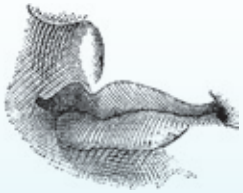
{ the essense of life }



2012-2013

AnnualReport

COUNCIL FOR MEDICAL SCHEMES

CMS
Council
for Medical Schemes

ANNUAL REPORT
COUNCIL FOR MEDICAL SCHEMES

RP | 109/2013
ISBN | 978 0 621 41764 7

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the essense

The essense of life is being insightful, listening to advice, having the foresight to discuss what's important to you. It's a sense of knowing. The CMS cares about people... Each interaction is with you in mind, so lend us an ear and we will tell you a story.

the essense of life

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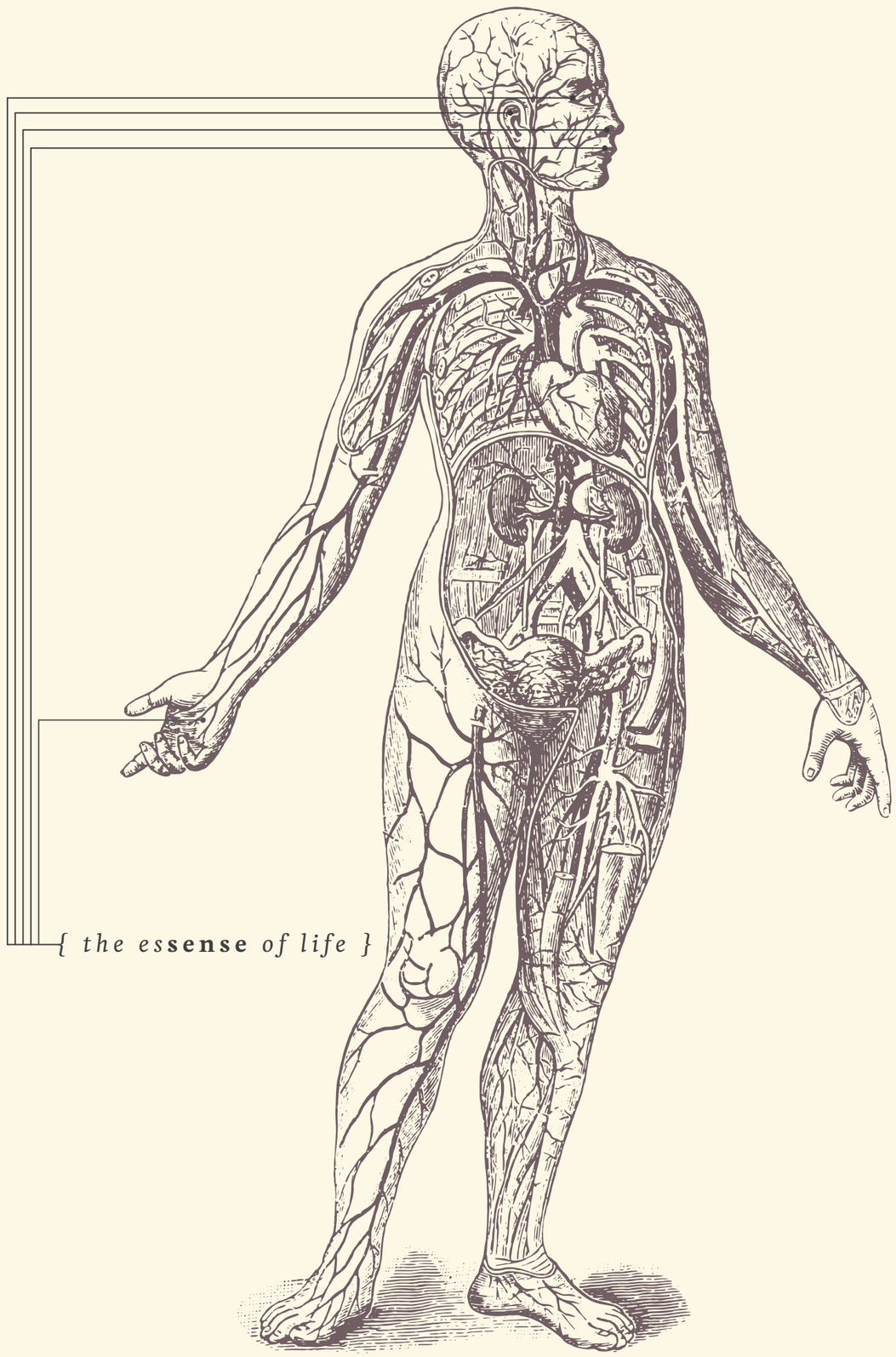

CHAPTER 1
GENERAL INFORMATION

"If you'd rather live surrounded by pristine objects than by the traces of happy memories, stay focused on tangible things. Otherwise, stop fixating on stuff **you can touch** *and start caring about stuff that touches you."*

Martha Beck

GENERAL INFORMATION OF THE COUNCIL FOR MEDICAL SCHEMES

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SizweNtsalubaGobodo

EXTERNAL AUDITORS

Auditor-General of South Africa (AGSA)

BANK

Absa Group Limited (Absa)

CHAIRPERSON OF COUNCIL

Prof. Yosuf Veriava (from 28 November 2012)
Trevor Bailey (Acting) (1 July-27 November 2012)
Dr Rejoice Simelane (1 November 2011-30 June 2012)

CHIEF EXECUTIVE & REGISTRAR

Dr Monwabisi Gantsho (from 1 June 2010)

COUNCIL SECRETARIAT

Khayalethu Mvulo (Acting) (from 1 November 2012)
Gugulethu Tlali (1 September 2011-31 October 2012)

