OPINION: State likes to see poor in hospital queues

Patrick Masobe: Business Day, 26 February 2020

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As recently as March 2019 the Council for Medical Schemes (CMS) released a discussion document seeking industry input on how best to go about implementing lowcost benefit options (LCBOs), with the intention of introducing measures to provide protection of healthcare cover at medical schemes for low-income households. The project to introduce minimum benefits specially tailored for LCBOs was meant to be implemented as a measure to replace risk-based health insurance products, which were until recently subject to an exemption framework. In December, just nine months later, as the holiday mood began to settle over SA, the council announced that no further exemptions to the insurance products would be granted and the replacement LCBOs would no longer be developed and rolled out - no exemptions, no exceptions, finish and klaar.

And what rationale was cited for this about-turn? Again, we are told, it is to protect the healthcare interests of low-income households, this time through aligning with national health policy in pursuit of the ever-elusive National Health Insurance (NHI). A key critique of the LCBO model is the potential that members on such plans could be largely reliant on public health facilities, and therefore such plans may not help to reduce pressure on state facilities. It should be noted, however, that not all products marketed for the low-income segment are necessarily directing members to state health facilities.

These very same products ultimately serve to reduce pressure on government hospitals as they are specifically designed to keep members healthy and productive.

Options provided in terms of health insurance products, and even the bargaining council medical schemes established with certain exemptions to the Medical Schemes Act to provide cover for blue-collar workers, are to be similarly scrapped, again with the noble aim of aligning with the broader health policy discussion that seeks to ensure adequate access to care, irrespective of the economic status of the population.

In the meantime, where do the regulator’s decisions on LCBOs leave the majority of South Africans who cannot afford private healthcare? In a position where there are simply no options to access private health care, so they are back at square one - waiting in long queues for the overburdened state system to provide health care. And that will now extend to people currently on some form of cover on insurance or other exempted products. The demarcation framework that flowed from an agreement between the ministers of health and finance in 2015 has been extended twice so far, and recent developments raise the question: where do the ministers stand on the registrar’s recent pronouncements?

Prohibiting LCBOs at this point in the transition towards universal health coverage will have far-reaching and harmful effects, not least on the poor people these regulations claim to champion. In the absence of a workable alternative framework that could be implemented by the cut-off date in March, it is unconscionable to expose those who may have had access to insurance products and other exempted products to the potential risks associated with having no cover and no safety net (which was what LCBOs were going to provide), including the threat of possible bankruptcy if faced with a catastrophic health event. Fair administrative procedure should surely require that when regulatory changes on this scale are proposed, people who are likely to be adversely affected be afforded the opportunity to voice their concerns and be consulted on the timing of implementation. We have no indication that this has taken place, even though it has been estimated that as many as 2-million people may be stripped of access to private healthcare

through the eradication of affected health insurance products without providing an alternative solution, through LCBOs or otherwise.

Whether the state healthcare system has the resources and capacity to adequately provide for these additional patients is doubtful, to say the least. Further to the above, the prescribed minimum benefits (PMBs) review process to include aspects of primary healthcare cover will either impoverish the comprehensive basket of services currently provided or drive up the costs associated with providing PMB cover to the point where even fewer South Africans can afford medical scheme membership, even though schemes operate on a not-for-profit basis.

The Health Market Inquiry report has recommended several targeted reforms that could achieve proper balance regarding medical scheme regulations and puts forward a number of measures to address concerns around risk-pooling, costs and efficiency.

As we move towards the implementation of NHI, expected to roll out by 2026, mere hope for a more inclusive healthcare system will not sustain those facing serious medical challenges. There is no doubt that reform is needed as both the private and public healthcare sectors evolve to provide an effective, sustainable and well-governed health system that meets the healthcare needs of all South Africans. The drastic action of cutting off low-income households from the only available means of funding access to private healthcare without providing an alternative substitute model is surely not a necessary or logical step to achieving NHI.