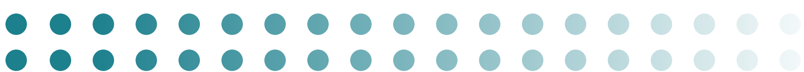
Medical aid insights

2024/2025

An analysis of key trends in the medical schemes industry from 2005 to 2024



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Introduction

The Technical and Actuarial Consulting Solutions team at Alexforbes is proud to present this year's Medical Aid Insights.

We are confident that 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 that the industry is facing.

This analysis covers key statistics and trends over the 20-year period from 2005 to 2024, based on the consolidated financial results for all registered medical schemes as disclosed in the annual report released by the Council for Medical Schemes (CMS). Our focus is on the 10 largest open and the 10 largest restricted medical schemes by principal membership. The results pertaining to Sizwe Hosmed Medical Scheme were omitted from the CMS industry report due to the unavailability of the final audited annual financial statements at the time of compilation. As a result, they have also been excluded from the analyses contained in this report for 2024. All illustrations containing historical results include Sizwe Hosmed Medical Scheme for the years 2005 to 2023. All comparisons made between 2023 and 2024 results exclude Sizwe Hosmed Medical Scheme for consistent evaluation.

The number of beneficiaries covered by medical schemes has remained relatively stable over the past decade, surpassing the 9.0 million mark with effect from 31 December 2022. Between 31 December 2023 and 31 December 2024, beneficiaries in open schemes declined by 1.2%, while beneficiaries in restricted schemes increased by 2.4%, resulting in a net increase in scheme beneficiaries of 0.6%.

Five open medical schemes experienced an increase in beneficiaries, of which the highest increase was 4.4%. Suremed Health recorded the largest year-on-year decrease in beneficiaries among open schemes of 32.8%. During the same period, six restricted schemes experienced beneficiary growth above 5%, namely LA Health Medical Scheme (7%), Umvuzo Health Medical Scheme (5%), Retail Medical Scheme (5%), Foodmed Medical Scheme (5%), Alliance-Midmed Medical Scheme (6%) and Government Employees Medical Scheme (5%).

If you would like to discuss any of the issues addressed here in more detail, please speak to your Alexforbes consultant or contact one of the specialists listed at the end of this publication.

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Key industry updates

LCBO and Demarcation Framework Developments (2019–2025)

Initial decision and stakeholder engagement

In December 2019, the CMS announced that products under the Demarcation Exemption Framework would no longer be permitted beyond March 2021. This decision prompted appeals and stakeholder discussions in January and February 2020, leading to the establishment of advisory committees to develop a revised framework.

Framework extensions

In January 2022, the CMS extended the Demarcation Exemption Framework to March 2024, conditional on compliance with defined exemption criteria. This was further extended to March 2025 via Circular 16 of 2024, and again to 31 March 2027 through Circular 9 of 2025, maintaining the same compliance conditions for insurers and financial services providers.

Development of LCBO guidelines

In September 2022, the CMS issued Circular 53, inviting public comment on the Draft LCBO Framework Report and Risk Assessment Report, with the deadline extended to 30 November 2022. By March 2023, the CMS was finalising the LCBO guidelines for submission to the Minister of Health. In February 2025, the CMS issued a further call for public comment on the LCBO Report, which included recommendations and concerns about LCBO alignment with the National Health Insurance (NHI).

Circular 9 of 2025 – Renewal Framework

This circular provides an update on the Demarcation Exemption Renewal Framework, specifically for insurers conducting medical scheme business, reinforcing the regulatory expectations and timelines.

Medical Scheme Levies

Circulars 45 of 2023 and 34 of 2024:
Approved levies for medical schemes 2024/2025

As per Circular 45 of 2023, the proposed levy for the 2024/2025 financial year was R48.62 per member per year. The approved levy with effect from 1 April 2024 was R48.58 according to Circular 34 of 2024 and as published in Government Gazette 50986.

Circulars 46 of 2024 and 21 of 2025:
Approved levies for medical schemes 2025/2026

As per Circular 46 of 2024, the proposed levy for the 2025/2026 financial year was R51.49 per member per year. This levy was approved with effect from 1 April 2025 according to Circular 21 of 2025 and as published in Government Gazette 52937.

Circular 38 of 2025:
Proposed levies for medical schemes 2026/2027

As per Circular 38 of 2025, the proposed levy for the 2026/2027 financial year was R54.66 per member per year. This levy has not yet been approved at the time of this publication.

Broker Fees

Circular 2 of 2024:
Adjustment on fees payable to brokers with effect from 1 January 2024

The maximum amount payable to brokers in terms of Section 65 of the Medical Schemes Act 131 of 1998 was set to R116.74 plus value added tax (VAT) or 3% plus VAT of the contributions payable in respect of that member, whichever is the lesser.

Circular 2 of 2025:
Adjustment on fees payable to brokers with effect from 1 January 2025

The maximum amount payable to brokers in terms of Section 65 of the Medical Schemes Act 131 of 1998 was set to R121.84 plus VAT or 3% plus VAT of the contributions payable in respect of that member, whichever is the lesser.

Circular 2 of 2026:
Adjustment on fees payable to brokers with effect from 1 January 2026

The maximum amount payable to brokers in terms of Section 65 of the Medical Schemes Act 131 of 1998 was set to R125.86 plus VAT or 3% plus VAT of the contributions payable in respect of that member, whichever is the lesser.

Prescribed Minimum Benefit (PMB)

Circular 17 and 33 of 2023:

Revision and development of PMB definition guidelines for mental health, ulcerative colitis and Crohn's disease.

The CMS has commenced the process to revise PMB definition guidelines in respect of mental health, and to develop PMB definition guidelines for inflammatory bowel disease (ulcerative colitis and Crohn's disease). These guidelines allow medical schemes to interpret the PMB provisions to ensure that claims are paid in accordance with the Regulations to the Medical Schemes Act.

Circular 15 of 2023:

Update on the review of the Prescribed Minimum Benefits

The CMS has updated stakeholders on the updated review of the Prescribed Minimum Benefits to which all medical scheme beneficiaries are entitled. They confirmed that the review currently underway includes a greater focus on a primary healthcare service package.

IFRS 17 accounting disclosures

With effect from 1 January 2023, the IFRS 17 accounting standard was implemented for all insurance contract providers, which includes medical schemes. This had several implications for medical schemes' financial results. The additional requirements include the need to recognise non-healthcare expenses as directly attributable and non-directly attributable expenses. Directly attributable expenses are then recognised alongside healthcare expenses as part of insurance service expenses, while non-directly attributable expenses are recognised as part of other operating expenses. Additional risk margins on some of the liabilities are required to be disclosed. A scheme's net results are disclosed as amounts attributable to future members as part of the scheme's insurance service result.

Circular 41 of 2023:
The CMS engaged with the industry on the format of the accounting disclosures of medical schemes under IFRS 17.

Circular 12 of 2024:
Requirements for Annual Financial Statements and ASR for 2023.

Circular 22 of 2025:
Introduced Audit Quality Indicators for financial statement audits.

Circular 43 of 2023:
Industry feedback requested on Annual Statutory Return (ASR) specifications.

Circular 13 of 2025:
Deadlines and indicators for monthly submissions aligned with IFRS 17.

Circulars 28 and 45 of 2025:
Revised the SAICA Medical Schemes Accounting Guide.

Scheme developments

Sizwe Hosmed Medical Scheme

- The scheme experienced a significant deterioration in solvency ratio, from 25.59% in 2022 to 15.73% in 2023.
- The CMS placed the scheme under statutory management in terms of section 5A of the Financial Institutions (Protection of Funds) Act with effect from 31 July 2024.

Medshield Medical Scheme and Fedhealth Medical Scheme

- An exposition document was submitted to the CMS on 23 June 2025 in respect of a proposed amalgamation between Medshield Medical Scheme and Fedhealth Medical Scheme.
- This exposition was subsequently retracted, as stated in Circular 39 of 2025, following an updated financial assessment of the amalgamation.

Lonmin Medical Scheme and Sisonke Health Medical Scheme

- As stated in Circular 8 of 2025, the amalgamation between Sisonke Health Medical Scheme and Lonmin Medical Scheme was confirmed with effect from 1 April 2025.

National Health Insurance Bill

The National Health Insurance Bill (now known as the Act), was signed into law on 15 May 2024. The Act outlines the establishment of a National Health Insurance Fund responsible for implementing and governing NHI. This Fund is a financing mechanism, focusing on strategic purchasing of healthcare services from accredited providers on behalf of users.

The NHI Fund's role encompasses deciding which health services to purchase based on health needs, negotiating prices and service levels with providers, and utilising alternative reimbursement mechanisms like diagnostic-related groupers (DRGs) and capitation fees. It is intended to operate with autonomy but remains under the direct control of the National Department of Health (NDoH) and the Minister of Health.

The NDoH proposed the elimination of tax credits for individuals with medical aid, with the intention of allocating the corresponding funds to the NHI Fund. This envisioned transition will substantially impact individuals' monthly disposable income, impacting essential expenses such as food, utilities and debt service obligations. This change would have the most pronounced effects on middle class South Africans, who are already grappling with challenges including elevated unemployment rates and soaring living costs. There is currently no indication of when the medical aid tax credits will be phased out or eliminated. The 2026 Budget was tabled on 25 February 2026, during which it was confirmed that medical aid tax credits would be retained and increased in line with inflation.

In 2023, Discovery Health (Pty) Ltd made a submission on the Bill highlighting the following:

- The Bill could have adverse effects on service delivery and the employees of provincial health departments.
- Limiting the role of medical schemes may increase the burden to the state, leading to increasing catastrophic out-of-pocket healthcare expenditure across the system, a loss of healthcare professionals from the country, damage to the private healthcare sector as well as tarnished investor confidence.

On 6 March 2025, the Minister of Health published draft regulations in preparation for the promulgation of the NHI Act. Focusing on Section 55 of the Act, the draft regulations detail the governance structure and appointment processes of the NHI Fund.

Medical schemes in their current form will remain until such time as the Act has been clearly defined and set into practice, with no detail of such date currently communicated. The promulgation of the Act is expected to experience significant delays as a result of legal challenges. To date, several organisations have filed applications to legally challenge the Act, including Solidarity, SA Private Practitioners Forum, South African Medical Association, the Board of Healthcare Funders, the Health Funders Association, Sakeliga, the Western Cape Provincial Government and the Hospital Association of South Africa.

Several of these organisations launched a direct legal challenge to the Constitutional Court, seeking to have the NHI Act declared unconstitutional and invalid, with the argument that Parliament failed to conduct a proper public consultation process before passing the legislation.

Nine High Court legal cases challenging the Act have been placed on hold pending the Constitutional Court's review of public participation challenges. The Constitutional Court's review took place over the period 5 to 7 May 2026.

As part of the 2025 and 2026 Budget reviews, the NDoH allocated funds for the strengthening of the health system and the preparation of the NHI policy, including a patient information system and medicine distribution systems.

Private healthcare cost regulations

On 14 February 2025, the Minister of Trade, Industry and Competition gazetted exemptions to competition law, allowing industry stakeholders to collectively determine healthcare service tariffs, standardised diagnosis, procedure, medical device and treatment codes, as well as quality measurements, formularies and treatment protocols. These regulations are in response to the recommendations of the Competition Commission's Health Market Inquiry and aim to introduce transparency in healthcare pricing, reduce unforeseen co-payments and eliminate exploitative billing practices.

Industry stakeholders were invited to submit comments on the proposed regulations. Several stakeholders have raised concerns on the impact of these regulations, including the impact of government control over pricing and the opportunity for providers to offset lower tariffs through higher service volumes, driving up overall healthcare costs.

Section 59 report findings
released April 2025

Background

The investigation was initiated under the Medical Schemes Act (131 of 1998) to probe allegations of unfair racial discrimination and procedural unfairness by medical schemes in South Africa. The inquiry focused on how fraud, waste, abuse and error (FWAE) systems were used to target healthcare providers.

Key findings

Systemic Racial Discrimination:
The report found that black healthcare providers were disproportionately flagged and penalised by FWAE systems. Black providers were 1.5 to 3.5 times more likely to be found guilty of FWAE compared to non-black counterparts. In some disciplines (e.g., physiotherapy, psychology and social work), the disparity was even more severe with some disciplines up to 12 times more likely.

Algorithmic Bias:
Medical schemes often relied on neutral software or whistle-blower tips, but the outcomes still showed racial bias. The panel criticised the schemes' reliance on flawed data and algorithms that failed to account for confounding factors.

Statistical Errors:
The report highlighted mathematical errors in the schemes' risk ratio calculations and questioned the validity of their internal assessments.

Panel Response

The panel, led by Adv. Tembeka Ngcukaitobi SC, Adv. Adila Hassim SC, and Adv. Kerry Williams, rejected the schemes' defences and emphasised the need for systemic reform.

They recommended ongoing monitoring by the CMS to prevent future discriminatory practices.

Political and Legal Reactions

Parliament's Portfolio Committee on Health welcomed the findings and is engaging with the Minister of Health to ensure accountability. Complaints have been lodged against major schemes and administrators like Discovery, Government Employees Medical Scheme (GEMS), and Medscheme.

In March 2026, the CMS released Circular 10, which sets out immediate regulatory expectations and industry obligations for medical schemes. These include ceasing discriminatory practices included in FWAE, audit, recovery and payment processes and avoiding unreasonable clawbacks from healthcare providers.

The circular also sets out transitional measures pending the development and adoption of a Universal Code of Conduct. These measures include CMS inspections, mandatory data submission to the CMS on FWAE processes and enhanced transparency and record keeping by medical schemes. The Universal Code of Conduct will be a legally binding behavioural framework developed in consultation with industry stakeholders to address systemic issues in FWAE processes.

Performance indicators

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

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

Size and scale

Larger schemes tend to have a 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

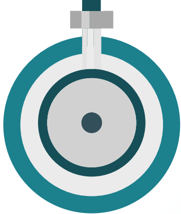
Claims experience will be more favourable for younger populations with lower chronic prevalence.

Financial results

The trend in a scheme's financial results illustrates the adequacy of their pricing.