GLOSSARY, ACRONYMS, AND ABBREVIATIONS

A:	African
Absa:	Absa Group Limited
Accounting Authority:	Council, the Board of the CMS
Accounting Officer:	Chief Executive & Registrar
Act:	Medical Schemes Act 131 of 1998
ad hoc:	formed, arranged, or done for a particular purpose only
Afrisam:	Afrisam SA Medical Scheme
AFS:	Annual Financial Statements
AGM:	Annual General Meeting
AGSA:	Auditor-General of South Africa
AIDS:	Acquired Immune Deficiency Syndrome
Altron:	Altron Medical Aid Scheme
APP:	Annual Performance Plan
Apr:	April
ASB:	Accounting Standards Board
Barloworld:	Barloworld Medical Scheme
beneficiaries:	principal members + dependants (total membership of medical scheme)
BEPS:	Built Environment Professional Associations Medical Scheme
Bestmed:	Bestmed Medical Scheme
BHF:	Board of Healthcare Funders of Southern Africa
BHP:	Broken Hill Proprietary Company (Australia)
BI:	Business Intelligence
BMD:	bipolar mood disorder
BMI:	Body Mass Index
BMU:	Benefits Management Unit
BMW:	Bayerische Motoren Werke AG (Germany)
Board:	Board of Trustees
bona fide:	genuine; real
Bonitas:	Bonitas Medical Fund
BoT:	Board of Trustees
BP:	British Petroleum (United Kingdom)
Bpk:	Beperk
BR:	broker number
C:	Coloured
CAMAF:	Chartered Accountants (SA) Medical Aid Fund
CC:	Closed Corporation
CCC:	Customer Care Centre
CDL:	Chronic Diseases List
CEO:	Chief Executive Officer
CFO:	Chief Financial Officer
Chief Executive & Registrar:	Accounting Officer of the CMS
Clicks:	Clicks Group Medical Scheme
CMS:	Council for Medical Schemes
COMMED:	Community Medical Aid Scheme
Companies Act:	Companies Act 71 of 2008
Compcare:	Compcare Wellness Medical Scheme
Competition Act:	Competition Act 89 of 1998
Council:	Accounting Authority, the Board of the CMS
CPA:	Consumer Protection Act 68 of 2008
CPF:	Consumer Protection Forum
CPI:	Consumer Price Index
CPIX:	CPI excluding interest rates on mortgage bonds
CRC:	Clinical Review Committee
CRI:	Composite Risk Index
CT (scan):	Computerised Tomography
Dec:	December
de facto:	in fact, whether by right or not
DENOSA:	Democratic Nursing Organisation of South Africa
dependant:	member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DHMS:	Discovery Health Medical Scheme
Discovery Health:	Discovery Health Medical Scheme
Discovery Health (Pty) Ltd:	an administrator
DoH:	Department of Health
Dr:	Doctor
DRG:	Diagnosis-Related Group
DSP(s):	designated service provider(s)
DTP:	Diagnosis and Treatment Pair
e:	electronic
ECIPA Healthcare:	East Cape Medical Business Systems (Pty) Ltd
Edms:	Eiendoms
EDMS:	Electronic Document Management System
EDO(s):	efficiency-discounted option(s)
EE:	Employment Equity
e.g.:	*exempli gratia* (for example)
etc.:	et cetera (and other similar things; and so on)
E&V:	Entry & Verification
EVG(s):	Entry & Verification Guideline(s)
EWS:	Early Warning System
excl.:	excluding
EXCO:	Executive Committee (Council sub-committee)
Executive Authority:	Minister of Health
f:	fax
FAIS Act:	Financial Advisory and Intermediary Services Act 37 of 2002
FAIS Ombud:	Office of the Ombud for Financial Services Providers
Fedhealth:	Fedhealth Medical Scheme
Fishmed:	Fishing Industry Medical Scheme
FSB:	Financial Services Board
FSP:	Financial Services Provider
FSU:	Financial Supervision Unit
GAAP:	Generally Accepted Accounting Principles
GAE:	Gross Administration Expenditure
GCI:	Gross Contribution Income
GEMS:	Government Employees Medical Scheme
Genesis:	Genesis Medical Scheme
Gen-Health:	Gen-Health Medical Scheme
Golden Arrows:	Golden Arrows Employees Medical Benefit Fund
GP:	general practitioner
GRAP:	Generally Recognised Accounting Practice
HASA:	Hospital Association of South Africa
HIV:	Human Immunodeficiency Virus
Hosmed:	Hosmed Medical Aid Scheme
HPCSA:	Health Professions Council of South Africa
HR (Unit):	Human Resources (Unit)
HWSETA:	Health and Welfare Sector Education and Training Authority
I:	Indian
IAS:	International Accounting Standard
IBM:	International Business Machines Company (USA)
IBNR:	Incurred But Not Reported
ICD-10:	International Classification of Diseases – 10th Revision
ICON:	Independent Clinical Oncology Network (Pty) Ltd
ICT:	Information & Communication Technology
ICU:	Intensive Care Unit
i.e.:	*id est* (that is to say)

IFRS:	International Financial Reporting Standards
Inc.:	Incorporated
incl.:	including
Ingwe:	Ingwe Health Plan
INSETA:	Insurance Sector Education and Training Authority
inter alia:	among other things
IRBA:	Independent Regulatory Board of Auditors
ISBN:	International Standard Book Number
IT:	Information Technology
ITAP:	Industry Technical Advisory Panel
Jan:	January
Jul:	July
Jun:	June
KM:	Knowledge Management
KZN:	KwaZulu-Natal
Large scheme:	≥ 30 000 beneficiaries
Liberty:	Liberty Medical Scheme
Lonmin:	Lonmin Medical Scheme
Ltd:	Limited
MAC:	Ministerial Advisory Committee
Mar:	March
MCO:	managed care organisation
MEDCOR:	Medical Scheme for the Department of Correctional Services
Medipos:	Medipos Medical Scheme
Medium scheme:	≥ 6 000 members but < 30 000 beneficiaries
Medscheme:	Medscheme Holdings (Pty) Ltd
Medshield:	Medshield Medical Scheme
Metropolitan:	Metropolitan Health Corporate (Pty) Ltd
Minemed:	Minemed Medical Scheme
MIS:	Management Information System
Moremed:	Moremed Medical Scheme
MoU:	Memorandum of Understanding
MPR:	Medicine Price Registry
Mr:	Mister
MRC:	Medical Research Council
MRI (scan):	Magnetic Resonance Imaging
Mrs:	Missus
Ms:	Miss
MSO:	Medical Services Organisation (Pty) Ltd
N/A:	Not Applicable
Naspers:	Naspers Medical Fund
NC:	Not Comparable
NCC:	National Consumer Commission
NCF:	National Consumer Forum
NGO:	non-governmental organisation
NHC:	Net Healthcare
NHE:	Non-Healthcare Expenditure
NHI:	National Health Insurance
NHISSA:	National Health Information System of South Africa
NHRPL:	National Health Reference Price List
NI:	New Indicator
NIMAS:	National Independent Medical Aid Society
no.:	number
NPA:	National Prosecuting Authority of South Africa
NPC:	National Press Club
Oct:	October
Office:	Office of the Chief Executive & Registrar (of Medical Schemes)
OHMC:	Operational Health Management Conference
ORG:	brokerage number
pab:	per average beneficiary
pabpa:	per average beneficiary per annum
pabpm:	per average beneficiary per month
PAIA:	Promotion of Access to Information Act 2 of 2000
pam:	per average member
pampa:	per average member per annum
pampm:	per average member per month
pasbpm:	pabpm in respect of schemes which had savings transactions
pb:	per beneficiary
pbpa:	per beneficiary per annum
pbpm:	per beneficiary per month
PCN:	Practice Code Number
PCNS:	Practice Code Numbering System
PDF:	Portable Document Format
PDP:	Personal Development Plan or Professional Development Programme
PEED:	Pharmaceutical Economic Evaluation Directorate
pensioner:	beneficiary at least 65 years old
period under review:	the CMS financial year 1 April 2012 to 31 March 2013
PET (scan):	Positron Emission Tomography
PFMA:	Public Finance Management Act 1 of 1999
Pharos:	Pharos Medical Plan
PMB(s):	prescribed minimum benefit(s)
pm:	per member
pmpa:	per member per annum
pmpm:	per member per month
PMSA:	personal medical savings account
PO:	Principal Officer
POATIA:	Promotion of Access to Information Act
POLMED:	South African Police Service Medical Scheme
POPI:	Protection of Personal Information Bill
PPPFA:	Preferential Procurement Policy Framework Act 5 of 2000
PPS:	Professional Provident Society
principal member:	member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Prof.:	Professor
Pro Sano:	Pro Sano Medical Scheme
Protea:	Protea Medical Aid Society
Pty:	Proprietary
R:	Rand (South African currency)
RAF:	Risk Assessment Framework
RCI:	Risk Contribution Income
RDC:	Regulatory Decisions Committee
Ref.:	Reference
REF:	Risk Equalisation Fund
Registrar:	Registrar of Medical Schemes
Remedi:	Remedi Medical Aid Scheme
Resolution Health:	Resolution Health Medical Scheme
RETAP:	Risk Equalisation Technical Advisory Panel
R&M (Unit):	Research & Monitoring (Unit)
RMA:	Rand Mutual Association
RP (number):	Government Printing Works (number)
RTM:	Real-Time Monitoring
SA:	South Africa(n)
SABC:	South African Broadcasting Corporation
SABINET:	Southern African Bibliographic Information Network
SAHRC:	South Africa Human Rights Commission
SAICA:	South African Institute of Chartered Accountants
SAMA:	South African Medical Association
SAMWUMed:	South African Municipal Workers Union Medical Scheme
SAPS:	South African Police Service
SCA:	Supreme Court of Appeal

