Chapter 3: Corruption and Citizens' Financial Security in Public Service Medical Schemes: The Case of South Africa

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Abstract

The article reports on an empirical exploration of public service medical schemes governance, its variations and the dire financial repercussions and financial security for the members of such schemes in South Africa. Given the class-based 'dual nature' of the medical scheme terrain in South Africa through the existence of 'open' and 'restricted' schemes (the latter dominated by public-service ones), existing violations of good governance take a wide variety of forms and types, despite the existence of legislation such as the Public Finance Management Act 1 of 1999 (PFMA), the Medical Schemes Act of 1998 and the regulatory body, the Council for Medical Schemes (CMS).

It is understandable that the beneficiaries of public services of this nature expect them to provide affordable, honest, accountable and useful services and products that are in accordance with their needs and financial means and resources. In this case the beneficiaries are able to guarantee their financial security, appropriate and accurate free credit reports that allow them to make decisions that are in accordance with their financial needs.

In such a situation and given the duality of the market, such services ought to be delivered in a transparent, accountable and responsible manner, where accountability and common respect of the partners makes this financial relationship sustainable. In this instance citizens utilize such products and services with the hope of a provision of a corrupt free service that is realistic and sustainable, and guarantee financial security to citizens.

The research was based on the qualitative frame of reference and included a scrutiny of primary and secondary documentary material as well as unstructured interviews with senior public service officials.

Keywords: Corruption, medical schemes, 'open' and 'restricted' medical schemes, GEMS

Introduction and Context

Medical schemes violation of good governance associated with fraud and corruption is one of the many facets of health care corruption, avarice and greed, whether individual or collective. Like all healthcare fraud and corruption, this is an ever-growing 'industry', taking advantage of systemic, organizational and administrative weaknesses and challenges facing this multi-billion industry. Such corruption takes a variety of types and forms both nationally and internationally, such as falsification of patient data; referrals to specific medical service providers or/and suppliers; provision of false invoices; collusion between patients and medical scheme staff; kickbacks operations; misrepresentation of diagnoses; miscoding or misquoting of claims, and collusion (Salter 2010; Russell 2015; Whistleblowers International 2016; United Nations 2017).

Healthcare fraud directly impacts the quality and cost of care that a patient receives, and can put patients' lives at risk when they are exposed to treatment or procedures that are not medically warranted. Since medical aid fraud and corruption takes a wide variety of forms, detection, investigation, monitoring and prevention are not easy. This reality is exacerbated by the fragmentation and lack of coordination amongst medical aid schemes and the lack of consolidation, especially amongst the 'restricted' ones. The non-existence of a 'central data-base' in the sector in fact helps fraud and corruption at all levels, as collective coordination is lacking.

The Medical Scheme Terrain in South Africa

There are 82 existing medical aid schemes in South Africa. They are governed by the Medical Schemes Act of 1998 and are regulated by the Council for Medical Schemes (CMS), a well- respected body that in 2017 received an unqualified audit report from the Auditor General of South Africa), for a record 17th time in a row (Auditor General 2017). This is an achievement unparalleled in the history of South African regulators and state institutions in their attempts to manage their financial affairs and comply with the dictates of the Public Finance Management Act 1 of 1999 (PFMA).

CMS has structured the regulatory processes of duties, responsibilities and obligations of the schemes such as compliance enforcement, administrative

accreditation, management of healthcare organisations and brokers, and investigations for all role players in the industry (both service providers and beneficiaries), according to the dictates of the Medical Schemes Act.

The 82 medical scheme entities comprise 22 'open' and 60 'restricted' schemes with 8.879 million members as at 31 December 2016, a small increase of 0.78% in comparison with the previous year and 8.814 million in 2014. Because of the significance of the Council of Medical Schemes and its role in the sector and society at large, it is deemed important to briefly deal with the key fundamentals facing the medical schemes in the country, based on the official documents of the regulator for the last financial year (Council of Medical Schemes 2016).

It has been widely acknowledged that the introduction of the Government Employees Medical Scheme (GEMS), a public service scheme, had a significant impact on the increase of paid membership since its launch in 2006, and its actions mobilised hundreds of thousands of civil servants throughout the years. An analysis of the figures in terms of contributions and expenditure per financial year provides interesting information for this study. Gross contributions until December 2016 amounted to R163.9b, an increase of 8.1% in comparison to the year before.

