

12 *The challenges of pursuing private health insurance in low- and middle-income countries: lessons from South Africa*

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South Africa's apartheid history of legislated discrimination on the basis of race has left a legacy of massive income inequalities – with, at 0.63 in 2011, one of the highest Gini coefficients in the world (World Bank, 2017) – and inequalities in access to social services. It has also left an indelible imprint on the health sector, where private health insurance was developed to serve white workers, whereas the public health sector served the majority black population and lower-income whites.¹ Since the first democratic elections in 1994, there has been considerable commitment to addressing these inequalities. However, progress has been limited: income inequalities have in fact been growing and inequalities within the health sector are increasingly related to class rather than race.

The development of private health insurance, and policy related to it, has been heavily influenced by the social and political context. Medical schemes (the name given to private health insurance organizations in South Africa) were introduced at the turn of the 20th century, under British rule, for white mineworkers, and restricted to white South Africans until the 1970s. The number of schemes grew rapidly from the 1940s, alongside the growth of private providers. The apartheid government actively promoted privatization of health care financing and provision during the 1980s, deregulating medical schemes in 1988. Following transition to a democratic government in 1994, there were concerted efforts to re-regulate medical schemes, but in spite of

¹ The use of the terms African, Coloured, Indian (and the combined group black) and white indicates a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology, but is necessary for highlighting the impact of former apartheid policies on the health system.

these reforms, medical schemes still reflect inequities in South African society. Only the wealthiest are able to afford medical scheme cover and they are often supported by their employers and by a substantial government subsidy through tax deductions for contributions. There have been ongoing debates about introducing some form of mandatory prepayment system to address inequities in the public–private health sector mix. Although a Green Paper on introducing a so-called National Health Insurance system was released in 2011 (Department of Health, 2011), followed by a White Paper in 2015 (Department of Health, 2015), policy proposals are yet to be finalized. This chapter explores health system inequalities, the substantial inefficiencies that plague the system and the role of private health insurance within the system.

Health system context and the role of private health insurance

South Africa has a dual health system. The private sector serves the higher-income minority and the public sector serves the vast majority of the population. Before 1994, the public health sector was very fragmented, with separate health departments for each race group and for each of the four former provinces and 10 former homelands.² In addition, curative and preventive primary care services were provided in separate facilities and administered by different health authorities and, until the late 1980s, there were separate hospitals and other public sector health care facilities for blacks and whites. Distribution of facilities was biased towards historically white areas, while certain geographic areas (rural areas, particularly former homeland areas, township areas and informal settlements) were systematically underfunded as a result of apartheid policies (McIntyre & Gilson, 2002). The public health sector was also biased towards hospital-based, curative care.

After 1994, a single Department of Health was created at the national level and one in each of the nine newly created provinces. A district health system has also been instituted and considerable emphasis placed on improving primary care, with an extensive clinic upgrading and building programme and a redistribution of financial resources to the primary

² The 1913 ‘Natives Land Act’ confined Africans to living in ten ‘homelands’, which were established along ‘tribal lines’. They were highly fragmented geographic areas scattered throughout South Africa and comprised less than 14% of the total surface area of the country.

care level. In addition, there have been efforts to redistribute public health care funds between provinces to redress historical inequities.

Medical schemes (non-profit organizations initially known as Friendly Societies) have existed since 1889. At first they were only open to whites; membership for groups other than whites began in the late 1970s (McIntyre & Dorrington, 1990). Historically, there has also been significant private provision of health care, including general practitioners (GPs) in solo or group practice, a limited number of primary care clinics run by nongovernmental organizations and some commercial health maintenance-type organizations. Initially, private hospitals were limited to non-profit mission hospitals in rural areas and industry-specific facilities such as on-site hospitals at large mines. For-profit hospitals developed later and have experienced particularly rapid growth since the 1980s, promoted by an explicit government policy of privatization and deregulation. This rapid growth has continued. By the end of the 1990s, as many as 73% of doctors worked in the private sector (van Rensburg & van Rensburg, 1999). Private hospital beds have been increasingly concentrated in three large hospital groups – Netcare, Life and Medi-Clinic (who together own 84% of all private hospital beds) (van den Heever, 2007). With the exception of nongovernmental organizations, most private providers are heavily concentrated in the metropolitan and other large urban areas.

Health care expenditure was approximately US\$30.78 billion in 2013/14, equivalent to 8.6% of gross domestic product in that financial year (Department of Health, 2015). About 48% of total health care expenditure is channelled via public financing entities (including the national, provincial and local Departments of Health, the Departments of Defence, Correctional Services and Education as well as statutory funds for workers' compensation and road accidents). Private expenditure accounts for 50% of total funds. Medical schemes and provincial health departments each account for nearly 42% of total health spending. However, while medical schemes covered only 16% of the population in 2013, 84% of the population depends on provincial health department services, particularly for specialist and inpatient care. Direct out-of-pocket payments to providers account for nearly 7% of all health care funds.

Box 12.1 provides an overview of the health system. It is evident that one of the greatest challenges facing the health system is the inequitable public–private mix in health care financing and provision – the private

Box 12.1 Overview of the South African health system**Revenue collection***Sources of funds*

- Burden of funding placed both on companies and individuals, but households ultimately bear most of the burden of funding health care services (through tax, insurance contributions and out-of-pocket payments). Employers increasingly offer their employees integrated cost-to-company packages and medical scheme contributions are effectively borne by the individuals because increased contribution levels reduce other elements of remuneration.
- Some population groups are not expected to contribute (for example, the lowest income groups do not have to pay income tax but do pay other forms of tax such as value added tax (VAT); pregnant women, children under six, the disabled, the elderly and the poor are exempt from user fees at government hospitals).
- Very little donor funding in South Africa (less than 2% of total health care funding).

*Contribution mechanisms**General tax revenue*

- Generated from personal income tax (35.8% of total tax revenue); VAT (26.5%); company tax (20.9%) and a range of customs, excise and other taxes and levies (16.8%).
- Personal income tax is structured progressively with exemptions for low-income earners and the marginal tax rate ranging from 26% to 41%.
- Company tax is charged at a flat rate of 28%.
- VAT is charged at 15%, but many basic foods are exempt from tax.

Private voluntary health insurance: medical schemes

- Community-rated contributions.
- Very few medical schemes relate contributions to income level; contributions are generally at a flat rate linked to a specific benefits package. A few company-based schemes provide income cross-subsidies.

Box 12.1 (cont.)

- Government offers a significant tax break to those with private medical scheme membership. Although partially reformed over the past decade (where total scheme contributions are now a taxable fringe benefit in the hands of the employee, with a generous amount of US\$233 per person for the first two family members and US\$157 per person^a thereafter in the 2016/2017 tax year being regarded as a tax deductible allowance), those with the highest incomes benefit most from the subsidy, whereas those below the tax threshold receive no benefits.

Out-of-pocket payments

- User fees at public sector hospitals (there are no fees for primary care services) are differentiated according to income levels – the poor are exempt from fees (but there are difficulties in proving eligibility for exemptions). There are three additional income categories with very low fees for the lowest-income groups.
- Some low-income workers, who are not members of medical schemes, use private general practitioners (GPs) and retail pharmacies and pay on an out-of-pocket basis.
- The biggest share of out-of-pocket payments is attributable to medical scheme members, either in the form of cost sharing or payments for services that are not covered under the benefits package. Cost sharing is either in the form of flat amounts (co-payments) or percentage shares of the total bill (coinsurance).

