

Savings under NHI: Non-Healthcare Costs

The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.

This policy brief analyses non-healthcare costs in medical schemes and considers evidence from other markets on administration expenses. The brief concludes with thoughts on how to determine what a reasonable amount might be for non-healthcare costs in future.

1. Official Definition of Non-Healthcare Costs

The definition of non-healthcare expenditure, used since the early 2000s by the Council for Medical Schemes¹, is: Non-health expenditure =

- administration costs
- + managed care management services
- + broker fees and other distribution costs
- + net reinsurance loss
- + bad debts *

* [bad debts written off – bad debts recovered + increase in provision for bad debts]

The wording of the categories in Annexure K of the Annual Report² has subsequently changed and been brought in line with accounting standards but the basic structure of the calculation remains unchanged.

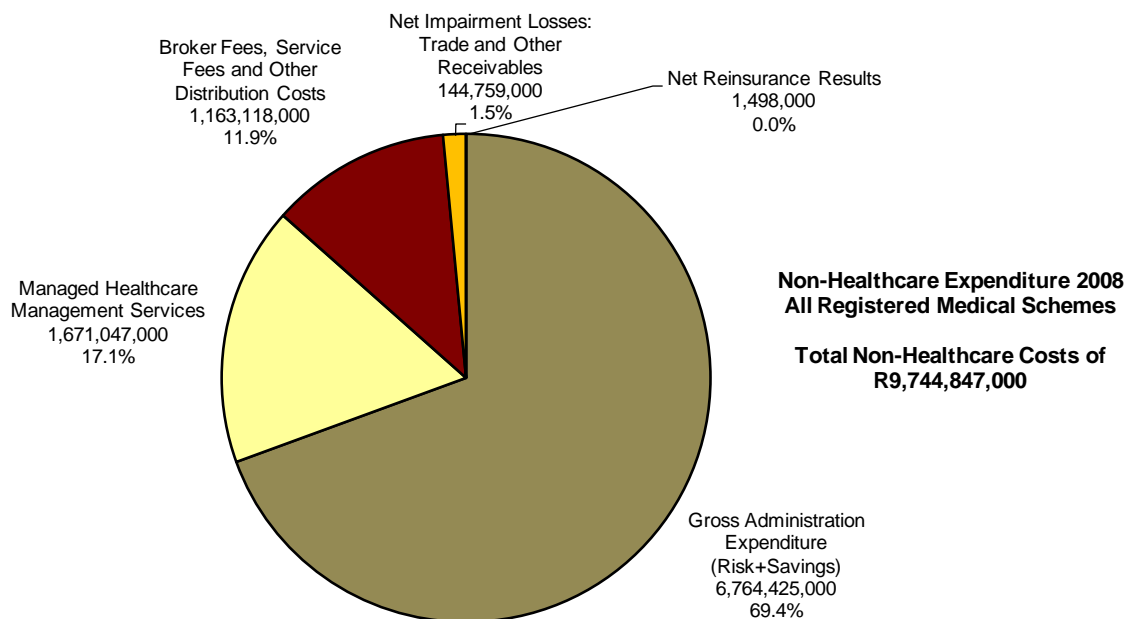


Figure 1: Non-Healthcare Expenditure 2008 for All Registered Medical Schemes

The medical schemes industry spent R9.745 billion on non-healthcare costs in 2008. This was 13.2% of total gross contributions for the year, which were R74.089 billion. Non-healthcare costs were R105.33 per beneficiary per month.

There are significant differences between open and restricted schemes^a and variations by size of scheme, as shown below on a per beneficiary per month (pbpm) basis. The definitions of size^b are those used in analysis by the Council for Medical Schemes since 2000³.

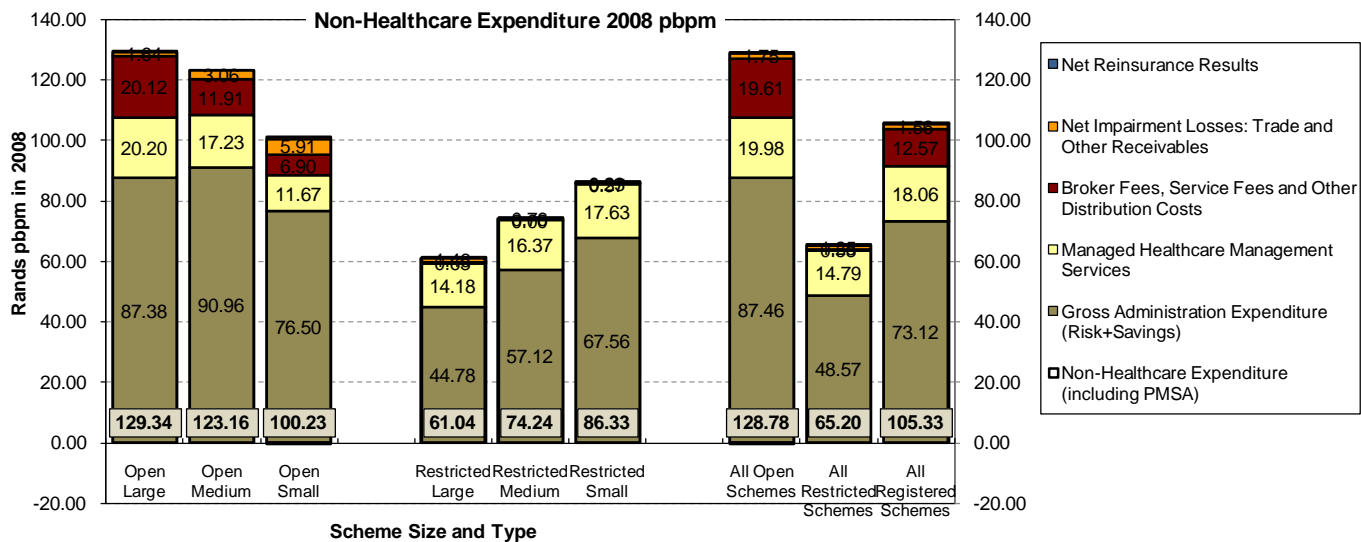


Figure 2: Non-Healthcare Expenditure 2008 by Size and Type of Medical Scheme

Non-healthcare costs (NHC) for open schemes (R128.78 pbpm) are substantially higher, and almost double that of restricted schemes (R65.20 pbpm). Of interest is that NHC are lower as the size of scheme increases for restricted schemes, as would be expected with economies of scale (from R86.33 pbpm for small schemes to R61.04 pbpm for large schemes, which is 71% of the small scheme amount). However for open schemes the larger the scheme, the higher the non-healthcare costs (from R100.23 for small schemes to R129.34 for large schemes, which is 129% of the small scheme amount).

These summary features mask a significant variation in NHC between schemes, even when differentiated by type and ranked by size, as shown overleaf.

^a In terms of the Medical Schemes Act, No. 131 of 1998, Restricted membership schemes are allowed to restrict who may become a member. They are typically employer or union-based. Allowable definitions for restricting membership include:

- employment in a profession, trade, industry or calling
- employment or former employment by particular employer, class of employers
- membership or former membership of profession, professional association or union.

Open schemes must accept anyone who wants to become a member.

^b A large scheme has more than 30,000 beneficiaries. A small scheme has fewer than 6,000 members. Medium schemes are neither large nor small, by definition. It is preferable to think of size in terms of beneficiaries as this is the driver of stability in financial results. The definition of small schemes being related to members is a historical artifact from an earlier Act which set the minimum size of medical schemes as 2,500 members. The Medical Schemes Act of 1998 set the minimum size for new schemes as 6,000 members. There are however many small schemes that continue to operate below this size: 9 of the 37 open schemes and 48 of the 82 restricted schemes were classified as small in 2008.