The gross healthcare expenditure on the part of medical schemes for the same period was R151.21b, an increase of 8.9% in comparison to the previous year. R56.61b or 37.44% of the amount was paid to hospitals (R56.32b to private ones, with an increase of 9.80% in comparison to the previous financial year). R10.15b was paid to 'allied' and 'supplementary' healthcare professsionals, showing an increase of 8.01%, while R 36.32b was paid to a wide range of specialists, with an increase e of 9.92% in comparison to the previous year. The amount was 24.02% of total medical aid payments made during the year. General practitioners received R8.96b or 5.93% of healthcare benefits paid, while consumables and medicines dispensed by pharmacists and providers (excluding hospitals), received R 23.95b (15.84% of benefits paid) (Council of Medical Schemes 2017).

R 73.1b was the total cost of prescribed minimum benefits (PMBs), while the total risk benefits reached R 136b or 54% of total risk benefits paid. R 11.9b was spent on administration and broker costs reached R2.0b, 10% more than the previous financial year.

A deficit of R 2.39b was reflected for all medical aid schemes, with R 955.7m for the 'open' ones and R 1 435.1b for the 'restricted' ones, the result of an increase in claims; net assets were R 54.1b. The sector's solvency ratio

decreased in 2016 to 31.6% in comparison to 32.6% in the previous year (Council for Medical Schemes 2017).

The public-service controlled medical schemes are classified as 'restricted medical schemes' and it has been estimated that more than 41% of medical schemes members in the country belong to such schemes. Despite the existing differences between the open and restricted schemes, both categories are legally bound by the dictates of the Medical Schemes Act of 1998.

While in the early years of the new Millennium there were at least 95 such schemes registered in South Africa, their number at present has shrunk to 60. One of the key reasons for such decline is that many of such entities have suffered from a number of weaknesses related to limited number of members, in-fighting amongst the leaders and lack of knowledge that could lead to sustainability **(Interview No. 1, Senior Public Servant, and Gauteng Province).**

In most cases, the restricted schemes have been small in terms of principal membership when compared to the open ones, and it is interesting to note that there are at least 25-30 such schemes that have been allowed to operate illegally, as they did not have 6000 principal members when they registered or at least until the end of 2015. The Government Employees Medical Scheme (GEMS) is the numerically and influence-wise largest restricted scheme, with more than 700 000 principal members and over 1.2 million dependents. It is the second biggest scheme in the country, controlling 17% of the market share, with DISCOVERY at 32% being the top-ranking company.

GEMS is followed by the South African Police (SAPS) scheme (POLMED), that has over 200 000 principal members and just under 400 000 dependents (Fin24 2017a). Transmed Medical Fund, that provides services to Transnet Group employees including those in the entity's present and past subsidiaries, accommodates the largest number of pensioners in comparison with other schemes (with average age of over 50 years), and its claims ratio in 2015 was 105.3%.

In terms of the proportion of contributions used to fund claims, in general, the risk claims ratio of restricted medical schemes (94.9%) has been higher than that of the open schemes (at 88.7%) in 2015. In 2015, restricted schemes spent 6% of their contribution income on non-healthcare expenditure, and open schemes spent just over 10%. Restricted schemes tend to be cheaper to administer, as the companies who employ the members often absorb some of the costs of running the scheme. They also do not pay any broker fees.

Of the restricted schemes, Sasolmed paid out just under R1600 in claims per member per month, Profmed just under R1400 and GEMS just over R1200. Profmed had the highest non-healthcare expenditure of the restricted schemes, coming in at over 16%.

The vast majority of the largest restricted schemes in the country (8 out of 10), did not have an operating surplus in 2015 (Transmed, Sasolmed. Nedgroup, Polmed, Platinum Health, Bankmed, GEMS and Profmed). With the exception of GEMS, all restricted medical schemes had a solvency level of over 60%, and two of them (Transmed and Platinum) had solvency levels below 25%, the recommended level (Fin24 2017b).

