Designing a healthy future

Strategic and Emerging Issues in the Medical Scheme Industry

First Southern African edition

July 2012

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Foreword

Welcome to the first edition of PwC's survey on Strategic and Emerging Issues in the Medical Scheme Industry. Our team of industry specialists is proud to present their work and we are convinced that the contents provide a comprehensive overview of the issues and challenges facing the industry today.

Looking ahead, the medical scheme industry can expect many challenges following the introduction of National Health Insurance (NHI), the demarcation between health insurance and medical scheme cover, and the constantly evolving regulatory environment. New member growth prospects and the sustainability of existing membership continue to be impeded by reduced consumer discretionary income and an increase in medical costs. The medical scheme industry in Southern Africa faces unique challenges and it is important that it evaluates and adapts to the needs of the emerging market.

We believe this survey will facilitate identification of issues and trends in order to allow Trustees to proactively plan to meet the challenges they face. The survey covers 53% of the industry in South Africa, based on principal members at 31 December 2010. We have identified the major trends, emerging issues and differences in opinions, which I believe you will find useful to benchmark and evaluate your scheme against.

The key objectives of this survey are to:

- Raise the awareness of medical schemes to emerging trends and issues in the Southern African medical scheme industry;
- Establish industry trends;
- Understand the strategic thinking of principal officers in the industry; and
- Provide insight into how the medical scheme industry might evolve over the next three years.

Key themes of this survey include:

- Scheme performance;
- NHI;
- Regulation; and
- Solvency and risk management.

I would like to thank the principal officers and executives who participated in the survey. We greatly appreciate the openness, insight and vision you have provided on key topics.

I trust that you will find this survey thought-provoking and insightful. If you would like to discuss any of the issues addressed in more detail, please speak to one of your contacts at PwC or those listed at the end of the survey.

Your feedback on the content of this survey would also be appreciated, as this will help us to ensure that we are addressing the issues on which you are most focussed.

Ilse French
Medical Scheme's Leader – Southern Africa
2 July 2012

Executive summary

Background

This inaugural survey focuses on strategic and emerging issues in the Southern African medical scheme industry and is first of its kind. While the survey aims to provide an industry-wide perspective, where meaningful, it also reports on the differences between restricted and open medical scheme participants.

The survey is based on the results of an online questionnaire completed by respondents. The questionnaire was completed anonymously by principal officers of 20 schemes registered in South Africa and one from Namibia.

This represents 53% of the South African industry, based on principal membership of 1 882 755 at 31 December 2010. The Namibian respondent represents 29% of the industry in that country, based on principal membership of 18 772 on 31 December 2010. The questionnaire took approximately one hour to complete and the survey was completed between February and April 2012.

Participant profile

The information provided has been considered proprietary and remains confidential.

The profiles of the 20 South African schemes that completed the survey are included below:

	Respondents	Total industry	Representation
Average principal members	1 882 755	3 582 008	53%
Gross contributions (R'000)	R51 698 112	R96 481 617	54%
Gross relevant healthcare expenditure (R'000)	R44 351 888	R84 912 234	52%

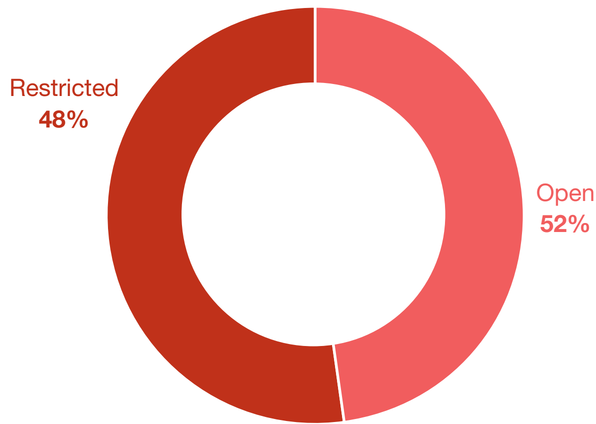
Source: Council for Medical Schemes Annual Report 2010/2011

The profile of the Namibian scheme that completed the survey is included below:

	Respondent	Total industry	Representation
Average principal members	18 772	64 546	29%
Net contributions (N$'000)	N$378 078	N$1 533 121	25%
Healthcare expenditure (N$'000)	N$302 395	N$1 283 065	24%

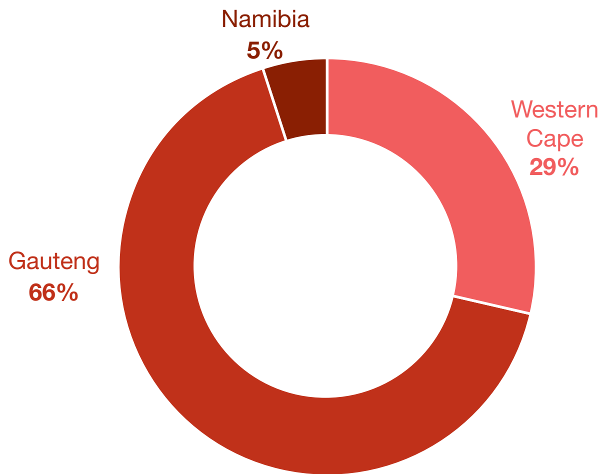
Source: Annual financial statements 2010/2011

Figure 1: Open or restricted scheme participation



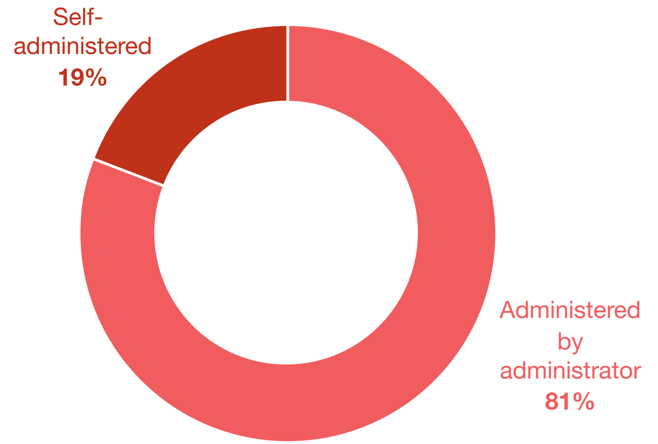
Base: 21 respondents

Figure 2: Headquarter location



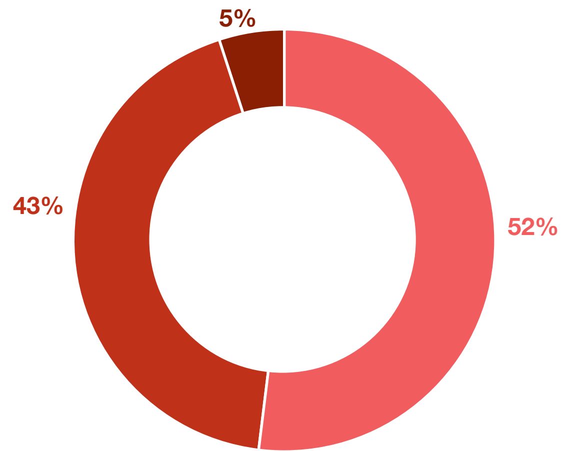
Base: 21 respondents

Figure 3: Management model



Base: 21 respondents

Figure 4: Scheme size



- Large ≥ 30 000 principal members
- Medium ≥ 6 000 principal members < 30 000 principal members
- Small < 6 000 principal members

Base: 21 respondents

Percentages quoted in this report are based on the number of respondents as a proportion of the total respondents of 21, or as otherwise indicated in cases where the question applies only to medical schemes in South Africa.

Survey at a glance

Scheme performance

- 71% of schemes had contribution rate increases of between 5% and 10% for 2012, with hospital and specialist costs driving these increases.
- Rising costs are managed by managed healthcare interventions, risk transfer arrangements and clinical risk management programmes.
- 90% of schemes think wellness programmes, disease and lifestyle management will reduce costs for the schemes.
- 57% of schemes said that an investigation by the Competition Commission into healthcare costs could be useful.
- 95% of respondents were of the view that Prescribed Minimum Benefits (PMBs) paid in full result in excessive benefits being paid by medical schemes.
- 76% of schemes do not believe that medical scheme trustees are over-compensated.

National Health Insurance (NHI)

- 60% of schemes believe that the current two-tier healthcare system is sustainable.
- All schemes are of the view that the provision of healthcare in South Africa is deteriorating.
- 55% of schemes do not think that the introduction of NHI will change the current state of health in South Africa.
- 65% of schemes believe that the medical insurance needs of members will differ in 2015.
- Increased access to healthcare and improved service delivery to the previously disadvantaged are some of the benefits schemes believe will result from the introduction of NHI.
- 60% of schemes believe NHI will result in more growth opportunities for the medical scheme industry.
- Retaining membership and affordability of cover are the key challenges the medical scheme industry will be faced with following the introduction of NHI.

Information-technology (IT)

- Managing data and data quality was identified by the schemes as the major technology weaknesses within the industry.
- Improved operational efficiency is considered the key benefit of investment in IT.
- Almost half of the schemes have considered the role of e-health in reducing costs and improving accessibility.

Regulation

- 70% of schemes expect the intensity of regulation of medical schemes to increase substantially over the next three years.
- The majority of schemes are of the view that the investment limits to which schemes have to adhere have an adverse impact on investment returns.
- 75% of medical schemes will see a decrease in solvency margins if personal member savings accounts are removed from the financial statements of the scheme.
- 80% of schemes have considered the impact of the Consumer Protection Act.
- The majority of schemes are concerned about the burden of regulation and believe the costs of regulation are detrimental to members' interests.

Solvency and risk management

- 81% of schemes believe that the current solvency margin calculation is inappropriate and support a more risk-based solvency approach.
- 62% of schemes are not in favour of the new international insurance contract accounting standard (IFRS 4 Phase II).
- The most important risks ranked by the schemes were membership movements, an aging risk profile and unhealthy members.
- Top-ranked risk challenges include member attitudes towards medical cover and compliance and regulatory requirements.

Market environment

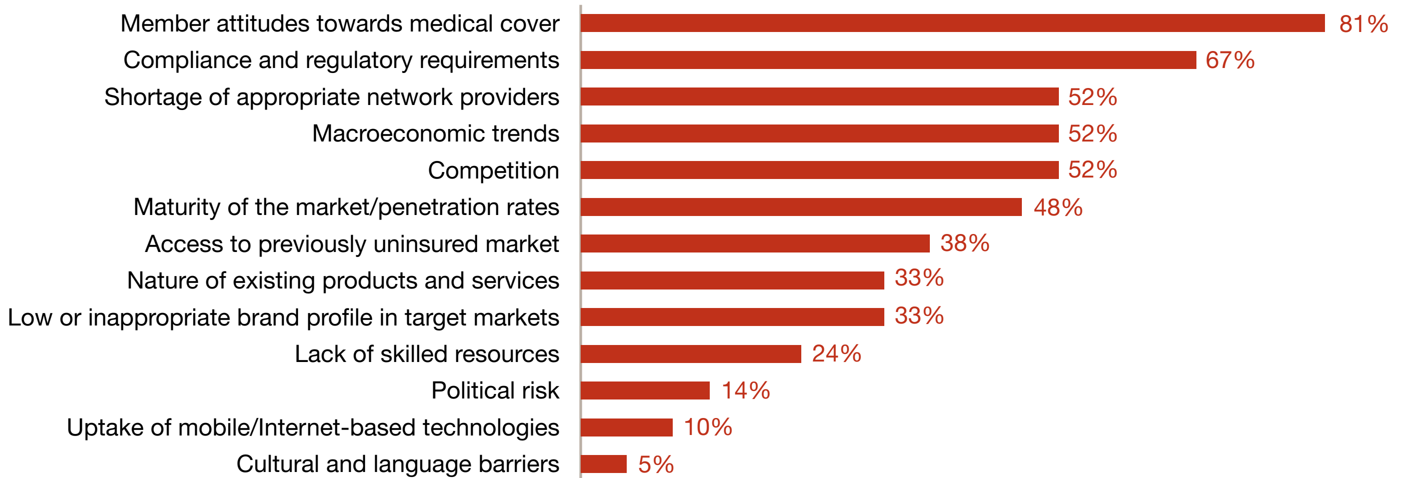
- Increased cost efficiency and bargaining power in tariff negotiation are some of the advantages of recent mergers in the medical scheme industry.
- Economies of scale are seen as the major driver of change in the medical scheme industry today.
- Healthcare costs were regarded as the most pressing issue.

Scheme performance

The last few months have seen the media spotlight focused on increases in medical scheme contribution rates and rising medical costs. There is no price regulation to guide the tariffs charged by service providers and schemes are of the opinion that this is to the schemes' detriment.

Q: What do you regard as the principal challenges that your scheme will face over the coming year in your key growth markets?

Figure 5: Principal challenges facing medical schemes



Base: 21 respondents

Only about 15% of the South African population has medical scheme cover and the lower-income market is likely to be a key growth market for most medical schemes.

Over 80% of schemes included member attitudes towards medical cover as a challenge in key growth markets. This may indicate that the target market may not realise the need for cover or not be willing to purchase cover and forgo alternate spending. This could also refer to the abuse of cover by members.

Compliance and regulatory requirements were also recognised as a significant challenge. One of these requirements is for all options to provide cover for PMBs. This requirement creates a barrier to entry as there is a minimum contribution schemes need to charge in order to provide PMBs. Individuals that cannot afford this are therefore unable to afford any cover.

A shortage of appropriate network providers was seen as a key challenge in growth markets.

Contracting with network providers allows medical schemes to provide benefits in a more cost-effective way as rates and contracts can be negotiated with these providers due to the increased volumes. Contracting with these providers is therefore a key tool in providing cover to the lower-income market.

Other challenges identified include macroeconomic trends, competition and maturity of the market/ penetration rates.

Important changes facing the medical scheme industry

Q: In your opinion, what are the most important changes/ developments taking place in the medical scheme industry at present?

Common changes and developments listed by schemes include:

- The establishment of NHI;
- The cost of providing PMBs;
- Increasing healthcare costs;
- Balancing affordability of cover for members with comprehensive benefits; and
- Over-regulation and regulatory compliance.

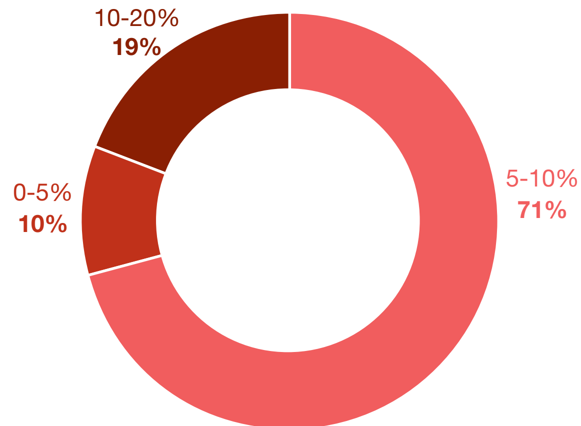
Most of the issues noted above are discussed in more detail in the sections on NHI, solvency and risk management, and regulation.

Q: Identify the three major strengths and three major weaknesses of the Southern African medical scheme industry at present?

Strengths	Weaknesses
Private healthcare services and managed care The high quality of care provided by service providers in the private sector was identified as a major strength. The private sector in South Africa is highly developed. The benefits of this to schemes include higher member satisfaction and lower future cost of claims in cases where adequate care is provided. Managed care was also included in the list of strengths. Managed care arrangements, when used effectively, can assist schemes in providing quality care in a cost-effective way.	**Affordability of contributions and high increases in the cost of medical care** Medical inflation in South Africa is in excess of consumer price inflation. Reasons for this include a shortage of medical practitioners/specialists. Scheme contribution rates therefore have to increase at an unsustainable rate. The requirement to include PMBs in all benefit options creates a barrier to entry in that it is difficult for schemes to offer more affordable lower-cost options.
Systems Some schemes listed the systems of schemes (IT, administration and other) as a strength. This indicates that schemes have dedicated substantial resources to developing adequate systems. The benefits of this include faster claims processing and better quality data for pricing, monitoring and risk management.	**Over-regulation** Excessive regulation and regulatory intervention were cited by many participants as a weakness for the schemes. The cost of compliance as well as the restrictions enforced by regulations reduce the medical schemes' ability to manage the affordability of contributions.
Good governance Good governance was identified as a strength in the industry. Good governance results in members' best interests being considered in all areas. It also results in the efficient management and operation of schemes.	**Lack of national tariff list** There is currently no national tariff list used by all schemes. Each scheme therefore compiles its own list of scheme tariffs. This lack of consistency results in providers charging different rates and results in a lack of transparency in healthcare costs.

Q: What was the overall increase in contribution rates in your scheme for 2012?

Figure 6: Increases in contribution rates



Base: 21 respondents

Fifteen out of the 21 schemes had 2012 contribution increases in the 5-10% range.

Only two schemes had an increase of less than 5%, while the remaining four implemented increases in excess of 10%.

Q: What is your estimate of the annual growth in contribution rates (%) in your scheme for 2012 and per year over the next three years?

On average, the schemes estimate that their contribution rate increase will remain stable at around 8.8% for the next three years. From the 21 responses received, the average increase for open schemes was 9.1% and 7.8% for restricted schemes. This is consistent with the increase in contribution rates for 2012, as the majority of increases were between 5% and 10%.

The stable rate of increase reflects the perceived stability in the rate of medical inflation as well as regulatory and competitive pressures to keep the contribution rates as low as possible.

The challenge to attract new and lower-income members to schemes also contributes to stable levels of annual increases.

Since the average rate of increase is above both the projected price and projected salary inflation, it is unlikely that this rate of increase will be sustainable in the future. As medical scheme contributions make up an increasingly higher proportion of individuals' incomes, the affordability of medical cover decreases. This may result in a 'buy-down' in respect of medical cover and healthcare costs will need to be managed more efficiently in order to avoid this.

Q: What was the most significant factor that contributed to the contribution rate increase?

More than two-thirds of respondents attributed the increase in contribution rates to increases in hospital and specialist costs. Only three schemes cited changes in membership profiles and the ageing demographics of the schemes' membership as reasons for the increase in contributions.

Q: How did your scheme manage the rising costs, specifically the impact on contribution rates and benefits?

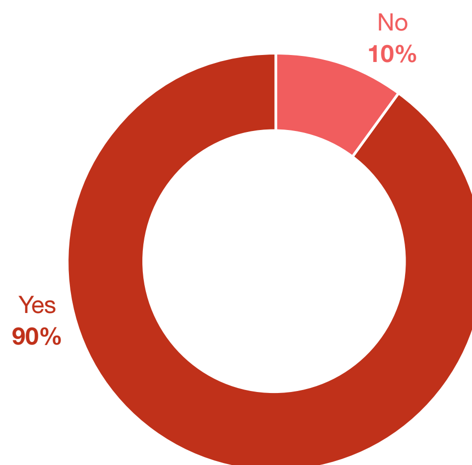
Most schemes revisited their cost structures. Some of the revisions include the following initiatives:

- Managed healthcare interventions (29%);
- Negotiated more favourable terms with major service providers (24%);
- More rigorous claim assessment to identify fraudulent claims (10%);
- Risk transfer arrangements (10%);
- Clinical risk management programmes (10%); and
- Actuarial analysis of benefits provided and restructuring of these benefits (10%).

Three schemes utilised income on investments to subsidise risings costs, while one scheme was addressing spend on non-healthcare costs.

Q: Do you think that making wellness programmes, disease and lifestyle management part of your product offering will reduce costs for your medical scheme?

