The 23rd Annual BHF Conference

CAPE TOWN ICC
4-8 MAY 2024

Beyond Barriers: Navigating the Future for Sustainable Healthcare

OFFICIAL COMMENTS ON THE SYSTEM OF MEDICAL SCHEMES – A FACTUAL REVIEW

Prof Alex van den Heever

Chair in the Field of Social Security Systems Administration and Management Studies

WITS SCHOOL OF GOVERNANCE
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Report focus

The report upon which this presentation is based provides a factual review of various comments made by official representatives of Government who form, or have formed, part of the National Health Insurance (NHI) process regarding the system of medical schemes

The 23rd Annual BHF Conference

CAPE TOWN ICC | 4-8 MAY 2024

Approach

- Selection of official representatives and documents
- Structure comments according to theme
- Critical analysis of strategic purpose of the comments
- Factual review
- Summary of findings

Why were these assertions made?

In all instances, the private health system "failures" are framed in emphatic, and sometimes hyperbolic terms as inevitable market-related imperatives (characterised as "*rampant commercialism*") that will always undermine the goals of UHC (Pars 83-87).

A central premise that can be inferred throughout is that all expenditure on **health care should be public expenditure – by definition – as health care is a "public good"**.

****

The need to justify this premise, however, requires an analysis of the current health system that concludes:

first, *that the financing of the private health system in South Africa is a driver of all important failures in the health system as a whole*; and

second, that privately financed health systems will always result in these failures.

Assertion 1: The system of medical schemes is unsustainable

"With 7.8 million South Africans on medical aid, many other schemes were 'headed for collapse' because they ran unsustainable financing models. She cited evidence to the Parliamentary Portfolio Committee on Health in September that 18 schemes already reaching insolvency levels were advised by the Council for Medical Schemes to 'either merge or close shop'. 'Regardless of the NHI, if private sector medical schemes premium increases continue at this rate they'll become non-existent anyway,' she contended." (Bateman, 2009)

The assertion that the medical schemes system is not viable and financially failing is not supported by the factual evidence. Over the period of 2005 to 2022, medical schemes have maintained stability in all relevant variables. This assertion is assessed as false.

- First, the number of medical scheme beneficiaries has increased by just over one million from 2009 to 2022.
- Second, while the number of medical schemes has been decreasing during to market consolidation, the beneficiary numbers have remained stable and increasing over the period 2005 to 2022.
- Third, in 2022, medical schemes had consolidated reserves equivalent to 49.2% of Gross Contribution Incomes (GCI) or R114 billion. This significantly exceeds the required reserve ratio of 25%.
- Fourth, the cost of brokers has never been reported as a systemic concern.
- Fifth, total non-health costs per average beneficiary per month for all medical schemes have declined by 34.7% in real terms from 2005 to 2020 The decline for open schemes is 32.9% and for restricted schemes 22.1%.

- Sixth, there has been no significant adverse change in the average age of medical scheme beneficiaries from 2005 to 2022. The average age in 2005 was 32, and in 2022 34.
- Seventh, the reduction in the number of schemes has resulted in an improvement in the number of beneficiaries per scheme (from 52,138 in 2005 to 127,398 in 2022) while overall beneficiary numbers increased (from 6.8 million in 2005 to 9 million in 2022).
- Eighth, medical scheme expenditure as a percentage of GDP has remained a stable percentage of GDP despite an increase in coverage.
  - From 2016, public sector expenditure overtook medical schemes expenditure, and has been increasing ever since.
  - In 2005 the public sector spent approximately 2.6% of GDP on health in comparison the medical schemes at 3.5.
  - By 2021, public health expenditure moved to 4.0% of GDP where medical schemes expenditure declined slightly to 3.4% of GDP.
  - There is, therefore, no indication that cost increases have destabilised medical schemes.

