CMS
Council
for Medical Schemes

INDUSTRY REPORT 2024

For You. For Health. For Life.

COUNCIL FOR MEDICAL SCHEMES

THE MEDICAL SCHEMES INDUSTRY IN 2024

CONTENTS

PART A

HEALTHCARE UTILISATION INDUSTRY REPORT 2024

CONTENTS

PART B

FINANCIAL PERFORMANCE INDUSTRY REPORT 2024

LIST OF ACRONYMS/ABBREVIATIONS

CDL	Chronic Disease List
CT	Computerised Tomography
CPI	Consumer Price Index
DTP	Diagnosis And Treatment Pairs
EDO	Efficiency Discounted Options
FFS	Fee-for-service
GP	General Practitioner
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Accounts
OOP	Out-of-pocket Payments
Pabpa	Per Average Beneficiary Per Annum
Pppm	Per Patient Per Month
Pet	Positron Resonance Tomography
PMBs	Prescribed Minimum Benefits
SANAC	South African National Aids Council
UPFS	Uniform Patient Fee Schedule

CHRONIC DISEASE LIST

ADS	Addison's Disease
AST	Asthma
BCE	Bronchiectasis
BMD	Bipolar Mood Disorder
CHF	Cardiac failure
CMY	Cardiomyopathy
COP	Chronic Obs. Pulmonary Disease
CRF	Chronic Renal Disease
CSD	Crohn's Disease
DBI	Diabetes Insipidus
DM1	Diabetes Mellitus 1
DM2	Diabetes Mellitus 2
DYS	Dysrhythmias
EPL	Epilepsy
GLC	Glaucoma
HAE	Haemophilia
HIV/AIDS	Human Immunodeficiency Virus /AIDS
HYL	Hyperlipidaemia
HYP	Hypertension
IBD	Ulcerative Colitis
IHD	Coronary Artery Disease
MSS	Multiple Sclerosis
PAR	Parkinson's Disease
RHA	Rheumatoid Arthritis
SCZ	Schizophrenia
SLE	Systemic Lupus Erythematosus
TDH	Hypothyroidism

LIST OF ABBREVIATIONS

AFS	Annual Financial Statements
AQIs	Audit Quality Indicators
BHF	Board of Healthcare Funders
CMS	Council for Medical Schemes
CPI	Consumer Price Index
DAE	Directly Attributable Insurance Service Expenditure
FASR	Financial Annual Statutory Return
HMI	Health Market Inquiry
IBNR	Incurred But Not Reported
IFRS	International Financial Reporting Standards
IFRS 17	International Financial Reporting Standard 17: *Insurance Contracts*
IR	Insurance Revenue
IRBA	Independent Regulatory Board for Auditors
ISE	Insurance Service Expenditure
JSE	Johannesburg Stock Exchange
MCO	Managed Care Organisation
MSA	Medical Schemes Act (131 of 1998)
NdoH	National Department of Health
NHE	Non-Healthcare Expenditure
OCI	Other Comprehensive Income
pabpm	per average beneficiary per month
pampm	per average member per month
pb	per beneficiary
pbpm	per beneficiary per month
PHC	Primary Healthcare Package
PIE	Public Interest Entity
PMBs	Prescribed Minimum Benefits
pmpm	per member per month
PMSAs	Personal Medical Savings Accounts
SAICA	South African Institute for Chartered Accountants
Stats SA	Statistics South Africa

LIST OF MEDICAL SCHEMES

Medical Schemes registered in terms of the Medical Schemes Act (131 of 1998), as of 31 December 2024:

Registration number	Name of medical scheme	Type of scheme
1005	AECI Medical Aid Society	Restricted
1465	Alliance-Midmed Medical Scheme	Restricted
1012	Anglo Medical Scheme	Restricted
1571	Anglovaal Group Medical Scheme	Restricted
1279	Bankmed	Restricted
1507	Barloworld Medical Scheme	Restricted
1252	Bestmed Medical Scheme	Open
1526	BMW Employees Medical Aid Society	Restricted
1512	Bonitas Medical Fund	Open
1237	BP Medical Aid Society	Restricted
1590	Building & Construction Industry Medical Aid Fund	Restricted
1034	Cape Medical Plan	Open
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Restricted
1491	Compcare Medical Scheme	Open
1544	Consumer Goods Medical Scheme	Restricted
1068	De Beers Benefit Society	Restricted
1125	Discovery Health Medical Scheme	Open
1572	Engen Medical Benefit Fund	Restricted
1202	Fedhealth Medical Scheme	Open
1271	Fishing Industry Medical Scheme (Fishmed)	Restricted
1086	Foodmed Medical Scheme	Restricted
1554	Genesis Medical Scheme	Open
1253	Glencore Medical Scheme	Restricted
1270	Golden Arrow Employees' Medical Benefit Fund	Restricted
1598	Government Employees Medical Scheme (GEMS)	Restricted
1566	Horizon Medical Scheme	Restricted
1591	Impala Medical Plan	Restricted
1559	Imperial and Motus Medical Aid	Restricted
1087	Keyhealth	Open
1145	LA-Health Medical Scheme	Restricted
1197	Libcare Medical Scheme	Restricted
1599	Lonmin Medical Scheme	Restricted
1466	Makoti Medical Scheme	Open
1547	Malcor Medical Scheme	Restricted
1495	Massmart Health Plan	Restricted

Registration number	Name of medical scheme	Type of scheme
1039	MBMed Medical Aid Fund	Restricted
1149	Medihelp	Open
1506	Medimed Medical Scheme	Open
1548	Medipos Medical Scheme	Restricted
1140	Medshield Medical Scheme	Open
1167	Momentum Medical Scheme	Open
1600	Motohealth Care	Restricted
1241	Multichoice Medical Aid Scheme	Restricted
1584	Netcare Medical Scheme	Restricted
1214	Old Mutual Staff Medical Aid Fund	Restricted
1441	Parmed Medical Aid Scheme	Restricted
1186	PG Group Medical Scheme	Restricted
1563	Pick n Pay Medical Scheme	Restricted
1583	Platinum Health	Restricted
1194	Profmed	Restricted
1201	Rand Water Medical Scheme	Restricted
1430	Remedi Medical Aid Scheme	Restricted
1176	Retail Medical Scheme	Restricted
1013	Rhodes University Medical Scheme	Restricted
1424	SABC Medical Aid Scheme	Restricted
1038	SAMWUMed	Restricted
1234	Sasolmed	Restricted
1531	Sedmed	Restricted
1568	Sisonke Health Medical Scheme	Restricted
1486	Sizwe Hosmed Medical Scheme	Open
1209	South African Breweries Medical Aid Scheme (SABMAS)	Restricted
1580	South African Police Service Medical Scheme (POLMED)	Restricted
1464	Suremed Health	Open
1578	TFG Medical Aid Scheme	Restricted
1592	Thebemed	Open
1582	Transmed Medical Fund	Restricted
1579	Tsogo Sun Group Medical Scheme	Restricted
1597	Umvuzo Health Medical Scheme	Restricted
1520	University of Kwa-Zulu Natal Medical Scheme	Restricted
1291	Witbank Coalfields Medical Aid Scheme	Restricted
1293	Wooltru Healthcare Fund	Restricted

LIST OF ANNEXURES

HEALTHCARE UTILISATION

LIST OF ANNEXURES

FINANCIAL PERFORMANCE

STATEMENT BY THE CHAIRPERSON OF COUNCIL

DR THANDI MABEBA

Chairperson of Council

> "This report offers a comprehensive overview of performance and trends across South Africa's medical schemes, capturing insights from both the supply side and the private sector's funding capacity. It highlights key governance, operational, and strategic considerations, providing stakeholders with an evidence-based understanding of the current landscape. By carefully consolidating and interpreting these data, the Council equips members, schemes, and policymakers with actionable intelligence to support sustainable, informed decisions."

The Council for Medical Schemes (CMS) is mandated under Section 7(e) of the Medical Schemes Act (131 of 1998) to collect and disseminate information about the private healthcare sector. This mandate is central to our role in promoting transparency, accountability, and informed decision-making within the medical schemes environment. The release of this industry report reflects this responsibility, serving as both a vital resource for the sector and a guide for policy development and strategic planning.

This report offers a comprehensive overview of performance and trends across South Africa's medical schemes, capturing insights from both the supply side and the private sector's funding capacity. It highlights key governance, operational, and strategic considerations, providing stakeholders with an evidence-based understanding of the current landscape. By carefully consolidating and interpreting these data, the Council equips members, schemes, and policymakers with actionable intelligence to support sustainable, informed decisions.

As a strategic asset to the industry, the report demonstrates the Council's commitment to strengthening the effectiveness of the private healthcare system while safeguarding beneficiary interests. The insights contained within it are intended to foster constructive engagement, guide prudent policy interventions, and assist the sector in navigating the complexities of a rapidly evolving healthcare environment.

I wish to extend my sincere appreciation to the Honourable Minister of Health, Dr Aaron Motsoaledi, the Deputy Minister of Health, Dr Joe Phaahla, and the National Department of Health for their steadfast leadership and continued support as I assume the responsibilities of this office.

My deep gratitude also goes to the Council and its committees, and to Dr Musa Gumede, Chief Executive and Registrar of the CMS, for their strategic leadership. Under Dr Gumede's stewardship, the Regulation and Policy, Research and Monitoring divisions collaborated effectively to deliver this important work. I am grateful for the long term vision, operational support and stewardship that underpinned every stage of this project.

Dr Thandi Mabeba
Chairperson of Council
Council for Medical Schemes

FOREWORD BY THE CHIEF EXECUTIVE & REGISTRAR

DR MUSA GUMEDE

Chief Executive and Registrar

> "Medical schemes operate in a complex environment characterised by stagnant membership, an ageing demographic profile, escalating healthcare costs and affordability constraints. The Council for Medical Schemes' (CMS) primary mandate is to protect the interest of beneficiaries. The purpose of this report is to highlight not only the continued financial soundness of medical schemes, but also to comment on trends that would inform future policy directions."

It is my honour, as the Chief Executive and Registrar of the Council for Medical Schemes (CMS), to present the Industry Report for 2024. For the first time since 2022, we are able to deliver an Industry Report that provides a truly integrated review, merging the critical data on healthcare utilisation with a full assessment of the financial performance of medical schemes across South Africa.

This combined publication offers the industry the in-depth analysis of key trends and findings that are essential to inform policy directions that will continue to safeguard the interests of beneficiaries and ensure the financial sustainability of medical schemes.

Demographic Trends and Membership Profile

In 2024, the medical schemes environment continued to operate under complex conditions marked by modest membership growth, an ageing beneficiary population, and rising demand for healthcare services. While overall industry membership increased by just 1.35%, the underlying trends reveal a changing landscape. Restricted schemes, particularly those linked to specific sectors or government entities, remained the main drivers of growth, expanding by 2.41%. In contrast, open schemes recorded a 1.31% decline, resulting in a net increase of just over 41 000 beneficiaries. This brings the total number of lives covered to 9.17 million, all of whom the CMS continues to safeguard through the regulation of 71 medical schemes, 33 administrators, 43 managed care organisations, and more than 10 000 accredited brokers and brokerages combined.

The data further revealed an ageing membership profile, with the average age increasing by 0.29 years. As older beneficiaries typically require more frequent and intensive healthcare, this shift continues to influence utilisation patterns across key benefit categories.

Healthcare benefits and utilisation of services

As utilisation increases are closely linked to demographic pressures, the modest membership growth and increase in the average beneficiary age contributed to greater demand for healthcare services across schemes. Total healthcare expenditure increased by 8.52% to R259.3 billion, driven largely by hospital services, specialist care, and medicines.

On a per-beneficiary basis, healthcare expenditure rose by 7.8%, while out-of-pocket payments climbed to R46.3 billion, highlighting ongoing affordability concerns for members.

- Hospital-based care

  Hospital benefits increased by 9.71% and remained the largest component of overall benefits paid, accounting for 35.95% of the total. Although private hospital admissions per 1 000 beneficiaries declined slightly, the cost per admission increased by 9.88%.

  Based on discussions with the five largest medical schemes, the marked increase in the in-hospital cost per event seems to be driven by supplier-induced demand. Many scheme rules provide for fully funded baskets of care for pre-authorised admissions, and increased utilisation of services unrelated to the primary reason for admission has been observed.

- Specialists, medicines, and out-of-hospital services

  Specialist services remained a major driver of utilisation, while medicines dispensed continued to represent a significant proportion of out-of-hospital benefits. Restricted schemes consistently showed higher utilisation of medicines, general practitioners, and allied health services, reflecting the demographic and structural differences between scheme types.

  Nonetheless, there are encouraging signs of progress. Schemes continue to prioritise investment in primary healthcare and chronic disease management, which are critical areas to ensure long-term system sustainability and better health outcomes.

Financial performance of medical schemes

The financial landscape of medical schemes reflects the pressure created by rising utilisation and the cost of delivering care. Insurance revenue per average beneficiary per month increased by 8.65%, significantly outpacing CPI (4.40%). This repricing was necessary to stabilise benefit options following years of contribution restraint, particularly during the post–COVID–19 recovery period.

Relevant healthcare expenditure per beneficiary, however, grew even faster by 9.03%, exacerbating the misalignment between benefit costs and pricing. Consequently, the relevant healthcare expenditure ratio rose to 96.18%, well above pre-pandemic levels. It is anticipated that higher contribution increases will continue in the foreseeable future to address the misalignment between the benefits provided and the pricing thereof. CMS envisage the repricing to transpire as an incremental process.

Tariffs and cost pressures

The CMS welcomes ongoing engagement towards establishing a multilateral negotiating environment for funders and practitioners to determine reference tariffs. [1]This would relieve medical schemes from rapidly escalating costs, as tariffs are currently not determined through a competitive process as a result of information asymmetry.

Prescribed Minimum Benefits (PMBs) and benefit review

Regulation 8 of the Medical Schemes Act (131 of 1998), a well-established standard in the industry, requires full payment for the diagnosis, treatment, and care of Prescribed Minimum Benefit (PMB) conditions, which accounted for 57.43% of risk benefits paid during 2024.

The CMS and the National Department of Health (NDoH) are collaborating on the development of a standardised benefit package and the review of PMBs, which is focused on establishing, costing and implementing a Primary Healthcare (PHC) package of services as part of the PMBs. Efforts are also underway to align the CMS PHC package with the Department of Health's NHI PHC draft package. Updates on these initiatives are available on the CMS website under the Media Centre tab.

---

1 The Minister of Trade, Industry and Competition issued Government Gazette No. 52111 on 14 February 2025 in which the public was invited to comment on the draft interim block exemption for tariffs determination in the Healthcare Sector.

Managed healthcare services

Managed healthcare arrangements continued to play a central role in promoting appropriate, evidence-based care and controlling costs. These interventions are implemented through mechanisms such as evidence-based clinical protocols, medicine formularies, funding guidelines, and managed care provider networks. Although this report does not assess the value proposition of these arrangements, it outlines their scope and financial impact across the industry.

Accredited managed healthcare services increased by 7.67% from R5.74 billion in 2023 to R6.18 billion in 2024, with 99.11% of beneficiaries covered by such arrangements. A clear correlation persists between an option's demographic profile and its managed care fees: options with older or higher-risk beneficiaries incur higher expenditure per member. Disease-specific contracts also tend to be more costly than scheme-level contracts due to the loss of volume-based discounts.

Risk transfer and reinsurance arrangements

While medical schemes generally hold sufficient reserves to self-insure and therefore make limited use of traditional reinsurance, risk transfer arrangements have increasingly been utilised to manage insurance risk. In 2024, schemes incurred R5.00 billion in capitation fees and realised R5.65 billion in value from these arrangements. Pharmacy benefit management remains the largest component of risk transfer in both open and restricted scheme environments.

Additional data on beneficiary coverage under accredited managed healthcare and risk-transfer arrangements is provided in the Annexures to this report.

Solvency

The net assets in terms of Regulation 29 of the MSA increased by 0.66% to R109.24 billion in 2024. During the financial year, increases in the unrealised fair value market movements of investments were observed. It should be noted that these market movements are excluded from the Regulation 29 reserve levels. The medical scheme industry ended 2024 with a very healthy solvency ratio of 40.87%.

Conclusion

The findings presented in this report reinforce the need for strategic interventions, proactive regulation, and strong stakeholder collaboration. Moreover, while medical schemes have successfully managed to provide temporary financial relief post-COVID-19 through restrained contribution increases, the under-pricing of insurance services has resulted in an insurance service deficit that now requires careful correction.

Put differently, for every R100.00 received in insurance revenue, R96.18 was paid in relevant healthcare expenditure, and R6.89 in directly attributable insurance service expenditure (DAE) during 2024. This resulted in a shortfall of R3.07 that was funded from the R8.64 received in other income/expenditure (including investment income). The current product pricing does not support reserve building or maintenance, making sustainable pricing, stronger cost management, and enhanced oversight essential priorities moving forward.

Acknowledgements

I wish to convey my heartfelt appreciation to the Council, the governing body of the CMS, for its consistent oversight, strategic vision, and unwavering commitment to advance the medical schemes environment.

A special word of thanks is also extended to the Policy, Research and Monitoring and the Financial Supervision Units for their diligence, technical expertise, and dedication in producing this report. Their commitment to accuracy, insight, and professional excellence is deeply valued.

As we reflect on the insights contained in this report, I remain committed to work closely with all stakeholders to translate these findings into meaningful actions that reinforce the sustainability and responsiveness of the medical schemes environment.

Dr Musa Gumede
Chief Executive and Registrar
Council for Medical Schemes

Healthcare Utilisation Industry Report 2024

LIST OF TABLES

LIST OF FIGURES

DEMOGRAPHIC ANALYSIS

Trends in the number of medical schemes

From 2000 to 2024, the number of medical schemes in South Africa steadily decreased, indicating a clear trend of consolidation. At the start of the period, there were 47 open schemes and 97 restricted schemes, giving a total of 144.

This number went up slightly to 146 in 2001, but that was the high point. After that, the numbers started to shrink year after year. Open schemes saw the most significant decline. They held steady at 49 until about 2003, but then the decline became more pronounced, especially between 2006 and 2010, when the count dropped from 41 to 27.

By 2024, only 16 open schemes remained. That is a reduction of about two-thirds over 25 years, which works out to an average decline of roughly 4.6% per year. Restricted schemes followed a slower path. They went from 97 in 2000 to 55 in 2024, which is a 43% decline overall.

This suggests they were more stable, probably because their membership bases are tied to specific employers or industries. The total number of schemes fell from 146 in 2001 to 71 in 2024, a reduction of almost half. That is about a 51% decline at an average yearly rate of 2.9%.

There were moments when the numbers held steady for a year or two, such as open schemes staying at 23 in 2014-2015 or restricted schemes at 60 between 2014 and 2016, but those were temporary pauses.

The long-term picture is clear: the industry has been shrinking steadily, with open schemes hit hardest, restricted schemes holding on better, and the total number of schemes now less than half of what it was at the start of the century. These trends are highlighted in Figure 1 below.

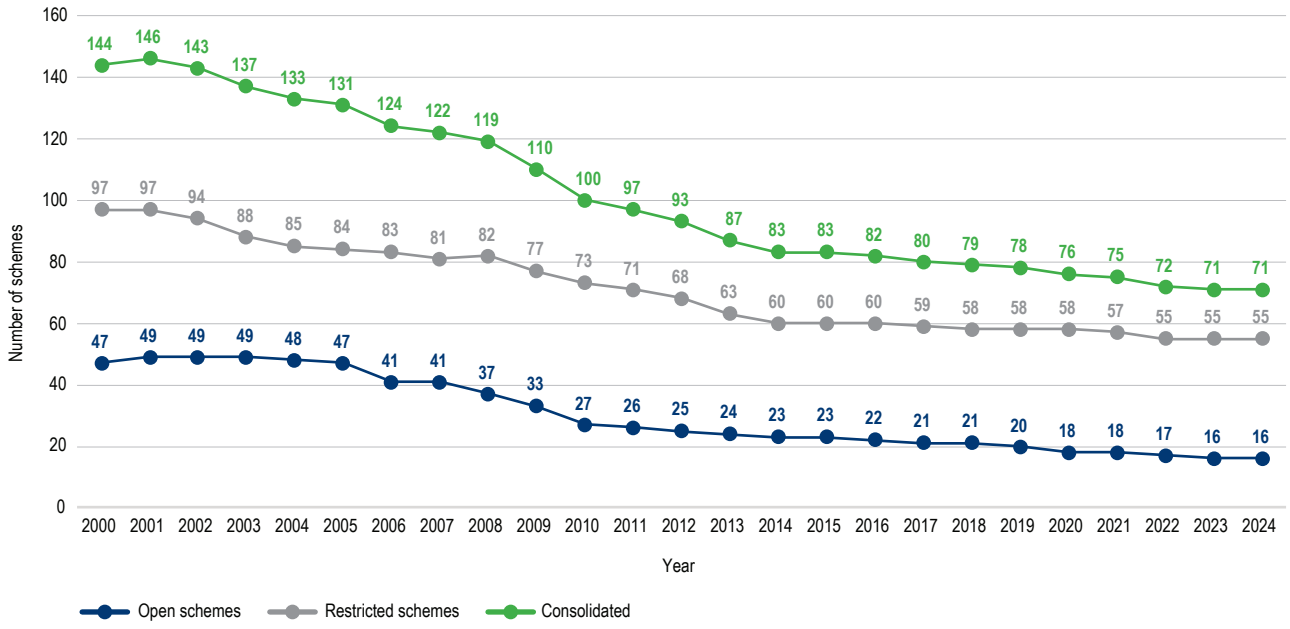


Figure 1: Number of medical schemes by scheme type (2000-2024)

Between 2002 and 2024, the number of large, medium, and small schemes showed noticeable changes. Large schemes started at 40 in 2002, gradually declined, experienced occasional small rebounds, and reached 21 by 2024.

Medium schemes fluctuated modestly, peaking around 32 in 2007 before settling near 20 in later years. Small schemes consistently decreased from 76 in 2002 to 30-31 in the mid-2010s, briefly dropping to a low of 22 in 2022 before rebounding to 30 by 2024, indicating an overall shrinking trend.

There is a gradual reduction in large and small schemes, while medium schemes remained relatively stable with minor fluctuations, suggesting a possible consolidation trend or shift in distribution over time.

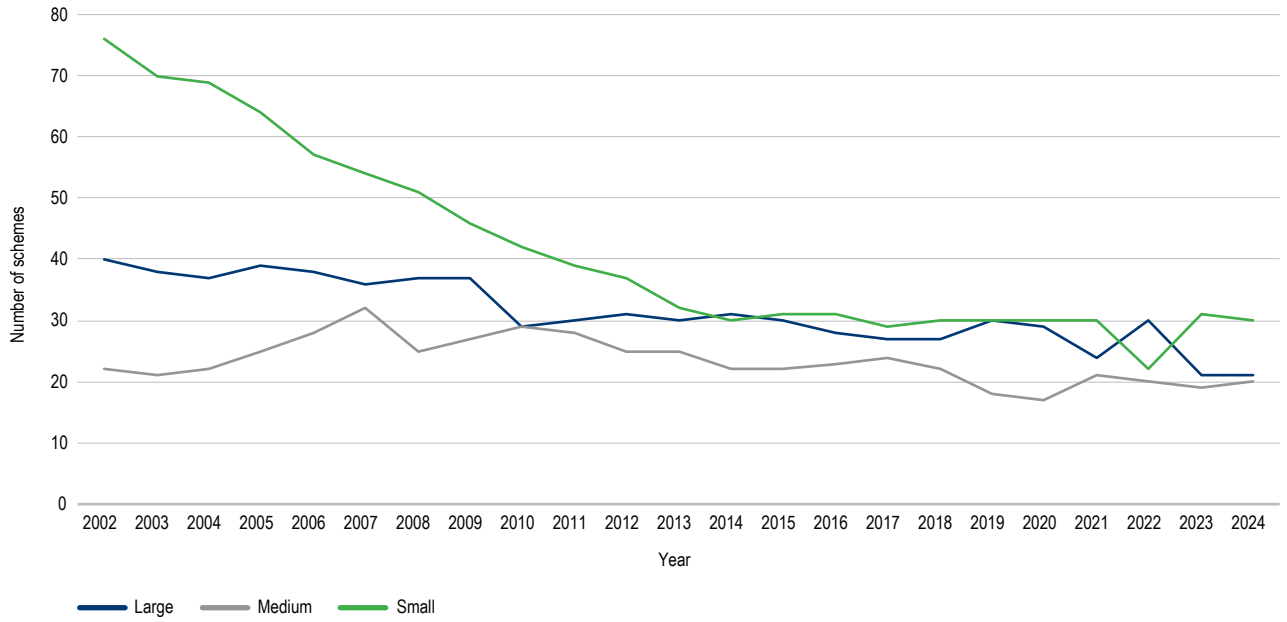


Figure 2: Number of schemes by size (2002-2024)

Note: Small<6000 members; Medium≥ 6000 members but <30000 beneficiaries; Large≥ 30000 beneficiaries.

Benefit Options

From 2002 to 2024, the number of open schemes benefit options remained relatively stable, starting at five and gradually increasing to seven by 2016, where it largely stabilised—the benefit options for restricted schemes consistently held at two throughout the period, showing no variation. The consolidated schemes exhibited minor fluctuations, mostly hovering around three, with occasional increases to four in select years such as 2016, 2022, 2023, and 2024.

Figure 3 below shows slow but steady growth in open schemes, stability in restricted schemes, and slight variability in consolidated schemes over the 23 years.

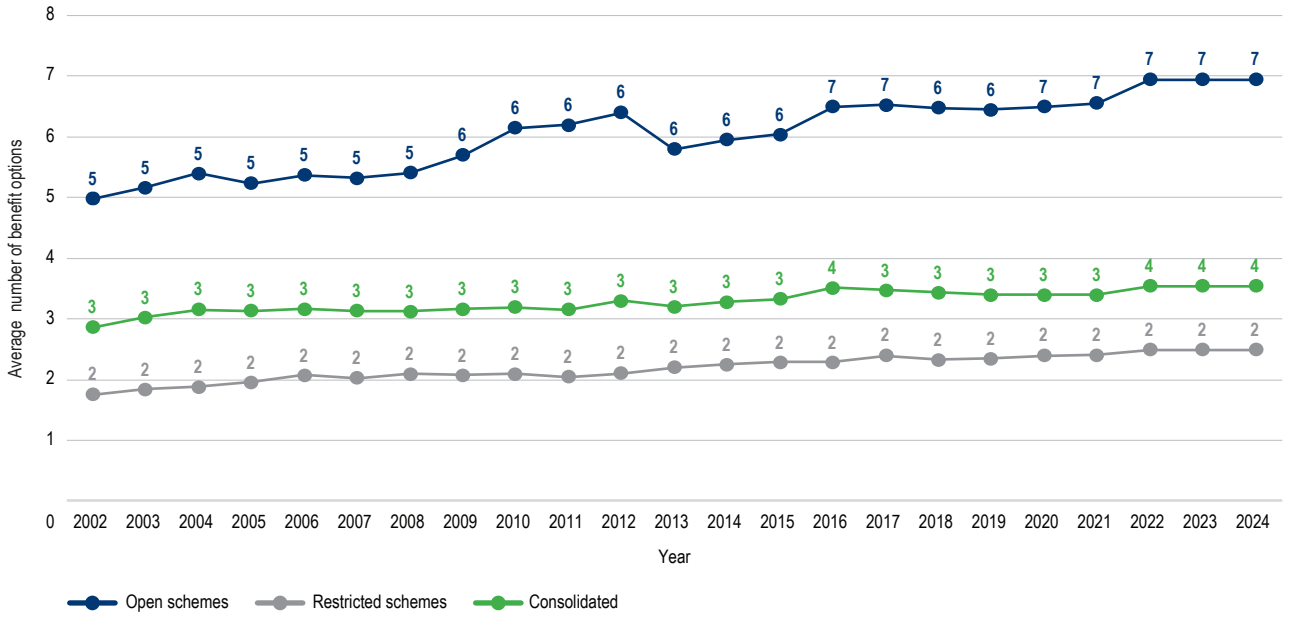


Figure 3: Average number of benefit options by scheme type (2002-2024)

From 2017 to 2024, the number of Efficiency Discounted Options (EDO) grew steadily from 50 to 73, showing that more choices were being made available over time by medical schemes. The lives covered under EDOs also rose significantly, especially from 2021 to 2023, when membership jumped from under one million to over 1.7 million before dropping slightly in 2024. In contrast, non-EDO lives remained much higher overall but fluctuated more, peaking above 3.2 million in 2020 before falling to just over 2.6 million by 2024. Interestingly, the percentage of lives on non-EDOs spiked sharply from around 30% in the earlier years to more than 60% after 2022, suggesting a shift in preference or reporting. Overall, the data points to growth in EDO options and coverage but also highlights volatility in how members move between EDOs and non-EDOs.

Table 1: Number of EDOs and lives covered (2017-2024)

	2017	2018	2019	2020	2021	2022	2023	2024
Number Of EDO Options	50	50	64	66	66	72	71	73
Number of lives covered on EDOs	758 746	792 699	976 592	1 006 142	980 039	1 619 062	1 728 436	1 4761 54
Number of lives covered on non-EDOs	2 961 870	2 922 085	2 883 595	3 284 792	3 253 462	2 748 081	2 964 396	2 603 231
% of lives on non-EDOs	26%	27%	34%	31%	30%	59%	63%	64%

Demographic Information

In 2024, the medical scheme industry covered around 14.6% of the South African population. Open schemes were by far the largest, covering 10.4% of the population, while restricted schemes covered 4.6% of the population.

The introduction of the Government Employees Medical Scheme (GEMS) in 2006 contributed to the growth of restricted schemes throughout the period, and from that point, their membership kept climbing steadily. From 2006 onwards, restricted schemes started to grow steadily, reaching over 3 million by 2009 and continuing to expand each year.

By contrast, open scheme membership remained relatively stable with only minor fluctuations, ranging from 4.7 to 5 million.

Between 2000 and 2024, restricted schemes grew at an annual growth rate of around 3.2%, while open schemes remained almost flat with an annual growth rate of just 0.06%.

The industry's growth rate was modest at an annual growth rate of 1.35%, showing that the rise of restricted schemes has mainly influenced the expansion. This shift pushed the total industry population upwards, climbing from about 6 729 551 in 2000 to 9 168 534 by 2024.

Between 2023 and 2024, open schemes fell by 1.31%, while restricted schemes grew by 2.41%, pushing the overall industry up by 0.45% from 9 127 453 in 2023 to 9 168 534 (+41 081) in 2024. The restricted schemes have nearly doubled in size, eventually driving most of the overall growth in the sector.

By 2024, restricted schemes reached over 4.4 million, narrowing the gap with open schemes, which slightly declined to about 4.74 million. Restricted schemes made up 48.3% of the industry, while open schemes contributed 51.7%. On a year-to-year basis, open schemes fell by 1.31% between 2023 and 2024, while restricted schemes grew by 2.41%, pushing the overall industry up by 0.45%. The gap between the two types of schemes had almost closed, with open schemes covering about 7.5% of the South African population and restricted schemes around 7% of the population.

Although the industry's total membership grew by roughly 2.4 million between 2000 and 2024, the share of South Africans on medical schemes fell slightly from about 15% of the population in 2000 to 14.6% in 2024. This can be attributed to the South African population growth outpacing the growth of medical schemes.

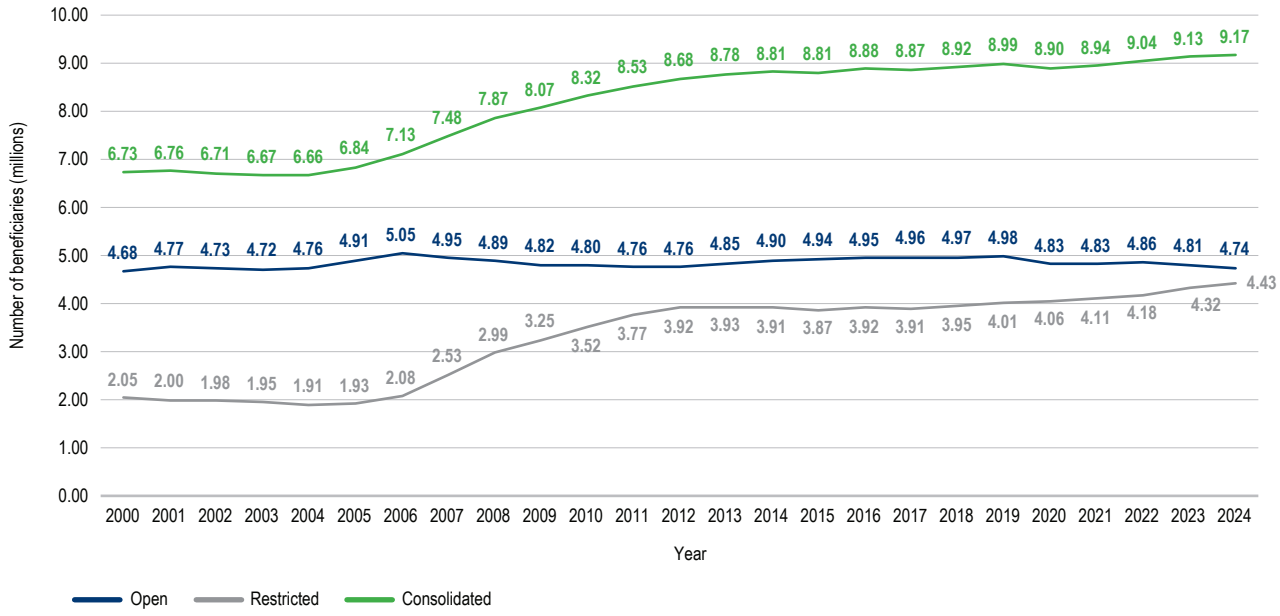


Figure 4: Number of beneficiaries by scheme type (2000-2024)

Membership Data: Growth and Declines — Top Select 29 Schemes

Restricted schemes, which generally serve specific employee groups or sectors, show a range of growth and decline patterns. Notably, several restricted schemes experienced modest growth, with LA-Health Medical Scheme leading at a 6.7% increase, followed closely by Alliance-Midmed (5.8%), Umvuzo Health Medical Scheme (5.4%), and the Government Employees Medical Scheme (GEMS) at 5.2%.

The steady growth of GEMS is particularly significant as it represents a government-funded scheme aimed at providing comprehensive health coverage to public sector employees. This highlights the continued reliance and trust in state-supported healthcare provision. Other government-funded schemes, such as the LA-Health Medical Scheme, are leading with a 6.7% increase, indicating stability in membership.

However, not all restricted schemes showed positive trends. Several, including SAMWUMED, PG Group, Platinum Health, and the Golden Arrows Employees' Medical Benefit Fund, faced 5% to 5.3% declines. In contrast, others, such as BP Medical Aid Society and Medipos Medical Scheme, experienced more significant drops of 27.7% and 36.6%, respectively. These declines may reflect shifting employer affiliations, changing member preferences, or competition from open schemes offering broader coverage options.

Open schemes, available to the general public, also exhibited considerable declines. FedHealth dropped by 6%, MediHelp by 6.6%, and Suremed Health suffered the most severe reduction at 32.8%. Cape Medical Plan and Compcare similarly experienced double-digit membership decreases. These patterns suggest that some open schemes struggle to retain or attract members in an increasingly competitive market.

While the government-funded and certain sector-specific restricted schemes continue to show growth, many other restricted and open schemes face membership challenges. The sustained increase in government-funded schemes like GEMS underscores the importance of state-supported health coverage in ensuring access to medical care for public sector employees, even as private and industry-specific schemes experience varying fluctuation levels.

Table 2: Membership growth and declines (selected list of schemes)

Scheme Type	Scheme Name	% Change
Growth	LA-HEALTH MEDICAL SCHEME	6.7%
	ALLIANCE-MIDMED MEDICAL SCHEME	5.8%
	UMVUZO HEALTH MEDICAL SCHEME	5.4%
	GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	5.2%
	RETAIL MEDICAL SCHEME	5.1%
	FOODMED MEDICAL SCHEME	5.1%
Decline	SAMWUMED	-5.0%
	PG GROUP MEDICAL SCHEME	-5.2%
	PLATINUM HEALTH	-5.2%
	GOLDEN ARROWS EMPLOYEES' MEDICAL BENEFIT FUND	-5.3%
	LIBCARE MEDICAL SCHEME	-5.4%
	DE BEERS BENEFIT SOCIETY	-5.6%
	LONMIN MEDICAL SCHEME	-5.9%
	FEDHEALTH MEDICAL SCHEME	-6.0%
	MOTOHEALTH CARE	-6.1%
	MEDIHELP	-6.6%
	FISHING INDUSTRY MEDICAL SCHEME (FISH-MED)	-6.8%
	CAPE MEDICAL PLAN	-8.8%
	SOUTH AFRICAN BREWERIES MEDICAL SCHEME	-9.1%
	SIZWE HOSMED MEDICAL SCHEME	-9.1%
	SISONKE HEALTH MEDICAL SCHEME	-10.0%
	MBMED MEDICAL AID FUND	-10.1%

Scheme Type	Scheme Name	% Change
Decline	COMPCARE MEDICAL SCHEME	-10.3%
	MAKOTI MEDICAL SCHEME	-11.4%
	BMW EMPLOYEES MEDICAL AID SOCIETY	-14.1%
	TRANSMED MEDICAL FUND	-14.2%
	BP MEDICAL AID SOCIETY	-27.7%
	SUREMED HEALTH	-32.8%
	MEDIPOS MEDICAL SCHEME	-36.6%

Figure 5 shows that in 2024, the number of registered beneficiaries exhibited a steady upward trend, starting at about 9.07 million in January and increasing to roughly 9.17 million by December. On average, the registry grew by just over 8 500 people each month. January recorded the lowest figure, while December reached the highest. Although the monthly percentage increases were generally small, under 0.1%, they remained consistently positive, highlighting stable and continuous growth in beneficiary numbers throughout the year.

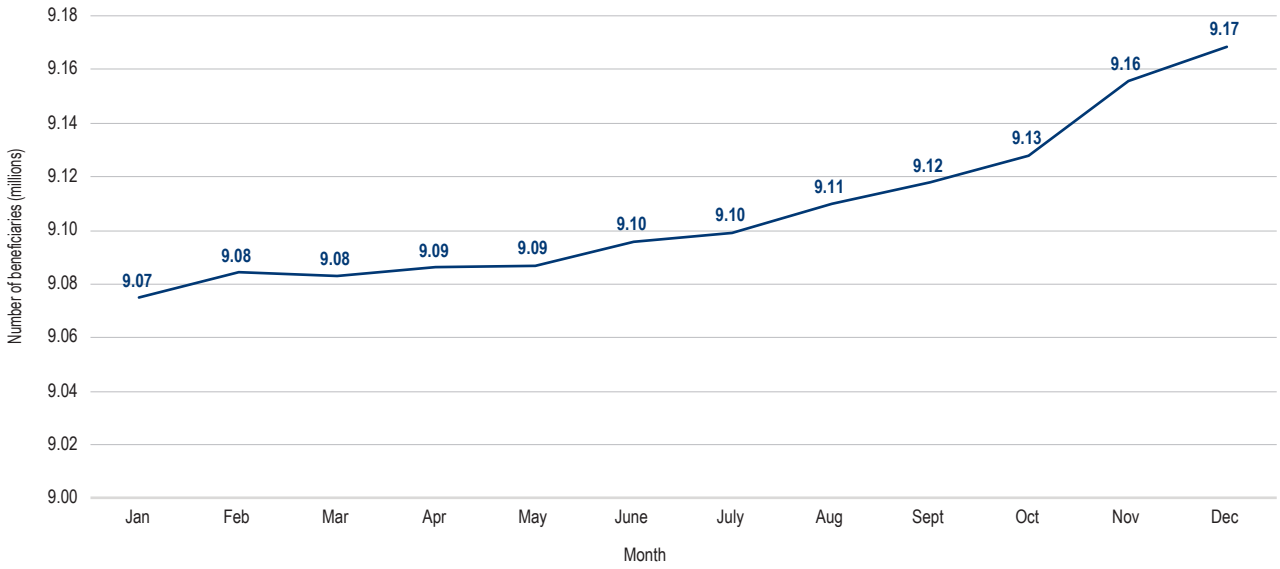


Figure 5: Number of beneficiaries registered at the end of each month (2024)

Figure 6 shows that open schemes experienced a slight decline in both members and dependants, with members dropping from 2 372 503 in 2023 to 2 358 504 in 2024, and dependants decreasing from 2 433 641 to 2 384 686. In contrast, restricted schemes recorded moderate growth, as members increased from 1 775 267 to 1 806 837 and dependants rose from 2 546 042 to 2 618 507.

When combining both scheme types, the consolidated figures show a slight overall increase in members, moving from 4 147 770 in 2023 to 4 165 341 in 2024, and a more notable increase in dependants from 4 979 683 to 5 003 193.

This suggests that although open schemes faced a slight reduction, the growth in restricted schemes helped maintain overall stability in the medical scheme population.

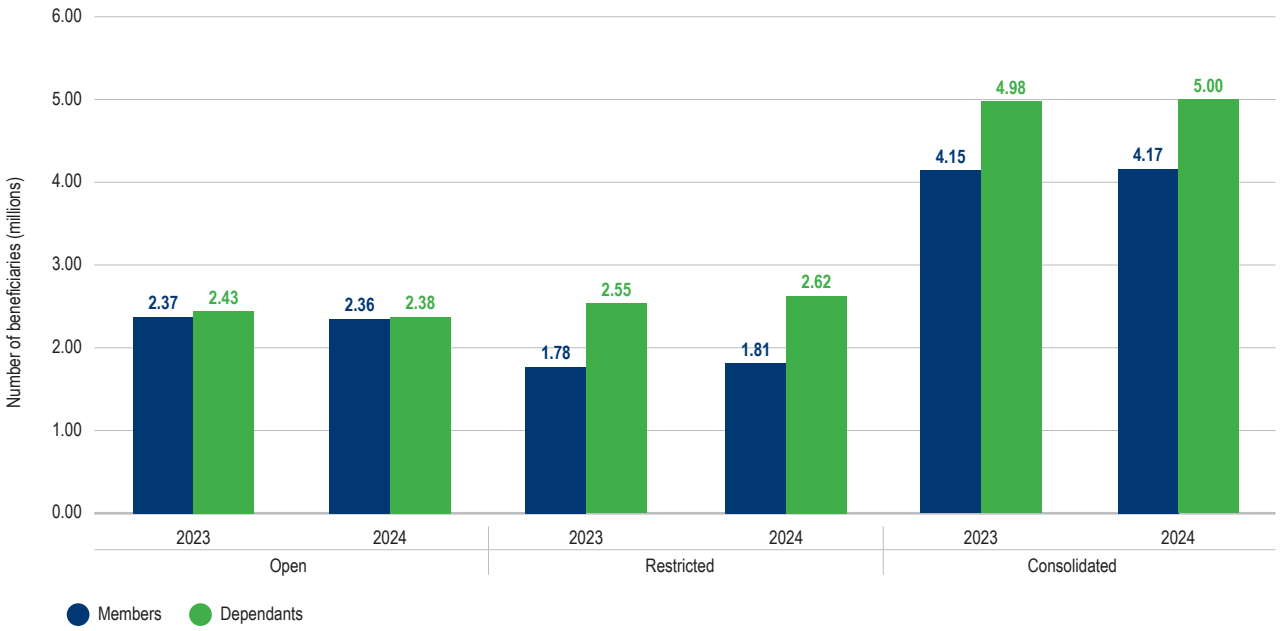


Figure 6: Number of principal members and dependents (2023-2024)

Figure 7 shows that membership growth in 2008 was much higher at 4.80%, but over the years, it gradually declined, with only slight increases in some years. From around 2012 onwards, growth remained relatively low and never returned to the earlier higher levels. In 2020, there was even a decline of -1.47%, which might be linked to the effects of the COVID-19 pandemic and its impact on people's finances. After that, growth rose slightly but stayed below 2%, ending at just 0.42% in 2024.

The growth of dependants followed a similar pattern, though at generally lower rates. It started at 2.62% in 2008 and steadily declined over the years, even turning negative in 2014, 2015, and again in 2020. After 2021, there was a slight recovery, with growth hovering around 1%, but by 2024 it had slowed again to 0.47%.

Figure 7: Membership percentage changes by beneficiary type (2008-2024)

Figure 8 shows that between 2008 and 2024, open schemes experienced very slow and inconsistent growth in both members and dependants. Member growth in open schemes remained below 2% for most years, with some years showing slight declines, especially in 2020, 2023, and 2024. Dependant growth for open schemes was mainly negative, suggesting a steady drop in dependants over time. In contrast, restricted schemes performed better, particularly in the early years, with strong growth of over 10% in 2008 and 2009. Although this growth slowed in later years, restricted schemes continued to show more stability, with moderate increases in members and dependants from 2021 onwards. Open schemes have struggled to maintain growth, while restricted schemes have shown more consistent improvement in recent years.

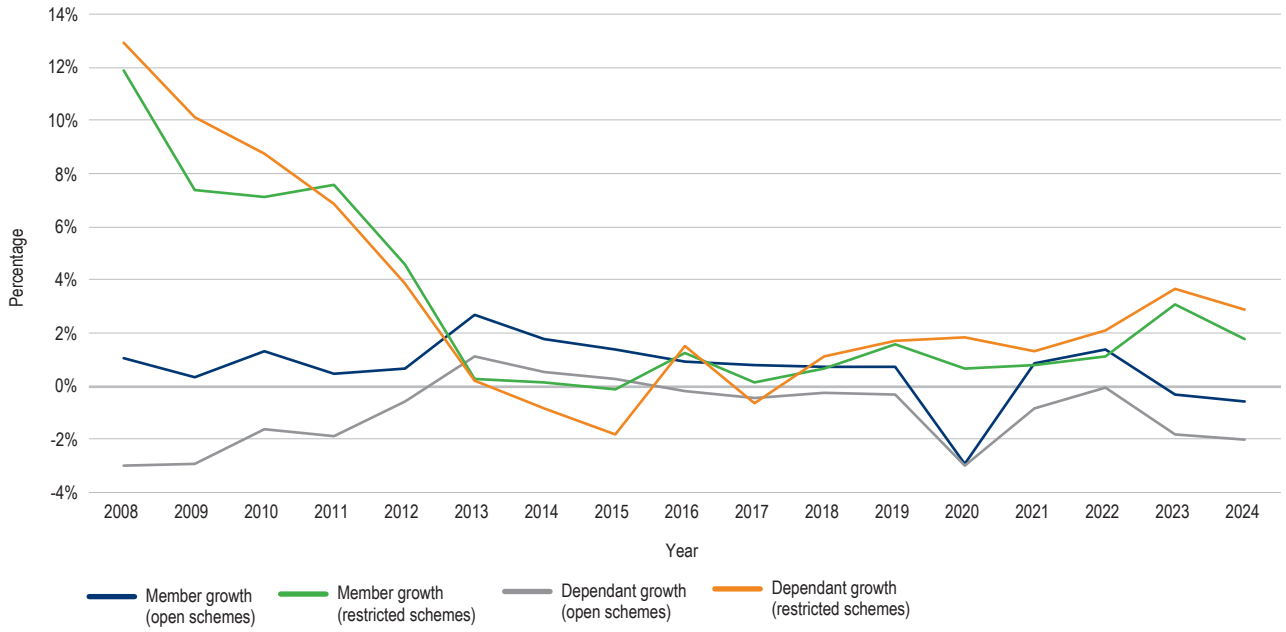


Figure 8: Membership changes by beneficiary type in open and restricted schemes (2008-2024)

Figure 9 shows the number of dependants covered for every main member in a medical scheme over time. From 2008 to 2024, open schemes showed a steady drop in their dependency ratio, falling from 1.29 to 1.01. This means that members in open schemes cover fewer dependants over time.

Restricted schemes, on the other hand, have stayed more stable. Their ratio went from 1.39 in 2008 to 1.45 in 2024, showing that members in these schemes still tend to include more dependants.

When the consolidated schemes were combined, the overall dependency ratio stayed almost the same, around 1.20. This shows that while open schemes cover fewer dependants, restricted schemes help keep the overall average steady.

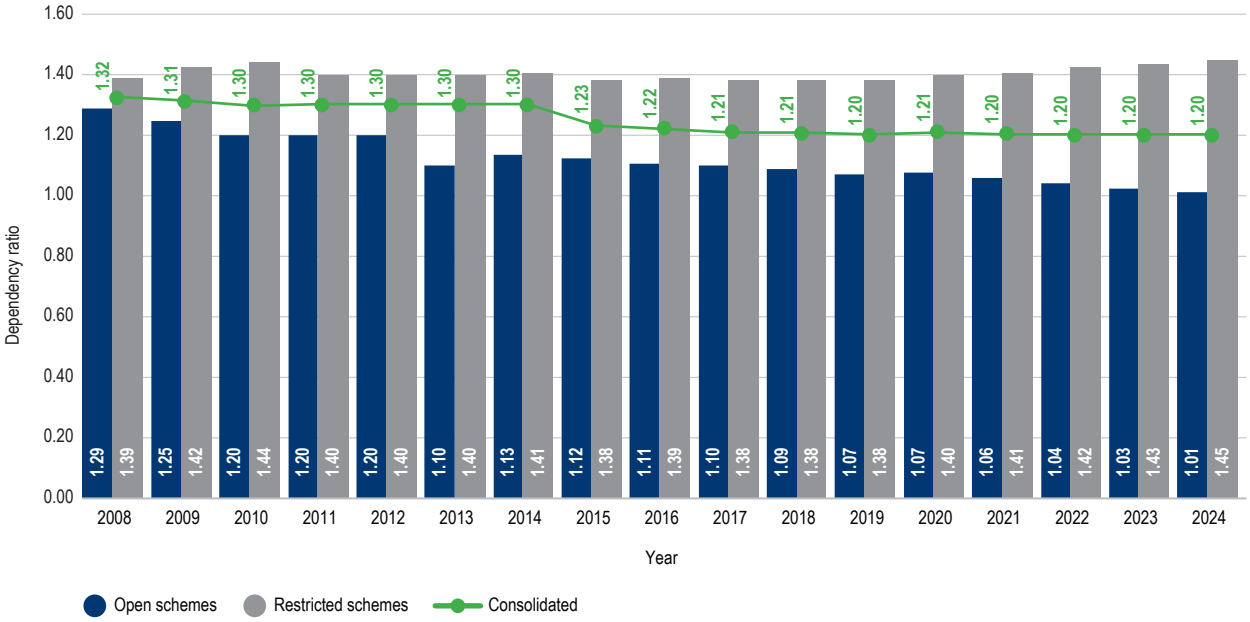


Figure 9: Dependency ratio in schemes (2008-2024)

From 2018 to 2024, the population shows interesting trends across different age bands. Among the youngest children under 1 year, the numbers dropped for both genders from 127 213 to 107 510 for females and from 131 247 to 110 861 for males, showing a decline of roughly 15% over six years.

The 1-4 and 5-9 age bands also decreased slightly, while teenagers and young adults aged 15-24 saw a slight increase, particularly females, from 305 545 to 360 257 in the 15-19 group. In contrast, the adult population aged 30-49 remains relatively stable, with minor fluctuations.

The most notable growth is in the older age groups: those aged 65 and above increased significantly, with females in the 85+ age band rising from 37 249 to 47 107 (around 26%) and males from 16 537 to 21 340 (around 29%). This pattern highlights an ageing population, with fewer young children and a steadily growing elderly population.

Figure 10: Age and gender distribution of beneficiaries (2018, 2023 and 2024)

Between 2004 and 2024, the average age of beneficiaries in open medical schemes steadily increased from 32.5 to 36.4, showing a clear upward trend of nearly four years over two decades. Restricted schemes, in contrast, have remained relatively stable, moving slightly from 33.0 years in 2004 to 31.8 years in 2024.

Consolidated schemes, which combine both types, also show a gradual increase from 32.0 to 34.2 years. When excluding specific schemes like the Discovery Health Medical Scheme (DHMS) and the Government Employee Medical Scheme (GEMS), open schemes still grew from 34.7 years in 2012 to 36.1 years in 2024, while restricted schemes edged up from 31.2 to 31.8 years.

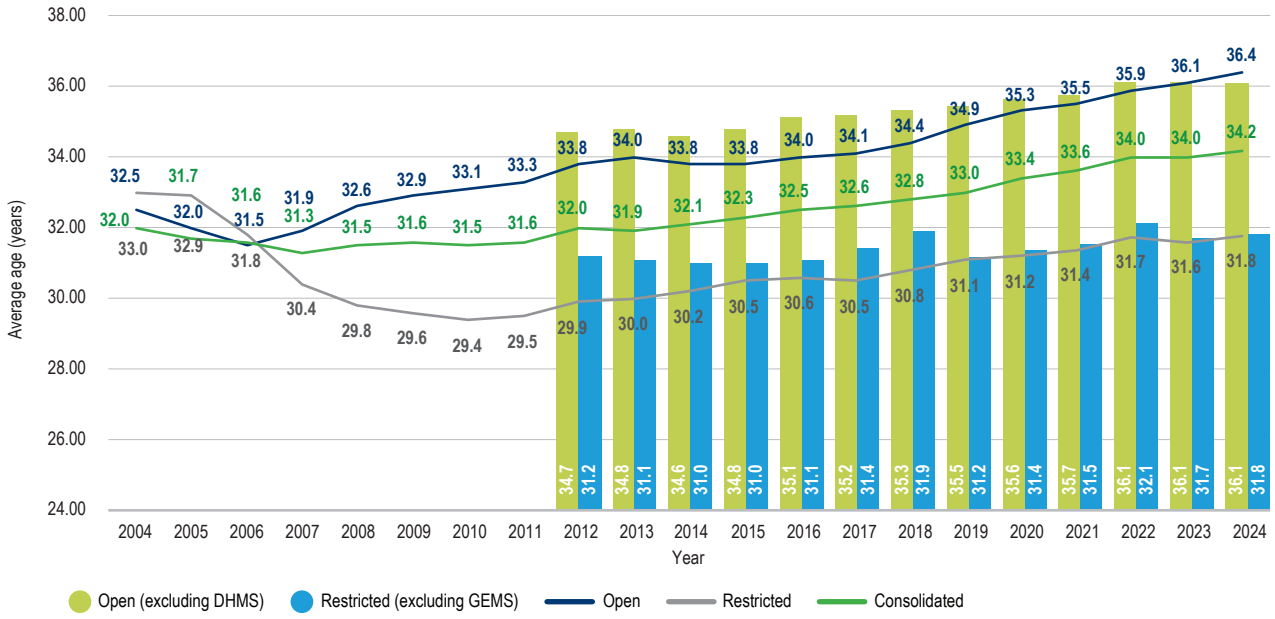


Figure 11: Average age of beneficiaries (2004-2024)

Table 3 shows that between 2016 and 2024, the average age and pensioner ratio across medical schemes have shown a steady upward trend, reflecting an ageing membership base.

In open schemes, the average age increased from about 34 years in 2016 to 36.4 years in 2024, while the pensioner ratio rose from 9.2% to 12.1%.

Females in open schemes had higher average ages and pensioner ratios than males.

Restricted schemes had younger members overall, with the average age only rising from 30.6 to 31.8 years and a more minor increase in pensioner ratio from 6.3% to 7.3%. When all schemes are combined, the average age grew from 32.5 to 34.2 years, and the pensioner ratio climbed from 7.9% to 9.8%. These patterns indicate that the medical scheme population is ageing gradually, which could have long-term cost and sustainability implications for the sector.

Table 3: Average age, pensioner by gender and scheme type (2016-2024)

Type Of Scheme	Gender	Average Age (Years) and Pensioner ratio (%)	2016	2017	2018	2019	2020	2021	2022	2023	2024
Open Schemes	Female	Average age	34.7	34.9	35.2	35.6	36.2	36.4	36.8	37.1	37.4
		Pensioner ratio	10.1	10.9	11.6	11.3	11.8	12.0	12.5	12.9	13.4
	Male	Average age	33.2	33.3	33.5	33.8	34.3	34.5	34.8	35.1	35.3
		Pensioner ratio	8.2	8.9	9.6	9.2	9.6	9.6	10.0	10.3	10.7
	Total	Average age	34	34.1	34.4	34.9	35.3	35.5	35.9	36.1	36.4
		Pensioner ratio	9.2	10.0	10.7	10.3	10.7	10.9	11.3	11.7	12.1
Restricted Schemes	Female	Average age	31.9	31.8	32.1	32.2	32.7	32.8	33.2	33.2	33.4
		Pensioner ratio	7.1	7.4	7.9	7.4	7.6	7.7	7.9	8.0	8.4
	Male	Average age	29.1	28.9	29.3	29.3	29.5	29.6	29.9	29.7	29.7
		Pensioner ratio	5.2	5.4	5.8	5.3	5.5	5.5	5.7	5.7	5.9
	Total	Average age	30.6	30.5	30.8	31.1	31.2	31.4	31.7	31.6	31.8
		Pensioner ratio	6.3	6.5	6.9	6.5	6.6	6.7	6.9	6.9	7.3
All Schemes	Female	Average age	33.4	33.5	33.8	34.1	34.5	34.7	35.1	35.2	35.4
		Pensioner ratio	8.8	9.3	9.9	9.5	9.8	10.0	10.3	10.5	10.9
	Male	Average age	31.5	31.4	31.7	31.9	32.2	32.3	32.6	32.6	32.7
		Pensioner ratio	7.0	7.4	7.9	7.6	7.8	7.8	8.1	8.2	8.5
	Total	Average age	32.5	32.6	32.8	33	33.4	33.6	34	34	34.2
		Pensioner ratio	7.9	8.4	9.0	8.6	8.9	9.0	9.3	9.4	9.8

Government-Funded or State-Linked Schemes

Between 2023 and 2024, overall membership across government-funded medical schemes grew modestly by 3.8%, from 3 169 152 to 3 290 886 beneficiaries. The Government Employees Medical Scheme (GEMS), the largest closed and government-funded scheme, is experiencing an increase of 5.2%, reflecting continued growth in public sector coverage. LA-Health also saw a healthy rise of 6.7%, while Parmed, Rand Water, and Rhodes University Medical Scheme experienced small positive growths between 1.5% and 2.9%.

Conversely, some government-funded schemes showed declines. Medipos dropped sharply by 36.6%, and Transmed fell by 14.2%, signalling membership challenges. Minor decreases were observed for SAMWUMed (-5%), SABC (-2.5%), Polmed (-0.5%), and the University of Kwa-Zulu Natal Medical Scheme (-3%).

Table 4: Government-funded or state-linked medical schemes (2023 and 2024)

Scheme Name	2023	2024	% Change
Government Employees Medical Scheme (GEMS)	2 274 671	2 394 054	5.25%
LA-Health Medical Scheme	259 582	276 998	6.71%
Medipos Medical Scheme	16 746	10 609	-36.65%
Parmed Medical Aid Scheme	4 123	4 241	2.86%
Rand Water Medical Scheme	9 504	9 646	1.49%
Rhodes University Medical Scheme	2 468	2 507	1.58%
SABC Medical Aid Scheme	7 925	7 728	-2.49%
SAMWUMed	72 420	68 788	-5.02%
South African Police Service Medical Scheme (Polmed)	495 606	493 206	-0.48%
Transmed Medical Fund	19 810	17 003	-14.17%
University Of Kwa-Zulu Natal Medical Scheme	6 297	6 106	-3.03%
Total	**3 169 152**	**3 290 886**	**3.84%**

Distribution of Beneficiaries by Province in 2024

Figure 12 shows the geographic distribution of beneficiaries per province in 2024, with the data primarily based on the principal member's address.

Gauteng accounts for the largest share, with nearly 40% of the total, reflecting its status as the country's most populous and economically active province. Western Cape and KwaZulu-Natal follow, holding 15.5% and 14.4% respectively. Together, these three provinces contribute 69.1% of all beneficiaries, meaning that more than two-thirds of the total are concentrated in just a few regions.

The remaining provinces, Eastern Cape, Mpumalanga, Limpopo, North-West, Free State, and Northern Cape, account for the smaller share, ranging from about 2% to 7% each.

This distribution highlights a strong concentration of beneficiaries in the more urbanised and economically developed provinces, while the smaller and less populated regions contribute a comparatively modest portion.

Figure 12: Distribution of beneficiaries by province (2024)

Table 5 shows the distribution of beneficiaries per province between 2023 and 2024. Gauteng continues to dominate, with 3 578 411 beneficiaries in 2024, reflecting a modest increase of 1.38%. Western Cape and KwaZulu-Natal follow, with 1 418 041 and 1 317 460 beneficiaries, respectively, showing small but steady growth. Gauteng, Western Cape, and KwaZulu-Natal account for over 60% of all beneficiaries, highlighting the concentration in the more populous and economically active provinces.

Other provinces show mixed trends: Eastern Cape and Limpopo recorded slight increases of 1.04% and 2.11%, while Free State, Mpumalanga, North-West, and Northern Cape experienced modest declines, with Mpumalanga showing the most significant drop at 6.88%. Notably, "Other/Unspecified province" and "Outside the Republic" saw substantial growth of 14.39% and 120.18% respectively, indicating increasing participation from areas not captured in standard provincial data. Overall, total beneficiaries across all provinces increased slightly by 0.45%, suggesting relatively stable coverage with minor shifts between regions.

Table 5: Distribution of beneficiaries by province (2023 and 2024)

Province Name	2023	2024	% Change
Eastern Cape	668 146	675 070	1.04 %
Free State	414 470	405 969	-2.05%
Gauteng	3 529 855	3 578 411	1.38%
Kwa-Zulu Natal	1 302 597	1 317 460	1.14%
Limpopo	498 749	509 250	2.11%
Mpumalanga	578 240	538 444	-6.88%
North-West	499 642	496 023	-0.72%
Northern Cape	192 648	191 748	-0.47%
Other/Unspecified province	28 943	33 108	14.39%
Outside the Republic	2 275	5 009	120.18%
Western Cape	1 411 888	1 418 041	0.44%
All provinces	**9 127 453**	**9 168 533**	**0.45%**

Table 5 shows the growth in beneficiaries across provinces for 2023 and 2024, by open and restricted schemes. Gauteng remains the most significant contributor, with over 3.5 million beneficiaries in 2024. While the open schemes in Gauteng slightly declined by 1.38%, restricted schemes grew by 6.16%, indicating a strong uptake. KwaZulu-Natal and Limpopo also saw modest growth in restricted schemes (3.95% and 3.01% respectively), even as their open schemes decreased slightly.

In contrast, provinces like Free State and Mpumalanga experienced declines in both open and restricted schemes, with Mpumalanga's restricted schemes showing a notable drop of 10.27%.

The Eastern Cape displayed a slight decline in open schemes (-1.99%) but growth in restricted schemes (3.13%).

North-West and Northern Cape remained relatively stable, with minimal changes in both scheme types. Overall, the combined industry growth across all provinces was modest at 0.45%, indicating stability in the total number of beneficiaries. However, it highlights shifts within scheme types, with restricted schemes generally gaining ground while open schemes saw slight declines.

Table 6: Growth in the number of beneficiaries by province and scheme type (2023 and 2024)

	2023		2024		% Change		
Province Name	Open	Restricted	Open	Restricted	Open	Restricted	Industry
Eastern Cape	273 228	394 918	267 794	407 276	-1.99%	3.13%	1.04%
Free State	153 586	260 884	150 670	255 299	-1.90%	-2.14%	-2.05%
Gauteng	2 239 976	1 289 879	2 209 060	1 369 351	-1.38%	6.16%	1.38%
Kwa-Zulu Natal	663 324	639 273	652 932	664 528	-1.57%	3.95%	1.14%
Limpopo	147 791	350 958	147 731	361 519	-0.04%	3.01%	2.11%
Mpumalanga	230 851	347 389	226 745	311 699	-1.78%	-10.27%	-6.88%
North-West	166 103	333 539	162 122	333 901	-2.40%	0.11%	-0.72%
Northern Cape	68 164	124 484	66 834	124 914	-1.95%	0.35%	-0.47%

Schemes with less than 6 000 members

Table 7 presents medical schemes with membership figures below 6 000, detailing the number of beneficiaries in 2023 and 2024 by scheme type, along with the percentage change. There are 27 restricted schemes within this category compared to three open schemes.

Most schemes experienced a decline in beneficiaries, with Suremed Health (-32.79%) and Medipos Medical Scheme (-36.65%) seeing the largest drops, indicating significant challenges or shifts in those plans.

On the positive side, Alliance-Midmed Medical Scheme (+5.79%) and Horizon Medical Scheme (+3.54%) showed growth, suggesting increased demand or stability. Overall, the data highlights a mixed trend, with a slight majority of schemes losing beneficiaries, averaging a modest decline across the board.

Table 7: Medical schemes with fewer than 6 000 members (2023 vs. 2024)

Scheme Type	Scheme Name	Beneficiaries 2023	Beneficiaries 2024	% Change
Open	Cape Medical Plan	6 972	6 360	-8.78%
	Makoti Medical Scheme	8 643	7 655	-11.43%
	Suremed Health	1 912	1 285	-32.79%
Restricted	AECI Medical Aid Society	11 116	10 579	-4.83%
	Alliance-Midmed Medical Scheme	3 624	3 834	5.79%
	Anglovaal Group Medical Scheme	4 428	4 281	-3.32%
	Barloworld Medical Scheme	9 134	8 734	-4.38%
	BMW Employees Medical Aid Society	8 043	6 905	-14.15%
	BP Medical Aid Society	2 353	1 702	-27.67%
	Building & Construction Industry Medical Aid Fund	12 069	12 033	-0.30%
	De Beers Benefit Society	7 893	7 451	-5.60%
	Engen Medical Benefit Fund	5 672	5 625	-0.83%
	Fishing Industry Medical Scheme (Fish-Med)	4 177	3 891	-6.85%
	Golden Arrows Employees' Medical Benefit Fund	4 670	4 424	-5.27%
	Horizon Medical Scheme	1 890	1 957	3.54%
	Libcare Medical Scheme	11 210	10 608	-5.37%
	Malcor Medical Scheme	10 631	10 797	1.56%
	MBMED Medical Aid Fund	9 318	8 381	-10.06%
	Medipos Medical Scheme	16 746	10 609	-36.65%
	Multichoice Medical Aid Scheme	7 753	7 638	-1.48%
	Parmed Medical Aid Scheme	4 123	4 241	2.86%
	PG Group Medical Scheme	2 634	2 497	-5.20%
	Rand Water Medical Scheme	9 504	9 646	1.49%
	Rhodes University Medical Scheme	2 468	2 507	1.58%
	SABC Medical Aid Scheme	7 925	7 728	-2.49%
	Sedmed	2 283	2 266	-0.74%
	TFG Medical Aid Scheme	6 240	6 029	-3.38%
	Tiger Brands Medical Scheme	9 153	8 780	-4.08%
	Tsogo Sun Group Medical Scheme	8 436	8 496	0.71%
	University Of Kwa-Zulu Natal Medical Scheme	6 297	6 106	-3.03%

HEALTHCARE BENEFITS

Note that total benefits paid (benefits paid from the risk pool plus savings) reported in the utilisation section of this report differ slightly from gross benefits reported in the financial statutory returns report. For more information, read notes in Annexures C to F. All values in this section are stated in nominal terms unless otherwise indicated.

Total healthcare benefits paid

Total healthcare expenditure on benefits paid in 2024 increased to R259.3 billion, up by 8.52% from the 2023 reported amount of R239.0 billion. The claims paid per average beneficiary per annum (pabpa) increased by 7.84% from R26 404 69 in 2023 to R28 474 15 in 2024.

The proportion of healthcare expenditure paid towards hospital services was 35.95%, with expenditure on all specialists accounting for 28.02%, followed by medicine dispensed at 14.05%, and then supplementary and allied health professionals at 8.47%.

Risk benefits paid comprised 91.09% of total benefits paid, with savings at 8.91%, which represents a shift of just over one percentage point from previous years. Total hospital expenditure accounts for 39.34% of risk benefits paid, with all specialists accounting for 28.92%, followed by medicine dispensed at 11.48%. Risk benefits paid per beneficiary increased by 8.71% from R23 857.59 in 2023 to R25 936.12 in 2024.

Medicines dispensed accounted for 40.25% of expenditure from medical savings accounts, followed by expenditure on specialists at 18.81%, supplementary and allied health professionals at 17.85%, and general practitioners at 12.50%. Expenditure paid from medical savings accounts toward hospital services was 1.33%. The benefits paid from medical savings accounts pabpa decreased by 0.36% to R2 538.03 in 2024. These proportions highlight how benefit options are designed and are graphically presented in Figure 13.