Collecting organizations

- Tax is collected by the South African Revenue Service. The South African Revenue Service improved its tax collection mechanisms in the 2000s (through initially offering an amnesty to those who had not been tax compliant previously and then actively investigating noncompliance and imposing heavy fines) and, as a result, tax revenue has increased dramatically.
- Health insurance contributions are collected directly from members (often employer and employee payroll contributions) by the medical schemes. Each scheme has a Board of Trustees, which oversees the scheme's activities.

Box 12.1 (cont.)**Risk pooling***Coverage and composition of risk pools*

- Medical schemes cover only 16% of the population and include high- and some middle-income formal sector workers and their immediate dependants. There is risk pooling within individual schemes in relation to the Prescribed Minimum Benefits (PMB) package (see section on Recent developments), but most schemes have individual medical savings accounts for primary care services. There are 83 medical schemes (2015) that compete with each other for members, and each scheme has a number of benefits packages (known as options), so there is a considerable fragmentation into some 300 small risk pools.
- The remaining 84% of the population is largely dependent on tax-funded health services, and comprises low-income formal sector workers, informal sector workers, the unemployed and the poor. A small part of this population pays out of pocket to purchase primary care services in the private sector, but is entirely dependent on the public sector for specialist and inpatient services. Therefore, there is a very large risk pool and anyone who needs care and is unable to pay will receive a user fee exemption (the exemption policy is liberally applied).
- There is no risk pooling between the tax funded pool and the medical schemes. The public–private mix is therefore the main challenge to equity: while medical schemes cover only 16% of the population, 50% of funds are in the private sector (the 42% funded through medical schemes and most of the 7% of out-of-pocket payments are made by scheme members).

Allocation mechanisms

- At present, there is no risk equalization between individual medical schemes; although risk equalization was proposed, which would have increased pooling between individual schemes, this has never been introduced. Even if it were introduced, this will not address the lack of pooling between the tax-funded pool and medical schemes environments unless there is explicit risk pooling across the sectors (McLeod, 2012b).

Box 12.1 (cont.)

- Tax funds are centrally collected. Funds are allocated from the central government to provinces (for all sectors) using a needs-based formula and then each province has the autonomy to decide how to allocate these funds to individual sectors (for example, health and education); that is, South Africa has a fiscal federal system.

Purchasing***Benefits package***

- Those using tax-funded health services have a relatively comprehensive benefits package. No set of services is specified; instead South Africans have access to a full range of health services from those provided at primary care clinics through to those provided at highly specialized hospitals. Certain very expensive services (such as dialysis and organ transplantation) are implicitly rationed through resource constraints.
- All medical schemes have to cover services in the PMB package, which includes inpatient care, certain specialist services and care for common chronic conditions. Each scheme offers different benefits options, which include the PMB and various other services. Although schemes are not permitted to impose financial limits or charge co-payments for services in the PMB, there are considerable limits and co-payments for other services and large out-of-pocket payments for care outside the PMB package. The PMB package accounts for just over 50% of risk benefit expenditure in medical schemes, that is, excluding benefit expenditure paid from medical savings accounts. Some schemes (or benefits options within a scheme) specify the service providers that can be used (for example, a specific chain of private primary care clinics or a specific private hospital group or sometimes public hospitals) while others permit free choice of provider. Scheme members may choose to use public sector hospitals, for which their scheme will be expected to pay (although fees charged at public hospitals are the highest for medical scheme members, they are nevertheless lower than at private hospitals). There is an incentive for scheme members to declare their insurance status at public hospitals as the scheme will cover the entire bill. However, submission of bills by public hospitals to schemes is notoriously poor, not least because hospitals do not retain user fee revenues but instead remit them to the provincial Treasury.

Box 12.1 (cont.)***Purchaser–provider relationship and provider payment mechanisms***

- Public sector facilities are allocated budgets from the provincial Department of Health, via districts, which are expected to develop plans and budgets that reflect the health needs of the local populations. All public sector staff are paid salaries.
- Medical schemes are the largest purchaser of private sector services (although some individuals purchase services directly from these providers). Medical schemes have not been very active in their purchasing activities and private providers have relatively more power in the process of purchasing and agreeing reimbursement mechanisms and rates (for example, the three large private hospital groups dominate these processes relative to the 83 schemes). Despite attempts at reform, private providers are still often paid on a fee-for-service basis. Some general practitioners have accepted capitation payments from medical schemes that serve lower-income groups. There are also a few private primary health care clinics that employ salaried staff. Private hospitals prefer to bill on a fee-for-service basis, but have agreed to per diem payments and case rate reimbursement for common operations with some schemes.

Provision

- There is an extensive and well-distributed network of public sector primary health care facilities. The hospital network is less well developed and hospital distribution is uneven (there is an average of 458 people per public hospital bed), with specialist services being heavily concentrated in certain provinces. The number of health professionals working in the public health sector is very low relative to the population it serves. There is considerable controversy at present about staff to population ratios in South Africa due to the poor quality of human resource data. However, according to the most recent estimates there were approximately 27 doctors per 100 000 inhabitants and 10.7 medical specialists per 100 000 inhabitants in the public sector in 2010 (Day & Gray, 2010).

Box 12.1 (cont.)

- The private health sector is very well developed but is heavily concentrated in the large metropolitan areas. There are three large private hospital groups (there is an average of 266 people per private hospital bed). The majority of health care professionals work in the private sector, despite serving a minority of the population. The most recent estimates indicate that there were 37 general practitioners per 100 000 inhabitants and 57 medical specialists per 100 000 inhabitants in the private sector in 2010 (Day & Gray, 2010).
- There is growing interest in complementary medicine among higher-income groups and 11 healing modalities (such as homeopathy) are formally recognized (Gqaleni et al., 2007). It is estimated that there are over 185 000 traditional healers in South Africa (Gqaleni et al., 2007) (that is, about 230 people per traditional healer) and these are in the process of becoming registered.^b Payment for complementary and traditional medicine is almost entirely on an out-of-pocket basis.

Sources: Authors; all medical scheme information in this box is taken from CMS (2016).

Notes: ^a Average exchange rate in 2016: US\$1 = 14.7 South African Rand.

^b The Traditional Health Practitioners Act of 2007 was signed into law in 2008. The Interim Traditional Health Practitioners Council was inaugurated in 2013 (Sabinet, 2013).

health sector has the majority of financial and human resources, which are used to serve a minority of the population.³

Private health insurance market development and trends

Brief historical overview

The early history of private health insurance saw the unregulated formation of company-based health care funds, which were subsequently formalized under the Friendly Societies Act (1956) and later under the

³ Medical scheme members are the major users of private sector services. By 2010, 'whites' made up only 35.7% of medical scheme beneficiaries (McLeod, 2012a). Hence, the minority using private services is now based on class or income level, rather than race.

