Health care costs too high – let's cut them

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Johannesburg - Health care costs in SA are high and growing ahead of inflation, while at the same time most South Africans still receive a substandard product. Why is this so and how can we address it?

It is not that we spend too little; it is because we are not getting bang for our buck. We need more efficiency in state hospitals combined with an increased spend on preventative and primary care.

Within the private sector, we need to look at current legislation, including prescribed minimum benefits (PMBs) and community rating combined with open enrollment. The problem of high health care costs can be solved if we work together and address the right issues.

In SA, health care expenditure (both public and private) amounts to c.8.8% of GDP (according to the World Bank), which is well above the global average of 6.9%.

Even if we only consider public health care spend, at 4.3% of GDP, SA is above the global average of 4.1%. Despite this high health care spending, our infant mortality rate is still 33.6 per 1 000 live births, which is higher than the global average of 24.2 and a multiple of the 5.8 of high income countries.

Despite recent improvements, our life expectancy (62.9 years) remains meaningfully below the global average of 71.4 years. The outcomes we achieve in SA, especially for those dependent on public sector health care (where infant mortality is higher and life expectancy lower) are not reflective of the money that we spend. Why is that?

Public Health Care needs more primary care and increased efficiency

In the public sector, the main causes of high health care inflation and a substandard product are a shortage of preventative and primary care as well as inefficiencies within the system, in my opinion.

By any measurement, the public health care system in SA is very hospital focused. According to the District Health Barometer of 2014/2015, public health spend per capita in SA was R2 737 in 2014, of which only R742 was for primary health care (27%).

From this data, I estimate that we spend c.57% of our public sector health budget on hospitals (central, provincial and district). This is well above most other countries in the world, both developed and emerging. Developed economies such as Greece (42%), Australia (40%) and Canada (30%) spend much less on hospitals and more on primary care (e.g. 38% for Australia).

Emerging economies such as Niger and Ghana spend more than 50% on primary care and other countries such as Burundi, Cote d'Ivoire and Sierra Leone also spend more than SA as a proportion.

The problem with such a low spend on primary health care is that too many people land up in hospital who could have avoided this with the help of primary care. Part of this story is one of prevention, ensuring that conditions are diagnosed (HIV, TB, etc.) and treated, children are immunized and properly nourished, people are better educated on preventative care, including diet, safe sex, the dangers of smoking, exposure to carcinogens, etc.

The other part of the story is one of high-cost treatment being sought when the availability of low-cost treatment could have dealt with the condition. Many people dependent on the public sector go to hospital emergency rooms for the treatment of conditions where primary care (if available) could have been sufficient. Such conditions could include colds and flu, gastro enteritis and minor injuries.

Over time, an increase in primary care spending in the public sector could substantially reduce the burden on hospitals and help to reduce health care inflation. A meaningful boost to primary care, could also reduce private sector health care spend if it offers a viable alternative to GP visits for medical aid members.

In my opinion, the National Health Insurance (NHI) proposed for SA, should have a meaningful focus on primary health care.

The inefficiencies within the public health system in SA can and should be addressed through improved administration. Too often we hear about problems within government hospitals such as the unavailability of beds, nurses or medicine. Improved administration should be a priority of the National Department of Health, which could lead to savings and improved product.

Where the necessary skills and systems are not readily available, the involvement of the private sector should not be ruled out. We have one of the best private health care industries in the world and there must be an opportunity for the skills, technology and systems to benefit the public sector as well.

Private health care needs more primary care and a relook at legislation

The private health sector in SA provides a good product to those that are covered, but at a great cost, which is growing well ahead of inflation. According to the Council for Medical Schemes (CMS) 2014/2015 Annual Report, medical aid contribution increases over the period from 2002 to 2014, exceeded CPI by 4% p.a. on average.

The true escalation is higher than this because the CMS's calculation does not take into account that there is downgrading between options, thereby sacrificing certain benefits, and the fact that medical schemes also reduce benefits over time within options to counter some of the cost pressure.

