CHAPTER 5

HEALTH CARE AND FUNDING IN SOUTH AFRICA

Learning Outcomes

When you have completed this chapter you will be able to

- list and briefly describe the role of private providers in the health care environment;
- describe the key issues facing the provision of health care in South Africa today;
- explain the legal controls in place within the health care industry;
- explain the tax aspects applicable to the provision of health care;
- list and describe the health care products available;
- describe the administration of health care schemes in South Africa;
- briefly explain the key financial aspects of health care schemes;
- explain in some detail the concept of managed care;
- list and describe the vehicles used in health care management;
- explain the concept of disease management.

5.1 THE HEALTHCARE ENVIRONMENT

The healthcare environment is a complex one. On the one extreme there is the need for primary healthcare services such as inoculations, assistance in routine childbirth, fundamental hygiene and the treatment of minor ailments. At the other extreme is the possibility of advanced, but very expensive, surgical treatment such as the transplanting of human organs. These are often only available to those who are able to obtain some form of financial assistance, either from the State or from some kind of health insurance.

South Africa, like many other developing countries in times of change, is currently undergoing a transformation in the healthcare sector.

A key issue in this is the balance between state assisted health services and the services provided by the private sector.

5.1.1 MAJOR MEDICAL COVER

Medical inflation for the last few years has been running at between 8-10% per annum, (Stats SA 2010), with the result that South Africa is facing a major health care crisis.

Medical aid societies, which play a vital role in providing medical expenses cover have, to a growing extent, been faced with the options of increasing member contributions, or reducing benefits, or both.

As a result, there is an increasing divergence between the medical expenses they pay, and what practitioners usually charge. Obviously, this can place a severe strain on the finances of those affected, especially where major medical treatments are involved.

This uncovered a pressing need that life insurers strive to fill. Plans have been marketed which provide hospital cash benefits, as well as lump sum payments. These can be used, not only to cover the difference between actual costs and medical aid reimbursements, but also the innumerable other costs resulting from major surgery or prolonged medical treatment. This trend led to the appearance of a multitude of sophisticated health care products. The marketing of major medical policies by life insurers has been stopped by Government. No new policies are now sold, however, existing major medical policies continue to provide their members with benefits, when claims for major surgery or procedures are made.

Major medical, or surgery benefit cover, cannot be related to the actual cost of the treatment, as reimbursement of actual costs remains the exclusive domain of medical aid societies. Therefore, policies either consist of a fixed maximum benefit amount with a listing of specialised operations for which a stated percentage of the maximum benefit will be paid out, for example, 100% for open heart surgery but only 10% for the removal of tonsils, or the cover is expressed in terms of units with a different number of units payable for various procedures. The reason for this approach is to relate the amount of the benefit payment to the likely costs of the treatment, based on a scale of assumed severity.

It is usual for companies to offer this cover on the basis of:

- the life insured only;
- the life insured and spouse; or
- the whole family.

The exclusions are similar to those under the hospital cash plans. With some plans, a stipulated expiry age for the cover, similar to the hospital cash plan, is applicable.

5.1.2 HOSPITAL CASH PLANS

A number of life insurance companies market hospital cash plans. Various versions of the plan are available. Essentially, they all provide payment of a daily amount while the policyholder, any of his dependants, is hospitalised.

Premium rates are calculated according to age at entry, the amount of benefit required and whether the proposer's spouse, or spouse and children are included. Benefits for children are usually restricted to children under the age of 25 and still dependant on the proposer.

There are fixed minimum and maximum daily benefit amounts which can be purchased. Benefits, and the policy, cease at the expiry age selected by the proposer at the commencement of the policy. This is usually linked to the age 65, 70 or 75 next birthday of the proposer.

There are a number of exclusions and exceptions, for example:

- any pre-existing medical conditions will usually not be covered for two years after the commencement date;
- any sexually transmitted diseases;
- normal maternity confinement;
- cosmetic surgery, unless reconstructive, and treatment for obesity;
- hospitalisation caused by the abuse of drugs or alcohol; or
- hospitalisation caused by attempted suicide, self-inflicted injury or certain hazardous activities.

It is usual to quote rates per day of benefits. The benefit is often increased for days spent in intensive care, or if the policyholder is hospitalised whilst overseas. Cover normally only applies where the period of hospitalisation is longer than three days, which eliminates a high percentage of smaller claims. A maximum claim period is also sometimes applied, varying between six months and two years.

With a relatively strict limit on the amount of cover that can be obtained under Hospital Cash Plans due to underwriting considerations and the rapidly rising cost of hospitalisation, these plans are increasingly being seen as providing supplementary coverage to the client rather than full cover.

5.1.3 THE ROLE OF THE GOVERNMENT

The government has pledged itself to the creation of a countrywide state-assisted health provision scheme at the level of primary healthcare, with selected facilities providing more advanced, specialist health services at affordable rates.

The more affluent sector of the population tends to make use of private facilities on a more frequent basis.

5.1.4 PRIVATE PROVIDERS

Private providers play a number of different roles which have an impact on health care.

Drug manufacturers

Many companies operating in the field of the manufacturing of medicines in South Africa are local subsidiaries of international drug manufacturers. Apart from the provision of medicines, they also provide important education and training to pharmacists and other distributors of medicines, such as hospital dispensaries.

Chemists

Chemists, also known as pharmacists, supply medicines to the public, usually on the prescription of medical practitioners such as doctors or specialists. They are also able to offer certain medicines over the counter, without a prescription, and may even provide basic medical advice for simple, non-threatening ailments such as colds, coughs and itches.

