

CMS news

Issue 2 of 2009-2010

**Why South
Africans join
medical
schemes –
and why
they don't**



1. Some can – and do. 2. Others can too – but choose not to. 3. Most would like to – but cannot. This edition of *CMS News* talks about the determinants of medical scheme membership – and why South Africans belong to one of the three groups identified above.

Instead of universal access to care (which would be ideal), we face a universal problem. The international community has been trying to find ways of ensuring universal access to quality health-care to its citizens for generations. Very few countries have achieved an acceptable level of success.

South Africa may be no different in its attempts to make healthcare accessible to all its people but it faces its own unique set of circumstances and challenges. Solutions to the problems of our health system will have to be creative.

It is encouraging that most players in our healthcare system seem to agree that we first need to address the plight of those for whom access to care remains a distant dream when it is, in fact, their basic right, so fundamental that you find it in the UN Universal Declaration of Human Rights.

Let us not forget that the greatness of a nation is measured by the way in which it treats its most vulnerable.

Let us all extend a hand in solidarity to those who too often cannot fend for themselves.

And let us not forget that little things can make a big difference. Small structural changes can have a huge positive impact on medical scheme membership in our country.

Editorial Committee

Publisher

Council for Medical Schemes (CMS)

Editorial Committee

Alan Rothberg

Aleksandra Serwa

Alex van den Heever

Editor

Aleksandra Serwa

Contributors

Aleksandra Serwa

Alex van den Heever

Anton de Villiers

Daisy Ditsheane

Florence Maphanga

Julindi Scheepers

Michael Willie

Mondi Govuzela

Mpho Sehloho

Paresh Prema

Patrick Matshidze

Paul Bosch

Phumla Khanyile

Thulani Matsebula

Address

Block E

Hadefields Office Park

1267 Pretorius Street

Hatfield

Pretoria

Copyright: *CMS News* is published by the Council for Medical Schemes (CMS). All material is copyrighted and cannot be used without the written permission of the publisher. The views expressed by external stakeholders do not necessarily reflect the views of the CMS. All material is correct at the time of going to print.

Contents

How and why people join medical schemes	1
The determinants of medical scheme membership	2
Who could be a member ... but isn't?	3
Benefit design a barrier to entry?	4
How affordability influences membership	6
Analysing the growth in medical scheme membership	7
Brokers speak out	8
Observing the industry: our latest discoveries	10
How schemes and options disappear	12
He is finally here: meet Paresh Prema, the first Head of Benefits Management	13
Keeping an eye on the industry: our Research & Monitoring Unit	14
Reading matter	16

How and why people join medical schemes

Various factors enable groups of individuals to join medical schemes.

Most South Africans join a medical scheme through their employment. Another reason why individuals join medical schemes is because they are seeking a perceived higher quality of care in the private sector, particularly for hospitalisation. Most people cannot afford to pay out-of-pocket for private hospitalisation, therefore they enrol in medical schemes.

There are people who join medical schemes purely because they are risk-averse, meaning that they are not compelled by their employer to do so but join because they understand the catastrophic nature of healthcare expenditure. Medical scheme cover gives these individuals access to better resourced healthcare facilities that would otherwise be beyond their reach.

Another reason why people join medical schemes is because they can afford to; membership becomes part of their overall approach to healthy living. These individuals consider check-ups and routine visits to general practitioners as essential and provide for these services through medical scheme cover. A tax benefit currently exists for being enrolled in a medical scheme and some individuals take advantage of this.

There exists a group of individuals which would benefit from membership in a medical scheme. But several constraints make realising this goal impossible.

Medical scheme membership is predominantly income-related: only high-income groups effectively access reasonable cover. This lack of affordability is a severe constraint that prevents low-income groups from joining medical schemes.

Low-income groups participating in the medical schemes environment are usually able to do so through their employers. However, many employer groups have relinquished the running of in-house or restricted medical schemes in recent years and the subsequent subsidies that accompany the monthly medical scheme contributions. Low-income individuals faced with “total cost-to-company” remuneration packages are consequently forced to make trade-offs between healthcare cover and other consumption priorities. Medical schemes have struggled to formulate benefit packages that would accommodate low-income individuals whilst at the same time affording them reasonable cover.

Then there are those South Africans who can afford medical scheme cover but are either unwilling or not adequately informed about the pros and cons of medical scheme membership;

they do not join a medical scheme as a result.

Most people view medical scheme membership as a grudge purchase; it is something they do not willingly prioritise over other household needs. And so an individual who is young and healthy may not see the need to make a monthly payment towards a scheme which he or she may not have to use for many years to come. A lack of understanding of the concept of risk-pooling, whereby the healthier subsidise the healthcare needs of the sicker, usually means that many individuals approach medical scheme membership with a mentality that asks: “What’s in it for me?” People who do not see an immediate benefit for themselves inevitably opt out of the environment. Some of these individuals will seek membership in a medical scheme at a later stage in their lives; we all get older and start experiencing more ailments. The Medical Schemes Act, however, protects the existing members of medical schemes by allowing the imposing of waiting periods and late-joiner penalties aimed at individuals who behave in this manner.

Improving the affordability of medical scheme contributions is central to any efforts to encourage more South Africans to join medical schemes.

Bringing together healthier and sicker individuals facilitates a form of cross-subsidisation whereby the sicker people do not pay contributions according to their health status. This measure improves affordability.

Another strategy for improving affordability is ensuring that individuals pay contributions according to their income levels but have access to healthcare benefits according to need. Low-income groups are hence afforded access to a package of healthcare services that would otherwise have been out of their reach. High-income earners would then also experience a discount in their contributions because the number of contributors into the risk pool would have been broadened.

Engaging in mass education and awareness campaigns would also contribute towards informing people about the social solidarity nature of medical scheme cover. Many people continue to resist medical scheme membership because they do not understand how they can make monthly payments whilst not incurring any claims.

In spite of this lack of understanding, research has shown that medical scheme membership would increase significantly if contributions became more affordable. ■

By Patrick Matshidze
ACTING REGISTRAR
OF MEDICAL
SCHEMES AND
HEAD: RESEARCH &
MONITORING (until
30 November 2009)

“People need to understand the social solidarity nature of medical scheme cover.”

The determinants of medical scheme membership

The strongest determinant of medical scheme participation is household income.

By **Alex van den Heever**
INDEPENDENT
HEALTH ECONOMIST
AND SENIOR
ADVISOR TO THE
COUNCIL FOR
MEDICAL SCHEMES

According to an analysis of the General Household Survey conducted in 2006, families join a scheme when medical scheme contributions fall roughly below 16% of gross household income.

A very reliable indicator of medical scheme participation is the number of tax payers (rather than registered tax payers). In 2006 there were roughly 3 000 740 tax payers and 2 985 350 principal members. This very close numeric correlation suggests that earning levels sufficient to require the payment of personal tax is an indicator of medical scheme affordability. This implies that, barring other structural factors, medical scheme membership will only rise if the number of personal tax payers rises.

The increased medical scheme participation seen in recent years is in part related to employment growth affecting the number of tax payers, the implementation of the Government Employees Medical Scheme (GEMS), and the development of effective low-income options. GEMS, however, reflects the leveraged impact possible through employer mandates and a relatively minor income cross-subsidy (via the employer).

