Can medical scheme reform lead to fairer distribution of limited resources? A funding perspective

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While many South Africans were celebrating 10 years of democracy, frustrated doctors took to the streets to voice their dissatisfaction about the state of health care in our country. Both public and private-sector workers joined the protest against deteriorating working conditions in public facilities, inadequate patient care and various government intervention strategies. Private-sector doctors were motivated in particular by the impending Medicines Control Amendment Act (forcing the special licensing of dispensing doctors) and the proposed Certificate of Need (regulating where doctors may practise in future). Such legislation is perceived as heavy-handed, uninformed and a destructive interference.

Amid such frustration and confrontation, and mindful of arguably inept introduction of some aspects of government policy and legislation, we believe it timely to review some of the positive aspects of recent developments in health care. We refer particularly to changes within the medical scheme environment. Medical scheme legislation has resulted in the unusual, but opportune, situation of private medical schemes and their managed care organisations being governed by principles of social health — a concept, we believe, not widely acknowledged or understood as yet by a majority of stakeholders. Current and proposed legislation has paved the way for solidarity and is encouraging improved funding and delivery models of health care, with the ultimate objective of fairer distribution of resources and better access to health care.

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Social health insurance (SHI)

South Africa's progressive constitution is highly protective of the individual's socio-economic rights, including the right to have access to 'health service' (Chapter 2, section 27, Constitution of the Republic of South Africa, 1996). There is an obligation on the state's leadership not only to respect and protect the right to health care, but also to implement such a right. Therefore, to facilitate the progressive realisation of quality health care for all, government is committed to a system of SHI.[1] The objectives of such health care funding reform would be to reduce inequities in health care financing by improving cross-subsidisation of the sick and poor by the healthy and wealthy and by increasing revenue through mandatory contributions specifically earmarked for spending on health care services.[2] Funding disparities include the following.

1. Private-sector health care spending is more than 5 times the per capita expenditure of the public sector. Or, presented differently, the private sector spends R35.5 billion to serve only 17% of the population, whereas the other 83% of the population only have R32.2 billion to share.[3]

2. Until recently, there was discrimination within the private sector against the sick and those with lower incomes.

Prior to 2000, the private sector was deregulated and was largely managed according to standard insurance principles. Individual risk-rating techniques and benefit designs (paradoxically) favoured, especially in the open-scheme environment, young and healthy membership, while discouraging older and more ill membership.

The private sector therefore not only consumes a disproportionate amount of health care monies, but despite such it has failed to provide adequately for its poorer and sicker members. Where members have exhausted limited benefits, the private sector has historically abdicated its responsibilities, leaving such patients to be cared for by an already overburdened state. Further, year-on-year health care inflation in the private sector that repeatedly exceeds the consumer price index (CPI) is threatening voluntary membership as medical scheme contributions increasingly become less affordable. Such signs ominously predict further disparities between the 'have's' and 'have not's' with regard to health care access. Therefore, as part of its plan to achieve the overall objective of 'better life for all' in post-apartheid South Africa, the government is seeking to reform both financing of 'private' health care and budget allocation by medical schemes. To achieve its goals the following legislative changes have been proposed and partially implemented.

Ensuring access to a social health package — Medical Schemes Act of 1998

With medical schemes acting as the vehicles through which health care within an SHI system will be purchased, legislation governing the private funding industry has been introduced progressively since the year 2000. Such legislative change is aimed at enabling a 'public health' approach to resource allocation. Noteworthy aspects mandated by the Medical Schemes Act (No. 131 of 1998) and its regulations include the following.

1. Open enrolment, whereby medical schemes cannot deny membership on the basis of age or pre-existing illness.

2. Community-rating as opposed to risk-rating, whereby schemes charge community-based membership rates instead of fees based on an individual's perceived financial risk to that scheme.

3. Prescribed minimum benefits (PMBs), whereby schemes are obliged to cover a minimum set of hospital-based and chronic illness benefits without financial limitations in at least one provider network and at the minimum level of care provided by public-sector facility. The PMBs therefore describe the basic health care package (the 'social health package') that all scheme members should have access to without financial limitations.

