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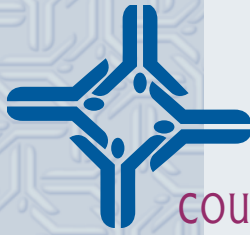
Regulating in the public interest:

Taking stock and looking to the future

A Five-Year Review of the
Council for Medical Schemes



COUNCIL FOR MEDICAL SCHEMES



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OUR VISION

A medical schemes industry which is regulated to protect the interests of members and to promote fair and equitable access to private health financing in order to maximise the health of South Africa.

STRATEGIC OBJECTIVES

- Secure an appropriate level of protection of beneficiaries of medical schemes and the public by authorizing the conduct of medical schemes business and monitoring the financial performance and soundness of schemes;
- Provide support and guidance to trustees and promote understanding of the medical schemes environment by trustees, beneficiaries and the public;
- Foster compliance with the Act by medical schemes, administrators and brokers and initiate enforcement action where required;
- Investigate and resolve complaints raised by beneficiaries and the public;
- Monitor the impact of the Act, research developments and recommend policy options to improve the regulatory environment;
- Foster the continued development of the Council as an employer of choice and;
- Develop strategic alliances nationally, regionally and internationally.

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1. INTRODUCTION

1.1. Purpose of the review

The Council for Medical Schemes ("the Council") is approaching completion of its fifth year following its restructuring as a parastatal organisation, in terms of the Medical Schemes Act, 131 of 1998 ("the Act"). Before 2000, the administrative structure of the Council functioned as a small deputy directorate within the Department of Health.

Legislative reforms brought about by the Act (repealing the Medical Schemes Act, 72 of 1967) introduced a new policy direction for the medical schemes industry, and considerably expanded the powers and functions of a reconstituted Council for Medical Schemes, now given the status of a juristic person in terms of the Act.

Pursuant to the new legislative framework, an Office of the Registrar of Medical Schemes was established in 2000, with a view to carrying out the statutory functions conferred on the Registrar in terms of the Act and serving as the executive arm of the Council.

Whereas start-up funding for the new Council and the Registrar's office was provided by government, this funding was replaced by levies charged to medical schemes in terms of the Council for Medical Schemes Levies Act, 58 of 2000 ("the Levies Act").

This five-year review is intended to serve a dual purpose. First, it will provide a basis for the Council to reflect critically on its progress over the past five years in terms of achievements and shortcomings, to take stock of where it is now, and to learn from this experience in strategically positioning itself optimally to address the challenges which currently present themselves and which are anticipated in the next five years.

Secondly, it will be provided to the Minister of Health from the Council for her consideration in relation to the requirement of section 6(3) of the Levies Act that the Minister shall commission an assessment of the performance of Council at least once every five years.

Some of the questions that receive consideration in this review include the following:

- To what extent is the Council successfully performing its functions in terms of the Medical Schemes Act?
- How far has the Council gone toward meeting its own strategic objectives?
- To what extent have the objectives of the Medical Schemes Act been met?
- Where are the gaps and shortcomings, and what still needs to be done to address these issues?

How far has the Council gone toward meeting its own strategic objectives?

1.2. Situational Analysis 2000

The Act, and the regulations made thereunder, became fully operational in 2000. One of the key interventions of the Act was to establish the Council for Medical Schemes as a juristic person, which would report to the Minister of Health, supported by a fully-fledged office of the Registrar of Medical Schemes.

This was done in recognition of the fact that an industry which received more than R30 billion in contribution income at the time, and which funded health care to some 7-million beneficiaries, could not continue to be regulated by a small sub-directorate within the Department of Health.

Even more importantly, though, there was a need to create a regulatory structure that would have the capacity and flexibility to redirect further development of the private health funding sector in a manner consistent with national health policy being developed by the post-apartheid government.

The need for review of regulatory direction was particularly pertinent given the policy of deregulation of the medical schemes industry which had characterised the previous government's policy in the late 1980s and early 1990s. There was clear evidence that this policy was not contributing to contemporary national health objectives, such as equity in financing and access to health care. For example, exclusion and risk-rating practices, particularly in the open schemes environment, resulted in age- and risk-rated financing and significant declines in coverage of vulnerable groups, including pensioners.

Access to coverage by vulnerable groups was also being negatively affected by erosion of benefits, imposition of more-restrictive benefit limits, increased shifting of risk onto members through the growth of medical savings accounts, the emergence of commission-based brokers with financial incentives to discourage membership by high-risk applicants, a decline in post-retirement subsidies, and rapid cost escalation. As a result, vulnerable groups were becoming increasingly reliant for care on an already overburdened public sector. This was compounded by the practice of "dumping" patients who had run out of benefits in private hospitals into the public sector, without funding the public sector for continued care for these patients.

At the same time, deregulation and inadequate regulatory capacity had allowed other problems to emerge in the medical schemes environment, including poor solvency levels among a significant number of medical schemes, the emergence of unregistered entities doing the business of medical schemes, and inadequate accountability and member participation in scheme governance. Rapid cost escalation had resulted in virtual stagnation in medical scheme membership since the mid-1990s.

Many of these problems were specific to the way medical schemes ran their business, and could therefore be targeted by legislation specifically regulating the medical schemes industry. Other problems were endemic to the South African health system more generally, and were typically challenges affecting health systems globally. In these instances, the Medical Schemes Act alone would have little or no capacity to remedy the problems, and the Act had to be seen simply as a plank in a far broader reform process within the health sector, or even within other sectors. And indeed, government's intention was that the Act should be the first statutory plank in a broader health system reform

Deregulation had allowed significant problems to emerge, including poor solvency levels and inadequate accountability and member participation in scheme governance.

process leading to the introduction of social health insurance.

A particularly pertinent example of a problem which significantly affects the medical schemes environment, but which largely falls outside the regulatory parameters of the Act, is rapidly-escalating costs of health care delivery. Addressing this problem required legislative and policy interventions on the supply side, and subsequent statutory developments such as the Certificate of Need process prescribed in the National Health Act, and the recent fiercely contested medicine pricing regulations, have been put in place as supply-side regulatory measures. Another problem which seriously affects medical scheme membership, but which falls outside of the domain of the Act, is the trend among employers to reduce or remove post-retirement subsidies for medical scheme membership. Employer conduct in the design of employee benefits is a labour relations issue, as opposed to an issue that falls within the domain of health law.

The provisions of the Medical Schemes Act had four principal areas of regulatory focus:

- First, the Act sought to promote non-discriminatory access to private health funding.
- Second, the Act sought to put medical schemes on a more sound financial footing.
- Third, the Act sought to improve scheme governance in the interests of members.
- Fourth, the Act sought to improve consumer protection through enhanced regulatory oversight.

The Council was accordingly established as a juristic person with the following functions in terms of the Act:

- To protect the interests of beneficiaries of medical schemes at all times;
- To control and coordinate the functioning of medical schemes in a manner that is complementary to national health policy;
- To make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;
- To investigate complaints and settle disputes in relation to the affairs of medical schemes;
- To collect and disseminate information about private health care;
- To make rules, not inconsistent with the provisions of the Act, for the purpose of the performance of its functions and the exercise of its powers;
- To advise the Minister on any matter concerning medical schemes and;
- To perform any other functions conferred on the Council by the Minister or the Act.

The Act sought to promote non-discriminatory access to private health funding.

1.3. Setting up the regulatory and operational infrastructure

The first task of the Council in 2000 was establishing the office of the Registrar from scratch – which was no easy task. At the outset, funding had to be

Considerable attention was also given to developing a good system of corporate governance.

obtained to run the business of Council and the office of the Registrar. Only limited start-up funding was provided by the Department of Health, so a priority in the first few months was to ensure signature by the President of the Council for Medical Schemes Levies Bill, to publish notice of intention to impose levies and to put in place a system to manage collection of levy income from medical schemes.

A financial management system was put in place that complied with the provisions of the Public Finance Management Act ("PFMA"), and which had the capacity to manage complex budgeting and expenditure processes. An audit committee was established, and audit procedures set up, in accordance with the provisions of the PFMA.

Human resource management entailed significant challenges too. Staff were rapidly recruited and trained to fill positions required by the new office, together with all the human-resource management processes that went along with that. The staff complement grew rapidly to its current capacity of close to 60 people, many of whom are professionals from a wide range of disciplines who bring diverse skills to the activities of the Council. Ensuring an appropriate demographic mix was also a key consideration in recruitment practice and policy.

Considerable attention was also given to developing a good system of corporate governance. The role of the Council (as opposed to the office of the Registrar) was defined to include:

- Leading and controlling the affairs of the organisation;
- Making strategic decisions affecting the operations of the organisation;
- Exercising those legislative functions set aside by the Act to be exercised only by Council;
- Overseeing the discharge by the executive management of the day-to-day business of the Council;
- Taking specific decisions that are judged by the executive management and Council to be of such significance as to require to be taken by Council;
- Setting appropriate policies to manage risks to the operations and achievement of Council's regulatory objectives, taking into account the nature and extent of risks facing the Council, their likelihood of crystallising, and the Council's ability to reduce the incidence and impact of risks that do materialise;
- Maintaining a sound system of financial controls, taking into account the costs of particular controls relative to the benefits obtained in managing related risks and;
- Maintaining high-level relations with stakeholders and other agencies, including government.

The Council has also adopted a Code of Good Conduct that is underpinned by the requirement that all Council members shall bring independent judgment to bear on issues of strategy, performance, resources and standards of conduct. Other important components of the Code include access to suitable training, advice and information, supplied in a timely manner, and in a format and quality appropriate to enable Council to discharge its duties.

The Council has also set up a number of sub-committees as part of its operations. An audit committee has been established, whose key function is to

advise the Council on the quality of the financial management of the Registrar's Office and on the internal audit function. A human resources committee has been established that also serves as a remunerations committee. A number of other technical committees have been set up to facilitate Council's regulatory role and to advise executive management on pertinent issues.

In seeking to position itself most effectively as an agent to perform these functions, and to promote fulfilment of the objectives of the Act, the Council set itself strategic objectives, which are reviewed from time to time. The seven strategic objectives are to:

- Secure an appropriate level of protection of beneficiaries of medical schemes and the public by authorising the conduct of medical schemes business and monitoring the financial performance and soundness of schemes;
- Provide support and guidance to trustees and promote understanding of the medical schemes environment by trustees, beneficiaries and the public;
- Foster compliance with the Act by medical schemes, administrators and brokers and initiate enforcement action where required;
- Investigate and resolve complaints raised by beneficiaries and the public;
- Monitor the impact of the Act, research developments and recommend policy options to improve the regulatory environment;
- Foster the continued development of the Council as an employer of choice and;
- Develop strategic alliances nationally, regionally and internationally.

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2. STRATEGIC REVIEW: PAST, PRESENT AND FUTURE

This section critically reflects on Council’s activities and direction in relation to each of the strategic objectives outlined above. For each objective, there is consideration of:

- Some of the major accomplishments and shortcomings of Council over the past five years in meeting the specific objective (the past);
- Current processes aimed at furthering the objective and potential gaps in these processes (the present) and;
- What Council still needs to achieve in relation to that objective (the future).

A major revision of statutory returns to be furnished by medical schemes was undertaken.

2.1. Securing protection of members through monitoring financial soundness and authorising scheme conduct

2.1.1. Financial soundness

2.1.1.1. Visiting the past

The small medical schemes sub-directorate within the Department of Health, which existed prior to 2000, simply lacked sufficient skills, capacity or resources to monitor financial soundness effectively within a multi-billion rand industry. As a result, key instruments for monitoring financial soundness were not in place. Financial returns furnished by medical schemes were inadequate, the unit lacked effective remedy against medical schemes that failed to submit them, and annual reports of the Registrar analysing these returns had not been published since 1996.

Immediately on establishment of the new office of the Registrar in 2000, three key priorities were set for the short term.

First, the backlog on analysis of financial returns and publication of annual reports had to be cleared. This was critical to allow demographic and financial trends in the industry to be monitored. Within the first few months of establishment of the office, the backlog had been cleared with publication of the 1997, 1998 and 1999 reports and attention was focused on review of the financial status of schemes in 2000.

Secondly, a process of engagement was initiated with the South African Institute of Chartered Accountants (SAICA) to develop a new guide for accounting and auditing of medical schemes, to reflect the requirements of the Act as well as updated accounting standards.

Thirdly, a major revision of statutory returns to be furnished by medical schemes was undertaken. This was done to accommodate revisions to the

SAICA accounting guide, to provide better monitoring of financial soundness and regulatory compliance and to allow for more effective tracking of financial and demographic trends in the medical schemes environment.

This preliminary work established an important baseline for understanding the financial status of the environment in which the new office came into being, and from which to launch future initiatives aimed at improving the financial soundness of medical schemes. Serious problems undermining the financial stability of the medical schemes industry were identified at this early stage, which would largely set the financial research and supervisory agenda of the Council for the next four years. Some of these problems are listed below:

- At the end of 2000, almost 50% of the members of registered medical schemes belonged to schemes with perilously-low solvency levels of less than 10%;
- With the exception of 1997, from 1995 to 2000, medical schemes suffered an overall deficit on operations. In 2000, this amounted to a R1-billion deficit;
- Administration and other non-health expenditure had been rapidly increasing since the mid-1990s, contributing to a rapidly declining claims ratio, meaning proportionately less contribution income available for the payment of claims;
- Among the contributors to high levels of non-health expenditure were the inexplicably-high levels of net reinsurance losses (R207 million in 2000; R334 million in 2001; R297 million in 2002). These losses had become significant from about 1997 onwards;
- Levels of medical scheme expenditure on health brokers (R230 million in 2000) were a concern in an environment in which total membership remained static. Even more concerning was the fact that these amounts did not include substantial portions of unreported "co-administration" expenditure paid to brokers by administrators - indirectly paid by medical schemes via administration fees and;
- Increases in expenditure on benefits continued to exceed inflation, with spend on hospitals, medicines and specialists outstripping spend on other benefits.

In response to these identified issues, proper resourcing of the Financial Supervision Unit became a priority of Council, and a number of key interventions were initiated. A few of the major interventions are discussed below.

