DIAGNOSIS
2017/2018

Analysing the key trends in the medical schemes industry from 2000 to 2016

Alexander Forbes Health Technical and Actuarial Consulting Solutions

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INTRODUCTION

Alexander Forbes Health's Technical and Actuarial Consulting Solutions team is proud to present this year's *Diagnosis*.

This publication will give you a comprehensive view of the performance of the South African medical schemes industry as well as some of the changes and challenges facing the industry.

This analysis covers key statistics and trends over the 17-year period from 2000 to 2016, based largely on the consolidated financial results for all registered medical schemes, with specific focus on the 10 largest open and the 10 largest restricted medical schemes by principal membership.

The final demarcation regulations and the gazetted National Health Insurance White Paper have resulted in much debate in the medical schemes industry in 2017. The expected consolidation process of both schemes and benefit options in 2018 has resulted in some uncertainty for many schemes. If you would like to discuss any of the issues addressed in more detail, please speak to your Alexander Forbes Health consultant or contact one of the specialists listed at the end of this publication.

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KEY INDUSTRY DEVELOPMENTS

Industry consolidation

At the Board of Healthcare Funders conference in July 2017 the acting registrar of the Council for Medical Schemes (CMS) indicated in his presentation that the CMS would consider the consolidation of risk pools across smaller medical schemes in South Africa. According to the *Medical Schemes Act 131 of 1998* (as amended), the registration of a new medical scheme requires a minimum membership of 6 000 principal members per scheme and 2 000 principal members per scheme option.

The CMS has issued Circular 51 of 2017, clarifying its approach to consolidation and reiterating its commitment to improving financial protection for medical scheme members through effective risk pooling. This circular sets out the Council's approach to consolidation as a consultative process involving key stakeholders and focusing only on the 31 medical schemes that currently have fewer than 6 000 members. However, the review will also include schemes servicing local government and state-owned entities as well as civil servants at a national or provincial level.

A National Health Insurance (NHI) Implementation Committee on Consolidation has been established and tasked with restructuring the current healthcare financing arrangements in the lead-up to the creation of a central NHI fund. This is to be achieved through five transitional arrangements covering the following segments of the population:

- the unemployed
- the informal sector
- the formal sector comprising large businesses
- the formal sector comprising small and medium-sized businesses
- the public sector

The unemployed and the informal sector will be covered through the creation of new funding arrangements. The formal sectors would see the consolidation of existing medical schemes into one fund with mandatory coverage in which PMBs will be replaced with a more comprehensive benefit package. The public sector would see similar funding changes to the formal sector along with changes to current government healthcare subsidies.

INDUSTRY TIMELINE

1998

- The ***Medical Schemes Act*** is signed into law. It introduces prescribed minimum benefits (PMBs), community-rated contributions and open enrolment.

2000

- The ***Medical Schemes Act*** comes into effect and the Council for Medical Schemes (CMS) is established.

2003

- The ***National Health Act*** gives a framework for a structured and uniform health system.
- Personal medical savings accounts are limited to 25% of gross contributions.

2004

- A Competition Commission ruling bans the system of collective tariff setting between schemes and healthcare providers.
- Single exit price (SEP) is implemented for pharmaceutical manufacturers.
- The National Health Reference Price List (NHRPL) is first published by the Department of Health.
- Medical schemes must maintain a 25% solvency level.

2005

- The Government Employees Medical Scheme (GEMS) is registered.
- The ***Children's Act*** stipulates the age of consent for minors to medical and surgical treatment.

2006

- The Council for Medical Schemes takes over publication of the National Health Reference Price List, a guideline for healthcare service tariffs.

2008

- The **Medical Schemes Amendment Bill** is proposed, providing for the risk equalisation fund, low-income benefit options, improved governance, and an amendment of the definition of the business of a medical scheme.
- The Health Professions Council of South Africa scraps ethical tariffs, used by providers as a ceiling for patient accounts.

2009

- The ***Competition Amendment Act*** is signed into law, providing a legal framework and giving formal powers to the Competition Commission to conduct market enquiries.
- The **Protection of Personal Information Bill** is published to protect personal information processed by public and private bodies, including medical schemes and industry stakeholders.

2010

- Dispensing fee regulation is introduced for pharmacists and licensed health professionals.
- The High Court rules the National Health Reference Price List invalid and sets it aside.
- The High Court dismisses the Board of Healthcare Funders' court application to seek clarity on the meaning of Regulation 8(1).
- The Council for Medical Schemes publishes the prescribed minimum benefits code of conduct to ensure compliance with Regulation 8(1) – 'pay in full'.

2011

- The ***Consumer Protection Act*** comes into effect, supporting a culture of consumer rights and responsibilities.
- The Green Paper on the National Health Insurance Policy is published.

2017

- The revised National Health Insurance (NHI) White Paper is gazetted on 30 June 2017. This version does not provide updated estimates of the NHI costs, but identifies additional potential sources of funding, including the removal of medical aid tax credits as well as the public sector medical aid subsidies.
- The findings and recommendations of the Competition Commission's Health Market Inquiry are delayed to 30 November 2017.
- The Constitutional Court overturns the Supreme Court's ruling that required schemes to hold medical savings account assets separately from the rest of the scheme's assets. This means that:
  - medical savings account assets will now form part of the scheme's assets
  - assets can be invested in investment classes other than cash
  - interest on medical savings account assets can accrue to the scheme
- An NHI Implementation Committee on Consolidation is established to oversee the restructuring of the industry before the full implementation of NHI. This process includes:
  - consolidating those schemes with fewer than 6 000 members into larger schemes
  - merging public sector schemes
  - reducing the number of benefit options offered by the remaining schemes

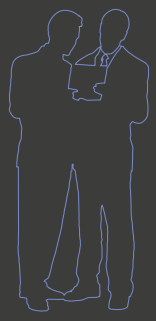
2016

- The Competition Commission Inquiry into Private Healthcare is delayed, with the draft report not being published by August 2016 as proposed in the revised timelines.
- The Council for Medical Schemes releases a proposed risk-based solvency framework to replace the controversial 25% statutory minimum that has been in place since the introduction of the ***Medical Schemes Act***.
- Final demarcation guidelines are published in a joint statement by the Department of Health and National Treasury. These guidelines allow hospital cash plans and gap cover to continue, but prohibit primary healthcare insurance products which will fall under the CMS and require exemption from the ***Medical Schemes Act***.

2015

- The Competition Commission Inquiry into Private Healthcare continues, with medical schemes and administrators being requested to provide claims and tariff information for the last 17 years.
- The Minister of Health publishes a draft amendment to Regulation 8. Medical schemes are no longer required to pay for prescribed minimum benefits at cost, but rather at either a contracted rate or the 2006 guideline tariff plus inflation.
- The Council for Medical Schemes approves the framework for exemption and allows low-cost benefit options to be introduced from 1 January 2016. The framework is then withdrawn soon afterwards.
- The National Health Insurance White Paper is published on 10 December 2015. It proposes a single payer system with no option to opt out and medical schemes being limited to offer complementary cover.

> "2014 – the Financial Services Board introduces **Treating Customers Fairly** (TCF)"



2014

- The 12-member board of the newly established Office of Health Standards Compliance is named.
- The Competition Commission Inquiry into Private Healthcare begins.
- The **Draft Road Accident Fund Benefit Bill** provides for a no-fault benefit scheme and a new administrator to replace the Road Accident Fund.
- The Financial Services Board introduces Treating Customers Fairly, a market conduct framework of regulatory reform.
- The National Department of Health publishes a National Health Insurance booklet.

> "2013 – the ***Protection of Personal Information Act*** came into law"

2012

- The ***Taxation Laws Amendment Act*** provides for a new medical tax credit system to replace medical tax deductions. The definition of a dependant is widened in the ***Income Tax Act*** to be the same as that in the ***Medical Schemes Act***.
- Draft demarcation regulations propose the removal of most gap cover products and hospital cash plans.

2013

- The ***Financial Services Laws General Amendment Act*** amends the ***Medical Schemes Act*** by widening the definition of the business of a medical scheme.
- Schemes must hold members' medical savings account (MSA) contributions separate from scheme reserves and allow interest to accrue to positive MSA balances.
- The ***National Health Amendment Act*** provides for the establishment of the Office of Health Standards Compliance (OHSC), a key building block of National Health Insurance.
- The Competition Commission Inquiry into Private Healthcare is announced.
- The ***Protection of Personal Information Act*** is signed into law.

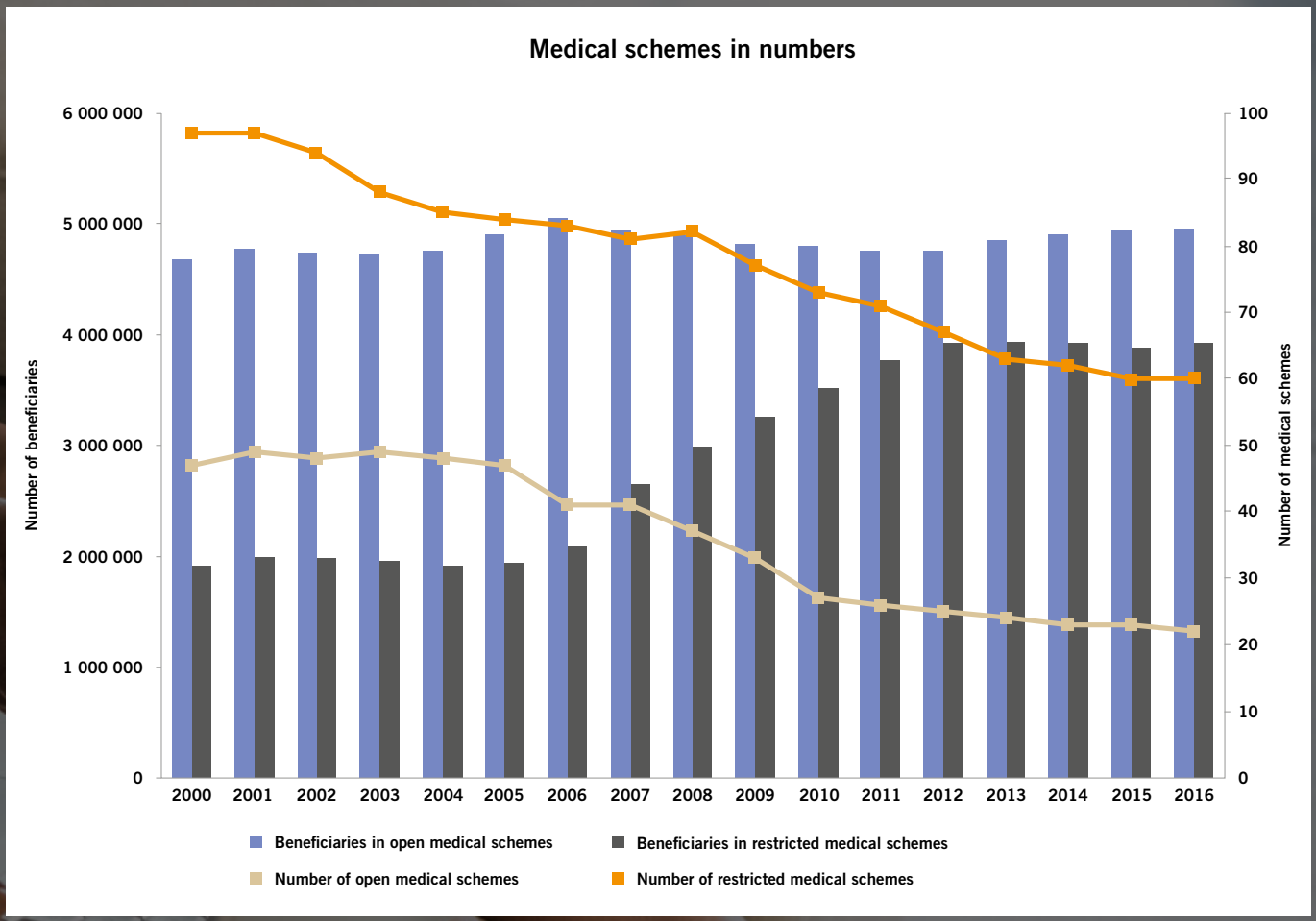
PERFORMANCE INDICATORS

This section analyses the key statistics influencing the performance of medical schemes.

When evaluating the performance of medical schemes, key factors to consider are as follows:

- **Size and scale:** Larger schemes tend to have more stable and more predictable claims experience. They should also have greater negotiating power when setting prices.
- **Membership growth:** Increasing membership reduces the volatility of a scheme's claims, and improves the profile, as new members tend to claim less than the average member in their first year of membership.
- **Membership profile:** Claims experience will be more favourable for younger populations with lower chronic prevalence.
- **Financial results:** The trend in a scheme's financial results illustrates the adequacy of their pricing.
- **Solvency levels:** Although the current statutory solvency level of 25% of gross contribution income may be inappropriate, each scheme should have sufficient reserves after considering each of the previous factors.

2.1 Size and scale



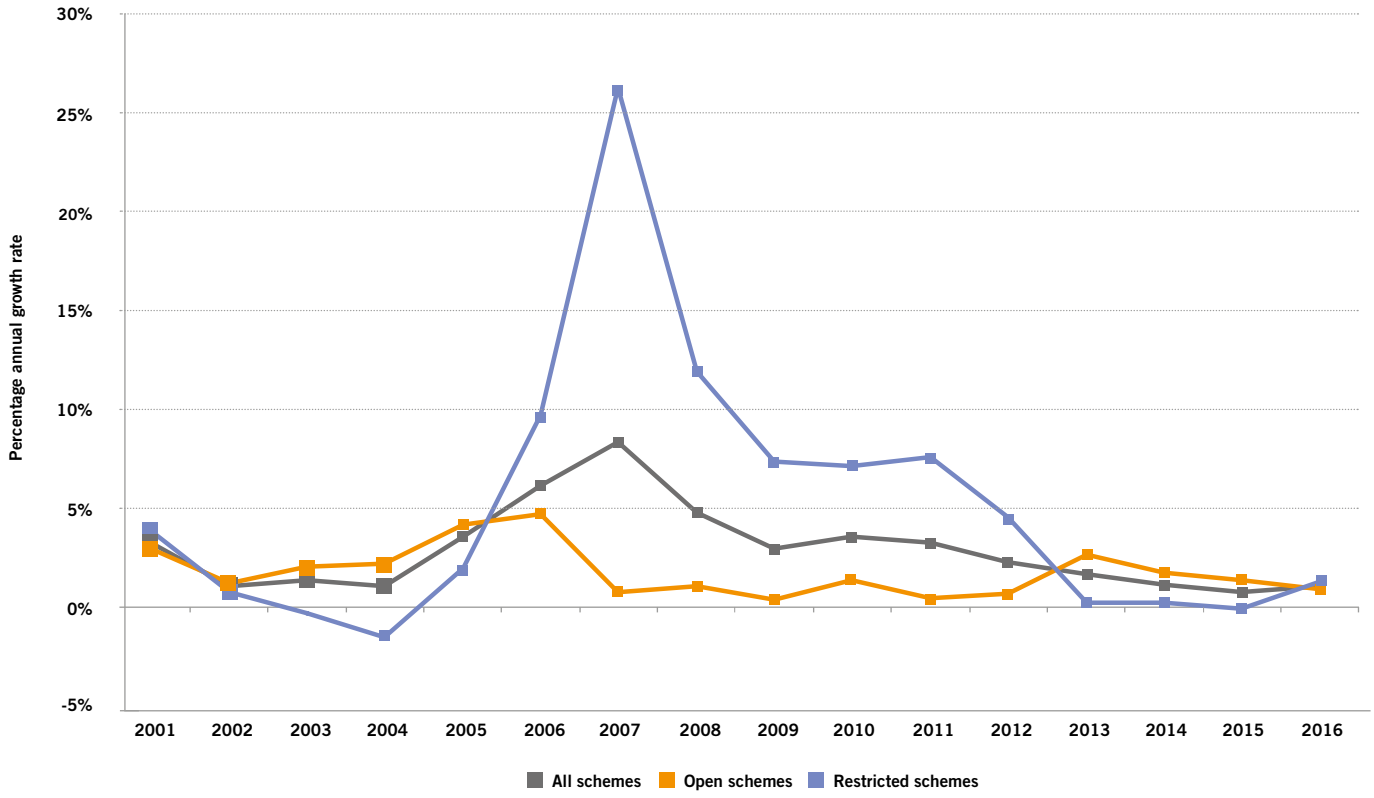
At the end of 2016 there were 82 registered medical schemes in South Africa, reducing from 83 schemes at the end of 2015 because LMS Medical Fund (previously Liberty Medical Scheme) amalgamated with Bonitas Medical Fund with effect from 1 October 2016. From the end of 2000 to the end of 2016 the number of medical schemes in existence reduced from 144 to 82, which represents a 43% decrease in the number of registered medical schemes over 16 years, mainly as a result of amalgamations among the smaller, less sustainable schemes. The number of open medical schemes has decreased by 25 (53%) compared to a decrease of 37 (38%) restricted medical schemes over the 16-year period. This consolidation appears to be driven mainly by the difficulty in maintaining the financial sustainability of small schemes in the current environment and particularly for restricted medical schemes, by the significant amount of management time needed to manage an employer-based restricted scheme.