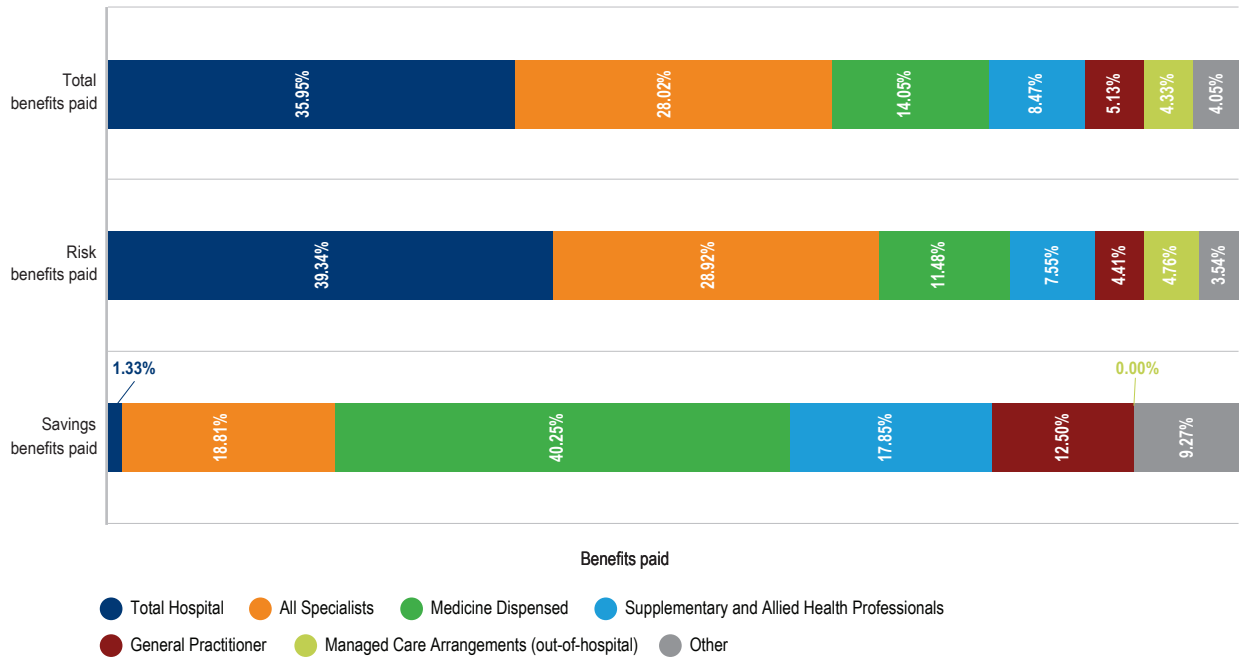


Figure 13: Total Benefits, Risk Benefits and Savings

**Other consists of other health services, dentists, dental specialists, ex gratia payments and other unspecified benefits*

Open schemes paid 36.52% of benefits toward hospital services, which is slightly higher than the 35.26% paid by restricted schemes. Open schemes paid more benefits to specialists, 29.58% compared to 26.10% paid by restricted schemes.

Total hospital expenditure increased by 9.71% between 2023 and 2024, from R85.0 billion to R93.2 billion. A slightly larger percentage of benefits is paid towards hospital services in open schemes at 36.52% compared to 35.26% in restricted schemes. The average amount paid per beneficiary for hospital services increased by 9.02% to R10 237.36 from R9 390.40. Just over 90% of total expenditure on hospitals was paid to private hospitals.

In contrast, restricted schemes paid more benefits toward medicines dispensed, supplementary and allied health professionals, and general practitioners. Open schemes paid 1.47% more benefits toward managed care arrangements than restricted schemes. Figure 14 illustrates these differences.

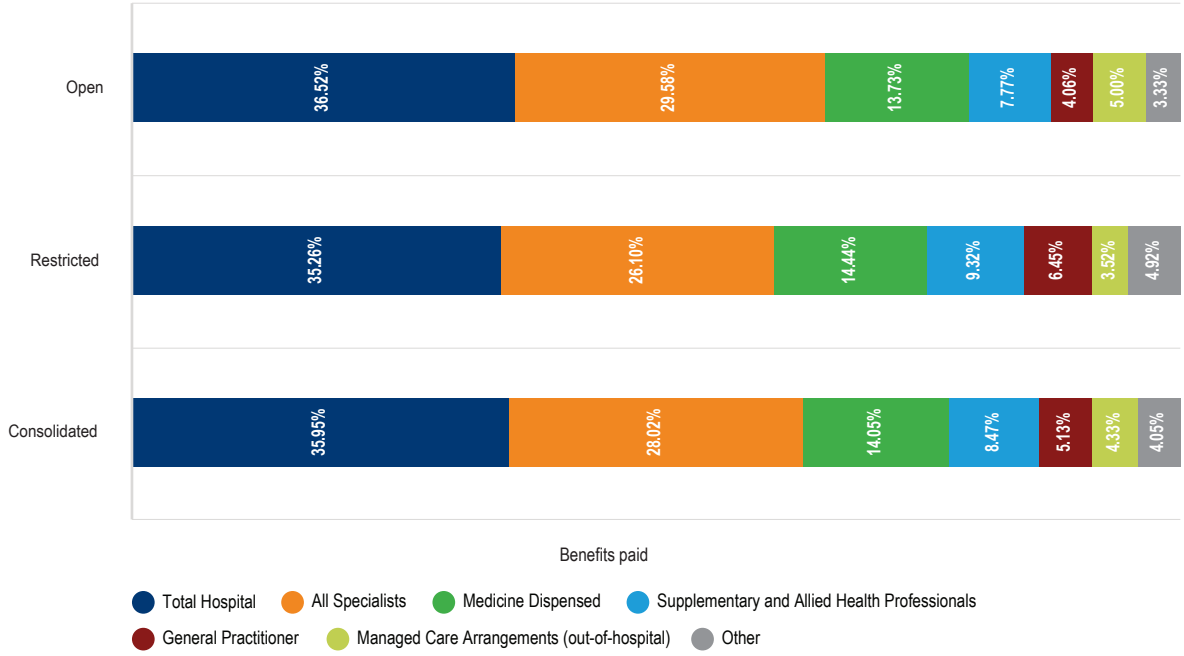


Figure 14: Distribution of healthcare benefits paid in 2024 by discipline group

**Other consists of other health services, dentists, dental specialists, ex gratia payments and other unspecified benefits*

Hospital Services Paid

Expenditure on hospital services paid on a fee-for-service (FFS) basis amounted to R71.0 billion in 2024, an increase of 10.84% from R64.1 billion in 2023. Close to 85.89% of this expenditure is attributed to ward fees, theatre fees and consumables, with expenditure on medicines consisting of only 9.73% at R6.9 billion.

The highest increase was observed for fee-for-service: other at 25.63%, followed by fee-for-service: medicines at 12.09%. The services under the other will require unbundling to further understand the procedures covered and manage the expenditure. The alternative reimbursement models and per diem fees increased by 8.14% and 3.91%, respectively, while FFS theatre fees and consumables rose by 11.28% and 11.21%, respectively. Expenditure paid to state or provincial hospitals (UPFS) increased by 8.11%. The values are presented in Figure 15.

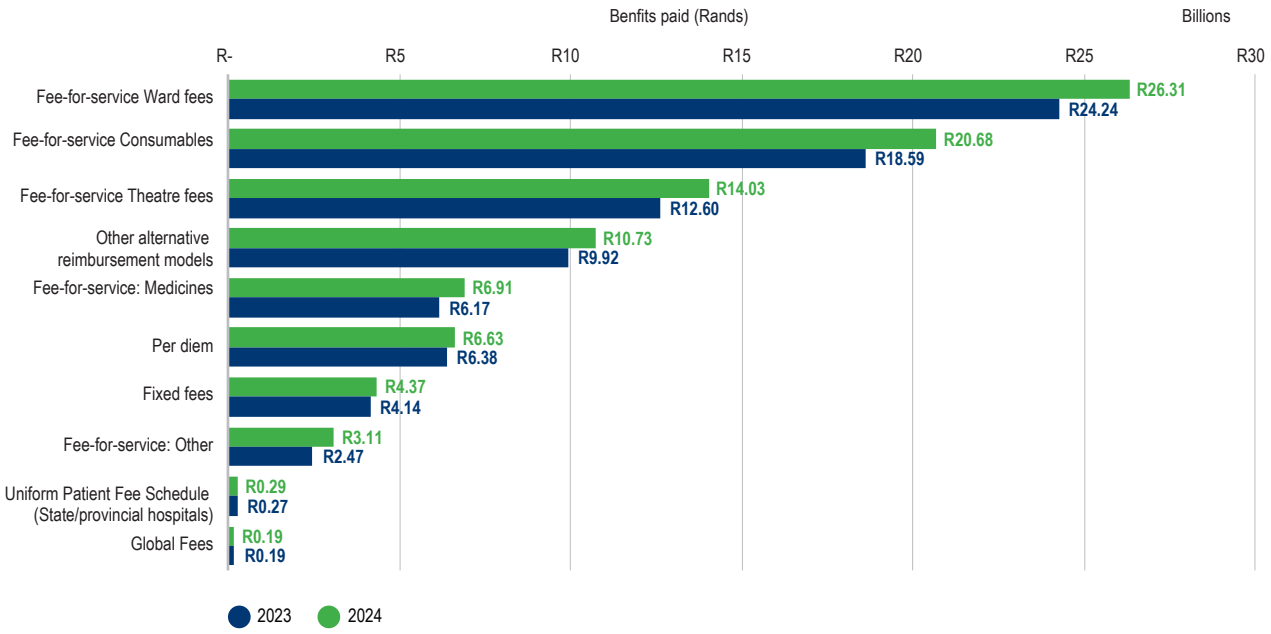


Figure 15: Reimbursement methods for hospital services 2023–2024

Medicines Dispensed

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals amounted to approximately R36.4 billion. This represents an increase of 5.19% compared to the R34.6 billion spent in 2023. Pharmacies were paid R31.5 billion of all benefits paid towards medicines dispensed in 2024, and remain the most significant cost driver, although it decreased slightly in relative proportions from 87.13% in 2023 to 86.46% in 2024.

General Practitioners accounted for 3.40% of medicines dispensed, while all other providers accounted for 9.47%. The most significant year-on-year increase was observed for Orthotists & Prosthetists, which increased by 60.27%, with Clinical services close behind at 20.35%. A slight decrease was observed for General Medical practices at 0.13%. Table 8 lists the top 11 dispensing providers.

Table 8: Benefits paid for medicines dispensed - top 11 disciplines

Discipline	2023		2024		
	R'000	% of total	R'000	% of total	% change
Pharmacies (60)	R30 176 584.14	87.13%	R31 499 800.28	86.46%	4.38%
General Medical Practice (014)	R1 178 049.90	3.40%	R1 176 520.60	3.23%	-0.13%
Clinical services (90)	R724 144.56	2.09%	R871 489.55	2.39%	20.35%
Ophthalmology (26)	R502 449.56	1.45%	R543 487.00	1.49%	8.17%
Diagnostic Radiology (38)	R444 479.66	1.28%	R510 023.22	1.40%	14.75%
Orthotists & Prosthetists (87)	R273 435.85	0.79%	R410 890.09	1.13%	50.27%
Speech therapy and Audiology (82)	R175 779.18	0.51%	R202 797.24	0.56%	15.37%
Independent Practice Specialist Radiation Oncology (40)	R177 989.93	0.51%	R192 817.74	0.53%	8.33%
Registered nurses (88)	R164 224.34	0.47%	R186 631.44	0.51%	13.64%
Surgery/Paediatric surgery Independent Practice Specialist (42)	R122 177.25	0.35%	R144 446.17	0.40%	18.23%
Nuclear Medicine (25)	R96 228.98	0.28%	R108 049.73	0.30%	12.28%
Grand Total	**R34 632 620.51**	**100%**	**R36 430 990.51**	**100%**	**5.19%**

Benefits paid per event

Figure 16 shows benefits paid to different discipline groups per event (visit) for both in and out of hospital by scheme type. Total benefits paid per event are calculated as total benefits paid (from risk and savings) divided by the number of visits to a provider. The cost (or benefits paid) per event must be interpreted with caution, as the calculation does not consider other factors such as the number of hours spent per event. Events paid in-hospital from beneficiaries' medical savings accounts constitute a very small part of the expenditure and primarily relate to visits to dentists and dental specialists.

Expenditure paid per event for in-hospital services is consistently higher than for out-of-hospital services across all disciplines and scheme types. The gap in expenditure between in-hospital and out-of-hospital services is widest for dental specialists, surgical specialists, and anaesthetists, who were paid R6 535, R6 295, and R5 463 more for in-hospital services, respectively. Restricted schemes paid more per visit to pathologists, supplementary and allied health professionals for out-of-hospital services, and dentists' visits in-hospital. General Practitioners represent the lowest expenditure per event across all categories. These differences are highlighted in Figure 16.

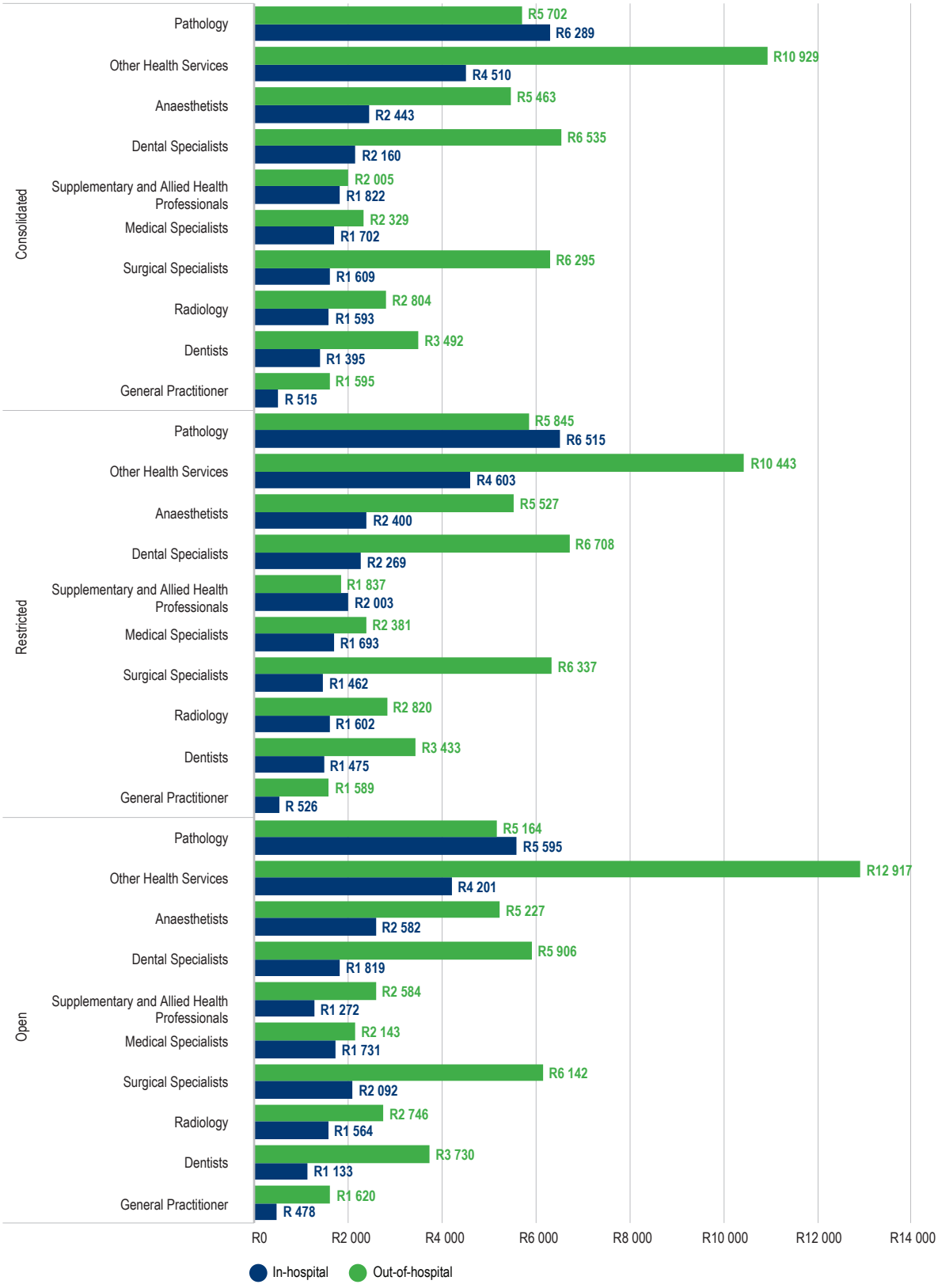


Figure 16: Benefits paid per event (visit) 2024

Table 9 depicts expenditure by event and setting. The average benefits paid per event for out-of-hospital events had a moderate overall increase of 5.99% with the most notable increases observed for Pathology at 13.51%, Dental Specialists at 12.45% and Medical Specialists and General Practitioners at 6.57% and 6.75%, respectively. Smaller increases were reported for Radiology, Surgical Specialists and Anaesthetists at 3.36%, 1.26%, and 1.9%, respectively.

The average in-hospital benefits paid per event increased significantly by 10.64%, driven by Supplementary and Allied Health Professionals at 24.72%, Dentists at 13.75%, and Surgical and Medical Specialists at 9.66% and 9.26%, respectively. The significant increase observed for Supplementary and Allied Health Professionals is attributed to substantial increases reported for Pharmacies and Medical Scientists, as well as the inclusion of Specialists in Sports and Exercise Medicine in that discipline group.

Table 9: Expenditure by event and setting

	2023	2024	
	Average paid per event	Average paid per event	% change
Out-of-hospital			
General Practitioner	R490	R515	5.18%
Dentists	R1 327	R1 393	4.95%
Radiology	R1 494	R1 580	5.76%
Surgical Specialists	R1 589	R1 601	0.75%
Medical Specialists	R1 607	R1 700	5.75%
Supplementary and Allied Health Professionals	R1 733	R1 801	3.93%
Dental Specialists	R1 903	R2 163	13.67%
Anaesthetists	R2 386	R2 357	-1.23%
Pathology	R5 526	R6 273	13.51%
In-hospital			
General Practitioner	R1 517	R1 588	4.69%
Dentists	R3 147	R3 456	9.83%
Radiology	R2 613	R2 830	8.29%
Surgical Specialists	R5 750	R6 239	8.51%
Medical Specialists	R2 087	R2 319	11.16%
Supplementary and Allied Health Professionals	R1 599	R2 027	26.74%
Dental Specialists	R6 393	R6 492	1.54%
Anaesthetists	R5 022	R5 424	8.00%
Pathology	R5 468	R5 743	5.04%

Trends in total healthcare benefits paid at constant prices[1]

Figure 17 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2005. These figures have been adjusted for inflation, using 2024 as the base year. The figures are reported in real (or constant) terms, implying that the historical data have been adjusted to 2024 prices.

The bulk of medical schemes' total expenditure continues to be paid to private hospitals and specialists. The trend in private hospital expenditure shows a general upward trend with only four periods of decline over the 19 years (2006, 2017, 2020, and 2022), ranging between 0.85% and 12.03%. It increased from R42.9 billion in 2005 to R92.9 billion in 2024 with an annual average increase of 4.15%. In 2024, the increasing trend continued, rising by 4.15% from 2023.

Benefits paid to specialists in 2024 amounted to R72.7 billion, a 5.23% increase in real terms when compared to the 2023 figure of R69.0 billion. This is slightly lower than the average annual increase of 6.27% observed from 2005 (R22.9 billion) to 2024.

1 Historical (pre-2014) provider classifications have been used in order to create continuity and preserve historical data. The groupings differ slightly with provider classifications used in other sections of the report.

Expenditure on medicine dispensed decreased by 0.74% year-on-year between 2023 and 2024, contrasting with the 2.65% average annual increase from 2005 (R22.1 billion) to 2024 (R36.4 billion). Similarly, expenditure on General Practitioners showed an average annual increase of 2.71%, with a notable rise of 3.07% between 2023 and 2024.

The only decreasing trend observed over the 19 years was in benefits paid to provincial hospitals, which declined by 58.41% from 2005 (R718.5 million) to 2024 (R298.9 million), corresponding to an average annual decrease of 4.51%. A year-on-year increase of 0.4% was reported between 2023 and 2024, from R297.7 million in 2023.

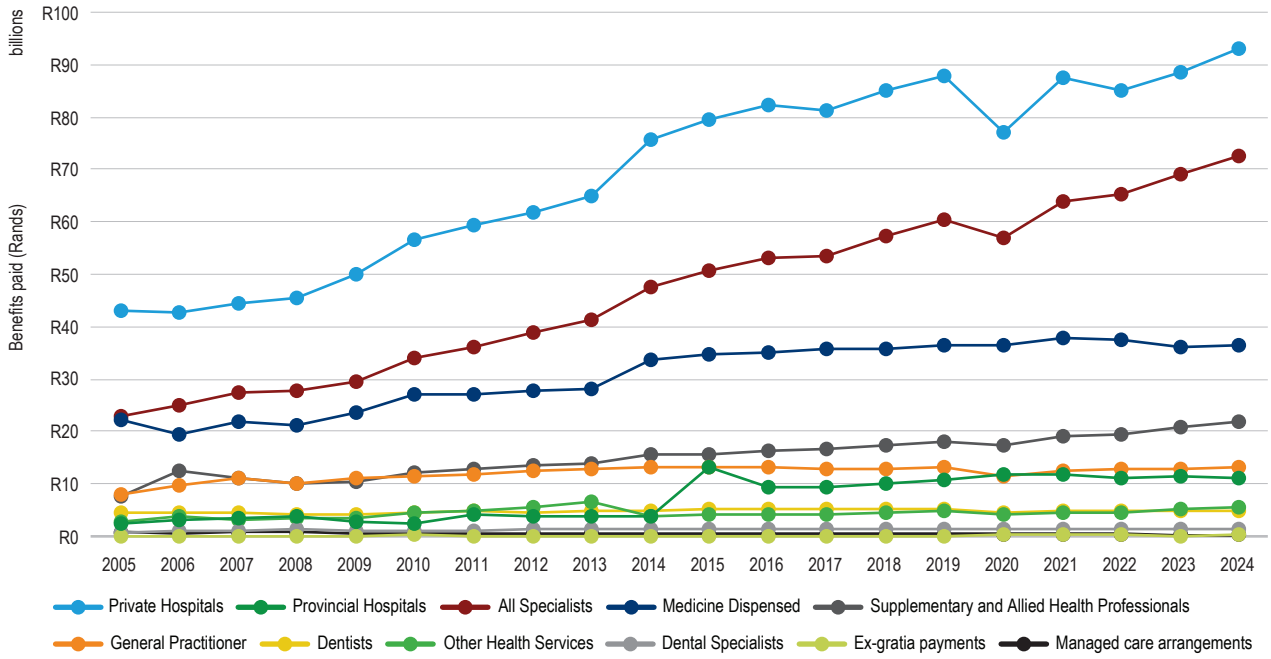


Figure 17: Total healthcare benefits paid 2005-2024 (2024 prices)*

** All values are adjusted for inflation using the Consumer Price Index (CPI) for 2024 as a base period*

*** Historical values are revised when the base period changes and will not correspond to the values reported in previous annual reports.*

Healthcare benefits paid per beneficiary

Figure 18 shows the changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2005 to 2024 in real terms. The trend in expenditure per average beneficiary, per annum, varies based on changes in the number of beneficiaries and is accentuated by fluctuations in total expenditure.

The trend in expenditure in private hospitals pabpa fluctuated over the 19 years with an overall increasing trend. There was an initial period of decline corresponding to sharp growth in beneficiaries between 2005 and 2008, followed by dips in 2017, 2020, and 2022, ranging between 1.8% and 11.8%. The overall increasing trend was most notable in 2014 (16.4%), which averaged at 2.34% from R6 448.26 in 2005 to R9 784.67 in 2024.

The overall increasing trend in benefits paid to specialists pabpa only declined in 2008 and 2020 (2.7% and 5.8%), with an average annual increase of 4.3% over the period. The expenditure increased by 4.5% year on year between 2023 (R7 638.55) and 2024 (R7 979.09).

The trend in benefits paid to general practitioners pabpa showed limited real growth over the period, with an average annual increase of 0.96% and only 2.3% year on year growth between 2023 (R1 428.91) and 2024 (R1 461.97).

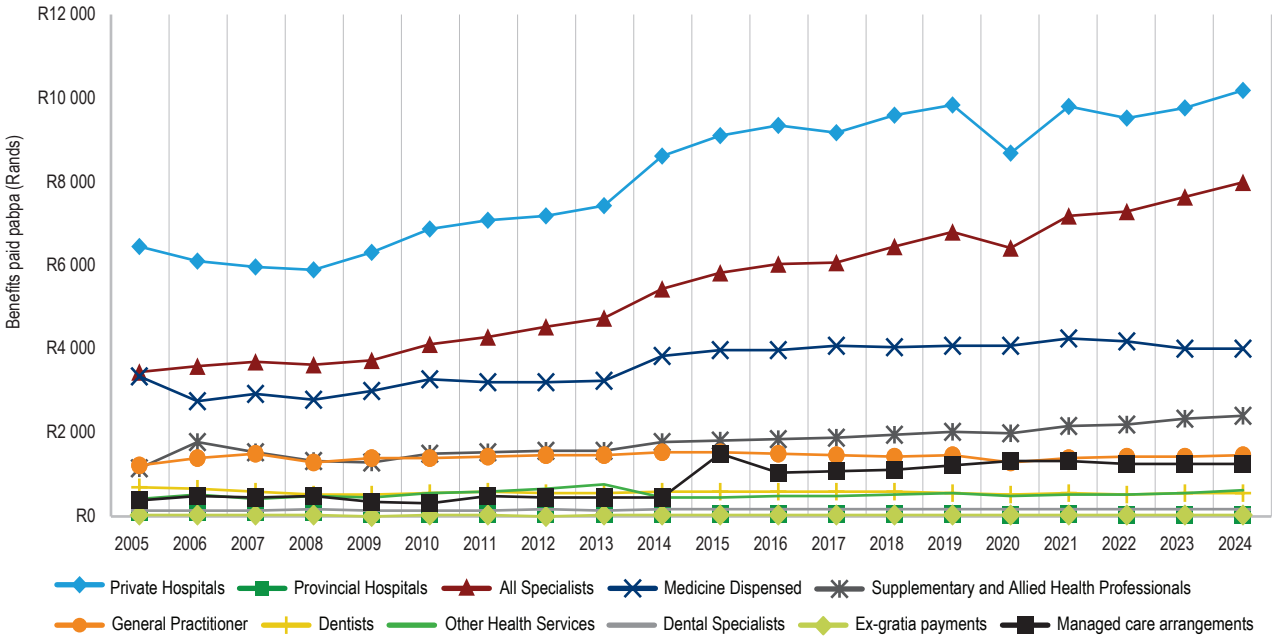


Figure 18: Total healthcare benefits paid per average beneficiary per annum 2005-2024 (2024 PRICES)*

** All values are adjusted for inflation using the Consumer Price Index (CPI) for 2024 as a base period.*

*** Historical values are revised when the base period changes and will not correspond to the values reported in previous annual reports.*

Healthcare benefits paid per age band

Figure 19 shows the per capita healthcare expenditure across healthcare services by age group. Expenditure for beneficiaries over the age of 44 years rises above the average cost per beneficiary of R28 474.15, and peaks for beneficiaries in the age band 85 years+ at R96 651.16 per average beneficiary.

Expenditure on primary healthcare providers, general medical practitioners and dentists continues to be overshadowed by the expenditure on specialists, hospitals and medicines dispensed, which, when combined, consists of over 80% of the cost per age band. Expenditure on hospitals and all specialists is high for beneficiaries less than one year old. It increases again from the age bands from 20 years and rises above the average for age bands above 54 years.

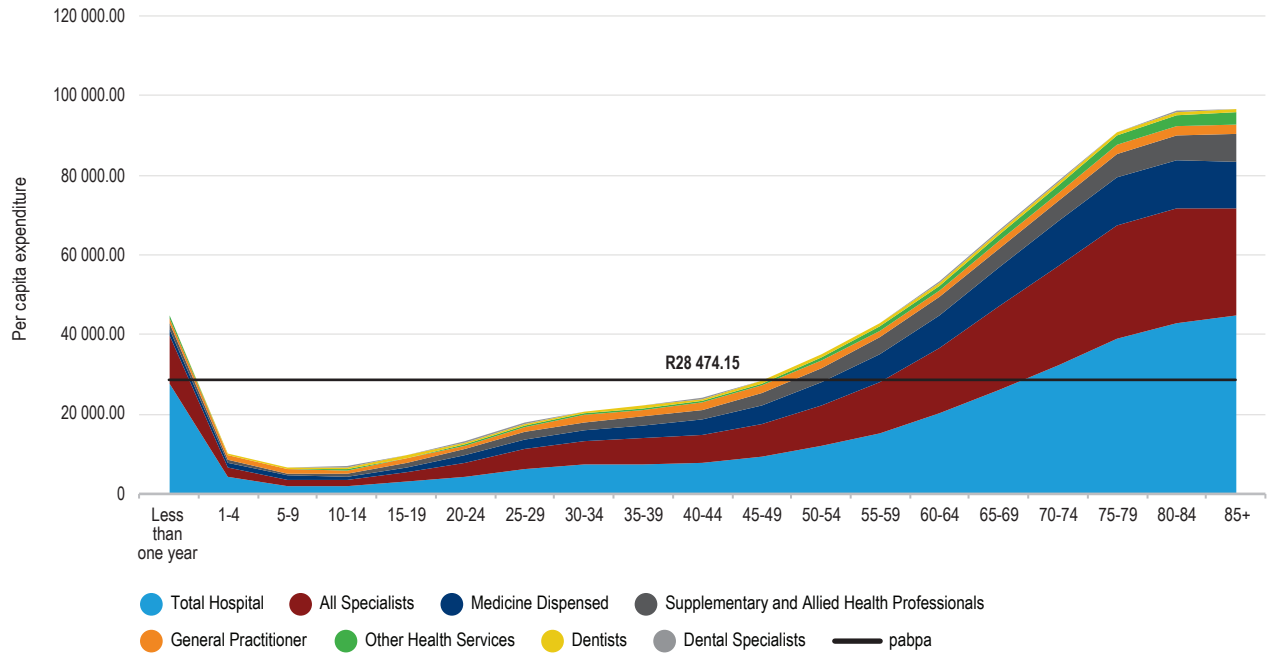


Figure 19: Expenditure per capita by age band 2024

** Values exclude managed care fees, capitation fees, ex gratia payments and other unspecified benefits.*

Figure 20 depicts the number of beneficiaries in 2023 and 2024 compared to the average amount paid for benefits for each age band. Expenditure for beneficiaries aged 60 and above increases significantly, ranging from approximately R53 281.42 to R96 651.16 per beneficiary per annum. On a year-on-year basis, expenditure increased on average by 6.79%, with the highest increase of 9.89% for beneficiaries under 1 year old.

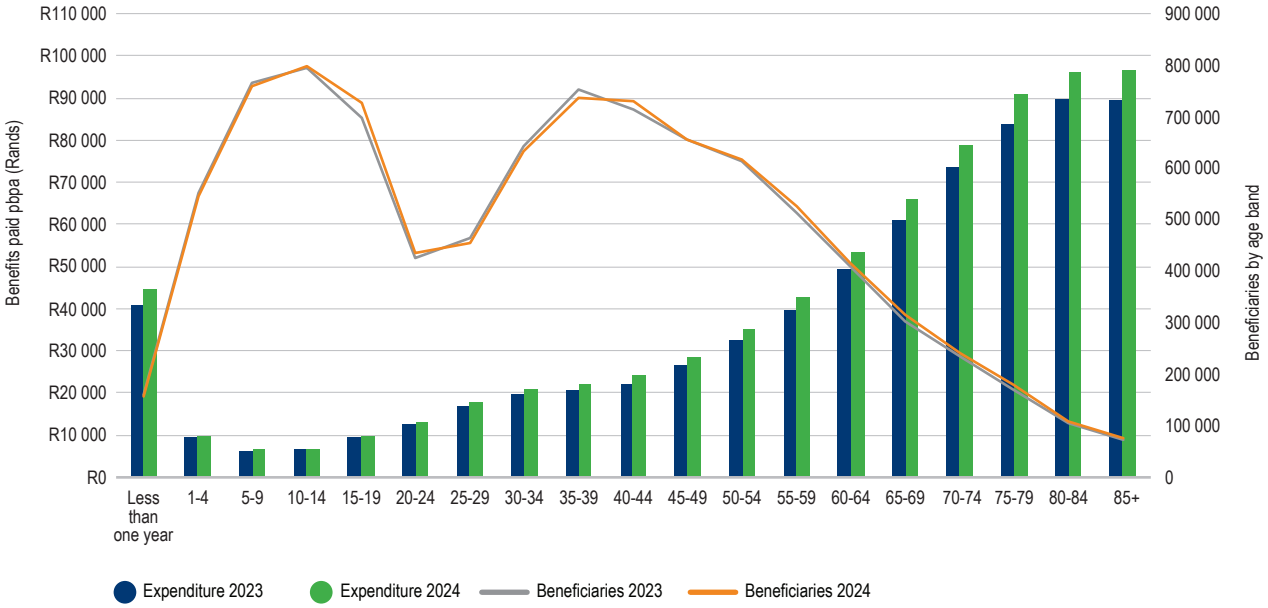


Figure 20: Expenditure by age band 2023 and 2024

** Values exclude managed care fees, capitation fees, ex gratia payments and other unspecified benefits.*

Figure 21 depicts the proportion of total expenditure by age group. Proportionally more benefits are paid towards beneficiaries in the age bands above 45 years. Beneficiaries aged 20 to 44 years represent the most significant proportion (33.14%) but account for only 24.35% of the expenditure. The 45 to 65 and 65+ age bands account for the highest proportions of expenditure, which comprises the highest increases in healthcare costs.

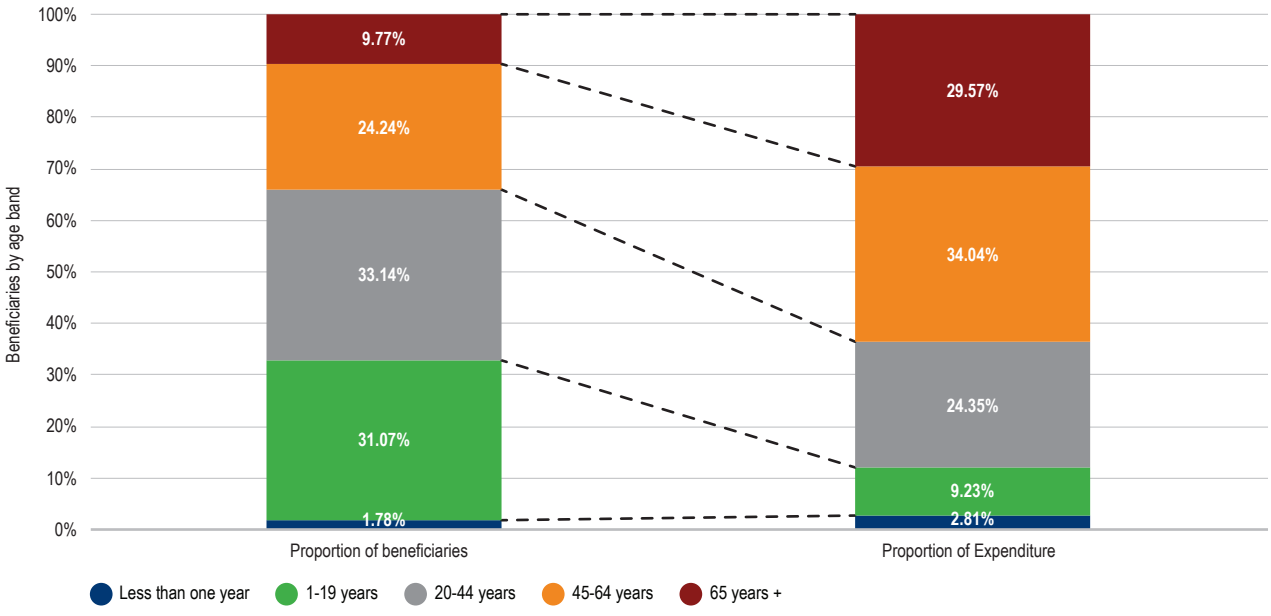


Figure 21: Proportion of total healthcare expenditure by age group in 2024

Out-Of-Pocket Payments

Out-of-pocket payments (OOPs) are calculated as the difference between the claimed amount and the amount that was paid from the medical scheme risk. This understates the true OOPs that members incur, as medical schemes likely do not fully capture and submit all costs associated with seeking healthcare. The proportion of expenditure paid from the medical savings account (MSA) is included as OOP because the MSA is not an insured benefit and does not offer cross-subsidisation.

Figure 22 depicts the estimated out-of-pocket payments for 2024 (outer ring) and 2023 (inner ring). The most significant component remains that of medicines dispensed, constituting 35.09% of OOPs in 2024, only marginally lower than the 35.1% recorded in 2023. OOPs paid to specialists increased slightly between 2023 and 2024, recording 27.59% and 28.47% respectively.

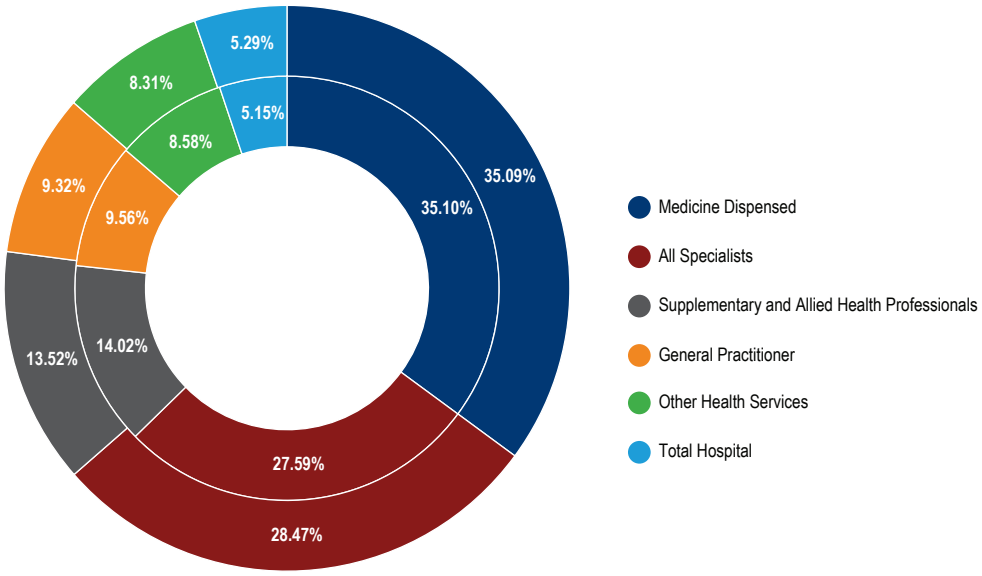


Figure 22: Out-of-pocket payments distribution by discipline group

Figure 23 offers a closer look into OOPs by splitting the expenditure into the proportion paid from MSA and that paid by the member. This reveals that total hospitals, all specialists and other health services constitute the most significant proportions of expenditure paid by members. In contrast, GPs, dentists and supplementary and allied workers constitute the most significant expenditure from the MSA. The largest expenditure from the medical savings account is paid for medicines dispensed at R9.30 billion, while members pay R6.94 billion. Members pay more OOP for specialist services at R8.83 billion compared to R4.54 billion paid from savings accounts. Other health services account for the lowest OOP paid by members, and total hospital services account for the lowest paid from the MSA.

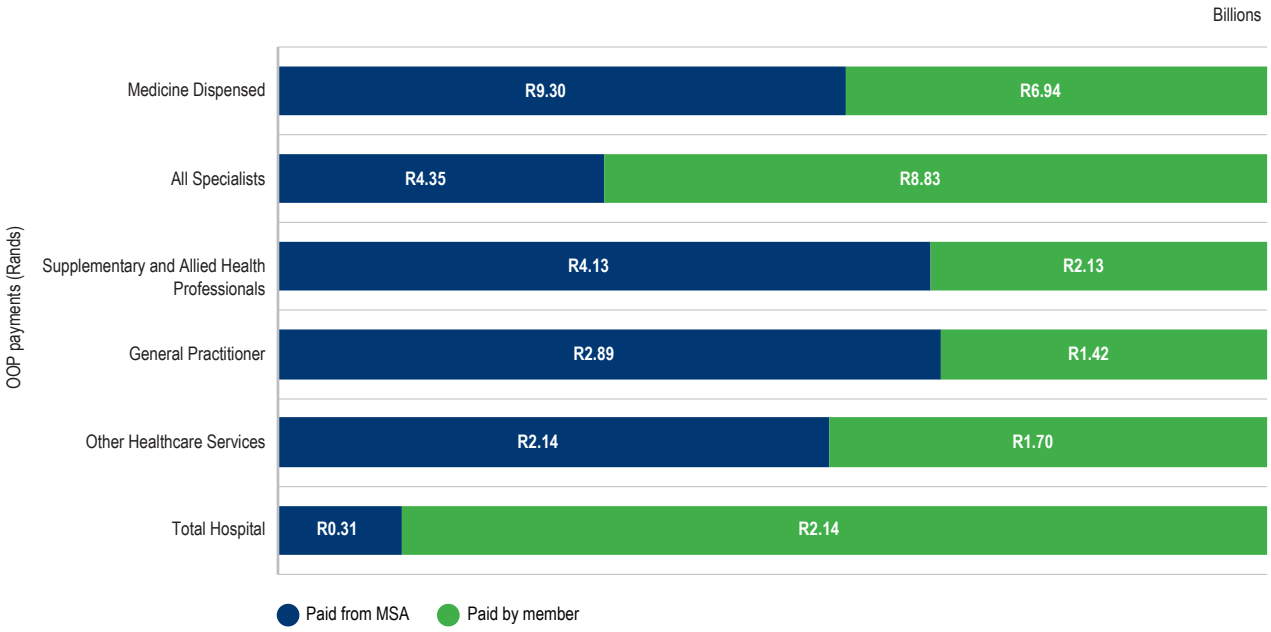


Figure 23: Out-of-pocket payment in Rands by discipline group

Figure 24 depicts the split of OOPs by scheme type between 2023 and 2024. Generally, OOPs are lower in restricted schemes, which, by design, tend to be more comprehensive. The total OOP increased at an average annual rate of 6.09% from R27.2 billion in 2015 to R46.3 billion in 2024 at a consolidated level. OOP paid by members increased at an average yearly rate of 6.49%, with open schemes at 6.88% and restricted schemes at 5.46%.

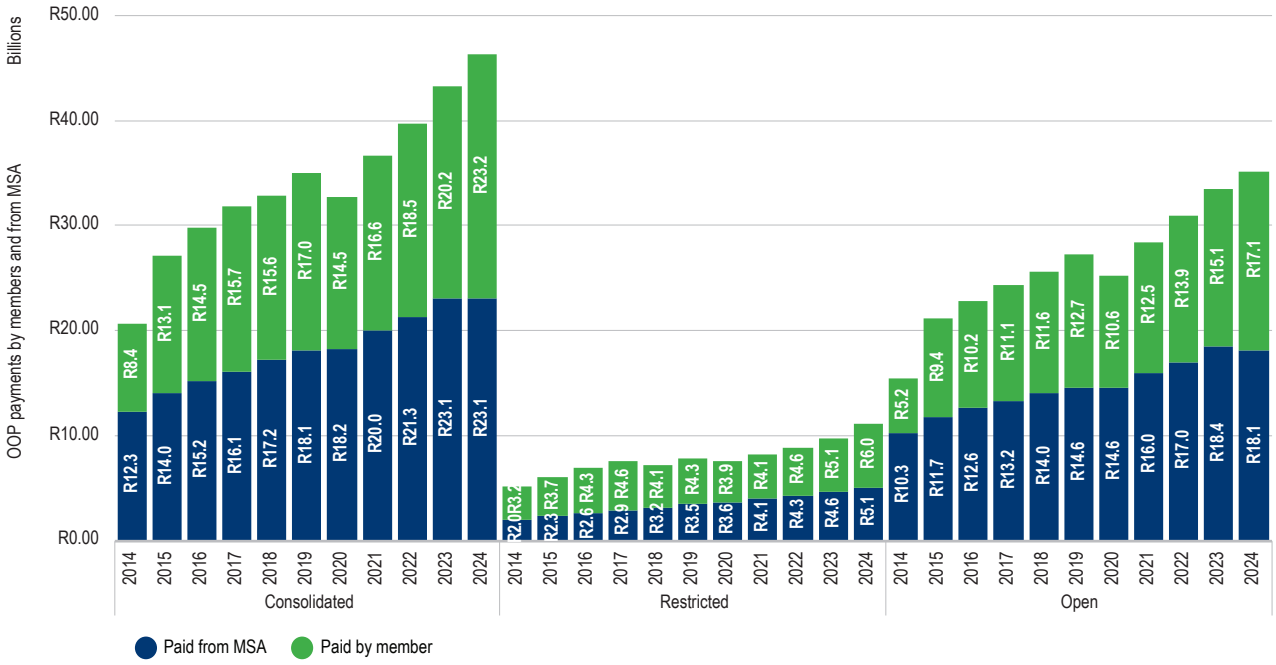


Figure 24: Out-of-pocket payment by scheme type

Prescribed Minimum Benefits

Expenditure on prescribed minimum benefits (PMBs) is mainly driven by beneficiary profile, prevalence of chronic conditions and expenditure on treatment. The term 'beneficiary profile' refers to the level of cross-subsidisation between the young and old, as well as the sick and healthy. Medical schemes need membership growth in young and healthier populations to remain sustainable.

Total PMB expenditure makes up 52.31% of total benefits paid, which has consistently increased in recent years after breaching 50% in 2018.

Total expenditure on PMB increased by 9.09% from R124.36 billion in 2023 to R135.66 billion in 2024, split between CDL and DTP expenditure at R25.03 billion and R110.63 billion, respectively.

Figure 25 compares the PMB expenditure for different age groups between 2023 and 2024 against the number of beneficiaries in each age group for those years. The expenditure generally increases with age for both years. It rises significantly for ages above 49 years. The highest expenditure is reported for beneficiaries 85 years and older. The number of beneficiaries decreases with increasing age, showing fluctuations among those under 20 years and between 30 and 59 years. The lowest number of beneficiaries is reported among those aged 20 to 29 years. The PMB expenditure pabpm increased by 8.49% from R1 145.07 in 2023 to R1 242.27 in 2024

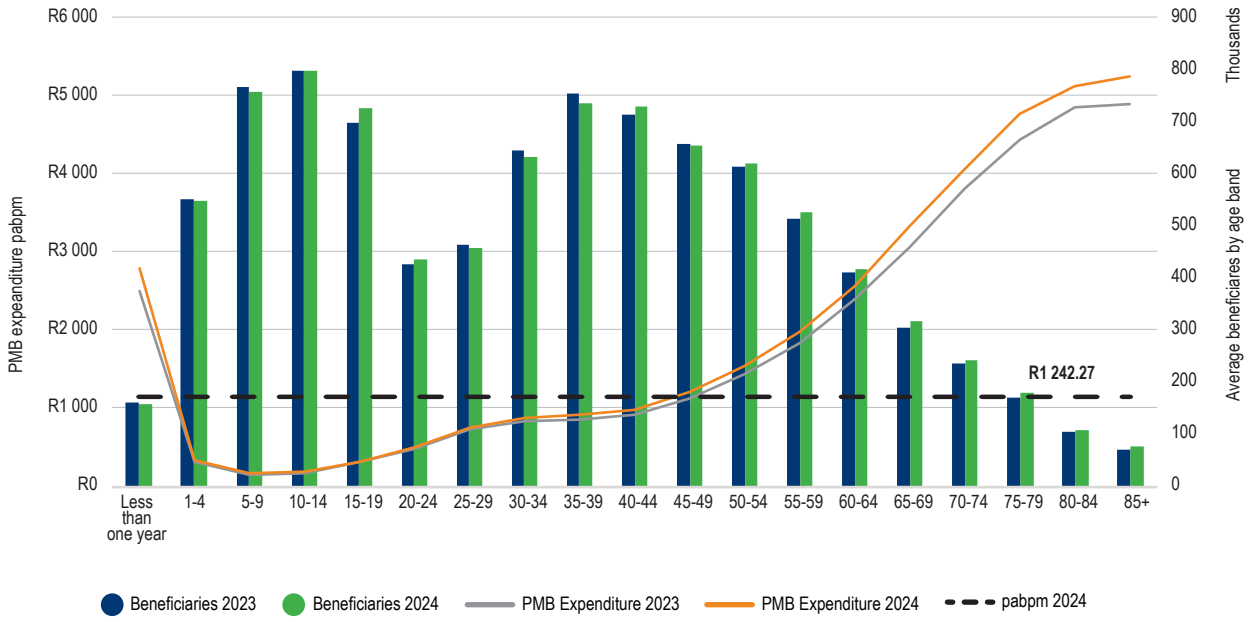


Figure 25: PMB expenditure by age band for 2023 and 2024

Chronic Condition Benefits

Table 10 presents the out-of-hospital and in-hospital expenditure trend for CDL conditions, comparing the average per patient per month (pppm) expenditure. The most significant percentage increases of out-of-hospital spending were reported for CRF at 45.6%, HAE at 20.47% and IHD at 14,38%. In-hospital expenditure for DBI increased significantly from 2023 by 174.4%, followed by HAE at 82.1% and CRF at 59.7%, with HAE and CRF reported with the highest per patient per month costs at R30 019.15 and R11 387.08, respectively. These significant increases stem from schemes that reported more than doubling their expenditure.

Decreasing expenditure was reported for DBI and IBD out-of-hospital. In contrast, only BCE reported a decrease in per-patient-per-month (pppm) in-hospital expenditure, with reductions of 1.01%, 2.93%, and 3.84%, respectively.

Table 10: Patient expenditure per chronic disease list (CDL) in hospital and out of hospital

CDL Condition	Out-of-hospital			In-hospital		
	Expenditure pppm 2023	Expenditure pppm 2024	% change	Expenditure pppm 2023	Expenditure pppm 2024	% change
HYP	R162.68	R176.75	8.64%	R2 722.80	R3 100.10	13.86%
IHD	R366.34	R419.01	14.38%	R5 324.91	R6 672.18	25.30%
DM2	R318.92	R357.10	11.97%	R2 640.95	R3 109.86	17.76%
EPL	R549.19	R621.96	13.25%	R2 255.13	R2 915.60	29.29%
CHF	R368.45	R417.54	13.32%	R4 186.47	R5 433.62	29.79%
AST	R173.28	R183.42	5.85%	R1 896.81	R2 263.14	19.31%
CRF	R3 954.03	R5 757.08	45.60%	R7 128.81	R11 387.08	59.73%
BMD	R518.05	R548.39	5.86%	R3 066.41	R3 602.44	17.48%
HYL	R65.28	R67.77	3.81%	R2 212.46	R2 298.73	3.90%
COP	R419.04	R452.80	8.06%	R3 283.36	R3 948.72	20.26%
DM1	R496.88	R528.20	6.30%	R2 806.26	R3 344.74	19.19%
CMY	R242.72	R263.25	8.46%	R5 638.25	R5 816.52	3.16%
DYS	R298.04	R325.61	9.25%	R5 470.08	R6 238.05	14.04%
HIV	R326.02	R367.53	12.74%	R1 962.08	R2 678.06	36.49%
TDH	R68.76	R72.83	5.92%	R1 974.86	R2 322.63	17.61%
RHA	R562.50	R574.53	2.14%	R1 914.76	R2 375.41	24.06%
GLC	R354.02	R400.84	13.22%	R1 556.27	R1 628.28	4.63%
IBD	R952.23	R924.32	-2.93%	R1 786.48	R2 145.23	20.08%
SLE	R369.97	R399.67	8.03%	R2 237.23	R3 007.21	34.42%
BCE	R289.70	R323.11	11.53%	R2 875.59	R2 765.12	-3.84%
SCZ	R736.84	R798.11	8.32%	R2 966.09	R4 068.21	37.16%
PAR	R563.75	R582.52	3.33%	R2 367.67	R3 493.91	47.57%
MSS	R4 716.35	R5 136.58	8.91%	R1 994.46	R3 079.87	54.42%
CSD	R1 980.59	R2 004.13	1.19%	R3 147.86	R3 473.51	10.34%
ADS	R168.10	R179.97	7.06%	R1 727.79	R1 798.31	4.08%
HAE	R38 712.02	R46 636.26	20.47%	R16 420.67	R30 019.15	82.81%
DBI	R715.49	R708.25	-1.01%	R1 960.52	R5 380.41	174.44%

Figure 26 depicts the proportion of beneficiaries registered on schemes' disease management programs against the per-patient-per-month (pppm) expenditure for the CDL conditions.

Hypertension, hyperlipidaemia and diabetes mellitus type 2 remain the most prevalent conditions on the CDL of medical schemes. Haemophilia had the highest expenditure per patient treated (although it has the lowest prevalence), followed by chronic renal failure and multiple sclerosis.

Expenditure on most chronic conditions increased from 2023 to 2024, with an average of 7.12%. Increases of over 17% were reported for Addison's, Haemophilia, and Chronic Renal Failure.

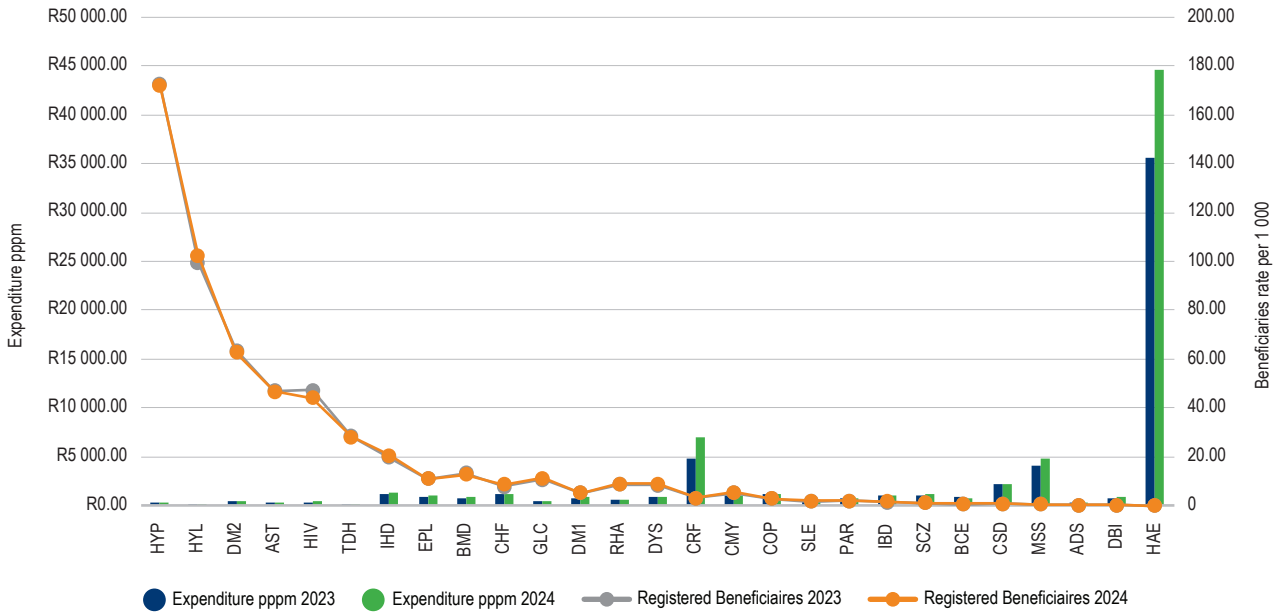


Figure 26: Expenditure per patient per month on CDL compared to beneficiaries registered on DMP

Diagnosis and Treatment Pair Benefits

Diagnosis and treatment pairs (DTPs) are a set of procedures and treatments linked to specific, prescribed minimum benefit (PMB) conditions. Table 11 lists the top 20 expenditures on DTPs for 2023 and 2024.

Reported expenditure on out-of-hospital treatment of DTPs increased by 11.85% to R25.4 billion in 2024 from R22.7 billion in 2023. Treatable Breast cancer, major affective disorders, and default emergencies for out-of-hospital remains the costliest DTPs, accounting for 32.55% of total out-of-hospital expenditure at R8.28 billion. The most significant increases occurred in Metastatic infections or septicaemia, respiratory conditions in newborns and respiratory failure.

The reported expenditure on in-hospital treatment of DTPS increased by 8.87% to R85.2 billion in 2024 from R78.3 billion in 2023. Table 12 on the next page highlights significant cost increases across most categories, specifically for metastatic infections, spinal cord compression, ischaemia, or degenerative disease.

Table 11: Diagnosis and treatment pair benefits are paid out-of-hospital

	Out-of-hospital						
	2023			2024			% change
Diagnosis	R (million)	% of total	Average per patient	R (million)	% of total	Average per patient	Year on year
Default emergency DTP code for claims that cannot be classified as DTP or CDL	3 409.56	14.99%	4 602.90	3 794.56	14.92%	4 702.37	11.29%
Major affective disorders, including unipolar and bipolar depression	2 290.84	10.07%	5 886.82	2 689.50	10.57%	6 743.48	17.40%
Cancer of breast - treatable	1 653.14	7.27%	41 630.40	1 796.27	7.06%	44 269.26	8.66%
End stage renal disease regardless of cause	1 022.76	4.50%	81 827.56	1 143.32	4.49%	84 540.18	11.79%
Cancer of the gastro-intestinal tract; including oesophagus; stomach; bowel; rectum; anus - treatable	1 020.21	4.49%	55 277.69	1 102.74	4.34%	59 112.38	8.09%
Cancer of prostate gland - treatable	939.68	4.13%	31 780.15	1 101.77	4.33%	35 139.76	17.25%
Pregnancy	816.71	3.59%	5 999.56	895.26	3.52%	7 614.15	9.62%
Cataract; aphakia	609.53	2.68%	13 295.09	719.85	2.83%	16 265.53	18.10%
HIV-infection	515.47	2.27%	1 446.41	604.93	2.38%	1 508.09	17.36%
Acute leukaemia's; lymphomas	582.88	2.56%	50 378.94	601.57	2.36%	57 368.49	3.21%
Multiple myeloma and chronic leukaemia's	519.33	2.28%	71 238.53	522.87	2.06%	79 174.41	0.68%

Diagnosis	Out-of-hospital						
	2023			2024			% change
	R (million)	% of total	Average per patient	R (million)	% of total	Average per patient	Year on year
Closed fractures/ dislocations of limb bones/epiphyses (excluding fingers and toes)	374.36	1.65%	7 700.52	406.78	1.60%	8 749.98	8.66%
Acute glomerulonephritis and nephritic syndrome	318.83	1.40%	29 917.79	382.82	1.51%	32 987.53	20.07%
Cancer of lung; bronchus; pleura; trachea; mediastinum & other respiratory organs - treatable	346.32	1.52%	69 710.72	370.43	1.46%	77 805.96	6.96%
Stroke (due to haemorrhage; or ischaemia)	250.37	1.10%	9 194.96	293.96	1.16%	10 748.38	17.41%
Menopausal management; anomalies of ovaries; primary and secondary amenorrhoea; female sex hormones abnormalities NOS; including hirsutism	262.78	1.16%	1 872.34	282.79	1.11%	2 073.84	7.62%
Bacterial; viral; fungal pneumonia	247.31	1.09%	2 609.37	251.54	0.99%	3 317.51	1.71%
Malignant melanoma of skin - treatable	279.84	1.23%	41 323.08	250.67	0.99%	34 970.41	-10.42%
Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina	206.71	0.91%	7 604.54	247.90	0.97%	8 367.96	19.93%
Retinal detachment; tear and other retinal disorders	216.58	0.95%	9 141.54	242.78	0.95%	11 107.63	12.10%
Grand Total	**22 740.59**	**100%**	**2 512.64**	**25 436.22**	**100%**	**2 793.54**	**11.85%**

Table 12: Disease treatment pairs' benefits paid in-hospital

Diagnosis	In-Hospital						
	2023			2024			% change
	R (million)	% of total	Average per patient	R (million)	% of total	Average per patient	Year on year
Metastatic infections; septicaemia	4 005.00	5.12%	85 951.65	5 204.32	6.11%	126 959.43	29.95%
Pregnancy	4 437.07	5.67%	33 102.35	4 456.43	5.23%	39 237.80	0.44%
Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina	3 688.99	4.71%	79 089.96	4 017.83	4.72%	89 856.09	8.91%
Major affective disorders; including unipolar and bipolar depression	3 491.71	4.46%	36 255.30	3 939.93	4.62%	41 809.19	12.84%
Default emergency DTP code for claims that cannot be classified as DTP or CDL	3 380.57	4.32%	36 995.09	2 859.92	3.36%	29 251.55	-15.40%
Closed fractures/dislocations of limb bones/epiphyses (excluding fingers and toes	2 853.62	3.65%	46 733.95	3 385.71	3.97%	66 083.29	18.65%
Cataract; aphakia	2 452.96	3.13%	38 875.95	2 596.49	3.05%	43 541.89	5.85%
Bacterial; viral; fungal pneumonia	2 410.77	3.08%	24 945.06	2 368.38	2.78%	31 245.95	-1.76%
Respiratory conditions of newborn	2 141.70	2.74%	78 215.51	2 244.13	2.63%	127 297.47	4.78%
Spinal cord compression; ischaemia or degenerative disease NOS	1 564.03	2.00%	68 090.00	1 878.53	2.21%	82 377.43	20.11%
Stroke (due to haemorrhage; or ischaemia)	1 595.00	2.04%	44 351.05	1 743.88	2.05%	54 263.89	9.33%
Life-threatening cardiac arrhythmias	1 555.84	1.99%	61 236.74	1 755.16	2.06%	67 410.38	12.81%
Respiratory failure; regardless of cause	1 392.66	1.78%	122 409.90	1 661.09	1.95%	156 958.55	19.28%
Cancer of the gastro-intestinal tract; including oesophagus; stomach; bowel; rectum; anus - treatable	1 354.56	1.73%	84 570.04	1 505.25	1.77%	105 653.88	11.12%
Non-inflammatory disorders and benign neoplasms of ovary; fallopian tubes and uterus	1 324.10	1.69%	29 600.81	1 455.36	1.71%	36 185.87	9.91%
Obstruction of the urogenital tract; regardless of cause	1 282.08	1.64%	37 173.70	1 383.06	1.62%	43 122.24	7.88%
Adult respiratory distress syndrome; inhalation and aspiration pneumonias	1 327.84	1.70%	76 846.75	1 321.84	1.55%	99 566.12	-0.45%
Hernia with obstruction and/or gangrene; uncomplicated hernias under age 18	1 178.62	1.51%	32 212.54	1 254.31	1.47%	36 852.43	6.42%
Gastroenteritis and colitis with life-threatening haemorrhage or dehydration; regardless of cause	1 128.30	1.44%	15 012.21	1 289.99	1.51%	17 306.88	14.33%
Gallstone with cholecystitis and/or jaundice	1 016.60	1.30%	43 961.10	1 112.27	1.31%	52 091.90	9.41%
Total	**78 248.91**	**100%**	**10.27**	**85 189.90**	**100%**	**13.07**	**8.87%**

QUALITY OF CARE IN MEDICAL SCHEMES

This section of the report highlights the key process indicators for selected conditions from 2019 to 2024. The conditions covered include Asthma, COPD, HIV, Diabetes Type 2, Hypertension, Chronic Heart Failure, and Ischemic Heart Disease. Furthermore, the section will explore emerging gaps in HIV Disease Management.

Under respiratory conditions, Figure 27 below indicates the coverage ratios for Asthma, while Figure 28 indicates the coverage ratios for COPD. The coverage ratios for COPD are higher than those for Asthma across this period for both lung function testing and flu vaccination, indicating higher levels of utilisation related to these indicators for COPD beneficiaries compared to Asthmatic beneficiaries. Flu vaccine coverage continues to show improvement following a decline during the COVID-19 pandemic. In 2024, Flu vaccine utilisation amongst registered beneficiaries stood at 12% for Asthma beneficiaries and 25% for COPD beneficiaries, up from 10% and 18% in 2020 for the respective conditions.

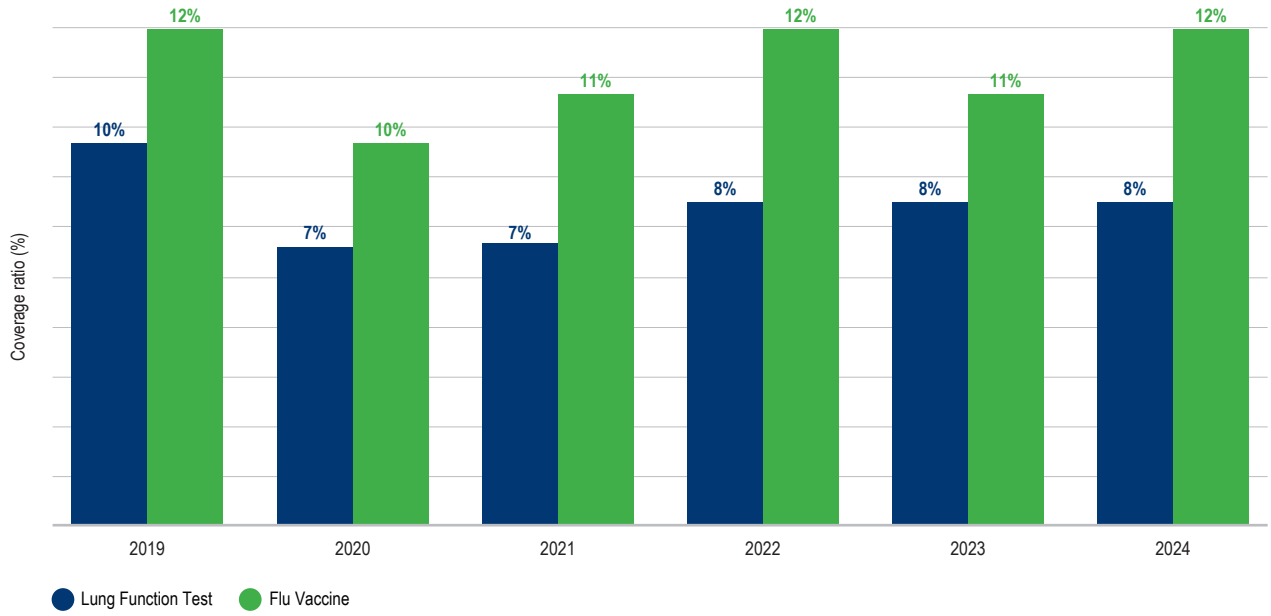


Figure 27: Coverage ratios for Asthma

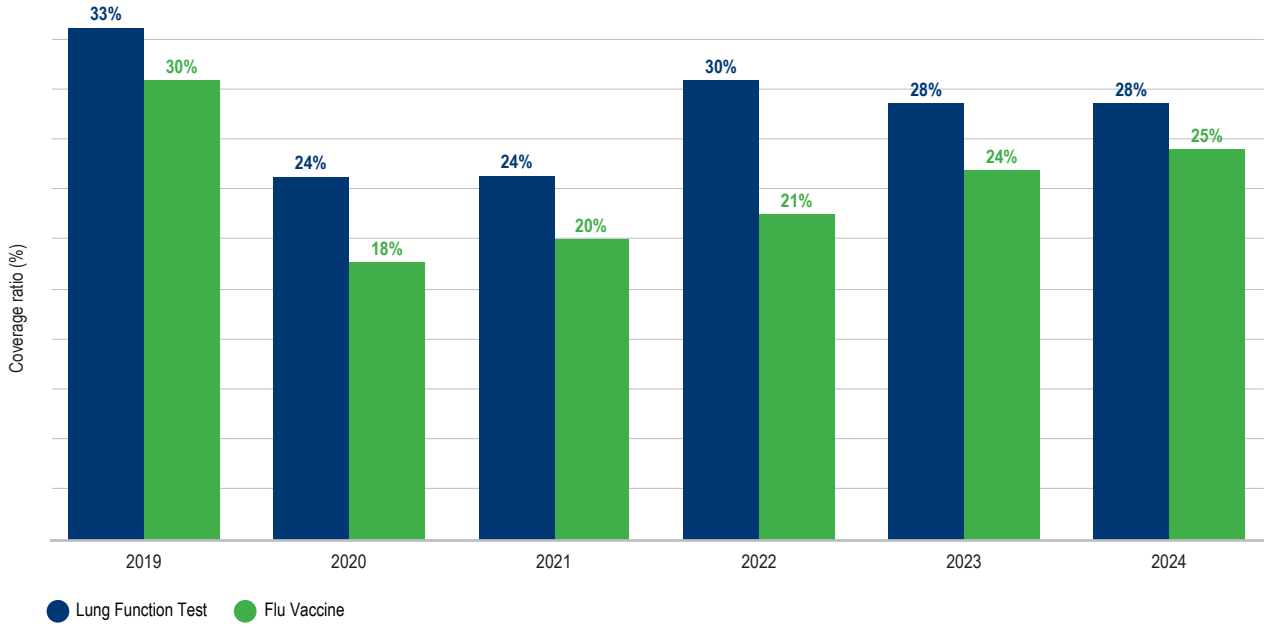


Figure 28: Coverage ratios for COPD

Figure 3 indicates the coverage ratios for Diabetes Type 2. The coverage ratio for beneficiaries with at least one Creatine test improved to 69% in 2024 from 64% in 2023. Similarly, the coverage ratios for beneficiaries with at least two HbA1c tests continue to improve, with 43% of registered beneficiaries utilising this test in 2024, compared with 36% in 2021.

