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Director-General: Health
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Attention: Director - Social Health Insurance

SUBMISSION ON THE DRAFT MEDICAL SCHEMES AMENDMENT BILL

NOTICE 1724 OF 2006

INTRODUCTION

The AIDS Law Project (ALP) is a section 21 not-for-profit company and a registered law clinic. It seeks to develop, implement and use laws and policies to protect and advance the rights of people living with and affected by HIV/AIDS. In so doing, it aims to ensure a rights-based response to the HIV/AIDS epidemic that it believes is best suited to reducing new HIV infections and minimising the negative social impact of AIDS. The ALP was part of the Centre for Applied Legal Studies (CALS) at the University of the Witwatersrand, Johannesburg from 1993 until 2006. It is now an independent organization that is formally associated with the Wits School of Law.

Fundamental to our work is the Constitution of the Republic of South Africa, 1996 – the rights that it entrenches; the positive and negative obligations that it imposes on the state; and the structures that it recognises and empowers to ensure the realisation of the values upon which our democratic state is based. In respect of the right to have access to health care services, this means government has a duty to take all reasonable steps to ensure that the best, fairest and most equitable health system possible within available resources is established. Amongst other things, this also means that in South Africa, "health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities". [1]

[1] See 'Committee of Enquiry - Health Chapter. Inquiry into the Various Social Security Aspects of the South African Health System'. Department of Health, 14 May 2002. Available at http://www.doh.gov.za/docs/reports/2002/inquiry/index.html. "Taylor Report".

CONTEXT

The ALP welcomes the opportunity to make a submission on the draft Medical Schemes Amendment Bill ("the draft Bill") in so far as it deals with risk equalisation. We do so against the following background:

1. We accept that the health sector should operate on the basis of *solidarity*. In the private sector different groups with different health needs should not get treated unfairly within a scheme. In the public sector, all health users must be guaranteed a minimum basic set of health services.
2. That the Risk Equalisation Fund ("REF") – and other regulatory measures aimed at the private sector – must form part of broader health care reform, including the development, adoption and implementation of National Health Insurance (NHI). This is essential if we are to work towards achieving a more effective and unified health system, and is also in line with the recommendations of the 'Committee of Inquiry into the Various Social Security Aspects of the South African Health System' ("Taylor Report") as well as its mandate.[2]
3. We believe that the rationale of the REF, which is ensure that all schemes bear the same risk in making prescribed minimum benefits (PMBs) available to their members, is a sound one.[3]
4. We therefore support the REF on the condition that it forms part of a broader set of regulatory measures to equalise risk across and within *all* sectors, not just the private sector.

National Health Insurance (NHI)

While we support the implementation of an REF, we are concerned that regulatory measures to equalise risk and improve access to health services that have been proposed, developed and implemented since 1994 have been limited to the private sector[4] (Prescribed Minimum Benefits (PMBs), Tax reform[5], Government Employee Medical Schemes (GEMS), REF and Low Income Medical Scheme (LIMS)). In other

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[2] See Taylor Report 2002 (Terms of Reference, 2000, par. 2.2.5.). "The public and private sector environments must be examined with a view toward ensuring universal access to basic health care."

[3] We agree that 'the primary objective of the Risk Equalisation Fund in South Africa is to protect the environment of open enrolment and community rating. The purpose is to prevent competition between medical schemes from occurring on the basis of risk selection. In doing so it will encourage competition between medical schemes on the basis of cost and quality of healthcare delivery'. See Department of Health (2002), *Inquiry Into the Various Social Security Aspects of the South African Health System*. Policy Options for the Future.14 May 2002.

[4] According to the Council for Medical Schemes, the medical schemes sector covers about 7 million employed and/or income earning lives.

[5] The value of the tax subsidy toward the private health system is substantial and is estimated at R7,8 billion. It currently lacks clear public policy objectives with associated identifiable positive outcomes. The subsidy therefore needs to be reconsidered within a broader subsidy reform framework.

words, Phases 1 – 3 will be finalised in 2007.[6] However, Phase 3 measures relate to the private sector only. Similar and other measures such as state/income mandatory subsidisation and a risk equalisation fund for the public sector – in other words, NHI – seem to have fallen off the agenda and/or been inexplicably delayed.