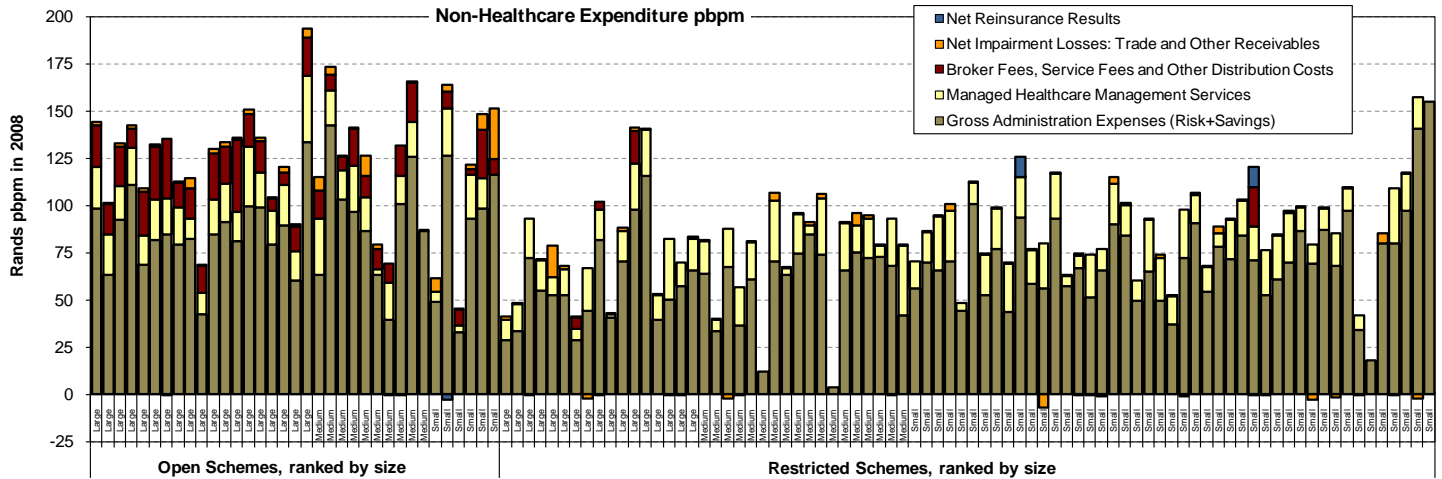


Figure 3: Non-Healthcare Expenditure 2008 for Individual Medical Schemes, Organised by Size and Type

Very few trends can be determined from the above graph, other than to find broker fees and distribution costs being common amongst open schemes although not completely absent in restricted schemes. Bad debts also seem to be more common amongst medium and small open schemes. There was a very wide range of non-healthcare costs in medical schemes in 2008, from the highest scheme, Compicare Wellness Medical Scheme at R193.38 pbpm to the lowest, Impala Medical Plan at only R3.28 pbpm. Compicare is a large open scheme administered by Status Medical Aid Administrators (Pty) Ltd, while Impala is a medium-sized restricted scheme that is self-administered and manages its own healthcare facilities.

2. Unpacking Gross Administration Expenditure

In Figure 1 it was shown that Gross Administration Expenditure was the largest component of non-healthcare costs. This item, from Annexure K of the Annual Report², is broken down into more detailed areas by combining information from Annexure Q and Annexure P^c. The table below and graphs overleaf show this more detailed breakdown.

Table 1: Detailed Non-Healthcare Expenditure 2008

	R millions	Percentage of Total	Rands pbpm
Administration Fees paid to Administrator	5,181	53.2%	56.00
Trustees, Principal Officer and External Audit	151	1.5%	1.63
Marketing and Advertising	327	3.4%	3.54
Other Unspecified Gross Administration Expenditure	1,105	11.3%	11.95
Managed Healthcare Management Services	1,671	17.1%	18.06
Broker Fees and Distribution Costs	1,163	11.9%	12.57
Bad Debts on Trade and Other Receivables	145	1.5%	1.56
Net Reinsurance Results	1.5	0.0%	0.02
Total Non-Healthcare Expenditure	9,745	100.0%	105.33

^c The Council for Medical Schemes refused to make the Annexures, which are available on paper and in PDF form, available in Excel for researchers. The data was kindly converted from PDF by Andrew Good and Pierre Robertson of Lifechoice, in partnership with Barry Childs of Lighthouse Actuarial Consulting. The tables were checked by Heather McLeod against the printed Annual Reports.

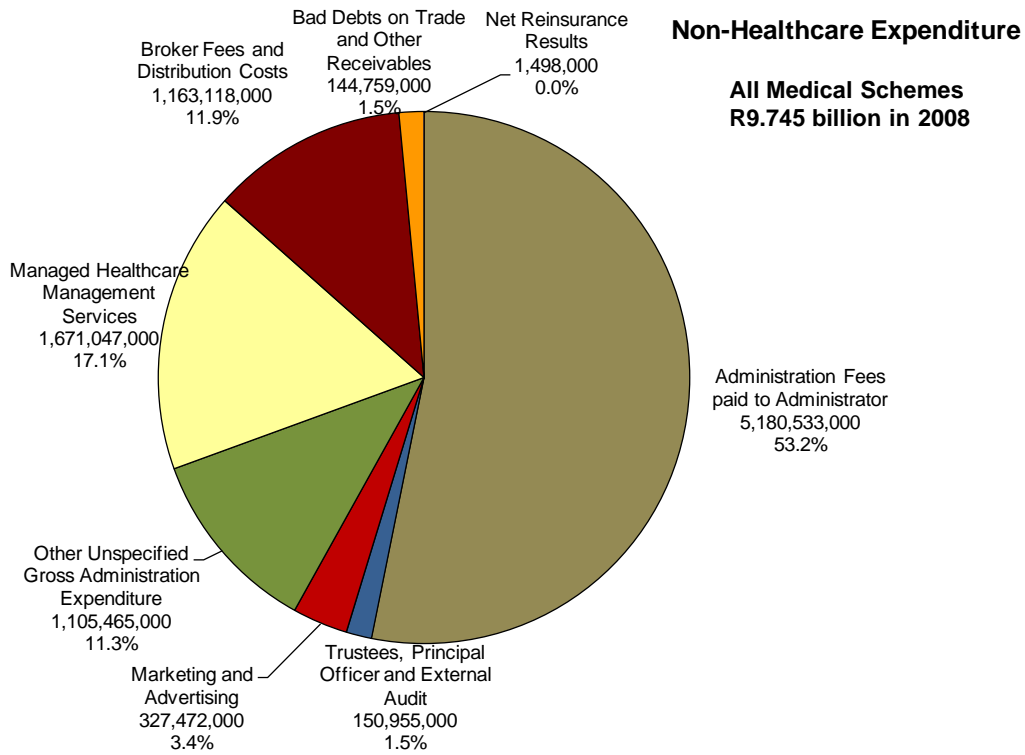


Figure 4: Detailed Non-Healthcare Expenditure 2008 for All Registered Medical Schemes

Expanding the Gross Administration Expenditure item from Annexure K using information from Annexures Q and P. A substantial slice of R1.1 bn or 11.3% of the total is still not explained from the information available. This unexplained portion is found to be greater for open medium-sized schemes in aggregate, as shown below. But when investigated at individual scheme level there were no discernible patterns by type and size.

