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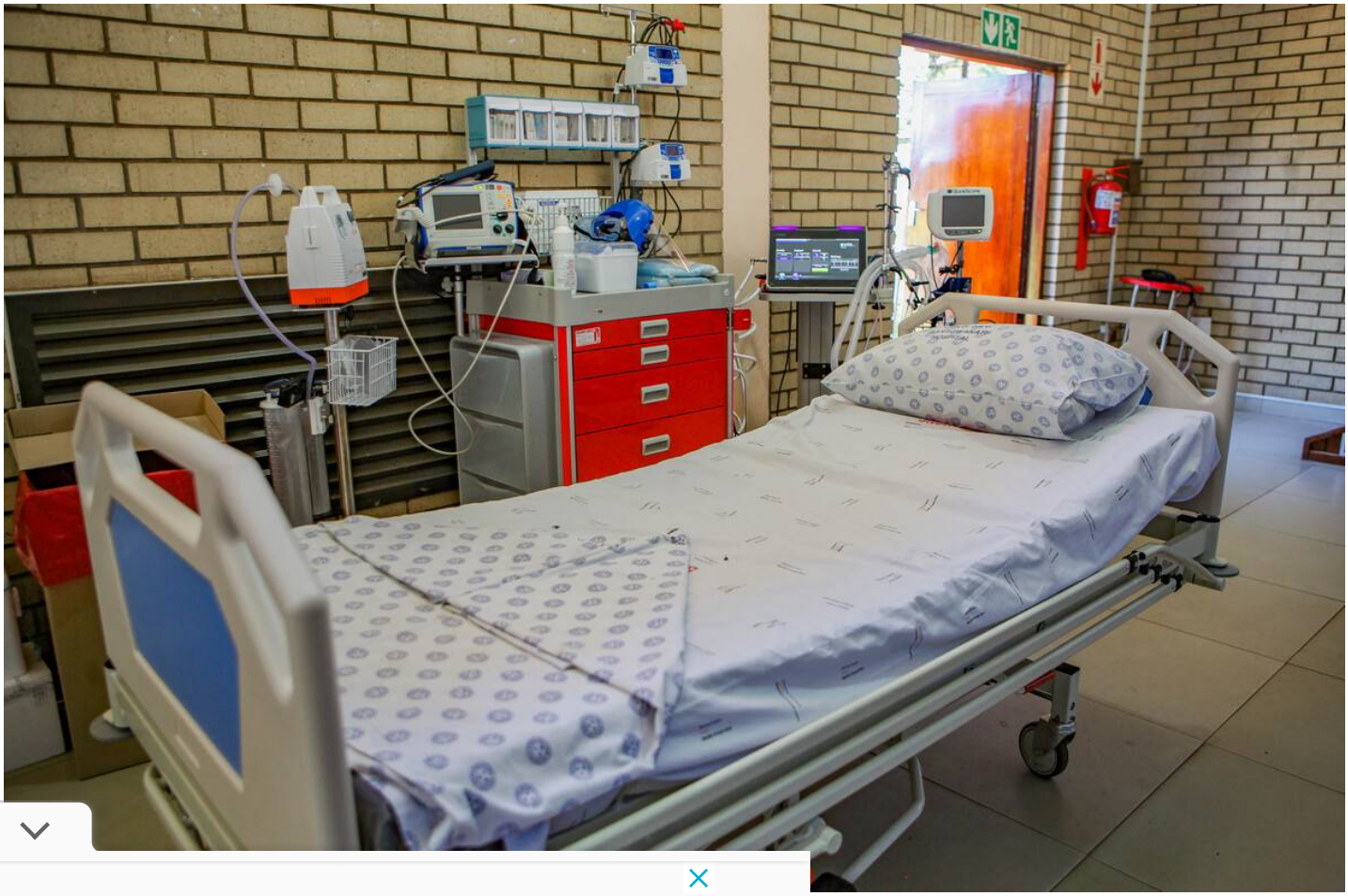
How South Africa is legislating its way into a healthcare crisis

By Chris Bateman



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Clumsy law-making on healthcare and the failure to correct it have resulted in medical schemes carrying an almost unlimited liability for prescribed minimum benefits (PMBs), while nearly 10 million people are being denied low-cost benefits for primary healthcare.

