HEALTH FUNDERS
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HFA State of Medical Schemes Report 2026 (SOMS)

HEALTH FUNDERS
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Part A

VOICE OF THE PRINCIPAL OFFICER

How medical scheme leaders see membership, affordability, sustainability, regulation and innovation

Survey conducted 11 to 23 August 2026
Findings reported in aggregate

1. Introduction

South Africa's medical schemes operate in a challenging economic and social environment. Slow economic growth, high unemployment and pressure on household incomes continue to limit the ability of many South Africans to afford private healthcare cover. At the same time, businesses face cost pressures that constrain their capacity to grow and create employment.

These pressures are reflected in the labour market. According to Statistics South Africa's Quarterly Labour Force Survey for the second quarter of 2026, the official unemployment rate increased to **33.6%**, from 32.7% in the first quarter. The position is even more challenging for younger South Africans, with the unemployment rate among people aged 15 to 34 rising to **47.4%**.

Employment and medical scheme membership are closely linked. When fewer people enter formal employment, or employers are unable to expand their workforces, the pool of potential new medical scheme members is constrained. This has particular implications for younger entrants, who are important to maintaining a balanced risk pool. A lower inflow of younger members contributes over time to an ageing membership profile, placing further upward pressure on healthcare costs and, ultimately, member contributions.

Affordability, membership growth and sustainability are therefore closely connected. This relationship is evident in the responses to the **Voice of the Principal Officer** survey. Principal Officers identified contribution affordability, employment and income insecurity, and employer and industry growth or contraction as important influences on membership. They also highlighted the difficulty of attracting younger members in an environment characterised by high youth unemployment and limited access to affordable entry-level cover.

Against this backdrop, the **Voice of the Principal Officer** presents the perspectives of those responsible for leading and safeguarding South Africa's medical schemes. Their responses provide insight into the pressures affecting membership, affordability and financial sustainability; the regulatory and reform agenda; and the opportunities presented by innovation and technology.

2. Executive summary

South Africa's medical scheme leaders describe a sector that remains resilient and socially important, but is operating under sustained affordability, demographic, cost and regulatory pressure. The findings point to a reinforcing cycle: constrained household and employer finances limit membership growth; a weaker inflow of younger members worsens risk profiles; and rising healthcare costs make cover increasingly difficult to afford.

Central finding

Affordability is the thread connecting membership, sustainability and reform. Principal Officers (POs) do not believe that these pressures can be addressed through operational measures alone. They call for regulatory reform that expands affordable cover, modernises Prescribed Minimum Benefits (PMBs) and completes the solidarity architecture required for stable risk pooling.

2.1 Five messages from Principal Officers

1. **Membership is under pressure**. 12 of the 28 respondents reported a decline in total membership, compared with 7 reporting growth. Around 4 in 10 reported increases in membership terminations, dependants being removed from cover and contribution payment difficulties. Changes in employer or industry size were the most frequently selected driver of recent membership behaviour.
2. **Cost pressures are broad based and expected to persist.** Mental healthcare and specialist expenditure produced the strongest above-budget signals. Oncology, hospital expenditure, high-cost medicines and Prescribed Minimum Benefits (PMBs) also featured prominently. Looking ahead, respondents identified PMB obligations, high-cost medicines, new technologies and healthcare cost inflation as leading risks to sustainability.
3. **Governance and active management remain important stabilisers.** Prudent financial governance was the most frequently identified significant contributor to sustainability, followed by effective benefit management, data analytics, risk management and managed care. The findings show that schemes are actively using financial, clinical and operational levers to respond to mounting pressure.
4. **The regulatory agenda is absorbing substantial management attention.** PMBs and the PMB review require the greatest attention, alongside data protection and cybersecurity, Council for Medical Schemes (CMS) reporting requirements, contribution and benefit approvals, and provider-network regulation. Respondents consistently called for greater regulatory certainty, coordination and flexibility.
5. **Technology is delivering measurable value, but AI requires strong governance.** Automated claims processing, data analytics and fraud detection show the clearest realised benefits. Respondents expect AI to support clinical risk identification, fraud detection and administrative efficiency, while identifying cybersecurity, inadequate human oversight and data privacy as major risks.

2.2 What the sector is asking for

The responses point to a coherent reform agenda. The immediate priorities are completing the PMB review, introducing regulated low-cost benefit options (LCBOs) and improving tariff and cost discipline. Respondents also called for stronger risk pooling through risk equalisation and wider participation, together with clearer, more predictable and enabling regulation.

Despite the pressures facing the sector, POs remain clear about the value medical schemes provide. They see schemes as enabling timely access to quality healthcare, protecting households against unpredictable healthcare costs, relieving pressure on the public health system and sustaining healthcare capacity and economic activity.

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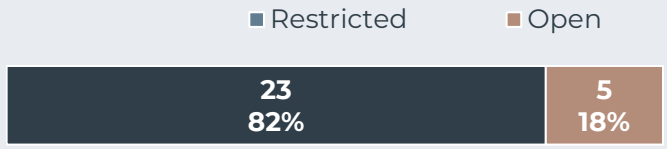
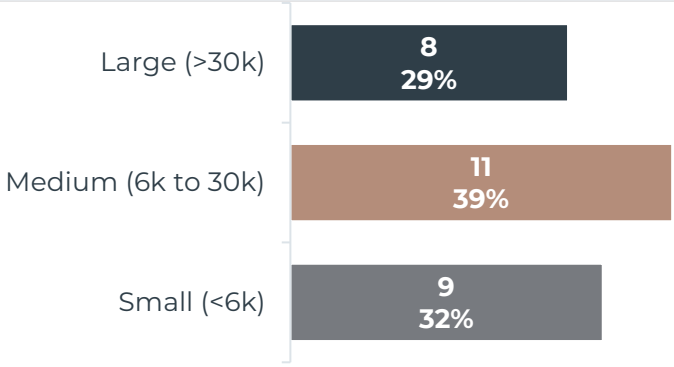
About the survey

The HFA invited POs to provide their perspectives for the inaugural State of Medical Schemes Report 2026. The survey covered scheme profile, membership and affordability, financial sustainability, governance and regulation, innovation, and the societal contribution of medical schemes.

Measure	Survey base
Valid responses	28
Scheme type	
Scheme size (beneficiaries)	

Methodology notes: Responses were received from 28 POs representing schemes of different sizes. As questions were not compulsory, the number of responses to some questions or sub questions was fewer than 28. Findings reflect respondent schemes and are not weighted by membership. Open-text responses were coded into recurring themes; no comment is attributed to an individual or scheme. Percentages are rounded to the nearest whole number. Multiple-response questions are reported as a share of all valid respondents and therefore do not always total to 100%. The survey is descriptive and reflects the views of participating POs rather than those of the medical schemes industry as a whole.

3. Membership and affordability

43%	37%	42%	42%
Respondents reported a decrease in membership	**Reported an increase in terminations**	**Reported an increase in dependants removed**	**Reported an increase in payment difficulties**

3.1 Member responses to affordability pressure

Movement between benefit options was less pronounced than outright pressure on cover. Most respondents reported no material change in upgrades or downgrades. However, around 4 in 10 respondents reported increases in membership terminations, dependants removed from cover and contribution payment difficulties. This suggests that affordability pressure may be expressed through reducing or relinquishing cover, not only by moving to a cheaper option.

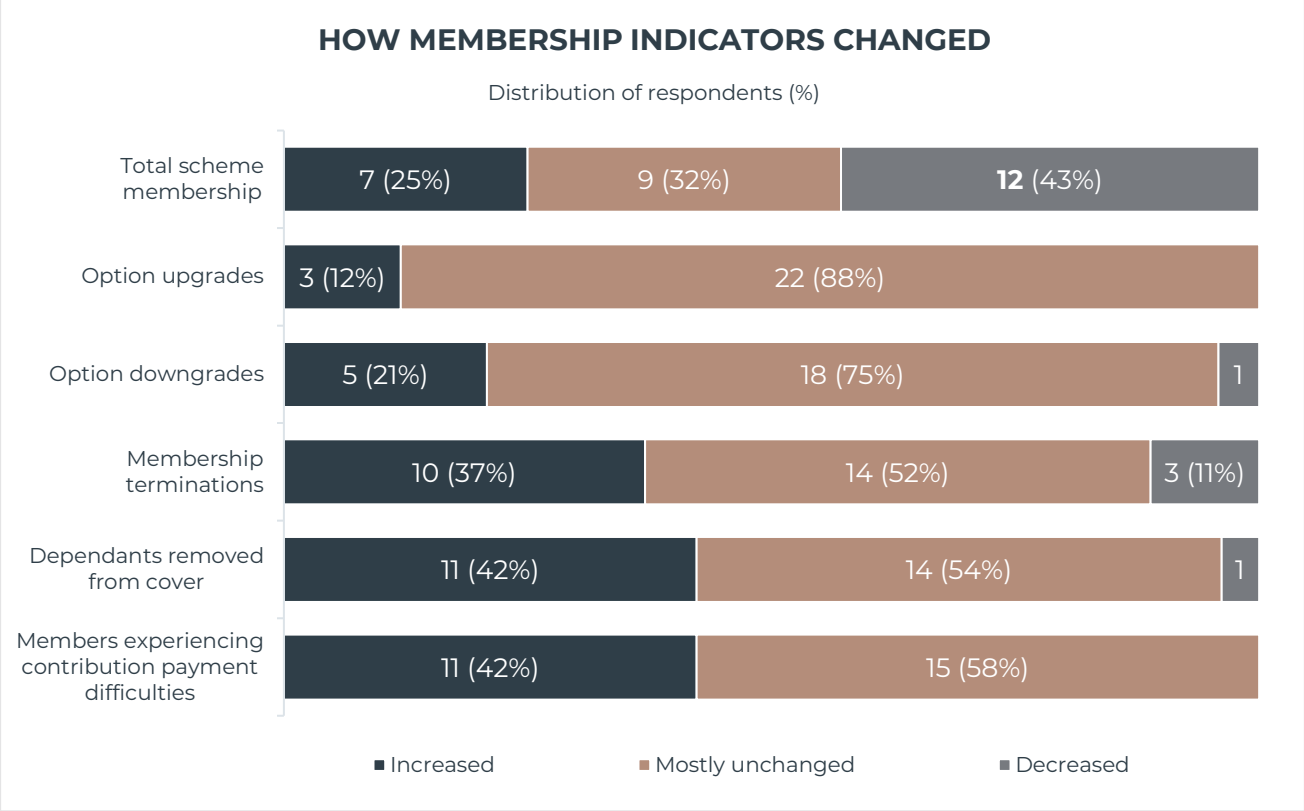


Figure 1. Direction of change reported by POs.

3.2 What is driving membership changes?

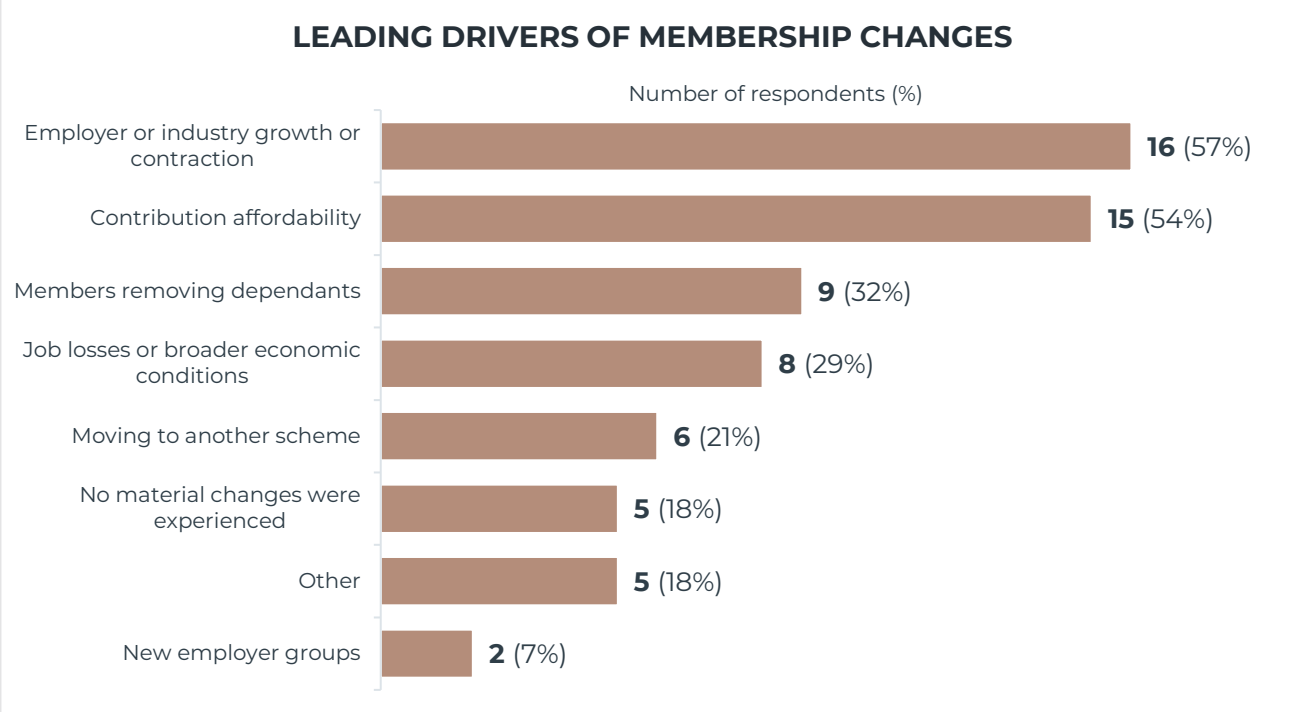


Figure 2: Leading drivers of membership behaviour; Note: Multiple selections were permitted.

Employer or industry growth or contraction was the most frequently selected driver of membership behaviour, cited by 16 of 28 respondents. This was followed by contribution affordability, selected by 15 respondents, and job losses or broader economic pressures, selected by 9. Nine respondents also reported members removing dependants from cover. Together, the findings show that membership trends are being shaped by the interaction between contribution affordability, employment conditions and changes in employer or industry size.

3.3 Barriers to membership growth

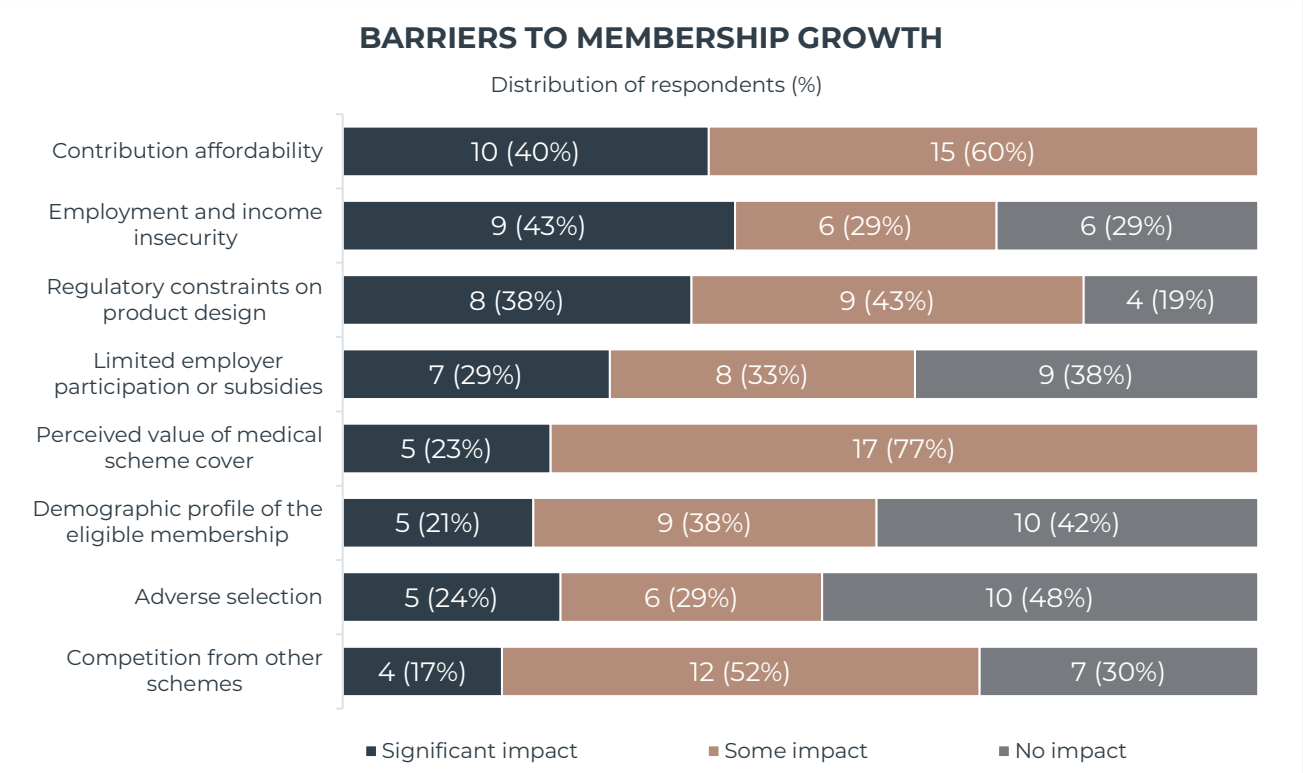


Figure 3: Barriers to membership growth

Contribution affordability emerged as the most pervasive barrier to membership growth, with all 25 respondents who rated it reporting at least some impact. Employment and income insecurity and regulatory constraints on product design were also prominent, while the perceived value of medical scheme cover was widely regarded as having some impact. Overall, the findings show that growth is being constrained by a combination of affordability pressures, economic insecurity and limited flexibility to offer products that meet the needs of prospective members.

3.4 Attracting younger members

POs identified affordability as the central obstacle to attracting younger members, compounded by high youth unemployment, limited employer recruitment and inadequate subsidies. Respondents also noted that younger people may regard medical scheme cover as expensive, inflexible or less relevant to their immediate needs, particularly while they remain healthy. These challenges are reinforced by the limited availability of affordable entry-level options.

Implication

The challenge is not simply marketing to younger people. It requires a credible value proposition at an affordable entry price, including regulated LCBOs, supported by employment growth and a regulatory framework that enables appropriate product design..

4. Financial sustainability

POs see financial sustainability as a multidimensional challenge. Healthcare cost inflation, affordability, membership, ageing, new technology and open-ended benefit obligations interact. The leading risks are therefore difficult to manage in isolation.

4.1 Member responses to affordability pressure

Mental healthcare produced the strongest cost signal: 20 of 22 respondents said expenditure increased above budget, including 10 reporting a significant increase above budget. Specialist expenditure followed, with 22 of 24 reporting at least some above-budget increase. Oncology, PMBs and hospital expenditure were also widely reported to be above budget.

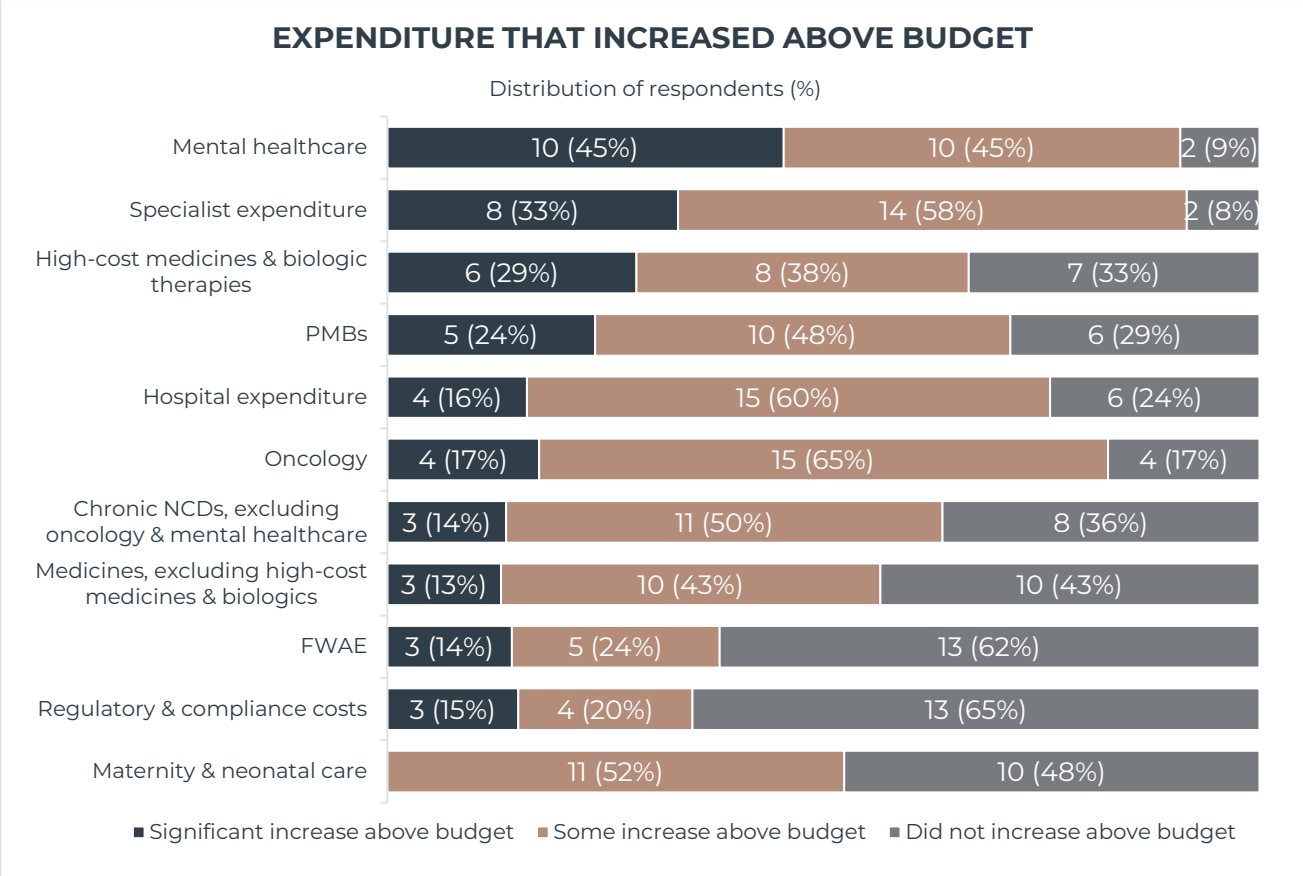


Figure 4. Expenditure that increased above budget

4.2 The three-year risk outlook

PMB obligations were rated as very significant by 15 of 23 respondents. High-cost medicines and new technologies followed at 13 of 21. Healthcare cost inflation, contribution affordability and an ageing or worsening risk profile were each rated as very significant by 11 respondents.