Momentum Health and Metropolitan Medical Scheme amalgamated with effect from 1 July 2017, while Discovery Health Medical Scheme and the University of Witwatersrand Staff Medical Aid Fund are expected to merge on 1 January 2018. The Community Medical Aid Scheme (COMMED) was liquidated in 2017, with Bonitas Medical Fund agreeing to take on the existing COMMED members with no underwriting.

Despite the observed decrease in the number of medical schemes, the industry has grown by 1.45 million principal members (57.0%) and 2.29 million beneficiaries (34.7%) since 2000. The 82 medical schemes operating in South Africa at the end of 2016 served a total of 3.99 million principal members and 8.88 million beneficiaries. The number of principal members covered on medical schemes increased by 1.0% in 2016, while the total number of beneficiaries under cover increased by 0.8%, with greater growth in beneficiaries being observed on restricted medical schemes. A total of 58.8% of principal members participated in open medical schemes at the end of 2016 with the balance of 41.2% participating in restricted medical schemes. This compares to 58.9% and 41.1% respectively at the end of 2015.

The graph below shows the percentage change in medical scheme membership over the last 16 years.

Annual percentage growth in membership



There is a significant difference between the trends in the annual growth rate of open and restricted medical schemes, with the divergence in the trend beginning in 2006 with the registration of the first members on GEMS. Following the significant increase in restricted scheme membership attributable to GEMS in 2006 and 2007, the annual growth in restricted schemes reduced each year, with very little growth being observed in the restricted schemes from 2013 to 2015. In 2016 principal membership of open medical schemes grew by 0.9% while membership of restricted schemes grew by 1.3%, with net growth of 41 175 members across the industry during the year.

The minimum membership requirement set by the Council for Medical Schemes for registering a new medical scheme is 6 000 principal members. At the end of 2016 there were three open medical schemes and 28 restricted schemes with fewer than 6 000 principal members. The open schemes with membership below this threshold are Cape Medical Plan (5 463 principal members), Makoti Medical Scheme (2 427 principal members) and Suremed (1 364 principal members).

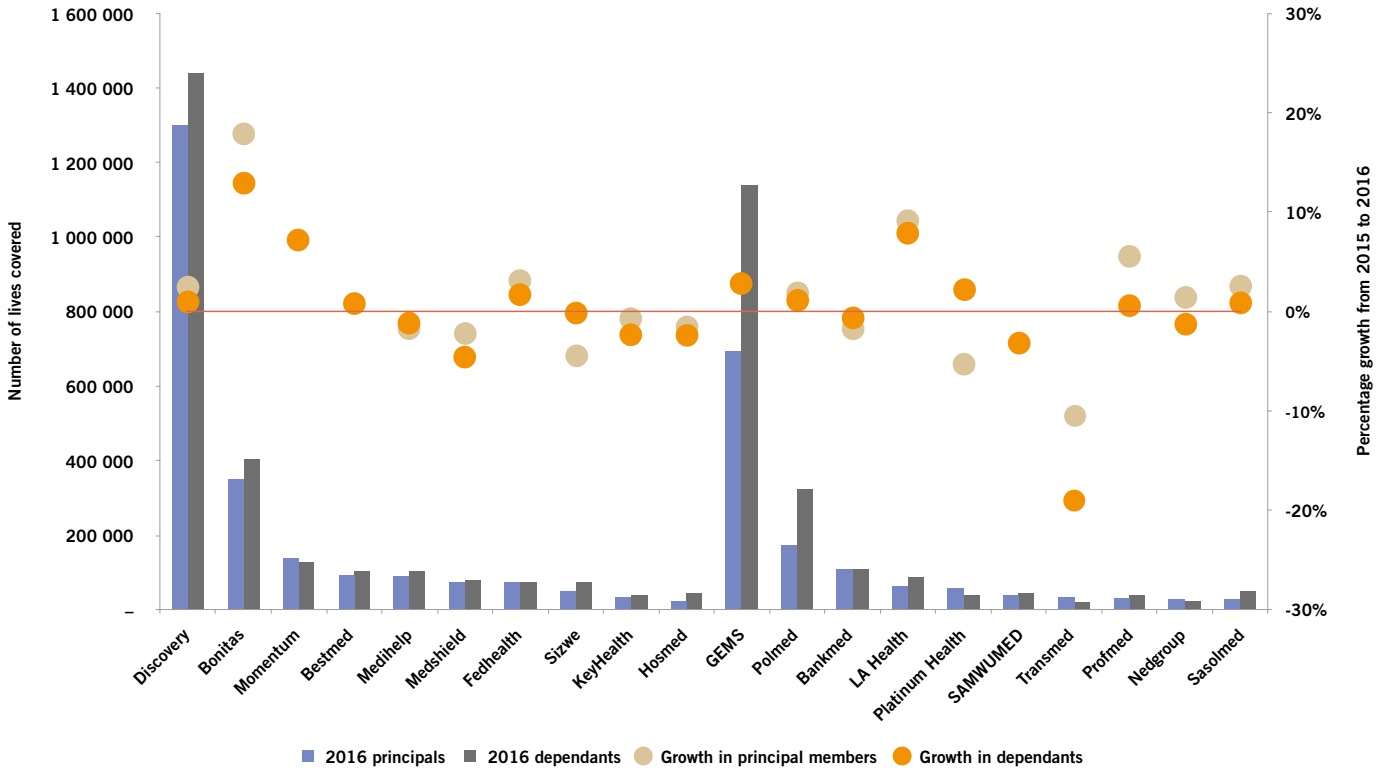
A large membership base allows for lower claims volatility and helps schemes, or their administrators, negotiate more competitive reimbursement rates and fees with the various healthcare service providers. This ensures that medical scheme members have lower shortfalls or copayments when using these designated service providers.

A small membership base generally results in a more variable claims experience which increases the risk of contributions not being set at an appropriate level to cover all claims and expenses. This variability is compounded further by the negative impact of high cost claims, especially in the current environment where schemes are required to pay in full for the cost of prescribed minimum benefits, regardless of the rates charged.

Despite these risks, a fair number of restricted schemes are still performing well. Of the 31 schemes referred to earlier that have fewer than 6 000 members, only nine achieved a surplus before investment income in 2016, down from 16 in 2015, which indicates the severity of claims in 2016 as well as the volatility to which smaller schemes are exposed.

The graph below ranks the top 10 open schemes and top 10 restricted schemes according to the number of principal members at 31 December 2016. This represents 88.2% of all principal members participating on a registered medical scheme, or 95.7% and 77.4% of open and restricted medical scheme membership respectively.

Membership by medical scheme



Bonitas amalgamated with LMS Medical Fund in 2016, resulting in growth of 17.8% in the number of principal members during the year. As a result of that amalgamation, Hosmed Medical Aid Scheme is a new entrant to the top 10 open medical schemes in 2016 with 25 528 principal members. Topmed Medical Scheme and Resolution Health Medical Scheme are the 11th and 12th largest open schemes at 31 December 2016, with 22 355 and 17 956 principal members respectively.

The top 10 restricted medical schemes by principal membership have remained unchanged in 2016. However, LA Health Medical Scheme is now the fourth largest restricted scheme as a result of the 8.9% growth in principal members over the year, with Platinum Health down to fifth place because of a loss of 5.2% of its membership. Transmed continued to lose membership, with an 11.9% and 17.7% reduction in the number of principal members and dependants respectively during the year.

Umvuzo Health Medical Scheme and the Chartered Accountants (SA) Medical Aid Fund (CAMAF) are the 11th and 12th largest restricted schemes at 31 December 2016, with 26 319 and 24 957 principal members respectively.

Five of the open schemes and six of the restricted schemes considered here experienced positive growth in 2016, with the remaining nine experiencing a reduction in membership numbers.

The number of beneficiaries with medical scheme cover grew by 0.8% in 2016, after the net loss of lives observed in 2015. The number of principal members covered increased by 1.0%, which again resulted in the average family size in the industry reducing from 2.23 at 31 December 2015 to 2.22 at 31 December 2016, which may indicate financial pressures resulting in fewer dependants being added to cover. There is also a tendency in the market for members to only add beneficiaries to cover when they need medical attention. This anti-selective risk is greatest for those schemes with the fewest underwriting controls, as they are most vulnerable to these high claimers.

2.2 Market share

The industry's net growth of 68 558 principal members over the 2016 financial year was driven by the growth on Discovery Health Medical Scheme (Discovery) which experienced net growth of 29 589 principal members, as well as the Government Employees Medical Scheme (GEMS) which grew by 19 589 principal members.

Discovery's total market share based on the number of principal members has increased from 16% in 2001 to 33% at the end of 2016, compared to a decrease in market share for the rest of the open schemes from 54% in 2001 to 26% in 2016.

This decline in open medical scheme membership (excluding Discovery) is due to many members choosing to move from their current medical scheme to join Discovery Health and the movement of eligible public sector employees from the open scheme market to GEMS since its inception.

In 2016 GEMS's total market share was 17%, compared to 2% in 2006 when the first members joined. The rapid growth in membership includes eligible government employees transferring from other open schemes, the amalgamation with Medcor in 2010 and the transfer of a group of 16 000 pensioners from Medihelp to GEMS early in 2012. The increase in GEMS's market share in the past was assisted by continued new member growth, stimulated by an attractive employer subsidy. However, that employer subsidy was not increased for a number of years from 2011, which may have contributed to the slowdown in membership growth. The increase in the public sector subsidy with effect from 1 January 2016 is likely to have contributed towards the growth in lives covered on GEMS during the year. The total market share of the balance of the restricted schemes has decreased from 30% to 24%, driven by a number of amalgamations of restricted schemes into the open medical schemes environment.

2.3 Membership profile

One of the most important contributing factors to a scheme's performance is the risk profile of its members, with some of the key statistics being:

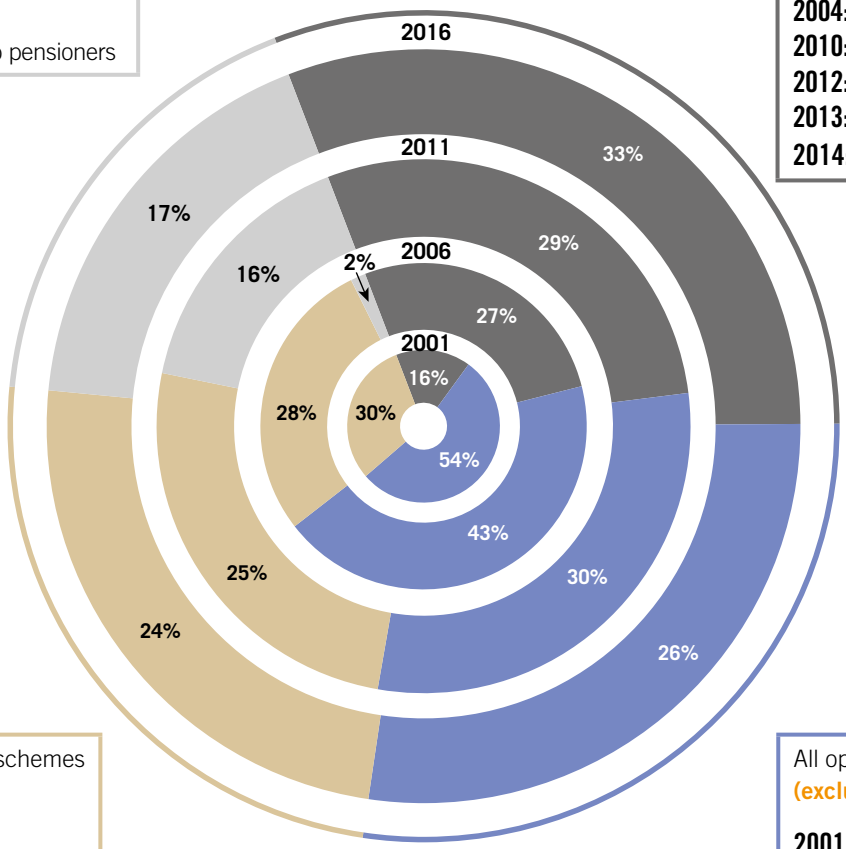
- average age of beneficiaries
- pensioner ratio (defined as the percentage of beneficiaries over the age of 65 years)
- average family size

This section considers the trends in each of the above factors.

Market share by principal membership

GEMS
2010: Medcor
2012: Pre-92 Medihelp pensioners

Discovery
2004: AngloGold
2010: Afrisam, Umed
2012: Edcon
2013: Nampak, IBM
2014: Altron, Afrox, PG Bison

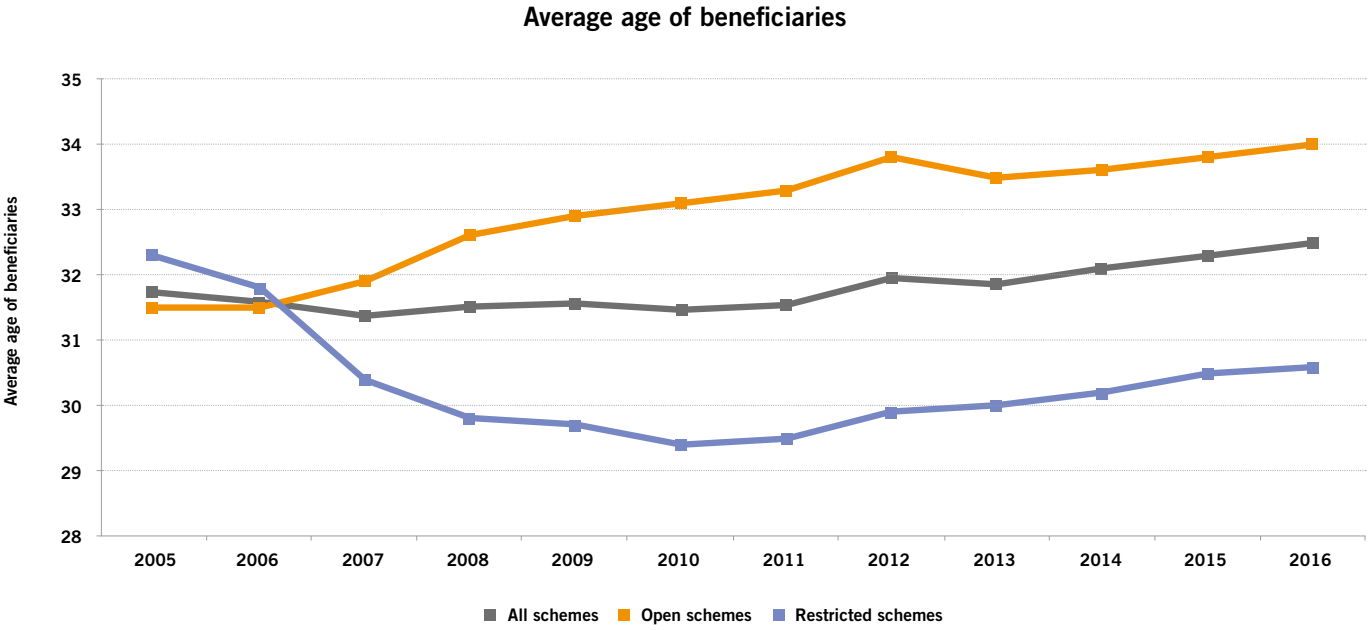


All restricted medical schemes **(excluding GEMS)**

2001 to 2016
Net reduction of 37 schemes

All open medical schemes **(excluding Discovery)**

2001 to 2016
Net reduction of 27 schemes

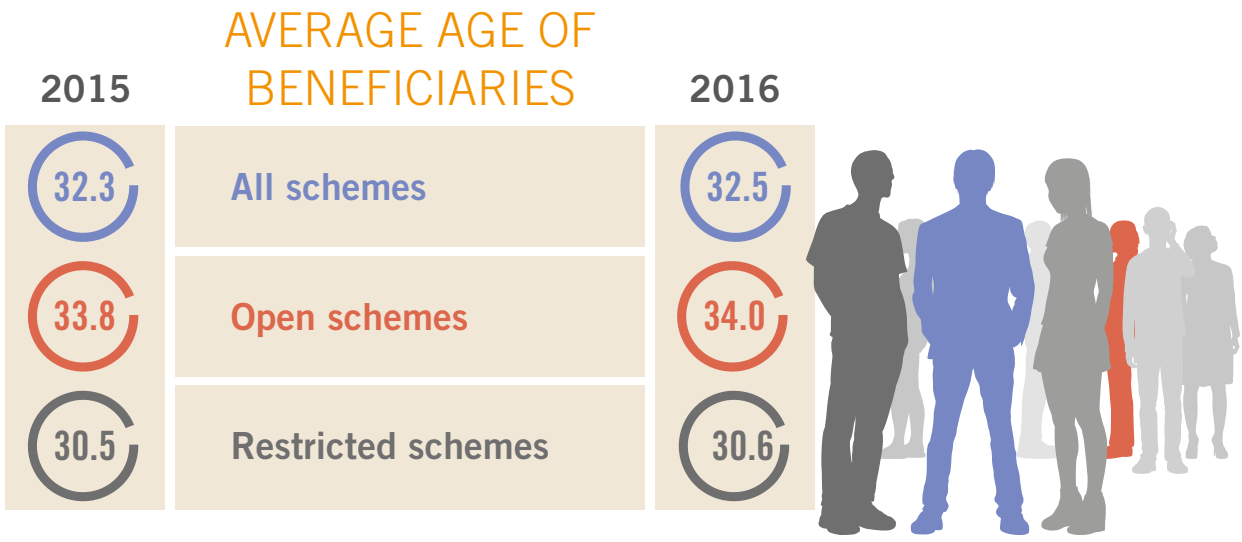


Note: Average age was recorded in the CMS Annual Reports from 2005 only.