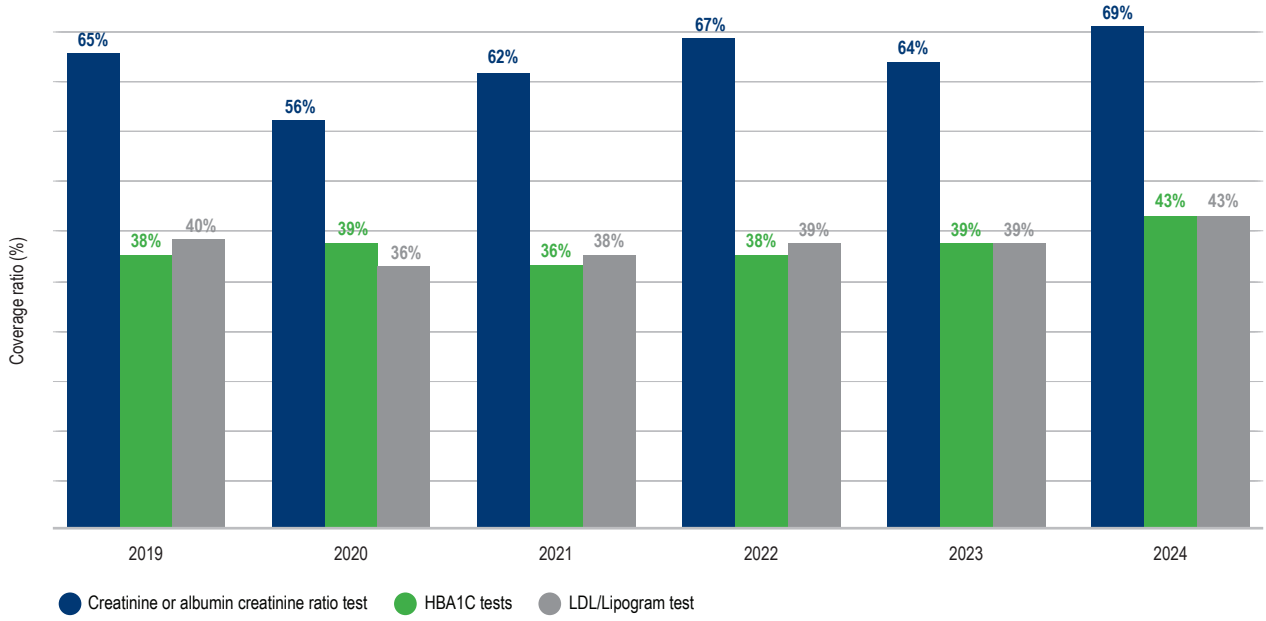


Figure 29: Coverage ratios for Diabetes Type 2

Figure 30, 31, and 32 depict coverage ratios for cardiovascular conditions. Figure 30 indicates the coverage ratios for Hypertension. The coverage ratio for beneficiaries with at least one cholesterol test is 51% in 2024, which is an improvement from 47% registered during 2021. The coverage ratios for the beneficiaries with at least one creatinine test, as well as the coverage ratio for the electrocardiogram, have remained flat since 2021.

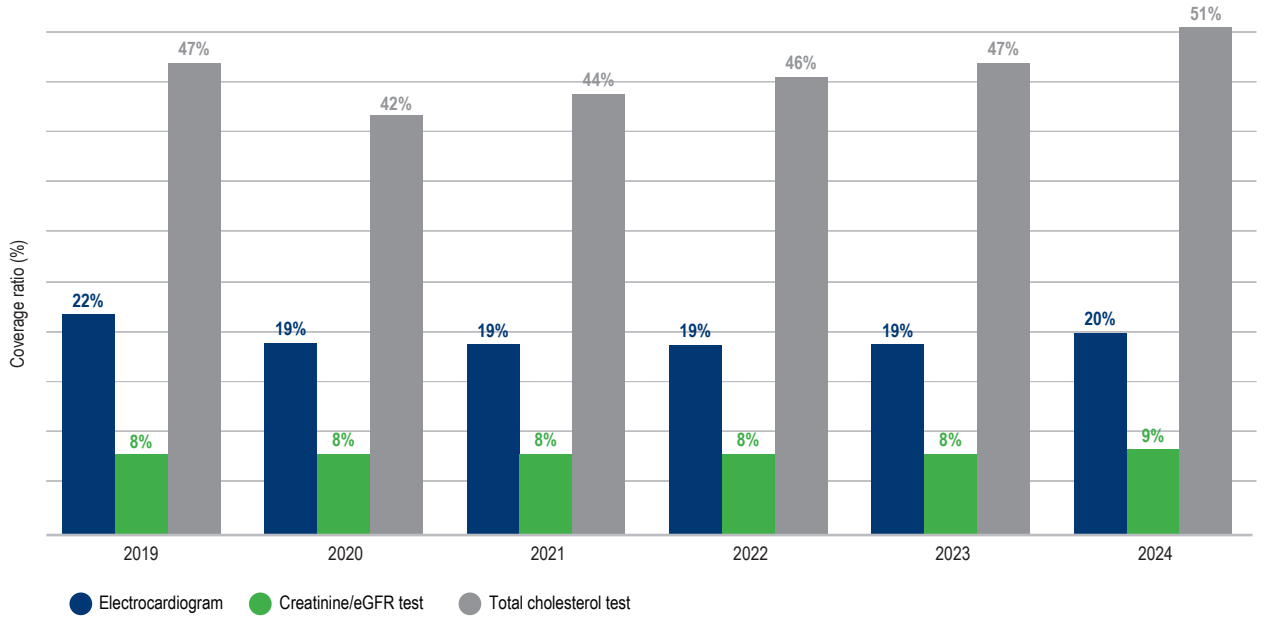


Figure 30: Coverage ratios for Hypertension

Figure 31 indicates the coverage ratios for Ischemic Heart Disease. Aspirin coverage improved to 71% in 2023, from a low of 60% in 2019. However, there is a marked decline in aspirin coverage to 66% in 2024. The utilisation of at least one electrocardiogram was 50% in 2024, while that for at least one lipogram was 39%.

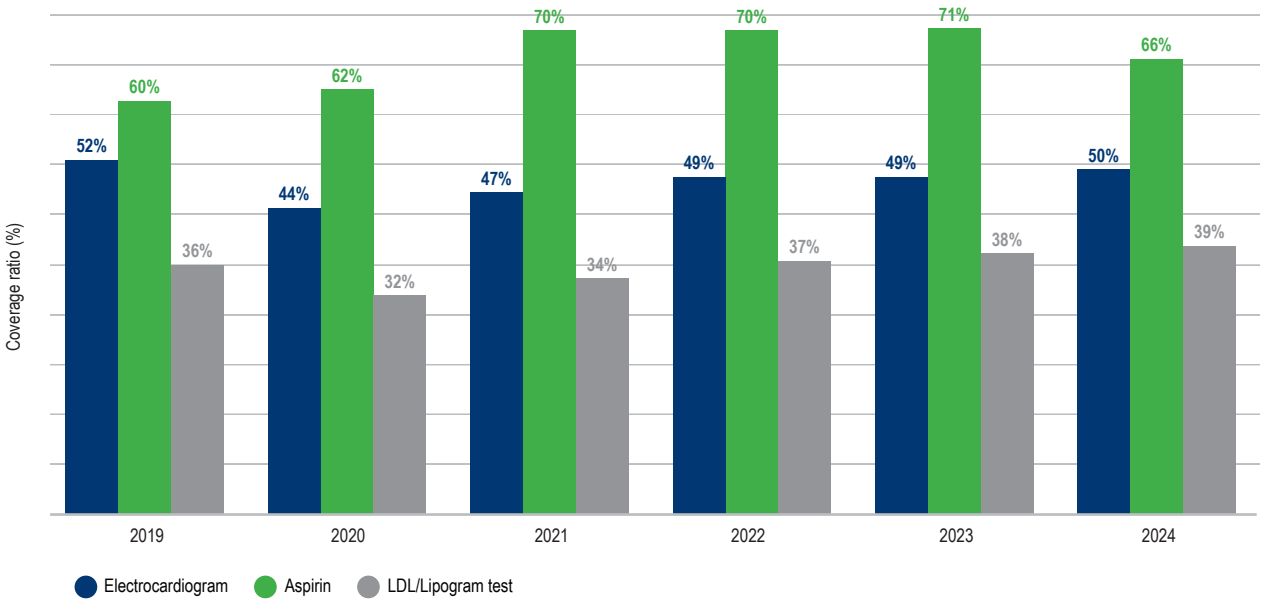


Figure 31: Coverage ratios for Ischemic Heart Disease

Figure 32 depicts the coverage ratios for Congestive Heart Failure. In 2024, 67% of registered beneficiaries had at least one renal function test, which marks an improvement from the 2020 utilisation of 58%. The utilisation of renal function testing has also improved to 49% in 2024, compared to 44% in 2021. Utilisation of flu vaccination remains low at 18% amongst registered beneficiaries; however, it has improved significantly from the low levels recorded in 2021.

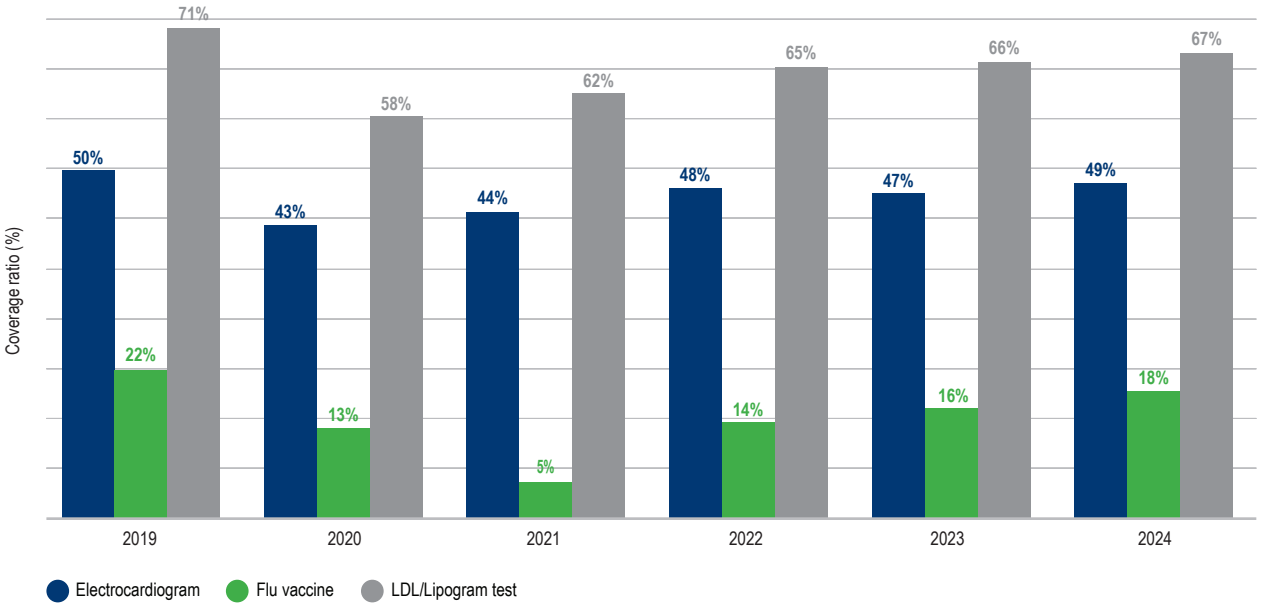


Figure 32: Coverage ratios for Congestive Heart Failure

Emerging gaps in HIV Disease Management

The CMS, in collaboration with the South African National Aids Council (SANAC), collects private sector HIV utilisation data bi-annually. SANAC has used the data collected through this initiative to support comprehensive HIV surveillance and ensure that there is harmonisation in HIV program policies between the National Department of Health (NDoH) and the private sector. This section will utilise the SANAC dataset and present industry-level coverage for HIV, as well as a gap analysis across age groups. The HIV coverage ratios at the industry level cover the period from 2021 to 2024, as shown in Figure 33, while the gap analysis will focus on 2024, as shown in Figure 34.

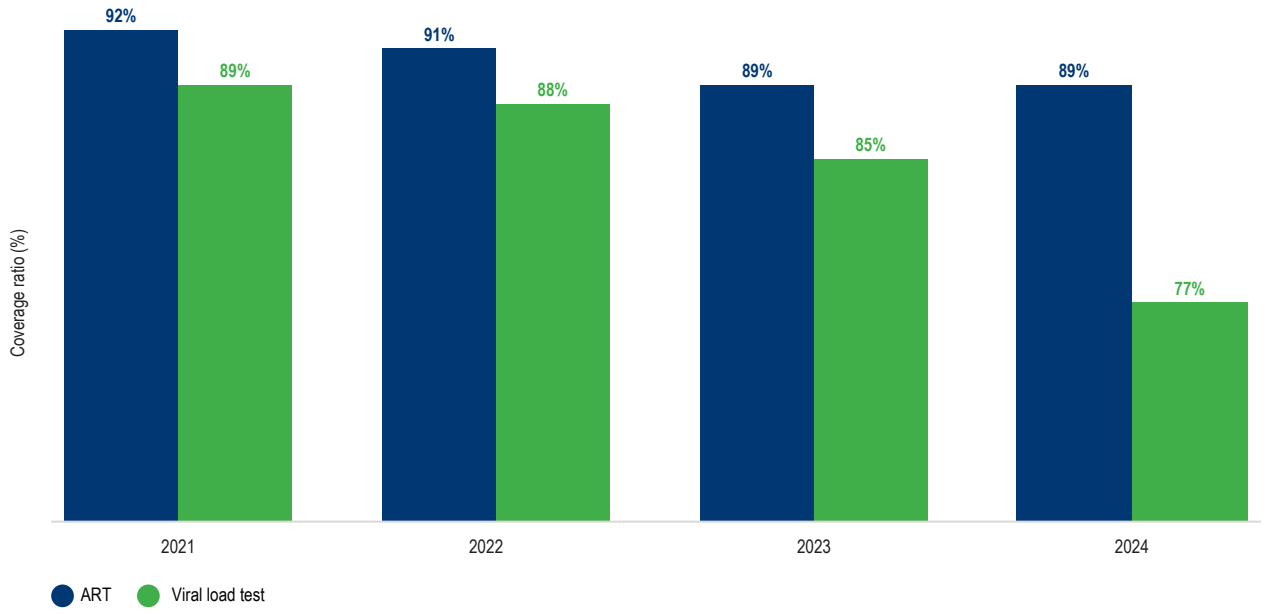


Figure 33: Coverage ratios for HIV

Figure 33 depicts coverage ratios for HIV, with a focus on antiretroviral treatment (ART) and viral load testing. ART coverage has declined marginally from 92% in 2021 to 89% in 2024. However, the decline in viral load testing has been more acute in this period, from 89% in 2021 to 77% in 2024. The decline in viral load testing may be due to various factors, including treatment illiteracy and follow-up gaps within HIV disease management programmes (DMPs).

Gap Analysis

The gap analysis will be presented as the difference between ART coverage and viral load suppression coverage. Viral load suppression can be interpreted as a proxy for ART adherence; therefore, the difference between ART and viral load suppression indicates the effectiveness of HIV disease management in medical schemes.

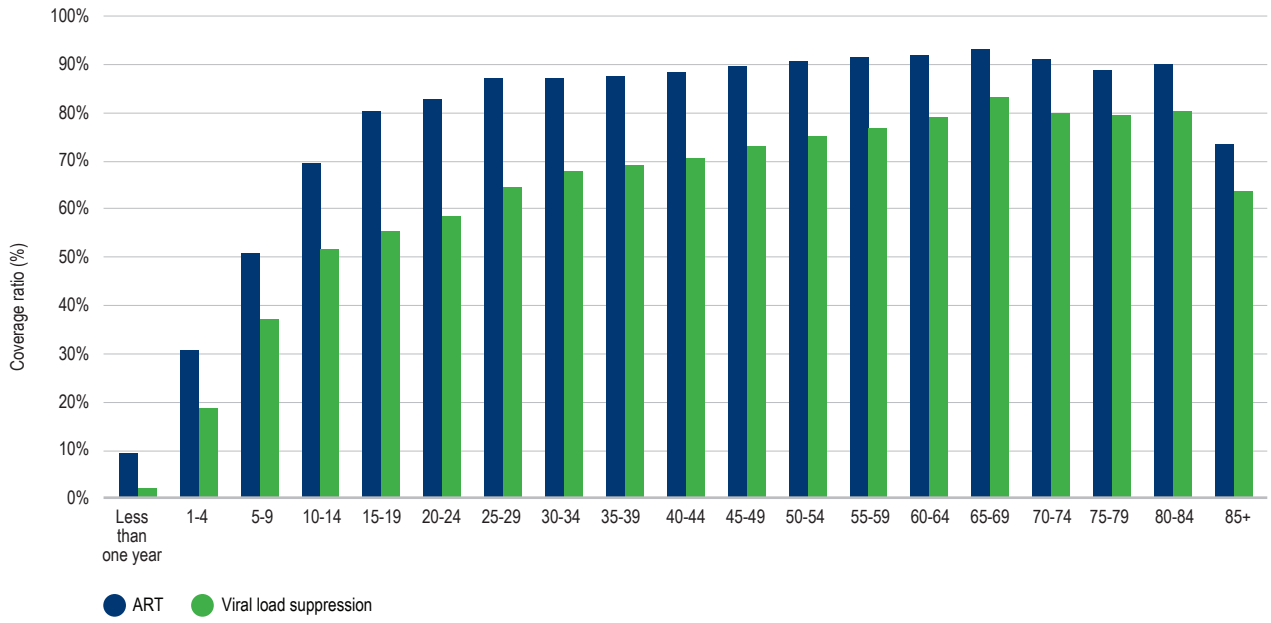


Figure 34: Distribution of ART and viral load suppression

Figure 34 depicts the distribution of ART and viral load suppression coverage across age groups in 2024. There is a gap between the two distributions across all age groups. However, the widest gaps emerge amongst beneficiaries aged 15-29 years, with an average gap of 24%. The narrowest gap is amongst those aged 65 and above, with an average gap of 10%. This finding highlights that HIV DMPs are becoming ineffective amongst adolescents and young adults, meaning that medical schemes need to consider targeted approaches to this age cohort.

UTILISATION OF HEALTHCARE SERVICES

Utilisation of General Practitioner (GP) health services

Figure 35 shows the proportion of beneficiaries who visited a General Practitioner (GP) at least once in in-hospital and out-of-hospital settings by scheme type in 2023 and 2024. GP services were predominantly accessed in out-of-hospital settings; however, a gradual increase in the number of beneficiaries visiting GPs in-hospital was observed across both scheme types. For open schemes, the proportion of beneficiaries accessing GPs out-of-hospital decreased from 90.35% in 2023 to 89.62% in 2024, while in-hospital increased from 9.65% to 10.38%. Restricted schemes reflected a similar trend; the proportion of beneficiaries accessing GPs out-of-hospital declined from 88.25% to 87.39% and in-hospital consultations rose from 11.75% to 12.61%. On a consolidated basis, out-of-hospital consultations fell from 89.28% to 88.44%. In comparison, in-hospital consultations increased from 10.72% to 11.56%, indicating a steady increase in in-hospital utilisation even though the majority of GP services remain accessed outside hospital settings.

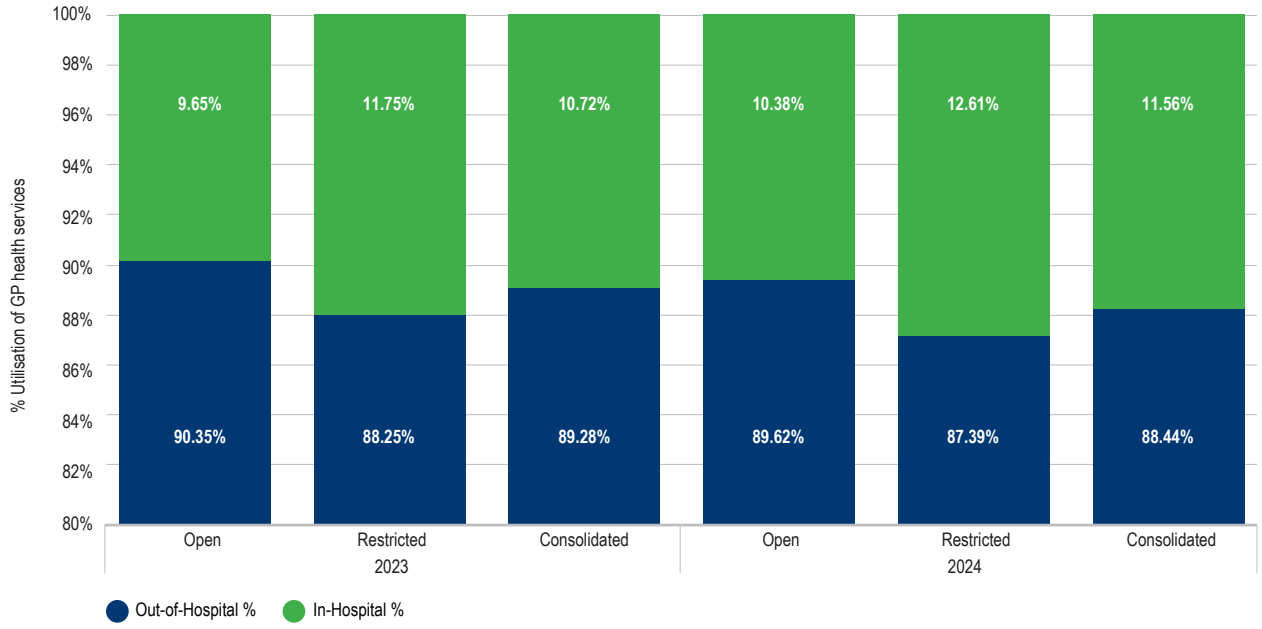


Figure 35: Utilisation of GPs health services in 2023 and 2024

Table 13 illustrates the expenditure and utilisation of GP services in out-of-hospital settings for medical scheme beneficiaries between 2023 and 2024. The number of beneficiaries who visited GPs at least once decreased slightly by 0.65%, from 6.53 million in 2023 to 6.49 million in 2024, with open schemes declining by 4.36% and restricted schemes increasing by 3.03%. The average number of beneficiaries per 1 000 followed the same trend, falling by 0.65% from 715.29 to 707.48, with open schemes seeing a 3.10% drop, while restricted schemes rose by 3.03%. The average number of GP visits per patient increased, rising slightly from 3.27 to 3.29 (0.62%), with open schemes recording a decline (2.08%) and restricted schemes an increase (2.20%). At the same time, the average amount claimed per GP visit increased by 6.18%, from R528.61 to R561.28, with open schemes showing a sharper increase of 7.86% compared to 5.36% in restricted schemes. The average total amount paid per visit rose by 5.31%, from R484.01 in 2023 to R509.71 in 2024, with open schemes paying R509.79 and R509.64 by restricted schemes. However, the amount that beneficiaries had to pay out-of-pocket per visit grew by 15.62% (from R44.61 to R51.57).

Table 13: Utilisation of GP health services (out-of-hospital) in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with at least 1 visit	3 247 277	3 105 546	-4.36	3 281 465	3 380 977	3.03	6 528 742	6 486 523	-0.65
Average number of beneficiaries per 1 000 (ratio)	680.25	654.74	-3.10	759.37	764.00	3.03	715.29	707.48	-0.65
Average number of visits per patient (ratio)	3.01	2.95	-2.08	3.53	3.61	2.20	3.27	3.29	0.615
Average amount claimed per visit (R)	558.02	601.90	7.86	503.78	530.77	5.36	528.61	561.28	6.18
Average medical savings account amount paid per visit (R)	215.96	221.57	2.60	68.27	67.89	-0.56	135.89	133.81	-1.53
Average risk amount paid per visit (R)	268.67	288.22	7.28	415.21	441.75	6.39	348.12	375.90	7.98
Average total amount paid per visit (R)	484.63	509.79	5.19	483.48	509.64	5.41	484.01	509.71	5.31
Amount not paid per visit	73.39	92.11	25.50	20.30	21.12	4.10	44.61	51.57	15.62

Utilisation of general dental practitioner health services

Figure 36 shows the proportion of beneficiaries who visited a general dental practitioner at least once, with the majority of beneficiaries accessing these services in out-of-hospital settings. On a consolidated basis, the share of beneficiaries using out-of-hospital services dropped slightly from 99.24% in 2023 to 99.20% in 2024, while in-hospital use decreased from 0.76% to 0.80%. For open schemes, the proportion of beneficiaries accessing both out-of-hospital and in-hospital dental services remained stable between 2023 and 2024 at 99.46% and 0.54% respectively. In restricted schemes, the proportion of beneficiaries using out-of-hospital services decreased from 99.04% in 2023 to 98.99% in 2024, while in-hospital use increased from 0.96% to 1.01%.

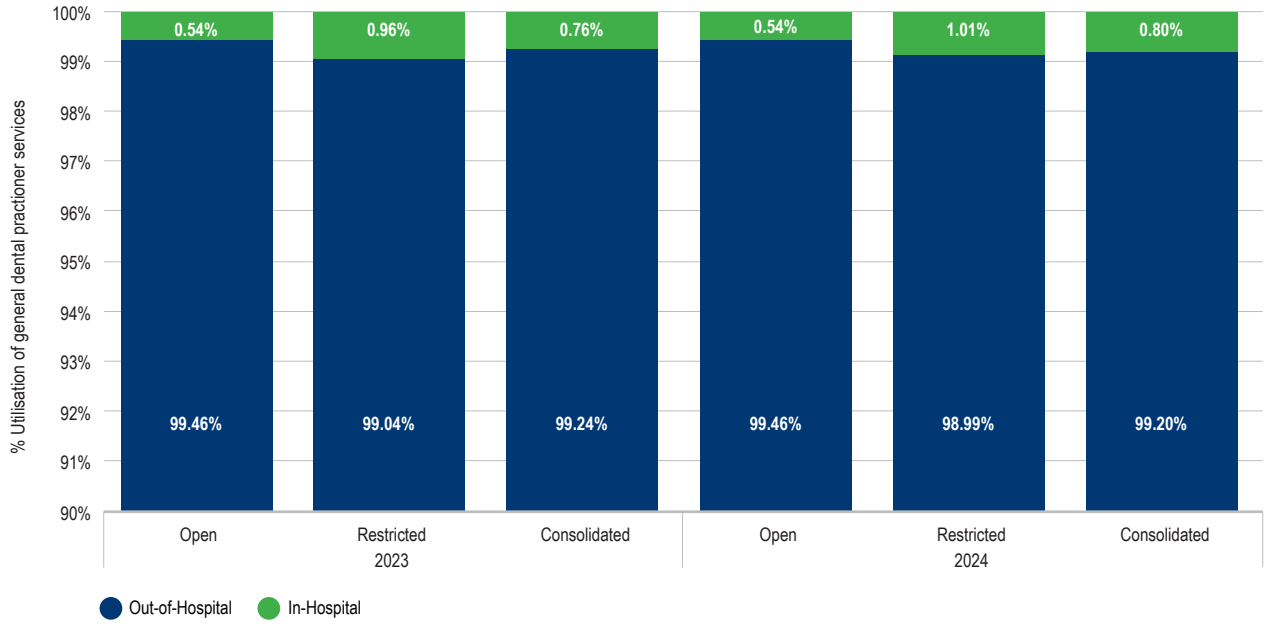


Figure 36: General dental practitioner health services in 2023 and 2024

Table 14 further reinforces the above trends by illustrating growing demand for out-of-hospital dental services. The total number of beneficiaries visiting a dentist annually rose from 1.94 million in 2023 to 1.98 million in 2024, reflecting a 2.13% increase. Open schemes reported a decline (2.05%) whilst restricted schemes increased by 5.90%. The overall average visit per beneficiary decreased (1.39) from both schemes, with a majority decrease from open schemes (2.23%) compared to 0.63% from restricted schemes. Despite the observed reduction, the average total amount claimed per visit saw an increase (3.92%), driven by a 7.44% increase in risk account payment and a slight decrease (1.15%) in medical savings account. This indicates not only higher reliance on scheme risk pools for dental care but also a growing utilisation of out-of-hospital dental services, aligning with the trends observed in Figure 36 above.

Table 14: General dental practitioner health services (out-of-hospital) in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with at least one visit	919 284	900 479	-2.05	1 018 875	1 079 014	5.90	1 938 159	1 979 493	2.13
Average number of beneficiaries per 1 000 (ratio)	191.27	189.85	-0.75	235.78	243.83	3.41	212.34	215.90	1.68
Average number of visits per patient (ratio)	1.76	1.72	-2.23	1.73	1.72	-0.63	1.74	1.72	-1.39
Average amount claimed per visit (R)	1838.54	1 933.11	5.14	1 441.67	1 522.22	5.59	1 631.44	1 709.07	4.76
Average medical savings account amount paid per visit (R)	902.49	927.59	2.78	93.51	97.21	3.96	480.34	474.82	-1.15
Average risk amount paid per visit (R)	483.25	487.02	0.78	1 249.46	1 321.59	5.77	876.87	942.08	7.44
Average total amount paid per visit (R)	1 385.74	1 414.61	2.08	1 342.97	1 418.80	5.65	1 363.42	1 416.90	3.92
Amount not paid per visit	452.80	518.50	14.51	98.70	103.41	4.77	268.02	292.17	9.01

Utilisation of dental specialist health services

Figure 37 shows the proportion of medical scheme beneficiaries who had at least one dental specialist visit, by setting (in-hospital versus out-of-hospital), in 2023 and 2024. The majority of beneficiaries accessed these services at out-of-hospital settings, with a slight decrease from 96.06% to 96.01% in 2023 and 2024. Among open schemes, the proportion of beneficiaries who had at least one out-of-hospital dental specialist visit increased slightly from 96.09% in 2023 to 96.21% in 2024, while restricted schemes rose from 95.64% to 96.07%. The consolidated in-hospital consultations increased slightly from 3.94% in 2023 to 3.99% in 2024. This trend suggests beneficiaries prefer out-of-hospital consultations, which may be associated with lower consultation costs.

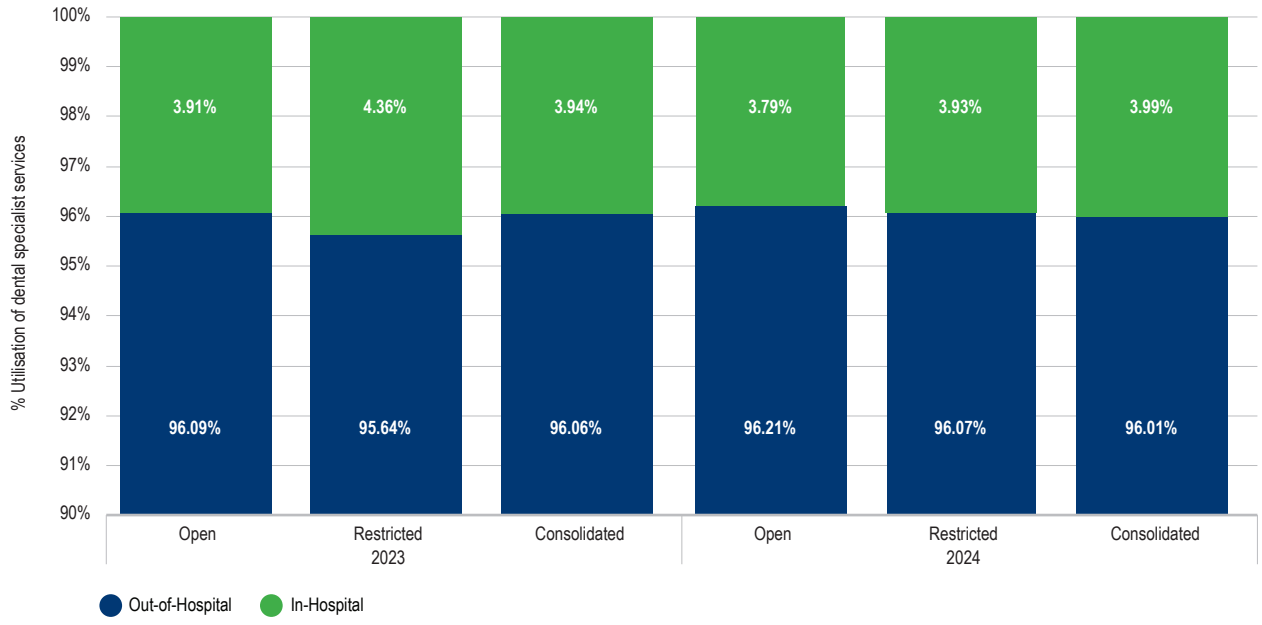


Figure 37: Dental specialist health services in 2023 and 2024

Table 15 displays the utilisation of dental specialist health services in out-of-hospital settings by medical schemes beneficiaries in 2023 and 2024. The total number of beneficiaries with at least one visit was higher for restricted schemes (261.817) compared to open schemes (143,935). In 2023, the average number of beneficiaries per 1 000, increased by 3.69%, with restricted schemes rising from 55.23 to 59.16, compared to a 3.34% decrease from open schemes. The average visits per beneficiary decreased slightly, with open schemes reporting a drop from 2.07 to 1.99 and restricted schemes reporting a drop from 1.59 to 1.53. The overall average amount claimed per visit increased by 6.02% (R2 637.75), with open schemes reporting the higher amount of R3828, compared to R1 787.97 from restricted schemes. Claims payment sources varied, with open schemes largely paying from medical savings accounts, and restricted schemes' claims largely paid from the risk account.

Table 15: Utilisation of dental specialist health services in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with at least one visit	150 884	143 935	-4.61	238 666	261 817	9.70	389 550	405 752	4.16
Average number of beneficiaries per 1 000 (ratio)	31.39	30.35	-3.34	55.23	59.16	7.12	42.68	44.25	3.69
Average number of visits per patient (ratio)	2.07	1.99	-4.03	1.59	1.53	-3.43	1.78	1.69	-4.54
Average amount claimed per visit (R)	3 506.71	3 828.19	9.17	1 646.33	1 787.97	8.60	2 487.89	2 637.75	6.02
Average medical savings account amount paid per visit (R)	1 310.51	1 384.06	5.61	137.98	136.45	-1.11	668.39	656.10	-1.84
Average risk amount paid per visit (R)	1 058.30	1 095.84	3.55	1 289.65	1 392.70	7.99	1 185.00	1 269.05	7.09
Average total amount paid per visit (R)	2 368.81	2 479.90	4.69	1 427.63	1 529.15	7.11	1 853.39	1925.15	3.87
Amount not paid per visit	1 137.90	1 348.29	18.49	218.69	258.82	18.35	634.50	712.60	12.31

Utilisation of medical specialist health services

Figure 38 and Table 16 show the proportion of medical scheme beneficiaries who had at least one medical specialist visit between 2023 and 2024, by setting. In 2023, 61.20% of beneficiaries had at least one out-of-hospital visit, while 38.80% had at least one in-hospital visit. By 2024, there was a slight shift towards in-hospital utilisation, increasing to 39.79%, with a corresponding decrease in out-of-hospital visits to 60.21%. This pattern was consistent across scheme types, although restricted schemes recorded a higher share of beneficiaries with at least one in-hospital visit (42.08%) compared with open schemes (37.99%), indicating that restricted scheme beneficiaries are more likely to use in-hospital medical specialist services.

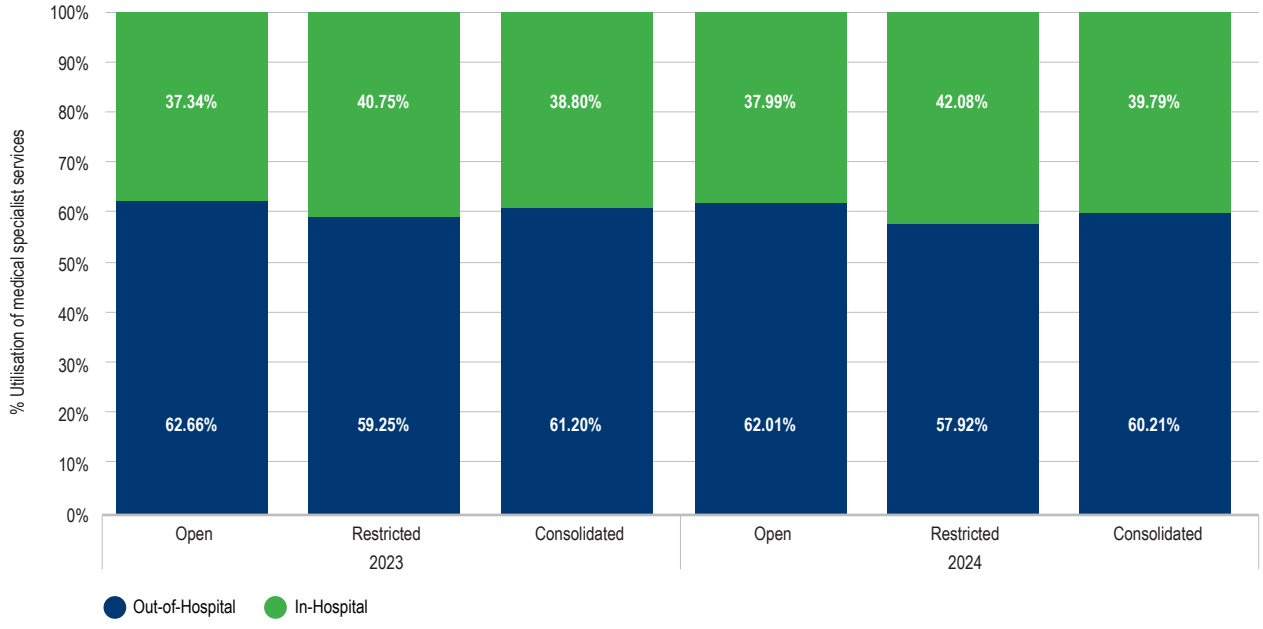


Figure 38: Medical specialist health services in 2023 and 2024

Complementing the above patterns, table 16 provides further detail on the overall utilisation of medical specialist services. The total number of beneficiaries with at least one visit (1 980,787) decreased by 0.25%, drive by a 2.46% increase in restricted schemes despite a slight decline in open schemes (2.15%). The average number of beneficiaries per 1 000 decreased by 0.69%, while the average visits per patient rose by 0.89%.

The average amount claimed per visit by medical specialists increased from R1 942 in 2023 to R1 917 in 2024, an increase of 7.42%, with claims predominantly paid from risk benefits, which rose by 9.01%, compared with a change from medical savings accounts (-1.81%). The portion not covered by medical schemes increased by 8.35%, with restricted schemes showing a 8.12% rise and open schemes an 9.41% increase.

Table 16: Utilisation of medical specialist health service in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with at least one visit	1 164 472	1 139 383	-2.15%	821 216	841 404	2.46%	1 985 688	1 980 787	-0.25%
Average number of beneficiaries per 1 000 (ratio)	242.3	240.2	-0.86%	190.0	190.1	0.05%	217.6	216.0	-0.69%
Average number of visits per patient (ratio)	2.2	2.2	1.52%	2.2	2.2	0.05%	2.2	2.2	0.89%
Average amount claimed per visit (R)	2 008.3	2 170.8	8.09%	1 523.6	1 627.5	6.82%	1 808.7	1 942.9	7.42%
Average medical savings account amount paid per visit (R)	348.0	338.6	-2.70%	114.3	120.7	5.61%	251.7	247.2	-1.81%
Average risk amount paid per visit (R)	1 334.2	1 475.5	10.59%	1 314.6	1 404.4	6.83%	1 326.1	1 445.7	9.01%
Average total amount paid per visit (R)	1 682.2	1 814.1	7.84%	1 428.8	1 525.1	6.73%	1 577.9	1 692.8	7.29%
Amount not paid per visit	326.0	356.7	9.41%	94.7	102.4	8.12%	230.8	250.0	8.35%

Utilisation of surgical specialist health services

Figure 39 and Table 17 illustrate the utilisation of surgical specialist services by medical scheme beneficiaries in 2023 and 2024. In 2023, a higher proportion of beneficiaries consulted surgical specialists in out-of-hospital settings, largely driven by restricted schemes (54.33%) compared to open schemes (49.60%). By 2024, these proportions decreased slightly to 53.77% in restricted schemes and 48.57% in open schemes. In-hospital consultations remained higher in open schemes (51.43%) than in restricted schemes (46.23%). Overall, in-hospital consultations increased across schemes from 48.47% in 2023 to 49.23% in 2024, whilst out-of-hospital consultations decreased from 51.53% to 50.77%.

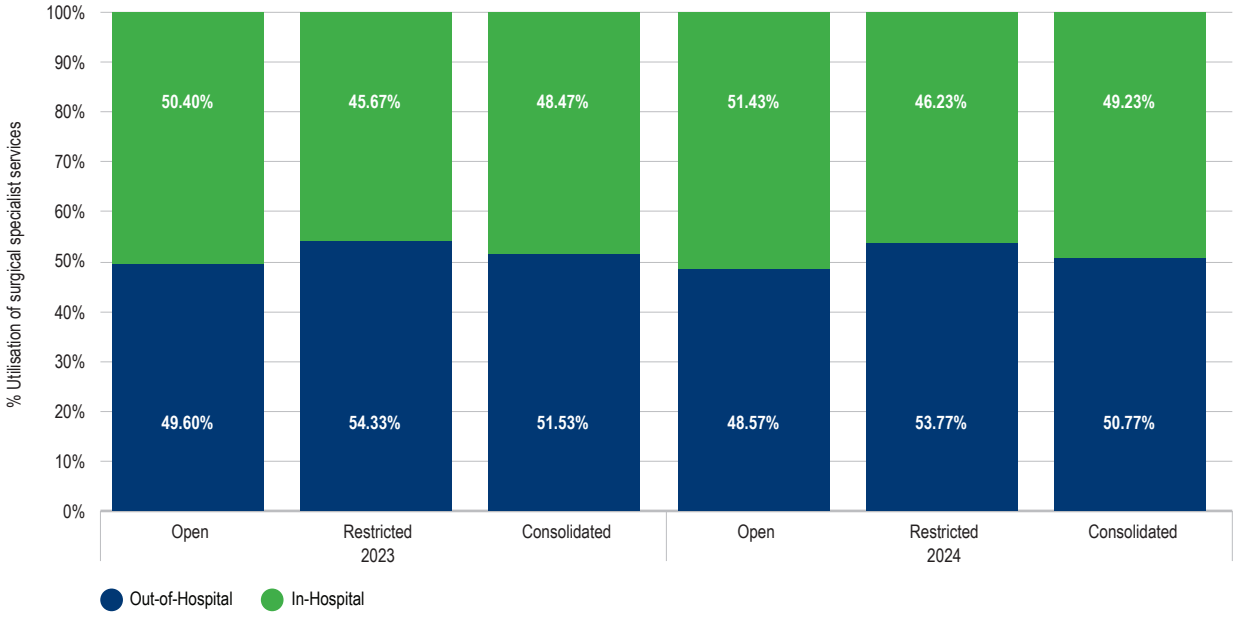


Figure 39: Surgical specialist health services in 2023 and 2024

Table 17 presents a slight increase in the beneficiaries visiting surgical specialists (both in and out-of-hospital) from 2.06 million in 2023 to 2.07 million in 2024. The average number of beneficiaries per 1,000 decreased slightly by 0.11% from 228.05 to 227.79 over the period. Open schemes had a higher proportion of beneficiaries consulting surgical specialists (252.88) compared to restricted schemes (200.62).

The average number of patients increased by 2.10% from 1.96 to 2.01 per patient. The average amount claimed per visit increased by 8.21% from R4 518.31 to R4 889.21. The overall average amount paid per visit increased by 7.54% to R4 138.89, from R3848.69, and the proportion not covered by medical schemes increased from R669.62 to R750.32, with restricted schemes reporting the highest growth at 14.65%.

Table 17: Surgical specialist health services in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total no of beneficiaries with at least one visit	1.221.995	1.197.407	-2.01%	841.898	877.229	4.20%	2.063.893	2.074.636	0.52%
Average number of patients per 1 000 beneficiaries (ratio)	254.50	252.88	-0.64%	198.15	200.62	1.25%	228.05	227.79	-0.11%
Average number of visits (ratio)	1.94	1.98	2.13%	2.00	2.04	1.95%	1.96	2.01	2.10%
Average amount claimed per visit (R)	4.981.63	5.440.30	9.21%	3.868.11	4.160.57	7.56%	4.518.31	4.889.21	8.21%
Average medical savings account amount paid per visit (R)	194.45	193.86	-0.30%	54.38	57.61	5.94%	136.16	135.18	-0.72%
Average risk amount paid per visit (R)	3.997.13	4.362.72	9.15%	3.313.12	3.529.02	6.52%	3.712.52	4.003.70	7.84%
Average total amount paid per visit	4.191.58	4.556.58	8.71%	3.367.50	3.586.63	6.51%	3.848.69	4.138.89	7.54%
Amount not paid per visit	790.05	883.72	11.86%	500.62	573.94	14.65%	669.62	750.32	12.05%

Utilisation of support specialists' health services

Figure 40 shows the utilisation of support specialist services by beneficiaries of medical schemes in 2023 and 2024. Support specialists include anaesthetists, radiologists, and pathologists. Overall, the proportion of consultations with support specialist services within the hospital setting increased slightly from 39.37% to 39.72% in 2024. In contrast, out-of-hospital consultations decreased from 60.63% to 60.28% during the period under review.

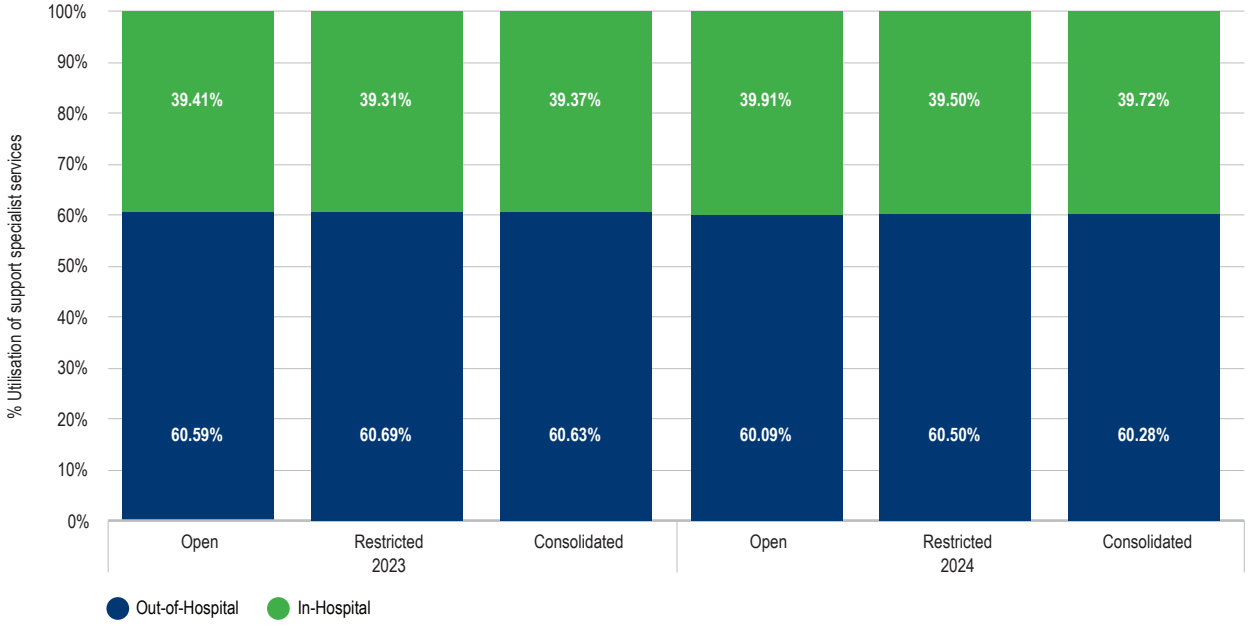


Figure 40: Utilisation of support specialist health services in 2023 and 2024

The total number of beneficiaries consulting support specialists (Table 18) increased slightly from 7.56 million in 2023 to 7.69 million in 2024 (1.84%), driven mainly by growth in restricted schemes (6.34%, 3.5 million), while open schemes recorded a decline (1.66%, 4.2 million). The average number of beneficiaries per 1 000 visiting support specialists rose from 827.73 to 839.17 (1.38%), with restricted schemes showing higher growth (3.84%) than open schemes, which reported a slight decline (0.35%). The overall average number of visits per patient increased slightly from 2.21 to 2.23 (1.03%). The average amount claimed per visit increased by 7.37%, from R2 078 to R2 231, paid primarily from risk benefits, with open schemes paying an average of R1 947.78 whilst restricted paid slightly less at R1 790.64.

Table 18: Utilisation of support specialist health services in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with at least one visit	4 254 182.	4 183 771	-1.66	3 300 855.	3 510 202.	6.34	7 555 037	7 693 973	1.84
Average number of patients per 1 000 beneficiaries (ratio)	885.15	882.06	-0.35	763.86	793.20	3.84	827.73	839.17	1.38
Average number of visits per patient (ratio)	2.13	2.15	0.75	2.30	2.33	1.02	2.21	2.23	1.03
Average amount claimed per visit (R)	2 298.15	2 492.63	8.46	1 814.77	1 942.60	7.04	2 077.83	2 230.87	7.37
Average medical savings account amount paid per visit (R)	253.80	251.54	-0.89	50.09	52.70	5.21	160.95	156.91	-2.51
Average risk amount paid per visit (R)	1 798.23	1 947.78	8.32	1 682.23	1 790.64	6.44	1 745.36	1 873.00	7.31
Average total amount paid per visit (R)	2 052.04	2 199.32	7.18	1 732.32	1 843.34	6.41	1 906.31	2 029.91	6.48
Amount not paid per visit	246.12	293.31	19.17	82.45	99.25	20.38	171.52	200.96	17.16

Utilisation of supplementary and allied health professional services

Figure 41 shows the utilisation of supplementary and allied health professional services in both in-hospital and out-of-hospital settings by scheme type for the years 2023 and 2024. Overall, the proportion of beneficiaries accessed these services in out-of-hospital settings, accounting for 79.85% in both years, compared to 20.15% in-hospital. Across scheme types, restricted schemes consistently recorded a higher share of out-of-hospital use, rising slightly from 81.11% in 2023 to 81.21% in 2024, while open schemes showed a marginal decline from 78.62% to 78.40% over the same period.

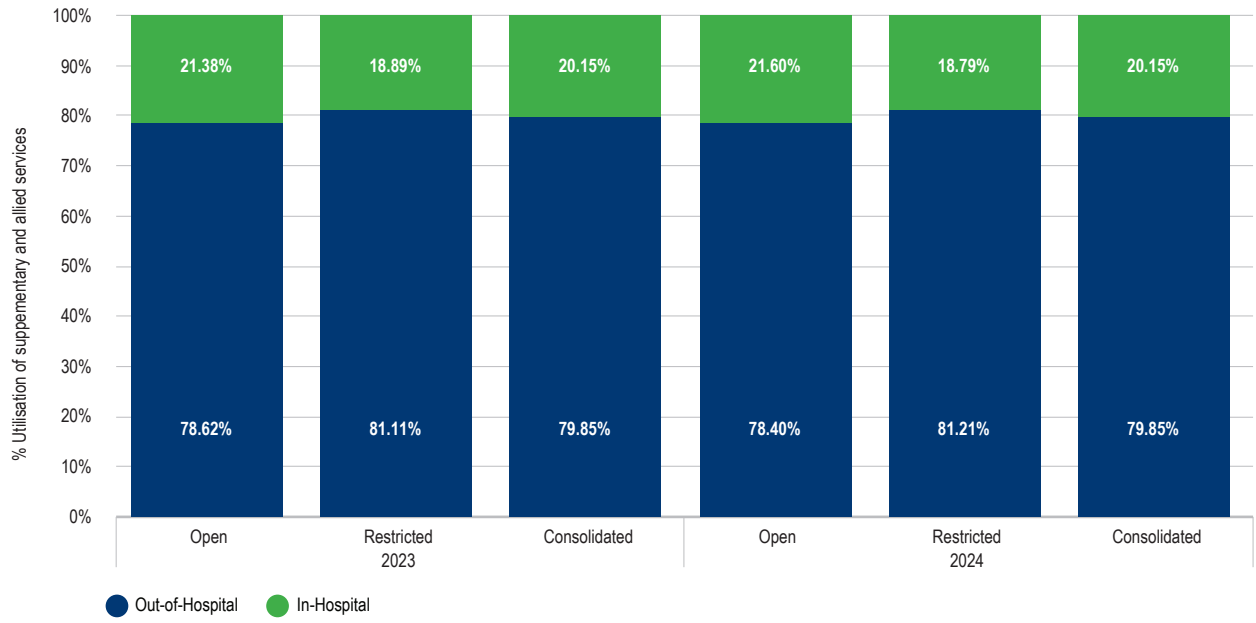


Figure 41: Utilisation of supplementary and allied health professional services in 2023 and 2024

The number of beneficiaries utilising supplementary and allied health professional services with at least one visit, rose by 5.27% to 5.88 million in the out-of-hospital settings (Table 19), with restricted schemes showing higher growth (10.74%) and a slight reduction in open schemes (0.01%). The overall average number of beneficiaries per 1 000 increased by 4.80%, while average visits per patient remained stable at around three with a slight reduction (0.3%). The average amount claimed per patient increased by 4.35% to R1 367.64, and the total amount paid increased by 4.30% to R1 246.80.

Table 19: Utilisation of supplementary and allied health professional services in 2023 and 2024

	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Total number of beneficiaries with least 1 visit	2 844 838	2 844 547	-0.01	2 742 272	3 036 881	10.74	5 587 110	5 881 428	5.27
Average number of patients per 1 000 beneficiaries (ratio)	591.92	599.71	1.32	634.59	686.25	8.14	612.12	641.48	4.80
Average number of visits per patient (ratio)	3.21	3.21	0.22	2.80	2.79	-0.15	3.00	2.99	-0.3
Average amount claimed per patient (R)	1 316.67	1 380.53	4.85	1 303.33	1 353.75	3.87	1 310.57	1 367.64	4.35
Average medical savings account amount paid per patient (R)	348.61	334.62	-4.01	123.76	126.06	1.85	245.92	234.25	-4.75
Average risk amount paid per patient (R)	815.55	878.78	7.75	1108.68	1 156.74	4.34	949.43	1 012.55	6.65
Average total amount paid per patient (R)	1 164.17	1 213.40	4.23	1 232.44	1 282.80	4.09	1 195.35	1 246.80	4.30
Amount not paid per patient	152.50	167.13	9.59	70.88	70.95	0.09	115.22	120.84	4.88

Analysis of admissions to hospitals

Tables belows present the utilisation of hospital services, with admissions categorised into same-day and overnight (Table 20 and Table 21), overnight inpatient (Table 22 and Table 2023), and same-day inpatient (Table 2024 and Table Table 205) for 2023 and 2024. Overall, admissions to hospital facilities for schemes analysed increased by 1.5% over the review period.

Admissions to **day clinics (76/77)** in Table 20, rose by 4.82% from 235 674 in 2023 to 247 023 in 2024, with restricted schemes driving growth at 8.53% while open schemes saw a 3.09% growth. The number of distinct beneficiaries admitted grew by 3.55% to 197 933 .Admissions per 1 000 beneficiaries increased by 4.35% from 25.82 to 26.94, where restricted schemes increased by 5.98% to 18.29 and open schemes increased by 4.46% to 35.02.

The overall admissions to **private hospitals (57/58)**, showed an increase of 1.14 %, from 2.14 million in 2023 to 2.17 million in 2024, with open schemes decreasing (3.07%) and restricted schemes increasing (6.04%). The number of beneficiaries admitted increased slightly by 0.65%, while admissions per 1 000 beneficiaries increased (0.57%). The average length of stay decreased from 3.24 days to 3.22 days, driven mostly by the 2.12% decline in open schemes average legth of stay to 3.31 compared to restricted scheme increase of 1.5% to 3.11 days.

Admissions to **provincial hospitals (56)** decreased by 6.17% to 120,803 in 2024, - this experience was driven by one open scheme that has seen a decline in the usage of public hospitals over the past years resulting in 54.41% decline in 2024, while restricted schemes saw an increase of 1.41% to 112 877. The admissions per 1 000 beneficiaries saw a decrease of 6.59% to 13.18 per 1000 beneficiries.

.

Table 20: Analysis of all (same-day and overnight inpatient) admissions to hospitals in 2023 and 2024

	Open			Restricted			Consolidated		
Hospital group (PCNS number)	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**
Day clinics (76/77)									
Number of admissions	161 117	166 103	3.09%	74 557	80 920	8.53%	235 674	247 023	4.82%
Number of beneficiaries admitted	132 790	135 105	1.74%	58 352	62 828	7.67%	191 142	197 933	3.55%
Number of admissions per 1 000 beneficiaries	33.52	35.02	4.46%	17.25	18.29	5.98%	25.82	26.94	4.35%
Number of admissions per patient	1.21	1.23	1.33%	1.28	1.29	0.80%	1.23	1.25	1.22%
Private hospitals a & b status (057/058)									
Number of admissions	1 154 385	1 118 897	-3.07%	991 980	1 051 850	6.04%	2 146 365	2 170 747	1.14%
Number of beneficiaries admitted	874 107	843 474	-3.50%	751 335	792 466	5.47%	1 625 442	1 635 940	0.65%
Number of admissions per 1 000 beneficiaries	241.59	237.23	-1.81%	244.69	252.54	3.21%	243.01	244.41	0.57%
Number of admissions per patient	1.32	1.33	0.45%	1.32	1.33	0.53%	1.32	1.33	0.49%
Average length of stay (days)	3.38	3.31	-2.12%	3.07	3.11	1.50%	3.24	3.22	-0.67%
Provincial hospitals (056)									
Number of admissions	17 499	7 977	-54.41%	111 304	112 877	1.41%	128 803	120 854	-6.17%
Number of beneficiaries admitted	14 231	4 858	-65.86%	49 524	47 846	-3.39%	63 755	52 704	-17.33%
Number of admissions per 1 000 beneficiaries	3.64	1.68	-53.81%	25.76	25.51	-0.97%	14.11	13.18	-6.59%
Number of admissions per patient	1.23	1.64	33.54%	2.25	2.36	4.97%	2.02	2.29	13.50%
Average length of stay (days)	1.32	2.80	112.36%	0.31	0.29	-5.85%	0.45	0.46	2.33%

Admission to **rehabilitation hospitals and hospices (47/59/79)** (Table 21) grew by 9.09%, from 18,404 in 2023 to 20,077 in 2024. Beneficiaries admitted and admissions per 1 000 beneficiaries showed an increase of 10.48 % to 2.94 in 2024, driven by restricted schemes experience. The average length of stay decreased marginally from 16.62 days to 16.17 days in 2024

Admission to **sub-acute facilities (49)** remained relatively stable, increasing marginally by 0.59% from 30,259 in 2023 to 30,439 in 2024. However, the number of beneficiaries admitted declined slightly (0.79%). Admissions per 1 000 beneficiaries increased by 0.14 % while the average number of admissions per patient increased to 1.18 from 1.16 in 2023. The average length of stay was consistent at around 11 days.

Admissions to **mental health institutions** continue to show growth in the industry, rising by 9.73% from 74,983 in 2023 to 82,279 in 2024, which was matched by the increase (10.24%) in the number of beneficiaries admitted. Admissions per 1 000 beneficiaries also increased by 9.24%, from 8.22 to 8.97 The average length of stay reduced slightly to 11.28 days from 11.34 days in 2023.

Table 21: All (same-day and overnight inpatient) admissions to health facilities in 2023 and 2024

	Open			Restricted			Consolidated		
Hospital Group (PCNS number)	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**
Mental health institutions (055)									
Number of admissions	37 488	38 309	2.19%	37 495	43 970	17.27%	74 983	82 279	9.73%
Number of beneficiaries admitted	30 856	31 682	2.68%	32 345	37 992	17.46%	63 201	69 674	10.24%
Number of admissions per 1 000 beneficiaries	7.80	8.08	3.55%	8.68	9.94	14.51%	8.22	8.97	9.24%
Number of admissions per patient	1.21	1.21	-0.47%	1.16	1.16	-0.16%	1.19	1.18	-0.46%
Average length of stay (days)	10.28	10.06	-2.11%	12.39	12.34	-0.42%	11.34	11.28	-0.50%
Rehabilitation hospitals and hospices (47.59.79)									
Number of admissions	10 485	10 465	-0.19%	7 919	9 612	21.38%	18 404	20 077	9.09%
Number of beneficiaries admitted	7 362	7 666	4.13%	5 612	6 417	14.34%	12 974	14 083	8.55%
Number of admissions per 1 000 beneficiaries	2.18	2.21	1.13%	3.74	4.59	22.76%	2.66	2.94	10.48%
Number of admissions per patient	1.42	1.37	-4.15%	1.41	1.50	6.15%	1.42	1.43	0.50%
Average length of stay (days)	16.07	15.93	-0.87%	16.50	16.44	-0.39%	16.26	16.17	-0.51%
Sub-acute facilities (049)									
Number of admissions	17 580	16 946	-3.61%	12 679	13 493	6.42%	30 259	30 439	0.59%
Number of beneficiaries admitted	15 320	14 708	-3.99%	10 716	11 123	3.80%	26 036	25 831	-0.79%
Number of admissions per 1 000 beneficiaries	3.66	3.57	-2.33%	2.93	3.05	3.92%	3.32	3.32	0.14%
Number of admissions per patient	1.15	1.15	0.40%	1.18	1.21	2.53%	1.16	1.18	1.39%
Average length of stay (days)	11.54	11.22	-2.77%	11.05	11.53	4.36%	11.33	11.36	0.21%

Overnight inpatient admissions

Admissions to **day clinics (76/77)** in (Table 22) showed the most notable increase, rising by 37.38% between 2023 to 2024, with a 34.52% growth in the number of beneficiaries admitted. Growth was higher in restricted schemes (35.46%) compared to open schemes (33.99%). Admissions per 1 000 beneficiaries rose by 36.76% from 0.76 to 1.07 – this experience is characterised by very volatile numbers.

Admissions to **private hospitals (57/58)** rose overall by 1.39%, reaching 1,47 million admissions. This growth was driven by restricted schemes at 6.74% while open schemes saw a decline of 2.65%. A marginal increase of 0.82% was experienced in the industry admission rate per 1 000 beneficiaries which increased to 165.53, while the average length of stay for overnight admissions remained largely unchanged at 4.7 days

Admissions to **provincial hospitals (56)** fell by 7.09%, with restricted schemes decreasing to 7,124 admissions (7.42%) and open schemes to 3,526 admissions (6.42%). Despite fewer admissions, the average length of stay increased by 3.49%, reaching 5.20 days.

Table 22: Overnight in-patient admissions to health facilities in 2023 and 2024

	Open			Restricted			Consolidated		
Hospital group (PCNS number)	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**
Day clinics (76/77)									
Number of admissions	4 329	6 010	38.83%	2 651	3 579	35.01%	6 980	9 589	37.38%
Number of beneficiaries admitted	4 248	5 692	33.99%	2 397	3 247	35.46%	6 645	8 939	34.52%
Number of admissions per 1 000 beneficiaries	0.90	1.27	40.67%	0.61	0.81	31.83%	0.76	1.05	36.76%
Number of admissions per patient	1.02	1.06	3.61%	1.11	1.10	-0.34%	1.05	1.07	2.12%
Private hospitals a & b status (057/058)									
Number of admissions	826 271	804 343	-2.65%	623 811	665 860	6.74%	1 450 082	1 470 203	1.39%
Number of beneficiaries admitted	600 584	581 561	-3.17%	456 832	483 629	5.87%	1 057 416	1 065 190	0.74%
Number of admissions per 1 000 beneficiaries	172.92	170.53	-1.38%	153.87	159.87	3.90%	164.18	165.53	0.82%
Number of admissions per patient	1.38	1.38	0.53%	1.37	1.38	0.83%	1.37	1.38	0.65%
Average length of stay (days)	4.72	4.60	-2.54%	4.88	4.92	0.84%	4.79	4.75	-0.92%
Average age (years)	41.33	43.52	5.30%	34.83	35.28	1.29%	40.09	40.43	0.85%
Provincial hospitals (056)									
Number of admissions	3 768	3 526	-6.42%	7 695	7 124	-7.42%	11 463	10 650	-7.09%
Number of beneficiaries admitted	2 425	2 242	-7.55%	5 343	5 056	-5.37%	7 768	7 298	-6.05%
Number of admissions per 1 000 beneficiaries	0.78	0.74	-5.18%	1.78	1.61	-9.60%	1.26	1.16	-7.51%
Number of admissions per patient	1.55	1.57	1.22%	1.44	1.41	-2.17%	1.48	1.46	-1.11%
Average length of stay (days)	6.09	6.32	3.74%	4.50	4.65	3.20%	5.03	5.20	3.49%

As reflected in Table 23, admissions to **mental health institutions** increased by 9.65% between 2023 and 2024, driven by restricted schemes (17.59%) compared to a rise in open schemes (1.47%). Beneficiaries admitted increased by 10.25% to 68,237, with restricted schemes admitting more (37,705) than open (30,532). Admissions per 1 000 beneficiaries also increased to 8.72 in 2024 from 7.99 in 2023.

Rehabilitation hospitals and hospices also recorded growth, with admissions rising by 3.25% to 17 021 in 2023, and nember of beneficiaries admitted increasing by 8.76% to 13 107. The average length of stay increased by 5.13% to 19.08 days in 2024 from 18.15 days of the previous year.

Admissions to **Sub-acute facilities**, experienced a slight decline, with reduction in the number of admissions (0.86%). The number of admissions per 1 000 beneficiaries decreased by 1.3% to 3.04 in 2024, while the average length of stay increased by 1.68% to 12.39 days.

Table 23: Overnight inpatient admissions to health facilities in 2023 and 2024

	Open			Restricted			Consolidated		
Hospital group (PCNS number)	**2023**	**2024**	**% change**	**2023**	**2024**	**%change**	**2023**	**2024**	**%change**
Mental health institutions (055)									
Number of admissions	35 908	36 435	1.47%	37 010	43 520	17.59%	72 918	79 955	9.65%
Number of beneficiaries admitted	29 844	30 532	2.31%	32 048	37 705	17.65%	61 892	68 237	10.25%
Number of admissions per 1 000 beneficiaries	7.47	7.68	2.81%	8.56	9.83	14.83%	7.99	8.72	9.16%
Number of admissions per patient	1.20	1.19	-0.82%	1.15	1.15	-0.05%	1.18	1.17	-0.55%
Average length of stay (days)	10.73	10.58	-1.42%	12.55	12.47	-0.69%	11.66	11.61	-0.43%
Rehabilitation hospitals and hospices (47.59.79)									
Number of admissions	9 627	9 566	-0.63%	6 859	7 455	8.69%	16 486	17 021	3.25%
Number of beneficiaries admitted	6 929	7 196	3.85%	5 122	5 911	15.40%	12 051	13 107	8.76%
Number of admissions per 1 000 beneficiaries	2.00	2.02	0.69%	3.24	3.56	9.93%	2.38	2.49	4.56%
Number of admissions per patient	1.39	1.33	-4.32%	1.34	1.26	-5.82%	1.37	1.30	-5.07%
Average length of stay (days)	17.50	17.42	-0.43%	19.06	21.20	11.24%	18.15	19.08	5.13%
Average age (years)	64.27	62.62	-2.57%	47.73	48.94	2.54%	56	55.78	-0.39%
Sub-acute facilities (049)									
Number of admissions	16 794	16 154	-3.81%	11 346	11 745	3.52%	28 140	27 899	-0.86%
Number of beneficiaries admitted	14 620	14 034	-4.01%	9 831	10 002	1.74%	24 451	24 036	-1.70%
Number of admissions per 1 000 beneficiaries	3.49	3.41	-2.53%	2.63	2.65	1.08%	3.08	3.04	-1.30%
Number of admissions per patient	1.15	1.15	0.21%	1.15	1.17	1.75%	1.15	1.16	0.86%
Average length of stay (days)	12.08	11.77	-2.56%	12.35	13.25	7.30%	12.19	12.39	1.68%

Same-day admissions

Same-day inpatient admissions (Table 24) showed mixed trends between 2023 and 2024. **Day clinic** admissions increased by 3.82% overall, with restricted schemes growing much more (7.56%) than open schemes (2.11%). Admissions to **private hospitals** increased slightly by 0.61%, driven by a reduction in open schemes (4.13%) compared to the increase in restricted schemes (4.84%). **Provincial hospital** admissions experienced an overall decrease of 6.08%,driven by the volatile open scheme expereince where one scheme contributed to the 67% decrease in admissions, while restricted schemes expereinced a 2.07% increase in admissions.

