

Chapter 5

Private Healthcare

With health insurance becoming more expensive, it becomes more difficult to address problems such as expanding coverage for the uninsured and providing prescription drugs for seniors

USA Today, 2002: 8A

Medical schemes are non-profit organisations and their main objective is to assist members with their medical expenses

Da Costa, 2000:56

5.1 Introduction

Before the author embarks on establishing what risks South African medical aids face, it is necessary that an understanding of the background and workings of the medical scheme environment be obtained.

De Beers Consolidated Mines initiated private healthcare administration in 1889. After the Second World War, the existence of such schemes had increased to a stage where, by 1960, there were 169 schemes providing cover to 1.5 million lives (Davies, 1995: 3). By 1980, this number had increased to 289. These increasing trends are in stark contrast to the 145 medical schemes currently registered with the Council of Medical Schemes in South Africa (Da Costa, 2000: 67). Reasons for this dramatic decline were alluded to in chapter 1.

5.2 Aim

The aim of this chapter will be to:

- Provide insights into the status of private healthcare in the United States and Europe;
- introduce the concept of medical schemes and how such activities are governed in South Africa; and
- present empirical survey results relating to the South African private healthcare environment.

5.3 United States and Europe

5.3.1 United States

47% of healthcare costs in the United States are covered by state and federal reimbursement under Medicare and Medicaid programmes (Vaughn *et al.*, 1999: 375).

Medicare is a social insurance programme primarily for those over 65 or disabled whereas Medicaid is a needs-based programme for the poor. Virtually all persons over the age of 65 are covered under the Medicare programme. It is estimated that approximately 60% of Medicare covered persons purchase additional private healthcare cover to supplement their Medicare cover (*ibid.*).

Roughly, 85% of persons under the age of 65 are covered by private health insurance, usually by an employer-sponsored plan. The private healthcare industry is composed of three broad types of service providers (Vaughn *et al.*, 1999: 375-376):

- *Commercial insurance companies:* There are approximately 1200 insurance companies that sell health insurance, providing around 78 million persons with hospital and surgical expense benefits. This includes 38 million persons covered under fully insured group plans and 7 million persons covered under individual policies. These commercial insurance companies comprise property and liability insurers, life insurers and dedicated health insurers.
- *Blue Cross and Blue Shield:* These associations are usually organised under special state enabling legislation to provide for prepayment of hospital and surgical expenses. The Blue Cross plans were originally organised by individual hospitals to permit and encourage prepayment of hospital expenses. Blue Shield plans occupy the same position in the surgical expense field that Blue Cross plans occupy in the

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hospitalisation field. Together they insure an estimated 67.1 million persons.

- *Capitating healthcare providers:* Capitating healthcare providers include health maintenance organisations and physician hospital organisations or provider sponsored organisations. Health maintenance and provider sponsored organisations differ from commercial insurers in that they are also healthcare providers. The insurance element in their operations derives from the manner in which they charge for their services, which is called a capitation. Under the capitation approach, individual subscribers pay an annual fee and in return receive a wide range of healthcare services.

A recent trend in the United States is a growing number of group health insurance plans are being self-ensured by major employers. This is often done to reduce the extent of associated costs. Cost advantages stem from two major sources. Firstly, by eliminating the premium, the employer eliminates the premium taxes assessed by the government and secondly, most states request that group insurance policies include certain prescribed benefits. Self-insured plans are exempt from these mandated benefits requirements (ibid.).

Regarding the status of the healthcare in America, the following excerpts appeared in a United States newspaper:

1. (USA Today, 2002: 8A)

“On average, workers paid 27% more toward their insurance premiums and 16% more for family health coverage, according to a survey of more than 3000 companies by the non-profit Kaiser Family Foundation.

...‘we expect costs to rise at higher rates for the next several years,’ says Altman...‘With health insurance becoming more expensive, it becomes more difficult to address problems such as expanding

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coverage for the uninsured and providing prescription drug coverage for seniors,' says Altman."

2. (USA Today, 2003: 4A)

"More than 1 million low-income Americans have lost or might lose government-subsidised health care as states try to contain rapidly escalating costs.

The cuts and potential reductions represent 2% of the 47 million Americans who receive Medicaid, the federal-state health care program for the poor and disabled. Last year, Medicaid cost \$250 billion, up 13.4% from 2001."

Table 5.1: Distribution of Health-Insured Population (Vaughn *et al.*, 1999: 377)

Population	Persons insured (Millions)	% of population
Commercial insurance companies	78	29
Blue Cross and Blue Shield	67	25
Self Insured Plans	62	23
Capitating Health Care Providers	60	22
Medicare	38	14
Medicaid	38	14

The private healthcare environment in the United States faces two main problems, viz. access to healthcare and cost (Vaughn *et al.*, 1999: 394-400):

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- *Access to healthcare:* It is estimated that over 40 million Americans have no medical aid coverage. The majority of these persons are poor. Their plight is compounded by the fact that poverty accentuates poor health and poor health in turn often breeds poverty.

The problem of access is not only limited to the economically disadvantaged. It also exists for persons who, because of personal hazards, are unable to obtain health insurance in the standard marketplace. Plans for small employers may exclude coverage for certain employees and persons who must purchase insurance individually often find that they cannot obtain it. It is estimated that this equates to 3 percent who have no medical aid coverage.

Finally, access to healthcare is also a concern for residents of rural areas where the issue is not of a financial nature but rather the absence of healthcare facilities. Many rural areas lack doctors and hospitals and residents must travel to cities to receive essential care.

- *Healthcare costs:* The following factors are listed as being responsible for the upward trend in increased healthcare costs in the United States:
 - *Aging population:* Since people are living longer, increased costs for healthcare are evident.
 - *Excessive capacity:* Although advances in medical technology create justifiable increases in cost, they can also be a source of waste and inefficiency.
 - *Defensive medicine:* The increasing litigious atmosphere of the United States, evidenced by an epidemic of malpractice suits, encourages physicians to practice defensive medicine, an inclination that compounds the impact of technology on costs. Advances in technology create increasingly expensive testing equipment with vastly expanded diagnostic powers. The threat of

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malpractice suits strengthens the physician's inclination to use the equipment to perform more and higher-cost diagnostic testing.

- *Insurance-encouraged utilisation*: Highlights the built-in tendency for people to use more healthcare services when insured.
- *Cost-shifting*: When government plans (viz. Medicare and Medicaid) attempt to control costs by reducing the amounts they pay to providers, the providers must compensate by increasing the fees they charge others. This cost-shifting concept is one reason why the cost of private healthcare insurance has increased so rapidly.
- *Mandated benefits*: All states in the United States have passed laws mandating medical aids to cover certain medical expenses to providers. These mandated benefits tend to increase the cost of medical aid coverage.