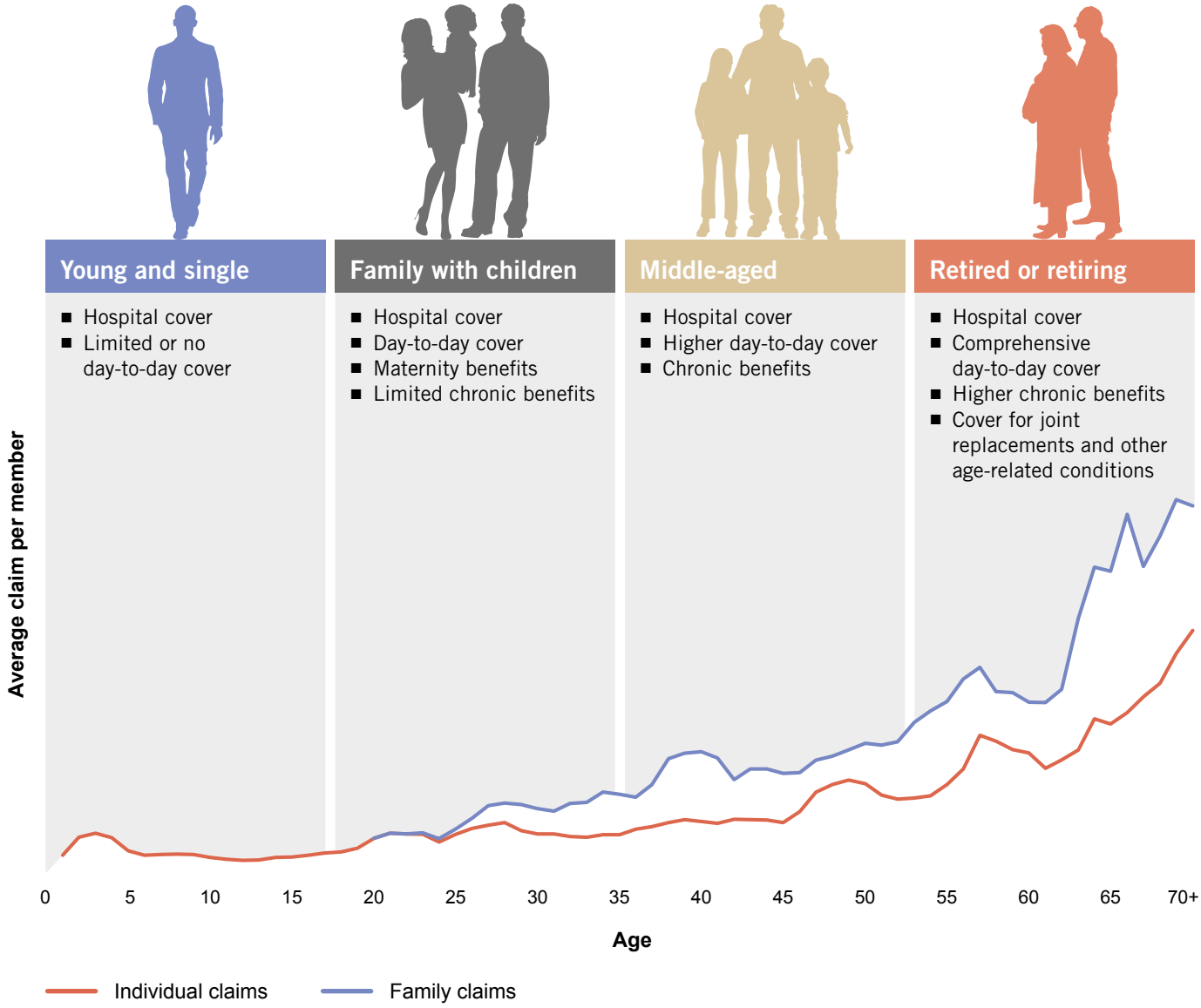
The average age of beneficiaries in the medical schemes industry has remained fairly constant since 2005, with a marginal increase from 32.3 years in 2015 to 32.5 years in 2016. The average age of both open and restricted schemes increased slightly in 2016, with a slightly bigger increase experienced by open schemes. The average age of beneficiaries on open schemes increased by 0.2 years to 34.0 years, while the average age on restricted schemes increased from 30.5 to 30.6 years at the end of 2016.

From 2006 to 2010 the average age of beneficiaries in the restricted scheme environment reduced consistently each year. This was due to the rapid growth of GEMS, with significant numbers of younger members joining the scheme during the early years. From 2011 the growth driven by GEMS slowed down, and this has resulted in the average age of restricted scheme beneficiaries increasing from that point.

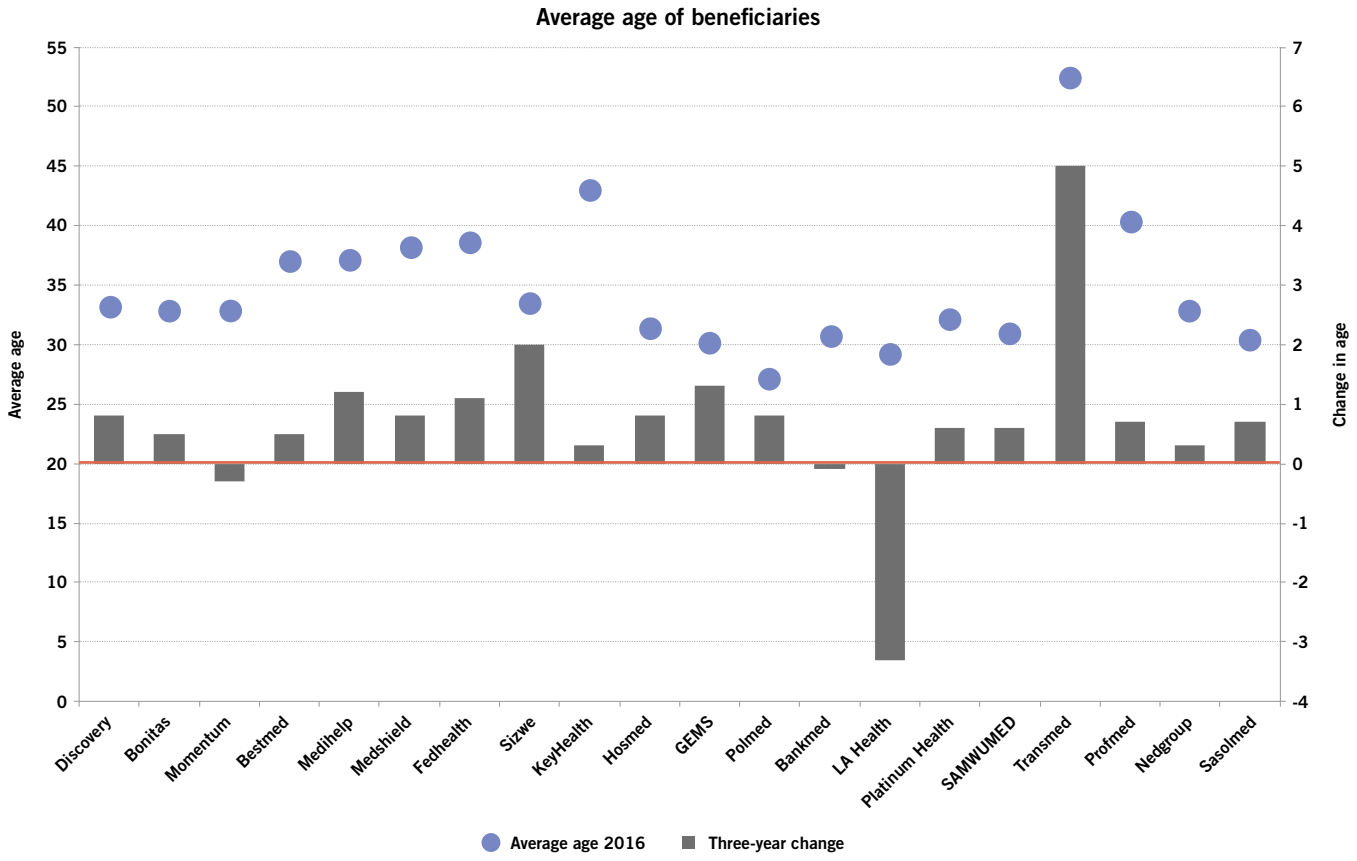
As a scheme ages, we expect the average claims per member to increase, with a generally accepted benchmark of a 2% increase in average claims per year increase in average age. A typical claims curve is shown on page 16.



A typical claims curve over a member's lifetime

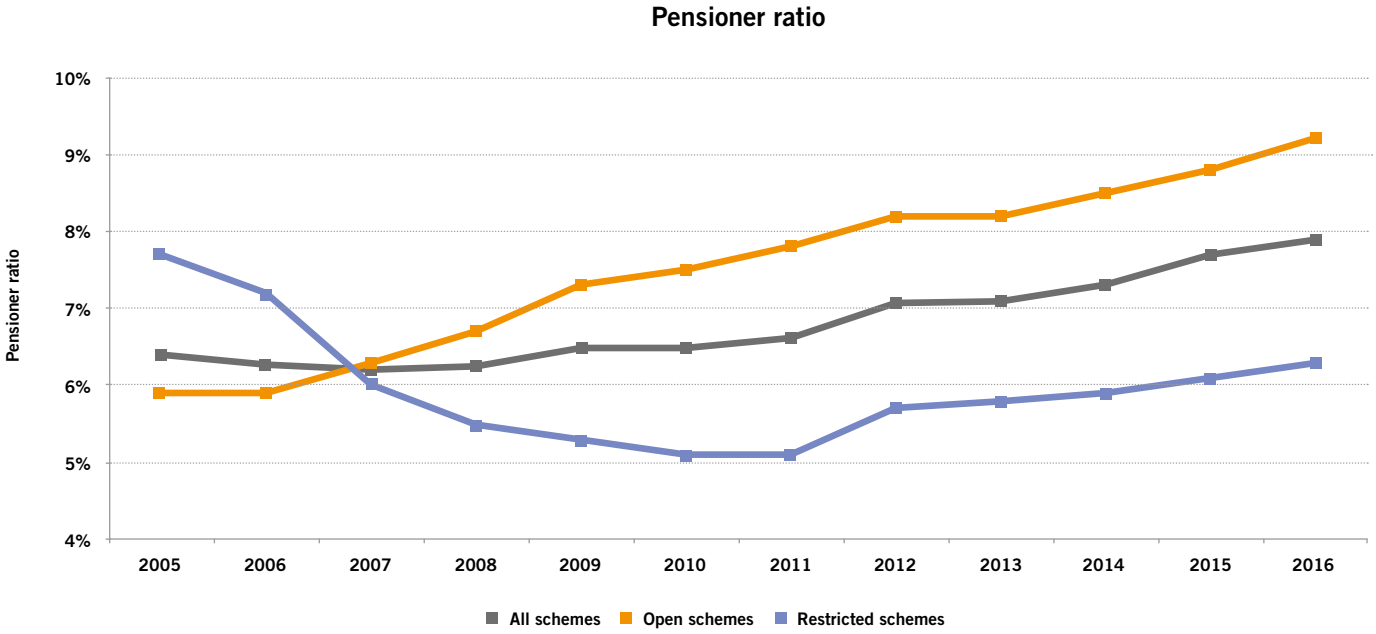


The following graph considers the average age of beneficiaries for each scheme included in this year's analysis. It also includes the change in the average age of each scheme from 31 December 2013 to 31 December 2016.



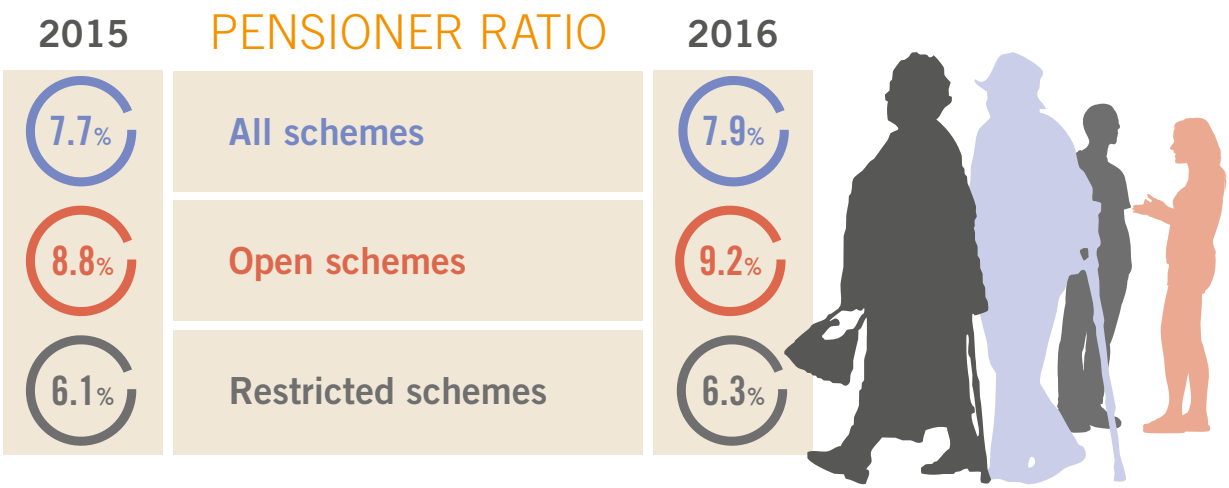
While the absolute age of a scheme's membership is important and indicative of the likely claims profile, the change in this figure serves as an indicator of a change in the profile that would result in the medical scheme needing to take corrective action in its pricing of benefits, especially if the age were to increase.

Of the 20 schemes included in this year's *Diagnosis*, KeyHealth has the highest average age of beneficiaries in the open schemes, whereas Transmed has the highest average age in the restricted schemes. In addition to a high average age, Transmed also has an extremely high pensioner ratio, in part because membership is voluntary. Transmed's average age has also increased significantly over the last three years as a result of the loss of a significant number of younger, healthier beneficiaries. LA Health's average age has reduced significantly over the last three years as a result of the high rate of growth from younger and healthier members. Momentum and Bankmed also experienced decreases in the average age of beneficiaries over the three-year period. As in previous years, Polmed has the lowest average age of all the schemes considered.

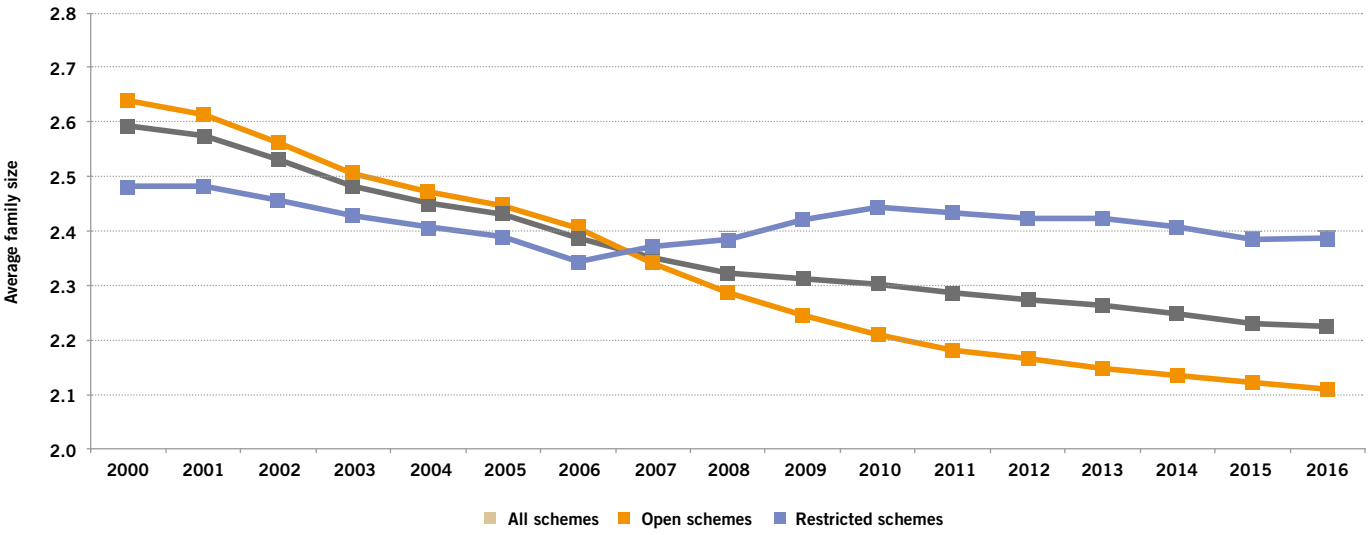


Note: Pensioner ratios were recorded in the CMS Annual Reports from 2005 only.

The average pensioner ratio across the industry increased from 7.7% to 7.9% in 2016. Open schemes have experienced a greater increase in the pensioner ratio than restricted schemes, with an increase from 8.8% to 9.2% from 2015 to 2016 compared to the increase from 6.1% to 6.3% on restricted schemes.