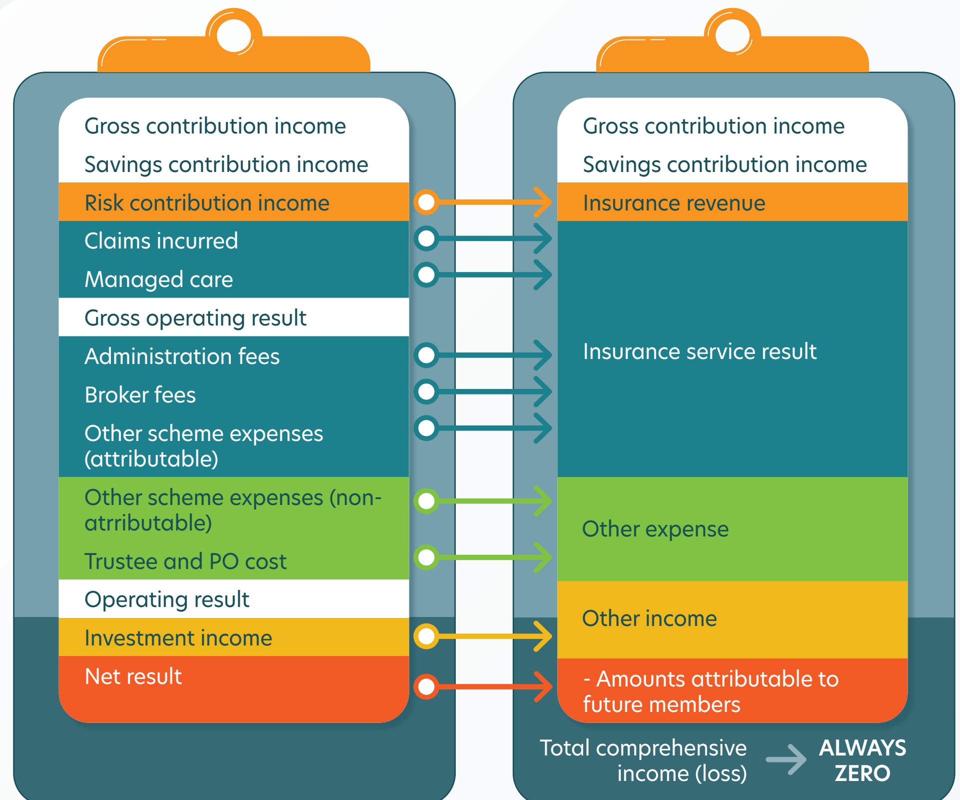
Solvency levels

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.

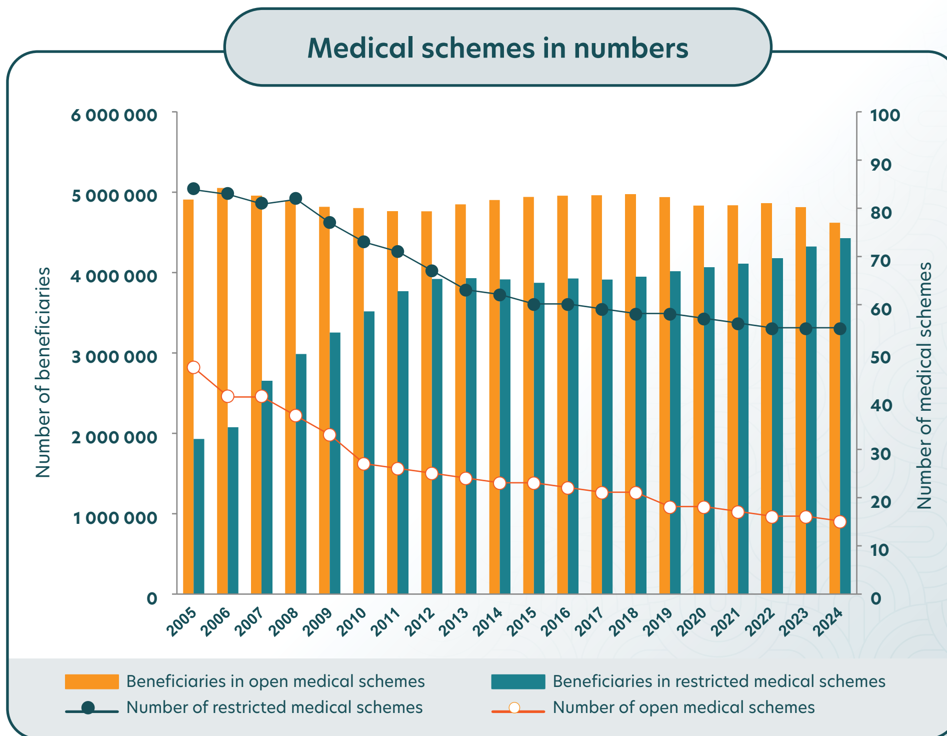


For consistency and ease of comparison with prior year results, the outcomes presented in this report are based on IFRS 4 (the previous accounting standard). Please refer to the illustration below for further clarity.

IFRS4 versus IFRS17 Illustrated



Size and scale



At the end of 2024, there were 71 registered medical schemes in South Africa (16 open and 55 restricted). This figure reduces to 70 when excluding Sizwe Hosmed. Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section. No changes are noted in the total number of medical schemes since December 2023.

From the end of 2005 to the end of 2024, the number of medical schemes reduced from 131 to 70, which represents a 46% decrease in the number of registered medical schemes over 20 years, mainly as a result of amalgamations among the smaller, less sustainable schemes.

The number of open medical schemes has decreased by 32 (68%), compared with a decrease of 29 (35%) restricted medical schemes over the 20-year period.

This consolidation appears to be driven in part by the:

- difficulty in maintaining the sustainability of small schemes in the current environment, particularly for restricted medical schemes
- significant amount of management time needed to manage an employer-based restricted scheme

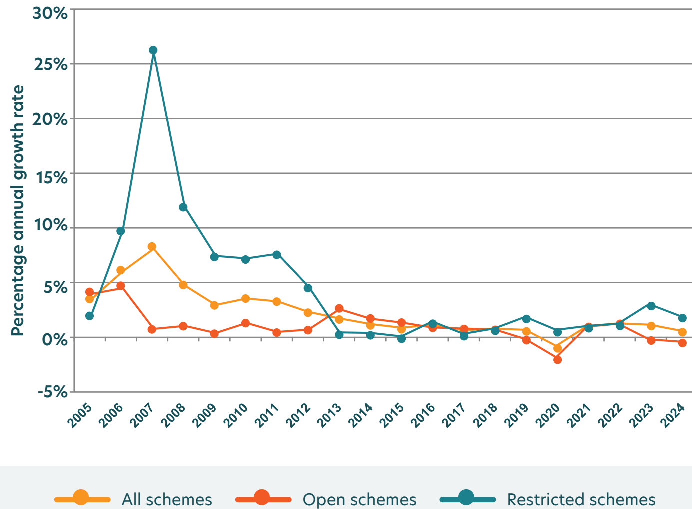
Despite reductions in the number of medical schemes, the industry has grown by 1.3 million principal members (46%) and 2.2 million beneficiaries (32%) since 2005. The 70 medical schemes operating in South Africa at the end of 2024 had a total of 4.11 million principal members and 9.04 million beneficiaries.

Over the past decade, the total number of beneficiaries covered by medical schemes has steadily increased, exceeding 9.0 million as at 31 December 2022 and in the years thereafter.

Between December 2023 and December 2024, no open medical schemes recorded a year-on-year increase in beneficiaries exceeding 5%. In contrast, six restricted schemes experienced beneficiary growth above 5% during the same period. These included the Alliance-Midmed (5.8%), Foodmed (5.1%), GEMS (5.2%), LA Health (6.7%), Retail Medical Scheme (5.3%), and Umvuzo (5.3%).

Between 2023 and 2024, total beneficiaries in open schemes declined by 1.2%, driven primarily by losses in Discovery, Medihelp and Fedhealth. In contrast, restricted schemes saw a 2.4% increase in beneficiaries, driven primarily by growth in GEMS, LA Health and Umvuzo. Overall, this resulted in a net increase of 0.6% in total scheme beneficiaries.

A total of 56.1% of principal members participated in open medical schemes at the end of 2024, with the balance of 43.9% participating in restricted medical schemes. This is compared to a total of 56.6% in open medical schemes and 43.4% in restricted medical schemes in 2023, indicating a slight shift in membership towards restricted schemes.



A notable divergence in the annual growth trends of open and restricted medical schemes began in 2006, coinciding with the registration of the first members on GEMS. This led to a sharp increase in restricted scheme membership in 2006 and 2007, largely driven by GEMS.

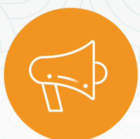
From 2013 to 2018, the growth rates of open and restricted schemes converged, before diverging (again) in 2019.

For open schemes, growth rates reduced significantly in 2020, followed by a significant rebound in 2021 and a marginal increase in 2022. Marginal reductions occurred in open scheme membership in 2023. For restricted schemes, growth rates marginally increased between 2020 and 2022, followed by a significant increase in 2023. In 2024, the growth rate reduced for open and restricted schemes.

Sizwe Hosmed membership in 2023 and 2024 was excluded when calculating the growth rate for 2024 in this graph. In 2024, principal membership in open schemes declined by 0.5%, while restricted schemes membership saw a 1.8% increase. This resulted in a net industry-wide membership growth of 0.5%, equating to 20 340 additional principal members.

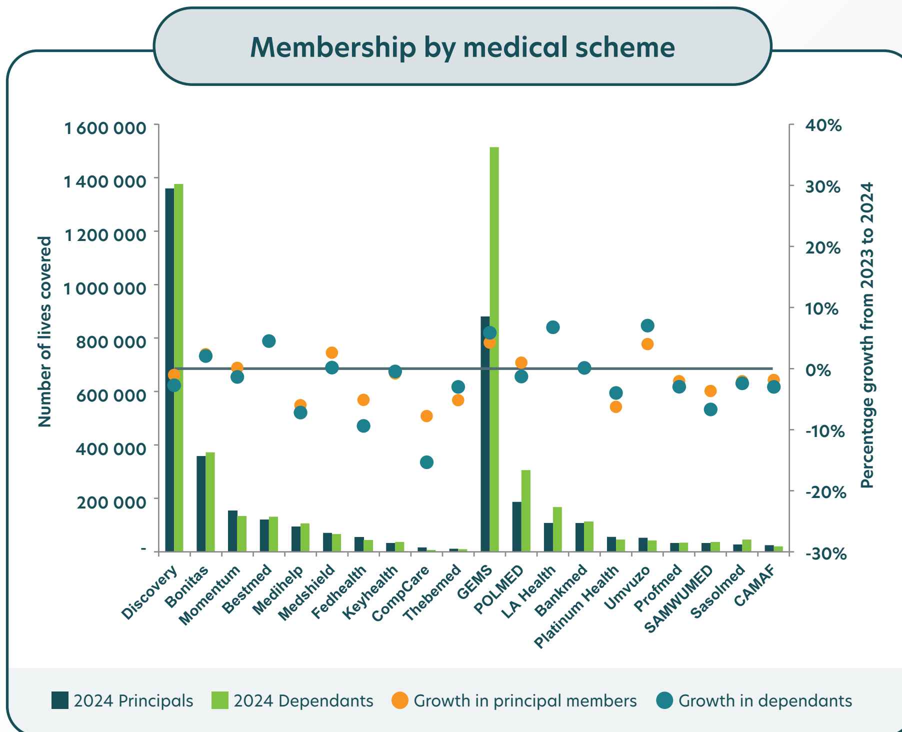
According to CMS regulations, a minimum of 6 000 principal members is required to register a new medical scheme. As at the end of 2024, 3 open schemes and 27 restricted schemes fell below this threshold. The open schemes with fewer than 6 000 principal members were: Cape Medical Plan (3 233), Makoti Medical Scheme (5 451) and Suremed Health (687).

A large membership base offers several advantages for medical schemes. It reduces claims volatility and enhances a scheme's or administrator's ability to negotiate more favourable reimbursement rates and service fees with healthcare providers. This, in turn, helps minimise out-of-pocket expenses such as shortfalls or co-payments for members using designated service providers. Conversely, schemes with smaller membership bases tend to experience more variable claims patterns, increasing the risk that contributions may not be appropriately set to cover all claims and expenses. This risk is further amplified by high-cost claims, particularly in the current environment where schemes are obligated to fully cover the cost of PMBs, regardless of the rates charged by providers.



Despite the challenges associated with small membership bases, a few restricted schemes have demonstrated strong performance. Of the **27 restricted schemes** with fewer than **6 000** principal members, six managed to achieve a surplus before investment income in 2024.

The graph below ranks the top 10 open schemes and top 10 restricted schemes according to the number of principal members as at 31 December 2024. This represents 92.3% of all principal members participating on a registered medical scheme, or 98.9% and 83.8% of open and restricted medical scheme membership, respectively.



In 2024, four open schemes and five restricted schemes included in this analysis recorded growth in membership, while the remaining schemes saw a decline.

Among the open medical schemes, Bestmed experienced the highest increase in principal membership, rising by 4.4%. In contrast, CompCare saw the largest decline, with a 7.8% drop in principal membership.

Among restricted medical schemes, LA Health achieved the highest growth in principal membership, rising by 6.6%, while Platinum Health saw the largest decline, with a 6.3% decrease.

In 2024, GEMS was the main driver of growth in overall beneficiaries in the industry, contributing 119 383 additional beneficiaries during the year.

Market share

Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section.

The industry recorded a net increase of 20 340 members during the 2024 financial year, largely driven by growth in the following schemes:

GEMS:
Contributed the largest increase, with 35 772 more members

Bonitas:
Added 8 212 members over the same period

LA Health:
Increased by 6 768 members

Bestmed:
Added 5 108 members

Umvuzo:
Grew by 2 045 members

In contrast, the following schemes recorded the largest decreases in members during the 2024 financial year:

Discovery:
Contributed the largest decrease, with 14 485 fewer members

Medihelp:
Decreased by 6 093 members

Platinum Health:
Decreased by 3 773 members

Medipos:
Decreased by 3 220 members

Fedhealth:
Decreased by 3 022 members

These gains and losses collectively accounted for the majority of the industry's overall membership growth.

From the top 10 open and top 10 restricted schemes considered, Momentum, Medshield, POLMED and Bankmed also experienced positive growth in membership.

Discovery's total market share, based on the number of principal members, has increased from 26.9% in 2006 to 33.1% at the end of 2024, compared with a decrease in market share for the rest of the open schemes from 43.4% in 2006 to 23.0% in 2024.

From the top 10 open and top 10 restricted schemes considered, the following schemes experienced an increase in market share by more than 0.5% between 2018 and 2024:

GEMS: Increased by **4.0%**

LA Health: Increased by **0.8%**

Bestmed: Increased by **0.6%**

Bonitas: Increased by **0.5%**

Umvuzo: Increased by **0.5%**

The decline in open medical scheme membership (excluding Discovery) can be attributed to two key factors:

1

Member migration to Discovery Health Medical Scheme:
A significant number of individuals have opted to leave their existing open medical schemes in favour of joining Discovery, driven by its perceived value offerings, brand strength and comprehensive benefits.

2

Shift of qualifying public sector employees to GEMS:
Since the inception of GEMS, many eligible public sector workers have transitioned from open schemes to GEMS, contributing to the overall reduction in open scheme membership.

