BARGAINING COUNCIL MEDICAL SCHEMES IN SOUTH AFRICA REPORT 30 JUNE 2025

PERFORMANCE AND FINANCIAL SUSTAINABILITY OF BARGAINING COUNCIL MEDICAL SCHEMES IN SOUTH AFRICA: A 2023 CROSS-SECTIONAL ANALYSIS

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Executive Summary

Bargaining Council Medical Schemes (BCMS), established through collective bargaining agreements between employers and employees, provide industry-specific medical coverage primarily to lower-income and industrial workforces. As restricted schemes, BCMS operate within defined sectors and are typically overseen by sectoral bargaining councils. This cross-sectional descriptive study examines the performance and structural characteristics of BCMS registered and regulated by the Council for Medical Schemes (CMS), drawing on 2023 annual statutory returns data. The analysis benchmarks BCMS against open and restricted schemes across several dimensions, including governance structures, solvency levels, membership demographics, healthcare expenditure, and administrative efficiency. The analysis of BCMS highlights a membership profile with a weighted average age of 33.23 years, slightly younger than open schemes (36.06 years) but older than other restricted schemes (31.54 years). Some BCMS also reported claims ratios exceeding 120%, suggesting potential challenges in maintaining financial sustainability. Fees directly linked to insurance service delivery (DAE) varied considerably, with per-member-per-month (PMPM) costs ranging from R62.57 to R314.82. Notably, in four of the five BCMS examined, payments for accredited administration services accounted for more than 86% of total DAE, a proportion higher than observed in restricted schemes (80.29%) and open schemes (72.15%). These findings highlight potential inefficiencies in outsourcing administrative services and suggest a need to assess their cost-effectiveness. From a practical perspective, the study underscores the importance of tailored regulatory support that recognises the distinctive, labour-linked nature of BCMS. Scheme trustees are further encouraged to strengthen governance practices and optimise administration costs to safeguard the long-term sustainability of their schemes.

Keywords: *Bargaining Council Schemes, beneficiary, cost-containment, governance, insurance, solvency, sustainability, board of trustees*

1. Introduction

South Africa's health system is underpinned by progressive financing, driven mainly by private medical schemes serving wealthier populations; however, the distribution of healthcare benefits remains disproportionately pro-rich and misaligned with the actual burden of disease (Ataguba & McIntyre, 2012). This inequity poses significant challenges for the design and implementation of a universal health system. Within this context, Bargaining Council Medical Schemes (BCMS) occupy a critical yet often overlooked space in the private sector. Established under the Labour Relations Act through statutory bargaining councils, BCMS provide industry-specific medical cover to lower-income and industrial workers via collectively negotiated agreements between employers and employee representatives (Budlender & Sadeck, 2007; NDoH, 2025). By extending healthcare access to historically marginalised labour market segments, these schemes contribute meaningfully to broader equity and efficiency goals. Although BCMS membership is relatively small compared to open and other restricted schemes, it is indispensable in offering affordable, tailored healthcare to vulnerable workforce segments often excluded from mainstream private healthcare (Budlender & Sadeck, 2007; Ramjeeii & McLeod, 2007).

Historically referred to as exempt schemes, BCMS have been allowed certain deviations from full compliance with the Medical Schemes Act, particularly concerning Prescribed Minimum Benefits (PMBs), to accommodate their unique operational contexts (NDoH, 2025). Nevertheless, they remain bound by key regulatory requirements, including solvency and governance standards set out in the Medical Schemes Act 131 of 1998. Despite this framework, considerable disparities persist across schemes, particularly in trustee remuneration, demographic risk profiles, and financial sustainability, highlighting ongoing systemic challenges within the sector (CMS, 2023). BCMS therefore offer a distinctive case study within South Africa's evolving health system, providing valuable insights into cost containment, representative governance, and risk pooling tailored to working-class populations. Against this backdrop, the primary objective of this study was to evaluate the performance of selected BCMS compared to open and other restricted schemes, with particular focus on governance practices, demographic characteristics, insurance revenue, fees directly attributable to insurance service expenditure, and solvency trends.

2. Literature Review

South Africa's two-tiered healthcare system is characterised by a majority reliant on an underfunded public sector and a minority accessing costly private care, resulting in persistent inequities that undermine system efficiency (Ataguba & McIntyre, 2012; Rensburg, 2021). BCMS emerge within this context as niche players, balancing low-income affordability with sector-specific coverage (Budlender & Sadeck, 2007; Ramjeeii & McLeod, 2007). Although their overall membership base remains relatively small, BCMS play a vital role in expanding healthcare access for blue-collar and informal sector workers. By pooling resources and collectively negotiating benefits, these schemes bridge coverage gaps, enabling traditionally underserved labour segments to access essential health services within the broader South African healthcare system.