Yet the Taylor Report recommended that –

> "[I]n the medium- to long-term South Africa [should] move toward a National Health Insurance system compatible with multiple funds and a public sector contributory environment as defined in the 1995 NHI Committee Report. The last phase envisages the implementation of a universal contributory system, which would to a substantial degree replace general tax funding a source of revenue. General tax as a supplementary source of revenue may nevertheless prove desirable. ...
>
> The final phase essentially envisages the establishment of a contributory environment for all groups and individuals assessed to be in a position to contribute toward the health system. These contributions would not replace medical scheme contributions, but rather fund a proposed subsidy provided to medical schemes. All contributions and general tax allocations should ultimately be made directly to a Central Equity Fund (CEF) which would in turn allocate them to the public sector and medical schemes based on a risk-adjusted equity formula." [Chapter 15, at page 4]

However, what is worrying is that while a Ministerial Task Team (MTT) on Social Health Insurance (SHI) has been set up, a NHI task team has not been appointed as yet.[7] Therefore, while we support the rationale for introducing an REF in the private sector we have serious concerns about the time with which it is taking government to also implement other necessary and similar measures in the public sector.[8]
Without NHI, we will be burdened with an even more fragmented and unequal health care system.[9]

The Taylor Report on REF

In 2002, the Taylor Report called for the immediate implementation of an REF. In particular, it saw the REF as a way of creating a much larger risk pool out of a number of smaller independent risk pools. The Taylor report also made recommendations with respect to the content of legislation that would be necessary to implement an REF, dealing with:

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[6] The expected adoption of the REF is early 2007 with LIMS sometime in 2007.
[7] In 2004 the Minister of Health appointed a Ministerial Task Team (MTT) on Social Health Insurance to support the implementation of the SHI system in South Africa over the next five years. The MTT is made up of officials from the Department of Health, the Department of Social Development and the Council for Medical Schemes. In January 2005 Cabinet approved the shadow implementation of the Risk Equalisation Fund (REF) and placed the responsibility for implementation with the Council for Medical Schemes. Cabinet approved the implementation of REF in July 2005. See *RETAP Recommendations Report No. 8 Adopted at RETAP Meeting on 20 April 2006.*
[8] Since 1995, the objective of health policy has been to introduce a mandatory contributory environment in addition to the non-contributory tax funded public health system. See 1995 National Health Insurance Committee of Inquiry.
[9] In addition to proposing the reforms listed under Phase 1-3, the Taylor report also recommended the introduction of NHI under Phase 4. NHI would essentially ensure that both contributors and non-contributors benefit from a universal health system.

(a) The governance structure;
(b) The mechanism and calculation according to which medical schemes pay in funds;
(c) The mechanism via which earmarked tax contributions are made to the fund;
(d) The mechanism and formula according to which general tax contributions are made to the fund;
(e) The prospective or retrospective nature of the assessment of relative risk between Schemes;
(f) The formula according to which funds are to be distributed to individual medical schemes;
(g) The formula and mechanism according to which funds are distributed to any public statutory fund for non-medical scheme contributors;
(h) The timing of receipts and payments (e.g. quarterly or annually); and
(i) Confidentiality requirements.[10]

While some of the above issues are dealt with in the draft Bill, several are excluded (see b, c, d, f, g). We propose that all the areas identified by the Taylor report listed above be specifically included in the draft Bill. Below we explain why this is necessary.

SUBMISSION ON DRAFT BILL

We support the governance measures proposed in the draft Bill for the administration and oversight of the REF (sections 19A – H).

However, given the financial significance and importance of the REF, the draft Bill is very short on detail in many respects relating to the REF. It seems that a great deal will be dealt with in regulations (though subject to section 67 of the Act). It is therefore extremely difficult to make a detailed submission on the technical aspects of implementing the REF.

Our submission is therefore limited to two aspects of the draft bill, namely:

1. Calculation of financial transfers/methodology and the regular review of the methodology (sections 19I and K respectively); and
2. Exemptions from the REF and the impact of LIMS on REF.

1. Methodology

a. Inclusion and guidance

[10] See Taylor report, note 1 above. Chapter 7.

b. Participation and consultation

Inclusion and guidance

The methodology for arriving at the formula to determine the actual amounts payable into the REF – as well as amounts payable by individual schemes – is not included in the draft Bill. We are therefore not in a position to comment on the methodology, nor will we be able to do so when an amendment bill is eventually tabled in the National Assembly. The exclusion of the methodology from the draft Bill is therefore unfortunate, because Parliament provides the ideal forum for a proper debate and discussion on this central issue. Instead, the draft Bill – without even providing any guidance – leaves the matter to be dealt with in the regulations.

