AN ASSESSMENT OF THE MEDICAL AID INDUSTRY IN BOTSWANA AND THE NEED FOR MEMBER PROTECTION

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ABSTRACT

Medical aid sits in the intersection between health care and finance. It provides an essential financial tool that enables better management of medical expenses. There is a tension between the need to fulfil public health objectives while ensuring the prudential regulation of financial institutions. Therefore, for medical aid services and products to provide sufficient financial protection, it is imperative that their markets are sound and safe for members, with a robust institutional framework of Medical Aid Funds (MAF) regulation and supervision. This paper wishes to add to the growing call for more effective regulation of medical aid funds. To this end, an assessment and analysis of the extent to which members are protected will be undertaken. There is an analysis of the prevailing regulatory environment for medical aid funds. The paper argues that medical aid is a product sui generis which requires specific regulation. It provides recommendations on how this regulation will be achieved.

1. INTRODUCTION

The most recent attempt to regulate the provision of Medial Aid has not resolved the challenges pertaining to their regulation. The state is aware of the regulatory quagmire of medical aids, which is evidenced by the various permutations in the regulation of Medical Aid.[1] Attempts to resolve this have consisted of defining it as a particular type of financial product, and tacking

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[1] The state has been aware of the issue of the fragmented regulation of MAF. The Ministries of Trade and Industry, Health and Finance have all claimed that they were not responsible for the licensing of medical aid schemes. There is some debate in the medical aid industry as to what role the Ministry of Finance and Development Planning, under which NBFIRA falls, should play in the regulation of private health-care provision. Online Editor, 'NBFIRA drafting regulatory framework to regulate Medical Aids' Sunday Standard (Gaborone, 19 January 2012). https://www.sundaystandard.info/nbfira-drafting-regulatory-framework-to-regulate-medical-aids/ accessed 20 September 2020; For example, in a letter dated October 28th 2011 from the Department of Health Services to the Botswana Dental Authority, it was stated that, 'While Medical Aid institutions deal with health-related matters, they are neither regulated by the Ministry of Health nor the Botswana Health Profession Council'.

on the existing regulation of that financial sector to regulate medical aid. In the current iteration of regulation, it is defined as a Fund, and the regulatory rules for funds apply to them. Section 2(1) of the Non-Bank Financial Institutions Regulatory Authority (NBFIRA) Act of 2023,[2] defines a Medical Aid Fund (MAF) as a scheme which provides cover for financial or other assistance to persons in connection with prescribed medical services. The regulation of medical aids has been narrowly focused on ensuring that they do not affect the broader financial markets.[3] Other aspects which pertain to the medical aids are regulated in a piecemeal fashion by various regulatory authorities.[4] This has inevitably led to gaps in regulation which have left the consumers of healthcare financing unprotected thereby impacting the healthcare sector. This paper explores the regulation of medical aid in six parts. Part one outlines the historical development of medical aid, and part two analyses the regulatory framework of MAFs. Part three explores the risks inherent in the provision of medical aid, followed by Part four which discusses the challenges of regulating MAFs using existing regulatory mechanisms. Part five is an exploration of the most suitable mechanism to regulate MAFs and part six is the conclusion.

2. HISTORICAL OVERVIEW OF MEDICAL AID FUNDS

The development of medical aid in Botswana followed a similar trajectory as the provision of private health care in post-colonial Africa.[5] Upon gaining independence, the government intervened directly in the financing of the provision of healthcare. The delivery of public healthcare is taxpayer funded, and is largely free.[6] In instances where payment is made at the point of service, these are minimum sums which are not meant to ensure cost recovery, and have no bearing on the condition being treated. The state did not oppose the introduction of private healthcare, which was largely regarded as playing a role of reducing the burden on the

[2] Non-Banking Financial Institutions Regulatory Authority Act 2023.
[3] This is evident in the vision and mission statement of NBFIRA which is 'To regulate and supervise Non-Bank Financial Institutions for the purpose of contributing towards financial stability' see https://www.nbfira.org.bw/vision-and-mission#:~:text=To%20regulate%20and%20supervise%20Non,of%20contributing%20towards%20financial%20stability accessed 5 November 2023.
[4] The regulatory authorities include the Ministry of Health, the Non-Banking Financial Institutions Regulatory Authority, Botswana Health Professions. Council and the Competition and Consumer Authority.
[5] Noel Soderlund and Salani Khosa, 'The potential role of risk equalization mechanisms in health insurance: the case of South Africa'(1997) 12 (4) *Health Policy and Planning* 341.
[6] Olusola Ogunseye, 'Analysis of the Health Financing Structure of Botswana' (2020)7 *Health Systems and Policy Research* 1 DOI: 10.21767/2254-9137.100108.

taxpayer funded healthcare system.[7] Soon thereafter, subscription-based schemes to finance access to private healthcare, known as medical aid began to emerge.[8] They came into existence since 1969, with the establishment of BOMAID, and have since increased in number, size and power. [9] However, the availability of private healthcare does not oust the state's responsibility to members of medical aids, as they also rely on the taxpayer funded public healthcare system.

The early models of subscription-based healthcare financing were established by mutual not for profit business associations, known as medical aid societies, wherein the members are also owners.[10] As such, a large number of these are registered in terms of the Societies Act.[11] This has led to the subscribers being referred to as 'members' of a scheme. This wording has extended to refer to all subscribers of all schemes, including those which are not community based.[12] Other medical aids are incorporated in terms of Trust Property Control Act of 2022 or the Companies Act (Chapter 42;01). Incorporation gives medical aid schemes legal personality, and the legal framework which determines their regulation and the level of member participation. The business association creates a scheme, which is responsible for maintaining

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[7] Oathokwa Nkomazana, 'A Healthcare Case Study from Botswana, Africa' in VI Lakshmanan et al (eds) *Smart Villages*. (Springer 2022) doi.org/10.1007/978-3-030-68458-7_23.

[8] Soderlund (n 5).