Research Methodology

The utilization of the qualitative method and paradigm at the empirical level was the basis of the research project. This was rooted in a multiplicity of data collection patterns that involved the dissection of primary and secondary material including government and departmental documents, press and official reports, journal articles and books, as well as interviews with public and private sector officials. The anonymity and confidentiality of all participants were guaranteed.

The selection of the officials both in government and statutory professional bodies was based on the principles and implementation of the judgmental sampling technique. They were selected because of their expert knowledge and understanding of the research field.

The analysis of data took place through the use of descriptive and interpretative techniques based on content analysis that led to direct and/or indirect interpretation.

Corruption in Medical Schemes: A Snapshot

The medical aid sector in South Africa has become a seriously 'concentrated'/ oligopolistic sector dominated largely by the 'BIG 3': MEDSCHEME, Metropolitan Health (MMI) and DISCOVERY that are in control of over 80% of all medical scheme membership (Fin24 2017b). Throughout the years, it has been replete with corruption and fraud. However, fraud and corruption affect all of the existing entities.

The most visible fraud and corruption reality in the medical aid scheme terrain is related to perpetual collusion between healthcare service providers and

medical aid members at all operational levels and throughout the sector. However, the corrupt relationships between medical practitioners, mediators, members and staff of both closed and targeted medical schemes, are also key in the fraud terrain **(Interview No. 2, Senior Public Servant, and Gauteng Province).**

Research by the Healthcare Forensic Management Unit (HFMU) of the Board of Healthcare Funders of Southern Africa (BHF) in 2015, has indicated that more than 7% of all medical aid claims in South Africa have, over the years, been fraudulent, with strong possibilities that such actions could reach the 15% of the claims received. This means that the principal members of any medical aid scheme are obligated to pay an additional amount of between R192 and R410 per month **(Interview No 5, Medical Scheme Board Member).**

It can be understood that such increases dent the financial security of lowly paid employees Department of Health 2017:39 - 40).

Such collusion is related to direct or indirect abuse of medical aid benefits and fraud wastage, and has been a challenge of major proportion in the sector for decades, with serious repercussions for the provision of quality-driven and affordable healthcare.

In quantitative terms, if an approximate amount of the R150b per year is spent in South Africa and 10% of claims are fraudulent; this results to fraudulent costs of R15b. Such realities affect every single stakeholder in the sector, and schemes and circumstances obligate them to work collectively in order to eliminate corrupt practices, especially the lower paid beneficiaries who are hard hit by these illegal acts. It is estimated that medical aids lose between R9 and R19b every year due to fraud, abuse and waste. A forensic analysis over a period of 5 years of the transactions of medical aid and consulted service providers through the use of the latest technology including forensic software algorithms able to identify corrupt acts and fraud, estimated that fraud has reached over R22b a year, meaning that members have lost more than R2500 due to fraud and corruption (Buthelezi 2017).

The industry has accepted that the culprits are members of an ever-increasing minority of uncaring, dishonest and corrupt personnel, operating in the form of informal syndicates involved in a number of practices that include acts such as fake invoices; charging excessively high levels of service than those delivered; submitting claims in false names; billing for services that have not been not provided; claims by pharmacies for genuine medication while dispensing generic medication; claiming from medical schemes for medicine while buying cosmetics, baby powders or other items; ‘card sharing’, as health pro-

fesssionals submit claims of non-members who use a member's card; fraud committed by healthcare professionals and service providers; provision of fake sick notes so the member can claim from the medical aid scheme, and fraudulent change of diagnosis so that a member can access specific expensive benefits. The so-called 'card farming' is a scheme whereby medical aid scheme members 'lend' their membership card for a fee or free of charge to non-members, who can then use them for a number of treatments or to purchase non-medical merchandise from pharmacies and submit the claims covering the costs to the scheme **(Interview No 6, Private Hospital Manager, Gauteng, October 2017).**

One of the more well-known and recent scams to hit one of the biggest private medical aids in South Africa, involves lump sums which are paid out by Hospital cash plans that are schemes operating by insurance companies. These companies provide members with lump sums of money when hospitalisation takes place, and are directly and indirectly abused through fraudulent schemes instead of helping to cover the shortfalls not fully covered by the medical schemes. The admission of people who are not sick to hospital, aided by private medical practitioners, helps the 'syndicate' members submit false claims to the schemes and the provider of the cash plan, who then split the lump sums involved with the medical practitioners. In all such cases, both the medical scheme and the insurer lose substantial amounts of money. It has become evident that fraud committed in the process of claiming for hospital cash plan benefits has been spread widely throughout the country. By 2014, the number of such plans fluctuated between 1-1.5 million, covering over 2.4 South Africans and with a monthly increase of 50 000 new policies monthly (Fin24 2013).