Medical Schemes Act (1967) (see Box 12.2). Medical schemes were initially subject to community rating and minimum benefits requirements, and different schemes provided very similar benefits. Reforms implemented during the 1980s and early 1990s led to increasing use of private insurance principles (McLeod, 2005). The 1986 Browne Commission supported the application of risk and experience rating of contributions, as well as more individualized benefits (Department of Health, 2002). It also argued that there would be significant cost savings if members paid small claims themselves and only claimed from pooled funds after paying an initial amount. These measures would substantially reduce the size of risk pools and the degree of cross-subsidy between young, old, healthy and sick people.

Before 1989, a medical scheme could only vary its contribution rates based on income and number of dependants. After 1989, contributions could also be based on age, geographic area, extent of cover provided, length of membership, size of group and actual claims experience. Schemes were therefore able to reduce existing cross-subsidies in line with the view prevailing among insurance companies that cross-subsidies within health insurance were unfair. Hence, in 1994, the first democratic government inherited a medical scheme system characterized by risk rating. The same year, a leading scheme introduced personal medical savings accounts (MSAs), with no intervention from the regulator, and other schemes rapidly followed suit (see Chapter 13 in this volume).

Aggressive competition among medical schemes for low-risk members (risk selection) in the 1990s had adverse consequences in terms of health care equity and access, with older people and those with chronic diseases particularly affected. Throughout the 1990s, benefits declined and vulnerable groups were increasingly excluded from coverage. By 1999, no open scheme⁴ permitted anyone over the age of 55 to join as an individual member and almost all open schemes applied lifetime exclusions for pre-existing conditions and used experience rating without restriction (Department of Health, 2002). Since 1994, policy formulation and legislation have turned back to solidarity principles, although medical schemes still operate in a voluntary membership environment. The substantially revised Medical Schemes Act No. 131 (1998) (the Act) has applied since 1 January 2000.

⁴ Schemes may choose to restrict their membership if they are attached to a large employer, union or other defined group. In contrast, open schemes must freely admit anyone who applies.

Box 12.2 Key developments in the market for private health insurance in South Africa, 1889–2015**1880s to 1950s: Before regulation**

- First employer-based private health insurance scheme, De Beers Consolidated Mines Ltd Benefit Society, set up (1889). Seven such schemes develop (1910)
- Public Health Act to coordinate health care (1919)
- Private practitioners develop. Rapid growth in unregulated medical schemes (48 schemes in 1940)
- Gluckman Commission proposes national health service similar to the British model but the political landscape shifts and the proposal is not implemented (1944) (Gluckman, 1944)
- Change of government and the beginning of the formal apartheid years (1948)
- Advisory Council for Medical Fund Societies formed (1950) to act as a representative in negotiations with organized doctors

1950s to 1970s: Early regulation and tariff conflict

- Financial control of schemes imposed by the Friendly Societies Act (1956). This included the need to maintain financial accounts, appoint an auditor, impose restrictions on loans to members, follow a certain process for mergers and submit annual accounts to the regulator. No legislated control of solvency margins
- Continued rapid growth in the number of schemes (to 169 schemes in 1960). These only serve the needs of the urban white middle class, for which membership is de facto mandatory via employment
- Calls for more regulation, but not mandatory membership, by Reinach Committee of the Snyman Commission (1962) (Reinach Committee, 1962)
- First Medical Schemes Act (No. 72 of 1967) creates Central Council for Medical Schemes to look after the interests of schemes with a registrar to oversee their activities. Minimum benefits for members and community rating formalized
- Remuneration Committee established to deal with fee-setting conflict between schemes and the medical profession (1969)
- Continued growth of medical schemes, which reach their highest number of 305 (1974)

Box 12.2 (cont.)

- Conflict between providers and schemes on tariffs escalates. Remuneration Committee is abolished and fees to be set by statutory medical council provided that doctors no longer contract out of tariff schedule (1978)
- Contracted-in doctors can send bills directly to medical schemes rather than to patients for payment (1980)

1984 to 1994: Free market reforms and risk rating

- Medical Schemes Amendment Act No. 59 of 1984 aims “to prevent the socialization of health services” and introduces a series of market reforms. Contracting-in is abolished. Each profession and supplier group to determine their own tariffs through their own statutory control bodies. Representative Association of Medical Schemes to determine the scale of fees for schemes after consultation with providers. If provider charges are equal to or less than the scale of benefits, the scheme must pay the provider directly (1984)
- Browne Commission (1986) argues that the public interest is served through the gradual privatization of public health services with the state responsible only for indigent patients. Recommends removal of minimum benefits, freedom in benefit design, risk rating for specific member groups (for example, age categories) and making consumers financially responsible for the cost of low-cost, high-frequency doctor claims
- Amendment to Regulation 8 of the Medical Schemes Act No. 72 of 1967 allows the market to determine the number of schemes and risk rate contributions (1989)
- Medical Schemes Amendment Act, No. 23, introduces further far-reaching changes, abolishing statutory guaranteed minimum benefits package and guaranteed payment for claims. The statutory role of the Representative Association of Medical Schemes in fee-setting also abolished. Schemes allowed to exclude or limit cover, risk rate to a greater extent and supply health care directly to members through their own facilities and by employing health professionals (1993)
- Melamet Commission established and reports just before transition to democratic government (Melamet Commission, 1994).

Box 12.2 (cont.)

Further deregulation recommended and insurance (underwriting at enrolment, freedom in benefit design, risk-rated premiums) argued to be the best way of providing health cover. Recommendations also include allowing brokers to charge commission, using a statutory actuary, investing in listed companies' shares and removing protections for retired persons. Insurance products provide non-indemnity cover, typically a fixed amount paid on occurrence of an event regardless of the actual spending. In contrast, medical schemes provide indemnity cover (the amount reimbursed is linked to actual spending). Insurance products to compete with medical schemes and both to be governed by a single piece of legislation. Scheme supervision and the role of trustees to be strengthened while the schemes to be given more autonomy: freedom with disclosure. Supervision of the industry and the regulator's office to be significantly strengthened with an independent statutory body (1993–1994)

1994 to 2000: Return to solidarity under democratic government

- African National Congress elected in the first democratic elections. Key African National Congress Health Plan published. Role of medical schemes to be further investigated, but principles already established for social health insurance (1994)
- Philosophical direction recommended by the Melamet Commission rejected and replaced by the strategic direction from the National Health Insurance Committee of Inquiry (1995) (South Africa (Republic), 1995)
- Completely revised Medical Schemes Act No. 131 (1998) prepares medical schemes for future social health insurance. Core principles of open enrolment, community rating and PMB re-established. Supervision of the industry substantially strengthened by the establishment of the Council for Medical Schemes (CMS) and the Registrar as an independent statutory regulator (1998, implemented from January 2000)
- Indemnity business (Medical Schemes Act) demarcated and legitimate health insurance (Long-term and Short-term Insurance Acts) clarified (1998). In effect, all indemnity cover (that is, related to actual spending) can only be offered by medical

Box 12.2 (cont.)

schemes. Health insurance products supplied by long- and short-term insurers can only provide non-indemnity cover and must not allow for payments directly to health care providers

