

# Chapter 1

## Introduction

If we want things to stay as they are,  
things will have to change

Giuseppe di Lampedusa 1896-1957

Change is no longer linear, but exponential

De Loach, 2000:8

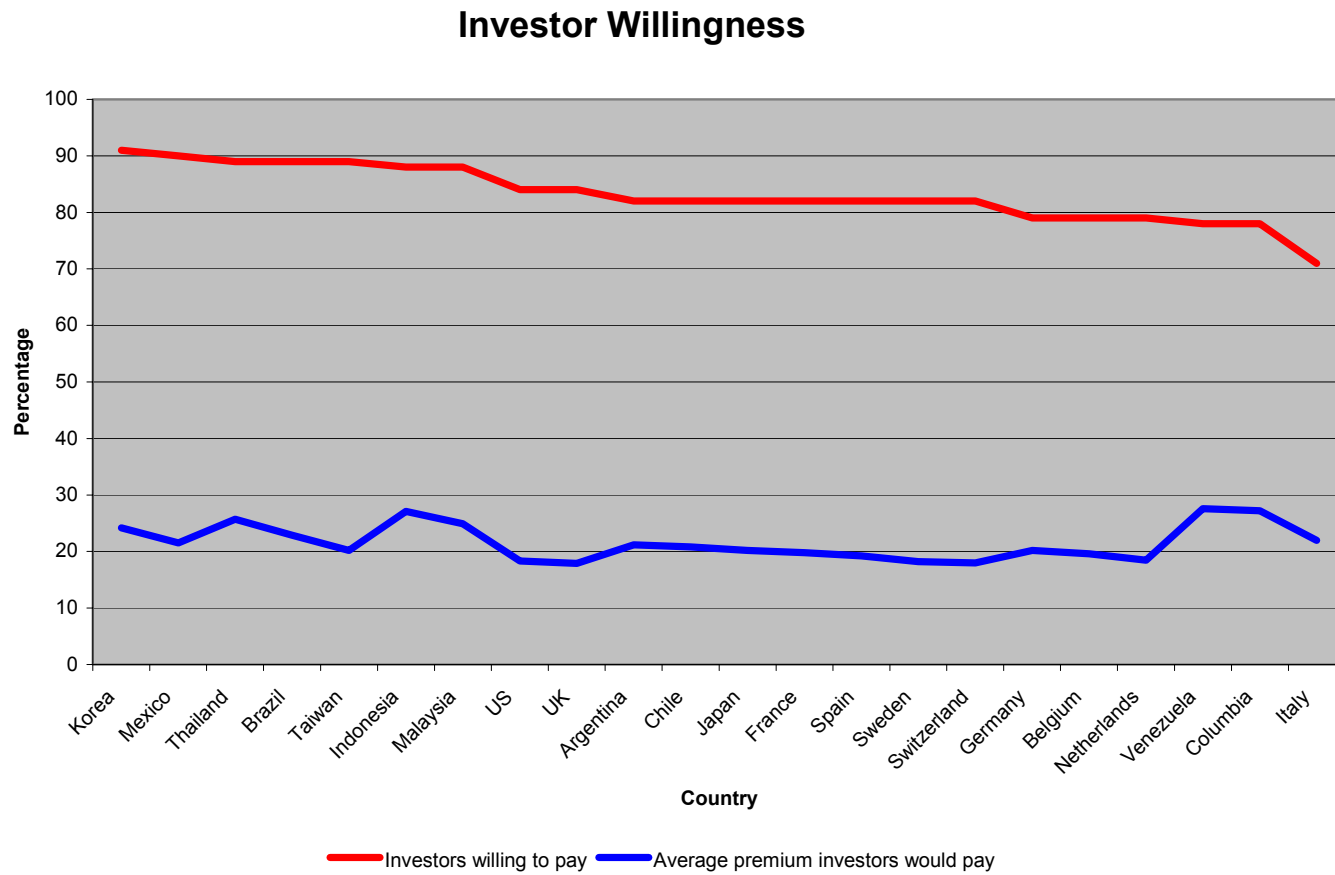
## **1.1 Background**

Constant change in the business environment exposes corporations to new risks that require unique solutions. The types of new risks faced by businesses are considered endless and necessitate the effective coordination of limited resources (Makhari, 2001). New risk types include reputation, e-commerce and earning volatility (De Loach, 2000: 25-28). It is perceived that the only way in which such future challenges can be faced, is to give urgent attention to improving corporate governance standards, standardising risk management techniques and furthering best practice (Makhari, 2001).

Mervyn King commented that international investors are willing to pay a premium for companies with good corporate governance (Chalmers, 2001). King's statement is confirmed by an international study conducted by McKinsey & Company in figure 1.1 below. The study indicates that over 80% of surveyed investors are willing to pay a premium of between 18 to 27% for organisations that administer an effective corporate governance programme. Corporate risk management forms an integral part of such a programme. (Pickford, 2001: 293).

Table 1.1 provides a summary of results from a KPMG corporate governance survey conducted in 2001. In the survey, the importance of risk management amongst other various elements of corporate governance criteria is emphasised. Respondents include approximately 30% of companies listed on the South African JSE Securities Exchange.

Figure 1.1: Investor willingness (McKinsey & Company, 2000)



Since today's fast paced business environment bombards organisations with a diverse array of risk events, organisations are developing a variety of risk management strategies. In this environment, internal auditors have an opportunity to contribute to, or even drive, their client's corporate risk management activities (Roth *et al.*, 2002: 57).

The R30 billion a year private healthcare administration industry in South Africa is undergoing rapid change and faces significant instability (Shevel, 2001). Not only is the environment becoming increasingly complicated, there is also an attendant increase in regulatory oversight (Huntington, 2001). Furthermore, recent newspaper articles relay concerns that private healthcare funders will reserve the right to send their members to public institutions due to the rising costs associated with service provision (Moya, 2003a: 1).