This meant that in 2014, the average medical aid cost R1 330 per average beneficiary per month, which could mean that for an average family of four, the cost could be over R5 000 per month. Note that the "average medical aid" would not offer comprehensive benefits but it would include the so-called prescribed minimum benefits (PMBs)

The three main culprits for the high inflation and cost are lack of preventative and primary care; community rating combined with open enrollment; and PMBs.

To effectively deal with the problem, we need to significantly increase our focus on healthier living, early detection and chronic disease management (through increased investment in clinics) rather than the expensive treatment of diseases in hospitals. At the same time, we need to reconsider medical schemes legislation, with a specific focus on PMBs, community rating and open enrollment.

Primary care offers a better solution

In the case of the private health industry, an even lower proportion of total contributions is spent on primary and preventative care than in the public sector. According to the CMS Annual Report Annexures, only 9.5% of contributions made in 2014 were towards medical savings accounts.

This is extremely low (granted, the CMS figures do not reflect out of pocket spend by members) and likely driven by 1) the high cost of medical aid (many people opt for hospital plans only) and 2) the fact that the medical savings account contribution is capped at 25% by law.

Imagine how much healthier people would be if more money in the private sector was spent on primary and preventative care and imagine how much lower health care costs would be if people were treated by nurses and GPs before being sent to expensive specialists and to hospitals. The phenomenon of supplier induced demand is more fuel on the cost fire.

Few people would query their doctor on whether a certain pathology or radiology test is really necessary – especially if a third party (such as a medical scheme) pays for the test.

An extreme example of what aggressive primary care and preventative treatment can do to medical aid costs is that of the Impala Medical Plan. In 2014, the Impala Medical Plan cost R402 per average member per month, which is only 30% of the average for the whole industry.

How is it possible that Impala can be so much cheaper? The answer lies in the fact that Impala focuses heavily on prevention and primary care. Impala's members are almost always required to first see a primary health care nurse, before being able to see a GP and then moving on to a specialist.

In other schemes, members often skip these steps and go straight to specialists or are sometimes admitted by doctors into hospitals because medical savings accounts have been exhausted.

There are a few other reasons why the Impala scheme is much cheaper, including 1) membership is compulsory (so the healthy helps to cross-subsidise the unhealthy), 2) the average age of an Impala member is lower at 29.1 years vs. 32.1 years on average for all schemes (health care for the old is more expensive), and 3) lower administration costs (3.1% of contributions vs. 8.0% for all schemes on average). However, despite these additional factors, the primary and preventative care model appears to play the greatest role.

In my opinion, there should be a serious drive to encourage the increased use of primary and preventative care by medical aids in SA. It may be useful to lift the 25% restriction on medical savings accounts and for medical aids to actively encourage members to use nurses and GPs before moving to the more expensive options.

It may also be useful if the public sector's primary care offering increases meaningfully, both in quantity and quality so that it can offer competition to the private sector. Imagine the savings if you only needed to purchase a hospital plan, whilst all your primary care needs are dealt with by public clinics. Over time, this should lead to much lower inflation of hospital plans as well. This should be a focus of the NHI, in my opinion.

An efficient NHI can help to deal with community rating and open enrolment

An important reason why open medical schemes are more expensive than restricted medical schemes is community rating, combined with open enrolment. Community rating means that everyone in a specific medical scheme is charged the same for a specific set of medical aid benefits, no matter what age or of what health or sickness profile they are.

The fact of the matter is that older people will require medical attention (especially expensive medical attention) more often than young people. If a scheme therefore has a higher average age, it will need higher contributions per member than a scheme with a lower average age. Open enrolment means that you are not forced to join a scheme, you can voluntarily decide to join, but the medical scheme may not deny you membership.

There are some counters to this anti-selection risk such as late joiner penalties but they are relatively ineffective. The problem here is that if it is your choice, you are more likely to join a scheme if you are older (and more likely to need medical attention), if you are more likely to need maternity care or if you have a pre-existing condition (that requires medical care).

If everyone was forced to join regardless of health status or age, schemes would have a larger proportion of healthy members, a lower average age profile and as a result, lower contributions per member.

In my opinion, there are two workable solutions to deal with this conundrum.