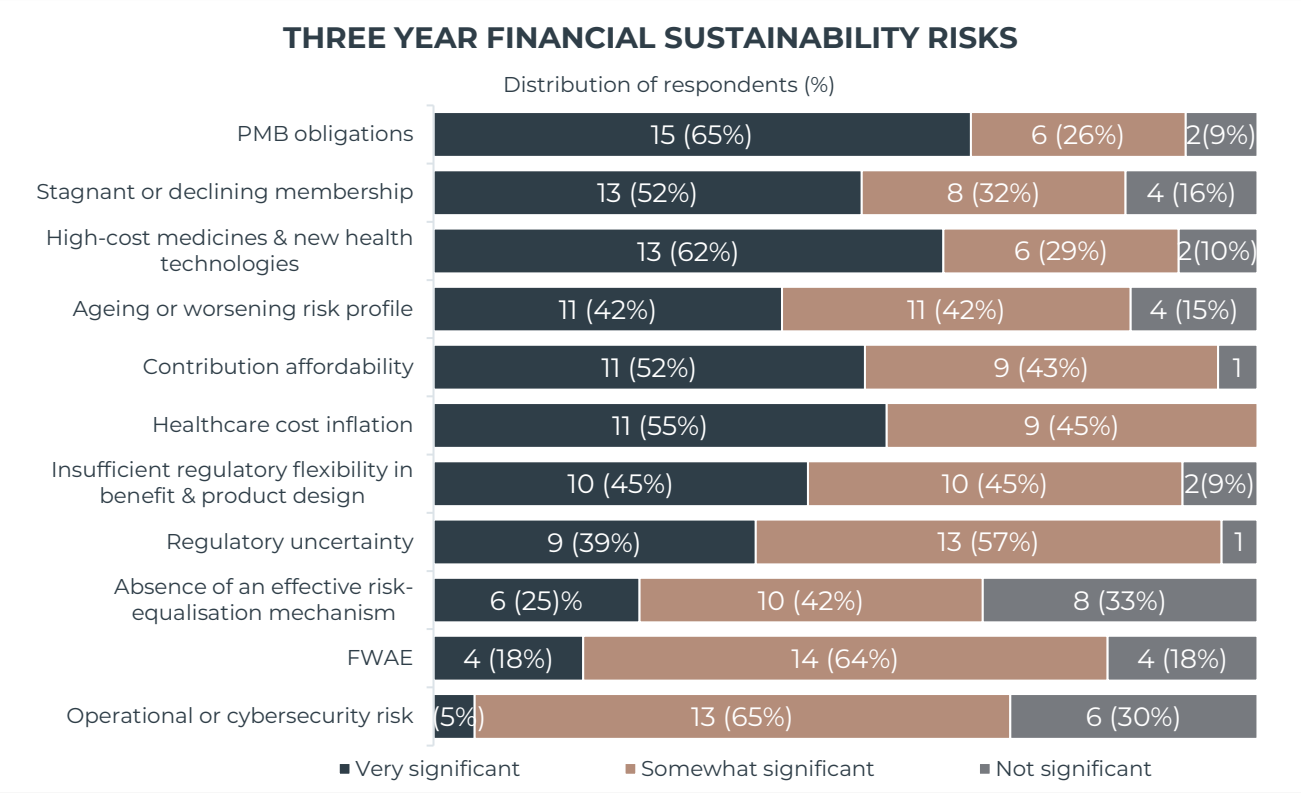


Figure 5. The broader measure combines somewhat and very significant ratings.

4.3 What has strengthened sustainability

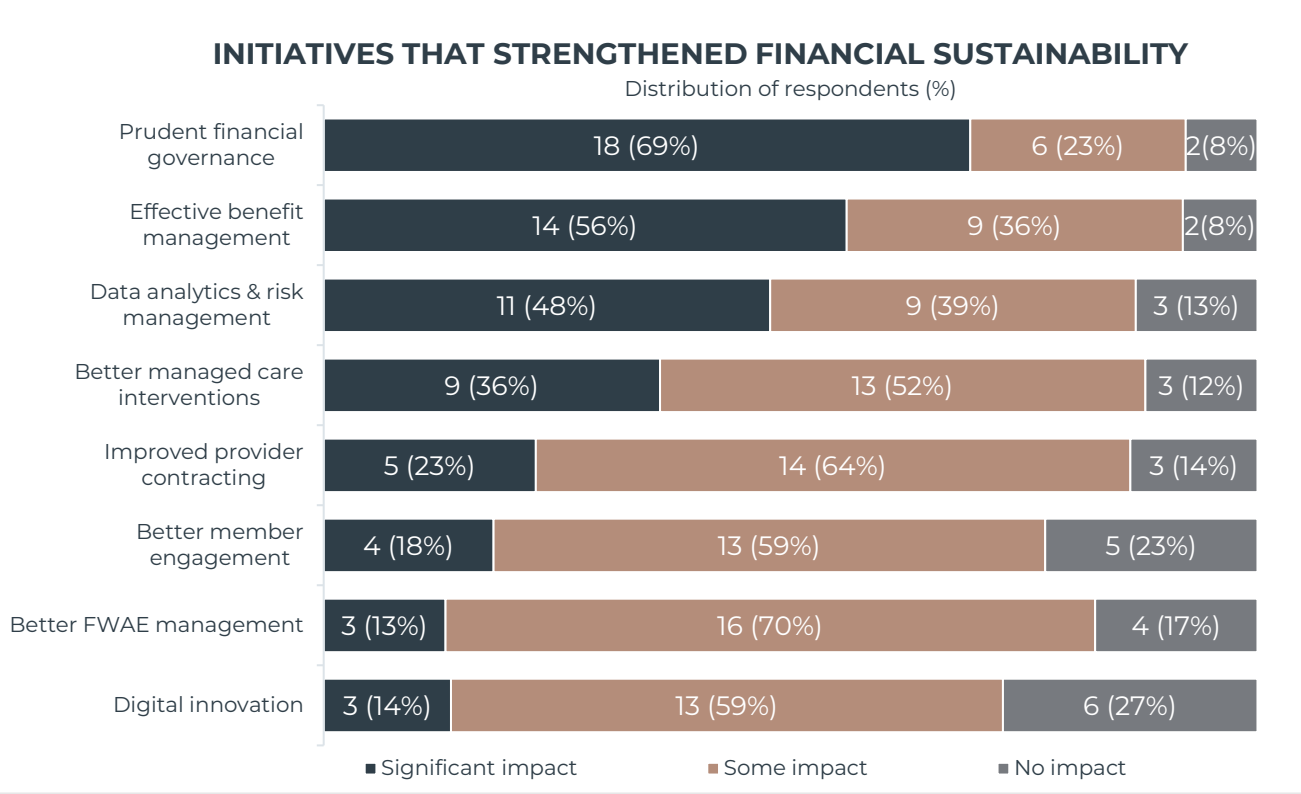


Figure 6. Initiatives that strengthened financial sustainability.

The results also show that schemes are not passive in the face of these pressures. Prudent financial governance was the strongest stabilising factor, rated as having a significant impact by 18 of 26 respondents. This was followed by effective benefit management (14 of 25), data analytics and risk management (11 of 23), and improved managed care interventions (9 of 25).

A platform for resilience

The strongest reported stabilisers combine governance, benefit management, data and managed care. Provider contracting, fraud management, member engagement and digital innovation tend to be viewed as useful supporting capabilities rather than stand-alone solutions.

5. Governance, regulation and reform

5.1 The most pressing issues facing medical schemes

POs identified five recurring priorities affecting their schemes:

- **Affordability and sustainability**. Balancing affordable contributions with rising healthcare costs, adequate benefits and long-term financial stability.
- **Membership pressures:** Reversing membership losses, attracting younger members and limiting adverse selection as healthier members opt out.
- **Regulatory uncertainty:** Inconsistent regulatory decisions, unclear policy direction and insufficient flexibility in benefit and product design.
- **PMB and provider-cost pressures:** Managing expanding PMB obligations, medical inflation, specialist costs and related legal uncertainty.
- **Delayed structural reform:** Introducing LCBOs, risk equalisation and other reforms needed to expand affordable cover and strengthen risk pools.

Central finding

Schemes' most pressing challenge is maintaining affordable, valuable cover while protecting membership and financial sustainability in an uncertain regulatory environment.

5.2 Where management attention is concentrated

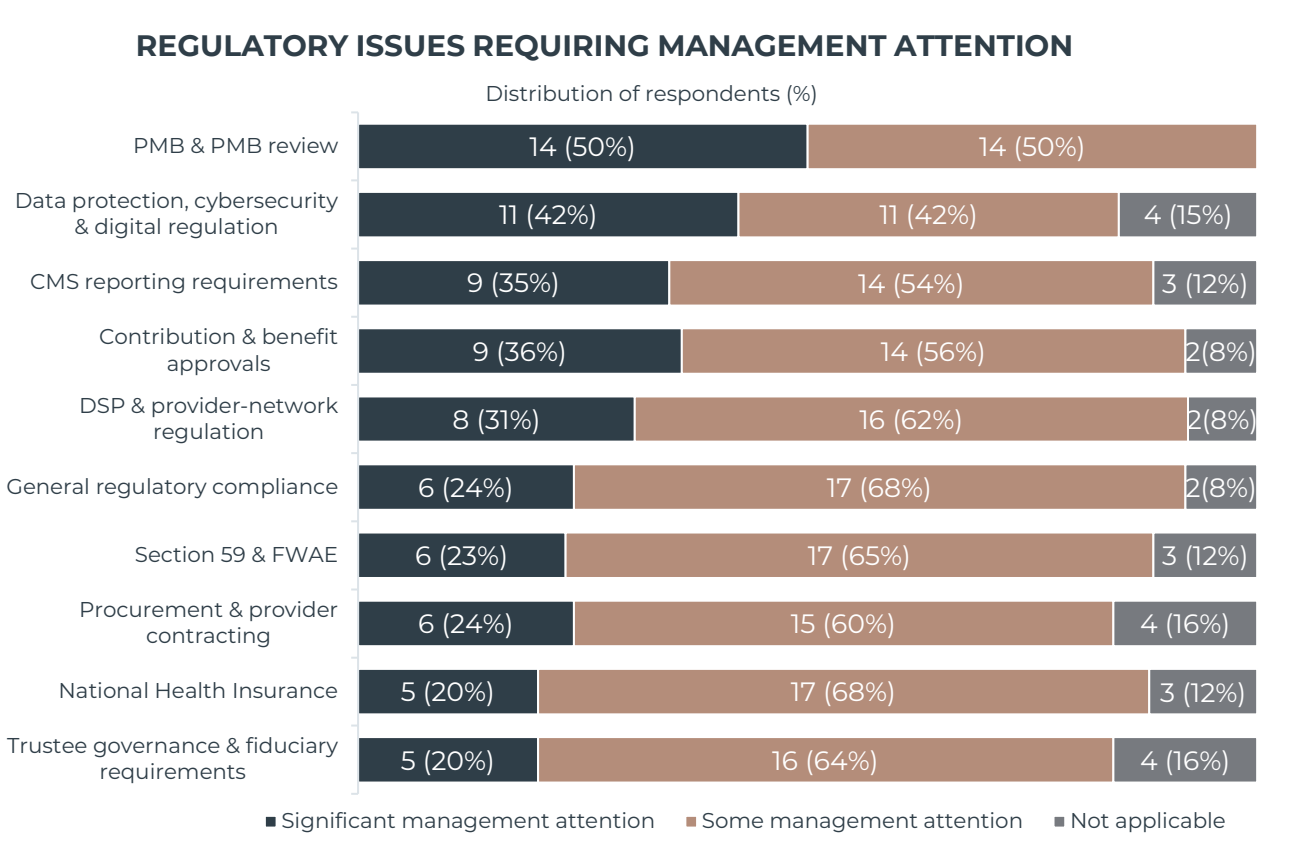


Figure 7. Most listed issues require at least some management attention.

The results show that schemes are managing a broad and demanding regulatory agenda. PMBs and the PMB review require the greatest attention, followed by data protection, cybersecurity and digital regulation, CMS reporting requirements, contribution and benefit approvals, and Designated Service Provider (DSP) and provider-network regulation.

Although fewer respondents rated National Health Insurance (NHI), trustee governance, provider contracting and Section 59 and Fraud, Waste, Abuse and Error (FWAE) as requiring significant attention, most indicated that these matters still demand ongoing management focus.

Overall, the findings point to a substantial regulatory burden spanning benefit design, cost management, reporting, governance, digital regulation and healthcare reform. Greater regulatory certainty, consistency and coordination would allow schemes to direct more management capacity towards affordability, member value and sustainability.

5.3 The reform agenda emerging from open responses

PMB reform emerged as the dominant regulatory priority. Respondents called for a more current, clearly defined and financially sustainable benefit package, supported by tariffs or other explicit cost parameters. The introduction of regulated LCBOs was the second major theme. A smaller but strategically important group placed both reforms within a broader solidarity framework that includes risk equalisation, wider mandatory participation and a consistent regulatory approach to competing insurance products.

Reform theme	What respondents are seeking
PMB review and cost discipline	A modernised benefit package, clearer scope and stronger mechanisms to manage provider charges.
LCBOs	Regulated entry-level cover that expands access and competes on a fair basis.
Risk pooling and equalisation	A more complete solidarity framework that reduces adverse selection and supports stable cross-subsidies.
Regulatory certainty and flexibility	More predictable decisions, clearer guidance and appropriate room for product and benefit innovation.
Provider tariff framework	Greater pricing transparency and practical mechanisms to contain open-ended costs.

Reform is viewed as a package

The responses suggest that affordability reform, PMB reform and stronger risk pooling should be designed as mutually reinforcing components. Advancing only one component may leave the underlying sustainability problem unresolved.

6. Innovation and future readiness

Technology has moved beyond experimentation in several core scheme functions. The clearest realised benefits arise where tools improve high-volume administration, decision-making and financial control.

6.1 Technologies already producing measurable benefits

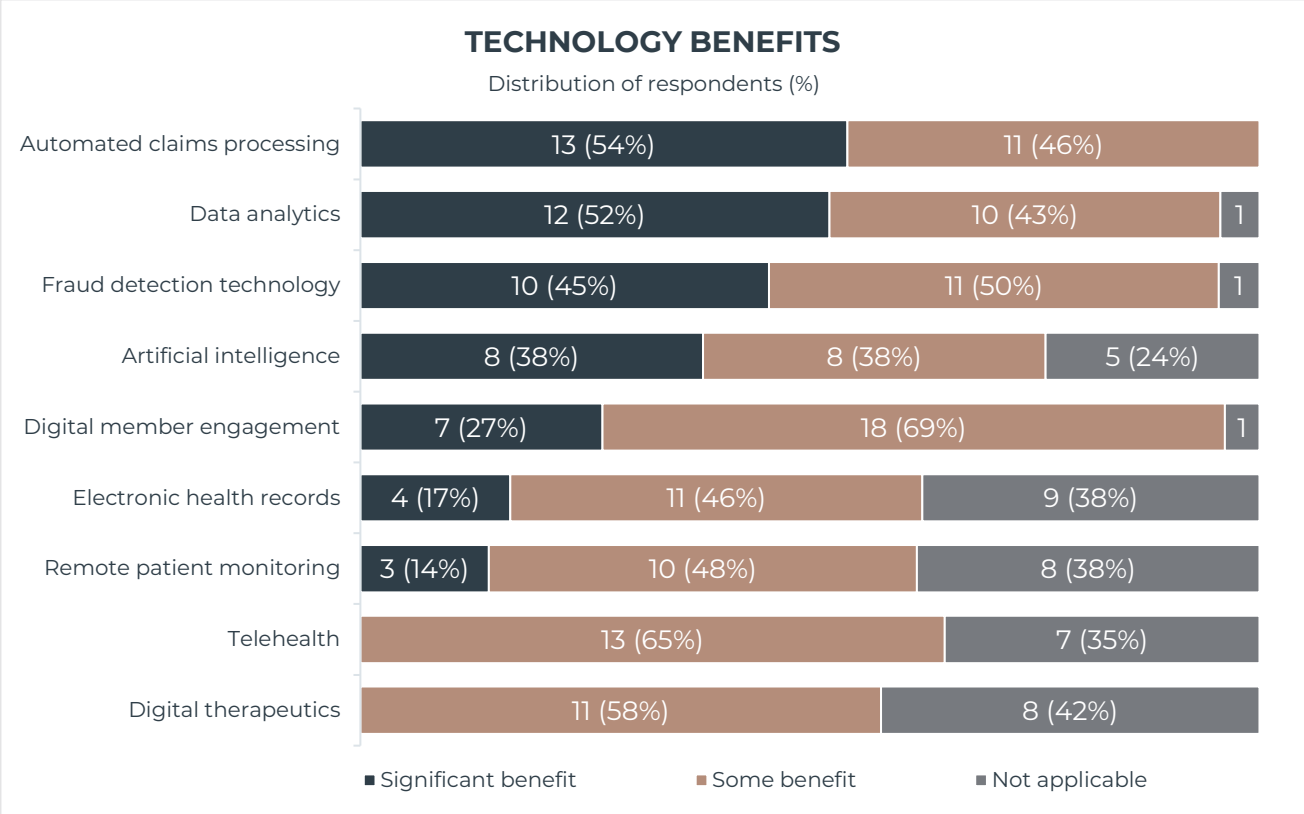


Figure 8. Realised benefits are strongest in core administrative and analytical functions.

Technology is already delivering measurable value across core medical scheme functions. Automated claims processing produced the clearest results: all 24 respondents who rated it reported at least some benefit, and 13 reported a significant benefit.

Data analytics and fraud detection technology also performed strongly, demonstrating their value in improving decision-making, risk management and financial control. Digital member engagement generated benefits for almost all respondents, although these were more often described as moderate than significant.

Artificial intelligence is beginning to show measurable value, but adoption and results remain uneven. Electronic health records, remote patient monitoring, telehealth and digital therapeutics produced more limited benefits, with a relatively large proportion of respondents indicating that these technologies were not yet applicable to their schemes.

Overall, the clearest benefits are currently being realised in administrative automation, analytics, fraud detection and member engagement, while clinically oriented digital technologies remain at an earlier stage of adoption.

6.2 Where AI is expected to matter most

Expectations were highest for FWAE, which 19 of 25 respondents rated as an area of significant AI benefit. This was followed by clinical risk identification, rated as significant by 18 of 25 respondents. Administrative efficiency, cybersecurity and claims processing also ranked strongly. Respondents were more cautious about provider contracting and benefit design, although most still expected at least some benefit.

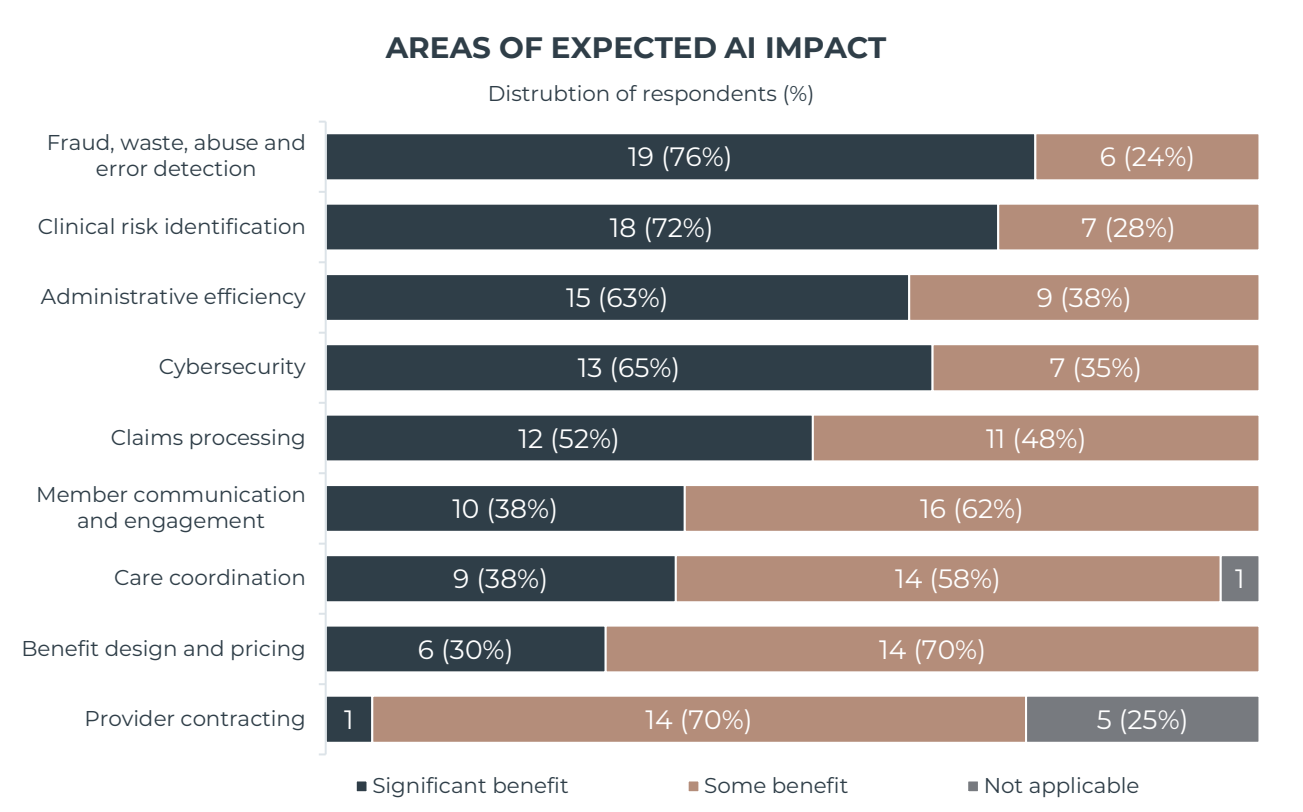


Figure 9. Share rating the expected benefit as significant.

