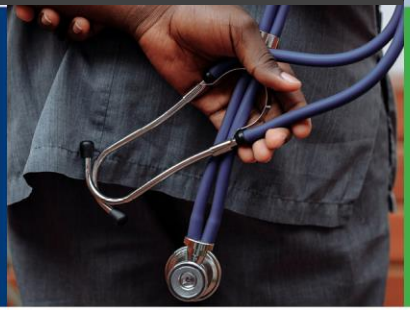
CMS

Council for Medical Schemes

Analysis and Interventions on High Levels of Out-of-Pocket Payments: A 2023 Overview of Chronic Disease and Diagnostic Treatment Pairs





Policy, Research and Monitoring

December 2024

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

Photo Credit. Pexels

Published March 2025.

EXECUTIVE SUMMARY

Background

The financial burden of healthcare, particularly Out-of-Pocket (OOP) expenses, poses significant challenges for medical scheme members in South Africa. Chronic Disease List (CDL) conditions contribute substantially to these costs, which are influenced by scheme type, care settings, geographic location, and age demographics.

Study Aim and Objectives

This study analysed the distribution and determinants of OOP expenses among medical scheme beneficiaries. The specific objectives were to:

1. Identify the top CDL conditions with the highest OOP costs.
2. Compare expenditures between open and restricted schemes.
3. Evaluate the impact of care settings (in-hospital vs. out-of-hospital) on OOP costs and
4. Assess geographic and age-related disparities in OOP expenditure.

Methods

The study utilised data from statutory returns submitted by medical schemes for 2023. A detailed analysis focused on the top CDL conditions incurring the highest OOP costs. Data were stratified by scheme type, care setting, provincial demographics, and age groups. Descriptive statistics and comparative methods were employed to identify patterns and disparities in OOP expenditures.

Results

Open schemes reported higher total OOP expenditures than restricted schemes, with out-of-hospital care accounting for most costs. Chronic renal disease was the costliest condition per affected beneficiary, averaging over R5000 in OOP expenses, followed by haemophilia and cardiomyopathy. Provincial disparities were evident, with KwaZulu-Natal incurring the highest OOP expenditures. Age-specific analyses showed that children under five faced high costs for conditions like cardiomyopathy and cardiac failure, while adults over 75 incurred significant expenses for diseases like bronchiectasis.

Findings

The study highlighted several key insights:

- High OOP expenditures were often linked to prevalent CDLs rather than inherently costly conditions.
- Gap cover products mitigated some OOP expenses but potentially masked catastrophic health expenditure (CHE).
- Geographic disparities in OOP costs were influenced by access to specialists and treatment facilities and

• Vulnerabilities were particularly pronounced among paediatric and geriatric populations.

Recommendations

To reduce OOP burdens and promote equitable healthcare, the following measures are recommended:

• Enhance medical scheme coverage for high-cost CDLs, especially for vulnerable populations such as children and the elderly.

• Incorporate innovative benefit designs to alleviate financial strain.

• Address geographic disparities by improving access to specialist care and treatment facilities in high-cost regions like KwaZulu-Natal and

• Develop targeted interventions for paediatric and geriatric populations to reduce age-specific financial vulnerabilities.

These recommendations aim to create a more inclusive and sustainable healthcare system for medical scheme beneficiaries in South Africa.

ACRONYMS AND ABBREVIATION

ASR:	**Annual Statutory Returns**
BO:	**Benefit option**
CDL:	**Chronic Disease List (as part of PMBs)**
CHE:	**Catastrophic Health Expenditure**
CMS:	**Council for Medical Schemes**
DTP:	**Diagnosis-Treatment Pair (as part of PMBs)**
HCP:	**Health Care Provider**
HMI:	**Health Market Inquiry**
MSA:	**Medical Schemes Act, No. 131 of 1998**
NDoH:	**National Department of Health**
NHI:	**National Health Insurance**
OOP:	**Out-of-pocket**
PMB:	**Prescribed Minimum Benefit**
PPN:	**Preferred Provider Network**
SEP:	**Single Exit Price**
UHC:	**Universal Health Coverage**
WHO:	**World Health Organization**

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

1. BACKGROUND

Out-of-Pocket (OOP) healthcare expenses significantly impact individuals' financial stability, particularly those managing chronic conditions. In South Africa, CDL conditions, which require long-term treatment and care, contribute disproportionately to these costs. OOP expenditures often arise from gaps in medical scheme coverage, leading to financial strain and, in some cases, catastrophic health expenditure (CHE). This highlights the importance of understanding the drivers behind these expenses.

Medical schemes in South Africa are categorised into open and restricted types, each with varying benefit structures and member demographics. Open schemes generally cater to a broader population, potentially leading to higher OOP costs due to diverse healthcare needs. In contrast, restricted schemes often serve employer groups or specific industries, providing tailored benefits that may better mitigate OOP expenses. This dichotomy underscores the need for targeted analyses to guide policy interventions. Geographic and demographic factors also influence OOP expenses. Provinces with better access to healthcare facilities, such as KwaZulu-Natal, often incur higher OOP costs due to reliance on specialist care. Similarly, age-related vulnerabilities are evident with paediatric and geriatric populations facing unique challenges in managing CDL conditions. These disparities emphasise the importance of equitable healthcare policies that address regional and demographic differences. Innovative benefit designs, including gap cover products, have emerged as potential solutions to reduce OOP burdens. However, these products may mask the true extent of CHE, complicating efforts to assess the financial impact of healthcare.

2. INTRODUCTION

Financial hardship resulting from OOP payments is experienced where OOP payments are large in relation to a person's ability to pay for health services (1). OOP payment is defined as any direct payment made by households for healthcare goods or services at the time-of-service use (1, 2). In the South African private health sector, OOP is calculated as the difference between the amount claimed and the amount that was settled from the medical scheme risk (3). Furthermore, OOP payments can be classified as formal, where costs are clearly receipted and accounted for as part of a health finance tracking system, or informal, where they are not tracked and accounted for. OOP payments are the most regressive and inequitable means of healthcare funding, preventing the cross-subsidisation between the rich and the poor and the healthy and the sick, causing significant barriers to accessing healthcare (4, 5). These involuntary payments can displace household resources and lead to impoverished households if Catastrophic Health Expenditure (CHE) are incurred. OOP payments go against the principles of social solidarity that form the foundation of the private medical scheme industry. Poorer households that face difficulties paying medical bills may delay or forgo needed health care, negatively impacting their health and well-

being. While undesired, OOP payments have pros and cons in their use within medical schemes and as a strategy to contain the rampant inflation of health care (see Table 1 below). Additionally, their inclusion in the medical scheme rules allows medical schemes to employ risk management strategies to manage and contain costs. However, cost containment strategies should not negatively impact the quality and effectiveness of care.

Table 1: Advantages and disadvantages of OOP payments

Advantages	**Disadvantages**
Cost containment strategy	Catastrophic spending: OOP payments that exceed a household's ability to pay for healthcare.
	Perceived poor quality of care and use of less effective interventions to reduce costs.
Decrease unnecessary service utilisation.	Impoverishment: High OOP payments can lead to impoverishing spending.
Encourage the use of preventive services provided free of charge or at a lower price.	Poor health outcomes: High OOP payments can lead to poor health outcomes, such as not complying with treatment plans or skipping preventive screenings.
May deter unhealthy behaviour and provide incentives for a healthier lifestyle (preventive care).	Encourages inequities in health (healthcare is based on means not need).

The unaffordability of medical scheme membership results in downgrades in membership, exacerbating OOP health expenditure. Increasing OOP health expenditure highlights the importance of a member choosing the most suitable option based on their needs. While private medical aid coverage positively impacts increasing healthcare utilisation and health in general, OOP payments aid in creating financial hardships, especially amongst the most vulnerable (4).

Due to the differences in the quality of healthcare and convenience offered within the private health sectors, it would not be possible to fully prevent OOP payments since there are members willing and able to pay OOP for healthcare (5). Therefore, countries should aim to keep their OOP expenditure below 15-20% of current health expenditure (6). The WHO recommends reducing OOP to below 20 percent of the total health expenditure to address health financing and equity issues and ensure financial protection on the continent (6). At the country level, South Africa's OOP health expenditure as a percentage of current health expenditure is 5.51%, which is on par with middle-income and some high-income countries and out-performs OOP in other African countries (6).

OOP should be differentiated between situations where the beneficiary is purposefully making a choice that is not cost-effective or is outside of benefits (voluntary use of a non-DSP, choice of an out-of-formulary drug, new technologies) or where a limit or threshold based on benefit option is faced, as opposed to cases where the beneficiary is not fully informed or unable to make an active choice. The National Health Accounts provides a useful framework for considering and tracking different types of OOP payments.