[9] There are currently five medical aid funds in operation within the country. These include the establishment Botswana Public Officers' Medical Aid Scheme (BPOMAS) in 1990, Pula Medical Aid Fund (PulaMed) in 1991, Botsogo Health Plan in 2005 and Doctors (Pty) Ltd t/a Doctors Aid Medical Aid Scheme in 2010. Non-Bank Financial Institutions Regulatory Authority, 'Medical Aid Funds'< https://www.nbfira.org.bw/medical-aid-funds> accessed 3 April 2024; Established in 1990, BPOMAS has more than 87 00 principals clients close to 200 000 lives covered and has been a key player in providing medical aid cover to its members, offering comprehensive support from birth to the unfortunate event of death, where funeral cover is provided. <https://thevoicebw.com/dawn-of-a-new-era-3/#google_vignette accessed 3 April 2024; MAS in Botswana regard themselves as a sector, and within the region MAS have regional organisation to facilitate their cooperation and self reguation. It is the Board of Healthcare Funders of Southern African (BHF), which is a representative organisation for medical schemes in Botswana, eSwatini, Lesotho, Namibia, South Africa, Zambia and Zimbabwe. This is an organisation that provides relevant, up-to-date information, engages with government on behalf of medical schemes and provides services to the industry see https://bhfglobal.com/ accessed 3 April 2024.

[10] Soderlund (n 5).

[11] There are restrictions for unincorporated societies, with more than 20 members, as these are legally required to incorporated. See Section 515(1) of the Companies Act (Chapter 42:01) which provides as follows '(1) No company, association, syndicate or partnership consisting of more than 20 persons shall be formed in Botswana for the purpose of carrying on any business that has for its object the acquisition of gain by the company, association, syndicate or partnership, or by the individual members thereof, unless it is registered as a company under this Act or is formed in pursuance of some other law.' As such, a number of Medical Aid Funds and they are primarily incorporated in terms of the Societies Act of 2022. Incorporation in terms of the Societies Act of 2022 is preferred by those seeking to establish not for profit associations for mutual benefit.

[12] Charles Hongoro, and Lilani Kumaranayake, 'Do They Work? Regulating for-Profit Providers in Zimbabwe' (2000) 15(4) *Health Policy and Planning* 368.

membership and collecting subscriptions.[13] The subscriptions collected by the scheme, are placed into a Fund, which is either managed by the scheme, or its management is subcontracted to separate organisations known as fund administrators.[14]

3. REGULATORY FRAMEWORK

The business relations of MAF are multifaceted as seen through relationships with its members, health practitioners, other MAFs and the various regulatory authorities. Their business relationships are largely governed by contract law, with a limited interface with the regulatory authorities. The principles of freedom to contract and the sanctity of contracts are accepted. [15] Fortunately, there has been statutory intervention to blunt the extremes in contract law, to prevent the abuse of power in contractual relations, through the Consumer Protection Act and the Competition Act.[16] The primary regulatory authority is the one established for the non-bank financial sector known as Non-Bank Financial Institutions Regulatory Authority (NBFIRA). The Ministry of Health regulates healthcare providers which medical aids may use by standard setting, through registration and licensing requirements for healthcare providers and healthcare

[13] Di McIntyre et al 'Commercialisation and extreme inequality in health: The policy challenges in South Africa' (2006) 18 *Journal of International Development* 435.

[14] Mario Peter Da Costa, 'Using Outsourcing as a Competitive Edge: the Case of Medical Aid Schemes' (2018) *International Journal of Management Science and Business Administration 23* DOI: 10.18775/ijmsba.1849-5664-5419.2014.51.1003.

[15] These agreements are entered to in a manner similar to insurance contracts, wherein the persons seeking medical aid complete a proposal form, and are the offeror. This offer is accepted by the MAF, whereafter the member is required to pay subscriptions. In this process, the prospective member has limited leverage and ability to negotiate the standard form contract and the contract is accepted as is. Therefore, all pertinent contract rules emerge with respect to it. That is, offer and acceptance, terms and performance, and breach, A regular proposal form of medical aid cover, for example, would include questions pertinent to the risk sought to be insured (that is, risk of contracting illness, disease, or death), age of the Applicant, knowledge of any known conditions or diseases (such as high blood pressure or diabetes), whether the applicant is currently taking any medication and for what, type of job profile of the applicant, and so forth. Upon completion of the said form (the offer), it is typical for the MAF to accept it, after providing the terms of the policy, including the premium to be charged. see Arhum Tariq Rafi, 'An Insurance Contract- A Sui Generis Contract?' (Courting the Law, 8 September 2017) <https://courtingthelaw.com> accessed 5 October 2020; Section 55(1), Insurance Industry Act, 2015.

[16] The Consumer Protection Act is aimed at protecting the interests of consumers by regulating unfair business practices. These are business practices which, directly or indirectly, have or are likely to unfairly affect any consumer. A forum for dispute resolution for aggrieved consumers to lodge complaints for contravention of the Act is also provided. The Competition Act regulates the competition environment and business conduct, to restrain anti-competitive behaviour which may affect the business environment. See *Botswana Medical Aid Society v Competition and Consumer Authority CACGB-254-22 and Botswana Medical Aid Society v Competition and Consumer Authority MAHGB-000040-21*.

facilities.[17] There is tension pertaining to the quality and depth of the regulation of MAF.[18] Presently, there are no specific entry requirements to become a provider of medical aid services. Once in business, the financial products offered by MAF are largely self-regulated, as there are no mechanisms to ensure that these financial products fulfil the promised goals, to the consumers.[19]

A critical aspect of freedom of contract is the ability to choose the persons that one enters into the contract with. Therefore, medical aids choose their members and service providers. This has an effect on the profitability and competition of the healthcare market. The ability of MAF to select their members is contentious given that the type of services which MAFs provide are largely regarded as a commodities and essential services. This opens up the conversation on discrimination. Membership selection differs depending on whether it is a closed or open scheme. Closed schemes have specific qualifying criteria, usually based on their place of work, profession and industry, whereas open schemes have enrolment which is open to all members of the public who can afford to pay subscriptions.[20] Membership discrimination in closed schemes is not an issue as employers and professions are permitted to provide benefits solely for their employees and members. Discrimination on membership selection is an issue for open schemes, whose membership is open to the public. Due to the nature of their business, there is the risk of discrimination occurring based on the age, health condition or other factor.[21] People with poorer health conditions are generally more expensive to treat, and would be a drain on the resources of the MAF.