To address the two main struggles of access and cost, the United States is considering the following solutions (ibid.):

- *Single payer plan*: Under this approach, a country-wide system for comprehensive health insurance would be funded by taxes and administered by a federal agency. It would eliminate the need for medical aids and provide a substitute that would allow benefits for hospital, dental, optometric, home and nursing care. The federal agency would establish a national budget for healthcare and set fees paid to providers.
- *Employer-mandated health insurance*: Under this approach, employers would be required to provide healthcare to their employees or to pay payroll tax that would help fund benefits provided by a government programme. The plans typically require the employer to pay only a certain percentage of the premiums for employees. Those not receiving insurance from their employer may be required to purchase insurance either individually or from the government programme.
- *Individual mandates*: This approach places the burden for the purchasing of health cover on the individual. Those who could not

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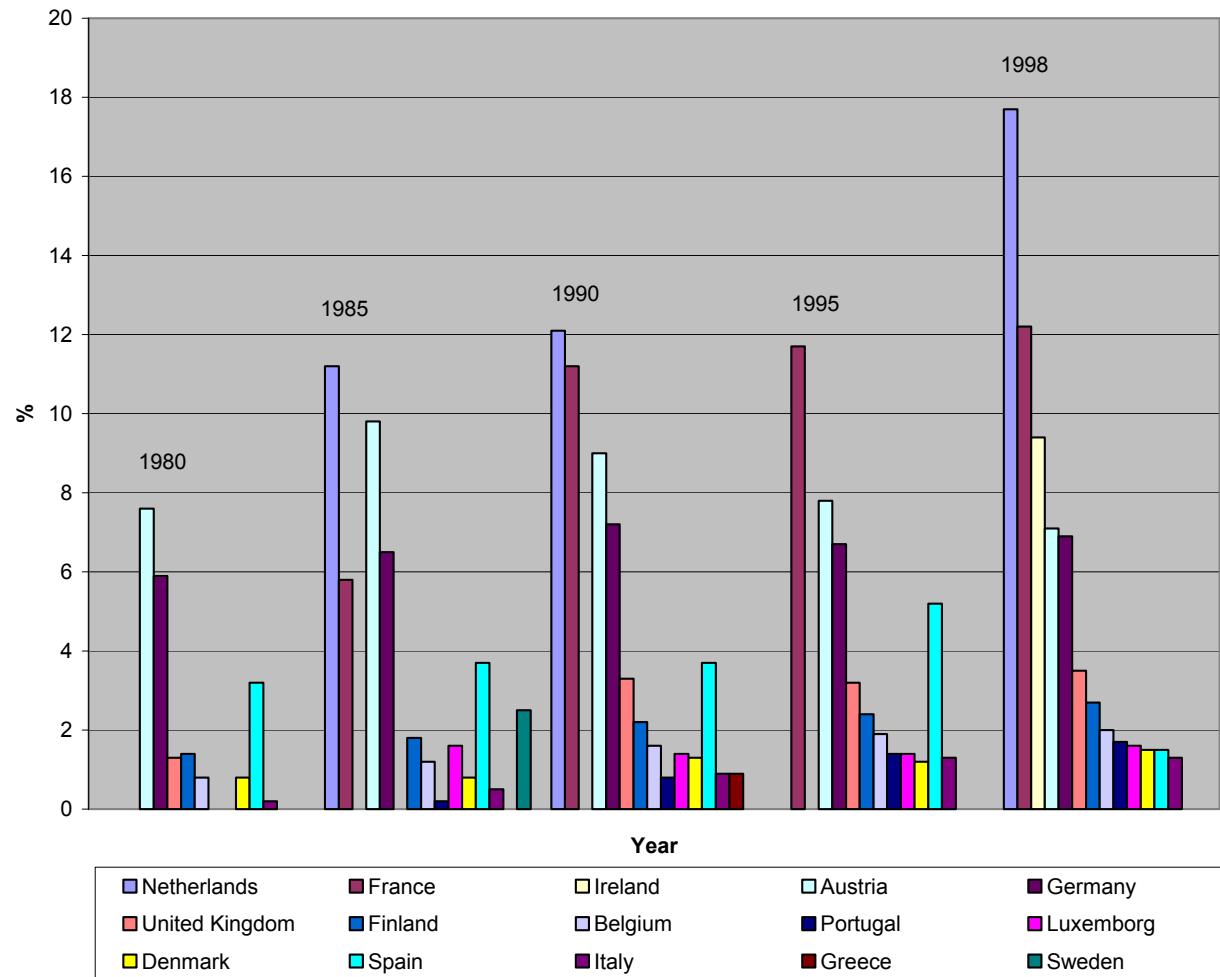
afford health insurance would be eligible for tax credits to subsidise the cost. Many individuals prefer this approach to a national healthcare system, as it retains individual choice and responsibility.

5.3.2 Europe

Private health insurance does not play a dominant role in the European Union as it does in the Americas. For largely historical reasons, governments in Europe have aimed to preserve the principle of healthcare funded by the state (Mossialos *et al.*, 2002: 128).

Figure 5.1 provides information on the extent of European private healthcare as a percentage of total health expenditure for the period 1980-98.

Figure 5.1: European private healthcare spend as a percentage of total health expenditure (Mossialos *et al.*, 2002: 132)



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Private healthcare plans are classified as substitutive, supplementary or complementary (Mossialos *et al.*, 2002: 19):

- *Substitutive*: Most healthcare systems in Europe are mainly financed through taxation or contributions from employees and employers. This means that participation in the statutory healthcare system is usually mandatory. In Germany, the Netherlands and Spain, however, certain groups of people are either not covered by the statutory healthcare system or are allowed to abstain from joining. This leaves them free to purchase voluntary health insurance as a substitute for statutory protection.
- *Complementary*: This type of plan provides full or partial cover for services that are excluded or not fully covered by the statutory healthcare system.
- *Supplementary*: Supplementary health insurance increases consumer choice and access to different healthcare services, guaranteeing superior accommodation and amenities and more crucially, faster access to treatment, especially in areas of healthcare with long waiting lists. This type of plan is often referred to as double coverage and is especially prevalent in Greece, Italy, Portugal, Spain and the United Kingdom.

Table 5.2 provides details on the percentage of population covered by voluntary health insurance within the various countries of the European Union. It is interesting to note that the distribution of coverage for private healthcare in many of the European countries is heavily skewed in favour of consumers with high incomes (Mossialos *et al.*, 2002: 136).

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Table 5.2: Percentage of population covered by voluntary health insurance²
(Mossialos *et al.*, 2002: 133)

Country	%
Luxembourg	75
France	53
Ireland	42
Belgium	30
Netherlands	29
Denmark	28
Finland	22
Spain	17.6
Austria	17
United Kingdom	11.5
Portugal	10
Greece	10
Germany	9
Italy	5
Sweden	0.5

The following excerpt relates to the European Union's regulatory control framework that oversees insurance plans such as voluntary health schemes (Mossialos *et al.*, 2002: 135):

² Combined results for substitutive, complementary and supplementary health plan types.

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“The European Commission has issued directives leading to the creation of a single market for life and non-life insurance within Europe. The third non-life insurance directive adopted by national law in July 1994 abolished national controls on premium prices and prior notification of policy conditions for voluntary health plans.

