

CMS news

December 2008

**The journey continues
– 2009 promises to
take us closer to
Healthcare For All**



Perspective

Looking back at the R2008 in the rear-view mirror, we take a self-reflective trip down memory lane and share it with you in this edition of *CMS News*: we may have hit a speed bump when the Medical Schemes Amendment Bill was withdrawn from Parliament but the journey has certainly been a rewarding one, the wind-screen always clear. We've made good progress on our way to our desired destination.

Looking ahead, the R2009 looks just as exciting. We've never been afraid of uncharted terrain and look forward to what the next stage of the adventure will bring.

Personal or professional, at home or elsewhere, whatever journey you decide to embark on this Festive Season, we hope it's a satisfying one.

Editorial Committee

Contents

2008 in retrospect	1
Legislative developments in 2008	2
Meet our new Head of Compliance	4
REF and PMBs walk hand in hand	6
Meet our experts on risk equalisation	8
Opinion: Health reform in South Africa: the way forward	10
Low-income medical schemes	12
Getting closer to trustees	13
Remember!	14
Reading matter	16

Publisher

Council for Medical Schemes

Editorial Committee

Stephen Harrison

Aleksandra Serwa

Phumla Khanyile

Editor

Aleksandra Serwa

Contributors

Aleksandra Serwa

Alex van den Heever

Boshoff Steenekamp

Patrick Matshidze

Phumla Khanyile

Stephen Harrison

Stephen Mmatli

Thulani Matsebula

Address

Council for Medical Schemes

Block E

Hadefields Office Park

1267 Pretorius Street

Hatfield

Pretoria

Copyright: *CMS News* is a quarterly publication published by the Council for Medical Schemes. All material published is copyrighted and cannot be used without the written permission of the publisher.

t: +27 (0)12 431 0581

f: +27 (0)12 431 0681

e: a.serwa@medicalschemes.com

2008 in retrospect

2008 must rate as one of the more challenging years in the history of the Council for Medical Schemes.

In 2008 and into 2009, we decided to focus on improving governance in medical schemes, protecting risk pools, and containing the costs of healthcare.

Although enabling legislation to support those objectives was introduced to Parliament this year, the Medical Schemes Amendment Bill was withdrawn from Parliament and will not be passed this year. As a result, critically important amendments to the Medical Schemes Act – including the amendment to the definition of the “business of a medical scheme” following the controversial ruling of the Supreme Court of Appeal in the *Guardrisk* matter – are being held in abeyance.

The absence of enabling legislation also continues to be the single biggest impediment to implementing the Risk Equalisation Fund (REF).

If that were not enough, this year also saw us grappling with thorny legal issues, including the liquidation of Renaissance Health Medical Scheme and Humanity Medical Scheme, and the extent of scheme obligations to cover the costs of prescribed minimum benefits (PMBs) where members involuntarily used non-designated service providers.

The Auditor-General has furnished the Council with an unqualified audit every year since its inception in 2000.

The Department of Health published a draft National Health Reference Price List (NHRPL) with all schedules increasing by 8.7%. This, and the fact that certain stakeholders have made public threats of potential litigation against the Department, means that this process remains an area of financial risk for the medical schemes

industry for 2009.

But it hasn't been all doom and gloom. Despite the absence of enabling legislation, the REF process is progressing well and, with the Department, we

published the terms of reference for the 2008 review of PMBs as well as a document on the governance, process, structure and objectives of the PMB review process. We are currently reviewing the comments from stakeholders to inform the process going forward.

One of the highlights of 2008 will no doubt be the fact that, with the help of the National Prosecuting Authority, we finally managed to bring to justice former trustees and the administrator of Gen-Health Medical Scheme. We are thrilled that many years of investigation have paid off at long last.

A new committee has been established within the Office of the Registrar to improve the coordination and synchronization of legal and compliance processes in the Office. The Regulatory Decisions Committee facilitates rapid and effective decision-making on legal and compliance issues, and enhances the quality of advice provided to Council members on these matters.

Our work will never end – but we continue to look into the future with hope and optimism, secure in the knowledge that we can count on the cooperation of the medical schemes industry and our international partners.

“We continue to look into the future with hope and optimism, secure in the knowledge that we can count on the cooperation of the medical schemes industry and our international partners.”

By Patrick Matshidze
ACTING REGISTRAR
OF MEDICAL
SCHEMES

Strategic priorities for 2009-10

- Supporting the legislative process of the Medical Schemes Amendment Bill
- Improving governance in medical schemes
- Containing escalating costs of healthcare
- Protecting risk pools
- Facilitating the formation of a regulatory framework to encourage the establishment of low-income medical schemes

Legislative developments in 2008

After much anticipation that Baby Bill would finally be born during 2008, the labour ran into complications. The new expected delivery date is uncertain.

By **Stephen Harrison**

SENIOR SPECIALIST:
STRATEGY

The Medical Schemes Amendment Bill was dubbed “Baby Bill” some time ago, and like expectant parents we have watched its progress – or lack thereof – for too long. Its passage seemed imminent this year when the Bill was introduced to Parliament, but the shifting policy landscape ensured that this was not to be. It was referred back for further consideration.