Assertion 2: Commercial imperatives are fatal to health systems

"Cape Town - A month after Health Minister Aaron Motsoaledi called the private health care system a "monster", his deputy re-applied the label. "The system is monstrous and brutal," Deputy Health Minister Gwen Ramokgopa said in the National Assembly on Wednesday. In October, Motsoaledi controversially described private healthcare in South Africa as a "brutal system", and a monster "that will swallow us whole". Ramokgopa, responding to a question in the House about the remarks, told MPs there was a need to deal with the "uncontrolled, unregulated commercialisation of health care" in the country. This undermined the principle of health care as a public good." (Staff reporter, 2011a)

The view that private and commercial features of health systems are incompatible with UHC systems is not supported by the evidence and is assessed as false.

- Many countries have established regulated private health financing arrangements that are characterised as social health insurance (SHI), as they involve a combination of regulatory measures, pooling mechanisms and government subsidies that guarantee the right of access to healthcare.
- Within the developing world, these can be found in countries such as, inter alia, Columbia, Chile, China, India, Brazil, Mexico and Thailand.
- Industrialised countries that incorporate private financing into their systems include Germany, Israel, Belgium, Ireland, the Netherlands, France, Israel, Japan, the United States and Australia.

Assertion 3: Health services are "public goods"

"Health Minister Aaron Motsoaledi on Sunday said private healthcare was a 'brutal system' because it had commercialised an essential service. … "How can we run such a brutal system … the government will not fold its arms when there is such rampant commercialisation in the healthcare sector," he said at a general practitioners' meeting in Durban." (Staff reporter, 2011b)

"He said the use of a public good for excessive profit was unacceptable which was why the state had introduced the National Health Insurance (NHI)." (Staff reporter, 2011b)

The assertion that healthcare is a "public good" is assessed as mistaken and false.

- The term “public good” is, however, a technical term used in economics to refer to product markets where the exclusion principle cannot be applied (i.e. the good is jointly consumed).
- In other words, where you cannot exclude access to the product in exchange for either payment or other eligibility criteria

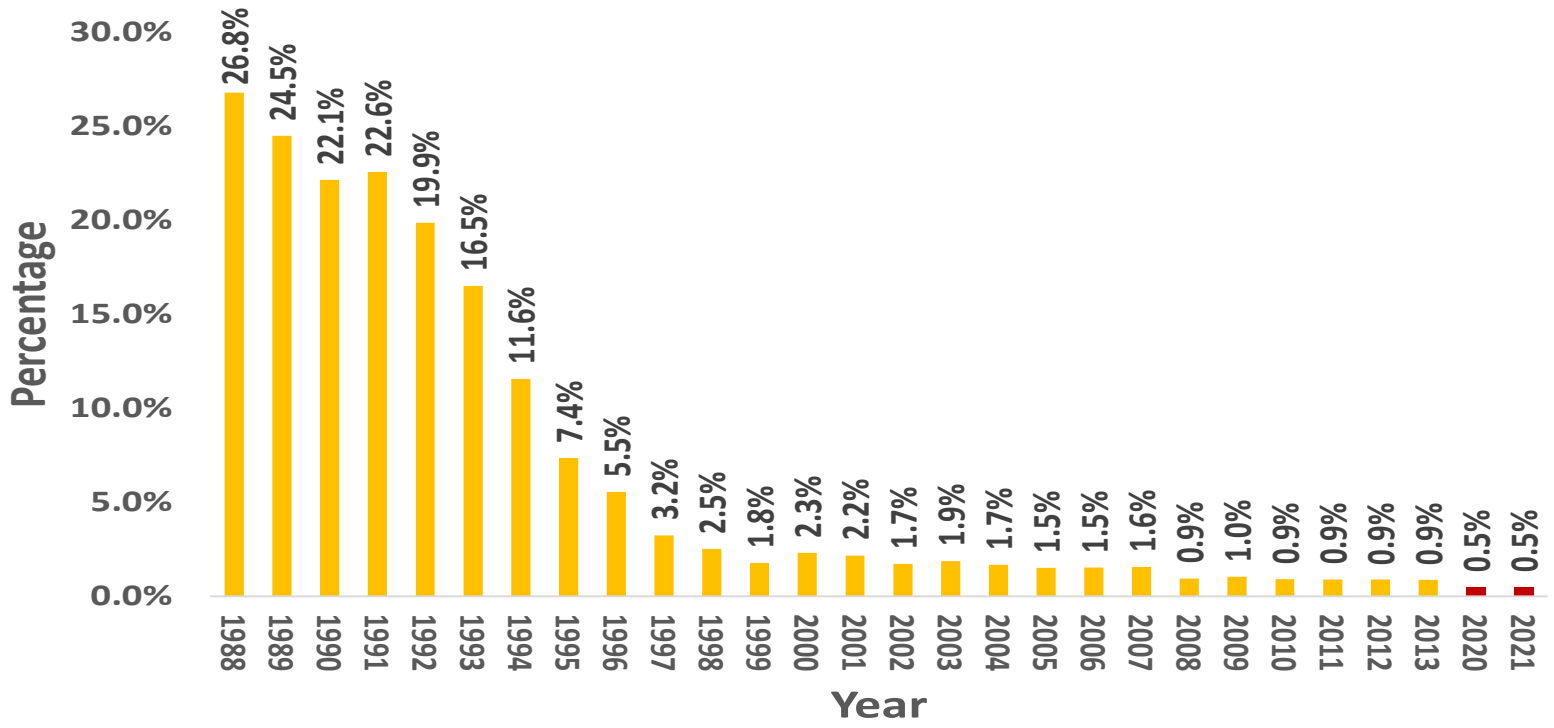
Assertion 4: Medical scheme benefits run out