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[17] Lilian Kamaranayake et al 'How do countries regulate the health sector? Evidence form Tanzania and Zimbabwe' (2000) 15(4) *Health Policy and Planning* 357; This is done through legislation such as the Public Health Act and the Botswana Health Professions Act, monitors both the public and private healthcare service providers.

[18] Hongoro (n 12).

[19] There has always been a reluctance to regulation financial products to ensure that they fulfil their stated goals as evidenced by the states refusal to regulate insurance.

[20] Profmed, 'The Difference Between Open and Closed Medical Schemes' (5 July 2019) <https://profmed.co.za/the-difference-between-open-and-closed-medical-schemes/> accessed 8 April 2023 BPOMAS is a closed Scheme, which provides medical aid cover to public service employees as well as employees of parastatals (that were previously Government departments) who opt to remain members of the Scheme <https://www.bpomas.co.bw/?q=our-profile> accessed 8 April 2023.

[21] Soderlund (n 5).

3.1 Relationship between Medical Aid Funds and the healthcare sector

The MAF can only enter into healthcare service agreements with persons that are registered and licensed by the Ministry of Health. The Ministry of Health regulates by standard setting, and one of the standards set was the Essential Health Service Package (EHSP) whose overall goal is the attainment of universal coverage of high-quality essential health services.[22] The purpose of the EHSP is to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities.[23] It falls short of giving specific requirements for MAFs to provide designated services to their members in terms of their contracts. In their relationship with the private healthcare sector, MAFs are an essential financial lifeline for healthcare practitioners as most people cannot afford private healthcare.[24] This gives them a disproportionate influence on the shape of the industry. In this relationship, MAFs coordinate with each other and act as a collective. MAFs establish framework agreements through their administrators, or the individual MAFs create their own agreements. The framework agreements are entered into with the associations which represent members of that medical profession in private practice. These agreements outline the services which MAFs provide, the tariffs, and how these payments are made. To access the benefits of the framework agreements, the individual healthcare providers need to be registered with the MAFs. Due to freedom of contract, MAFs have the discretion to choose who to admit to their network, and they do not have to accept all registered healthcare practitioners.[25] These healthcare providers which are not on the list of prescribed health services cannot be paid by MAFs for clients that are members of MAFs. This leverage allows MAFs to shape the industry through the choice of healthcare provider and the treatment which members may use.

3.2 Financial regulation of MAF

[22] Ministry of Health, 'The Essential Health Service Package for Botswana' (March 2010) 13.
[23] Ibid.
[24] Jane E Doherty 'Regulating the for profit health sector: lessons from East and Southern Africa' (2015) *Health Policy and Planning* 93.
[25] See list of approved healthcare service providers under PulaMed https://pulamed.co.bw/providers; See list of approved healthcare service providers under BoMAid < https://www.bomaid.co.bw/service-providers/> accessed 6 September 2023.

MAF have been designated as a non-bank financial institution and need to comply with the requirements of the NBFIRA Act. This Act regulates MAF, solely as a financial services provider.[26] As Funds, their regulatory regime is no different from other Funds[27] regulated under the NBFIRA Act.[28]. The regulatory framework governing Funds is not overly detailed, and there is a lack of publicly accessible information regarding the solvency of MAFs.[29] NBFIRA is aware of these deficiencies, and has tried to cure them by encouraging MAFs to comply with the prudential rules which are applicable to insurance. These include requirements for actuarial assessments to monitor their risk exposure from membership, claims and investment risks is not surprising as MAF were once regulated as insurance. This lack of detailed regulation leads to the possibility of default and the funds not meeting their long-term obligations to their members.[30] A notable instance is exemplified by Symphony Health Trust, which, in the absence of a Board of Trustees, found itself incapable or otherwise unable to fulfil its designated functions and objectives.[31]

Their relationship with the public health sector is tenuous, with controversy on whether MAF should contribute to the cost of treatment when their members use public facilities.[32] On the one hand, the state is required to provide healthcare services to all citizens, on the other hand the MAF would have paid for healthcare had these services been accessed at private facilities. This is further complicated by MAF routinely dumping their customers on the public healthcare

[26] The regulatory authority responsible for implementing this Act is NBFIRA, which was established in 2008 to oversee the licensing and regulation of all non-banking financial institutions, including MAF.

[27] Retirement Funds Act, 2022, which is an Act to provide for the continuation of licensing, regulation and administration of all retirement funds, including pension and provident funds, funds administrators; and for matters incidental to or connected therewith.

[28]Section 5(2)(d), NBFIRA Act, 2023; David Llewelyn, 'Institutional Structure of Financial Regulation: The Basic Issues' (World Bank and IMF Conference Aligning Supervisory Structures with Country Needs, Washington DC 6-7 June 2006) <https://www.researchgate.net/publication/255585648> accessed 9 September 2020; International Association of Insurance Supervisors (IAIS), 'Issues Papers on Group- wide Solvency Assessment and Supervision' (Basel, 2009), 17.

[29] Keith Jefferis and others (n 6) 175.

[30] Non-Bank Financial Institutions Regulatory Authority, 'Symphony Health Trust – Termination and Transfer of Membership' (Public Notice, 18 April 2018) <www.nbfira.org.bw/regulated-entities-list> accessed 9 September 2020.

