

4.8 BENEFIT EXPENDITURE: COMPARISON ACROSS SCHEME TYPES

For ease of comparison, this section presents data on benefit expenditure for one year (1998) in all four scheme types. The percentage breakdown of expenditure (Table 4.39) highlights differences in the **pattern** of expenditure by scheme type, and the Rand expenditure per member per month (Table 4.40) highlights differences in the **level** of expenditure.

Table 4.39: Benefit expenditure by type of scheme (percentage) 1998

1998: Percentage of total benefits	Open registered	Closed registered	Non-reporting	Exempted
General practitioners	10.6%	10.0%	10.5%	13.0%
Medical specialists	19.8%	19.5%	16.6%	20.1%
Dentists	7.0%	6.4%	3.5%	6.0%
Dental specialists	1.2%	1.2%	0.4%	0.6%
Medicine (excluding hospitals)	24.9%	22.0%	29.3%	23.2%
Private hospitals (including medicine)	26.9%	31.8%	31.7%	28.5%
Provincial hospitals (including medicine)	0.8%	0.6%	1.0%	0.6%
Ex-gratia benefits	0.1%	0.2%	0.0%	0.6%
Other benefits	8.8%	8.3%	7.2%	7.3%
Total benefits	100.0%	100.0%	100.0%	100.0%

Source: Registrar's office

Table 4.40: Benefit expenditure by type of scheme (Rpmpm) 1998

Rand per member per month 1998	Open registered	Closed registered	Non-reporting	Exempted	All
General practitioners	74	76	72	34	71
Medical specialists	137	148	114	53	132
Dentists	48	48	24	16	44
Dental specialists	8	9	3	2	7
Medicine (excluding hospitals)	173	166	202	61	167
Private hospitals (including medicine)	187	241	218	76	196
Provincial hospitals (including medicine)	5	4	7	2	5
Ex-gratia benefits	1	2	0	2	1
Other benefits	61	63	50	19	58
Total benefits	694	756	690	265	681

Source: Registrar's office

Patterns of expenditure

The patterns of benefit expenditure show some marked differences in the different kinds of schemes.

Open schemes, which had a very similar total expenditure per member to non-reporting schemes, had a markedly different pattern of expenditure. They spent substantially more on medical specialists, dentists and dental specialists, and 'other benefits', and substantially less on medicines and hospitals than non-reporting schemes. This pattern would appear to indicate a younger, healthier membership and benefit designs with greater flexibility in relation to elective spending. (The open schemes spent half as much on ex gratia payments as the closed or exempted schemes: this was also a pointer to their membership profile, which was less likely to exceed benefit limits and require humanitarian assistance.)

Closed schemes had a far higher level of benefit expenditure overall, some 9% higher than either open or non-reporting schemes. The differences were most marked in private hospital expenditure (28.9% higher than in open schemes, 10.5% higher than in non-reporting schemes). The comparison with open schemes was most striking, as the expenditure level for non-reporting schemes was skewed by the fact that one of the schemes (Transmed) had a state hospital package with sizeable membership. (If Transmed members on the state hospital package were removed from the calculation, it is likely that private hospital expenditure per member for the rest of the membership would be even higher in this group than in the closed schemes.)

Non-reporting schemes spent a far lower proportion on dentistry and a markedly higher proportion (and Rand amount) on medicines than open and closed

registered schemes. This was an unexpected pattern, given the fact that one of the schemes (Transmed) had its own pharmacy chain, which could have been expected to lower the costs of medicine. The demographic profile of membership (with its high proportion of pensioners) may go some way towards explaining this pattern. These schemes had the highest utilisation of provincial hospitals.

Exempted schemes spent a larger proportion of their total expenditure on general practitioners and specialists (though, given their cost structure, this translates to a much lower Rand amount). This was predictable, given the benefit structure of some of these schemes, which had minimal major medical benefits, especially hospital benefits. However, the increase in expenditure on private hospitals was the most marked feature of the period 1996-1998. If the exempted schemes were split by cost and benefit level, this pattern would be far more marked in the lower cost schemes. (The narrow benefit structure was also obvious in the low expenditure on 'other' benefits, compared with the other kinds of schemes.)

4.7 BENEFITS BREAKDOWN: MEDICAL SPECIALISTS AND 'OTHER BENEFITS' 1998

A benefit category can obscure marked differences between sub-categories. The benefit category 'medical specialists', for example, contains some 20 specialties. Overall the category amounted to 19.4% of total benefit expenditure in 1998. However, this expenditure was by no means evenly spread between the different specialist categories and patterns of expenditure varied between the types of scheme.

4.9.1 Medical specialists

In table 4.41, the benefit category 'medical specialists' is disaggregated, in order to identify patterns in expenditure.

Table 4.41: Breakdown of expenditure on medical specialists by type of scheme 1998

Benefits as % of total Medical specialist: 1998	Open registered	Closed registered	Non-reporting	Exempted	All schemes
Pathologists	22.4%	22.4%	19.6%	21.4%	22.1%
Radiologists	20.3%	21.5%	20.8%	20.5%	20.7%
Physicians	9.0%	8.6%	9.7%	10.7%	9.0%
Gynaecologists	8.9%	7.5%	8.4%	5.9%	8.4%
Anaesthetists	6.6%	6.9%	7.3%	6.8%	6.7%
Surgeons	4.7%	5.0%	5.9%	5.6%	4.9%
Ophthalmologists	4.9%	5.5%	1.8%	5.4%	4.8%
Orthopaedic surgeons	4.5%	4.8%	5.1%	5.1%	4.7%
Radiotherapists	3.4%	3.4%	4.5%	5.7%	3.6%
Paediatricians	3.6%	3.1%	3.3%	2.2%	3.4%
Otorhinolaryngologists	2.5%	2.3%	2.1%	2.1%	2.4%
Urologists	2.0%	2.0%	2.2%	2.3%	2.0%
Psychiatrist	1.8%	1.5%	3.9%	0.8%	1.9%
Neuro-surgeons	1.4%	1.5%	1.6%	1.6%	1.4%
Dermatologists	1.3%	1.2%	0.9%	0.9%	1.2%
Neurologists	1.1%	1.1%	1.1%	0.9%	1.1%
Thoracic Surgeons	1.0%	1.1%	1.5%	1.5%	1.1%
Plastic & reconstructive surgeons	0.6%	0.7%	0.4%	0.5%	0.6%
Specialists in Physical Medicine	0.0%	0.0%	0.0%	0.0%	0.0%
Total medical specialist benefits paid	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Registrar's office

Patterns of expenditure

Expenditure was very highly concentrated in two diagnostic specialities, pathology and radiology, each of which accounted for more than 20% of total expenditure, with a very similar pattern in all the scheme types. Exempted schemes spent lower proportions on gynaecology, which was likely to be a factor of membership demographics.

Non-reporting schemes had lower expenditure on ophthalmologists, which mirrored the pattern of lower optical expenditure generally (see table below). Expenditure on psychiatrists was relatively higher in non-reporting schemes, which is likely to be related to job stress in the police and correctional services (see table below).

4.9.2 'Other benefits'

In table 4.42, the benefit category 'other benefits', which amounted to 8.5% of total benefit expenditure in 1998, is disaggregated in order to track patterns in expenditure.

The content of this benefit varied markedly between schemes, but in general it included the allied health professions and complementary healers.

Table 4.42: Breakdown of expenditure on ‘other benefits’ by type of scheme 1998

Benefits as % of total other benefits: 1998	Open registered	Closed registered	Non-reporting	Exempted	All schemes
Optometrists & Spectacles	47.3%	43.4%	35.4%	47.0%	45.2%
Physiotherapists	13.7%	13.9%	12.9%	14.2%	13.7%
Psychologists	7.2%	7.3%	13.8%	3.9%	7.8%
Blood Transfusion	3.9%	4.3%	6.0%	6.7%	4.3%
Appliances	3.6%	4.4%	1.9%	3.5%	3.6%
Cardiac Technologists	2.5%	2.4%	4.2%	3.0%	2.6%
Speech Therapists	2.2%	2.1%	2.3%	1.3%	2.1%
Nursing	1.4%	2.8%	1.0%	0.7%	1.7%
Ambulance Services	1.4%	1.9%	2.4%	2.0%	1.6%
Occupational Therapists	1.5%	1.6%	1.9%	0.8%	1.5%
Chiropractors	1.0%	1.0%	0.2%	1.8%	1.0%
Homeopaths	1.0%	1.0%	0.1%	1.0%	0.9%
Chiropodists	0.5%	0.5%	0.1%	1.2%	0.5%
Orthoptists	0.3%	0.1%	0.6%	0.0%	0.3%
Dieticians	0.3%	0.3%	0.0%	0.1%	0.2%
Other	12.3%	12.9%	15.6%	12.8%	12.8%
Total other benefits paid	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Registrar's office

Patterns of expenditure

Expenditure on ‘other’ benefits was low, ranging from 7.3% to 8.8% in 1998. In Rands per member per month terms, this translated to R19 in exempted schemes, R50 in non-reporting schemes, R61 in open schemes, and R63 in closed schemes. Spending was highly concentrated, with optometrists and spectacles accounting for nearly half of the expenditure, followed by physiotherapists and psychologists.

Expenditure patterns were similar in the different types of schemes, with some notable variations. The non-reporting schemes spent a larger proportion of ‘other benefits’ on psychologists. (See comment on psychiatrists above.) The non-reporting schemes spent a lower proportion on optometric services. There was no clear reason for this, but it may be related to limits in the benefit designs.

4.9.2.1 Complementary medicine benefits

The first medical scheme marketed specifically as a product for people interested in complementary medicine was launched in 1999. (See Appendix 3 for a detailed review

of complementary medicine in South Africa¹.) In general, however, very limited benefits are available through medical schemes and most expenditure is paid directly by consumers. Chiropractic is the most widely covered modality, followed by homeopathy. This is almost certainly because these are the only two modalities for which practitioners are registered with the Interim Allied Health Professions Council and practice numbers have been issued. Medical schemes also cover complementary medicine inadvertently to the extent that medical doctors practice complementary medicine, for example, homeopathy or acupuncture.

Reasons cited for the lack of funding of complementary medicine by medical schemes are:

- (a) The lack of understanding of modalities, procedures performed and medicines;
- (b) The large variation in cost;
- (c) The lack of a definition of ‘good practice’; and
- (d) The wide range of modalities.

The authors of the complementary medicine study contained in Appendix 3 were unable to obtain data on expenditure by medical schemes on complementary medicine. Where traditional medical schemes cover complementary medicine at all, visits to practitioners fall under the category ‘auxiliary services’ and any products dispensed fall under the ‘acute medication benefit’ or else under ‘the over-the-counter medicines benefit’. The financial limits under these categories are often so low that the data in existence is of little practical use.