But open medical schemes, affecting 70% of all beneficiaries, cannot implement income cross-subsidies, and would only be able to rely on a government intervention to achieve a similar effect. As a consequence they must rely on trying to make packages affordable. Although this will meet with some success, it will be limited and related to improvements generally in formal employment and the number of tax payers unless a desired package can be offered at a cost that falls within the affordability threshold.

A significant number of people without medical scheme cover pay for private ambulatory services despite having access to free public services. Expressed as a catchment population, this amounts to roughly 10% of the total population. On average these households spend around 2% of their gross income on these services.

Surveys carried out as part of the Low Income Medical Scheme (LIMS) process, however, identified a preference for many non-medical scheme members to obtain coverage for more than just

ambulatory services, specifying emergency and maternity care.

Quite clearly people choose insurance mechanisms for expenses that are more catastrophic and infrequent in nature. Within the context of health-care they would also be concerned about access to services that are regarded as safe. This would be a particular concern in relation to emergency and maternity care, given the poor record of the public sector in both areas. Given this, it is possible that low-income groups would pay more for this coverage than they would for ambulatory care.

Consequently, existing out-of-pocket expenditure levels on ambulatory care would not reflect the potential demand for coverage for insurable events which would be valued differently. Very slight changes in employer support, government subsidies, and differential pricing for these services could dramatically increase the demand for this form of cover, even without a relaxation of prescribed minimum benefits (PMBs). However, exempting certain income classes from the PMB requirement could attract roughly 5 million additional beneficiaries into partial catastrophic cover options. Changes to the existing tax subsidy to prioritise lower-income groups, as proposed by National Treasury, would ensure that around 2 million of the 5 million would have access to comprehensive cover, including PMBs.

Given the uncertain direction of health policy at present, keeping medical scheme costs in check remains a priority. During 1999-2004 medical scheme costs rose sharply relative to international trends. This undoubtedly led to the exclusion of lower-income groups at the margins of participation. But a fairly dramatic change in contribution costs occurred from 2005 onward, with index changes converging back on international trends. This has also contributed to participation at the margin from 2006.

A more rational cost trend may require that prices are determined in a concerted manner by all role players rather than relying on price competition, which is almost entirely absent from the provider market at present. Concerted actions to respond to price determination would have the advantage of driving up the demand for cover and increasing the normal demand for services while simultaneously reducing the pressure on health-care providers to artificially drive up prices and demand.

Hopefully South Africa will be in a position to take advantage of these opportunities in future. ■

“ Keeping medical scheme costs in check remains a priority.

”

Who could be a member ... but isn't?

Many South Africans have the desire to join a medical scheme but are prevented from doing so.

Most South Africans realise that being enrolled on a medical scheme is the only avenue through which private providers, especially hospitals, can be accessed. This is because the services of private providers are often priced beyond what most individuals and households in South Africa can afford.

Most South Africans, given a choice, would seek care in the private health sector due to the well-documented problems with state facilities. Consequently, the majority of individuals that are not enrolled on a medical scheme are not doing so out of choice.

The inability to join a scheme is largely attributable to affordability constraints which, in turn, arise from various conditions, some of which are outlined below.

The biggest barrier

Lack of affordability is the single biggest constraint that forces many to abandon medical scheme membership. Private provider charges are the single most important contributor to medical scheme contributions. The private healthcare sector has experienced a sustained cost-escalation trend for most of the past decade, resulting in contributions increasing at levels that have consistently been above inflation.

Two groups of individuals are affected by the affordability constraint.

The first consists of those who have never belonged to a medical scheme. Most of these either do not have sufficient income or have not yet held jobs where medical scheme membership is a condition of employment. The unemployed, self-employed, and low-income earners fall into this group.

The second group are those who have previously belonged to a medical scheme but have had to lapse their membership for various reasons.

Research indicates that medical scheme coverage drops dramatically for people aged 20-29 and over 50. Individuals in the 20-29-year age group include those that used to depend on their parents for membership but were forced to relinquish their membership due to statutory provisions. (The Medical Schemes Act (Act 131 of 1998) stipulates that you can remain a child dependent on your parents' medical scheme cover up to the age of 21.) Since these young adults are just entering the job market, they may not be

earning enough to afford medical scheme cover – even if they want to sign up for it. It is, however, also conceivable that several of these young and healthy individuals are simply postponing their enrolment and thus engaging in anti-selection behaviour.

Many people over the age of 50 are also likely to be former medical scheme members who have subsequently been compelled to relinquish membership as they enter retirement. Medical scheme membership is correlated with employment and many South Africans are unable to afford contributions without support from their employers. This situation becomes worse at retirement when most people's incomes drop substantially.

The efforts of the medical schemes industry to introduce products for low-income earners have met with very little success. Existing products are still priced at levels unaffordable to most low-income earners. Purchasing these products often implies that low-income earners have to spend 30-40% of their income on cover compared to less than 10% spent by middle- to high-income earners. Low-income individuals can thus meaningfully participate in the medical schemes industry only through substantial subsidies from their employers.

Some suggest that the requirement for prescribed minimum benefits (PMBs) in medical schemes is a major obstacle to devising medical scheme products for low-income earners. Subsequent recommendations have been made for a modified PMB package targeted specifically at low-income earners. It is not clear how such a product would be structured but perhaps it would need to be introduced with caution to avoid creating the perception of "a medical scheme product for the poor" which is likely to greatly affect the potential uptake of such a product.

It is important to emphasise that those currently not participating in the medical schemes environment, even though they desire to, are not a homogenous group. Strategies to facilitate their enrolment must thus be structured to accommodate their unique expectations and pay special attention to the issue of affordability. ■

By Thulani Matsebula

SENIOR POLICY ANALYST

(until 30 November 2009; HEAD: RESEARCH & MONITORING from 1 December 2009)

“The issue of affordability deserves special attention.”

”

Benefit design a barrier to entry?

Many prospective medical scheme members see the complexity inherent to the industry as a barrier to entering the environment. But is this barrier real?

By **Paresh
Prema**
HEAD: BENEFITS
MANAGEMENT

Medical schemes are originally set up to be entities that undertake to pay for medical expenditure in return for a contribution. The advantage of using medical schemes is made apparent by being able to pool the contributions together and pay for benefits based on need and not affordability. This intention is still the basis why medical schemes operate in South Africa; it offers value to medical scheme members, as originally intended. Individuals purchase medical scheme cover to ensure that medical bills will be paid in instances where they may face unexpected health-care costs in the future.

Purchasing medical scheme cover, and in particular a specific benefit option within a scheme, gives members access to a range of benefits. These benefits are governed by the Medical Schemes Act 131 of 1998 and there are minimums that apply in terms of benefits that schemes must provide. Benefits over and above these minimums are subject to the option chosen by members on joining a medical scheme.

Over the years schemes used the interventions allowed for in the Act to manage the benefits that they provide. In addition to these interventions, schemes also brought about many innovations into the industry; this has effectively resulted in benefit designs becoming ever more complex. This complexity can be seen as a barrier to entry into medical schemes as it detracts from the actual benefits that the medical scheme option provides. The barrier may also be created as new entrants into the medical schemes environment are being overwhelmed with the level of complexity and amount of choice in the industry at present; this is an unintentional consequence of benefit design.