6.3 AI opportunity must be matched by governance

Cybersecurity was the most frequently identified significant AI risk, cited by 19 of 25 respondents. Inadequate human or clinical oversight followed, with 16 of 27 rating it significant, and data privacy and confidentiality with 15 of 25. Inaccurate outputs, algorithmic bias, regulatory uncertainty and overreliance on technology also drew substantial concern.

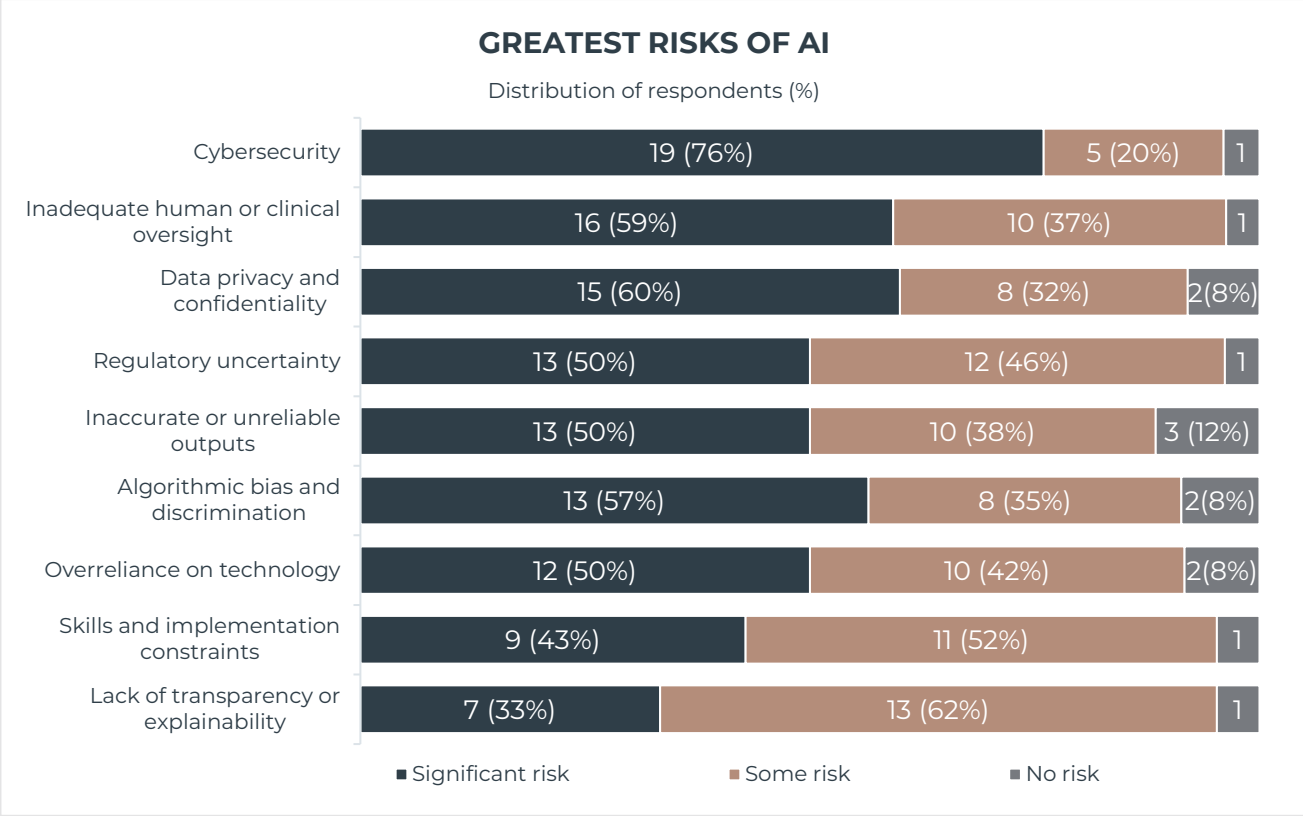


Figure 10. The broader measure combines some and significant risk ratings.

Responsible adoption

The survey supports a practical approach to AI: prioritise high-value use cases, retain accountable human and clinical oversight, protect confidential data, validate outputs, monitor bias and build regulatory clarity alongside implementation.

7. The value medical schemes provide

When asked about the single greatest contribution of medical schemes to South African society, POs consistently returned to access, financial protection and health-system capacity. Their responses position schemes not only as financing mechanisms but also as institutions that pool risk, provide certainty at the point of need and help sustain a substantial part of the country's healthcare capacity.

7.1 Four dimensions of value

Dimension	How POs described it
Access to quality care	Enabling members to obtain hospital, specialist, medicine and other healthcare services when needed.
Financial protection and peace of mind	Pooling contributions so that households are not required to meet large, unpredictable healthcare costs alone.
Relief for the public system	Financing care for millions of people and reducing pressure on already constrained public services and budgets.
Economic and social contribution	Supporting a healthier and more productive workforce, sustaining healthcare professionals and infrastructure, creating employment and contributing to broader economic activity.

The Principal Officers' perspective

Medical schemes convert regular contributions into timely access to care and protection against financial shocks. Their value extends beyond individual members through reduced pressure on the public sector, sustained clinical capacity and a healthier workforce.

8. Conclusion: resilience requires reform

The survey presents a sector under significant pressure, but one that continues to respond actively through governance, benefit management, innovation and cost control. POs remain confident in the social value of risk pooling and access to quality healthcare, while recognising that the operating environment is becoming less forgiving.

Affordability pressures are weakening membership growth and making it harder to attract younger members. Demographic pressure and rising utilisation increase costs. New medicines and technologies bring substantial clinical value but require better assessment, contracting and prioritisation. Regulatory uncertainty consumes management capacity and constrains the sector's ability to respond.

A sustainable path forward therefore requires coordinated action. The priorities emerging from POs are clear:

- expand affordable access through regulated entry-level options;
- complete the PMB review and strengthen cost discipline;
- improve risk pooling and reduce adverse selection;
- provide predictable, proportionate and enabling regulation;
- support evidence-based benefit management, contracting and managed care; and
- adopt digital tools and AI with strong governance, privacy and human oversight.

Taken together, these measures would help medical schemes protect existing members, reach more South Africans and continue contributing to a more resilient health system.

Part B

Beyond the Numbers
Scale, Value, Impact

A snapshot of the protection provided by medical schemes in 2025

1. Methodology and interpretation

This report is based on aggregated responses supplied by Medscheme, Momentum Health, Professional Provident Society Healthcare Administrators and Discovery Health. Collectively, the responding administrators provided data covering over 5.74 million beneficiaries, equivalent to 62% of all medical scheme beneficiaries for the year ended 31 December 2025. Results are anonymised. The figures are rounded for ease of reading and are intended to illustrate the scale and nature of protection provided within the responding universe.

The analysis that follows is organised around six practical expressions of medical scheme protection: high-cost claims, care at the start of life, oncology treatment, prolonged hospital admissions, access to expensive medicines, and protection across older age groups. These examples should be read together as a picture of risk pooling in action, rather than as separate clinical categories.

2. At a glance

2.1 Medical schemes protect members from costs that few households could absorb on their own

The administrator responses illustrate the breadth of that protection, from neonatal and childhood care to oncology, complex hospital admissions, rare-disease medicines and care in advanced age. They also show the essence of risk pooling: contributions collected across a broad membership base are used to meet exceptionally high costs when individual members need care.

R20.7m highest annual claim for one beneficiary	**34 888** beneficiaries with claims above R500 000	**975 528** beneficiaries whose costs exceeded contributions
92 789 babies born	**132 800** beneficiaries receiving oncology treatment	**381 days** longest hospital stay for 41-year-old patient

2.2 What the responses show

- Medical scheme protection operates across the life course. High-cost claims were recorded in every age band, including children and young adults.
- A relatively small number of cases can involve very large costs. The highest annual claim for one beneficiary reached R20.7 million.
- Schemes support care over long periods as well as at high intensity. The longest hospital admission was 381 days for a 41-year old beneficiary who had a parasitic brain infection called toxoplasma meningoencephalitis.
- Oncology remains a major area of need. 132 800 beneficiaries were reported to be receiving oncology treatment, while 265 oncology beneficiaries had claims above R1 million.
- Risk pooling has tangible value. During 2025, nearly 1 million beneficiaries on policies incurred healthcare costs exceeding their annual contributions.

3. Protection against high-cost claims

3.1 Highest annual claim per beneficiary by age band

The clearest expression of medical scheme value is the ability to absorb costs that would otherwise expose households to severe financial strain. The highest claim in every age band exceeded R4.9 million and rose to R20.7 million among beneficiaries aged 65 and older.

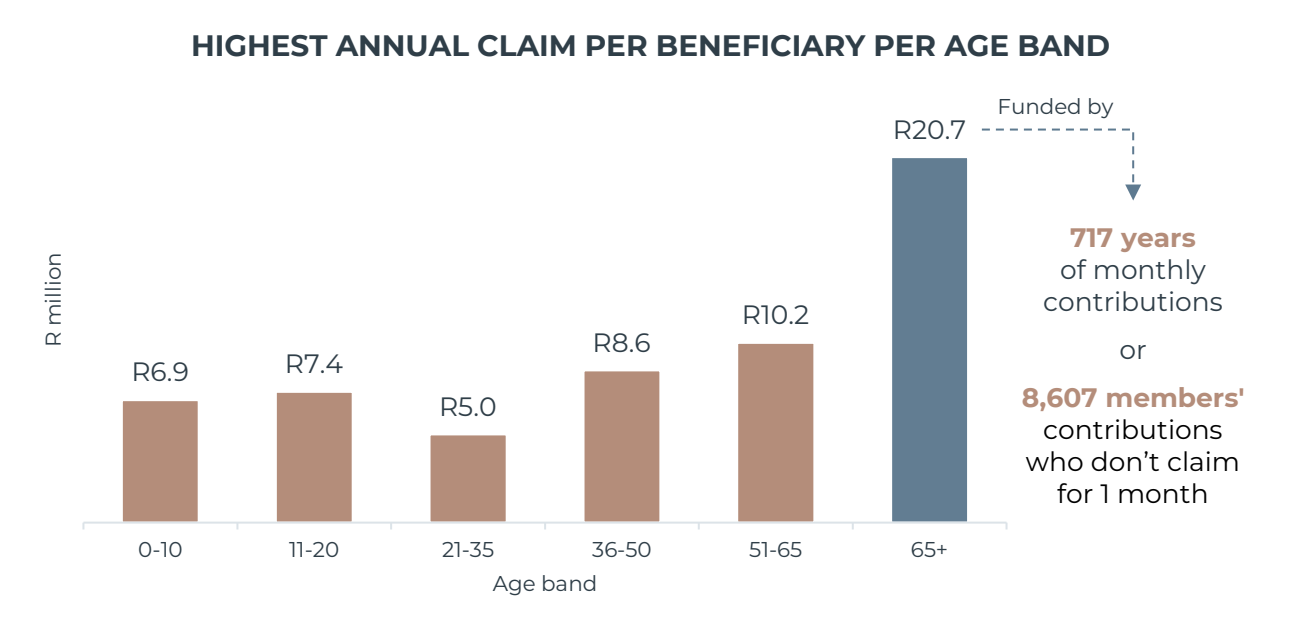


Figure 1: Highest annual claim per beneficiary per age band

At the assumed average contribution of R2,400 per member[1], it would take one member 717 years to contribute R20.7 million. Put differently, funding this amount would require 8,607 members' combined monthly contributions for 1 month, assuming none of those members incurred claims of their own.

[1] CMS Industry Report 2024. The average contribution was increased by 8% to approximate the 2025 average. Numbers are rounded for ease of reading.

3.2 Number of beneficiaries with high-cost claims

High-cost cases were not isolated. Respondents reported 34 888 beneficiaries[2] with annual claims above R500 000, 10 179 above R1 million and 2 522 above R2 million.

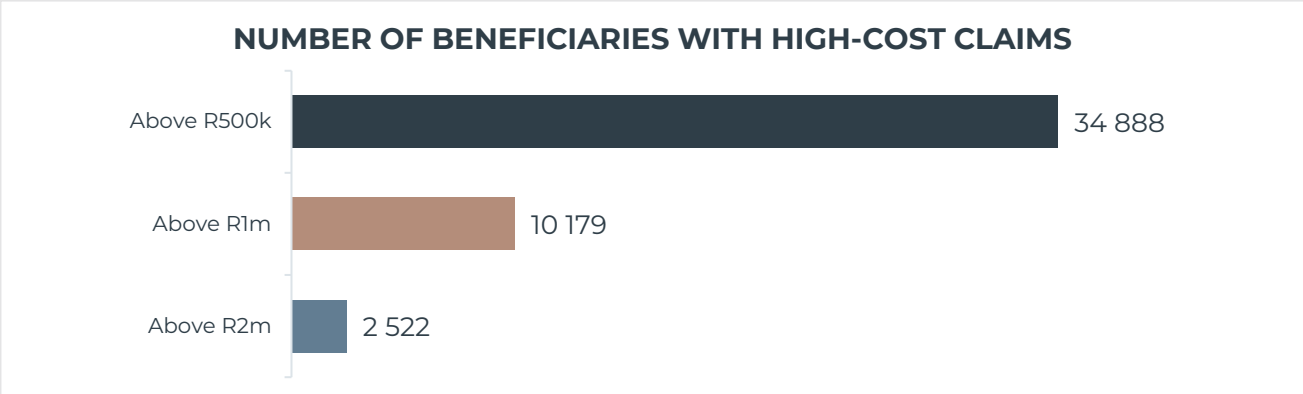


Figure 2: Number of beneficiaries with high-cost claims

4. Protection from the beginning of life

The responses recorded 92 789 babies born to scheme members during 2025. For one neonatal beneficiary, total claims reached R9.8 million. This illustrates both the intensity of care that may be required at the start of life and the financial protection that risk pooling provides.

92 789	**R9.8m**	**309 days**
babies born in 2025	**highest neonatal claims for one beneficiary**	**longest reported neonatal admission**

The longest reported neonatal admission lasted 309 days. A separate case involving an extremely low-birth-weight infant with respiratory distress required a hospital stay of 199 days.

[2] These figures are cumulative; the 34 888 beneficiaries include the 10 179 beneficiaries with claims above R1 million and the 2 522 with claims above R2 million.

5. Oncology care

Respondents reported 132 800 beneficiaries receiving oncology treatment. The highest oncology-related claim for a single beneficiary was R3.3 million. In total, 265 oncology beneficiaries had claims above R1 million, of whom 219 were aged 45 or older.

132 800
beneficiaries receiving oncology treatment

R3.3m
highest oncology claim for one beneficiary

265
oncology beneficiaries with claims above R1m

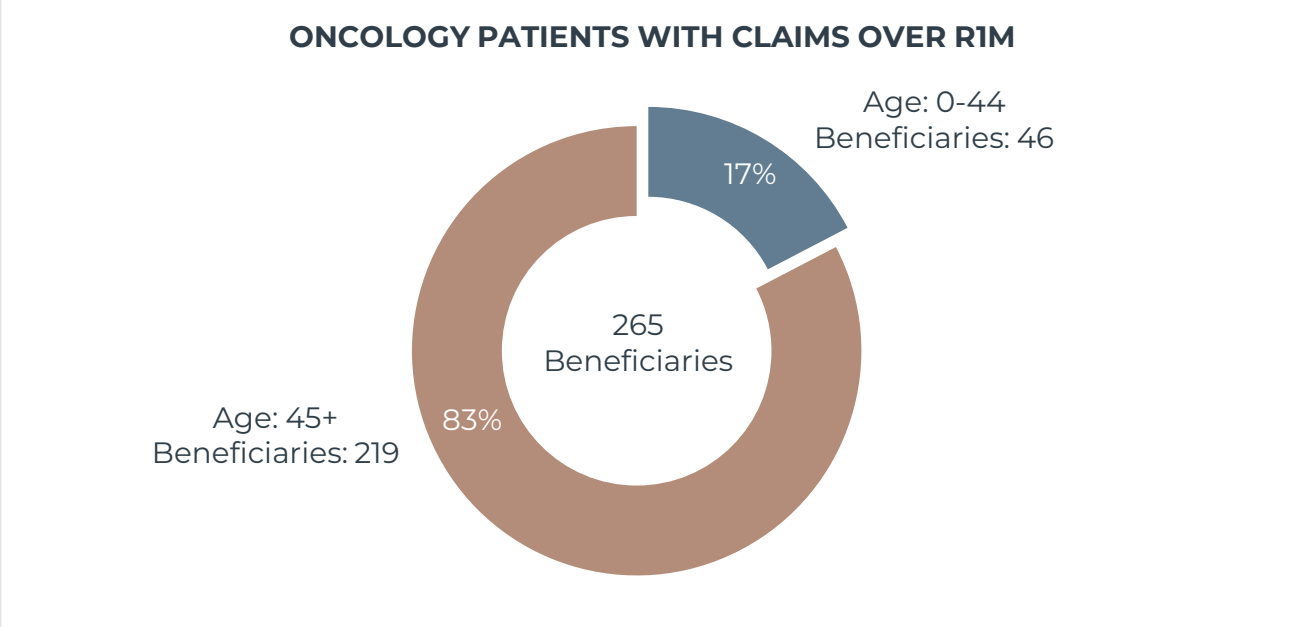


Figure 3: Number of oncology patients with claims over R1m

6. Sustaining complex and prolonged care

Medical scheme protection is not limited to a single procedure or episode. The 10 longest continuous admissions reported ranged from 158 days to 381 days. The longest hospital admission was 381 days for a 41-year old beneficiary who had a parasitic brain infection called toxoplasma meningoencephalitis.

The 10 longest admissions included cases involving neonatal respiratory distress, sepsis, cerebral infarction and complex surgical care, illustrating the prolonged clinical and financial support that may be required at different stages of life.

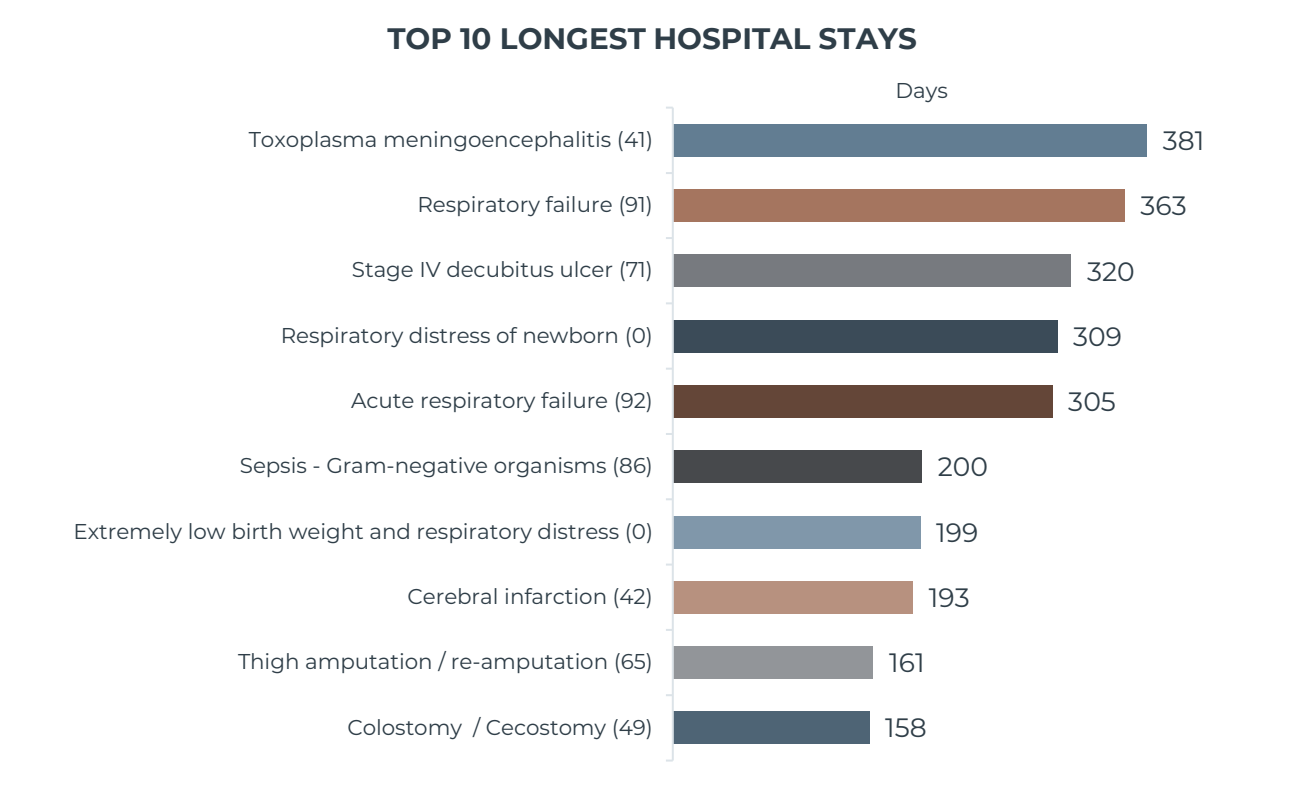


Figure 4: Top 10 longest hospital stays

7. Access to high-cost medicines

The highest medicine claims reflect the cost of treating rare and complex conditions. The 5 highest-cost medicine cases reported ranged from R4.5 million to R7.2 million. The highest claim was R7.2 million for Elaprase, used to treat Hunter syndrome, for a 13-year-old beneficiary. Four of the five highest claims were for Myozyme, an enzyme replacement therapy for Pompe disease. These cases illustrate how risk pooling enables access to medicines whose costs would be beyond the means of most households.