Figure 7: Potential of wellness management programmes to reduce costs

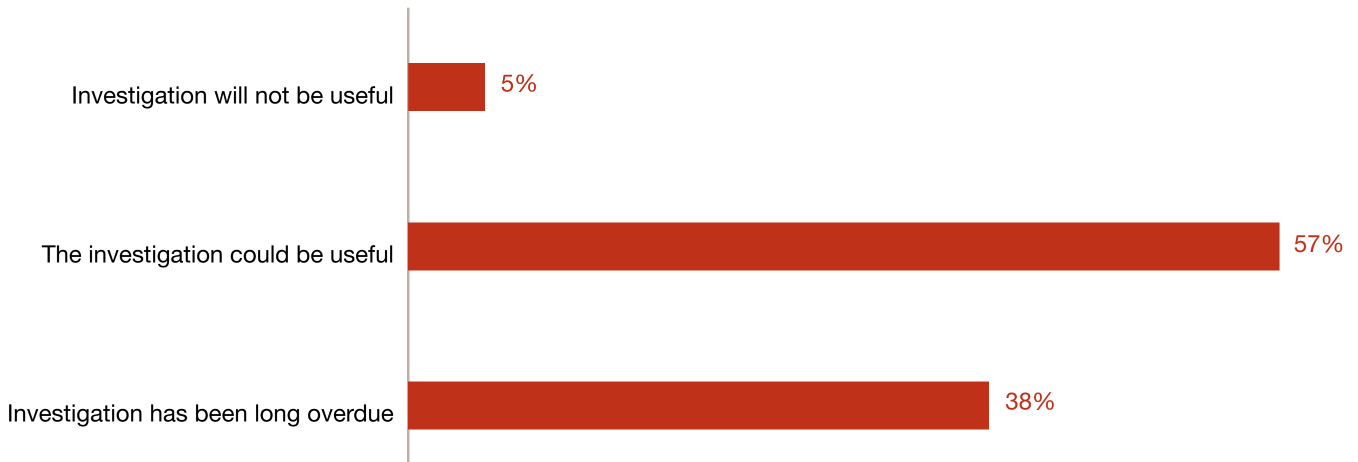


Base: 21 respondents

Ninety percent of schemes believe that wellness programmes as well as disease and lifestyle management initiatives will reduce costs for schemes. With the technology available today, schemes can use interoperable devices, real-time integrated data and embedded intelligence within an engaged social community to support patient behavioural change and improve outcomes. Preventive services such as physicals, health-risk assessments, biometric screenings and management of chronic conditions can contribute to a reduction in costs for schemes.

Q: The Competition Commission recently announced that it was considering an investigation into healthcare costs. Would such an investigation be overdue or not?

Figure 8: Competition Commission investigation of healthcare costs



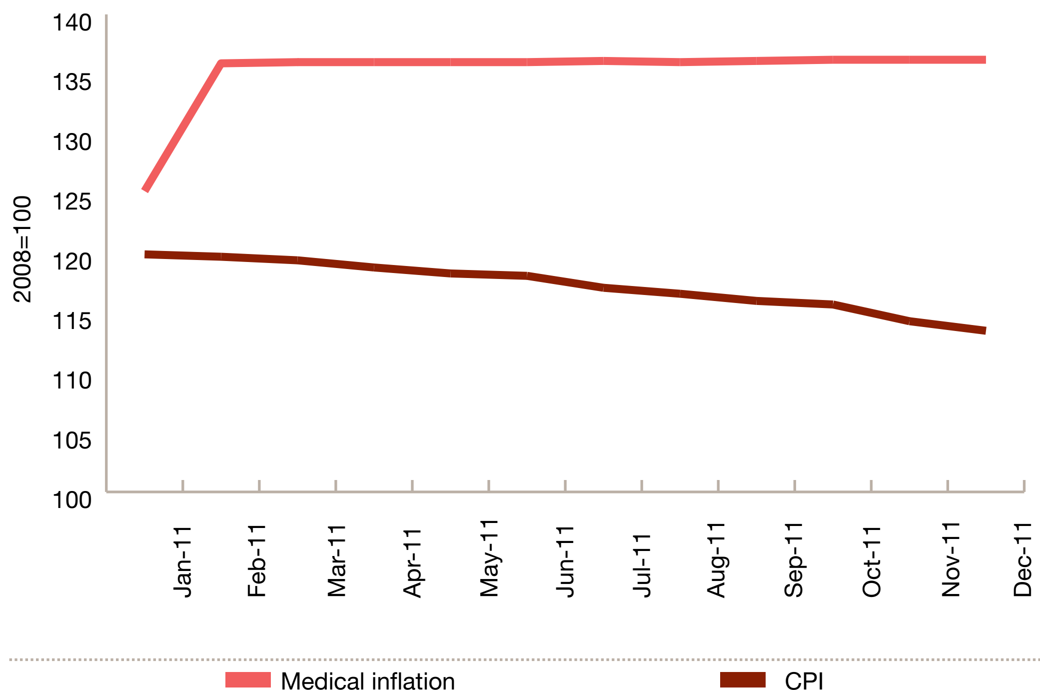
Base: 21 respondents

Fifty-seven percent of schemes are of the opinion that an investigation could be useful, while 38% believe that such an investigation is long overdue. Currently there is no healthcare cost pricing regulation that regulates provider pricing. Members and schemes are therefore not protected by a regulated set of tariffs. As a result of this, members and schemes are exposed to high provider prices.

This should be seen against the bakdrop that many schemes also feel that excessive tariffs are often charged.

As the graph below illustrates, there are significant variances between consumer price inflation (CPI) and medical CPI. Members often receive only CPI-linked salary increases, which in turn puts pressure on schemes to keep increases as low as possible.

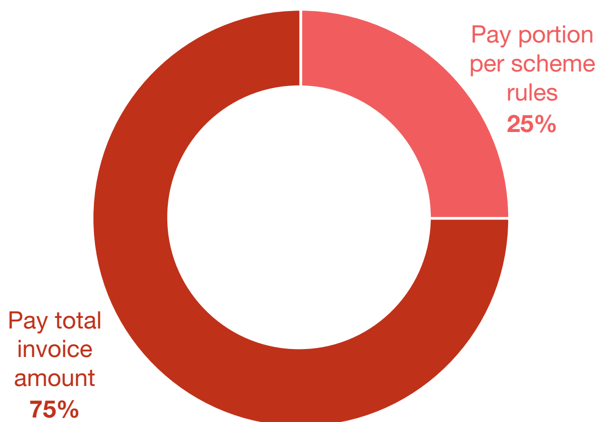
Figure 9: CPI vs Medical inflation



Source: Statistic South Africa

Q: In respect of PMBs, does your scheme pay the full invoice amount for the PMB treatment or the amount per the approved scheme rules?

Figure 10: Payment level for PMB treatment

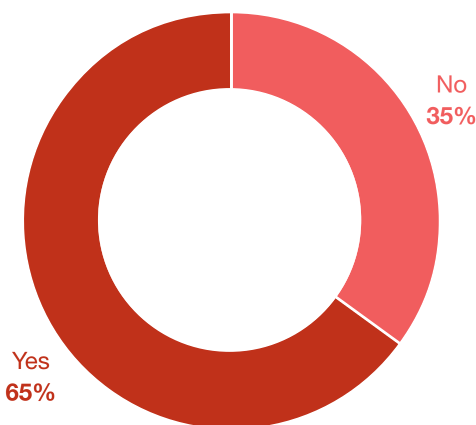


Base: 20 South African respondents

A disagreement has arisen in the medical scheme industry since the Council for Medical Schemes (CMS) enforces its interpretation that 'pay in full' in terms of Regulation 8: Prescribed Minimum Benefits, means payment in full to the healthcare service provider on invoice and not payment in full in terms of the rates of the benefits of the rules of the individual scheme.

Q: In respect of the payment of PMBs, has your scheme obtained an opinion on what the term 'pay in full' means per Regulation 8 of the Medical Schemes Act?

Figure 11: Legal advice regarding what 'pay in full' means

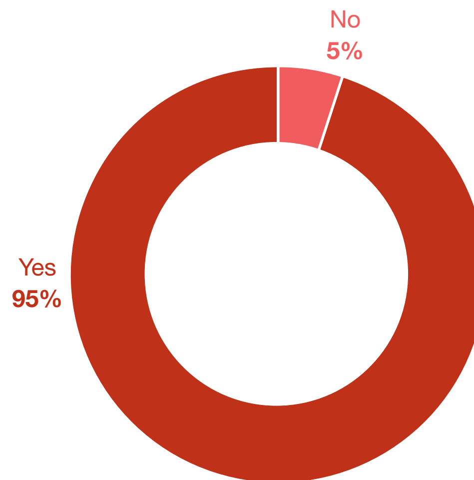


Base: 20 South African respondents

Thirteen out of the 20 South African schemes have obtained legal advice on what the term 'pay in full' means.

Q: In your view, does paying in full for PMBs expose the scheme to paying excessive benefits to the detriment of the members?

Figure 12: Financial exposure due to 'pay in full'



Base: 20 South African respondents

> *The NHI package of services and the Prescribed Minimum Benefits (PMBs) will be very much aligned and this will help members to make a seamless transition from medical schemes to NHI.*
>
> *Humphrey Zokufa, Chief Executive of the Board of Healthcare Funders of South Africa*

Only one scheme said that PMBs do not expose their scheme to paying excessive benefits, as the scheme has entered into provider network contracts.

Strong views were presented by the schemes that answered 'Yes', as they believe that schemes are exploited by excessive tariffs charged by service providers.

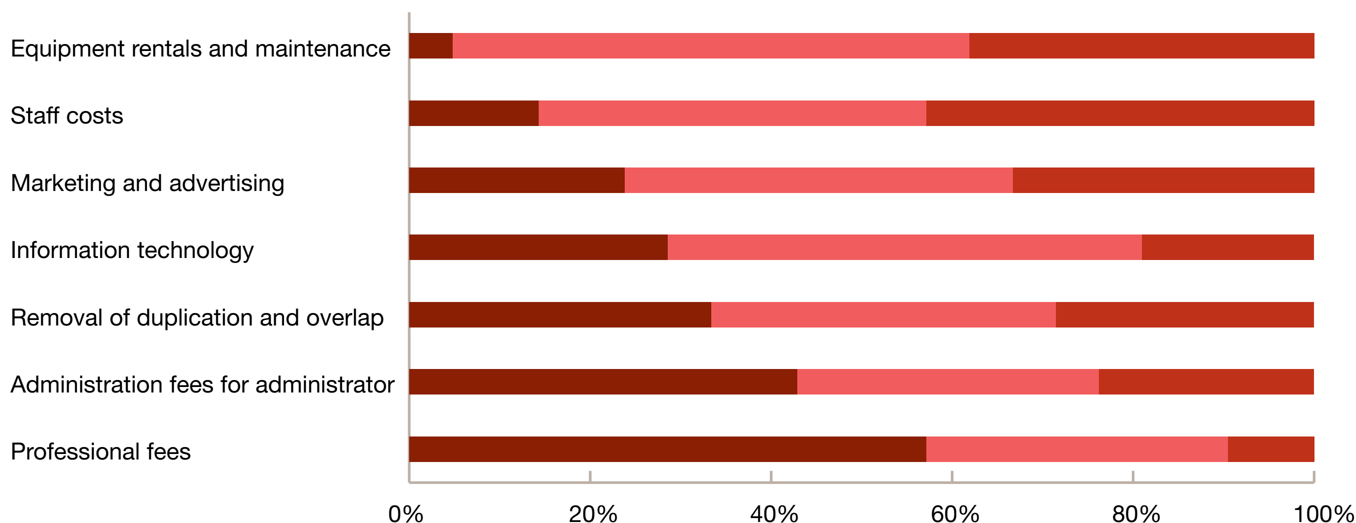
Some of the schemes have observed an increase in provider tariffs since the communication by the Registrar of Medical Schemes regarding PMBs.

They say claim tariffs submitted are in excess of scheme tariffs and that service providers exploit the lack of price control by ratcheting up costs, knowing that the schemes are obliged to pay.

Schemes say that the lack of price regulation is to the detriment of their members. As there is no control over what a provider can charge, members' benefits are at risk due to the unwarranted, uncontrolled expenditure which they believe often borders on unethical, unscrupulous behaviour.

Q: In consideration of the healthcare industry, where do you believe the greatest focus will be on cost management for the next three years? Please rank them in importance from 1 to 7 (1 = high; 7 = low).

Figure 13: Short-term cost management priorities



Base: 21 respondents

Figure 13 shows a mixed ranking of cost management priorities in the next three years, with the three top ranking considerations being:

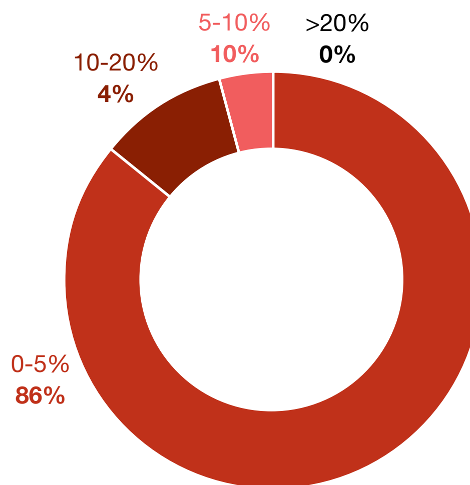
- Professional fees;
- Administration fees for administrator; and
- Removal of duplication and overlap.

The removal of duplication and overlap is a primary focus area. This is in line with the latest PwC Health Research Institute Consumer Survey (HRI survey) in which respondents identified data-related issues most important: filling out information multiple times, difficulty accessing health record information and repeating tests because information is not available and timely.

These inefficiencies provide opportunities to improve the medical administration system and capitalise on the savings.

Q: By what percentage do you perceive you can reduce current operating costs (non-healthcare costs), if at all?

Figure 14: Potential to reduce current operating costs



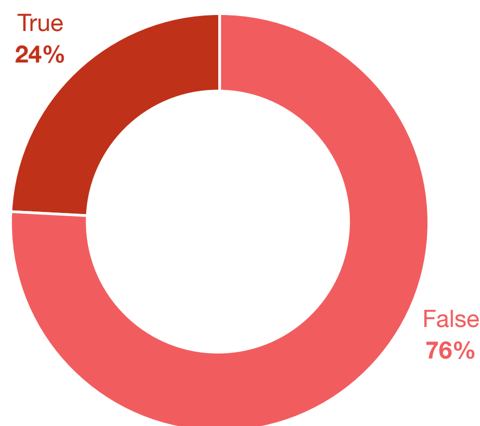
Base: 21 respondents

Eighteen schemes (86%) believe that cost savings of up to 5% can be achieved, while only three were of the opinion that they could cut operating costs by more than 5%. Ninety percent of open schemes were of the opinion that savings of up to 5% can be achieved while only 80% of restricted schemes shared that view.

In PwC's South African Insurance survey, released in June 2012, 48% of insurance companies were of the opinion that costs could be reduced by up to 5%. In contrast to this survey, 86% of medical schemes could reduce costs by up to 5%.

Q: A recent newspaper headline read 'Medical schemes trustees coining it'. Do you believe this statement to be true?

Figure 15: Remuneration of trustees



Base: 21 respondents

Medical schemes trustees coining it

Ten non-profit medical schemes in South Africa spent a total of more than R28m on salaries for trustees in 2010. The head of compliance and investigations at the Council for Medical Schemes (CMS), Stephen Mmatli, said payments to trustees had increased over the years in a 'concerning' trend. "The whole argument is that the bulk of your costs must go to healthcare, not lining your pockets." He told the newspaper that trustee remuneration was meant to be a stipend rather than a salary. Trustees' salaries were contributing to rising costs of medical aids. Being a trustee was 'now seen as a career', even though the duties of the position meant short meetings four times a year, he said. A recent CMS report revealed that the council wished to replace the entire board of two medical schemes who over-inflated trustees salaries, among other things.

The Times, 7/9/2011. 'Medical schemes trustees coining it'.http://www.fin24.com/Companies/Health/Medical-schemes-trustees-coining-it-20110907

A quarter of schemes believe that medical scheme trustees are 'coining it' and that certain schemes are over-compensating their trustees.

Three-quarters of schemes are of the view that schemes are highly regulated and that trustees have a fiduciary duty towards the governance of the scheme and should be remunerated for services rendered.

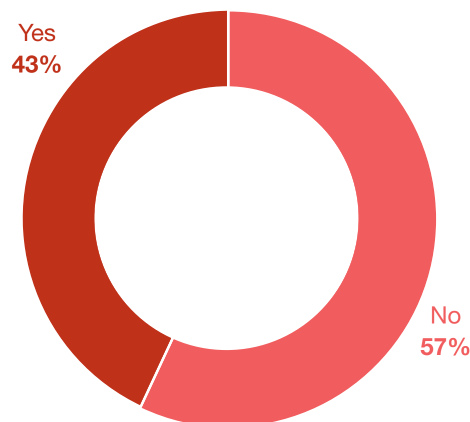
Seventy three percent of open schemes believed the above statement to be false and trustees are not over compensated whilst 80% of restricted schemes shared this view. Four of the schemes that participated in the survey did not pay any remuneration to their trustees.

Two schemes observed that trustees face significant risks and current remuneration is not sufficient for the risks that they are taking.

One respondent questioned the 50% member representation requirement and whether the members were best suited for the position.

Q: Do you think that medical schemes should be intermediated?

Figure 16: Use of intermediaries



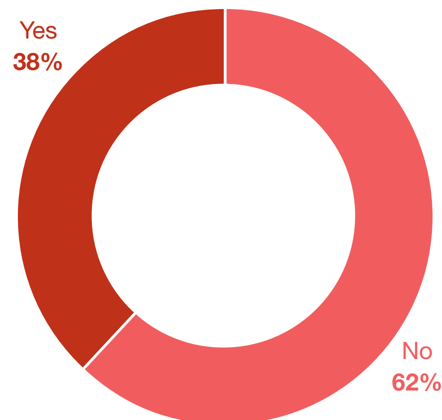
Base: 21 respondents

Twelve schemes (57%) believe that schemes should not be intermediated. Sixty-four percent of the open schemes were of the opinion that schemes should be intermediated.

Ten schemes did not make use of intermediaries, while the remaining 11 made use of the services of 15 062 brokers.

Q: Do you think that the cost of intermediation justifies the benefit to the member?

Figure 17: Value of intermediaries



Base: 21 respondents

Thirty-eight percent of schemes think that the cost of intermediation is justified by the benefit to the member of having expert guidance when choosing benefit options.

Thirty-eight percent of schemes think that the cost of intermediation is justified by the benefit to the member of having expert guidance when choosing benefit options. Since out-of-pocket expense risk could financially ruin a family, it is crucial that the appropriate benefit option be chosen to meet both their financial and healthcare needs. At the same time, they believe that brokers should have sufficient knowledge to explain important aspects of benefit options such as designated service provider networks and PMBs.

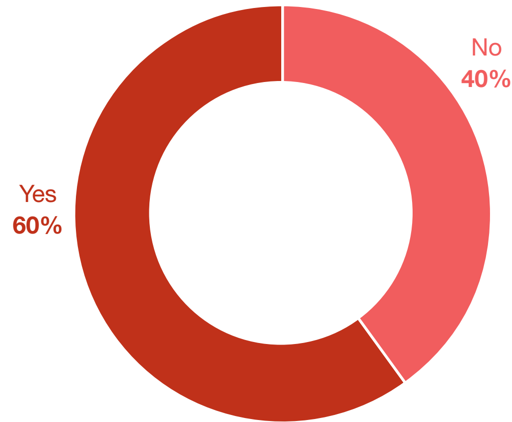
The 62% of schemes that were of the view that intermediation costs were not justified indicated that brokers did not provide the best advice and service to members.

