Risk and the South African private healthcare environment

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ABSTRACT

The ability to learn from catastrophe and the science of anticipating and managing the aftermath of such events has challenged man for centuries. From its insurance origins, corporate risk management has developed into a fully fledged management function and is progressing into business areas that were originally considered unrelated. The evolution of risk management into such a corporate approach recognises that risks are interrelated and that significant benefits may be achieved from evaluating and monitoring them on a company-wide basis.

The private healthcare environment today is facing pressing issues that include:

- A dramatic increase in regulatory oversight within the industry;
- the need for more innovative actuarial and financial models to address countrywide epidemics such as HIV and AIDS;
- increased prevalence of high risk re-insurance practices which aim at ensuring 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.

Key words

Corporate risk, Corporate risk management, Corporate risk in private healthcare, External risks, Healthcare, Healthcare environment, Internal risks, Private healthcare, Risk management

1 BACKGROUND

From its insurance origins, corporate risk management has developed into a fully fledged management function and is progressing into business areas that were originally considered unrelated. The evolution of risk management into a corporate risk approach recognises that risks are interrelated and that significant benefits may be achieved from evaluating and monitoring them on a company-wide basis.

Suggested methodologies and observations included in this research project are supported by the results of an empirical research project representing 27% of medical schemes. The methodology applied to obtain the information was as follows:

- A random sample of 80% of medical schemes registered with the Council of Medical Schemes in South Africa was selected.
- These medical schemes were requested to complete a comprehensive questionnaire covering the key aspects of the research project.

The research project considers the evolution of risk management from an extremely narrowly focused financial science to an anticipatory and proactive approach that supports a business model of creating value. The most distinct reason why previous risk management techniques have been considered unsuitable is that risks have often been assessed in isolation and that the focus has been on their hazardous or downside element.

Healthcare administration organisations are on a development continuum with respect to managing risks and creating increased stakeholder value. How far such organisations progress on this continuum and the rate of such change will be dependant on past experiences, structural set-up as well as its desire to be world-class.

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 2002:57).

2 PURPOSE AND REASON FOR THE RESEARCH PROJECT

The purpose of this research project was to:

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

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 research. The following specific areas of weakness have been identified[1]:

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

3 RISK AND CORPORATE RISK MANAGEMENT

Based on an assessment of literature the following updated definitions of "corporate risk management" and "risk" were set for the research project:

- *Corporate risk management*[2]*:* A structured process of identification, assessment and the continuous management of the combined risks aimed at ensuring stakeholder expectations are achieved.
- *Risk*[3]: A concept used to express uncertainty about all possible future events, which could significantly influence the achievement of the organisation's collective business objectives.

4 THE SOUTH AFRICAN PRIVATE HEALTHCARE ENVIRONMENT

The purpose of a medical aid scheme is found in section 1 of the Medical Schemes Act No. 131 of 1998:

"Business of a medical scheme" means the business of undertaking liability in return for a premium or contribution-

- *To make provision for the obtaining of any relevant health services;*
- *to grant assistance in defraying expenditure incurred in connection with the rendering of any health service; and*
- *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 other person, in association with or in terms of an agreement with a medical scheme.*

Medical aid coverage works on the basic principles of insurance and pays for the services received by members and dependents from practitioners of their choice (Da Costa 2000:56). The scheme pays for the cost of medical care within prescribed benefits. Providers are paid for services rendered with medical schemes effectively guaranteeing payment to providers on condition that they charge in accordance with these predefined benefits (Da Costa 2000:68).

Medical schemes in South Africa are classified as either open or closed. Open schemes allow members of the public to join and membership is not restricted in terms of affiliation to a company or organisation. Larger companies normally establish closed schemes. Membership is restricted to employees or members of such companies. Of the 145 medical schemes registered with the Council of Medical Schemes as at January 2002, 35% were classified as open (www.medicalschemes.com).
Private healthcare exists as a result of the following conditions (Mossialos *et al.* 2002:136):

- Consumer demand for such cover exists;
- the cover may be provided at a price that the individual is willing to pay; and
- external factors such as the country's financial environment technically permits the provision of such a service.

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[1] Assumption based on author's personal evaluation of risk management literature:
- Valsamkis *et al.* 2000
- Vivian 1996, 1985
- De Villiers *et al.* 1991
- Morkel 1988

[2] Source references referred to:
- King Committee 2002:76
- IFAC 1999:6
- Pickford 2001:67
- Academy for Healthcare Management 1999:2-4
- De Loach 2000:5
- Valsamakis *et al.* 2000:22

[3] Source references referred to:
- De Loach 2000:93
- King Committee 2002:76
- Valsamakis *et al.* 2000:35
- Chong *et al.* 2000:36
- Harrington *et al.* 1999:3
- Skipper 1998:6
- IFAC 1999:6
- Academy for Healthcare Management 1999:2-2
- Young *et al.* 2001:7
- McNamee *et al.* 1998:2

In addition to the abovementioned conditions, the following high-level considerations will usually influence the success of a medical scheme (ibid):

- The ongoing monitoring of the state of health of the covered population;
- the ongoing monitoring of the magnitude of loss when illness does occur;
- changes to the level of taxes and subsidies provided by government and the employer; and
- changes in the level of income and education of the consumer.

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 administrative 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). 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 The ability to effectively manoeuvre in 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 at approximately 7 million with an overall increase in older members (Bisseker 2001:34). In 2003, medical scheme membership was still pegged at 7 million (Kahn 2003:1).

    It is estimated that 85% of employers who partially contributed towards employees' medical aid contributions noted a rise in such costs following the reform of the Medical Schemes Act. In parallel with 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 schemes should retain accumulated funds, expressed as a percentage of gross annual contributions, to attain a solvency level of 13.5% of contributions by the end of 2001. By the end of 2002, schemes were to have reached 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 and Phelps Credit Rating Company 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 of services provided;
  - regulate and lower costs 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 this survey were drawn from 16 diverse sectors, including council members, healthcare providers,

healthcare administrators and managed care organisations.

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.

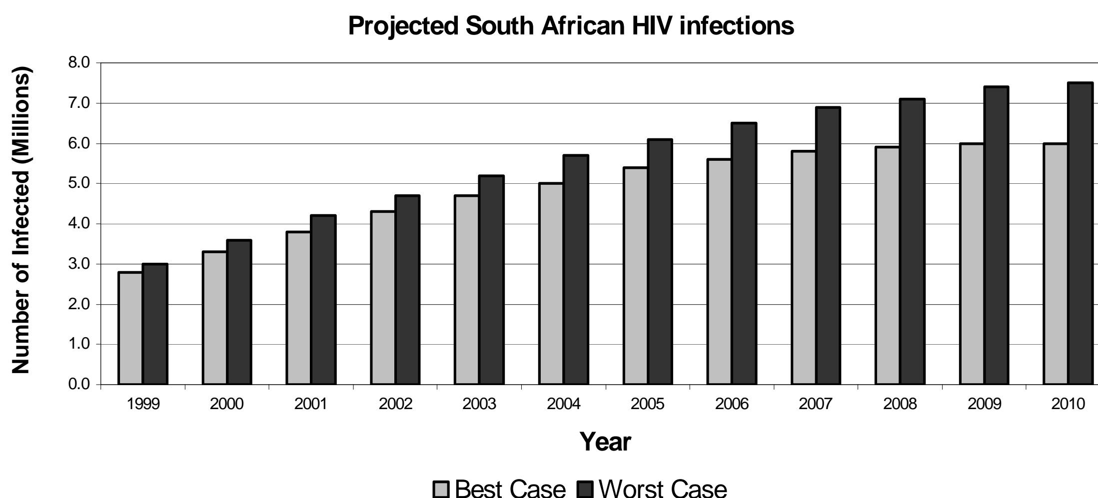
3 To provide cost-effective cover to members suffering with terminal diseases such as HIV and AIDS without increasing membership costs of other healthier members (Editorial 2001b: United effort can contain AIDS). Certain nationally accepted projections on South Africa's population for 2020 were initially 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 below provides a comparison between the private and public healthcare sector costs for treating an HIV patient. Figure 1 provides projections on the expected increase in HIV infections over the next 10 years.