SCOPA:	Standing Committee on Public Accounts
Selfmed:	Selfmed Medical Scheme
Sep:	September
SEP:	Single Exit Price
SGM:	Special General Meeting
Sizwe:	Sizwe Medical Fund
SLA:	Service Level Agreement
SLE:	systemic lupus erythematosus
Small scheme:	< 6 000 members
SOP:	Standard Operating Procedure
SP:	Strategic Plan
SRM (data):	Schemes Risk Measurement (data) (former REF data)
t:	telephone
t/a:	trading as
TAP:	Technical Advisory Panel (on Annexure B / Regulation 30)
TB:	tuberculosis
Thebe Ya Bophelo:	Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd
TIP:	Trustee Induction Pack
Topmed:	Topmed Medical Scheme
ToR:	Terms of Reference
Transmed:	Transmed Medical Fund
TRC:	Truth and Reconciliation Commission
UJ:	University of Johannesburg
UK:	United Kingdom
Umvuzo:	Umvuzo Health Medical Scheme
UNISA:	University of South Africa
USA:	United States of America
v:	versus
V Med:	V Medical Aid Administrators (Pty) Ltd
w:	website
W:	White
WCMAS:	Witbank Coalfields Medical Aid Society
WHO:	World Health Organisation
WIP:	Work In Progress
Wits:	University of the Witwatersrand
WSP:	Workplace Skills Plan

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Explanatory notes for the year ended 31 December 2012

STRATEGIC OVERVIEW

STRATEGIC OVERVIEW

The Council for Medical Schemes (CMS) is a regulatory authority responsible for overseeing the medical schemes industry in South Africa. It administers and enforces the Medical Schemes Act 131 of 1998.

VISION • MISSION • VALUES • STRATEGIC GOALS

Vision

The Council for Medical Schemes strives to be a fair custodian of equitable access to medical schemes in order to support the improvement of universal access to healthcare.

Mission

The Council for Medical Schemes regulates the medical schemes industry in a fair and transparent manner, and achieves this by:

+ protecting the public and informing them about their rights, obligations, and other matters in respect of medical schemes;
+ ensuring that complaints raised by members of the public are handled appropriately and speedily;
+ ensuring that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
+ ensuring the improved management and governance of medical schemes; and
+ advising the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives.

Values

The values of the Council for Medical Schemes stem from those underpinning the Constitution and its specific vision and mission.

Being an organisation that subscribes to a rights-based framework where everyone is equal before the law, where the right of access to healthcare must be protected and enhanced, and where access must be simplified in a transparent manner, the following values are key requirements of all employees at the Council for Medical Schemes:

+ *Ubuntu* – we need each other to achieve our goals.
+ We strive to be consistent in our regulatory approach.
+ We approach challenges with a "can do" attitude.
+ We are proud of our achievements.
+ We are occupied by doing something of value.

The essense of life is being insightful, listening to advice, having the foresight to discuss what's important to you. It's a sense of knowing. The CMS cares about people... Each interaction is with you in mind, so lend us an ear and we will tell you a story.

Strategic goals

Goal 1: Access to good quality medical scheme cover is maximised.

Ensure that at all times barriers to scheme access are minimised and that coverage provided by schemes is of a high standard. Improved risk-pooling is achieved through enhanced community-rating, open enrolment, and prescribed minimum benefits.

By 2013, firm policy recommendations must be incorporated in government policy, and proposals towards amendments of the Medical Schemes Act must be made to implement these arrangements.

Goal 2: Medical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected.

Ensure that at all times medical schemes are governed in the interests of beneficiaries by ensuring that the principles of good corporate governance are fully adhered to and that appropriate action is taken against corporate governance failures.

By 2013, amendments to the Medical Schemes Act must be in place to strengthen the governance provisions, and governance failures are addressed prior to scheme failures.

Ensure that at all times medical schemes are sensitive to the specific needs of beneficiaries, are financially sound, and offer protection against catastrophic financial incidents. Schemes must also be sensitive to broader social considerations through the introduction of appropriate regulatory measures and their enforcement.

By 2013, the Council for Medical Schemes must have a well-functioning system to cater for the electronic filing of scheme rules, near real-time financial monitoring, and a well-functioning Composite Risk Index system.

Through the control and coordination of the availability of information emanating from regulated entities, their education and training activities, participation in public discussions, and the publication of material in lay and official publications, the Council for Medical Schemes will contribute to ensuring that members, their dependants, and the public are informed of their rights.

By 2013, the Council for Medical Schemes will have an updated version of communication guidelines (which schemes must adhere to), most schemes' marketing material will be analysed before release, and scheme communication with members will be monitored.

Goal 3: The Council for Medical Schemes is responsive to the needs of the environment by being an effective and efficient organisation.

Through the improvement of complaints regimes, information collection and dissemination, financial and other best-practice monitoring systems, and the effective internal organisation of the Office of the Registrar (including improved IT systems, enhanced human resources policies and procedures, adherence to financial management, and other internal measures), the Council for Medical Schemes will constantly adapt and upgrade its way of doing business.

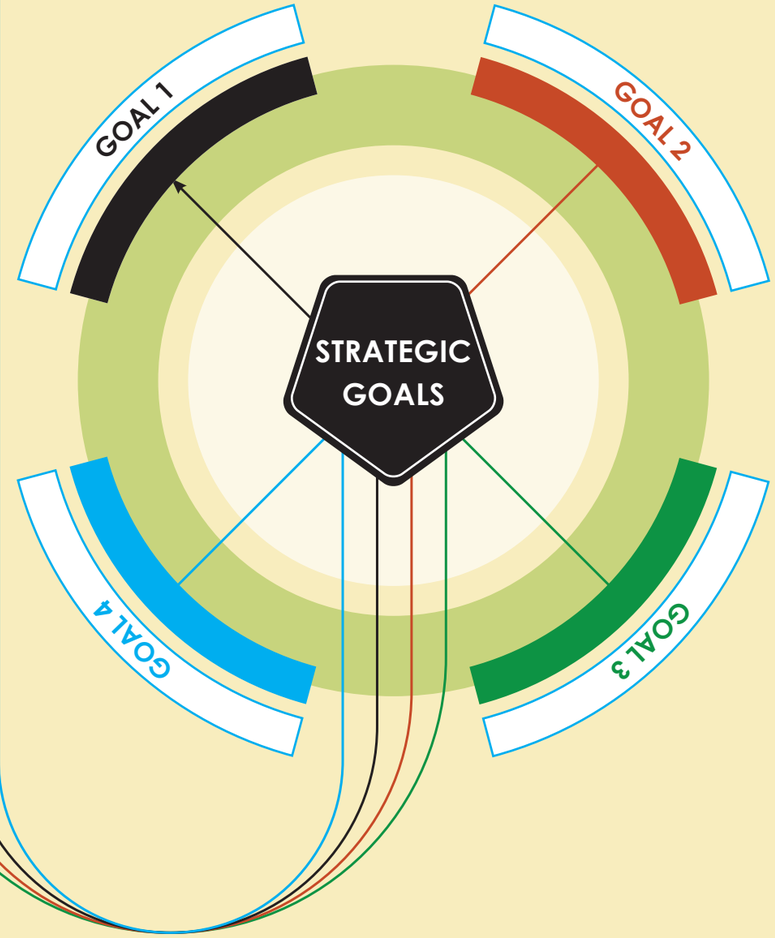
To improve its efficiency, the Council for Medical Schemes will reduce the proportion of the budget allocated to support functions to less than 40% by 2013.