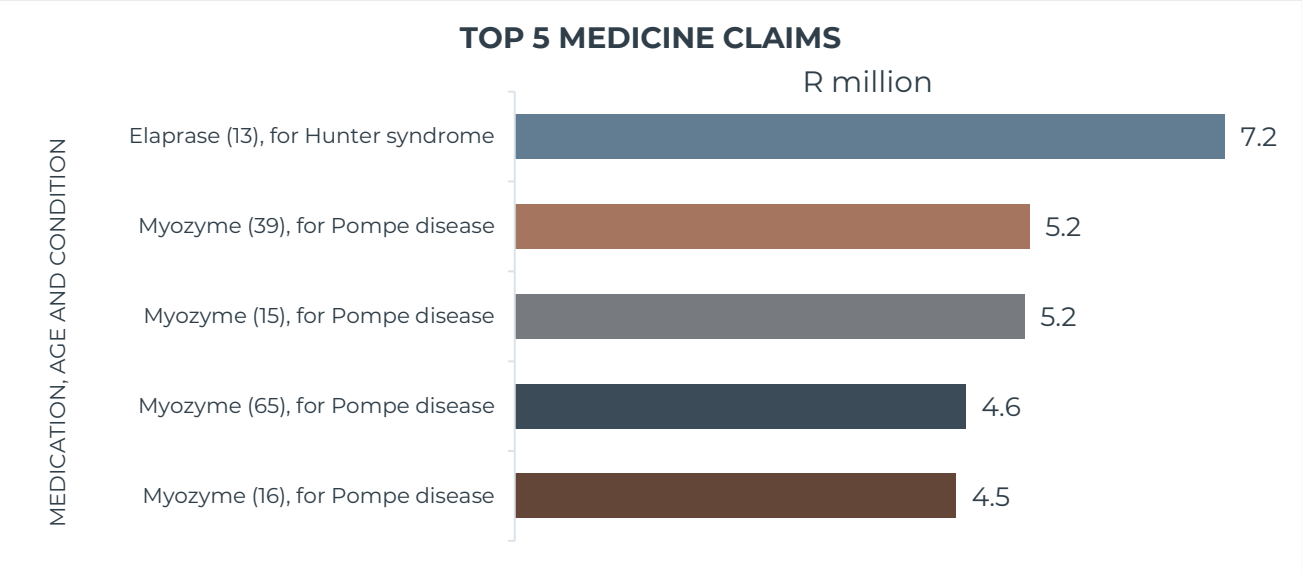


Figure 5: Top 5 medicine claims

8. Protection across generations

The submitted data span more than a century of life. The oldest female beneficiary was 114 and the oldest male beneficiary was 106. Respondents reported 321 beneficiaries aged over 100, comprising 270 (84%) women and 51 (16%) men.

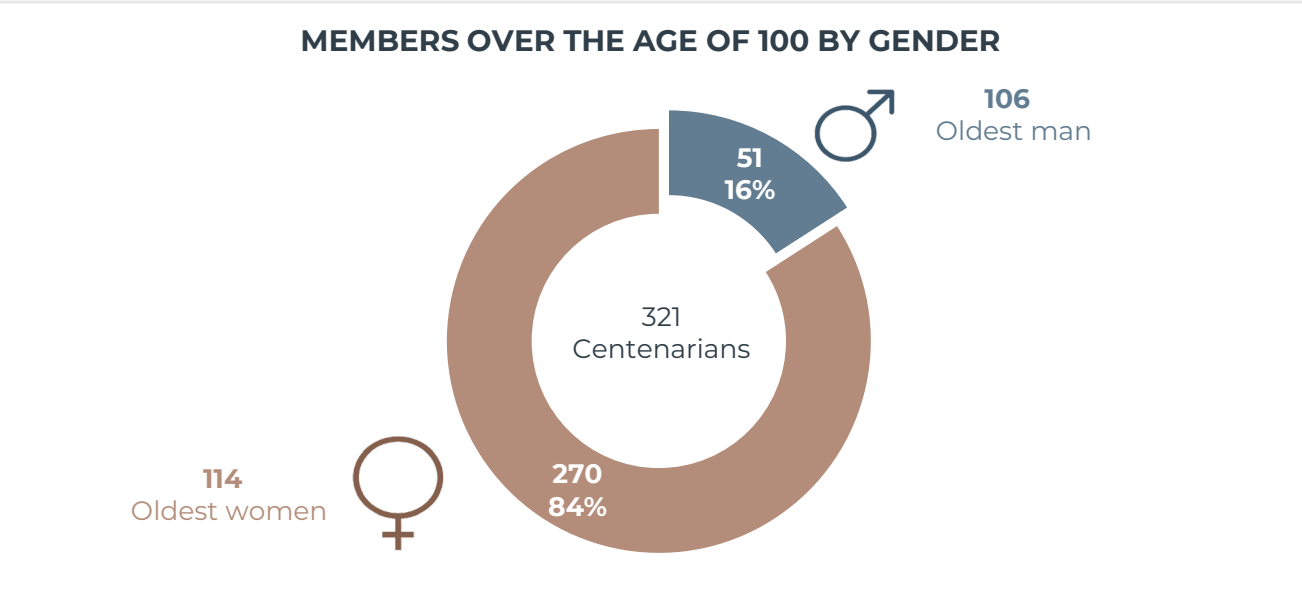


Figure 6: Members over the age of 100

Together with the neonatal, oncology and high-cost claims data, these figures show that medical schemes provide protection across generations and through very different healthcare needs.

9. The value of risk pooling

In 2025, 975 528 beneficiaries, representing 17% of the surveyed population, incurred healthcare costs that exceeded their annual contributions. The figures show why medical schemes are more than a mechanism for paying routine healthcare expenses. They pool risk across members and over time, making it possible to fund care when one person's needs far exceed their own contributions.

Not every member will claim more than they contribute in every year, nor is that the test of value. Members contribute while they are well so that the shared pool can protect those who face expensive, prolonged or unexpected care, knowing that they may need the same protection in future. Staying continuously covered strengthens this social compact: it shares risk across healthier and sicker members and across each member's lifetime, while protecting the individual against the cost and uncertainty of future illness.

10. Conclusion

Behind the aggregate figures are individual lives: a premature baby requiring months in hospital, a person living with cancer, a child needing a rare-disease medicine, or an older beneficiary facing a prolonged admission. No member can know when that level of care will be needed. Medical schemes turn millions of individual contributions into shared protection: members support one another across generations and over time, while each member gains protection against costs that few households could absorb. In this way, medical schemes benefit both the individual and society. Continuous, lifelong membership sustains the solidarity of the risk pool and preserves protection for the moment it is needed. That is the impact beyond the numbers.

Part C

What if...

South African introduced mandatory membership and a Risk Equalisation Framework?

HEALTH FUNDERS ASSOCIATION

insight actuarial solutions

Co-authored by Insight Actuaries
(Daniel Shapiro, Christoff Raath)

1. Executive Summary

South Africa's medical scheme framework remains incomplete. Open enrolment and community rating protect members from exclusion and contributions based on their health risk. However, schemes are not compensated for predictable differences in the risk profiles of their populations. At the same time, voluntary participation allows younger and healthier people to remain outside the system until they anticipate needing healthcare.

This creates two related problems. Risk is distributed unevenly between schemes, while the medical scheme population as a whole has stagnated and aged.

The analysis considers two complementary reforms. A Risk Equalisation Framework (REF) would redistribute funding between schemes to compensate for predictable differences in demographic risk. Mandatory membership would broaden the overall risk pool, reduce adverse selection and bring more younger and lower risk people into the system. Affordability measures would also be needed to ensure that people required to join can reasonably afford the available cover.

The principal findings are:

- Medical scheme membership increased from 6.74 million beneficiaries in 2005 to 8.98 million in 2024, with much of the growth occurring following the establishment of GEMS in 2006. Membership has remained broadly unchanged over the past decade, while the average beneficiary age increased from 31.7 to 34.5 years and the pensioner ratio rose from 6.4% to 10%.
- The illustrative risk equalisation analysis shows substantial differences in expected PMB costs between schemes because of their demographic profiles. Of the 70 schemes modelled, 31 would receive transfers and 39 would contribute. Recipient schemes account for approximately 48% of beneficiaries and contributor schemes for 52%.
- The estimated annual redistribution between schemes is approximately R5.9 billion, equivalent to approximately 2% of total annual medical scheme contributions. This would principally be a transfer between schemes rather than being a new healthcare system cost. It would allow schemes to compete more fairly on efficiency, quality, care management and member value rather than on risk selection.
- Risk equalisation would address the uneven distribution of risk between schemes, but it would not improve the size or age profile of the medical scheme population as a whole. If introduced in the current voluntary market without affordability measures, it could increase costs for schemes or options with younger and lower income members and encourage some of these members to leave the risk pool entirely.
- It is important to stress that risk equalisation does not create more funding, it simply redistributes funding according to risk (which in this case has been measured based on age).
- Extending mandatory membership to employed people above the income tax threshold could add approximately 8.79 million people to the modelled medical scheme population. Based on General Household Survey (GHS) data, this would increase the modelled pool from 9.96 million[1] to 18.75 million people, an increase of approximately 88%.
- Two approaches were used to estimate the potential effect of mandatory membership: a demographic model and a restricted scheme proxy.

[1] GHS data is derived from weighted household survey responses. The resulting estimate of 9.96 million covered people is higher than the CMS administrative count of 8.98 million registered beneficiaries. The difference may reflect survey sampling, population weighting and respondents not always distinguishing between medical scheme membership and other medical insurance products.

- GHS data is derived from weighted household survey responses. The resulting estimate of 9.96 million covered people is higher than the CMS administrative count of 8.98 million registered beneficiaries. The difference may reflect survey sampling, population weighting and respondents not always distinguishing between medical scheme membership and other medical insurance products.
- The demographic model estimates that mandatory membership above the income tax threshold could reduce average expected PMB risk cost by approximately 10% based on age and sex. Including the maternity adjustment increases the estimated reduction to approximately 13%. Extending participation to all employed people produces a modelled reduction of approximately 18%, although affordability and subsidy requirements become substantially greater below the income tax threshold of approximately R100k a year. This does not consider the impact of anti-selection based on burden of disease beyond just age, which would increase the impact further.
- The restricted scheme proxy approach provides allows explicitly for the anti-selection effect by considering the difference in the current claim profiles of open and restricted membership schemes and assuming that the new entrants follow the latter. This approach suggests that reducing adverse selection could lower average expected PMB risk cost by up to 30%. This should be treated as an indicative upper estimate because differences between open and restricted schemes may also reflect other aspects of their demographic profiles, employment characteristics, benefit design, utilisation patterns and purchasing arrangements.

Taken together, the analysis indicates a reduction of approximately 13% for mandatory membership above the income tax threshold and approximately 18% if participation were extended to all employed people. The restricted-scheme proxy indicates that the effect of broader and more stable participation could potentially be as high as 30%, although this should be treated as an indicative upper estimate.

These estimates relate to expected PMB risk cost. They should not be interpreted as equivalent reductions in medical scheme contributions, which also fund benefits outside the PMB package, administration, managed care, reserves and other expenses.

The central policy conclusion is that risk equalisation, mandatory participation and affordability measures should be designed as an integrated and carefully sequenced reform package. Risk equalisation would support fairer competition between schemes. Mandatory membership would broaden and strengthen the overall risk pool. Income related support, affordable benefit options and appropriate exemptions would be needed to ensure that broader participation is realistic and sustainable.

Central finding

A Risk Equalisation Framework could redistribute approximately R5.9 billion annually between schemes to compensate for predictable differences in demographic risk. Mandatory membership above the income tax threshold could expand the modelled medical scheme population from 9.96 million to 18.75 million and reduce average expected PMB risk cost by approximately 13%. The restricted scheme approach indicates that the potential reduction could be as high as 30% where participation is broader and more stable.

Limitations and interpretation

The analysis presents modelled scenarios rather than forecasts. The results depend on the population estimates, income thresholds, age profiles, PMB cost curve and other assumptions used.

The mandatory membership model uses General Household Survey (GHS) data as published by Statistics South Africa to estimate the covered and uncovered populations. The GHS figure for the covered population is a weighted survey estimate and is higher than the CMS administrative count of registered beneficiaries. The model also does not fully account for disease burden, behavioural responses, contribution affordability, employer responses, administrative costs, benefit design, subsidies, reserve requirements or the timing of implementation.

The restricted scheme estimate of up to 30% should be treated as an indicative upper estimate. Differences between open and restricted schemes may reflect factors other than adverse selection, including their demographic profiles, employment characteristics, benefit design and purchasing arrangements.

The risk equalisation results are also illustrative and are based on aggregated scheme level data. Actual transfers would require current and validated data, a legally defined common benefit package, an agreed risk adjustment formula, appropriate treatment of smaller schemes and formal governance, audit and dispute resolution arrangements.

The results therefore show the possible direction and scale of the reforms. They should not be interpreted as precise forecasts of their effect on individual schemes or member contributions.

2. The unfinished reform architecture

South Africa's medical scheme framework combines open enrolment and community rating with voluntary participation. Schemes must accept eligible applicants and may not charge members more because they are older or less healthy. However, the system has no mechanism to compensate schemes for predictable differences in the risk profiles of their members. At the same time, people who can afford cover may remain outside the pool until they anticipate needing healthcare.

This is an incomplete solidarity framework. Community rating protects higher risk members from contributions based on their health risk, but voluntary participation permits adverse selection. The absence of risk equalisation also leaves individual schemes carrying materially different expected costs. This creates pressure to attract and retain younger and healthier members, even though competition should focus primarily on risk management efficiency, quality and value.

2.1 The policy lesson

In 2009, Professor Heather McLeod and Pieter Grobler examined the scheme and household impacts of mandatory cover and a Risk Equalisation Framework (REF) as interdependent reforms[2]. Their central conclusion remains relevant: risk equalisation should not be introduced into a voluntary market as a stand-alone measure. If it increases contributions for younger or lower income members before affordability is addressed, those members may leave, further weakening the risk pool that the reform is intended to protect. A coherent reform package therefore requires three reinforcing mechanisms:

- Mandatory participation to broaden the pool and limit anti-selection;
- Risk equalisation to redistribute funding for predictable differences in health risk between schemes; and
- Income-related support and affordable benefit options so that participation is realistic for lower-income households

The Final Report of the Health Market Inquiry published in September 2019 made a similar finding.

The modelling in this report revisits the first two mechanisms using current data. It asks how a progressive membership mandate could change the size and demographic profile of the pool, and what transfers might be required to equalise the risk differences that would remain between schemes.

[2] Heather McLeod and Pieter Grobler, "The Role of Risk Equalization in Moving from Voluntary Private Health Insurance to Mandatory Coverage: The Experience in South Africa".

2.2 What risk equalisation should and should not do

A REF is intended to compensate schemes for predictable differences in the expected cost of providing a defined common benefit package. Schemes with higher risk populations would receive transfers, while schemes with lower risk populations would contribute to the framework. The precise transfer and settlement arrangements would depend on the institutional design.

The purpose is not to reimburse actual claims, protect inefficient schemes or eliminate the financial consequences of decisions that schemes can control. It is to neutralise predictable risk differences that schemes cannot price directly under community rating. Comparable risk adjustment arrangements operate in countries including the Netherlands, Germany, Australia and Ireland, although their design differs according to each country's health financing system.

A credible framework would require prospective and auditable risk factors, budget neutrality, standardised data, independent governance, transparent reconciliation and appeals processes, and safeguards against coding manipulation. It should be introduced progressively, beginning with shadow calculations before any financial transfers take effect.

3. Why reform is needed

The medical scheme system remains resilient, but it has not achieved sustained population growth. Beneficiary numbers increased from 6.74 million in 2005 to 8.98 million in 2024, with most of this growth occurring before 2014. Over the same period, the average beneficiary age increased from 31.7 to 34.5 years and the pensioner ratio rose. By contrast, South Africa's population increased from approximately 54 million in 2014 to 63 million in 2024, while medical scheme membership remained broadly unchanged. Medical scheme membership has therefore not kept pace with national population growth, leaving a relatively static risk pool to support a progressively older and higher cost population.

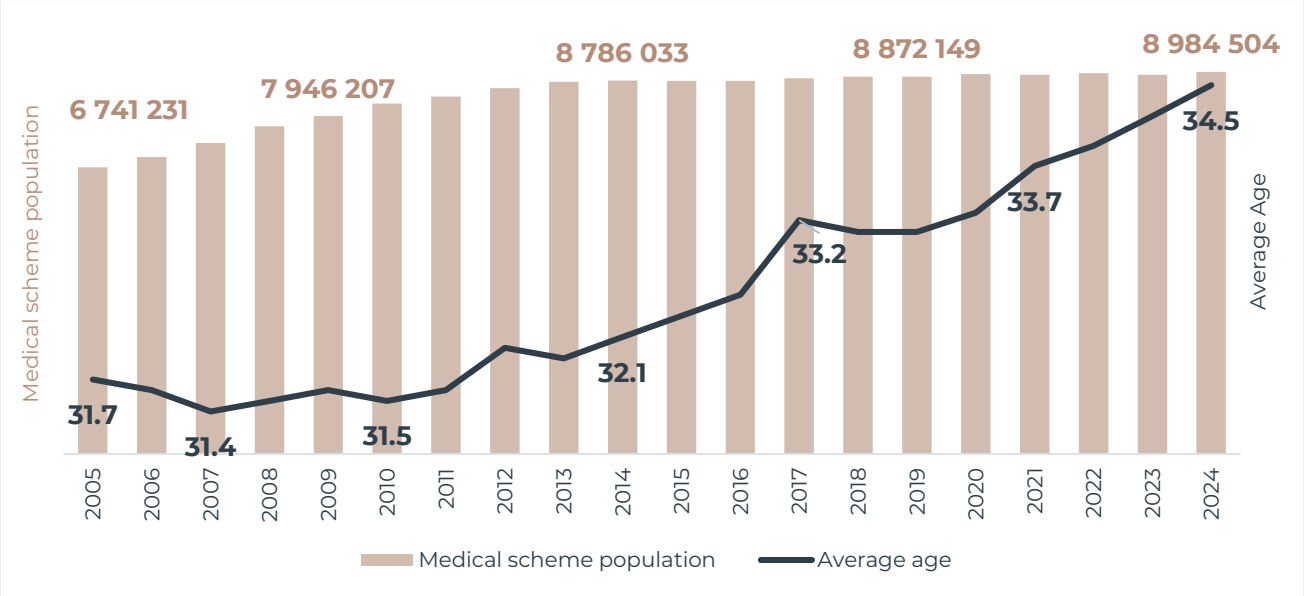


Figure 1: Medical scheme beneficiaries and average age, 2005–2024 Source: CMS annual reports.

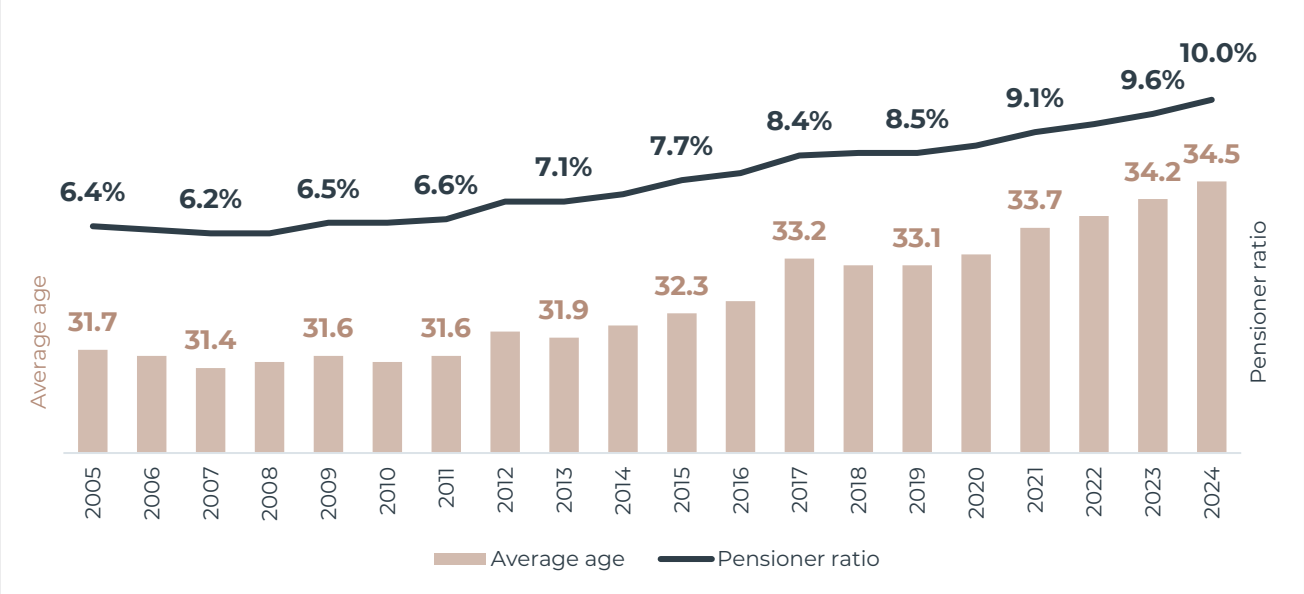


Figure 2: Medical scheme average age and pensioner ratio, 2005–2024 Source: CMS annual reports.

The average beneficiary age increased from 31.7 years in 2005 to 34.5 years in 2024, while the pensioner ratio rose from 6.4% to 10%. The simultaneous increase in both measures confirms that the demographic pressure is not a temporary fluctuation. It reflects a structural change in the composition of the covered population.