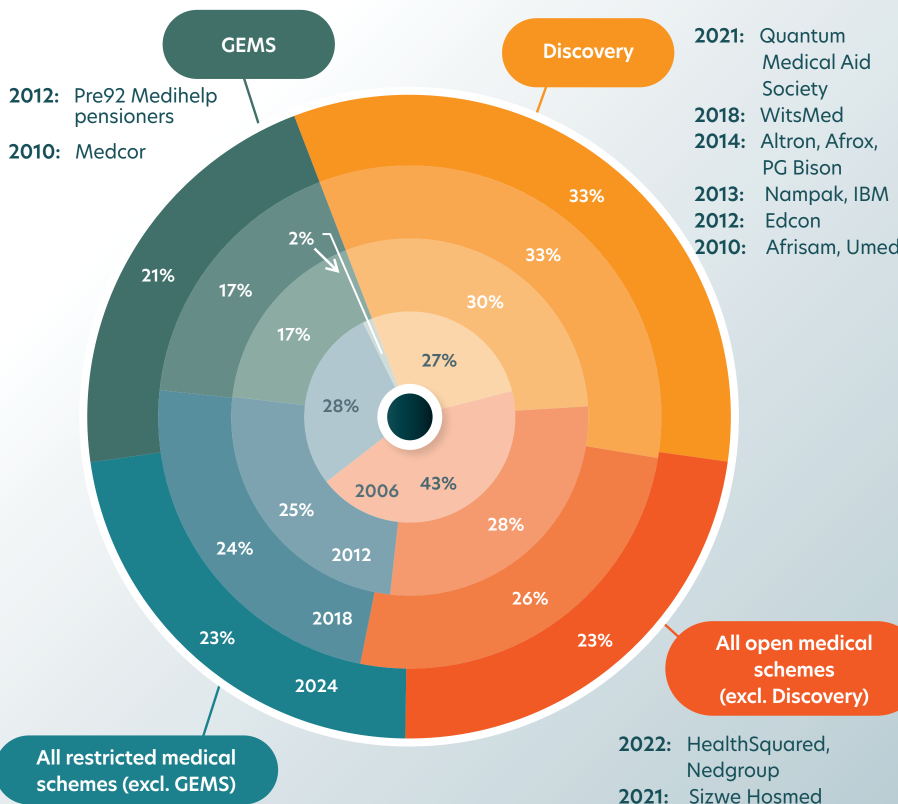
Between 2006 and 2024, GEMS experienced substantial growth in market share – from just 1.5% when its first members joined in 2006 to 21.4% by 2024. This rapid expansion in membership can be attributed to several key developments:

Migration of qualifying government employees:
A large number of public sector workers who were previously members of open medical schemes transitioned to GEMS, drawn by its tailored benefits and affordability.

Amalgamation with Medcor in 2010:
The integration of Medcor, a scheme previously serving certain government departments, significantly boosted GEMS' membership base and reinforced its position within the public sector.

Transfer of pensioners from Medihelp in 2012:
In early 2012, approximately 16 000 pensioners were moved from Medihelp to GEMS, further contributing to its growth and expanding its coverage among retired government employees.

Market share by principal membership



GEMS has historically experienced continued growth in new membership, largely driven by the appeal of a generous employer subsidy. This subsidy played a key role in increasing the scheme's market share. However, while member contributions to the scheme have risen by an average of 8.6% per annum since 2015, the employer subsidy has only increased by 7.3% annually over the same period. This widening gap between contribution growth and subsidy support may have contributed to a slowdown in membership growth, as affordability concerns become more pronounced for potential and existing members.

Membership profile

In this section, Sizwe Hosmed information for 2023 was included for the comparisons made between 2023 and 2024, as excluding Sizwe Hosmed did not have a significant impact on the 2023 results.

One of the most critical factors influencing a medical scheme's performance is the risk profile of its membership base. This profile is shaped by several key demographic indicators, including:

Average age of beneficiaries: Older populations typically incur higher healthcare costs, impacting claims experience and scheme sustainability.

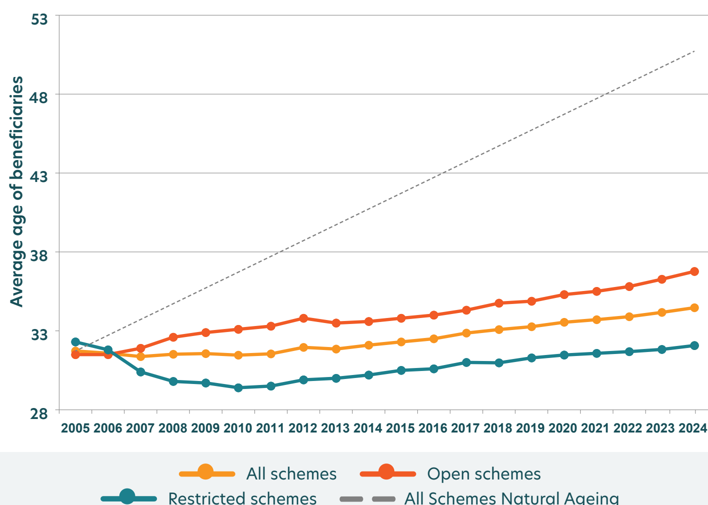
Pensioner ratio: Defined as the proportion of beneficiaries aged 65 and older, this metric reflects the ageing trend within the scheme.

Average family size: Larger families may lead to higher overall claims, depending on utilisation patterns and benefit design.

Let's examine the trends in each of these indicators to gain a deeper understanding of their impact on the schemes' performance over time.

Average age of beneficiaries

	2023	2024
All schemes	34.2	34.5
Open schemes	36.3	36.8
Restricted schemes	31.8	32.1

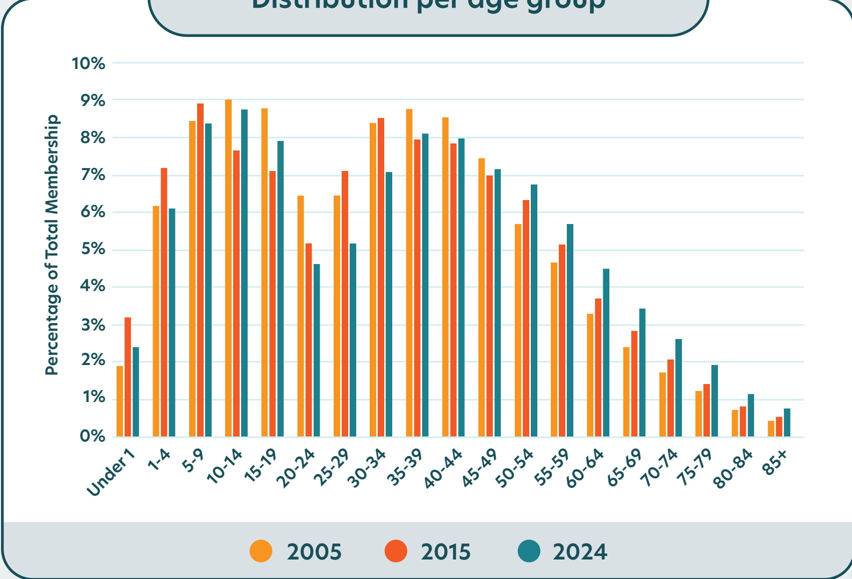


The average age of beneficiaries in the medical schemes industry remained relatively stable between 2005 and 2011. However, from 2012 onward, there has been a consistent upward trend, with notable increases observed in 2012 and since 2017. In 2024, the average age increased by 0.3 years for all schemes, with an increase of 0.5 years for open schemes and an increase of 0.3 years for restricted schemes.

In the case of restricted schemes, the average age of beneficiaries declined steadily from 2006 to 2010. This was largely driven by the rapid expansion of GEMS during its early years, as it attracted a substantial number of younger members. From 2011, the pace of growth in GEMS membership began to slow, leading to a reversal in this trend and a subsequent increase in the average age of beneficiaries within restricted schemes.

The grey line in the preceding graph represents natural ageing, which is the theoretical scenario in which the average age of beneficiaries increases by one year annually, assuming no membership turnover. This serves as a benchmark for expected ageing in a static population. In contrast, actual ageing within medical schemes has been significantly lower than this natural trajectory, highlighting the impact of membership churn and the ongoing addition of younger beneficiaries to the schemes.

As a scheme matures, it is expected that average claims per member will rise, with a commonly used benchmark indicating a 2% increase in claims for every one-year increase in average age. This relationship is typically illustrated by a claims curve, which is shown at the bottom of this page.



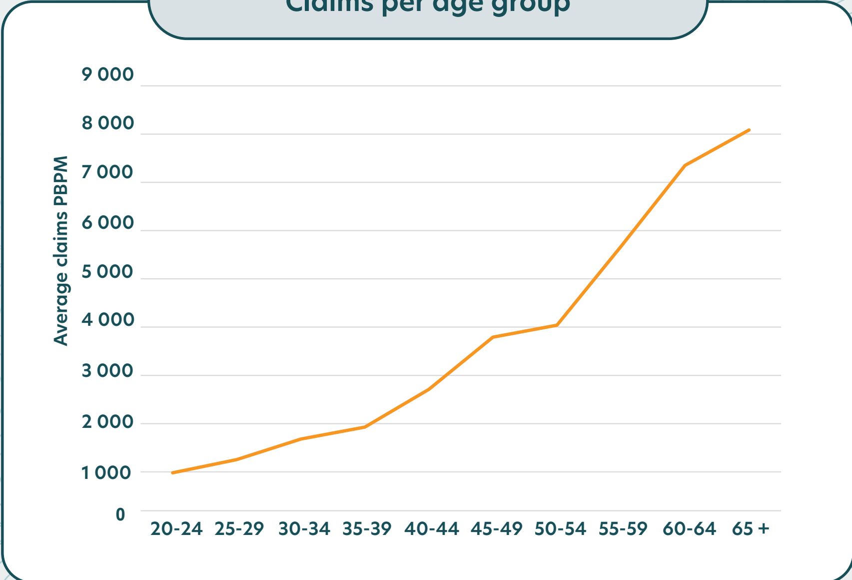
This graph shows the distribution of membership by age group for 2005, 2015 and 2024.

From 2005 to 2024, the age distribution of medical scheme members has shifted noticeably, with a declining proportion of younger working individuals seeking coverage.

The accompanying graph illustrates a clear ageing trend, with the proportion of beneficiaries aged 50 and older steadily increasing. Since healthcare claims typically rise with age, schemes must adopt proactive strategies to maintain affordability and ensure accessibility for younger members.

This graph presents an estimated claims curve, showing the estimated average per-beneficiary-per-month (PBPM) claims incurred by beneficiaries across different age groups.

The claims for each age group were estimated as the risk claims paid for all medical scheme options with an average age falling in the specified age group. A distinct pattern emerges - older beneficiaries incur higher average claims.



Typical medical needs over a member's lifetime

Young and single

Hospital cover

Limited or no day-to-day cover

Family with children

Hospital cover

Day-to-day cover

Maternity benefits

Limited chronic benefits

Middle aged

Hospital cover

Higher day-to-day cover

Chronic benefits

Retired or retiring

Hospital cover

Comprehensive day-to-day cover

Higher chronic benefits

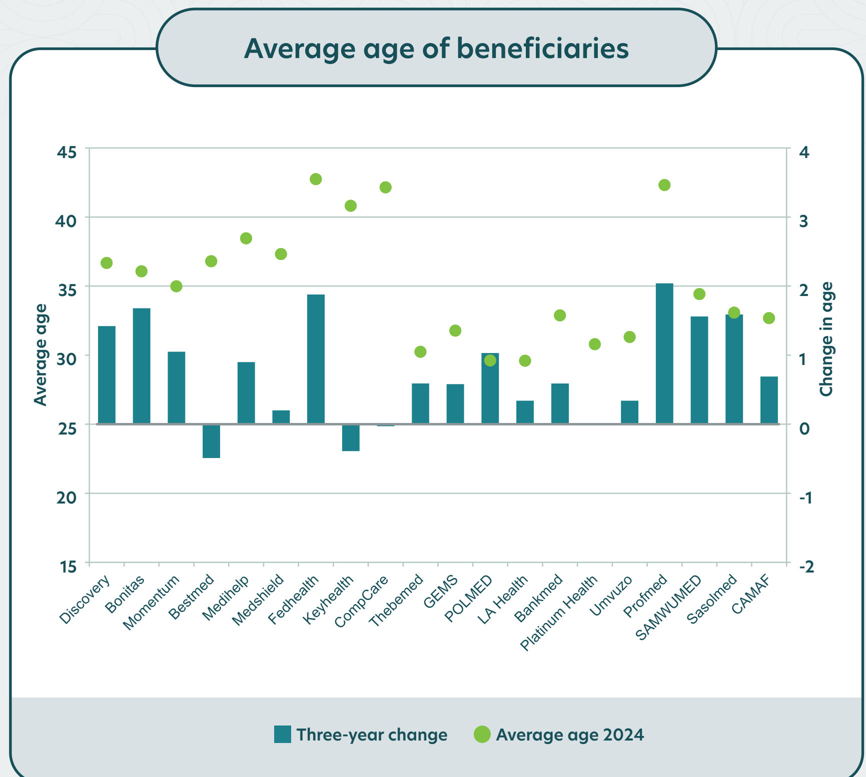
Cover for joint replacements and other age-related conditions

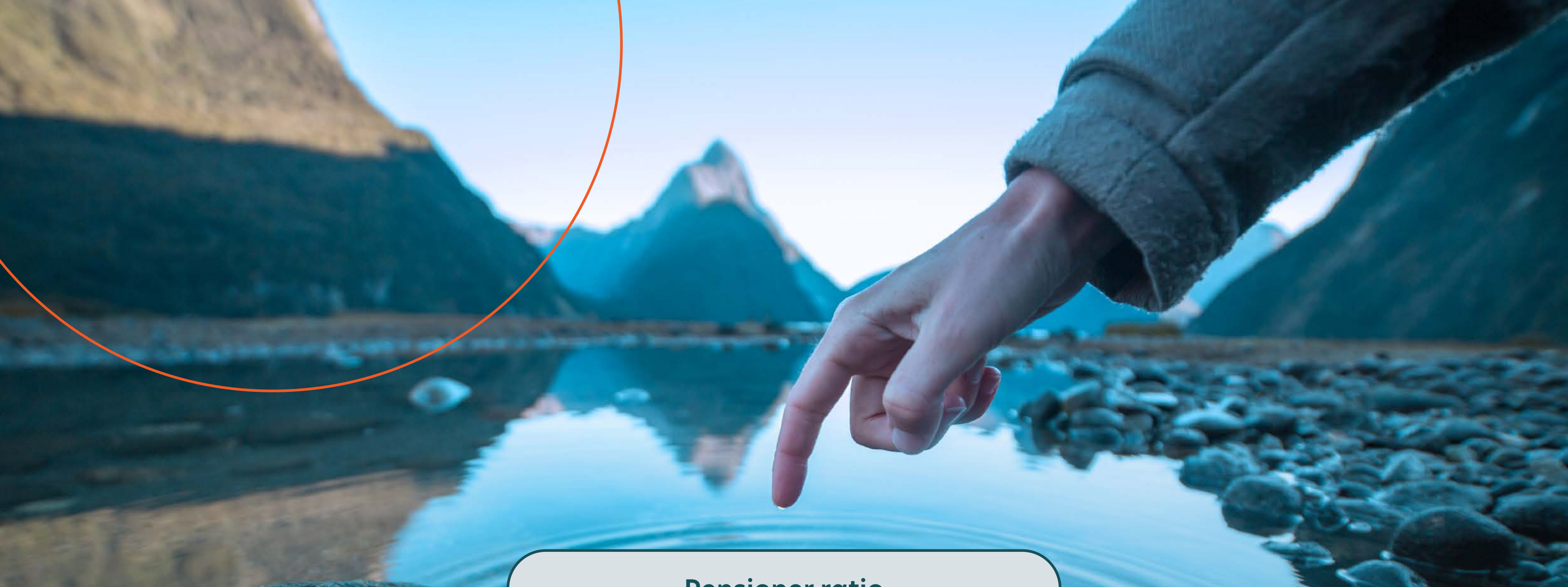
The following graph considers the average age of each of the 20 schemes included in this year's analysis. It also includes the change in the average age of each of the schemes from 31 December 2021 to 31 December 2024.

