



International Actuarial Association Health Section
2007 Colloquium

13th - 16th May 2007 Cape Town, South Africa

MAKING HEALTH INSURANCE MARKETS WORK FOR THE POOR IN SOUTH AFRICA

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IAAHS 2007

IAA Health Section Colloquium

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CTICC

www.iaahs2007.com



FinMark Trust

- Independent trust formed in April 2002
- Initial funding from the UK's Department for International Development (DFID)
- Mission: *"Making Financial Markets Work for the Poor"* in Africa
- Facilitating and catalysing the next generation of development around access to financial services.
- Member of the CGAP Working Group on Micro Insurance
- Further information available at www.finmarktrust.org.za

Why does access matter?

Poor people need financial services

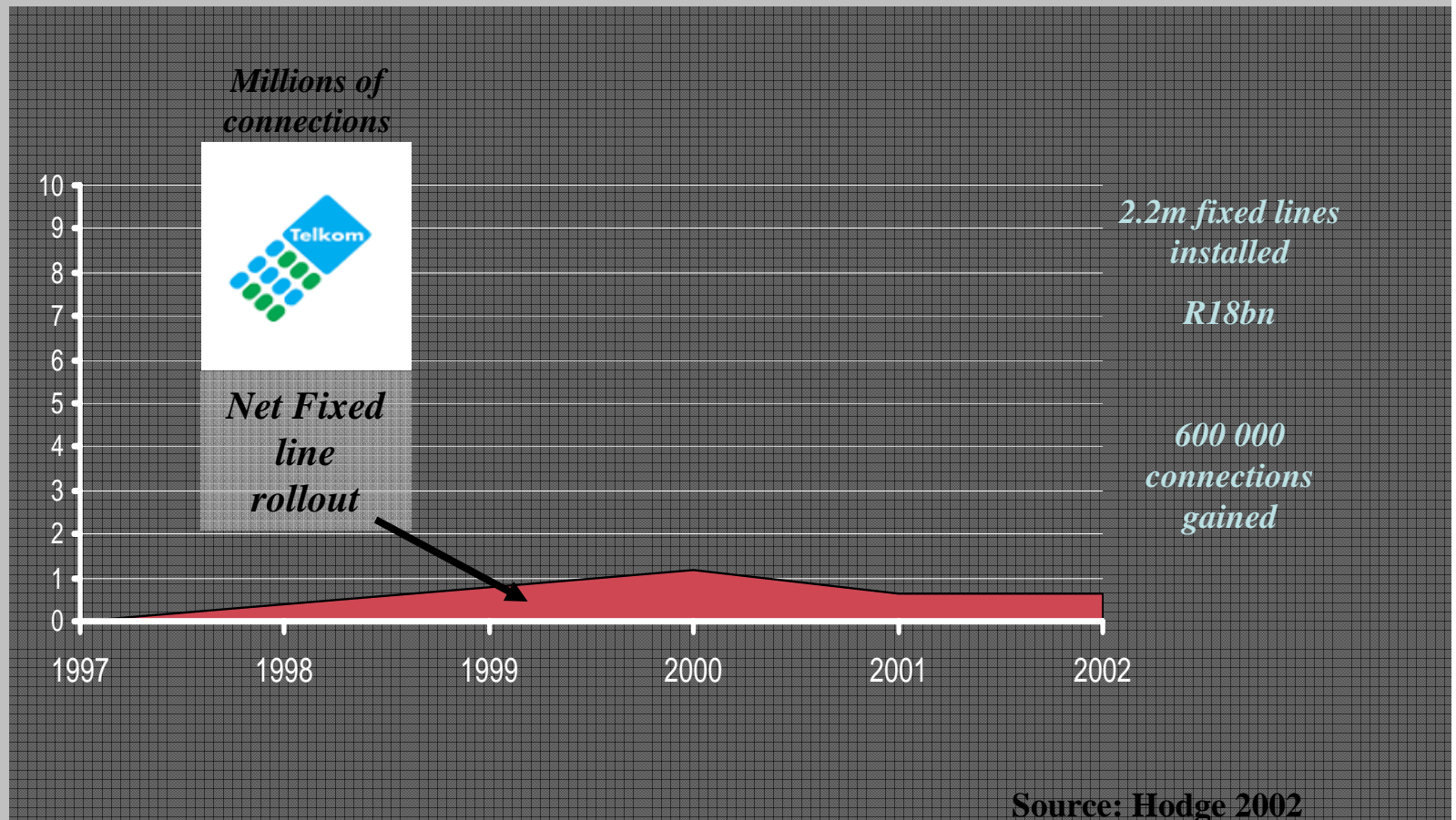
- To provide a path out of poverty
- So that a temporary misfortune won't push them into destitution

But in addition:

- A political and social priority
- A priority for growth
- HENCE it affects everyone