The remaining portion of this chapter will highlight some of the most noteworthy challenges facing the private healthcare industry.

**Table 1.1: Corporate governance priorities (KPMG, 2001)**

<b>Corporate Governance Factor</b>	<b>Increase emphasis (%)</b>
1. Employment equity/transformation	56
2. Succession management	56
3. Management performance and effectiveness	50
4. Organisational performance measures	48
5. Vision and Strategy	47

Continued...

<b>Corporate Governance Factor</b>	<b>Increase emphasis (%)</b>
6. Board composition and leadership	44
<b>7. Risk Management</b>	<b>42</b>
8. Board accountability, remuneration and performance	41
9. Internal control	34
10. Values and ethics	33
11. Internal and external reporting	32
12. Social and community involvement	24
13. Worker participation	22
14. Policy making and compliance	20
15. Environmental issues	20
16. Audit committee functioning	19
17. Compliance with laws and regulations	18

## **1.2 Challenges facing South African private healthcare**

At present, 16% of South Africa's population is supported by private healthcare (Bisseker, 2001: 34). The following significant challenges are facing the private healthcare environment:

1.2.1 Effectively manoeuvring an environment facing continuous volatility in terms of legislative requirements:

- Possible implementation of risk equalisation which would compel medical schemes to compete on the basis of their ability to contain

costs through their benefit structure and by encouraging members to make effective use of healthcare services (Editorial 2001a: Sector braces for social health move).

- Inability to deny health cover to high-risk individuals thereby limiting the medical schemes ability to protect the funds of healthier members (Jackson, 2001). The Medical Schemes Act was revised in 1998 to broaden access to those traditionally denied cover. The immediate impact was a dramatic increase in existing member contributions. Hardest hit were the young and wealthy whose contributions had to be increased by as much as 200% in 2000 to cross-subsidise the sick and old (Financial Mail, 2000: 365). Overall, private healthcare membership has stagnated to approximately 7 million with an overall increase in older members (Bisseker, 2001: 34). In 2003, medical scheme membership is still pegged at 7 million (Kahn, 2003: 1)

It is estimated that 85% of employers who partially contributed towards employee's medical aid contributions noted a rise in such costs following the reform of the Medical Schemes Act. In addition to raising contributions to combat the initial negative impact of the reform, employers were tending to reduce benefits to members (Heard, 2001).