So-called ‘new generation’ medical schemes typically cover complementary medicine through members’ savings accounts. Data collection on expenditure from individual savings accounts varies widely amongst schemes. Data will be collected when the product design includes a threshold over which benefits are paid from a collective pool. The usefulness of this data is compromised as:

- (a) There is no standardised coding practice for complementary medicine; and
- (b) Schemes focus data collection and analysis on major cost drivers (e.g. chronic medication and hospitalisation), rather than on day-to-day expenses.

The annual reports of the Registrar of Medical Schemes give expenditure on major categories of benefits but the delay in the production of these reports meant that, at the time when the complementary medicine study was done, the latest available data was from 1996. The existing categorisation of benefit payments would not allow complementary medicine expenditure to be fully isolated. Some work has been done to establish the most effective way to extract data on complementary medicine expenditure from medical schemes. A method using practitioner numbers to extract information would seem to be the most useful, but this can only be done once practice numbers have been allocated to all complementary practitioners.

¹ Caldis *et al* (2000)

Sections 4.3 to 4.9 have analysed the income and expenditure of medical schemes from various perspectives. All analyses, however, indicate an inflationary pattern of expenditure. Faced with spiralling expenses, along with membership shifts, schemes have sought to stabilise their financial bases in various ways. One approach to the management of unpredictable expenses has been to take out reinsurance policies and this issue is discussed in the following section.

4.10 REINSURANCE

4.10.1 Introduction

Reinsurance is the process of transferring risk to an external party in return for a premium. In theory, the purpose of reinsurance is to insure against unusual risks which could jeopardise the viability of a medical scheme. The need for health services is not perfectly predictable. Actuarial predictions of costs (and consequently contributions) are based on trends and demographic patterns, but unpredictable events can have a dramatic effect on the actual expenditure of schemes, particularly when the schemes are small. For this reason, some schemes choose to smooth the risk by taking out reinsurance. In recent years, the use of reinsurance has grown dramatically as is evident in the Registrar's Reports, which include reinsurance as one of the elements of 'non-claim related expenditure' (net reinsurance flow = premiums minus claims paid).

The Registrar's office had some concerns about the reliability and completeness of this data and consequently instituted an investigation into the use of reinsurance by medical schemes over the period 1996-1999. The concern was whether schemes were using reinsurance appropriately and were, on the whole, receiving value for money. A paper summarising the key features of the investigation into the use of reinsurance by medical schemes, and updating the results with data submitted after the first report, is appended as Appendix 1². This section is drawn from the paper, rather than the Registrar's Reports.³

The Registrar called for data from all schemes on the usage of reinsurance in the period 1996 to 1999. The review was aided by information supplied by the section 45(1) request sent to health insurers in December 1999. These insurance companies had been asked to supply information on any reinsurance contracts with medical schemes.

The report presented to the Council for Medical Schemes in May 2000 indicated clear problems with reinsurance agreements and cases where the contracts were resulting in substantial losses for members of schemes. It was shown that reinsurance had become a conduit for systematically removing surplus from medical schemes, thus undermining the security of members of those schemes.

² HD McLeod, PG Slattery and AM van den Heever, 'The use and abuse of reinsurance in Medical Schemes', Paper presented at the convention of the Actuarial Society of South Africa, October 2000.

³ Since the first draft NHA report, the Registrar's Report for 1999 has been produced. Where appropriate, final figures are inserted in footnotes for comparative purposes.

4.10.2 The patterns of usage of reinsurance

In the typical model for the conventional use of reinsurance in medical schemes, the trustees of the scheme contract with a reinsurance company and any profit share is paid to the scheme. Any registered insurer that is licensed for health business may also legally conduct health reinsurance. Specialist reinsurers dominate the business as they are best placed to provide pricing expertise and have a large client base to provide for the sharing of risk between schemes and different lines of business.

4.10.3 Growth in Reinsurance from 1996 to 1999

1.1

There was a significant increase in the number of reinsurance agreements with medical schemes in the period under review. The increase in reinsurance premiums paid showed a dramatic and disproportionate increase, as shown in Table 4.43⁴.

Table 4.43: Reinsurance in medical schemes from 1996 to 1999

	1996	1997	1998	1999
Number of schemes using reinsurance	13	20	30	56
Reinsurance premium paid (Rm)	32.1	246.6	1,318.6	1,714.7
% increase		668.2%	434.7%	30.0%

Source: McLeod *et al* (2000)

4.10.4 The Use of Reinsurance by Type of Scheme

At the beginning of 2000 there were 105 closed schemes and 50 open schemes in South Africa. According to statutory returns, 30 of each type made use of reinsurance in 1999: 28.6% of closed schemes, compared with 60% of open schemes⁵. The extent of reinsurance was greater in open schemes, which accounted for 85% of total premium.

Closed schemes typically entered into conventional reinsurance contracts with the major specialist reinsurers. Of the closed schemes which used reinsurance in 1999, the majority made use of specialist reinsurers. Only one closed scheme is known to have entered into a reinsurance arrangement that allowed for the extraction of profit from the scheme as discussed below. The total reinsurance premium paid over the period in respect of conventional reinsurance arrangements for closed schemes included in the Council research project was R15.3m and the loss to schemes (i.e. reinsurance premiums paid less

⁴ Final figures from Registrar's Report, 1999:
30 Closed schemes R283.2 million total premium (15%)
30 Open schemes R1.618 billion total premium (85%)
Total: R1.901 billion

⁵ Registrar's Report, 1999

reinsurance recoveries) was R2.0m, giving a loss ratio (i.e. reinsurance recoveries expressed as a percentage of reinsurance premiums) of 87%.⁶

A notable feature of the primary reinsurance of open schemes is that specialist reinsurers were not dominant. Of the 22 conventional reinsurance arrangements covered in the Council research project, only half were with specialist reinsurers. The counter-parties named in the other conventional arrangements included some unusual organisations (e.g. agents) and the legality of some of these will need to be clarified. A surprising finding in the Council research project was that the conventional model of reinsurance accounted for only 3% of the premium paid by open schemes in 1999. When measured by premium the business of removing profit to another legal entity dominated all other types of reinsurance. In the open schemes, funds were removed to another legal entity. Most cases were of open schemes transferring reserves to other entities in the same group of companies. The use of reinsurance to extract profit is discussed below.

The review also noted in a number of instances the use of a sole reinsurer, which typically reinsured all the risk business of the medical scheme, operating with only one client. Without a large number of clients, the risk spreading opportunities are no different from those of the scheme itself. Typically these arrangements were in very large schemes.

Table 4.44 below sets out three broad categories of organisations which provided primary reinsurance to medical schemes, the numbers of medical schemes reinsured with each and the reinsurance premium (for 1999), as included in the Council research project.

Table 4.44: Organisations which provided reinsurance to open schemes in 1999

Organisation	Number of Open Schemes	Reinsurance Premium
Specialist Reinsurers	11	R11.9m
Independent insurers (or agents)	11	R38.0m
Organisations with a corporate relationship with the medical scheme or administrator	7	R1655.5m

Source: McLeod *et al* (2000)

It is notable that specialist reinsurers were not dominant in the primary reinsurance of open schemes. Only half of the conventional reinsurance arrangements were with specialist reinsurers. The total known reinsurance premium paid over the period 1996-1999 in respect of conventional reinsurance arrangements was R94.0m and the loss to schemes was R11.4m, giving a loss ratio of 88%.⁷

Organisations with a corporate relationship with the medical scheme or administrator dominated the reinsurance market in medical schemes. The total known premium in

⁶ Note that these figures are drawn from the research report, not the Registrar's Reports.

⁷ Given the figures provided in the statutory return for 1999, these figures are underestimates.

respect of such contracts over the period 1996-1999 was R3.2bn and the loss to schemes was at least R165m directly.⁸ The investment income lost by schemes as a result of reinsurance could have been of the order of a further R150m. The method adopted by one insurer meant a further loss to schemes of investment income of R77m. Thus the total loss to schemes from this form of reinsurance is estimated to have been of the order of R400m.

4.10.5 The Use of Reinsurance by Size of Scheme

For the investigation, the definitions of size were:

- (a) Small: fewer than 6,000 principal members (the minimum number of members required for registration under the new legislation);
- (b) Medium: between 6,000 and 15,000 principal members; and
- (c) Large: more than 15,000 principal members or 30,000 beneficiaries.

It would be expected that small schemes would need to make more use of reinsurance than large schemes. Table 4.45 shows that, as expected, the Council survey revealed that most closed schemes which used reinsurance were small schemes. Only 5.5% of reinsurance premium was attributable to large closed schemes. The surprising finding was that 95.7% of reinsurance by open schemes was entered into by large schemes, i.e. those with over 30 000 beneficiaries. Most reinsurance is therefore done by schemes that should have sufficient members to spread their risk internally.

Table 4.45: Reinsurance by size of scheme in 1999

	Small	Medium	Large	Incomplete data	Total
Closed Schemes					
Number of Schemes	8	2	3	11	24
Reinsurance Premium (Rm)	6.6	2.2	0.5		9.3
Proportion of Premium	71.0%	23.5%	5.5%		100%
Open Schemes					
Number of Schemes	6	4	13	6	29
Reinsurance Premium (Rm)	8.5	65.5	1,631.4		1,705.4
Proportion of Premium	0.5%	3.8%	95.7%		100%

Source: McLeod *et al* (2000)

4.10.6 The use of reinsurance to extract profit

One of the major reasons for the dramatic increase in reinsurance is that it has apparently become a means of extracting profit from non-profit medical schemes. This practice

⁸ As above, all figures in this paragraph are underestimates.

appears to have become common knowledge amongst insurers. UBS Warburg, a merchant bank reporting for investment managers, (Symeonides 2000), openly describes the various reinsurance structures as methods for extracting profits from medical schemes. These arrangements can only occur where there is no arms-length arrangement between the medical scheme, the administration company and any of the other contracting parties.

‘Although the administration company/health insurer would argue that reinsurance is necessary to secure and to manage the financial position of the scheme, the potentially lucrative reinsurance commissions or retrospective profit shares also provide a strong incentive for reinsurance. The scheme trustees are ultimately responsible for any decision to reinsure, but in practice the administration company/health insurer is typically more closely involved than the trustees in the day-to-day affairs of the scheme and often has a strong vested commercial interest in how these affairs are conducted. This may change as a result of the new legal requirements relating to trustees.’ (Symeonides 2000:18). [Authors’ emphasis].

The report describes two methods to extract profit from non-profit medical schemes using contracts of reinsurance. Both methods require the collusion of the medical scheme trustees with external contracting parties, or very weak trustees.

