COMMUNITY RATING AND OPEN ACCESS – GOOD INTENTIONS, BAD IDEAS

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Isn't it surprising how so often good intentions translate into bad ideas? One of the Department of Health's recent policy documents, Reforming Financing of Private Health Care in South Africa: The Quest for Greater Access and Efficiency, is one such idea. The good intentions of Minister Nkosazana Zuma are clearly headlined in the document title. Her ongoing crusade to improve the lot for the previously underprivileged, in terms of access to the high quality network of private hospitals and improving levels of efficiency within the medical community, deserves applause. Improving efficiency is an aspect of health care management that seems to have escaped South Africa, and most of the world, for the past 20 years.

The policy document reinforces the Department of Health's commitment to 'community rating' and 'open access'. What exactly are these and why are they so threatening?

- **Open access:** a system in which members' age and existing health profiles may not disqualify them for medical cover in any approved medical scheme.
- **Community rating:** a system in which all members pay the same level of premium contribution, irrespective of their current or historical health, or their age. Rating will, however, be allowed based on family size and social status, as defined by personal income.

Therefore, combined community rating and open access will lead to all approved medical schemes being required to accept any applicant, providing they are able to pay the community rate. The exception here is 'in-house' schemes, established for the benefit of a limited group of employers, who may restrict access to current and former employees of a specified employer group, but must accept any applicant from within that group.

What is the problem? It is rather glib to say it will take us back to the 'bad old days', but only 5 years ago, medical scheme costs were spiralling out of control and managed care and member savings accounts were unheard of. Firstly, the Melamet Commission of Inquiry, and then the deregulation of

the medical sector in the Medical Schemes Amendment Act 1993, gave us hope with the abolition of guaranteed payments, minimum payments and, crucially, the removal of a ban on risk rating. Since then annual rates of inflation have dropped from norms of 30% to 40% to between 10% and 15% in well managed schemes. The trend continues downwards.

The new reforms, particularly open access and community rating, will undermine all that has been achieved in the last 5 years. The government wants to take us back to an era in which the system ignored the fact that medical aid costs are higher for aged and sick members. As medical scheme contributions increased, the young and healthy sought sanctuary outside medical schemes. The demographic profile of the fund consequently worsened, premiums increased further and more of the healthy members left – and so the spiral of decline continued.

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Not only will reintroducing a ban on risk rating regenerate the inflationary spiral of the past, it will also stifle market innovation and, ironically, the cross-subsidisation the government is so anxious to achieve. The sick and elderly will seek out the most comprehensive benefit structure they can afford, while the young and healthy will only seek medical cover when they become ill. The problem is that community rating and open access are totally incompatible with voluntary health care coverage.

It may be said that the reforms will move medical cost inflation between funds without necessarily increasing the whole. This is also not true. If you are in a scheme where, no matter what you claim, no matter how ill you are when you join, you will pay the same rate as everyone else, it is only human nature to ensure you get good value for money. This means claiming as much as you can on elective benefits such as dental and optical benefits. How many people do you know who, at the end of the medical aid year, realise that they must use up their entitlement and rush to buy spectacles or go for that check-up with the dentist? Importantly, with open access the incentive to control costs is lost – just join a scheme with low benefits until you need medical treatment and then move to one with higher benefits. Under this new regime, it seems that the responsibility will fall to the medical community to self-regulate and control its fee levels in the face of increasing demand and utilisation of medical services.

The government intends to penalise those members who enter later in life, but has given no indication of what sort of penalties will be levied. Will they be enough to protect schemes? If they are too small, no one will join until they need to. If they are too high, no one will be able to afford to join later in life, creating a strain on the national health scheme the government is also keen to avoid.

Other aspects of the proposed reforms, the banning of co-payments and coinsurance, the establishment of a minimum set of benefits and an increase in the minimum size of medical schemes are all counter-productive in the government's war on the inequality of medical access. The uniformity which these reforms, when combined, will produce within an impotent health care market seems to run surprisingly counter to the national goals of freedom of choice and tolerance of diversified needs.

A group calling itself the Concerned Medical Schemes Group, representing 2.6 million medical aid members' lives has argued vigorously against the government's proposals. While this group can be said to have their own interests at heart, tending as they do to have a lower than average risk profile within their funds, it comes as some surprise that the response from the health care industry has been far from uniform. To castigate this group for exercising their opinion based on self-interest is missing the point. This group has also done much within the health care industry to lead the fight against spiralling costs and, largely, has been relatively successful. To take away all that has been achieved in five years with a piece of well-meaning, but rather ill conceived legislation demands further scrutiny.

GOOD IDEA: LIMITING INDIRECT DISCRIMINATION

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The Department of Health is proposing that discrimination on the basis of health status be substantially limited within the private insurance market for health. This is to be achieved through a combination of requirements: community rated premiums; open enrolment; and that all schemes provide a set of prescribed minimum benefits. Open enrolment, which is directed only at open schemes, will prevent schemes from