Our Constitution recognises that Parliament has an obligation to ensure that when it empowers the executive to act (by giving discretionary powers such as the power to publish regulations), it provides sufficient guidance for the exercise of such powers – primarily to guard against the violation of rights[11]. In this case, if no guidance is offered regarding the considerations that need to be taken into account in developing the methodology, the resultant statute may not pass constitutional muster.

We therefore propose that the methodology be addressed in the draft Bill itself, or at the very least, that the draft Bill provides sufficient guidance on how it should be determined.

Participation and consultation

We propose that all stakeholders participate in the finalisation of the methodology. This will not be difficult because the Technical Task Team on the REF has already completed significant work on the REF contribution tables.[12] In particular, given that the Council will be responsible for the administration, governance and oversight of the REF, it follows that if the methodology is dealt with in the regulations, that they be published by the Minister acting in – and not after – consultation with the Council.[13] Adequate and proper consultation is extremely important for at least two further reasons: first, there are still

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[11] See for example *Dawood v Minister of Home Affairs; Shalabi v Minister of Home Affairs; Thomas v Minister of Home Affairs 2000 (1) SA 997 (CC).*

[12] The Risk Equalisation Technical Advisory Panel (RETAP) was established by the Ministerial Task Team on 20 October 2004 as a consultative group to assist in the development of technical requirements for implementation of the Risk Equalisation Fund (REF). See RETAP Recommendations Report No. 8. Adopted at RETAP Meeting on 20 April 2006. This report is a formal recommendation from RETAP to the Council for Medical Schemes, which is responsible for the implementation of the REF. The Council for Medical Schemes will need to satisfy itself as to the appropriateness of the recommendations and to formalise a decision on the planned methodology for the REF Contribution Table 2007.

[13] Also, the Council for Medical Schemes will need to satisfy itself as to the appropriateness of the recommendations of the RETAP Report and to formalise a decision on the planned methodology for the REF Contribution Table 2007. So while the Council's de facto role seems to be very clear, the draft bill makes it quite tenuous.

several outstanding policy issues that must still be decided;[14] and second, the absence of proper consultation on the methodology is likely to result in government facing legal action.[15] This would unnecessarily delay the implementation of the REF.

2. Exemptions

Section 19H(2) allows that "the Council may, where it considers it necessary for the development of a newly registered medical scheme, exempt that medical scheme for a specific period from participation in risk equalisation."

There are three problems with this section:

1. That it allows for an exemption from the REF in the first place. We deal with this below.
2. That even if such an exemption were to be regarded as reasonable (which we believe it is not), that it duplicates section 8H of the Act,[16] which already provides for a process whereby the Council can exempt a scheme from complying with any part of the Act –for example, it has exempted the Bargaining Council Schemes from having to fund PMBs. It is therefore unclear why section 19H(2) has been included in the draft Bill at all.
3. The Council's exemption powers are not guided by further detail in legislation. The legislature should identify the policy considerations that would render an exemption permissible to avoid the arbitrary exercise of power by the Council.

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[14] For example, while the Taylor Report recommended – amongst others – 'sex' (gender) as a risk factor that should be included in calculating the contribution tables, the Technical Task Team on the REF has set out the explained why gender should only be included as a risk factor from 2008 onwards. In relation to both the REF and LIMS, the report states as follows: "Risk equalisation parameters should be as simple as possible. Initial recommendations for this would be the use of age, gender and chronic/non chronic status only" at page 11. See RETAP Recommendations Report No. 8. Adopted at RETAP Meeting on 20 April 2006. According to RETAP suggestions about risk factors for incorporation by the Risk Equalisation Fund include:

- Metabolic storage diseases – including the rare lysosomal storage disorders such as Gaucher Disease, Hurler's Syndrome (including Hurler Schie and Schie (MPS I)), Hunter's Syndrome (MPS II), Maroteaux Lamy Syndrome (MPS VI), Pompe's Disease and Fabry Disease.
- Neo-nates
- Oncology.

