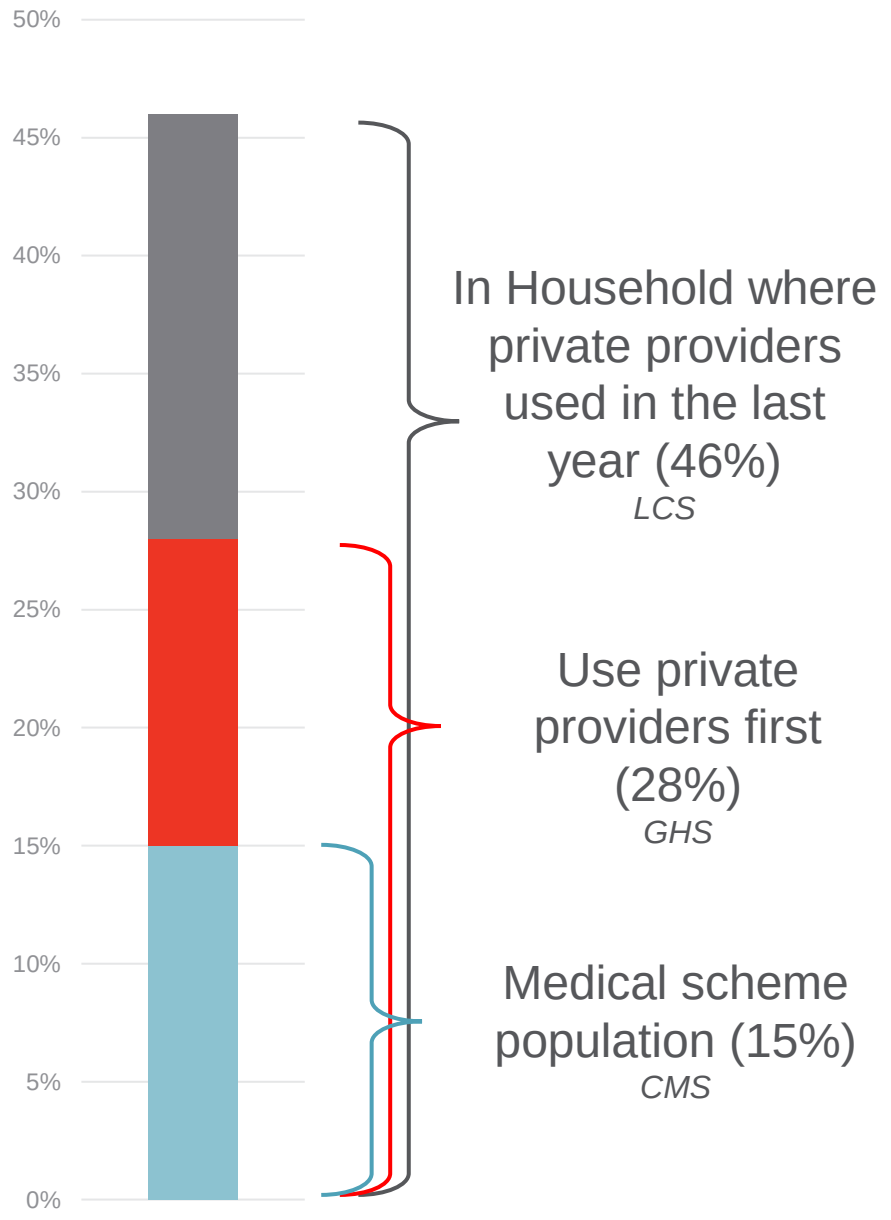
More necessary if other reforms not complete (REF and income cross subsidies, or payroll charge used to fund scheme basic benefit package) OR gap between public and private funding remained to large.

Another 5-10 million lives added to private sector risk pools with a benefit subset (primary care only, not hospital care)

