



COUNTRY CASE STUDY

HEALTH INSURANCE

IN SOUTH AFRICA

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1. OVERVIEW OF POLITICAL, SOCIO-ECONOMIC AND HEALTH CONTEXT

South Africa is one of the largest economies in Africa and is categorised as an upper-middle income country by the World Bank, with a Gross National Income (GNI) per capita in 2002 of USD 2,750. It has high unemployment levels and very high levels of income inequality. These income inequalities are a reflection of South Africa's political history of 'apartheid', which maintained economic and political power for the white minority and systematically disadvantaged the black population. Since the transition to a democratically elected government in 1994, economic growth has occurred, but income inequalities have in fact become worse.

Macro- & socio-economic and demographic indicators	
GDP (USD Billions (2003/4))	169
GNI per capita (USD 2002)	2,750
Gini coefficient (2001)	57.3
Urbanisation (% of total population)(2003)	56.9
Literacy (% of population aged 15+)(2004)	82
Population (Millions 2005)	46.5
Unemployment (official-expanded)	27-41%

Labour force structure by sector (2004)(millions)	
Formal sector excluding agriculture	7.8
Commercial agriculture	0.930
Informal sector excluding agriculture	1.8
Small-scale and subsistence agriculture	0.337
Domestic Labourers	1.0
Health sector financing/expenditure indicators	
Health expenditure, total (as a percentage of GDP)(2002)	8.7%
Health expenditure, public (as a percentage of GDP)(2002)	3.5%
Health expenditure, public (% of total health expenditure)(2003)	38.6%
Health expenditure per capita (\$) (2002)	689
Health status indicators	
Infant mortality rate (per 1000 live births)(2003)	53
Under 5 mortality rate (per 1000 live births)(2000)	95
Adult mortality _{45q15} (%) (2000)	42.9
Life expectancy at birth (years)(2003)	48.4

Sources: WHO National Health Accounts website for health care financing statistics; World Bank website for all other data

Income inequalities are reflected in the health status of the population. Not only does South Africa have relatively high infant and other mortality rates, there are also major inequities in mortality. For example, infant mortality in the early 1990s was six times

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greater in the African than the white population. South Africa also has very low, and declining, average adult life expectancy, which is largely attributed to the HIV/AIDS epidemic.

2. CURRENT STRUCTURE OF AND FUNCTIONING OF THE HEALTH SYSTEM

South Africa has a two tier health system with a large private health sector, funded primarily from individual and employer insurance contributions, out-of-pocket payment and government tax subsidies and a public health sector almost fully funded by the taxes. The health sector accounts for 8.7% of the country's GDP – 3.5% of this expenditure is in the public sector (serving over 80% of the population) and the other 5.2% of expenditure is in the private sector (serving less than 20% of the population). This once again reflects the apartheid inheritance.

Public sector services have a strong base of primary care services with clinics at community level and referral district, regional and central hospitals. The public system is structured in such a way that provinces are responsible for tertiary, secondary and some primary curative care while local governments are responsible for environmental health services and have traditionally provided preventive primary care services. The public system is largely funded from centrally collected general tax revenue. Facilities receive budgets and staff are employed on a salaried basis. Although donor funding historically has been low, this is increasing mainly due to foreign funding for HIV/AIDS programmes. Primary care services are provided free of charge. The poor are exempt from fees at hospitals, and there is an income-related user fee structure for other public hospital users. There is a commitment in the Bill of Rights to ensuring access to health care for all South Africans.

Private primary care is provided by general practitioners (GPs), whilst private sector specialists and hospital groups (dominated by three large groups which are listed on the national stock exchange) provide private specialist and hospital care. The private sector is largely funded by private health insurance (called medical schemes in South Africa) and by direct out-of-pocket payments (OOP). The OOP are mainly for GP care and over-the-counter medicines. It is indirectly funded by the tax system by means of a tax deduction on contributions to medical schemes. Employer-based

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clinics, non-governmental organisations also exist, but serve a limited section of the population.

The public-private mix is one of the greatest equity challenges facing the South African health system, as indicated in the following data:

- 14.4% of the population is covered by medical schemes and are able to secure most of their health services in the private sector. The per capita annual expenditure on this group, combining both medical scheme expenditure and out-of-pocket payments by medical scheme members, was equivalent to approximately R9,700 per beneficiary in 2005.
- A further 21.1% of the population, used the private sector on an out-of-pocket basis mainly for primary care, but are entirely dependent on the public sector for hospital (particularly inpatient) care. The per capita annual expenditure on this group, including their out-of-pocket payments to private primary care providers and government spending on hospital care, was equivalent to nearly R1,500 per person in 2005.
- The remaining 64.5% of the population can be said to be entirely dependent on the public sector for all their health care services. For this group, less than R1,300 was spent per person for government primary care and hospital services.