The European Union’s approach to the creation of a single market, based on liberalisation and substantial deregulation, demonstrates its concern for the financial viability of voluntary health insurers rather than consumer protection. Given the market failures inherent in voluntary health insurance, it could be argued that relying primarily on market mechanisms may not be the best way of delivering cost-effective and competitively priced voluntary health insurance products.”

The author concludes by stating that he believes increased regulatory developments are necessary to ensure that the European Union market works more efficiently and allocates resources in a more equitable manner (ibid.).

5.4 The business of a medical aid scheme

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

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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). Certain other concepts unique to the medical scheme environment are included in table 5.3.

Medical schemes in South Africa are classified as either open or closed. Open schemes allow members from the public to join and are thus not restricted in terms of membership. 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). Figure 5.2 depicts the top 20 open medical schemes for 1999 based on the number of average lives covered.

Figure 5.2: Top 20 open medical schemes (Financial Mail, 2000: 368):

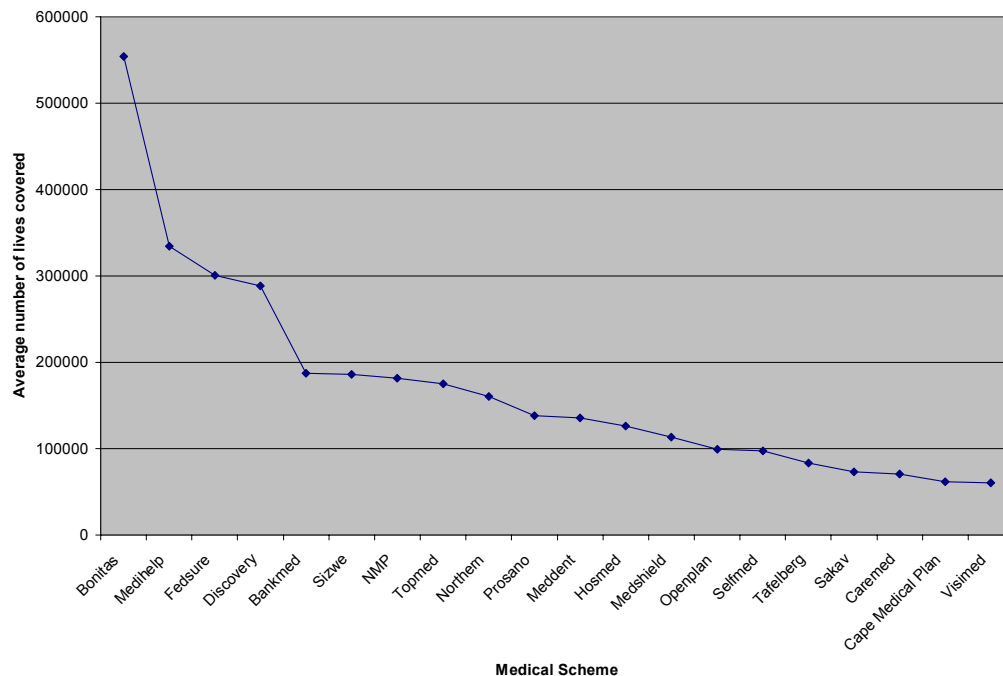


Table 5.3: Medical scheme concepts

Concept	Explanation
<i>Board of Trustees</i>	Persons charged with managing the affairs of a medical scheme and which have been elected or appointed under the fund rules (Medical Schemes Act, 1998).
<i>Medical scheme fund rules</i>	<p>Rules, constitutions and/or agreements, in terms of which the member receives healthcare benefits and in terms of which the fund is administered (SAICA, 2001). This includes (Medical Schemes Act, 1998):</p> <ul style="list-style-type: none"> • The provisions of the law, charter, deed of settlement, memorandum of association or other documents by which the medical scheme is constituted; • the articles of association; and • provisions relating to the benefits and contributions received.
<i>Member</i>	A natural person, admitted to membership of a fund who is entitled to healthcare benefits, in terms of the rules of the fund, in exchange for a contribution (SAICA, 2001).
<i>Healthcare benefits</i>	The entitlement to healthcare services that a member has in terms of the rules of the fund (SAICA, 2001).

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Concept	Explanation
<i>Savings plans</i>	<p>Certain funds provide for member savings plan account facilities to assist the members in (ibid.):</p> <ul style="list-style-type: none"> • managing cash flow for costs to be borne by members during the accounting period by; • self funding their out of hospital expenditure; and • meeting or self-funding member co-payments for provider services rendered.
<i>Managed care</i>	<p>Involves capitation contracts through which the utilisation of health care is monitored and efficiency, quality and cost effectiveness of the delivery of relevant health services is managed (ibid).</p>
<i>Claims incurred</i>	<p>An amount, net of discount, payable to the provider or the member for healthcare benefits supplied to the member, in terms of the rules of the fund (SAICA, 2001).</p>
<i>Reinsurance</i>	<p>A fund, in order to spread its risk, may re-insure defined risks. Reinsurance is aimed at protecting the administrator of the medical scheme against insolvency or possible significant losses which it itself cannot effectively address by means of self-insurance (Pickford, 2000: 262).</p>

Continued...

Concept	Explanation
<i>Solvency requirements</i>	Regulation 29 of the Regulations to the Medical Schemes Act of 1998 requires that the scheme maintain accumulated funds, expressed as a percentage of gross annual contributions. As alluded to in chapter 1, 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 demand for private healthcare is driven by 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 countries financial environment technically permits the provision of such a service.

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.

Figure 5.3 depicts the business functions incorporated within a conventional healthcare administration organisation. Each of the functions is assigned to a business category of overall governance, core, support or assurance. The following sources were consulted in preparing the representation:

- Academy for Healthcare Management, 1999
- De Loach, 2000

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- Discovery, 2001
- Council of Medical Schemes, 2001
- Harrington *et al.*, 1999
- Financial Mail, 2000
- Hymans, 2001
- SAHR Study, 2000a
- SAHR Study, 2000b

To support figure 5.3, respondents to the empirical study were requested to indicate whether any significant functions were omitted. No additional functions were cited. Details on the activities performed within each of the functions are elucidated upon in table 5.4.