Table 24: Same-day inpatient admissions to hospitals in 2023 and 2024

Hospital group (PCNS number)	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Day clinics (76/77)									
Number of admissions	156 788	160 093	2.11%	71 906	77 341	7.56%	228 694	237 434	3.82%
Number of beneficiaries admitted	128 542	129 413	0.68%	55 955	59 581	6.48%	184 497	188 994	2.44%
Number of admissions per 1 000 beneficiaries	32.62	33.75	3.46%	16.64	17.48	5.03%	25.06	25.90	3.36%
Number of admissions per patient	1.22	1.24	1.42%	1.29	1.30	1.01%	1.24	126	1.35%
Private hospitals a & b status (057/058)									
Number of admissions	328 114	314 554	-4.13%	368 169	385 990	4.84%	696 283	700 544	0.61%
Number of beneficiaries admitted	273 523	261 913	-4.24%	294 503	308 837	4.87%	568 026	570 750	0.48%
Number of admissions per 1 000 beneficiaries	68.67	66.69	-2.88%	90.81	92.67	2.05%	78.83	78.88	0.05%
Number of admissions per patient	1.20	1.20	0.12%	1.25	1.25	-0.03%	1.23	1.23	0.13%
Average length of stay (days)	0.02	-	100.00%	0.01	0.00	-13.82%	0.00	0.00	-9.30%
Provincial hospitals (056)									
Number of admissions	13 731	4 451	-67.58%	103 609	105 753	2.07%	117 340	110 204	-6.08%
Number of beneficiaries admitted	11 806	2 616	-77.84%	44 181	42 790	-3.15%	55 987	45 406	-18.90%
Number of admissions per 1 000 beneficiaries	2.86	0.94	-67.15%	23.98	23.90	-0.33%	12.86	12.02	-6.50%
Number of admissions per patient	1.16	1.70	46.29%	2.35	2.47	5.39%	2.10	2.43	15.80%
Average length of stay (days)	0.02	0.00	-100.00%	0.00	0.00	-87.75%	0.00	0.00	-84.94%

Admissions to **mental health institutions** (Table 25) increased overall by 12.54%, rising from 2,065 in 2023 to 2,324 in 2024. This growth was largely driven by open schemes (18.6%), while restricted schemes recorded a decline (7.22%). **Rehabilitation hospitals and hospices and sub-acute facilities** reported an encrease in admissions. It is worth noting that their experience is characterised by volatile numbers due to low volumes.

Hospital admissions by level of care

Table 25 presents hospital admission rates and average length of stay by level of care for 2023 and 2024. At the consolidated level, general ward admissions increased by 0.97 %, from 161.98 admissions per 1 000 beneficiaries in 2023 to 163.55 in 2024. This overall marginal increase was driven by restricted schemes, which increased by 2.11 %, whilst open schemes saw an increase of just 0.52 %. The average length of stay in general wards increased slightly by 0.12% to 3.92 days in 2024 at the industry level.

High-care admissions also showed an increase at the industry level at 1.19% to 26.19 beneficiaries per 1 000 beneficiaries. The overall average length of stay in high care increased by 2.33% from 4.14 days to 4.23 days.

ICU admissions had the highest increase compared to other ward types at 4.28% from 11.69 to 12.19 per 1 000 beneficiaries in 2024. This trend presented variations between scheme types, with open schemes rising by 3.90% to 12.79 per 1 000 beneficiaries, while restricted schemes fell by 1.65% to 10.80 per 1 000 beneficiaries. The average length of stay for ICU admissions increased from 5.78 days in 2023 to 6 days in 2024, showing a 4.28% increase in the industry.

Table 25: Hospital admissions by level of care

	Open			Restricted			Consolidated		
Hospital group (PCNS number)	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**
Number of admissions to general ward									
Number of admissions per 1 000 beneficiaries	166.02	166.88	0.52%	152.61	155.83	2.11%	161.98	163.55	0.97%
Average length of stay (days)	3.89	3.93	1.15%	3.97	3.88	-2.40%	3.91	3.92	0.12%
Number of admissions to high care									
Number of admissions per 1 000 beneficiaries	26.43	27.46	3.90%	24.60	23.24	-5.55%	25.88	26.19	1.19%
Average length of stay (days)	4.04	4.26	5.30%	4.37	4.16	-4.66%	4.14	4.23	2.33%
Number of admissions to ICU									
Number of admissions per 1 000 beneficiaries	12.00	12.79	6.63%	10.98	10.80	-1.65%	11.69	12.19	4.28%
Average length of stay (days)	5.76	6.09	5.74%	5.81	5.75	-1.18%	5.78	6.00	3.87%

Analysis of admissions to private hospitals by demographic characteristics

Figure 42 the data shows admission rates per 1 000 beneficiaries into private hospitals by age group and gender in 2024. Male admission rates were higher than females in the 40-44 years age group onwards and peaking in the 80-84 years age group (1,572.0 versus 1,505.5). Females peaked in the 80-84 age group (1,505.5).

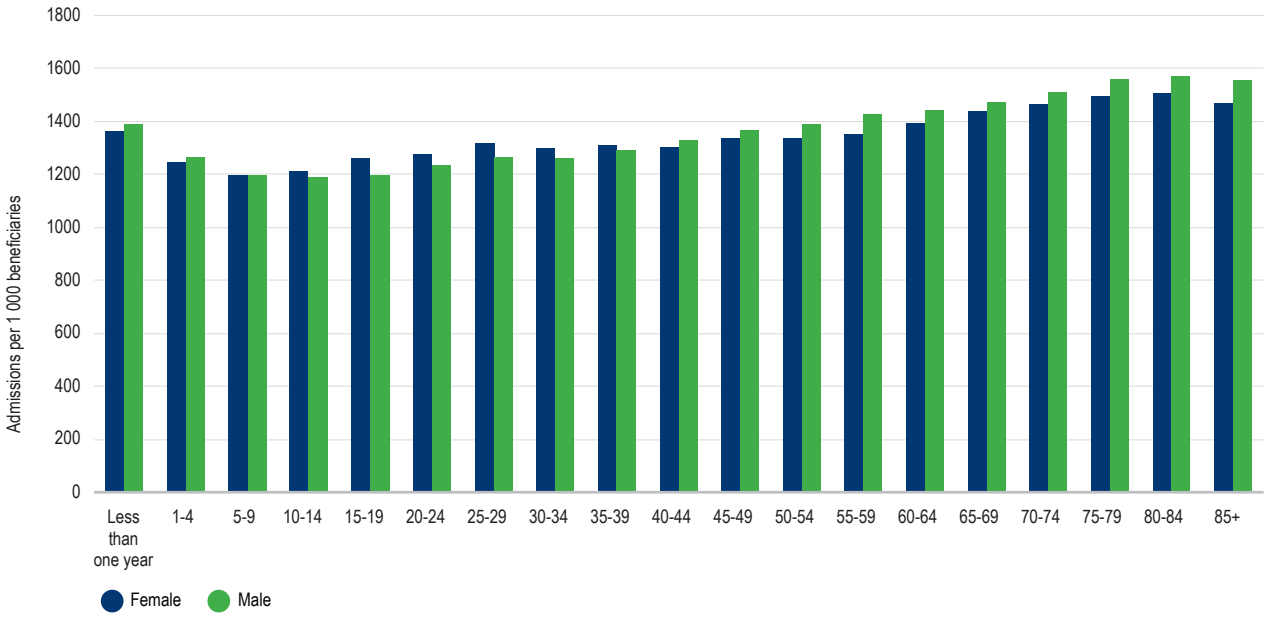


Figure 42: Admission rates (per 1.000 beneficiaries) for private hospitals by gender

Figure 43 shows admission rates per 1 000 beneficiaries in provincial hospitals by age group and gender in 2024. Female admission rates were higher than males through early and mid-adulthood, peaking at 55-59 years (36.6 versus 21.5). Male rates surpassed females in older age groups from 70 years onward, reaching a maximum at 60-64 (2 758 versus 2 593). Overall, female admissions dominated in most adult age groups, while males led in late adulthood and elderly ages, from age group 70-74 years.

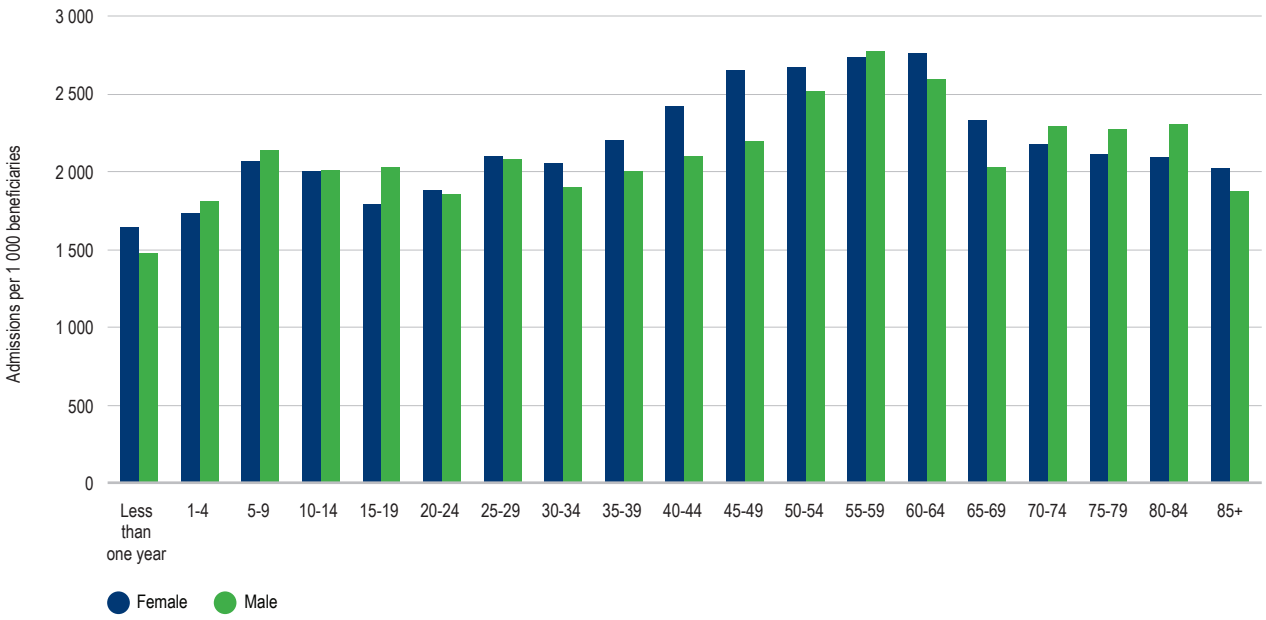


Figure 43: Admission rates (per 1 000 beneficiaries) for provincial hospitals by gender

Figure 44 shows admission rates per 1 000 beneficiaries by age group and gender for day clinics in 2024. Admissions rates varied. Males surpassed females at most age groups except between age groups 5-9 and 10-14 years and again at ages beyond 85 years.

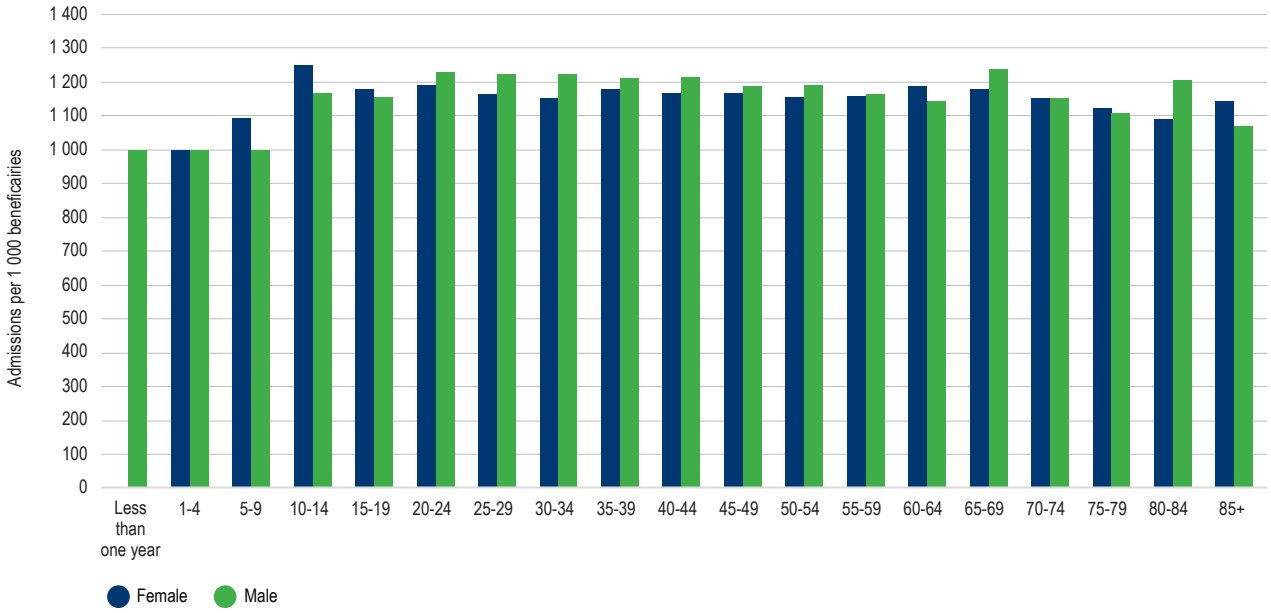


Figure 44: Admission rates (per 1 000 beneficiaries) to day clinics in 2024 by gender

Figure 45 shows admission rates per 1 000 beneficiaries for mental health institutions in 2024. No admissions were recorded for those under 10 years. Females consistently had higher admission rates than males across most age groups, particularly between 10 and 84 years, peaking at 20-24 years (15.54) and for males at 25-29 years (12.90). Male admissions exceeded females only in the 85 years (1.96).

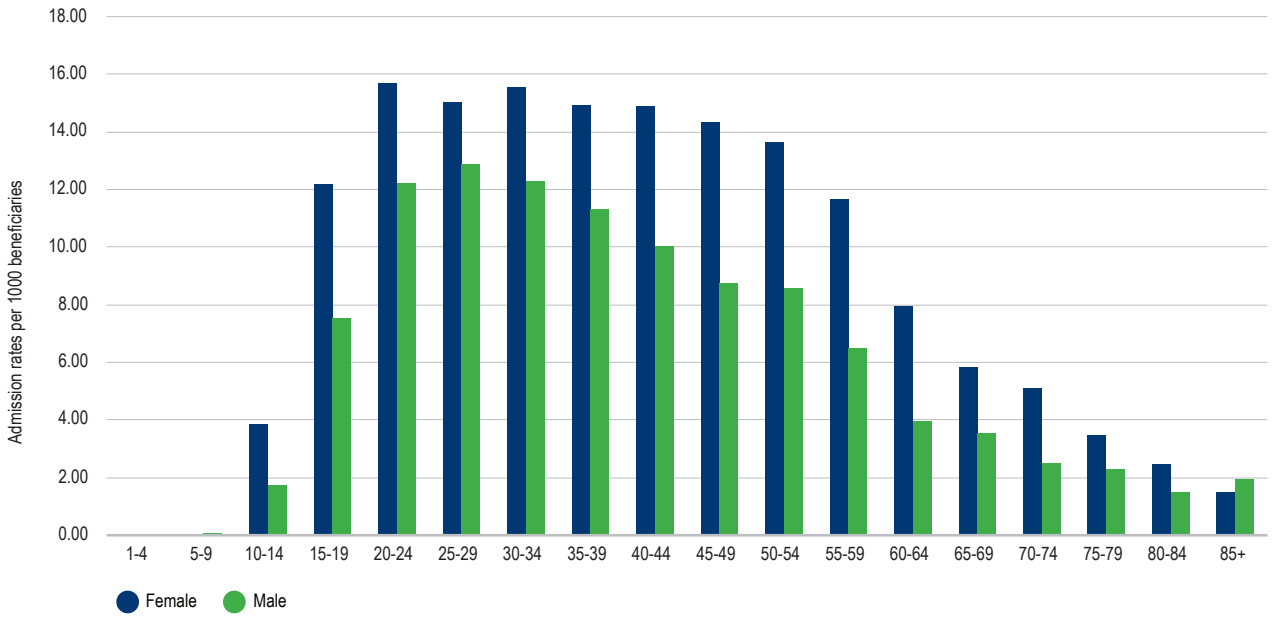


Figure 45: Admission rates (per 1 000 beneficiaries) in mental health institutions in 2024

Utilisation of medical technology

Figure 46 illustrates the utilisation of selected medical technologies by medical scheme beneficiaries in 2023 and 2024. Medical technologies include renal dialysis, computerised tomography (CT) scans, magnetic resonance imaging (MRI), angiograms, positron resonance tomography (PET) and bone density scans. All five technologies saw an increase in utilisation between 2023 and 2024; however, the top three were CT scans, MRIs and renal analysis. The use of CT scans increased by 4.79% from 55.08 per 1 000 beneficiaries in 2023 to 57.72 per 1 000 beneficiaries in 2024. A small number of beneficiaries utilised PET (0.85 per 1 000); however, it saw the most significant increase of 8.79% over the reporting period.

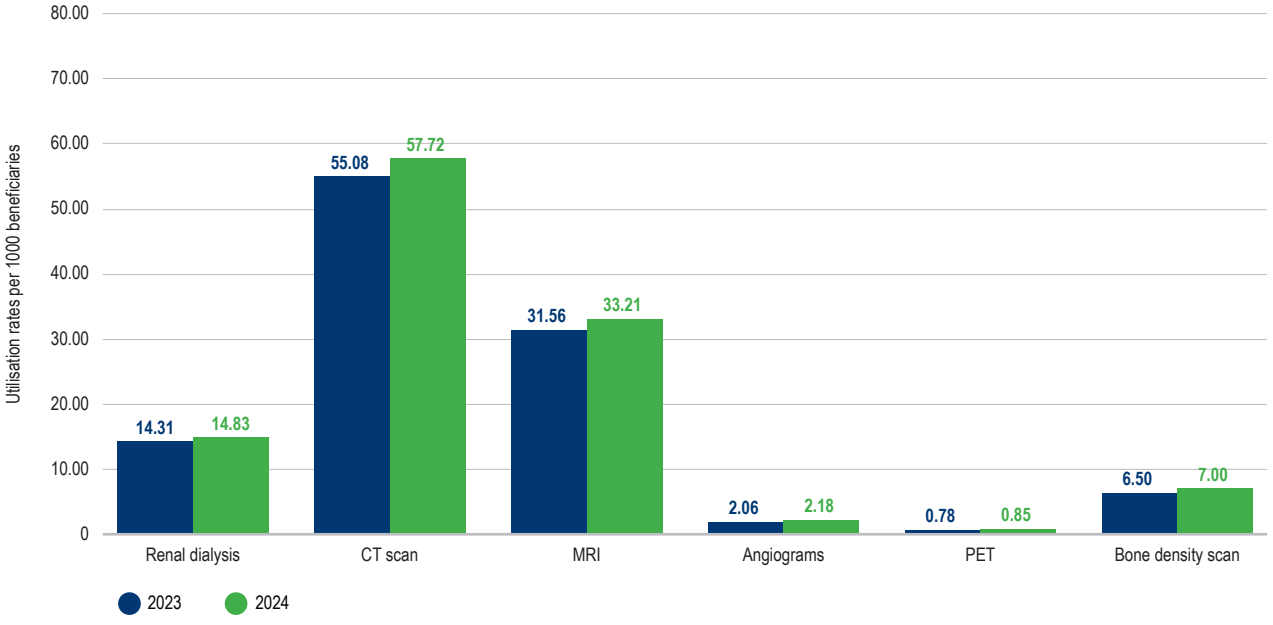


Figure 46: Utilisation of medical technology in 2023 and 2024

Figure 47 shows the utilisation rates of selected medical technologies by scheme type in 2024. All technologies had an increase in utilisation during the reporting period. A high number of beneficiaries belonging to open medical schemes utilised the CT scans (64.28 per 1 000 beneficiaries) and MRI scans (38.31 per 1 000 beneficiaries), respectively, compared to beneficiaries in restricted schemes. The overall utilisation of medical technologies was generally higher in open medical schemes than in restricted schemes.

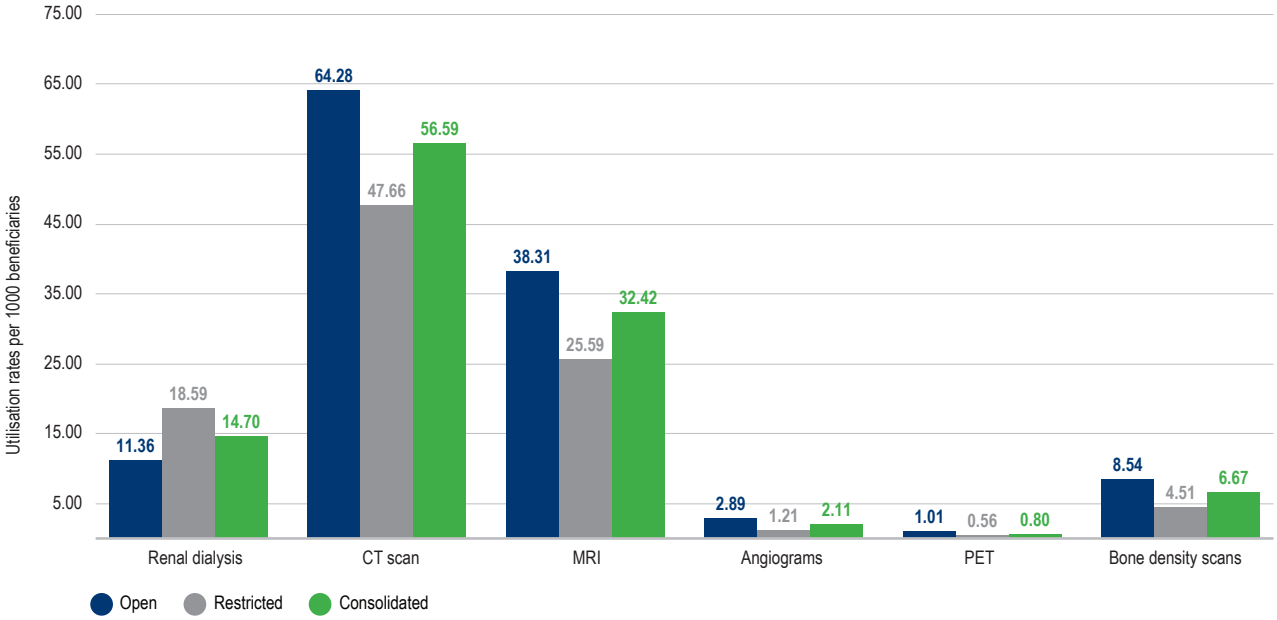


Figure 47: Utilisation of medical technology by scheme type in 2024

Utilisation of selected health services indicators

Significant changes in healthcare services related to the Sustainability Development Goals were observed during the period under review. Changes in the demographic characteristics of beneficiaries may explain the changes highlighted below.

These health services are focused on ensuring the overall well-being of the medical scheme members by primarily focusing on preventative measures. While there have been improvements in certain areas, it is concerning that areas such as immunisation experienced significant declines.

Maternal and reproductive health services in 2023 and 2024

The number of birth admissions was 24.36 per 1 000 beneficiaries in 2024, a 3.93% decrease from 25.38 in 2023. This experience continued the trend from previous years, when birth admissions declined by 3.97% between 2022 and 2023. Unlike the 2023 experience, in 2024, this decline was more pronounced in the open scheme environment.

The number of birth admissions of women between 15 and 19 years of age decreased by 4.25% to 7.37 per 1 000 beneficiaries.

A decline of 6.05% was observed in the number of caesarean sections performed during the period under review.

Terminations of pregnancy increased by 7.71% from 0.38 per 1 000 beneficiaries to 0.41% per 1 000 beneficiaries. A noteworthy increase of 17.39% was observed in the number of terminations of pregnancy, performed during the first 12 weeks of pregnancy, while those performed within 13 and 20 weeks declined by 3.82%

Looking at female beneficiaries between 15-49, the contraceptive coverage decreased significantly within the open schemes at 8.19%, while the restricted schemes experienced an increase of 6.11%. This resulted in the industry experiencing a slight 0.99% decrease.

Table 26: Utilisation of maternal and reproductive health services

Selected health services****	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Maternal health									
Baby born alive in health facility who weighs less than 2500g (per 1 000 live births)	4.20	4.43	5.44%	7.04	8.31	18.13%	5.71	6.52	14.30%
Death of an infant 0-28 days of age (per 1 000 live births)	0.23	0.18	-23.23%	0.11	0.08	-21.88%	0.17	0.13	-23.22%
Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15-49 years (per 1 000 female beneficiaries aged 15-49 years)	16.40	14.61	-10.92%	12.27	12.88	4.99%	14.42	13.76	-4.54%
Number of birth admissions (per 1 000 female beneficiaries)	29.25	27.48	-6.04%	21.23	21.18	-0.22%	25.35	24.36	-3.93%
Number of birth admissions to women between 15-19 years (per 1 000 female beneficiaries aged 15-19 years)	3.59	2.88	-19.87%	10.96	10.81	-1.38%	7.70	7.37	-4.25%
Number of birth admissions to women under 15 years (per 1 000 female beneficiaries aged under 15 years)	0.11	0.01	-90.13%	0.18	0.17	-7.13%	0.15	0.10	-34.08%
Number of caesarean sections performed (per 1 000 birth admissions)	630.92	613.96	-2.69%	625.11	559.57	-10.48%	628.56	590.53	-6.05%
Number of mammograms paid for (per 1 000 female beneficiaries aged 50-69 years)	381.62	370.03	-3.04%	229.03	242.11	5.71%	310.15	308.33	-0.59%
Number of pap smears paid for (per 1 000 female beneficiaries aged 15-69 years)	153.56	135.48	-11.77%	110.52	116.23	5.16%	133.04	126.10	-5.22%
Postnatal visits by a mother within 6 weeks after delivery (per 1 000 birth admissions)	217.25	241.11	10.98%	109.94	115.70	5.24%	173.66	187.10	7.74%
Subdermal contraceptive implant inserted just under the skin of a woman aged 15-49 years upper arm (per 1 000 female beneficiaries aged 15-49 years)	0.08	0.08	6.71%	1.56	1.80	15.83%	0.78	0.92	17.35%
Surgical procedure to prevent a man from being fertile (per 1 000 male beneficiaries aged 15-49 years)	6.20	5.74	-7.50%	2.71	2.55	-5.96%	4.51	4.16	-7.77%
Surgical procedure to protect a woman from further pregnancy (per 1 000 female beneficiaries aged 15-49 years)	4.02	3.99	-0.72%	2.40	2.22	-7.44%	3.17	3.04	-4.03%
Termination of Pregnancy at 13-20 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations)	336.05	348.33	3.65%	239.78	206.38	-13.93%	289.88	278.81	-3.82%
Termination of Pregnancy in the first 12 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations)	540.73	580.86	7.42%	606.63	766.70	26.39%	572.34	671.88	17.39%
Termination of Pregnancy performed under safe conditions in a health facility (per 1 000 female beneficiaries)	0.39	0.42	7.73%	0.38	0.41	7.75%	0.38	0.41	7.71%
Total number of live births (per 1 000 birth admissions)	989.12	984.75	-0.44%	938.30	968.81	3.25%	968.48	977.89	0.97%
Contraception Coverage									
Number of women using contraceptives (per 1 000 female beneficiaries aged 15-49 years)	202.15	185.60	-8.19%	212.00	224.96	6.11%	206.87	204.82	-0.99%

Mental Health Coverage in 2023 and 2024

Number of beneficiaries with depression declined by 1.66% to 84.9 per 1 000 beneficiaries, similarly the number of those diagnosed with psychosis declined by 2.24% to 5.13 per 1 000 beneficiaries.

Table 27: Utilisation of mental health services

	Open			Restricted			Consolidated		
Selected health services****	2023	2024	% change	2023	2024	% change	2023	2024	% change
Mental Health Coverage									
Number of beneficiaries with depression (per 1 000 beneficiaries)	92.69	90.94	-1.89%	79.27	78.43	-1.05%	86.34	84.90	-1.66%
Number of beneficiaries with psychosis (per 1 000 beneficiaries)	5.68	5.46	-3.91%	4.78	4.79	0.23%	5.25	5.13	-2.24%

Immunisation Coverage in 2023 and 2024

Immunisation coverage mostly covers children and for the period of review, the experience has worsened in the industry highlighting a need for an industry-wide, targeted approach to ensuring immunisation.

The number of children over nine months old who have received the measles vaccine declined significantly by 65.86% in 2024, reaching only 1.45 per 1 000 beneficiaries under 15 years old. Unpacking this decline by scheme type shows similar trends; open schemes saw a 65.57% decline, resulting in a rate of 1.07 per 1 000 beneficiaries under 15 years while restricted schemes experienced an equally high decline of 66.31%, resulting in a rate of 1.74 per 1 000 beneficiaries under 15 years. It is worth noting that during the 2023 period, there was a national campaign for measles vaccination and thus these figures represent a reversion to the pre-2023 levels.

Table 28: Immunisation coverage

	Open			Restricted			Consolidated		
Selected health services****	2023	2024	% change	2023	2024	% change	2023	2024	% change
Child Health Coverage									
Number of children (0-59 months) with diarrhoea receiving oral rehydration solution (ORS) (per 1 000 beneficiaries aged under 5 years)	31.95	28.37	-11.22%	147.95	179.61	21.40%	94.96	112.63	18.61%
Number of children aged 6-59 months with malaria (per 1 000 beneficiaries aged under 5 years)	0.50	0.10	-80.13%	0.46	0.31	-33.75%	0.48	0.22	-55.32%
Immunisation Coverage									
Number of beneficiaries with influenza vaccine (per 1 000 beneficiaries)	34.18	41.39	21.08%	33.02	43.88	32.90%	33.43	43.01	28.64%
Number of children (0 years and older) who received OPV vaccine (per 1 000 beneficiaries aged under 15 years)	9.77	9.02	-7.67%	4.05	3.66	-9.59%	6.63	6.01	-9.33%
Number of children (0-1 year) who received BCG vaccine (per 1 000 beneficiaries aged under 1 years)	1.43	1.63	14.60%	0.83	0.76	-8.93%	1.11	1.16	4.59%
Number of children (1-15 years) who received Hepatitis A vaccine (per 1 000 beneficiaries aged under 15 years)	1.85	1.84	-0.76%	1.61	1.34	-16.65%	1.72	1.56	-9.28%
Number of children (1year and older) who received MMR vaccine (per 1 000 beneficiaries aged under 15 years)	30.00	21.58	-28.09%	16.36	12.00	-26.69%	22.53	16.20	-28.06%
Number of children (3 - years) who received Quadrivalent vaccine (per 1 000 beneficiaries aged under 15 years)	2.82	2.18	-22.86%	1.27	1.15	-9.45%	1.97	1.60	-18.77%

Selected health services****	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Number of children (6 weeks- 5 years) who received PCV vaccine (per 1 000 beneficiaries aged under 5 years)	53.20	40.54	-23.79%	31.48	25.89	-17.77%	41.40	32.38	-21.80%
Number of children (6 weeks) who received Rotavirus vaccine (per 1 000 beneficiaries aged under 1 years)	48.66	38.60	-20.67%	23.75	25.82	8.69%	35.42	31.70	-10.49%
Number of children (6 years and older) who received Td vaccine (per 1 000 beneficiaries aged under 6-15 years)	6.51	6.87	5.65%	4.10	4.10	-0.08%	5.18	5.31	2.52%
Number of children (9 months and older) who received chickenpox vaccine (per 1 000 beneficiaries aged under 15 years)	13.45	11.93	-11.35%	6.19	5.97	-3.55%	9.47	8.59	-9.35%
Number of children (9 months and older) who received Measles vaccine (per 1 000 beneficiaries aged under 15 years)	3.11	1.07	-65.57%	5.17	1.74	-66.31%	4.24	1.45	-65.86%

Cancer Coverage

The cancer coverage tracks the number of beneficiaries diagnosed with various forms of cancer within the industry between 2023 and 2024.

Among female beneficiaries, the number of those diagnosed with breast cancer increased by 4.65% in the industry, reaching 11.75 per 1 000 beneficiaries. Beneficiaries diagnosed with cervical cancer saw a reduction of 4.47%, dropping to 1.7 per 1 000 beneficiaries.

While the diagnosis rate declined for cervical cancer, screening (only performed for beneficiaries in the 30-49 age band) increased by 0.3% to 68.9 per 1 000 beneficiaries, highlighting a positive trend following the decline experienced in the previous reporting period.

For male beneficiaries, the diagnosis rate for prostate cancer declined by 1.68%, falling to 29.19 per 1 000 beneficiaries in the over-40 age group.

Beneficiaries diagnosed with liver cancer and lung cancer in 2024 amounted to 0.23 per 1 000 beneficiaries and 0.79 per 1 000 beneficiaries in the industry, respectively. These figures represent a decline from 2023 of 0.07% for liver cancer and 3.54% for lung cancer.

Table 29: Cancer coverage

Selected health services****	Open			Restricted			Consolidated		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Cancer Care coverage									
Number of beneficiaries with breast cancer (per 1 000 female beneficiaries)	14.80	15.75	6.44%	7.62	7.89	3.55%	11.23	11.75	4.65%
Number of beneficiaries with cervical cancer (per 1 000 female beneficiaries)	2.12	1.94	-8.46%	1.43	1.46	2.32%	1.78	1.70	-4.47%
Number of beneficiaries with colon cancer (per 1 000 beneficiaries)	2.21	1.98	-10.09%	1.12	1.54	37.15%	1.69	1.77	4.48%
Number of beneficiaries with liver cancer (per 1 000 beneficiaries)	0.23	0.20	-15.55%	0.23	0.26	17.04%	0.23	0.23	-0.07%
Number of beneficiaries with lung cancer (per 1 000 beneficiaries)	0.99	0.80	-18.87%	0.63	0.78	23.02%	0.82	0.79	-3.54%
Number of beneficiaries with prostate cancer (per 1 000 male beneficiaries aged 40 years and older)	33.48	29.33	-12.40%	24.27	29.01	19.49%	29.69	29.19	-1.68%
Number of women aged 30-49 years screened for cervical cancer (per 1 000 female beneficiaries aged 30 to 49 years)	61.91	57.48	-7.17%	76.38	81.32	6.47%	68.78	68.99	0.30%

HIV, TB and Eye Care

The number of unique beneficiaries tested for HIV increased by 9.38%, rising to 37.21 per 1 000 beneficiaries in 2024 from 34.02 per 1 000 beneficiaries in 2023.

Meanwhile, beneficiaries with a confirmed TB diagnosis reduced by 18.07% across the industry, falling to 0.54% per 1 000 beneficiaries from 0.66 per 1 000 beneficiaries.

The number of beneficiaries receiving cataract surgery has increased by 5.4% from 10.67 per 1000 beneficiaries to 11.25 per 1 000 beneficiaries. This experience was primarily driven by the restricted schemes, with a 23.5% increase to 11.88 per 1 000 beneficiaries, while the open schemes declined by 8.24% to 10.66 per 1 000 beneficiaries

Table 30: HIV, TB and Eye Care coverage

	Open			Restricted			Consolidated		
Selected health services****	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**	**2023**	**2024**	**% change**
HIV and TB									
Number of HIV negative beneficiaries issued with Post Exposure Prophylaxis (PEP) following Occupational Exposure (per 1 000 beneficiaries)	11.20	9.36	-16.43%	38.52	39.09	1.49%	24.13	23.71	-1.75%
Number of HIV negative beneficiaries issued with Post Exposure Prophylaxis (PEP) following Sexual Assault (per 1 000 beneficiaries)	0.33	0.22	-31.57%	37.48	38.33	2.27%	17.92	18.62	3.91%
Number of circumcisions in 15-49 year old males (per 1 000 male beneficiaries aged 15-49 years)	5.30	3.65	-31.06%	7.25	7.08	-2.28%	6.16	5.19	-15.72%
Number of unique beneficiaries tested for HIV (per 1 000 beneficiaries)	27.41	30.48	11.20%	41.38	44.43	7.38%	34.02	37.21	9.38%
Number of unique beneficiaries with confirmed TB diagnosis (per 1 000 beneficiaries)	0.72	0.59	-17.50%	0.59	0.48	-18.48%	0.66	0.54	-18.07%
Eye Care Coverage									
Number of beneficiaries who received cataract surgery among those in need in a specified time period (per 1 000 beneficiaries)	11.62	10.66	-8.24%	9.62	11.88	23.50%	10.67	11.25	5.40%

Financial Performance Industry Report 2024

LIST OF TABLES

LIST OF FIGURES

EXPLANATORY NOTES TO THE ANNUAL REPORT

As of 11 July 2025, **Sizwe Hosmed Medical Scheme** had not as yet submitted its final audited annual financial statements for the financial year ended 31 December 2023. The scheme was therefore ***excluded*** from the Annexures and Annual Report.

The following scheme was placed under statutory management in terms of Section 5A of the Financial Institutions (Protection of Funds) Act, 2001:

Registration number	Name of medical scheme
1486	Sizwe Hosmed Medical Scheme

The following medical scheme's name was changed effective 1 January 2024:

Registration number	Name of medical scheme	Old name
1544	Consumer Goods Medical Scheme	Tiger Brands Medical Scheme

The following medical scheme changed its administrator effective 1 January 2024:

Registration number	Name of medical scheme	New administrator
1234	Sasolmed	Discovery Health (Pty) Ltd *Previously administered by Momentum Health Solutions (Pty) Ltd*

The following previous bargaining council schemes obtained exemptions from providing a full set of Prescribed Minimum Benefits (PMBs):

Registration number	Name of medical scheme
1590	Building & Construction Industry Medical Aid Fund
1271	Fishing Industry Medical Scheme (Fishmed)
1086	Foodmed Medical Scheme
1270	Golden Arrow Employees' Medical Benefit Fund
1600	Motohealth Care

The following schemes are fully capitated:

Registration number	Name of medical scheme
1271	Fishing Industry Medical Scheme (Fishmed)
1591	Impala Medical Plan
1466	Makoti Medical Scheme

The following schemes provided relief to its members via contribution holidays during 2023 and 2024:

Registration number	Name of medical scheme	Month
1237	BP Medical Aid Society	January 2023
1578	TFG Medical Aid Scheme	January 2023
1186	PG Group Medical Scheme	January 2024
1430	Remedi Medical Aid Scheme	November 2024

The auditors' reports on the following schemes' Annual Financial Statements (AFS) had an emphasis of matter paragraph:

Registration number	Name of medical scheme	Auditor name	Emphasis of matter
1599	Lonmin Medical Scheme	BDO South Africa Incorporated	The financial statements had been prepared on a non-going concern basis due to the amalgamation of the scheme with Sisonke Health Medical Scheme with effect 1 April 2025.
1548	Medipos Medical Scheme	Middel & Partners	As of 31 December 2024, (*The South African Post Office SOC*) is indebted to the scheme for contribution income amounting to R609 198 572. It is however uncertain how many cents on the Rand the scheme will receive on this amount. The matter of the South African Post Office's non-payment of contributions is an ongoing issue and has been exacerbated by the fact that (*The South African Post Office SOC*) was placed under business rescue. In June of 2024 the scheme received R82.5 million as a first round of settlement of the debt as agreed with the Business Rescue Practitioners. The scheme awaits the second round of payment of 18 cents to the Rand. However, this is dependent on (*The South African Post Office SOC*) receiving funding from Treasury. There continues to be uncertainty as to the future business model and size of the South African Post Office, which places material uncertainty on what the future contributions for the Scheme will be.

The following two schemes' 2024 AFS had been rejected:

Registration number	Name of medical scheme	Auditor name	Reasons for rejection
1201	Rand Water Medical Scheme	Strachan & Crouse	The financial years presented as headings on the Statement of Financial Position were switched around.
1597	Umvuzo Health Medical Scheme	Ransome Russouw	• IFRS 12 Disclosure of Interests in Other Entities: the scheme did not provide the required disclosures in relation to its unconsolidated structured investments. • IFRS 17 Insurance contracts: - Non-adherence to paragraph 78 (disclosure of insurance contracts at portfolio level). - Non-adherence to paragraphs 98 and 99 (disclosure of Liability for Remaining Coverage (LRC) and Liability for Incurred Claims (LIC) reconciliations). - Non-adherence to paragraph 98 (separate reconciliations for insurance contracts issued and reinsurance contracts). - Incorrect classification of assets and liabilities between IFRS 9 Financial instruments and IFRS 17 Insurance contracts. - Estimated recoveries on reinsurance arrangements were not based on scheme cost. - Non-adherence to paragraph 128(a) (sensitivity analysis in relation to changes in risk variables) - Incorrect disclosures in respect of disclosures required by paragraph 126 (cumulative unrealised gains not deducted for solvency purposes) • Inaccurate accounting policies. • Insufficient disclosure of other operating expenditure. • Audit report makes no reference to scheme's classification as a Public Interest Entity (PIE).

No medical schemes' Financial Annual Statutory Return (FASR) were unlocked for correction. The above-mentioned reasons for rejecting the schemes' AFS did not result in material changes to the FASR.

IFRS ACCOUNTING STANDARDS: IMPLEMENTATION OF IFRS 17 *INSURANCE CONTRACTS*

Medical schemes are required to prepare their annual financial statements in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board. IFRS 17 *Insurance Contracts* is applicable for medical schemes' 2023 year-ends, with a retrospective application (i.e. the comparatives had to be restated). The application resulted in significant changes in the terminology used and the classification of financial information in medical schemes' financial statements. This industry report was prepared based on the new terminology.

The change in classification also resulted in deviations in industry trends. The CMS has, therefore, prepared this report by comparing only three years of data.

For your ease of reference, a summary of the main changes had been included below. Kindly refer to the 2023 Financial Performance Industry Report for a more detailed explanation of the changes.

Main changes

The main changes in the financial statements of medical schemes due to the implementation of IFRS 17 Insurance Contracts can be summarised as follows (kindly note that the below does not represent a technical discussion, but instead seeks to provide a simplified explanation for the lay person):

Change in grouping / classification

Statement of Financial Position

Kindly refer to Annexure B for the detailed industry Statement of Financial Position. The individual schemes' data is disclosed in Annexure E.

IFRS 17 requires the separate classification of insurance contract assets and liabilities from other financial assets and liabilities.

IFRS 17 explicitly requires insurance contract assets and liabilities to be disclosed separately from reinsurance contract assets and liabilities.

Statement of Comprehensive Income

Annexure C depicts the industry's Statement of Comprehensive Income. The individual schemes' performance and results are contained in Annexure F.

Insurance revenue

Insurance revenue (gross contributions excluding medical savings accounts contributions) was previously known as risk contributions.

As IFRS 17 requires the expected premium receipts to be recognised, the figure is net of estimated unrecoverable contributions (i.e. bad debts).

Insurance service expenditure (ISE)

Insurance service expenditure represents new IFRS 17 terminology. The figure consists of:

- Net claims incurred*
- Accredited managed healthcare services (no transfer of risk)*
- Directly attributable insurance service expenditure (DAE)

*These figures are included in the calculation of relevant healthcare expenditure.

This report focuses on trends experienced in the relevant healthcare expenditure, as it is clearly defined in the Medical Schemes Act (131 of 1998) (MSA).

Relevant healthcare expenditure comprises of:

- Net claims incurred*
- Accredited managed healthcare services (no transfer of risk)*
- Reinsurance results

*These figures are included in the calculation of insurance service expenditure.

Directly attributable insurance service expenditure (DAE)

Operational expenditure was previously known as non-healthcare expenditure. IFRS 17 now requires schemes to split their operational expenditure between those considered directly attributable in servicing/providing the insurance contract, and those not directly attributable.

The DAE is also now included in the insurance service expenditure figure (which is very similar to how the cost of sales is determined in a manufacturing business).

IBNR calculation/Risk adjustment

The main change in the measurement of the figures due to the implementation of IFRS 17 relates to the provision for outstanding claims.

IFRS 17 requires schemes to consider the present value of its probability weighted scenarios for its cash flows, meaning the liability is calculated based on known factors as at year-end.

IFRS 17 furthermore requires a risk adjustment for non-financial risk, i.e. the compensation that the medical scheme requires for bearing uncertainty about the amount and timing of the cash flows. When considering that the liability was already determined based on the probability weighted scenario of its cash flows, combined with the very short-term nature of the liability, the risk adjustment theoretically represents a very small component of the total liability.

The risk adjustment represented in most medical schemes is the only change in the measurement of the liability compared to previous years.

Mutual entities definition

Medical schemes meet the definition of mutual entities for accounting purposes, as the residual interest of the entity is due to its members (or policyholders). This results in medical schemes no longer disclosing members' funds and reserves in their Statement of Financial Position, but rather reclassifying and renaming the previously known accumulated funds as a non-current liability now known as "amounts attributable to members". For purposes of calculating liquidity ratios in this report, this figure had been omitted from the total liabilities figure, as this amount will only be settled upon the liquidation of a medical scheme.

**Sizwe Hosmed Medical Scheme has been excluded from the Annexures and Annual Report.*

A snapshot of the medical schemes industry

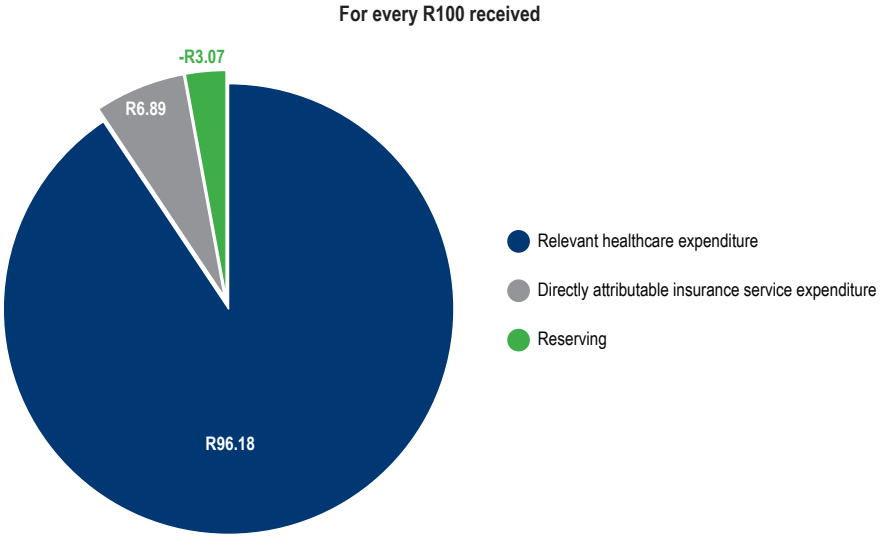


Figure 1: For every R100.00 received

Figure 1 illustrates that medical schemes utilised their built-up reserves to fund their operations. For every R100.00 received in insurance revenue, an additional R3.07 of the reserves or investment income was utilised to fund the R96.18 paid in relevant healthcare expenditure, and R6.89 in directly attributable insurance service expenditure (DAE).

Figure 2 demonstrates the reliance placed on investment income to achieve a net surplus:

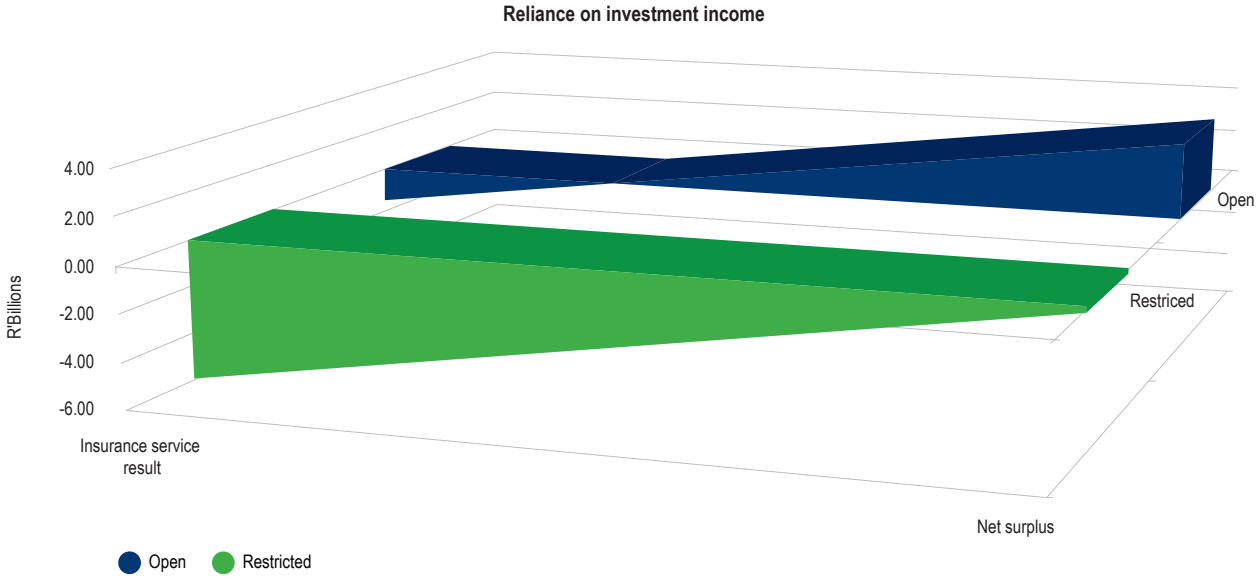


Figure 2: Reliance on investment income

Open medical schemes incurred an insurance service deficit of R1.49 billion for the financial year ending 31 December 2024. After accounting for investment income, the open scheme industry incurred a net surplus of R3.33 billion.

Restricted schemes similarly incurred an insurance service deficit of R5.99 billion for the year under review. However, after investment income was taken into account, the restricted scheme industry attained a net deficit of R0.20 billion.

It is clear that both the open and restricted scheme industries were underpriced on an insurance service result (or operational result) level for the 2024 year.

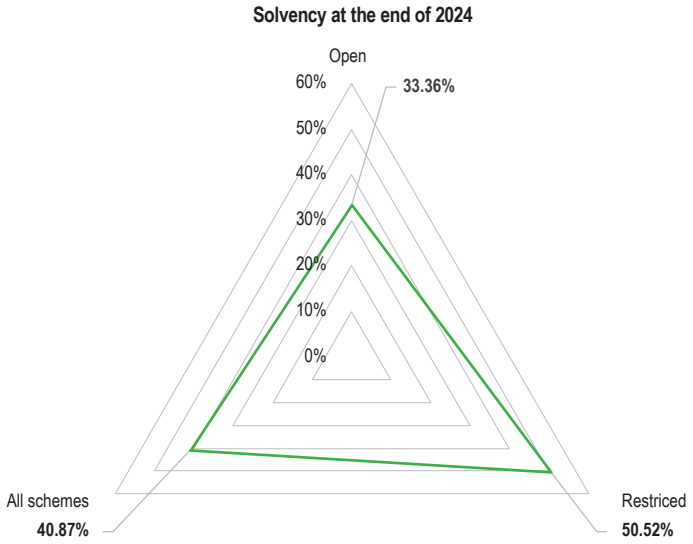


Figure 3: Solvency at the end of 2024

Figure 3 shows that the medical scheme industry is financially sound, as the industry solvency of 40.87% exceeds the minimum required solvency level of 25.00%.

Medical schemes price for a break-even result at an insurance result level. Pricing corrections and benefit adjustments are therefore necessary for future periods to ensure that reserves are maintained. Due to the industry's healthy financial position, these corrections can be implemented incrementally.

Membership

A slight increase in scheme membership was observed. At the end of 2024, there were 4.11 million members and 9.04 million beneficiaries (2023: 4.09 million members and 8.99 million beneficiaries), with an average number of dependents per member of 1.20 (2023: 1.20).

The demographic profile of beneficiaries deteriorated slightly, from an average age of 34.18 years per beneficiary and pensioner ratio of 9.57% in 2023, to an average age of 34.47 years per beneficiary and a 9.97% pensioner ratio in 2024. Generally, the open schemes industry had a higher age profile than that observed in the restricted scheme environment.

For a more detailed analysis of membership changes, kindly refer to the Healthcare Utilisation Industry Report for 2024.

Insurance revenue (IR)

Insurance revenue increased by 9.42% from R222.97 billion in 2023 to R243.97 billion.

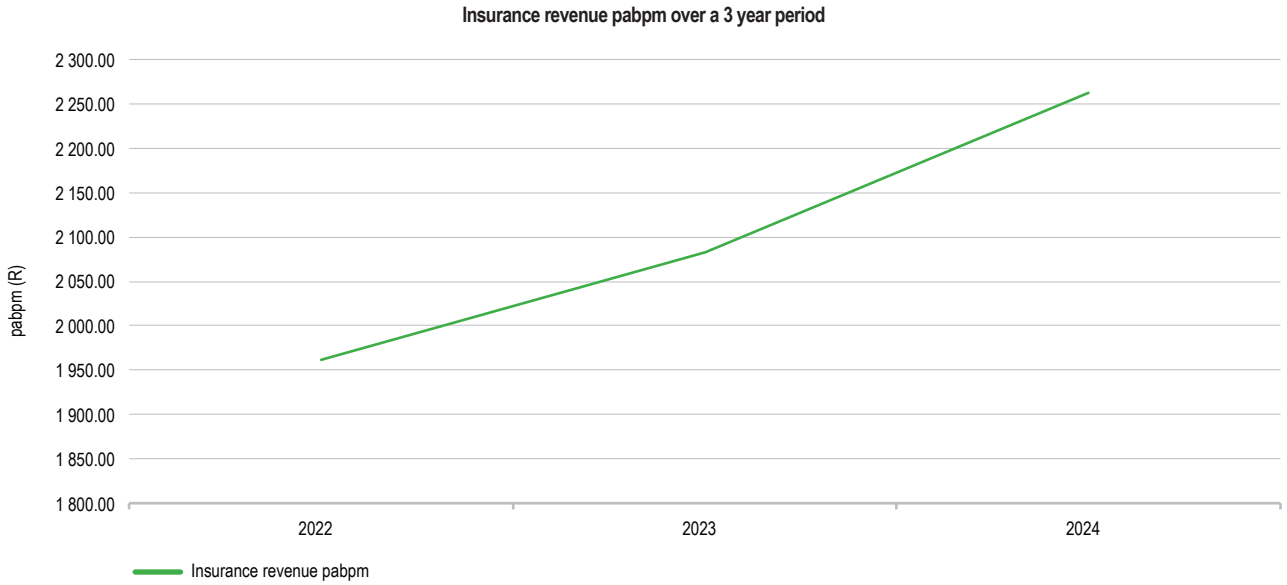


Figure 4: Insurance revenue per average beneficiary per month over a three year period

pabpm = per average beneficiary per month

Insurance revenue per average beneficiary per month increased by 8.65% from R2 082.78 in 2023 to R2 262.90 in 2024. This is higher than the average CPI of 4.40% (as published by Statistics South Africa (Stats SA) in its *Table B2 – CPI headline year-on-year rates)* for the year.

Schemes implemented contribution increases below consumer inflation in 2021 and 2022. This was the result of a collaborative effort between the CMS and the industry, aimed to provide financial relief to members during the economic downturn. Schemes could implement these interventions due to reserves built-up during the 2020 Covid-19 pandemic.

Schemes started correcting the pricing of their products by implementing higher contribution increases in 2023 and 2024. It is important to note that due to, *inter alia*, affordability constraints, the under-pricing will be addressed over a period of time (meaning higher increases than CPI are expected in the coming years).

Relevant healthcare expenditure

Relevant healthcare expenditure comprises of:

- Net claims incurred
- Accredited managed healthcare services (no transfer of risk)
- Net income/(expense) from reinsurance contracts held (i.e. risk transfer arrangements)

The total relevant healthcare expenditure incurred by medical schemes increased by 9.81% from R213.69 billion in 2023 to R234.64 billion.

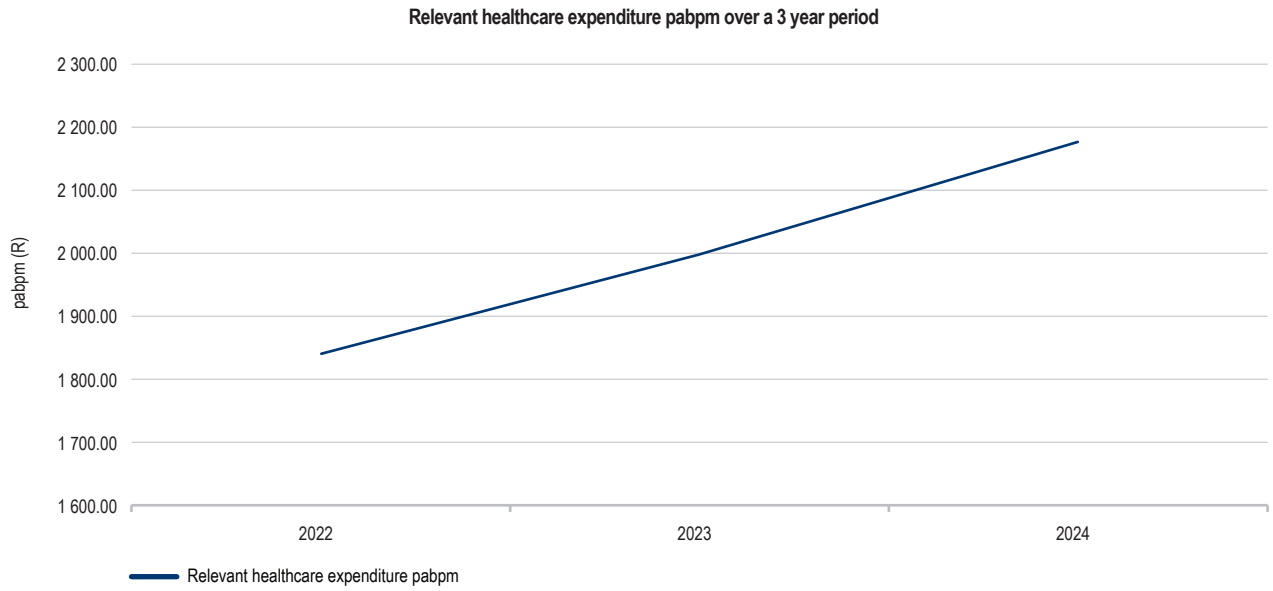


Figure 5: Relevant healthcare expenditure per average beneficiary per month over a three year period

pabpm = per average beneficiary per month

Relevant healthcare expenditure per average beneficiary per month increased by 9.03% from R1 996.17 in 2023 to R2 176.35 in 2024. This exceeded the increase of 8.65% in the insurance revenue pabpm, and the average CPI of 4.40%.

The increase is correlated to changes in tariffs and utilisation. For a more detailed analysis of the underlying components, kindly refer to the Healthcare Utilisation Industry Report for 2024.

Tariffs

Historically, tariffs were determined through central negotiations between the South African Medical Association (SAMA) and the Board of Healthcare Funders (BHF). This practice ended in 2003 following the Competition Commission's prohibition of collective bargaining under the Competition Act. Since then, tariffs are set bilaterally, which has raised concerns about transparency and consistency.

The Health Market Inquiry (HMI) Final Report (September 2019) recommended, among other measures, the establishment of a multilateral negotiating framework for reference tariffs, a national maximum tariff for Prescribed Minimum Benefits (PMBs), and a shift towards Alternative Reimbursement Models. It also highlighted the need for a supply-side regulator.

On 14 February 2025, the Minister of Trade, Industry and Competition published Government Gazette No. 52111, inviting public comment on the draft Interim Block Exemption for Tariffs Determination in the Healthcare Sector. The proposed exemption would allow collective determination of tariffs, coding standards, and quality metrics for both PMBs and non-PMBs, under a structured framework involving a Tariffs Governing Body and a Multilateral Negotiating Forum. The exemption is intended to apply for three years, subject to extension.

The CMS supports the development of a multilateral pricing negotiation framework as a tool to enhance transparency and ensure the sustainability of medical schemes.

Utilisation

The CMS continues to monitor market dynamics, including an ageing membership base, benefit option proliferation, and rising healthcare costs. In 2024, medical scheme membership grew by only 0.56%, while the average age increased by 0.29 years, contributing to higher utilisation rates.

The CMS awaits the outcome of the National Department of Health's (NDoH) review of the Low-Cost Benefit Options (LCBO) framework and is monitoring related legal proceedings, including the BHF appeal following the High Court's dismissal of its application in April 2025.

A notable trend in 2024 was a significant increase in in-hospital cost per event, which seems to be driven by supplier-induced demand. Many scheme rules provide for fully funded baskets of care for pre-authorised admissions, and increased utilisation of services unrelated to the primary reason for admission has been observed.

The CMS and NDoH are collaborating on the development of a standardised benefit package and the review of PMBs which is focused on establishing, costing and implementing a Primary Healthcare (PHC) package of services as part of the PMBs. Efforts are also underway to align the CMS PHC package with the NDoH NHI PHC draft package. Updates on these initiatives are available on the CMS website under the Media Centre.

Relationship between contributions and relevant healthcare expenditure

Figure 6 shows the relationship between insurance revenue and relevant healthcare expenditure paid over the past three years.

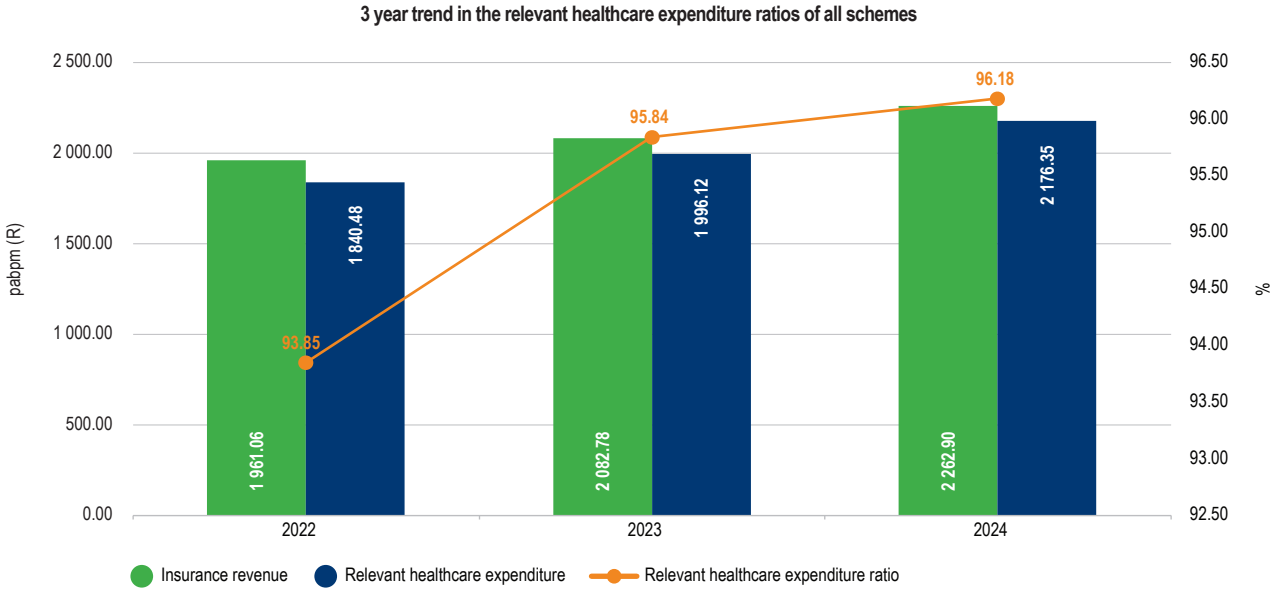


Figure 6: Three year trend in the relevant healthcare expenditure ratios of all schemes

pabpm = per average beneficiary per month

Further releases in pent-up demand and utilisation increases due to an ageing population, and previous lower contribution increases to aid members during the economic downturn, resulted in an increased relevant healthcare expenditure ratio. 2024 saw an increase of 0.35% in the relevant healthcare expenditure ratio to 96.18%. This is significantly higher than the pre-Covid 19 pandemic ratios of 90.23% and 90.58% in 2018 and 2019, respectively. Significant repricing and benefit adjustments are therefore needed.

Figure 7 clearly illustrates the seasonality of claims for the past two years. The same trend was observed in both years: an increase in relevant healthcare expenditure in the first quarter of the year as members gain access to new benefits, increases in relevant healthcare expenditure over the winter months, and a downward trend in the last quarter of the year.

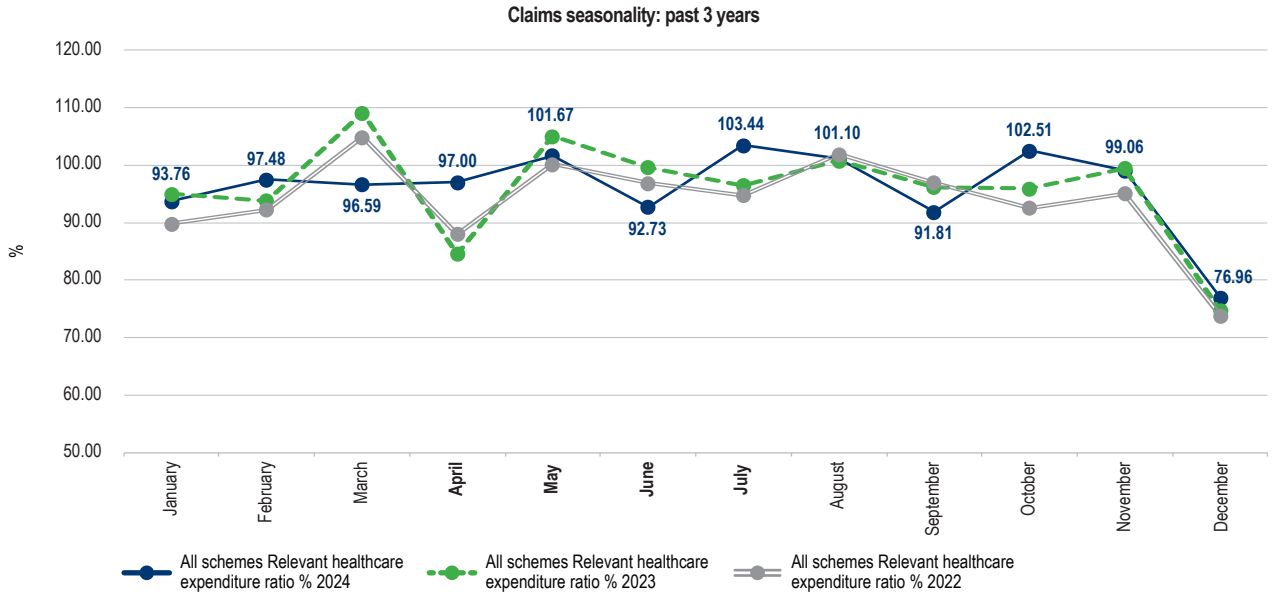


Figure 7: Seasonality of relevant healthcare expenditure for the past three years

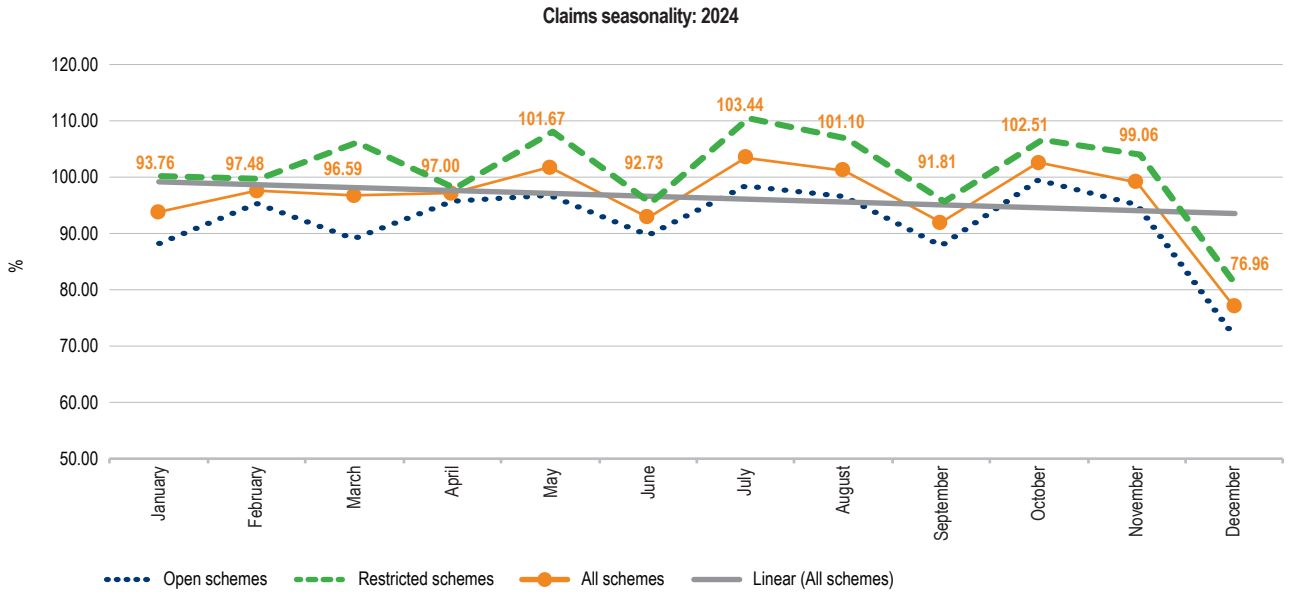


Figure 8: Seasonality of relevant healthcare expenditure for 2024

Both open and restricted schemes follow the same general trend. The trend is however more pronounced in the open scheme industry.