Doctors

Many doctors in South Africa work as private practitioners, either as general practitioners (GP's) or dentists, who do basic diagnostic steps and provide treatments, or as specialists in one or more fields, such as eye specialists, gynaecologists, cardiologists and radiologists.

Private clinics

There are a variety of private clinics or hospitals in South Africa, mostly owned by large groups. They make use of a combination of their own support medical staff and private practitioners, who use their facilities to treat patients.

Medical aids

Medical aid companies are registered in accordance with the Medical Schemes Act. They are benefit funds, in that they take in monthly contributions from members and reimburse medical expenses according to set scales of benefits.

Medical Assist

There are several companies providing an emergency treatment and transportation service, using fleets of cars, small motorboats, helicopters and small aircraft to take trained paramedics to the site of an emergency, and to transfer the patient to the appropriate medical care centre. Access to such a service is often a part of some schemes.

5.1.5 KEY ISSUES

Several major issues are a source of constant debate within the healthcare environment.

The changing level of state health provision

Whilst it may seem advantageous to ensure that the State is able to provide adequate healthcare facilities for all, it must be remembered that this can only be funded out of taxation revenue and often is not the most efficient delivery system.

The uneven distribution of health service usage

It is a fact that most of the individual's healthcare expenditure will occur after the age of retirement. In fact, the amount spent on medical care up to age 65 is often only 20% of the total that will be spent by the average individual.

This places a tremendous strain on the financial resources of retired people, already often under pressure from post-retirement inflation which outstrips pension adjustments.

Another factor is the uneven distribution of medical expenses between the averagely healthy individual, and the person who is born with some form of costly health impairment or is involved in a serious accident that results in extensive medical requirements.

As a rule, the 80/20 principle applies - 80% of the medical expenses will generally be incurred by 20% of the population.

Cross-subsidisation

It should be accepted that any medical aid or medical insurance scheme must, by definition, allow a certain degree of cross-subsidisation from the healthy to the ill, otherwise individuals would simply take care of their medical costs through private savings accounts.

Under medical aid schemes it is normal for the younger members to subsidise the older members. Similarly, it is generally accepted that separate rates for males and females to reflect the different healthcare service usage by the sexes is not necessary. Smokers also do not pay more than non-smokers, and little attempt is made to rate according to other habit or occupational classes.

Cross-subsidisation also frequently occurs between those with large dependant families and single members. New generation health insurers are increasingly tending to apply differential rates to eliminate some of the cross-subsidisation.

Increasingly, funds are finding that the rate of growth of new members is not keeping pace, through a combination of the trend to lower population growth rates and through the younger, healthier members opting not to join a medical scheme. This is placing a severe strain on the funding process, which is made worse by the fact that people are tending to live longer than before and, hence, there are more older members.

Insurance principles versus primary care

It is a standard principle of insurance that the correct risks to insure are those which arise relatively infrequently, frequently enough to derive a reasonable costing basis for the insurance cover, and which result in high costs. Frequent occurrences, which do not result in undue financial hardship at the time of their happening, are best borne by the individual out of savings or cash flow.

Some health insurance schemes, which operate according to insurance principles as a whole, advance the argument that this should mean that the individual is responsible for the day-to-day costs of GP consultations, and pharmacy prescriptions, either out of a special medical savings scheme or out of pocket. Chronic illness and surgery, on the other hand, should be the domain of the insurer.

Out of pocket expenses on health by South African consumers rose from around R1 billion in 1993 to over R37,5 billion in 2010.

Medical aids work on a different basis, assuming that all medical expenses should be covered, since they are involuntary on the part of the individual.

Fraud and abuse

It is known that the South African healthcare system is prone to fraud and abuse. In some cases doctors, or other suppliers, take advantage of the uninformed nature of their patients to over-prescribe treatment, or even to simply charge for services not rendered.

Patients are known to have been in cahoots with providers to create medical bills for fictitious services, with the medical aid payment being split between the parties.

Similarly, abuse takes place when patients seek the services of a doctor for a simple ailment, rather than consulting a pharmacy direct, because un-prescribed medication would be for their own account.

The employer's liability

Much as employers have assumed an obligation towards pensioners in the provision of a pension, it is clear that the rising costs of medical care, and the usage made of these services by pensioners, is increasingly becoming a similar issue. Where precedents have been set, it is fair to assume that pensioners will claim that they have an expectation of continued benefits.

Liabilities to the employer then consist of whatever portion of the contributions is carried by them, plus the cost implications of the impact of the claims that may be submitted and the resultant possibility of general contribution increases.

Possible treatment of this liability can be handled through:

- increasing pensions;
- the withdrawal of the subsidy;
- reducing scheme benefits;

- funding for the benefits;
- paying a lump sum on retirement to settle the liability;
- offering a defined Rand benefit; or
- agreeing on a defined contribution level only.

5.2 THE LEGAL CONTROLS ON THE HEALTHCARE ENVIRONMENT

5.2.1 LEGISLATIVE OUTLINE

Most healthcare schemes are registered under the Medical Schemes Act. However, it is also common for some of the business to be held by registered life insurers, where compliance with the Long Term Insurance Act and the Companies Act is required in the usual way.

There is considerable debate taking place on the ongoing nature of medical services. In particular, the Minister of Health is seeking to implement some form of centralised medical scheme funded through a form of compulsory membership, which would be similar to an extra health taxation.

In addition, there is a growing trend towards legislation setting out only the broad parameters under which the various players will operate, with Regulations issued by the Minister being relied on for more of the day to day controls.

Other legislation which has a direct bearing on the business, includes the:

- Occupational Health and Safety Act;
- Labour Relations Act;
- Basic Conditions of Employment Act; and
- Compensation for Occupational Injuries and Diseases Act (COID).