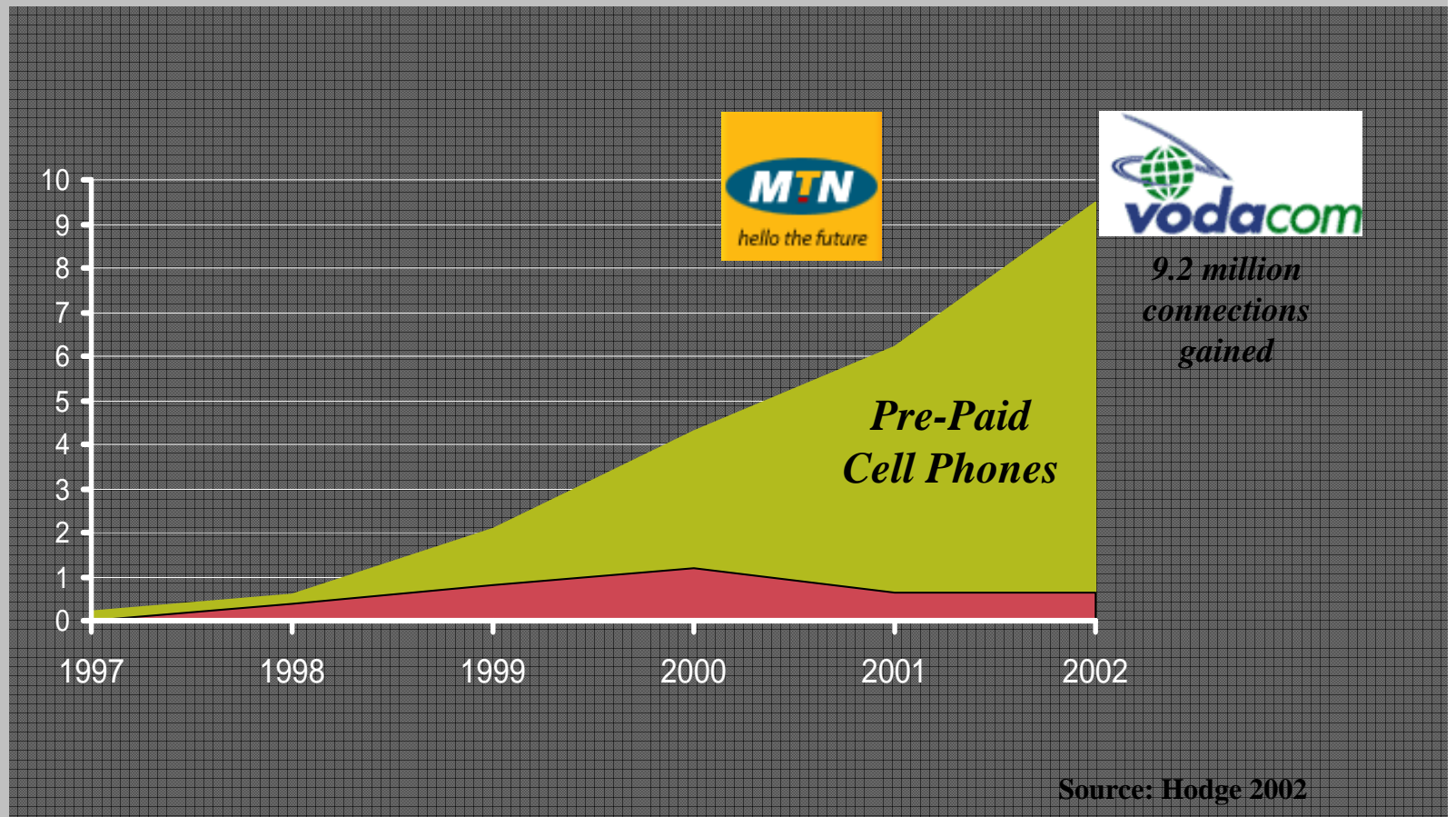


In 1996, Telkom was given a fixed line monopoly in exchange for expanding access to telephony



A cautionary tale about expanding access

...and along came..



We partner with innovators to open sustainable market access

FinMark Trust:

- Demand side information – FinScope / Financial Diaries

- Working with regulators to assess impact on access to financial services

- SUPPORTING INNOVATION

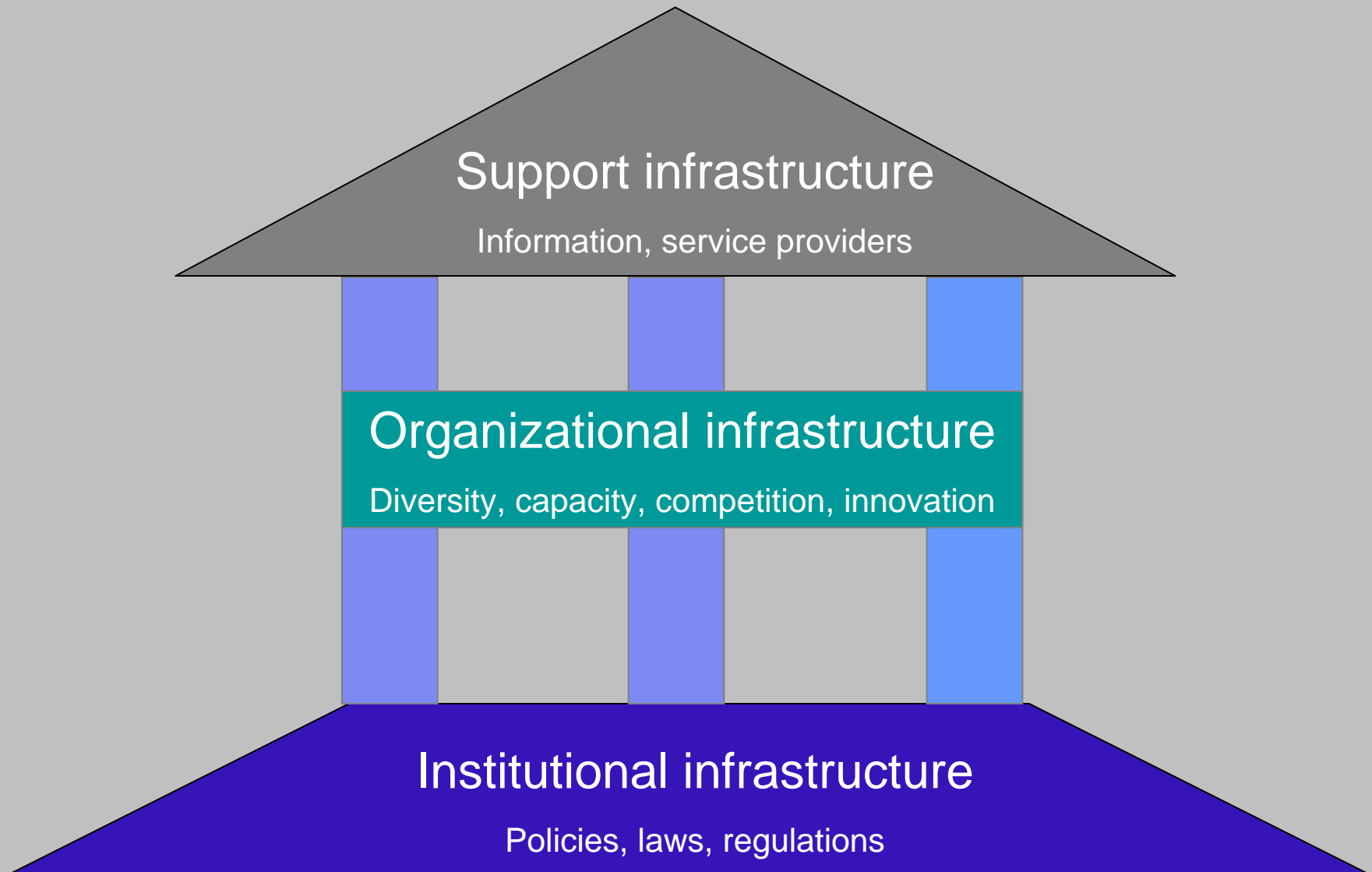
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*9.2 million
connections
gained*



