CMS

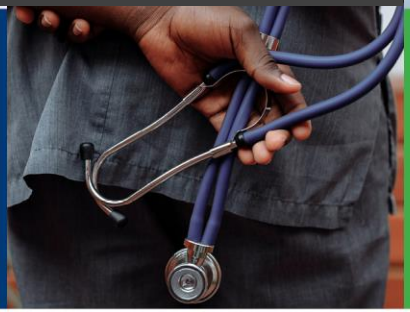
Council for Medical Schemes

A review of government-funded medical schemes and medical schemes with less than 6000 members




Council for Medical Schemes

April 2024

This document is released by the Policy Research and Monitoring Division (PRMD) within the CMS. Functioning as a dedicated entity, the PRMD serves both medical scheme beneficiaries and the general public. Its core responsibilities encompass the execution of research projects, data collection, and analysis to evaluate and monitor healthcare utilisation and performance of the sector, assess and report on emerging trends within medical schemes. The unit is additionally tasked with quantifying risk within these schemes and formulating recommendations to advance regulatory policy and implementation. A primary objective of the PRMD is to actively contribute to developing policies that reinforce safeguarding the interests of both beneficiaries and the broader public. The research team comprises specialists with diverse expertise in health economics, statistics, epidemiology, public health, and financial analysis.

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EXECUTIVE SUMMARY

This report reviews the performance of government-affiliated or state-associated medical schemes, including those accommodating fewer than 6000 principal members. Drawing upon data from the Council for Medical Schemes (CMS) Industry Report and annexures generated by the Financial Supervision subunit of the Regulations division, the state employees' medical schemes are found to encompass 1.2 million principal members and 3.0 million beneficiaries in 2022, constituting approximately 33.5% of the medical scheme industry and a noteworthy 72.5% of restricted schemes in terms of beneficiaries. Within the cohort of the 11 state employees' medical schemes, four depict membership figures below 6,000. The demographic characteristics of state-funded medical schemes are characterised by an average age ranging from 28.9 to 57.3 years. Additionally, the dependent ratio ranged from 0.5 to 1.7, while the pensioner ratio ranged between 3.4% and 49.4%. The Gross Contribution Income of these medical schemes amounted to R70.1 billion, and the Gross Relevant Healthcare Expenditure, inclusive of the Personal Medical Savings Account (PMSA) and managed healthcare claims, registered a percentage range between 87.6% and 103.4%, with SAMWUMED surpassing the 100% threshold. An analysis of the solvency ratio, a pivotal metric regulated by the Medical Schemes Act, (MSA) indicates that ten of the 11 schemes complied with Regulation 29, maintaining a solvency ratio above the mandated 25%. Notably, Transmed lagged with a solvency ratio of 17.9%. The reviewed medical schemes concluded the year with reserves of R38.6 billion as of December 2022. The schemes' gross administration expenditure (risk + PMSA) amounted to R3.5 billion, with the LA-Health medical scheme incurring higher non-healthcare expenditures than other schemes. At the same time, AGM-related fees reached a collective sum of R3.1 million. Noteworthy expenditure practice differences were observed, with Medipos, SAMWUMED, and POLMED disproportionately allocating resources to AGMs relative to their membership. Medipos AGM expenditure was significantly higher than other reviewed schemes relative to membership. Lastly, this study depicted varying remuneration practices among the schemes, with GEMS average fees per trustee per annum significantly higher than other schemes. Strengthening governance structures within government-funded schemes, addressing trustee fee disparities, and promoting consistency aims to foster trust and accountability, creating a more equitable and efficient organisational framework. Transparent communication and educational campaigns targeting scheme stakeholders are pivotal for successful consolidation, necessitating policy adjustments to grant the CMS the authority for effective interventions and aligning policies with the healthcare landscape for sustainable government-funded medical schemes. The analysis and findings offer valuable insights for healthcare policymakers, practitioners, and researchers, especially regarding government-funded medical schemes.

ACRONYMS

AGM	Annual General Meeting
BoT	Board of Trustees
CMS	Council for Medical Schemes
CDL	Chronic Disease List
FSU	Financial Supervision Unit
GAE	Gross Administration Expenditure
GCI	Gross Contribution Income
GEMS	Government Employees Medical Scheme
MCO	Managed Care Organisations
MSA	Medical Schemes Act
NHI	National Health Insurance
NIA	National Intelligence Agency
PMB	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Account
POLMED	South African Police Service Medical Scheme
RUMed	Rhodes University Medical Scheme
SABC	South African Broadcasting Corporation
SAMWUMED	South African Municipal Workers Medical Scheme
SAPO	South African Post Office
SAPS	South African Police Service
SANDF	South African National Defence Force
SASS	South African Secret Service
UKZN	University of KwaZulu-Natal Medical Schemes

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1. INTRODUCTION

Government-funded medical schemes and subsidies are essential to healthcare financing, ensuring citizens' access to medical services. These medical schemes, often established, managed, and/or associated with the government, aim to provide financial assistance or insurance coverage for healthcare expenses. With an increasing demand for healthcare that is both equitable and efficient, the strategic consideration of consolidating risk pools becomes a significant avenue for exploration. A thorough understanding of the landscape is attained by examining critical aspects such as membership profiles, financial frameworks, and historical performance metrics. In response to the scenario characterised by fragmented risk pools and the inherent threat posed by schemes with minimal membership, the CMS previously formulated a consolidation framework for medical scheme consolidation. This framework was designed to pad the sustainability of smaller risk pools and mitigate the associated risks of schemes with a limited number of members, acting as a safeguard against potential mergers and liquidations. Acknowledging the limitations embedded in the consolidation regulatory framework for medical schemes is crucial. Notably, the CMS does not have the authority to mandate mergers, as this prerogative falls within the purview of the board of trustees of each scheme. Therefore, the study highlights the necessity for a regulatory framework that would allow the CMS to effectively promote and manage the consolidation of risk pools, ultimately benefiting scheme members and the overall healthcare system. Furthermore, drawing parallels between government-funded medical schemes and their predominant role in providing government subsidies adds another layer to the narrative. This common element underscores their alignment with broader governmental healthcare initiatives, emphasising the interconnectedness of these schemes with the national healthcare landscape.

2. PURPOSE

The study aims to enhance understanding of government-funded medical schemes and their risk pool consolidation. It examines the structure and performance of these schemes and smaller risk pools, explores the rationale for consolidation, assesses regulatory frameworks, identifies limitations, draws comparisons, and presents policy implications. Additionally, the report evaluates the performance of government-funded schemes and those with fewer than 6,000 principal members, comparing them to closed schemes and the broader industry.

3. METHODS

This study employed a mixed-methods research design to comprehensively investigate the organisational dynamics and risk pool consolidation within government-funded medical schemes. Purposive sampling focused on schemes with fewer than 6,000 principal members, closed schemes and government-affiliated or state-associated medical schemes. Quantitative data were gathered through secondary data such as CMS annexures, annual reports, and respective medical schemes, providing insights into organisational structures and financial performance. Qualitative data were obtained through document analysis of scheme materials and information in the public domain, allowing for a deeper understanding of the rationale for consolidation and organisational decision-making. Data analysis involved descriptive statistics, comparative studies, and thematic analysis. Ethical considerations were paramount throughout the research, as well as limitations, such as the use of publicly available data. Ultimately, this study aimed to offer valuable insights for healthcare stakeholders by informing decisions related to risk pool consolidation and organisational dynamics within government-funded medical schemes.

4. INCLUSION AND EXCLUSION CRITERIA

The analysis included state-funded medical schemes with a membership size below 6000. It is essential to highlight that specific medical scheme, such as Medshield, Discovery Health Medical Scheme, Bonitas Medical Scheme, and others, exhibit distinct dynamics that cannot be generalised. These dynamics occur when the maim member works in a different sector while the spouse who is registered as a dependant is employed by the state or vice versa.