2000 to 2008: Preparation for social health insurance

- Taylor Committee reports on a comprehensive social security framework, proposing to change retirement and health care funding from voluntary to mandatory for formally employed people (2002) (Department of Social Development 2002)
- Long-awaited National Health Act establishes the framework for the health system consisting of public, private and nongovernment components. The Department of Health to act as the steward of the whole health system, with responsibility for regulating the private sector to achieve national health objectives (2003)
- Competition Commission rules that collective fee-setting by the organizations representing medical schemes, health care providers and hospitals is not lawful. Temporary measures put in place for the CMS to determine national reference prices on behalf of the Department of Health. These used in negotiations between individual schemes and providers. Reimbursement levels typically expressed as a percentage of the National Health Reference Price List (NHRPL), although very large schemes also develop their own fee schedules (2004)
- Formula Consultative Task Team designs and obtains industry consensus on formula for risk equalization between schemes (McLeod et al., 2004). International Review Panel supports its findings and calls for urgent implementation (Armstrong et al., 2004). Task Team dealing with income cross-subsidies reports but does not obtain consensus or approval (2004)
- Extension of minimum benefits in medical schemes to cover diagnosis, treatment and medicine according to therapeutic algorithms for 25 common chronic conditions (2004)
- Introduction of regulations on medicine pricing (at the level of manufacturers, logistics service providers and dispensing fees for pharmacists and doctors). Spending on medicines, previously the main cost driver in medical schemes, now lower than spending on hospitals or specialists (2004)

Box 12.2 (cont.)

- Low Income Medical Schemes stakeholder consultative process reports on ways of extending cover to low-income workers (Broomberg, 2006), but no formal acceptance by the government (2006)
- Medical Schemes Amendment Bill No. 58 of 2008 provides for the establishment of a Risk Equalization Fund to be managed by the CMS to set up a framework for paying risk-adjusted amounts to medical schemes (2007, but not passed)
- Retirement reform accelerated as plans for a mandatory social retirement system are explored by an Inter-Ministerial Task Team (Ministerial Task Team on SHI, 2005). Health reforms lag behind (2007)
- Regulatory framework for NHRPL, to be managed by the Department of Health, established after delays. Some providers charge 300% of NHRPL and conflict in fee-setting escalates with members of medical schemes bearing the brunt of escalations. Industry concerned about hospital costs and calls for a central bargaining chamber for fee-setting (2007)
- Department of Health prepares NHRPL, but this is challenged in court by private provider groups. No effective regulation or guidance on private provider fees in place (2008–2011)

2008-present: Efforts to move towards universal health coverage

- The 52nd National Conference of the African National Congress (ruling party), held in Polokwane in mid-December 2007, commits to pursuing what is termed a National Health Insurance System. Substantive reform of medical scheme environment put on hold
- Green Paper on the National Health Insurance released in August 2011; suggests medical scheme cover could be restricted to top-up insurance
- The Competition Commission began a Market Inquiry into the Private Healthcare Sector in January 2014. The brief is to enquire into the state, nature and form of competition in the private health sector
- White Paper on the National Health Insurance released in December 2015; similar implications for medical scheme cover as Green Paper

The 1998 Medical Schemes Act

Since 1998, medical schemes have been clearly demarcated as the only vehicles providing for the reimbursement of actual spending on health (known as indemnity cover). Hence, any funding arrangement that is intended to assist in meeting the actual costs of medical services must satisfy the requirements of the Medical Schemes Act. These requirements include being registered under the jurisdiction of the Council for Medical Schemes (CMS), having financial guarantees, maintaining prescribed solvency levels, having at least 6000 principal members,⁵ adhering to product design requirements and regular reporting to the Registrar of Medical Schemes, who is the chief executive of the CMS.

Crucially, the Act re-introduced three key principles to enhance risk pooling within schemes (Doherty & McLeod, 2003):

- *open enrolment*: open schemes have to accept anyone who wants to become a member at standard rates;
- *community rating*: everyone must be charged the same standard rate, regardless of age or state of health. Community rating currently applies to each benefits option in each medical scheme rather than for the industry as a whole;
- *prescribed minimum benefits*: a minimum benefits package as regulated by the CMS must be offered by all schemes. Beneficiaries must be covered in full for the specified conditions⁶ with no financial limits or cost sharing. Schemes may insist on the use of a contracted network of preferred providers and drug formularies to manage care.

As the Act came into force, some schemes attempted to create hybrid products combining a medical scheme plan with high deductibles (no

⁵ That is, members who pay contributions. Beneficiaries are all those covered by the medical scheme, including the families of principal members.

⁶ The PMB package is a list of some 270 diagnosis and treatment pairs primarily offered in hospital (introduced on 1 January 2000); all emergency medical conditions (clarified from 1 January 2003); diagnosis, treatment and medicine according to therapeutic algorithms for 25 defined chronic conditions on the Chronic Disease List (introduced on 1 January 2004). The goal of introducing PMB was to cover potentially catastrophic costs and the costs of the most common chronic diseases.

underwriting, community rating, low commission) with a health insurance policy that exactly met the deductible (underwriting, risk rating, very high commission). The net effect was essentially to continue to offer risk-rated cover. Another challenge to the new environment included the excessive use of reinsurance contracts to transfer all of the risk from the non-profit medical scheme to a registered long-term insurer in the same financial group. These activities required decisive action by the new regulator. Despite considerable opposition over several years, the regulator prevailed and the industry settled down to the new legislative environment.

The Medical Schemes Act of 1998 provided for much stronger governance of medical schemes and the industry as a whole. Each scheme is now governed by a board of trustees, of which half are elected by members, and their duties are codified by the Act. The Act also tasked the CMS with the protection of beneficiaries, rather than with the protection of the industry, as was previously the case. Its executive arm, the office of the Registrar of Medical Schemes, has grown substantially from being a small deputy directorate within the Department of Health to being a statutory body with expanded regulatory powers. Funded by a levy on medical scheme members, the office is staffed by a professional team including accountants, lawyers, health economists and health professionals. In addition to regulation, the CMS is responsible for accrediting organizations that provide services to medical schemes.

Trends in private health insurance

Medical schemes have steadily declined in number from 305 in 1974 to 83 schemes in 2015 (CMS, 2016), and further consolidation is expected. In 1994, open and restricted schemes had approximately equal numbers of members. Open medical schemes, under the direction of aggressive insurance companies, began to use brokers to attract business with favourable risk profiles and gradually the entire open scheme market followed. Brokers were only legally recognized from 2000, by which time nearly 70% of all medical schemes members belonged to open schemes. Brokers' costs incurred by open schemes constituted 1.2% of gross contribution income and 14% of non-health care spending by these schemes in 2015 (CMS, 2016). This cost is of concern because it

mostly relates to members being ‘churned’ from one open scheme to another, rather than to acquisition of new members. By 2007 there were more individual health brokers accredited with the CMS (over 9700)⁷ than there were GPs (approximately 7000; Econex, 2009).

Member numbers have increased steadily from 1.4 million in 1974 to 3.95 million in 2015, and the number of beneficiaries grew from 3.5 million to 8.8 million over the same period (CMS, 2016). In the mid-2000s, there were an estimated 1.5 million people without cover who live in households in which somebody has cover (McLeod, 2007). Although these numbers are somewhat dated, they highlight that some families do not register all their children with schemes. While there are age restrictions whereby children cannot be covered when they reach 21 years, a key issue influencing coverage is that contributions must be paid for each dependant (even though the contribution rate per child is lower than that for adults), suggesting that some families struggle to afford medical scheme cover.