Benefits provided by medical schemes

The Act and its Regulations stipulate the minimum benefits that must be provided by all medical schemes. They are called the prescribed minimum benefits (PMBs) and consist of 270 conditions, any emergency medical condition, and 26 chronic conditions on the so-called Chronic Diseases List

(CDL), all listed in the Regulations and for which treatment is to be provided by medical schemes. Section 33(2)(a) of the Act requires that all options provide for PMBs.

The level of additional benefits provided on top of PMBs will depend on the option elected by the member within the medical scheme.

Design considerations allowed in the Act

The Act allows for various interventions to assist schemes in their benefit design considerations that they intend to market. Medical schemes use these interventions as a way to manage and transfer some of the risks associated with providing health-care services. The intention behind allowing

schemes to use these benefit design considerations was to enable the medical schemes industry to provide evidence-based and cost-effective care for those that are most in need. These interventions include personal medical savings accounts, co-payments and deductibles, managed care initiatives, and designated service providers or DSPs.

Schemes continue to make use of these interventions which, in turn, has resulted in added complexity in the medical schemes industry as we know it. This additional layer of complexity is not easily understood by prospective members seeking to purchase a medical scheme option. The use of easily understandable, everyday language is unfortunately not the practice in the industry, and the variety of names for the different benefits in schemes can be difficult for a layperson to understand. The definitions provided in the sidebar on the next page are just a brief description of the range of benefit design considerations that medical schemes have available to them; understanding these would help potential medical scheme members understand modern benefit design.

The design options available to schemes may be seen as another method in which a scheme limits the availability of medical services. This may seem as having the effect of a barrier to potential members intending to join a medical scheme.

“The complexity and amount of choice in the industry is an unintentional consequence of benefit design.”

”

Accessibility of benefits

In the medical schemes industry, the healthcare provided to members is divided into various categories. The two broad categories are out-of-hospital (also termed day-to-day) benefits and in-hospital benefits. It is common for schemes to try and minimise the cost of day-to-day benefits by transferring cost and/or risk to members through the introduction of personal medical savings accounts and DSPs.

By limiting the out-of-hospital benefits to savings accounts, schemes leave the decision as to which service to use and when to use it, in the hands of the member. This approach is used to enable the member to make decisions around the need for day-to-day benefits and their use. These benefits were not included in the list of minimum benefits that must be provided to members when the Regulations were enacted.

In-hospital benefits, at least those covering PMBs, must be paid from the risk pool of the scheme, with limitations applying in certain instances only, for instance where the member voluntarily decided to use a non-DSP. PMBs ensure that schemes provide minimum benefits and do not allow schemes to change their benefit design to reduce potential members' access to these benefits.

Is there a barrier?

The benefits available to medical scheme members are clearly defined in the Act. It is the method of delivery of services adopted by schemes that adds further to the complexity of benefit design. The Act requires that all information regarding the benefits applicable to members be made available. Information that is readily available and accessible by members includes the rules of their scheme, protocols, and formularies, to name a few. It is in the members' best interest to understand their benefits and how they are provided by their scheme.

The principles of open enrolment and community rating are statutes in the Act enabling fair treatment of beneficiaries and non-discrimination. The impression being created by complex benefit designs is that they almost circumvent these intentions in instances where schemes use the tools provided in the Act to help them manage their risk. This may be seen, from the outside, as a barrier to entry by individuals previously not members of medical schemes. But these perceived barriers are merely false impressions created by the misunderstanding of the methods employed by schemes to provide a vehicle to fund medical services. ■

Complex terms made simple

Referral mechanism: accessibility of benefit is dependent on obtaining a referral from a healthcare provider; e.g. when you need a referral from your GP to go to a specialist

Pre-authorisations: you need to obtain authorisation from the scheme before you undergo a medical procedure; used by scheme to manage the medical services provided to the member based on appropriateness and effectiveness based on protocols set out by the scheme; not a guarantee of payment for service(s)

Personal medical savings accounts: accounts set up by scheme for use by a member for medical services, excluding the offsetting of contributions and PMBs

Designated service providers (DSPs): networks established by scheme that provide medical services to its members; for primary, secondary, and tertiary care; based on cost-effectiveness and efficiency of services provided; accessibility to DSPs needs to be effectively managed to ensure effectiveness of DSP arrangement; the use of DSPs for primary

care is based on networks or capitation agreements (i.e. a fee paid per member per month for medical service provided)

Co-payments and deductibles: amounts payable by member; applied where member chooses not to obtain service from a DSP; require member to pay some of the cost of providing the service; amount is specified in rules of scheme

Protocols: procedures which the scheme specifies for treatment of specific illnesses; determined on basis of evidence-based medicine, taking into account cost-effectiveness and affordability

Formularies: list of medications that scheme provides without additional payment by member; for acute or chronic conditions; based on evidence-based medicine, taking into account cost-effectiveness and affordability

Managed care organisation: organisation contracted by scheme to provide and manage a healthcare service based on clinical and financial risk assessment to facilitate appropriateness and cost-effectiveness of the relevant health service

How affordability influences membership

Statistics show that most South Africans cannot join the private health sector because the medical scheme contributions are simply too costly for them.

By **Mondi Govuzela**

RESEARCH ANALYST:
RISK EQUALISATION
FUND

The General Household Survey (GHS) which was conducted in 2007 estimated that the percentage of South Africans belonging to medical schemes declined from 15% in 2002 to 14% in 2007. According to these estimates, there were 6.8 million medical scheme beneficiaries in the year 2007 while 40.8 million South Africans did not enjoy access to private health cover in 2007.

However, in its Annual Report covering the financial year 2007-2008 the Council for Medical Schemes (CMS) reported that there were 7.5 million beneficiaries as at the end of 2007 – significantly more than was reported in the 2007 GHS findings. The overall medical scheme membership had grown to 7.8 million by the second quarter of 2009. This growth may be attributed primarily to the Government Employees Medical Scheme (GEMS) which has managed to increase its membership by more than 50% from 2007.

Using the figures compiled by the CMS, the number of South Africans covered by medical

schemes and enjoying access to private doctors and hospitals has increased from 14% in 2004 to 16% at the end of 2008.

So the growth in medical scheme membership has been slow. There can be little doubt that this is primarily due to affordability issues.

Participation in the private health insurance environment is known to be strongly associated with income levels of individuals and households.

A more in-depth analysis of the 2006 GHS shows that about 80% of people who earn at least R15 000 are beneficiaries of medical schemes, as shown in the figure below.

It is also worth noting that medical scheme coverage decreases to less than 50% for people whose salaries are R4 000 and below. This may suggest that people prefer to use private health services once the affordability barrier is overcome.

