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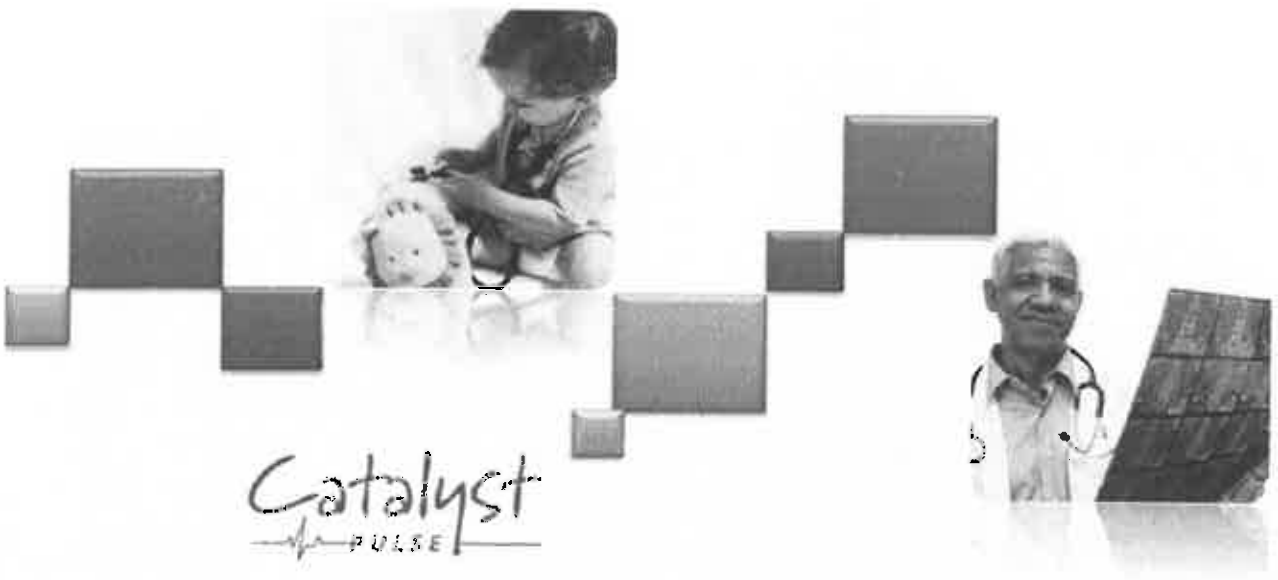

Final Report

Research to identify the role of Gap Cover insurance in the current South African Healthcare enviornement

April 2012

RATIONAL BEHIND THIS RESEARCH REPORT

On Friday 2 March 2012 Government gave notice of its intention to curtail the selling of various Health insurance products with the publication of draft regulations on proposed new rules with regard to a clearer demarcation between insurance and medical scheme products.

The stated purpose of the draft Regulations is to ensure that health insurance products, including Gap Cover, do not infringe on the Medical Schemes Act 131 of 1998 which governs medical schemes.

In a joint statement both National Treasury and the Department of Health indicate that the draft Regulations aim to find an appropriate balance between the role played by certain health insurance products and the need to protect key principles underpinning medical schemes.

While several insurance products marketed by both life and short term insurance companies are highlighted by regulators, for the purposes of this research the only health insurance product evaluated in this report is "Gap Cover insurance" (Gap Cover)

The definition of Gap Cover for the purposes of this research is insurance Cover which will cover the shortfall of hospital costs, between actual costs incurred and the medical scheme tariff covered under a scheme members benefit option.

REGULATOR OBJECTIONS TO GAP COVER

Long- and short-term health insurance products, which provide similar benefits to medical schemes, could **harm medical schemes by attracting younger and generally healthier members away from schemes**

Risk pools are undermined when healthier members join cheaper options, which typically pay lower rates to specialists, and insure themselves against the costs of using a higher-charging specialist through a Gap Cover policy.

Younger, healthier members opting out of schemes if left unchecked, "could result in increasing costs for the older and less healthy who remain dependent on medical schemes for their cover".

"Gap Cover" insurance policies are **fulfilling the role of a medical scheme**

"Gap Cover "insurers **discriminate against policy holders by risk rating** based on the policy holder's health.

The belief that an insurance policy offers the same protection as a medical scheme, when in fact the **protection is partial and conditional**. This may result in individuals being under covered when serious health events arise.

RESEARCH PARAMETERS

1. Data was collected from the top 11 open plan medical schemes as well as GEMS which is the largest medical scheme within the closed scheme environment. Together these schemes represent 70% of the total private healthcare medical scheme market
2. Relevant data was collected from various industry experts and scientific sources with relevance pertaining to the purposes of this research
3. Given the scope of insurance Cover offered by Gap Cover , only major medical in hospital costs (including specialists) were examined with regard to the percentage paid by medical schemes across all benefit options available, in line with or above NHRPL .
4. Data was drawn from the three main underwriters in the Gap Cover insurance market. These companies represent 90% of the Gap Cover market
5. When doing a comparative study on premium costs for Gap Cover the most expensive Gap Cover premium currently available in the market was used alongside an aggregate rate for the industry consisting of all monthly premiums currently used in the Gap Cover market.

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OBSERVATIONS

- ***Gap Cover insurance cannot attract younger and healthier members away from the medical scheme environment as without belonging to a medical scheme, younger healthier members are unable to access Gap Cover insurance.***

- ***It is highly unlikely that the underlying risk pools within the current medical scheme environment would be negatively affected by Gap Cover insurance. The large majority of current policy holders who have taken out Gap Cover insurance belong to the middle band of benefit options available across the various medical schemes in the current Private Healthcare environment. Actuarial data shows, that in most instances it is this middle band members who belong to the middle band of benefit options, that are currently cross subsiding the more costly comprehensive as well as the lower income options in most schemes.***

- ***Gap Cover insurance policies do not fulfil the role of a medical scheme for the following reasons:***
  - ***All benefits are paid directly to the to the policy holder and not to a service provider***
  - ***Gap Cover insurance is not available to any person who is not a member of a medical scheme***
  - ***Gap Cover insurance plays the role of "reinsurer" for a medical scheme member, against major medical costs not covered by their current benefit option***
  - ***No out of hospital day to day cover is offered by Gap Cover insurance products***
  - ***If no benefit option is available with the policyholders medical scheme, or if the annual stipulated limit has been researched, then no Gap Cover benefit is payable.***

- ***Exclusions and waiting periods contained within Gap Cover insurance policies are based on exclusions contained within most medical scheme policies. All Gap Cover policy holders are charged a set rate for the same cover and no policy holder must undergo a medical examination before being eligible for cover. Health evaluations are based on full disclosure by the person applying , as is the case with medical scheme application as well.***

- ***Research shows that policy holders are fully aware of the scope of cover offered under a Gap Cover insurance policy and do not view Gap Cover as a replacement for belonging to a medical***

scheme. Unlike a hospital "cash back" insurance plan, it is not possible for a non medical scheme member to obtain Gap Cover insurance. In most instances the association is with the medical scheme and Gap Cover insurance is seen as a value add product offered by the scheme itself.

- *The principle of social solidarity whereby the young and healthy cross-subsidise the health care costs of the elderly and sick can only work successfully in a mandatory membership environment. As long as this does not form a part of the current legislation on private medical schemes, cross subsidisation and risk pools will be impaired.*

- *The Gap Cover insurance market has grown from a need for medical scheme members to insure themselves against uncovered medical expenses. Medical schemes in the current healthcare environment are unable to provide a greater scope of benefit cover due to healthcare inflation and the marginal growth of the core membership base.*

- *Until such time as costs for the provision of healthcare services can be pegged and a balance can be found, where both the provider and payer can agree on a costing structure, medical scheme members will be liable for all costs charged and not covered by their medical scheme benefit.*

- *Healthcare provider costs cannot be curbed while medical schemes are unable to use their collective bargaining power to negotiate provider rates.*

- *Affordability has been shown to be the major concern and challenge for medical scheme members. Research shows that disallowing Gap Cover insurance, will not force medical scheme members to buy up. Most members are already at the limit of their budgetary constraints as far as medical scheme premiums are concerned and can only look to accommodating the annual premium increases above CPI.*

- *International experience shows that insurance products are viable alternatives within a National Health Environment for areas where a service is rationed or healthcare needs cannot be accommodated. Legislation should therefore be looked at with a long term view of future needs within an NHI environment.*

- ***It is the opinion of this researcher that with the challenges facing the medical scheme industry and the medical scheme member, it would be of more advantage for medical scheme members if the regulator were to address concerns around Gap Cover with the insurance companies with an aim of finding a solution that will not once again disempower the medical scheme member.***

- ***To remove medical scheme members right to protect themselves from major medical costs not covered by their medical scheme, is to disadvantage the very people legislation is supposed to protect. This could well result in medical scheme members being left with no alternative but to seek redress through the countries judicial system.***

INDUSTRY BACKGROUND

MEDICAL SCHEME REGULATIONS

[1]The medical schemes industry was de-regulated in 1989 and 1993 through legislation passed by the apartheid government. This was in response to calls from the industry to free it from controls that it claimed limited its ability to deal with cost escalation. Indeed, between 1982 and 1992 medical scheme contributions had risen steadily from 7.1% of the average salary to 15.2%, while salaries had not changed much in real terms.

Cost escalation continued into the first term of office of the post-apartheid government. However, total contributions grew faster than inflation between 1996 and 1998, even though medical scheme membership remained stable. With risk-rating, high-risk members – typically the elderly or chronically ill – had their contributions loaded, were given life-long exclusions for pre-existing conditions or were denied membership completely. Another practice that escalated was the 'dumping' of private patients on the public sector once their (now more limited) benefits had been exceeded.

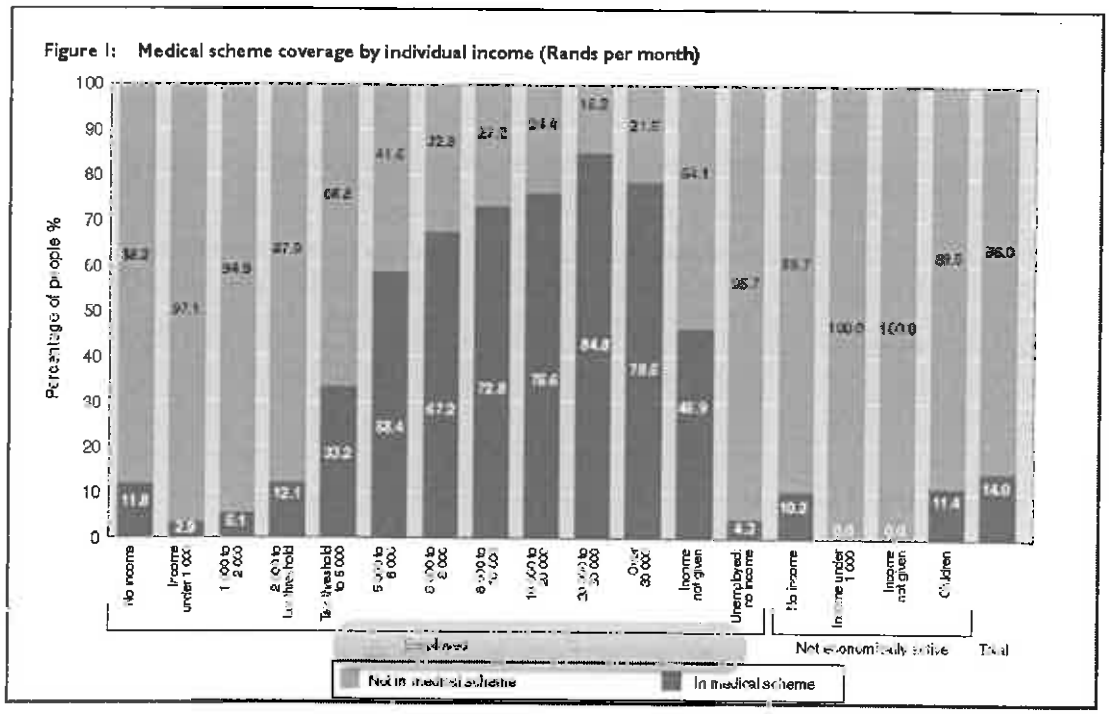
In response to the defects of the South African private health insurance market, government passed a new Medical Schemes Act, No. 131, in 1998. The Act and accompanying regulations of 1999 were implemented from January 2000, and were followed by several amendments. Amongst other things, the Act made it compulsory for every scheme to accept all eligible applicants ('open enrolment') and to charge contributions that were differentiated only on the basis of income and the number of dependants, and not on age or the risk of ill-health ('community rating'). In addition, the Act made it compulsory for every scheme to offer a comprehensive package of hospital and outpatient services, known as the Prescribed Minimum Benefits (PMBs)

The Act supported the principle of **social solidarity** whereby the young and healthy cross-subsidise the health care costs of the elderly and ill. The explicit tool used by the Act to force this extension was the combination of mandatory open enrolment, community-rating and PMBs. While community-rating and PMBs would increase the costs of cover for younger individuals, the designers of the Act hoped that the collective effects of opening up schemes to a large low-income market, creating larger risk pools and applying pressure to compete on the basis of efficiency, would bring down the costs of cover for the bulk of members. However the one aspect of this act that would have had the greatest impact on anti selection was mandatory membership and this was not included.