Table 1: Average cost per patient comparison (SAHR Report 2000a)

HIV Development Stages	*Average Cost Per Patient (Rands/Yearly)*	
	Private Medical Schemes	*Public Healthcare*
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: Projected South African HIV infections (SAHR Report 2000b)



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 are most often found within a sector within private healthcare referred to as managed care organisations (Academy for Health Care Management 1999:2-5).

4 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.

5 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.

6 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 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 to enter this volatile market. Tables 2 and 3 below provide details of the survey responses that highlight the perceived differences between current public and private healthcare

Table 2: Reactions to public healthcare (Markdata 2001:27)

Criteria	***%***
Public healthcare adequate	9
Public care needs improvement	35
Use of private facilities essential	56

Table 3: Preferred modes of service delivery (Markdata 2001:27)

Criteria	***%***
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

7 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 financial year, 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%.

In a bid to ease the rampant increase in medical premiums, new regulations took effect under the Medical Schemes Act at the start of 2004 take effect. These new regulations 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 which public care is being forced include (ibid.):

- Asthma;
- 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.

8 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 entice many healthcare administrators to employ complex and risky mathematical models and information systems to ensure business survival and benefit optimisation for members.

From the above challenges it can be seen that the private healthcare administration organisation faces 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).

The following figures at the end of this research report (appendix) provide additional insight into the South African Private Healthcare environment:

- *Figure 2 - Corporate governance:* Corporate governance refers to the maintenance of acceptable relationships between the management of an organisation, its board, shareholders and other relevant stakeholders (Valsamakis *et al.* 2000:74). Another definition refers to corporate governance as holding the balance between economic and social goals and between the individual and communal goals (King Committee 2002:5).
- *Figure 3 - Pressing environmental issues.*
- *Figure 4 - Importance of functions within the medical scheme environment.*
- *Figure 5 - Functions of the Council of Medical Schemes:* According to the Medical Aid Schemes Act No. 131 of 1998, the Council of Medical Schemes is established to ensure compliance with the said Act and associated regulations. The broad functions of the Council, which convene at least four times annually, include (Medical Schemes Act 1998):
  - o Protect the interests of members at all times;
  - o control and coordinate the functioning of medical schemes in a manner that is complementary to the national health policy;
  - o make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of the relevant health services;
  - o investigate complaints and settle disputes; and
  - o collect and disseminate information regarding private healthcare.

Details on the scales applied in figures throughout the remainder of the article are as follows:

Importance	>8 = Crucial…..7…..6 = important…..5…..4…..3 = cognisant…..2….. 1 = unnecessary…..0 = N/A
Organisational Status	>8 = Managed/optimised…..7…..6 = defined…..5…..4….. 3 = repeatable…..2…..1 = initial/rudimentary
Difficulty in Implementing	>8 = Major restructuring required…..7…..6 = six to twelve months management attention needed…..5…..4….. 3 = 1 to 3 months management attention…..2….. 1 = no problems encountered

5 RISKS FACING THE SOUTH AFRICAN PRIVATE HEALTHCARE ADMINISTRATOR

Table 4 below provides a prioritised list of risks derived from the empirical research project conducted. It is evident from the table that the individual risks of confidentiality, compliance with legislation and ensuring that prescribed benefits are not exceeded; top the list of major risks faced by South African medical schemes.

The Academy for Healthcare Management in the United States provides some indication of which risks are considered important for a healthcare organisation in the United States (Academy for Healthcare Management 1999:2-6 to 2-9):

- Strategic planning;
- legislative compliance (with specific reference to maintaining required statutory solvency levels);
- budgeting;
- incorrect premiums; and
- benefits exceeded.

In Europe, legislative compliance and the development of a suitable regulatory framework are cited as the most pressing issues (Mossialos *et al.* 2002:128). Although the United States and European risks are not prioritised, it is interesting to note that all of these risks appear within the top 15 risks reflected in table 4.

Table 4: Prioritised risks

No	Risk Category	Risk Description	Details
1.	Strategy and Statutory	Confidentiality	Unauthorised personnel have access to financial and/or medical information.
2.	Strategy and Statutory	Legislative compliance	Control mechanisms to ensure compliance with governing legislation are not in place.
3.	Medical risk management and chronic benefits	Benefits exceeded	Members exceed their benefit allowances.
4.	Finance and Administration	Key reconciliations	The finance department does not reconcile or follow-up outstanding items on reconciliations between all systems and the general ledger on a sufficiently frequent basis.
5.	Finance and Administration	Budgeting	No formal budgeting system in place and no ongoing monitoring of expenses.
6.	Strategy and Statutory	Strategic planning	Senior management has not taken responsibility for developing long- to short-range business plans that will allow the medical scheme's mission and goals to be achieved.
7.	Claims management	Key claims operations	Performance in terms of key claims operations is inadequate.
8.	Information technology	System development methodology	The existing system development methodology does not address all key control areas expected within a systems development environment.
9.	Strategy and Statutory	Strategic risk assessment	Management has not established its own systematic risk assessment framework that should be applied on a consistent basis.
10.	Actuarial risk management	Actuarial risks	The following 5 criteria are not considered in actuarially based calculations: • *Asset risk:* The risk of adverse fluctuations in the value of assets. • *Underwriting risk:* The risk that premiums will not be sufficient to pay for services or claims. • *Credit risk:* The risk that providers and plan intermediaries paid through reimbursement methods that require them to accept utilisation risk will not be able to provide the services contracted for and the risk associated with recoverability of the amounts due from reinsurers. • *Business risk:* The general risk of conducting business including the risk that actual expenses will exceed amounts budgeted. • *Economic risk:* The risk that is inherent in the South African economy: for example, the Dollar/Rand exchange rate fluctuations, and interest rate fluctuations.
11.	Premium risk management	Incorrect premiums	Incorrect premiums charged to members.
12.	Premium risk management	Incorrect allocations	Premiums received are not correctly allocated resulting in: • Members receiving inadequate or no benefits. • High incidences of client queries and dissatisfaction.
13.	Premium risk management	Debtor management	Outstanding debtors are not properly managed in terms of: • Ageing of debtors • Reconciliations • Follow-up of debtors and tracing accounts
14.	Premium risk management	Member withdrawals	Member withdrawal debt (claw back) is not proactively managed and followed-up resulting in high debt collection and legal costs to the scheme.
15.	Premium risk management	Premium refunds	Incorrect or unauthorised premium refunds resulting in loss of income for the scheme.

Continued…

No	Risk Category	Risk Description	Details
16.	Medical risk management	Contradictory medication	Appropriate checks are not conducted to ensure that medicines prescribed are mutually compatible.
17.	Customer management	Service levels agreements	Non-achievement of service level agreements and customer service expectations in terms of: • Call centre management • Provider relations • Marketing initiatives • Public relations and reputation management.
18.	Claims management	System inputs	System input standards are inadequate or not in place.
19.	Medical risk management	Case management	Lack of concurrent and retrospective case management.
20.	Premium risk management	Preferred provider arrangements	Lack of understanding of, and ineffective application of preferred provider arrangements.
21.	New business and brokers	Underwriting protocols	Underwriting of new members not compliant with medical aid rules.
22.	Information technology	System capacity	No measurement or ongoing monitoring of system capacity, resulting in key applications being unavailable.
23.	Information technology	Logical access	Uncontrolled logical access to systems may result in unauthorised admittance to confidential data.
24.	People management	Sufficient resources	Insufficient human resources to achieve business objectives.
25.	Strategy and Statutory	Governance recommendations	The scheme does not address existing corporate governance standards and other oversight body recommendations.
26.	Assurance	Follow-up process	No formalised follow-up process in place to track items / issues reported to management.
27.	Assurance	Recommendations provided	No formalised assurance services process in place to provide recommendations to management on weaknesses identified.
28.	Medical risk management	Pre-authorisation procedures	Incorrect pre-authorisation procedures when loading in-hospital events.
29.	Information technology	Disaster recovery	Inability to continue business activities in case of a disaster, as a result of a lack of a disaster recovery plan.
30.	Assurance	Assurance structure	Assurance services do not address existing corporate governance standards and other oversight body recommendations.
31.	Premium risk management	Lapses and suspensions	Lapses and suspensions are not followed up timeously, resulting in losses for the scheme.
32.	Medical risk management	Member needs revisited	Suitable monitoring controls to assess the members' needs for chronic medication on a regular basis are not in place.
33.	New business and brokers	Unsupported records	Not all members loaded are supported by an authorised application form.
34.	Claims management	Tracking of claims	Inadequate controls with regards to collection, and inefficient claims tracking procedures.
35.	Medical risk management	Bill audit review	Inadequate bill audit review process.
36.	New business and brokers	New business applications	New business applications are not distributed to all outbound activities and services in a timely manner.
37.	Premium risk management	Quoted premiums	Premiums quoted disagree with actual premiums charged.
38.	New business and brokers	Broker commissions	Performance appraisals in terms of key broker commissions and operations are inadequate.