These controls mainly came into force in 1994 after the Melamet Commission of Enquiry, which recommended considerable deregulation of the industry. It had previously been allowed to work through medical aid schemes only, and had worked strictly on the statutory scale of benefits (RAMS) with guaranteed, direct payment of accounts. Changes resulted in only laid down minimum and maximum benefits, and resulted in far more innovation, including the birth of the new generation schemes.

5.2.2 THE MEDICAL SCHEMES ACT 1998

The activities of registered medical schemes are largely governed by this Act through the Council for Medical Schemes.

The Act defines a medical scheme as a scheme established with the object of making provision for the:

- obtaining of any service by members thereof and by dependants of such members;
- granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
- rendering of a service to members thereof or to dependants, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme.

The scope of the services to be provided by a medical scheme is also defined in the Act and includes:

- physical or medical examination;
- diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- giving of advice in relation to the treatment of a health condition;
- prescription of any medicine, appliance or apparatus related to a health condition; and
- nursing or midwifery.

Services also include ambulance services and accommodation in a hospital or nursing home as necessitated by the person's medical condition.

Key areas covered by the Act, apart from the financial reporting include:

- requirements for the rules concerning the management of the scheme, such as:
  - the basis of the calculation of the membership fee;
  - details of how benefits will be handled for retired members and the dependants of deceased members;
  - powers of the officers of the scheme;
- 20% of encumbered assets must be held in interest bearing investments, and some rulings on the use of funds, for example medical schemes may operate their own hospitals or pharmacies, may seek insurance cover for their liabilities, and so on;
- details of the powers of the Registrar and the requirements for a Board of Trustees to be set up for each scheme.

Note that medical or hospital insurance plans carry the normal commission according to short term or long term insurance legislation, whilst other scheme providers tend to pay intermediaries through a component of the scheme held as insurance or the provident fund portion.

Many of the requirements of the Act are included in the regulations of the Act such as:

- minimum and maximum benefits;
- the administration fee that may be charged by a scheme;
- commission due to intermediaries who introduce members to a scheme; and
- the minimum number of members that will constitute a new medical scheme.

The Act stipulates that the Minister must allow interested parties a 90 day period wherein any comments may be submitted to any proposed regulations. It is only where the medical schemes industry will be detrimentally affected by the delay that the Minister is allowed to issue an immediate regulation.

Prescribed Minimum Benefits Package

The Medical Schemes Act provides for minimum benefits which each fund must provide, from the date of commencement of the Regulations. It also provides for the prescribed minimum benefits (PMBs) package that medical schemes must offer in terms of the Act. These, as well as a list of 270 diagnostic, treatment and care procedures, are contained in an annexure to the Regulations

The objective of specifying a set of prescribed minimum benefits within the regulations is two-fold:

- to avoid incidents where individuals lose their medical scheme cover in the event of serious illness, and the consequent risk of unfunded utilisation of public hospitals; and
- to encourage improved efficiency in the allocation of private and public health care resources.

The Department of Health recognises that there is constant change in medical practice and available medical technology. Consequently, the Department monitors the impact, effectiveness and appropriateness of the prescribed minimum benefits provisions.

A review is conducted at least every two years by the Department that involves the Council for Medical Schemes, stakeholders, provincial health departments and consumer representatives. In addition, the review focuses specifically on development of protocols for the medical management of HIV/AIDS.

These reviews provide recommendations for the revision of the regulations and the list of prescribed minimum benefits on the basis of:

- inconsistencies or flaws in the current regulations;
- the cost-effectiveness of health technologies or interventions;
- consistency with developments in health policy; and
- the impact on medical scheme viability and its affordability to members.

Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in the annexure in at least one provider or provider network, which must at all times include the public hospital system.

Prescribed treatment for a specified list of chronic conditions is covered under the prescribed minimum benefits package.

5.2.3 FINANCIAL REPORTING

Section 35 of the Medical Schemes Act of 1998 clearly outlines the requirements for the financial reporting of registered schemes.

The financial statements must be prepared annually, and within 6 months of the end of the tax year of the fund and submitted to the Registrar. Copies must also be made available to members.

The required financial statements include:

- a balance sheet;
- an income statement;
- a cash flow statement;
- a report from the auditor; and
- various other returns as may be required by the Registrar.

Additional information that must be provided to the Registrar includes:

- details of the members and their dependants;
- the number of registered members and their dependants for each month of the year;
- an analysis of the benefits paid during the year under the main provider categories;
- an analysis of the other benefit types paid out;
- an analysis of specialist services;
- an analysis of administrative expenses;
- bad debts written off and the provision made for future bad debts;
- an analysis of the investments held by the fund; and
- a schedule of debtors.

According to the guidelines issued by the South African Institute of Chartered Accountants, the statements should fairly represent the business of the scheme and should contain an explanation of all material information.

5.2.4 TAXATION ASPECTS

The current taxation approach to medical services in South Africa is somewhat disjointed with the use of a benefit fund for medical benefits having been prevalent where the fund was in fact not a medical aid registered in terms of the Medical Schemes Act.

Such a fund is described in paragraph "c" of the definition of a benefit fund in the preliminary part of the 1st Schedule of the Income tax Act as:

> "*any fund (other than a pension fund, provident fund or retirement annuity fund) which, in respect of the year of assessment in question, the Commissioner is satisfied is a permanent fund bona fide established for the purpose of providing sickness, accident or unemployment benefits for its members, or mainly for this purpose and also for the purpose of providing benefits for the dependants or nominees of deceased members."*

Recent legislative changes have in fact stopped the registration of new schemes under paragraph "c" of the definition of benefit funds in the Income Tax Act.

