Gender Pay Gap

Amongst Medical Schemes CEOs

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ABOUT POLICY RESEARCH & MONITORING DIVISION (PRMD)

This report is published by the Policy Research and Monitoring division (PRMD) of the CMS. The division serves beneficiaries of medical schemes and members of the public by conducting research, collecting, and analysing data to monitor, evaluate, and report on trends in medical schemes, measure risk in medical schemes, and develop recommendations to improve regulatory policy and practice. Altogether, the division is comprised of policy analysts, health economists and clinical experts.

ABSTRACT

Every sector of the economy is undergoing transformation, essential for long-term viability and sustainability. The underrepresentation of black women in managerial roles is even more lacking in some of these sectors. Studies have repeatedly shown a growing pay gap and that women are underrepresented in leadership positions. The evaluation of the gender pay gap in this study was focused explicitly on Principal Officers (POs) / Chief Executive Officers (CEOs) of medical schemes in South Africa.

A subsample of 50 registered medical schemes with CEO fees (pay) exceeding **R120 000** per annum made up the study population of 71 registered medical schemes. In addition to taking demographic information like gender and race into account, financial data such as CEO fees (earnings or pay) and government structure indicators like board size were also considered. Other factors considered were scheme type (sector) and scheme size. The study design was a descriptive cross-sectional analysis of medians and interquartile ranges. The necessary non-parametric tests were used to compare variables of interest.

According to the study, white CEOs predominated in the medical scheme industry, which is heavily biased toward white male CEOs. According to the analysis, of the 50 medical schemes, there were 32 (64%) white CEOs as opposed to 18 (36%) black CEOs. The pay for CEOs increases with the size of the scheme, with large schemes paying considerably more than small schemes. The study found that the median pay of CEOs was higher in open schemes than in closed schemes. In large schemes, the pay gap between male and female CEOs was 39%; however, the pay gap in small schemes was 6%. To foster workplace equity and parity, the medical schemes sector must tackle discrepancies and adopt additional measures to diminish inequality and bridge the pay disparity between male and female CEOs.

Keywords: *Gender Equity, Medical Schemes, Principal Officers/ CEO, Pay gap, transformation*

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1. BACKGROUND

Despite global economic changes in every sector, businesses must embrace economic transformation and inclusive growth to survive and thrive. Transformation is seen as the solution to addressing South Africa's socio-economic challenges, particularly the lingering effects of historical injustices on various economic sectors (Coetzee & Moosa, 2020). Though the definition of transformation is extensive depending on the context, Musonda, Gumbo and Okoro (2019) view it "as the catalyst to address the country's socio-economic problems and their associated impact on different sectors and the economy". Khan, Leena, Naidoo and Naidoo (2013) define transformation as the "intentional social, political, and intellectual project of planned change aimed at addressing historical disadvantages, inequities, and serious structural dysfunctions". In the context of South Africa, transformation focuses on racial division, where one race is dominant over all other races (Bécares & Priest, 2015). An issue at the heart of the transformation is the disparity between management positions for people of different race and gender (Rivera-Romano, Fresno, Hernández-Lemus, Martinez-Garcia & Vallejo, 2020).

Furthermore, several reports indicate that there is still work to be done before the organisation reaches all its racial and gender equity goals (Stamarski & Son Hing, 2015). There is still gender pay gaps in the workforce, especially in executive and top management positions. In South Africa, the gender gap in CEO positions for JSE-listed companies is a pressing issue (Shongwe, 2019; PWC, 2022). Even though things have significantly improved recently, progress has been uneventful, especially in some sectors of the economy. The percentage of female CEOs and chairs is shown in the graph below, which has increased from 4.9% in 2004 to just under 20% in 2021 (BWASA Women in Leadership Census, 2021).