Goal 4: The Council for Medical Schemes provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the National Health Insurance development process.

Through reviewing the needs of the environment, the Council for Medical Schemes and government will constantly collect and upgrade the collection of information for the purposes of ongoing and strategic review of the private health system.

Through its privileged position in the health system, the Council for Medical Schemes will form strategic relations with regional and international institutions, consult, research, and collate information for the purposes of influencing stakeholders and to provide strategic advice to government as well as technical assistance to major strategic health reforms.

By 2013, the Council for Medical Schemes will have completed at least one major project to support this goal.



LEGISLATIVE AND OTHER MANDATES

CONSTITUTIONAL MANDATES

Section 27 of the Constitution places the obligation on the state to make reasonable legislation to progressively realise access to healthcare. The Medical Schemes Act 131 of 1998 represents such legislation, which creates the framework for non-discriminatory access to medical schemes. More details on access to medical schemes are presented in the 2011/2012-2014/2015 Strategic Plan of the CMS.

Section 36 of the Constitution deals with the limitation of rights, and spells out strict criteria which must be adhered to whenever rights included in the Bill of Rights are limited by law. Section 22 of the Constitution guarantees the freedom of trade, which may be limited by law. The Medical Schemes Act limits the business of a medical scheme to those parties who are registered by the CMS and requires such parties to comply with the provisions of the Medical Schemes Act.

LEGISLATED MANDATES

The Medical Schemes Act established the CMS. Section 7 of the Act confers the following functions on the Council (the Accounting Authority or Board of the CMS):

a) "protect the interests of the beneficiaries at all times;
b) control and coordinate the functioning of medical schemes in a manner that is complementary with the national health policy;
c) make recommendations to the Minister [of Health] on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;
d) investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act;
e) collect and disseminate information about private healthcare;
f) make rules, not inconsistent with the provisions of this Act, for the purpose of the performance of its functions and the exercise of its powers;
g) advise the Minister [of Health] on any matter concerning medical schemes; and
h) perform any other functions conferred on the Council [for Medical Schemes] by the Minister [of Health] or by this Act."

POLICY MANDATES

The CMS, as an organ of state, is obliged to discharge its legislated mandate in a coherent manner, which is consistent with national policy.

Government's programme of action: 10 priority areas up to 2014

1) Speed up economic growth and transform the economy to create decent work and sustainable livelihoods.
2) Introduce a massive programme to build economic and social infrastructure.
3) Develop and implement a comprehensive rural development strategy linked to land and agrarian reform and food security.
4) Strengthen the skills and human resource base.
5) Improve the health profile of all South Africans.
6) Intensify the fight against crime and corruption.
7) Build cohesive, caring, and sustainable communities.
8) Pursue African advancement and enhanced international cooperation.
9) Ensure sustainable resource management and use.
10) Build a developmental state, improve public services, and strengthen democratic institutions.

The Department of Health's *10-Point Plan*

1) Provide strategic leadership and create a social compact for better health outcomes.
2) Implement a National Health Insurance (NHI) Plan.
3) Improve quality of services.
4) Overhaul the healthcare system and improve its management.
5) Improve human resources planning, development, and management.
6) Revitalise infrastructure.
7) Accelerate the implementation of the HIV/AIDS & Sexually Transmitted Infections National Strategic Plan 2007-2011, and increase focus on TB and other communicable diseases.
8) Mass-mobilise for better health of the population.
9) Review the drug policy.
10) Strengthen research and development.

In his budget speech of February 2011, the Minister of Finance indicated that considerable amounts had been allocated towards the improvement of the public health system in preparation for NHI in the 2011-2012 budget, and that government would engage with potential funding models for NHI in the next period. Subsequently the Department of Health published a draft policy paper in the *Government Gazette* of 12 August 2011, and the CMS engaged with this draft policy with the aim of submitting comprehensive comment to the Minister of Health by the end of 2011.

Key elements in the implementation of an NHI

a) Finalise policy proposal on the National Health Insurance (NHI).
b) Finalise draft of legislation to support the creation of the NHI.
c) Set up the National Quality Management and Accreditation Body.
d) Perform an audit of health ICT at all levels of the national health system (public sector only).
e) Draft the National ICT Strategy for Health.

RELEVANT COURT RULINGS

The Guardrisk court case, which ruled that some gap cover health insurance products are not in contravention of the Medical Schemes Act, places a particular burden on the Council for Medical Schemes to protect medical schemes as the preferred health insurance vehicle. This ruling has led to a proliferation of health insurance products, which threatens medical scheme risk pools and requires extensive interventions by the CMS.

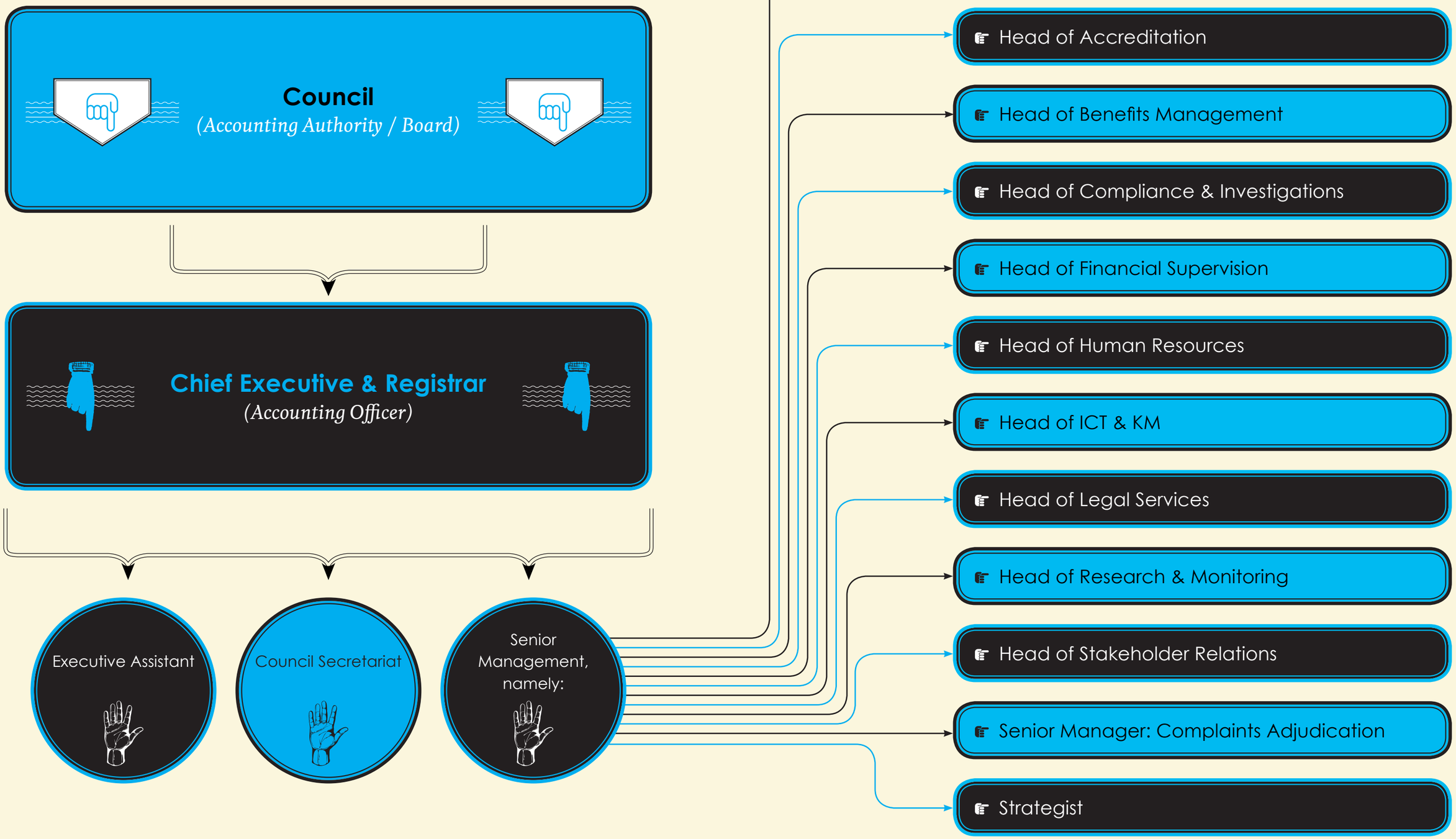
Close collaboration with National Treasury has resulted in the development of a draft set of Regulations under the Insurance Laws, which are due for publication soon. The objective of these Regulations is to address the demarcation between medical schemes and health insurance products.

