MEDICAL SCHEMES

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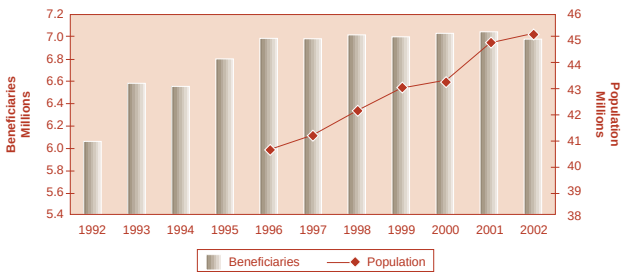
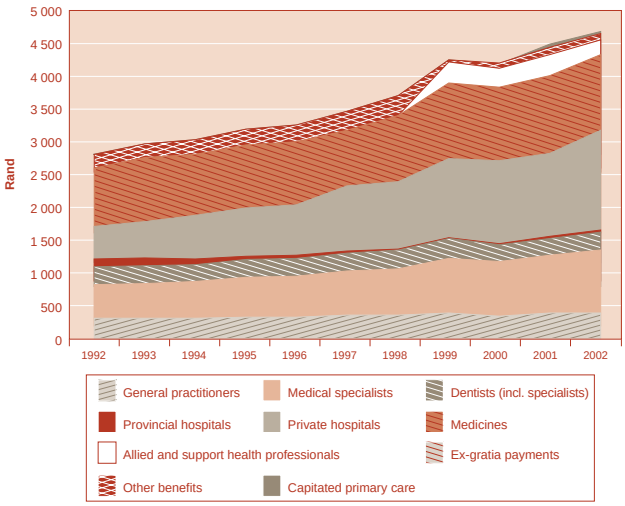
Medical Schemes Council

Number of medical scheme beneficiaries versus total population



Total benefits per beneficiary per annum (real 2001 prices)



Key Messages

- The Medical Schemes Act seeks to promote equitable access to health care resources.
- Open enrolment and community rating provisions of the Act have been successful in preventing direct discrimination against more vulnerable sectors.
- Indirect forms of discrimination emerged with adjusted chronic disease benefits.
- The Minister responded by expanding the prescribed minimum benefits to include common chronic conditions.
- The number of beneficiaries has remained relatively stable at about 7 million since 1996, making an increasing proportion of the population dependent on the public sector.
- Disproportionate spending on the private versus public sector populations per capita is increasing.
- Escalating health care costs are the main factor in above-inflation increases in medical scheme contributions.
- A reducing claims ratio also indicates a higher proportion of non-health expenditure.

Framework for Monitoring and Evaluation

South Africa:

- Statutory returns required by the Medical Schemes Act, No. 131 of 1998, to the Medical Schemes Council.

Key Indicators

Number of medical schemes beneficiaries

Pensioner ratio

Claims ratio

Medical Aid coverage

Per capita health expenditure

Key References and Data sources

Medical Schemes Council Annual Reports

Introduction

The Medical Schemes Act 1998 (Act No. 131 of 1998), which fully came into effect on 1 January 2000, sought to promote equitable access to health care resources in various ways. The Act was passed against a background of legally permitted discrimination by medical schemes against older and less healthy members and applicants through risk-rating and denial of membership, permitted by deregulation of the industry in the late 1980s and early 1990s. Research conducted by Söderland, for example, showed a decline of the proportion of pensioner members in commercial open medical schemes from some 7% in 1985 to just over 1% in 1995.[1]

The Act sought to ensure non-discriminatory access to medical scheme coverage, particularly through requirements of community rating of premiums and open enrolment of applicants to medical schemes. It also introduced a set of prescribed minimum benefits, the stated objectives of which are: to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals; and to encourage improved efficiency in the allocation of private and public health resources.[2]

For people to benefit from non-discriminatory access to medical scheme coverage, the Act also had to include protections in relation to the financial stability and appropriate governance of the medical schemes environment. This was critically important in the context of a previously largely under-regulated environment. The Act therefore includes a number of provisions to strengthen these areas, including *inter alia* requirements that at least half of the members of a board of trustees must be elected from amongst members of the scheme, and medical schemes have to maintain minimum reserve levels as a percentage of gross annual contributions, increasing incrementally to 25%.