In order to clarify the situation as it currently exists, we will therefore look at the taxation approach applied to the employer and employee separately.

Employer expenses

Expenditure by an employer on medical services for an employee in terms of a registered medical aid scheme, ranks as a deduction in terms of Section 11(l) of the Income Tax Act. This section allows as a deduction against the income of an employer:

> "*any sum contributed by an employer for the benefit of his employees to a pension, provident or benefit fund."*

The amount paid by the employer, and permitted as a deduction is based on a percentage of the approved remuneration of the employee in question. The Commissioner is required to approve any deduction of an amount that is equal to, or less than, 10% of the approved remuneration of the employee.

The Commissioner does, however, have the discretion to approve deductions that are in fact greater that 10%. It is now common for a deduction of up to 20% to be considered normal. Where the Commissioner can be convinced that a greater level of deduction is justified, he has used this discretion to allow deductions of as high as 25% to 30% of the total cost to the employer of the equivalent of employee's remuneration.

Properly structured and registered medical schemes fell into the category of **benefit funds** and contributions to a medical aid or a medical scheme specifically set up and registered as a medical aid in accordance with the Medical Schemes Act, were (and still are) tax deductible.

With the changes brought about the employer is not able to register a benefit fund for the provision of medical benefits, other than a medical aid scheme, to its employees. This does, however, not have a direct impact on the tax position of the employer. As the employer can argue that the expense of providing medical benefits is an expense incurred in the production of income, the deduction will be allowed in accordance with Section 11(a) of the Income Tax Act which is the general deduction formula.

Employee expenses

In accordance with Section 18 of the Income Tax Act:

1. *Any taxpayer, who is a natural person, is allowed to deduct from his income expenses of a medical nature.*

The tax treatment of medical scheme contributions and other medical expenses

The National Treasury and the South Africa Revenue Service (SARS), in consultation with the Department of Health, undertook a review of the tax treatment of medical expenses, and the tax treatment of medical scheme contributions and other medical expenses was changed with effect from 1 March 2006.

Below is a summary of the tax dispensation of contributions to medical schemes and other medical expenses.

1. Taxpayers 65 years and older and retired individuals

It is important to note that taxpayers older than 65 years continue to be able to deduct all medical scheme contributions and other medical expenses from their taxable income. Also, individuals who took early retirement, but still enjoy medical scheme coverage paid for by their former employers, will continue to enjoy this as a tax-free benefit.

2. Taxpayers 65 years or younger

Three types of medical expenses qualify for preferential tax treatment:

(a) Contributions to medical schemes

Members of a medical scheme can make contributions to the medical scheme themselves, their employers can make the contributions or contributions can be split between an employee and the employer.

In terms of the new legislation, all (i.e. 100% of) contributions will qualify for preferential tax treatment, irrespective of who makes the contribution. This preferential tax treatment is, in the 2010/2011 tax year limited to a monetary amount of R670 for each of the first two beneficiaries and R410 for each additional beneficiary. (The "$^2/_3$ rule" has fallen away.)These monetary caps are increased every year. (In 2011/2012 this has increased to R720 for each of the first two beneficiaries and R440 for each additional beneficiary.)

Example 1 (using 2010/2011 monthly monetary caps)

Mary is employed and her employer pays $^2/_3$'s of her total medical scheme contributions. She is married and does not have any children. The total medical scheme contribution for her and her husband amounts to R2 100 per month. Therefore her employer contributes R1 400 and she pays R700 from her after-tax salary. Currently, she will have to pay tax on R60 of the employer's contribution, as the legislation states that only R1 340 of her medical scheme contributions, R670 each for her and her husband will qualify as being tax exempt.

Example 2 (using 2010/2011 monthly monetary caps)

Dumisa is self-employed, married and has four children. He is a member of a medical scheme and his family of six is covered by this scheme. His total medical scheme contribution amounts to R2 300 per month or R27 600 per year:

- R800 for him;
- R600 for his wife; and
- R300 for his first three children;
- the fourth child is covered but no contribution is payable.

In terms of the current legislation, Dumisa will be able to deduct R2 980 (R670 × 2 + R410 × 4) from his monthly income, or R35 760 per annum, for income tax purposes.

(b) Medical expenses paid by individuals (including medical scheme contribution paid by the individual)

Medical expenses paid for by the taxpayer in excess of 7,5 percent of his income, are tax-deductible. This threshold excludes medical scheme contributions which qualify as a tax deduction under subsection (a). Where a taxpayer has a disability, or has a dependant with a disability, all medical expenses of the family unit will also be tax deductible.

Example 3

Vusi is single and his employer pays $^2/_3$ of his medical scheme contributions. His total monthly medical scheme contribution is R750 of which his employer pays R500. Vusi's contribution towards his medical scheme is therefore R250. In addition he incurred other out of pocket medical expenses (due to an unforeseen injury) of R2 000. These expenses were not covered by the medical scheme. The cost of his medical expenses for the year was therefore R5 000. In terms of the legislation the employer contribution to his medical scheme coverage will remain tax-free.

He will also be allowed to deduct medical expenses exceeding 7,5 percent of his income. His salary is R50 000 per annum and he is therefore allowed to deduct all medical expenses in excess of R3 750.

The cost of his actual medical expenses is R5 000 and he may therefore claim R1 250 (R5 000 less R3 750) as a tax deduction for this particular tax year.

(c) Employer provided medical treatment

Currently, no taxable benefit will arise for the employee where the employer provides medical treatment to employees at their place of work. Such medical treatment is normally covered under a company's occupational health initiative. However, should the medical treatment be provided to employees' families, employees would be liable to pay tax on the value of this benefit. Where the employer pays for medical treatment for the employee and/or his family and this treatment is provided at a place other than the employee's workplace, the employee will have to pay tax on the value of this benefit.