Furthermore, other optional medical schemes offering coverage for government employees were not considered within the scope of this research. The exclusion of these schemes was driven by the aim to specifically focus on state-funded and smaller-sized schemes to achieve a targeted and meaningful analysis of their organisational dynamics and risk pool consolidation. **Table 1** below shows the list of the government-affiliated or state-associated medical schemes.

Table 1: Government-affiliated or state-associated medical schemes

Medical Scheme	Features
South African Police Service Medical Scheme (POLMED)	- Eligible for South African Police Service (SAPS) employees and their dependents
Government Employees Medical Scheme (GEMS)	- Registered in 2005 for government employees' healthcare needs
LA Health Medical Scheme	- Operates in Local Government for over 50 years - Accredited by South African Local Government Bargaining Council to cover Local Government employees
SABC Medical Scheme	- Provides healthcare coverage to SABC employees and their dependents
Rand Water Medical Scheme	- Associated with Rand Water, a water utility company.
South African Municipal Workers Union Medical Scheme (SAMWUMED)	- Caters to municipal workers, including local government employees
Transmed Medical Fund	- Established in 1910 to support railways and harbour workers - Registered as a medical scheme in 1999
MEDiPOS Medical Scheme	- Serves South African Post Office (SAPO) employees and its pensioners
Parmed Medical Scheme	- Established in 1974 as a restricted scheme for specific government officials
Rhodes University Medical Scheme (RUMed)	- Restricted to Rhodes University employees, retirees, and their dependents
University of KwaZulu-Natal Medical Scheme	- Established in 1983 to ensure the best possible healthcare benefits for the employees of the University of KwaZulu-Natal and their immediate family members registered on the scheme.

5. ANALYSIS, RESULTS AND DISCUSSIONS

5.1 State Employees Medical Schemes Risk pools

The state employees' medical schemes, as defined in this report, comprise individuals employed by various entities, including the South African Police Service (SAPS), local government and associated agencies, state-owned enterprises, national and provincial departments, entities listed in Schedule 3 of the State Act (excluding SANDF, NIA, SASS, and SAPS), employees of Rhodes University, and members of the South African Parliament. These schemes extend coverage to both serving and former employees and their dependents. In 2022, the state employees' medical schemes accounted for 1.2 million principal members and provided healthcare services to 3.0 million beneficiaries. This represents a substantial 33.4% of the medical scheme industry and a 72.3% share in restricted schemes concerning beneficiaries. The demographic profile of individuals covered by state-funded medical schemes is an average age range of 28.95 to 57.28 years. Additionally, the dependent ratio within these schemes ranged from 0.5 to 1.7, while the pensioner ratio fluctuated between 3.64% and 49.44%. Notably, the average age of members enrolled in state employees' medical schemes exhibits diversity, with only four out of the 11 schemes having a weighted average age lower than closed schemes' average age of 31.69 years, as illustrated in **Figure 1**. This demographic overview provides insights into beneficiaries' composition and age distribution within state-funded medical schemes, informing healthcare service provision and resource allocation considerations.

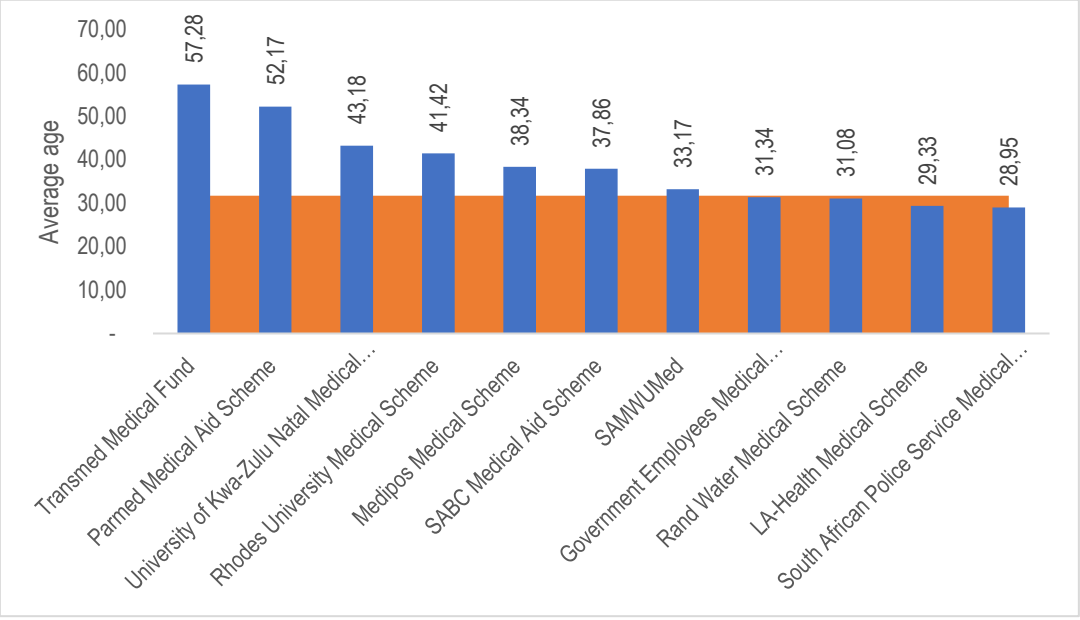

Figure 1: Average age of state employees' medical schemes

5.2 Benefits paid.

Regarding benefits paid towards the utilisation of health services by members of medical schemes, the most significant proportion of benefits was paid towards hospitals (**Table 2**). The analysis revealed the distribution of healthcare resource utilisation across various medical schemes in South Africa. SAMWUMED and Medipos had the highest proportion of benefits paid towards hospital services at 36,75% and 36,48% of all benefits paid, respectively. The Government Employees Medical Scheme (GEMS) was the third highest amongst the schemes at 35.11% allocation in total hospitals, followed by the LA-Health Medical Scheme at 34.68%. Regarding specialist engagement, the Parmed Medical Aid Scheme and the University of KwaZulu-Natal Medical Scheme had the highest proportion of benefits paid, above 25%. Regarding medicine dispensation, the Parmed Medical Aid Scheme allocates a significant 21.20%, indicating a considerable emphasis on pharmaceutical services. Transmed Medical Fund stands out with a notably high allocation of 26.50% in medicine dispensed, reflecting a focus on prescription services. In the realm of supplementary and allied health professionals, SAMWUMED leads with a percentage of 11.51%, suggesting an emphasis on a diverse range of health services.

The distribution of resources among general practitioners showcases a diverse landscape, with the South African Police Service Medical Scheme (POLMED) allocating 7.89%, indicating a substantial engagement with primary healthcare providers. Managed care arrangements, particularly those out-of-hospital, are prominently featured in SAMWUMED, which allocates 8.45%, highlighting a strategic approach to healthcare management. Regarding dental services, the Rhodes University Medical Scheme demonstrates a considerable allocation of 4.23%, emphasising the importance of oral health within the scheme. The data also points to disparities in the engagement of dental specialists, with Transmed Medical Fund dedicating a minimal 0.03%, indicating a lower focus on specialised dental services. Analysing the overall landscape, the consolidated figures for open and restricted schemes show that 35.46% is allocated to total hospitals, highlighting the significance of inpatient care. The distribution across other categories underscores the diverse strategies employed by these medical schemes to meet the varied healthcare needs of their beneficiaries.