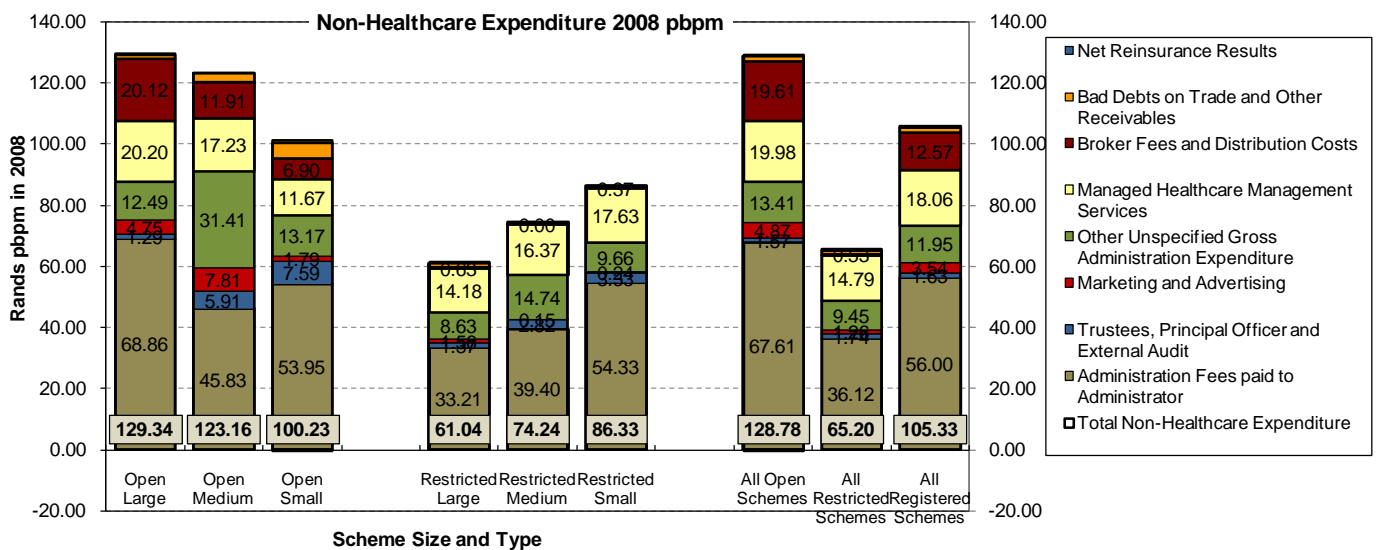


Figure 5: Detailed Non-Healthcare Expenditure 2008 by Size and Type of Medical Scheme

3. Non-Healthcare Costs by Administrator

The relationship between the amount received by the administrator as administration fees and total fees was compared to the reported Gross Administration Expenditure of medical schemes by administrator, using additional information from Annexure U² as shown below. It was found, surprisingly, that there does not seem to be any common relationship between these items and that patterns seem very different by administrator.

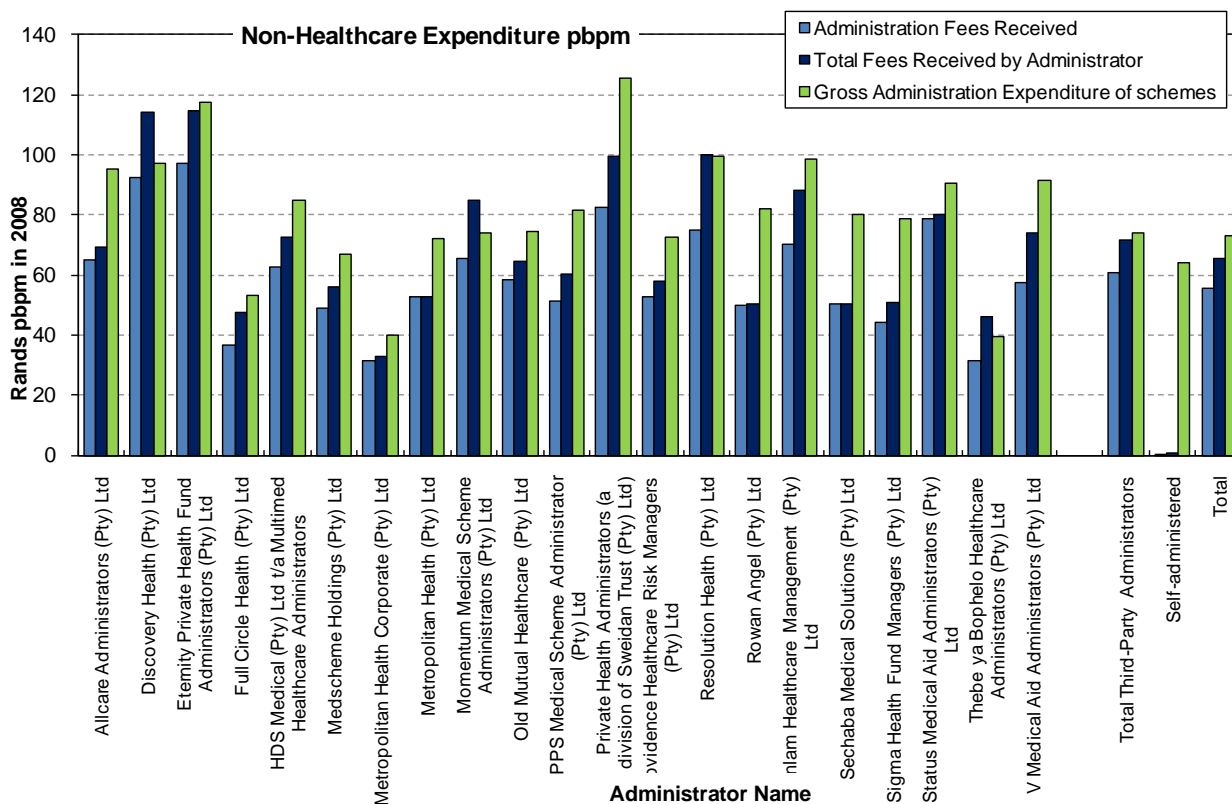


Figure 6: Administration Fees, Total Fees and Gross Administration Expenditure 2008 by Administrator

In Figure 7 the full non-healthcare costs are aggregated across all the schemes administered by each of the third-party administration companies accredited by the Council for Medical Schemes. Note the two Metropolitan brand names, Metropolitan Health (Pty) Ltd and Metropolitan Health Corporate (Pty) Ltd with different aggregate cost structures.

The degree to which there are differences between schemes administered by the same administrator was unexpected. For example, in 2008 Metropolitan Health (Pty) Ltd administered 5 schemes with non-healthcare costs ranging from R67.74 to R130.95 pbpm, for an average of R95.41 pbpm. Metropolitan Health Corporate (Pty) Ltd administered a further 13 schemes with NHC ranging from R40.91 to R99.30 pbpm, for an average of R54.97 pbpm. It is simply not feasible to look at an administrator and generalise about the non-healthcare costs of the schemes under administration.

Self-administered schemes have levels of “other” costs that are not that dis-similar to the amounts paid to administrators. Whereas the third-party administrators received in aggregate R61.32 pbpm in administration fees with a further R7.71 in “other” administration expenditure, the self-administered schemes had a large amount, R55.79 pbpm, in “other” administration expenditure. In aggregate, the self-administered schemes spent less on managed care (R11.73 compared to R18.67 pbpm) and on broker fees (R7.26 compared to R13.08 pbpm). The average non-healthcare cost for all self-administered schemes was thus R83.94 pbpm compared to third-party administered schemes of R107.40 pbpm (127.9% of the self-administered amount).