Studies have highlighted the varied governance models across the medical schemes landscape, with board diversity emerging as a determinant of board effectiveness. In the South African context, diversity in board composition has been shown to enhance strategic oversight and governance outcomes, extending beyond conventional markers such as gender and ethnicity to encompass broader experiential and stakeholder representation (Nzimakwe, 2021). BCMS, shaped by their collective bargaining origins, often shows trustee structures that are more inclusive and representative, reflecting the interests of both employers and employees (CMS, 2022; CMS, 2023). In contrast, other restricted medical schemes tend to favour streamlined, corporate-style governance frameworks designed for operational efficiency, potentially at the expense of broader stakeholder engagement. This divergence raises important questions about the trade-offs between inclusivity and efficiency in health system governance, particularly in contexts where equity and accountability are paramount. These differences in governance structures often mirror the demographic composition of scheme membership, with BCMS typically serving lower-income, industrial workers. In contrast, restricted corporate schemes cater to more homogeneous, often higher-income groups.

Demographic risks are central to scheme viability; medical schemes face increased financial strain from ageing membership profiles with costs rising approximately 1.9% per additional year of age and a need to attract younger members to sustain risk pools, highlighting the challenges of open enrolment without mandatory cover or risk equalisation (Wayburne & Bradley, 2013). Younger populations generally correlate with lower healthcare utilisation and

higher cross-subsidisation capacity. However, ageing membership and low-income contributions can destabilise smaller schemes without adequate reserves (Wayburne & Bradley, 2013). Therefore, the demographic composition of a scheme's membership reflects not only its governance and historical design but also a key determinant of its long-term financial sustainability.

Financial sustainability across BCMS presents a varied landscape. While some schemes maintain robust solvency levels, often exceeding statutory requirements, others struggle with stagnating revenue growth, constrained by limited membership expansion and the structural limitations inherent to their sector-specific nature (CMS, 2023). These challenges are further compounded by ageing membership profiles and relatively low contribution levels, which place pressure on risk pools and threaten long-term viability. In response, many schemes, including BCMS, have increasingly outsourced administrative and managed care services as a strategic mechanism to improve operational efficiency and reduce fixed overhead costs (CMS, 2023). Outsourcing allows schemes to access specialised expertise, address internal capacity constraints, and streamline operations, particularly for smaller schemes with limited in-house resources. Evidence from the small and medium-scale enterprises (SMEs) sector further supports this approach, indicating that outsourcing back-office and support functions can significantly enhance organisational performance, whereas outsourcing accounting functions has minimal impact (Agburu, Anza, & Akuraun, 2017). Outsourcing can strengthen the financial sustainability of resource-constrained entities such as BCMS when applied strategically. However, this approach also carries risks: administrative fees, which often constitute a substantial portion of non-healthcare expenditure, may escalate and, if poorly managed, undermine overall efficiency (Bryce & Useem, 1998; CMS, 2022; Willie, 2024). Consequently, striking the right balance between internal capacity and reliance on third-party administrators is a key determinant of BCMS's financial resilience in an increasingly competitive, resource-limited healthcare environment.

3. Theoretical Framework

This study is anchored in Institutional Theory (Figure 1), which provides a framework for understanding how regulatory mandates, normative expectations, and cultural-cognitive belief systems shaped organisations. Rather than interpreting organisations solely as rational actors pursuing technical efficiency, institutional theory emphasised that legitimacy was achieved through alignment with prevailing institutional logics (Scott, 2008). Janićijević (2014) argued

that the convergence of these institutional pressures, manifested through coercive, mimetic, and normative mechanisms, results in organisational isomorphism, in which organisations across sectors adopt similar structures and practices to preserve legitimacy. Institutional pressures manifest in multiple ways: regulatory (compliance with solvency and governance standards), normative (expectations from unions and employers), and cognitive (shared assumptions about scheme viability and healthcare provision in specific sectors). This framework helps interpret BCMS structures and performance as responses to external policy mandates and internal stakeholder dynamics.

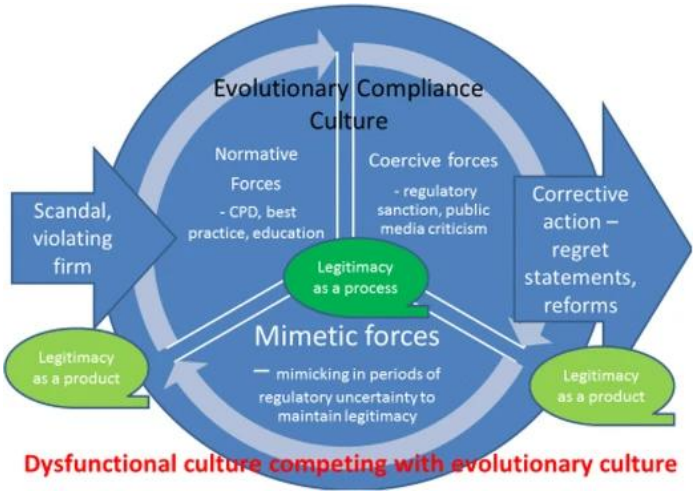

Figure 1: Institutional theory

Source: Adapted from Burdon & Sorour (2020).