As the proportion of older members increases, there are progressively fewer younger and lower risk members available to cross subsidise the higher expected healthcare costs of older members. Without sufficient growth in younger membership, this places sustained upward pressure on average claims costs.

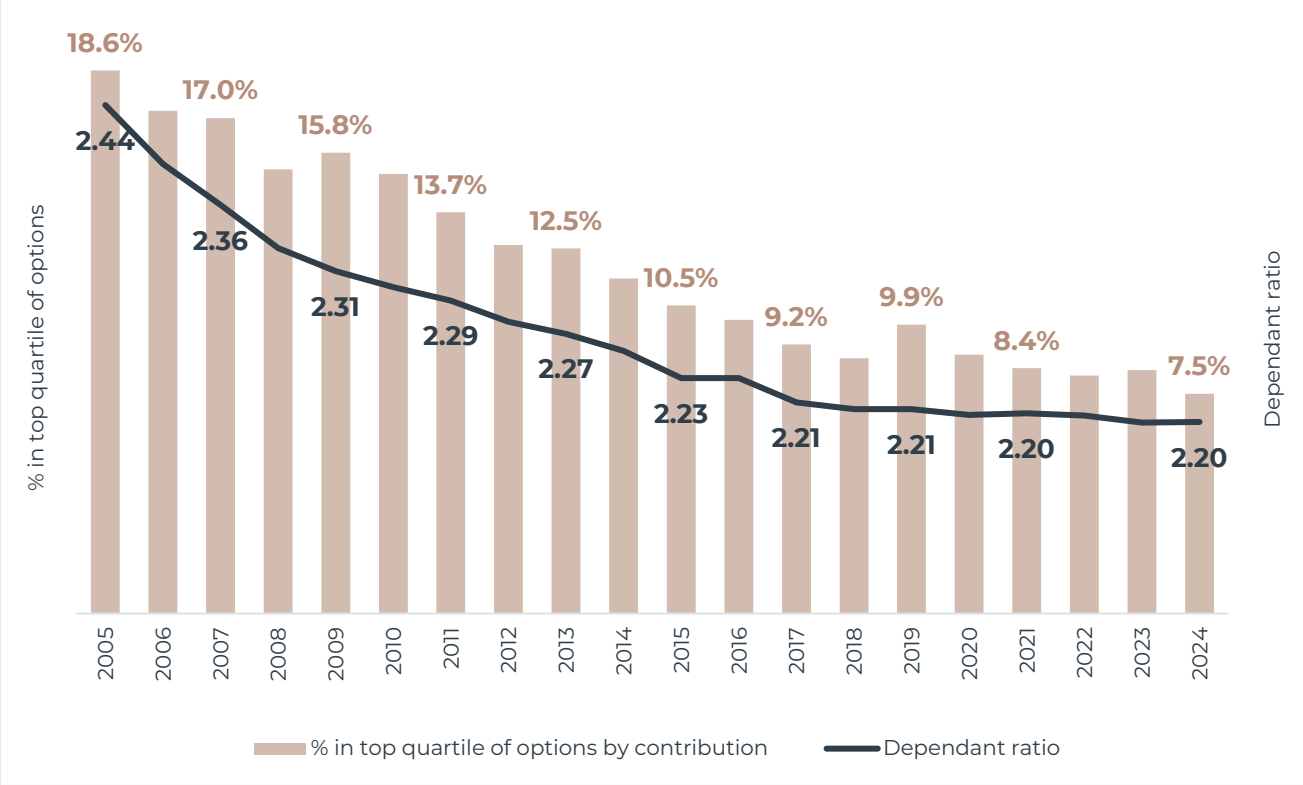


Figure 3. Medical scheme option distribution and dependant ratio, 2005–2024 Source: CMS annual reports

Affordability pressure is also changing how households retain cover. In 2005, approximately 18.6% of beneficiaries were enrolled in options falling within the highest contribution quartile. This proportion declined to 7.5% by 2024. Over the same period, the reported dependant ratio declined from 2.44 to 2.20.

These trends indicate a movement towards less expensive benefit options and fewer dependants remaining on medical schemes. While this may allow households to preserve some level of cover, it can also reduce the comprehensiveness of their protection. It may further contribute to anti- selection within the option structure, as more comprehensive options retain progressively older and higher risk populations and become increasingly difficult to sustain. This pattern is consistent with the affordability concerns identified by Principal Officers elsewhere in SOMS

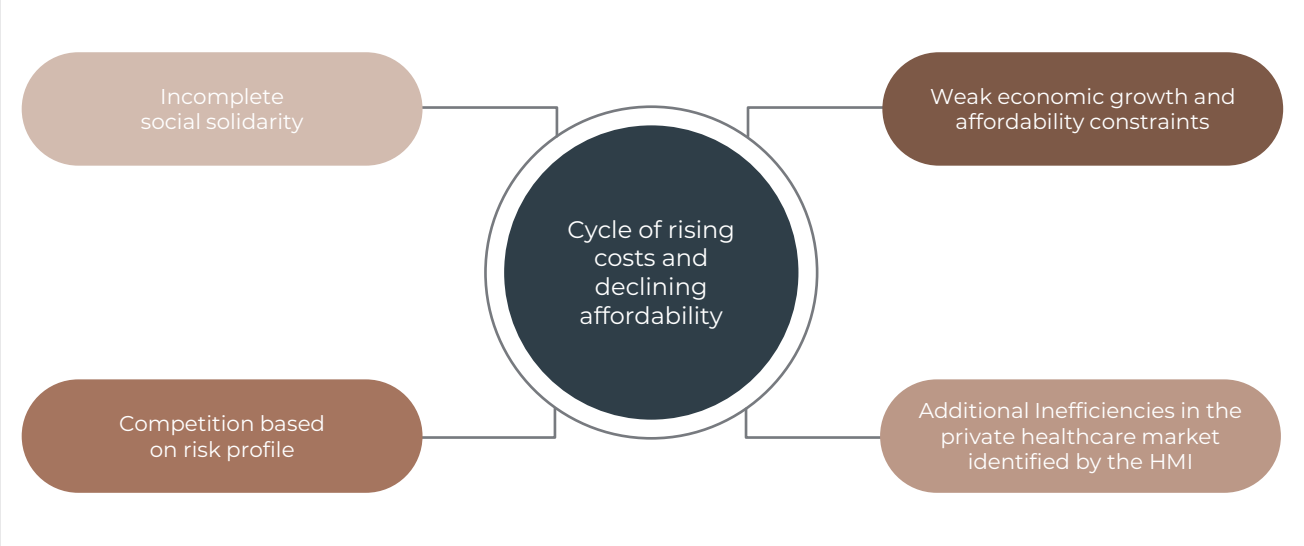


Figure 4. The cycle of ageing, rising costs and declining affordability

Limited membership growth and an ageing population place upward pressure on claims costs. Higher claims costs contribute to contribution increases, which further weaken affordability and make younger people less likely to join or remain within medical schemes. This reduces the inflow of younger and lower risk members, further weakening the risk pool and contributing to a continuing cycle of rising costs and declining affordability.

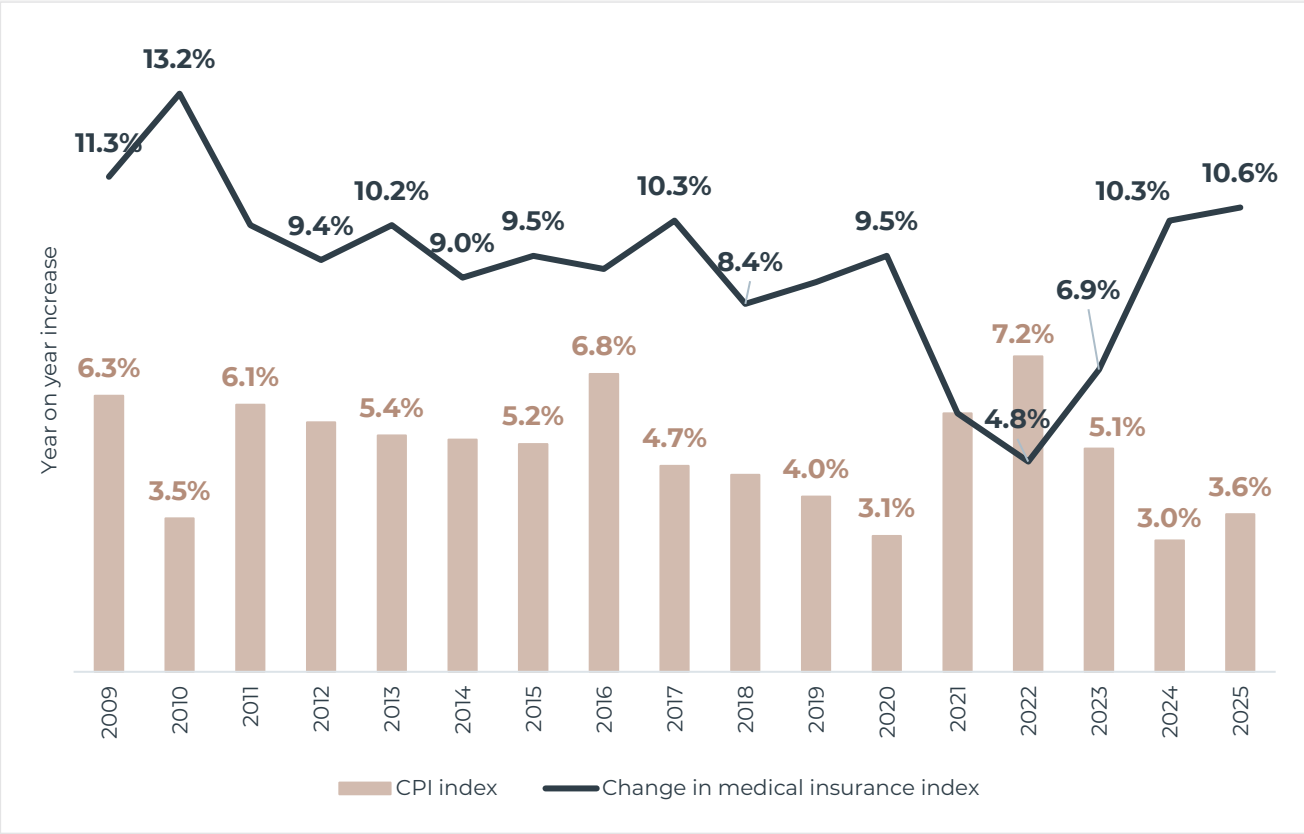


Figure 5. Medical scheme contribution index increases compared with CPI Source: StatsSA CPI tables

Medical scheme contribution increases have generally exceeded headline CPI. This reflects a combination of healthcare inflation, utilisation, benefit obligations, demographic change and other healthcare cost pressures. A deteriorating risk profile is therefore an important contributor to contribution growth, but it is not the only cause.

In the absence of risk equalisation, competition between schemes is also influenced by the need to attract and retain lower risk members. This diverts competition away from factors that schemes can more directly control, including efficient purchasing, care management, service quality and member value.

The analysis that follows focuses on the incomplete solidarity framework and its implications for medical scheme costs and sustainability. Other factors also contribute to rising expenditure:

- Weak economic growth and affordability constraints: Low economic growth, high unemployment and constrained household incomes limit the ability of younger people to enter and remain within the medical scheme system.
- Private healthcare market inefficiencies: The Health Market Inquiry identified provider concentration, fee for service incentives and supplier induced demand as factors contributing to higher healthcare expenditure.

The result is a familiar adverse selection dynamic. A relatively fixed medical scheme population becomes progressively older and more costly, placing upward pressure on contributions and making cover less affordable to new entrants. Contribution increases can then reinforce non participation, creating a cycle that cannot be corrected solely through improvements in efficiency at individual scheme level.

4. Risk equalisation: stabilising competition

Community rating means that members cannot be charged more because they are older or less healthy. However, schemes with older or less healthy members still face higher expected healthcare costs. Schemes with younger and healthier members therefore have a financial advantage that is not linked to how efficiently they operate or manage care. Risk equalisation would compensate schemes for these differences. This would allow schemes to compete more fairly on efficiency, quality, care management and member value.

4.1 Estimating the PMB cost

Figure 6. Estimated PMB risk cost by medical scheme Source: Insight Actuaries modelling.

PMB costs are estimated for each medical scheme based on its demographic profile, using a PMB cost curve by age. The industry community rate of R1,242 per beneficiary per month (pbpm) is the average expected PMB cost across all schemes in 2024. Figure 6 shows that expected PMB costs vary substantially between schemes. The range from the lowest to the highest is more than 3.5 times for the same package of benefits. This is based on the different age profiles, rather than differences in their actual claims expenditure or operating efficiency since the REF is a prospective measure.

4.2 Scale of redistribution

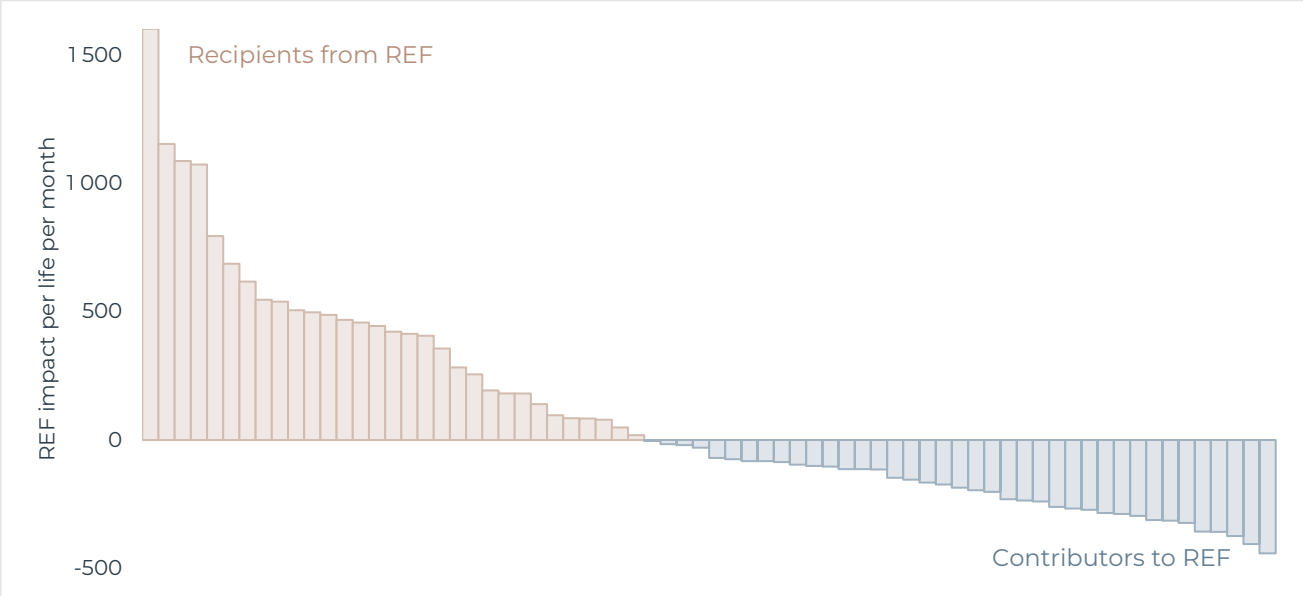


Figure 7. Illustrative REF adjustment by medical scheme Source: Insight Actuaries modelling.

Figure 7 shows the estimated monthly REF adjustment for each scheme. Schemes with expected PMB costs above the industry community rate would receive funds. Schemes with expected costs below the community rate would contribute. Overall, the net payments and receipts balance out giving a zero-sum game.

The largest receipts are generally associated with schemes that have older beneficiary populations and higher expected PMB costs. Risk equalisation would compensate these schemes for the additional demographic risk they carry. It would also reduce the financial advantage enjoyed by schemes with younger and lower risk populations.

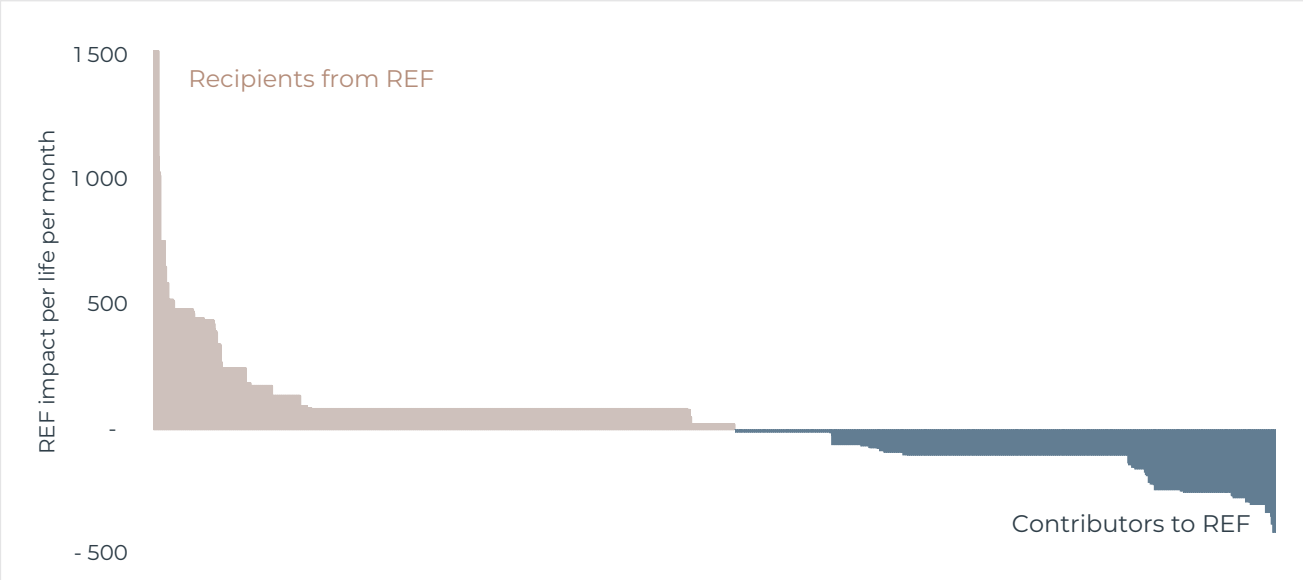


Figure 8. Beneficiary weighted distribution of illustrative REF adjustments Source: Insight Actuaries modelling.

Figure 8 shows how the estimated adjustments are distributed across schemes and beneficiaries. The largest adjustments are generally found among smaller schemes, which cover a relatively small proportion of the total beneficiary population. Most beneficiaries belong to larger schemes where the estimated adjustment is closer to the industry average

The tables below summarise the estimated redistribution. A positive amount represents a receipt from the REF, while a negative amount represents a contribution to the REF.

Measure	Recipients	Contributors
Schemes	31	39
Beneficiaries	4.25m (48%)	4.66m (52%)
Largest modelled monthly adjustment	+R1,604 pbpm	−R441 pbpm

Table 1. Scale of redistribution Source: Insight Actuaries modelling.

Of the 70 schemes modelled, 31 would receive transfers and 39 would contribute. Recipient schemes account for approximately 4.25 million beneficiaries, or 48% of the modelled population. Contributor schemes account for approximately 4.66 million beneficiaries, or 52%.

Size (Beneficiaries)	Open	Restricted
Small (<6k)	R408 (33%)	R397 (32%)
Medium (6k to 65k)	R227 (18%)	R227 (18%)
Large (65k to 220k)	R220 (18%)	-R93 (-7%)
Very Large (>220k)	R62 (5%)	-R158 (-13%)

Table 2. Monthly REF adjustment by scheme size and type Source: Insight Actuaries modelling.

Table 2 shows that small open and restricted schemes would receive the largest adjustments per beneficiary. The amounts are shown as Rands pbpm and as a percentage of the average pbpm. This reflects their relatively older beneficiary populations and higher expected PMB costs. Very large open schemes would receive a smaller amount per beneficiary, while very large restricted schemes would make the largest contribution per beneficiary.

Size (Beneficiaries)	Open	Restricted
Small (<6k)	R9 665 599	R141 412 958
Medium (6k to 65k)	R354 465 499	R165 410 574
Large (65k to 220k)	R2 405 928 171	-R691 648 287
Very Large (>220k)	R2 835 393 102	-R5 220 627 616

Table 3. Total annual REF adjustment by scheme size and type Source: Insight Actuaries modelling.

The total financial effect is also influenced by the number of beneficiaries in each scheme category. Very large open schemes would receive approximately R2.8 billion annually, despite having a relatively small adjustment per beneficiary. Very large restricted schemes would contribute approximately R5.2 billion because of their more favourable risk profiles and large beneficiary populations.

Overall, the analysis indicates annual redistribution of approximately R5.9 billion, equivalent to approximately 2% of total annual medical scheme contributions. This would not represent a new cost to the healthcare system. It would principally be a transfer from schemes with lower expected demographic risk to schemes with higher expected demographic risk.

The relatively even distribution of beneficiaries between recipient and contributor schemes shows that risk equalisation would operate across the medical scheme system. It would not be a limited support mechanism for only a small number of schemes.

Some contributor schemes may include a high proportion of lower income beneficiaries. Risk equalisation addresses differences in health risk, but it does not address differences in members' ability to pay. Income related support may therefore be needed to protect affordability for lower income members who could otherwise face higher contributions.

4.3 Why risk equalisation should not be implemented in isolation

Risk equalisation would distribute prospective demographic risk more fairly between schemes, but it would not increase the size or improve the age profile of the medical scheme population as a whole.

If introduced in the current voluntary market without affordability measures, REF could increase costs for schemes or options with younger and lower income members. These members may be more sensitive to contribution increases and could respond by leaving the system. This would further weaken the overall risk pool.

REF should therefore form part of a broader reform package that includes expanded participation and measures to improve affordability. Mandatory membership addresses the size and composition of the overall risk pool within which risk equalisation would operate.