Corruption in the Public Service Medical Schemes

It has been widely reported that while the open medical schemes, spear-headed by the 'Big 3' have attempted with what has been called 'notable successes' to curtail fraud and corruption in their operations (Greve 2017; Ensor 2018), this cannot be said of public service medical scheme providers. These are basically the ones that deal with the majority of beneficiaries who are state employees with fluctuating incomes and financial resources. These groups comprise mostly of lower to medium remunerated employees who when the cost of living increases together with their medical aid prices, they become financially vulnerable because their economic security and stability are threatened.

The reports of the widening spectrum of fraud in the sector were direc-

tly associated with the expansion and growth of the industry in a highly competitive environment and its expansion from KwaZulu-Natal to the Eastern Cape, provinces predominantly populated by public servants. Other provinces alerted a number of role players such as the relevant ombudspersons and the Association for Savings and Investment SA, which attempted to investigate the problem (Health24 2016).

The fraud that became evident especially since early 2011, and which has since expanded seriously, prompted Brian Galgut, the past Long-term Insurance Ombudsperson, to highlight the abuse of the schemes as the perpetrators' terrain had become more diversified and adventurous, boosted by a substantial new crop of medical service providers and practitioners involved in all schemes.

It can be understood that the expansion of such fraud and corruption will inevitably impact negatively on both the medical aids sector and especially their members, because both will, especially the latter group, incur additional costs in terms of increases in premiums for hospital cash plans for the members and higher expenses for excessive claims for the schemes. The firms will also face additional costs for investigations (*City Press* 2013).

Given these realities, it seems that a case study that received some publicity is merely a drop in the ocean of corruption. However, some lessons can be learnt after the fact.

The case of 200 members of the South African Broadcasting Corporation (SABC) was reported publicly without making news-paper headlines. Employees of the corporation colluded with a number of medical practitioners and service providers in order to commit fraud against the SABC medical aid scheme operated by Medscheme at the time.

Following the evidence, 134 staff members were charged and after the completion of the disciplinary processes, 123 of them were dismissed with immediate effect (Polity 2015). In many ways, such a fraudulent act, irrespective of its coordinated or uncoordinated nature, pales into insignificance when compared to the multi-million rand case of the Government Employees Medical Scheme (GEMS) recently. By 2017, GEMS had 1.833 million beneficiaries and is the scheme that provides medical cover to 57% of eligible public servants.

The corruption in the entity blossomed as substantial number of members and healthcare practitioners and companies were involved in fraudulent claims, including significant in-hospital claims. In the latter cases, the claims were fraudulent in respect of the length of admission and the complete lack of serious radiology or pathology or radiology tests while in

hospital. Most of the corrupt claims were directly related to benefits associated with hospital cash back plans.

Perpetual corruption at GEMS led the relevant regulatory authorities to believe that the scheme could be insolvent by the 2016 financial year and would be bailed out by the Treasury. Such a movement would be detrimental to the belief and ambition that it could be a model to be followed in the future realization of the National Health Insurance plan.

The fact that the Council of Medical Schemes did not put GEMS under curatorship after the failure to meet minimum statutory requirements of solvency ratio is significant. GEMS' ratio stood at 5% (the solvency ratio is 25%). Its 2016 deficit was R1.2b and its reserves 2%.

During 2016, GEMS raised the members' contributions from R1 389 to R1 764, a 21% increase (Norje 2016). By 2016, the GEMS website items, Fraud Zone, Blow the whistle on fraud! Fraud against GEMS, Fraud Forum, Types of fraud, Implications of fraud and Fraud Awareness, were ALL discontinued.