While the average age of a scheme's membership is a useful indicator of its expected claims experience, it is the change in this metric over time that signals a shift in the underlying risk profile. An upward trend in average age typically implies higher healthcare costs, prompting the scheme to consider adjustments to benefit pricing and benefit offerings to maintain financial sustainability.

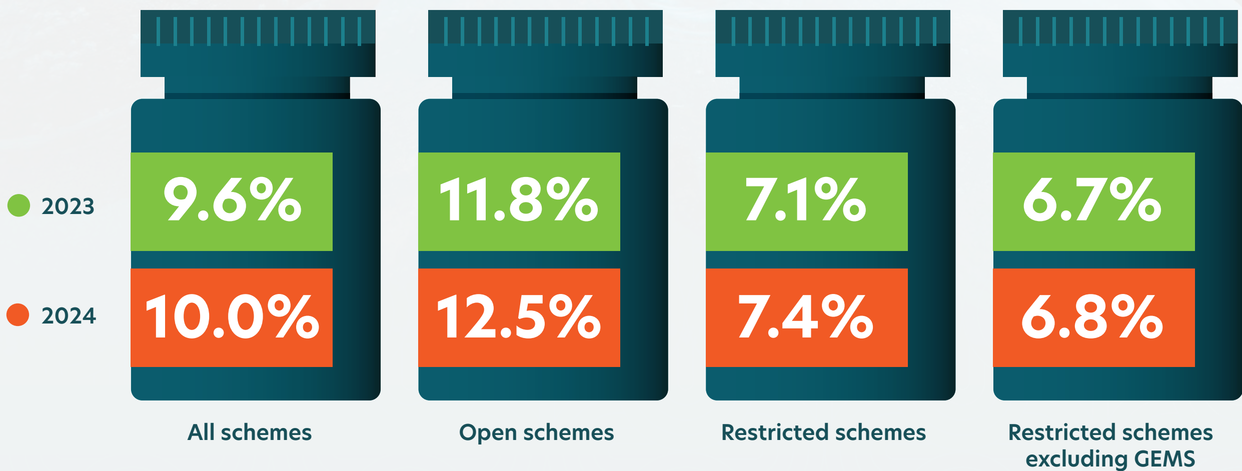
Among the 20 schemes featured in this year's Medical Aid Insights, Fedhealth and Profmed have the highest average beneficiary ages in the open and restricted scheme categories, respectively. Over the past three years, Profmed has experienced the most pronounced ageing, with its average age increasing by 2.0 years, while Bestmed recorded the largest decrease, with a drop of 0.5 years in average age. LA Health and POLMED continue to have the lowest average ages among all schemes reviewed.

Average age of beneficiaries





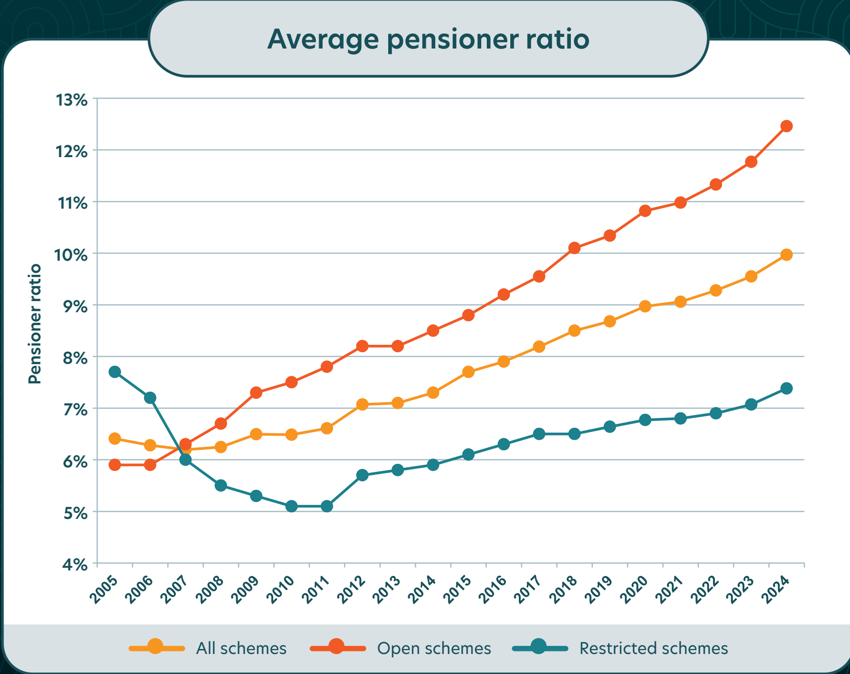
Pensioner ratio

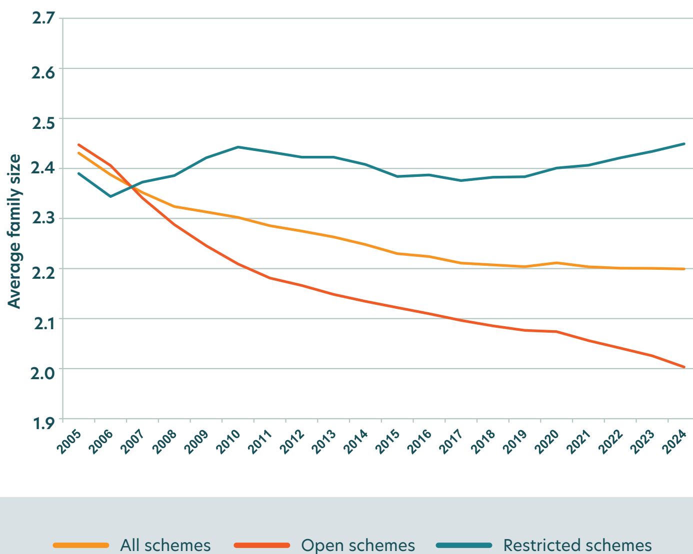


The average pensioner ratio across the medical schemes industry increased from 9.6% to 10.0% in 2024, reflecting the shift in the age distribution of the industry. Within this, restricted schemes saw an increase from 7.1% to 7.4%, while open schemes experienced a rise from 11.8% to 12.5% over the same period. The increase in the pensioner ratio is largely due to the increase in the ratio on GEMS (from 7.4% to 7.8%). Excluding GEMS, restricted schemes saw an increase from 6.7% to 6.8%.

This upward trend in pensioner ratios aligns with the broader increase in the industry's average age and highlights the growing proportion of older beneficiaries – an important consideration for scheme sustainability and pricing strategies.

Average pensioner ratio





Since 2005, the average family size in the medical schemes industry has generally declined, with a brief increase in 2020, followed by a slight decrease in 2021. From 2021 onwards, the average family size has stabilised at 2.2 beneficiaries per member.

However, this overall stability conceals divergent trends within the industry:

- Open schemes experienced a decline in average family size from 2.03 in 2023 to 2.00 in 2024
- Restricted schemes saw a modest increase from 2.43 in 2023 to 2.45 in 2024

One possible reason for a decline in average family size is that some members may no longer be able to afford medical cover for their entire family. This challenge becomes more pronounced when children lose eligibility for contribution subsidies, making continued coverage less affordable.

Additionally, as dependent children transition into self-supporting adulthood, they no longer qualify as dependants on their parents' medical scheme and instead become principal members themselves.

These dynamics influence average family size in two key ways

1. Removing dependants from a scheme reduces the average family size
2. New single-member enrolments also contribute to a lower average family size

Another factor that affects family size is dependant movements due to anti-selection. In some cases, dependants whose cover was previously removed may be re-added when they require medical attention again, such as during pregnancy. To manage this anti-selective behaviour, medical schemes often apply waiting periods before benefits become accessible.

Contributions

Medical schemes operate on the principle of risk pooling, where contributions are determined based on a combination of key financial factors:

- **Claims:** The projected healthcare costs of the entire membership base
- **Non-healthcare expenses (NHE):** Administrative and operational costs
- **Investment income:** Returns generated from the scheme's invested assets

Risk pooling is a fundamental principle in health insurance and medical schemes. It refers to the practice of **spreading financial risk across a large group** of members to make healthcare more affordable and predictable for everyone.

In essence, the financial sustainability of a medical scheme can be expressed through the following equation:

$$\text{Contributions} + \text{Investment Income} \geq \text{Claims} + \text{Expenses}$$

Risk contribution and investment income (industry)

The majority of schemes' income is received through contribution income. By ensuring that contribution and investment income exceeds claims and expenses, schemes ensure that they can meet their obligations while maintaining long-term viability.

If claims and expenses exceed contributions and investment income during a benefit year, the scheme will need to draw from its reserve funds to cover the shortfall.

Risk contribution income | Investment income

When a scheme's claims and expenses exceed contributions, investment income is used to cover the shortfall. Any surplus investment income is then added to the scheme's reserves to support or improve solvency levels.

As non-profit entities, medical schemes allocate any surplus to reserves to buffer against claims volatility. Due to the way solvency is defined, reserve levels must increase proportionally with contributions to maintain solvency.

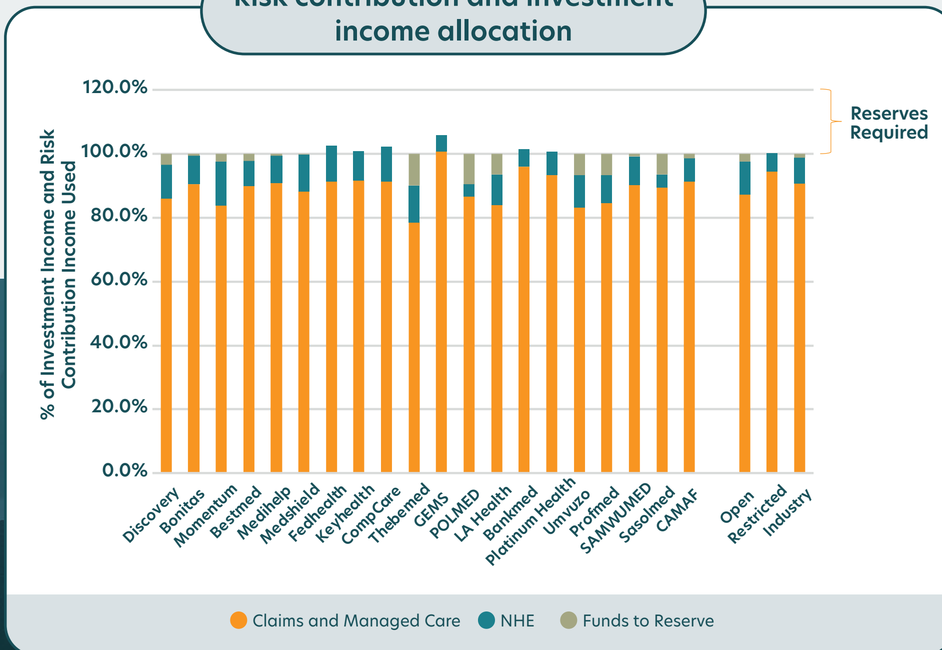
If investment income is insufficient to cover a shortfall, the scheme must draw from its existing reserves, which reduces solvency. Schemes may rely on investment income to meet rising claims costs and adverse claims experience.

Some schemes deliberately set contributions below required levels, using investment income to subsidise claims and expenses – especially those with reserves exceeding statutory requirements. However, this approach is unsustainable over time, as it leads to under-pricing and eventually necessitates larger contribution increases. It also erodes solvency.

Contribution increases should reflect the underlying cost trends. If claims remain stable, contributions must be set to cover expected future claims. A lower increase is only appropriate when there's a permanent reduction in claims, such as benefit option restructuring or lower hospital tariffs. Otherwise, deferring increases may lead to larger adjustments later. For example, if claims are temporarily low due to external factors (e.g., lockdowns), but expected to return to normal, a lower increase now could result in higher increases later unless claims behaviour permanently changes.

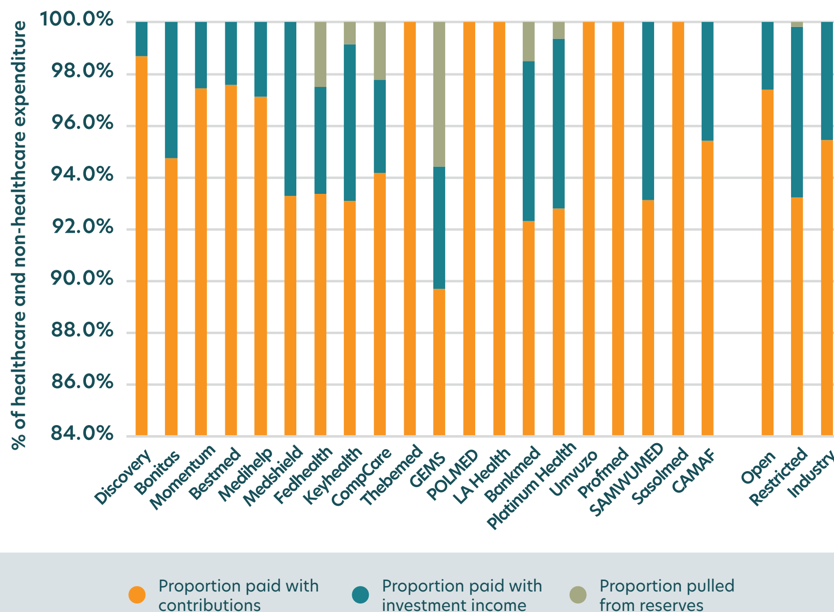
Due to reduced spending as a result of reduced accessibility of healthcare providers and limited elective procedures during COVID-19, some schemes implemented lower contribution increases or delayed them to return excess reserves to members. Contribution holidays have also been used for this purpose. Member affordability, especially in restricted schemes, significantly influences contribution decisions.

