# The Medical Schemes Amendment Act

## An Appropriate Response to the Crisis?

***Patrick Masobe & Max Price***

The Medical Schemes Amendment Bill, tabled before parliament this year, proposed radical changes to the current medical aid system. Medical schemes are currently required to guarantee payment to providers of care who agree to charge patients within a tariff of fees that has been determined by the Representative Association of Medical Schemes (RAMS). The new law will abolish such guarantee of direct payment by medical schemes to providers.

At present, medical schemes are bound by law to offer members a minimum package of benefits which is, in fact, quite comprehensive. The schemes have to pay, within certain limits, for doctors' fees, hospital costs and medicines. The amendments will do away with these prescribed benefits. The status of RAMS as a statutory body will be repealed and its scale of benefits will thus be reduced to guidelines.

At the same time the new act will have the effect of facilitating the development of managed health care options such as health maintenance organisations (HMOs) and preferred provider organisations (PPOs).

## Why the Changes?

The private health sector has been in crisis for some time now. Central to this has been the escalating costs of private care, which have risen on average by 26% each year. On the one hand, the rising costs make private care increasingly unaffordable for members of medical schemes and their employers. On the other, these escalations in costs place tight constraints on medical schemes' ability to attract new members. Faced with impending collapse, the medical aid industry put tremendous pressure on the government to come up with this 'rescue package' in the form of the Medical Schemes Amendment Act.

The bill has engendered an acrimonious and, at times, misplaced debate between its supporters and its opponents. It has garnered ardent support from the private medical aid sector, which has argued that it will allow medical

schemes to negotiate payments with providers in return for concessions that they might demand, and will provide incentives for containment of costs.

## Is Loss of Provider Choice the Key Issue?

A number of general practitioners and their organisations are very much against these changes and have argued that the new amendments will result in patients losing their choice of providers. Medical aid schemes will require members to go to those providers who offer discounted fees or are employed by HMOs. This lobby has also argued that the repeal of a guarantee of payment will increase providers' exposure to bad debts. The costs of administration will also escalate as schemes enter into separate contracts with a large number of providers.

There are a number of laudable points in the bill and we should not lose sight of these in the process of assessing its failings. To the extent that the amendments facilitate the development of managed care and allow medical schemes the option of reimbursing providers on a capitation, instead of fee for service basis, it is a good thing. This will probably reduce the costs of private care.

We would also argue that opposition to the bill on the basis that patients will lose choice of providers is unconvincing. Most schemes have member representation on their boards and are unlikely to effect changes that members are vigorously opposed to. What is likely to happen is that members will be free to choose either more cost effective managed care options or to pay higher premiums for traditional medical aid cover with greater freedom of choice.

## Will the Bill Benefit the Public Sector?

The argument by supporters of the bill that it will benefit the public sector also runs hollow. The repeal of the requirement for a minimum package of benefits will result in the introduction of variable packages which allow schemes to rate members on the basis of risk presented. The consequence will be a loss of cross subsidisation as the young and healthy choose cheaper packages and the old and infirm are confronted with the more expensive ones. Many people in the latter group are unlikely to afford such packages and will be forced to drop out of the system.

Thus, from the public sector point of view, the fundamental criticism of the bill is that the advent of variable packages will erode cross subsidisation in the medical aid system and will push a lot more elderly and sickly people into

**How do patients benefit from the Medical Schemes Amendment Act?**
***Photo: Ismail Vawda***

the public sector. The people most in need of health care will be least able to afford medical cover and the higher medical costs of these patients will be borne by the public sector. This will further increase the imbalances between the two sectors.

The minimum package requirement has had other profoundly positive effects which would be lost if it were abolished. Millions of patients were able to obtain much of their health free from the majority of general practitioners and specialists who were 'contracted in'. These patients are not always able to pay 'the first rand' when they need care. The new act will mean that many patients may, for the first time, be faced with significant out of pocket expenses at a time when they need essential care the most. Once again, such patients are likely to be off loaded onto an already overstretched public sector.

## Forward Funding

One solution to this problem would be for legislation requiring medical schemes to forward fund, that is to hold in reserve funds for the future care of present contributors. This will prevent the proliferation of 'fly by night' schemes offering cheaper packages to the young and healthy, and forcing the elderly and sickly into the public sector as a result of the more costly packages they are confronted with. The representation made by the Medical Association in this regard ought to be supported.

Though the advent of managed care should go some way towards putting a lid on escalating costs, there may be other reasons why costs of health insurance may remain high. If medical schemes were required to forward fund, then it is unlikely that the cost of health insurance would drop substantially. In fact, cost may even go up. If contributions reflected their true costs to medical schemes and insurance, private care would remain relatively expensive.

## The Amendment Act or an NHI?

The proposed changes will leave large numbers of medical scheme members without the ability to meet the substantial out of pocket expenses they will face, and thus without adequate cover. The introduction of flexible packages will fracture the cross subsidisation that is a feature of the current system. Those people faced with expensive packages, the old and sick, are unlikely to afford them. Such patients will inevitably have to be cared for by a public sector already struggling to provide adequate care to almost 80% of the population.

Though few people would dispute the dire need for radical reform to the private health sector in South Africa, and though this bill makes a contribution by facilitating the development of managed care options, it nevertheless fails to extend private sector care to a larger proportion of the population. It falls well short of providing health care to all South Africans. We have argued elsewhere for a National Health Insurance (NHI) system that will incorporate the private sector and will ensure the equitable provision of cost effective care to all South Africans. Such an NHI system should be the result of a process of negotiations among all those concerned with health for all South Africans.

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