The first arrangement occurs where a medical scheme takes out reinsurance with its administration company which has an insurance license. The administrator/insurer then reinsures with an outside reinsurer which includes a profit share arrangement. The administrator/insurer and the external reinsurance company will often belong to the same group of companies. For the administrators involved in such activity it was noted that a substantial proportion of their reported profit came about as a result of the reinsurance of a medical scheme.

The second arrangement occurs in instances where the administrator has no insurance license. Here the medical scheme contracts directly with a reinsurer which has a special profit share arrangement with the administrator and/or Managed Care Organisation. The effect on the scheme is identical to that of the first type of arrangement.

1.2 4.10.7 *The Loss of Funds earmarked for Health Care Expenditure*

Over the four year period covered in the Council’s survey, less than five percent of reinsurance agreements examined improved the underwriting result of medical schemes (i.e. paid out more than the premium paid). It should be pointed out that when the losses suffered by medical schemes as a result of the loss of investment income are taken into account the position looks even worse. The reinsurance losses ranged from 7% of accumulated reserves to over 100%, despite the fact that many of these schemes had reserves below the 25% minimum required. In certain instances schemes would have had adequate reserves if they did not take out reinsurance. In many instances it is apparent that funds would have been put to better use had they been left with the medical scheme to meet health care expenses.

4.10.8 Regulation of reinsurance

Arising out of the report, the Council for Medical Schemes prepared proposed regulations on reinsurance for publication in the Government Gazette. The intention is to ensure that greater oversight of reinsurance contracts with medical schemes is provided by the Registrar. The proposed regulations will ensure that all contracts are reviewed by the regulator and thereby pre-empt the creation of inappropriate reinsurance arrangements. All contracts not explicitly approved by the regulator will consequently be illegal. Agreements will not be permitted where there is no spreading of risk or where clear conflicts of interest exist between the Board of Trustees, the reinsurer, the administrator, and any brokers concerned. Actuaries and advisors to schemes will need to demonstrate that identifiable risks of an unusual nature exist and that it is in the members' interests to enter into the contract of reinsurance.

4.11 SUMMARY

The analysis of medical schemes data reveals disturbing trends in private sector health care funding and coverage. Despite evidence of underpricing, contribution increases are consistently higher than CPI, a trend which will make medical scheme cover increasingly unaffordable. Unless this trend is checked, there is little potential for increasing the insured population, one of the policy objectives of the Medical Schemes Act. In fact, there is a danger that the membership of medical schemes may actually shrink, as lower income members find contributions unaffordable. There is little evidence in the data available of success in managed care initiatives to contain costs in a sustained way. The decrease in medicine expenditure in 1997 may have been due to pharmacy benefit management programs, but seems to have been a one-off effect as expenditure increased again in 1998 at a rate higher than general scheme inflation. Private hospital expenditure appears to be unaffected by hospital managed care programmes. It will be important to monitor the impact of such programmes in the future, in order to ensure that they do not merely constitute an additional expense to schemes.

There is some clear evidence of the fragmentation of risk pools, a key concern underlying the Medical Schemes Act. The drop in membership of closed schemes and their apparent ageing are cause for concern, especially in combination with cost escalation. Together, these trends could cause further loss of membership.

Reserve levels are disturbingly low. It is not clear how open schemes with very low reserves will meet the targets set in the Medical Schemes Act: there is the danger that they will drive away members by the even higher contribution increases necessary to accumulate reserves. The process of reserve accumulation is clearly being impeded in some schemes by the inappropriate use of reinsurance.

In the period under review, membership of medical schemes was effectively static, which is likely to be related to a combination of inflationary costs and shifts in employment, with increasing contracting out and a growing trend towards total cost of employment remuneration packages. In a voluntary membership environment, these trends have the potential to shrink the membership yet further and, in the process, to undermine the stability of medical schemes.

5. HEALTH INSURANCE

Though medical schemes are a form of health insurance, in the South African context health insurance products are distinguished from medical schemes. Health insurance products are not currently subject to the regulatory framework of the Medical Schemes Act or the supervision of the Council for Medical Schemes. They fall under the ambit of the Financial Services Board and are allowed considerably greater latitude than medical schemes in terms of detailed reporting. In particular, they are allowed to operate on a for-profit basis.

The Health Expenditure Review pointed to rapid growth of health insurance, a phenomenon which has not, in view of the information reported in this section, materialised. One of the factors in the slow growth of this sector in the period under review may have been the fact that the deregulation of the industry in the late 1980s and early 1990s allowed medical schemes to risk rate their contributions, refuse applications for membership and exclude benefits for pre-existing conditions – in effect, with the exception of operating on a for-profit basis, to operate like insurance products. The Medical Schemes Act of 1998 changed these conditions, re-establishing the distinction between medical schemes and insurance products. The maintenance of a clear demarcation between the two is vital to the policy objectives of the Act. If health insurance products are allowed to do the business of medical schemes, without being subject to the regulatory framework (in particular, community rating and open enrolment), they have the potential to undermine the medical schemes environment.

It is important to have baseline information on health insurance products in the period before the Act was implemented in full, in order to measure the impact of the Act. The information in this section is drawn from a summary report on a review of health insurance products, commissioned by the Council for Medical Schemes and completed in May 2000⁹ and appended as Appendix 2.

5.1 REVIEW PROCESS

In December 1999 the Department of Health, acting in combination with the Registrar of Medical Schemes and in consultation with the Financial Services Board (FSB), requested all insurance companies who might be doing the business of a medical scheme to supply relevant information to determine whether their activities fell under the remit of the Council for Medical Schemes.

⁹ ‘Demarcation between Medical Schemes and Health Insurance’, Office of the Registrar of Medical Schemes, May 2000.

Responses

Not all respondent insurance companies were doing the business of a medical scheme. Out of the total of 108 requests for information only 35 companies (around 104 products) were found to have products which may be doing health-related business. (The companies are listed in the full report.)

Not all companies responded to the request for information or provided all the requested information. Use was therefore also made of external reviews and product information supplied to the Office of the Registrar of Medical Schemes.

The information was compared against existing product reviews to ascertain whether all the main products were reflected in the analysis.

5.2 HEALTH INSURANCE PRODUCTS

In all, six types of health insurance structure were identified. All other insurance products, such as top-up cover, gap cover and multiple benefit products, were either portions of or combinations of the main types. ('Gap' insurance products pay the difference between different tariffs, for example, between the Board of Healthcare Funders' tariffs and South African Medical Association tariffs, or between the BHF tariffs and the actual fees charged by hospitals. 'Top-up' insurance products are designed to upgrade benefits, for example to pay for a private hospital ward, when a medical scheme only pays for a general ward.)

The six major types of health insurance products are:

- Hospital: provides cover for in-hospital events;
- Major medical: provides cover for specified procedures and out-of-hospital medical expenses;
- Emergency transport: covers ambulance and related services expenses;
- Dread disease: covers the costs of catastrophic medical events;
- Accident: provides cover for the costs associated with various forms of accident;
- Disability: provides cover for the various consequences of becoming disabled.

The last two (accident and disability products) were judged not to be doing the business of a medical scheme, as they are largely income-replacement products, with payments not triggered by medical service utilisation. Consequently expenditure on such products has been excluded from the calculation of private sector health expenditure. Estimated coverage and costs of the different products are outlined in table 5.1 below.

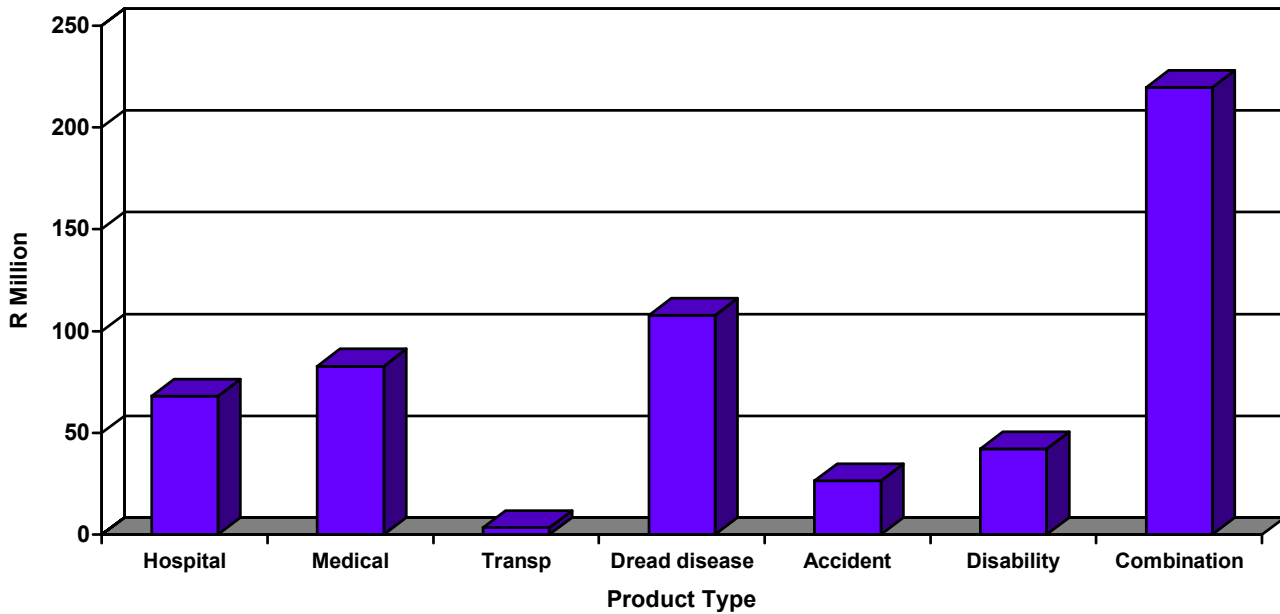
Table 5.1: Estimated costs and beneficiaries by product type, 1999

Estimated costs and beneficiaries					
Product type	Medical Scheme Business	Beneficiaries	% of total	Annual Premium income (Rands)	% of total
Hospital	Yes	104,876	5.6%	68,313,558	12.4%
Major Medical	Yes	79,527	4.2%	82,800,000	15.0%
Emergency transport	Yes	24,000	1.3%	3,439,307	0.6%
Dread disease	Yes	446,050	23.7%	107,715,863	19.6%
Accident	No	225,561	12.0%	26,574,400	4.8%
Disability	No	492,946	26.2%	42,239,749	7.7%
Combination hospital & Major medical	Yes	508,422	27.0%	219,580,330	39.9%
Total		1,881,382	100.0%	550,663,208	100.0%
Total 'doing Medical Scheme business'		1,162,875	61.8%	481,849,058	87.5%

The total annual premium income for 1999 for insurance products judged to be doing the business of a medical scheme was estimated at R482 million, compared with R28.805 billion in gross contributions for medical schemes (Registrar's Report, 1999).