- **Reinsurance:**

In June 2000, 14 medical schemes that had been particularly adversely affected by reinsurance losses were requested to provide details of reinsurance arrangements. The findings of this evaluation process revealed that reinsurance arrangements were inappropriate in many cases, resulting in many schemes serving as conduits for reserve funds to be transferred to third parties. As a consequence, funds that should rightfully have been accruing as reserves within medical schemes for the benefit of members were being diverted elsewhere. In some cases, 100% quota-share arrangements were in place. Some of the contracts involved substantial conflict of interest between the contracting parties. In various cases, it was apparent that trustees had not been fully informed about the implications of the contracts that they had entered into on behalf of

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the medical schemes.

Concerns with some of the preliminary findings of the reinsurance evaluation led to inspections being conducted into a number of medical schemes, including an inspection of Discovery Health Medical Scheme ("DHMS"). The inspection called into question the appropriateness of DHMS's reinsurance arrangements as well as the accounting treatment of these arrangements in the financial statements of DHMS. This resulted in the Registrar rejecting the financial accounts of DHMS. It also became clear that, unless DHMS contained inappropriate reinsurance losses, it would be unable to meet the statutory solvency requirements. A protracted and legally-contested process followed, attempting to compel DHMS to review its existing reinsurance arrangements, which drew considerable media and political attention due to the size of DHMS and the significance of Discovery Health Limited in the financial market. This process was exhausting and draining of the resources of a Registrar's Office largely in its formative stage. Nevertheless, it culminated in a directive in May 2002, whereby DHMS was compelled to restructure its reinsurance arrangements to the satisfaction of the Council and to put in place a business plan to ensure that DHMS would meet the 25% solvency requirements of the Act by the end of 2004, as required by the Act. In 2004, the Registrar refused to approve any reinsurance at all for DHMS, resulting in a significant sum, which would have been a reinsurance loss, rather forming part of the scheme's reserves.

As part of the measures to contain inappropriate use of reinsurance, the Council issued Reinsurance Guidelines at the beginning of 2002. The Medical Schemes Amendment Act, 55 of 2001, which came into effect on 1 March 2002, also provided for greater oversight of reinsurance practices by the office of the Registrar.

Aside from Council's interventions in respect of DHMS, actions by the Registrar in respect of inappropriate reinsurance arrangements saw the return of R9 million to Omnihealth, R42 million to Medcover 2000, and R4 million to KZN Medical Scheme. By 2003, net reinsurance losses industry-wide had dropped to R123 million, a 58.5% decrease since the preceding year and to R7 million in 2004. Active review of reinsurance contracts by the office of the Registrar continues in order to ensure that, where these contracts are entered into, they are appropriate and in the best interests of members.

- **Monitoring tools: early warning system and risk-based framework**

The most important tools available to the Council to monitor the financial soundness of medical schemes are the statutory returns that are required to be furnished by medical schemes to the Registrar. It soon became apparent that the requirement of the Act for returns to be furnished on an annual basis to the Registrar was inadequate effectively to monitor financial performance within medical schemes.

An amendment to the Act was therefore effected by means of the Medical Schemes Amendment Act, 55 of 2001, to provide for the submission of unaudited financial returns, including management accounts, on a quarterly basis, while maintaining the requirement for audited statutory returns to be furnished on an annual basis. The Amendment Act came into effect on 1 March

2002. The system of quarterly returns was implemented immediately thereafter, together with publication of a new format for standardised management accounts to be used by medical schemes. External IT developers assisted in providing a user-friendly web-based interface for statutory returns, so that annual and quarterly returns can now be completed and submitted online.

These developments, and in particular the quarterly returns, have now become firmly entrenched and have immeasurably improved the capacity of the Office of the Registrar and trustees to monitor financial soundness within medical schemes. They have become an early warning system to alert Council to potential financial problems developing within medical schemes.

Signs of financial distress in medical schemes are now detected far more quickly than before, enabling even-closer monitoring to take place in affected schemes, and interventions to be designed to reverse avoidable financial failures. Typically this involves development of business plans by the trustees in cooperation with the Office of the Registrar and monthly monitoring of progress in implementing these business plans.

The “Risk Based Framework” was another tool developed within the Registrar’s Office to facilitate prioritisation of resources in monitoring financial soundness of medical schemes. This framework categorised medical schemes into “impact bands” in relation to their significance to the Council’s statutory objectives and to the medical schemes environment. Risk assessment plans and risk mitigation plans have been developed for so-called “high impact” schemes, and have been the basis for intensified monitoring of these schemes.

Despite effective monitoring and intervention by the office of the Registrar, the past five years have seen a number of medical schemes failing financially, resulting in liquidations or amalgamations with other medical schemes. This is regarded as inevitable due to the fact that our assessment is that South Africa has too small a medical scheme population to accommodate viably the number of medical schemes that currently exist. In this scenario, sizes of risk pools become too small to spread risk effectively, and medical schemes become unsustainable. A process of natural attrition has therefore led to an overall reduction in the number of medical schemes over the past fifteen years, and this trend has continued in the period under review. From more than 300 medical schemes in 1974, by the end of 2003 there were 149. Between 2000 and 2003, there was a 12.9% decline in the number of registered medical schemes.

In principle, a zero failure environment is impossible and financial failure of medical schemes is sometimes inevitable. The important thing to do is to ensure that members are protected in such instances.

From 2000 to 2003, 26 amalgamations took place and 23 medical schemes were wound-up or dissolved. During the same period, 17 new medical schemes were registered. In virtually every case of an amalgamation or liquidation, we believe that satisfactory arrangements were in place to ensure that members were not unduly prejudiced through unpaid claims or the imposition of new waiting periods by schemes to which they transferred.

However in two cases, namely the liquidations of Phila (2001) and Vulamed (2003), concerns were raised in various quarters that members had been inadequately protected in the process of winding up of the schemes. Both

Signs of financial distress ... designed to reverse avoidable financial failures.

Compared to five years ago, the medical schemes industry is on a far-sounder footing.

cases demonstrated the fine balance that needs to be achieved through attempts to save the scheme from financial failure, on the one hand, and the need to protect members from the consequences of financial failure when it occurs.

If, when there is still a chance of financial turn-around by a medical scheme, the Registrar is seen to be taking active steps to protect members in anticipation of closure of the scheme (for example through negotiating conditions for transfer of members to other schemes), this is likely to cause a run of membership on the scheme, typically driven by brokers attempting to secure the interests of their clients. This, in turn, can undermine efforts to rescue the scheme and can result in its certain collapse. On the other hand, if efforts to rescue the scheme are unsuccessful and sufficient measures are not in place to protect the interests of the members, members will be left high and dry anyway. In the case of Phila and Vulamed, while efforts were made to save the schemes from financial ruin and to protect members in the event of failure, it may be argued that the fine balance between these two objectives was not adequately achieved.

Repeats of problems of this nature can be avoided if members are automatically protected by operation of law in the event of liquidation or amalgamation of the medical scheme. At present, members lack these basic protections and are dependent on successful prior negotiations to protect them, which also gives rise to the difficulties from a regulatory perspective that were described above in relation to Phila and Vulamed. This matter is currently the subject of in-depth review, and is further discussed below in relation to protection of members.

2.1.1.2. Reflecting on the present

Even though there is still some way to go before bringing all medical schemes up to the statutorily-prescribed solvency level of 25%, there can be no doubt that, compared to five years ago, the medical schemes industry is on a far-sounder footing.

- Whereas in 2000, almost 50% of members of registered medical schemes belonged to schemes with solvency levels of less than 10%, at the end of 2004 only 3% of members were in schemes with a solvency level of less than 10%.
- In 2000, the average solvency level was 13.35% among open medical schemes and 36.20% among restricted medical schemes. By the end of 2004, this had risen to 28% among open medical schemes and 58% among restricted membership schemes.
- Whereas in 2000, schemes showed an operating deficit of R1 billion, by 2004 schemes showed a total surplus from operations of R2,7 billion.

This dramatic financial turn-around of the medical schemes industry is regarded as a major success attributable to implementation of the new Act. However, continued escalation of both health care and non-health care costs at rates significantly above headline inflation threatens to undermine these gains and to reverse long-term sustainability of medical schemes.

From 2000 to 2003, total non-health care costs increased by approximately 66.9%. The bulk of this expenditure was due to administration costs, which represent close to 70% of non-health expenditure. In this period, administra-

tion costs increased by 80.4%. Managed care costs escalated by 24.5%, broker fees by 152.6% and bad debts by 107.7%.

Note, though that while the substantial expenditure on broker fees continues to be a matter of grave concern in an environment in which the overall number of beneficiaries is stable, or slightly declining, the dramatic apparent increase from R354 million in 2002 to R581 million in 2003 and R700 million in 2004 is likely to be more a reflection of more-accurate reporting on broker expenditure than of real increases in spend on brokers. This is as a result of passage of the Medical Schemes Amendment Act, 62 of 2002 (which took effect on 1 May 2003), which effectively outlawed the payment of so-called co-administration fees to brokers, that had previously been paid by administrators and went largely unreported. Following this amendment, medical scheme payments to brokers, which are payable within prescribed financial limits, have to be paid directly from the medical scheme to the broker – and accounted for as such.

It is also worth noting that while bad debt also remains a concern, the huge increases shown above are largely attributable to one or two schemes which changed their accounting treatment of bad debts.

Of course, while non-health costs are a source of major concern, the impact on total expenditure of above-inflationary increases on health care costs places even greater pressure on member contributions because health costs account for some 80% of total expenditure of medical schemes.

Private hospitals account for more than one third of total medical scheme expenditure on health benefits, and it is this expenditure that has seen the greatest rate of increase over the past decade.

- From 1997 to 2003, total private hospital benefits paid grew in real terms from R96.88 per beneficiary per month (pbpm) to R160.60 pbpm. This represents an increase of 65.8% over the period or an annual increase of 8.8% above inflation.
- Private hospital ward fees grew in real terms from R42.44 pbpm in 1997 to R61.60 pbpm in 2003. This represents an increase of 45.2% over the period or an annual increase of 6.4% above inflation.
- Private hospital medicine benefits paid over the period increased in real terms by 84.0% or an annual increase of 10.7% above inflation.

Consumables increased in real terms by 74.0% or an annual increase of 9.7% above inflation. Theatre fees showed the largest increase in real terms over the period at 94.3% or an annual increase of 11.7% above inflation.

Aside from contributing to increased contribution levels, and thereby negatively affecting affordability of medical schemes, this increased spend on private hospitals results in less money being available to fund other benefits such as primary health care. Hospital-influenced benefits (which we have categorised as hospital expenditure, specialists and support disciplines) grew from 38.9% of the benefit pie in 1990 to 60.4% in 2003. In the same period, the proportion of medical scheme benefits on general practitioners, dentists and primary care dropped from 25% to 14%.

This is a major concern from the perspective of national health policy because it is likely to be resulting in decreased access to primary care benefits,

Private hospitals account for more than one third of total medical scheme expenditure on health benefits, and it is this expenditure that has seen the greatest rate of increase over the past decade.

The greater the extent of market concentration of hospital groups, the weaker is the position of medical schemes.

and increased out-of-pocket expenditure by members of medical schemes. The extent of out-of-pocket expenditure by beneficiaries of medical schemes is difficult to assess accurately. However, the need for further research in this regard is becoming increasingly important.

One of the most important contributory factors to this increase in hospital expenditure is the significant market power of the three large hospital groups, and the minimal countervailing power offered by medical schemes.

Most hospital catchment areas are subject to 100% market control by a single hospital group, with many more in a position where more than 60% of the market is controlled by a single group. The degree of market concentration is increased when more-specialised hospital services are accounted for. A hospital may have acute beds but no operating theatre, ICU or MRI scanner.

Medical schemes, which tend to have members that cross the geographical catchment areas, need to offer a consistent set of benefits with standardised benefit limits and co-payments to its members. This places them in a difficult position when negotiating any arrangement with hospital groups that have 100% market share in specific catchment areas. Although one catchment area faced by a medical scheme may have competing hospitals, another may be dominated by a single service provider, or multiple service providers falling within one group. The medical scheme quite quickly becomes a price taker in such circumstances.

Medical schemes are typically placed in a difficult position when negotiation fails with a hospital group. Either their members may be refused entry to a private hospital group unless a substantial out-of-pocket deposit is made; or they will be treated at the hospital and “balance billed” for the difference between the medical scheme reimbursement rate and the hospital tariff. Medical scheme members faced with such an eventuality will prefer to shift schemes to ones which does not leave them vulnerable to hospital-based out-of-pocket payments. Thus schemes which take the higher fees demanded by a hospital group will have a greater possibility of member retention than those that allow their members to be balance billed. The greater the extent of market concentration of hospital groups, the weaker is the position of medical schemes.

The resulting dynamics have been demonstrated most acutely in private hospital responses to the medicine pricing regulations published by the Minister of Health in 2004. Although the intention of government in making these regulations was to reduce the costs of healthcare, the hospital groups made it clear that they would respond to reductions in profit on medicines by shifting costs to ward and theatre fees to ensure no decrease in revenues to hospitals. Medical schemes reported that they had little alternative but to accept the terms determined by the hospitals.

2.1.1.3. Looking to the future

A number of key policy concerns and challenges lie ahead in further promoting and maintaining financial soundness among medical schemes, some of which are discussed below.

From a perspective of solvency, continued attention needs to be paid to those medical schemes that still fail to meet the statutorily-prescribed solvency

levels, of which there were 26 in 2003. It is, however, important that the focus on bringing these medical schemes into compliance with the Act does not detract from continued close scrutiny of the financial soundness of those schemes that have met the prescribed solvency levels. Experience has shown that even a 25% solvency level can be rapidly reduced to insolvency especially in the context of fraudulent or negligent management.

At the same time, one of the key regulatory issues moving forward is to ensure proper management and investment of exceptionally high reserves that have accumulated within medical schemes. Mechanisms need to be found to ensure that schemes use these reserves in the best interest of their members. Some of the issues and ideas which have been mooted in this regard, and which need further consideration, include the following:

- A better understanding needs to be developed within the industry of how solvency and reserves can help in managing contribution levels and improving access to benefits;
- It has been suggested that an investment dispensation should be created whereby medical schemes are encouraged jointly, or on their own, to purchase hospitals, with a view to encouraging competition in the hospital environment and thereby driving down hospital costs;
- The idea has been mooted that, once a particular solvency threshold has been reached which ensures financial stability to the scheme, “excess reserves” above the threshold may be allowed to be distributed to members of the scheme on an equitable basis.