Financing of SHI — mandatory cover, the risk equalisation fund and tax reform

To improve cross-subsidisation of health care and to increase pre-paid revenue earmarked specifically for health care services, government is pursuing income-based mandatory contribution to an 'SHI' fund (also referred to as the risk-equalisation fund or REF). Such a fund is aimed at financing a basic health care package for all those contributing. With medical schemes being the vehicles through which such a fund will be allocated, the government is also seeking to define a formula whereby such monies are allocated fairly to individual schemes to provide the necessary cover.[4] As schemes currently differ in their demographic profile and the associated PMB burden, it is important that funds are distributed according to schemes' risk profiles. Such an approach of risk equalisation across schemes should have the added benefit of forcing schemes to compete on efficiencies, rather than benefit designs that attract the young and healthy and discriminate against the sick and elderly. The ability to purchase cost-effective quality health services should become a major differentiating factor between schemes.

Furthermore, government has appointed a task team to investigate fairer distribution of tax-based funds specifically earmarked for health care.[5] Tax subsidies afforded to those with comprehensive private medical insurance are in excess of the per capita health contribution by government to the public sector. It is likely that current tax subsidies will be replaced, at least partially, by a fixed per capita contribution from government to the SHI fund.

Not only do the individual components of the financing of an SHI fund necessitate wisdom and expertise, but careful co-ordination of these initiatives, including their implementation, is of paramount importance. The challenge for government is to ensure significant growth of medical scheme membership. This can only be achieved if the mandatory contribution by individuals is accepted as affordable.

Critical success factors for the delivery of affordable quality health care

For fully fledged SHI to succeed in South Africa, the focus must be on creating efficiencies in the delivery of 'privately' funded health care. This necessitates: (*i*) the establishment of alternative reimbursement models for delivery of health care services; and (*ii*) prioritisation of resource allocation based on sound scientific, economic and ethical principles

Simplistically, without creating the necessary efficiencies and priorities, medical scheme contributions will become increasingly unaffordable, with the result that fewer rather

than more individuals will elect to pre-fund an appropriate level of health care coverage. This is of particular relevance where employers are moving towards cost-to-company reimbursement packages, or capped medical scheme contributions, which shifts the entire burden of spiralling health care costs onto the employee. Percentage-based medical scheme subsidies for employees are not sustainable in an environment where inflation on medical scheme contributions continues to exceed the CPI. Furthermore, broad mandatory cover, a key component of the proposed SHI system, is likely to be opposed by trade union movements unless contributions are accepted as affordable and the quality of care as reasonable. The focus must therefore be on affordability and quality, with quality determined by both ease of access and level of care.

Establishment of alternative reimbursement models for delivery of health care services

The commercial relationships that to a large degree still dominate the delivery of privately funded health care are flawed. In a fee-for-service environment there is insufficient incentive for service providers to focus on the delivery of cost-effective practices and to minimise waste. Furthermore, relationships based on doubtful incentives (e.g. rebates and kickbacks) have been inflationary — by encouraging overservicing, by artificially increasing prices and by promoting expensive care that has marginal benefit. In an environment of oversupply, where rationing through a queueing system does not apply (as it does in the public system), providers are inadequately incentivised to manage limited resources. In order for providers to acknowledge the limitations of resources, some type of accountability for budget management is called for. This thinking underpins the burgeoning trend of alternative reimbursement models, such as global fees and capitation, which aim to share financial risk between funders and providers and thus align the groups' financial incentives. Such strategic partnerships, which incentivise not only sharing of financial risk but also increased autonomy and accountability of doctors in allocation of scarce health care resources, will be critical for successful implementation of a new model. As these models succeed, non-health-care costs relating to administration and managed care should decrease.

Furthermore, it is contended that as a result of monopolistic behaviour private sector health care delivery is not sufficiently competitive. This is seen as an opportunity for the State to promote use of public-sector facilities. If public-sector facilities can succeed in drawing medical scheme funds, such monies could be used to cross-subsidise quality of health care to the indigent population of our country. Of course the key is for public institutions to be truly competitive, both in the tariffs charged for predefined services and in the services offered, including the technical expertise of their professional staff.

The future is therefore dependent on risk-sharing agreements that include not only schemes and private-sector providers, but also the state.

Prioritisation of resource allocation

Prioritisation of health care resources is a core component determining the affordability and quality of health care delivery. For allocation to be just, purchasing limitations of community funds have to be acknowledged. Furthermore, allocation of funds must be based on sound scientific, economic and ethical criteria, with the latter encompassing both procedural and substantive aspects of decision making. Such an approach is necessary at all levels of policy definition. In the private sector, these levels include: (*i*) government (the macro level); (*ii*) schemes and their contracted managed care companies (the meso level); and (*iii*) the doctor-patient relationship at the point of service (the micro level).