Based on the available information, the distribution of health coverage is as follows. Over 84% of the population is entirely dependent on tax-funded hospital-based services (inpatient care and specialist outpatient care). About 20% of this population uses private sector primary care services (mainly GPs and retail pharmacies) on an out-of-pocket basis while the remaining 80% use public sector primary care services. Just over 16% of the population is covered by medical schemes. About 45% of medical scheme beneficiaries belong to schemes with an MSA component.

The problem of medical scheme affordability is considered to be the greatest obstacle to growth in the industry. At higher income levels, some 75–85% of the employed are already members. This share falls rapidly for lower-income groups so that, among those with earnings just above the tax threshold, only one third are members (McLeod, 2010). Less than 10% of workers with earnings below the tax threshold can afford medical scheme cover. This drop in affordability is compounded by the inability of many lower-income families to cover all of their family members, even with an employer subsidy.

⁷ From Council for Medical Schemes schedules of brokers, available at: www.medicalschemes.com.

*Changes in relation to key actors*⁸

Although medical schemes are non-profit entities, they are surrounded by a number of for-profit entities that provide administration, marketing, managed care, consulting and advisory services. Consumers can therefore confuse the non-profit medical schemes and the high-profile listed companies that act as third-party administrators. Since 2000, scheme administrators and managed-care companies have been required to be accredited by the CMS. There has been some consolidation among the largest administrators, but many small administrators have been set up to profit from this lucrative business. In 2015, there were 16 third-party administrations, down from 23 in 2009 (CMS, 2016). The market is highly concentrated and the largest three administrators provide services for 80% of beneficiaries. Less than 7% of beneficiaries belong to schemes that are self-administered. In 2015, there were 25 accredited managed-care organizations; there are some concerns about the risk-taking role of some of these organizations. As indicated earlier, the increasing and substantive involvement of brokers over the past decade and a half is also of concern.

The role of employers in medical schemes has been declining for some time. Over the past decade, a growing number of employers have chosen to limit their involvement with medical schemes to paying

⁸ A small market for nonindemnity health insurance (allowing for underwriting and risk rating and characterized by high rates of commission), provided by short-term and life insurance companies supervised by the Financial Services Board, accounts for about 1.1% of private health expenditure. According to the Long-term Insurance Act (Act 52, 1998) and Short-term Insurance Act (Act 53, 1998), health insurance policies may not indemnify policyholders against actual medical expenses, but instead must offer a sum that is assured and defined in advance of any health care provision and may not directly reimburse health care providers. However, the insurance industry, and in particular short-term insurers, continued to sell indemnity products in defiance of the 1998 legislation. A landmark judgement in December 2006 that would have terminated this practice was appealed. The initial judgement was overturned and an appeal by the regulator to the Constitutional Court was turned down. The Minister of Health produced revised wording for the definition of the business of a medical scheme in the Medical Schemes Amendment Bill, which was introduced to parliament in mid-2008 but subsequently withdrawn in an attempt to enforce the original intention of the 1998 legislation. As these products have very limited coverage, they are not dealt with further in this chapter.

contributions to open medical schemes. This is partly due to the changing nature of employment, with people no longer spending their entire working life with one employer. In the 1970s, it was typical for an employer to provide medical cover and other employee benefits over and above a cash salary. In the 1980s and 1990s there was a growing move to so-called cost-to-company remuneration; as employers became concerned about the total cost of an employee (cash salary plus benefits), they fixed the total remuneration level, but also gave employees more flexibility in choosing cash or benefits. Medical scheme membership is seldom offered as an additional benefit but included as part of an employee's total remuneration. Moreover, the presence of brokers and the incentives offered to them to direct members to open schemes has exacerbated the declining role of employers.

Trends in relation to income and risk cross-subsidies

Medical schemes are not permitted to differentiate contributions by age, gender or state of health, but they can use income-related contributions as a factor to build in a deliberate cross-subsidy from high-income to low-income workers. The proportion of options within restricted schemes making use of income-related contributions has declined significantly over time, from 83.9% in 2004 to 61.0% in 2006. Nevertheless, restricted schemes make greater use of income-related contributions than open schemes. Open schemes struggle to obtain reliable income information and have largely moved away from any internal income cross-subsidies, not least because they fear attracting low-income older people instead of more desirable low-income, young workers.

Since 1994, surveys have documented a significant movement towards excluding pensioners from company funding for health care, which reduces risk cross-subsidies within medical schemes. The full effect of transferring investment risk and medical inflation risk to older people and future pensioners will take some time to unfold. McLeod et al. (2003) described the issue as “a future affordability time bomb”, warning that it will affect the industry when those joining companies from around 2000 onwards reach retirement age. The issue has been receiving some attention from the Department of Social Development as part of the evaluation of retirement reform proposals (McLeod, 2007) that postulate setting up a mandatory social security system for retirement.

Developments over the last decade

A very positive development over the last decade has been the government's re-establishment of a restricted scheme for public sector workers. In the apartheid years, the public sector had a restricted scheme for each racial group, but during the 1990s public sector workers were allocated an employer subsidy for medical schemes and could use this to join any open medical scheme of their choice. This approach fuelled the growth of the role of brokers in the 1990s. A review of remuneration for public sector employees identified major shortcomings in relation to medical scheme cover, including inequality in access to cover, affordability concerns, lack of value for money, spending inefficiencies and little integration with public sector health care (McLeod & Ramjee, 2007). Despite a relatively generous medical scheme subsidy, less than half of the 1 million state employees were using the subsidy, and those that did so were using open schemes.

In 2002, the cabinet approved a framework policy for a new restricted medical scheme for public sector employees only, centred on the principles of equity (equal access to basic benefits), efficiency (with respect to costs and delivery of benefits) and choice of benefits (employees could choose more expensive cover and pay for it themselves). The Government Employees Medical Scheme was registered in January 2005 and became operational in January 2006. Government attracted potential members by offering a higher medical scheme subsidy within the Government Employees Medical Scheme and making it the only option available for new employees. The scheme grew rapidly and by December 2009 it had over 400 000 principal members or over 1.1 million beneficiaries. It has since grown more slowly, reaching a peak of 1.85 million beneficiaries in 2013 and declining to 1.77 million beneficiaries in 2015 (CMS, 2016). (The evolution of the number of beneficiaries of open and restricted schemes is shown in Fig. 13.2 in Chapter 13.) It is the largest restricted scheme, accounting for over 45% of all restricted scheme beneficiaries, and the second-largest medical scheme in South Africa. The high subsidies, income-related contributions and strong purchasing power of the new scheme proved successful in many respects. In particular, a low-wage-earning civil servant and his or her family are able to join the lowest cost option without contributing (that is, the government pays the full contribution). The implementation of the Government Employees Medical Scheme sets an example to other employers by

demonstrating that it is possible to develop benefits packages that are affordable to all employees.

There were also efforts to promote risk pooling across individual schemes and across benefits options within schemes. A proposed amendment to the Medical Schemes Act in 2008 would have given the CMS responsibility for the operation of a Risk Equalization Fund. However, this amendment was never passed by parliament; efforts to introduce a range of new regulations of medical schemes were overtaken by the ruling party's decision to rather pursue a tax-funded, single purchaser system (see below). The purpose of the Risk Equalization Fund that was proposed was to protect open enrolment and community rating by ensuring that risk selection (deliberately attracting the young and healthy) was penalized. The Risk Equalization Fund would have created an industry-wide risk pool for those covered by medical schemes, and ensured an industry-wide community rate for the PMB, regardless of the age and disease profile of each option.

