



RESOLUTION
underwriters

SUBMISSION

IN RESPONSE TO

DRAFT REGULATIONS
ON DEMARCATION BETWEEN HEALTH INSURANCE POLICIES
AND MEDICAL SCHEMES

SUBMISSION DATE: 23 APRIL 2012



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23 April 2012

For Attention:

National Treasury

By E-Mail: STDemarcation@treasury.gov.za

Re: Submission in Response to Draft Regulations on Demarcation between Health Insurance Policies and Medical Schemes

Attached please find our submission in response to the above Draft Regulations for your consideration.

Sincerely

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1. Overview

It is our understanding that the draft Demarcation Regulations (Hereinafter the “Regulations”) published on 2 March 2012 aims to establish clear guidelines for both Short-Term Insurers and Medical Schemes in what the appropriate role for each would be. Additionally the Regulations aim at protecting Medical Schemes and its membership.

It is imperative that these Regulations protect, rather than impede, consumers and Medical Scheme Members. We believe that the Regulations fall short of this ideal.

We therefor submit herewith our comments on the Regulations and its likely impact.

2. The current state of affairs.

These are various factors making healthcare coverage increasingly expensive and inaccessible for South Africans.

Both Medical Schemes and Short-Term Insurance (Accident and Health) policies are important enablers for consumers to access private healthcare. Only a marginal portion of South Africans are Medical Scheme Members and the proportion has and will remain relatively stable. New entrants into the market mainly enter restricted Schemes, mostly through the Government Employees Medical Scheme, and not open schemes. The larger problems of poor cross-subsidisation are more evident in open schemes.

The growth rate as reported by the Council of Medical Schemes (CMS) bears out the assertion that there is not likely to be a massive spike in the uptake of Medical Scheme Membership, even if all Accident and Health Short-Term Insurance products are removed from the market.

Medical Scheme membership is not compulsory, and less than 17% of South African citizens belong to a Medical Scheme. Medical Scheme Members, like all consumers, have been

adversely affected by the economic climate and many members are as a result downgrading to lower-cost options.

Section RR, page 31 of the 2010-2011 Annual Report from the CMS (**Annexure A**) confirms that their research indicates the main reason for member buy-down as being affordability.

Consumers increasingly tend to opt for hospital plans instead of full comprehensive medical plans. In addition to the affordability issues consumers are also increasingly willing to manage their day-to-day expenses to a larger extent. (This is in any event part of their responsibly on many comprehensive Medical Schemes as consumers are required to manage their medical savings accounts themselves.)

There is ever increasing pressure on our under-resourced, oversubscribed Public Healthcare System which will be monumentally exacerbated if consumers are forced to relinquish scheme membership due to the increasing cost and decreasing benefits offered.

Section RO, page 163 of the 2010-2011 Annual Report from the CMS (**Annexure B**) state *"While expenditure on medical specialists has been increasing steadily since 2000, a trend-break occurred in 2004 with expenditure on specialists starting to increase at a much higher rate"*.

This statement clearly links back to the removal of cost containment methods such as collective bargaining, The Health Professions Council South Africa (HPCSA) ethical tariff list and most importantly the National Health Reference Price List (NHRPL) from the system. In effect there is now no limit on the fees that a healthcare practitioner can charge. The only benchmark other than the NHRPL is the "maximum ethical fees" published by the HPCSA and these are most definitely not limited to any "Medical Scheme Rate".

Cost studies performed by the Healthcare profession for the Reference Price List process in any event indicated that professional fees should be between two and three times the then Reference price rate. Practitioners will continue to charge rates that is acceptable and reimburses them commensurate to their skills, investment in their practices and which

allows them to earn an income that they perceive as fair. The blanked enforcement of any rate is not a solution to the perceived gap in the rate at which Medical Schemes reimburse practitioners versus their charges.

Whilst this is already an alarming state of affairs it is by no means exhaustive of the extent of the problem. In reality the vast majority of practitioners charge in excess of Medical Scheme rates with a significant amount charging well in excess of the “maximum ethical fees”. Consumers in effect can therefore have an open-ended liability for healthcare cost which is clearly not in their interest.

3. Accident and Health Short-Term Insurance

Accident and Health Short-Term Insurance is any form of insurance compensating an individual for loss as a result of an accident or illness.

The amalgamating of all Accident and Health products under a single “umbrella” leads to significant confusion in the market and amongst consumers. The Regulations and the subsequent comments in the media make it clear that these differing products should be treated as exactly that.

It is not an apples-with-apples comparison to place hospital insurance plans next to a Gap Cover Product and treating the two as similar.

It is therefore prudent to clarify that our comments herewith relates to Gap Cover and Co-Payment Cover Products, which should be clearly distinguished from products classified as “Top-up” covers.

3.1. Available products

Differing Product Offerings currently available include, but are not limited to:

- Hospital Cash Back products
- Hospital Short-Term Insurance products
- Top-Up Cover products
- Co-Payment / Deductible Cover products
- Gap Cover products

3.1.1. Hospital Cash Back products

These products are designed to provide cover at a set amount per day for hospitalisation, usually exceeding a certain time period. This amount is not necessarily related to the actual cost of hospitalisation.

3.1.2. Hospital Short-Term Insurance Products

Hospital Short-Term Insurance products are designed to pay out a stated benefit that is linked to specific procedure or diagnoses. Again, these stated benefits are not necessarily related to the actual cost of hospitalisation.

Both Hospital Cash Back products and Hospital Short-Term Insurance products are still classified as Accident and Health Short-Term Insurance policies under the Regulations. Products under Category 1 of the Regulations are far more likely to be perceived as replacement products for a Medical Scheme, especially so in a market where the average consumer has very little insight in to the actual cost of healthcare.

It is our contention that these products pose a significant risk to Medical Schemes as replacement products.

3.1.3. Top-Up Cover Products

Top –Up Cover products can provide cover in one of two ways:

3.1.3.1. Overall Annual Limit cover is designed to provide additional cover once the overall annual hospital limit on the Medical Scheme has been reached where further hospitalisation is then covered by the Top-Up Cover product.

3.1.3.2. Sub-Limit Cover is designed to provide cover once the insured exhausts a sub-limitation imposed by a Medical Scheme (for instance on a specific disease class). Additional treatment under the sub-limit imposed by the Medical Scheme is then covered by the Top-Up Cover product.