There were some 1.2 million beneficiaries of health insurance products in 1999, compared with 7.0 million in medical schemes. The largest concentration of these beneficiaries was in combined hospital/major medical plans, as seen in figure 5.1 below.

Figure 5.1: Health Insurance Products 1999



Given the information available, it is not possible to estimate accurately the extent of overlap. However, it is likely that there was a significant duplication of membership, with medical scheme members taking insurance products, primarily as top-ups. The Medical Schemes Act does not allow membership of more than one medical scheme, but has no jurisdiction over insurance products. The Review made a series of recommendations in relation to the demarcation between medical schemes and health insurance: including closure of certain products, closure of others to new business and revision of some products to avoid overlap with medical schemes business. The process of establishing demarcation and considering the recommendations is being undertaken by a joint committee of the Financial Services Board and the Medical Schemes Council and had not been finalised at time of writing.

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6. NON-MEDICAL SCHEME EXPENDITURE BY FIRMS

In addition to the contributions which firms make to medical schemes on behalf of their employees (which may be seen as part of the total wage bill), private firms in South Africa incur significant expenditure on other forms of health care cover for their employees. In particular, firms are required to pay a levy to the Workers' Compensation fund (based on their risk profile and wage bill), which may be drawn upon to cover the costs of health care for injuries occurring at the workplace. Some firms also provide and fund on-site health services for their employees, ranging from limited primary and/or occupational health care in non-mining firms, to comprehensive health care (from primary health care through to specialist hospital referral services) on the mines. The private NHA team attempted to obtain information on all aspects of such expenditure (contributions to medical schemes have been addressed in Section 4).

6.1 METHODOLOGY

Information on contributions to Workers' Compensation and the expenditure on health services from this source (as opposed to wage replacement, disability and death payments) was obtained directly from the Workers' Compensation Commissioner.

Estimated direct expenditure for on-site health services by the mining industry was obtained with the assistance of Dr Le Grange of the Chamber of Mines, who undertook a survey of all mines on behalf of the NHA team. The NHA team drafted a questionnaire on health service expenditure and the number of employees covered for 1996, 1997, 1998 and 1999, which Dr Le Grange distributed to all mining companies. The Chamber of Mines then collated information from the completed questionnaires and provided aggregate data to the NHA team. Not all mines returned completed questionnaires, and thus the survey results were extrapolated to estimate total spending by the mining industry. Average expenditure per employee covered was calculated from the survey, which was then multiplied by the total estimated number of mining employees covered by on-site services. In the previous Health Expenditure Review (McIntyre *et al.* 1995), it was estimated that nearly three-quarters of mine employees used on-site health services on a regular basis (the remainder using other services covered by their medical schemes). This proportion was applied to the total number of mining employees in 1996, 1997, 1998 and 1999, as derived from Statistics South Africa labour reports.

In the case of firms outside of the mining industry, a list of all clinics operated by private firms was obtained from the national Department of Health, with whom these clinics are required to register. Mines were excluded (to avoid duplication with the Chamber of Mines survey), and the list was then stratified according to the size of the firm (using two strata: those with 500 employees or less and those with more than 500 employees). A random sample of 10% of firms in each stratum was drawn. Questionnaires requesting information on health service expenditure and the number of employees covered by these services for 1996, 1997, 1998 and 1999 were then faxed to each firm included in the

sample. The average annual expenditure on on-site health services per employee was calculated from the data provided by survey respondents. This was then extrapolated to all non-mining industry clinics based on the total number of employees covered by such services. The estimated total number of employees for 1999 was obtained from the national Department of Health's private firms' clinic register. The number covered in 1996, 1997 and 1998 was then estimated based on the change in total non-agricultural employment in South Africa over this period (using Statistics South Africa employment estimates). Thus, it was assumed that the number of employees covered by on-site health services declined in proportion to the overall decline in employment in South Africa. Unfortunately, the response rate in this firm survey was relatively low, and the estimates for expenditure by firms should thus be treated with caution. However, the estimates derived from this survey are comparable to those reported in the previous Health Expenditure Review (McIntyre *et al.* 1995), after adjusting for average inflation since 1992/93 and the overall decline in employment.

6.2 RECENT TRENDS IN NON-MEDICAL SCHEME EXPENDITURE BY FIRMS

Expenditure by firms is summarised in Table 6.1 below.

Table 6.1: Worker's compensation expenditure and direct expenditure by firms

	1996	1997	1998	Annual growth rate	
				1997-8	1997-8
Workers' Compensation	335,192,808	374,439,360	418,281,155	11.7%	11.7%
Mines	514,078,614	461,615,442	461,954,848	-10.2%	0.1%
Other firms	120,645,491	128,958,500	143,907,310	6.9%	11.6%
TOTAL	969,916,913	965,013,302	1,024,143,313	-0.5%	6.1%

Expenditure by the Worker's Compensation Fund increased at rates in excess of general inflation in the period under review (CPI: 8.6% for 1997 and 6.9% for 1998). On-site health care expenditure by firms outside the mining sector increased at a rate below inflation for 1997 and above inflation for 1998, and above inflation for the two years combined. This occurred in spite of decreasing employment in the formal business sector. However, there was an overall decline in on-site health care expenditure in the mining industry between 1996 and 1997 and a very limited increase in the period 1997 to 1998. The major reason for this was the massive decline in mining employment between 1996 and 1998 (see Table 6.2 below). During this period, certain mines closed, along with their on-site health services, while others down-scaled their health services in line with staff reductions. There was also some growth in medical scheme membership on the mines, which could have caused a small shift of expenditure away from in-house services.

(Personal communications: Welcome Mboniso, National Union of Mineworkers; Dr Brian Brink, Chief Medical Advisor, Anglo American.)

Table 6.2: Employment figures 1990 and 1998

Year	Numbers employed in:	
	Mining sector	Other formal business sector
1990	758,000	4,714,097
1998	421,000	4,514,224

Source: Statistics South Africa

6.3 SUMMARY

It is extremely difficult to obtain accurate data on direct health service expenditure by firms on a routine basis and one currently has to rely on sample survey results. Based on available data, there has been a considerable decline in on-site health service expenditure within the mining industry, which matches the decline in the number of employees covered by such care (see Section 3). This is a result of a dramatic reduction in employment within this industrial sector. Given that mines provide access to relatively comprehensive on-site services, the declining population coverage and health service expenditure has implications for the public sector, who will be called upon to provide care for a large proportion of the growing pool of unemployed mine workers. As employment declines were lower in the rest of the formal sector, on-site health service expenditure has continued to increase among non-mining firms between 1996 and 1998, as has medical expenditure by the Worker's Compensation Fund.

7. OUT OF POCKET EXPENDITURE

Out of pocket (OOP) expenditure refers to household payments direct to health service providers. In most instances, this relates to payments to private providers, although households due make limited payments to public hospitals in the form of user fees. In the case of medical scheme households, out of pocket payments can refer to:

- co-payments for benefits covered by the scheme
- expenditure on items/services not covered by the medical schemes and
- health expenditures made once the annual benefit limits set by the scheme have been reached.

These three categories of expenditure by medical scheme beneficiaries are sometimes referred to as the 'schemes gap'.

7.1 METHODOLOGY

Data on out of pocket expenditure have been obtained from three major sources:

- The 1995 household Income and Expenditure Survey (IES) conducted by Statistics South Africa;
- The Registrar of Medical schemes; and
- AC Neilson (a private firm which routinely compiles data on the sale of over-the-counter (OTC) medicines).

The IES provided data for 1995 on out of pocket health expenditure for both medical scheme and non-medical scheme households. Data for non-medical scheme households' expenditure for the years 1996-8 was calculated using the 1995 IES expenditure and inflating this using the consumer price index (CPI). It is internationally acknowledged that household surveys tend to underestimate expenditure levels. These estimates should thus be treated with caution. Given the tendency for household surveys to underestimate expenditure, the registrar's data on out of pocket expenditure for medical scheme households has been used for the years 1996-8 (see further discussion below). Both medical scheme and non-medical scheme data has been supplemented with over-the-counter drug expenditure data from AC Neilson. Caution was exercised to avoid double-counting over-the-counter drug expenditure when combining the different data sets.

The Registrar's reports, as from 1996, provide data on the gap between claims that were submitted and those that were paid (the difference being paid by the member). Given that claims for items not covered by the scheme, or once the limit has been reached, are less likely to be submitted, these figures are likely to be an underestimate of the total value of the 'schemes gap'. However, comparison of the IES and the registrar's data on household contributions suggests that underestimation by the IES is likely to be greater. It is for this reason that the registrar's data has been utilised as the basis of estimating medical scheme households' out of pocket expenditure. However, the Registrar's 1998

data is also unreliable, with some schemes reporting total claims charged as being 1000% of claims paid. The worst excesses have been cleaned, but the data should still be interpreted with caution.

Disaggregated data on out of pocket expenditure on complementary medicine products is presented in section 8. These complementary medicine expenditure estimates have not been added to the out of pocket expenditure estimates presented in this section, due to the potential for double counting.

7.2 EXPENDITURE

Out of pocket expenditure on private health care is outlined in Table 7.1 below, which compares expenditure for medical scheme and non-medical scheme households for the years 1995 to 1998. It should be borne in mind that some of the data is unreliable, an issue discussed previously. Italicised figures indicate data that are regarded as less reliable.

Table 7.1: Out of pocket expenditure for medical scheme and non-medical scheme households 1995-1998

Year	Total out of pocket expenditure by MS* households (including OTC drug expenditure)	Total non-MS household expenditure (including OTC drug expenditure)	Total out of pocket expenditure	Annual growth
1995	<i>1,241,005,252</i>	<i>1,119,241,177</i>	<i>2,360,246,428</i>	
1996	<i>3,846,525,401</i>	<i>1,688,714,050</i>	<i>5,535,239,451</i>	135%
1997	<i>3,466,419,282</i>	<i>1,911,071,373</i>	<i>5,377,490,655</i>	-3%
1998	<i>5,348,138,296</i>	<i>2,142,470,608</i>	<i>7,490,608,904</i>	39%

Sources: IES for non-MS households in all years; IES for MS households in 1995 and Registrar's reports for MS households in 1996, 1997 and 1998.

* MS = medical scheme

Note: Italicised text indicates data that is regarded as less reliable.

The concern that the data from the IES 95 is an underestimate is underlined by the significant increase in out of pocket expenditure by medical scheme households from 1995 to 1996. The substantial growth in 1998 is likely to be due to the inaccuracies in the Registrar's data. Given these problems, the most reliable years are likely to be 1996 and 1997, with expenditure at approximately R5.5 billion.