Figure 5.3: Functions within the administration organisation

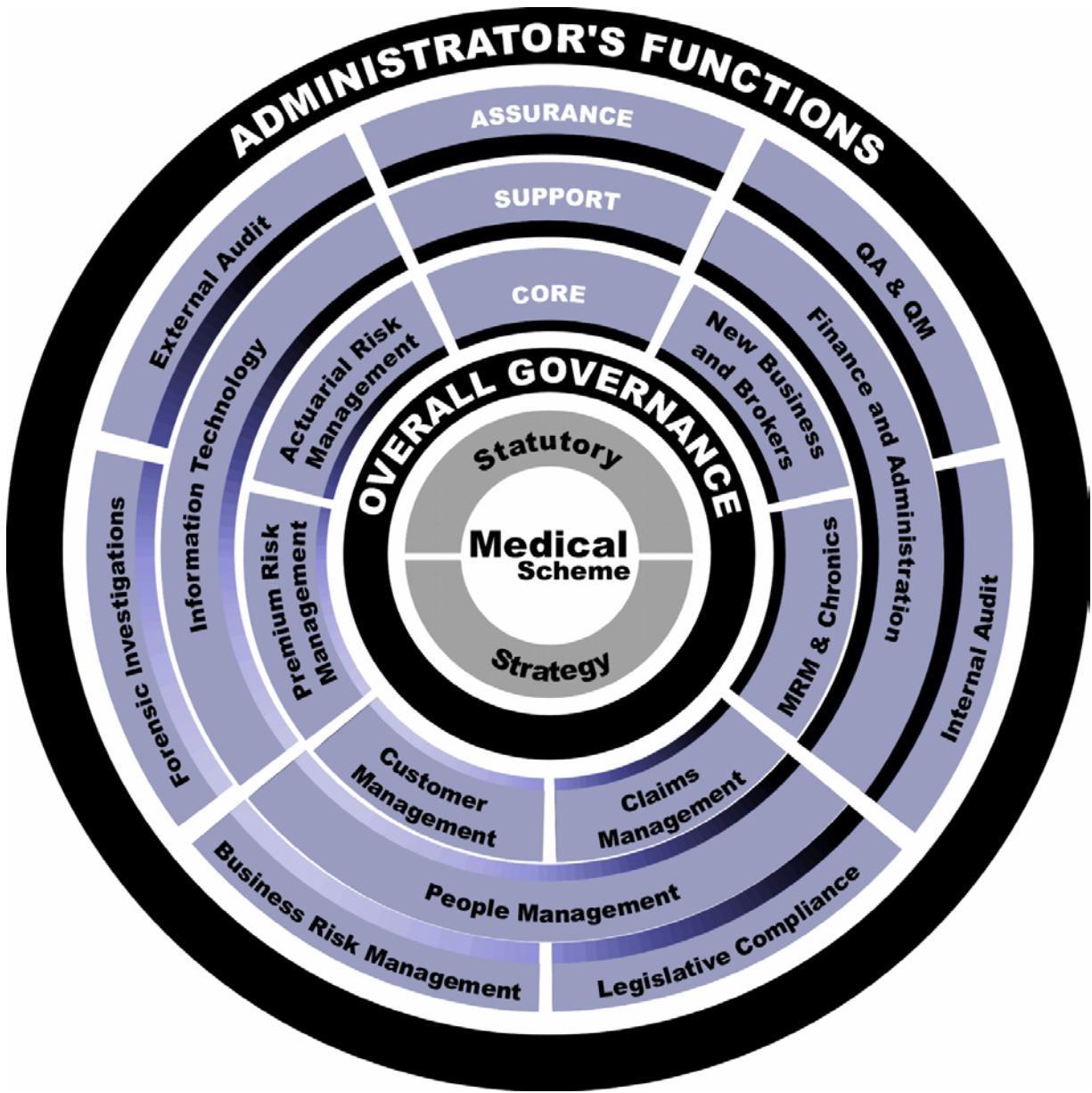


Table 5.4: Key activities performed within each of the functions

<i>Type</i>	<i>Function</i>	<i>Key activities</i>
<i>Overall governance</i>	Strategy	Research and development and long-term strategic planning
	Statutory	Trustee responsibilities and legislative compliance management
<i>Core</i>	Actuarial Risk Management	Forecasting and actuarial functions
	Premium risk management	Collection of premiums and debtor management
	Customer management	Call centre and customer relationship initiatives
	Claims management	Claims payments and assessing
	Medical risk management and chronic benefits	Pre-authorisation of hospital take-ins and chronic medication applications
	New business and brokers	New member take-on and broker management
<i>Support</i>	Finance and administration	Regular financial reporting and administration
	People management	Staff utilisation optimisation and succession planning
	Information technology	Key support systems and systems development

Continued...

<i>Type</i>	<i>Function</i>	<i>Key activities</i>
<i>Assurance</i>	Quality assurance or management	Daily monitoring and feedback of key transaction processes
	Internal audit	Objective assessment of risks
	External Audit	Statutory reporting review and auditing
	Forensic investigations	Fraud detection and prevention
	Risk management	Proactive risk management assistance and coaching
	Legislative compliance	Objective coordination of compliance with the Medical Schemes Act and other associated legislation

5.5 Roles and responsibilities of governing bodies

In 1993, the state president, Mr FW de Klerk, appointed a Commission of Inquiry into the manner in which medical expenses were being provided for. The commission was chaired by the Honourable Mr Justice Melamet and had as members Professor WD Reekie and Mr CC van der Meulen. The issues investigated by the commission were (Davies, 1995:8):

- The funding of schemes;
- the insurance industry's involvement in the healthcare cover industry; and
- the role of intermediaries in medical schemes.

The most significant recommendation from the commission was to give greater power to the Registrar of Medical Schemes to acquire information timeously and to inspect the financial records of a medical scheme (ibid).

The first Medical Schemes Act that was promulgated in 1967 survived a number of amendments until 1998 (SAHR, 2000a). The issues addressed by the current Medical Aid Schemes Act No. 131 of 1998 include (Medical Schemes Act, 1998):

- Establishment of the Council of Medical Schemes as a juristic person;
- to provide for the appointment of the Registrar of Medical Schemes;
- to make provision for the registration and control of medical scheme activities; and most importantly
- to protect the interests of the members of medical schemes.

According to the abovementioned Act, 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 4 times annually, includes (ibid.):