See also The Taylor Report which recommended the following risk factors to be taken into account:
(a) Age and sex;
(b) Members with chronic conditions;
(c) Benefit levels;
(d) Mortality.

[15] See for example, *Minister of Health v New Clicks South Africa (Pty) Ltd* 2006 (2) SA 470 , which saw pharmacies succeeding in their challenge to the appropriateness of the dispensing fee, a central feature of the dispute. The court stated that participatory democracy and consultation must operate with the enactment of original legislation, the stage when the general principles of the original statute are being converted into operational standards and procedures, and at the stage of the implementation.

[16] See Medical Schemes Act 131 of 1998, as amended:
Section 8. Powers of Council.—The Council shall, in the exercise of its powers, be entitled to—(h) exempt, in exceptional cases and subject to such terms and conditions and for such period as the Council may determine, a medical scheme or other person upon written application from complying with any provision of this Act; [Para. (*h*) substituted by s. 3 of Act No. 55 of 2001.]

Exemption

The exemption of newly registered schemes from the REF -particularly the LIMS market- goes against the rationale of risk pooling. If new schemes are allowed to seek exemption, the risk pool will be fragmented, even if for a specified period.

The draft Bill also offers no guidance about what the Council should take into account in making a decision to grant an exemption or not in these circumstances. The wording in the draft bill is very broad. For example, while the Council will determine the 'period', a maximum period is not stipulated in the draft Bill, potentially allowing the Council to grant fairly long or very short exemptions. It is also unclear what 'necessary development' means. Given that the draft bill offers no guidance to the Minister regarding his/her powers in finalising the methodology and no guidance to the Council regarding the exemption process (that is, if it is regarded as a legitimate mechanism) the implementation of the REF could be severely compromised. We are therefore concerned that many schemes will try and use this provision to argue for an exemption, and that in the time it takes for the Council to consider the exemption and then grant/refuse it, that significant financial transfers to the REF will not be secured or that it will be delayed.

In any event, even *if* it is reasonable to exempt certain schemes from the REF – the problem is that section 8H of the Act already allows the Council to grant exemptions 'from any provision of the Act'.

The following problems therefore emerge:

If section 19 H (2) is retained, it duplicates the power of the Council as set out in section 8H; or

If section 19 H (2) is deleted, then section 8H of the Act would have to be amended so that guidance is offered to the Council on how to exercise its exemption power with respect to the REF.

If it is accepted that schemes should not be exempted from the REF, then section 8H would have to be amended so that it does not allow the council to exempt a scheme from the relevant provisions in the Act relating to the REF because as section 8H stands, it allows the Council to grant an exemption from any provision of the Act.

LIMS and REF

In addition, the adoption and introduction of LIMS will have a direct impact on the REF pool of people and hence the calculations and methodology. We propose that instead of

exempting low-income schemes from participation in the REF, a clear strategy of how best to deal with the risk created by the entry of possibly thousands of low income workers in the medical schemes arena is urgently needed. This is because LIMS will fundamentally affect the main REF pool calculations "because the impact of a change in the age and disease profile of beneficiaries will need to be estimated".[17]

For this reason the Technical Task Team has already suggested that a "separate REF system should be established for LIMS schemes as soon as possible. Ideally, this should be established by the time of launch of LIMS schemes, but in any event, by no later than 6 months after launch of the LIMS schemes". And that "the LIMS REF system should be governed and operated on the same principles and within the same infrastructure as the main REF".[18]

In other words, we do not believe that the REF can commence without a resolution of how the REF and the LIMS market will interact. Our proposal is therefore that the legislature must ensure that:
The REF's methodology and financial calculations cannot be determined without a thorough understanding and agreement by industry, government and the Council about how LIMS should be treated within the REF.

We hope that the department will consider our submissions in its deliberations with the Council in the finalisation of the draft Bill and regulations.

Kindly also note that our submission is endorsed by the Treatment Action Campaign (TAC).

If you have any queries please do not hesitate to contact me on 083 27 999 62.

Sincerely

Fatima Hassan
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[17] RETAP Recommendations Report No. 8. Adopted at RETAP Meeting on 20 April 2006.
[18] According to the Technical Task Team, while LIMS is expected to be fully operational by late 2007/ early 2008, no work has as yet begun on a LIMS REF pool. RETAP Recommendations Report No. 8. Adopted at RETAP Meeting on 20 April 2006.

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