At its strategic planning session in November, the Council for Medical Schemes expressed concern that critically important reform measures contained in the Bill are once again on hold. These reforms include the following:

- an amendment to the definition of the “business of a medical scheme” to address difficulties in the demarcation between insurance products and medical schemes arising from the Guardrisk judgment earlier this year;
- the legislative framework to allow for the introduction of risk equalisation in order to level the playing fields between schemes with different membership risk profiles, and instead promote healthy competition on the basis of factors such as efficiency, service levels, and ability to negotiate favourable prices;
- corresponding changes to the contribution structure and benefit design of medical schemes which, when implemented alongside risk equalisation, will ensure that community rating within medical schemes is optimally protected;
- important provisions to improve corporate governance in medical schemes, including a clearer differentiation between the governance and oversight role of trustees, and the executive management role of principal officers; and
- provision for a special regulatory dispensation to be created to promote the emergence of medical scheme products among low-income earners.

“

There is clearly a need for a framework to be put in place to allow for collective negotiations to take place between health funders and providers.

”

The Council also took note of the fact that the National Health Amendment Bill, which sought to create a framework for collective negotiations between medical schemes and healthcare providers, also did not proceed through Parliament but was referred back for further consideration.

Although some of the detail of the Bill had been contentious, there is clearly a need for a framework to be put in place to allow for collective negotiations to take place between health funders and providers. Without this, the untenable situation will continue whereby prices and benefit levels are largely determined independently of each other; schemes and provider systems have to deal with the confusion of multiple tariff structures, and members are faced with unpredictable and potentially catastrophic out-of-pocket payments where there is a mismatch between the price charged and the benefit amount. In addition, the absence of negotiated prices presents significant regulatory challenges in ensuring that members enjoy comprehensive cover for prescribed

minimum benefits.

These are problems which adversely affect medical schemes, providers and, most importantly, consumers. It is therefore important that the notion of a statutory framework for collective negotiation is not shelved, but that the window of opportunity is optimally utilised to engage in further research and consultation with stakeholders to create a rational framework of health service pricing and benefit determination in future.

Before getting too despondent about legislative progress in 2008, the year certainly had its redeeming features.

Although the Council raised concerns about the impact of preliminary drafts of the Insurance Laws Amendment Bill on the medical schemes environment, the final wording of the legislation as enacted has the potential to contribute toward providing a clearer framework for demarcation consistent with health policy objectives.

In terms of the Insurance Laws Amendment Act, the Minister of Finance may make regulations identifying a kind, type or category of contract as

a health policy (which is not subject to regulation in terms of the Medical Schemes Act). Those regulations must be made:

- “in consultation with” the Minister of Health – meaning that there must be agreement between the Ministers of Health and Finance;
- after consultation between the National Treasury, the Registrar of Short- or Long-Term Insurance and the Registrar of Medical Schemes; and
- after having regard to the objectives and purpose of the Medical Schemes Act – including the principles of community rating, open enrolment and cross-subsidisation within medical schemes.

In addition, those regulations must provide for an insurer to submit specified information on any such product to the Registrar of Long- or Short-Term Insurance, as the case may be, and to the Registrar of Medical Schemes within specified timeframes. The regulations may further provide for matters relating to the design and marketing of such products.

Finally, at the time of writing this article it appeared that the Medicines and Related Substances Amendment Bill would narrowly beat the deadline of the Parliamentary session drawing to a close. The Bill promises more effective oversight of medicines, medical devices and other products like foodstuffs and cosmetics which contain scheduled substances.

In terms of this Bill, the existing Medicines Control Council will be replaced by a new regulatory authority, the South African Health Products

Reform measures in the Medical Schemes Amendment Bill include:

- an amendment to the definition of the “business of a medical scheme”;
- the legislative framework to allow for the introduction of risk equalisation;
- corresponding changes to the contribution structure and benefit design of medical schemes;
- important provisions to improve corporate governance in medical schemes; and
- provision for a special regulatory dispensation to be created to promote the emergence of medical scheme products among low-income earners.

be lodged against decisions of the Authority.

The Council resolved at its strategic planning session to approach the Minister of Health to

Regulatory Authority, headed by a CEO who is accountable to and reports to the Minister of Health. The new Authority will be responsible for the registration of medicines, scheduled substances (as well as cosmetics or foodstuffs containing scheduled substances), medical devices and in-vitro diagnostic medical devices. Without being registered or special authorisation being granted, these products cannot be sold. Any person may object to the registration of these products on public interest grounds, and provision is made for appeals to

“**The Council remains concerned that critically important reform measures contained in the Medical Schemes Amendment Bill are once again on hold.**”

the status of processes to develop recommendations for revisions to the regulatory framework relating to broker remuneration.

It promises to be an interesting year ahead! ■

Meet our new Head of Compliance

The Council for Medical Schemes has a new Head of Compliance.

A man of few words, Stephen Mmatli nonetheless agreed to tell CMS News more about himself.

By Stephen Mmatli
HEAD OF COMPLIANCE

I was born and raised in Tembisa, a township east of Johannesburg. I matriculated from Promat College in Kempton Park and then obtained two degrees from the University of KwaZulu-Natal: first a Bachelor's in Administration and later an LLB. This is when I discovered my love of the law.