Average family size



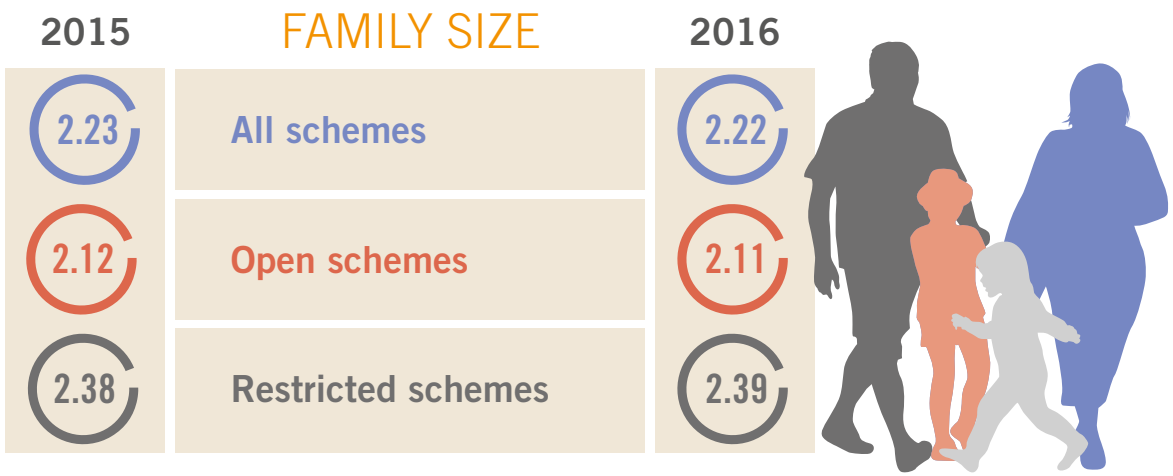
In 2016 the average family size for restricted medical schemes increased slightly from 2.38 to 2.39. This was driven by the growth in dependants covered on GEMS over the year.

However, the average family size for the entire medical schemes industry has declined over the last 16 years, and this trend continued in 2016. This indicates that fewer dependants per principal member are being registered with medical schemes each year. This may be due to affordability constraints of members who can no longer afford to provide medical cover for their entire family, particularly in the absence of employer subsidies. Those beneficiaries who have been removed from cover may be added back on to the membership when they need medical cover, for example during a pregnancy, and medical schemes may use waiting periods to try to control this anti-selective behaviour.

Those beneficiaries who have been removed from cover may be added back on to the membership when they need medical cover, for example during a pregnancy, and medical schemes will use waiting periods to try to control this anti-selective behaviour.

In addition, as members' dependent children become self-supporting, they become ineligible for membership as dependants on their parents' medical scheme and in turn become principal members themselves. This has a direct impact on the average family size in two ways:

- Dependants being removed from a medical scheme will reduce the average family size.
- Individuals joining a medical scheme as single members will also reduce the average family size.



2.4 Contributions

Medical schemes work on the concept of risk pooling, where the risk contribution charged to members depends on a combination of these factors:

- Claims: the expected medical expenses of the entire membership group
- Non-healthcare expenses: the costs associated with any administration of claims and day-to-day operations
- Investment income: the interest or returns expected from the scheme's assets

Where the scheme's claims and expenses exceed the contributions, investment income is required to subsidise this shortfall. Any remaining investment income is then added to the reserves of the scheme and serves to increase its solvency levels. However, where investment income is not sufficient to cover this shortfall, the scheme is forced to use its existing reserves, which results in decreasing solvency levels. A scheme may decide to use investment income to cover claims or expenses for a number of reasons, including increasing claims costs, short-term adverse claims experience and cross-subsidisation between benefit options.

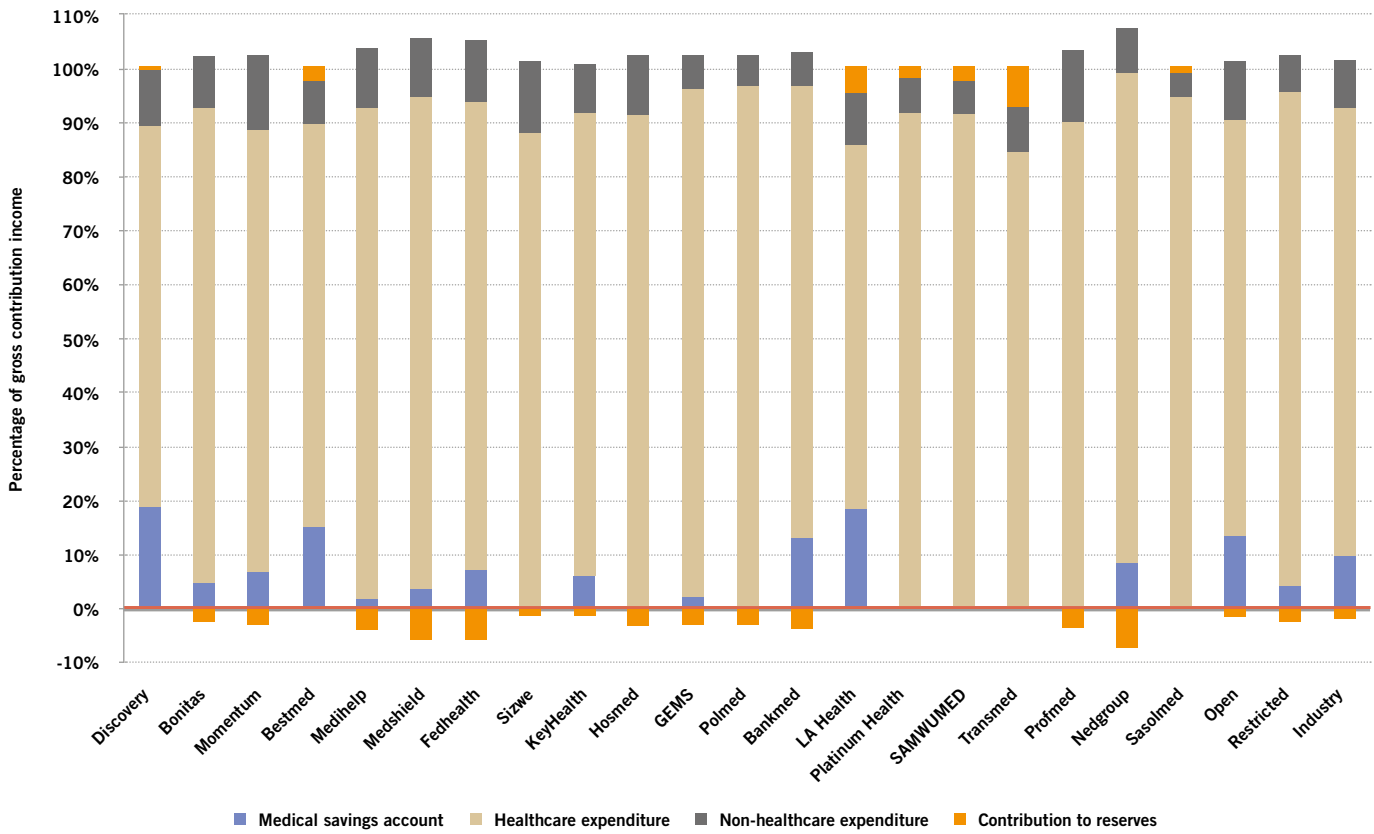
Some schemes may intentionally set contributions to use part or all of the investment income to subsidise claims and expenses, particularly schemes which have significant reserves in excess of the statutory requirements. However, this would not be sustainable in the long term, as over time the scheme would become underpriced and would ultimately need to adjust its pricing with larger contribution increases in future years.

The graph below considers the allocation of contribution income for the top 10 open schemes and top 10 restricted schemes, together with the totals for open and restricted schemes and the industry as a whole. Where the contribution to reserves sits below the 0% line, schemes have used part or all of their investment income to fund for claims and expenses.

In simple terms, the financial operations of a medical scheme can be described by four main factors, shown in the equation:

$$\text{contributions} + \text{investment income} \geq \text{claims} + \text{expenses}$$

Allocation of contribution income in 2016



In some cases, where investment income has not been sufficient, schemes have had to use their existing reserves, placing pressure on solvency levels.

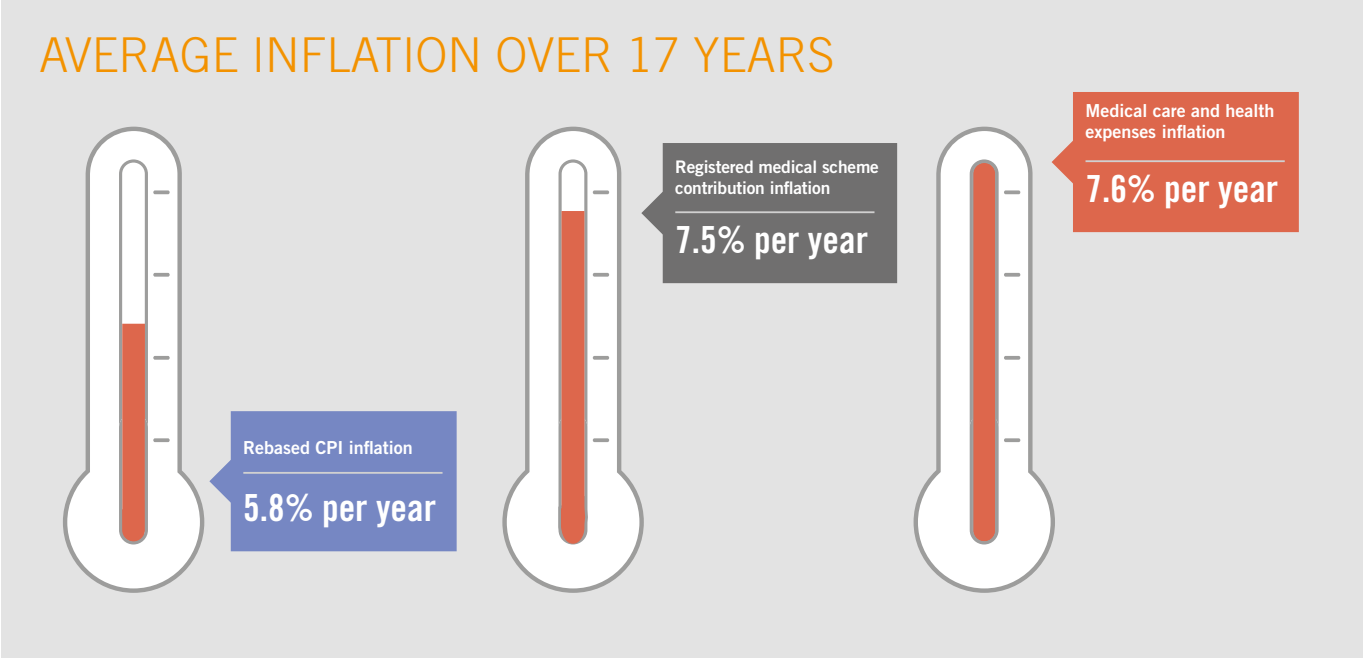
In 2016, 13 of the 20 schemes considered did not have sufficient contribution income to cover both their claims and non-healthcare expenses in full and so used investment income and in some cases their existing reserves to subsidise the cost incurred. Two open schemes, Discovery and Bestmed, and five restricted schemes, LA Health, Platinum Health, SAMWUMED, Transmed and Sasolmed, had sufficient contribution income to add to their reserves during the year.

In the following sections we consider each component of the medical scheme pricing equation in more detail. However, we will first look at some of the inflationary trends that we have seen in the industry over the past 17 years.

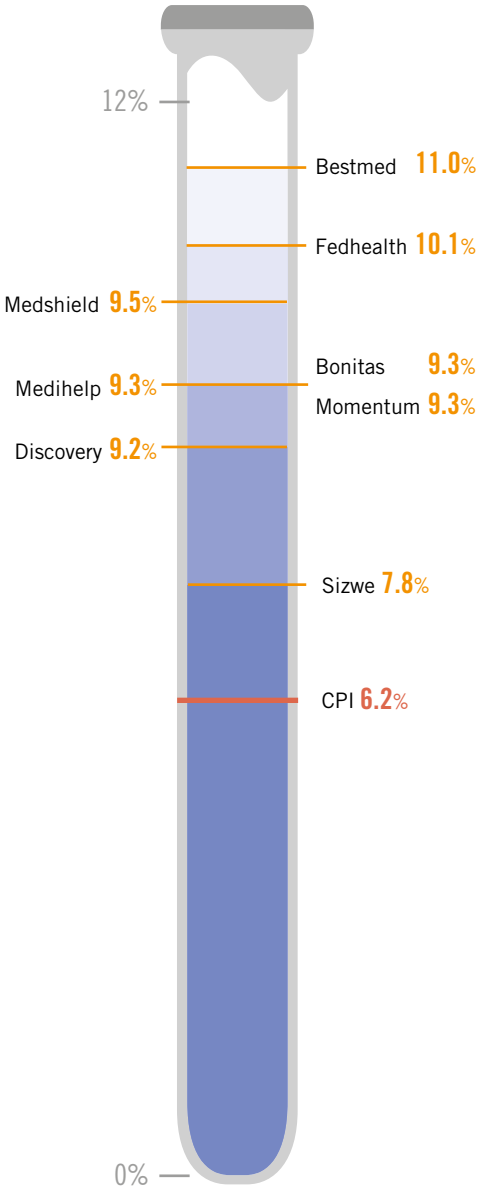
2.5 Inflationary trends

The graph below compares medical scheme contribution inflation, along with medical care and healthcare expense inflation trends, to consumer price index (CPI) inflation over the last 17 years, where:

- **CPI inflation** is the weighted average price inflation in different sectors and indicates the general level of price increases. Viewed in isolation, it doesn't necessarily give an accurate reflection of cost pressures in a particular sector. Individual sectors may experience cost increases that differ from CPI inflation, as is the case in the healthcare sector.
- **Medical scheme contribution inflation** is calculated for all medical schemes who submit annual financial returns to the Registrar of Medical Schemes. Percentage increases are based on the average contribution per principal member per month, and allow for normal medical scheme contribution increases, as well as buy-ups and buy-downs to other benefit options. Changes in contributions as a result of family size or family composition are also taken into account.
- **Medical care and health expense inflation** is measured by Statistics South Africa and is based on that component of CPI which relates to doctors' fees, nurses' fees, hospital fees, nursing home fees, medical and pharmaceutical products and therapeutic appliances.



Average annualised contribution increases 2007 to 2018



The general observation in the industry is that medical inflation (medical care and health expenses inflation) will be approximately 2% to 3% higher than CPI inflation over the long term. However, increases in a particular year may be significantly higher because of adverse claims experience. The deviation from CPI is mainly due to:

- high increases in healthcare service provider fees
- a rising burden of disease
- increasing hospital admission rates
- more use of benefits
- new medical technologies
- the requirement to maintain reserves of at least 25% of gross contribution income
- certain benefit enhancements

CPI inflation has averaged 5.8% over the last 17 years, while medical care and health expenses inflation has been on average 7.6% per year, resulting in a gap of 1.8% per year. Over the same period, average medical scheme contribution inflation was 7.5% per year, resulting in actual increases in medical scheme contributions per principal member exceeding CPI inflation by at least 1.7% per year.

The gap between medical scheme contribution inflation and CPI inflation has reduced in recent years, most likely as a result of efforts by medical schemes in managing the costs charged by providers. While this would have a direct impact on medical scheme contribution increases, the further reduction in the gap between average medical scheme contribution inflation and CPI inflation indicates the extent of member buy-downs to lower cost benefit options, new entrants joining low-income options, and changes to family size, possibly through the removal of dependants as a result of affordability constraints.

The graph on the left provides a high-level summary of the average headline contribution increases announced by medical schemes since 2007 and compares this to average CPI. Note that we have taken an arithmetic average for illustrative purposes and have only included the medical schemes where this information is available. Also note that these increases are based on the headline increases announced by individual schemes and the method of calculation may vary. It does, however, provide some useful information on real contribution increases faced by members.

The average contribution increases for the top nine open medical schemes since 2007 have far exceeded average CPI. The margin between the level of CPI and the industry's contribution rate was highest from 2008 to 2011. Since 2012 the contribution increases have tended to be closer to CPI as schemes have aimed to limit increases in contributions to increase competitiveness and minimise membership losses as a result of affordability constraints. Increases announced for 2017 were higher than in prior years because of a significant increase in the use of in-hospital benefits reported by many schemes. However, the contribution increases for 2018 are lower again, in part because of the lower level of CPI inflation in 2017.

2.6 Healthcare expenditure

One of the main components influencing the performance of a medical scheme is its healthcare expenditure, or claims experience. In this section we consider the claims ratio as well as the actual level of claims that are paid by medical schemes.