- Raise and manage capital so that the administrator of the medical scheme maintains prescribed solvency ratios. The Regulations to the Medical Schemes Act of 1998 provide that the scheme should maintain accumulated funds, expressed as a percentage of gross annual contributions. Medical aid schemes are required to attain a solvency level of 13.5% of contributions by the end of 2001. By the end of 2002, schemes have to reach a solvency level of 17.5% (Du Preez, 2001).
- The introduction of amnesty periods during which late joiner penalties would not be applied to people who joined schemes for the first time in their lives. The industry estimated that 150 000

families qualified for such amnesty in 2000. The inability of medical schemes to charge penalties for late joining has a dramatic effect on the medical contributions charged to existing contributors of the scheme (Financial Mail, 2000: 366).

Duff & Phelps Credit Rating Co. had the following to say regarding the increased legislative requirements (Financial Mail, 2000: 374):

*“The new act is expected to induce an increase in merger activity as those schemes that are less capable of absorbing these new pressures enter into strategic partnerships and amalgamations... inevitably some schemes will also fall by the wayside.”*

In a research report conducted by the Council of Medical Schemes, the following were identified as additional areas where increased regulatory oversight could be expected (Markdata, 2001: 20):

- Ensure quality services;
- regulate and lower cost of membership;
- act against corruption;
- ensure satisfaction of beneficiaries;
- provide information to beneficiaries;
- ensure rapid claim processing;
- ensure full coverage of costs;
- ensure non-discrimination;
- ensure financial stability of medical schemes;
- act on complaints;
- provide training to beneficiaries;
- regulate governance of medical schemes;
- ensure competence of medical scheme staff;
- ensure full family coverage;
- allow flexibility of payment;
- effective management of chronic illness benefits;
- standardise fees; and

- ensure minimum benefits.

Stakeholders represented in the survey included 16 various industries, e.g. council members, healthcare providers, healthcare administrators and managed care organisations.

1.2.2 In February 2001 a more rigorous auditing and accounting guideline on medical schemes was issued by the South African Institute of Chartered Accountants. The Institute convened a project group representing the broad spectrum of the medical schemes industry to align existing financial reporting by medical schemes with international standards. (Hymans, 2001). The updated guideline addresses issues such as legislation, corporate governance, auditing and uniformity of financial reporting.

1.2.3 To provide cost effective cover to members suffering with terminal diseases such as HIV and AIDS without increasing membership costs of other healthier members (Editorial 2001b: United effort can contain AIDS). Certain nationally accepted projections on South Africa's population for 2020 were initially set at 80 million. These have, however, been revised to roughly 50 million due to the effect of HIV and AIDS (Thomas *et al.*, 2001).

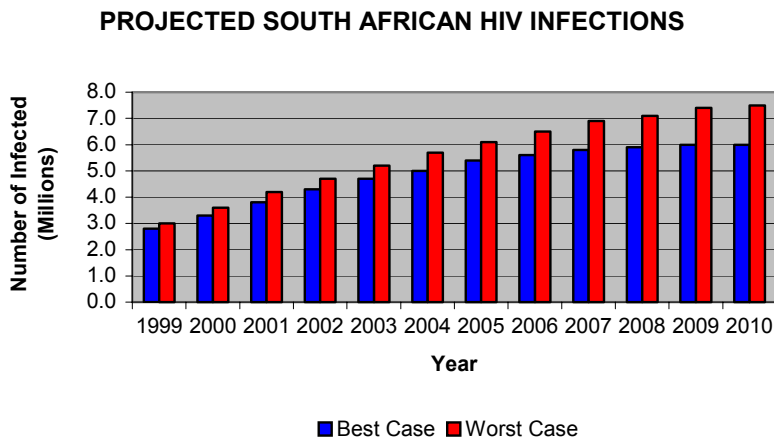
Table 1.2 below provides a comparison between the private and public healthcare sector costs for treating an HIV patient. Figure 1.2 provides projections on the expected increase in HIV infections over the next 10 years.