Another tricky issue which needs policy consideration is whether there may be circumstances in which reserves should be permitted to “follow” members. This becomes particularly pertinent in the context of the envisaged Government Employees Medical Scheme, which is expected to result in increased levels of market consolidation. If, for example, a substantial portion of members of a medical scheme (who may have been long-standing members of that scheme) leave that medical scheme because they are required to join the new Government Employees Medical Scheme, it may be unfair for the reserves which their contributions largely helped to accumulate, to remain in the medical scheme which they left as opposed to being transferred to the Government Employees Medical Scheme where they would continue to benefit from the accumulated funds. At present, reserves legally remain in the original scheme and do not follow members who transfer to other schemes. Any change to this principle would have to be very carefully thought through, due to the financial implications for medical schemes and the complexities that would be involved in determining an equitable portion of the reserves to be transferred.

Also on the issue of accumulation of reserves, there has long been an argument that the current prescribed solvency requirements are too crude, and do not take account of factors which may diminish the financial risk of medical schemes, including arrangements involving the sharing or transfer of risk or other factors mitigating risk in specific cases.

Some industry players favour movement toward a risk-based capital approach, which has been applied in some jurisdictions internationally. The view of the Council to date on this issue has been that it merits further research and consideration, but that it cannot be automatically transported into the

Experience has shown that even a 25% solvency level can be rapidly reduced to insolvency especially in the context of fraudulent or negligent management.

The other area of major future concern is how better to contain levels of contribution increases.

South African medical schemes environment. In addition, basic preconditions for the introduction of a risk-based capital approach to solvency need to be put in place to support its implementation. It is not viewed as an especially urgent innovation to the legislative framework on solvency regulation in relation to medical schemes. A greater priority would be to consider reforms which relate solvency not only to contributions but also to claims.

On the other hand, risk-based capital solvency requirements for managed health-care entities are eminently sensible, and need to form part of the developing governance structure for managed health-care entities.

The other area of major future concern is how better to contain levels of contribution increases. Not only do high contribution levels negatively affect the ability of members of the public to join medical schemes, but they also differentially affect lower-income and more-sickly members, through compelling buy-down, dropping out, or greater out-of-pocket payments. This in itself is discriminatory.

The office of the Registrar is now taking a far more critical view of high contribution increases, and requires substantial motivation for increases above projections of CPIX. In future, there may be a need to formalise rate-filing provisions in the legislation, in a manner similar to statutory rate-filing provisions in the US.

Of course, containing levels of contribution increases in the face of continued above-inflationary increases in both non-health expenditure and health expenditure of medical schemes will be very difficult and may result in reduction in benefits and greater out-of-pocket expenditure by members. There thus needs to be a greater focus from a regulatory perspective on containing these increases. Particularly in the case of health-care providers, implementing measures to reduce cost escalation typically will not fall within the jurisdiction of the Council, but the Council must be instrumental in ensuring that the necessary policy and regulatory measures are implemented through whichever department or agency has the power to do so.

In relation to non-healthcare costs, the Medical Schemes Act needs to be amended to extend the power of the Council to contain non-health expenditure of medical schemes. Currently, in terms of section 44(8) of the Act, the Registrar may, on the authority and in accordance with the instructions and directions of the Council, from time to time place any restriction on the administration costs of a medical scheme in respect of any financial year, and may for this purpose prescribe the basis on which such costs shall be calculated.

Whereas this section has been invoked on occasion, it would be far more effective in containing costs if the Registrar was empowered to limit the administration fees chargeable by administrators, as opposed to merely the administration expenditure of medical schemes. In addition, this section of the Act should be explicitly extended to include other non-health costs such as marketing and to allow the Registrar to intervene in any situation where there is evidence of fruitless or wasteful expenditure by medical schemes. This should also stop medical schemes from classifying non-health costs as costs other than administration in order to circumvent application of this provision of the Act.

In addition, developments in the industry which should result in a lowering of administration costs should be monitored carefully to ensure that they

indeed have such an effect. One example of this is the move toward more capitation arrangements and more-globalised fees. Such remuneration arrangements should in time result in diminished need for detailed claims review processes by administrators, which should in turn lead to the lowering of administration costs to medical schemes. Unfortunately, there has seldom been evidence of lower costs of administrators being passed onto medical schemes as diminished administration fees. For example, there is little evidence that administrators' savings from non-payment of co-administration fees to brokers have been passed onto medical schemes through lower administration fees.

This also points to the fact that, while greater statutory powers to intervene in non-health expenditure of medical schemes is likely to be of some value, much of the difficulties experienced in this regard can be attributed to endemic problems in scheme governance, which need to be addressed with broader strategies.

As far as health care costs are concerned, the need for more-stringent regulation of hospital costs has become indubitably apparent. The Council has instituted a formal process of investigating increases faced by medical schemes in respect of hospital expenditure. The envisaged process involves a technical committee, which has been tasked with drafting a report to Council, for submission to the Minister of Health. The task team is made up of members of Council and members of the Office. One or two other external experts may be invited to participate.

The Committee will establish a list of issues it will investigate consistent with its terms of reference and then identify how each issue will be taken forward. The team will engage with external stakeholders, gather formal evidence including through the use of affidavits, and commission and perform research. The outcome of the process will be a full report and recommendations to the Minister. The report will review what is happening in the market, identify the extent of the problem, suggest solutions to problems identified, and make recommendations on the way forward. The report will build on work already done in relation to submissions developed for the Competition Tribunal on the proposed disposal of the assets of Afrox Health Care to Bidco.

In moving forward, it is clear that there needs to be further sharpening and refinement of the regulatory tools and approaches available to Council in continuing to ensure greater financial stability of medical schemes, and more-appropriate management of the financial affairs of medical schemes in the best interests of their members.

2.1.2. Authorising scheme conduct

2.1.2.1. Visiting the past

The Act provides that no person may conduct the business of a medical scheme unless that person is registered as a medical scheme in terms of the Act. The rules of medical schemes, which set out the reciprocal obligations between schemes and their members, need to be approved by the Registrar on an annual basis to certify that they meet the requirements of the Act. In addition, the Act requires that persons acting as brokers, administrators and managed-care

The need for more-stringent regulation of hospital costs has become indubitably apparent.

The Act requires that persons acting as brokers, administrators and managed-care organizations need to be accredited by the Council.

organisations need to be accredited by the Council.

When the office of the Registrar was established in 2000, there was a substantial backlog of rule approvals from the Department of Health. The upshot was that schemes were essentially operating without any registered rules. The first priority of the Registration and Accreditation division of the office was to clear this backlog, paying particular attention to the need to ensure that these rules complied with the provisions of the new Act, especially those provisions relating to open enrolment, community rating and non-discrimination. The implications of the new Act for rule formulation took some time for officers of medical schemes to understand, and there were intense interactions between schemes and officials from the office of the Registrar relating to rule amendments. These interactions informed further development of the model rules provided to guide medical schemes in the wording of their own rules. The model rules have been incrementally developed since then, to respond to changes in legislation and to clarify areas of ambiguity or uncertainty. The last major changes to the model rules took place at the end of 2003. The registration of scheme rules continues to be an arduous and time-consuming, yet vitally important, component of Council's activities.

One of the problems associated with rule approvals has been the fact that the office has, typically, been unable to approve rules submitted late in the year before the date of implementation of those rules. This creates a problem from a legal perspective because schemes have often been operating with unregistered rules for a period of time. Where problems in benefit design or contribution structures have been identified, it has sometimes been too late to remedy them because they have already been operational for some time, and mid-year changes may result in prejudice to the scheme or its members. This problem is difficult to resolve, because, typically, medical schemes can only determine benefit and contribution levels for the following year in around September and October, because of the need to assess a sufficiently long period of risk and expenditure experience in the existing year to project impact of benefit and contribution changes for the following year. Nevertheless, during 2004 the Registrar requested medical schemes to submit benefit and contribution changes by no later than the end of October, to allow timeous review of these changes by the office. Complexity has been added to this process during 2004, however, as a result of delays in publishing certain schedules of the National Health Reference Price List (NHRPL) until after the end-October deadline.

A grey area in the policy and regulatory framework around registration of medical schemes has been in relation to bargaining council funds that have historically been regulated by the Department of Labour in terms of the Labour Relations Act. Differences of legal interpretation of the Medical Schemes Act, read in conjunction with the Labour Relations Act, combined with fears among some labour organisations of the implications for the bargaining council funds of regulation in terms of the Medical Schemes Act, hampered progress toward defining a rational policy direction for regulation of these schemes. To date, the issue remains unresolved, although there is now some progress toward finding a way forward, as is discussed below.

The accreditation of some 7000 health brokers was facilitated through the

development of an accreditation database by the IT division of the Council. This is considered to be an important function of the Office of the Registrar given high medical-scheme expenditure on brokers each year, and the potential for brokers to impact positively or negatively on the achievement of the policy objectives of the Medical Schemes Act.

It was in this context that one of the more contentious developments in regulation of the medical schemes environment took place in 2002. At this time, the Financial Services Board ("FSB") tabled draft amendments to the Financial Advisory and Intermediary Services ("FAIS") Bill, which sought to repeal relevant portions of the Medical Schemes Act providing for the accreditation of health brokers by the Council. The Council argued that this would constrain the capacity of the Minister of Health to give effect to policy changes aimed at curbing destabilisation of the medical schemes environment through large-scale member movement between medical schemes or limiting non-health expenditure by medical schemes, of which commissions payable to brokers are an important component.

Differences of opinion between the Ministries of Health and Finance on this issue escalated to the point whereby the Deputy President became involved to find a way to unblock the impasse. A resolution that recognised the centrality of health policy in this regard was finally achieved between the Council and the FSB during March 2002. In terms of this resolution, provisions of FAIS purporting to repeal portions of the Medical Schemes Act were removed. It was agreed that while health brokers would be subject to licensing and the common code of conduct established by FAIS, these brokers would continue to be required to be accredited by the Council in terms of the Medical Schemes Act. In this way, the power of the Health Minister to continue to exercise policy and regulatory interventions on matters specific to achievement of the objectives of the Medical Schemes Act remained intact. This resolution also resulted in various changes being made to the Medical Schemes Act, by means of the Medical Schemes Amendment Act, 2002.

Resolution of problems in implementation of this cross-regulatory framework on health brokers has been facilitated by a joint technical team between the Office of the Registrar and the FSB, tasked with managing this interface.

The Act also requires persons acting as third-party administrators to be accredited by the Council. One of the technical deficiencies of the Act was that it did not contain a phase-in period for administrators to be accredited, so technically commencement of the Act would have immediately rendered the operation of existing administrators unlawful until such time as they had received accreditation from the Council. This was bound to take time, given the need to develop accreditation standards for administrators and to put in place the infrastructure to carry out this function. This resulted in a temporary legal lacuna. The second problem was that, whereas the Act required accreditation of administrators, the regulations initially provided little in the way of a regulatory framework to support the accreditation process.

Deficiencies in the regulatory framework around accreditation of administrators were remedied by means of amendments to the general regulations under the Act, which took effect on 1 January 2003. In the interim, an extensive process of consultation had taken place around the development of stan-

During 2004 the Registrar requested medical schemes to submit benefit and contribution changes by no later than the end of October, to allow timeous review of these changes by the office.

More stringent accreditation standards will be applied in the next phase of accreditation.

dards for the accreditation of administrators. In 2003, a tender was awarded to a consortium comprising COHSASA, KPMG and Sithole Inc to finalise the accreditation standards from a technical perspective, and to undertake the on-site evaluations of administrators necessary for the evaluation of accreditation applications. Because of the newness of this process, and lack of experience among all parties of implementing an accreditation process among medical-scheme administrators, the early phases of implementation of the contract were somewhat rocky, and took more time than had initially been expected. By the end of 2003, pilot evaluations had been conducted. And thereafter the on-site evaluation of administrators commenced in earnest. Concerned about the delays and the invidious legal position in which many legitimate administrators found themselves while waiting for their evaluations, Council took a decision in 2004 that bona fide applicants should be granted accreditation, conditional upon their subsequent successful evaluation in terms of the formal accreditation process. Many of these administrator accreditations had been concluded by the end of 2004.

Similar technical legal problems were associated with accreditation of managed-care organisations, which are required to be accredited with effect from 1 January 2004.

Extensive amendments to the regulations under the Act, which took effect on 1 January 2003, created the legal framework for accreditation of managed-care organisations, and put in place a number of basic requirements for the conduct of managed health-care activities. But, difficulties in developing appropriate accreditation standards for the rather fluid emerging managed care environment also contributed to delays in getting this process off the ground. Again, in order to protect legitimate organisations from potentially adverse legal consequences of operating without registration, during 2004 the Council issued preliminary accreditation notices conditional upon subsequent successful evaluations of these entities.

A basic “phase one” process of accreditation has been embarked upon, to ensure that minimum standards for the operation of managed-care organisations are in place, to establish a regulatory foothold in this emerging market environment, and to allow for more effective information gathering about entities purporting to do managed care business. In this process, given a degree of uncertainty around the parameters of the definition of managed health-care in the regulations, the intention has been to err on the side of inclusivity rather than exclusivity. As the regulations and accreditation standards develop with time, decisions can be made about more targeted regulatory interventions. More stringent accreditation standards will be applied in the next phase of accreditation within two years of the first round, which will focus on areas of particular policy concern, including the appropriateness of various forms of risk transfer in the managed care environment.

2.1.2.2. Reflecting on the present

During 2004, added complexity came into the process of rule approvals, in relation to difficulties which some medical schemes had in interpreting the requirements of the regulations, which took effect on 1 January 2004, in relation to designated service providers (DSPs). In retrospect, insufficient guidance

was provided to medical schemes upfront on what the office would regard as acceptable co-payments payable on prescribed minimum benefits when services are voluntarily obtained outside of a DSP. This compounded the annual problem of some medical schemes operating with as yet unregistered rules.

At the same time, rule approval processes are periodically reviewed to eliminate any potential inconsistencies which may have developed over time between the rules and the requirements of the Act. Specific attention is currently being given to benefit structures that have developed to include so-called “annual routine benefits”, and benefit options with differential contribution tables. Both these features have now been determined to be *ultra vires* the Act. Medical schemes are being advised to phase out this type of benefit structure with effect from 2006.

In relation to bargaining council medical schemes, a situational analysis was initiated jointly in 2004 between the Council and the Department of Labour, to gain a better understanding of these schemes and the environment in which they operate in order to properly inform policy decisions that need to be made in this regard.

