World Health Organization

WHO COUNTRY OFFICE FOR SOUTH AFRICA

In reply please refer to: **HSS/18/01**

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Adv Clint Oellermann
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Dear Oellermann

Subject: SUBMISSION ON REGULATORY GAPS IN HEALTHCARE FINANCING

The World Health Organization (WHO) would like to congratulate the 'Health Market Inquiry' (HMI) for initiating a discussion on the need for and impact of selected interventions to address regulatory gaps within healthcare financing in South Africa, with the aim of strengthening competition. We are pleased to submit comments for your consideration as a part of your deliberations based on experiences globally.

The WHO firmly believes that patients as consumers will be the main beneficiaries if the recommended regulatory changes are undertaken to fill the regulatory gaps in healthcare financing in South Africa.

Please find attached answers to questions posed in the HMI "Call for Submissions and Participation in Seminar" issued on 1 December 2017.

Regards,

Dr Rufaro Chatora
WHO Representative

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WHO Comments related to the specific questions:

1 ANTISELECTION

1.1 What evidence, if any, illustrates the extent of anti-selection in the medical scheme market, what are the underlying drivers and how has this changed over time?

It is nearly impossible to prevent anti-selection in the private voluntary health insurance, however low it may be. The potential underlying drivers are related to socio-economic status, age, race, among others.

Global evidence shows that only mandatory Social health insurance mechanisms such as the proposed National Health Insurance in South African Context can minimize anti selection and improve equity in the health financing. Therefore the Government should aim at speeding up the implementation of NHI to address anti-selection in longer term. To tackle anti-selection and to increase meaningful competition in the short term, the following approach could be considered:

- **Increasing the age for dependent eligibility to 26 years**[1]: There is a dip in membership after the age of around 18, when the eligibility for dependence status on parent's medical scheme option ends. Extending this age limit will improve the probability of low income people under 26 years (especially among the previously disadvantaged groups) to remain on the parent's medical scheme; improve the risk profile of the medical scheme membership and its overall revenues.
- **Savings accounts' structure, function and existence should be reconsidered:** Saving accounts allow the beneficiaries to create individual pools which are used to purchase primary care and other services not covered by the medical schemes. They decrease the amount of funds in overall pools and might be redundant in case of the change of prescribed minimum benefits.
- **Redesigning the tax subsidy** to be applicable only to low income population will incentivize low income earners to purchase the medical scheme products. The current tax credit system benefits all medical scheme members, including the 10% of the richest SA population, which undermines the redistributive impact of government policies.

1.2 How is anti-selection related to developments in income, employment and demographics?

The presented evidence by HMI in the analysis of Funders, Practitioners and Facilities shows that the poor, the unemployed and blacks have lower affordability for private health insurance premiums and private healthcare in South Africa. **Introduction of the NHI** will improve coverage for the populations currently left out of the health insurance coverage and will hence reduce the existence of anti-selection.

[1] CMS Annual Report 2016/2017

2 RISK POOLING

2.1 How to improve risk pooling in the market so as to improve competition

Large pools are preferred as they can increase resource availability, take advantage of economies of scale and reduce the contributions required to protect against uncertain needs, while still ensuring there are sufficient funds to pay for services. Large pool makes the systems potentially very effective in managing risk because of "the law of large numbers." This law increases their financial viability compared with fragmented private systems. Even the best risk-equalization models in competitive health insurance markets have imperfections and cannot sufficiently compensate for the cost distribution[2]. In a multiple pool system, the larger the pools the more stable the results over time.

However, in the present circumstances, the smaller medical schemes in South Africa should be considered for merger into larger risk pools. The minimum limit of self-sustaining option above existing limits should increase to improve competition in the short term.

2.2 What impact does the lack of a medical scheme wide mechanism to equalize for risk have on medical schemes and the cost of cover?

The funders' analysis confirms the claims that medical aid schemes are not able to control effectively cost increases as well as utilization increases that benefit their beneficiaries. The analysis confirms that the challenges of the private healthcare are systemic and cannot be overcome under the current regulatory and legislative framework.

Introduction of supplementary voluntary health insurance in parallel to the NHI will medical scheme wide mechanisms, decrease prices, increase competition in the sector and enable everyone in South Africa to access necessary services, based on the needs, together with allowing choice for those who choose to purchase supplementary health insurance.

2.3 If there is a need for a risk equalization mechanism: What are the various mechanisms that can be introduced? What impact will it have on competition? Who will benefit and who will be harmed by introducing these mechanisms to adjust for risk across medical schemes?