The July 2010 High Court ruling which set aside the National Health Reference Price List (NHRPL) Regulations has left a vacuum in the determination of private healthcare prices. The CMS assisted the Department of Health in the publication of a discussion document on the determination of healthcare prices in the private sector. The Minister of Health has appointed a task team to engage with comments on the discussion document and to advise him on further options.

In November 2011 the High Court dismissed the Board of Healthcare Funders of Southern Africa (BHF) application, whereby they argued that prescribed minimum benefits (PMBs) must be paid for only at scheme tariff level and not in full as determined by the Medical Schemes Act. This amounts to an important victory for medical scheme members. If the BHF were successful, the implication would have been that the effect of PMBs to ensure solidarity in healthcare would have been severely undermined.

ORGANISATIONAL STRUCTURE

ORGANISATIONAL STRUCTURE



STATEMENT OF THE CHAIRPERSON OF COUNCIL

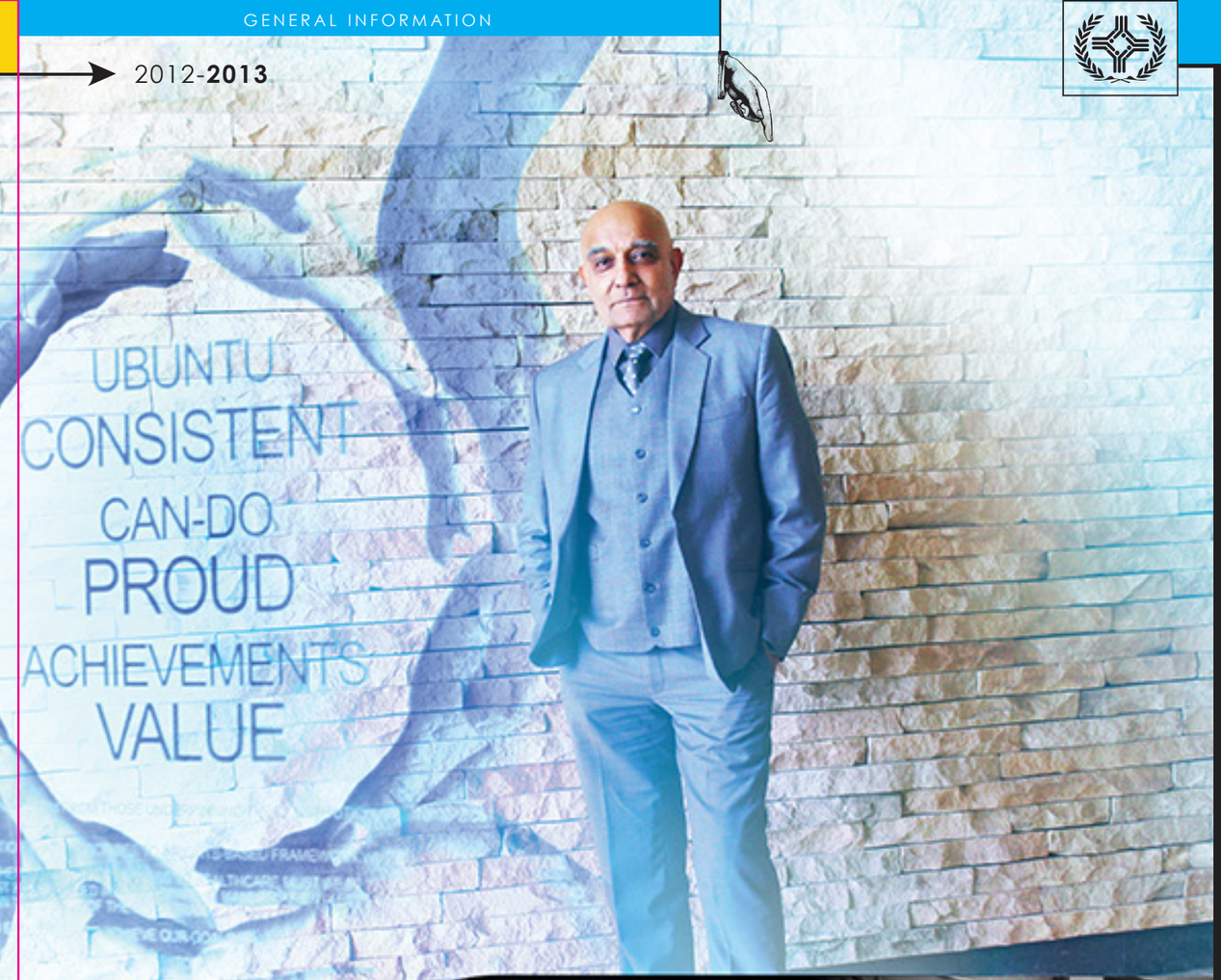
PROF. YOSUF VERIAVA

CHAIRPERSON OF COUNCIL

COUNCIL FOR MEDICAL SCHEMES

The Council for Medical Schemes (CMS) continued to execute its mandate in the financial year under review.

By guiding the medical schemes industry into unprecedented stability and performance, the CMS continued to support efforts aimed at strengthening the entire health system of the country.



Prof. Yosuf Veriava • Chairperson of Council

COUNCIL FOR MEDICAL SCHEMES

The CMS strategy

In the period during which I have been the Chairperson of Council, I have been impressed by the efficient operational aspects and the overall achievements of the CMS. These are evident in the *Overview of the Chief Executive & Registrar* which follows; it accurately reflects the accomplishment of the vision and mission of this regulator.

Our vision is to ensure equitable access to medical schemes, and our mission includes protecting and informing the beneficiaries of these schemes as well as the general public about their rights.

The CMS performance

The financial health and long-term sustainability of medical schemes and the businesses affiliated with them remained one of our priorities in the year under review. Only medical schemes which are well-managed and financially sound as well as empowered and supported by both good legislation and a strong regulator are able to offer adequate protection against ill health and guarantee respect for the constitutional imperative of fair treatment for all.