Table 7.2 examines the out of pocket expenditure per beneficiary per month, derived from the previous table. Expenditure per beneficiary per month indicates that non-medical scheme households spend approximately 9% of medical scheme households'

spending on out of pocket payments. It should be noted that monthly medical scheme contributions by households are not included here, and thus the figures do not represent total expenditure on health by those households that have medical scheme cover. However, the data in Table 7.2 for non-medical scheme households represents their total estimated expenditure on health services.

Table 7.2: Out of pocket expenditure per beneficiary per month (rands) 1995-8

Year	Out of pocket expenditure per MS* beneficiary	Out of pocket per non-MS beneficiary	Non-MS expenditure as percentage of MS expenditure
<i>1995</i>	<i>15</i>	<i>2.8</i>	<i>19.2%</i>
1996	47	4.2	9.0%
1997	42	4.6	11.1%
1998	65	5.1	7.8%

Sources: IES for non-MS households in all years; IES for MS households in 1995 and Registrar's reports for MS households in 1996, 1997 and 1998.

* MS = medical scheme

Note: Italicised text indicates data that is regarded as less reliable.

7.2.1 Out of pocket expenditure by provider

Table 7.3 gives a breakdown of out of pocket expenditure for medical scheme and non-medical scheme households for 1996 by provider. Expenditure on medical practitioners (including specialists) accounts for approximately equal proportions of total out of pocket expenditure in medical scheme and non-medical scheme households (28% and 26% respectively). Medicine (both prescription and over the counter) forms the major proportion of health expenditure in both groups (55% for medical scheme households, and 48% for non-medical scheme households). However, the bulk of this expenditure is prescription medicine for medical scheme households (38%), and over-the-counter medicine for non-medical scheme households (37%). Out of pocket expenditure on hospitals is a higher proportion for non-medical scheme households (18%), as hospital expenditure for medical scheme households is largely covered by their schemes.

Table 7.3: Out of pocket expenditure by provider 1996

Provider 1996	Medical scheme households		Non-medical scheme households	
	Total	Payments as Percentage of total	Total	Payments as Percentage of total
<i>General practitioner</i>	339,876,127	9%		
<i>Medical specialists</i>	454,423,887	12%		
<i>Dentists</i>	218,502,770	6%		
<i>Dental specialists</i>	54,649,493	1%		
Medical practitioners	1,067,452,277	28%	439,943,691	26%
<i>Prescription Medicine</i>	1,457,981,214	38%	179,442,446	11%
<i>Over the counter medicine</i>	642,658,397	17%	631,453,099	37%
Medicine	2,100,639,611	55%	810,895,546	48%
<i>Private hospitals</i>	284,083,664	7%		
<i>Provincial hospitals</i>	29,244,689	1%		
Hospitals	313,328,353	8%	310,759,048	18%
Other benefits	365,105,160	9%	127,115,765	8%
Total out of pocket payments	3,846,525,401	100%	1,688,714,050	100%

7.2.2 'Over the counter' medicine expenditure by households

Table 7.4 gives total expenditure on over the counter drugs, purchased without a prescription, according to the type of retailer. Total expenditure increases over the three years from R1.3 billion to R1.9 billion, growing on average at 20% per annum. In 1996/7 the drug retailers held the dominant position in the market, with 53% of sales. However, due to average annual growth of 27% pa, the food retailers recorded the greatest proportion of sales by 1998/9.

Table 7.4: Expenditure on over the counter medicines 1996/7 to 1998/9* by type of retailer

Type of retailer	1996/7		1997/8		1998/9		Average annual growth rate
	Rands	Percentage	Rands	Percentage	Rands	Percentage	
Food retailers	627,691,524	47%	707,798,627	45%	993,241,581	52%	27%
Drug retailers	706,107,478	53%	863,326,221	55%	921,888,409	48%	15%
Total	1,333,799,002	100%	1,571,124,848	100%	1,915,129,990	100%	20%

Source: AC Nielson.

* Data were obtained from AC Nielson in financial years (April 1996 – March 1997) and are presented in this format in this table. However, these data have been translated into calendar year estimates for incorporation in overall out of pocket expenditure, to ensure comparability of data.

Table 7.5 examines over the counter medicine expenditure according to the type of drug. Stomach remedies and laxatives, analgesics, and vitamins show a similar growth rate (22-23%), while expenditure on cough and cold remedies increased at a slower rate. Analgesics account for nearly half of total expenditure.

Table 7.5: Expenditure on over the counter medicines 1996/7 to 1998/9 by type of medicine

Drug type	1996/7	1997/8	1998/9	Average proportion of different categories of medicine	Average annual growth rate
Stomach remedies, laxatives & slimming aids	356,489,905	428,837,933	533,407,059	27.3%	22.3%
Cough & cold remedies, nasal sprays etc	278,363,359	320,351,674	356,313,233	20.0%	13.2%
Topical acne preparations	63,365,238	68,873,543	73,445,672	4.3%	7.7%
Analgesics	562,457,248	668,146,016	840,745,246	42.9%	22.3%
Vitamins & Supplements (Food retailers only)	73,123,252	84,915,682	111,218,780	5.6%	23.6%
Total	1,333,799,002	1,571,124,848	1,915,129,990	100.0%	19.8%

Source: AC Nielson

7.3 UTILISATION

One of the major gaps in data concerns utilisation of medical services on an individual basis. The only source at present is the October Household Survey. Data from this source are particularly suspect and should be read with caution. They are included here to highlight broad trends. The data suggests substantial (and unsurprising) differences between medical scheme members and non-members in both patterns and levels of utilisation.

Changes in expenditure levels are driven by both price increases and changes in utilisation of health services. With the data available, it is not possible to determine which of the two is the predominant factor, but analysis of the available utilisation data reveals that it plays a significant role in expenditure growth.

Table 7.6 compares utilisation of those with medical scheme coverage with those who do not have medical scheme cover. These health care utilisation estimates were derived from the October Household Surveys undertaken by Statistics South Africa in 1995 and 1998.

Table 7.6: Consultation in last month by medical scheme coverage 1995 & 1998

Population who have visited a health worker in the last month	1995		1998	
	Numbers	Percentage	Numbers	Percentage
Without medical aid	3,052,176	9.3	2,558,696	7.2
With Medical aid	1,135,477	16.3	709,849	12.1
<i>Unknown coverage</i>			40,846	4.8

Source: October household survey 1995 and 1998

The utilisation rates of individuals covered by a medical scheme were nearly double those not covered, as might be expected, given that medical scheme beneficiaries are more likely to be wealthier, and will not have to bear the full cost out of pocket. There was a fall in utilisation rates between 1995 and 1998: 2% for non-medical scheme individuals and 4% for medical scheme individuals. It is unclear whether this is due to falling real incomes, or differences in the sample population within the survey. As indicated in earlier sections, it appears that the 1998 October household survey undercounted the medical scheme population, with the undercount being more substantial in some provinces than in others. It is unclear whether this would have influenced the estimated utilisation rates.

Table 7.7: Distribution of those who consulted a health worker in the last month according to place of consultation, by medical scheme coverage (1995 & 1998)

Place of consultation of those who visited a health worker in the last month	1995		1998	
	Without medical scheme	With medical scheme	Without medical scheme	With medical scheme
Public sector	71%	33%	69%	21%
Private sector	29%	67%	31%	79%

Source: October Household survey 1995 & 1998

A substantial proportion of those without medical coverage choose to attend the private sector in 1995, and this proportion rose from 29% to 31% in 1998 (Table 7.7). Utilisation of the public sector fell for both groups: by 3% for those without coverage, and by 12% for those with coverage. Not only has there been a flight of medical scheme members from the public sector, but there has also been a relative shift towards the private sector amongst those without scheme cover.

If utilisation of the private sector by non-medical scheme beneficiaries is examined by income quintile, 20% of the lowest quintile choose the private sector (Table 7.8). This

may be due to poor access to public facilities, or a willingness to pay for perceived higher quality or greater privacy in the private sector.

Table 7.8: Percentage of without coverage who consulted a health worker, who choose the private sector

Income quintile 1995	Percentage of those without medical aid, who consulted a health worker, and chose to go to the private sector
Lowest	20.5
2	25.6
3	26.3
4	31
Highest	46.3

7.4 SUMMARY

Given the magnitude of estimated out of pocket expenditure in South Africa (being the second largest category of financing intermediaries and accounting for nearly a quarter of total private health expenditure – see Section 3), despite the massive underestimation of such expenditure by recent household surveys, it is essential that efforts are made to obtain more accurate routine data on this category of financing intermediaries as a matter of urgency.

Data that are available indicate that medical scheme members incur significant out of pocket expenses, particularly on medical practitioners and prescribed medicines. This highlights the trend towards increasing co-payments and levies on day-to-day medical care and on prescribed medicines, including chronic medicines. If these trends continue, when combined with medical scheme contribution increases that are far outstripping the rate of inflation, it is likely that medical scheme membership will continue to decline (see Section 4), which has implications for the demand for public sector health services. While non-medical scheme members incur considerable expenditure on using private practitioners, their largest single expenditure item appears to relate to the purchase of over the counter medicines for self-treatment. A growing section of the non-medical scheme population is choosing to use private providers for minor acute care, but are likely to remain heavily reliant on the public sector for hospital care. The public-private mix implications of these expenditure trends require further detailed analysis.

8. CONCLUSIONS AND RECOMMENDATIONS

This section draws together some of the key findings of the private NHA research project, considers the policy implications of these findings and assesses whether existing policy on the private sector has achieved the intended results. These conclusions are preceded by a critical review of the quality of data available for this project, which should be borne in mind when reviewing the key findings. It also provides various recommendations, particularly in relation to mechanisms for improving the quality of routine private health sector data for future NHA purposes.

8.1 DATA LIMITATIONS AND GAPS AND RECOMMENDATIONS FOR IMPROVED ROUTINE PRIVATE SECTOR DATA COMPILATION

8.1.1 Overview of data quality

This report provides relatively comprehensive data on health care financing and expenditure in the South African private health sector, in the sense that information is provided on all the key sources, financing intermediaries and providers in this sector. However, total private sector health care expenditure is significantly underestimated in this report due to limitations of certain data, particularly direct household or out of pocket expenditure.

The most comprehensive and accurate data are available for medical schemes. This is largely due to the fact that medical schemes are legally required to submit detailed financing and expenditure information to the Registrar on an annual basis. While there have been some reporting problems in the past, medical scheme reports are now scrutinised and the data cleaned.

In relation to health insurance products, published data are only available for 1999 from the special survey commissioned by the Office of the Registrar of Medical Schemes (see Appendix 2). This survey was relatively comprehensive, but insurance data for the period under review (1996-1998) should be interpreted with some caution as they were estimated using inflation data.