Figure 1: Women in leadership positions (2004-2021):

Adapted from BWASA census (2021)

Additional work must be done to address the underrepresentation of women in senior leadership positions in the business sector (Shongwe, 2019). Despite being the most numerous, black African women are notably underrepresented in executive roles, evident in both the public and the private sectors (Teasdale, Fagan & Shepherd, 2012; Shongwe, 2019; Matotoka & Odeku, 2021). The representation of black women in managerial positions is even more blatantly lacking in transformation (McKinsey & Company & LeanIn, 2015; Shongwe, 2019; Matotoka & Odeku, 2021). This paper deliberately focuses on medical scheme leadership roles and stratifies these by gender and race to assess levels of representation in this regard. The paper considers the income gap stratified by scheme size, scheme type, and board size.

2. LITERATURE REVIEW

Despite the advantages of having more women in senior management positions or as business shareholders, women are still underrepresented compared to men (Shongwe, 2019; Mwashita, Zungu & Abrahams, 2020). Women have made great strides in dismantling gender stereotypes in all facets of life, and more and more are entering traditionally thought of as male-dominated professions (Huddy & Terkildsen, 1993; Finnemore & Cunningham, 1995; Stamarski & Son Hing, 2015; Tabassum & Nayak, 2021). Although the percentage varies by country, industry and sector, some sectors have made progress toward ensuring diversity and inclusivity regarding women's representation in leadership roles (Hill, Miller, Benson & Handley, 2016; Perdue, 2017; Agbim, 2018; PWC, 2022). One of the transformed industries in the US, with the highest percentage of female CEOs at 50%, has been the healthcare insurance sector (Cumming, 2022). Comparatively not a CEO but at the director level, the healthcare sector in South Africa reflects the highest women representation at 33.6% across nine (9) healthcare provider companies. The trend comparison analysis of the percentage of female CEOs in JSE-listed companies and state-owned entities is shown in Figure 2 below (BWASA census, 2021). The graph shows stark differences over ten years regarding females holding less than 6% of CEO positions in JSE-listed companies. In contrast, SEOs show a fluctuating but downward trendline. In SOEs, women made up nearly 18% of CEOs in 2004, but by 2021, that percentage had almost halved to 11% (BWASA census, 2021).

