PRESS RELEASE

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Press release 14 of 2012: Regulator of medical schemes releases Annual Report

The Council for Medical Schemes (CMS or Council) has just released its latest Annual Report, for the 2011-2012 financial year.

The report, consisting of three separate documents, can be downloaded from Council's website (www.medicalschemes.com).

For the first time, the Annexures (schedules which describe the industry in numerical detail) are available not only in Portable Document Format (PDF), but also in Excel format.

The specific links are:

- Annual Report 2011-2012 (printed publication): https://dl.dropbox.com/u/101411211/CMSAR20112012.pdf
- Annexures in PDF: http://www.medicalschemes.com/files/Annual%20Reports/CMSAR20112012Annexures.pdf

Council is the regulator of the medical schemes industry.

The report contains an overview of the operations of medical schemes in their 2011 financial year as well as a summary of Council's activities in its financial year spanning 1 April 2011 to 31 March 2012.

The report shows that:

Fewer schemes but more beneficiaries

- In 2011, the number of medical schemes continued to drop, but the number of beneficiaries continued to grow.
- At the end of 2011 there were 97 medical schemes registered in South Africa, compared to 100 schemes at the end of 2010.

- From 144 schemes in the year 2000 to the current 97, the trend is likely to continue. However, the industry is far from being an oligopoly. Consolidation is the result of amalgamations and liquidations (voluntary and involuntary) due to the prevailing economic circumstances in the medical schemes industry; it is not driven by Council.
- In 2011, the number of principal members increased by 3.3% to 3 730 565 and that of dependants increased by 2.0% to 4 795 844, resulting in the total number of beneficiaries increasing by 2.5% to a total of 8 526 409.

Open schemes are older and restricted schemes are younger

- In 2011 open medical schemes continued to grow older while restricted medical schemes continued to grow younger.
- The average age of beneficiaries in open schemes increased from 31.5 years in 2006 to 33.3 years in 2011.
- The average age of beneficiaries in restricted schemes was 32.1 years in 2006; this dropped to 31.1 years in 2011.

Contributions and benefits

- Medical schemes received 11.3% more in contributions in the 2011 financial year compared to 2010, or a total of R107.4 billion.
- Of this, R93.6 billion was paid out in healthcare benefits. This was an increase of 10.3% on the R84.9 billion paid out in the previous year.
- The total benefits paid per beneficiary per month increased by 7.8% from R856.6 in 2010 to R923.7 in 2011.

Expenditure on hospitals and specialists

- Of the total benefits paid to healthcare providers, medical schemes spent R34.1 billion or 36.6% on hospital services.
- Expenditure on private hospitals accounted for R33.8 billion, an increase of 9.7% from 2010.
- Public hospitals were paid R304.1 million in the 2011 financial year.
- Payments to medical specialists accounted for R21.3 billion or 22.8% of benefits paid in 2011, a year-on-year increase of 13.5%.

Other healthcare expenditure

- General practitioners received R6.8 billion (7.3%) of the total benefits paid by medical schemes to healthcare providers. This was an increase of 9.7% on 2010.
- Benefits paid to dentists accounted for R2.6 billion in 2011, an increase of 1.7% on 2010.
- Supplementary and allied health professionals received R7.3 billion from medical schemes in the year 2011, compared to R6.7 billion in 2010.
- Expenditure on medicines dispensed by pharmacists and providers other than hospitals increased by 8.6% on 2010 to R15.2 billion. This amounted to 16.3% of scheme benefits paid in 2011.

Non-health expenditure

- Administration expenditure of all medical schemes rose by 4.7% from R7.8 billion in 2010 to R8.2 billion at the end of 2011.
- Expenditure on managing benefits (managed healthcare management fees) grew by 8.3% to R2.4 billion.
- Brokers were paid an additional 5.0% or R1.4 billion in 2011.
- Impairment losses on receivables (previously known as bad debts) decreased by a significant 37.8% to R104.7 million compared to the R168.2 million recorded at the end of 2010.
- Total non-health expenditure (i.e. administration fees, fees paid for managed care, broker fees, impairments, and reinsurance) rose by 4.8% to R12.1 billion in 2011 from R11.6 billion in 2010.
- Since 2005, when Council started to apply more pressure on medical schemes to reduce their non-health expenditure, there has been a gradual decline in non-health costs in real terms (after adjusting for inflation).