Risk contribution and investment income allocation



The accompanying graph compares how risk contributions and investment income in 2024 were used by the top 10 open and restricted schemes, as well as for the industry in total. Where claims and expenses exceed contribution and investment income, schemes have used reserves to fund the remaining claims and expenses, putting pressure on solvency. Where claims and expenses are lower than contribution and investment income, schemes were able to add funds to their reserves.

Payment of healthcare and non-healthcare expenditure



This chart shows the proportion of healthcare expenditure (claims and managed care expenses) and non-healthcare expenditure that was paid using contributions, investment income and existing reserves.

In 2024, 14 of the 20 schemes considered did not have sufficient contribution income to cover both their claims and non-healthcare expenses in full and therefore, used investment income and, in some cases, their reserves to subsidise the cost incurred. Of these 14 schemes, 6 schemes did not have sufficient investment income and, as a result, experienced a negative net result for the year.

Each component of the medical scheme pricing equation is considered in more detail in the sections that follow. To set the context, we begin by examining the inflationary trends that have shaped the industry over the past 20 years.

Inflationary trends

This section discusses the inflationary trends that have been experienced in the industry, taking into account consumer price index (CPI) inflation up to 31 December 2025 and medical scheme contribution inflation up to 1 January 2026.

The illustration below compares medical scheme contribution inflation, along with medical care and healthcare expense inflation trends, to CPI inflation over the past 20 years, where:

CPI inflation is the weighted average price inflation in different sectors and indicates the general level of price increases published by Statistics South Africa. Viewed in isolation, it does not necessarily give a true 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 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.

Medical scheme contribution inflation is calculated for a selected set of proxy 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.

20-year period average

6.7%	Registered medical scheme contribution inflation (proxy schemes)
5.7%	Medical care and health expenses inflation
5.3%	Rebased CPI inflation

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

The deviation from CPI is due to:

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

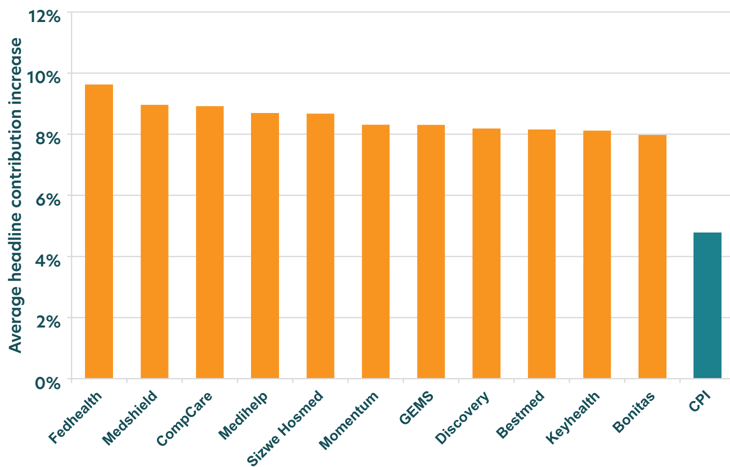
Over the last 20 years, CPI inflation has averaged 5.3%, while medical care and health expenses inflation has averaged 5.7%, resulting in a gap of 0.4% per year. Over the same period, average medical scheme contribution inflation was 6.7% per year, resulting in actual increases in medical scheme contributions exceeding CPI inflation by 1.4% per year, on average.

In previous years, the gap between medical scheme contribution inflation and CPI inflation narrowed, likely due to schemes actively managing provider costs. While cost management directly influences contribution increases, a reduction in the gap also reflects member behaviour, such as:

- Buy-downs to more affordable benefit options,
- New entrants joining low-income plans,
- Changes in family composition, including the removal of dependants due to affordability pressures.

In recent years, a widening of the gap has been experienced, with contribution increases significantly surpassing CPI inflation. This is largely a result of reduced CPI inflation experienced in recent years, along with continued increases in healthcare utilisation and associated contribution increases.

Average contribution increases 2016 to 2026



This illustration compares the average headline contribution increases since 2016 for medical schemes, for which data were available, with the average CPI. For simplicity, an arithmetic average was used. These increases reflect headline announcements, and calculation methods may vary across schemes. Nonetheless, the comparison offers valuable insight into the real contribution increases experienced by members.

Bonitas recorded the lowest average contribution increase over the period, largely due to relatively low increases between 2021 and 2024. Sizwe Hosmed implemented significantly higher increases than other open schemes in 2025 and 2026 of 13.7% and 19.2%, respectively, following lower-than-average increases implemented in prior years.

For the open schemes in the graph above, average contribution increases for 2021 and 2022 were approximately 5.2% and 5.3%, respectively. The onset of COVID-19 led to a significant drop in claims experience, prompting schemes to implement lower or delayed contribution increases and, in some cases, contribution holidays for the 2021 and 2022 benefit years.

The gap between medical scheme contribution inflation and CPI inflation widened in 2025 and 2026. In 2025, contribution increases across these open medical schemes ranged from 9.3% to 13.7%, reflecting heightened claims costs and utilisation across the industry compared to prior years.

For 2026, contribution increases among the same schemes ranged from 7.2% to 19.2%. Sizwe Hosmed's increase was significantly higher than other open schemes, with Momentum implementing the second highest increase among the observed schemes of 9.9%. Although slightly more contained than in 2025, these increases remain significantly higher than CPI inflation.

Healthcare expenditure

Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section. Therefore, the 2023 figures stated in the comparisons do not match the results in the graphs, as Sizwe Hosmed's experience has been included in the graphs up to 2023.

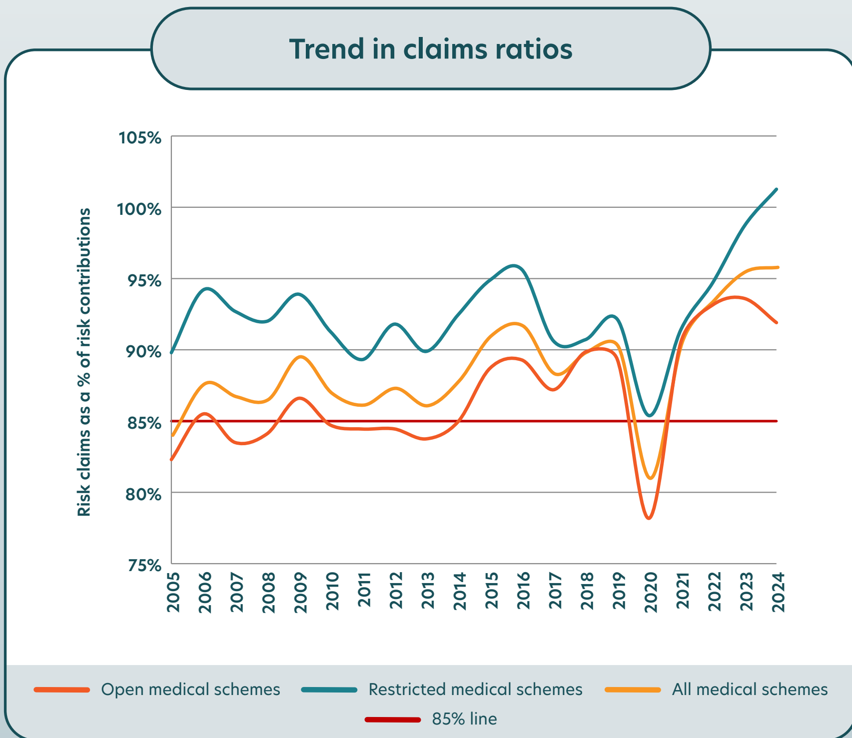
One of the key factors influencing the performance of a medical scheme is its healthcare expenditure, particularly its claims experience. This section examines both the claims ratio and the actual value of claims paid by schemes.

Healthcare expenditure refers to all payments made for claims incurred by members. The risk claims ratio is defined as the proportion of risk claims to risk contributions, excluding any allocations relating to medical savings accounts. It reflects how much of the contributions are used to fund members' healthcare costs.

The overall risk claims ratio in 2023 was 95.8% for all medical schemes, which rose to 96.2% in 2024. In 2024, restricted schemes experienced a significantly higher ratio of 101.3%, while open schemes experienced a lower ratio of 91.9%.

Restricted schemes typically do not incur certain non-healthcare expenses such as marketing, distribution and broker fees. This allows them to allocate a greater share of contributions directly to claims, resulting in higher claims ratios compared to open schemes. This trend was consistent for the period analysed, apart from 2018 and 2021, when claims ratios between scheme types were relatively similar. The lowest claims ratio over the past 20 years occurred in 2020, largely due to the impact of the COVID-19 pandemic, which significantly reduced healthcare utilisation.

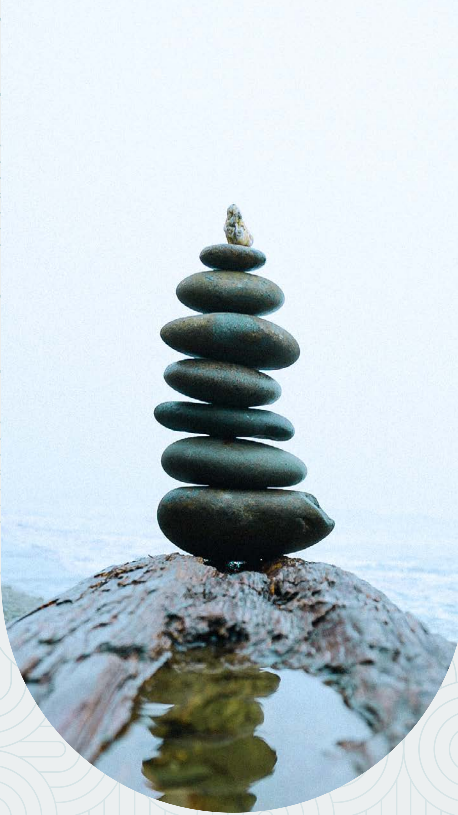
The graph below also reveals a cyclical trend, likely driven by the lag effect of annual pricing adjustments by medical schemes. When a scheme experiences adverse claims in a given year, it typically responds by increasing contributions or reducing benefits in the following year. These actions help to lower relative claims. These corrective measures often span multiple years, contributing to the observed cycle.



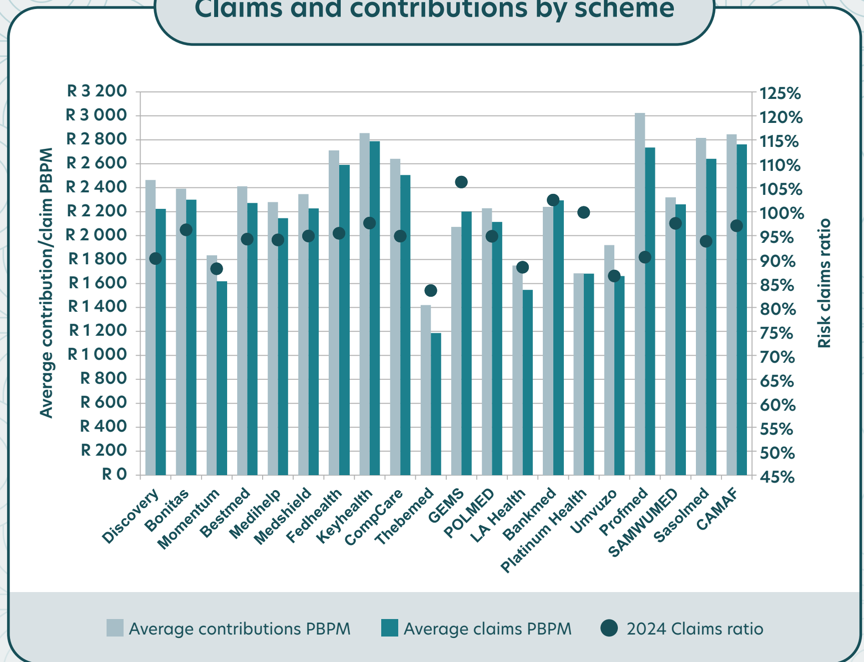
A notable spike in the claims ratio between 2014 and 2015 can be attributed, in part, to the inclusion of managed care fees in healthcare expenditure from 2015 onwards.

Claims ratios were at their lowest in 2020 due to the reduced overall healthcare utilisation experienced during COVID-19. In 2021, claims ratios returned to levels similar to those seen in 2019. However, a significant increase in risk claims ratios was observed between 2021 and 2023, reflecting the post-COVID-19 rebound in healthcare utilisation, along with further increases in healthcare utilisation. This is also reflective of the reduced contribution increases that were implemented for the 2021 and 2022 benefit years, due to observed periods of low claims, along with the need to keep medical scheme contributions affordable over the challenging economic period.

In 2024, claim ratios reduced for open schemes and increased significantly for restricted schemes.



Claims and contributions by scheme



Medical schemes typically finalise their benefit and contribution reviews in September each year, before the full membership and claims data for that year is available. If adverse claims experience occurs in the first half of the year, it is reflected in the data used for pricing, allowing schemes to make adjustments such as higher contributions or benefit changes in the following financial year.

However, when adverse experience arises in the second half of the year, it cannot be factored into the upcoming pricing cycle. As a result, schemes must address this shortfall in the subsequent year, which can place additional pressure on pricing decisions. Moreover, adverse experience in the second half of the year directly affects the scheme's reserves and solvency levels heading into the new financial 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 CMS' generally accepted guideline of 10% of contributions
- building and maintaining reserves at a sustainable level

Although 85% is the 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**
- **level of non-healthcare expenses**
- **need for reserve building**
- **scheme's long-term strategy**

The graph above specifies the average contributions received and the average claims paid per beneficiary per month, as well as the risk claims ratio in 2024 for the 20 schemes included in Medical Aid Insights this year. These claims ratios include any managed care fees incurred by the schemes.

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 above shows that Keyhealth paid the highest amount in claims per beneficiary in 2024, while Profmed had the highest contribution income per beneficiary during the year. GEMS experienced the highest claims ratio of these schemes, with a claims ratio of 106.2% for 2024. Thebemed had a claims ratio of 83.5% for 2024, the lowest claims ratio of the 20 schemes considered.

The actual healthcare costs funded by medical schemes are driven largely by service usage among medical scheme members, 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')
- advances in diagnostic technology and biological drugs

The increase in the actual cost of claims can be managed 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 depends on the:

- richness of benefits offered
- split of members between high-cover and low-cover options
- 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 depends 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.

Under IFRS 17, risk contributions from members are included as insurance revenue and claims incurred are included in insurance service expenses. While the standard groups gross contributions and claims into broader categories for financial reporting, these terms are still used in practice.

Non-healthcare expenditure

Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section. Therefore, the 2023 figures stated in these comparisons do not match the results in the graphs, as Sizwe Hosmed's experience has been included in the graphs up to 2023.