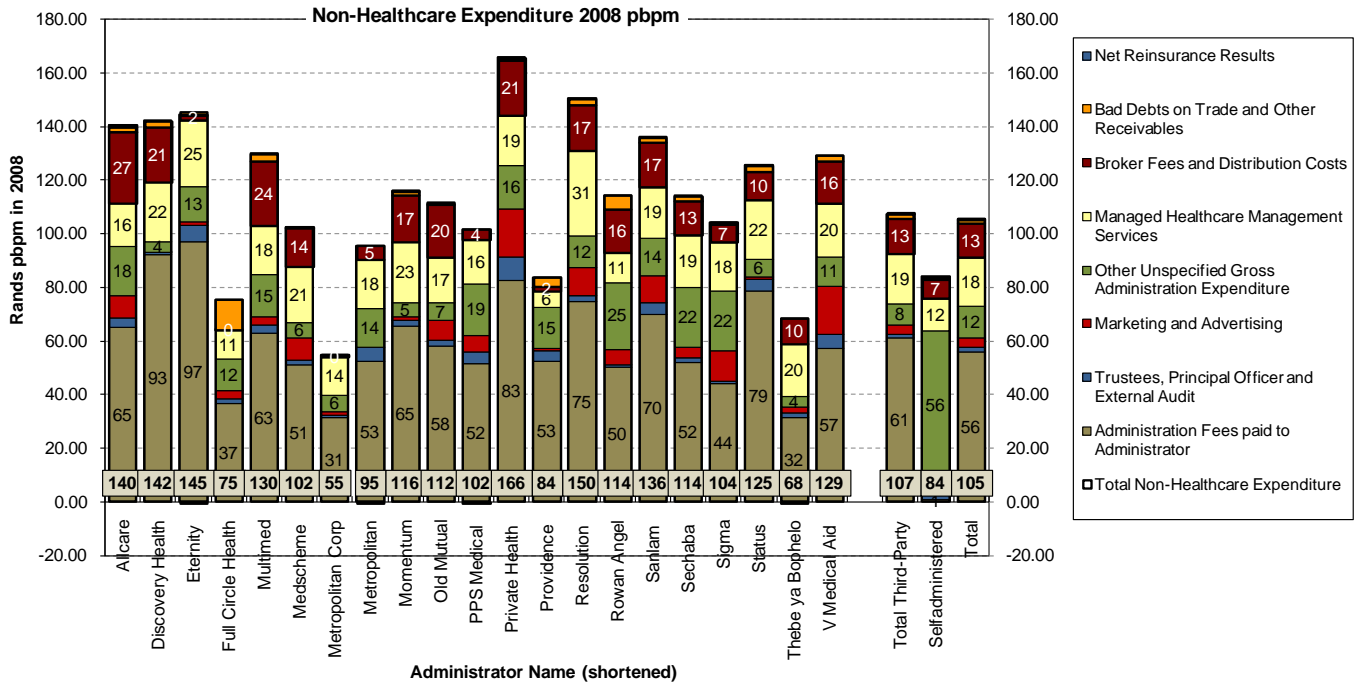


Figure 7: Detailed Non-Healthcare Expenditure 2008 by Administrator

4. Non-Healthcare Costs of Schemes with more than 100,000 Beneficiaries

It is usually expected that there are significant economies of scale in administration and it might thus be expected that schemes of a similar size have similar non-healthcare costs. This is shown not to be the case in the graph below.

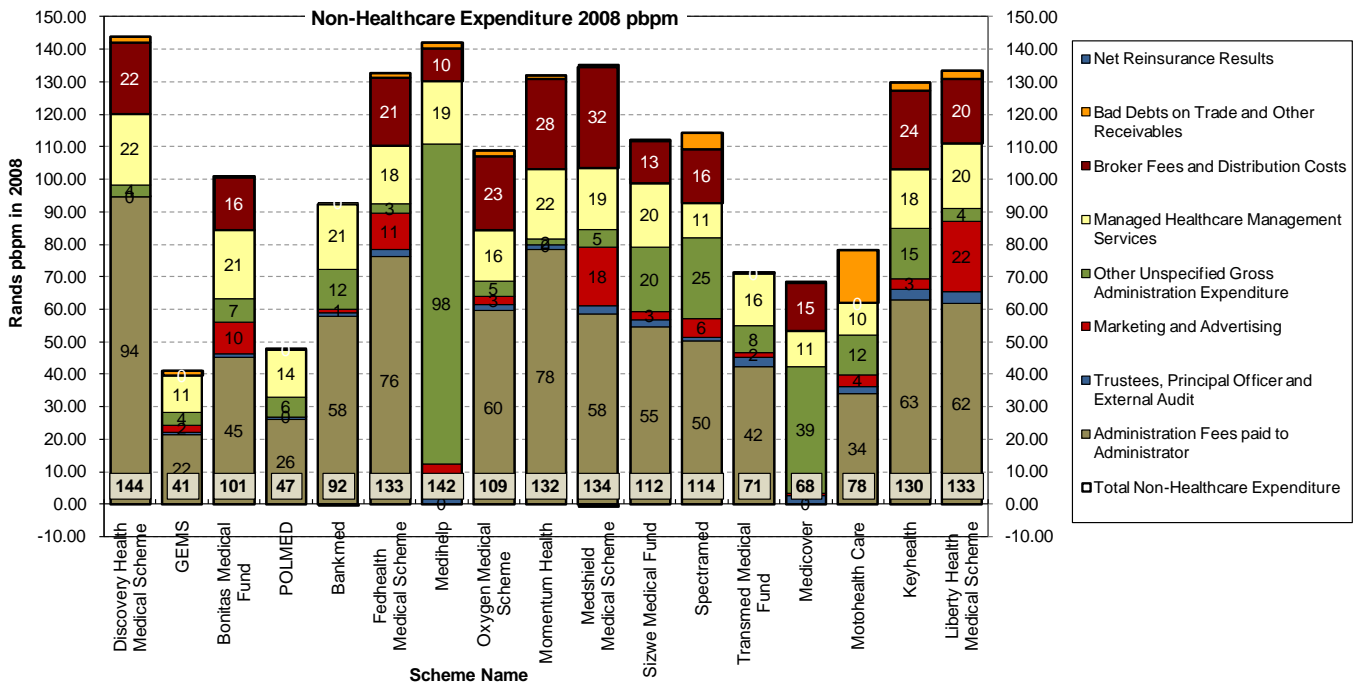


Figure 8: Detailed Non-Healthcare Expenditure 2008 for Medical Schemes with more than 100,000 Beneficiaries

Discovery Health Medical Scheme is by far the largest scheme in the country, with an average of 1,928,108 beneficiaries in calendar 2008. The non-healthcare costs for this scheme were the highest of the very large schemes, at R144.03 pbpm. As an open scheme expenditure on brokers is expected and the scheme spent R21.76 pbpm on brokers and distribution costs. The CMS annexures do not allow a separate amount to be isolated for marketing and advertising expenses for this scheme.

In contrast, the second biggest scheme, GEMS, had non-healthcare costs of only R40.91 pbpm in 2008. The major difference is in the administration fees paid to the administrator: Discovery Health Medical scheme paid R94.48 pbpm to Discovery Health (Pty) Ltd while GEMS paid R21.54 pbpm to Metropolitan Health Corporate (Pty) Ltd. The amount spent by GEMS on managed care management services was about half that spent by Discovery Health Medical Scheme.

5. Historical Non-Healthcare Costs

The graph below shows non-healthcare costs for medical schemes since records were first kept in 1974. The graph is shown in real terms, in other words after inflation has been removed, on a per beneficiary per month basis.