National health insurance

NHI is a financing system that aims to ensure all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI fund.

Q: Do you believe that the current two-tier healthcare system (private and public) is sustainable?

Figure 18: Sustainability of the current healthcare system



Base: 20 South African respondents

> *Today, discrimination has been cleared and abolished by the constitution. Unfortunately, we discover that we still have two healthcare systems, which, this time, are no longer defined by law. It is not written anywhere, it is not allowed by the constitution, but it is there, and it exists… Whether you belong to one or the other is no longer determined by your colour, but by how much money you have in your pockets.*
>
> *Dr Aaron Motsoaledi, National Minister of Health*

There is no country in the world where healthcare is financed entirely by government. While the provision of healthcare is widely recognised as the responsibility of government, private capital and expertise are increasingly viewed as welcome sources to bring about efficiency and innovation.

What is less clear, however, is the appropriate balance of public to private resources in financing and managing healthcare. Debates on this topic include discussions about various structures that ensure the best possible return for both taxpayers and the private sector. One such structure is a public-private partnership (PPP).

Governments are increasingly looking to this model to solve larger problems in care delivery and wellness. As PPPs move from replacing crumbling inpatient structures to managing care delivery, the impact on overall costs is far more substantive and sustainable.

However, wrestling down the rapid pace of medical cost increases adds a higher level of difficulty and complexity. But PPPs can evolve to bend the cost curve.

Across the globe, these partnerships are being designed to make the government and private industry more accountable for maintaining each nation's most precious national resource: the health of its citizens.

Sixty percent of respondents are of the view that the current healthcare system is sustainable. Six schemes believe the NHI should play a vital role in providing sustainable healthcare to all South Africans and that there should be one integrated healthcare system.

Four schemes suggested that the two-tier system has been successful in many other countries and private healthcare is a choice people make. However, five schemes said that the public healthcare system is in distress because of overcrowding and strain in the public sector. They argued that an overhaul is urgently needed to provide effective healthcare to all South Africans.

Q: In your view, is the state of provision of healthcare in South Africa deteriorating?

All respondents answered 'Yes' to this question.

Asked if they think the introduction of NHI will change the current state of health in South Africa, 55% were of the opinion that the introduction of NHI will not change the current state of health. Their explanations for taking this view include:

- The Government has an obligation to provide healthcare and it currently does, however, not at the standard required, which is a managerial problem;
- Management of facilities, maintenance and appropriate budget monitoring and spending should be addressed prior to the introduction of NHI;
- NHI alone is not the solution, as working conditions need to be improved, primary care has to be revived, pharmaceutical distribution for state-owned facilities should be decentralised and a booking system should be introduced; and
- A total overhaul of basic resources should take place before NHI is introduced.

Fifteen percent of schemes said that NHI may change the current state of healthcare if proper management is introduced together with a concerted effort from government to eliminate waste and inefficiencies, and introduce the required skills and expertise to run the NHI system efficiently.

A quarter of the schemes agreed that the introduction of the NHI will change the current state of healthcare if it is implemented in accordance with the focus contained in the Green Paper.

Q: In your view, how will the medical insurance needs of the members of 2015 differ from those of today?

Thirty-five percent of schemes were of the view that members will move away from comprehensive cover to more essential hospital and specialist cover.

More than a third said that the insurance needs of members would not change between now and 2015.

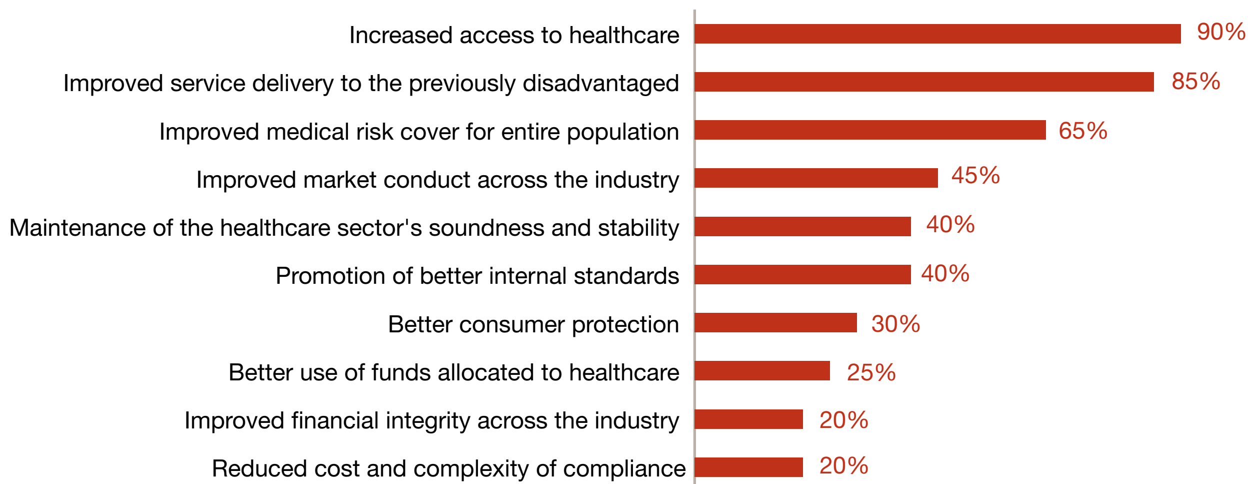
One in five schemes expect an increase in lifestyle chronic diseases, burden of disease, ageing population and obesity, which will result in higher medical costs.

One respondent suggested that if NHI is introduced, specific private system insurance will be necessary and should be introduced.

Another scheme recognises an opportunity to expand on current medical insurance products, as those citizens that can afford medical insurance products will have a need for more comprehensive cover and quality of care that the NHI might not be able to provide.

Q: Do you believe the NHI system will result in the following benefits for the healthcare industry?

Figure 19: Benefits of NHI



Base: 20 South African respondents

Figure 19 above records that the majority of participants believe that NHI will have the following benefits:

- Increased access to healthcare;
- Improved service delivery to the previously disadvantaged; and
- Improved medical risk cover for the entire population.

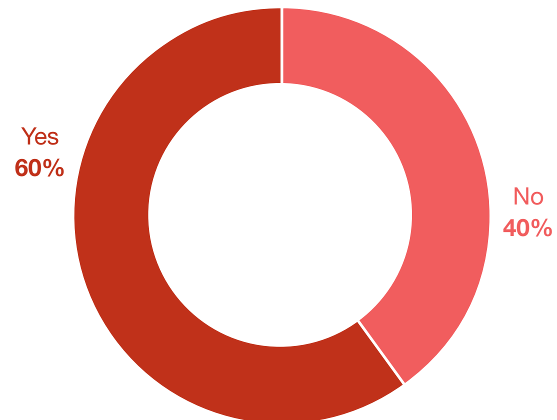
However, respondents did not believe that NHI will:

- Reduce the cost and complexity of compliance;
- Improve financial integrity across the industry;
- Result in better use of funds allocated to healthcare; or
- Lead to better consumer protection.

> *We must live in hope and action towards the delivery of sustainable healthcare for all.*
>
> *Survey respondent*

Q: Do you believe the NHI system will result in more growth and business opportunities for the medical scheme industry?

Figure 20: Opportunities from NHI



Base: 20 South African respondents

> *Even with a fully-developed NHI, there will still be supplementary health insurance products that will have to be regulated.*
>
> *Dr Monwabisi Gantsho, Registrar of the Council for Medical Schemes*

Respondents who answered 'Yes' to this question were then asked how they believe the opportunities opened up by NHI could be realised by the medical scheme industry.

There were a number of divergent responses and no common theme could be identified. These included:

- An increase in the use of private health insurance;
- Schemes should be working more closely with employer groups to provide quicker access to healthcare for employees;
- More innovative insurance products to retain and grow the private healthcare market; and
- Volume benefits as a greater portion of the population will be covered.

Q: What will the main impact on your product offering be with the implementation of NHI?

Impact	Responses
More innovative product offerings	9 of the schemes were of the view that benefit offerings would change as there will be a greater focus on more advanced care and services
Changes to product offerings	6 of the schemes were of the view that benefits might be reduced
No impact	3 of the schemes were of the view that there will be no change in product offerings
Insufficient information	2 of the schemes were of the view that there is not sufficient information on NHI to assess the impact on product offerings

Q: In your view, what will be the key challenges for the medical scheme industry following the introduction of the NHI? Please explain.

Five key challenges for the medical scheme industry were identified:

- Maintaining membership of younger and healthier members;
- Changes in conditions of employment of members, especially restricted schemes;
- Affordability of cover provided to members;
- Sustainability of current funding levels and cost structures; and
- Consolidation of medical schemes.

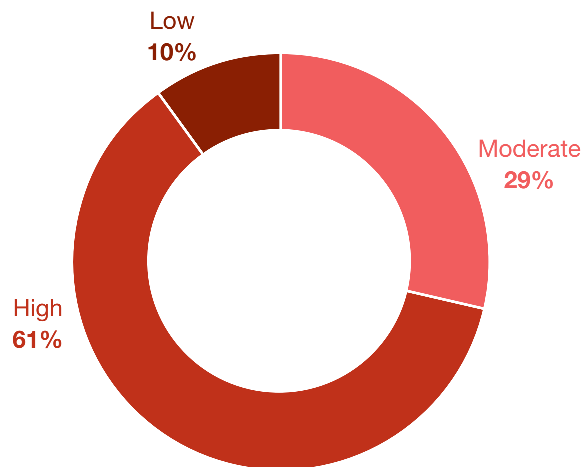
Market environment

The market environment has undergone significant changes in recent years with the number of schemes reducing drastically, which brought forth advantages as well as disadvantages. One such an advantage as identified by the survey respondents was the greater spread of risk in the risk pools of the schemes.

National Treasury released draft regulations on the demarcation between health insurance policies and medical schemes in March 2012 and this could have a significant impact on the market as the regulations provide an opportunity for insurers to enter the market with innovative products that meet the new requirements.

Q: What is your perception of the level of intensity of mergers and consolidation activity that is likely to take place in the medical scheme market, taking into account that the number of medical schemes has reportedly decreased from 124 in 2006 to 99 in January 2011.

Figure 21: Expected levels of merger and consolidation activity



Base: 21 respondents

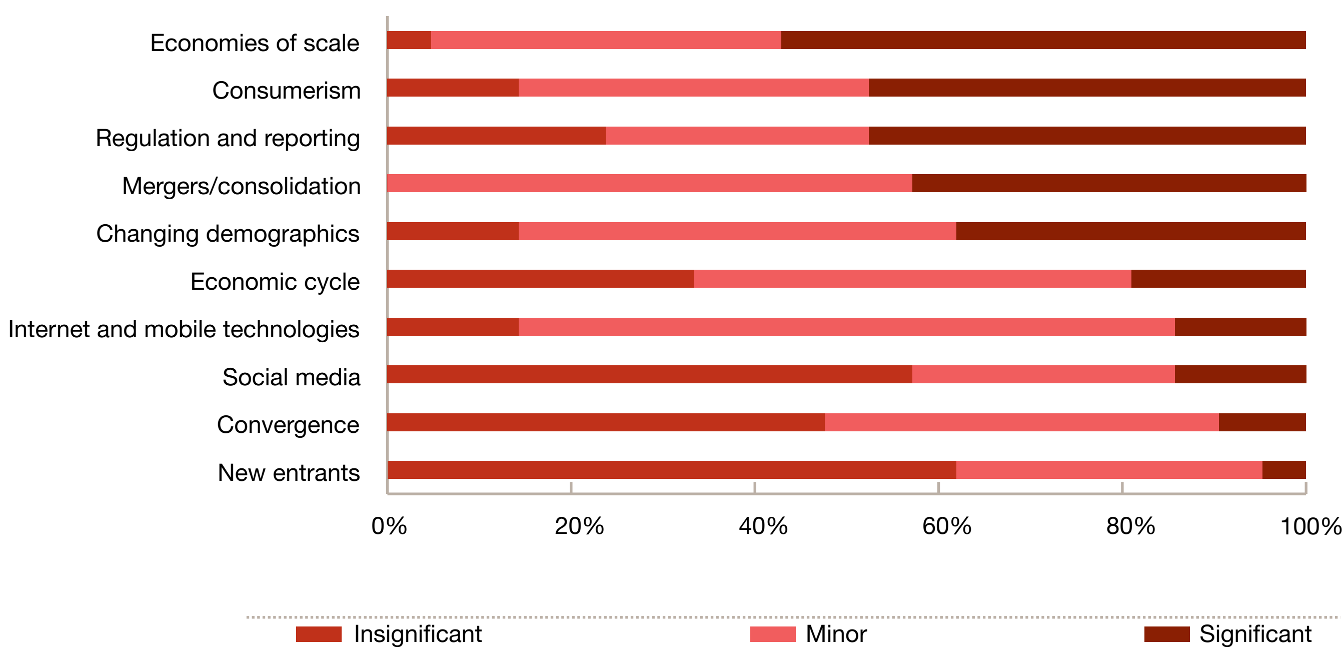
Q: What impact did mergers have on the medical scheme industry? Please explain.

Responses are summarised in the table below:

Advantages of the mergers	Disadvantages of the mergers
• Increased cost efficiencies; • Reduction of non-healthcare costs; • Consolidation and greater spread of risk in risk pools; • Stability and sustainability of schemes; • Bargaining power in negotiating tariffs with providers and introduction of networks; • Improved service quality; and • Bigger market and financial leverage.	• Undesired monopoly; • Larger schemes become larger; and • Reduces choice and flexibility for members.

Q: What do you see as the major drivers of change in the industry today?

Figure 22: Major drivers of change



Base: 21 respondents

The major drivers of change identified include:

- Economies of scale;
- Consumerism;
- Regulation and reporting;
- Mergers/consolidation; and
- Changing demographics.

Some of the insignificant drivers of change identified include:

- New entrants;
- Convergence; and
- Social media.

The growth of internet and mobile technologies was not identified as a likely major driver of change. This is in contrast to PwC's Health Research Institute Consumer Survey, in which mobile technologies was identified as the driver that holds greatest promise for keeping people healthy, managing diseases and lowering healthcare costs. Mobile devices can enable health and wellness to be delivered through mass personalisation.

Q: What are the most pressing issues facing your scheme?

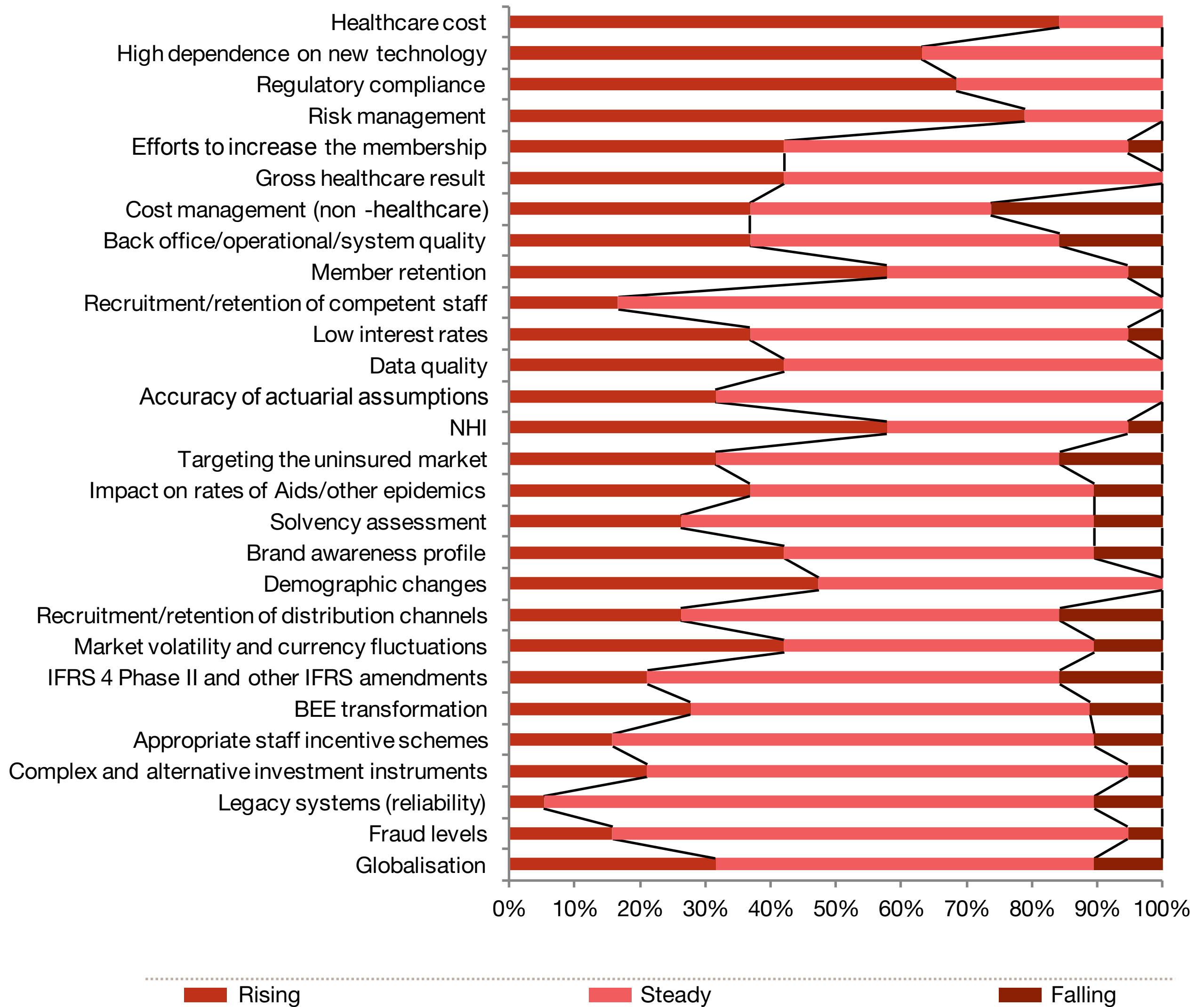
Figure 23: The most pressing issues

Base: 21 respondents

Schemes were asked to rank 28 pressing issues in severity.

Q: Are your most pressing issues rising, steady or falling in significance?

Figure 24: Trends in issues faced by schemes



Base: 21 respondents

Prominent rising issues	Prominent steady issues	Prominent falling issues
• Healthcare cost; • Risk management; • Regulatory compliance; • High dependence on new technology; • Member retention; and • NHI.	• Legacy systems (reliability); • Fraud levels; • Recruitment/retention of competent staff; • Complex and alternative investment instruments; • Appropriate staff incentive schemes; • Accuracy of actuarial assumptions; • Solvency assessment; and • IFRS 4 Phase II and other IFRS amendments.	• Cost management (non-healthcare); • Recruitment/retention of distribution channels; • Targeting the uninsured market; • Back office/operational/system quality; • Globalisation; • BEE transformation; • Impact on rates of Aids/other epidemics; • Brand awareness profile; and • Market volatility and currency fluctuations.

Information technology

Q: Identify three major technology weaknesses in the medical schemes industry

Schemes cited managing data and data quality as one of the major weaknesses within the industry. Good quality data is critical to designing appropriate price plans, managing solvency, estimating outstanding claims liabilities and managing and assessing benefits. Elements of data quality that require attention include managing data through a repository or warehouse and implementing and maintaining data quality processes.