A working market requires... but how does SA's health insurance market fare?



Agenda

- Health care principles
- Health policy in South Africa
- The healthcare sector in South Africa
- Improving low income access
- Application of MMW4P concepts

Healthcare principles

What are the objectives of health systems?

- Improving population health;
- Respond to expectations;
- Provide financial protection against costs of ill health

(WHO 2000)

WHO “Health for all”

- Access to high quality essential care
- Defined according to:
 - Effectiveness
 - Cost
 - Social acceptability

Health Policy in SA

- Right of access in Constitution (subject to resources)
- Social solidarity principles
- Target of a social health insurance (SHI) environment
- Means testing at state facilities

The healthcare sector in SA

Assessing SA's achievements: Health Expenditure compared

	THE as % GDP	Gov(health) % THE	PHI % THE	Gov(health) % Gov(total)
Botswana	5.6	58.2	41.8	7.5
Brazil	7.6	45.3	54.7	10.3
China	5.6	36.2	63.8	9.7
Democratic Rep. of Congo	4	18.3	81.7	5.4
South Africa	8.4	38.6	61.4	10.2
United Kingdom	8	85.7	14.3	15.8
United States of America	15.2	44.6	55.4	18.5
Zimbabwe	7.9	35.9	64.1	9.2

Assessing SA's achievements: Healthcare Resources - Personnel

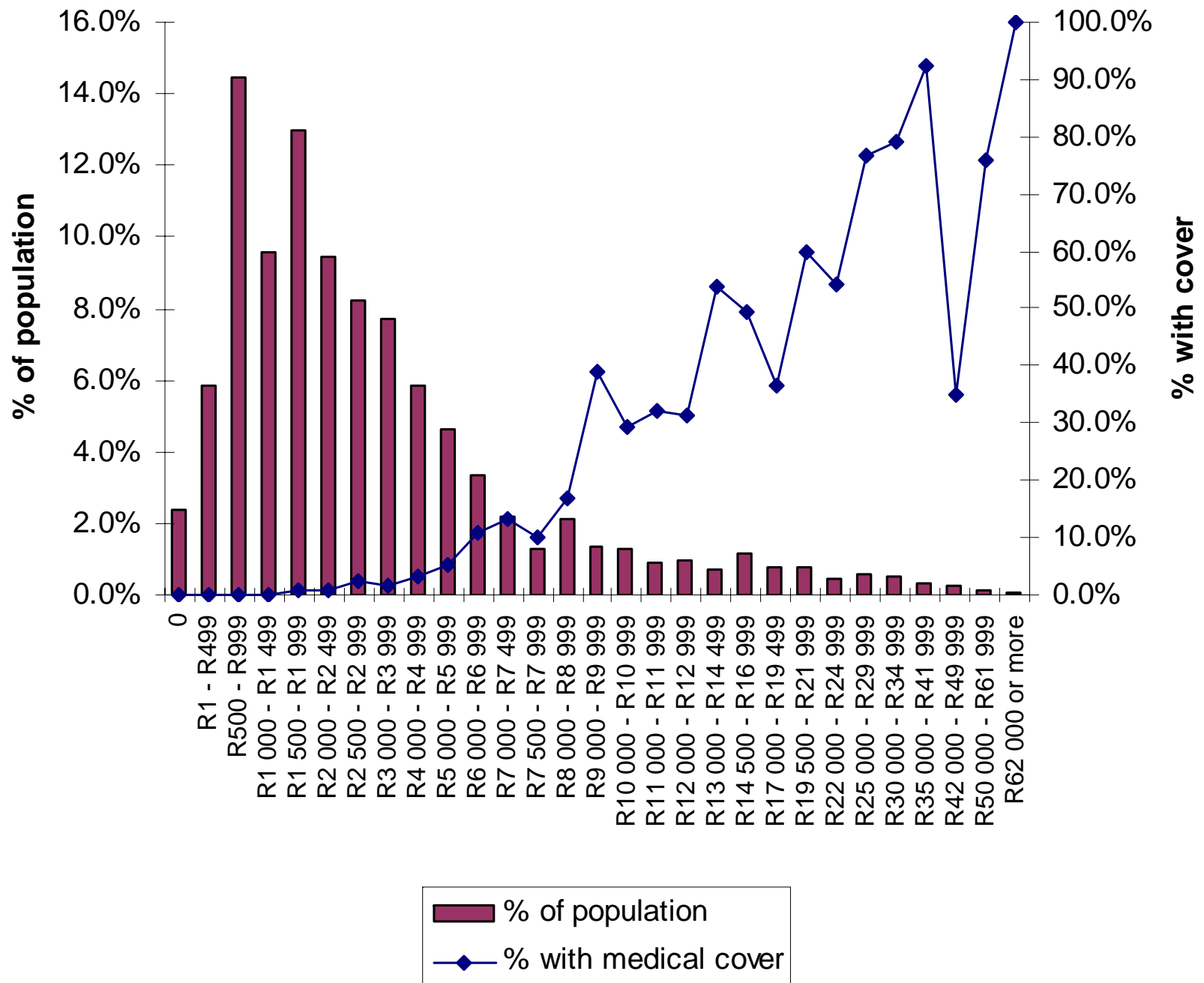
Density per 1000 population	Physicians	Nurses	Dentists	Pharmacists
Botswana	0.40	2.65	0.02	0.19
Brazil	1.15	3.84	1.11	0.30
China	1.06	1.05	0.11	0.28
Democratic Rep. Congo	0.11	0.53	-	0.02
South Africa	0.77	4.08	0.13	0.28
United Kingdom	2.30	12.12	1.01	0.51
United States of America	2.56	9.37	1.63	0.88
Zimbabwe	0.16	0.72	0.02	0.07

