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Date	12 January 2018

Dear Paulina and Pamela

HMI'S HEALTHCARE REGULATORY FRAMEWORK DOCUMENT OF 1 DECEMBER 2017 / MEDICLINIC'S SUBMISSIONS

We refer to our letter dated 9 January 2018 with Mediclinic's submissions on the aforementioned document ("**HFR Framework**"), and the note prepared by Alex van den Heever for the HMI on *Age and Population Group* dated December 2016 ("**Van den Heever Note**") which was (amongst others) sent to us pursuant to our request for the research on which the HFR Framework is based. Mediclinic hereby makes the following submissions in respect of the Van Heever Note, which should be read with its submissions on the HFR Framework.

The Van Heever Note makes findings relating to the age of the medical scheme beneficiary profile. Importantly, the note states that "[*t*]*he CMS data demonstrate minimal change in the average age of scheme beneficiaries over the period 2005 to 2014 as can be seen in Table 2. Using the General Household Survey (GHS) data an equivalent analysis can be performed for the period 2002 to 2014 with a similar result. According to the GHS only a slight change in the demographic profile of schemes is evident*."[1]

While average age changes have been minimal, it is important to note that the cost of delivering care to older <u>and</u> younger patients is materially higher than to the middle age bands. Mediclinic has submitted its own data to show the effects hereof in the cost of delivering care to patients who were admitted at Mediclinic facilities. The Van den

[1] Van den Heever Note. Page 5.

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Heever Note makes inferences based on average age without account of the costs associated with the older and younger age bands. It is evident that the age of patients is only one component of the utilisation of services. The disease burden of these patients has also been shown to be deteriorating over time for patients admitted to Mediclinic facilities.[2] The Van den Heever Note neglects to assess the effect of changing distribution of beneficiaries across age bands, particularly the increasing proportions of lives in the older age bands as illustrated in Figure 2. These effects will not necessarily be captured in changes in average age. A robust assessment of the chronicity of patients, the age band proportions across the schemes' profiles, and the proportion of non-claiming members is necessary to fully account for the costs to the industry.

Inferences made in the Van den Heever Note about mandatory membership being unable to eliminate the "*double-hump*" are anecdotal without a proper assessment of the affordability of membership for the uninsured and the proportion of uninsured individuals who are employed.

As was mentioned in Mediclinic's previous submission on this topic, research undertaken by Insight Actuaries and Consultants for Finmark Trust estimates that the cost of anti-selection is approximately R13.5 billion (2016) or 23% for open medical schemes. Importantly, the findings note that "*the differential in age profile exists even when comparing the medical scheme population to the formally employed population. This is a natural effect of a voluntary environment: people are more likely to seek cover when they need care*." [3]

Yours faithfully

ANDRE DE LANGE / SUSAN MEYER
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[2] Market Inquiry into the Private Healthcare Sector / Mediclinic's submissions in response to the Call for Submissions dated 1 August 2014. Pages 47 to 52.

[3] Erasmus D, Ranchod S, Abraham M, Bloch J, Carvounes A, Dreyer K. Challenges and opportunities for health finance in South Africa: a supply and regulatory perspective. Johannesburg: FinMark Trust; 2016. Available at: http://www.finmark.org.za/wp-content/uploads/2016/06/south-africa-health-finanince-overview.pdf.
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