Continued…

No	Risk Category	Risk Description	Details
39.	New business and brokers	Accreditation of brokers	No accreditation process for brokers.
40.	Information technology	User problems	Loss of productivity due to user problems not being addressed timeously.
41.	People management	Orientation and training	Appropriate orientation programme for new personnel is absent, and ongoing training is not provided to maintain the knowledge and skills levels of all personnel.
42.	Finance and Administration	Journals	Adjusting journals and journal descriptions is not controlled and the necessary authorisation is not obtained.
43.	Assurance	Assurance risk assessment	Assurance services have not established their own systematic risk assessment framework, or it is not consistently applied.
44.	Medical risk management	Monitoring of pharmacists	Little or no control in place to effectively monitor the decisions made by pharmacists.
45.	Information technology	Physical access	Uncontrolled access to the high risk IT premises may result in damage to company resources.

6 CORPORATE RISK MANAGEMENT PROGRAMME

Respondents to the empirical research project were requested to note what improved benefits they believed a corporate risk management programme could bring to the administration of the medical scheme and how well they believed this was being addressed within their organisations. In addition to this, respondents were also requested to detail their existing concerns regarding corporate risk management initiatives underway within their respective organisations. Figure 6 details the benefit results, whereas figure 7 outlines the respondents' concerns.

A suggested corporate risk management programme based on current literature[4] is introduced in figure 8 and is supported by the overall results presented in section 7 below. Section 7 provides a list of selected issues queried within each of the key phases of the programme depicted in figure 8.

7 SUMMARY OF KEY ISSUES OF THE CORPORATE RISK MANAGEMENT PROGRAMME

7.1 *Figure 9 - Implementation feasibility phase:* Top executive commitment and buy-in is considered the most important element of the methodology initiation phase. The need for up-to-date systems and data to provide timely information was considered to be the most difficult step to implement within this phase.

7.2 *Figure 10 - Adopt goals, objectives and oversight phase:* suitable oversight structure and the need for clearly defined roles and responsibilities are considered very important within the adopted goals, objectives and oversight phase. The most difficult implementation step within this phase was clearly defining roles and responsibilities.

7.3 *Figure 11 - Risk tolerances phase:* Both the need for a defined common language and approved risk tolerances are rated as relatively important. Of these two issues, the implementation of risk tolerances is considered the most difficult. All respondents had progressed poorly in implementing the elements of common language and risk tolerance levels.

7.4 *Figure 12 - Risk management strategies phase:* Approved risk management strategies are considered to be essential in ensuring that trustee and senior management expectations are met when addressing unacceptable levels of risk. Progress in this area was poor.

7.5 *Figure 13 - Uniform process (consistency phase):* Respondents concurred that a need existed for a consistent risk management process. It was pleasing to note that respondents believed they had made significant inroads in adopting a uniform process even though it was considered relatively difficult to implement.

7.6 *Figure 14 - Uniform process (quantification) phase*: The most utilised risk quantification techniques included group facilitated qualitative prioritisation and risk mapping. The group-facilitated technique was the most advanced in terms of implementation status within healthcare administration organisations. Also, the Delphi method was not applied by any of the respondents as a means of quantifying risk.

7.7 Figure 16 - Project management and continuous improvement phase:

- The issue of consolidated reporting and integration of assurance service functions

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- [4] De Loach 2000
- IFAC 1999
- Kendall 1998
- King Committee 2002
- McNamee *et al.* 1998
- PricewaterhouseCoopers 2000a
- PricewaterhouseCoopers 2000b
- Valsamakis *et al.* 2000

was of greatest importance. The integration of such assurance service functions was considered to be one of the most difficult elements to implement.

- Ensuring that the corporate risk management initiative was actively involved in strategic initiatives was the other most difficult element to implement. However, with regard to implementation within their organisations, respondents indicated that this continuous improvement element was the most advanced.
- The utilisation of external risk management experts was the least important of the continuous improvement elements. It appears that healthcare organisations preferred to improve the corporate risk management processes based on own experience and internal demands from senior management and the medical scheme's trustees.
- The use of pilot projects as a means of obtaining an early glimpse of how the final corporate risk management process would operate was important and could be implemented within a period of three to six months.

8 CONCLUSION

External and internal risks threaten the achievement of organisational objectives. If not adequately controlled, these risks may lead to significant adverse consequences that impact on the performance of business processes and the performance of the healthcare administration organisation as a whole. Consequently, the significance of these risks should be assessed at all levels of the medical scheme and should be regularly monitored. Significant risks should be traced to their root causes in order that appropriate risk management strategies are developed and implemented to reduce risk levels to at least accepted tolerance levels, if not below these levels.

It is the overall opinion of the authors that corporate risk management within the healthcare administration industry will become a cornerstone of effective business management. It will influence the manner in which such organisations of the future are structured and the way in which strategic planning is performed. Not only will it improve corporate governance practices but will allow organisations to become adept at addressing new threats and possible areas of opportunity, thereby adding value for their stakeholders.

Although respondents to the empirical study have not attained a level where corporate risk management is fully implemented, it is apparent that this is their ongoing ambition.