Voluntary insurance operates on 'mutuality' principles where members are assessed or underwritten on application and pay according to their risk. Social systems operate on 'solidarity' principles where contributions are not linked to risk. Contributions may be paid equally (as under community-rating) or according to ability to pay. Solidarity, when fully implemented, requires that contributions are mandatory for defined groups. Mandatory membership is required to avoid anti-selection risks, i.e. the practice of remaining uninsured while you are young/healthy and then only joining a scheme when you are old/sickly, especially since acceptance is guaranteed.

[1] Health Systems Trust 2007 Chapter 4 Medical Schemes

FIGURE 1: MEDICAL SCHEME COVERAGE BY INDIVIDUAL INCOME (RANDS PER MONTH)[2]



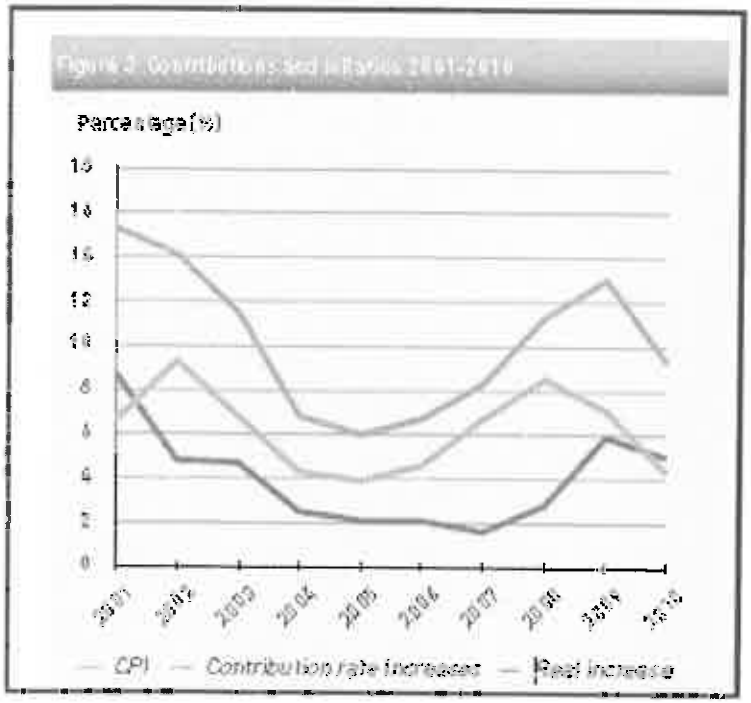
This omission could potentially have added an additional 6 million lower income medical scheme members to the private healthcare market. Within the Private Healthcare market generally, although some low cost options may be drawing lower-income earners into the market, in a general sense medical scheme membership has shown minimal growth over the past ten years, while the costs of cover have generally continued to escalate unabated.

Indeed, contribution increases in registered medical schemes have consistently outpaced inflation since the 1980s. Membership of a medical scheme is becoming more costly.

In this regard the Act certainly has not impacted positively on this trend: on the contrary, it may have sparked off both the rapid increase in contributions and the increasing divergence between contributions and benefits. Added to this is the fact that incomes tend to be inflation-linked and do not keep up with the escalation in medical scheme contributions.

[2] Health Systems Trust 2008 chapter 4 Medical Schemes

FIGURE 2: MEDICAL SCHEME CONTRIBUTIONS AND INFLATION 2001 – 2010 [3]



Between 1995 and 2000, expenditure by registered schemes on hospitals grew rapidly (at an average annual rate of 11%) to reach 31% of total benefit expenditure in 2000. In the CMS annual report 2010/11 scheme expenditure on healthcare benefits was shown to have increased by 11.0% to R84.7 billion in 2010 from R76.3 billion in 2009.

Hospitals accounted for R31.1 billion of the R84.7 billion paid to all healthcare providers. Medical scheme expenditure on private hospitals increased in 2010 by 10.1% to R30.8 billion compared with a 2.6% decrease in their spending on provincial hospitals (to R281.5 million).

Expenditure on medicines dispensed by pharmacists and providers other than hospitals increased to R14.0 billion in 2010, an increase of 5.6%. Payments to specialists increased by 12.2% to R18.8 billion. Expenditure on general practitioners (GPs) increased by 9.0% to R6.2 billion while payments to dentists increased by 13.2% to R2.5 billion. Expenditure on dental specialists decreased by 11.5% to R601.3 million. Expenditure on supplementary and allied health professionals increased by 11.5% to R6.7 billion in 2010.

Clearly, less and less of each rand spent on health care benefits is going towards the less expensive primary care services provided by general practitioners. Hospitals in 2010 accounted for 36% of the healthcare spend. Specialist for 22% of the healthcare spend with medicines dispensed by out of hospital pharmacists at 17% and General practitioners only 7%.

[3] CMS annual report 2010/11

While the, the Act makes it compulsory for schemes to provide at least the PMBs, the designers of the 1998 Act focused on hospital care partly because, from an individual's point of view, the need for this type of care is unpredictable, while the care itself is expensive. This makes it difficult for individuals to fund this type of care out of their own pockets, as they might be able to do for primary care.

The 1998 Act outlawed monetary limits on PMBs which, by definition, are considered essential services. Monetary limits are still allowed on other, top-up benefits, often through a fairly complex set of rules. Indeed, three-quarters of low-cost options rely on monetary limits to control spending on top-up hospital benefits.

As it is low-income groups that utilise these options, are the least likely to be able to afford to pay out-of-pocket for services over and above the limit. This form of cost-control may deny access to services needed by these groups. And becomes important in cases where such services are in fact essential, even though they are not presently part of the PMBs.

A key challenge facing the private health sector is the rapid increase in contributions to and spending by medical schemes. Although the South African private sector is heavily regulated, these increases have not been addressed effectively either through government regulation or through action by the private health sector itself. There are now serious questions about the affordability and sustainability of private healthcare insurance in South Africa.

NON-IMPLEMENTATION OF A RISK EQUALISATION FUND (REF):

[4]The function of an REF is to extend the principle of risk-pooling from individuals to medical schemes. In the interest of the overall stability of the scheme environment, all medical schemes would need to participate in an REF that receives money from some schemes and redistributes it to others according to the risk profile of each scheme's members relative to the average of all schemes. Risk equalisation is also important for the viability of small schemes, which could otherwise be compromised by uneven distribution of risk within their members.

Considerable work was done by government committees between 1995 and 2005 to research and develop proposals for an REF. By 2006 a 'shadow' risk equalisation process to test the reporting and operational requirements of such a mechanism was in place. The Department of Health took the decision that the risk equalisation mechanism be housed within the Council for Medical Schemes (CMS) and that the legislative framework should proceed by way of amendment to the Medical Schemes Act No.131 of 1998. Cabinet finally gave the full go-ahead in January of 2006, with funds approved for the full implementation of the required systems over the next two years. The implementation of the systems and results of the shadow process were seen as central to obtain final approval for the passing of the legislation.

However, despite the full implementation of the systems and the finalisation and approval of legislation by Cabinet in 2008, further progress with the legislation was blocked by ANC lobbies on the grounds that it would undermine the implementation of a full NHI scheme.

[4] Van den Heever, Trends in government policies, p.27

DISTRIBUTION OF DOCTORS IN SOUTH AFRICA

South Africa has a huge shortage of Doctors. Speaking at a New Age business briefing [5]Health Minister Dr Aaron Motsoaledi acknowledged that the skills shortage issue was phenomenal. He said South African medical schools were currently only producing 1 000 doctors per annum.

While there are an estimated 27,641 Doctors practising in South Africa, approximately 23,407 South African born and trained Doctors are believed to be practicing in Australia, Canada, New Zealand and the United State. This does not include Doctors practicing in the United Kingdom and other countries. Of the 27,000 doctors practising 12,238 are specialists serving a population of 48 million. Most registered doctors work in the Private Sector

These figures are contained in a presentation compiled by Mark Sonderup and Phopi Ramathuba for the SA Medical Associations (SAMA) 2011 annual conference. Sonderup is a specialist at UCT Medical school and Ramathuba chairs the SAMA committee for public Sector Doctors. From 1998 to 2006 South Africa trained 14145 Doctors and specialists. In the same period the Health Professions Council of South Africa has issued more than 20,000 certificates of good standing to medical practitioners leaving the country for positions in other countries.[6]

The country needs to train an estimated 46,000 more nurses and 12,500 doctors simply to urgently staff current private and public sector hospitals. The extent of the staff shortages is sucking the industry into a vicious cycle which sees more and more doctors in burn out and leaving the country. This is especially true of public sector doctors.

South Africa compares unfavourably with other middle income countries in terms of medical and dental professional's per 1000 of the population. The United Kingdom has 120,000 doctors for a population of 60 million. South Africa has 27,000 for a population of 48 million. According to figures from the World Health Organisation (WHO) and the CMSA, South Africa does not compare favourably with other middle-income countries such as Brazil and Mexico either. South Africa currently has 0.57 general practitioners for every 1 000 members of the population, while Brazil has 1.85 per 1 000 and Mexico 1.90 per 1 000. Our country, then, has only one-third of the doctors and specialists compared to those practising in other developing countries, based on WHO indicators. The shortage in medical skills is now so severe that many essential services in the public sector can no longer be rendered without increased risk to the patient.

[5] Government Communication and Information System Date: 23 Apr 2012 Title: SA to produce more doctors

[6] Taken from a detailed research report compiled by the College of Medicine of SA (CMSA) published in the South African Medical Journal

TABLE 1: COMPARATIVE BENCHMARKS FOR STAFFING PER 10,000 POPULATION AND HEALTH CUTCOMES [7]

Indicator	International Benchmarks						SA Current
	Brazil	Chile	Costs Rica	Columbia	Thailand	Argentina	
Doctors	17.31	15.71	20.42	19.43	8.72	31.96	5.43
Nurses	65.59	10.45	22.19	5.83	33.21	4.87	36.1
Pharmacy	5.81	3.72	5.34	0	2.92	5.08	2.29
Oral Health	13.69	7.44	4.85	8.26	1.73	9.28	1.2
Total	**102.39**	**37.32**	**52.8**	**33.52**	**46.59**	**51.19**	**45.02**
IMR (per 1,000 live births)	17.3	7	9.6	16.2	12	13	43.1
MMR(per100,000 live births)	75	18.2	26.78	75.6	12.2	40	165.5

FACTS AND FIGURES[8]

- 37 333 doctors are registered with the HPCSA (1 April 2011)
- 22 820 GPs are registered with the HPCSA (1 April 2011)
- 32 854 GPs will be needed by 2014 (*Private Hospital Review*, 2008)
- 29.9 % of public sector posts are vacant (2006 *Health Review*)
- 25% of clinical posts in the public sector were abolished in favour of a 30% increase in administrative posts .
- 12 238 specialists are registered with the HPCSA (1 April 2011)

Private sector health care professionals are heavily concentrated in the provinces with the largest metropolitan areas. For example, while Gauteng (the province in which Johannesburg and Pretoria are located) has only 21% of the total population and 37% of medical scheme members, 45% of private sector doctors, dentists and pharmacists work in this province.

The main users of private providers' services are medical scheme members (15% of the population). Some South Africans who are not covered by medical schemes (less than 20% of non-scheme members) do utilise the services of private providers and pay for this on an out-of-pocket basis. The formal private providers most frequently used by this group are private GPs and private pharmacies (traditional and spiritual healers are also used by this group). Those who are not covered by medical schemes are unable to afford to use private hospital inpatient services.

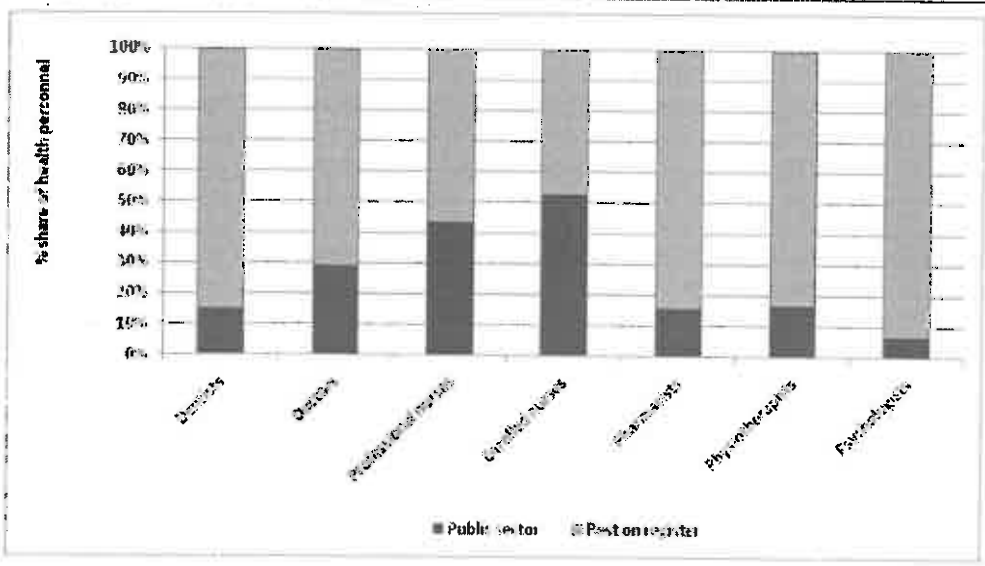
[7] Source: National Department of Health, 2011.