In the longer term, successful implementation of these reforms is seen as an important foundation for implementation of social health insurance. Policy in relation to medical schemes and social health insurance is linked in the strategic plans of the Department of Health, which identifies implementation of social health insurance and enactment of associated enabling legislation as a key objective.[3]

Framework

On an annual basis, the Registrar of Medical Schemes issues an Annual Report containing data in relation to key indicators to enable medical schemes to benchmark their performance and policy analysts to assess the impact of implementation of the Act and other extraneous factors.[a] These reports are based on analyses of audited statutory returns, which are required by the Act to be submitted to the Council for Medical Schemes ("the Council") annually. This chapter provides a synopsis of some of the key data reflected in the 2002-3 Annual Report of the Registrar of Medical Schemes. [4]

Data collection through these statutory returns has been constrained by the types of data that have traditionally been collected by medical schemes, with Council investigations revealing serious gaps in the type and quality of data that medical schemes tended to collect. The Council has responded by initiating research and consultative processes aimed at identifying a more comprehensive dataset that medical schemes should collect.[5]

a Electronic copies of these reports dating back to 1998 are available on the website of the Council for Medical Schemes (http://www.medicalschemes.com

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Table 1: Summary of some of the key indicators currently monitored by the Registrar of Medical Schemes on an annual basis

Demographics

- Total number of beneficiaries of medical schemes: "Beneficiary" is defined as a member of a medical scheme or a person admitted to a medical scheme as a dependant of a member
  - Number of beneficiaries of open medical schemes
  - Number of beneficiaries of restricted medical schemes
  - Number of beneficiaries of bargaining council funds[b]
- Dependants ratio, defined as the average number of dependants per medical scheme member, in registered medical schemes[c]
- Pensioner ratio, defined as the proportion of members of medical schemes who are 65 years or older, in registered medical schemes

Benefits Paid

- Total expenditure on benefits paid by medical schemes
  - Total benefits paid out of schemes' risk pools
  - Total benefits paid out of medical savings accounts[d]
  - Average benefits paid per beneficiary per month
- Proportion of benefits paid per provider category

Financial Indicators

- Operating results of medical schemes
  - Surplus or deficit from operations of medical schemes
  - Nett investment income of medical schemes
  - Nett surplus or deficit of medical schemes
- Total contributions paid by members of medical schemes
  - Total contributions paid to risk pools
  - Total contributions paid to medical savings accounts
- Claims ratio: This expresses the proportion of member contributions that has been utilised for the payment of benefits claimed by members of medical schemes, as opposed to allocation of contributions for non-health benefits and the building of reserves.
- Total non-health expenditure of medical schemes
  - Total administration expenditure
  - Total expenditure on managed care services
  - Nett reinsurance surplus or deficit
  - Total expenditure on broker fees
  - Bad debts
- Overall industry average solvency ratio, defined as accumulated funds (i.e. the nett asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable reserves) as a percentage of gross annual contributions.
- Average cash paying ability of schemes, measured in months of cover: This is the number of months' claims that medical schemes are able to cover from existing cash reserves.

Indicators which can be calculated from the above data include:

Medical aid coverage: Proportion of population covered by medical schemes (number of beneficiaries divided by total population from StatsSA mid-year population estimates).

Public sector dependent population: This is an adjustment of the total population to the number assumed to be dependent on services in the public health sector based on medical scheme (health insurance) coverage. It is calculated by subtracting the number of people with medical scheme cover (determined from medical scheme membership reports, or surveys indicating percentage of population on medical schemes) from the total population.