In terms of the tax dispensation, all benefits derived from employer provided medical treatment (on- and off-site) will be tax-free in the hands of the employee, provided certain criteria are met. Only Prescribed Minimum Benefits may be provided tax-free at an off-site location. In cases where the off-site employer provided medical treatment constitutes the business of a medical scheme it must be granted exemption from complying with the requirements of a medical scheme by the Registrar of Medical Schemes in order to qualify for tax-free treatment. Where the off-site medical treatment does not constitute the business of a medical scheme it may be provided tax-free if it is only provided to employees, or their immediate dependants, who are not members of a medical scheme.

Example 4

John is not a member of a medical scheme and he and his wife are HIV positive. His employer funds a confidential off-site HIV / AIDS programme for its employees and their immediate families at a monthly cost of R500 per person treated. John and his wife participate in this employer programme and receive free medical treatment. Currently John is liable to pay income tax on the monthly fringe benefit of R1 000 and the confidentiality of the programme is jeopardised due to this tax charge. In terms of the amended income tax legislation John will receive this benefit tax-free provided the abovementioned criteria is met.

3. Who qualifies as a dependant

The Income Tax Act was amended to include a definition of dependant for purpose of medical scheme contributions. This definition is in line with the definition of dependant in the Medical Schemes Act and recognises the fact that an individual may want to extend coverage to persons other than his immediate family. Medical scheme contributions made by the taxpayer to cover his parents or other persons in his care will qualify for preferential tax treatment.

However, in the case of out of pocket medical expenses only expenses incurred in respect of immediate family members, for example, spouses and children will qualify for preferential tax treatment. This more restrictive definition also applies to employer provided treatment and is aimed at limiting abuse and to favour wider medical scheme coverage.

Tax on funds

Growth on funds held by a medical aid scheme or a benefit fund other than a provident fund are not taxed.

The interest on a medical savings account is currently not taxed, although mention has been made of a possible change to this in the future.

The tax on growth in a pre-funding instrument using a provident fund is the same as for any provident fund - currently 0%.

5.2.5 THE INSPECTION OF FINANCIAL INSTITUTIONS ACT AND THE FSB

The Registrar of Medical Schemes has all the power and duties conferred or imposed in terms of the Inspection of Financial Institutions Act of 1962. Included in these powers are the right to lodge applications to court for the cancellation and suspension or dissolution of funds.

The Registrar may cancel the registration of a fund:

(a) if he is satisfied that the fund has ceased to exist; or

(b) if he has agreed that the fund was registered by mistake.

The Registrar may apply to court for the cancellation or suspension of the registration of a fund if:

(a) the fund has wilfully violated any provision of the Medical Schemes Act; or

(b) after investigation, he is of the opinion that cancellation or suspension is necessary.

The Registrar may also apply to court for the winding up of a fund if he is of the opinion that there is no satisfactory solution to a fund in an unsound financial condition.

5.3 HEALTHCARE PRODUCTS

5.3.1 TRADITIONAL MEDICAL AIDS

The contributions paid in by members usually vary according to their salary band, and size of the family covered. They are adjusted over time, to take into account the actual claims experience of the members.

Before 2004 there were two tariffs. One was used by the medical aid companies, and was negotiated by the Board of Health Care Funders. The other was negotiated by the South African Medical Association (SAMA), and used by doctors. In 2004, the Competition Commission outlawed the setting up of tariffs. From then on, medical aids and providers such as doctors and hospitals set their own tariffs.

Until August 2010, the National Health Reference Price List (NHRPL) was used as a cost guideline for health care providers such as doctors and hospitals, and the funders which are medical aid schemes.

As a result of a court case, the guidelines set by the NHRPL were set aside, and a freemarket scenario emerged where health care providers charge what they feel is appropriate, and health care funders pay what they feel is appropriate. It is hoped that a more definitive pricing system will be reinforced to bring uniformity to the health care industry

It is common practice for schemes to offer members a choice of cover, varying from a low cover plan, where relatively strict limits are imposed in return for a lower membership fee, to a fully comprehensive plan at a far higher contribution level.

5.3.2 HEALTH INSURANCE PLANS

Typical plans include the following:

- a hospital plan, which pays out a fixed amount for every day or night spent in a hospital, often with double benefits if intensive care is required;
- major medical cover, which pays out cash sums for various types of major surgery undergone, with the amount varying according to the perceived complexity, and hence cost, of the treatment.

5.3.3 MEDICAL AID WITH SAVINGS

Generally these schemes offer cover for the more serious medical costs on an insured basis. Low cost / high frequency costs such as general pharmacy expenses are either left to the member to pay on their own account or covered out of a type of savings account under which a regular monthly contribution from the member is invested in a medical savings account.

5.3.4 MANAGED HEALTH CARE SYSTEMS

Managed health care operators try to manage the cost side of the equation through a variety of different efforts, while Preferred Provider Organisations (PPO's) seek to do the same thing by selecting only certain providers in the various categories (hospitals, GP's, opticians) and striking price deals with them in return for the volume of patients referred. In extreme cases this even extends to the PPO owning the facilities, such as the hospital, and employing the providers on a salary basis.

5.3.5 PROFESSIONAL PROVIDENT SOCIETY

The Professional Provident Society (PPS) is an autonomous society founded by professional people to satisfy the security needs of their fellow members within the professions. The PPS is registered in terms of the Pension Funds Act as a pension fund and is wholly owned by its members. The society is managed by a council elected by its members with several professional societies also represented.