The restricted scheme industry's relevant healthcare ratios are significantly impacted by the claims experience of Government Employees Medical Scheme's (GEMS). The scheme's Board of Trustees made a strategic decision to wind down the scheme's reserves to a lower solvency level, which, together with the higher utilisation noted across the industry, resulted in an increased relevant healthcare expenditure ratio due to the inherent under-pricing.

The top ten schemes with the highest relevant healthcare expenditure ratios for both open and restricted schemes in 2024 are shown in Tables 1 and 3 below.

Table 1: Ten open schemes with highest relevant healthcare expenditure ratios

Ref. no.	Name of medical scheme	Relevant healthcare expenditure ratio		Average age per beneficiary		Solvency	
		2024	2023	2024	2023	2024	2023
Open scheme industry average		*91.91*	*93.41*	*36.77*	*36.35*	*33.36*	*34.28*
1464	Suremed Health	123.04	101.18	46.48	40.87	105.27	110.11
1034	Cape Medical Plan	102.06	106.34	45.56	44.41	58.79	71.58
1087	Keyhealth	97.62	98.16	40.81	40.75	35.67	43.10
1512	Bonitas Medical Fund	96.18	93.18	36.06	35.80	38.56	41.47
1202	Fedhealth Medical Scheme	95.46	98.02	42.74	42.53	32.33	36.09
1140	Medshield Medical Scheme	94.92	96.20	37.32	37.63	59.41	62.88
1491	Compcare Medical Scheme	94.88	102.30	42.14	41.75	21.83	25.14
1554	Genesis Medical Scheme	94.73	83.39	37.66	37.46	243.40	250.33
1506	Medimed Medical Scheme	94.55	99.46	32.43	32.22	87.84	93.32
1252	Bestmed Medical Scheme	94.24	95.58	36.79	36.88	33.23	36.89

Cape Medical Plan, Fedhealth Medical Scheme and Suremed Health experienced changes of more than 5.00% in their average membership during the year.

It is interesting to note that although all ten schemes' relevant healthcare expenditure ratios exceed the open scheme industry average of 91.91%, only Medimed Medical Scheme has an average age younger than that of the industry (32.43 years compared to the industry average of 36.77 years). Medimed Medical Scheme's high solvency of 87.84% allows the scheme more leeway to address any potential pricing deficits and to absorb high-cost claims.

The majority of the schemes listed in the table above are high impact schemes. The low number of members on Suremed and Cape Medical Plan exposes it to significant claims volatility risk.

Table 2 displays the percentage deviations from the industry averages of 93.41% for 2023 and 91.91% for 2024, highlighting open schemes that experienced increases in their relevant healthcare expenditure ratios in excess of 2.00% from 2023 to 2024.

Table 2: Relevant healthcare expenditure ratio: open schemes with a deviation of more than 2.00% from industry average

Ref. no.	Name of medical scheme	% change in relevant healthcare expenditure ratio	% deviation from average relevant healthcare expenditure ratio of 91.91	% deviation from average relevant healthcare expenditure ratio of 93.41
			2024	2023
1464	Suremed Health	21.61	33.87	8.32
1512	Bonitas Medical Fund	3.22	4.65	(0.25)
1554	Genesis Medical Scheme	13.60	3.07	(10.73)

All the schemes listed in Table 2 also feature on the list of the schemes with the highest relevant healthcare expenditure ratios (see Table 1). All these schemes have solvency ratios that are above the minimum required statutory level of 25.00%, which allow these schemes more leeway to address any potential pricing deficits and to absorb high-cost claims.

Suremed Health's small average membership of 1 406 beneficiaries results in it being subjected to increased claims volatility risk.

Table 3: Ten restricted schemes with highest relevant healthcare expenditure ratios

Ref. no.	Name of medical scheme	Relevant healthcare expenditure ratio		Average age per beneficiary		Solvency	
		2024	2023	2024	2023	2024	2023
Restricted scheme industry average		*101.26*	*98.75*	*32.07*	*31.83*	*50.52*	*56.68*
1270	Golden Arrow Employees' Medical Benefit Fund*	134.24	128.10	36.85	36.33	520.01	453.81
1068	De Beers Benefit Society	121.38	116.05	52.49	51.34	170.87	180.82
1186	PG Group Medical Scheme**	114.05	87.80	33.35	32.73	133.55	132.49
1012	Anglo Medical Scheme	112.63	112.38	41.36	41.48	491.54	475.04
1424	SABC Medical Aid Scheme	112.39	100.77	39.18	38.64	81.75	85.53
1441	Parmed Medical Aid Scheme	108.58	105.27	53.08	53.03	83.07	91.55
1559	Imperial and Motus Medical Aid	106.78	90.97	31.15	30.90	133.10	144.35
1197	Libcare Medical Scheme	106.41	101.54	35.51	34.78	94.30	104.64
1598	Government Employees Medical Scheme (GEMS)	106.18	102.35	31.77	31.51	31.15	42.42
1241	Multichoice Medical Aid Scheme	104.81	110.33	27.81	27.35	74.75	84.15

**Golden Arrow Employees' Medical Benefit Fund is a previous bargaining council scheme, and it has a PMB exemption.*

*** PG Group Medical Scheme was granted an exemption to provide a two-month contribution holiday to its members during 2024.*

Of the ten schemes whose relevant healthcare expenditure ratio exceeds the restricted scheme industry average of 101.26%, only Imperial and Motus Medical Aid Scheme, GEMS and Multichoice Medical Aid Schemes' average ages are younger than that of the industry (31.15 years, 31.77 years and 27.81 years respectively, compared to the industry average of 32.07 years).

Anglo Medical Scheme has previously entered into an arrangement with the participating employer groups to receive funding to cover both the ongoing and the future costs of providing benefits for its higher than usual proportion of pensioner members.

De Beers Benefit Society and GEMS experienced membership changes of around 5.00% during the year, which deteriorated their demographic profiles.

All the listed schemes, except for GEMS, have low average membership figures, exposing them to significant claims volatility.

All the schemes listed have solvency levels exceeding the minimum required level of 25.00%, which allows them more leeway to address any potential pricing deficits and absorb high-cost claims.

GEMS' high relevant healthcare expenditure ratio is attributable to various factors such as the scheme's long-term strategy to reduce the scheme's reserves to a lower solvency level, increased take-up of lower benefit options and increased in-hospital costs per event.

Table 4 shows the percentage deviation from the industry average of 98.75% and 101.26% for 2023 and 2024 respectively, for restricted schemes, that experienced increases in excess of 5.00% in their relevant healthcare expenditure ratios from 2023 to 2024.

Table 4: Relevant healthcare expenditure ratio: restricted schemes with a deviation of more than 5.00% from industry average

Ref. no.	Name of medical scheme	% change in relevant healthcare expenditure ratio	% deviation from average relevant healthcare expenditure ratio of 101.26	% deviation from average relevant healthcare expenditure ratio of 98.75
			2024	2023
1186	PG Group Medical Scheme*	29.90	12.63	(11.09)
1424	SABC Medical Aid Scheme	11.53	10.99	2.05
1559	Imperial and Motus Medical Aid	17.38	5.45	(7.88)
1590	Building & Construction Industry Medical Aid Fund	6.31	0.83	(2.74)
1568	Sisonke Health Medical Scheme	7.10	0.68	(3.61)
1430	Remedi Medical Aid Scheme**	8.96	0.43	(5.48)

**PG Group Medical Scheme was granted an exemption to provide a two-month contribution holiday to its members during 2024.*

***Remedi Medical Aid Scheme was granted an exemption to provide a one-month contribution holiday to its members during 2024.*

Compared to open schemes, more restricted schemes experienced increases in their relevant healthcare expenditure ratios.

Half of the schemes listed in Table 4 (PG Group Medical Scheme, SABC Medical Aid Scheme and Imperial and Motus Medical Aid) also feature on the list of schemes with the highest relevant healthcare expenditure ratios (see Table 3).

All the schemes, with the exception of Remedi Medical Aid Scheme, have low average membership figures, exposing them to significant claims volatility risk.

Sisonke Health Medical Scheme experienced a membership loss of almost 10.00%, which resulted in a deterioration of its demographic profile.

Relevant healthcare expenditure pabpm

When adjusted to lives, relevant healthcare expenditure increased by 8.67% to R2 204.02 pabpm in the open scheme industry and by 9.50% to R2 147.18 pabpm in the restricted scheme industry.

The two tables below (Table 5 and Table 6) depict the data of the ten schemes with the highest relevant healthcare expenditure incurred pabpm per industry. Schemes with demographic profiles worse than the industry average were highlighted.

Table 5: Ten open schemes with the highest relevant healthcare expenditure incurred pabpm

Ref. no.	Name of medical scheme	Average beneficiaries	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure incurred		Insurance service result
		31 Dec 2024	Years	%	pabpm	As % of IR	R'000
1464	Suremed Health	1 406	46.48	26.85	3 277.74	123.04	(13 325)
1087	Keyhealth	72 130	40.81	20.40	2 787.66	97.62	(109 490)
1202	Fedhealth Medical Scheme	102 818	42.74	22.60	2 587.42	95.46	(122 028)
1491	Compcare Medical Scheme	26 589	42.14	21.31	2 505.55	94.88	(34 082)
1034	Cape Medical Plan	6 569	45.56	24.58	2 491.61	102.06	(24 485)
1512	Bonitas Medical Fund	727 946	36.06	11.46	2 299.95	96.18	(831 788)
1252	Bestmed Medical Scheme	250 320	36.79	12.71	2 272.92	94.24	56 981
1140	Medshield Medical Scheme	138 538	37.32	13.65	2 227.67	94.92	(145 239)
1125	Discovery Health Medical Scheme	2 727 318	36.67	12.08	2 223.74	90.21	(164 711)
1149	Medihelp	207 794	38.45	15.62	2 145.15	94.10	1 983

pabpm = per average beneficiary per month

IR = Insurance Revenue

The majority of the schemes depicted in the table above have average ages and pensioner ratios which are above the open scheme industry averages of 36.77 years and 12.46%. The relevant healthcare expenditure incurred pabpm of these schemes (except for Medihelp) are also higher than the open scheme industry average of R2 204.02 pabpm.

Only two schemes' (Bonitas Medical Fund and Discovery Health Medical Scheme) demographic profiles have averages younger than the industry average. The relevant healthcare expenditure ratio of Discovery Health Medical Scheme is below the open scheme industry average of 91.91%.

Bonitas Medical Fund's relevant healthcare expenditure ratio of 96.18% is very high, but it is the result of a deliberate strategy to ensure affordability, and to increase benefits (with a focus on preventative healthcare). The relevant healthcare expenditure ratio does not materially deviate from its budget.

Suremed Health's relevant healthcare expenditure ratio increased by more than 20.00%. The scheme's small average membership of 1 406 beneficiaries subjects it to a high claims volatility risk.

Table 6: Ten restricted schemes with the highest relevant healthcare expenditure incurred pabpm

Ref. no.	Name of medical scheme	Average beneficiaries	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure incurred		Insurance service result
		31 Dec 2024	Years	%	pabpm	As % of IR	R'000
1441	Parmed Medical Aid Scheme	4 178	53.08	36.94	6 791.61	108.58	(34 494)
1237	BP Medical Aid Society	1 787	60.22	53.88	4 902.26	99.72	(2 264)
1068	De Beers Benefit Society	7 636	52.49	41.87	4 668.29	121.38	(96 415)
1424	SABC Medical Aid Scheme	7 826	39.18	18.84	3 404.31	112.39	(46 471)
1005	AECI Medical Aid Society	10 867	39.17	21.42	3 337.49	101.17	(15 814)
1012	Anglo Medical Scheme	17 413	41.36	23.04	3 175.08	112.63	(96 109)
1507	Barloworld Medical Scheme	8 993	33.44	11.30	3 121.07	97.16	(2 720)
1544	Consumer Goods Medical Scheme	8 929	39.26	16.22	3 111.71	97.88	(7 154)
1572	Engen Medical Benefit Fund	5 623	43.00	21.77	3 035.75	89.55	13 816
1197	Libcare Medical Scheme	10 849	35.51	10.34	2 872.64	106.41	(38 640)

pabpm = per average beneficiary per month
IR = Insurance Revenue

All listed schemes' demographic profiles are higher than the restricted scheme industry average. These schemes also have very small risk pools, which result in increased claims volatility. The relevant healthcare expenditure incurred pabpm of all these schemes are in general higher than the figures incurred in the open scheme environment (barring the expenditure incurred by Suremed Health).

Some of these schemes' insurance service results are close to reaching the break-even point, which suggests that they are appropriately priced for their risk profile.

Engen Medical Benefit is the only scheme that incurred an insurance service surplus. The scheme's relevant healthcare expenditure ratio is lower than the restricted scheme industry average of 101.26%.

De Beers Benefit Society receives an annual employer grant that is recognised as other income (i.e. below the insurance service result level).

Anglo Medical Scheme has previously entered into an arrangement with the participating employer groups to receive funding to meet the ongoing and future cost of providing benefits for its higher than usual proportion of pensioner members.

SABC Medical Aid Scheme experienced an increase in excess of 10.00% in their relevant healthcare expenditure ratio, suggesting adverse experience during 2024.

Liability for incurred claims

The liability for incurred claims (previously known as the outstanding claims provision) is a provision made for the estimated cost of healthcare benefits incurred before the end of the accounting period but that have not been reported to the medical scheme by that date. This provision is determined as accurately as possible by evaluating several factors, which may include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to gender and age, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. The major change brought by the implementation of IFRS 17 Insurance contracts is the introduction of a risk adjustment for non-financial risks. The purpose of the risk adjustment is to allow for uncertainty in the estimated future cash flows related to the claims provision (i.e. the introduction of probability). In accordance with the requirements of Regulation 6 to the MSA, members and providers have at a minimum four months (a longer period might be determined by Scheme Rules) to submit their account or statements. Generally medical schemes therefore have a short run-off period after the service date, resulting in a limited variability in the future cash flows.

Different models (or a blend thereof) are typically used to determine the liability for incurred claims, and include *inter alia*:

- The Basic Chain Ladder (BCL) method involves using run-off triangles constructed using treatment periods (typically months) as origin periods and analysing the development of payments per period. Development factors that are weighted by the cumulative claims values from which they arise are used. The key assumption is that for each origin period, the expected amount of claims paid in each development period is a constant proportion of the total claims for that origin period. The development factors are then applied to claims which have already been observed to determine the amount of the reserve needed.
- The Cost Per Event method (CPE) makes use of an estimate for the cost per event combined with the known number of pre-authorisations (less the expected number of authorisations that do not lead to an event) and considers the expected case-mix of events to estimate the ultimate claims liability.
- The Bornhuetter-Ferguson method (BFM) produces an estimate that considers a balance between a pure Chain Ladder Method approach and consideration of expected claims volumes and seasonality. The primary assumption is that patterns in claims activities and the rate of claims payment in the past will continue to be seen in the future. The method is typically employed for the last months in the financial year, which are the most sensitive to the run-off factors.
- A two parameter Weibull Distribution, which is fitted to the run-off factors and considering a Monte Carlo Simulation.
- The risk adjustment is typically determined at a specific confidence level via a Bootstrapping approach, a Value-at-Risk method or a standard deviation method. The CMS has observed that medical schemes' risk adjustment was in general determined at a 75.00% confidence level.
- Back testing is then performed whereby the scheme considers the claims processed in 2025 in respect of services provided in 2024 to consider the need for disclosure should there be a material difference with the actual payments and the provision as at 31 December.

The final risk adjustment values varied significantly from 0.00% to almost 75.00% of the liability for incurred claims. Risk adjustments greater than 13.00% was due to confidence levels typically exceeding 75.00%, and schemes with smaller and older populations which are exposed to claims volatility. The following are examples of schemes with higher confidence levels, and the effect of their risk adjustment:

- Bonitas Medical Fund with a risk adjustment of 13.65% used a confidence level of 90.00%
- CAMAF with a risk adjustment of 32.60% used a confidence level of 85.00%
- Massmart Health Plan with a risk adjustment 74.81% used a confidence level of 95.00%
- MBMed Medical Aid Fund with a risk adjustment 14.67% used a confidence level of 85.00%
- Parmed Medical Aid Scheme with a risk adjustment 14.97% used a confidence level of 85.00%.

The prior year's liability utilised is determined by dividing the payments made in respect of the previous year by the liability at the beginning of the year. This percentage indicates how accurate and complete these factors were considered in the estimation of the liability for incurred claims figure. Percentages exceeding 100.00% might indicate a deliberate attempt to address financial soundness concerns by understating the provision. It should however be noted that IFRS 17 required retrospective implementation, which resulted in the previous year's liability being restated.

Table 7 depicts the open schemes whose prior year's liability utilised exceeded 105.00%.

Table 7: Open schemes with under-provisions greater than 5.00% of previous year's claims

Ref. no.	Name of medical scheme	Name of administrator	Actuary	Model used*	Average beneficiaries	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure		Prior year claims provision utilised
			2024		31 Dec 2024	Years	%	pabpm	As % of IR	%
1252	Bestmed Medical Scheme	Self-Administered	Insight Actuaries and Consultants	Chain Ladder Model	250 320	36.79	12.71	2 272.92	94.24	114.74
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	NMG Consultants and Actuaries (Pty) Ltd	Chain Ladder Model	72 130	40.81	20.40	2 787.66	97.62	114.41
1149	Medihelp	Self-Administered	3ONE Consulting Actuaries	Bornhuetter-Ferguson method	207 794	38.45	15.62	2 145.15	94.10	107.90
1592	Thebemed	Momentum Thebe Ya Bophelo (Pty) Ltd	Momentum Health Solutions (Pty Ltd - actuarial division	Chain Ladder Model	23 473	30.24	0.41	1 186.38	83.53	105.09

**Based on details provided in Part 1.4 Question 12(b) of the FASR. When compared to the disclosure contain in AFS, this represents a very high level summary of the method, and in some instance secondary model information had been omitted.*

pabpm = per average beneficiary per month

IR = Insurance Revenue

All four schemes listed in the table above employed different actuarial firms to calculate their IBNR.

Table 8 depicts the restricted schemes whose prior year's liability utilised exceeded 105.00%.

Table 8: Restricted schemes with under-provisions greater than 5.00% of previous year's claims

Ref. no.	Name of medical scheme	Name of administrator	Actuary	Model used*	Average beneficiaries	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure		Prior year claims provision utilised
			2024		31 Dec 2024	Years	%	pabpm	As % of IR	%
1201	Rand Water Medical Scheme	Afrocentric Integrated Health Administrators (Pty) Ltd	Insight Actuaries and Consultants	Chain Ladder Model	9 255	31.18	5.82	2 717.91	95.87	147.68
1214	Old Mutual Staff Medical Aid Fund	Universal Healthcare Administrators (Pty) Ltd	Universal Healthcare Services (Pty) Ltd	Chain Ladder Model	29 124	35.96	11.07	2 117.06	96.51	107.03
1086	Foodmed Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	NMG Consultants and Actuaries (Pty) Ltd	Monte Carlo simulation	16 855	31.78	2.91	115.44	67.19	105.96
1068	De Beers Benefit Society	Self-Administered	Insight Actuaries and Consultants	Health Monitor Model (the model combines traditional chain ladder techniques and the Bornhuetter-Ferguson method)	7 636	52.49	41.87	4 668.29	121.38	105.12

**Based on details provided in Part 1.4 Question 12(b) of the FASR. When compared to the disclosure contained in the AFS, this represents a very high level summary of the method, and in some instance secondary model information had been omitted.*

pabpm = per average beneficiary per month

IR = Insurance Revenue

*** Foodmed Medical Scheme is a previous bargaining council scheme and has a PMB exemption.*

Four low impact restricted schemes were identified in the table above. Lower membership results in greater claims volatility, which would impact the prior year's liability for incurred claims.

Own facilities

Only two schemes operated own facilities during the year under review:

- Platinum Health Medical Scheme entered into capitation fee contracts with a number of participating employer groups to render work-based health services to the employees and contractors of the employer groups. The services are rendered at the participating employer groups' premises, and include occupational health care, rehabilitation and functional assessment, curative care and trauma emergency services.
- Sisonke Health Medical Scheme operated medical centres.

Accredited managed healthcare services (no transfer of risk)

Managed healthcare principles are utilised to ensure that medical scheme members receive appropriate and cost-effective healthcare within the constraints of what is affordable. These principles also address abuse and over-utilisation of services. These interventions can take various forms, such as evidence-based clinical protocols, medicine formularies, funding guidelines, and managed care provider networks.

Accredited managed healthcare services increased by 7.67% from R5.74 billion in 2023 to R6.18 billion in 2024. In 2024, 4 076 137 members (99.11% of the total scheme membership) were covered by these managed healthcare arrangements.[1] Kindly refer to Annexure K for more information on the individual arrangements per scheme, and Annexure O for more information on the demographic profile of the options which had managed care arrangements.

This report does not address the value proposition of these arrangements.

Table 9 provides the breakdown of the components of the accredited managed healthcare services fees (no transfer of risk) paid by the industry.

Table 9: Breakdown of the main components of accredited managed healthcare services fees

Components of accredited managed healthcare services	Open schemes % of total fee	Restricted schemes % of total fee
Active disease risk management services	28.00	13.82
Disease risk management support services	0.58	10.05
Dental benefit management services	1.03	4.79
Hospital benefit management services	33.22	16.95
Managed care network management services and risk management	23.41	43.72
Pharmacy benefit management services	13.77	10.67

No correlation in the breakdown between the services provided by the open and restricted industries were observed. This is due to the different demographic profiles (open medical schemes generally have older members with higher chronicity) and benefit designs (restricted schemes generally have richer benefits) utilised by the two industries.

Generally, open medical schemes spent more on hospital benefit management services, active disease risk management services, and managed care network management services and risk management services.

The provision of managed care network management services and risk management services represents the biggest component (43.72%) of the total fee in respect of restricted schemes.

Annexures J and K contain more information on the different contracts, as well as the breakdown of the services, contracted by medical schemes.

Table 10 depicts the ten largest schemes (by number of average beneficiaries) and shows their total expenditure on accredited managed healthcare services. The industry-accredited managed healthcare services average was 2.64% of IR. It should be noted that the high relevant healthcare expenditure ratios are a function of sub-inflation contribution increases registered post the Covid 19-pandemic and the increased utilisation with the release of pent-up demand, rather than a reflection of the value added by these arrangements.

1 Kindly note that where schemes did not provide information on the number of members contracted per individual managed care arrangement, the total number of scheme members was used as proxy. More detail is contained in Annexure K.

Table 10: Accredited managed healthcare services (no transfer of risk) of the ten largest schemes

Ref. no.	Name of medical scheme	Type	Average beneficiaries	Relevant healthcare expenditure ratio	Accredited managed healthcare services	
					as % of IR	pmpm
1125	Discovery Health Medical Scheme	Open	2 727 318	90.21	2.98	147.46
1598	Government Employees Medical Scheme (GEMS)	Restricted	2 329 344	106.18	2.23	122.19
1512	Bonitas Medical Fund	Open	727 946	96.18	3.18	154.25
1580	South African Police Service Medical Scheme (POLMED)	Restricted	494 899	94.83	1.68	98.99
1167	Momentum Medical Scheme	Open	285 489	88.08	3.63	122.83
1252	Bestmed Medical Scheme	Open	250 320	94.24	2.34	116.11
1279	Bankmed	Restricted	221 545	102.42	2.67	123.19
1145	LA-Health Medical Scheme	Restricted	274 237	88.38	2.14	94.46
1149	Medihelp	Open	207 794	94.10	1.22	60.58
1140	Medshield Medical Scheme	Open	138 538	94.92	1.37	62.37

IR = Insurance Revenue

pmpm = per member per month

The pmpm-data for the 2024 year is skewed to some extent, as not all schemes provided information on the number of members and beneficiaries covered by each arrangement. Where no data had been provided, the number of members per scheme was used as a proxy. Kindly refer to Annexure K, where an indication was made of whether actual data or proxy data was used.

Table 11 provides the breakdown of the components of the accredited managed healthcare services fees (no transfer of risk) paid by open medical schemes whose fees exceed the industry average of R136.51 per member per month (pmpm).

Table 11: Open schemes with fees paid to accredited managed healthcare service providers that exceeds the industry average pmpm

Ref. no.	Name of Scheme	Average members	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Fee paid in respect of accredited managed healthcare services		Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				%	% of IR	% of IR	pmpm R	%	%	%	%	%	%
1512	Bonitas Medical Fund	356 713	36.06	11.46	96.18	3.18	154.25	28.97	-	3.55	34.26	16.46	16.77
1087	Keyhealth	34 292	40.81	20.40	97.62	2.45	147.95	8.44	-	-	75.52	9.25	6.79
1125	Discovery Health Medical Scheme	1 351 211	36.67	12.08	90.21	2.98	147.46	31.69	-	-	29.97	28.38	9.97

pmpm = per member per month

IR = Insurance Revenue

Of the schemes listed in Table 11, only Keyhealth' s demographic profile is worse than the industry average (36.77 years per beneficiary and pensioner ratio of 12.46%).

Discovery Health Medical Scheme is the only scheme whose relevant healthcare expenditure ratio is lower than the industry average of 91.91%.

Table 12 provides the breakdown of the components of the accredited managed healthcare services fees (no transfer of risk) paid by restricted medical schemes whose fees exceed the industry average of R111.00 per member per month (pmpm). The table contains data on the ten schemes with the highest expenditure.

Table 12: Restricted schemes with fees paid to accredited managed healthcare service providers that exceeds the industry average pmpm

Ref. no.	Name of Scheme	Average members	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Fee paid in respect of accredited managed healthcare services		Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				%	% of IR	% of IR	pmpm R	%	%	%	%	%	%
1465	Alliance-Midmed Medical Scheme	1 649	34.79	8.66	98.64	3.12	196.56	86.03	-	-	-	-	13.97
1194	Profmed	34 209	42.31	21.61	90.49	2.71	167.79	8.32	-	2.79	69.71	-	19.18
1424	SABC Medical Aid Scheme	3 842	39.18	18.84	112.39	2.66	165.44	22.00	-	2.53	35.47	26.17	13.83
1507	Barloworld Medical Scheme	3 989	33.44	11.30	97.16	2.17	160.28	27.36	-	3.00	46.17	7.00	16.46
1237	BP Medical Aid Society	1 032	60.22	53.88	99.72	1.70	150.27	36.64	-	3.01	22.83	13.03	24.50
1039	MBMed Medical Aid Fund	3 746	30.54	7.55	93.34	2.47	146.59	19.99	-	3.19	45.11	13.27	18.44
1597	Umvuzo Health Medical Scheme	52 657	31.31	0.80	86.55	4.18	144.26	32.13	-	-	57.69	-	10.18
1544	Consumer Goods Medical Scheme	4 381	39.26	16.22	97.88	2.11	137.91	2.38	30.90	-	33.36	8.44	24.93
1531	Sedmed	1 068	45.47	25.46	97.34	2.31	137.61	-	-	-	55.22	-	44.84
1520	University of KwaZulu-Natal Medical Scheme	3 237	44.32	23.34	92.83	2.55	137.46	31.99	-	-	31.01	27.00	10.00

pmpm = per member per month

IR = Insurance Revenue

The majority of the schemes' (listed in Table 12) demographic profile is worse than the industry average (average age of 32.07 years per beneficiary and pensioner ratio of 7.38%).

Alliance-Midmed Medical Scheme outsourced some of their accredited managed healthcare services from 1 January 2024. The scheme also obtained accreditation as an accredited managed healthcare service provider on 1 April 2024. The accreditation resulted in the salaries paid to internal staff for purposes of providing these services, being reallocated from administration expenditure to accredited managed healthcare services.

Tables 13 and 14 lists the most expensive accredited managed healthcare service arrangements on a per member per month basis, split per industry. Details of the services contracted are also provided.

The pmpm- data for the 2024 year is skewed to some extent, as not all schemes provided information on the number of members and beneficiaries covered by each arrangement. Where no data had been provided, the number of members per scheme was used as a proxy. Kindly refer to Annexure K, where an indication was made of whether actual data or proxy data was used.

Table 13: Open schemes: ten most expensive accredited managed healthcare service arrangements pmpm

Ref. no.	Name of Scheme	Accredited managed care organisation	Members	Fee paid in respect of accredited managed healthcare services	Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				pmpm R	%	%	%	%	%	%
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 359 379	147.46	31.69	-	-	29.97	28.38	9.97
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 154	137.91	9.05	-	-	81.02	9.93	-
1512	Bonitas Medical Fund	Private Health Administrators (Pty) Ltd	54 162	136.00	40.48	-	-	31.31	12.89	15.32
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	304 555	131.91	21.21	-	-	41.44	17.06	20.29
1512	Bonitas Medical Fund	Alignd (Pty) Ltd	10 057	129.59	-	-	-	-	100.00	-
1167	Momentum Medical Scheme	Momentum Health (Pty) Ltd	154 685	122.19	19.28	8.26	4.89	39.51	15.70	12.36
1202	Fedhealth Medical Scheme*	Medscheme Holdings (Pty) Ltd	56 018	113.82	15.11	-	0.69	45.51	20.45	18.25
1491	Compcare Medical Scheme*	Universal Care (Pty) Ltd	17 357	107.82	6.22	13.58	1.26	28.47	36.08	14.40
1506	Medimed Medical Scheme	Momentum Thebe Ya Bophelo (Pty) Ltd	6 126	97.03	21.31	-	-	45.60	-	33.07
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	687	75.21	4.35	-	-	49.35	-	46.29

pmpm = per member per month

** No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

The majority of the contracts listed above makes provision for the delivery of multiple services. Only one contract, Alignd (Pty) Ltd, the provider of which is not related to any accredited administrator, makes provision for the delivery of a single service.

Table 14: Restricted schemes: ten most expensive accredited managed healthcare service arrangements pmpm

Ref. no.	Name of Scheme	Accredited managed care organisation	Members	Fee paid in respect of accredited managed healthcare services	Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				pmpm R	%	%	%	%	%	%
1566	Horizon Medical Scheme	Aid for Aids Management (Pty) Ltd	28	1 110.12	100.00	-	-	-	-	-
1507	Barloworld Medical Scheme	Aid for Aids Management (Pty) Ltd	219	404.49	100.00	-	-	-	-	-
1237	BP Medical Aid Society*	Momentum Health (Pty) Ltd	996	149.43	36.23	-	3.02	22.96	13.10	24.64
1424	SABC Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	3 809	149.16	13.49	-	2.80	39.34	29.03	15.34
1597	Umvuzo Health Medical Scheme	RX Health (Pty) Ltd	53 237	144.26	32.13	-	-	57.69	-	10.18
1507	Barloworld Medical Scheme	Medscheme Holdings (Pty) Ltd	3 914	137.63	15.41	-	3.50	53.77	8.15	19.17
1520	University of Kwa-Zulu Natal Medical Scheme*	Discovery Health (Pty) Ltd	3 224	137.46	31.99	-	-	31.01	27.00	10.00
1526	BMW Employees Medical Aid Society	Discovery Health (Pty) Ltd	2 752	137.20	30.99	-	-	32.00	26.99	10.00
1547	Malcor Medical Scheme	Discovery Health (Pty) Ltd	4 538	136.11	31.04	-	-	31.98	26.98	10.00
1465	Alliance-Midmed Medical Scheme	Self-administered scheme: in-house managed healthcare	1 684	135.94	100.00	-	-	-	-	-

pmpm = per member per month

** No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

Generally, contracts that only cover members affected by a specific disease, are more expensive than those which is signed at a scheme level due to the volume discounts that are applied.

A huge variation in the fees charged by Aid for Aids Management (Pty) Ltd to different schemes were noted (also refer to Table 17). The fee structure is dependent on a number of factors such as the scheme size, demographics and risk profile, HIV prevalence, and the scope of work included in the contract.

Per the data included in Table 14, only the two self-administered schemes have contracts with entities that are not related to accredited administrators.

Table 15 provides the breakdown of the components of the accredited managed healthcare services fees (no transfer of risk) paid by ten open medical schemes with the highest accredited managed healthcare services fees pmpm paid to its administrator and its related parties.

Table 15: Ten open schemes with highest fees paid to its administrator and related parties in respect of accredited managed healthcare services pmpm

Ref. no.	Name of Scheme	Name of administrator	Average members	Fee paid in respect of accredited managed healthcare services	As % of total fees paid to accredited MCOs	Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				pmpm R	%	%	%	%	%		
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 351 211	148.35	100.00	31.69	-	-	29.97	28.38	9.97
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	356 713	147.75	80.78	29.19	-	-	37.25	15.33	18.23
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 292	137.91	93.21	9.05	-	-	81.02	9.93	-
1512	Bonitas Medical Fund	Private Health Administrators (Pty) Ltd	54 162	136.00	13.31	40.48	-	-	31.31	12.89	15.32
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	56 917	125.72	100.00	24.36	-	0.61	40.55	18.22	16.26
1167	Momentum Medical Scheme	Momentum Health (Pty) Ltd	152 638	123.83	99.48	19.28	8.26	4.89	39.51	15.70	12.36
1491	Compcare Medical Scheme*	Universal Healthcare Administrators (Pty) Ltd	17 927	107.82	100.00	6.22	13.58	1.26	28.47	36.08	14.40
1506	Medimed Medical Scheme	Momentum Thebe Ya Bophelo (Pty) Ltd	6 226	97.03	100.00	21.31	-	-	45.60	-	33.07
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	771	75.21	78.95	4.35	-	-	49.35	-	46.29
1252	Bestmed Medical Scheme	Self-Administered	119 896	71.17	60.38	12.56	-	-	50.48	13.58	23.39

pampm = per average member per month

** No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

The open scheme industry average for accredited managed healthcare services fees paid to scheme administrators and their related parties is R135.72 pmpm. Only three schemes listed in Table 15 exceed the industry average in respect of their core administrator. The contracts with administrators and their related parties represent 80.78% or more of these schemes' total expenditure in this regard.

Table 16 provides the breakdown of the components of the accredited managed healthcare services fees (no transfer of risk) paid by ten restricted medical schemes with the highest accredited managed healthcare services fees pmpm paid to its administrator and its related parties.

Table 16: Ten restricted schemes with highest fees paid to its administrator and related parties in respect of accredited managed healthcare service pmpm

Ref. no.	Name of Scheme	Name of administrator	Average members	Fee paid in respect of accredited managed healthcare services	As % of total fees paid to accredited MCOs	Active disease risk management services	Disease risk management support services	Dental benefit management services	Hospital benefit management services	Managed care network management services and risk management	Pharmacy benefit management services
				pmpm R	%	%	%	%	%	%	%
1424	SABC Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	3 842	164.02	100.00	22.00	-	2.53	35.47	26.17	13.83
1507	Barloworld Medical Scheme	Medscheme Holdings (Pty) Ltd	3 989	157.27	100.00	27.36	-	3.00	46.17	7.00	16.46
1237	BP Medical Aid Society	Momentum Health (Pty) Ltd	1 032	149.43	99.43	36.23	-	3.02	22.96	13.10	24.64
1465	Alliance-Midmed Medical Scheme*	Self-Administered	1 649	138.82	69.16	100.00	-	-	-	-	-
1520	University of Kwa-Zulu Natal Medical Scheme*	Discovery Health (Pty) Ltd	3 237	137.46	100.00	31.99	-	-	31.01	27.00	10.00
1526	BMW Employees Medical Aid Society	Discovery Health (Pty) Ltd	3 102	137.20	100.01	30.99	-	-	32.00	26.99	10.00
1547	Malcor Medical Scheme	Discovery Health (Pty) Ltd	4 632	136.11	99.38	31.04	-	-	31.98	26.98	10.00
1039	MBMed Medical Aid Fund	Medscheme Holdings (Pty) Ltd	3 746	135.12	100.00	19.99	-	3.19	45.11	13.27	18.44
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 209	133.84	79.77	9.11	-	3.50	87.39	-	-
1544	Consumer Goods Medical Scheme*	Universal Healthcare Administrators (Pty) Ltd	4 381	133.32	97.63	-	31.65	-	34.17	8.65	25.54

pmpm = per member per month

** No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

All the schemes listed incurred higher expenditure than the restricted scheme industry average for accredited managed healthcare services fees paid to scheme administrators and their related parties of R91.35 pmpm (the industry average is directly correlated to GEMS' R84.20 pmpm). Half of the schemes listed above only contracted with its administrator and its related parties for the provision of these services. Kindly refer to Annexure K for more detail on the individual contracts per scheme.

Aid for Aids Management (Pty) Ltd, Alignd (Pty) Ltd and RX Health (Pty) Ltd were included in Tables 13 and 14 as some of the providers with the most expensive contracts. Tables 17 to 18 compare the fees charged to various schemes for each individual provider. Reference to Annexure K can also be made.

It is important to note that Aid for Aids Management (Pty) Ltd is a related party to Medscheme Holdings (Pty) Ltd, and as such was also included in the Tables 15 and 16.

Table 17: Accredited managed healthcare service arrangements with Aid for Aids Management (Pty) Ltd

Ref. no.	Name of Scheme	Members	Fee paid in respect of accredited managed healthcare services	Active disease risk management services
			pmpm R	%
1566	Horizon Medical Scheme	28	1 110.12	100.00
1507	Barloworld Medical Scheme	219	404.49	100.00
1441	Parmed Medical Aid Scheme	2 489	21.96	100.00
1209	South African Breweries Medical Aid Scheme (SABMAS)	8 982	19.05	100.00
1038	SAMWUMed	32 885	17.15	100.00
1424	SABC Medical Aid Scheme	3 809	16.28	100.00
1512	Bonitas Medical Fund	304 555	14.87	100.00
1039	MBMed Medical Aid Fund	3 453	14.41	100.00
1202	Fedhealth Medical Scheme	56 018	13.92	100.00
1548	Medipos Medical Scheme	5 797	7.22	100.00

Table 18: Accredited managed healthcare service arrangements with Alignd (Pty) Ltd

Ref. no.	Name of Scheme	Members	Fee paid in respect of accredited managed healthcare services	Disease risk management support services	Managed care network management services and risk management
			pmpm R	%	%
1512	Bonitas Medical Fund	10 057	129.59	-	100.00
1548	Medipos Medical Scheme	5 797	2.31	100.00	-

Medipos Medical Scheme omitted to provide information on the number of members covered by their Alignd (Pty) Ltd arrangement. The number of members per scheme was used as a proxy. The fees charged per scheme is therefore not comparable as the scheme's fee might be understated.

Table 19: Accredited managed healthcare service arrangements with RX Health (Pty) Ltd

Ref. no.	Name of Scheme	Members	Fee paid in respect of accredited managed healthcare services	Active disease risk management services	Hospital benefit management services	Pharmacy benefit management services
			pmpm R	%	%	%
1597	Umvuzo Health Medical Scheme	53 237	144.26	32.13	57.69	10.18
1465	Alliance-Midmed Medical Scheme	1 684	33.16	100.00	-	-

Alliance-Midmed Medical Scheme omitted to provide information on the number of members covered by their RX Health (Pty) Ltd arrangement. The number of members per scheme was used as a proxy. The fees charged per scheme is, therefore, not comparable as the scheme's fees might be understated.

Tables 20 and 22 contain details on the accredited managed healthcare services fees pmpm paid for those options that had the highest relevant healthcare expenditure ratios. Tables 21 and 23 contain details on the accredited managed healthcare services fees pmpm paid for those options that had the worst demographic profiles.

Annexure O provides more information on accredited managed healthcare services incurred per option.

The Table 20 contains data on all the options that incurred relevant healthcare expenditure ratios in excess of 115.00%.

Table 20: Accredited managed healthcare services fees pmpm paid in respect of options with the highest relevant healthcare expenditure ratios (open schemes)

Benefit option ID	Ref. no.	Name of medical scheme	Name of benefit option	Members as at 31 December	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Accredited managed healthcare services	
					years	%	% of IR	% of IR	pmpm R
2342	1464	Suremed Health	Explorer	123	42.97	27.17	145.02	1.91	47.43
2348	1202	Fedhealth Medical Scheme	myFed	1 657	49.56	36.62	142.78	2.82	77.20
1810	1464	Suremed Health	Challenger*	122	52.94	36.89	129.67	1.26	122.95
2337	1125	Discovery Health Medical Scheme	Executive*	7 123	47.41	29.67	127.23	1.19	154.72
6058	1140	Medshield Medical Scheme	Premium Plus*	1 200	63.07	56.84	123.10	0.72	65.07
2321	1512	Bonitas Medical Fund	BonComprehensive*	3 592	58.22	48.27	121.40	1.68	194.81
2032	1491	Compcare Medical Scheme	MedX	1 809	59.76	51.16	118.96	2.02	107.43
1811	1464	Suremed Health	Navigator	362	45.95	24.44	118.35	2.08	116.71
2174	1252	Bestmed Medical Scheme	Rhythm 2*	1 448	49.20	31.71	117.57	3.01	121.03

pmpm = per member per month

IR = Insurance Revenue

**represents the scheme's most comprehensive option / series of options*

No correlation was noted between the options' relevant healthcare expenditure ratios (or its size) and the accredited managed healthcare services fees pmpm contracted. The majority of the options had less than 2 500 members, which figure is considered by the CMS as an indication of the minimum number of members necessary for an option to be self-sustainable. Five of the nine options listed are the schemes' most comprehensive benefit options / series of options and had very poor demographic profiles (generally, pensioner ratios of between 29.00% and 57.00% were observed).

The Table 21 contains data on all the options that incurred relevant healthcare expenditure ratios in excess of 125.00%.

Table 21: Accredited managed healthcare services fees pmpm paid in respect of options with the highest relevant healthcare expenditure ratios (restricted schemes)

Benefit option ID	Ref. no.	Name of medical scheme	Name of benefit option	Members as at 31 December	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Accredited managed healthcare services	
					years	%	% of IR	% of IR	pmpm R
2062	1270	Golden Arrow Employees' Medical Benefit Fund**	Advance*	248	46.56	19.36	185.99	3.84	92.07
2153	1201	Rand Water Medical Scheme	Option B Plus	242	27.26	1.73	181.71	2.35	85.06
1927	1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Alliance Plus Benefit Option*	527	56.72	43.98	157.28	0.90	118.60
1781	1293	Wooltru Healthcare Fund	Comprehensive Option*	372	56.94	44.39	144.04	1.37	105.51
2122	1430	Remedi Medical Aid Scheme	Comprehensive*	5 059	43.56	20.83	140.63	1.68	106.74
2260	1598	Government Employees Medical Scheme (GEMS)	Onyx*	17 281	65.84	62.51	139.90	1.47	122.19
1764	1579	Tsogo Sun Group Medical Scheme	Classic Comprehensive*	426	43.10	19.12	139.33	2.02	116.00
1892	1279	Bankmed	Bankmed Plus*	2 582	58.68	47.90	137.29	1.33	122.51
1825	1012	Anglo Medical Scheme	Managed Care Plan*	3 238	60.06	53.68	136.56	2.00	147.06
6042	1582	Transmed Medical Fund	Prime Plan*	142	76.72	87.04	135.57	2.39	313.97
2318	1214	Old Mutual Staff Medical Aid Fund	Traditional Plan*	2 470	56.19	43.59	128.88	1.69	114.14

pmpm = per member per month

IR = Insurance Revenue

**represents the scheme's most comprehensive option / series of options*

***Golden Arrow Employees' Medical Benefit Fund is a previous bargaining council scheme, and it has a PMB exemption.*

No correlation was noted between the options' relevant healthcare expenditure (or its size) and the accredited managed healthcare services fees pmpm contracted.

The high relevant healthcare expenditure ratios in the majority of the listed options is a function of high claims volatility due to the very low membership, rather than just a direct correlation to the poor demographic profile. Ten of the 11 benefit options listed are the schemes' most comprehensive benefits options / series of options.

Transmed Medical Fund's Prime Plan's pmpm figure was skewed due to the low membership on this option (i.e. the fixed costs needed to be shared amongst the smaller membership base).

The Table 22 contains data on all the open scheme options that had pensioner ratios greater than 45.00%.

Table 22: Accredited managed healthcare services fees pmpm paid in respect of options with the highest pensioner ratios (open schemes)

Benefit option ID	Ref. no.	Name of medical scheme	Name of benefit option	Members as at 31 December	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Fee paid in respect of accredited managed healthcare services	
					years	%	% of IR	% of IR	pmpm R
2362	1087	Keyhealth	Platinum*	1 389	72.60	78.81	96.55	2.24	309.34
6028	1034	Cape Medical Plan	My Health 200 Plus*	105	71.62	72.48	81.58	-	-
6034	1252	Bestmed Medical Scheme	Pace 4*	1 608	68.10	69.03	109.78	0.87	119.87
2019	1202	Fedhealth Medical Scheme	maxima PLUS*	575	68.31	68.18	82.87	0.74	142.90
1829	1149	Medihelp	MedPlus*	1 236	68.88	67.01	73.63	1.08	173.95
2039	1167	Momentum Medical Scheme	Summit*	216	66.23	66.77	76.21	1.48	289.35
1830	1149	Medihelp	MedElite*	7 145	65.78	63.78	96.59	1.20	107.93
2015	1202	Fedhealth Medical Scheme	maxima EXEC*	2 005	64.65	59.98	104.58	1.22	148.55
6058	1140	Medshield Medical Scheme	Premium Plus*	1 200	63.07	56.84	123.10	0.72	65.07
2033	1491	Compcare Medical Scheme	Pinnacle	996	60.37	55.08	112.13	1.04	118.47
2032	1491	Compcare Medical Scheme	MedX*	1 809	59.76	51.16	118.96	2.02	107.43
1905	1087	Keyhealth	Gold	9 613	60.14	50.46	101.79	2.55	221.90
6025	1491	Compcare Medical Scheme	Dynamix*	841	59.16	50.31	92.25	1.21	117.92
2170	1252	Bestmed Medical Scheme	Pace 2*	7 738	58.70	48.74	106.57	1.35	120.39
2321	1512	Bonitas Medical Fund	BonComprehensive*	3 592	58.22	48.27	121.40	1.68	194.81
2169	1252	Bestmed Medical Scheme	Pace 3*	4 609	58.37	48.15	104.85	1.12	118.92

pmpm = per member per month

IR = Insurance Revenue

**represents the scheme's most comprehensive option / series of options*

In general, the worse an option's demographic profile, the higher the pmpm fees incurred for accredited managed healthcare services. Typically, the more comprehensive options have the worst profile of members. 14 of the 16 options listed were the respective schemes' most comprehensive options or series of options.

It is important to note that no data was collected in respect of the members contracted on each benefit option as it relates to individual accredited managed healthcare services arrangements. This might have resulted in skewed pmpm-figures on a benefit option level. Annexure K provides more information on the number of members per arrangement, and Annexure O contains information at a benefit option level.

Of the benefit options listed in Table 22, Keyhealth incurred the highest expenditure (R309.34 pmpm) on its Platinum option, with the third highest expenditure being incurred on its Gold option (R221.90 pmpm). The scheme had contracted with Performance Health (Pty) Ltd and Professional Provident Society Healthcare Administrators (Pty) Ltd to provide accredited managed healthcare services on all of their options, to all of the scheme members.

Momentum Medical Scheme contracted with Lifesense Disease Management (Pty) Ltd and Momentum Health (Pty) Ltd to provide accredited managed healthcare services on all of their options, to all of the scheme members. The scheme's Summit option incurred the second highest expenditure (R289.35 pmpm).

Medshield Medical Scheme did not provide data in respect of the number of members contracted per individual managed care arrangement. The total number of option members was used as proxy. The scheme had contracts with Dental Information Systems (Pty) Ltd (DENIS), HaloCare (Pty) Ltd, ICON Managed Care (Pty) Ltd, Mediscor PBM (Pty) Ltd and Medscheme Holdings (Pty) Ltd during the 2024 financial year. The Premium Plus option's relevant healthcare expenditure ratio of 123.10% is the highest of those options included in Table 22.

Table 23 contains data on all the options within restricted schemes that had pensioner ratios greater than 45.00%.

Table 23: Accredited managed healthcare services fees pmpm paid in respect of options with the highest pensioner ratios (restricted schemes)

Benefit option ID	Ref. no.	Name of medical scheme	Name of benefit option	Members as at 31 December	Average age per beneficiary	Pensioner ratio	Relevant healthcare expenditure	Fee paid in respect of accredited managed healthcare services	
					years	%	% of IR	% of IR	pmpm R
2060	1270	Golden Arrow Employees' Medical Benefit Fund**	Primary	19	84.62	100.00	118.71	15.83	96.49
2359	1582	Transmed Medical Fund	Guardian	3 375	81.76	94.71	86.81	3.93	142.44
6042	1582	Transmed Medical Fund	Prime Plan*	142	76.72	87.04	135.57	2.39	313.97
1930	1548	Medipos Medical Scheme	Option A*	546	79.74	86.01	85.69	0.50	58.46
1855	1145	LA-Health Medical Scheme	LA Comprehensive*	986	70.62	71.89	104.26	1.02	99.31
1854	1145	LA-Health Medical Scheme	LA Core*	3 241	68.28	70.37	108.52	1.23	98.20
2319	1214	Old Mutual Staff Medical Aid Fund	Traditional Plus Plan*	185	68.59	70.19	97.40	1.07	121.17
1903	1194	Profmed	ProPinnacle*	1 124	64.51	64.36	113.04	0.96	167.26
2260	1598	Government Employees Medical Scheme (GEMS)	Onyx*	17 281	65.84	62.51	139.90	1.47	122.19
1944	1237	BP Medical Aid Society	BPSA Medical Society	996	60.22	53.88	99.72	1.70	150.27
1825	1012	Anglo Medical Scheme	Managed Care Plan*	3 238	60.06	53.68	136.56	2.00	147.06
6023	1600	Motohealth Care	Hospicare	360	59.31	53.10	114.28	1.74	68.52
1902	1194	Profmed	ProSecure Plus*	1 923	58.11	51.94	95.69	1.64	168.75
1892	1279	Bankmed	Bankmed Plus*	2 582	58.68	47.90	137.29	1.33	122.51

IR = Insurance Revenue

**represents the scheme's most comprehensive option / series of options*

***Golden Arrow Employees' Medical Benefit Fund is a previous bargaining council scheme, and it has a PMB exemption.*

pmpm = per member per month

A number of the accredited managed healthcare services pmpm figures were skewed by the low membership on the option. In general, the worse an option's pensioner ratio, the higher the pmpm fees incurred for accredited managed healthcare services. Ten of the 14 options listed represented the scheme's most comprehensive option / series of options.

Transmed Medical Fund's Guardian option is a ring-fenced option catering for the South African Transport Services (SATS) pensioners only. The scheme receives additional funding from the employer group, Transnet, to ensure the continued membership of these pensioners.

Reinsurance results

In the last few years, medical schemes have increasingly undertaken risk transfer arrangements to manage their insurance risks. Table 24 reflects the main components of such arrangements:

- The capitation fees which schemes paid to third parties to manage their risks
- The estimated costs that schemes would have incurred had they not used risk transfer arrangements
- The net effect thereof (i.e. reinsurance result)

The reinsurance result ("net income/(expense)") column reflects the value derived from the risk transfer arrangement. (Annexure O provides further details.)

Table 24: Reinsurance results

	Capitation fees			Estimated recoveries			Reinsurance result*		
	2024 R'000	2023 R'000	% growth	2024 R'000	2023 R'000	% growth	2024 R'000	2023 R'000	% growth
Open schemes	3 288 886	3 244 259	1.38	3 884 463	3 676 768	5.65	595 698	432 203	37.83
Restricted schemes	1 713 773	1 943 251	(11.81)	1 763 794	2 011 903	(12.33)	85 041	97 828	(13.07)
All	**5 002 659**	**5 187 510**	**(3.56)**	**5 648 257**	**5 688 671**	**(0.71)**	**680 739**	**530 031**	**28.43**

* *The reinsurance result (on risk transfer arrangements) includes an amount of R35.14 million in respect of profit- and loss-sharing agreements (2023: R28.87 million). These arrangements are not allowed in terms of Section 26(5).*

Table 25 provides the breakdown of the components of the capitation fees paid by the industry in respect of risk transfer arrangements.

Table 25: Breakdown of the main components of capitation fee paid in respect of reinsurance arrangements (risk transfer arrangements)

Components of capitation fee paid iro risk transfer arrangements	Open schemes	Restricted schemes
	% of total fee	% of total fee
Active disease risk management services	-	5.21
Disease risk management support services	-	0.94
Dental benefit management services	20.94	2.43
Health care services (risk transfer)	12.03	20.96
Hospital benefit management services	-	1.37
Managed care network management services and risk management	17.12	0.33
Pharmacy benefit management services	24.67	43.69
Emergency transport	8.34	3.53
Other (specify)	16.90	21.52

Pharmacy benefit management services represent the biggest component of the risk transfer arrangements in both the open and restricted scheme industries. The services contracted in the open scheme environment seem to be clustered around pharmacy benefit management, dental benefit management services, and managed care network management services and risk management.

Although a wider variety of services were contracted within the restricted scheme industry environment, the same cluster of services as in the open scheme industry was observed.

Annexures J and L contain more information on the different contracts, as well as the breakdown of the services, contracted by medical schemes.

Table 26 lists the ten schemes that incurred the greatest losses in respect of their significant risk transfer arrangements, and Table 27 details the ten benefit options that reported the greatest losses.

Table 26: Schemes with the highest reinsurance losses

Ref. no.	Name of medical scheme	Beneficiaries	Capitation fees	Estimated recoveries	Reinsurance result	Reinsurance result as % of capitation fees
		31 Dec 2024	R'000	R'000	R'000	%
1580	South African Police Service Medical Scheme (POLMED)	493 273	748 794	674 489	(39 285)	(5.25)
1271	Fishing Industry Medical Scheme (Fishmed)*	3 891	23 556	19 295	(4 261)	(18.09)
1583	Platinum Health	108 842	14 801	11 321	(3 480)	(23.51)
1592	Thebemed	23 945	23 172	20 678	(2 494)	(10.76)
1145	LA-Health Medical Scheme	259 513	49 327	47 799	(1 528)	(3.10)
1491	Compcare Medical Scheme	25 487	5 853	4 751	(1 102)	(18.83)
1507	Barloworld Medical Scheme	8 825	4 411	3 683	(728)	(16.50)
1506	Medimed Medical Scheme	13 927	8 787	8 203	(584)	(6.65)
1547	Malcor Medical Scheme	383	4 216	3 676	(540)	(12.81)
1176	Retail Medical Scheme	26 403	2 262	1 756	(506)	(22.37)

**Fishmed is a previous bargaining council scheme and has a PMB exemption. It is a fully capitated scheme.*

Fewer medical schemes incurred reinsurance losses in 2024, compared to 2023 (the inverse to the trend noted from 2022 to 2023). This is due to the annual repricing of reinsurance arrangements.

A total of 18 or 34.62% of those schemes that had capitation agreements during the year, incurred losses on their capitation arrangements (2023: 28 or 52.83%).

Momentum Medical Scheme had previously been topping this particular list. A change in how the estimated recoveries are calculated occurred in the determination of the 2024 figures, and 2023 was also restated. The scheme previously made use of costs assumptions supplied by the third party service provider, instead of using those specific to the scheme.

Table 27: On a per option level: ten contracts with the highest reinsurance losses

Ref. no.	Name of medical scheme	Name of benefit option	Name of contract	Beneficiaries	Average age per beneficiary	Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Reinsurance result	Reinsurance result as % of capitation fees
				31 Dec 2024	Years	R'000	R'000	R'000	R'000	%
1167	Momentum Medical Scheme	Ingwe	Momentum Health (Pty) Ltd	57 947	27.07	184 234	159 750	-	(24 484)	(13.29)
1580	South African Police Service Medical Scheme (POLMED)	Aquarium	Scriptpharm Risk Management (Pty) Ltd	239 327	23.79	358 209	99 285	235 820	(23 104)	(6.45)
1125	Discovery Health Medical Scheme	KeyCare Plus	Dental Risk Company (Pty) Ltd (DRC)	306 614	32.24	142 546	122 581	-	(19 965)	(14.01)
1580	South African Police Service Medical Scheme (POLMED)	Marine	Scriptpharm Risk Management (Pty) Ltd	253 946	35.09	390 585	575 205	(200 800)	(16 180)	(4.14)
1149	Medihelp	MedAdd	Dental Risk Company (Pty) Ltd (DRC)	42 054	34.03	12 902	7 891	-	(5 011)	(38.84)
1512	Bonitas Medical Fund	Primary	Europ Assistance Worldwide (South Africa) Services (Pty) Ltd	224 141	32.00	4 808	407	-	(4 401)	(91.53)
1279	Bankmed	Bankmed Essential Plan	Discovery Health (Pty) Ltd	8 256	29.30	7 798	3 512	-	(4 286)	(54.96)
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Network Choice Benefit Option	Preferred Provider Negotiators	9 798	26.98	4 635	756	-	(3 879)	(83.69)
1597	Umvuzo Health Medical Scheme	Ultra Affordable	Netcare 911	40 400	35.70	11 932	8 307	-	(3 625)	(30.38)
1271	Fishing Industry Medical Scheme (Fishmed)*	Standard	Momentum Health (Pty) Ltd	1 930	28.28	17 292	13 839	-	(3 453)	(19.97)

**Fishmed is a previous bargaining council scheme and has a PMB exemption. It is a fully capitated scheme.*

Of the options that incurred the highest reinsurance losses per contract, Momentum Medical Scheme's Ingwe option, POLMED's Aquarium and Marine options, and Discovery Health Medical Scheme's KeyCare Plus option incurred reinsurance losses in excess of R15 million. Of these four options, only POLMED's Marine option's demographic profiles was older than the industry average.

It is interesting to note that Momentum Health (Pty) Ltd, Scriptpharm Risk Management (Pty) Ltd and Dental Risk Company (Pty) Ltd (DRC) appeared twice on the list. Momentum Health (Pty) Ltd and Dental Risk Company (Pty) Ltd (DRC) represented contracts with two different schemes.

Annexure O provides more information of the reinsurance result per benefit option, whilst Annexure P provides details on the contract performance per option.

Table 28 lists the contracts on which schemes incurred the biggest losses in respect of their reinsurance contracts (i.e. per contract across all options), with comparative 2023 figures.

Table 28: Contracts with the highest reinsurance losses

Ref. no.	Name of medical scheme	Contract name	2024					2023				
			Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Reinsurance result	Reinsurance result as % of capitation fees	Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Reinsurance result	Reinsurance result as % of capitation fees
			R'000	R'000	R'000	R'000	%	R'000	R'000	R'000	R'000	%
1580	South African Police Service Medical Scheme (POLMED)	Scriptpharm Risk Management (Pty) Ltd	748 794	(674 489)	(35 020)	(39 285)	(5.25)	713 492	(645 667)	(29 176)	(38 649)	(5.42)
1125	Discovery Health Medical Scheme	Dental Risk Company (Pty) Ltd (DRC)	146 357	(125 850)	-	(20 508)	(14.01)	149 955	(147 724)	-	(2 231)	(1.49)
1512	Bonitas Medical Fund	Europ Assistance Worldwide (South Africa) Services (Pty) Ltd	14 866	(8 467)	-	(6 399)	(43.04)	14 179	(10 517)	-	(3 662)	(25.83)
1252	Bestmed Medical Scheme	Europ Assistance Worldwide Services (South Africa) Proprietary Limited	7 769	(1 437)	-	(6 332)	(81.50)	8 015	(693)	-	(7 322)	(91.36)

The need for reinsurance as a financial risk management tool is typically low within the medical schemes environment as schemes have ample funds to self-insure. Medical schemes contract with specialist providers to manage their claims to ensure the appropriate cost and quality of the services provided.

Two Europ Assistance Worldwide (South Africa) Services (Pty) Ltd contracts feature on the list and represent the biggest percentage losses incurred on individual contracts. The provider only issued these two contracts for the period under review.

Scriptpharm Risk Management (Pty) Ltd also only had two schemes as their clients during the year: Bonitas Medical Fund and the above-mentioned POLMED contract. Bonitas Medical Fund incurred a positive reinsurance result of R159.12 million (compared to POLMED's loss of R38.65 million).

Table 29 illustrates the range of fees charged by Scriptpharm Risk Management (Pty) Ltd contracts.

Table 29: Reinsurance arrangements with Scriptpharm Risk Management (Pty) Ltd

Ref. no.	Name of Scheme	Members	Reinsurance: capitation fees paid	Pharmacy benefit management services
			pmpm R	%
1580	South African Police Service Medical Scheme (POLMED)	187 312	333.13	100.00
1512	Bonitas Medical Fund	358 717	188.48	100.00

Table 30 illustrates the range of fees charged by Dental Risk Company (Pty) Ltd (DRC) contracts.

Table 30: Reinsurance arrangements with Dental Risk Company (Pty) Ltd (DRC)

Ref. no.	Name of Scheme	Members	Reinsurance: capitation fees paid	Dental benefit management services
			pmpm R	%
1149	Medihelp	95 540	105.00	100.00
1012	Anglo Medical Scheme	3 985	101.61	100.00
1125	Discovery Health Medical Scheme	184 081	66.26	100.00
1578	TFG Medical Aid Scheme*	2 856	45.11	100.00
1145	LA-Health Medical Scheme*	108 612	21.08	100.00
1430	Remedi Medical Aid Scheme*	21 121	16.04	100.00

* *No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

LA-Health Medical Scheme, Remedi Medical Aid Scheme and TFG Medical Aid Scheme omitted to provide information on the number of members covered by their DRC arrangement; the number of members per scheme was used as a proxy. The fees charged per scheme is therefore not comparable as these schemes' fees might be understated.

Table 31: Reinsurance results for providers with more than six client schemes

Name of medical scheme	Number of contracts issued	Capitation fees	Estimated recoveries	Reinsurance result	Reinsurance result as % of capitation fees
		R'000	R'000	R'000	%
Discovery Health (Pty) Ltd	9	232 447	(232 309)	(138)	(0.06)
ER24 EMS (Pty) Ltd	7	10 368	(11 338)	970	9.36
Momentum Health (Pty) Ltd	9	671 476	(677 385)	5 909	0.88
Netcare Hospitals (Pty) Ltd t/a Netcare 911	17	129 763	(166 086)	36 324	27.99
Preferred Provider Negotiators (Pty) Ltd	9	371 784	(450 886)	79 102	21.28
The Centre for Diabetes and Endocrinology (Pty) Ltd	9	59 685	(70 776)	11 090	18.58

Five of the six providers that had more than six client schemes during the year, charged less in capitation fees than what the schemes would have incurred if they self-insured the risk: Centre for Diabetes and Endocrinology (Pty) Ltd, ER 24 EMS (Pty) Ltd, Momentum Health (Pty) Ltd, Netcare Hospitals (Pty) Ltd t/a Netcare 911 and Preferred Provider Negotiators (Pty) Ltd. The total net estimated loss incurred by the providers on these contracts ranged between 9.00% and 30.00% of the capitation fees paid. The fifth provider, Discovery Health (Pty) Ltd's fee structure is close to a break-even result.

The Centre for Diabetes and Endocrinology (Pty) Ltd terminated all their contracts at the end of April 2025.

Table 32: Reinsurance arrangements with Discovery Health (Pty) Ltd

Ref. no.	Name of Scheme	Members	Reinsurance: capitation fees paid	Active disease risk management services	Health care services (risk transfer)
			pmpm R	%	%
1547	Malcor Medical Scheme	135	412.96	100.00	-
1279	Bankmed*	107 718	156.92	-	100.00
1520	University of Kwa-Zulu Natal Medical Scheme*	3 224	37.87	100.00	-
1572	Engen Medical Benefit Fund	3 002	33.73	100.00	-
1578	TFG Medical Aid Scheme*	2 856	29.73	100.00	-
1145	LA-Health Medical Scheme*	108 612	14.80	100.00	-
1430	Remedi Medical Aid Scheme*	21 121	12.72	100.00	-
1176	Retail Medical Scheme	16 289	11.57	100.00	-
1241	Multichoice Medical Aid Scheme*	3 475	11.18	100.00	-

* *No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

Bankmed, University of Kwa-Zulu Natal Medical Scheme, TFG Medical Aid Scheme, LA-Health Medical Scheme, Remedi Medical Aid Scheme and Multichoice Medical Aid Scheme omitted to provide information on the number of members covered by their Discovery Health (Pty) Ltd arrangement; the number of members per scheme was used as a proxy. The fees charged per scheme is therefore not comparable as these schemes' fees might be understated.

Table 33: Reinsurance arrangements with Momentum Health (Pty) Ltd

Ref. no.	Name of Scheme	Members	Reinsurance: capitation fees paid	Disease risk management support services	Health care services (risk transfer)	Hospital benefit management services	Managed care network management services and risk management
			pmpm R	%	%	%	%
1271	Fishing Industry Medical Scheme (Fishmed)	1 651	1 188.98	-	-	100.00	-
1293	Wooltru Healthcare Fund	6 791	918.46	21.60	78.40	-	-
1506	Medimed Medical Scheme	85	483.33	-	-	-	100.00
1563	Pick n Pay Medical Scheme	1 178	452.74	-	100.00	-	-
1566	Horizon Medical Scheme	591	437.25	-	100.00	-	-
1464	Suremed Health	203	428.98	-	-	-	100.00
1167	Momentum Medical Scheme	104 730	393.93	-	62.79	-	37.21
1568	Sisonke Health Medical Scheme	1 220	383.33	-	-	-	100.00
1600	Motohealth Care*	13 845	369.23	-	100.00	-	-

* *No data was provided in respect of the number of members contracted per individual managed care arrangement. The total number of scheme members was used as proxy.*

The contract fee ranges between R369.23 – R483.33 pmpm for healthcare services, and managed care network services and risk management. No correlation between scheme size and the fee charged was noted.

The Wooltru Healthcare Fund and Fishmed contracts included services not rendered on the other contracts (disease risk management support services and hospital benefit management services).

Relationship between the risk and savings components

Some medical schemes provide for personal medical savings account facilities to assist the members in:

- Managing cash flow for costs to be borne by members by self-funding their out-of-hospital expenditure.
- Meeting or self-funding member co-payments for provider services rendered.

These represent out-of-pocket payments managed by the scheme on the members' behalf.

Savings plan facilities are more prevalent in open schemes than in restricted schemes:

- 50.96% of open scheme options provide these facilities, whilst only 29.69% of restricted scheme options cater for savings plan accounts.
- More than half (53.40%) of open scheme members belong to these options, whilst only 22.52% of restricted scheme members have signed up for these options.

Contributions to members' personal savings accounts

Contributions to personal medical savings accounts to the value of R23.29 billion were received in 2024. When measured on a pbpm basis with respect to only those schemes that use medical savings accounts, this represented R545.17 pbpm.

This represents a reduction of the amounts previously contributed towards savings (2023: R24.29 or R561.56 pbpm). In order to ensure the affordability of their 2024 year's contribution increases, some schemes have converted savings portions to risk. A similar trend was observed in the 2025 year's contributions and benefits registration.

Savings contributions represented 17.87% of gross contributions. This means that less than 1/5 of the registered contributions received by medical schemes that provides savings facilities, represents out-of-savings payments.

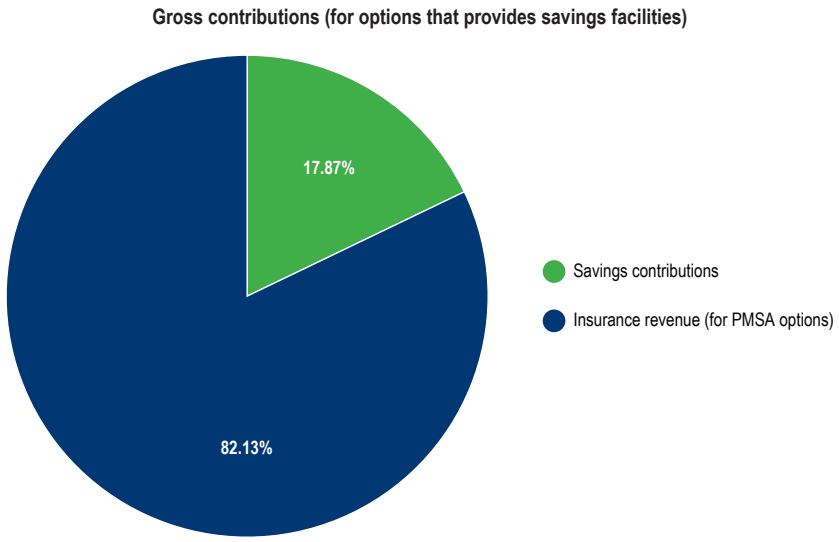


Figure 9: Gross contributions (for options that provide savings facilities)

Claims paid from members' personal savings accounts

Claims paid from medical savings accounts amounted to R22.51 billion in 2024. On a pbpm basis for options which offer medical savings accounts, medical savings accounts claims of R526.78 pbpm were incurred.

The savings claims ratio increased from 2023's 93.25% to 2024's 96.67%.

Savings claims paid represented 18.67% of gross relevant healthcare expenditure, indicating that 1/5 of the claims paid by medical schemes offering savings facilities constitute out-of-savings payments.