[8] THIS ARTICLE HAS BEEN PUBLISHED IN THE BULLETIN, THE NEWS MAGAZINE BY THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA) FOR SOUTH AFRICA'S HEALTHCARE PROFESSIONALS

The three largest private hospital groups have bought out smaller, previously independent hospitals, to such an extent that over 76% of private for-profit hospital beds are now located in hospitals owned by these hospital groups. This is of considerable importance as it has changed the balance of power between purchasers (medical schemes) and providers; the ability of these hospital groups to dictate prices for their services has contributed to the very rapid increase in medical scheme expenditure on private hospital services in recent years.

There is also vertical integration within the private for-profit sector; two of the largest private hospital groups also own the two private ambulance operators.

FIGURE 3: APPROXIMATION OF THE PUBLIC-PRIVATE MIX OF VARIOUS HEALTH PROFESSIONALS (2007) [9]



[10]In 2008 The CMS released a report focussing on pricing within the medical scheme industry and at that time made recommendations for a range of corrective measures to address uncontrolled escalation in health costs, including:

- removing market power imbalances between medical schemes and providers through re-establishment of central bargaining;
- removing conflicts of interest and other perverse practices in the health care supply chain;
- allowing salaried employment of doctors by private hospitals, which does not raise concerns of perverse conflict of interest;
- revision of the private hospital licensing system to address inappropriate market concentration;
- strengthening governance arrangements of medical schemes in the interests of members; and

If these measures had been put in place it would have gone a long way to addressing the ongoing battle with healthcare inflation

[9] **Source:** Day and Gray (2008)

[10] **REPORT ON MEDICAL SCHEMES COST INCREASES 2008**

TARIFFS FOR PAYMENT OF MEDICAL EXPENSES

Trying to understand how medical aid tariffs are calculated in the current private healthcare environment can be difficult, given all the industry jargon and acronyms such as BHF, NHRPL, ICD-10 and PMB and MMAP® (Maximum Medical Aid Price). Each of these terms has a specific meaning when navigating information provided by medical practitioners and medical aid providers.

Until recently, there were three tariff structures in South Africa:

- The Board of Healthcare Providers (BHF) tariff list,
- The HPCSA ethical medical rates
- The National Health Reference Price List (NHRPL).

In January 2004, the BHF tariff was discarded, in December 2008 the HPCSA ceased publishing its suggested rates and only NHRPL rates are currently used.

BOARD OF HEALTHCARE PROVIDERS (BHF) TARIFF

Until 2004, the BHF published its own list of recommended tariffs, which was developed through negotiation between the BHF and the South African Medical Association SAMA).

The BHF list was ruled in contravention of the competition act, which regulates activity between businesses and organisations that should be competitors. Therefore, the BHF is no longer publishing its list of recommended medical tariffs and this list been superseded by the NHRPL rates

NATIONAL HEALTH REFERENCE PRICE LIST (NHRPL)

The NHRPL was designed by the Council for Medical Schemes on behalf of the Department of Health and first published in 2004. This list does not contain negotiated prices, and is created by gathering submissions from all disciplines of health service with suggestions regarding the actual cost of running a practice.

Hospitals do not yet take part in the classification process and thus the NHRPL methodology of calculating its rates does not yet pertain to these institutions. Until HASA (Hospital Association of South Africa) and the Department of Health have reached consensus on the methodology that needs to be applied to calculate hospital tariffs, medical aid providers negotiate with these healthcare providers on an individual basis to decide on pricing.

It must be understood that the NHRPL is not always reflective of actual prices that may be charged at medical practices, but its rates are more of a guideline for practitioners and medical aid schemes around which they can calculate tariff structures and design benefit structures so as to minimise additional payments from insured members.

In the same way that doctors are not bound by the NHRPL, medical aid schemes are free to calculate their own medical scheme rates (MSR rates). Each medical aid scheme tends to use its own Medical Scheme Rate (MSR), which is created using the NHRPL as a guideline.

In October 2010 the Department of Health (DOH) and the Council for Medical Schemes

(CMS) released a discussion document[11]. They stated that the purpose of this document was to "stimulate debate and to elicit participation in a policy development process."

They noted that there were two parallel but distinct processes;

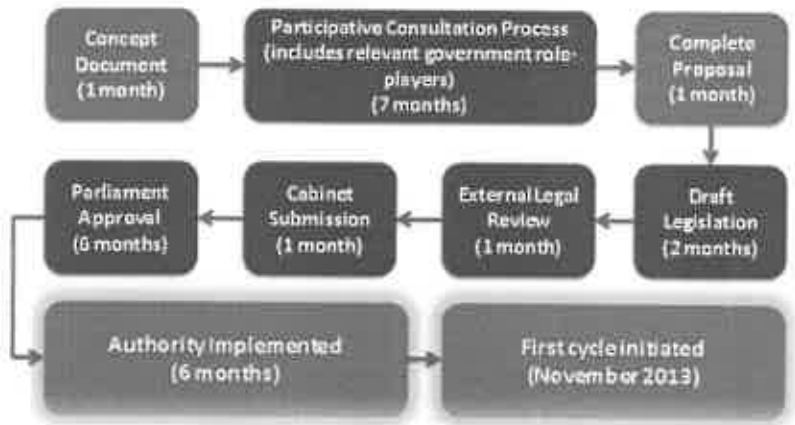
1. The first process is consultative in nature and seeks to arrive at the establishment of a healthcare price determination authority that would take at least three years before a proposed authority could be operational.

2. The second process aims to establish voluntary interim tariff negotiations led by a public authority. This process was supposed to commence after delineated exemption from certain provisions of the Competition Act has been obtained.

In the discussion document a diagram is given setting out the estimated duration for price determination and implementation

FIGURE 4: ESTIMATED DURATION OF POLICY DEVELOPMENT FOR PRICE DETERMINATION AND IMPLEMENTATION NHRPL

Figure 1: Estimated duration of the price-determination-policy development and implementation



In a second diagram they show that the envisaged pricing authority could be a commission that would function independently to ensure that the trust of all stakeholders could be achieved. The figure also identifies four potential functions of the authority:

1. The first is to manage a negotiation chamber where relevant healthcare prices could be negotiated on an annual basis.

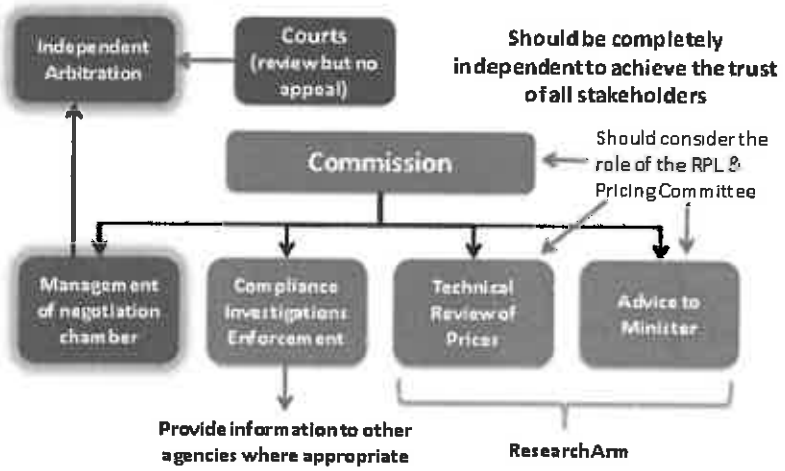
2. The second shows that provision should be made for an arbitration mechanism to ensure that prices are determined timeously.

3. The third and fourth proposes a compliance or enforcement function, as well as research function which could perform technical analysis of prices. This function could incorporate the RPL function as well as the current medicine pricing committee, and could have the express function of providing advice to the Minister in respect of healthcare costs. The research arm might also consider alternate remuneration mechanisms.

[11] **THE DETERMINATION OF HEALTH PRICES IN THE PRIVATE SECTOR**

FIGURE 5: KEY FEATURES OF THE ENVISAGED HEALTH PRICE DETERMINATION AUTHORITY

Figure 2: Key features of the envisaged health price determination authority



In the latest developments Minter of Health Dr Aaron Motsoaledi has stated that he intends to engage the Competition Commission on a decision that de regulated pricing in the private healthcare industry. [12] He said that lack of pricing regulation had created uncontrolled commercialism in the private sector brought about by the inability of medical schemes to enter into collective price benchmarking which was banned in 2004.

He further committed to the overhaul of all 52 health districts and the establishment of a pricing statuary commission to ensure that healthcare costs did not continue to "spin out of control in the private sector"

THE HPCSA ETHICAL MEDICAL RATES

Historically, there was another list of published rates which HPCSA (Health Professions' Council of South Africa) published: the so-called ethical medical tariffs. The HPCSA announced in November 2008 that it would no longer publish these ethical tariffs.

HPCSA also scrapped the previous limit of 300% of NHRPL thus freeing providers to charge any amount

[12] *UNREGULATED PRICING 'BAD FOR HEALTHCARE' 25 04 2012* **LONDIWE BUTHELEZI: BUSINESS REPORT**

IMPACT ON THE PAYMENT ENVIRONMENT WITHIN THE MEDICAL SCHEME INDUSTRY

The change in price regulation has had many repercussions throughout the medical and medical aid communities. The new system has undoubtedly filtered down to medical aid members.

There are two different methods of paying a doctor or specialist if a patient has medical aid:

1. Medical aid providers can pay their MSR directly to the patient or member. The patient is therefore responsible for paying the doctor the full amount for the procedure.

2. The medical aid provider can pay the doctor directly. In this case the patient or member will only be expected to contribute financially if the doctor's fees exceed the provider's contribution.

Medical aid providers are now unable to predict exactly what a doctor will charge for a specific procedure and so generally provide cover in relation to their MSR. If a particular medical aid scheme provides members with 200% of their MSR and the doctor charges the same amount or less, the patient is completely covered. If, however, the medical practitioner charges 250%, the patient is expected to pay the difference using their own funds

Increased competition in private healthcare will help put pressure on prices and encourage innovation in lower-cost delivery and a more stable pricing environment.

An online survey conducted by the CMS and published in the 2010/11 annual report as part of their member movement study, was used to better understand why members move between benefit options. It revealed that the most common reason members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options. The other common reason for changing benefit options was limited access to benefits, i.e. when members feel that they do not have adequate benefits in their current option, they seek out an option that offers the benefits that meet their needs.

[13]In a study published by Old Mutual Actuarial Consultants in 2010 - approximately three quarters of members interviewed indicated that they feel that their scheme is too expensive

Medical inflation can't be controlled by a simple annual cap on medical aid rate increases. The council put an 8% limit (5% CPIX plus 3%) on medical aid increases for 2012, but the high increase in the cost of medical services has continued.

In the face of rising prices from medical professionals and hospitals, the 8% cap is most often achieved by reducing benefits or members have been required to make co-payments for treatment. The burden of costs not Covered by medical aid becomes the responsibility of the medical scheme member.

Thorough measurement and a more comprehensive approach to supply and demand factors are needed urgently if medical inflation is to be tackled

[13] 2010 **OMAC Healthcare Monitor** Fact sheet

[14]According to the NHI Green Paper, South Africa spends 8.3 per cent of gross domestic product (GDP) between public sector (4.2 per cent) and private (4.1 per cent) sectors. A further 0.2 per cent (in foreign aid and the NGO sector) makes up a total of 8.5 per cent, which is extremely high expenditure, especially for a middle-income developing country. The World Health Organisation (WHO) recommends that countries spend at least 5 per cent of GDP on health and average expenditure for middle income countries is 5.8 per cent

Despite this high expenditure, South African health outcomes compare very poorly to those of countries which have similar national income and health expenditure. Life expectancy indicators vary according to data source but the most optimistic, contained in South Africa's Country Report on the Millennium Development Goals (MDGs), shows a decline for men from 57.6 years in 2001 to 55.3 years in 2009 and in the same period, for women from 64.8 to 60.4. According to a WHO calculation of disability-adjusted-life-years, South Africans can expect only 48 years of healthy life.

The main elements of the crisis are a public sector which is so badly designed and managed that health outcomes are poor and a private sector which serves its customers well, but at prices which ensure that only a small minority of the population can afford adequate coverage South Africa also carries a very high burden of disease amongst sectors of the population who cannot afford private healthcare interventions

Extensive studies commissioned by the British Medical Journal the LANCET, but conducted by South Africa's own scientists and researchers; clearly reveal that South Africa is going through four pandemics. "Put differently, the country is faced with a quadruple burden of disease

The first, most severe and very expensive burden or pandemic is that of HIV/AIDS and TB. The second is the unacceptably high maternal and child mortality. The third is an alarming and ever-increasing incidence of non-communicable disease, such as high blood pressure and other cardiovascular diseases, Diabetes Mellitus, chronic respiratory disease, the various cancers and mental health.

Violence and injury - The fourth and last one is what every South African knows and worries about, because of media reports on the situation on a daily basis. "It is the pandemic of violence and injury.

All of these are aggravated by the inequitable distribution of human and financial resources between the public and private sectors with resources mostly residing in the private sector.

[14] REFORMING HEALTHCARE IN SOUTH AFRICA What role for the private sector? Centre for Development and Enterprise 2011

[15]HEALTH INSURANCE PRODUCTS IN SOUTH AFRICA

Products in the health category in South Africa fall into both the "life" insurance and the short term markets. In short the difference between the two is:

Life insurance products are for "life", and once they have been entered into, they cannot be cancelled by the insurer (unless the insured defaults on the payment of the premium or there has been material non-disclosure by the client).

Short-term insurance contracts are essentially renewable at the discretion of the insurer, and are subject to (annual) adjustments to the premium and/or conditions of the policy.

