the medical sector in the Medical Schemes Amendment Act 1993, gave us hope with the abolition of guaranteed payments, minimum payments and, crucially, the removal of a ban on risk rating. Since then annual rates of inflation have dropped from norms of 30% to 40% to between 10% and 15% in well managed schemes. The trend continues downwards.

The new reforms, particularly open access and community rating, will undermine all that has been achieved in the last 5 years. The government wants to take us back to an era in which the system ignored the fact that medical aid costs are higher for aged and sick members. As medical scheme contributions increased, the young and healthy sought sanctuary outside medical schemes. The demographic profile of the fund consequently worsened, premiums increased further and more of the healthy members left – and so the spiral of decline continued.

> '... open access and community rating will undermine all that has been achieved in the last 5 years ... (taking) us back to an era in which the system ignored the fact that medical aid costs are higher for aged and sick members.'

Not only will reintroducing a ban on risk rating regenerate the inflationary spiral of the past, it will also stifle market innovation and, ironically, the cross-subsidisation the government is so anxious to achieve. The sick and elderly will seek out the most comprehensive benefit structure they can afford, while the young and healthy will only seek medical cover when they become ill. The problem is that community rating and open access are totally incompatible with voluntary health care coverage.

It may be said that the reforms will move medical cost inflation between funds without necessarily increasing the whole. This is also not true. If you are in a scheme where, no matter what you claim, no matter how ill you are when you join, you will pay the same rate as everyone else, it is only human nature to ensure you get good value for money. This means claiming as much as you can on elective benefits such as dental and optical benefits. How many people do you know who, at the end of the medical aid year, realise that they must use up their entitlement and rush to buy spectacles or go for that check-up with the dentist? Importantly, with open access the incentive to control costs is lost – just join a scheme with low benefits until you need medical treatment and then move to one with higher benefits. Under this new regime, it seems that the responsibility will fall to the medical community to self-regulate and control its fee levels in the face of increasing demand and utilisation of medical services.

The government intends to penalise those members who enter later in life, but has given no indication of what sort of penalties will be levied. Will they be enough to protect schemes? If they are too small, no one will join until they need to. If they are too high, no one will be able to afford to join later in life, creating a strain on the national health scheme the government is also keen to avoid.

Other aspects of the proposed reforms, the banning of co-payments and coinsurance, the establishment of a minimum set of benefits and an increase in the minimum size of medical schemes are all counter-productive in the government's war on the inequality of medical access. The uniformity which these reforms, when combined, will produce within an impotent health care market seems to run surprisingly counter to the national goals of freedom of choice and tolerance of diversified needs.

A group calling itself the Concerned Medical Schemes Group, representing 2.6 million medical aid members' lives has argued vigorously against the government's proposals. While this group can be said to have their own interests at heart, tending as they do to have a lower than average risk profile within their funds, it comes as some surprise that the response from the health care industry has been far from uniform. To castigate this group for exercising their opinion based on self-interest is missing the point. This group has also done much within the health care industry to lead the fight against spiralling costs and, largely, has been relatively successful. To take away all that has been achieved in five years with a piece of well-meaning, but rather ill conceived legislation demands further scrutiny.

GOOD IDEA: LIMITING INDIRECT DISCRIMINATION

Alex van den Heever

Alex van den Heever (BA (Hons), MA (Economics)), is a senior researcher at the Centre for Health Policy, University of the Witwatersrand Medical School. He started off with the Central Economic Advisory Service (CEAS) in 1989, working in the area of government finance, monetary policy, and trade and industrial policy. During 1993 he worked with the Industrial Development Corporation of South Africa. He joined the Centre for Health Policy in 1994, where he is involved in research on health economics and financing.

The Department of Health is proposing that discrimination on the basis of health status be substantially limited within the private insurance market for health. This is to be achieved through a combination of requirements: community rated premiums; open enrolment; and that all schemes provide a set of prescribed minimum benefits. Open enrolment, which is directed only at open schemes, will prevent schemes from

being able to deny cover to any applicant willing to pay the community rate of the scheme. The minimum benefit requirement will limit the extent to which indirect discrimination against certain groups can be created in schemes through manipulating benefits.