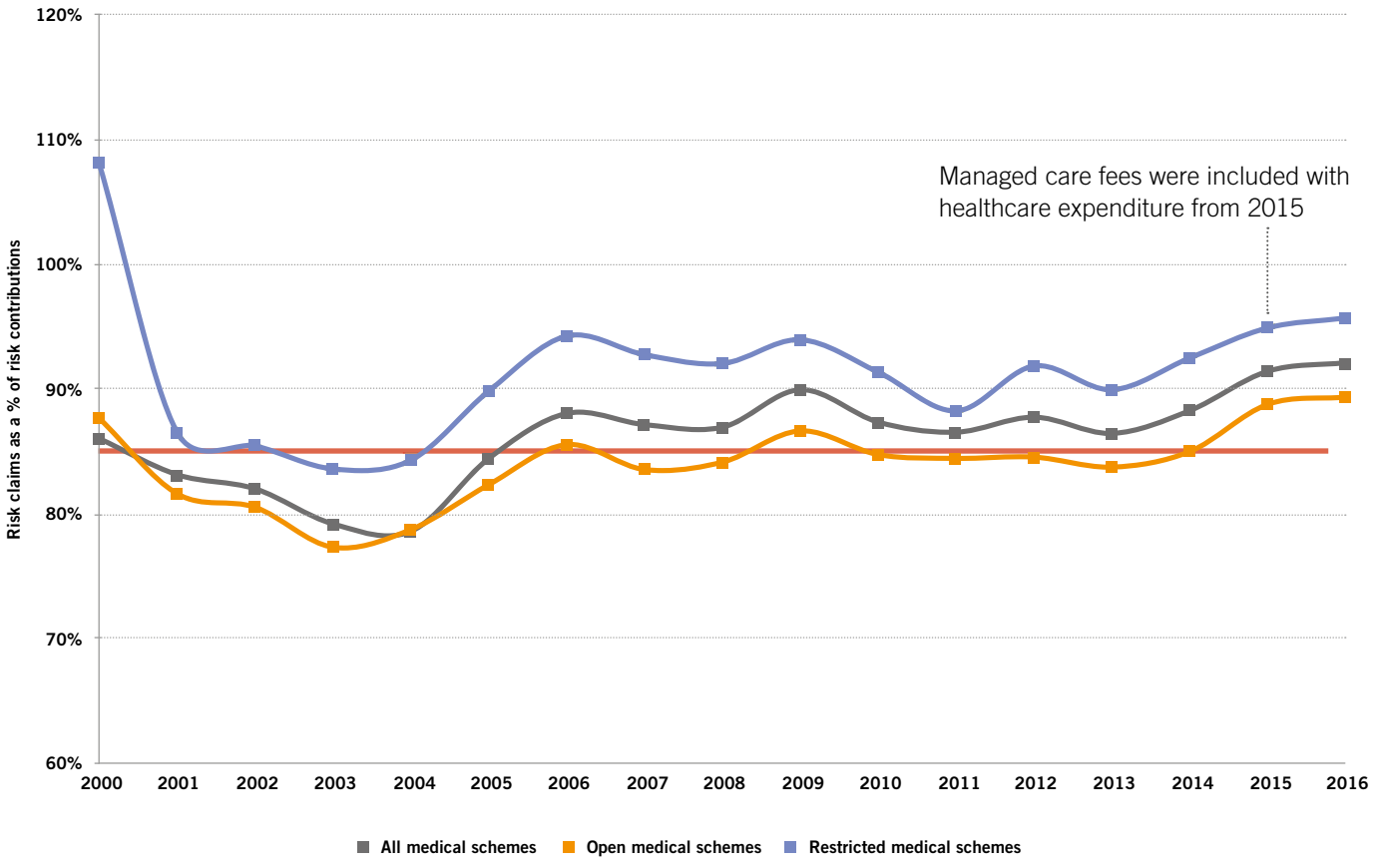
Healthcare expenditure includes all payments made for claims incurred by members. The risk claims ratio is defined as the ratio of risk claims to risk contributions (the proportion of contributions that are used to fund claims, excluding any allowance for medical savings accounts).

The risk claims ratio for all medical schemes increased from 91.4% in 2015 to 92.1% in 2016. For the 2016 benefit year, open medical schemes had an overall risk claims ratio of 89.3% compared to the 95.6% experienced by restricted medical schemes. The industry as a whole experienced a higher claims year in 2016 than in 2015, with the average claims ratio increasing for the third successive year. The noticeable increase in the claims ratio from 2014 to 2015 was in part due to the inclusion of managed care fees in healthcare expenditure from 2015.

Many restricted schemes do not incur certain non-healthcare expenditure items such as distribution costs, marketing expenses and broker fees. As a result, they can often afford to use a higher percentage of risk contributions towards risk claims than open medical schemes. This trend is illustrated in the graph below.

The graph below also shows a cyclical trend. This is most likely caused by the lag effect of medical schemes' annual pricing exercises. Where a scheme has experienced adverse claims during the year, it would usually only correct that experience through higher contributions or benefit reductions (and therefore lower relative claims) in the next financial year, and this corrective action often needs to take place over at least two years.

Trend in claims ratios



Medical schemes usually finalise their benefits and contributions reviews in September each year, without the full membership and claims experience data of that year. Where experience has been worse than expected in the first part of the year and is therefore included in the data used for pricing, allowances can be made for this experience in the next financial year.

However, where the adverse experience occurs in the second half of the year, it cannot be allowed for in the pricing of benefits into the next year, and so this adverse experience must be made up in the following year. In addition, the adverse experience in the second half of the year has a direct impact on the reserves and solvency levels of the scheme going into the next year.

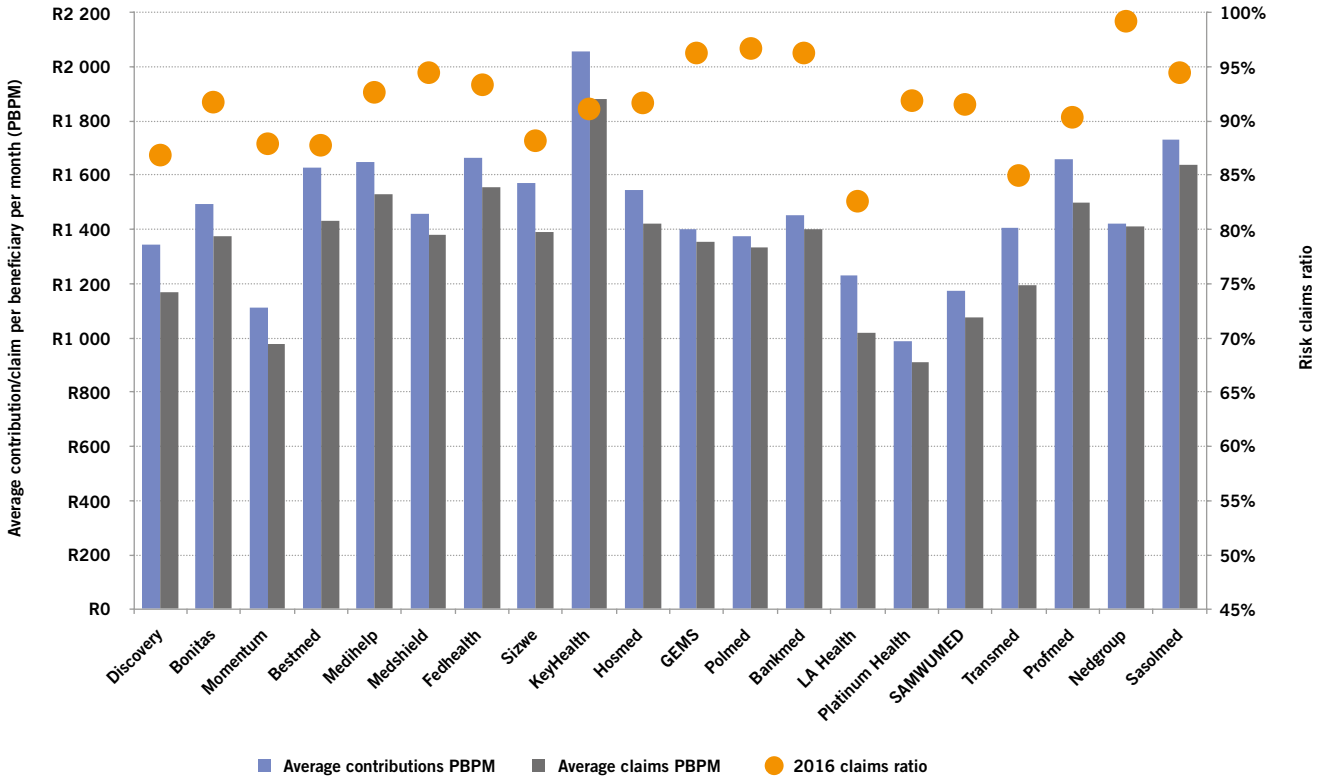
In general, medical schemes with a risk claims ratio of above 85% face the challenge of achieving an operating surplus (contributions less claims and expenses) while containing non-healthcare expenses below the Council of Medical Schemes' generally accepted guideline of 10% of contributions and building reserves to a sustainable level.

Although 85% is the generally accepted benchmark for the claims ratio, the ideal ratio for a particular scheme will depend on its current circumstances, such as:

- the current adequacy of contributions
- the level of non-healthcare expenses
- the need for reserve building
- the scheme's long-term strategy

The graph below illustrates the average claims paid per beneficiary per month (PBPM), as well as the risk claims ratio in 2016, for the 20 schemes included in the *Diagnosis* this year. These claims ratios all include any managed care fees incurred by the schemes.

Claims and contributions by scheme



While the claims ratios show the adequacy of contribution levels, the actual average claims paid per beneficiary indicate the level of benefits provided by a scheme. The graph on the previous page shows that KeyHealth paid the highest amount in claims per beneficiary in 2016, and also had the highest contribution income per beneficiary during the year. Nedgroup experienced the highest claims ratio of these schemes, with a claims ratio of 99.4% for the 2016 year. Transmed had a high claims ratio of 105.3% in 2015, but managed to reduce this to 85.2% for 2016. LA Health had a claims ratio of 82.9% for 2016, the lowest claims ratio of the 20 schemes considered.

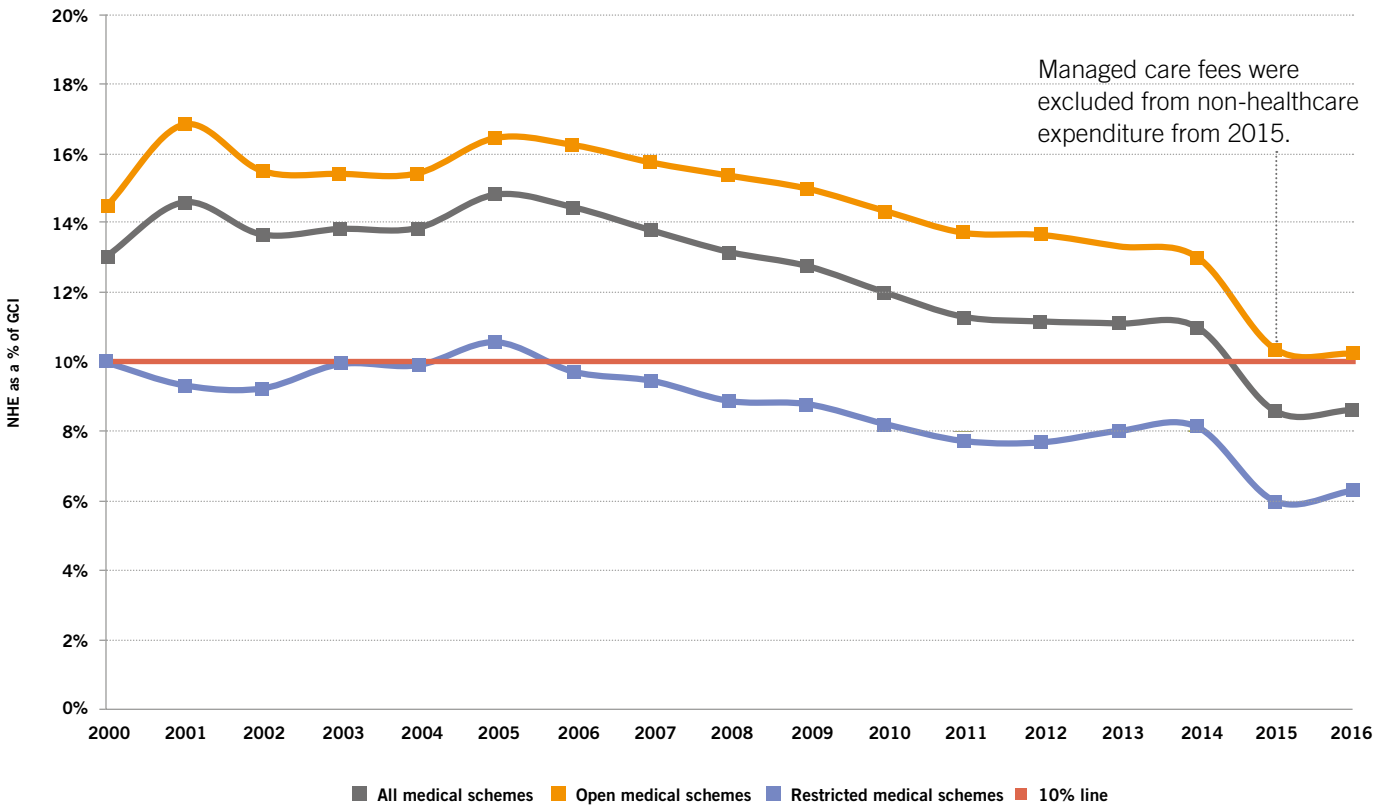
The actual healthcare costs funded by medical schemes are driven largely by the use of services as well as the actual cost of claims. The use of services is influenced by demographic factors (age profile and pensioner ratio), the incidence and distribution of disease (often called disease burden) and advances in diagnostic technology and biological drugs. The actual cost of claims can be influenced by the negotiating power of a particular medical scheme or its administrator.

The level of the average claims and contributions per beneficiary for a particular scheme will depend on a number of factors, including the richness of benefits offered, the split of members between high-cover and low-cover options as well as the demographic profile of the scheme in terms of average age and chronic prevalence. The relationship between contributions and claims for a particular medical scheme will depend on the pricing philosophy followed by that scheme. A scheme with a significant level of reserves might intentionally price for an operating deficit to use some of those reserves, while a scheme which does not meet the statutory solvency requirements may have higher contributions than their demographic and claims profile would require to build reserves.

2.7 Non-healthcare expenditure

Non-healthcare expenditure (NHE) includes administration fees, broker commission, distribution costs, bad debts, and reinsurance costs. Up to 2014 managed care fees were reported as part of non-healthcare expenditure. However, since 2015 managed care fees have been recognised as part of healthcare expenditure, which means that there is a marked reduction in the proportion of gross contribution income spent on NHE from 2014 to 2015.

Trend in non-healthcare expenditure



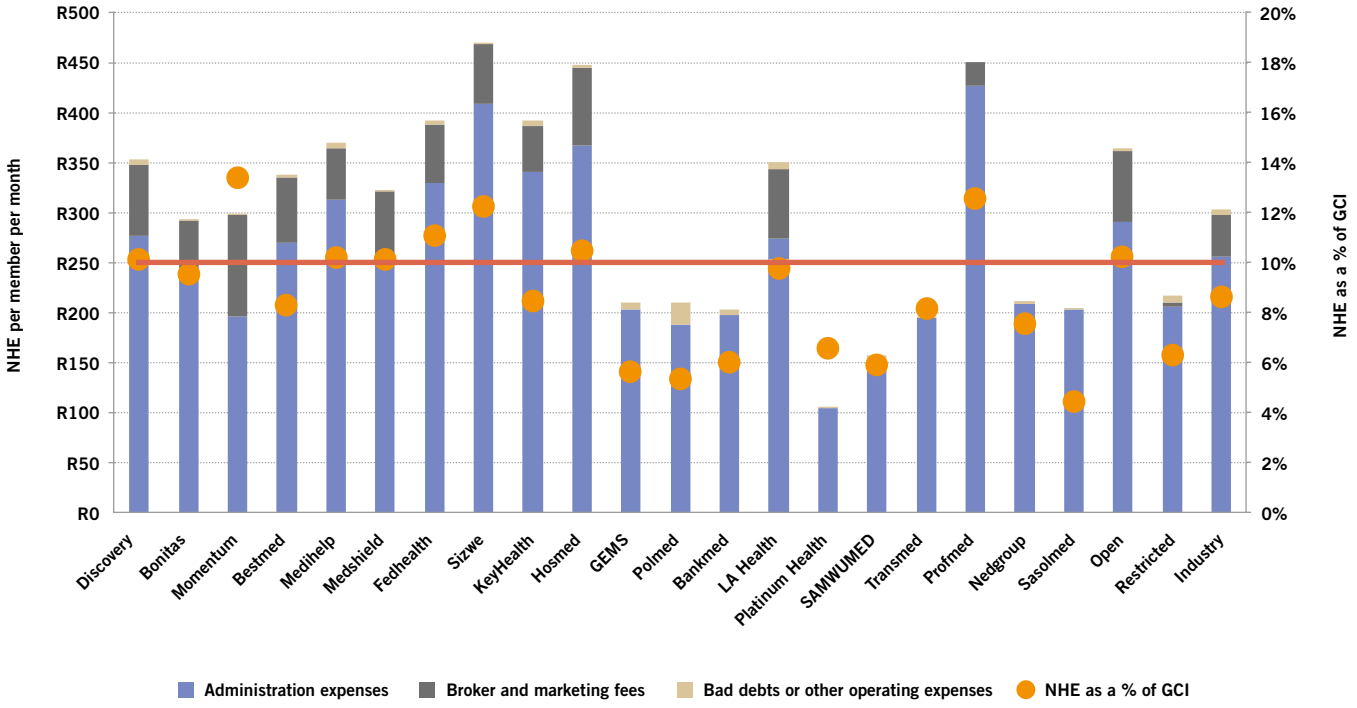
Total non-healthcare expenditure, as a proportion of gross contribution income, increased marginally in 2016 for the medical schemes industry as a whole. This increase was driven by an increase from 6.0% to 6.3% in the proportion of gross contribution income spent on non-healthcare expenditure by restricted medical schemes. For open schemes, the NHE proportional spend reduced from 10.4% to 10.2%. The lower level of non-healthcare expenditure within restricted schemes is driven to a large extent by GEMS whose non-healthcare expenditure was 5.6% of gross contribution income in 2016, up from 5.0% in 2015.