My degrees in hand, I went on to complete a practical training course with the Association of Law Societies of South Africa, following which I was fortunate enough to be accepted for my articles at Deneys Reitz Attorneys in Johannesburg, one of the three largest commercial law firms in the country. I worked in their Liability Insurance

Division where I was exposed to litigation practice involving inter alia business insurance, motor and personal injury insurance as well as professional indemnity. I then moved to the firm's Labour Unit where I was involved in labour litigation, contracts of employment, advice on retrenchments and rationalization, and labour implications of acquisitions and mergers. Thereafter I moved to their Aviation Unit where I was exposed to inter alia advice on

licensing air transportation, accidents enquiries, and liability claims.

After serving my articles and successfully completing my admission exams, I was admitted as an attorney of the High Court of South Africa. After a few more months with Deneys I joined Moribo Leisure and Entertainment – a company with interests in hotel resorts, gaming and lottery – as a Compliance Officer. I had to make sure the organisation was complying with statutory and regulatory requirements, and this included liaising with the National and Provincial Gaming Boards.

I left Moribo in search of new challenges and soon joined the Compensation Fund to head their Legal Services Division. The fund is a statutory body established within the Department of Labour in terms of the Compensation for Occupational Injuries and Diseases Act to provide for the compensation of employees who are injured or die on duty. I was responsible for the general management of the division which consisted of

15 employees (including legal practitioners), putting up systems, coordinating litigation, and liaising with State Attorneys. I was also charged with advising on legislative amendments, conducting research, and presiding over disciplinary hearings. I left the fund after achieving milestones such as developing and implementing strategic plans for the division, aligning the division with organisational goals, developing its people, and putting in place systems and procedures for the delivery of its objectives. I then joined the Council for Medical Schemes (CMS), where I have recently been promoted to Head of Compliance.

I joined the CMS as a Legal Advisor, assisting the Head of the Legal Services Unit. I saw the appointment as a challenge, especially because I was new to the medical schemes industry. But I quickly familiarised myself with it and the statutory framework that informs the strategic objectives of the CMS. Having joined the CMS shortly after it had been established and not long after the promulgation of the Medical Schemes Act 131 of 1998, I was fortunate to have been exposed to the regulatory interventions as a result of policy challenges in respect of reinsurance losses, which included the first inspection into Discovery Health Medical Scheme that looked into the appropriateness of the scheme's reinsurance arrangements. I was also involved in the development of the risk-based regulatory framework to facilitate the prioritization of resources in monitoring the financial soundness of schemes, and served on the task team that had to develop and finalise the administrator accreditation standards from a technical perspective.

I have served on the technical team between the Office of the Registrar and the Financial Services Board tasked with managing the interface between the Medical Schemes Act and the Financial Advisory and Intermediary Services (FAIS) Act in respect of the accreditation of brokers. I was also involved in the task team that looked at the fair treatment of members, developed governance guidelines, and worked on the bulking project. I have been responsible for leading a theme project on the development of fit and proper standards for trustees and Principal Officers.

In 2006 I was promoted to the position of Senior Legal Advisor, with increased responsibilities that included providing secretarial functions to the Council. I also took on new roles in respect

I am looking forward to this exciting new challenge. Compliance is central to regulation.



of the appeals committee, including the Appeal Board.

During the course of my career I have personally taken proactive steps to invest in my training and development. At the University of Johannesburg I obtained an Advanced Diploma in Labour Law and completed a Programme on Governance; here I was also awarded the Law Faculty Dean's award for top student. I have completed a Management Development Programme with the Wits Business School and a Senior Management Programme at the University of Pretoria's Graduate School of Business. I also have a Postgraduate Diploma in Legislative Drafting, which was sponsored by the Commonwealth. These initiatives prepared me for positions in senior management and provided me with an understanding of issues such as strategic management, strategic leadership, organisational behaviour, operations and project management as well as strategic financial management.

My new challenge

Having recently been appointed Head of Compliance at the CMS, I am looking forward to this exciting new challenge.

Compliance is central to regulation. After almost seven years with the CMS, I believe I have developed a better understanding of the industry as well as the level of compliance by the regulated entities. I have learnt to appreciate that effective regulation demands that the regulator has a wide range of regulatory interventions, both incentives and sanctions, and applies them appropriately.

My vision for the unit is to ensure proper co-ordination of enforcement and compliance

strategies, which will incorporate service standards and turn-around times for the unit. These service standards must be published. We also need to develop standardised enforcement processes.

It is important to measure and monitor compliance in order to know whether we have had a positive and sustainable impact on compliance behaviours and public confidence. The effectiveness of our enforcement actions must be measured by developing an annual performance account for enforcement, incorporating feedback from the entities and persons who have been subject to our enforcement.

Effectively communicating our compliance and enforcement activities to the public and the regulated community is also important for me, as it maximizes the deterrent and educational effect of these actions, and helps the public understand the value of our enforcement programmes. Effective publicity is especially important for enforcement because deterrence depends on the regulated community's awareness of our enforcement actions.

The benefit to the regulated entities is that they are able to see a direct result of good behaviour; they get a transparent explanation for the actions that the regulator takes. These actions should be proportionate to the risk and consistent between the regulated entities in similar circumstances. ■

“

It is important to measure and monitor compliance in order to know whether we have had a positive and sustainable impact on compliance behaviours and public confidence.

”

REF and PMBs walk hand in hand

REF? PMBs? Don't let industry jargon put you off. The Risk Equalisation Fund and prescribed minimum benefits both come down to a simple yet fundamental principle: everyone doing their bit to provide adequate healthcare to those who need it most.