Table 2: Percentage of Benefits paid in 2022

Scheme Name	Total Hospitals	All Specialists	Medicine Dispensed	Supplementary and Allied Health Professionals	General Practitioner	Managed care arrangements (out-of-hospital)	Dentists	Other Health Services	Dental Specialists
GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	35,11%	25,22%	16,44%	8,79%	7,09%	2,27%	2,28%	2,20%	0,47%
LA-HEALTH MEDICAL SCHEME	34,68%	23,71%	17,05%	9,77%	6,78%	2,72%	2,52%	1,93%	0,74%
MEDIPOS MEDICAL SCHEME	36,48%	22,24%	17,19%	9,70%	5,08%	1,40%	2,93%	1,42%	1,25%
PARMED MEDICAL AID SCHEME	30,42%	29,93%	21,20%	9,55%	2,79%	1,01%	2,72%	1,59%	0,80%
RAND WATER MEDICAL SCHEME	32,48%	22,96%	18,53%	9,48%	7,30%	1,96%	2,02%	0,41%	0,57%
RHODES UNIVERSITY MEDICAL SCHEME	30,10%	24,03%	20,91%	10,02%	6,39%	2,75%	4,23%	0,37%	0,73%
SABC MEDICAL AID SCHEME	31,92%	25,91%	17,84%	10,37%	4,29%	3,64%	3,26%	1,68%	1,08%
SAMWUMED	36,75%	24,12%	13,04%	11,51%	8,40%	1,47%	1,85%	2,15%	0,71%
SOUTH AFRICAN POLICE SERVICE MEDICAL SCHEME (POLMED)	33,29%	24,47%	15,87%	10,16%	7,89%	8,45%	2,50%	2,50%	0,65%
TRANSMED MEDICAL FUND	31,48%	25,54%	26,50%	4,96%	5,18%	3,48%	0,16%	2,26%	0,03%
UNIVERSITY OF KWAZULU-NATAL MEDICAL SCHEME	30,37%	27,22%	19,67%	10,95%	4,35%	3,10%	2,77%	0,80%	0,64%
Open schemes	**36,07%**	**28,46%**	**14,99%**	**7,65%**	**4,28%**	**5,11%**	**1,66%**	**1,78%**	**0,60%**
Restricted schemes	**34,64%**	**25,12%**	**16,25%**	**8,72%**	**6,55%**	**4,06%**	**2,39%**	**2,00%**	**0,60%**
Consolidated (Open & Restricted Schemes)	**35,46%**	**27,03%**	**15,53%**	**8,11%**	**5,25%**	**4,66%**	**1,97%**	**1,88%**	**0,60%**

5.3 Governing structure

In accordance with Section 57 of the MSA, the board structures of closed schemes are outlined to include both nominated and elected trustees. This composition varies depending on the specific sector. This distinction is a pivotal factor influencing the overall composition of the board. The number of trustees constituting the board in state employees' medical schemes ranges from 7 to 19, reflecting the diverse governance structures within these schemes. The remuneration philosophy for trustees exhibits significant variability across schemes, with some offering considerably higher remuneration packages than others. As of 2022, the average trustee fees for the GEMS were found to be the highest in the industry, surpassing the average for closed schemes by 13 times and exceeding the second-largest state-funded closed scheme, Polmed, by four times, standing at R1.3 million annually.

In contrast, Polmed and LA-Health Medical Schemes reported trustee fees of R375 thousand and R213 thousand per annum, respectively. This substantial disparity in remuneration across schemes underscores the complexity of remuneration philosophies within the industry. Moreover, it is essential to highlight the significance of assessing changes between respective years, particularly in scheme performance, board size, and scheme size. In this regard, an intriguing observation is the noteworthy doubling of trustee fees for GEMS between the assessed years, emphasising the dynamic nature of remuneration structures within state employees' medical schemes and their responsiveness to industry intricacies.

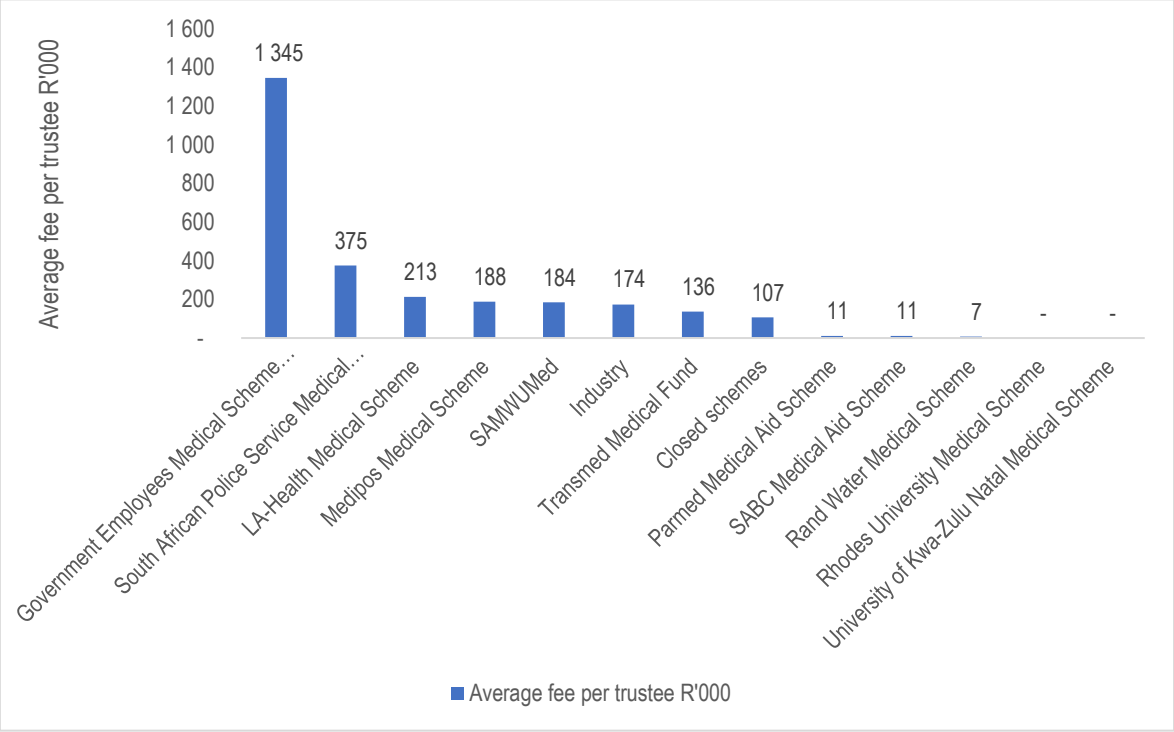

Figure 2: Average fee per trustee pr annum R'000- State-funded medical schemes-2022

5.4 Contributions and Risk Claims -2022

In 2022, the state employees' medical schemes accounted for R70.5 billion in gross contribution income, accounting for 30.34% of the industry's contribution income. For the year 2022, the risk contribution per average beneficiary per month ranged between R 1563,36 and R 5665,06 per month. Besides GEMS, SAMWUMED, and LA-Health Medical Scheme, most schemes had risk claims contribution income greater than the closed scheme average of R1960,92. **Figure 3** below shows that Parmed Medical Aid Scheme members contributed more than R5 000 per month.