An electronic health record is a systematic collection of electronic health information about individual patients or populations. A record is stored digitally and has the potential to be shared across different health care settings. Electronic health records may include data about the medical history of a patient including immunisation, pathology and radiology test results, and personal information. Exchanging such information must comply with data privacy legislation. Many schemes agree that the existence of an electronic health record would assist with the pricing of options and design of benefits, the assessment of treatment, providing managed care and administering preventative health care.

Member and beneficiary identification at point of service is seen as a challenge and is an area where fraud may occur. Smart cards could provide a solution to record details, including biometric information, to adequately identify a member and maintain an electronic health record.

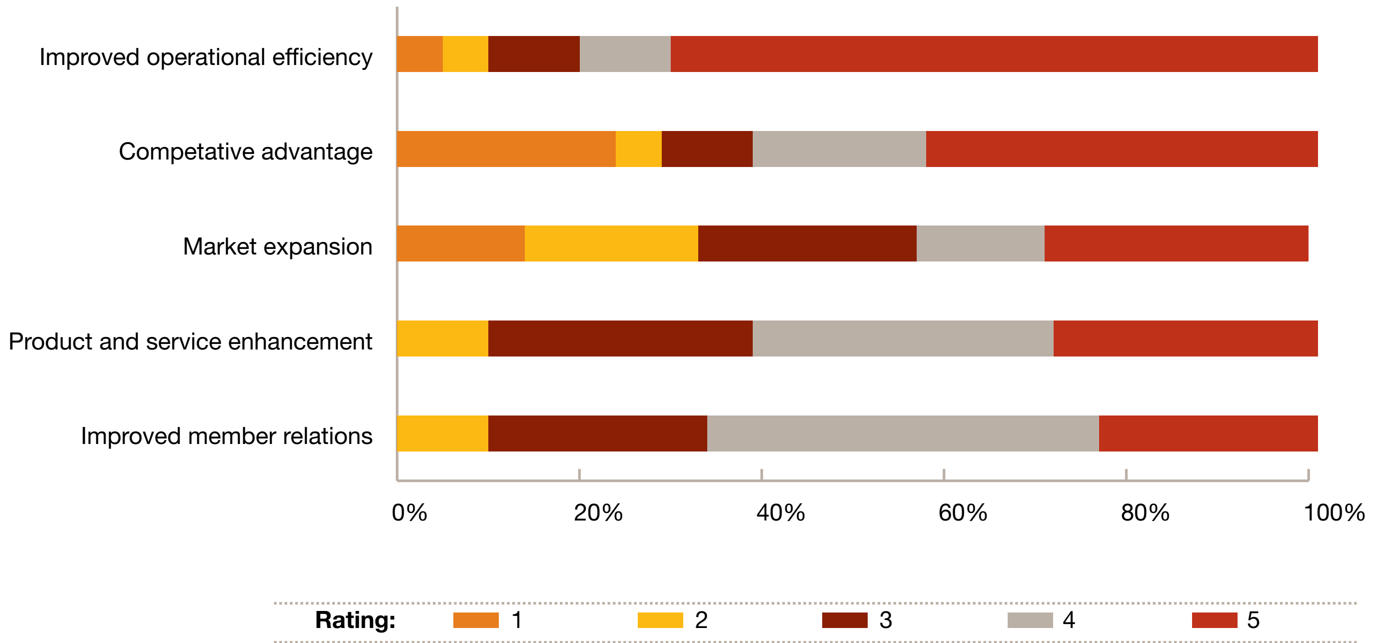
The medical scheme industry is reliant on straight-through processing to meet member service levels. Claims processing capabilities and connectivity with healthcare providers are seen as critical to the success of managing the benefit assessment and approval process. Many schemes feel that these areas will require improvement to meet service-level demands required in the industry.

Claims assessment is complex and systems are often not adequate to deal with clinical rules and provider fraud. Some schemes found the coding of PMBs on the ICD-10 coding system a challenge because it is based on the diagnosis code and not on the treatment applied. This makes it difficult to configure rules to assess the validity of treatments applied for PMBs.

There are, furthermore, a limited number of system service providers to choose from. The cost of technology is seen as a challenge, especially for smaller schemes as system cost is normally fixed and the cost per member may not be viable. Feedback from respondents was inconclusive in respect of the return on investment received from IT spend.

Q: What do you perceive to be the key benefits of your IT investment? Please score on a scale of 1-5, where 1 is of lowest and 5 is of greatest benefit.

Figure 25: Benefits of IT investment



Base: 21 respondents

Most schemes believe that their systems provide a competitive advantage compared to other schemes and administrators. Schemes also believe that their systems assist with improved operational efficiency and product and service enhancement. Some believe that systems can assist with market expansion through flexibility, scale and reach.

Q: Have you considered the role of e-health in reducing costs and improving accessibility?

e-health is a discipline at the intersection of information science, computer science and healthcare.

Almost half the schemes are confident that e-health can improve interactions between members and providers, especially in remote areas where people have mobile devices.

However, some have not considered the role that e-health can play in reducing costs and improving accessibility. Social media has been listed as an area to be explored in respect of communication with members.

Regulation

Regulation of the South African medical scheme industry is governed by the Medical Schemes Act and the Regulations thereto.

Respondents mentioned the burden of regulatory compliance in virtually every section of the survey. Schemes cite compliance and regulatory requirements as the second-biggest challenge facing the industry, with excessive regulation and regulatory intervention by the CMS cited by many schemes as a weakness in the industry.

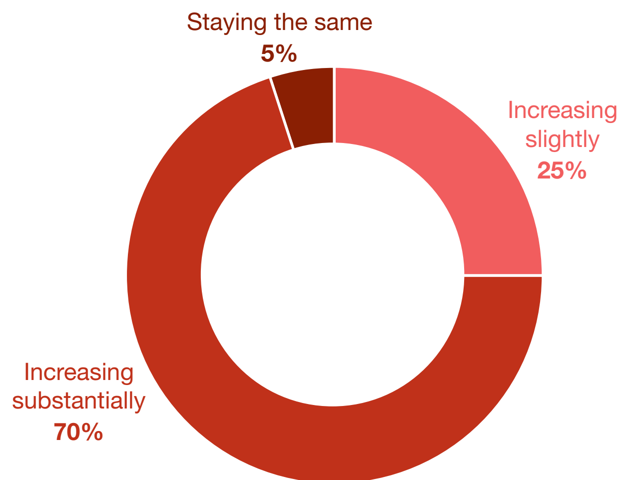
Seventy percent of schemes expect the intensity of regulation to increase substantially over the next three years. This is not unexpected given recent developments in respect of Regulation 8 on the payment of PMBs.

Circular 38/2011 and 5/2012 have implications for medical savings accounts and the more-recent draft regulations on the demarcation between health insurance policies and medical schemes will also have an impact. In addition, there have been numerous publicised interventions by the CMS in the affairs of schemes over governance issues as well as intervention by the Registrar of Medical Schemes and the Competition Commission in the provider market.

There is also an expectation that the Regulator will continue to monitor and impose new requirements across different parts of their operations. On top of these issues, NHI means that the operating environment has become more complex and unpredictable.

Q: How do you see the intensity of regulation of the medical scheme industry changing over the next three years?

Figure 26: Expected intensity of regulation



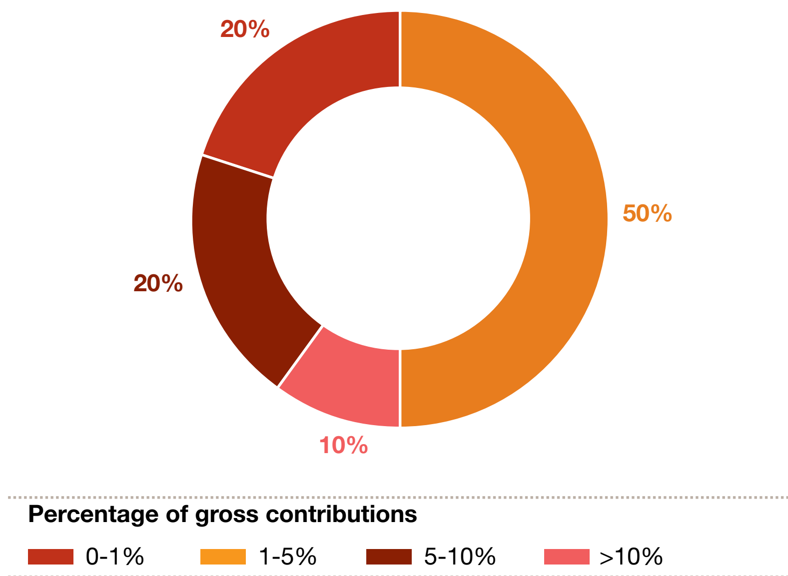
Base: 20 South African respondents

Seventy percent of schemes see the intensity of regulation increasing substantially over the next three years with only one of the view that it would stay the same. None believed it would decrease.

This is likely as a result of the impending Medical Schemes Amendment Bill as well as the increasing scrutiny of schemes by the CMS.

Q: In your view, what is the estimated cost to your scheme of implementation and annual compliance with the regulatory regime expressed as a percentage of gross contributions for the 2011 financial year?

Figure 27: Cost of regulation

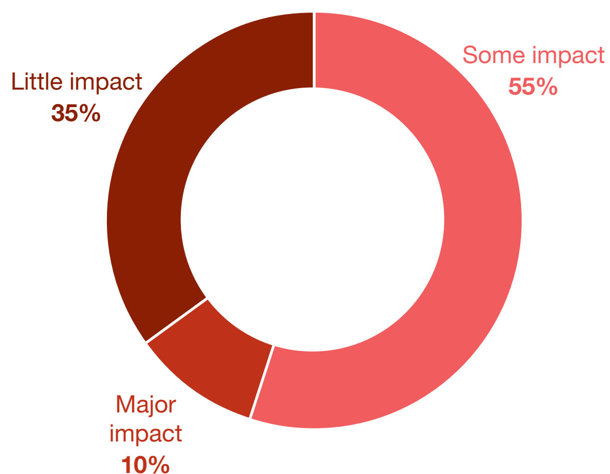


Base: 20 South African respondents

Half of schemes surveyed currently spend 1-5% of their annual gross contributions on compliance. This will increase if the expected increase in intensity of regulation materialises.

Q: Annexure B of the Regulations provides investment limits to which schemes must adhere. What is the impact of the limitation on the investment return that is earned by the scheme?

Figure 28: Impact of investment limits

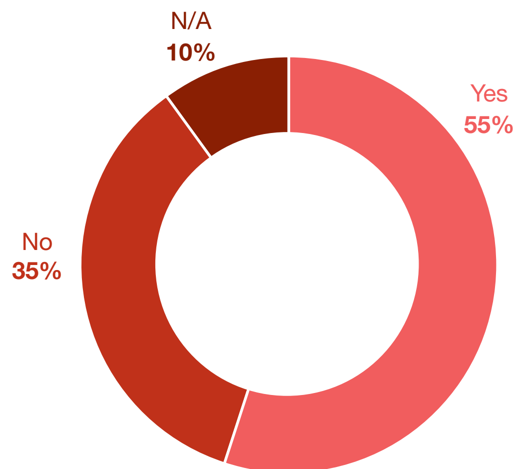


Base: 20 South African respondents

More than a third of schemes see Annexure B as having little impact on the investment returns of the scheme while the rest view this as having some or major impact. Comments received from those who believe there will be little impact, indicate that the limitations suit the industry by enforcing conservative investment policies on the schemes. Those who responded that the limitations had some impact, were generally in favour of the limitations, but noted that the restrictions do result in lower investment returns than would otherwise be possible.

Q: Circular 38 of 2011, issued by the Council for Medical Schemes, requires schemes to remove personal member savings accounts from the financial statements of the scheme. Does the scheme have the system and resources to adhere to these requirements?

Figure 29: Removal of personal member savings accounts from financial statements



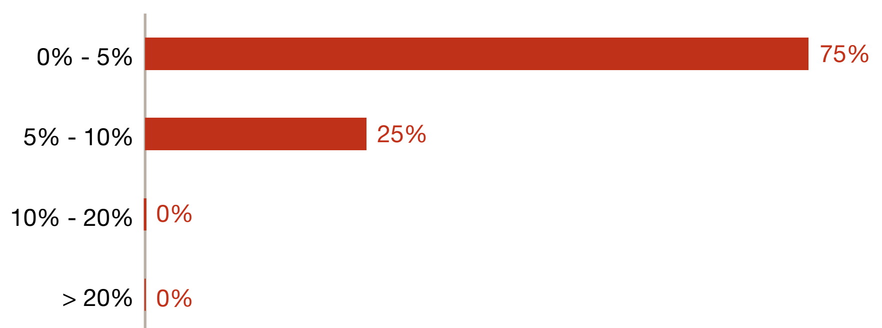
Base: 20 South African respondents

At the time of completing the survey, the industry was split over their readiness to comply with the requirements of Circular 38, with a small majority of the view that they do have the system and resources in place to comply.

Looking at the split between open and restricted schemes, it is evident that the restricted schemes are able to implement the requirements more easily, with only two out of eight responding 'No', whereas for the open schemes, five out of 10 responded 'No'. The other two schemes surveyed do not offer savings accounts.

Q: By what percentage will the current solvency margin of the scheme decrease as a result of the decline in investment income resulting from the requirements of Circular 38?

Figure 30: Decline in solvency margin



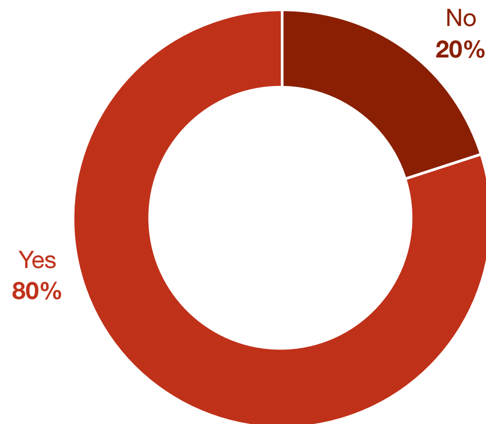
Base: 20 South African respondents

The majority of respondents indicate that the impact of Circular 38 on their solvency will be less than 5%. The impact on solvency is mainly as a result of schemes no longer benefiting from a portion or all of the investment returns earned on member savings balances with the full investment return on these funds being allocated to the members.

Sixteen of the schemes surveyed had members' savings accounts. Of these 12 were of the opinion that the impact on their solvency will be less than 5%, while the other four schemes were of the opinion that it will be less than 10%.

Q: Have you considered the impact of the Consumer Protection Act on your scheme?

Figure 31: Impact of the Consumer Protection Act



Base: 20 South African respondents

Eighty percent of schemes have considered the impact of the Consumer Protection Act on their scheme. A third of those who have considered it, cite changes in communication with members as the leading impact, followed by increased member complaints and challenges, which schemes need to defend, with a consequent increase in expenditure by the schemes.

One scheme commented that the Act does not apply to schemes based on the legal evidence they have seen. The schemes who have not yet considered the impact are likely awaiting the outcome of the CMS application for exemption from certain sections of the Act.

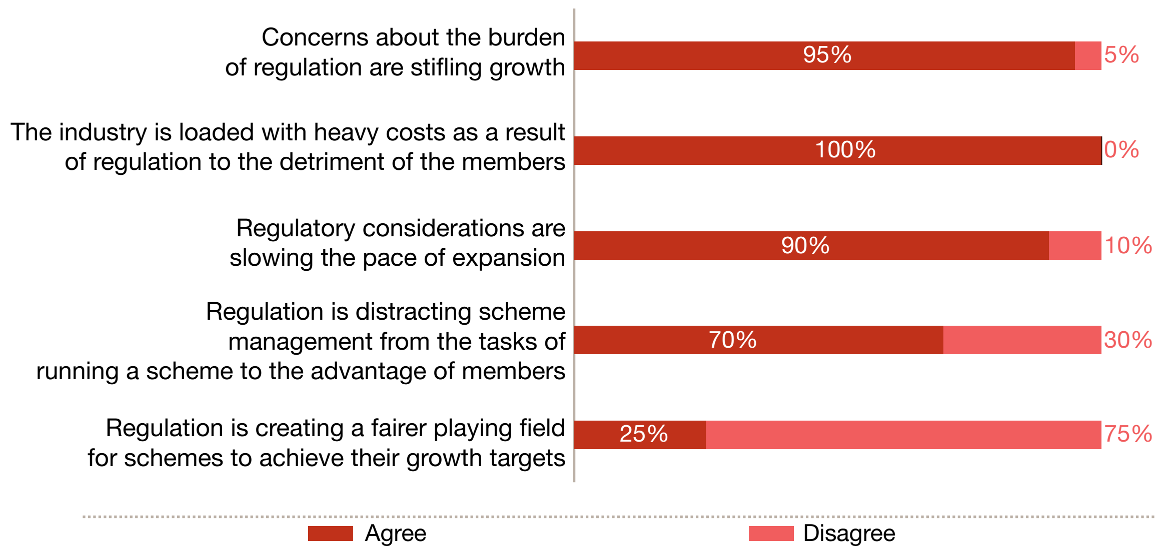
Q: What do you consider to be the main impact of the Protection of Personal Information Bill on your scheme?

More than a third of schemes commented that they do not see the Protection of Personal Information Bill having a big impact due to the confidentiality requirements in respect of member records that are already in force through existing legislation in the Medical Schemes Act and Regulations thereto.

However, just as many identified the likelihood of increased costs to ensure compliance, through additional monitoring and administration of personal information.

Q: Do you agree or disagree with the following statements about regulation?

Figure 32: Ramifications of regulation



Base: 20 South African respondents

It is evident from Figure 32 and the comments received that medical schemes believe the industry suffers from too much regulation. A number of schemes commented that there is a need for regulation in the industry, but that the extent of regulation and the manner in which it is enforced have led to detrimental consequences for the industry and ultimately the medical scheme members.

One example cited is the interpretation of Regulation 8 requiring payment of PMBs in full. Another is the failure of the CMS to introduce the Risk Equalisation Fund, which would have facilitated a fairer playing field for schemes.

Respondents believe the industry suffers from too much regulation.

Solvency and risk management

The solvency ratio of a scheme is calculated as the accumulated funds (excluding cumulative unrealised gains on investments) divided by gross annual contributions in respect of a particular accounting period. This measure does not allow for any risk transfer arrangements or for the individual risk profile and size of the scheme. It also does not take the asset profile of the scheme into account. Savings contributions are treated in the same way as risk contributions.

Weaknesses in the current manner in which the solvency ratio is calculated were strongly represented by the responses in the survey.

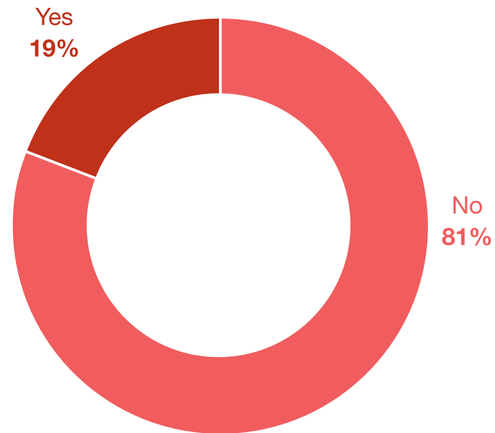
Medical schemes enter into insurance contracts with its members whereby on the occurrence of a health event the member is reimbursed for any loss suffered as a result thereof. Schemes may enter into risk transfer arrangements to transfer some insurance risks to a third party which mitigates the risk accepted under direct healthcare contracts by schemes.