NHE includes administration fees, broker commission, marketing costs and bad debt.

Non-healthcare expenditure under IFRS 17

Attributable expenses

- Included in insurance service expenses line on income statement.
- Includes expenses like:
  - Claims processing
  - Member communication
  - Policy administration
  - Broker commission

Non-attributable expenses

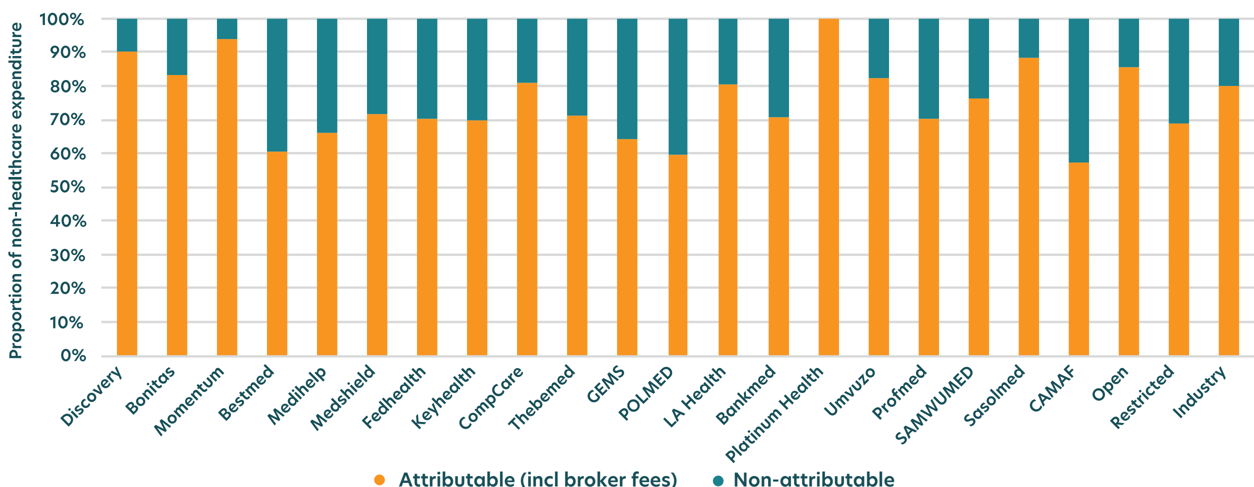
- Included directly on the face of the income statement.
- Includes expenses like:
  - Governance and compliance costs
  - General IT infrastructure
  - Marketing unrelated to servicing contracts
  - Bad debts

Under IFRS17, non-healthcare expenditure is split into attributable and non-attributable expenses.

- Attributable expenses are those directly related to the administration and servicing of insurance contracts. Examples include claims processing, member communication, broker commission and policy administration. These are included in the measurement of the insurance contract and form part of the insurance service result.
- Non-attributable expenses, on the other hand, are overheads or general business costs that cannot be directly linked to insurance services, such as governance and compliance costs, bad debts, general IT infrastructure or marketing unrelated to servicing contracts. These are excluded from the insurance service result and are reported separately in the income statement.

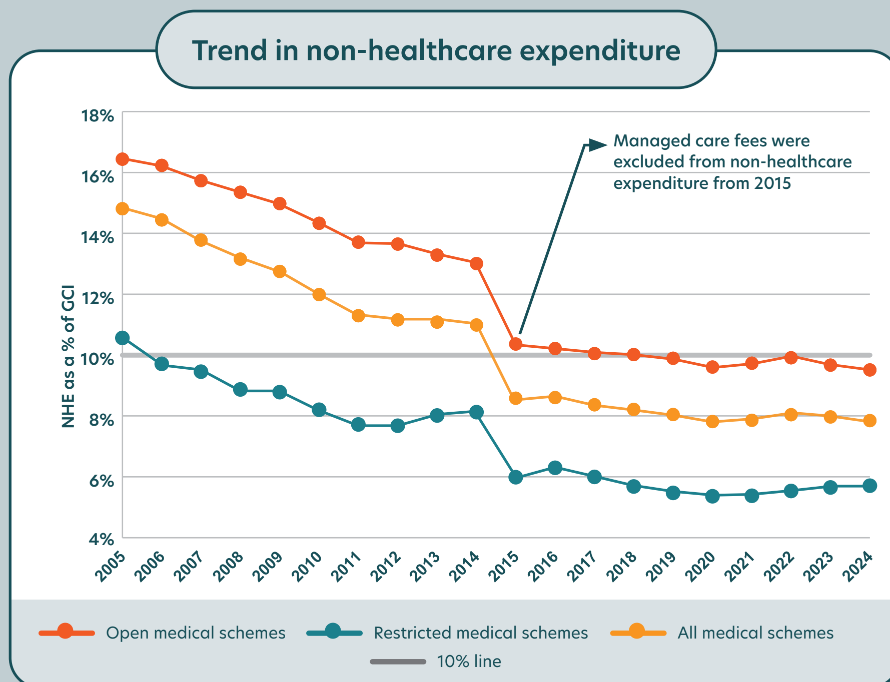
A scheme's attributable expenses are expected to be higher than its non-attributable expenses. The graph below shows the proportions of total non-healthcare expenditure which were classified as directly attributable and non-attributable expenses:

Attributable vs non-attributable expenses



In 2024, open schemes reported a higher proportion of attributable expenses relative to total non-healthcare expenses than restricted schemes. This is partially due to the higher broker fees incurred by open schemes, which form part of attributable expenses.

Up to 2014, managed care fees were reported as part of NHE. However, managed care fees have been recognised as part of healthcare expenditure since 2015, which means that the proportion of gross contribution income spent on NHE reduced significantly from 2014 to 2015.



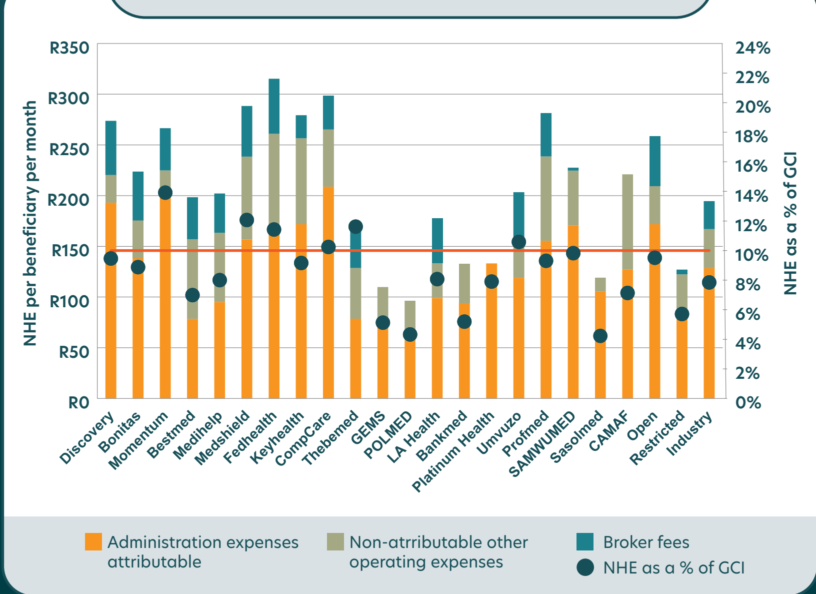
In 2023, total non-healthcare expenditure as a percentage of gross contribution income (GCI) was 7.92% for all medical schemes. In 2024, this declined slightly across the medical scheme industry to 7.85%. Among open schemes, the NHE ratio decreased from 9.64% to 9.51%, indicating improved cost efficiency. In contrast, restricted schemes saw a marginal increase in their NHE ratio, rising from 5.65% to 5.71%.

Among the top 10 open and top 10 restricted schemes considered, Momentum reported the highest NHE ratio in 2024 of 13.9%, while Sasolmed reported the lowest NHE ratio of 4.2%.

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

Given that NHE tends to increase with CPI while contributions increase with medical scheme contribution inflation, usually exceeding CPI by 2% to 3% annually, it is expected that the proportion paid to NHE would decrease over time, irrespective of whether additional cost control measures are introduced. In addition, broker fees paid each year do not increase at the same rate as contributions. This is due to the commission cap in place, which does not increase at CPI and contributes to the decreased NHE percentage. As a result, a more suitable measure of NHE is the absolute cost per beneficiary per month.

The graph on the next page illustrates the components of NHE for the top 10 open and top 10 restricted schemes for 2024, as well as for open and restricted schemes, and the medical schemes industry as a whole. The marked difference between non-healthcare expenses of open and restricted medical schemes is evident from the graph.



Even after excluding broker fees, the non-healthcare expenses of open and restricted medical schemes differ significantly. This disparity may be partly due to sponsoring employers of restricted schemes absorbing some of the administrative expenses through their corporate structures, thereby reducing the costs reflected in the schemes' financials.

There is no standard definition for what qualifies as administration fees, which contributes to the variation in reported costs across the industry. Some administrators may include additional services – such as actuarial support – under administration, which can inflate the reported administration expense profile.

The illustration below shows the breakdown of NHE expenditure into its different components across the industry in 2024.

Financial performance

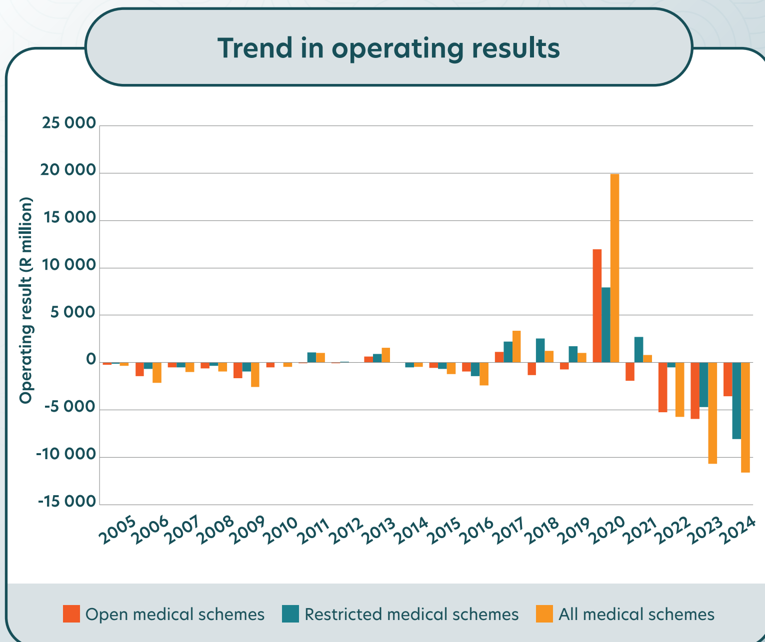
Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section. Therefore, the 2023 figures stated in these comparisons do not match the results in the graphs, as Sizwe Hosmed's experience has been included in the graphs up to 2023.

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 NHE are deducted from the 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 NHE

The industry experienced an operating deficit of R11.64 billion in 2024, which grew from a deficit of R10.20 billion in 2023. The worsened performance is observed among restricted schemes and can be attributed to the increase in claims ratios between 2023 and 2024.



The trend of deteriorating financial results observed in the medical schemes industry since 2014 began to reverse in 2017, with surpluses also experienced in 2018 and 2019. During these years, the industry recorded operating surpluses of R1.22 billion and R1.03 billion, respectively.

In 2020, the operating surplus surged to unprecedented levels, largely due to favourable claims experience resulting from the COVID-19 pandemic, which significantly reduced healthcare utilisation. By 2022, financial pressures resurfaced, with deficits incurred for open and restricted schemes between 2022 and 2024.

Restricted schemes experienced an operating deficit of R8.07 billion in 2024. Excluding GEMS, restricted schemes collectively achieved an operating deficit of R1.42 billion, with only 13 of 55 restricted schemes incurring a surplus. Open schemes, on the other hand, experienced an operating deficit of R3.57 billion, with Bonitas and Discovery contributing deficits of R1.16 billion and R1.06 billion to this figure, respectively. Notably, Thebemed was the only open scheme in the industry to incur an operating surplus in 2024.

Pricing strategies can shape the operating results incurred by schemes. Schemes may price to generate surpluses to meet statutory solvency requirements and reduce surplus targets once these requirements are met. Conversely, schemes with accumulated reserves well above regulatory requirements may price to generate an operating deficit to return some of these reserves back to members.

The net result of a medical scheme is the surplus or deficit remaining after investment income is added to the operating result.

In 2024, after accounting for investment and other income, the industry posted a net surplus of R3.13 billion, up from R1.69 billion in 2023. Open schemes recorded a net surplus of R3.33 billion (2023: R524 million deficit), while restricted schemes achieved a net deficit of R200 million (2023: R2.22 billion surplus).

In terms of scheme-level performance, 10 of 15 open schemes and 43 of 55 restricted schemes achieved a net surplus in 2024, compared to 5 of 15 open schemes and 37 of 55 restricted schemes in 2023.

Under IFRS 17, the scheme's performance is split over the following lines on the income statement:

- Insurance service result - this is the insurance revenue less the insurance service expenses.
- Other income - such as investment income.
- Other expenses - this includes expenses related to investments, as well as other indirectly attributable expenses.
- Amounts attributable to future members - this is equal to the negated value of the net surplus/(deficit). It reflects the inverse of the portion of the insurance service result that is retained in the scheme and added to accumulated funds, ensuring sustainability for future members.
- Total comprehensive income/(loss) for the year - this line is zero for medical schemes because all surpluses or deficits generated from insurance activities are shown as amounts attributable to future members, which are then transferred to or deducted from accumulated funds. Since medical schemes are mutual entities and do not distribute profits, there is no residual income left to report as comprehensive income. This treatment ensures that the financial statements reflect the scheme's purpose of serving both current and future members, rather than generating returns as other entities do.

As the operating result is no longer displayed directly on the income statement, the operating result can be calculated from the available components using one of the following methods:

- Using the negative of the amounts attributable to future members line (which equates to the net result), subtract all investment related income, and add all investment related expenditure. The result is the operating result.
- Using the insurance service result, add all non-investment related income (if applicable) and subtract all non-investment related expenditure. The result is also the operating result.