APPENDIX

Figure 2: Corporate governance within the private healthcare environment

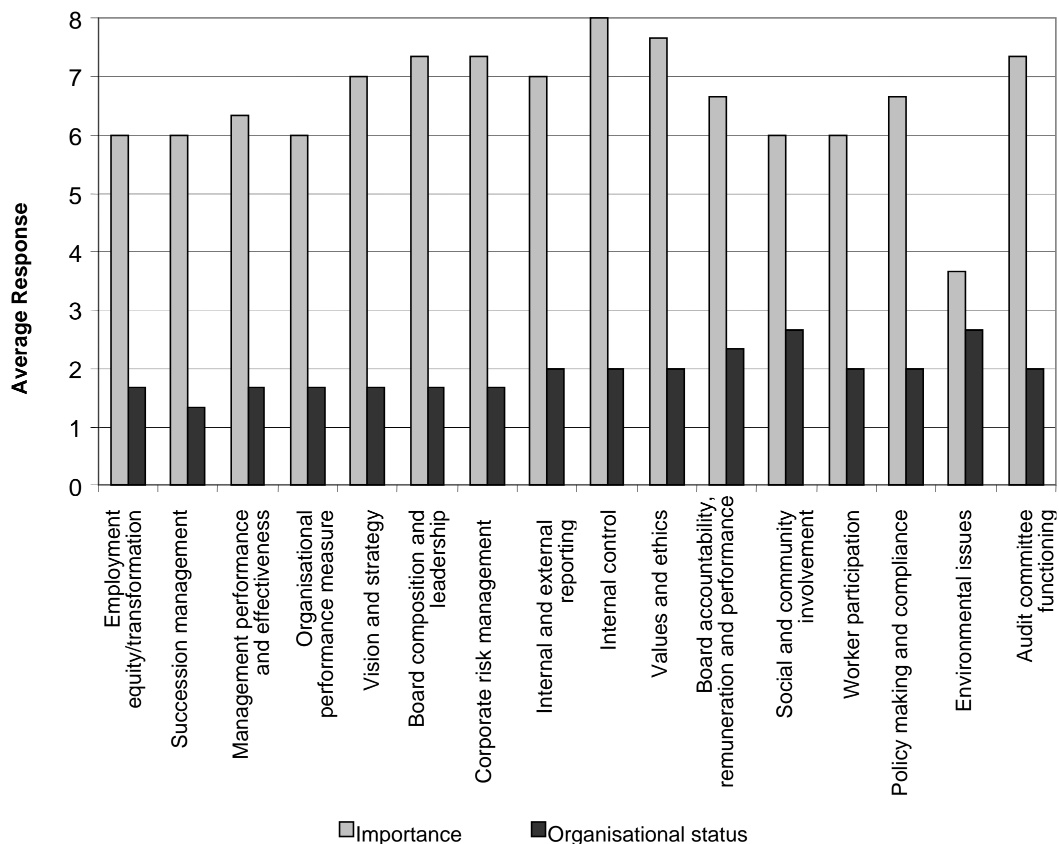


Figure 3: Pressing environmental issues

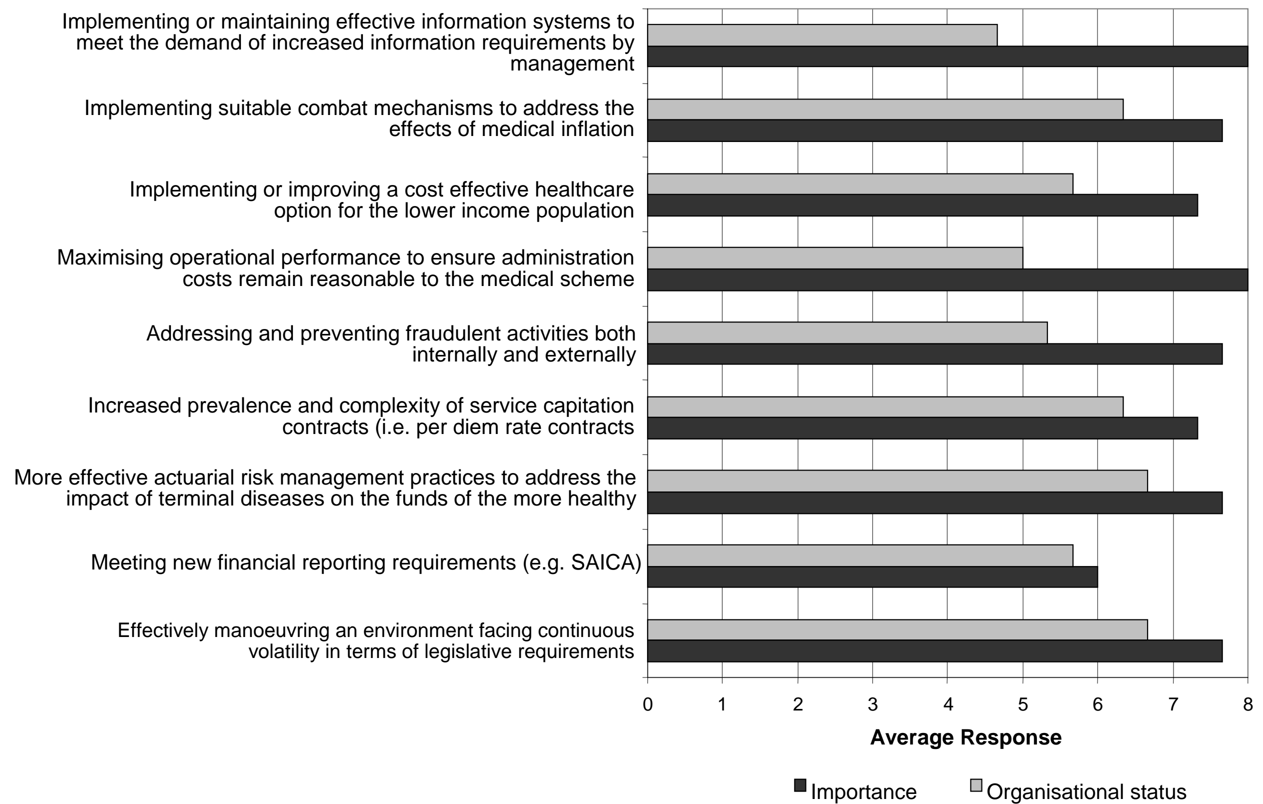


Figure 4: Importance of functions within the medical scheme environment

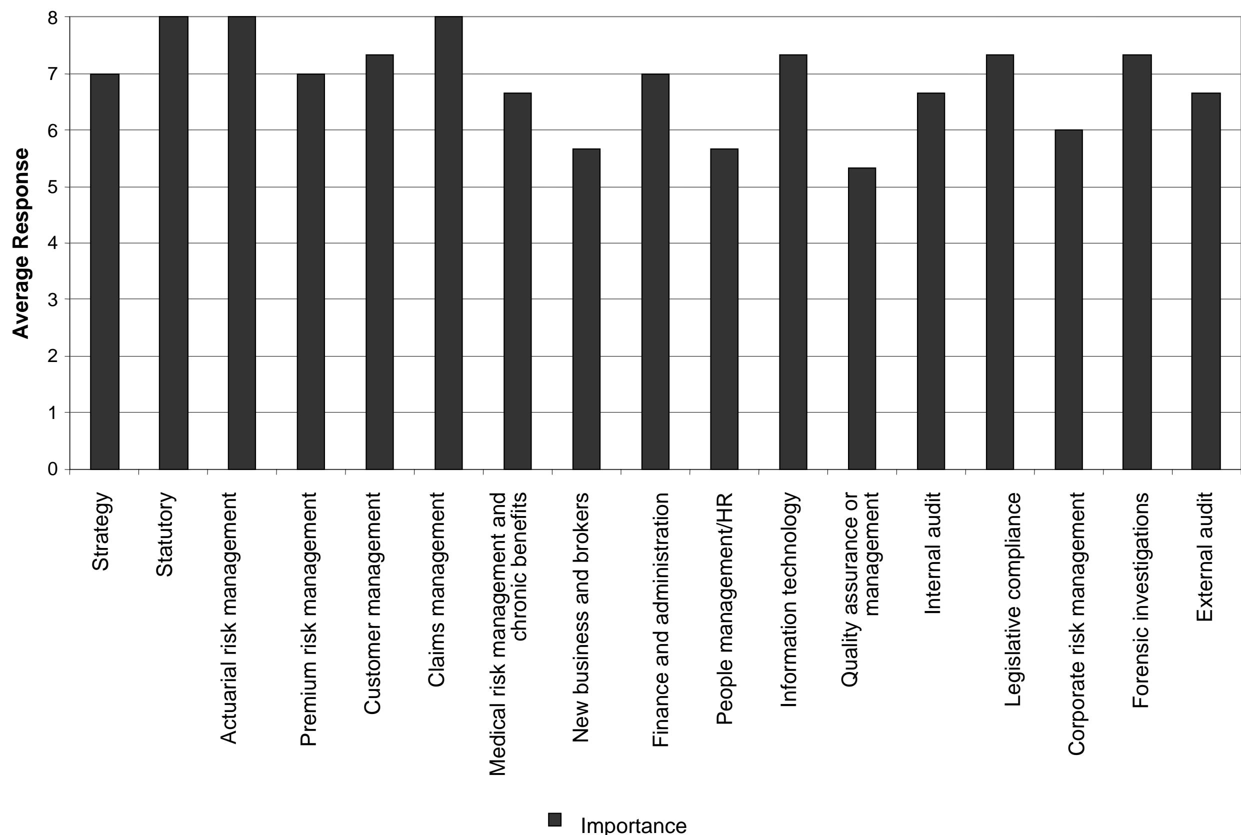


Figure 5: Functions of the Council of Medical Schemes

