



Annual Report 2007-08: A synopsis of findings

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Membership

In 2007 the number of beneficiaries covered by medical schemes increased by 5.0% to 7 478 040. (These membership numbers exclude members of bargaining council schemes and Motohealth Care Medical Scheme.)

Membership of restricted schemes grew by 21.7% – this growth may be attributed to the Government Employees Medical Scheme (GEMS) which increased its membership by more than 300.0% from 2006. The restricted Renaissance Health Medical Scheme reported an increase of more than 50.0% in the number of its beneficiaries but this growth was unfortunately accompanied by a plummeting solvency, resulting in the scheme being placed under curatorship in May 2008.

The ratio of dependants to active members remained unchanged at 1.4 for 2007.

The pensioner ratio decreased from 6.3% to 6.2%. The average age of beneficiaries decreased from 31.6 years in 2006 to 31.4 years in 2007.

Contributions and claims

The contributions that schemes collected from their members increased by 12.3% to R64.7 billion, while the claims that schemes paid on behalf of their members rose by 10.2% to R56.3 billion from R51.1 billion in 2006. Contribution increases were higher for open schemes compared to restricted schemes.

The percentage of contributions that schemes spent on claims – known as the claims ratio – was slightly lower. In 2007 schemes spent on average 86.0% of contributions on claims, compared with 88.0% in 2006. Perhaps the generally younger member profile contributed to the lower claims.

The proportion of money that was paid out to members who have personal medical savings accounts decreased. This may be indicative of an increase in what is generally termed “self-payment gaps” via mechanisms such as thresholds and deductibles – members funding benefits out of their own pockets.

Benefits

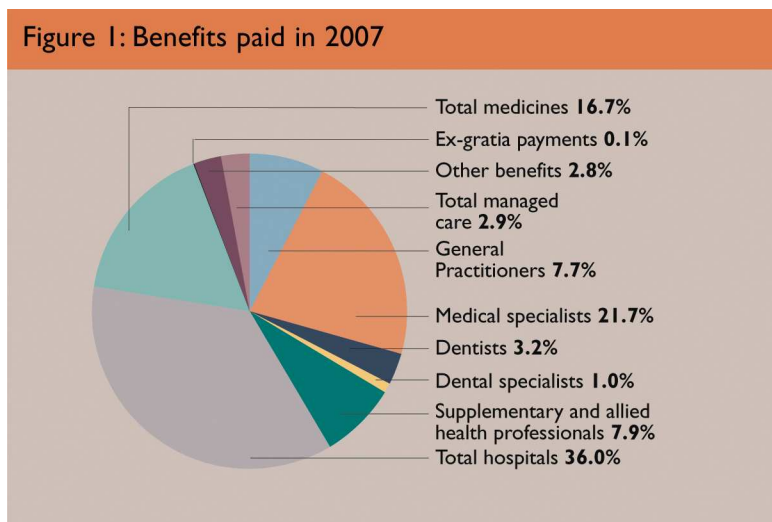
Of the total amount they spent on healthcare, schemes paid R20.2 billion (36.0%) to hospitals (see Figure 1 below). Expenditure on private hospitals increased by 12.5% to R19.9 billion in 2007. This increase was 5.3% when adjusted for inflation. The number of beneficiaries admitted to private hospitals increased to 180 per 1 000 beneficiaries from 171 per 1 000 in 2006. The number of admissions increased by 7.3%. This is a reverse of the trend that was seen previously where the utilisation of private hospitals was inversely

proportional to expenditure, in other words an increase in expenditure on private hospital was not coupled with a related increase of the number of admissions.

Payments to medical specialists accounted for R12.2 billion (21.7%) of benefits paid. This represented an increase of 11.0% on 2006 or an inflation-adjusted increase of 4.3%. There were more beneficiaries who visited physicians, psychiatrists and clinical haematologists in 2007 compared to the previous year.

But general practitioners were paid R4.3 billion (7.7%) of the total benefits paid, representing a decrease of 1.5% on 2006 (8.5% after adjusting for inflation). A similar trend was seen in the utilisation of general practitioner services.

Of the total amount they spent on healthcare in 2007, schemes paid R9.4 billion (or 16.7%) on medicines dispensed by pharmacists and providers other than hospitals. This is an increase of 8.2% compared with the R8.7 billion spent in 2006.



Non-healthcare expenditure

Total non-healthcare expenditure (administration fees, fees for managed healthcare, broker fees, impairments, and reinsurance) rose by about 7.3% to R8.9 billion in 2007 from R8.3 billion in 2006. When expressed as a percentage of contributions, it was 13.8% overall.