The environment in which medical schemes operate in South Africa is distinct in that schemes cannot fully underwrite risks due to the regulatory enforcement of open enrolment and community rating. The measures schemes use to manage the risk profile of members is to include benefit limits, co-payments, exclusions on pre-existing conditions, clinical protocols, case management programmes and managed care programmes.

Due to the number of risks that schemes face, it is important that these risks are identified, monitored and managed. Unlike insurers, medical schemes are not required to calculate risk-based capital, but some schemes see it necessary to measure their risks and perhaps put in place mitigation techniques to reduce this risk.

Q: Do you believe that the current manner in which the solvency margin of a medical scheme is calculated is appropriate?

Figure 33: Appropriateness of solvency margin calculation



Base: 21 respondents

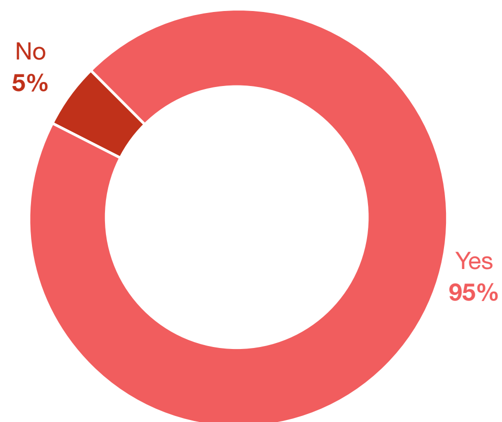
Eighty-one percent of schemes believe that the manner in which the solvency margin is calculated is inappropriate.

The main reasons given for this include the size, individual risk profile and other relevant factors relating to a scheme are not taken into account when the solvency margin is calculated.

The schemes that believe the current manner in which the solvency margin is calculated is appropriate said that this was a good indication of the overall good standing of the scheme.

Q: Would you support a more focused risk-based solvency approach?

Figure 34: Support for a risk-based solvency approach

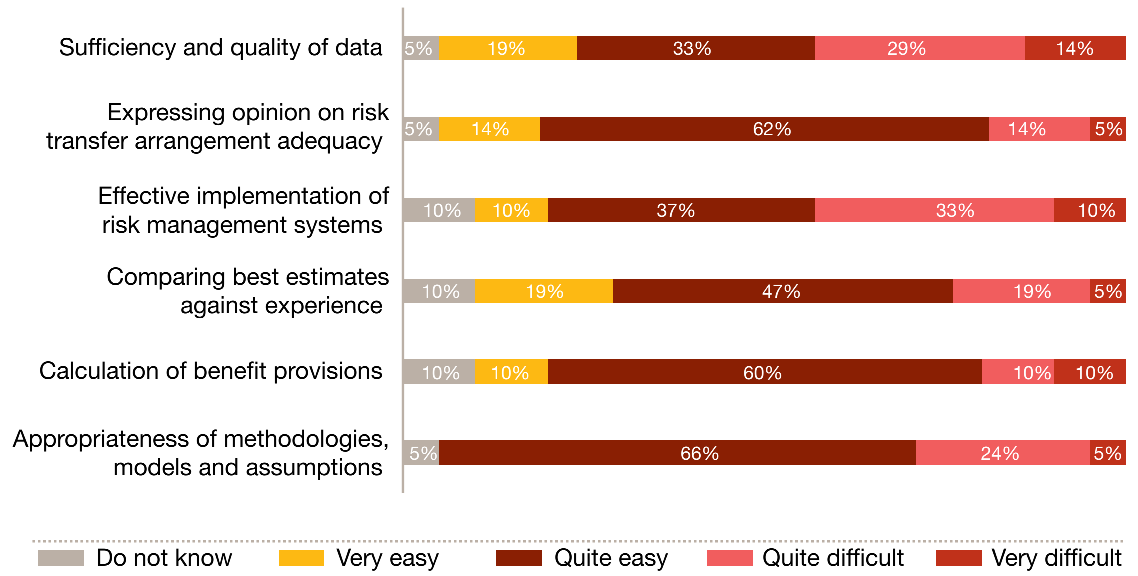


Base: 21 respondents

The 25% requirement is arbitrary and a risk-based measure should be used as this would provide more appropriate scheme reserves. While a risk-based approach is more complex, it would be a much better indicator of the solvency position of a scheme.

Q: In your view, how difficult will it be to implement each of the following actuarial functions if a more complex solvency assessment model is introduced for the industry?

Figure 35: Difficulty of implementing actuarial functions



Base: 21 respondents

The majority of schemes indicate that most actuarial functions would be very easy or fairly easy to implement if a more complex solvency assessment model is introduced.

A number of schemes indicate that sufficiency and quality of data could be a challenge if a more complex solvency assessment model is introduced. This is expected as a more complex measure will require more detailed data than currently used and may require an upgrade in systems. A possible solution to this would be for schemes to start collecting data that they anticipate will be required if such a model is introduced.

Q: Are you in favour of the IFRS 4 Phase II ('Insurance contracts') proposals for medical scheme contracts?

Sixty-two percent of schemes are not in favour of the new standard being proposed.

The implementation of IFRS 4 ('Insurance Contracts') Phase II is anticipated in 2015 and all schemes will have to comply with the requirements.

IFRS 4 Phase II has been in development for more than a decade and the Exposure Draft was published in August of 2010. According to the Exposure Draft the introduction of Phase II will illuminate the 'black box' of financial statements and provide all financial statement users and preparers, members, brokers, competitors and regulators with greater comparability and transparency about performance as a direct result of consistent measurement and presentation models.

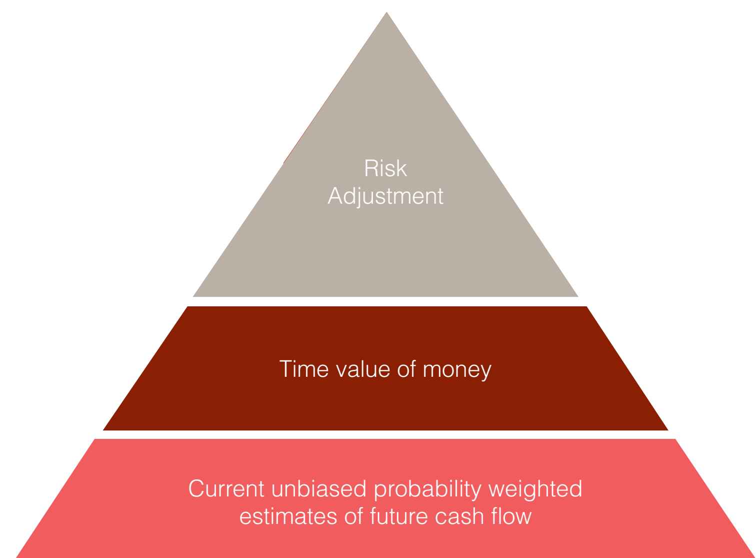
Q: Does your scheme have the capabilities to implement the proposed IFRS 4 Phase II?

The 'building blocks' below set out the measurement approach used to measure the schemes' claims liability.

The main areas of difficulty envisaged relates to measuring the mean cash flows for the claims liability as well as calculating an explicit risk adjustment. Systems, data and technical skill requirements will be challenging, as will assessing and communicating the adequacy of the liability.

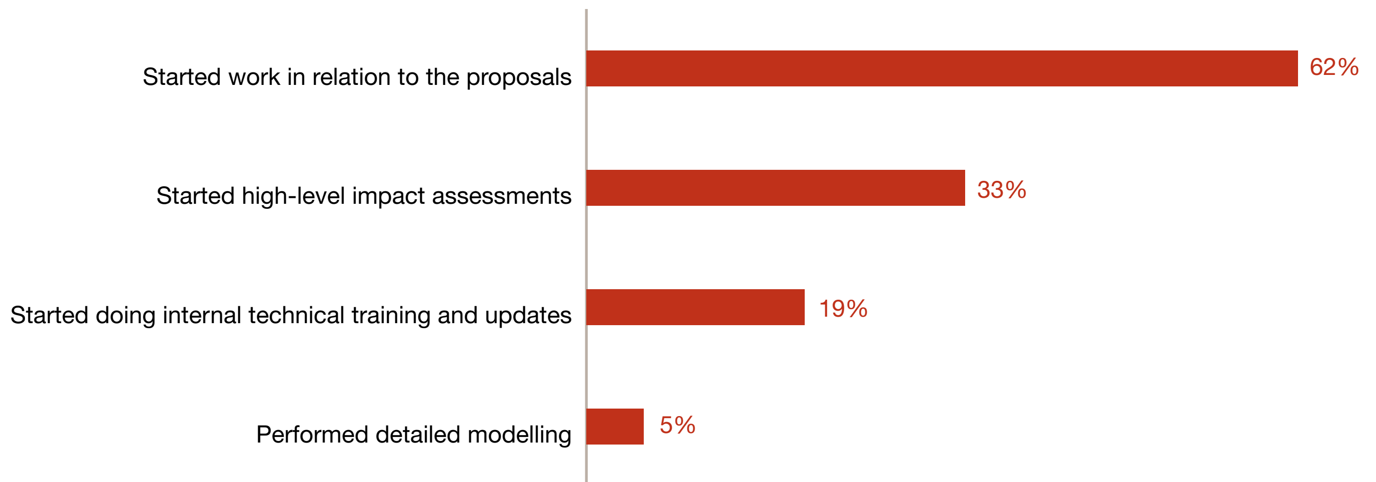
Fifty-seven percent of schemes indicate that they have the capabilities to address the challenge mentioned above. Forty-three percent of schemes will therefore need to improve systems, resources and skills in order to meet the requirements of IFRS 4 Phase II.

Proposed building blocks model for the measurement of claims liabilties



Q: Please indicate if your scheme is doing any of the following activities to prepare for IFRS 4 Phase II?

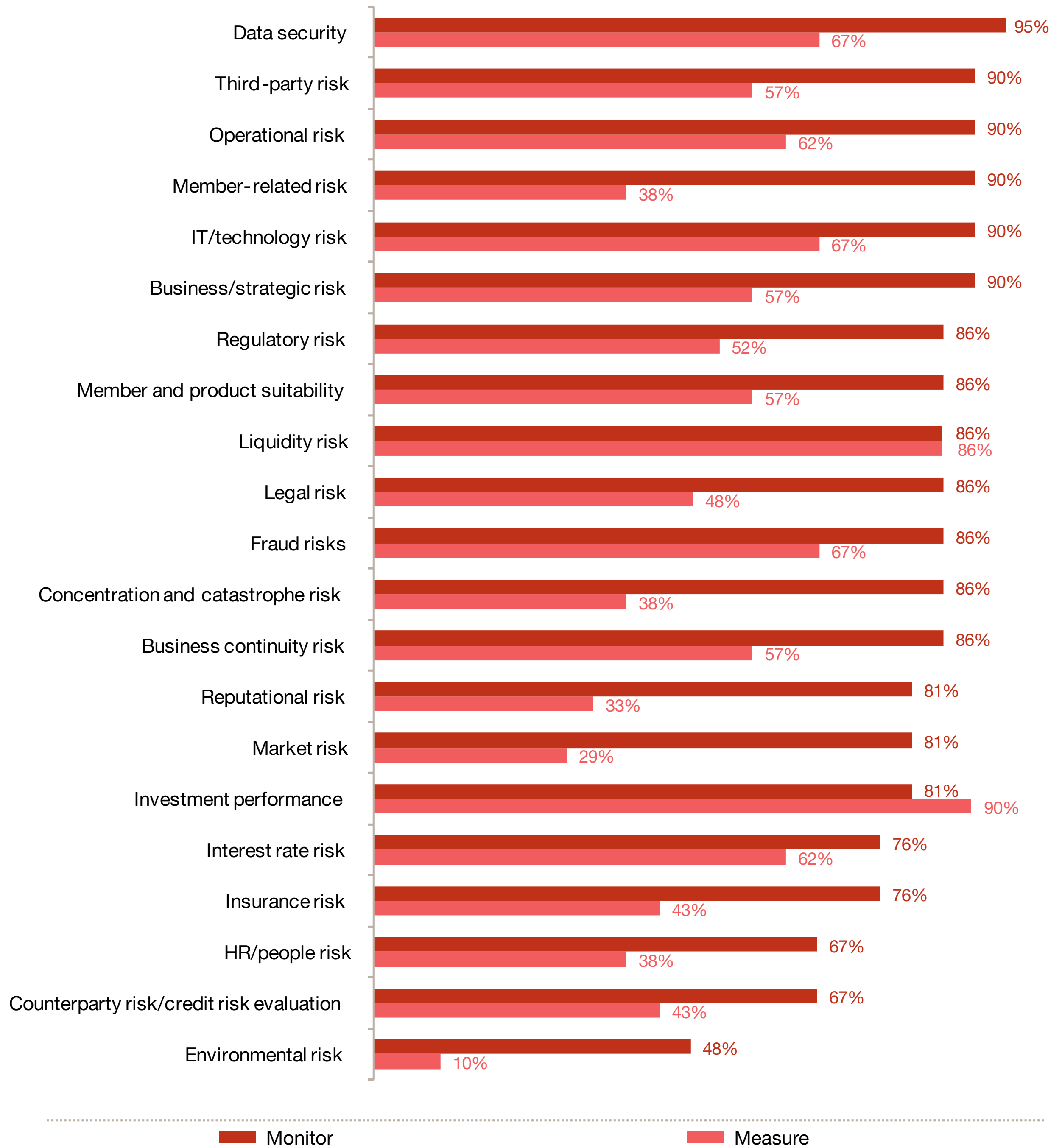
Figure 36: Preparation for IFRS 4 Phase II



Base: 21 respondents

Q: Does your scheme have processes in place to measure and monitor each of the following risks?

Figure 37: Processes in place to monitor and measure risk



Base: 21 respondents

Twenty-one types of risks were identified and schemes were asked to record which risks they monitored and to indicate whether they had metrics in place to quantify and measure these risks. Risks were sorted according to the percentage that monitored them. For example, 95% of schemes indicated that they monitored data security risk, making it the most monitored risk. However, only 67% of schemes measured this risk.

While a significant proportion of schemes do monitor the risks identified above, a smaller proportion of them actually measure the risk being monitored.

The top risks monitored by schemes are:

- Data security;
- Third-party risk;
- Operational risk;
- Member-related risk;
- IT/technology risk; and
- Business/strategic risk.

These concerns suggest that data quality is a priority for most schemes. This is because data is imperative to accurate pricing and risk management processes, which both significantly impact the operations and solvency of a scheme.

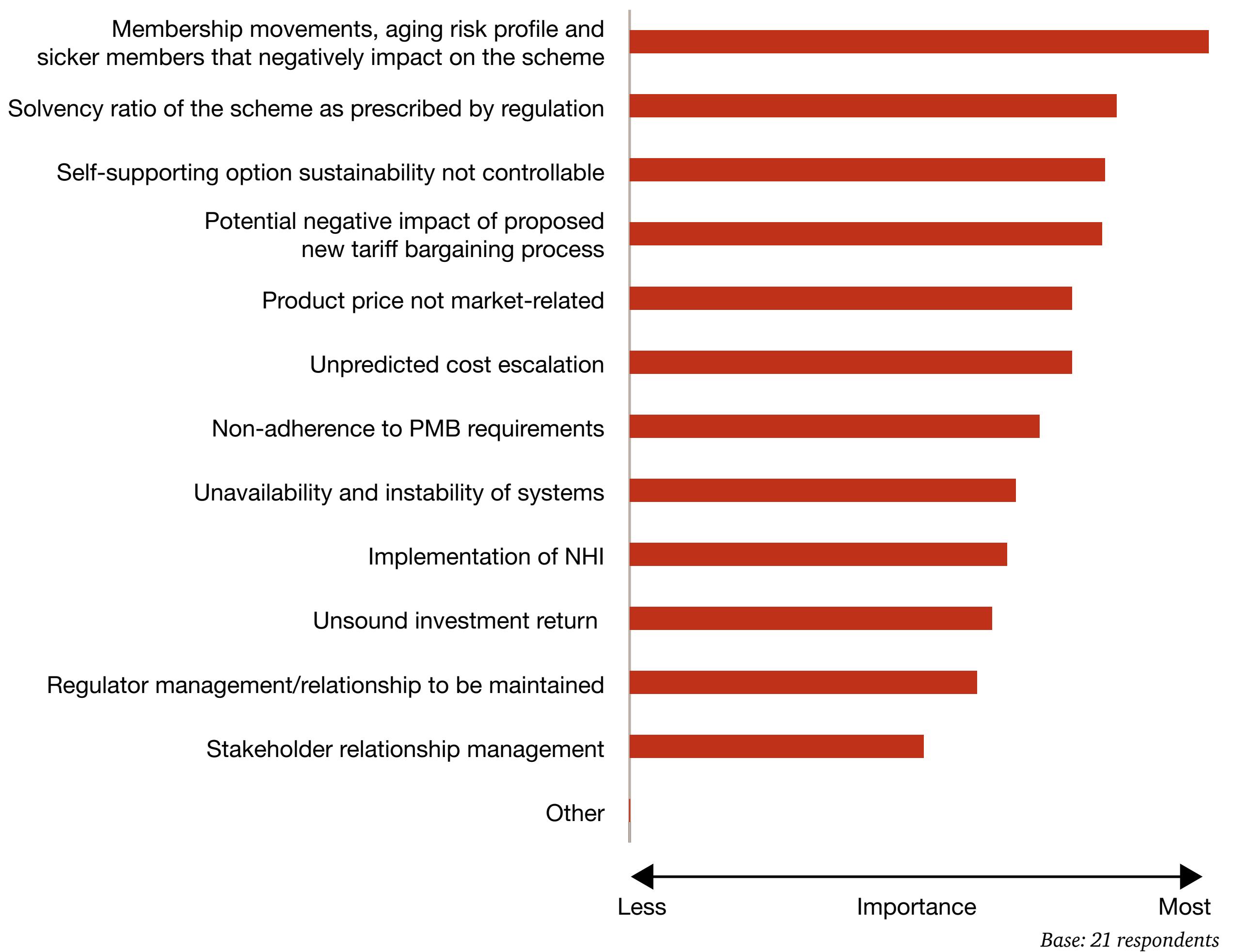
Schemes' third parties include outsourced service providers. Although risk is transferred to managed care service providers, these organisations do not have any regulatory capital requirements for this risk.

If a scheme has a contract with a service provider for the provision of benefits to its members and the provider is unable to provide these benefits, for example in the case of insolvency, the scheme is still liable for these benefits or services. It is therefore important for schemes to monitor their third-party risk exposure.

Operational risks include fraud and failed internal processes. Responses indicate that most schemes have measures in place to detect fraudulent behaviour.

Q: Below is a list of medical scheme-related risks. Please rate them in importance.

Figure 38: Medical scheme-related risks



Base: 21 respondents

It was found that the top three risks faced by the industry are:

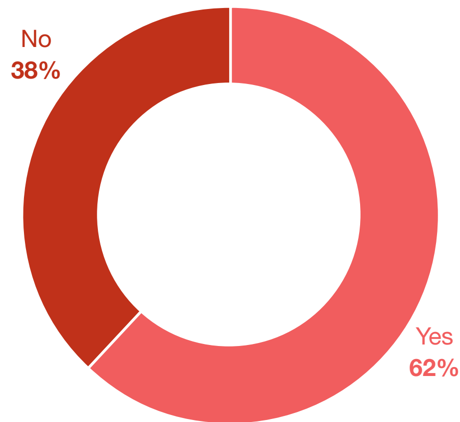
- Membership movements, ageing risk profile and sicker members that negatively impact on the scheme;
- Solvency ratio of the scheme as prescribed by regulation; and
- Self-supporting option sustainability not controllable.

