

21 July 2008

**Terms of reference: Facilitating access to private health financing for low-income South Africans**

**1. Introduction**

The Centre for Financial Regulation and Inclusion (Cenfri) is a non-profit research centre, established in March 2008 with support of the FinMark Trust. Cenfri's mission is to support financial sector development and financial inclusion through facilitating better regulation and market provision of financial services. We do this by conducting research, providing advice and developing capacity building programmes for regulators, market players and other parties operating in the low-income market.

Cenfri was appointed to manage the FinMark Trust's research on microinsurance (including health insurance). Created with initial funding from the UK's Department for International Development, FinMark Trust is an independent trust whose business is controlled by five trustees from countries in Southern Africa. Its mission is summarised in its slogan: "Making financial markets work for the poor". In pursuit of this objective, FinMark Trust supports and promotes institutional and organisational development towards the objective of increasing access to financial services by the un- and under-served of Africa.

This project will be funded by the FinMark Trust and managed by Cenfri on behalf of the FinMark Trust. It is a first step towards a wider engagement with the market for health financing to explore market-based financing for access to health services by the low-income population in South Africa.

More information on Cenfri and the FinMark Trust can be found at <http://www.cenfri.org> and <http://www.finmark.org.za>.

**2. Background**

During the last ten years, South Africa has achieved remarkable progress in the area of financial inclusion for lower-income households in specifically the banking and, to a lesser degree, insurance markets. Limited or no progress has been made in including low-income individuals in the voluntary private medical schemes market.

*Impact of limited healthcare on the poor.* Health financing and services are critical in the alleviation of poverty and vulnerability. The combination of loss of income and the costs incurred

by lower-income households during periods of illness can have a devastating effect on their welfare. This often forces households to dispose of hard-earned assets, eat into savings (when this is available) or even take children out of school to augment the family's earnings. Such events do not only have a major effect on the present generation but also undermine the intergenerational transfer of wealth and gradual emergence out of poverty. In contrast, appropriate healthcare can increase a person's working life even for severe illnesses such as HIV and AIDS. This does not only improve the quality of life for patients, but allows them to provide for their families.

*Restrictive healthcare services and financing markets in SA.* Adequate health services are not available to a large proportion of South Africans and, in particular, to the poor. The limits of public provision are reflected in the finding of the Consultative Investigation into Low Income Medical Schemes (LIMS) that low-income people have a preference for private healthcare. According to survey data used in this investigation, greater satisfaction is derived from the use of private health facilities than from public health facilities and the perception exists that the private sector is able to provide better services (than the public sector) for more serious health problems<sup>1</sup>. At the same time, private healthcare is, however, not easily accessible. A well-functioning health financing market supports the development of a market for private health services by attracting service providers because a financing mechanism exists which can ensure that they are remunerated for their services. Current financing systems are, however, increasingly unaffordable and exclusionary. Without appropriate health financing mechanisms, private healthcare is not an option for the majority of low-income South Africans.

*Access depends on both healthcare funding and services.* Access to appropriate healthcare is dependent on the availability of healthcare financing, as well as the availability of a healthcare services network that is able to deliver services funded by these financing mechanisms. In understanding the overall functioning of the health system in South Africa, consideration needs to be given to both the health financing and services components and their interaction. Three sources of funding are used in South Africa to finance healthcare.

- *Public funding* for the public health system.
- *Private funding relying on insurance products.* There are two types: Medical scheme membership where, in return for a premium, financial risk is transferred from the medical scheme member to the medical scheme to cover medical expenses; and stated benefit insurance products such as hospital cash plans that pay a stated benefit on the occurrence of a health event.
- *Private out-of-pocket (OOP) expenditure* to purchase medical services. This funding source does not entail any risk pooling.

*Limited and stagnant medical scheme membership.* The interest of this project is specifically in medical schemes as a means of financing healthcare. During the last ten years, medical scheme membership has shown little growth, remaining restricted to a small proportion of South Africans. The number of medical scheme beneficiaries increased rapidly from 4.8m in the early 1980s to 6.3m by early 1990s and 6.9 million in 1997 (McIntyre et al, 2007). By 2007, total medical scheme membership (including members of both restricted and open schemes) had increased to only 7.1m (Council for Medical Schemes, 2007), despite a number of years of high economic growth and seeming economic mobility. While it may be fair to say that the higher-income market for medical schemes is saturated, middle- to lower-income groups remain excluded.