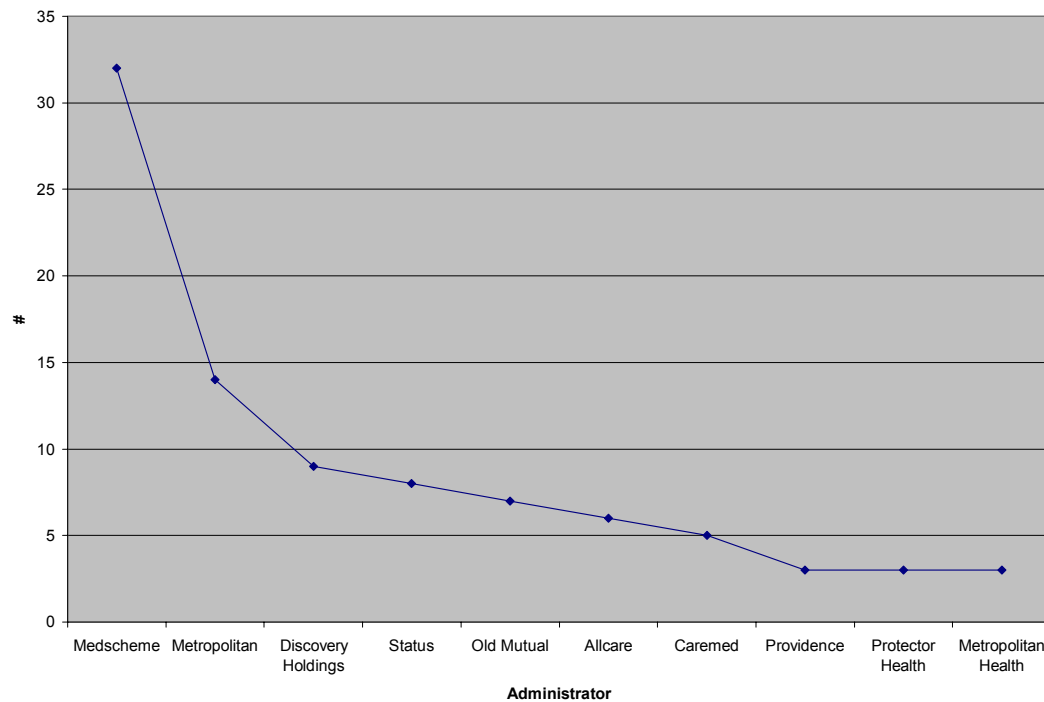
- Protect the interests of members at all times;
- control and coordinate the functioning of medical schemes in a manner that is complementary with the national health policy;
- make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of the relevant health services provided for by the medical schemes and such other services as the Council may, from time to time, determine;
- investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act;
- collect and disseminate information regarding private healthcare;
- implement rules, not inconsistent with the provisions of the Act, for the purpose of the performance of its functions and the exercise of the Council's powers;
- advise the Minister of Health on any matter concerning medical schemes; and
- perform any other functions conferred on the Council by the Minister or by the Act.

The Council receives funding from government, levies from medical schemes and other sources such as fines and interest on overdue levies.

5.6 Roles and responsibilities of medical scheme administrators

A medical scheme has a board of trustees that is responsible for the management and overall governance of the fund. In accordance with section 57(1) of the Act, every fund is to have a board of trustees consisting of persons who are fit and proper to manage the business. Below are key guidelines from the Act regarding the role of trustees (Medical Schemes Act, 1998):

- At least 50% of the members of the board of trustees are to be elected from amongst the members of the fund. A person who is a director or an employee of the third party administrator of a fund is not allowed to be a member of the board of trustees of that fund.
- The duties and responsibilities of the board of trustees are set out in sections 57(4) and 57(6) of the Act. These include ensuring that proper registers, books and records of all operations of the fund are kept and that proper internal control systems are employed by or on behalf of the fund.
- In accordance with section 37(1) of the Act, the board of trustees is to cause annual financial statements to be prepared and is to submit copies thereof, together with the report of the board of trustees, to the Council within four months after the end of the accounting period.
- In accordance with section 37(5) of the Act, the trustees are to prepare a report that deals with every matter, which is material for the appreciation by members of the fund, of the state of affairs and the business of the fund.
- Responsible for establishing an audit committee as required in section 36 of the Act.

Figure 5.4: Top 10 administration organisations (www.medicalschemes.com):

The trustees of the medical scheme will either create an administration organisation or delegate the full administration function to a specialist company (Davies, 1995:4). The specialist administration company should only have responsibilities in respect of general administration and should not assume any of the functions of the trustees (Davies, 1995:4). Figure 5.4 depicts the number of medical schemes administered by the top 10 specialist administration organisations registered with the Council of Medical Schemes as at January 2002.

In return for providing administration services, the administration organisation will charge a fee. These costs include but are not limited to (SAICA, 2001):

- fees and disbursements paid or payable to the trustees;
- fees and disbursements paid or payable to a third party fund administrator for the administration of the fund;
- other contracted services that are not of a claims nature;

- administration and consulting contracts with advisors;
- actuarial valuations and legal fees;
- depreciation;
- lease rentals;
- interest paid on finance leases;
- association fees;
- fees and disbursements to the auditors;
- fidelity guarantee and professional indemnity insurance premiums, and
- penalties.

Section 58 of the Medical Schemes Act No. 131 of 1998 and Chapter 6 of the associated regulations govern the roles and responsibilities of the private healthcare administrator. The key responsibilities covered by the regulations include (Regulations, 1999):

- Agreement in respect of administration;
- termination of administration agreements;
- appointment of external auditors;
- indemnity and fidelity guarantee insurance;
- maintenance of financial soundness; and
- dissolution or liquidation of business.

To ensure that members' interests are protected, the Council of Medical Schemes initiated a process to promote the formal accreditation of administrators (Council of Medical Schemes, 2001). A draft guideline on such requirements was issued in 2001. In August 2002 a follow-up circular indicating that the Council had finalised the process of soliciting proposals in terms of which administrators would be accredited under the Medical Schemes Act and regulations was issued (Council of Medical Schemes, 2002). The panel chosen to conduct the evaluation and assessment of the infrastructure of administrators consists of a joint venture amongst the Council for Health Service Accreditation of Southern Africa, KPMG Consulting and

SB&T Incorporated. The evaluation process to be conducted by this joint venture entails (ibid.):

- The setting up of audit mechanisms, standards and criteria for accreditation.
- Conducting a pilot study at a medium sized administrator.
- Developing and finalising the process for application and assessment of all administrators.
- Provision of questionnaires to administrators and subsequent on site visits at administration facilities to verify submitted information.
- Evaluation of administrator performance in terms of the standards and criteria.
- Submission of a detailed report by the panel on whether accreditation should be given to the administrator or not.
- An ongoing assessment of established criteria against international best practice.

5.7 Statutory financial reporting

Medical schemes are required to produce audited financial statements each year. Their financial year runs from the 1st of January to the 31st of December. The audited statements and certain statistical information must be supplied to the Council of Medical Schemes. The Council utilises all audited financial statements that are received as well as associated information to prepare their annual report, which is publicly available (Davies, 1995: 6).

As was noted in chapter 1, more rigorous auditing and accounting guidelines on medical schemes was issued by the South African Institute of Chartered Accountants in February 2001 (Hymans, 2001). To assist in implementing and continuously improving these guidelines, the Institute convened a Medical Schemes Project Group comprising appropriate representation from (www.isaca.org):

- The external auditing profession;
- the medical schemes industry;
- the regulators of medical schemes; and
- the actuarial profession.

The aims of the project group include (ibid):

- The enhancement of the quality and effectiveness of:
 - Financial reporting by medical schemes;
 - the audits of medical schemes;
 - the risk management process in medical schemes; and
 - corporate governance in the medical schemes industry.
- To assist in the development of audit and accounting pronouncements for medical schemes.
- To assist in the development of continuing professional education for members and associates involved in the medical schemes industry.

The financial statements of a medical fund should fairly present the financial position of the fund, changes in funds and reserves, the results of its operations and cash flows for the accounting period. The appointed external auditor of the medical scheme is required to verify the fair presentation (SAICA, 2001).

In view of the complex nature of an audit of a medical scheme, the auditor may obtain assurance from a variety of audit techniques. These include tests of control and tests of detail of transactions and balances, including analytical procedures and review procedures. It may also involve other auditors and the use of experts. The auditor exercises judgement in determining the most effective combination based on the information available, the deemed risks and materiality. The combination of procedures should ensure sufficient evidence is gathered to address the audit assertions of completeness,

occurrence, existence, measurement, valuation, rights and obligations, and presentation and disclosure (ibid.).