[31]It was placed under curatorship pursuant to a court order issued by the High Court on 21 December 2017. On February 20, 2018, the Curator, pursuant to a resolution passed by the beneficiaries (members) of Symphony Health Trust at a Special General Meeting on February 19, 2018, issued an invitation for proposals. This invitation sought submissions from suitably qualified and experienced medical aid schemes or analogous entities registered and operating within Botswana for the acquisition and administration of Symphony Health Trust.

[32] Doherty (n 24).

system.[33] This creates tension as they are contractually required to provide their members with private healthcare, which tends to be more luxurious. Interestingly, there is limited regulation to frame their relationship pertaining to the use of public healthcare facilities, by members of MAF. Their financial relationship with the public healthcare system needs to be clarified.

4 RISKS AND MORAL HAZARD IN HEALTHCARE FUNDING

The provision of subscription based healthcare is subject to inherent systemic risks posed by members, administrators, and service providers.[34] Members pose a moral hazard as they receive services without paying at the point of service, there is the potential of a moral hazard by the members. The administrators pose a prudential risk through the agency problem, which arises whenever a business is managed by professionals who are not the owners. The administrators pose a moral risk in that the sums of the fund may be skimmed, in the form of administration fees which deprives the members of the MAFs from receiving adequate benefit from their membership. There is also the moral hazard in the opportunistic behaviour by service providers.[35] The seemingly "unlimited funds" of the MAFs, give rise to opportunistic behaviour on the part of healthcare providers. Members of MAFs are susceptible to being over treated, and often the most expensive treatment options are recommended, when cheaper alternatives are available. All these risks have a direct impact on the costs of providing healthcare and the ability of MAFs to remain solvent. These need to be regulated to limit the impact of these moral hazards on MAFs on the broader health sector. This adds to the strain in the healthcare system, as when MAFs fail to meet their obligations, the members are off loaded onto the public healthcare system. It also defeats the purpose of medical aid, which in part is to reduce pressure on the public healthcare system and to provide their members with a respite from the underfunded public healthcare system.

MAFs have a fiduciary duty to remain solvent, and ensure that funds are not exhausted in order to fulfil their long-term obligations. To achieve this, the MAFs have sought to mitigate

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[33] Ciara Staunton, Carmen Swanepoel and Melodie Labuschaigne, 'Between a rock and a hard place: Covid 19 and South Africas response' (2020) *Journal of Law and the Biosciences* 1.
[34] Soderlund (n 5).
[35] Ernest Moloi, 'KPMG damns Medical Aid Funds' *Botswana Guardian* (Gaborone, 31 July 2013) <http://www.botswanaguardian.co.bw> accessed 9 September 2020; Catarina Goulão and Julian Perelman, 'Interactions between Public and Private Providers' in A. Culyer (ed.) *Encyclopedia of Health Economics* (2014) DOI 10.1016/B978-0-12-375678-7.01317-1.

the risks which arise from these systemic issues through the incorporation of provisions in their contracts which limit their effect.[36] The risks which MAFs are exposed to are self-regulated through their contracts. [37] In these contracts, MAFs dictate the terms since the power dynamic is skewered in their favour. The contracting parties often lack comprehensive knowledge regarding the risk categories and the evaluative criteria utilized by the MAFs in determining the extent of coverage. They also encounter significant challenges in independently acquiring this information due to the specialized nature of medical aid, coupled with a generally limited comprehension of the foundational aspects of medical aid coverage among consumers. The measures used to remain solvent range from excluding persons from membership, restricting access to benefits and financial criteria.[38] These measures used include premium differentiation for different tiers of membership, maximum benefit limits, financial contribution at the point of service (co-payment), and pre-qualification conditions to access benefits.[39]

Open and closed schemes present different prudential risks which relate to their administration and the pricing of their products. Closed schemes are typically self-administered and are managed internally by employees of the scheme. The said schemes also face a prudential risk of the funds collected being diverted to fulfil other business needs of the organisation. This

[36] On July 19 2023, BOMAID announced to its members that it will now be limiting the amount of visits allowed to GP's and Specialists to a specific number per specific cover per year, i.e if you are part of their Comprehensive Plus Health Plan "you are entitled to a standard 5 General Practitioner beneficiary visits per year and 2 specialist visits.". The rest of the visits that a member will take will be covered by them 100% unless otherwise negotiated with the medical aid provider. https://www.bomaid.co.bw/2023-benefit-booklet/ accessed 23 August 2023.

[37] Once received by the member, the agreement, which is usually contained in the MAF Book of Rules, is seldom read and almost never fully understood. However, the peculiarities of MAF make it undesirable to leave these contracts in the realm of the common law for insurance. Insurance Industry Act, 2015. Insurance Industry Regulations, 2019, International Insurance Act, 2005. International Insurance Regulations, 2007 the Insurance Industry Regulations the International Insurance Act, and the International Insurance Regulations. The insurance industry in Botswana is well developed and has grown significantly since independence. The contribution of the insurance sector to the economy in 2018 remained constant at 3.5% as the increase in total gross written premiums grew to P5.4bn in 2018 from P5bn in 2017. Botswana has twenty insurance companies, out of which thirteen are non-life insurers and reinsurers, and seven are life insurers. See also Franklin M Schultz 'The Special Nature of the Insurance Contract: A Few Suggestions for Further Study' 1950 15(3) Law and Contemporary Problems 376, 377

[38] See BPOMAS Rule Book effective 1 April 2023 https://www.bpomas.co.bw/sites/default/files/Rule%20Book%20Review_Clean%20Version_Approved.pdf accessed 23 August 2023; BoMaid Book of Rules established 1 November 1970 and revised in 2004 https://bomaid.co.bw/wp-content/uploads/2016/09/Bomaid-Book-of-Rules.pdf accessed 23 August 2023.