The first is to promote preventative and primary health care to the utmost through de- or re-regulation in the private sector (possibly even to the point of scrapping the current PMB regulation and compelling preventative and primary care as the minimum benefit package of medical schemes or

health insurance) and for the public health care (NHI) to heavily re-focus on preventative and primary care Everyone who is employed in SA will likely be required to make a contribution to the NHI and as a result, it will not be voluntary in nature.

The second solution is to reduce the number of prescribed minimum benefits that schemes are forced to offer and to allow members to cover these benefits by buying top-up medical insurance.

Whereas the current regulatory regime regarding health insurance and medical schemes admittedly has many shortcomings (even admitted to officially or unofficially by the regulators) it has become clear that government (and in particular the National Department of Health) is so pre-occupied with rolling out NHI that any other regulation under its ambit is not getting priority or attention despite its negative unintended consequences and the uncertainty it creates amongst various role players especially in the private sector.

This has become a major detractor for the meaningful reform that is alluded to above.

Prescribed Minimum Benefits (PMBs) raise the bar too high for ordinary people

The existence of PMBs have created two problems with health care costs, namely that it significantly raises the threshold cost of health care and that there is evidence of abuse of this structure. PMBs are a list of minimum benefits that every medical scheme in SA has to provide to its members, including an extensive list of 270 conditions as well as a large number of chronic conditions from epilepsy and glaucoma to schizophrenia and colitis.

In an ideal world where everyone has the means to afford expensive medical aid, it makes sense to cover any possible contingency under the sun. However, many people are not able to afford medical aid that is made more expensive due to the extensive risks that need to be covered.

The existence of PMBs creates an all or nothing conundrum for these people. Either they spend a large amount of money (which many cannot afford) and be extensively covered or they have to forego private medical aid altogether. In the case of so many people, the latter option has to be taken whilst for those that can afford medical aid, costs continue to escalate.

It is a bit like being forced to take out comprehensive motor vehicle insurance that includes a rental car, roadside assistance and free weekly car wash when you only wanted to cover third party, fire and theft. If you cannot afford the full package, you are forced to go without any cover.

I will not go into a great deal of detail on the abuse of PMB as publicly available information is limited (I prefer to cite my sources) and I have not done the more in depth research myself yet. I hope to follow up on this issue.

In brief though, there are commentators that feel that 1) because PMBs are mandatory within medical schemes, there are GPS, specialists and surgeons that reclassify uncovered conditions to fall within the ambit of the PMBs and 2) that PMB regulation obliges schemes to pay service providers of PMBs what they charge (they are not allowed to dictate lower rates), which leads to PMB costs are inflated (relative to non-PMB costs).

In the latest Council for Medical Schemes Annual Report, it was disclosed that the average cost of PMBs increased by 13.4% from R500 per beneficiary per month (pbpm) in 2013 to R567pbpm in 2014. This implies that for a family of four, it would have cost R2268 per month to cover just PMBs. By 2016 this could have increased to more than R2700 per month (assuming 10% annual inflation).

This is clearly unaffordable for the vast majority of South Africans and could be construed to be unconstitutional in the light of it possibly contravening Section 27 of the SA Constitution which reads:

1. Everyone has the right to have access to-
a. health care services, including reproductive health care;

b. sufficient food and water; and
c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
3. No one may be refused emergency medical treatment.

The issue of high health care costs is a pressing one and needs to be addressed appropriately. Instead of finger pointing, we need to find constructive solutions.

It is in everyone's interest that we reign in the costs and inflation associated with health care costs. Focusing on prevention is paramount in my opinion, but will require political will, changed regulations and co-operation from the private sector. Inefficiencies within the public sector must be addressed and the private sector should be called upon to become involved.

The Department of Health should seriously look at current legislation (especially PMBs) and should not be scared to change what is not working. The introduction of the NHI should do more that broaden coverage for ordinary South Africans, it should also be very focused on primary and preventative care which can reduce overall health care costs in both the public and private sector. Together, we can achieve this.

Do you agree with my assessment on what drives health care costs up and how to counter this? Were you aware of the detrimental impact that PMBs have on costs? Do you see the benefit on spending much more on prevention and primary care?

By Marius Strydom On Fin24