Per capita health expenditure: Amount spent on health care per person (in Rands). In the case of the private sector, this is calculated from average benefits paid per beneficiary per month x 12 to obtain annual per capita expenditure.

b An open medical scheme is a medical scheme open to any member of the public. A restricted medical scheme is a medical scheme in respect of which eligibility to membership is restricted to a certain category of persons – typically employees of a particular employer or class of employers. A bargaining council fund is a sickness fund established and currently regulated in terms of labour relations legislation, typically under the auspices of a particular bargaining council.

c Registered medical schemes exclude bargaining council funds.

d The risk pool of a medical scheme is the fund in which member contributions are pooled, effectively allowing cross-subsidisation to take place. A limited portion of member contributions may be paid into an individualised account, called a personal medical savings account, typically used to pay for day-to-day discretionary expenses.

Data

Table 2 provides a synopsis of the data provided by the 2002-3 Annual Report of the Registrar of Medical Schemes, in relation to the key indicators identified in Table 1. The data reflect the situation of medical schemes as at the end of the 2002 calendar year.

Table 2: Data on medical schemes, 2002

Demographics	
Total number of beneficiaries of medical schemes	6 962 914
✧ Number of beneficiaries of open medical schemes	4 730 936
✧ Number of beneficiaries of restricted medical schemes	1 982 934
✧ Number of beneficiaries of bargaining council funds	249 044
Dependants ratio	1.53
Pensioner ratio (registered medical schemes[e])	5.90%
Benefits Paid	
Total expenditure on benefits paid by medical schemes (R thousand)	R35 645 725
✧ Total benefits paid out of schemes' risk pools (R thousand)	R32 035 150
✧ Total benefits paid from medical savings accounts (R thousand)	R3 610 574
✧ Average benefits paid per beneficiary per month	R424.81
Proportion of total benefits paid per provider category	
✧ Total hospitals	32.18%
• Private hospitals	31.63%
• Provincial hospitals	0.55%
✧ Medicines	24.28%
✧ Medical specialists	19.83%
✧ General practitioners	8.48%
✧ Dental specialists	0.81%
✧ Dentists	4.93%
✧ Allied and support health professionals	6.76%
✧ Capitated primary care	0.76%
✧ Ex-gratia payments	0.07%
✧ Other benefits	1.90%

e This excludes bargaining council funds.

Financial Indicators	
Operating results	
✧ Surplus / (deficit) from operations of medical schemes (R'000)	R1 136 114
✧ Nett investment income of medical schemes (R'000)	R1 360 430
✧ Nett surplus / (deficit) of medical schemes (R'000)	R2 496 544
Total contributions paid by members of medical schemes (R'000)	R43 268 733
✧ Total contributions paid to risk pools (R'000)	R39 054 978
✧ Total contributions paid to medical savings accounts (R'000)	R4 213 755
Claims ratio	82.0%
Total non-health expenditure of registered medical schemes (R'000)	R5 837 055
✧ Total administration expenditure (R'000)	R4 082 074
✧ Total expenditure on managed care services (R'000)	R965 858
✧ Nett reinsurance surplus / (deficit) (R'000)	(R297 053)
✧ Total medical scheme expenditure on broker fees (R'000)	R354 224
✧ Bad debts (R'000)	R137 846
Overall average solvency ratio of registered medical schemes	23.1%
Average cash paying ability of registered medical schemes (months)	3.47

The following table includes indicators which may be calculated from the data from the Medical Schemes Council.

Table 3: Additional indicators relating to private sector health financing

	1998	1999	2000	2001	2002
Medical Aid Coverage (%)	16.6	16.2	16.2	15.7	15.4
Per Capita health expenditure (private sector) (Rand)	3 099	3 726	3 868	4 396	5 098
Public Sector Dependent Population	35 138 989	36 065 167	36 286 805	37 794 516	38 208 994

Analysis

Open enrolment and community rating provisions of the Medical Schemes Act have been successful in preventing direct discrimination against more vulnerable sectors of the medical scheme population, which was prevalent prior to implementation of the Act. From 2001 to 2002, for instance, pensioner ratios in registered medical schemes remained stable at 5.9%.[4] Indirect forms of discrimination emerged, however, most significantly through many medical schemes adjusting benefit design to reduce chronic disease benefits in all but the most expensive options, resulting in significant differential adverse financial impact on sufferers of chronic diseases and attrition of health coverage for the most vulnerable groupings.[6] The Minister responded by expanding the prescribed minimum benefits to include 25 common chronic medical conditions with effect from 1 January 2004.[7]

Figure 1 demonstrates that the total number of beneficiaries of medical schemes has remained relatively stable at approximately 7 million since 1996. The total number of beneficiaries declined marginally from 2001 to 2002 by 0.89%.