5.8 Empirical survey results

Scales applied in the empirical study were as follows:

<i>Importance</i>	>8 = Crucial.....7.....6 = important.....5.....4.....3 = cognisant.....2..... 1 = unnecessary.....0 = N/A
<i>Organisational Status</i>	>8 = Managed/optimised.....7.....6 = defined.....5.....4..... 3 = repeatable.....2.....1 = initial/rudimentary
<i>Difficulty in Implementing</i>	>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

Figure 5.5: Empirical study results: corporate governance

With regard to the various components of corporate governance, assign levels of importance to such components relating specifically to the medical scheme and indicate how well they are being managed

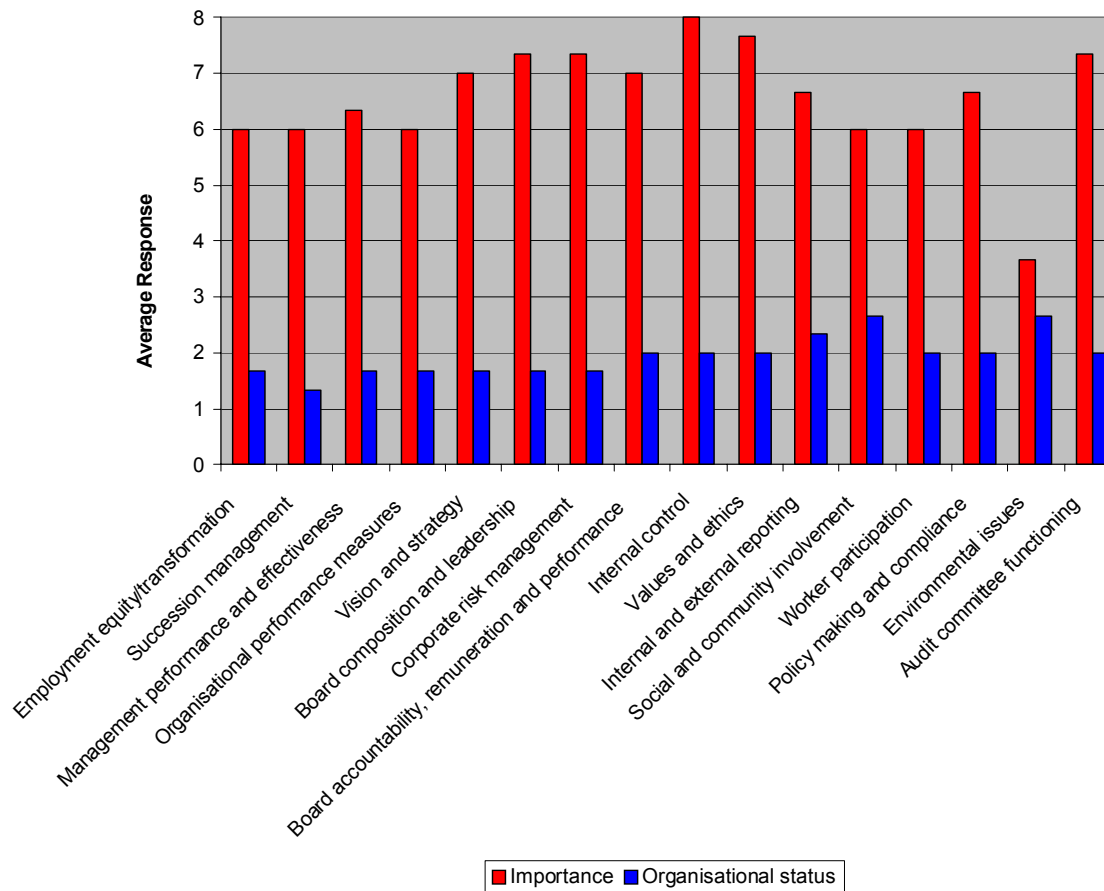


Figure 5.6: Empirical study results: pressing issues

Which of the following factors are considered the most pressing issues facing the medical scheme environment and how well are they being addressed?