5. Mandatory membership: broadening the pool

Mandatory membership changes who participates in the medical scheme risk pool. Younger and healthier employed people may remain outside medical schemes while they expect relatively low healthcare costs and seek cover only when their anticipated need increases. This weakens the risk pool and increases the average cost for those who remain covered.

The analysis uses two approaches to estimate the possible effect of reducing adverse selection:

- Demographic approach
- Restricted scheme proxy approach

The demographic approach estimates the effect of adding currently uncovered employed people to the medical scheme population. The restricted scheme approach considers the experience of schemes where membership is linked to employment or membership of a defined occupational group. More details around the assumptions and factors affecting the adverse effects can be found in the annexures.

5.1 Demographic approach

The demographic approach uses GHS and labour market data to estimate the number, age and income profile of employed people who are not currently covered by medical schemes.

The analysis begins with employed people earning above R750k per annum, who are more likely to be able to afford cover, and then progressively expands to lower income tax thresholds. This allows the effect of broader participation to be considered in stages.

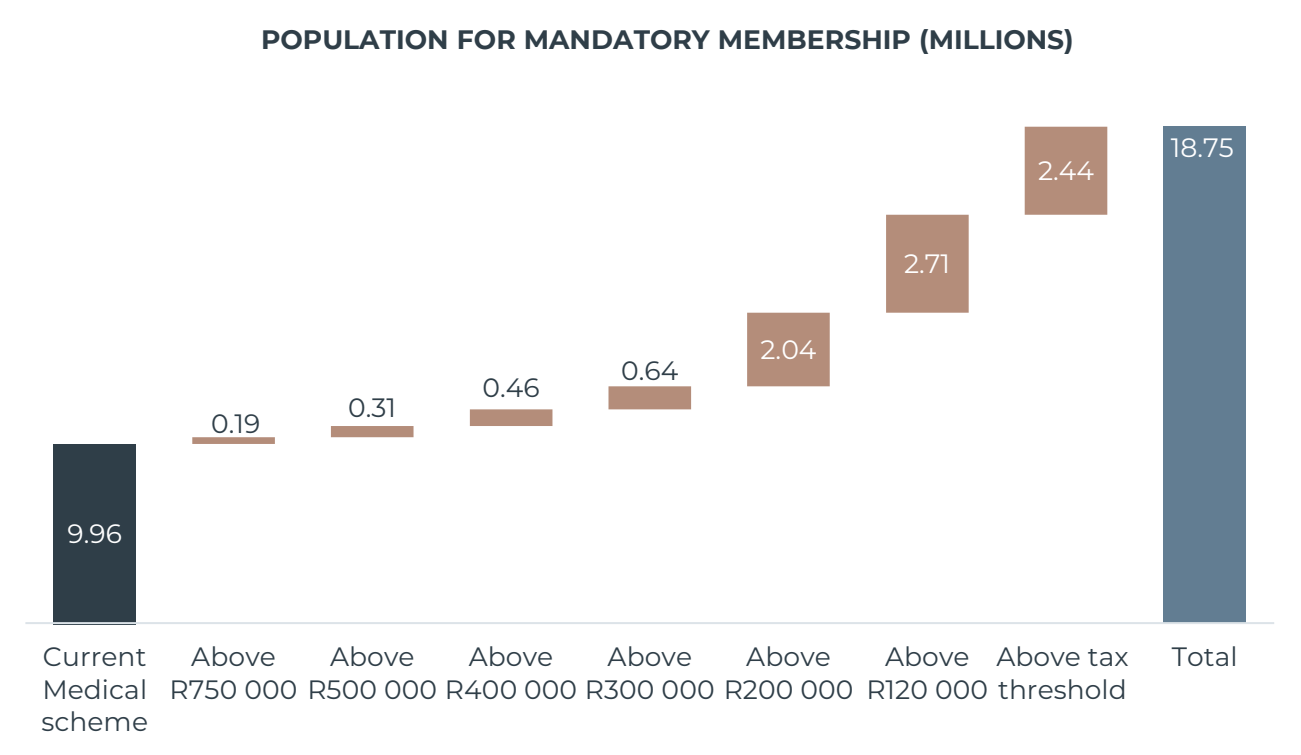


Figure 9. Modelled population under current coverage and mandatory membership above the tax threshold (measured in millions of people) Source: Insight Actuaries modelling.

The GHS model[3] estimates that approximately 9.96 million people are currently covered. A further 8.79 million uncovered people are above the income tax threshold. Including this group would increase the modelled covered population to approximately 18.75 million, an increase of 88%.

This is an estimate of the population that could become eligible for mandatory membership. It is not a forecast of the number of people who would enrol immediately.

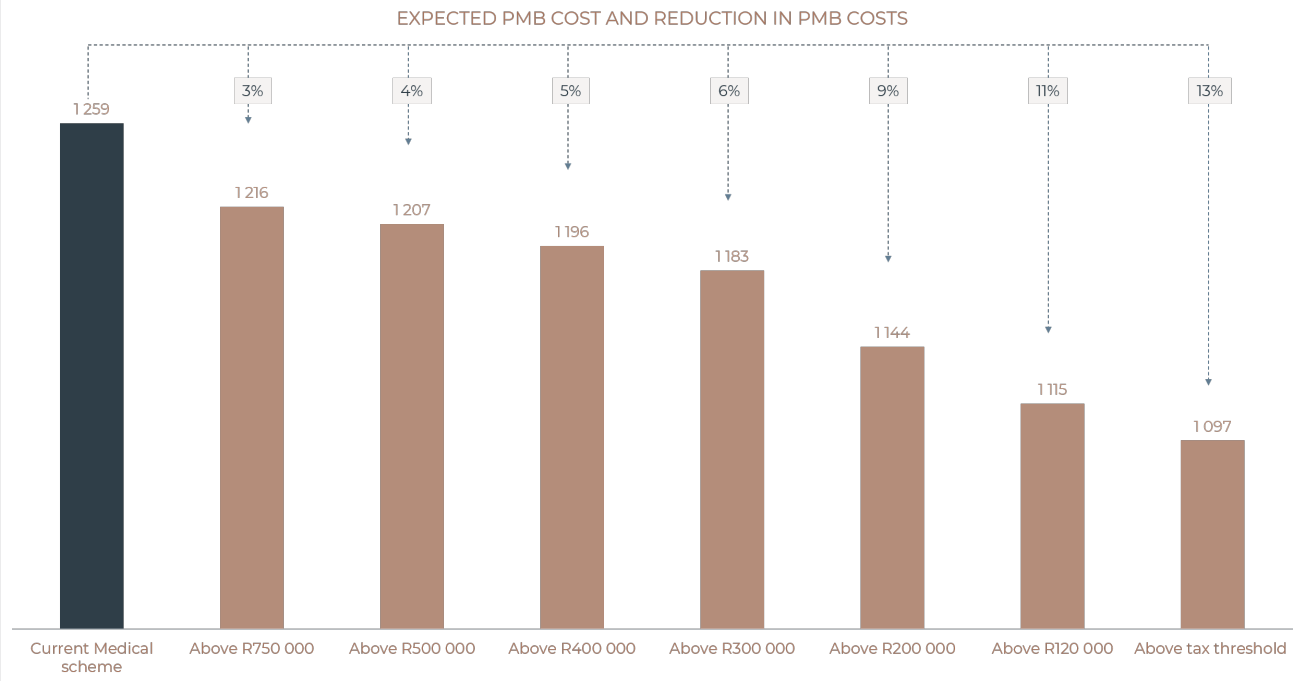


Figure 10. Expected PMB risk cost under selected mandatory-membership thresholds Source: Insight Actuaries modelling.

The people entering the pool above the income tax threshold are, on average, younger and lower risk than the current medical scheme population. Adding them improves the age profile of the pool and reduces the average expected PMB risk cost.

Based on age and maternity anti-selection, the model estimates that the expected PMB risk cost would fall from R1,259[4] to approximately R1,097 per beneficiary per month at the income tax threshold. This is a reduction of approximately 13% after allowing for the maternity adjustment.

If membership were extended to all employed people, the expected PMB risk cost would fall further to approximately R1,031 per beneficiary per month, a reduction of approximately 18%. However, the affordability and subsidy requirements would become much greater below the income tax threshold.

Important distinction

A reduction in expected PMB risk cost does not result in an automatic contribution reduction of the same amount. Contributions also fund benefits outside the PMB package, administration, managed care, reserves and other expenses. The model nevertheless shows that broader participation could improve the underlying risk base from which more affordable products could be designed.

[3] The GHS figure of 9.96 million is based on weighted household survey responses and is higher than the CMS administrative count of approximately 9.1 million registered beneficiaries. The GHS data also has a slightly different age distribution resulting in a slightly different expected PMB cost compared to that used in the REF estimate. The GHS estimate is used in the model to maintain consistency between the current and uncovered population estimates.

[4] The REF calculations use CMS figures for the population. The mandatory contribution calculations use GHS figures for the population.

Stage	Eligible group	Modelled cumulative population	Expected PMB cost	% change
Current	Existing scheme members	9.96m	R1,259 pbpm	0%
Initial mandate	Employed above the tax threshold	18.75m	R1,097 pbpm	13%
Further expansion	All employed people	37.80m	R1,031 pbpm	18%

Table 4. Potential implementation. Source: Insight Actuaries modelling.

A phased mandate could begin with employed people above the income tax threshold, where the ability to contribute is strongest. It could expand as affordable products, employer mechanisms and targeted income support become available.

Mandatory membership should not be introduced before affordable cover is available. Clear exemptions and hardship protections would also be needed where the cost of cover is not reasonable in relation to household income.

5.2 Restricted scheme proxy approach

Restricted medical schemes provide a second way to estimate the possible effect of adverse selection. Membership of these schemes is generally linked to employment or membership of a defined occupational group. They therefore tend to operate as more stable and relatively closed risk pools.

Eligible employees are more likely to join and remain covered regardless of their immediate healthcare needs. This reduces the opportunity for people to enter or leave the pool according to their expected claims.

The analysis compares the cost experience of restricted schemes with that of open schemes, where membership is more voluntary and members can move more easily between schemes or leave cover.

The comparison indicates that broader and more continuous participation could reduce expected PMB risk cost by up to approximately **30%.** This is higher than the estimate produced by the demographic model because the restricted scheme approach may capture a wider range of effects associated with more stable membership.

The **30%** result should be treated as an indicative upper estimate rather than a precise forecast. Differences between open and restricted schemes may also arise from their age profiles, employment characteristics, benefit design, utilisation patterns and purchasing arrangements. The full difference in cost experience cannot therefore be attributed only to adverse selection. More information on this can be found in the appendix.

5.3 Effect of mandatory membership

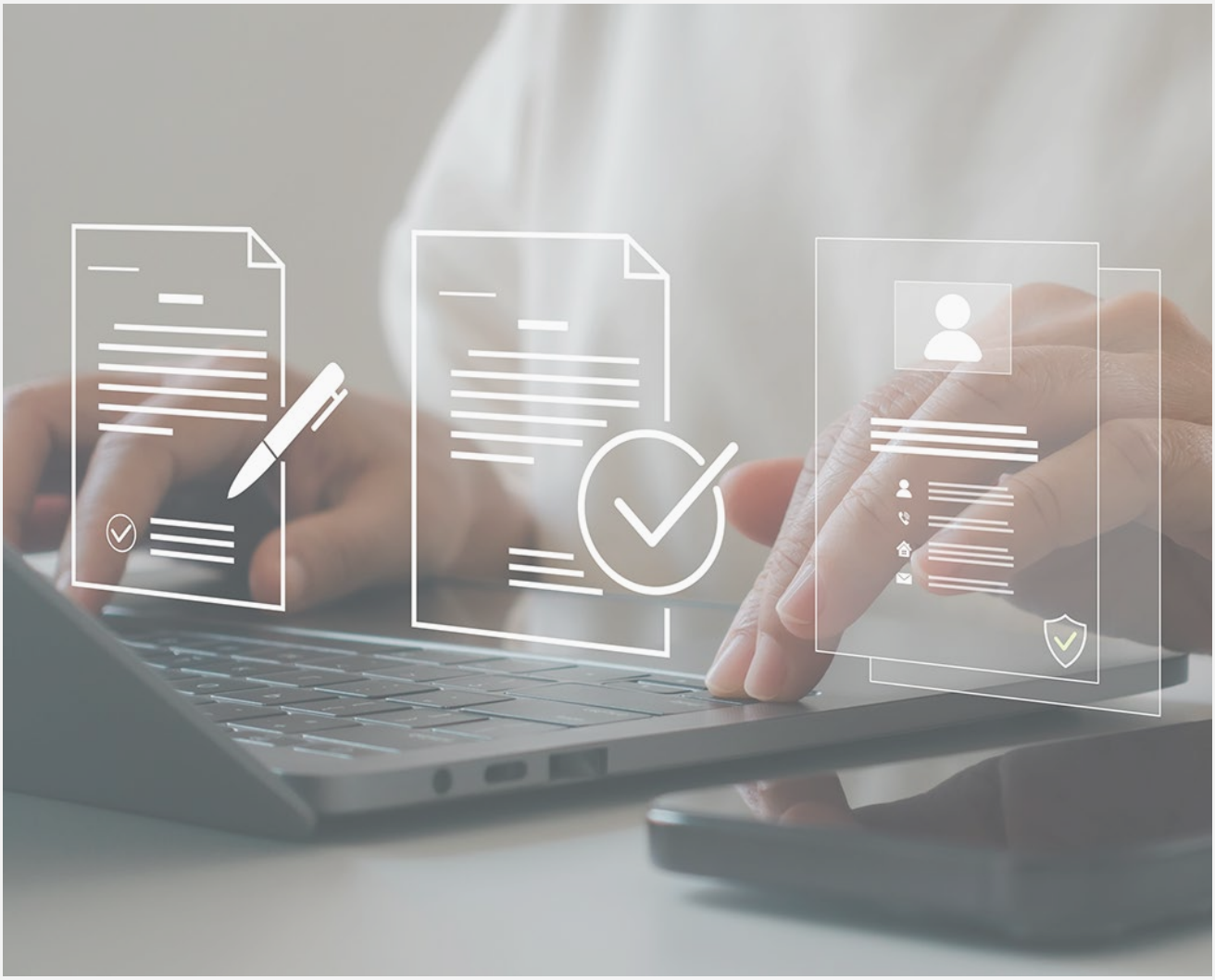
The two approaches provide a range for considering the potential effect of mandatory membership.

The demographic approach estimates that extending membership to employed people above the income tax threshold could reduce average expected PMB risk cost by approximately 13%. Extending participation to all employed people increases the estimated reduction to approximately 18%, although affordability becomes a greater challenge. This is likely an underestimate as it does not consider the impact of anti-selection due to burden of disease, in addition to age. Additionally, individuals with a higher propensity to claim may be more likely to obtain or retain medical scheme cover, even after adjusting for differences in underlying health status and expected healthcare needs.

The restricted scheme proxy approach suggests that the reduction could be as high as 30% where participation is broader, more stable and less influenced by members' anticipated healthcare needs.

The demographic approach indicates a reduction in average expected PMB risk cost of approximately 13% for mandatory membership above the income tax threshold and approximately 18% if participation were extended to all employed people. The restricted-scheme proxy suggests that the effect of broader and more stable participation could potentially be as high as 30%, although this should be treated as an indicative upper estimate rather than a directly comparable PMB cost estimate.

These estimates relate to expected PMB risk cost. They should not be interpreted as equivalent reductions in medical scheme contributions.



6. Why the reforms work best together

Reform	Primary problem addressed	System effect
Mandatory membership	Younger and lower risk people who can afford cover remaining outside the medical scheme pool.	Expands the pool, improves its risk profile and reduces adverse selection.
Risk equalisation	Uneven distribution of risk between schemes	Redistributes funding so that schemes compete on efficiency, quality and value rather than on risk selection.
Affordability measures	Lower income households being unable to afford mandatory cover.	Makes broader participation more realistic and reduces the risk that members leave because of higher contributions.
Combined framework	A stagnant and ageing pool, unequal risk between schemes and barriers to affordability.	Creates a broader, more stable and more competitive regulated market

The reforms address different parts of the same structural problem. Mandatory membership broadens the overall pool and brings in more younger and lower risk people. Risk equalisation shares the cost of the risk differences that remain between schemes. Affordability measures help ensure that the people required to join can reasonably afford the available cover. These measures could include a revision of PMBs to prioritise needed care and appropriate treatment requirements as well as PMB exempt plans and other lower cost benefit options. However, the detailed design and implementation of these affordability reforms fall outside the scope of this report.

Implemented together, these reforms can support a larger and more stable risk pool, fairer competition between schemes and more affordable access to medical scheme cover.

Strategic conclusion

The objective is not to protect individual schemes from competition. It is to ensure that schemes compete on the factors they can control, including service, purchasing, care management and member value, rather than on their ability to attract lower risk members.

7. Implementation principles

The modelling illustrates the potential effect of the reforms but does not provide a complete implementation design. Any future reform would require detailed policy, legal, actuarial and administrative development. The following principles should guide that process:

- **Define the mandate clearly:** The eligible population, income threshold, treatment of dependants, employer obligations, available products and affordability exemptions would need to be specified.
- **Address affordability before enforcement:** Affordable benefit options, appropriate income support and clear consumer protections would need to be available before people are required to join.
- **Introduce risk equalisation progressively:** The risk equalisation model should operate in shadow form before financial transfers begin. This would allow the data, calculations and reconciliation processes to be tested.
- **Establish strong data and governance arrangements:** Implementation would require reliable beneficiary and risk data, independent oversight, appropriate privacy protections, audit processes and a clear mechanism for resolving disputes.
- **Coordinate across the system**: Tax policy, employer payroll systems, scheme registration and regulatory supervision would need to operate together.
- **Monitor the effect of the reforms:** Coverage, affordability, movement between options, employer compliance, scheme solvency, quality of care and unintended consequences should be monitored throughout implementation.

These principles are not intended to provide a detailed implementation plan. They identify the main conditions that would need to be addressed before mandatory membership and risk equalisation could be introduced.

8. Conclusion

The analysis points to a coherent reform direction. Risk equalisation could redistribute approximately R5.9 billion annually so that schemes are compensated for predictable demographic risk that they cannot price directly under community rating. Mandatory membership above the income tax threshold could reduce average expected PMB risk cost by approximately 13%, increasing to approximately 18% if participation were extended to all employed people. A separate restricted-scheme proxy indicates that the potential effect of broader and more stable participation could be as high as 30%, although this should be treated as an indicative upper estimate.

These findings do not establish a final policy design. A lower expected PMB risk cost does not translate automatically into an equivalent contribution reduction, and the analysis does not fully reflect disease burden, behavioural responses, administration, benefit design or subsidy costs. The results do, however, demonstrate the potential scale of the opportunity and the cost of leaving the existing framework incomplete.

The reform objective is not to insulate schemes from competition. It is to ensure that they compete on service, purchasing, care management, quality and member value and not on their ability to attract favourable risks. That requires mandatory participation, risk equalisation and affordability measures to be designed as a sequenced and integrated package.

Annexures: A1. Evidence of adverse selection

Adverse selection by income and age

The analysis uses 2025 GHS data to estimate the age and income profiles of the population reporting medical scheme coverage and the currently uncovered population. An age based PMB cost curve is then applied to estimate expected costs under different coverage scenarios.

The GHS estimate of the currently covered population is based on weighted household survey responses and is higher than the CMS administrative count of registered beneficiaries. The GHS estimate is used throughout the model to ensure consistency between the covered and uncovered population estimates.

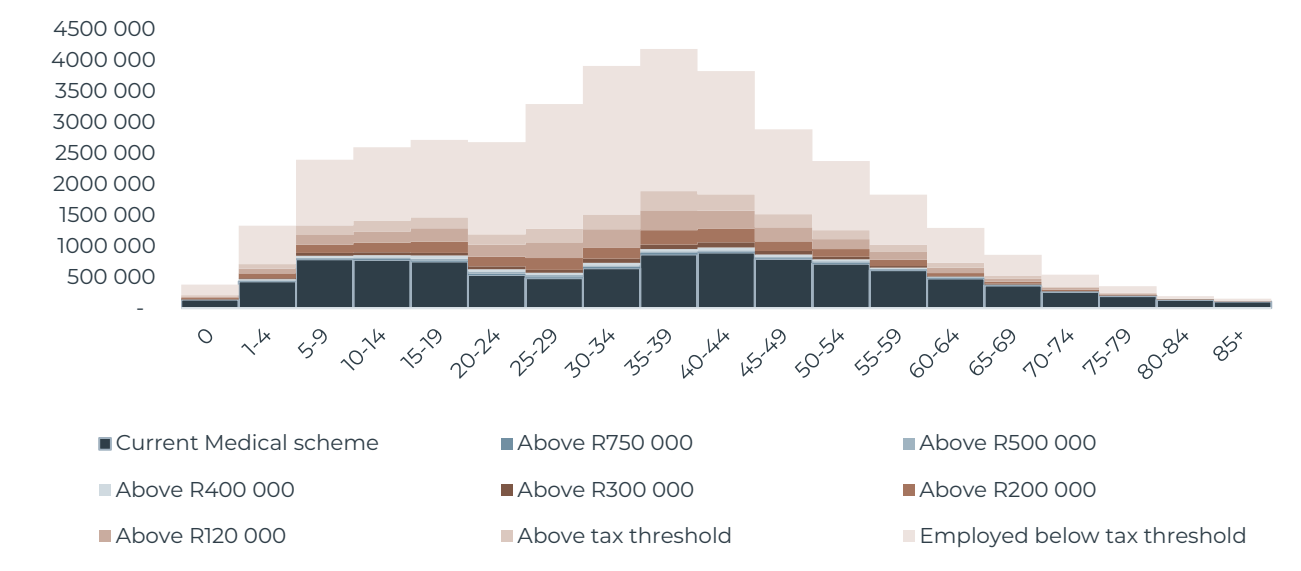


Figure A1. Modelled population by age and income threshold. Source: Insight Actuaries modelling.