Reduced OOP expenditure for lower income households

Alleviation of high frequency low intensity usage of public health system

Improved access to primary care diagnosis and treatment



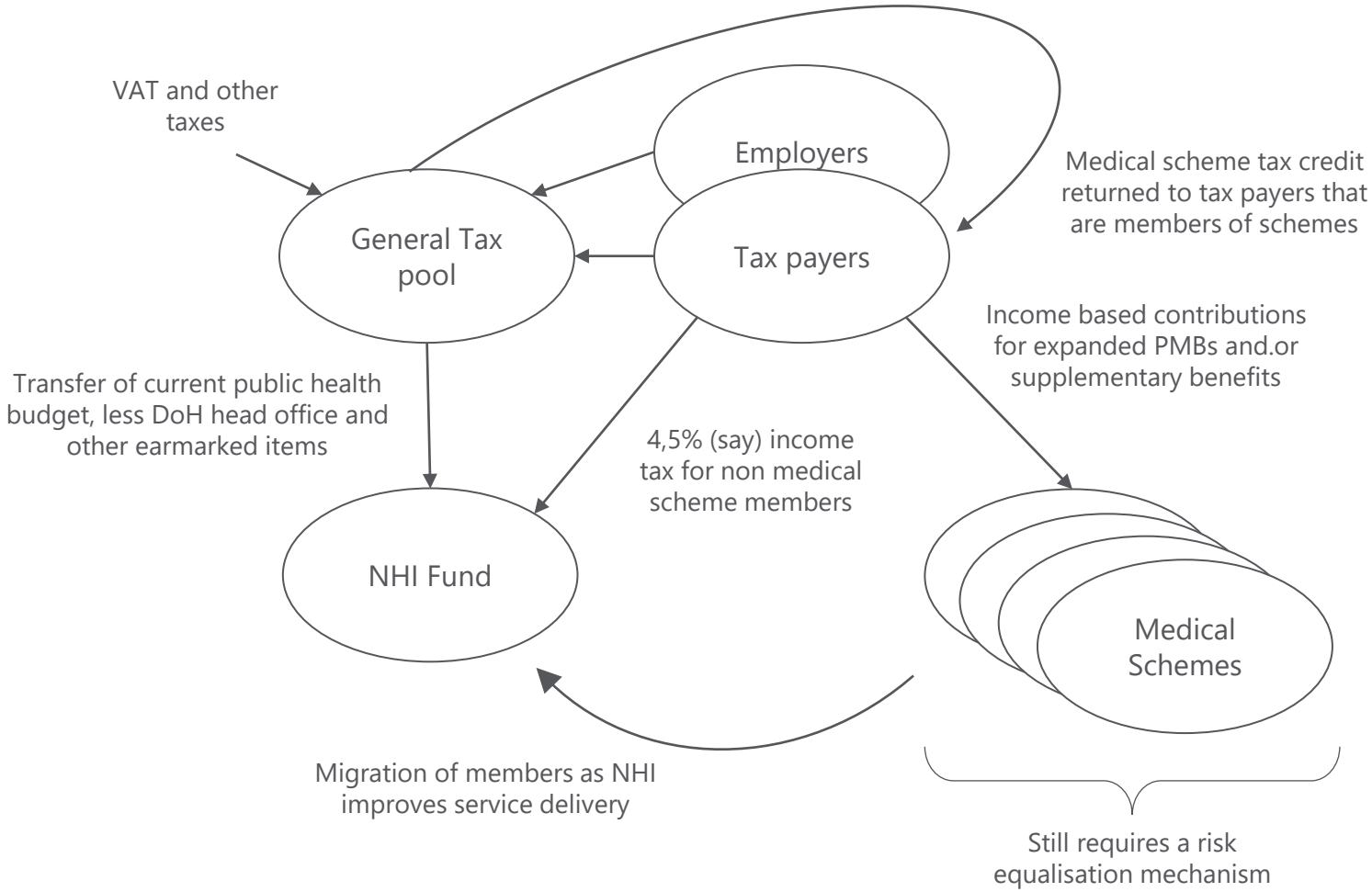
Additional funds for NHI

R30bn

Suggested shortfall for 15 specified programs to improve access and service delivery (NHI Bill memo)

- ~ Medical Schemes tax Credit of R25bn (grossed up), assuming it can be appropriated from the NRF
- ~ 1.5% payroll tax on all income earners above the tax threshold
- ~ 4,5% income tax on all current non-medical scheme members earning above the tax threshold