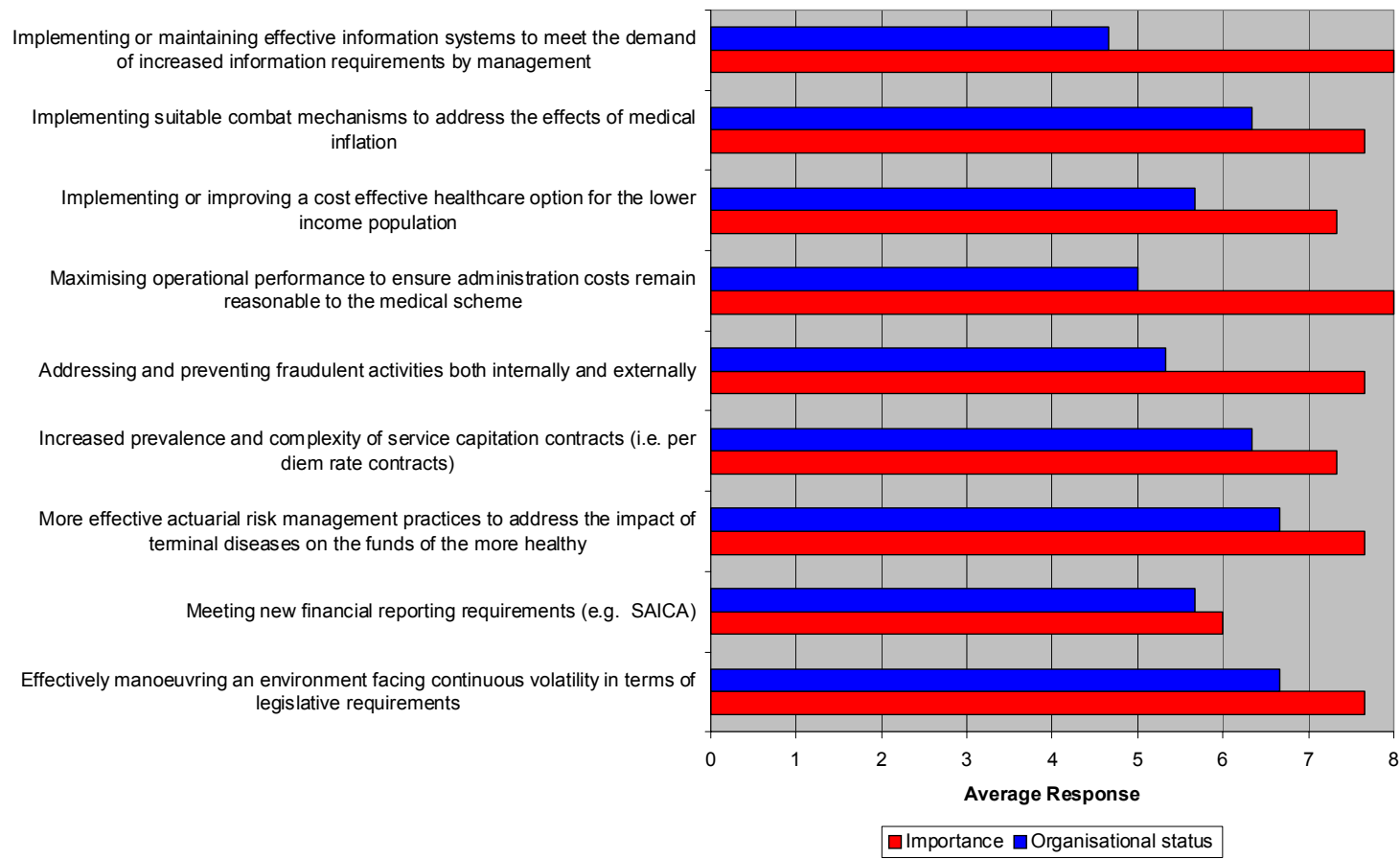


Figure 5.7: Empirical study results: importance of functions

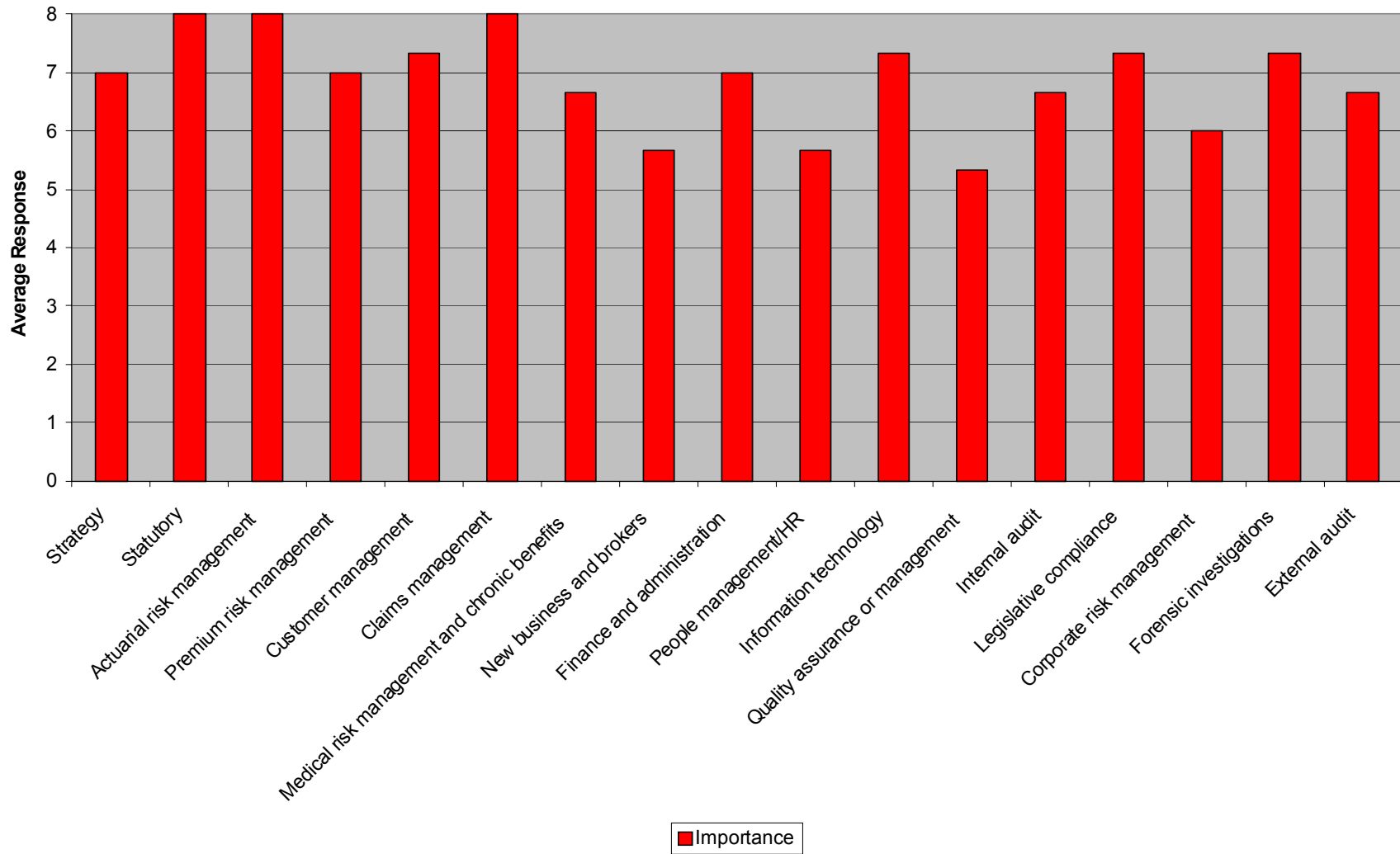
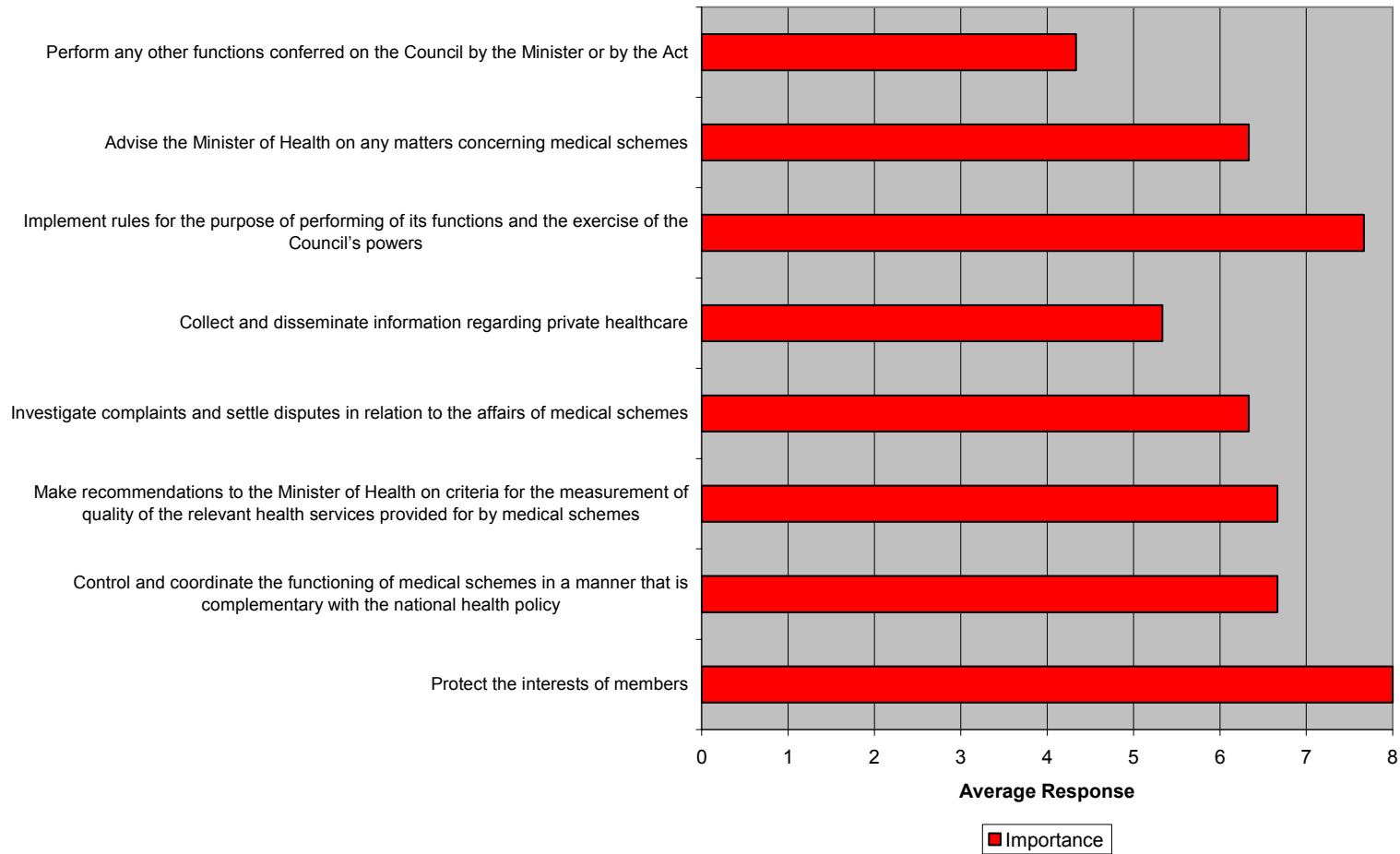