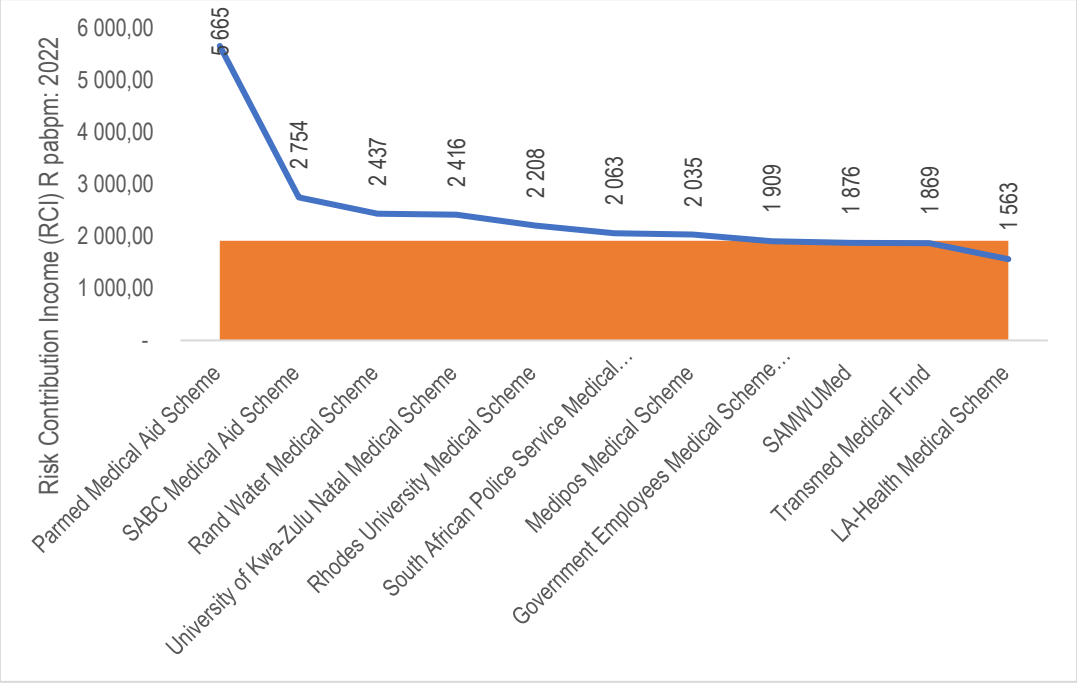

Figure 3: Risk contribution income per average beneficiary per month – 2022

Most state-funded medical schemes exhibited a risk claims ratio below 90%; however, a few deviated from the closed average of 95.01%. Notably, GEMS, Parmed, and SAMWUMED reported risk claims of 96.45%, 97.67%, and 103.42%, respectively. The figure below further indicates no direct relationship between age and claims ratio. This observation is particularly notable in SAMWUMED, which had a younger age profile but registered the highest claims ratio among the state-funded medical schemes.

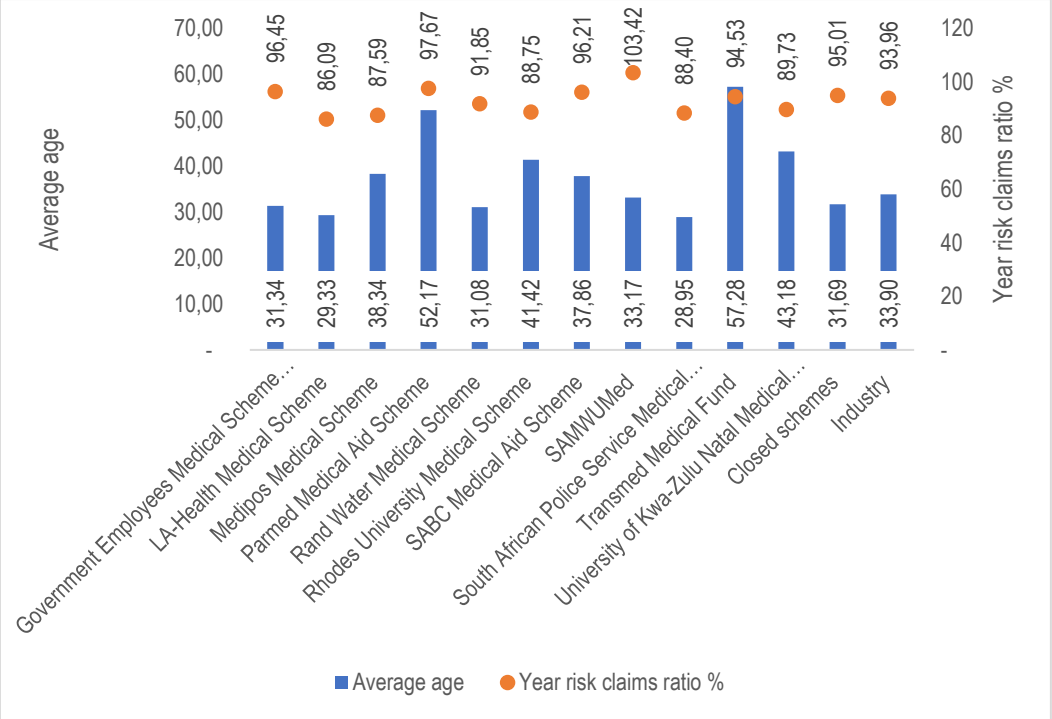

Figure 4: Risk Claims ratio, Average age – 2022

The graph below illustrates the association of claims against solvency ratios, revealing noteworthy patterns within the performance of medical schemes (**Figure 5**). Notably, nine medical schemes exhibited solvency ratios surpassing 20%, underscoring their financial soundness. A notable exception was observed in the case of Transmed. Furthermore, the graph highlights one scheme, SAMWUMED, with a claim ratio exceeding 10%, suggesting the potential scenario of disbursements surpassing collected premiums. On the other hand, specific schemes, namely Rhodes University, Polmed, LA-Health, and Medipos, experienced elevated claims ratios. Intriguingly, the graph does not reveal a direct relationship between claims and solvency ratios, emphasising the unique relationship between these variables in medical scheme performance.

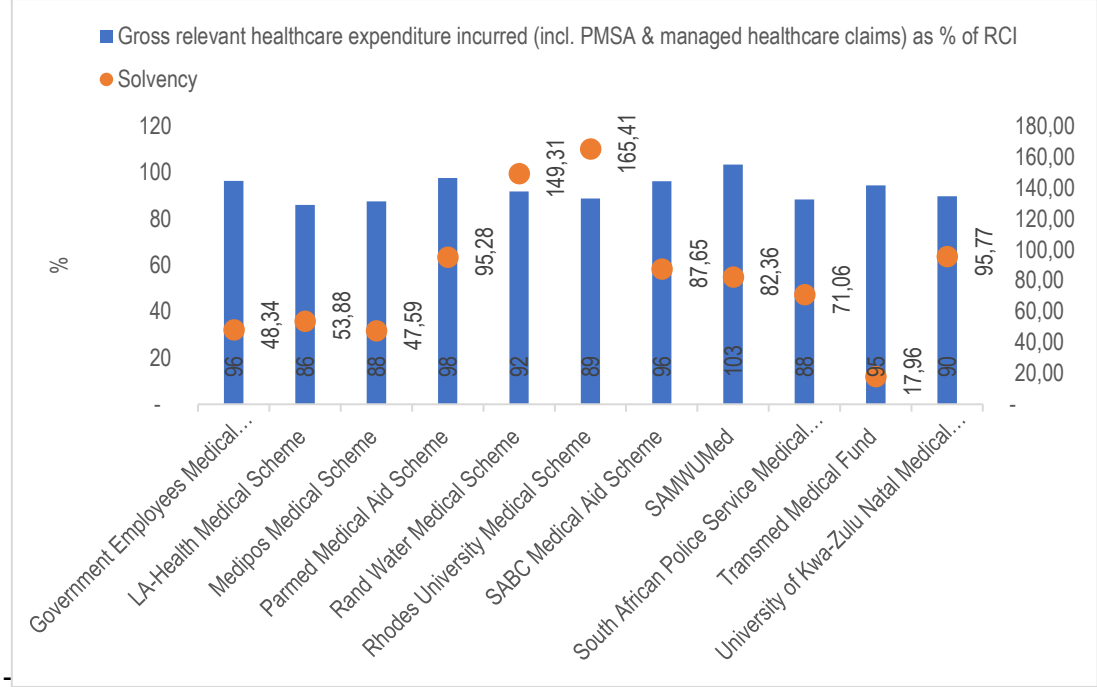

Figure 5:: Risk claims ratio and Solvency-2022

5.5 Administration expenditure

The medical scheme's business model entails outsourcing administration functions to for-profit entities such as administrators, while others conduct these functions in-house. Administration tasks for medical schemes are typically outsourced to third-party administrators, managed care organisations (MCOs), and brokerage firms. The reviewed schemes incurred R3.5 billion, which accounted for 67% of closed schemes and 22% of industry administrative services expenditure for the period under review (**Table 3**).