The indicator most widely used to measure financial hardship associated with OOP payments for households is the incidence of catastrophic spending on (7). CHE has a potentially severe impact on the household where households may need to sell assets to finance the accumulated health cost or obtain credit, thus impacting lifestyle and standard of living, which negatively affects their welfare, ultimately affecting health outcomes (8-11). The World Bank analysis of global health expenditure has specifically looked at CHE, which is defined as the percentage of the population spending more than 10% of their household budget on OOP health expenses. For South Africa, this was found to be 1.41% (across the whole population). This puts South Africans' risk of CHE on a similar level to that of people living in the UK (1.64%) or Panama (1.4%). Koch and Setshegetso (2020) found that CHE was rare and that very few households were subsequently impoverished because of healthcare costs (12). However, these studies do not consider the financial barriers most South Africans experience in accessing healthcare, and many forgo healthcare due to OOP payments.

Studies suggest that well-designed policies and strategies can help countries successfully reduce OOP payments (13). In the private medical scheme environment, public health sector reforms that apply key strategies to abolish user fees or charges in public health facilities and exempt specific community groups such as the poor and the vulnerable (the elderly, pregnant women, and children) from excessive OOP payments should be considered. Many countries have measures in place to protect vulnerable groups from OOP payments in the form of partial or total exemptions or caps (14).

.

3. RATIONALE

The rationale for this study lies in the growing financial burden placed on medical scheme beneficiaries due to OOP expenditures, particularly in the context of chronic diseases and DTPs. OOP payments, including co-payments, deductibles, and gap cover, represent a significant portion of healthcare costs for many individuals, which can profoundly impact access to necessary treatments and services.

Despite efforts to manage costs through structured benefit designs and managed care protocols, disparities in OOP expenditures remain prevalent across different medical schemes, beneficiary demographics, and geographical areas. Specifically, beneficiaries with chronic conditions often face escalating costs for long-term

treatments, hospitalisation, and medications. This financial strain may discourage timely healthcare access, delay treatments, and contribute to poor health outcomes, especially for vulnerable groups such as those with low socio-economic status or chronic conditions requiring expensive, ongoing care.

The findings of this research study will offer insights into the effectiveness of current benefit designs, managed care protocols, and cost-containment measures while highlighting the disparities in healthcare access caused by high OOP costs. Furthermore, the study aims to assess the role of gap cover and other supplementary insurance products in mitigating the financial burden on beneficiaries. Ultimately, this study aims to provide evidence-based recommendations to policymakers, medical schemes, and healthcare providers on improving cost management strategies, ensuring financial protection for beneficiaries, and enhancing access to necessary healthcare services, particularly for those with chronic conditions.

4. PROBLEM STATEMENT

Rising OOP healthcare expenses in South Africa's medical schemes pose a significant financial burden, especially for those with chronic diseases and high-cost DTPs. Vulnerable populations, including those with chronic renal disease, haemophilia, and cardiomyopathy, are disproportionately affected, with rural areas facing additional challenges due to limited access to specialised care. While gap cover helps mitigate some OOP costs, it often doesn't fully address the financial burden. The lack of effective monitoring and regulation of OOP expenses by medical schemes and an oversight framework to control and protect beneficiaries exacerbate disparities and limit solutions to control costs. This study, therefore, aims to identify key cost-driving conditions and provide recommendations for improving cost management and financial protection for beneficiaries.

5. AIM

This study aims to analyse the factors driving these OOP expenses, focusing on the top seven most costly chronic diseases and exploring the impact of scheme type, regional disparities, and age-related factors. Examining these variables, the aim is to offer insights into how medical schemes can more effectively align with the needs of their beneficiaries while alleviating the financial burden associated with chronic disease management.

6. RESEARCH OBJECTIVES

This study aimed to analyse the distribution, determinants, and impact of OOP healthcare expenses among medical scheme beneficiaries in South Africa, specifically focusing on high-cost CDL conditions and DTPs. It sought to identify the key factors contributing to high OOP costs and explored disparities in OOP expenditures

across different demographic groups, care settings, and medical scheme types. The specific objectives of this study were as follows:

1. **Identify the top CDL conditions with the highest OOP costs**: This objective focuses on examining the chronic diseases that result in the highest OOP expenditures, both in terms of total costs and average costs per affected beneficiary. The aim is to pinpoint the specific CDLs that place the greatest financial burden on medical scheme members.

2. **Compare expenditures between open and restricted schemes**: The study will compare OOP expenditures between open and restricted medical schemes, analysing differences in the prevalence and financial impact of high-cost conditions in these scheme types. This will help identify whether scheme type influences OOP burden and which scheme model offers more financial protection for beneficiaries.

3. **Evaluate the impact of care settings (in-hospital vs. out-of-hospital) on OOP costs**: This objective examines how the setting of care (in-hospital vs. out-of-hospital) affects the overall OOP expenditure for beneficiaries, with an emphasis on determining whether in-hospital treatments contribute significantly to higher costs compared to out-of-hospital care.

4. **Assess geographic and age-related disparities in OOP expenditure**: This objective evaluates how geographic location (urban vs. rural provinces) and age group (e.g., children, working-age adults, elderly) influence OOP spending, focusing on regions with higher healthcare costs or access challenges and vulnerable age groups that may incur larger expenses.

7. METHODS

This study adopts a quantitative research design to analyse the distribution and determinants of OOP healthcare expenses among medical scheme beneficiaries in South Africa. The research employs a cross-sectional analysis, drawing on existing medical scheme data from 2023 to assess the financial burden of CDL conditions and diagnostic DTPs. This method allows for an in-depth exploration of OOP expenditure patterns across medical schemes, care settings, geographic regions, and demographic groups.

7.1. Data Collection

Data for this study were sourced from statutory returns submitted by medical schemes to the Council for Medical Schemes (CMS) in South Africa. These returns contain detailed information on the total and average OOP expenditure per beneficiary for various conditions, including CDLs and DTPs. Additionally, the data include scheme types (open vs. restricted), beneficiary age groups, and geographic location (urban vs. rural provinces). The dataset for 2023 includes anonymised, aggregated figures that ensure confidentiality while providing insights into OOP expenditure trends.

7.2. Study Population

The study population comprises beneficiaries enrolled in both open and restricted medical schemes in South Africa. The analysis focuses on high-cost CDLs and DTPs identified in the statutory returns. The study will also explore variations in OOP costs by age, province, and care setting (in-hospital vs. out- of-hospital).

7.3. Data Analysis

The analysis was conducted using descriptive and inferential statistical methods to address the research objectives. The following steps were employed:

7.3.1. Descriptive Statistics: This presented the total and average OOP expenditure for the top CDL conditions and DTPs, stratified by scheme type, care setting, geographic region, and age group. Means or averages, computed as the total expenditure adjusted for beneficiaries/utilising beneficiaries, were used to summarise expenditure data.

7.3.2. Comparative Analysis: This assessed the impact of care settings (in-hospital vs. out-of-hospital) and scheme types (open vs. restricted) on OOP costs. It highlighted the factors that significantly influenced the financial burden on beneficiaries.

7.3.3. Geographic and Age-related Disparities: The study used geographic region and age group as categorical variables to assess disparities in OOP spending.

7.3.4. Ethical Considerations

The study adhered to ethical research standards, ensuring the confidentiality and anonymity of all medical scheme beneficiaries. The data in this analysis were aggregated and anonymised to prevent the identification of individual beneficiaries. Ethical approval was sought from relevant institutional review boards or ethics committees.

8. LITERATURE REVIEW

Legislative Framework and Assessment for OOP

The legislative framework, as outlined in the Medical Schemes Act 131 of 1998 (MSA), about benefit content configuration, pricing of options, cost sharing provisions, and registration of benefit options to OOP payments is discussed below. Guaranteed benefits regulation 8 (1) of the MSA requires that *"any benefit option that is offered by a medical scheme must pay in full, without co-payments or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions".* Regulation 8 (1) seeks to protect the interests of members of medical schemes regardless of benefit options and address unfair risk selection and denial of care by medical schemes.

Section 8 (2) (a) further states that *"...The diagnosis, treatment and care costs of a Prescribed Minimum Benefits condition will only be paid in full by the medical scheme if those services are obtained from a Designated Service Provider (DSP) in respect of that condition..."* Whilst, Section 8 (2) (b) points out that *"…a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme may be imposed on a member if that member or his/her dependant obtains such services from a provider other than a DSP, provided that no co-payment or deductible is payable by a member if the service was involuntary obtained from a provider other than a designated service provider"*.

Solvency ratio Regulation 29 (2) of the MSA regulations requires that schemes must maintain accumulated funds expressed as a percentage of gross annual contributions of not less than 25%. Related to this, section 35 of the MSA seeks to encourage financial soundness of schemes through stricter controls to extend financial stability. OOP payments also allow medical schemes to ensure financial soundness and the required solvency levels in line with Regulation 35 (2). Medical schemes, therefore, design benefit options with some form of patient channelling mechanisms and cost-sharing arrangements, especially with regards to accessing the PMB package and access to care within certain benefit options such as network, capitation and efficiency discounted options. This means that OOP payments are legally permissibly although they must be incurred by members in a lawful way.