Policy-makers also signalled a desire to reduce the number of benefit options. In 2004, an International Review Panel argued that only a limited number of supplementary benefits options should be allowed above the PMB (Armstrong et al., 2004). The 2008 Medical Schemes Amendment Bill took a different line, suggesting that all hospital events should be covered in a single basic pool and that benefits above that level must also be pooled across all members in the scheme that choose an extension of cover. In essence, this would have changed benefit design from a series of vertical silos, each with its own community rate, to a series of horizontal pools and non-overlapping benefits pools, each with a community rate. Members would then have been able to choose which benefits they wanted and the contribution rate would have been determined by summing the prices of components of the benefits package. There was a strong negative reaction to this proposal from the schemes and the bill was not passed. Benefit package reform has largely stalled; the only change, introduced in 2008, was to allow efficiency-discounted options (EDOs) (CMS, 2016: p.27). There is no difference in benefit coverage between EDOs and non-EDOs; EDOs are simply more restrictive in the network of service providers that members can use. By 2016, only eight open schemes had introduced an EDO (CMS, 2016).

Assessment of market performance

This section critically assesses the effects of voluntary private health insurance (in the form of medical schemes) on financial protection, equity in financing, equity in the use of health care, efficiency and quality of care; it also analyses its effects on the overall health system.

Financial protection

The extent to which medical schemes have contributed to ensuring universal protection against the financial risks of ill health has changed considerably over time. In colonial times, South Africa had a strong public health sector that covered almost all citizens. Mission hospitals served some rural populations where there were no public facilities, but over time these hospitals were integrated into the public health sector. During the apartheid era, separate public health services were provided for white and black people (for example, there were always at least two public hospitals in large towns). Token user fees were charged at public facilities and as there was no incentive for facilities to generate user fee revenue, given that all revenue was transferred to the Treasury, fee exemptions were applied liberally. Generous exemptions constituted substantial protection from direct health care costs, although many patients, particularly in rural areas, had to incur considerable transport costs due to the relatively limited provision of services in rural areas.

Medical schemes initially developed to cover the costs of privately provided primary care (particularly GP visits, retail pharmacy services and some specialist care), essentially a response to the rising expectations of wealthier, particularly white, people. In this way, they provided financial protection for those who wished to spend more on health care. However, the costs that were covered, mainly for routine primary care, were relatively small, and medical scheme members are now expected to cover these costs on an out-of-pocket basis or through MSAs.

In the 1980s, there was an explicit government policy of promoting the growth of the private sector (Working Group on Privatization and Deregulation, 1986; South Africa (Republic) 1987). As noted by a policy-maker at that time: "Health authorities must not be seen as an infinite source of health facilities and medical care. More people

should be able to make use of private health facilities” (Ross, 1982). As a result, by 1990, 62% of general doctors and 66% of specialists worked in private practice (Rispel & Behr, 1992), compared with about 40% of doctors in the early 1980s (Naylor, 1988), and the number of for-profit general hospital beds nearly doubled from around 9900 beds in 1988 to over 18 400 in 1993 (McIntyre et al., 1995). Public facilities were racially desegregated in 1988 and the use of public hospitals by medical scheme members began to decline very rapidly, with an equally rapid growth in the use of private hospitals. During this period, medical scheme membership among the black population grew particularly fast, largely as a result of trade union demands for employers to provide medical scheme cover to black staff and as part of the government’s efforts aimed at “the co-option of certain groups of urban blacks by improving their immediate living environment and welfare services, and by offering them a stake in the capitalist system” (Price, 1989).

These developments made out-of-pocket payments for privately provided health care unaffordable, particularly in relation to the growing use of private specialist and hospital care. Consequently, medical schemes are now an important mechanism for providing protection from potentially catastrophic costs for those who choose to use private facilities. However, medical schemes also provide less financial protection than previously because of rapidly rising health care costs and reductions in benefits (increasing cost sharing and growing exclusion of services from cover). Many scheme members cover these costs out of pocket. By the late 1990s, two thirds of all out-of-pocket payments for health care were made by medical scheme members (Cornell et al., 2001). The most significant development in recent years has been the introduction of PMBs in 2000. These have been critical to providing financial protection for those choosing to use privately provided health care.

Equity in financing

Contributions to medical schemes are community rated and so not explicitly linked to age or health status. However, given that each scheme has a number of different benefit options, it is possible that there is an element of self-selection into more comprehensive and higher-cost benefits options by higher-risk members, if they have sufficiently high incomes to afford these options. The most recent financing incidence study found that the incidence of medical scheme contributions is regressive across

members. Contributions by the lowest-income 40% of members are equivalent to 14% of household consumption expenditure, whereas contributions by the richest quintile of members are less than 6% (McIntyre, 2010). This is largely due to most contributions being charged as a flat monetary amount. Higher-income individuals tend to choose more comprehensive benefits packages and thus, in general, pay higher contributions than lower-income groups, but the regressivity of contributions indicates that the differentiation of the flat contribution rate across benefits packages is not as great as the differences in income levels across members.

When considering the overall incidence of health financing across all South Africans, medical scheme contributions are strongly progressive for two main reasons (Ataguba & McIntyre, 2012). First, the highest-income groups belong to medical schemes and, second, the contributions these groups make to schemes are very high. However, the fact that the magnitude of the contributions is related to inefficiencies and poor cost containment within this environment (see below) detracts from this so-called progressivity: a far greater proportion of the population could benefit from the funds in medical schemes if the schemes operated more efficiently. Also, although the higher-income groups that belong to medical schemes bear the greatest burden for financing health care, they also derive all the benefits provided by the schemes.

Evaluation of the impact of medical schemes on equity in financing also needs to take into account the substantial subsidy provided by the government in the form of tax relief for contributions. According to the most recent estimates, these tax credits amounted to 16 billion South African Rand in the 2014/2015 financial year (Department of Health, 2015). In addition, the government devotes a considerable amount of general tax revenue to pay medical scheme contributions on behalf of civil servants, estimated to exceed 20 billion South African Rand in 2014/2015 for the largest civil servant schemes. These tax credits and contributions to medical schemes reduce the amount of tax resources available for those who rely on publicly funded health services. The magnitude of this subsidy has been repeatedly criticized by health sector analysts, especially since the tax deductions particularly benefit those with the highest incomes and do not benefit employees who fall below the income tax threshold. Partly as a result of these criticisms, the Treasury revised tax concessions for medical schemes in 2005, spreading the subsidy more equitably across tax payers; nevertheless substantial public funds are directed to supporting medical schemes.

Equity in provision and use

Private providers are heavily concentrated in urban areas; this does not create too many barriers to accessing services for medical scheme members because most of them live and work in urban areas, although as service provision is relatively biased towards the wealthiest localities within urban areas, it is the lowest income scheme members who face limitations in access. Nevertheless, given the overall magnitude of private provision relative to the population served, there are very few barriers to service access for medical scheme members.