Table 3*:* Gross administration expenditure

	Gross administration expenditure R'000	
Scheme name	**2022**	**2021**
Government Employees Medical Scheme (GEMS)	2 436 355	2 169 905
LA-Health Medical Scheme	413 975	384 369
Medipos Medical Scheme	34 398	32 450
Parmed Medical Aid Scheme	10 811	10 419
Rand Water Medical Scheme	11 998	11 386
Rhodes University Medical Scheme	4 118	3 820
SABC Medical Aid Scheme	15 763	14 589
SAMWUMED	115 930	99 199
South African Police Service Medical Scheme (POLMED)	434 153	433 415
Transmed Medical Fund	52 168	55 723
University of KwaZulu-Natal Medical Scheme	12 919	12 315
State-funded schemes	3 542 588	3 227 590
Closed schemes	5 276 765	4 961 915
Industry	15 891 120	14 960 310

When normalised for the number of beneficiaries, When accounting for the average monthly member, Parmed, LA-Health, and SABC Medical Aid Scheme incurred expenditures higher than the industry average of R326 (**Figure 6**). At the same time, only two schemes, GEMS and POLMED, had gross administration expenditures lower than the industry average of R258. When adjusted for gross contribution income, Transmed and LA-Health recorded Gross Administration Expenses (GAE) as a percentage of Gross Contribution Income (GCI) higher than the industry average of 6.85%, with Transmed incurring 9.65% and LA-Health 7.33%, respectively. In contrast, SABC Medical Aid Scheme, Government Employees Medical Scheme (GEMS), Rand Water Medical Scheme, Parmed Medical Aid Scheme, and South African Police Service Medical Scheme (POLMED) had a GAE as a percentage of GCI less than that of closed schemes, amounting to 5.31%.

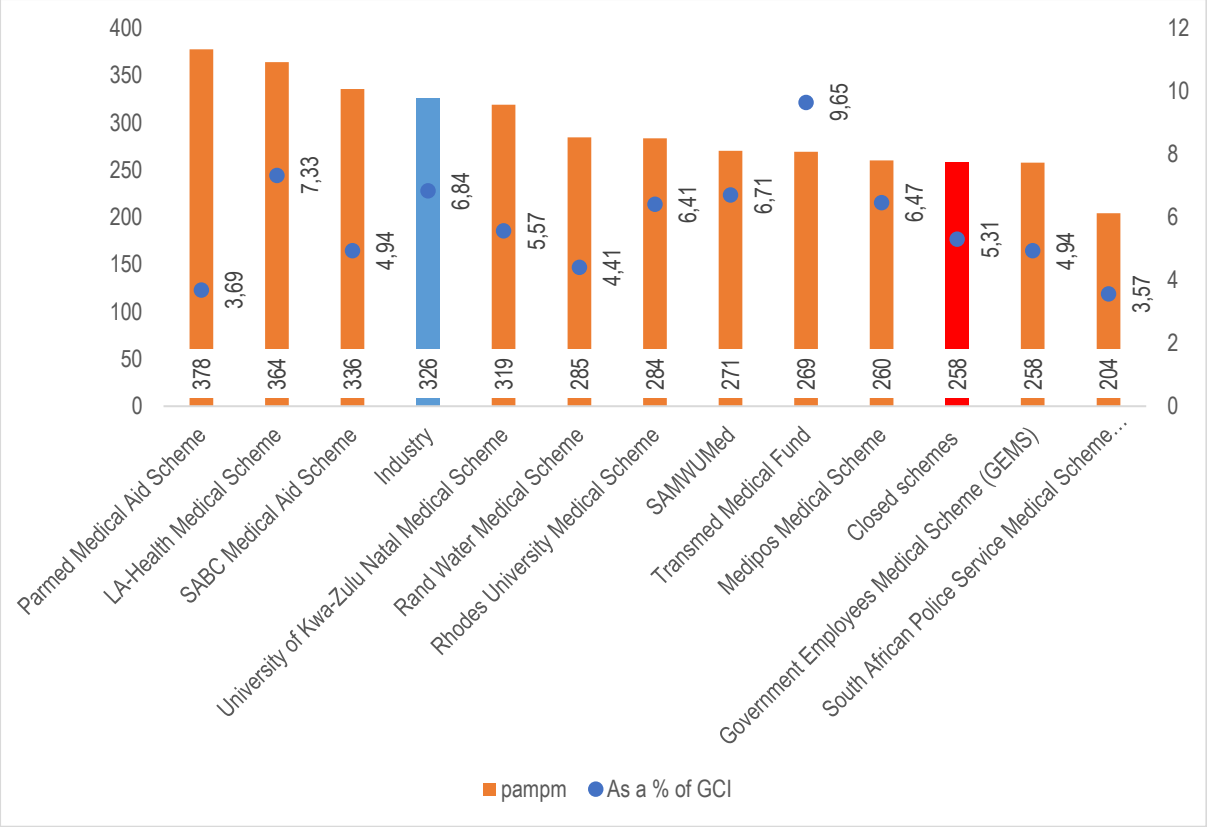

Figure 6: Gross administration expenditure (Risk +PMSA) as % of GCI- state-funded schemes

5.6 Fees related to AGMs and marketing services

The table below illustrates a noteworthy decrease in fees related to the Annual General Meeting (AGM) across the examined schemes **(Table 4)**. This decline is evident consistently across all schemes, potentially indicative of a trend where some schemes leverage technology and adopt hybrid models for their AGMs. However, a closer examination of the data reveals that specific schemes allocate significantly more resources to AGMs. Notably, Medipos outstrips the expenditures of other schemes relative to lives covered. Other schemes exhibiting potentially elevated levels of AGM-related expenditure include the SAMWUMED, the South African Police Service Medical Scheme (POLMED), and the University of KwaZulu-Natal Medical Scheme.

Table 4: Fees related to AGMs

	Annual General Meeting expenditure R'000		
	2022	**2021**	**% change**
Government Employees Medical Scheme (GEMS)	400	1 413	-72
LA-Health Medical Scheme	54	89	-39
Medipos Medical Scheme	404	505	-20
Parmed Medical Aid Scheme	-	-	
Rand Water Medical Scheme	-	-	
Rhodes University Medical Scheme	-	-	
SABC Medical Aid Scheme	-	-	
SAMWUMED	483	563	-14
South African Police Service Medical Scheme (POLMED)	1 712	3 634	-53
Transmed Medical Fund	-	6	-100
University of KwaZulu-Natal Medical Scheme	55	-	
Closed schemes	4 468	6 889	-35
Industry	29 171	38 116	-23

Six of the eleven schemes under review incurred marketing expenditure (**Table 5**). The average spending per average member per month (pampm) ranged from R7.75 to R49.70. The data highlights that LA-Health had a marketing expenditure in 2022 of R49.70 per month, whereas POLMED recorded a lower figure at R12.07 per month amongst schemes that reported marketing expenditure. LA-Health marketing spending was three times that of closed schemes and nearly twice across all medical schemes. When adjusted for Gross Contribution Income (GCI), LA-Health marketing expenditure was the highest among the reviewed schemes, accounting for 1% of GCI. This notable difference and variance imply that variations in marketing expenses are not exclusively linked to the size of the schemes. Consequently, further exploration into the factors driving marketing expenditure in medical schemes is warranted.