Unregulated consultant tariffs and the reluctance of the Council for Medical Schemes (CMS) — the government's chief proxy — to approve low-cost benefits schemes are driving medical inflation and sending medical aid premiums soaring, according to Rajesh Patel, the head of health systems strengthening at the Board of Healthcare Funders (BFH), and Charlton Murove, the head of research.

They said the National Health Insurance (NHI), which looms on a 10- to 20-year time horizon, would effectively put paid to medical schemes. The government says the NHI aims to enable equitable access to quality healthcare.

The BHF is the representative organisation for the majority of medical schemes in South Africa, Namibia, Zimbabwe, Botswana and Lesotho.

Patel and Murove said healthcare in South Africa is unnecessarily complex, with dismal regulatory oversight in which patients suffer financial hardship while struggling to negotiate a healthcare funding jungle.

Against this backdrop, industry experts have welcomed a recent web-based innovation, MedicalAid.comm, which provides accurate medical aid comparisons through a sliding premium affordability button while listing benefits.

"One of the biggest oversight challenges is PMBs [prescribed minimum benefits] — a set of conditions which medical schemes are obliged to pay for in full — but have no idea what they're in for," Murove said.

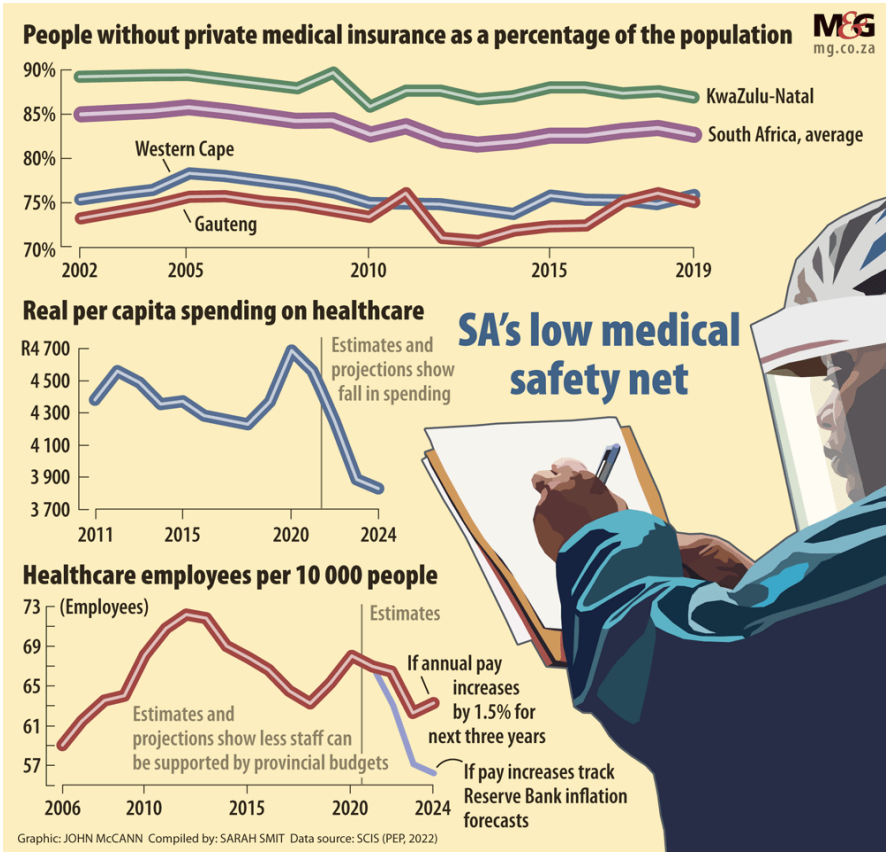
"To make matters worse, healthcare practitioners (consultants mainly), determine the cost, often charging more than their usual tariffs when it's a PMB-related condition. There's also upcoding, which is when a healthcare provider makes a PMB-related diagnosis so they can get access to this unlimited bucket of funds."