Approval of benefit options Section 33 (2) outlines the process to be followed for approval of benefit options. Stated in this section is that *"approval of benefit options will be subject to provision of prescribed minimum benefits, self-supporting in-terms of membership and financial performance, financially sound, the option should not jeopardise the financial soundness of any existing options within the medical scheme".* Benefit options once approved by the Registrar under section 33 (2) may make members incur OOP to ensure the provision of prescribed minimum benefits, self-supporting in-terms of membership and financial performance, financially sound, the option should not jeopardise the financial soundness of any existing options within the medical scheme and OOP's are a means to ensure that benefit options remain self-supporting and viable.

Limits benefits under Regulation 9 states that "*a medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the Prescribed Minimum Benefit (PMB), pro-rata to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned*".

Member communication on benefit change under section 29 (l) makes it mandatory for the scheme to communicate with their members on any change in contributions, membership fees, benefits or any other condition affecting their membership. Subsection (o) states that medical schemes should include in their rules the scope and level of

minimum benefits that are to be available to beneficiaries. Effective member communication is paramount for medical schemes to provide sufficient financial protection for their members in compliance with the MSA. Member empowerment about their rights and responsibilities is a cornerstone of ensuring cost-effective access to the PMB package. OOP payments must be communicated clearly to members of medical schemes so that members can avoid OOP payments where possible. Sub-regulation (2) dictates that when a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the member. Sub-regulation (6) dictates when a medical scheme may not prohibit, or enter an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider before receiving authorisation from the medical scheme or any other party, regarding an emergency medical condition.

CMS reported OOP expenditure

The CMS defines OOP payments or expenditures as the difference between what the health service provider claims and the amount paid from the medical scheme risk pool, including the amount paid from the medical savings account as part of OOP (3). According to the CMS Annual Report (2023), the private health industry incurred an OOP expenditure of over R43.3 billion in the 2023/2024 financial year. This represents an 18% increase from the R36.7 billion of OOP payments incurred in 2021 (16). This may be an underestimate since medical schemes may not fully capture and submit all costs associated with seeking healthcare, and members may choose not to notify medical schemes if they know that the scheme will not cover the cost of the care. Figure 1 below shows the estimated OOP for 2023 (outer ring) and 2022 (inner ring) payments. Medicines dispensed, all specialist payments and payments related to supplementary and allied health workers constituted 76.43 and 76.7% of all OOP payments for 2022 and 2023, respectively (16). It is known that restricted schemes incur less OOP payments since their benefit design is regarded as more comprehensive. Restricted schemes may also have better risk-pooling due to fewer benefit options, thus leading to lower OOP payments.

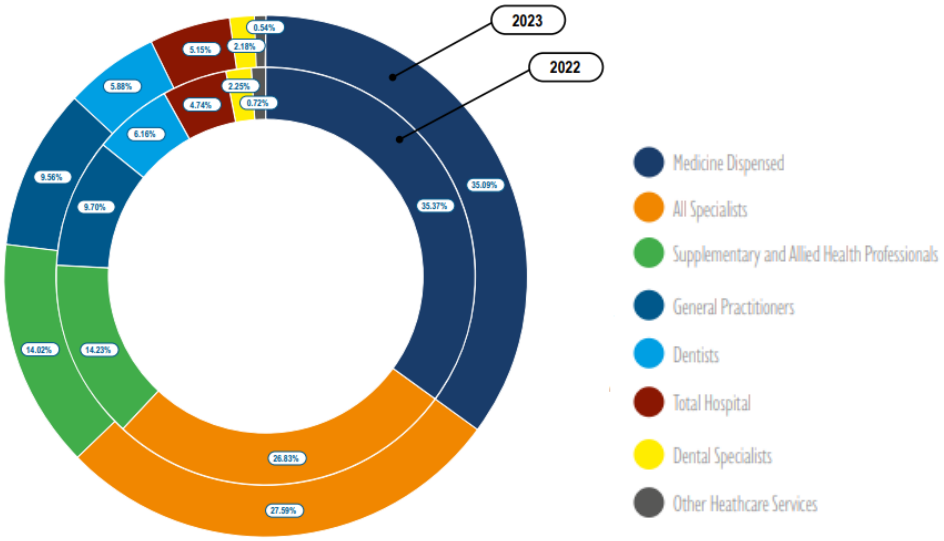


Figure 1: Out-of-pocket payments by discipline group (CMS Industry Report, 2023)(16)

Conditions most likely to incur OOP payments are non-communicable diseases, especially cancer, but infectious diseases are more likely to push people into poverty (17, 18). OOP health expenditure is more likely to be catastrophic when people receive in-patient care, receive end-of-life care, and the costs for those who do not survive are higher (19). While medical schemes have been reasonably successful in controlling the costs of medical services such as medical consultations and hospitalisation costs, they have been less so with the price of consumables such as drug costs and utilisation-related price increases. One of the reasons for the increasing drug costs is that health providers can benefit financially by selling drugs at retail prices.

CHE and OOP payments

CHE occurs when a household's OOP expenditure exceeds a certain percentage of their capacity to pay for health care (20). CHE is defined as OOP payments greater than 40% of the costs for basic needs, including food, housing and utilities (20). Capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs (food, housing and utilities). CHE is a reliable measure of financial risk protection, as discussed in the literature and documented in many countries (21, 22). It measures the degree of financial risk protection and assesses whether a system can protect its citizens from extreme financial hardship (19, 21, 22). Extreme financial hardship or distress is the worst financial and economic outcome possible for a household to have to endure because of seeking healthcare. Those confronted with CHE are generally from low-income households, especially vulnerable groups and experience more chronic health conditions (WHO). Over 100 million people are estimated to be pushed into poverty due to OOP payments every year (WHO). CHE is also used as a metric to monitor progress towards Universal Health Coverage and the Sustainable Development Goal (SDG) 8. This goal envisaged that all people should have access to health services, financial risk protection, quality essential health care services, and safe, effective, quality, and affordable essential medicines and vaccines. Measurements aimed at decreasing CHE can be utilised by health policy assessments when considering healthcare policies and

interventions. Despite the usefulness of this metric, varying calculations used to derive CHE have led to inconsistent calculations and difficulties comparing studies and estimates (23). CHE can only be measured when health services are used and costs related to healthcare are paid. Therefore, its use is limited since poor households may avoid seeking care due to affordability constraints, which represents an underestimate of CHE.

Determinants for OOP and CHE

Socio-demographic factors

A meta-analysis analysing 34 studies in Sub-Saharan Africa (SSA), revealed that factors such as household economic status, type of health provider, socio-demographic characteristics of household members, type of illness, social insurance schemes, geographical location, and household size, are significant risk factors associated with CHE (21). Age, household size and per capita consumption expenditure are major determinants of OOP payments in Nigeria (8). In Zambia, households headed by individuals younger than 25 had lower OOP payments than those aged 64 years and above. households residing in urban areas, married households and male-headed households had higher OOP than their counterparts (9). Factors responsible for high OOP were related to costs associated with hospitalisation and medical supplies (11). At the micro-level, variations in OOP health expenditure are mainly caused by variations in socio-economic status, income, gender, age, geographical location, elderly population, health insurance, and education of the households (9, 10).

Type of healthcare sought

A South African study on the determinants of CHE found that the major factors determining CHE besides poverty were spending on hospitalisation and medical supplies. CHE was approximately 14 times higher amongst poorer households and 3.2 times higher for those that incurred hospitalisations (11). Money spent on health insurance was also found to be protective against CHE (11). A WHO report on the key drivers of CHE expenditure found that OOP expenditure on medicines poses the largest financial burden compared to any other OOP payment, followed by hospitalisation (24). It was found that while the cost of medicines may be small as compared to in-patient services, medicine spending can accumulate quickly, especially for people with chronic conditions.

Chronic disease

OOP payments due to chronic disease are high due to the high costs associated with chronic conditions, the prolonged treatment required, and the affordability constraints experienced by many poorer households. A 2022, scoping review study conducted by Rahman, Gasbarro & Alam, on financial risk protection from OOP payments, found that diabetes, cancers and heart disease, caused 0–17%, 7.6–58% and 26.8–63.8% of households to incur CHE, respectively. Cancer treatment-related hospitalisation led to the highest proportion of households (40–50%) borrowing money, selling assets, or seeking contributions from friends and family (25).

Provision of Primary Healthcare (PHC)

PHC remains the main and first point of contact with the health system. Thus, prioritising efforts to ensure its use and functionality would decrease OOPs and improve the health system's efficiency, equity, and effectiveness (26).

Affordable access to pharmaceutical products

Ensuring access to pharmaceutical products at affordable prices could also reduce household OOP payments, representing more than two-thirds of households' OOP payments (26). Increasing access is particularly important for essential drugs to control common communicable and non-communicable conditions.