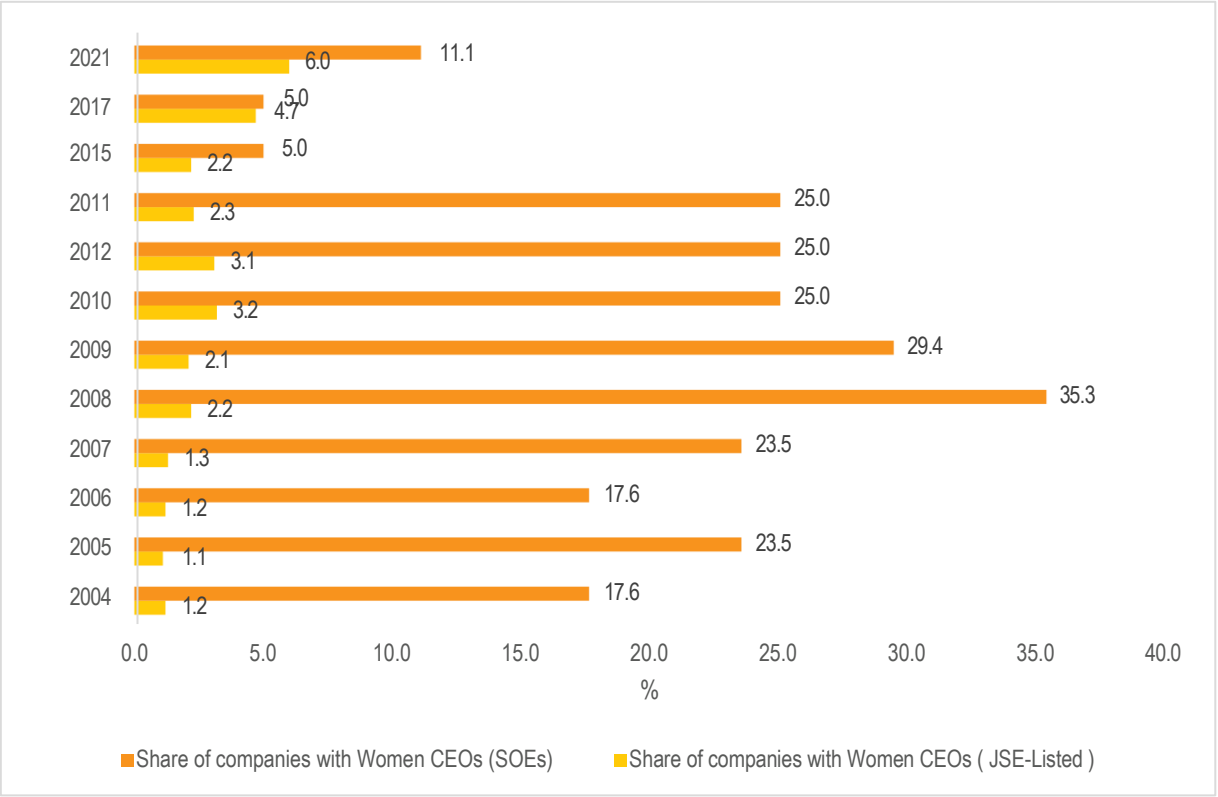

Figure 2: Percentage of Women CEOs JSE listed entities v. SOEs (2004-2021):

Adapted from BWASA census (2021)

As businesses strive to meet transformation and B-BBEE scorecards, race and gender representation in board positions, chief executives, and even the chief financial officer roles are generally gaining popularity (Moraka, 2013; Prinsloo, 2017). To diversify the representation of women in top management positions, the South African government considered various frameworks and implemented compliance standards where in some instances, there has been an improvement (Van Der Schyff, 2017; Shongwe, 2019; Matotoka & Odeku, 2021). The Employment Equity Act's implementation has led to an increase in the number of women working. Earlier reports by the Businesswomen's Association Census (2007) indicated that women comprise 42.9% of all workers in the Republic of South Africa. The International Labour Organization (ILO) reported that South Africa's female workforce participation rate was 47%, while the World Bank reported that the global rate is 52% (World Bank, 2022; ILO,2022). Employers who abide by employment equity laws and labour law reform contribute to this change, but more needs to be done to increase women's participation in executive positions and the workforce.

On the other hand, there are stark differences between CEOs' remuneration philosophies by gender, which is still an issue globally (Chen, Torsin, & Tsang, 2021). Executive remuneration is defined as the total cash remuneration of executive directors of the company as disclosed in published annual reports (Scholtz & Smit, 2012; Madlela & Lehloenya, 2016). There is a considerable gender pay disparity in top management positions, with the gender pay gap estimated to be 5–45% less than that of their male counterparts (Kahn & Motsoeneng; 2014; Bussin &Nienaber, 2015; NBI, 2021;). A recent study conducted in South Africa showed that the gender pay gap is most pronounced in the top JSE-listed companies (PWC, 2022). Understanding the reasons for the gender pay gap in the highest-ranking executive positions is essential, primarily when the executive is tasked with protecting the interests of the shareholders. Gender representation and pay gaps in leadership roles for non-profit organisations such as medical schemes have not been explored.

3. OBJECTIVES

This study sought to evaluate the gender pay gap and the representation of women among South African medical scheme CEOs/ POs. The study's secondary goal was to assess the degree of transition in medical organisations regarding leadership roles.

4. METHODOLOGY

The study design was a retrospective cohort of 50 registered medical schemes where CEOs' fees were incurred as of December 2022. This cross-sectional descriptive statistical analysis focused on characteristics of CEO fee-related characteristics. The minimum data also included financial information, such as the principal officer fees (earnings), board size, and demographic factors like gender and ethnicity. The Council for Medical Schemes (CMS) industry report annexures served as the secondary data source, and additional secondary sources, such as scheme-integrated reports, were used to triangulate the CEOs' gender and ethnicity. The median or mean of the average difference between the pay for all working men and women in the sample is typically the non-adjusted gender pay gap or gender wage gap. The study considered the median pay as a small number of high earners who significantly affect the average wage; average pay is typically much higher than median pay. Table 1 below depicts a descript of variables used in the study.

