NEW MEDICAL SCHEME RESEARCH RELEASED: ANSWERS AND YET MORE QUESTIONS FOR THE FUTURE OF SOUTH AFRICA'S HEALTHCARE SYSTEM

- Findings show the critical role of the medical scheme industry in access to healthcare.
- Medical schemes' total spend on private hospitals in South Africa has decreased by 0.8% in real terms.
- Schemes need to attract or sustain better risk profile to avoid a downward spiral and possible failure.
- Growth in membership critical: only two medical schemes grew over the period.
- Equalisation fund would enable schemes to compete on the quality of delivery of healthcare.
- Competition Commission investigation will shed more light on the numbers behind the numbers.

[Johannesburg, 5 September 2014] Medical schemes' total spend on private hospitals in South Africa has decreased by 0.8% in real terms over the last year - a dramatic turnaround after years of significantly overshooting inflation. This and other instructive data was released this week in the Council for Medical Schemes (CMS) Annual Report for 2013/14.

According to Lara Wayburne, Head of Actuarial and Specialised Consulting at NMG Benefits, while this is a great result for members, the question remains which factors could have led to this outcome, or whether this could be the start of an improved trend in healthcare cost inflation.

Legislation governing medical schemes specifies a minimum set of health conditions that all schemes are required to cover – called prescribed minimum benefits (PMBs). PMBs are a key driver of costs. For the first time, research published in the annual report has uncovered the actual costs involved in providing coverage of the PMBs – approximately R512 paid per beneficiary per month averaged across all medical schemes.

However, the research figures also show significant variation in costs between schemes in covering the PMBs on a per-member basis. "It could be that schemes showing higher-than-average PMBs costs tend to be schemes with older and less healthy members".

NMG suggests these schemes may well struggle to cover the required PMBs going forward at competitive price levels, unless they are able to improve their risk profile by attracting younger members. Failure to do this could cause a downward spiral, where healthy members leave for cheaper medical schemes or benefit options. This then concentrates older and less healthy members in certain schemes which in turn leads to even higher costs which could cause a scheme to fail.

Further research conducted by NMG shows that claims increase by 1.9% for every additional year of average membership age. This highlights the importance of attracting younger members, as one way to keep contribution levels at reasonable levels. The industry has not grown membership in recent years, which leaves schemes increasingly exposed to a deterioration in age and health profile, as existing members grow older with associated higher claims costs.

"Because of medical scheme cost dynamics (largely driven by legislated minimum benefit cover) *coupled* with legislation that prevents schemes from engaging in price differentiation in terms of factors like age and health, we support the need for the recommended "risk equalisation fund".

This fund would require schemes to cross-subsidise based on membership profile. A scheme with a younger membership would have to contribute to a central fund. However, a scheme with an older membership would be able to draw a subsidy from the fund to apply against contributions. It is hoped this would enable schemes to compete on the quality of delivery of healthcare to members rather than on attracting healthier members.

These issues are especially pertinent in light of the recently initiated Competition Commission's market inquiry. The Commission's inquiry was set up to investigate the competition and causes of price increases in the private healthcare sector.

We hope that the Commission's work will cover the slowing growth of medical scheme membership. Only two schemes saw significant membership growth during 2013: Discovery Health Medical Scheme (~50,000 new members) and the Government Employees Medical Scheme (GEMS) (~20,000 new members). Both schemes have been active in setting up networks for members, taking advantage of economies of scale, and leveraging their bargaining power to give their members better value for money.

NMG says that they hope that the Commission will also review the ability of smaller medical schemes to benefit from lower prices, particularly given the current environment in which each scheme is legally required to negotiate individually with healthcare service providers.

Says Wayburne: "it would be extremely useful to see some of the claims cost drivers, excluding the two big players, in order to make sense of the costs carried by the smaller players."

"The findings show convincingly that the medical scheme industry plays a critical role in providing access to healthcare. Improvement in access to private healthcare can only occur once we have a full understanding of all factors impacting costs. We can then make informed decisions on how to improve the sector as a whole."

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Note to editor:

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NMG Benefits is a financial services firm specialising in Employee Benefits. The company has 400 employees spread across South Africa. It provides advice and consulting services to more than 350 corporate clients and their members across the following service lines: Healthcare, Retirement, Actuarial, and Personal Wealth. NMG Benefits boasts one of the largest and most diverse actuarial teams in South Africa with specialists in healthcare and retirement. Visit: www.nmg.co.za

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