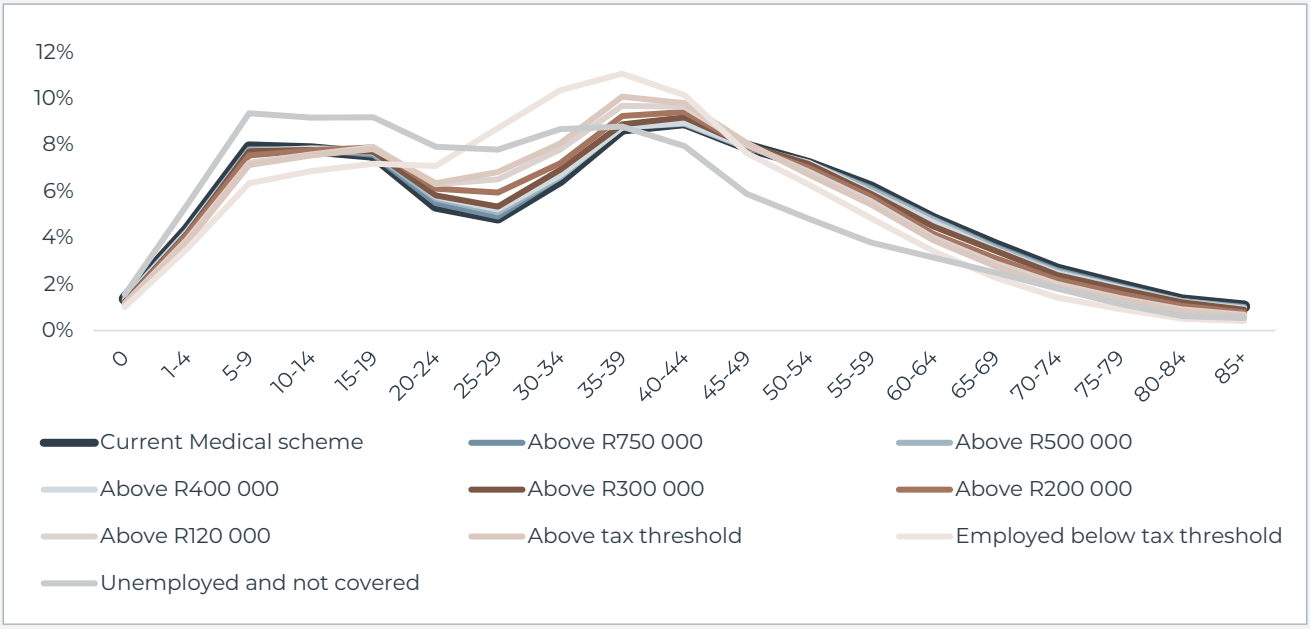


Figure A2. Age profile of the modelled population under alternative income thresholds. Source: Insight Actuaries modelling

Figures A1 and A2 show that younger adults between approximately 20 and 35 years of age are less represented in the current covered population than in the broader population. Younger adults generally have lower expected healthcare costs and may be less likely to purchase medical scheme cover where contributions are high relative to their expected healthcare needs. This pattern is consistent with adverse selection.

As more of the currently uncovered population is included at progressively lower income thresholds, the gap in the younger age groups narrows. The proportion of pensioners also declines as the modelled risk pool expands.

This change in the age profile reduces the expected average cost of the PMB package. It also strengthens cross subsidisation by bringing more younger and lower cost people into the pool and spreading healthcare costs across a broader population.

Maternity

Age is not the only possible source of adverse selection. The maternity analysis considers whether women are more likely to obtain or retain medical scheme cover when they expect maternity related expenditure and leave once that need has passed.

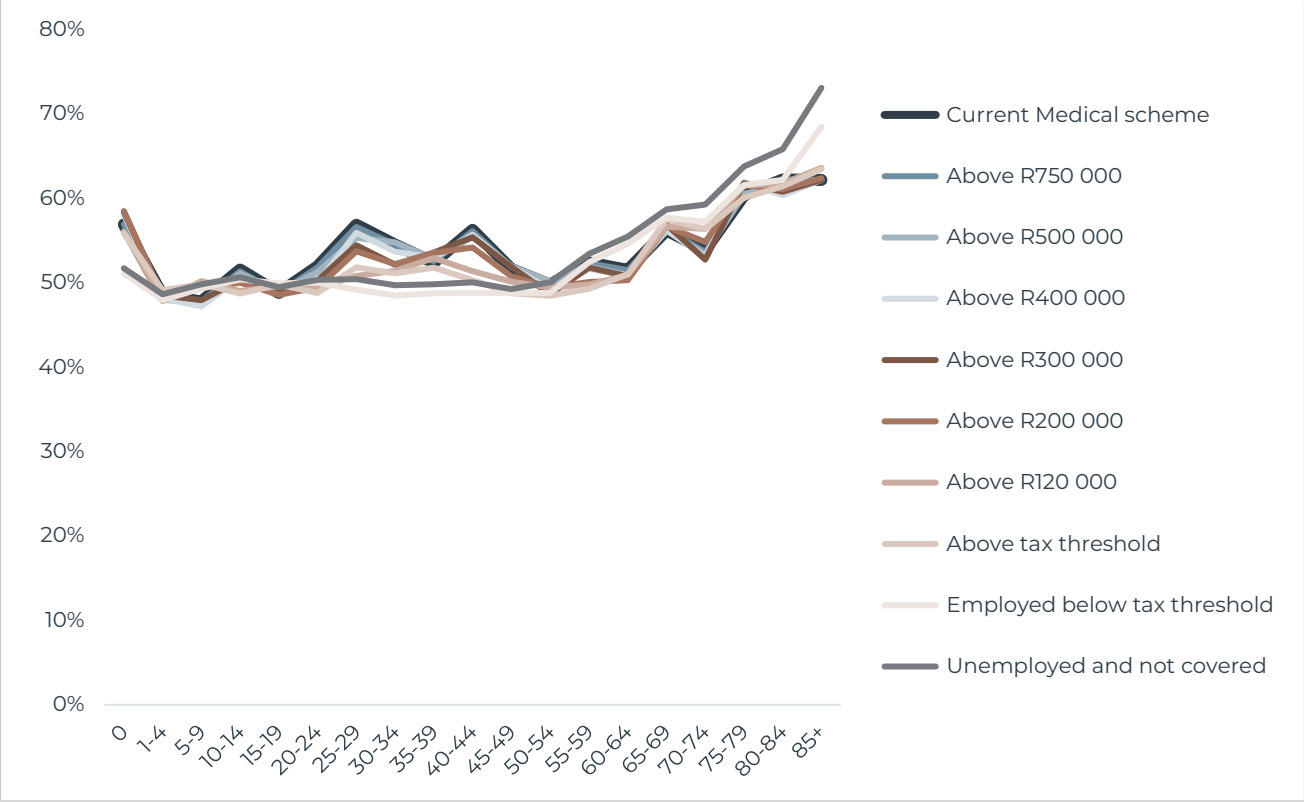


Figure A3. Female representation by age under alternative coverage scenarios. Source: Insight Actuaries modelling.

Figure A3 shows that women are more highly represented in the current covered population at ages when maternity events are most likely. As more of the currently uncovered population is included, the proportion of women in these age groups moves closer to 50%, resulting in a more balanced profile.

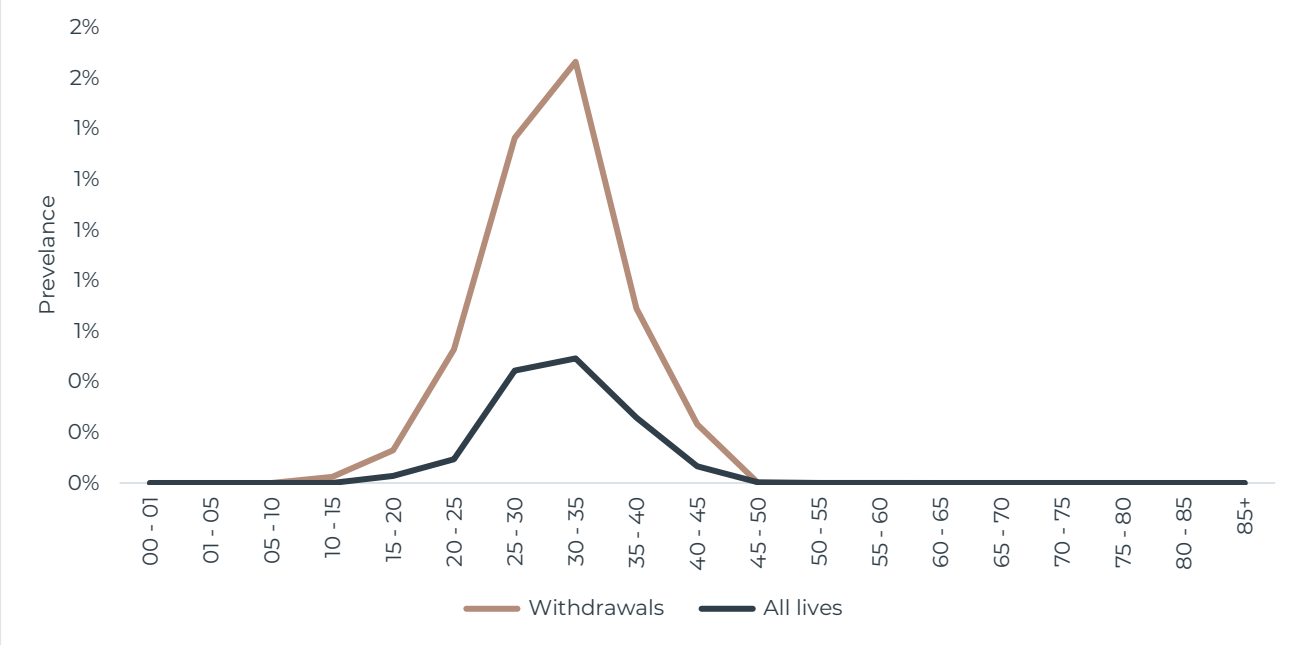


Figure A4. Maternity prevalence among members withdrawing shortly after a maternity event. Source: Insight Actuaries modelling.

Figure A4 compares the prevalence of maternity events across the overall medical scheme population with the prevalence among members who leave their scheme within three months.

Maternity events are substantially more common among members who leave within three months than across the medical scheme population as a whole. This pattern is consistent with some members retaining cover during a period of expected maternity expenditure and leaving soon afterwards.

Including the maternity adjustment increases the estimated reduction in expected PMB risk cost at the income tax threshold from approximately 10% to 13%. The resulting expected cost is approximately R1,097 per beneficiary per month.

Disease burden: an important uncertainty

The disease burden of currently uncovered people could materially affect their expected healthcare costs if they entered medical schemes.

Available data does not allow differences in disease burden between current beneficiaries and potential entrants to be estimated with the same confidence as age, sex and maternity. Disease burden has therefore not been included in the model.

The estimated cost reductions should consequently be interpreted as the effects of changes in the demographic and maternity profiles of the modelled population. They do not provide a complete estimate of the claims experience of new entrants. Burden of disease is expected to increase the impact of adverse selection further. The impacts estimated in this document using the demographic method thus understate the impact of anti-selection.

Restricted Scheme Proxy Approach

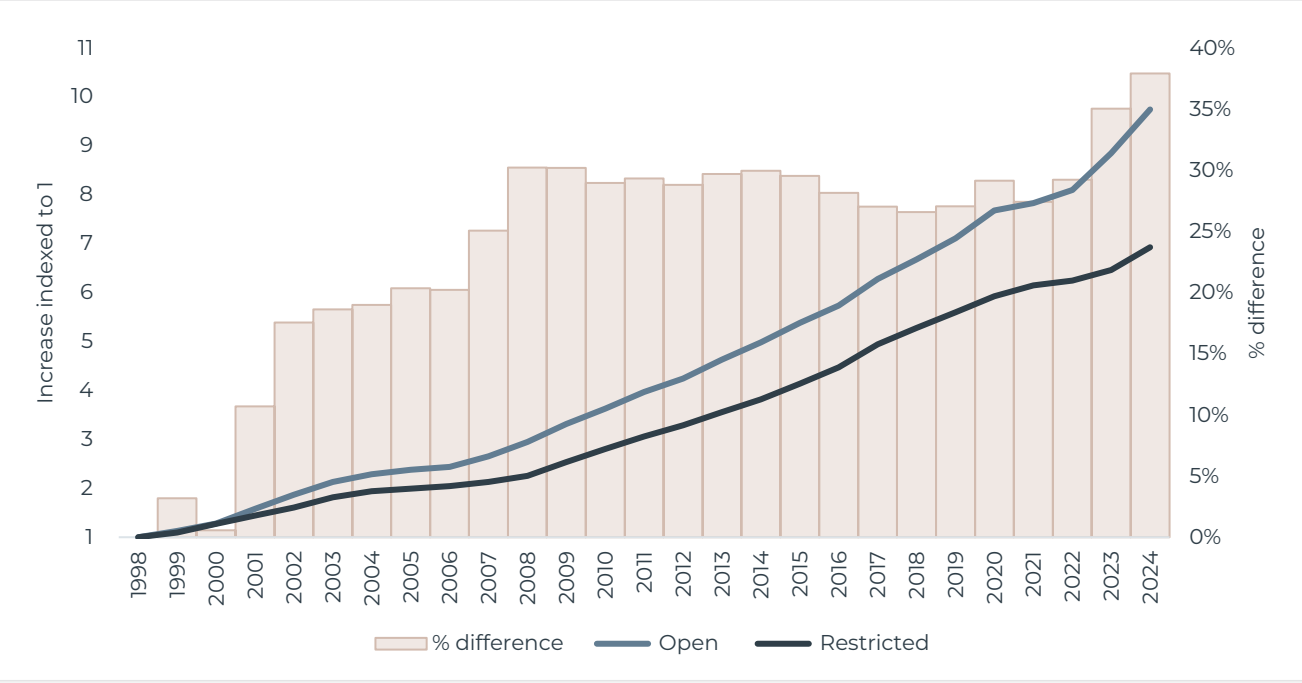


Figure A5. Long term growth of contributions between open and restricted medical schemes. Source: CMS annual report

The figure shows long-term growth in contributions from 1998 to 2024. The starting point of 1998 is relevant as this represents the beginning of the period in which the Medical Schemes Act and its requirements for open enrolment and community rating came into effect.

Over the period, open medical schemes experienced higher increases in contributions than restricted medical schemes. The difference developed relatively quickly, with the increase in open scheme costs approximately 30% higher than restricted schemes by 2008. The difference remained at a similar level from 2008. The COVID-19 pandemic caused a temporary reduction in the increases across both types of schemes. Following the period, open schemes experienced large increases, offsetting the lower increases. Restricted schemes did not experience the same rebound, although this may occur in the years after 2024.

The difference in cost increases between open and restricted schemes provides an indication of the impact of adverse selection in the open medical scheme market. Restricted schemes tend to have more stable membership characteristics and are less exposed to the selective movement of members into and out of schemes.

This analysis should not be interpreted as a precise estimate of the impact of adverse selection, as the two groups of schemes differ in other respects. Nevertheless, the persistent difference in contribution increases provides a broad indication of additional cost pressures associated with open schemes. The 30% difference can be viewed as an upper bound for the potential impact of adverse selection.

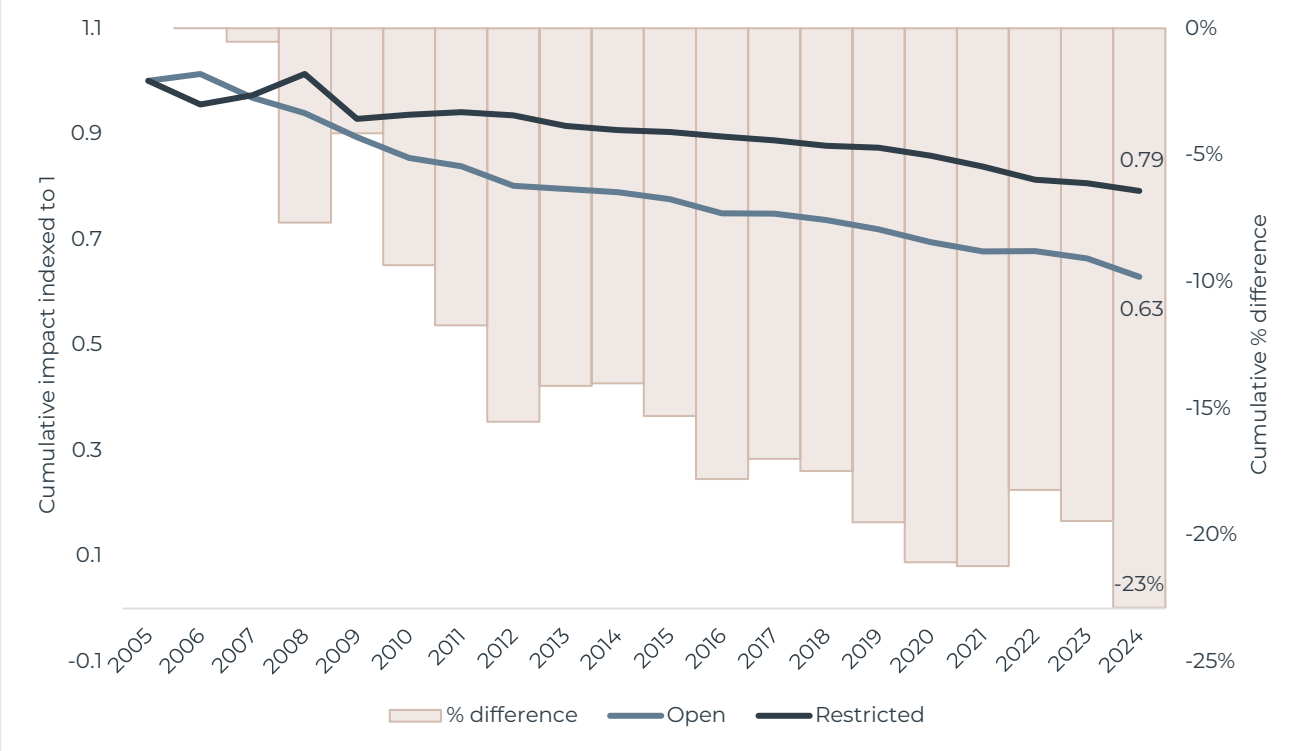


Figure A6. Impact of changes in the mix of medical scheme options

The figure shows the impact of changes in the mix of medical scheme options on contributions for open and restricted schemes. Changes in option mix have decreased contributions on open medical schemes more than on restricted schemes. This shows that open schemes are more exposed to members joining, or buy-down to lower-cost options. The greater impact on open schemes may include selective buy-downs, whereby healthier members are more likely to move to lower-cost options and sicker members remain on more comprehensive options.

Part D

Judgements that Matter

From the courts to regulatory appeal bodies, important decisions are shaping the environment in which medical schemes operate. We highlight some of the rulings that matter most and consider what they could mean for the sector.

01. Termination of Medical Scheme Membership for Non-Disclosure of Material Information

Swanepoel N.O. (Executor in the Estate Late Mignon Adelia Steyn) v Profmed Medical Scheme [2024] ZACC 23

Background

The Constitutional Court considered whether Profmed was entitled to terminate Mrs Steyn's membership, and that of her dependants, under section 29(2)(e) of the Medical Schemes Act (MSA) on the basis that she had allegedly failed to disclose material information when applying for membership. The alleged non-disclosures related to a previous hip arthroscopy and a diagnosis of gastritis. Profmed declined to reimburse approximately R400 000 in medical expenses and terminated the membership.

Profmed was initially successful before the CMS Appeal Committee and the Appeal Board. Although Mrs Steyn succeeded in the High Court, the Full Bench overturned that decision. Following the refusal of leave to appeal to the Supreme Court of Appeal, the matter came before the Constitutional Court. The judgment provides important guidance on the meaning of "material information" and the circumstances in which a medical scheme may lawfully terminate membership for non-disclosure.

Constitutional Court Judgement

The Constitutional Court upheld the appeal and held that Profmed had not lawfully terminated the member's membership under section 29(2)(e).

Key Findings of the Court

1. **Materiality must be determined objectively.** The meaning of "material information" must be interpreted with reference to the MSA, the scheme rules, the membership application and established common law principles relating to material non-disclosure.
2. **Section 29(2)(e) does not define material information**. In the absence of a statutory definition, materiality is determined by asking whether a reasonable and prudent person would regard the undisclosed information as relevant to the medical scheme's assessment of the membership risk. Whether a condition qualifies as a Prescribed Minimum Benefit (PMB) is unrelated to whether information is material for purposes of section 29(2)(e).
3. **Inducement is a requirement**. Section 29(2)(e) did not abolish the common law requirement that the non-disclosure must have induced the medical scheme to enter into the contract.
4. **The medical scheme bears the onus of proof.** A scheme seeking to terminate membership must establish that the undisclosed information was objectively material and the non-disclosure induced it to conclude the membership contract.
5. **A diagnostic procedure is not necessarily a material medical condition**. On the facts, the hip arthroscopy constituted a diagnostic procedure rather than a medical condition requiring disclosure, while the evidence did not establish that gastritis constituted a material underwriting risk.
6. **Evidence is essential**. Profmed failed to produce evidence demonstrating that disclosure of the information would have affected its underwriting decision or that it would have acted differently had the information been disclosed.
7. **Section 29A(7) provided contextual support**. The Court noted that the statutory limitation on the request for historical medical information reinforced its conclusion regarding the hip arthroscopy. However, this was not the principal basis for the decision.

Medical Schemes' Statutory Framework

The judgment raises several questions. The ability of a medical scheme to terminate membership must be understood within the broader framework of the MSA, which includes the principle of open enrolment, prohibiting medical schemes in general from turning eligible applicants away. In this environment, medical schemes have limited ability to manage their risk.
The court did not consider the broader framework, particularly the open enrolment obligation, when it applied the common law element of inducement to contract. However, as a decision of the highest judicial body in the South African legal system, the judgment remains in force until the Constitutional Court reaches a different conclusion in a similar matter.

