A HEALTH EXPENDITURE REVIEW OF THE SOUTH AFRICAN PRIVATE HEALTH CARE SECTOR FROM 2003 TO 2006

Submitted to:

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BY

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ABSTRACT

Introduction

South Africa has a two tiered health care system: a private sector catering for seven of the 47 million people and public sector providing care to the majority. The private sector consists of for-profit providers that are funded either through medical schemes, health insurance policies or out of pocket expenditure. To attain the goal of the health care system of improving health, it is essential that healthcare financing is understood. The provision of quality, accurate and comprehensive financial data is necessary for the efficient mobilization and allocation of financial resources. Health Expenditure Reviews and National Health Accounts provide such invaluable information.

Aim

To provide a trend analysis of health financing and expenditure data for the private health care sector in South Africa from 01 January 2003 to 31 December 2006.

Methods

This study is employs an observational, descriptive cross-sectional design.
The methodology used in the study is adapted from the World Health Organization's guide to producing National Health Accounts. Data was obtained from the Council for Medical Schemes annual reports and from Statistics South Africa Income and Expenditure Survey. The annual average medical inflation for each of the years was removed from the nominal value so that a real trend analysis could be observed.

Results

For the four year period, the overall cost-drivers of consolidated schemes were private hospitals (31.0-35.0%), medical specialists (20.0-21.0%), medicines dispensed out of hospital (17.0-22.0%) and non-healthcare expenditure like administration and broker fees (14.0-15.0%).

From the households' consumable expenditure on health, 37.0% was spent on medical services, 35.0% on pharmaceutical products and 11.0% on hospital services.

Discussion

The majority of expenditure in the private sector is through medical schemes. The precise amount spent by households is unknown due to the lack of data but it is a large amount for the South African household.

Proper National Health Account Matrices could not be constructed since access to data was limited, not routinely available and not disaggregated at the required level.

Recommendations

Better quality information on out-of-pocket household expenditure and expenditure in the traditional sector is needed. To improve access to the private sector, the proposed policy and legislative changes need to be implemented.

Number of words = 350

DECLARATION

I, Nisha Nadesan-Reddy declare that:

(i) The research reported in this dissertation, except where otherwise indicated, is my original research.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

(iii) This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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ACRONYMS AND ABBREVIATIONS

ASSA: Actuarial Society of South Africa

AIDS: Acquired Immune Deficiency Syndrome

ANC: African National Congress

ART: Antiretroviral Therapy

ASGISA: Accelerated Shared Growth in South Africa

CDL: Chronic Disease List

CIHCF: Clothing Industry Health Care Fund

CMS: Council for Medical Schemes

COICOP: Classification of Individual Consumption According to Purpose

CPIX: Consumer Price Index

DHIS: District Health Information System

DMP: Disease Management Programmes

DOH: Department of Health

GDP: Gross Domestic Product

GEAR: Growth, Employment and Redistribution Strategy

GEMS: Government Employees Medical Scheme

GHS: General Household Survey

GP: General Practitioner

HAART: Highly Active Antiretroviral Therapy

HASA: Hospital Association of South Africa

HER: Health Expenditure Review

HIV: Human Immunodeficiency Virus

HPCSA: Health Professions Council of South Africa

ICD: International Classification of Diseases

ICHA: International Classification for Health Accounts

ICU: Intensive Care Unit

IES: Income and Expenditure Survey

LIMS: Low Income Medical Schemes

MCH: Managed Health Care

MDG: Millennium Development Goal

MSA: Medical Savings Account

NGOs: Non-Governmental Organisations

NHA: National Health Accounts

NHRPL: National Health Reference Price List

OECD: Organization for Economic Co-operation and Development

OOP: Out-of-pocket

PABPM: Per Average Beneficiary per month

PHC: Primary Health Care

PHR*plus*: Partners for Health Reform*plus*

PMB: Prescribed Minimum Benefits

PSU: Primary Sampling Unit

RDP: Reconstruction and Development Plan

REF: Risk Equalisation Fund

SA: South Africa

SEP: Single Exit Price

SHA: System of Health Accounts

SHI: Social Health Insurance

Stats SA: Statistics South Africa

TB: Tuberculosis

VAT: Value Added Tax

WHO: World Health Organisation

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CHAPTER I

1.1 ORGANIZATION OF THIS REPORT

This dissertation has six chapters. The first chapter introduces the concepts of National Health Accounts (NHA) and Health Expenditure Reviews (HER). It expands on the South African context for the report, describes the organisation of the present health care system and finally looks at the purpose and specific objectives of the report. The second chapter presents the literature review. It details the framework of a health system and looks at the financing of such a system. It also discusses in depth the framework and concepts of National Health Accounts. Chapter three describes in detail the methodology and data sources used in this research report. Chapter four presents the results of the Health Expenditure Review of the South African private health care sector for the four year period from 2003 to 2006. Chapter five discusses the results in relation to the research objectives and the National Health Accounts framework. The limitations of the research are also presented in this chapter. Finally, chapter six concludes the report and makes recommendations for improving a similar study in the future.

1.2 INTRODUCTION

This chapter draws a distinction between National Health Accounts (NHA) and Health Expenditure Reviews (HER) and describes the importance and purpose of such financial reports. The background describes the country of South Africa in terms of its socio-economic, epidemiological and health indicators. This is followed by a description of the present day South African health system and the challenges that it faces. Finally the purpose and objectives of this study are discussed.

NHA consists of two components: Health Expenditure Reviews and the health finance outcome indicators associated with health expenditure.

Health Expenditure Reviews provide health-related financial information quantifying the total expenditure on the health sector, the sources of health finance, how much each source contributes to the health sector and how these funds are spent. [1]

NHA are a progression of Health Expenditure Reviews using the same analytic framework and presenting the same type of data. The difference between the two is reflected in the particular methodology with data collection for Health Expenditure Reviews usually being once-off while NHA rely more on statistical modelling since they are compiled on a continuous basis.[1] NHA also includes the financing intermediaries which are the organisations that receive funds from sources and pay for or purchase health care with those finances. [1]

Health Expenditure Reviews and NHA evaluate the size of the health sector relative to other sectors in the country, the pattern of the flow of funds within the health sector, the distribution of health care financing between the different sources (public, quasi-public and private) and the different financing intermediaries and the distribution of expenditure. This evaluation provides information on the efficiency and equity of health care financing.[2]

This descriptive cross-sectional study was commissioned by the South African National Department of Health (NDOH) to undertake a health expenditure review of the South African Public and Private health care sector for the following four financial years i.e. 2003, 2004, 2005 and 2006. This study focuses on the private health care sector only. The public health care sector expenditure review will be dealt with in another report.

The purpose of the study is to describe and analyze the flow of funds into the services and activities in respect of the private sector for the above-mentioned years.

1.3 BACKGROUND

As part of the background, the country of South Africa will be described so that the Health Expenditure Review can be understood in terms of the context in which it occurs.

1.3.1.1 The South African Context

The country of the Republic of South Africa will be described in terms of its geographical location, its socio-economic and epidemiological profile in terms of the health status of its people.

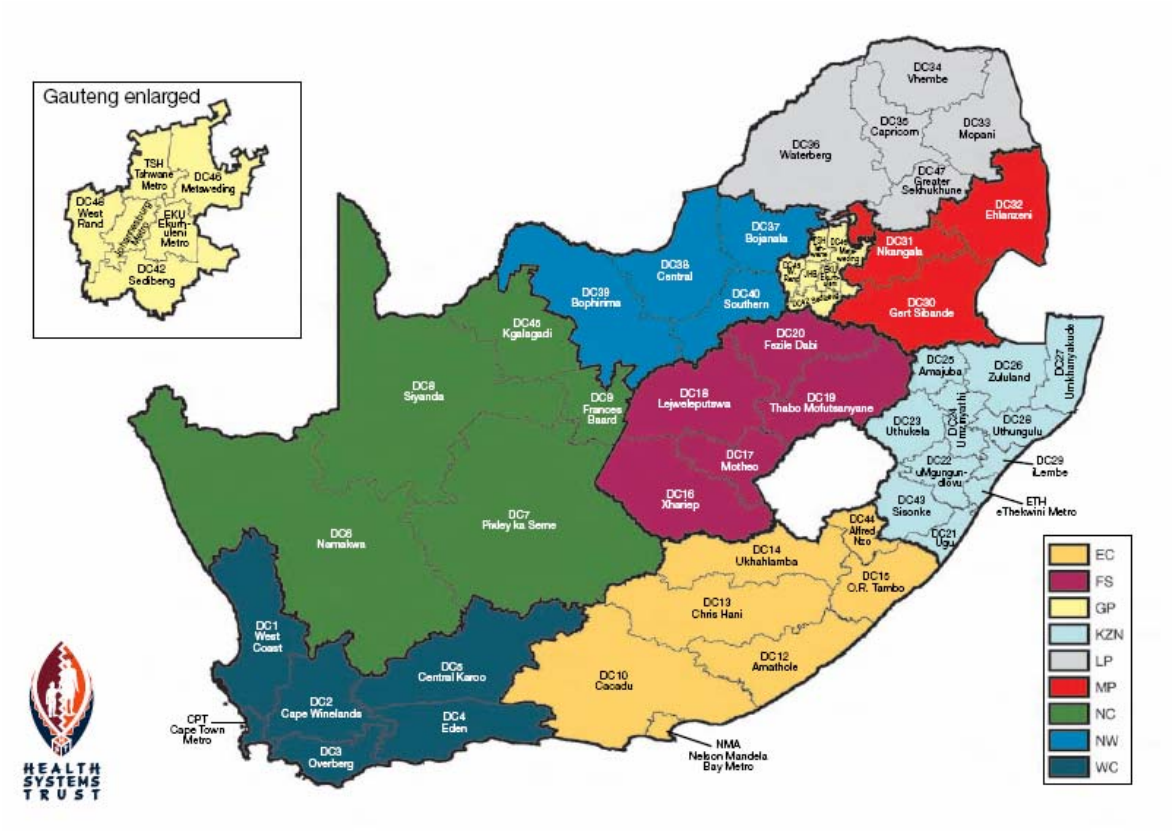
1.3.1.2 Geography

South Africa, located at the southern most tip of the African continent, is bordered by the Atlantic Ocean on the west and the Indian Ocean on the south and east. Its immediate neighbours are Namibia in the northwest, Zimbabwe and Botswana in the north, and Mozambique and Swaziland in the northeast.[3] South Africa has a population of almost 47.8 million people[4] comprising four predominant ethnic groups: African 75.2%, White 13.6%, Coloured 8.6% and Indian 2.6%. It has eleven official languages and is rich in cultural and religious diversity.

South Africa is demarcated into nine provinces: Gauteng, Northern Province, Mpumalanga, North West, KwaZulu-Natal, Eastern Cape, Western Cape, Northern Cape, and the Free State (Figure 1). Each province has urban and rural areas. These have been further demarcated into 52 health districts (Figure 2).

Source: South African Health Review, 2007[5]

Figure 1: Map showing South Africa and the nine provinces



Source: District Health Barometer 2006/07[4]

Figure 2: Map of 52 health districts of South Africa, as per 2006 demarcation

1.3.1.3 Socio-economic Indicators

South Africa is classified as a middle-income, emerging market with an abundant supply of natural resources that include inter alia, gold, iron, coal, copper, platinum, and gem diamonds. [6] It possesses well-developed financial, legislative, communications, and transport sectors. A modern infrastructure supporting an efficient distribution of goods to major urban centres throughout the region constitutes a significant asset. The South African macro-economic policies focus on targeting inflation and liberalizing trade so as to increase job growth and household income.

However, due to the legacy of apartheid, there remain remnants of inequity, inequality and poor access leading to poverty, high unemployment and a lack of economic empowerment among the disadvantaged groups.

According to the 2001 Census, 57.5% of the population lived in the urban areas while the rest reside in the rural areas. Its population typically reflects the demographic features of a developing country, with 32.1% falling below the age of 15 years while only 7.3% are over the age of 60.[7] According to a 2006 report for the Department of Social Development, the average unemployment in the rural areas was 79.1% whilst 62.6% experience this social phenomenon in the urban areas.[7] However, the unemployment rate according to the official definition is merely 25.5%.

In 2006, 14.5% of the population resided in informal housing, with 63.5% using electricity for cooking and 85.8% having access to piped water.[7] There nevertheless remain 9.5% of households that have inadequate sanitation i.e. no toilets.[7] Currently, 10.4% of the population aged 20 years and older have undergone no schooling, the majority of these being both female and from the Black population group.[7]

Approximately half of households (47.2%) lived on an income of less than R800.00 per month in 2005.[4] The Gini coefficient, which is a measure of income inequality, was 0.685 in 2006 (1 being total inequality).[7]

1.3.1.4 Epidemiological Profile and Health Indicators

South Africa is committed to the Millennium Development Goals (MDGs) which aims to decrease infant, children under 5 and maternal mortality by 2015. Target 8 of MDG 5, aspires to halting and reversing the spread of Tuberculosis (TB), Malaria, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and other infectious diseases by 2015.[8] Despite this, South Africa remains one of four countries in which life expectancy at birth has decreased by four years or more between 1990 and 2001.[7] According to Statistics

South Africa, the life expectancy at birth for females was 51.7 years in 2007, while that of males was 48.4 years.[7] Such data regarding the longevity of the general population has been largely attributed to the burden of infectious disease, particularly HIV.

According to the World Health Report of 2006, South Africa spends 8.4% of its Gross Domestic Product (GDP) on health.[9] This figure represents a high proportion for a middle-income country according to international standards.[10] According to the same report, government's expenditure on health is 3.2% of the GDP which is 38.6% of the total expenditure on health. The South African government allocated R59.2 billion from their annual budget for health in the public sector in 2007/08. This amount constitutes 3.1% of GDP and 11.1% of government expenses.[11] However, when compared to other middle-income countries, the health status indicators in South Africa score worse in comparison with certain other middle-income countries that spend a smaller percentage of their GDP on health, such as Brazil, Cuba and Thailand (Table 1).

Table 1: Comparison of health care expenditure and health status indicators in certain high and middle income countries

Country	Health care expenditure as % GDP, 2002	Life expectancy at birth, 2003	Infant mortality rate per 1 000 live births, 2003
South Africa	8.3	48	53
High income countries			
Australia	9.5	80	6
Canada	9.6	80	5
United Kingdom	7.7	78	5
Middle income countries			
Brazil	7.9	71	33
Chile	5.8	78	8
China	5.8	72	30
Costa Rica	9.3	78	8
Cuba	7.5	77	6
Egypt	4.9	70	33
Estonia	5.1	71	8
Malaysia	3.8	73	7
Thailand	4.4	70	23

Source: UNDP, 2005;[3] WHO National Health Accounts database.[a]

Source: Chapter 3, South African Health Review, 2007[12]

In 2005, the South African infant mortality rate was recorded at 53.6 per 1000 live births and according to the Actuarial Society of South Africa (ASSA) 2003 model, was estimated to be 46.1 per 1000 live births in 2007.[7] In 2005, the under 5 mortality rate was 72.1 per 1000 live births. This mortality rate was either equivalent or higher than other developing countries that do not have access to the financial resources and existing infrastructure present in South Africa. The most common causes of death were lower respiratory tract infections, gastroenteritis and septicaemia. In 60.0% of such cases, a link to HIV being present could be established.[7]

The number of maternal deaths in South Africa has also been increasing over the past few years. The maternal mortality in 2003 was 1154 (Maternal Mortality Ratio = 110).[7] This figure was higher than the number reported in 2001 and 2002 of 990 and 1078 respectively, and was partly attributed to an improvement in reporting following the Saving Mothers report.[7] The

increase occurred also as a result of an increase in non-pregnancy related infections, the majority of which are HIV related.

HIV and HIV-related infections represents the major health challenge facing the South African health system owing to the health consequences of the disease and its impact on other aspects of the individual's life, their family and the community. It is estimated that 64.0% of the 39.5 million people living with HIV in 2006 live in Sub-Saharan Africa [13] and that South Africa is firmly located at the centre of this pandemic. The majority of these victims of the pandemic include the vulnerable i.e. Black Africans, women, children, the economically active age group, those residing in rural and informal areas and those falling within the poverty bracket. According to the 2006 antenatal sero-prevalence survey, the HIV prevalence was estimated to be 29.1%. Approximately a quarter of those infected (23.1%) were in the age group 15-24 years.[7] The highest HIV prevalence rates, according to this survey, were in the KwaZulu-Natal (39.1%) and the Mpumalanga provinces (32.1%).[7]

There is also a high rate of HIV and Tuberculosis co-infection in South Africa. As a result thereof, the country contributes approximately 80.0 to the global burden of TB cases and ranks as seventh out of 22 high-burden TB countries.[14]

Therefore, the HIV hyper-epidemic possesses far-reaching social consequences beyond merely the health sector and has resulted in an excess of a million children being orphaned.[7] This desperate situation has furthermore impacted on the South African economy with the inevitable loss of productive employees and skilled labourers. There are currently a significant number of child-headed households and more people are requiring social grants, creating a further financial burden on an already resource-strained economy.

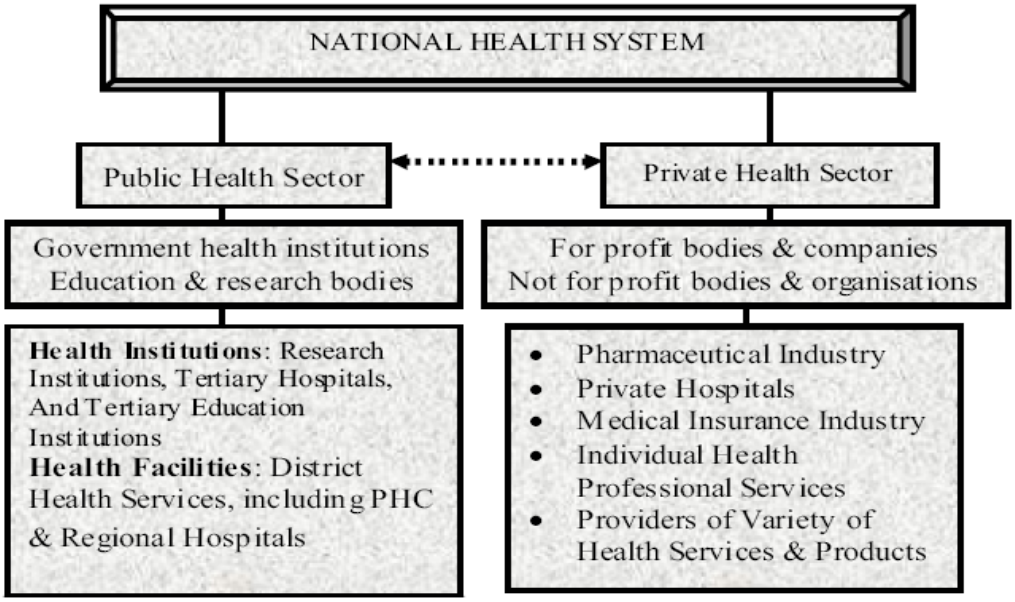
1.3.2 The Organization of the South African Health System

The present day health system will be described in terms of the transformation it has undergone and the current status, with the challenges it faces, will be discussed.

1.3.2.1 The Policy and Legislative Environment

The advent of democracy in 1994 led to the transformation of the South African government and all its departments. The process of transformation has been and remains evolutionary leading to ongoing restructuring and reformation, particularly in the health care sector which was fragmented and inefficient.[9] The cornerstones for rebuilding the health system were equity, affordability, accessibility and efficiency. Therefore, understanding health care financing flows is especially important for the effective and efficient mobilization and allocation of resources to enable the new health system to attain its ultimate goals of improving the health status of all South Africans.

Health care in South Africa is provided by a complex combination of government (public) and private sector providers (Figure 3). Within this two-tiered health system, the public sector provides health care for approximately 40 million people, while the private sector caters for 6.9 million people or 14.0% of the population.[4]



Source: A National Human Resources Plan for Health, 2006[15]

Figure 3: Organisation of the South African health system

The constitution of South Africa adopted in December 1996, provides the context for the legislative framework for the reformation of the health care sector. Section 27 1(a) of the constitution states that everyone, including vulnerable groups such as children and prisoners, has the right to have access to health care services. The State has an obligation to respect, protect, promote and fulfil the stipulated health care rights.[16] This obligation of the State extends to the private health care providers and in the particular instance of anyone who may require emergency care. Therefore, no person may be refused emergency treatment even if they are not a member of a medical scheme or cannot afford the private sector's user fees.

In January 1995, the Minister of Health at the time, Dr NC Dlamini-Zuma, appointed a Committee of Inquiry into a National Health Insurance System with the objective of achieving universal, non-discriminatory access to quality primary health care (PHC) via a National Health Insurance System.[17] This report recommended five main policy changes:[18]

- The Primary Health Care benefits package: free access to comprehensive Primary Health Care services

- Building Primary Health Care delivery capacity
- Financing improved Primary Health Care services
- Containing overall health care costs
- Reforming the private sector to promote cost-containment and the re-distribution of resources as well as reforming medical aid schemes and private insurances.

In 1997, a follow-up committee recommended a phased approach towards improving the access of all South Africans to health care by beginning with the introduction of a scheme for Social Health Insurance (SHI), followed by National Health Insurance.

The 1997 White Paper for the Transformation of the Health System in South Africa [19] paved the way for health care reform from the viewpoint of equity, accessibility and affordability. This policy document outlined the government's goal of achieving a unified, equitable health system based on a comprehensive Primary Health Care approach. The fragmented and ethnic-based health system inherited from the apartheid era would be replaced by a single national department of health whose management would be decentralized by the creation of a district health system. The policy framework also made provision for greater collaboration between the private and public sectors, for example, through public-private partnerships.

In the process of transforming the health sector more than 23 pieces of legislation were enacted. The National Health Act (Act 61 of 2003) promulgated in April 2005 replaced the Health Act of 1977.[20] The National Health Act, based on and reflecting the principles of the White Paper of 1997 reaffirmed the right of pregnant women and children under six years of age to access free health care services and the right of everyone to free primary health care services Chapter five established a district health system based on the Primary Health Care approach and involved the decentralization of management through the process of devolution, delegation and de-concentration. The function of the district health system would be to promote co-operative governance between the national, provincial and local spheres of government and ensure the co-ordination and integration of services within the health district.

The introduction of the Medical Schemes Act (Act 131 of 1998) [21] and its amendments in 2001 provided the legislative environment to regulate all medical schemes to ensure the fair treatment of its beneficiaries. The Medical Schemes Act of 1998 replaced the previous Act of 1967 that permitted the practice of risk-rating. The new Act made provision for open-enrolment and community-rating to improve equity and access, particularly for those in need and the elderly. Community-rating ensured that members of a scheme paid standardised contributions irrespective of their age, gender or state of health. A set of prescribed minimum benefits (PMBs) was introduced that ensured provision of care for 27 chronic conditions including HIV that medical schemes had previously not been obliged to provide.

Section 3 of the Medical Schemes Act of 1998 established a statutory body designated as the Council for Medical Schemes (CMS).[21] The CMS regulates medical schemes and accredits brokers, administrators and managed care organizations that provide services to medical schemes. The Council supervises a large health care industry consisting of approximately 124 medical schemes.[22] An amendment to the Medical Schemes Act in 2007 expanded the role of the CMS to operate the Risk Equalisation Fund (REF), a provision which will create a medical scheme's industry-wide risk pool and community rating for PMBs.

The overarching government funding strategy for health services was underpinned by introduction of the consecutive macro-economic policies of the Growth, Employment and Redistribution Strategy (GEAR) introduced in 1996, and the Accelerated Shared Growth in South Africa (ASGISA) introduced in 2006.[23] These policies focused on economic growth by promoting private investment, improvement in productivity and better improved competitiveness.[1] Growth, Employment and Redistribution Strategy focused on reducing government debt by restraining government expenditure in line with the prevailing fiscal and economic realities.[12]

1.3.2.2 Health Care Financing and Expenditure in South Africa

The main sources of finance for health care in South Africa include the government, households, employers, donors and non governmental organizations (NGOs).[10] Government provides the major source of health care financing for the public sector generated through tax revenues that includes general income tax, company tax, value added tax (VAT), taxes from the sale of alcohol and cigarettes, licenses and from the sale of certain public sector utilities inter alia electricity and water. All spheres of government, national, provincial and local, contribute to the health sector. However, government health budgets were constrained in the late 1990s due to the Growth, Employment and Redistribution Strategy macroeconomic policy so that health care expenditure, although showing a real increase, failed to maintain a parallel increase in accordance with population growth. Since 2002/03, a steady increase in the health budget as been observed, with R62.7 billion being allocated for the 2007/08 financial year.[11] However, such a development is not leading to a significant increase in the real per capita spending on this vital sector since there is a greater demand on the public health segment of resources due to the HIV pandemic.[12] Health has also received a diminished slice of the budget allocation in recent years, decreasing from 11.5% in 2000/01 to 10.9% in 2007/08.[12] Reflecting this reality, social security and welfare, other social and economic services have had their contributions increased instead.

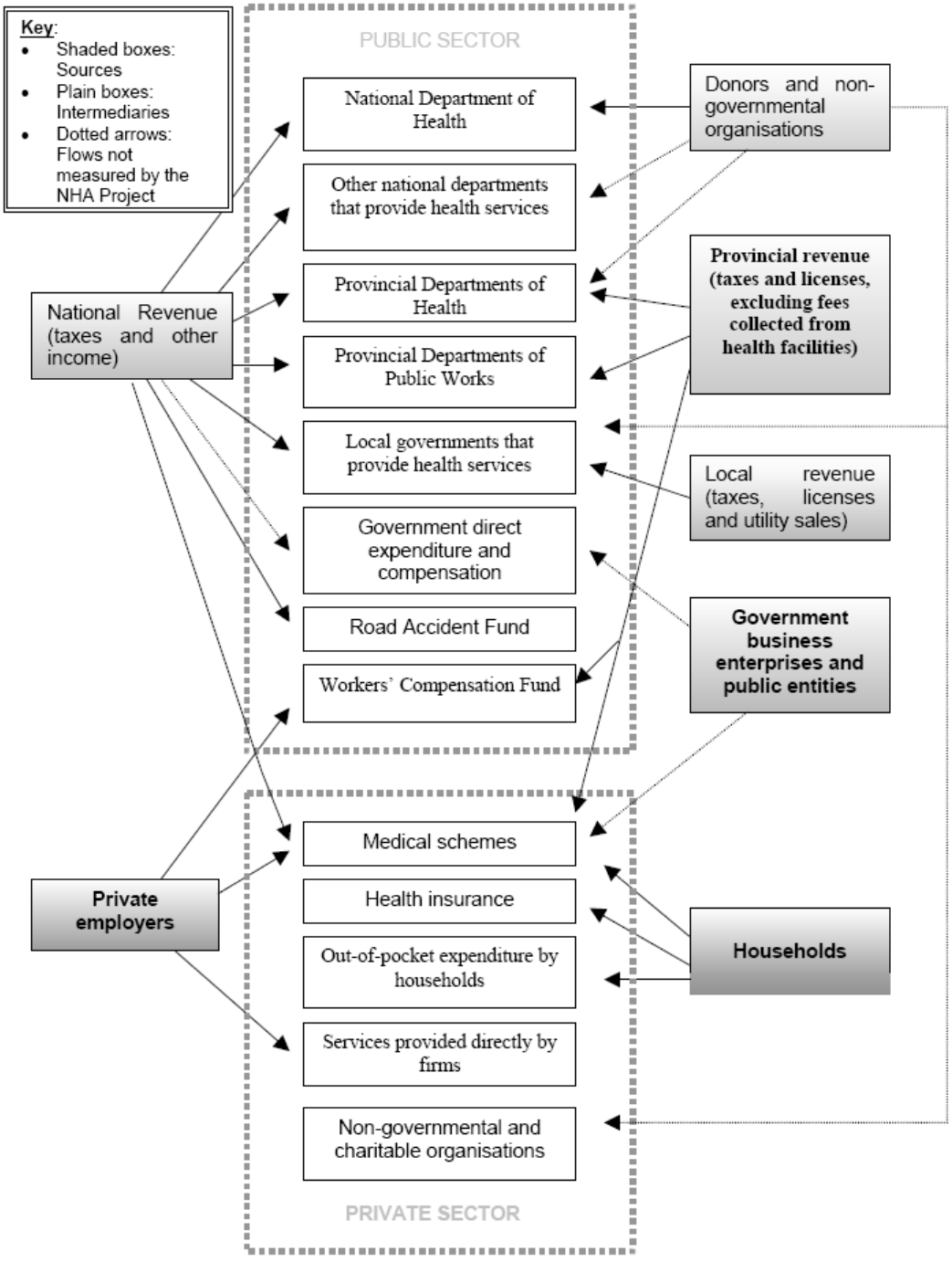
Health may indeed have enjoyed a sizable allocation from the budget compared to previous years but it is an established fact that the private sector consumes the majority of the resources. For the fiscal year 2006/07, a total of R135 billion was spent on both public and private health care which was equivalent to 8.0% of GDP.[7] R58 billion was devoted to the public sector consisting of 40 million people, while R79 billion was spent on the 6.9 million people in the private sector.[7] Of the R79 billion spent in the private sector, R59 billion was from medical schemes while the balance of R20 billion was funded out-of-pocket (OOP). Such a skewed distribution translates into R1500 per capita in the public sector versus R9420 per capita in the private sector. Despite the reformation of the health system that has already been completed, resulting in improved access to health care, there remains a major inequity in the financial distribution of resources between the public and private health care systems.

Households comprise the second largest source of health care financing in South Africa.[10] This occurs via contributions to medical schemes, health insurances and direct out-of-pocket expenditure to allopathic and alternative health care providers and pharmacies. The out-of-pocket expenditure accounts for almost 14.0% of all health care financing and 25.0% of private health care expenditure but this amount is almost certainly an under-estimation.[12]

Employers constitute the third largest source of health care financing and include both private companies and government and its subsidiaries.[10] They may provide health care services on site at the workplace or make contributions to medical schemes and insurances for their employees. The latter includes the Workman's Compensation Fund which is a financing intermediary in the public health care sector. In South Africa, government is the largest employer and contributes to medical schemes on behalf of their employees but these contributions are funded from tax revenues. It is for this particular reason that the government created the Government Employees Medical Scheme (GEMS), a restricted scheme for civil servants which became operational in January 2006.[24]

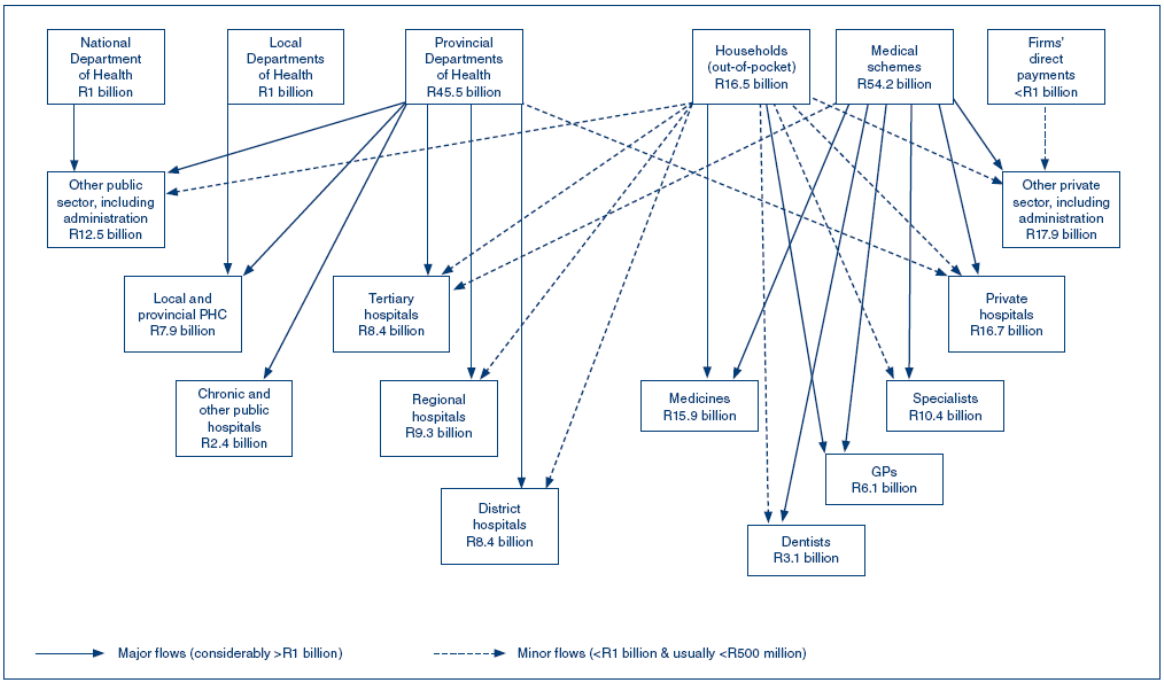
Donors and NGOs are the fourth source of health care financing but, unlike other countries in Africa, are not the main sources in South Africa.[10]

Figure 4 shows the flow of funds from the financing sources to the health care providers while Figure 5 indicates the health care expenditure in South Africa for 2005. The financing intermediaries are the organizations that receive the health care funds and purchase health services. In South Africa, approximately 40.0% of total health care funds flow via the public sector financing intermediaries: the national, provincial and local health departments. The majority, 60.0%, flows via the private sector intermediaries, the medical schemes and private health insurances. Medical schemes form the largest financing intermediaries receiving 46.0% of the funds, while provincial health departments follow, being the recipient of 38.0% of finances (Figure 5).[12]



Source: Chapter 2, South African Health Review, 2002[10]

Figure 4: Flow of funds from financing sources to financing intermediaries in the public and private health care sectors in South Africa



Source: McIntyre, 2007;[1] National Treasury, 2006;[2] National Treasury, 2007;[4] CMS, 2006;[5] Cornell, 2001.[6]

Source: Chapter 3, South African Health Review, 2007[12]

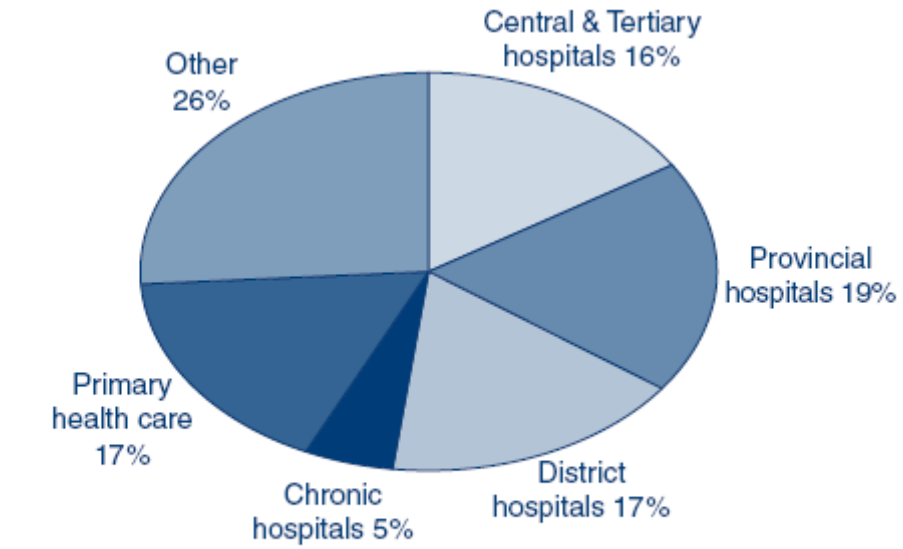
Figure 5: Health care expenditure in South Africa in 2005

1.3.2.3 The Public Sector

In South Africa, the majority of the population is uninsured and dependent on the public sector for their health care. This amounted to 40 824 000 people according to the 2006 General Household Survey (GHS).[7] The majority of the uninsured reside in KwaZulu-Natal, Gauteng, Eastern Cape and Limpopo provinces and originate from a Black ethnic background.[7]

The health sector is divided between the three spheres of government with the national sphere responsible for policy formation, the provincial sphere undertaking policy implementation and local government accountable for providing municipal health services and primary care service delivery, if agreed with province.[23] Previously the health system in South Africa was structured on the basis of ethnicity and provided a predominantly hospi-centric service with hospitals consuming 89.0% of the budget while a mere 11.0% was allocated to Primary Health Care.[12] With the advent of democracy and the policy of transformation adopted, the Primary Health

Care approach was prioritised and this focused on essential, comprehensive (prevention, treatment and health promotion), and accessible, acceptable and affordable care. As a result thereof, a redistribution of expenditure among the different health care levels occurred, with more than a third now allocated to the district level i.e. primary care and district hospitals, followed by the provincial level (almost a fifth) and finally by tertiary and central hospitals (Figure 6).[12]



Source: National Treasury.[2,4]

Source: Chapter 3, South African Health Review, 2007[12]

Figure 6: Distribution of total government health care expenditure in 2005

Other includes administration, facility maintenance, health professional training, ambulance and other patient transport

At present, there are a total of nine provincial health departments, with 52 demarcated health districts and 263 sub-districts. The primary level of care consists of approximately 4100 clinics and community health centres while the secondary and tertiary levels comprise 400 provincial hospitals, the majority being at a district level while the rest are regional and central facilities.[25]

1.3.2.4 The Private Sector

Private health care is purchased from health care providers predominantly by medical schemes which receive their funding via contributions form both employers and employees. Providers include health care workers, indispensable health facilities such as laboratories and hospitals, complementary, traditional and allied health professionals.

Medical schemes are voluntary, private health insurance organizations that came into operation in South Africa in 1889.[23] They operate as non-profit organizations that are recognized as a scheme when registered under section 24 (1) of the Medical Schemes Act No. 131 of 1998.[21] According to section 1 of the Medical Schemes Act, No. 131 of 1998,

> the "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution to:
> (a) make provision for the obtaining of any relevant health service;
> (b) grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
> (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme. (Medical Schemes Act, No.131 of 1998)[21]

According to the 2006 General Household Survey, 13.7% (approximately 6.9 million) of the population belonged to medical schemes, yet approximately 56.0% of health care expenditure was funded from the private sector.[26] This number has remained largely unchanged in the last few years. In 2005, approximately R9500 per person was spent on those covered by medical schemes, R1500 per person was spent by those using private Primary Health Care services and only R1300 per person was spent on patients using public health care sector facilities.[12] Private hospitals are not accessible to the majority of South Africans since they are expensive and usually situated in urban areas. There are approximately two hundred private hospitals in South Africa, of which the majority are small, short-stay hospitals with less than two hundred

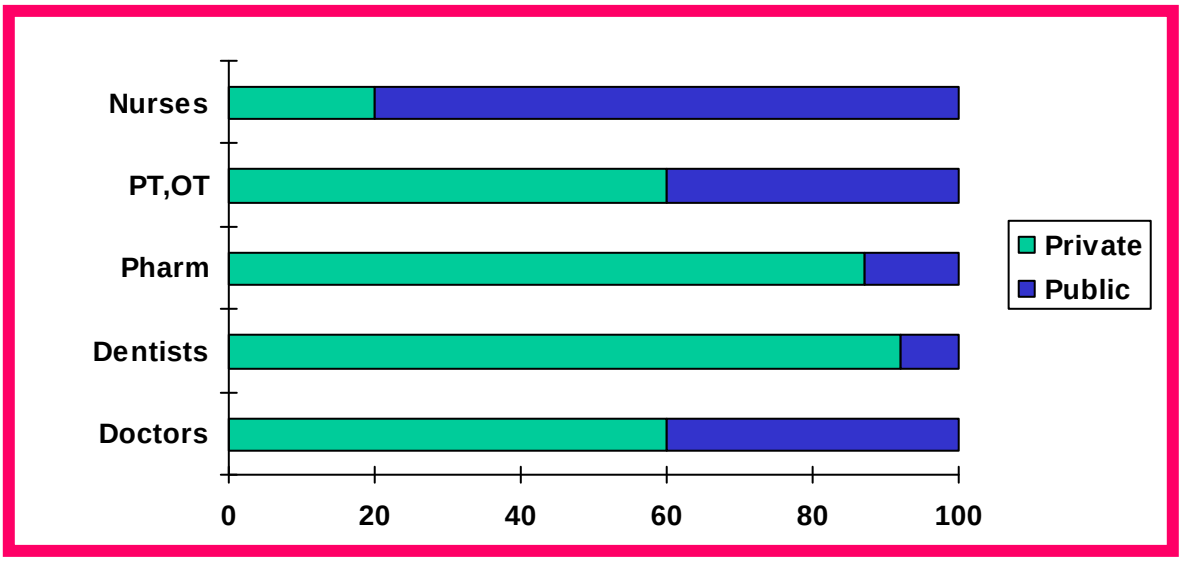
beds on average and where patients are admitted for less than thirty days.[27] There are nine private hospital groups which enjoy ownership of a total of 216 hospitals. The majority of these private health facilities are located in Gauteng province (n=95), Western Cape (n=39) and KwaZulu-Natal (n=27).[27] The Northern Cape and Limpopo province possess the least number of private hospitals, numbering merely three and five respectively. The three largest private hospital groups are Netcare, Medi-Clinic and Life Health care which account for 66.5% of private hospitals, 75.6% of private hospital beds and 80.0% of theatres.[27]

The number of private hospitals has increased by 34.0% since 1998 and the number of private beds by 32.0%.[27] Such a phenomenon could be explained by the preference of the insured population for the private sector due to the long waiting times in the public sector and the perception that the public sector provides poor quality health care. There has also been a reduction in the number of beds in the public sector.

Expenditure in the private health care sector has increased annually and has exceeded the inflation rate in the last few years.[12] The main cost drivers have been private hospitals, medical specialists, non-administrative costs and medicines. Out-of-pocket expenses, as a result of co-payments for medications, medical and dental specialists, account for approximately 25.0% of private health care financing.[12]

There exists also a mal-distribution distribution of health care workers between the public and private health care sectors (Figure 7). Furthermore, a skewed distribution of the workload is extremely pronounced. For example a pharmacist working in the public sector sees twelve times and a generalist doctor consults seven times the number of patients compared to those working in the private sector. A nurse in the public sector is responsible for six times more and a specialist doctor sees twenty-three times more the number of patients than the private sector.[12] According to the ethical rules of the Health Professions Council of South Africa (HPCSA), private hospitals are not allowed to appoint doctors or other health professionals except for nurses.[27] Therefore, the use of various incentives to attract health professionals to establish practices in their institutions is resorted to. It is estimated that 7000 medical specialists practise

in the private sector compared to 4000 in the public sector.[27] Among the 4000 in the public sector, a number practice under a Limited Private Practice Scheme. Therefore, it is difficult to establish the precise number of such specialists in the private sector, except to conclude that the majority thereof work in the private domain of the health industry.



Source: PowerPoint Presentation in National Health Systems Module, Masters in Public Health, University of KwaZulu-Natal, 2007[25]

Figure 7: Distribution of health personnel between the public and private health care sectors

The private sector thus faces many challenges including[26]:

- A lack of affordability and sustainability due to annual increases in medical scheme contributions accompanied by decreased benefit packages.
- Inequity, since a minority of the population belongs to medical schemes, most of the private health facilities are located in urban areas and the majority of health care workers work in the private sector. Government also subsidies medical scheme contributions and the training of health workers through tax exemptions.
- A lack of universal coverage of essential services. The private sector focuses on curative rather than preventive services
- There is inadequate competition in the private health care sector with the overriding reality of three groups dominating.

- There are many inefficiencies in the medical care of patients by health care workers and specialists due to financial incentives.

1.3.2.5 Medical Inflation and the Consumer Price Index

The consumer price index (CPIX) is an economic indicator that measures the monthly and yearly price changes in the cost of basic goods and services (e.g. food and beverages, transport, medical care) in comparison with a fixed base period. It assesses how much it would cost to purchase the same group of foods and services compared to a base-time period.[28] Inflation is measured employing a basket of goods and services that a typical consumer uses and this is then constructed by a statistical agency using the Income and Expenditure surveys conducted every five years by Statistics South Africa. The inflation basket reflects the influence of price increases for the average consumer and, in South Africa, this basket includes 1200 items.[29]

Medical inflation is an economic condition characterised by an increase in the prices of medical goods and services and the subsequent declining purchasing power.[30] In South Africa, medical inflation constitutes 8.1% of the consumer price index (CPIX), a figure which the authorities utilise as the preferred inflation measure.[29] The core components that make up medical inflation includes: doctor and nursing fees, hospitals and nursing homes, medical and pharmaceutical products, therapeutic appliances, contribution to medical schemes and insurance.[29]

In South Africa, the mean medical inflation index has invariably been above the mean consumer price index (Figure 8). This implies that beneficiaries have been paying more for the same medical services and goods over the years and such an amount has consistently been above the rate of increase of basic consumer goods and services. Figure 8 shows the trends of the mean medical inflation index and the CPIX from 2003 to 2006. Over the four years, both indices have exhibited an upward trend with the medical inflation index exceeding the consumer price index. Such an increase has also reflected the steeper trend with an average

increase of eleven points in the mean medical inflation index compared to four points in the consumer price index.

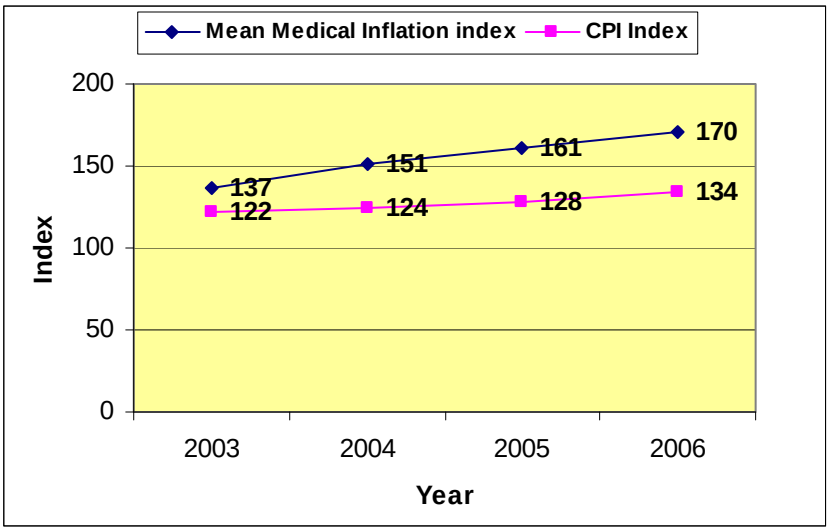


Figure 8: Mean medical inflation index compared to the mean consumer price index from 2003 to 2006[*†]

Figure 9 compares the average medical and consumer inflation percentages from 2003 to 2006. Medical inflation increased by approximately 1.0% in 2004 when compared to 2003 and showed a decrease of 3.2% in 2005 when compared to the previous year. Medical inflation peaked in 2004 at 9.9% when the CPIX was at its lowest at 1.4%. During 2004, medical inflation exceeded the CPIX by 8.5%. The last time the CPIX had experienced such a low level was in 1963.[31] The reason for this disparity remains unclear but the rapid economic growth prevalent at that time proved a major factor in causing the phenomenon of such a lower consumer price index.

The difference between the medical and consumer price indices began narrowing in 2005 when the CPIX began increasing. In 2006, medical inflation exceeded the CPIX by 1.4%.

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[*] Jammine A. Personal Communication - Econometrix, 14 January, 2008.

[†] Twala L. Personal Communication – Council for Medical Schemes, 14 January, 2008.

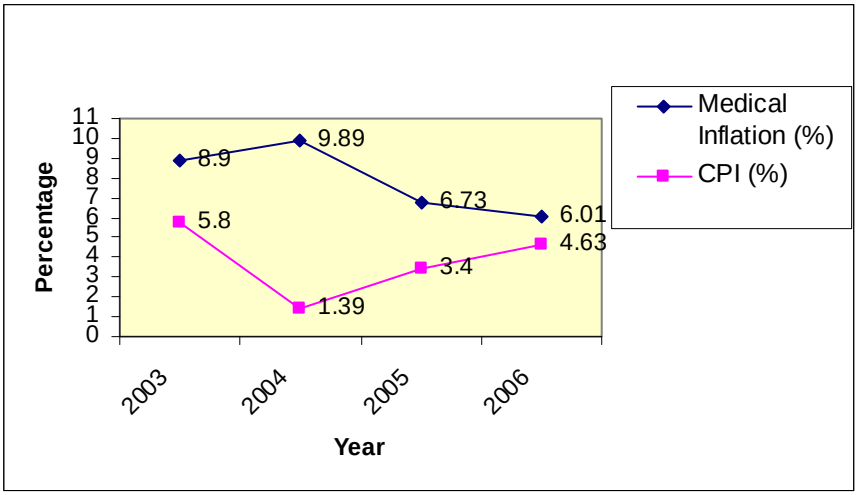
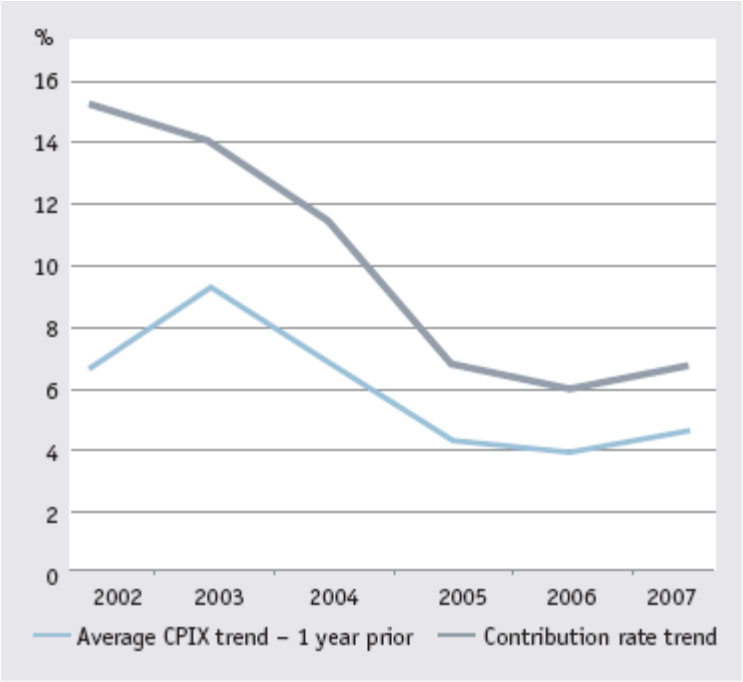


Figure 9: Mean medical inflation compared to the consumer price index (percentage) from 2003 to 2006



Source: Council for Medical Schemes 2006/2007 Annual Report, 2007[32]

Figure 10: Contribution rate changes and the Consumer Price Index 2003 to 2006

Figure 10 compares the average CPIX trend and the medical scheme contribution rate trend from 2002 to 2006. The contributions made to medical schemes have always exceeded the consumer price index. However, from 2003 onwards, the beneficiaries' contribution rate to

medical schemes has mirrored the changes in the consumer price index with a narrowing in the difference between the two rate changes. From 2005, the contribution rate trend has shown a similar trend to the CPIX.

1.3.3 Previous National Health Accounts Reports in South Africa

The first Health Expenditure Review was completed by McIntyre *et al* in 1995 and reviewed the 1992-1993 financial years.[33] This report provided information to the new policy-makers aiding the reformation of the health system following the advent of democracy.

The second, a NHA study, commencing in 1999 was conducted for the following three financial years: 1996/97, 1997/98 and 1998/99. This was conducted for both the private and public sectors, thereby producing an overall picture of health care financing and the uses of the funds.[1] The report on the private health care sector in South Africa was published in 2001.[33]

The second report on the public sector demonstrated increased government (public) spending on health care, a re-distribution of funds between the different provinces and a shift of funds to Primary Health Care up until 1997/98.[1] However, the period,1998/99 revealed a decrease in the per capita spending of government on health care, a reversal of re-distribution between provinces and a limited increase in Primary Health Care expenditure. This change was attributed to the macroeconomic policies arising from the adoption of GEAR, fiscal federalism and the reality that the health sector now received a smaller proportion of the overall budget.[1]

On the other hand, the private health sector report showed an increase in expenditure, an increase in the number of private beds but a decrease in the number of people who would enjoy regular access to private health care. The report concluded that both the cost and inequity existing between the public and private sectors increased in the three financial years that were reviewed.[1]

Among the recommendations suggested were that government improve its collaboration and interaction with the private sectors. It was also recommended that the private sector be regulated by government due to its expansion and that various necessary steps be taken to stem the exodus of health care workers from the public sector as a result of better remuneration elsewhere.

However, the NHA report was not without its limitations, particularly due to the lack of accurate data obtainable from both sectors. The private sector data was largely limited to those arising from medical schemes which at the time still needed much organization. Out-of-pocket expenditure was inclined towards having been both inaccurate and under-estimated but there was no other source for triangulation. Basic information on the numbers and location of private health care providers was inadequate.

1.4 PROBLEM

For a Health Expenditure Review to provide valuable information to improve the health system, it remains essential that it be conducted periodically, at one or two-yearly intervals. However, in South Africa there has existed a distressing gap between 1999 and the present. Therefore, financial information has not been available to policy-makers to enable them make evidence-informed decisions and address the important issues of financial sustainability, efficiency and equity.

It is therefore hoped that this report bridges that gap by providing information on the financial years from 2003 to 2006. The data used in this report is from the submissions that the various medical schemes made to the Council for Medical schemes. The quality and quantity of the submitted data has gradually improved following the establishment of this statutory regulatory body. This report is therefore based on the published data from the Council for Medical Schemes Annual Reports and from the Statistics South Africa website.

It is hoped that the information generated by this report can be used by the relevant policy-makers to make evidence-informed decisions allowing for better planning of health services, for the improvement of the health system, for the evaluation of policy implementation and for the efficient and equitable allocation of resources.

1.5 PURPOSE OF THE RESEARCH

The purpose of the study is to undertake a health expenditure review of the South African private healthcare sector from 2003 to 2006. The report will undertake a comparative trend analysis of contributions and expenditure in the South African private health care sector over the four year period and how these funds have been expended on the different provisions of healthcare.

1.6 SPECIFIC OBJECTIVES OF THE RESEARCH

The objectives of this study included the following:

a. To identify all components of private healthcare sector expenditure

b. To describe the flow of resources in the private health care sector

c. To analyze the main functions of healthcare financing; resource mobilization and allocation; pooling and insurance; purchasing of care and the distribution of benefits.

d. To address the following questions:

   - Where do the health resources come from in the private health care sector in South Africa in the financial years 2003 to 2006?
   - Where do these resources go?
   - What kinds of services and goods are provided in the private health care sector in South Africa in the financial years 2003 to 2006?
   - Whom do they benefit and the population covered by the private healthcare sector in South Africa in the financial years 2003 to 2006?

- The distribution of financing between different sources in the private healthcare sector in South Africa in the financial years 2003 to 2006.

1.7 OPERATIONAL DEFINITIONS USED IN THE STUDY

The Council for Medical Schemes categorises medical schemes as follows:

1) **Registered medical schemes**

   These are medical schemes registered by the CMS under section 24(1) of the Medical Schemes Act No. 131 of 1998.[21]

2) **Registered open medical schemes**

   Medical schemes registered under section 24(1) of the Medical Schemes act and open to all individuals who want to join.[34]

3) **Registered Restricted Medical Schemes**

   Medical schemes registered under section 24(1) of the Medical Schemes act and the rules of this scheme restrict the eligibility for membership by reference to[34]-

   - employment or former employment or both employment or former employment in a profession, trade, industry or calling;
   - employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers;
   - membership or former membership or both membership or former membership of a particular profession, professional association or union; or
   - any other prescribed manner

4) **Consolidated Medical Schemes**

   This includes all medical schemes.

5) **Bargaining Council Medical Schemes**

These are low-income schemes that focus on certain industries like clothing workers or food workers and they provide partial cover in South Africa e.g. The Clothing Industry Health Care Fund (CIHCF). Bargaining council schemes are unique in that benefits are negotiated as part of terms and conditions of service. They have not been able to comply fully with the Medical Schemes Act and have been granted exemptions for certain benefits like the Prescribed Minimum Benefits (PMBs).[23]

6) **Non-health expenditure**

These include administration fees; fees paid for managing health benefits (managed health care), broker fees, other acquisition costs and impaired receivables (bad debts).

7) **Acquisition costs**

Expenditure incurred by a medical scheme in initiating, underwriting and selling a policy of membership. These costs are ultimately fees paid to brokers and other distribution costs.

1.8 SUMMARY

South Africa is a middle-income country located at the tip of the African continent but it is fraught with socioeconomic inequalities. Historical legislation during the apartheid era led to inequities in the access to health care and this resulted in a fragmented and inefficient health system in South Africa. It has dual system with a first-world private health care sector consuming the majority of resources while serving a minority of the population and a challenged, overburdened public health system serving the majority.

Health sector reform was lead by the introduction of legislation such as the Medical Schemes Act No.131 of 1998, which was aimed at increasing access to wider population through removing barriers of adverse selection bias and risk rating. However, there have not been regular, systematic expenditure reviews which made financial information available to enable

policy-makers to make evidence-informed decisions and address the important issues of financial sustainability, efficiency and equity in the private sector.