**By Dr Boshoff
Steenekamp**

**SPECIALIST:
REF PROJECT**

The Risk Equalisation Fund (REF) project team at the Council for Medical Schemes manages the various REF projects but also the review of prescribed minimum benefits (PMBs). Funded by the Department of Health, both projects rely heavily on the support functions in the Office of the Registrar and collaborate with other functional units at the Office. Both were discussed at our annual strategic planning session in November:

Developing REF

Two elements are required in a socially responsible healthcare funding mechanism: income cross-subsidisation and risk cross-subsidisation. The former is where high-income earners contribute to the healthcare funding of low-income earners; the latter is where young and healthy medical scheme beneficiaries share in the risk of funding healthcare for older and sicker beneficiaries. While the principles of community rating, open enrolment and PMBs all serve to improve risk cross-subsidisation between members belonging to the same scheme, risk equalisation will allow for income cross-subsidisation between schemes: low-risk schemes will pay into the fund while high-risk schemes will receive subsidies from the fund.

The whole purpose of the REF project is to prepare the Office for a system of risk equalisation. This involves building the organisation, developing software, analysing REF returns and the financial impact of REF on the industry, conducting research to support the analysis of REF returns, and participating in the development of the legal framework that is required for the introduction of REF.

Subsequent to a request by the Minister of Health in 2005 to test a REF formula and prepare the Office for the fund, the Council established a REF Steering Committee to govern the REF project. A team with skills in administration, data management, statistical analysis, epidemiology, clin-

ical research and project management was appointed. To complement these skills, the Council also appointed an external actuarial and statistical services panel.

REF requires a sophisticated software system, which is currently being developed. Its key components include a secure web-based portal for schemes to submit their beneficiary data on the REF registry, a workflow system that will coordinate the analysis of data submissions, a data warehouse that will store REF submissions in a manner that facilitates the rapid generation of reports, and an audit module that will allow the Council to verify whether schemes have correctly submitted data.

Our analysis of data of the first six months of each year was presented at various public conferences, seminars and workshops, and an annual report on REF was published each year. Schemes have been receiving comments on their submissions bi-annually.

Reviewing PMBs

PMBs are prescribed in terms of the Medical Schemes Act 131 of 1998 (Act). They must be offered to all beneficiaries of registered medical schemes.

PMBs ensure that beneficiaries enjoy access to certain healthcare services and prevent the "dumping" of patients onto the public health sector as soon as they have run out of benefits. PMBs also play an important role in the protection of risk pools. In the absence of PMBs, schemes would be able to design options that do not offer those benefits typically needed by older and sicker beneficiaries, such as benefits for chronic diseases. Such options would attract only the young and healthy.

But schemes also offer comprehensive options which attract sicker and older people. This practice causes the splitting of risk pools and enables schemes to "cream skim" – select beneficiaries that represent preferred risks.

The Act requires a periodic review of PMBs. This review will lead to recommendations for the revision of the Regulations of the Act on the basis of inconsistencies or flaws in the current Regulations, the cost-effectiveness of health tech-

“

The quality of REF submissions from medical schemes has been improving.

”

nologies or interventions, the consistency with developments in health policy, and the impact on the viability of medical schemes and their affordability to members.

Strengthening community rating and stabilising risk pools are but two factors that affect the PMB review process. Within the constraints of affordability and sustainability, the benefits of primary healthcare and preventative care cannot be ignored. The burden of disease must also be considered. The impact of PMB regulation in achieving an inclusive, cost-effective, efficient and non-discriminatory environment must be noted. The larger context of this review must be cognisant of the progressive realisation of the rights to healthcare; this represents a shift towards more appropriate coverage consistent with social security objectives. The latest consultation document also states that as greater clarity is achieved on the proposed National Health Insurance (NHI) model, the PMB review process may need to be modified to remain consistent with the NHI objectives.

In support of quality care and the appropriate utilisation of services, and to encourage efficiencies, the PMB review document proposes that a comprehensive set of benefit definitions be developed. These definitions would include standardised entry and verification criteria, baskets of care, formularies, protocols and incentives to provide services in the most appropriate clinical setting and at the most appropriate level of care.

The PMB Review Committee will continue to engage with the comments received on the second draft of the PMB review consultation document, and to work on the detailed process towards the completion of this project. A priority matter that will be discussed is the development of a rational process to identify the contents of the PMB package. Consideration for the views of

special interest groups – such as patient groups, pharmaceutical manufacturers, providers and funders – remains a challenge; we must strike an affordable balance in a rational manner. ■

“

Despite the fact that Parliament is yet to consider the Medical Schemes Amendment Bill, the technical and preparatory work of the REF project team must continue.

”

RETAP – or the Risk Equalisation Technical Advisory Panel – is a stakeholder body open to anyone with the relevant technical expertise and/or an interest in developing and implementing the Risk Equalisation Fund. RETAP provides assistance with technical work related to the development of the fund.

Meet our experts on risk equalisation

By **Phumla
Khanyile**

COMMUNICATIONS
OFFICER

Funded by the Department of Health and backed by all at the Council for Medical Schemes (CMS), the Risk Equalisation Fund – or REF – is all about equalising risk with regard to the age and disease profiles of medical scheme beneficiaries in relation to the prescribed minimum benefit (PMB) conditions. This is necessary to stabilise risk pooling and protect community rating in schemes, and to ensure that schemes compete on the basis of efficiency and service delivery rather than on their ability to unfairly select beneficiaries with good risk profiles at the expense of other schemes. Meet the team brave enough to have taken on this mammoth task.