Data for other components of the private health sector should be interpreted with considerable caution. Information on direct expenditure by firms was based on a survey which had a relatively low response rate. Of greater concern are the estimates for out of pocket expenditure. Direct household expenditure for non-medical scheme members had to be drawn entirely from household surveys, which have been shown internationally to underestimate expenditure patterns (as respondents are required to recall health care expenditure for the previous year). In the case of medical scheme members, household survey estimates have been supplemented by data from the Office of the Registrar and the figures are thus considerably more reliable. However, this still represents an underestimate of expenditure as schemes do not have comprehensive records of out of pocket expenditure by members: for example, members are unlikely to submit claims to

their medical schemes for services outside the benefit package or once their benefits have been used up. The internationally accepted method of addressing the underestimation by household surveys is to supplement this information with data on out of pocket expenditure (and/or total expenditure from which expenditure by other financing intermediaries can be deducted) obtained directly from providers. Unfortunately, data were not available from private providers.

Data on private health sector provision are also poor. There is no accurate information on the total number and geographic distribution of different categories of health practitioners working in the private sector. While there are data on the number and distribution of private hospitals and beds, there are no data on utilisation of these services.

It is critically important to improve the quality of routine data on all aspects of the private health sector to inform future policy development and to monitor the impact of policy changes. Recommendations on mechanisms for addressing these gaps are presented in the remainder of section 8.1.

8.1.2 Detailed description of data gaps and recommendations on addressing current data problems

Health care provision

This study was heavily dependent on one source for information on the number and distribution of private hospitals and beds (Engelhardt, 1999). This is problematic, particularly given the voluntary nature of this source. There is no guarantee of continuity, nor indeed any statutory requirement for hospitals to provide this information to the existing source. In addition, it is impossible to obtain disaggregated information on the levels of care available, and the facilities and services provided in the different private facilities. There is also no financial, staffing or utilisation data, which is unsurprising given the competition between the different hospital groups.

Recommendation: The national Department of Health, in consultation with the provincial health departments, should consider developing a statutory return for private hospitals as a requirement for continued licensing. A return should be filled in for each hospital (as opposed to aggregate group information) and should include: geographic location, number of beds (by different categories), number and type of employed staff, number and type of independent practitioners working in the hospital, description and quantities of equipment and various special facilities, utilisation statistics (casualty visits, other ambulatory care visits, inpatient days, etc.) and financial information (total income and/or income from non-medical scheme members). This would need to be developed in consultation with the industry, particularly in relation to the format for provision of sensitive information (such as financial and utilisation data). This issue is likely to be complicated by any moves in the public hospital sector to attract private patients

and, thus, compete with the private hospital sector. However, rational health planning is impossible without more extensive information on this sector.

This research project ran into particular difficulties in accessing accurate information on private practitioners. There were significant variations in data from different sources, which could not be resolved. It is particularly difficult to determine whether the practitioners are currently active in the private sector, the public sector (or both), or engaged in some other profession. Complementary medicine practitioners were an exception to this rule: given the current registration regime and the fact that they operate only in the private sector, there is reliable information on at least five categories of practitioners (chiropractors, herbalists, homeopaths, naturopaths and osteopaths).

There are at least three potential sources of information on private practitioners: the statutory councils (including the Health Professions' Council, Dental Technicians' Council, the Nursing Council, Pharmacy Council, Interim Allied Health Professions' Council and the Interim Co-ordinating Committee for Traditional Medical Practitioners); the professional associations such as SAMA; and the Practice Code Numbering System operated by the Board of Healthcare Funders. None of these sources was able to provide an up to date record of practitioners *currently* operating in the private sector.

Recommendation: The national Department of Health should critically examine the registration system operated by the Health Professions Council and other related councils, particularly in relation to classifying practitioners' current status. It may be possible to link an information requirement to the procedure for Continuing Medical Education necessary to maintain registration. This would require practitioners to update the Council on current status (i.e. whether in clinical practice or not, and whether operating in the public or private sectors, or a combination) and on the geographic location of their practice. Similar registration requirements should be considered for the other Councils. The Council for Medical Schemes should assess the appropriateness and efficiency of the current Practice Code Numbering System and consider whether it is necessary to allocate this function to a different body, or whether a sufficiently improved service can be provided under the current arrangements. It is important to determine the number and geographic distribution of practitioners and it would be very useful to obtain estimates of the number of patients seen by the different categories of practitioners in the private sector (see later section on more accurate estimation of out of pocket expenditure). There is a particular dearth of information on traditional medical practitioners and it could take a number of years for the Interim Co-ordinating Committee for Traditional Medical Practitioners to become fully operational. The national Department of Health should, thus, consider commissioning a separate study to compile accurate baseline information on this sector (including numbers of different types of traditional practitioners and utilisation and expenditure data).

Medical Schemes

Expenditure by medical schemes is the single most significant element in private health care expenditure. The project experienced significant problems in accessing accurate and up to date data on this expenditure. These problems were due largely to backlogs and delays in the old office of the Registrar for Medical Schemes, which were compounded by changes in the reporting format and a level of disruption caused by major legislative changes (the Medical Schemes Act and its accompanying Regulations). There was a backlog of several years in the production of annual reports, which was further delayed when the Council for Medical Schemes identified serious problems with the data and instituted an investigation of these problems and a process of cleaning the data, which was ongoing throughout the NHA project.

An additional problem with the Registrar's data related to information gaps. In particular, there is no information on the distribution of contributions between employers and employees (which is important to determine the sources of funds for NHA purposes). There were also significant gaps in demographic information, with age distribution available for only part of the total membership. There is no information on income, occupation or industry breakdown of membership. Consequently, this had to be drawn from October Household survey results for 1995, a less reliable source. Similarly, provincial distribution was based on part of the membership of a large administrator (Medscheme). Another key gap in the Registrar's database is that of disaggregated information on health service utilisation by medical scheme members.

The income and expenditure data from the Registrar is soundly based, but some problems remain. Some of these relate to problems in the uniform classification of expenditure by schemes, others to insufficient disaggregation of expenditure. As indicated above, there is no information on utilisation of services, which would enable estimates of unit costs. For example, it is possible to calculate the annual increase in global expenditure on medicine, but not what this expenditure represents: more medicine for all members, or simply more expensive medicine, perhaps for a smaller number of members. There is no information on the breakdown of utilisation of, and expenditure on, acute and chronic medicine, or generic and ethical drugs.

Simply expressed, it is impossible to evaluate on the basis of information currently available the spread of benefits across the membership and the costs of different medical services. Without this kind of analysis, it is not possible to establish the health impact of private health care expenditure. A minority of schemes use diagnostic coding or link expenditures by sickness incident or disease. Most schemes operate only with procedure codes: they know what procedures were performed, but not why they were performed or the outcome.

Hospital expenditure is a particular cause for concern. There was a marked reduction on expenditure in provincial hospitals, which went along with major increases in private hospital expenditure. However, it is not possible to state with confidence whether the reduction in expenditure relates directly to a reduction of utilisation of provincial

hospitals, or is due in part to billing inefficiencies. It is also not possible to estimate unbilled utilisation. A comparison of hospital utilisation between and within schemes would be facilitated by utilisation information: though unbilled utilisation of provincial hospitals would not show up in such an analysis, significant differences in utilisation between different groups and schemes, taking into account demographic profiles and benefit levels, would point to possible areas of under-billing.

It is not possible to compare savings and non-savings account schemes accurately with the information currently available. It is not possible to isolate the effects of this design from compounding factors of age, health status and income profiles. In order to assess the impact of savings account benefit designs, it would be necessary to have information on the demographics of such schemes and a breakdown of utilisation of day-to-day benefits. Accurate information on out of pocket expenditure by members in savings account schemes would be helpful, but likely to be difficult to obtain for all expenditure once limits have been reached.

Non-claims expenditure would require greater analysis, particularly expenditure on managed care. In theory, the expense of managed care is justified in two ways: clinically, in terms of ensuring better care, and financially, in minimising waste and ensuring cost-effective care. Neither clinical nor financial outcomes are reported to the regulator at present. The Council for Medical Schemes is required to accredit and supervise three groups, in addition to medical schemes: brokers, administrators and managed care operators. The first group has been accredited, while criteria for accreditation of the others are currently being developed. Given the increasing expenditure on non-health service expenditure, proper reporting by these groups is crucial and mechanisms for oversight will have to be developed.

Reinsurance has been identified by the Council for Medical Schemes as a problematic area, potentially resulting in a significant loss of funds intended for health care expenditure. This issue has been addressed in the short term, but will require regulation and ongoing monitoring.

In general, the Registrar's information is most comprehensive on open and closed registered schemes. While non-reporting schemes have recently come under the ambit of the Medical Schemes Act, historic information on these schemes is less reliable. The fourth group of schemes, the exempted schemes, still fell within the ambit of the Labour Relations Act in the period under review. While the Registrar has information on these schemes, it is by no means comprehensive. The rules, benefit structures and contribution levels of the majority of these schemes are significantly different from those of registered schemes. They currently operate under a *de facto* continuation of their previous exemption, but will be required to develop plans to move towards compliance with the Act in the course of the next few years.

Recommendations: The national Department of Health should liaise with the Registrar's Office and the Council for Medical Schemes, which is engaged in a process of revising the statutory returns required from medical schemes, in order

to ensure that the data needs of the NHA process are accommodated in the new requirements. In addition, the Council has a legislative requirement to advise the Minister on the development of appropriate outcomes measures to apply to medical schemes. This is a complex and challenging task, which will require the involvement of the national Department of Health. The Department should engage with the Registrar's office in setting up an appropriate structure to start this process.

More generally, now that the Council has been established as a parastatal, it is important to develop a formal mechanism for contact between the Department and the Council in order to locate the activities of the Council firmly within the ambit of national health policy. The purpose of this structural contact would be:

- to inform the Council about the development of health policy;
- to facilitate involvement by (or input from) the Council when appropriate on issues relating to the private sector (e.g. the development of public hospital policies and structures to deal with medical scheme patients); and
- to discuss and expedite the publication of additional regulations which may be required from time to time.

It is important that the Council is thoroughly informed about departmental policy, which is the framework for its operation, and *vice versa*, and equally important that the Council's extensive experience of the private sector is properly fed into the appropriate structures in the Department.

The Registrar's Reports do not provide information on employer subsidy for medical schemes, but the Department could potentially access this via the South African Revenue Service (SARS), as employers claim subsidy as a tax deduction. Accurate data on medical scheme contributions by employers would enable the Department both to ensure that companies are complying with the legal limit on tax deductibility and to track the cost to the fiscus of this policy. Tracking developments in subsidy policy is an important element of checking whether the Medical Schemes Act is having undesirable results: for example, if there is an increased trend towards remuneration on a package basis, resulting in medical scheme membership becoming an optional benefit, this could have a marked impact on the demographics of schemes and consequently their cost levels and contributions.