Assessing SA's achievements: Health Coverage

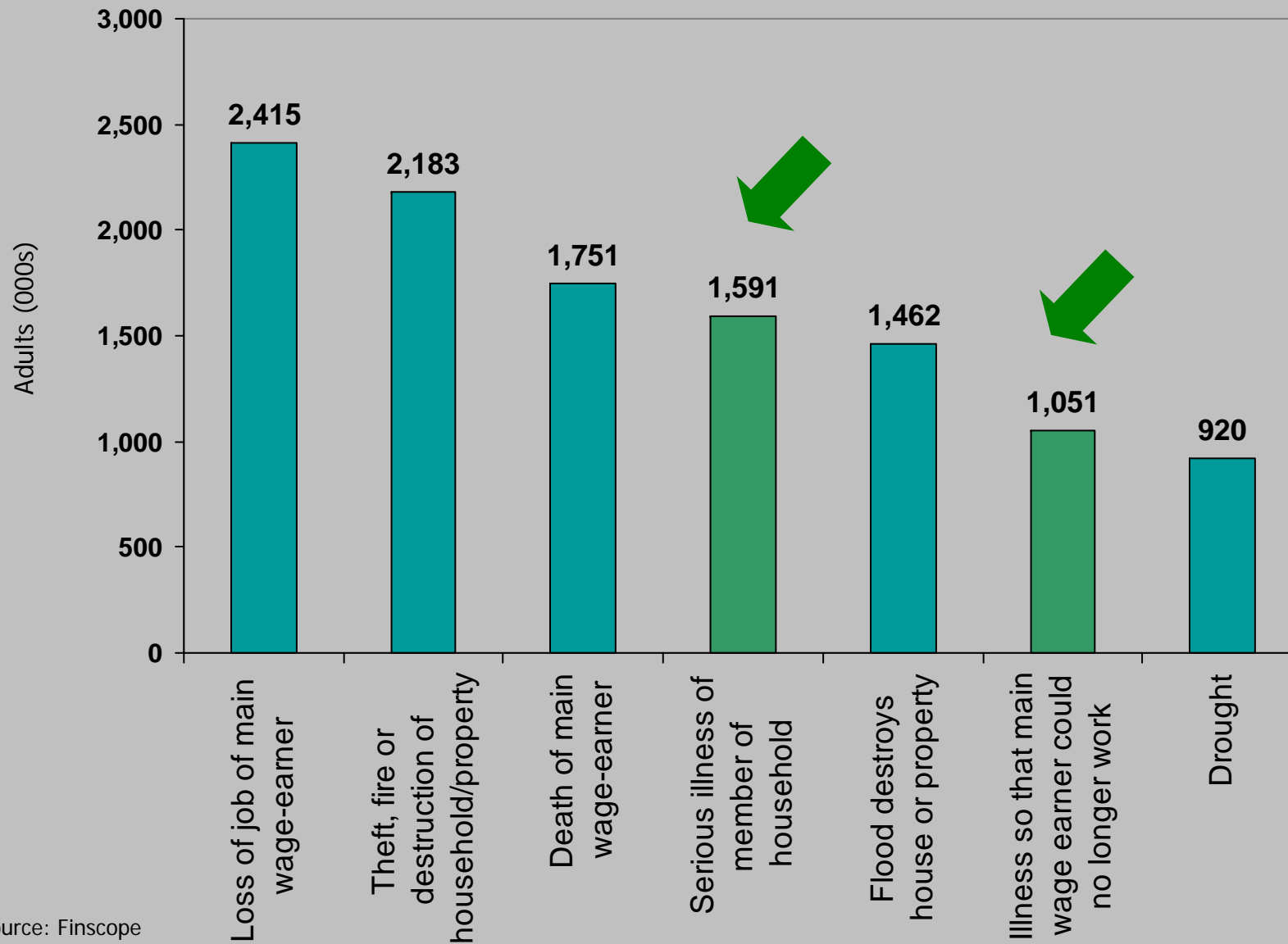
	Public Sector	Private Sector
Total expenditure (Rbn)	37	43
% of expenditure	46%	54%
Population covered (thousands)	38 541	6 962
% of population	85%	15%
Expenditure per person pa (2003 Rand values)	R960	R6 176

Assessing SA's achievements: Access

	2004	2005	2006
Medical Cover	11%	10%	9%
Medical Aid/ Scheme	10%	9%	8%
Hospital Plan	3%	3%	2%
Medical Insurance	2%	2%	1%