Table 1: Key definitions

Medical schemes	A medical scheme is a non-profit organisation with a board of trustees that must be registered with the CMS. In exchange for a monthly contribution or premium, medical schemes in South Africa provide members with coverage for their medical expenses.
Scheme type	The Medical Schemes Act of 1998 defines open schemes as open membership. As a result, they accept anyone who wants to become a member and pay the premium (Medical Schemes Act 131 of 1998). Closed or restricted medical schemes are limited to an employer or union (Medical Schemes Act 131 of 1998).
Scheme size	A large scheme has more than thirty thousand (30,000) beneficiaries; A medium scheme has less than thirty thousand (30,000) beneficiaries and more than six thousand (6,000); A small scheme has fewer than six thousand (6,000) members.
PO or CEO fees (Pay) unit of measure	Reported in South African Currency: 1$= ZAR18 per annum.

5. INCLUSION AND EXCLUSION CRITERIA

The review focused on the CEOs/POs of medical schemes who held their positions as of December 31, 2021. The demographic information collected included gender and race, with the definitions of race based on the categories outlined in South Africa's legal framework, including the Employment Equity Act of 1998 and the Census Act of 1996. These categories include Black, Coloured, Indian/Asian, and White, and are primarily based on historical racial classification, social and economic status, and cultural identity. It's important to note that there has been debate and criticism surrounding these categories, as they do not fully capture the complexity and diversity of South Africa's population.

To ensure the accuracy of the demographic data, face validity was used to validate the information collected from multiple data sources, including integrated annual reports. Face validity refers to the initial appearance of a test or assessment and the extent to which it appears to measure what it is intended to measure based on a surface-level examination. However, it is important to note that face validity alone does not guarantee the validity of the test or assessment.

6. ANALYSIS AND RESULTS

6.1. Sector and size effect

The study included 50 of the 71 registered medical schemes that remunerated their CEO with a cut-off of R120 000 pa. The 51 medical schemes accounted for R220 Billion (98% of revenue generated by the industry in 2021). The results showed 18 (36%) black COEs compared to 32 (64%) white. When adjusting for gender, the results showed that 23 (46%) CEOs were females, while 27 (54%) were males. The results show CEO fees increased with scheme size but differed by scheme type. Open schemes paid more than restricted schemes, large, closed schemes, and median CEO fees were 75% of large open schemes. This gap was narrower in median and small schemes, 88% and 97%. Table 2 below shows descriptive statistics of CEO fees by scheme size and scheme type.

Table 2: CEO fees by scheme type and scheme size

Scheme type	Scheme size	N	Median (IQR) R'000
Open	**Large**	8	5,014 (3,438 - 6,536)
	Medium	5	2,037 (2,029 - 2,760)
	Small	3	657 (365 - 1,894)
Restricted	**Large**	14	3,763 (2,721 - 4,820)
	Medium	9	1,702 (856 - 2,516)
	Small	11	635 (492 - 708)

6.2 Gender and sector effect

Table 3 below shows descriptive statistics of CEO fees by scheme size and scheme type. The results showed that CEOs differed when adjusting for gender and scheme type. The median pay for females in open schemes was R3,4 million compared to the median pay of R1,2 million in closed schemes, depicting a pay gap of 75%. The median pay for males in open and closed schemes was similar, whereas, in open schemes, male CEOs' median pay was R2,6 million compared to R2,1 million, which depicts a pay gap of 20%.

Table 3: CEO fees by gender and scheme type

Gender	Race	N	Median (IQR) R'000
Female	**Open**	9	3,438 (2,760 - 3,662)
	Restricted	14	1,197 (635 - 2,917)
Male	**Open**	9	2,570 (657 - 6,365)
	Restricted	18	2,131 (678 - 4,125)

6.2. Gender and scheme size effect

Table 4 below shows descriptive statistics of CEO fees adjusted for the gender of the CEO and scheme size. The median pay for female CEOs in large open schemes was R3,5 million per annum, significantly higher compared to female CEOs in small schemes with a median of R628 000. The median pay gap between female CEOs in large and medium schemes was 40%, while between large and small schemes was 81%. Similar analysis when adjusting for male CEO median pay gap between large and medium schemes was 58% and 85% between large and small schemes. A direct comparison between female and male CEOs in large schemes was 25%, while female CEOs in medium schemes earned more than their male counterparts. The median pay gap between female and male CEOs in small schemes is only 6%.