The single exit price (SEP) is the regulated maximum price patients should pay for their medicines. Consumers' final price for their medicines is the sum of the SEP and dispensing fee. At present, the structure of the dispensing fee is regressive (27). The dispensing fee makes up a higher proportion of the total cost of lower-priced medicines. There are key shortcomings in the policy and regulatory framework since manufacturers' prices are strictly regulated irrespective of quantities sold, they have an incentive to price as high as would be financially viable when selling small quantities (27). The Medicines Act contributes to this problem by not providing enabling legislation for regulators to challenge manufacturers' prices if they deem them too high.

Benefit option design and OOP payments

Benefit options differ in their degree of service and cost coverage, and they provide a range of benefit packages that include coverage for PMBs made available from the risk pool. Some options also provide a medical savings account, with a set percentage of each premium (up to a maximum of 25%) accruing to the account. Funds in a savings account are not pooled, and the rest come from the risk portion of the premium. Funds from the MSA are still considered to be "household funds" and are thus regarded as OOP payments, although their use would exclude CHE.

In a benefits enrichment survey conducted by the CMS in 2021 (n=4541), 41.62% of members advised that they chose their benefit option based on healthcare needs compared to the 40.45% who chose it based on affordability (28). Whilst healthcare needs and affordability are the most important considerations when determining a suitable benefit option, approximately 18% of members choose reasons such as innovative product designs, cover for medications and a medical savings account (28). Of the people surveyed, 45% (IQR: 13-64%) of the members advised that they had run out of benefits in the last year, and 50% chose a benefit option based on their health needs. This demonstrates the complexity of benefit designs where members still run out of savings even when they believe they have chosen an adequate benefit option to address their health needs.

The Competition Commission's Health Market Inquiry (HMI) Report (2019) suggests that medical schemes have introduced a wide range of benefit options as a way for members to self-select, based on their own perceived risk (29). The HMI has expressed concern that the range of options and lack of transparency to members means that competition between schemes is based on demographics (attracting young healthy members) rather than lower contributions and richer benefits (value for money). The growth of savings options and declining comprehensive options are cited as evidence of this. Currently, risk pooling in medical schemes occurs at the level of individual benefit options. In the absence of a Risk Equalisation Fund, the community rate for PMBs within an option varies depending on their age and health profile (30). Members are confused by multiple benefit options and lack of comparability. A standardised framework presenting benefit options and an option classification system, as proposed by the Council for Medical Schemes (CMS), will assist in addressing these concerns.

Communication in the design and offering of benefit options has previously posed a problem. A healthcare survey of medical scheme members conducted by OMAC Actuaries & Consultants in 2011 revealed that nearly half of medical scheme members do not know what is covered by their benefit option, resulting in benefit options that do not meet their needs. It was also found that benefits are sometimes not effectively communicated for members to understand. This resulted in the CMS issuing a communications guideline for medical schemes in 2014.

Cost containment strategies employed by medical schemes in respect of PMB cover

Although PMBs cater for some day-to-day benefits, they focus largely on in-hospital care and chronic illness. Therefore, a high proportion of options do not offer day-to-day coverage. According to the MSA, schemes must pay for these PMBs' diagnosis, treatment and care costs in full, without any co-payments or the use of deductibles. It, therefore, does not prescribe how much providers can charge for their services. Pre-authorisation, chronic disease management, DSPs, formularies and treatment protocols are used almost universally across the industry as cost-containment strategies. Schemes use a complex range of co-payments and deductibles, and penalties are charged for non-compliance with scheme rules, for using non-formulary medicines, for out-of-network providers, etc.

Preferred provider networks and designated service providers

Medical schemes may restrict their members from obtaining healthcare services from a network of preferred providers. These networks are called Designated Service Providers (DSPs) when they pertain to the provision of PMBs. These networks are established to reduce healthcare costs, by negotiating volume discounts from providers or securing agreements with providers to practice cost-effective medicine according to a defined set of clinical protocols (30). This cost-containment strategy means medical schemes can offer discounted plans that restrict members to these providers on their networks. A DSP is a healthcare provider or group of providers (including hospitals, doctors and pharmacies), designated by medical schemes to provide services to members for diagnosing, treating and caring for medical conditions, including PMB conditions. The use of DSPs means that the

care and treatment should be covered in full. DSPs are important because they make healthcare more affordable and accessible to members while healthcare providers benefit from increased patient volumes. They also often have a direct payment arrangement with the medical scheme, which means the member does not have to pay the medical provider upfront; thus, no OOP payment is incurred. Members may choose to use non-DSP providers but may be liable for higher fees or co-payments associated with the care and treatment for their condition. However, the MSA stipulates that medical schemes must ensure adequate access, so there are some circumstances where the scheme must pay for non-DSP services. These include when timely or urgent healthcare is required or if there is no health provider within the member's proximity.

OOP payments may arise where the medical scheme uses the state as a service provider, and the member would prefer obtaining care in the private sector and may be willing to pay OOP. However, the onus is on the medical scheme to ensure that the state facility designated provider is readily available to accommodate and provide services to their members. When approving scheme rules, the CMS requires schemes to demonstrate that they have assessed their DSPs and have assurance of service availability.

There is also a concern that schemes may be appointing hospitals as DSPs but have no DSP specialists who operate at those hospitals. Member access for beneficiaries may be questionable regarding geographic coverage of the networks. The maintenance of network cost coverage would reduce the number of members' OOP payments. Medical schemes should review their benefit options with a view to enhancing benefits, thereby decreasing OOP payments. In a CMS analysis conducted on the CMS complaints database from January 2019 to September 2020, regarding complaints related to DSPs (n=244), 88.4% of DSP-related claims were due to involuntary non-DSP use.

Pre-authorisation

Medical schemes use pre-authorisation to manage costs and check that you have the required benefits before you have an expensive procedure or treatment. Pre-authorisation should, however, alert you to potential scheme payment shortfalls and ways to avoid them. Forty percent of members surveyed faced co-payments after obtaining pre-authorisation; of those, 30 percent did not understand why their claims were not paid in full (28). If authorisation is not granted, the claims are either not reimbursed or only reimbursed for a certain percentage. the exact terms of such reimbursement are specific to the scheme and option.

Co-payments deductibles and gap cover

Some benefit design measures may cause a transfer of risk or cost to members, in the form of co-payments. These are designed to promote clinically appropriate and cost-effective health choices. There are many co-payments that

may arise due to reference pricing, charges above scheme rates, non-DSP use, set co-payments applicable to specific benefits, to name a few. Co-payments or user-fees are used in some health systems as a deterrent to service use and as a cost-containment (demand-management) measure. However, international evidence indicates that co-payments, by placing a burden on patients at the point of service, disproportionately deters use by the most vulnerable, particularly the lowest socio-economic groups and thereby entrenches inequalities in access to and use of needed health care (31). Co-payments often increase the total cost of health care as the use of needed health care is simply deferred until an illness is serious, requiring more costly services including hospitalisation. Co-payments can come in the form of an "admission co-pay" for admission to a health facility, or a "procedure co-pay" for procedures while in hospital. Co-payments occur in situations where highly priced commodities are used. There are large variations in the amounts charged between schemes and benefit options. A penalty co-payment fee is billed if a beneficiary voluntarily makes use of a non-network provider or DSP.

A deductible makes the member responsible for all healthcare costs up to a certain amount. Once the member reaches the threshold, the medical scheme will share in the cost either fully or the benefits may be subject to other cost-sharing.

Gap cover complements your medical aid plan and doesn't extend to services outside your benefits. Gap cover is an insurance that covers the shortfall of hospital costs between actual cost incurred and the medical scheme tariff under a scheme benefit option. Gap cover is designed to provide individuals with financial assistance in cases where they must make OOP payments. In most instances, these relate to hospitalisation cases. Gap cover products assist members by reducing OOP.

Managed care and OOP payments

Practices aimed at reducing the overall expenses of a medical scheme include rationing of healthcare services through clinical protocols, management of members' access, constraining supply formularies, and managed-care protocols, to name a few. According to the MSA, managed care is defined as clinical and financial risk assessment and management of healthcare to facilitate appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable use rules-based and clinical management-based programmes. It aims to influence providers' decision-making to facilitate the appropriateness and cost-effectiveness of health services. Each medical scheme or managed care organisation is responsible for its own clinical management-based programmes that should be evidence-based and appropriate. A challenge is that these protocols are not freely available for assessing what is or isn't covered, as well as the reasons and evidence. Thus, health providers are not aware of what is covered and what is not covered. Managed care refers to several strategies that can be used by medical schemes to manage the costs associated with healthcare services and treatment. For example, using

set treatment plans (protocols) and medicine lists (formularies), using case managers to help determine the best care options for a particular patient in a particular setting and using DSP's or preferred providers.

Scheme protocols

Medical scheme protocols are rules that outline which treatments and medicines a medical scheme will cover. These protocols are used to manage members' use of benefits and reduce the risk for the scheme.