Restricted schemes are expected to have lower non-healthcare costs primarily because they have lower or no distribution expenses or broker fees and certain operating expenses may be subsidised by their participating employers. Some restricted schemes, for example Profmed and GEMS, do compete with the open market to a certain extent, and as a result will budget for marketing expenses and possibly broker fees.

As we assume that NHE increases with CPI while contributions increase with medical inflation, which is usually 2% to 3% more than CPI on average each year, we would expect the proportion paid to NHE to decrease over time, irrespective of whether additional cost control measures are introduced. In addition, broker fees paid each year may not increase at the same rate as contributions because of the cap in place that does not increase at healthcare cost inflation, which also contributes to the decreased NHE percentage. As a result, a more suitable measure of NHE is the absolute cost per member.

The graph on the next page illustrates the components of NHE for the top 10 open and top 10 restricted schemes for 2016, as well as for open and restricted schemes, and the medical schemes industry as a whole.

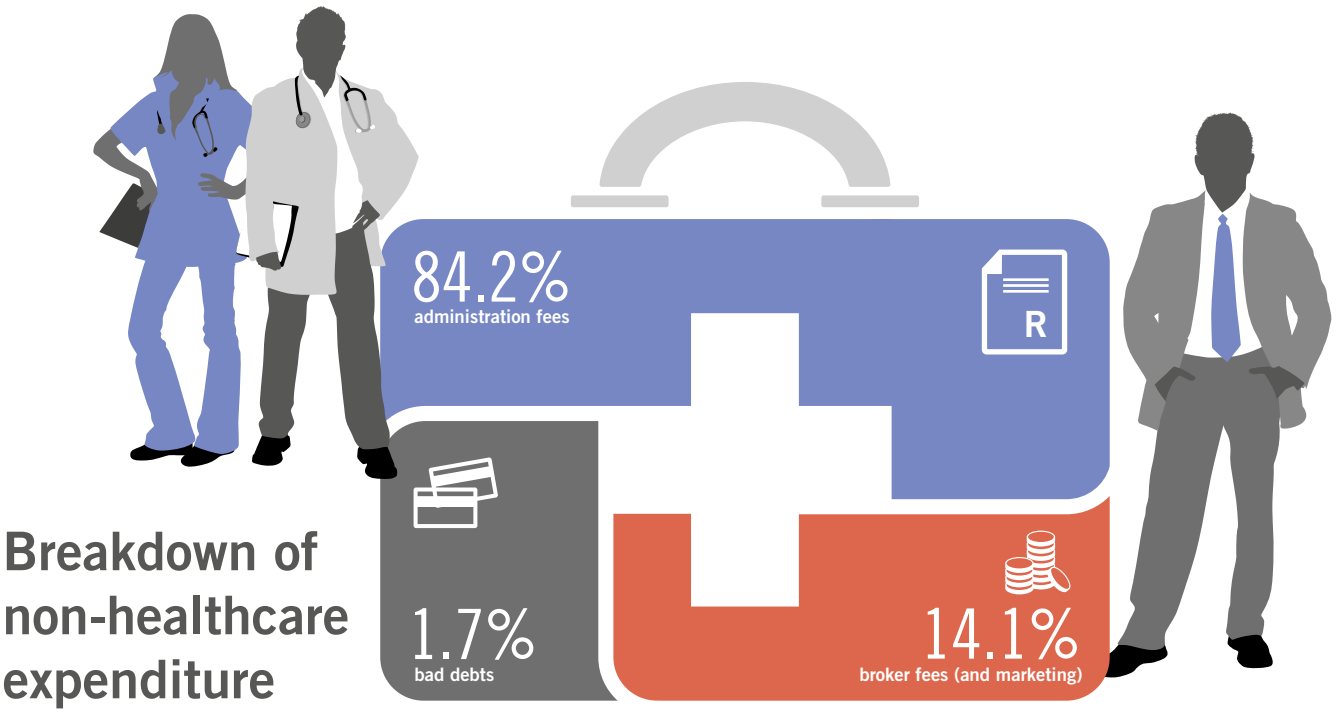
Non-healthcare expenditure by scheme



The marked difference between non-healthcare expenses of open and restricted medical schemes is evident from the graph above. Even after excluding broker fees, the pure administration costs of open and restricted medical schemes are significantly different. This may be due to the sponsoring employers of the restricted schemes taking on some of the expenses incurred in the running of the medical scheme through the corporate entity, and so reducing the costs borne by the medical scheme itself.

There is no fixed definition for which expenses can be included as administration fees, and this contributes to the varied level of administration fees across the market. Some administrators may include services other than pure administration, for example actuarial services, which will affect the overall profile of administration expenses.

The figure below shows the breakdown of non-healthcare expenditure into its different components across the industry in 2016.



2.8 Financial performance

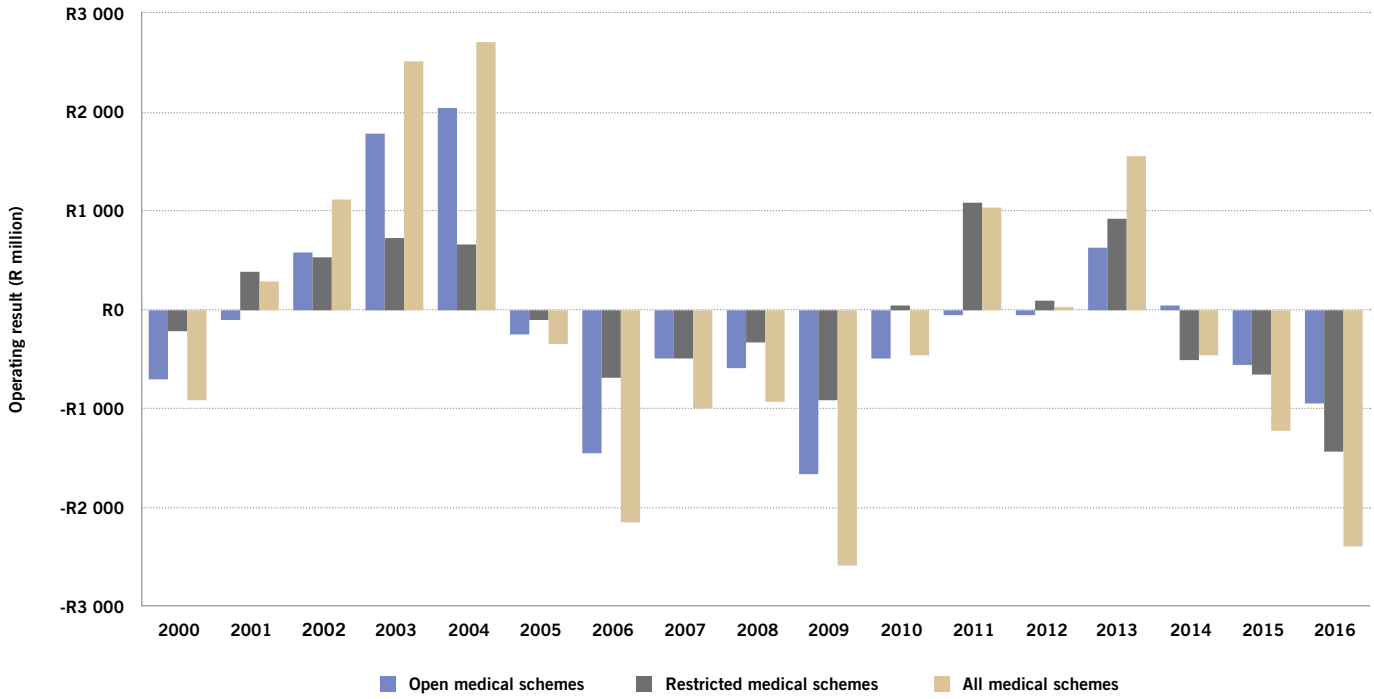
One of the key factors used to measure the performance of a medical scheme is the scheme's operating result. A scheme's **operating result** is an indication of its financial soundness after claims and non-healthcare expenditure are deducted from contribution income. It shows the surplus or deficit before investment income.

Drivers of strong financial performance by medical schemes include:

- appropriate benefit pricing
- adequate risk management and claims control
- favourable age and risk profile of the membership base
- low non-healthcare expenditure

The trend of deteriorating financial results that we have observed in the industry since 2014 continued in 2016, with the industry as a whole experiencing an operating deficit of R2.390 billion in 2016. Restricted schemes incurred an operating deficit of R1.435 billion while open schemes incurred an operating deficit of R0.956 billion. In 2014 the industry ended the year with an operating deficit of R464.51 million, with restricted schemes attaining an overall operating deficit of R504.58 million and open medical schemes achieving a small operating surplus of R40.07 million. The industry ended 2015 with a significant operating deficit of R1.219 billion, with open schemes recording a deficit of R565.63 million at an operational level and restricted schemes showing a deficit of R653.78 million.

Trend in operating results



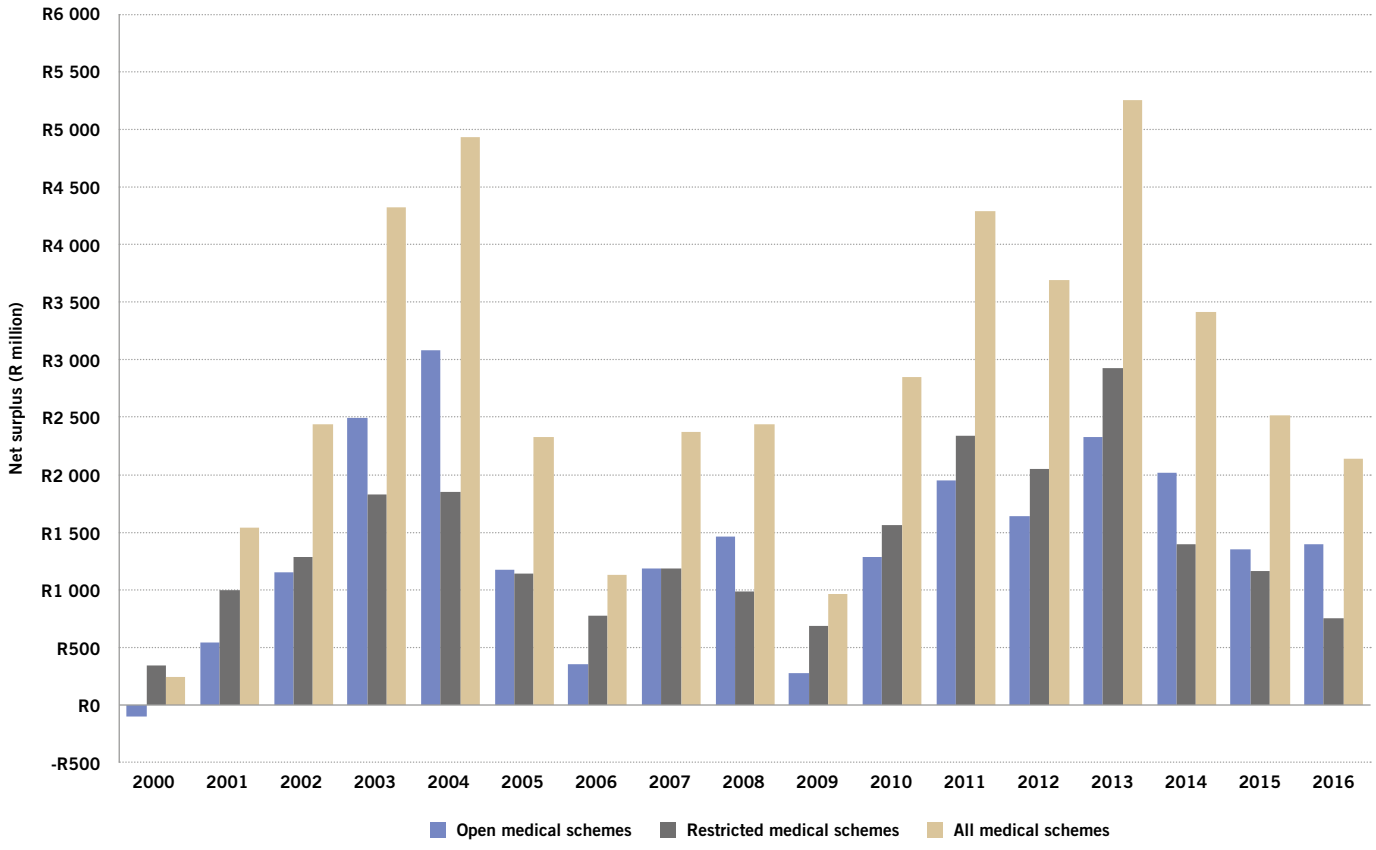
The longer-term trend in operating results since 2000 has been driven in large part by the prevailing regulations. Medical schemes were priced to target significant surpluses in the years prior to 2004 in order to meet the regulatory solvency requirements by 2004. During the years following 2004 many schemes had met the solvency requirements and so no longer had to price for larger surpluses. They were, however, then faced with significant increases in claims over the following years as a result of a change in service provider charging habits with the requirement to pay PMBs at costs.

In 2015, 8 of 23 open schemes and 26 of 60 restricted schemes achieved an operating surplus. In 2016, 5 of 22 open schemes and 23 of 60 restricted schemes achieved an operating surplus.

Schemes incurring operating deficits have to rely on investment income to achieve a breakeven result on a net level. In 2016, with the addition of investment and other income, the industry achieved a net surplus of R2.142 billion, compared to the overall net surplus of R 2.517 billion achieved in 2015. Open schemes achieved an overall net surplus of R1.391 billion (2015: R1.353 billion) and restricted schemes achieved an overall net surplus of R 0.751 billion (2015: R1.164 billion).

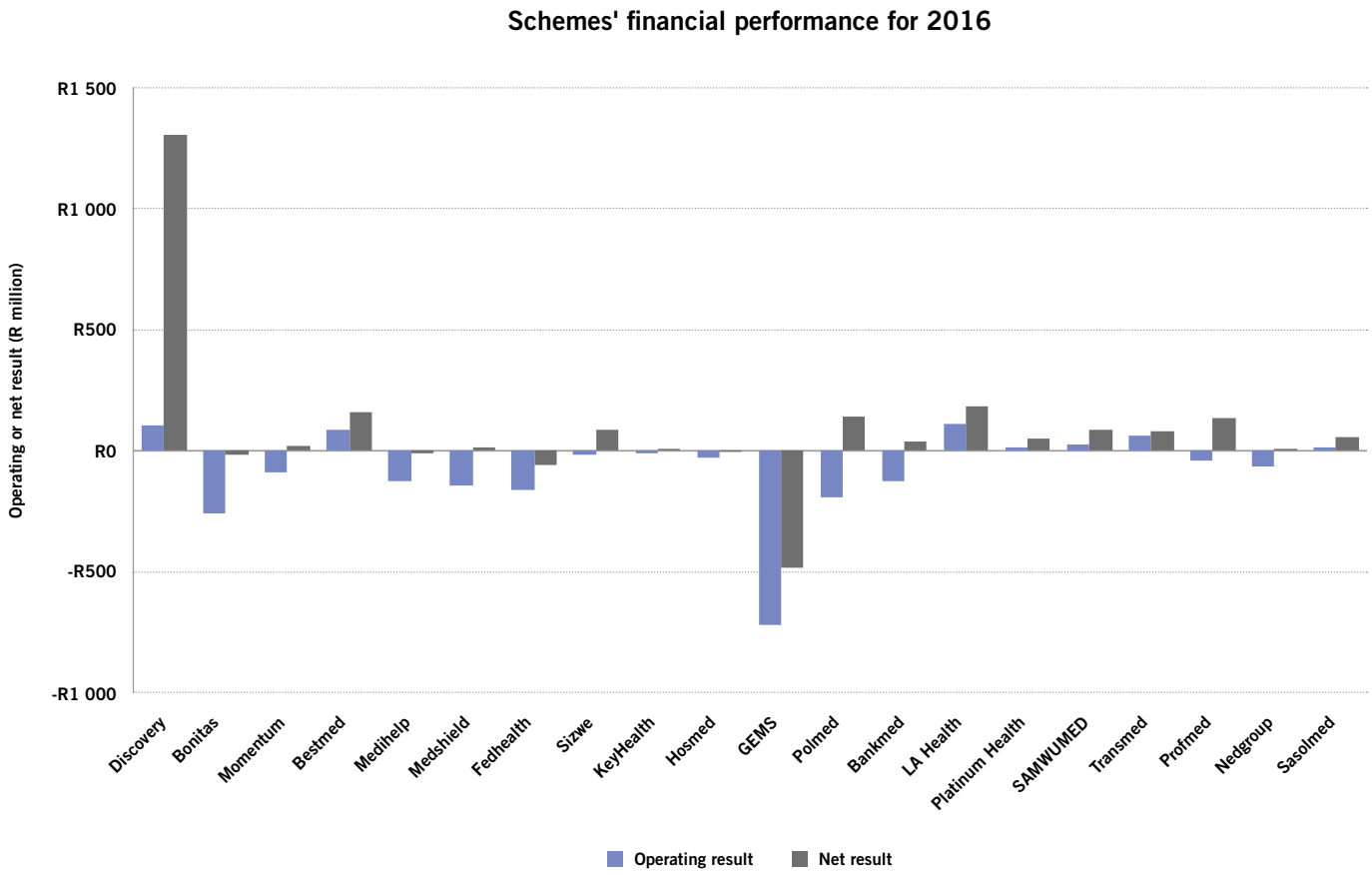
In 2015, 17 of 23 open schemes and 50 of 60 restricted schemes achieved a net surplus, compared to 12 of 22 open schemes and 45 of 60 restricted schemes in 2016.