Figure 5.8: Empirical study results: functions of the Council

Which of the following functions of the Council of Medical Schemes are considered important?



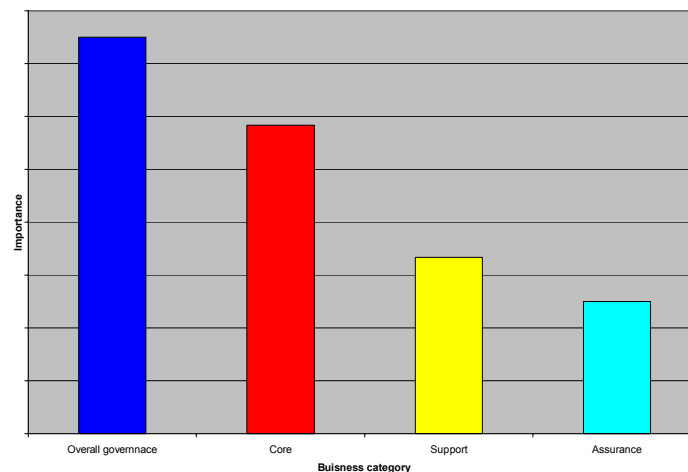
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Based upon the responses detailed in figures 5.5 to 5.8, the following observations apply:

- Values and ethics, internal control, corporate risk management and audit committee functioning are identified as the most significant corporate governance issues facing healthcare administration organisations today. Of these criteria, respondents indicated that they were being poorly managed within their organisations.
- Information systems and the maximising of operational performance to inhibit administration costs are identified as the most pressing issues facing medical schemes. As will be noted later, these concerns and any other high-risk issues can be effectively managed through a corporate risk management programme.
- The individual business functions of statutory, actuarial risk and claims management are identified as the most critical within the healthcare administration organisation.

Figure 5.9 depicts the results of consolidating the individual business functions of figure 5.3 into the four business categories of overall governance, core, support and assurance.

Figure 5.9: Empirical study results: prioritised business categories



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Figure 5.9 confirms that overall governance, which consists of the statutory and strategy elements, is of paramount importance in today's medical scheme environment. Organisations require effective business plans, participative boards of trustees and senior management teams to ensure the survival of their organisations.

Comments included in the King Report on Corporate Governance in South Africa support claims that strategic initiatives and operational activities (also known as core) should be the most focused upon risk categories in all industries (King Committee 2002: 78):

“Circumstances demanding close attention would include substantive changes to the operating environment, new personnel, new or revamped information systems, rapid growth, new technology, new products or activities, corporate restructuring, acquisitions and disposals”

- Implementing governing rules and ensuring a member's interests are protected are identified by respondents as the top 2 functions of the Council of Medical Schemes.

5.9 Summary

Insights from the private healthcare environment in the United States and Europe are provided. The most noteworthy of these being:

- 47% of healthcare costs in the United States are covered by state and federal reimbursement programmes.
- 23% of the United States population utilise private healthcare or medical scheme plans to complement state and federal reimbursement programmes.
- The United States population has experienced an average 27% increase in the cost of medical scheme plans. It is expected that this increasing trend will continue for several years to come.

University of Pretoria etd - De La Rosa, S (2003)

- The private healthcare environment in the United States faces two main problems, viz. access to healthcare and cost.
- Private healthcare plans in Europe are subdivided into substitutive, complementary and supplementary plans.
- The European country utilising the highest degree of private healthcare plans was Luxemburg (75% of population) while Sweden utilised the least (0.5% of population).
- The country with the highest private healthcare spend, as a percentage of total health expenditure for 1998, was the Netherlands while Austria was the lowest.

This chapter introduces the primary aim of the medical scheme as the business of undertaking liability in return for a premium or contribution by a member to make provision for the receiving of any relevant health services by that member.

The Council of Medical Schemes was introduced as the governing body of all medical schemes in South Africa. Legislation governing the South African medical schemes environment is encompassed in the Medical Aid Schemes Act No. 131 of 1998 and its associated regulations.

In certain instances, the board of trustees responsible for the activities of the medical scheme may decide to outsource the administration activities to a specialist organisation. Such an organisation, often termed the administration company, will take responsibility for the general administration and not any fiduciary responsibilities in terms of managing or governing the scheme.

The following significant issues are identified from the empirical study conducted:

- Values and ethics, internal control, corporate risk management and audit committee functioning are identified as the most significant corporate governance issues facing healthcare administration organisations.

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- Information systems and the maximising of operational performance to inhibit administration costs are identified as the most pressing issues facing medical schemes.
- Governance and core activities were identified as the two most significant risk categories within medical schemes.
- Implementing governing rules and ensuring that a member's interests are protected are identified as the top two functions of the Council of Medical Schemes.

5.10 Conclusion

As can be seen from the information included in Chapter 1 and the research detailed above, medical schemes throughout the world are a risky business. These organisations are required to provide exceptional cover to consumers whilst retaining costs in a highly regulated environment. This is no easy task and requires that risks be managed proactively so that suitable assurance may be provided to stakeholders that their funds and benefit provisions are safe.

The next chapter will focus on identifying the types of medical scheme risks prevalent within the South African medical aid organisation.