Formulary lists

A medical scheme formulary is a list of safe and effective medicines that a medical scheme will cover to treat certain conditions. They often include generic drugs, which are less expensive but equally effective. Schemes may only cover medication in full if it is prescribed from the formulary. Although formulary use is based on evidence and cost-effectiveness, the onus is on medical schemes to update the health technology assessments regularly to ensure advancement and new technologies are considered. Pharmaceutical costs passing though hospitals are a major cost driver for OOP payments. Hospitals obtain substantial discounts from manufacturers, which are not passed on to patients. OOP expenditure for medicines accounts for 33% of the spending on medical schemes (2021). The introduction of Regulations Relating to a Transparent Pricing System has seen a reduction of 31% in the prices of medicines (as seen in 2005), whilst medical scheme expenditure from medical schemes has remained constant at approximately 17% of total spending, the OOP expenditure by beneficiaries have increased significantly over the years with expenditure in open schemes and closed schemes 31% and 17.6%. A 2010 WHO report on CHE found that medicine expenditure poses a considerable financial burden. Spending on medicines causes more households to face financial catastrophe than spending on in-patient or outpatient services in almost all countries included in this study (24). While the cost of medicines may be small as compared to in-patient services, medicine spending can accumulate quickly, especially for people with chronic conditions.

There are also various other factors in the market that aid high OOP medicine expenditure, such as patent protection, regulated pricing, and the impact of state tender pricing on private sector prices. The impact of these measures on driving costs should be considered along with an assessment of the level of the original single exit price plus increments for each product. Co-payments may ensue if a beneficiary makes use of a drug or treatment outside the prescribed formulary. This could be a percentage of the cost of the drug or the difference between the price of the formulary medicine and the price of the medicine used. However, if you have side effects from a formulary drug, if a substitute drug affects your health or has been non-effective in your treatment, a beneficiaries healthcare provider may motivate for the use of a non-formulary drug which the scheme would be liable to cover in full.

This area of medicines OOP payments could receive more oversight from the CMS, as seen from the high OOP payments pertaining to medicines and the voluminous complaints in relation to non-payments and co-payments for treatments incurred by members. The CMS also issue a number of PMB definition guidelines per year which detail the entitlements and minimum benefits that all affected beneficiaries should receive. More power should be exercised to ensure compliance of medical scheme protocols and formularies with these CMS guidelines.

9. CMS COMPLAINTS DATABASE

An analysis of the CMS complaints database from March 2023 to August 2024 revealed that there were 239 complaints lodged due to payment disputes stemming from the exclusion of benefits. Non-payment resulting from declined pre-authorisations was due to deviations from protocol (n=101), benefit exclusions (n=194), waiting periods (n=14) and non-disclosures (n=14).

The figure below shows the complaints broken down per underlying issue and the resolution outcome. A significant number of complaints were related to benefit exclusion based on benefit design, which medical schemes are entitled to exclude.

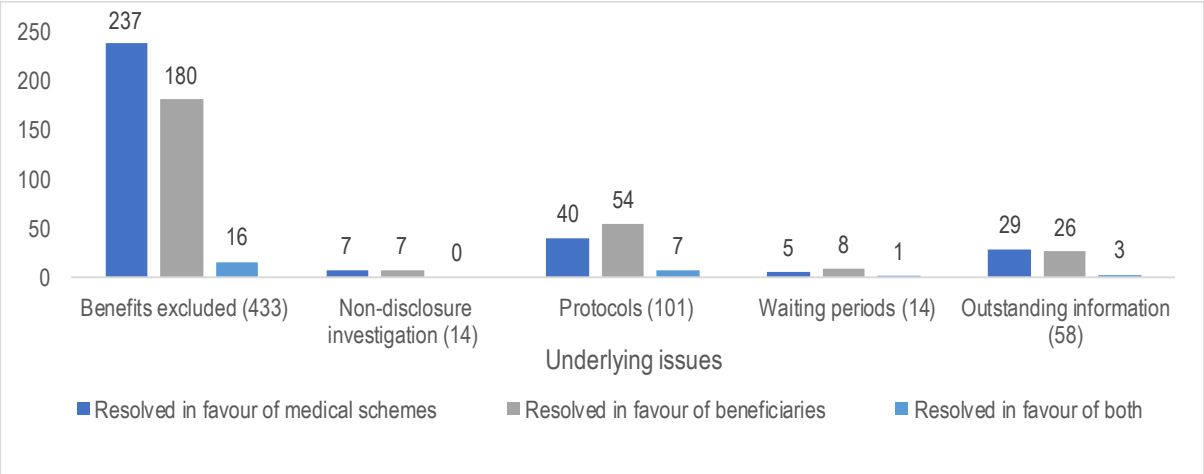


Figure 2: Resolved complaints per underlying issues.

Observations from the complaints saw a number of rejections of claims of non-PMB conditions, which were sequelae of PMB conditions which should be covered by medical schemes, and incorrect linking of newly diagnosed conditions to a condition-specific waiting period; another trend observed was inadequate or no DSP specialists at approved DSP hospitals.

The findings from the complaint database trends resulting in OOP payments from non-payments, shortfalls, non-DSP use generally result from two major issues originating from complex benefit design and poor communication to beneficiaries regarding their entitlements.

In a separate analysis of complaints data from 2018-2023, of the 15 935 complaints submitted to the CMS, 8 874 (56.7%) complaints were due to issues emanating from shortfalls, non-payments, benefit exclusions and unpaid accounts, which may have resulted in unplanned member OOP expenditure.

10. ANALYSIS OF THE MEDICAL SCHEME OOP ANNUAL STATUTORY RETURNS DATA

An analysis of the top 7 CDLs incurring the highest total OOP expenditure incurred in 2023 is shown in the figure (Figure 3) below. It is important to note that this high OOP expenditure seen here may be due to high prevalence CDLs rather than high OOP expenditure. Open schemes incur more OOP than restricted schemes and out-of-hospital care incurs the most OOP expenses.

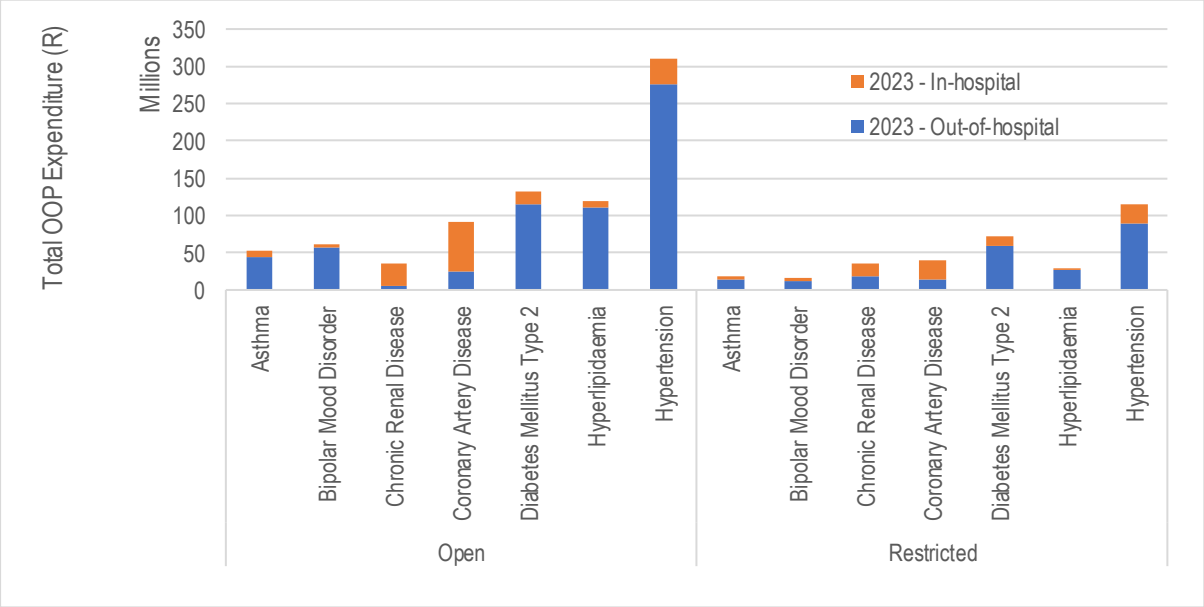


Figure 3: Total OOP expenditure for the top seven by scheme type and setting (2023)

Figure 4 below shows the top 8 CDLs with the highest average OOP expenditure per affected beneficiary for 2023. These high-cost OOP conditions are most incurred through in-hospital care and treatment. It may be important to note that gap cover would often cover the OOP expense incurred by members and thus may not represent true CHE. The costliest CDL in terms of OOP expenditure per affected beneficiary is chronic renal disease (over R5000 per beneficiary), which may require dialysis, renal transplants and costly medications, followed by haemophilia, requiring blood products and treatments and cardiomyopathy.