Finally, the phase one accreditation both of managed care organisations and of administrators is rapidly nearing completion. Accreditations, when granted, are made subject to appropriate conditions which will allow the Council to rapidly intervene by withdrawing the accreditation of these entities if they are found to violate these conditions. The challenge from an administrative and systems perspective is to ensure that compliance with those conditions is adequately monitored.

Particularly in relation to the administrator evaluation process, positive feedback has been received that the evaluation process itself has assisted administrators in thinking of new ways to improve service and efficiencies in their business.

2.1.2.3. Looking to the future

Clearly, from a logistical perspective, there is still a need for more thinking into ensuring timeous submission of rules and expediting the rule approval process so that medical schemes are not operating without unregistered rules for any period of time. The experience of requiring medical schemes in 2004 to submit benefit and contribution changes by the end of October will need to be reviewed and, if it is found to have resulted in efficiency gains, should be considered for entrenchment in the Act or regulations. Implementation of online rule approvals and website access to the rules of all medical schemes should also assist in expediting the rule approval process.

A more fundamental issue contributing to this problem, however, is the unnecessary complexity of medical scheme rules, which also makes the business of medical schemes too complex. There is an urgent need to move the business of schemes to greater simplicity. In this regard, work has commenced on the development of a basic benefit package and of a few standardised supplementary benefit packages, which will also encourage medical schemes to compete more effectively on price, efficiency and choice of designated service providers. In the process, various elements of benefit structures need to be standardised, including the structure of medical savings accounts, how they

Positive feedback has been received that the evaluation process itself has assisted administrators.

There is a need for the Council to ensure standardisation of the way in which benefit structures get presented to the Council for approval

relate to deductibles, and their thresholds.

As an interim step before even greater standardisation of benefit structures, there is a need for the Council to ensure standardisation of the way in which benefit structures get presented to the Council for approval. This should facilitate expedited review and approval processes.

In relation to accreditation of administrators, decisions need to be taken on whether the function of evaluation of administrators should continue to be outsourced, or should be continued in-house. The Council holds the view that it is unrealistically resource-intensive to conduct accreditation of administrators (and brokers and managed-care organisations too, for that matter) every two years, and will be recommending to the Minister that this period should be extended in the regulations.

This will allow resources to be directed more effectively at monitoring compliance of conditions, identifying problem entities, and where appropriate, invoking the suspension and withdrawal provisions of the regulations in targeted cases. Priority should then be given to strengthening the capacity and ability of the Office of the Registrar to perform these compliance-related functions on an ongoing basis.

Greater attention also needs to be given to understanding the conditions conducive to investment by administrators and other entities in the medical schemes environment, and more particularly what needs to be done to encourage medical schemes to invest in their own administrative capacity.

There are a number of other areas that warrant further consideration by Council in relation to the achievement of this strategic objective, from a broad strategic and policy perspective.

The first such area is the regulation of brokers. There is a need for clearer delineation of the role of brokers between non-independent marketing agents of medical schemes, on the one hand, and independent brokers who advise and serve as agents of employers and members on the other. At present this distinction is blurred. The advice rendered by brokers to employers and members cannot be regarded as independent in the context of contracts between those brokers and the medical schemes whose products they are selling, and ongoing remuneration of those brokers by medical schemes.

In the preferred future scenario, brokers would register either as non-independent marketing agents of schemes, or as independent advisors to individuals and/or employers. Marketing agents would be entitled to remuneration for services rendered by schemes, the quantum of which would continue to be subject to regulation. This would be done in terms of a contract entered into between the broker and the medical scheme concerned. Independent advisors, on the other hand, would have no contracts with medical schemes, and would not be remunerated by those schemes. Contracts would rather be entered into between the broker and the individual or employer client, with the quantum of remuneration payable being at the client's discretion or subject to negotiation between the parties. Members would have to be clearly advised as to the accreditation status of the broker as a non-independent marketing agent, or as an independent advisor.

The second area for consideration is the further development of the regulatory framework for managed health-care. Obvious deficiencies in the existing

framework relate to uncertainties about the scope of the definition of managed health-care organisations (and accordingly precisely which entities fall within and outside the net requiring accreditation), as well as inadequate regulation of arrangements entailing the transfer of risk. In the absence of effective regulation of risk transfer arrangements in the context of managed care, there is a risk that similarly inappropriate arrangements will develop as occurred in the context of reinsurance. In addition, in the context of risk transfer, there needs to be further evaluation of the extent to which solvency regulation is required (see above discussion of risk-based capital approaches to solvency).

Thirdly, the legal and administrative uncertainty over the regulation of bargaining council schemes must be resolved once and for all. A significant concern is the lack of adequate legal protections that members of these schemes are currently exposed to. Even though several such schemes reported good solvency levels, there are concerns that these levels are not sustainable and that, despite good solvency, members have access to inadequate or sub-standard benefits. Another concern that has been raised is the apparent overlap between the use of medical contributions in some sick benefit funds to fund not only medical aid contributions but other social benefits too, sometimes via the administration fees payable to bargaining councils.

Nevertheless, in considering potential policy responses to unresolved issues of regulation of these funds, it needs to be acknowledged that by and large they are carrying out an important function that is complementary to the objectives of the Council for Medical Schemes. These schemes provide an alternative to many of their members who otherwise would not afford medical scheme coverage. Bargaining council schemes themselves acknowledge their strategic importance. While several schemes reported during interviews that they are not averse to being more fully regulated, they fear that integration under the Medical Schemes Act would threaten their existence as an integral part of the collective bargaining process. Any move to integrate them under the regulatory umbrella of the Medical Schemes Act should take this concern into consideration.

Preliminary recommendations by the research analysts involved in the situational analysis of bargaining council schemes suggest that it is necessary to separate out the business of the medical scheme from other social benefits derived from the collective bargaining process. Discussions with affected bargaining councils and labour organisations should emphasise the benefits to be derived by their members from being brought under the regulatory umbrella of the Medical Schemes Act, particularly in the context of moves towards risk equalisation and social health insurance.

In relation to the prescribed minimum benefit (PMBs) requirements of the Act, there needs to be acknowledgement that, whereas some of these funds collect contributions which are adequate to cover the costs of PMBs, a special dispensation may need to be developed in relation to coverage of PMBs by other funds, especially if integration of these schemes takes place at a time when income-related cross subsidies are not yet in place.

It is also worth bearing in mind that some of these funds have developed some interesting preferred provider organisation arrangements, or have in place operations that resemble health maintenance organisation arrangements.

In the absence of effective regulation of risk transfer arrangements in the context of managed care, there is a risk that similarly inappropriate arrangements will develop as occurred in the context of reinsurance.

An extensive trustee-training programme was implemented in 2001.

These funds have many years of experience in providing health care directly to their members. These models should be seriously investigated to determine whether they can be rolled out to cover more members from their relevant economic sectors.

The ability of the Council for Medical Schemes to put in place mechanisms for the appropriate regulation of Bargaining Council Schemes is ultimately dependent on total buy-in from critical stakeholders. The central role of the Department of Labour in this whole process is acknowledged and their involvement should be assured with every step. The Council already has the support of the Department of Labour, which has indicated concerns over its own capacity to regulate adequately the operation of these funds. The Department has, however, voiced political concerns that the Council should provide a viable strategy on how it is going to take over regulation of such funds without creating upheaval in the labour relations environment. This should be achieved by first ensuring the total buy-in of strategic unions. The National Association of Bargaining Councils (NABC) is also another vital stakeholder in the process. Even though not all bargaining councils are subscribers to this organisation, it nevertheless possesses strategic influence over its members and other non-member bargaining councils.

2.2. Support and guidance to trustees; promoting understanding of medical scheme environment

2.2.1. Support and guidance to trustees

2.2.1.1. Visiting the past

Ensuring proper governance in medical schemes has been a key concern of the Council in the past four years, because there was clear acknowledgement of the fact that this was a major key to protection of members' interests. One of the very first activities of the office of the Registrar in 2000 was to organise a series of governance workshops for principal officers and trustees of medical schemes with a view to supporting governance initiatives in compliance with the new Act, as well as to discuss constraints which trustees of schemes were experiencing.

An extensive trustee-training programme was implemented in 2001, to educate trustees on the Act, on their roles and responsibilities, on principles of good corporate governance, administration of medical schemes and on financial governance. This programme has since been extended to monthly trustee-training programmes in centres around the country, with basic modules for new trustees and more-advanced modules for trustees who have served for longer periods. Advanced modules include training on issues such as developments in national health policy and clinical governance. Regular trustee-training programmes are supplemented by annual "roadshows" to engage with trustees about the findings of the Annual Report of the Registrar, and other policy developments.

During 2002, the Council commissioned the University of Pretoria to con-

duct a survey of governance practices among trustees of medical schemes, with a view to better understanding governance practices and providing information to allow trustees to benchmark their governance practices against best industry practice. The study reinforced the view that sound governance of medical schemes was critical to their successful operation and to the best interests of members. The study found many aspects of board function that were working well. At the same time, there were many gaps in board performance against reasonable expectations, some widespread and serious. Specific recommendations were made as to how improvements could be effected. The findings of the study and the recommendations were workshopped with trustees around the country.

At the same time, the Office of the Registrar has always been available to provide additional support to trustees where this has been requested.

In general, it would appear that trustees have performed well in increasingly acting independently in the best interests of members. Unfortunately, however, there continue to be too many instances of governance failure. In some cases, such as Telemed, KZN Medical Scheme, and Medicover 2000, this has resulted in the Council approaching the High Court to place these schemes under curatorship. In the case of KZN Medical Scheme, no sooner had the scheme's curatorship been lifted than it had to be placed under curatorship again. In other cases, Council has applied other forms of intervention to resolve crises in governance, including inspections, and suspension or removal of members of boards of trustees. Actions by Council against trustees have taken the Council into some litigious terrain, but this has not deterred the Council from continuing to act in the interests of members.

2.2.1.2. Reflecting on the present

Despite generally high standards of governance among medical schemes, the number of instances of governance failure remains a concern. In light thereof, work has intensified in the past year on improving standards of governance guidelines available to trustees and the training material provided during trustee training programmes.

In addition, a major emphasis of Council during 2004 has been placed on better understanding the causes of governance failure, and this has become the subject of a theme project during 2004. In the first phase of this project, case studies were made of eight medical schemes which had experienced governance failures in the past few years. In this context, governance failures were defined as the violation of the principles of good governance resulting in the total collapse of the medical scheme or severe difficulties encountered by the scheme. In these case studies, some of the factors that had contributed to failure included:

- Strong administrator influence on the affairs of the scheme;
- Lack of arms-length relationships between trustees and third-party contractors, and other conflicts of interest;
- Division within the board;
- Fraudulent conduct;
- Poor financial oversight and;
- Poor expertise and skills mix of the board.

The Office of the Registrar has always been available to provide additional support to trustees where this has been requested.

Not enough is done to ensure that elected or appointed trustees are indeed “fit and proper”.

2.2.1.3. Looking to the future

Many of the remaining problems experienced in the medical schemes environment are merely symptomatic of core shortcomings in governance. Regulatory attention therefore needs to continue to be directed at this issue.

Based on the findings of the theme project on causes of governance failure, an assessment will need to be made of whether the existing legislative model of medical scheme governance (which is predicated on promoting member participation and ensuring independence of trustees from parties with commercial interest), is itself a contributory factor toward governance failures, or whether these failures would occur in any event even if the model were different.

A key weakness in the Council’s approach to governance problems is that not enough is done to ensure that elected or appointed trustees are indeed “fit and proper,” as required by the Act. More substantive guidance on the definition of “fit and proper” needs to be provided in the Act, and practical mechanisms need to be found to put this requirement into effect.

There is also an argument that trustees found guilty of willfully or negligently mismanaging the affairs of a medical scheme should be more severely dealt with, to serve as a deterrent to others. At the same time, the Council needs to continue to develop its trustee-training programme to ensure that the potential for governance failure due to skills shortages is minimised.

A more fundamental matter relates to the “elections” that are held to appoint trustees. There is now overwhelming evidence to suggest these processes are far from adequate and are prone to undue influence from many parties. There is a need to conduct a review of these processes to minimise these risks. The Belgian model may hold some promise in this regard. A better understanding is also required of the conditions that need to be created to incentivise greater member interest and participation in the affairs of their medical schemes.

2.2.2. Promoting understanding of the medical schemes environment

2.2.2.1. Visiting the past

One of the findings of the Stakeholder Analysis, conducted for the Council in 2000/1 was that only 2% of medical scheme beneficiaries claimed to know the provisions of the new Medical Schemes Act very well, with 6% knowing them fairly well and 9% knowing them slightly. Two thirds of beneficiaries, and 90% of non-beneficiaries, knew nothing of the new dispensation.

At the time of the survey, there was little knowledge of the Council, and the services it offered, among beneficiaries of medical schemes. 3% of beneficiaries indicated that, if they had a complaint or needed information, they would approach the Council as a first resort. 17% of beneficiaries indicated that they would use the Council as a last resort for a complaint or query – about as many as would resort to legal action.

In response to these findings, a very active consumer-education programme has been embarked upon in the past five years, by means of workshops, educational seminars, use of the media, exhibitions, and production and distribution of educational material (pamphlets and Z-cards) dealing with the rights

and responsibilities of members.

These activities were conducted with the following consumer groups: provincial consumer affairs officers; consumer groups (e.g. Consumer Union, National Consumer Forum, and Consumer Leagues); paralegal officers; community advice centres and other non-governmental organisations; trade unions (shop stewards, education officers and benefit coordinators); employee assistance practitioners; and government departments. Synergies with other regulators in consumer education initiatives were advanced through interaction with the Regulators' Consumer Forum.

The focus areas of the workshops included an understanding of the role of the Council, member rights under the Act and complaints procedures. Some of the findings from these initiatives were included in the Fair Treatment Project, which is discussed below.

2.2.2.2. Reflecting on the present

Anecdotally it would appear that consumer understanding of the medical schemes environment has improved significantly over the past five years. Certainly, as far as consumer awareness of rights and responsibilities in relation to medical schemes are concerned, responses have been positive from the extensive workshops that have been held. A positive trend has also been increasingly informed media coverage of issues within the medical schemes environment, which is both an indicator of, and contributor to, better consumer awareness of medical schemes.

