Private medical aid membership

What is the impact on health care use and out-of-pocket payments in South Africa?

Key points

- In South Africa, medical scheme membership does not guarantee lower out-of-pocket payments.
- Scheme members have to make substantial co-payments.
- A form of insurance that ensures adequate use of health services is needed. Ideally, this should be a form that ensures universal access to health care, for example, the proposed National Health Insurance.

Introduction

In South Africa, total health care spending is over 8% of the country's gross domestic product.

The private sources of finance, comprising the contributions to medical schemes and out-of-pocket payments, account for over 60% of total health care spending.

Private medical schemes alone account for over 43%. Only less than one-sixth of the population are covered by these schemes. This is primarily the richer segment of the South African population.

Because private medical schemes account for a substantial portion of total health care spending, and also have a high level of health care spending per scheme member, it is expected that they should at least provide financial protection to the enrolled members.

This policy brief examines the extent to which medical scheme membership shields scheme members from out-of-pocket payments.

This is important for the design of the National Health Insurance (NHI) in the country.

Photo courtesy of the Consortium for Research on Equitable Health Systems 2010

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Authors: The research was conducted by Dr John E. Ataguba from the Health Economics Unit, University of Cape Town and Dr Jane Goudge from the Centre for Health Policy, University of the Witwatersrand.

For more information about this policy brief: please contact: john.ataguba@uct.ac.za

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Box 1: About medical aid membership, coverage and payments

- Private medical schemes offer voluntary membership and they almost exclusively cover formal sector workers and sometimes their dependents.
- Each scheme offers a number of alternative benefit options that includes the mandatory prescribed minimum benefits (PMBs) and a combination of other services. The PMB package includes some hospital-based interventions and certain chronic diseases.
- The contribution that each scheme member makes is related to the benefit option selected. Therefore, contributions are the same for each member for that benefit option.
- Because of the nature of medical schemes, each provides cover to only those who enrol. This cover is mainly for services provided in the private sector. However, scheme members may utilise public sector services. This is expected to be paid for by their schemes but it is rarely the case.
- Over the years, members' contributions to medical schemes in South Africa have been increasing and are becoming unaffordable.
- These members still have to make substantial co-payments when using health services. These co-payments represent additional out-of-pocket payments demanded by the health services provider from scheme members.
- In some cases, in order to cushion the effect of unaffordable contributions, a scheme member downgrades to a low cost benefit option that provides limited cover. Some choose to purchase cover for hospitalisation alone and pay out-of-pocket for outpatient services.
- The out-of-pocket payments and choice of low cost options can create financial burdens for scheme members.
- With the exception of a few 'closed' schemes whose membership is restricted to a specific company or industry, there are currently over 100 medical schemes operating in the country.

Key findings

- Membership of medical schemes means that the member will have significantly more private health care visits per year compared to a non-scheme member.
- There are no significant differences between scheme and non-scheme members in the number of visits per person per year to public health care facilities.
- Membership of medical schemes does not guarantee lower out-of-pocket payments for scheme members compared to non-members. Scheme members pay substantial out-of-pocket payments in addition to their contributions to the medical schemes to use health services.
- The negative impact that membership of a medical scheme has on out-of-pocket payments risks destroying the very essence of insurance. This calls for a need to address the issue.

Policy recommendations

- Fees charged by private health care providers have increased and generally exceed the amounts that medical schemes are willing to pay for. This results in members having to make substantial out-of-pocket payments. There is a need to move away from fee-for-service payments, which often leads to over-servicing, cost escalation, and assessment and regulation of less effective medications and interventions.
- Generally, substantial out-of-pocket payments represent a burden on scheme members. This should not be the case for members that purchase insurance to cover for unexpected expenses. In addition, scheme members face increasing contribution rates that are higher than the general inflation rates. There is therefore a need to limit, as much as possible, out-of-pocket payments that adversely affect scheme members and also address the rising contribution rates. Health insurance needs to be designed in a form that not only ensures adequate use of health services but also provides financial protection to the insured as reflected in the current commitment for a National Health Insurance (NHI). The NHI should ensure that out-of-pocket payments are limited. The NHI may well obviate the existing gap between providers' fees and schemes' reimbursement rates.