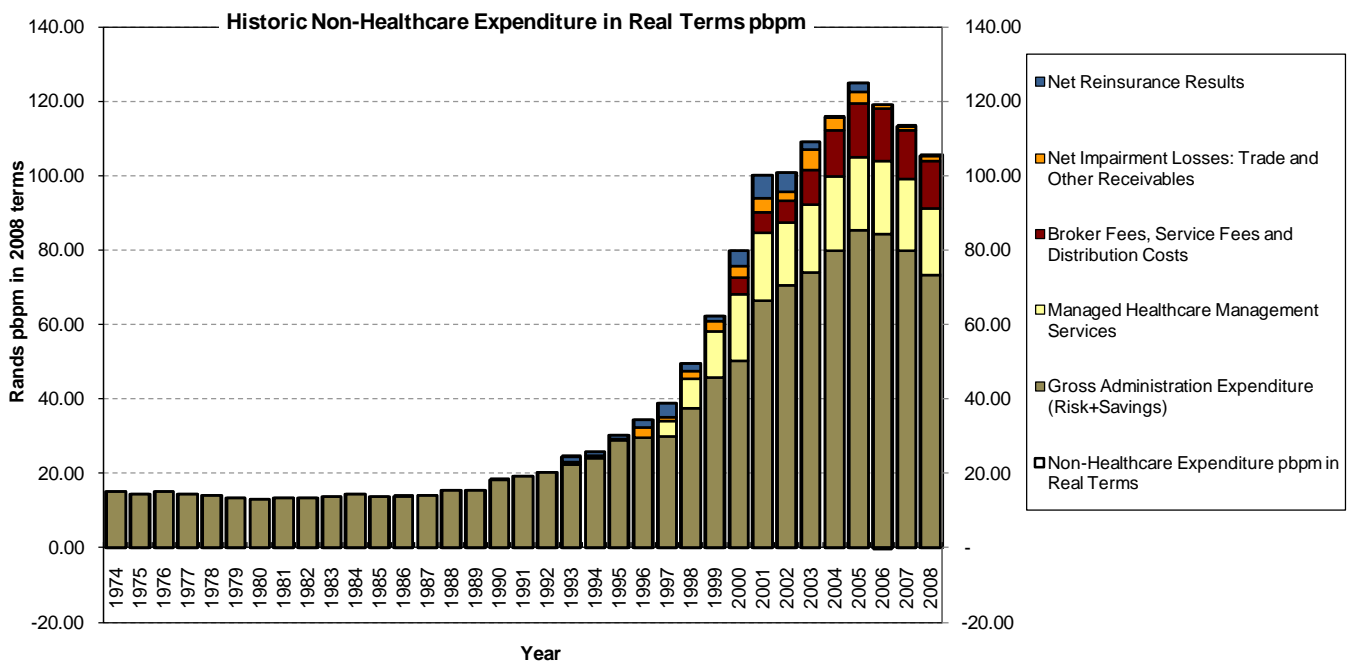


Figure 9: Historic Non-Healthcare Expenditure in Real Terms

In real terms, non-healthcare costs remained very similar from 1974 to the end of the 1980s. There were substantial increases in real non-healthcare costs from mid 1994 to 2004. Aggregated across all registered schemes, there appears to have been a substantial reduction in NHC since the high reached in 2004.

Payments to brokers by open schemes are thought to have begun in approximately 1993 but these were not legislated until the Medical Schemes Act of 1998 which came into effect from 1 January 2000. Calendar year 2000 is the first year in which the Council for Medical Schemes showed the amount paid to brokers as a separate item. Managed Healthcare Management Services are shown as a separate item from 1997 although the first managed care services also date from 1993. Reinsurance was a substantial problem in open schemes in the late 1990s and early 2000s⁴ but has since become more rarely used. Expenditure on all the components of non-healthcare costs has only been shown separately for open and restricted schemes since 2004, as illustrated in real terms below.

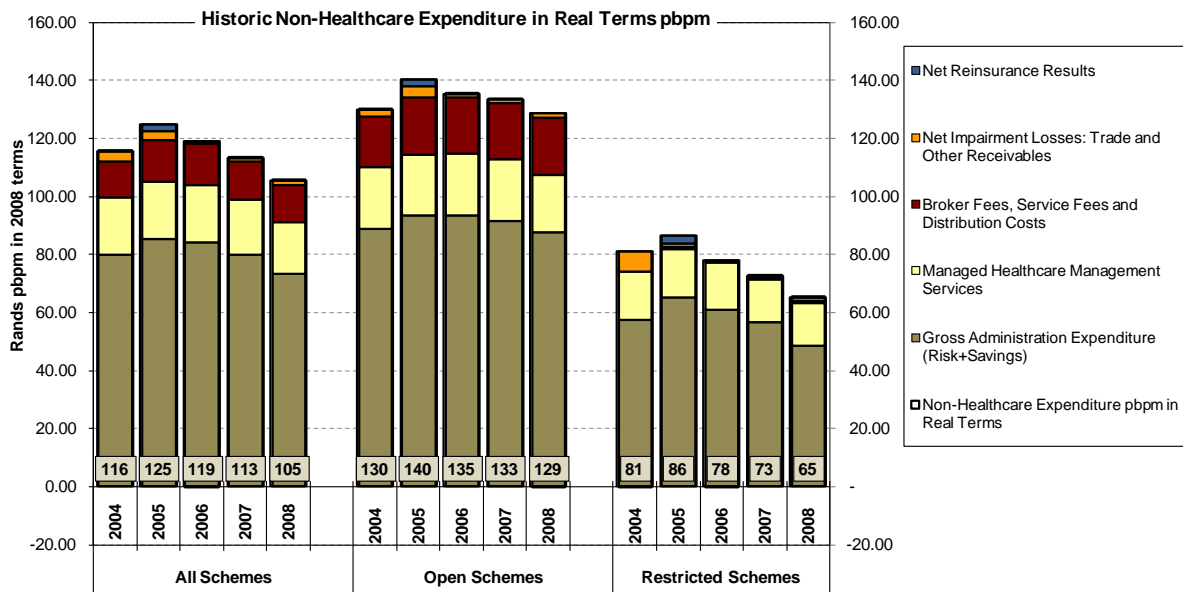


Figure 10: Historic Non-Healthcare Expenditure in Real Terms, by Type of Scheme

There appears to have been a greater reduction in NHC in real terms in restricted schemes. This is probably partly due to the effect of GEMS which began operations in January 2006 and had 825,000 beneficiaries by end 2008. GEMS had NHC of R40.91 pbpm in 2008 which was the lowest of the large medical schemes. As GEMS has grown rapidly, so more members have moved from open schemes that had higher NHC. As GEMS has grown, so it becomes a larger proportion of total restricted scheme membership, thus bringing down the average for restricted schemes as a whole. With GEMS accounting for around 10% of the total industry membership by 2008, it brings down the consolidated total as well.

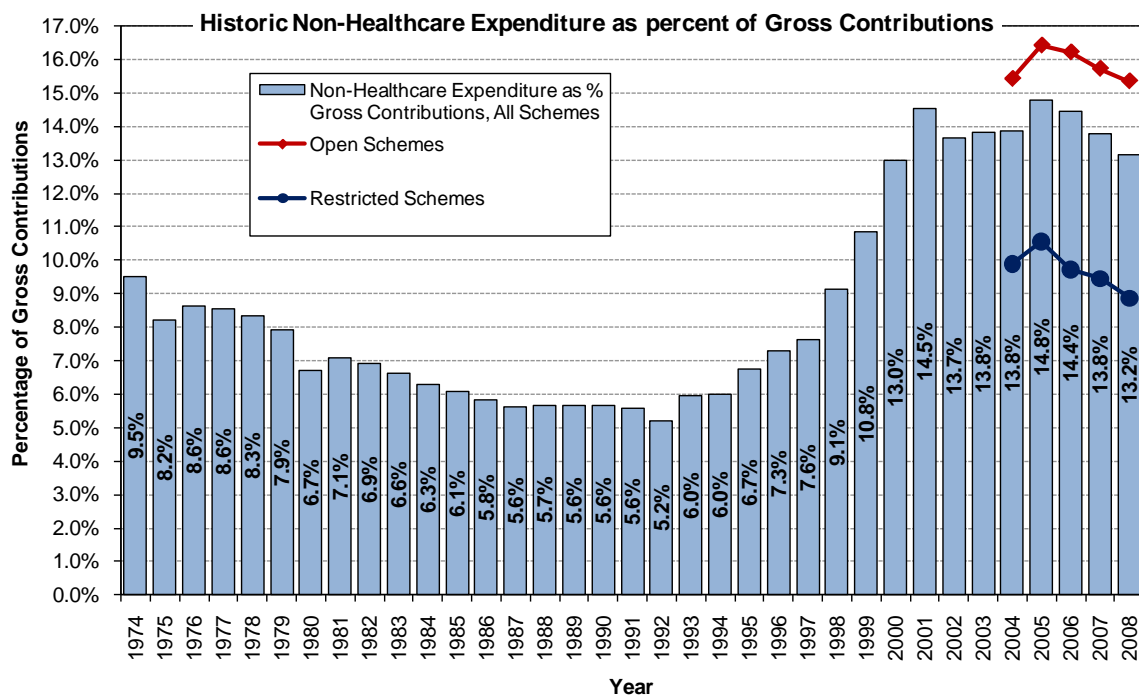


Figure 11: Historic Non-Healthcare Expenditure relative to Gross Contributions

The graph above shows that relative to total contributions, non-healthcare costs steadily reduced from 9.5% in 1974 to reach a level of 5.2% in 1992. NHC accelerated sharply in the 1990s to reach 14.5% in 2001 before moderating to the current level of 13.2% in 2008. In aggregate, open schemes spent 15.3% of total contributions and restricted schemes spent 8.9% on total non-healthcare costs. Discovery Health Medical Scheme spent 16.0% of total contributions on non-healthcare costs in 2008 while GEMS spent 6.1%. The lowest NHC percentage in the industry was Impala Medical Plan at 1.4% while the highest was 32.8% of total contributions by Moremed Medical Scheme.