Compliance with and enforcement of the Medical Schemes Act remained on our regulatory radar, especially when it comes to good governance, which is a pillar of any healthy organisation and industry. Mergers were again the natural and even expected outcomes of a healthy and robust free market economy as was observed during the year under review.

The efforts of the CMS must be acknowledged in contributing to the fact that the medical schemes industry has never been as healthy as it is now and beneficiaries enjoy unprecedented protection of their rights and interests.

Strategic relationships

Much progress was made in efforts to distinguish and protect medical schemes in terms of legislation and other regulatory frameworks. A memorandum of understanding was signed between the CMS and the Competition Commission, and others to follow include the National Prosecuting Authority of South Africa (NPA), the National Consumer Commission (NCC), and the Public Protector South Africa, to name but a few.

Challenges facing the CMS

The CMS faces many challenges. Notable in this regard are its efforts to improve the quality and health outcome for all the scheme beneficiaries.

Furthermore, the CMS is not restricted in its efforts to consider only issues relating to the medical schemes industry and its beneficiaries. It also has a strong commitment towards the strengthening of the overall healthcare system and the provision of services which will be accessible to all the citizens in our country. It is, as a consequence of this consideration, fully supportive of the processes involved in the establishment of a National Health Insurance (NHI) system. The experience gained and the expertise which exists within the CMS is an important national resource in this regard.

The year ahead

The year ahead might present further challenges, but I am sure that Council together with the staff in the Registrar's Office will continue to impeccably face these challenges and achieve successes. The CMS will continue to exercise its rights and duty in its capacity as regulator and protector of the medical schemes industry.

Appreciation

On behalf of all my colleagues on Council, I must thank and acknowledge the Chief Executive & Registrar and his staff for compiling this Annual Report as well as their sterling efforts towards fulfilling the responsibilities and obligations of this regulatory body.

Conclusion

Finally, my fellow Council members and I pledge our continued commitment to strengthening the relationship of the CMS with the Ministry of Health and the many others who are equally convinced of the need to promote equitable access to private health financing and quality care. The CMS stands firm in its conviction that every South African is entitled to quality healthcare.

Prof. Yosuf Veriava
Chairperson of Council
Council for Medical Schemes
31 July 2013

OVERVIEW OF THE CHIEF EXECUTIVE & REGISTRAR

DR MONWABISI GANTSHO
CHIEF EXECUTIVE & REGISTRAR
COUNCIL FOR MEDICAL SCHEMES

I am pleased to present the Annual Report of the Council for Medical Schemes (CMS) for the financial year spanning 1 April 2012 to 31 March 2013, in which the CMS continued to execute its mandate as prescribed by the Medical Schemes Act 131 of 1998.

For its 13th year in existence, the CMS looked after the best interests of members and medical schemes alike to ensure that the industry remains stable, financially sound, and sustainable in the long run while adhering to the principles of good governance.

In the year under review, the CMS remained resolute in its conviction that a healthy private health financing industry, guided and protected by an empowered regulator and effective ombudsman, only contributes to the goal of achieving universal access to quality care which is envisaged by the ongoing strategic review of South Africa's entire health system.

Dr Monwabisi Gantsho • Chief Executive & Registrar

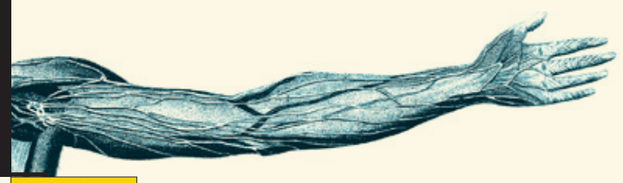
COUNCIL FOR MEDICAL SCHEMES

Strengthening the healthcare system

National Health Insurance (NHI)

The policy proposal on a National Health Insurance (NHI) system for South Africa, published in a Green Paper in August 2011, captures the intention of the Department of Health (DoH) to strategically reform the country's health system in an effort to broaden access to quality healthcare services for all South Africans.

CMS staff members serve on the technical sub-committees of the Ministerial Advisory Committee (MAC) on NHI, but no meetings were held during the period under review. The Office of the Chief Executive & Registrar of the CMS nevertheless continued to interact with the Minister of Health, the Department of Health as well as National Treasury on the ongoing development of an NHI scheme for South Africa.



Medical Schemes Amendment Bill

The CMS was established in 2000 following the promulgation of the Medical Schemes Act in 1998. In its dual role as both regulator and ombudsman of the medical schemes industry, the CMS continues to acquire knowledge, insight, and experience in executing its mandate to serve and protect the public interest through the effective regulation of the industry that has been entrusted to it.

A regulatory authority such as the CMS is, however, only as effective as its enabling legislation. Having identified gaps in the Medical Schemes Act, including the necessity to strengthen provisions pertaining to the governance of medical schemes and the prescribed minimum benefits (PMBs), the Office of the Chief Executive & Registrar continued to work on the Medical Schemes Amendment Bill in the year under review.

The Bill aims to:

1) improve solidarity in healthcare funding;
2) provide clarity on the demarcation between medical schemes and commercial health insurance products;
3) improve the delivery of PMBs;
4) prevent unfair discrimination against vulnerable beneficiaries;
5) improve the effectiveness of complaints resolution;
6) improve the fairness of the CMS appeals processes;
7) prevent financial irregularities and mismanagement in medical schemes;
8) strengthen the regulation of healthcare brokers; and
9) lead to improved data collection on human resources in the private sector.

Council, which is the Accounting Authority and Board of the CMS, approved the Bill early in 2013. The Bill will be submitted to the Minister of Health early in the new financial year.

Demarcation between medical schemes and health insurance

The process of the Demarcation Workgroup which was established by National Treasury in 2009 to draft Regulations that would clearly demarcate medical schemes from health insurance products culminated in the Minister of Finance publishing draft demarcation Regulations in March 2012 for public comment.

The Office of the Chief Executive & Registrar was, in the year under review, in constant interaction with Treasury, the Department of Health, and the Financial Services Board (FSB) on finalising the draft demarcation Regulations which seek to provide proper differentiation between health insurance policies regulated through insurance laws by the FSB, and medical schemes regulated through the Medical Schemes Act by the CMS.

Council supports demarcation Regulations which, once enacted, will prevent harmful health insurance products from operating, and will not in any way undermine the principles and provisions of the Medical Schemes Act.

The Medical Schemes Act establishes a unique social security framework which offers members of medical schemes protection that is unavailable through other means. Only the Medical Schemes Act contains provisions on open enrolment, community rating, PMBs, as well as a strict governance requirement and oversight by the CMS that serve the public interest in the context of access to healthcare. Commercially driven health insurance products doing the business of a medical scheme are not subject to the same regulatory oversight and conduct themselves in ways which undermine the social protection offered by the Medical Schemes Act and medical schemes themselves.

Health quality and outcomes pilot

Section 7 of the Medical Schemes Act prescribes that Council shall "make recommendations to the Minister [of Health] on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine".

The CMS had published the first draft of a framework document for the measurement of health quality and outcomes in the medical schemes environment in the previous reporting period. The document had addressed the need to objectively determine the role that medical schemes occupy in the attainment of overall health system objectives.