In terms of use of health services, an analysis of data from the only household survey that permits the calculation of utilization rates indicate greater utilization rates among medical scheme members (an average of 5.5 outpatient visits per beneficiary per year and 144 inpatient admissions per 1000 beneficiaries per year) in 2008 than among those who are not members (4.1 outpatient visits per person and 92 inpatient admissions per 1000 people per year) (Harris et al., 2011). Use of services by medical scheme members occurs largely in the private sector (85% of outpatient and 82% of inpatient care), with very limited use of private providers by those not covered by medical schemes (17% of outpatient and 4% of inpatient care).

Medical schemes have played an important role in removing financial barriers to using health care when needed for those with cover. However, in terms of the overall health system, they have entrenched inequities in access to health care between those with private cover and those relying on publicly funded health care. Developments since 1995 may have changed this pattern. Severe reductions in medical scheme cover of routine health care spending may have led to differences in rates of service use by socioeconomic status⁹ among medical scheme members. The introduction of free primary care at public facilities in 1996 has also reduced financial barriers to health care for those without medical scheme cover. Unfortunately, recent data on utilization rates that could demonstrate these likely changes are not available.

⁹ This may not be the case for PMB-covered services, to which all medical scheme members are entitled, irrespective of socioeconomic status.

Quality of care and efficiency in the delivery of services

There are almost no data that would allow evaluation of the quality of care or efficiency of service delivery. There is no routine assessment of the quality of care purchased by the medical schemes, and patients have limited recourse when they receive poor quality of care. They may report providers to the Health Professions' Council of South Africa, but experience has shown that this institution seldom takes action. A Hospital Rating Index developed by the largest medical scheme administrator (Discovery), which took into account cost, quality and value for money, was scuttled due to vociferous opposition from private hospitals. The reality is that scheme members often have no real choice of hospital. Almost all private specialist practices are based in private hospitals and thus the specialist to whom one is referred automatically determines the hospital of admission. In addition, choice of hospital for specific procedures is usually limited outside the largest metropolitan areas.

Although data on efficiency are limited, it is evident that medical schemes have few incentives to operate efficiently. Evidence on the rate of spending increases, particularly in the periods 1981–1993 and 1996–2004 (McIntyre et al., 1995, 2007), indicates that schemes have paid very little attention to ensuring that services are provided at the lowest possible cost. This appears to have continued over the last decade. Medical schemes use the standard set of managed-care practices, such as pre-admission certification and drug utilization review, but it is not clear that these have been effective. One initiative aimed at enhancing technical efficiency is the promotion of generic medicine use through user charges for prescriptions, but this is a relatively passive approach on the part of the schemes. Government legislation and regulation, such as enabling generic substitution by pharmacists and medicine-pricing regulations, have been far more effective in controlling the costs of medicines than actions by medical schemes.

Medical schemes have very limited purchasing power and are unable to effectively negotiate reimbursement rates with providers, either in terms of the form of payment mechanism or the level of the reimbursement rate. This is particularly true in relation to private hospitals (which account for the largest portion of medical scheme spending), given how concentrated the market has become, with three groups owning over 80% of all private hospital beds (van den Heever, 2007).

A few of the largest medical schemes have succeeded in negotiating a per diem rate with certain private hospital groups, and a few schemes serving low-income employees pay GPs on a capitation basis, but fee-for-service is by far the dominant payment mechanism. As indicated in Box 12.2, former statutory mechanisms for establishing provider reimbursement rates are no longer in place. There has been discussion since 2007 about establishing a central bargaining chamber, and in 2014 the Competition Commission initiated a Market Inquiry into the Private Healthcare Sector to address growing concerns about the high costs of private health care.

In terms of allocative efficiency, there is potential for medical schemes to change their benefits packages as health care priorities change, but there is no evidence that they have adapted benefits on this basis. Once again, it is regulatory intervention that has promoted allocative efficiency goals. For example, the PMBs have focused on chronic diseases and hospital care to address the major burden of disease among scheme members, including adding AIDS to the list of chronic diseases, a clear demonstration of allocative efficiency concerns. The PMBs have also been involved in the development of very detailed treatment protocols, to enhance cost-effectiveness. However, medical schemes have undermined allocative efficiency by reducing cover of primary care, which must be paid for via MSAs or out of pocket, whereas specialist visits are still usually covered. This has promoted a relative reduction in the use of GPs and an increase in the use of specialists.

The existence of 83 schemes and some 300 benefit options does not contribute to administrative efficiency. The rate of increase in non-health care spending within medical schemes, particularly in the late 1990s and early 2000s, was dramatic. This spending, which includes administrative costs, managed-care management services, reinsurance costs and broker fees, accounted for only 8.4% of total scheme spending in 1997 but had increased to 16.2% by 2006 (CMS, 2008). This was of considerable concern, especially given that managed-care efforts do not seem to be particularly effective and brokers are not introducing new members but simply juggling existing members between different schemes. The Council for Medical Schemes consistently interrogated these costs in their annual reports. By 2015, non-health care spending had been reduced to 8.6% of medical scheme spending (CMS, 2016).

Impact on the health system

The existence of voluntary private health insurance has had a profound and largely negative impact on the overall health system. First, it has seriously limited the potential for income and risk cross-subsidies, separating 16% of the population (the highest earners) from the rest of the population. At present, there is no risk pooling between schemes, or between different benefit options within schemes. Of more concern is the fact that the wealthy minority belong to schemes that dispose of 42% of the financial resources in the health sector. This disproportionate spending highlights the system's deficiency in relation to income cross-subsidies.

Second, voluntary private health insurance has been the main contributor to high and rapidly increasing health care spending, which is not translated into commensurate improvement in health status. Public spending on health care flatlined in real per person terms from the mid-1990s to 2003, whereas the spending spiral in medical schemes continued unabated, with real contribution rates per beneficiary increasing by over 6% per year between 1996 and 2006. However, real public spending on health care has been increasing over the past decade, while medical scheme contributions have continued to grow at rates well above the consumer price index. Real per person spending on medical scheme beneficiaries was 3.6 times greater than the government's per person spending on nonbeneficiaries in 1996. This differential rose rapidly to 7.6 times by 2003, but has since declined to 4.8 times in the early 2010s.

Third, private provision could not have grown as rapidly in the absence of voluntary private health insurance. Prepayment to schemes (as opposed to out-of-pocket payments to private providers) and the fee-for-service provider payment mechanism have induced a migration of health professionals from the public to the private sector. This has created a vicious cycle of health professional incomes becoming far higher in the private sector (with the possible exception of nurses), resulting in a further exodus of staff to the private sector; a growing number of professionals serving a stagnant pool of medical scheme beneficiaries, leading to increases in the fees charged by these professionals as well as supplier-induced demand and uncontrolled growth in medical scheme spending; and medical scheme cover becoming increasingly unaffordable at the same time as schemes being unable to expand cover to lower-income workers. All of this leaves the public sector with a limited number

of health professionals attempting to serve the needs of the vast majority of the population in the context of growing health needs, particularly those related to the HIV/AIDS epidemic, contributing substantially to a decline in the quality of publicly provided care.

Proposed mandatory prepayment for universal coverage

The possibility of introducing some form of mandatory (social or national) health insurance has been a subject of considerable debate since the late 1980s. The objectives of all proposals to date have been to address problems in the medical scheme environment and the public–private mix by promoting social solidarity in health care funding (McIntyre & van den Heever, 2007).