Administration expenditure, which is the biggest component of non-healthcare expenditure, rose by 6.7% to R6.3 billion at the end of December 2007 from R5.9 billion in 2006. Expenditure on managing benefits (managed healthcare fees)

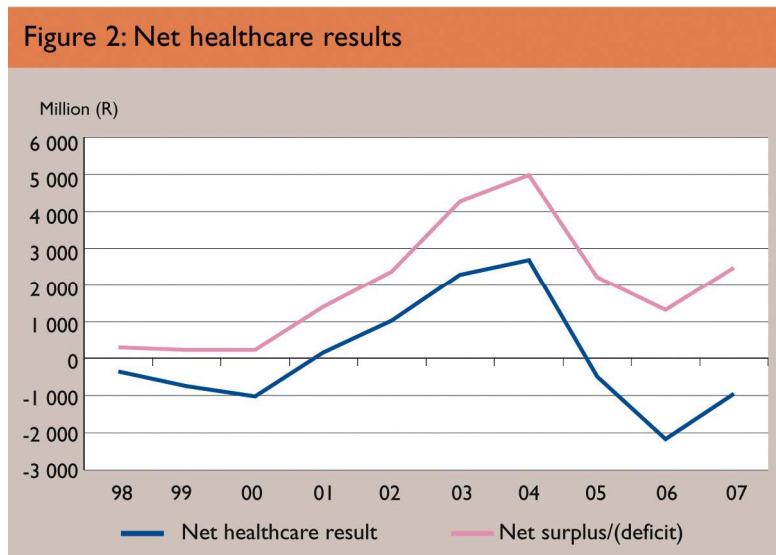
grew by 9.6% to R1.5 billion. Brokers were paid an additional 6.1%, raising their fees to R1.0 billion from R983.0 million in 2006.

Low-cost options tended to have lower claims but higher non-healthcare expenditure. Further work is needed to understand this.

Net healthcare results

The investment objectives of schemes are to maximise the return on their investments on a long-term basis and to outpace inflation, thus resulting in real returns for them. The higher the reserve levels of a scheme, the more aggressive such a strategy would be.

Schemes reported an operating deficit of R992.0 million in 2007 (see Figure 2 below). This was a substantial decrease from R2.1 billion in 2006. Investment income increased by 28.9% to R2.4 billion while income from other sources added another R1.0 billion. These additional sources of income helped schemes to convert the operating deficit into a final surplus for the year of R2.4 billion, which was a 107.6% increase on the 2006 surplus of R1.1 billion. A closer look at these results indicates that there is no single reason for the turnaround in the performance of schemes. It is also still too early to make a determination on the sustainability of this trend, especially given the volatility associated with investment income. Therefore, schemes should guard against relying too heavily on investment income as a way of boosting their reserves.



Accumulated funds and solvency

Net assets or members' funds, defined as total assets less total liabilities, rose by 9.5% to R26.8 billion from R24.5 billion in 2006.

Schemes' reserves are expressed as a percentage of gross annual contributions, generally known as the solvency ratio. By law, schemes are required to have 25.0% of their contribution income in reserves. On average, at the end of 2007, the solvency ratio remained relatively unchanged at 37.8% compared to 2006. Open schemes had a lower average solvency ratio (28.6%); restricted schemes had an average solvency ratio of 58.9%. Most beneficiaries of restricted schemes found themselves in schemes that met the 25.0% solvency levels required by law, but the opposite is true for open schemes. However, the Council for Medical Schemes (CMS) engages with schemes on a regular basis to discuss their turnaround strategies and address problems such as high non-healthcare costs.

Resolving complaints

The Office of the Registrar constantly monitors complaints to identify trends that may indicate problem areas within particular schemes so that compliance actions can be effected where necessary. The CMS received 2 891 complaints from members about their schemes in 2007 – a 30.0% increase on the number of complaints in 2006. Most of these complaints related to unpaid accounts (1 066).

The second biggest category of complaints concerned the limitation or exclusion of benefits related to prescribed minimum benefits, formularies and designated service providers. The third biggest category of complaints related to schemes' refusal to issue authorisation. Another significant issue with regards to complaints had to do with the payments of accounts in respect of services provided by healthcare providers whose practice code had lapsed.

Regulatory improvement is an essential part of our well-being. The CMS is committed to advancing the interests of beneficiaries and promoting access to quality healthcare for all South Africans. This will ensure that more of the healthcare Rand is spent on relevant healthcare services and to build up reserves, thus ensuring that members have the requisite cover when they need it most. □