The aim of this health expenditure review is to provide information on the total amount spent on health care in the private sector in South Africa from the 1 January 2003 to the 31 December 2006, to identify the sources of financing and the goods and services that these were spent on. A comparative trend analysis will be done to provide information on how these have changed over the years. It is hoped that the provision of this information will enable policy makers to make decisions to improve the health system for all South Africans.

CHAPTER II: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents the literature reviewed for this study. It begins by describing a health system as defined by the World Health Organisation. It then looks at financing such a health system with emphasis on what constitutes health expenditure. It examines the history of health accounts and describes the concept, attributes, uses and limitations of NHA in greater detail. As mentioned in the introduction in Chapter one, both Health Expenditure Reviews and NHA are based on the same analytic framework and use the same type of data, and since there isn't an abundance of literature on Health Expenditure Reviews, the literature on NHA was reviewed.

2.2 PURPOSE OF THE LITERATURE REVIEW

The purpose of this literature review is to understand the concepts of the health system and financing of the system as defined by an international organisation like the World Health Organisation. It also examines the framework of NHA according to international standardised methodology as detailed in the Organization for Economic Co-operation and Development manual so that health accounts across different countries can be compared.

2.3 SCOPE OF LITERATURE REVIEW

The following databases and websites were searched for literature on NHA:

- Pubmed, including Medline (598 abstracts retrieved)
- EbscoHost Reseach Database (113 abstracts retrieved)
- ScienceDirect (359 abstracts retrieved)
- Sabinet (2 abstracts retrieved)
- The World Health Organization
- The World Bank

- The Organization for Economic Co-operation and Development
- Partners for Health Reform

There were approximately 1,100 articles, reports and/or publications identified. The titles and/or abstracts of the articles, reports and/or publications were examined and the following keywords were used to determine which literature was suitable:

- National Accounts
- National Health Accounts or NHA
- NHA conducted in developed countries
- NHA conducted in OECD countries
- NHA conducted in developing countries
- Methods for conducting NHA
- Uses of NHA in budgeting
- Health Expenditure Reviews

The abstracts of those articles containing those keywords were printed and examined in relation to their relevance. Those that contained information relevant to this analysis and those that matched keywords were selected for use.

2.3 LITERATURE REVIEWED

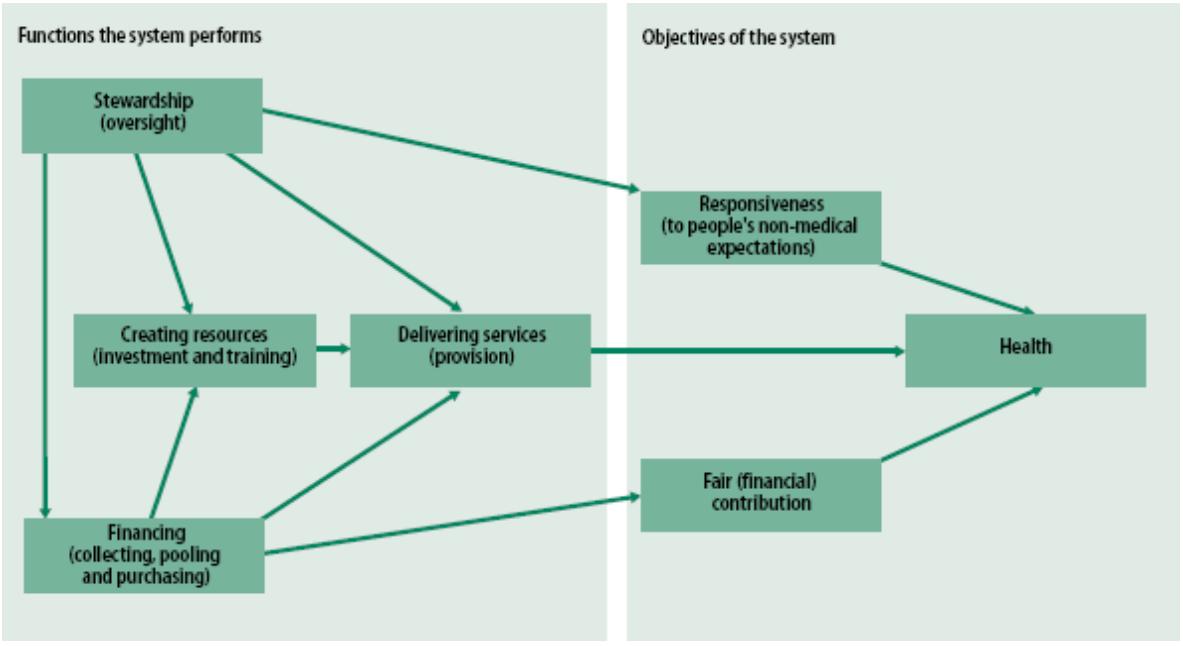
Literature was reviewed on concept of a health system and its functions, how such a health system is financed. The history of health accounting was explored and finally NHA was reviewed in depth.

2.3.1 The Health System

A health system is defined by the World Health Organization's 2000 report as all the activities whose primary purpose is to promote, restore and improve health.[35] It has four functions namely;

1. Stewardship (oversight)
2. Creating resources (investment and training)
3. Delivering services (provision)
4. Financing (collecting, pooling and purchasing)

These functions allow the health system to reach its objectives of not just improving health, but also being responsive to the legitimate needs of the population it serves and allowing for the fairness of financial contribution (Figure 11).



Source: The World Health Report 2000[35]

Figure 11: Relationship between the functions and objectives of a health system

Stewardship is probably the most important function of the health system from the viewpoint that it facilitates the promotion of good governance. Stewardship involves the careful and responsible management of the well-being of the population and establishing the best and fairest possible health system. It is concerned with the trust and legitimacy with which its activities are viewed by the people and it is concerned with maintaining and improving such national resources for the benefit of the population.[26]

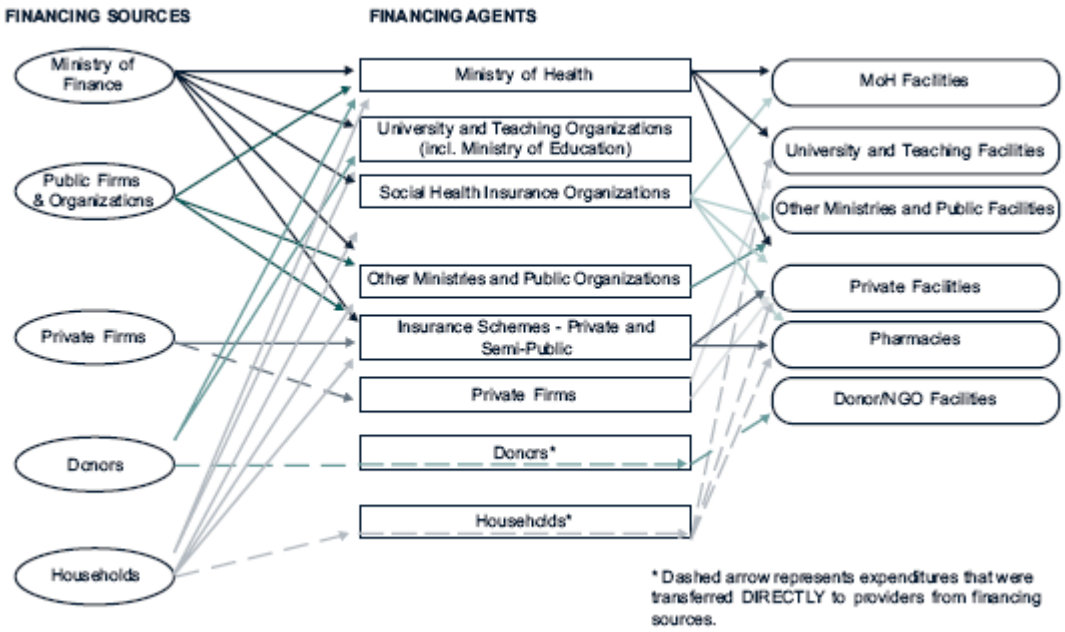
The conclusion can therefore be drawn that the health system does not constitute an isolated, vertical entity but represents a multidimensional, collaborative effort to improve the health of the population it serves.

2.3.2 Financing of the Health System

Health care is financed from different sources which can be categorized as public, e.g. general tax revenue, dedicated taxes, deficit financing and donor funding; quasi-public e.g. social health insurance, lotteries; and private e.g. direct household expenditure, medical aid schemes, community financing and charitable donations.[36]

The four main sources in South Africa include the following: government (the largest contributor), households, employers (government and private companies) and donors and non-governmental organizations.[10]

These different sources of financing and the distribution of each source leads to outputs from the health system in the form of programmes and services. This is termed the flow of funds and these flows can be rather complex (Figure 12).



Source: Bhawalkar *et al.* Understanding National Health Accounts, 2003[37]

Figure 12: Flow of funds through the health system

Health care financing forms an essential and important consideration in improving health, especially for middle- and low-income countries since financial resources enjoy an important role in improving and maintaining the health of a population. The mobilization of health finance and their efficient and effective allocation are essential to meet the needs of the health system and the population it thereby serves.

To achieve the health system goals, there needs to be adequate and fairly accurate financial data which is often lacking in developing countries, including South Africa. Policy and decision-makers may have inadequate financial information for the health sector and as a result make ill-informed decisions which could have a negative impact on the health system and the population. Health Expenditure Reviews and NHA provide invaluable information that aids the health policy process so that evidence-informed decisions are made and the health system's performance is improved.[38] They were therefore established to understand and track the flow of funds in the health system and to link these expenditures to health outcomes in the form of indicators thereby improving the overall performance of the health system.

To track this flow of funds in the health sector, it is important that the boundaries of the health system are clearly delineated at the outset since it helps standardize what is included as health care expenditures and facilitates cross-country comparison. Partnerships for Health Reform (PHR) have used the following comprehensive definition for health expenditures:

Health expenditures are defined as all expenditures or outlays for prevention, promotion, rehabilitation, and care; population activities; nutrition and emergency programmes for the specific and predominant objective of improving health. Health includes both the health of individuals as well as of groups of individuals or populations.

> Expenditures are defined as health expenditures on the basis of their primary purpose, regardless of the primary function or activity of the entity providing or paying for the associated health services. Expenditure for the purpose of training or education of health sector personnel, which impacts health-sector specific knowledge and skills, as well as health-related research and administration, are defined as being for the purpose of health improvement when applying this definition. (Berman and Thompson 1999)[39]

Thus the expenditure can be summarized as measuring what was spent, in monetary terms, on a certain good or service and is retrospective unlike a budget which is prospective. NHA examines what health activities are done rather than who does it or where it is done. It also does not distinguish between effective and ineffective health activities, so that it is the purpose of the activity that is important and not the outcome.

2.3.3 The History of Health Accounting

Historically, the origins of health expenditure reviews began in 1960 when Abel-Smith, together with the World Health Organization, conducted the first national study comparing the health expenditure of Sri Lanka (formerly Ceylon) and Chile.[40] In 1967, he then undertook a follow-up study of fourteen developing countries from Africa, America, the Eastern

Mediterranean, and the Western Pacific. Thereafter, in the 1970s and 1980s, other countries began conducting their own reviews. The United States has been collecting data since 1964 and the Organization for Economic Co-operation and Development (OECD) has compiled data of health expenditure in 24 OECD countries since the 1960s.[41] It is estimated that more than 60 countries have conducted one or more exercises in health accounting.[41]

Although this data was very useful, no comparison or analysis between countries could be undertaken due to different methods having been used. Thus, towards the latter part of the 1980s and the beginning of the 1990s, a need for a standardized methodology in drawing up NHA was recognized.[40] Thereafter, there have been various publications issued by the World Health Organization, the World Bank, the OECD, and the United States Agency for International Development and Partners for Reform on NHA methodology, uses and implementation.

2.3.4 What Are National Health Accounts?

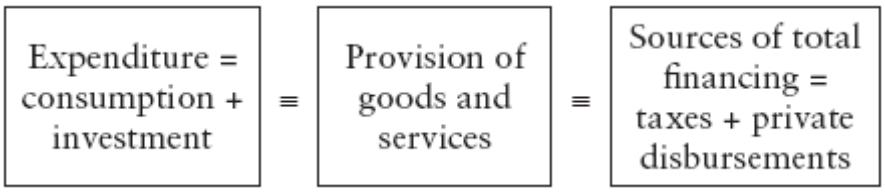
NHA can be seen as a tool used worldwide to describe, analyze and summarize the financing of health systems, thereby providing necessary and important evidence to policy-makers so that informed decisions can be made to improve the performance of health systems.[42]

It addresses four basic sets of questions:[41]

- where do health resources come from,
- where do they go,
- what goods and services they purchase and
- whom do they benefit?

The expenditure data is systematically organized into a standard set of tables according to an international classification scheme. It is uncomplicated and can be read and understood by decision-makers, even those without knowledge of health economics.[37]

Alternatively, NHA can be viewed as the following:[41]



Source: Poullier *et al*. National Health Accounts: Concepts, Data sources and Methodology, 2003[41]

Figure 13: National Health Accounts - a sequence of identities

This means that the value of all the resources spent on health is equal to the sum of the value of all goods and services produced and delivered in that health system, which in turn is equal to the resources provided to the system.[41]

The methodology used in NHA is drawn from the principles of health accounting arising from the System of Health Accounts (SHA) of the OECD. This manual, published in 2000, provides a framework for those who wish to use the OECD standardized approach.[43] It also provides the International Classification for Health Accounts (ICHA) scheme, which categorizes such health expenditures.[37] System of Health Accounts measures health expenditure and covers the financing agents, providers and functions. NHA employs the International Classification for Health Accounts scheme but simplifies it further, based on the needs of the country. NHA uses System of Health Accounts classification of health expenditures but disaggregates it further and examines an additional aspect, namely financing sources.

The main purpose of NHA is as a management tool for planning, monitoring and evaluation of the health policy process. However, the information it provides must be supported by other non-financial data such as the epidemiology of disease in that country and provider utilization rates so that an appropriate decision can be made.

2.3.5 The National Health Accounts Framework

NHA measures health expenditure as a percentage of the Gross Domestic Product (GDP). Such comprehensive analytical data identifies the following categories of health care entities in the health system:[2, 37]

2.3.5.1 Financing Sources – Where Does the Money Come From?

The major categories of funding for health care expenditure which is not always attributed to the 'original source'.[2] These are the institutions and entities that provide money to the financing agents and include general tax revenue, social security, the private sector such as companies, Non-governmental organizations, the medical schemes and out-of-pocket expenditure.

2.3.5.2 Financing Agents (also known as Financing Intermediaries) – Who Manages and Organizes the Funds?

Financing Agents refers to the organisations or groups who receive funds from sources and pay for or purchase health care therewith. These include the department of health, private medical insurance, NGOs and companies.[2]

2.3.5.3 Uses

Uses refer to the activities that health care funds are actually spent on. These include different categories:[2]

i. **Providers – To whom did the money go?**

The explicit categories of organizations or individual practitioners who provide health services, namely public and private hospitals, clinics, nursing homes, community health centres, private practices.

ii. **Functions – What type of service or product was actually produced?**

The type of health service provided (curative, preventive, pharmaceutical products, etc.) with the funds.

iii. **Line items (Cost of factor of Production):**

The type of inputs to health services (personnel, drugs, medical equipment, etc.)

iv. **Beneficiaries:**

The value of goods and services produced are classified according to: geographic boundaries, demographic characteristics, economic strata and disease categories/interventions.

NHA therefore analyses and reflects the flow of funds from[37]:

- Financing sources to Financing Agents
- Financing Agents to Providers
- Financing Agents to Functions
- Providers to Functions

2.3.6 Attributes of National Health Accounts

The NHA process possesses ten attributes[41, 44]:

a. **Comprehensiveness**: The data covers the entire health system, both public and private, as well as any other institution providing or paying for an activity whose primary purpose is to improve health. Thus, it monitors all health care expenditure, sources, inputs and outputs and financial flows within the health system.

b. **Consistency**: The same standardised classifications, definitions and concepts are used for each entity and every transaction is measured. This maintains internal validity and avoids contradictions. It also allows for any gaps and deficiencies to be identified in the system of reporting and allows for quality improvement.

c. **Comparability**: applying identical rules and methods is necessary for analyses of changes in health financing over time and across countries.

d. **Bookkeeping and imputations**: Economic functions, which are not quantified in the available sources of information, must be estimated and entered as an accounting system does not just stop at integrating dispersed data from various sources;

e. **Multidimensionality and compatibility**: expenditure information is complemented by non-financial information (demographic, epidemiological and human, tangible and intangible capital), thereby providing an estimate of flow in an overall context.

f. **Accuracy and transparency**: the levels and time series provides information that policy-makers can safely use to make appropriate decisions.

g. **Timeliness**: trends of selected components of NHA may demonstrate rapid and deep changes compared to survey data which constitute structural information whose relationships evolve only slowly. NHA provides policy makers with information when they require it.

h. **Recurrence**: Continuity of estimates represents the only way whereby to judge if results of estimates are exceptional or expected. This entails the benefit of learning to improve the quality of the estimates and diminish the costs of producing them.

i. **Policy sensitivity**: Provides information describing components of the health system and this may be used in planning suitable macroeconomic policies. The information should include everything that is relevant to a country's health policy development.

j. **Distributions**: The amount of resources spent among different health care providers, patients, goods and services.

2.3.7 Uses of National Health Accounts

The following describes the uses of NHA according to the World Health Organisation guide for low-income and middle-income countries[44]:

I. The flow-of-funds information contained in the NHA allows policy makers to identify whether financing is in line with policy priorities. It also enables policy makers to determine where effective levers for policy change lie.

II. NHA information on financing sources, financing agents, functions or providers can provide snap shot comparisons between countries.

III. NHA tables can be constructed to link financing sources or agents to cost of factors of production. This information can help policymakers assess whether there is an appropriate allocation of funds on personnel, on pharmaceuticals, and on equipment.

IV. NHA tables can be constructed to reveal the beneficiaries of health expenditure, addressing distributional equity and effectiveness issues. Such tables reveal to policy makers whether scarce resources are actually spent on national priorities.

V. Beneficiary groups:

- demographic characteristics of beneficiaries:— age, sex, race, urban or rural residence, ethnicity, etc;
- socioeconomic status of beneficiaries:— grouped along the lines of educational attainment, income, wealth, or occupation;
- health status of beneficiaries:— groupings typically include condition or disease state, functional status, or type of intervention received

VI. Regions: sub national groups of the entities involved in the financing or consumption of goods and services transacted within the health accounts boundaries.

2.3.8 Limitations to National Health Accounts

Despite its multifold benefits to the health system, there are some drawbacks to NHA:[45]

- They do not provide information on how efficiently (both allocative and technical) finances are allocated and spent i.e. value-for-money.

- They do not provide information on how to improve the financing of services by increasing the amount of resources available and by using and allocating existing resources more efficiently.
- Policy-makers may use information from national health accounts selectively i.e. only when it supports their existing policies.
- Access to good quality data is often difficult, especially in developing countries, particularly in respect of the private sector who often entertain fears that the data may be used against them.
- NHA does not include other economic costs e.g. indirect non-medical costs (time off work), intangible costs (pain, suffering).

2.4 SUMMARY

The health system can be viewed as a dynamic entity whose goal is to improve the health of the population it serves. This is done by responsible, good governance whereby the population served is not impoverished as a result of their contributions to health care. To attain the goals of the health system, financial resources need to be allocated equitably, efficiently and effectively. The allocation of funds in health can be tracked in the form of health accounting so that policy makers are informed when introducing changes to improve the country's health system's performance.

NHA has been undertaken since the 1960s but due to different methodologies, comparisons between countries could not be done. It is for this reason that the International Classification for Health Accounts was developed to categorise health expenditures and NHA disaggregates this and examines the flow of funds from financing sources to financing agents to providers and the health service provided. This comprehensive financial information, if done reliably and according to standardised methodologies provides valuable information to policy makers when

considered together with non-financial influences like the country's human resources, demographic and epidemiological profile.

Despite the wealth of information that NHA provides, it is not without its limitations. It is difficult to construct comprehensive, accurate tables particularly in low and middle-income countries, due to a lack of good quality data. From the information that is provided, one cannot determine if a country's resources have been allocated so that the best value for money is obtained. However, these limitations do not obviate the need for both health expenditure reviews and NHA since the information they provide far outweighs any limitations.

CHAPTER III: METHODS

This chapter describes the methodology employed in undertaking this study of the private health care sector in South Africa from 2003 to 2006. It describes the study design, the study population, the data sources and statistical analysis and lists the ethical approval by the University of KwaZulu-Natal.

3.1 INTRODUCTION

The methodology used in conducting this Health Expenditure Review is based on the World Health Organization's guide to producing National Health Accounts: with special applications for low-income and middle-income countries.[44, 46] The World Health Organization's guide demonstrates how to implement NHA using the International Classification for Health Accounts developed by the Organisation for Economic Co-operation and Development. This international classification has already been reviewed and validated and standardizes presentation of data so that comparisons on health expenditure can be formulated across countries. It has been adapted for local use in South Africa which is classified as a middle-income country.

The approach in generating the Health Expenditure Review began with the assembling of a team consisting of collaboration between the University of KwaZulu-Natal Health Outcomes Research Unit and the Department of Public Health Medicine. The researcher identified the sources of data required for the expenditure review and collected, entered, analyzed and wrote this report.

3.2 TYPE OF RESEARCH

Health systems research – a health economic analysis

3.3 STUDY DESIGN

This study uses an observational, descriptive cross-sectional study deign.

3.4 TARGET POPULATION

The population using the private healthcare sector in South Africa

3.5 STUDY POPULATION

This study focuses on the private health care sector in South Africa and includes all contributors to the private health care sector from 2003 to 2006. This includes all people that contribute to medical schemes for the aforementioned time period.

3.5.1 Selection of study population

There was no sampling of the study population since all contributors to medical schemes were included as per the data collected by the Council for Medical Schemes. Those people using the private health care sector and paying out-of-pocket were also included.

3.6 PERIOD OF STUDY

The study focuses on four specific financial years beginning on the 01 January 2003 and ending 31 December 2006. It is important to acknowledge that, in South Africa; the private health care sector's financial year begins 01 January and ends on the 31 December. In contrast, the public sector's financial year begins on the 01 April and ends on the 31 March.

3.7 DATA SOURCES

There were two main data sources that were used in this Health Expenditure Review: the Council for Medical Schemes database and Statistics South Africa's Income and Expenditure Survey (IES) of 2006.

3.7.1 Council for Medical Schemes

This provided the main data source for this study. Data on heath care and non-health care expenditure by medical schemes was provided by the Council for Medical Schemes database for the years 2003-2004, 2004-2005, 2005-2006 and 2006-2007. This covers the fiscal years from 01 January 2003 to 31 December 2006. Expenditure data was obtained for all elements relevant to the private health care sector including private hospitals, general practitioners, medical specialists, pharmacies, dentists, traditional and complementary practitioners, non-governmental organizations, insurance companies, employers and households. These elements were available in the Registrar of Medical Schemes database which has already been audited. Where there was a need for clarification of data, the researcher approached the Council for Medical Schemes directly.

The Council for Medical Schemes administers the data of people who spend their money on medical scheme benefits. This Annual Statutory Return (Appendix 1) is the data source for the Council for Medical Schemes database. All registered medical schemes are required to electronically submit an Annual Statutory Return containing information on the demographic profiles of beneficiaries, member movement between schemes, waiting periods imposed, utilisation of health care services, expenditure on health care services and annual financial statements.[‡]

[‡] Willie M. Council for Medical Schemes - Personal Communication: Information on Data Collection for Medical Schemes, 10 December, 2007.

3.7.2 Statistics South Africa for Household Out of Pocket Expenditure on Health

The data source on out-of-pocket expenditure i.e. household expenditure was obtained from the IES that was conducted by Statistics South Africa from September 2005 until August 2006.[47] This survey is undertaken every five years and collects information on the various sources of income (monetary or in-kind) acquired by the sampled households and the manner whereby this income was spent. One of the objectives of this survey is to provide an independent source of information that is required to estimate the final private consumption expenditure component of NHA.

The survey employed a two stage sampling technique. The first stage sampled 3000 primary sampling units (PSUs), which were obtained from the Statistics South Africa's Master Sample. The second stage involved the selection of eight dwelling units from each PSU resulting in a total of 24 000 dwelling units being sampled. This sample was then spread out over twelve survey periods of one month each i.e. each household participated over one month.

For the first time, the IES survey used both a diary and recall method to collect data from the households. Fieldworkers administered a main questionnaire over five separate visits which collected data on the acquisition of goods and services in the preceding eleven months. During the month in which the household was surveyed, they had to keep a diary in which they recorded their acquisitions on a daily basis. The purpose of the diary was to decrease or eliminate recall bias introduced by the questionnaire. Both methods recorded a response rate of 93.5%.

Data was collected on the following household expenditure categories: housing, water, electricity, gas and other fuels; health; education; food and non-alcoholic beverages; clothing and footwear; transport, recreation and culture, etc. These categories were coded according to the United Nations' Classification of Individual Consumption According to Purpose (COICOP), which ensures that the items receive a high quality description. The data was further disaggregated by sex, population group, province and settlement type (urban or rural).

This survey forms the only easily accessible and available source of information on a relatively "grey" zone in expenditure but it is subject to limitations. According to Statistics South Africa, the two major limitations of the survey were movement of households and boundary changes. Certain households relocated from rural to urban areas, while others moved out of areas due to seasonal changes and because of vacations.

3.8 VARIABLES

1. Total expenditure on health care by the private sector in South Africa
2. Total number of medical schemes submitting annual statutory returns. This was then disaggregated by medical scheme type
3. Membership of consolidated medical schemes and by scheme type
4. Age distribution of beneficiaries including the pensioner ratio.
5. Non-health expenditure by medical schemes
6. Nominal and Real expenditure by medical schemes disaggregated according to scheme type i.e. consolidated, open and restricted:
    a. Total overall benefits paid. This category was further disaggregated according to the benefits paid out of the risk and saving pool and included the following:
        - Medical Specialists and Clinical support specialists. This was disaggregated further according to the different sub-specialities
        - General Practitioners
        - Dentists
        - Dental Specialists
        - Supplementary and allied health professionals
        - Total hospital expenditure which includes both the private and provincial hospitals.
        - Private hospital expenditure which includes ward fees, theatre fees, consumables, medicines dispensed in hospital and managed care arrangements (in-hospital benefits).
        - Provincial hospital expenditure which includes ward fees, theatre fees,

consumables and medicines dispensed in hospital.

- Complementary Medicines
- Medicines. This was disaggregated according to dispensation by pharmacists, practitioners, medical specialists, allied and support health professionals and other professionals
- Managed care arrangements (out-of-hospital benefits)
- Ex-Gratia Payments
- Other Benefits which includes appliances, prostheses, home oxygen, blood courier services, ambulance services, and other.

7. Utilization of services by the different types of medical schemes which looked at the following categories:
   a. Burden of chronic diseases
   b. Average length of stay by medical scheme beneficiaries in both private and public hospitals
   c. Vital statistics i.e. number of births, number of live births and number of deaths by medical scheme beneficiaries in both public and private hospitals
   d. Number of medical scheme beneficiaries admitted to private and public hospitals. This was disaggregated according to the scheme and ward type i.e. day clinic, theatre, intensive care unit, high care and the general ward. It also looked at those beneficiaries admitted to hospital for Prescribed Minimum Benefits.
   e. Number of beneficiaries of the different medical scheme type visiting a Primary health care provider which includes the general practitioner, dentist and private nurse.
8. Average expenditure, in both nominal and real terms, per beneficiary per month out of the risk pool and medical savings account
9. South African household expenditure on health
10. Contributions per annum to out-of-pocket expenditure on health
11. Percentage of out-of-pocket expenditure on health according to the different categories

3.8.1 Reliability and Validity of Data Source

This was a secondary analysis of data published by the Council for Medical Schemes in their annual reports for the four financial years. There was no access to the primary data source but the Council for Medical Schemes has a number of quality assurance steps in place to ensure that medical schemes submit complete and accurate data when completing their online annual statutory return submission. This data is audited by accredited accountants prior to being published and therefore the data published by the Council for Medical Schemes can be assumed as reliable and valid.

The data on out-of-pocket household expenditure published by the Statistics South Africa IES of 2006 must be interpreted with caution due to the lack of good quality, reliable data when conducting such a survey. Again, there was no access to the primary data sources but Statistics South Africa validates its data before publishing the results of the survey. This was the best available and accessible data on out-of-pocket expenditure at the time of the study.

3.9 BIAS AND LIMITATIONS

Since the study population included all those that contributed to medical schemes, who submitted their annual statutory return from 2003 to 2006, there was no selection bias. However, there was no access to the primary data source to confirm this.

There was no access to other data sources on out-of-pocket expenditure on health for triangulation of the information published in the IES.

Information on contributions to short and long term health insurance policies could not be accessed.

There are no confounders and measures of association in this study since it is a descriptive, cross-sectional study. The results of this Health Expenditure Review cannot be generalised to

the health sector in South Africa or that of other middle-income countries since it is limited to the private health sector only.

3.10 STATISTICAL ANALYSIS

Data was entered onto Microsoft Office Excel 2003 spreadsheets by the researcher. This entry was cross-checked by a data analyst in the Health Outcomes Research Unit.

The average medical inflation and consumer price index for the year was calculated for each year from 2003 to 2006. The respective inflation percentages were removed from the nominal value for each year to obtain the real value, which was used compare all expenditure relative to the base year of 2003.

The data was shown in line graphs, column graphs, bar charts, tables and descriptive statistics. The software package, Microsoft Office Excel 2003 was used to generate the graphs, charts, tables and calculate the descriptive statistics.

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3.11 ETHICS

The study protocol was approved by the University of KwaZulu-Natal, Nelson R. Mandela School of Medicine's Post-graduate Education Committee for a Masters in Medicine degree (Public Health), PGR 006/07 (Appendix 2). The study received expedited ethical approval from the Biomedical Research Ethics Committee of the Nelson R Mandela School of Medicine South Africa: Reference number BEO 27/08 (Appendix 3 and 4). No permission was required for the use of the data since all data sources were in the public domain and the source acknowledged.

3.12 SUMMARY

This Health Expenditure Review forms part of health systems research and presents the flow of funds in the South African private health care sector from its two main sources viz. medical schemes and households. This cross sectional study examined all the available and accessible financial data for the private health sector from 2003 to 2006 and analysed it using descriptive statistics and graphical representation. Due to the study design, expedited ethical approval was granted.

All data used in this study was validated prior to being in the public domain and the researcher had no access to the primary data to confirm any reduction in bias. However, the data was published by the Council for Medical Schemes and Statistics South Africa which are two organizations that produce reliable and valid information so the data can be assumed to be of the best available quality.

CHAPTER IV: RESULTS

4.1 INTRODUCTION

This section analyses the flow of funds in the private health care sector i.e. where the money came from (income) and where it went (expenditure) from 2003 to 2006. Analysis of this trend would enable stakeholders to determine the biggest cost-drivers and expenditure trends. This would allow for appropriate planning of health services to improve the efficiency and effectiveness of the health system.

In order to analyze the impact of inflationary pressures on private healthcare, both the nominal and real values were compared. The nominal value represents the face or par value of the money in the different years. The real value is the amount that takes inflation into account and is equal to the nominal value less inflation. This expenditure review considered both the nominal and the real values in the different expenditure categories from 2003 to 2006. Real values have been calculated as the nominal value less medical inflation so that prices were standardized to the base year of 2003 and, therefore, a true comparison of trends was reflected.

4.2 FLOW OF FUNDS FROM THE SOURCES TO THE FINANCING INTERMEDIARIES

This section describes the mechanism by which private healthcare is funded. The two most important sources of funding in the private sector are employers, employees and households. Figure 14 shows a schematic representation of the flow of funds from the two main financial sources to the financial intermediaries which are the medical schemes and the households themselves. Funds flow from the financing intermediaries to the providers which are the organisations or practitioners who provide these health care services. These providers include predominantly general practitioners, medical specialists, dentists, private hospitals, medicines, supplementary and allied health professionals. A significant proportion of the funds received

by the medical schemes also go towards non-health care expenditure which includes administration costs.

The flow of funds from these providers was then analysed to determine the functions that these funds served i.e. the type of service that these funds provide - preventive, curative, etc. This final pathway is difficult to demonstrate explicitly and inferences were made from the utilisation of services data. Finally, the outcomes in terms of demographic data, clinical outcomes and disease categories are difficult to determine since such data is not collected. However, the amount per capita expenditure was calculated.

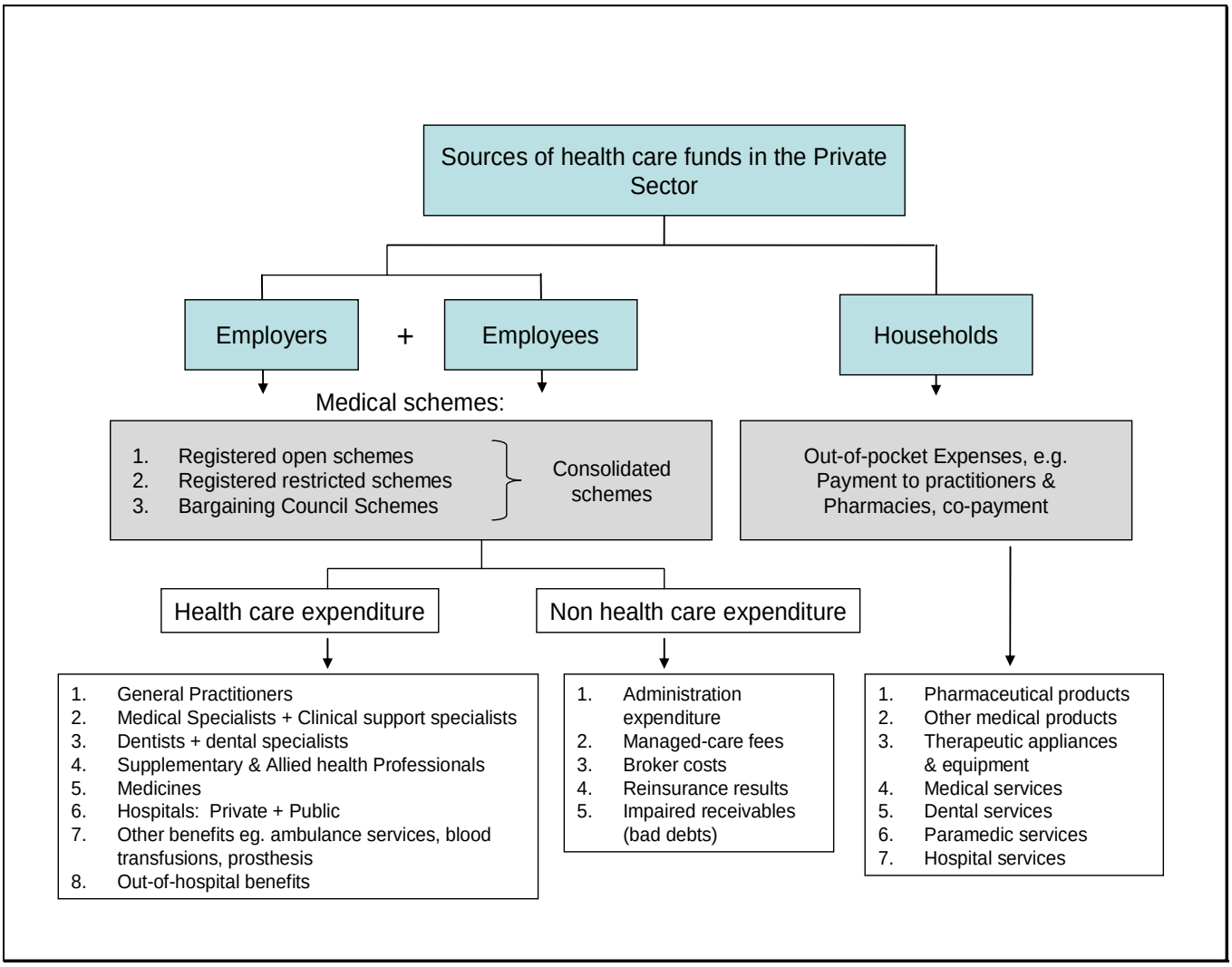


Figure 14: Schematic representation of the flow of funds in the private health sector in South Africa from its sources to the providers and functions

Employers contribute partly of fully to employees' medical schemes and some private companies offer occupational health services at the workplace. Government, which functions as the largest employer in South Africa, also contributes to medical schemes. Prior to January 1996, government paid the contribution to the medical scheme of the employees' choice but since the introduction of the Government Employees Medical Scheme (GEMS) which came into operation in 1996, government provides contributions to members belonging to this scheme only.

Households which include employees and other members of the population also contribute to medical aid schemes and other private insurances. Contributions of members to medical schemes represent the major sources of funding for privately purchased medical care.

Households also pay out of pocket for health care by directly paying health practitioners and dispensing pharmacies as well as co-payments for benefits not covered or partially covered by schemes.

Table 2 shows the total expenditure on health care in the private sector from 2003 to 2006 from the two main sources: medical scheme contributions and household expenditure. The Council for Medical Schemes Annual Reports provided the data on the gross contribution income for the medical schemes. The IES conducted by Statistics South Africa provided the information on out-of-pocket expenditure for 2006. The previous survey was conducted in 2000. Based on the 2006 figures, medical inflation was removed and an estimate of out-of-pocket expenditure was then calculated for the years 2003 to 2005.

Table 2: Total expenditure (in Billions of South African Rands) on health care in the South African private sector from 2003 to 2006

	2003	2004	2005	2006
1. Medical Schemes:				
Gross contribution income	R 48,600,000,000	R 51,500,000,000	R 54,200,000,000	R 57,600,000,000
2. Out-of-pocket Expenditure on health	R 8,897,000,000	R 9,766,000,000	R 10,838,000,000	R 11,620,000,000
Total expenditure on health in private sector	**R 57,497,000,000**	**R 61,266,000,000**	**R 65,038,000,000**	**R 69,220,000,000**

4.2.1 Medical Schemes

Medical schemes are the largest financing intermediary/agent in the private health care sector in South Africa. Membership to schemes can be either to open schemes, restricted schemes and bargaining council schemes. Open schemes are registered under section 24(1) of the Medical Schemes act and open to all individuals who want to join. Restricted schemes are also registered under the Medical Schemes act and restrict the eligibility for membership to employees or former employees of employer managed schemes such as Bankmed, to which only the banking sector employees may belong. The bargaining council schemes are low-income schemes providing partial cover in South Africa e.g. The Clothing Industry Health Care Fund. They are unique in that benefits are negotiated as part of terms and conditions of service.

The total number of registered medical schemes varies each year due to the processes of liquidation or amalgamation. These schemes submit financial and other information to the Council for Medical Schemes each year.

Figure 15 shows the total number of medical schemes submitting statutory returns from 2003 to 2006. In 2006, there were 124 registered medical schemes which submitted their information in an Annual Statutory return.[48] As mentioned previously, as a result of consolidation, liquidation and the non-submission of returns, this number has steadily decreased over the years from a high of 157 in 2003.

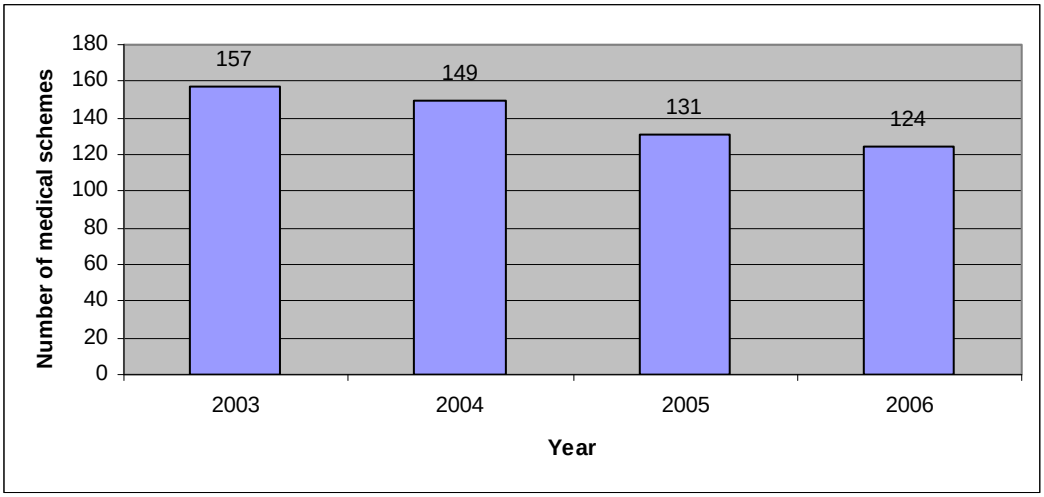


Figure 15: Total number of medical schemes submitting annual statutory returns from 2003 to 2006

Figure 16 indicates the number of medical schemes submitting annual statutory returns by medical scheme type i.e. open, restricted and bargaining council schemes. For a medical scheme to be recognised as an operational entity, it has to be registered under section 24 (1) of the Medical Schemes Act No. 131 of 1998.[21]All these schemes are then required to electronically submit an Annual Statutory Return. Therefore all schemes must be registered in order to operate but may fail to submit an Annual Statutory Return like Bargaining Council medical schemes. There are no medical schemes that submit an Annual Statutory Return but are not registered.

The decrease observed in the overall number of operational medical schemes, although present in all schemes is most obvious in Bargaining Council schemes who have failed to submit complete returns for 2005 and 2006. The reason for this is not clear but may be due to the fact that the maintenance of such schemes is becoming increasingly difficult.

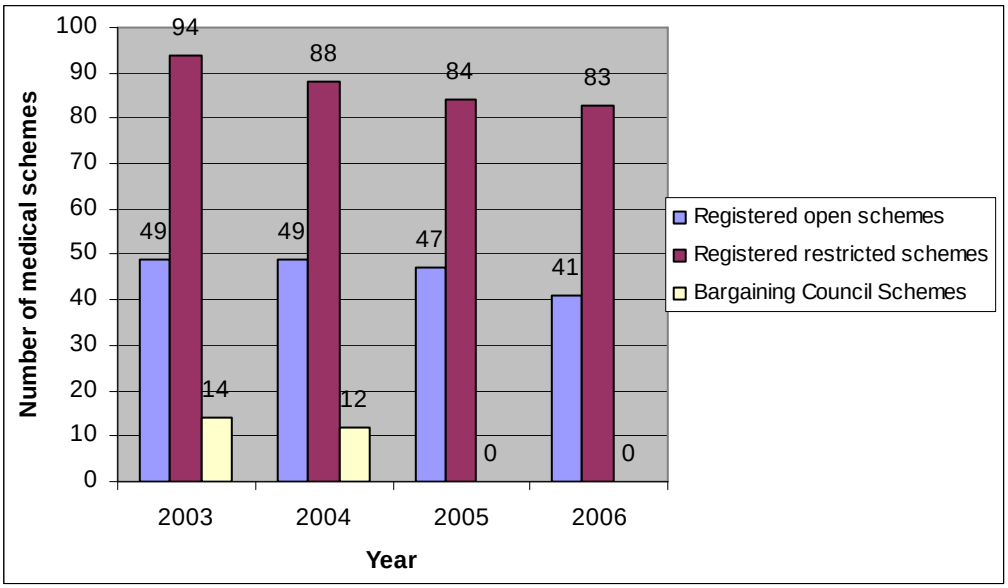


Figure 16: Number of medical schemes submitting annual statutory returns by scheme type from 2003 to 2006

Figure 17 shows the total number of principal members belonging to consolidated medical schemes from 2003 to 2006. It is important to note that for the years 2005 and 2006, bargaining council members have been excluded since data on those schemes were not submitted. The small decrease in 2005 from 2004 is likely to be due to the exclusion of members belonging to this scheme type. In 2006, the total number of principal members belonging to medical schemes was 2 985 350, representing an increase of 6.2% from 2005. This large increase was most likely due to GEMS which came into operation in January 2006 and has resulted in more people being covered by a medical scheme.

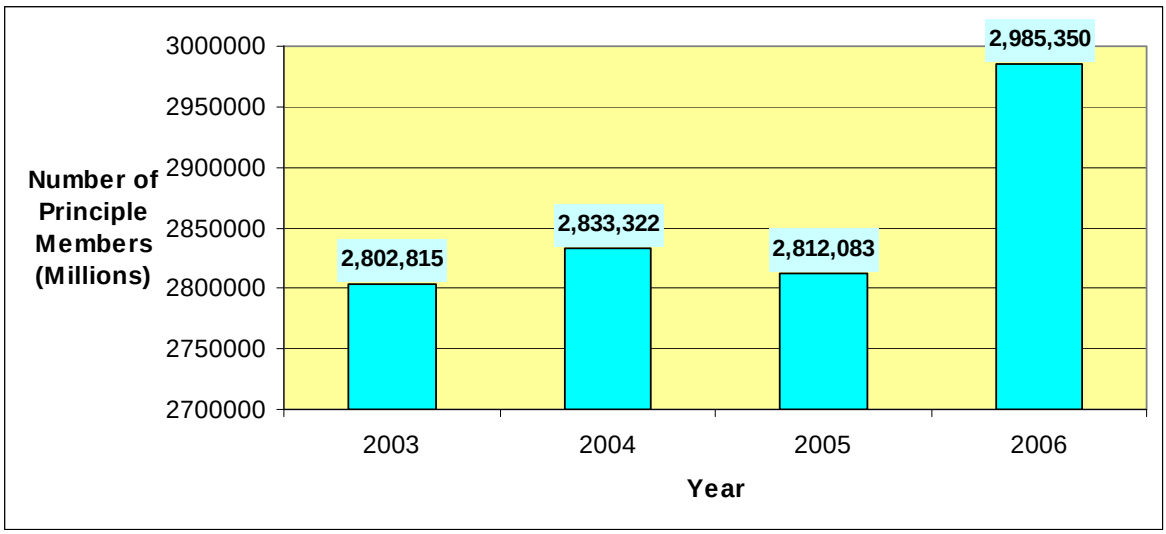


Figure 17: Number of principle members belonging to consolidated medical schemes from 2003 to 2006

Figure 18 shows the total number of beneficiaries (principle members and their dependants) covered by a medical scheme for the period 2003 to 2006. Despite the exclusion of bargaining council schemes in 2005 and 2006, this number has remained fairly constant at around seven million people from 2003 until 2005. However, the number increased marginally in 2006 by 4.3% compared to the previous year. This increase in beneficiaries is again partly attributed to the introduction of GEMS.

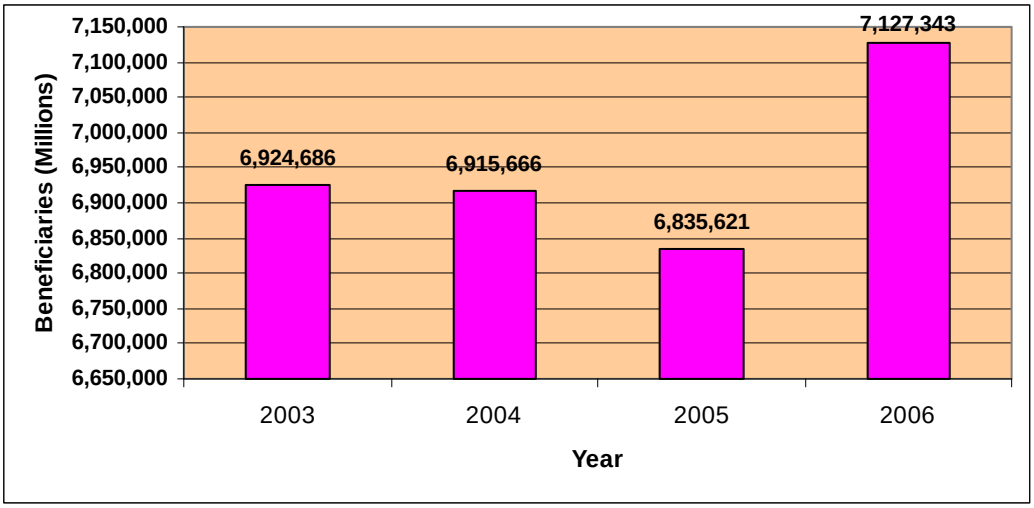
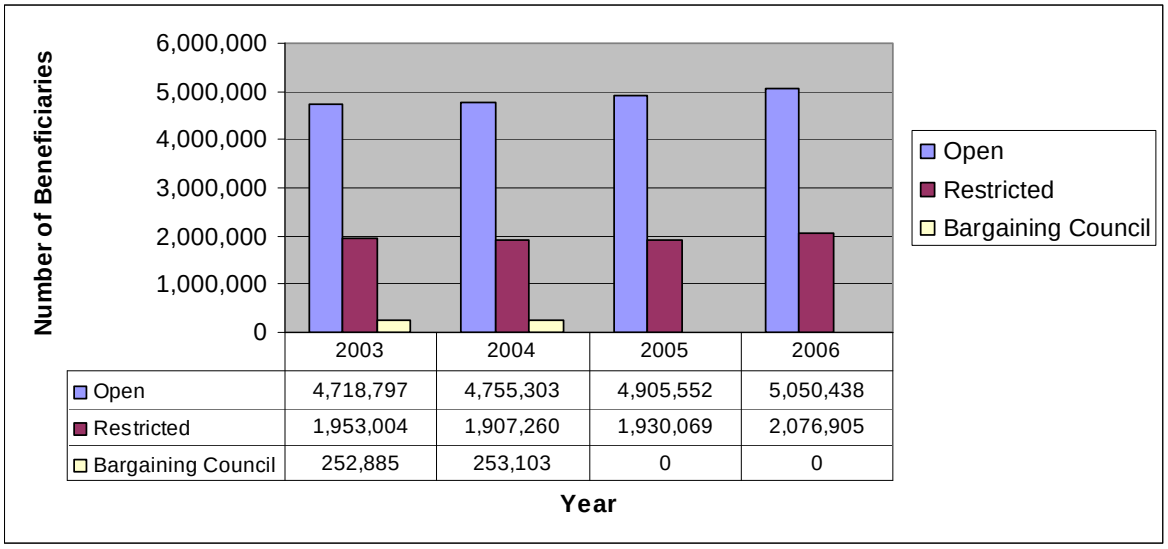


Figure 18: Total number of beneficiaries covered by a medical scheme from 2003 to 2006

Figure 19 shows the distribution of beneficiaries according to the three types of medical schemes. Open medical schemes have always attracted the most members and have reflected an upward trend since 2003. The number increased from 4 718 797 in 2003 to 5 050 438 in 2006. The majority of people enjoying medical scheme cover now belong to open schemes which may suggest that employer operated schemes have become less financially viable. The bargaining council schemes are not represented in 2005 and 2006 due to incomplete statutory returns.



	2003	2004	2005	2006
Open	4,718,797	4,755,303	4,905,552	5,050,438
Restricted	1,953,004	1,907,260	1,930,069	2,076,905
Bargaining Council	252,885	253,103	0	0

Figure 19: Number of beneficiaries belonging to the different types of medical schemes from 2003 to 2006

Figure 20 shows the average age of beneficiaries belonging to medical schemes for the period from 2003 to 2006. This ranged from 32 years in 2003 and 2004 to 31 years in 2006. In the last two financial years there was a bimodal distribution of the ages of beneficiaries with coverage being lower in the 20-29 year old age group. [32, 49]

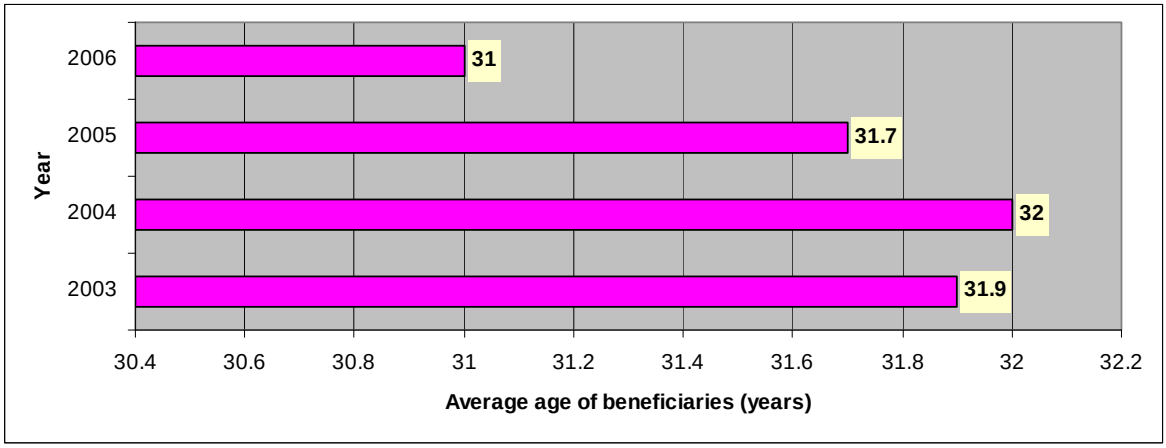


Figure 20: Average age of beneficiaries belonging to medical schemes from 2003 to 2006

Figure 21 shows the pensioner ratio percentage for medical schemes from 2003-2006. The proportion of pensioners i.e. the number of beneficiaries aged 65 years and older has decreased since 2004. The pensioner ratio in 2005 and 2006 was 6.4% and 6.3% respectively, compared to 6.7% in 2004 (Figure 21). Restricted schemes possessed a higher proportion of pensioners when compared to open schemes and this was a common trend observed for all the years.[32] This is likely to be due to the fact that members of restricted schemes are former employees or dependants of former employees of corporations with such schemes and, as a result of subsidization, remain beneficiaries.

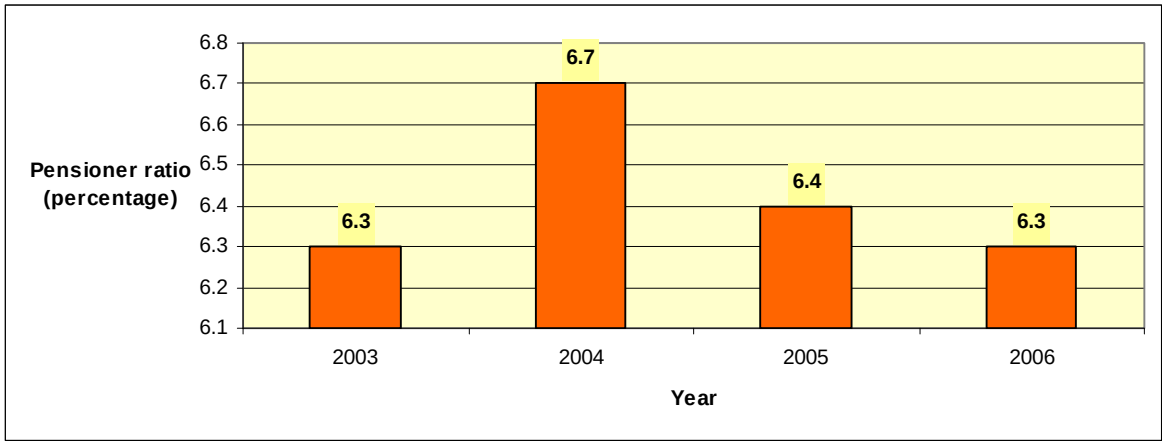


Figure 21: Pensioner ratio in medical schemes from 2003 to 2006

Table 3 shows the income and expenditure of consolidated medical schemes from 2003 to 2006. Revenue from contributions has steadily increased from R48.6 billion in 2003 to R57.6 billion in 2006. This revenue is collected voluntarily from employers and individual beneficiaries. Despite this increase, the medical schemes only generated a surplus from operations in 2003 and 2004. This was followed by an operating deficit which increased substantially in 2006 when compared to 2005 from R406.54 million to R2.15 billion. However when income from investments and other sources were taken into account, the medical schemes showed a net surplus in each year. Both health and non-health expenditure has increased over the last four years.

Table 3: Income and expenditure (in Billions of South African Rands) for consolidated medical schemes from 2003 to 2006

	2003	**2004**	**2005**	**2006**
Gross contribution income	48.60	51.50	54.20	57.60
Savings contribution income	5.00	5.50	6.30	6.20
Net contribution income	43.60	46.00	47.90	51.40
Net claims incurred	34.50	35.30	40.30	45.20
Other operating income	0.21	0.25	0.36	0.42
Net investment income	1.70	1.60	1.80	1.90
Total expenditure on health benefits	38.70	40.80	45.80	51.10
Total non-health expenditure	6.60	7.10	8.00	8.30
Surplus/Deficit from Operations	***2.40***	***2.80***	***-0.40***	***-2.10***
Net surplus/(Deficit)	**4.40**	**5.00**	**2.30**	**1.10**

4.2.2 Out-of-Pocket Expenditure on Health

South African households provide the second source of finances for the private health care sector in terms of out-of-pocket expenditure. This source is difficult to accurately record and quantify since there are no accurate recording of transactions that occur outside the allopathic health care sector and such information is accompanied by several biases, the most common being recall bias.

Statistics South Africa conducts an IES every five years in South Africa. Table 4 shows the income and expenditure of the South African household in the latest IES conducted in 2006.