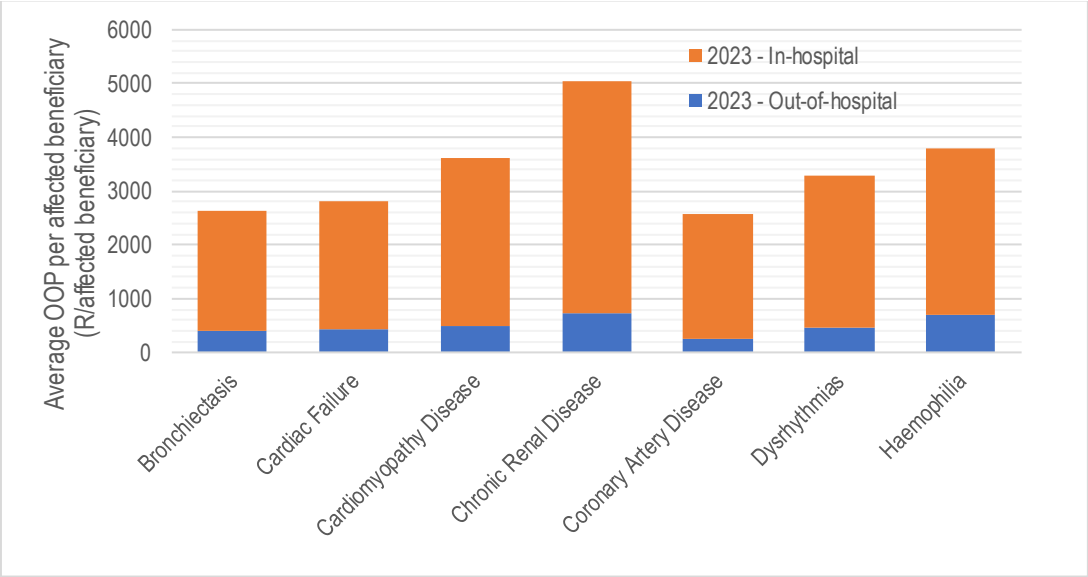


Figure 4: Average OOP per affected beneficiary for in- and out-of-hospital treatment for the top seven highest OOP CDLs (2023)

Three mostly urban and three mostly rural provinces were analysed to compare the OOP expenses incurred. Figure 5 below demonstrates the differences in average OOP per affected beneficiary per selected province. Observations demonstrate that Kwa-Zul Natal incurs the highest OOP expenditures. It may be important to note that the observations seen below may be due to differences with treating specialists and distance and availability of treating facilities. Other factors such as fraud, waste and abuse may occur regionally and may warrant further analysis. There are no overt disparities in OOP expenditure between rural and urban provinces.

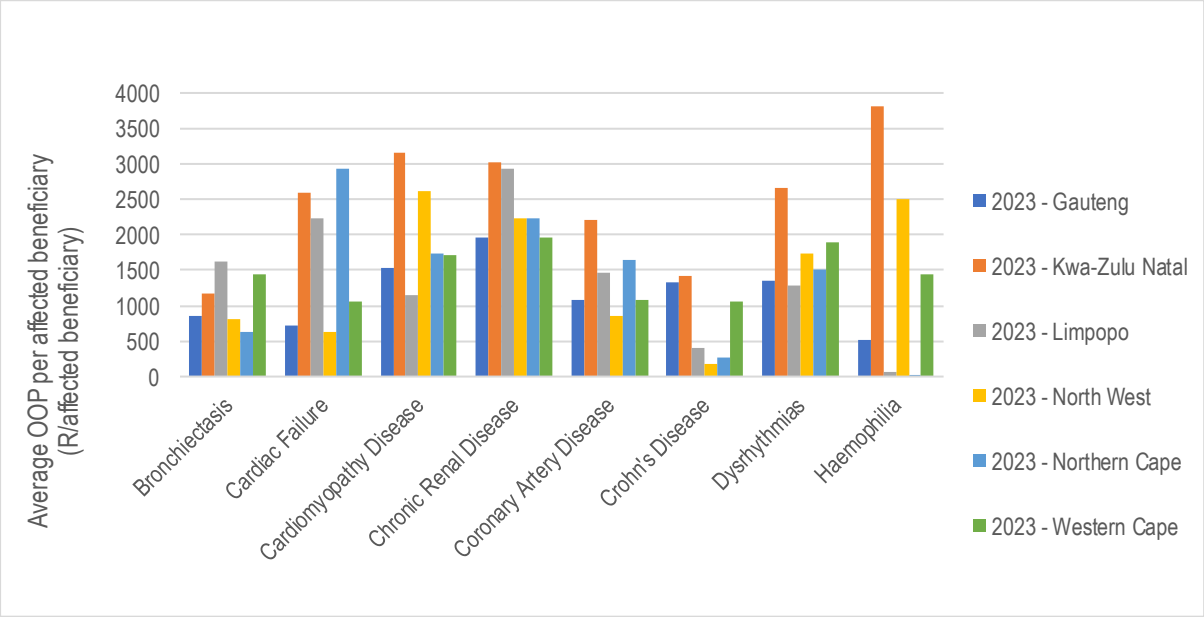


Figure 5: Average OOP per affected beneficiary per selected province for the top seven highest OOP CDLs (2023)

Figure 6 below demonstrates the average OOP per affected beneficiary for the costliest CDLs per age group. We can see those diseases affecting our vulnerable <5-year population that incur large OOP payments are cardiomyopathy and cardiac failure and bronchiectasis, affecting mostly the >75-year age group.

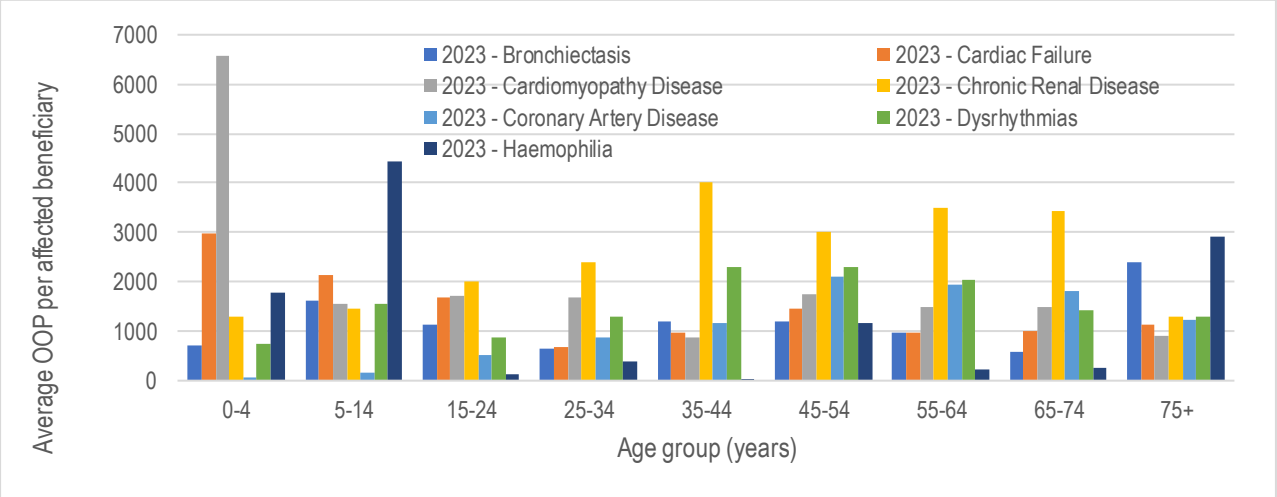


Figure 6: Average OOP per affected beneficiary per age-group category for the top seven highest OOP CDL (2023)

Table 2 below demonstrates the top 10 DTPs with the highest average OOP per affected beneficiary and the highest top 10 DTPs with the most total OOP expenditure. Benign and malignant brain tumours, benign tumours of the pancreas and valvular disorders incur the highest average OOP per affected beneficiary. The DTPs with the highest total OOP expenditure are emergency conditions, pregnancy and closed fractures.

Table 2: Top 10 DTPs incurring the highest average OOP per affected beneficiary and highest total OOP.