Typical "health" insurance products in South Africa include:

Dread disease (critical illness) Cover – is for things like cancer, heart attack, stroke, kidney failure. It pays out over and above anything paid for by your medical aid or any other medical insurance. Statistically this is your most likely area of claim.

Impairment Cover is similar to disability Cover but is not a "subjective" form of Cover. The degree of impairment can usually be objectively measured by means of pre-specified definitions such as loss of a limb or limbs, loss of sight or hearing, fingers, major burns among many others.

Funeral policies are payable when the insured person dies (watch out for the exclusions on these policies). Typically there is little (if any) underwriting and as a result anyone can be Covered and the premium is quite expensive relative to the Cover provided.

Income protection and disability Cover is not really "medical" Cover but will often qualify for a claim if you can't work as a result of a medical condition. Income replacement Cover is more expensive but is the most likely area of a successful claim. Typically, disability Cover is subjective (at what stage are you disabled?) and as a result, the experience for would-be claimants can be quite difficult.

Hospital insurance is usually sold as a short-term insurance product (often advertised on TV) and pays a specified amount per day spent in hospital. No hospitalisation – no pay.

Gap Cover is a relatively new form of medical insurance cover. It is a short-term product that covers the Gap between what the hospital charges and what the medical aid pays. Again, no hospital, no cover.

[16] In South Africa however, health insurance dates as far back as the mid-1980s. Health insurance as we know it today was not always so streamlined. It started with Hospital Cash Products: probably the earliest form of health insurance, still sold in many of the major markets around the world. The cover varied as to the level of benefits and deferment periods and in many markets, was sold as part of a disability income product. The market in South Africa began developing in the mid-1980s, and by 1989 there were some 50 000 policies in place. This grew rapidly during the early 1990s, with the main sales channels being direct marketing through mailings and advertisements in the press.

[15] (Information obtained from Financial Planning Institute.)

[16] (Gregg Sneddon, Health24, March 2011)

Major medical Cover, similar to what we know today, was first started in the USA in the 1950s with benefits payable on occurrence of major medical events like surgery or chronic diagnosis. These kinds of products became available to South Africans in the mid-1980s, initially sold on a group basis. Since the early 1990s however, these products became available to individual policy holders. They have also been offered on a universal basis where the benefit is packaged with an endowment benefit by a life office.

By 1991 at least 13 South African insurers were marketing either Hospital Cash or major medical policies. These products did not fit clearly into either short-term or life business as they incorporated aspects of both. The initial split of business between life offices and short-term insurers was probably 80/20 as a result of the development skills and financial strength of the life offices. The short-term proportion increased as direct marketing has been used extensively as a sales channel by short-term insurers.

The Dread Disease product is recognised worldwide as a South African creation. These products were developed in the early 1980s and have largely become a standard addition to individual life products. Disability products are offered on a lump sum of income basis and the income benefits are usually included under pension or provident fund arrangements on a group basis. These products may also be purchased on a group or individual basis. The experience on these products varied significantly from one insurer to another depending on their underwriting and claims control. By 1994, the annual premiums for dread disease and group lump sum disability business totalled approximately R21 million while the premium income for permanent health insurance (income replacement) market totalled approximately R582 million.

In 1996, the Department of Health released a draft discussion document on the financing of the private health industry in South Africa. The document reiterated the need found by the Melamet Commission in 1994 of a single legislative framework for all healthcare products.

At the same time, the Short-term Insurance Act and the Long-term Insurance Act were also undergoing revision. The 1996 amendments to the Long-term Act had included medical schemes as funds under the definition of a "life policy" to facilitate the re-insurance of medical scheme benefits by life insurance funds. A separate definition for a "health policy" was introduced and was worded in such a way as to ensure that the way a medical scheme works (i.e.: paying medical expenses to a health service provider) is not replicated through a health policy. Thus, demarcation was considered at the time when the legislation was originally drafted.

By 1998 there was a significant market in both group and individual businesses. The annual premiums for dread disease and group lump sum disability business had grown to R535 million while the premium income for permanent health insurance totalled over R870 million. The new Long-term Insurance Act, the Short-term Insurance Act and the Medical Schemes Act were all promulgated in 1998. The wording in each allowed for the separation between indemnity business and health insurance. However, the interpretation of this led to further acrimony and unresolved resistance by the insurance industry.

[17] Following a High Court ruling in 2007, which prohibited the sale and marketing of so-called 'Gap' insurance products, a court ruling in April 2008 gave Guardrisk (a subsidiary of Alexander Forbes) the go-ahead to provide its niche insurance offering to South African consumers.

[17] FA News April 2008

With medical aid schemes under pressures due to rising medical costs and increasing regulation, since 2008 various other players besides Guardrisk have entered this area. With the difference between what medical schemes pay for in hospital expenses and the cost to medical aid members continuing to widen, this market has grown to just over 300,000 policyholders..

GAP COVER INSURANCE

GETTING THE FACTS RIGHT - WHAT IS GAP COVER?

Gap Cover insurance has evolved from an environment of ongoing disparity between what is covered by a medical scheme for major medical expenses and what is charged by healthcare providers within the private healthcare market

Gap Cover insurance products only cover a specified event or area of healthcare cost – major medical. All policies provide an aggregate per annum limit per individual and per family for major medical events and only come into effect once the medical scheme has paid a provider as per the benefit stated in the medical scheme handbook for benefit options.

Some policies will also cover additional out of hospital major medical costs where access to these benefits within the medical scheme environment has increasingly been limited as medical schemes try to save costs. These benefits include areas such as Chemotherapy, Dialysis's, MRI and Cat scans.

All policyholders who want to take out Gap Cover must be full members of a medical scheme and must qualify for the benefit being claimed for. All current Gap Cover polices available operate within the limitations of cover offered by the medical scheme benefit option of the policyholder – no payment for benefits not covered by the scheme. Outside of additional major medical benefits there is also a policy that if there is no hospital admission there is no payment. Therefore Gap Cover insurance is not involved in any out of hospital costs unless stated in the policy document

If younger healthier members in the medical scheme environment opt out of medical scheme cover, they are no longer eligible for Gap Cover.

[18]GETTING THE FACTS RIGHT: COST DRIVERS IN PRIVATE HEALTHCARE

Gap Cover insurance has evolved from an environment of ongoing disparity between what is covered by a medical scheme for major medical expenses and what is charged by healthcare providers within the private healthcare market. This scenario is unlikely to change in the next five years

The average annual cost of belonging to a medical scheme has increased fivefold in real terms since 1980. Average cost in 1980 was R1 805 (adjusted to 2008 prices to make comparison meaningful). By 2008 this had risen to R9 610 per life per annum. Data from the annual reports of the Council for Medical Schemes over the 30-year period since 1980 allow identification of cost drivers. The costs of benefits (93 per cent of costs in 1980 and 87 per cent in 2008) are the more significant drivers of increases.

[18] REFORMING HEALTHCARE IN SOUTH AFRICA What role for the private sector? Centre for Development and Enterprise 2011

Such significant increases should not be viewed in isolation, nor automatically and simplistically attributed to greed. In the face of consumer anger, medical schemes and providers (especially hospitals and professional associations) have offered competing explanations, each attempting to blame someone else. Left-leaning and government interests blame 'capitalist vultures'. Medical schemes blame the increases on providers, who they say are exploiting medical schemes by over-charging and by over-using services. Hospitals blame users for being older and sicker. Insurers and hospitals blame regulations for driving them not to compete on the basis of price. In many cases different interests offer competing analyses of the same facts.

One uncontroversial contributor to the rising price of medical aid is continuing reduction in use of state facilities by insured individuals. In 1989, provincial hospital care purchased by scheme members (which was already in decline) accounted for 27 per cent of schemes' expenditure (R149 of R410 in 2008 prices). Since then there has been a dramatic decline in parallel with the drop in standards of public hospital care

The range of diagnostic procedures and treatments has widened and includes increasing numbers of new and expensive procedures. The South African burden of disease has also changed in various ways, as has the demographic makeup of the insured population, as is the economy in which the prices of different inputs do not change uniformly. The regulatory environment has also not remained constant. Despite these difficulties, medical schemes and hospitals agree that a major driver of costs is increased hospital admissions.

The profile of the insured population has changed to one that includes more individuals who are relatively high risk, especially infants under one year of age and adults older than 40 years. Higher risk individuals need, on average, more medical attention, which costs more. So changing the risk profile of a group of insured individuals should be expected to lead to some cost increases.

The relative number of dependents on medical insurance has also declined, especially in open schemes. This may be evidence of the impact of reduced affordability, especially since it occurred against a backdrop of overall GDP growth and an increasing population

According to those in the hospital industry these changes explain increased admissions and lengths of stay. This view, which blames the changing patient profile, is disputed by the medical schemes. The 2008 CMS report on cost increases maintains that none of the frequently-cited factors – HIV/AIDS, legitimate utilisation, technology, nursing costs – can explain the increases. The CMS argues that they account for too small a fraction of claims. The same report argues that the main cost drivers are excessive investment in technology and utilisation patterns which are contrary to international trends (where hospital use in medically comparable populations enjoying similar health outcomes is declining). The CMS also documents both the rise in average age of members of open schemes, and the declining dependent ratio, but disputes the view that either is a major cost driver.

Whether or not the investment in technology by hospitals amounts to an incentive for doctors to use it, there is evidence of a pattern of over-servicing. The medical scheme industry sees this as an important cause of price increases. African private health sector has more MRI and CT scanners per million people than each of the United Kingdom, Canada, Germany and France

A second disputed area is the Prescribed Minimum Benefit (PMB) framework. This arises from the Medical Schemes Act of 1998, and makes a specific schedule of benefits mandatory for any scheme. Again, this interpretation is disputed. The most dramatic increases in the price of private insurance occurred before, rather than after, the

implementation of the PMB-framework. Since then prices have been comparatively flat in real terms.

Another important factor is the absolute shortage of doctors and specialists. Skills shortages affect the private sector as well as the public sector and help to drive up prices. [19]In research conducted in 2010 65% of Specialists interviewed indicated that they had no capacity for increased patient volumes. 8% of Specialists interviewed indicated a four week waiting period for new patients to get an appointment and 13% indicated a minimum two month waiting period. The implications of this are that increased patient volume is no incentive to leverage cheaper prices.

Research shows that 60 percent of specialists within the private sector practice from rooms within a private hospital. Hospital groups compete for the available skills as these drive hospital occupancy. However the hospital themselves have little control over allocation of services. Specialists decide who is admitted, which wards they should stay in and what diagnostic procedures, prescriptions and treatments should be used. Practitioners remunerated on a fee-for-service basis have little incentive to spend cautiously. Doctors and specialists are under no significant pressure to compete over price.

Medical schemes with sufficient numbers of members have been able to use this to leverage and set up provider networks where they are able to negotiate pre set tariffs that will be charged by providers for procedures and payment to the provider is guaranteed. These prices are higher than NHRPL but provide the medical scheme and the member with measurable costs. However even the largest medical scheme within the open medical scheme environment has not been able to encourage all specialist providers to participate in their networks.

TABLE 2: SHORT FALL IN COST CHARGED VERSUS WHAT IS PAID AT NHRPL / MSR[20]

Procedure	Cost	Medical Aid Payout	Shortfall	Gap Claim
Appendicectomy	R3,595.23	R1,198.41	R2,396.82	R2,396.82
Caesarean Section	R10,572.19	R2,689.80	R7,883.39	R7,883.39
Coronary Bypass	R26,376.35	R13,163.46	R13,212.89	R13,212.89
Hysterectomy	R12,977.80	R4,751.00	R8,226.80	R8,226.80
Tonsillectomy	R12,297.70	R4,119.91	R8,177.79	R8,177.79
Wisdom Teeth Removal	R6,260.00	R1,958.50	R4,301.50	R4,301.50

[19] Catalyst Pulse Specialist response to a possible NHI environment 2010
[20] www.CovertheGap.co.za