Boshoff Steenekamp (Project Specialist and Team Leader)

Boshoff started his career as a medical practitioner and later became the regional head for the Department of Health in the former Western Transvaal. He has worked for the North West Department of Health and AngloGold. He joined CMS in 2005 to run the REF project.

His passion for REF is contagious. "We view our work as an extension of our advocacy for improved healthcare delivery for all South Africans. Once REF is introduced, there will be improved access to healthcare for millions of people."

Boshoff enjoys spending time with his wife and children. He also likes off-road motorcycling and occasionally takes part in Enduro races. "I admit I might be getting too old for such adventurous pastimes so I participate in the events for seniors."

Anton de Villiers (Senior Analyst)

Armed with a degree in mathematical statistics and a PhD in operations research, Anton joined the REF team in 2006 with a background in lecturing and consulting on market research, absenteeism management and HIV research.

At the CMS he deals with the analysis of REF returns, the calculation of expected values, the clustering of benefit options, and the parallel testing of appropriate IT systems.

"REF is all about fairness."



Like Boshoff, Anton also enjoys relaxing with his wife and children in his spare time.

Mondi Govuzela (Research Analyst)

Mondi joined the CMS four years ago to develop data evaluation techniques and assist with the analysis of REF data submitted by schemes. He holds an Honours degree in epidemiology and is currently taking a break from his Master's in epidemiology and biostatistics with Wits University.

"REF will introduce fairness and true solidarity to private healthcare," he believes. "Schemes will no longer have an incentive to focus on the young and healthy to the detriment of the old and sick. I'm very excited to be a part of the reforms currently taking place in the private healthcare sector."

In his spare time Mondi is at the gym (his new-



found hobby) or debating topical social issues with friends. He's currently rereading Steve Biko's *I write what I like*.

Nkuli Mlaba (Clinical Analyst)

Nkuli is the most recent addition to the REF team, having joined the CMS in October this year. She

is responsible for auditing and validating data submitted by schemes in the REF shadow period.

Before joining the CMS, Nkuli used to run her own medical practice in Soweto and later worked as a clinical researcher in the Reproductive Health and HIV Unit at Wits University. Already a qualified medical doctor, she is currently completing a Master's degree in public health.

Nkuli describes herself in the famous words of Benjamin Franklin: "I am civil to all, sociable to many, familiar with few, friend to one or two, and enemy to none." This mother of two enjoys



reading, listening to jazz, and watching movies. "I also enjoy walking and jogging; it is a great way to keep fit and spend time with my family."

Carrie-Anne Cairncross (Analyst)

Carrie-Anne joined the CMS as a temp at reception six years ago. Her journey up the corporate ladder to her current position is worth admiring. Part of the REF team since April, she is now responsible for managing REF data and analysing



the risk data of schemes. At the time of writing this article, Carrie-Anne was on maternity leave, expecting her second child.

"With REF, South Africa will have a more stable medical schemes industry."

Baanetse Selebi (Personal Assistant)

Baani joined the CMS two years ago to be a personal assistant to our Research and Monitoring Unit. She moved to REF earlier this year.

"It has been an educational experience. My team is mentoring in nature. There is a new thing to learn each day."

Before joining the CMS, this mother of two worked for non-governmental organisations for 10 years – as a secretary, coordinator, educator, trainer and counsellor. "This is where I learnt to be a voice of reason to young people faced with having to make good choices in life."

Baani decided to major in industrial and organisational psychology through UNISA "just to get to the core of why people act in strange ways sometimes". She has also completed training in office and project management. ■



Health reform in South Africa: the way forward

Health systems are not difficult to understand, yet health reform has become one of the most misunderstood areas of policy in South Africa.

By **Alex van den Heever**
SENIOR ADVISOR

Terms such as “National Health Insurance” (NHI), “Social Health Insurance”, “universality” and “equity” are used interchangeably as if their loaded meanings are self-evident and universally understood. In reality, these terms are far from clear and need to be properly defined when applied within any particular country context. A more recent addition to this list is “over-regulation”, a term typically applied to aspects of the private health system.

The improper use of these terms can be ascribed largely to particular interests, whether purportedly acting for or against the public interest, who wish to either prescribe or fob off reforms while deflecting any rational probing of the underlying issues. In this way, for instance, any person or organisation arguing for equity as an objective, usually without any relationship to any specific outcome to be achieved, is able to label any counter-position as arguing for “inequity”.

Similarly, any private interest group, currently deriving significant financial advantage from systemic biases in the private health system, merely has to invoke the mantra of “over-regulation” to remove any deeper questioning of the potential avoidable harm that proper regulation may offer.

Using loaded terminology in this way is a well-understood tactic in all struggles over resources and power; and it is not particular to South African health debates. Within reasonably democratic and open societies deliberate attempts to remove the use of reason from public discourse are countered through independent and public argument which can be used to place pressure on accountable government structures.

Although South Africa may be regarded as reasonably democratic and open, the extent to which profound discussions on social security and healthcare are aired in public is limited by the many institutional factors. These include: limited academic knowledge of the fields involved, the absence of solid public institutions with a strong institutional memory of public policy and social security, leadership issues, and a system heavily dominated by private interests who are better organised and funded than civil society.