The graph below uses tables published in the analysis section of the Annual Reports of the Council for Medical Schemes to consider the trends in administration plus managed care services expenditure on a Rands per beneficiary per month basis, splitting open and restricted schemes and third-party and self-administered schemes.

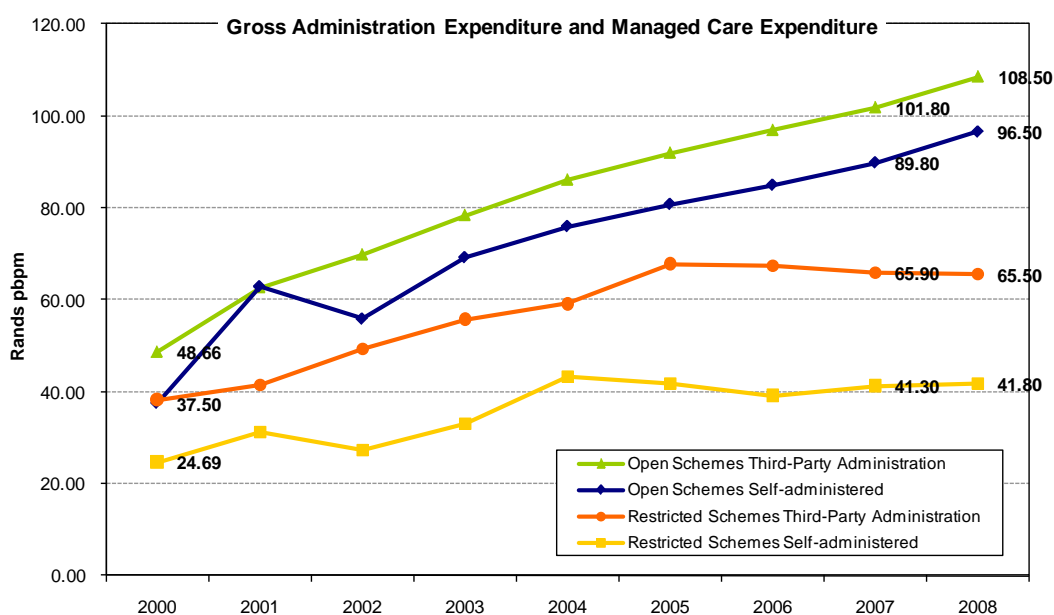


Figure 12: Historic Gross Administration and Manged Care Expenditure in Medical Schemes

The trend in restricted schemes is noticeably different from that in open schemes. The trend in open third-party administered and open self-administered schemes is remarkably similar in shape. Restricted schemes, although having a different shape, also display a consistency in recent trends between third-party and self-administered schemes. The question remains: what is an appropriate level for administration expenses and for total non-healthcare costs?

6. Studies of Administration Costs in Other Countries

It is particularly difficult to compare non-healthcare expenditure across different healthcare systems. Even within one country, comparing costs across different forms of organisation of health funding is problematic⁵: “For example, in the United States, health maintenance organisations (HMOs) may treat administration associated with salaried medical staff as claims, whereas commercial carriers will treat the cost of making such payments to providers as administrative expenses.”

At an aggregate level, healthcare administration costs from national accounts shows that the USA has very high costs relative to other large countries, as shown below.

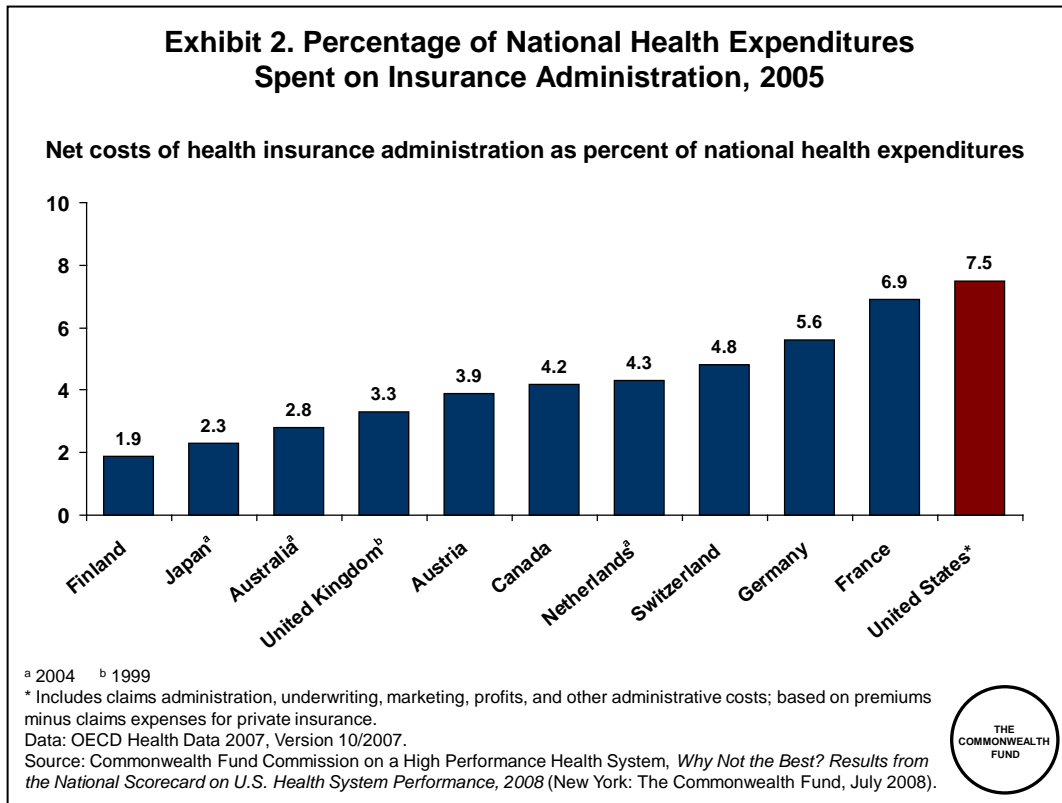


Figure 13: National Health Expenditures Spent on Insurance Administration, 2005⁶

However aggregate levels mask significant differences in the role played by private health insurance and the figures above are a mix of costs in public systems and private health funds. The OECD Report on Private Health Insurance⁵ comments and provides examples of administration expenses as follows: “Private insurers face high overhead costs. Marketing, policy management and underwriting represent the largest fraction of administrative expenses, but insurers also incur the cost of billing, product-innovation, agents’ commission and distribution. Where insurers enter into arrangements with health care providers, multiple contractual negotiations add to insurers’ administrative burdens. It is no surprise, therefore, that private insurers have higher administrative costs (per person insured and as a fraction of total cost) than do public health coverage programmes.”

“In the United States, administrative data (cited, for example, in Woolhandler et al., 2003⁷) show that the average administrative costs of private insurers (11.7% in 1999) exceed those of the public programmes Medicare (3.6%) and Medicaid (6.8%). Similarly, the administrative cost of Medicare in Australia (3.7% in the year 2001-02) is well below the PHI industry average (11.1%). Some funds have been more successful than others in keeping administrative costs to levels comparable to the single-payer public programme (Colombo and Tapay, 2003⁸).^d High average administrative costs for private insurers are also found in other OECD countries, such as the Netherlands (10.4%), Canada (13.2% in 1999), Ireland (9.7% in 2002)^e and Germany (14% in 2002).^f

^d “The private industry average also shows significant variation across carriers, with administrative expenses ranging from 1% to over 20%, some of which are comparable to those of single-payer public programmes. Such large variation could be in part due to differences in the definition and classification of expenses. Funds with membership restricted to certain employment categories also have lower average administrative costs, averaging 7.7% compared to 11.3% for funds with open membership, which reflect their lower underwriting cost.”