[39] See BPOMAS Benefit Guide 2023/2024; https://www.bpomas.co.bw/sites/default/files/BENEFIT-GUIDE.pdf accessed 23 August 2023; Alexander Marius Van den Heever, 'Private Sector Health Reform in South Africa' (1998) Health Economics 281.

risk is similar to that faced by in-house pension funds, which was regulated by the Retirement Funds Act.[40] However, some are administered by third-party, for-profit companies known as fund administrators.[41] Those which have external fund administrators suffer from the same prudential risk as open schemes. The fund administrators are in charge of the credit control function, claims, membership, and financial management. There is little control of the prices charged by commercial administrators which leaves opportunity for overcharging, and may extract profit in non-profit schemes. Ideally in non-profit schemes, any surplus is ploughed back into the plan for the benefit of the members. The pricing of medical aid products poses a solvency risk for the Funds. Closed schemes are more likely to be financially solvent, as their membership is guaranteed, the subscriptions they collect tend to be income based, and often involve income related cross subsidies from richer to poorer members. Therefore, they do not have to compete on the basis of lower premiums.[42] Some open schemes compete on lower premiums, which may lead to a solvency risk and the possibility that the products sold may not fulfil the stated coverage. When they compete in terms of price; there is a risk that their subscriptions may be set artificially low to attract members. Therefore, there is the possibility of the sale of financial products which do not fulfil the stated coverage. This could have an impact on their solvency and their ability to fulfil their obligations to their members.

[40] Retirement Funds Act, 2022; see also Katarzyna Romaniuk, 'Pension insurance schemes and moral hazard: The Pension Benefit Guaranty Corporation should restrict the insured pension plans portfolio policy' (2021) 82 *The Quarterly Review of Economics and Finance* 37; Cadoni, Marinella, Roberta Melis, and Alessandro Trudda, 'Pension funds rules: Paradoxes in risk control' (2017) *Finance research letters* 20.

[41] While open schemes can be self-administered, it is common for them to outsource administration to specialized firms, which can provide professional management services, regulatory compliance, and administrative efficiency. For instance, Pula Medical Aid Fund, which is a private-open scheme, is administered by Associated Fund Administrators Botswana (AFA) (Pty) Ltd. However, BPOMAS is administered by a separate legal entity known as Health Risk Management Botswana (HRMB). BPOMAS was previously administered by Associated Fund Administrators Botswana (AFA) until 1 July 2023. Further, Section 2(1), NBFIRA Act, 2023: Medical Aid Fund Administrator means a body corporate that provides administration or similar services to a medical aid fund in terms of an administration agreement and which has been licensed as such by the Regulatory Authority. AFA 'Medical Aid Fund Administration' https://www.afa.co.bw/index.php/medical-aid-fund-administration accessed 23 August 2023.

[42] Van den Heever (n 39).

4.1 Financial measures to control risk

MAFs use financial measures in their contracts to reign in the moral hazards which arise from the provision of subscription-based healthcare services.[43] These include requirements that members contribute financially at the point of service, membership tiers and benefit limits. Contributions at the point of service take the form of co-payments, balance billing and indirect billing.[44] These may be used individually or in combination, allowing for various permutations. Co-payments require members of MAFs to pay a percentage of the price, whenever they access health care. Balance billing occurs where MAFs set a reference price for professional services and goods such as medication. In instances where the prices set by the practitioners are higher, the difference is paid by the member of the MAF. When balance billing is used, the MAF members pay both the co-payment and difference between the reference price and the service providers' price. Often, members are unaware of the difference between co-payment and balance billing, as they both require payment at the point of service. Indirect billing occurs when MAF members pay directly to the service providers, and are then reimbursed the reference price for that service by the MAFs.[45] The standard practice is that MAFs pay service providers directly, and indirect billing is an exception to the rule. This also has the effect of shaping the health service industry by determining which services are more readily accessible to the members.[46] These measures are an effective tool as they reduce the inappropriate utilization of healthcare services.[47] The use of financial incentives to limit the abuse of benefits is controversial and has led to tension between MAFs, their members and the service providers.[48] These financial measures assume that all use is abusive and does not provide any basic care standards which need to be provided without financial contribution at the point of service by members. If the members do not have money to contribute, they are forced to use the public

[43] Myung Ja Kim and Eunhee Lee, 'How to reduce excessive use of the health care service in Medical Aid beneficiaries: Effectiveness of community-based case management' (2020) *International Journal of Environmental Research and Public Health* 2503.
[44] Van den Heever (n 39).
[45] Richard Laing, Ntobeko M. Mpanza, and Hazel Bradley, 'Reasons why insured consumers co-pay for medicines at retail pharmacies in Pretoria, South Africa' (2019) *African Journal of Primary Health Care and Family Medicine* 1.
[46] Therese Fish and Shivani Ranchod Ramjee, 'Unaffordable medical scheme contributions: A barrier to access to private health cover in South Africa' (2007) *South African Journal of Business Management* 29.
[47] Josh Kaplan and Ranchod Shivani, 'Analysing the structure and nature of medical scheme benefit design in South Africa' (2014) *South African health review* 165; Kim (n 43).
[48] Innocent Selatlhwa, 'Sidilega, Bomaid Relationship on Sickbed' *MmegiOnline* (Gaborone, 17 October 2022) <https://www.mmegi.bw/news/sidilega-bomaid-relationship-on-sickbed/news> accessed 20 June 2024.

health sector. Service providers argue that the use of reference prices in balance billing and indirect billing is a punitive tool against service providers whenever there are disagreements about prices between them and the MAF. Healthcare service providers believe that these measures are used to force them to accept lower prices, since MAF are the largest funders of private healthcare.

4.2 Aligning benefits with contribution

There are four measures used to align benefits with contribution in an effort to maintain the solvency of MAFs. These include waiting periods, membership ties, benefit limits and restrictions on access to specialist treatment. Waiting periods are delays in timelines to access benefits, these are meant to deter persons from only seeking membership of MAFs when they want treatment for specific health conditions, and then leave (anti-selective behaviour). These persons drive up costs as they would access benefits without contributing to the fund.[49] The implementation of delays in timelines also varies between new members and existing members transferring from another MAFs. It is normally applied to new members of MAFs, and existing members transferring from another scheme are exempted from these waiting periods. The delays in timelines are not regulated by legislation and there are no maximum time limits for waiting periods.