3. OVERVIEW OF HEALTH INSURANCE IN SOUTH AFRICA

Private health insurance evolved with economic growth and was started by employers wishing to protect their employees from health care costs and ensure a healthy workforce. Medical schemes typically provided health care cover for those in high-income employment in the urban areas i.e. the white upper middle class and their dependants. Health insurance is still only financially accessible to some middle- but mostly to high-income earners.

Health insurance in South Africa has a long history dating back to the 1800s when De Beers Consolidated Mines established the first medical insurance fund for its employees. The number of schemes grew rapidly until 1960 when there were 169 schemes in existence. As indicated in the table below, this increased more gradually until the mid-1990s, but has decreased somewhat since then.

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Growth in the number of medical schemes 1889-2004

1889	1910	1940	1960	1960-1994	1994-2004
1 st medical scheme	7 schemes	48 schemes	169 schemes	169-200 schemes	200 – 147 schemes

Medical schemes, which are ‘not-for-profit’ organisations are funded by employee and employer contributions; the schemes then manage and administer the funds and reimburse providers with the support of ‘for profit’ administrators and managed care organisations. All schemes are regulated by the Council for Medical Schemes.

Medical schemes currently provide cover for about 14% of the total population of South Africa (i.e. 6.7 million beneficiaries). A wide range of benefits are covered including hospital cover, prescription acute and chronic medication, some primary care and other services (dentistry, optical, maternity care, mental health, medical devices and prosthetics). Over the past decade coverage remained stagnant but most recently has been declining in absolute terms. In the face of a growing population this means coverage has been declining as a percentage of the population. The main reason for this real decline in membership is that medical scheme cover is becoming increasingly unaffordable, due to an uncontrolled cost spiral, for most of the working class.

Many policy and regulatory changes have been implemented in the industry. The most notable of these include: the reintroduction of community rating and open enrolment (i.e. anybody who is eligible to join a scheme cannot be denied access on the basis of their risk profile); the reintroduction of statutory guaranteed minimum benefits; and efforts to develop a risk equalisation mechanism.

4. STRUCTURE AND FUNCTIONING OF THE HEALTH INSURANCE SYSTEM

4.1. Contributions

Medical schemes operate on a ‘pay-as-you-go’ contribution system meaning that contributions are paid on a monthly basis with no accumulation of contributions paid

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and not used – once a member is unable to pay contributions they no longer have access to the benefits provided by the scheme. Contributions are community-rated and are not income-related; the size of your contribution is linked only to the benefit option you choose.

The main type of contribution is those paid on a monthly basis by every principal member into the scheme's pooled funds. These contributions are used to finance the core benefit package, i.e. they are used to finance claims made by all members of the scheme for services specified in the core benefit package (mainly hospital care, specialist care and chronic illness).

The other type of contribution, which is a quite recent development, is payments into the personal Medical Savings Accounts (MSA) of members. These are contributions that are also paid on a monthly basis but the difference is that they are paid into a personal account which is maintained by the scheme – this account can be used to pay for 'everyday' health expenses (e.g. GP visits, dental and eye care not covered in the core benefit package). The MSAs accumulate funds not used to pay for personal claims, which are allowed to roll over into the next year for the personal use of the member. The MSA option is only available in some medical schemes. The MSAs however do not allow for risk pooling as members are simply prefunding their own ongoing health expenditures.

4.2. Benefit packages and co-payments

Within the industry, different schemes provide a variety of different benefit options at differing contribution levels. All schemes are however required to provide unlimited access (without any co-payment) to a defined set of statutory minimum benefits, in order to provide financial protection for members against 'catastrophic costs'. These Prescribed Minimum Benefits (PMBs) were reintroduced by legislation in 2000. The PMBs cover all non-elective hospitalisations and outpatient care for a specified list of conditions. Many schemes exclude primary care for non-chronic conditions from their benefit package (although these are often covered under a medical savings account). For services outside the PMBs, schemes can exclude these services entirely (which are then paid for on an out-of-pocket basis) or include them in the benefit package but levy co-payments. Discussions are under way to include primary care

benefits in the PMBs so that a comprehensive standardised Basic Benefit Package (BBP) can be developed.

5. KEY ISSUES

5.1. Affordability of health insurance

The affordability of medical scheme membership is a serious problem in South Africa. Contributions vary depending on the type of benefits that members seek; the more extensive the benefit coverage the higher the contribution level. Average monthly contributions (excluding MSAs) over the past 5 years have ranged from R334-R583; if MSAs are added then total contributions have ranged from R376-R633. These total contribution rates vary per beneficiary per month but it can roughly be estimated that a family of 4 may well be paying contributions that at a minimum, range from R1,504-R2,532 per month. Nearly 70% of those employed in the formal sector earn less than R2500 per month. It is also of concern that two-thirds of out-of-pocket payments in South Africa are made by medical scheme members, highlighting that belonging to a scheme does not provide full financial protection due to benefit package limits and co-payments.

5.2. Costs drivers in the industry

Cost increases in the South African medical scheme industry are consistently above inflation. From the period 1974 to 1999, real costs (excluding administration) have increased by 249.7%. The major cost drivers have been the increasing use of expensive technology, the high burden of non-medical costs such as administration fees, managed care fees, brokerage fees, and reinsurance fees and also the fee-for-service provider reimbursement system.