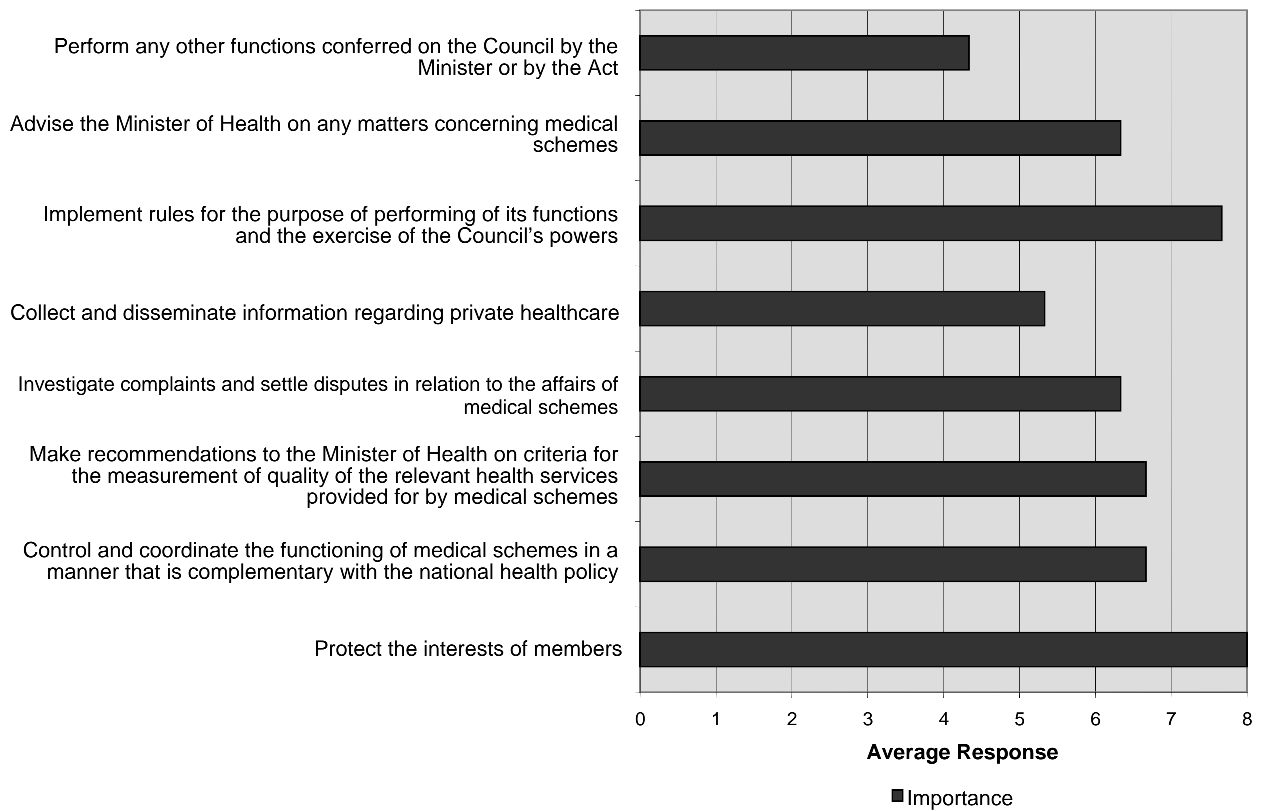


Figure 6: Benefits of corporate risk management and current management practice

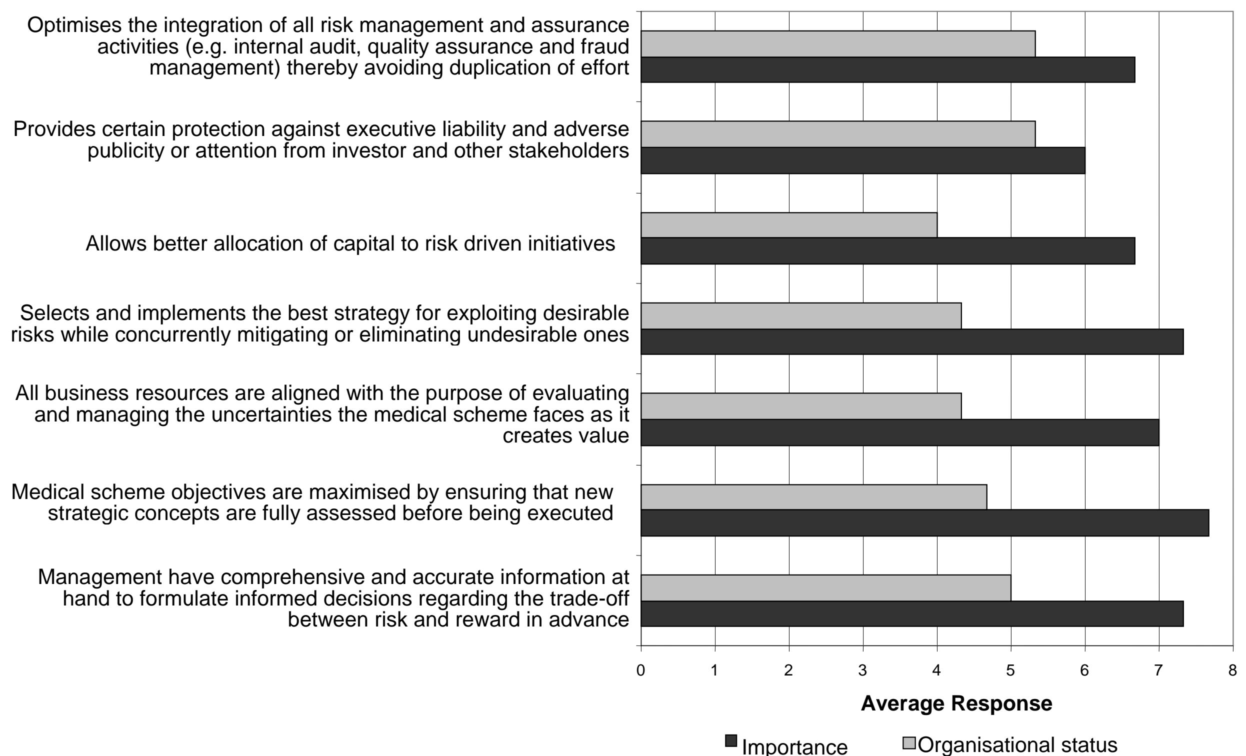


Figure 7: Concerns regarding corporate risk management

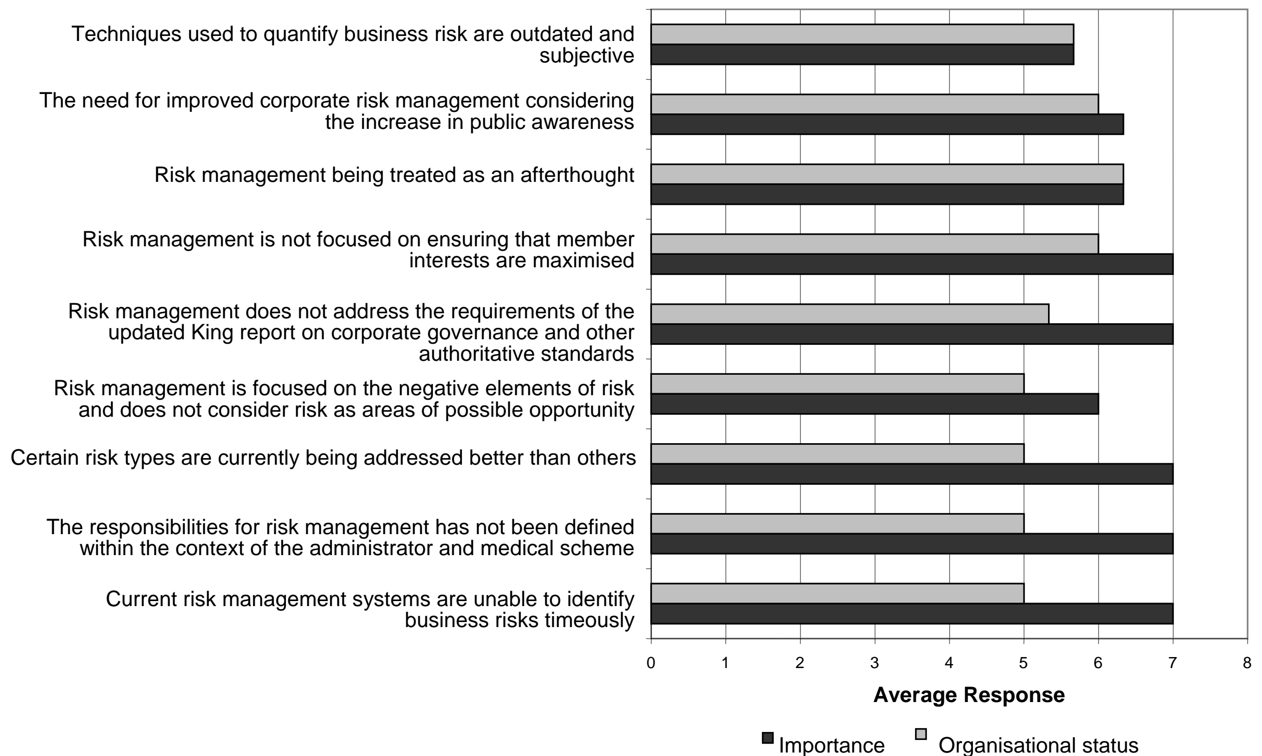


Figure 8: Corporate risk management programme for South African Private Healthcare