Premium differentiation is used by MAFs to establish different tiers of membership based on cost, which provide varying levels of access to health benefits.[50] These pertain to varying levels of maximum benefit limits, and access to specialist services. Maximum benefit limits are the maximum amount which MAFs may pay towards a members medical costs.[51] The limits often refer to a calendar year, but for some services the limits may extend to periods which span two to three years or a lifetime.[52] Once this limit is exceeded, the individual may pay out of pocket or is transferred to the public sector. The benefit limits also extend to restrictions for access to specialist services through requirements for authorisation prior to use.[53]

[49] Laing (n 45).
[50] ibid n-16, n-17
[51] Van den Heever (n 39).
[52] Fish (n 46).
[53] In many instances, specialists can only be accessed after recommendation by a general practitioner. Access to some specialists' services may require additional direct authorization by the MAF. The restrictions on direct access, ensure that there is no direct access, and there is vetting to determine whether the service is necessary for that member. Kaplan (n 47).

For some services, members of MAFs are referred to the public health sector for access to specialist services. The use of maximum benefit amounts is controversial as these sums are arrived at unilaterally by the MAFs and they are not individualized. They apply to all members of the tier without an investigation of the health status of the individual member. MAFs argue that these benefit limits serve as incentives for members and healthcare practitioners to be more economical in their treatment.[54] These measures create a risk that members may be vulnerable to the possibility of not having coverage for essential healthcare.[55] In many instances, members of MAFs only find out that their coverage has been exhausted when it runs out. It has also been argued that the use of these arbitrary financial limits is an abdication of the MAFs responsibility for the oversight of patients. However, it is questionable whether the role of MAFs extends to individual patient oversight as they are just the financiers of healthcare. MAFs argue that these sums are not set arbitrarily, which is evidenced by the fact that these are rarely exhausted.[56] It is also argued that the use of benefit limits is a trade-off for community rating, since all members contributed the same amount without reference to their specific health conditions.

4.3 Direct provision of services

The direct provision of services by MAFs is a measure which seeks to manage financial risks, while ensuring that members receive healthcare services. Due to economics of scale, MAFs can provide services at a cost much lower than private practitioners providing the same service.[57] This creates tension between the needs of members, and the financial needs of medical professionals. MAFs contend that focus should be on making healthcare accessible for members of MAFs and not on the financial viability of the medical profession in private practice. The direct provision services by MAFs removes the requirement, for maximum benefit limits, co-payment and balance billing, which makes services cheaper for members.[58] The issue of direct provision of healthcare is tied to broader questions of whether the provision of healthcare is a profession or a business. If it is a profession, the provision of services should be restricted to members of the profession. However, it is a business, anyone should be allowed to open the

[54] As an incentive for private hospitals to be more economical and avoid over treating by discharging patients that do not require further hospitalization. Laing (n 45).
[55] Fish (n 46).
[56] Though this cannot be independently verified.
[57] Da Costa (n 14).
[58] Laing (n 45).

business and employ members of the profession as employees to provide the services, which MAFs are permitted to do. Since the provision of medical services is a business and other business operations are allowed to provide healthcare services, this conversation should not be restricted to MAFs. By providing these services cheaply MAFs reduce pressure on the public health system, by making these services available to members that would otherwise use the public system. It is unclear whether medical aids should be allowed to extend these services for a fee to non-members due to competition law issues.

5. CHALLENGES IN USING THE EXISTING REGULATORY FRAMEWORK TO REGULATE MAF

The regulation of medical aid has been limited to using existing regulatory frameworks with varying levels of success. The most comprehensive regulation occurred during the short stint when medical aid was defined and regulated as insurance, in terms of Section 2 of the repealed NBFIRA Act of 2007. This designation as insurance was not unexpected as MAFs, share a number of similarities with insurance. An argument can be sustained that MAF are a species of insurance, for in terms of the common law, the services provided by MAF fulfil the requirements of a contract of insurance. MAF share the *essentialia* of insurance because, in exchange for the payment of subscriptions, the insurers pay for the medical costs.[59] The regulation of the insurance industry is primarily aimed at ensuring the financial soundness of the industry, but does not regulate the quality of the product sold.[60] To date NBFIRA still relies on insurance law to regulate MAF, and sends circulars of dubious legal authority encouraging MAF to comply with the regulatory rules established for insurance.[61]

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[59] This was illustrated in the judgment in *Thomson* v *Thomson* where it was stated that a medical aid scheme is, if not in law then in substance, a form of insurance. They point to the fact that similar to insurance, one pays a premium against which there may be no claim, or claims less than the value of the premiums, or claims which far exceed the value of the premiums. This has also be confirmed in other cases, such as in D'Ambrosi v Bane and others, where it was stated that medical aid is no different from any other form of insurance which offers cover against injury or damage in return for premium payments. Thus judicial authority is that medical aid schemes are a form of insurance See Schedules 1and 2 of Insurance Industry Act, 2015; D'Ambrosi v Bane and others (2007) 1 ALL SA 570 (C).

[60] World Bank and International Monetary Fund (IMF), *Financial Sector Assessment, A Handbook* (Washington, 2005) 173 <https://worldbank.org> accessed on 5 October 2020.

[61] In practice, MAF incorporate the common law *naturalia* of insurance contracts, into their contracts. These principles are that these are contracts of utmost good faith, and that the insurer is only liable to the extent of the four corners of the contract. The concept was famously codified by Lord Mansfield in *Carter* v *Boehm* (1766) 3 Burr 1905 where he established that an insurance contract is a contract of utmost good faith. A breach of this duty

The regulation of MAF as insurance is not peculiar to Botswana, as some states within the region regulate it as such.[62] While MAF can be said to be a species of insurance, there are sufficient differences to justify its classification as being a district type of contract.[63] The main difference was tied to the fact that MAFs contribute to the fulfilment of social goals, specifically access to healthcare.[64] It is also regarded as a commodity my members.[65] This is further exacerbated by the fact that insurance legislation does not regulate the quality of services which insurers provided, and by extension the quality of medical aid products was also not regulated.[66] Arguments persist that medical aid requires more than prudential regulation, and should be expanded to ensure the fulfilment of public health goals.[67] This requires improved regulation of the products to ensure that they provide basic minimum health services.[68] More robust regulation of the medical aid industry is required to preserve the integrity of both the financial markets and the health sector.