Net results, reserves, and solvency

- The net healthcare result of all medical schemes changed from a deficit of R459.6 million observed in 2010 to a surplus of R1.0 billion in 2011. This substantial improvement can be largely attributed to the fact that medical schemes had a lower claims ratio in 2011: 86.5% compared with 87.3% in 2010.
- Investment and other income amounted to R3.4 billion and resulted in medical schemes making a final surplus of R4.3 billion in 2011.
- Net assets or members' funds, defined as total assets less total liabilities, rose by 13.0% to R36.8 billion in 2011.
- Reserves (accumulated funds) grew by 13.9% to R35.0 billion from the R30.7 billion recorded in 2010. This translated into an industry average solvency ratio of 32.6% at the end of 2011 compared with 31.8% in 2010, an increase of 0.8%. This level is still higher than the prescribed solvency level of 25.0% and is largely explained by the continued growth in the membership of the Government Employees Medical Schemes (GEMS).
- The solvency ratio of open schemes increased by 3.6% to 28.6% while that of restricted schemes decreased from 38.6% in 2010 to 38.3% in 2011.

Council's operations during the 2011-2012 financial year

Council continued to support the strategic review of the South African health sector, and appreciated the opportunity to engage with the much-awaited Green Paper on a system of National Health Insurance (NHI). Council's submission on the NHI policy paper is available on its website (http://www.medicalschemes.com/files/National%20Health%20Insurance/CMSCommentsOnDraftNHIPolicy_20120119.pdf).

Having identified areas in the Medical Schemes Act 131 of 1998 which require strategic revision to ensure that Council is able to discharge its duties in a more effective manner, Council continued to work on the Medical Schemes Amendment Bill.

The jurisdictional delineation between the regulatory span of control of Council and that of the Financial Services Board (FSB) continued to be an important area of focus in the financial year under review. The effective protection of beneficiaries and regulation of medical schemes are critically dependent on all entities and products seeking to do the business of a medical scheme being subjected to the rigorous oversight and strict protections contained in the Medical Schemes Act. A serious threat continued to be posed to the sustainability of medical scheme risk pools and the NHI by the proliferation of insurance products which encroach on the preserve of preferred healthcare financing. Council therefore continued to participate in the process aimed at demarcating medical schemes from health insurance products which threaten to undermine the social solidarity principles enshrined in the Medical Schemes Act and offer inadequate benefits under the guise of a viable alternative to protection that can only be obtained from medical schemes. Health insurance products such as gap and top-up cover discriminate against the most vulnerable groups in society, which is why Council continued to promote the protection of provisions aimed at protecting both the sick and the elderly.

One such provision is that on prescribed minimum benefits, or PMBs. Council celebrated a significant victory against the Board of Healthcare Funders of Southern Africa (BHF) when the High Court confirmed the need for PMBs to exist.

PMBs speak to the heart of the Medical Schemes Act as they protect beneficiaries against unforeseen health events which could otherwise ruin them financially. The undisputable, wide-reaching benefits of PMBs are discussed in more detail in the Annual Report; Council also debunks some of the myths surrounding this key provision of the Medical Schemes Act.

Medical schemes in contravention of the requirements of the PMB provisions face the risk of being deregistered.

Another success story worth highlighting saw the Supreme Court of Appeal reaffirming Council's right, even responsibility, to speak freely and openly on matters affecting medical schemes and beneficiaries. Council serves and protects the public and welcomes the Supreme Court's recognition that it must be allowed to discharge its mandate without fear, favour, or interference.

Last but certainly not least, the Auditor-General provided Council with its 12th unqualified audit report in a row for the manner in which Council managed its financial affairs and complied with the requirements of the Public Finance Management Act 1 of 1999 (PFMA) and other applicable legislation.

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