These products are excluded from the definition of Accident and Health Short-Term Insurance products in the Regulations. It is again our contention that these products do pose a risk to Medical Schemes as it might encourage scheme members to buy-down onto a lower cover option which can be enhanced with one of these products.

3.1.4. Co-Payment / Deductible Cover Products

Co-Payment / Deductible Cover products are designed to cover the co-payments/deductibles imposed in terms of Medical Scheme rules. These excesses may be either procedure related or admission related.

Co-Payment Cover products are completely distinct from “Top-Up Cover” insurance or hospital insurance plans and should be treated as such.

3.1.5. Gap Cover Products

Gap Cover Products are designed to cover the difference between the Medical Scheme Rate and Private Rates charged by Healthcare Professionals for in-hospital treatment.

Gap Cover Products are completely distinct from “Top-Up Cover” insurance or hospital insurance plans and our contentions are outlined in our submission.

These products are currently excluded from the Regulations although they do not pose any of the risks the Regulation aim to address. Our further submissions address this contention.

4. Foundation of the reasoning behind the Regulations.

Schedule B, Point 3 of the Regulations clarifies the Policy principles that informed the Regulations as follows:

4.1. To support and enhance the objectives and purpose of the Medical Schemes Act (MSA) (community rating, open enrolment and cross-subsidisation)

Whilst progress has been made in the Medical Schemes Industry on achieving the principles of community rating and open enrolment the fragmented option design and non-implementation of the Risk Equalisation Fund is widely accepted as the biggest reason for cross-subsidisation not effectively being achieved. Constant referral to Accident and Health Short-Term Insurance policies being the biggest risk to Medical Schemes in this regard is completely unfounded in reference to Gap Cover Products.

Gap Cover Products can and should not be judged on the criteria used for Medical Schemes. The entire purpose of the Regulations is to differentiate Medical Schemes and Short-Term Insurance policies. To apply cross-judgement then to Short-Term Insurance products is counterproductive and will only serve to further muddle the waters on product differentiation.

4.2. To counter the possible negative effect Accident and Health Short-Term Insurance policies may have on Medical Schemes

As stated *"Accident & Health Policies may result in –*

- *Younger and healthier persons terminating, limiting or reducing their Medical Scheme cover*
- *A negative impact on the life-cycle protection offered by Medical Schemes*
- *Medical Schemes reducing benefits"*

The wording of the Regulations is indicative of the uncertainty of this statement.

There is no empirical evidence that the existence of the majority of Accident and

Health policies have any impact on the decisions of consumers to enter the Medical Scheme market.

Section RR, page 37 of the 2010-2011 Annual Report from the CMS (**Annexure C**) indicates the average Principal Member's Gross Contribution to Medical Schemes at R1 467, 00 per principal member per month.

If one takes account of Scheme Options offered at this average contribution rate the reimbursement rate for practitioners in hospital is 100% of the Scheme rate, most often also linked to a specified network of providers.

The average Scheme member therefor has only the Scheme rate as benefit and any charge in excess of this amount is for the pocket of the scheme member. In essence the average Medical Scheme member will have an out of pocket expense amount that is charged in excess of the scheme rate.

Scheme Options offering reimbursement of in-hospital practitioners at 200% or more of the Scheme rate is priced significantly higher.

This can be evidenced from a breakdown in the most subscribed Medical Schemes' membership as well as the most subscribed Medical Scheme Options.

4.2.1. Most subscribed Medical Schemes

The Annexures to the CMS Annual Report 2010-2011 identifies the most subscribed schemes as Discovery, Bonita's and GEMS (Government Employees Medical Scheme) (**Annexure D & E**).

- The 3 most subscribed Medical Schemes offer 24 Benefit Options.
- Only 7 benefit options will reimburse medical practitioner costs in hospital more than the Medical Scheme rate.
- Only 2 of these options will reimburse practitioner costs at more than 200%.

- 17 of the 24 options will reimburse only 100% of the Medical Scheme rate for practitioner charges.
- The overall average contribution over the 24 options amounts to R1 575, 21.
- The overall average premium allocated to a Medical Savings Account (MSA) across the 24 options amounts to R175.00.

To increase the cover to an option that will provide cover in excess of the Medical Scheme rate, the average premium will increase to R2 118, 29.

The average MSA contribution on such schemes will increase to R 442.71. This is an increase of 34.48% on current contributions.

4.2.2. Most Subscribed Medical Scheme Options

The Annexures to the CMS Annual Report 2010-2011 (**Annexure D & E**) identifies the most subscribed Medical Scheme options as:

- (1) GEMS – Emerald,
 - (2) Discovery –Classic Comprehensive, KeyCare Plus, Classic Saver, Coastal Saver, Classic Priority, Coastal Core, Essential Saver and
 - (3) Bonitas Standard and Primary.
- Of the 10 most subscribed Medical Scheme options only 3 options will reimburse medical practitioner costs in hospital at 200% of the Medical Scheme Rate
 - None of the top 10 subscribed options will reimburse practitioner costs to more than 200%.
 - 7 of these options will reimburse practitioner charges to 100% of the Scheme rate only.
 - The average contribution on these 10 options amounts to R1 527.50.
 - The average premium allocated to a Medical Savings Account (MSA) amounts to R208, 00.

Upgrade to options within these Medical Schemes offering reimbursement at 300% would push up the average contribution to R3 205, 00 and the MSA contribution to R 649.00.

This is an overall increase of 109.82% on current contributions.

It is simply out of reach for the majority of scheme members to afford.

In addition to self –funding the Medical Savings account scheme members already have to provide, on the vast majority of scheme options, all additional practitioner charges (in and out of hospital).

It would therefore be questionable to expect any significant buy-up on Medical Schemes where the increased cost does not guarantee that the member would not continue to have significant out of pocket expenses which is now to be coupled with a significantly higher scheme contribution. It is far more likely that consumers will downgrade to lower cost options and merely then maintain their self-funding of additional healthcare expenses.

There is no empirical evidence that consumers will buy-down on options as a result of having Gap Cover Products. In essence consumers view Gap Cover Products as essential additional cover for costs that is not covered by a Medical Scheme but which can amount to a substantial cost to the consumer.

4.3. To ensure that consumer rights are protected and consumers are adequately advised of the difference between Accident and Health Short-Term Insurance versus Medical Scheme Membership.