As evidenced by the consequences of the

belief that HIV does not cause AIDS, myths held by senior public representatives play an important role in slowing down the normal evolution of policy. Although this egregious myth is a thing of the past, many remain that could prove just as harmful.

Over the past year, three basic propositions have been put forward as bases for policy health formulation:

- 1 South Africa's health reforms have been adequate and proportionate, but are struggling to cope under an altered burden of disease due to the unavoidable HIV and AIDS pandemic.
- 2 South Africa's health reforms have focused disproportionately on regulating the relatively efficient private health system rather than dealing with the acute problems of the public system.
- 3 Inequity is the cause of South Africa's poor health outcomes. It can only be addressed through the implementation of a universal single-tier health system.

Depending on which of the above are accepted as closest to the truth, widely divergent policy prescriptions would ensue. Accepting the first proposition would suggest the problem is primarily about resources rather than the quality of health policy to date and the resulting institutional framework. Acceptance of the second would contradict the first and infer that poor performance within the public system was avoidable had sufficient policy focus been allocated to addressing the real priorities. It also suggests that the private system should not be regarded a high priority as it focuses on income earners with systematically better health status, and works relatively well. The third proposition agrees with the second in accepting that the public system is avoidably under-performing, but blames this on the existence of a two-tier health system. The harm arises from the predatory nature of the private system which is able to attract scarce human resources away from the public system.

All three propositions become a little frail when a little scratching below the surface is done. Proposition 1 would be plausible if there were some evidence that the public health system was working well apart from the altered burden of disease. But there is abundant evidence demonstrating that public health services are generally

There is a need to ensure that public health institutions are sufficiently enabled to devise and implement competent public health strategies.

poorly run independently of resource constraints and the HIV and AIDS pandemic. For instance, not a single health district in South Africa is able to achieve World Health Organisation (WHO)-required detection and cure rates for tuberculosis. In public hospitals avoidable maternal mortality is at levels unprecedented by international standards, indicating poor service quality. Also, most health outcome improvements occur internationally with lower public health expenditure than found in South Africa.

For proposition 2 to be plausible there would need to be evidence that government has focused excessively on private sector regulation over the past 14 years, and that this effort monopolised scarce policy-making resources from “regulating” the public system. Were this to be the case, more policy achievements and movement would have been expected over the past 14 years in achieving basic social security objectives. However, South Africa still permits discrimination on the basis of health status, and has no effective measures in place to deal with over-supply and pricing. Virtually no private system reforms of substance have been implemented, placing South Africa well behind countries with an equivalent level of development. Although the public health consequences of this shortfall are limited, the social security implications are significant. Many income earners face substantial financial harm due to their having to pay for any catastrophic expense incurred. Presently they do not even have access to a free public hospital system.

The third proposition fails the evidence test, as almost all developing countries have two-tier health systems with far better health outcomes than South Africa. There is furthermore no verifiable or rational causal linkage between the existence of a private system and the poor performance of a public system either domestically or internationally. For this link to be established, one would have to demonstrate some transmission mechanism independently of poor governance in the public system. However, whereas overwhelming evidence exists for the latter, there

is no systematic evidence of the former. Where private arrangements result in under-insurance and unfairness, in most normal societies these are substantially mitigated through regulatory interventions.

Importantly, single-tier universal health systems are exclusively a feature of highly industrialised countries with relatively even distributions of income and high levels of formal employment. These systems are very expensive and provide only minimal improvements in life expectancy for the additional expense.

Leading from the above, an alternative fourth proposition would state:

4 The public health system is characterised by systemic underperformance arising from a flawed institutional model which is causally related to the failure to meet basic public health goals, while the private health system lacks the regulatory interventions required to meet the most basic objectives of a contributory system of social security.

The fourth proposition conceptually distinguishes between the goals of public health and social security, and suggests that both have been neglected in policy development over the past 14 years. The former achieves improvements in public health outcomes through publicly provided services, while the latter

addresses access to personal health services and income protection through regulated contributory insurance-based systems. Although the two involve distinct strategies, there is no rational reason for them to be pursued sequentially – i.e. public health before social security – as there are no identifiable trade-offs. On the one hand there is a need to ensure that public health institutions are sufficiently enabled to devise and implement competent public health strategies, while on the other, laws need to be in place to prevent discrimination on the basis of health status, ensure good governance, and remove systemic cost increases. This proposition therefore requires recognition of the distinct goals of the public health system with the contributory private health environment as the core of a much-needed social security arrangement for health. ■



Laws need to be in place to prevent discrimination on the basis of health status and systemic cost increases.



Low-income medical schemes

In the interest of making private healthcare more accessible to all South Africans, the creation of a regulatory framework to facilitate the emergence of low-income medical schemes remains a key concern for the Council for Medical Schemes. The issue was discussed at its annual strategic planning session in November.

By **Thulani Matsebula**
SENIOR POLICY ANALYST

In 2005, a Ministerial Task Team on Social Health Insurance invited stakeholders to investigate possible avenues to enable more low-income households and individuals to join the medical schemes environment.

A stakeholder-driven consultative process produced a report to the task team in April 2006. It showed that low-income individuals and households utilise private healthcare services extensively and that they pay for these services predominantly on an out-of-pocket basis. It was accordingly important that low-income earners should not be denied the opportunity of risk-pooling to protect them against catastrophic out-of-pocket expenses.