More research needs to be conducted to enable us to talk to the issue of affordability in the context of the South African medical schemes industry, but the latest estimates do seem to

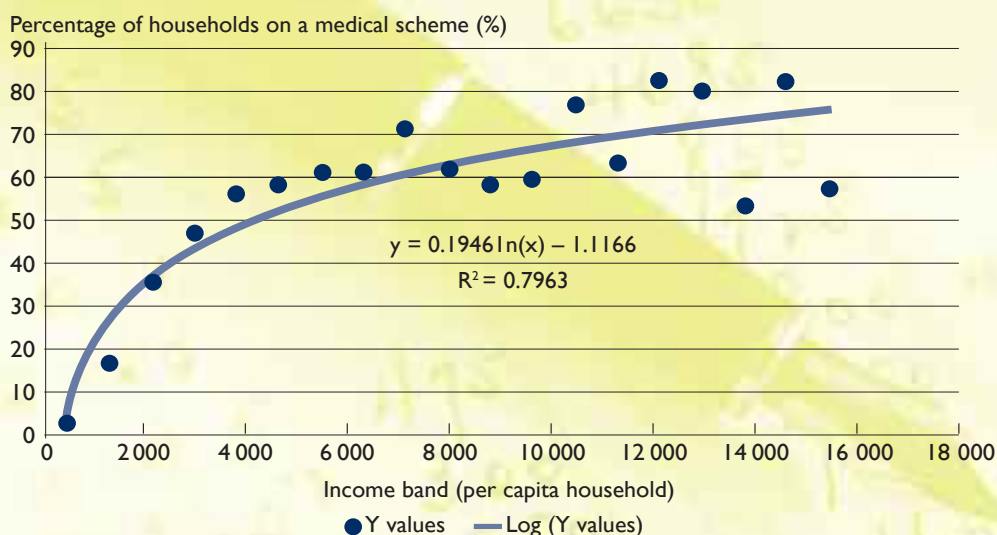
suggest that households opt out of their medical scheme when the monthly contribution equals or exceeds 16% of their total income for the month.

Still, the majority of those who are not members of a medical scheme have little or no income at all.

South Africa is facing many challenges when it comes to the provision of universal care and healthcare cover for all its citizens. ■

“The growth in medical scheme membership has been slow. There can be little doubt that this is primarily due to affordability issues.”

Medical scheme participation by households who earn up to R16 000 per capita on a monthly basis (2006)



Source: Alex van den Heever

Analysing the growth in medical scheme membership

More and more South Africans are joining medical schemes. What are schemes doing to attract new members?

In the past 10 years, the number of South Africans belonging to a medical scheme has grown by about 1.6 million and currently stands at just below 8 million (see graph below).

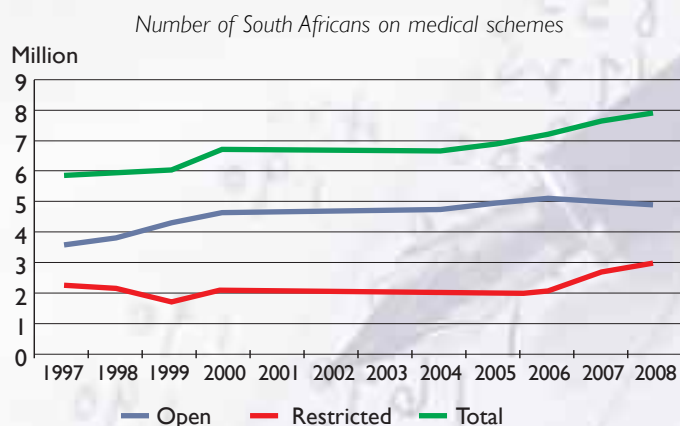
Many South Africans signed up for private health cover between 1999 and 2000 because the new Medical Schemes Act came into effect in 1999. It did away with risk-rating on the basis of existing medical conditions and forbade schemes to determine contributions based on factors such as age, gender, health status, race etc. This substantial growth in beneficiary numbers can also be ascribed to an "amnesty" period that permitted people who had never belonged to a medical scheme before, to join without a late-joiner penalty.

People left schemes in 2001-2004 because of the economic slowdown which occurred at that time but they started signing up again from 2005 to 2007 due to the economy picking up and formal employment increasing; our research shows that medical scheme membership correlates with employment figures. We have not seen evidence that the current economic recession is causing people to leave medical schemes.

In 2005-2008, membership growth occurred primarily at the lower end of the cost spectrum (low-cost options are options whose average contribution per beneficiary is below the industry average). Whereas the overall increase in beneficiaries was about 15.0%, the increase in beneficiaries on low-cost options was 26.0% during that time. The percentage of beneficiaries on low-cost options increased from 45.9% of all beneficiaries in 2005 to 50.0% in 2008.

The success of low-income options

Low-income options are benefit options that have either capitation or network arrangements.



Looking at the 57 low-income options in 2007, the number of lives covered increased by 13.6% in 2008; the average age decreased by 0.23 years and the average contribution increased by 12.4%.

GEMS and employer subsidies

The Government Employees Medical Scheme (GEMS) has been experiencing phenomenal growth in membership. Most of its new members are young and leave behind older members in their previous schemes; this has a negative effect on their operating results and puts pressure on their solvency.

GEMS is an employer-based scheme which does not impose waiting periods on new members (underwriting). And the subsidy offered by their employer may be another reason why people flock to GEMS.

So what are schemes doing to attract new members?

Overall membership may have been growing at only 3-5.0% over the past few years, but some open schemes managed to increase their membership by 5-12.0% or 5 000-31 000 new members per annum – and this despite losing members to GEMS.

The contributions of schemes whose membership base has been growing are generally lower than those of other schemes but affordable contributions on their own neither attract nor retain members; they must go hand in hand with adequate benefits and a wide range of options. This is particularly important when employer groups join a scheme as opposed to individuals.

Extra non-benefits and access to "lifestyle clubs" by themselves do not attract new members either, but they do offer people – especially the younger, low-claiming members – what are perceived as additional benefits or rewards for membership on top of adequate health cover.

Many schemes also seem to have realised that an equal amount of effort must be put into *retaining existing members* as into attracting new ones. "It is no good welcoming new members through the front door while existing members are leaving in greater numbers via the back door," a Principal Officer told us recently. ■

By **Daisy Ditshoene**
(SENIOR BENEFITS ANALYST)
& **Paul Bosch**
(SENIOR FINANCIAL ANALYST)

Schemes employ growth strategies based on factors such as:

- offering value for money;
- offering more affordable benefit options;
- using selective contracting with preferred provider networks to ensure contributions are kept low without sacrificing cover;
- ensuring superior customer service;
- building relationships with employers and intermediaries; and
- making and/or keeping their products simple and understandable.

Brokers speak out

In this edition of *CMS News* we explore the possible reasons why South Africans join medical schemes – and why they don't. When trying to understand their reasons, who better to ask than the very people who help others make crucial decisions about their healthcare cover – in this case, the broker fraternity?

By **Florence Maphanga** (SENIOR ACCREDITATION ANALYST), **Dr Anton de Villiers** (SENIOR ANALYST: DATA MANAGEMENT) & **Aleksandra Serwa** (COMMUNICATIONS MANAGER)*

In the context of our medical schemes industry, South Africans can arguably be divided into three groups: those who sign up for private healthcare cover because they can and want to, those who could sign up but prefer not to, and finally those who would like to belong to a medical scheme – but for some reason can't.

A total of 545** brokers and brokerages participated in our survey in which we asked them to give reasons why these three groups of people behave the way they do. We also wanted healthcare brokers to tell us what could – and perhaps should – in their opinion be done to help those South Africans who face obstacles to accessing what is, after all, their basic human right: the right to access quality healthcare, regardless of their age, social class, or status of health.

“I can and I do” – why do people join medical schemes?

It seems that most people who join a medical scheme do so because they want to feel protected against unforeseen and financially catastrophic health events that might require hospitalisation. This according to an overwhelming majority of brokers polled (411 of the 545 or 75%).

“People join medical schemes to protect themselves from financial ruin brought on by a hospital bill and the cost of chronic medication,” Jorsh Engelbrecht, a sole proprietor with approximately 600 clients in the Pietermaritzburg area, told us in the survey. “The cover for out-of-hospital needs is a mere extra benefit.”