The 'self-supporting option sustainability not controllable' relates to claims exceeding contributions in a particular option.

Some of the reasons for this could be the risk profile of members on an option being different to that assumed when pricing the option. As schemes cannot underwrite and price in accordance with members' individual risk profiles, this could represent a significant risk to schemes.

Q: Has your scheme entered into risk transfer arrangements?

Figure 39: Risk transfer



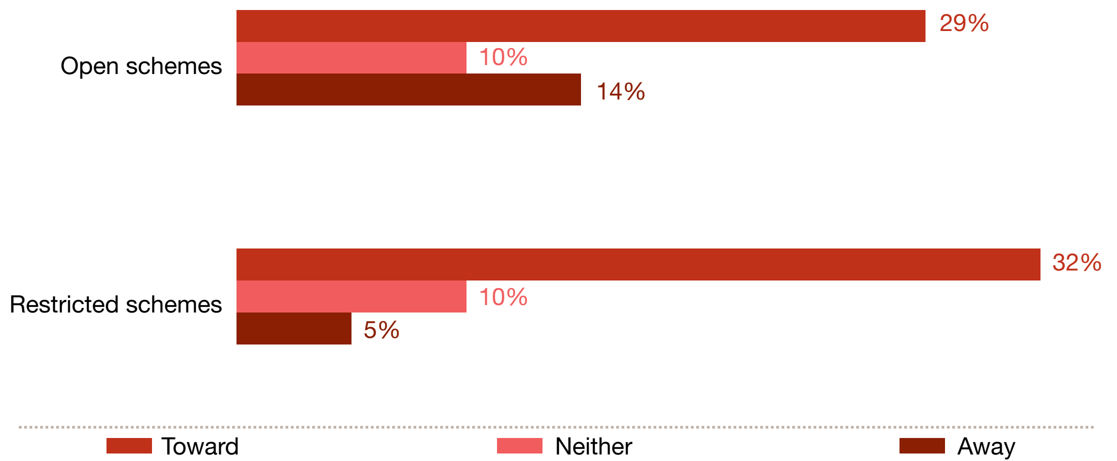
Base: 21 respondents

Currently 13 of the 21 schemes have entered into risk transfer arrangements.

Eight of these are restricted schemes and the remaining five are open schemes.

Q: Do you see a move towards or away from risk transfer agreements as part of your risk management strategy? Please comment.

Figure 40: Risk management strategy



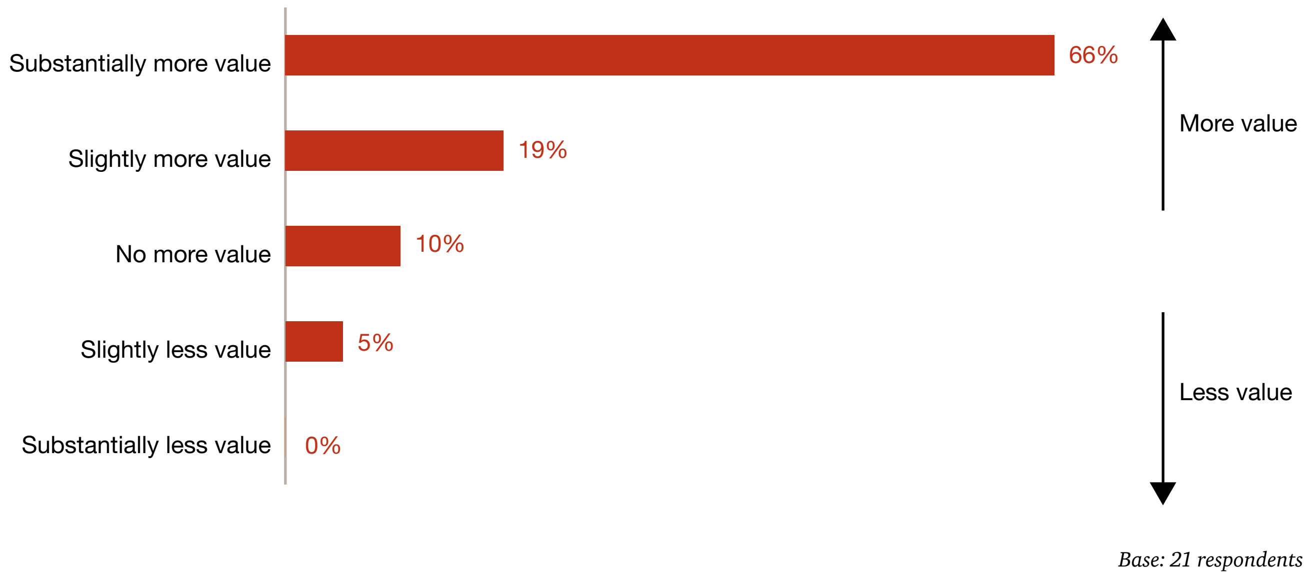
Base: 21 respondents

Approximately half of schemes indicate that a move towards risk transfer arrangements is anticipated. However, some schemes believe there would only be a move towards these arrangements for certain disciplines.

Four of the schemes said that a move away from risk transfer arrangements is likely because the costs of risk transfer arrangements outweighed the benefits.

Q: Is your scheme's risk management function adding more value to your business now compared to three years ago?

Figure 41: Value of risk management function



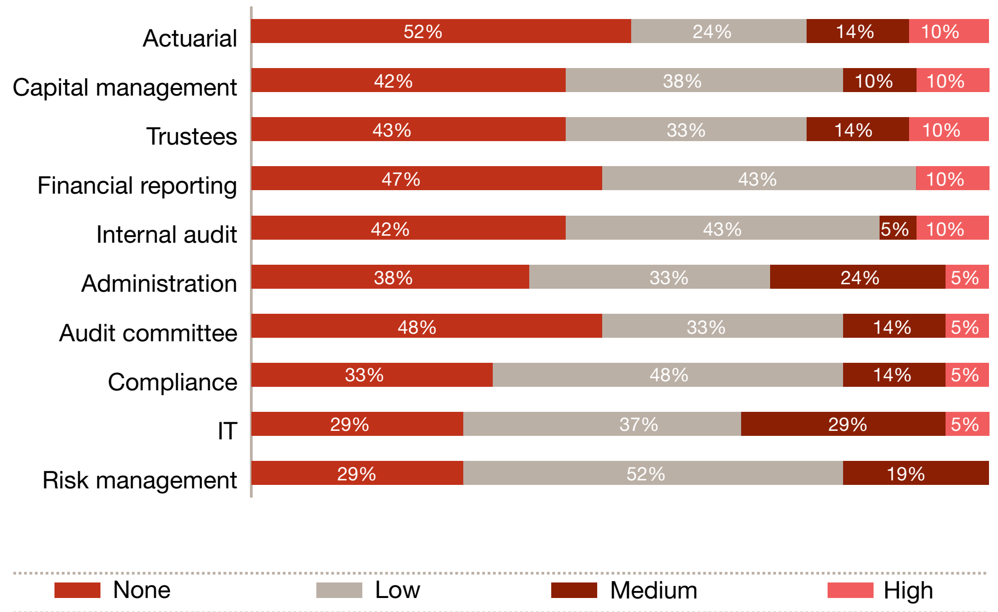
Base: 21 respondents

Since the financial crisis there has been an increasing drive to understand risks in the financial services industry and medical schemes have followed suit. However, the medical schemes environment in South Africa is faced with additional risks because they are not allowed to underwrite. Schemes have therefore turned to alternative techniques to manage the risk profile of members.

The increasing focus on risk management, coupled with technological and skills developments, have enabled schemes to better identify risks and find ways to manage these risks. Incentivising healthy lifestyles, increasing their ability to detect fraudulent behaviour and faster claims processing systems, are a few of the techniques currently being used. Schemes recognise the value this is adding to their risk profiles as well as their overall efficiency.

Q: In which areas are you currently experiencing the greatest shortage of skills?

Figure 42: Skills shortages



Base: 21 respondents

Figure 42 illustrates that there is no particular pressing skills shortage in the medical scheme environment.

Peer review

Q: Rank the top five medical schemes in terms of success, market share, service levels, performance, presence and impetus.

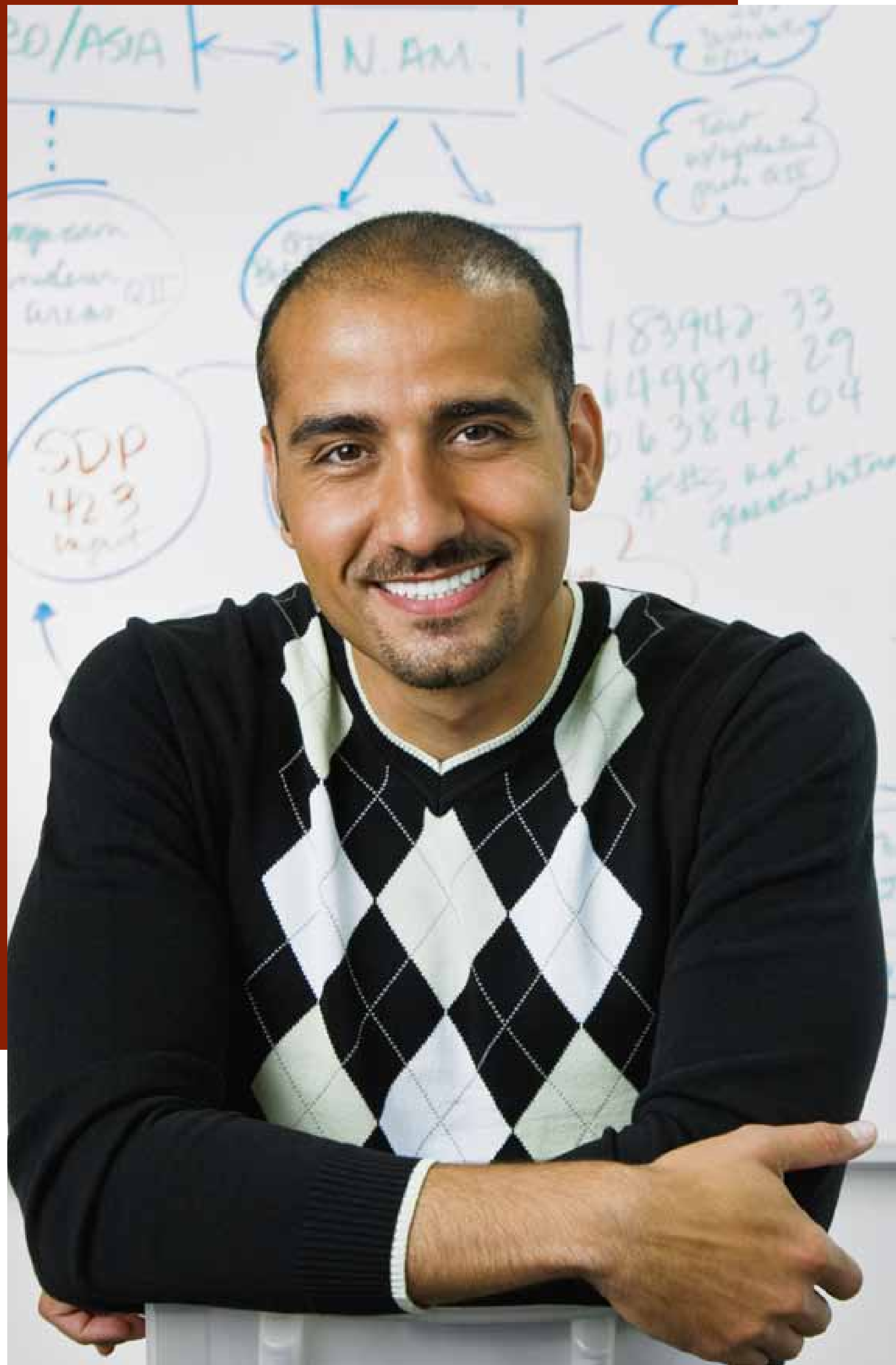
The 21 schemes that participated in the survey provided a peer assessment of schemes in the industry. A simple scoring method was used and each ranking received one point. This allowed the schemes to be ranked according to a cumulative total score. Respondents were not permitted to rank their own institution. The points received by the schemes have been included in the table below in brackets.

It is recognised that this ranking is a subjective process and that the results are intended to acknowledge perceptions in the marketplace. This is not a quantitative measure of success.

Peer review

Scheme	Ranking (votes received)
Discovery	1 (17)
Bonitas	2 (13)
Fedhealth	3 (10)
GEMS	4 (9)
Momentum	4 (9)
Medihelp	5 (6)

Industry statistics



Income statement details of registered schemes for the year ended 31 December 2010

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Open schemes															
1252	Bestmed Medical Scheme	65 857	141 759	37.2	11.9	1.1	1 940 274	1 658 138	192 524	43 518	50 793	2 731	-	(7 431)	124 799
1512	Bonitas Medical Fund	271 441	628 542	30.9	4.7	1.3	6 797 119	5 760 879	596 046	198 841	150 646	6 056	-	84 650	277 578
1034	Cape Medical Plan	6 654	14 841	35.7	11.0	1.2	108 055	111 390	16 317	-	-	141	-	(19 793)	3 643
1552	Community Medical Aid Scheme (COMMED)	11 127	25 385	37.3	11.4	1.2	349 275	309 550	40 497	8 047	3 836	993	-	(13 648)	(2 927)
1491	Compcare Wellness Medical Scheme	13 319	29 470	38.5	12.5	1.1	407 931	340 980	44 675	13 361	8 359	(912)	-	1 467	18 635
1125	Discovery Health Medical Scheme	983 862	2 171 742	31.6	6.1	1.2	22 121 964	17 950 160	2 737 395	787 871	633 601	37 827	-	(24 889)	594 072
1202	Fedhealth Medical Scheme	80 996	172 030	35.9	8.6	1.1	2 255 095	1 831 468	207 491	47 246	60 049	3 489	-	105 352	`157 109
1554	Genesis Medical Scheme	7 147	20 530	31.0	5.3	1.9	157 603	134 498	20 621	-	2 377	22	-	84	15 811
1561	Gen-Health Medical Scheme[4]	13 255	31 688	-	-	-	249 786	321 291	29 842	6 759	4 636	(30)	-	(112 714)	(108 657)
1466	Good Hope Medical Aid Society	3 095	7 509	29.3	0.5	1.3	37 637	34 098	3 115	77	1 073	64	-	(790)	3 022
1537	Hosmed Medical Scheme	37 580	97 741	30.5	2.2	1.5	1 000 134	820 645	106 207	18 119	22 620	1 125	-	31 417	44 053
1577	Ingwe Health Plan[5]	15 317	18 484	-	-	-	67 927	50 833	10 005	2 664	1 742	96	-	2 587	5 544
1087	Keyhealth	42 601	97 898	40.2	15.6	1.3	1 479 777	1 384 250	122 678	26 599	24 367	11 543	-	(89 660)	(36 419)
1576	Liberty Medical Scheme[6]	76 680	170 008	34.5	8.8	1.2	1 713 164	1 566 727	185 160	50 699	38 078	36 684	-	(164 186)	(96 206)
1149	Medihelp	120 040	237 282	39.9	19.0	1.0	3 752 263	3 398 663	300 360	56 910	38 908	11 901	-	(54 478)	30 393

1 Pb: per beneficiary
2 Including managed care healthcare benefits
3 Including broker services fees and other distribution costs paid
4 Gen-Health Medical Scheme was liquidated with effect from 12 October 2010. Members were transferred to Medshield Medical Scheme.
5 Ingwe Health Plan amalgamated with Momentum Health on 1 September 2010.
6 Liberty Health Medical Scheme changed its name to Liberty Medical Scheme on 1 January 2010.

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1506	Medimed Medical Scheme	4 237	11 038	28.7	3.6	1.6	79 165	65 296	7 224	1 361	-	43	-	5 242	12 674
1140	Medshield Medical Scheme	82 661	193 636	34.6	8.6	1.3	1 903 850	1 723 099	128 553	39 229	80 716	12 343	-	(80 090)	10 799
1167	Momentum Health	79 100	168 060	33.4	8.0	1.0	1 744 607	1 432 886	173 368	48 380	65 523	1 833	-	22 617	70 188
1166	National Independent Medical Aid Society (NIMAS)	9 875	20 971	40.6	15.7	1.1	255 977	227 401	18 250	3 621	3 782	739	-	2 186	6 835
1215	Oxygen Medical Scheme[7]	42 866	98 924	-	-	-	767 644	638 737	77 478	16 196	9 974	(1 402)	-	26 661	56 033
1546	Pharos Medical Plan	7 119	16 196	36.6	11.8	1.3	211 075	181 005	31 154	4 551	4 952	1	-	(10 588)	(6 707)
1454	Pro Sano Medical Scheme	31 370	68 541	38.4	12.7	1.2	794 085	719 051	82 660	25 508	7 967	802	-	(41 904)	435
1196	Protea Medical Aid Society	6 345	7 031	29.5	8.3	0.1	33 853	32 918	7 855	1 085	215	608	-	(8 828)	(7 503)
1575	Resolution Health Medical Scheme	29 194	65 282	31.4	3.8	1.2	578 575	464 523	84 281	20 843	15 391	(110)	-	(6 353)	5 780
1446	Selfmed Medical Scheme	9 863	20.234	43.1	21.2	1.0	285 063	239 135	32 924	4 226	1 544	315	-	6 919	152 733
1486	Sizwe Medical Fund	65 318	161 753	32.3	6.8	1.5	1 792 323	1 651 603	167 982	37 927	31 119	134	-	(96 442)	(27 160)
1141	Spectramed	44 111	95 146	35.1	8.1	1.1	1 268 562	1 114 127	133 206	14 213	18 091	18 702	-	(29 779)	570
1464	Suremed Health	1 575	3 707	33.3	6.1	1.3	40 911	35 911	6 877	799	1 229	246	-	(4 151)	(846)
1592	Thebemed	6 753	17 979	26.9	0.2	1.4	108 868	93 202	13 975	5 139	3 111	(76)	-	(6 483)	(5 791)
1422	Topmed Medical Scheme	11 381	24 303	38.2	13.9	1.1	270 053	245 952	30 581	6 632	6 586	368	-	(20 067)	(8 336)
Subtotal		**2 180 739**	**4 837 710**	**33.1**	**7.5**	**1.2**	**52 572 615**	**44 538 416**	**5 609 302**	**1 490 423**	**1 291 287**	**146 277**	**-**	**(503 090)**	**1 290 156**
Restricted schemes															

7 Oxygen Medical Scheme amalgated with Medical Scheme on 1 October 2010

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1005	AECI Medical Aid Society	7 338	15 423	40.7	22.0	1.1	259 452	237 647	15 099	6 243	-	312	-	151	20 166
1487	Afrisam SA Medical Scheme[8]	1 053	2 208	-	-	-	13 506	11 229	1 405	326	-	14	-	533	1 263
1567	Afrox Medical Aid Society	3 309	7 614	31.5	7.6	1.3	83 768	89 582	7 447	1 277	-	15	-	(14 553)	(4 613)
1465	Alliance Midmed Medical Scheme	1 902	4 925	27.7	3.4	1.6	47 470	54 502	4 824	1 300	-	12	-	(13 168)	(9 182)
1534	Altron Medical Aid Scheme	4 025	8 950	36.7	12.9	1.2	104 756	108 221	9 359	1 185	-	104	-	(14 112)	(9 510)
1012	Anglo Medical Scheme	11 731	26 813	38.6	18.1	1.3	357 208	380 154	25 534	6 732	-	83	-	(55 295)	194 000
1571	Anglovaal Group Medical Scheme	4 293	8 770	39.1	18.8	1.0	101 545	94 571	11 162	2 983	-	293	-	(7 463)	5 185
1279	Bankmed	101 139	201 250	30.0	6.4	1.0	2 358 654	2 057 484	198 472	61 160	-	595	-	40 943	160 459
1507	Barloworld Medical Scheme	5 857	12 479	37.4	17.6	1.1	226 404	207 457	11 404	5 445	-	56	-	2 043	19 928
1526	BMW Employees Medical Aid Society	2 168	5 977	29.3	1.7	1.8	66 400	63 240	3 750	1 716	-	(13)	-	(2 294)	566
1237	BP Medical Aid Society	2 319	5 222	40.5	21.1	1.3	68 568	76 134	4 043	1 669	-	38	-	(13 316)	5 375
1590	Building & Construction Industry Medical Aid Fund	4 916	12 279	30.7	3.1	1.5	61 869	49 311	8 124	777	-	-	-	3 657	6 666
1593	Built Environment Professional Associations Medical Scheme (BEPS)	1 997	4 610	34.0	6.5	1.3	51 482	42 596	2 946	1 025	1 251	2	(93)	3 569	4 139

