SASCI

South African Society of Cardiovascular Intervention

SUBMISSION BY SASCI ON

LOW-COST BENEFIT OPTIONS (LCBOS)

To: lcbo@medicalschemes.co.za

By: 30 November 2022

1. About SASCI

SASCI, the South African Society of Cardiovascular Intervention has been in various health sector developments and is actively participating in submissions on the National Health Insurance, medical scheme matters, such as the PMBs and general health reforms. SASCI was also an active participant in Health Market Inquiry (HMI) processes.

SASCI is affiliated to SA Heart. SASCI represents cardiologists with a special interest in cardiovascular intervention. The society, a registered not for profit entity, also acts in an advisory capacity to funders, industry, members and government on subject matters relating to interventional cardiology.

SASCI has partnered with medical schemes in specific projects relating to specific cardiology interventions, and offer a peer guidance service to assist members who may be outliers in terms of practicing cardiology.

2. General remarks

SASCI supports the introduction of measures aimed at assisting persons to contribute to risk- and financial pooling systems so as to provide coverage for their own healthcare. This also alleviates the burden on the state sector, an objective stated in Annexure A to the Regulations to the Medical Schemes Act, 1998.

The LCBO proposals are reminiscent of the Low-Income Medical Schemes (LIMS) process in the mid-2000's.[1] However, health policy has shifted significantly since then, and a social health insurance system as an intermediate step to a national health insurance, has been replaced by a non-contributory, tax-based NHI. It is clear from the NHI Bill that medical schemes, and conceivably then also LCBOs, would be prohibited from covering care covered by the NHI. Primary Healthcare (PHC), which is the benefit package proposed to be offered by LCBOs, are the first benefits that the NHI will offer, and that other entities will be prohibited from offering.

LCBOs also seem to no longer be proposed as exemptions to the current regulatory regime, within the power of the Registrar of Medical Schemes. Instead, significant changes to the Medical Schemes Act and/or Demarcation regulations in terms of insurance legislation, are suggested. In SASCI's understanding, the Minister of Health is unlikely to introduce amendments to the Act in Parliament.

[1] https://www.medicalschemes.co.za/download/2543/low-income-medical-scheme-publications/19178/lims-final-report-draft-28-2-06.doc.

One of the key proposals for LCBOs is it being exempted from the PMBs. In contrast, the PMB Review project,[2] which started in 2017, creates further policy as it proposes the *inclusion* of PHC into medical schemes. Why create LCBOs that render PHC, for it to be competed with by the PMBs and then to be taken away once the NHI comes into effect?

SASCI therefore envisages that the proposals relating to LCBOs may not come to fruition at all. It is recommended that the CMS obtains policy clarity from its Council, and the Minister of Health.

The CMS's policy views on the demarcation framework seems to contradict the LCBO document. In SASCI's understanding the CMS- and National Department of Health objective is to limit, and not increase, insurance-based healthcare products. The LCBO document however do seem to support both medical schemes-run LCBO's, as well as LCBO's run by insurance companies. The LCBO-Risk document appears to prefer a transition of insurance products into LCBOs under the Medical Schemes Act, including its conversion into not-for-profits.

3. Specific Comments

The LCBOs proposal rests on an assumption of household income of R18 000 per month, but without making this a hard and fast requirement. It seems unclear how schemes, or insurance companies will prevent persons outside of such thresholds to join the LCBOs, or to resign their current medical scheme cover.

The second concern relates to the PHC cover to be offered by LCBOs. SASCI wishes to raise the following points in this regard:

- PHC interventions, specifically in cardiovascular conditions such as hypertension and diabetes, in many case leads to the need for referral. LCBOs would therefore increase screening and monitoring. This in turn would therefore increase the need for specialist referrals. The absence of any such cover, and the absence of any emergency care (save for emergency transport), could be problematic.

- If subject to the managed care regulations in the Medical Schemes Act, LCBOs would have to provide alternatives for patients who are not adequately treated with their PHC conditions. The importance of well-controlled hypertension and diabetes is well-known and well-documented. An Essential Medicines List-based formulary will not comply with the requirements as set by the law. For patients on insurance-based LCBOs only, there may be inadequate care provided, and increase clinical risk to the patient, and potentially the LCBO.

- There are two types of streams of gatekeeping proposed for the LCBOs, namely nurse-based-, and GP-based gatekeeping. The SA Nursing Council on 5 June 2022 released new Scope of Practice Regulations, which prohibits private nurse practitioners for all nurses, save for those with a specialist qualification and such specialist registration (no registers being currently in place). The Nursing Act, 2005, in section 56(6), also only allows nursing professionals in

[2] https://www.medicalschemes.co.za/publications/#2009-2094-wpfd-pmb-review.

the public sector to diagnose, treat and prescribe, or organisations so designated by the Minister as fulfilling a public health function, where no general practitioner is available.

SASCI also does not see any data that underpins assumptions relating to *willingness* to belong to LCBOs, versus no private cover, or versus medical scheme cover. Affordability seems to be set at the R18 000 per month household income

The costing of the LCBOs seems fairly high, ranging from R150 to R500 per beneficiary per month – the reports are not totally clear on this and exactly how it was calculated. This is when compared to the average medical scheme expenditure on the full set of PMBs, which includes all emergency care, all 26 chronic conditions (CDLs) and all 270 Diagnosis and Treatment Pairs (DTPs), which is reported for 2021 in the CMS Industry Report as R1 012 per beneficiary per month. It is acknowledged that scale may affect this, but the pricing seems a bit on the high side, in particular non-healthcare costs and where employers, and not individuals, will be targeted to increase cover. The addition of unnecessary costs to the LCBOs in the form of managed care and administration seems unnecessary where benefit design is simple, as proposed. Nurse-driven PHC is estimated at R62 to R70 per visit, and GP care is estimated at R75 to R85 per visit. It is not clear whether such reimbursement levels would be sustainable, and what the figures are based on.

Reference is made to a potential to "buy up", but it is not clear how that would work, e.g. from an insurance-based LCBO into a medical scheme, and how issues such as late joiner penalties and waiting periods would work.

In this instance, would it not make more sense to increase medical scheme in existing households with at least one member in a scheme, or to increase cover in the over R18 000 household income range: the General Household Survey 2019, states that 67% of households with incomes over that amount do have at least one member belonging to a medical scheme – so targeting existing scheme members to increase household coverage do seem like an opportunity. The CMS Industry Report of 2021 data, shows a dependency ratio of only 1.2. It also seems strange, in spite of the repeated reporting by the CMS on this, that there is no effort to bring the young and health, employed persons, into the medical schemes fold. The latest industry report shows that the proportion of 1 to 44-year old's is more, but their expenditure must less. The gap lies in the age group 15 to 34 years of age.

SASCI is also concerned that the *willingness* to pay for an LCBO, versus comprehensive cover via a PMB options, versus no private cover, have not been research, or released in the documents. The assumption that the tax subsidy will continue and will assist in defraying the cost of LCBO products, cannot be taken for granted, in light of the most recent statements by the Minister of Health, that all tax subsidies in health will be scrapped, so that such taxes can go into the NHI Fund.

4. Conclusion

SASCI thank the CMS for this opportunity. It remains available to discuss any aspect of this submission, and in particular the provision of PHC that is a necessary element in cardiovascular healthcare, and matters pertaining to referrals, as well as secondary and tertiary care.

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