Is this finding not merely a reflection of a fundamental human need? We all want to avoid misfortune and most of us put our health first. But, to state the obvious,

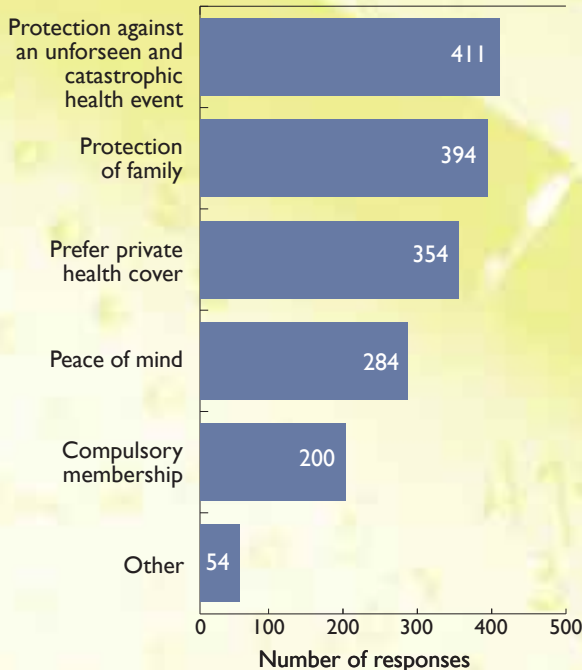
not everything is under our control. Who of us is immune to the mysterious workings of fate? Accidents happen. And they can and too often do put at risk the entire livelihoods of families. We have all heard of people being forced to use their life savings and sell their houses to foot costly hospital bills after a loved one was involved in a car accident or a natural disaster.

People, presumably those with younger children in particular, also want to know that their families will be properly looked after in the case of a health tragedy that might occur in future. This motivation for joining a medical scheme came in second in the broker survey. It seems closely related to the first.

“I can but I don't” – why do some choose not to join?

Many South Africans can – and we believe that for their own good they should – join a medical scheme. But they choose not to. According to our

“I can and I do”



“I can but I don't”



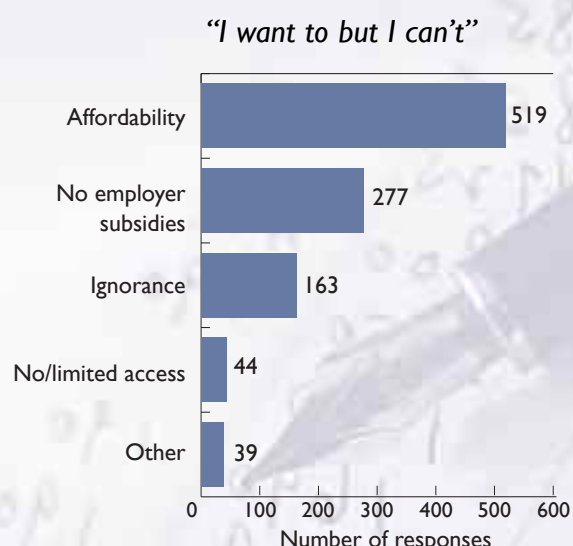
poll, this is primarily because they feel that “they don’t need private healthcare cover right now”.

Interesting. We know you don’t want to be involved in an accident – and we sincerely hope you never are. But can you predict whether or not this bad luck will befall you or your loved ones, let alone when? What if it does? We expected the frequency of this answer to correspond with the frequency of “ignorance” – surely people think they can escape the clutches of capricious gods because they don’t know any better? Sure enough, brokers ranked ignorance second. But when we dug deeper, only 168 of them (or 31%) answered “yes” to both options. Further research is needed to make more sense of this observation.

Late-joiner penalties and waiting periods that medical schemes impose on potential members were also cited as possible reasons why people opt not to join the private health insurance sector. The brokers polled believe these reasons are especially true for those who return to South Africa and foreign nationals over the age of 35.

“I want to but I can’t” – how can access to private health cover be promoted?

Then there are those who wish they could join a medical scheme but are prevented from doing so.



“

We support the concept of quality healthcare for all South Africans.

”

“People understand the value of good healthcare,” says Frederick Hurter of Chrismar Brokers in Polokwane.

“All my clients who join a medical scheme see it as a responsibility towards themselves as well as their family,” says Johanna Cicione of JC Medical Aid Brokers in Nelspruit. “I have yet to meet clients who are not interested in joining a medical scheme.”

So why do so many South Africans remain excluded from the private healthcare system? A staggering 95% of the brokers polled think people do not join medical schemes because of one simple reason: affordability.

It seems private health insurance is simply too expensive for most South Africans. According to brokers, this reason far outweighs any other obstacles to enjoying the sense of security stemming from being a member of a medical scheme.

The graph on this page also shows that the second-biggest reason why people cannot sign up for private healthcare cover cited by brokers is the fact that many of them do not have access to employer subsidies for medical scheme membership; this, however, again points to affordability.

Brokers’ comments on all three questions made it very clear that an overwhelming majority of South Africans prefer private health cover because they have virtually no confidence in our state healthcare facilities.

Looking ahead

Perhaps we need to refocus. As a society concerned about the well-being of our neighbours, perhaps we should remind ourselves of what this is really all about. And perhaps we should start reflecting by taking another look at our Constitution. There is nothing ambiguous about it: “Everyone has the right to have access to [...] healthcare services.”

As the Council for Medical Schemes, we support the concept of quality healthcare for all South Africans. We also support efforts to promote access to private health cover.

Because we tend to agree with Steven Akakios of Omega Management CC in Johannesburg: “There is little future without health.” ■

** A word of appreciation must go to Danie Kolver, Head of our Accreditation Unit, and Senior IT Programmer Wellington Mekhoe for their guidance and assistance with the drafting and dissemination of the survey.*

*** We would like to extend a word of sincere thanks to all 545 brokers and brokerages who participated in our survey. Thank you for your time and openness in sharing your thoughts and concerns with us.*

Observing the industry: our latest discoveries

One of our responsibilities as the Council for Medical Schemes is to collect information on the industry and share the findings of our research endeavours and analyses in a transparent manner. We have just published our Annual Report* covering the financial year 2008-2009. Here are some of the more interesting figures.

By **Michael Willie**
(RESEARCH ANALYST)
& **Julindi Scheepers**
(CHIEF FINANCIAL ANALYST)

Membership

By the end of 2008, almost 8 million South Africans belonged to a medical scheme. More specifically, between January and December 2008 the number of beneficiaries (principal members and their dependants) increased by 3.5% to 7 874 826**. Membership of the so-called restricted or employer-based schemes grew by 12.5%. This may be attributed to the Government Employees Medical Scheme (GEMS) which increased its membership by 52.8% from 2007.

The ratio of dependants to principal members decreased from 1.4 in 2007 to 1.3 in 2008.

The pensioner ratio remained unchanged at 6.2%.

The average age of beneficiaries increased from 31.4 years in 2007 to 31.5 years in 2008.

Contributions and claims

In 2008, schemes collected R74.1 billion in contributions from their members; this is an increase of 13.2% on 2007. During the same period of time, schemes paid R64.9 billion in claims on behalf of their members, a rise of 13.6% from R57.1 billion in 2007. Contribution increases were higher for open schemes compared to restricted schemes.