FIGURE 6: MEDICAL SCHEME COST TRENDS COMPARED TO INTERNATIONAL BENCHMARKS

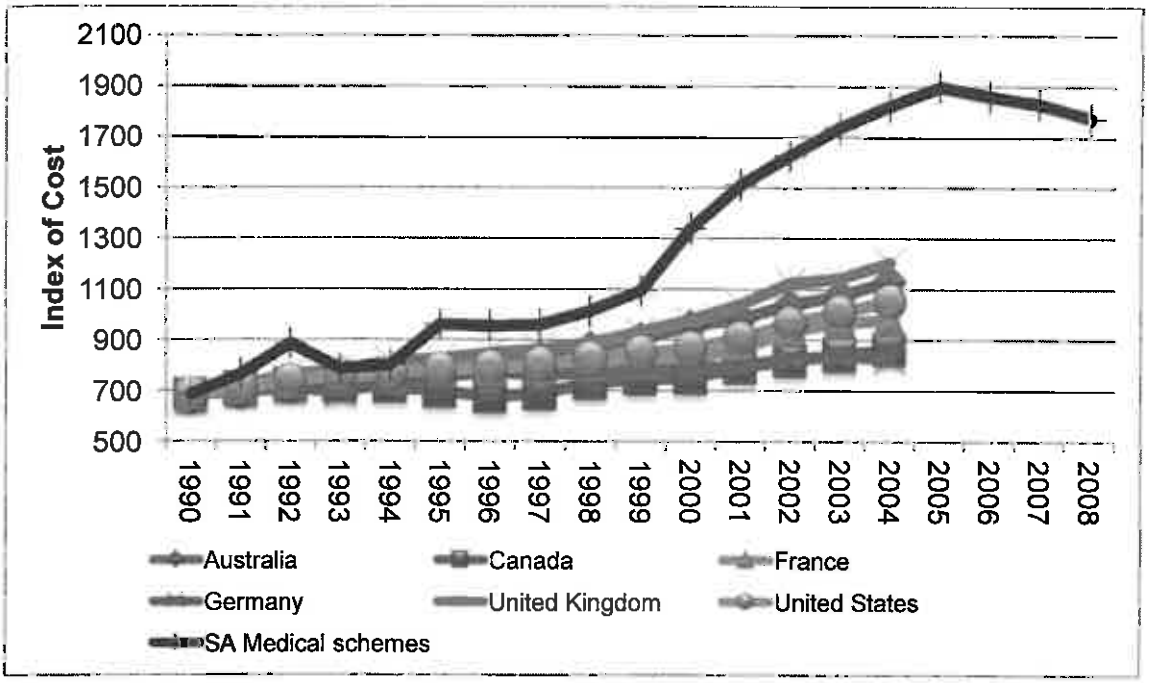
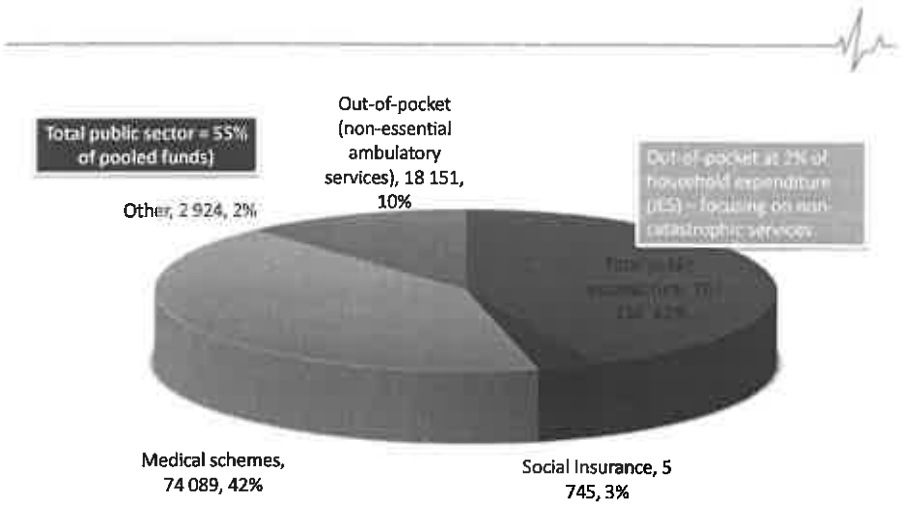
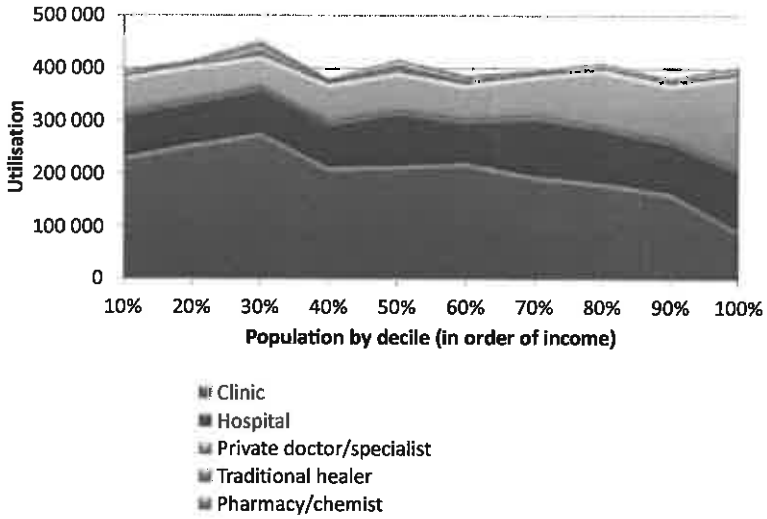


FIGURE 7: NATIONAL HEALTH EXPENDITURE 2008



Sources: Budget Statements, Council for Medical Schemes, Annual Reports of Social Insurance Funds

FIGURE 8: ANNUAL SERVICE UTILIZATION BY DECILE (NMS)



Van den Heever, Health Fiscal Incidence Analysis, National Treasury, 2009

The very low utilisation of services other than Clinic, Hospital and Private Doctor/Specialist means that these services are reviewed by province. The national analysis retains all the services purely for the sake of completeness.

This slide shows how the magnitude of utilization varies by population decile, in order of income, for the non-medical scheme population. Of interest is the clear substitution of private doctor/specialist services for clinic services from the 7th decile.

This shows that for ambulatory care higher income groups prefer to pay privately for services even though they are not Covered by a medical scheme and public services are free.

TABLE 3: TOTAL MONEY PAID OUT TO TOP 12 SPECIALIST DICIPLINES

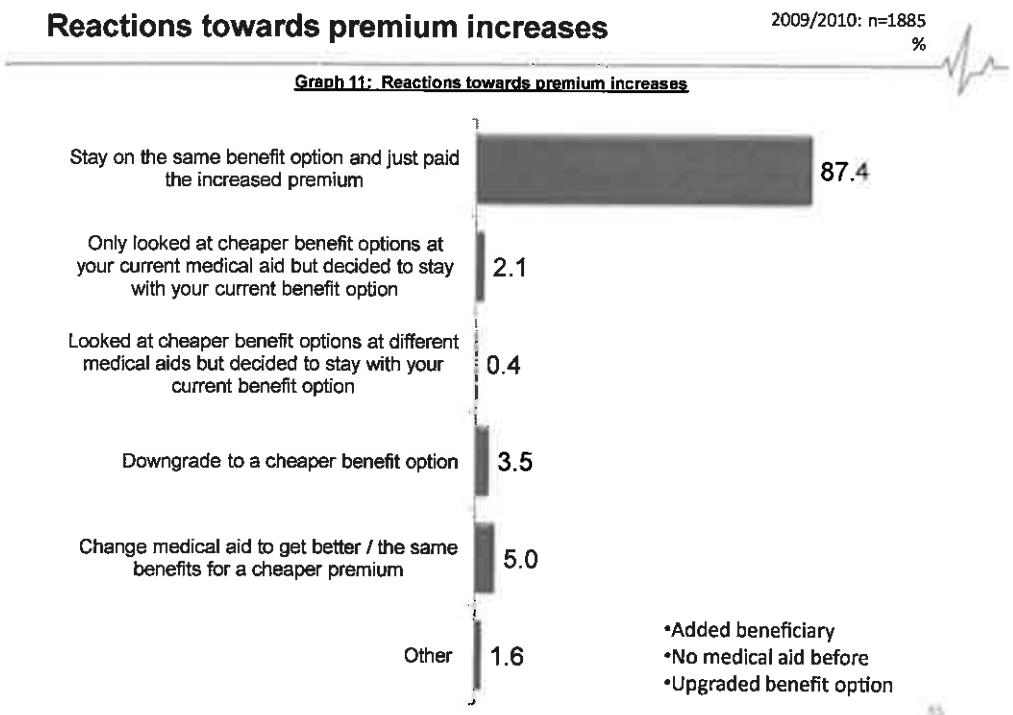
Money paid out to specialists 12 highest amounts	
Total paid out medical specialists	**R 1 602 382 165**
Pathologists	30.2%
Radiologists	18.5%
Gynaecologists	12.1%
Paediatricians	5.6%
Ophthalmologists	4.8%
Physicians	4.7%
Cardiologists	2.9%
Orthopaedic surgeons	2.8%
Psychiatrists	2.4%
Otorhinolaryngologists (ENT)	2.3%
Surgeon	2.0%

[21]GETTING THE FACTS RIGHT: MEMBERS AND MEDICAL SCHEMES

Affordability is a major challenge for medical scheme members when faced with the annual price increase in medical scheme premiums. Much has been claimed in public forums by various organisations and leadership sources with regard to member "buy down " to cheaper medical scheme benefit options. Data collected by Catalyst Pulse over the past three years across members and healthcare intermediaries indicates that there is very little movement of members across benefit options. The majority of medical scheme members mostly remain on the benefit option that they have chosen despite increased medical scheme premiums.

Healthcare intermediaries indicate that movement between options range year on year between 4 and 7% with a larger percentage buying up than those who buy down. The largest contributing factor say intermediaries is that new members are buying more appropriately when they join a scheme in line with their budget and life stage.

FIGURE 9: SWITCHING BEHAVIOR WHEN FACED WITH PREMIUM INCREASES [22]



[21] REFORMING HEALTHCARE IN SOUTH AFRICA What role for the private sector? Centre for Development and Enterprise 2011

[22] Catalyst Pulse annual tracking study PHP 2009/10

TABLE 4: SWITCHING BEHAVIOR WHEN FACED WITH PREMIUM INCREASES GAP COVER POLICY HOLDER OVERALL [23]

Overall	Gap Cover Research 2012	PHP
Did nothing other than just pay the increased premium	78	87
Looked at cheaper benefit options at your current medical aid ONLY but decided to stay with your current benefit option	4	2
Looked at cheaper benefit options at different medical aids but decided to stay with your current benefit option	1	1
Downgraded to a cheaper benefit option	-	4
Upgraded my benefit option	-	5
Changed medical aid to get better / the same benefits for a cheaper premium	-	2
Remained on my current benefit paid the increased premium and took out a medical insurance Gap Cover product	16	
Downgraded to a cheaper option and took out medical insurance Gap Cover product	-	

By age category	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus
Did nothing other than just pay the increased premium	78	64	68	79	83	86
Looked at cheaper benefit options at your current medical aid ONLY but decided to stay with your current benefit option	4	7	6	6	4	1
Looked at cheaper benefit options at different medical aids but decided to stay with your current benefit option	1	4	1	3	0	0
Downgraded to a cheaper benefit option	-	0	0	0	0	0
Upgraded my benefit option	-	0	0	0	0	0
Changed medical aid to get better / the same benefits for a cheaper premium	-	4	0	0	0	0
Remained on my current benefit paid the increased premium and took out a medical insurance Gap Cover product	16	21	25	10	13	13
Downgraded to a cheaper option and took out medical insurance Gap Cover product	-	0	0	0	0	0

[23] Interviews were completed with 300 Gap Cover policyholders

By Total Household income category	Overall	R6000 - 9999	R10000 - 19999	R20000 plus
Did nothing other than just pay the increased premium	78	**85**	69	78
Looked at cheaper benefit options at your current medical aid ONLY but decided to stay with your current benefit option	4	-	5	6
Looked at cheaper benefit options at different medical aids but decided to stay with your current benefit option	1	-	4	-
Downgraded to a cheaper benefit option	-	-	-	-
Upgraded my benefit option	-	-	-	-
Changed medical aid to get better / the same benefits for a cheaper premium	-	-	-	-
Remained on my current benefit paid the increased premium and took out a medical insurance Gap Cover product	16	15	**21**	16
Downgraded to a cheaper option and took out medical insurance Gap Cover product	-	-	-	-

Research completed with policyholders who currently have "Gap Cover insurance, to ascertain if the behaviour pattern deviates from the norm with members who have Gap Cover insurance in place shows the same pattern.

Respondents in the 20 – 30 year age category were the age group most likely to take out Gap Cover insurance and respondents in the R10,000 – 20,000 per month total household income bracket. This income bracket is where unexpected expenses have the greatest impact on very tight budgets, and where life stage costs of child bearing and young families are most likely.

In the top eleven open plan medical schemes across all benefit options, only 36% of benefit options offered the option of a network of providers where all costs would be covered. 45% of these were lower income options. 60% of the benefit options offered under 200% of NHRPL for hospital costs and 80% of the benefit options paid less than 200% of NHRPL for Specialist costs.

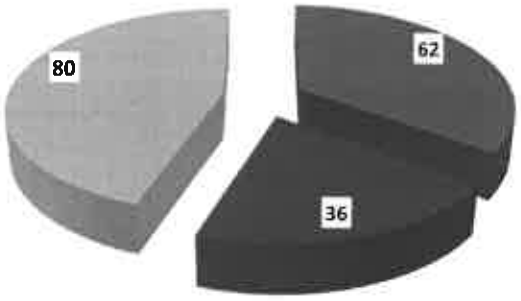
In an evaluation of 2012 medical scheme benefits offered across 30 closed and open schemes representative of 80.5% of the total medical scheme membership the following data was collected.