Table 4: Income and expenditure of the average South African household for the year 2006

	2006
Average Household Income	R 74,589
Average Household Expenditure	R 56,152
Average Household expenditure on health per annum	R 933
Percentage of total expenses	1.7%

Source: Statistics South Africa Income and Expenditure Survey, 2006[47]

According to the Statistics South Africa IES of 2005/2006, the average household in South Africa receives an income of R74, 589 and spends approximately 75.0% of their income on consumable expenditure. Health care comprises 1.7% of the overall consumable expenditure and includes payment to health practitioners (both allopathic and complementary), dispensing pharmacies and co-payments. It also includes the traditional practitioners who are reportedly consulted by the majority of the population (60.0%).[50] It does not include contributions to medical schemes and private insurances. At the end of August 2006, the average household spent R933 on health care.

The last time the IES was conducted was in 2000, so there were no precise expenditure amounts for 2003 to 2005. Therefore, medical inflation was removed from the 2006 amount and the average Out-of-pocket expenditure on health care was determined (Figure 22). It must be noted that 2006 provided the baseline for this calculation. This amount has therefore reflected an increase comparable to the medical inflation trend but this is likely to be both inaccurate and grossly underestimated. Unfortunately, there are no other sources providing information on the household expenditure.

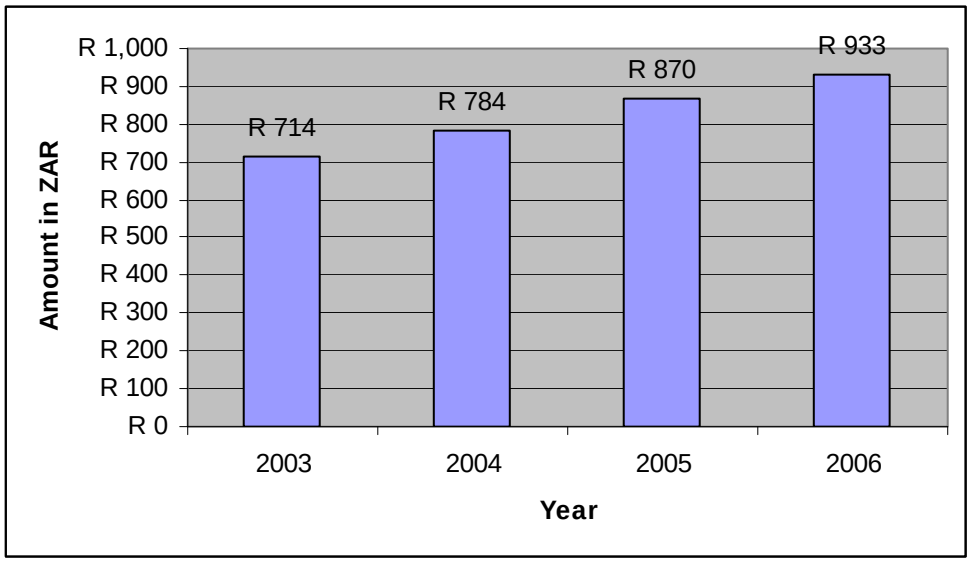
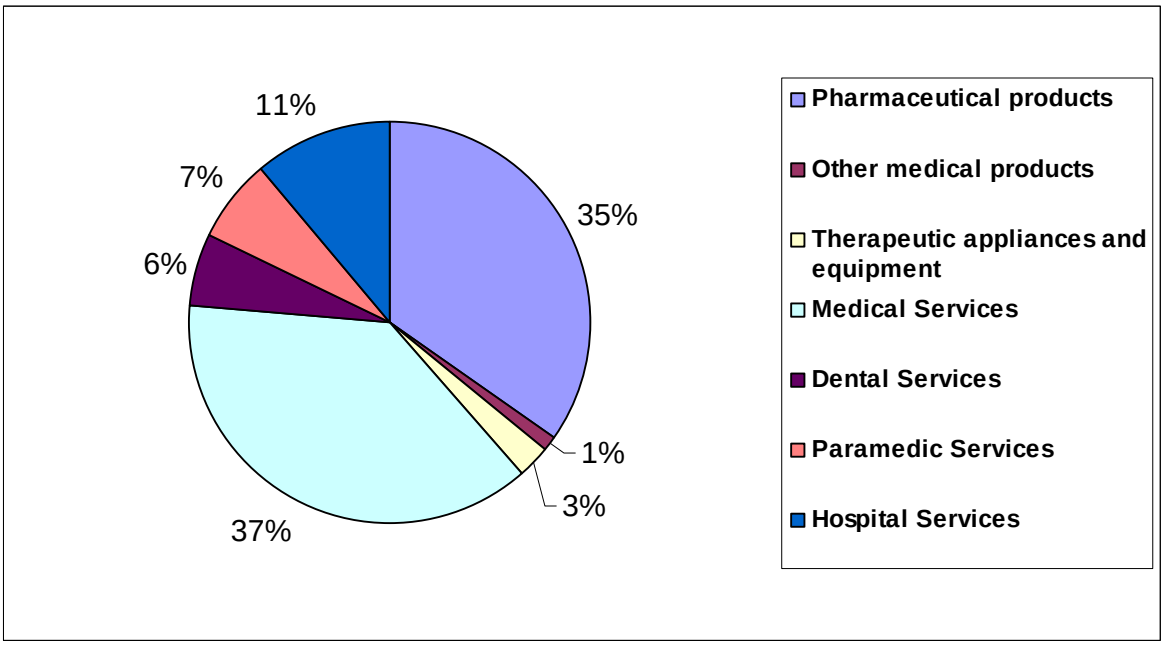


Figure 22: Average South African household expenditure on health per annum from 2003 to 2006

The Out-of-pocket expenditure on health was disaggregated according to the different categories including medical services, dental services, hospital services and paramedic services. These and the other categories are shown in Figure 23. It is evident that medical services, which included consultations with General Practitioners (GPs), specialists and traditional healers, accounted for the largest expense i.e. 37.0%. Pharmaceutical products represented the next largest expense accounting for 35.0% of the health expenditure.

The data collected by the survey was also disaggregated according to ethnic groups. It showed that the Black population spent approximately half of the amount allocated to health on medical services while the Coloured, Indian and White populations spent the majority of their budget on pharmaceutical services.[47]



Source: Statistics South Africa Income and Expenditure Survey 2005/06, 2006[47]

Figure 23: Percentage of out-of-pocket expenditure on health according to the different categories for the year 2006

If one compared the Out-of-pocket on health to the contributions made by beneficiaries to medical schemes, it is visibly apparent how much more is spent per beneficiary per annum on medical schemes than per household on health care (Figure 24).

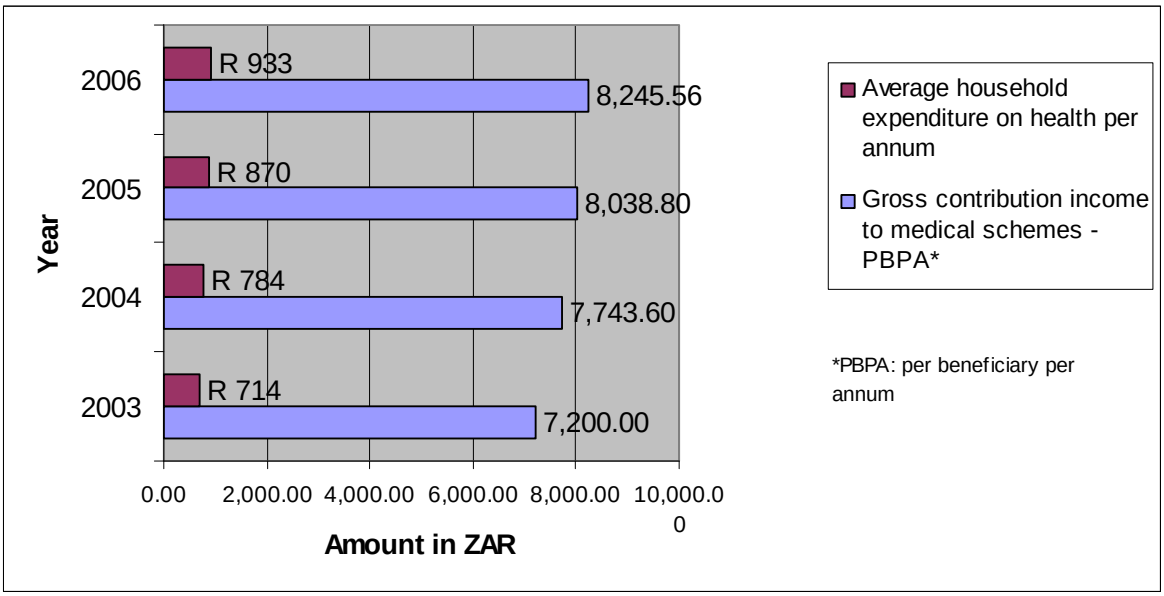


Figure 24: Contributions per annum to out-of-pocket expenditure on health compared to the contributions per annum per beneficiary to medical schemes from 2003 to 2006

Information on out of pocket expenditure in South Africa is scarce. However, the Low Income Medical Scheme (LIMS) specific national household survey (the HH survey) provides some additional information on out of pocket expenditure. However, this survey interviewed approximately 5.1 million non-rural households with a gross household income of R6000 or less per month. Therefore, this interview was targeted to the South African households with a lower income and low levels of medical scheme coverage and formal employment.[51] Therefore, any results would be biased due to the small sample size covered by medical schemes.

According to this survey, of the individuals of medical schemes that attended out-patient facilities, transport, professional fees and medicines were the largest expenditures accounting for 43.0%, 33.0% and 20.0% of the total out of pocket expenditure, respectively.[51] Households earning an income between R2500 – R6000 and partially covered by medical schemes, spent an average of R40 per month or 1.0% of their income on out of pocket on health expenditure.[51] This result is not too far off from the 1.7% according to the IES survey. Households, with an income in the same band and full medical aid cover, spent an average of R38 per month or

1.3% (95% Confidence Interval -0.7% - 3.3%) of their income on out of pocket health expenditure. These results are not a true estimate of the population in that income group owing to the wide confidence interval.[51]

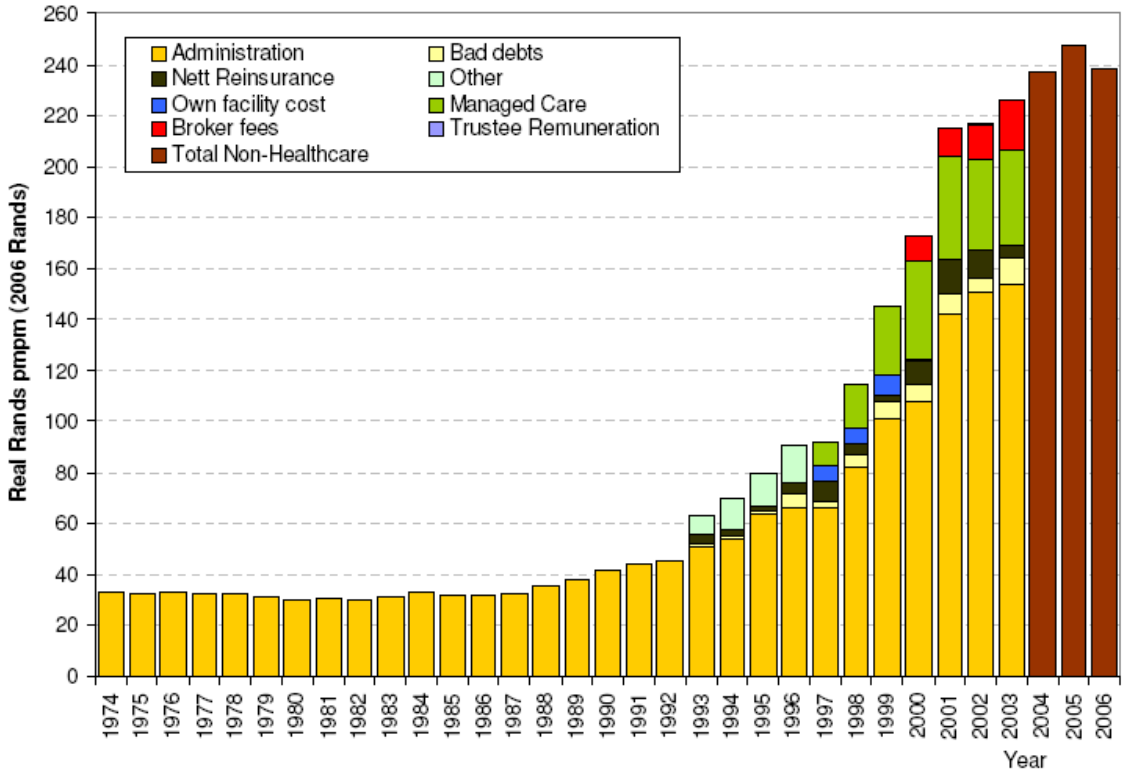
No other data sources could be found to provide information on out of pocket expenditure.

4.3 THE FLOW OF FUNDS FROM THE FINANCING INTERMEDIARIES TO THE PROVIDERS

This section will be discussed according to non-health and health expenditure. Health expenditure is then disaggregated according to the overall benefits paid by the different scheme type and further disaggregated to benefits paid out of the risk and savings pools.

4.3.1 Non-Health Care Expenditure

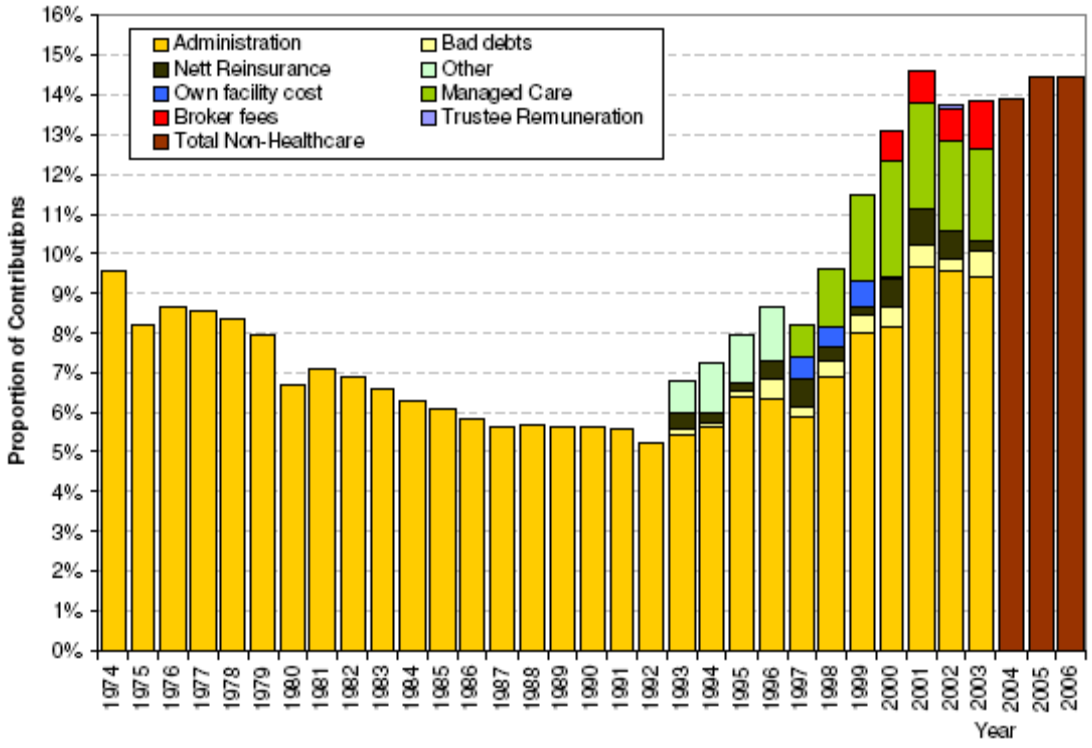
According to Professor Heather McLeod, medical aid scheme members pay one of the highest non-health care costs in the world.[52] Figure 25 shows the non-health care costs per member per month from 1974 to 2006 in real terms (2006 South African Rands). This cost has increased from about R20 per member per month in 1974 to approximately R240 in 2006.[52]



Source: McLeod H. PowerPoint presentation at Annual Board of Healthcare Funders Conference, 2008[53]

Figure 25: Non-health care costs in 2006 South African Rands per member per month

Non-health care costs make up between 14.0% and 15.0% of medical schemes' annual expenditure (Figure 26).



Source: McLeod H. PowerPoint presentation at Annual Board of Healthcare Funders Conference, 2008[53]

Figure 26: Non-health care costs as a percentage of members' contributions

Table 5 shows the different categories of non-health care expenditure for consolidated medical schemes from 2003 to 2006. This amount has increased from R6.6 billion in 2003 to R8.3 billion in 2006. Non-health care expenditure has consistently increased from 2003 but the largest increase of R900 million was observed between 2004 and 2005. This represented an increase of 12.7% when compared to 2004. The percentage increase in 2004 was 7.6% when compared to 2003 and was 3.8% in 2006 when compared to 2005.

Administration expenditure accounted for 68.0% of the total non-health expenditure in 2003, 69.0% in 2004 and 2005 and 71.0% in 2006. Acquisition costs are the costs incurred by

medical schemes when initiating, underwriting and selling a policy of membership. These costs are ultimately paid to brokers and for other distribution costs.[49] This category was not calculated for the 2003 and 2006 financial years and the reason for this non-calculation remains unclear. It may have been incorporated into broker fees but this is not made explicit in the report.

According to the Medical Schemes Act, brokers are those people who provide a service or advice by introducing a member to a medical scheme or ongoing advice regarding access to, or benefits offered, by a medical scheme.[54] At present, there are more than 9000 brokers and they are paid 3.0% of the monthly premiums received by medical schemes.[52] Broker fees include all commissions, service fees and other distribution costs paid to brokers. These costs have substantially increased in the four years. In 2006, broker fees increased by 7.2% when compared to 2005. The largest percentage increase was seen in 2005 when broker fees increased by 30.3% when compared to 2004. This increase was almost a third more than the 21.2% increase observed in 2004 when compared to 2003.

Table 5: Different categories of non-health care expenditure for consolidated medical schemes from 2003 to 2006

	2003	***2004***	***2005***	***2006***
1. Administration Expenditure (Billions)	4.5	4.9	5.5	5.9
2. Managed Health Care Expenditure (Billions)	1.1	1.2	1.3	1.4
3. Acquisition Costs (Millions)	NC	769	939	NC
4. Broker Fees (Millions)	581	704	917	983
5. Reinsurance (Millions)	-123	-7.8	2.6	2.1
6. Impaired Receivables (bad debts) - (Millions)	322	213	202	72.4
Total non-health Expenditure (Billions)	**6.6**	**7.1**	**8**	**8.3**

NC = Not captured

Figure 27 shows the different categories that contribute to non-health expenditure from 2003 to 2006. Administration and Managed Health Care (MHC) are the main contributors to non-health care expenditure while impaired receivables, also known as bad debts, have decreased by 64.2% since 2005.[32]

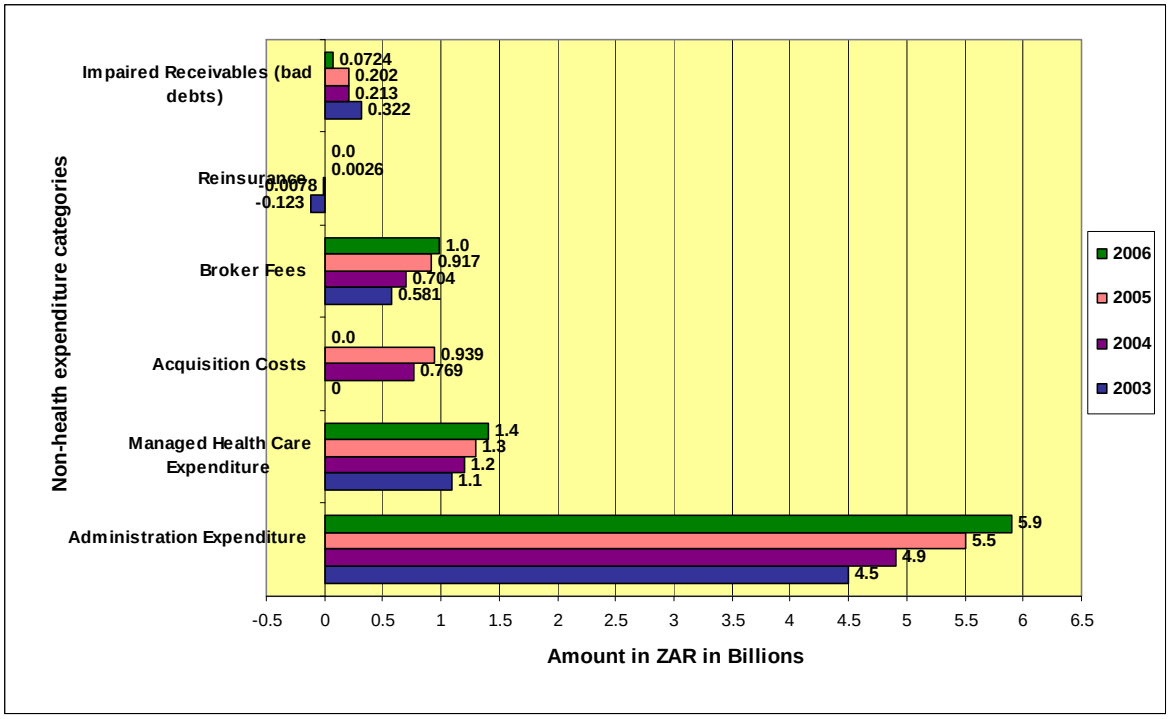


Figure 27: Different categories of non-health expenditure by consolidated medical schemes from 2003 to 2006

4.3.2 Expenditure on Healthcare Benefits by Medical Schemes

This section analyses the total expenditure for all registered medical schemes (open and restricted). The expenditure refers mainly to payments made out of medical savings accounts and risk pooled benefits. It excludes any out of pocket benefits made through co-payments. The benefits paid are analysed both in nominal and real terms (excluding medical inflation).

4.3.3 Analysis of Overall Benefits Paid to the Various Service Providers from 2003 to 2006

This section looks at all the money that was paid to the various service providers over the four year period and disaggregates this financial data according to scheme type.

4.3.3.1 Consolidated Schemes

From the income generated by all schemes, Figure 28 shows the nominal and real values of the overall benefits paid by the consolidated medical schemes to the various service providers from 2003 to 2006. The nominal value of the total benefits paid shows a much steeper curve than the real value which is derived when medical inflation is removed.

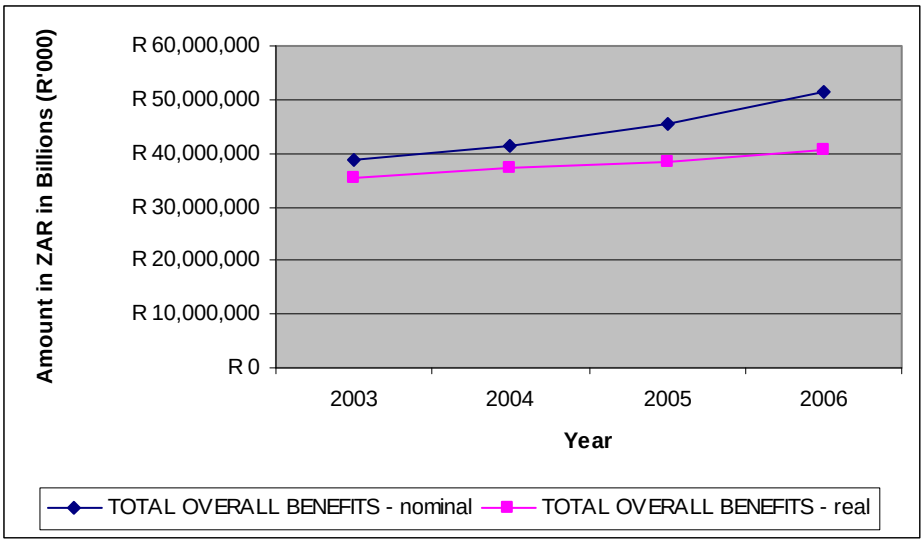


Figure 28: Nominal versus the real (without medical inflation) value of the total benefits paid by consolidated schemes to the various service providers from 2003 to 2006

Table 6 shows the nominal and real values of the overall benefits paid by consolidated medical schemes to the various service providers from 2003 to 2006. There was a 12.4% increase in the nominal value in 2006 when compared to 2005 and an increase of 32.5% when compared to the base year, 2003. However, the real increase in 2006 was 5.7% when compared to 2005 and 14.9% when compared to the base year of 2003.

Table 6: Nominal and real values (without medical inflation) paid by consolidated medical schemes to the various service providers from 2003 to 2006

	2003	*2004*	*2005*	*2006*
	R'000	***R'000***	***R'000***	***R'000***
TOTAL OVERALL BENEFITS - nominal	R 38,697,052	R 41,473,538	R 45,620,539	R 51,290,062
TOTAL OVERALL BENEFITS - real	R 35,253,014	R 37,371,805	R 38,342,054	R 40,516,306

In contrast, when the nominal value is compared to the real (without CPIX), the difference observed between the two is negligible. Figure 29 shows the nominal value against the value without the consumer price index.

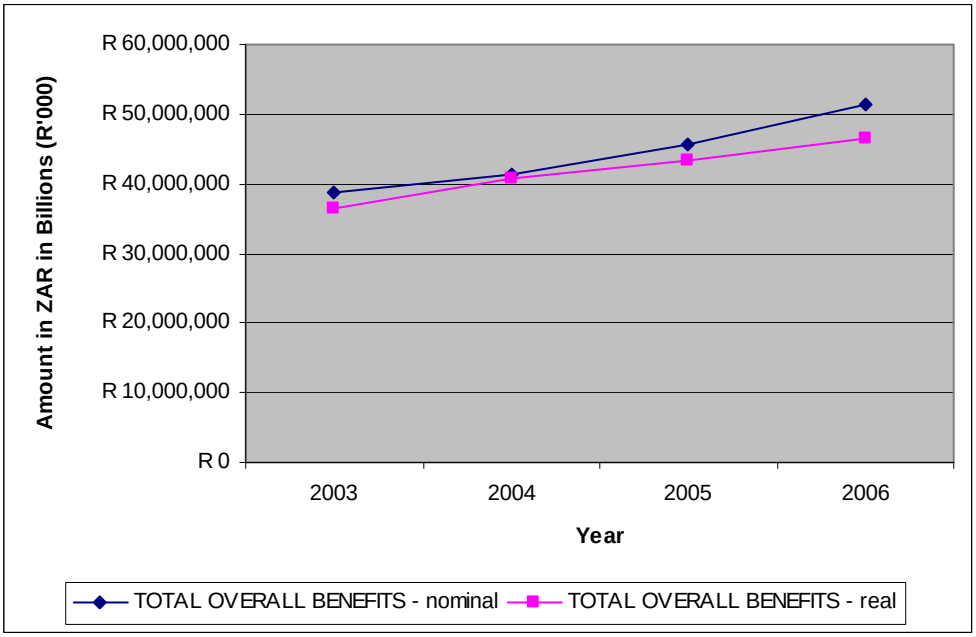


Figure 29: Nominal versus the value without the Consumer Price Index of the total benefits paid by consolidated medical schemes to the various service providers from 2003 to 2006

Table 7 shows the difference between the nominal value and that without CPIX paid by consolidated schemes to the different service providers across the four years. The increase in the nominal value in 2006 was 12.4% when compared to 2005 and 32.5% when compared to 2003. The increase observed when CPIX was removed was 7.2% in 2006 when compared to 2005 and 27.8% when compared to the base year of 2003.

Table 7: Nominal versus the values, without The Consumer Price Index, paid by consolidated medical schemes to the various service providers from 2003 to 2006

	2003	***2004***	***2005***	***2006***
	R'000	***R'000***	***R'000***	***R'000***
TOTAL OVERALL BENEFITS - nominal	R 38,697,052	R 41,473,538	R 45,620,539	R 51,290,062
TOTAL OVERALL BENEFITS - real without CPIX	R 36,452,623	R 40,897,056	R 43,456,875	R 46,595,405

Figure 30 shows both nominal and real values (without medical inflation) of the overall benefits paid by consolidated medical schemes to the various service providers for the period from 2003 to 2006.

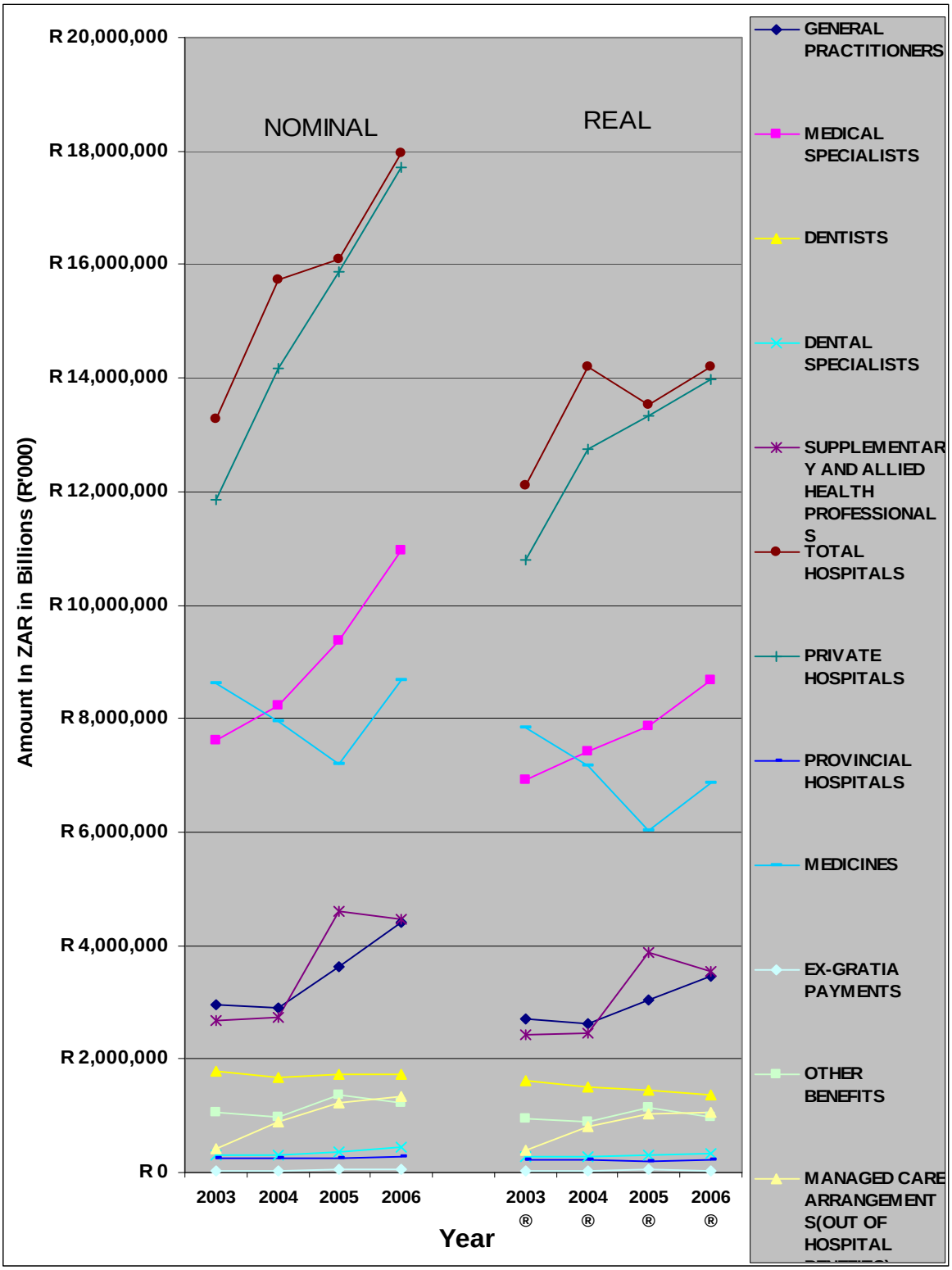


Figure 30: Comparison of the nominal and real values of the overall benefits paid by consolidated medical schemes to the various service providers from 2003 to 2006

The top five overall cost-drivers for the years 2003 to 2006 were private hospitals, medical specialists, medicines, supplementary and allied health professionals and general practitioners. The other categories have not shown as great an increase as these five mentioned.

The overall benefits paid to private hospitals has shown a steep increase from approximately R12 billion in 2003 to approximately R18 billion in 2006. Over a period of one year from 2005 to 2006 there was a marked increase from R15.9 billion to R17.7 billion (Table 8). It should be noted that hospital billing includes theatre fees, ward fees, consumables and medicines dispensed but not fees paid to health care practitioners within both the private and public sector hospitals. In contrast actual benefits paid to public hospitals used by private patients remained fairly constant but at a negligible level. Total hospital expenditure has been the largest expenditure in all four years accounting for 34.3% of overall expenditure in 2003, 38.0% in 2004, 35.3% in 2005 and 35.0% in 2006, amounting to more that one third of total benefits paid from medical aid contributions.

Benefits paid to medical specialists has shown an increasing trend over the four year period. This category includes the clinical support specialists, amongst others anaesthetists, radiologists and pathologists. In 2006, this accounted for the second largest expenditure (21.4% of total expenditure), with an increase of 17.2% from the previous year (2005).[32]

Medicines were the third largest expenditure paid by medical schemes. This category includes payment of medicines dispensed by practitioners, specialists, pharmacists, allied and support health professionals and other health professionals. While this expenditure was increasing markedly compared to other categories in the 1980s and early 1990s, this increase appeared to be in line with inflation (medical). In contrast with other categories of expenditure, benefits paid for medicines began decreasing in 2003, with the largest decreases in 2004 and 2005.[12] While medicines accounted for 22.3% of total expenditure in 2003, it has decreased to 15.8% in 2005 and 16.9% in 2006.[32, 49, 55]

The decreases shown in Figure 30 were due to two regulatory interventions. Pharmacists were required by law to offer patients a generic substitute for any medicine prescribed unless the doctor stated that the medicine should not be substituted. This increased use of generic medicine (increase of 14% between 2003 and 2005) led to a decrease in the amount of money spent on medicines.[12] The Medicines and Related Substances Control Amendment Act (Act 90 of 1997) brought about regulations to control the price of medicines. Discounts to private hospitals and dispensing doctors were outlawed. This had previously been an incentive for these institutions to keep a medicine on their formulary. Manufacturers were required to sell at a Single Exit Price (SEP) which has led to an average price decrease of approximately 22.0%.[12]

Benefits paid to General Practitioners and Supplementary and Allied Health Professionals have also shown an increasing trend across the four years.

Tables 8 and 9 shows the nominal and real values of the overall benefits paid by consolidated medical schemes to the different service providers for the period from 2003 to 2006.

Medicines have started showing an increase in 2006 when compared to 2004 and 2005. This may be due to the prescribed minimum benefits which have disease management programmes for chronic diseases including HIV.

Dentists have shown a decrease while managed health care, also known as out of hospital benefits, has shown an increasing trend over the four years.

Table 8: Nominal values of the overall benefits paid by consolidated medical schemes to the various service providers from 2003 to 2006

Consolidated Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 2,955,394	R 2,904,348	R 3,633,079	R 4,393,335
Medical specialists	R 7,604,740	R 8,240,506	R 9,366,224	R 10,972,992
Dentists	R 1,772,584	R 1,680,059	R 1,716,293	R 1,737,575
Dental specialists	R 293,997	R 305,528	R 368,672	R 433,702
Supplementary and allied health professionals	R 2,673,648	R 2,737,137	R 4,600,186	R 4,470,804
Total hospitals	R 13,283,344	R 15,743,973	R 16,106,734	R 17,976,795
Private hospitals	R 11,847,504	R 14,159,969	R 15,863,749	R 17,703,161
Provincial hospitals	R 248,792	R 261,908	R 242,986	R 273,634
Medicines	R 8,617,709	R 7,959,349	R 7,185,153	R 8,674,563
Ex-gratia payments	R 24,315	R 26,015	R 56,771	R 50,387
Other benefits	R 1,047,237	R 990,223	R 1,373,737	R 1,236,892
Managed care arrangements (out of hospital benefits)	R 424,084	R 886,399	R 1,213,690	R 1,343,017
Total benefits	**R 38,697,052**	**R 41,473,538**	**R 45,620,539**	**R 51,290,062**

Table 9 shows the overall benefits paid by consolidated medical schemes with medical inflation removed. Private hospitals, medical specialists and medicines remain the three biggest cost-drivers with supplementary and allied health professionals and general practitioners making up the rest of the top five expenditure categories.

Table 9: Real values of the overall benefits paid by consolidated medical schemes to the various service providers from 2003 to 2006

Consolidated Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 2,692,364	R 2,617,108	R 3,053,443	R 3,470,491
Medical specialists	R 6,927,918	R 7,425,520	R 7,871,899	R 8,668,055
Dentists	R 1,614,824	R 1,513,901	R 1,442,469	R 1,372,588
Dental specialists	R 267,831	R 275,311	R 309,853	R 342,601
Supplementary and allied health professionals	R 2,435,693	R 2,466,434	R 3,866,254	R 3,531,687
Total hospitals	R 12,101,126	R 14,186,894	R 13,537,001	R 14,200,672
Private hospitals	R 10,793,076	R 12,759,548	R 13,332,783	R 13,984,516
Provincial hospitals	R 226,650	R 236,005	R 204,219	R 216,156
Medicines	R 7,850,733	R 7,172,169	R 6,038,805	R 6,852,424
Ex-gratia payments	R 22,151	R 23,442	R 47,714	R 39,803
Other benefits	R 954,033	R 892,290	R 1,154,565	R 977,076
Managed care arrangements (out of hospital benefits)	R 386,341	R 798,734	R 1,020,053	R 1,060,909
Total benefits	**R 35,253,014**	**R 37,371,805**	**R 38,342,054**	**R 40,516,306**

®: Real values (medical inflation removed)

Table 10 shows the real percentage increase or decrease paid by consolidated medical schemes to the various service providers from 2003 to 2006. The table excludes medical inflation. Private hospitals increased by almost 30.0% by 2006 when compared to the base year of 2003. Medical specialists increased by 25.0% in 2006 when compared to the base year of 2003 while supplementary and allied health professionals grew by almost 50.0%. Managed health care has exhibited the largest increase of 175.0% when compared to the base year of 2003.

The three categories that have shown a decrease when compared to the base year includes dentists, provincial hospitals which claim the revenue for the private sector patients admitted there and medicines.

Medicines demonstrated an increase in 2006 of 13.5% when compared to 2005 but an overall decrease of 13.0% when compared to the base year of 2003. As mentioned previously, medicines showed a decrease of 9.0% in 2004 when compared to 2003 and a decrease of approximately 16.0% in 2005 when compared to 2004.

Table 10: Real percentage increase/decrease paid by consolidated schemes to the various service providers when compared to the previous years and the base year of 2003

Consolidated Schemes	***2003 ®***	***2004 ®***	***2005 ® vs 2004***	***2005 ® vs 2003***	***2006 ® vs 2005***	***2006 ® vs 2004***	***2006 ® vs 2003***
General Practitioners	0.00	-2.80	16.67	13.41	13.66	32.61	28.90
Medical Specialists	0.00	7.18	6.01	13.63	10.11	16.73	25.12
Dentists	0.00	-6.25	-4.72	-10.67	-4.84	-9.33	-15.00
Dental Specialists	0.00	2.79	12.55	15.69	10.57	24.44	27.92
Supplementary And Allied Health Professionals	0.00	1.26	56.75	58.73	-8.65	43.19	45.00
Total Hospitals	0.00	17.24	-4.58	11.87	4.90	0.10	17.35
Private Hospitals	0.00	18.22	4.49	23.53	4.89	9.60	29.57
Provincial Hospitals	0.00	4.13	-13.47	-9.90	5.85	-8.41	-4.63
Medicines	0.00	-8.64	-15.80	-23.08	13.47	-4.46	-12.72
Ex-Gratia Payments	0.00	5.83	103.54	115.40	-16.58	69.79	79.69
Other Benefits	0.00	-6.47	29.39	21.02	-15.37	9.50	2.42
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	106.74	27.71	164.03	4.01	32.82	174.60
Total Benefits	**0.00**	**6.01**	**2.60**	**8.76**	**5.67**	**8.41**	**14.93**

®: Real values (medical inflation removed)

4.3.3.2 Registered Open Medical Schemes

Figure 31 shows the overall trend paid by registered open medical schemes to the different service providers from 2003 to 2006. The majority of members belong to this type of medical scheme since there are no strict eligibility criteria. The top five cost-drivers remain the same for both the nominal and real values: private hospitals, medical specialists, medicines, supplementary and allied health professionals and general practitioners.

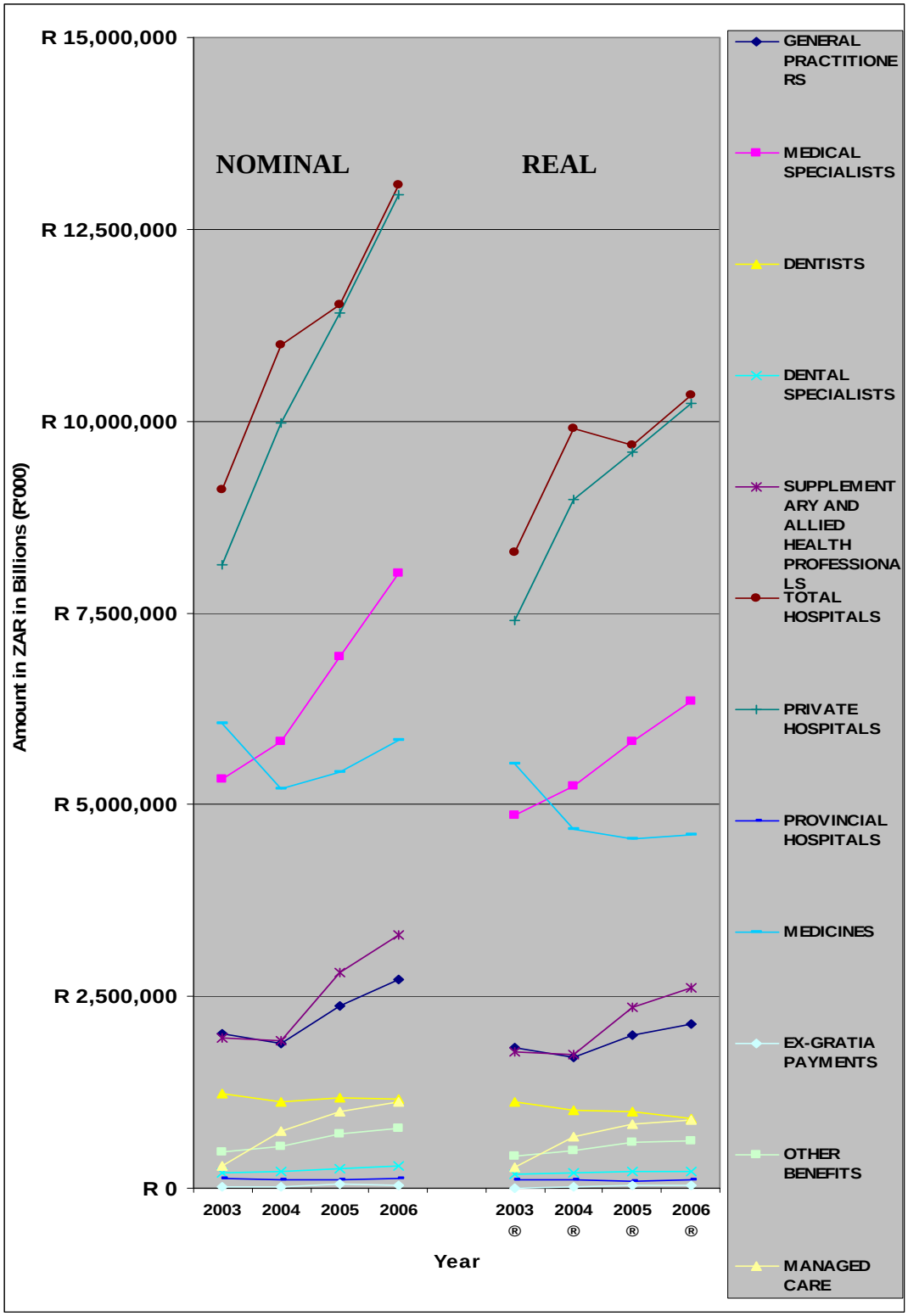


Figure 31: Comparison of the nominal and real values of the overall benefits paid by registered open medical schemes to the various service providers from 2003 to 2006

Table 11 shows the nominal values paid by registered open medical schemes to the different service providers from 2003 to 2006. The increased amount paid to total hospitals is largely attributable to private hospital expenditure and not due to the provincial hospitals. This implies that provincial hospitals do not submit any claims to medical schemes for private patients admitted to their facilities either because they are not aware that the patient belongs to the medical scheme or they are unable to classify illnesses and procedures using the correct billing practice.

Ex-gratia payments, other benefits and out of hospital benefits have also shown an increasing trend since 2003.

Table 11: Nominal values paid by registered open medical schemes to the various service providers from 2003 to 2006

Registered Open Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 2,017,075	R 1,891,372	R 2,367,083	R 2,712,848
Medical specialists	R 5,329,095	R 5,822,115	R 6,924,692	R 8,024,938
Dentists	R 1,235,415	R 1,129,262	R 1,179,897	R 1,155,523
Dental specialists	R 204,650	R 211,839	R 260,575	R 281,705
Supplementary and allied health professionals	R 1,960,570	R 1,923,567	R 2,812,043	R 3,301,621
Total hospitals	R 9,105,319	R 10,989,839	R 11,520,668	R 13,077,111
Private hospitals	R 8,131,406	R 9,966,935	R 11,411,188	R 12,949,113
Provincial hospitals	R 126,502	R 112,770	R 109,480	R 127,997
Medicines	R 6,064,263	R 5,201,125	R 5,427,538	R 5,835,228
Ex-gratia payments	R 9,744	R 12,084	R 46,362	R 40,215
Other benefits	R 467,539	R 537,971	R 706,544	R 787,196
Managed care arrangements (out of hospital benefits)	R 292,388	R 741,400	R 990,223	R 1,126,761
Total benefits	**R 26,686,058**	**R 28,460,575**	**R 32,235,625**	**R 36,343,145**

Table 12 shows the real values, without medical inflation, paid by the registered open medical schemes to the different providers from 2003 to 2006. It is interesting to note that the real amount paid to dentists has shown a downward trend over the four years from approximately R1.1 billion in 2003 to R912.8 million in 2006.

Table 12: Real values paid by registered open medical schemes to the various service providers from 2003 to 2006

Registered Open Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 1,837,555	R 1,704,315	R 1,989,429	R 2,143,000
Medical specialists	R 4,854,806	R 5,246,308	R 5,819,899	R 6,339,256
Dentists	R 1,125,463	R 1,017,578	R 991,651	R 912,799
Dental specialists	R 186,436	R 190,888	R 219,002	R 222,531
Supplementary and allied health professionals	R 1,786,079	R 1,733,326	R 2,363,398	R 2,608,098
Total hospitals	R 8,294,946	R 9,902,944	R 9,682,614	R 10,330,193
Private hospitals	R 7,407,711	R 8,981,205	R 9,590,601	R 10,229,081
Provincial hospitals	R 115,243	R 101,617	R 92,013	R 101,111
Medicines	R 5,524,544	R 4,686,734	R 4,561,607	R 4,609,507
Ex-gratia payments	R 8,877	R 10,889	R 38,965	R 31,768
Other benefits	R 425,928	R 484,766	R 593,819	R 621,841
Managed care arrangements(out of hospital benefits)	R 266,365	R 668,076	R 832,239	R 890,079
Total benefits	**R 24,310,999**	**R 25,645,824**	**R 27,092,623**	**R 28,709,070**

®: Real values (medical inflation removed)

Table 13: Real percentage increase/decrease paid by registered open medical schemes to the various service providers when compared to the previous years and the base year of 2003

Registered Open Schemes	*2003 ®*	*2004 ®*	*2005 ® vs 2004*	*2005 ® vs 2003*	*2006 ® vs 2005*	*2006 ® vs 2004*	*2006 ® vs 2003*
General Practitioners	0.00	-7.25	16.73	8.26	7.72	25.74	16.62
Medical Specialists	0.00	8.06	10.93	19.88	8.92	20.83	30.58
Dentists	0.00	-9.59	-2.55	-11.89	-7.95	-10.30	-18.90
Dental Specialists	0.00	2.39	14.73	17.47	1.61	16.58	19.36
Supplementary And Allied Health Professionals	0.00	-2.95	36.35	32.32	10.35	50.47	46.02
Total Hospitals	0.00	19.39	-2.22	16.73	6.69	4.31	24.54
Private Hospitals	0.00	21.24	6.79	29.47	6.66	13.89	38.09
Provincial Hospitals	0.00	-11.82	-9.45	-20.16	9.89	-0.50	-12.26
Medicines	0.00	-15.17	-2.67	-17.43	1.05	-1.65	-16.56
Ex-Gratia Payments	0.00	22.67	257.84	338.96	-18.47	191.74	257.87
Other Benefits	0.00	13.81	22.50	39.42	4.72	28.28	46.00
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	150.81	24.57	212.44	6.95	33.23	234.16
Total Benefits	**0.00**	**5.49**	**5.64**	**11.44**	**5.97**	**11.94**	**18.09**

®: Real values (medical inflation removed)

Table 13 compares the real (without medical inflation) percentage increase or decrease paid by the registered open schemes to the different service providers compared to the preceding years and the base year, 2003.

General practitioners initially showed a decrease of 7.0% in 2004 but subsequently have been paid an overall increase of 16.7% in 2005 and 7.7% in 2006 when compared to the previous years. In 2006, they received an increase of 16.6% when compared to the base year of 2003.

Private hospitals, medical specialists, supplementary and allied health professionals and ex-gratia payments all showed an increase of more than 30.0% when compared to the base year.

Medicines, dentists and benefits paid by registered open schemes to provincial hospitals showed a downward trend over the four years when compared to the base year of 2003.

4.3.3.3 Registered Restricted Medical Schemes

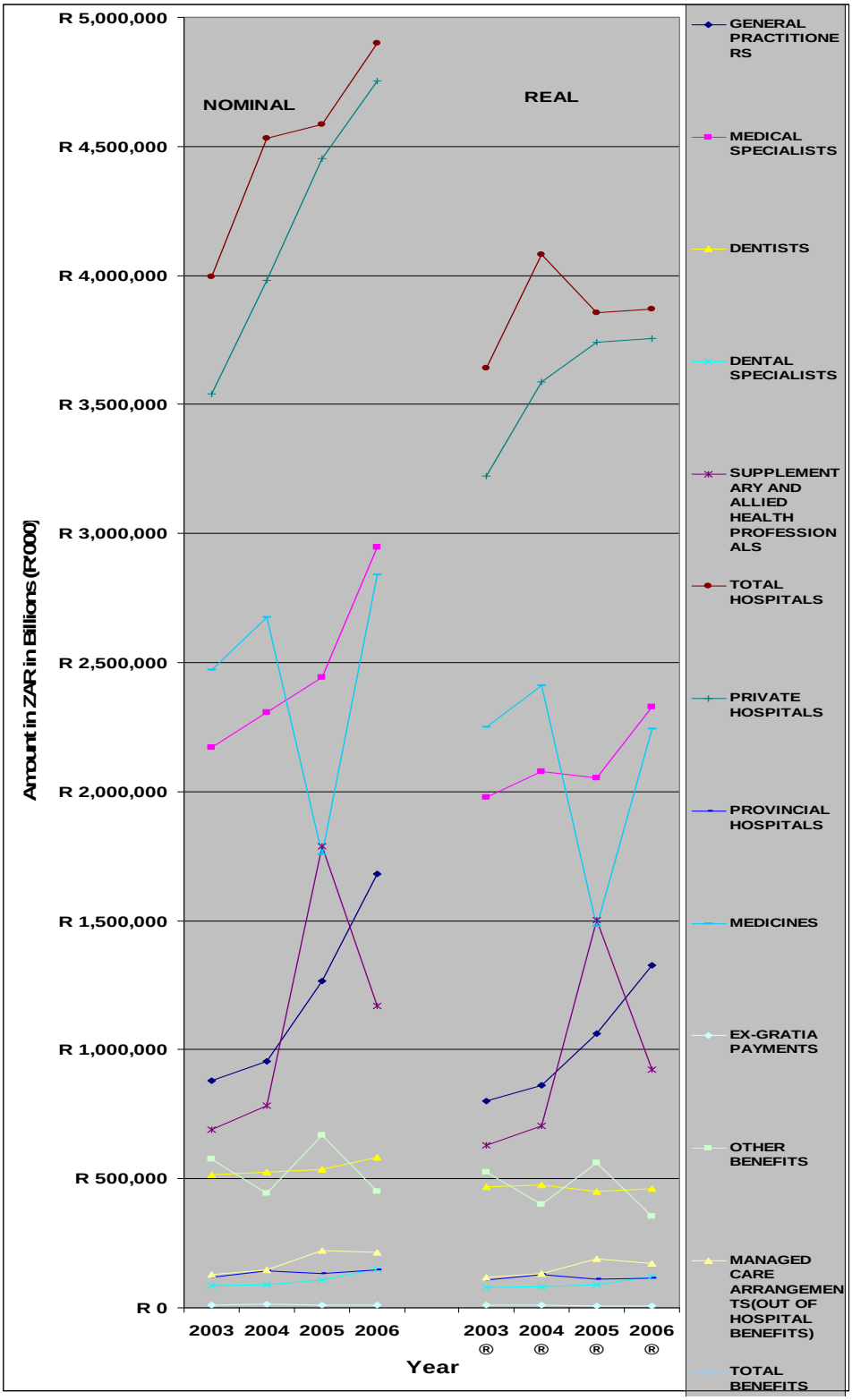


Figure 32: Comparison of the overall benefits, both nominal and real, paid by registered restricted schemes to the various service providers from 2003 to 2006

Figure 32 is a line graph showing the nominal and real (without medical inflation) overall benefits paid by registered restricted schemes to the various service providers from 2003 to 2006.

The cost drivers in this scheme type remain the same as for open schemes i.e. private hospitals, medical specialists, medicines, supplementary and allied health professionals and general practitioners.

Table 14 shows the nominal values of the overall benefits paid by registered restricted schemes to the various service providers from 2003 to 2006. The amounts paid by registered restricted are much less than registered open schemes since the latter has a smaller number of members.

Table 14: Nominal values paid by registered restricted schemes to the various service providers from 2003 to 2006

Registered Restricted Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 880,402	R 954,689	R 1,265,996	R 1,680,488
Medical specialists	R 2,169,248	R 2,306,296	R 2,441,533	R 2,948,055
Dentists	R 514,298	R 525,953	R 536,397	R 582,052
Dental specialists	R 86,467	R 90,660	R 108,097	R 151,996
Supplementary and allied health professionals	R 691,426	R 782,400	R 1,788,143	R 1,169,183
Total hospitals	R 3,996,439	R 4,529,998	R 4,586,066	R 4,899,684
Private hospitals	R 3,539,130	R 3,979,647	R 4,452,560	R 4,754,048
Provincial hospitals	R 117,671	R 142,666	R 133,506	R 145,636
Medicines	R 2,471,130	R 2,674,301	R 1,757,614	R 2,839,335
Ex-gratia payments	R 12,485	R 13,750	R 10,409	R 10,172
Other benefits	R 576,997	R 444,656	R 667,193	R 449,696
Managed care arrangements(out of hospital benefits)	R 129,290	R 144,999	R 223,467	R 216,256
Total benefits	**R 11,528,183**	**R 12,467,702**	**R 13,384,915**	**R 14,946,917**

Table 15 shows the real values, without medical inflation, of the overall benefits paid by registered restricted schemes to the various service providers from 2003 to 2006. The amounts paid by restricted schemes are smaller than that of open schemes since there are fewer members. While ex-gratia payments have shown a real decrease when compared to the base year in restricted schemes they have increased by more than 200.0%, in open schemes.

Table 15: Real values paid by registered restricted schemes to the various service providers from 2003 to 2006

Registered Restricted Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 802,046	R 860,270	R 1,064,014	R 1,327,492
Medical specialists	R 1,976,185	R 2,078,203	R 2,052,001	R 2,328,800
Dentists	R 468,525	R 473,936	R 450,818	R 459,789
Dental specialists	R 78,771	R 81,694	R 90,851	R 120,068
Supplementary and allied health professionals	R 629,889	R 705,021	R 1,502,855	R 923,590
Total hospitals	R 3,640,756	R 4,081,981	R 3,854,387	R 3,870,479
Private hospitals	R 3,224,147	R 3,586,060	R 3,742,181	R 3,755,434
Provincial hospitals	R 107,198	R 128,556	R 112,206	R 115,044
Medicines	R 2,251,199	R 2,409,813	R 1,477,197	R 2,242,917
Ex-gratia payments	R 11,374	R 12,390	R 8,748	R 8,035
Other benefits	R 525,644	R 400,680	R 560,746	R 355,235
Managed care arrangements(out of hospital benefits)	R 117,783	R 130,659	R 187,814	R 170,830
Total benefits	**R 10,502,175**	**R 11,234,646**	**R 11,249,432**	**R 11,807,236**

®: Real values (medical inflation removed)

Table 16 shows the real percentage (without medical inflation), increase or decrease in the various expenditure categories for registered restricted medical schemes. This is the overall expenditure paid and the year on year comparison to the base year of 2003.