The percentage of contributions that schemes spent on claims – known as the “claims ratio” – was slightly higher in 2008. Schemes spent on

average 86.9% of contributions on claims, compared with 86.5% in 2007.

The proportion of money that schemes paid out to members who have personal medical savings accounts decreased in 2008. This may be indicative of an increase in what is generally termed “self-payment gaps” created via mechanisms such as thresholds and

deductibles: members funding benefits out of their own pockets.

Benefits

Of the total amount they spent on healthcare, schemes paid R20.2 billion (37.0%) to hospitals (see Figure 1). They spent 17.4% more on private hospitals: R23.7 billion. (This increase was 6.5% when adjusted for inflation.) Interestingly enough, the number of beneficiaries admitted to private hospitals decreased to 177.3 per 1 000 beneficiaries from 181.8 per 1 000 beneficiaries in 2007. We also noted a declining trend in the number of unique admissions since 2002. The decline was 21.0% and 2.0% for all admissions and beneficiaries admitted to private facilities respectively between 2007 and 2008.

Schemes paid R14.0 billion or 21.7% of total benefits to medical specialists. This is an increase of 13.7% on 2007 or an inflation-adjusted increase of 2.2%. More beneficiaries visited physicians, psychiatrists, and clinical haematologists in 2008, continuing a trend previously observed.

General practitioners (GPs) were paid R5.2 billion (8.1%) of the total benefits, representing a significant increase of 18.5% on 2007 (6.5% after adjusting for inflation). A similar increasing trend was noted in the utilisation of GP services.

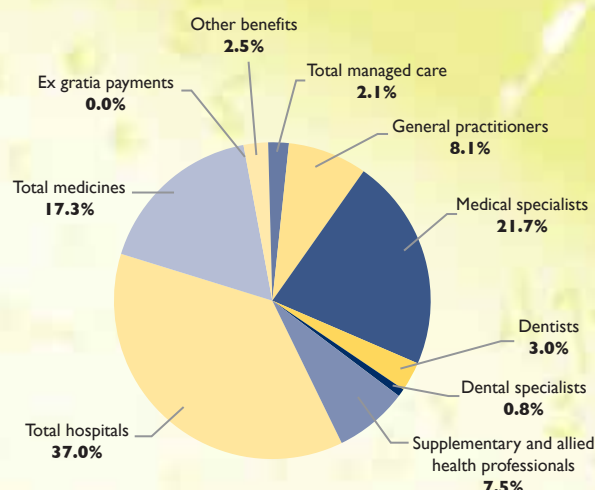
Of the total amount they spent on healthcare in 2008, schemes paid R11.2 billion (or 17.3%) on medicines which were dispensed by pharmacists and healthcare providers other than hospitals. This is a significant increase of 18.2% compared with the R9.5 billion spent in 2007.

Non-healthcare expenditure

Total non-healthcare expenditure (administration expenditure, fees for managed healthcare: management services, broker costs, impairments, and reinsurance) rose by about 8.1% to R9.7 billion in 2008 from R9.0 billion in 2007. When expressed as a percentage of contributions, it was 13.2% overall.

Spending on administration, which is the biggest component of non-healthcare expenditure, rose by 6.5% to R6.8 billion at the end of December 2008 from R6.4 billion in 2007.

Figure 1: Total benefits paid in 2008



Expenditure on managing benefits (managed healthcare fees) grew by 9.4% to R1.7 billion. Brokers were paid an additional 11.6% in 2008, bringing their fees to R1.2 billion from R1.0 billion in 2007.

Low-cost benefit options tended to have fewer claims but higher non-healthcare expenditure. Further work is needed to understand this.

Net healthcare results

Schemes tend to have two investment objectives: to maximise the return on their investments on a long-term basis, and to outpace inflation, which results in real returns. The higher the reserve levels of a scheme, the more aggressive such a strategy would have been.

Schemes reported an operating deficit of R929.4 million in 2008 (see Figure 2); this is less than the R1.0 billion deficit observed in 2007. Net investment and other income may have decreased by 12.3% to R3.4 billion in 2008 but these additional sources of income helped schemes to convert their operating deficit into a final surplus for the year of R2.4 billion, which is a 12.4% decrease on the 2007 surplus of R2.8 billion.

A closer look at these results indicates that there is no single reason why the performance of schemes started improving from 2006. It is also still too early to make a determination on the sustainability of this trend, especially given the volatility associated with investment income and the current economic circumstances. Therefore, schemes should guard against relying too heavily on investment income as a way of boosting their reserves.

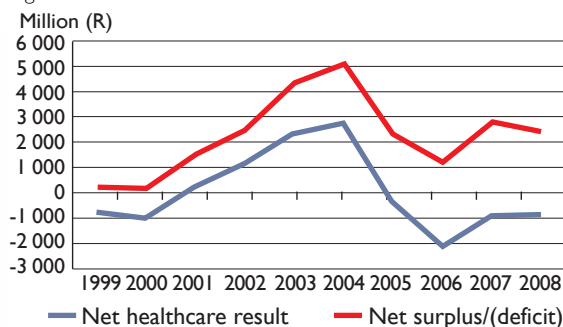
Funds and solvency

Net assets or members' funds, defined as total assets less total liabilities, rose by 5.8% to R28.8 billion from R27.3 billion in 2007.

The reserves of schemes are expressed as a percentage of gross annual contributions, generally known as the "solvency ratio". By law, schemes are required to store 25.0% of their contribution income as reserves.

The average solvency ratio for the industry decreased from 38.0% in 2007 to 36.6% at the end of 2008. Open schemes had a solvency ratio of 29.8% (2007: 28.6%); restricted schemes had an average solvency ratio of 49.8% (2007: 58.7%).

Figure 2: Net healthcare results



The healthier solvency ratio of open schemes is mainly attributable to Discovery Health Medical Scheme attaining the statutory solvency level at the end of 2008. The lower solvency ratio of restricted schemes is contrary to the better solvency experienced by GEMS. This inverse variance indicates that a number of restricted schemes suffered severe losses in 2008.

Most beneficiaries found themselves in schemes that met the 25.0% solvency or reserve level required by the Medical Schemes Act.

The Council for Medical Schemes engages regularly with schemes that do not meet the statutory solvency ratio to discuss their turnaround strategies and address problems such as high non-healthcare costs.

Resolving complaints

We monitor the complaints that we receive from beneficiaries to identify trends that may indicate problem areas in particular schemes so that compliance actions can be affected where necessary.

Our Complaints Adjudication Unit received 3 138 complaints in 2008; most of these related to unpaid accounts (1 166 or 37.2% of all complaints received).

Final thoughts

Continuous regulatory improvement is an essential part of the well-being of the medical schemes industry. As the Council for Medical Schemes, we remain committed to advancing the interests of beneficiaries and promoting access to quality healthcare for all South Africans. We also aim to ensure that more of the healthcare Rand is spent on relevant healthcare services and for building up reserves, thus ensuring that beneficiaries have the requisite cover when they need it most. ■

* All our Annual Reports are available on our website www.medicalschemes.com.

** These numbers exclude the beneficiaries of bargaining council schemes.

How schemes and options disappear

In our recently published Annual Report, we observe that there were fewer schemes and fewer benefit options in 2008 than in the previous year. Why did this happen – and what does it mean?