"That is saying to us there are challenges here. You cannot keep on going and doing things the same way. You know why? Well the thing is, they milk patients they milk citizens of this country generally come July everybody's medical aid is almost totally finished. What they do they say thank you very much. You have been seeking this hospital, but this hospital needs money, go out and look for money. And what do those patients do. They come and line up in the public hospital. So the public hospital that is looking after 40,000 cancer patients that were there from January to July, suddenly there are 10,000 patients who have been discharged from the private healthcare sector with can that cannot be treated because they don't have money anymore in their pocket. This has to be sorted out. We cannot call it like that anymore." (Power FM, 2020)

The assertion that medical scheme members are being systematically dumped on public hospitals is assessed as false.

- Medical schemes must cover PMBs
- Where use is made of public hospitals, medical schemes must reimburse the public sector
- Oncology benefits cannot be exhausted
- There has been a systematic decline in medical scheme beneficiary use of public hospitals
- ICU services cannot run out – coverage is required so long as the service is clinically indicated
- **Despite these repeated assertions, no systematic study has ever been carried out by the NDOH on this issue**

Figure 2: Medical scheme expenditure on provincial hospitals as a percentage of total hospital expenditure from 1988 to 2021**1**



1 *Note that the data for 2014 to 2019 is not provided for practical reasons. However, the data merely trends from 2013 to 2020.*

Assertion 5: Out-of-pocket payments account for a significant part of total health expenditure

"Out of pocket payment (sic) accounts for a significant part of total health expenditure and this could be in the form of co-payments, or direct payment to private providers particularly by those who are not covered by medical schemes. Even for those who are covered by medical schemes, the extent of co-payments confirms that the current system does not provide full cover. However, for those who are not on medical aid this could have catastrophic effects." (National Department of Health, 2011c, Par 35)

The assertion that out-of-pocket expenditure constitutes significant portion of total health expenditure is assessed as false.

- The assertion that South Africa has problematic levels of OOP expenditure is not based on any empirical evidence or systematic study that can be located.
- According to the World Health Organisation, out of 187 countries, South Africa has the 11th lowest OOP expenditure (World Health Organisation, 2000 to 2020) with expenditure at less than 1% of GDP.

Assertion 6: The distribution of financial resources for health care is inequitable

"The amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity. Per capita annual expenditure for the medical aid group has been estimated at R11,150.00 in contrast to public sector dependent population where the per capita annual health expenditure is estimated at R2,766.00. This is not an efficient way of financing healthcare." (National Department of Health, 2011c, Par 31)

The disparity in per capita health expenditures between the public sector and medical schemes does not, on the face of it, reflect health inequity. It also does not offer a clear instance of harm to public health system users. The assertion that disparities in public and private per capita expenditures are evidence of health inequity are, therefore, regarded as false.