Many countries tackle adverse selection by providing financial incentives to the members of the medical schemes (tax credits or penalties in the USA or in Australia). Others include waiting periods, community rating, automatic renewals and other regulatory measures decreasing the adverse selection behaviour of a VHI. Creating a large risk pool, however, does not automatically translate into low premiums or low risk; what is similarly important is the diversity of risks included in a pool.

To ease the financial burden of health insurance funds with higher-risk and/or low income members and to lower the potential for risk selection, many countries create risk equalization funds (REF) and redistribute funds according to a risk-adjustment scheme. Usually, REF is a legislative requirement that

[2] See for example - http://dx.doi.org/10.1016/j.healthpol.2017.09.007

will affect all medical aids. REF would allow the wealthy to cross-subsidize lower-income earners, and the healthy cross-subsidize the sick. Central to such a system are:

- Mandatory medical scheme membership
- Income-related contributions
- A minimum set of healthcare benefits to which all those contributing are entitled (commonly known as the Prescribed Minimum Benefits or PMB's)

Other than achieving cross-subsidization, REF is also aimed at achieving efficiencies within the Voluntary Health Insurance (VHI) system. Instead of competing on the basis of advantageous risk pools, funders are expected to compete on the basis of service delivery.

Considering the existing medical schemes in South Africa have very different demographic profiles, schemes with a high proportion of elderly and/or chronically ill beneficiaries are impacted more negatively by PMB legislation (whose aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable) than those with predominantly young and healthy members, thus compromising their ability to compete effectively. Hence, REF would distribute the financial risk more evenly amongst all schemes.

In essence, REF would create a mechanism whereby money will flow from schemes with low-risk members to those with low income and/or high-risk members thus increasing the ability of such members to afford VHI. The question is, to what extent will the schemes providing coverage for the predominantly young and healthy members be hurt by such legislation?

3 Medical Scheme Benefits

3.1 What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?

- **Measure and publish quality scores across medical scheme options:** Publishing quality and outcomes, comparable to the NCQA Health Insurance Plan Ratings in the US based on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Surveys (CAHPS) which ask consumers and patients to report on and evaluate their health care experiences, improves competition for consumers as they can easily execute their choice and compare products. This includes mandatory reporting by all private health establishments. CMS should be vested with these powers in South Africa

- **Decreasing the number of options offered and their standardization across the industry:** Product standardization will enable rational choice of consumers by comparing products and refocus the medical aid schemes on improving quality and prices. It will also increase the size of pools as many current options with small number of beneficiaries will be merged. Product standardization has to be complemented with reforming the prescribed minimum benefits to offer more primary care and preventative services, and aligning the benefits to the NHI benefit entitlements.

- **Improving information about medical schemes' products and their value:** As many of the HMI analyses have shown (for example the Summary of Consumer Survey Results), consumers choose medical aid scheme cover mainly from irrational fear of the quality of services in public facilities. Products-options are not easy to comprehend and are difficult to navigate, not only for consumers, but also for providers when informing the patient about the level of their copayment. Even the regulator, Council for Medical Schemes, has difficulties in stratifying the products. Standardization of medical scheme products and information about potential costs and benefits of each product would allow consumers to execute rational choice, thus improving competition.

  As was noted by other research by the HMI (Health outcome measurement and reporting: Improving the cost and effectiveness of clinical care in a competitive private healthcare sector in South Africa), the information on quality and outcomes of private healthcare in South Africa is scant and not structured. Improving and standardizing information on quality of care provided by individual providers and the overall performance of individual medical scheme products will improve the competition in the market.

4 Conclusion - Under the current legislative framework WHO recommends:

1. Government should amend the MSA to increase the age until which young dependents can stay as dependents on their parents' benefits until 26 years of age
2. Each scheme should have low number of standardized options to improve the consumer choice and comparability of products based on information on quality and outcomes,
3. Government subsidies to medical schemes should be revisited to benefit low income South Africans
4. The current minimum size of the risk pool should be significantly increased, in a phased-in manner
5. Limiting the scope for conflict of interest among stakeholders of the private health sector
6. Savings accounts and their role should be revisited
7. Affordability of medical scheme products should be increased
8. CMS should be vested with the powers to measure and publish quality scores across medical scheme options. This includes mandatory reporting by all private health establishments
9. Medical schemes should align their information systems and data collection to the future NHI
10. The governance of medical schemes should be revisited and impact on competition of cross-ownership and cross-management should be evaluated