By **Mpho Sehloho**
SENIOR BENEFITS
ANALYST

In terms of the Medical Schemes Act, every scheme must have a sufficient number of members contributing to that scheme. The Act also prescribes the minimum number of members that must be admitted when a new scheme is registered.

Medical schemes are by definition not-for-profit entities, but this does not mean that they should not be financially sound. This Office registers schemes on the proviso that they do not prejudice public interest, and that they are or will be able to comply with all the provisions of the Act.

Given the current economic climate, it has become even more crucial for schemes to adhere to the requirements of the Act, especially as far as financial sustainability is concerned. When the law is ignored, we see more liquidations and amalgamations, fewer benefit options, and fewer new schemes being registered.

Section 57(1) of the Act requires a scheme to have a Board of Trustees who are fit and proper to manage the entity in accordance with applicable laws and the registered rules of the scheme. Trustees must act with due care, diligence, skill, and good faith to ensure that the interests of beneficiaries are protected at all times. While it is true that many Boards try to salvage their troubled schemes, the same cannot be said for others. Poor governance structures have a direct impact of the number of medical schemes in existence; the Registrar needs to intervene at times by instructing a scheme to either liquidate or amalgamate with a suitable partner where its Board failed to exercise its fiduciary duties.

Schemes rely on assumptions to determine how much claims are likely to cost them. If a scheme underestimates the number and nature of the claims it can expect, it may end up underpricing its contributions. This, in turn, will make it difficult for the scheme to attain the minimum

funds prescribed by law, and threaten the independence and sustainability of its benefit options.

Schemes that have underpriced their benefit options with the hope of attracting the younger and healthier South Africans often find themselves having to make up for the mistake by raising their contributions and/or reducing their benefits. A vicious cycle is then created – one that the industry has come to call the “death spiral” of a scheme: because the scheme now has higher contributions and/or reduced benefits, the young and healthy leave the scheme; the profile of the scheme deteriorates because only the older and sicker members are left behind; the contributions suddenly become insufficient to pay for the benefits being offered, so the scheme ups its contributions yet again and/or cuts the benefits.

Many schemes have shut down because they were unable to get themselves out of this “death spiral”. Some schemes are currently being forced to wind down because more and more young and healthy members either opt for cheaper options or completely opt out of the industry for insurance-type plans. But buy-downs to more affordable options do not result in savings on claims for the scheme; they only exacerbate its dire financial situation.

The global economic meltdown has not left medical schemes in South Africa unscathed. Companies are bearing the brunt of the downturn; restricted schemes are being forced to amalgamate or liquidate. Smaller restricted schemes are forced to amalgamate with open schemes. Some companies abandon their liability in terms of post-retirement funding for their pensioners and members are left worse off. Those that cannot afford contributions are forced to leave the medical schemes environment. When affordability becomes an issue, members buy down to cheaper options and so fuel the “death spiral” of their struggling scheme.

Market consolidation is desired because where there are bigger risk pools, there is better stability. As the Office of the Registrar, we have to ensure that consolidation is effectively managed in order to adequately protect the interests of beneficiaries and to ensure that competition is enhanced rather than reduced. ■

“
Medical schemes
may be not-for-
profit entities, but
they should be
financially sound.
”

	2006	2007	2008
The number of registered medical schemes	124	122	114
The number of registered benefit options*	391	393	372

* In 2008, 119 options (59.5%) in open schemes and 99 options (57.6%) in restricted schemes made losses.

He is finally here

Paresh Prema is the first Head of the Benefits Management Unit at the Council for Medical Schemes. He made time in his demanding schedule to tell CMS News why he decided to join us – and where he sees his team going.

The foundation

“I was born in Johannesburg and grew up in a small town in the North West province. I am the youngest of three children. My earliest childhood memory is of the little flat we lived in and having a keen interest in all things technical and modern.

My upbringing was one in which morals and doing the right thing played a central part. This was further nurtured by living in a close-knit family where parents ingrained in us that respect, integrity, and culture are pillars of strength. I was fortunate to grow up in a community where people always lent a helping hand; it instilled in me a sense of giving and sharing.”

The gut feeling

“The decision to pursue a career as an Actuary was based on a hunch – and the opportunity it presented. I completed my Bachelors Degree in Actuarial Science at the University of the Witwatersrand and started working at an actuarial consultancy where I learned what it really meant to be an Actuary – and it confirmed the values which I had been taught while growing up.”

The discovery

“It was not long into my career that I was exposed to the health industry and the intricacies of its legislation. I soon developed an appreciation of the role that the regulator played in the industry to ensure the well-being of beneficiaries and sustainability of medical schemes. I guess coming to the CMS is a natural progression; I get to put the thinking into practice on a daily basis.”

The Council for Medical Schemes

“The decision to apply for a position at the CMS was easy. The organisation appealed to me because it looked like a place where I could add value and think about the bigger picture. Knowing that there



By Paresh Prema
(HEAD: BENEFITS MANAGEMENT)
& **Aleksandra Serwa**
(COMMUNICATIONS MANAGER)

are no Actuaries here further emphasised the need for those skills at the CMS. And being Head of Benefits Management would further enable me to apply the experience I have gained to the practical challenges facing the industry today.

I am proud to be South African and determined to help improve the lives of other South Africans. I see challenges as opportunities to make a difference in the everyday lives of others and believe in the spirit of giving.”

“

I am proud to be South African and determined to help improve the lives of other South Africans.

”

The vision

“I think it is my role to bring a little science and actuarial perspective into the normal processes at the Benefits Management Unit.

My vision is to create a standard in the way schemes operate when evaluating their benefits and contributions and to assist trustees in looking out for members' best interests.”

Besides all that?

“The little spare time that I have is spent with my wife and family. They are a critical support structure that makes life more fulfilling. Other interests are hiking, reading, and movies.

I have a creative mind and enjoy anything to do with cars and technology. I am a cultural and very spiritual person with pride in my heritage and roots.

I believe that humour is an essential part of life.” ■

Keeping an eye on the industry

Our analysts are crucial to our success. These highly specialised professionals help us be a more effective regulator and protector of members' rights by continually sharing with us their observations and insights into a complex industry.

By **Phumla Khanyile**
CALL CENTRE
AGENT

The Research & Monitoring (R&M) Unit plays a vital role in ensuring that the decisions taken at the Council for Medical Schemes (CMS) are appropriate and correct, and based on evidence and facts. This they do by monitoring and investigating regulatory and policy trends and developments in the medical schemes environment.

Patrick Matshidze (Head of Research & Monitoring until 30 November 2009)

Patrick has been managing three spheres of the CMS simultaneously for over a year now. Besides being the Head of R&M, he has been the Acting Registrar and Chief Executive of the CMS and Acting Head of Benefits Management up until the appointment of the new BMU Head recently.

"We have developed good structures at the



CMS which are functioning well and in an integrated manner. I also get a lot of support from Council members and industry players," Patrick told *CMS News*. "I have been privileged to lead a highly skilled and dedicated team of executives and staff. Together, we have witnessed an increasing number of South Africans being covered by medical schemes, improved compliance and proper governance of medical schemes, and an increased visibility of the CMS thanks to the appointment of a Communications Manager and

our multimedia approach."

Patrick unwinds by watching sport on TV, especially soccer, rugby, cricket, and golf, and following the Formula One races. He occasionally goes fishing at the Vaal river. He has been trying his hand at mastering a newly acquired toy: an alto saxophone.