4. Research Methods

The study adopted a cross-sectional descriptive research design and relied on secondary data drawn from the Council for Medical Schemes (CMS) Industry Reports and scheme-level disclosures. A purposive sampling strategy was employed to select five registered BCMS for analysis: Motohealth Care, Foodmed, the Fishing Industry Medical Scheme (Fishmed), the Golden Arrow Employees' Medical Benefit Fund, and the Building & Construction Industry Medical Aid Fund.

Table 1 below depicts the characteristics of the selected BCMS from diverse industries, highlighting their benefit designs and funding models. These schemes were included based on

criteria reflecting sector representation and funding diversity. They were compared to closed and open schemes to evaluate their characteristics and performance within the broader medical scheme landscape.

Table 1: Characteristics of Selected BCMS

Scheme Name	Industry Sector	Benefit Design	Funding Model
Building & Construction Industry Medical Aid Fund	Construction	Low-cost, PMB-inclusive, PHC services	Employer-employee contributions
Fishing Industry Medical Scheme (Fishmed)	Fishing & Maritime	Basic cover with primary care and emergency services	Hybrid funding, contributions via the employer
Foodmed Medical Scheme	Food Processing	Primary and limited hospital care	Fixed employer contributions
Golden Arrow Employees' Medical Benefit Fund	Public Transport	Chronic and PHC benefits, limited hospital cover	Closed scheme; employer-supported
Motohealth Care	Motor Industry	Multiple options, including PHC and hospital plans	Contribution tiers by income level

Key variables analysed include the number of trustees, numbers and remuneration, member-to-dependant ratios, average beneficiary age, pensioner ratios, solvency, and insurance revenue per average beneficiary per month (pabpm). Comparative dimensions of analysis included averages for restricted and open schemes. Tables, graphs and narrative analyses are used to synthesise findings and draw policy-relevant conclusions.

5. Results

5.1 Governance Structures: A Comparison Between Bargaining Council and Restricted Medical Schemes

Building on the preceding discussion of their defining characteristics, BCMS are distinguished by governance structures that reflect their sectoral and labour-based origins. Operating within the framework of collective bargaining agreements between employers and employee representatives, these schemes embody participatory governance principles that shape the composition, size, and operational dynamics of their Boards of Trustees. For example, the Building & Construction Industry Medical Aid Fund reports a comparatively large board comprising 13 trustees. In contrast, Foodmed Medical Scheme and Fishmed have boards of 8 trustees. This variation reflects a broader representational approach characteristic of sector-based governance models, as illustrated in Table 2 below.

Table 2: Governance structures and average trustee fees -2023

Bargaining Council Medical Schemes	Average fee per trustee R'000 per annum	No. of trustees
Building & Construction Industry Medical Aid Fund	46 000	13
Fishing Industry Medical Scheme (Fishmed)	-	8
Foodmed Medical Scheme	125 000	8
Golden Arrow Employees' Medical Benefit Fund	-	7
Motohealth Care	123 000	6
Sub-total: registered restricted schemes	103 366	
Sub-total: registered open schemes	418 760	
Total registered schemes	180 497	

Restricted medical schemes (those that serve specific employer groups or industries but are not governed by bargaining councils) typically operate under more streamlined corporate governance models. These often feature fewer trustees and a stronger focus on fiduciary oversight rather than collective representation. The average number of trustees for BCMS in this analysis ranges from 6 to 13, comparable to those of restricted schemes.

Analysis of trustee remuneration across medical scheme types highlights a clear pattern of variation linked to scheme structure and financial context. Among BCMS, fees per trustee range from R46,000 per annum in the Building & Construction Industry Medical Aid Fund to R125,000 in Foodmed, with Motohealth Care reporting R123,000. Fishmed and Golden Arrow Employees' Medical Benefit Fund did not incur trustee remuneration. Compared with other scheme types, BCMS trustee fees exceed the R103,366 observed in registered restricted schemes but remain substantially below the R418,760 average reported for open medical schemes. Across all registered schemes, the average trustee fee amounts to R180,497 per annum.

5.2 Demographic Profile of BCMS: A Comparative Review

Figure 2 presents the comparative age distribution across BCMS, open schemes, restricted schemes (including and excluding BCMS), and the medical scheme industry. BCMS, as a subset of restricted schemes, reports a weighted-average age of 33.23 years, slightly below the industry average of 33.93 years. Open schemes show a much higher weighted-average age of 36.06 years, reflecting an older beneficiary base, while restricted schemes, excluding BCMS, have a lower average age of 31.54 years. These patterns indicate that BCMS primarily serve a younger, economically active workforce. However, their membership remains slightly older

than the broader restricted scheme population, likely reflecting the specific demographic and employment characteristics of the sectors represented by bargaining councils.

Table 3 further contextualises the demographic profile of BCMS relative to the broader South African medical scheme landscape. Despite their strategic importance, BCMS represent a small sector proportion, accounting for only 0.74% of total beneficiaries and 1.56% of the restricted scheme population. This underscores the niche role of BCMS in extending health coverage to targeted industrial and sectoral workforces that mainstream private healthcare arrangements may otherwise underserve.