6. LEGISLATIVE PROTECTION OF MEMBERS OF MAF

Comprehensive protection of members of medical aids requires effective regulation of MAFs to address the systemic issues affecting MAFs and not leave these in the realm of contract.[69]

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by one party entitles the other party to avoid the contract. Burch J in *Pfiester* v *Missouri State Life Insurance Company* 85 Kan. 97 (1911) stated that insurance contracts are *sui generis*, and the rules of a legal system devised to govern the formation of ordinary contracts cannot be mechanically applied to them.

[62] See Schedules 1and 2 of Insurance Industry Act, 2015; With the exception of South Africa, Namibia and Zimbabwe, which have specific acts which regulate the conduct of MAF; The history of medical schemes in South Africa began in 1889 and their status was formalized initially under the Friendly Societies Act (No.25 of 1956) and later the Medical Schemes Act (No. 72 of 1967). The Act was repealed and replaced by the Medical Schemes Act (No. 131 of 1998). (*Department of Social Development. Transforming the Present-Protecting the Future: Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa; March 2002*); Heather McLeod and Shivani Ramjee, 'Medical schemes: pooling of resources and purchasing of health care' 2007 1 South African Health Review 47. Chris Bateman, 'Medical aid system: Change way overdue' 2012 102(3) South African Medical Journal 118-120. 21 of these medical schemes are open to the public and 59 are restricted medical schemes, mostly offered by big companies exclusively for the benefit of their employees South Africa, as the biggest economy has the largest number of MAS in the region with 82 medical schemes with approximately 8.88 million members

[63] There are several characteristics which set MAF apart from other insurance contracts, being that they are viewed as commodities, occupy a distinct role in society and they provide an essential service. Mayank Mishra, 'Locating the role of altering nature of public healthcare as a'commodity'in a market society" (2023) *International Journal of Human Rights and Constitutional Studies* 147.

[64] Kamaranayake (n 11).

[65] Mishra (n 63).

[66] Hongoro (n 12).

[67] Doherty (n 24).

[68] Thabo Fiona Khumalo, 'A Critical Examination of Developments in the Regulation of the Insurance Industry in Botswana' (2016) 23 *University of Botswana Law Journal* 180.

[69] McIntyre (n 13)..

MAF occupy a unique role in society as they straddle the space between financial services and the provision of healthcare. These two aspects are inseparable for MAFs to fulfil their role in facilitating the provision of private healthcare. While MAFs are recognised as an economic sector, it is also necessary for it to be legally regarded as a sector. In the region some states legally regard medical aid as a sector, and have designated legislation and regulatory authorities which are specifically responsible for regulating medical aid.[70] The regulatory bodies established by the state set minimum health standards, supervise private health financing by medical schemes, interpret the laws and provide a forum for all the parties in the healthcare industry to interact.[71] Such comprehensive regulation requires the active involvement of the Ministry of Health as they have the necessary capacity to align them with the healthcare goals of the state.[72] Having the nexus of regulation at the Ministry of Health ensures that MAFs contribute to the collective good by assisting in the fulfilment of the healthcare goals of the state, by lessening the burden on the state.

6.1 Establishing a regulatory framework

The need to regulate MAFs, is not in dispute, as evidenced by the various iterations of its regulation, there is no agreement on the question of how best to regulate MAFs. There is a clear need for a legal regime which goes beyond trying to put MAF into a pre-existing regulatory box, which is limited to purely financial definitions which do not take into account the complexities of medical aid. To achieve this, the following eight measures need to be put in place. First, a broader definition of what constitutes medical aid is necessary to assist in separating it from similar financial services such as insurance.[73] In the region, there are more comprehensive definitions of medical aid, such as the one provided in the South African Act, which is multifaceted.[74] These definitions encompass the payment of subscriptions towards a health services, refers to prescribed health benefits, and the ability as the medical aid schemes to provide the services directly to their members.[75] These definitions when read together are

[70] For instance, South Africa and Zimbabwe have a specific regulatory authority which regulates MAF separately from other financial services.
[71] Act 61 of 2003 The Medical Schemes Act, supplements the National Health Act
[72] Ibid; Van den Heever (n 39).
[73] Medical Aid Scheme in other regions is the equivalent of Medical Aid Fund in the context of Botswana.
[74] Doherty (n 24).
[75] Van den Heever (n 39).

comprehensive, which allows for greater understanding of what constitutes a medical aid. In all the regional permutations, the definitions of medical aid are tied to the provision of quality healthcare services.

Second, there is a need for measures which ensure that medical aids fulfil stated goals of providing access to healthcare. They need to contribute to broader public health goals by reducing the burden on the public health care system.[76] The establishment of regulatory authorities specifically for MAFs housed at the Ministry of Health will facilitate ongoing monitoring of the MAFs to fulfil these objectives. The regulation for MAFs needs to go beyond the collection of financial statistics. Third, since MAFs are financially akin to insurance, they need to be prudentially regulated to ensure that they fulfil their long-term obligations. There would be a need to legislated detailed financial regulation to ensure this.[77] Fourth, the quality of products which medical aids provide, which insurance law has consistently shied away from need to be regulated. This would require the legislating of minimum health requirements which MAF should fulfil,[78] which includes minimum package of benefits to all members.[79] In some states these benefit packages are not detailed and are benchmarked against the primary healthcare provided by the state. These secure access to healthcare for members and protects them from catastrophic out-of-pocket expenditure.[80] Better regulations would encourage improved efficiency in the allocation of both private and public healthcare resources.