The macro level

Laws and policies of the country influence access to health insurance plans and benefit designs. Before 2000, when the medical schemes industry was deregulated, government did not influence the use of private health care funds. However, with the introduction of legislation to facilitate the roll-out of SHI, government is dictating a minimum level of care that has to be funded by all (the PMBs). The original objectives of such a package included: (*i*) prevention of dumping on the public health system; (*ii*) protection of cover for necessary and high-cost items; and (*iii*) the promotion of more appropriate behaviour in benefit design, costing and management of costs.

The focus was on ensuring access to hospital-based benefits at a minimum level of care commensurate with that available in public-sector facilities for specific diseases. Such an approach was protective of public-sector resources, and consumers. However, with the recent inclusion of chronic medicine and other primary care benefits for limited, but generally common indications, it appears that the focus in the definition of PMBs has shifted towards creating a stand-alone (or SHI) package. Mindful of this, it may have been fairer if government had elected to opt for an inclusive set of basic benefits, instead of an exclusive set of comprehensive benefits. That is, instead of limiting ambulatory cover strictly to 25 diseases (at a level of care that sometimes exceeds standard practice within tertiary public-sector facilities), more inclusive disease coverage at a more basic level of care may be more compatible with the local concept of an SHI package. In particular, rarer diseases that can be regarded as 'similar' to PMB-listed chronic diseases (e.g. ankylosing spondylitis versus rheumatoid arthritis) should have been considered for inclusion. It is unlikely that they pose any significant actuarial risk, there is no sound reason for excluding them compared with similar diseases that have been assigned PMB status, and

'adaptation' of disease codes is likely to result in their payment anyway. The focus should be on giving the majority of patients with chronic illnesses — which are amenable to good results at affordable cost — a fair chance to reasonable health care access. It is therefore critical that the primary objectives of the basic package are crystallised and that legislators do not lose sight of these.

The temptation to benchmark the basic level of care against that of First-World socialised health systems, e.g. those of Australia and the UK, must also be resisted. Not only do these countries have greater resources for expenditure on health care than South Africa[6] and different infrastructures for the delivery of health care, but their needs differ based on disease patterns. Whereas in First-World countries the prevention and treatment of westernised diseases is often prioritised, South Africa has to distribute its funds fairly to address its triple burden of disease, viz. infectious diseases, including the HIV pandemic, trauma and lifestyle-related illnesses. Furthermore, the inclusion of interventions with marginal benefit, those expensive even in First-World terms, and those that could be regarded as enhancement technologies have no place within an essential South African package. Failure to apply the stated objectives consistently and transparently in the definition of PMBs will result in an inappropriate basic health package. Government cannot afford enigmas if policymakers are to resist pressures by vociferous and powerful stakeholders.

The meso level

The level of health care that may be funded for individual members of private schemes is determined by the elected governing body of medical schemes (the Board of Trustees), and the contracted managed-care companies. Before 2000, many trustees relied almost exclusively on actuarial and marketing strategies to ensure scheme viability and open-market competitiveness. Unlimited oncology benefits coupled with unrealistic shrinking of chronic medicine benefits are examples of such irrational, unsustainable forms of budget allocation. However, the introduction of PMB legislation and the proposed risk-equalisation fund is forcing a population-based approach to benefit prioritisation and structuring. If schemes are to remain viable they have to rely increasingly on clinical risk-management programmes to control expenditure. Typically, managed-care organisations are appointed to manage such risk. Although benefit utilisation management companies contracted on a fee-for-service basis have added value, an integrated as opposed to top-down management approach is the way of the future. This implies both alignment of financial incentives between funders and providers, and collaboration on clinical policy issues. In such an evolving environment patients may well feel vulnerable. It is therefore crucial that managed-care organisations have a robust infrastructure for the development of clinical standards — not only to ensure that resources are prioritised optimally based on sound scientific, economic and ethical reasoning, but also to ensure that standards of care are explicit. This allows for both external scrutiny and for benchmarks against which member complaints can be judged. To ensure fairness, members must be provided with readily accessible processes that in the event of dispute allow them a fair and objective hearing. This is particularly important where tough and uncomfortable decisions of no funding have been made. In the private sector, clinically based rationing is largely focused on promoting the most efficient treatment where alternative therapies exist, e.g. by means of formularies, reference pricing, and step-wise treatment approaches. However, in a socialised system there will increasingly be interventions that are simply excluded, especially those that have marginal benefit and are very expensive. Nevertheless, as long as policy decisions are based on sound reasoning and collated in an open manner as mandated by medical scheme regulations, we believe that the new funding platform lends itself to fairer resource allocation than in the past. Obviously such a statement is made with the expectation that trustees do not actively discriminate in a different manner, namely on a disease-specific basis. There have been reports of schemes excluding payment of certain non-legislated chronic diseases altogether from their overall risk pools, where treatment is cost-effective and readily available from the state. Such decisions should be actively opposed.