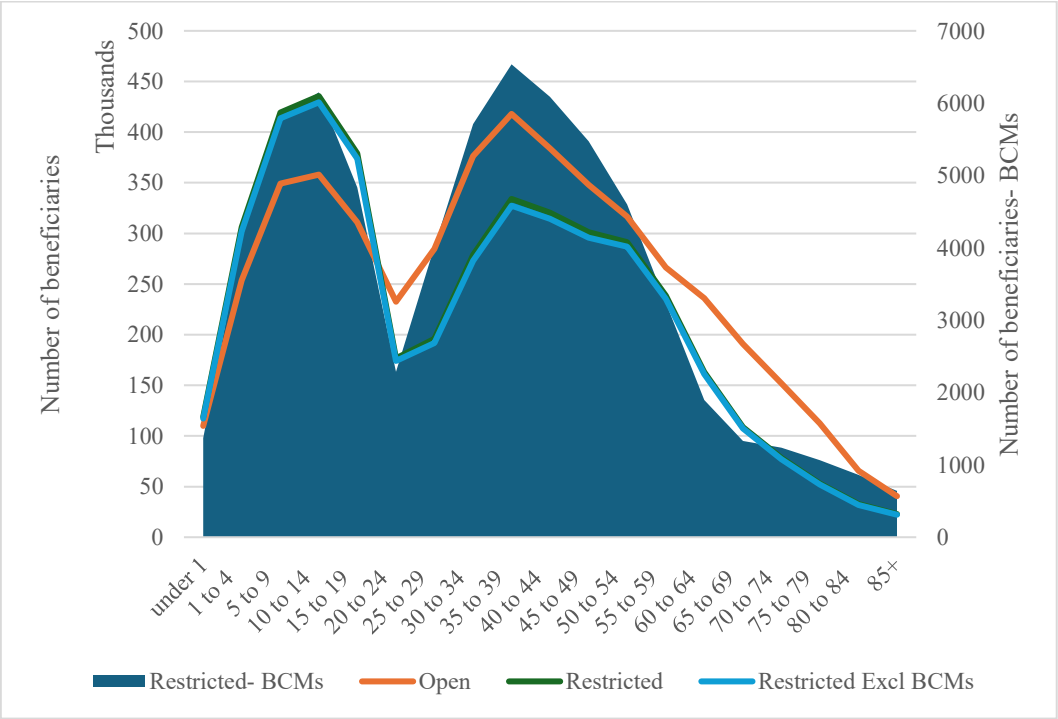

Figure 2: Age distribution of BCMS beneficiaries in comparison with restricted, open and industry

Regarding membership size, Motohealth Care is the largest among the BCMS, with 29,848 beneficiaries, while Fishmed is the smallest, with just over 4,000 beneficiaries. The dependants' ratios across BCMS vary, with schemes such as the Building & Construction Industry Medical Aid Fund and Fishmed reflecting higher ratios (1.8 and 1.4, respectively), indicating a greater proportion of dependants per principal member, often associated with younger, family-oriented populations. Notably, Fishmed has the youngest profile (27.5 years), suggesting it predominantly serves an active working-age population in a physically

demanding sector. The pensioner ratio, a key indicator of the ageing burden on schemes, is lower across most BCMS, particularly for Fishmed (0.4%) and the Building & Construction Industry Medical Aid Fund (2.1%), compared to the industry level of 9.3% and 11.3% for open schemes. However, Motohealth Care stands out with a notably higher pensioner ratio of 13.9%, indicating a more mature membership profile and potentially higher healthcare utilisation and cost pressures.

Table 3: Demographic characteristics of BCMS compared with open and closed schemes - 2023

Bargaining Council Medical Schemes	No. of Members	No. of Dependants	No. of Beneficiaries	Dependants' ratio	Age (years)	Pensioner ratio (%)
Building & Construction Industry Medical Aid Fund	4 467	7 847,0	12 314	1,8	28,1	2,1
Fishing Industry Medical Scheme (Fishmed)	1 773	2 404,0	4 177	1,4	27,5	0,4
Foodmed Medical Scheme	9 016	7 495,0	16 511	0,8	30,5	2,2
Golden Arrow Employees' Medical Benefit Fund	2 600	2 070,0	4 670	0,8	35,7	4,9
Motohealth Care	14 540	15 308,0	29 848	1,1	37,3	13,9
Sub-total: registered open schemes	2 374 997	2 436 010,0	4 811 007	1,0	35,8	11,3
Sub-total: registered restricted schemes	1 775 703	2 546 263,0	4 321 966	1,4	31,7	6,9
Total registered schemes	4 150 700	4 982 273,0	9 132 973	1,2	33,9	9,3
BC Medical Schemes as a % of closed schemes	1,82	1,38	1,56			
BC Medical Schemes as a % of all schemes	0,78	0,70	0,74			

5.3 Insurance Revenue Performance of BCMS

The analysis of insurance revenue (IR) per average beneficiary per month (pabpm) provides essential insights into BCMS's revenue-generating capacity relative to the broader medical scheme landscape. As summarised in Table 4, BCMS display considerable variation in IR, reflecting differences in member income levels, sectoral affordability constraints, and benefit design structures. Motohealth Care records the highest IR among BCMS at R1,910 pabpm, equivalent to 96.16% of the average IR of all registered restricted schemes and 91.52% of the combined scheme average. This positions Motohealth Care close to the industry average, suggesting it operates more like larger, commercially structured schemes, likely supported by a broader membership base and a range of benefit options.