Perpetual fraud, corruption and mismanagement across the board in GEMS led hundreds of its members who felt the consequences of perpetual annual increases calling for the medical aid schemes' scrapping from the map, as they had been perpetually rejected by most medical practitioners. There was evidence presented that fraud and corruption within the organization had led to the medical aids of members becoming exhausted as early as February and many of them turned to bank loans or 'mashonishas' (money lenders). This meant that members could not use their benefits and were subsequently rejected without any medical service and facilities.

The newly established Educators Union of South Africa (EUSA) stated on the day of their recognition from the Labour Department, that one of the key objectives of the union was the complete scrapping of the corrupt GEMS and that they had planned country-wide picketing demonstrations demanding its immediate closure by the state (EUSA 2018).

There have been cases where large numbers of GEMS members witnessed their funds being 'exhausted' after two months and large numbers of medical practitioners and pharmacies refusing to accept the medical scheme's cards. A few days after its official registration, hundreds of the union's members held picketing demonstrations outside GEMS offices together with ambulances representing SARAESA (the South African Private Ambulance and Emergency Services Association), medical practitioners representing NHCPA (the National Healthcare Professionals Association). All constituencies called for the immediate scrapping of the medical scheme (Masuku 2018).

Perhaps the most 'daring' corruption act committed by GEMS was exposed through its 'collaboration' with a private public relations company, which provided 'free medical advice' online to the medical scheme's members. The service was called 'House Call with Dr. Joe' and operated since 2014. It was advertised as a personalised health care advice column and was 'managed' by Martina Nicholson Associates, who handles public relations for GEMS and a number of other medical schemes. While the firm insisted initially that medical practitioners were employed, it surfaced that it was company employees who answered questions on depression, fertility, cancer, pharmaceutical needs, and infections, through the use of GOOGLE. Although GEMS and the public relations company insisted that all responses were written and signed by two medical doctors and provided 'proof' of such transactions, three independent medical practitioners showed that many answers were incorrect, a fact verified in the process by employees of the public relations company. In the process of investigating the case, a number of medical practitioners pinpointed many unscientific and incorrect responses provided that dealt with serious health conditions and diseases such as breast cancer risk, children's Attention Deficient Disorder, HIV/AIDS, diabetes and birth control, children's recurrent pneumonia, as well as 'cut and paste'-based wrong answers provided by 'Google services'. In fact, as the story unfolded, without really hitting the headlines, both GEMS and the public relations company insisted that this was just an 'educational guide' for members and not 'medical advice to patients'.

Such a 'defensive' position hid the fact that the pretention of those operating the system was not only unethical and illegal in their totality, but according to the Health Professions Council of South Africa, committing a 'criminal offence'. According to the Health Professionals Ethics Conduct of 2010, only registered and competent are authorized to take part in any form of tele-medicine practice in the country (Child 2017).

Despite the fact that there have been efforts to fight fraud and collusion through cooperation and open communication in the 'restricted' schemes, and there were existing arrangements in place for sharing information and reporting fraud and collusion, in 2016 less than half of the schemes utilised estimates of losses to increase their anti-corruption capabilities. This could have been achieved through a careful dissection of the existing detected realities and the training of specialist staff to deal decisively with fraud and corruption. At the time, less than 30% of them provided such training to the staff dealing with and fighting corruption and fraud, despite all of them having introduced anti-fraud and corruption policies **(Interview 5, Medical Scheme Board member).**

Things have improved somehow through the schemes' collaboration with the Healthcare Forensic Management Unit (HFMU), which has been helpful in decreasing the existing collusion, corruption and fraud risks to a certain extent, hoping to achieve in the future the total eradication of the scourge. They have been instrumental in increasing the communication channels and information sharing in the sector to a large degree (Fin24 2015).

While collusion has been there almost from the first day of the sector's existence, there are corrupt practices associated with the very governance and operational realities of medical aid schemes that have existed for many years. One of those well-known is the exorbitant 'stipends' that the scheme trustees pay themselves, obviously through the 'utilisation' of member contributions. Trustees are people who under 'normal circumstances' would be supposedly volunteering their occasionally valuable services. One of the reasons for such deeds is the fact that existing legislation does not provide rules, regulations or guidelines that monitor, evaluate or determine trustees' 'stipends' or other forms of payment. Given this situation, it is understandable that such money is paid for remuneration associated with attendance at meetings, travel, meals, accommodation and similar expenses. A comparative view of such processes paints the picture clearly.