Figure 1: Trend analysis of number of medical scheme beneficiaries, 1992-2002[4]

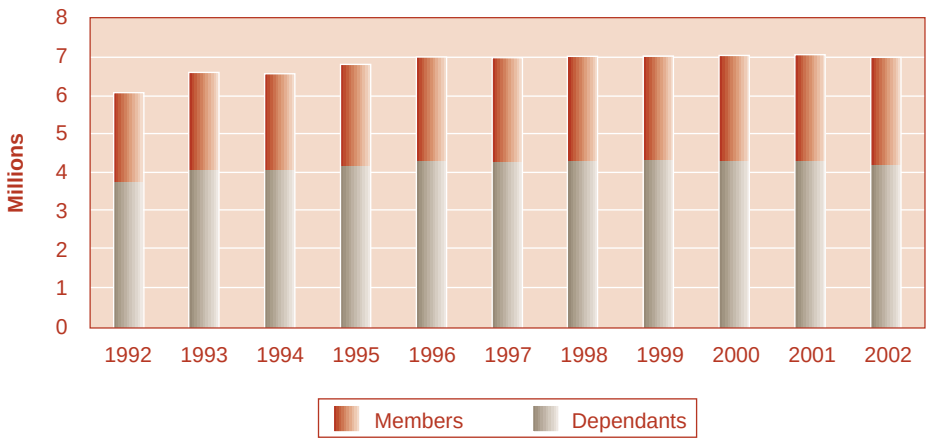
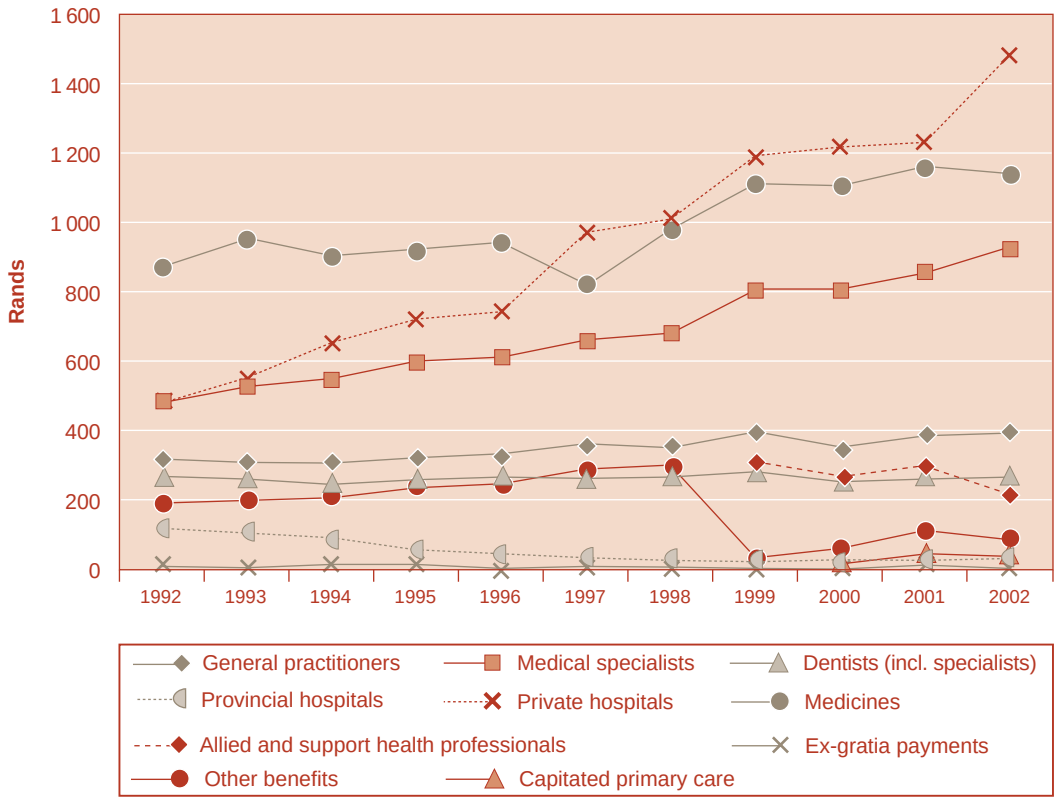