Thulani Matsebula (Senior Policy Analyst until 30 November 2009; Head of Unit from 1 December 2009)

Thulani is an economist with a love for healthcare.

"The positive impact that economists make in the lives of communities inspired me to pursue an MSc in Health Economics with City University in London. Health economists also contribute greatly to the structuring of health systems."

How does he do it? "To be a good economist and researcher, you have to be comfortable with being alone most of the time, and you need to be a thinker; always questioning the way things happen."



Employed by the CMS since 2004, he says cracking the cost-escalation problems in the industry would be a milestone in his career.

Thulani enjoys spending time with family and playing his guitar.

He also enjoys running; he has completed five marathons so far.

Phakamile Nkomo (Research Analyst)

Phakamile is known to colleagues as "Phaks". Armed with a BCom degree with majors in Economics and Business Management and years of experience in public administration and policy advocacy, Phaks says he enjoys monitoring industry conduct and performance, and specifically the optimisation of private health funding allocations to achieve the greatest good for the greatest number



of South Africans.

After another long day of applying his mind to truth-validating methods, Phaks enjoys continuously rediscovering himself in his son's youth and in the bosom of his wife's love.

Michael Willie (Research Analyst)

"I am goal-oriented, ambitious, generous, and easy-going. Playful at times. I get a kick from making a difference in other people's lives."

Michael's love for figures dates back to his schooling days in the Eastern Cape where his mathematics teacher inspired him to become a statistician. He is fascinated by data mining and analysis, and the fact that the work of a researcher is centred on emerging knowledge.

"It takes a combination of skills to know how to visualise the established knowledge and then



come up with ways of improving it."

Michael spends his spare time with family and friends watching movies. He is also a published writer; an aspiring actor; an unqualified relationship counsellor; and a motivational speaker.

Busi Khuzwayo (PA: Research & Monitoring)

Born and bred in Durban, peace-loving Busi joined the CMS team one year ago. This is the woman who guards the door to the Acting Registrar and Head of her Unit, and who ensures that the Unit is coordinated and functioning in synergy.

Busi finds joy in spending quality time with her husband and their 14-year-old son. They also enjoy shopping sprees. ■



Reading matter

Between 1 June and 31 October 2009, we continued to post a variety of publications on our website. Visit www.medicalschemes.com to gain insight into the complexities of regulating an industry that affects millions of lives.

Do you want to know more about the ins and outs of the South African medical schemes industry? Perhaps you are curious about the latest policy developments in this dynamic environment? Do you need to find out whether your medical scheme is registered and your healthcare broker accredited?

Our team of dedicated experts specialises in many different fields. We would like to encourage you to engage with us – and why not start by visiting our website from time to time?

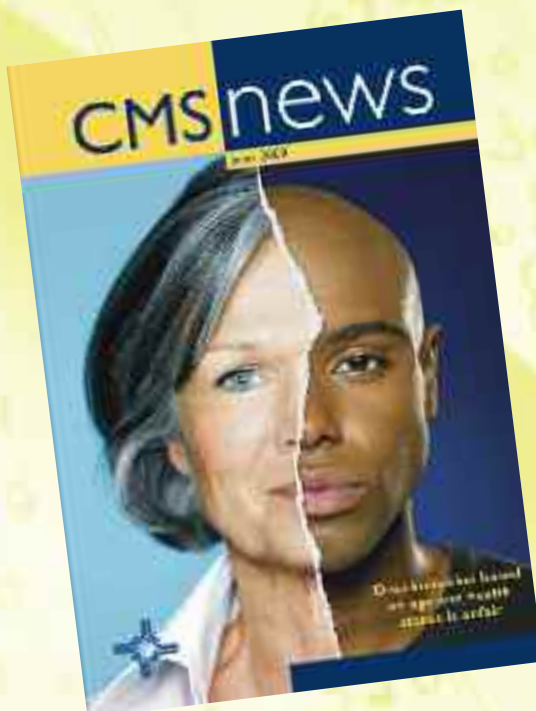
In the last few months, we published numerous documents on our website. They included:

- our latest Annual Report, which gives an in-depth overview of the trends and developments that we have observed in the industry in 2008-2009;
- an issue of *CMS News*, our official paper-based newsletter aimed at external stakeholders;
- 4 issues of CMScript, our e-newsletter dedicated to prescribed minimum benefits (PMBs), as defined in Section 29(1)(o) and Regulation 7 of the Medical Schemes Act (Act 131 of 1998);
- 23 Circulars, including Circular 12 to clarify the appropriate use of modifier code 0019, Circular 21 on the issues we encountered during the evaluation of medical scheme administrators, Circular 24 to clarify the meaning of “payment in full” for PMB conditions provided for in Regulation



8(1) of the Act, and Circular 29 on our draft accreditation standards for managed care organisations (published for your comments);

- 7 guidelines and manuals, including on the preparation of different business plans and on standard management accounts;
- 8 judgements on appeals;
- 4 press releases, including on Resolution no longer being an administrator and managed care organisation;
- 3 reports on the Risk Equalisation Fund (REF) project, including the complete report on the analysis of REF shadow returns for 2008;
- 82 documents on the PMB review process;
- 2 pamphlets aimed at educating consumers about their rights and responsibilities as members of medical schemes, namely the *Consumers Guide on Prescribed Minimum Benefits and Chronic Medication*, and the *What is the Council for Medical Schemes?* pamphlet;
- the application form for accreditation and renewal as a medical scheme administrator;
- application forms for accreditation and renewal as a healthcare broker or a healthcare broker organisation (brokerage);
- the application form for accreditation as a managed care organisation; and
- amended accreditation standards for managed care organisations. ■



Reception

t: +27 (0)12 431 0500

f: +27 (0)12 430 7644

Call Centre

ShareCall: 0861 123 CMS (267)

Resource Centre

t: +27 (0)12 431 0500

f: +27 (0)12 430 7644

e: information@medicalschemes.com

Use our website to:

- view lists of registered schemes as well as accredited brokers, managed care organisations and scheme administrators in South Africa;
- download information (forms, the Medical Schemes Act 131 of 1998 and Regulations);
- read the latest news, developments and upcoming workshops; and
- lodge a complaint online.

Complaints

t: +27 (0)12 431 0500 / 0861 123 CMS (267)

f: +27 (0)12 431 0560 / +27 (0)12 430 7644

e: complaints@medicalschemes.com

Complaints procedure

- First, complain to your scheme. Phone the scheme or write to the Principal Officer. Give full details of your complaint and include any supporting documents.
- If you are not satisfied with the outcome of your complaint to the scheme, complain to the Registrar of Medical Schemes (in writing).
- If you are aggrieved by the decision of the Registrar of Medical Schemes or by the decision of the scheme's disputes committee or by any other decision relating to the settlement of your complaint, appeal to the Council.
- If you are aggrieved by the decision of the Council, appeal to the Appeal Board.

How to avoid complaints

- Make sure you know and understand the rules of your scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option that you have chosen.
- Make sure your contributions are paid in full and on time every month.

This newsletter is printed on environmentally friendly paper.



Council for Medical Schemes

**Private Bag X34
Hatfield
0028**

**Block E
Hadefields Office Park
1267 Pretorius Street
Hatfield
Pretoria**

t: +27 (0)12 431 0512

f: +27 (0)12 431 0602