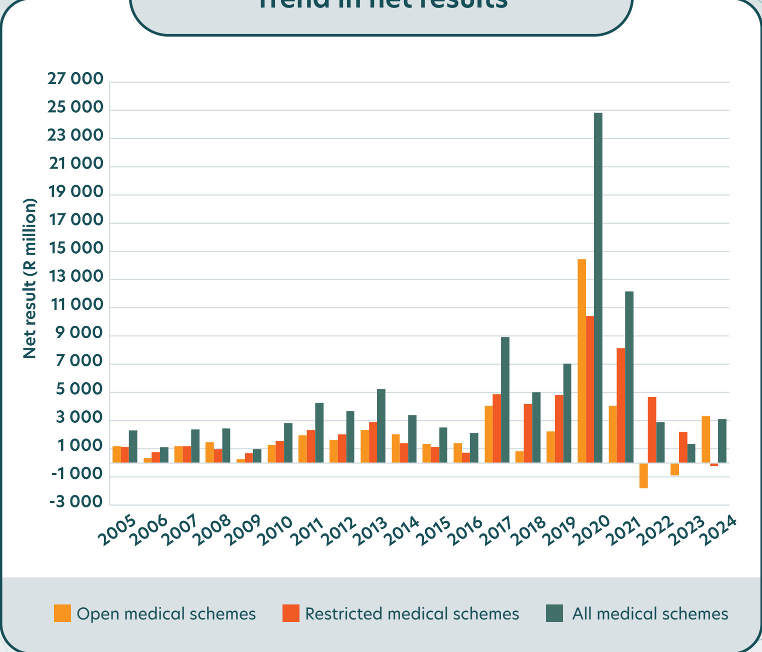
The net result can easily be obtained as the negated value of the amounts attributable to future members.

The graph on the bottom right shows the financial performance of the top 10 open schemes and top 10 restricted schemes in 2024.

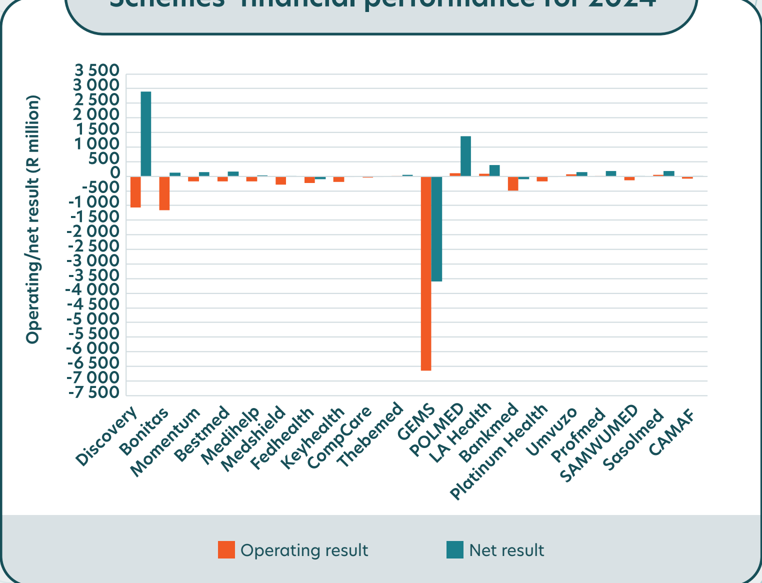
Of the 20 schemes considered in this year's Medical Aid Insights, only one open scheme and five restricted schemes attained an operating surplus in 2024, while the remaining schemes made operating deficits. The schemes that attained an operating deficit had to rely on investment income to subsidise claims and NHE.

After investment income, 7 out of 10 open schemes and 7 out of 10 restricted schemes achieved a net surplus.

Trend in net results



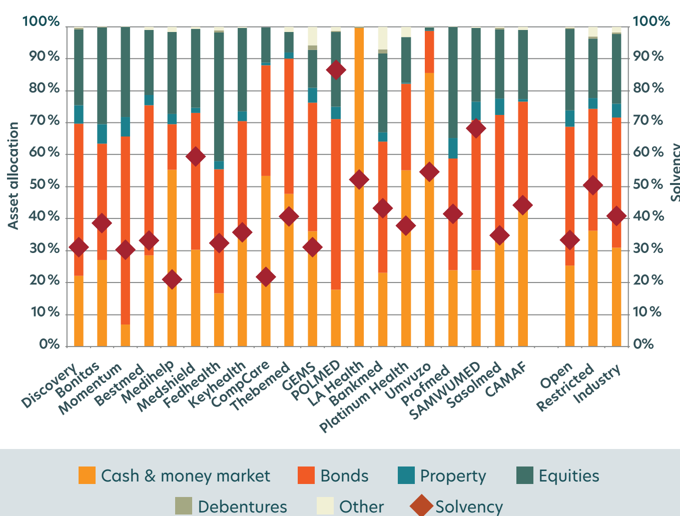
Schemes' financial performance for 2024



Investments

Where medical schemes do not achieve operating surpluses, they rely on the investment returns earned over the year to fund part of their claims and NHE. In 2024, 56 of 70 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 keep pace with, and preferably exceed, claims inflation. At present, however, most medical schemes follow highly conservative investment strategies as shown in the graph below. The graph shows the asset allocation for the 20 schemes under consideration in this publication.



In 2024, open schemes held 25.4% of assets in equities, with 43.3% in bonds and 25.4% in cash or cash equivalents. In contrast, restricted schemes held 18.5% of assets in equities, 38.2% in bonds and 36.2% in cash or cash equivalents.

Overall, all medical schemes in the industry held 21.9% in equities, 40.7% in bonds and 31.0% in cash or cash equivalents. The balance is mainly held in property, with some exposure to debentures and insurance policies.

Asset class limits are 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%.

Medical schemes are permitted to invest up to 50% of their portfolios in higher-risk asset classes, which are expected to deliver returns above CPI inflation. There are no limits on investments in conservative asset classes, such as cash, money market instruments and bonds, although exposure to individual issuers is restricted to ensure diversification.

The strong preference for cash among medical schemes appears to be driven by a need for liquidity, given their short-term liabilities, and concerns about investment risk, specifically the potential for negative returns or a loss of scheme assets.

However, for schemes that rely on investment income to offset operating deficits, consistently low returns may pose a long-term risk. Claims expenditure and, therefore, contributions typically grow faster than CPI, and to maintain solvency, accumulated funds need to grow in line with contributions. If investment returns lag behind claims inflation, solvency levels will decline, which may necessitate higher contributions or reduced benefits, both of which can negatively impact members.

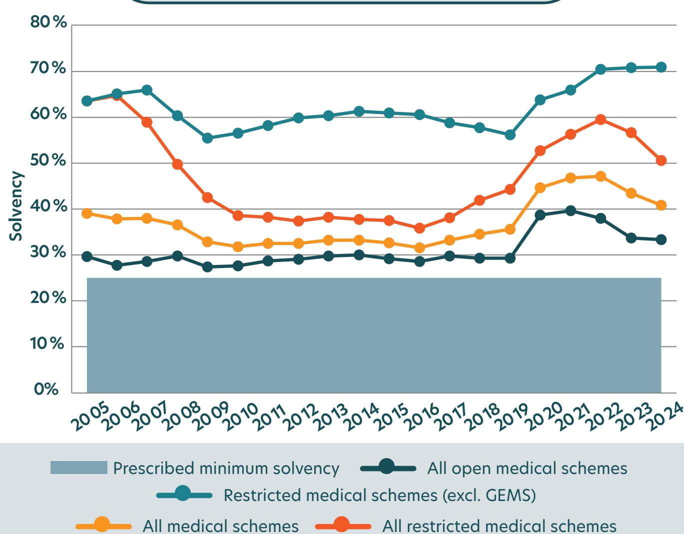
For schemes that do not meet the statutory solvency requirement, conservative investment strategies may inadvertently increase financial risk. Even schemes that currently meet the solvency threshold could see it eroded over time if returns remain below claims inflation, resulting in exposure to the same pressures on contributions and benefits.

Where reserves are sufficient, there is a strong case for allocating a portion of assets to higher-yielding investments permitted under Annexure B of the regulations. Conversely, underfunded schemes may benefit from investing in riskier assets to boost returns, grow reserves and improve solvency, though this depends on the absolute size of the asset base and the scheme's risk appetite.

Solvency levels

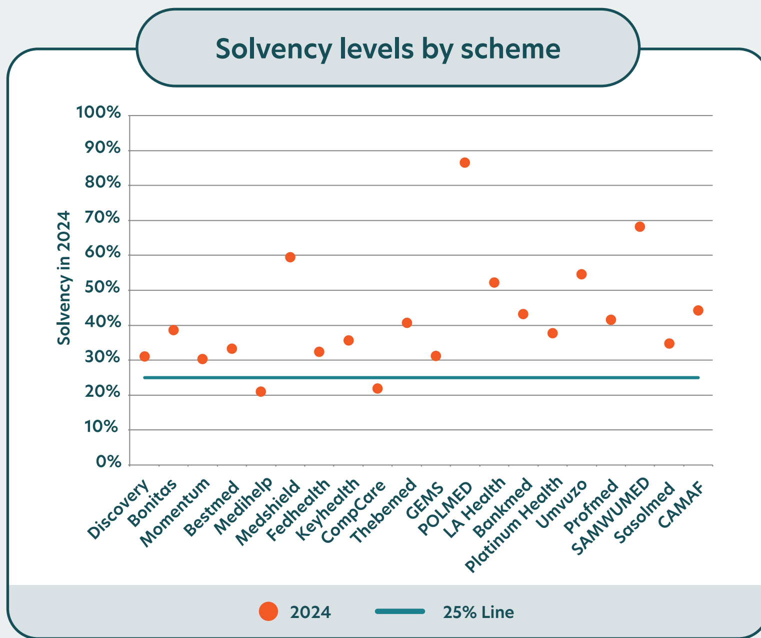
Sizwe Hosmed has been excluded from 2023 and 2024 in the comparisons made in this section. Therefore, the 2023 figures stated in these comparisons do not match the results in the graphs, as Sizwe Hosmed's experience has been included in the graphs up to 2023.

- The solvency ratio represents the level of reserves (accumulated funds excluding unrealised gains and losses) held by a medical scheme, expressed as a percentage of its gross annualised contributions. In terms of Regulation 29 of the Medical Schemes Act, all schemes are required to maintain a minimum solvency ratio of 25%.
- The graph below illustrates the solvency levels of both open and restricted schemes over the past 20 years, compared to the statutory minimum.
- On average, restricted schemes have maintained higher solvency levels than open schemes. However, from 2006 onwards, the average solvency of restricted schemes declined, largely due to rapid membership growth in GEMS. In contrast, the solvency levels of open schemes remained relatively stable between 2006 and 2019.
- During 2020 and 2021, the industry experienced a significant increase in average solvency levels, driven by large surpluses resulting from reduced claims during the COVID-19 pandemic. This upward trend continued briefly but began to turn around in 2023, following a normalisation of claims patterns and, possibly, the strategic decision to return excess reserves to members.
- In 2024, the average solvency ratio for all schemes declined to 40.9%, down from 43.9% in 2023. For open schemes, solvency dropped from 34.3% to 33.4%, while restricted schemes saw a decrease from 56.7% to 50.5%.



Medical schemes that do not meet the statutory minimum solvency 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 2024, 8 out of the 10 top open schemes and all of the top 10 restricted schemes achieved the statutory minimum solvency level of 25%. The open schemes that failed to meet the 25% statutory minimum solvency were Medihelp and CompCare. Their solvency levels were 21.0% and 21.8%, respectively. The last known solvency level for Sizwe Hosmed was 6.62% in July 2025, according to a CMS media report published on 3 September 2025, down from 15.7% in 2023.

The graph below illustrates the solvency levels at the end of 2024 for the 20 schemes considered.



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 review 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

Schemes showing membership growth are penalised from a solvency perspective. In contrast, the solvency calculation formula rewards schemes losing members. As a result, schemes that are growing are less competitive because of the need to build and maintain solvency levels.

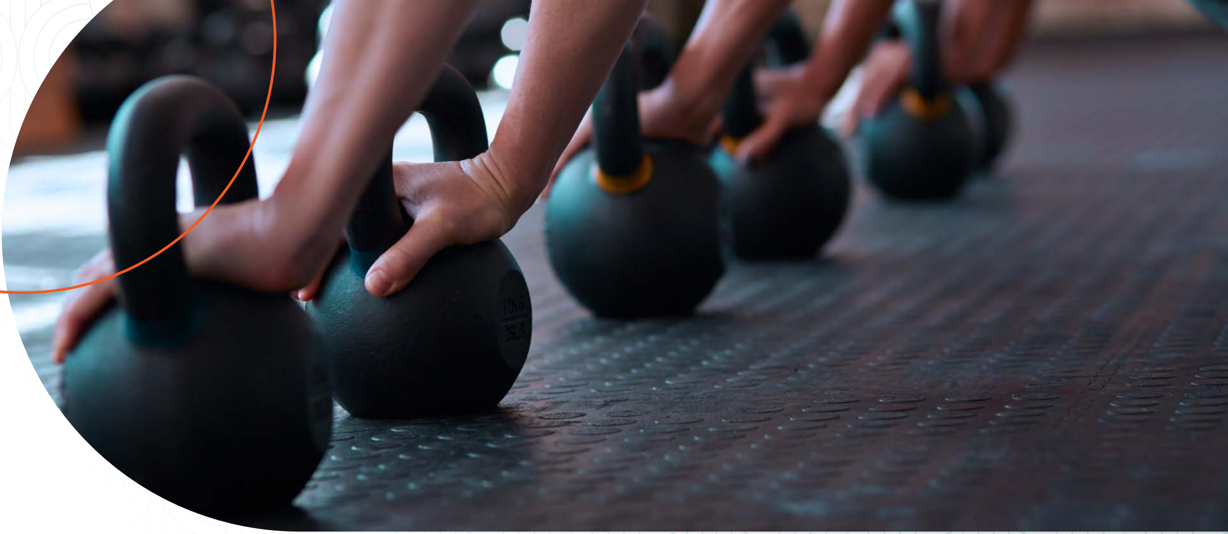
The CMS released Circular 68 on 25 November 2015, which discusses a review of the current solvency framework and outlines a proposed alternative risk-based solvency framework. In 2016, the industry was invited to comment on:

- the proposed move to a risk-based solvency framework
- their proposed calculation
- how the transition from the existing solvency calculation should be managed

Workshops were held with various stakeholders. In 2019, the CMS published an update on the review of the solvency framework. The review included comments from industry stakeholders on the merits and drawbacks of the proposed framework.

According to the CMS Annual Report 2022/2023, the Risk-Based Capital (RBC) framework was halted after it was found that it would lead to varying capital requirements for medical schemes. For over-capitalised schemes, it could lead to lower contributions and benefit enhancements, while for under-capitalised schemes, it could potentially lead to contribution hikes, benefit reductions, member attrition and difficulty attracting new members. As such, the CMS decided not to directly pursue the RBC approach but will use it as an early warning tool and initiate a shadow process for evaluation and adjustment.

Alexforbes 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 has become increasingly important for all industry stakeholders. Throughout this publication, we have analysed key statistics of medical schemes, but it is difficult to assess how these statistics work together to affect the sustainability of a medical scheme.

The Alexforbes Health Medical Schemes Sustainability Index attempts to do this by combining certain key factors and considering their impact on a medical scheme in future years.

The index has been calculated from a base year of 2012 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.