When compared to Table 13, presented earlier for registered open schemes, general practitioners received an increase of almost 8.0% in 2006 when compared to 2005 and an overall increase of 17.0% when compared to the base year. This figure is in stark contrast to

registered restricted schemes where general practitioners were paid an increase of 25.0% in 2006 when compared to 2005 and an overall increase of 66.0% when compared to the base year. However, medical specialists and private hospitals also showed increasing trends as was demonstrated with open schemes that showed a higher percentage increase.

Ex-gratia payments and managed care arrangements, which showed a more than 200.0% overall increase in registered open schemes, followed different trends in registered restricted schemes. Ex-gratia payments declined after 2004 and decreased by an overall 29.0% in 2006 when compared to the base year. Managed care arrangements showed an overall increasing trend but this was much smaller when compared to open schemes, a mere 45.0% compared to 234.0%.

Table 16: Real percentage increase/decrease paid by registered restricted medical schemes to the various service providers when compared to the previous years and the base year of 2003

Registered Restricted Schemes	***2003 ®***	***2004 ®***	***2005 ® vs 2004***	***2005 ® vs 2003***	***2006 ® vs 2005***	***2006 ® vs 2004***	***2006 ® vs 2003***
General Practitioners	0.00	7.26	23.68	32.66	24.76	54.31	65.51
Medical Specialists	0.00	5.16	-1.26	3.84	13.49	12.06	17.84
Dentists	0.00	1.15	-4.88	-3.78	1.99	-2.99	-1.86
Dental Specialists	0.00	3.71	11.21	15.33	32.16	46.97	52.43
Supplementary And Allied Health Professionals	0.00	11.93	113.16	138.59	-38.54	31.00	46.63
Total Hospitals	0.00	12.12	-5.58	5.87	0.42	-5.18	6.31
Private Hospitals	0.00	11.23	4.35	16.07	0.35	4.72	16.48
Provincial Hospitals	0.00	19.92	-12.72	4.67	2.53	-10.51	7.32
Medicines	0.00	7.05	-38.70	-34.38	51.84	-6.93	-0.37
Ex-Gratia Payments	0.00	8.94	-29.39	-23.08	-8.15	-35.15	-29.35
Other Benefits	0.00	-23.77	39.95	6.68	-36.65	-11.34	-32.42
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	10.93	43.74	59.46	-9.04	30.75	45.04
Total Benefits	**0.00**	**6.97**	**0.13**	**7.12**	**4.96**	**5.10**	**12.43**

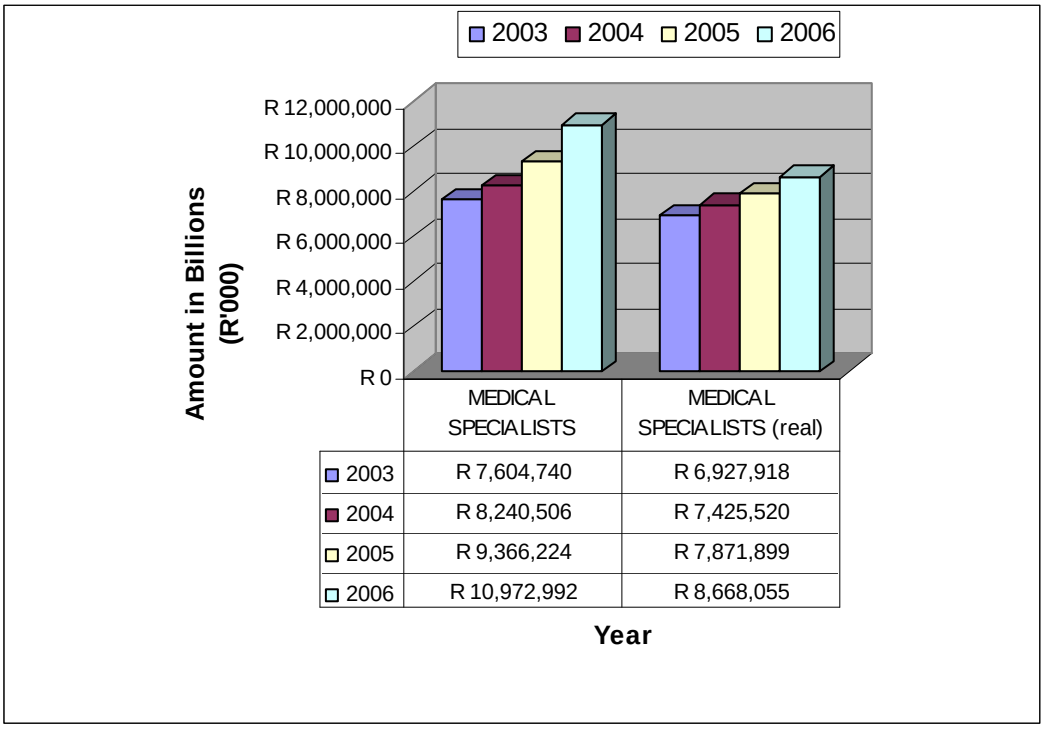
®: Real values (medical inflation removed)

4.3.4 The Cost Drivers

The three main cost drivers in the private health care sector for the financial period from 2003 to 2006 were medical specialists, private hospitals and medicines. These are discussed further in the section below.

4.3.4.1 Medical Specialists

Medical specialists were one of the biggest cost-drivers in the four years. Figure 33 shows the nominal and real overall benefits paid by consolidated medical schemes to the category of medical specialists. This category has exhibited an increasing trend over the four years. There was a nominal increase of 13.7% in 2005 when compared to 2004 and an increase of 17.2% in 2006 compared to 2005. However, the real increase in 2005 was 6.0% when compared to 2004 and 10.1% in 2005 when compared to 2006.



	MEDICAL SPECIALISTS	MEDICAL SPECIALISTS (real)
2003	R 7,604,740	R 6,927,918
2004	R 8,240,506	R 7,425,520
2005	R 9,366,224	R 7,871,899
2006	R 10,972,992	R 8,668,055

Figure 33: Nominal and real values paid by consolidated medical schemes to medical specialists from 2003 to 2006

Tables 17 and 18 indicate the nominal and real benefits paid by consolidated medical schemes to selected categories of medical specialists from 2003 to 2006. These tables do not include all the categories of medical and clinical support specialists paid by the schemes but these categories account for more than 75.0% of the expenditure (an average of 77.9%).

Table 17: Nominal values paid by consolidated medical schemes to the different categories of medical specialists from 2003 to 2006

	Nominal			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Total	**R 7,604,740**	**R 8,240,506**	**R 9,366,224**	**R 10,972,992**
Medical specialists				
Obstetricians & Gynaecologists	R 568,120	R 622,156	R 698,301	R 755,629
Physicians	R 378,726	R 419,492	R 475,272	R 573,058
Cardiologists	R 188,620	R 228,774	R 267,934	R 300,320
Ophthalmologist	R 341,826	R 346,835	R 401,653	R 462,818
Orthopaedic Surgeon	R 384,104	R 424,958	R 495,713	R 570,186
Paediatrician	R 230,319	R 257,741	R 316,222	R 388,329
Surgeons	R 375,886	R 406,876	R 459,979	R 500,681
Clinical support specialists				
Anaesthetist	R 570,249	R 623,253	R 715,253	R 967,900
Radiologist	R 1,459,040	R 1,589,423	R 1,818,287	R 2,100,266
Pathologist	R 1,195,532	R 1,468,425	R 1,832,835	R 2,088,678

Table 18 shows the real values, without medical inflation, paid by all medical schemes to medical specialists for the four year period.

Table 18: Real values paid by consolidated medical schemes to different categories of medical specialists from 2003 to 2006

	Real			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Total	**R 6,927,918**	**R 7,425,520**	**R 7,871,899**	**R 8,668,055**
Medical specialists				
Obstetricians & Gynaecologists	R 517,557	R 560,625	R 586,891	R 596,905
Physicians	R 345,019	R 378,004	R 399,445	R 452,684
Cardiologists	R 171,833	R 206,148	R 225,187	R 237,236
Ophthalmologist	R 311,403	R 312,533	R 337,572	R 365,601
Orthopaedic Surgeon	R 349,919	R 382,930	R 416,625	R 450,415
Paediatrician	R 209,821	R 232,250	R 265,771	R 306,758
Surgeons	R 342,432	R 366,636	R 386,592	R 395,510
Clinical support specialists				
Anaesthetist	R 519,497	R 561,613	R 601,139	R 764,587
Radiologist	R 1,329,185	R 1,432,229	R 1,528,190	R 1,659,094
Pathologist	R 1,089,130	R 1,323,198	R 1,540,417	R 1,649,940

The categories not included in Tables 17 and 18 are listed below and the nominal and real values (without medical inflation) that are received by these medical specialists from consolidated medical schemes are shown in Tables 19 and 20:

- Dermatologists
- Pulmonologists
- Gastroenterologists
- Neurologists
- Psychiatrists
- Medical Oncologists
- Neurosurgeons

- Nuclear Medicine Physicians
- Clinical Haematologists
- Otorhinolaryngologists
- Rheumatologists
- Paediatric Cardiologists
- Specialists in Physical Medicine
- Plastic & Reconstructive Surgeons
- Radiation Oncologists
- Thoracic Surgeons
- Urologists
- Laboratory Technologists
- Other

Table 19: Nominal values paid by consolidated medical schemes to the other categories of medical specialists, (omitted from Table 17), from 2003 to 2006

	Nominal			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Dermatologists	R 73,566.00	R 68,139.00	R 84,357.00	R 90,395.00
Pulmonologists	R 41,109.00	R 44,873.00	R 54,147.00	R 61,388.00
Gastroenterologists	R 39,861.00	R 41,785.00	R 47,934.00	R 56,328.00
Neurologists	R 66,805.00	R 69,739.00	R 82,342.00	R 96,639.00
Psychiatrists	R 132,185.00	R 133,690.00	R 154,101.00	R 202,808.00
Medical Oncologists	R 83,550.00	R 89,634.00	R 73,807.00	R 74,715.00
Neuro-surgeons	R 132,698.00	R 153,832.00	R 156,304.00	R 197,248.00
Nuclear Medicine	R 43,489.00	R 45,136.00	R 44,215.00	R 57,254.00
Otorhinolaryngologists	R 173,703.00	R 181,443.00	R 205,957.00	R 219,793.00
Paediatric Cardiologists	R 8,891.00	R 11,254.00	R 12,529.00	R 15,625.00
Specialists in Physical Medicine	R 2,446.00	R 1,760.00	R 138.00	R 142.00
Plastic & Reconstructive Surgeons	R 45,591.00	R 44,344.00	R 49,540.00	R 55,960.00
Thoracic Surgeons	R 59,587.00	R 96,005.00	R 111,736.00	R 119,854.00
Urologists	R 155,551.00	R 165,809.00	R 190,936.00	R 208,537.00
Clinical Haematology	NC	NC	R 5,885.00	R 11,501.00
Rheumatology	NC	NC	R 7,616.00	R 9,582.00
Radiation Oncology	NC	NC	R 373,881.00	R 420,311.00
CLINICAL SUPPORT SPECIALISTS				
Laboratory Technologists	R 9,662.00	R 15,066.00	R 531.00	NC
Radiotherapists	R 299,187.00	R 315,184.00	NC	NC
Other	R 514,439.00	R 374,879.00	R 228,821.00	R 367,050.00

NC: Not captured

Table 20: Real values paid by consolidated medical schemes to the other categories of medical specialists, (omitted from Table 18), from 2003 to 2006

	Real			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Dermatologists	R 67,018.63	R 61,400.05	R 70,898.34	R 71,407.04
Pulmonologists	R 37,450.30	R 40,435.06	R 45,508.17	R 48,493.12
Gastroenterologists	R 36,313.37	R 37,652.46	R 40,286.42	R 44,496.00
Neurologists	R 60,859.36	R 62,841.81	R 69,204.83	R 76,339.45
Psychiatrists	R 120,420.54	R 120,468.06	R 129,515.11	R 160,207.08
Medical Oncologists	R 76,114.05	R 80,769.20	R 62,031.53	R 59,020.71
Neuro-surgeons	R 120,887.88	R 138,618.02	R 131,366.63	R 155,814.99
Nuclear Medicine	R 39,618.48	R 40,672.05	R 37,160.76	R 45,227.49
Otorhinolaryngologists	R 158,243.43	R 163,498.29	R 173,097.79	R 173,624.29
Paediatric Cardiologists	R 8,099.70	R 10,140.98	R 10,530.07	R 12,342.88
Specialists in Physical Medicine	R 2,228.31	R 1,585.94	R 115.98	R 112.17
Plastic & Reconstructive Surgeons	R 41,533.40	R 39,958.38	R 41,636.19	R 44,205.30
Thoracic Surgeons	R 54,283.76	R 86,510.11	R 93,909.19	R 94,678.02
Urologists	R 141,706.96	R 149,410.49	R 160,473.30	R 164,732.67
Clinical Haematology	NC	NC	R 4,946.08	R 9,085.15
Rheumatology	NC	NC	R 6,400.91	R 7,569.25
Radiation Oncology	NC	NC	R 314,230.52	R 332,022.39
CLINICAL SUPPORT SPECIALISTS				
Laboratory Technologists	R 8,802.08	R 13,575.97	R 446.28	NC
Radiotherapists	R 272,559.36	R 284,012.30	NC	NC
Other	R 468,653.93	R 337,803.47	R 192,313.98	R 289,949.15

NC: Not captured

It is evident from both Tables 17 and 18 that the clinical support specialists (radiologists and the pathologists) account for the majority of the expenditure. In 2006, these two categories of specialists accounted for approximately 38.0% of the total amount paid to medical specialists. Possible explanations for this may include the inappropriate and sometimes unnecessary ordering of tests by other specialists, for diagnostic and therapeutic purposes.

The other categories of specialists that account for a greater percentage of the expenditure category include the anaesthetists, obstetricians and gynaecologists, physicians and orthopaedic

surgeons. These categories provide some indications as to the service utilization pattern seen in the private sector.

4.3.4.2 Private Hospitals

Private hospitals have been the largest cost-driver amongst all scheme types and it is this category that has been responsible for the increase seen in the total hospitals category.

The private hospital industry in South Africa has steadily expanded and increased over the years. According to the Hospital Association of South Africa (HASA), a not for profit organization that represents the interests of more than 90.0% of the private hospitals in South Africa, the number of beds has increased from 24 154 in 2002 to 28 467 in 2007 (Table 21).[56]

Table 21: Number of private sector beds per annum from 2002 to 2007

Year	*Number of Beds*
2002	24,154
2003	24,314
2004	26,593
2005	27,138
2006	27,443
2007	28,467

The three major hospital groups which own the majority of the private sector beds include Netcare, Life Health Care and Medi-clinic.[56]

The private hospital category includes the fees for the ward. The private sector charges per bed type. The sector defines the category of bed types differently from the public sector and it includes the following categories: medical, surgical, maternity, Intensive Care Unit (ICU), Neonatal Intensive Care Unit, Specialised Intensive Care Unit, High Care, Paediatric,

Psychiatric and Day Ward. Each type has a tariff depending on the equipment and nursing care required.[56]

The expenditure attributed to private hospitals includes mainly the ward fees, theatre fees, consumables like needles, syringes, swabs, medicines dispensed in hospital and other in-hospital benefits.

Figure 34 shows both the nominal and real (without medical inflation) values paid by all medical schemes to the three components which account for the majority of the expenditure in the private hospital category. From the graph below, it is obvious that the ward and theatre fees account for the majority of the expenditure.

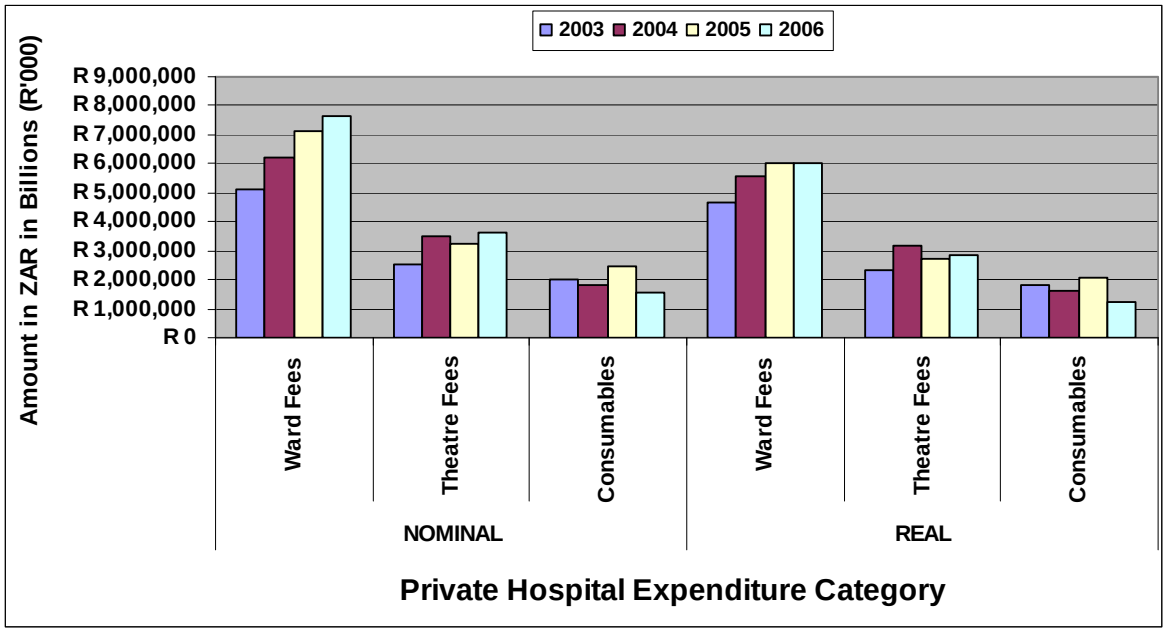


Figure 34: Nominal and real values of private hospital expenditure for consolidated medical schemes from 2003 to 2006

Table 22 shows the percentage that ward and theatre fees contribute to the private hospital expenditure category. These two items are responsible for almost two-thirds of the overall benefits paid to private hospitals from consolidated medical schemes from 2003 to 2006.

Table 22: Percentage that ward and theatre fees contribute to the private hospital expenditure category from 2003 to 2006

	YEAR			
	2003	**2004**	**2005**	**2006**
Percentage of total	65	69	66	64

Table 23 shows the nominal amounts paid by the consolidated medical schemes in the private hospital category from 2003 to 2006. This has been disaggregated according to the various categories that contribute to this expenditure. Global or per diem fee values were recorded for 2003 and 2004. Thereafter, it was replaced by managed care arrangements. The per diem fee is the fee charged for the medical service per day

Table 23: Nominal values of the consolidated medical schemes private hospital expenditure categories from 2003 to 2006

Consolidated schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Private hospitals	**R 11,847,504**	**R 14,159,969**	**R 15,863,749**	**R 17,703,161**
Ward Fees	R 5,088,898	R 6,205,309	R 7,137,965	R 7,647,413
Theatre Fees	R 2,555,363	R 3,509,652	R 3,269,348	R 3,625,483
Consumables	R 1,977,487	R 1,820,837	R 2,430,851	R 1,525,389
Medicines Dispensed	R 2,225,755	R 2,624,170	R 1,953,662	R 2,394,555
Global/ per diem fee	R 1,187,049	R 1,322,096	NC	NC
Managed Care Arrangements (In Hospital Benefits)	NC	NC	R 1,071,923	R 2,510,320

NC = Not captured

Table 24 shows the real values, without medical inflation, paid by all medical schemes to the disaggregated constituents of the private hospital expenditure category from 2003 to 2006. It is interesting to note that theatre fees decreased to R2.7 million in 2005 from R3.1 million in 2004. Consumables showed an irregular trend from decreasing in 2004, to increasing by approximately R400 000 in 2005 and then decreasing again in 2006 by more than R800 000 when compared to 2005. This represented a decrease of almost 40.0% in 2006 and 2006 was the year when this was the lowest from all four years. The decrease in expenditure of consumables may be due to better scrutiny of the billing system.

Table 24: Real values of the consolidated medical schemes private hospital expenditure categories from 2003 to 2006

Consolidated schemes	***Real***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Private hospitals	**R 10,793,076**	**R 12,759,548**	**R 13,332,783**	**R 13,984,516**
Ward Fees	R 4,635,986	R 5,591,604	R 5,999,145	R 6,041,032
Theatre Fees	R 2,327,936	R 3,162,547	R 2,747,743	R 2,863,931
Consumables	R 1,801,491	R 1,640,756	R 2,043,023	R 1,204,973
Medicines Dispensed	R 2,027,663	R 2,364,640	R 1,641,967	R 1,891,566
Global/ per diem fee	R 1,081,402	R 1,191,341	NC	NC
Managed Care Arrangements (In Hospital Benefits)	NC	NC	R 900,904	R 1,983,014

NC = Not captured

4.3.4.3 Medicines

Medicines dispensed out of hospital remained one of the top three cost-drivers in the private sector. Due to legislation, it moved from second to third position after 2003. Figure 35 shows the nominal and real values paid by consolidated medical schemes for medicines dispensed both in and out of hospital. Medicines dispensed out of hospital include those dispensed by medical specialists, pharmacists, practitioners, allied and support health professionals and other health professionals. The medicines dispensed in hospital include those which are dispensed to private sector patients both in the private and public hospitals.

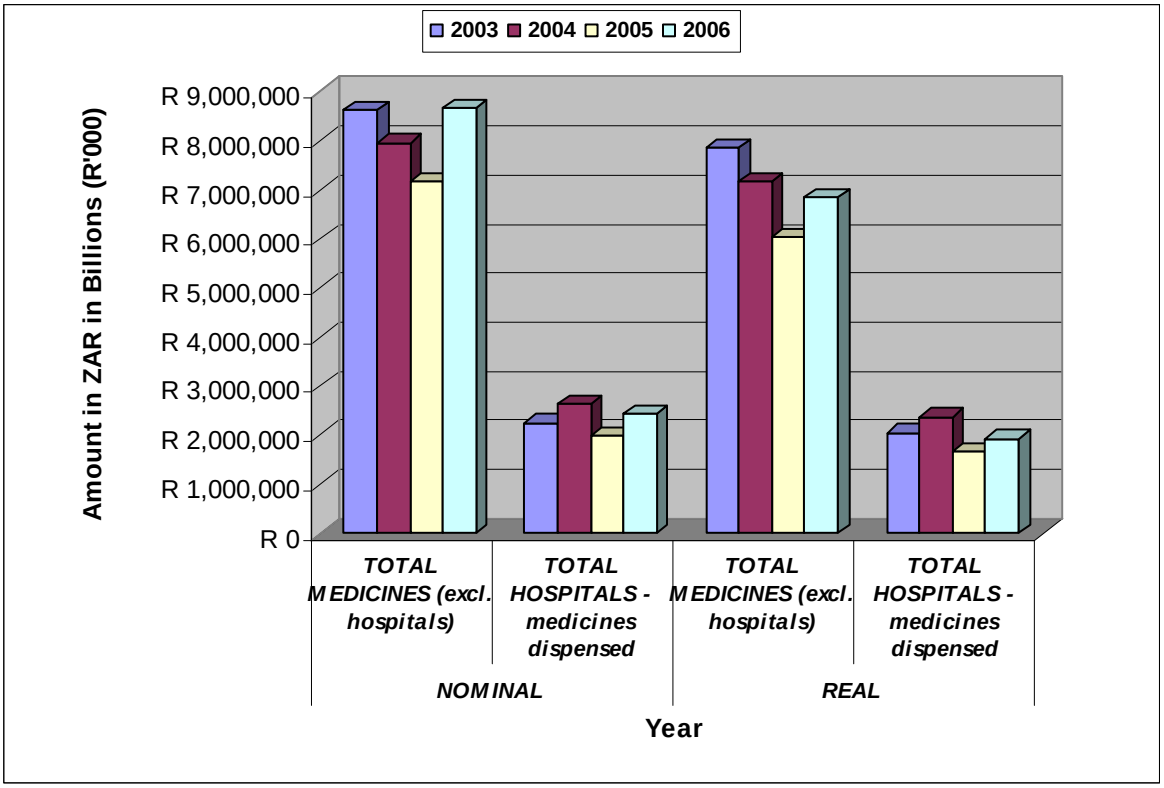


Figure 35: Nominal and real medicines benefit paid by consolidated medical schemes both in and out of hospital from 2003 to 2006

Table 25 shows the nominal values paid by consolidated medical schemes for medicines from 2003 to 2006. This has been disaggregated according to the different categories as collected by the Council for Medical Schemes. This data has improved over the four years as the annual statutory return forms were modified

It is evident that the majority of medicines dispensed out of hospitals are by pharmacists and this amount decreased in 2004 and 2005 when compared to 2003. This was probably as a result of the legislation regarding a Single Exit Price and the dispensing of generic medicines which had come into effect during that time period.

Medicines dispensed by private hospitals have shown a fluctuating trend with an increase in 2004, a decrease of more than R600 million in 2005 and a subsequent increase in 2006. Medicines dispensed by provincial hospitals have shown a dramatic decline of almost 50.0% in

2004 when compared to 2003 and have subsequently tripled in 2005 when compared to 2004. The increase in 2006 is not as dramatic as that seen in 2005. The reason for the dramatic decline in 2004 is unclear and may be due to problems in the billing of medical schemes. Patients on medical schemes that are admitted to a provincial hospital do not always inform the hospital that they are members of a scheme and, if they do, the administrators in public sector institutions may not have the appropriate knowledge to bill these schemes. This often leads to the provincial hospitals not recovering their revenue and accounts for the smaller amounts shown in the tables below.

Table 25: Nominal values of the medicines benefit paid both in and out of hospital to the different service providers from 2003 to 2006

Consolidated Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Medicines dispensed by Pharmacists	R 6,747,924	R 6,599,204	R 6,381,065	R 7,491,044
Medicines dispensed by Practitioners	R 1,837,393	R 1,336,677	R 769,128	R 933,314
Medicines dispensed by Medical Specialists	NC	NC	NC	R 158,436
Medicines dispensed by Allied and Support Health Professionals	R 32,392	R 23,468	R 34,960	R 16,005
Medicines dispensed by Other Health Professionals	NC	NC	NC	R 75,764
Total medicines (excl. hospitals)	**R 8,617,709**	**R 7,959,349**	**R 7,185,153**	**R 8,674,563**
Private hospitals-medicines dispensed	R 2,225,755	R 2,624,170	R 1,953,662	R 2,394,555
Provincial hospitals-medicines dispensed	R 26,774	R 13,445	R 39,743	R 40,140
Total hospitals - medicines dispensed	**R 2,252,529**	**R 2,637,615**	**R 1,993,405**	**R 2,434,695**

NC = Not captured

Table 26 shows the real values, without medical inflation, paid by consolidated medical schemes to the health care professionals and hospitals dispensing medicine from 2003 to 2006. For the year 2004, it is interesting to note that medicines dispensed by private hospitals showed an increase of approximately R300 000 when compared to the base year 2003 while medicines dispensed out of hospital showed a decrease.

Table 26: Real values of the medicines benefit paid both in and out of hospital to the different service providers from 2003 to 2006

Consolidated Schemes	*Real*			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
Medicines dispensed by Pharmacists	R 6,147,359	R 5,946,543	R 5,363,004	R 5,917,510
Medicines dispensed by Practitioners	R 1,673,865	R 1,204,480	R 646,418	R 737,266
Medicines dispensed by Medical Specialists	NC	NC	NC	R 125,156
Medicines dispensed by Allied and Support Health Professionals	R 29,509	R 21,147	R 29,382	R 12,643
Medicines dispensed by Other Health Professionals	NC	NC	NC	R 59,849
Total medicines (excl. Hospitals)	**R 7,850,733**	**R 7,172,169**	**R 6,038,805**	**R 6,852,424**
Private hospitals-medicines dispensed	R 2,027,663	R 2,364,640	R 1,641,967	R 1,891,566
Provincial hospitals-medicines dispensed	R 24,391	R 12,115	R 33,402	R 31,708
Total hospitals - medicines dispensed	**R 2,052,054**	**R 2,376,755**	**R 1,675,369**	**R 1,923,274**

NC = Not captured

4.3.5 Analysis of Risk Benefits Paid

This section presents the results of the expenditure by medical schemes out of the risk pool.

4.3.5.1 Consolidated Schemes

The major portion of total benefits is paid from the risk pool shared by all members. All contributions by medical scheme members on the same option are combined in a risk pool and claims are paid from this pool according to the benefit schedule outlined by that medical scheme.[57] Benefits paid from the risk pool include those paid to hospitals for admissions and those illnesses on the chronic diseases list (CDL). Medical schemes often have limits for hospital admissions and sub-limits for other categories of non-hospital benefits such as medicines and out-patient visits.

Provided that the member has not exhausted the option benefits, and that the chosen option provides the claim benefit, the medical scheme will pay the claim irrespective of how much the member has contributed to the scheme at the time of the claim.

Figure 36 shows the nominal and real trends (excluding either medical inflation or the consumer price index), for benefits paid by consolidated medical schemes from the risk pool for the time period from 2003 to 2006. When medical inflation was removed from the total amounts paid from the risk pool, the curve indicated a slight increase in the gradient compared to the steep gradient evident in the nominal curve. This shows that the benefits paid out of the risk pool showed a real increase of 14.1% from the base year, 2003, compared with the 32.0% increase observed in the nominal values.

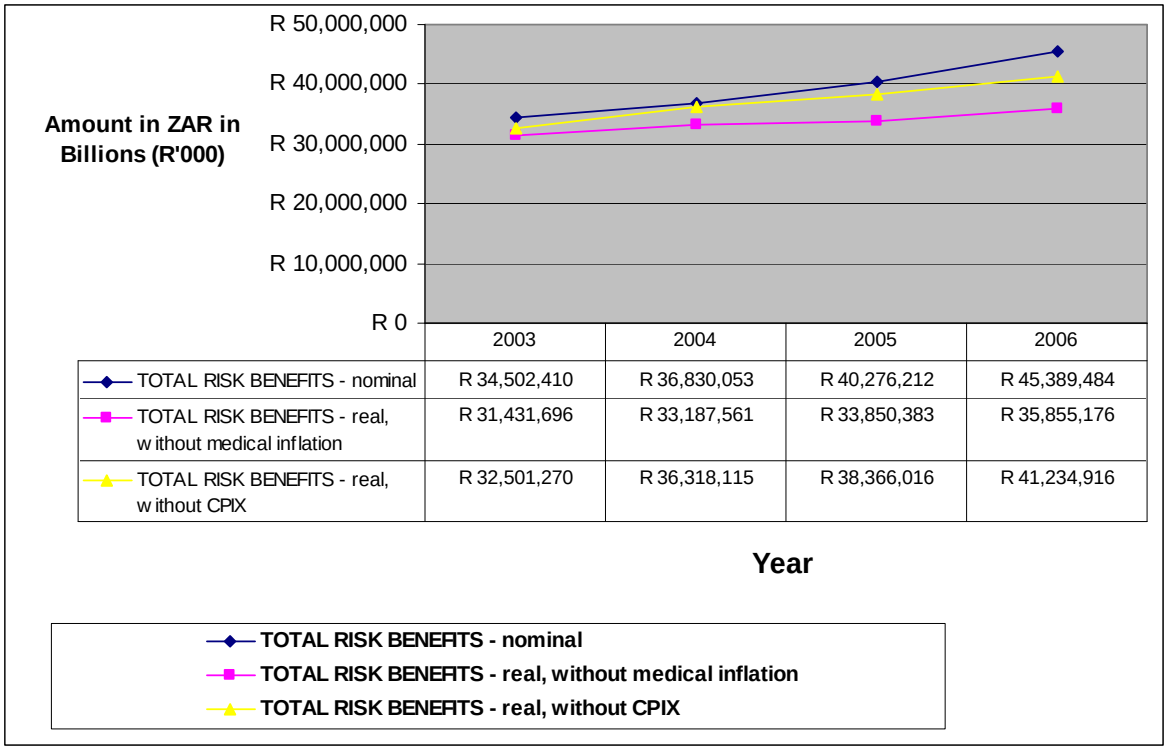


Figure 36: Trend of the nominal and real values paid by consolidated medical schemes out of the risk pool from 2003 to 2006

Figure 37 shows both the nominal and real values, without medical inflation, paid by consolidated medical schemes out of the risk pool to the various service providers from 2003 to 2006. The five main cost-drivers remain as private hospitals, medical specialists, medicines, supplementary and allied health professionals and general practitioners.

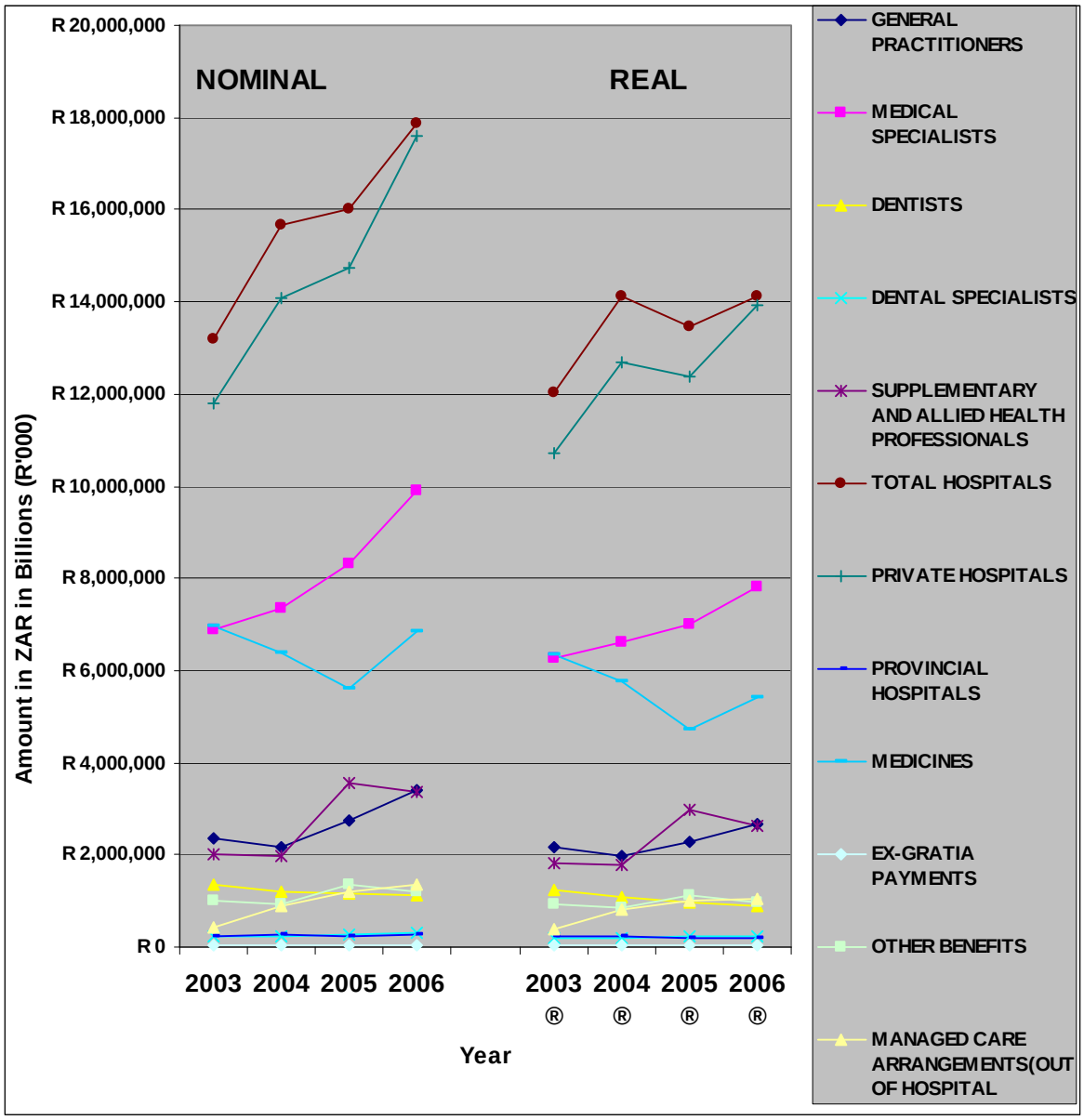


Figure 37: Comparison of the nominal and real values paid by consolidated medical schemes out of the risk pool to the various service providers from 2003 to 2006

Tables 27 and 28 show the nominal and real benefits paid out of the risk pool for the period 2003 to 2006.

Table 27 shows the nominal values paid out of the risk pool by consolidated medical schemes to the different service providers from 2003 to 2006. Of the top five cost-drivers, private hospitals were paid R2 billion more in 2004 than 2003 and almost R3 billion more in 2006 than in 2005. Medical specialists were paid more in each year and received approximately R1.5 billion more in 2006 than in 2005. The downward trend observed in the medicines category in 2004 and 2005, was replaced by an increase of R1.2 billion in 2006.

Table 27: Nominal benefits paid from the risk pool to the different providers by consolidated medical schemes from 2003 to 2006

Consolidated Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 2,366,238	R 2,182,463	R 2,737,445	R 3,393,188
Medical specialists	R 6,896,792	R 7,342,966	R 8,328,674	R 9,896,434
Dentists	R 1,368,499	R 1,212,883	R 1,145,743	R 1,123,589
Dental specialists	R 222,351	R 216,772	R 260,956	R 315,037
Supplementary and allied health professionals	R 2,016,895	R 1,964,701	R 3,556,924	R 3,352,259
Total hospitals	R 13,202,634	R 15,673,161	R 16,033,048	R 17,879,207
Private hospitals	R 11,779,554	R 14,093,446	R 14,723,907	R 17,614,691
Provincial hospitals	R 236,031	R 257,619	R 239,025	R 264,516
Medicines	R 6,963,760	R 6,380,276	R 5,607,279	R 6,833,755
Ex-gratia payments	R 24,300	R 25,967	R 56,755	R 50,135
Other benefits	R 1,016,858	R 944,466	R 1,335,698	R 1,202,923
Managed care arrangements (out of hospital benefits)	R 424,084	R 886,399	R 1,213,690	R 1,342,957
Total benefits	**R 34,502,410**	**R 36,830,053**	**R 40,276,212**	**R 45,389,484**

Table 28 shows the real values, with medical inflation removed, of the benefits paid out of the risk pool by consolidated medical schemes to the different service providers from 2003 to 2006. The large increases between the years observed when the nominal values are viewed are not as obvious with the real increases. Therefore, although the increasing trends seen among the cost-drivers remain, these are not as large in real terms.

Table 28: Real benefits paid from the risk pool to the different providers by consolidated medical schemes from 2003 to 2006

Consolidated Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 2,155,643	R 1,966,617	R 2,300,702	R 2,680,430
Medical specialists	R 6,282,978	R 6,616,747	R 6,999,884	R 7,817,634
Dentists	R 1,246,703	R 1,092,929	R 962,947	R 887,573
Dental specialists	R 202,562	R 195,333	R 219,322	R 248,862
Supplementary and allied health professionals	R 1,837,391	R 1,770,392	R 2,989,438	R 2,648,099
Total hospitals	R 12,027,600	R 14,123,085	R 13,475,071	R 14,123,582
Private hospitals	R 10,731,174	R 12,699,604	R 12,374,796	R 13,914,629
Provincial hospitals	R 215,024	R 232,140	R 200,890	R 208,953
Medicines	R 6,343,985	R 5,749,267	R 4,712,671	R 5,398,288
Ex-gratia payments	R 22,137	R 23,399	R 47,700	R 39,604
Other benefits	R 926,358	R 851,058	R 1,122,595	R 950,242
Managed care arrangements (out of hospital benefits)	R 386,341	R 798,734	R 1,020,053	R 1,060,862
Total benefits	**R 31,431,696**	**R 33,187,561**	**R 33,850,383**	**R 35,855,176**

®: Real values (medical inflation removed)

Table 29 shows the real (without medical inflation) percentage increase or decrease in the benefits paid out of the risk pool by consolidated medical schemes from 2003 to 2006.

Managed health care (out of hospital benefits) has shown the largest percentage increase since 2003. It increased by more than 100.0% in 2004 and subsequently this increase slowed down in 2005 and 2006. Private hospitals received an increase above the medical inflation rate each year and in total received a 30.0% increase when compared to the base year of 2003. Medical specialists were paid almost twice the percentage increase in 2006 (11.7%) than in 2005 (5.8%) and 2004 (5.3%).

Medicines showed a decrease of 9.4% in 2004 and 25.7% in 2005 when compared to the base year, 2003. It then increased from 2005 by 14.6% in 2006. However, overall the amount paid out of the risk pool to medicines dispensed out of hospital decreased by almost 15.0% when compared to the base year of 2003.

Table 29: Real percentage increase/decrease paid from the risk pool by consolidated medical schemes to the various service providers from 2003 to 2006

Consolidated Schemes	*2003*	*2004*	*2005 ® vs 2004*	*2005 ® vs 2003*	*2006 ® vs 2005*	*2006 ® vs 2004*	*2006 ® vs 2003*
General Practitioners	0.00	-8.77	16.99	6.73	16.50	36.30	24.34
Medical Specialists	0.00	5.31	5.79	11.41	11.68	18.15	24.43
Dentists	0.00	-12.33	-11.89	-22.76	-7.83	-18.79	-28.81
Dental Specialists	0.00	-3.57	12.28	8.27	13.47	27.40	22.86
Supplementary And Allied Health Professionals	0.00	-3.65	68.86	62.70	-11.42	49.58	44.12
Total Hospitals	0.00	17.42	-4.59	12.03	4.81	0.00	17.43
Private Hospitals	0.00	18.34	-2.56	15.32	12.44	9.57	29.67
Provincial Hospitals	0.00	7.96	-13.46	-6.57	4.01	-9.99	-2.82
Medicines	0.00	-9.37	-18.03	-25.71	14.55	-6.10	-14.91
Ex-Gratia Payments	0.00	5.70	103.86	115.47	-16.97	69.26	78.90
Other Benefits	0.00	-8.13	31.91	21.18	-15.35	11.65	2.58
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	106.74	27.71	164.03	4.00	32.82	174.59
Total Benefits	**0.00**	**5.59**	**2.00**	**7.70**	**5.92**	**8.04**	**14.07**

®: Real values (medical inflation removed)

4.3.5.2 Registered Open Medical Schemes

Figure 38 shows both the nominal and real values, with medical inflation removed, of the benefits paid out of the risk pool by registered open medical schemes to the different service providers from 2003 to 2006. The top five cost-drivers remain unchanged and show an increasing trend. However, payments to dentists display a downward trend.

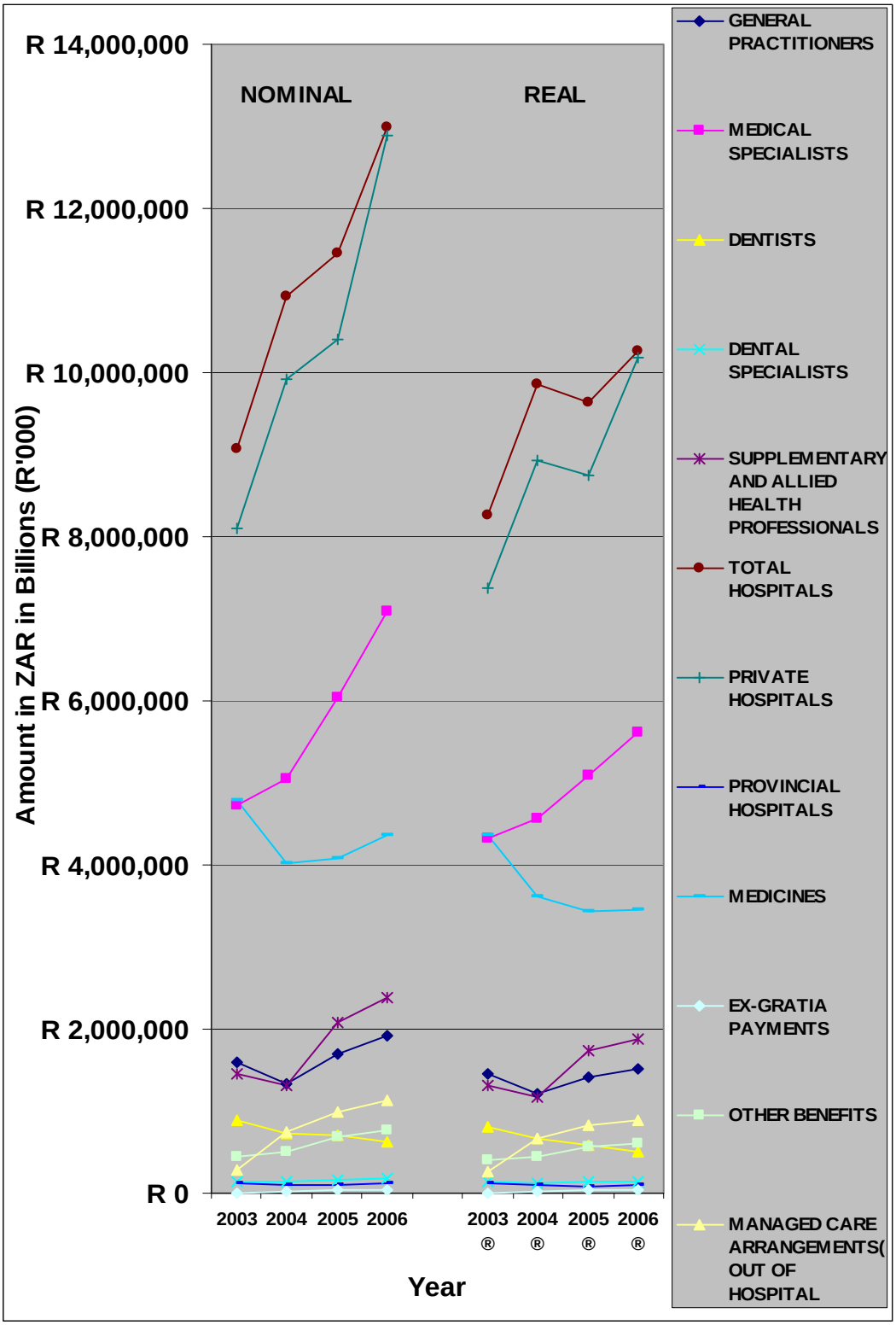


Figure 38: Comparison of both the nominal and real values paid by registered open medical schemes out of the risk pool to the various service providers from 2003 to 2006

Table 30 shows the nominal amount paid out of the risk pool by registered open schemes to the different service providers from 2003 to 2006. Apart from the major cost-drivers, both ex-gratia payments and managed care arrangements have increased substantially over the last four years. Ex-gratia payments are discretionary or additional benefits which a medical scheme may consider and usually come into effect when a member is undergoing undue hardship either due to the nature of the medical condition or a financial crisis. Medical schemes are not obliged to make provision for this benefit in the rules and members have no statutory right to it either.[58] These payments have increased from approximately R10 million in 2003 to more than R40 million in 2006. Managed care arrangements increased from approximately R300 million in 2003 to more than R1 billion in 2006.

Table 30: Nominal values paid by registered open medical schemes out of the risk pool from 2003 to 2006

Registered Open Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 1,586,292	R 1,342,942	R 1,690,822	R 1,926,978
Medical specialists	R 4,736,256	R 5,059,163	R 6,046,979	R 7,099,177
Dentists	R 892,193	R 732,640	R 699,113	R 628,992
Dental specialists	R 144,530	R 135,530	R 167,596	R 179,839
Supplementary and allied health professionals	R 1,446,659	R 1,306,704	R 2,071,910	R 2,378,712
Total hospitals	R 9,074,696	R 10,929,417	R 11,459,834	R 12,999,233
Private hospitals	R 8,103,130	R 9,909,179	R 10,402,484	R 12,878,967
Provincial hospitals	R 124,155	R 110,104	R 105,984	R 120,266
Medicines	R 4,781,306	R 4,011,826	R 4,087,561	R 4,362,406
Ex-gratia payments	R 9,732	R 12,053	R 46,354	R 40,201
Other benefits	R 444,818	R 501,662	R 680,039	R 759,955
Managed care arrangements(out of hospital benefits)	R 292,388	R 741,400	R 990,223	R 1,126,335
Total benefits	**R 23,408,869**	**R 24,773,338**	**R 27,940,430**	**R 31,501,828**

Table 31 shows the real amounts, with medical inflation removed, that were paid out of the risk pool by registered open schemes to the various service providers from 2003 to 2006.
Private hospitals remain the largest cost-driver and increased from R7.4 billion in 2003 to R10.2 billion in 2006.

Table 31: Real values paid by registered open medical schemes out of the risk pool from 2003 to 2006

Registered Open Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 1,445,112	R 1,210,125	R 1,421,061	R 1,522,206
Medical specialists	R 4,314,729	R 4,558,812	R 5,082,220	R 5,607,956
Dentists	R 812,788	R 660,182	R 587,574	R 496,869
Dental specialists	R 131,667	R 122,126	R 140,857	R 142,063
Supplementary and allied health professionals	R 1,317,906	R 1,177,471	R 1,741,349	R 1,879,051
Total hospitals	R 8,267,048	R 9,848,498	R 9,631,486	R 10,268,673
Private hospitals	R 7,381,951	R 8,929,161	R 8,742,830	R 10,173,670
Provincial hospitals	R 113,105	R 99,215	R 89,075	R 95,003
Medicines	R 4,355,770	R 3,615,056	R 3,435,415	R 3,446,059
Ex-gratia payments	R 8,866	R 10,861	R 38,958	R 31,757
Other benefits	R 405,229	R 452,048	R 571,543	R 600,322
Managed care arrangements(out of hospital benefits)	R 266,365	R 668,076	R 832,239	R 889,742
Total benefits	**R 21,325,480**	**R 22,323,255**	**R 23,482,701**	**R 24,884,698**

®: Real values (medical inflation removed)

Table 32 reflects the real percentage increase or decrease in the amounts paid out of the risk pool by registered open schemes to the different service providers from 2003 to 2006.
It is interesting to note that general practitioners were paid 16.3% less in 2004 when compared to the base year and subsequently received an increase of 17.4% in 2005 and 7.0% in 2006. The overall increase in 2006, when compared to the base year, was a mere 5.3% as opposed to the almost 25.0% increase observed when the data for consolidated schemes was analyzed. Private hospitals and medical specialists showed similar percentage increases when compared to consolidated schemes. However, medicines showed a larger decrease in the real amounts

paid to dispensing practitioners than in consolidated schemes. In 2006 when the amount paid for medicines out of the risk pool began an upward trend, just 0.30% increase was paid by the registered open schemes.

Table 32: Real percentage increase/decrease paid from the risk pool by registered open medical schemes to the various service providers from 2003 to 2006

Registered Open Schemes	***2003 ®***	***2004 ®***	***2005 ® vs 2004***	***2005 ® vs 2003***	***2006 ® vs 2005***	***2006 ® vs 2004***	***2006 ® vs 2003***
General Practitioners	0.00	-16.26	17.43	-1.66	7.12	25.79	5.33
Medical Specialists	0.00	5.66	11.48	17.79	10.34	23.01	29.97
Dentists	0.00	-18.78	-11.00	-27.71	-15.44	-24.74	-38.87
Dental Specialists	0.00	-7.25	15.34	6.98	0.86	16.32	7.90
Supplementary And Allied Health Professionals	0.00	-10.66	47.89	32.13	7.91	59.58	42.58
Total Hospitals	0.00	19.13	-2.20	16.50	6.62	4.27	24.21
Private Hospitals	0.00	20.96	-2.09	18.44	16.37	13.94	37.82
Provincial Hospitals	0.00	-12.28	-10.22	-21.25	6.66	-4.24	-16.00
Medicines	0.00	-17.01	-4.97	-21.13	0.31	-4.67	-20.89
Ex-Gratia Payments	0.00	22.50	258.70	339.42	-18.49	192.39	258.19
Other Benefits	0.00	11.55	26.43	41.04	5.04	32.80	48.14
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	150.81	24.57	212.44	6.91	33.18	234.03
Total Benefits	**0.00**	**4.68**	**5.19**	**10.12**	**5.97**	**11.47**	**16.69**

®: Real values (medical inflation removed)

4.3.5.3 Registered Restricted Medical Schemes

Figure 39 shows both the nominal and real (without medical inflation) trends in payment by registered restricted medical schemes from the risk pool from 2003 to 2006. The five main cost-drivers remain the same as for registered open medical schemes but ex-gratia and managed care arrangements which had shown upward trends in registered open schemes, show an almost straight line trend in restricted schemes.

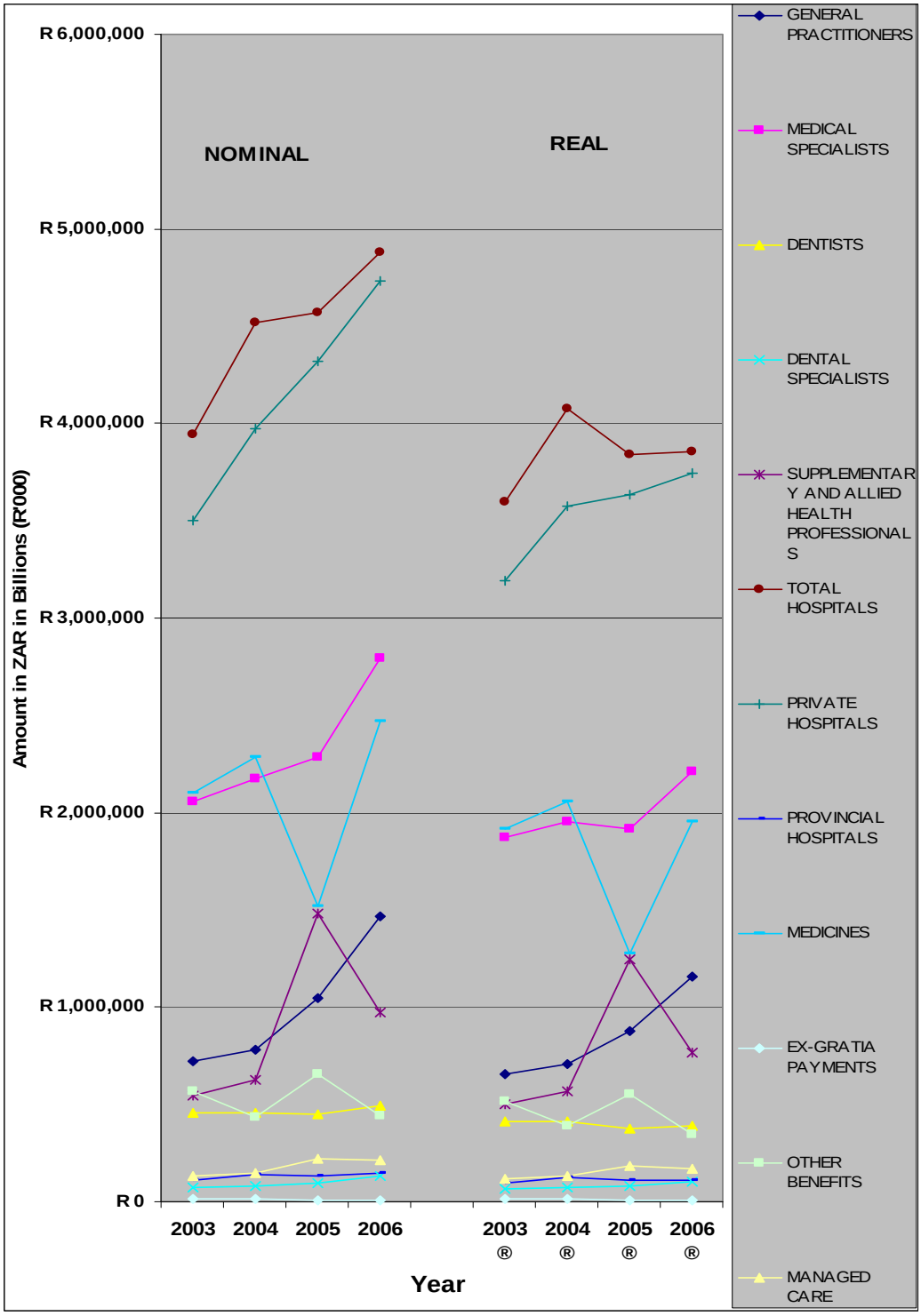


Figure 39: Comparison of the nominal and real values paid by registered restricted medical schemes from the risk pool to the various service providers from 2003 to 2006

Table 33 shows the nominal amounts paid by registered restricted schemes out of the risk pool to the various service providers from 2003 to 2006. As indicated in Figure 40, ex-gratia payments and managed care arrangements have not shown the major escalating trends that were observed in registered open schemes. It is also of interest to note that the dental benefit which had shown a decrease in open schemes, shows an increase in the nominal amount paid in 2006 when compared to 2005 from R446 million to R494 million.