Trend in net surplus



The graph below shows the financial performance of the top 10 open schemes and top 10 restricted schemes in 2016.

Of the 20 schemes considered in this year's *Diagnosis*, 13 did not attain a surplus at an operating level in 2016 and therefore had to rely on investment income to subsidise claims and non-healthcare expenditure. Four of the 10 open schemes and one of the 10 restricted schemes also did not attain a surplus at a net result level, and so were net disinvestors for the 2016 benefit year.

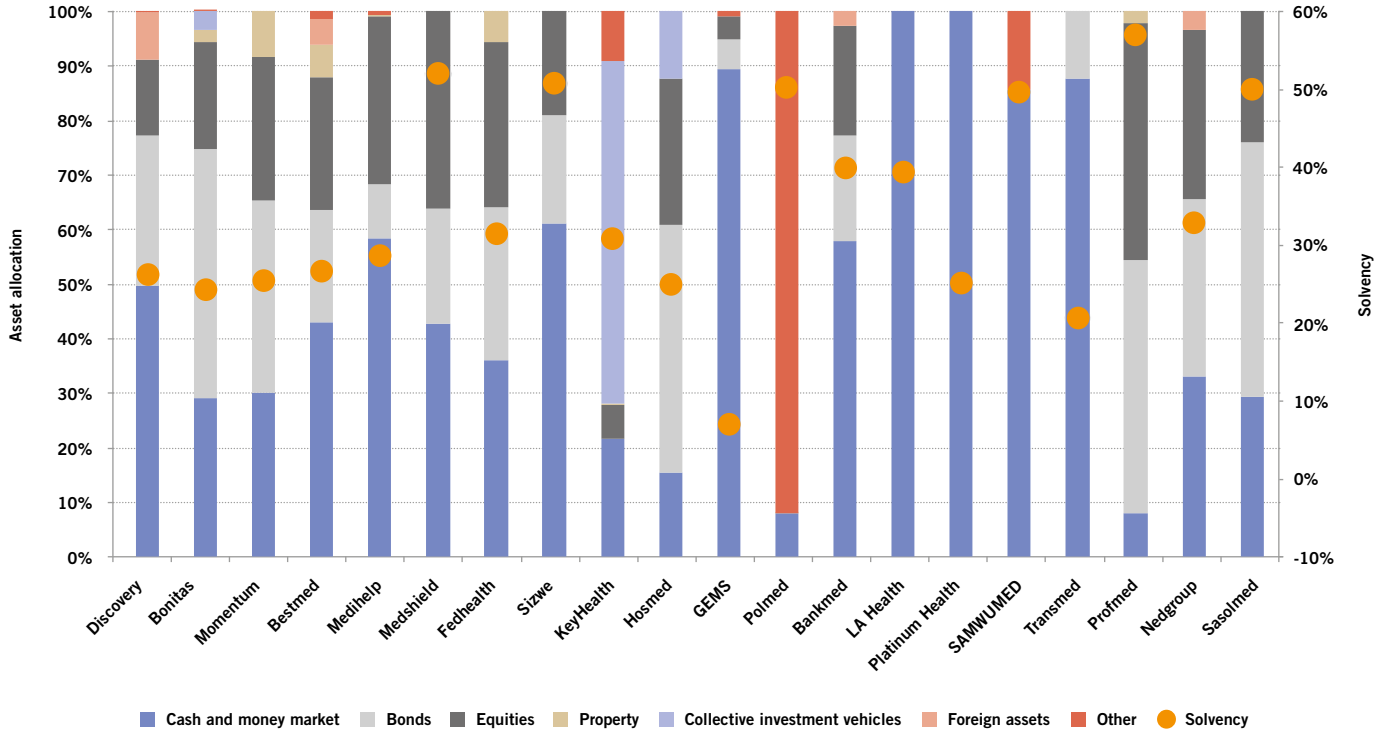


2.9 Investments

Where medical schemes do not achieve operating surpluses, they become reliant on the investment returns earned over the year to fund part of their claims and non-healthcare expenditure. In 2016, 54 of 82 medical schemes failed to achieve an operating surplus and therefore had to draw on their investment returns, placing additional pressure on solvency levels.

This strategy is not sustainable unless investment returns are able to keep pace with, and preferably exceed, claims inflation. At present, however, most medical schemes follow very conservative investment strategies as shown in the following graph. The graph shows the asset allocation for the 20 schemes under consideration in this publication.

Asset allocation at 31 December 2016



In 2016 open schemes held 18.7% of assets in equites, with 33.7% being held in bonds and 40.1% of assets being held in cash. In the restricted scheme environment, schemes held 22.1% of assets in equities, 20.6% in bonds and 50.7% in cash or cash equivalents. The balance is held in property mainly, with some exposure to debentures and insurance policies.

There are asset class limits placed on medical schemes in *Annexure B of the Regulations to the Medical Schemes Act*, but most schemes are operating well inside the limits for riskier asset classes. The limit on equities is 40%, while the limit on property is 10%. This implies that schemes could have up to 50% of their investments in these higher-risk asset classes, whose returns are generally expected to exceed CPI inflation. The allowable exposure to conservative asset classes, such as cash, money market instruments and bonds, is unlimited. The only restrictions on these asset classes are on the exposure to specific issuers, to ensure some level of diversification.

Medical schemes' preference for cash in particular appears to be driven by a preference for liquid assets, given the short-term nature of medical scheme liabilities, as well as concerns about risks related directly to the investments (the possibility of making negative returns or losing scheme assets). However, for the long-term sustainability of the scheme, average returns below medical inflation may pose a greater risk, especially for schemes that rely on investment returns when they fail to achieve an operating surplus.

In particular, claims expenditure tends to grow faster than CPI. To maintain solvency year on year, the accumulated funds need to increase in line with the increase in contributions. If investment returns cannot keep pace with the increase in claims inflation and accumulated funds increase at a rate less than contributions, then solvency levels will decrease, resulting in a need to either increase contributions further – which would exacerbate this issue – or reduce benefits.

As a result, for schemes failing to meet the solvency requirement, low investment returns as a result of conservative asset allocations may in fact be increasing risk for the scheme. For schemes meeting the solvency threshold, this can be eroded over time if returns are below claims inflation, and they may be missing an opportunity to maintain affordable contribution increases in the future.

Where a scheme already has sufficient reserves, there is a strong argument to invest at least some of the reserves in more risky asset classes as allowed by Regulation B. Conversely, schemes that are not adequately funded can increase their expected return by investing in more risky assets, which will then increase the reserves held and thereby the solvency ratio. This also depends on the absolute value of the asset base.

2.10 Solvency levels

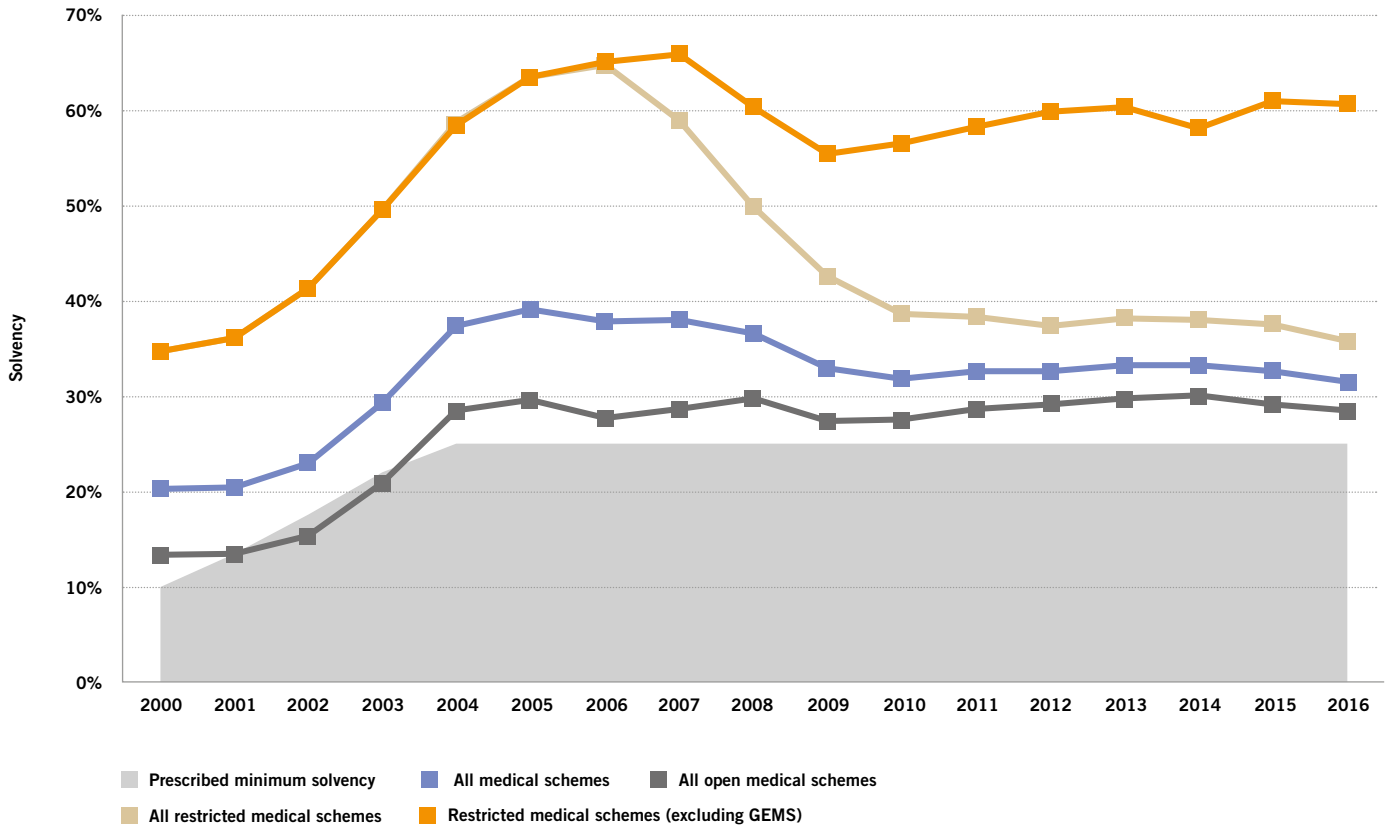
The solvency ratio is the level of reserves (accumulated funds) that a medical scheme needs to hold as a percentage of gross annualised contributions. Regulation 29 promulgated in terms of the *Medical Schemes Act* prescribes that medical schemes maintain a minimum solvency ratio of 25%.

The graph below shows the solvency levels of open and restricted schemes against the statutory level over the past 17 years. The increase in industry solvency levels from 2000 to 2004 is primarily attributable to the calculated efforts of medical schemes to build reserves to the prescribed minimum solvency level that was required by 31 December 2004.

Restricted schemes on average have maintained higher solvency compared to open schemes. From 2006 the solvency level for all restricted schemes has declined because of rapid membership growth in GEMS. The average solvency of open schemes has remained relatively stable since 2006.

In 2016 the average solvency for all schemes decreased slightly to 31.6% (2015: 32.6%). The solvency ratio of open schemes decreased from 29.2% in 2015 to 28.6% in 2016. The overall solvency level for restricted schemes reduced from 37.5% in 2015 to 35.8% in 2016.

Trend in solvency levels



Medical schemes who do not meet the regulatory required minimum level of 25% need to submit a business plan to the CMS outlining their plans to achieve this level. This may include benefit reductions or additional contribution increases.

In 2016 three open and three restricted medical schemes were unable to achieve the statutory minimum solvency level of 25%:

- Bonitas Medical Fund
- Resolution Health Medical Scheme
- Thebemed
- GEMS
- Lonmin Medical Scheme
- Transmed Medical Fund

In 2014 COMMED's solvency level was below 25%. However, the financial results for this scheme have been excluded from the CMS' Annual Reports for 2015 and 2016.

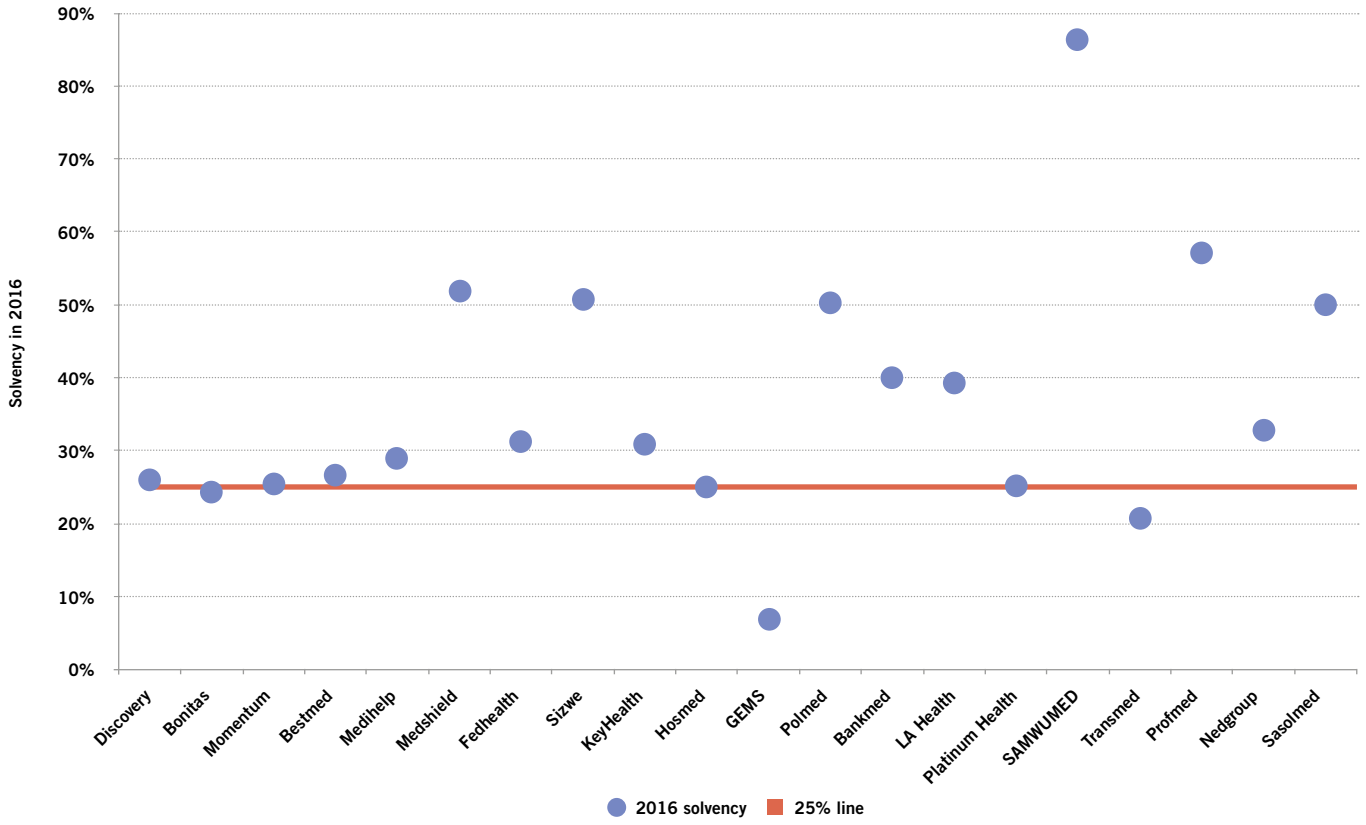
The graph below illustrates the solvency levels for the 20 schemes considered at the end of 2016.

The suitability of the current solvency framework requiring schemes to allocate a minimum of 25% of gross contributions to reserves has long been debated. Reasons that support the need to revisit the current framework include:

- **Appropriateness of a one-size-fits-all approach**
  Medical scheme claims experience is likely to be more stable for larger schemes, so the solvency requirements should be less onerous, while solvency requirements for smaller schemes should be higher.
- **Nature of the solvency calculation formula**
  On the one hand, schemes showing membership growth are penalised from a solvency perspective. On the other hand, schemes losing members are rewarded as a result of the nature of the solvency calculation formula. Therefore, schemes that are growing are less competitive because of the need to build and maintain solvency levels.