As stated *“The absence of clear demarcation may result in consumers believing:*

- *That accident and health policies offer the same protection as a Medical Scheme , when in fact the protection is partial and conditional and/or*
- *that accident and health policies are Medical Schemes”*

The wording of the Regulations is indicative of the uncertainty of this statement.

The cover provided under both Gap Cover Products and Co-Payment products is in no way a replacement for a Medical Scheme and is not perceived in the market as such. It is clearly positioned to provide cover completely outside of what a Medical Scheme would do. In fact – Gap Cover Products will only ever cover self-payment portions that a Medical Scheme would not cover.

The preamble to the **Consumer Protection Act 68 of 2008** clearly states the enactment of legislation to:

- *“promote and protect the economic interests of consumers;*
- *improve access to, and the quality of, information that is necessary so that consumers are able to make informed choices according to their individual wishes and needs; and*
- *promote and provide for consumer education, including education concerning the social and economic effects of consumer choices;..”*

In essence denying consumers the ability to provide for costs NOT covered by a Medical Scheme, in addition to already self-funding a Medical Savings Account, cannot possibly fit this description. It is contrary to the economic interest of consumers to be denied the ability to protect their own interests.

A clear need exists to enable consumers to be educated on the extent of exposure they currently have to out-of-pocket expenses, as well as existing mechanisms to address this exposure as they see fit. Additionally it is imperative that cognisance is taken of the devastating economic effect that the withdrawal of this right would have on them.

Consumers will not support a product that does not provide value. It is clear from the amount of Gap Cover Products that exist in the market that consumers are vocal in their support of these products.

Consumers not only want to have the peace of mind that Gap Cover Products provides – they need to have a vehicle of funding the significant shortfalls that they will incur when hospitalised.

Existing legislation under the FAIS Act 37 of 2002 provides for the responsibility of Financial Advisors to adequately explain benefits and products and provide the consumer with the most appropriate product for their needs. Again, with reference to the existence of policies in the marketplace, it is clear that these are valuable products that fill a required need.

Recourse exists under the FAIS act where a consumer is provided with incorrect financial advice. The decrease of focus on the important role of intermediaries within the Medical Schemes market contributes to the poor state of member education on the benefits and limitations that exist within the Medical Scheme sphere.

This is not the case within the Gap market. Costs, benefits and exclusions are clearly disclosed in terms of the applicable legislation. Business is placed through licenced Intermediaries only and, in terms of the Binder Regulations, this will continue to be the state of affairs.

To reiterate - Gap Cover Products are not confused with Medical Scheme Membership and positioning Gap Cover Products as such is not logical.

5. Additional comments

5.1. Constitution of the Republic of South Africa 108 of 1996

Section 27 of the **Constitution of the Republic of South Africa 108 of 1996** outlines the overriding governing principles related to Healthcare:

27. Health care, food, water and social security.-

- 1) *Everyone has the right to have access to –*
 - a) *health care services, including reproductive health care;*
- 2) *The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*

There is no dispute as to the inequality within the Healthcare structures. The Medical Schemes environment is by no means the representative body of the majority of citizens. As such legislation that protects only its rights in comparison to others can and should never be enacted. Whilst there is general agreement that Medical Schemes should be protected the blanket banning of products that allow citizens to access healthcare is contrary to the interest of South Africans.

5.2. Dangers of Self-Funding of healthcare

Benefit options on most Medical Schemes already places primary healthcare into a 'self-managed' saving component. Once the members' *own* funds in this pool are depleted such a member would have to continue *self-funding* any required care whilst still having to fund a Medical Scheme contribution.

In effect members who are unable to fund their own care will hold off on procedures or tests which, as early intervention, would enable the member to access appropriate health care timeously.

These members therefor only access healthcare when they have no other choice, at a point where they are evidentially ill. As such the treatment period and intensity would be much higher, resulting in higher costs to both the member and the Medical Scheme.

The same principles apply to scheme members who are unable to fund the self-payment gap on Medical Scheme co-payments or specialist costs in hospital. In effect, Gap Cover Product policies provide a much needed safety net to enable

members, who are aware that their costs will not be covered by their Medical Schemes, and who are unable to fund this shortfall themselves, to access appropriate medical care timeously.

5.3. Prescribed Minimum Benefit (PMB's)

Whilst a laudable objective issues around PMB's must be resolved and contending that this is a cure-all for consumer healthcare is inaccurate.

Much has been made in the media on the *locus standi* finding in the Board of Healthcare Funders (BHF) application regarding PMB's. The fact is that the finding did not address the validity of **Regulation 8 of the Medical Schemes Act** and that this regulation therefor remains open to future challenge. Additionally the PMB condition list has not been reviewed every two years as required, and has not been revised since 2000.

The PMB list is by no means exhaustive of all medical treatment required. In practice benefits for non-PMB treatment will continue to decrease to accommodate the subsidisation of PMB treatment, especially since these have to be paid in full as invoiced.

6. Challenges to the Objectives and purpose of the Medical Schemes Act

6.1. Open enrolment

Open enrolment provides that no one may be declined membership of an open Medical Scheme, irrespective of their age or state of health.

Open enrolment therefor allows the consumer, when he chooses to join a Medical Scheme, to do so. It does not incentivise such a consumer to do so at the earliest opportunity – in fact, it encourages him to do so only when the need arises. The attitude of “I will wait for the NHI / wait until I have a family/don't need it right now”

is well entrenched. Anti-selection is a consistent risk to Medical Schemes as well as insurance companies and is most practiced by pregnant women and those who with serious chronic disease.

As Medical Scheme membership remains non-mandatory for the employed the abolition of Accident and Health policies by itself will not incentivise young people to join Medical Schemes. It is additionally important to note that not all Gap Cover Products impose exclusions based on the age of an applicant. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

6.2. Community rating

Community rating provides that Medical Scheme contribution rates may not differ based on a person's age or state of health.

Again, it is important to note that not all Gap Cover Products require differing contribution rates based on age or state of health. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

6.3. Cross Subsidisation

Cross-Subsidisation aims at offsetting the posed risk of sick, usually older members by subsidising them through the contribution of healthier, mostly younger members. In essence a balance must be found between healthier and sicker members to ensure that a product would remain sustainable.