Other benefits which includes amongst others, ambulance services, blood transfusion services, home oxygen, prostheses, mental institutions, alcohol and drug rehabilitation have demonstrated a fluctuating trend, decreasing both in 2004 and 2006, when compared to the previous year.

Table 33: Nominal values paid by registered restricted medical schemes out of the risk pool from 2003 to 2006

Registered Restricted Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 722,304	R 782,213	R 1,046,623	R 1,466,209
Medical specialists	R 2,054,139	R 2,171,708	R 2,281,695	R 2,797,258
Dentists	R 453,434	R 455,399	R 446,630	R 494,597
Dental specialists	R 74,942	R 78,212	R 93,361	R 135,198
Supplementary and allied health professionals	R 548,584	R 626,827	R 1,485,014	R 973,547
Total hospitals	R 3,946,352	R 4,519,608	R 4,573,215	R 4,879,974
Private hospitals	R 3,499,457	R 3,970,880	R 4,321,423	R 4,735,723
Provincial hospitals	R 107,257	R 141,043	R 133,042	R 144,251
Medicines	R 2,100,138	R 2,284,526	R 1,519,718	R 2,471,349
Ex-gratia payments	R 12,481	R 13,732	R 10,401	R 9,934
Other benefits	R 569,340	R 435,208	R 655,659	R 442,967
Managed care arrangements (out of hospital benefits)	R 129,290	R 144,999	R 223,467	R 216,622
Total benefits	**R 10,611,005**	**R 11,512,432**	**R 12,335,782**	**R 13,887,655**

Table 34 shows the real amounts, with medical inflation removed, paid by registered restricted schemes, out of the risk pool, to the different service providers from 2003 to 2006. Private hospitals shows a much smaller increase in the real amounts paid by restricted schemes than open schemes but general practitioners have shown a steeper increase than the open schemes. Payment to supplementary and allied health professionals doubled in 2005 when compared to 2004 but then decreased after that in 2006. Open schemes, on the other hand showed a consistent increase across the four years. Ex-gratia payments have shown a real decrease in restricted schemes, declining from R11 million in 2003 to R7.8 million in 2006. This is in stark contrast to open schemes which showed a 258.0% increase when compared to the base year of 2003. This implies that the number of ex-gratia payments have decreased over the four year period in restricted schemes.

Table 34: Real values paid by registered restricted medical schemes out of the risk pool from 2003 to 2006

Registered Restricted Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 658,019	R 704,852	R 879,641	R 1,158,224
Medical specialists	R 1,871,321	R 1,956,926	R 1,917,664	R 2,209,679
Dentists	R 413,078	R 410,360	R 375,373	R 390,704
Dental specialists	R 68,272	R 70,477	R 78,466	R 106,799
Supplementary and allied health professionals	R 499,760	R 564,834	R 1,248,089	R 769,048
Total hospitals	R 3,595,127	R 4,072,619	R 3,843,586	R 3,854,909
Private hospitals	R 3,188,005	R 3,578,160	R 3,631,966	R 3,740,959
Provincial hospitals	R 97,711	R 127,094	R 111,816	R 113,950
Medicines	R 1,913,226	R 2,058,586	R 1,277,256	R 1,952,229
Ex-gratia payments	R 11,370	R 12,374	R 8,742	R 7,847
Other benefits	R 518,669	R 392,166	R 551,053	R 349,919
Managed care arrangements (out of hospital benefits)	R 117,783	R 130,659	R 187,814	R 171,119
Total benefits	**R 9,666,626**	**R 10,373,852**	**R 10,367,682**	**R 10,970,478**

®: Real values (medical inflation removed)

Table 35 shows the real percentage (without medical inflation) increase or decrease in the amounts paid by restricted scheme out of the risk pool, to the various service provider from 2003 and 2006. It compares each year to the base year and to previous years.

Private hospitals and medical specialists were paid an overall real increase of 17.3% and 18.1% respectively, when compared to the base year of 2003. This percentage change is much lower than for open schemes where the increase in these expenditure categories was approximately 30.0%. General practitioners, on the other hand were paid larger percentage increases by restricted schemes as compared to open schemes, increasing by 7.0% in 2004, 25.0% in 2005, 32.0% in 2006 and an overall 76.0% when compared to the base year.

Supplementary and allied health professionals received 121.0% more in 2005 than in 2004 but this then decreased by 38.0% in 2006 resulting in an overall increase of 56.0% which is approximately 13.0% more than the 43.0% increase seen in open schemes.

Ex-gratia payments showed a decrease of 31.0% when compared to 2003.

Table 35: Real percentage increase/decrease paid from the risk pool by registered restricted medical schemes to the various service providers from 2003 to 2006

Registered Restricted Schemes	*2003 ®*	*2004 ®*	*2005 ® vs 2004*	*2005 ® vs 2003*	*2006 ® vs 2005*	*2006 ® vs 2004*	*2006 ® vs 2003*
General Practitioners	0.00	7.12	24.80	33.68	31.67	64.32	76.02
Medical Specialists	0.00	4.57	-2.01	2.48	15.23	12.92	18.08
Dentists	0.00	-0.66	-8.53	-9.13	4.08	-4.79	-5.42
Dental Specialists	0.00	3.23	11.34	14.93	36.11	51.54	56.43
Supplementary And Allied Health Professionals	0.00	13.02	120.97	149.74	-38.38	36.15	53.88
Total Hospitals	0.00	13.28	-5.62	6.91	0.29	-5.35	7.23
Private Hospitals	0.00	12.24	1.50	13.93	3.00	4.55	17.34
Provincial Hospitals	0.00	30.07	-12.02	14.44	1.91	-10.34	16.62
Medicines	0.00	7.60	-37.95	-33.24	52.85	-5.17	2.04
Ex-Gratia Payments	0.00	8.83	-29.35	-23.12	-10.23	-36.58	-30.98
Other Benefits	0.00	-24.39	40.52	6.24	-36.50	-10.77	-32.54
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	10.93	43.74	59.46	-8.89	30.97	45.28
Total Benefits	**0.00**	**7.32**	**-0.06**	**7.25**	**5.81**	**5.75**	**13.49**

®: Real values (medical inflation removed)

4.3.6 Analysis of Savings Benefits Paid

Medical savings accounts were first introduced in medical schemes in the 1990's as an attempt to control costs and prevent the abuse of schemes.[59] At the time of its introduction, there was no regulatory environment to regulate it and medical schemes used them as a means of risk-rating groups. With the personal savings account, a member assumes responsibility for certain defined day to day out of hospital expenditures like frames for glasses, payment to general practitioners, specialists, medicines not included on the chronic medicines lists, dentists and other health care practitioners.[60] However, should the money not be adequate to cover the expense, then the member would have to fund the expense out of his/her pocket.[57]

The Medical Schemes Act No. 131 of 1998 provided the legislative environment for the regulation of medical savings accounts [59] and the amount that can be set aside has been restricted to 25.0%. This avoids depleting the risk pool and helps curb shifting more of the risk

to members. There can be advantages or disadvantages to medical savings accounts depending on the health status of the member. A healthy individual can accumulate an adequate amount of money while a sick individual who frequently visits the general practitioner may rapidly deplete their savings and have to pay out of pocket.

Certain medical schemes offer thresholds which can be viewed as a safety net. This means that when the member has spent a certain amount on essential claims, then the scheme would pay for those essential claims from the risk pool.[57]

Figure 40 shows the total contributions made to all medical schemes medical savings accounts (MSAs) by beneficiaries and the claims that were paid out from this account for the years 2003 to 2006. The amount paid into Medical Savings Accounts by beneficiaries has shown an increase from R5 billion in 2003 to R6.3 billion in 2005. This contribution has remained fairly static in 2006 at R6.2 billion probably due to the decrease in the number of schemes in 2006. The amounts paid out from these savings accounts have steadily increased each year and the gap between the amount saved and the amount paid out has narrowed since 2003. In 2006, of the R6.2 billion paid into Medical Savings Accounts, an amount of R300 million remained at the end of the year while the rest was paid out from claims. This implies that the majority of beneficiaries used the funds in their savings account to pay their out of hospital expenses.

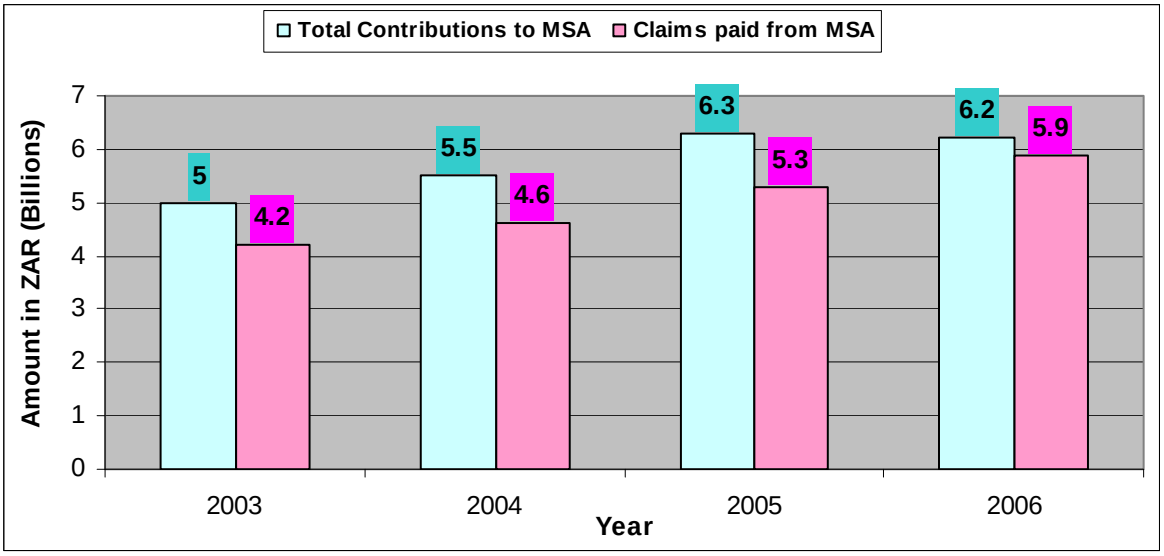


Figure 40: Total contributions by beneficiaries and claims paid from the medical savings account from 2003 to 2006

4.3.6.1 Consolidated Medical Schemes

Figure 41 shows the nominal and real trends, with the removal of medical inflation and the consumer price index, of the total benefits paid out of medical savings by consolidated schemes for the period 2003 to 2006. Medical inflation which has consistently exceeded the consumer price index has resulted in higher amounts paid out from the medical savings account.

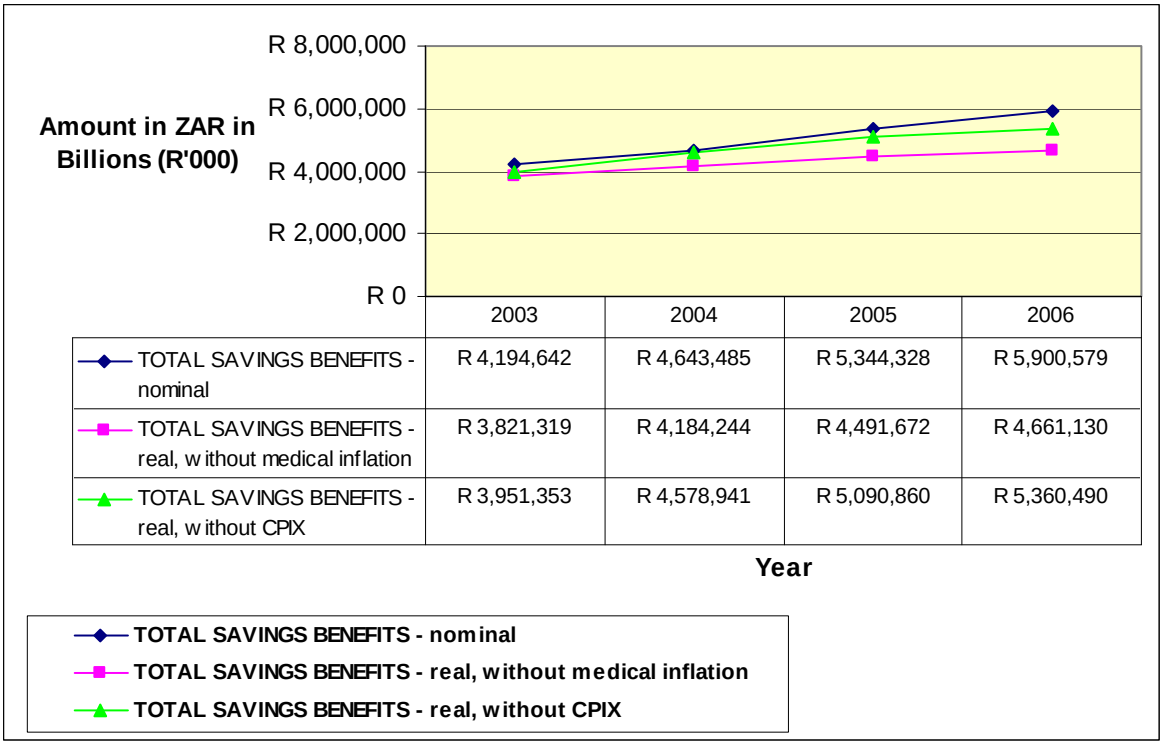


Figure 41: Comparison of both the nominal and real trends of the total benefits paid out of the medical savings account by consolidated medical schemes from 2003 to 2006

Figure 42 graphically shows both the nominal and real (without medical inflation) trends of the benefits paid from beneficiaries' medical savings accounts by consolidated medical schemes, to the different service providers from 2003 to 2006. It is of interest to note the change in the cost-drivers. Although payments for medicines began decreasing in 2004, it became the number one cost-driver and began showing an upward trend again. Supplementary and allied health professionals, medical specialists, general practitioners and dentists made up the rest of the top five cost-drivers. Private hospitals are covered from the risk pool.

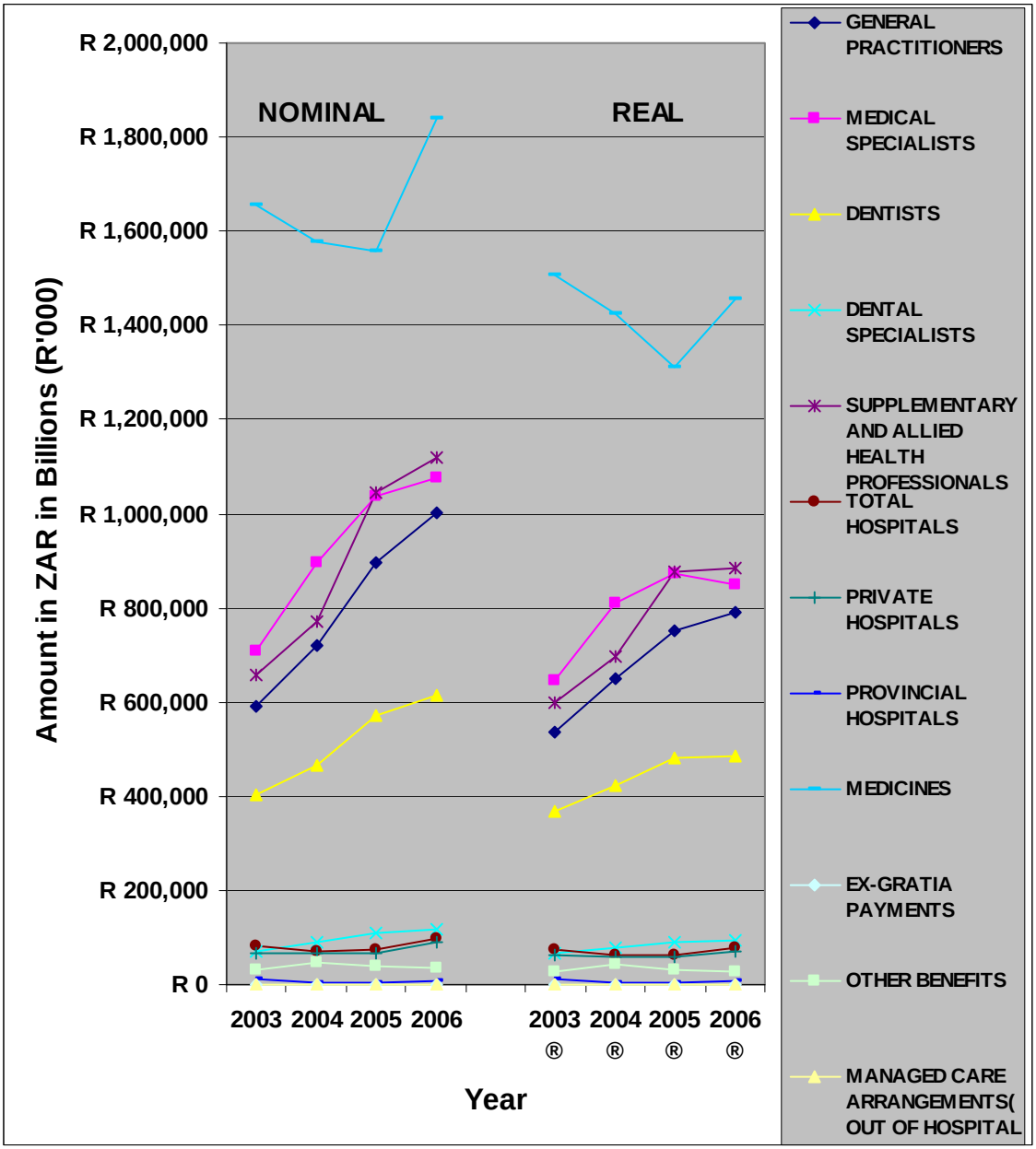


Figure 42: Comparison of the nominal and real values paid by consolidated medical schemes from the savings account from 2003 to 2006

Tables 36 and 37 show both the nominal and real (with medical inflation removed) amounts paid out of the savings accounts by consolidated schemes to the various service providers from 2003 to 2006. Medicines dispensed out of hospital accounts for almost one-third of the amount paid out of the savings benefit. In 2003, medicines accounted for 39.4% of the total amount paid from the savings account while in 2004, 2005 and 2006, it accounted for 34.0%, 29.2% and 31.2% respectively.

Supplementary and allied health professionals which include the optometrist, podiatrist, physiotherapist, dietician, private nurse and complementary medicine practitioners such as homeopaths and ayurvedic practitioners have shown an increasing trend to become the second largest expenditure to be paid out of medical savings accounts. Medical specialists and general practitioners are the other two categories accounting for expenditure from the savings account.

Table 36: Nominal benefits paid out of the savings accounts by consolidated medical schemes to the different service providers from 2003 to 2006

Consolidated Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 589,156	R 721,885	R 895,634	R 1,000,148
Medical specialists	R 707,949	R 897,540	R 1,037,550	R 1,076,558
Dentists	R 404,085	R 467,176	R 570,551	R 613,986
Dental specialists	R 71,646	R 88,756	R 107,716	R 118,665
Supplementary and allied health professionals	R 656,753	R 772,436	R 1,043,262	R 1,118,545
Total hospitals	R 80,710	R 70,812	R 73,686	R 97,588
Private hospitals	R 67,950	R 66,523	R 67,919	R 88,470
Provincial hospitals	R 12,761	R 4,289	R 3,960	R 9,117
Medicines	R 1,653,949	R 1,579,074	R 1,557,874	R 1,840,808
Ex-gratia payments	R 16	R 48	R 16	R 252
Other benefits	R 30,378	R 45,758	R 38,039	R 33,969
Managed care arrangements (out of hospital benefits)	R 0	R 0	R 0	R 60
Total benefits	**R 4,194,642**	**R 4,643,485**	**R 5,344,328**	**R 5,900,579**

Table 37: Real benefits paid out of the savings accounts by consolidated medical schemes to the different service providers from 2003 to 2006

Consolidated Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 536,721	R 650,491	R 752,741	R 790,061
Medical specialists	R 644,942	R 808,773	R 872,015	R 850,421
Dentists	R 368,121	R 420,972	R 479,523	R 485,015
Dental specialists	R 65,270	R 79,978	R 90,531	R 93,739
Supplementary and allied health professionals	R 598,302	R 696,042	R 876,816	R 883,589
Total hospitals	R 73,527	R 63,809	R 61,930	R 77,089
Private hospitals	R 61,902	R 59,944	R 57,083	R 69,886
Provincial hospitals	R 11,625	R 3,865	R 3,328	R 7,202
Medicines	R 1,506,748	R 1,422,904	R 1,309,325	R 1,454,136
Ex-gratia payments	R 15	R 43	R 13	R 199
Other benefits	R 27,674	R 41,233	R 31,970	R 26,834
Managed care arrangements(out of hospital benefits)	R 0	R 0	R 0	R 47
Total benefits	**R 3,821,319**	**R 4,184,244**	**R 4,491,672**	**R 4,661,130**

®: Real values (medical inflation removed)

Table 38 shows the real percentage increase or decrease paid out of the medical savings accounts of consolidated medical schemes to the various service providers when compared to the base year of 2003 and the previous years.

Although medicines were the largest expense out of savings accounts, this amount actually decreased by 6.0% in 2004 and 13.1% in 2005 when compared to the base year of 2003. However, in 2006, the amount paid for medicines increased by 11.0% when compared to the previous year 2005 and by 2.0% when compared to 2004. Overall, it witnessed a decrease of 3.5% and this change was largely due to the single exit price and generic medicines policy.

Medical specialists were paid a smaller percentage increase of 7.8% in 2005 when compared to the 25.4% increase received in 2004. In 2006, they received 2.5% less than they did in 2005 but overall there was an increase of almost 32.0% when compared to the base year.

General practitioners received successive increases from 2003 but the percentage increase decreased with each successive year from 21.2% in 2004, to 15.7% in 2005 and 5.0% in 2006.

Ex-gratia payments showed the largest percentage increase of more than a 1000.0% from the base year but in real rand amounts, this increased from R15 in 2003 to R199 in 2006 (Table 37).

Table 38: Real percentage increase/decrease paid by consolidated medical schemes from the savings account from 2003 to 2006

Consolidated Schemes	***2003***	***2004***	***2005 ® vs 2004***	***2005 ® vs 2003***	***2006 ® vs 2005***	***2006 ® vs 2004***	***2006 ® vs 2003***
General Practitioners	0.00	21.20	15.72	40.25	4.96	21.46	47.20
Medical Specialists	0.00	25.40	7.82	35.21	-2.48	5.15	31.86
Dentists	0.00	14.36	13.91	30.26	1.15	15.21	31.75
Dental Specialists	0.00	22.54	13.19	38.70	3.54	17.21	43.62
Supplementary And Allied Health Professionals	0.00	16.34	25.97	46.55	0.77	26.94	47.68
Total Hospitals	0.00	-13.22	-2.94	-15.77	24.48	20.81	4.84
Private Hospitals	0.00	-3.16	-4.77	-7.79	22.43	16.59	12.90
Provincial Hospitals	0.00	-66.76	-13.88	-71.37	116.39	86.35	-38.05
Medicines	0.00	-5.56	-7.98	-13.10	11.06	2.19	-3.49
Ex-Gratia Payments	0.00	196.74	-68.91	-7.74	1380.34	360.24	1265.71
Other Benefits	0.00	48.99	-22.46	15.52	-16.07	-34.92	-3.04
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Benefits	**0.00**	**9.50**	**7.35**	**17.54**	**3.77**	**11.40**	**21.98**

®: Real values (medical inflation removed)

4.3.6.2 Registered Open Medical Schemes

Figure 43 shows both the nominal and real trends of the various expenditure categories shown by the medical savings accounts of registered open schemes from 2003 to 2006. Medicines remain the largest expenditure category. Whereas payments made to the medical specialist category showed a downward trend from 2003, it has now become the second largest expenditure in open schemes and is equivalent to payments to supplementary and allied health professionals in consolidated schemes. The dentists and dental specialists are the other categories that show an upward trend over the four year period.

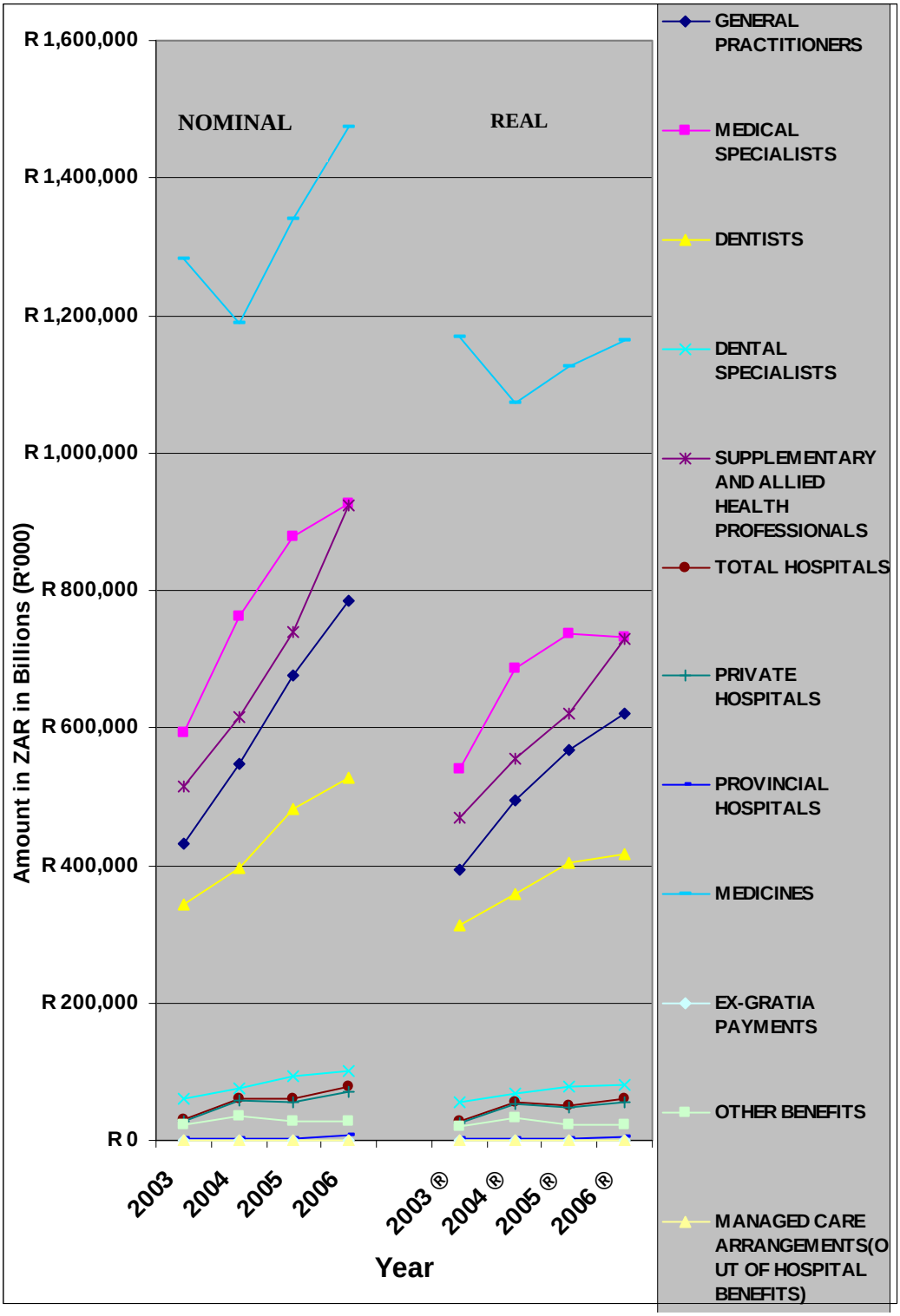


Figure 43: Comparison of the nominal and real values paid by registered open medical schemes from the savings account from 2003 to 2006

Tables 39 and 40 show both the nominal and real amounts paid by registered open schemes out of the medical savings accounts from 2003 to 2006. Medicines dispensed out of hospital was the largest expense by registered open schemes accounting for 39.0% of the total amount paid out of the medical savings account in 2003. In 2004, it accounted for 32.0% of the expenditure while in 2005 and 2006 it accounted for 31.0% and 30.0% respectively. Payments to medical specialists were the second largest expenditure and accounted for 18.0% of the total benefits paid in 2003, while in 2004, 2005 and 2006 it accounted for 21.0%, 20.0% and 19.0% respectively. The third and fourth largest expenditure was for the supplementary and allied health professionals and the general practitioners.

Table 39: Nominal benefits paid out of the savings accounts by registered open medical schemes to the different service providers from 2003 to 2006

Registered Open Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 430,783	R 548,431	R 676,260	R 785,869
Medical specialists	R 592,839	R 762,952	R 877,712	R 925,761
Dentists	R 343,221	R 396,622	R 480,784	R 526,531
Dental specialists	R 60,121	R 76,309	R 92,979	R 101,866
Supplementary and allied health professionals	R 513,910	R 616,863	R 740,133	R 922,909
Total hospitals	R 30,624	R 60,421	R 60,835	R 77,878
Private hospitals	R 28,277	R 57,755	R 55,572	R 70,146
Provincial hospitals	R 2,347	R 2,666	R 3,497	R 7,732
Medicines	R 1,282,957	R 1,189,299	R 1,339,978	R 1,472,822
Ex-gratia payments	R 12	R 31	R 8	R 14
Other benefits	R 22,721	R 36,309	R 26,505	R 27,240
Managed care arrangements(out of hospital benefits)	R 0	R 0	R 0	R 426
Total benefits	**R 3,277,189**	**R 3,687,237**	**R 4,295,195**	**R 4,841,317**

Table 40: Real benefits paid out of the savings accounts by registered open medical schemes to the different service providers from 2003 to 2006

Registered Open Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 392,443	R 494,191	R 568,367	R 620,793
Medical specialists	R 540,076	R 687,496	R 737,678	R 731,300
Dentists	R 312,674	R 357,396	R 404,078	R 415,930
Dental specialists	R 54,770	R 68,762	R 78,145	R 80,468
Supplementary and allied health professionals	R 468,172	R 555,855	R 622,049	R 729,047
Total hospitals	R 27,898	R 54,445	R 51,129	R 61,519
Private hospitals	R 25,760	R 52,043	R 46,706	R 55,411
Provincial hospitals	R 2,138	R 2,402	R 2,939	R 6,108
Medicines	R 1,168,774	R 1,071,677	R 1,126,193	R 1,163,448
Ex-gratia payments	R 11	R 28	R 7	R 11
Other benefits	R 20,699	R 32,718	R 22,276	R 21,518
Managed care arrangements(out of hospital benefits)	R 0	R 0	R 0	R 337
Total benefits	**R 2,985,519**	**R 3,322,569**	**R 3,609,922**	**R 3,824,372**

®: Real values (medical inflation removed)

Table 41 shows the percentage increase or decrease, in real terms, of the benefits paid out of medical savings accounts by registered open schemes from the base year 2003 to 2006. Medicines, although forming the largest expenditure category, showed a decrease of 8.3% in 2004 and 3.6% in 2005 when compared to the base year, 2003. However, in 2006, it increased by 3.3% when compared to 2005 but overall there was a decrease of 0.50% from the base year. Medical specialists showed an overall increase of 35.4% from the base year of 2003. General practitioners showed an increase of almost 30.0% in 2004 when compared to 2003. Thereafter, in 2005 and 2006 it increased by 15.0% and 9.0% respectively when compared to previous years. Managed care arrangements were only recorded for the year of 2006 and therefore could not be compared to previous years.

Table 41: Real percentage increase/decrease paid by registered open medical schemes from the savings account from 2003 to 2006

Registered Open Schemes	*2003 ®*	*2004 ®*	*2005 ® vs 2004*	*2005 ® vs 2003*	*2006 ® vs 2005*	*2006 ® vs 2004*	*2006 ® vs 2003*
General Practitioners	0.00	25.93	15.01	44.83	9.22	25.62	58.19
Medical Specialists	0.00	27.30	7.30	36.59	-0.86	6.37	35.41
Dentists	0.00	14.30	13.06	29.23	2.93	16.38	33.02
Dental Specialists	0.00	25.55	13.65	42.68	2.97	17.02	46.92
Supplementary And Allied Health Professionals	0.00	18.73	11.91	32.87	17.20	31.16	55.72
Total Hospitals	0.00	95.16	-6.09	83.27	20.32	12.99	120.51
Private Hospitals	0.00	102.03	-10.26	81.31	18.64	6.47	115.10
Provincial Hospitals	0.00	12.36	22.34	37.46	107.82	154.25	185.66
Medicines	0.00	-8.31	5.09	-3.64	3.31	8.56	-0.46
Ex-Gratia Payments	0.00	155.53	-75.93	-38.50	64.48	-60.41	1.16
Other Benefits	0.00	58.07	-31.91	7.62	-3.40	-34.23	3.96
Managed Care Arrangements(Out Of Hospital Benefits)	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Benefits	**0.00**	**11.29**	**8.65**	**20.91**	**5.94**	**15.10**	**28.10**

®: Real values (medical inflation removed)

4.3.6.3 Registered Restricted Medical Schemes

Figure 44 shows both the nominal and real (without medical inflation) amounts paid out of the medical savings accounts by registered restricted medical schemes for the period 2003 to 2006. Medicines, as seen in open schemes, constituted the biggest expenditure by restricted schemes.

Supplementary and allied health professionals and general practitioners were the next two largest expenditures with the former showing a sharp decrease after 2005. Medical specialists, which formed the second largest expenditure by open schemes, were the fourth largest expenditure in restricted schemes. A possible explanation for this is that medical specialist visits are covered by the risk pool in restricted schemes.

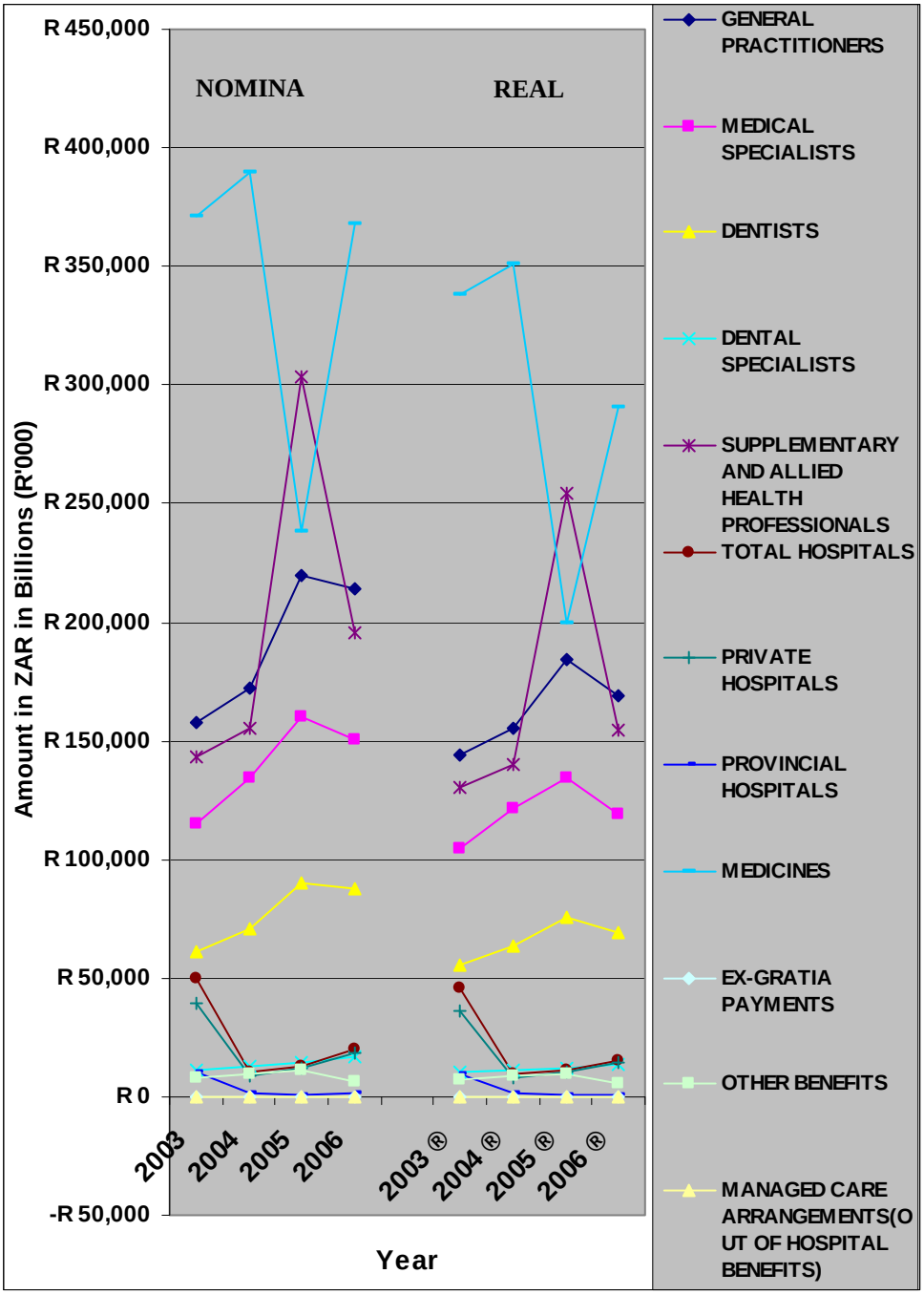


Figure 44: Comparison of the nominal and real values paid by registered restricted medical schemes from the savings account from 2003 to 2006

Tables 42 and 43 show the nominal and real amount (with medical inflation removed), paid out of the medical savings accounts by registered restricted schemes to the various service providers for the period 2003 to 2006. Payments made to supplementary and allied health professionals increased by approximately R1 billion from 2004 to 2005 and subsequently decreased from 2005 to 2006 by R619 million. Managed health care arrangements were only recorded for 2006 and showed a negative amount.

Table 42: Nominal benefits paid out of the savings accounts by registered restricted medical schemes to the different service providers from 2003 to 2006

Registered Restricted Schemes	***Nominal***			
	2003	**2004**	**2005**	**2006**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 158,098	R 172,476	R 219,373	R 214,279
Medical specialists	R 115,110	R 134,588	R 159,838	R 150,797
Dentists	R 60,864	R 70,554	R 89,767	R 87,455
Dental specialists	R 11,525	R 12,448	R 14,736	R 16,799
Supplementary and allied health professionals	R 142,842	R 155,574	R 303,129	R 195,636
Total hospitals	R 50,087	R 10,390	R 12,851	R 19,710
Private hospitals	R 39,673	R 8,768	R 12,347	R 18,325
Provincial hospitals	R 10,413	R 1,623	R 464	R 1,385
Medicines	R 370,992	R 389,775	R 237,896	R 367,986
Ex-gratia payments	R 3	R 17	R 8	R 238
Other benefits	R 7,657	R 9,448	R 11,534	R 6,729
Managed care arrangements(out of hospital benefits)	R 0	R 0	R 0	-R 366
Total benefits	**R 917,178**	**R 955,270**	**R 1,049,133**	**R 1,059,262**

Table 43: Real benefits paid out of the savings accounts by registered restricted medical schemes to the different service providers from 2003 to 2006

Registered Restricted Schemes	***Real***			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
	R'000	**R'000**	**R'000**	**R'000**
General practitioners	R 144,027	R 155,418	R 184,353	R 169,269
Medical specialists	R 104,865	R 121,277	R 134,322	R 119,121
Dentists	R 55,447	R 63,576	R 75,437	R 69,085
Dental specialists	R 10,499	R 11,217	R 12,384	R 13,270
Supplementary and allied health professionals	R 130,129	R 140,188	R 254,738	R 154,542
Total hospitals	R 45,629	R 9,362	R 10,800	R 15,570
Private hospitals	R 36,142	R 7,901	R 10,376	R 14,476
Provincial hospitals	R 9,486	R 1,462	R 390	R 1,094
Medicines	R 337,974	R 351,226	R 199,919	R 290,689
Ex-gratia payments	R 3	R 15	R 7	R 188
Other benefits	R 6,976	R 8,514	R 9,693	R 5,316
Managed care arrangements(out of hospital benefits)	R 0	R 0	R 0	-R 289
Total benefits	**R 835,549**	**R 860,794**	**R 881,652**	**R 836,758**

®: Real values (medical inflation removed)

Table 44 shows the real percentage increase or decrease in the amounts paid out of medical savings accounts by registered restricted schemes from the base year of 2003 to 2006. Medicines showed a fluctuating trend across the four years. Medicines increased by 3.9% in 2004 when compared to 2003. It then decreased by 43.1% in 2005 when compared to 2004 and increased by 45.4% in 2006 when compared to 2005. Overall, medicines decreased by 14.0% when compared to 2003. Supplementary and allied health professionals showed an increase of 81.7% in 2005 when compared to 2004 but then decreased by 10.2% in 2006. Ex-gratia payments showed a large percentage increase when compared to previous years and the base year, but these percentages must be viewed and interpreted with caution since the real rand value amounts were small in comparison to other expenditure categories.

Table 44: Real percentage increase/decrease paid by registered restricted medical schemes from the savings account from 2003 to 2006

Registered Restricted Schemes	*2003 ®*	*2004 ®*	*2005 ® vs 2004*	*2005 ® vs 2003*	*2006 ® vs 2005*	*2006 ® vs 2004*	*2006 ® vs 2003*
General Practitioners	0.00	7.91	18.62	28.00	-8.18	8.91	17.53
Medical Specialists	0.00	15.65	10.76	28.09	-11.32	-1.78	13.59
Dentists	0.00	14.66	18.66	36.05	-8.42	8.66	24.60
Dental Specialists	0.00	6.83	10.40	17.95	7.16	18.31	26.39
Supplementary And Allied Health Professionals	0.00	7.73	81.71	95.76	-39.33	10.24	18.76
Total Hospitals	0.00	-79.48	15.35	-76.33	44.17	66.30	-65.88
Private Hospitals	0.00	-78.14	31.33	-71.29	39.51	83.22	-59.95
Provincial Hospitals	0.00	-84.58	-73.34	-95.89	180.58	-25.19	-88.47
Medicines	0.00	3.92	-43.08	-40.85	45.40	-17.24	-13.99
Ex-Gratia Payments	0.00	460.51	-56.11	145.99	2696.51	1127.30	6779.14
Other Benefits	0.00	22.05	13.85	38.95	-45.16	-37.56	-23.80
Managed Care Arrangements (Out Of Hospital Benefits)	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Benefits	**0.00**	**3.02**	**2.42**	**5.52**	**-5.09**	**-2.79**	**0.14**

®: Real values (medical inflation removed)

4.3.7 Utilisation of Services by Medical Scheme Beneficiaries

The utilisation of services by medical scheme beneficiaries answers the question of what health services are purchased by the financing intermediary, the medical schemes. Utilisation patterns provide a crude estimation of how beneficiaries benefit from the health services provided[23]. This includes both out of hospital and in hospital benefits as well as the burden of disease.

4.3.7.1 The Burden of Disease

The medical schemes collect data on the burden of disease for 27 disease categories. These conditions are part of the Prescribed Minimum Benefits (PMBs). PMBs were introduced by the Medical Schemes Act of 1998 to ensure that beneficiaries have access to an essential package of benefits irrespective of their contribution or their medical scheme option. There are no financial limits or co-payments with Prescribed Minimum Benefits but they do not include

primary care benefits. Conditions covered by the Prescribed Minimum Benefit package would be treated according to a pre-determined therapeutic algorithm which defines the scope of diagnosis, treatment and medical management of them. The regulations governing Prescribed Minimum Benefits were promulgated in 1999 but came into effect on 1 January 2000. An extensive list of the 270 conditions is included and from 1 January 2004, 25 chronic conditions were added to the chronic disease list which is complementary to the Prescribed Minimum Benefits.[23]

The conditions include: Addison's disease, asthma, bronchiectasis, cardiac failure, cardiomyopathy disease, chronic renal disease, chronic obstructive pulmonary disease, coronary artery disease, Crohn's disease, diabetes insipidus, diabetes mellitus type 1 and type 2, dysrhythmia, epilepsy, glaucoma, haemophilia, hyperlipidaemia, hypertension, hypothyroidism, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, schizophrenia, systemic lupus erythematosis and ulcerative colitis. Antiretroviral therapy for HIV was included in January 2005.[23] Data has also been collected on bipolar mood disorder.

Figure 45 shows the distribution of the five major chronic disease conditions amongst the beneficiaries of consolidated schemes from 2003 to 2006. These five include asthma, diabetes mellitus type 2, HIV, hyperlipidaemia and hypertension.

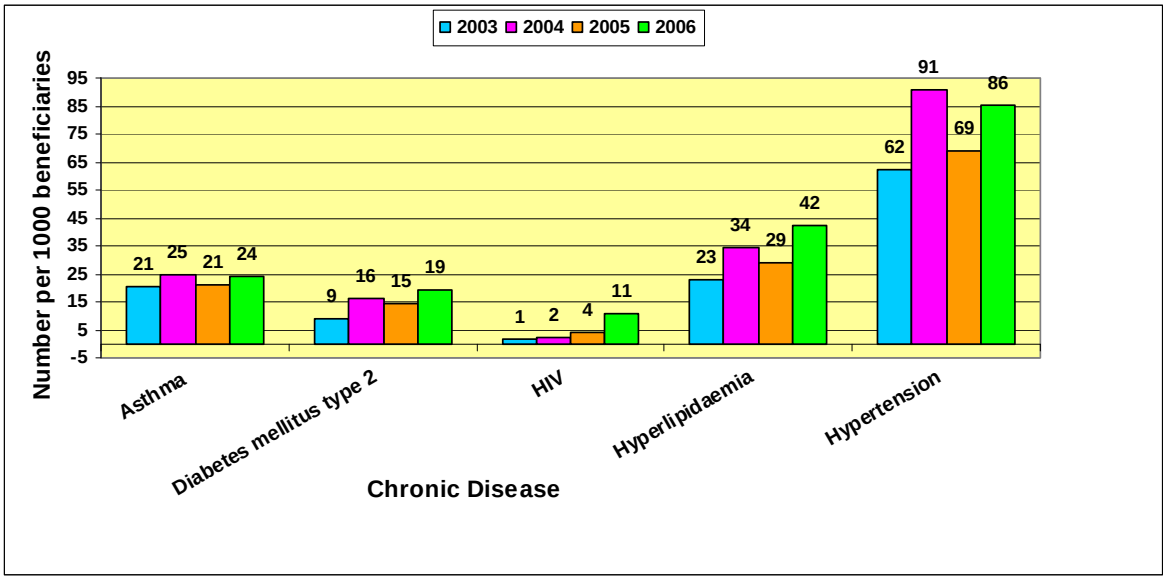


Figure 45: Burden of disease per 1000 beneficiaries of consolidated medical schemes from 2003 to 2006

It is evident that hypertension is the commonest chronic condition with 86 per 1000 beneficiaries being treated for the condition in 2006. This is then followed by hyperlipidaemia, asthma, diabetes mellitus type 2 and HIV.

Hypertension, hyperlipidaemia and diabetes mellitus type 2 are all strong risk factors for the development of coronary artery disease which is a chronic disease of poor lifestyle management. Thus coronary artery disease is the sixth most common condition. In 2003, 8.8 per 1000 beneficiaries were being treated for ischaemic heart disease, as it was then named. In 2004 and 2005, 13.6 and 11.9 per 1000 beneficiaries respectively, were being treated for the disease. This then increased to 17.1 per 1000 beneficiaries in 2006. Coronary artery disease covers a spectrum of conditions from angina to myocardial infarction which can be fatal if not appropriately treated.

Since the population covered by medical schemes has been fairly stable over the four year period, a possible reason for the increased burden of disease observed since 2004 is due to the fact that these conditions became part of the prescribed minimum benefit package. These

results must still be interpreted with caution since certain medical schemes did not submit data and the criteria for defining the condition may have changed. However, overall the quality of data reported by medical schemes to the CMS has improved with time.

The prevalence of HIV appears lower than the national average (29.1% according to the antenatal sero-prevalence survey)[7] among members of medical schemes. Although this disease is more common among the poor and the vulnerable, it was largely unreported among private health care patients on medical schemes because the schemes had restricted access to antiretroviral therapy to dual- and in some cases mono-therapy. These restrictions to access to treatment and care were largely due to financial limits but such a restriction could have dire consequences on a patient living with HIV since it could lead to the development of viral resistance.[55] As mentioned earlier, antiretroviral therapy for HIV has been included as a PMB since January 2005. Beneficiaries, who are HIV positive and require treatment, are now able to access antiretroviral therapy despite the ceiling on their medical savings account. This is likely to have led to an increase in the number of cases reported as seen in 2006 when 11 per 1000 beneficiaries were recorded as being treated for HIV.

Medical schemes manage HIV-positive beneficiaries through Disease Management Programmes (DMPs) and community treatment programmes e.g. Aid for AIDS, Lifesense, Discovery Health, Right to Care and the Treatment Action Campaign. An estimated 67 600 patients are on Highly Active Antiretroviral Therapy (HAART) in the private sector.[61] However, a challenge facing the private sector is that Disease Management programmes do not provide integrated management of HIV, AIDS, Tuberculosis and Sexually Transmitted Infections, so HIV-positive patients do not benefit from holistic care. A similar challenge is being faced by HIV positive patients who are in the public sector but there are plans to attempt to remedy this situation.

Figure 46 shows the prevalence of the five major chronic conditions amongst beneficiaries of both registered open and restricted schemes from 2003 to 2006. Although the registered open medical schemes have a larger number of beneficiaries, those belonging to restricted medical schemes have a higher burden of chronic diseases. This could imply that the members belonging to open schemes, like Discovery Health, are often younger, healthier individuals who are at a lower risk for the development of chronic lifestyle diseases. Open schemes also offer incentives to its beneficiaries like subsidized gym subscriptions and other lifestyle management programmes in the hopes of encouraging healthy lifestyles and keeping its beneficiaries low risk.

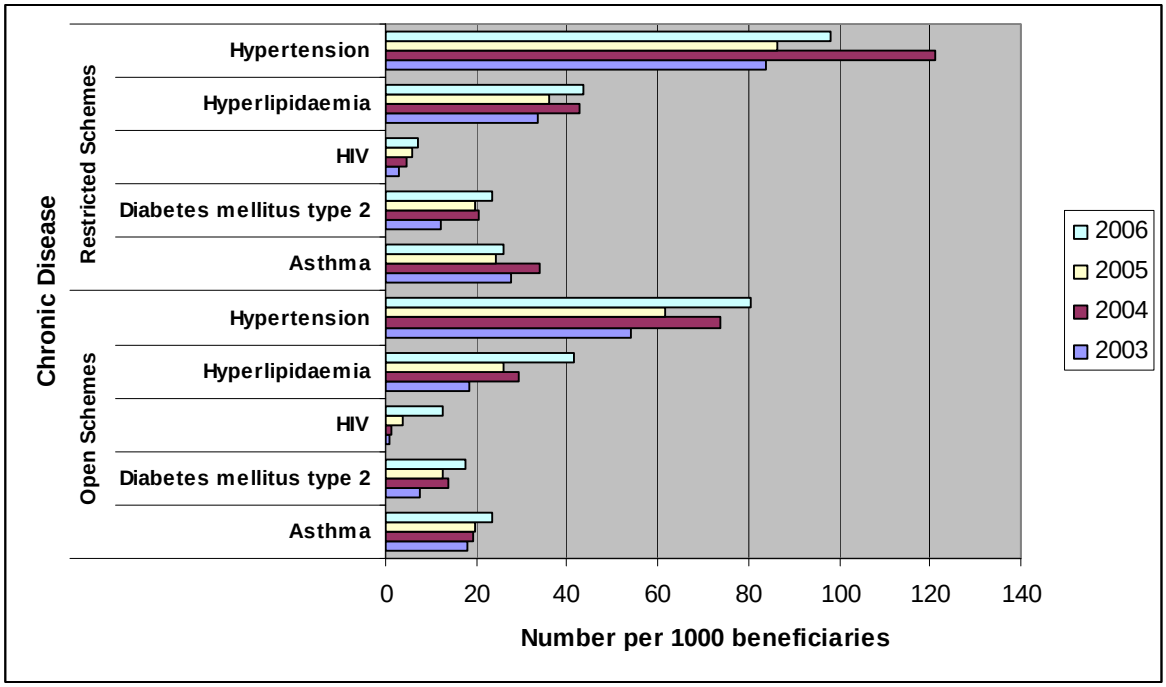


Figure 46: Burden of chronic diseases amongst beneficiaries of both registered restricted and open schemes from 2003 to 2006

4.3.7.2 Average Length of Stay in Hospital

Figure 47 shows the average length of stay in hospital of beneficiaries of consolidated medical schemes for the period 2003 to 2006. This has been disaggregated into both the private and public sector hospitals. The average length of stay in hospital for the year 2003 was not recorded in the Council for Medical Schemes annual report.

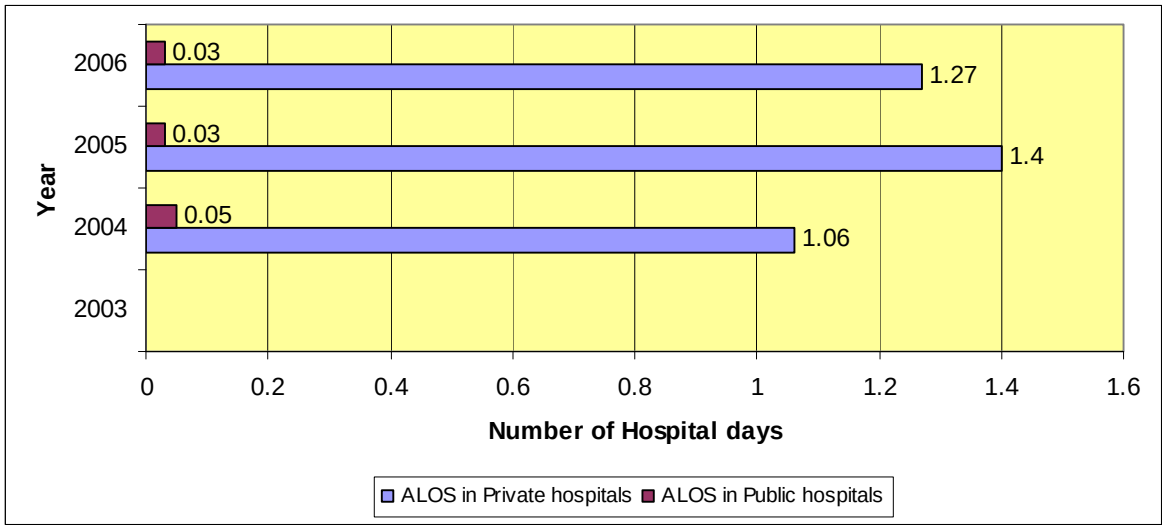


Figure 47: Average length of stay per 1000 beneficiaries of consolidated medical schemes, in private and public hospitals from 2003 to 2006

The average length of stay of a medical scheme beneficiary in a public sector hospital has been 0.04 days over the three year period. This can be extrapolated to less than one hour per day. An explanation for this could be that if a beneficiary is taken to a state hospital in an emergency, that person is soon transferred to a private sector hospital once they are stabilized. The average length of stay noted is in stark contrast to the public sector where the national average in 2006 was 5.2 days according to the District Health Information System (DHIS). This indicator for 2006 exceeds the national target which is 3.2 days [7] and may be a consequence of admissions related to HIV.

The financial restriction imposed on beneficiaries by medical schemes could explain the shorter length of stay in the private sector institutions. Alternatively, it could also imply that beneficiaries may be admitted injudiciously. Some beneficiaries, in an attempt to avoid depleting their medical savings account and out-of-pocket payments, may opt for in-patient care for an out-patient diagnosis and procedure.

4.3.7.3 Vital Statistics

Figure 48 shows the vital statistics i.e. the number of births, the number of live births and the number of deaths per 1000 beneficiaries of consolidated medical schemes from 2003 to 2006. The use of public sector facilities by medical scheme beneficiaries is minimal. The number of births per 1000 beneficiaries has increased since 2003 from 7.8 per 1000 beneficiaries in 2003 to 10.0 per 1000 beneficiaries in 2005 and 2006.

The number of live births has remained fairly stable at approximately 6.0 per 1000 beneficiaries except for a decrease of 4.0 per 1000 beneficiaries in 2004. The majority of births are by caesarean section (Table 45). Table 45 shows the number of pregnancies and caesarean sections per 1000 beneficiaries of consolidated medical schemes from 2003 to 2006. It is evident from the table that the majority of pregnancies are delivered by caesarean section. Indeed, according to the District Health Information System, the caesarean section rate in the private sector was 61.9% in 2005. This data was retrieved from the Risk Equalisation Fund study conducted in 2005. However, this study was based on data from just four medical scheme administrators.[7] In contrast, the rate in the public sector increased from just 16.0% in 2003 to 17.6% in 2006.[7] The number of deaths increased from 0.67 per 1000 beneficiaries in 2003 to 1.55, 1.60 and 1.40 per 1000 beneficiaries in 2004, 2005 and 2006 respectively.