**Table 1.2: Average cost per patient comparison (SAHR Report, 2000a)**

<i>HIV Development Stages</i>	<i>Average Cost Per Patient (Rands/Yearly)</i>	
	<i>Private Medical Schemes</i>	<i>Public Healthcare</i>
Stage 1 and 2 (Initial)	3 000	1 300
Stage 3 (Advanced)	14 200	6 200
Stage 4 (AIDS)	38 300	17 000

**Figure 1.2: Projected South African HIV infections (SAHR Report, 2000b)**



1.2.4 Increasing prevalence and complexity of service capitation contracts entered into between medical schemes and service providers. (Finger, 1998). Such contracts provide for a per diem rate (i.e. a fixed daily rate as opposed to a charge per item) for procedures that contribute towards the improved management of provider costs. The per diem rates, which were negotiated in 2000, awarded hospital groups an effective 7% increase compared to hospitals demands of 9% (ibid.).

These capitation contracts often form part of a movement in private healthcare referred to as managed care organisations (Academy for Health Care Management, 1999: 2-5).

1.2.5 Dramatic increase in the extent of fraudulent activity by service providers and members within the private healthcare environment (Huntington, 2001). The 1999 KPMG South African Fraud Survey indicated that 86% of respondents from various industries believed that the future extent of fraud would increase (KPMG, 1999: 2). In a similar survey conducted in 2002, 75% respondents believed that fraud would increase (KPMG, 2002: 6). In both surveys, it was indicated that the most appropriate way in which this increase could be curbed was by way of improved internal control.

1.2.6 Maximising operational performance in terms of (Academy of Healthcare Management, 1999):

- Paying service providers accurately and timeously;
- bearing or sharing the risk of not having sufficient funds to support its ongoing operations;
- determining the rates to be charged for its products without violating existing legislative standards;
- planning strategically for growth and expansion of products by continuously scanning the medical needs and requirements of current and prospective members;
- analysing financial markets and information; and
- managing the flow of funds into and out of medical schemes.

1.2.7 Industry is searching for a cost-effective mechanism to provide benefits to an additional 7 million South African blue-collar workers who have jobs but are uninsured.

Many medical schemes have attempted to enter into this low-income market through the use of service capitation contracts but have found it difficult since it involves a switch to a new business paradigm (Financial Mail, 2000: 368). The poor level of service provided by the current public healthcare industry in relation to its private counterpart is increasing pressure on the private industry to identify new ways in entering this volatile market. Tables 1.3 and 1.4 below provide details on the response between current public and private healthcare while Figure 1.3 indicates how the need for the broadening of access to groups previously excluded, is on the increase.

**Table 1.3: Reactions to public healthcare** (Markdata, 2001: 27)

<i>Criteria</i>	<i>%</i>
Public healthcare adequate	9
Public care needs improvement	35
Use of private facilities essential	56