It is argued by certain commercial interest groups that this combination of reforms will result in a disincentive for the young and healthy to join.

The Department acknowledges that within a voluntary environment, with more aggressive marketing of multiple benefit options, the healthy may be persuaded to choose cover, or comprehensive cover, only when unhealthy – a problem traditionally termed adverse selection. However, it is proposing that adverse selection be dealt with through specific regulations which allow schemes to prevent people from joining only when their risk status changes or when an immediate medical crisis strikes. The Department has indicated that people who join medical schemes for the first time later in life will be treated differently to those who have been members for most of their lives. And those who join for the first time with a pre-existing condition will not be covered for that condition for a specified period. However, those who join early and remain in cover their entire lives clearly do not represent an adverse selection problem.

'By removing the ability to discriminate against the old and the sick, medical schemes will be forced to compete on the basis of adding value.'

In essence, therefore, the argument from the Department of Health's perspective is that within an aggressive commercial market for health insurance, if community rating is not legislated for, it will lead to under-insurance with many unhealthy people either unable to find insurance at affordable prices or directly denied access.

Targeting adverse selection rather than health status will allow the private market to offer medical scheme cover in a manner that is fair and open to all willing participants. Furthermore, people who exclude themselves voluntarily from medical scheme cover will not be able to impact on the average cost of health care in any way if they try to join later. They either never join a scheme, or when they do, they fully compensate for unpaid contributions. Either way their decision will have very limited adverse selection implications.

Forms of risk and experience rating are common in other forms of insurance, such as motor vehicle insurance. However, equity concerns are a major reason why experience or risk rating is discouraged in health care. This because illness and injury are often beyond the patient's control. In addition there is good reason to cross-subsidise the unhealthy, as all people face the prospect that their health will deteriorate in the future, at which time they will become the recipients of the cross-subsidy.

Opponents of the Department's proposals frequently introduce the Australian case as to why community rating does not work within voluntary health insurance market. Australia has faced declining private health insurance membership for some years now, which is attributed to the legislated community rated environment. The only similarity between the two countries, however, is the use of the term community rating. Australia has a National Health Insurance (NHI) system with a free, high quality, public hospital system. Neither of these exist in South Africa. All doctor consultations in Australia are financed through the NHI, leaving a small top-up insurance market for discretionary private hospital services, primarily focused on elective procedures. Australia largely maintains its community rating system for consumer protection, and not for health systems reasons. In fact if community rating were removed, it is unlikely that many young people would join, as catastrophic cover, favoured by the young, is already provide free by the state in good quality facilities.

An important implication of the Department of Health's proposals relates to their preventing the effortless route to cost-containment. As it will not be possible to cut costs by eliminating the 5 to 10% of members who have the highest medical expenses, schemes will have to confront the issue of medical cost-containment directly. Those aggressively competing for members will have to do so on the basis of their ability to enter into more effective contractual arrangements with providers, which cap cost increases while maintaining service quality. Various interest groups representing commercial medical schemes have recently been claiming to have 'contained' medical cost increases. Not mentioned, however, is that this was achieved by excluding cover from expensive or potentially expensive members. Underlying medical cost increases have not been addressed. Nor could they have been, as the existing medical scheme's movement remains an unsophisticated purchaser of health care.

Finally, the Department of Health reforms are, by removing the ability to discriminate against the old and sick, in effect forcing medical schemes (with their associated intermediaries) and the provider system to compete on the basis of adding value. This is an alternative to the current market where insurers compete to sell less and less cover to those who do not need it, and a provider system which tries to sell as much health care as possible that is not needed. At some point in time these irreconcilable goals would have had to clash if the private market was to have any sort of future. The Department of Health is indirectly forcing resolution of this contradiction sooner rather than later. And one hopes everybody will be the better for it.