8 Afrsam SA Medical Scheme amalgamated with Discovery Health Scheme on 1 June 2010

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	23 823	41 436	29.0	5.0	0.8	594 648	496 596	68 635	14 676	-	41	-	14 699	32 743
1521	Clicks Group Medical Scheme	576	1 177	33.7	4.4	1.1	9 839	9 061	1 232	324	-	(16)	-	(761)	(9)
1068	De Beers Benefit Society	6 854	15 257	41.3	16.6	1.2	227 019	217 435	14 443	982	-	(1)	-	(5 841)	26 096
1484	Edcon Medical Aid Scheme	3 645	7 314	31.5	8.4	1.0	70 422	55 075	8 537	2 188	-	232	-	4 391	6 390
1572	Engen Medical Benefit Fund	3 590	8 271	36.1	13.1	1.3	118 618	107 356	6 508	3 095	-	33	-	1 626	7 452
1585	Eyethumed Medical Scheme	2 254	5 009	31.3	0.6	1.3	25 984	21 978	4 376	458	291	689	-	(1 808)	(466)
1271	Fishing Industry Medical Scheme (Fishmed)	826	2 117	25.5	0.3	1.6	4 617	3 830	963	193	-	(2)	-	(367)	108
1086	Food Workers Medical Benefit Fund	14 827	20 105	30.2	0.2	0.3	16 681	9 854	3 474	-	-	-	-	3 353	4 850
1578	Foshini Group Medical Aid Scheme	2 740	5 680	30.3	5.6	1.1	63 701	60 252	3 885	1 885	-	10	-	(2 331)	(211)
1568	Gold Fields Medical Scheme	8 951	20 109	29.3	1.3	1.2	201 173	176 756	19 384	5 890	-	147	-	(1 004)	4 546
1270	Golden Arrow Employees Medical Benefit Fund	2 684	6 410	32.3	6.3	1.4	22 364	36 147	3 635	1 397	-	14	-	(18 829)	204
1598	Government Employees Medical Scheme (GEMS)	477 736	1 335 772	26.9	2.6	1.8	13 162 764	12 452 177	635 646	262 113	-	17 105	-	(204 277)	(120 470)

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1523	Grintek Electronics Medical Aid Scheme	1 124	2 752	31.3	2.9	1.5	32 999	31 029	2 968	824	-	35	-	(1 857)	86
1111	IBM (SA) Medical Scheme	2 166	4 863	36.4	10.9	1.2	49 386	35 474	5 626	1 298	-	65	-	6 922	8 428
1591	Impala Medical Plan	8 368	17 614	29.0	1.9	1.1	61 297	56 657	989	-	-	-	-	3 651	3 666
1559	Imperial Group Medical Scheme	6 289	14 794	28.9	2.5	1.3	184 098	161 357	15 719	3 192	-	(532)	-	4 362	15 487
1145	LA-Health Medical Scheme	28 662	63 514	34.4	13.2	1.2	744 987	623 866	77 303	18 076	14 232	896	-	10 614	36 805
1197	Libcare Medical Scheme	5 508	12 461	30.0	5.5	1.3	141 134	123 858	14 232	4 597	-	163	-	75	12 654
1599	Lonmin Medical Scheme	15 620	16 684	36.0	-	0.1	90 282	77 407	8 461	7 819	-	4	-	(3 410)	3 986
1547	Malcor Medical Scheme	4 778	11 031	32.8	7.3	1.3	150 374	157 999	12 289	2 684	41	(2)	(107)	(22 744)	412
1495	Massmart Health Plan	2 371	5 197	29.6	1.9	1.2	61 172	52 626	4 881	1 887	-	6	-	1 772	6 326
1039	MBMed Medical Aid Fund	3 227	8 519	29.4	4.3	1.6	95 267	81 600	5 007	2 553	-	27	-	6 080	9 711
1548	Medipos Medical Scheme	10 625	22 820	35.9	14.4	1.1	329 809	282 914	21 170	6 234	-	(408)	-	19 898	55 658
1535	Metrocare	1 364	3 254	36.9	8.3	1.4	46 955	51 777	3 005	1 061	-	8	-	(8 895)	(2 852)
1105	Metropolitan Medical Scheme	6 023	14 214	27.2	4.1	1.3	143 604	137 495	11 168	3 039	-	18	-	(8 115)	15 322
1569	Minemed Medical Scheme	6 890	15 014	36.6	9.0	1.2	206 206	178 541	10 800	3 904	-	(66)	-	13 028	13 561
1566	Moremed Medical Scheme	1 369	2 390	25.7	2.3	0.7	13 622	12 390	3 535	388	-	7	-	(2 699)	(1 772)
1600	Motohealth Care	32 368	74 037	32.8	7.9	1.3	660 600	570 316	63 317	15 245	1 003	343	-	10 377	42 825
1154	Nampak SA Medical Scheme	5 226	12 358	35.3	10.2	1.4	156 536	159 677	12 648	2 849	-	11	-	(18 650)	1 070
1241	Naspers Medical Fund	6 687	13 009	30.7	5.7	0.9	144 162	127 453	13 150	4 699	-	(3)	-	(1 136)	11 419
1469	Nedgroup Medical Aid Scheme	25 060	48 874	32.4	9.0	0.9	522 186	519 887	43 223	8 826	-	(498)	-	(49 252)	(22 111)

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1584	Netcare Medical Scheme	16 129	37 775	27.8	2.4	1.4	405 787	404 753	25 887	11 117	-	(138)	-	(35 832)	(7 439)
1214	Old Mutual Staff Medical Aid Fund	14 198	29 324	32.2	8.3	1.1	311 999	280 439	27 335	7 008	-	502	-	(3 284)	7 751
1441	Parmed Medical Aid Scheme	2 287	5 469	44.2	24.7	1.4	149 530	136 181	6 480	583	-	(1 041)	-	7 327	15 198
1515	PG Bison Medical Aid Society	607	1 310	39.9	16.1	1.2	19 931	19 644	1 813	381	-	9	-	(1 916)	(129)
1186	PG Group Medical Scheme	1 265	2 684	33.7	11.9	1.1	32 870	33 073	2 522	732	-	(92)	-	(3 366)	2 793
1563	Pick & Pay Medical Scheme	7 545	16 144	29.1	3.3	1.2	148 489	126 984	14 663	5 388	-	76	-	1 378	65 861
1583	Platinum Health	32 363	56 074	31.0	2.3	0.7	444 210	407 314	31 638	1 670	-	-	-	3 588	21 014
1194	Profmed	25 181	62 454	37.3	10.7	1.5	761 802	636 555	77 222	17 042	4 588	54	-	26 341	59 103
1516	Quantum Medical Aid Society	7 004	14 619	30.6	6.6	1.1	112 855	100 897	14 103	4 205	-	(253)	-	(6 098)	20 716
1201	Rand Water Medical Scheme	2 943	7 411	31.3	7.0	1.5	104 786	103 492	5 200	1 220	-	-	-	(5 126)	944
1430	Remedi Medical Aid Scheme	15 905	36 838	29.7	4.5	1.3	483 561	401 084	25 450	5 910	-	42	-	51 075	65 663
1176	Retail Medical Scheme	7 238	13 620	30.9	6.2	0.9	112 496	97.369	14 105	4 564	-	69	-	(3 612)	3 924
1013	Rhodes University Medical Scheme	1 018	2 186	38.9	14.2	1.2	27 484	24 665	1 901	542	-	(84)	-	460	2 097
1209	SA Breweries Medical Aid Society	9 614	21 927	28.5	4.0	1.3	234 592	209 074	19 448	6 124	-	189	-	(242)	23 545
1424	SABC Medical Aid Scheme	4 523	9 852	33.8	10.4	1.2	139 237	128 690	9 285	3 400	-	81	-	(2 218)	6 656
1038	SAMWUMed	30 542	73 193	30.4	3.8	1.4	565 965	440 031	30 480	8 984	3 193	439	-	82 837	107 194
1527	Sappi Medical Aid Scheme	4 101	9 444	36.0	13.0	1.3	128 608	121 245	8 001	2 593	-	(5)	-	(3 227)	2 575
1234	Sasolmed	28 239	74 559	29.5	4.1	1.6	1 025 567	929 196	45 970	24 944	-	270	-	25 187	66 247

Ref. no	Name of medical scheme	Average members	Average beneficiaries	Average age pb[1]	Pensioner ratio (65 + years)	No. of dependants per member	Net contribution	Net relevant healthcare expenditure[2]	Administration expenses	Managed healthcare management services	Broker costs[3]	Net impairment losses: trade & other receivables	Net reinsurance results	Net healthcare result	Net surplus/ (deficit) after consolidation results
				Years	%		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1531	Sedmed	844	1 972	44.0	23.4	1.3	19 113	20 057	723	-	-	-	-	(1 667)	431
1243	Siemens Medical Scheme	2 671	5 972	33.0	8.8	1.2	71 262	75 414	5 632	2 365	-	(42)	-	(12 107)	(9 248)
1580	South African Police Service Medical Scheme (POLMED)	170 868	475 882	25.7	2.4	1.8	5 111 356	4 284 580	219 013	106 321	-	575	-	500 867	662 125
1544	Tiger Brands Medical Scheme	4 923	11 389	38.7	16.8	1.3	176 978	165 300	8 490	3 621	-	18	-	(451)	14 208
1582	Transmed Medical Fund	73 464	143 904	42.7	21.9	1.0	1 192 518	1 256 933	116 122	39 592	-	1 617	-	(221 745)	(190 407)
1579	Tsogo Sun Group Medical Scheme	3 229	6 750	26.0	2.1	1.1	58 263	49 144	7 019	2 049	-	48	-	4	3 648
1434	Umed[9]	7 884	18 156	-	-	-	173 891	179 115	11 418	5 069	-	(908)	-	(20 803)	(13 485)
1597	Umvuzo Health Medical Scheme	18 345	35 862	29.1	0.4	1.0	217 301	178 210	23 122	6 364	6 660	174	-	2 771	5 334
1520	University of KwaZulu Natal medical Scheme	3 388	7 293	37.5	13.9	1.2	71 254	62 933	7 594	2 155	-	367	-	(1 795)	10 389
1282	University of Witwatersrand Staff Medical Aid Scheme	3 098	6 382	38.4	14.0	1.1	114 750	98 649	7 462	2 430	-	(74)	-	6 283	9 853
1291	Witbank Coalfields Medical Aid Scheme	10 432	26 065	29.2	4.1	1.5	211 097	211 681	15 042	1 974	-	55	-	(17 655)	25 238
1293	Wooltru Healthcare Fund	8 842	18 155	28.9	4.6	1.1	187 579	173 194	17 588	3 155	-	103	-	(6 461)	5 721
1253	Xstrata Medical Aid Scheme	8 301	24 666	23.0	0.5	2.0	190 905	171 757	10 435	5 242	-	26	-	3 446	8 137
Subtotal		**1 401 269**	**3 405 817**	**29.4**	**5.1**	**1.4**	**35 159 627**	**32 088 619**	**2 213 151**	**760 958**	**31 260**	**21 912**	**(200)**	**43 527**	**1 562 012**
Total		**3 582 008**	**8 243 527**	**31.5**	**6.5**	**1.3**	**87 732 242**	**76 627 035**	**7 822 453**	**2 251 381**	**1 322 547**	**168 189**	**(200)**	**(459 563)**	**2 852 168**

Source: Council for Medical Schemes Annual Report 2010

9 Umed amalgamated with Discovery Health Medical Scheme on 1 August 2010.

Balance sheet details of registered schemes as at 31 December 2010

Ref.no	Name of medical scheme	Non-current assets	Current assets	Total assets	Members funds	Non Current liabilities	Current liabilities	Savings ability	Outstanding claims provision		Net assets per Regulation 29	Solvency ratio
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	Prior year claims provision utilised %[1]	R'000	%
1252	Bestmed Medical Scheme	898 940	185 073	1 084 013	758 286	13 453	312 274	193 825	49 100	89.0	706 634	32.4
1512	Bonitas Medical Fund	1 148 506	2 111 916	3 260 423	2 633 417	-	627 006	36 348	232 673	100.4	2 520 628	36.5
1034	Cape Medical Plan	125 459	96 801	222 260	198 249	-	24 012	9 170	7 300	102.6	161 756	130.1
1552	Community Medical Aid Scheme (COMMED)	35 045	77 269	112 314	74 536	-	37 778	-	28 375	98.2	67 097	19.2
1491	Compcare Wellness Medical Scheme	886	208 980	209 867	142 678	-	67 189	32 810	13 057	100.0	140 291	30.4
1125	Discovery Health Medical Scheme	-	9791 908	9 791 908	6 847 076	-	2 944 833	1 718 442	560 597	106.9	6 817 337	24.7
1202	Fedhealth Medical Scheme	515 043	608 170	1 123 212	793 560	-	329 653	200 442	76 304	104.6	738 314	30.7
1554	Genesis Medical Scheme	29 637	189 954	219 591	195 318	-	24 274	8 646	9 920	92.8	188 856	108.0
1861	Gen-Health Medical Scheme[2]	-	-	-	-	-	-	-	-	223	-	-
1466	Good Hope Medical Aid Society	292	49 001	49 293	47 336	-	1 957	-	-	151.3	47 054	125.0
1537	Hosmed Medical Scheme	19	232 064	232 084	149 214	-	82 870	-	41 862	104.4	148 305	14.8
1577	Ingwe Health Plan[3]	-	-	-	-	-	-	-	-	97.1	-	-
1087	Keyhealth	275 597	175 728	451 325	201 456	3 656	246 213	92 320	86 042	106.5	190 641	12.1
1576	Liberty Medical Scheme[4]	703 363	217 096	920 459	523 844	-	396 615	178 970	94 183	99.7	514 113	27.0
1149	Medihelp	236 686	1265 048	1 501 733	1 162 446	54 671	284 616	23 301	147 996	102.7	1 040 737	27.4
1506	Medimed Medical Scheme	-	119 708	119 708	103 867	-	15 841	9 773	4 000	75.5	103 867	110.2
1140	Medshield Medical Scheme	1 274 848	262 076	1 536 924	1 128 278	-	408 646	91 983	168 000	94.9	1 016 678	62.6
1167	Momentum Health	-	643 840	643 840	401 455	-	2423 385	85 550	107 495	100.2	401 455	20.2
1166	National Independent Medical Aid Society (NIMAS)	-	83 323	83 323	51 450	-	31 873	13 073	8 467	89.2	51 450	18.4
1215	Oxygen Medical Scheme[5]	-		-	-	-	-	-	-	98.4	-	-
1546	Pharos Medical Plan	-	56 693	56 693	37 727	-	18 966	2 436	13 331	90.0	37 727	17.5
1454	Pro Sano Medical Scheme	317 400	140 414	457 814	250 007	-	207 807	126 321	39 322	110.1	213 295	24.4
1196	Protea Medical Society	9	9 222	9 231	1 745	-	7 486	-	2 289	99.5	1 745	5.2
1575	Resolution Health Medical Scheme	1 401	175 325	176 726	104 379	-	72 347	21 771	30 561	95.0	104 379	17.6
1446	Selfmed Medical Scheme	1 518	309 143	310 660	280 956	67	29 637	86	15 272	91.6	273 000	95.8

1 Prior year claims provision utilised = prior year payments / provision at the beginning of the year.

2 Gen-Health Medical Scheme was liquidated with effect from 12 October 2010. Members were transferred to Medshield Medical Scheme.

3 Ingwe Health Plan amalgamated with Momentum Health on 1 September 2010.

4 Liberty Health Medical Scheme changed its name to Liberty Medical Scheme on 1 January 2010.

5 Oxygen Medical Scheme amalgamated with Medshield Medical Scheme on 1 October 2010.

Ref.no	Name of medical scheme	Non-current assets	Current assets	Total assets	Members funds	Non Current liabilities	Current liabilities	Savings ability	Outstanding claims provision		Net assets per Regulation 29	Solvency ratio
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	Prior year claims provision utilised %[1]	R'000	%
1486	Sizwe Medical Fund	411 311	365 703	777 014	611 677	69	165 268	-	65 634	96.0	575 322	32.1
1141	Spectramed	59 721	277 369	337 090	265 399	-	71 691	18	53 071	101.5	247 703	19.5
1464	Suremed Health	-	42 344	42 344	30 181	-	12 163	5 805	2 800	105.6	30 181	67.8
1592	Thebemed	11	13 344	13 355	6 295	-	7 060	-	4 439	103.6	6 295	5.8
1422	Topmed Medical Scheme	64 711	77 072	141 783	105 947	-	35 836	9 322	18 249	104.9	100 324	34.1
Sub-total registered Medical Schemes		**6 100 402**	**17 784 585**	**23 884 987**	**17 106 777**	**71 917**	**6706 293**	**2 860 411**	**1 880 340**	**98.1**	**16 445 186**	**27.4**
Registered schemes: restricted												
1005	ACI Medical Aid	168 720	41 777	210 497	200 218	-	10 280	-	9 000	100.6	178 088	68.6
1487	Afrisan SA Medical Scheme	-	-	-	-	-	-	-	-	-	-	-
1567	Afrox Medical Aid Society	113 801	5 047	118 848	110 438	-	8 410	-	5 932	101.1	110 265	131.6
1465	Alliance Midmed Medical Scheme	-	64 189	64 189	38 834	-	25 354	20 570	2 891	88.7	38 119	68.5
1534	Altron Medical Aid Scheme	41 982	29 682	71 664	31 013	-	40 651	35 015	3 100	100.8	25 527	19.5
1012	Anglo Medical Scheme	98 723	2 163 435	2 262 158	2 151 603	-	110 555	86 040	21 575	100.3	1 926 597	460.2
1571	Anglovaal Group Medical Scheme	90 197	68 831	159 028	122 752	-	36 276	28 592	3 300	93.6	110 805	81.8
1279	Bankmed	566 955	1 517 252	2 084 207	1 590 744	5 893	487 570	335 111	74 434	96.6	1 410 384	51.2
1507	Barloworld Medical Scheme	86 933	91 926	178 859	141 262	15 496	22 102	-	9 043	95.8	135 392	59.8
1526	BMW Employment Medical Aid Society	40 945	21 089	62 034	56 498	-	5 537	2 584	2 500	103.7	53 482	79.7
1237	BP Medical Aid Society	55 833	9 617	65 450	60 286	-	5 164	-	2 887	94.2	59 774	87.2
1590	Building & Construction Industry Medical Aid Fund	564	50 235	50 799	45 023	-	5 776	-	4 250	96.1	44 524	72.0
1593	Built Environment Professional Associations Medical Scheme(BEPS)	-	17 003	17 003	9 676	-	7 327	3 729	3 128	103.3	9 676	15.9
1043	Chartered Account(SA) Medical Aid Fund(CAMAF)	313 720	136 054	449 774	350 392	-	99 382	62 188	24 000	97.8	256 735	40.0
1521	Clicks Group Medical Scheme	-	9 037	9 037	8 166		872	12	300	121.6	8 166	83.0
1068	De Beers Benefit Society	197	384 248	384 446	351 993	9 683	22 770	-	13 200	93.0	316 456	139.4
1484	Edcon Medical Aid Scheme	-	41 911	41 911	30 902	-	11 009	6 184	1 170	99.4	30 902	36.2
1572	Engen Medical Benefit Fund	28 900	74 799	103 699	84 203	-	19 495	9 510	4 957	96.7	71 133	54.0
1585	Eyethu Medical Scheme	7 172	19 374	26 546	22 643	-	3 904	-	987	62.0	21 668	83.4
1271	Fishing Industry Medical Scheme(Fishmed)	2 171	5 034	7 205	6 611	-	594	-	182	46.9	6 578	142.5
1086	Food Workers Medical Benefit Fund	76 508	2 458	78 966	78 250	-	716	-	-	-	61 263	367.3
1578	Foshini Group Medical Aid Scheme	14 885	26 030	40 915	37 031	-	3 884	-	1 785	85.2	32 038	50.3