Table 5: Marketing expenditure per member per month pampm

	Marketing and advertising expenditure		
	2022 pampm	2021 pampm	as % of GCI
Government Employees Medical Scheme (GEMS)	12,07	15,56	0,23
LA-Health Medical Scheme	49,70	47,41	1,00
Medipos Medical Scheme	3,42	3,21	0,09
Parmed Medical Aid Scheme	-	-	-
Rand Water Medical Scheme	-	-	-
Rhodes University Medical Scheme	-	-	-
SABC Medical Aid Scheme	-	-	-
SAMWUMED	12,73	12,72	0,32
South African Police Service Medical Scheme (POLMED)	7,57	5,91	0,13
Transmed Medical Fund	12,14	10,12	0,43
University of KwaZulu-Natal Medical Scheme	-	-	-
Closed schemes	16,19	17,47	0,33
Industry	26,21	26,36	0,55

5.7 Medical Scheme Reserves

This section outlines and unpacks the purpose of medical scheme reserves, what they are funded for, and CMS' role in their governance. Furthermore, it highlights some of the associated risks. The Medical Schemes Act (131 of 1998) (MSA) prescribes that those reserves must always be maintained at a minimum of 25% of annualised gross contributions, except for new medical schemes where case phase-in solvency ratios apply. Medical scheme reserves are derived from various sources, which are outlined as follows:

- Retained surplus between contributions and claims,
- Investment Income,
- Over-payment recoveries and
- Other sources.

On December 31, 2022, total reserves per Regulation 29 for all medical schemes amounted to R110 billion, while those for restricted and state-funded schemes were R59.2 billion and R38.6 billion, respectively (**Table 6**). The reviewed schemes accounted for 65% of reveres in 2022 in closed schemes and 35% of reserves at industry levels. The figures depicted are based on the impact of state-funded schemes, which account for nearly a third of the savings.

Table 6: Year-end reserve position (per Regulation 29) state-funded schemes

	Year-end reserve position R'000	
	2022	**2021**
Government Employees Medical Scheme (GEMS)	23 821 772	22 286 215
LA-Health Medical Scheme	3 044 482	2 794 435
Medipos Medical Scheme	267 111	212 760
Parmed Medical Aid Scheme	279 233	264 022
Rand Water Medical Scheme	406 201	372 948
Rhodes University Medical Scheme	106 193	97 231
SABC Medical Aid Scheme	279 947	269 536
SAMWUMED	1 422 668	1 521 863
South African Police Service Medical Scheme (POLMED)	8 644 701	6 367 973
Transmed Medical Fund	97 135	112 330
University of KwaZulu-Natal Medical Scheme	222 165	201 102
	38 591 608	***34 500 415***
Closed schemes	59 167 211	54 649 414
Industry	109 762 555	105 706 294

Table 7 illustrates the estimated Prescribed Minimum Benefits (PMB) cost based on the treated prevalence of CDLs called community rate at the benefit option level for the 11 medical schemes that were reviewed. The community rate is used to measure the risk profile of medical schemes. The benefit options for state employees' medical schemes presented a community rate that ranged from R471,03 to R5 374,62. Of the 28 benefit options, 11 had a community rate lower than the industry average PMB cost of R1,141.52 pabpm. Prime plan and Guardian, which belong to Transmed Medical Fund, had a price four times the industry average PMB cost. The high cost for these two options may be attributed to older age profiles.

Table 7: The estimated Prescribed Minimum Benefits (PMB) cost in 2022

Scheme Name	Option Name	Community Rate (R)
RHODES UNIVERSITY MEDICAL SCHEME	RUMED	1 558,69
SAMWUMED	OPTION A	1 223,74
	OPTION B	1 404,50
LA-HEALTH MEDICAL SCHEME	LA ACTIVE	839,09
	LA COMPREHENSIVE	3 663,21
	LA CORE	3 318,68
	LA FOCUS	693,04
	LA KEYPLUS	683,07
RAND WATER MEDICAL SCHEME	OPTION A	751,90
	OPTION B PLUS	471,03
SABC MEDICAL AID SCHEME	SABC PLAN 009	1 357,75
PARMED MEDICAL AID SCHEME	PLAN - 007	2 102,32
MEDIPOS MEDICAL SCHEME	OPTION A	2 804,03
	OPTION B	848,84
	OPTION C	595,00
SOUTH AFRICAN POLICE SERVICE MEDICAL SCHEME (POLMED)	AQUARIUM	590,17
	MARINE	1 267,93
TRANSMED MEDICAL FUND	GUARDIAN	4 232,63
	LINK PLAN	1 814,87
	PRIME PLAN	5 374,62
	SELECT PLAN	2 249,40
GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	BERYL	885,36
	EMERALD	1 354,17
	EMERALD VALUE	1 153,69
	ONYX	3 507,10
	RUBY	909,59
	TANZANITE ONE	671,92
UNIVERSITY OF KWAZULU-NATAL MEDICAL SCHEME	SAVINGS PLUS PLAN	1 513,42

6. MEDICAL SCHEMES WITH LESS THAN 6 000 MEMBERS

6.1 Smaller Risk Pools

The minimum membership requirement for a medical plan at registration is outlined in Section 2 (3) of the Medical Schemes as follows:

"The minimum number of members required for the registration of a medical scheme established after these regulations have come into operation is 6 000, and this number must be admitted within a period of three months of registration of the medical scheme."

The minimum number of members required after registration, which may change depending on factors including market conditions and sustainability threats owing to a potential reduction in membership, is not specified in the referred section. Among the ten state employees' medical schemes, 5 had fewer than 6 000 members, namely the Rhodes University Medical Scheme, Parmed Medical Aid Scheme, University of KwaZulu-Natal Medical Scheme, Rand Water Medical Scheme, and SABC Medical Aid Scheme. **Table 8** depicts the characteristics of schemes with fewer than 6,000 members, represented by 29 medical schemes (3 restricted schemes and 26 closed schemes). Membership in these schemes ranged from 994 to 5 993 principal members and accounted for 194 015 beneficiaries, collected R5,5 billion in GCI, and incurred R345,8 million on gross administration services. These schemes are financially sound, with over a 25% solvency ratio as of December 2022. The solvency levels ranged between 43.15% and 397.7%.

Table 8: Medical schemes with less than 6 000 members:2022

Category	N	Principal members	Beneficiaries	GCI GAE R'000	GAE R'000
> 6000 Members	29	91 907	194 015	5 543 533	345 810
Open	3	10 694	18 240	351 964	33 869
Closed	26	81 213	175 775	5 191 569	311 941
6000 + Members	42	4 015 322	8 845 244	226 944 471	15 545 310
Open	13	2 370 643	4 842 128	132 780 748	10 580 487
Closed	29	1 644 679	4 003 116	94 163 723	4 964 823
Consolidated	71	4 107 229	9 039 259	232 488 004	15 891 120

Figure 7 illustrates the relationship between administration expenditure and gross contribution income. Notably, among the seven small, restricted risk pools, all exhibit a risk claims ratio surpassing 100%, ranging between 100% and 126%. Meanwhile, within the three open schemes, only one registers a risk claims ratio exceeding 100%, specifically at 108.54%.

Despite these schemes facing higher claims ratios, it is noteworthy that they maintain financial soundness, with solvency levels consistently above the critical 25% threshold. This resilience suggests effective financial management and strategic planning, ensuring the continued stability and viability of the schemes even in the face of elevated risk claims ratio.