Health Insurance

Expenditure on health insurance products proved to be lower than predicted by earlier studies (e.g. McIntyre *et al.* 1995). This is likely to be partially due to methodological differences between the earlier and the current studies, but could also represent a decline in health insurance business. Health insurers are governed by the Financial Services Board, rather than the Council for Medical Schemes, and the information available on them is consequently not comparable with medical schemes data. Most significantly, the information is only on premium income. Insurance products are for-profit entities, and

there is no requirement to report on the breakdown of expenditure. Consequently, it is impossible to quantify the actual expenditure on health care, let alone the distribution of such expenditure, or the non-health care expenditure (administration fees and costs, brokerage fees paid) or profits. It is also not possible at present to estimate the overlap in membership between medical schemes and health insurance, to establish the breakdown between those who hold health insurance policies as a substitute for medical schemes and those who use them as a top-up for medical schemes (especially for hospital care).

Recommendation: The national Department of Health should engage with the Council for Medical Schemes in the process of reaching a resolution on the issue of demarcation between medical schemes and health insurance.

Non-medical scheme expenditure by firms

Reliable and comprehensive information on expenditure by firms, with the exception of Worker's Compensation, was extremely difficult to access. Given the nature of this information, it may be possible to develop a regular reporting system that would enable the national Department of Health to collect this information on a regular basis.

Recommendation: The national Department of Health should explore the full range of possible mechanisms for accessing information from companies in both the mining and non-mining sectors, in order to establish the simplest and most efficient mechanism. There are a number of potential sources of routine data, such as: the system of workplace clinic permits (administered by the national Department of Health), the Workers' Compensation system and the South African Revenue Service. A condition for the renewal of workplace clinic permits could be the provision of information on the services provided, including expenditure, staffing and utilisation information. Equally, a condition for rebates on Workers' Compensation levies or reduction of the levy rate could be the provision of information not only on accident and disease statistics, but expenditure on and utilisation of workplace services. Clearly, in both cases there would be an incentive to over-state both expenditure and utilisation, but this could potentially be countered by random inspections or requirements for documentary evidence. The SARS could well be the most reliable source for expenditure on services, given that employers claim such expenditures against tax. However, this would need to be supplemented by information on the nature of the services and facilities and on utilisation, which could be obtained from one of the other two sources. The Department could also investigate the possibility of accessing information on workplace facilities from the Department of Labour's inspectorate, which could be requested to collect such information routinely in the course of inspections. The National Centre for Occupational Health should be approached for information on any past, current or planned projects relating to the assessment or costing of workplace services (whether primary health care or strictly 'occupational' in nature). Such information could be fed into the process of mapping and describing services and expenditure.

The national Department of Health should also engage in discussions with the Medical Bureau for Occupational Diseases about mining services. Given the role of the MBOD in overseeing health in the mining industry, it would seem logical that it has a comprehensive database of services. If not, the DOH should start a process ensuring that the MBOD collects the appropriate data on services and facilities, expenditure and utilisation.

Out of Pocket Expenditure

Out of pocket expenditure falls into two broad categories: payments for use of health services by medical scheme members and by non-scheme members. The Income and Expenditure Survey (IES) is the only source for data on non-medical scheme members and has certain inherent problems, particularly related to possible misunderstandings of the questions on health expenditure. Data for medical scheme members was accessed from both the Registrar's Office and the IES, which allowed some cross-checking and indicated potential problems with the IES. Changes in the benefit structures of medical schemes, particularly from the mid 1990s, resulted in a greater proportion of out-of-pocket spending, but also militated against accurate capturing of this information: in schemes with savings accounts, members were unlikely to submit accounts for day-to-day expenses once they had reached their savings account limits. Consequently this data is lost to the Registrar's Reports.

Utilisation data were drawn from the October Household Survey (1995 and 1998), which had certain problems including probable undercounting of the medical scheme population. The apparent fall in utilisation rate between 1995 and 1998 is not explicable with the information available. However, it would be extremely useful to have reliable comparative information on utilisation between the public and private health sectors.

Obtaining expenditure on 'over the counter' (OTC) medicine required considerable negotiation with the company that collects information on such expenditure on a routine basis for commercial use. Ultimately, the data was purchased in aggregate format from this company.

Recommendation: The national Department of Health should critically evaluate the health-related questions in the IES and the OHS, with a view to recommending questionnaire alterations and possible additions to Statistics South Africa. This could improve the accuracy of information gathered through this process and contribute to future NHA estimates. However, the international literature recommends that household survey data on out of pocket expenditure should be supplemented with data from health care providers. The Department could investigate, in collaboration with the Pharmacy Council and/or the appropriate associations in the pharmaceutical industry, the possibility of developing a mechanism for gathering information on volumes (and if possible value) of drug sales in the private sector. Earlier recommendations on accessing

financial data from private hospitals and independent private practitioners would also assist in improving the accuracy of out of pocket expenditure estimates. The Department could also discuss with SARS the possibility of accessing information on the gross income of particular groups of providers: while there is an incentive to underreport cash income, this would provide some additional information on non-medical schemes income, particularly for general practitioners.

8.2 SUMMARY OF KEY FINDINGS AND THEIR POLICY IMPLICATIONS

Despite the limitations of some of the data presented in this report, some clear trends in the private health sector are evident, and certain conclusions and policy-related recommendations can be proposed.

8.2.1 Private health care provision

The available data indicates that there has been a continued growth in overall private sector provision. Private hospital beds have increased by nearly 9% per year since 1994, with a heavy concentration of these beds in Gauteng, KwaZulu-Natal and the Western Cape. Given the lack of accurate data for private health care practitioners, firm conclusions cannot be drawn on the extent of growth in this group. However, there are indications that the number of complementary medicine practitioners has increased rapidly in the 1990s, and that complementary and traditional medical practitioners are an important and substantial category of providers. Private health care practitioners are also concentrated in the urban provinces, with relatively limited access to such providers in the poorer, rural provinces.

There is a need for government to develop a clear and integrated policy in relation to private providers. There have been various initiatives to regulate aspects of private health care provision, but this regulatory framework is fragmented and has not addressed all categories of private health care providers. It would, thus, appear to be a priority to develop a more integrated approach to private provider regulation, which is not onerous to monitor, but is designed to provide incentives for addressing some of the expenditure challenges facing the private health sector.

The moratorium on the development of new, or expansion of existing, private hospitals, and the subsequent 'certificate of need' process, does not appear to have had much impact as the rate of growth in private hospital beds was almost identical in the period after these policy initiatives (i.e. from 1994 onwards) to the period before 1994. This suggests that the effectiveness of private hospital regulation requires detailed review. International literature on regulation shows that attempting to control quantity directly is unlikely to be successful and that it is important to change the incentive framework that encourages the building of new hospitals. In addition, it is essential that accurate data on the numbers and geographic distribution of private health care practitioners be obtained

as a matter of urgency. Such data should be used in combination with information on public sector personnel to develop an integrated policy on human resource distribution. In particular, the recommendations of the Commission of Inquiry into a National Health Insurance System (South Africa 1995), with respect to alternative mechanisms for drawing on private providers to service a larger section of the population, should be revisited. Given the difficulty of employing medical personnel within the public sector in certain rural areas, contractual arrangements with private providers already working in these areas could be considered, such as sessional appointments for a range of private practitioners and contracts with general practitioners for the referral of patients from public sector nurse-based clinics. However, this would need to be accompanied by efforts to improve the capacity of provincial Departments of Health to negotiate and monitor public-private health service contracts to ensure that the goal of improved access to quality health services at an affordable cost to government is achieved (Mills 2000).

8.2.2 Trends in private health sector population coverage and total expenditure

There has been a trend of declining coverage of the population by institutional financing intermediaries between 1996 and 1998. While there has been a slight increase in the number of medical scheme beneficiaries over this period, there has been a substantial decline in the number of mining employees who have access to comprehensive workplace health services. There has also been a decline in coverage in non-mining firms, largely due to declining employment levels in South Africa. However, there is evidence that a sizeable, and possibly growing, section of the population are using private sector services and paying for these services on an out of pocket basis.

Despite this declining overall private sector coverage, private health care expenditure (both in overall terms and within medical schemes) has been increasing very rapidly, at a rate double that of inflation, between 1996 and 1998. This is due primarily to substantial increases in expenditure by medical schemes, but also to increasing out of pocket payments.

Most of this expenditure is funded by households (60% in 1996), with employers contributing the remaining 40% of private health sector funding. Given that out of pocket expenditure is likely to be significantly underestimated (due to deficiencies in the available household survey data), it is likely that households are funding an even greater proportion of private health sector activities in South Africa.

The major portion of households' health care funds do not flow directly to providers, but take the form of contributions to medical schemes. These contributions account for 60% of total household health care expenditure. An even greater proportion (90%) of employers' health care funding takes the form of contributions to medical schemes. Thus, medical schemes are the largest single financing intermediary in the private health sector. Households are the second largest financing intermediary, in terms of their direct payments to health care providers. Firms are the third largest intermediary in terms of

their direct expenditure on workplace health services. Health insurance companies and the Worker's Compensation Fund are the smallest intermediaries.

Given this financing pattern, priorities for government policy should be those of household expenditure issues and the regulation of medical schemes. The regulation of medical schemes is closely associated to household expenditure patterns, in that spiralling costs within medical schemes are resulting in benefit reductions, increases in co-payments and levies, and declining membership which can all translate into increased household expenditure. Direct household expenditure on private providers is also affected by perceptions of declining quality and inaccessibility in public sector services (whether in terms of waiting and opening times, geographic or cultural access). Given the low employment levels and high poverty rate in South Africa, the necessity for households to incur increasing levels of out of pocket expenditure, in order to access health services that are perceived to be of acceptable quality, should also be a policy concern for the government.

8.2.3 Recent trends in medical scheme expenditure and related issues

The data on medical schemes presented in this report form the backdrop to the introduction and implementation of the Medical Schemes Act of 1998. The data reinforce the need for regulation of the medical schemes industry and for the policy framework envisaged in the Act. The Act is designed to expand access to membership: it is clear from the data that growth was static under the previous regulatory regime. The Act enforces community rating and guaranteed access as mechanisms to expand access: the baseline data in this report suggest a membership already ageing before the implementation of the Act. The key issue is whether the provisions are able to stabilise the medical schemes market, so that schemes can retain and attract younger members, while accommodating an increase in the numbers of elderly members and dependants.