In the report, industry stakeholders recommended that low-income medical schemes (LIMS) should be subject to an alternative minimum benefit package tailored to the specific preferences of this market, within affordability constraints. The proposed package focused on a set of primary health-care benefits.

To prevent the destabilisation of existing medical schemes through buy-downs to LIMS products, proposals were put forward to ensure that LIMS products were sufficiently demarcated from the offerings of the existing medical schemes environment. These proposals included a household income restriction on eligibility for these products, and exclusion of cover for private hospitalisation (other than in

emergencies).

Responding to these proposals, provision was made in the Medical Schemes Amendment Bill for the regulatory requirements under the Medical

“To prevent the destabilisation of existing medical schemes through buy-downs to LIMS products, proposals were put forward to ensure that LIMS products were sufficiently demarcated from the offerings of the existing medical schemes environment.”

lishment of an appropriate regulatory framework for these products. ■

Schemes Act to be varied for low-income products where this was reasonably necessary to create the conditions for the emergence of such products, and in the best interests of low-income consumers.

This legislative framework has unfortunately not been finalised as passage of the Medical Schemes Amendment Bill has been delayed.

In the meantime, a few schemes have applied to be exempted from certain provisions of the Medical Schemes Act in an attempt to introduce LIMS options as part of their existing product offerings. The Council is seeking advice on the ambit of its powers to grant these applications, but in the meantime has resolved to approach the Minister of Health to discuss the need to expedite the estab-

“Low-income earners should not be denied the opportunity of risk-pooling to protect them against catastrophic out-of-pocket expenses.”

”

Getting closer to trustees

If you're a Board member, you've probably heard of our Education and Training Unit. In fact, you probably know the team personally. It has been helping trustees run their schemes and teaching the public about the medical schemes industry since 2000. But times change and the Council changes with them.

Mindful of international best practice, the Council for Medical Schemes regularly reviews the strategies of its various Units to ensure they stay true to ... best practice. This year, a revised strategy for our Education and Training Unit was developed and presented to Council members at our annual strategic planning session in November; and while its finer details are still being finalised, there's no doubt it holds considerable implications for the Council – and all medical schemes in the country.

Initiated by the Registrar of Medical Schemes earlier this year, the objective of the project was to critically review our existing strategy on reaching out to consumers and developing the skills and knowledge of trustees, and to develop recommendations for implementation. The review was conducted by an external consultant and managed by our Research and Monitoring Unit.

Essentially, the revised strategy proposes a change in the Unit's focus: more emphasis on trustee training without compromising our gains on consumer education. This is more in line with the Council's strategic focus going into the 2009-10 financial year: that of improving governance in medical schemes.

"I am sure that the new strategy will immensely benefit all medical schemes and beneficiaries through the proposed trustee training," says Gugu Nkosi, an Education and Training Officer at the Council.

Council members adopted the revised strategy on the understanding that it will not only place more emphasis on trustees but also continue to promote an understanding of the medical schemes environment among consumers by raising awareness of the Council's strategic focus areas of improved governance, cost containment and the protection of risk pools. The new approach holds serious structural, process and staffing implications for the Council.

But this is nothing new to the Education and Training Unit. Founded in 2000, its mandate has

“

Council members adopted the revised strategy on the understanding that it will not only place more emphasis on trustees but also continue to promote an understanding of the medical schemes environment among consumers.

”

had to evolve with the ever-changing role and responsibilities of the Council as the medical schemes industry continues to grow more sophisticated and complex. The team was initially located in the Communications Unit and later moved to the Compliance Unit, its initial focus on trustees expanding with time to embrace consumers and, most recently, healthcare providers, in relation to prescribed minimum benefits.

Our new education and training strategy is expected to be finalised and operationalised in the 2009-10 workplan. ■

“

I enjoyed the training session and have already alerted my colleagues on the Board to the suggestions made to improve governance.

(Red Metrowich, Chairman of the Governance Committee of Fedhealth)

”

By Aleksandra Serwa
COMMUNICATIONS
MANAGER

Remember!

Do you recall the last time you were dared? We dare you to show you care – for men, women and children, in South Africa and abroad, abused or not – by daily acts of compassion. Remember: each year has 365 days – not only 16.

By **Phumla Khanyile**
COMMUNICATIONS
OFFICER

“The abuse of women and children is a national scourge that no organisation can afford to ignore,” says the Acting Registrar of Medical Schemes, Patrick Matshidze.

He was speaking to *CMS News* about the support of the Council for Medical Schemes for abused women and children throughout the world – while the Council was commemorating the international campaign of 16 Days of Activism against Gender Violence which runs from 25 November to 10 December annually.

The Council aims to establish itself as an employer of choice for many young professional women, especially those having to balance their careers with family responsibilities. Policies have been put in place to safeguard both men and women against all kinds of abuse, the latest being the harassment policy which Council members approved at their recent annual strategic planning meeting and which has

“

**At the Council,
we strive to foster
a spirit of oneness
and a culture
of caring.**

”

since been implemented.

Our Human Resources team conducts an equity analysis every year, looking at gender and race representation in the organisation to prepare its recruitment priorities for the coming financial year.

Employees of the Council are also given the opportunity to further their studies through our Professional Development Programme. A number of women in managerial positions have attended empowering workshops, including those on “women in leadership”. The Council’s maternity leave policy grants mothers-to-be up to

four months of leave and their full monthly salary.