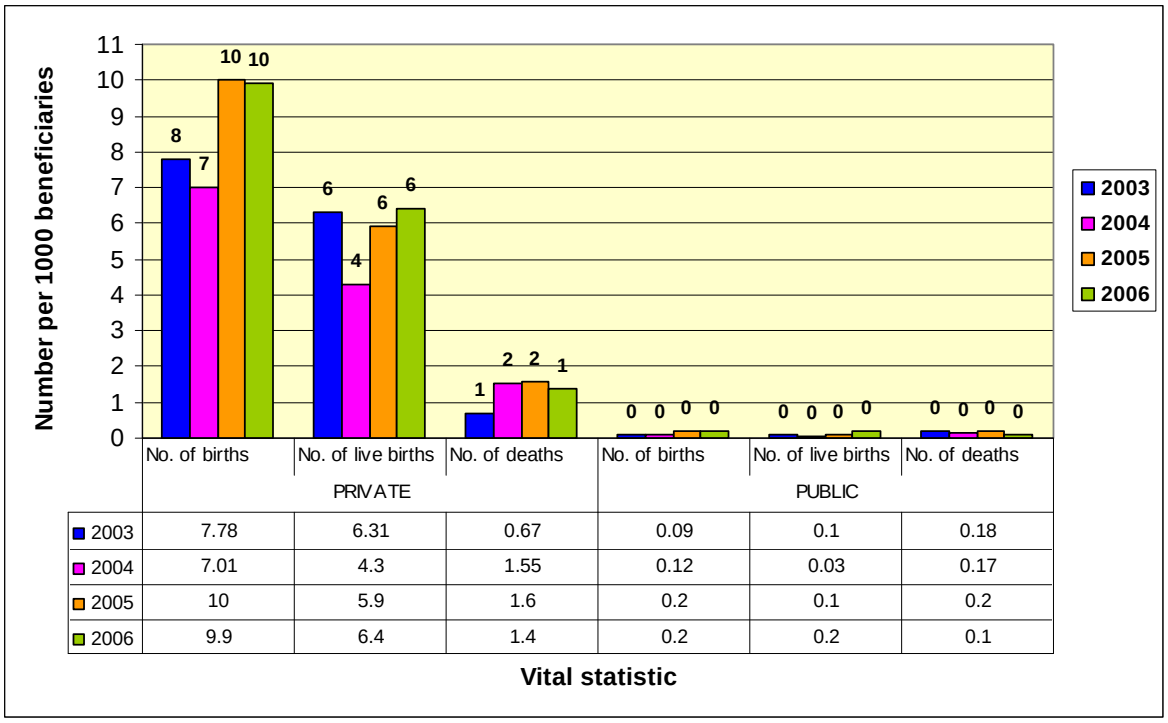


Figure 48: Vital statistics of beneficiaries of consolidated medical schemes from 2003 to 2006

Table 45: Number of pregnancies and caesarean sections, per 1000 beneficiaries, of consolidated medical schemes from 2003 to 2006

	Per 1000 Beneficiaries			
Consolidated Schemes	**2003**	**2004**	**2005**	**2006**
Pregnancies	7.7	6.72	8.2	10.5
Caesarean sections	5.25	5.6	8.3	7.1

4.3.7.4 Number of Medical Scheme Beneficiaries admitted to Hospital

Table 46 shows the in-hospital utilization of services in both the public and private sector by beneficiaries of consolidated schemes from 2003 to 2006. Since 2004, data has been disaggregated according to the hospital ward type i.e. Intensive care unit (ICU), high care and general ward. Ward fees in these different categories differ significantly with ICU being the most expensive. Therefore, such data provides insight into admission to certain wards that account for the increased cost and also the use of these facilities by beneficiaries. Since 2006,

data has been collected on the number of beneficiary days in hospital which was 1296 days per 1000 beneficiaries for the year 2006.

The number of beneficiaries of consolidated schemes admitted to private hospitals has decreased since 2003 from 243.5 per 1000 beneficiaries to 170.7 per 1000 beneficiaries in 2006. A similar pattern is observed in the public sector hospitals but the number of beneficiaries that use the public sector is one tenth that of the private sector institutions. The number of beneficiaries of consolidated schemes admitted to private hospitals for Prescribed Minimum Benefits has increased from a mere 3.2 per 1000 beneficiaries in 2003 to 73.1 and 274.0 per 1000 in 2005 and 2006. This is likely due to the regulations regarding the mandatory cover of patients for Prescribed Minimum Benefit conditions.

The number of beneficiaries admitted to the Intensive Care Unit and high care in private hospitals has remained fairly stable across the three years from 2004 to 2006. However the number admitted to the general ward has increased from 79.4 per 1000 in 2004 to 114.3 per 1000 in 2006. The majority of consolidated medical scheme beneficiaries admitted to public sector hospitals are admitted to the general ward and this number has decreased in 2006 to 2.9 per 1000 compared to 4.4 and 7.2 per 1000 in 2004 and 2005.

Table 46: In-hospital utilization of services in both the private and public sector facilities by beneficiaries of consolidated medical schemes (per 1000) from 2003 to 2006

Consolidated Schemes	*Number of Beneficiaries per 1000*			
	2003	**2004**	**2005**	**2006**
Private Hospitals				
Beneficiaries Admitted To Hospitals	243.49	197.95	207.6	170.7
Beneficiaries' Days In Hospital	NC	NC	NC	1269.0
Beneficiaries Admitted To Hospitals For PMB	3.23	28.71	73.1	274.0
Beneficiaries Admitted To Day Clinics And Operating Theatres	12.51	13.48	12.1	9.9
Beneficiaries Admitted To Intensive Care Unit	NC	7.15	6.6	7.4
High-Care Ward	NC	10.76	12	13.2
General Ward	NC	79.37	112.3	114.3
Public Hospitals				
Beneficiaries Admitted To Hospitals	24.31	11.54	13.5	8.2
Beneficiaries Admitted To Hospitals For PMB	0.08	1.48	7.4	4.4
Beneficiaries Admitted To Intensive Care Unit	NC	0.05	0.2	0.1
High-Care Ward	NC	0.03	0.1	0.2
General Ward	NC	4.37	7.2	2.9

NC: not captured

Table 47 and 48 show the in-hospital utilization of services in both the private and public sector hospitals by beneficiaries of registered open and restricted medical schemes from 2003 to 2006. The number of beneficiaries admitted to private hospitals has shown a downward trend in both scheme types, but restricted schemes have a higher number of beneficiaries admitted to hospital than open schemes. This may be because restricted schemes offer a better benefit package with smaller out of pocket expenses. In the public sector hospitals, the number of beneficiaries admitted to hospital was initially higher in open schemes in 2003 (26.9 per 1000) but this has subsequently decreased. In 2006, twice the number of beneficiaries of restricted schemes was admitted to hospital when compared to open schemes (13.8 per 1000 versus 6.0 per 1000). The number of beneficiaries admitted for PMBs to private hospitals has increased in both scheme

types and in 2006, 285.0 per 1000 beneficiaries of open schemes were admitted for PMBs compared to 247.0 per 1000 beneficiaries for restricted schemes.

There were more beneficiaries of open schemes admitted to private hospital high care units than in restricted schemes. The number of beneficiaries admitted to the general ward has witnessed an initial increase in 2005 (112.3 per 1000) when compared to 2004 (67.3 per 1000) but then decreased to 107.1 per 1000 in 2006. In restricted schemes, the numbers have always been higher than open schemes and have shown an upward trend across the three years increasing from 108.3 per 1000 in 2004 to 132.1 per 1000 in 2006.

Table 47: In-hospital utilization of services in both the private and public sector facilities by beneficiaries of registered open medical schemes (per 1000) from 2003 to 2006

Registered Open Schemes	***Number of Beneficiaries per 1000***			
	2003	**2004**	**2005**	**2006**
Private Hospitals				
Beneficiaries Admitted To Hospitals	255.31	190.43	188.6	170.0
Beneficiaries' Days In Hospital	NC	NC	NC	1002.8
Beneficiaries Admitted To Hospitals For PMB	4.14	26.69	73.4	285.0
Beneficiaries Admitted To Day Clinics And Operating Theatres	12.07	7.64	10.4	10.0
Beneficiaries Admitted To Intensive Care Unit	NC	7.85	6.6	7.3
High-Care Ward	NC	12	12.4	13.7
General Ward	NC	67.33	112.3	107.1
Public Hospitals				
Beneficiaries Admitted To Hospitals	26.87	9.23	12.2	6.0
Beneficiaries Admitted To Hospitals For PMB	0.1	0.66	7.8	3.6
Beneficiaries Admitted To Intensive Care Unit	NC	0.03	0.2	0.0
High-Care Ward	NC	0.04	0.1	0.1
General Ward	NC	3.21	8.3	3.8

NC: not captured

Table 48: In-hospital utilization of services in both the private and public sector facilities by beneficiaries of registered restricted medical schemes (per 1000) from 2003 to 2006

Registered Restricted Schemes	*Number of Beneficiaries per 1000*			
	2003	**2004**	**2005**	**2006**
Private Hospitals				
Beneficiaries Admitted To Hospitals	220.18	216.04	255.7	172.6
Beneficiaries' Days In Hospital	NC	NC	NC	1921.0
Beneficiaries Admitted To Hospitals For PMB	1.44	33.57	72.2	247.2
Beneficiaries Admitted To Day Clinics And Operating Theatres	13.37	27.52	16.4	9.6
Beneficiaries Admitted To Intensive Care Unit	NC	5.47	6.6	7.4
High-Care Ward	NC	7.78	10.9	12.2
General Ward	NC	108.33	112.3	132.1
Public Hospitals				
Beneficiaries Admitted To Hospitals	19.25	17.09	16.8	13.8
Beneficiaries Admitted To Hospitals For PMB	0.05	3.43	6.2	6.4
Beneficiaries Admitted To Intensive Care Unit	NC	0.11	0	0.2
High-Care Ward	NC	0.03	0	0.4
General Ward	NC	7.15	4.2	0.7

NC: not captured

4.3.7.5 Primary Health Care

Table 49 shows the average number of visits by beneficiaries to primary care providers, according to the medical scheme type, for 2003 and 2004. This data was not available for 2005 and 2006. In all scheme types, the average number of visits to a general practitioner was three times per year and once a year for dentists. Data on visits to a private nurse was collected from 2004 onwards and their services were hardly used for that year.

Table 49: Average utilization of services per year provided by primary providers according to the different medical scheme types from 2003 to 2004

	Open Schemes		*Restricted Schemes*		*Consolidated Schemes*	
Average Utilisation of Services per year	**2003**	**2004**	**2003**	**2004**	**2003**	**2004**
Visits to a General Practitioner per year	3.43	3.03	3.46	3.93	3.44	3.3
Visits to a Dentist per year	0.68	0.54	0.64	0.63	0.67	0.57
Visits to a private Nurse per year	NC	0.01	NC	0.03	NC	0.02

NC: not captured

Figure 49 and Table 50 shows the number of beneficiaries, per 1000, of consolidated medical schemes visiting primary health care providers at least once per year from 2003 to 2006. General practitioners are the preferred provider for primary health care in the private sector when compared to private nurses. This is probably due to lack of knowledge of the scope of practice of a nurse. However, there has been an increase in visits to private nurses. As a result of benefit option restrictions, the number of visits to dentists has decreased over the years since it is likely that this has to be paid out of pocket.

General practitioners received the most number of visits across the four years and beneficiaries of restricted schemes were more likely to visit a General Practitioner once a year when compared to registered open schemes (Table 50). However, this trend showed a decrease in 2006 when compared to the previous four years and this was probably as a result of the increased number of restrictions imposed on the different options of medical schemes and the switching of beneficiaries to cheaper options as a result of affordability.

As observed in Table 50, a larger number of beneficiaries of registered restricted schemes visited a Primary Health Care provider at least once per year.

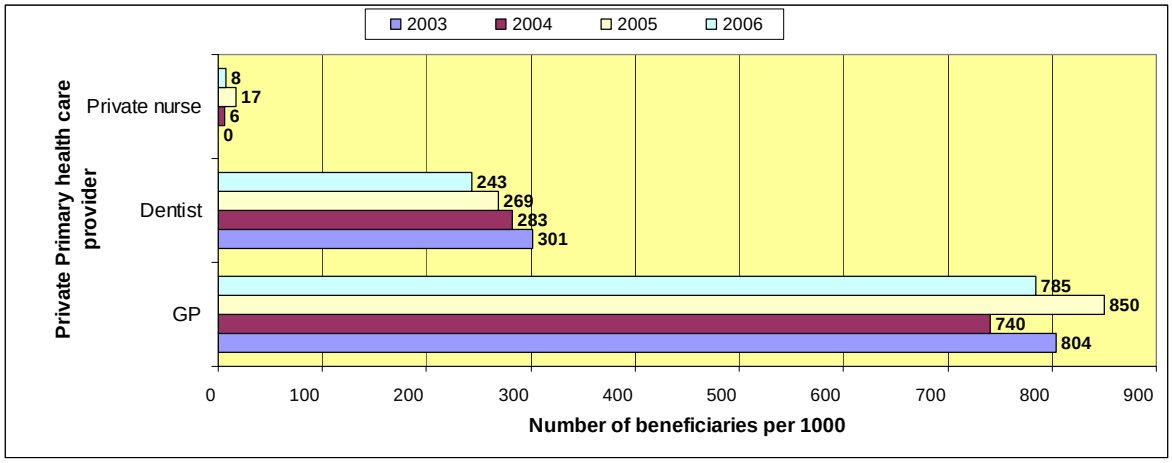


Figure 49: Number of beneficiaries (per 1000) of consolidated medical schemes visiting a private primary health care provider at least once a year from 2003 to 2006

Table 50: Number of beneficiaries, of the different medical scheme types, visiting a primary health care provider at least once a year from 2003 to 2006

Beneficiaries Visiting A Provider At Least Once A Year	***Per 1000 Beneficiaries***			
	2003	**2004**	**2005**	**2006**
Registered Open Schemes				
Primary Providers				
GP	815.95	710.99	813.1	770.2
Dentist	299.7	260.65	253	231.9
Private Nurse	NC	4.91	6.1	6.4
Registered Restricted Schemes				
GP	779.72	811.13	943.2	819.7
Dentist	303.63	335.59	309.1	270.1
Private Nurse	NC	8.15	44.8	10.6
Consolidated Schemes				
GP	803.76	740.5	849.9	784.6
Dentist	301.02	282.7	268.8	242.9
Private Nurse	NC	5.9	17.0	7.6

NC: not captured

Table 51 displays the total number of visits to Primary Health Care providers in the different types of medical schemes from 2005 to 2006. This data was not collected in 2003 and 2004. Beneficiaries of restricted schemes frequented a Primary Health Care provider more often than those belonging to open medical schemes. The reason for this may be that restricted schemes have benefit packages designed with the benefit of visiting a Primary Health Care provider whereas this tends to be funded by the medical savings in open medical schemes.

Table 51: Total number of visits to primary providers among the different types of medical schemes from 2003 to 2006

Total Number Of Visits To Primary Providers	***Per 1000 Beneficiaries***			
	2003	**2004**	**2005**	**2006**
Registered Open Schemes				
Primary Providers				
GP	NC	NC	3136.3	3015.2
Dentist	NC	NC	598.9	522.2
Private Nurse	NC	NC	19.2	23.1
Registered Restricted Schemes				
GP	NC	NC	3990.5	3643.6
Dentist	NC	NC	888.1	733.8
Private Nurse	NC	NC	38	38.3
Consolidated Schemes				
GP	NC	NC	3377.7	3197.4
Dentist	NC	NC	680.7	583.5
Private Nurse	NC	NC	24.5	27.5

NC: not captured

4.3.7.6 Specialists

Tables 52, 53 and 54 show the number of beneficiaries (per 1000) of the different medical scheme types that visit medical and clinical support specialists at least once a year. All the medical and clinical support specialities have not been included in these tables. The ones included are those that receive the most visits by beneficiaries.

Among the medical specialists, the gynaecologists, physicians and paediatricians are the most frequented. This has increased across the years apart from 2004 where the number of visits to all specialists was reduced by almost 50.0%. The reason for this is unclear but the data is drawn from the Council for Medical Schemes annual report of 2004.[55]

Among the clinical support specialities, the pathologists and radiologists were frequented the most. This is usually because beneficiaries have to undergo diagnostic tests prior to any treatment.

Table 52: Number of beneficiaries of consolidated medical schemes visiting medical and clinical support specialists at least once a year from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Consolidated Medical Schemes				
Gynaecologist	84.93	47.80	86.20	80.90
Physician	53.78	36.70	64.50	62.90
Cardiologist	16.24	11.50	21.10	20.80
Ophthalmologist	38.89	24.80	40.10	39.10
Orthopaedic Surgeon	43.41	27.40	45.30	44.50
Paediatrician	50.98	28.60	59.60	58.50
Surgeon	42.83	29.70	43.80	47.60
Anaesthetist	88.81	55.30	85.90	88.30
Radiologist	201.47	127.30	222.20	210.80
Pathologist	326.70	199.70	360.80	322.40

Table 53: Number of beneficiaries of registered open medical schemes visiting medical and clinical support specialists at least once a year from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Registered Open Medical Schemes				
Gynaecologist	86.55	35.63	88.00	84.50
Physician	53.19	27.11	63.10	63.40
Cardiologist	16.00	9.19	21.10	21.50
Ophthalmologist	38.26	19.31	39.80	39.60
Orthopaedic Surgeon	52.69	20.58	45.00	45.10
Paediatrician	53.04	20.45	60.40	61.40
Surgeon	41.06	22.42	42.20	48.20
Anaesthetist	86.07	41.75	85.40	91.00
Radiologist	197.78	94.57	219.50	216.50
Pathologist	325.17	151.13	355.30	329.20

Table 54: Number of beneficiaries of registered restricted medical schemes visiting medical and clinical support specialists at least once a year from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Registered Restricted Medical Schemes				
Gynaecologist	80.92	77.94	81.70	72.00
Physician	55.25	60.48	67.90	61.70
Cardiologist	16.84	17.36	21.10	19.00
Ophthalmologist	40.46	38.38	40.80	37.90
Orthopaedic Surgeon	45.19	44.24	46.10	43.00
Paediatrician	45.89	48.78	57.50	51.30
Surgeon	47.21	47.64	47.70	46.10
Anaesthetist	95.57	88.81	87.30	81.90
Radiologist	210.61	208.32	229.10	197.00
Pathologist	330.50	320.20	374.80	305.80

Tables 55, 56 and 57 display the total number of visits by beneficiaries of the different scheme types to medical and clinical support specialists from 2003 to 2006.

The beneficiaries of restricted schemes had a greater number of total visits to the clinical support specialists like the anaesthetists, radiologists and pathologists.

Table 55: Total number of visits by beneficiaries of consolidated medical schemes to medical and clinical support specialists from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Consolidated Medical Schemes				
Gynaecologist	237.92	200.00	258.20	222.40
Physician	215.97	192.90	264.70	258.50
Cardiologist	43.79	43.10	68.60	56.20
Ophthalmologist	74.01	69.00	103.30	81.60
Orthopaedic Surgeon	94.66	87.20	110.10	100.90
Paediatrician	188.72	163.70	209.50	201.40
Surgeon	103.59	98.80	118.40	117.80
Anaesthetist	122.94	111.80	149.20	129.30
Radiologist	356.08	335.60	456.20	392.60
Pathologist	830.20	777.30	1435.30	1003.80

Table 56: Total number of visits by beneficiaries of registered open medical schemes visiting medical and clinical support specialists from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Registered Open Medical Schemes				
Gynaecologist	240.16	196.47	260.60	231.50
Physician	204.99	174.97	257.80	257.70
Cardiologist	42.30	42.20	67.60	57.80
Ophthalmologist	71.89	67.04	99.90	81.80
Orthopaedic Surgeon	92.76	83.97	109.40	103.00
Paediatrician	190.74	162.22	216.50	211.40
Surgeon	98.73	94.25	115.10	119.40
Anaesthetist	116.34	108.10	144.50	133.20
Radiologist	346.22	325.18	451.60	402.80
Pathologist	824.18	737.14	1356.80	982.00

Table 57: Total number of visits by beneficiaries of registered restricted medical schemes visiting medical and clinical support specialists from 2003 to 2006

	Per 1000 beneficiaries			
	2003	**2004**	**2005**	**2006**
Specialists: Registered Restricted Medical Schemes				
Gynaecologist	232.37	208.71	252.20	200.10
Physician	243.14	237.35	281.90	260.70
Cardiologist	47.49	45.49	71.20	52.40
Ophthalmologist	79.24	73.96	111.70	81.20
Orthopaedic Surgeon	99.34	95.06	111.90	95.90
Paediatrician	183.74	167.21	192.10	176.80
Surgeon	115.6	109.96	126.70	114.00
Anaesthetist	139.27	120.87	161.00	119.80
Radiologist	380.47	361.37	467.70	367.90
Pathologist	845.10	877.01	1632.10	1057.30

4.3.8 Average Expenditure per Beneficiary per Month

This looks at the average amount of money, both in nominal and real terms, spent by the medical schemes on each beneficiary per month from 2003 to 2006. It examines the combined amount paid out of the risk pool, savings account and the two combined.

4.3.8.1 Analysis of Total Benefits Paid

Tables 58 and 59 shows the nominal and real amounts of the overall benefits (from both the risk pool and the medical savings account) spent on the average beneficiary member per month from 2003 to 2006. The overall nominal amount spent per beneficiary has increased since 2003 from R470.39 to R612.20 in 2006. However, when medical inflation is removed, the amount increased from R428.53 in 2003 to R483.60 in 2006. This represents a real increase of R55.07 from the base year of 2003 which equates to a 12.9% increase.

Private hospitals, medicines and medical specialists were the three biggest cost drivers across the four years. Private hospitals showed a real increase of R35.72 per annum per beneficiary in 2006 when compared to the base year, 2003, and this figure represents an increase of 27.2%. Medicines showed a real decrease of 14.3% in 2006 when compared to the base year and medical specialists showed an increase of 22.9% in 2006 when compared to 2003.

Table 58: Overall nominal amount spent per average beneficiary member per month from 2003 to 2006

Per Average Beneficiary per Month	***Nominal***			
	2003	**2004**	**2005**	**2006**
General Practitioners	R 35.93	R 35.09	R 44.90	R 52.40
Medical Specialists	R 92.44	R 99.55	R 115.80	R 131.00
Dentists	R 21.55	R 20.30	R 21.20	R 20.70
Dental Specialists	R 3.57	R 3.69	R 4.60	R 5.20
Supplementary And Allied Health Professionals	R 32.50	R 33.07	R 56.90	R 53.40
Total Hospitals	R 161.47	R 190.20	R 199.10	R 214.60
Private Hospitals	R 144.02	R 171.06	R 196.10	R 211.30
Provincial Hospitals	R 3.02	R 3.16	R 3.00	R 3.30
Medicines	R 104.75	R 96.15	R 88.80	R 103.50
Ex-Gratia Payments	R 0.30	R 0.31	R 0.70	R 0.60
Other Benefits	R 12.73	R 11.96	R 17.00	R 14.80
Managed Care Arrangements(Out Of Hospital Benefits)	R 5.16	R 10.71	R 15.00	R 16.00
Total Benefits	**R 470.39**	**R 501.03**	**R 563.90**	**R 612.20**

Table 59: Overall real (with medical inflation removed) amount spent per average beneficiary per month from 2003 to 2006

Per Average Beneficiary per Month	*Real*			
	2003 ®	**2004 ®**	**2005 ®**	**2006 ®**
General Practitioners	R 32.73	R 31.62	R 37.74	R 41.39
Medical Specialists	R 84.21	R 89.70	R 97.32	R 103.48
Dentists	R 19.63	R 18.29	R 17.82	R 16.35
Dental Specialists	R 3.25	R 3.33	R 3.87	R 4.11
Supplementary And Allied Health Professionals	R 29.61	R 29.80	R 47.82	R 42.18
Total Hospitals	R 147.10	R 171.39	R 167.33	R 169.52
Private Hospitals	R 131.20	R 154.14	R 164.81	R 166.92
Provincial Hospitals	R 2.75	R 2.85	R 2.52	R 2.61
Medicines	R 95.43	R 86.64	R 74.63	R 81.76
Ex-Gratia Payments	R 0.27	R 0.28	R 0.59	R 0.47
Other Benefits	R 11.60	R 10.78	R 14.29	R 11.69
Managed Care Arrangements(Out Of Hospital Benefits)	R 4.70	R 9.65	R 12.61	R 12.64
Total Benefits	**R 428.53**	**R 451.48**	**R 473.93**	**R 483.60**

®: Real values (medical inflation removed)

Tables 60 and 61 shows both the nominal and real (with medical inflation removed) values spent per average beneficiary member per month out of the risk pool and from the medical savings account from 2003 to 2006. From the tables below, it is evident that the majority of the money spent on the average beneficiary per month, arises out of the medical schemes risk pool.

There was an overall real increase of 12.0% in 2006, when compared to the base year, of the total benefits paid per average beneficiary per month, out of the risk pool. It increased from R382.07 in 2003 to R427.99 in 2004. In contrast, the total benefits paid for the average beneficiary member per month, out of the savings account, increased by 19.7% in 2006 when compared to 2003.

Table 60: Nominal and real values spent per average beneficiary per month out of the risk pool from 2003 to 2006

Per Average Beneficiary per Month	***Nominal***				***Real***			
	2003	**2004**	**2005**	**2006**	**2003 ®**	**2004 ®**	**2005 ®**	**2006 ®**
General Practitioners	R 28.76	R 26.37	R 33.80	R 40.50	**R 26.20**	**R 23.76**	**R 28.41**	**R 31.99**
Medical Specialists	R 83.84	R 88.74	R 103.00	R 118.10	**R 76.38**	**R 79.96**	**R 86.57**	**R 93.29**
Dentists	R 16.64	R 14.65	R 14.20	R 13.40	**R 15.16**	**R 13.20**	**R 11.93**	**R 10.59**
Dental Specialists	R 2.70	R 2.62	R 3.20	R 3.80	**R 2.46**	**R 2.36**	**R 2.69**	**R 3.00**
Supplementary And Allied Health Professionals	R 24.52	R 23.73	R 44.00	R 40.00	**R 22.34**	**R 21.38**	**R 36.98**	**R 31.60**
Total Hospitals	R 160.49	R 189.34	R 198.20	R 213.40	**R 146.21**	**R 170.61**	**R 166.58**	**R 168.57**
Private Hospitals	R 143.19	R 170.26	R 182.00	R 210.20	**R 130.45**	**R 153.42**	**R 152.96**	**R 166.05**
Provincial Hospitals	R 2.87	R 3.11	R 3.00	R 3.20	**R 2.61**	**R 2.80**	**R 2.52**	**R 2.53**
Medicines	R 84.65	R 77.08	R 69.30	R 81.60	**R 77.12**	**R 69.46**	**R 58.24**	**R 64.46**
Ex-Gratia Payments	R 0.30	R 0.31	R 0.70	R 0.60	**R 0.27**	**R 0.28**	**R 0.59**	**R 0.47**
Other Benefits	R 12.36	R 11.41	R 16.50	R 14.40	**R 11.26**	**R 10.28**	**R 13.87**	**R 11.38**
Managed Care Arrangements (Out Of Hospital Benefits)	R 5.16	R 10.71	R 15.00	R 16.00	**R 4.70**	**R 9.65**	**R 12.61**	**R 12.64**
Total Benefits	R 419.40	R 444.93	R 497.90	R 541.80	**R 382.07**	**R 400.93**	**R 418.46**	**R 427.99**

®: Real values (medical inflation removed)

Table 61: Nominal and real values spent per average beneficiary per month out of the medical savings account from 2003 to 2006

Per Average Beneficiary per Month	***Nominal***				***Real***			
	2003	**2004**	**2005**	**2006**	**2003 ®**	**2004 ®**	**2005 ®**	**2006 ®**
General Practitioners	R 7.16	R 8.72	R 11.10	R 11.90	**R 6.52**	**R 7.86**	**R 9.33**	**R 9.40**
Medical Specialists	R 8.61	R 10.84	R 12.80	R 12.80	**R 7.84**	**R 9.77**	**R 10.76**	**R 10.11**
Dentists	R 4.91	R 5.64	R 7.10	R 7.30	**R 4.47**	**R 5.08**	**R 5.97**	**R 5.77**
Dental Specialists	R 0.87	R 1.07	R 1.30	R 1.40	**R 0.79**	**R 0.96**	**R 1.09**	**R 1.11**
Supplementary And Allied Health Professionals	R 7.98	R 9.33	R 12.90	R 13.40	**R 7.27**	**R 8.41**	**R 10.84**	**R 10.59**
Total Hospitals	R 0.98	R 0.86	R 0.90	R 1.20	**R 0.89**	**R 0.77**	**R 0.76**	**R 0.95**
Private Hospitals	R 0.83	R 0.80	R 0.80	R 1.10	**R 0.76**	**R 0.72**	**R 0.67**	**R 0.87**
Provincial Hospitals	R 0.16	R 0.05	R 0.00	R 0.10	**R 0.15**	**R 0.05**	**R 0.00**	**R 0.08**
Medicines	R 20.11	R 19.08	R 19.50	R 22.00	**R 18.32**	**R 17.19**	**R 16.39**	**R 17.38**
Ex-Gratia Payments	R 0.00	R 0.00	R 0.00	R 0.00	**R 0.00**	**R 0.00**	**R 0.00**	**R 0.00**
Other Benefits	R 0.37	R 0.55	R 0.50	R 0.40	**R 0.34**	**R 0.50**	**R 0.42**	**R 0.32**
Managed Care Arrangements(Out Of Hospital Benefits)	R 0.00	R 0.00	R 0.00	R 0.00	**R 0.00**	**R 0.00**	**R 0.00**	**R 0.00**
Total Benefits	R 50.99	R 56.10	R 66.10	R 70.40	**R 46.45**	**R 50.55**	**R 55.55**	**R 55.61**

®: Real values (medical inflation removed)

4.4 SUMMARY

For the financial years 2003 to 2006 the two most important funding sources were employers and their employees, who contributed to medical schemes, which represented the largest financial intermediary and households who contributed an out of pocket payment to health care. Medical schemes contributed more than 80.0% to the expenditure by the private health care sector. The number of medical schemes submitting Annual Statutory Returns to the Council for Medical Schemes, decreased from 157 in 2003 to 124 in 2006. However, the number of beneficiaries belonging to medical schemes has remained fairly constant from 2003 to 2005 but increased in 2006 following the introduction of the Government's own medical scheme restricted to civil servants. The vast majority of beneficiaries belonged to open type schemes.

Non-health care expenditure like administration costs, broker fees and bad debts accounted for between 14.0% and 15.0% of a medical schemes expense while the balance was spent on health care. This was disaggregated into many categories such as medical specialists and its various sub-specialities, dentists, supplementary and allied health professionals, hospitals, medicines, etc. The three largest cost drivers in the private sector for the four year period, in real terms, were medical specialists, private hospitals and medicines dispensed out of hospitals.

The common chronic conditions that beneficiaries of medical schemes sought treatment for included the diseases of lifestyle such as hypertension, hyperlipidaemia and type 2 diabetes mellitus. Beneficiaries of medical schemes frequented the General Practitioner for Primary Health Care. Among the medical specialists, gynaecologists, physicians and paediatricians received the most visits.

Finally, the total amount expended by medical schemes per average beneficiary per month increased, in real terms, by 12.9% from R428.53 in 2003 to R483.60 in 2006. The majority of this money was out of the risk pool and spent on the aforementioned three cost drivers.

CHAPTER V: DISCUSSION

This chapter discusses the findings of the health expenditure review according to the NHA framework. It analyses the flow of funds from the financing sources to the financing intermediaries/agents to the health providers and finally the health service or product that this flow resulted in.

5.1 INTRODUCTION

According to the World Health Organization health system framework, the goals of a country's health system are: to improve the level of health by providing safe, quality, accessible and equitable health care; to be responsive to the population it serves; to offer social and financial risk protection and to improve the efficiency of the system.[62] One of the building blocks that will enable the achievement of such a health system is a good health financing plan with adequate health funds that are allocated and used efficiently and effectively. In order to attain this, it is important to quantify the current financial resources and its distribution within the health sector. NHA determines the total health expenditure in a country and provides this information to health policymakers so that the goals of the health system can be realized.[42] The purpose of NHA is to track the flow of funds within the health sector from its origin to its providers.[37] Policy makers can use such information to allocate resources efficiently and effectively and to regulate the health sector to bring about equity. However, the comprehensive, routine data on health expenditure that is required to construct the matrices is often deficient and inaccessible in developing countries like South Africa. It is for this reason that a proper National Health Account could not be conducted at the time and a Health Expenditure review was done instead.

The purpose of this health expenditure review was to identify all the components of private health care expenditure in South Africa and describe the flow of resources in this sector for the four year financial period from 01 January 2003 until the 31 December 2006. It sought to

address the following objectives for the four year period: where do the health resources in the private health care sector come from and how the financing between the different sources are distributed, where do the resources go, the services and goods that are provided by the private health care sector and the beneficiaries and population that they cover.

South Africa ranks as a middle-income country with a population of 47 849 800 people in 2007.[7] According to the World Health Organization, the South African government spent 9.6% and 9.9% of its total expenditure on health in 2004 and 2005, respectively.[63] This equated to 8.5% and 8.7% of the Gross Domestic Product (GDP) which is similar to high income countries like the Americas.[64] Indeed, South Africa has the highest total per capita health care spending in Africa.[65] Therefore, South Africa theoretically has an adequate amount of financial resources to provide universal coverage of a basic level of care but such a situation does not exist.[65] Despite the amount of money spent on health in South Africa, the health system has produced worse outcome measures in terms of the Infant Mortality Rate than other middle-income countries who frequently spend less on health care.[12]

The democratic South African government inherited a fragmented, inequitable health system from the apartheid era so despite the current expenditure on health, there remain inadequate financial resources to cater for the basic health care needs of all the country's citizens. The government has failed to attain its health system goal of being responsive to the needs of the entire population it serves. Currently a two-tiered health system co-exists: an overburdened, tired public health sector which serves the majority of the population, an estimated 86%, and a well resourced private health care sector serving a minority of the population who have the ability and willingness to pay for it. It is this private sector that attempts to bridge the unmet need for quality health care.

5.2 THE FINANCING SOURCES

In South Africa, the sources of health care financing include general taxes, private medical schemes and out-of-pocket payments. In 2005 these sources accounted for an estimated 40%, 45% and 14% respectively.[65]

The South African private health care system is financed primarily through two main sources. The prepaid funding method includes the voluntary private health insurance organisations i.e. the medical schemes which are categorised as open, restricted or Bargaining Council schemes. These schemes collect revenue, in the form of monthly contributions, from both employers and employees on a voluntary basis. Medical schemes are therefore the financing agents and accounted for 77.3% of the total private expenditure on health from 2003 to 2005.[63]

The second form of funding is out of pocket expenditure. The latter is probably the most regressive form of funding of health care since the household spends the proportion of income that would normally be used to purchase basic necessities, on health care interventions.[66] These contributions do not flow via a financing agent since they are used to purchase health care services directly.

5.2.1 Contributions to Medical Schemes

The population of South Africans receiving health care from the private sector has remained fairly constant at approximately seven million people. These beneficiaries of private health care services, are equivalent, according to Statistics South Africa, 2006, to 14.0% of the total population.[24] Despite this relatively small number of beneficiaries, private expenditure accounted for the majority of total expenditure on health: 59.9%, 59.4% and 58.3% in 2003, 2004 and 2005 respectively.[63] It has been estimated that five percent of the GDP spent on health flows through medical schemes in the private sector.[67]

Contributions to medical schemes are paid by employers and employees who pay either part of or the full subscription respectively to the medical scheme. Households, who are not in

employment but have the ability to pay, also contribute voluntarily to medical schemes. Of the seven million people benefiting from the private health care sector, an estimated 27.2% of those covered by medical schemes are formally employed and 13.5% are self-employed.[24] The medical schemes offer a variety of benefit packages which are priced according to the package of care provided. These options are chosen depending on one's ability to pay the required subscription. The usual scenario is that the greater a person's income, the greater the likelihood that the person would choose the more expensive option providing a more comprehensive care package. The vast majority of beneficiaries, 81.2% and 78.3%, belong to the higher income brackets of between R20 000 – R30 000 per month and over R30 000 per month, respectively.[24] Therefore it can be concluded that the beneficiaries of medical schemes originate from better socio-economic circumstances than the rest of the population and it's this rich group that benefits from the majority of the country's expenditure on health.

The total expenditure by the private sector on health has increased each year since 2003 from R57.5 billion to R69.2 billion (Table 2) but this amount is a conservative estimate since the out-of-pocket expenditure is likely to be underestimated as the only reliable data was available for the year 2006 while the data for 2003 to 2005 was determined based on the 2006 figures. Medical schemes accounted for an average of 83.8% of total expenditure by the private sector. This is greater than the World Health Organization's estimated 77.3% but this is probably as a result of the missing data on other private health insurances.

The gross contribution to medical schemes has increased on an annual basis since 2003 by almost R3 billion each year. However, the population covered by medical schemes has remained almost unchanged throughout the time period except for the year 2006 when Government Employees Medical Scheme (GEMS) became operational. The rate of increase was 6.0% in 2004, 5.2% in 2005 and 6.3% in 2006. The average percentage increase of 5.8% was consistently above the consumer price index. This rate remains significant but it is much lower than it was in the late 1980s and early 1990s when the real percentage increase was between 25.0% and 30.0%.[12] These increases above the Consumer Price Index create difficulty for the population to maintain their membership since affordability becomes a problem as there

are other competing household priorities like paying for basic necessities. The benchmark set by the Office of the Registrar of Medical Schemes is CPIX + 3.0 %.[24] Medical schemes which offer options with increases above this target have to provide a motivation for such a request. This intervention is likely to protect members of medical schemes and could account for the narrowing between the Consumer Price Index and the contribution rate trend as seen in Figure 10.

5.2.2 Households

Out of pocket expenditure includes all the payments that households make from their disposable income towards health care interventions. Both medical scheme members and non-scheme members that seek care from the public sector contribute to this source. The latter would include foreign nationals either visiting or residing in the country. Medical scheme members pay out of their pocket when co-payments are required for benefits from the medical schemes like acute medication or specialist consultation that is above the recommended tariff, when the service rendered is not covered by the scheme option and when the scheme is exhausted. Non-scheme households pay for any healthcare received by the private sector including pharmacists, general practitioners, other allied health professionals and traditional healers.

Households may also contribute to other short and long term health insurances which pay out a defined amount of money for selected defined major medical procedures, dreaded diseases, disabilities, accidents or hospital stays but due to the lack of data on these contributions, this has been excluded from the expenditure review. However, it is estimated that health insurance may account for R762 billion per year which is equivalent to 0.60% of total health expenditure and 1.1% of private health expenditure.[24] In the majority of cases, households covered by these health insurances and life policies are often the same people that belong to medical schemes.

The out of pocket spending of 0.02% from the 2006 IES seems to be underestimated. Another source of information on out of pocket expenditure for this report was the Low Income Medical

Schemes' (LIMS) specific national household survey which provided a biased assessment of out of pocket expenditure since the sample size of households covered by medical schemes was very small. The LIMS household survey sampled a total of 5.1 million non-rural households with an income of less than R6000 per month and just 7.3% of individuals were members of a medical scheme.[51] However there was no other information available that allowed for the triangulation of the IES. According to other research reports, out of pocket spending accounts for almost 25.0% of the total expenditure in the private health care sector in South Africa.[12, 23] According to the World Health Statistics 2008, from 2003 to 2005, out of pocket expenditure comprised 17.4% of private expenditure on health.[63] This discrepancy in the percentages demonstrates that there are no accurate reports on out of pocket expenditure but that this nevertheless represents a significant funding source in South Africa.[68]

According to the 2001 NHA private sector report, household out-of-pocket expenditure comprised 22.4%, 18.9% and 22.5% of total expenditure on health in 1996, 1997 and 1998, respectively.[33] Of these amounts, medical scheme members contributed between 65% and 70% of the expenditure while those not covered by schemes contributed the rest. In this health expenditure review, out-of-pocket expenditure accounted for 15.5%, 15.9%, 16.7% and 16.8% for total expenditure on health in the private sector for 2003, 2004, 2005 and 2006, respectively. It was not possible to disaggregate the data on out-of-pocket expenditure according to medical scheme and non-medical scheme coverage as this data was not available for this health expenditure review.

For the period 2003 to 2006, out-of-pocket expenditure was estimated to be from R8.9 billion to R11.6 billion (Table 2). It was acknowledged in the 2001 report that the data sources for these amounts were unreliable.[33] Not much has changed since then. The same IES has been used to estimate out-of-pocket expenditure for both scheme and non-scheme members. The methodology used in the survey has been changed to improve the reliability of the data. According to the 2001 private sector report, medicines and medical practitioners accounted for the largest payments from households' pockets, accounting for 55.0% and 38.0% respectively for medical scheme members and 48.0% and 26.0% respectively for non-scheme members.[33]

Amendments to the medicines regulations have resulted in a decrease in this component of out of pocket expenditure. According to the 2006 IES, consultations to medical practitioners accounted for the biggest payment i.e. 37.0%, followed by expenditure on pharmaceutical products which accounted for 35.0% for both medical scheme and non-scheme members (Figure 23).

5.3 THE FINANCING AGENTS

The largest financing agent or intermediary in the private sector that receives money via the pre-payment method of financing is the medical schemes. This money is then used by these agents to pay providers for health services, products and activities.[42] The other financing agents in the private sector would include the long and short term insurance companies and occupational services provided by private companies but these are excluded in this health expenditure review due to a lack of access to that information. This health expenditure review focuses exclusively on the medical schemes.

Medical schemes are governed by the Medical Schemes Act, No. 131 of 1998 which came into operation on 1 January 2000. This act replaced the previous act of 1972 and introduced community-rating and the prescribed minimum benefits.[69] The Council for Medical Schemes (CMS) is a statutory regulatory body that was established in 2000 by the Medical Schemes Act of 1998 to protect the interests of medical scheme beneficiaries, to ensure that medical schemes complied with the national health policy and to make recommendations to the Minister of Health.[49] The Medical Schemes Act of 1998 was amended in 2001. There were no new policies introduced but certain member rights were extended to the dependants, the practice of re-insurance was further regulated and the powers of the Council for Medical Schemes to act in the interest of beneficiaries were strengthened.[69]

According to the legislation, medical schemes registered under the Council for Medical Schemes require financial guarantees, must have at least 6000 members, maintain prescribed solvency levels and report regularly to the Registrar of Medical Schemes.[24] The schemes

submit annual statutory returns to the council and following the auditing of this data, annual reports are compiled and it is these reports that provided the data for this health expenditure review.

There are three different types of registered schemes: open, restricted and Bargaining Council schemes. Open schemes do not make any restrictions as to who may join, restricted schemes are reserved for people employed in a certain profession, trade or industry, like GEMS, and the Bargaining Council schemes which are restricted to low income groups like workers in the clothing industry. There are no unregistered schemes since that would be contravening the Medical Schemes Act No.131 of 1998.

Overall, the number of medical schemes has increased since its origins in 1889 and there has been the creation of more open than restricted schemes. This trend that was observed in the past has subsequently changed. The number of medical schemes that submitted annual statutory returns to the Council for Medical Schemes has decreased from 2003 to 2006 (Figure 15) and this reduction is probably due to the lack of sustainability of the business of medical schemes as a result of the policy and legislative changes. Therefore, some schemes have been liquidated while others have amalgamated with more sustainable schemes.[24]

There has been a decrease in all three scheme types submitting Annual Statutory Returns. The rate of decrease in the number of registered open schemes has initially been greater than that of restricted schemes and this is linked to the members' ability to pay and the affordability of such schemes. There was a decrease of 14.6% in restricted schemes and a decrease of Bargaining Council schemes from 12 to zero (Figure 16). The latter, although they exist, have not submitted any financial information in the last two years i.e. 2005 and 2006. These schemes have therefore been excluded in the data analysis. Such information would have been useful since these schemes cater for the lower income groups and if they are unable to provide for their beneficiaries, these people use the public sector facilities increasing the burden on it.

January 2005 saw the registration of a new restricted scheme for public sector employees, GEMS. GEMS became operational a year later in January 2006 and has since become the largest restricted scheme and the third largest medical scheme in the country.[24] This scheme is now compulsory for all new government employees. It offers affordable, basic health cover to all civil servants in the different income groups thereby promoting equity and improving access. Thus, an employee earning a low income, who previously could not have afforded medical scheme cover, can now join the lowest cost option in GEMS without become impoverished. It also provides a benchmark scheme for the future when mandatory cover of all formally employed people comes into operation.

An average of 70.0% of beneficiaries belonged to open medical schemes across the four years. However, since the introduction of GEMS, the percentage of principle members and beneficiaries belonging to restricted schemes has started to increase. There was a 7.6% increase in 2006, when compared to 2005, in the number of beneficiaries belonging to restricted schemes in contrast to open schemes which increased by 3.0% in the same time-period (Figure 19).

The average age of beneficiaries belonging to medical schemes across the four year period was 31.7 years (Figure 20). This young age group is usually economically active and may be able to afford the monthly premiums since they are usually employed. This age group is also less likely to be affected by chronic diseases of lifestyle and therefore are not seen as a" higher risk" to medical schemes. The number of pensioners, aged 65 years and older, has decreased since 2004 (Figure 21). The reason for this decline is unknown but it may be assumed that this is a natural attrition rate or that pensioners are unable to afford the increases in contributions that have been recorded for the period from 2003 to 2006. If the elderly are no longer able to afford private health care, the burden will fall onto the public sector.

Overall, for the four year period, medical schemes spent an average of 85.4% of their expenditure on health benefits while the balance was spent on non-health (Table 3). Medical schemes are categorised as not-for- profit organizations but the administrators responsible for

managed care, marketing, advisory service and consulting are for-profit institutions.[24] The non-health expenditure was responsible for an overall 15.0% of total (health and non-health) expenditure by medical schemes from 2003 to 2005 and 14.0% in 2006.

Administration expenditure and managed health care constituted the two largest cost-drivers among the non-health expenditure for the four year period (Table 5, Figure 27). Acquisition costs, which are incurred when schemes initiate, underwrite and sell a membership, would have been the third largest cost-driver among all non-health expenditures but this was not recorded for 2003 and 2006 (Table 5). The reason for this is unclear but may be due to a lack of data submitted by schemes. Broker fees were the next largest cost-driver. Brokers are responsible for introducing members to medical schemes and were legally recognized in 2000. They generally encourage people to join or move across to open schemes since these schemes pay brokers a fee for the introduction of new members. For the financial period under review, the increase in broker fees had exceeded the increase in new members.[49] For the same period, impaired receivables or bad debts consistently decreased with the largest decrease of 64.2% observed in 2006 when compared to 2005.

The burden of non-health expenditure is usually borne by the members of schemes and results in affordability challenges. Monthly premiums include these costs and over the years, these costs have been increasing. This has meant that maintaining a membership with a scheme has become increasingly expensive for the member. The amendments to the Medical Schemes Act of 1998 were promulgated to address some of these challenges by promoting improved corporate governance among medical schemes.[70, 71]

5.4 THE HEALTH PROVIDERS

This addresses the objective of the kinds of goods and services provided by the private health sector.

The health providers are the institutions or the health care professionals that actually deliver the health care service and were discussed in the results under the following major categories:

- General practitioners
- Medical specialists
- Dentists
- Dental specialists
- Supplementary and allied health professionals
- Hospitals: private and public
- Medicines
- Ex-gratia payments
- Other benefits

The health providers are paid by the financing agent, which in this expenditure review, is exclusively the medical schemes. They are paid either out of the risk pool or the medical savings account, if the scheme option has one.

In general, beneficiaries covered by registered restricted medical schemes had more beneficiaries who were admitted to hospital (Table 48), who visited primary care providers (Table 50) and who were treated for the common diseases on the Chronic Disease List (Figure 46) than members belonging to open schemes. However, the majority of beneficiaries belonged to open medical schemes. A possible explanation for this could be that the benefit packages offered by restricted schemes provided adequate cover for these benefits with little or no co-payment.

Overall the five biggest cost-drivers for all schemes were the private hospitals, medical specialists, medicines, supplementary and allied health professionals and the general practitioners. These five providers, when paid out of the risk pool, remained the biggest cost-drivers for both open and restricted schemes. The five cost-drivers spanned all the levels of the health system from the first level of care where the general practitioners provided basic primary

health care services to the quaternary level where private hospitals and medical specialists provided highly specialised care.

The overall amount spent on the average beneficiary per month showed a real increase of R55.08 in 2006 from the base year 2003 and this is equivalent to an overall increase of 13.0% (Table 59). The smallest percentage increase of 2.0% was observed in 2006 when compared to 2005 and this increase was below both the consumer price index (4.6%) and the medical inflation rate (6.0%). Of the money spent per average beneficiary per month, the majority, 30.0% to 35.0% was on private hospitals while 20.0% to 21.0% was spent on medical specialists. Medicines which initially accounted for 22.0% of the expenditure per beneficiary per month in 2003, decreased to 16.0% and 17.0% in 2005 and 2006 respectively.

5.4.1 Private Hospitals

The amount paid by the financing agents, the medical schemes to private hospitals, the biggest cost-driver in the private sector, has shown an increasing trend from 2003 to 2006. The number of beds in the private hospitals has consistently increased each year (Table 21). The largest increase of 9.4% was observed in 2004. This coincided with the year that the mean medical inflation was at its highest at 9.9% while the consumer price index was at its lowest at 1.4% (Figure 9). This increase in beds was accompanied by the largest real increase of almost R2 billion in the amount paid by consolidated schemes to private hospitals, an increase of 18.2% when compared to 2003 (Table 24). The increase in the real amount of money (with medical inflation removed) paid for ward and theatre fees was responsible for this (Table 22). These two accounted for almost two-thirds of all private hospital expenditure.

Despite both the increase in the number of private hospital beds and the amount paid out to the institutions, the population covered by medical schemes has remained static while the length of stay was an average of 1.2 days for the four year period (Figure 47). There are possibly a number of reasons for this anomalous short length of stay; beneficiaries may be injudiciously

admitted to circumvent the need to pay out of the saving accounts for certain investigations or where benefit options may be exhausted should a member be admitted for a longer time period.

Therefore, the increasing amount of money paid by medical schemes to private hospitals has not been to cover additional beneficiaries or a longer hospital stay. It may be attributed to the use of more expensive type wards like high care or intensive care, more day surgical procedures being done, an increase in the number of beneficiaries admitted or an increase in the price of ward and theatre fees.

Despite the increase in the amount of money expended on private hospitals and ward fees, the number of beneficiaries admitted to private hospitals has shown a downward trend over the four year period, with a decrease of 36.9 beneficiaries per 1000 in 2006 when compared to the previous year (Table 46). This decrease was greater in restricted schemes which had a decrease of 83.1 per 1000 beneficiaries compared to open schemes which showed a decrease of 18.6 per 1000 beneficiaries (Tables 47 and 48). There has been an increase in the number of beneficiaries admitted to the more expensive wards like the Intensive Care Unit and High care and this was observed for both open and restricted schemes (Tables 46, 47 and 48). This could have accounted for increasing ward fees. In 2006, additional 0.8 and 1.2 beneficiaries per 1000 were admitted to the Intensive Care Unit and High care ward, respectively (Table 46). This was similar for both open and restricted schemes.

There has also been a decline in the number of beneficiaries admitted to day clinics and operating theatres. Overall for consolidated schemes, this showed a decrease of 2.6 and 2.2 per 1000 beneficiaries in 2006 when compared to 2003 and 2005 (Table 46). The decrease has been most obvious in the restricted schemes with a decrease of 6.8 beneficiaries per 1000 in 2006 when compared to 2005.

The increase in private hospital expenditure could be as a result of an increasing number of beneficiaries admitted for Prescribed Minimum Benefits (PMBs). Beneficiaries admitted for

the PMBs have shown an upward trend across the four years, being the most in 2006. A total of 27 conditions form part of the PMBs. Beneficiaries have been covered for these since 2004 and HIV was added to the list in 2005. HIV/AIDS and the accompanying opportunistic infections could have accounted for the large increases in the number of beneficiaries admitted to hospitals in 2005, and particularly, 2006. All medical schemes cover PMBs without any co-payments or additional cost to the beneficiary provided that the patient is treated according to a defined therapeutic algorithm. Therefore, beneficiaries are more willing to stay in hospital should a doctor recommend so, since they would not have to pay out-of-pocket. The unlimited coverage of PMBs may also have allowed health professionals to admit patients more frequently and sometimes injudiciously. The short average length of stay of 1.2 days may also be due to the fact that beneficiaries admitted were not critically ill but rather were admitted as a precautionary measure or for diagnostic tests that would not have been covered out of hospital.

5.4.2 Medical specialists

Like private hospitals, payments made to medical specialists have also shown an upward trend for the four year period. There was a real increase of an average of 7.8% in the amount paid to all categories of medical specialists by consolidated medical schemes from 2004 to 2006, when compared to the base year of 2003 (Table 18). The largest increase of 10.1% was in 2006 (compared to 2005) which coincided with an increase in the pool of beneficiaries belonging to medical schemes as a result of the introduction of GEMS. A possible explanation for this would have been that these new beneficiaries covered by the restricted scheme would now be able to access private medical specialists due to scheme cover. However, this was not evident by the number of visits to the medical specialists. Despite the increased expenditure, the number of visits per 1000 beneficiaries of consolidated and restricted schemes, in particular, showed a decrease in 2006 when compared to 2005 (Tables 52, 54, 55 and 57). The increased expenditure could therefore have been the result of an increase in the consultation fees.

The clinical support specialists, radiologists and pathologists, accounted for approximately 40% of expenditure by medical schemes to medical specialists practising in the private sector (Table 18). For the four year period, the radiologists accounted for an average of 19.3% and pathologists 18.0% of the total amount paid by consolidated medical schemes to medical specialists, with medical inflation removed (Table 18). This may be due to the fact that x-rays and other radiological diagnostic tests like Computer Tomography (CT) Scans, angiograms and blood tests are ordered more frequently in the private sector to aid the clinical diagnosis of the patient. There may be a tendency towards unnecessary investigation of patients in the private sector because there are no financial or technological constraints and also because patients are more knowledgeable and demanding. The anaesthetists accounted for the third highest expenditure while from the category of medical specialists, the obstetricians and gynaecologists, the physicians and the surgeons accounted for the highest expenditure (Table 18).

This expenditure is supported by the number of visits per 1000 beneficiaries made to these medical and clinical support specialists. The pathologists received the most visits from beneficiaries. An average of 302.4 per 1000 beneficiaries had some pathology test done at least once per year (Table 52). However, the radiologists were paid the most by medical schemes and this may suggest that radiology diagnostics are more expensive.

From the medical specialists, the gynaecologists and physicians received the most visits and these two categories of medical specialists were also paid the most by medical schemes. Although the amount expended by medical schemes on paediatricians was less than for other specialists, they were the third most frequented medical specialist, receiving an average of 190.8 visits by beneficiaries of consolidated medical schemes across the four year period (Table 55).

It has been observed that both the number of pregnancies and the number of caesarean section per 1000 beneficiaries has shown an increasing trend over the four year period (Table 45). This

would correlate with the expenditure by medical schemes on obstetricians and gynaecologists since a specialist would be paid more for a delivery by caesarean section compared to the normal vaginal route.

Based on the data collected from the medical schemes, the cost per beneficiary visit to the medical specialists over the four year period visit was estimated per 1000 beneficiaries as shown in Tables 18 and 55. For the four year period, the anaesthetists were paid an average of R4747.84, which was the highest amount per beneficiary per year by consolidated medical schemes (with medical inflation removed). In contrast, for the four year period, consolidated medical schemes paid the radiologists and pathologists an average real amount of R3894.06 and R1432.78 per beneficiary visit, respectively. The obstetricians and gynaecologists were paid an average of R2483.85 per beneficiary visit. The consolidated schemes paid the physicians and paediatricians an average real amount of R1704.34 and R1330.57, respectively. This calculation did not take into account the other factors that would vary the cost of a visit like the type of radiological diagnostic test undertaken, the pathology test ordered, the type of service rendered at each visit and whether the consultation was done on an in-patient or out-patient basis.

The amount paid by the medical schemes to the medical specialists is not the total amount received by the specialists since there may be a co-payment by beneficiaries for tests not entirely covered by schemes. This information is not captured by the schemes since the beneficiaries are responsible for this payment out-of-pocket. There also may be a percentage of patients who pay for a service entirely out-of-pocket since they do not belong to a medical scheme or their scheme does not cover the test or their scheme benefits are exhausted for that financial year. The number of the patients with these challenges is unknown but these are important issues to consider for the sustainability of the private sector in the future.

From the data collected on the 27 PMB conditions, the top five chronic diseases that burden the beneficiaries of consolidated medical schemes included hypertension, hyperlipidaemia, asthma,

type 2 diabetes mellitus and HIV (Figure 45). These conditions have been on the upward trend since 2003. This could be due to better data quality and collection as well as the fact that treatment and management for these conditions require no out-of-pocket payment if they are treated according to the evidence – based algorithm. These chronic diseases of lifestyle usually requires management by a general practitioner and physician and therefore correlates well with the amount of money and number of visits these health professionals received.