As previously noted, in the absence of making membership to a scheme compulsory for a large group of people, the tendency to not spend money on such membership until it becomes a necessity will continue.

Yet again, it is important to note that Gap Cover Products rely on the principles of cross-subsidisation as much as Medical Schemes do. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

7. Utilisation experience

During 2010 the average claim submitted amounted to R 3 624.01

During 2011 the average claim submitted amounted to R 4 083.80

This represents an increase of 12.69% in claim amounts.

8. The actual impact

We note with interest the statements contained in the Comments on the National Health Insurance Policy Paper of 12 August 2011 specifically related to current healthcare spend.

Point 14.3, page 42 of the report (**Annexure F**) states:

"..... out-of-pocket payment, which is the most regressive form of healthcare financing, amounts to only 1.5% of GDP in South Africa, way below the international median."

With reference to Table 8 South African Healthcare expenditure in the public and private sectors 2007/08 to 2013/14 (3), page 41 (**Annexure G**) however, no indication is given of the proportion of Healthcare spend that currently is self-funded through Medical Savings Accounts.

Additionally there is no indication as to whether these figures include the current spend through insurance products – rather than only contributions to such products. In essence the current spend is underreported with regards to real Healthcare spend effect from the fees paid by Insurers, the non-reporting of Medical Savings Accounts as well as the real out-of-pocket spend that results from this.

9. Closing

The objectives of open-enrolment, community-rating and cross subsidisation are commendable. So are the principles supporting Prescribed Minimum benefits. Unfortunately various challenges still exist to these principles and objectives and these must be resolved.

To place the blame for these objectives not being met at the door of Short-Term Insurance products is disingenuous at best whilst the damage to the consumer on the removal of such products will be vast.

The Regulations should provide much needed protection to Medical Schemes and its principles – however, to position Gap Cover Product policies as a threat to Medical Schemes and its supporting principles cannot be viewed as a solution.

The Healthcare environment is challenging – all role-players acknowledge this. To provide access to quality healthcare should remain a high priority and this can only be achieved by taking cognisance of all the available mechanisms and utilising these correctly.

It remains our contention that a great deal of uncertainty as to the actual impact of the removal of Gap Cover Products from the definition of Accident and Health policies still remains and must be fully explored.

In the absence of a sensical review of the real impact the Regulations as they stand will cause more harm than good.

The CMS itself has repeatedly acknowledged that affordability of contributions is the biggest barrier to entry into the market. Healthcare costs have consistently increased at levels above inflation and the same is true of contributions and self-payments gaps on Medical Schemes. In addition consumers are increasingly under pressure to fund ever-higher food, transport, electricity and other costs.

In light of the economic environment it would be nonsensical to expect Medical Scheme membership to increase where the income levels of households and individuals are decreasing. Likewise, consumers are unlikely to buy up to higher priced options on Medical Schemes as the benefit of these options is not outweighed by the cost.

It is delusory to state that the reason for consumers not taking up Medical Scheme membership is related to the availability of Gap Cover Products and a review of the Regulations is there for imperative.

Annexure A



How members use healthcare services

This project was a continuation of our efforts to address cost escalation in the private health sector. Our initial objectives was to explore the way in which members of medical schemes use healthcare services and to recommend strategies to reduce cost escalation in the medical schemes industry.

It is important to understand the major trends in the utilisation of healthcare services so as to determine areas of potential cost fluctuations and to recommend appropriate cost control strategies that can be designed and implemented. Recommendations can be made for roll-out in the private health sector.

Our Research & Monitoring Unit compiled a list of 100 medical scheme utilitarians in 1998, which included in- and out-of-hospital care, specialists, diagnostic services and medicines. The primary objective was to select medical schemes, which had been established before the 1990s and based on a non-random sampling technique.

The following way have emerged from the analysis:

- Medical schemes use different information technology (IT) platforms to capture and interpret member information.
- There is a significant trend in how medical schemes and administrators capture data to costs. Some schemes capture data primarily on a fee-for-service basis, while others also include secondary codes.
- For schemes that have access to patients' clinical notes, which makes it difficult for them to collect utilisation data.
- There is no consistent use of all medical reimbursement systems, with some medical schemes using diabolical-related groups (DRGs) and others still on fee-for-service.
- There are vast differences in the reimbursement rates for the different shareholders.
- There are no industry norms or standards on utilisation measures.

The next phase of this project will entail collecting cost utilisation data from medical schemes from which trends will be ascertained.

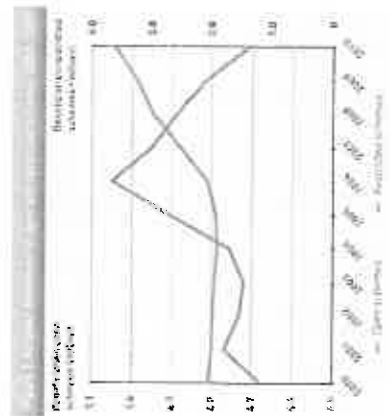
How members move between schemes and options

The Research & Monitoring Unit conducted a study on member movement in the medical schemes in January.

The study explored member movement at both scheme and option level. It looked at movement trends from open to restricted schemes and from high-cost to lower-cost options. The study also analysed the factors which influence members' decisions to change benefit options within their medical scheme.

The research findings confirmed a trend towards consolidation among medical schemes.

Open schemes have experienced a significant loss of members in recent years while membership in restricted schemes has been growing; this can be explained by government employment policy, which is open to restricted schemes.



The study on member movement also revealed the effect of contribution increases on the industry and members of medical schemes when they move between benefit options within their scheme.

The nominal increase in average risk contributions per member benefited by the per scheme financial in 2006/2007 was 10.0% and the comparative figure for 2005/2006 was 11.2% for open schemes, which was slightly higher than restricted schemes.

The average increase for restricted schemes in gross contribution per average beneficiary per month was 3.9% for 2006/2007 and the comparative figure for 2005/2006 was 11.3%.

The contribution increases averaged by schemes in 2007/2010 were 15.7% for open schemes (a deviation of 4.2% from the actual increase that the CIRS eventually approved) and 12.2% for restricted schemes (a deviation of 1.1% from the final increase). The considerable difference between these estimated contribution increases and the actual increases in the average contribution in the medical schemes indicates that some members transfer from more contribution options to cheaper options with the consequent effect on contributions; this phenomenon is more pronounced in open schemes.