However, the Council does not have an objective basis on which to assess overall levels of consumer awareness of the Act and of the Council itself. It is therefore imperative that the 2000/1 stakeholder analysis is now followed up with a more-limited repeat survey. This will also provide the opportunity to gauge the extent to which consumer reactions toward changes brought about by the Act, and toward the strategic objectives of the Council, may have changed over the past five years.

In interactions with consumers, it would appear that there is also a sentiment that re-regulation of the medical schemes industry has covered some bases for consumers, but has still allowed gaps in protection for others. Many of the gaps were highlighted in the Fair Treatment conference held earlier in 2004. This is indicative of the fact that while significant gains have been made by the Council in the past five years in relation to prudential regulation, there is still much room for improvement in relation to market conduct regulation, and greater focus should be placed on this aspect in planning processes of Council.

2.2.2.3. Looking to the future

Experience in interacting with consumers during the consumer education programmes has highlighted the need for Council to work through the realities of the law from the perspective of a consumer (rather than of a scheme or of a doctor, for instance).

The Act, and Council's regulatory approaches, need to be reviewed from the perspective of a consumer who would first be looking for a scheme, dealing with brokers, gathering and deciphering marketing material, signing contracts

Consumer understanding of the medical schemes environment has improved significantly over the past five years.

There is a need for the consumer education efforts of the Council to place more emphasis on reaching employers

with obligations and rights, becoming a party to a set of rules with arcane concepts (co-payments or managed care) pondering how the rules relate to the marketing material (a study all on its own), trying to understand waiting periods, deciphering complex products, wondering how to get appropriate cover, what is covered, what choices there are, what her/his rights are when the application form is signed, how to access debit orders, electronic processing, issues of confidentiality and so on. This thinking must then be followed through to the resolution of complaints, disputes and how to enforce rights by having a system that penalises “wrong-doers” in the system. And then, the focus must turn to ensuring good health outcomes from the health-care coverage that is provided.

A particularly large gap faced by consumers is that between what is registered in scheme rules and what consumers face with limited and sometimes misleading marketing information or consumer information.

A previous draft regulatory requirement that all marketing material should be submitted to the office at the same time as contribution and benefit changes was rejected due to practical reasons. However, other ways of ensuring appropriate marketing material must be found. For example, occasional surveys of marketing material and of communication with members could be conducted by the Council. Alternatively, voluntarily submitted marketing and member communications could become the subject of a competition, which would require outside people to agree to be judges and to look at the material from a perspective of plain language, simplicity and accuracy.

Also, there is a need for the consumer education efforts of the Council to place more emphasis on reaching employers who spend billions of rands annually purchasing health care, partly in the form of subsidies, for their staff.

As a general rule, although there are exceptions, employers take little notice of the effects of this purchase aside from the bottom line, and give little thought to how it might best be maximised. Given the types of complaints by consumer groups, many employers are also not aware of many of the types of problems encountered by their employees with their medical schemes, and with the health care problems of their employees in general.

This has not always been the case. The mines and railways were among those employers that did see these issues, although they resolved the problems for one group only. At present, the civil service is another employer that seeks to have greater input into the health-care options of staff. In addition, several employers, albeit belatedly, saw the need for interventions when it came to HIV/AIDS. Employers therefore have some track record in taking appropriate action.

The issues that can prompt employers to looking at staff healthcare needs are wide-ranging and worth taking into account.

- Increasingly, unions both here and abroad are placing health care on their list of demands along with salary increases.
- In certain instances – like HIV/AIDS and TB – it makes simple economic sense to ensure that employees are treated.
- With health-care expenditure showing few signs of declining, it is prudent to ensure that the money is well spent.
- Some purchases of health-care products are simply bad, with employers

failing to see the effects of the scheme and benefit options on staff, forcing families to leave schemes to cut expenses.

- Medical schemes with current governance structures can be pressurised by employers into building benefit options that might suit their own employee profile.
- Some products sold to employers are illegal and when stopped, can cause hardship and difficulty to staff.
- Health outcomes in the USA are now an important factor for employers when considering how well their dollars are spent. Having been through high inflation and low coverage of workers, and more recently the lowered prices of managed care interventions with fewer good outcomes, there is a growing emphasis on ensuring that when money is spent on health care of employees, the outcome is worthwhile.
- Most importantly, however, employers are by now likely to understand that not participating in a dialogue will minimise their ability to have a say at the end of policy processes, particularly in the context of changes to the tax subsidy system, of establishment of a risk equalisation fund and of implementation of Social Health Insurance, together with mandatory health-care cover.

A knee-jerk reaction from employers is likely to be to want to bail out of expensive obligations (as they have been doing already to the extent that large numbers of pensioners have lost their cover). The issue here would be to find ways of ensuring that employers spending money on health care, do it prudently and wisely – by making them take an interest in these issues.

A method of drawing employers into this would be to provide a group of well-structured meetings under the more general heading of the future of health care (including social health insurance, the risk equalisation fund, and so on) and place into that environment a notion of how employers can become more involved and interested in medical schemes.

Particularly important in these interactions would be to promote an increased understanding among employers of cost to company of health-care funding alternatives and the tax expenditure subsidy. The interactions should be driven by an understanding that employer strategies can, in some instances, have a great impact on access to health care. These strategies therefore need to be informed by a better understanding among employers of changes to the health-care environment, and the impact of these changes on them, and, consequently, on the need for greater involvement of employers with the financing vehicle.

It would be important to reach certain groupings of employers first. The Chambers of Commerce and other industry bodies are a good place to start. The Durban Chamber of Commerce has a division which actively looks at health issues with an emphasis on AIDS. The Chamber of Mines has a division heading up its healthcare initiatives. Multinational firms tend to belong to bodies such as AmCham and one can also target individual large employers. The list might include banking groups (or the Banking Council), major insurers, universities and the like.

One would want to ensure the presence of decision makers in companies, and not their healthcare brokers – and this may perhaps mean smaller target-

Increasingly, unions both here and abroad are placing health care on their list of demands.

Providers are literally at the interface between members and their benefits.

ed groups, over a dinner and with somebody present to introduce the event who would be irresistible to an employer. The Minister of Health may be requested to provide opening remarks. The Council could also take a “road-show” like this into the boardrooms of the some of the organisations on request.

Healthcare providers constitute the other constituency which, strategically, needs far more attention in the deployment of Council’s resources in relation to communication and education. Providers are literally at the interface between members and their benefits and entitlements of access to health care, and are often the first to identify difficulties in relation to member access to medical scheme benefits.

They also have a direct financial interest in ensuring that members are properly informed about entitlements to medical scheme benefits and of their rights *vis-à-vis* their schemes, because it impacts on their own reimbursement. Provider conduct in relation to practices such as split billing and balance billing has the potential to impact negatively on member access to health care. Their cooperation is also critical in relation to the implementation of cost effective and rational managed health-care measures.

It is clear, though, that all communication and education activities of Council have to be underpinned by the development and implementation of a communication strategy that delivers effective, clear and timely information about medical schemes to consumers, employers, health- care providers and the public.

2.3. Foster compliance with the Act and initiate enforcement action where required

2.3.1. Visiting the past

Much of the focus of Council’s activities since 2000, in particular in relation to trustee training and ongoing interactions with industry players, has been on developing an environment based on voluntary compliance. Unfortunately, in many cases this is not enough and the Council has had to resort to coercive forms of enforcement. This has been facilitated through the establishment of a dedicated compliance office, which is staffed by a Head of Compliance who works in close liaison with the legal and complaints divisions of Council.

In the early stages of implementation of the Act, some industry players resisted policy reforms, particularly through developing and maintaining products to circumvent the provisions of the Act – in particular in relation to open enrolment and community rating. Considerable time, for example, was spent dealing with “health insurance” products that were, in fact, doing the business of a medical scheme. Delineation of health insurance from medical scheme products became known as the “demarcation” issue.

During 2000, discussions took place between the Council, the Financial Services Board (“FSB”) and the Policy Board of the FSB to resolve areas of uncertainty around demarcation. This culminated in a joint statement between the Council and the FSB clarifying the demarcation issue.

Attention then turned to insurers, whose products crossed the line, including so-called “hybrid” products. This drew angry responses from stakeholders such as the Life Offices Association, the South African Insurance Association, Discovery Health Limited and Fedsure, and various strategies were deployed to discredit the work of Council in this regard.

Progress was ultimately made during 2000 with Fedsure withdrawing its hybrid product from the market. Yet other industry players held out, and Liberty maintained its Liberty Lifestyle policy despite pressure from the Council for this product to be withdrawn. At the end of 2003, the Council instructed the Registrar to take legal action, in the High Court if necessary, to enforce the demarcation framework.

In the face of pending legal action, the Liberty Group backed down and opted to stop selling its Liberty Lifestyle and Medical Lifestyle policies in order to ensure compliance with the provisions of the Medical Schemes Act. The agreement between Liberty and the Registrar ensured that while these policies would no longer be sold, existing policy-holders’ rights would still be protected. To that end, limited temporary exemptions were granted in respect of existing policy-holders.

Other unregistered operations have also been targeted by enforcement actions of Council over the past few years, and a number of such operations have closed or modified their products in relation to interventions of Council to ensure compliance with the Act. Sometimes, these responses have been voluntary. At other times, it has been necessary to resort to prosecution actions.

An example of the latter was Africa Health, a bogus operation that openly sold unregistered “medical scheme” products on the market, even employing brokers to sell these products on its behalf. In the process, poorer and less-educated people were targeted by the marketing of this product. Unfortunately, the process of prosecution through the courts in this case proved to be slow. Ultimately, however, the operators of Africa Health were successfully prosecuted for contraventions of the Medical Schemes Act, but they escaped the more serious charges of fraud.

Much of the work of this division has entailed the coordination of inspections, either prompted by *prima facie* concerns of financial or governance irregularities, or merely routine inspections to ensure compliance with particular provisions of the Act, such as the regulation of commission payable to brokers.

Inspections have, on occasion, been met with fierce legal resistance. One example of this, during 2003, was an inspection ordered into the affairs of Medshield based on *prima facie* concerns about the relationships between the medical scheme, its administrators, its brokers and various other entities, that appeared to have been detrimental to the interests of members of the scheme. The medical scheme’s brokers, MAPP, successfully applied to the High Court for an interdict to stop the inspection. The applicants requested that the matter be heard on the constitutionality of the use of the Inspection of Financial Institutions Act. MAPP later withdrew this application, and paid Council’s legal costs in the matter. In settlement, they agreed to repay some R20 million back to the medical scheme.

Inspections have, on occasion, been met with fierce legal resistance.

Enforcement efforts continue to be hampered by slow prosecution and judicial processes

2.3.2. Reflecting on the present

On the whole, the industry has come to accept – and in most cases support – the policy direction of the new Act, which has led overall to higher levels of voluntary compliance.

There will, however, continue to be instances of fraudulent and obstructive behaviour on the part of a minority of players in the market, and this will continue to be met by aggressive enforcement actions. The demarcation issue will, for instance, continue to be a focus of enforcement actions on the part of Council.

Enforcement efforts continue to be hampered by slow prosecution and judicial processes, and the office of the Registrar is attempting to address this issue as best as it can by developing closer relationships with the National Prosecuting Authority and other specialised commercial crime investigating authorities.

An even more difficult challenge in enforcement than the “major” crimes are the more common “smaller” circumventions of the provisions of the Act, such as the requirement for medical schemes to pay claims within 30 days. Broader processes within the office, such as the administrator accreditation process, are aimed at addressing these issues. But unpaid claims continues to be by far the source of the highest number of complaints reaching the office, and it is simply not feasible to institute prosecution proceedings against medical schemes on the basis of failure to comply with the 30-day payment requirement in every individual circumstance.

2.3.3. Looking to the future

Although the MAPP challenge to the constitutionality of the Council invoking the provisions of the Inspection of Financial Institutions Act never went further, this does highlight the need for a review of the enforcement remedies available to the Council to ensure that in all respects they meet the requirements of the Constitution.

Consideration should be given to commissioning a review of the enforcement provisions by an expert both in criminal and in constitutional law from the constitutionality perspective, as well as to suggest improvements that can be made to the legislative framework to ensure that Council has optimal powers of enforcement at its disposal. Where appropriate, amendments to the law can be introduced. If appropriate penalties are not available, there is no use threatening offenders with sanction, and the Council runs the risk of becoming a toothless structure.

Various other considerations need to be taken into account in any review of enforcement remedies and procedures available to Council.

- To be effective in promoting compliance, enforcement actions need predictability. Council should be working towards a situation where it is quite clear to all regulated entities that a particular type of infraction will attract a particular response. This requires coherent application of compliance tools and allows for better definition of penalties. These infraction categories and relevant responses could be codified in a compliance manual.
- Notwithstanding the need for predictability, some degree of flexibility in enforcement procedures must remain, given the fact that the appropriateness of compliance procedures is in some instances policy-specific. Appropriate

compliance strategies for demarcation infractions may not necessarily be the appropriate strategy for reinsurance-related offences, and so on.

- There is a need for “lesser” forms of penalty, which are less severe than, for instance, withdrawing the registration of a medical scheme. At the same time, development of these penalties needs to take account of their impact. For example, fines imposed on medical schemes may be detrimental to the schemes’ members, as opposed to serving as a disincentive to the perpetrators of an offence.
- Development of appropriate sanctions needs to take account of the important issue of redress for past violations, especially where these have resulted in financial loss to schemes. Unless this is done, past ill-gotten gains are in a sense legitimised, and non-compliance is incentivised.
- Another important consideration that ought to permeate any review of Council’s enforcement procedures is that, as a regulator, the Council exerts influence through its enforcement actions, and enforcement is principally about the messages that Council gives and the timing of such messages. For the messages to be effective, Council has to find a way of shortening as much as possible the time between an event occurring and the subsequent enforcement actions, while retaining fair administrative procedure. At the moment this time is sometimes too long, and lacks clarity predictability. This often results in the impact of Council’s enforcement actions being muted or misunderstood.

Finally, and perhaps most importantly, there is a need for the Council to move away from a focus on counting enforcement actions for their own sake to a focus on increasing levels of compliance within the medical schemes environment. Such a change in focus would allow for the deployment of a whole array of “tools” for compliance, including:

- Education;
- Outreach;
- Partnership;
- Consensus and;
- Facilitation.

In this context it is important to explore whether the organisational structure of the Registrar’s Office is indeed geared towards a shift in emphasis from counting outputs to measuring compliance levels, which is consistent with the search for results, for effectiveness and for mission accomplishment.