Reality of household risk in LSM 1-5



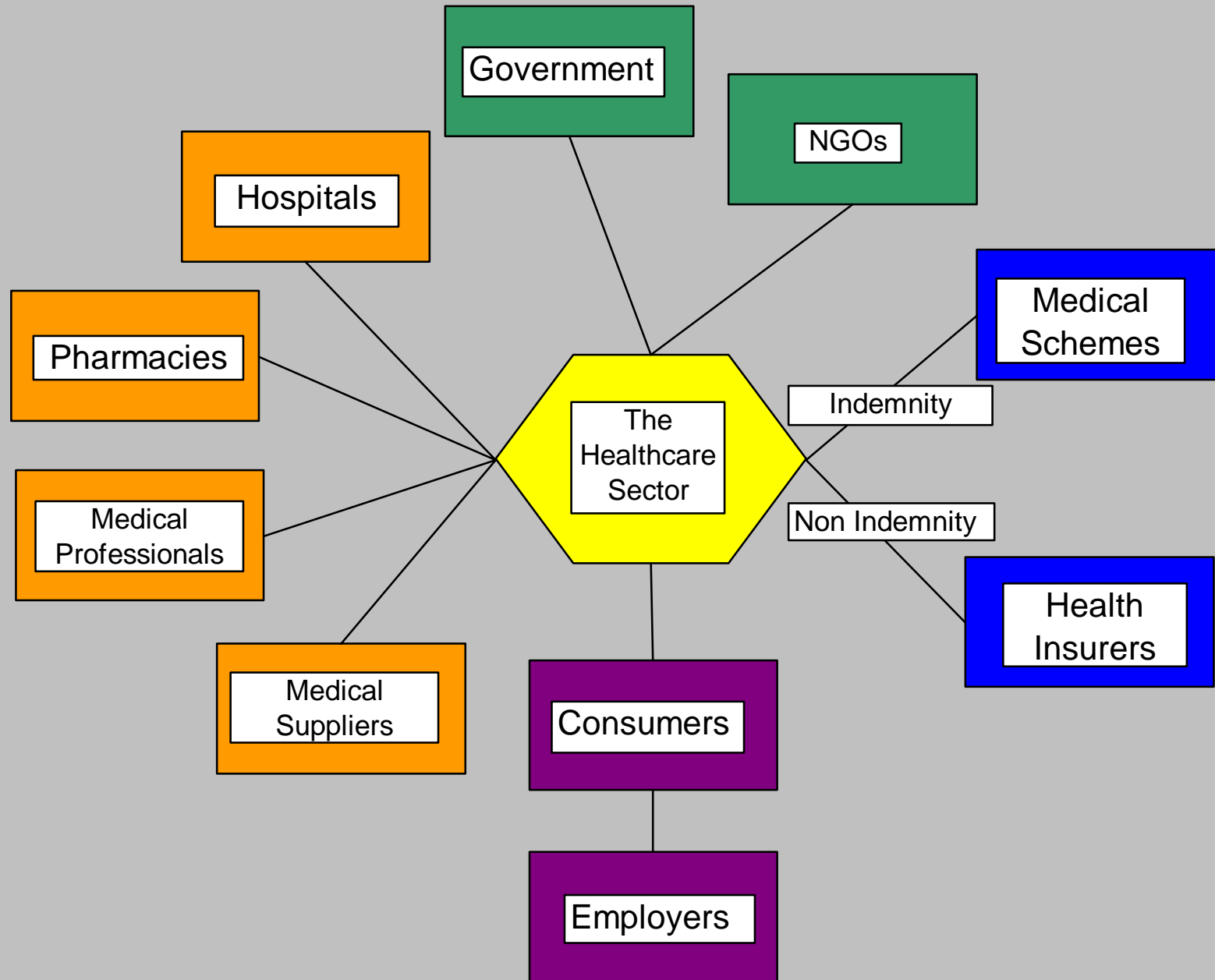
The healthcare market
analysed

Peculiarities of the Healthcare Sector

- Size of the sector
- Role of public regulation
- Emotional significance
- Desired health \geq actual health (derived demand)

But we need rules for the allocation of scarce resources

A complex inter-dependent market



Increasing demand for health

- Demographic factors (ageing)
- Technological factors
- Increased education and awareness (creates expectations)

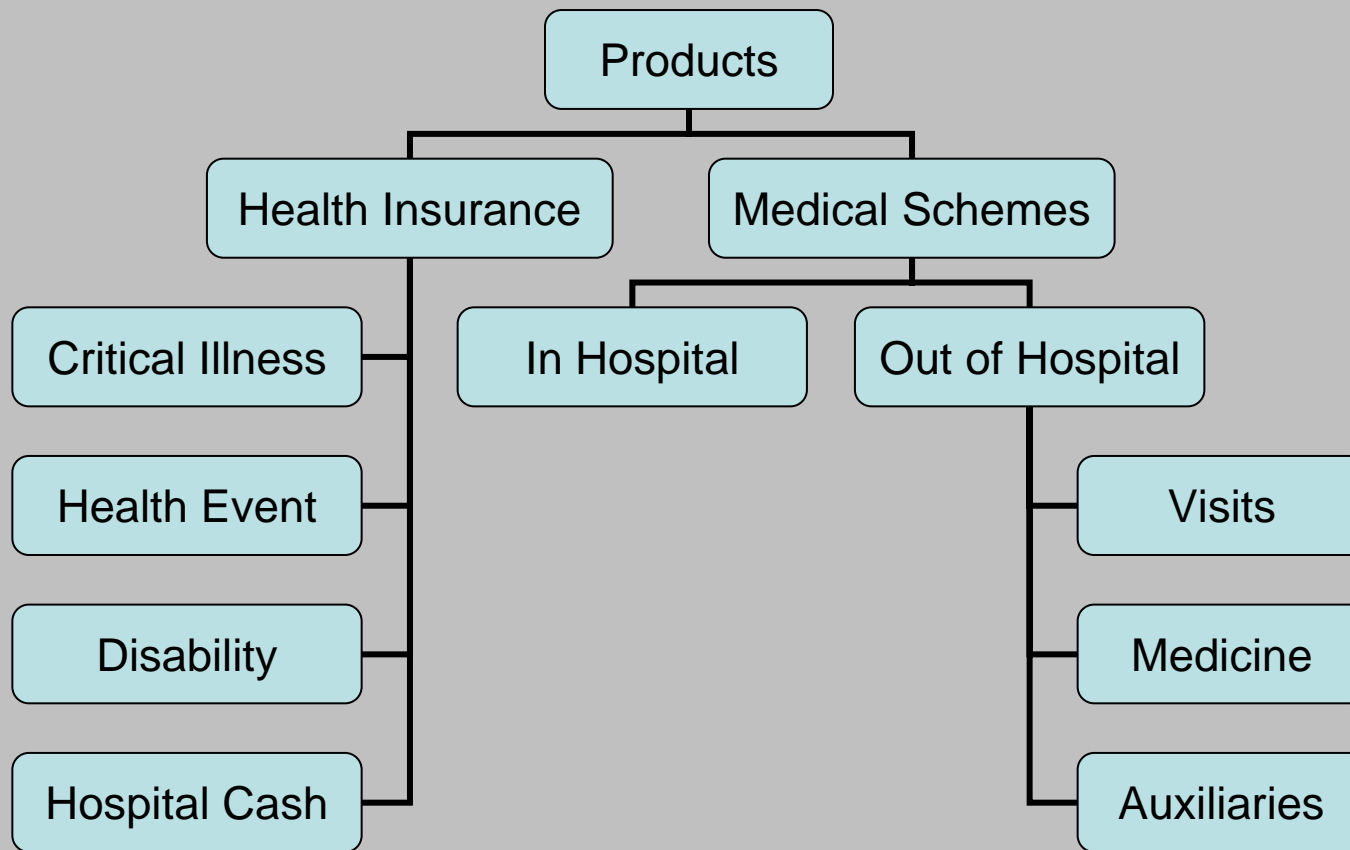
Healthcare Needs: Causes of Premature Mortality