An online survey was conducted to understand how members of medical schemes choose or change a benefit option. This survey was part of the member movement study and was used to better understand why members move between benefit options. The study revealed that the most common reason why members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options. The other common reason for changing benefit options was limited access to services, i.e. when members felt that they do not have adequate benefits in their current option, they seek out an option that offers the benefits that meet their needs.

Finally, this study on member movement confirmed that medical schemes do calculate and list one another for membership. Very few schemes compete based on efficiency measures when purchasing healthcare for their beneficiaries. Overall, medical schemes still resort to fee-for-service measures and directly increase their contribution to accommodate the ever-increasing healthcare costs.

Practice Code Numbering System (PCNS)

Regulation 5 of the Medical Schemes Act requires suppliers of healthcare services to include a practice code number on accounts submitted to medical schemes for payment.

The CIRS accordingly has the responsibility to ensure that a system is in place for the issuing of such practice code numbers.

Currently the Practice Code Numbering System (PCNS) is controlled out to the Board of Healthcare Funders of Southern Africa (BHFA).

The CIRS monitors on a quarterly basis the key statistical information about all providers registered in the PCNS.

Annexure B

Healthcare benefits paid from medical savings accounts

Healthcare benefits paid from medical savings accounts amounted to R13.3 billion (10.0%) of total benefits in 2010.

Figure 21 shows that clinicians took up the largest share of medical savings accounts expenditure in 2010 (34.2%). Medical specialists accounted for 19.3% and 67% for 14.1%.

Supplementary benefits providers took 16.1% of the benefit paid from medical savings accounts.

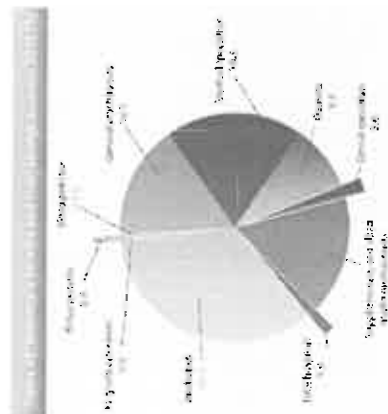
As in previous years, expenditure on hospital and dental specialists accounted for a comparatively small proportion of benefits paid from medical savings accounts (1.5% and 2.6% respectively).

Trends in total healthcare benefits paid

Figure 21 shows the distribution of healthcare benefits paid by medical schemes to different types of providers since 2000. These figures have been adjusted for inflation.

By 2010, medical scheme expenditure on private hospitals had increased in real terms by 121.0% to R30.2 billion compared to R13.2 billion in 2000. Private hospital expenditure accounted for 27.9% of all healthcare benefits paid in 2000; the comparative figure in 2010 was 24.0%.

Expenditure on private hospitals appeared to stabilise around 2006 and 2008 but a strong upward trend began to emerge in 2009, mirroring that in 2010 private hospital expenditure accounted for 30.4% of all healthcare benefits paid by medical schemes; this was slightly less than the 31.7% noted in 2009.



Benefits paid to medical specialists in 2010 amounted to R18.8 billion, an increase of 107.4%

in real terms when compared to the R9.2 billion that was spent on this item in 2000. While expenditure on medical specialists has been increasing steadily since 2000, a trend-break occurred in 2004 with expenditure on specialists starting to increase at a much higher rate.

Expenditure on medicines increased by 11.1% to R14.0 billion in 2010 from R12.6 billion in 2000 but as a proportion of total healthcare benefits, it decreased from 27.0% in 2000 to 17.0% in 2010. In 2009-2010, medicines expenditure remained consistently at 17.0% relative to all benefits paid.

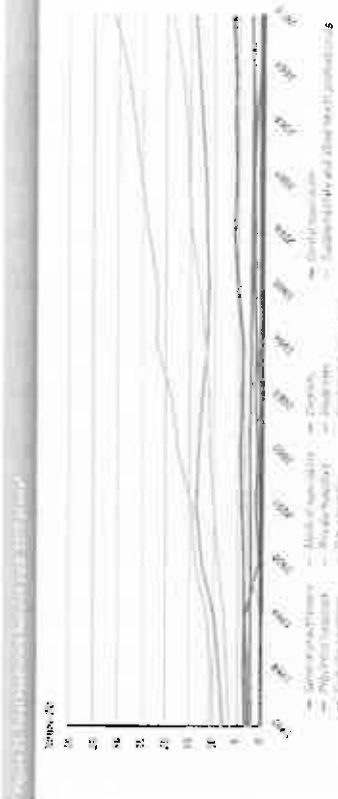
Total expenditure on GPs amounted to R6.2 billion in 2010, which is an increase of 63.2% compared with the R3.8 billion spent in 2000. There was an increase of 4.2% on benefits paid to GPs from R2.4 billion in 2009 to R2.5 billion in 2010.

Healthcare benefits paid per beneficiary

Figure 22 shows the changes in healthcare expenditure per beneficiary per month (pbpm) from 2000 to 2010.

When adjusted for inflation and membership, expenditure on private hospitals increased by 76.4% from R172.9 pbpm in 2000 to R306.0 pbpm in 2010. An upward trend could be observed between 2000 and 2004, followed by almost stabilisation in 2004-2005. From 2005 the trend in private hospitals expenditure per beneficiary per month started accelerating remarkably and the steep upward trend continued in 2010.

After peaking in 2006, expenditure on medicines continued to decline until 2007. It was



Source: Medical Schemes Association, based on data from the Department of Health, 2011.

Annexure C

Details of scheme	Open to members since	Approved to receive benefits	2010
Spouses registered in January 2010	174	188	532
Private insurance	0	0	0
Not participating in the open scheme, private and restricted schemes, restricted schemes	4	2	11
Child and adult dependent, adult dependent	0	0	0
Non-UK (none)	7	0	0
UK (none)	0	0	0
Approved to receive benefits	140	145	236
Approved to receive benefits	171	145	316

• There is a significant increase in the number of people who are approved to receive benefits in the open scheme.

open and restricted schemes to determine whether this deviation from the norm was a one-off occurrence or the beginning of a new trend.

The above table above also highlights the fact that the average family contribution in restricted schemes is 11.5% lower than in open schemes. This substantiated the purpose of restricted schemes that they are able to provide medical scheme benefits at a lower affordable level than open schemes can.