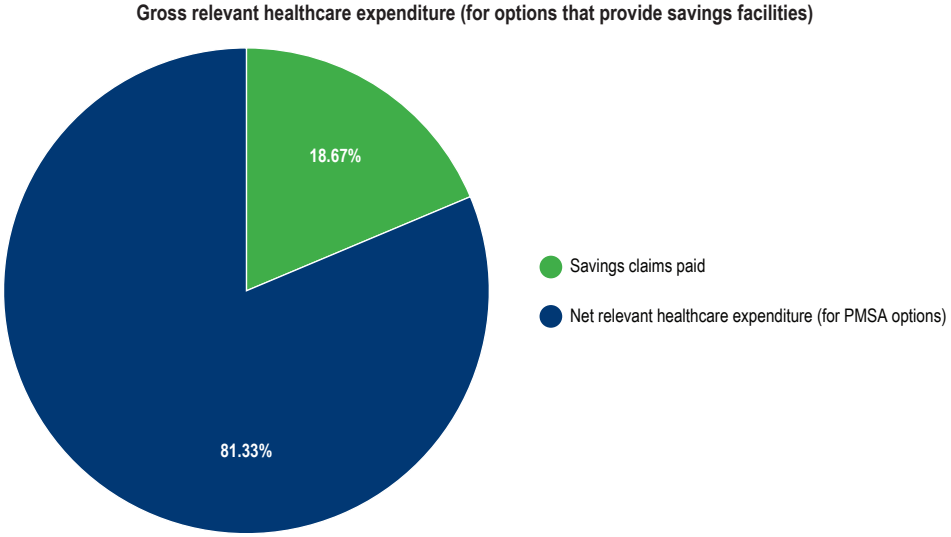


Figure 10: Gross relevant healthcare expenditure (for options that provide savings facilities)

Directly attributable insurance service expenditure (DAE)

The following cash flows are included within the boundary of an insurance contract, and therefore represent components of directly attributable insurance service expenditure:

- Insurance acquisition cash flows (cash flows arising from the cost of selling, underwriting and starting a group of insurance contracts).
- Claims handling costs (i.e. the costs the entity will incur in investigating, processing and resolving claims under existing insurance contracts, including legal and loss-adjusters' fees and internal costs of investigating claims and processing claim payments).
- Policy administration and maintenance costs (such as costs of premium billing and handling policy changes).
- An allocation of fixed and variable overheads (such as the costs of accounting, human resources, information technology and support, building depreciation, rent, and maintenance and utilities).

The CMS issued Circular 29 of 2023 requesting comments from the industry on the proposed split of its operational expenditure between directly attributable and non-directly attributable expenditure. However, the results of the feedback from the industry were not conclusive.

In subsequent engagement with stakeholders, an opinion was conveyed that contrary to other insurance entities, medical schemes only have one product line to service. Medical schemes will therefore not incur any expenditure that is not necessary in servicing its portfolio of insurance contracts. All (previously known as) non-healthcare expenditure should therefore be considered as directly attributable expenditure. CMS will be engaging further with the industry in respect of the appropriate classification of non-healthcare expenditure.

During 2024, medical schemes classified their accredited administration services fees as DAE. Other than these fees, no observable trend was established in the allocation of medical schemes' administration expenditure between DAE and non-DAE.

The DAE for all medical schemes at the end of 2024 was reported at R16.82 billion, an increase of 6.77% from R15.75 billion in 2023.

The DAE ratio (as a percentage of IR) decreased from 7.06% in 2023 to 6.89% in 2024.

Figure 11 depicts the main components of directly attributable insurance service expenditure.

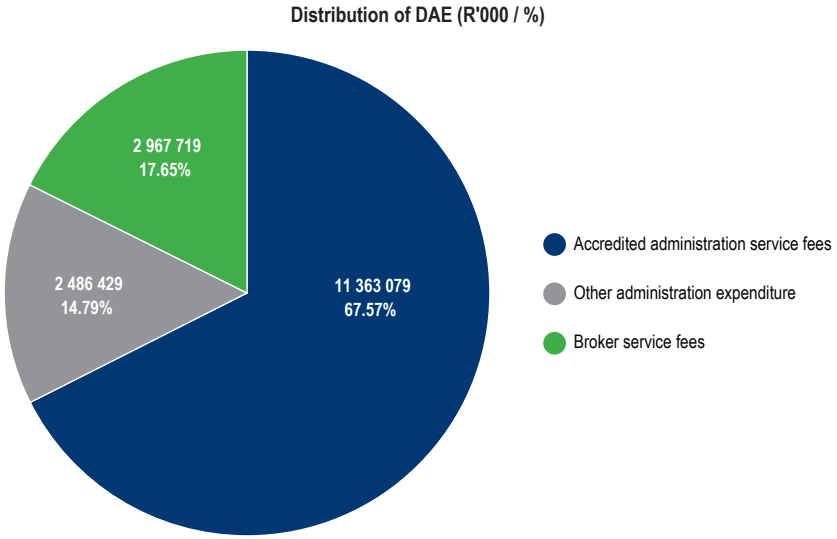


Figure 11: Distribution of DAE

Fees paid in respect of accredited administration services is the largest component of directly attributable insurance service expenditure (DAE) (67.57%), followed by broker service fees (17.65%) and other administration expenditure (14.79%).

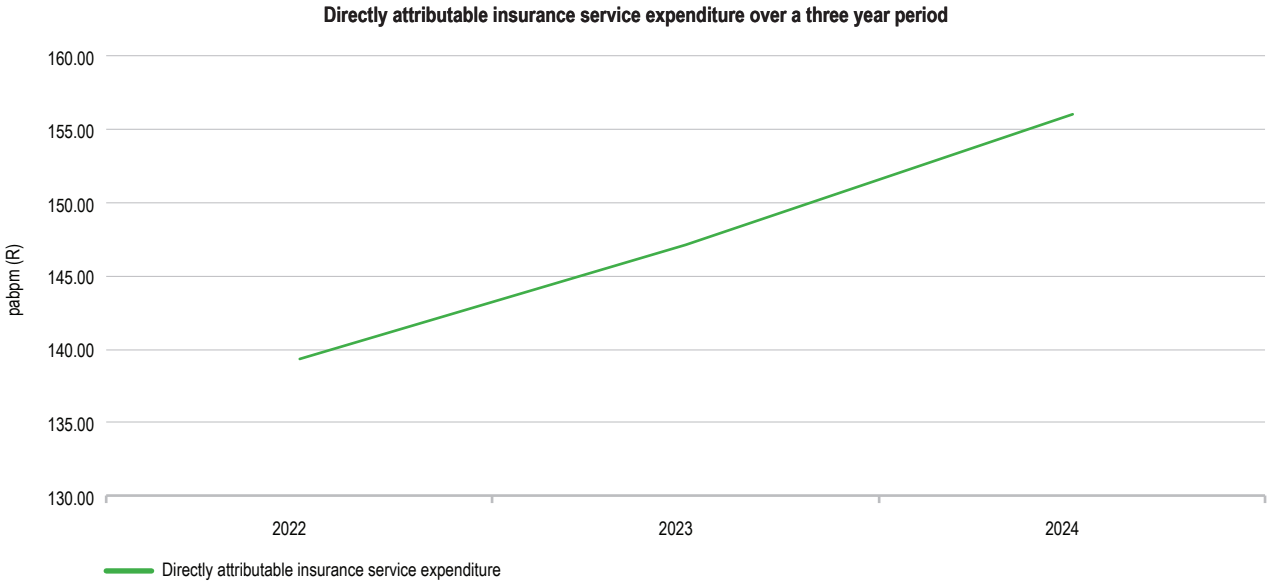


Figure 12: Directly attributable insurance service expenditure pabpm over a three year period

pabpm = per average beneficiary per month

Directly attributable insurance service expenditure pabpm has increased by 6.02%. This is slightly higher than the average CPI of 4.40% (as published by Statistics South Africa in their Table B2 – CPI headline year-on-year rates) for the year. In the interest of member protection, it is important that such expenditure be associated with a discernible value proposition.

Based on the Figure 13, which shows a comparison of directly attributable insurance service expenditure between open and restricted schemes, it is evident that expenditure in restricted schemes is much lower than in open schemes on a pabpm basis. This is partly because restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

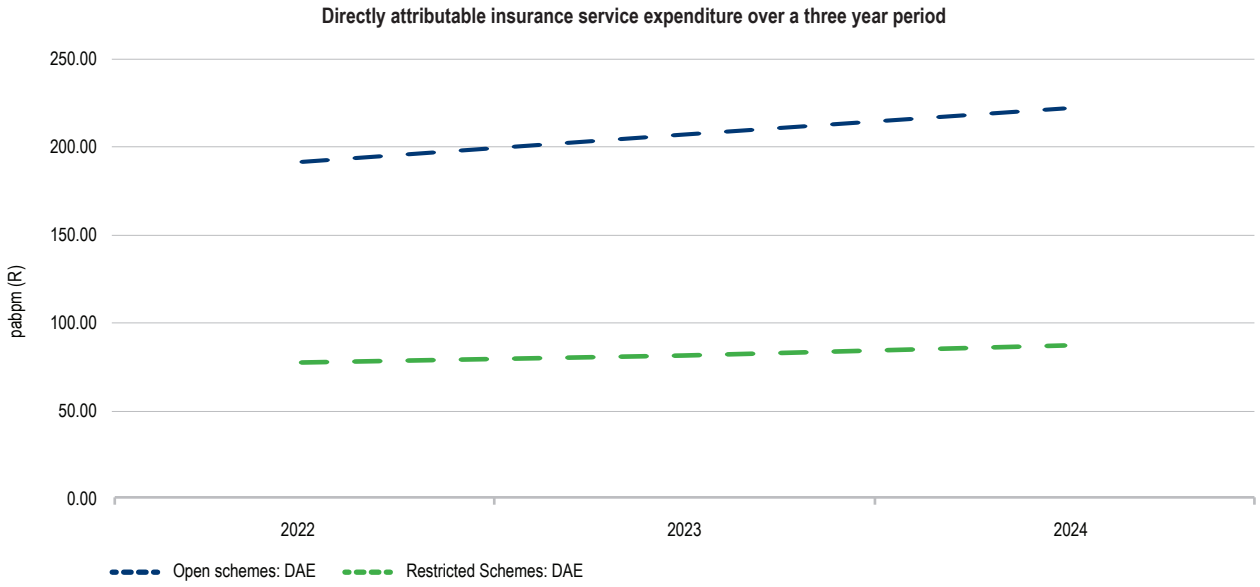


Figure 13: Directly attributable insurance service expenditure in open and restricted schemes over a three year period

pabpm = per average beneficiary per month

Directly attributable insurance service expenditure per administration model

Table 34 shows DAE by type of scheme administration.

Table 34: Directly attributable insurance service expenditure over a three year period

	Open schemes				Restricted schemes			
	Self -administered		Third party		Self -administered		Third party	
	pampm R	% change	pampm R	% change	pampm R	% change	pampm R	% change
2022	267.77	8.09	410.99	6.65	212.41	13.16	183.19	4.55
2023	289.42		438.34		240.36		191.52	
2024	305.15	5.44	464.99	6.08	283.60	17.99	204.93	7.00

pampm = per average member per month

When evaluating the year-on-year increase, cognisance should be taken that further engagement on the allocation of administration expenditure between DAE and non-DAE still needs to take place to ensure consistency across the industry.

The DAE pabpm in the open scheme industry is significantly higher than that of the restricted scheme industry. The same trend is noted when comparing the costs incurred in respect of third party administered and self-administered schemes respectively between the two industries. This is partly because restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

Two restricted self-administered schemes also changed their model to an outsourced-arrangement in mid-2023 (Foodmed Medical Scheme and Rand Water Medical Scheme). This would also affect the allocation of DAE on a year-on-year basis.

Open schemes

During the year 2024, there were five self-administered open schemes (2023: five), representing 621 597 average beneficiaries or 13.48% (2023: 13.20%), and 11 third party-administered open schemes (2023: 11), representing 3 989 619 average beneficiaries or 86.52% (2023: 86.80%).

The costs incurred by third-party administered schemes were 1.52 times higher than that incurred by self-administered schemes.

Restricted schemes

During the year 2024, there were eight self-administered restricted schemes (2023: ten), representing 352 992 average beneficiaries or 8.07% (2023: 8.30%), and 47 third-party administered restricted schemes (2023: 45), representing 3 900 893 average beneficiaries or 91.93% (2023: 91.70%).

An inverse trend was noted in the restricted scheme environment where the costs incurred by third party-administered schemes were lower of that of self-administered schemes.

Accredited administration services

Fees paid in respect of accredited administration services (and co-administration) to third-party administrators is the main component of DAE. The R11.36 billion incurred in 2024 represented 67.57% of DAE. The 2024 accredited administration service fees represented an increase of 6.84% from the R10.63 billion incurred in 2023.

When adjusted for members, the R262.84 pampm incurred in respect of the 2024 year, represented a 6.14% increase from 2023. This is higher than the average CPI for 2024. It should however be noted that a number of administrators aided schemes in trying to curb their contributions, by agreeing to zero or very low increases in their administration fees, post the Covid-19 pandemic.

However, when evaluating the increases per industry, it was noted that the fee in the open scheme environment increased by 6.17% from R320.40 pampm in 2023 to R340.18 pampm in 2024. The average members in the open scheme industry decreased slightly (0.49%) to 2 295 443 average members at the end of 2024 and is not an attributing factor to the increase.

The fee in the restricted scheme environment increased by 8.12% from R153.62 pampm in 2023 to R166.09 pampm in 2024. The average number of members in the restricted scheme industry increased by 2.25% and could also not be considered as an attributing factor to the increase in the administration fee, especially given as most of the growth occurred in GEMS, who incurs an amount much lower than the restricted scheme industry average in terms of administration fees pampm.

Figure 14 depicts the main components of accredited administration service fees.

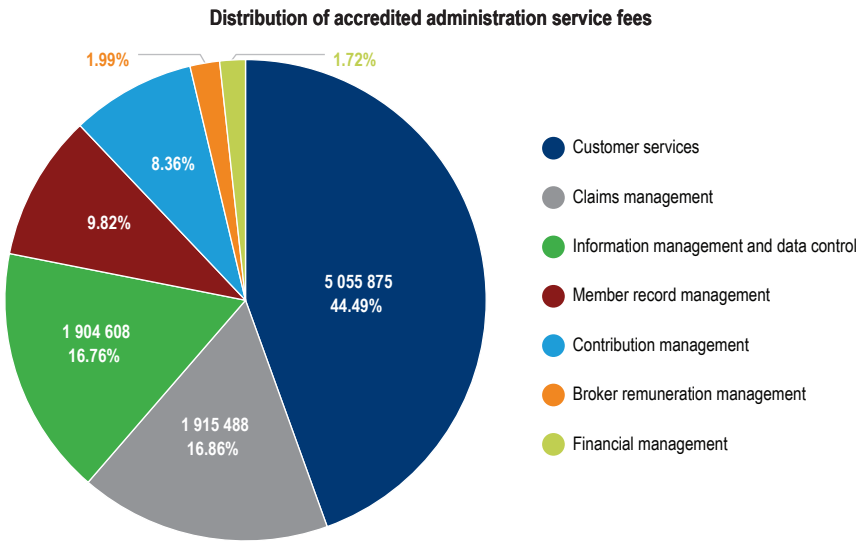


Figure 14: Distribution of accredited administration service fees

Customer services (44.49%), information management and data control (16.76%) and claims management (16.86%) represented the bulk of the fees.

Table 35 depicts the breakdown of the total fee paid in respect of accredited administration services per industry.

Table 35: Breakdown of fees paid to third-party administrators in respect of accredited administration services

Component of accredited administration service	Open schemes	Restricted schemes
	% of total fee	% of total fee
Member record management	10.56	7.93
Contribution management	8.64	7.67
Claims management	14.21	23.56
Financial management	1.34	2.69
Information management and data control	16.79	16.69
Broker remuneration management	2.69	0.21
Customer services	45.78	41.25

The distribution of the accredited administration services is similar in both the open and restricted scheme industries. The main difference relates to the provision of broker remuneration management which is not prevalent in the restricted scheme industry.

Annexures Q and W provide the detailed breakdown of the accredited administration services provided per scheme. This report does not address the quality and efficiencies of the various services provided.

Tables 36 and 38 show the ten schemes with the highest fees paid in respect of accredited administration services to their administrators (pampm), delineated by industry. The data does not include payments made to co-administrators. Tables 37 and 39 depicts the breakdown of the fees.

Table 36: Ten open schemes with the highest fees paid in respect of accredited administration services pampm

Ref. no.	Name of Scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services
				pampm R
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 351 211	387.08
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	56 917	299.47
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 292	284.20
1491	Compcare Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	17 927	279.96
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	771	263.62
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	356 713	257.71
1506	Medimed Medical Scheme	Momentum Thebe Ya Bophelo (Pty) Ltd	6 226	237.15
1167	Momentum Medical Scheme	Momentum Health (Pty) Ltd	152 638	232.24
1592	Thebemed	Momentum Thebe Ya Bophelo (Pty) Ltd	12 379	147.33
1466	Makoti Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	5 636	100.96

pampm = per average member per month

Only Discovery Health Medical Scheme's accredited administration service fees of R387.08 pampm exceeded the open scheme industry average of R340.18 pampm by 13.79%. The scheme's fee increased by 7.16% from the 2023 figure of R361.22 pampm. The scheme's size, relative to the industry, was the driver behind the open scheme environment's higher than CPI increase in its average fee per member per month.

Discovery Health Medical Scheme also pays R42.37 pampm (compared to the open scheme industry average of R49.07 pampm) to Discovery Health (Pty) Ltd in respect of other administration expenditure: internal audit services (2.72%), distribution services (7.01%), marketing services (47.51%), forensic investigations and recoveries (5.79%), governance (1.31%), and other (35.63%). Kindly refer to Table 42 for more information on the ten open schemes with the highest fees paid to its accredited administrator in respect of other administration expenditure.

Typically, schemes can negotiate volume discounts in respect of their accredited administration service fees. Although the services provided by the various administrators of schemes and the benefit option design may vary, there does not seem to be a correlation between the scheme size and the administration fees charged in the open scheme environment. No correlation between schemes administrated by the same accredited administrator was noted.

Table 37: Ten open schemes with the highest fees paid in respect of accredited administration services pampm - breakdown of components

Ref. no.	Name of Scheme	Average members	Fee paid in respect of accredited administration services	Member record management	Contribution management	Claims management	Financial management	Information management and data control	Broker remuneration management	Customer services
			pampm R	%	%	%	%	%	%	%
1125	Discovery Health Medical Scheme	1 351 211	387.08	10.15	8.93	11.23	0.37	18.23	1.44	49.64
1202	Fedhealth Medical Scheme**	56 917	299.47	10.29	10.29	18.64	6.48	5.12	1.43	47.75
1087	Keyhealth	34 292	284.20	6.57	16.00	18.64	1.96	22.06	-	34.77
1491	Compcare Medical Scheme	17 927	279.96	12.41	19.18	14.34	5.90	13.78	3.49	30.90
1464	Suremed Health*	771	263.62	6.67	7.55	21.48	13.64	25.96	0.85	23.82
1512	Bonitas Medical Fund**	356 713	257.71	14.01	5.39	23.73	4.31	15.10	10.79	26.66
1506	Medimed Medical Scheme*	6 226	237.15	6.26	7.11	23.58	13.74	25.02	0.28	24.01
1167	Momentum Medical Scheme	152 638	232.24	9.80	7.49	31.34	3.84	3.14	3.24	41.16
1592	Thebemed*	12 379	147.33	6.38	7.25	22.09	13.22	25.51	1.07	24.49
1466	Makoti Medical Scheme	5 636	100.96	21.09	30.44	-	14.20	31.79	2.47	-

Pampm = per average member per month

**The scheme is administered by Momentum Thebe Ya Bophelo (Pty) Ltd.*

***The scheme is administered by Medscheme Holdings (Pty) Ltd.*

The relationship between the various accredited administration services provided by Momentum Thebe Ya Bophelo (Pty) Ltd, and the total fees paid by the schemes under their administration, is similar.

However, this observation does not apply to the open schemes administered by Medscheme Holdings (Pty) Ltd, suggesting that the schemes negotiated their contracts separately. Bonitas Medical Fund also outsourced the administration of its Boncap option to Private Health Administrators (Pty) Ltd from 1 January 2023 onwards.

Table 38: Ten restricted schemes with the highest fees paid in respect of accredited administration services pampm

Ref. no.	Name of scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services
				pampm R
1201	Rand Water Medical Scheme	Afrocentric Integrated Health Administrators (Pty) Ltd	3 619	302.82
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 209	298.72
1520	University of Kwa-Zulu Natal Medical Scheme	Discovery Health (Pty) Ltd	3 237	292.61
1590	Building & Construction Industry Medical Aid Fund	Universal Healthcare Administrators (Pty) Ltd	4 449	289.05
1571	Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	2 215	287.40
1241	Multichoice Medical Aid Scheme	Discovery Health (Pty) Ltd	3 521	281.53
1578	TFG Medical Aid Scheme	Discovery Health (Pty) Ltd	2 878	280.75
1572	Engen Medical Benefit Fund	Discovery Health (Pty) Ltd	3 003	280.14
1013	Rhodes University Medical Scheme	Momentum Thebe Ya Bophelo (Pty) Ltd	1 254	267.28
1234	Sasolmed	Discovery Health (Pty) Ltd	28 475	265.36

pampm = per average member per month

All the schemes listed in the table above, incurred accredited administration service fees higher than the industry average of R166.89 pampm. This is to be expected, as the majority of these schemes have very low membership, and the inherent fixed costs of administrating a scheme are therefore shared amongst the smaller membership base. These schemes would also not be able to leverage from volume discounts.

Rand Water Medical Scheme changed its administration model from being self-administered to being third-party administered by Afrocentric Integrated Health Administrators (Pty) Ltd on 16 June 2023.

It was noted that six schemes from the Discovery Health (Pty) Ltd-administrator stable are included in the list above, with fees ranging from R265.36 to R292.61 pampm; the median fee (based on three schemes with similar membership sizes) is approximately R280.81 pampm. Higher fees pampm would typically be incurred due to lower membership, additional services provided, and differences in benefit design.

Table 39: Ten restricted schemes with the highest fees paid in respect of accredited administration services pampm - breakdown of components

Ref. no.	Name of Scheme	Average members	Fee paid in respect of accredited administration services	Member record management	Contribution management	Claims management	Financial management	Information management and data control	Broker remuneration management	Customer services
			pampm R	%	%	%	%	%	%	%
1201	Rand Water Medical Scheme	3 619	302.82	5.43	6.47	20.79	48.71	2.08	-	16.52
1194	Profmed	34 209	298.72	9.05	10.37	21.90	6.92	27.23	1.15	23.39
1520	University of Kwa-Zulu Natal Medical Scheme	3 237	292.61	10.31	9.06	11.41	0.37	18.49	-	50.36
1590	Building & Construction Industry Medical Aid Fund	4 449	289.05	8.39	12.10	21.16	6.73	20.45	-	31.18
1571	Anglovaal Group Medical Scheme	2 215	287.40	10.31	9.06	11.40	0.37	18.49	-	50.36
1241	Multichoice Medical Aid Scheme	3 521	281.53	10.31	9.06	11.40	0.37	18.48	-	50.37
1578	TFG Medical Aid Scheme	2 878	280.75	10.31	9.06	11.40	0.37	18.49	-	50.37
1572	Engen Medical Benefit Fund	3 003	280.14	10.31	9.06	11.41	0.37	18.49	-	50.36
1013	Rhodes University Medical Scheme	1 254	267.28	6.38	7.25	22.08	14.29	25.51	-	24.48
1234	Sasolmed	28 475	265.36	10.24	8.99	11.32	0.37	18.36	-	50.72

The relationship between the various accredited administration services provided by Discovery Health (Pty) Ltd for the schemes under their administration is similar, suggesting a boilerplate agreement.

The smaller schemes seem to spend almost half of their accredited administration service fees on customer services, followed by information management and data control, and claims management.

Table 40: Ten restricted schemes with the highest year-on-year increases in respect of accredited administration services pampm

Ref. no.	Name of scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services	% change
				pampm R	
1234	Sasolmed	Discovery Health (Pty) Ltd	28 475	265.36	104.31
1201	Rand Water Medical Scheme	Afrocentric Integrated Health Administrators (Pty) Ltd	3 619	302.82	92.77
1599	Lonmin Medical Scheme	Discovery Health (Pty) Ltd	10 394	79.01	7.47
1600	Motohealth Care	Momentum Health (Pty) Ltd	14 180	176.15	7.42
1209	South African Breweries Medical Aid Scheme (SABMAS)	3Sixty Health (Pty) Ltd	9 038	211.21	7.00
1598	Government Employees Medical Scheme (GEMS)	Metropolitan Health Corporate (Pty) Ltd	861 772	117.80	6.89
1145	LA-Health Medical Scheme	Discovery Health (Pty) Ltd	107 481	252.71	6.60
1520	University of Kwa-Zulu Natal Medical Scheme	Discovery Health (Pty) Ltd	3 237	292.61	6.57
1176	Retail Medical Scheme	Discovery Health (Pty) Ltd	15 875	252.28	6.53
1279	Bankmed	Discovery Health (Pty) Ltd	107 699	183.58	6.43

pampm = per average member per month

Sasolmed changed its administrator from Momentum Health Solutions (Pty) Ltd to Discovery Health (Pty) Ltd on 1 January 2024. The scheme indicated that the change in fees related to the tailor-made service offering procured after a formal tender process. Included in the 2024 fee is also a four month winding-down payment made to the previous administrator.

Rand Water Medical Scheme changed their administration model from being self-administered to being third-party administered by Afrocentric Integrated Health Administrators (Pty) Ltd during the 2023 financial year. The scheme did not complete the 2023-return accurately to reflect this arrangement, and therefore the prior year data is skewed.

Notably, six of the Discovery Health (Pty) Ltd-administrator stable schemes experienced higher increases than the remainder of the industry (the industry average increase was 6.12%), with an average increase of approximately 6.72%, with Sasolmed being an outlier with a 104.31% increase.

Lonmin Medical Scheme, Motohealth Care, SABMAS and the University of Kwa-Zulu Natal Medical incurred membership losses during the year. This led to the fixed costs inherent in administrating a medical scheme, being spread across a smaller membership base.

Rand Water Medical Scheme, Sasolmed and University of Kwa-Zulu Natal Medical Scheme is also included in Table 38, which lists the ten restricted schemes with the highest fees paid in respect of accredited administration services pampm.

Broker service fees

Broker service fees represented the second largest component of DAE, at 17.65% of total DAE in 2024. Broker costs increased by 4.61% from R2.84 billion in 2023 to R2.97 billion in 2024.

For schemes that pay broker service fees, these fees represented 22.34% of DAE.

The broker service fee paid on a pampm basis was R106.95 pampm; R106.57 pampm in respect of open schemes and R111.42 pampm relating to restricted schemes.

Previously the data was limited to the extent that it was based on full scheme membership (and not restricted to members who incurred this expenditure), relative to the statutory limit imposed. The CMS had started collecting data on the membership covered by broker arrangements in the year 2022. It should however be noted that where schemes did not provide adequate information in the annual statutory return, the scheme's average membership was used in the 2023 data.

- The total industry average of R106.95 pampm represented an increase of 5.41% from R101.46 pampm in 2023.
  - A 4.02% increase in the open scheme environment was observed.
  - A 22.78% increase in the restricted scheme environment was observed.

The 22.78% increase in the restricted scheme environment was due to a decrease in the reported members covered experienced:

- LA-Health Medical Scheme reported 9 473 less members covered in the 2024 year.
- Consumer Goods Medical Scheme reported 4 152 less members covered in the 2024 year (total membership was used in the 2023 year).
- SAMWUMed reported a decrease of 1 251 members.

LA-Health Medical Scheme and SAMWUMed both reported increased fees, despite the lower number of members covered by these arrangements.

Kindly refer to Annexure Q for more information per scheme.

92.79% of average members in open schemes were covered by broker arrangements during 2024, compared to 10.18% in the restricted scheme industry.

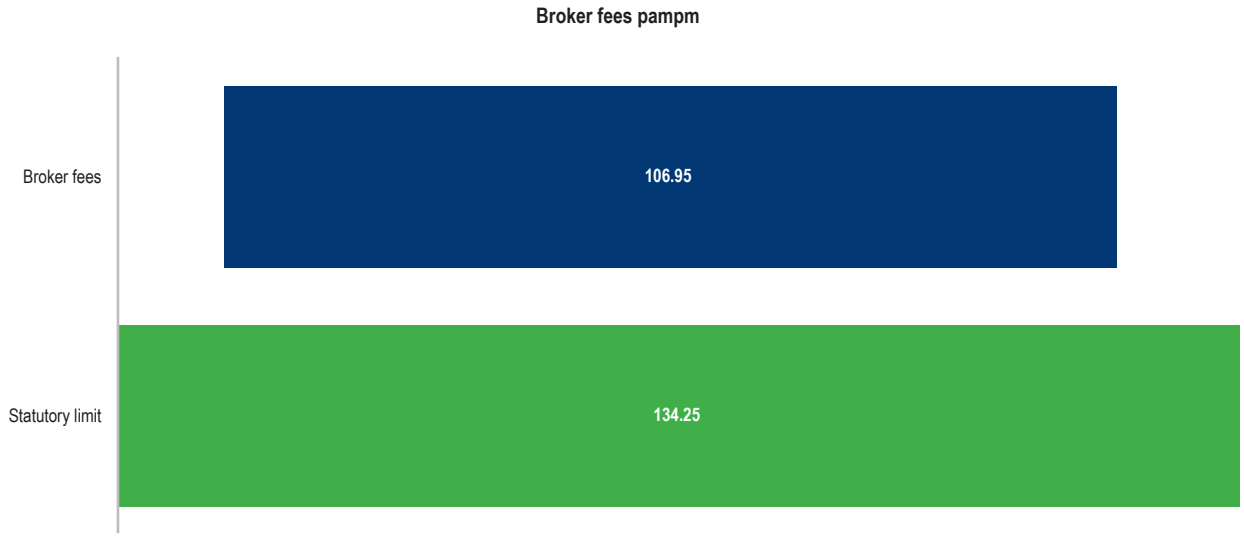


Figure 15: Broker fees pampm

The fees paid to brokers represented 79.66% of the statutory limit of R134.25 pampm imposed by the Government Gazette issued on 11 December 2023.

Figure 16 shows the schemes with broker service fees higher than the industry average of R106.95 pampm during 2024. These eleven schemes represented 86.07% of total membership that paid for broker service fees, and 89.99% of total broker service fees paid.

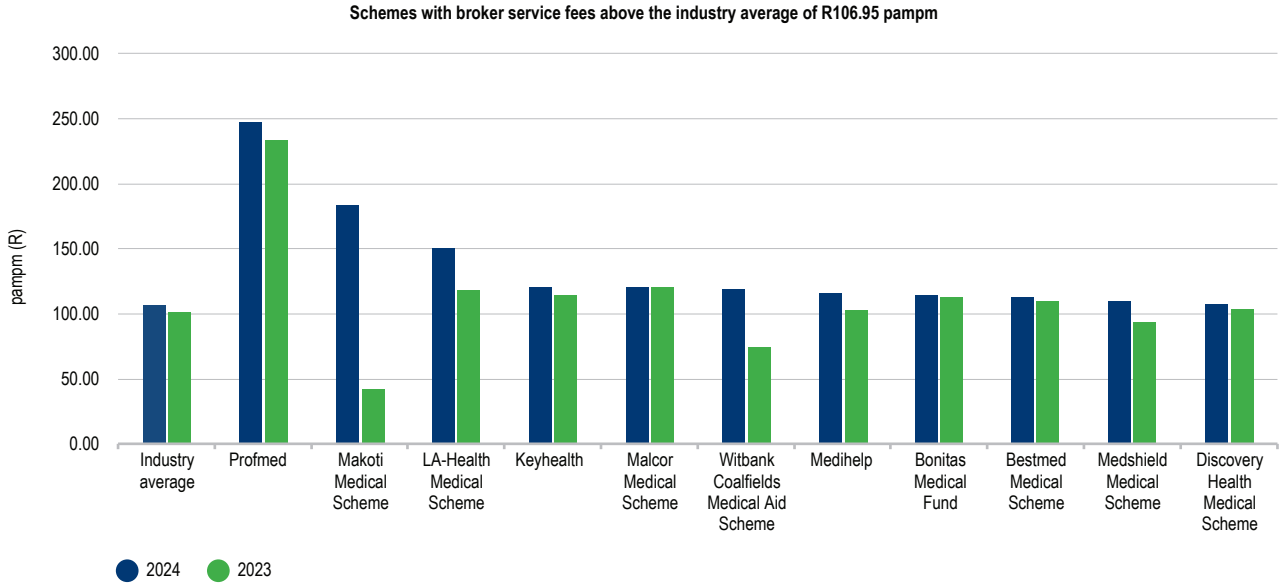


Figure 16: Schemes with broker fees above the industry average of R106.95 pampm

Profmed included in their broker remuneration of R247.90 pampm, expenditure incurred relating to internal new business consultants remuneration and expenses.

Makoti Medical Scheme's sharp increase in fees is attributable to a change in the reported number of members covered by broker agreements.

Other directly attributable administration expenditure

Other directly attributable administration expenditure, being the third largest component of DAE in all medical schemes, grew by 9.14% from R2.28 billion in 2023 to R2.49 billion in 2024.

Open schemes increased their other directly attributable administration expenditure by 9.09% from R1.25 billion in 2023 to R1.36 billion in 2024. Restricted schemes increased their other directly attributable administration expenditure by 9.20% from R1.03 billion in 2023 to R1.12 billion in 2024.

Figure 17 depicts the main components of other directly attributable administration expenditure.

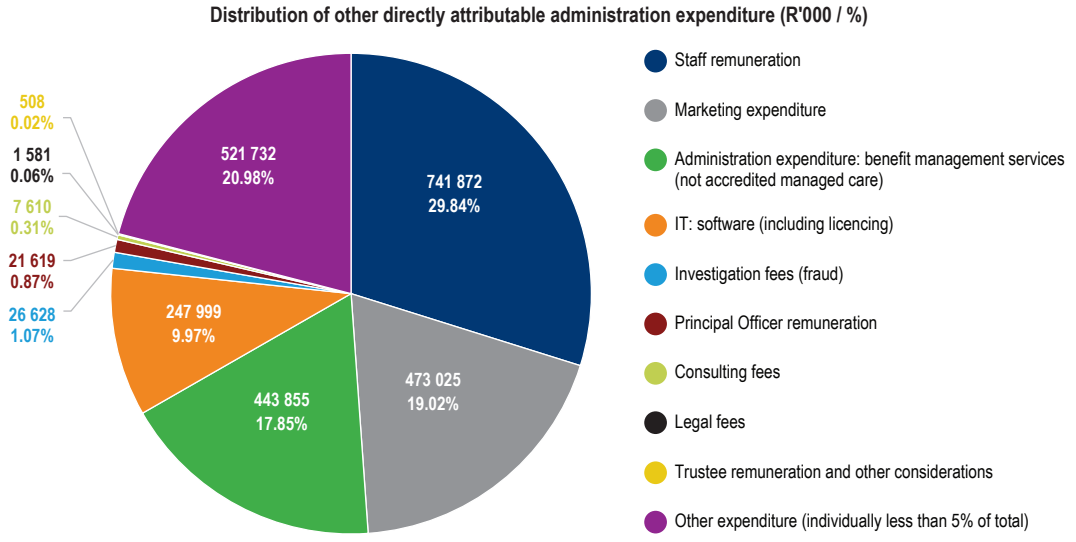


Figure 17: Distribution of other directly attributable administration expenditure

Staff remuneration (29.84%), marketing expenditure (19.02%), administration expenditure: benefit management services (not accredited managed care) (17.85%) and IT: software (including licensing) (9.97%) account for more than three quarters of the total other directly attributable administration expenditure.

Other non-directly attributable administration expenditure

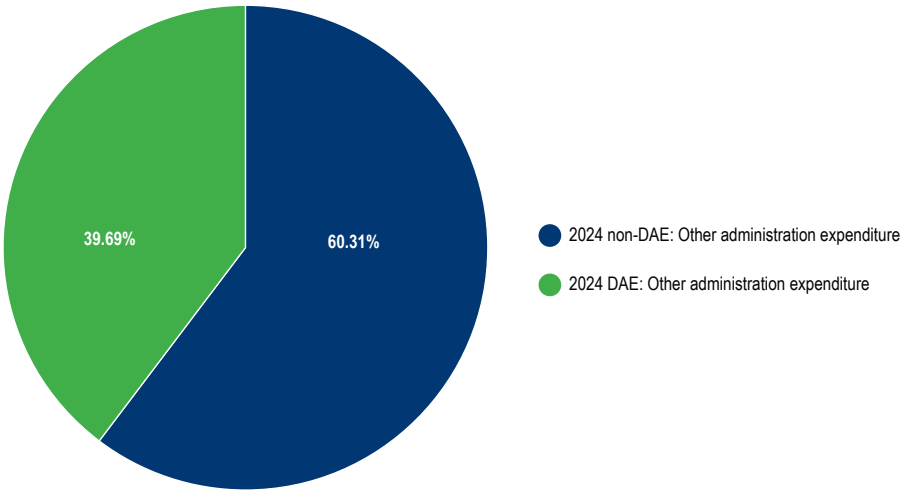
Relationship between DAE and non-DAE

It is expected that the trend between the allocation of DAE and non-DAE changes as the IFRS 17 journey matures. CMS had arranged stakeholder engagement sessions which seeks to standardise the allocation to some extent in future.

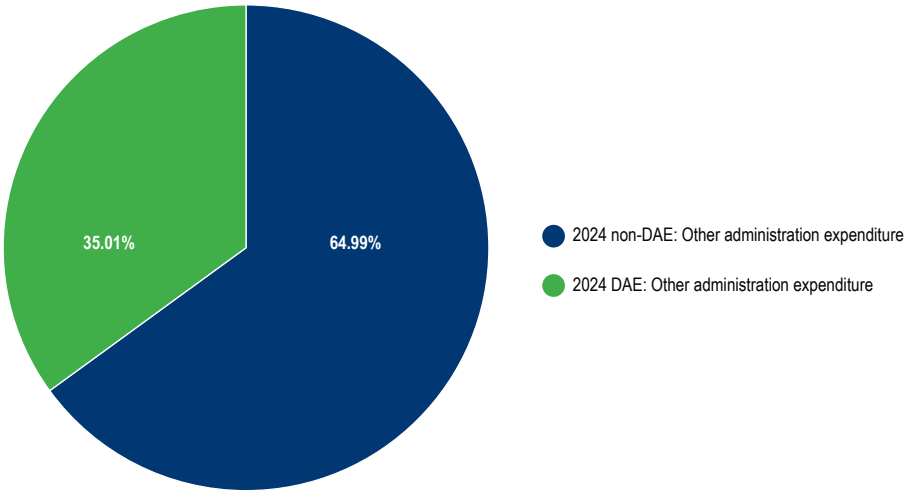
As administration fees are in general categorised as DAE, the majority of the administration expenditure incurred by medical schemes are considered to be DAE: 76.92% in 2024 (open schemes: 82.09%, restricted schemes 67.59%).

However, when considering the classification of other administration expenditure (i.e. other than administration fees) as DAE, open schemes designated 39.69% of their other administration expenditure as DAE, whilst the restricted scheme environment had a lower proportion of 35.01%.

Open schemes: Other administration expenditure DAE versus non-DAE



Restricted schemes: Other administration expenditure DAE versus non-DAE



Figures 18 and 19: Other administration expenditure: DAE versus non-DAE per industry

During the CMS' analysis of the schemes' 2024 annual financial statements, no clear pattern in the allocation between the expenditure emerged, for example:

- Actuarial fees incurred for the calculation of the liability for incurred claims and pricing of products were split as follows: 42.91% was classified as DAE and 57.09% as non-DAE.
- IT Infrastructure expenditure was classified as follows:
  - IT Hardware (not capitalised): 95.33% DAE and 4.67% non-DAE
  - IT: Software (including licencing): 72.99% DAE and 27.01% non-DAE
  - IT: Networking (including hosting): 54.75% DAE and 45.25% non-DAE
  - IT: Other: 69.88% DAE and 30.12% non-DAE

Further engagement on the classification of medical schemes' operational expenditure is therefore necessary.

Distribution of non-DAE

Figure 20 depicts the main components of non-directly attributable administration expenditure.

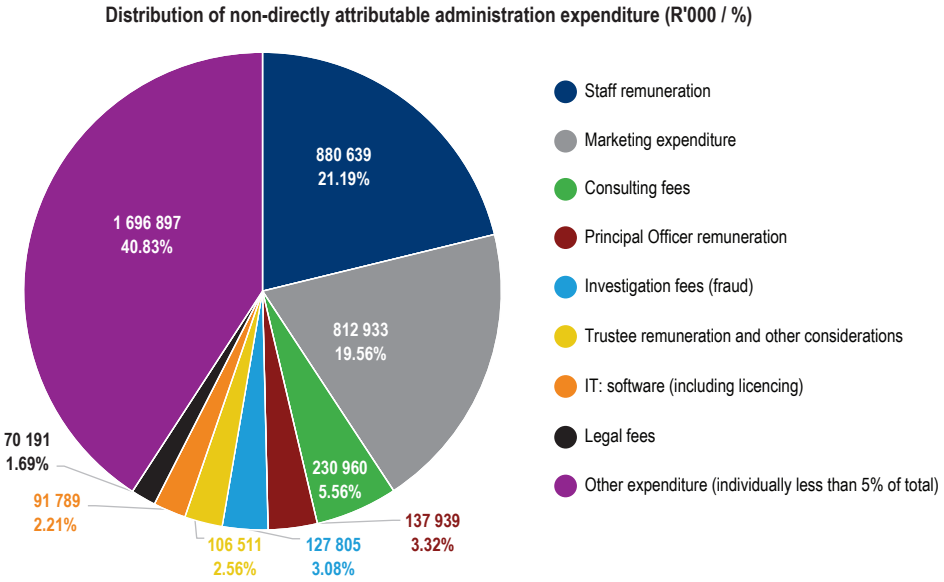


Figure 20: Distribution of non-directly attributable administration expenditure

Staff remuneration (21.19%) and marketing expenditure (19.56%) represented the biggest individual administration expenditure items of the total non-directly attributable administration expenditure. The remainder of the individual line items that make up this expenditure, represents individually less than 5.56% of the total expense.

Combined DAE and non-DAE other administration expenditure

As the IFRS 17 journey is still in its initial stages, and the allocation between DAE and non-DAE has not yet matured, separate analysis of the individual components of DAE and non-DAE might not be meaningful. For purposes of evaluating other administration expenditure, the combined DAE and non-DAE components were assessed.

Refer to Annexure S for more information on the expenditure incurred per scheme.

Fees paid to accredited administrators in respect of other administration expenditure

Fees paid to accredited administrators in respect of other expenditure were valued at R1.56 billion in 2024.

Table 41 depicts the breakdown of the total fee paid in respect of other administration expenditure.

Table 41: Breakdown of fees paid to third-party administrators in respect of other administration expenditure

Component of other administration expenditure	Open schemes	Restricted schemes
	% of total fee	% of total fee
Actuarial services	1.44	0.96
Benefit management services	0.15	0.43
Internal audit services	4.70	8.27
Distribution services	5.48	0.61
Broker services (accredited brokers and in-house sales and marketing services)	-	0.14
Marketing services	43.85	19.80
Third party claim recovery services	0.67	0.46
Forensic investigations and recoveries	6.98	24.66
Governance and compliance services rendered	5.55	28.01
Other	31.19	16.65

The majority of the fees paid in respect of other administration expenditure relates to marketing services (43.85%) in the open scheme environment. In the restricted scheme environment, the main components related to governance and compliance services rendered (28.01%), forensic investigations and recoveries (24.66%), followed by marketing services (19.80%).

Annexure W provides a detailed breakdown of the other administration services per scheme and also expand on some of the data limitations experienced.

Table 42 lists the schemes with the highest fees paid in respect of other administration expenditure to its administrators (pampm).

Table 42: Ten schemes which paid the highest fees to accredited administrators in respect of other administration expenditure pampm

Ref. no.	Name of Scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services	Fee paid to accredited administrator in respect of other administration expenditure	Other fees as % of accredited administration services fees
				pampm R	pampm R	%
1167	Momentum Medical Scheme	Momentum Health (Pty) Ltd	152 638	232.24	169.55	73.01
1600	Motohealth Care	Momentum Health (Pty) Ltd	14 180	176.15	71.30	40.48
1145	LA-Health Medical Scheme	Discovery Health (Pty) Ltd	107 481	252.71	67.05	26.53
1548	Medipos Medical Scheme	Medscheme Holdings (Pty) Ltd	6 952	126.87	49.40	38.94
1563	Pick n Pay Medical Scheme	Momentum Health (Pty) Ltd	6 002	143.55	47.10	32.81
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	56 917	299.47	45.33	15.14
1005	AECI Medical Aid Society	Medscheme Holdings (Pty) Ltd	5 245	171.51	45.11	26.30
1186	PG Group Medical Scheme	Momentum Health (Pty) Ltd	1 270	236.02	43.57	18.46
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 351 211	387.08	42.37	10.95
1293	Wooltru Healthcare Fund	Momentum Health (Pty) Ltd	9 381	202.45	38.74	19.14

pampm = per average member per month

Open schemes

Of the open schemes listed above, Momentum Medical Scheme exceeded the open scheme industry average of R49.07 pampm.

All three open schemes listed above, also appear in table 36 (Ten open schemes with highest fees paid in respect of accredited administration services pampm).

Momentum Medical Scheme's fee paid in respect of other administration expenditure represented 73.01% of its fee in relation to accredited administration services. It is also more than double the fee paid by the scheme with the second highest expenditure pampm.

The bulk of the fee paid to the accredited administrator related to marketing expenditure and distribution services:

- Momentum Medical Scheme: 54.11% in respect of marketing expenditure.
- Fedhealth Medical Scheme: 33.72% in respect of marketing expenditure, and 41.66% in relation to distribution services.
- Discovery Health Medical Scheme: 47.51% in respect of marketing expenditure.

Restricted schemes

Whilst all of the restricted schemes included in the table exceeded the restricted scheme industry average of R21.52 pampm, none are included in table 38. It is interesting to note that four schemes administered by Momentum Health Solutions (Pty) Ltd are included in the list, followed by two schemes administered by Medscheme Holdings (Pty) Ltd, and one scheme administered by Discovery Health (Pty) Ltd.

The bulk of the fees paid to the accredited administrator by the two schemes with the highest fees, related to marketing expenditure and distribution services:

- Motohealth Care: 58.43% in respect of marketing expenditure.
- LA-Health Medical Scheme: 68.56% in respect of marketing expenditure.

The remainder of the restricted schemes' fees mainly related to governance and compliance services, and internal audit services rendered.

Self-administered schemes

Figure 21 depicts the distribution of administration expenditure in self-administered schemes.

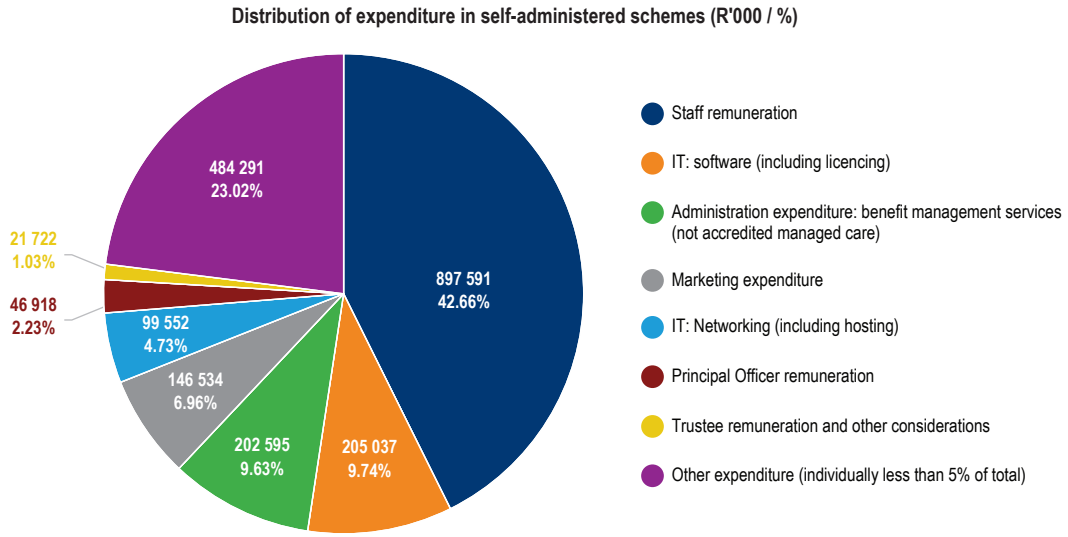


Figure 21: Distribution of expenditure in self-administered schemes

The main components of administration expenditure incurred by self-administered schemes were:

- Staff remuneration (42.66%)
- IT: software (including licensing) (9.74%)
- Administration expenditure: benefit management services (not accredited managed care) (9.63%)
- Marketing expenditure (6.96%)
- IT: networking (including hosting) (4.73%)

The remainder of the administration expenditure line items (except for depreciation at 3.11%) represented individually less than 2.25% of the total administration expenditure incurred.

Self-administered schemes designated the majority of their big expense ticket items as DAE, with marketing expenditure representing the only outlier:

- Staff remuneration (79.93%)
- IT: software (including licensing) (76.02%)
- Administration expenditure: benefit management services (not accredited managed care) (99.95%)
- Marketing expenditure (34.78%)
- IT: networking (including hosting) (94.06%)

Staff remuneration

Table 43 provides information on the ten open schemes which incurred the highest staff remuneration (on a R'000 basis). This expenditure excludes principal officer remuneration and trustee remuneration.

Table 43: Ten open schemes with the highest staff remuneration

Ref. no.	Name of Scheme	Name of administrator	Average members	Staff remuneration	
				R'000	pampm R
1149	Medihelp	Self-Administered	97 851	241 659	205.81
1252	Bestmed Medical Scheme	Self-Administered	119 896	214 631	149.18
1140	Medshield Medical Scheme	Self-Administered	70 979	181 214	212.76
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 292	47 369	115.11
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 351 211	34 862	2.15
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	356 713	31 653	7.39
1554	Genesis Medical Scheme	Self-Administered	8 690	28 140	269.85
1034	Cape Medical Plan	Self-Administered	3 317	11 590	291.18
1167	Momentum Medical Scheme	Momentum Health (Pty) Ltd	152 638	4 215	2.30
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	56 917	1 915	2.80

pampm = per average member per month

Half of the schemes listed above are third party-administered schemes. There is a clear distinction between the administration models when evaluating the expenditure per average member per month, with Keyhealth a clear outlier. The scheme only outsourced its core medical scheme administration services to third party administrators, reserving certain primary management functions to scheme personnel. Keyhealth is included in Table 36 as the open scheme which paid the third highest fee in respect of accredited administration services pampm (R284.20 pampm).

Table 44 provides information on the ten restricted schemes which incurred the highest staff remuneration (on a R'000 basis). This expenditure excludes principal officer remuneration and trustee remuneration.

Table 44: Ten restricted schemes with the highest staff remuneration

Ref. no.	Name of Scheme	Name of administrator	Average members	Staff remuneration	
				R'000	pampm R
1598	Government Employees Medical Scheme (GEMS)	Metropolitan Health Corporate (Pty) Ltd	861 772	492 535	47.63
1583	Platinum Health	Self-Administered	57 930	82 544	118.74
1580	South African Police Service Medical Scheme (POLMED)	Medscheme Holdings (Pty) Ltd	187 501	58 916	26.18
1038	SAMWUMed	Self-Administered	33 316	58 328	145.90
1279	Bankmed	Discovery Health (Pty) Ltd	107 699	23 883	18.48
1597	Umvuzo Health Medical Scheme	Self-Administered	52 657	22 171	35.09
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Self-Administered	26 362	21 987	69.50
1291	Witbank Coalfields Medical Aid Scheme	Self-Administered	9 913	20 726	174.23
1068	De Beers Benefit Society	Self-Administered	4 218	13 471	266.14
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 209	8 695	21.18

pampm = per average member per month

Four of the schemes listed above are third party-administered schemes. There is a clear distinction between the administration models when evaluating the expenditure per average member per month.

It should be noted that administering a scheme incurs certain minimum costs. The pampm-figures are distorted when the fixed costs are shared among a smaller membership base. This is clearly evidenced by De Beers Benefit Society's staff remuneration figure. The De Beers Benefit Society figure is still lower than the expenditure incurred by similar sized self-administered open schemes.

Marketing and advertising expenditure

Marketing and advertising expenditure increased by 7.53% to R1.29 billion in 2024. When adjusted for lives, this translated to R27.64 pampm (2023: R25.91 pampm).

Tables 45 and 46 show the five open and five restricted schemes with the highest marketing and advertising expenditure in excess of the respective industry averages and provides details of the individual contracts entered into.

Table 45: Open schemes with highest marketing and advertising expenditure

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider	%
		2024	2023	%	2024	2023	%			of total fees
		pampm	pampm	change			change		R'000	
1202	Fedhealth Medical Scheme	104.12	102.18	1.90	56 917	59 851	(4.90)	Ad-hoc expenditure	-	-
								The Cheese Has Moved (Pty) Ltd	71 112	100.00
1167	Momentum Medical Scheme	91.74	86.54	6.01	152 638	154 773	(1.38)	Ad-hoc expenditure	-	-
								Momentum Health (Pty) Ltd	168 028	100.00
1512	Bonitas Medical Fund	54.02	52.25	3.39	356 713	351 061	1.61	Ad-hoc expenditure	24 338	10.52
								Afrocentric Distribution Services (Pty) Ltd	91 512	39.57
								Agile Alternative Business Solutions	57 257	24.76
								Meta Media Pty Ltd	26 428	11.43
								Adclick Africa Pty Ltd	18 159	7.85
								Hippo Comparative Services (Pty) Ltd	7 763	3.36
								Medquote (Pty) Ltd	5 346	2.31
								Du Maurier Communications	436	0.19
1592	Thebemed	45.08	34.49	30.70	12 379	12 828	(3.50)	Ad-hoc expenditure	3 640	54.36
								Momentum Thebe Ya Bophelo (Pty) Ltd	3 056	45.64
1087	Keyhealth	42.23	50.17	(15.83)	34 292	34 533	(0.70)	Ad-hoc expenditure	3 366	19.37
								Brand ET AL	7 691	44.25
								I Lead ET AL	5 680	32.68
								Vanabi Communications	326	1.88
								MIP Holdings	317	1.82
	Open scheme industry average*	**33.31**	**32.03**	**4.00**	**2 292 126**	**2 303 220**	**(0.48)**			

pampm = per average member per month

** The industry averages are based on those schemes which incurred the specific type of expenditure.*

All of the schemes listed, except for Bonitas Medical Fund, experienced net losses in their average membership, whilst the industry showed a slight growth.

It is interesting to note that the majority of the fee that was paid by the five schemes that incurred the highest expenditure, were paid to the accredited administrator or its related parties.

This raise concerns on the value added by these arrangements. The CMS Compliance and Investigations Unit evaluates all third-party contracts during their routine inspections. Schemes are also encouraged to re-evaluate their contracts with their accredited administrator, specifically as it pertains to marketing expenditure.

Fedhealth Medical Scheme's marketing and advertising expenditure of R104.12 pampm exceeds the industry average by 212.58% and is 13.49% more than the expenditure incurred by the next highest scheme, Momentum Medical Scheme.

Table 46: Restricted schemes with highest marketing and advertising expenditure

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider	%
		2024	2023	%	2024	2023	%			of total fees
		pampm	pampm	change			change		R'000	
1194	Profmed	74.99	67.56	11.00	34 209	35 120	(2.59)	Ad-hoc expenditure	1 266	4.11
								Faith and Fear	24 906	80.90
								Baby Yum Yum	2 809	9.12
								MSL	1 411	4.58
								ICE-Tags	300	0.97
								Novus Group	94	0.31
1597	Umvuzo Health Medical Scheme	64.59	59.39	8.76	52 657	50 914	3.42	Ad-hoc expenditure	-	-
								Rain Catchers	40 815	100.00
1145	LA-Health Medical Scheme	46.21	43.30	6.72	107 481	100 934	6.49	Ad-hoc expenditure	-	-
								Discovery Health (Pty) Ltd	59 595	100.00
1600	Motohealth Care	45.92	43.59	5.35	14 180	14 932	(5.04)	Ad hoc expenditure	726	9.29
								Momentum Health (Pty) Ltd	7 089	90.72
1568	Sisonke Health Medical Scheme	19.74	43.88	(55.01)	10 309	11 445	(9.93)	Ad-hoc expenditure	2 442	100.00
	Restricted scheme industry average*	**19.44**	**16.77**	**15.92**	**1 585 227**	**1 543 037**	**2.73**			

pampm = per average member per month

**The industry averages are based on those schemes which incurred the specific expenditure.*

Typically, restricted schemes do not incur any marketing expenditure as their membership is limited to specific employer groups. However, some of these schemes are restricted to a specific industry or profession, resulting in their operations being more similar to those of open schemes in this respect.

Interestingly, the restricted schemes' marketing expenditure per average member per month for the four schemes with the highest expenditure, exceeds even the open scheme industry's average of R33.31 pampm. Profmed experienced a significant year-on-year increase in their pampm-figure.

Only Umvuzo Health Medical Scheme and LA-Health Medical Scheme experienced net membership growth (their average number of members increased by 3.42% and 6.49%, respectively).

Sisonke Health Medical Scheme expenditure pampm decreased by 55.01% on an annual basis. The scheme purchased medicine bags as a once-off promotional expenditure in 2023.

External auditors

Audit Quality Indicators (AQIs) are essential tools used to measure and assess the effectiveness of audit processes, ensuring the reliability and credibility of financial reporting. These indicators are integral to maintaining transparency, accountability, and trust in the auditing profession.

International best practices, as outlined by organisations and regulators such as the Independent Regulatory Board for Auditors (IRBA), International Auditing and Assurance Standards Board (IAASB) and the International Federation of Accountants (IFAC), emphasize the importance of AQIs in fostering continuous improvement in audit quality.

AQIs refers to a portfolio of qualitative and quantitative measures provided by an audit firm to an audit committee of their client, or future client, for use in transparency reports and for regulatory purposes. These measures could be used to enhance dialogue about, and an understanding of, auditors and their audits as well as ways to evaluate their audit quality.

In that way, users can be better informed about key matters that may contribute to the quality of an audit (both at audit firm level and audit engagement level). This could benefit audit committees in discharging their oversight responsibilities regarding the external audit process, including the appointment or reappointment of the external auditor.

In a March 2025 stakeholder engagement session held with the audit committees of medical schemes, the AQIs had been adopted for implementation for consideration during the appointment of auditors for the 2027 financial year. Subsequently, the proposed reports to be submitted by audit committees to the CMS to facilitate the approval of the appointment of the auditors as required in terms of Section 36(2), had been circulated for comment.

One of the AQIs adopted for implementation, refers to the extent of fees paid to schemes' external auditors for services beyond the external assurance function. This could highlight potential possible independence concerns.

Schemes' audit committees must evaluate the appropriateness of the services to be provided, and the fee relative to the audit fee, to ensure that the provision of such services does not impair the external auditor's independence or objectivity.

Table 47: Schemes with fees paid to external auditors in respect of other services rendered

Ref. no.	Name of medical scheme	Name of audit firm	External auditor: fees paid in respect of other services			
			2024	%	2023	%
			R'000	of audit fee	R'000	of audit fee
1512	Bonitas Medical Fund	Deloitte & Touche	2 761	41.25	-	0.00
1214	Old Mutual Staff Medical Aid Fund	PricewaterhouseCoopers Inc	26	1.35	17	1.54
1145	LA-Health Medical Scheme	Deloitte & Touche	15	0.87	14	1.31

Over the past few years, a significant reduction in quantum of fees paid to the external auditor in relation to other services had been noted. This is an encouraging trend that reflects well on potential threats to the independence of external auditors being eliminated.

IRBA has prescribed an IRBA Rule on Enhanced Auditor Reporting for the Audit of Financial Statements of Public Interest Entities (EAR Rule). This EAR Rule was effective for audits of financial statements of PIE medical schemes for the 2024 financial year. The EAR Rule requires the disclosure of fee-related matters in the auditor's report on the AFS, if it was not disclosed appropriately in the notes to the AFS. This would allow the readers of the AFS to assess the independence of the external auditors.

Bonitas Medical Fund's Board of Trustees approved a non-assurance review to be performed by its external auditors. The engagement included a review of the scheme's relational governance, as well as the scheme's transactional governance with respect to its administration and managed care contracts. The scheme indicated that it's Audit and Risk Committee considered the potential threat to independence, evaluated the safeguards put in place by its external auditor and concluded that the independence of the external auditor will not be impaired. The review is performed every two years.

Governance related expenditure

During the past few years governance related expenditure incurred by medical schemes has come under scrutiny.

Remuneration and other considerations of trustees accounted for 0.59% of administration expenditure (combined DAE and non-DAE).

CMS issued Circular 41 of 2014 Guideline for remuneration of medical schemes' trustees which aimed to provide guidance on role definition (i.e. the trustee's role is akin to that of a non-executive director), and alignment of schemes' Trustee Remuneration Policy with the principals of the King Report on Governance for South Africa, issued in September 2009 (King III), read together with the King III Remuneration Practice Notes. The Trustee Remuneration Policy should also be cognisant of the not-for-profit nature of medical schemes.

Table 48 show the ten schemes with the highest average trustee fees. Figures 22 - 27 shows the breakdown of trustee remuneration for the ten schemes with the highest remuneration. Further details are contained in Annexure S.

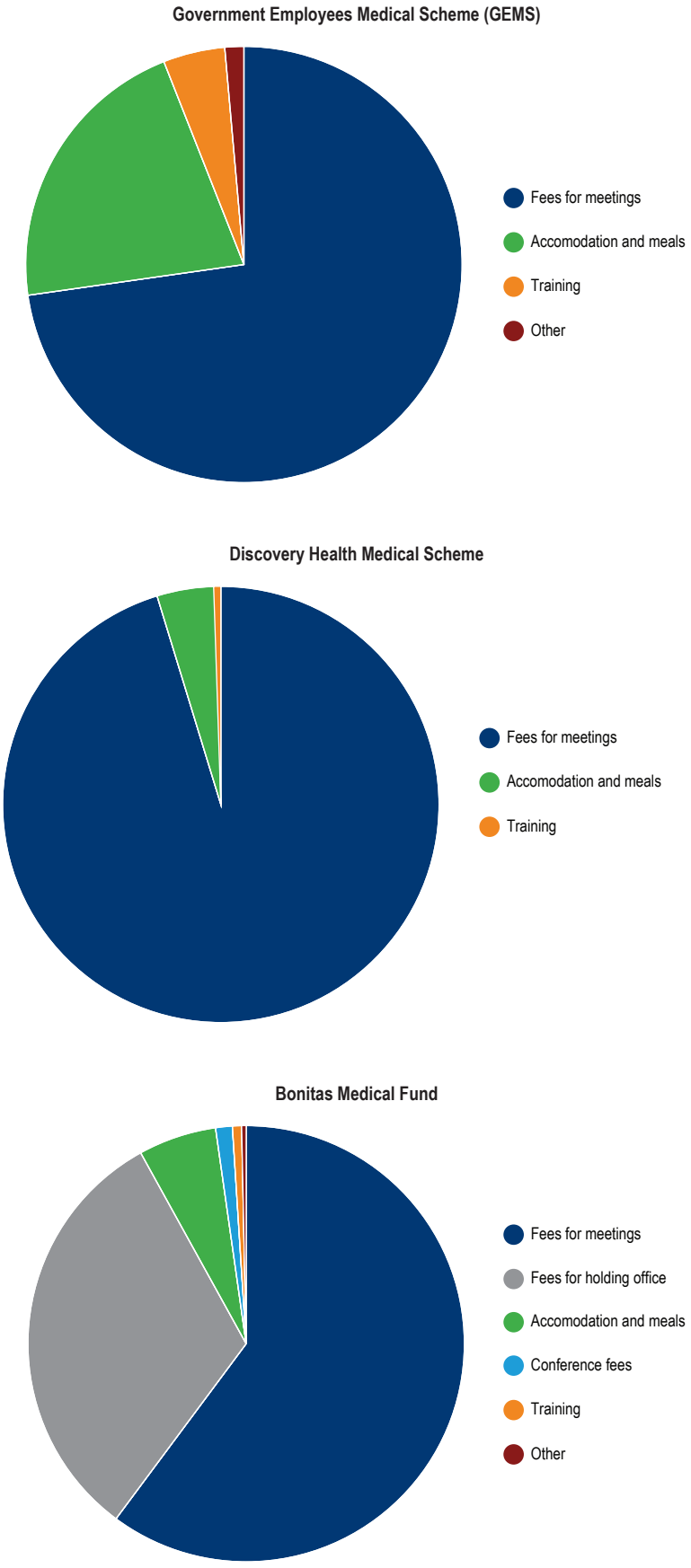
Table 48: Ten schemes with the highest trustee fees

Ref. no.	Name of medical scheme	Type	Trustee remuneration & other considerations		No. of trustees		Average fee per trustee	
			2024	2023	2024	2023	2024	2023
			R'000	R'000			R'000	R'000
1598	Government Employees Medical Scheme (GEMS)	Restricted	14 821	14 025	14	10	1 059	1 403
1125	Discovery Health Medical Scheme	Open	12 598	11 950	8	10	1 575	1 195
1512	Bonitas Medical Fund	Open	8 111	6 660	11	10	737	666
1580	South African Police Service Medical Scheme (POLMED)	Restricted	6 571	6 324	14	19	469	333
1167	Momentum Medical Scheme	Open	5 290	4 307	13	11	407	392
1202	Fedhealth Medical Scheme	Open	5 029	4 757	9	10	559	476
1140	Medshield Medical Scheme	Open	4 639	4 189	7	10	663	419
1087	Keyhealth	Open	4 602	3 585	9	9	511	398
1597	Umvuzo Health Medical Scheme	Restricted	4 199	3 174	10	10	420	317
1252	Bestmed Medical Scheme	Open	4 106	3 017	12	11	342	274

When evaluating the fees incurred as a percentage of the schemes' Regulation 29 reserves, the following schemes' fees ranged between 0.04% - 0.10%: GEMS, Discovery Health Medical Scheme, Bonitas Medical Fund and POLMED.

Schemes need to consider the most appropriate size for Boards to still be effective and efficient in discharging their duties and responsibilities. The average number of trustees for the schemes included in the table is ten trustees.

The following figures compare the distribution of the various fees paid to trustees per scheme that paid more than R500 000.00 in average fees per trustee.



Figures 22 - 24: Composition of trustee remuneration for the five schemes who paid in excess of R500 000.00 in average fee per trustee

The majority of the fees incurred by GEMS and Discovery Health Medical Scheme relate to fees for meetings, followed by accommodation and meals, and training.

Bonitas Medical Fund also made a payment to its trustees for holding their office.

The remuneration of principal officers of medical schemes amounted to 0.86% of administration expenditure in 2024.

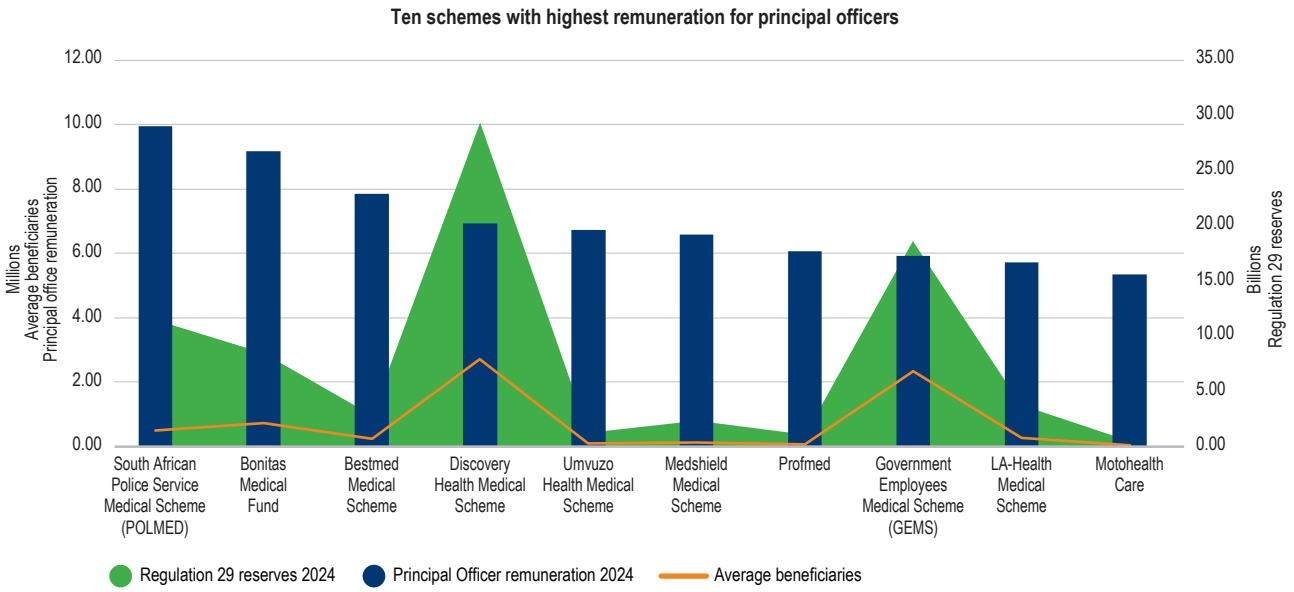


Figure 25: Ten schemes with highest remuneration of principal officers

When comparing the principal officer remuneration between various schemes, the following factors should inter alia be taken into consideration: membership size, demographic profile, Regulation 29 reserves, complexity of benefit design and administration model.

