MEDICAL SCHEMES

Should mandatory membership of medical schemes be reintroduced?

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BHF : info@fanews.co.za

The medical aid industry in South Africa is losing R13.5 billion each year due to the anti-selection pressures imposed on the industry because healthcare cover is not mandatory.

This is the view of Barry Childs, CEO of Lighthouse Actuarial Consulting and CareGuage. His opinion is based on a detailed comparison between open and restricted schemes over the past 11 years.

Childs was speaking on the second day of the Board of Healthcare Funders' (BHF) Southern African conference, currently underway at the Champagne Sports Resort in the Drakensberg.

According to Childs, mandatory membership would also mean that medical scheme contributions would be an average of 14% lower across the board, with as much as a 23% saving for open scheme members.

Childs believes that the BHF should be pushing for the legislation change which would make health cover mandatory.

He urged the BHF to continue to engage government on reforms such as mandatory membership and solvency reform.

Dr Humphrey Zokufa, Managing Director of the BHF, disagreed that these were the most important reforms necessary.

“The BHF has visited 43 of its 73 members since January, and all have asked us to deal with Regulation 8 and the PMB issue,” he responded after the presentation. “They all agree that it is the biggest threat to the viability of medical schemes in this country.”

The traditional argument for mandatory membership is that it solves the problem of people only joining medical schemes when they are older, or in the case of women when they plan to fall pregnant and are likely to have higher medical costs.

Childs realised that by looking at the differences between open and restricted schemes he could work out the effect of non-mandatory cover on the industry.

“This provided 11 years' worth of data,” he said. “The restricted schemes effectively provided a control study, without anti-selection, for a comparison with open schemes.”

Childs found that in the 1990s, open schemes were 12% cheaper than restricted schemes. Over following years, this was reversed, with restricted schemes now 14% more expensive. If the comparison is made for the years between 2000 and 2012, the differences are even more marked, with open schemes showing a cost increase of 30%.

“Open scheme contributions increased 2.6% faster than restricted schemes which in turn increased 2% faster than inflation,” he said.

So what caused this divergence? Childs interrogated the data to see if removing the two largest medical schemes GEMS (restricted) and Discovery (open) would make a difference.

In terms of healthcare and non healthcare costs, the divergence remained. Child's research did show, however, that the inclusion of GEMS has seen a marked impact on the efficiency of restricted schemes.

What about sustainability? Childs found that restricted schemes are making more surpluses, and have higher reserve levels, despite having had lower contribution inflation.

“Real price inflation is only a part of the cost escalation issue – utilisation is a much bigger force,” he said. “Mandatory membership would not get back the money that has been lost but it would make a difference in the future.”

Dr Zokufa agreed with Childs' findings but felt that any changes must be contextualised correctly. He believes that mandatory cover should only be introduced as a precursor to NHI.

“The problem with mandatory cover is that the new members become cannon fodder for the high cost members. The people with less benefits effectively subsidise those who have more benefits and claim more. It can only work if the money collected from the new members is ring-fenced for their benefit. Each option level must be self sufficient,” he said.