DTPs Incurring Highest OOP Expenditure (2023)		
Top 10 Highest OOP Costs per Affected Beneficiary	**Average OOP (R/affected beneficiary)**	**Total OOP (R)**
Benign and malignant brain tumours; treatable	3 301,80	23 415 688,08
Benign neoplasm of islets of Langerhans	3 210,15	201 195,62
Diseases and disorders of aortic valve NOS	3 073,99	23 663 363,35
Tetralogy of Fallot (TOF)	3 048,31	1 161 173,03
Coronary artery anomaly	2 902,60	34 831,24
Acute leukaemia; lymphomas	2 700,99	33 365 045,49
Cancer of bones- treatable	2 673,52	5 989 565,04
Dissecting or ruptured aortic aneurysm	2 671,56	1 804 325,12
Intraspinal and intracranial abscess	2 638,35	3 024 075,52
Cancer of lung; bronchus; pleura; trachea; mediastinum & other respiratory organs- treatable	2 516,47	28 468 675,97
Top 10 Highest OOP Expenditure		
Default emergency DTP code for claims that cannot be classified as DTP or CDL	719,13	233 939 917,19
Pregnancy	660,78	187 067 604,30
Closed fractures/ dislocations of limb bones / epiphyses G¦ (excluding fingers & toes	1 154,51	113 258 165,92
Major affective disorders; including unipolar and bipolar depression	271,99	100 782 501,56
Cataract; aphakia	1 231,57	90 857 250,58
Spinal cord compression; ischaemia or degenerative disease NOS	2 296,95	87 223 505,24
Metastatic infections; septicaemia	1 264,25	75 043 444,06
Cancer of the gastro-intestinal tract; including oesophagus; stomach; bowel; rectum; anus - treatable	1 742,16	70 889 830,20
Cancer of breast - treatable	1 423,20	67 091 306,12
Non-inflammatory disorders and benign neoplasms of ovary; fallopian tubes and uterus	713,70	57 641 604,69

11. DEFINING POSSIBLE STRATEGIES TO MANAGE THE RISK OF OOP PAYMENTS

The framework presented in Table 3 outlines a structured approach for controlling and monitoring OOP expenditures among medical scheme beneficiaries, focusing on three key strategies: risk avoidance, risk sharing, and risk transfer. Risk avoidance aims to mitigate OOP expenses by addressing gaps in member knowledge, particularly around benefit options, DSPs, and available medical services. Key policy interventions include simplifying and standardising benefit designs, enhancing education and communication to inform members about their coverage and ensuring equitable access to DSPs through geographic mapping. Additionally, the framework recommends systematic tracking of co-payments and OOP expenditures, with regulatory caps to protect low-income members from financial hardship. Risk-sharing strategies focus on improving treatment protocols and formularies, particularly for high-cost conditions, by making them more transparent and regularly updated. The framework also calls for disclosing PMB and non-PMB treatment protocols, formulary details to members, and

price regulation through reference pricing. Risk transfer highlights the importance of integrating PHC into PMB coverage to prevent downstream health costs and emphasises the need for improved financial informed consent practices. To support better decision-making, the framework advocates for educational campaigns to help members understand their healthcare options and economic implications. Finally, the framework recommends tracking complaints related to OOP costs to identify issues early and mitigate financial strain on beneficiaries.

.

Table 3: Framework for monitoring and controlling

Strategic Focus	Issue	Reasons for high OOP payments	Policy interventions	Specific interventions policy
DSPs	OOP from non-DSP use	Beneficiaries uninformed on DSP use	Establish national guidelines for geographical mapping of DSPs across all medical schemes.	Schemes must contract with specialists in underserved regions and improve communication strategies to educate members on DSP networks.
		DSPs are unavailable for certain specialities not within geographical proximity.	Geographical mapping of DSPs by schemes and speciality	Medical schemes should regularly update DSP availability, especially for remote regions and specialised care
Benefit design and standardisation	Beneficiaries uninformed on various BOs	Simplify and standardise medical scheme benefit options	Mandate clear, transparent, and simplified benefit options with comprehensive comparison tools for members.	Require schemes to disclose the financial impacts of each BO, including co-payments and OOP expenses.
		Numerous and complex benefit design	Standardisation and simplification of benefits research	Provide a regulatory framework for schemes to disclose the financial impact of each benefit option
Co-payment and OOP Payment Monitoring	Co-payments and OOP payment monitoring related to benefit design	Lack of co-payment visibility	Introduce national tracking mechanisms for co-payments and OOP expenses	Medical schemes must report OOP expenses per member, and cap OOP costs for low-income groups.
		Medical schemes to report on co-payments per member per annum	Implement policies that require medical schemes to set upper limits or caps for co-payments.	Introduce a regulatory framework to ensure OOP expenses are capped, particularly for low-income groups.
	Formularies and protocols (PMB conditions)	Gaps in formularies and treatment protocols	Ensure formularies and treatment protocols are evidence-based, regularly updated and publicly available.	Medical schemes should disclose formularies and treatment protocols for PMB conditions to members.
		Lack of transparency in protocols	Request protocols and formularies for high-cost conditions from medical schemes	Mandate a publicly accessible database of formularies and treatment protocols, ensuring updates reflect the latest medical evidence.

Price Regulation and Reference Pricing	Lacking price regulation	Price variability across healthcare providers	Introduce reference pricing models and price regulation for high-cost procedures and medications.	Regulatory bodies must monitor pricing trends and ensure pricing discrepancies are addressed.
	Formularies and protocols (non-PMB conditions)	Lack of coverage for non-PMB conditions	Require disclosure of formularies and protocols for non-PMB conditions to members.	Schemes should inform members about the limits and exclusions of their benefits and provide pricing transparency.
		Formularies and protocols not disclosed to members and HCPs	Mandate disclosure of formularies and protocols for non-PMB conditions.	Establish a regulatory framework that requires schemes to inform members about their benefits, limits, and exclusions.
Primary health care	In-hospital PMB care is covered, and medical savings or OOP covers out-patient care.	Outpatient care costs covered from medical savings or OOP	Expand PHC services within the scope of PMBs.	Include chronic disease management, mental health care, and maternal care in PMB coverage, and consider telemedicine options for greater access.
Unempowered members	Financial informed consent	Members unaware of potential OOP costs	Partner with providers to ensure financial information is made available before services are rendered	Implement a national standard for financial informed consent across all healthcare providers, including clear cost breakdowns.
Informed decision-making	Uninformed members making poor decisions	Lack of education on benefit options	Implement a national education campaign to help members make informed choices regarding their medical scheme and benefits.	Provide mandatory educational tools (digital, workshops, etc.) to explain the financial impact of different benefit options.
Complaints monitoring	Complaints on OOP payments	OOP payment disputes not tracked	Establish a centralised body for tracking and addressing OOP-related complaints, including shortfalls and co-payment disputes.	Require schemes to report complaints about OOP expenses and provide public access to these reports to ensure transparency and accountability.
		Shortfalls, non-payments, and issues with DSPs	Scheme tracking and handling of complaints	Create a formal process for handling OOP complaints, identifying systemic issues, and providing early warnings of emerging trends in OOP payments.

12. FUTURE RESEARCH DIRECTIONS

The framework outlined above highlights several key areas where future research is needed to improve further the management of OOP expenses for medical scheme beneficiaries. One critical area for investigation is developing and implementing protocols and formularies, which are essential in ensuring that treatment options and medications are both effective and cost-efficient. Additionally, further research into benefit design is crucial to identify ways medical schemes can optimise coverage to meet the evolving needs of beneficiaries while managing costs. A comprehensive analysis of medical scheme rules, including benefit options, co-payments, and DSPs, is also necessary to understand how these factors influence OOP expenses. Such research would provide valuable insights into how medical schemes can refine their offerings to better control and reduce OOP payments, ultimately improving financial protection for beneficiaries.

13. RECOMMENDATIONS

Based on this study's findings, several key recommendations have emerged to manage better and mitigate expenses for medical scheme beneficiaries. First, medical schemes should prioritise protecting their members as contribution increases exceed inflation by limiting exposure to OOP expenses. This can be achieved by enriching benefit designs to meet members' evolving needs. Offering comprehensive coverage that emphasises preventive care and effective management of chronic conditions will help mitigate the financial burden on members while maintaining scheme sustainability in the face of rising costs. Second, there is a pressing need to enhance the monitoring and regulation of OOP costs. Standardised reporting mechanisms, developed by the government and medical schemes, would allow for better tracking and control of OOP expenditures. Such measures would protect beneficiaries from excessive costs, particularly for chronic and high-cost conditions.

Third, gap cover products should be standardised to provide more comprehensive and equitable coverage, particularly for prescribed PMBs. Policymakers should consider mandating minimum coverage standards for gap cover plans to ensure alignment with PMBs and offer beneficiaries greater financial protection. Fourth, targeted financial assistance or coverage should be introduced for chronic diseases and high-cost conditions like chronic renal disease and haemophilia, which contribute to significant OOP expenses. This could involve reducing co-payments, increasing coverage, or tailoring benefit designs to meet the specific needs of these beneficiaries. Fifth, increased awareness and transparency are crucial. Beneficiaries must be better informed about the potential for high OOP costs, especially for conditions that require frequent or costly treatments. Medical schemes and gap cover plans should ensure that beneficiaries understand the benefits and limitations of their coverage, enabling them to make more informed decisions.

Sixth, addressing geographic and demographic disparities is essential. There are noticeable differences in OOP expenses between urban and rural areas, with rural areas often facing higher costs due to limited access to healthcare facilities. Medical schemes should develop policies to reduce these disparities and ensure equitable access to necessary care in rural areas. Additionally, addressing age-related disparities, particularly among vulnerable groups like children and the elderly, should be a priority through more tailored benefit designs. Finally, integrating preventive and primary care into medical scheme offerings can help reduce OOP expenses in the long term by improving early detection and managing health conditions before they escalate into more costly treatments.