The figure above contains information relating to scheme sizes (based on membership and Regulation 29 reserves).

The following schemes are self-administered: Bestmed Medical Scheme, Umvuzo Health Medical Scheme and Medshield Medical Scheme. These schemes' higher expenditure is therefore expected.

For more information on the number of benefit options, demographic profiles and claims profiles, reference can be made to Annexure O. It was interesting to note that the schemes (GEMS and Discovery Health Medical Scheme) with the highest number of beneficiaries and Regulation 29 reserves under management, did not incur the highest principal officer remuneration. These schemes are third-party administered. There is no correlation between the number of benefit options, membership size and Regulation 29 reserves.

For more information on accredited managed care and risk transfer arrangements, reference can be made to Annexure J.

Trends in DAE, relevant healthcare expenditure and reserve-building

Table 49 shows the five open schemes with directly attributable insurance service expenditure greater than the industry average of R221.05 pabpm.

Table 49: Trends in relevant healthcare expenditure, directly attributable insurance service expenditure, and reserve-building as a percentage of insurance revenue among open schemes

Ref. no.	Name of medical scheme	Directly attributable insurance service expenditure		Relevant healthcare expenditure		Directly attributable insurance service expenditure		Reserve-building (insurance service result)		
		2024	2023	2024	2023	2024	2023	2024	2023	%
		pabpm	pabpm	As % of IR	As % of IR	As % of IR	As % of IR	As % of IR	As % of IR	change
1034	Cape Medical Plan	260.42	209.64	102.06	106.34	10.67	9.75	(12.73)	(16.09)	20.88
1167	Momentum Medical Scheme	250.13	235.78	88.08	90.68	13.64	14.22	(1.72)	(4.90)	64.90
1125	Discovery Health Medical Scheme	246.27	229.07	90.21	92.41	9.99	10.43	(0.20)	(2.84)	92.96
1491	Compcare Medical Scheme	242.10	236.06	94.88	102.30	9.17	9.95	(4.05)	(12.25)	66.94
1202	Fedhealth Medical Scheme	221.99	219.38	95.46	98.02	8.19	8.77	(3.65)	(6.79)	46.24
	Industry average - open schemes	**221.05**	**207.22**	**91.91**	**93.41**	**9.22**	**9.54**	**(1.13)**	**(2.95)**	**61.69**

pabpm = per average beneficiary per month

IR = Insurance Revenue

All five schemes listed above incurred insurance service deficits. This is an industry wide phenomenon that occurred as a result of the under-pricing of contributions in the 2021 and 2022 years – for the purpose of aiding members in the economic downturn after the Covid-19 pandemic. Corrective pricing had occurred in the 2024 and 2025 benefit years.

Cape Medical Plan has a very low membership base, with a poor demographic profile, which exposes it to claims volatility. Cape Medical Plan is a self-administered scheme and classified all of its expenditure as other administration expenditure (i.e. the scheme incurred no accredited administration service fees or broker service fees). It should further be noted that administering a scheme incurs certain minimum costs. The pampm-figures are distorted when the fixed costs are shared among a smaller membership base.

The composition of the DAE of the remaining four schemes who incurred the highest expenditure is reflected below:

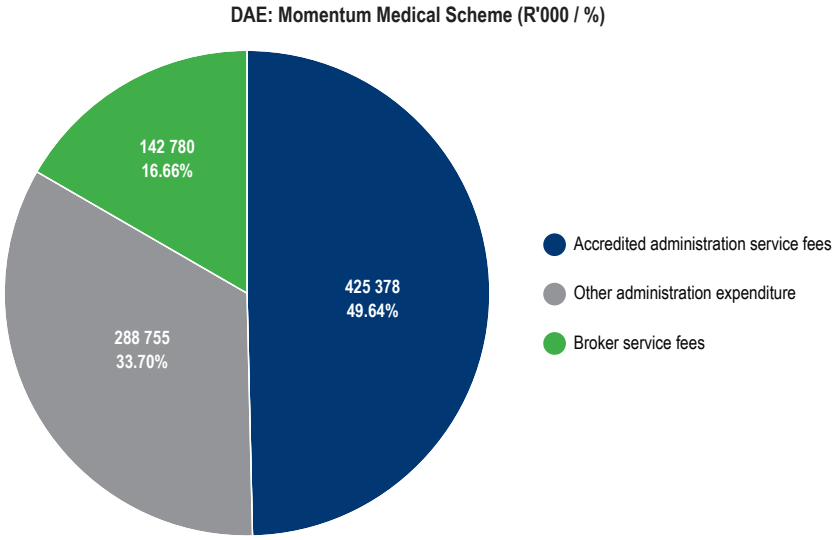


Figure 26: DAE: Momentum Medical Scheme

Momentum Medical Scheme's accredited administration services fees represent 49.64% of its DAE, followed by other administration expenditure at 33.70%.

The scheme's fee of R232.24 pampm paid to Momentum Health Solutions (Pty) Ltd in respect of accredited administration services on a pampm basis is lower than the open scheme industry average of R340.18 pampm. It is the eighth highest fee in the industry (refer to Table 36.)

The fee paid to the accredited administrator in respect of other administration expenditure of R169.55 pampm exceeded the open scheme industry average of R49.07 pampm. This fee consists of:

- 54.11% marketing services
- 36.44% other services
- 4.56% actuarial services
- 2.23% third party claim recovery services
- 1.94% governance and compliance services rendered
- 0.74% internal audit services

When comparing its marketing and advertising expenditure, the R91.74 pampm exceeded the open scheme industry spend of R33.31 pampm.

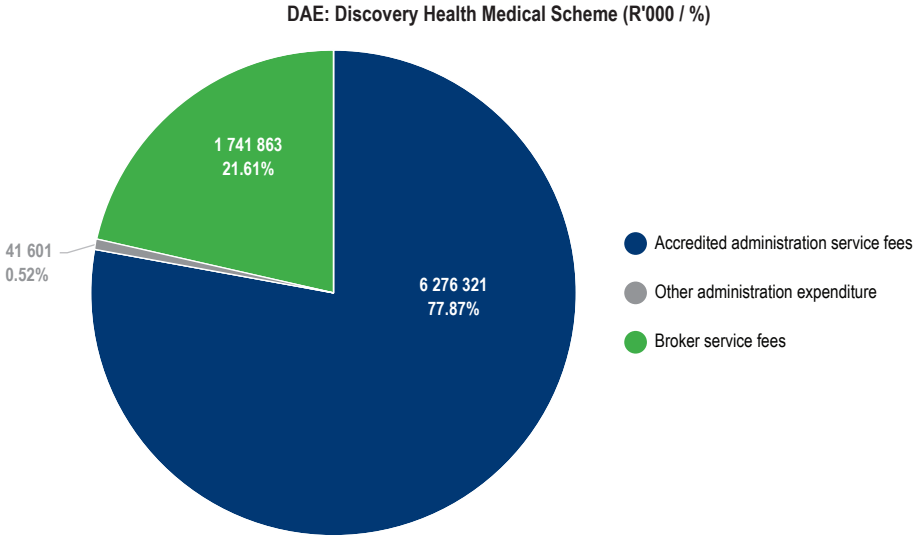


Figure 27: DAE: Discovery Health Medical Scheme

Discovery Health Medical Scheme's accredited administration services fees represent 77.87% of its DAE, followed by broker service fees at 21.61%.

The scheme's fee of R387.08 pampm paid to Discovery Health (Pty) Ltd in respect of accredited administration services on a pampm basis is higher than the open scheme industry average of R340.18 pampm. It is the highest fee in the industry (refer to Table 36.)

The fee paid to the accredited administrator in respect of other administration expenditure of R42.37 pampm is lower than the open scheme industry average of R49.07 pampm. This majority of the fee relates to the provision of marketing services (47.51%) and (35.63%) various other services such as quality management and monitoring services, advanced data analytics, digital service offering, product innovation, etc.

When comparing its marketing and advertising expenditure, the R20.13 pampm is lower than the open scheme industry spend of R33.31 pampm and is indicative of costs shared amongst a broader membership base.

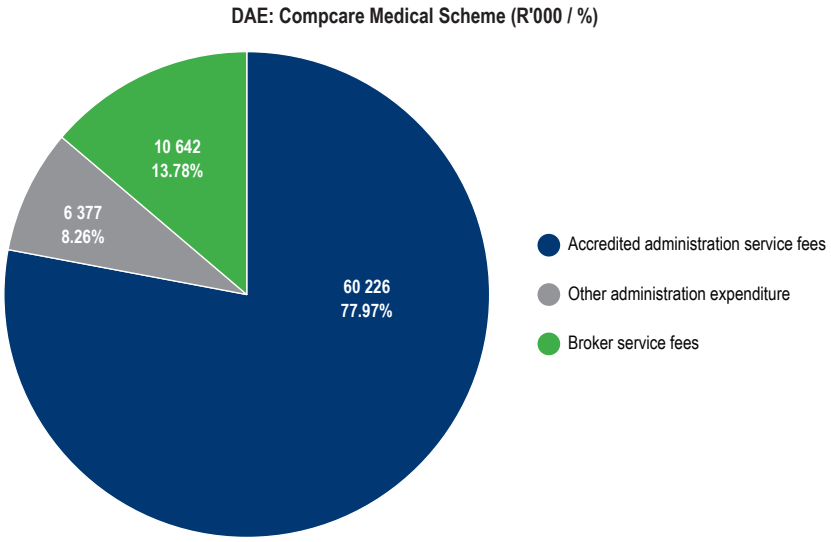


Figure 28: DAE: Compcare Medical Scheme

Compcare Medical Scheme's accredited administration services fees represents 77.97% of its DAE, followed by broker service fees (13.78%)

The scheme's number of dependents per member is significantly lower than the industry norm, making pampm comparisons to industry averages more relevant. The scheme's DAE of R359.07 pampm is significantly lower than the open scheme industry average of R444.05 pampm.

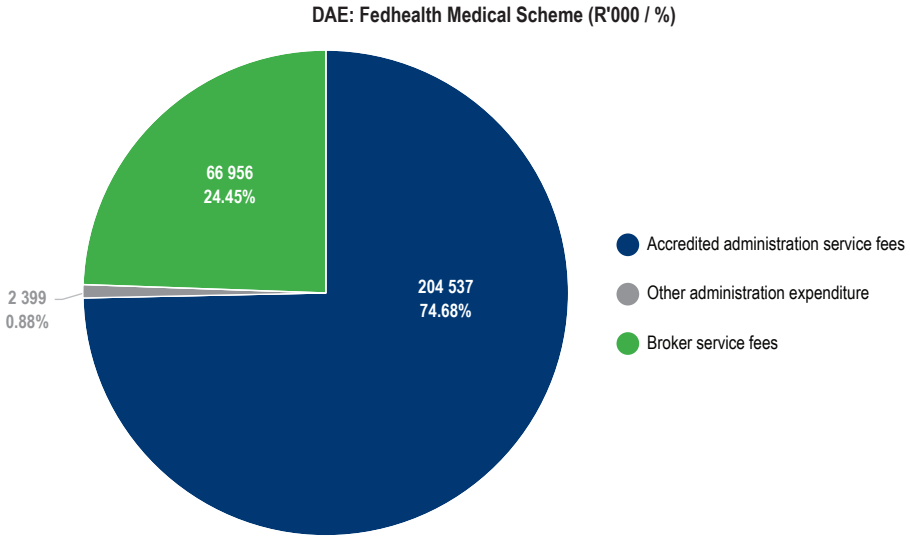


Figure 29: DAE: Fedhealth Medical Scheme

Fedhealth Medical Scheme's accredited administration services fees represent 74.68% of its DAE, followed by broker service fees at 24.45%.

The scheme's fee of R299.47 pampm paid to Medscheme Holdings (Pty) Ltd in respect of accredited administration services on a pampm basis is lower than the open scheme industry average of R340.18 pampm. It is however the second highest fee in the industry (reference should be made to Table 36.)

The fee paid to the accredited administrator in respect of other administration expenditure of R45.33 pampm is lower than the open scheme industry average of R49.07 pampm. This fee consists of mostly of distribution services (41.66%) and marketing services (33.72%.)

When comparing its marketing and advertising expenditure, the R104.12 pampm exceeded the open scheme industry spend of R33.31 pampm.

The scheme's average fee paid per trustee is R559 000.00, which exceeds the open scheme industry average of R467 000.00.

Table 50 shows five restricted schemes with the highest directly attributable insurance service expenditure pabpm. These schemes' directly attributable insurance service expenditure exceeded the industry average of R87.38 pabpm.

Table 50: Trends in relevant healthcare expenditure, directly attributable insurance service expenditure, and reserve-building as percentage of contributions among restricted schemes

Ref. no.	Name of medical scheme	Directly attributable insurance service expenditure		Relevant healthcare expenditure		Directly attributable insurance service expenditure		Reserve-building (insurance service result)		
		2024	2023	2024	2023	2024	2023	2024	2023	%
		pabpm	pabpm	As % of IR	As % of IR	As % of IR	As % of IR	As % of IR	As % of IR	change
1068	De Beers Benefit Society	229.80	183.45	121.38	116.05	5.98	5.09	(27.36)	(21.14)	(29.42)
1194	Profmed	198.31	196.68	90.49	86.69	6.56	7.05	2.95	6.26	(52.88)
1038	SAMWUMed	173.46	95.08	97.55	104.26	7.49	4.58	(5.04)	(8.84)	42.99
1597	Umvuzo Health Medical Scheme	167.03	150.22	86.55	84.27	8.69	8.30	4.76	7.43	(35.94)
1566	Horizon Medical Scheme	161.52	158.89	77.80	61.87	12.97	13.92	9.23	24.21	(61.88)
	Industry average – restricted schemes	**87.38**	**81.21**	**101.26**	**98.75**	**4.12**	**4.09**	**(5.38)**	**(2.84)**	**(89.44)**

pabpm = per average beneficiary per month

IR = Insurance Revenue

When excluding Government Employees Medical Scheme (GEMS) from the restricted scheme industry average, directly attributable insurance service expenditure increases to R106.64 pabpm.

It should be noted that the figures are not always comparable to the industry average due to the lower number of lives on some restricted schemes. Fixed costs are therefore shared by the smaller membership base. The lower membership base would at a certain point, become unsustainable.

Table 51 depicts the membership of the five restricted schemes highlighted in Table 50 above.

Table 51: Trends in directly attributable insurance service expenditure and membership among restricted schemes

Ref. no.	Name of medical scheme	Directly attributable insurance service expenditure		Average beneficiaries	
		2024	2023	2024	2023
		pabpm	pabpm		
1068	De Beers Benefit Society	229.80	183.45	7 636	8 033
1194	Profmed	198.31	196.68	69 680	71 859
1038	SAMWUMed	173.46	95.08	70 091	73 680
1597	Umvuzo Health Medical Scheme	167.03	150.22	95 629	91 070
1566	Horizon Medical Scheme	161.52	158.89	1 928	1 833

pabpm = per average beneficiary per month

The three schemes with the highest membership's composition of directly attributable insurance service expenditure are reflected below:

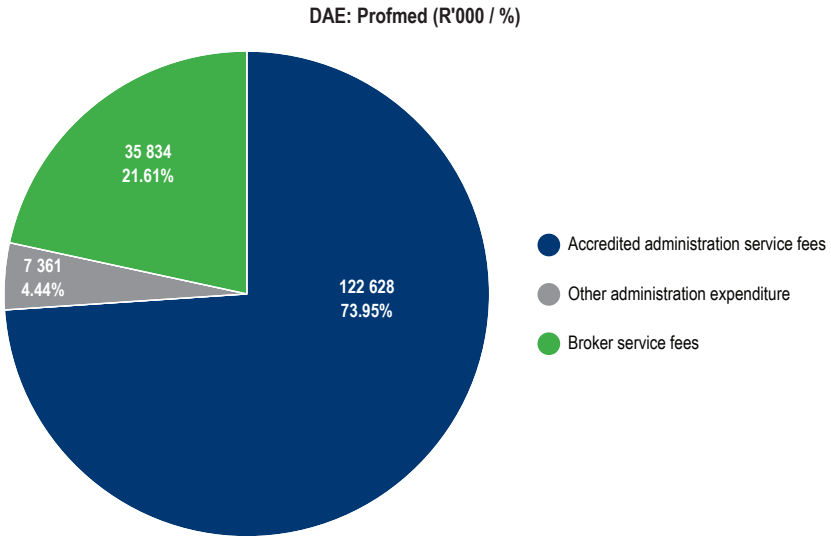


Figure 30: DAE: Profmed

Profmed's accredited administration services fees represent 73.95% of its DAE, followed by broker service fees of 21.61%.

The scheme's fee of R298.72 pampm paid to Professional Provident Society Healthcare Administrators (Pty) Ltd in respect of accredited administration services on a pampm basis is higher than the restricted scheme industry average of R166.89 pampm (reference should be made to Table 38). When considering the scheme's eligibility criteria, it should be noted that the types of costs incurred are more appropriately compared to the open scheme industry. The scheme's expenditure is lower than the open scheme industry average of R340.18 pampm.

The fee paid to the accredited administrator (R11.82 pampm) in respect of other administration expenditure is lower than the industry average of R21.52 pampm.

The scheme incurs broker fees due to the nature of its eligibility criteria. The fee of R247.90 pampm is significantly higher than the open scheme industry average for broker service fees of R106.57 pampm. This also exceeds the statutory limit of R134.25 pampm. The scheme confirmed that the broker service fees included expenditure incurred relating to internal new business consultants remuneration and expenses.

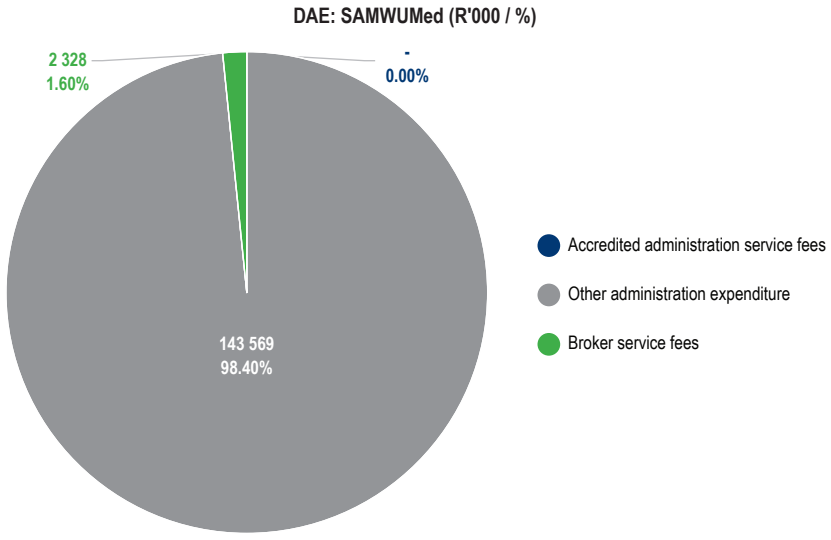


Figure 31: DAE: SAMWUMed

SAMWUMed is a self-administered scheme and therefore did not incur any accredited administration services fees. The majority of the DAE is incurred in respect of other administration expenditure.

SAMWUMed entered into an agreement with Medscheme Holdings (Pty) Ltd to provide integrated claims processing services and to rent their administration system. The co-administration agreement had not been reflected correctly on the CMS database, and the scheme was therefore not able to complete the appropriate parts of the FASR correctly.

When considering the scheme's eligibility criteria, it should be noted that the types of costs incurred are more appropriately compared to the open scheme industry. The scheme's DAE of R173.46 pabpm is much lower than the open scheme industry average for DAE of R221.05 pabpm.

The scheme incurs limited broker fees due to the nature of its eligibility criteria. The fee of R5.90 pampm is lower than the open scheme industry average for broker service fees of R106.57 pampm

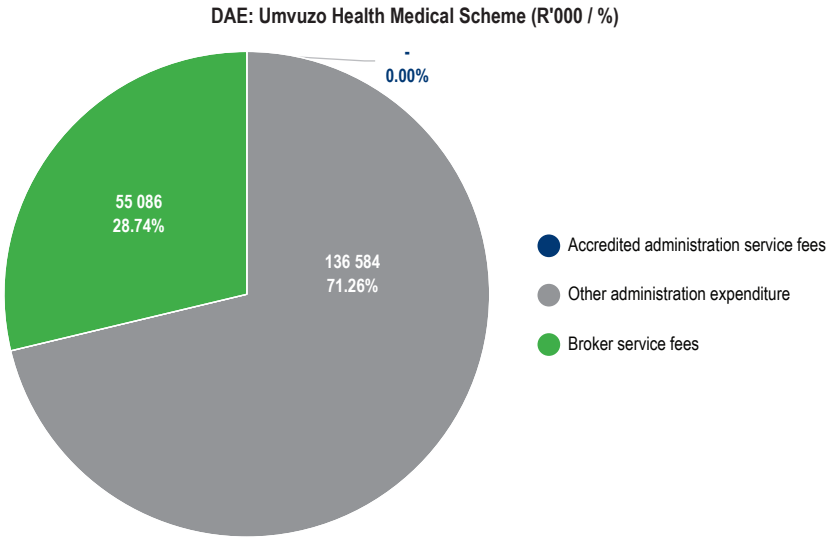


Figure 32: DAE: Umvuzo Health Medical Scheme

Umvuzo Health Medical Scheme is a self-administered restricted scheme. When considering the scheme's eligibility criteria, it should be noted that the types of costs incurred are more appropriately compared to the open scheme industry.

The scheme's DAE of R167.03 pabpm is much lower than the open scheme industry average of R221.05 pabpm.

The scheme incurs broker fees due to the nature of its eligibility criteria. The fee of R94.01 pampm is lower than the open scheme industry average for broker service fees of R106.57 pampm

Financial performance in real terms

Figure 33 depicts information on insurance revenue, relevant healthcare expenditure and directly attributable insurance service expenditure pabpm in real terms over the two-year period (i.e. adjusted for CPI).

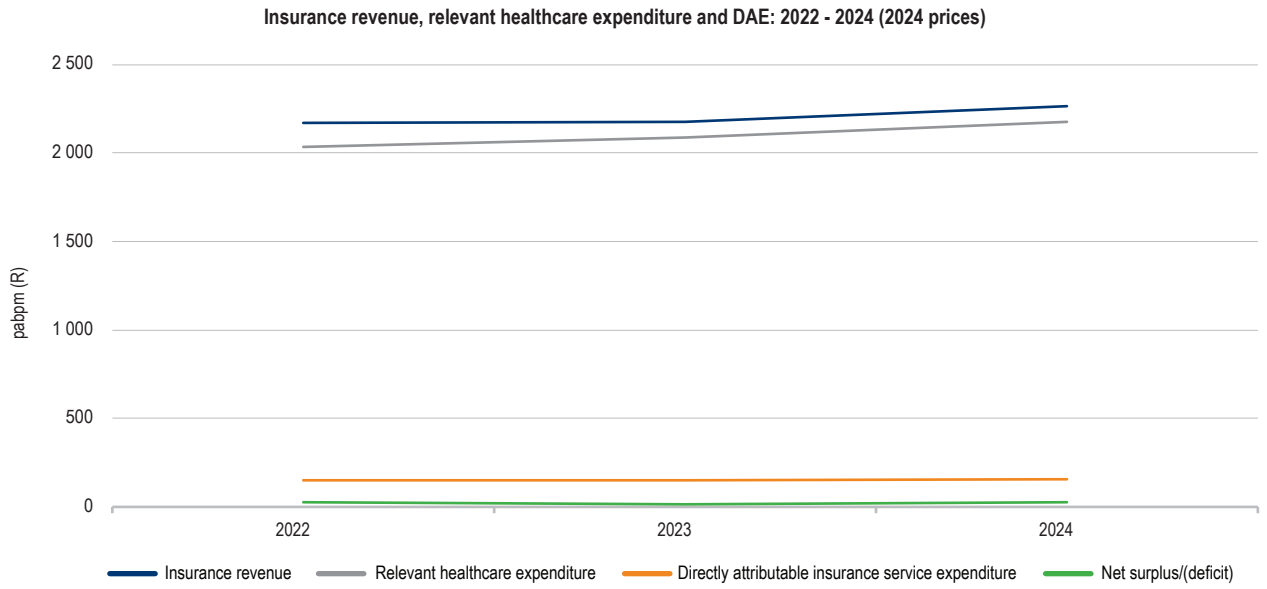


Figure 33: Insurance revenue, relevant healthcare expenditure, directly attributable insurance service expenditure over a three year period (in 2024 prices)*

pabpm = per average beneficiary per month

**Values for 2022 and 2023 were adjusted for CPI*

Insurance revenue pabpm increased by 4.35% over the three-year period, whilst relevant healthcare expenditure pabpm increased by 6.94%. The increased utilisation from inter alia an ageing population and tariff price negotiations as highlighted by the Health Market Inquiry remains a concern (refer to paragraph Relevant healthcare expenditure).

Directly attributable insurance service expenditure pabpm was stable over the period, a marginal increase of 1.27% was observed. This should, however, be evaluated against the backdrop of lower than CPI increases in 2021 and 2022, which resulted in non-healthcare expenditure of schemes decreasing by 1.35% in real terms over the five-year period of 2018 – 2022.

Insurance service result and Net results

The insurance service result (previously known as the net healthcare result) of a medical scheme indicates its position after relevant healthcare expenditure and directly attributable insurance service expenditure are deducted from insurance revenue.

The insurance service result for all medical schemes combined reflected a deficit of R7.49 billion in 2024 (2023: R6.47 billion deficit). Open schemes incurred an insurance service deficit of R1.49 billion (2023: R3.60 billion deficit), and restricted schemes generated a combined insurance service deficit of R5.99 billion (2023: R2.88 billion deficit). The worsened performance is due to the increased relevant healthcare expenditure during 2024. Kindly refer to paragraph Relevant healthcare expenditure for a more detailed explanation of the increases in tariffs and utilisation observed.

Both the South African bonds and equity markets performed well during 2024, particularly during the second half of the year. The JSE All Share Index produced returns of 14.92% in 2024, whilst the All Bond Index (ALBI) exceeded this with a performance with returns of 17.00%. The investment income positively contributed towards a net surplus of R3.13 billion in 2024 (2023: net surplus of R1.69 billion).

Open schemes made a R3.33 billion surplus (2023: R523.86 million deficit) and restricted schemes had a deficit of R200.39 million (2023: surplus of R2.21 billion).

The insurance service result and net results of all schemes for the three year period from 2022 to 2024 are reflected in Figure 34.

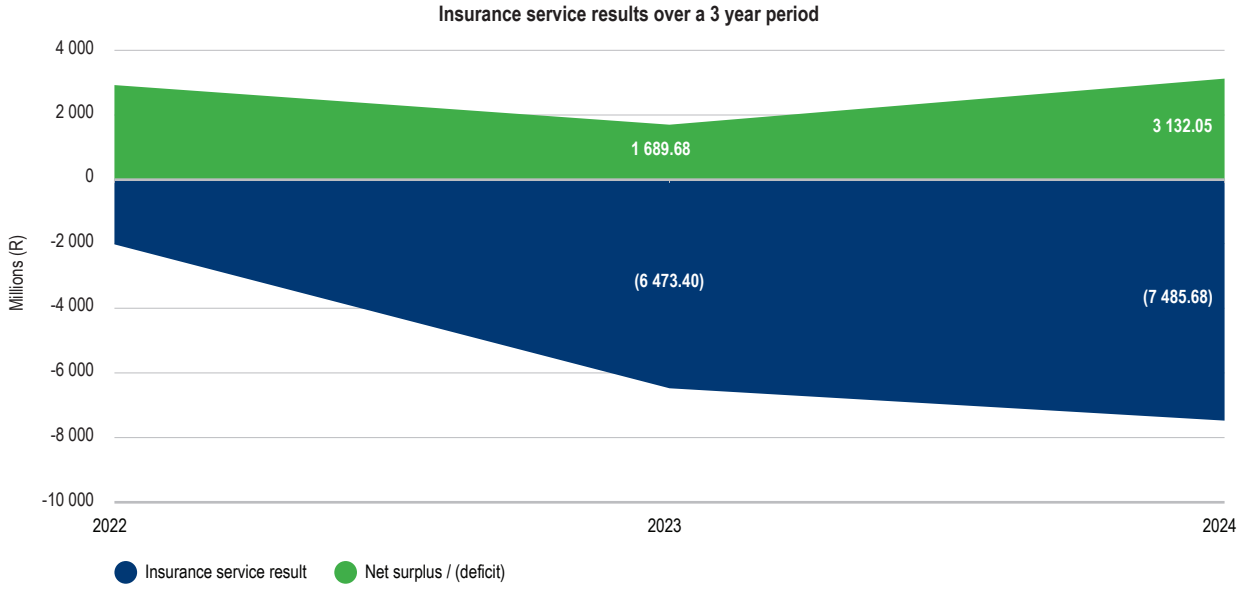


Figure 34: Insurance service results over a three year period

A total of 80.00% (12 of 15) of open schemes and 60.00% (33 of 55) of restricted schemes incurred insurance service deficits during the year. The high number of schemes incurring net insurance deficits is a function of the explicit under-pricing of the 2021 and 2022 benefit years that has not been fully corrected.

Table 52 shows the 20 schemes which incurred the highest insurance service deficits during 2024. They represent 96.00% of all beneficiaries of schemes that suffered operating deficits (refer to Annexure F for more detail.) Investment income has generally boosted the performance of schemes.

Table 52: 20 schemes with highest insurance service deficits

Ref. no.	Name of medical scheme	Type	Insurance service result			Solvency ratio	
			2024	2023	%	2024	2023
			R'000	R'000	growth	%	%
1598	Government Employees Medical Scheme (GEMS)	Restricted	(5 551 731)	(2 957 786)	(87.70)	31.15	42.42
1512	Bonitas Medical Fund	Open	(831 788)	(185 730)	(347.85)	38.56	41.47
1279	Bankmed	Restricted	(393 775)	(279 691)	(40.79)	43.23	48.98
1583	Platinum Health	Restricted	(164 981)	2 436	(6 872.62)	37.73	41.01
1125	Discovery Health Medical Scheme	Open	(164 711)	(2 083 007)	92.09	31.01	30.61
1140	Medshield Medical Scheme	Open	(145 239)	(173 536)	16.31	59.41	62.88
1202	Fedhealth Medical Scheme	Open	(122 028)	(225 555)	45.90	32.33	36.09
1087	Keyhealth	Open	(109 490)	(119 099)	8.07	35.67	43.10
1167	Momentum Medical Scheme	Open	(108 417)	(283 248)	61.72	30.28	31.34
1038	SAMWUMed	Restricted	(98 065)	(162 324)	39.59	68.19	73.46
1068	De Beers Benefit Society	Restricted	(96 415)	(73 484)	(31.21)	170.87	180.82
1012	Anglo Medical Scheme	Restricted	(96 109)	(91 037)	(5.57)	491.54	475.04
1430	Remedi Medical Aid Scheme	Restricted	(85 443)	27 033	(416.07)	64.88	72.18
1559	Imperial and Motus Medical Aid	Restricted	(49 996)	24 707	(302.36)	133.10	144.35
1424	SABC Medical Aid Scheme	Restricted	(46 471)	(12 992)	(257.69)	81.75	85.53
1197	Libcare Medical Scheme	Restricted	(38 640)	(20 681)	(86.84)	94.30	104.64
1600	Motohealth Care	Restricted	(37 395)	(21 930)	(70.52)	64.40	64.98
1441	Parmed Medical Aid Scheme	Restricted	(34 494)	(23 232)	(48.48)	83.07	91.55
1491	Compcare Medical Scheme	Open	(34 082)	(97 213)	64.94	21.83	25.14
1568	Sisonke Health Medical Scheme	Restricted	(25 155)	10 821	(332.46)	48.34	50.23

During 2021 and 2022 schemes deliberately underpriced their benefits (thereby utilising their reserves) in an attempt to cushion members against high contribution increases during the economic downturn that followed the Covid-19 pandemic. This resulted in quite a number of schemes being underpriced at an insurance service result level at the end of 2023 and 2024; this would require correction in later years.

Nine of the schemes listed above (compared to six of the twenty schemes that incurred the highest insurance service deficits during 2023), incurred net surpluses after investment income was considered.

GEMS' Board of Trustees determined a long-term strategic target of a lower solvency level; the scheme was therefore deliberately underpriced during the year under review to wind down its reserves. The scheme also encountered the same increased utilisation experienced across the industry.

All the schemes listed in Table 52 had a solvency level above the minimum statutory requirement of 25%, except for Compcare Medical Scheme.

Compcare Medical Scheme's solvency decreased by 13.17% from 25.14% to 21.83% at the end of 2024. Due to the scheme's smaller size and poor demographic profile, it is exposed to significant claims volatility risk. For more information as to the financial performance of Compcare Medical Scheme, kindly refer to Beneficiaries of schemes which failed to reach 25% solvency.

Accumulated funds and Solvency

Reserves of medical schemes

The reserves of medical schemes serve to protect member's interests and guarantee the continued operation of schemes. They also serve as a buffer against unforeseen, large-scale health events such as the Covid-19 pandemic.

Schemes provided various financial relief measures to members during the Covid-19 pandemic and subsequent economic downturn, such as utilising personal medical savings accounts to offset contributions, the relaxation of credit policies, contribution holidays and lower future contribution increases.

Medical schemes generally price for a break-even result at an insurance service result level. Due to the lower contribution increases registered during the past few years, the medical scheme industry incurred insurance service deficits. After taking investment income into account, a net surplus was achieved.

Most schemes started to correct their pricing during the 2024 year, but a few schemes were still able to provide relief to members via contribution holidays.

Reserve building

Table 53: Relevant healthcare expenditure, directly attributable insurance service expenditure and reserve-building as a percentage of insurance revenue

	Relevant healthcare expenditure	Directly attributable insurance service expenditure	Reserve-building*
	% of IR	% of IR	% of IR
2022	93.85	7.10	(0.95)
2023	95.84	7.07	(2.91)
2024	96.18	6.89	(3.07)

IR = Insurance Revenue

**Reserve building is measured at the insurance service result sub-total*

Table 53 above illustrates the relationship between relevant healthcare expenditure, directly attributable insurance service expenditure and reserve building. Relevant healthcare expenditure has a greater impact on reserve building than directly attributable insurance service expenditure: during periods of high relevant healthcare expenditure the industry experienced a reduction in reserves, while in periods with lower relevant healthcare expenditure the reserves increased.

An increased reliance on the use of investment income / previously built-up reserves has been observed: the R0.95 of every R100 received in Insurance Revenue in 2022 increased to R3.07 in 2024.

Regulation 29 reserves

Regulation 29 specifies that the net asset value used in the solvency calculation is determined as follows:

- All cumulative unrealised net gains are to be excluded from the computation of accumulated funds (i.e. even if the credit was taken to income)
- Cumulative unrealised net losses are ignored in the calculation of accumulated funds as per Circular 13 of 2001
- Any consolidated results from subsidiaries are included in the cumulative unrealised results to ensure that the solvency calculation is based on scheme-only results
- Funds set aside for specific non-claims purposes are to be excluded
- Encumbered assets in respect of non-scheme liabilities are to be excluded

Figure 35 below shows that all medical schemes incurred a net surplus of R3.13 billion compared with R1.69 billion in 2023, representing an increase of 85.36%. This is driven by the higher returns derived from investments, rather than a correction in the pricing of the products.

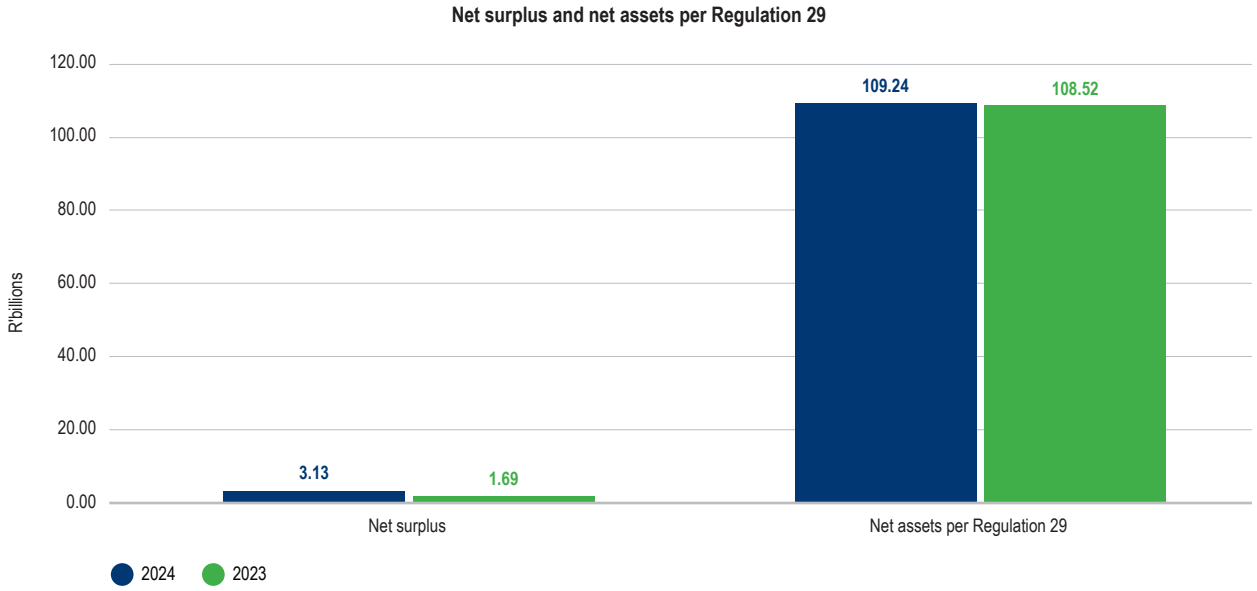


Figure 35: Net surplus and net assets per Regulation 29

The net assets in terms of Regulation 29 of the MSA increased by 0.66% from R108.52 billion in 2023 to a reported R109.24 billion in 2024.

During the 2023 and 2024 financial years, increases in the unrealised fair value market movements of investments were noted. It should be noted that these market movements are excluded from the Regulation 29 reserve levels. The increase in the Regulation 29 reserves observed per Figure 35 is therefore not directly correlated to the net surplus incurred by the industry but rather represents only 22.99% of the total net surplus.

Solvency

As was observed from Table 53, for every R100.00 received in insurance revenue, R96.18 was paid in relevant healthcare expenditure, and R6.89 in directly attributable insurance service expenditure (DAE) during the 2024 year. This resulted in a shortfall of R3.07 that was funded from the R8.64 received in other income / expenditure (including investment income). The current pricing of the products therefore does not provide for reserve building or maintenance, i.e. the increase in the denominator used in the solvency calculation (annualised contributions) is not offset by a similar increase in the Regulation 29 reserve value: this resulted in a reduction in the industry solvency level.

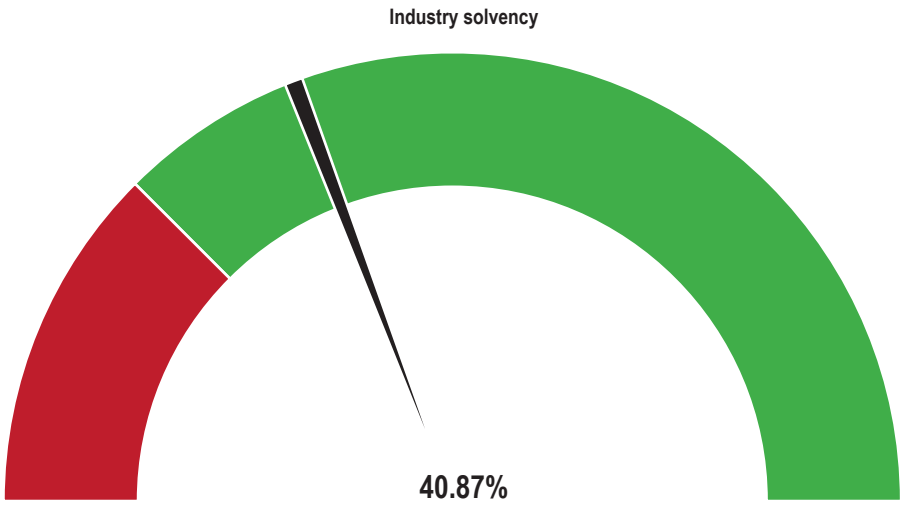


Figure 36: Industry solvency of 40.87%

The 2024 industry solvency ratio of 40.87% exceeds the minimum required Regulation 29 ratio of 25% (2023: 43.94%).

The solvency ratio of open schemes decreased by 2.68% to 33.36% in 2024 (2023: 34.28%). Restricted schemes experienced a decrease of 10.87% in their solvency ratio, 50.52% from 56.68% in 2023.

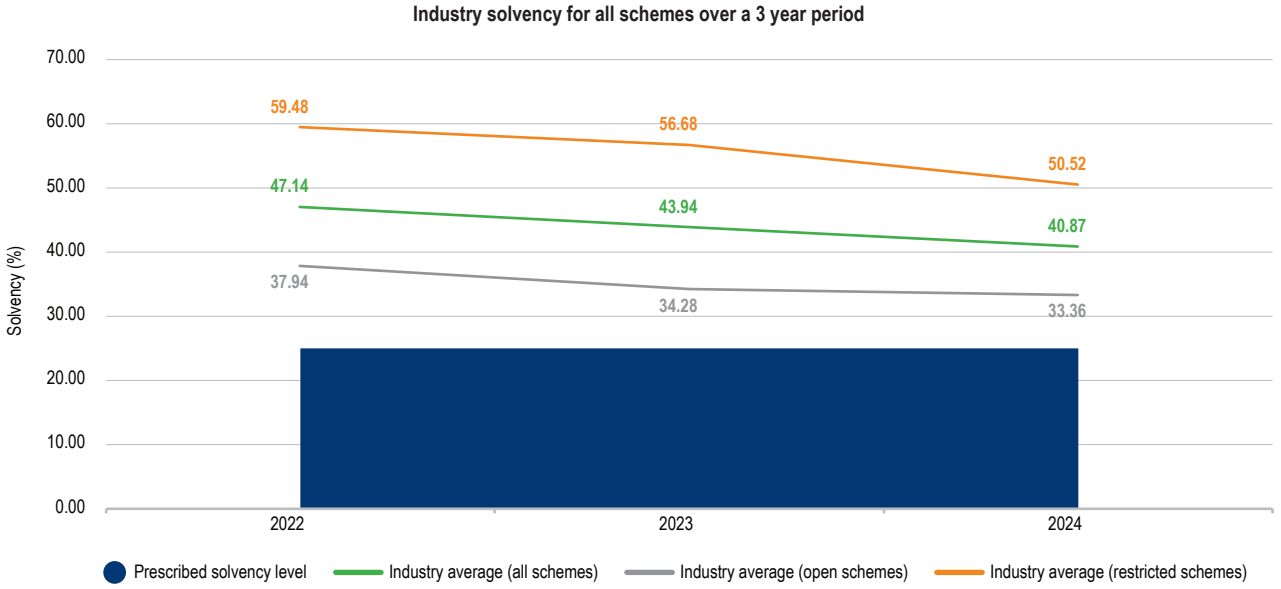


Figure 37: Industry solvency for all schemes over a three year period

The decrease in the solvency levels in both industries is attributable to lower (and negative) reserving priced for in gross contribution income (i.e. the growth in reserves did not keep up with the growth in contributions).

Beneficiaries of schemes which failed to reach 25% solvency

Figure 38 show the number of beneficiaries in medical schemes that have yet to attain the prescribed solvency ratio of 25% and also depict them as a percentage of the total beneficiaries in all schemes.

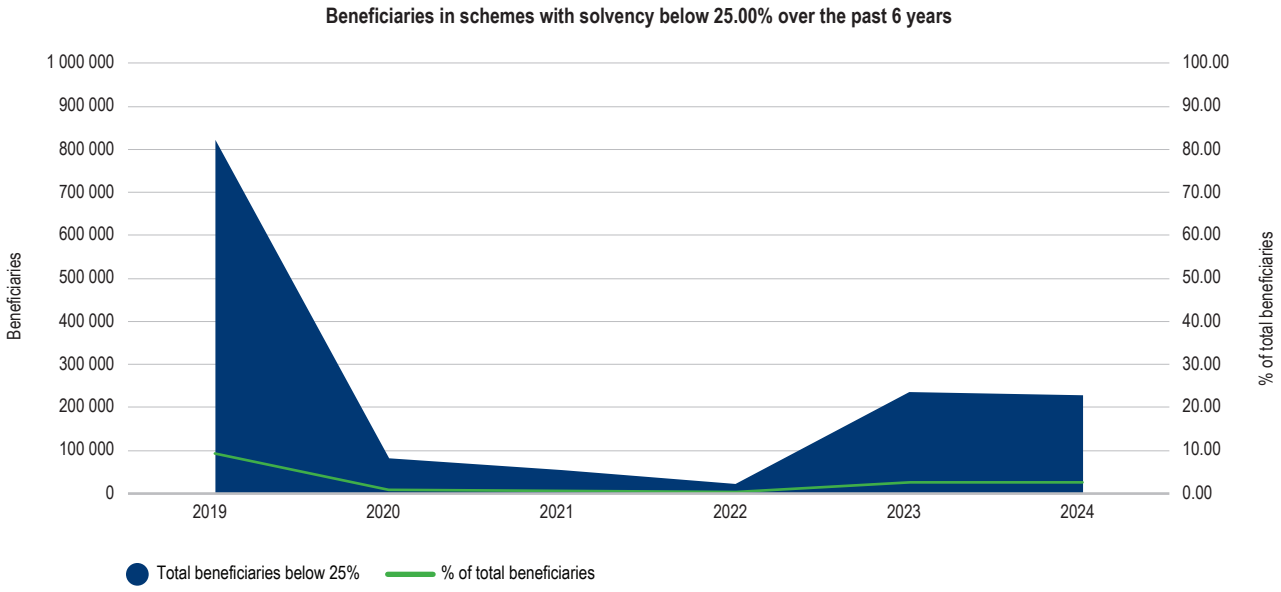


Figure 38: Beneficiaries in schemes with solvency below 25% over the past six years

Schemes that did not meet the required minimum solvency level of 25% account for 2.52% of all medical scheme beneficiaries.

Open schemes

A total of 4.93% of beneficiaries in open schemes were covered by Medihelp and Compcare Medical Scheme, which failed to meet the prescribed solvency level in 2024.

Restricted schemes

No restricted medical schemes failed to meet the minimum required solvency level at the end of 2024 (Transmed Medical Fund attained 25.00% during 2024).

Table 54 provides a summary of performance of schemes that were below the required statutory minimum solvency of 25% as of 31 December 2024.

The CMS closely monitors schemes below the 25% solvency ratio by having regular meetings with them to assess their performance against their business plans.

Table 54: Summary of performance of schemes below 25% solvency

Ref. no.	Name of scheme	Average beneficiaries	Average age pb	Pensioner ratio	Relevant healthcare expenditure ratio		Insurance service result		Solvency ratio	
		2023	2023	2023	2023	2022	2023	2022	2023	2022
			years	%	%	%	R pabpm	R pabpm	%	%
1149	Medihelp	207 794	38.45	15.62	94.10	100.92	0.80	(146.82)	20.99	23.84
1491	Compcare Medical Scheme	26 589	42.14	21.31	94.88	102.30	(106.82)	(290.53)	21.83	25.14

pabpm = per average beneficiary per month
pb = per beneficiary

Medihelp deliberately underpriced its benefits during the Covid-19 pandemic in an attempt to provide relief to its members. The scheme experienced a 3.89% decrease in its insurance revenue pabpm from 2021 to 2022 (refer to the 2022 Annexures), compared to an average CPI of 6.9% during the same period. The scheme corrected their pricing for the 2024 financial year and experienced an increase of 13.79% in its insurance revenue pabpm, compared to the average CPI of 4.40%. The scheme submitted the required Business Plan in terms of Regulation 29, which was subsequently approved by the Registrar.

Schemes with higher demographic profiles are at particular risk of the so-called “death spiral”, where adjustments to price appropriately for the profile of its members might result in the unaffordability of contributions and the subsequent loss of its younger members, thereby exacerbating the effect. Compcare Medical Scheme is a smaller medical scheme with a very poor demographic profile, and the scheme is therefore exposed to significant claims volatility risk. The scheme has restructured its benefits for the 2025 financial year in an attempt to address the scheme’s underlying membership risks. The Registrar has subsequently approved the scheme’s Regulation 29 Business Plan.

More information on the results of these schemes is available in Annexure G.

Liquidity ratios

Medical schemes meet the definition of mutual entities for accounting purposes. This results in medical schemes no longer disclosing members' funds and reserves, but rather reclassifying and renaming the previously known accumulated funds as a non-current liability now known as "Amounts attributable to members". For purposes of calculating liquidity ratios, this figure had been omitted from the total liabilities figure, as this amount will only be settled upon the liquidation of a medical scheme.

The principle of matching assets with liabilities is particularly important in the context of sufficient liquidity to cover liabilities, as and when they arise. The scheme's outstanding claims liability is a provision based intrinsically on the provision of Regulation 6(1) of the MSA, in which all accounts must be submitted within four months. Section 59(2) requires all claims to be settled within 30 days of being received. Medical scheme liabilities are accordingly short-term in nature.

The liquidity of medical schemes is further assured by the minimum requirement imposed by Explanatory Note 2 of Annexure B – where 20% of a scheme's Regulation 30 reserves need to be invested in cash and cash equivalents.

The norm for current assets to current liabilities is 1:1. A current ratio of between 1.5 and 3 is considered healthy.

The norm for total assets to total liabilities is 2:1.

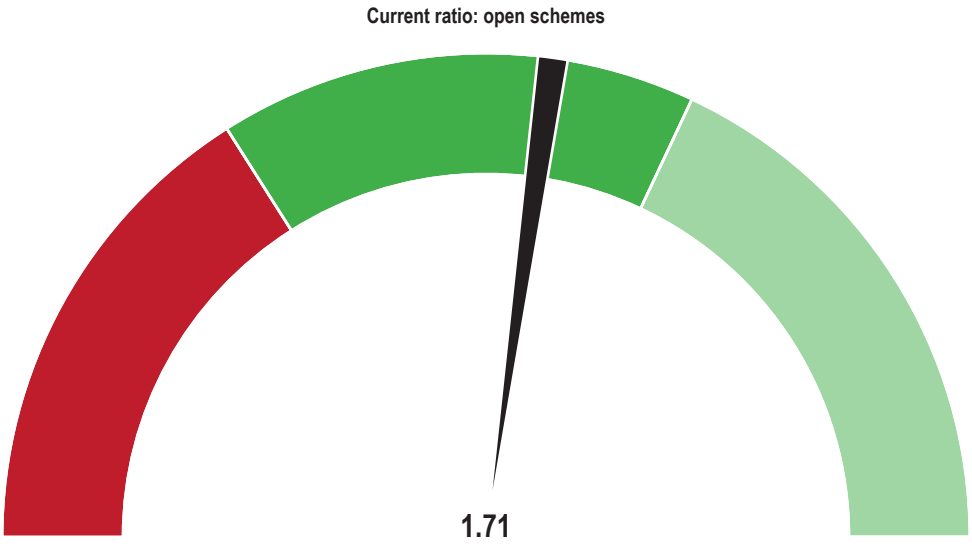


Figure 39: Current ratio - open schemes

The current-assets-to-current-liabilities ratio in open schemes was 1.71:1 in 2024 (1.54:1 in 2023).

The total-asset-to-total-liability ratio for open schemes in 2024 was 4.64:1 (2023: 3.99:1).

Both these ratios indicate that the industry is financially sound and able to pay its liabilities as and when they become due.

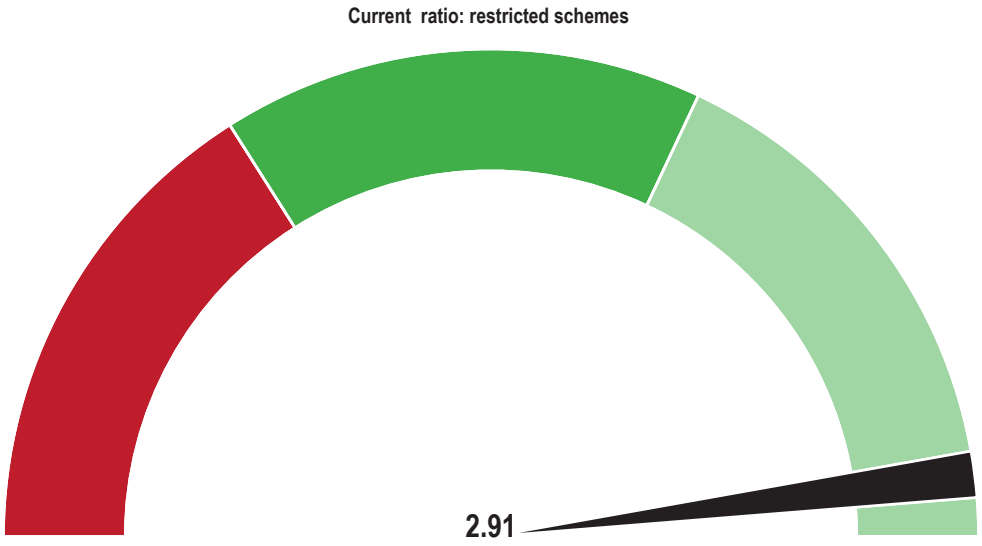


Figure 40: Current ratio - restricted schemes

The current-assets-to-current-liabilities ratio in restricted schemes was 2.91:1 in 2024 (2.95:1 in 2023).

The total-asset-to-total-liability ratio for restricted schemes in 2024 was 6.11:1 (2023: 5.84:1).

Both these ratios indicate that the industry is financially sound and able to pay its liabilities, as and when they become due.

The high current ratio indicates the ineffective management of scheme funds. In general, the high ratio should be corrected by considering the investment into longer investment horizon assets which would typically result in higher yields.

The financial soundness of a medical scheme is also measured by its ability to pay claims from cash and cash equivalents.

Figure 41 depicts the claims-paying ability of schemes measured in months of cover, which is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

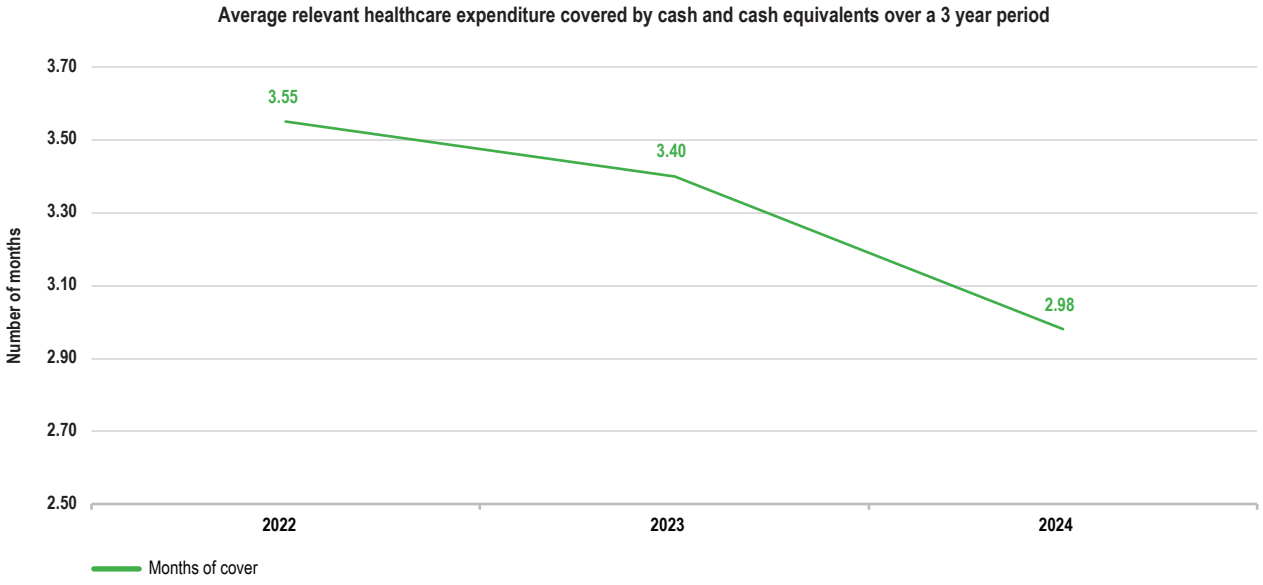


Figure 41: Average relevant healthcare expenditure covered by cash and cash equivalents over a three year period

The length of cash coverage decreased from 3.55 months in December 2022 to 2.98 months in December 2024.

Payment cycles of medical schemes in 2024 were an average of 8.51 days compared with the 10.08 days in 2023.

Benefit options

Table 55: Results of benefit options

	Open schemes	% representing	Restricted schemes	% representing	Total
Scheme results*					
Number of options	104	45.02	127	54.98	231
Members represented	2 305 428	56.06	1 807 343	43.94	4 112 771
Number of schemes	15	21.43	55	78.57	70
Insurance service result (R'000)	(1 492 618)		(5 993 059)		(7 485 677)
DAE as % of IR	9.22		4.12		6.89
Relevant healthcare expenditure ratio (%)	91.91		101.26		96.18
Relevant healthcare expenditure pbpm	2 200.59		2 121.38		2 161.83
IR pbpm	2 394.36		2 094.88		2 247.80
Options with members >= 2 500					
Number of options	66	46.15	77	53.85	143
Members represented	2 262 952	56.36	1 752 221	43.64	4 015 173
Insurance service result (R'000)	(1 340 382)		(5 846 388)		(7 186 770)
DAE as % of IR	9.30		4.11		6.94
Relevant healthcare expenditure ratio (%)	91.74		101.31		96.14
Relevant healthcare expenditure pbpm	2 171.59		2 108.12		2 151.35
IR pbpm	2 367.13		2 080.92		2 237.81
Options with members < 2 500					
Number of options	38	43.18	50	56.82	88
Members represented	42 476	43.52	55 122	56.48	97 598
Insurance service result (R'000)	(164 666)		(146 670)		(311 336)
DAE as % of IR	6.34		4.38		5.38
Relevant healthcare expenditure ratio (%)	98.15		99.92		98.83
Relevant healthcare expenditure pbpm	3 920.61		2 658.00		3 167.57
IR pbpm	3 994.69		2 660.04		3 205.15

IR = Insurance Revenue

DAE = Directly attributable insurance service expenditure

pbpm = per beneficiary per month

**The insurance result incurred on discontinued options from 2023 (i.e. data included in Other rows per Annexure H) was included in the scheme results but excluded from the benefit option results where stratification based on number of members in registered options took place.*

Table 56: Results of loss-making benefit options

	Open schemes	% representing	Restricted schemes	% representing	Total
Total loss-making options					
% of total options	60.58		54.33		57.14
Number of options	63	47.73	69	52.27	132
Members represented	1 202 766	50.55	1 176 691	49.45	2 379 457
Insurance service result (R'000)	(4 890 107)		(9 335 225)		(14 225 332)
DAE as % of IR	8.16		3.65		5.85
Relevant healthcare expenditure ratio (%)	98.34		108.19		103.38
Relevant healthcare expenditure pbpm	2 588.83		2 423.69		2 497.70
IR pbpm	2 632.46		2 240.30		2 416.05
Loss making options with members > =2 500					
Number of options	38	48.72	40	51.28	78
Members represented	1 176 802	50.63	1 147 449	49.37	2 324 251
Insurance service result (R'000)	(4 592 625)		(9 012 449)		(13 605 074)
DAE as % of IR	8.23		3.64		5.88
Relevant healthcare expenditure ratio (%)	98.06		108.10		103.20
Relevant healthcare expenditure pbpm	2 554.95		2 401.45		2 470.21
IR pbpm	2 605.61		2 221.52		2 393.58
Loss making options with members < 2 500					
Number of options	25	46.30	29	53.70	54
Members represented	25 964	47.03	29 242	52.97	55 206
Insurance service result (R'000)	(297 482)		(322 776)		(620 258)
DAE as % of IR	5.67		4.02		4.86
Relevant healthcare expenditure ratio (%)	107.88		111.34		109.57
Relevant healthcare expenditure pbpm	4 323.63		3 608.52		3 935.89
IR pbpm	4 007.63		3 241.11		3 592.01

IR = Insurance Revenue

DAE = Directly attributable insurance service expenditure

pbpm = per beneficiary per month

The following registered option was not in operation during the 2024 financial year, and was therefore omitted from this report:

- SAMWUMed's Savings option was registered with effect 1 January 2023, but the scheme deferred the implementation.

Compcare Medical Scheme's Mumed option was deregistered on 30 June 2024.

During 2024, 231 registered benefit options were operating in 70 medical schemes (*excluding Sizwe Hosmed Medical Scheme.)

Open schemes accounted for 45.02% or 104 of the registered benefit options during 2024. On average, open schemes had 6.93 options per scheme and an average of 22 168 members per option during the year.

Restricted schemes had 127 options during the year, representing 54.98% of all options. Restricted schemes had an average of 2.31 options per scheme, with an average of 14 231 members per option as of 31 December 2024.

Of the 231 benefit options registered and operating during 2024, 132 (57.14%) incurred insurance service losses.

In the year under review, 63 options, representing 47.73% of loss-making options were in open schemes and 69, representing 49.45% of loss-making options, were in restricted schemes.

The CMS considers 2 500 members to be the lowest number of members at which an option is still sustainable. Of the 231 benefit options during the year, 88 (38.10%) had fewer than 2 500 members per option. Of these 88 options, 54 (61.36%) incurred insurance service losses in 2024:

- At the end of 2024, there were 38 options in open schemes with fewer than 2 500 members. They had an average of 1 117.79 members per option and represented 36.54% of all open scheme options.
- Restricted schemes had 50 options with fewer than 2 500 members. The average number of members per option was 1 102.44 and these options represented 39.37% of all restricted scheme options.

The remaining 143 options had more than 2 500 members per option. Of these, 54.55% or 78 options incurred insurance service losses. Cognisance should be taken of the deliberate under-pricing of benefits during the 2021 and 2022 benefit years.

Insurance service losses pbpm in options with fewer than 2 500 members were 2.39 times greater than those for options with more than 2 500 members – an average of R-518.58 pbpm compared with R-217.38 pbpm.

Table 57 shows option results by demographics.

Table 57: Demographics of registered options at year-end

	Open	Restricted	Total
Average age pb	**36.77**	**32.07**	
Insurance service result pbpm	**(26.93)**	**(112.83)**	
Number of options with average age greater than or equal to the industry average	**62**	**76**	**138**
Number of options incurring insurance service results better or equal to the industry average	20	37	57
Number of options incurring insurance service results worse than the industry average	42	39	81
Number of options with average age below the industry average	**41**	**50**	**91**
Number of options incurring insurance service results better or equal to the industry average	30	39	69
Number of options incurring insurance service results worse than the industry average	11	11	22

pb = per beneficiary

pbpm = per beneficiary per month

There were 62 options with an average age above 36.77 years for options in open schemes, and 41 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 76 benefit options had beneficiaries with an average age higher than 32.07 years for all options in restricted schemes. A total of 50 options had younger beneficiaries.

As expected, options covering older and sicker lives are more likely to incur worse insurance service results than the rest of the industry.

Investments

Section 35(1) of the MSA states that “a medical scheme shall at all times maintain its business in a financially sound condition”. The primary reason for this is the protection of a scheme’s members by ensuring sufficient funds available for the scheme to meet its obligations to its members and service providers, as and when it becomes due.

Assets generated through contributions received from members are typically invested in a manner to ensure both growth of reserves and liquidity to facilitate access to these funds when required to meet obligations (which is generally short-term in nature).

Section 35(5) states that “a medical scheme shall have such assets in the Republic in the particular kinds or categories as may be prescribed”. Thus, Annexure B, read in conjunction with Regulation 30 of the Act, was introduced to regulate investments by medical schemes to achieve a balance between growth, liquidity and managing investment risks by placing limitations on the exposure to the various investment classes.

A medical scheme is in essence a fund based on the principle of social solidarity. The current dispensation encourages investments in local infrastructure such as municipalities, Land and Agricultural Bank, Trans-Caledonian Tunnel Authority, SA National Roads Agency (SANRAL), Eskom, and Transnet, whilst still limiting the risk exposure to these investments by restricting it to bonds and limiting the investments to 20.00%. Similarly, investments in local companies are encouraged, but individual exposure is limited to 2.50%, 5.00% and 7.50% based on the capital structure of these entities; overall exposure to local equities is limited to 40.00%.

The diversification of assets is an acknowledged risk management tool. For these purposes Annexure B allows foreign investments but restricts it to low risk (and therefore lower yield) investments such as cash and bonds. Offshore equity exposure is prohibited.

Schemes are encouraged by Annexure B to invest its assets in the South African environment. Medical schemes had investable assets* to the value of R142.99 billion. 94.81% of these assets are invested in local assets, whilst 5.19% are invested in foreign assets.

*Investable assets comprise total assets excluding trade and other receivables, personal medical savings account trust investments, (IFRS16) right of use assets, intangible assets, and encumbered assets.

Figure 42 and Figure 43 provide information on the detailed breakdown of the investments of medical schemes as at the end of 2024 (investments in policies of insurance were broken down into its underlying assets).

Only 9.01% of open scheme investments were in policies of insurances (2023: 8.69%). 11.92% of the restricted scheme industry assets were invested in policies of insurance (2023: 10.70%).

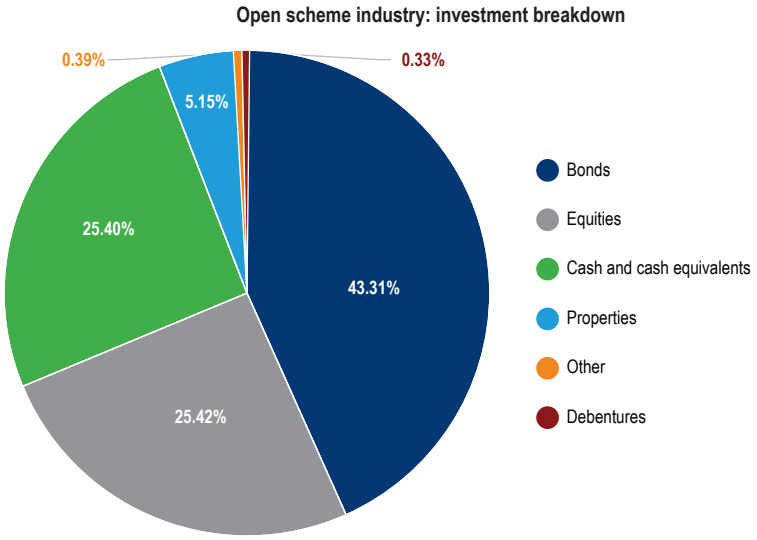


Figure 42: Open scheme industry – investment breakdown

Open schemes invested assets to the value of R68.84 billion (2023: R65.09 billion). 94.51% of these assets are invested in local assets, whilst 5.49% is invested in foreign assets.

No significant changes in the composition of the industry's assets were noted. The majority investments in open schemes were still in category 2 assets (bonds), accounting for 43.31% (2023: 41.61%), followed by category 4 assets (equities) at 25.42% (2023: 26.75%) and category 1 assets (cash and cash equivalents) at 25.40% (2023: 25.42%). 5.15% of assets were invested in category 3 (property) (2023: 5.30%).

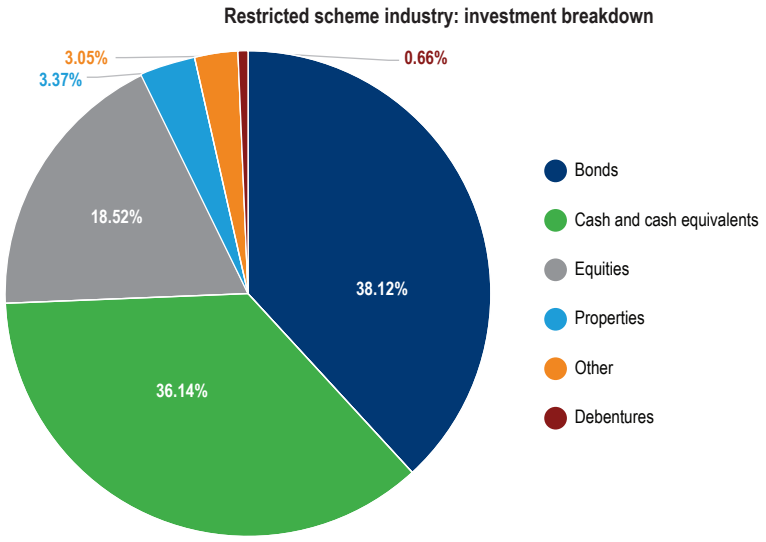


Figure 43: Restricted scheme industry – investment breakdown

Restricted schemes invested assets to the value of R74.14 billion (2023: R74.36 billion). The majority of these assets (95.10%) are invested in local assets, whilst 4.90% is invested in foreign assets.