The fact that restricted schemes have, for the first time, increased their contributions by more than open schemes have is concerning because if this could be taken up, the differential between open scheme contributions and restricted scheme contributions may reduce. This in turn raises the issue whether it is preferable to have restricted schemes in an environment where the financial soundness of lower contribution schemes is jeopardised by the various challenges facing the industry.

The more contribution increases in restricted schemes, the more of principal members and adult and child dependants in medical schemes. The information in this section is a summary based on medical scheme submissions in respect of the annual benefit

changes and contribution increases for 2011; it is based on projections in these submissions.

The average gross contribution increase was 9.1% per principal member, 9.4% per adult dependent and 8.1% per child dependent. In open medical schemes, it was 9.1% per principal member, 9.4% per adult dependent and 8.0% per child dependent. In restricted medical schemes, it was 10% per principal member, 9.7% per adult dependent and 9.7% per child dependent.

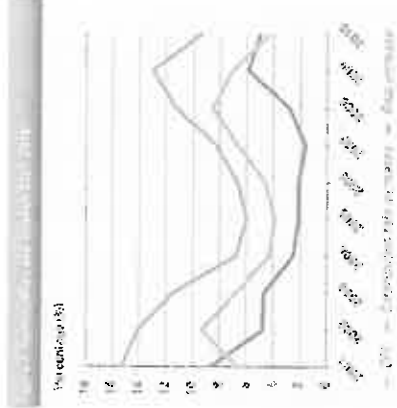
Risk contributions: year-on-year percentage rate changes

The average risk contribution increase for all medical schemes in 2011 was 9.1%. The comparative increase for open and restricted schemes were 9.7% and 9.7% respectively.

The average risk contribution increase was 8.9% per principal member, 9.5% per adult dependent and 9.6% per child dependent. The principal member, adult dependent and child dependent risk contribution percentage increase for open scheme was 9.2%, 9.2% and 8.6% respectively. The principal member, adult dependent and child dependent risk contribution percentage increase for restricted schemes was 9.3%, 9.1% and 10.1% respectively.

Contribution rates relative to general price indicators

Figure 3 shows the historical and current trends in the Consumer Price Index (CPI) (inflation) relative to contribution rates in medical schemes between 2001 and 2010. We also incorporated the real increase in medical scheme contribution (amount by which medical contribution increases are greater than inflation).



Our research shows that since the year 2002, medical scheme contributions have been similar to inflation.

The trend noted for the past 10 years, of contribution increases in open schemes being higher than in restricted schemes, was not maintained in the period under review. It is interesting to note that the average real increase in contributions throughout the period 2001 to 2010 is in the region of 0.9%. This is higher than the CPI + 0.3% rise recommended by the Office of Fair Trading for the long-term affordability of the medical schemes industry as increased in future may not necessarily be able to keep pace with contribution increases.

From the graph we can also infer that there were two periods in which the real increase in medical scheme contributions was double the inflation rate

at the time, but in the years 2001 and 2010. This is varying. As a result the contribution rate for 2011 is 10.0% higher than the 2001 contribution rate in real terms. This means that the average medical scheme contribution rate in 2011 is 10.0% higher than the 2001 contribution rate for the top 100 contribution holders removed.

Gross contributions and risk contributions 2011

The average monthly gross contribution for 2011 per principal member, adult dependent, child dependent and family was as follows:

Health risks covered by 2011 member	Principal member	Adult dependent	Child dependent	Family
Open schemes	81.56	81.56	81.56	81.56
Restricted schemes	81.56	81.56	81.56	81.56
All schemes	81.56	81.56	81.56	81.56

The average monthly risk contribution for 2011 per principal member, adult dependent, child dependent and family was as follows:

Health risks covered by 2011 member	Principal member	Adult dependent	Child dependent	Family
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All schemes	81.56	81.56	81.56	81.56

Non-health expenditure increases compared to gross contribution increases

The average increase in total non-health expenditure – which includes administrative costs associated with collecting contributions and paying out benefits, printing costs associated with scheme brochures and benefit guides, the cost of funding call centres and legal costs – for all medical schemes in 2011 was 6.8%. The comparative increase for open and restricted schemes were 5.6% and 7.1% respectively.

The principal member, adult dependent and child dependent non-health cost increase for all medical schemes were 6.3%, 6.4% and 5.9% respectively.

Annexure D

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641	2642	2643	2644	2645	2646	2647	2648	2649	2650	2651	2652	2653	2654	2655	2656	2657	2658	2659	2660	2661	2662	2663	2664	2665	2666	2667	2668	2669	2670	2671	2672	2673	2674	2675	2676	2677	2678	2679	2680	2681	2682	2683	2684	2685	2686	2687	2688	2689	2690	2691	2692	2693	2694	2695	2696	2697	2698	2699	2700	2701	2702	2703	2704	2705	2706	2707	2708	2709	2710	2711	2712	2713	2714	2715	2716	2717	2718	2719	2720	2721	2722	2723	2724	2725	2726	2727	2728	2729	2730	2731	2732	2733	2734	2735	2736	2737	2738	2739	2740	2741	2742	2743	2744	2745	2746	2747	2748	2749	2750	2751	2752	2753	2754	2755	2756	2757	2758	2759	2760	2761	2762	2763	2764	2765	2766	2767	2768	2769	2770	2771	2772	2773	2774	2775	2776	2777	2778	2779	2780	2781	2782	2783	2784	2785	2786	2787	2788	2789	2790	2791	2792	2793	2794	2795	2796	2797	2798	2799	2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820	2821	2822	2823	2824	2825	2826	2827	2828	2829	2830	2831	2832	2833	2834	2835	2836	2837	2838	2839	2840	2841	2842	2843	2844	2845	2846	2847	2848	2849	2850	2851	2852	2853	2854	2855	2856	2857	2858	2859	2860	2861	2862	2863	2864	2865	2866	2867	2868	2869	2870	2871	2872	2873	2874	2875	2876	2877	2878	2879	2880	2881	2882	2883	2884	2885	2886	2887	2888	2889	2890	2891	2892	2893	2894	2895	2896	2897	2898	2899	2900	2901	2902	2903	2904	2905	2906	2907	2908	2909	2910	2911	2912	2913	2914	2915	2916	2917	2918	2919	2920	2921	2922	2923	2924	2925	2926	2927	2928	2929	2930	2931	2932	2933	2934	2935	2936	2937	2938	2939	2940	2941	2942	2943	2944	2945	2946	2947	2948	2949	2950	2951	2952	2953	2954	2955	2956	2957	2958	2959	2960	2961	2962	2963	2964	2965	2966	2967	2968	2969	2970	2971	2972	2973	2974	2975	2976	2977	2978	2979	2980	2981	2982	2983	2984	2985	2986	2987	2988	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Annexure E