The PPS offers the following to all those that qualify:

- sickness, disability and accident cover, whether of a temporary or permanent nature;
- a savings element in the form of a tax-free lump sum benefit at retirement, death or prior termination of membership;
- group life insurance - protection of dependants at death before retirement with lump sum disability benefits as a rider benefit;
- hospital benefits - (a double sickness benefit) during the hospitalisation of the member;
- pension provisions - the PPS Retirement Annuity Fund; and
- a medical aid scheme - (Profmed).

Note that in 2004 the PPS launched a full service life insurance company to market additional services into its existing customer base and as a way of broadening its membership.

Membership

A person, whose application for membership is successful, becomes a member of the PPS and buys shares in the society. The value of the shares purchases is linked to the benefits paid out to a member in the event of death, disability, retirement or termination of membership.

An applicant does not qualify for membership of the PPS by virtue of his membership of an approved professional society only. He must hold a recognised professional qualification and also be a practising member of his profession or must utilise his qualification in the occupation he is practising at the time of application and during his membership. It also includes salaried persons - not only the self-employed, for example - an attorney who works as a legal representative at a firm.

5.3.6 DEMARCATION OF HEALTH INSURANCE AND MEDICAL SCHEMES

The area of the demarcation of medical schemes and health insurance needs to be carefully managed, as there is a fair amount of confusion about it in the market.

The matter has hardly been resolved satisfactorily, although the Council for Medical Schemes and the Financial Services Board were eventually able to agree on an "Agreement on the demarcation between the business of a medical scheme and health insurance". The agreement was issued as a joint press statement on 7 September 2000.

Agreement on the demarcation between the business of a medical scheme and health insurance

The Council for Medical Schemes and the Financial Services Board (FSB) are in agreement on the demarcation between the business of a medical scheme and health insurance.

Both the Council and the FSB recognize that a key feature of the business of a medical scheme is the fact that it indemnifies individuals against health care expenses.

Health insurance is voluntary cover paid from after-tax income to protect individuals against unforeseen health events. Medical scheme business is voluntary cover partly paid out of before-tax income, which aims to indemnify people against the actual expenses incurred in respect of a relevant health service - as defined in the Medical Schemes Act.

The Medical Schemes Act governs medical schemes business and health insurance business is governed by the Long and Short Term Insurance Acts.

Health insurance is based on a health event, which should only be triggered by the diagnosis of a health condition. The amount of the benefit payable on health insurance must not be retrospectively determined, but must be determinable at the occurrence of the event. The benefits payable by a health policy must therefore not relate directly to the cost of treatment of the event or the condition.

In any instance where the business involves the undertaking of a liability to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service, then that business constitutes medical scheme business. This includes situations where a fixed sum per day is paid for a hospital stay, or where benefits are determined with reference to medical procedures or services.

The Council and FSB emphasise that at any time where policy benefits take the form of hospitalisation and/or the payment of medical costs, that business will be regarded as medical scheme business.

Health insurers may not offer cessions to service providers. Benefits must be paid to the policyholder and may not be paid by health insurers to service providers in return for services rendered.

Health insurance may not be sold on a conditional basis to members of a medical scheme. No reference to a medical scheme can be made in the marketing or sale of health insurance products.

Both parties have committed themselves to properly monitor the environment to ensure that no products are created that will infringe on the agreed demarcation.

In this regard the Registrar of Medical Schemes and the Registrar of Insurance have agreed to develop a memorandum of understanding that will guide effective implementation of the agreed demarcation. A joint working group will be formed for this purpose.

The Registrars have furthermore, agreed on a set of guidelines that interested parties can take into account to ensure compliance with the legislation (see annexure 1).

Both the Council and the FSB are committed to ensuring that all attempts should be made to ensure that the legitimate rights of policyholders are secured.
In this regard, the two registrars will, during the next few weeks explore a phased approach together with interested parties to ensure that relevant policyholders are dealt with in an appropriate manner.

In something of a landmark ruling, a court ruled that short term insurance cover schemes aimed at topping up medical aid schemes by providing cover for the gap between the tariff amounts charged according to the National Health Reference Price List (NHRPL) and the actual amount charged, are not acceptable as insurance policies, and such cover would have to be the domain of medical aids. However, this decision was subsequently overturned on appeal. It is understood that the authorities are now relooking at the legislation in order to again seek to address the issue and gain better control over benefits offered, as they believe that insurers providing underwritten benefits are basically "cherry-picking" the better lives, leaving medical aids to pick up the more sickly members.

(Refer also to the ASISA's Code on Demarcation.)

5.4 ADMINISTRATION OF HEALTH SCHEMES

5.4.1 UNDERWRITING ISSUES

The underwriting of health cover is made somewhat more complex by the fact that in most cases, cover is being granted on the basis of a family unit, which may even include the immediate extended family of a member who are dependant on him, such as his grandparents, rather than an individual life. Although the Medical Schemes Act does not allow schemes to exclude new members entirely, it is common practice to require information about the state of health of a new member.

Dependent on the information provided it is not uncommon for existing ailments to be excluded from a scheme's benefits. These exclusions are generally implemented even though rates are normally adjusted on an annual basis in order to fairly reflect the claims experience of the members.

In the same way as a group life scheme, medical aid administrators will view compulsory membership groups under relatively large schemes differently to individual - voluntary - applications.

Medical aid administrators generally also offer a free cover facility to compulsory membership groups, varying in approach according to the size of the group.

Where a new member is seeking cover for the first time schemes will often impose a three-month waiting period during which subscriptions are payable but benefits cannot be enjoyed. This is a way of limiting anti-selection by people who have already become aware of a medical condition before seeking cover. Transferring members who are seeking to move from one compulsory scheme to another compulsory scheme when changing jobs must be accepted immediately where they have been a member, or a dependant member, of another registered scheme for a continuous period of two years.