**Table 1.4: Preferred modes of service delivery** (Markdata, 2001: 27)

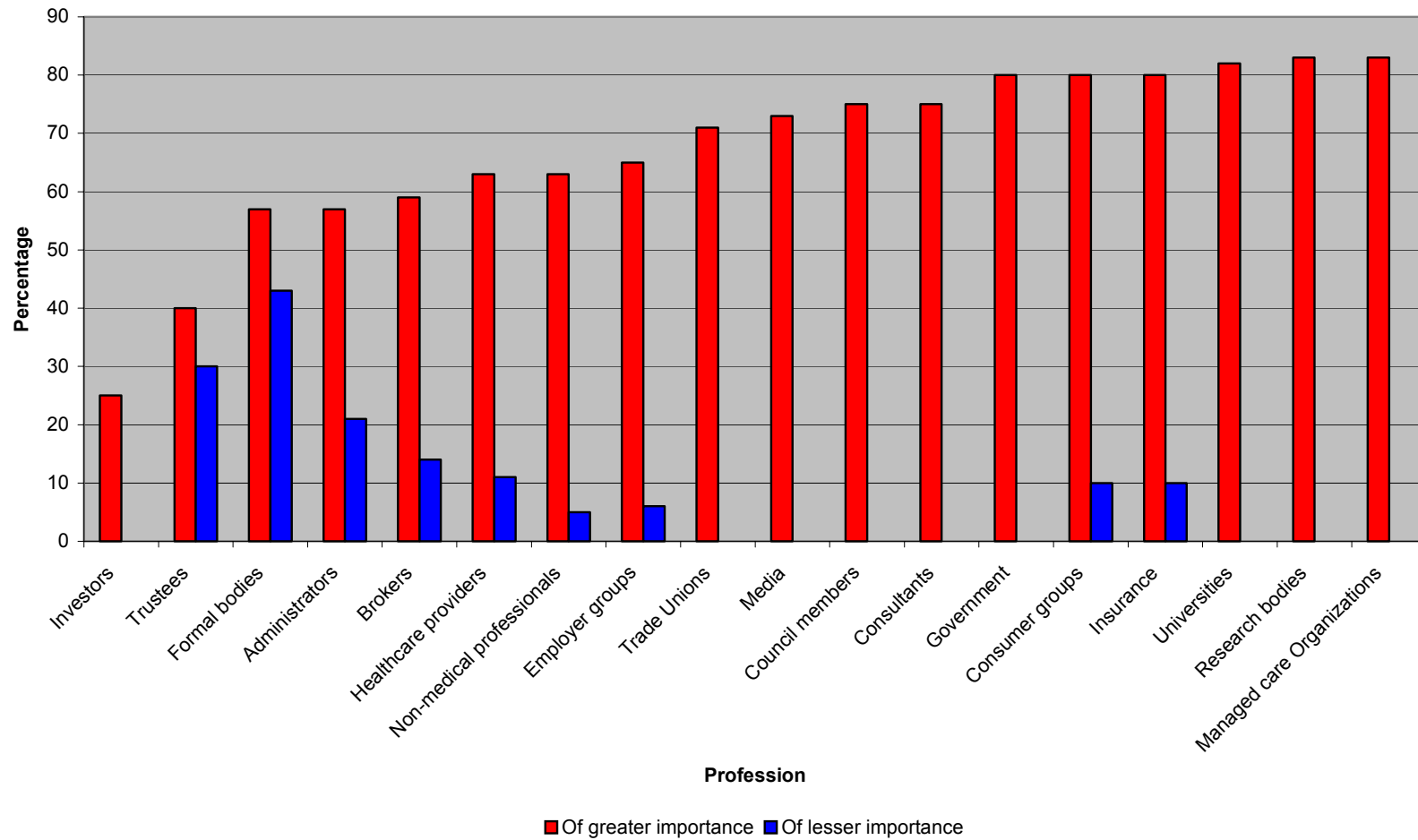
<b>Criteria</b>	<b>%</b>
Private medical schemes	49
Free or low cost public healthcare	19
Health insurance for high costs	18
State subscription based medical scheme	13
Other responses (various)	1

1.2.8 For most of the nineties, medical inflation exceeded general inflation causing health care benefits to consume almost 10% of the average employer's payroll costs. For the 2001 year, most schemes increased their contribution rates by 17% on average. Since employers can no longer afford such substantial increases, many will seek ways of reducing medical benefits to contain costs. It is expected that, should such trends continue, a member may be spending almost 30% of his or her salary on medical aid by 2009 (Bisseker, 2001: 34). Over the past decade premium increases have generally exceeded the Consumer Price Index (CPI) by 5%. For 2003, medical premiums are set to rise between 12% to 18%, whereas CPI is expected to be between 7% to 7.5% (Kahn, 2003: 1).