Our newly introduced flexi-time policy appears to be working well for all staff members; our career pathing and succession planning policies help young professionals to blossom in their respective fields of expertise.



Our driver and messenger Luke Mpala (left) delivers napkins, gloves and masks to the Kagisano hospice in Mabopane (2005). With him is Kaifus Selepe, a volunteer at the hospice.

Reaching out

At the Council, we strive to foster a spirit of oneness and a culture of caring. Each year we organise a charity benefit auction where monies are raised for worthy social causes which have in the past included the purchasing of appliances for women's shelters and the donating of food to hospices and orphanages.

If we want to create a better world for future generations, the men and women and children that are to come after us, we need to start acting now. Every year for the past three years we have partnered with Cell C in their "Take a Girl Child to Work" campaign. We give these ambitious girls a glimpse of their not-so-distant future: their working lives.

A few years ago the Council also adopted a home for abused children as its project for the "Make a Difference" campaign. This idea was conceived by the Registrar of Medical Schemes Patrick Masobe and was wholeheartedly embraced by all staff members. Every July and September we converge on the Mabopane Lotus Home for Children to fix their broken furniture, scrub the floors, paint the walls, cook for the children and play with them, if even for a day.

It doesn't take much; it's also the little gestures



Daisy Ditshoene, a Senior Analyst in the Council's Benefits Management Unit, is happy to clean windows at the Lotus Children's Home in Mabopane during our "Make a Difference" Day in September 2007.

that often make a big difference in other people's lives. So we encourage everyone not to care from a distance but to put down your pens, roll up your sleeves, and show you care for all our men, women and children. ■



Thembekile Phaswane, Manager of the Complaints Adjudication Unit (currently on maternity leave), demonstrates to Hlanganani High School students how to analyse complaints during the Cell C "Take a Girl Child to Work" campaign (2007).

Reading matter

Between 1 September and 30 November 2008, the Council for Medical Schemes continued to populate its website with a variety of publications, including three discussion documents of particular importance to the medical schemes industry.

The acting Registrar Patrick Matshidze invites all stakeholders to comment on these discussion documents by 6 February 2009:

- the broker remuneration regulatory framework;
- corporate governance guidelines for medical schemes; and
- the fit and proper standards for trustees and principal officers.

Invitation
to
comment

The remaining documents published between September and November were:

- Annual Report 2007-08 (and a synopsis of its key findings)
- The application form to lodge a complaint against a broker
- Nine Circulars (including the guideline to trustees for submissions of reinsurance contracts, and the guideline for the preparation of a business plan where a scheme is not meeting the statutory solvency requirements)
- September 2008 edition of CMS News, our quarterly external newsletter
- Five judgments on appeals (DBV v Registrar; EMC v Registrar; Medihelp v Registrar; Oxygen v Registrar; and VWF v Medihelp)
- Five press releases (including on the liquidation of Renaissance Health Medical Scheme and Humanity Medical Scheme, and on the former trustees of Gen-Health)
- A draft report on minimum datasets
- Three reports on the Risk Equalisation Fund (REF) (version 4 of the entry and verification guidelines, the methodology to determine the weighting table for 2009, and the weighting and count tables for 2009)
- Six documents on the Risk Equalisation Technical Advisory Panel (RETAP) (including the guidelines for the identification of beneficiaries with REF risk factors in accordance with the REF entry and verification criteria (draft 4), and agendas and minutes of RETAP meetings)
- Quarterly reports for the period ended 31 March 2008



For all our discussion documents, Annual Reports, Circulars and more, visit our website www.medicalschemes.com.

Reception

t: +27 (0)12 431 0500

f: +27 (0)12 430 7644

Call Centre

ShareCall: 0861 123 CMS (267)

Resource Centre

t: +27 (0)12 431 0500

f: +27 (0)12 430 7644

e: information@medicalschemes.com

Communications desk (media enquiries)

t: +27 (0)12 431 0581

f: +27 (0)12 431 0681

e: mediadesk@medicalschemes.com

Use our website to:

- view lists of registered schemes as well as accredited brokers, managed care organisations and scheme administrators in South Africa;
- download information (forms, the Medical Schemes Act 131 of 1998 and Regulations);
- read the latest news, developments and upcoming workshops; and
- lodge a complaint online.

Complaints

t: +27 (0)12 431 0500 / 0861 123 CMS (267)

f: +27 (0)12 431 0560 / +27 (0)12 430 7644

e: complaints@medicalschemes.com

Complaints procedure

- First, complain to your scheme. Phone the scheme or write to the Principal Officer. Give full details of your complaint and include any supporting documents.
- If you are not satisfied with the outcome of your complaint to the scheme, complain to the Registrar of Medical Schemes (in writing).
- If you are aggrieved by the decision of the Registrar of Medical Schemes or by the decision of the scheme's disputes committee or by any other decision relating to the settlement of your complaint, appeal to the Council.
- If you are aggrieved by the decision of the Council, appeal to the Appeal Board.

How to avoid complaints

- Make sure you know and understand the rules of your scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option that you have chosen.
- Make sure your contributions are paid in full and on time every month.



Council for Medical Schemes

**Private Bag X34
Hatfield
0028**

**Block E
Hadefields Office Park
1267 Pretorius Street
Hatfield
Pretoria**

t: +27 (0)12 431 0581

f: +27 (0)12 431 0681