2.4. Investigate and resolve complaints

2.4.1. Visiting the past

An important function of the Council, in terms of the Act, is the investigation and resolution of complaints and settlement of disputes in relation to the affairs of medical schemes.

In 2000, a dedicated Complaints Unit was set up within the Office of the Registrar to deal with complaints. As with so many other processes within the Office, the priority of the new unit was to clear a huge backlog of complaints

There is a need for the Council to move away from a focus on counting enforcement actions for their own sake to a focus on increasing levels of compliance

Most complaints are resolved through mediation.

that had developed within the Department of Health.

The number of complaints directed to the Office has never really declined, and complaints continue to be received at an average of approximately 200 per month. This is not necessarily an indication that consumers are not experiencing an improvement in market conduct by medical schemes, but is as likely to be attributable to consumers become increasingly aware of the Council. This is nevertheless a far cry from the experience of the Control Office responsible for oversight of sickness funds in Belgium, which reported that it deals with only a handful of complaints each year!

Complaints are received typically from members, legal advice offices, consumer groups acting for members and health-care providers. Complaints may be submitted online, or may be faxed, emailed or posted, and analysts are available to assist members in the lodging of a complaint. Most complaints relate to unpaid accounts, but a large spectrum of issues generates complaints. Other common issues complained about include unfair termination of membership, unauthorised deductions and benefit exclusions, unfair reversals of payments to providers, unfair imposition of waiting periods or late-joiner penalties.

A complaints database was developed by the IT Division of Council, to allow for the proper capturing and tracking of complaints. This database has also allowed statistics on complaints to be monitored by management. These statistics frequently provide insights into potential problems within schemes or the industry more generally which extend beyond individual members.

Rates of complaints are also tracked in relation to individual medical schemes, which often provide an early warning of administrative or governance problems in the scheme. Complaints numbers tend to peak in times of problems with particular medical scheme. So, for example, KZN Medical Scheme generated large numbers of complaints in the lead-up to it being placed under curatorship. Complaint numbers dropped off significantly when the scheme was placed under curatorship.

Most complaints are resolved through mediation, although the complaints division must not infrequently resort to using the dispute and appeal mechanisms laid down in the Act.

The establishment and management of the complaints function of the Council have not been easy, and the unit has not always functioned sufficiently effectively. At times, unacceptable backlogs were allowed to develop, in large part because of delays by schemes in dealing with issues referred to them, but also because of failure to adhere to critical procedures in the Registrar's Office.

In addition, it became apparent that some of the analysts themselves did not fully understand the provisions of the Act, which led to institution of more regular in-service training, which was combined with training on customer service.

The Council also established a committee of Council, dedicated to hearing appeals against decisions of scheme disputes committees and decisions of the Registrar in the resolution of complaints. Complaints against decisions of this committee (and against any other decisions of the Council) can be lodged with the Appeal Board, established by the Minister in terms of section 50 of the Act.

2.4.2. Reflecting on the present

Greater attention to in-service training and to efficiencies within the complaints division is producing better results. The division is still, however, burdened with high levels of “unnecessary” complaints, which could be avoided through more education of consumers as to their rights and responsibilities. This points back to the need to continue and, in fact, to escalate consumer education initiatives of Council, as discussed above.

However, the biggest challenge to efficiency in the complaints resolution process remains its complexity. There are simply too many levels to the process, which may potentially involve the principal officer, the scheme’s disputes committee, the Registrar, the Council or its appeal committee, the Appeal Board, and then the courts at different levels. In contested cases, this process can be very drawn out and draining of emotional and financial resources, especially those of complainants. The adage “justice delayed is justice denied” is particularly apt in this context.

With regard to customer service, the Council has during 2004 ensured that all members of staff attended a course on improving customer service. The Council is currently in the process of finalising a Service Charter for its customers which will outline a number of service standards, including service standards with regard to resolution of complaints, replies to written correspondence, telephone responses, standards with regard to the registration process, etc.

2.4.3. Looking to the future

The procedures laid down in the Act for resolution of complaints need to be urgently reviewed. This review needs to take into consideration principles of: reasonableness and procedural fairness; equity; transparency; accessibility; and expeditiousness. Specific areas which need consideration include:

- The circumstances in which an aggrieved party should be able to complain directly to the Council, as opposed to first following dispute resolution procedures within schemes;
- Potentially prescribing time periods in which disputes committees of schemes must be convened and/or the disputes finalised, together with penalties for failure to meet these time frames;
- Expedited processes for the resolution of urgent complaints.

In particular, attention should be given to the possibility of reducing the number of “levels” which a complaint may potentially need to go through prior to its resolution. This may entail the creation of an office of an “ombud,” potentially separate from the office of the regulator, with powers to make binding or non-binding determinations on disputes.

Various models may be looked at in this regard. In Australia, the Private Health Insurance Ombud deals with inquiries and complaints about any aspect of private health insurance. The Ombud is independent of the private health funds, private and public hospitals and health service providers. Closer to home, the Financial Advisory and Intermediary Services Act, Act No. 37 of 2002 now provides for the office of an Ombud, who is authorised to investigate complaints by consumers arising from intermediaries giving advice, and to make rulings in respect of those complaints.

The biggest challenge to efficiency in the complaints resolution process remains its complexity.

Dispute resolution processes at scheme level need to be standardised

A more comprehensive document has been prepared by the Complaints Division exploring a number of alternative models.

The first option suggested in this document is for the Act to be amended to require all complainants, except for emergency cases, to have fully exhausted dispute resolution processes at scheme level before an appeal is made directly to the Council. Complaints would then follow the normal process of complaints to the Appeal Board, and ultimately to the courts. The dispute resolution process at scheme level would be more fully prescribed in the Act or regulations. In this way, time-consuming complaints at the level of the Registrar's office would be by-passed, and resources of the office would be concentrated on speedily channeling complaints through the appeals process. However, there is no guarantee that dispute resolution processes at scheme level will be either expeditious or impartial. It is also likely that this process would be too burdensome on members of the Appeals Committee of Council.

The second option would be to maintain the existing system, but to amend the Act to better regulate dispute resolution processes at scheme level, to require mandatory exhaustion of dispute resolution processes at scheme level before complaints are lodged with the Registrar (except in emergency cases), and to clarify perceived ambiguity in the Act in relation to the circumstances in which an appeal may be lodged to Council. Whereas this would assist in dealing with some of the anomalies in the complaints process, it does not deal with concerns raised in relation to issues such as the prolonged time it takes to resolve complaints.

The third suggested option would be to provide for dispute resolution processes at scheme level, to formalise mediation and arbitration procedures to be followed by the office of Registrar in dealing with complaints, in particular to provide for binding arbitration decisions to be made in the event of failure of mediation to resolve issues (similar to powers of the CCMA), and then to enhance the powers of Council to prosecute offending parties for contraventions of the Act. The appeal against such a decision would lie to the High Court. The advantages of this process is that it allows for flexibility in procedures, and gives rise to binding agreements or arbitration awards without the matter going through a whole series of appeal processes. This approach gets closer to the ombud model, but there is an argument that the functions of ombud and regulator are properly separated. Arbitration proceedings are also quasi-judicial in nature, and would require specialised expertise.

Whatever model is ultimately selected, it is clear that dispute resolution processes at scheme level need to be standardised and more fully prescribed through regulation, and that all complaint resolution processes need to be informed by basic principles of administrative law, including the requirements of procedural and substantive fairness.

2.5. Monitor impact of Act, research developments, recommend policy options

2.5.1. General research and policy developments

2.5.1.1. Visiting the past

Virtually every intervention of Council described above was underpinned by some form of research to ensure that, as far as possible, standards of best practice are maintained. In this section, some of the major research outputs and processes of Council since 2000, which have not been discussed elsewhere in this report, are described.

Soon after the establishment of the office in 2000, the Council commissioned a comprehensive stakeholder analysis by MarkData (Pty) Ltd with a view to supporting the development of strategic direction for the Council and to providing consolidated research in respect of stakeholder positions *vis-à-vis* the various strategic options available to Council. The process included interviews with some 217 stakeholders, and a survey of 2201 households. A fascinating report was produced, which highlighted strengths and weaknesses of Council's first year in operation under the new Act, as well as public and stakeholder opinions on various policy options available to the Council. This led to some far-reaching changes to the way that the office of the Registrar functioned and was structured.

Another early project was a survey conducted by the Research and Monitoring Division to evaluate data collection practices within the medical schemes industry, focusing primarily on indicators for access to health care, utilisation, cost and quality of care. The results showed that, while medical schemes generally collected good data on scheme expenditure, collection of data on other key variables was very patchy and in many cases non-existent.

This study formed the basis for extensive modification of the statutory returns required to be furnished to the Office of the Registrar. It also resulted in the establishment of a committee, with experts from the industry, on the standardisation of data and billing practices. This committee produced a report containing guidelines in the following areas: minimum datasets, diagnostic and procedure coding, electronic switching, pharmaceutical coding, and privacy and confidentiality of member information.

The report in turn gave rise to further changes to the statutory returns, and set in motion a process toward mandating industry-wide implementation of ICD10 diagnostic coding. An ICD10 task team was established at the beginning of 2004 with representation of the Department of Health, medical schemes and administrators, providers and switching companies. Its brief was to develop a strategy for the implementation of ICD10 in the medical schemes environment. This included an assessment of the readiness of funders, providers, switching companies and other relevant stakeholders to implement ICD10 during 2005. The process culminated in a report, and all indications are that ICD10 will indeed be rolled out in the course of 2005.

As policy discussions developed around potential modifications to the prescribed minimum benefits ("PMBs"), Council saw the need for any policy

All indications are that ICD10 will indeed be rolled out in the course of 2005.

The PMB costing study found that the package was well covered within overall industry expenditure on benefits and was unlikely to put upwards pressure on contributions.

developments in this regard to be underpinned by updated research on the affordability of the PMB package. In 2002, the Centre for Actuarial Research (University of Cape Town) was commissioned to conduct the research. The study found that the complete PMB package was well covered within overall industry expenditure on benefits, and was therefore unlikely to put upward pressure on contributions. After meeting costs associated with the PMB package, schemes in general still had more than half of their pooled contributions for other benefits and non-healthcare costs in excess of those already accounted for in the PMB price.

One of the strong recommendations of the report was also that the PMB package needed to be better defined, by linking the diagnostic codes in the PMB list to ICD10 codes. This resulted in a process of ICD10 coding of the entire PMB package, which was completed toward the end of 2004.

One of the principles adhered to in research processes within Council, is the need to ensure that policy recommendations take into account international experience. Research processes have been enriched by various interactions with international experts on health system development and private health funding.

In 2001, six members of the Council and staff undertook a study tour to Belgium, the Netherlands and Ireland to understand the experience of these countries in implementing similar measures to those provided for in the new Act. As a follow-up to this visit, in February 2003, the Council hosted members of the Belgian Control Office of Sickness Funds, and the industry representative body, to have more detailed discussion of their experiences with government, industry and labour representatives in South Africa. This experience was most positive, and especially assisted in thinking through policy options on tariff setting practices and the introduction of a risk equalisation fund.

Discussions with the Belgians, and contacts established through their facilitation, gave rise to a further process involving the hosting of international experts in South Africa. In this case the Department of Health, in conjunction with the Council, invited a team of international experts to review technical proposals on risk equalisation, which had been developed for the Department by two task teams established by the Director-General of Health. The review panel was made up of six experts with direct experience and knowledge of related reforms in Australia, the United Kingdom, Ireland, Netherlands, Germany and France. The review panel provided a fascinating report that assessed the proposed policy framework for risk equalisation, providing suggestions for improvements and advising on best-practice options to the South African proposals.

A related study tour took place in 2004, where three staff members visited the Netherlands, Ireland and Oregon to investigate first-hand experience in developing, implementing and administering a basic benefit package, which is a key component of the risk equalisation proposals.

Many of the research processes undertaken by the Council translated into legislative and other policy interventions, of which there were a number in the period under review. In all these cases, the Council worked closely with the Department of Health in developing and supporting the legislative and policy processes.

Two significant amendments were made to the Act since 2001.

The Medical Schemes Amendment Act, 55 of 2001, became effective on 1 March 2002. This Act provided for improved tools for monitoring and enforcement by Council, as well as greater oversight over reinsurance practices of medical schemes. It placed new restrictions on improper marketing and conditional selling. Provision was made for greater independence of trustees, principal officers and auditors, as well as for the disclosure of trustee remuneration. There were also changes to the provisions regarding application of waiting periods.

The Medical Schemes Amendment Act, 62 of 2002, came into operation on 1 May 2003. The Act expanded the definition of “health broker” to allow for consistency with the Financial Advisory and Intermediaries Act (FAIS). Health brokers became subject to the regulatory framework provided by FAIS, without compromising the Minister of Health’s and Council’s jurisdiction over health brokers. The Act also restricted the categories of persons who may compensate brokers for broker services, to limit perverse financial incentivisation of brokers.

Substantial amendments were made to the regulations published under the Act in November 2002. These amendments took effect on 1 January 2003, with the exception of amendments introducing the chronic disease list, and providing for delivery of PMBs through designated service providers. The latter amendments took effect on 1 January 2004. Significant amendments were made in the following respects:

- The PMB package was extended to include a set of chronic diseases to reduce opportunities for indirect discrimination against chronic disease sufferers through benefit design. Provision was made for medical schemes to pay the costs of PMBs in full in designated service providers, or where services were involuntarily obtained out of network. The HIV benefit and some cancer-related and psychiatric benefits were amended in various respects.
- A more-comprehensive regulatory framework was provided for managed health-care, focusing on: accreditation of managed care organisations; greater transparency in protocols and benefit limits; and evidence based medicine.
- A more extensive regulatory framework was provided for the accreditation of brokers, and further limitations were placed on the quantum of commission payable to brokers, in order to reduce perverse incentives. An expanded regulatory framework was also provided for administrator accreditation.
- The regulation of investments was updated to take into account the exigencies of the medical schemes environment, and provision was made for the phasing in of solvency requirements for new schemes.
- The wording of late-joiner penalty provisions was revised to reduce uncertainty on interpretation.

The publication of these regulations was followed, in October 2003, by the gazetting of a set of therapeutic algorithms in respect of 24 of the 25 conditions on the chronic disease list, which effectively defined the parameters of the benefits which are required to be provided by medical schemes in relation to these conditions. The process of developing these algorithms in accordance with evi-

The PMB package was extended to include a set of chronic diseases to reduce opportunities for indirect discrimination.