The micro level

The doctor-patient relationship is a key determinant of resource allocation. In the past, distribution of funds in the private health care sector was determined almost exclusively by these parties. However, as inflation of private-sector health care continued to spiral, medical schemes and government have taken a prominent role in determining the prioritisation of expenditure. Such involvement has been resented by many practitioners as they perceive their professional autonomy and judgement to be challenged. This response has been further fuelled by the accompanying administrative burden relating to complex benefit designs and reimbursement rules, and the perception that member benefits continue to decrease despite increasing scheme contributions and meddling by bureaucrats. Neither doctors nor patients have been informed adequately that the determinants of affordability of health care delivery have shifted. Historically, affordability was determined by individual benefit limits alone. However, within the PMB ('unlimited') environment, resource allocation (payment rules), especially with regard to funding of the essential health care package, is determined increasingly by group considerations.

Although the resilience, patience and integrity of most providers in this changing and stressful environment are

highly commended, we believe there are factors impeding the transition towards rational and more sustainable use of health care resources, namely: (*i*) unrealistic expectations of health care interventions, which are fuelled by those with commercial interests in their use; (*ii*) benchmarking clinical practices in the private sector against those of the USA and other well-resourced countries; (*iii*) insufficient acceptance and guidance by independent local specialist groups of what constitutes a fair level of clinical care in a resource-constrained environment; and (*iv*) subscription to the ethos that provision of the 'best' health care services — whatever the cost to society or other scheme members — must take precedence over all other ethical considerations and obligations

We are in no way suggesting that doctors abandon 'best practice principles'. Instead we would like to propose critical appraisal of what constitutes best practice in our resource-restrained context and how such practice is applied. 7 Because of strong marketing forces, incomplete information and time constraints, doctors are often disadvantaged when evaluating new advances in health care . The fact that best care is often 'established and cheap' care, conservative care or aggressive lifestyle intervention is easily ignored. Further, there needs to be acceptance that not all 'best care' can be prioritised within a societal benefits package.

For government to succeed in its endeavours to improve access to quality care, doctors (particularly those servicing members of medical schemes) need to embrace the concept of resource allocation based on socialistic principles. This includes defining sound clinical policies relevant to the South African situation.[8,9]

Conclusion

By introducing the concept of social governance of medical schemes, legislation has enabled an environment of fairer budget allocation within the private sector. Furthermore, it is protecting drainage of public-sector resources by medical scheme members. However, for the full intentions of social health reform to be realised, especially as further legislation facilitating SHI is promulgated, the health care market must respond responsibly. First and foremost there must be widespread acceptance of population-based prioritisation of health care resources. Secondly, such prioritisation must be based on sound scientific, economic and ethical thinking. It is critically important for all role-players, especially practising providers of care, to participate in the debate and influence decision-making meaningfully. In an environment where trust is established between funders and providers, reimbursement policies could indeed support individual doctors in the day-to-day management of patients, especially where patients have unrealistic demands and expectations. At all levels, resource allocation as a result of political and commercial pressures must be minimised. The sentiment that the end-point can only be mediocre medicine must be abolished. A re-focus on excellent clinical skills and judgement by practitioners (instead of the injudicious use of modern technologically based diagnostics and interventions[10]) and the promotion of centres of excellence that will provide the latter, where indicated, can continue to ensure access to first-class medical care. Although there are many hurdles to be overcome and many challenges to be faced, we believe that the appropriate ethos for success has been introduced by the new legislative platform governing private medical schemes. Failure to understand or accept these changes, and failure to act within the spirit of the legislation, could, however, result in increasing government intervention that may ultimately prove to be destructive.

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