Figure 2: Total benefits paid per beneficiary per annum (real prices, 2001 base year)[4]



Slow employment growth in South Africa, combined with continued escalation of medical scheme contributions, has contributed to the overall lack of growth in coverage since 1996. This raises the concern that an increasing proportion of South Africa's growing population is reliant on limited public health care resources.

Disproportionate expenditure on private health funding of medical scheme beneficiaries relative to public sector expenditure equally raises equity concerns. Average medical scheme cost per beneficiary now exceeds the total expenditure of government per capita, for all its functions and departments. In nominal terms, medical scheme contributions per beneficiary were R6 214 per annum in 2002, while total government expenditure on the main budget (including all national and provincial functions and transfers to local government) amounted to R5 364 per capita. The ratio of public sector health expenditure to gross medical scheme contributions per beneficiary has also risen from 1:4.5 in 1997 to 1:7.1 in 2002.[f]

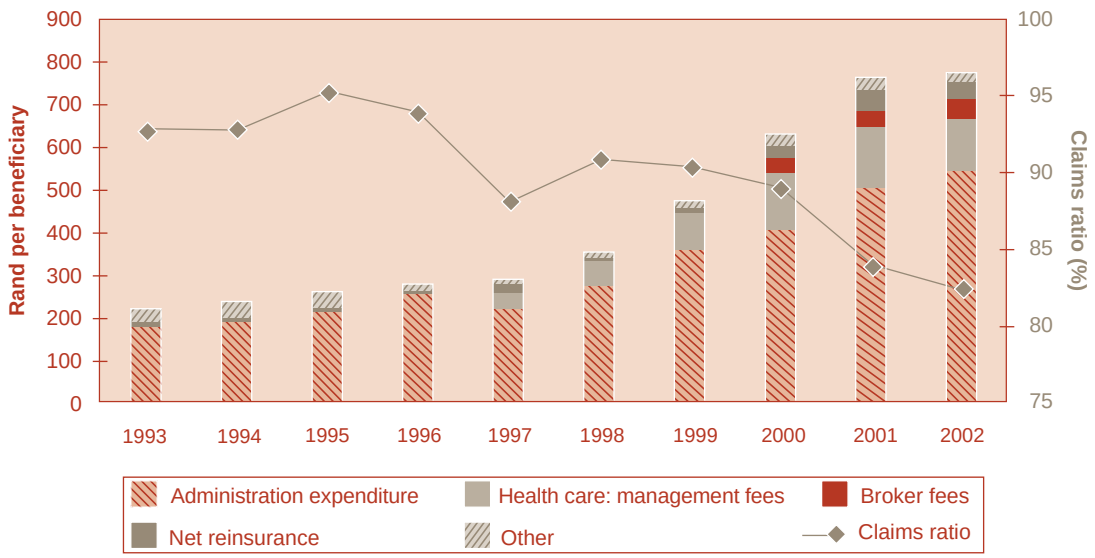
Escalating health care costs continue to be the main factor driving medical scheme contribution increases, with continued above-inflation increases in costs of private hospitals, medicines and medical specialists being the major cost drivers. Trends in expenditure on health benefits, per provider category, are shown in Figure 2.