Initially, the focus was on introducing a social health insurance scheme with mandatory contributions and membership for formal sector workers and their dependants, or at least those formal sector workers above the income tax threshold. The Treasury opposed such proposals, viewing social health insurance contributions merely as another tax that would increase the tax-to-gross domestic product ratio above the level it deems desirable and place a burden on what is believed to be an already over-taxed middle-income group (McIntyre, Doherty & Gilson, 2003). The Treasury was also concerned about the potential impact on employment levels if mandatory contributions were to increase the cost of labour, a concern shared by employer groups.

Although initially anxious about the potential implications of social health insurance, medical schemes were generally supportive of these proposals, given that it was envisaged that medical schemes would serve as financial intermediaries or insurers under social health insurance (as in the Dutch health system). Not only would this secure their future within the health system, it would also expand their membership base to include all formal sector workers and their dependants. Private for-profit providers were of a similar view; they anticipated that extending insurance coverage through social health insurance would translate into a larger group of patients being able to use their services.

However, the reform direction changed when, in December 2007, the African National Congress (the ruling political party) adopted a resolution at its policy conference to implement what was termed National Health Insurance (NHI). At first it appeared that this would mean that efforts would be made to create a more integrated funding pool, with

formal sector workers making mandatory insurance contributions and government contributing on behalf of the rest of the population. It was unclear what the role of medical schemes would be, but the Government Employees Medical Scheme was seen as the foundation of the proposed NHI.

The Minister of Health released a Green Paper on NHI in August 2011 (Department of Health, 2011), which proposed more extensive reforms than those envisaged previously. This document indicated that the NHI reforms would be phased in, and that the focus of the first phase was to create the conditions for the efficient and equitable provision of quality services within the public health system. Ten health districts were designated as NHI pilot sites in 2012, where concerted efforts were made to address deficiencies in facility and equipment infrastructure and improve service quality. Although the first phase was envisaged as lasting 5 years, there remains much work to be done to improve health service quality in the public sector. This is critical as the public health sector has the greatest infrastructure, serves the majority of the population and would continue to be the backbone of health service delivery in future.

In the second phase of reforms, the emphasis would be on establishing an NHI fund. Although termed insurance, the NHI fund is not envisaged as a contributory insurance scheme with benefits tied to contributions. Instead it would be a tax-funded public institution, whose primary role would be that of a strategic purchaser of health services from both public and private providers. Together, the two phases of reforms are intended to ensure universal entitlements to comprehensive health services for which there would be no user fees at the point of service delivery. The role of medical schemes is seen as that of providing top-up insurance.

A White Paper on the NHI was released in December 2015 (Department of Health, 2015). This reiterated the proposed approach outlined in the Green Paper. It also discussed potential sources of funding for the NHI fund, namely a combination of continued allocations to the health sector from general tax revenue as well as possibly a surcharge on personal income tax, increases in value added tax and/or other tax increases. There was a call for public comment on the White Paper; the revised White Paper has yet to be released.

Although neither the Green nor the White Paper clearly states the reasons for the shift in reform direction, several likely motivations are apparent. The emphasis in these reforms is on moving towards universal

health coverage with a universal entitlement to financial protection from the costs of health care and access to quality health services. Pursuing social health insurance for the benefit of formal sector workers and their families would likely entrench inequalities in health service access across socioeconomic groups, whereas a single funding pool would dramatically improve both income and risk cross-subsidies in the overall health system. A monopsony purchaser could use its financial power to ensure that the cost of health services is affordable and sustainable and to pay providers in a way that creates the appropriate incentives to promote efficient delivery of quality care and an equitable distribution of services across the country (McIntyre, Brijlal & Nkosi, 2015), something that medical schemes have been unable to achieve.

Although there is potential for the NHI proposals to move the South African health system towards a universal health system, many challenges would need to be overcome. There are widespread concerns that there has been little progress in finalizing a policy and detailed implementation plans for health care financing reforms almost a decade after the ruling party's commitment to the NHI approach. At the same time, any substantive legislation or regulation of medical schemes has been put on hold. This policy hiatus not only contributes to uncertainty for all health sector actors and the public, but also means that existing health system challenges remain unaddressed.

Conclusions

South Africa provides an excellent example of the dangers of pursuing voluntary private health insurance and serves as a stark warning for other low- and middle-income countries not to follow that path. None of the arguments presented in favour of private insurance coverage are upheld in the South African context. There is no evidence that medical schemes have promoted efficiency and, in fact, their track record on technical and administrative efficiency has been dismal. Medical schemes are unable to control rapid increases in health care spending and non-health care spending grew particularly dramatically until placed under relentless scrutiny by the CMS. Although there are no accurate data on technical quality of care in the public and private sectors, there is undoubtedly a perception among South Africans that the private sector offers better quality of care than the public sector. This is in no small part due to the disparities in staff-to-population ratios (particularly in

relation to specialists) in the two sectors. Thus, voluntary private health insurance has not led to higher quality of care; it has simply contributed to rising quality differentials that did not exist in the past.

There is no doubt that considerable additional financial resources have been drawn into the health system through the development of medical schemes. However, these resources only benefit the 16% of the population covered by medical schemes. Most importantly, these schemes have not significantly relieved pressure on government budgets. Instead, considerable government resources are used to sustain them, both through tax relief on medical scheme contributions and through government contributions to very costly medical scheme cover for civil servants. In the context of the disproportionate share of people with HIV/AIDS who rely on publicly financed and provided care, it is the public sector that bears the major burden of meeting the health needs of South Africans.

Finally, while medical schemes in their early years of development provided a prepayment option for those who were paying out of pocket for privately provided health care, this has not been the case for some time now. Medical scheme members face considerable out-of-pocket payments due to cost sharing and coverage exclusions. Schemes have been unable to expand coverage to low-income workers who use private primary care providers on an out-of-pocket basis; indeed, coverage declined relatively dramatically as a percentage of the population, from about 17% of the population in the early 1990s to under 15% in 2003, and only began increasing again with the introduction of Government Employees Medical Scheme in 2006.

The South African health system has reached a critical point. On the one hand, the public sector has seen an exodus of health professionals and received no real per person funding increase for the decade up to 2003, despite growing health needs arising from the HIV/AIDS epidemic and an epidemiological transition. Over this period, staff morale and quality of care declined at alarming rates in the public sector. Although government funding for the health sector has increased over the last decade, the task of rebuilding a deeply undermined public health system is enormous. On the other hand, the voluntary private health insurance environment is faced with spending increases that have spiralled out of control. Government regulatory efforts have been helpful in some respects, but they do not tackle the fundamental issues of the quantity and distribution of private providers or the price of private sector

services. For these and related reasons, South Africa is seriously considering pursuing a more integrated funding system to achieve universal coverage to address existing income and risk cross-subsidy problems. However, excessive delays in finalizing proposed reforms have created a policy vacuum and challenges facing the South African health system are mounting by the day.

Postscript

Since this Chapter was drafted, the Competition Commission's Health Market Inquiry released its final report in late 2019 (<http://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf>). The findings are in line with the analysis presented in this Chapter. In addition, the National Health Insurance Bill was submitted to parliament in 2019, and is undergoing public comment (https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf). The Bill is in line with the policy direction laid out in the White Paper.

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