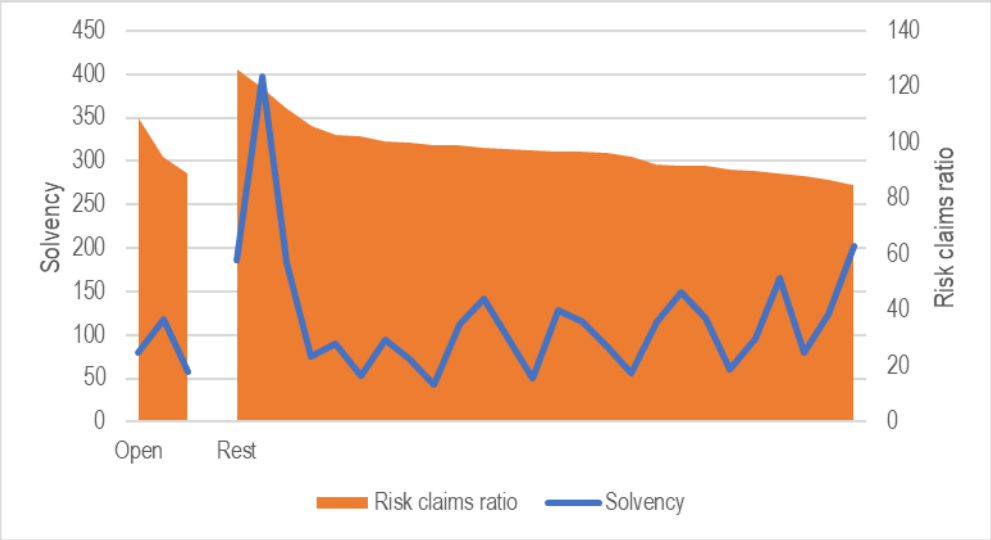

Figure 7: Risk claims ratio and solvency ratio of smaller risk pools by scheme type -2022

The graph (**Figure 8**) below extends the analysis by examining the Gross Administration Expenditure (GAE) as a proportion of Gross Contribution Income (GCI) within smaller risk pools. Notably, one of the three open schemes incurred GAE exceeding 10% relative to GCI. In contrast, as a general trend, closed schemes recorded GAE levels below 10% relative to GCI, with only four out of the 26 closed schemes deviating from this pattern. Specifically, the GAE percentages for these four schemes were 21.66%, 14.65%, 14.31%, and 12.53%, namely Horizon Medical Scheme, Fishing Industry Medical Scheme (Fish-Med), Golden Arrow Employees' Medical Benefit Fund and Building & Construction Industry Medical Aid Fund, respectively. This observation underscores the overall efficiency of closed schemes in managing administration expenditure concerning their gross contribution income, with the majority maintaining a GAE below the 10% threshold.

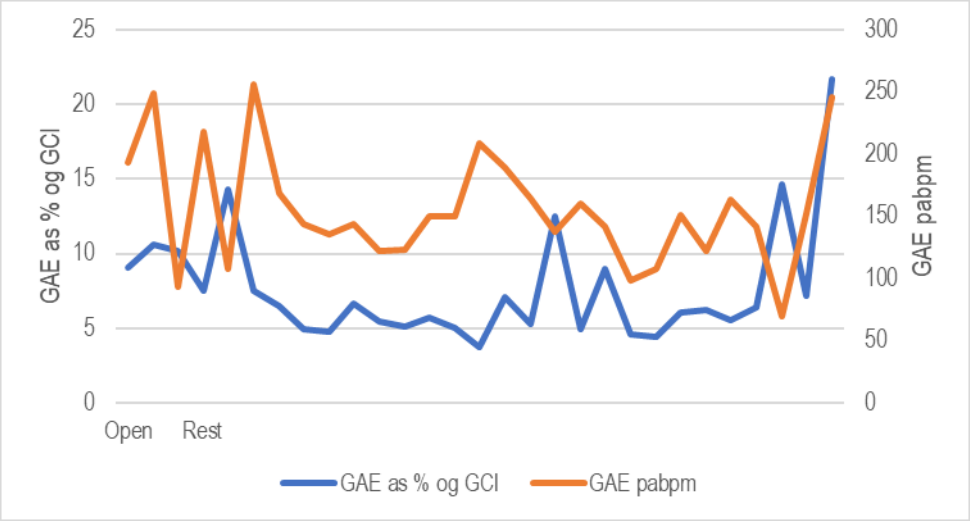

Figure 8: GAE as a % of GCI and GAE pabpm for smaller risk pools by scheme type -2022

7. GOVERNMENT EXPENDITURE ON MEDICAL SUBSIDIES FOR STATE EMPLOYEES

Table 9 below summarises government expenditure on medical subsidies for state employees. The total government medical scheme subsidy increased by 6.1% from R34.87 billion in the 2021/22 financial year to R37.0 billion in the 2022/23 financial year. In 2022/23, the highest amount of R14.4 billion subsidised employees working for the National Departments, constituting 39.2% of the total subsidy, followed by Gauteng at 12.7%, KwaZulu KwaZulu-Natal at 12.6%, the Eastern Cape at 8.0%, and Limpopo at 6.8%, while other provincial governments received below 6.0% of the total subsidy (less than R2.0 billion). The variation in fund allocation is primarily due to staff composition. Between 2020/21 and 2021/22, the National Department's expenditure on medical subsidies increased significantly by 195%, from R4.67 billion to R13.79 billion, as a result of the addition of the POLMED medical scheme, which was not included in the 2020/2021 dataset.

Table 9: Government subsidy for the period 2020/21 to 2022/23

	2020/21	2021/22	2022/23
Sphere		**Expenditure R'000**	
National Departments	4,676,149	13,798,068	14,496,525
KwaZulu KwaZulu-Natal	4,124,593	4,444,344	4,669,402
Gauteng	3,630,957	4,263,812	4,683,100
Eastern Cape	2,629,061	2,811,575	2,954,318
Limpopo Province	2,258,450	2,405,564	2,522,118
Western Cape	1,634,130	1,812,990	1,952,276
Mpumalanga	1,620,886	1,787,211	1,913,446
Free State	1,347,098	1,515,972	1,633,709
North West	1,351,632	1,506,226	1,625,124
Northern Cape	487,351	526,348	558,435
Total	**23,760,307**	**34,872,112**	**37,008,455**

Figure 9 below illustrates that the medical tax credit increased by 15.3% from R26.37 billion in 2018 to R30.40 billion in the 2022 tax year. The rate of increase in tax credit rebates decreased between the 2020 and 2021 tax years. Between 2019 and 2020, additional expenses increased significantly by 13.5%, going from R6.79 billion to R7.71 billion. In 2022, additional expenditures accounted for 26.4% of the total medical tax credit, a slight decrease from 26.5% in 2021.