Prescribed minimum benefits are poorly defined in regulation, creating too many grey areas that can be taken advantage of, Patel weighed in.

"South Africa's version, passed in 2003, was based on research done in Oregon in the United States, except that there, they have put in place defined procedures and coding, while here we've dropped the technical specifications, blurring interpretations," Patel said. "So, service providers are incentivised to charge as much as possible.

"When you access a consultant, you don't know the cost and you're not able to negotiate. While there are Health Professions Council of South Africa ethical rules around informed consent, in practice this doesn't occur enough. There's often no discussion around price, irrespective of PMBs. Often a patient goes to a doctor and the receptionist asks: 'Do you have gap cover?'

“If you say yes, they charge more. People don’t know about PMBs and non-PMBs. Also, when you are sick, you’re at your most vulnerable. If, for example, you have cancer — are you able to say let’s negotiate a price for my care?” Murove posited.



(Graphic: John McCann/M&G)

Even for those who work in this environment, it’s a minefield, Patel said, calling for better stewardship and oversight. “We’re currently sitting with a politicised healthcare system. There is more politics at play than efforts to solve the problem.”

Allowing more affordable low-cost benefit options (medical aid products, not insurance) would enable people who cannot afford higher end medical plans to at least access primary healthcare products, Patel said, taking a huge burden off the state.

He noted that the Competition Commission’s 2019 Health Market Inquiry chaired by former chief justice Sandile Ngcobo had said there should be some consultant tariff ceiling and made specific recommendations, but the health department had not moved on implementing any of them.

“We applied for exemption from the Competition Commission so we could do collective bargaining while the government gets its act together, but politics came into play, and we’ve now been sitting with the Competition Commission for over two years.”

Patel said a holistic review of PMBs and allowing low-cost benefit options (LCBOs), “would change the entire environment”, but bemoaned the shortage of skills and seeming lack of will in the health department and the CMS.

“The [department] has simply relegated it to the CMS who haven’t moved on this for

nearly eight years. I mean a single medical aid can change its benefits within one year, but the CMS seems incapable. They say they're busy reviewing PMBs, but it's treacle-slow," he added.

Murove went further, accusing the CMS of deliberately trying to frustrate the feasibility of medical schemes to further the NHI — while rendering patients vulnerable.

"We've taken them to court on judicial review and what we saw in their documentation was a very deliberate attempt to delay LCBOs as much as possible. We can clearly see that if they did approve LCBOs, the NHI would become less appealing to the public," he said.

"Approving LCBOs would make a big difference to millions of lives, especially with the medical tax savings — and medical schemes would be far more sustainable. In the [department of health's] estimation allowing LCBOs will create a bigger pool of people who won't need an NHI because they're being looked after by medical schemes."

Both Patel and Murove said that young and healthier patients were moving to unregulated insurance products, leaving the sick and older people in medical schemes and creating "a vicious cycle" in which medical aid premiums were becoming increasingly expensive.

"The more this happens the more youngsters (often newly married with young children) move out into insurance, leaving older people paying increasingly. Medical aids will just get increasingly expensive — which suits the NHI proponents," Patel said.

"If you want social solidarity you need to reduce the number of risk pools. If you don't attract the young people, you can't keep contributions down and you'll always have contributions more than CPI [consumer inflation] plus five percent."

Murove and Patel said both the BHF and the Orthopaedic Society of South Africa had applied for exemption from the Competition Commission.