According to the 2013 CMS annual report, the trustees of the then top six medical schemes received R25 021 000 each. The interesting detail of the comparison pointed to the fact that GEMS notably, the Government Employees Medical Scheme, or the *public sector* medical scheme) had the highest cost of R795 100 (Council for Medical Schemes' Annual Report 2013). The average remuneration per trustee was R568 000. Fedhealth, Hosmed, Bonitas, and Discovery paid an average of R 3 600 000 per year to trustees.

In 2016, DISCOVERY overtook GEMS in comparison and paid an average of R673 000 to all six trustees. The corruption- and scandal-ridden GEMS was relegated to second, paying R597 000 to its 12 trustees (double the number in comparison to the private sector operators).

The leadership of the financial supervision of CMS has been on record as indicating that such extravagance in 'stipends' was a serious concern for the entity, which was reinforced through comparative research undertaken by the council in collaboration with a reputable tax and advisory firm EY. The research, broadly based on the unpacking of remuneration of trustees, considered the 'stipends' exorbitant and dealt seriously with the weaknesses of the Medical Schemes Act and especially its Regulation No. 6, that needed urgent review. The role of the Registrar of the Medical Aid Schemes should

also become more instrumental in the determination of trustee remuneration (Council for Medical Schemes' Annual Report for 2016). This is one of the key issues facing medical aid schemes in terms of governance, and the reality is that despite continuous efforts on the part of the Council for Medical Schemes and its Compliance and Investigations Unit to rectify such situations, it is almost chronic (Council for Medical Schemes' Annual Report 2014). By its own admission, the sector's statutory body, which has the duty and responsibility to regulate it, lacks the authority charged with regulating the industry and has not been able to make a significant positive change in respect of the present poor governance.

Over the years, there have been a number of medical aid schemes that have been placed under curatorship most in the restricted category indicating the poor management and leadership that is the ultimate foundation of bad or weak governance.

The question that arises, then, is what the exact role of the very well-paid trustees in tightening governance is, given the fact that the stipend of a number of trustees of schemes under curatorship has been almost doubled in a short period of time. There have been members' complaints of serious manipulation in trustees' appointments and their continuous abuse of overseas trips, inordinate fees, and other excesses (Fin24 2015a).

Despite the fact that the CMS leadership and relevant organs have been working for seven years towards a plan determining guidelines of remuneration for trustees, as well as training in respect of their obligations, duties and responsibilities, no outcomes have been achieved at present.

The record shows that there have been a number of issues directly connected to the current status of poor governance especially in terms of the restricted medical schemes, such as lack of active membership participation at Annual General Meetings, which are in most occasions inaccessible or badly timed; poor attendance and lack of interest on the part of members; lack of appropriately structured agenda items; lack of transparency on the part of trustees and the schemes in general; lack of continuous communication with scheme members, and the absence of direct information to members on their own duties, responsibilities and obligations (Council for Medical Schemes' Annual Report 2014).

It has become evident that lack of member interest and public participation is a significant reason for the perpetration of bad governance that, according to the CMS, is also affected by a number of gaps in the existing key legislation. The entity in 2004 put forward a number of amendments to the

Medical Schemes Act of 1998, aiming at strengthening the foundations of governance of the medical aid schemes. The amendments were withdrawn as the leadership of the Council supported the government's focus on the NHI (the National Health Insurance), but new hopes were raised when the act was back for consideration **(Interview 5, Medical Scheme Board Member).**

For a number of years and on a number of occasions, the CMS included a section called '*Undesirable business practices',* where specific incidents of poor and bad governance practices and corruption were identified, including this item in Section 61(3) of the Medical Schemes Act. These were the results of inspections identified in Section 44(4) (a) of the same Act. Over the years, the inspection discovered, amongst other things mainly in the restricted medical schemes, 'irregular payments to consultants'; removed trustees spending R27m of the scheme to 'fight their removal'; 'remuneration for three members to the extent of R1.8m while fighting against their removal; fraud, misconduct and other irregularities; interference by the employer in scheme affairs; schemes' refusals to allow governance issues to be investigated; illegal dissolution of audit and risk committees, and illegal payments for the principal officer and the trustees for entertainment (the Cape Town Jazz Festival). During one financial year, there were 10 investigations and one High Court case Council for Medical Schemes' Annual Report 2012; 2013; 2014; 2015).