In the year under review, an analysis of disease management process indicators was conducted. The outcome of the analysis resulted in the decision to split the pilot project into two phases:

Phase 1 of pilot: Programme evaluation

The first phase of the pilot project (conducted in the 2012-2013 financial year under review) resulted in the formulation of a new research design which was to inform the piloting of a monitoring and evaluation framework in order to test the construct validity and reliability of an identified set of impact indicators. The method of the research design was a prospective (formative) analysis. The objective was to test the objectives of disease management programmes against their observed impact. The evaluators conducted the analysis from the healthcare purchaser (beneficiary) perspective.

Phase 2 of pilot: Evaluation of programme implementation

The second phase of the pilot (to be conducted in the new financial year) will see the implementation evaluation of disease management programmes. The focus is expected to be on evaluating process indicators rather than impact indicators.

Integrating the financing and delivery of healthcare

In the year under review the Research & Monitoring Unit (R&M) of the CMS concluded a study on models for integrating the financing and delivery of healthcare services – models where healthcare funders (medical schemes) deliver healthcare services because the medical scheme(s) and the associated hospitals are owned by the same company. The project specifically aimed to describe and explore the healthcare delivery model used in South Africa's mining sector.

A case study methodology was employed to enable an in-depth enquiry. Two sets of semi-structured questionnaires for managers and health professionals were administered within the two selected case studies; the participants included the Chairperson of the Board of Trustees and the Principal Officer of the same scheme. Health professionals at facility level included senior health managers, general practitioners, pharmacies, and medical advisors. The facilities included hospitals and clinics owned by the schemes.

Table 1 outlines the participants in the study.

Table 1: Participants in the study exploring models for integrating the financing & delivery of healthcare services

Participants	Number
Chairperson of the Board of Trustees	1
Principal Officer of the medical scheme	1
Senior health managers	3
General practitioners	11
Chief / professional nurses	6
Pharmacists	3
Allied health practitioners	6
Dentists	4
Managers (incl. case managers)	8
Medical advisor	1
Total	**44**

Responses of the study participants were triangulated with quantitative information collected through a detailed data collection tool. The tool consisted of important fields such as demographic indicators, healthcare financing measures, health systems indicators, and proxy diagnostic technology utilisation statistics.

Some of the key findings were:

1) The mining sector models for integrating the financing and delivery of healthcare services provide an outline of a number of unique provider arrangements and their benefits towards cost containment and health outcomes.

2) Models for integrating the financing and delivery of healthcare services eliminate the perverse supply-side incentives associated with fee-for-service reimbursement.

3) Fee-for-service models pose an administrative burden for funders (medical schemes) and private hospitals alike, but few healthcare providers are reimbursed on a fee-for-service basis in the mining sector, so this administrative burden is avoided.

4) The use of scheme-owned primary healthcare facilities as gatekeepers (responsible for managing a patient's treatment, including authorising referrals, hospitalisation, and lab tests) facilitates the cost-effective delivery of healthcare.

5) Mining hospitals enable better coordination of care through effective referral and communication between different health professionals on the one hand and primary healthcare centres on the other.

6) The employment of doctors by medical schemes, as seen in the mining sector, ensures greater standardisation of the drugs and pharmaceuticals that doctors prescribe.

7) Models which integrate financing and healthcare delivery facilitate the use of standardised treatment protocols which assist in reducing variability in health outcomes.

Monitoring diagnosis coding (ICD-10)

The Medical Schemes Act prescribes that all healthcare providers – including doctors, hospitals, and allied professionals – are required to use the International Classification of Diseases – 10th Revision (ICD-10) codes when diagnosing patients and submitting claims to medical schemes.

The functions of implementing and monitoring ICD-10 coding have been residing within the Health Information Systems chief directorate at the Department of Health since 2012, but the CMS has retained the responsibility for collating ICD-10 compliance reports.

Data specifications for collecting the quarterly submissions from medical schemes were revised in the year under review and are expected to be implemented in the 2013-2014 financial year.

Based on these quarterly submissions, the CMS monitors the extent to which healthcare providers comply with the legal requirement to include a valid ICD-10 code when they submit their claims to medical schemes.

As at December 2012, the compliance level of providers submitting a valid ICD-10 code to medical schemes was 97.5%.

Practice Code Numbering System (PCNS)

Regulation 5 of the Medical Schemes Act requires the suppliers of healthcare services to include a Practice Code Number (PCN) on the accounts they submit to medical schemes for payment. As the custodian and enforcer of the Medical Schemes Act, the CMS has the responsibility of ensuring that a system is in place for the issuing of such numbers.

The tender process for the Practice Code Numbering System, or PCNS, was concluded in 2012, and a new company – E2 Solutions (Pty) Ltd – was awarded the tender for the administration of the PCNS from 2014 to 2016.

The contract of the current service provider, namely the Board of Healthcare Funders of Southern Africa (BHF), will be extended until December 2013 in view of the required handover and transition.

Guaranteed benefits, a pillar of the Medical Schemes Act

Benefits guaranteeing access to healthcare can only be found in medical schemes due to provisions in the Medical Schemes Act. This unique piece of legislation guarantees members of medical schemes the access to a set of prescribed minimum benefits, commonly called the PMBs, which ensure that members are protected against health events which could otherwise ruin them financially.

PMBs are the minimum, as opposed to the maximum, benefits that your medical scheme must legally cover, regardless of the benefit option you are on. PMB conditions are diagnosis-driven, which means that it is irrelevant how you came to have a PMB condition.

Your scheme must pay for your PMB conditions in full (as per the healthcare provider's invoice) and from its risk pool; your scheme is not allowed to use your personal medical savings account (PMSA) to pay for PMB conditions.

PMBs cover the diagnosis, treatment, and care of roughly 300 of the most serious, often life-threatening, and most expensive health conditions, including any emergency condition, 270 diseases such as cancer and tuberculosis, and 25 chronic conditions, including epilepsy, asthma, and hypertension. PMBs cover catastrophic costs, not preventative or primary care.

PMBs go hand in hand with DSPs. A designated service provider (DSP) is a preferred healthcare provider (e.g. doctor, pharmacist, hospital) that is your scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment.

The CMS publishes an electronic newsletter on members' rights to PMBs, called *CMScript*. All issues are available on the CMS website.

The Supreme Court of Appeal on PMBs

As reported in the previous financial year, the Board of Healthcare Funders of Southern Africa (BHF) had challenged the PMB-prescribing Regulation 8 of the Medical Schemes Act back in 2011.

The BHF is the representative body of a number of medical schemes and administrators; Regulation 8 of the Medical Schemes Act is fundamental in that it states that medical schemes must pay for the diagnosis, treatment, and care of all PMB conditions in full, or at the price charged by the healthcare provider.

In a legal process that took almost a year, the BHF – who was later joined by the South African Municipal Workers' Union National Medical Scheme (SAMWUMed) – was seeking to have Regulation 8 interpreted to mean that schemes must pay for PMB conditions only up to the scheme tariff, effectively aiming to change the meaning and purpose of the PMB provisions in the Medical Schemes Act.

The High Court handed down its ruling in November 2011: PMBs remain in place, and the law which prescribes them stands, both unchanged. The BHF's application for the new interpretation was dismissed with costs.

The High Court ruling effectively reaffirmed the need for PMBs and the protection they offer to members of medical schemes.

Council, who was the first respondent in the matter together with 12 others, has always stood – and continues to stand – by the prevailing, straightforward interpretation and implementation of the provisions on PMBs.

The BHF was subsequently refused leave to appeal and elected to petition the Supreme Court of Appeal (SCA) on this issue. The SCA refused the petition on the basis that no reasonable prospect of success existed.