Among the more obvious areas to address are inappropriate application forms, unfair contracts, and language and benefit options which are too complex to understand.

dence-based medicine was driven by the clinical division of the Research and Monitoring unit of Council. The outstanding algorithm (for bipolar mood disorder) could not be gazetted due to legalities around the widespread off-label use of drugs in treating this condition. The algorithms are under continuous review to ensure that they are responsive to evidence-based changes in medical practice.

The development of these therapeutic algorithms was an important initiative in relation to the statutory function of the Council of promoting quality and measurement of outcomes of the relevant health services provided for by medical schemes.

Section 61 of the Medical Schemes Act provides another vehicle to create law, in the form of undesirable business practice declarations by the Registrar of Medical Schemes. This must be done with the concurrence of the Minister of Health and the Council.

The Registrar invoked this power during 2004 in response to concerns arising from the disposal of the assets of self-administered schemes. The notice prohibited sale of the assets of an administrator without fair value as well as entering into an administration contract without a fair and open evaluation process, or with a party in whom officials or employees of the scheme had direct or indirect financial interest.

Yet another important policy development which has substantially affected the activities of the Council, is the National Health Reference Price List (NHRPL). Given the complexity of this issue from a technical and historical perspective, it is dealt with as a separate section, below.

2.5.1.2. Reflecting on the present

Research and policy processes within Council continue to respond to the dynamic medical schemes environment.

Activities of Council are increasingly integrated into “theme projects,” designed to produce results with greatest impact on the strategic objectives of Council. The ongoing work on governance and risk assessment frameworks, discussed above, are examples of these theme projects.

Another theme project which will continue to influence the regulatory agenda of the Council for years to come, is the Fair Treatment of Beneficiaries Project. The objective of this project was to understand causes of potential unfairness to consumers in the medical schemes environment and then to formulate strategies to deal with them. Broad consultation took place in the drawing up of a draft report which was then tabled at a conference in February 2004, opened by the Minister of Health. The consultative meeting was attended by representatives of consumer bodies, medical schemes, trade unions and other stakeholders.

This work placed the focus squarely on the manner in which schemes treat members, and provided an excellent opportunity for trustees to review the operations of their own schemes. The recommendations made at the February conference have already resulted in a greater emphasis on consumer protection in the operational plans and budgets of the Council. Among the more obvious areas to address are inappropriate application forms, unfair contracts, and language and benefit options which are too complex to understand.

Yet another ongoing theme project is a project designed to determine the appropriateness of, and to develop guidelines for, contractual arrangements involving capitation and risk transfer. Capitation contracts were received from more than 80 medical schemes at the request of the Council. These contracts are being evaluated with the assistance of a database allowing for analysis of structure of the contract, extent of risk transfer, and other critical variables. The findings of this project will serve as a basis for ensuring compliance with prevailing legislation, and will inform the development of accreditation standards for the second phase of the managed care accreditation process.

A project is also ongoing to monitor the impact of the new legislation relating to designated service providers and the chronic disease list, which took effect at the beginning of 2003. The primary purpose of this project, which has been awarded to an outside consultant, is to gain a better understanding of the effect of these policies on a range of issues, including delivery of PMBs, change in benefit design and contribution levels, and overall impact on schemes, beneficiaries and providers.

Various policy development initiatives are also underway. Representatives of Council have been appointed to a Ministerial task team to further investigate options for the implementation of risk equalisation and social health insurance. This work is being complemented by ongoing research in the Office into the development of a basic benefit package, which will form the core of benefits subject to income and risk-based cross-subsidies in the implementation of social health insurance, as well as work on the development of regulatory options to promote the emergence of a low cost funding environment.

Another important policy intervention of the Council is the extension of the PMB for HIV/AIDS to include provision of anti-retroviral therapy within the parameters of the national treatment guidelines applicable in the public sector. Amendments to the regulations were finalised in December 2004, implementing relevant changes with effect from 1 January 2005.

Finally, an extremely important process that has been initiated is the creation of a task team to investigate options to afford better protection to members in the event of scheme failure. Proposals currently being investigated by this task team include among others:

- Amendments to section 29A of the Act to provide for waiving of waiting periods in the event of a scheme being placed in liquidation;
- The creation of a dispensation whereby members are elevated to the position of preferred creditors of a scheme, in particular as far as this relates to outstanding claims payable to providers; and
- The establishment of a fidelity fund to support members affected by liquidation of a scheme, funded through a once-off levy on medical schemes.

Another important policy intervention of the Council is the extension of the PMB for HIV/AIDS to include provision of anti-retroviral therapy

2.5.1.3. Looking to the future

Numerous challenges confront the Council in the immediate future, and will need to be monitored and managed.

As of 2005, medical schemes will require submission of ICD10 codes on accounts submitted to medical schemes. There will undoubtedly be a period of transition, in particular as health-care providers get used to the new requirements. This is expected to result in increased numbers of complaints submit-

A process is underway to evaluate potential areas for amendment of the current Act and regulations.

ted to the Council, which will need to be effectively managed. There is also a need for greater attention to be paid to possible confidentiality infringements in the context of submission of diagnostic codes.

As of 1 January 2006, the Public Service intends to establish its own medical scheme. This will raise particular challenges from a regulatory perspective, as it is likely to result in considerable consolidation of membership giving rise to increased numbers of amalgamations of schemes. The work that is underway in respect of protection of members will become of particular importance in this context. The creation of this scheme also raises particular challenges in relation to the way in which the reserves of affected schemes should be monitored.

More generally, moves toward implementation of Social Health Insurance (SHI) and a Risk Equalisation Fund (REF) will have significant implications for the structure of the industry, and consequently significant impact on the way the industry must be regulated. Every indication is that the Council will be integrally involved in the establishment of the REF in the short to medium term, including through the development and maintenance of databases of beneficiary information. In the longer term, current SHI proposals, facilitated by tax subsidy reforms, anticipate the potential influx of some 8 million new beneficiaries into medical schemes. That is bound to have profound implications for the way that the industry is managed, and the regulatory capacity needed to cope with it.

In the meantime, a process is underway to evaluate potential areas for amendment of the current Act and regulations. Quite a few technical amendments need to be made, but there are also areas of regulation that need to be reviewed from a policy perspective. These include, *inter alia*:

- Extremely important strengthening of confidentiality protections, especially in the context of the mandatory use of ICD10 coding;
- The application of late-joiner penalties, in particular in the context of people who were previously unable to afford membership of a medical scheme;
- Revision of complaints and appeal processes, as discussed above;
- Regulation of risk sharing and capitation arrangements, arising from the theme project currently underway in relation to these issues;
- Provisions to facilitate the integration of bargaining council schemes under the Act, as discussed above;
- The regulation of medical savings accounts, and other vehicles that transfer risk onto members, which will be considered in the context of work being done around benefit design;
- The conducting of the business of health brokers, and corresponding factors relating to broker remuneration, as discussed above;
- The legal nature of the relationship between medical schemes, providers and members, and rights and duties which arise therefrom, in light of changing dynamics in reimbursement practices;
- Potential rate filing provisions, as discussed above and;
- Recommendations for legislative reform emanating from the Protection of Members Task Team.

2.5.2. National Health Reference Price List (NHRPL)

2.5.2.1. Visiting the past

By way of background to the NHRPL, most private health funding in South Africa is at present paid in terms of a fee for service reimbursement mechanism. As the number of defined health service items runs into the thousands, the administration of payments by medical schemes is contingent on some form of standardised billing structure. This structure is typically loaded onto the computerised systems of intermediaries such as switching companies, which allow for the IT systems of providers and funders to talk to each other. In the absence of a standardised structure on which providers would bill and funders would pay, there would be unworkable confusion in funding administration, which would most likely grind to a halt – with bills not being paid.

Once the structure is in place, medical schemes need some reference price against which to define their benefits. Instead of each benefit option of every medical scheme defining its benefits in terms of a couple of hundred pages of health service line items with prices attached, it is only practical for schemes to define benefits as a percentage of some standard price. Equally, providers should be able to determine their charges by reference to some form of standard pricing structure.

Historically, the standard pricing and structure used by schemes and providers for these purposes were a set of tariffs set by BHF (known as the “recommended scale of benefits”) and recommended sets of tariffs set by professional or industry associations, such as SAMA and HASA. Over the past few years, differences between BHF and these professional and industry associations over the structure of this list had resulted in some very messy disputes and deadlocks – which had at times seriously compromised health financing administration. But, however imperfect and confrontational they were, they nevertheless provided standardised pricing structures required for the determination of medical scheme benefits and provider charges.

The major flaw with this system was that they amounted to collusive price setting between persons with competing commercial interest in those prices. This was bound to catch the Competition Commissioner’s eye sooner or later. And in July 2003, the Commissioner announced that formulation of the BHF, SAMA and HASA tariffs amounted to violations of the Competition Act – and that use of these lists was to cease forthwith.

With hindsight, the Commissioner’s decision created the stimulus for much-needed attention and consideration to a historical system of tariff setting that was deeply flawed in a number of respects.

But with a new benefit year looming, to prevent the administrative machinery of the private health funding system grinding to a halt, an alternative reference pricing structure had to be put in place urgently. Toward the end of September 2003, an understanding was finally reached between the Department of Health, the Competition Commission and the Council that the Council, in conjunction with the Department of Health, would prepare a reference price list (as opposed to a recommended tariff structure). The Department and Council were parties with public interest, as opposed to commercial interest, in formulating this instrument. Time frames on this were

Medical schemes need some reference price against which to define their benefits.

The historical recommended tariff structures had developed over 30 years, and a revolution was not going to be effected overnight.

obviously sub-optimal, and there was recognition that the process would have to be as good as it could be within that limited time.

Bearing in mind that Council had no previous experience of this, the challenge was immense. A vast gap in technical knowledge had rapidly to be bridged. Equally complex was the need to establish communications and interaction with a host of bodies representing 30 disciplines or categories of health service, each with its own politics and historical baggage.

Each of those 30 disciplines had a whole host of unresolved issues, and efforts were made to dampen expectations. Vast swathes of these issues would have to go unaddressed, and Council had to be very selective in prioritising areas of focus. The historical recommended tariff structures had developed over 30 years, and a revolution was not going to be effected overnight. Changing that system had to be done cautiously, slowly and incrementally. To do otherwise would have been irresponsible as small changes to structure can often have huge financial implications – and these need to be clearly understood first. A complete overhaul of the system will take years.

Obviously, because the BHF recommended scale of benefits had formed the basis of medical scheme benefit determination, that structure had to provide the departure point for the NHRPL. From there, areas were prioritised for focus within extremely limited constraints. Even within those constraints, the 2004 NHRPL introduced substantial departures from the BHF structure in areas where these self-evidently needed to be made. In fact, in 2004 more than one third of the total structure was changed through modification, addition or deletion.

Obviously, that means that something approaching two thirds of the structure remained the same – but this was either in areas where no change was needed, or where we had no better information with which to evaluate potential changes, or where an area or a discipline were simply not prioritised for intervention.

At the same time, we had to be cognisant of the financial implications of what we were doing, and the only financially responsible way of approaching the issue in the face of uncertainty was to stick quite strictly to the principle of overall cost neutrality to medical schemes. And so, with one or two significant exceptions (such as GP consultations), the NHRPL 2004 stuck to an overall projected financial impact (taking utilisation figures into account) equivalent to the official treasury projection of CPIX, namely 4.9%.

If inflation had been running at 7-8%, as it had in the recent past, the inflationary adjustment would have caused less unhappiness. But as it happened, 4.9% sounded low, and this generated unease. On the medical practitioners' side, the consequence of the once-off adjustment from BHF relative value units (RVUs) to SAMA RVUs, also resulted in the nominal change to rand conversion factors (RCFs) being greater than, or less than, the 4.9%. Where the RCFs adjusted by less than 4.9%, there was a misperception generated that Council had calculated expenditure increases at substantially less than the inflationary value. This was not the case.

The NHRPL had several discernible effects during 2004. First, although it was intended merely as a reference price, many medical schemes, initially at least, determined their benefits as equivalent to NHRPL. A large contributory

factor to this was that, due to the extraordinary circumstances last year, the NHRPL was published after medical schemes had to publish their benefits for 2004. It was quite impossible therefore for schemes to say they had pay 80% or 110% of something when they had no idea what it would look like. Most schemes therefore proceeded in blind faith that we would not do something grossly financially irresponsible, and pegged their benefits at NHRPL. Subsequently, however, many medical schemes have amended their benefits to differentiate them from NHRPL, or to differentiate benefits by benefit option by applying different percentages of NHRPL in different benefit options.

Secondly, in the case of hospitals, while most independent hospitals appear to have followed the NHRPL, the three big hospital groups simply disregarded the NHRPL reference price and determined their own prices unilaterally to derive their targeted profit margins.

Thirdly, in provider groups that are highly concentrated, an unprecedented level of negotiation between funders and providers was stimulated in those instances where providers felt they wanted more than NHRPL. Pathologists are a very good example of this.

Fourthly, many providers who felt dissatisfied with the increases resorted to balance billing of patients.

Fifthly, and perhaps most importantly, discourse changed in discussion with provider groups and there was a growing recognition of the need for far more work to be done on understanding practice and input costs in the environment.

2.5.2.2. Reflecting on the present

In the absence of an alternative, the Council continued the process of developing a reference price list for 2005. This has involved active interaction with funders and with provider groups in many of the 30 or so disciplines represented in the NHRPL. It is hoped that the product will provide a considerable improvement on the 2004 list (while not being revolutionary and still applying a cautious approach so as not to do something which will have serious unpredictable financial consequences).

Although time and resources were limited, significant progress has already been made in the NHRPL toward a more scientifically accurate list based on evidence of actual costs in the environment. This has affected not only the pricing but also the structure of quite a number of schedules.

The principle of cost neutrality has remained a guiding principle in the development of the reference price list for 2005, although there have been substantial deviations in instances where these are clearly justified when looking at the issue from a clinical and costing perspective. This has resulted in significant upward adjustments to the value of medical practitioner consultations as well as to the reference prices of quite a number of the auxiliary disciplines – where cost modeling and evaluation demonstrated that services had been significantly undervalued in the past.