Table 4: Insurance Revenue (pabpm) for BCMS as a % of Restricted and Total Schemes

Bargaining Council Medical Schemes	Insurance Revenue (IR) Pabpm	Insurance Revenue (IR) for Bargaining schemes as % of closed schemes	Insurance Revenue (IR) for Bargaining schemes as % of all schemes
Building & Construction Industry Medical Aid Fund	1 183	59,58	56,70
Fishing Industry Medical Scheme (Fishmed)	519	26,14	24,88
Foodmed Medical Scheme	167	8,41	8,00
Golden Arrow Employees' Medical Benefit Fund	803	40,45	38,49
Motohealth Care	1 910	96,16	91,52
Sub-total: registered open schemes	2 176		
Sub-total: registered restricted schemes	1 986		
Total registered schemes	2 087		

In contrast, Foodmed Medical Scheme has the lowest IR at R167 pabpm, representing only 8.41% of the IR of restricted schemes and 8.00% of all schemes. This extremely low revenue reflects its strong orientation toward affordability, likely serving lower-income workers through a highly cost-contained benefit package. While this supports access, it raises concerns about long-term sustainability and the adequacy of benefits. Fishmed and the Golden Arrow Employees' Medical Benefit Fund report moderate IRs at R519 and R803 pabpm, respectively. While lower than the industry average, they reflect the realities of sector-specific wage levels and contribution limits agreed upon through collective bargaining structures. The Building & Construction Industry Medical Aid Fund shows a relatively higher IR of R1,183, accounting for 59.58% of restricted schemes' IR and 56.70% of all schemes, indicating moderately priced contributions relative to a mid-range benefit package.

When comparing BCMS's average IR to that of all restricted schemes (R1,986) and all registered schemes (R2,087), most BCMS fall below the industry level. This reflects their targeted, low-cost nature and underscores the importance of careful risk pooling and financial oversight to ensure sustainability.

5.4 Claims experience

Figure 3 presents a comparative analysis of relevant healthcare expenditure and claims incurred as a percentage of insurance revenue (IR) across five BCMS, alongside industry benchmarks for open schemes, restricted schemes, and the total pool of registered medical schemes. The data reveal that the Golden Arrow Employees' Medical Benefit Fund has the higher expenditure ratios, with relevant healthcare expenditure reaching 128.10% of IR and claims incurred at 122.07%. This indicates a level of healthcare utilisation well beyond premium income, suggestive of financial pressure or strategic cross-subsidisation.

By contrast, the Foodmed Medical Scheme demonstrates the lowest ratios among the schemes compared, with relevant healthcare expenditures and claims incurred comprising only 59.68% and 58.73% of IR, respectively, potentially indicative of underutilisation, cost containment strategies, or benefit design limitations.

BCMS schemes display varied performance in healthcare expenditure efficiency. For instance, Motohealth Care and the Building & Construction Industry Medical Aid Fund show strong alignment between income and claims outflows, with ratios close to or exceeding 96%. At the same time, Fishmed remains below both the open and restricted scheme averages.

When benchmarked against industry-wide aggregates, open schemes report relevant healthcare expenditure as a percentage of IR at 93.60% and claims incurred at 90.87% of IR, respectively. In comparison, restricted schemes report higher ratios at 98.71% and 96.69%. The overall average across all registered schemes is 95.88% for relevant healthcare expenditure and 93.47% for claims incurred. While BCMS generally maintain expenditure profiles within industry norms, these figures underscore that scheme-specific disparities exist, reflecting differences in demographic composition, benefit design, and healthcare utilisation patterns.