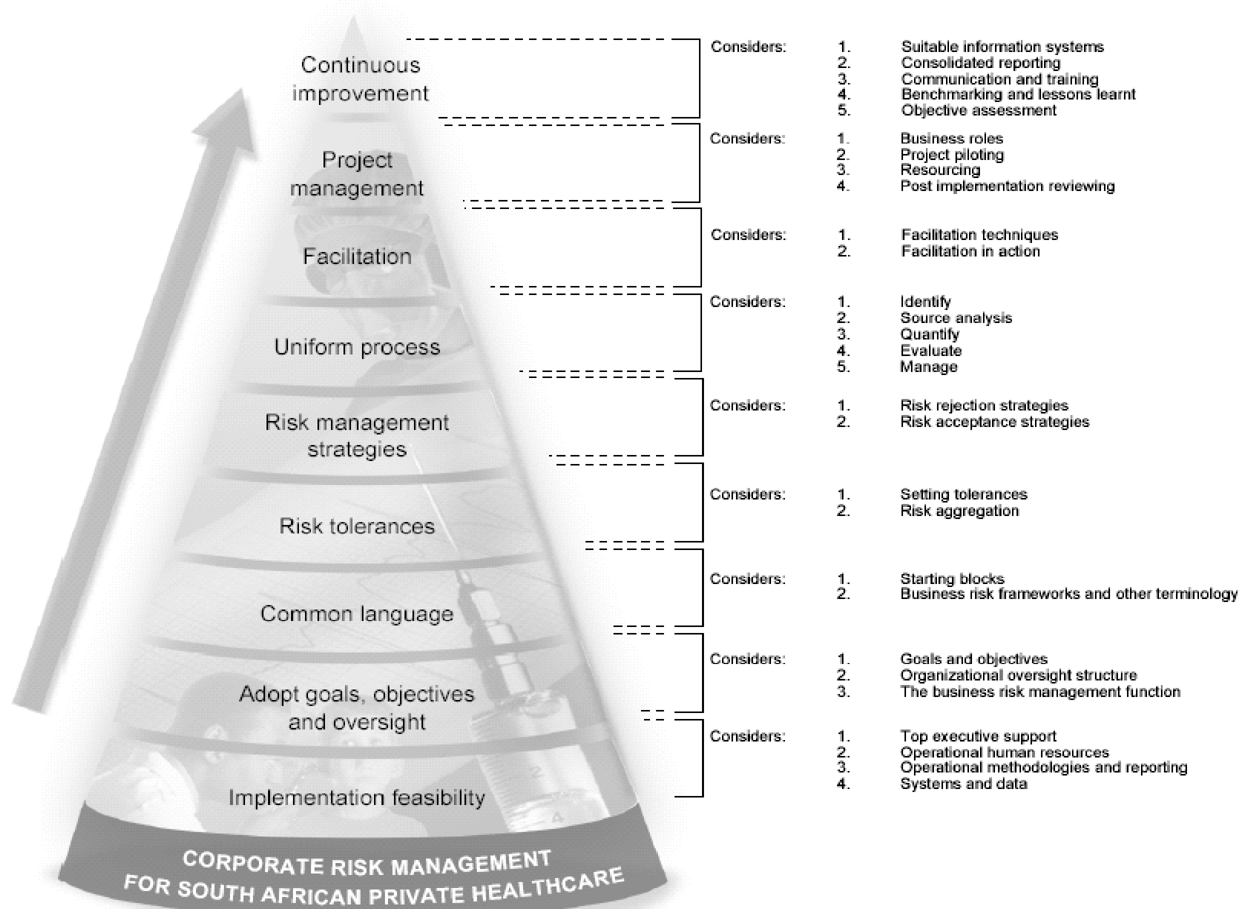


Figure 9: Methodology initiation phase

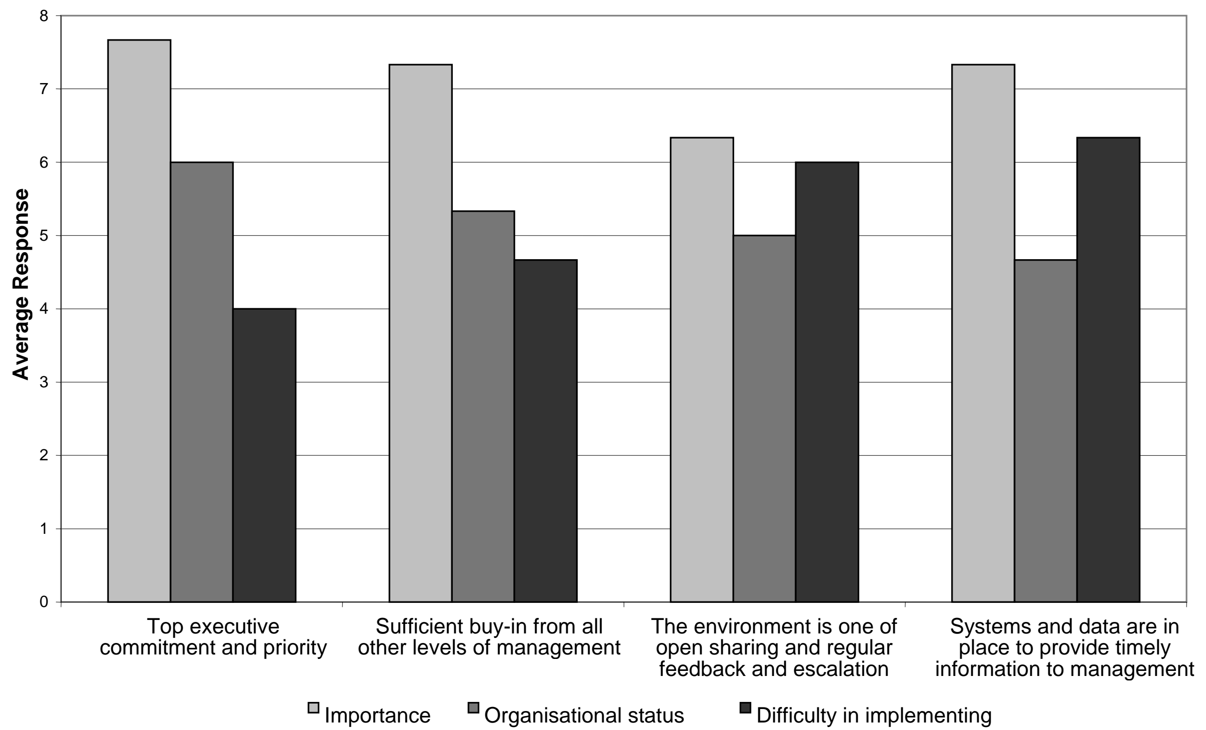


Figure 10: Adopt goals, objectives and oversight phase

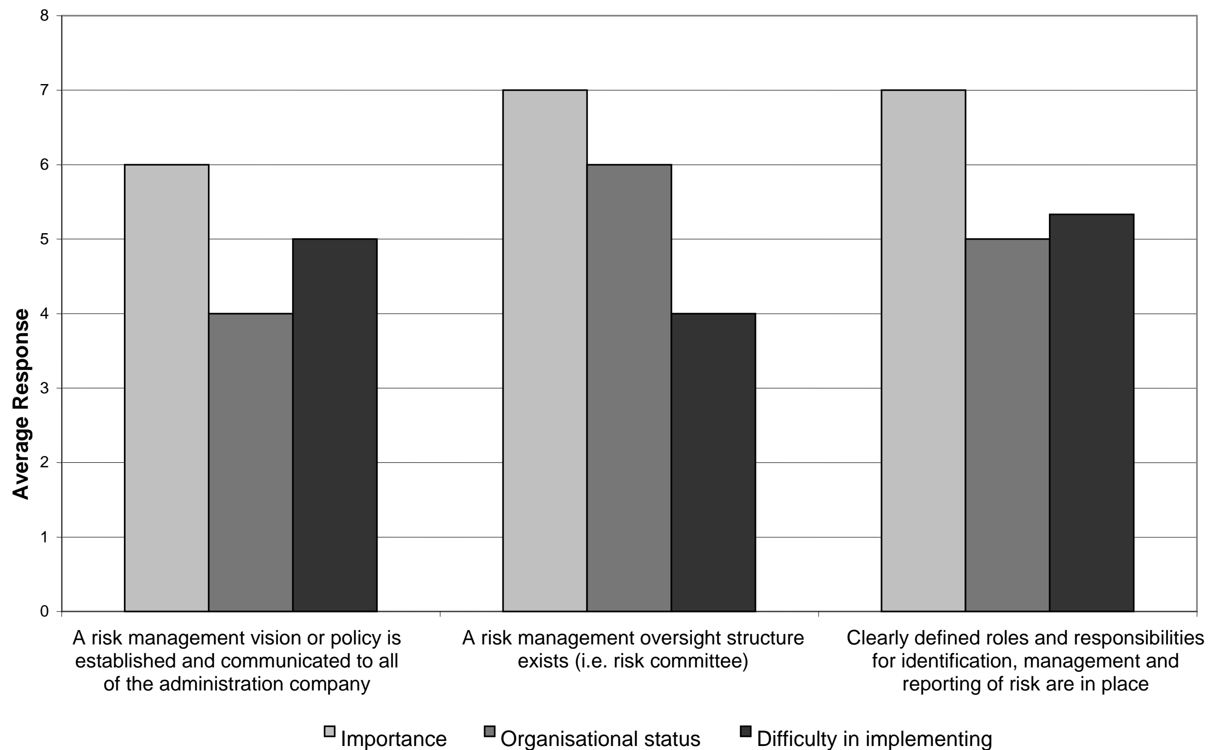


Figure 11: Risk tolerances phase