One problem which unfortunately emerged in the process of development of the NHRPL 2005, is that some of the schedules (and their corresponding projected expenditure impacts) could only be released even in draft form after the end of October deadline for submission of contribution and benefit

While most independent hospitals appear to have followed the NHRPL, the three big hospital groups simply disregarded the NHRPL reference price.

changes to the Registrar's office for approval. Fortunately, these tended to be low-expenditure schedules, but this may still have negatively affected the ability of schemes to price effectively. Strategies will have to be put in place to prevent recurrence of this problem in development of the 2006 list, if this function still remains with Council.

Another limitation on the process for the 2005 NHRPL, as with the 2004 NHRPL, was the complete non-participation of private hospitals. This constrained the ability of the NHRPL to make any significant improvements to values within this list. It is hoped that this matter can be resolved in the future.

2.5.2.3. Looking to the future

The future of the NHRPL as a function of Council is subject to further political process, given section 90(1)(u) of the National Health Act 2004 which enables the Minister to make regulations regarding processes for the determination and publication of health reference price lists.

To the extent that the NHRPL remains a function of Council, the challenge in the NHRPL will be to publish a set of reference prices which reflect fair reimbursement for health services rendered, based upon sound and defensible research on actual costs of services rendered and reasonable income expectations of health service providers. With the experience of the NHRPL during 2004, we held a workshop in February 2005 with funders and provider groupings to develop consensus on principles underpinning costing methodologies. This workshop was intended to kick start the process of development of the NHRPL for 2006, and to generate a far greater degree of transparency in health service costing. An explosion of costed submissions is expected in 2005, given the clear commitment of the NHRPL in 2005 to base prices on satisfactorily-costed motivations, as opposed to merely applying a standard inflator.

At the same time, it is important that Council works with provider groups, other stakeholders such as the Board of Healthcare Funders (BHF), government and academic institutions in funding and promoting increased research into health care cost in the South African environment. By so doing, the NHRPL and the associated billing structures have the potential of increasingly becoming a valuable resource in understanding real costs of health service delivery not only as a basis for negotiations between funders and providers, but also ultimately as an important tool in health service planning, evaluation and delivery. This is a really resource-intensive process, but it has the potential to offer significant rewards.

In the medium- to longer-term, various strategic opportunities exist for development of the NHRPL. As South Africa moves toward implementation of social health insurance, it should provide a good basis for work toward cost-effectiveness analysis and correspondingly for the assessment of quality of care and outcomes research.

The future of the NHRPL is subject to further political decision to the extent that this remains our function, we will publish reference prices based on actual costs.

2.6. CMS as employer of choice

2.6.1. Visiting the past

The setting up of the Registrar's Office, and the rapid recruitment and training of staff during 2000 and 2001, has already been discussed.

A number of policies were also developed and implemented over the years. A performance management system was developed that ensured development of proper performance contracts, evaluation of performance, and effective reward for effort and delivery.

An IT division was established, with the skills and capacity to undertake and manage the development of a comprehensive infrastructure of databases, web-enabled services, end-user support services and network management services. A website was established which enabled stakeholders and members of the public access to a broad range of information, documents and services.

2.6.2. Reflecting on the present

Looking back, the set-up phases of the office were an experience best not repeated in a hurry. Nevertheless, they laid the basis for a stable and pleasant working environment, conducive to achievement of the objectives at hand.

The quality of basic infrastructure and processes in the office is demonstrated by the fact that, since 2000, the Council has enjoyed unqualified audit reports from the Auditor-General, without exception. The report for the 2003/4 financial year was again unqualified, despite an unfortunate incident of fraud perpetrated against the organisation by a former member of staff. The Auditor-General's office was satisfied that adequate and decisive steps were taken timeously in relation to this crime and to prevent any recurrence in the future.

Staff development has been prioritised within the work of Council. In line with policies to improve career development and staff retention, internal promotions have been favoured where possible rather than recruitment from outside. Skills development has been promoted through leadership training programmes, encouragement of members of staff to attend conferences, generous study leave benefits, and financial assistance for study programmes. In some instances, staff members have been afforded the opportunity to attend international conferences.

A strategic framework is being developed to align organisational goals with "people strategies," including emphasis on leadership, employment equity, recruitment practices, performance management processes, culture, values and organisational structures. A coalition of staff, called CMS Active and representing all operating units, was nominated to work with HR managers on further development of these issues and the requisite policies and procedures. In an effort to reduce stress levels among staff, a wellness programme has also been implemented in the workplace.

Ongoing attention to improving performance management has resulted in the appointment of an external team of consultants to conduct an overall review of the existing performance management system.

Staff development has been prioritised within the work of Council.

It is important for Council to further reflect on what incentives can be created for the retention of this expertise within the Registrar's Office

2.6.3. Looking to the future

Various challenges confront the Council moving forward, particularly in relation to retention of key staff. Some staff members have been in the employ of Council for five years now, and have developed key skills and experience that cannot easily be replaced.

This is regarded as a critical time, in which such members of staff are considering their futures. It is important for Council to further reflect on what incentives can be created for the retention of this expertise within the Registrar's Office, and on whether enough growth and development opportunities are being provided for staff.

Staff retention strategies need to take account of the reality that there is limited room for upward mobility of staff members in the relatively small and flat structure of the Office of the Registrar. Accepting that retention of staff will not always be possible, it is also important that more attention should be given to succession planning, to ensure continuity of services in the event of key staff members leaving the organisation.

The Council has directed that succession planning should become a key performance indicator in departments, and that there must be frank discussion between the Registrar and senior staff, regarding their own development plans.

Finally, it is also time that an overall review is conducted on the organisational structure of the Office of the Registrar, to take account of shifts in the strategic direction of the Council, many of which have been discussed in this document. There is a need to ensure that the organisational structure is properly aligned with the Council's strategic objectives. The Council has requested the Registrar to make a presentation to the HR committee in this regard, as well as on any suggested changes to the structure of employment packages. Among the particularly important issues for consideration from a perspective of organisational structure are the potential new infrastructural requirements in relation to the envisaged risk equalisation fund.

2.7. Development of strategic alliances

2.7.1. Visiting the past

Much of the period since 2000 has involved establishing channels of communication and interaction with stakeholders who are affected by, and may in turn affect, the strategic objectives of the Council.

The extensive interaction with consumer organisations has already been discussed. Numerous research processes within the office have involved setting up structures involving the participation of stakeholders and industry players. Various examples of this have already been discussed in this report. Another example of this is the Financial Soundness Task Team, established with experts from the industry and related stakeholders, to investigate and discuss issues relating to the financial soundness of medical schemes on an ongoing basis. While relations with the industry representative body, the Board of Healthcare Funders of Southern Africa (BHF) have not always been what we would have liked, we continue to work on these, understanding fully that there will always

be a healthy level of tension in these relations.

Legal and compliance processes have been supported by strategic interactions with law enforcement agencies, such as the Office for Serious Economic Offences and the Specialised Commercial Crimes Unit, resulting in much easier access to these authorities. Furthermore, early cooperation was been established between the Council and associations representing lawyers, including the Black Lawyers Association and NADEL, which has enabled far greater diversity in the selection of lawyers to represent Council.

From a political perspective, the importance of keeping the Portfolio Committee of Health informed of progress and developments was recognised from early on. The Council has accordingly greatly appreciated generous opportunities afforded to it by the Portfolio Committee to address it on industry related developments, and to interact with it on amendments to the Act and regulations.

Mention has already been made of the importance of interactions with foreign counterparts and delegations, including the Belgian regulators and the International Review Panel on the REF. Various foreign delegations have been hosted at our offices, and a cooperative relationship has developed with the Council's Namibian counterpart, NAMFISA. In 2002, the Registrar was also invited by the Association of Mutual Funds Internationally (AIM) to make a presentation to a conference in Marrakech, Morocco, on experiences in implementing the new regulatory framework in South Africa.

2.7.2. Reflecting on the present

The strategic liaisons that have developed since 2000, some of which are described above, continue to provide the basis for fruitful cooperation with the Council.

In addition, standing liaison committees have been formalised between the Council and various entities, including: the Financial Services Board (FSB), the Health Professions Council of South Africa (HPCSA), the South African Institute of Chartered Accountants (SAICA), and the South African Medical Association (SAMA). These structures have given rise to opportunities for valuable interactions on key policy issues.

2.7.3. Looking to the future

There is still a need for even greater coordination of policy direction within government on key issues pertaining to health and economic policy that affect the private health funding industry. There have been too many instances where legislative or policy initiatives between Departments, or even between regulatory bodies established under the auspices of the Health Department, have not been sufficiently aligned.

A possible start to achieving this objective would be for the Council to be represented on the Provincial Health Restructuring Committee (PHRC) of the Department of Health, which currently includes representation of the heads of the national and provincial departments of health, and is responsible for making policy recommendations to MINMEC.

There is also a need to extend contact to other regulators or industry associations, whose activities might impact on members of medical schemes, such as the Credit Bureaus and the Micro-Finance Regulatory Council. The Council

Legal and compliance processes have been supported by strategic interactions with law enforcement agencies

has also identified the need for greater participation in the Regulators’ Forum.

The NHRPL has also opened new fronts of interaction with health care providers. Significant opportunities exist through these interactions to positively impact on quality of care rendered to members of medical schemes. However, interactions around the NHRPL are inevitably fairly precarious in relation to relationship development, and unless managed strategically, they can have the opposite effect.

Finally, the importance of far more interaction with employer groups and labour organisations has already been discussed in the context of consumer empowerment and moves toward the integration of bargaining council schemes under auspices of the Act.

There is also a need to extend contact to other regulators or industry associations,

3. CONCLUSION

This document has been a critical reflection on the extent to which the Council is satisfactorily meeting its strategic objectives, and thereby performing its statutory functions. Certainly, tremendous progress has been made over the past five years and great strides have been made toward ensuring that beneficiaries of medical schemes are adequately protected within a well-regulated environment.

At the same time, it is clear that the policy interventions of the Act, and the experience of Council in implementation of the Act, have not been without their shortcomings. There is still a very long way to go to meet the vision of the Council, namely:

A medical schemes industry which is regulated to protect the interests of members and to promote fair and equitable access to private health financing to maximise the health of South Africans.

These concluding remarks are confined to some broad statements on the extent to which the statutory objectives of the Act have been met. There is then an attempt to assimilate the disparate remaining difficulties in the medical schemes environment into a few broad thematic concerns, with a view to guiding strategic direction of policy initiatives in the future.

As discussed in the introduction, the Act had four broad objectives: to promote non-discriminatory access to private health funding; to put medical schemes on a more sound financial footing; to improve scheme governance in the interests of members; and to improve consumer protection through enhanced regulatory oversight.

Considerable progress has been made in promoting non-discriminatory access to private health funding through measures such as open enrolment, community rating, and the protection of a prescribed set of minimum benefits from arbitrary attrition. Practices of overt and direct discrimination on the basis of age and health status have largely been contained. Far more difficult structural problems have emerged though, which result in older and sickly members facing greater financial obstacles in access to health care than healthier, younger lives.

This has typically resulted from marketing, recruitment and benefit design practices of medical schemes which have resulted in some medical schemes accommodating membership with disproportionately high risk levels relative to other medical schemes. Accordingly, the accumulation of older or sickly members in some schemes has resulted in those schemes facing much higher costs for the same benefits than other schemes – and accordingly passing on disproportionately higher contribution levels to their members. It is in this context that substantial work has taken place in relation to the establishment of a risk equalisation fund (REF), which would neutralise the effects between schemes of health risk and, rather, incentivise competition based on efficien-

Considerable progress has been made in promoting non-discriminatory access to private health funding

Levels of consumer protection have undoubtedly been significantly improved through the creation of a strong Council.

cies. It is intended for the REF to be fully operational in 2006, and to serve as the precursor for more fundamental reforms paving the way for social health insurance.

The above discussion in relation to financial soundness of medical schemes should leave the reader in no doubt that medical schemes are on a far sounder financial footing now than they were five years ago. This must be one of the most tangible areas of success of the Act. This success has been achieved largely through minimum reserve requirements, more stringent financial controls within medical schemes, and closer regulatory scrutiny of the financial affairs of medical schemes. A number of factors threaten the long-term financial stability of the medical schemes industry though. These include unacceptably high levels of escalation of non-health expenditure of medical schemes, as well as continued and uncontrolled escalation in some areas of health-care expenditure, most notably expenditure on private hospitals. These issues need urgent attention and various initiatives to address them are discussed above. Other important factors for priority attention are the utilisation of regulation of "excess" accumulated reserves and the need for refinements to instruments for solvency regulation.

Progress has been made toward improving scheme governance in the interests of members through measures such as mandatory member representation on boards of trustees, and disallowing representation on boards of persons with financial interest in operation of the scheme. However, this remains an area of key concern for the Council as there are still too many instances of governance failure. Considerable work is still underway to understand the causes of such failures, based upon an understanding that if these issues could be satisfactorily addressed, many of the remaining problems in the environment will be removed.

Levels of consumer protection have undoubtedly been significantly improved through the creation of a strong Council, supported by a highly skilled and professional Office of the Registrar with the commitment to give the Council the backing it requires.

Moving forward, greater attention needs to be given by Council to extending its regulatory oversight and consumer protection responsibilities more into the arena of quality of care and measurement of comparative health outcomes of medical scheme interventions. There is also a need for further review of the organisational structure of the Registrar's Office and strengthening of the enforcement tools available to it, to ensure that it has the necessary "teeth" to intervene in the interests of members.

Finally, it is possible to identify four broad thematic concerns that are regarded as critical factors in determining the success of otherwise of a policy framework aimed at protecting access to equitable private health funding and thereby promoting access to health care within this environment. The first is effective governance of medical schemes, a concern that has been repeatedly emphasised in this review. The second is price-setting behaviour by medical schemes and providers, because this will ultimately determine the comprehensiveness of coverage of medical scheme beneficiaries. The third is rationing behaviour. In the context of unlimited resources, decisions have to be made about limitations on access to health-care coverage, and it is important that

these decisions are rational, clinically evidence-based and promote optimal cost-effectiveness.

The final concern is the need for an appropriate supply-side regulatory framework. Insufficient control of entry of expensive technology and inadequate planning of health care facility development in the private sector contribute to rapidly escalating health costs, which threatens the long-term sustainability of the private health-funding environment.

T P Masobe

Prof N Padayachee

Greater attention needs to be given by Council to extending its regulatory oversight and consumer protection responsibilities more into the arena of quality of care.