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<sup>1</sup> The LIMS process included a national household survey of more than 3,500 low-income households. This survey focused on healthcare expenditure and utilisation, as well as the surveyed households' preferences and willingness to pay for insurance cover.

*High costs of medical schemes present significant access barrier.* The limited and stagnant coverage of medical schemes in terms of members and beneficiaries is symptomatic of a medical schemes market that is exclusionary and restrictive. There are diverging views and perspectives on why medical schemes and healthcare services are so expensive. This study therefore seeks to identify the main drivers of medical schemes costs as a first step to developing a strategy to make health financing more affordable to low-income South Africans.

*Potential factors driving healthcare and health financing costs.* The costs of medical scheme products are affected by both non-health expenditure (e.g. administration costs, intermediation costs paid to brokers and agents) and claims expenditure (e.g. hospital expenses, medicines, changing profile of lives covered). Regulatory costs are not always taken into account as a potential driver of medical scheme costs. It is possible that various changes to the way that medical schemes are regulated during the last ten years may have contributed to the increasing costs of medical schemes.

The cost of medical insurance is influenced by, inter alia, the following factors:

*The administrator-mutual fund relationship.* In South Africa, medical schemes (or, what the client views as the medical scheme) consist out of two organisational components:

- the third-party administrator that is responsible for all administration and management of claims and benefits and that is a profit-taking entity; and
- the mutual fund or risk carrier, a non-profit entity required to operate on solidarity principles.

Given the mutual risk carrier and the administrator's different orientations in terms of profit, questions have been raised on whether the right incentives and controls are in place to ensure that the administrator consistently acts in the members' interest and minimises costs as far as possible. It may be possible that the fundamental difference in nature between these two entities will always lead to a second-best outcome for medical scheme members.

*Specialist capture and supply-induced demand.* In the current debate it is also suggested that the capture of medical specialists and perverse incentives set for these specialists by private hospitals contribute to the larger problem of supply-induced demand. Private hospitals can and do compete with each other on the basis of the number, type and quality of specialists they are able to attract to their specific hospital. One way of attracting (or "capturing") specialists is for hospitals to provide access to expensive equipment (e.g. a CAT scan machine) that specialists prefer to use. Due to the presence of a "guaranteed" third-party-payer (medical schemes), hospitals are able to invest in such equipment at virtually no risk as they are able to pass the costs on to the members of medical schemes. However, once a specialist is attached to a specific hospital (where he/she will also benefit from the use of hospital facilities), the specialist may be incentivised to meet certain targets related to the number of patients seen, creating the incentive to over-treat patients and, especially, medical scheme members. It is not clear to what extent this practice occurs.

*Limited competition in the private hospital market.* During the last twenty years, a dramatic change has taken place in the ownership of private hospitals in South Africa, with more hospital beds being concentrated in the hands of a few hospitals. In 1996, independent hospitals owned nearly 50% of private hospital beds in South Africa, but by 2006 their market share had decreased to about 16% (Van den Heever, 2007 as quoted in McIntyre et al., 2007). Currently, the market for private hospitals is heavily concentrated, with 84% of hospital beds in private hospitals being owned by three hospital groups: Netcare, Medi-Clinic and Afrox Life (Van den Heever, 2007 as quoted in McIntyre et al., 2007). Given the fact that hospitals absorb 35% of all

benefits paid by medical schemes to medical providers, the occurrence of anti-competitive pricing practices in an already overly concentrated market would have a large impact on the costs of medical schemes. McIntyre et al. (2007: 26) recently concluded that “there are clear indications that these groups are using their oligopoly power to charge excessively high prices and not engage in price competition with each other”.

*Prescribed minimum benefits.* According to Section 29(1)(o) of the Medical Schemes Act of 1998 a medical scheme is not allowed to “carry on any business” unless it has made provision in its rules for “the scope and level of minimum benefits that are available to beneficiaries as may be prescribed”. The prescribed minimum benefits (PMBs) are contained in the regulations to the Medical Schemes Act and came into force on 1 January 2000. The PMBs are generally criticised as being too focused on tertiary or hospital-based care and not providing sufficient cover for primary care. It could therefore lead to a bias in favour of hospital-based health care provision. At the same time third-party administrators may prefer to provide the medical care required in a hospital setting as hospitals are able to provide them with good quality information on treatment received by the client, providing an easier cost control mechanism than if they were to contract with smaller medical providers.