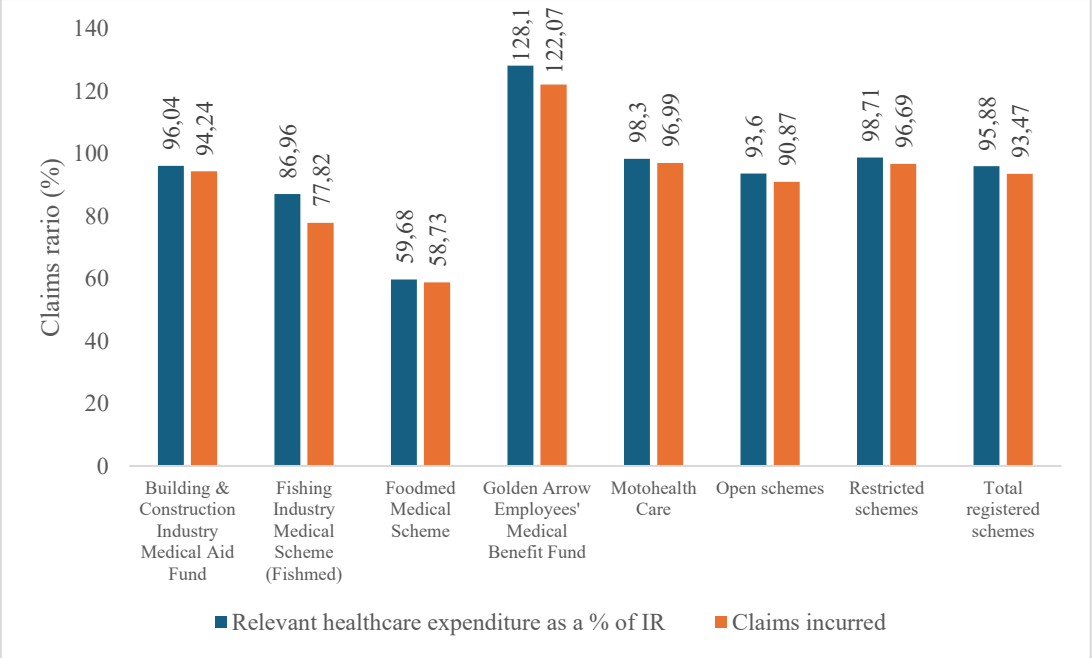

Figure 3: Claims experience-2023

5.5 Financial Performance of BCMS

BCMS's financial performance reflects varying degrees of capital strength and solvency stability, as illustrated by its net assets and solvency ratios. BCMS maintains sound financial positions, with solvency ratios well above the statutory minimum of 25%, indicating strong capital buffers. Figure 4 and Table 5 below present a comparative analysis of solvency ratios and net asset levels, as defined under Regulation 29, positioning BCMS against broader sectoral and industry benchmarks.

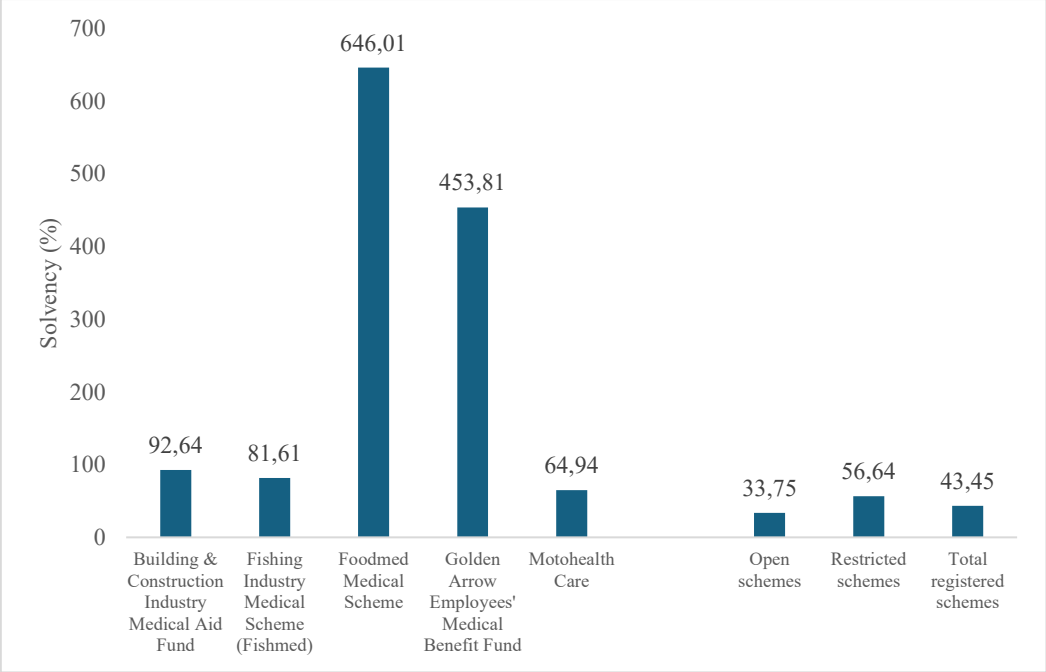

Figure 4: Solvency ratio for the select five BCMS, open, closed and industry comparison.

Notably, the Foodmed Medical Scheme and Golden Arrow Employees' Medical Benefit Fund report exceptionally high solvency ratios of 646.01% and 453.81% respectively, underpinned by robust net asset holdings of R220.9 million and R208 million. These figures suggest conservative financial management and potentially low claims utilisation, enabling these schemes to accumulate substantial reserves. Similarly, the Building & Construction Industry Medical Aid Fund maintains a solid solvency ratio of 92.64%**,** backed by R153.9 million in net assets. Fishmed**,** though smaller in scale, still posts a healthy solvency ratio of 81.61%**,** suggesting prudent risk management and adequate capital adequacy for its size.