Table 4: CEO fees by gender and scheme size

Gender	Scheme size	N	Median (IQR) R'000
Female	**Large**	9	3,461 (3,401 - 4,625)
	Medium	6	2,109 (1,197 - 2,760)
	Small	8	628 (489 - 898)
Male	**Large**	13	4,620 (3,030 - 6,365)
	Medium	8	1,931 (389 - 2,602)
	Small	6	665 (492 - 678)

6.3. Correlation analysis

Figure 3 below shows that the two variables explained only 6% of the variability; this was also not statistically significant, with a p-value of 0.09 (R- squared=0.0582, Adj R- squared=0.0386). Figure 3 illustrates the relationship between CEO fees and board size regarding the number of trustees. When considering their demographic traits, such as gender and race, which are shown in Figures 4 and 5, respectively, similar results were notable.

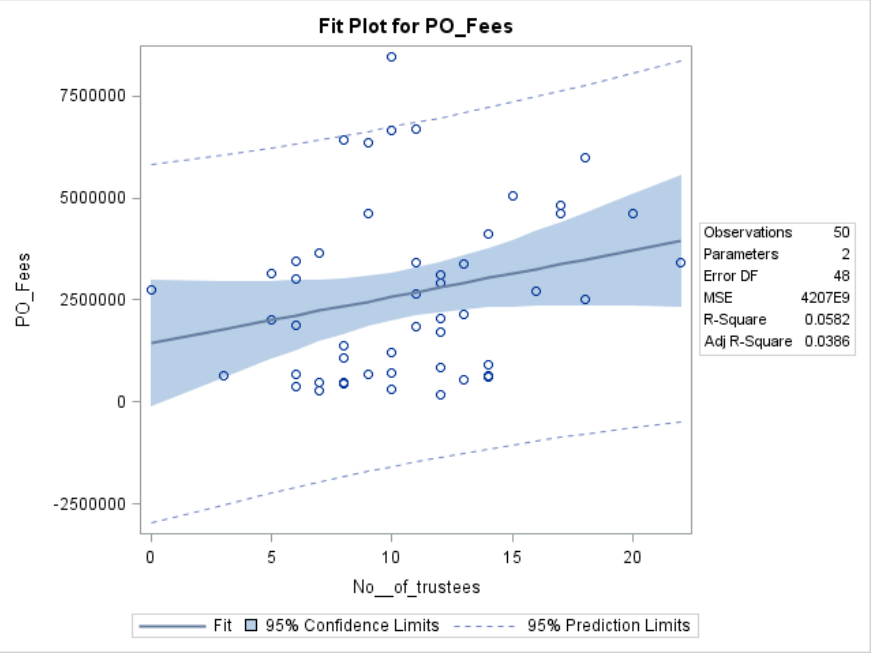

Figure 3: Fit Plot for CEO fees and No. of trustees

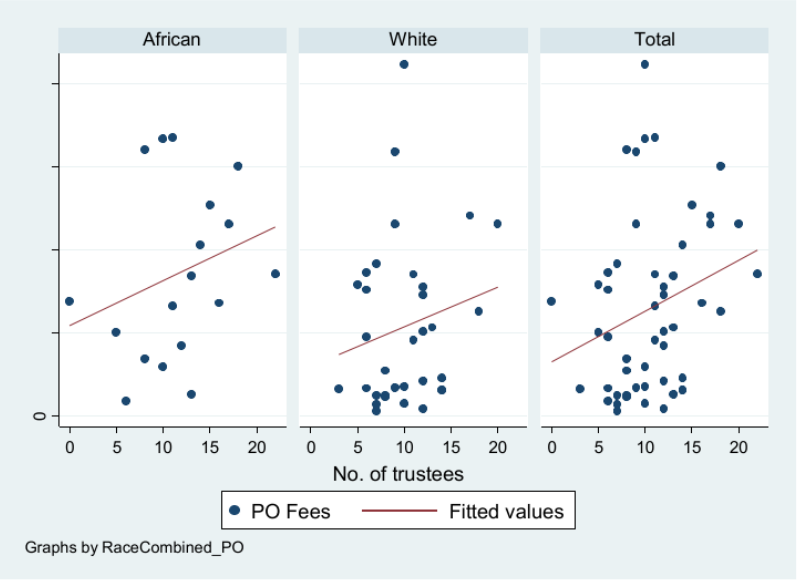

Figure 4: Fit Plot for CEO fees vs the No of trustees adjusted for race

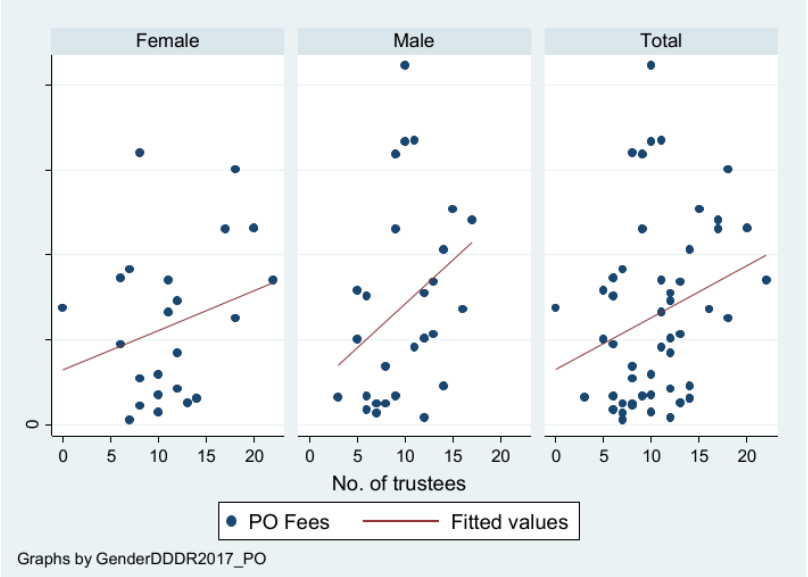

Figure 5 Fit plot: CEO fees vs No of trustees adjusted for gender

7. DISCUSSION

According to the analysis, of the 50 medical schemes, there were 32 (64%) white CEOs as opposed to 18 (36%) black CEOs. This study found that there were more white CEOs compared to black CEOs in medical schemes. When adjusting for gender and sector, this trend also persisted. In South Africa, women hold only 23% of the positions that involve making economic decisions, and only 4% of CEOs positions, according to Scheepers, Douman and Moodley (2018). This study finds that women accounted for 46% of the CEOs in the medical schemes industry, which was significant compared to other sectors. Relative ratios were split between white male vs female CEOs and black male vs females, 18:14 and 9:9, respectively.

The CEO pay in medical schemes rises with the size of the scheme, with large schemes paying considerably more than small schemes. The positive correlation between firm size and the gender pay gap has been demonstrated in the literature; Bussin (2018) studied the Chief executive officer compensation sensitivity in the South African mining industry and could found that organisation size plays an influential role in CEO compensation levels. 2011). Heinze and Wolf (2010) found that firm market power grows with firm size, the gender wage gap shrinks, and the author also suggested that industry characteristics may contribute to pay inequality, which is supported by the current study.

Contrarily, other studies find that wage inequality is more sensitive to random size variation in large than in small industries and that pay inequality is not truly a function of change in industry size in an absolute number of firms (Aarstad & Kvitastein, 2021). The study discovered that open schemes paid CEOs more than closed schemes, which may also reflect the characteristics of open and closed schemes. Open schemes compete for membership, and open enrolment is more pertinent to open schemes than closed schemes. Despite the country's numerous laws, legal framework, and guidelines prohibiting gender discrimination at work, the median gender pay gap in South Africa, reported by the United Association of SA (UASA), remained between 20% and 35% (UASA, 2022).