It is evident that the medical schemes industry has largely been unsuccessful in containing medical cost escalation. Where limited success has been achieved in containing medical costs, it seems to have been through the use of capitated primary care networks. In a study conducted in 2001, it was found that seven of the ten lowest cost benefit options in the medical schemes environment made use of capitated primary care benefits.[8] Notwithstanding this, in 2002, capitated primary care benefits accounted for only 1.9% of primary care expenditure of medical schemes and global or per diem fees accounted for only 5.4% of hospital expenditure. It is anticipated, however, that amended regulations which incentivise schemes to enter into contractual arrangements for the delivery of prescribed minimum benefits, and which take effect on 1 January 2004,[7] will stimulate far more extensive use of preferred provider networks. These regulations may also result in medical schemes entering into more extensive contractual arrangements with the public sector, resulting in an increase in revenue to public hospitals which currently account for an almost negligible portion of medical scheme expenditure.

The other factor contributing to escalating medical scheme contributions is non-health care expenditure, including administration expenditure, managed care services, reinsurance, expenditure on broker fees and bad debts. A trend analysis of non-health expenditure is shown in Figure 3, which also shows the decline in claims ratio to 82.0% in 2002. Various regulatory initiatives and legislative changes have been effected over the past 12 to 18 months to curb excessive non-health expenditure by medical schemes, but the 2002 data were still too early to gauge the true impact of these initiatives.

Importantly, the 2002 figures demonstrated that despite cost pressures, beneficiaries of medical schemes continue to experience a more financially stable environment. Overall average solvency ratios increased from 20.4% in 2001 and 20.2% in 2000 to 23.1% in 2002, in excess of the statutorily prescribed level of 17.5% for 2002. The nett operating surplus (including investment income) of medical schemes was R2.5 billion in 2002, an increase of 72% on the previous year. Average claims paying ability increased from approximately 2.7 to 3.5 months in 2002.[4]

Figure 3: Real non-health expenditure per beneficiary (2001 prices) and claims ratio[4]



f M Blecher, Director: Social Sector, National Treasury, personal communication.

Recommendations

The immediate focus of policy and regulatory development in relation to private health expenditure in the country must be on mechanisms to stem rampant cost inflation and thereby to create the conditions for the emergence of affordable medical scheme options for low income employees. Until now, there has been effective regulation of the private health funding industry, but insufficient regulation of the supply side of the market.

Recent legislative interventions such as regulation of pricing of medicines and the introduction of certificate of need requirements through the National Health Bill, have the potential to significantly impact on escalating medical expenditure. In addition, the incentivisation of medical schemes and providers to enter into contractual preferred provider arrangements has the potential to result in significant cost control in the medium to long term. The impact of these initiatives must be closely monitored by government to ensure that they have the desired effect, and that adjustments can be made where necessary.

At the same time, it is important that government adopts a concerted strategy to address perverse incentives and distortions in pricing in the environment. In this regard, the increasing focus of the Competition Commission of South Africa on anti-competitive pricing in the health care industry[9] is to be welcomed, and should go hand-in-hand with initiatives from the Department of Health to address these issues.

Conclusions

In conclusion, the data provided in this report demonstrate that significant progress has been made by government in providing financial stability to a previously under-regulated medical schemes environment, and to limiting opportunities for discrimination by health care funders against older and more sickly members of the medical scheme population. Where abuses in this regard continue to be observed, regulatory and legislative measures are being put in place to address them.

The remaining problems in this environment relate to continuing cost escalation, with related decrease in affordability of medical scheme contributions and growing disparity between health expenditure in private and public health. Particularly worrying is the statistic that public sector health expenditure to gross medical scheme contributions per beneficiary have risen from 1:4.5 in 1997 to 1:7.1 in 2002.

Growing disparities in the distribution of health care expenditure between public and private sectors contribute to increasing inequity in the South African health system, and it is therefore imperative that policy and legislative initiatives for the implementation of social health insurance are expedited.

References

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9 Competition Commission. Competition Commission finds pharmaceutical firms in contravention of the Competition Act. Media Release No. 29 of 2003. 16 October 2003; Competition Commission Exco recommends health care investigation be referred to tribunal. Media Release No. 16 of 2003. 17 July 2003.
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