In 2015 the Council for Medical Schemes released Circular 68 on 25 November 2015 which discusses a review of the current solvency framework and outlines a proposed alternative risk-based solvency framework. In 2016 the industry was invited to comment on the proposed move to a risk-based solvency framework, their proposed calculation, as well as how the transition from the existing solvency calculation should be managed, and workshops were held with various stakeholders. There has been no further communication from the CMS on the implementation of the proposed framework, but we anticipate further work on this in 2018.

Solvency levels by scheme



3

ALEXANDER FORBES HEALTH MEDICAL SCHEMES SUSTAINABILITY INDEX

With the continued consolidation of medical schemes in the industry as well as rising claims costs, the sustainability of medical schemes and the assessment thereof have become increasing important for all industry stakeholders. Throughout this publication we have analysed key statistics of medical schemes, but it is difficult to assess how these work together to affect the sustainability of a medical scheme.

The Alexander Forbes Health Medical Schemes Sustainability Index attempts to do this by combining certain key factors and considering their impact to a medical scheme in future years. The index has been calculated from a base year of 2006 and considers the following factors:

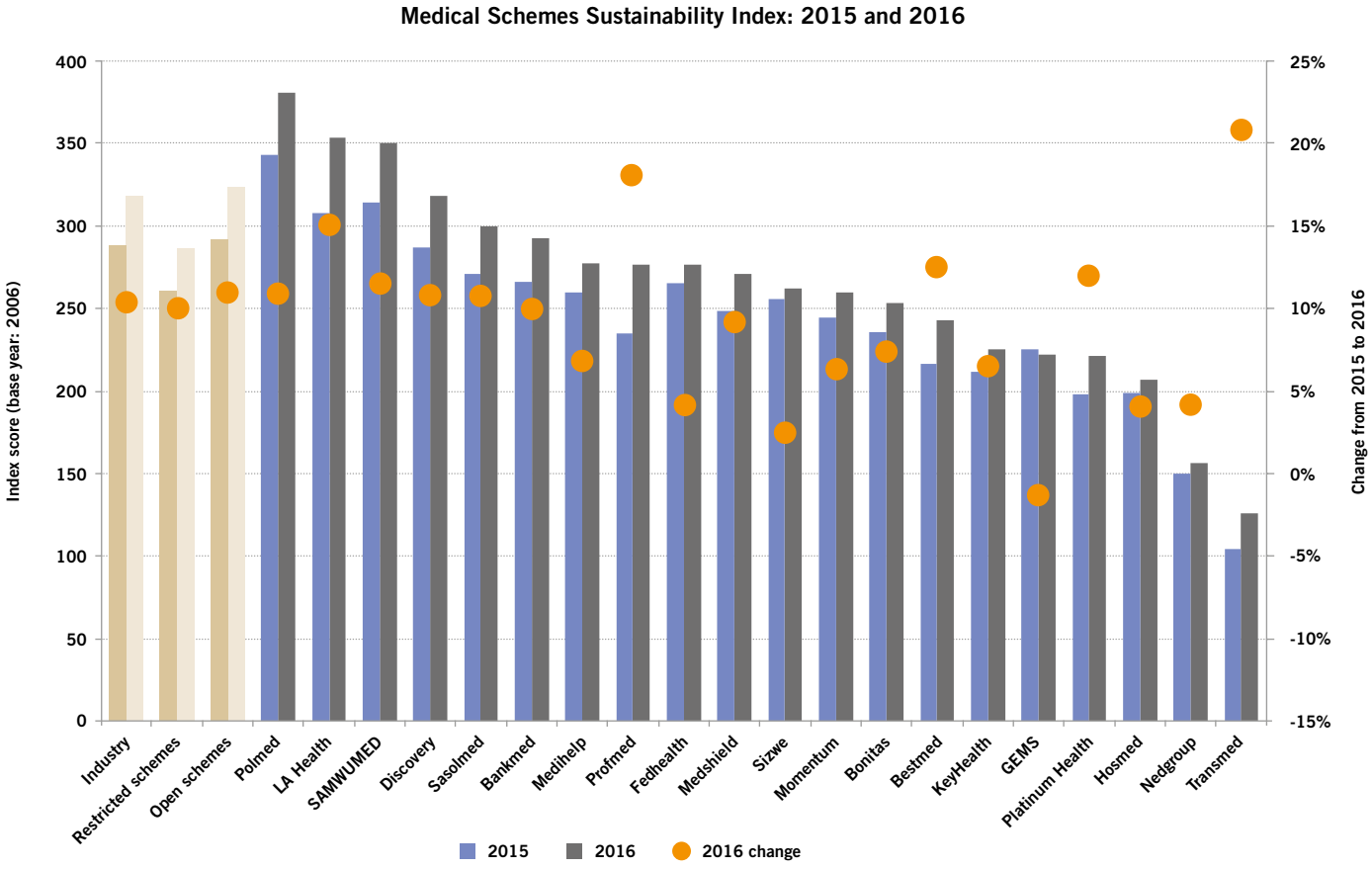
- The **size** of the scheme relative to the average scheme size in the industry. A larger membership base would reduce volatility in the claims experience and benefit from economies of scale.
- **Membership growth** over time indicates that benefits are attractive. In addition, an increase in size serves to reduce volatility of the scheme's claims experience.
- The change in the **average age** of beneficiaries over time. An increasing average age indicates a worsening profile and higher expected claims. This would require a medical scheme to adjust its base pricing for benefits through either contribution increases or benefit reductions.
- The **operating result** of the scheme relative to the industry each year, as this would indicate the medical scheme's performance relative to its peers.
- The change in the **operating result per beneficiary** each year. The operating result should give an indication of the suitability of current contribution levels and whether higher or lower contribution increases can be expected in the next year.
- The change in the accumulated funds per beneficiary held at the end of each year. **Accumulated funds** essentially act as a buffer against adverse claims experience, and an increase in the accumulated funds per beneficiary would improve this buffer.
- The scheme's **actual solvency** relative to the statutory requirement. Although there is debate regarding the suitability of the current statutory requirement, schemes whose solvency is below 25% are required to have business plans in place with the CMS and their contribution increases would include an element of additional reserve building going forward. Higher than average contribution increases would serve to reduce the scheme's marketability.

If the 25% solvency requirement is replaced with a risk-based capital requirement, this component of the index would be replaced with actual solvency relative to the risk-based requirement.

- The **trend in the scheme's solvency**. Increasing solvency levels over time would also support the sustainability of a medical scheme.

Using a base year of 2006, these factors are considered for each of the years from 2007 to 2016 with the final index score reflecting the cumulative impact over this period. The medical schemes are ranked from highest to lowest to give an indication of their relative sustainability. It is important to note that the purpose of the index is to provide a comparative assessment between schemes. For this reason, the relative positioning is more important than the absolute score. It is also important to note that small differences in the scores (between 10 to 20 points) are not significant.

The graph below shows the 2015 and 2016 index scores for each of the top 10 open and top 10 restricted medical schemes, using a base year of 2006.



The biggest increases in the index for 2016 were observed for Transmed and Profmed, who improved their 2015 scores by 20.8% and 17.8% respectively. Transmed has consistently been one of the worst performers on the index in the past because of its:

- sustained loss of membership
- worsening demographic profile
- low and worsening solvency ratio
- persistent operating deficits

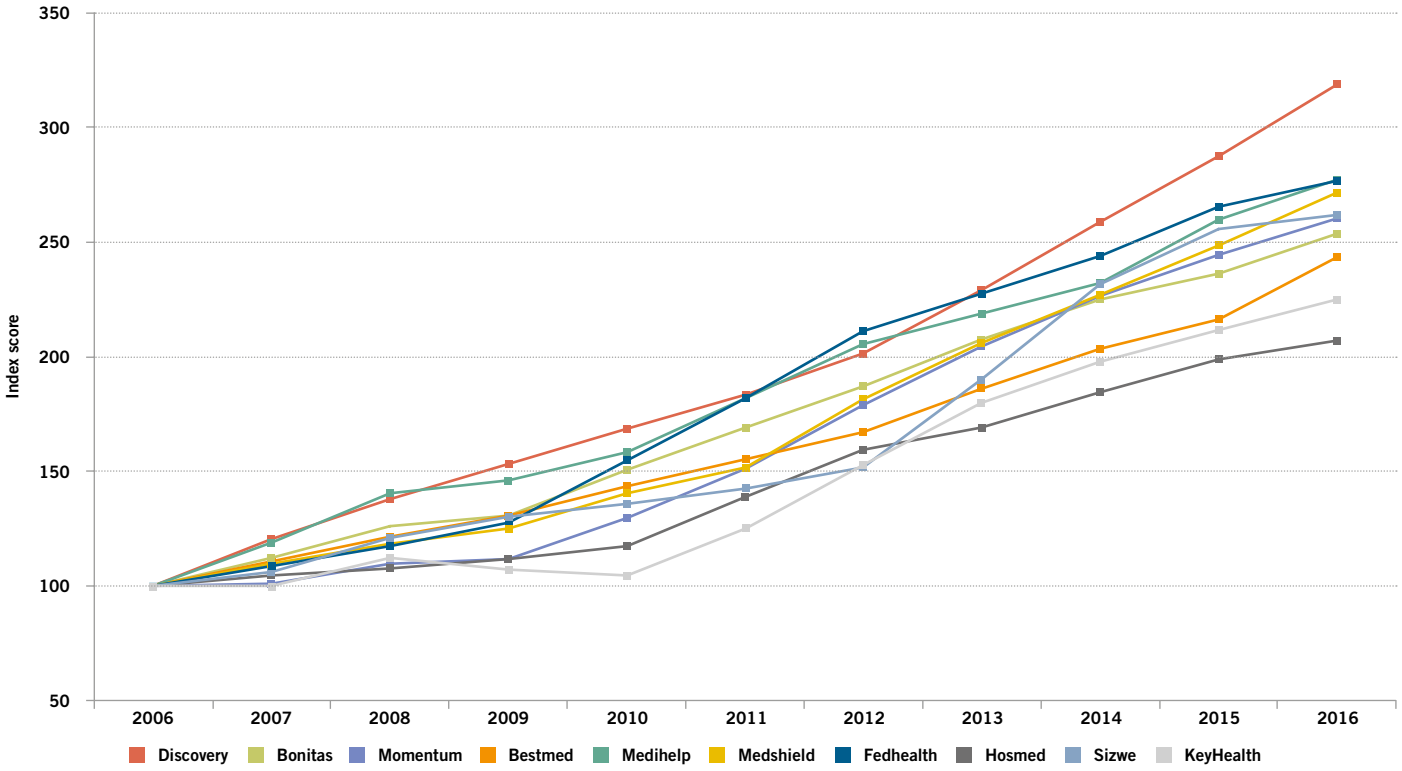
The notable improvement in Transmed's score was driven by a marked improvement in the financial performance and a significant improvement in the solvency ratio, from 14.1% to 20.8% in just one year.

Despite incurring an operating deficit, Profmed reflected a material increase in the accumulated funds and solvency ratio over the year, and continued to increase its membership base with a marginal increase in the average age of beneficiaries.

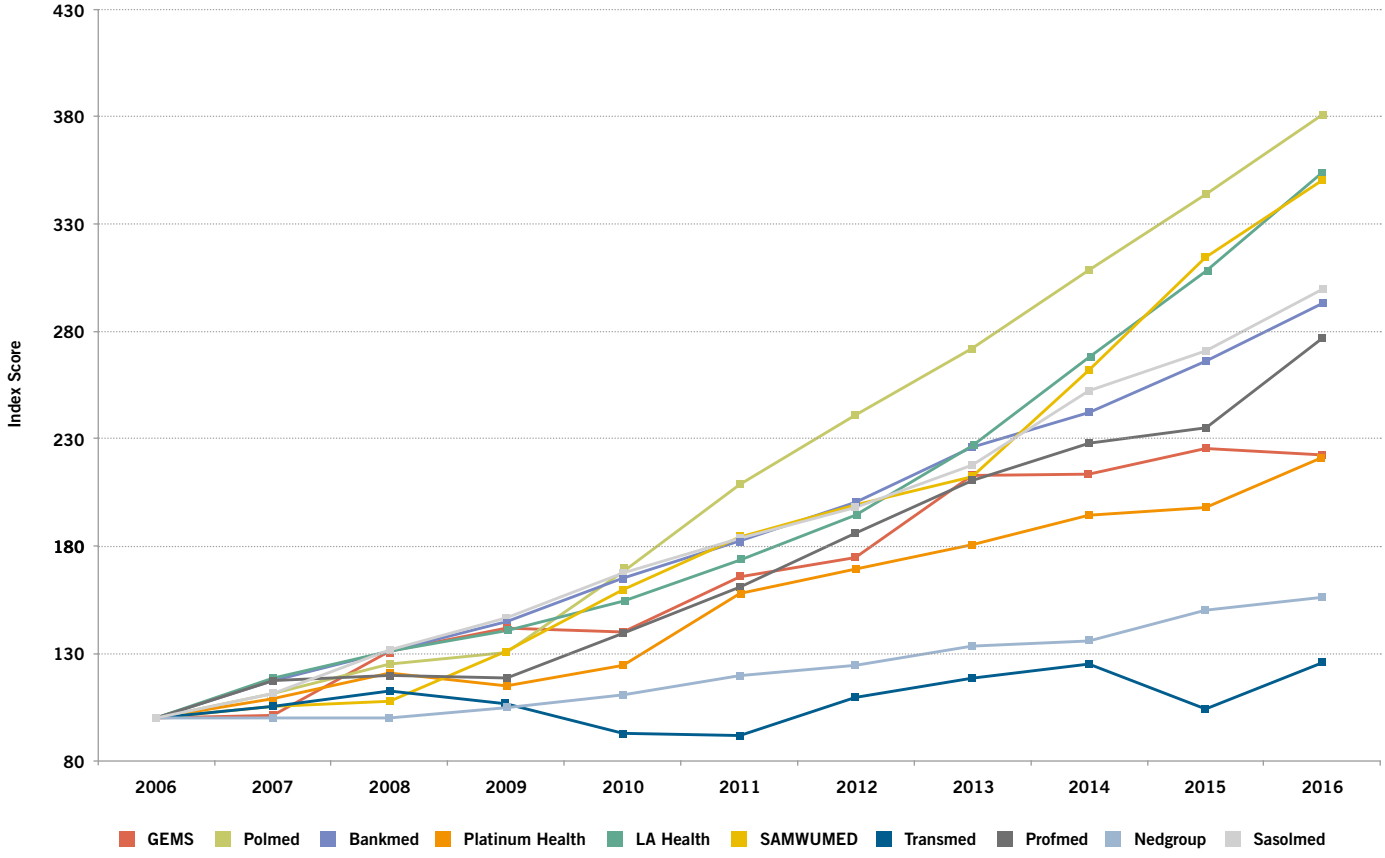
GEMS experienced a decline in its index value in 2016. The scheme incurred deficits at both operating and net levels in 2016, which resulted in a material decline in the solvency level to 7.0%, which is substantially below the minimum statutory level of 25%.

Polmed is still the top performer in the index over the 10-year period considered, although it was not the top performer for 2016. The scheme achieved a fair operating deficit for 2016, still increased its level of reserves, and maintained a solvency level above 50.0%, which is significantly above the minimum of 25%.

Open schemes index trends



Restricted schemes index trends



4

CONCLUSION

From the analysis, the following key observations can be made:

- The number of medical schemes reduced to 82 in 2016. One amalgamation took place in 2016, with LMS Medical Fund (previously Liberty Medical Scheme) amalgamating with Bonitas Medical Fund with effect from 1 October 2016.
- The number of principal members increased marginally by 1.0% from 2015 to 2016, compared to growth of 0.8% from 2014 to 2015. Principal members at the end of 2016 totalled 3 992 102 (2015: 3 950 927).
- The average age of beneficiaries increased slightly to 32.5 years at the end of 2016 (2015: 32.3 years), with the pensioner ratio increasing slightly to 7.9% (2015: 7.7%).
- Family size has continued to decrease. At 31 December 2016 the average family size was 2.22 compared to 2.23 at the end of 2015.
- The risk claims ratio for all schemes increased from 91.4% in 2015 to 92.1% in 2016.
- Total non-healthcare expenditure as a percentage of gross contribution income increased marginally from 8.58% in 2015 to 8.61% in 2016.
- A total of 28 of 82 schemes (34.1%) achieved an operating surplus in 2016. By comparison, 41.0% (34 of 83) of schemes achieved an operating surplus in 2015.
- In 2016 most scheme assets were held as cash, either in bank accounts or via money market instruments.
- The average solvency for all schemes decreased slightly from 32.6% at the end of 2015 to 31.6% at 31 December 2016.

Overall, the profile of the industry remained fairly stable and the financial position is sound despite a third consecutive year of losses for many schemes.

The year 2018 may hold some challenges as the industry is faced with consolidation measures in the build-up to the full implementation of NHI. We look forward to the recommendations of the Competition Commission's Health Market Inquiry to assist with controlling both costs and contributions in the industry.

ALEXANDER FORBES HEALTH

Technical and Actuarial Consulting Solutions (TACS) is a professional independent actuarial and consulting team within Alexander Forbes Health (Pty) Ltd. The Alexander Forbes Health team has been delivering innovative and customised healthcare solutions to corporate clients, medical schemes and individuals since 1991.

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Sources

Council for Medical Schemes Annual Reports (2000 to 2016)
Audited annual financial statements of medical schemes

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Produced by Alexander Forbes Communications
Photos: Gallo Images

13789-2017-11