^e “These data refer to the main government-owned insurer, VHI. Administrative costs for the second main insurer, BUPA, are not known.”

^f “Includes both underwriting and other administrative costs (PKV, 2003)”

A recent study by the Commonwealth Fund in the USA⁶ showed that: “Documents filed with the U.S. Securities and Exchange Commission show that the administrative costs of the largest health insurance companies averaged from 13 percent to 18 percent of premium revenue in 2008.” However there were significant variations by both size and geography: “The administrative cost component of private insurance premiums runs from 5 percent to 40 percent, depending on the market and state in which the insurance policy is purchased. Insurance carriers currently sell policies in three different markets—large employer group, small employer group (firms with fewer than 50 employees), and individual.” “Administrative costs and profits consume an estimated 25 percent to 40 percent of premiums in the individual market, 15 percent to 25 percent for companies with fewer than 50 employees, and 5 percent to 15 percent for firms with more than 50 employees. The costs of commissions alone in the small-group market, where brokers play a key role in identifying pertinent insurance policies, run from 4 percent to 11 percent of premiums.”

Although the total amount spent on administration in the UK appears relatively low in Figure 13, the issue of a national health system over-burdened by administration has been a major concern. It has been reported that the NHS, with a staff of nearly 1.3 million is now the world’s third biggest employer, after the Chinese Army and the Indian State Railways⁹. Of greater concern is that only half of the employees are clinical employees^h. The matter was considered serious by all political parties and in recent reformsⁱ, there are promises to cut the administrative burden substantially. The Secretary of State for Health, in his speech on the reforms, said^j “For too long, processes have come before outcomes, as NHS staff have had to contend with 100 targets and over 260,000 separate data returns to the Department each year.” “We will remove unjustified targets and the bureaucracy which sustains them. We will rebalance the NHS, reducing management costs by 45% over the next four years.” The proposed reforms of the NHS include devolving financial responsibility to GP groups. A concern is that this simply moves the administrative burden to many smaller groups.

How should administration be defined in comparisons? The classic study 1999 of total administration costs in the USA and Canada⁷ produced numbers of a very different magnitude to those quoted by The Commonwealth Fund above: “For the United States and Canada, we calculated the administrative costs of health insurers, employers’ health benefit programs, hospitals, practitioners’ offices, nursing homes, and home care agencies in 1999. ... After exclusions, administration accounted for 31.0% of health care expenditures in the United States and 16.7% of health care expenditures in Canada. Canada’s national health insurance program had overhead [expenditure] of 1.3%; the overhead among Canada’s private insurers was higher than that in the United States (13.2% percent vs. 11.7%).” “The average U.S. hospital devoted 24.3% of spending to administration. ... In Canada, hospital administration cost 12.9% of hospital spending ...”. “In total, physicians’ administrative work and costs [in the USA] amounted to 26.9% of physicians’ gross income.” Costs were lower in Canada, at 16.1% of gross income.”

The difference in costs is considered to have multiple sources. “Several factors augment U.S. administrative costs. Private insurers, which have high overhead in most nations— 15.8 percent in Australia, 13.2 percent in Canada, 20.4 percent in Germany, and 10.4 percent in the Netherlands — have a larger role in the United States than in Canada. Functions essential to private insurance but absent in public programs, such as underwriting and marketing, account for about two thirds of private insurers’ overhead. A system with multiple insurers is also intrinsically costlier than a single-payer system. For insurers it means multiple duplicative claims-processing facilities and smaller insured groups, both of which increase overhead.”

^g <http://www.timesonline.co.uk/tol/news/uk/health/article1050197.ece>

^h http://www.kingsfund.org.uk/current_projects/general_election_2010/key_election_questions/how_many_managers.html

ⁱ See papers on reform of the UK NHS in 2010: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

^j http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117366

“Fragmentation also raises costs for providers who must deal with multiple insurance products — at least 755 in Seattle alone — forcing them to determine applicants’ eligibility and to keep track of the various copayments, referral networks, and approval requirements. Canadian physicians send virtually all bills to a single insurer. “The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers.” But even so the authors admit that not all costs are included in the estimates and critically that: “Our analysis also omits the costs of collecting taxes to fund health care”.

A very useful paper on identifying all the administration at various levels of the whole healthcare system was produced by Kenneth Thorpe in 1992⁹. “At issue is the true magnitude of administrative costs, how they are measured, what they produce, where they are found, and what opportunities exist for reducing them.”

Exhibit 1
Administrative Costs. By Function And Sector Of The U.S. Health Care System

Function/ component	Health insurance	Hospitals	Nursing homes	Physicians	Firms	Consumers/ individuals
Transaction - related	Claims processing	Admitting, billing	Admitting, billing	Billing	Tracking employee hires/ terminations	Submitting claims
Benefits management	Statistical analyses, quality assistance, plan design	Management information systems	Management information systems	Management information systems	Internal analyses	Tracking expenses eligible for reimbursement
Selling and marketing	Underwriting, risk/ premiums, advertising	Strategic planning, advertising	Strategic planning	Advertising	Flexible benefit programs	Search costs
Regulatory/ compliance	Premium taxes, reserve requirements	Waste management	Discharge planning	Licensing requirements	Filing summary plan descriptions, COBRA obligations	Mandated benefit laws

^a COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, which includes provisions for continuation of coverage when an employee leaves a firm.

Figure 14: Administration Costs by Function and Sector⁹

Following this study, Thorpe concluded that “It is not clear whether a high ratio of administrative to total expenses should be cheered or jeered; this is also evident in the lack of consensus on administrative costs in the literature.” However he was of the opinion that administrative costs in the USA system could be reduced. “Difficulties abound in comparing administrative costs within the U.S. health care system. How much more complex, then, are the trade-offs and measurement issues implicit in comparing administrative spending among nations. Relative to those in the United States, administrative costs in Canada are low. Part of the lower costs in Canada are traced to its universal single-payer system and the use of global hospital budgets. Yet, in addition to its pure transaction-related functions, administrative systems in the United States have broader objectives than does the Canadian system. Canada does not produce the billing and clinical data used in the United States to reimburse providers, for medical education, and for clinical and health services research.”

In a paper entitled "The High Cost of Administration in Health Care: Part of the Problem or Part of the Solution?", Bovjberg¹⁰ writes: " The problem is figuring out how to economize cheaply, consistent with one's other goals. It also seems plausible that fiscal discipline could be more inexpensively enforced from inside an organization, through a shared culture and informal norms, than through external orders. ... Generally, insurers and other managers of care seem to use outside controls, utilization review, discounted payment, and the like. ... Canada and other countries generally have low administrative spending in part because they rely on physicians and hospitals themselves to economize, often essentially within a global budget or understood limits on growth. Provider administration can also be low because they are not required to disclose just how they economize, including whether they do so 'efficiently' by omitting low-value spending first. ... The real challenge to the market and to policy advocates is achieving a patient- oriented balancing of costs and benefits, keeping in mind that every patient is also a payer. Getting the patient the best value, not any argument over the 'right' level of administrative costs, is what really matters in medicine now."

7. Conclusions and Implications for Health Insurance in South Africa

In estimates for COSATU¹¹, Patrick Bond and colleagues made assumptions about savings in administration expenses in moving to National Health Insurance as follows: "Assuming a single payer system with no duplicate coverage by the private insurance companies ...:

- For hospitals, the percentage of revenue spend on administration is assumed to be 26%, and savings are assumed to be 22% from NHI single-payer centralisation of administration (based on studies comparing the US and Canada).
- For physician costs, the percent of revenue due to administration is assumed to be 30%, and *savings are assumed to be 36%*.
- *Overall administration of the NHI is assumed to be 3% of the total cost, which is similar to other countries with NHI."*

These assumptions have not been tested in South Africa and researchers are encouraged to determine the current levels of administration costs in the public and private sectors in South Africa.