Table 5: Net assets per Regulation 29 R'000

Bargaining Council Medical Schemes	Net assets per Regulation 29 '000
Building & Construction Industry Medical Aid Fund	153 930
Fishing Industry Medical Scheme (Fishmed)	21 397
Foodmed Medical Scheme	220 892
Golden Arrow Employees' Medical Benefit Fund	208 023
Motohealth Care	503 832
Open schemes	*48 851 336*
Restricted schemes	*60 309 565*
Total registered schemes	*109 160 901*

Among the BCMS, Motohealth Care stands out as the largest in net assets **(**R503.8 million**),** yet its solvency ratio is comparatively lower at 64.94%**.** While still above the statutory minimum, this indicates relatively higher claims or operational costs to accumulated reserves, which may reflect its larger and more diverse membership base. When compared with broader industry benchmarks, BMCS demonstrate stronger financial stability, achieving higher solvency ratios than both open (33.75%) and restricted medical schemes (56.64%). This suggests that, despite their smaller scale, BCMS maintain more conservative reserve strategies, potentially due to the volatility associated with their specific sectors and employment-linked contributions.

5.6 Expenditure Directly Attributable Insurance Service Expenditure (DAE)

Figure 5 below provides a comparative overview of Directly Attributable Insurance Service Expenditure (DAE) expressed as a percentage of insurance revenue (IR) and as a per-average-member-per-month (pampm) cost across selected BCMS, open schemes, restricted schemes, and the total registered medical scheme population. Among the BCMS, Foodmed Medical Scheme stands out with the highest DAE relative to IR at 20.94%, yet its pampm cost (R62.57) remains the lowest in absolute terms. This suggests a lean membership base or highly constrained resource allocation, resulting in high proportional expenditure but low per capita cost. By contrast, the Building & Construction Industry Medical Aid Fund and the Golden Arrow Employees' Medical Benefit Fund reflect more moderate DAE percentages (9.73% and 12.14%, respectively), with corresponding pampm values of R314.82 and R177.99, indicative of operational scale and potentially more robust administrative structures.

Fishmed reports a relatively low DAE percentage (8.27%) and the lowest pampm expenditure among BCMS at R101.26, reflecting potentially limited overhead expenditure but possibly constrained administrative capacity.

Motohealth Care depicts the lowest DAE as a percentage of IR among all listed schemes (4.79%). Yet, its pampm cost (R188.81) is comparable to those of other BCMS, possibly indicating administrative efficiency or cost-containment strategies as well as other factors not fully explored in the current report.

Industry benchmarks show that registered open schemes report a significantly higher average DAE percentage (9.52%) and pampm expenditure (R420.78) than restricted schemes, which are only 4.07% of IR and R196.14 pampm. The total average across all registered schemes is 7.08% of IR, with a pampm figure of R325.18.

5.7 Administrative Cost Allocation Among Medical Schemes

Table 6 below presents the proportion of Directly Attributable Insurance Service Expenditure (DAE) allocated to accredited administration services across selected BCMS, alongside industry averages for open, restricted, and total registered medical schemes. The data, as depicted in Table 6, reveal variation among BCMS in the proportion of DAE allocated to administration fees. Golden Arrow Employees' Medical Benefit Fund reports the highest allocation at 94.27%, closely followed by Fishmed (88.15%), Building & Construction Industry Medical Aid Fund (87.03%), and Motohealth Care (86.85%). These high proportions suggest a significant reliance on third-party administrators or internal administrative operations for core scheme functions. In contrast, Foodmed Medical Scheme stands out with a notably low percentage (26.76%). Industry averages show that restricted schemes dedicate 80.29% of DAE to accredited administration services, while open schemes allocate a comparatively lower 72.15%. The overall average across all registered schemes is 74.17%, indicating that most BCMS are above the industry norm.

Table 6: Fees Paid in Respect of Accredited Administration Services as a Percentage of DAE

	Fee paid for accredited administration services, as a % of DAE.
Building & Construction Industry Medical Aid Fund	87,03
Fishing Industry Medical Scheme (Fishmed)	88,15
Foodmed Medical Scheme	26,76
Golden Arrow Employees' Medical Benefit Fund	94,27
Motohealth Care	86,85
Open schemes	*72,15*
Restricted schemes	*80,29*
Total registered schemes	*74,17*

6. Discussion

This study examined the performance and financial sustainability of selected BCMS in South Africa using 2023 data, confirming existing literature and new insights into sector-specific dynamics. The findings reaffirm that BCMS maintain governance structures rooted in their labour-sector origins, characterised by broader trustee representation and lower remuneration than in restricted and open schemes (CMS, 2022). This collective governance approach reflects the normative pressures described in Institutional Theory, where unions and employer stakeholders expect inclusive oversight. Such practices demonstrate fiscal prudence and accountability, supporting the overarching mandate of BCMS to provide affordable healthcare for industrial workers, in contrast to the more commercially driven remuneration practices observed in larger schemes.

From a demographic perspective, BCMS predominantly serve younger, economically active populations, with pensioner ratios lower than the industry average, consistent with their niche role in covering sector-specific employees (CMS, 2005; Budlender & Sadeck, 2007; NDoH, 2025). However, the relatively higher pensioner ratio in schemes such as Motohealth Care signals emerging demographic risk, a factor the literature identifies as a key driver of long-term sustainability (CMS, 2023). These findings highlight the importance of adopting flexible benefit designs and strengthening risk management strategies, especially amid shifting employment patterns in the sector and the growing likelihood of an ageing member base.