Two policy issues could not be addressed in the Act, but have powerful implications for the stability and viability of the medical schemes industry. The issues of whether membership is compulsory or optional within an employment group, and whether employees have a choice of schemes or not, fall within the sphere of industrial relations and are subject to the contractual relationship between employer and employees. The problem is that in a voluntary membership environment community rating is undermined, because the young and/or healthy can choose not to join schemes. This results in an older and sicker membership profile for schemes as a whole, thus raising average cost levels and starting a vicious spiral of declining and ageing membership, further increases and further loss of membership. The problem is exacerbated when members are given a choice of schemes: younger and healthier members will generally opt for schemes (or options) with lower benefit levels and cheaper contributions. Older and sicker members will generally need higher benefit levels and thus be obliged to join schemes with higher contributions. The fact that these are community-rated is insufficient protection as the membership will have too few low risk members to provide an effective cross subsidy to the high risk members.

There is no detailed discussion in this report on public employees, but this report needs to be read in the context also of the impact on government as an employer and on the fiscus of trends in medical scheme contributions and expenditure. The policy of government as an employer needs to be revisited in this context: currently, membership is voluntary and members may choose any scheme, to which government will contribute two thirds of the contribution, with a specified Rand ceiling which increases with the medical price index annually. This policy contributes to churning of membership between schemes and to the undermining of cross-subsidisation as young public employees may move at will to schemes with low pensioner ratios, increasing the difficulty of cross-subsidisation in the schemes they leave.

Developments in medical schemes have a potential impact also on government as a provider. The data reveals a concentration of membership and expenditure in Gauteng, KwaZulu-Natal and the Western Cape, which is unsurprising given that these contain major metropolitan centres, but which has significant implications for public sector planning. Expenditure, and consequently, contributions continued to outstrip inflation at a pace which is cause for concern. Current premium levels and increases are the major reason why coverage is not expanding meaningfully and has serious implications for the sustainability of the system and consequent knock-on effects for the public sector: members who leave the system because it is unaffordable, will increase the burden on the public sector, especially the hospitals. High inflation also leads to benefit restrictions, which in turn lead to more use of public sector, as members reach their limits.

The baseline data in this report suggest that the managed care interventions introduced so far have failed to stem rising costs. This is not unexpected, as the interventions failed to tackle the providers' incentive to 'over-supply', in an environment in which the patient has less information than the provider and is likely to defer to the provider's decision despite higher costs. Contracts between medical schemes and providers that transfer some of the risk (and therefore costs) of over-supply are more likely to be successful to be successful in limiting expenditure. Such contracts can, however, only be developed on the basis of accurate and comprehensive data on membership profiles, utilisation patterns and costs. It is likely to be some time before schemes are able to introduce risk-sharing contracts across the board.

The financial stability of the medical schemes market has a broader economic impact, both on companies, in terms of their subsidies, and on individuals, in terms of their own contributions (which impact on the income available for other household spending). The failure to predict expenditure accurately on an annual basis has led to schemes failing to match contributions and expenditure, resulting in the raiding of reserves in some years, followed by shock contribution increases. The reserve levels of schemes are major cause for concern and the levels specified in the Medical Schemes Act will need to be carefully monitored, with intervention when necessary to ensure they are maintained. Unpredictable increases increase the likelihood of employers choosing to make membership voluntary as part of a total employment package. This development has the potential to further undermine medical schemes, as those most likely to opt to leave

medical schemes are the young and healthy. The loss of their cross-subsidy intensifies the inflationary pressure on the remaining members, leading to a spiral of eroding membership and unsustainable cost increases.

The most significant developments in expenditure in the period were the dramatic increase in private hospital expenditure, which went along with a switch from provincial hospitals, and the growth in non-benefit expenditure. The Council needs to develop an accreditation mechanism for managed care entities as a matter of priority, as well as exploring reporting mechanisms which allow for the assessment of the cost-effectiveness of managed care programmes. The increase in managed care expenditure in the period under review, including hospital and chronic medicine management programmes, appears to have had no impact on hospital expenditure, but may have been one of the factors resulting in a decrease in medicine expenditure in 1997. However, as medicine expenditure increased again in 1998, the ability of such programmes to deliver sustained cost-containment must be questioned. Priorities in the Department's drug policy need to be examined carefully in the light of the developments of the last few years. It is clear that schemes need assistance in reducing their drug costs: if government can implement policies which drive down drug costs in the private sector as well as in the public sector, this will have a direct result on the sustainability and coverage of medical schemes, and a knock-on effect on the public sector, which will be released from the 'dumping' of ex-scheme members or members who run out of benefits.

There is a clear need for the Council for Medical Schemes to develop a system for proactive monitoring to establish whether the Medical Schemes Act is having the desired effects of expansion of coverage, cross-subsidisation, ensuring a minimum level of benefits and preventing 'dumping' on public sector facilities. The first three issues have been dealt with above under data recommendations. However, the issue of public hospitals needs further discussion. Improved billing systems in public hospitals will improve their income, but as this hidden saving disappears, there will be an additional cost to those schemes which currently make use of public services. Improved billing will also serve as an increased incentive for the employed to join schemes to access hospital cover. However, the Department should seriously take note of the dropping utilisation of public hospitals by medical scheme members and consider competing for medical scheme patients. The strategy might be to compete first for high cost, low frequency procedures, or for a particular segment of the medical schemes market (such as low income members, who are currently not reliably covered by medical schemes). In fact, the development of a public hospital package for low income members is at the core of the 1997 Social Health Insurance (SHI) proposals. Even without the introduction of SHI, the development of such a package could substantially increase the coverage of medical schemes by making membership affordable to a lower income group.

There is an urgent need for the Department to clarify the policy and practice of public hospitals in relation to medical schemes. At present, there is significant confusion about access (especially for the Prescribed Minimum Benefits), fee systems and billing. There appear to be differences between provinces and between different levels of hospitals in terms of policy and practice on admission of private patients, in addition to capacity

constraints. Access issues need to be clarified in discussions first between the Department and the provinces, given their role in service delivery, and then with the medical schemes industry.

8.2.4 Health insurance trends

Health insurance constitutes a smaller than expected share of total expenditure. However, it has the potential to undermine the policy objectives of the Department in the Medical Schemes Act, if demarcation between medical schemes and health insurance is not clearly established and maintained in the future. From a policy perspective, it is vital to retain the current tax dispensation (which does not allow a tax benefit for insurance contributions) and the current rules in the Medical Schemes Act (which do not recognise periods of membership of insurance schemes for the purpose of offsetting late joiner penalties).

8.2.5 Non-medical scheme expenditure by firms

Expenditure by firms on workplace health services for their employees, both in terms of the amount of expenditure and as a percentage of total private sector expenditure, has declined between 1996 and 1998. This trend is largely due to declining employment in South Africa, which has adversely impacted on the number of employees covered by on-site health services. Even if employment levels improve, direct expenditure on workplace health services may continue to decline given the relative shift towards open medical schemes. In instances where employees provide both on-site health services and medical scheme cover for their employees, such cover has traditionally been with closed medical schemes. Employers were, thus, able to influence the design of the scheme's benefit package to exclude those services provided on-site. However, as more employers move to open medical scheme cover for their employees, the extent of duplication of service cover between open schemes and on-site services may increase, which could result in the rationalisation or discontinuation of certain workplace health services.

From a policy perspective, it will be important for the public health sector to monitor employment trends closely. If formal sector employment levels continue to decline, fewer people will have access to private workplace health services, however limited these may be in some cases. This will translate into an increased reliance on public health services by the newly unemployed, particularly in relation to hospital care. This highlights the importance of government not only adopting a holistic approach to policy for the public and private health sectors, but also to routinely evaluate the potential impact of broader government policy, such as labour legislation and macro-economic policy developments.

8.2.6 Out of pocket expenditure by households

Unfortunately, an accurate and comprehensive estimate of direct household expenditure could not be determined in this study. The data presented here is likely to be a significant underestimate of out of pocket expenditure. Despite this, direct household expenditure was found to be substantial (accounting for nearly a quarter of all private sector expenditure) and has been increasing over the 1996 to 1998 period. Out of pocket expenditure by non-medical scheme members on private providers accounts for approximately 6% of total private sector expenditure, suggesting a strong desire by non-scheme households to use private sector health services.

The majority of out of pocket payments are attributable to expenditure on medicines. In the case of medical scheme members, the highest category of out of pocket expenditure is that of prescription medicines. This partly relates to increasing co-payments and levies on prescriptions and the separation of chronic and acute medicine benefits. Acute medicines are increasingly being funded out of personal savings account funds, and thus have to compete with other day-to-day health services funded from these accounts. In the case of non-medical scheme members, 'over the counter' medicines account for the largest share of drug expenditure. This reflects the tendency of many non-scheme households to use pharmacists as a first line health care provider, or to self-medicate.

It is interesting that out of pocket expenditure by medical scheme members on medical practitioners is more than double that by non-medical scheme households. This expenditure is in addition to scheme expenditure on practitioners and consequently the gap in utilisation is even greater. The figure comprises co-payments and payments once members reach scheme limits. The phenomenon of members reaching limits has increased in recent years because of cost containment measures: traditional schemes introducing lower limits for specific benefits, especially out of hospital benefits, and new generation schemes assigning day to day benefits to savings accounts. There are also relatively high levels of out of pocket expenditure by medical scheme members on private hospitals. In addition to co-payments, this expenditure would include private ward fees and payments for surgical procedures not covered under medical scheme benefits (e.g. cosmetic surgery).

It is of considerable concern that, despite the increase in medical scheme contributions at a rate more than double that of inflation, benefit packages are shrinking and out of pocket payments by medical scheme members increasing. This trend should be monitored, particularly to assess whether the new Medical Schemes Act will ameliorate this situation. As indicated previously, the implications of increasing out of pocket expenditure by non-scheme members on private health care, due to inaccessibility or perceived poor quality of public sector care, requires detailed evaluation.

8.3 CONCLUSION

This study was constrained by severe obstacles to obtaining accurate and comprehensive data on health care provision, financing and expenditure within the private health sector. At present, there are formal mechanisms for private sector data collection only in relation

to medical schemes. There is an urgent need to establish mechanisms for collating comprehensive private sector data on a routine basis. Given the competitive value of much of these data, these mechanisms need to be negotiated with the relevant financing intermediaries and private provider organisations. Confidentiality of such data must be guaranteed, in the sense that individual providers or financing intermediaries will not be identified in any public reports.

Despite the limitations of the data contained in this report, it is evident that the private sector is substantial and is growing in terms of the number of providers working in this sector and the level of expenditure by private funding sources and financing intermediaries. Recent policy initiatives have been fragmented, in that they attempt to deal with specific providers or financing intermediaries in isolation, and some of these policies appear to have had limited impact. Thus, it is critical to develop a coherent, integrated and comprehensive policy relating to the private health sector. It is only when the inter-relationship between financing intermediaries and providers within the private health sector, as well as the inter-relationship of the public and private health sectors, is recognised and translated into appropriate policy that the overall national health system will function efficiently and equitably to meet the health needs of all South Africans.

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