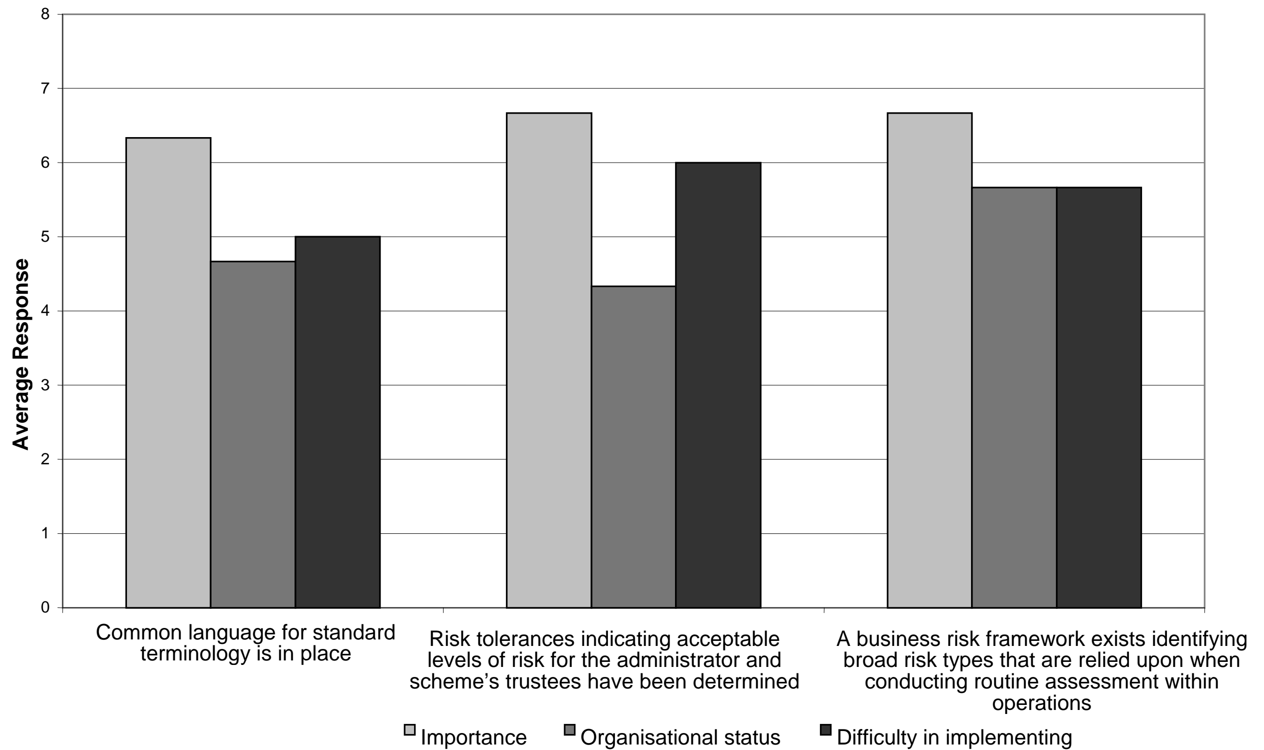


Figure 12: Risk management strategies phase

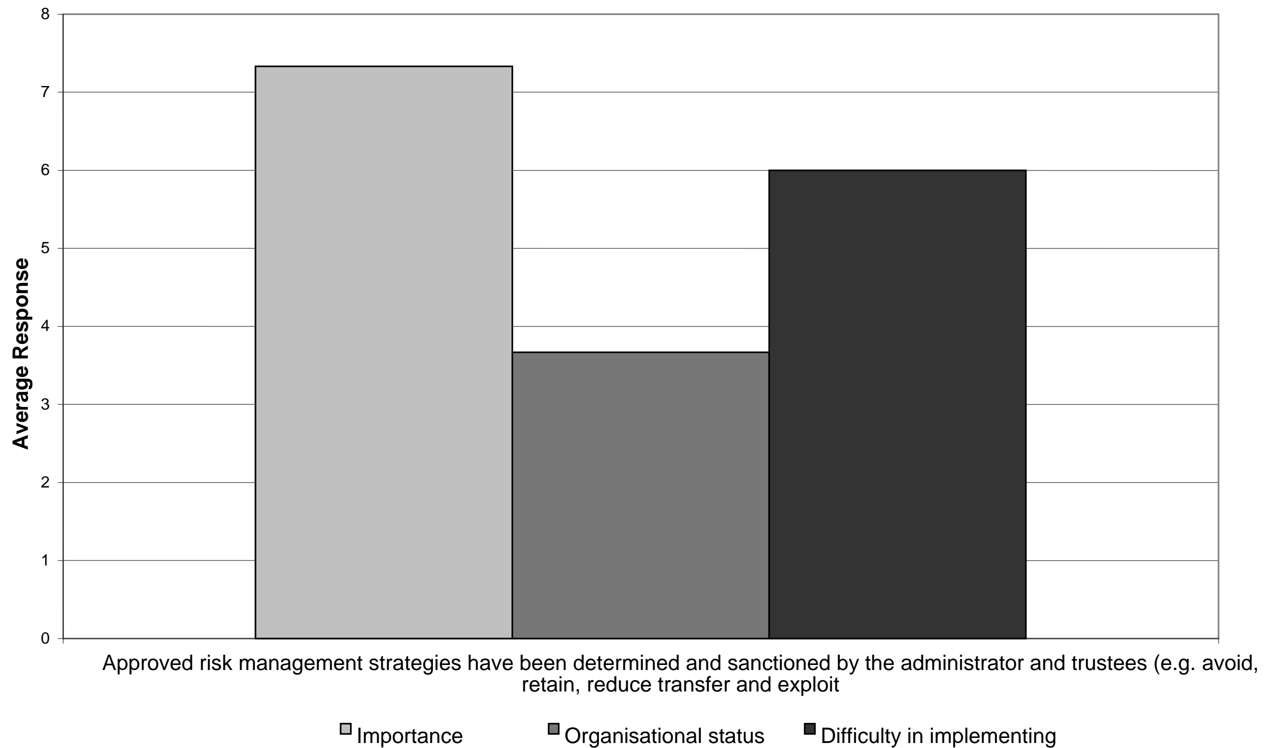


Figure 13: Uniform process (consistency) phase

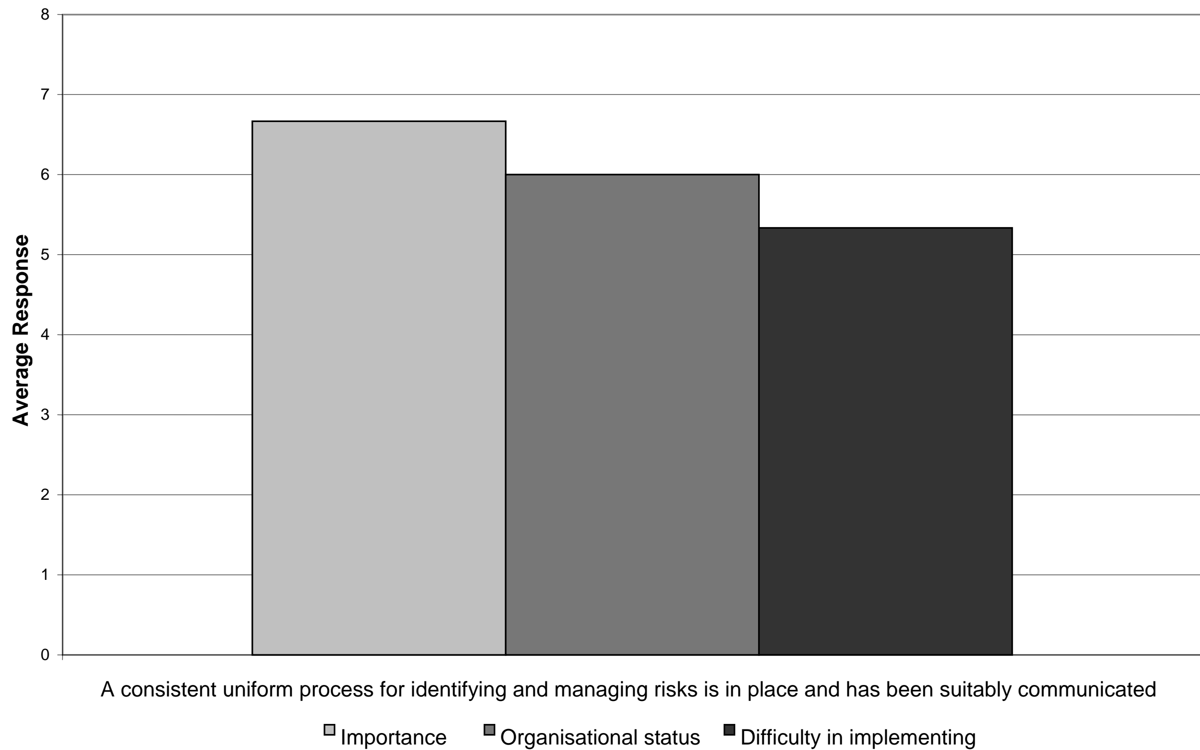