[24] TABLE 5: MEDICAL SHEME BENEFIT REIMBURSMENET % OF NHRPL

Re-imbursement category NHRPL or Medical scheme tarrif	Number of main members	% of sample members
100% options	2 075 170	70%
120- 125% options	85 928	3%
150% options	32 292	2%
200% options	681 224	23%
300% options	51 993	2,5%
Total members represented	**2 926 607**	

The implications of this are that even if the medical scheme member were to buy up to the most expensive benefit option available within the suite of benefits offered by their medical scheme it would be of no avail in protecting them from unexpected in hospital costs. According to the CMS' Annual Report 2010-2011, of the 316 benefit options offered by 100 registered medical schemes, only 22% provide in-hospital Cover in excess of 100% of the relevant medical scheme tariff

FIGURE 10: TOP 11 OPEN PLAN MEDICAL SCHEMES AND GEMS - PAYMENT RATES– MAJOR MEDICAL BENEFIT PAYMENT OPTIONS AS A % OF BENEFIT OPTIONS AVALIABLE [25]



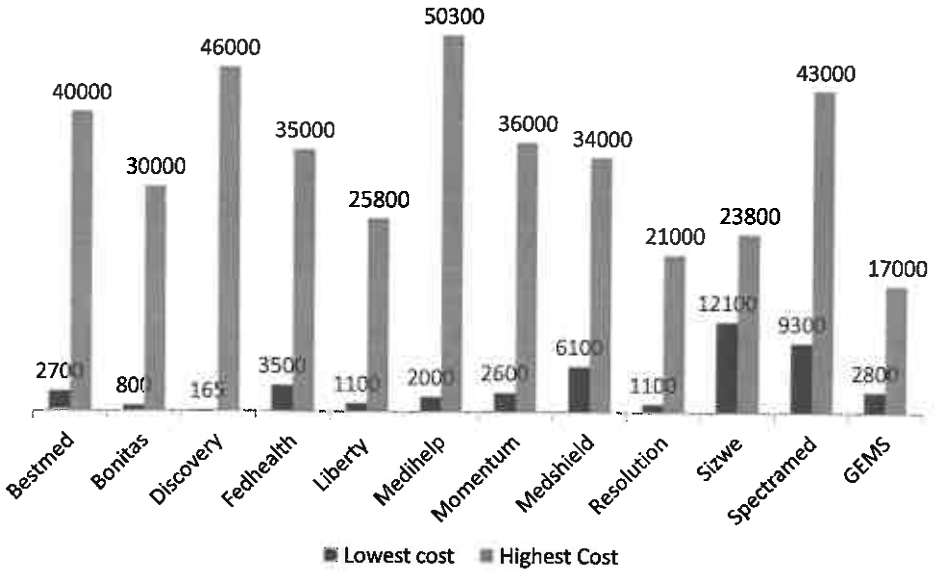
Benefit brochures 2012

[24] Scheme benefit options 2012
[25] Scheme benefit brochures 2012

Unfortunately upgrading to a more costly benefit option for most medical scheme members will simply enhance the out of hospital benefit available. In 80% of options available across the top 10 open plan medical schemes and the top 5 closed schemes, upgrading to a higher benefit option will not enhance benefits available with regard to major medical in hospital costs to the point where they are unlikely to have any out of pocket expenses.

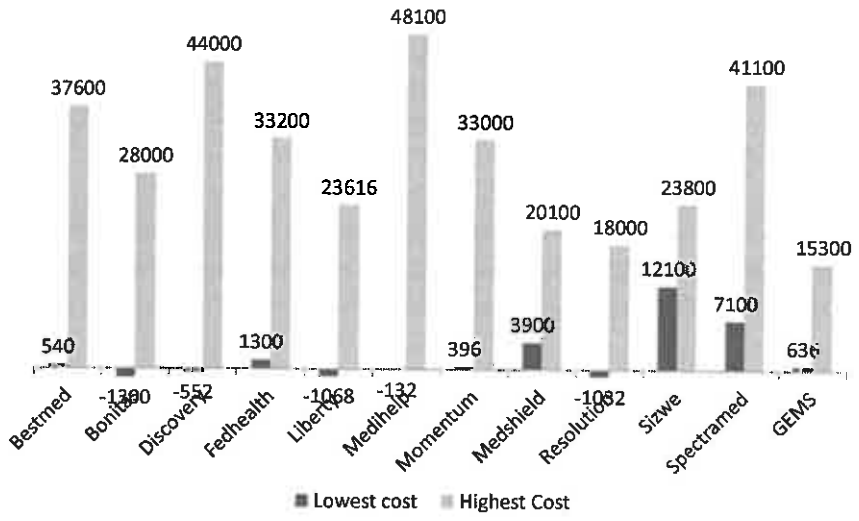
In most instances it is much more cost effective for a medical; scheme member to take out Gap Cover insurance for unexpected major medical costs incurred in hospital than it is to upgrade to a medical scheme benefit option that cannot offer the guarantee of total cover for in hospital / major medical costs.

FIGURE 11: APROXIMATE ANNUAL COST TO MEMBER TO UPGRADE TO NEXT BENEFIT OPTION VERSUS TAKING OUT GAP COVER WITH A PREMIUM OF R145 PER MONTH (R1745 PER ANNUM)



Premium to cover Principal member, 1x Adult dependent 1x Child dependent

FIGURE 12: APROXIMATE ANNUAL COST TO MEMBER TO UPGRADE TO NEXT BENEFIT OPTION VERSUS TAKING OUT GAP COVER WITH A PREMIUM OF R329 PER MONTH (R3948) PER ANNUM)



Premium to cover Principal member, 1x Adult dependent 1x Child dependent

Although the CMS recommended than medical scheme premium increases should not exceed more than 6% for 2012, in reality all increases were mostly between 8 – 12%. Consistently year on year for the past 5 years medical scheme premium increases have been a minimum of 2% above CPI.

[26]In most instances medical scheme members do not have an option as to which medical scheme they can choose. Research shows that in 72% of instances it is the employer who makes a choice and chooses the medical scheme. Even where companies have moved to a cost to company structure, in most instances it is a condition of employment that the employee must have medical scheme cover and the employer will offer a company scheme.

When looking at premium costs one of the issues that need to be remembered is that for 74% of medical scheme members the employer contributes to their medical scheme premium. In most instances this is 50% of the medical scheme premium. So members as such are not exposed to the full cost of their medical scheme premium.

For a household of 2 adults and 1 child on a medium benefit option offering 100% of NHRPL for all in hospital costs, with one of the top 10 open plan medical schemes, the medical scheme premium after employer contribution would account for 13% of their total income. To upgrade to a higher option that would offer 300% of NHRPL payment with regard to in hospital expenses would increase their medical scheme contribution to 33% of their total household income. To take out Gap Cover that would assure them of payment of the difference between the 100% of NHRPL paid by the medical scheme to 500% of NHRPL will increase their medical contributions by 2% from 13% to 15% of total household income per month.

[26] Catalyst Pulse PHP 2010

TABLE 6: PERCENTAGE OF SALARY TO UPGRADE VERSUS TAKING OUT GAP COVER INSURANCE

	Medical scheme deduction	% of R10,000 total household income
Medium benefit option 150% NHRPL monthly premium after 50% employer contribution	R 1327	13%
Medium benefit upgraded option 300% NHRPL monthly premium after 50% employer contribution	R 3.629	33%
Medium benefit option 150% NHRPL monthly premium after 50% employer contribution plus R140 Gap Cover premium to 500% NHRPL	R 1,467	15%

The reality for medical schemes is that they are unable to offer Cover at 300% of NHRPL across all schemes. The middle benefit options are cross subsiding most top end and low end medical scheme benefit options. The top end benefit options because these options mostly have a high claims to contribution ratio and the lower end benefit options because premium income does not cover claims payment.

Unprofitable benefit options can also not always just be closed, because higher-claiming members then move into another option that is not priced at the right level to pay the prescribed minimum benefits (PMBs) that schemes must by law provide to members. Very sick members, such as those with cancer, renal failure or diabetes, will never contribute enough to cover their claims. Besides using the greater benefits offered on top options, these members have higher hospital and PMB claims.

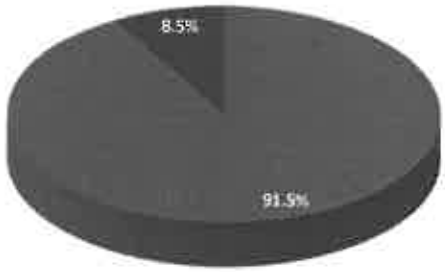
While the intention of the Medical Schemes Act was to ensure that sicker members of schemes were not charged more than healthy members, the impact is that higher options have a similar problem with deficits, and have to be cross subsidised from plans with healthier profiles.

Similarly, low-income plans tend to run deficits because of the relatively low contribution levels on these plans. This is also largely in line with the intention of the Act, which is that the poorest receive a subsidy from the relatively wealthy. The overall view is that the most important issue is to ensure the sustainability of the scheme as a whole. However the way this is done by many schemes is to continue to cut benefits on middle and lower options to absorb these losses.

GETTING THE FACTS RIGHT: MEDICAL SCHEME MEMBERS UNDERSTANDING OF THE ROLE OF GAP COVER

FIGURE 13: DEMOGRAPHICS OF GAP COVER POLICY HOLDERS WITHIN THE MEDICAL SCHEME MEMBER ENVIORNMENT [27]

Gap cover policyholders as a % of total medical scheme market



CMS Annexure for the year ended 31 December 2010 Industry Data suppliers Gap Cover Insurance

To gain a better understanding of policy holders understanding of the role that Gap Cover Insurance plays research was done with 300 policy holders.

Results produced the following findings:

- Policy holders interviewed **DO NOT** perceive Gap Cover to **replace a medical scheme product**.
- Gap Cover is perceived as **an enhancement** to assist in paying for the cost Gap between what the medical scheme pays and what is charged by medical providers
- The association with Gap Cover insurance Cover is more aligned to the medical scheme than it is to the insurance industry
- Respondents are very clear in their understanding of the scope of Cover offered by Gap Cover insurance and its stated purpose
- Three factors are the main contributors to the reason why medical scheme members have taken out Gap Cover. They are :
    - Inability to accommodate the increased cost of buying up to a higher medical scheme benefit option
    - Concerns as to how member would pay in hospital medical costs that are not Covered by their medical scheme benefit
    - The fact that even if member were to upgrade their medical scheme benefit option in
    - most circumstances it would not Cover all in hospital medical costs

89% of the policy holders who participated in the research indicated that they had been members of a medical scheme for three years or longer. Most have taken out Gap Cover insurance in the past 2 years

[27] CMS Annexure for the year ended 31 December 2010 Industry Data suppliers Gap Cover insurance

TABLE 7: POLICYHOLDERS MEMBERSHIP OF A MEDICAL SCHEME

	Length of membership of a medical scheme	Length of membership of current medical scheme	Length of membership of current benefit option	Length of time member has had Gap Cover
<1 year	2	4	6	18
1 – 2 years	8	18	25	46
3 -5 years	13	23	24	22
6 – 10 years	19	16	15	9
> 10 years	57	39	29	4

Policyholders indicated a clear understanding of the NHRPL rate of payment or of their own medical scheme tariff that would be paid in the even of of a claim. Younger respondents had better understanding of NHRPL while older respondents were more aware of the medical scheme tariff.

TABLE 8: POLICYHOLDERS UNDERSTANDING OF THE RATE PAID BY THEIR MEDICAL SCHEME

Understanding of NHRPL / medical scheme tariff	Overall	20 - 29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
It is a fixed price that is regulated to be paid to medical scheme providers	28	46	35	28	21	22	15	25	38
It is the price the medical schemes pay to healthcare providers	61	46	56	66	65	63	65	61	52
Don't Know	11	7	7	7	13	15	20	12	10

When asked at what rate their current medical scheme paid for in hospital costs 29 % of the policyholders were unaware of the rate paid by their scheme. 52% indicated that the rate aid was 100% of NHRPL with only 19% indicating that payment was made at 200% plus of NHRPL

TABLE 9: RATE PAID BY MEDICAL SCHEME FOR INHOSPTIAL COSTS

Current rate paid by the medical scheme for hospitals and specialists	
100% NHRPL or Scheme Tariff	52
200%	9
300%	5
400%	5
Don't Know	23

TABLE 10: POLICYHOLDERS UNDERSTANDING OF THE INSURANCE COVER OFFERED BY GAP COVER INSURANCE - UNPROMPTED

Unprompted - *What is your understanding of the insurance Cover that this policy gives*	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
Gap Cover pays costs not Covered by medical scheme	98	100	100	98	94	99	100	98	99
I am not sure what Cover this policy provides	1	0	0	2	4	0	0	1	0
Some other reason	1	0	0	0	2	1	0	1	1

Policyholders indicated a very clear understanding of the role of Gap Cover Insurance

TABLE 11: POLICYHOLDERS UNDERSTANDING OF GAP COVER INSURANCE - PROMPTED

Prompted – Which ONE phrase that I am going to read best describes your understanding of Gap Cover insurance	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
Gap Cover is a substitute for medical aid Cover	4	7	3	2	6	3	4	7	3
Gap Cover is an additional medical scheme benefit offered by a medical scheme	76	68	75	77	75	78	76	68	75
Gap Cover insurance is an insurance product offered by an insurance company who are not connected to a medical scheme	21	25	23	21	19	18	21	25	23
None of the above	-	-	-	-	-	-	-	-	-

Of interest is the very strong association that policyholders have with the concept that Gap Cover is an additional benefit offered by a medical scheme. Within this context it is perceived as a value add product and enhances the value medical scheme members perceive their medical scheme to offer.

TABLE 12: REASONS GIVEN FOR TAKING OUT GAP COVER INSURANCE

	Overall	20 - 29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
Given to us as part of our company employee benefits - employer pays the premium	15	11	17	20	13	14	20	12	19
Offered to us by our employer but we pay the premium ourselves	12	7	8	13	15	15	15	12	10
The medical scheme does not pay enough to Cover my medical bills if I need to be hospitalized and I am concerned as to how I would afford to pay what is not Covered	**61**	**75**	62	52	65	60	**65**	**67**	54
The medical scheme benefits have changed and we have to pay a co payment for certain procedures which I cannot afford	9	11	7	11	6	9	-	7	11
I have a health condition that the medical aid do not give very much Cover for and so I needed to insure the risk	8	0	8	10	4	10	10	10	5
The medical aid has limited the amount of money they will pay out for certain health conditions and I want to make sure I will have enough money to Cover every eventuality	**36**	39	**41**	28	37	32	15	**45**	**41**

Affordability of unexpected medical costs is the main reason presented for taking out Gap Cover insurance. This underpins the findings of other research quoted in this report where affordability is a very real challenge for many medical scheme members.