Ref.no	Name of medical scheme	Non-current assets	Current assets	Total assets	Members funds	Non Current liabilities	Current liabilities	Savings ability	Outstanding claims provision		Net assets per Regulation 29	Solvency ratio
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	Prior year claims provision utilised %[1]	R'000	%
1568	Gold Fields Medical Scheme	75 577	65 685	141 262	125 131	-	16 131	-	10 600	100.9	121 993	60.6
1270	Golden Arrow Employees Medical Benefit Fund	17 144	6 998	24 142	20 048	-	4 094	-	1 545	101.4	19 721	88.2
1598	Government Employees Medical Scheme (GEMS)[6]	3 626	2 023 388	2 027 013	943 593	557	1 082 863	106 602	471 866	102.9	943 593	7.1
1523	Grintek Electronics Medical Aid Scheme	6 321	23 276	29 598	26 522	-	3076	125	650	140.0	26 227	79.5
1111	IBM (SA) Medical Scheme	6 264	26 586	32 850	24 094	-	8756	6 044	800	108.1	23 830	39.4
1591	Impala Medical Plan	21 173	8 609	29 782	22 355	-	7427	-	2 544	100.0	18 297	29.9
1559	Imperial Group Medical Scheme	139 266	73 064	212 330	201 353	-	10977	-	5 600	113.1	178 723	97.1
1145	LA-Health Medical Scheme	2 107	398 511	400 618	276 388	2 909	121 320	81 289	19 200	99.1	275 040	30.6
1197	Libcare Medical Scheme	149 413	38 853	188 266	144 055	-	44 211	34 168	7 841	97.7	143 781	81.6
1599	Lonmin Medical Scheme[7]	-	27 771	27 771	17 417	-	10 354	-	2 600	90.3	17 417	19.3
1547	Malcor Mecical Scheme	34 503	29 387	63 890	41 476	-	22 413	1 855	16 615	99.8	38 247	25.1
1495	Massmart Health Plan	29 103	59 741	88 844	55 688	-	33 156	29 630	2 978	80.5	55 688	68.3
1039	MBMed Medical Aid Fund	12 204	58 682	70 886	66 784	-	4 102	-	3 912	103.3	66 616	69.9
1548	Medipos Medical Scheme	306 098	110 743	416 841	352 149	-	64 692	39 125	9 500	96.1	313 010	94.4
1535	Metrocare	74 275	36 277	110 551	108 018	-	2 534	-	1 914	101.6	90 247	192.2
1105	Metropolitan Medical Scheme	115 520	15 182	130 702	121 856	-	8 846	-	4 598	96.1	103 149	71.8
1569	Minemed Medical Scheme	318	48 940	49 257	33 591	-	15 667	451	10 500	98.1	33 591	16.1
1566	Moremed Medical Scheme[8]	7 754	2 029	9 783	7 804	-	1 979	276	1 169	93.9	6 118	44.0
1600	Motohealth Care[9]	276	430 066	430 343	373 614	-	56 728	14 542	36 086	95.3	368 996	49.0
1154	Nampak SA Medical Scheme	-	189 419	189 419	150 276	-	39 144	28 044	8 937	98.8	91 385	53.8
1241	Naspers Medical Fund	83 422	62 257	145 679	109 944	-	35 734	22 792	7 015	109.1	101 479	57.8
1469	Nedgroup Medical Aid Scheme	264 106	828 559	1 092 665	232 748	809 549	50 368	16 207	25 697	112.1	232 748	41.6
1584	Netcare Medical Scheme	-	356 046	356 046	233 227		122 819	52 057	31 107	100.2	195 240	41.0
1214	Old Mutual Staff Medical Aid Fund	163 771	37 992	201 763	145 857	-	55 906	29 559	12 648	107.0	132 295	40.6
1441	Parmed Medical Aid Scheme	90 685	51 022	141 707	122 809	-	18 898	-	6 700	108.1	103 732	69.4
1515	PG Bison Medical Aid Society	-	29 693	29 693	27 350	-	2 343	-	1 801	76.3	27 350	137.2
1186	PG Group Medical Scheme	-	80 797	80 797	59 789	-	21 008	13 294	3 281	95.3	48 996	113.1
1563	Pick & Pay Medical Scheme	200 023	129 686	329 710	268 281	-	61 429	50 154	6 988	109.8	211 820	107.1

6 Government Employees Medical Scheme (GEMS) was registered on 1 January 2005 but started operations with effect from 1 January 2006.

7 The scheme was registered in 2006 and a phase-in solvency ratio of 22.0% applies.

8 An encumbered asset was excluded in the calculation of the solvency ratio.

9 The scheme was registered in 2007 and a phase-in solvency ratio of 17.5% applies.

Ref.no	Name of medical scheme	Non-current assets	Current assets	Total assets	Members funds	Non Current liabilities	Current liabilities	Savings ability	Outstanding claims provision		Net assets per Regulation 29	Solvency ratio
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	Prior year claims provision utilised %[1]	R'000	%
1583	Platinum Health	-	231 002	231 002	130 149	8 297	92 555	-	19 500	108.7	120 139	27.1
1194	Profmed	210 481	243 563	454 044	395 925	-	58 119	-	22 528	93.4	359 263	47.2
1516	Quantum Medical Aid Society	177 794	14 586	192 380	174 556	-	17 824	9 840	3 000	109.6	161 888	120. 7
1201	Rand Water Medical Scheme	-	97 038	97 038	86 628		10 410	-	6 700	101.4	86 628	82.7
1430	Remedi Medical Aid Scheme	231 178	161 410	392 588	298 319		94 270	74 740	9 027	94.8	287 360	56.1
1176	Retail Medical Scheme	-	169 992	169 992	142 787		27 205	9 975	3 200	93.7	114 571	91.7
1013	Rhodes University Medical Scheme	-	25 673	25 673	23 668		2 005	-	1 600	95.2	23 668	86.1
1209	SA Breweries Medical Aid Scheme	182 543	100 406	282 949	232 933		50 017	35 646	10 108	93.3	219 167	85.8
1424	SABC Medical Aid Scheme	99 599	95 312	194 911	104 159		90 752	67 134	5 500	98.5	83 741	51.1
1038	SAMWUMed	20 198	439 594	459 792	406 787	3 059	49 947	-	43 285	80.8	398 844	70.5
1527	Sappi Medical aid Scheme	54 490	36 131	90 620	62 159		28 461	19 235	4 623	94.4	62 156	40.9
1234	Sasolmed	172 975	409 539	582 515	528 511		54 004	-	31 491	93.8	503 102	49.1
1531	Sedmed	14 394	1 640	16 033	12 849		3 184	-	1 987	101.8	12 828	67.1
1243	Siemens Medical Scheme	74 853	29 118	103 971	47 372		56 599	51 149	4 224	92.9	41 052	43.2
1580	South African Police Service Medical Scheme(POLMED)	981 986	1 361 295	2 343 281	1 927 846		415 436	-	177 373	102.1	1 861 385	36.4
1544	Tiger Brands Medical Scheme	4 685	110 083	114 769	101 343	1 000	12 426	-	5 384	102.0	94 478	53.4
1582	Transmed Medical Fund	241 810	101 758	343 569	181 715		161 853	56 936	56 922	106.6	181 676	14.1
1579	Tsogo Group Medical Scheme	-	64 541	64 541	51 821		12 719	8 316	1 800	93.3	51 821	68.2
1434	Umed[10]	-	-	-	-		-	-	-	-	-	-
1579	Umvuso Health Medical Scheme	-	69 363	69 363	29 887		39 477	1 099	11 369	110.2	29 887	13.8
1520	University of Kwa-Zulu Natal Medical Scheme	51 186	73 181	124 367	86 556		37 812	31 014	2 050	106.1	72 968	76.9
1282	University of Witwatersrand Staff Medical Aid Scheme	50 863	29 335	80 198	74 561		5 637	-	4 918	79.8	65 436	57.0
1291	Witbank C oalfields Medical Scheme	154 773	290 678	445 450	341 760	2 181	101 510	76 418	10 500	91.5	304 446	109.9
1293	Wooltru Healthcare Fund	121 642	39 697	161 338	149 875	-	11 463	-	6 621	100.1	148 443	79.1
1253	Xstrata Medical Aid Scheme	47 599	25 789	73 387	63 927		9 460	-	6 250	98.8	62 050	32.5
Sub-total registered Medical Schemes		**6 404 206**	**14 249 010**	**20 653 216**	**15 496 846**	**858 624**	**4 297 746**	**1 557 251**	**1 353 272**	**97.4**	**14 243 903**	**38.4**
Total registered schemes		**12 504 608**	**32 033 595**	**44 538 203**	**32 603 623**	**930 541**	**11 004 039**	**4 417 662**	**3 233 612**	**97.8**	**30 689 089**	**31.6**

Source: Council for Medical Schemes Annual Report 2010

10 Umed amalgamated with Discovery Health Medical Scheme on 1 August 2010.

Source: Council for Medical Schemes Annual Report 2010

About PwC

A world-leading professional services firm

PwC is truly a global organisation committed to helping our clients meet the challenges posed by the global economy. We are one of the largest knowledge businesses in the world – a leader in every market in which we operate. Worldwide, we possess an enviable breadth and depth of resources, yet we work locally, bringing appropriate local knowledge and experience to bear – and using the depth of our resources to provide a professional service, specifically tailored to meet our clients' needs.

The service we offer to clients is underpinned by our extensive coverage and breadth of skills. When PwC was formed on 1 July 1998, it immediately became the largest professional services firm ever created. This marked a quantum leap in global professional services, bringing together thousands of people all over the world possessing considerable collective expertise and sharing a single goal of enhancing client value.

Servicing our markets

The objectives of our service offering are to build trust and enhance value for our clients and stakeholders. To meet the requirements of our clients, as well as regulators, our services are grouped into three distinct service lines, namely Assurance, Advisory and Tax.

We continue to operate as a multi-competency organisation offering a range of high-quality services to clients. In our business change is the only constant and we are continually adapting our range of services to ensure our sustainability and that of our clients and stakeholders. As market needs change, so will our service offering.

Assurance

Our Assurance group provides audit assurance to clients through PwC Incorporated on their financial performance and operations, as well as helping them improve their external financial reporting and adapt to new regulatory requirements.

The true value of an audit is not solely in ensuring compliance with exacting rules, regulations and standards. Instead it lies in our focus on substance over form and on progressing toward a reporting and audit model that communicates better information about a company's long-term value and the risks that are being taken to achieve such value.

Our leading-edge audit approach can be tailored to meet the needs of any size organisation, as evidenced by our appointment as auditor to some of the largest organisations as well as to thousands of small and mid-sized businesses.

In every case, our service offering is underpinned by our deep industry knowledge, wide international experience, and global network of skilled professionals.

This deep industry knowledge is one of the foundations of our success. Our teams are aligned to the industry groupings in which they have the most expertise, enabling them to deliver tailored solutions to complex issues in these sectors. Our traditional core competency has been augmented over the years by the development of additional services that address our clients' requirements.

Our audit clients include many of the top performing companies on the JSE Securities Exchange SA, as well as many small and mid-sized businesses. In addition to audit, other services provided include accounting and regulatory advice, and attest and attest related services.

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Advisory

Advisory provides advice and assistance based on financial, analytical and business process skills to corporations, government bodies and intermediaries in the implementation of strategies relating to:

- Creating/acquiring/financing businesses;
- Integrating them into current operations;
- Enhancing performance;
- Improving management and control;
- Dealing with crises; and
- Restructuring and realising value.

Offered by trained professionals specialising in their respective fields and industries, we provide advisory services in an objective manner that help our advisory clients create stakeholder value, build trust and communicate with the marketplace.

To best serve our advisory clients and build new businesses, we understand their needs through each stage of what we call the business lifecycle.

To this end, our advisory services are built around four key client priorities: transactions; performance improvement; governance, risk and compliance; and crisis management.

Our competencies span the breadth of these priorities, and we bring them to our clients in a variety of service offerings.

Transactions

Comprehensive services related to financial transactions, including financial due diligence, valuations, financial modelling, negotiating and structuring acquisitions and disposals, raising finance, and developing exit strategies.

Performance Improvement

Services to assist our clients in identifying and implementing cost saving initiatives, and improving management, control and quality.

Risk Advisory Services

Services to assist our clients in measuring and monitoring ongoing governance, sustainability and compliance infrastructures, and the efficiency and effectiveness of financial, non-financial and information technology controls and systems.

Comprehensive services related to business recovery, restructuring, dispute analysis and forensic investigations.

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Tax

Taxation is one of the biggest cost items in any business, yet it is one of the most manageable. Using state-of-the-art methodologies and technology, coupled with specialist skills, our national team of advisers can assist clients to manage their tax risk and where possible, minimise their tax burden by providing innovative, often proven, practical tax and business solutions.

Our advice covers all aspects of Southern African direct and indirect taxes, exchange control regulations and employee-related issues. Through our extensive network of offices we are also able to provide advice on structuring international business operations and investments.

Corporate Tax

Corporate Tax provides specialist advice to assist South African corporates to manage taxation costs and cash flows. Our specialists are informed on current regulatory and business developments, and use this knowledge to maximise the return to our clients through corporate tax planning.

Human Resource Services

We have an established human resource practice delivering solutions to the people-related issues encountered by our clients.

By combining our human resource and tax professionals, we are able to offer our clients breadth and depth of expertise in employment tax, reward, equity incentives, personal tax, social security and employment benefit services.

Our experts providing expatriate tax services examine all aspects of deploying people globally, from creating non-standard assignment programmes to managing costs through effective tax planning, process improvements and outsourcing. They are supported by highly experienced immigration specialists in South Africa and worldwide, providing advice on the immigration law and various permit categories.

Indirect Tax

Encompassing value-added tax (VAT), customs and excise duties and RSC levies, indirect tax is an increasingly complex area; every transaction in a business is affected. Our Indirect Tax team advises corporate clients on local and cross-border issues, utilising our global expertise and networks. Our clients operate across the full spectrum of industry, and we use our expertise to advise them on the best solution to their local, regional, and international issues, often utilising our global network to bring best practice to our clients.

International Tax Structuring

We provide business solutions to specific, complex client needs that serve to manage global tax risk and, where possible, minimise the global tax burden, taking into account exchange control as appropriate. We work as part of an integrated local and international industry-focused team of business advisers, to provide specialist international tax and exchange control services.

Transfer Pricing

We develop transfer pricing policies that are practical, defensible and consistent with our client's overall business strategy. Our services include transfer pricing risk assessments and full transfer pricing studies. We also provide advice on current and proposed transfer pricing legislation in South Africa and abroad.

Tax Compliance Centre

We provide specialist income tax compliance services to companies, based on global best practice models. The Centre runs state-of-the-art income tax compliance processes, and has a dedicated compliance manager responsible for each outsourcing contract to ensure the timely and efficient delivery of tax returns.

Tailored electronic tax data collection applications and robust risk management and quality control procedures ensure the delivery of high quality tax returns.

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Private Company Services

Business leaders regard business as personal. Our past and continued involvement with business leaders gives us a broad understanding of the unique demands and challenges facing private companies today. Our response is simple – to develop professionals who understand these challenges and rise to them. These Trusted Business Advisers (TBAs) work closely with our industry experts to provide tailor-made solutions specifically geared to adding value in the private company environment. A TBA acts as a gateway to all the knowledge and expertise of our entire organisation, combined with comprehensive knowledge of local markets and industries. Through our TBAs, clients have access to an integrated service delivery approach encompassing any combination of our firm's services.

Trust and excellence are the foundations of our relationships. We foster those relationships by engaging our clients in conversations around the issues, risks and opportunities of the day, in order to ensure that their businesses continue on the road to sustainable profitability and growth. We also know that life is about more than business. It is also about individuals. We therefore extend our involvement to offering advice on personal finances, taxation, succession, estate and retirement planning. We assist clients with every facet of their business in order to add real value, and help them achieve their business goals and dreams.

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A focus on industries

One of the foundations of our success is our ability to adapt our services to meet the needs of our clients. Internationally, teams are aligned to the industry groupings in which they have the most expertise, enabling them to deliver tailored solutions to problems in these sectors.

The depth of our industry expertise, like our international perspective, is an attribute that our clients value highly. We invest significant resources in building and sharing such expertise.

We have organised ourselves around industries to:

- Share the latest research and points of view on emerging industry trends;
- Locate individual experts on each issue, wherever they are based;
- Develop industry-specific performance benchmarks, based on global best practices;
- Share methodologies and approaches in complex areas such as financial instruments and tax provisioning; and
- Collaborate on accounting or technical issues unique to a particular industry, especially when interpretive guidance is needed.

Our clients range from the country's largest and most complex organisations to some of its most innovative entrepreneurs – we are privileged to work with such an unrivalled client base.

We serve many of the leading businesses in every sector on which we focus; those businesses value our rigorous, practical approach, characterised by a detailed understanding of individual client issues and by deep industry knowledge and experience. We have organised ourselves around industries to:

- Share the latest research and points of view on emerging industry trends;
- Locate individual experts on each issue, wherever they are based;
- Develop industry-specific performance benchmarks, based on global best practices;
- Share methodologies and approaches in complex areas such as financial instruments and tax provisioning; and
- Collaborate on accounting or technical issues unique to a particular industry, especially when interpretive guidance is needed.

Our industry groups are:

- Financial Services;
- Consumer and Industrial Products and Services (CIPS);
- Technology, InfoComm, Entertainment and Media (TICE);
- Mining;
- Public Sector;
- Health Care;
- Higher Education; and
- Agribusiness.

Financial Services

The financial services industry landscape is continually changing and increasing in complexity, causing firms to face a diverse array of challenges and concerns. Corporate governance, risk management and regulatory issues continue to impact the industry. Firms have expanded international operations around the globe to tap into new markets as a source of growth, increase their competitiveness, satisfy demand and better leverage their expertise. To assist our clients, our professionals have in-depth knowledge of the issues driving change in the various sectors of the financial services industry.

This knowledge, combined with our specialised skills, enables us to design and implement cost-effective multidisciplinary solutions to meet the challenges and opportunities facing our clients.

We act as auditors to more financial services companies in South Africa than any other professional services firm.

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