Transitional reconfiguration

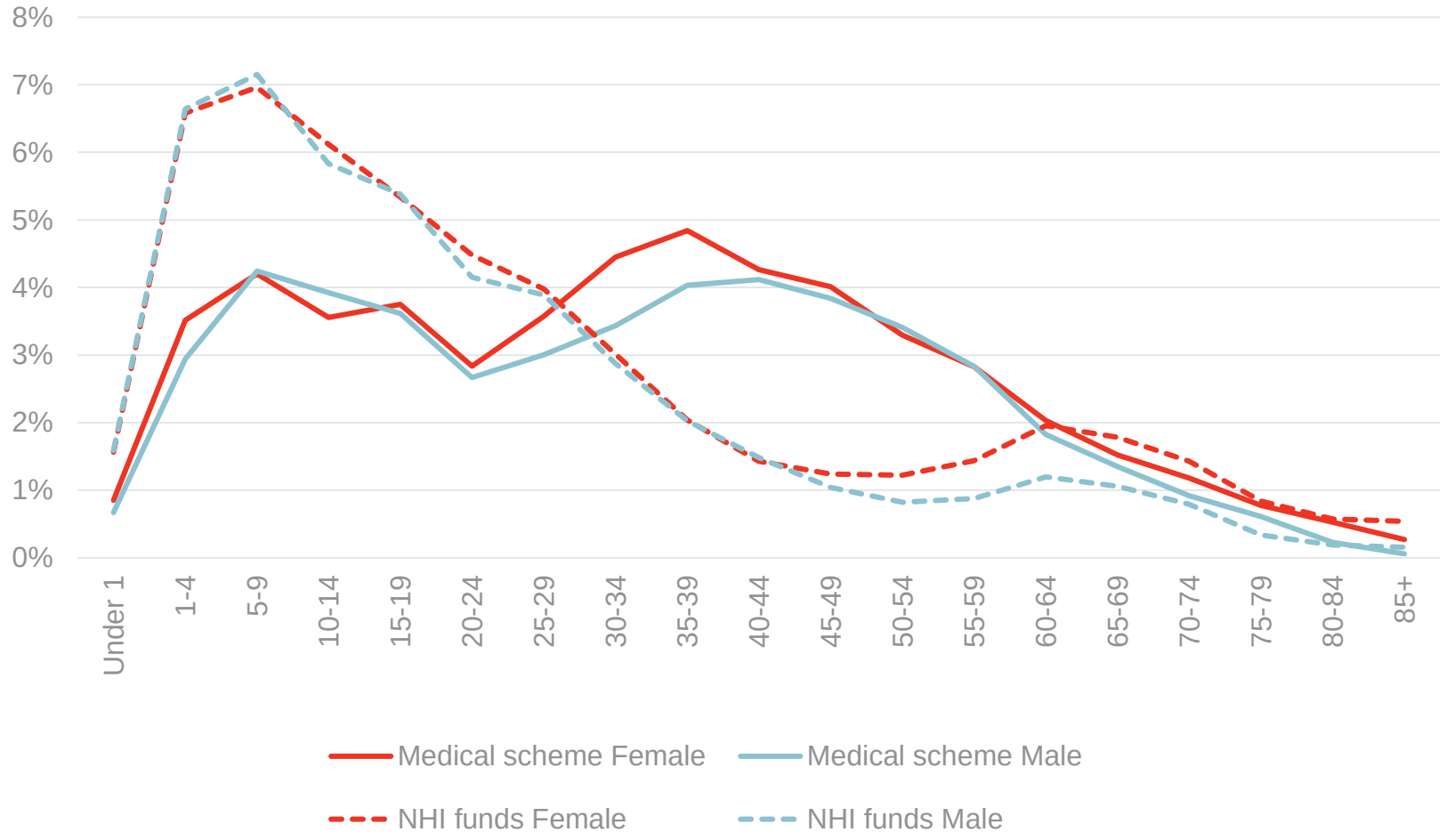


The total income to the NHI Fund under the scenario where all medical scheme members drop off their scheme and income taxpayers make the 4,5% NHI contribution. The total public health budget, including the NDoH and NHI funds would amount to R340 billion, or ~6,7% of GDP which amounts to R470 per capita per month.

Remove means test for public health access

Permit contracting between private funding and public institutions (improved revenue and service delivery)