GETTING THE FACTS RIGHT: DOES HAVING GAP COVER IMPACT ON MEDICAL SCHEME MEMBERS DECISIONS ABOUT BENEFITS

Respondents were asked what impact taking out Gap Cover insurance had on their decision making process with regard to remaining on their current benefit option or moving to a cheaper option.

84% of the policyholders interviewed indicated that taking out Gap Cover insurance did not cause them to downgrade their medical scheme benefit option. The higher percentages of policyholders who did change their benefit option to a cheaper option were in the 20 – 29 age group and the R6 – 10,000 income category.

TABLE 13: IMPACT OF GAP COVER INSURANCE ON BENEIFT CHANGES

	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
No I did not change my medical scheme benefit option	84	71	82	90	85	86	80	80	80
I changed my medical scheme benefit to a cheaper benefit option	12	18	14	8	8	13	20	15	13
I changed my medical scheme benefit to a more expensive benefit option	3	7	3	2	8	1	-	5	5
Changed jobs	1	4	1	-	-	-	-	-	2

When asked about the impact taking out Gap Cover insurance had had on decisions around their medical scheme benefit 43% indicated that because of taking out Gap Cover they could afford to remain on their current benefit option and not buy down. 33% indicated that buying up to a higher option on their medical scheme would not help them as it would not provide additional Cover for in hospital costs and 20% indicated that Gap Cover would ensure that they did not have any financial difficulties if there were unexpected in hospital costs as they could only afford a cheaper benefit option with limited benefits.

TABLE 14: IMPACT ON CURRENT MEDICAL SCHEME BENEFIT OPTION FROM TAKING OUT GAP COVER INSURANCE

Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
Taking out Gap Cover insurance means I do not have to buy up to a more expensive benefit option to ensure my medical costs are all Covered								
24	18	24	13	29	30	40	18	25
Taking out Gap Cover insurance means I can afford to remain on my current benefit option and I do not have to buy down to a cheaper benefit option to ensure I would have money to pay for unexpected medical expenses								
43	32	35	59	35	47	50	38	48
I have to have Gap Cover insurance because none of the medical benefit options offered by my scheme offer full Cover for medical expenses								
33	43	35	31	42	23	15	37	40
My income is such that I can only afford a cheaper medical scheme benefit option and I have Gap Cover insurance so that I will not suffer financial hardship from unexpected medical costs.								
20	18	21	15	31	15	10	14	14
My medical scheme offer a network of doctors / hospitals but I have taken Gap Cover insurance so I can choose which doctors / hospitals I use								
19	21	25	20	12	22	10	16	16

I am a pensioner and cannot afford the level of Cover I enjoyed when I was employed full time. I have had to take out a cheaper medical scheme option and have Gap Cover insurance to pay for unexpected medical expenses								
8	7	8	10	2	29	30	6	4
My employer does not offer a subsidy for the higher medical scheme benefit options that would offer full Cover for all medical expenses but has offered us Gap Cover insurance to make sure all medical costs would be Covered.								
1	-	-	2	-	2	5	2	1

GETTING THE FACTS RIGHT: WHAT IF GAP COVER IS TAKEN AWAY AND NO LONGER AVALIABLE

Respondents were asked what the scenario would be if Gap Cover insurance were no longer available and they faced unexpected in hospital medical costs. 42% of the policyholders indicated that they would have to go into debt to be able to pay the amount owing off over a period of time and 35% indicated that they would be unable to repay any money not Covered by medical aid.

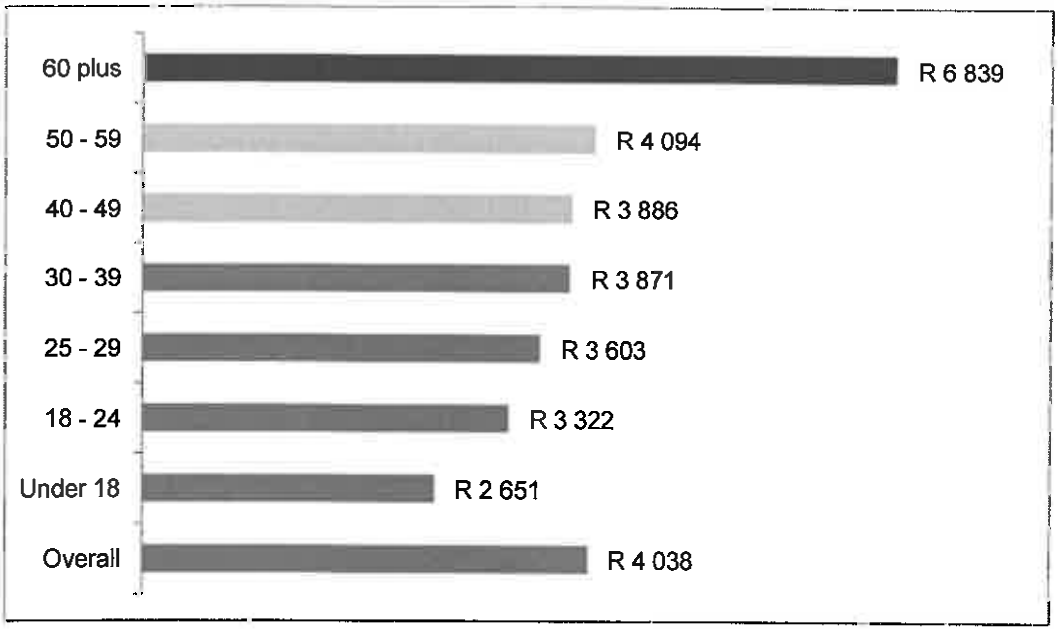
TABLE 15: ABILITY TO PAY SHORTFALL ON IN HOSPTIAL MEDICAL COSTS IF IT SHOULD ARISE.

	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
Yes I would be able to pay the shortfall that occurred straight away without having to go into debt	21	21	28	18	25	15	5	25	23
I would be able to pay the shortfall straight away but would have to make use of a debt facility or borrow money and repay it over a period of time	17	18	21	23	17	10	5	13	31
I would have to make a payment arrangement with the doctor/s	**25**	29	21	26	23	29	35	20	23
I would not be able to repay the shortfall as I cannot not accommodate it in my budget	**35**	29	28	31	**33**	**45**	**55**	**41**	21

TABLE 16: IF NO GAP COVER IS AVALIABLE WHAT IS THE LIKELIHOOD THAT POLICYHOLDERS WOULD BUY UP TO A MORE EXPENSIVE BENEFIT OPTION

	Overall	20 - 29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
I can afford to upgrade and I would upgrade to a more expensive option	10	7	18	15	4	5	10	10	14
I can afford to upgrade but my medical scheme pays the same benefit across all benefit options	12	11	12	13	19	11	-	8	12
If Gap Cover insurance were no longer available I would have no option but to upgrade even though I cannot really afford it	29	32	34	34	33	16	5	36	33
I would not be able to pay more for medical scheme premiums as I cannot accommodate it in my budget	44	43	34	36	40	64	85	43	35

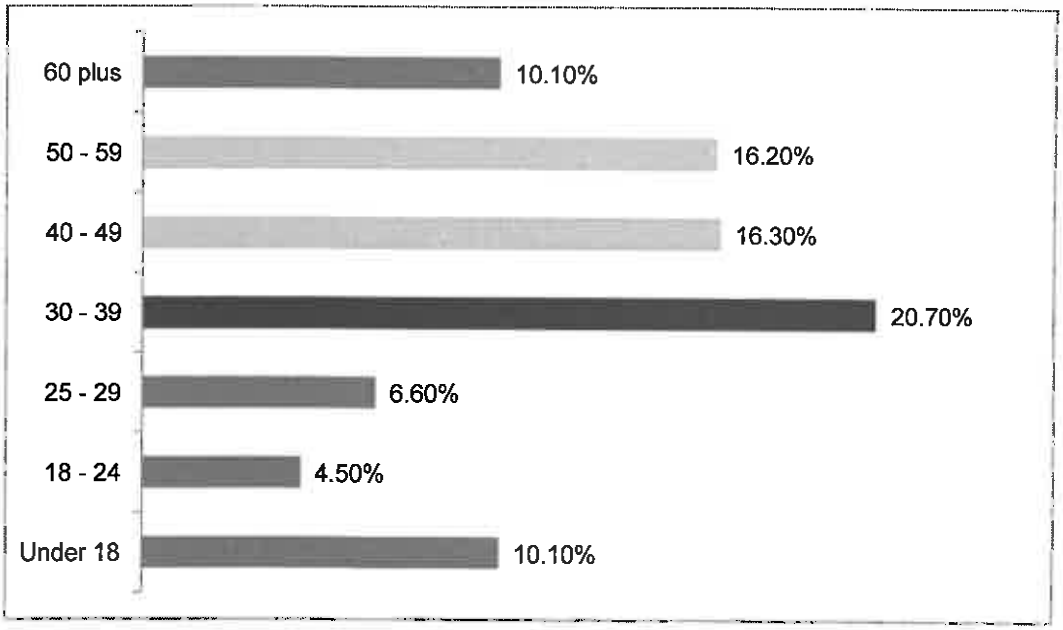
FIGURE 14: AVERAGE VALUE OF CLAIMS PAID OUT BY AGE GROUP [28]



[28] Data supplied by Gap Cover insurers who participated in this study. n = 48 600 claims

We are able to see that the average cost of claims being paid out by Gap Cover increase as policy holders get older. We are also able to see that the highest number of claims received is in the 30 – 39 year age Gap. A high percentage of these are associated to childbirth.

FIGURE 15: PERCENTAGE OF TOTAL CLAIMS PAID BY GAP COVER INSURANCE BY AGE GROUPING [29]



When asked to indicate the claim amount paid out by their Gap Cover insurance 51% of policyholders interviewed indicated that the amount paid out was in excess of R6000.

TABLE 17: MONEY PAID OUT TO POLICYHOLDERS FOR IN HOSPTIAL CLAIMS 2011 -12 [30]

	Overall	20 -29	30 - 39	40 - 49	50 - 59	60 plus	R6000 - 9999	R10000 - 19999	R20000 plus
R1-3000	17	36	10	27	13	15	18	16	21
R4-5000	17	9	17	15	13	23	36	21	14
R6-10000	27	36	32	33	21	21	27	24	31
R10-R15000	14	-	20	12	17	11	9	22	11
R16-20000	6	-	5	3	8	9	-	5	6
More than R20000	4	-	2		13	6	9	7	1
Don't know	14	18	15	9	17	15	-	5	15

[29] n = 46800 claims
[30] n = 162 policyholders who claimed from their Gap Cover insurance

GETTING THE FACTS RIGHT: EXCLUSIONS TO COVER

Gap Cover providers have been accused of pre selection of policy holders and the exclusion of potential claimants by reason of age or pre existing conditions. Examination of the exclusions listed by medical schemes and Gap Cover insurers show very similar patterns with regard to scope of Cover.

In comparing the exclusions of the two benefits, allowance must be made for the fact that Gap Cover is not offering full medical scheme Cover but is only offering Cover for major medical in hospital expenses not covered by a policyholder's medical scheme.

EXCLUSIONS PERMITTED BY A MEDICAL SCHEME

Medical Schemes may not refuse an application by a prospective member to join the fund. They are however allowed (by the CMS) certain measures to protect their risk.

All new medical scheme members who are below the age of 35 and have never belonged to a medical scheme will be subject to a 3 month waiting period before being able to access any medical scheme benefits including PMB Cover and a 1 year waiting period for any pre existing condition.

Where a new member has never belonged to a medical scheme and is 35 years of age or above late joiner penalties may be applied, calculated as a percentage of years without credible Cover from age 35.

If a member has belonged to a medical scheme for 2 or more years but has experienced a break of more than 90 days between membership then the 3 month waiting period will apply as well as a 12 month condition specific waiting period

If a member belonged to a medical scheme for two years or longer, without a break of no longer than 90 days, no exclusions may be imposed, but a 3 month waiting period may well be.

For all PMB conditions a medical scheme may appoint a Designated Service Provider (DSP). This is a healthcare provider (doctor, pharmacist, hospital, etc) that is the medical scheme's first choice when a PMB condition needs attention. State facilities can be designated as a DSP only where services are reasonably available and accessible. When a member makes a choice not to use the DSP, they may have to pay a portion of the claim (a co-payment).

Medical schemes often put rules in place that state which treatments and medicines they will cover and which not. These are so-called protocols and formularies that schemes use to manage members' use of benefits and reduce the schemes' risk. The minimum standards for treatment of all PMB conditions have been published in the Government Gazette, and are known as treatment algorithms. A scheme may decide for which medicines it will pay for a medical condition, but the treatment may not be below the published standards.

Exclusions / Scope of Cover is also based on the particular benefit option that is chosen by a medical scheme member. Other standard exclusions may include:

- Cosmetic procedures and treatments
- Otoplasty for bat-ears, portwine stains and blepharoplasty (eyelid surgery)
- Breast reductions or enlargements and gynaecomastia
- Obesity
- Frail care

- Infertility
- Wilfully self-inflicted illness or injury
- Alcohol, drug or solvent abuse
- Wilful and material violation of the law
- Wilful participation in war, terrorist activity, riot, civil commotion, rebellion or uprising
- Injuries sustained or healthcare services arising during travel to or in a country at war
- Experimental, unproven or unregistered treatments or practices
- Search and rescue
- Any costs for which a third party is legally responsible

There are also various other exclusions or benefit ceilings included in the various benefit options available through a medical scheme with regard to the scope of Cover given under a policy. These are mostly based on the premium being paid for the Cover.