Sl. No.	Particulars	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33	2033-34	2034-35	2035-36	2036-37	2037-38	2038-39	2039-40	2040-41	2041-42	2042-43	2043-44	2044-45	2045-46	2046-47	2047-48	2048-49	2049-50	2050-51	2051-52	2052-53	2053-54	2054-55	2055-56	2056-57	2057-58	2058-59	2059-60	2060-61	2061-62	2062-63	2063-64	2064-65	2065-66	2066-67	2067-68	2068-69	2069-70	2070-71	2071-72	2072-73	2073-74	2074-75	2075-76	2076-77	2077-78	2078-79	2079-80	2080-81	2081-82	2082-83	2083-84	2084-85	2085-86	2086-87	2087-88	2088-89	2089-90	2090-91	2091-92	2092-93	2093-94	2094-95	2095-96	2096-97	2097-98	2098-99	2099-00	2100-01	2101-02	2102-03	2103-04	2104-05	2105-06	2106-07	2107-08	2108-09	2109-10	2110-11	2111-12	2112-13	2113-14	2114-15	2115-16	2116-17	2117-18	2118-19	2119-20	2120-21	2121-22	2122-23	2123-24	2124-25	2125-26	2126-27	2127-28	2128-29	2129-30	2130-31	2131-32	2132-33	2133-34	2134-35	2135-36	2136-37	2137-38	2138-39	2139-40	2140-41	2141-42	2142-43	2143-44	2144-45	2145-46	2146-47	2147-48	2148-49	2149-50	2150-51	2151-52	2152-53	2153-54	2154-55	2155-56	2156-57	2157-58	2158-59	2159-60	2160-61	2161-62	2162-63	2163-64	2164-65	2165-66	2166-67	2167-68	2168-69	2169-70	2170-71	2171-72	2172-73	2173-74	2174-75	2175-76	2176-77	2177-78	2178-79	2179-80	2180-81	2181-82	2182-83	2183-84	2184-85	2185-86	2186-87	2187-88	2188-89	2189-90	2190-91	2191-92	2192-93	2193-94	2194-95	2195-96	2196-97	2197-98	2198-99	2199-00	2200-01	2201-02	2202-03	2203-04	2204-05	2205-06	2206-07	2207-08	2208-09	2209-10	2210-11	2211-12	2212-13	2213-14	2214-15	2215-16	2216-17	2217-18	2218-19	2219-20	2220-21	2221-22	2222-23	2223-24	2224-25	2225-26	2226-27	2227-28	2228-29	2229-30	2230-31	2231-32	2232-33	2233-34	2234-35	2235-36	2236-37	2237-38	2238-39	2239-40	2240-41	2241-42	2242-43	2243-44	2244-45	2245-46	2246-47	2247-48	2248-49	2249-50	2250-51	2251-52	2252-53	2253-54	2254-55	2255-56	2256-57	2257-58	2258-59	2259-60	2260-61	2261-62	2262-63	2263-64	2264-65	2265-66	2266-67	2267-68	2268-69	2269-70	2270-71	2271-72	2272-73	2273-74	2274-75	2275-76	2276-77	2277-78	2278-79	2279-80	2280-81	2281-82	2282-83	2283-84	2284-85	2285-86	2286-87	2287-88	2288-89	2289-90	2290-91	2291-92	2292-93	2293-94	2294-95	2295-96	2296-97	2297-98	2298-99	2299-00	2300-01	2301-02	2302-03	2303-04	2304-05	2305-06	2306-07	2307-08	2308-09	2309-10	2310-11	2311-12	2312-13	2313-14	2314-15	2315-16	2316-17	2317-18	2318-19	2319-20	2320-21	2321-22	2322-23	2323-24	2324-25	2325-26	2326-27	2327-28	2328-29	2329-30	2330-31	2331-32	2332-33	2333-34	2334-35	2335-36	2336-37	2337-38	2338-39	2339-40	2340-41	2341-42	2342-43	2343-44	2344-45	2345-46	2346-47	2347-48	2348-49	2349-50	2350-51	2351-52	2352-53	2353-54	2354-55	2355-56	2356-57	2357-58	2358-59	2359-60	2360-61	2361-62	2362-63	2363-64	2364-65	2365-66	2366-67	2367-68	2368-69	2369-70	2370-71	2371-72	2372-73	2373-74	2374-75	2375-76	2376-77	2377-78	2378-79	2379-80	2380-81	2381-82	2382-83	2383-84	2384-85	2385-86	2386-87	2387-88	2388-89	2389-90	2390-91	2391-92	2392-93	2393-94	2394-95	2395-96	2396-97	2397-98	2398-99	2399-00	2400-01	2401-02	2402-03	2403-04	2404-05	2405-06	2406-07	2407-08	2408-09	2409-10	2410-11	2411-12	2412-13	2413-14	2414-15	2415-16	2416-17	2417-18	2418-19	2419-20	2420-21	2421-22	2422-23	2423-24	2424-25	2425-26	2426-27	2427-28	2428-29	2429-30	2430-31	2431-32	2432-33	2433-34	2434-35	2435-36	2436-37	2437-38	2438-39	2439-40	2440-41	2441-42	2442-43	2443-44	2444-45	2445-46	2446-47	2447-48	2448-49	2449-50	2450-51	2451-52	2452-53	2453-54	2454-55	2455-56	2456-57	2457-58	2458-59	2459-60	2460-61	2461-62	2462-63	2463-64	2464-65	2465-66	2466-67	2467-68	2468-69	2469-70	2470-71	2471-72	2472-73	2473-74	2474-75	2475-76	2476-77	2477-78	2478-79	2479-80	2480-81	2481-82	2482-83	2483-84	2484-85	2485-86	2486-87	2487-88	2488-89	2489-90	2490-91	2491-92	2492-93	2493-94	2494-95	2495-96	2496-97	2497-98	2498-99	2499-00	2500-01	2501-02	2502-03	2503-04	2504-05	2505-06	2506-07	2507-08	2508-09	2509-10	2510-11	2511-12	2512-13	2513-14	2514-15	2515-16	2516-17	2517-18	2518-19	2519-20	2520-21	2521-22	2522-23	2523-24	2524-25	2525-26	2526-27	2527-28	2528-29	2529-30	2530-31	2531-32	2532-33	2533-34	2534-35	2535-36	2536-37	2537-38	2538-39	2539-40	2540-41	2541-42	2542-43	2543-44	2544-45	2545-46	2546-47	2547-48	2548-49	2549-50	2550-51	2551-52	2552-53	2553-54	2554-55	2555-56	2556-57	2557-58	2558-59	2559-60	2560-61	2561-62	2562-63	2563-64	2564-65	2565-66	2566-67	2567-68	2568-69	2569-70	2570-71	2571-72	2572-73	2573-74	2574-75	2575-76	2576-77	2577-78	2578-79	2579-80	2580-81	2581-82	2582-83	2583-84	2584-85	2585-86	2586-87	2587-88	2588-89	2589-90	2590-91	2591-92	2592-93	2593-94	2594-95	2595-96	2596-97	2597-98	2598-99	2599-00	2600-01	2601-02	2602-03	2603-04	2604-05	2605-06	2606-07	2607-08	2608-09	2609-10	2610-11	2611-12	2612-13	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Annexure F