While fraud, corruption and collusion in the sector has escalated, according to leaders and functionaries in the industry, reaching on many occasions highly sophisticated levels, the lack of utilisation of appropriate technological innovations exacerbates the problems despite the existence of international analytics devices that are able to fight waste, abuse and fraud. Such devices are able to provide identification of potential and/or existing abuse and fraud through a dissection, analysis, monitoring and evaluation of irregular claiming patterns leading to detection, planning and subsequent action. Detection leads to further investigation by specialists in forensics, followed by the company's calculated action **(Interview 3, Senior Public Servant, Gauteng Province).**

Given the fact that in all these cases it is not only medical service providers in conjunction with medical scheme members that commit corrupt acts, but on many occasions medical scheme employees who are involved directly or indirectly, there are operational and organisational realities that create the foundations of corrupt activities. This is especially the case of the restricted ones.

There has been evidence that the complexity and vast volumes of medi-

cal aid claims data every day are becoming a burden to the complex operational systems and are used or abused for corrupt and fraudulent acts **(Interview 4, Senior Public Servant, Gauteng Province).** This means that such volumes of electronic data daily make it extremely difficult, especially for inadequately skilled or corrupt employees to understand, detect and stop fraud. Such realities are exacerbated by the lack of fraud and risk management.

Terabytes of claims data reach medical schemes and are in need of processing and these need to be supplemented by pressures of continuous reporting, thus creating serious problems for risk management departments, especially in restricted schemes, which lack urgency and prioritisation of information technology, as well as personnel or skills in forensic data analysis (News24 2015).

It is accepted within the industry, that although the 'open' schemes have significantly updated their efforts to ratify the weaknesses of their organisational and administrative systems to mitigate fraud and corruption, the same cannot be said about the 'restricted' ones. The complaint lodging avenues of the latter, when their organisational mechanisms establish solid reasons for reporting fraud, are with the professional councils and the South African Police Services. Such actions mean that in most cases, investigation proceedings last very long, as most anti-corruption agencies, including SAPS, have over the years faced serious challenges in terms of prosecuting perpetrators of fraud and corruption. Thus medical schemes generally struggle to get fraudsters convicted for a number of serious reasons. Such realities allow fraudsters and corrupt staff, medical practitioners and service providers and members, to continue unabated **(Interview 5, Medical Scheme Board Member, Gauteng Province).**

Detection, monitoring and prevention of corruption in medical aid schemes is complex and fragmented, as different schemes, especially the public service ones, are operating in isolation and have not consolidated their efforts to fight fraud and corruption. Such a reality is the result of intense competition amongst different schemes, as those who succeed in fighting corruption create an aura of success and competitive advantage (Mothudi 2018:13).

Conclusion: What is to be Done?

Corruption at all levels of society has a wide number of negative effects such as the depreciation of the rand, leads to the depreciation of the national currency, become a serious barrier to local and foreign investment reduces funding for health, education, infrastructure and depreciates national currency, and cuts

down on public servants' wide variety of benefits such as medical aid. All these have a direct and indirect negative effect on the financial security and lives of the vast majority of the working and middle classes, including the public servants.

The almost perpetual depreciation of the rand because of corruption and political instability has direct and indirect effects on a number of health related products and services such as pharmaceutical, hospital expenses and medical aid scheme, especially the public sector ones (Woods & Mantzaris 2012).

So much is the South African stated concerned about corruption, abuse, waste and fraud, at all levels, services and products in both the private and public health care systems that the Head of SIU (the Special Investigating Unit) announced publicly that the Unit after a meeting in Pretoria announced the establishment of whose forum would be the fight against fraud, waste and all forms of corruption in all sectors of the healthcare terrain.

The new forum would be an integral part of the expanded ACTT (the Anti-Corruption Task Team, a multi-department team established as a new entity in 2009 aiming at meticulous detection, investigation and prosecution of all alleged cases of corruption in the sector.