"Between the funders and the service providers there's an urgent need to sit around the table to discuss what's reasonable and fair pricing. Hopefully, the regulators will come to the table, and we can do real structural reform. Let the players find their own solution instead of the [health department] ignoring our input. We're not against universal healthcare. We just want to reduce pressure on the healthcare system and have input into NHI benefits. LCBOs would be a primary healthcare package, like an entry point to the NHI environment — a mutually beneficial one."

They said the failure to implement the recommendations of the Health Market Inquiry "makes no sense in the bigger scheme of things" and that allowing low-cost benefit options under the CMS would provide "fertile ground" to trial healthcare provision in an NHI environment.

"It seems clear that the government has a perception that if you improve the medical scheme environment it will be a threat to NHI implementation. It seems clear that people on medical aid schemes will be the last to be brought into the NHI. However, if you trial a partnership with the private sector now, you'll reduce the burden on the state and can then eventually wind down on the medical schemes when it becomes an easy migration,"

Patel said.

The pair said offering low-cost benefit options packages at affordable premiums of about R200 to R300 a month for primary health cover would enable as many as 10 million people to benefit.

“Many are willing to pay from their own pockets to avoid taking time off work or losing income waiting in the public sector. It’s a significant number — and the medical tax credit they’d get just further increases the potential,” Patel added.

Media coverage of the government’s position revealed huge suspicion of the private sector as purely profit driven, Patel said.

“Instead, what’s true is that our sector has done much to add value. It’s sad that they see us in this way. It shows a lack of understanding. What they’re describing as bad in the insurance environment is something they’re perpetuating. They cite medical schemes’ administration costs. Well, LCBOs can be self-administered with nobody making any profit,” he argued.

“For those in the insurance market, moving to a medical scheme will be a great boon via the tax rebate. If an insurance product is not performing, they can increase premiums and cut benefits — and there’s no insurance ombudsman to run to. There’s been a deliberate misunderstanding of the facts and criticism of LCBOs.”

Asked about allegations of some doctors “gaming the system” by conducting unnecessary procedures, the chief executive of the South African Private Practitioners Forum (SAPPF), Simon Strachan, said although it did not have a monitoring mechanism, the profiling of doctors was done by almost every medical scheme administrator — or by the hospital itself for hospital-based consultants.

Many specialities and medical organisations partnered with funders to profile pre-identified “outlier” practices. Any suggestion that consultants were inflating their prices was “simply wrong”, he added.

“You have a duty to discuss payment options with your patient. I see nothing wrong in asking patients how they aim to pay for your services. One thing the SAPPF is very clear on is that healthcare professionals should have a one-off fee, not one for prescribed minimum benefits, and another for non-PMBs. You can decide whether to discount that fee or not. If you have gap cover, I should still charge you my regular fee.”

CMS registrar Sipho Kabane said a full report with multiple stakeholder input on low-cost benefit options, dating to before the Covid-19 pandemic, was given to Health Minister Joe Phaahla last November and included the CMS advice on the main recommendations made by the Health Market Inquiry.

“We’ve added our regulatory perspective — I don’t want to muddy the waters now by commenting,” he said.

A CMS review on what should be included in PMB conditions, in line with scientific

evidence, cost effectiveness and the protection of members and medical schemes was underway. One thrust would be including elements that reduced the need for curative and hospital services, thus improving health outcomes.

“We believe the only protection you enjoy as a medical scheme member are PMBs, which are a compulsory payment by schemes. We don’t think it makes sense to interfere and tamper with them,” Kabane added.

The CMS application to the appellate division of the supreme court in its legal wrangle with the BHF, due to be heard in April or May this year, could be rendered moot by the health minister’s decision.

“I’m sure we can find an amicable way to resolve the dispute,” he said.

Tags: Board Of Healthcare Funder, Charlton Murove, Health Care Professions Of South Africa, Low-Cost Benefit Options, Rajesh Patel, Article, Council For Medical Schemes, Department Of Health, Health, Healthcare, Joe Phaahla, National Health Insurance, NHI, Prescribed Minimum Benefits

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