Financially, BCMS present a dual reality. Schemes like Foodmed and Golden Arrow depicts strong solvency ratios exceeding statutory requirements, yet maintain low insurance revenue per beneficiary, reflecting tight cost containment to ensure affordability. While this supports short-term stability, it raises questions about benefit adequacy and long-term viability (CMS, 2023). In contrast, Motohealth Care demonstrates relatively higher revenue but a lower solvency ratio, suggesting greater claims exposure or operational costs associated with a more heterogeneous membership, consistent with documented sectoral variations in scheme performance.

Despite their smaller scale and constrained revenue base, BCMS demonstrate strong solvency performance, indicative of prudent capital management strategies tailored to their industrial contexts. These findings highlight the potential of BCMS as a cost-effective model for employment-linked health coverage and offer valuable lessons for policy and scheme design within South Africa's broader health financing reforms. Nonetheless, emerging demographic shifts and internal financial disparities underscore the need for continued regulatory oversight and the development of innovative risk-pooling mechanisms to safeguard both BCMS's sustainability and equity contributions in the evolving healthcare landscape.

7. Limitations of the study

This study has several limitations that should be considered when interpreting the findings. First, the analysis relied exclusively on publicly available secondary data from the CMS Industry Reports and scheme annual statutory returns data, which may limit the depth and granularity of financial and operational insights. Detailed internal operational data, such as service experience, member satisfaction, and other metrics, were not risk-adjusted for performance and were not analysed.

Second, the sample size was limited to five Bargaining Council Medical Schemes, representing a fraction of the total BCMS landscape, as they currently operate outside the CMS's purview. While these schemes were purposively selected to reflect diversity in industry sectors and funding models, the findings may not fully generalise to all BCMS, notably smaller or emerging schemes.

Third, the study's cross-sectional design limits the ability to assess trends over time or to capture dynamic changes in scheme membership, governance, or financial performance that could impact long-term sustainability.

Lastly, external factors such as macroeconomic conditions, labour market shifts, and policy changes influencing scheme operations were not explicitly controlled. This may affect the interpretation of the observed financial and demographic patterns.

Future research incorporating longitudinal data, larger sample sizes, and qualitative insights from stakeholders would strengthen the understanding of BCMS performance and their role in South Africa's evolving healthcare financing environment.

8. Study Recommendations

In light of the findings, several policy and operational recommendations are proposed to enhance the sustainability and institutional effectiveness of BCMS in South Africa. These recommendations are grounded in a critical analysis of their structural limitations, demographic dynamics, and financial performance. They aim to align BCMS operations with broader health financing reforms, while recognising their sector-specific mandates.

- **Tailored Regulatory Support**

Regulatory frameworks should be carefully recalibrated to reflect BCMS's distinctive governance and funding models. Oversight mechanisms must be flexible enough to accommodate sectoral diversity while remaining aligned with the core provisions of the Medical Schemes Act. In particular, solvency requirements and reporting standards should be tailored to the operational scale and demographic realities of BCMS, ensuring that compliance obligations are proportionate and do not impose undue burdens on these smaller, labour-linked schemes.

- **Adaptive and Inclusive Benefit Design**

BCMS should pursue a more dynamic approach to benefit package design to ensure relevance and affordability. This entails conducting regular actuarial reviews that consider demographic changes, such as rising pensioner ratios, and developing tiered or modular benefit options that cater to members' needs while aligning with their capacity to contribute.

- **Enhanced Data Governance and Performance Monitoring**

Improving the granularity and accessibility of scheme-level data, particularly concerning utilisation patterns, membership dynamics, and service experience, would enable more targeted interventions by regulators and scheme administrators. Establishing data-sharing protocols and analytics capabilities across schemes could also support comparative benchmarking and continuous quality improvement. Further reporting of non-financial data to supplement the financial performance indicators is also recommended.

- **Strengthening PMB Compliance and Equitable Benefit Design in BCMS**

Notably, given the comparatively lower contribution levels in most BCMS except for Motohealth Care, there is a substantial risk that these schemes may not fully fund PMBs, which must be covered in full regardless of the chosen benefit option. To address this, BCMS should continuously review benefit design, assess contribution adequacy, and strengthen cross-subsidisation mechanisms to ensure that PMBs are delivered fully and equitably across all member groups. Such measures are essential for safeguarding financial sustainability and the equitable provision of core healthcare benefits.

9. Conclusion

This study provides a comprehensive cross-sectional analysis of selected BCMS, highlighting their distinctive governance, demographic, and financial profiles within South Africa's medical scheme landscape. Despite generally lower insurance revenues, BCMS demonstrate strong solvency and cost-conscious governance, reflecting its labour-sector origins and commitment to affordable healthcare for industrial workers. However, demographic shifts, particularly ageing membership in some schemes, and significant variation in financial performance underscore the need for adaptive strategies and sustained regulatory support.

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Notes: **Please take note of the medical schemes' financial statements as outlined in the report, particularly in light of the implementation of IFRS 17.** **Link to report**

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