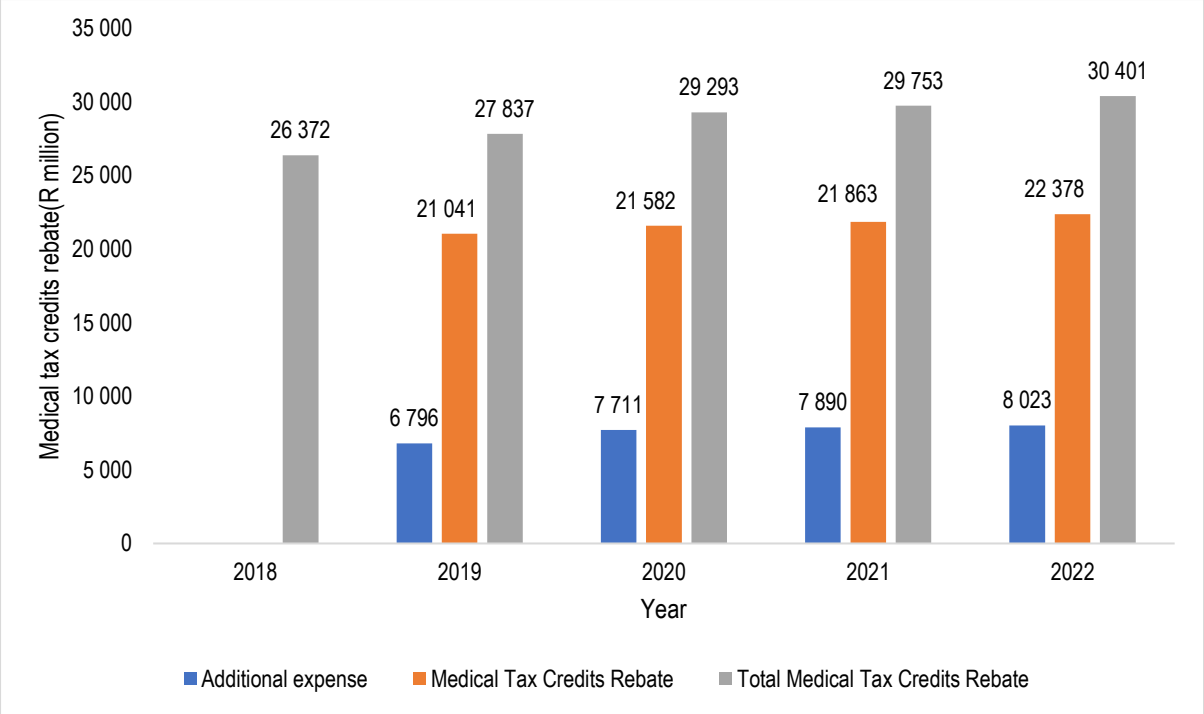

Figure 9: Estimated medical tax credits on contributions

8. SUMMARY OF FINDINGS

The key findings underscore the paramount importance of government-funded medical schemes in addressing the diverse healthcare needs of the population. As the demand for equitable and efficient healthcare continues to rise, a critical exploration into the consolidation of risk pools emerges as a strategic imperative. The CMS has proactively devised a consolidation framework to bolster sustainability and mitigate risks associated with smaller schemes. However, a notable gap exists as the CMS lacks the authority to mandate mergers, highlighting the urgent need for an empowered regulatory framework. The accompanying graph delineates the correlation between claims and solvency ratios, revealing distinctive patterns in the performance of medical schemes. Remarkably, nine out of 11 schemes maintain solvency ratios exceeding 20%, underscoring their financial soundness, with Transmed being a noteworthy exception. Government-funded schemes exhibited nearly a four percent growth in beneficiaries, constituting a third of the medical schemes industry. The study indicates that higher claims ratios, particularly in specific risk categories, are not necessarily tied to the age profile of beneficiaries. Noteworthy are schemes with lower age profiles but higher claims ratios, suggesting factors beyond demographics, such as claims management, systems proficiency, and other operational aspects, play a significant role. The research also reveals that a few of the 11 schemes incurred AGM-related fees, with

a decline in expenditure attributed to adopting technology and alternative AGM models. However, a concerning finding is the possible excessive expenditure on AGMs, surpassing the computed ratio, necessitating an assessment of their effectiveness and member engagement platforms. Disparities in trustee remuneration fees among state-funded schemes are evident, with GEMS exhibiting significantly higher average fees per trustee than closed schemes. The study sheds light on several schemes incurring administration expenditure exceeding 10%, notably observed in four smaller risk pools: Horizon Medical Scheme, Fishing Industry Medical Scheme (Fish-Med), Golden Arrow Employees' Medical Benefit Fund, and Building & Construction Industry Medical Aid Fund. These government-funded schemes seamlessly align with broader governmental healthcare initiatives, emphasising their interconnectedness with the national healthcare landscape. The comprehensive study scrutinises organisational structures, operational dynamics, and demographic characteristics, providing a nuanced understanding of informed decision-making and strategic interventions to enhance the effectiveness and sustainability of government-funded medical schemes.

9. RECOMMENDATIONS

An empowered regulatory framework is imperative to facilitate proactive measures by the CMS to encourage and oversee risk pool consolidation. This entails granting the CMS the necessary authority to mandate and guide consolidation efforts for the mutual benefit of scheme members and the broader healthcare system. Strengthening governance structures within government-funded schemes is equally crucial, necessitating a focused approach to address existing disparities in trustee fees and promoting consistency in remuneration practices. This initiative aims to create a more equitable and efficient organisational framework, fostering trust and accountability among scheme stakeholders.

Transparent communication and education form the bedrock of successful risk pool consolidation. Initiatives to enhance transparency should be coupled with comprehensive educational campaigns targeting scheme members, administrators, and other relevant stakeholders. By fostering a shared understanding of the advantages associated with risk pool consolidation, these efforts can cultivate a collaborative environment among schemes, ensuring a more seamless integration of risk pools.

Policy adjustments are warranted to support these endeavours further and address the limitations within the current regulatory framework. Granting the CMS the requisite authority to facilitate effective risk pool consolidation is pivotal for overcoming existing obstacles. This involves carefully examining and modifying policies to align with the dynamic healthcare landscape, allowing for more agile and responsive regulatory interventions. In essence, these recommendations collectively aim to create an environment

conducive to efficient risk pool consolidation, ultimately contributing to the sustainability and effectiveness of government-funded medical schemes.

10. IMPLICATIONS FOR HEALTHCARE MANAGEMENT AND POLICY

The analysis and findings presented in this study provide invaluable insights for policymakers, practitioners, and researchers operating within the healthcare management and policy sphere, particularly in the context of government-funded medical schemes. Notably, the distinctive aspect of these schemes lies in the subsidy element intricately connected to contributions. Furthermore, the study emphasises understanding how these schemes' structural and formal elements will evolve, especially in the context of the NHI implementation.

The findings derived from this research contribute substantially to the body of knowledge and facilitate informed decision-making. Specifically, they shed light on critical aspects such as risk pool consolidation and the evolving organisational dynamics within government-funded medical schemes. This knowledge is instrumental in guiding stakeholders as they navigate the complex landscape of healthcare policy and management, ensuring that decisions are well-informed and aligned with the evolving landscape of the healthcare sector.

11. FUTURE RESEARCH DIRECTIONS

Future research should delve deeper into the impact of regulatory changes on risk pool consolidation and assess the long-term effectiveness of consolidation strategies in enhancing the sustainability and efficiency of government-funded medical schemes. Additionally, exploring the perspectives of scheme members and healthcare providers could provide a more holistic understanding of the dynamics at play.

12. CONCLUSION

The study concludes that government-funded medical schemes play a critical role in healthcare, necessitating strategic consolidation of risk pools to ensure sustainability. Strengthening governance structures, addressing trustee fee disparities, and promoting consistency is essential for fostering trust and accountability, creating a more equitable and efficient organisational framework. Additionally, aligning key policy developments, such as the National Health Insurance (NHI), with the healthcare landscape is vital for the sustainable development of these schemes. These findings offer valuable insights for healthcare policymakers, practitioners, and researchers dedicated to enhancing the efficacy of government-funded medical schemes.

13. Acknowledgements

The source data used in this report was derived from the annexures generated by the Financial Supervision (FSU), which is the subunit of the Regulations Division at the CMS.

14. Ethical consideration

The study did not involve accessing or disclosing participants' personal or clinical data, nor did it directly involve treating patients. The data were evaluated and reported only at an aggregated level to ensure privacy and confidentiality.

15. REFERENCES

1. Ngcobo S, Fonn S, Bhengu N, Van Gent C, Nkonki L. Health Market Inquiry: Final findings and recommendations report. Pretoria: Competition Commission of South Africa; 2019. http://www.compcom.co.za/wp-content/ uploads/2014/09/Health-Market-Inquiry-Report.pdf. Accessed 22 December 2022.
2. Competition Commission of South Africa (CompCom). (2019). Health Market Inquiry: Final findings and recommendations report. Pretoria: Competition Commissioner. Retrieved from http://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf.
3. Council for Medical Schemes (CMS). 2022. Industry Report. Available at: https://www.medicalschemes.co.za/cms-industry-report-2021/. Accessed 22 December 2023
4. CMS. (2023). Industry report. Pretoria. Available at: https://www.medicalschemes.co.za/the-industry-report-2022-is-here/
5. Ssouth African Revenue Service. Medical Tax Credits: https://www.sars.gov.za/types-of-tax/personal-income-tax/medical-credits/ . Accessed 05 January 2024
6. Willie, Michael Mncedisi. (2023, August 5). The Effect of Marketing Initiatives and Expenditure on Organisational Performance in the South African Healthcare Market. *SSRN*. https://ssrn.com/abstract=4532254