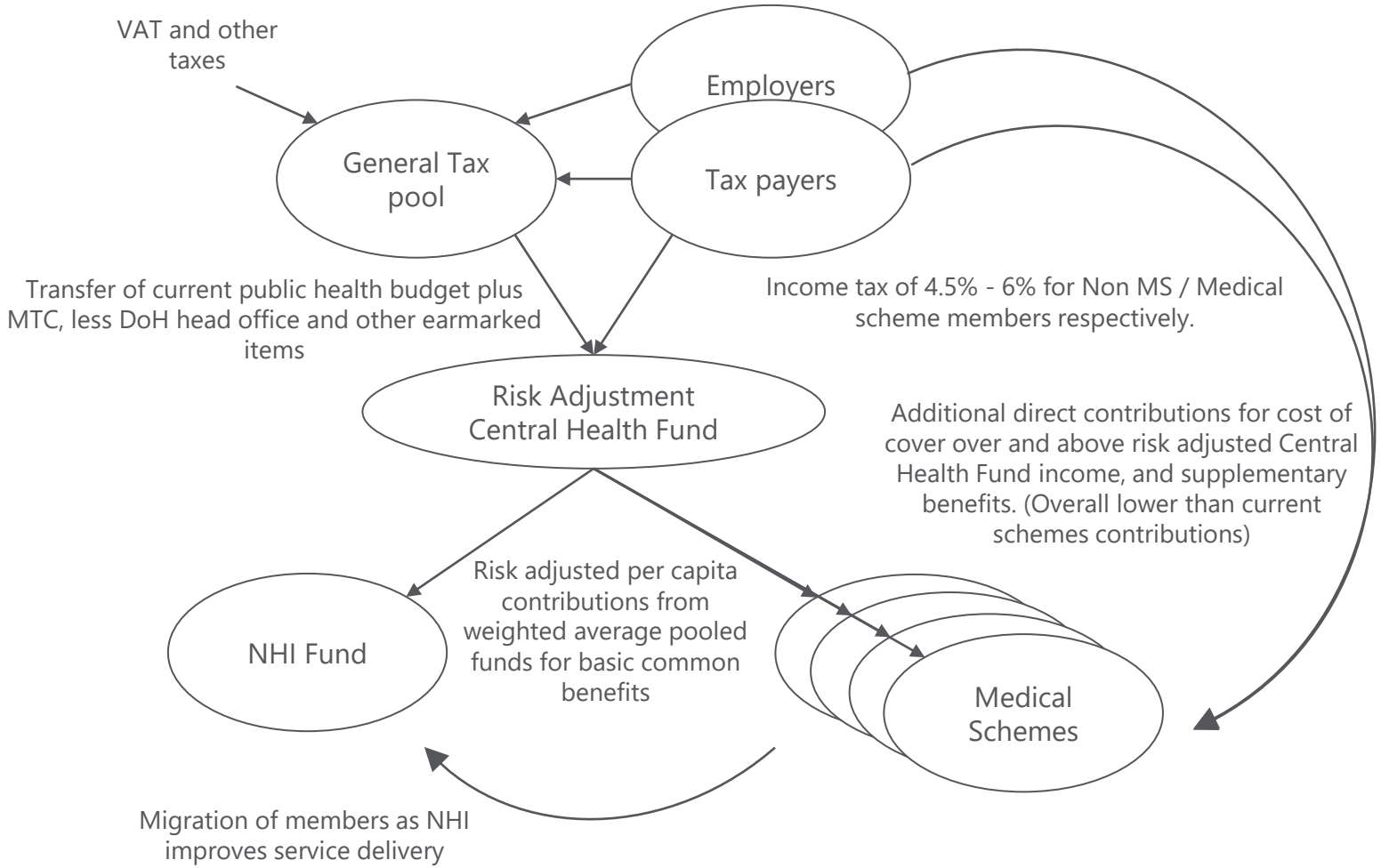
Unified system would need risk adjustment between sectors



Results in a 25% difference in per capita cost allowing only for age profile differences.

Would be offet to some extent by higher BoD in public sector

Unified multi-payer system



Public spend (with the additional R30bn) is R432 pcpm. PMBs are R976 pcpm (2018/2018 terms), or 6% of taxable income for medical scheme members.

Based on the current medical scheme membership mix, the net outgo from the Central Health Fund to the NHIF would be R495 per capita per month, a 32% increase on current public health expenditure per capita which would allow significantly expanded service procurement and capacity

The total NHIF budget under this model would be R295 Billion, before any movement of medical scheme members to the Fund. In the scenario where all medical scheme members drop off medical schemes in favour of the NHI, the NHIF budget would amount to R310 Billion (2017/2018 terms), assuming the 4,5% income tax contribution for NHIF members that are tax payers.

A plan is just an idea its until implemented

Mandatory prepayment is essential to achieve UHC

Past reform plans were well laid to get us to NHI progressively and remain sound

Choice remained a key feature of the intended system in the interim phases

Retaining choice will notably improve broad based buy-in to reforms

Portability reduces centralisation failure risk

Had planned reforms been continued we would have been much further down the road to UHC than where we are now (system is essentially unchanged for past 15 years)

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THANK YOU!