Figure 14: Uniform process (quantification) phase

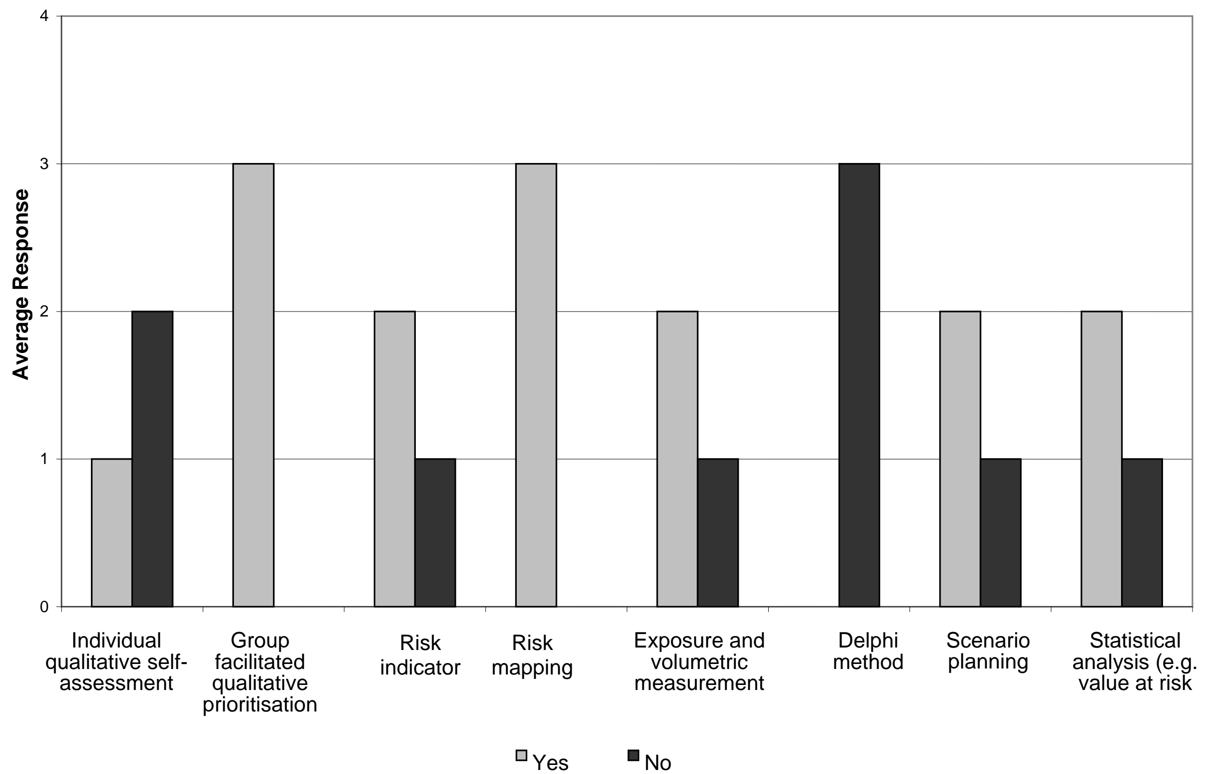
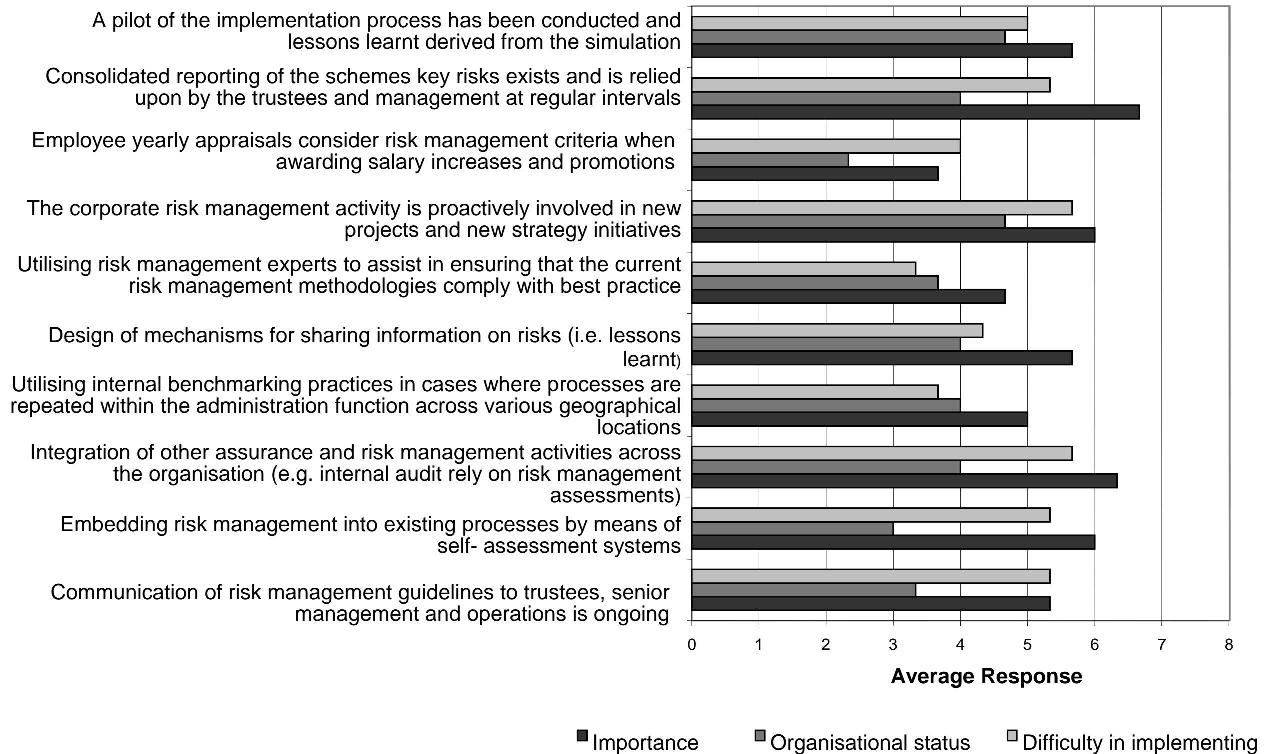


Figure 15: Project management and continuous improvement phase



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