Assertion 7: The distribution of health professionals is inequitable?

"Poor people may be getting free medical care in public hospitals. But you and I know that free care is very difficult to deliver without adequate resources. Resources are both financial and human. The cream of the South African society, i.e. those with huge financial resources and skills, have hived off from the rest of society to have their own health financing system (medical aid) and health provision system (private hospital). They have hived off with huge financial resources." (National Department of Health, 2020b, p. 4)

The assertion that medical schemes act as a constraint on the supply of health professionals into the public health system has no evidentiary foundation. First, the NDOH lacks the information systems to make such a claim. Second, the NDOH has not performed any systematic analysis to support such a claim. Third, official health workforce reports make no such claim. Fourth, the available information contradicts the assertion. This assertion is assessed as false.

Assertion 8: The subsidies provided to medical schemes are unfair

"Some people argue that medical aid scheme money is private money and we have no business to meddle in it. This is a serious distortion of facts The truth is that medical aid schemes are subsidized for a whopping R46,7 billion by the fiscus of the country. If it was not for this very heavy subsidy from the State, medical aid schemes will have ceased to exist. People who are not on medical aid do not have access to this subsidy." (National Department of Health, 2020b, p. 4)

The assertion that the tax credit provided to medical scheme households is inequitable is not supported by any systematic analysis, is contradicted by the official documentation that outlines the basis for the subsidy, involves a lower per capita allocation than the per capita value of public sector services, and is 75.4% paid for by medical scheme households. The various assertions come across as manipulative, deliberately excluding any assessment of how the subsidy is financed and the public value it delivers. The assertion that the tax credit is inequitable or accommodates private sector cost increases is not supported by the evidence and is assessed as false.

Assertion 9: Most medical scheme beneficiaries are white

"It is evident that the private sector predominantly caters to the privileged population, as highlighted in the statistics below: White: 77.7%; Indian/Asian: 45.1%; Coloured: 19.9%; and Black African: 9.3% (Statistics South Africa, 2021)." (Shisana, 2023a)

The assertion that most medical scheme members are "white" is factually incorrect and appears to be deliberately ambiguous. This assertion is assessed as false.

Here's what Statistics South Africa actually shows

Medical scheme population by population group - Source: Statistics South Africa (2022)

Population group	Thousands	% of total
Black African	4 872	50.2%
Coloured	954	9.8%
Indian/Asian	738	7.6%
White	3 136	32.3%
Total	9 699	100.0%

Assertion 10: Medical schemes are risk-rated

"All medical aid schemes have a risk-rating policy. They recruit younger, healthier members who are employed and need less medical attention, only to dump them or charge them more when they get sick, old and cannot afford premiums - sometimes after life-long contribution to such schemes." (Mkhize, 2009)

The assertion that medical schemes risk rate is assessed as false as the Medical Schemes Act prohibits risk rating.

Assertion 11: The perceptions of public health care quality are the same as for the private sector

"Despite the challenges in accessing medical care, evidence suggests no significant difference in the perception of healthcare quality between the public and private sectors. For instance, studies have shown that 81% of patients using general practitioners (GPs) and 81% of households using public healthcare services reported being satisfied with the care received (M'bouaffou et al., 2022; StatsSA, 2018)." (Shisana, 2023a)

The assertion that public and private sector healthcare users have equivalent perceptions of service quality is assessed as false with reference to the same information used to make the assertions. This assertion is assessed as false.

