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SAPPF HEALTH VIEW
JANUARY – JULY 2018

Attachment to SAPPF Health View June 2018

Reaction on Health Minister Aaron Motsoaledi's unveiling of healthcare bills

What do stakeholders think of SA's proposed new healthcare laws?

On 21 June 2018 Health Minister Aaron Motsoaledi unveiled two bills intended to move SA towards universal access to quality healthcare - the Medical Schemes Amendment Bill and the National Health Insurance (NHI) Bill.

Proposed changes to the Medical Schemes Amendment Act include the eradication of co-payments for medical aid members when medical aids do not cover their full doctor or hospital bills. Vaccinations, primary and preventative care and contraceptives will have to be paid for by medical aids, which generally do not cover preventative healthcare. The bill also proposes the abolition of medical aid brokers. An NHI fund will be mandatory, and everyone who can afford to, will pay towards it. It will be like a giant state-run medical aid. The fund will pay for all state and private healthcare in the country, including private specialists and hospitals.

Council for Medical Schemes:

Sipho Kabane, acting CEO of the CMS: Most medical schemes understand the need for universal healthcare. The new law would enforce accountability among companies and improve the effectiveness of the council. The CMS is currently conducting a review of the prescribed minimum benefits (PMBs) that is likely to take another two years. But expanded benefits are likely to add to the costs borne by schemes.

Board of Healthcare Funders:

BHF chairperson Dr Ali Hamdulay: BHF is committed to the NHI. It was "imperative" that the private sector work closely with the Department of Health, "and share their views, insights and knowledge to positively shape the healthcare landscape". Schemes need more details on how the scrapping of co-payments would be implemented.

The Public Servants Association:

The PSA said the abolishment of medical co-payments is especially welcomed as relief for workers who struggle with monthly medical aid scheme contributions.

Discovery Health:

CEO Jonathan Broomberg welcomed the NHI Bill as a step in the right direction for universal healthcare and praised the priorities it sets. He said the draft Medical SchemesnAmendment Bill contains numerous complex amendments to the Medical Schemes Act and Discovery is still studying the details.

Momentum Health:

Momentum is optimistic that the private healthcare system and NHI can operate together.

Government Employees' Medical Scheme (GEMS):

Dr Guni Goolub, principal officer: GEMS believes medical aid schemes will still have a role to play, even when the NHI comes into effect.

Fedhealth:
Jeremy Yatt, CEO: Affordability issues were out of the control of private healthcare practitioners, as these were requirements set out in legislation. Yatt expects a lot of pushback on the bill, from doctors and even brokers. This could end up in court battles costing the DoH millions and elongating the time frame to implement NHI.

Bonitas:
Kenneth Marion, CEO: From a servicing perspective, brokers are "invaluable", as they aid consumers in resolving their queries quickly and efficiently and help educate them.

Doctor exodus feared as NHI proposes bold cure
*On 27 June *The Star* reported that nearly 500 anaesthetists from public and private hospitals are threatening to leave the scarce and critical profession or emigrate, should the proposed National Health Insurance (NHI) be implemented. Some analysts warned that state-regulated fees would drive doctors to emigrate, leaving the health sector worse off than it is now.
***Norton Rose Fulbright director Michelle David** said doctors would not want to be told what to charge. She said it is not likely to be accepted by all stakeholders [doctors and hospitals] that the largest purchaser of services will also be able to set tariffs. David said doctors were likely to challenge NHI in the courts, as they have challenged price control before.
***Dr Johann Serfontein, consultant at HealthMan**, said there is an underlying assumption that specialists will be employed by private hospitals. Currently the law ensures doctors work for themselves but are based at private hospitals. A survey done by the South African Private Practitioners' Forum (SAPPF) showed that 55% of specialists do not want to be employed by hospitals. Therefore, one can safely assume those will be the ones considering emigration.
***Brian Ruff**, a former medical aid executive and **founder of private health group PPO Serve**, is positive about the focus of NHI as private healthcare is unaffordable. Ruff said South Africa has a very hospital-centred system. So much care happens unnecessarily in a hospital bed that could be done outside hospitals, such as at a GP's office or day clinics.

