Thursday, 21 June 2018

Press Conference on the Release of:

(i) Medical Schemes Amendment Bill;

(ii) The NHI Bill

Dr Aaron Motsoaledi, Minister of Health

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Ladies and gentlemen of the Media

Good afternoon

We have called this Press Conference to deal with two Bills -

- The Medical Schemes Amendment Bill; and
- The National Health Insurance (NHI) Bill

I will first present the Medical Schemes Amendment Bill and end with the NHI Bill.

Thereafter I will open the floor for Questions on both Bills to be dealt with at the same time.

THE MEDICAL SCHEMES AMENDMENT BILL

This Bill seeks to amend the Medical Schemes Act, 1998 (Act No. 131 of 1998), in order to align with the National Health Insurance White Paper and the National Health Insurance Bill.

The first reason for this amendment is that the implementation of NHI is not going to be a once-off event but it will take place in a phased-in approach. While this is happening the population of medical schemes beneficiaries need immediate relief from serious challenges experienced in the current medical scheme regime. The nature and magnitude of the challenges is that it will be undesirable for medical scheme beneficiaries to have to wait for long term changes.

The second reason for the amendment is to align the medical scheme environment to that which will exist under NHI so that there is a smooth, harmonious transition that does not unduly disrupt access to health care.

As it is now generally accepted, the cost of private healthcare is out of the reach of many citizens, even the well-to-do ones. The only argument that persists is what are the reasons for that. Because of this persisting argument, former Chief Justice Sandile Ngcobo has been appointed by the Competition Commission to conduct a Public Market Inquiry into the cost of Private Health Care.

He has been on it for more than 3 years now, and we are aware that he intends to release the provisional findings and recommendations for public comment on the 28 of June 2018 (next week).

Unfortunately we hear rumours that certain vested interest groups are trying to block the release of the findings to the extent that they might even interdict it. I can only assume that they do not want the public to know the truth.

While we do not know the contents of that Report, however we do know, because this was publicly done, that the presentation of the World Health Organisation (WHO) and the Organisation for Economic Cooperation and Development (OECD) stated that contrary to belief, only 10% of South Africa's population can afford what is being charged in Private Health Care.

Hence the amendments we are introducing are meant to provide much needed relief to patients finding themselves in serious financial hardships.

- The first amendment is to abolish what has come to be known as co-payments. Co-payments means that the scheme pays a portion of the bill that a provider (Hospital or Private doctor) charges to a patient. The rest of the money is supposed to be paid by the patient from their own pocket.

The amendment means that every cent charged to the patient must be settled fully by the scheme and the patient should not be burdened with having to pay.

There are people who will scream that this amendment is outrageous and calculated to destroy medical schemes and leave beneficiaries with nothing.

I wish to assure you that this was well thought of. The load of complaints received from the public by us in the Department of health as well as by the Council for Medical Schemes (CMS), i.e the medical schemes regulator, justifies this amendment.

Furthermore, the data at our disposal shows that medical schemes are holding reserves of close to R60 billion that are not being used.

Granted, there is a statutory requirement that medical schemes should have 25% of their income in reserve. This is to cater for emergencies. But presently the R60 billion is equivalent to 33% reserves, which means unnecessary accumulation at the expense of patients.

These huge reserves were accumulated partly through high premiums but also by introducing the co-payments such that medical schemes avoid having to pay or even dip into the reserves if the situation demands.

Furthermore the Council for Medical Schemes (CMS) is busy reviewing this statutory requirement of 25% with a view to releasing enough money for patients rather than holding a lot of reserves while patients suffer the hardships.

- The second amendment is to abolish the practice of using brokers within the medical scheme environment. Almost two thirds of principal members of medical aid schemes pay monthly to a broker as part of their premium. Many of these members do not even know that they are paying this money which in 2018 is R90.00 per month.

  The total amount paid to brokers in 2017 was R2,2 billion.

  We want this money to be made available to pay for direct health expenses of members rather than serving brokers who are actually not needed in the healthcare system.

  We are aware that most of the work supposedly done by brokers is actually done by the Council for Medical Schemes - the statutory body.

- The third amendment is to abolish the practice of Prescribed Minimum Benefits (PMBs) and replace it with comprehensive service benefits. Prescribed Minimum Benefits were mostly hospital-based conditions. Comprehensive service benefits will include Primary Health Care (PHC) like family planning, vaccination, screening and wellness services.

- The fourth amendment deals with the various unequal and even unfair benefit options which medical schemes are subjecting their members to. The amendment prevents any medical scheme from implementing any benefit option unless approved by the Registrar of the Council for Medical Schemes and in doing this the Registrar will have to determine first that such an option is in the best interest of the member.

- The fifth amendment is to declare the carrying on of the business of a medical scheme by a person not registered as a medical scheme to be a specific offence. This relates to various health plans and cash plans that purport to be selling health products like medical schemes do whereas they are not registered with the Council for Medical Schemes but opted to register with the FSB (Financial Services Board) now called Financial Sector Conduct Authority (FSCA).

  The FSCA has amended its rules to exclude such entities from registering with them.

- The sixth amendment is the creation of a central beneficiary and provider registry and the management thereof by the Registrar of the Council for Medical Schemes.

  This enables the Registrar of Medical Schemes to understand the trends of behaviour of medical scheme members in selection of medical scheme or options, their age profile, disease profile, health seekers behaviour, as well as their geographic distribution. This information will assist in the planning of NHI services.

  Presently medical schemes are reluctant to give this valuable information and there is no act to compel them.

- The seventh amendment is to introduce income cross-subsidisation model.

  The essence of NHI which must start now even with the present medical aid schemes is that the rich must subsidise the poor, the young must subsidise the old and the healthy must subsidise the sick. The present contribution table charges the same rate for a lower income earner and a high income earner for the same benefits. This practice completely negates the principles of income cross-subsidisation.

- The eighth amendment is to compel medical aid schemes to pass back savings if a member uses a designated service provider according to the rules of the scheme. Presently medical aid schemes compel members to use designated service providers in order to save money. This is a good practice to be encouraged but however the problem is that these savings are taken over by the scheme or the administrator instead of being passed on to the member in the form of premium reduction.

- The ninth amendment deals with the cancellation of membership and waiting periods between joining a scheme and accessing benefits. This is because under NHI there will be no penalty related to late joining or age. This is further to protect the interest of living spouses after the passing of the principal member or after retirement prior to payment of their benefits.

- The tenth amendment is Governance of medical schemes. This amendment for minimum educational requirement and expertise to be a member of a Board of Trustees or a CEO of a Medical Aid Scheme. We are aware that some Trade Union members do sit in the Medical Aid Trusts and we are not opposed to that.

All we are saying is that the Union has a right to appoint anybody with the requisite skills and qualifications to represent their interest if amongst their members there is no such a person. This is in line with what we would be proposing for the future of NHI.

Other amendments do not have to be flagged here but you will find them in the Bill and be able to comment on them.

I thank you

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