Another time when a form of underwriting is used by medical aids is where an existing member is seeking to upgrade the nature of the cover enjoyed from one with relatively low benefits to one with fuller cover. Usually this is only allowed on the anniversary of the scheme, while some schemes allow only one upgrade during the member's entire period of membership. Medical insurance plans naturally use standard underwriting procedures, whereas new generation health insurers tend to use a kind of simplified underwriting approach.

It is common to place a nine month exclusion on pregnancy and maturity benefits, and even a 12 month exclusion on special dentistry.

Underwriting seeks to achieve the following:

- a reduction in the variability of experience, thereby reducing the risk factor and allowing lower overall charges;
- a better alignment of the premium with the risk;
- a reduction or elimination, of the anti-selection factor; and
- protection of the risk pool of the members.

The main concerns linked to underwriting of this approach are that:

- they could lead to certain people not being able to obtain health insurance, often the people who need it most;
- even where cover is available, the process tends to group people of similar risk profile so that eventually the good risks all drift into a low-priced scheme and the remaining bad risks have no cross-subsidisation benefits and may not be able to afford the benefits.

5.4.2 ADMINISTRATION OF MEDICAL AIDS

Medical aid administration is a critical aspect of the service provided.

Functions performed include:

- handling of queries;
- receipt of claims from, either the service providers, or the member for reimbursement;
- checking for valid membership of the individuals to whom the service is to be provided;

- checking on the reasonableness of the services claimed and the relevant service cost codes which define the rates allowed for the various services;
- checking on ceilings for similar claims;
- processing and paying the claim; and
- preparing statistics and records for the monthly statements sent to members.

5.4.3 ADMINISTRATION OF HEALTH INSURANCE PLANS

The administration of health insurance plans is much the same as that for medical aids, although with health insurance plans the policy wording will play a greater role. It is also possible that the administrators will need to handle any reinsurance claims where the benefits exceed the limits that the insurance company can afford, or is prepared, to carry.

5.5 FINANCIAL ASPECTS OF HEALTHCARE SCHEMES

5.5.1 COSTING PRINCIPLES

The costing principles of a traditional medical aid scheme are somewhat different to those of an insurance scheme.

Medical aids

Medical aids tend to work on simplified group rating scales. A typical structure is shown below but it must be clearly understood that the prices quoted are purely an example and have no bearing on real costs to members:

Member	Principal member's monthly income				
	1000-2000	2001-3000	3001-4000	4001-5000	5001+
member	400	650	900	1 050	1 200
m+1	420	670	920	1 070	1 220
m+2	440	690	940	1 090	1 240
m+3	460	710	960	1 110	1 260
m+4 (or more)	490	740	990	1 140	1 290

Most schemes offer members a choice of three or four different types of scheme, each with a higher level of benefits, thereby duplicating the scale several times.

Insured schemes

Under the more insurance orientated schemes, there is more of an attempt to assess the individual experience and to cost for this.

Insurance plans taken through a life company tend to have guaranteed rates which vary with the age at commencement of the principal member but are then level for the full period of cover, usually to age 60 or 65. Individual claims experience cannot change this.

However, it should be noted that these plans offer a fixed benefit level, so that over time the insured may expose himself to a share of the costs as medical services charges rise. Recent developments in policy design, now allow the insurer to review the premium rates for the group as a whole, based on long term claim payouts.

Cover arranged through a short term insurer would have a similar initial rate structure but individual claims records are checked on an annual basis. This may result in higher rates being offered on renewal, or even in the cover being terminated.

Schemes marketed through life insurers generally offer fixed rates for the term of the cover, but reserve the right to adjust the actual charge on an annual basis to take into account medical inflation experienced.

The fixing of the employer's contribution

It is usual for employers to subsidise a part of the medical scheme costs, generally on a 50/50 basis. The issue of whether the different categories of employee are enjoying different levels of subsidisation from the employer, is a complex one. One way of solving this is through an overall package approach to remuneration which takes into account the employer's actual contributions. Insurance providers claim that by pricing more closely to the individual risk they are eliminating much of this problem in their product design.

5.5.2 HANDLING CROSS-SUBSIDISATION

There are four main components of the move to reduce cross-subsidisation. They are:

- using underwriting to equate the premium and the risk more closely;
- adopting a structure which allows for class groupings - by age, sex, occupation;
- making use of medical savings accounts or similar devices to curtail the overall fund's share of some risks; and
- allowing a drift of good lives into low-priced schemes and others into schemes priced according to risk profile.

Whilst these may well help to stop the young and healthy lives from opting out of health insurance schemes, they also have an adverse impact on the sickly and the aged. New generation schemes are also making considerable inroads into the elimination of cross-subsidisation.

5.5.3 PRE-FUNDING

The rapid escalation of healthcare costs, **after** normal retirement due to the increased usage as well as the medical cost inflation rate, has resulted in several attempts at creating funding mechanisms to cover these costs through contributions made during the working years.

Whilst it could be said that this is only a small part of the greater retirement planning issue, it is also clear that the reality is that it needs specific attention.

One of the more innovative approaches being used, is to link medical service usage during one's working years to contributions made to healthcare insurance plans, allowing individuals to build up a kind of credit account to be drawn on after retirement.

Other attempts include specific pre-retirement funding by means of set contributions, usually into a provident fund, because of the long term security, as well as the tax efficiency that these schemes offer.

A major concern in these efforts is often the direct link which is often observed between pre- and post-retirement medical costs. This means that it is those who have the higher costs during their working lives, who are also likely to need more medical services in retirement.