*The Competition Act and absence of collective bargaining.* Certain rulings made by the Competition Commission in terms of the Competition Act have led to an inability on the part of medical schemes to negotiate prices centrally with medical service providers. Centralised bargaining, e.g. when the Board of Healthcare Funders (the industry body for medical schemes) negotiates with a hospital group on behalf of all its members, is not allowed by the Commission as it is argued that this would be in contravention of the Competition Act. Medical schemes can only negotiate on an individual basis with individual hospital groups and other medical service providers. However, suggested amendments to the National Health Act currently being debated in Parliament could lead to a statutorily enforced centralised bargaining system between medical schemes and providers of medical services.

All of these factors are subject to significant debate with no clear consensus.

### **3. Project objectives and scope**

#### **3.1. Objectives**

*Understanding cost drivers and how to support inclusion.* The objective of this study is to understand the main drivers of medical schemes and health services costs and to identify strategies through which these costs can be reduced to support inclusion. To achieve this we seek to a) construct a comprehensive framework of the various factors (and their relative importance) that affects the costs of medical schemes in South Africa and to b) develop strategies through which health financing can be made more accessible to low-income South Africans.

#### **3.2. Scope**

Although access to medical scheme membership is not only affected by affordability (but also physical proximity, terms and conditions associated with the product and regulation), it is a critical determinant of access in South Africa. It is, therefore, the focus of this study. The study should consist of the following components:

- a) identify the cost components of medical schemes and their most important drivers – this should include consideration of the cost drivers of various healthcare services as input into medical scheme costs;

- b) identify the ways that the current regulatory framework that applies to medical schemes and the healthcare services market is impacting on medical schemes and health services costs;
- c) develop an appropriate framework to compare the cost of providing healthcare services in the private sector to the cost of healthcare provision in the public sector and consider the opportunities and challenges to reduce medical schemes' cost by increased utilisation of public sector healthcare services;
- d) identify possible courses of action that could decrease medical schemes' costs and unlock the medical schemes market for lower-income individuals.

*Optional:* Consultants should consider whether an international comparison on specific components of the analysis could add value to the study. The cost of this element must be indicated separately and its inclusion carefully motivated (including proposed countries to include in the comparison).

The following issues are proposed for consideration in the analysis:

*Affordability and costs:*

- The key drivers of affordability of medical schemes and how this has changed over the last 10-15 years. In considering this issue, it is important to keep in mind that affordability is also affected by the willingness of other parties, such as employers, to contribute to the premiums.
- The impact of medical schemes' governance structures on cost increases.
- The impact of health insurance (most notably gap cover) on medical schemes.
- Profit levels in the private hospital sector.
- The key drivers of increases in the general price levels of private hospital healthcare.
- The impact of the level of concentration of the private hospital sector on the costs of private hospitalisation.
- The impact of the emigration of healthcare personnel on the costs of private hospitalisation.
- The cost-efficiency of private hospital services compared to public hospital services, if a comparable unit of analysis is used.
- The role of alternative reimbursement methodologies in creating incentives for cost minimisation.

*Regulatory impacts on costs:*

- The impact of regulation on the costs of medical schemes.
- The impact of Prescribed Minimum Benefits (PMBs) on the costs of medical schemes. Here the consultant should also consider the re-defined PMB structure as proposed under the Low Income Medical Schemes (LIMS) project.
- The impact of the absence of centralised bargaining on cost increases (until now) and the impact of proposed changes in the National Health Amendment Bill on cost increases (future).
- The impact of current capital requirements on medical schemes' costs.

*Strategies to extend access:*

- Regulation of medical costs or price regulation for private hospitals.
- Changing the current basic benefit package (PMBs).
- The role of the LIMS process.
- The role of public private partnerships in creating a competitive environment.
- The entry of new service providers into the market.
- Alternative models of healthcare delivery.