14. CONCLUSION

This study has highlighted the significant impact of OOP expenses on medical scheme beneficiaries, with particular emphasis on chronic diseases, high-cost conditions, and the disparities between different healthcare settings, geographic areas, and age groups. The findings underscore the urgent need for medical schemes to adapt and evolve to better support their members amidst rising healthcare costs and contribution increases that exceed inflation. Enriching benefit designs, enhancing the monitoring and regulation of OOP expenditures, and standardising gap cover products are critical strategies that medical schemes can adopt to mitigate the financial burden on beneficiaries. These measures will help meet essential healthcare needs while safeguarding beneficiaries from excessive out-of-pocket costs.

Addressing geographic and demographic disparities will be crucial in promoting equitable access to care, particularly in rural areas and for vulnerable populations. Additionally, increasing awareness and transparency about the potential for high OOP costs will empower beneficiaries to make more informed decisions about their healthcare coverage.

Ultimately, by focusing on preventive care, chronic disease management, and targeted financial support for high-cost conditions, medical schemes can reduce the long-term financial strain on beneficiaries, improving overall health outcomes while maintaining scheme sustainability. The recommendations from this study provide a comprehensive framework for improving OOP management and enhancing the value of medical schemes in protecting the health and well-being of their members.

Author contributors

Dr. Samantha Iyaloo conducted the desktop review and analysis. Dr. Michael Willie developed the initial concept and provided valuable input on the report.

Acknowledgements

The authors are grateful to the Legal subunit (Corporate Services Division) and the Complaints and Adjudication subunit (Member Protection Division) at the CMS for their assistance in developing and finalising this report. They are also grateful to Mr Malwandla Manyisi for his assistance in preparing and providing the ASR data for analysis.

Ethical consideration

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

Declaration of interests

The author states that no financial or personal affiliations could have unduly influenced the content of this article.

15. REFERENCES

1. OECD Indicators: Financial hardship and out-of-pocket expenditure in health at a Glance 2023. OECD Publishing, Paris, France: OECD; 2023.
2. WHO. Out-of-Pocket Payments, User Fees and Catastrophic Expenditure. WHO; 2016. Available online: http://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/ (accessed 2 November 2024).
3. Council for Medical Schemes. Analysis of Schemes Risk Measurement Returns - 2016. Pretoria: CMS, 2017.
4. World Health Organization. World Health Statistics 2020: Monitoring Health for the SDGs. Available online: https://digitallibrary.un.org/record/3897953?ln=en#record-files-collapse-header (accessed on 29 November 2024).
5. World Health Organization. Tracking universal health coverage: 2017 global monitoring report, 2017. Available online: https://www.who.int/publications/i/item/9789241513555 (accessed on 18 November 2024).
6. World Health Organization African Regional Office. Atlas of African Health Statistics 2022: Health Situation Analysis of the WHO African Region. Available online: https://iris.who.int/bitstream/handle/10665/364837/9789290234852-eng.pdf?sequence=3 (accessed on 18 November 2024).
7. Cylus J, Thomson S, Evetovits T. Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bulletin of the World Health Organization. 2018 Sep 9;96(9):599.
8. Oyinpreye AT, Moses KT. Determinants of out-of-pocket healthcare expenditure in the South-South geopolitical zone of Nigeria. International Journal of Economics, Finance and Management. 2014 Oct;3(6).
9. Mwenge F. Progressivity and determinants of out-of-pocket health care financing in Zambia. Master's thesis, Health Economics Unit, School of Public Health; Family Medicine, University of Cape Town. Available online: https://open.uct.ac.za/bitstream/handle/11427/12369/thesis_hsf_2010_mwenge_f.pdf?sequence=1 (accessed on 18 November 2024).
10. Koch SF, Setshegetso N. Progressivity of out-of-pocket payments and its determinants decomposed over time. Development Southern Africa. 2021 Sep 3;38(5):731-49.
11. Babikir A, Satty A, Mwambi H. Determinants of out-of-pocket health expenditure and their welfare implications in a South African context. Journal of Economic and Financial Sciences. 2018 Jul 1;11(1):1-7.
12. Koch SF, Setshegetso N. Catastrophic health expenditures arising from out-of-pocket payments: Evidence from South African income and expenditure surveys. PloS one. 2020 Aug 11;15(8):e0237217.
13. Tabari-Khomeiran R, Delavari S, Rezaei S, Rad EH, Shahmoradi M. The effect of Iranian health system reform plan on payments and costs of coronary artery bypass surgery in private hospitals of Iran. Int J Hum Rights Health. 2019;12(3):208–14.
14. Paris V, Hewlett E, Auraaen A, Alexa J, Simon L. Health care coverage in OECD countries in 2012. Paris: OECD Working Paper No. 88, OECD Publishing, 2016. Available online: http://dx.doi.org/10.1787/5jlz3kbf7pzv-en (accessed on 120 November 2024).
15. Council for Medical Schemes. Analysis of Schemes Risk Measurement Returns - 2016. Pretoria: CMS, 2017.
16. Council for Medical Schemes (CMS). (2024). CMS Industry Report 2023/2024. Pretoria, South Africa. Available online: https://www.medicalschemes.co.za/the-cms-2023-industry-report-is-here/(accessed 3 November 2024).
17. Dalui A, Banerjee S, Roy R. Determinants of out-of-pocket and catastrophic health expenditure in rural population: A community-based study in a block of Purba Barddhaman, West Bengal. Indian journal of public health. 2020 Jul 1;64(3):223-8.

18. Sangar S, Dutt V, Thakur R. Comparative assessment of economic burden of disease in relation to out of pocket expenditure. Frontiers in public health. 2019 Jan 29;7:9.
19. Prakash Singh S, Khokhar A. Out-of-pocket expenditures and catastrophic expenditures on in-patient care among households of an urban village in Delhi. J Med Access. 2023 Dec 4;7:27550834231213704.
20. WHO Europe universal health coverage: financial protection. Available online: http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/universal-health-coverage-financial-protection (accessed 28 October 2024).
21. Njagi P, Arsenijevic J, Groot W. Understanding variations in catastrophic health expenditure, its underlying determinants and impoverishment in sub-Saharan African countries: a scoping review. Syst Rev. 2018;11:136.
22. Grigorakis N, Floros C, Tsangari H, Tsoukatos E. Macroeconomic and financing determinants of out of pocket payments in health care: evidence from selected OECD countries. J Policy Model. 2018;40:1290–312.
23. Nguyen HA, Ahmed S, Turner HC. Overview of the main methods used for estimating catastrophic health expenditure. Cost Effectiveness and Resource Allocation. 2023 Aug 8;21(1):50.
24. Saksena P, Xu K, Durairaj V. The drivers of catastrophic expenditure: outpatient services, hospitalisation or medicines. World health report. 2010;1:21.
25. Rahman T, Gasbarro D, Alam K. Financial risk protection from out-of-pocket health spending in low-and middle-income countries: a scoping review of the literature. Health Research Policy and Systems. 2022 Jul 29;20(1):83.
26. Bonilla-Chacin ME, Hossain MR, Mahmud MS, Amin MN, Sarker MA, Sadat MA, Paul S, Ahmed S, Begum T, Smith O, Kumar A. Pathways to Reduce Household Out-of-Pocket Expenditure. Washington: World Bank; 2020 Aug. Available online: https://openknowledge.worldbank.org/server/api/core/bitstreams/8c1fa148-4247-543d-b164-305afb7a88df/content (accessed on 18 November 2024).
27. National Planning Commission. Research on Pharmaceutical Pricing Policies: Final Report, February 2020. Available online: https://www.nationalplanningcommission.org.za/assets/Documents/Pharmaceutical%20Pricing%20Policy_%20Report%20February%202020.pdf (accessed 28 December 2024).
28. Ziqubu S, Willie MM. Medical Schemes Benefit Option Entitlement Survey [Internet]. 2022 May. Available online: https://www.researchgate.net/profile/Michael-Willie/publication/361006051_Medical_Schemes_Benefit_Option_Entitlement_Survey/links/62977f13c660ab61f8583406/Medical-Schemes-Benefit-Option-Entitlement-Survey.pdf (accessed 3 November 2024).
29. Competition Commission of South Africa. Health Market Inquiry Final Findings and Recommendations Report. Government Gazette No. 42861, 29 November 2019.
30. Kaplan J, Ranchod S. Analysing the structure and nature of medical scheme benefit design in South Africa. South African health review. 2014 Jan 1;2014(1):165-79.
31. Goudge, J., Gilson, L., Russell, S., Gumede, T., &Mills, A. (2009): The household costs of health care in rural South Africa with free public primary care and hospital exemptions for the poor. Tropical Medicine and International Health, 14(4), 458-467.