The increases in these expenditures have caused much concern to the Council for Medical Schemes and the Minister of Health. Government has proposed to regulate the private sector to allow for transparency in pricing and to ensure sustainability of the sector.[72] The draft National Health Amendment Bill proposes a facilitator to negotiate between the financing agents, the medical schemes and the health providers and the maximum tariff that may be charged for PMBs. The National Health Reference Price List (NHRPL) is used as a reference for this facilitation process.[70] The National Health Reference Price List is a standardized schedule of health service procedure codes and average reference prices that facilitate the billing process and provides a benchmark against which medical schemes can determine benefit levels and health care providers can determine the tariffs charged to patients.[73] It is hoped that this will promote transparency and decrease unfair business practices when determining tariffs that patients should pay.[72] The intention of such intervention from government is expected to improve accessibility and improve affordability. Efficiency gains that would result should have a neutral effect on a provider's income.

5.4.3 Medicines

Medicines which were previously the second largest cost-driver began decreasing in 2004 due to the legislative changes (Table 9). It moved to third position in both open and restricted schemes when paid out of the risk pool (Tables 31 and 34) but remained the top expenditure item paid from the savings account in both the scheme types (Tables 40 and 43). Medicines

have shown a fluctuating trend across the four years by decreasing due to legislative changes in 2004 and 2005 but increasing again in 2006 (Figure 35, Table 26).

Medicines were disaggregated according to whether they were dispensed in or out of hospitals. The minority of medicines were dispensed in hospital (Figure 35) and given to patients while they were admitted or to take home on their discharge. This has shown an alternating trend and the reason for this is unclear. There is also an amount of money expended by schemes to public sector hospitals for private patients using those facilities (Table 26). This small amount may be as a result of a lack of awareness of public sector administration staff of the medical scheme billing system, a failure to submit medical scheme claims within the stipulated timeframe or the failure of medical scheme beneficiaries to declare their coverage. This demonstrates part of the increasing burden that the public sector bears from the private.

Of the total medicines dispensed out of hospital, the pharmacists dispensed an average of 84.1% of the medicines over the four year period (Table 26). The amount paid by the scheme may not necessarily be the amount that the beneficiary claimed or cover the entire cost of the drug. Many medicines are only partially covered by schemes and therefore necessitate a co-payment by the beneficiary. This co-payment may explain why medicines were the largest cost-driver from the medical savings account (Table 37). A beneficiary can pay for most scheduled and over-the-counter drugs entirely from their medical savings account, if the scheme option has such an account and the drug is not a scheme exclusion. Many beneficiaries use their savings account funds this way to avoid out-of-pocket payments. An average of 14.9% of medicines were dispensed by General practitioners who hold a dispensing licence to do so while 0.3% were dispensed by supplementary and allied health professionals (Table 26).

The National Drug Policy (NDP) for South Africa, 1996, formed the background on which the medicines legislative changes were based.[69] One of the policy objectives was to lower the cost of drugs in both the public and the private sector by introducing a fair pricing system with the wholesale and retail mark-up being based on a fixed professional fee.[69] This led to the

Medicines and Related Substances Control Amendment Act (Act No.90 of 1997) and introduced the Single Exit Price (SEP) in 2004. The Single Exit Price applies to the drug throughout the supply chain from the manufacturer, who determines the Single Exit Price and ultimately, to the retailer. The retailer dispensing the medicine then adds on a dispensing fee for professional services and the consumer pays this amount. The regulations regarding the dispensing fee have yet to be finalised due to the dissatisfaction of many pharmacy groups but the Single Exit Price has been one of the contributors to the lower medicine expenditure.

The other factor contributing to a decline in medicines expenditure was the increased prescribing of generic medicines. Generic medicines are much cheaper than the original drugs with the ratio of average generic to originator price being 0.48.[74] Dispensing health service providers are also required to mandatory offer generic substitutes. Medical schemes supplement this by promoting the use of generic medicines by ameliorating or substantially decreasing the co-payments on acute and chronic generic medicines.

Despite these positive legislative changes, medicines remained a big cost-driver in the private sector beginning an upward trend again in 2006 but not to the same magnitude as that of 2003. Possible explanations for this increase could have been the increase in the number of beneficiaries belonging to restricted schemes in 2006 as a result of GEMS, the increased utilisation of medicines due to the unlimited benefits for conditions listed on the chronic disease PMB list and the increased use of acute medicines since the day-to-day benefits are no longer exhausted by these chronic conditions.[74]

5.4.4 Supplementary and Allied Health Professionals

Supplementary and allied health professionals were also a cost-driver in this health expenditure review and demonstrated an increasing trend over the four years. Supplementary and allied health professionals have shown an upward trend from 2003, increasing 1.3% in 2004 and a massive 56.8% in 2005 (Table 10). However, there was a subsequent decrease of 8.7% in 2006

when compared to 2005 but there was still a significant increase when compared to 2004 and the base year, 2003 (Table 10). The amount expended on this category of health professionals was larger for open schemes rather than restricted schemes (Tables 12 and 15). This difference may be as a result of the differing benefit packages that these types of schemes offer.

The observed increased trend is likely to be due to the increased utilisation of these health providers following legislative changes to the act in 1997. The subsequent decrease in 2006 may be due to rising health care costs owing to the fact that scheme benefit options have been revised so that this group of providers are paid by the beneficiary entirely or partially out-of-pocket in the form of a co-payment.

5.4.5 General Practitioners

General practitioners are the doctors who usually provide a primary health care service in the private sector and are the entry point for most people using the private health care system. The amount expended by consolidated medical schemes on general practitioners showed an interesting trend, decreasing in 2004 but rising again 2005 and 2006 (Figure 30). This trend was mirrored in open schemes (Figure 31) but differed in restricted schemes where it showed a continuous upward trend (Figure 32). When analysing the overall benefits paid to providers, general practitioners received larger percentage increases from registered restricted schemes than open schemes (Tables 13 and 16). This may be because the benefit packages offered by restricted schemes allow for more general practitioner visits while those belonging to open schemes may have to make co-payments or an entire out of pocket payment for simple out-patient visits.

For the four year period under review, general practitioners received an average of 794.7 visits per 1000 beneficiaries (Table 50). This differed between open and restricted schemes with open schemes recording an average of 777.6 visits per 1000 beneficiaries while restricted schemes recorded an increase of 7.8% more visits (Table 50). It is possible to estimate the cost

per beneficiary visit to the general practitioner for the years 2005 and 2006 (Tables 9 and 51). The total number of visits that these practitioners received in a year was not calculated for 2003 and 2004. For the year 2005, consolidated schemes paid general practitioners R904.00 per beneficiary visit while in 2006, this amount increased by 20.1% to R1085.41.

Other providers of health care services in the private sector that would be included in NHA have been included in the category "other benefits" and include:

- Nursing and Residential care facilities: Mental health institutions, alcohol and drug rehabilitation, step-down facilities, hospices.
- Ambulatory Health Care: Community Health Services, Clinical Services, Ambulance Services, Blood Courier Services, Blood Transfusion Services.

The data on these providers have not always been collected but these items have subsequently been added to the Council for Medical Schemes Annual Statutory Return after 2003 as these forms have improved.

Other providers of health care and health care related functions have not been included due to the lack of access to such data. These include the expenditure by employers to providers of occupational health services that are provided on-site.

5.5 THE HEALTH CARE FUNCTIONS

The national health system in South Africa is meant to have adopted the primary health care approach with a focus on preventative and promotive holistic health care. This has been reinforced with the provision of free primary health care to all users of public health facilities since 2006.[75] There are different levels of care within this health system. The first level of care is provided by the primary health clinics and is predominantly nurse driven. The second to fourth level of care is at the hospital level with four hospital types identified: district, regional, tertiary or central.[76] Each delivers a package of health services defined by the geographical

location, number of beds, the financial and technological resources available and the skills of the staff. Data is collected from the institutions at these various levels and entered into an electronic database, the District Health Information System (DHIS) for the purposes of monitoring and evaluation to improve the quality of care and service delivery on an on-going basis. This system has so far only been applicable to the public health care sector.

In contrast, the private health care sector adopts its own, almost independent system within the national system. The private health care sector focuses predominantly on hospi-centric, doctor-dependent, curative care that adopts a selective, vertical approach rather than the country's goal of comprehensive primary health care. This sector does not face the similar financial, human resource and technological constraints of its counterpart and because the service providers are paid on a fee-for-service basis, the greater the amount of services rendered, the greater the amount of income that a provider generates. The possible financial freedom is one of the attractions luring health professionals to work in the private sector.

In the private sector, general practitioners provide primary health care services on a fee-for-service basis. In contrast, primary health care is free of charge in the public sector and in many instances, beneficiaries belonging to medical schemes use the public sector for primary health care services to avoid spending money from their medical savings account or the risk pool so that they could use it at a later time. This adds to the already over-burdened public sector. There are no health promotion and prevention programmes in the private sector like the Expanded Programme on Immunization, family planning, cervical screening, etc. These activities along with health education depend on the patient's own initiative to ask for the service or information and the health service provider's willingness to provide the service and educate the individual. This is variable since there are no standard protocols or algorithms in place as there is no organization providing oversight. This is in contrast to the public sector where the National and Provincial Departments of health provide stewardship and oversight to the public health sector institutions.

There exists no referral pattern in the private sector. Patients may be referred to medical specialists by general practitioners or self-referred. They are then admitted, if necessary, to private hospitals, if they can afford it or if they are covered by medical schemes. There are no levels of care within the private hospital system like the public sector. Each private hospital is able to offer a variety of highly specialised services depending on the technology available and the skills of the practicing medical specialists.

In terms of an information system, the private sector strictly adheres to the International Classification of Diseases (ICD)-10 coding system whereby each patient's diagnosis, diagnostic test and therapeutic procedure is coded. Any failure to do so would result in a claim not being re-imbursed by medical schemes. The private sector does not have an equivalent DHIS system so health indicators cannot be calculated for comparison and there is no on-going monitoring and evaluation of the health system. There is also a general perception that because the care is expensive, it is of a better quality than that received in the public sector which is often a misconception since a fair amount of medical specialists that work in the public sector also work in private. This sector is also motivated by profit as a result of its fee-for-service structure so there's often a perverse incentive to admit patients, order diagnostic tests or offer surgical procedures.

The private sector is becoming increasingly unaffordable and if it continues to cover such a small percentage of the population, it is going to be unsustainable in the near future. This coupled with an existing fragile public health system emphasises the urgency in finding an alternative solution for the population of a middle-income country like South Africa. The ideal solution will be to form a unified health system combining the strengths of public and private health care sectors to provide universal coverage to the population of South Africa.

5.6 COMPARISONS TO OTHER COUNTRIES

5.6.1 Health Expenditure as a percentage of GDP

The total health expenditure, as a percentage of the GDP, increases as the income of a country increases.[64] According to the World Health Organization, in 1997, low-income countries like Nigeria, Kenya, Ethiopia, and Zambia spent an estimated 2-3% of their GDP on health while high-income countries like the United States of America, Canada, Australia, the United Kingdom and South Africa spent approximately 8 to 9% of their GDP on health.[64] According to NHA estimates, among the countries in Eastern and Southern Africa, the average GDP spent on health was 5.4% in the 1997/98 financial year but South Africa spent the highest percentage among them all; 7.5%.[77] Despite South Africa spending the equivalent of high-income countries on health care, its mortality rate for both adults and children mirrored low- and middle-income countries like Kenya, Malawi, Uganda, Botswana and Zimbabwe.[64]

5.6.2 Financing Sources

According to the 1997 NHA estimates of the 191 countries, including South Africa, all public health care sector financing is prepaid and the private sector financing is divided between private insurance that is voluntary or employment-related and out-of-pocket spending.[64] The NHA estimates found that private insurance was negligible in the majority of countries and a luxury since the majority of people are unable to afford this.[64] The population covered by voluntary private insurance in South Africa, is seven million people belonging to the richer income quintiles while the majority depend on the public sector which is funded by general taxes.

The 1997 NHA estimates of 191 countries, also found that as a country's income increases, there is increasing public expenditure on health accompanied by a decrease in the out-of-pocket spending.[64] This implies that countries with a higher-income have more public sources of funding for their health system, a form of prepaid health care funding, that benefits the entire population and the population is thereby protected from impoverishment due to decreased out-

of-pocket spending even though they may earn a higher income and could afford such payments.

However, public sources of funding in South Africa, although inadequate when compared to other middle-income countries, are greater than other countries in Eastern and Southern Africa. General taxes contributed about 40% of total health expenditure in South Africa but an average of 30% in other countries in Africa.[65, 77] In contrast, donor funding does not contribute to health care expenditure in South Africa but is a significant source in other countries in Eastern and Southern Africa accounting for an average of 27% in 1997.[77] The absence of donor funding in South Africa is a positive finding since it implies that the health system is reliant on its own resources and therefore more sustainable and robust.

Out-of-pocket expenditure is a regressive form of payment for healthcare because it leaves the poor more impoverished since they spend their income on health rather than other priorities like food and shelter or they may neglect their health altogether in order to afford these competing priorities. This can be avoided by having a method of prepayment for health care so that when one is sick this prepayment covers that episode of illness.[64] In 1997, NHA estimates for 191 World Health Organization member states, revealed that the poor and low-income countries are not protected from impoverishment by any prepayment method; rather their out-of-pocket expenditure is high and can vary from 20% to 80%.[64] Indeed, in Eastern and Southern African countries, household out-of-pocket expenditure on health care was the main sources of financing accounting for an average of 36% of total health care expenditure.[77]

South Africa is different to other African countries with regards to this finding. In this country, the population with the higher income is covered by the prepayment method of funding, the medical schemes, while the poor depend on the public health sector and out-of-pocket expenditure for healthcare. The latter has been estimated to account for approximately 14% of total health expenditure.[23] This is considerably less when compared to countries like Mozambique and Kenya where it accounts for 26% and 63%, respectively.[77]

Although this is a middle-income country, there is significant income inequality as measured by the Gini coefficient of 0.6.[67] There is therefore an urgent need to address this regressive form of payment for health care. In countries like India and Northern Viet Nam, surveys have revealed that the poor sell assets, borrow cash, spend less on essential items like food in order to pay for health care.[64] This data has not been collected in South Africa but the situation among the poor in this country is likely to be similar. Therefore, the South African government's policy towards a new financing strategy to achieve universal coverage of healthcare based on the principles of equity, solidarity and the right to health, is necessary and justified.[78]

This health expenditure review has demonstrated the need for a change in funding mechanisms in South Africa since the private sector providing care to the richer minority of South Africans receives a larger percentage of health care expenditure while the poor depend on an overburdened, under-resourced system. There must be increased prepayment for healthcare in the public sector with a concomitant decrease in out-of-pocket pending so that the entire population can access basic health care packages at no financial risk.

5.7 LIMITATIONS

This study was a health expenditure review and not a NHA study; therefore it is limited by its design and in the information that it provides.

5.7.1 Limitations of the Health Expenditure Review

- This health expenditure review was intended to bridge the gap between 1999 and the present but it looked at a period of four years only. The additional four years from 1999 until 2003 has not been reviewed.
- The expenditure review was limited to the South African private sector and therefore inferences can not be extrapolated to the public sector since they have a different financial database and different population profile.

- The review focused on a financial rather than an economic approach to costs. It recorded monetary values only and did not include the total cost of health care like the population's time off work and other indirect costs.
- The study was unable to classify the expenditure on beneficiaries of the private health sector according to the demographic characteristics, geographical location, epidemiological profiles, socioeconomic and health status since data was not available in such detail.
- The study was descriptive only and did not provide information on how efficiently the money in the private sector was spent.
- A proper NHA matrix according to the Organisation for Economic Cooperation and Development could not be conducted due to the lack of good quality comprehensive and complete data.

5.7.2 Limitations of the Data

- The study had access to limited data especially on household expenditure on health care. There was a gross underestimation on the out-of-pocket spending due to a lack of available data.
- The IES conducted by Statistics South Africa was the main source of information available and accessible on out-of-pocket expenditure for this review. It is conducted once every five years, with the most recent data available for 2006. There was no access to the primary data source to verify the reliability and validity of the published data.
- The data on out-of-pocket expenditure for 2003 to 2005 was estimated from 2006 by successively removing medical inflation from the 2006 estimate. Comparison of this expenditure is therefore an inaccurate estimation of real out of pocket expenditure.
- Both the IES and the Low Income Medical Scheme specific household survey may have been unintentionally biased as a result of sampling errors and errors in reporting.

- Respondents to this survey may have been prone to information bias in the form of recall bias since they may not have remembered the complete cost of a health intervention of a few weeks ago.
- Indirect and intangible costs were also excluded from these surveys and this health expenditure review. These costs are often forgotten when recalling an episode of poor health and questions surrounding these are usually neglected.
- Although these surveys provide valuable information on a grey zone of expenditure, the biases mean that the results have to be interpreted with caution.
- There was no access to the Annual Statutory Return of the Council for Medical Schemes which is the primary data source and therefore, the quality of the data could not be validated.
- The Council for Medical Schemes data does not include the money spent by scheme members on co-payments and costs not covered by a scheme's benefit package. These costs would result in an increase in the out-of-pocket expenditure on health care by those covered by a scheme. The co-payments for categories such as medical specialists, dentists and medicines have been increasing over the years and could amount to a significant amount of money expended by a household in addition to their medical scheme contribution.
- There were some inconsistencies between the Council for Medical Schemes annual reports for the same reporting period. For example, this was evident when looking at the number of beneficiaries belonging to the different type of medical schemes. For the year 2004, while one figure was quoted in the 2004-5 annual report, this differed from the 2004 figures shown in the 2005-6 annual report. This change was likely due to auditing and, in cases where this discrepancy occurred, the 2004 figure from the 2005-6 annual report was used since this was the benchmark against which the 2005 figures were measured.
- There was no data in the 2005 and 2006 Council for Medical Schemes Annual Reports on the number of Bargaining Council Medical Schemes and the number of members belonging to such a scheme type.

- Data from medical schemes focuses predominantly on curative care. Data on the amount of money spent on primary and rehabilitation services was either collected in a limited form or not collected at all from the medical schemes and therefore was not reported on. This curative approach to health care is not consistent with the government's vision of transforming and improving health care for all South Africans.
- There was no available data on diseases other than those on the chronic disease list of PMBs. This provided a biased picture of the burden of disease of the population served by the private health care sector since data on communicable diseases and injuries and trauma were not recorded.
- Data on the amount of money spent on the diagnosis and treatment of the chronic conditions listed under the PMBs is not collected. Rather data is collected on the number of beneficiaries receiving treatment for these conditions.
- Data on other health related functions in the private health care sector have not been collected since there is a lack of such data. This includes private institutions conducting research and those involved in the education and training of health care workers e.g. private nursing colleges.
- Data on expenditure by employers, in addition to their medical scheme contribution, e.g. contributions to the Workmen's Compensation Fund and for on-site occupational health clinics, were excluded due to a lack of access to that information.
- Data on insurance policies that cover certain health related costs and conditions could not be accessed and was therefore excluded from the financing source.
- The data available on the health functions provided by the health providers could not be disaggregated according to gender, age group and geographical region since data is not available at that level.

5.8 SUMMARY

South Africa is a developing country that has undergone historical political transformation. However, there remains inequity particularly in health whereby the private sector provides

health care to a minority of the higher-income citizens who enjoy a greater share of the country's total health expenditure.

The private sector is predominantly funded either through medical schemes or out-of-pocket. Medical schemes are a prepaid mechanism of funding but are becoming increasingly less affordable due to an increase in contributions above the consumer price index, and a smaller benefit package. Out-of-pocket payments, the most regressive form of funding since it leads to the impoverishment of people, accounts for a significant amount of total expenditure on health in this country. However, there is a lack of good quality data on this latter amount.

For the four year fiscal period, medical schemes paid out the most money to private hospitals, medical specialists and medicines. Households spent the majority of their money on medical practitioners and pharmaceutical products.

CHAPTER VI: RECOMMENDATIONS AND CONCLUSIONS

This is the final chapter and concludes the health expenditure review of the private health care sector in South Africa from 01 January 2003 to 31 December 2006

6.1 INTRODUCTION

This chapter concludes the study in light of the findings and discussion in the previous two chapters. Recommendations are made to improve such a review in the future.

6.2 CONCLUSIONS

This report has provided a description of the flow of funds in the South African private health care sector from 01 January 2003 until 31 December 2006 from the sources to the functions that are provided by these funds. A trend analysis of this flow of funds across the four year fiscal period was also observed.

At present, health care in the private sector is restricted mainly to those in employment because it is becoming increasingly unaffordable due to the cost. The main cost-drivers include private hospitals, medical specialists and medicines and these have been identified both by this report and by the country's policy-makers as being priorities that require intervention. These are being addressed through legislative and other regulatory measures. Such interventions and changes are mandatory if the private sector is to be a sustainable segment of the South African health system.

The limitations identified by this health expenditure review needs to be addressed so that a better quality Health Expenditure Review can be produced. This review on the private sector then needs to be complemented by a similar review of the public health sector so that a global picture of the South African health system can be gained. Thereafter, a proper National Health

Account can be conducted to ensure that there is an appropriate allocation of scarce resources and, ultimately the achievement of the health system goals.

6.3 RECOMMENDATIONS

6.3.1 Data requirements for expenditure review

The quality of the data that is collected needs to be improved so that a proper National Health Account Matrix can be constructed. This would include:

- An assembly of a NHA team
- The development of a standardised, validated data collection tool that would collect data that is comparable across the private and public health sectors.
- The establishment of a database that conforms to the World Health Organization's standards. This will allow for international comparisons with other middle-income countries. The introduction of the International Classification of Disease (ICD)-10 coding has started the process of standardised data collection but in order to be beneficial, this needs to be strictly implemented and consistently adhered to.
- Ensuring that all medical schemes timeously submit their Annual Statutory Returns, especially Bargaining Council Schemes. These schemes cater for people belonging to the lower income groups and the information submitted by these schemes would provide an idea of the affordability and sustainability of the scheme.
- Collecting additional information on out-of-pocket expenditure on health. This information is essential for confirming the reliability of the Statistics South Africa IES i.e. triangulation of the data.
    - It would be important to disaggregate this data according to medical scheme and non-scheme members since such data provides information on the ability of schemes to fully meet the demands of its beneficiaries and again provides information on the sustainability of the scheme.
    - Medical schemes with high co-payments are not sustainable as they become increasingly unaffordable while providing a less benefits to the beneficiary.

- Medical schemes with no or minimal co-payments and offering a comprehensive coverage of health services with their benefit packages would be most desirable.

- Improving data collection on household out-of-pocket expenditure may be achieved by collaborating with the Statistics South Africa research team to expand the survey and to add more questions on households' health care utilisation and expenditure.
  - It is particularly important to include the informal health sector viz. traditional and complementary medicine that is usually not covered by schemes. Questions on visits to traditional practitioners and/or healers and the purchase of traditional remedies should be included as this is an important but neglected aspect of South African household expenditure.
  - The NHA team could consider conducting a traditional healer survey to determine the revenue that these providers collect and the health reasons for people visiting them. This is an important private sector in South Africa in view of the culture and traditions of the population and is funded out-of-pocket but often forgotten as a health expenditure.
  - The IES questionnaire should also include questions on the amount of money that households spend on home-based care as this is unknown and often not recorded. In a country like South Africa with a high burden of communicable diseases like HIV/AIDS and non-communicable diseases that result in disability, problems of accessibility and affordability of health care become evident. Family members and care-givers providing home-based care become an important provider of health services and resources for this care are usually covered by the households out of their disposable income.
- The IES should be conducted at more frequent intervals. Consideration should be given to conducting it every two years instead of at five year intervals. This may provide more reliable and accurate data regarding household expenditure on health and will reduce the recall bias and loss to follow-up as a result of relocation or death.
- Information on short and long-term health insurance policies bought by households should be included in the next national health account report to ensure completeness of the financing agents since many of these policies run a medical scheme business. These

policies are usually funded entirely out-of-pocket and are often not seen as health expenditure therefore explicit questions regarding such insurances must be included.[33]

- Data on what employers spend on on-site occupational health and wellness services should be included to provide a complete picture of health expenditure in the private sector by employers.
- More data elements on health care functions need to be collected in order to construct a proper NHA matrix. This would include classifying the health care interventions according to the International Classification for Health Accounts i.e. preventive, curative, rehabilitation, etc. It would also involve the collection of such data according to demographic characteristics, geographical region, socioeconomic status and health status.
- Data on health expenditure must be collected on a routine basis and according to the internationally recognised NHA methodology so that comparisons can be made to previous years and across countries. Such information will allow policy makers to predict financing models for the future so that scarce resources in developing countries, like South Africa, can be appropriately allocated.
- HIV and AIDS is a leading cause of morbidity and mortality in South Africa. It is unknown what the extent of the burden of disease is among patients using the private sector since the prevalence surveys conducted are confined to the public sector only. Data on the utilisation of services by beneficiaries infected with HIV should be disaggregated according to age group, gender, and province. Such a measure will allow for comparison with the population that uses the public sector.

6.3.2 Inequities within the private sector

The amendments to the Medical Schemes Act of 1998 needs to be implemented so that private health care can be made more affordable, equitable and sustainable for beneficiaries. These regulations include:

- The improved governance of schemes. This promotes the independent and transparent operations of schemes which will lead to a decrease in non-administrative costs; a major cost-driver in the private health care sector.

- The bill proposes a revised benefit structure whereby medical schemes will have a fixed price for a set of common basic benefits which will be the same for all members for all options of the scheme.[79] These benefits would include the Prescribed Minimum Benefits and Non-PMB in-hospital benefits. In addition to this, supplementary benefit options would be available as an optional extra.
- This bill proposes the establishment of a risk equalisation fund, the goal of which is to make medical schemes more affordable.

6.3.3 Areas that require government intervention

- The introduction of the Low Income Medical Scheme should be considered. This scheme increases the affordability of private health care and would lead to an increase in the pool of people covered by medical schemes. The benefit would be a decrease in the burden on the ailing public sector.
- Finally, the ultimate goal of achieving the best possible health is by the introduction of a more equitable health system with universal coverage like the government's proposed National Health Insurance system which has been on the agenda since 1994.[78]
    - Such a system allows for cross-subsidization of income and risk and removes the out-of-pocket payments. It will be accompanied by concurrent health system strengthening in terms of infrastructure, human resources and technology.[78]
    - The implementation of a national insurance policy would not obviate the need for the private sector but will utilise it more efficiently and effectively so that more of the population benefits from it.
    - National health Insurance can only be successfully implemented following extensive consultation with the citizens of this country and all relevant stakeholders in the private and public sectors.

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APPENDIX 1: The Council for Medical Schemes Annual Statutory Return for 2006

ANNUAL STATUTORY RETURN IN TERMS OF SECTION 37 OF THE MEDICAL SCHEMES ACT 131 OF 1998

Medical Scheme:

Financial Period End: 2006

PART 1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

Name of Medical Scheme:	
Type of Scheme:	
Amalgamated:	☐ Yes ☐ No
Medical Scheme Amalgamated with:	
Amalgamation Effective From:	
Liquidated:	
Liquidation Effective From:	
Under Curatorship:	
Curatorship Effective From:	
Name Change:	☐ Yes ☐ No
Previous Name:	
Name Change Effective From:	dd/mm/yyyy
Financial Period End:	31 December 2005
Ref No.:	
1. Initials and Surname of Principal Officer:	
1.1 Postal Address:	
1.2 Telephone Number:	
1.3 Cell Phone Number:	
1.4 Fax:	
1.5 Email Address:	
2. Initials and Surname of Chairperson:	
2.1 Postal Address:	
2.2 Telephone Number:	
2.3 Cell Phone Number:	

PART 1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN (CONT.)

4. Registered Office of the Medical Scheme in the RSA (Physical Address):	
4.1 Postal Address:	
4.2 Telephone Number:	
4.3 Fax:	
4.4 Website Address:	
4.5 Email Address:	
5. Name of Administrator:	
5.1 Postal Address:	
5.2 Telephone Number:	
5.3 Fax:	
5.4 Website Address:	
5.5 Email Address:	
6. Person (Fund manager) Responsible for the Medical Scheme:	
6.1 Telephone Number:	

6.2 Cell phone Number:	
6.3 Fax:	
6.4 Email Address:	
7. Name of Person Responsible for the Completion of the Return:	
7.1 Telephone Number:	
7.2 Cell phone Number:	
7.3 Fax:	
7.4 Email Address:	
8. Auditors:	
8.1 Name of Audit Firm(s):	
8.2 Initials and Surname of the Responsible Partner(s):	
8.3 Telephone Number:	
8.4 Cell phone Number:	
8.5 Fax:	
8.6 Email Address:	

PART 1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN (CONT.)

9. Initials and Surname of the Liquidator / Curator:	
9.1 Telephone Number:	
9.2 Cell phone Number:	
9.3 Fax:	
9.4 Email Address:	

WE, THE UNDERSIGNED, CERTIFY THAT, TO THE BEST OF OUR KNOWLEDGE, THE PARTICULARS CONTAINED IN THIS RETURN ARE EXTRACTED FROM THE BOOKS, RECORDS AND RECONCILE TO THE AUDITED ANNUAL FINANCIAL STATEMENTS OF THE SCHEME AND THAT THE INFORMATION IS CORRECT.

Principal Officer:	
Signature:	
Date:	
Chairperson:	
Signature:	
Date:	
Trustee Signatory:	
Signature:	
Date:	

PART 1.2

BENEFIT OPTIONS

10.	Number of Benefit Options Reported on:	
	List benefit options by name:	

PART 1.3

BOARD OF TRUSTEES

11.	Number of Board of Trustees:	
	List Board of Trustees by name:	

PART 2

MEMBERSHIP

PART 2.1

MEMBERSHIP AT THE END OF THE FINANCIAL YEAR

	Benefit Options	Members	Adult Dependants	Child Dependants	Beneficiaries
2.1.1					
2.1.2					
2.1.2	***Consolidated Total***				

Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option:

PART 2.2

NUMBER OF REGISTERED MEMBERS AND DEPENDANTS AT THE END OF EACH MONTH

		Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.2.1	January					
2.2.2	February					
2.2.3	March					
2.2.4	April					
2.2.5	May					
2.2.6	June					
2.2.7	July					
2.2.8	August					
2.2.9	September					
2.2.10	October					
2.2.11	November					
2.2.12						
2.2.13	***Average***					

Please provide the reasons if the members and/or adult dependants and/or child dependants are zero in any month:

PART 2.3

AGE ANALYSIS OF BENEFICIARIES AS AT END OF THE FINANCIAL YEAR

		Consolidated Total		Per Benefit Option	Per Benefit Option
		Male	**Female**	**Male**	**Female**
2.3.1	Less than one year				
2.3.2	1-4 years				
2.3.3	5-9 years				
2.3.4	10-14 years				
2.3.5	15-19 years				
2.3.6	20-24 years				
2.3.7	25-29 years				
2.3.8	30-34 years				
2.3.9	35-39 years				
2.310	40-44 years				
2.3.11	45-49 years				
2.3.12	50-54 years				
2.3.13	55-59 years				
2.3.14	60-64 years				
2.3.15	65-69 years				
2.3.16	70-74 years				
2.3.17	75-79 years				
2.3.18	80-84 years				
2.3.19	85 years +				
2.3.20	***Total***				
	CUMULATIVE TOTAL				
	65 years + ratio				
	Average age per beneficiary				

PART 2.4.1

MEMBER MOVEMENT

		Number of new members joining the scheme			Number of new dependants joining the scheme	Number of members leaving the	Number of dependants leaving the scheme
		Number of members transferring from other schemes	Number of members not transferring from other	Total			
2.4.1.1	January						
2.4.1.2	February						
2.4.1.3	March						
2.4.1.4	April						
2.4.1.5	May						
2.4.1.6	June						
2.4.1.7	July						
2.4.1.8	August						
2.4.1.9	September						
2.4.1.10	October						
2.4.1.11	November						
2.4.1.12							
2.4.1.13	***Total***						

PART 2.4.2

AGE ANALYSIS OF MEMBER MOVEMENT FOR THE FINANCIAL YEAR

		Number of new members joining the scheme	**Number of new dependants joining the scheme**	**Number of members leaving the scheme**	**Number of dependants leaving the scheme**
2.4.2.1	Less than one year				
2.4.2.2	1-4 years				
2.4.2.3	5-9 years				
2.4.2.4	10-14 years				
2.4.2.5	15-19 years				
2.4.2.6	20-24 years				
2.4.2.7	25-29 years				
2.4.2.8	30-34 years				
2.4.2.9	35-39 years				
2.4.2.10	40-44 years				
2.4.2.11	45-49 years				
2.4.2.12	50-54 years				
2.4.2.13	55-59 years				
2.4.2.14	60-64 years				
2.4.2.15	65-69 years				
2.4.2.16	70-74 years				
2.4.2.17	75-79 years				
2.4.2.18	80-84 years				
2.4.2.19	85 years +				
2.4.2.20	***Total***				

PART 2.5
WAITING PERIODS

		Number of new beneficiaries to whom general waiting periods were imposed		Number of new beneficiaries to whom pre-existing condition exclusions were imposed		Number of new beneficiaries to whom late joiner penalties were imposed	
		New Beneficiaries	**Transferred Beneficiaries**	**New Beneficiaries**	**Transferred Beneficiaries**	**New Beneficiaries**	**Transferred Beneficiaries**
2.5.1	Less than one year						
2.5.2	1-4 years						
2.5.3	5-9 years						
2.5.4	10-14 years						
2.5.5	15-19 years						
2.5.6	20-24 years						
2.5.7	25-29 years						
2.5.8	30-34 years						
2.5.9	35-39 years						
2.5.10	40-44 years						
2.5.11	45-49 years						
2.5.12	50-54 years						
2.5.13	55-59 years						
2.5.14	60-64 years						
2.5.15	65-69 years						
2.5.16	70-74 years						
2.5.17	75-79 years						
2.5.18	80-84 years						
2.5.19	85 years +						
2.5.20	***Total***						

PART 2.6

UTILISATION

2.6.1	***Primary and emergency care services***	
2.6.1.1	Number of beneficiaries visiting GPs at least once a year	
2.6.1.2	Total number of visits to GPs	
2.6.1.3	Number of beneficiaries visiting dentists at least once a year	
2.6.1.4	Total number of visits to dentists	
2.6.1.5	Number of beneficiaries visiting private nurses at least once a year	
2.6.1.6	Total number of visits to private nurses	
2.6.1.7	Number of beneficiaries enrolled in primary care networks	
2.6.2	***Private Hospitals - beneficiaries:***	
2.6.2.1	Number of beneficiaries admitted	
2.6.2.2	Number of admissions	
2.6.2.3	Number of beneficiaries admitted for Prescribed Minimum Benefits	
2.6.2.4	Number of beneficiaries admitted at Day clinics/ unattached operating theatres (discipline 76	
2.6.2.5	Number of beneficiaries receiving MRI & CT scans	
2.6.2.6	Number of MRI & CT scans administered	
2.6.2.7	Number of pregnancies	
2.6.2.8	Number of births	
2.6.2.9	Number of live births	
2.6.2.10	Number of caesarean sections performed	
2.6.2.11	Number of mammograms paid for	
2.6.2.12	Number of pap smears paid for	
2.6.2.13	Number of deaths	
2.6.2.14	Number of beneficiaries receiving PET scans	
2.6.2.15	Number of PET scans administered	
2.6.2.16	Number of beneficiaries receiving angiograms	
2.6.2.17	Number of angiograms administered	
2.6.2.18	Number of beneficiaries receiving bone density scans	
2.6.2.19	Number of bone density scans administered	
2.6.2.20	Number of total days in hospital for beneficiaries	
2.6.2.21	Number of admissions to ICU	
2.6.2.22	Number of admissions to High Care	
2.6.2.23	Number of admissions to General Ward	
2.6.2.24	Number of admissions for Renal Dialysis	
2.6.2.25	Number of beneficiaries enrolled in hospital networks	
2.6.3	***Public Hospitals - beneficiaries:***	
2.6.3.1	Number of beneficiaries admitted	
2.6.3.2	Number of beneficiaries admitted for Prescribed Minimum Benefits	
2.6.3.3	Number of beneficiaries receiving MRI & CT scans	
2.6.3.4	Number of MRI & CT scans administered	
2.6.3.5	Number of pregnancies	
2.6.3.6	Number of births	
2.6.3.7	Number of live births	
2.6.3.8	Number of caesarean sections performed	
2.6.3.9	Number of births to women between 12 and 18 years	
2.6.3.10	Number of mammograms paid for	
2.6.3.11	Number of pap smears paid for	
2.6.3.12	Number of deaths	
2.6.3.13	Number of beneficiaries receiving PET scans	
2.6.3.14	Number of PET scans administered	
2.6.3.15	Number of beneficiaries receiving angiograms	
2.6.3.16	Number of angiograms administered	
2.6.3.17	Number of total days in hospital for beneficiaries	
2.6.3.18	Number of beneficiaries admitted in ICU	
2.6.3.19	Number of beneficiaries admitted in High Care	
2.6.3.20	Number of beneficiaries admitted in General Ward	
2.6.3.21	Number of beneficiaries admitted for Renal Dialysis	

PART 2.7

NUMBER OF BENEFICIARIES WITH THE FOLLOWING CHRONIC DISEASES

	Name of disease	Consolidated	Per benefit option
2.7.1	Addison's Disease		
2.7.2	Asthma		
2.7.3	Bipolar Mood Disorder		
2.7.4	Bronchiectasis		
2.7.5	Cardiac Failure		
2.7.6	Cardiomyopathy Disease		
2.7.7	Chronic Renal Disease		
2.7.8	Chronic Obstructive Pulmonary Disease		
2.7.9	Coronary Artery Disease		
2.7.10	Crohn's Disease		
2.7.11	Diabetes Insipidus		
2.7.12	Diabetes Mellitus Type 1		
2.7.13	Diabetes Mellitus Type 2		
2.7.14	Dysrythmias		
2.7.15	Epilepsy		
2.7.16	Glaucoma		
2.7.17	Haemophilia		
2.7.18	Hyperlipidaemia		
2.7.19	Hypertension		
2.7.20	Hypothyroidism		
2.7.21	Multiple Sclerosis		
2.7.22	Parkinson's Disease		
2.7.23	Rheumatoid Arthritis		
2.7.24	Schizophrenia		
2.7.25	Systemic Lupus Erythematosus		
2.7.26	Ulcerative Colitis		
2.7.27	HIV		

PART 2.8

UTILISATION OF SERVICES BY MEDICAL & DENTAL SPECIALISTS

	Health Professional (BHF PCNS Discipline code)	Total number of visits to specialists	Number of beneficiaries visiting at least once per year
	Medical Specialists:		
2.8.1	Dermatologists (12)		
2.8.2	Obstetricians & Gynaecologists (16)		
2.8.3	Pulmonologists (17)		
2.8.4	Specialist Physicians (18)		
2.8.5	Gastroenterologists (19)		
2.8.6	Neurologists (20)		
2.8.7	Cardiologists (21)		
2.8.8	Psychiatrists (22)		
2.8.9	Medical Oncologists (23)		
2.8.10	Neurosurgeons (24)		
2.8.11	Nuclear Medicine Specialists (25)		
2.8.12	Ophthalmologists (26)		
2.8.13	Clinical Haematologists (27)		
2.8.14	Orthopaedic Surgeons (28)		
2.8.15	Otorhinolaryngologists (30)		
2.8.16	Rheumatologists (31)		
2.8.17	Paediatricians (32)		
2.8.18	Paediatric Cardiologists (33)		
2.8.19	Physical Medicine Specialists (34)		
2.8.20	Plastic & Reconstructive Surgeons (36)		
2.8.21	Radiation Oncologists (40)		
2.8.22	Surgeons (42)		
2.8.23	CardioThoracic Surgeons (44)		
2.8.24	Urologists (46)		
	Clinical Support Specialists:		
2.8.25	Anaesthetists (10)		
2.8.26	Diagnostic Radiologists (38)		
2.8.27	Pathologists (48)		
2.8.28	Other Medical or Clinical Support Specialists (specify)		
	Dental Professionals:		
2.8.29	Dental Therapists (95)		
2.8.30	Dental Technicians (93)		
2.8.31	Maxilla, Facial & Oral Surgeons (62)		
2.8.32	Oral Pathologists (98)		
2.8.33	Orthodontists (64)		
2.8.34	Periodontists (92)		
2.8.35	Prosthodontists (94)		

PART 2.9

UTILISATION OF SERVICES BY SUPPLEMENTARY & ALLIED HEALTH PROFESSIONALS

	Health Professional (BHF PCNS Discipline code)	Total number of visits to Supplementary and Allied Health	Number of beneficiaries visiting at least once per year
2.9.1	Art Therapists (67)		
2.9.2	Audiologists (82)		
2.9.3	Biokineticists (75-009)		
2.9.4	Clinical / Medical / Laboratory Technologists (75)		
2.9.5	Dieticians (84)		
2.9.6	Hearing Aid Acousticians (83)		
2.9.7	Medical Scientists (69)		
2.9.8	Occupational Therapists (66)		
2.9.9	Optometrists (70)		
2.9.10	Orthoptists (74)		
2.9.11	Pharmacists (60)		
2.9.12	Physiotherapists (72)		
2.9.13	Podiatrists / Chiropodists (68)		
2.9.14	Psychologists (86)		
2.9.15	Radiographers (39)		
2.9.16	Registered Nurses (88)		
2.9.17	Social Workers (89)		
2.9.18	Speech Therapists (82)		
	Complementary Medicine Practitioners:		
2.9.19	Acupuncturists & Chinese Medicine Practitioners (107)		
2.9.20	Ayurvedic Practitioners (104)		
2.9.21	Chiropractors & Osteopaths (04 & 102)		
2.9.22	Homeopaths (08)		
2.9.23	Naturopaths & Phytotherapists (101 & 103)		
2.9.24	Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107)		
2.9.25	Other Supplementary & Allied Health Professionals (specify)		

PART 2.10

UTILISATION OF OTHER BENEFIT SERVICES

	Benefit Service (BHF PCNS Discipline Code)	Total number of claims from beneficiaries for	Number of beneficiaries who submitted at least one
2.10.1	Ambulance Services - Basic Life Support (13)		
2.10.2	Ambulance Services - Intermediate Life Support (11)		
2.10.3	Ambulance Services - Advanced Life Support (09)		
2.10.4	Blood and Blood Product Couriers (03)		
2.10.5	Blood Transfusion Services (78)		
2.10.6	Clinical Services - Oxygen Supplier (90-001)		
2.10.7	Clinical Services - Appliance supplier (90-002/007/013/014)		
2.10.8	Clinical Services - Prosthetic Supplier (90-		
2.10.9	Clinical Services - Other (90-008/009/010/011/012)		
2.10.10	Community Health Services (97)		
2.10.11	Drug and Alcohol Rehabilitation (47)		
2.10.12	Group Practice (50)		
2.10.13	Hospice (79)		
2.10.14	Mental Health Institutions (55)		
2.10.15	Sub Acute Facilities/Step Down Facilities (49)		
2.10.16	Other Benefit Services (specify)		

PART 2.11
UTILISATION OF MEDICINES

		Total number of scripts filled	Total number of items dispensed
2.11.1	***In Hospital:***		
2.11.1.1	Medicines dispensed by Pharmacists		
2.11.1.2	Medicines dispensed by General Practitioners		
2.11.1.3	Medicines dispensed by Medical Specialists		
2.11.1.4	Medicines dispensed by Supplementary and Allied Health Professionals		
2.11.1.5	Medicines dispensed by Other Health Professionals		
2.11.2	***Out-of-Hospital:***		
2.11.2.1	Medicines dispensed by Pharmacists		
2.11.2.2	Medicines dispensed by General Practitioners		
2.11.2.3	Medicines dispensed by Medical Specialists		
2.11.2.4	Medicines dispensed by Supplementary and Allied Health Professionals		
2.11.2.5	Medicines dispensed by Other Health Professionals		

PART 2.12

DISTRIBUTION OF MEMBERSHIP AT END OF FINANCIAL YEAR

	Consolidated	Members	Adult Dependants	Child Dependants	Beneficiaries
2.12.1	Gauteng				
2.12.2	Limpopo				
2.12.3	Mpumalanga				
2.12.4	North West				
2.12.5	Free State				
2.12.6	Kwa-Zulu Natal				
2.12.7	Western Cape				
2.12.8	Eastern Cape				
2.12.9	Northern Cape				
2.12.10	Outside the Republic				
2.12.11	***Consolidated Total***				

Please indicate how the scheme is collecting the data for this part:			
	Members	**Adult Dependants**	**Child Dependants**
Private Postal Address	☐ Yes	☐ Yes	☐ Yes
Business Postal Address	☐ Yes	☐ Yes	☐ Yes
Employer (Pay Point)	☐ Yes	☐ Yes	☐ Yes
Other (specify)			

PART 3

PART 3.1
ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR

		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member	Discount received
		R	R	R	R	R
3.1.1	General Practitioners					
3.1.2	Medical Specialists					
3.1.3	Dentists					
3.1.4	Dental Specialists					
3.1.5	Supplementary and Allied Health Professionals					
3.1.6	**Hospitals**					
3.1.6.1	*Unattached Operating Theatres/ Day Clinics*					
3.1.6.1.1	Ward Fees					
3.1.6.1.2	Theatre Fees					
3.1.6.1.3	Consumables					
3.1.6.1.4	Medicines dispensed					
3.1.6.1.5	**Subtotal 1**					
3.1.6.2	*Other Private Hospitals*					
3.1.6.2.1	*Fee for service arrangements*					
3.1.6.2.1.1	Ward Fees					
3.1.6.2.1.2	Theatre Fees					
3.1.6.2.1.3	Consumables					
3.1.6.2.1.4	Medicines dispensed					
3.1.6.2.1.5	**Subtotal 2**					
3.1.6.2.2	*Managed care arrangements (In hospital benefits)*					
3.1.6.2.2.1	Staff model-hospital care					
3.1.6.2.2.2	Global fee					
3.1.6.2.2.3	Per diem fee					
3.1.6.2.2.4	Hospital network					
3.1.6.2.2.5	Other (specify)					

3.1.6.2.2.6	**Subtotal 3**					

PART 3.1
ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR (CONT.)

3.1.6.3	*State / Provincial Hospitals*					
3.1.6.3.1	Ward Fees					
3.1.6.3.2	Theatre Fees					
3.1.6.3.3	Consumables					
3.1.6.3.4	Medicines dispensed					
3.1.6.3.5	**Subtotal 4**					
3.1.6.4	Total Hospitals					
3.1.7	**Medicine**					
3.1.7.1	Medicines dispensed by Pharmacists					
3.1.7.2	Medicines dispensed by General Practitioners					
3.1.7.3	Medicines dispensed by Medical Specialists					
3.1.7.4	Medicines dispensed by Supplementary and Allied Health Professionals					
3.1.7.5	Medicines dispensed by Other Health Professionals					
3.1.7.6	Total Medicines					
3.1.8	Ex-gratia-payments					
3.1.9	Other Benefits					
3.1.10	**Managed care arrangements (Out of hospital benefits)**					
3.1.10.1	Primary care network					
3.1.10.2	Staff model - primary care					
3.1.10.3	Other (specify)					
3.1.10.4	Total Managed Care Arrangements (Out of Hospital Benefits)					
3.1.11	**Total Risk Benefits**					

PART 3.2

ANALYSIS OF MEDICAL AND DENTAL SPECIALISTS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of	Amount paid by member
		R	R	R	R
	Medical Specialists:				
3.2.1	Dermatologists (12)				
3.2.2	Obstetricians & Gynaecologists (16)				
3.2.3	Pulmonologists (17)				
3.2.4	Specialist Physicians (18)				
3.2.5	Gastroenterologists (19)				
3.2.6	Neurologists (20)				
3.2.7	Cardiologists (21)				
3.2.8	Psychiatrists (22)				
3.2.9	Medical Oncologists (23)				
3.2.10	Neurosurgeons (24)				
3.2.11	Nuclear Medicine Specialists (25)				
3.2.12	Ophthalmologists (26)				
3.2.13	Clinical Haematologists (27)				
3.2.14	Orthopaedic Surgeons (28)				
3.2.15	Otorhinolaryngologists (30)				
3.2.16	Rheumatologists (31)				
3.2.17	Paediatricians (32)				
3.2.18	Paediatric Cardiologists (33)				
3.2.19	Physical Medicine Specialists (34)				
3.2.20	Plastic & Reconstructive Surgeons (36)				
3.2.21	Radiation Oncologists (40)				
3.2.22	Surgeons (42)				
3.2.23	CardioThoracic Surgeons (44)				
3.2.24	Urologists (46)				
	Clinical Support Specialists:				
3.2.25	Anaesthetists (10)				
3.2.26	Diagnostic Radiologists (38)				
3.2.27	Pathologists (48)				
3.2.28	Other Medical or Clinical Support				
3.2.29	***Total Specialists***				
	Dental Professionals:				
3.2.30	Dental Therapists (95)				
3.2.31	Dental Technicians (93)				
3.2.32	Maxilla, Facial & Oral Surgeons (62)				
3.2.33	Oral Pathologists (98)				
3.2.34	Orthodontists (64)				
3.2.35	Periodontists (92)				
3.2.36	Prosthodontists (94)				
3.2.37	***Total Dental Professionals***				

PART 3.3
ANALYSIS OF SUPPLEMENTARY & ALLIED HEALTH PROFESSIONALS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.3.1	Art Therapists (67)				
3.3.2	Audiologists (82)				
3.3.3	Biokineticists (75-009)				
3.3.4	Clinical / Medical / Laboratory Technologists (75)				
3.3.5	Dieticians (84)				
3.3.6	Hearing Aid Acousticians (83)				
3.3.7	Medical Scientists (69)				
3.3.8	Occupational Therapists (66)				
3.3.9	Optometrists (70)				
3.3.10	Orthoptists (74)				
3.3.11	Pharmacists (60)				
3.3.12	Physiotherapists (72)				
3.3.13	Podiatrists / Chiropodists (68)				
3.3.14	Psychologists (86)				
3.3.15	Radiographers (39)				
3.3.16	Registered Nurses (88)				
3.3.17	Social Workers (89)				
3.3.18	Speech Therapists (82)				
	Complementary Medicine Practitioners:				
3.3.19	Acupuncturists & Chinese Medicine Practitioners (105)				
3.3.20	Ayurvedic Practitioners (104)				
3.3.21	Chiropractors & Osteopaths (04 & 102)				
3.3.22	Homeopaths (08)				
3.3.23	Naturopaths & Phytotherapists (101 & 103)				
3.3.24	Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107)				
3.3.25	Other Supplementary & Allied Health Professionals (specify)				
3.3.26	**Total**				

PART 3.4
ANALYSIS OF OTHER BENEFITS

	Other Benefit Services (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.4.1	Ambulance Services - Basic Life Support (13)				
3.4.2	Ambulance Services - Intermediate Life Support (11)				
3.4.3	Ambulance Services - Advanced Life Support (09)				
3.4.4	Blood and Blood Product Couriers (03)				
3.4.5	Blood Transfusion Services (78)				
3.4.6	Clinical Services - Oxygen Supplier (90-001)				
3.4.7	Clinical Services - Appliance supplier (90-002/007/013/014)				
3.4.8	Clinical Services - Prosthetic Supplier (90-003/004/005/006)				
3.4.9	Clinical Services - Other (90-008/009/010/011/012)				
3.4.10	Community Health Services (97)				
3.4.11	Drug and Alcohol Rehabilitation (47)				
3.4.12	Group Practice (50)				
3.4.13	Hospice (79)				
3.4.14	Mental Health Institutions (55)				
3.4.15	Sub Acute Facilities/Step Down Facilities (49)				
3.4.16	Other Benefit Services (specify)				
3.4.17	**Total**				

PART 4

NOTES TO THE FINANCIAL STATEMENTS

PART 4.1

PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
4.1.1	**Gross Carrying Amount**						
4.1.1.1	At beginning of year						
4.1.1.1.1	- As previously reported						
4.1.1.1.2	- Prior year adjustment						
4.1.1.2	Additions						
4.1.1.3	Disposals						
4.1.1.4	Impairment write down						
4.1.1.5	Revaluation surplus						
4.1.1.6	Other movements (specify)						
4.1.1.7	Other group balances on consolidation						
4.1.1.8	Transfer of assets due to amalgamation						
4.1.1.9	***At end of year***						

4.1.2	**Accumulated Depreciation**						
4.1.2.1	At beginning of year						
4.1.2.1.1	- As previously reported						
4.1.2.1.2	- Prior year adjustment						
4.1.2.2	Depreciation charges						
4.1.2.3	Impairment charges						
4.1.2.4	Accumulated depreciation on disposals						
4.1.2.5	Other movements (specify)						
4.1.2.6	Other group balances on consolidation						
4.1.2.7	Transfer of assets due to amalgamation						
4.1.2.8	***At end of year***						
4.1.3	***Net Carrying amount at end of year***						

PART 4.2

INVESTMENTS

		Non-current	Current	Total
		R	R	R
4.2.1	Investment Property			
4.2.2	Available-for-sale Investments			
4.2.3	Held-to-Maturity Investments			
4.2.4	Investments Held at Fair Value Through Profit or Loss			
4.2.5	Other (specify)			
4.2.6	Group Investments on Consolidation			
4.2.7	Transfer of assets due to amalgamation			
4.2.8	***Total investments***			

PART 4.3 (a)

TRADE AND OTHER RECEIVABLES

		Total
		R
4.3.1	*Contributions outstanding:*	
4.3.1.1	- current	
4.3.1.2	- 30 days	
4.3.1.3	- 60 days	
4.3.1.4	- 90 days	
4.3.1.5	- 120 days +	
4.3.2	*Recoveries from members for co-payments paid and payable (except for contributions, loans and savings plan account advances)*	
4.3.2.1	- current	
4.3.2.2	- 30 days	
4.3.2.3	- 60 days	
4.3.2.4	- 90 days	
4.3.2.5	- 120 days +	
4.3.3	*Savings plan account advances*	
4.3.3.1	- current	
4.3.3.2	- 30 days	
4.3.3.3	- 60 days	
4.3.3.4	- 90 days	
4.3.3.5	- 120 days +	
4.3.4	*Risk transfer arrangements*	
4.3.4.1	*Commercial reinsurance contracts*	
4.3.4.1.1	Share of outstanding claims provision	
4.3.4.1.2	Share of claims reported not yet paid	
4.3.4.1.3	Less: Provision for impaired losses at year end	
4.3.4.2	*Other Risk transfer arrangements*	
4.3.4.2.1	Share of outstanding claims provision	
4.3.4.2.2	Share of claims reported not yet paid	
4.3.4.2.3	Less: Provision for impaired losses at year end	
4.3.5	Prepaid expenses on risk transfer arrangements	
4.3.6	Prepaid expenses on managed care arrangements	
4.3.7	Prepaid expenses	
4.3.8.1	Loans to members - Capital	
4.3.8.2	Loans to members - Interest	
4.3.9	Accrued interest	
4.3.10	Member balances	
4.3.11	Provider balances	
4.3.12	*Amounts owing by:*	
4.3.12.1	- Administrators	
4.3.12.2	- Reinsurer (other than claim recoveries)	

4.3.12.3	- Managed care organisations (other than claim recoveries)	
4.3.12.4	- Brokers	
4.3.12.5	- Other related parties (specify)	
4.3.13	Sundry debtors (specify)	
4.3.14	*Less: Provision for impaired losses at year end (excluding Risk Transfer arrangements)*	
4.3.15	Trade and other receivables of group companies on consolidation	
4.3.16	Transfer of assets due to amalgamation	
4.3.17	***Total trade and other receivables***	

- **Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due:**

- **Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due:**

PART 4.3 (b)

ANALYSIS OF MOVEMENTS IN RESPECT OF RISK TRANSFER ARRANGEMENTS

		Total
		R
4.3.1	*Commercial reinsurance contracts*	
4.3.1.1	Balance at beginning of year	
4.3.1.2	Less: Payments in respect of current year	
4.3.1.3	(Over)/under provision in respect of prior year	
4.3.1.4	Adjustment for current year	
4.3.2	*Other risk transfer arrangements*	
4.3.2.1	Balance at beginning of year	
4.3.2.2	Less: Payments in respect of current year	
4.3.2.3	(Over)/under provision in respect of prior year	
4.3.2.4	Adjustment for current year	
4.3.3	**Total Risk transfer arrangements assets**	

PART 4.4

CASH AND CASH EQUIVALENTS

		Total
		R
4.4.1	Call accounts	
4.4.2	Current accounts	
4.4.3	Fixed deposits	
4.4.4	Money market instruments	
4.4.5	Cash and cash equivalents of group companies on consolidation	
4.4.6	Transfer of assets due to amalgamation	
4.4.7	***Total cash and cash equivalents per balance sheet***	
4.4.8	Outstanding cheques	
4.4.9	***Total cash and cash equivalents per part 9 of the return***	

PART 4.5(a)

SAVINGS PLAN LIABILITY (SCHEME CARRIES THE RISK)