EXCLUSIONS PERMITTED BY A GAP COVER POLICY

Gap Cover insurance providers have taken certain measures to protect their risk

Gap Cover insurance providers do not ask potential policy holders for a full medical history before providing Cover. Contracts are entered into based on a full disclosure policy as with medical schemes.

Most Cap Cover policies provide standard exclusions based on similar exclusions within the medical scheme industry

For out-patient treatment except those specified under benefits. Generally there is a 3 month waiting period on all benefits, a 9 month waiting period on maternity benefits and a 12 month waiting period for a hysterectomy.

No payment will be made in the event the insured did not pre-authorise, make use of a Designated Service Provider or any condition set by the insured's Medical Aid.

If there is no benefit for the treatment and / or condition or if it is excluded and / or declined by the insured's Medical Aid or the Medical Aid pays less than the Medical Scheme tariff then no benefit or a limited benefit will be supplied

If the Overall Annual Limit for hospitalisation on the policy holders medical benefit option is exceeded.

In some policies there may be a 10% co payment placed on policyholders who are over 60 years of age.

Other standard exclusions can include:

- Any pre-existing conditions that have been specifically excluded by a medical scheme
- Any claim which is associated with any critical illness or injury for which a claim has previously been paid out under this policy.
- Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission;
- Investigations, treatment or surgery for obesity, its sequelae or cosmetic surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery other than as a result of an insured event otherwise insured. For the purpose of this exception cosmetic surgery shall include surgery for breast reduction or reconstruction unless necessitated as a result of treatment for cancer;

- Routine physical examination or any laboratory test or procedure of a purely diagnostic nature e.g. x-rays and scans or any other examination where there are no objective indications of impairment in normal health except in the course of a disability established by prior call or attendance of a Medical Practioner;
- Investigations, treatment or surgery for artificial insemination or hormone treatment for infertility;
- Suicide, attempted suicide or intentional self-injury;
- The taking of any drug or narcotic unless prescribed by and taken in accordance with the instructions of a Medical Practioner (other than the insured person) or drug addiction;
- An event directly attributable to the insured person having an alcohol content exceeding the legal limit or the insured person suffering from alcoholism or any illness caused by the use of alcohol;
- Participation in
  - Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers;
  - Aviation other than as a fare paying passenger;
  - Any form of race or speed contest (other than on foot or involving any non-mechanically propelled vehicle, vessel, craft or aircraft);
  - Professional sporting activities other than as a spectator.

Exclusions can vary across the various insurers but examination of the variables shows very little difference across all suppliers. There are also set universal premiums for the polices offered which are not based on age or health status.

INSURANCE PRODUCTS WITHIN A NATIONAL HEALTH ENVIORONMENT

As South Africa starts out on its journey to Universal Healthcare for all, policy experts from other countries will tell them from their long experience of a National / Universal healthcare system, that rationing of health care is inevitable.

All Healthcare systems "ration" care in some way or another and always have. In 1963 the then head of the United Kingdom's National Health service, Enoch Powell said " there is virtually no upward limit to the amount of healthcare an individual can consume"

That is as true today as it was then. Some sort of mechanism therefore has to exist to allocate the scarce resource of health care supply to all those who would like to consume it. It is not a matter of political ideology, it is just pure economics.

Not even the wealthiest society can provide every medical treatment that might provide some benefit to some patients - nor should a society try to provide any and all treatments that would provide some benefit.

Although the need for rationing may be clear, it is far less obvious how a society should allocate its limited health care budget. To what extent should a country rely on the free market to allocate health care (as we do, say, with automobiles), and to what extent should the government guarantee some level of access for people who are too poor to afford necessary care?

In trying to answer these questions, scholars have framed the debate with three key and overlapping questions:

- 1. Which considerations should be used in giving some patients a higher priority when health care resources are allocated?

– 2. Who should make the rationing decisions?[8] Should we rely on a governmental agency, the insurance companies that pay medical bills, treating physicians, or others?
– 3. How do we ensure that those responsible for implementing rationing decisions carry out their duty to limit health care spending?

The fundamental policy question regarding health care is should it remain essentially funded by the tax system and provided mainly free at the point of need? This is the route that South Africa has started to take with the role out of NHI

In rich developed countries, health care spending on average takes up nearly ten per cent of national income (GDP) and the projections for the years ahead see that figure continuing to rise.

The main aim of NHI is to provide a comprehensive, high quality service available on the basis of clinical need and not ability to pay. The Fundamental building blocks of the NHI are as follows:

- Providing a national universal (comprehensive) service
- Health care free at the point of use
- Medical care is not based on ability to pay that currently face most the NHS

CHALLENGES FACING AN NHI ENVIORNMENT

Some of the difficulties facing most Universal / National healthcare systems are:

- **Resource shortages**: Resource problems are the inevitable consequence of under-funding and under-investment in the health service over many years – affecting the quality and quantity of the capital stock available to health providers
- **Hospital waiting lists**: There are persistent delays in people receiving appointments to see consultants and delays in receiving emergency treatment
- **Problems in recruiting sufficient well qualified staff:** this leads to long hours for NHI staff and contributes to wide disparities in the quality of care and range of care from region to region and between local health authorities.
- **Health Care Rationing – An Inevitable Process:** Health rationing occurs because **demand for health care always outweighs supply**.

[31]**"Two-thirds of health trusts in England are rationing treatments for "non-urgent" conditions as part of the drive to reduce costs in the NHS by £20bn over the next four years.**

One in three primary-care trusts (PCTs) has expanded the list of procedures it will restrict funding to in the past 12 months.

Examples of the rationing now being used include:

- Hip and knee replacements only being allowed where patients are in severe pain. Overweight patients will be made to lose weight before being considered for an operation.
- Cataract operations being withheld from patients until their sight problems "substantially" affect their ability to work.
- Patients with varicose veins only being operated on if they are suffering "chronic continuous pain", ulceration or bleeding.
- Tonsillectomy (removing tonsils) only to be carried out in children if they have had seven bouts of tonsillitis in the previous year.
- Grommets to improve hearing in children only being inserted in "exceptional circumstances" and after monitoring for six months. '

[31] Article from the Independent newspaper THURSDAY 28 JULY 2011

The above extract was taken from a British newspaper article published in July 2011. In a free market, markets match supply and demand by altering price. This form of rationing relies on the simple fact that post-tax incomes are unequal and that those households on relatively low incomes will be the first to be priced out of the market. Rationing in an NHI is inevitable - no amount of resources from the Government funded by taxation could possibly meet all of our demands for health care when the NHI system remains based on the fundamental principle of most health services being free at the point of need.

Universal / National healthcare systems currently ration health resources in a variety of ways

- **Government rationing:** Ministers and Parliament decide on the overall size of the NHI budget thus dictating the type and volume of care the NHI can provide
- **A The National Institute for Clinical Excellence:** this would be a body of experts who contributes to rationing decisions by advising the NHI on clinical and economic benefits and costs of certain health care interventions
- **Health authorities and primary care groups allocate money to particular disease/treatment areas**: Treatment decisions for individuals are made at the clinical level by health care professionals

KEY FACTORS THAT PUT INCREASED FINANCIAL PRESSURES ON AN NHI SYSTEM:

Developments in medical technology and new treatments: The fruits of research and development in health sciences have brought us many new medical procedures (such as transplants); new treatments and new products (e.g. magnetic-resonance imaging scanners) New drugs including drugs that reduce the "risk" of disease rather than the symptoms of illness: The costs of drugs tends to fall in the long term as expensive new drugs protected by patent property rights are replaced by the emergence of generic drugs once this protection is lifted. But this process can take many years.

The costs of staffing: Healthcare is a highly labour intensive industry. The costs of pay and other employment costs can take up to sixty per cent of the operating expenses of a hospital.

Growing health problems: The pandemic of the burden of disease faced by the South African healthcare environment has been discussed at length in an earlier section of this report.

Expectations of patients and their families: Political promises of improved health outcomes

NHI INSURANCE MANDATE [32]

The government must mandate that all citizens purchase insurance, whether from private, public, or non-profit insurers. In some cases the insurer list can be quite restrictive, while in others a healthy private market for insurance is simply regulated and standardized by the government.

In this kind of system insurers are barred from rejecting sick individuals, and individuals are required to purchase insurance, in order to prevent typical health care market failures from arising.

Universal Coverage will not always necessarily mean a single tier system. Universal Coverage can be achieved through a combination of funding methods (i.e. a multi-tiered system). The WHO urged Governments in Africa to develop plans for universal protection

[32] The Executive Summary of NHI Policy Brief 7 Future Role of Private Health Insurance

against cost-of-illness that might include a combination of tax-based financing, mandatory social health insurance and private insurance in a multi-tier system.

For example, a national public health service funded from general taxation might form

- **Tier 1**: All employed, including public sector workers, might make mandatory contributions to

- **Tier 2:** With significant income cross-subsidies. This could include medical schemes, bargaining council schemes and other forms of workplace-based healthcare.

- **Tier 3:** Would be private Cover and be provided, for example, by medical schemes or insurance companies or paid by individuals out-of-pocket.

FIGURE 16: THE POSSIBLE ROLES FOR PRIVATE HEALTH INSURANCE WITHIN A TIERED NHI ENVIORNMENT

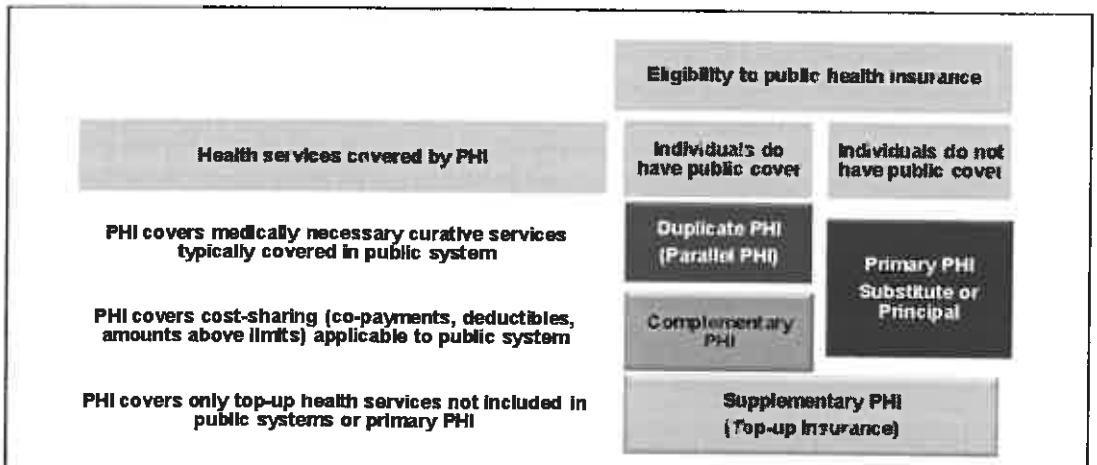


Figure 1: Possible Roles for Private Health Insurance
Source: Organization for Economic Co-operation and Development, 2004

Experience from other National / Universal Healthcare systems has shown that many people within these systems invest in **medical insurance** to ensure that they can be treated privately if they become ill and are unable to access the level of Cover needed within the National / Universal Healthcare system. This type of Cover therefore offers great peace of mind. Insurance products whether in the form of a private medical scheme or specified medical insurance for certain healthcare costs or conditions play a significant role.

It is virtually impossible for people to predict their future healthcare needs. Sudden illness or injury may require extensive and expensive medical care. While most of these costs may well be covered in a National / Universal healthcare environment, this is not always possible. In these situations most people are unlikely to have adequate means to allow them to easily cover these unexpected additional costs from their own resources. It in this "Gap", that Healthcare insurance products and private medical schemes has a role to play.

Private Health Insurance Cover

- Coverage for a basic package of benefits for out of hospital and in hospital costs which enhance NHI benefits and climate waiting periods. They also allow the member to choose a provider of their choice.

Critical Illness / Major medical Insurance

- Where state or private healthcare insurance only Cover a certain percentage of the cost of any of a listed number of healthcare conditions this insurance will pay the difference up to a stated overall limit per individual or family

Health cash plan

- A Health Cash Plan is a low cost health plan that pays cash sums towards the cost of a wide range of treatments. Cash sums are paid if you have to go into hospital, see a specialist, visit the dentist or optician, give birth or require alternative therapies such as homeopathy, acupuncture or physiotherapy.

Children's Health Insurance

- Packages tailored to the different healthcare and dental needs a child may have Cover up to the age of 18

Health Insurance Cover for Natural and Alternative Healthcare

- Where a patient wants the option to forgo regular medical treatment in favour of what's known as natural or alternative health care, or to utilise such treatment together with modern medicine.

Private Health Insurance for Reconstructive or cosmetic surgery

- Where private health funds Cover reconstructive surgery as a field but have major exclusions or restrictions. For cosmetic surgery not Covered by private insurance funds.

Travel Insurance

- Where healthcare costs outside of the country of residence are not Covered by a private insurance healthcare product

Catalyst Pulse developed this report as part of a syndicated study.

Participating companies were Guardrisk Insurance Company Ltd,, Ambledown Risk and Underwriting Managers (Pty) Ltd, Total Risk Administrators (Pty) Ltd and Xelus (Pty) Ltd

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