The Task Team's original mandate was expanded in 2014 in order to include a number of other programmes, that included intelligence, policy support and crime operations (Mabuza 2018)**.**

The realities identified in the article point to the truth that despite a number of successes in the relentless fight against fraud and corruption in the medical aid scheme terrain on the part of the operating in the free market sector, the same cannot be said of the 'restricted' ones. This fact continues to dent the financial security of all beneficiaries belonging to the working class and lower and middle-class categories of public servants.

A key solution that is urgently needed is a final and well-articulated decision of the leadership of all medical aid schemes, especially the public service ones, to unite as an industry and decide to join operations in the fight against fraud and corruption in their midst.

Such a decision will go a long way in showing the ever-growing membership that the schemes have realised that fraud and corruption are a major threat to the entities' existence, as well as the well-being of over 9 million members.

It is essential that the individual efforts of schemes and administrators are consolidated in an industry-wide central database to facilitate collective use and analysis of data, as it is done, for example, in the banking sector. The

Council for Medical Schemes can be instrumental in such a move as it is evident that fraud and corruption seem to be posing a serious threat to the medical schemes and their potential to save over R10b that is currently lost through fraud and corruption.

The success of medical aid scheme risk management, investigation detection and prevention at present is directly connected to the existence of solid technological assistance, what is known as 'back-end technology' and the 'big data innovations' that are instrumental in stream-lining and improving the anti-corruption environment that leads to easy and quick detection.

The new technological innovations characterized by up-to date analytical tools have been instrumental in dissecting data in effective ways. Advanced technology is an enabler of real-time mining of data, allowing the schemes to track and monitor member and provider profiles and actions, thus detecting fraud. Fraudulent behavior leading to fraud is tracked as identification of perpetrators becomes a reality, immediately enabling schemes to act decisively.

The latest preposition of the Council for Medical Schemes for the future consolidation of all public service employees into GEMS, has led to an occasionally healthy debate on the issue. This is not enough. A concerted effort to determine the best way forward is essential so that the long term financial security of all members is guaranteed. It is evident that a future consolidation of such a nature is in line with the governmental policy guidelines of the National Health Insurance. Given the existing realities in this terrain, it is most likely that strong opposition will be faced by both open and closed entities as well as the members themselves, given the dynamics, actions and inactions, as well as the behavior of the GEM's leadership.

However, such a decision will call upon each and everyone in the medical aim scheme terrain to answer the question: 'If the answer is 'no' how much do you really care about the wellbeing and financial security of all your members?'

The state contributes significantly to public servants' medical scheme contributions. Inevitably, workers belonging to active and strong trade unions will ultimately resist such steps that are seriously considered to be against their existing benefits. This is an issue of contention as the representation of over 30% of the industry members will operate under one 'roof' that will 'absorb' 10 schemes, including fraud-prone entities such as Rand Water and SABC. There is no doubt that a consolidated medical scheme would be ultimately beneficial as it could offer better savings and have stronger negotiating powers. Given its numerical strength, GEMS is possibly the best option. However, its

history and present disrepute are negative factors, raising suspicion especially if compared with Polmed, which is also numerically strong.

The possibilities of 'fast-tracking engagement strategies', where one or two schemes are used as 'experiments in the amalgamation' have no chance of success, because of history and existing particularities and differences. Only an open, frank and transparent debate amongst all stakeholders and role-players can lead to a consolidated public service medical scheme.

While the accusations and realities regarding the role of medical schemes and administrators in bullying the medical providers and patients are still prominent and confirmed in the past the state entities and administrators are legally obligated to look after and safeguard the funds of their beneficiary members and be in the forefront of the fight against abuse. They must come and act clean through their committed action to recover funds and thus help their members' financial by keep annual increases of medical aid under control.

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Interview No 3. Senior Public Servant, Gauteng Province, Johannesburg. (19 October 2017.)

Interview No 4. Senior Public Servant, Gauteng Province Johannesburg. (17 October 2017.)

Interview No 5. Medical Scheme Board Member, Gauteng Province, Pretoria. (19 October 2017.)

Interview No 6. Private Hospital Manager, Gauteng. (21 October 2017.)

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