The mirage of health cover

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Private hospital care, medicine prices and medical specialists' fees are some of the drivers of increasing health insurance costs, according to a new discussion document released by the FinMark Trust and Centre for Financial Regulation and Inclusion (Cenfri).

These are a few factors found among other trends making coverage increasingly expensive and inaccessible for poorer South Africans at a time when state healthcare infrastructure is crumbling, under-resourced and oversubscribed. Other significant cost drivers include lifestyle diseases that have resulted in rising claims but which can be controlled through behavioural changes -- such as giving up smoking, losing weight and exercising.

The report examined the growth in costs between 1997 and 2007. During this period health insurance costs grew 5% in excess of CPIX (consumer price inflation excluding mortgage costs), while they grew 4% in excess of general medical price inflation. The research has been released at a time when the debate over the implementation of a national health insurance scheme has intensified.

The NHI, which aims to introduce universal healthcare, has been lauded as a means to improve the lives of ordinary South Africans. But it has been criticised for the lack of detailed work on how to implement the plan without exorbitant cost to the country and infringement of the individual's right to choice.

The research aimed to understand how to contain the cost drivers behind medical schemes. The lessons learned could be used in the implementation of a national health insurance scheme that would be more affordable for more South Africans, according to Reg Magennis, the author of the report.

The research revealed that private hospital expenditure contributed 28% to all medical scheme expenditure and grew at a rate of 6.6% in excess of CPIX. The research found that the number and cost of inpatient days at private hospitals was helping to drive up private hospital expenditure.

"In recent years patient days, case mix and new technology have continued to drive fee-for-service costs per claim upwards," it stated. "Furthermore, claims involving procedures, with higher average costs, have grown faster than claims without procedures."

New technologies such as intervention radiology, endovascular surgery and computerised simulation scanning, to name a few, have contributed to rising costs. But although claims revenue has been growing, this was offset by rising staff costs and lower profits made from medicines and consumables (such as syringes), which are increasingly controlled through regulation or alternative pricing structures.

To compensate for shrinking profit margins, however, private hospitals took steps such as negotiating increased ward and theatre fees. Although medicines made up the largest portion of medical scheme expenditure, it grew 0.5% above inflation.

The report found that the introduction of single-exit pricing -- the legislated price for

pharmaceuticals -- had helped fight rising medicine costs. But doctors' prescribing behaviour has nullified this effect.

"There are strong indications that the number and mix of items per script and the number of scripts claimed per beneficiary are increasing," stated the report. "This may suggest that healthcare service providers are responding to price interventions by increasing levels of utilisation."

Magennis cautioned against the conclusion that healthcare providers are simply trying to increase profits at the expense of patients and insurers. "There is a complex interplay of patient-doctor dynamics here," he noted.

The desire for doctors to treat patients in the best way possible plays a part in deciding what technology, procedure or medicine to use, without thought given to the most efficient use of resources. But the fee-for-service system, the basic revenue structure of the healthcare sector, creates problems when it comes to questions of affordability of healthcare, he said.

"Fee-for-service does create incentives that don't necessarily focus on the management of limited resources. "Doctors will focus on patients, their areas of knowledge, their own customs and experiences at best, but at worst, through the incentives created, look for ways to boost income artificially and certainly without thought to costs for medical schemes."

The cost of specialists, meanwhile, grew 5.4% above CPIX, with specialist costs making up almost 18% of all medical scheme expenditure.

The research found that, after the Competition Commission outlawed centrally negotiated specialist tariffs in 2003, followed by the introduction of the health department's implementation of the national reference price (NRP), specialist fees have risen sharply. This is in part influenced by the fact that the only other benchmark aside from the NRP is the list of "maximum ethical fees" published by the Health Professions Council of South Africa, which can be up to 300% of the NRP.

Magennis noted that the decision to publish both these price lists without consulting health professions has been "one of the biggest disasters in the industry in the past five years".

The effect of prescribed minimum benefits on medical schemes was also seen as contributing to costs. Prescribed minimum benefits (PMBs), a set of defined minimum health benefits that medical schemes must cover by law, have seen a rise in claims, particularly as beneficiaries and healthcare providers have become more aware of them.

Although this is not necessarily a bad thing, Anja Smith, health financing coordinator for the Fin-Mark Trust, said that the way PMBs have been specified emphasises treatment over prevention -- a far more expensive way of achieving healthcare goals.

To make medical schemes more affordable, greater thought needs to be given to the services that will have the greatest effect on people's health within the available budget. This may include decreasing the number of prescribed minimum benefits or changing their focus.

The research also suggests ways of curbing costs to try to make health insurance more affordable. They include taking steps such as avoiding "fee-for-service and pricing systems incorporating

perverse incentives". This could include salaries and performance bonuses for healthcare professionals.

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