

BHF and Government: ‘I’ll change if you’ll change’



While government and private healthcare funders urged one another to make internal changes to enable faster progress towards a more equitable healthcare system, some concrete evidence of vitally needed partnership did emerge from the 15th annual Board of Healthcare Funders (BHF) conference.

Firstly, the 24 - 27 August conference in Durban, attended by over 900 delegates from all sectors of the healthcare funding industry, heard that the government’s new Essential Drugs List (EDL) Committee will include representatives of the private healthcare funding industry to finally obtain consensus on just which essential medicines should be available to patients. Secondly, a blueprint on how the National Department of Health (NDoH) can partner with the private healthcare funding sector in conducting economic evaluations of products to save both sectors time and money (and avoid longstanding unnecessary duplication) has been drawn up – by no less than the NDoH itself. National Health Minister Dr Aaron Motsoaledi

also pleaded with delegates to ‘embrace change’, warning that they would be hardest hit by the ‘exploding’ epidemic of non-communicable diseases if they failed to introduce health promotion and disease prevention measures.

Government promises National Health Commission

Motsoaledi said that reducing risk factors such as smoking, alcohol abuse, obesity and lack of exercise would be the focus of a National Health Commission he would be setting up in the near future. Chaired by Deputy President Cyril Ramaphosa, and assisted by the country’s top healthcare academics, business executives from the private and public health sectors and civil society, the commission would advise him on the most effective ways to stop the country’s escalating disease burden. This will be a groundbreaking first – given that some of the top medical aids he was addressing are world leaders in wellness and disease prevention programmes and have been itching to share their expertise for years. Motsoaledi

said that inefficiencies in the private and public sectors were caused by different things. While he was ‘trying’ to resolve the poor quality of care in the public sector, ‘exorbitant fees’ in the private sector rendered it too expensive – and therefore inefficient. He either failed to discuss, or deliberately avoided discussing, the long-awaited White Paper on National Health Insurance (he did say that universal health coverage was a ‘global phenomenon’ and there was ‘no walking away from it’). Nor did he venture into the political quicksand of the complexities behind high private sector costs, possibly because stalled government regulation (and deregulation) are chief among them. Christoff Raath, joint CEO of Insight Actuaries and Consultants, had no such aversion.

Unchain us, so we can help cover lives – top actuary

Hammering home now-persistent private sector pleas, Raath singled out the 25% solvency rate medical schemes must adhere to, the hugely expensive current Prescribed



Christoff Raath, joint CEO of Insight Actuaries and Consultants.

Minimum Benefits (PMBs), and the self-sustaining requirement that makes it illegal for schemes to implement risk and income cross-subsidies across options. He said without such cross-subsidisation and 'some form' of mandatory cover, the requirements for open enrolment, community rating and full payment of PMBs were threatening the very sustainability of the medical scheme industry. If just cross-subsidisation and mandatory cover were implemented or allowed, medical schemes could more easily 'come to the party', helping facilitate some form of universal coverage towards an overall National Health Insurance (NHI) goal. Illustrating just how much pressure the private sector could take off its public counterpart (while helping achieve greater healthcare access and equity), he said that medical schemes had the ability to cover between two and four million additional lives.

However, the current regulatory environment allowed very little scope for further growth or innovation, actually impeding the expansion of coverage to the 83% of the population that is not insured, and adding to the burden on state healthcare facilities.

Incremental change: beyond the 'big reform mindset'

Echoing a theme punted by actuarial colleagues at last year's Hospital Association of South Africa (HASA) congress, Raath said that government's decision to suspend its initial healthcare reforms halfway through its planned trajectory towards universal coverage (with the introduction of the NHI plans negating everything else) had resulted in 'an incomplete, semi-designed system in which health cover is becoming increasingly unaffordable'. There was no incentive for growth, as the risks for growth in the current not-for-profit environment outweighed the potential benefits of growth. Expanding on the 25% solvency requirement,

he said it impacted directly on affordability and growth because new or growing medical schemes could only achieve such reserve levels by raising premiums. He estimated that last year alone, between 1.5% and 2% of medical schemes' total contribution increases could be attributed to having to meet this solvency requirement. He said that between the country's two biggest medical schemes, Discovery Health and GEMS, around R24 billion was needed to meet this requirement.

Raath said that even the Council for Medical Schemes agreed there was no scientific basis for the 25% solvency requirement, which he said made the situation 'very distressing'. PMB conditions, per member per month, cost an estimated R550 - 1 000, negatively affecting healthcare affordability. Citing the Low Income Medical Scheme (LIMS) study in 2006, he said that people in low-income groups wanted and could afford to pay between R150 and R200 (R280 and R300 in today's prices) for a primary care package – including GP visits, optometry, medication and dental – and that they preferred a primary care package to tertiary cover. The government's attempt to move towards universal coverage would require a complete reconsideration of PMBs, which he described as 'unaffordable, prone to abuse from providers' and not meeting the needs of lower-income groups. Raath urged the private healthcare industry to 'look beyond the big reform mindset' and instead implement incremental improvements that allowed it to move in the direction of government's objective of universal coverage.

Regulate reimbursement, bring back our 'gatekeepers'

Dr Anban Pillay, NDoH Deputy Director-General: Health Regulatory and Compliance Management, singled out for criticism the lack of any current incentives to provide primary care benefits and the virtually unlimited private hospital benefits, saying that SA was unique in this respect. 'Where else are patients allowed direct access to high-cost specialists without any referral?' he asked, urging medical schemes to consider returning the 'gatekeeper' function to primary healthcare providers. He said that two of the main cost drivers were the lack of a proper patient referral system and the absence of a regulated reimbursement model.

Aligning PMBs to the proposed NHI system's focus on primary health, harmonisation of treatment guidelines for disease management, using public hospitals in selected cases and increasing access to primary healthcare medicines were all 'rich with opportunity' for public-private partnership. This would address

cost and efficiency issues in both sectors, Pillay added, saying that an effective primary healthcare system could reduce hospital use and lead to lower premiums for members. 'You should also consider a system where schemes partner with government to deliver PMBs', he suggested. The current demarcation process provided 'huge opportunities' for medical schemes to increase their memberships – if they were able to design options catering for the needs of the broader public and affordable to those who previously bought low-cost insurance products to cover their medical expenses.



Dr Anban Pillay, the NDoH's Deputy Director-General: Health Regulatory and Compliance Management.

'Waves of change, oceans of opportunity' – BHF's Zokufa

Dr Humphrey Zokufa, Managing Director of the BHF, said that evaluations of the prospective EDL committee would not be enforced but rather treated as an objective tool that could be used 'as a departure point for fairness in benefit design'. Asked about the government's failure to implement the Risk Equalisation Fund and letdown on introducing mandatory membership, his response was diplomatic (the conference theme was, after all, 'Waves of Change, Oceans of Opportunity'): 'We don't want to position the BHF in such a way that it works against the waves of change, but rather works with it to ensure that decisions are going in the right direction.' In doing so, the BHF would be in a position to see the 'oceans of opportunities' ahead. He urged both sectors to build bridges rather than increase tension by seeing themselves as two separate entities. The 'way forward' would be through public-private partnerships and the creation of centres of excellence that rendered affordable treatment of previously high-cost diseases, he concluded.

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