Figure 21: Incomplete cover even in high-end medical schemes (59)



Many members are dissatisfied with this arrangement (59). Note that, even though irritating, in comparison with catastrophic health events, the total cost of day-to-day care per household is not material. The social impact of not having cover for catastrophic events is that many households will become insolvent. Day-to-day care does not result in insolvencies (unless these are lifetime chronic conditions - the PMB chronic conditions are covered in full, while many medical schemes offer extended cover for other chronic conditions).

Figure 20 above shows that out-of-pocket payment, which is the most regressive form of healthcare financing, amounts to only 1.5% of GDP in South Africa, way below the international median. The corresponding percentages in the USA, Korea, Chile, and Ghana are 2.0%, 2.3%, 2.8%, and 3% respectively. This low South African percentage *includes* the out-of-pocket payments to private providers by the public who are not covered by medical schemes. Note that many members who do not belong to medical schemes make use of private providers (51 pp. 83, table 5.5)(12)(15). Through the implementation of NHI and improved service delivery in the public sector, this percentage will reduce.

14.3.2 Medical scheme costs

Paragraph 33 of the green paper (1 p. 11) states that there are very high administrator fees, broker costs and managed care costs, and that these increases have resulted in wage inflation.

Figure 22 (page 44) shows that the bulk of non-health costs are due to administration costs, and amounted to R949 pabpa in 2010. This part of the costs were R521 pabpa in 2000, when the office of the CMS was established, and then grew dramatically to peak at R1,137 pabpa in 2005. Various actions and interventions by the CMS has led thereto that this, and other non-health costs have been reduced to 2002 levels in 2010. Further reductions in these costs are possible through improved governance and broker regulation.

Annexure G

Table 8: South African Healthcare expenditure in the public and private sectors 2007/08 to 2013/14 (3)

Rand million	07/08	08/09	09/10	10/11	11/12	12/13	13/14	Annual real % change ¹⁸
Public sector								
National department of health	1,210	1,436	1,645	1,736	1,784	1,864	1,961	2.2%
Provincial departments of health	62,582	75,120	88,593	98,066	110,014	119,003	126,831	7.0%
Defence	1,878	2,177	2,483	2,770	2,961	3,201	3,377	4.3%
Correctional services	261	282	300	318	339	356	374	0.1%
Local government (own revenue)	1,625	1,793	1,829	1,865	1,977	2,096	2,221	-0.7%
Workmen's Compensation	1,287	1,415	1,529	1,651	1,718	1,804	1,894	0.5%
Road Accident Fund	764	797	740	860	980	1,029	1,080	-0.2%
Education	1,833	2,134	2,350	2,503	2,653	2,812	2,981	2.3%
Total public sector health	71,440	85,114	99,463	108,763	122,416	132,155	140,719	6.3%
Public sector increase on previous year		19%	17%	10%	12%	8%	6%	
Private sector								
Medical schemes	65,468	74,089	84,863	96,482	104,008	112,120	120,866	4.9%
Out of pocket	14,694	15,429	16,200	17,172	18,202	19,294	20,452	-0.4%
Medical insurance	2,179	2,452	2,660	2,870	3,094	3,336	3,596	2.6%
Employer private	1,041	1,172	1,271	1,372	1,479	1,594	1,718	2.6%
Total private sector health	83,382	103,142	104,994	117,826	126,783	135,344	146,632	3.8%
Donors or NGOs	3,835	5,212	6,319	5,787	5,308	5,574	5,852	1.1%
Total	158,857	188,568	210,782	224,452	244,517	264,093	293,213	4.9%
Total as % of GDP	7.6%	7.9%	8.6%	8.8%	8.7%	8.6%	8.3%	
Public as % of GDP	3.4%	3.7%	4.1%	4.1%	4.2%	4.0%	4.0%	
Public as % of total government expenditure (non-interest)	13.9%	14.0%	13.8%	14.1%	14.7%	14.7%	14.6%	
Private financing as % of total	52.6	50.8	49.8	50.5	49.8	49.7	50.0	
Public sector real rand per capita 10/11 prices	2,131	2,300	2,512	2,635	2,766	2,812	2,816	
Public per family of four per month real 10/11 prices	710	767	837	878	922	937	939	

14.2 Key trends in the public sector

Figure 18 (page 41) shows that the growth in expenditure by provincial departments is growing at a faster rate than the growth in expenditure by medical schemes. The implementation of the proposals in section 11.2 (page 18) and section 11.3 (page 22), which will contribute to control expenditure in the private sector, will accelerate this positive trend. An increase in public expenditures to achieve the 15% of total government expenditure in accordance with the Abuja agreement, will further support the correction of the inequitable funding. Such increased funding could be motivated through increased performance (see Recommendation 2, page 14).

¹⁸ This percentage was recalculated based on the latest inflation figures and represent the annual real percentage change from 07/08 to 13/14