Non-medical costs: Broker's fees were legislated in 1998 when the Medical Schemes Act was enacted. The legislation initially stated that brokers could be paid 3% commission for the first year of contributions for enrolling a new member in a scheme. While brokers initially attempted to enrol those who were not already members of schemes, when membership levels became static, brokers started to move members from one open scheme to another in a practise called 'churning' of members. New regulations limit brokers' commission to R50 per member per month,

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but this commission is now payable for the duration of the membership and not just the first year of enrolment.

Reinsurance and managed care fees have also been quite high as these have been used as a means of profit taking from schemes as many administrators, managed care organisations and reinsurers are run by the same company. The non-profit nature of schemes means that the only way that profits can be extracted is by excessive charging for services which the scheme needs such a reinsurance and managed care. To curb this, reinsurance contracts are now renewed every year after scrutiny by the Registrar of Medicals Schemes, to ensure that the pricing is correct and that contracts are only signed when required i.e. by small schemes with small risk pools, since by definition, large schemes should not need reinsurance contracts as they have relatively large risk pools.

Fee-for-service provider reimbursement: The system of paying providers for each service they provide to a medical scheme member is an incentive to oversupply health care services. This is especially expensive in a system where the use of primary care services, in the form of private sector GPs, is declining and the use of private specialists and hospitals is growing.

5.3. Fragmented risk pools

There are nearly 150 different schemes, each with a number of different benefit options, resulting in highly fragmented risk pools. Each benefit option is required to be 'self standing', and there is no risk-pooling between benefit options in schemes or between different schemes. There is, however, risk-pooling within each option due to legislated community rating and open enrolment. The South African government has recently initiated a Government Employees Medical Scheme (GEMS) which provides private health insurance for government employees. It is planned that in the long term, this scheme will be the only scheme for government employees therefore creating a scheme with a large risk pool.

5.4. Tax rebate

Another measure which has been initiated in order to try and bring down the costs of medical scheme membership is the restructuring of the tax rebate for medical scheme

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membership. Previously this rebate was structured such that the larger an individual's contribution to a medical scheme, and the higher their income level (and therefore their tax rate), the larger the tax rebate. This meant that a considerable amount of government funds were being directed to the medical expenditure of the relatively wealthy. This practise therefore entrenched inequities in an already inequitable system. In 2006, this rebate was restructured so that there is now a flat rebate of R500 and R300 for adult and child scheme beneficiaries instead of a rebate that increased with increased contributions and higher income levels.

6. FUTURE PLANS FOR HEALTH INSURANCE

6.1. Social Health Insurance

Social health Insurance has been on the policy agenda in South Africa for almost two decades. Issues that have limited progress towards implementing this system include: the high costs associated with private sector provision and financing; the high levels of unemployment (limiting the tax base); and most importantly, opposition by the national Treasury (i.e. Ministry of Finance). Two major reforms underway which are aimed at preparing for social health insurance are the establishment of a Risk Equalisation Fund and the development of medical schemes for low income earners in the formal sector.

6.2. The Risk Equalisation Fund (REF)

Risk equalisation is a system which allows for everyone in the medical schemes *industry* to pay the same industry rate for the same benefits. It is a necessary feature of an insurance industry where there is open enrolment and community rating. Currently in South Africa, schemes have different costs of providing the same benefits based on the total risk profile (i.e. age and health profile) of their members. Schemes with a low risk profile, such as those with many young and healthy members, have a lower cost of providing health care services and can amass large amounts of money especially where all schemes in the industry charge contributions which are similar. Those schemes with a high risk profile, such as those a high proportion of old and chronically ill members, have a higher cost of service provision and would therefore become financially vulnerable over time. A REF would equalise risks by either setting an industry cost of the prescribed minimum benefit package.

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Schemes with a high risk profile would receive money from the REF while schemes with a low risk profile would pay into the REF.

The aim of the REF is to achieve an effective single risk-pool across all schemes. The current distribution of members in schemes has been as a result of competing on the basis of risk selection, mostly by open schemes targeting young healthy members. With a system of risk equalisation, there will be no benefit in having low risk members and no high cost problems associated with having high risk members. Schemes will be competing to provide the benefits at the lowest cost so that they can reduce contributions and thus attract more members.

Discussions around the REF began in 2003 and it is anticipated that it will be implemented fully in 2008.

6.3 Low Income Medical Scheme (LIMS)

Policy options are currently being discussed to develop health insurance schemes or products for low income households in the formal sector. The primary aim of the LIMS is to increase health insurance coverage to include the 2.6 million households where there is at least one household member who is employed in the formal sector earning between R2,500 –R6,000. In this income band, only 13% of the income earners are currently members of medical schemes.

7. SUMMARY

Health insurance in South Africa is currently focused on providing financial risk protection for high-income households which can afford to pay for it. It is currently unaffordable for the majority of households.

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