Fifth, non-discrimination needs to be legislated through requirements for open enrolment and community rating through prohibiting the practice of risk rating.[81] Community rating refers to the practice of charging the same subscription to all members on a specific

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[76] The essential healthcare package thus consists of 270 hospital-based Diagnosis, cover for emergency medical conditions and an out-of-hospital treatment component as well as 25 chronic conditions. The benefits for chronic conditions include cover for the diagnosis, management and medicine according to therapeutic algorithms. The package is limited to a reasonable and socially acceptable minimum level of care, delivered efficiently and in compliance with evidence-based medicine, cost-effectiveness and affordability principles.

[77] Stephen Thomas and Lucy Gilson, 'Actor management in the development of health financing reform: health insurance in South Africa' (2004) 19(5) *Health Policy and Planning* 279.

[78] Ministry of Health, 'The Essential Health Service Package for Botswana' (n 23).

[79] Daisy Ditshoene, Paresh Prema and Aleksandra Serwa, 'What Medical Schemes Are All About' (CMS News, Issue 1, 2010-2011) <https://www.medicalschemes.com> accessed 4 November 2020.

[80] ibid

[81] Section 29(1)(n) of the Act ; The practice of risk-rating or the varying of contributions on the basis of age, gender, state of health, frequency of rendering health services and any other arbitrary ground is illegal.

benefit option within a medical scheme.[82] While there is no evidence of risk rating, community rating needs to be legally required. This promotes equity of access for membership of medical schemes and emphasizes cross-subsidisation between the high and low-risk profile members.[83] This also ensures that the most vulnerable members have access to affordable private healthcare and prevents price discrimination against people with high risk medical conditions is prevented. Therefore, all members on a particular option pay the same contribution, regardless of their age or health status or any other grounds.

Sixth, equity and fairness in the manner in which medical aids conduct their business should be legislated. Since members of MAFs do not have the capacity to negotiate, the state needs to intervene to create minimum standards which MAFs need to comply with. The conduct of business regulation should encompass both the type of service and the manner in which services are provided.[84]. The legislative protection of members would require the promulgation of specific minimum requirements to be incorporated into contracts and restricts some types of conduct.[85] This includes the need to restrict, the use of delays in accessing benefits for new members as a measure to control risk. This is restricted in some states in the region, through legislation on the maximum waiting periods to access benefits from Medical Aid Systems (MAS). This restricts the use of discriminatory measures as a means of controlling risk. The fairness component may need to be expanded to address competition issues in the healthcare sector, which includes the treatment of healthcare providers. The protection of members of medical aid is specific and cannot be encompassed by the Consumer Protection Act due to its specialised nature.

Seventh, effective user friendly enforcement mechanism, which are non-adversarial need to be created. This can be achieved through establishment of the office of an Ombudsman

[82] Khumalo (n 68).

[83] Ibid.

[84] Ditshoene (n 79); Further, open MAS are prohibited from excluding any applicant from membership in their rules. These provisions ensure that all persons who apply for membership are guaranteed membership of open MAS if they can afford to pay the premiums. It prohibits MAS from 'cherry picking' good profiles. Section 24(2)(e) of the Act Medical Schemes Act, Act 131 of 1998, Section 29(3)(a) of the Act Medical Schemes Act, Act 131 of 1998.

[85] Jane Doherty, 'Regulating the for-profit private health sector: lessons from East and Southern Africa' (2015). *Health Policy Plan* 93

for the resolution of issues relating to the industry.[86]. The use of specialised dispute resolution forums are cheaper, quicker and more effective than the court system in ensuring the enforcement of rights of members. It also allows for issues tied to MAFs to be investigated and resolved.

7 CONCLUSION

MAF have successfully managed to evade effective regulation in Botswana, they have maintained minimum financial regulation with virtually no regulation for the healthcare component.[87] The limited regulation of MAF is largely ineffective due to the fragmentation of responsibilities across a number of pieces of legislation and regulators. This is compounded by insufficient sharing of information between the regulators to enable the comprehensive implementation of existing rules. These shortcomings have led to distortion in the type, quantity, distribution and price of health services, as well as anti-competitive behaviour.[88] While self-regulation can be effective, its benefits are often overridden by economic incentives and the interests of MAFs.[89] This has led to the business model of MAF being largely subsidised by the state as many of their patients are off loaded onto the public sector when they exhaust their benefits or require uncovered medical assistance. While the unwillingness of the state to regulate the quality of products which insurers provide is established, MAF are a product *sui generis* which requires regulation and cannot be left to the whims of the industry.[90]

This limited regulation has made it possible for MAFs to protect themselves at the expense of their members. Their business practices and contracts are structured in a manner that is most beneficial for them. Consumer protection is primarily the responsibility of the state. The adoption of some regulatory practices from the region would be the first step towards a more comprehensive regulation of medical aid. In order to ensure that MAFs fulfil the broader goals

[86] Khumalo (n 68); The Ombudsman provides a specialized forum for the resolution of medical aid disputes in a cost effective, efficient, and fair way. This removes some of the disputes from the normal court system, which is perceived as largely biased against policyholders, since it applies the law strictly. All this is hinged on the development of greater transparency and extensive education campaigns as to inform patients, health insurance beneficiaries of their rights. Tamara Cohen, 'The Insurance Ombudsman – An Alternative Dispute Resolution Forum for the Insurance Industry' (1996) 8 *South African Mercantile Law Journal* 252.
[87] McIntyre (n 13).
[88] Kamaranayake (n 11).
[89] Di McIntyre (n 13).
[90] Thomas (n 77).

of society by contributing fully, the state needs to intervene to ensure that. Regulation would also protect members of MAFs cannot make informed decisions or participate effectively in their administration. Effective regulation would ensure that consumer expectations who regard MAFs as a commodities and not as contracts and thus do not expect coverage to end. This would ensure that medical aids fulfil broader social goals by reducing pressure on the public health system.