		Total
		R
4.5.1	Balance on savings plan liability at the beginning of the year (credit balance)	
4.5.2	Prior year adjustment	
4.5.3	Less: Advances on savings plan accounts	
4.5.4	Balance on savings plan liability at the beginning of the year (nett balance)	
4.5.5	*Savings plan account contributions received or receivable*	
4.5.5.1	- For the current year	
4.5.5.2	- Received in advance	
4.5.5.3	- Allocated to settle prior year advances	
4.5.6	Transfers from other schemes	
4.5.7	Interest paid on savings plan accounts	
4.5.8	Less: Transfers to other schemes	
4.5.9	Less: Claims paid on behalf of members	
4.5.10	Less: Administration expenses	
4.5.11	Less: Refunds on death or resignation	
4.5.12	Other (specify)	
4.5.13	**Nett balance at the end of the year**	
4.5.14	Add: Advances on savings plan accounts	
4.5.15	***Balance of savings plan liability at the end of the year (credit balance)***	
4.5.16	**Ageing of savings plan liability at the end of the year**	
4.5.16.1	Current Members	
4.5.16.2	Resigned members	
4.5.16.2.1	- 0 - 6 months	
4.5.16.2.2	- 6 months +	

PART 4.5(b)

SAVINGS PLAN LIABILITY (SCHEME DOES NOT CARRY THE RISK)

		Total
		R
4.5.1	Balance on savings plan liability at the beginning of the year (nett balance)	
4.5.2	Prior year adjustment	
4.5.3	**Balance on savings plan liability at the beginning of the year (nett balance)**	
4.5.4	*Savings plan account contributions received or receivable*	
4.5.4.1	- For the current year	
4.5.4.2	- Received in advance	
4.5.4.3	- Allocated to settle prior year advances	
4.5.5	Unrealised gains/(losses) on re-measurement to fair value of investments relating to savings plan	
4.5.6	Surplus/(deficit) on sale of investments relating to savings plan	
4.5.7	Transfers from other schemes	
4.5.8	Interest paid on savings plan accounts	
4.5.9	Other income (specify)	
4.5.10	Less: Claims paid on behalf of members	
4.5.11	Less: Impairment losses incurred	
4.5.12	Less: Impairment write down	
4.5.13	Less: Administration expenses	
4.5.14	Less: Other expenses (specify)	
4.5.15	Less: Refunds on death or resignation	
4.5.16	Less: Transfers to other schemes	
4.5.17	***Balance of savings plan liability at the end of the year (nett balance)***	
4.5.18	**Ageing of savings plan liability at the end of the year**	
4.5.18.1	Current Members	
4.5.18.2	Resigned members	
4.5.18.2.1	- 0 - 6 months	
4.5.18.2.2	- 6 months +	

PART 4.6

BORROWINGS

		Interest bearing borrowings		Non-interest bearing borrowings		Total
		Current	Non-current	Current	Non-current	
		R	R	R	R	R
4.6.1	Description (specify)					
4.6.2	Borrowings of group companies on consolidation					
4.6.3	Transfer of liabilities due to amalgamation					
4.6.4	***Total***					

PART 4.7

OTHER NON-CURRENT LIABILITIES

		Total
		R
4.7.1	Other non-current liabilities (specify)	
4.7.2	*Less: Current portion included in current liabilities*	
4.7.3	Balances of group companies on consolidation	
4.7.4	Transfer of liability due to amalgamation	
4.7.5	***Total other non-current liabilities***	

PART 4.8

TRADE AND OTHER PAYABLES

		Total
		R
4.8.1	Reported claims not yet paid	
4.8.1.1	Reported claims not yet paid – due to members (including outstanding cheques)	
4.8.1.2	Reported claims not yet paid – due to providers (including outstanding cheques)	
4.8.2.1	Stale cheques for claims expenses	
4.8.2.2	Stale cheques for expenses other than claims	
4.8.3	Net contributions received in advance	
4.8.4	*Payments received in advance under risk transfer arrangements*	
4.8.4.1	Payments received in advance under commercial reinsurance contracts	
4.8.4.2	Payments received in advance under other risk transfer arrangements	
4.8.5	Bank overdraft (current account)	
4.8.6	*Amounts owing to:*	
4.8.6.1	- Administrator	
4.8.6.2	- Reinsurer (other than claim recoveries)	
4.8.6.3	- Brokers	
4.8.6.4	- Managed care organisations	
4.8.6.5	- Other related parties (specify)	
4.8.7	Current portion of non-current borrowings and other non-current liabilities	
4.8.8	Amounts owing to members	
4.8.9	Unallocated deposits	
4.8.10	Post retirement benefits	
4.8.11	Other payables & accrued expenses (specify)	
4.8.12	Balances of group companies on consolidation	
4.8.13	Transfer of liability due to amalgamation	
4.8.14	***Total trade and other payables***	

PART 4.9

OUTSTANDING CLAIMS PROVISION

		A Total	B Outstanding claims provision - not covered by risk transfer	C Outstanding claims provision – covered by commercial	D Outstanding claims provision – covered by other risk
		R	R	R	R
4.9.1	*Balance at beginning of year*				
4.9.1.1	- As previously reported:				
4.9.1.2	- Prior year adjustment				
4.9.1.3	- Transfer of liability due to amalgamation (IN)				
4.9.2	Less: Payments in respect of the prior year				
4.9.3	(Under)/Over provision in respect of the prior year				
4.9.4	Adjustment for the current year				
4.9.5	Liability adequacy test (LAT) provision adjustment				
4.9.6	**Total outstanding claims provision at end of year**				
4.9.7	Transfer of liability due to amalgamation (OUT)				
4.9.8	***Total outstanding claims provision at end of year***				
	Representing:				
4.9.8.1	Estimated gross claims				
4.9.8.2	Less: Estimated recoveries from				
4.9.8.3	- co-payments				
4.9.8.4	- savings plan accounts				
4.9.8.5	***Balance at end of year***				

Please provide the reasons for any (under)/over provision which is more than 5% of the previous year's provision:

PART 4.10
GROSS CONTRIBUTIONS

		Total
		R
4.10.1	Gross contribution income	
4.10.2	Less: Savings plan account contribution income	
4.10.3	***Risk contribution income***	

Please provide the reasons if the gross contributions are zero:

PART 4.11

NETT CLAIMS INCURRED

		A Total	B In respect of risk carried by the scheme (including claims incurred in respect of commercial	C In respect of related risk transfer arrangements (excluding claims incurred in respect of
		R	R	R
4.11.1	*Gross claims paid and reported*			
4.11.1.1	- Direct benefits for the period			
4.11.1.2	- Direct benefits for the previous period			
4.11.1.3	- Direct benefits reported not yet paid			
4.11.1.4	- Managed care: healthcare benefits for the period (no transfer of risk)			0
4.11.1.5	- Managed care: healthcare benefits for the previous period (no transfer of risk)			0
4.11.1.6	- Managed care: healthcare benefits reported not yet paid (no transfer of risk)			0
4.11.1.7	- Services provided to members in own facilities			
4.11.2	Less: Savings plan claims paid			
4.11.3	Less**:** Discount received on claims			
4.11.4	Less: Claims recoveries from third parties			
4.11.5	**Nett actual claims paid and reported**			
4.11.6	Provision for outstanding claims at the end of the financial year			
4.11.7	Less: Provision for outstanding claims at end of the previous year			
4.11.8	***Nett claims incurred(excluding nett (income)/expense from other risk transfer arrangements)***			
4.11.9	Nett (income)/expense from other risk transfer arrangements		***0***	
4.11.10	***Total nett claims incurred***			

PART 4.12

MANAGED CARE: MANAGEMENT SERVICES

		Administrator	Other third parties	Total
		R	R	R
4.12.1	Provider service account review			
4.12.2	Specialist, hospital referrals and pre-authorisation			
4.12.3	Case management			
4.12.4	Disease management			
4.12.5	Primary care provider management			
4.12.6	HIV management			
4.12.7	Medicine bag management			
4.12.8	Health advice line			
4.12.9	Pharmacy benefit management			
4.12.10	Clinical review/auditing			
4.12.11	Maternity programme			
4.12.12	Disease/prescribed minimum benefit management			
4.12.13	Drug utilisation review			
4.12.14	Eternity Asthma programme			
4.12.15	Female Wellness programme			
4.12.16	Fraud Hotline			
4.12.17	Managed hospital care			
4.12.18	Managed health services, ambulance and helpline			
4.12.19	Hospital pre-authorisation			
4.12.20	Medical advisors			
	Delete this line			
4.12.21	Member counselling, compliance monitoring & risk assessment			
4.12.22	Member health portal			
4.12.23	Mental health programme			
4.12.24	Mothers-to-be programme			
4.12.25	Oncology utilisation programme			
4.12.26	One-care PMB management fee			
4.12.27	Optical management			
4.12.28	Provider profiling			
4.12.29	Stress-line			
4.12.30	Other (specify)			
4.12.31	***Total managed care: management services***			

PART 4.13

NETT (INCOME)/EXPENSES FROM OTHER RISK TRANSFER ARRANGEMENTS (EXCLUDING COMMERCIAL REINSURANCE CONTRACTS)

		Consolidated total	Per contract
		R	R
4.13.1	Premiums/fees paid (Capitation fees)		
4.13.2	Claims recoveries in respect of related risk transfer arrangements		
4.13.3	Other (specify)		
4.13.4	***Nett (income)/expense from other risk transfer arrangements***		

PART 4.14

NETT INCOME/(EXPENSES) FROM RISK TRANSFER ARRANGEMENTS: COMMERCIAL REINSURANCE CONTRACTS

		Consolidated	Per contract
		R	R
4.14.1	Reinsurance premiums paid		
4.14.2	Reinsurance claims recovered		
4.14.3	Provision for reinsurance claims recovered		
4.14.4	Profit/(Loss) on reinsurance arrangements		
4.14.5	Commissions on reinsurance agreements		
4.14.6	Discounts received		
4.14.7	***Nett income/(expense) from commercial reinsurance***		

PART 4.15 (a)
BROKER SERVICE FEES

		Broker service fees
		R
4.15.1	Paid to related parties	
4.15.2	Other (specify)	
4.15.3	***Total broker service fees***	

PART 4.15 (b)
OTHER DISTRIBUTION COSTS

		Other distribution costs paid to brokers
		R
4.15.1	Paid to related parties	
4.15.2	Other (specify)	
4.15.3	***Total distribution costs***	

PART 4.16

ADMINISTRATION EXPENSES

		Fund	Own Facilities
		R	R
4.16.1	Actuarial fees		
4.16.2	*Administration fees:*		
4.16.2.1	- Fees paid to the administrator		
4.16.2.2	- Indirect fees paid to the administrator		
4.16.3	Advertising		
4.16.4	Annual general meeting costs		
4.16.5	Association fees		
4.16.6	*Audit expense:*		
4.16.6.1	- Audit services		
4.16.6.2	- Audit expenses		
4.16.6.3	- Audit committees		
4.16.6.4	- Over/(under) provision of prior year's audit fees		
4.16.6.5	- Other non-audit expenses (specify)		
4.16.7	Bank charges		
4.16.8	Co-administration fees paid for ongoing services provided by third parties		
4.16.9	Computer expenses		
4.16.10	Consultancy fees (not the contracted administrator)		
4.16.11	Council for Medical Schemes expenses		
4.16.12	Debt collection fees		
4.16.13	Depreciation		
4.16.14	Electronic checking fees		
4.16.15	Entertainment		
4.16.16	Fidelity guarantee insurance premiums		
4.16.17	Insurance fees		
4.16.18	Internal audit fees		
4.16.19	Investigation fees		
4.16.20	Legal fees		
4.16.21	Marketing expenses		
4.16.22	MVA administration fees		
4.16.23	Operating leases and other rentals (incl. property rentals)		
4.16.24	Other levies		
4.16.25	Penalties		
4.16.26	Pharmacy administration fees		
4.16.27	Principal Officer fees & remuneration		
4.16.28	Principal Officer other considerations		

4.16.29	Printing and stationery		
4.16.30	Professional fees		
4.16.31	Professional indemnity insurance premiums		
4.16.32	Repairs and maintenance		
4.16.33	Staff remuneration		
4.16.34	Telephone, postage and fax		
4.16.35	Travel, accommodation and conferences		
4.16.36	Trustees' remuneration expenses		
4.16.37	Water and electricity		
4.16.38	Other administration expenses (specify)		
4.16.39	Less: Administration expenses recoverable/recovered		
4.16.40	Less: Administration expenses recoverable from savings plan accounts		
4.16.41	***Total administration expenses***		

PART 4.17

TRUSTEE REMUNERATION AND CONSIDERATIONS

		Fees for meeting attendance	**Fees for holding of office**	**Fees for consultancy services**	**Allowances**	**Training**	**Conference fees**	**Telephone expenses**	**Accommodation, travel and meals**	**Other disburse-ments and reimburse-ments**	**Total**
		R	**R**	**R**	**R**	**R**	**R**	**R**	**R**		
4.17.1	Per trustee member										
4.17.2	***Total trustee remuneration and considerations***										

PART 4.18

PROVISION FOR IMPAIRED LOSSES AT YEAR-END

		A Provision for impaired losses at beginning of year	B (Amounts Written Off)	C Increase/ (Decrease) for provision during the year	D Previous impairment losses recovered	E Nett impairment losses: Trade and other receivables	F Provision for impaired losses at year-end (B/S)
		R	R	R	R	R	R
4.18.1	Contributions owed by members					B+(C*-1)+D	Sum of A + C
4.18.2	Amounts owed in respect of member's					B+(C*-1)+D	Sum of A + C
4.18.3	Amounts owed by service					B+(C*-1)+D	Sum of A + C
4.18.4	Amounts owed by members in respect of					B+(C*-1)+D	Sum of A + C
4.18.5	Other					B+(C*-1)+D	Sum of A +
4.18.6	***Total***						

PART 4.19

GROSS INVESTMENT INCOME

		Total
		R
4.19.1	*Income from investments and property:*	
4.19.1.1	- Interest	
4.19.1.2	- Dividends received	
4.19.1.3	- Rentals	
4.19.1.4	- Policy income	
4.19.2	Other (specify)	
4.19.3	***Total gross investment income***	

PART 4.20

OTHER REALISED AND UNREALISED GAINS/(LOSSES)

		Total
		R
4.20.1	Profit/(loss) on disposal of property, plant and equipment	
4.20.2	Profit/(loss) on disposal of investment property	
4.20.3	Realised gain/(loss) on disposal of available-for-sale investments	
4.20.4	Realised gain/(loss) on disposal of investments carried at fair value through the income statement	
4.20.5	Unrealised gain/(loss) on revaluation of investment property	
4.20.6	Unrealised gain/(loss) on revaluation of investments carried at fair value through the income statement	
4.20.7	Other (specify)	
4.20.8	***Total realised and unrealised gains/(losses)***	

PART 4.21

OWN FACILITY SURPLUS / (DEFICIT)

		Total
		R
4.21.1	Income from services rendered to third parties	
4.21.2	Less: Total cost incurred in operating own facility	
4.21.2.1	Less: Total healthcare provider costs	
4.21.2.2	Less: Changes in inventories	
4.21.2.3	Less: Staff costs	
4.21.2.4	Less: Other costs incurred in operating own facility	
4.21.2.5	Add: Costs relating to members included in claims	
4.21.3	***Total own facility surplus/(deficit)***	

PART 4.22

FINANCE COSTS

		Total
		R
4.22.1	Borrowings	
4.22.2	Interest paid on savings plan accounts	
4.22.3	Other (specify)	
4.22.4	***Total finance costs***	

PART 4.23

SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

		Consolidated Total	Other	Per Benefit option
		R	R	R
4.23.1	Gross contribution income			
4.23.2	Less: Savings contribution income			
4.23.3	*Nett contribution income*			
4.23.4	*Gross claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect of*			
4.23.4.1	- Direct benefits for the period			
4.23.4.2	- Direct benefits for the previous period			
4.23.4.3	- Direct benefits reported not yet paid			
4.23.4.4	- Managed care: healthcare benefits for the period (no transfer of risk)			
4.23.4.5	- Managed care: healthcare benefits for the previous period (no transfer of risk)			
4.23.4.6	- Managed care: healthcare benefits reported not yet paid (no transfer of risk)			
4.23.4.7	- Services provided to members in own facilities			
4.23.5	Less: Savings plan claims paid			
4.23.6	Less**:** Discount received on claims			
4.23.7	Less: Claims recoveries from third parties			
4.23.8	*Nett actual claims paid and reported in respect of risk carried by the scheme (including claims incurred in*			
4.23.9	Provision for outstanding claims at the end of the financial year			
4.23.10	Less: Provision for outstanding claims at end of the previous year			
4.23.11	***Nett claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)***			
4.23.12	*Gross claims paid and reported in respect of related risk transfer arrangement (excluding claims incurred in respect of commercial reinsurance contracts)*			
4.23.12.1	- Direct benefits for the period			
4.23.12.2	- Direct benefits for the previous period			
4.23.12.3	- Direct benefits reported not yet paid			
4.23.13	*Nett actual claims paid and reported in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)*			
4.23.14	Provision for outstanding claims at the end of the financial year			
4.23.15	Less: Provision for outstanding claims at end of the previous year			

4.23.16	***Nett claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts).***			
4.23.17	*Nett income/(expense) on risk transfer arrangements*			
4.23.17.1	Premiums/fees paid (Capitation fees)			
4.23.17.2	Less: Estimated claims recoveries			
4.23.17.3	Other (specify)			
4.23.18	**Total nett claims incurred**			
4.23.19	Nett income/(expense) on commercial reinsurance contracts			
4.23.20	Less: Managed care: management services			
4.23.21.1	Less: Broker service fees			
4.23.21.2	Less: Other distribution costs			
4.23.22	Administration expenses			
4.23.23	Nett impairment losses: Trade and other receivables			
4.23.24	**Surplus/(Deficit) from operations**			
4.23.25	Members at the end of the financial year			
4.23.26	Beneficiaries at the end of the financial year			

PART 4.24

GUARANTEES SUPPLIED TO REGISTRAR IN TERMS OF THE ACT

		Total
		R
4.24.1	Name of institution	
4.24.2	***Total guarantees***	

PART 4.25

GUARANTEES AND SURETYSHIP FOR THIRD PARTY LIABILITIES (INCLUDING CONTINGENT LIABILITIES)

		Guarantees	Suretyships	Encumbered Assets	Other
		R	R	R	R
4.25.1	To whom				
4.25.2	***Total***				

PART 4.26

RELATED PARTY TRANSACTIONS

		Name	Nature of related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arms-length	Amount
					(Y/N)	R
4.26.1	Transactions for the year (income statement)					
4.26.2	Balances at year end (balance sheet)					
4.26.3	***Total***	***0***	***0***	***0***		

Please provide the reasons for the transactions/balances at year-end not at arms-length:

PART 5

BALANCE SHEET

		Current year	Previous year
		R	R
5.1	**ASSETS**		
5.1.1	**Non-current assets**		
5.1.1.1	Property, plant and equipment		
5.1.1.2	Investments		
5.1.1.3	Other non-current assets (specify)		
5.1.2	**Current assets**		
5.1.2.1	Inventories		
5.1.2.2	Trade and other receivables		
5.1.2.3	Investments		
5.1.2.4	Cash and cash equivalents		
5.1.3	***Total assets***		
5.2	**FUNDS AND LIABILITIES**		
5.2.1	**Members' funds**		
5.2.1.1	Accumulated funds		
5.2.1.2	Revaluation Reserve - Investments		
5.2.1.3	Revaluation Reserve - Property, plant and equipment		
5.2.1.4	Reserves set aside for specific purposes		
5.2.1.5	Other reserves		
5.2.1.6	Minority interest		
5.2.2	**Non-current liabilities**		
5.2.2.1	Borrowings		
5.2.2.2	Other non-current liabilities		
5.2.3	**Current liabilities**		
5.2.3.1	Savings plan liability		
5.2.3.2	Trade and other payables		
5.2.3.3	Outstanding claims provision		
5.3	***Total funds and liabilities***		

PART 6

INCOME STATEMENT

		Current year			Previous year		
		Continuing operations	Discontinued operations	Total	Continuing operations	Discontinued operations	Total
		R	R	R	R	R	R
6.1	Gross contribution income						
6.2	Less: Savings contribution income						
6.3	*Nett contribution income*						
6.4	Total Nett claims incurred						
6.5	Nett income/(expense) on commercial reinsurance						
6.6	Less: Managed care: management services						
6.7.1	Less: Broker service fees						
6.7.2	Less: Other distribution costs						
6.8	Less: Administration expenses						
6.9	Nett impairment losses: Trade and other receivables						
6.10	**Surplus/(Deficit) from operations**						
6.11	Nett impairment losses: Other						
6.12	Gross investment income						
6.13	Less: Investment management fees						
6.14	Less: Operating expenses on rental of investment property						
6.15	Other realised and unrealised gains/(losses)						
6.16	Other operating income (specify)						

6.17	Own facility surplus/(deficit)						
6.18	Less: Other operating expenses (specify)						
6.19	Less: Finance costs						
6.20	**Surplus/(Deficit) for the year**						

PART 7

STATEMENT OF CHANGES IN FUNDS AND RESERVES

PART 7.1

ACCUMULATED FUNDS

		Current year	Previous year
		R	R
7.1.1	*Balance at the beginning of the year:*		
7.1.1.1	- As previously reported		
7.1.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.1.2	Surplus/(Deficit) for the year		
7.1.3	*Transfer to/(from) accumulated funds*		
7.1.3.1	- Due to amalgamation		
7.1.3.2	- Due to re-measurement of property, plant and equipment		
7.1.3.3	- Other transfers		
7.1.4	Other (specify)		
7.1.5	***Balance at the end of the year***		

PART 7.2

REVALUATION RESERVES (INVESTMENTS)

		Current year	Previous year
		R	R
7.2.1	*Balance at the beginning of the year:*		
7.2.1.1	- As previously reported		
7.2.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.2.2	Unrealised gains/(losses) on revaluation of investments		
7.2.3	Realised gains/(losses) on derecognition of investments		
7.2.4	Revaluation adjustment		
7.2.5	Transfer (to)/from reserves		
7.2.6	Other (specify)		
7.2.7	***Balance at the end of the year***		

PART 7.3

REVALUATION RESERVE (PROPERTY, PLANT AND EQUIPMENT)

		Current year	Previous year
		R	R
7.3.1	*Balance at the beginning of the year:*		
7.3.1.1	- As previously reported		
7.3.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.3.2	Unrealised gains/(losses) on revaluation of property, plant and equipment		
7.3.3	Revaluation adjustment		
7.3.4	Transfer (to)/from reserves		
7.3.5	Other (specify)		
7.3.6	***Balance at the end of the year***		

PART 7.4

RESERVES SET ASIDE FOR SPECIFIC PURPOSES

		Current year		Previous year	
		Consolidated	**Per reserve**	**Consolidated**	**Per reserve**
		R	**R**	**R**	**R**
7.4.1	*Balance at the beginning of the*				
7.4.1.1	- As previously reported				
7.4.1.2	- Prior year adjustment (including effect of first time				
7.4.2	Transfer (to)/from reserves				
7.4.3	Other (specify)				
7.4.4	***Balance at the end of the year***				

PART 7.5

OTHER RESERVES

		Current year		Previous year	
		Consolidated	**Per**	**Consolidated**	**Per**
		R	**R**	**R**	**R**
7.5.1	*Balance at the beginning of the year:*				
7.5.1.1	- As previously reported				
7.5.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)				
7.5.2	Transfer (to)/from reserves				
7.5.3	Other (specify)				
7.5.4	***Balance at the end of the year***				

PART 8

CASH FLOW STATEMENT

		Current year	Previous year
		R	R
8.1	**CASH FLOWS FROM OPERATING ACTIVITIES**		
8.1.1	Cash flows from operations before working capital changes		
8.1.2	*Working capital changes*		
8.1.2.1	- (Increase)/Decrease in inventories		
8.1.2.2	- (Increase)/Decrease in trade and other receivables		
8.1.2.3	- (Decrease)/Increase in trade and other payables		
8.1.2.4	- (Decrease)/Increase in outstanding claims provision		
8.1.2.5	- (Decrease)/Increase in savings plan liability		
8.1.3	***Cash generated from operations***		
8.1.4	Interest paid		
8.1.5	Other (specify)		
8.1.6	**Nett cash from operating activities**		
8.2	**CASH FLOWS FROM INVESTING ACTIVITIES**		
8.2.1	Purchase of property, plant and equipment		
8.2.2	Proceeds on disposal of property, plant and equipment		
8.2.3	Purchase of investment property		
8.2.4	Proceeds on disposal of investment property		
8.2.5	Purchase of investments		
8.2.6	Proceeds on disposal of investments		
8.2.7	Interest received		
8.2.8	Dividend received		
8.2.9	Rentals received		
8.2.10	Other (specify)		
8.2.11	**Nett cash from/(used) in investing activities**		
8.3	**CASH FLOWS FROM FINANCING ACTIVITIES**		
8.3.1	(Repayments)/Increase in borrowings		
8.3.2	Other (specify)		
8.3.3	**Nett cash used in financing activities**		
8.4	**NETT INCREASE IN CASH AND CASH EQUIVALENTS**		
8.5	*Cash and cash equivalents at the beginning of the year*		
8.5.1	- As previously reported		
8.5.2	- Prior year adjustment		
8.6	Other (specify)		
8.7	Transfer of cash and cash equivalents due to amalgamation		
8.8	**CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR**		

PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Total Fair Value
		R
9.1	**CATEGORY ONE - Deposits and balances in current and savings accounts, Negotiable deposits, Money market instruments, Structured bank notes, Margin deposits with SAFEX and Collateralised deposits.**	
1(a)(i)	***BANKS with net qualifying capital and reserve funds > R5 billion***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1(a)(i)	
1(a)(ii)	***BANKS with net qualifying capital and reserve funds > R100 million***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1(a)(ii)	
1(a)(iii)	***DEPOSITS COLLATERALISED with securities issued by the government of the RSA where an appropriate ISMA has been concluded***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 1(a)(iii)	
	SUB-TOTAL: CATEGORY 1(a)	
1(b)	***TERRITORIES OUTSIDE THE REPUBLIC - Deposits and balances in current and savings accounts, negotiable deposit and money market instruments with a foreign bank***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1(b)	
9.2	**CATEGORY TWO - Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by:**	
2(a)	***INSIDE THE REPUBLIC***	
2(a)(i)	Instruments guaranteed by the government of the RSA	
2(a)(ii)	Local Authorities authorized by law to levy rates upon immovable property	
2(a)(iii)	Development Bank	
2(a)(iv)	Industrial Development Corporation (IDC)	
2(a)(v)	Infrastructure Finance Corporation Limited (INCA)	
2(a)(vi)	Land and Agricultural Bank	

	Name and Description	Total Fair Value
		R
2(a)(vii)	Trans-Caledonian Tunnel Authority (TCTA)	
2(a)(viii)	SA Roads Board	
2(a)(ix)	ESKOM	
2(a)(x)	Transnet	
2(a)(xi)	Per Bank with net qualifying capital and reserve funds > R5 billion - Name (specify)	
2(a)(xii)	Per Bank with net qualifying capital and reserve funds > R100 million - Name (specify)	
2(a)(xiii)	Per corporate institution not included in above categories, where debt is traded on the Bond Exchange	
2(a)(xiv)	Per other approved by Registrar institution not included in above categories	
	SUB-TOTAL: CATEGORY 2(a)	
2(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
2(b)(i)	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 2(b)	
9.3	**CATEGORY THREE - Immovable property, units in unit trust schemes in property share, shares & loans to & debentures in property companies**	
3(a)	***INSIDE THE REPUBLIC***	
3(a)(i)	Per Single property - Name (specify)	
	SUB-TOTAL: CATEGORY 3(a)	
3(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 3(b)	
9.4	**CATEGORY FOUR - SHARES, Convertible Debentures, Exchange traded funds, units in equity unit trust schemes, linked policies of insurance**	
4(a)(i)	***UNLISTED SHARES, UNLISTED DEBENTURES, LISTED SHARES AND CONVERTIBLE DEBENTURES IN THE DEVELOPMENT CAPITAL AND VENTURE CAPITAL SECTORS OF THE JSE***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(i)	
4(a)(ii)	***SHARES AND CONVERTIBLE DEBENTURES LISTED ON JSE (Other than DEVELOPMENT CAPITAL SECTOR):***	
4(a)(ii)(i)	***Per Company with market capitalisation of more than R50 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(i)	
4(a)(ii)(ii)	***Per Company with market capitalisation of between R5 billion and R50 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(ii)	
4(a)(ii)(iii)	***Per Company with market capitalisation of less than R5 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(iii)	

	Name and Description	Total Fair Value
		R
4(a)(iii)	***EXCHANGE TRADED FUNDS TRADED ON THE JSE:***	
4(a)(iii)(i)	***Per fund with diversified holdings across the component sectors of the JSE***	
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iii)(i)	
4(a)(iii)(ii)	***Per fund with holdings focused in sub-sectors of the JSE***	
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iii)(ii)	
4(a)(iv)	***UNITS IN EQUITY UNIT TRUSTS OR POOLED EQUITY MANAGED FUNDS***	
4(a)(iv)(i)	***Per unit trust with diversified holdings across the component sectors of the JSE***	
	Per unit trust - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iv)(i)	
4(a)(iv)(ii)	***Per fund with holdings focused in sub-sectors of the JSE***	
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iv)(ii)	
4(a)(v)	***POLICIES OF INSURANCE LINKED TO THE PERFORMANCE OF UNDERLYING EQUITIES OR EQUITY INDICES:***	
4(a)(v)(i)	***Per policy of insurance with diversified holdings across the component sectors of the JSE***	
	Per policy of insurance - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(v)(i)	
4(a)(v)(ii)	***Per policy of insurance with holdings focused in sub-sectors of the JSE***	
	Per policy of insurance - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(v)(ii)	
	SUB-TOTAL: CATEGORY 4(a)	
4(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 4(b)	
9.5	**CATEGORY FIVE - Listed and unlisted debentures**	
5(a)	***INSIDE THE REPUBLIC***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 5(a)	
5(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 5(b)	
9.6	**CATEGORY SIX - Policies of insurance not directly linked and directly linked to market value of underlying assets**	
6(a)(i)	***POLICY PROCEEDS ARE NOT DIRECTLY LINKED TO THE MARKET VALUE OF THE UNDERLYING ASSETS***	

	Name and Description	Total Fair Value
		R
	Per registered insurer (specify)	
	SUB-TOTAL: CATEGORY 6(a)(i)	
6(a)(ii)	***POLICY PROCEEDS ARE DIRECTLY LINKED TO THE MARKET VALUE OF THE UNDERLYING ASSETS***	
	Per registered insurer (specify)	
	SUB-TOTAL: CATEGORY 6(a)(ii)	
	SUB-TOTAL: CATEGORY 6(a)	
UNDERLYING ASSETS OF CATEGORY 6(a)(ii) INVESTED IN THE FOLLOWING CATEGORIES:		
9.6.1	**CATEGORY ONE - Deposits and balances in current and savings accounts, Negotiable deposits, Money market instruments, Structured bank notes, Margin deposits with SAFEX and Collateralised deposits.**	
1(a)(i)	***BANKS with net qualifying capital and reserve funds > R5 billion***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1 (a)(i)	
1(a)(ii)	***BANKS with net qualifying capital and reserve funds > R100 million***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1 (a)(ii)	
1(a)(iii)	***DEPOSITS COLLATERALISED with securities issued by the government of the RSA where an appropriate ISMA has been concluded***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 1 (a)(iii)	
	SUB-TOTAL: CATEGORY 1(a)	
1(b)	***TERRITORIES OUTSIDE THE REPUBLIC - Deposits and balances in current and savings accounts***	
	Per Bank - Name (specify)	
	Other (specify)	
	SUB-TOTAL: CATEGORY 1(b)	
9.6.2	**CATEGORY TWO - Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by**	
2(a)	***INSIDE THE REPUBLIC***	
2(a)(i)	Instruments guaranteed by the government of the RSA	
2(a)(ii)	Local Authorities authorized by law to levy rates upon immovable property	
2(a)(iii)	Development Banks	
2(a)(iv)	Industrial Development Corporation (IDC)	
2(a)(v)	Infrastructure Finance Corporation Limited (INCA)	
2(a)(vi)	Land and Agricultural Bank	
2(a)(vii)	Trans-Caledonian Tunnel Authority (TCTA)	
2(a)(viii)	SA Roads Board	
2(a)(ix)	ESKOM	

	Name and Description	Total Fair Value
		R
2(a)(x)	Transnet	
2(a)(xi)	Per Bank with net qualifying capital and reserve funds > R5 billion - Name (specify)	
2(a)(xii)	Per Bank with net qualifying capital and reserve funds > R100 million - Name (specify)	
2(a)(xiii)	Per corporate institution not included in above categories, where debt is traded on the Bond Exchange	
2(a)(xiv)	Per other approved by Registrar institution not included in above categories	
	SUB-TOTAL: CATEGORY 2(a)	
2(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
2(b)(i)	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 2(b)	
9.6.3	**CATEGORY THREE - Immovable property, units in unit trust schemes in property share, shares loans to debentures in property companies**	
3(a)	***IMMOVABLE PROPERTY, UNITS IN UNIT TRUST SCHEMES IN PROPERTY SHARES, SHARES IN PROPERTY COMPANIES, LOANS TO PROPERTY COMPANIES AND DEBENTURES OF PROPERTY COMPANIES***	
3(a)(i)	Per Single property - Name (specify)	
	SUB-TOTAL: CATEGORY 3(a)	
3(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 3(b)	
9.6.4	**CATEGORY FOUR - Shares, Convertible debentures, Exchange traded funds, units in equity unit trust schemes, linked policies of insurance**	
4(a)(i)	***UNLISTED SHARES, UNLISTED DEBENTURES, LISTED SHARES AND CONVERTIBLE DEBENTURES IN THE DEVELOPMENT CAPITAL AND VENTURE CAPITAL SECTORS OF THE JSE***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(i)	
4(a)(ii)	***SHARES AND CONVERTIBLE DEBENTURES LISTED ON JSE (Other than DEVELOPMENT CAPITAL SECTOR):***	
4(a)(ii)(i)	***Per Company with market capitalisation of more than R50 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(i)	
4(a)(ii)(ii)	***Per Company with market capitalisation of between R5 billion and R50 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(ii)	
4(a)(ii)(iii)	***Per Company with market capitalisation of less than R5 billion***	
	Per company - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(ii)(iii)	
4(a)(iii)	***EXCHANGE TRADED FUNDS TRADED ON THE JSE:***	
4(a)(iii)(i)	***Per fund with diversified holdings across the component sectors of the JSE***	
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iii)(i)	
4(a)(iii)(ii)	***Per fund with holdings focused in sub-sectors of the JSE***	

	Name and Description	Total Fair Value
		R
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iii)(ii)	
4(a)(iv)	***UNITS IN EQUITY UNIT TRUSTS OR POOLED EQUITY MANAGED FUNDS***	
4(a)(iv)(i)	***Per unit trust with diversified holdings across the component sectors of the JSE***	
	Per unit trust - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iv)(i)	
4(a)(iv)(ii)	***Per fund with holdings focused in sub-sectors of the JSE***	
	Per fund - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(iv)(ii)	
4(a)(v)	***POLICIES OF INSURANCE LINKED TO THE PERFORMANCE OF UNDERLYING EQUITIES OR EQUITY INDICES:***	
4(a)(v)(i)	***Per policy of insurance with diversified holdings across the component sectors of the JSE***	
	Per policy of insurance - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(v)(i)	
4(a)(v)(ii)	***Per policy of insurance with holdings focused in sub-sectors of the JSE***	
	Per policy of insurance - Name (specify)	
	SUB-TOTAL: CATEGORY 4(a)(v)(ii)	
	SUB-TOTAL: CATEGORY 4(a)	
4(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 4(b)	
9.6.5	**CATEGORY FIVE - Listed and unlisted debentures**	
5(a)	***INSIDE THE REPUBLIC***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 5(a)	
5(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 5(b)	
9.6.6	**CATEGORY SEVEN - Other assets not referred to elsewhere in this Annexure**	
7(a)(i)	***INVENTORIES***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 7(a)(i)	
7(a)(ii)	***DERIVATIVES:***	
	Per asset class category - Name (specify)	
	SUB-TOTAL: DERIVATIVES 7(a)(ii)	
7(a)(iii)	***OTHER ASSETS***	
	Per asset - Name (specify)	
	SUB-TOTAL: OTHER ASSETS 7(a)(iii)	
	SUB-TOTAL: CATEGORY 7(a)	

	Name and Description	Total Fair Value
		R
7(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 7(b)	
6(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign insurer - Name (specify)	
	SUB-TOTAL: CATEGORY 6(b)	
9.7	**CATEGORY SEVEN - Other assets not referred to elsewhere in this Annexure**	
7(a)(i)	***INVENTORIES***	
	Name (specify)	
	SUB-TOTAL: CATEGORY 7(a)(i)	
7(a)(ii)	***DERIVATIVES:***	
	Per asset class category - Name (specify)	
	SUB-TOTAL: DERIVATIVES 7(a)(ii)	
7(a)(iii)	***OTHER ASSETS***	
	Per asset - Name (specify)	
	SUB-TOTAL: OTHER ASSETS 7(a)(iii)	
	SUB-TOTAL: CATEGORY 7(a)	
7(b)	***TERRITORIES OUTSIDE THE REPUBLIC***	
	Per Foreign institution - Name (specify)	
	SUB-TOTAL: CATEGORY 7(b)	
9.8	**INTANGIBLE ASSETS**	
9.9	**TRADE AND OTHER RECEIVABLES**	
9.10	***TOTAL ASSETS***	
9.11	**LESS: ASSETS ENCUMBERED**	
9.**12**	**LESS: TRADE AND OTHER RECEIVABLES PLUS INTANGIBLE ASSETS**	
9.13	***TOTAL NETT ASSETS PER REGULATION 30***	

PART 9(b)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name of the person/company/institution managing the investments	Person/company/institution managing the investments		
		Managed on behalf of the scheme	Managed by the scheme	Total
		R	R	R
9.2.1	Name (specify)			
9.2.2	***TOTAL NETT ASSETS PER REGULATION 30***			

PART 10

MINIMUM ACCUMULATED FUNDS TO BE MAINTAINED BY A MEDICAL SCHEME IN TERMS OF REGULATION 29

PART 10.1

CUMULATIVE NETT GAIN ON RE-MEASUREMENT OF PROPERTIES AND INVESTMENTS

		Year to date
		R
10.1.1	Balance at beginning of period	
10.1.2	Unrealised gains/(losses) on revaluation of investments and property, plant and equipment included in the income statement	
10.1.3	Impairment losses and reversal of impairment losses on revaluation of investments and property, plant and equipment included in the income statement	
10.1.4	Realisation of cumulative gains or losses recognised in the income statement on disposal of investments	
10.1.5	Other (Specify)	
10.1.6	***Cumulative net gain on revaluation of investments and property, plant and equipment included in the income statement***	

PART 10.2

SOLVENCY RATIO

		Total
		R
10.2.1	Total members' funds per balance sheet	
10.2.2	Less: Unrealised non-distributable reserve	
10.2.3	Less: Funds set aside for specific purposes	
10.2.4	Less: Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement	
10.2.5	Less: Specific Assets Encumbered for third party liabilities	
10.2.6	Add: Sub-ordinated loan as approved by the Council	
10.2.7	***Total nett assets***	
10.2.8	**TOTAL NETT ASSETS**	
10.2.9	**ANNUALISED GROSS CONTRIBUTIONS**	
10.2.10	***SOLVENCY RATIO***	

Please indicate the reasons for not meeting 25% solvency:

PART 11

REPORT OF THE MANAGEMENT BOARD/COMMITTEE

GENERAL	Answer
1. Has there been a change in accounting policies? If Yes, provide full details.	☐ Yes ☐ No
2. Has there been a change in accounting estimates? If Yes, provide full details.	☐ Yes ☐ No
3. Has any company/institution/person to your knowledge received or dealt with the contributions of the scheme otherwise than in terms of Section 26(6) and 26(7)? If Yes, provide full details?	☐ Yes ☐ No
4. Are transfers to and from reserves fully disclosed in the attached financial statements? If No, provide full details.	☐ Yes ☐ No
5. Does the scheme have fidelity guarantee and professional indemnity insurance cover in terms of the Act? If No, provide full details.	☐ Yes ☐ No
6. Were any contract(s) in place during the financial year in respect of inter alia the following services provided to the members of the scheme: All managed care, administrative, brokerage etc. If Yes, with whom and what type?	☐ Yes ☐ No
7(a). Does the scheme make use of diagnostic coding? If Yes, what systems are used?	☐ Yes ☐ No
7(b). Does the scheme make use of surgical procedure codes? If Yes, what systems are used?	☐ Yes ☐ No
7(c). Did the scheme operate any unregistered options? If Yes, provide full details?	☐ Yes ☐ No
TECHNICAL PROVISIONS AND INTERNAL SYSTEMS	
8(a). Are underwriting, financial and investments results which can be relied upon for making management decisions, available timeously?	☐ Yes ☐ No
8(b). How frequently are these results available?	☐ Yes ☐ No
9. Are these results generally available for the calculation of provisions? If No, provide full details.	☐ Yes ☐ No
10. Is sufficient reliable data available for the calculation of provisions? If No, provide full details.	☐ Yes ☐ No
11(a). Has the basis for calculating provisions been changed from the past?	☐ Yes ☐ No
11(b). Are provisions calculated monthly/quarterly/half yearly/annually? Please provide full details to the methodology used.	☐ Yes ☐ No
12. Has an independent person verified the adequacy of provisions? If Yes, name, date and qualification.	☐ Yes ☐ No
ASSET COVER	
13(a). Are any assets encumbered in terms of section 35 (6)(a)? If Yes, provide full details.	☐ Yes ☐ No
13(b). Are any assets held by another person on behalf of the scheme in terms of section 35(6)(b) ? If Yes, provide full details.	☐ Yes ☐ No
13(c). Has there been any direct or indirect borrowing of money in terms of section 35(6)(c)? If Yes, provide full details.	☐ Yes ☐ No
13(d). Has any suretyship been given in terms of section 35(6)(d)? If Yes, provide full details.	☐ Yes ☐ No
14(a). Has any asset been revalued during the year under review? If Yes, provide full details.	☐ Yes ☐ No
14(b) Name, date and qualification of valuator.	☐ Yes ☐ No

ASSET COVER	
14(c) Whether it was done internally or externally.	☐ Yes ☐ No
15. Are all assets of the Scheme or title thereto held by the scheme in terms of section 26 and Regulation 24? If No, provide full details.	☐ Yes ☐ No
16. Do the notes to the financial statements fully include contingent liabilities and guarantees? If No, provide full details.	☐ Yes ☐ No
INVESTMENTS	
17. Are all investments made in accordance with proper authority from the Management Board/Committee? If No, provide full details.	☐ Yes ☐ No
18. Does the Scheme hold any investment in the business of any other medical scheme, participating employer group, the administrator of the Scheme or any person associated with the parties mentioned? If Yes, provide full details.	☐ Yes ☐ No
19. Did the Scheme grant a loan to any other medical scheme, participating employer group, the administrator of the Scheme or any person associated with the parties mentioned? If Yes, provide full details.	☐ Yes ☐ No
20. Are appropriate systems in place to enable the frequent and effective monitoring of investments?	☐ Yes ☐ No
21. Are the total assets in compliance with Annexure B? If not, please provide reasons for non-compliance.	☐ Yes ☐ No
22. Have there been any developments after the year end, which have a significant effect on the financial soundness of the Scheme? If Yes, provide full details.	☐ Yes ☐ No
23. Have there been any developments in respect of possible amalgamations, liquidations, and de-registrations of the Scheme? If Yes, provide full details (i.e. the name of scheme (amalgamating with) and the effective date (if finalised))	☐ Yes ☐ No
24. Did the Board/Committee meet as frequently as determined by the rules of the scheme? If No, provide full details.	☐ Yes ☐ No
25. After having taken all reasonable steps to obtain the necessary information, the Management Board/Committee hereby reports to the Registrar that:	☐ Yes ☐ No
(a) The internal controls and systems of the Scheme are designed to provide reasonable assurance as to the integrity and reliability of the published financial statements.	☐ Yes ☐ No
(b) Such controls and systems are based on established written policies and procedures and are implemented by trained, skilled personnel whose duties have been segregated appropriately.	☐ Yes ☐ No
(c) The controls are monitored by the Scheme and that all employees are required to maintain the highest ethical standards in ensuring that the business practices of the Scheme are conducted in a manner that, in all reasonable circumstances, is beyond reproach.	☐ Yes ☐ No
(d) It is confirmed that nothing has come to their attention to indicate that any material malfunctioning of the aforementioned controls, procedures or systems had occurred during the year under review.	☐ Yes ☐ No
(e) It is confirmed that there is no reason to believe that the medical scheme will not be a going concern in the year ahead.	☐ Yes ☐ No
26. Is the administration of the Scheme contracted to a third party? If so, Management Committee/Board should qualify par.25 (a)-(e) as such and obtain and append a letter of comfort from the Administrator in response to this information.	☐ Yes ☐ No

WE, THE UNDERSIGNED, CERTIFY THAT, TO THE BEST OF OUR KNOWLEDGE, THE PARTICULARS CONTAINED IN THIS RETURN ARE EXTRACTED FROM THE BOOKS, RECORDS AND RECONCILE TO THE AUDITED ANNUAL FINANCIAL STATEMENTS OF THE SCHEME AND THAT THE INFORMATION IS CORRECT.

Principal Officer:	
Signature:	
Date:	
Chairperson:	
Signature:	
Date:	
Trustee Signatory:	
Signature:	
Date:	

Part 12(a)

REPORT BY THE AUDITORS IN TERMS OF SECTION 37 AND 39 OF THE MEDICAL SCHEMES ACT 131 OF 1998

PART A: REPORT OF THE INDEPENDENT AUDITORS TO THE REGISTRAR OF MEDICAL SCHEMES.

We have audited Parts 4 to 9 of the annual statutory return of … (Name of medical scheme) for the year ended (date). This annual statutory return is the responsibility of the trustees. Our responsibility is to express an opinion on this annual statutory return based on our audit. We have initialed the applicable pages of the return for identification purposes.

We conducted our audit in accordance with International Standards on Auditing. Those standards require that we plan and perform the audit to obtain reasonable assurance that Parts 4 to 9 are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in Part 4 to 9 of the annual statutory return. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall statutory return. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, Parts 4 to 9 of the annual statutory return present fairly, in all material respects, the financial position of the scheme at (date) and the results of its operations and its cash flows for the year then ended, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Name
Registered Accountants and Auditors
Chartered Accountants (SA)

Address

Date

Pease take note that Part A is an example only. The applicable audit report must be prepared by the auditor and attached to return as Part 12A.

Part 12(b)

PART B: REPORT OF THE INDEPENDENT AUDITORS TO THE REGISTRAR OF MEDICAL SCHEMES

We have performed certain agreed upon procedures and enumerated below with respect to the compliance by …… (Name of medical scheme) as at (date). Our engagement was undertaken in accordance with the International Standard on Related Services applicable to agreed-upon procedures engagements. Our procedures were performed solely to assist the Registrar in evaluating the compliance by the medical scheme with the Medical Schemes Act 131 of 1998, as amended and the Regulations to the Act, and are summarized as follows:

Guarantee

We have inspected a copy of the guarantee(s) supplied to the Registrar in terms of section 24(5) of the Act and/or regulation 2(1)(j) of the Regulations to the Act; and/or sections 33(3) and 44(9)(b) of the Act.

(Details of exemptions noted)

Billing statements / Invoices

We have:

- Ensured that no dividends, rebates or bonus payments have been made to members in terms of section 26(5) of the Act.

  (Details of exemptions noted)

- Checked invoices for payment date, trace receipt of payment from cashbook to ensure that the payment was received within three days of payment becoming due, in accordance with section 26(7) of the Act; where the scheme failed to receive contributions within three days of payment becoming due, we have ensured that the remedial actions as stipulated in the rules of the scheme have been followed.

  (Details of exemptions noted)

- Checked whether invoices for amounts billed are equal to the registered contributions of the medical scheme's benefit options, in accordance with section 26(11) of the Act.

  (Details of exemptions noted)

Benefit options

Where the medical scheme has more than one benefit option registered, we have ensured that the scheme operates separate accounting records for every option (sections 33 and 37(4)(d) of the Act).

(Details of exemptions noted)

Investments

We confirm that according to the information and explanations given to us and as shown in the books and records of the scheme, the investments were made in accordance with the provisions of section 35(4), section 35(5), section 35(8) as well as regulation 30 read together with Annexure B of the Regulations to the Act.

(Details of exemptions noted)

Financial arrangements

We confirm that prior approval has been obtained from Council, in terms of section 35(6) of the Act, where the medical scheme has:

- Encumbered its assets.
- Allowed its assets to be held by another person on its behalf.
- Directly or indirectly borrowed money.
- By means of suretyship or any other form of personal security, whether under a primary or accessory obligation, gave security in relation to obligations between other persons.

(Details of exemptions noted)

Audit committee

We confirm that the scheme had an audit committee in operation for the entire financial year, and that the constitution of the audit committee was in line with the provisions of sections 36(10) and 36(11) of the Act.

(Details of exemptions noted)

Fidelity guarantee and professional indemnity

We confirm that the trustees took out and maintained an appropriate level of fidelity guarantee and professional indemnity as stipulated in section 57(4)(f) of the Act. We inspected policy number xxxx, which amounted to Rxxx, and ensured that the premiums were fully paid up.

(Details of exemptions noted)

Payment of benefits

We confirm that the medical scheme paid all benefits owing to members or suppliers of services within the stipulated time frame after the day on which the claim in respect of such benefit was received by the medical scheme, in accordance with section 59(2) of the Act, read together with regulations 6(2)(3)(4) of the Regulations to the Act.

(Details of exemptions noted)

We confirm that the medical scheme did not retain or withheld any payment to a member or supplier for service as a result of late submission or late re-submission of an account or statement, before the end of the fourth month from the last date of the service rendered as stated on the account, statement or claim; or during which such account, statement or claim was returned for correction (regulation 6(1) of the Regulations to the Act).

(Details of exemptions noted)

Non-accumulation of benefits

We confirm that the medical scheme did not provide for the accumulation of unexpended benefits by a beneficiary from one year to the next other than as provided in the personal medical savings accounts, as required by regulation 9A of the Regulations to the Act.

(Details of exemptions noted)

Personal Medical Savings Accounts

Where the medical scheme operates personal medical savings accounts, we have ensured that the rules of the scheme provide for the operation of such accounts (section 30(1)(e) of the Act).

(Details of exemptions noted)

Where the medical scheme operates personal medical savings accounts, we have ensured that an individual account for every applicable member has been kept in the accounting records.

(Details of exemptions noted)

We ensured that the amounts paid into a member's savings account did not exceed 25% of the registered gross contributions made in respect of the member during the financial year. (regulation 10(1) of the Regulations to the Act).

(Details of exemptions noted)

We ensured that credit balances in a member's personal medical savings account were timeously transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be, when such member changed medical schemes or benefit options during the financial year. (regulation 10(4) of the Regulations to the Act).

(Details of exemptions noted)

We confirm that where a member terminated his or her membership of the medical scheme or benefit option and enrolled in another benefit option or medical scheme without a personal medical savings account, or did not enroll in another medical scheme, the credit balances in the member's personal medical savings account were taken as a cash benefit (regulation 10(5) of the Regulations to the Act).

(Details of exemptions noted)

We confirm that the funds in the member's medical savings account were not used to pay for the costs of a prescribed minimum benefits, as required by regulation 10(6) of the Regulations to the Act.

(Details of exemptions noted)

Written Agreements

We have inspected written agreements entered into by the scheme with administrators and/or managed care organisations to ensure that the agreements provide for the scope and duties of the administrator/managed care organisation, the basis on which the administrator/managed care organisation is to be remunerated and the basis for termination of the agreements (regulations 15, 18 and 19 of the Regulations to the Act).

(Details of exemptions noted)

Compensation of brokers

We confirm that no person was compensated by the medical scheme in terms of section 65 of the Act for acting as a broker unless such person had a prior written agreement with the medical scheme and was accredited by the Council for Medical Schemes. (regulation 28(1) and 28B of the Regulations to the Act).

(Details of exemptions noted)

We confirm that all amounts paid to brokers by the medical scheme were in terms of regulations 28(2) and 28(5) of the Regulations to the Act.

(Details of exemptions noted)

Because the above procedures do not constitute either an audit or a review made in accordance with International Standards on Auditing or International Standards on Review Engagements, we do not express any assurance on the compliance as of (date).

Had we performed additional procedures or had we performed an audit or review of the financial statements in accordance with International Standards on Auditing or International Standards on Review Engagements, other matters might have come to our attention that would have been reported to you.

Our report is solely for the purpose set forth in the first paragraph of this report and for your information and is not to be used for any other purpose or to be distributed to any other parties. This report relates only to the matters specified above and does not extend to any financial statements of …. (Name of medical scheme), taken as a whole.

Name

Registered Accountants and Auditors

Chartered Accountants (SA)

Address

Date

APPENDIX 2: The University of KwaZulu-Natal, College of Health Sciences Postgraduate Education Committee Masters in Medicine (Public Health) approval

UNIVERSITY OF KWAZULU NATAL

COLLEGE OF HEALTH SCIENCES

NELSON R MANDELA SCHOOL OF MEDICINE

MEMORANDUM

TO:	FROM:
Professor I Moodley Health Outcome Research Unit DDMRI Nelson R Mandela School of Medicine	Nomsa Ndlovu Postgraduate Administration Nelson R Mandela School of Medicine 7 March 2008

Dear Professor Moodley

PROTOCOL: A Health Expenditure Review of the South African Private Health care Sector for the financial years 2003/04-2005/06.
Nadesan-Reddy N, student number 973124603, MMed,Community Health.

Protocol number: Ref.: PGR 006/07

The Postgraduate Education Committee considered the above application your responses to the queries regarding your proposal. The protocol is given full approval for your MMed degree. To conduct a study in various Health Care facilities you require permission from their Hospital managers.

Please note that the study **needs to be submitted for ethics approval**.

May I take this opportunity to wish you every success with your study.

Yours sincerely,

Nomsa Ndlovu
Postgraduate Administration

cc: Dr N Nadasen-Reddy, Department of Community Health, Nelson R Mandela School of Medicine

APPENDIX 3: The University of KwaZulu-Natal Biomedical Research Ethics Committee expedited approval

UNIVERSITY OF
KWAZULU-NATAL

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office
Room N40 - Govan Mbeki Building
University Road, WESTVILLE CAMPUS
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email:ngwenyap@ukzn.ac.za - Website: www.ukzn.ac.za

16 May 2008

Dr N Nadesan-Reddy
Public Health Medicine
Nelson R Mandela School of Medicine
University of KwaZulu-Natal

PROTOCOL: A Health Expenditure Review of the South African Private Health care Sector for the financial years 2003-2006.Public Health Medicine. Dr. Nisha Nadesan-Reddy.BE027/08

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 21 February 2008.

The study is given full ethics approval and may begin as at today's date: **16 May 2008.**

This approval is valid for one year from **16 May 2008.** To ensure continuous approval, an application for recertification should be submitted a couple of months before the expiry date. In addition, when consent is a requirement, the consent process will need to be repeated annually.

I take this opportunity to wish you everything of the best with your study. Please send the Biomedical Research Ethics Committee a copy of your report once completed.

The sub-committee's decision will be RATIFIED at a full sitting of the Biomedical Research Ethics Committee meeting to be held on **10 June 2008.**

Yours sincerely

Prof D Wassenaar
Chair: Biomedical Research Ethics Committee

APPENDIX 4: The University of KwaZulu-Natal Biomedical Research Ethics Committee recertification approval

UNIVERSITY OF
KWAZULU-NATAL

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/ResearchEthics11415.aspx

30 March 2009

Dr N Nadesan-Reddy
Public Health Medicine
Nelson R Mandela School of Medicine
University of KwaZulu-Natal

Dear Dr Reddy

PROTOCOL: A Health Expenditure Review of the South African Private Health care Sector for the financial years 2003-2006.Public Health Medicine. Dr. Nisha Nadesan-Reddy.BE027/08

RECERTIFICATION APPLICATION APPROVAL NOTICE

Approved: 16 May 2009
Expiration of Ethical Approval: 15 May 2010

I wish to advise you that your application for Recertification dated 25 March 2009 for the above protocol has been noted and approved by a sub-committee of the Biomedical Research Ethics Committee (BREC) for another approval period. The start and end dates of this period are indicated above.

If any modifications or adverse events occur in the project before your next scheduled review, you must submit them to BREC for review. Except in emergency situations, no change to the protocol may be implemented until you have received written BREC approval for the change.

The approval will be **ratified** by a full sitting of the Committee at a meeting to be held on **14 April 2009.**

Yours sincerely

Ramnarain

Ms D Ramnarain
Senior Administrator: Biomedical Research Ethics