### **3.3. Deliverables:**

- 3.3.1. Presentation of the interim findings at a workshop of interested stakeholders in the week of 24 November 2008. Cenfri will carry the direct cost for this workshop and will make the necessary arrangements. The consultant will be required to provide support to the workshop arrangements to ensure a good level of attendance.
- 3.3.2. A draft report containing a market and regulatory overview (and annexes where required) as basis for the overall analysis. This should be submitted to Cenfri and other identified stakeholders for comment by 8 December 2008.
- 3.3.3. A final publishable report containing a market and regulatory overview (and annexes where required) as basis for the overall analysis. This should be submitted to Cenfri by 23 January 2008.
- 3.3.4. A separate document containing strategic recommendations for Cenfri and the FinMark Trust in pursuing its work in the health financing and healthcare markets. This will be due with the final report by 23 January 2008.

### **4. Contents of proposal:**

This TOR does not seek to provide a definitive list of issues to be covered as this will be pre-empting the outcomes of the project. We strongly encourage consultants to propose other issues or different frameworks which they believe essential to meet the core objective of the study. The evaluation process will reward originality and the substance of approach suggested.

*Proposals to undertake this project must include:*

- 4.1. Statement of Qualifications of firm(s) (if no previous work record for the FinMark Trust).
- 4.2. Name & CV of staff members responsible (i) for overseeing the work; (ii) for undertaking the work.
- 4.3. The key issues that consultants think should be covered. This should be based on the issues highlighted above, but should ideally expand on them or highlight other issues to be considered.
- 4.4. The methodology to be followed.
- 4.5. Fee proposal & costs estimate, indicating the basis of calculation of fees.
- 4.6. Affirmative action scorecard.

An understanding of a Making Financial Markets Work for the Poor approach will be required. See Porteous, D., 2004. *Making Financial Markets Work for the Poor*. Available at: <http://www.finmarktrust.org.za>.

### **5. Budget and timeline:**

- *Budget:* We foresee that this project should cost between R600k and R800k and consultants are encouraged to tailor the scope and required analysis to work within this budget limit and propose optional components and additional phases/components of analysis as separate items in the proposal.
- *Question and briefing session:* A briefing session will be held at the offices of the FinMark Trust at 10:00 am on 1 August 2008. At this session, consultants will be able to ask any questions on clarification of the TOR.
- *Proposal deadline:* Proposals to undertake this work should be received by 12.00 pm (South Africa time) on 25 August 2008. Proposals should be forwarded electronically to Anja Smith at [anja@cenfri.org](mailto:anja@cenfri.org).
- *Commencement of project:* It is envisaged that the project will be awarded by 1 September 2008 with work commencing as soon as possible thereafter.

The consultant will be required to schedule regular (at least monthly) progress meetings with Cenfri to provide feedback on progress made and to allow for inputs and guidance. Two of these meetings will include brief presentations on progress to a project advisory committee.

**6. Basis of award:**

Cenfri will award the contract based on:

- 6.1. Relevant, demonstrated competence of firm(s) in this area: (25%)
- 6.2. Demonstrated expertise of key individuals to be involved in this project: (30%)
- 6.3. Content, quality and originality of proposal: (20%)
- 6.4. Affirmative action scorecard: ownership, management, staff development (10%)

*Note:* FinMark and Cenfri take the need for affirmative action seriously and reserve the right to compel the researcher to address this component in one form or other. We would of course wish to ensure that any arrangement works for all and would be flexible in agreeing the structure.

- 6.5. Fee basis: (15%)

**7. Contact:**

Questions or comments in respect of these terms of reference should be directed to Anja Smith before or on 13 August 2008. She can be contacted at [anja@cenfri.org](mailto:anja@cenfri.org) and at +27 83 426 3541.

**8. Recommended readings:**

Broomberg J., 2006. *Consultative Investigation into Low Income Medical Schemes: Final Report*. April. Available at: <http://www.medicalschemes.com>.

Council for Medical Schemes, 2008. *Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations*. Research Brief Number 1 of 2008. March. Available at: <http://www.medicalschemes.com> (accessed April 2008).

McIntyre, D., Thiede, M., Nkosi, M., Mutyambizi, V., Castillo-Riquelme, M., Gilson, L, Erasmus, E.I & Goudge, J., 2007. *SHIELD Work Package 1 Report: A critical analysis of the current South African Health System*. Available at: <http://web.uct.ac.za/depts/heu//SHIELD/reports/SouthAfrica1.pdf> (Accessed on 18 July 2008).

Health Task Group (Hospital Association of South Africa), 2008. *Private Hospital Review 2008: Examination of factors impacting on private hospitals*. Available at: <http://www.hasa.co.za> (Accessed April 2008).