In a bid to ease the rampant increase in medical premiums, new regulations will take affect under the Medical Schemes Act at the start of 2004. These new regulations will give private healthcare funders the right to force members to use public hospitals for certain conditions, including some conditions which are expensive to treat (Moya *et al.*, 2003b: 3). Illnesses for public care include (ibid.):

- Asthma;

**Figure 1.3: Broadening access to groups previously excluded (Markdata, 2001: 49)**



- glaucoma;
- epilepsy;
- drug addiction;
- Parkinson's disease;
- HIV testing, antiretroviral prophylaxis after rape or exposure to HIV; and the prevention of maternal transmission of HIV.

1.2.9 To meet the challenges of containing medical inflation and extending medical cover to lower income groups, scheme administrators require up to date data on claiming patterns, trends, pricing movements, utilisation variations and cash flow. (Editorial 2001c: The age of cost busters). This will drive many healthcare administrators to employ complex and risky mathematical models and information systems to ensure survival and benefit optimisation for members.

From the above challenges it is seen that the private healthcare administration organisation faces some significant risks now and into the future. Healthcare financiers will need to develop more innovative methods and risk management processes to ensure that members are provided with the most comprehensive benefits at the lowest cost possible (Huntington, 2001).

### **1.3 Purpose and reason for study**

#### *1.3.1 Purpose of study*

The purpose of this study will be to:

- identify risks facing the South African private healthcare administrator, and
- develop a suitable corporate risk management programme for the industry.

The study will be approached from the perspective of the internal auditor, with suitable insights and suggestions made from this standpoint.

### 1.3.2 Reason for undertaking study

Based on an evaluation of South African healthcare administration literature relating to corporate risk management, it would seem that little attention has been given to this field of study. The following specific areas of weakness have been identified<sup>1</sup>:

- Slowness of South African healthcare private administrators in adopting corporate risk management;
- increased regulatory risks that could be effectively addressed by a corporate risk management programme;
- slowness of professional bodies in promoting corporate risk management as one of the key processes within business management; and
- lack of industry awareness regarding developments in the field of corporate risk management based on international best practice.

### 1.4 Research methodology

The research methodology applied in this study consists mainly of an evaluation of literature in the fields of business management, internal auditing and risk management.

To identify the most pressing issues relating to corporate risk management and private healthcare administration, the results of an empirical study are presented in appropriate chapters.

### 1.5 Summary and conclusion

In this chapter, the author identifies the purpose of the study as being:

- The identification of risks facing the South African private healthcare administrator, and

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<sup>1</sup> Assumption based on author's personal evaluation of risk management literature:

- Valsamkis, 2000
- Vivian, 1996, 1985
- De Villiers, 1991
- Morkel, 1988

- developing a suitable corporate risk management programme for the industry.

The chapter provides detail on what has heightened the need for a more up to date risk management process within the healthcare administration environment. The most noteworthy of these being:

- Dramatic increase in regulatory oversight within the private healthcare industry;
- more exacting accounting and auditing standards;
- the need for more innovative actuarial and financial models to address countrywide epidemics such as HIV and AIDS;
- increased prevalence of capitation contracts to ensure the financial stability of healthcare service providers;
- increases in expected fraudulent activity;
- Increasing the scope of private healthcare to incorporate a larger share of the South African population; and
- providing effective healthcare cover to members whilst facing significant medical inflation increases.

The field of risk management is an exciting and dynamic process that may add untold value to the healthcare financier. This is necessary in an industry where expertise is thinly spread and operational risk and the prevalence of regulatory oversight are on the increase.

The following chapter will formally introduce the concept of risk, its origins and associated philosophy.