The current study also showed that the sector and scheme size and their impact on the pay gap changed with each level. The pay gap between male and female CEOs in large schemes was 39% but 6% in small schemes. A direct comparison between female and male CEOs in large schemes was 25%, while female CEOs' pay in medium schemes was higher than their male counterparts. The median pay gap between female and male CEOs in small schemes is only 6%. The pay gap in large schemes is wider than the information for other industries. According to the study, the sector with the highest gender pay gap in South Africa was the healthcare industry, with a pay gap of 45%. This was followed by the real estate sector, with a pay gap of 27%, and the financial sector, with a pay gap of 25%. Various factors affect pay disparities and gaps; at a broader level is the remuneration philosophy of each medical scheme. The compensation packages offered to CEOs consist of fundamental elements: basic salary, performance bonus, pay-outs

from long-term incentive awards, and grants of restricted stock, severance, and retirement package, which may vary by company remuneration philosophy (Frydman & Jenter, 2012; Mojapelo; 2016). The most common determinants of remuneration cited in the literature include the type of qualification or highest level of education, area of speciality, experience, performance-linked incentives, structure and operating model, complexity, operating environment and executive's position or scope of work (Bussin, 2018; Kumar, Sarkar & Dhiman, 2019; Ramgath & Bussin, 2022). Bussin & Ncube (2017) found a positive relationship between CEO and CFO remuneration (fixed pay and short-term incentives) and company performance in SOEs.

This study found that the median pay for female CEOs in open schemes was nearly three times higher than for female CEO pay in closed schemes, depicting a pay gap of 75%. The median pay for males in open and closed schemes was similar, whereas, in open schemes, male CEOs' median pay was R2,6 million compared to R2,1 million, which depicts a pay gap of 20%. This finding illustrates a new dimension where female leaders in closed schemes are paid less than those in open schemes; however, this was not as apparent when male CEOs were compared by sector. In medium- sized schemes, female CEOs' median pay was also slightly higher than male CEOs'; however, the study did not examine the underlying causes of this difference.

8. CONCLUSION

The research topic is novel in medical schemes. However, it has been studied extensively in JSE-listed companies and industries. This research shows that the gender pay gap in medical schemes is more pronounced than reported elsewhere. This new finding quantifies the size of the pay gap with female CEOs and highlights the significant disparity between open and closed schemes among female CEOs. The results help identify areas for improvement in luring thought leaders in the industry and further emphasises that more can be done to lessen inequality by drawing and keeping capable black CEOs in medical schemes and doing more to reduce the pay gap between female and male CEOs. The results may help medical schemes, companies, professionals, and executives understand how different pay scales affect gender equity.

9. LIMITATIONS

The research study is subject to some limitations. This study did not consider the key performance indicators, level of education, experience, or other variables that affect CEO pay in medical schemes. Annexure A below further depicts the varying distribution of CEO fees adjusted by race, gender and sector.

Board size is essential for governance structures, such as the board's composition, because the CEO reports to the board. The board dynamics of closed schemes differ from those of open schemes. closed medical aid schemes in South Africa typically have two key distinguishing characteristics. The first is that they are primarily unionised, meaning that they are designed to cater to the healthcare needs of members of specific trade unions or other professional associations. These closed schemes are often created through collective bargaining agreements between unions and employers and are typically only open to employees of specific companies or industries. The second distinguishing characteristic of closed medical aid schemes is that they are employer specific. This means that they are usually only available to employees of a specific employer or group of employers. This contrasts with open medical aid schemes, which are open to anyone who meets the eligibility requirements and pays the necessary premiums. The size of the BoT and the CEO fee were not correlated in this study. The impact of board size, various sector remuneration philosophies, key performance metrics, and incentives should be considered in future studies.

10. CONFLICT OF INTEREST

The author declares that no financial or personal relationships in writing this article may have influenced them inappropriately.

11. ETHICAL CONSIDERATIONS

The data used in this study is sourced from the CMS industry report and annexures in the public domain and was further triangulated with other sources such as schemes and integrated annual reports. The data were assessed and only reported at the consolidated level for privacy and confidentiality. No clinical or patient-specific information was accessed or reported while conducting this research.

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13. ANNEXURES A: DISTRIBUTION OF PO/CEO FEES BY SCHEME TYPE (SECTOR), GENDER AND RACE)