Using the same references…

Table 5.1: Level of satisfaction with public and private healthcare facilities by province, 2018

Level of satisfaction with the healthcare institution	Province									
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Public health care										
Very satisfied	47,9	58,8	42,3	49,1	50,8	40,3	52,5	59,0	72,1	**53,8**
Somewhat satisfied	21,6	30,6	26,3	23,2	31,7	26,0	27,7	26,3	15,7	**26,5**
Neither satisfied nor dissatisfied	11,1	4,7	15,5	11,5	11,1	15,1	10,5	6,2	5,1	**9,5**
Somewhat dissatisfied	8,9	3,6	8,2	8,8	3,8	5,3	4,8	4,0	4,2	**5,0**
Very dissatisfied	10,5	2,3	7,8	7,4	2,6	13,4	4,6	4,5	2,9	**5,2**
Total	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**
Private health care										
Very satisfied	93,7	95,5	91,0	92,1	89,3	89,0	93,2	95,8	91,9	**92,6**
Somewhat satisfied	3,7	3,6	4,2	5,1	7,4	9,1	4,6	2,9	5,8	**5,0**
Neither satisfied nor dissatisfied	0,9	0,7	2,4	1,3	2,7	0,3	1,4	0,9	0,0	**1,3**
Somewhat dissatisfied	0,9	0,0	0,7	0,2	0,3	1,3	0,6	0,0	0,3	**0,5**
Very dissatisfied	0,8	0,2	1,7	1,3	0,4	0,4	0,3	0,5	2,0	**0,6**
Total	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**

Table 5.1 shows that the users of private healthcare facilities seemed to be more satisfied with those facilities than users of public healthcare facilities across all provinces. Whereas 97,6% of users were satisfied or somewhat satisfied with private facilities (92,6% were very satisfied), only 80,3% of users of public healthcare facilities were somewhat satisfied or very satisfied. Only 53,8% of individuals that used public healthcare facilities were very satisfied. Of those that used private healthcare facilities, households in Mpumalanga were most likely to be 'very satisfied' (95,8%) followed by households in Eastern Cape (95,5%), Western Cape (93,7%) and Gauteng (93,2%). Households in Limpopo (72,1%) were most likely to be very satisfied with public healthcare facilities while those in North West (40,3%) were least likely to be very satisfied.

Summary

Assertion	Evaluation	Score
1	**The assertion that the medical schemes system is not viable** and financially failing is not supported by the factual evidence. Over the period of 2005 to 2022, medical schemes have maintained stability in all relevant variables. On a scale of 1 to 5, this assertion is, therefore, **assessed as false**.	1
2	The view that **private and commercial features of health systems are incompatible with UHC systems** is not supported by the evidence and is **assessed as false**.	1
3	The assertion that **healthcare is a "public good"** is **assessed as mistaken and false**.	1
4	The assertion that **medical scheme members are being systematically dumped on public hospitals** is **assessed as false**.	1
5	The assertion that **out-of-pocket expenditure constitutes significant portion of total health expenditure** is **assessed as false**.	1
6	The **disparity in per capita health expenditures between the public sector and medical schemes does not, on the face of it, reflect health inequity**. It also does not offer a clear instance of harm to public health system users. The assertion that disparities in public and private per capita expenditures are evidence of health inequity are, therefore, **regarded as false**.	1

Assertion	Evaluation	Score
7	**The assertion that medical schemes act as a constraint on the supply of health professionals into the public health system** has no evidentiary foundation. First, the NDOH lacks the information systems to make such a claim. Second, the NDOH has not performed any systematic analysis to support such a claim. Third, official health workforce reports make no such claim. Fourth, the available information contradicts the assertion. This assertion is **assessed as false**.	1
8	**The assertion that the tax credit provided to medical scheme households is inequitable** is not supported by any systematic analysis, is contradicted by the official documentation that outlines the basis for the subsidy, involves a lower per capita allocation than the per capita value of public sector services, and is 75.4% paid for by medical scheme households. The various assertions come across as manipulative, deliberately excluding any assessment of how the subsidy is financed and the public value it delivers. The assertion that the tax credit is inequitable or accommodates private sector cost increases is not supported by the evidence and is **assessed as false**.	1
9	**The assertion that most medical scheme members are "white"** is factually incorrect and appears to be deliberately ambiguous. This assertion is **assessed as false**.	1
10	**The assertion that medical schemes risk rate** is **assessed as false** as the Medical Schemes Act expressly prohibits risk rating.	1
11	**The assertion that public and private sector healthcare users have equivalent perceptions of service quality** is assessed as false with reference to the same information used to make the assertions. This assertion is **assessed as false**.	1

Discussion