Alex van den Heever¹² wrote as follows on the administration component of the ANC proposals for NHI^{13,14}: "The proposed NHIA [National Health Insurance Authority] envisages a vast organisation with national, provincial, and district structures. Functions include: enrolling the entire population and issuing them with membership cards; accrediting and overseeing every single private and public provider; managing the enrolment of the entire population with every single public and private health care provider; reimbursing every health provider based on enrolled members; reimbursing private and public hospitals; determining healthcare referral arrangements; negotiating all prices and reimbursement rates; and managing and avoiding fraud. ... Presently the South African Social Security Agency (SASSA) which has a similar configuration, but with more straightforward functions, has administration expenditure equivalent to 8% of turnover."

Section 6 above has shown that it is no simple matter to compare costs across countries, let alone assume that the total cost of administration will resemble that of any particular country. Note that SASSA has a level of administration expenditure relative to total funds that exceeds the non-healthcare expenditure relative to contributions of GEMS. The percentage of administration expenditure is very sensitive to the total amount flowing through the system and is not a particularly stable assumption. It is recommended that researchers should focus on the Rands needed per beneficiary, rather than the percentage, in making any assumptions about a future NHI.

The key to the amount of administration needed across the whole system is highly dependent on the form of reimbursement and the requirements to report that are placed on providers. Until these elements are known, estimating administration costs is a difficult exercise. As there is still no White Paper or any Government document on the proposed National Health Insurance system, it is more appropriate to focus on the level of administration expenses in medical schemes and to ask what parts of the current health insurance system are increasing the need for administration.

The International Review Panel in 2004¹⁵ argued that there should be much greater standardization of products to “reduce product competition based on the design of numerous benefits packages (which hardly benefits the consumer) and increase price competition among the medical schemes”.

It was shown in an earlier policy brief on risk pool size¹⁶ that “there were 355 separate risk pools in 2008, of which only 80 were sufficiently large to accept full healthcare risk, using the USA definition”. This means that there were 355 separate definitions of benefits in that year that affected not only administrators but also consumers, brokers, healthcare providers and the regulator. The amount spent on broker fees and distribution costs in 2008 was R1.163 billion. A further R0.327 billion was spent on marketing and advertising costs by medical schemes. There must be significant savings in both items if there were to be fewer packages allowed.

The complexity of South African medical scheme administration systems is made worse by every option having a unique benefit structure and its own rules. It cannot be expected that administrators or schemes will take the lead in reducing this complexity and it is an area in which Government must act as the steward of private healthcare. It is very difficult to estimate the potential savings for hospitals and doctors, given the lack of a published base-line administrative component to their turnover. But common sense says that there must be a significant reduction in the administration needed and the frustration and confusion levels for doctors and clerical staff.

In arguing the three most important changes that Government should make in the health insurance environment, McLeod and Ramjee said in 2007¹⁷: “In the medium-term, the most important goal is to move to a mandatory system for health care cover but there are still several reforms needed before mandatory cover is implemented. ... The most important immediate priority is to simplify and standardise benefit and option structures in medical schemes.”

Circular 8 in 2006¹⁸ began a consultation process on benefit and option design which has not been brought to completion in legislation. The stalled legislation needs to be revived in order to reduce unnecessary administration expenditure in existing medical schemes. While the design of NHI is discussed and, hopefully, publicly debated, let us not lose sight of simple changes that should be made to make the existing system more efficient. Every year lost by Government in making changes results in non-healthcare expenditure that could have been diverted to either providing more healthcare or reducing the cost burden on workers.

Produced for IMSA by
Professor Heather McLeod
27 August 2010

Resources on the IMSA Web-site

The following is available on the NHI section of the IMSA web-site: www.imsa.org.za

- The slides and tables used in this policy brief [PowerPoint slides].
- The historic series on non-healthcare expenditure, collated from Annual reports of the Council for Medical Schemes [Excel spreadsheet].

As the purpose of this series is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system, we would be delighted if you make use of it in other research and publications. All material produced for the IMSA NHI Policy Brief series and made available on the web-site may be freely used, provided the source is acknowledged. The material is produced under a Creative Commons Attribution-Noncommercial-Share Alike licence.



<http://creativecommons.org/licenses/by-nc-sa/2.5/za/>

References

1. Council for Medical Schemes. Annual Report of the Registrar of Medical Schemes 2001. Pretoria; 2002. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
2. Council for Medical Schemes. Report of the Registrar of Medical Schemes, 2008/2009. Pretoria; 2009. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
3. Council for Medical Schemes. Report of the Registrar of Medical Schemes 2000. Pretoria; 2001. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
4. McLeod HD, Slattery PG, Van den Heever AM. The use and abuse of reinsurance in medical schemes. *South African Actuarial Journal*. 2001;1:95-117. URL: <http://www.actuarialsociety.org.za/News-and-Publications/Vol.-1,-2001-586.aspx>
5. Organization for Economic Co-operation and Development. *Private Health Insurance in OECD Countries*; 2004. URL: http://www.oecd.org/document/10/0,3343,en_2649_37407_33913226_1_1_1_1,00.html
6. Collins SR, Nuzum R, Rustgi SD, Mika S, Schoen C, Davis K. How Health Care Reform Can Lower the Costs of Insurance Administration *Issue Brief*. The Commonwealth Fund; 2009. URL: <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jul/How-Health-Care-Reform-Can-Lower-the-Costs-of-Insurance-Administration.aspx>
7. Woolhandler S, Campbell T, Himmelstein DU. Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine*. 2003;349:768-775. URL: <http://www.nejm.org/doi/abs/10.1056/NEJMsa022033>
8. Colombo F, Tapay N. Private health insurance in Australia: a case study Organisation for Economic Cooperation and Development; 2003. URL: <http://hdl.handle.net/10147/43509>
9. Thorpe KE. Inside the black box of administrative costs. *Health Aff (Millwood)*. 1992;11:41-55. URL: <http://www.ncbi.nlm.nih.gov/pubmed/1500059>
10. Bovbjerg RR. Review Essay: The High Cost of Administration in Health Care: Part of the Problem or Part of the Solution. *Journal of Law, Medicine and Ethics*. 1995;23:186-194. URL: <http://heinonline.org/HOL/LandingPage?collection=journals&handle=hein.journals/medeth23&div=34&id=&page=>
11. Bond P, other authors unknown. Costs/Benefits Estimates for National Health Insurance. A summary analysis submitted to the Congress of SA Trade Unions. 2009. URL: <http://amandlapublishers.co.za/special-features/the-nhi-debate/214-estimatesfornhi>
12. Van den Heever A. National Health Insurance: Unpublished.; 2009.
13. African National Congress. National Health Insurance Plan for South Africa Prepared by the Task Team on National Health Insurance on behalf of the Health and Education Sub-committee 2009. URL: http://wikileaks.org/wiki/African_National_Congress_National_Health_Insurance_plan%2C_June_2009
14. African National Congress. National Health Insurance Policy Proposal: Prepared by the Health and Education Sub-committee and presented to the ANC National Executive Committee 13 July; 2009. URL: http://wikileaks.org/wiki/African_National_Congress_National_Health_Insurance_plan%2C_July_2009
15. Armstrong J, Deeble J, Dror DM, Rice N, Thiede M, Van de Ven WPMM. The International Review Panel Report to the South African Risk Equalization Fund Task Group. Pretoria; 2004. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>
16. McLeod H. Reducing Fragmented Risk Pools *National Health Insurance Policy Brief 8: Innovative Medicines South Africa*; 2010. URL: http://www.innovativemedicines.co.za/national_health_insurance_library.html
17. McLeod H, Ramjee S. Medical Schemes. In: Harrison S, Bhana R, Ntuli A, eds. *South African Health Review 2007*. Durban: Health Systems Trust; 2007. URL: <http://www.hst.org.za/publications/711>
18. Council for Medical Schemes. Circular 8 of 2006: Consultation on a Revised Benefit Design Structure for Medical Schemes. Pretoria; 2006. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=1>