Rank	Cause of Death	YLL	%
1	HIV/AIDS	4 665 410	39.0
2	Homicide/violence	902 592	7.5
3	Tuberculosis	595 277	5.0
4	Road Traffic Accidents	489 979	4.1
5	Diarrhoeal diseases	452 827	3.8
6	Lower respiratory infections	449 010	3.8
7	Low birth weight	393 763	3.3
8	Stroke	318 083	2.7
9	Ischaemic heart disease	284 438	2.4
10	Protein-energy malnutrition	171 433	1.4

SA Health legislation

- Regulation of health providers and professionals
- Medicine pricing regulation
- Medical scheme regulation
 - Guaranteed access
 - Minimum benefits
 - Community rating

Products in South Africa



Barriers to extending access

- Consumer education
- Cost of prescribed minimum benefits
- Irregular incomes
- Anti-selection / voluntary membership
- Low commission levels
- Perception that state care is free

Improving access in the low
income market

LIMS Target Population: R2500-R6000

	LIMS household survey 2005
Number of households (millions)	2.6
Number of individuals (millions)	11.5
% under the age of 16 years	26%
% over the age of 65 years	4%
Number of households with medical aid (millions)	0.505
Number of individuals with medical aid (millions)	1.37

Barriers to entry

	No household member working	One/more members working in formal sector	One/more members working in informal sector	Total
A: Value Proposition	79.2%	46.2%	62.0%	57.0%
B: Access Related	15.9%	42.5%	29.5%	33.9%
C: Choice	4.9%	10.5%	8.3%	8.8%
D: Other	7.2%	17.5%	14.5%	14.6%

Finscope cross tabulations

	Number with Medical Insurance	% of Medical Insurance with Product	% of Product with Medical Insurance
Bank	2,711,902	98%	17%
Funeral Insurance	1,971,967	71%	16%
Retirement	1,904,837	69%	60%
Asset Insurance	1,852,525	67%	64%
Life Insurance	1,742,062	63%	55%
Retail	1,624,677	58%	26%
Home loan	1,229,654	44%	54%
Loans	1,143,624	41%	35%
Investments	987,567	36%	69%
Savings	141,748	5%	7%

Utilisation levels

3 months prior to survey

Service	Medical Aid	No Medical Aid
Private GP	34%	7%
Public clinic	6%	15%
Workplace clinic	2%	0.5%
Specialists	5%	0.5%
Traditional healers		1%
Hospital admissions	6.1%	3.5%
% public sector admissions	17.5%	98.5%

Financial Diaries Project

- Average medical spending on doctors, traditional healers and medication is 1.6% of gross income.
- Rural households tend to spend a slightly higher proportion of income on medical items, as do poorer households.
- Only 1/10 of households have medical insurance, as opposed to 1/6 of households with at least one form of funeral insurance and often two.
- Those few households with higher medical expenses often do so for chronic illness.
- Several comment that community services do not provide adequate care, forcing them to seek expensive private care

LIMS: Cover Preferences

- Preference analysis (linked to costs)
- 20% - 25% indicated GP requirement
- 15% indicated private hospital requirement
- 14% indicated comprehensive requirement
- Proposed plan
 - GP consultations
 - Basic radiology and pathology
 - Dental and Optometry
 - Formulary medications
 - Emergency transport
 - Maternity care and specialists optional
 - *No private hospital coverage*

LIMS: Impact of Tax Subsidies

- Assumptions
 - Affordability is 8% of household income
 - Direct subsidy of R50 per month
 - 50% employer subsidy
 - Premium R150 per beneficiary per month
- Increase in coverage: R3.6m lives

Additional lives covered ('000s)

	Premium = R200 per month			Premium = R150 per month		
	NT subsidy R0	NT subsidy R25	NT subsidy R50	NT subsidy R0	NT subsidy R25	NT subsidy R50
5%	1,549	1,601	1,848	1,848	1,848	3,166
8%	1,848	3,166	3,265	3,266	3,589	3,589
12%	3,265	3,589	3,589	3,589	5,136	5,252