5.6 MANAGED CARE CONCEPTS

5.6.1 PRINCIPLES AND ISSUES

Managed care seeks to control the costs of medical attention through various means. Key issues include:

- the basic right of the individual to seek out the medical service which he chooses;
- the aspect of personal privacy surrounding medical records and treatment;
- the right of the medical practitioner to be free to prescribe the kind of treatment that he believes is appropriate for each patient without undue pressure or persuasion;
- the potential for medical practitioners to perhaps under-service patients where they are carrying the financial risk themselves, resulting in both a deteriorating service level and, ultimately, higher costs involved in recovering lost ground or due to an inability to cure the problem in the early stages.

5.6.2 PHYSICIAN / PROVIDER BEHAVIOUR MODELS

Considerable research has been done into the attitude of medical practitioners, who are seen to be crucial in the overall decision concerning the nature, and hence the cost, of the treatment that patients are to be subjected to. In this it is generally accepted that, whilst the patient is theoretically in charge of the entire process and is hence ultimately responsible for the kind of treatment and level of treatment to be supplied, the specialist nature of the medical practitioner's knowledge often mitigates against the patient really having much say. It is unlikely that a physician will want to prejudice his professionalism by laying out options for the patient to choose from.

5.6.3 VEHICLES IN HEALTHCARE MANAGEMENT

Various devices have been tried to overcome escalating costs, due to over-servicing. Some of the main methods are outlined below.

Co-payments

This is when the patient is held responsible for a set percentage of each medical bill. Studies in the USA by the Rand Corporation have shown that this system is pretty effective in limiting costs, while not having a serious impact on the quality of the healthcare through patients opting not to go for the appropriate attention.

Medical savings accounts

The individual contributes towards a fund from which medical expenses are paid but, as the fund is owned by the individual, there is a direct responsibility and motivation to limit the claims.

Experience has shown that this approach has much the same success rate as the co-payment scheme, although practically it is only used in conjunction with some form of full insurance for the more major medical eventualities, which the personal fund could not pay.

Clinical guidelines and professional education

This method seeks to achieve the appropriate level of service through a combination of patient education, and service provider guidelines, which serve to create a more realistic level of understanding of the practical balance in the decision about treatment. It has been found to be more successful in situations where there is considerable variation in the quality of service providers.

Utilisation reviews

This is a method of control in which a qualified third party checks the level of service being applied either:

- before the service is actually provided; or
- as a form of case management during the overall treatment process; or
- as a retrospective control, partly in the form of an audit of the bill.

Capitation

With the capitation system the service provider is contracted to provide the service for a flat fee and is hence encouraged to find the most suitable balance between cost saving and effectiveness - the latter will include the potential for a prolonged period before recovery is complete which would normally add to the overall costs.

The effect of the capitation system has been shown to be relatively successful and some schemes include some form of bonus or incentive scheme package to further control delivery decisions.

Service bundling

This is really a compromise between full fee-for-service and capitation in that it bundles a range of services to be provided at a fee. A complication which arises in practice is where referrals are made to providers outside of the agreement, which result in added costs being incurred by the patient outside of the prepaid bundle.

Networks

In their extreme form, these are Mutual Health Organisations (MHO's) or Preferred Providers Organisations (PPO's), in that they work along the lines of a selection of various providers, restricting the member's choice to boost volumes to the selected providers within the network in return for price advantages without sacrificing service levels. The capitation system of payment is sometimes used.

5.6.4 THE LIFESTYLE MANAGEMENT CONCEPT

A growing concept, which is gaining considerable support in developed countries, such as the United States of America, is the idea of disease management.

In broad terms it rests on two principles:

- prevention is better than cure; and
- the key to proper health care is total and continuous management of the individual's health.

The three major components of disease management are:

- provider networks;
- care management, which includes education of the patient, provider and payer; and
- outcomes measurement in terms of adherence to procedures, patient satisfaction, quality of life and cost / quality of medical services.

A major part of this is the building up of a lifelong medical history on individuals so that health changes can be detected at an early stage.

Benefits often include items such as medical advice lines and weight-loss or fitness programs.

Because preventative treatment is often cheaper than the ultimate cure once a condition has manifested itself, this is seen to be a more viable solution. Another key benefit of this approach is that it is seen to offer an improved level of lifestyle to the individual, who does not suffer the effects of health problems as often or as severely as under the cure approach.

QUESTIONS ON CHAPTER 5

Mental revision questions

Work through these mental revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. What is the role that government has committed itself to in the provision of health care?

2. Describe the term primary care as it applies to health care.

3. Describe the problems with fraud and abuse that are prevalent in the South African Health care system.

4. List the ways in which an employer's liability to pensioners can be dealt with.

5. List the disabilities that will qualify a person as handicapped in terms of the Income Tax Act.

6. What is the current rate at which retirement funds are taxed?

7. Briefly describe the benefits available from the Professional Provident Society.

Written questions

Attempt these questions after you have completed this chapter and its mental revision questions. Suggested answers to these questions are at the end of this book.

1. Write an essay in which you describe the main taxation aspects that apply to healthcare plans in South Africa.

2. Write an essay in which you discuss cross-subsidisation under medical schemes. In your answer you should outline what cross-subsidisation is, describe the more common fields of cross-subsidisation and comment on the pro's and con's of cross-subsidisation.

3. Write an essay in which you describe the more common devices used in healthcare management to overcome the problem of escalating costs due to over-servicing.

4. Write an essay in which you outline the underwriting process and issues in the healthcare market, including an explanation of what underwriting under this type of cover seeks to achieve.

5. Describe how a registered medical aid scheme differs from a so-called new-generation plan.