Implications for Medical Schemes

- The judgment does not remove a medical scheme's statutory right to terminate membership for material non-disclosure under section 29(2)(e). Rather, it clarifies the evidential and legal requirements that must be satisfied before such termination may lawfully occur.
- Medical schemes can no longer rely solely on the existence of an undisclosed medical fact when invoking section 29(2)(e). Schemes should at least be able to demonstrate, through objective evidence, that the undisclosed information was material to the underwriting assessment and resultant contracting terms.
- Medical schemes should establish the information they regard as material in their rules and application forms.

02. Funding of PMBs Pending Final Adjudication of Disputes

Medihelp Medical Scheme v De Wet and Others
(Case number A140/2023: Judgment delivered on 31 October 2025)
(Case number 2022-010688: Judgment on leave to appeal delivered on 17 December 2025)

Background

The case arose from a dispute concerning the funding of Elaprase (enzyme replacement therapy) for a four-year-old child with Hunter Syndrome (MPS II), a rare genetic disorder. The dispute proceeded through the adjudication structures under the Medical Schemes Act (MSA) and, in parallel, urgent High Court proceedings and related appeals.

The relevant procedural history was as follows:

- Pending the resolution of a complaint lodged with the Registrar of Medical Schemes, Rare Diseases South Africa obtained an urgent interim order in the High Court requiring Medihelp to fund all medical interventions prescribed by the beneficiary's treating practitioners, including Elaprase.
- The Registrar of Medical Schemes subsequently determined that Elaprase was not PMB level care.
- The CMS Appeal Committee disagreed with the Registrar's reasoning and found that Elaprase constituted PMB level care. However, it dismissed the appeal on the grounds of Medihelp's solvency at the time.
- An appeal was lodged to the CMS Appeal Board.
- When Medihelp ceased the funding of Elaprase, the therapy continued with the assistance of a donor.
- Another urgent application was lodged in the High Court to hold Medihelp in contempt of the earlier court order. The central issues were whether the interim order remained operative and whether Medihelp had failed to fund certain treatment in full and in accordance with the High Court order while the CMS Appeal Board process was still pending.

High Court Judgement

The High Court: -

- declared Medihelp to be in contempt of court for its refusal to fund the relevant treatment.
- ordered Medihelp to comply with the interim order pending determination by the Appeal Board of the outstanding dispute concerning liability for the cost of Elaprase,
- awarded a punitive cost order against Medihelp.
- held that further coercive relief (such as the arrest of the principal officer and the imposition of a fine on Medihelp) could be sought if Medihelp did not purge its contempt.

The Supreme Court of Appeal has granted Medihelp leave to appeal the judgment to the Full Court of the Gauteng Division.

Reasons for the Judgement

1. **The interim order remained binding:** The Court regarded the Appeal Committee's subsequent finding that Elaprase constituted PMB level care as reinforcing, rather than undermining, the prima facie rights on which the interim order had been granted.
2. **Third-party funding did not justify discharge of the interim order:** The availability of Elaprase through a donation did not, in the Court's view, relieve Medihelp of the obligations imposed by the existing court order.
3. **The asserted contractual right remained relevant despite donated treatment:** The Court held that the relevant prejudice was not confined to the question of whether the child continued to receive the medicine. The contractual entitlement underlying the interim relief remained material even while donors were supplying the medicine. This supported the continuation of interim protection pending the final determination of the statutory dispute.
4. **The order covered medically necessary treatment beyond Elaprase:** It was common cause that MPS II was a PMB condition. The child's medical management involved specialist consultations and allied health services, and Regulation 8 requires schemes to pay in full for the diagnosis, treatment and care costs of PMBs.
5. **Contempt of court:** The Court found that Medihelp had deliberately chosen not to comply with the interim order. It accordingly declared Medihelp to be in contempt, ordered compliance with the interim order, and authorised the applicants to seek further relief if non-compliance persisted.

Implications for Medical Schemes

- The judgment does not finally determine whether Elaprase is PMB level care. This issue remains before the CMS Appeal Board and a date for the hearing is awaited.
- Its immediate importance for medical schemes is that an extant court order must be implemented in accordance with its terms unless and until it is varied, discharged, or set aside. A pending statutory appeal, disagreement with the underlying merits, or the availability of third-party funding does not, on the reasoning of this judgment, permit a scheme to disregard the order. Where the scope or continued operation of an order is in dispute, schemes should seek expert legal advice.

03. Lawfulness of Section 59(3) Clawbacks

SAPS[1] Commercial Affairs (Pty) Ltd v Minister of Health and Others (Case No. 49159/2021) (17 June 2026)

Section 59(3)

Section 59(3) of the Medical Schemes Act permits a medical scheme to deduct from future benefits payable to a member or healthcare provider -

- amounts paid in good faith to which the recipient was not entitled, or
- losses sustained through theft, fraud, negligence or other misconduct.

Background

The applicant (a company representing the interests of physiotherapists) challenged the constitutional validity of section 59(3) in the High Court. They argued that it permits medical schemes to recover alleged overpayments or losses by unilateral deductions from future payments, thereby infringing the constitutional rights to just administrative action and access to courts (sections 33 and 34 of the Constitution).

Judgement

The High Court dismissed the application and declined to declare section 59(3) unconstitutional.

Key Findings

The Court held that -

1. Section 59(3) must be interpreted as part of section 59 and within the broader framework of the Medical Schemes Act (MSA), rather than as an isolated provision. The operation of section 59(3) is dependent upon compliance, at least, with sections 59(1) and 59(2).
2. The Regulations to the MSA are intended to provide the procedural mechanisms necessary for the implementation of the Act. If Regulation 6 does not adequately provide for dispute resolution regarding erroneous or unacceptable accounts, the appropriate remedy would be an amendment to the Regulation rather than invalidating section 59(3).
3. The MSA provides a statutory remedy for disputes through the appeal mechanism under section 48. The existence of that statutory remedy was a significant reason why the Court concluded that section 59(3) does not infringe sections 33 or 34 of the Constitution.
4. Complaints concerning billing codes, claims processing and the manner in which administrators manage disputes were not before the Court and therefore not assessed.

Appeal

The applicant has been granted leave to appeal the judgment.

[1] The applicant's name should be "SASP Commercial Affairs" and not "SAPS Commercial Affairs" as recorded in the case citation.

Considerations for Medical Schemes

Pending the outcome of any appeal

- Medical schemes remain entitled to rely on section 59(3).
- Any recovery process should operate within the statutory framework contemplated by section 59 as a whole and the applicable Regulations.
- Schemes should review their recovery, investigation, notification and dispute resolution procedures to ensure that they are consistent with the statutory framework. These procedures must be procedurally and substantively fair.

04. Refusal of Clinical Information for Claims Verification Triggers Section 59(3)

Medscheme Holdings (Pty) Ltd v Dr Tlou Mosime
(Case number 77485) (Heard on 3 March 2026)

Background

Medscheme identified irregularities in claims submitted by a general practitioner, including duplicate claims and an unusually high claiming rate compared with peers. It conducted a desktop audit and requested specified patient records to verify services claimed. As a result of the preliminary findings, it was necessary to conduct a retrospective analysis of claims. Despite repeated requests, the practitioner did not provide the records. Medscheme consequently withheld payments under section 59(3) of the Medical Schemes Act (MSA). The CMS Appeals Committee found Medscheme's invocation of section 59(3) unlawful. Medscheme appealed to the Appeal Board.

CMS Appeal Board

The Appeal Board considered

- Whether a scheme or its administrator may require a healthcare provider to produce clinical records to verify claims, and
- Whether section 59(3) may be invoked where the provider refuses to cooperate.

The Appeal Board upheld Medscheme's appeal. It set aside the Appeal Committee's ruling and confirmed the Registrar's ruling. As such, it confirmed Medscheme's entitlement to obtain the verifying information and to invoke section 59(3) following the practitioner's refusal to cooperate.

The Appeal Board made, among others, the following findings:

Access to clinical information

- Medical schemes may request clinical information under the MSA and the Protection of Personal Information Act (POPIA) to verify claims, determine benefit entitlements, detect fraud, waste and abuse, and conduct managed care reviews.
- The right to request clinical information is not unrestricted. Requests must be lawful, i.e.,
  - appropriate consent must be in place,
  - the information must be specific, relevant and proportionate to the purpose for which it is sought, and
  - the information must be securely processed, used only for the stated purpose and not disclosed to third parties without lawful grounds.
- Healthcare providers are generally obliged to cooperate with reasonable requests, provided valid consent exists, the requests are specific and relevant and do not violate the HPCSA's legislation and ethical guidelines on confidentiality.
- Medscheme's request was found to be specific, relevant and reasonable, and that the patients provided valid general consent authorising the release of relevant clinical information to their schemes. The practitioner's argument that patient confidentiality justified refusing to provide the requested information was rejected. She submitted confidential patient information to the scheme with her claims, triggering a request for further information. Hence, verifying information cannot be properly termed 'confidential patient records'.
- Reliance was also placed on Regulation 15J(2)(c), providing that a scheme is entitled, subject to the prescribed confidentiality requirements, to access treatment records and information concerning a beneficiary's diagnosis, treatment and health status in the contemplated circumstances.

Application of section 59(3)

- There is a distinction between claiming irregularities and established fraud or misconduct. An irregularity may be an anomaly or discrepancy with an innocent explanation. However, where a provider refuses to supply the records necessary to explain the irregularity and verify the claim, the Appeal Board may draw an adverse inference.
- The verification process serves the interests of medical scheme members. The refusal to provide records required to verify the clinical, financial and administrative validity of claims is a strong indication that the records may not exist or may not substantiate the claims.
- The practitioner's refusal to provide the clinical information prevented Medscheme from verifying whether she was entitled to the amounts claimed. The refusal was regarded as unreasonable and sufficient to permit Medscheme to invoke section 59(3) and recover amounts by deducting them from benefits payable to the provider.

Implications for Medical Schemes

- The decision strengthens the ability of medical schemes to conduct legitimate and appropriately targeted claims-verification processes. It confirms that healthcare providers cannot rely on patient confidentiality as a blanket basis for refusing to provide relevant clinical information when the scheme is lawfully entitled to obtain it.
- The decision should be applied within its factual context. It does not establish that every irregularity in a claim or failure to provide information automatically triggers section 59(3).
- Schemes should ensure that their verification processes are properly documented, requests for information are lawful, specific and proportionate, providers are given a reasonable opportunity to respond, and the facts and circumstances of the particular case support any decision to invoke section 59(3).

05. Schemes' Procurement Decisions Not Reviewable under PAJA

Famous Idea Trading 4 (Pty) Ltd t/a Dely Road Courier Pharmacy v Government Employees Medical Scheme and Others [2026] ZACC 5

Background

GEMS invited tenders for the appointment of service providers to provide courier pharmacy services. Famous Idea Trading 4 (Pty) Ltd, trading as Dely Road Courier Pharmacy (Famous Idea), submitted a tender. Famous Idea's tender was unsuccessful. It subsequently instituted proceedings in the High Court to review GEMS' decision to reject its bid and appoint another supplier. Famous Idea based its application on the grounds in the Promotion of Administrative Justice Act (PAJA), the principle of legality, and the common law. GEMS disputed the decision's reviewability, arguing that it did not exercise public power or perform a public function when it made the procurement decision. As such, the decision did not constitute administrative action reviewable under PAJA. The High Court held that the procurement decision was, in substance, a commercial decision concerning the medical scheme's procurement of services and dismissed the review application. Famous Idea appealed to the Constitutional Court.

Relevant PAJA Provision

The definition of "administrative action" in PAJA was central to determining whether GEMS' procurement decision was susceptible to administrative law review. PAJA defines "administrative action", insofar as relevant, as a decision taken, or failure to take a decision, by:

- an organ of state when exercising a power in terms of the Constitution or a provincial constitution, or exercising a public power or performing a public function in terms of legislation, or
- a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision, where the decision adversely affects the rights of any person and has a direct, external legal effect.

The critical question was therefore whether, when making the procurement decision, GEMS was exercising public power or performing a public function.

Constitutional Court Judgement

The Constitutional Court dismissed the appeal and held that the procurement decision did not constitute administrative action for purposes of PAJA.

Key Findings of the Court

1. **Status and nature of GEMS:** The Court considered the nature, powers and functions of GEMS in determining whether its procurement decision involved the exercise of public power. It held that GEMS is not an organ of state and that the business of a medical scheme does not, by its nature, entail the exercise of public power or performance of a public function. In reaching its conclusion, it considered, among others, that GEMS is a restricted medical scheme whose membership is not compulsory. A board of trustees governs GEMS, and although the Minister appoints 50% of its trustees, this does not mean that government controls GEMS. The trustees may amend the scheme rules without the Minister's involvement. Although the government contributes financially to GEMS membership in its capacity as employer, state funding is not, in itself, determinative of whether an entity or its functions are public in character.
2. **The procurement decision was commercial in nature:** GEMS did not exercise public power or perform a public function when it procured courier pharmacy services for its members' benefit. The procurement decision was commercial in nature.

3. **Private-law scrutiny remains possible:** Famous Idea had not pleaded that the tender conditions created a contract between it and GEMS. It could therefore not rely upon a contractual duty of fairness arising from the tender process. The Court nevertheless accepted, as a matter of principle, that tender conditions may, depending upon their terms, create contractual obligations between a private procurer and a tenderer. Where such a contract exists, it may carry an implied duty requiring a decision-maker to act honestly and in good faith and not arbitrarily, capriciously or unreasonably. Whether such obligations arise will depend upon the proper interpretation of the particular tender documentation and upon the contractual case being properly pleaded and proved.

Implications for Medical Schemes

- The judgment confirms that commercial decisions do not become exercises of public power merely because schemes operate within a statutory regulatory framework. Hence, a commercial procurement decision by a scheme does not necessarily amount to administrative action. The Court's conclusion followed from the nature of GEMS and the particular procurement function under consideration.
- Tender conditions may create contractual obligations that could be scrutinised judicially. Tender documentation should therefore be carefully drafted.
- Schemes embarking on a tender process should formulate and apply clear tender requirements and evaluation criteria. They should also ensure that procurement decisions are consistent with any contractual obligations arising from the tender process. Additionally, schemes should retain appropriate records, including the criteria applied, evaluations undertaken and decisions reached.

06. Undesirable Business Practice: Designated Service Providers and Co-Payments

The dispute raised by the Independent Community Pharmacy Association (ICPA) has a long history dating back to 2013. It has also involved the Minister and the Department of Health along the way.

Independent Community Pharmacy Association (ICPA) v Registrar of Medical Schemes & Council for Medical Schemes (CMS) (Appeal Board Decision dated 6 June 2016)

ICPA appealed the decision of the Registrar of Medical Schemes, acting with the concurrence of the CMS, not to initiate a process under section 61 of the Medical Schemes Act, to the CMS Appeal Board. The section 61 process was aimed at determining whether certain practices relating to the selection of Designated Service Providers (DSPs) and the imposition of 'penalty' co-payments should be declared undesirable business practices. The key issue that the Appeal Board had to decide was whether this refusal was lawful.

Appeal Board Ruling

The Appeal Board set the decision aside and ordered the Registrar to commence the section 61 process.

The Appeal Board held that -

- ICPA had established at least a prima facie case warranting investigation under section 61,
- the Registrar was obliged to exercise the statutory discretion properly when deciding whether to initiate the process, and
- the reasons advanced for refusing to commence the process for determining whether a declaration of undesirable business practice should be made were inadequate and, in certain respects, misunderstood the issues raised by ICPA.

Declaration of Undesirable Business Practices (23 April 2021)

Following the Appeal Board judgment, the section 61 process was completed, and certain practices were declared undesirable in the Government Gazette on 23 April 2021 (Notice 214) ("the Declaration").

The Declaration identifies the following as undesirable business practices -

- A medical scheme selecting DSPs for the provision of diagnosis, treatment and care relating to one or more prescribed minimum benefit (PMB) conditions without a procurement process that is fair, equitable, transparent, competitive and cost-effective, and
- For a medical scheme to impose co-payments that exceed the quantum of the difference between the charges of its DSPs and non-DSPs, including any other co-payments that are unfair to members or cannot be numerically justified.

The Declaration states that the CMS would publish guidelines on DSP selection and co-payments within 180 days of the Declaration's publication.

Guidelines in Support of the Declaration

The CMS published Circular 31 of 2021 in support of this Declaration, stating that -

- the wording of the Gazette is general in application,
- specific guidelines aimed at identifying instances of specific undesirable conduct would be developed following consultation with stakeholders, and
- implementation guidance would follow once that consultation process had been completed, with an anticipated target date before September 2021.

These guidelines have not been published to date.

HFA Engagement

HFA challenged the Declaration at the Appeal Board on behalf of its members, based on concerns about the Declaration's potential impact on scheme benefit design and affordability. The Appeal Board did not consider the merits of the case but upheld a preliminary jurisdictional point raised by the Registrar and the CMS that the Appeal Board lacked authority to hear HFA's appeal.

HFA continues to engage with the Department of Health, the CMS and ICPA to seek a constructive and practical resolution, while ensuring that medical schemes members remain protected. The CMS has recently advised that it is developing DSP guidelines.

Implications for Medical Schemes

- Although not enforced to date, the Declaration remains effective and enforceable. It effectively means that medical schemes found to be conducting unfair selection practices when selecting DSPs and charging excessive co-payments will be engaging in undesirable business practices. However, the absence of guidelines for the effective implementation of the Declaration creates uncertainty.
- Pending the publication of guidelines by the CMS or the constructive resolution of this matter, medical schemes should consider the following in their DSP selection processes and co-payment decisions:
  - DSP selection processes should be formally documented and objectively defensible,
  - Procurement criteria should be objective, transparent and consistently applied,
  - Co-payment methodologies should be evidence-based, proportionate and capable of numerical justification, and
  - Records should be maintained demonstrating procedural and substantive fairness.

07. Medical Scheme Recoveries from the Road Accident Fund

RAF Directives

First Directive (August 2022): The RAF instructed its regional managers to reject claims for past medical expenses when a claimant's medical scheme had already paid them based on the premise the claimant had suffered no recoverable loss.

Second Directive (13 April 2023): The RAF instructed officials to reject claims relating to Prescribed Minimum Benefits (PMBs) and Emergency Medical Conditions (EMCs).

Third Directive (2 November 2023): The RAF instructed officials to reject medical scheme reimbursement claims based on section 19 of the RAF Act.

Discovery Health (Pty) Ltd challenged the First Directive on an urgent basis to address the impact on medical scheme members. The litigation that followed has resulted in a series of judgments concerning the RAF's liability for medical expenses paid by medical schemes and the lawfulness of the RAF's internal directives.

Mbongwe Judgement (High Court – 27 October 2022)

Discovery Health (Pty) Ltd v Road Accident Fund and Another [2022] ZAGPPHC 768

- The High Court declared the RAF's First Directive unlawful for the following reasons:
  - the RAF had acted outside its powers,
  - the Directive was arbitrary and unlawful, and
  - payments received by a claimant from a private insurer or a medical scheme constitute a collateral benefit and do not reduce the RAF's liability to compensate the claimant.
- Accordingly, the RAF remains liable for the claimant's recoverable damages notwithstanding that the claimant's medical scheme initially paid the relevant medical expenses.
- The RAF unsuccessfully sought to challenge the Mbongwe judgment. Its applications for leave to appeal were dismissed, culminating in the Constitutional Court's refusal of leave to appeal in November 2023.

Following the Mbongwe judgment, the RAF issued the Second and Third Directives. Discovery Health approached the court for a declaratory order that these Directives contravened the Mbongwe judgement.

Mlambo Judgement (High Court – 17 December 2024)

Discovery Health (Pty) Ltd v Road Accident Fund and Another (2023/117206) [2024] ZAGPPHC 1303

- The majority judgment dismissed the application and held, among others, that:
  - medical schemes are not indemnity insurers but statutory, not-for-profit risk-pooling entities established under the Medical Schemes Act (MSA),
  - the principles on collateral benefits and subrogation do not automatically apply to schemes in the same manner as they apply to private insurers,
  - the MSA does not expressly confer a statutory right on medical schemes to recover PMB and EMC expenditure from the RAF, and
  - because the Second and Third Directives relied on different legal grounds, they were not determined by the Mbongwe judgment and therefore remained operative.
- The minority judgment concluded that the Second and Third Directives were an attempt to circumvent the earlier court order and that the RAF had failed to comply with its constitutional obligations.
- Discovery Health has appealed the Mlambo judgment to the Supreme Court of Appeal (SCA).

Courts Apply Established Legal Principles

The Courts continue to apply established principles governing recovery of medical expenses from the RAF. In February 2026, the Western Cape High Court (Road Accident Fund v Nicolaas Van Wyk (Case No. A186/2025) [2026] ZAWCHC (9 February 2026)) held that the RAF remains primarily liable for recoverable medical expenses notwithstanding prior payment by a medical scheme and the Directives rejecting such claims were unlawful and inconsistent with existing court orders.

SCOPA Enquiry

During 2025, Parliament's Standing Committee on Public Accounts (SCOPA) launched an inquiry into allegations of maladministration, financial mismanagement, wasteful and reckless expenditure, and related financial misconduct at the RAF. During the enquiry, HFA made a submission on behalf of its members. SCOPA has identified several governance failures at the RAF. The final enquiry report is pending.

Implications for Medical Schemes

- Pending Discovery Health's appeal, the legal issues determined in the Mlambo judgment have not yet been finally resolved and the Mbongwe judgment remains the binding authority in relation to the RAF's First Directive.
- The outcome of the appeal is expected to provide greater certainty regarding the recovery of medical expenses paid by medical schemes. Several schemes have reportedly received payments recently from the RAF.
- Where a scheme's rules require reimbursement after the member receives compensation from the RAF, those contractual arrangements remain enforceable between the scheme and its member.