High costs mar medical bill
***Dr Graham Anderson, principal officer at Profmed**, said medical aids could not afford to cover costs in full and damaging them would have a negative knock-on effect on private hospital groups.
***Warwick Bam, an insurance analyst at Avior Capital Markets**: Although the Minister has said using medical scheme reserves - which sit at 33% rather than the statutory 25% of total premiums - is one way for medical aids to cover co-payments, this was not sustainable as their current excess reserves would not cover co-payments beyond a few years. Anderson said the Minister must be careful of using all of schemes' reserves as medical schemes use these when high claims outnumber premiums.
***Elsabé Klinck, a healthcare consultant**: It was not yet clear how private-sector hospitals and administrators could provide services to the state. Klinck said the cost base of the services are different. Public sector hospitals don't have to pay rent for premises, and the doctors don't have to pay their own malpractice insurance premiums.

A copy of the Medical Schemes Amendment Bill can be found at:
https://www.dropbox.com/s/zjbynaqwy5zat20/Medical%20Schemes%20Amendement%20Bill.pdf?dl=0

More news on Medical Schemes

Consolidation of Medical Schemes

The Council for Medical Schemes (CMS), recently announced that it is pressing ahead with a draft consultative framework on compelling the consolidation of medical schemes. This implies the amalgamation of medical schemes that cover fewer than 6 000 families to create a larger risk pool and lower healthcare costs.

"But having fewer, bigger funds will remove competition and create a cartel that will suffer from what every other monopolised industry suffers from - higher costs, poorer quality, and less choice for end-users," wrote **Michael Settas (Free Market Foundation) in *Business LIVE 11 May* .**

About 90% of the medical schemes with fewer than 6 000 members are closed, employer-based schemes. In most of these, employers provide explicit subsidies to their employees and an additional, implicit cross-subsidy from higher income members to lower income members within their schemes. Enforcing amalgamation of these employer-based schemes, coupled with the Treasury's stated goal of removing medical tax credits, will result in a serious blow to lower income families," said Settas.

Medical scheme claims expenditure far outstrips inflation

Annual medical scheme claims expenditure rose on average by 11.3% a year over the past decade, far faster than consumer price inflation, which increased on average by just 6.1%, according to Discovery Health Medical Scheme (DHMS) data. Between 2008 and 2017, the tariffs charged by healthcare providers such as doctors and hospitals closely tracked moves in the consumer price index (CPI). Tariffs rose on average by 0.5% above CPI during this period, at 6.6%. The use of services rose 4.7% a year because of increased demand for services from an ageing medical scheme population, increase in the burden of chronic disease, changes to clinical practice and new technologies, drugs and hospitals.

Both DHMS and the GEMS experienced a sharp rise in hospital admissions in 2015-16. The financial impact of the VAT increase will extend to medical savings accounts (MSA) and out-of-pocket expenditure, whereby members can be expected to deplete their MSA balances much faster.

*****By rooting out fraudulent claims, Discovery Health saved R568-m for its client schemes last year. The main offence in 2017 was claims submitted for medicines and medical devices that were never supplied.

Council for Medical Schemes (CMS) publishes latest trend analysis

Only about 50% of beneficiaries currently claiming for CDL conditions are registered on a disease management programme, according to the CMS' latest trend analysis on chronic diseases in the private sector.

The council's GM for research and monitoring, Anton de Villiers, said patients registered on chronic programmes are sicker and claim more and that should be a concern for medical schemes. The council analysed data provided by medical schemes for the period 2011 to 2016 and found a significant increase in the prevalence of type 2 diabetes, which rose 35.4% to 31.5 cases per 1 000 members.

The prevalence of high cholesterol rose 19.7% to 41.2 cases per 1 000 beneficiaries and hypertension ticked up 10.6% to 91 cases per 1 000 beneficiaries, the report showed.

Total expenditure on PMBs constitutes 54% (R73.1-bn) of total risk benefits paid in 2016.

The expenditure on CDLs make up around 20% of the expenditure on PMBs.

This study is an update of the "Prevalence of chronic diseases in the population covered by medical schemes in South Africa" published by CMS in February 2017..

Why fraud is a multibillion-rand medical emergency

According to an article in the *South African Medical Journal*, policymakers should take cognisance of the fraud perpetrated against medical schemes and put mitigating strategies in place for the implementation of the NHI. This follows a study by two researchers from Unisa who interviewed 15 employees involved with fraud man-

agement at one of the biggest medical aid administrators. They heard how doctors, patients, brokers and syndicates are creaming off an estimated 10% of the more than R150-bn paid out every year. This backs a 2015 study which found that 52% of ethical transgressions punished by the Health Professions Council were for fraud. The most common fraud involved false claims.

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