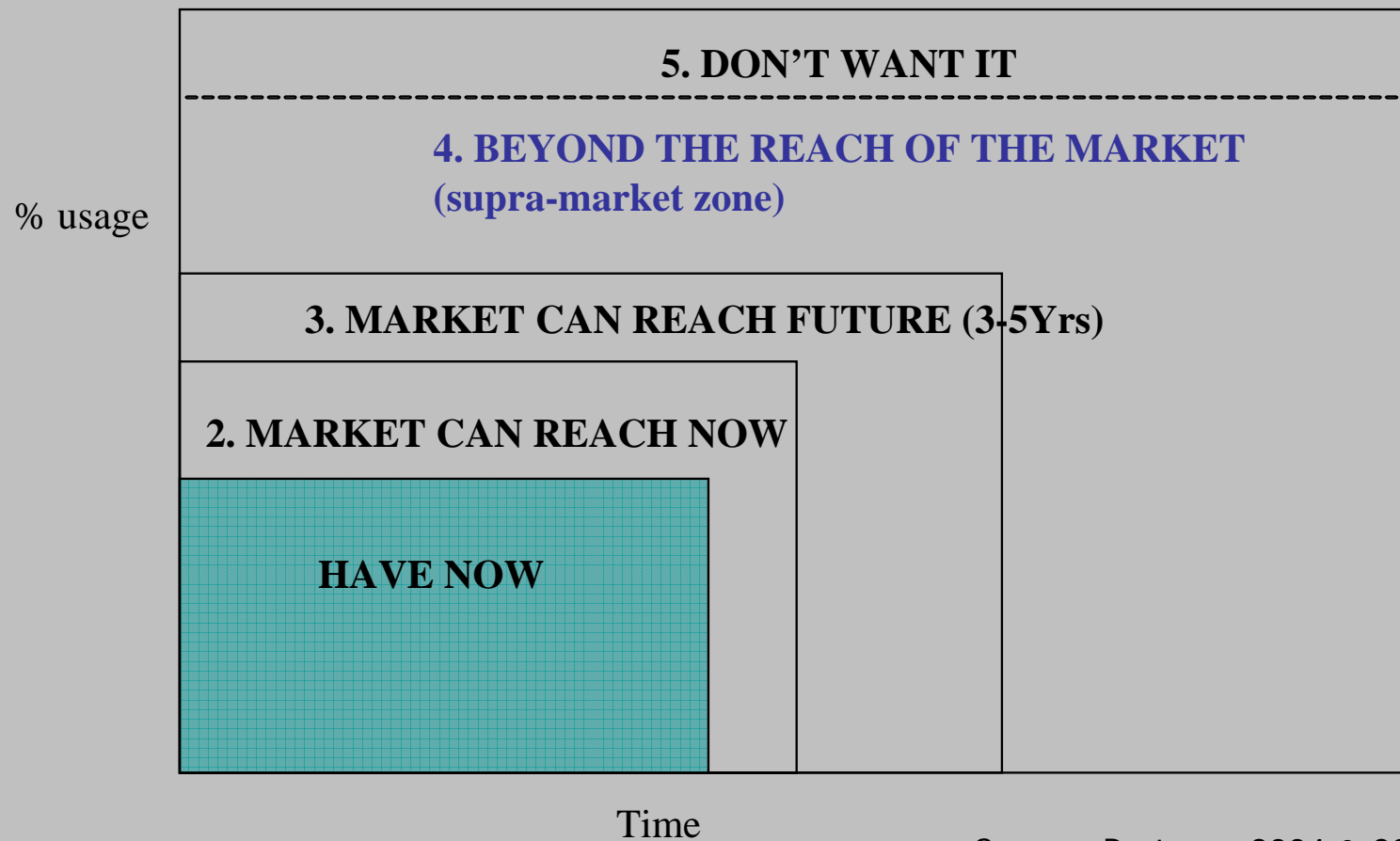
LIMS Recommendations

- Modification of medical scheme environment
- Differentiated minimum benefit package
- Protection of existing risk pool
- Buy-ups encouraged
- Urgent investigation required into legislative obstacles to emergence of cost effective integrated delivery models
 - HPCSA rules, guidelines, regulations
 - Scope of practice of various professions
- Engagement with trades unions and organised business on role in distribution

MMW4P Concepts

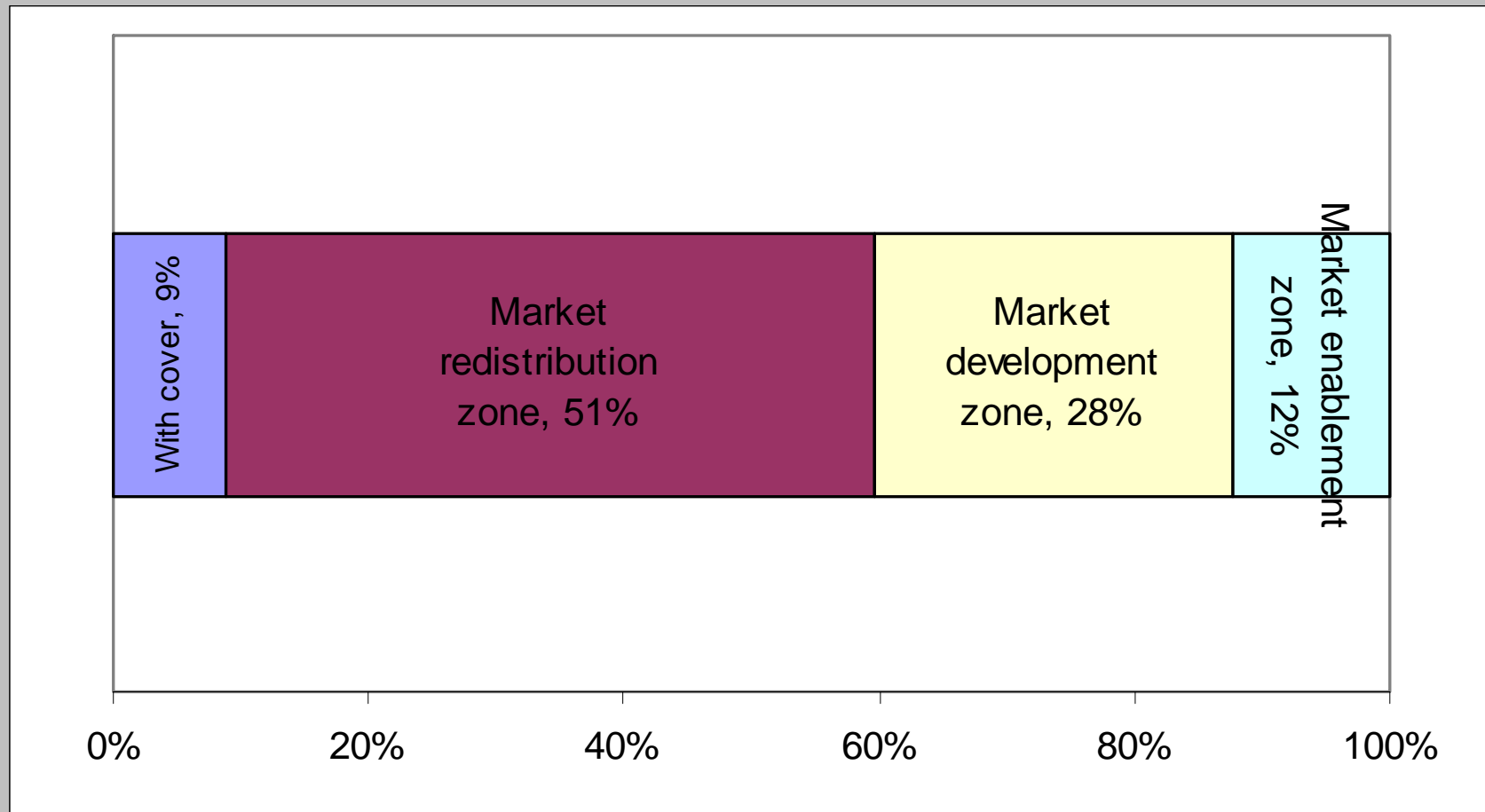
The Access Frontier:

The Access Frontier is defined as the “*maximum proportion of eligible consumers who presently have access to the product or service*”.



Source: Porteous 2004 & 2005 mimeo

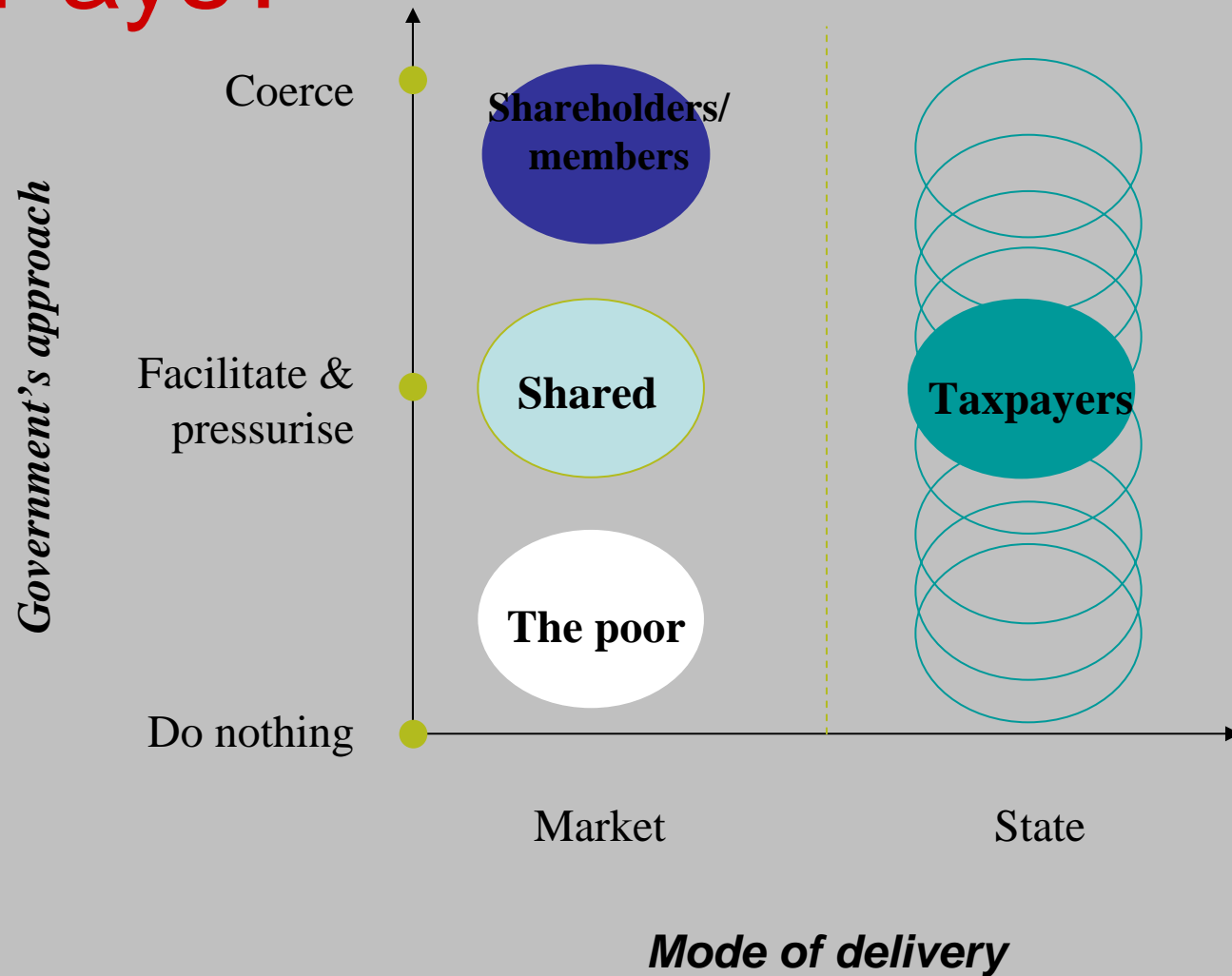
The Access Frontier



MMW4P

- Government's role:
 - Provision of service
 - Pay others to provide service
 - Transfer to consumers the means to buy service
 - Require existing providers to cross subsidise extension of service
 - *Create enabling environment*

Who Pays?



Enabling environment

- Appropriate vehicles for delivery
 - Mutual vs. for profit
 - Specialised vehicles (Alive+)
- Role of competition
 - Service providers
 - Funders
- Public/private partnerships
 - Existing points of access
 - Competition for hospitals
 - Additional revenue sources

Research Topics

- Supply of healthcare services
- Willingness to pay
- Funding of benefits
- Appropriate product design
- Funding vehicles
- Distribution mechanisms

What is the way forward?

- Consider regulatory role and structure
- Open architecture
 - Removes massive barriers to entry (eg does lack of reinsurance prevents new entrants?)
 - Facilitates rivalry, innovation and market expansion
 - BUT may be less stable AND
 - Requires a different role for state:
 - Leadership, coordination, facilitation, supervision