The change in the **accumulated funds** per beneficiary held at the end of each year. Accumulated funds act as a buffer against adverse claims experience, and an increase in the accumulated funds per beneficiary would improve this buffer.

Membership growth over time indicates that benefits are attractive. In addition, an increase in size serves to reduce the 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 scheme's **actual solvency** relative to the statutory requirement. Although the suitability of the current statutory requirement is debated, 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 in future. 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.

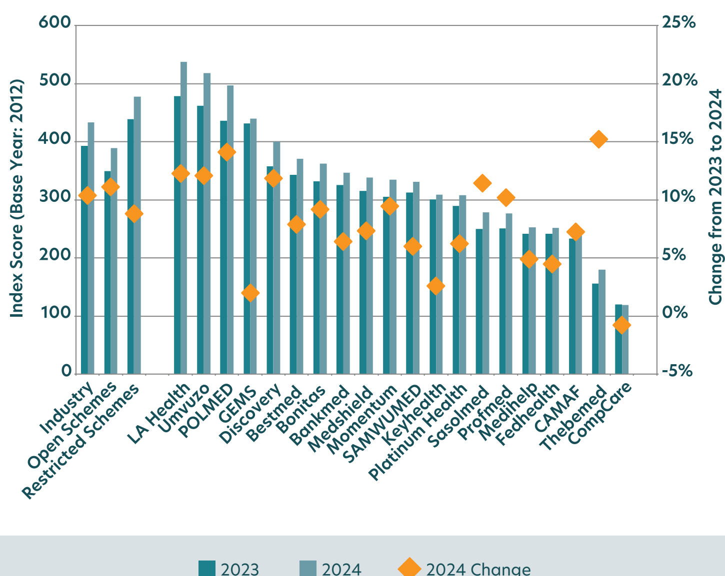
The **operating result** of the scheme relative to the industry each year, as this would indicate the medical scheme's performance relative to its peers.

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 **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 2012, these factors are considered for each year from 2013 to 2024, with the final index score reflecting the cumulative impact over this period. The medical schemes are ranked from highest to lowest to show their relative sustainability. The index aims to provide a comparative assessment between schemes. For this reason, the relative positioning is more important than the absolute score. Note that small differences in the scores (between 10 to 20 points) are not significant.

The following graph shows the index scores for each of the top 10 open and top 10 restricted medical schemes, using a base year of 2012.



The biggest increases in the index for 2024 were observed for Thebemed, which improved its 2023 score by 15.2%, followed by POLMED with an increase of 14.1%.

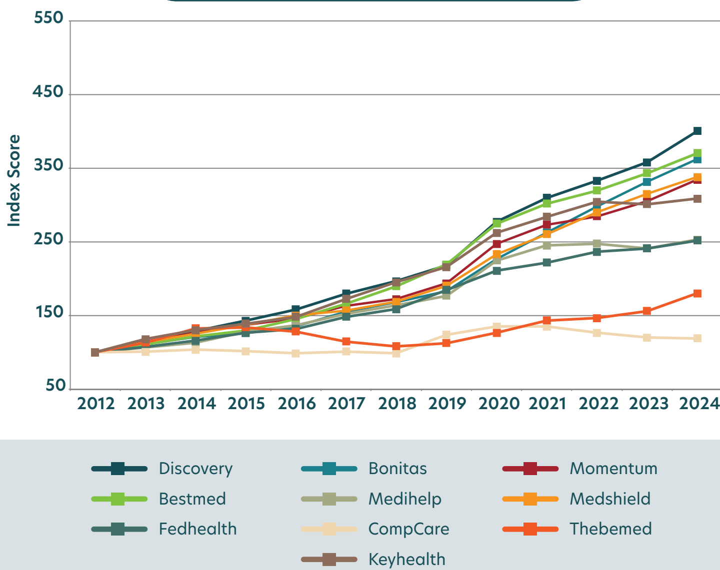
For Thebemed, solvency was the main driving factor of the improved sustainability score. Thebemed's solvency increased from 32.7% in 2023 to 40.7% in 2024. The scheme made both operational and net surpluses in 2023 and 2024. The scheme made a net surplus of R20.1 million in 2023 and R41.6 million in 2024.

For POLMED, the solvency increased from 80.5% in 2023 to 86.6% in 2024. However, POLMED experienced a 0.4% decline in beneficiaries from 2023 to 2024. The scheme made both operational surpluses and net surpluses in both 2023 and 2024. The scheme obtained a net surplus of R1.5 billion in 2023 and a net surplus of R1.4 billion in 2024.

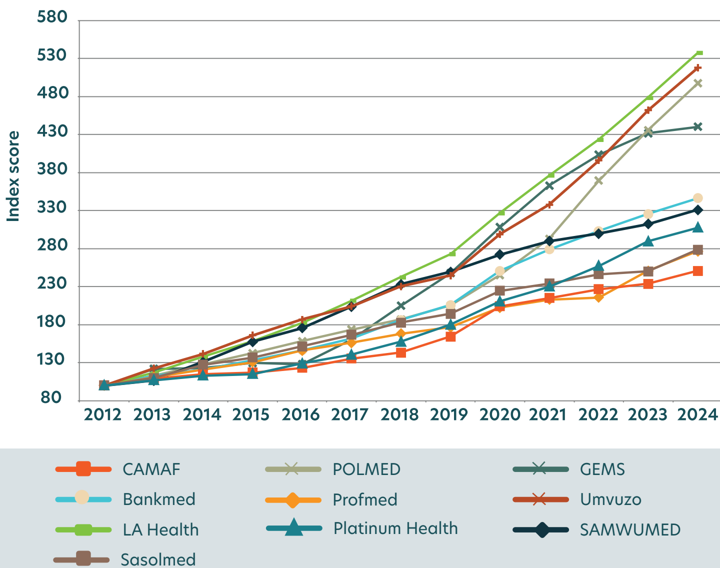
The open schemes which experienced the greatest improvements in their scores from 2023 to 2024 were Discovery, improving their score by 11.9%, followed by Momentum with 9.5%.

LA Health, Umvuzo and POLMED are now the top-performing restricted schemes, following GEMS experiencing a drop in its position due to losses made in both 2023 and 2024. GEMS made an operational loss of R3.9 billion in 2023, followed by a larger operational loss of R6.7 billion in 2024. Discovery remained the top-performing scheme in the open market, with Bestmed and Bonitas following closely behind. Although Bestmed experienced a decrease in solvency from 36.9% in 2023 to 33.2% in 2024, it experienced a 4.4% increase in beneficiaries between 2023 and 2024, with reductions in average age over the period.

Open schemes index trends



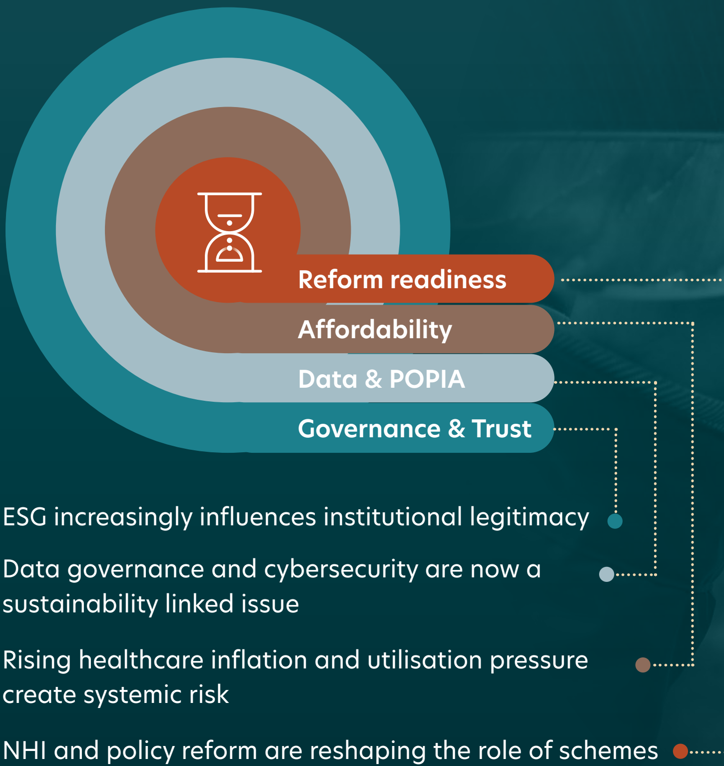
Restricted scheme index trends

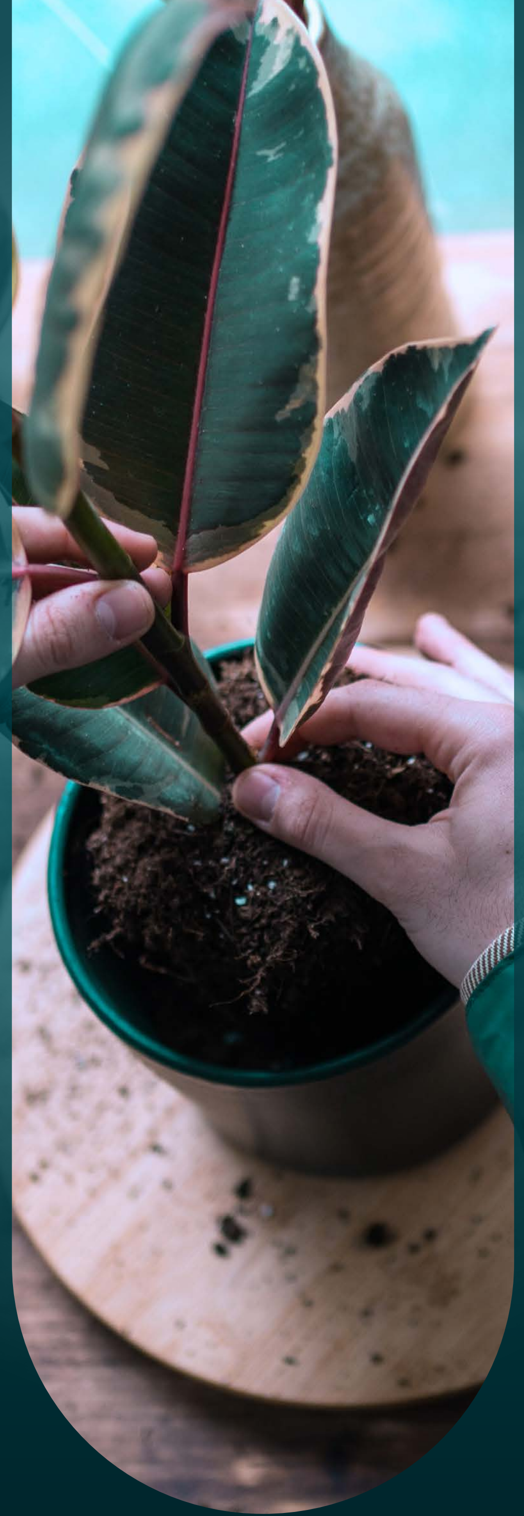


Sustainability in Medical Schemes

From ESG Reporting to Strategic System Stewardship

Sustainability in medical schemes is no longer a standalone reporting exercise. It is increasingly shaping affordability, governance, member trust and long-term institutional resilience.





- ESG increasingly influences institutional legitimacy
- Data governance and cybersecurity are now a sustainability linked issue
- Rising healthcare inflation and utilisation pressure create systemic risk
- NHI and policy reform are reshaping the role of schemes

The ESG Shift in Medical Schemes

Traditional ESG approach

- Narrative reporting
- Generic ESG disclosures
- Limited strategic integration
- Compliance focused

Emerging ESG expectations

- Decision-grade ESG data
- Enterprise risk integration
- ESG disclosure and reporting readiness
- Board-level strategic prioritisation

Key ESG focus areas for Medical Schemes

- Affordability and contributions
- Access to care and benefit design
- Cybersecurity and POPIA
- Fraud, waste and abuse management
- Governance and ethics
- Cybersecurity and POPIA
- Member trust and transparency
- ESG data maturity

How Alexforbes supports Medical Schemes

Strategy

- ESG strategy
- Double materiality
- Sustainability roadmaps
- ESG training and upskilling

Governance and reporting

- EISSB/IFRS S1&S2 readiness
- ESG reporting and disclosure
- Governance frameworks

Sustainability as system stewardship

The future of sustainability in South African medical schemes will not be determined by frameworks or reporting formats. It will be determined by how effectively schemes navigate the tension between affordability, access, financial sustainability and system reform.

Schemes that treat sustainability as a disclosure requirement will struggle to maintain legitimacy.

Schemes that treat sustainability as strategic system stewardship will shape the future of healthcare financing in South Africa.

Every sustainability maturity journey is unique. Do you know where you are in your journey? Do you have a roadmap to guide you?

Scan the QR code to complete our Sustainability Maturity Diagnostic Assessment for your organisation and Alexforbes will send you your custom Sustainability Maturity Diagnostic Report

OR

Contact Alexforbes for further information
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Conclusion

We can make the following key observations from the analysis:

- The number of medical schemes remained at **71** from 2023 to 2024. Only **70** medical schemes were analysed in this report due to Sizwe Hosmed not being reported in the CMS Annexures.
- The number of principal members increased marginally by **0.5%** from 2023 to 2024, compared with an increase of 1.2% from 2022 to 2023. Principal members at the end of 2024 totalled **4 112 771** (2023: 4 092 431).
- The average age of beneficiaries increased to **34.5 years** at the end of 2024 (2023: 34.2 years), with the pensioner ratio increasing to **10.0%** (2023: 9.6%).
- The average family size remained the same between 2023 and 2024 at **2.2**.
- The risk claims ratio for all schemes increased from **95.8%** in 2023 to **96.2%** in 2024.
- Total NHE as a percentage of GCI reduced from **7.9%** to **7.8%** from 2023 to 2024.
- A total of **14** of the 70 schemes (**25%**) achieved an operating surplus in 2024.
- In 2024, most scheme assets (**40.7%**) were held in bonds, followed by **31.0%** held as cash, either in bank accounts or through money market instruments, and **21.9%** held in equities.
- The average solvency of all schemes decreased from **43.9%** on 31 December 2023 to **40.9%** on 31 December 2024, with a decrease in average solvency observed among both open and restricted schemes.

All 2023 and 2024 figures stated above exclude Sizwe Hosmed.

Overall, the profile of the industry remained fairly stable, and the financial position is sound. However, operating losses were incurred for the majority of schemes, which is largely a result of increases in claims ratios. Should the claims and financial performance of schemes continue to worsen, this could result in contribution increases significantly above CPI in future, which may negatively impact membership growth and the overall sustainability of the medical schemes industry.

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We would like to thank the following members of the TACS team for their contribution to this year's publication:

- **Anjali Kalian**
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- **Veloshan Govender**
- **Jessica Nurick**

Sources: CMS Annual Reports (2005 to 2024)

Audited annual financial statements of medical schemes

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