Due to the higher investment returns experienced in the South African bond market, an increased proportion of restricted schemes' investments were invested in bonds (38.12% versus 2023's 36.27%) compared to cash and cash equivalents (36.14% versus 2023's 38.72%). Equities accounted for 18.52% (2023: 19.97%). 3.37% of scheme assets were invested in category 3 (property) (2023: 3.65%).

The high cash and cash equivalents exposure resulted in the high current-assets-to-current-liabilities ratio of 2.91:1 in restricted schemes (see Figure 40).

The following tables list the asset distribution of the ten largest schemes by asset base per asset category listed under Annexure B of the Regulations, as well split by local and foreign, and investment income:

Table 58: Asset distribution of the ten largest schemes by asset base

Ref. no.	Name of medical scheme	Average beneficiaries	Total investable assets	Category**						
				1	2	3	4	5	6*	7
			R'millions	%	%	%	%	%	%	%
1125	Discovery Health Medical Scheme	2 727 318	39 708.51	22.04	47.57	5.83	23.75	0.47	4.71	0.33
1598	Government Employees Medical Scheme (GEMS)	2 329 344	24 060.18	35.99	40.18	4.69	11.83	1.44	0.00	5.87
1580	South African Police Service Medical Scheme (POLMED)	494 899	12 845.67	17.74	53.38	3.76	23.48	0.22	0.00	1.41
1512	Bonitas Medical Fund	727 946	11 538.66	27.13	36.35	5.98	30.25	0.28	5.31	0.01
1279	Bankmed	221 545	4 518.75	23.00	40.99	2.99	24.65	1.21	16.87	7.16
1145	LA-Health Medical Scheme	274 237	4 279.44	99.59	0.00	0.09	0.00	0.31	0.00	0.00
1012	Anglo Medical Scheme	17 413	4 137.90	22.52	37.34	0.69	35.73	0.00	15.44	3.72
1252	Bestmed Medical Scheme	250 320	4 082.56	28.51	46.97	3.21	20.30	0.00	36.89	1.01
1140	Medshield Medical Scheme	138 538	3 013.16	30.24	42.86	1.54	24.59	0.00	22.06	0.76
1167	Momentum Medical Scheme	285 489	2 982.51	6.97	58.67	6.16	28.09	0.00	0.00	0.10

**Category 6 investments' underlying assets were also included in the relevant categories.*

*** Categories are referred to in Annexure B of the Act, read in conjunction with Regulation 30.*

The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its members when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities.

The liabilities of a medical scheme are short-term, and from Table 58 it can be observed that the majority of the allocation is in liquid investments.

An important risk management strategy is the diversification of investments. The schemes listed above (except for LA-Health Medical Scheme) have increased allocations towards equity and property investments, which are generally considered to be longer-term investments.

Table 59: Local and foreign asset distribution of largest ten schemes by asset base

Ref. no.	Name of medical scheme	Average beneficiaries	Total investable assets	Local*	Foreign*
			R'millions	%	%
1125	Discovery Health Medical Scheme	2 727 318	39 708.51	93.37	6.63
1598	Government Employees Medical Scheme (GEMS)	2 329 344	24 060.18	95.27	4.73
1580	South African Police Service Medical Scheme (POLMED)	494 899	12 845.67	98.87	1.13
1512	Bonitas Medical Fund	727 946	11 538.66	98.07	1.93
1279	Bankmed	221 545	4 518.75	92.11	7.89
1145	LA-Health Medical Scheme	274 237	4 279.44	100.00	0.00
1012	Anglo Medical Scheme	17 413	4 137.90	80.00	20.00
1252	Bestmed Medical Scheme	250 320	4 082.56	91.93	8.07
1140	Medshield Medical Scheme	138 538	3 013.16	88.73	11.27
1167	Momentum Medical Scheme	285 489	2 982.51	95.76	4.24

** The definitions of local and foreign assets refer to investments made within the Republic and outside the Republic as referred to in Annexure B of the Act, read in conjunction with Regulation 30.*

Larger medical schemes typically also seek to diversify their investments by increasing their foreign exposure.

Anglo Medical Scheme has previously entered into an arrangement with the participating employer groups to receive funding to meet the ongoing and future cost of providing benefits for its higher than usual proportion of pensioner members. The scheme has applied a long-term investment horizon to these additional funds. The scheme has received an exemption in terms of Section 8(h) to invest up to 15% of its Regulation 30(3A) excess assets in foreign equity.

Bankmed, Bestmed Medical Scheme and Medshield Medical Scheme gained exposure in foreign investments through cash and cash equivalents and bonds.

The following table illustrates the total net investment income of the industry split between open and restricted scheme:

Table 60: Asset base and investment income

	Total investable assets			Net investment income*			Net investment income as % of total investable assets		
	2024	2023	% growth	2024	2023	% growth	2024	2023	% growth
	R'millions	R'millions		R'millions	R'millions		%	%	
Open schemes	68 844.28	65 089.55	5.77	7 583.63	5 628.89	34.73	11.02	8.65	27.40
Restricted schemes	74 141.97	74 358.71	(0.29)	7 891.29	6 077.66	29.84	10.64	8.17	30.23
All schemes	**142 986.25**	**139 448.26**	**2.54**	**15 474.92**	**11 706.54**	**32.19**	**10.82**	**8.39**	**28.96**

**Net investment income represents investment income after considering asset management fees*

As mentioned in paragraph Insurance service result and Net results the financial markets experienced a significant boost in investment performance, specifically as it relates to the bond and equity markets.

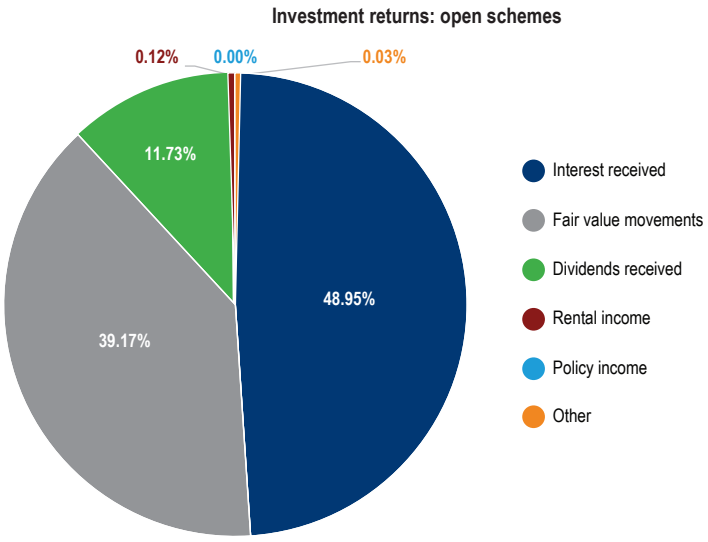


Figure 44: Investment returns in the open scheme industry

The type of investment income is closely related to the asset exposure. The high proportion of interest received (48.95%) is therefore expected due to the high exposure to bonds (43.31%) and cash and cash equivalents (25.40%) in the open schemes industry. Fair value appreciation* represented 39.17% of the total investment income, followed by dividend income (11.73%).

*As mentioned in paragraph Regulation 29 reserves, the cumulative fair value appreciation is excluded from the Regulation 29 reserves calculation.

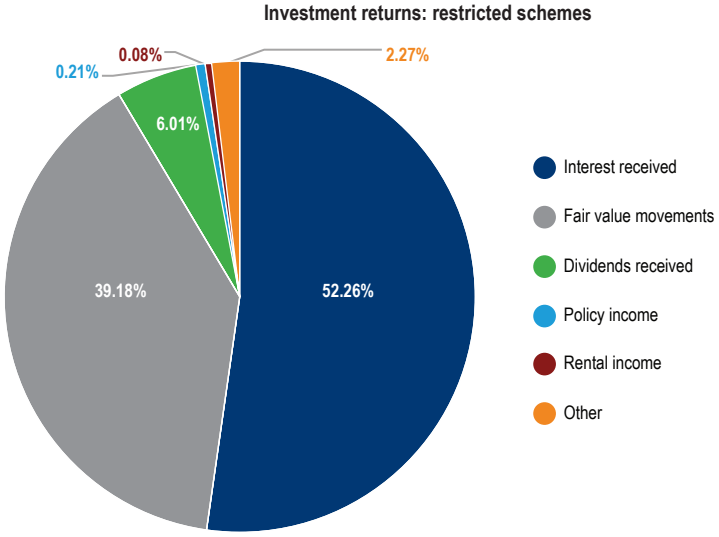


Figure 45: Investment returns in the restricted scheme industry

Restricted schemes invested 38.12% of their investments in bonds, followed by 36.14% in cash and cash equivalents. The higher proportion of interest received (52.26%) is therefore aligned with the schemes' exposure.

Fair value movements* constitute 39.18% of total investment income in the restricted schemes environment, followed by 6.01% in dividends received.

*As mentioned in paragraph Regulation 29 reserves, the cumulative fair value appreciation is excluded from the Regulation 29 reserves calculation.

Investment exposure: per category, sub-category and individual investment

Reference should be made to Annexure U, which contains details on the individual schemes' (and industry) asset allocation as at 31 December 2024.

Bonds

The investment in local bonds represents the biggest investment class for medical schemes in 2024: 37.00% of industry assets were invested in local bonds, with a 4.52% investment in foreign bonds. Figure 46 provides a breakdown of the exposure to local bond sub-categories.

It is important to note that Annexure B categorises property bonds separate from other local bonds. Property bonds have therefore been excluded from the analysis below.

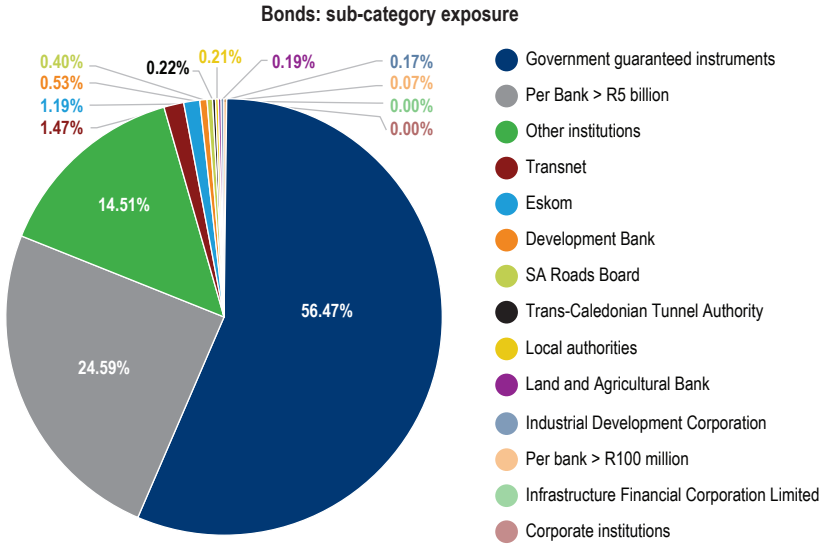


Figure 46: Bonds: sub-category exposure

The investment in government guaranteed investments constituted 56.47% of the total investment made in local bonds. Table 61 provides details of the five instruments within this sub-category with the highest exposure at an industry level.

Table 61: Government bonds: highest exposure to individual bonds

Government bonds: Top 5 instruments invested	Instrument code	R'millions	% of total government bonds	% of total investment
Republic of South Africa	R2032	3 491.26	11.95%	2.44%
Republic of South Africa	R2037	3 034.75	10.38%	2.12%
Republic of South Africa	R2035	2 656.03	9.09%	1.86%
Republic of South Africa	R2040	2 227.61	7.62%	1.56%
Republic of South Africa	R213	1 946.63	6.66%	1.36%

The largest exposure to an individual instrument back by the South African government (instrument code R2032) represents 11.95% of the industry investment in local bonds, or 2.44% of the total industry assets.

24.59% of the investment made in local bonds relates to investments in banks with net qualifying capital and reserve funds greater than R5 billion.

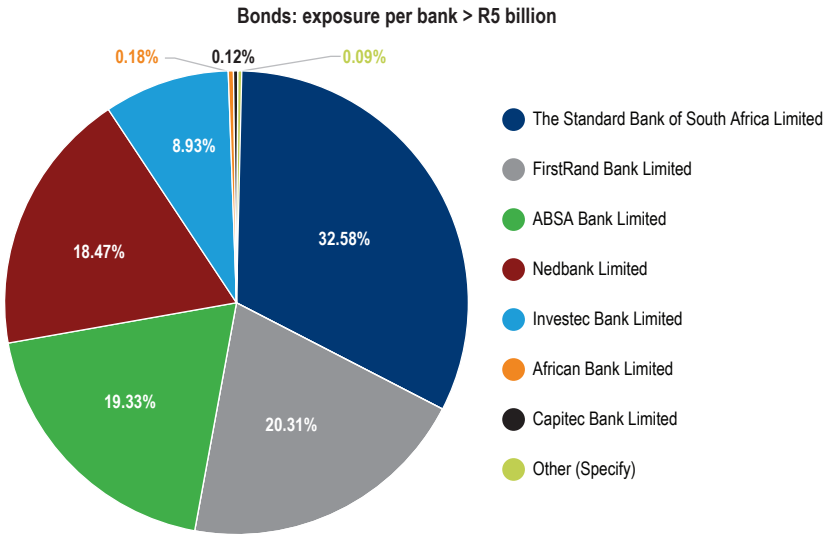


Figure 47: Bonds: exposure per bank >R5 billion

The exposure within this sub-category was mainly to the Standard Bank of South Africa Limited (32.58%), followed by FirstRand Bank Limited (20.31%), ABSA Bank Limited (19.33%), and Nedbank Limited (18.47%).

Table 62 provides details of the five instruments within this sub-category with the highest exposure at an industry level.

Table 62: Banks > R5 billion: highest exposure to individual bonds

Banks > R5 billion: Top 5 instruments invested	Instrument code	R'millions	% of total banks > R5 billion bonds	% of total investment
The Standard Bank of South Africa Limited	SBK002ZACISS	454.95	3.58%	0.32%
FirstRand Bank Limited	FRBI28	297.11	2.33%	0.21%
The Standard Bank of South Africa Limited	SBSS02	194.09	1.53%	0.14%
The Standard Bank of South Africa Limited	CLN975	191.92	1.51%	0.13%
Nedbank Limited	NBK21A	190.15	1.49%	0.13%

The largest exposure to an individual instrument issued by the Standard Bank of South Africa Limited (instrument code SBK002ZACISS) represented 3.58% of the investments in bonds in banks with net qualifying capital and reserve funds greater than R5 billion, or 0.32% of the total industry assets.

The investment in other institutions constituted 14.51% of the industry's investment in bonds. Table 63 explores the five instruments within this sub-category with the highest exposure at an industry level.

Table 63: Other institutions: Top 5 instruments invested

Other institutions: Top 5 instruments invested	Instrument code	R'millions	% of total other institution bonds	% of total investment
Standard Bank Group Limited	SBT109	133.36	1.78%	0.09%
Standard Bank Group Limited	SBT104	130.34	1.74%	0.09%
Absa Group Limited	AGT04	121.55	1.62%	0.09%
Standard Bank Group Limited	SBT110	121.33	1.62%	0.08%
Northam Platinum Limited	NHM016	115.72	1.54%	0.08%

The largest exposure to an individual instrument represents 1.78% of the investment made in this sub-category, or 0.09% of the total industry assets, and represented an investment in Standard Bank Group Limited (bond code SBT109).

Cash and cash equivalents

Cash and cash equivalents represents the second biggest investment class in the medical schemes industry. 31.26%, or R43.73 billion, of scheme assets were invested in local cash and cash equivalents at the end of 2024, with a 0.40% exposure to foreign cash and cash equivalents. Figure 48 provides a breakdown of the exposure to individual banks within the local cash and cash equivalents investment.

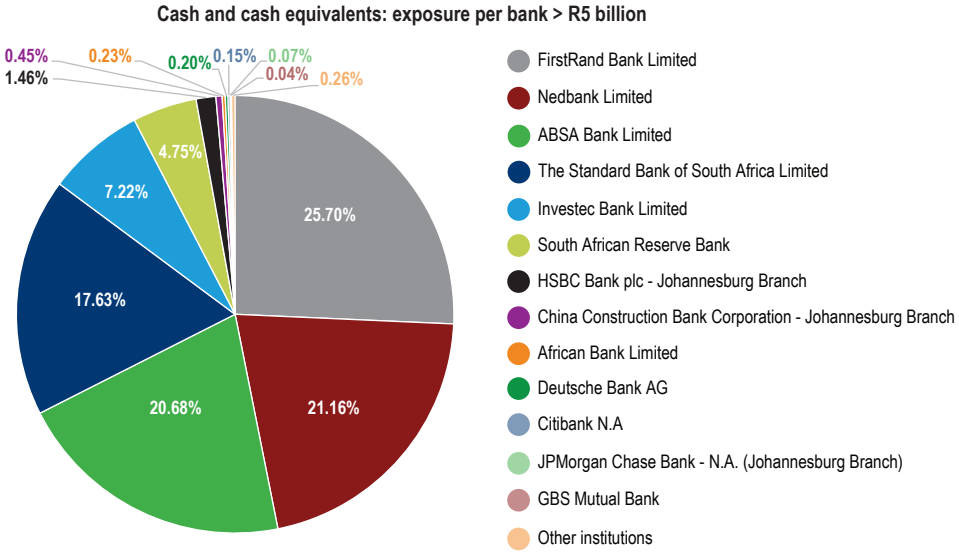


Figure 48: Cash and cash equivalents: individual bank exposure

The majority of the exposure within local cash and cash equivalents is to FirstRand Bank Limited (25.70%), followed by Nedbank Limited (21.16%), ABSA Bank Limited (20.68%), and The Standard Bank of South Africa (17.63%).

Equity

Local equity represents the third biggest investment class in the medical schemes industry. 21.96%, or R30.73 billion, of scheme assets were invested in local equity at the end of 2024, with a 0.36% exposure to foreign equity. Figure 49 provides a breakdown of the exposure to the various subcategories within the local equity investment.

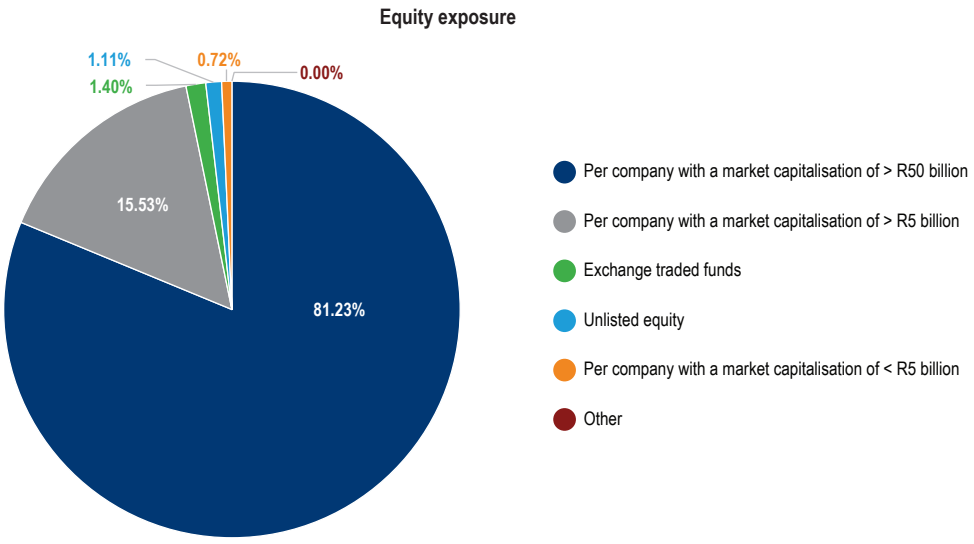


Figure 49: Equity investments: sub-category exposure

The majority of the investment (81.23% or R24.96 billion) was made in companies with market capitalisation exceeding R50 billion, followed by the investment in companies with a market capitalisation between R5 billion and R50 billion (15.53% or R4.77 billion).

Table 64 explores the ten instruments within the sub-category relating to companies with market capitalisation exceeding R50 billion, with the highest exposure at an industry level.

Table 64: Equity investments: highest exposure to individual instruments

Companies with market capitalisation exceeding R50 million: Top 10 instruments invested	Instrument code	R'millions	% of total equity	% of total investment
Naspers Ltd -N-	NPN	2 326.49	7.57%	1.63%
FirstRand Ltd	FSR	1 844.99	6.00%	1.29%
Prosus N.V.	PRX	1 650.86	5.37%	1.15%
Standard Bank Group Ltd	SBK	1 606.71	5.23%	1.12%
Absa Group Limited	ABG	1 009.48	3.29%	0.71%
Anglo American plc	AGL	990.09	3.22%	0.69%
AngloGold Ashanti plc	ANG	957.06	3.11%	0.67%
British American Tob plc	BTI	933.67	3.04%	0.65%
Gold Fields Ltd	GFI	906.63	2.95%	0.63%
Anheuser-Busch InBev SA NV	ANH	843.43	2.74%	0.59%

The largest exposure to an individual instrument represents 7.57% of the investment made in this sub-category, or 1.63% of the total industry assets, and represented an investment in Naspers Ltd (instrument code NPN).

Table 65 provides the breakdown of the super sector classification of the listed equity investments.

Table 65: Sector classification of listed equity investments

ICB Super Sector Long Name	R'millions	% of total equity	% of total investment
Asset Backed Securities	-	0.00%	0.00%
Automobiles and Parts	0.65	0.00%	0.00%
Banks	6 296.75	20.72%	4.40%
Basic Resources	5 415.30	17.82%	3.79%
Chemicals	448.49	1.48%	0.31%
Construction and Materials	143.21	0.47%	0.10%
Consumer Products and Services	880.79	2.90%	0.62%
Debt	94.99	0.31%	0.07%
Energy	296.27	0.98%	0.21%
Exchange Traded Products	429.44	1.41%	0.30%
Financial Services	1 448.19	4.77%	1.01%
Food, Beverage and Tobacco	2 455.41	8.08%	1.72%
Health Care	466.08	1.53%	0.33%
Industrial Goods and Services	1 124.19	3.70%	0.79%
Insurance	1 417.72	4.67%	0.99%
Media	12.01	0.04%	0.01%
Personal Care, Drug and Grocery Stores	2 020.43	6.65%	1.41%
Real Estate*	n/a	n/a	n/a

ICB Super Sector Long Name	R'millions	% of total equity	% of total investment
Retail	1 898.55	6.25%	1.33%
Technology	4 102.79	13.50%	2.87%
Telecommunications	1 063.55	3.50%	0.74%
Travel and Leisure	370.49	1.22%	0.26%
Utilities	-	0.00%	0.00%

** Annexure B categorises local listed property instruments separate from other local equity investments.*

Medical schemes invested 20.72% of its total listed equity investment in the Banks-sector of the Johannesburg Stock Exchange, followed by the Basic Resources (17.82%), and Technology (13.50%) sectors.

Property

It is important to note that Annexure B categorises local listed property instruments separate from other local bond and equity investments.

Medical schemes had 4.32% (or R6.04 billion) exposure to local property investments at the end of 2024.

Table 66: Property investments: highest exposure to individual listed instruments

Listed property: Top 5 instruments invested	Instrument code	R'millions	% of total property	% of total investment
NEPI Rockcastle N.V.	NRP	638.85	2.05%	0.45%
Growthpoint Properties Limited	GRT	460.25	1.47%	0.32%
Redefine Properties Limited	RDF	324.06	1.04%	0.23%
Hyprop Investments Limited	HYP	236.31	0.76%	0.17%
Vukile Property Fund Limited	VKE	233.20	0.75%	0.16%

The largest exposure to an individual instrument represents 2.05% of the investment made in this sub-category, or 0.45% of the total industry assets, and represented an investment in NEPI Rockcastle N.V. (instrument code NRP).

Table 67 aims to represent the total exposure to a single entity by virtue of all the various instruments (such as equity and bonds issued) invested in.

Table 67: Property investments: highest exposure to individual entities

Listed property: Top 5 institutions	R'millions	% of total property	% of total investment
NEPI Rockcastle N.V.	638.85	2.05%	0.45%
Growthpoint Properties Limited	603.74	1.93%	0.42%
Redefine Properties Limited	389.26	1.25%	0.27%
Fortress Real Estate Investments Limited	366.57	1.17%	0.26%
Vukile Property Fund Limited	324.20	1.04%	0.23%

The investment in Growthpoint Properties Limited, instrument code GRT, represented 1.47% of the property investment. However, when combining all the various instruments issued by the entity (equity and bonds) to determine the overall exposure, it increases to 1.93% of the total property investments, or 0.42% of total industry investment.

Debentures

Medical schemes had 0.51% (R0.71 billion) exposure to local debentures at the end of 2024.

Other assets

1.78% (R2.50 billion) of scheme investments were in local Other assets at the end of 2024.

Credit Linked Notes (CLNs) are included in Other assets due to the high probability of an embedded derivative (which is triggered should the credit linked event occur). In instances where the investment manager is able to confirm that no embedded derivatives exist, these instruments are reclassified to bonds.

CLNs represent the biggest component of Other assets.

Accredited administrators

Market share

Figure 50 shows the market share of medical scheme administrators and self-administered medical schemes based on the average number of beneficiaries administered at the end of 2024[2].

Where an entity provides the full suite of co-administration services for a specific benefit option, the membership had been included with the co-administrator (and excluded from the administrator):

- Bonitas Medical Fund outsourced the administration of the Boncap option to Private Health Administrators (Pty) Ltd from 1 January 2023 onwards. Medscheme Holdings (Pty) Ltd continues to administer all other scheme benefit options.
- Witbank Coalfields Medical Aid Scheme contracted Universal Healthcare Administrators (Pty) Ltd to provide select administration functions and network management for the Ntsika option.

In instances where the co-administrator only provides specific / partial administration services to members, the membership had not been taken in consideration:

- Government Employees Medical Scheme (GEMS) had a joint administration contract in place. Medscheme Holdings (Pty) Ltd is responsible for contribution and debt management as well as correspondence services, whilst Metropolitan Health Corporate (Pty) Ltd is responsible for member and claims management services as well as the provision of financial and operational information. Medscheme Holdings (Pty) Ltd is considered the co-administrator.
- SAMWUMed entered into an agreement with Medscheme Holdings (Pty) Ltd to provide integrated claims processing services and to rent their administration system. The co-administration agreement had not been reflected correctly on the CMS database, and the scheme was therefore not able to complete the appropriate parts of the FASR correctly.

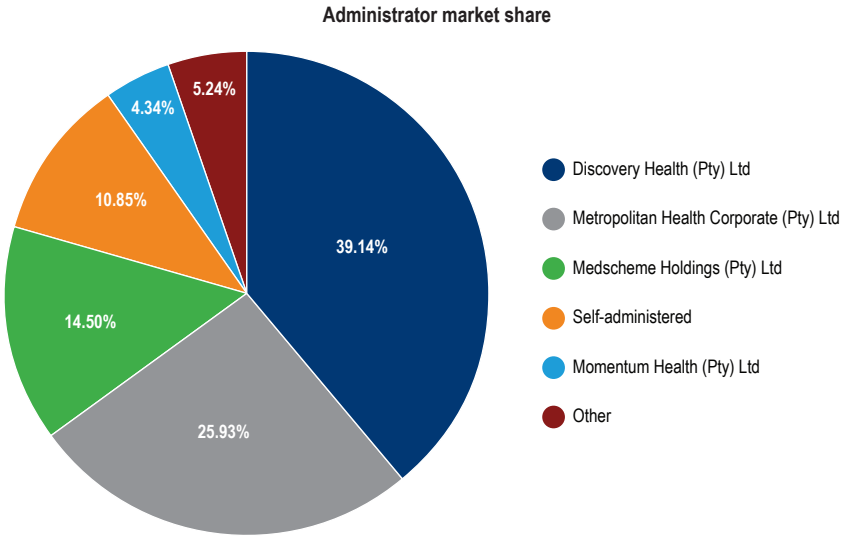


Figure 50: Administrator market share

2 The data that is presented here differs from Annexure V which is based on the average membership administered during the year.

Four third-party administrators continued to dominate the market in 2024, namely (in order of market share):

- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Medscheme Holdings (Pty) Ltd
- Momentum Health (Pty) Ltd

Collectively these companies administer 83.91% of the market.

Three medical schemes changed administrators during 2023 and 2024:

- Bonitas Medical Fund changed the administrator of the Boncap option Medscheme Holdings (Pty) Ltd to Private Health Administrators (Pty) Ltd on 1 January 2023. Medscheme Holdings (Pty) Ltd continues to administer all other scheme benefit options.
- South African Breweries Medical Aid Scheme (SABMAS) changed its administrator from Discovery Health (Pty) Ltd to 3Sixty Health (Pty) Ltd on 1 January 2023.
- Foodmed Medical Scheme changed its administration model from being self-administered to being third-party administered by Universal Healthcare Administrators (Pty) Ltd on 1 August 2023.
- Rand Water Medical Scheme changed its administration model from being self-administered to being third-party administered by Afrocentric Integrated Health Administrators (Pty) Ltd on 16 June 2023.
- Sasolmed changed its administrator from Momentum Health Solutions (Pty) Ltd to Discovery Health (Pty) Ltd on 1 January 2024.

The market share of the four largest third-party administrators seems to be stable.

Figure 51 indicates the market share for open schemes. Marginal changes based on membership changes within the individual schemes were observed over the last five years for open medical schemes.

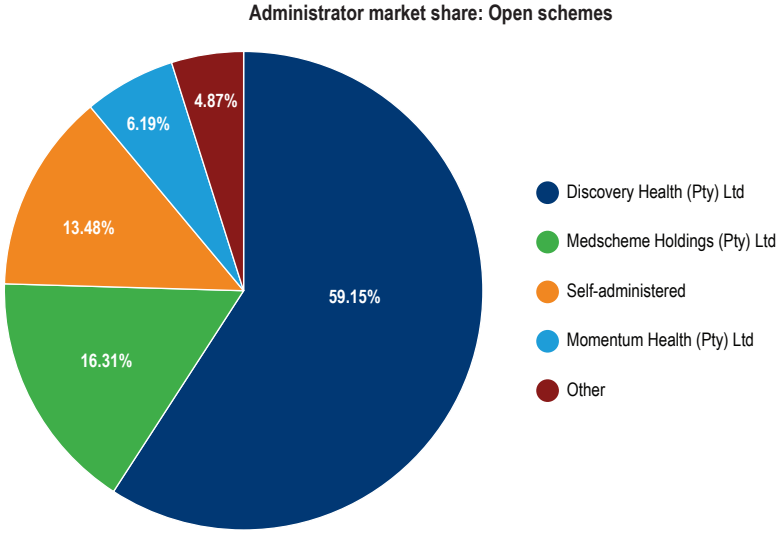


Figure 51: Administrator market share: Open schemes

** The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure X).*

Discovery Health (Pty) Ltd has the largest market share (59.15%) in the open schemes environment, followed by Medscheme Holdings (Pty) Ltd with a market share of 16.31%.

Figure 52 indicates the market share for restricted schemes at the end of 2024.

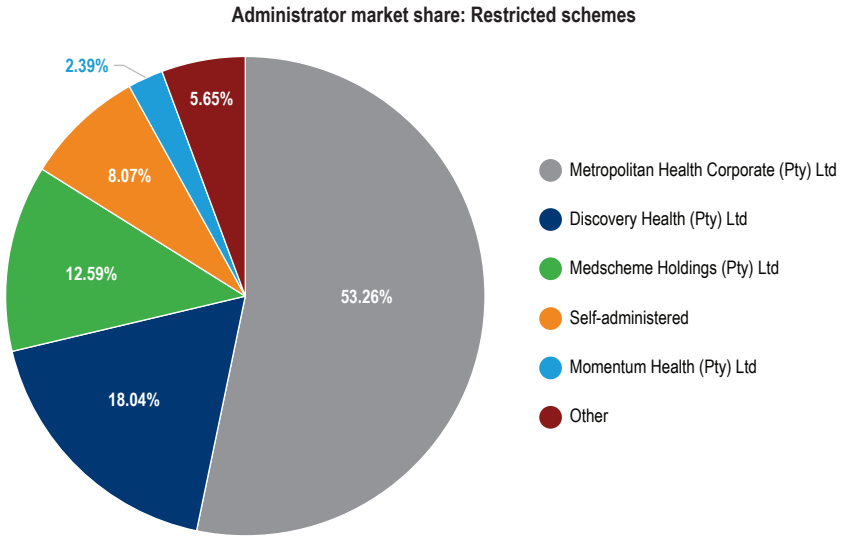


Figure 52: Administrator market share: Restricted schemes

** The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure X).*

Metropolitan Health Corporate (Pty) Ltd has the largest market share (53.26%) in the restricted schemes environment, followed by Discovery Health (Pty) Ltd with a market share of 18.04%.

Fees received in respect of accredited administration services and other administration expenditure

Circular 77 of 2019 (effective 1 January 2021) was issued to standardise the contracting and reporting of accredited administration services and other administration services. This ensures transparency which would allow for more efficient monitoring and comparability across the industry of the individual services contracted.

Accredited administrators received R11.36 billion in fees for accredited administration services, and R1.56 billion for other administration expenditure.

Figure 53 illustrates the split of the total fees received by the administrators in respect of accredited administration services and other administration expenditure.

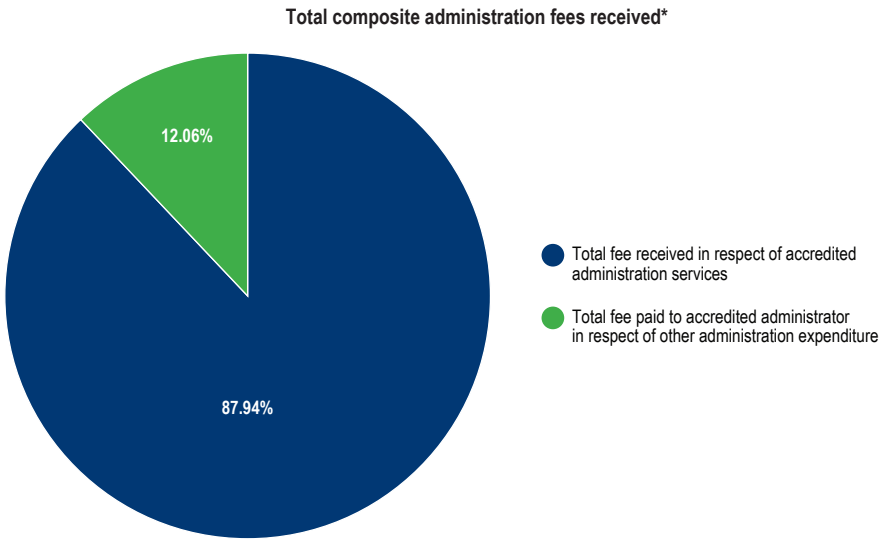


Figure 53: Split of total composite administration fees received

**In respect of accredited administration services and other administration expenditure*

The majority of the fees received by accredited administrators related to the provision of accredited administration services (87.94%), with the remainder (12.06%) relating to the provision of other administration expenditures such as forensic investigations and recoveries, governance and compliance services, internal audit services and marketing expenditure.

Table 35 and Table 41 in the paragraph Fees paid in respect of accredited administration services and other administration expenditure depict the breakdown of the fees paid in respect of accredited administration services as well as other administration expenditure per industry, respectively.

Figure 54 provides a breakdown of the composite fee received from the provision of both accredited administration services as well as other administration expenditure.

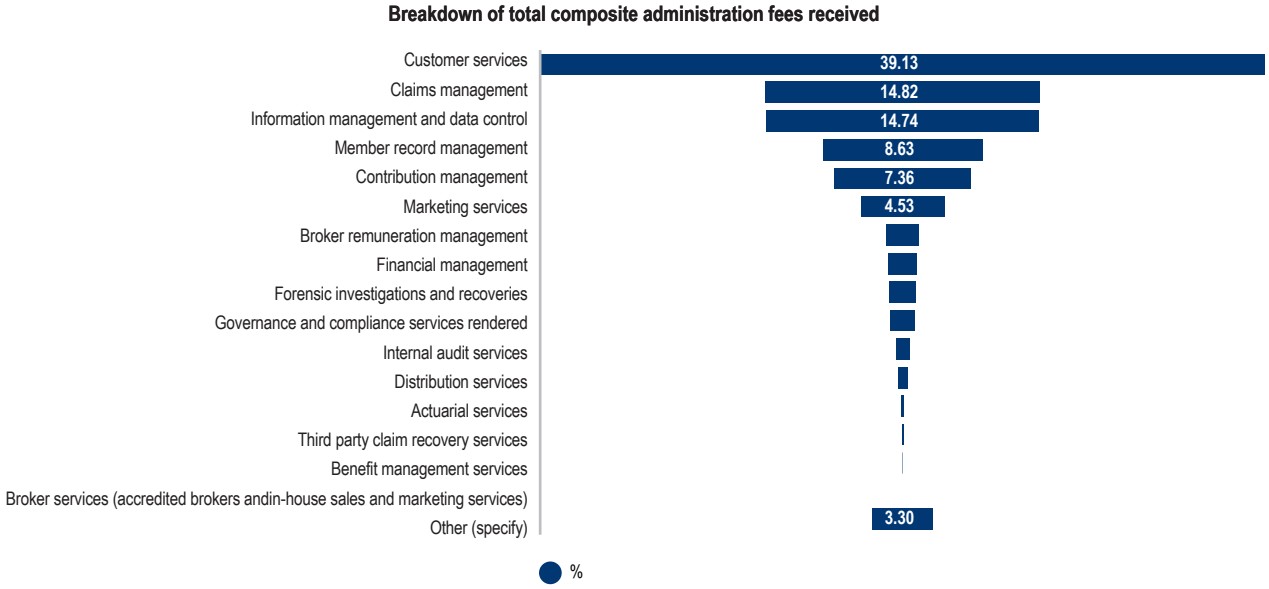


Figure 54: Breakdown of total composite administration fees received

The majority of the composite fees received related to the provision of accredited administration services: customer services (39.13%), followed by claims management (14.82%) and information management and data control (14.74%).

Marketing services constituted the largest component of the other administration services provided, at 4.53% of the total composite fee received.

For the breakdown of the various services provided by each administrator, reference can be made to Annexure X.

Table 68 lists the administrators whose total composite administration fees received (including co-administration fees) in respect of administration and other expenditure exceeds the industry average of R299.05 pampm.

It is important to note that the composite administration fee includes such other services such as forensic investigations and recoveries, governance and compliance services, internal audit services and marketing expenditure (where applicable). It is therefore not directly comparable with administrators who do not provide these services. For the breakdown of the various services provided by each administrator, reference can be made to Annexure X.

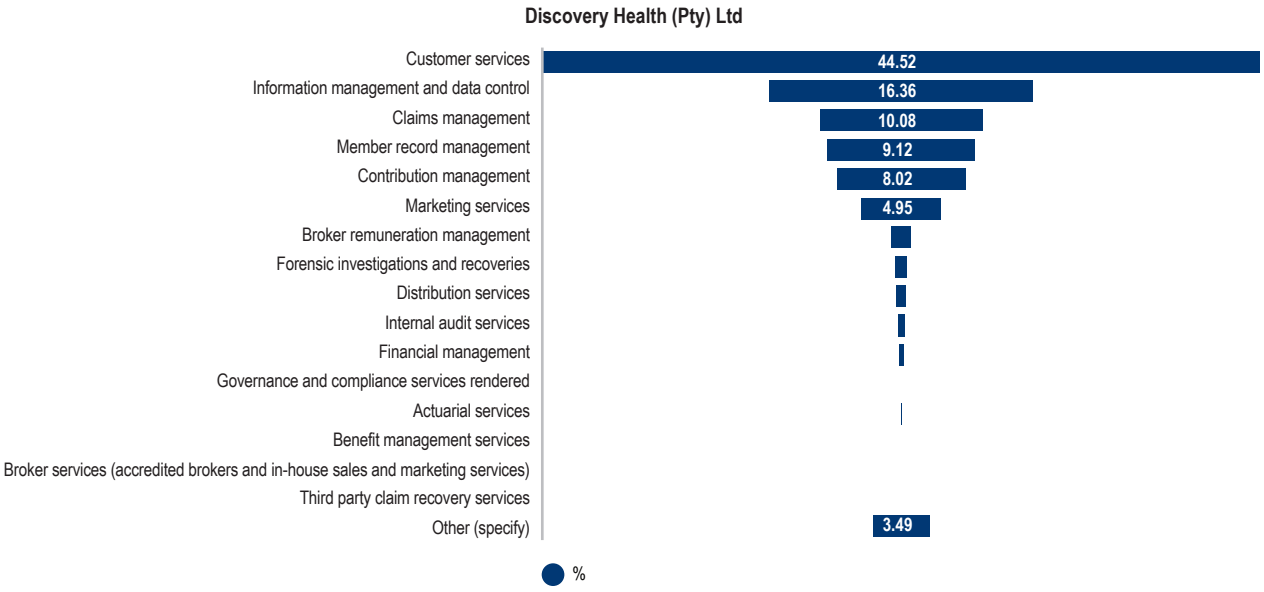
Table 68: Administrators with total composite administration fees received (including co-administration fees) exceeding industry average

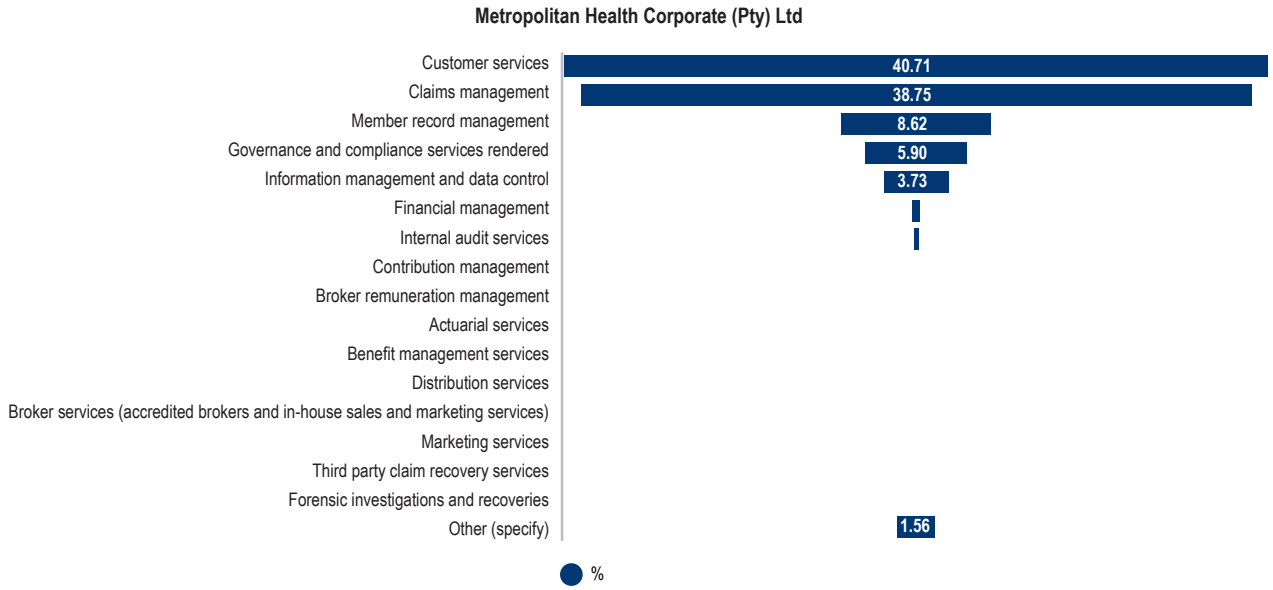
Administrator	No. of medical schemes	Average members	Average beneficiaries	Market share	Total composite administration fees received (including co-administration fees) in respect of accredited administration and other administration expenditure
				%	pampm
Discovery Health (Pty) Ltd	18	1 701 617	3 516 129	39.14	394.27
Momentum Health (Pty) Ltd	10	208 697	390 111	4.34	353.31
Afrocentric Integrated Health Administrators (Pty) Ltd	1	3 619	9 255	0.10	302.82

pampm = per average member per month

Discovery Health (Pty) Ltd.'s composite fee of R394.27 pampm exceeds the industry average of R299.05 pampm by 31.84%.

Figures 55 – 58 depicts the breakdown of the composite fees received for each of the four largest accredited administrators.



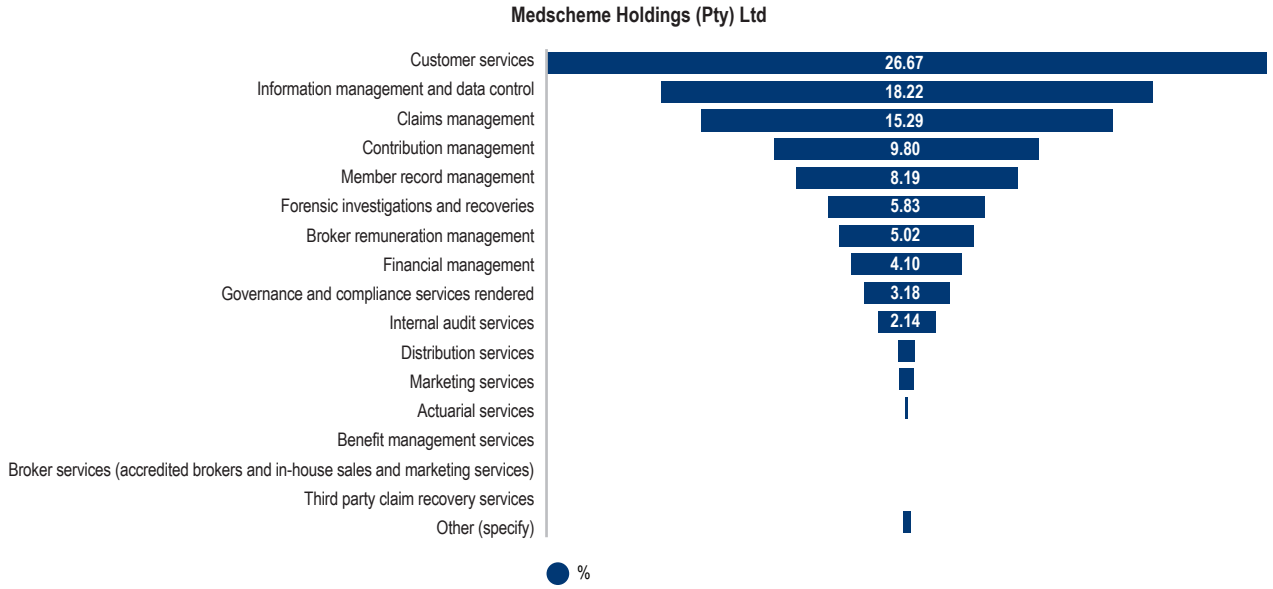


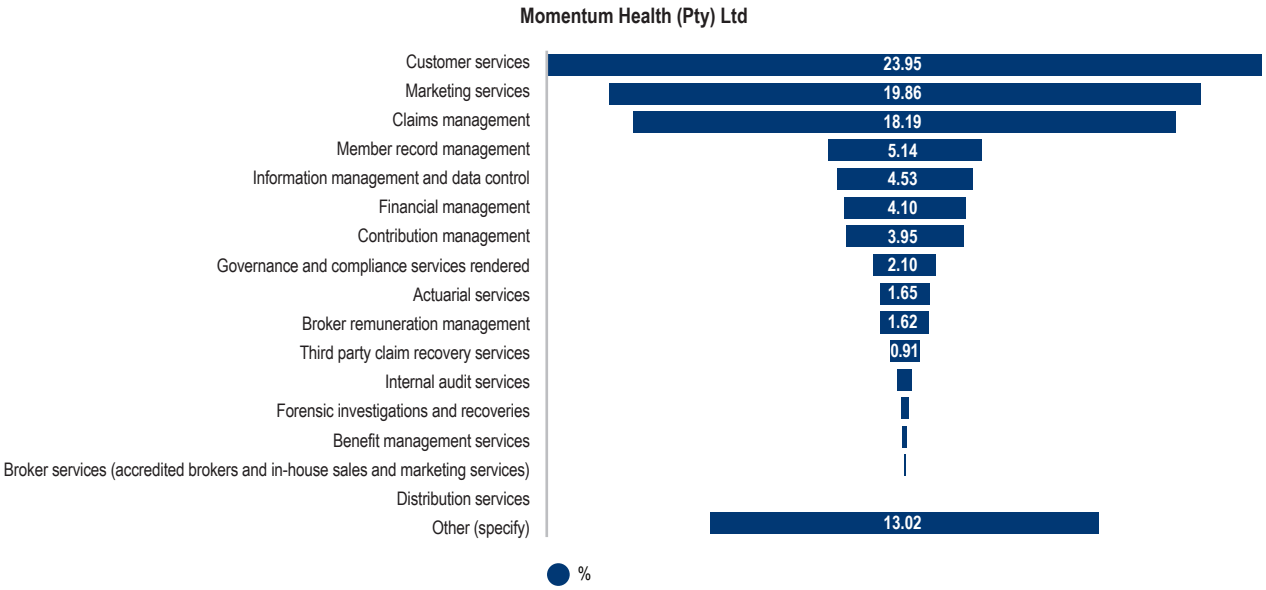
Figures 55 - 58: Breakdown of total composite administration fees received per administrator

The majority of the fees paid to both Discovery Health (Pty) Ltd (total composite administration fee R394.27 pampm) and Metropolitan Health Corporate (Pty) Ltd (total composite administration fee R127.71 pampm) related to the accredited administration services component of their product offering.

Customer services represented the biggest component at 44.52% and 40.71% for the two administrators respectively, followed by claims management, contribution management*, information management and data control and member record management (albeit not following the same sequence for the two administrators).

*As per the GEMS co-administration contract, contribution management services are provided by Medscheme Holdings (Pty) Ltd and not by Metropolitan Health Corporate (Pty) Ltd.





The majority of the fees paid to both Medscheme Holdings (Pty) Ltd (total composite administration fee R246.78 pampm) and Momentum Health (Pty) Ltd (total composite administration fee R353.31 pampm) related to the accredited administration services component of their product offering. Customer services represented the biggest component at 26.67% and 23.95% for the two administrators respectively, followed by claims management, contribution management, information management and data control and member record management (albeit not following the same sequence for the two administrators).

Marketing services represented the highest component of other administration expenditure provided by Momentum Health (Pty) Ltd (at 19.86% of the total composite fee received).

Table 69 indicates the total fees paid to the largest four administrators in terms of market share for all schemes, as well as the schemes falling under their administration.

Table 69: Total fees paid to the four largest administrators (excluding accredited managed healthcare services) - deviation from average per administrator

Ref. no.	Name of medical scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services		Fee paid to accredited administrator in respect of other administration expenditure		Average per administrator	Deviation from average per administrator
				pampm R	As % of DAE	pampm R	As % of DAE	pampm R	%
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 351 211	387.08	77.87	42.37	8.52	394.27	8.92
1520	University of Kwa-Zulu Natal Medical Scheme		3 237	292.61	100.00	27.03	9.24		(18.93)
1571	Anglovaal Group Medical Scheme		2 215	287.40	100.00	22.08	7.68		(21.51)
1241	Multichoice Medical Aid Scheme		3 521	281.53	100.00	21.61	7.68		(23.11)
1578	TFG Medical Aid Scheme		2 878	280.75	100.00	21.57	7.68		(23.32)
1572	Engen Medical Benefit Fund		3 003	280.14	100.00	21.53	7.69		(23.49)
1234	Sasolmed		28 475	265.36	95.00	25.04	8.96		(26.34)
1579	Tsogo Sun Group Medical Scheme		3 879	262.61	100.00	20.15	7.67		(28.28)
1145	LA-Health Medical Scheme		107 481	252.71	69.23	67.05	18.37		(18.90)
1430	Remedi Medical Aid Scheme		20 992	252.46	100.00	21.62	8.56		(30.48)
1176	Retail Medical Scheme		15 875	252.28	100.00	19.39	7.69		(31.10)
1547	Malcor Medical Scheme		4 632	233.03	89.55	21.30	8.18		(35.49)
1526	BMW Employees Medical Aid Society		3 102	229.56	100.00	22.59	9.84		(36.05)
1012	Anglo Medical Scheme		8 551	211.50	100.00	17.95	8.49		(41.80)
1253	Glencore Medical Scheme		7 675	196.85	100.00	17.09	8.68		(45.74)
1584	Netcare Medical Scheme		16 797	190.69	100.00	16.30	8.55		(47.50)
1279	Bankmed		107 699	183.58	95.00	23.80	12.32		(47.40)
1599	Lonmin Medical Scheme		10 394	79.01	100.00	6.48	8.20		(78.32)
1598	Government Employees Medical Scheme (GEMS)*	Metropolitan Health Corporate (Pty) Ltd	861 772	117.80	61.83	9.91	5.20	129.39	-
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	56 917	299.47	74.68	45.33	11.30	246.78	39.72
1507	Barloworld Medical Scheme		3 989	262.60	99.99	27.12	10.33		17.40
1441	Parmed Medical Aid Scheme		2 409	260.17	99.16	29.89	11.39		17.54
1512	Bonitas Medical Fund		356 713	257.71	57.43	32.13	8.44		17.45
1424	SABC Medical Aid Scheme		3 842	243.32	100.00	28.61	11.76		10.19
1039	MBMed Medical Aid Fund		3 746	225.20	97.22	32.19	13.90		4.30
1566	Horizon Medical Scheme		1 568	198.61	100.00	21.52	10.84		(10.80)
1005	AECI Medical Aid Society		5 245	171.51	100.00	45.11	26.30		(12.22)
1580	South African Police Service Medical Scheme (POLMED)		187 501	134.09	88.67	14.93	9.87		(39.61)
1548	Medipos Medical Scheme		6 952	126.87	100.00	49.40	38.94		(28.57)
1598	Government Employees Medical Scheme (GEMS)*		861 772	28.85	15.14	6.72	3.53		n/a
1038	SAMWUMed**		33 316	-	-	-	-		n/a

Ref. no.	Name of medical scheme	Name of administrator	Average members	Fee paid in respect of accredited administration services		Fee paid to accredited administrator in respect of other administration expenditure		Average per administrator	Deviation from average per administrator
				pampm R	As % of DAE	pampm R	As % of DAE	pampm R	%
1186	PG Group Medical Scheme	Momentum Health (Pty) Ltd	1 270	236.02	91.36	43.57	16.87	353.31	(20.87)
1167	Momentum Medical Scheme		152 638	232.24	49.64	169.55	36.24		13.72
1293	Wooltru Healthcare Fund		9 381	202.45	93.31	38.74	17.86		(31.73)
1559	Imperial and Motus Medical Aid		7 308	180.44	90.29	33.64	16.83		(39.41)
1237	BP Medical Aid Society		1 032	179.26	86.68	27.21	13.16		(41.56)
1270	Golden Arrow Employees' Medical Benefit Fund		2 565	177.32	90.11	27.19	13.82		(42.12)
1600	Motohealth Care		14 180	176.15	87.46	71.30	35.40		(29.96)
1582	Transmed Medical Fund		12 600	175.86	84.53	33.83	16.26		(40.65)
1563	Pick n Pay Medical Scheme		6 002	143.55	72.61	47.10	23.82		(46.04)
1271	Fishing Industry Medical Scheme (Fishmed)		1 721	94.33	87.79	17.43	16.22		(68.37)

DAE = Directly Attributable Insurance Service Expenditure

pampm = per average member per month

**GEMS: Medscheme Holdings (Pty) Ltd was responsible for contribution and debt management as well as correspondence services, whilst Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The fee charged per administrator is therefore not comparable with other schemes who have contracted for the full suite of accredited administration services.*

*** SAMWUMed entered into an agreement with Medscheme Holdings (Pty) Ltd to provide integrated claims processing services and to rent their administration system. The co-administration agreement had not been reflected correctly on the CMS database, and the scheme was therefore not able to complete the appropriate parts of the FASR correctly.*

In general, accredited administrators charge the highest fees to the open schemes under their administration - typically these schemes demonstrate inelastic demand due to the size of its operations and the potential of service disruption should a change in providers occur.

Another detractor to competition in the open scheme environment could be the close association between medical schemes and their administrators.

Compcare Wellness Medical Scheme applied to the Registrar to change its name to Universal Medical Scheme, in order to take advantage of its administrator's brand. The Registrar refused in terms of Section 23(1)(c) to register the name change, as it was deemed to be likely to mislead the public. In the Supreme Court of Appeal, case no. 267/2020, Compcare Wellness Medical Scheme v Registrar of Medical Schemes and Others, Judge of Appeal C Plasket, upheld the Registrar decision not to approve the proposed name change. Non-compliance with Section 23(1)(c) will be a focus area for the CMS in the medium term, especially as it is a possible detractor in competition in the open scheme administrator market.

Limited changes in the administration of open schemes have been observed over the past decade.

Fees received in respect of accredited managed healthcare services

Accredited administrators and their related parties received R5.45 billion in respect of accredited managed healthcare services (no transfer of risk) and R1.27 billion in relation to accredited managed healthcare services (risk transfer arrangements).

Table 70 shows the market share of administrators (and their related parties) including accredited managed healthcare services.

Table 70: Market share of administrators: including accredited managed healthcare services

Name of administrator	No. of schemes	Beneficiaries*	Total composite administration fees received (including co-administration fees) in respect of administration and other expenditure	Relevant healthcare expenditure	Accredited managed healthcare services (no transfer of risk) received	Accredited managed healthcare services (risk transfer arrangement): capitation fee received	Total fees received**
		Market share %	pampm R	pabpm R	pampm R	pampm R	pampm R
3Sixty Health (Pty) Ltd	1	0.21	213.99	2 022.15	94.47	-	307.87
Afrocentric Integrated Health Administrators (Pty) Ltd	1	0.10	302.82	2 717.91	-	-	605.65
Discovery Health (Pty) Ltd	18	39.14	394.27	2 182.63	139.53	72.70	545.93
Discovery Administration Services (Pty) Ltd	1	0.12	278.57	2 872.64	126.83	-	402.04
Medscheme Holdings (Pty) Ltd	12	14.50	246.78	2 331.41	101.59	-	513.52
GEMS			35.57				35.57
SAMWUMed			-				-
Metropolitan Health Corporate (Pty) Ltd	1	25.93	127.71	2 200.95	-	-	127.71
Momentum Health (Pty) Ltd	10	4.34	353.31	1 738.52	116.31	429.83	730.98
Momentum Thebe Ya Bophelo (Pty) Ltd	6	1.00	123.71	1 399.50	60.95	-	164.92
Private Health Administrators (Pty) Ltd	1	0.88	115.21	1 508.53	-	580.68	695.90
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	1.58	297.35	2 762.34	135.88	-	432.48
Self-Administered	13	10.85	-	1 977.96	69.33	-	42.16
Universal Healthcare Administrators (Pty) Ltd	8	1.36	183.22	1 760.50	84.03	-	258.05
Average	74	100.00	298.23	2 176.35	116.60	236.02	420.80

pabpm = per average beneficiary per month

pampm = per average member per month

**The above table reflect market share based on the number of beneficiaries administered during the year (i.e. includes mid-year administrator changes)*

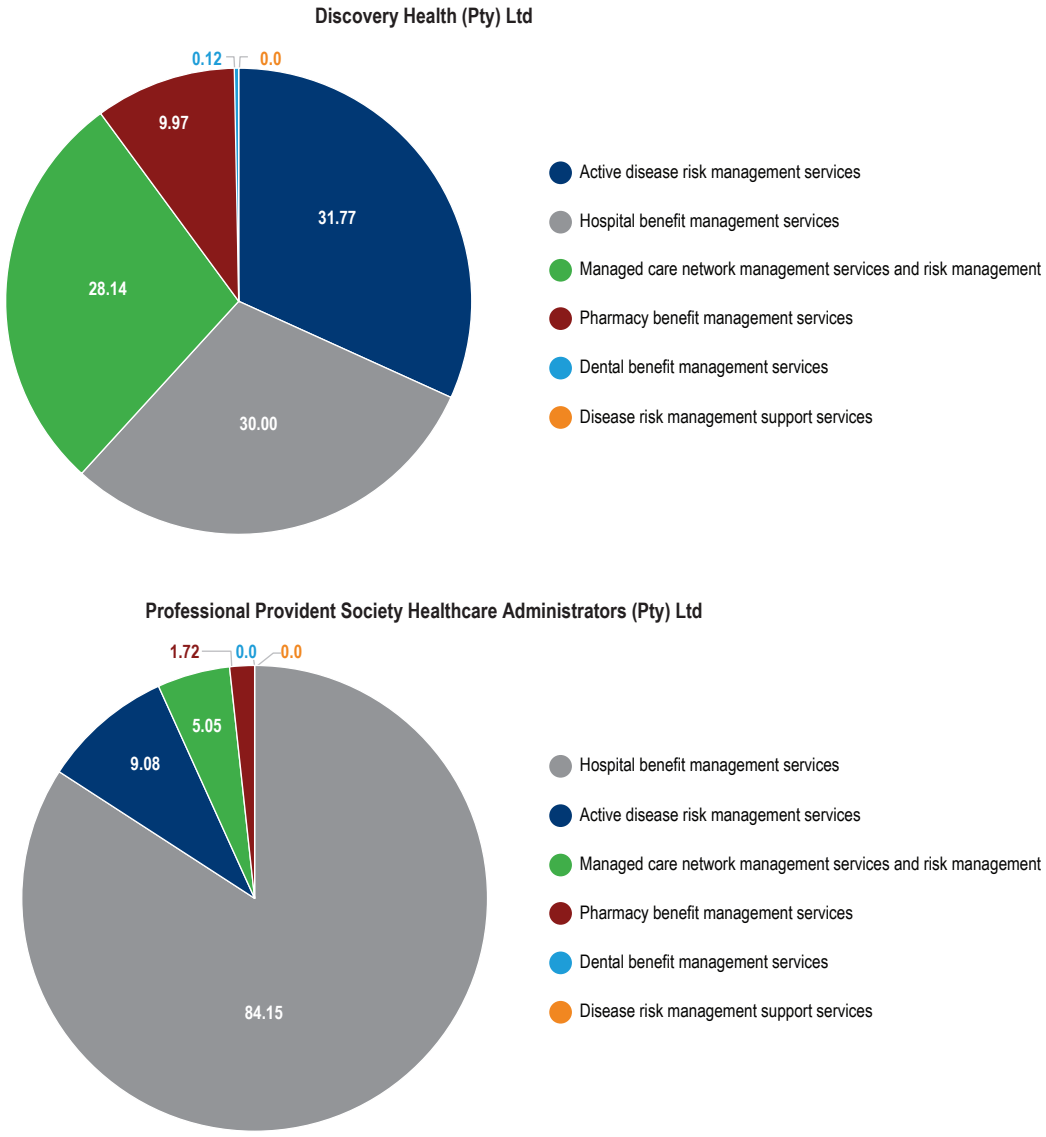
***The number of members on the benefit options covered by the individual arrangements have been used to calculate the pampm-figures. For the total fees' column, the total number of members under administration was used. The total figure is therefore not the sum of the pampm-fee per individual service.*

No correlation between market share and the total fee charged had been observed (i.e. no volume discounts were observed).

Accredited managed healthcare services (no transfer of risk) provided by scheme administrators and their related parties

The fees paid to accredited administrators and their related parties represents 88.19% of the total fee paid to accredited managed care organisations. In the open scheme industry, this represents 95.58% of the total contracted value.

Figures 59 and 60 depicts the breakdown of the accredited managed healthcare service fees received for the accredited administrators and their related parties who received fees of more than 15.00% in excess of the industry average of R116.60 pampm.



Figures 59 and 60: Breakdown of accredited managed healthcare service fees received per administrator and its related parties

The fee of R139.53 pampm paid to Discovery Health (Pty) Ltd and its related parties can be split into the following main components: active disease risk management services (31.77%), hospital benefit management services (30.00%), managed care network management services and risk management (28.14%) and pharmacy benefit management services (9.97%).

The fee paid to Professional Provident Society Healthcare Administrators (Pty) Ltd and its related parties in respect of accredited managed healthcare services (no transfer of risk) of R135.88 pampm can be split into the following main components: hospital benefit management services (84.15%), active disease risk management services (9.08%), managed care network management services and risk management (5.05%) and dental benefit management services (1.72%).

More information pertaining the breakdown of the fee paid per scheme per contract, into the various services provided, can be found in Annexure K. Annexure W contains details of contracts with the accredited administrator only.

Accredited managed healthcare services (risk transfer arrangements) provided by scheme administrators and their related parties

As medical schemes generally have sufficient reserve levels, their need for risk transfer arrangements is typically low as they have ample funds to self-insure. Open schemes typically contract with expert providers to manage specific risks (such as ambulance services, dental, optometry and radiology) from a cost and quality perspective.

Momentum Medical Scheme is the only open scheme with a risk transfer arrangement with its accredited administrator and its related parties. 62.79% of the fee relates to healthcare services, and 37.21% to managed care network management services and risk management.

The fee paid to Momentum Health (Pty) Ltd in respect of accredited managed healthcare services (risk transfer arrangements) of R393.93 pmpm is significantly higher than the total industry average of R236.02 pmpm. The fees paid to all accredited administrators and their related parties represent 25.41% of the total capitation fees paid in respect of risk transfer arrangements.

More information pertaining to the breakdown of the fee paid per scheme, into the various services provided, can be found in Annexure L. The performance of the individual benefit options (per risk transfer arrangement) is disclosed in Annexure P. Annexure W contains details of contracts with the accredited administrator only.

Table 71 shows the four administrators with the highest deviation from the 2024 industry average of R420.80 pampm in respect of total fees received by administrators and their related parties. More details on the fees received by each administrator can be found in Annexure X.

Table 71: Total fees paid to administrators (including accredited managed healthcare services and capitation fees paid in respect of risk transfer arrangements) - deviation from industry average

	Total composite administration fees received (including co-administration fees) in respect of administration and other expenditure	Accredited managed healthcare services (no transfer of risk) received	Accredited managed healthcare services (risk transfer arrangement): capitation fee received	Total fees received
	R298.23 pampm	R116.60 pampm	R236.02 pampm	R420.80 pampm
	%	%	%	%
Momentum Health (Pty) Ltd	18.47	(0.25)	82.12	73.71
Private Health Administrators (Pty) Ltd	(61.37)	(100.00)	146.03	65.38
Afrocentric Integrated Health Administrators (Pty) Ltd	1.54	(100.00)	(100.00)	43.93
Discovery Health (Pty) Ltd	32.20	19.67	(69.20)	29.74

Green represents administrators whose fees are lower than the industry average

Red represents negative outliers from the industry average.

No volume discounts have been observed.

Private Health Administrators (Pty) Ltd administered one benefit option: Bonitas Medical Fund's Boncap option. Afrocentric Integrated Health Administrators (Pty) Ltd only had one scheme (Rand Water Medical Scheme) under administration.

Momentum Health (Pty) Ltd (with 10 schemes under administration) charged higher fees in respect of accredited administration services and other administration services, and accredited managed healthcare services (risk transfer arrangements) than the rest of the industry.

Discovery Health (Pty) Ltd (with 18 schemes under administration) charged higher fees in respect of accredited administration services.

Since the implementation of the aforementioned Circular 77 of 2019, significant progress had been made in the standardisation of the classification of services provided by accredited entities, which resulted in better comparability between the individual services provided and the fees charged across the industry.

An inherent limitation of the analysis provided is that no comparisons between the quality and efficiencies of services provided by different third party service providers, could be made. Based on the data analysed, it does not seem as if the schemes with larger footprints are negotiating sufficient volume discounts.

Concluding remarks

The medical schemes industry was still underpriced in the 2024 year, and it is anticipated that this will be incrementally addressed through pricing adjustments over a period of time. There are currently no interventions addressing the demand side escalations as it pertains to the demographic profile deterioration of the medical scheme population.

During 2024 supply side driven utilisation increases were noted, specifically as it relates to non-related services to in-hospital basket of care admissions. Medical schemes will be addressing this pervasive behaviour through benefit changes.

The CMS and the National Department of Health (NdoH) are currently working on the introduction of a standardised benefit package and the review of prescribed minimum benefits. Alignment between the CMS primary healthcare package (PHC) and the NdoH PHC package is also taking place.

The CMS is excited to participate in the engagement on creating a multilateral negotiating environment for funders and practitioners to determine reference tariffs. This would relieve medical schemes from rapidly escalating costs, as tariffs are currently not determined through a competitive process.

Block A, Eco Glades 2 Office Park,
420 Witch–Hazel Avenue, Eco Park,
Centurion, 0157

Council for Medical Schemes,
Private Bag X34, Hatfield, 0028

+27 86 112 3267

0862 068 260

information@medicalschemes.co.za

www.medicalschemes.co.za

Council for Medical Schemes

@CMScares4U

Council for Medical Schemes

CMScares4U

RP230/2025

ISBN: 978-1-77997-967-4