Clarifying PMBs

The Office of the Chief Executive & Registrar planned to revise and publish 10 PMB definitions during the reporting period, but due to the unexpected increase in the workload of a retrospective nature as well as the unfilled vacancy within the Clinical Unit, this project had to be temporarily abandoned, meaning that no revised PMB definitions were published in the year under review.

Reviewing PMB Regulations

Annexure A to the Regulations of the Medical Schemes Act prescribes that PMBs must be reviewed at least every two years.

In 2010 Council submitted draft Regulations reviewing the existing PMBs to the Minister of Health for consideration and possible publication in the *Government Gazette* for public comment. The publication of these draft Regulations was imminent in the year under review, which is why the Office of the Chief Executive & Registrar decided not to proceed with the revision of the PMB Code of Conduct.

The PMB Code of Conduct

The PMB Code of Conduct was developed by the CMS in consultation with various stakeholders, including the Department of Health, back in 2010. This code seeks to ensure greater compliance with the PMB provisions contained in the Medical Schemes Act. It is available on the CMS website.

The myth surrounding PMBs

PMBs remained under constant attack in the year under review. Despite evidence to the contrary, there are those who persistently claim that PMBs drive up the costs of medical schemes and consequently push up the monthly contributions, which in turn allegedly makes medical schemes increasingly unaffordable and the medical schemes industry unsustainable in the long run.

Such attacks, though vociferous and unrelenting, remain unfounded. The CMS has been inviting parties making such allegations to come forward with evidence in support of their claims, but 13 years later, no such evidence has ever been brought to our attention.

In fact, our research paints a very different – and a very positive – picture of PMBs and their impact on the industry. Since PMBs were reintroduced with the Medical Schemes Act, the industry has been performing better than ever and medical schemes have reached a new level of financial soundness. Equally important is the fact that members of medical schemes remain protected against unforeseen and catastrophic health events.

Members are encouraged to familiarise themselves with PMBs, a fundamental and essential provision enshrined in the Medical Schemes Act which sets schemes apart from other forms of health insurance. Most of the complaints we receive every year are related to schemes refusing to pay for PMB conditions as prescribed by law.

Exemptions from PMB provisions

Regulation 8(h) of the Medical Schemes Act 131 of 1998 gives Council the power to grant exemptions from any provision of the Act.

In the year under review, Council maintained exemptions from PMBs with regard to the following bargaining council schemes:

1) Building & Construction Industry Medical Aid Fund
2) Fishing Industry Medical Scheme (Fishmed)
3) Food Workers Medical Benefit Fund
4) Golden Arrows Employees Medical Benefit Fund
5) Motohealth Care

The growth of the medical schemes industry

Status of schemes

In February 2013 the CMS published a list of all the registered medical schemes (and their contact details) in the *Government Gazette*, as is required by Section 25 of the Medical Schemes Act.

No entity applied to be registered as a new medical scheme during the period under review.

The number of medical schemes dropped from 95 in March 2012 to 90 in March 2013.

Status of options

Medical schemes continued to consolidate in the year under review, but for the first time in a number of years their consolidation did not result in the number of benefit options decreasing as well. The fact that the number of options increased despite the number of schemes having decreased can be explained by the fact that more medical schemes introduced efficiency-discounted benefit options in the year under review; there were 28 such options at the end of March 2012 and 37 at the end of March 2013. Another reason for the sudden reversal in the trend is that a number of medical schemes, especially restricted schemes, introduced options aimed at lower-income groups.

The total number of registered benefit options increased from 311 in March 2012 to 323 in March 2013. This represents an increase in the number of benefit options in open schemes, including the efficiency-discounted options, from 169 to 178 between 2012 and 2013, and an increase in the number of benefit options in restricted schemes from 142 to 145 during the same period.

Table 2: Benefit options as at 1 March 2013

Status of option	Open schemes options	Restricted schemes options	Total
Options registered as at 31 March 2012	**169**	**142**	**311**
Less: efficiency-discounted options	-28	0	-28
Options registered as at 31 March 2012 (excl. efficiency-discounted options)	**141**	**142**	**283**
New options	+6	+7	+13
Discontinued options	-1	0	-1
Discontinued options due to scheme mergers	-5	-2	-7
Discontinued options due to scheme liquidations	0	-2	-2
Options registered as at 31 March 2013 (excl. efficiency-discounted options)	**141**	**145**	**286**
Options with efficiency discounts*	+37	0	+37
Options registered as at 31 March 2013	**178**	**145**	**323**

* These options are registered as one option but they have differing contribution tables based on the provider choice offered to members; the total number of registered options for open schemes is therefore 141.

Efficiency-discounted options

Introduced in 2008, efficiency-discounted options (i.e. options with network arrangements) allow the monthly medical scheme contributions to be differentiated based on the healthcare providers available on a particular benefit option. This practice stands in conflict with the principle that contributions may be based only on income or family size, or both. Schemes must therefore be exempted from Section 29(1)(n) of the Medical Schemes Act before they can operate efficiency-discounted options, or EDOs.

In the year under review Council allowed two more medical schemes to introduce efficiency-discounted options, namely Compcare Wellness Medical Scheme and Medihelp.

This means that, as at the end of March 2013, a total of seven medical schemes were offering these options, the remaining five being Momentum Health, Discovery Health Medical Scheme (DHMS), Fedhealth Medical Scheme, Liberty Medical Scheme, and Thebemed.

The CMS has observed that only open medical schemes have decided to offer efficiency-discounted options to date.

The two oldest and largest efficiency-discounted options are available on the Custom, Incentive, and Extender options in Momentum Health, and on the Delta Network options in the DHMS.

The efficiency-discounted options in Momentum Health indicate positive operational results compared to options without network restrictions.

The Delta Network arrangement within the DHMS has also had a positive impact on the underwriting results of the Delta Network options. The loss ratio of these options is lower than that of non-Delta Network options. The efficiency-discounted Delta Network options have seen higher membership growth than the non-Delta Network options.

Benefit options with network arrangements are good for members and medical schemes alike. Such options offer members discounts because the scheme is able to obtain efficiency with a selected provider network. Members are subsequently offered a more efficient choice of providers while contributions remain fair and non-discriminatory. Efficiency-discounted options are good for medical schemes too; they result in cost savings for schemes because they allow schemes to negotiate better reimbursement and healthcare delivery terms with healthcare providers.

More detail on efficiency-discounted options

The fact that the number of options with network arrangements increased by 32.0% between 2012 and 2013, from 28 to 37, illustrates their value to members, medical schemes, and industry at large. Their popularity is expected to continue growing in future.

Since 2009 Momentum Health and the DHMS were the first schemes to introduce efficiency-discounted options, namely the Custom, Incentive, and Extender options and the Delta Comprehensive, Saver, and Core options respectively. These options have performed well, both financially and in terms of membership, by comparison with the main benefit options, thereby improving the overall combined performance of the options.

The DHMS efficiency-discounted options have seen an increase in membership of 308.9% since 2009 (109 823 new beneficiaries joined these options since 2009), compared to the growth of 4.6% on the non-efficiency-discounted options where 49 433 new beneficiaries joined since 2009.

This kind of membership growth has not been observed in Momentum Health's efficiency-discounted options which have in fact decreased in size. The CMS has observed a decrease of 1.1% in Momentum Health's efficiency-discounted options since 2009, although the decrease is not as high as the loss of membership in the scheme's non-efficiency-discounted options (7.7%).

The net healthcare performance of the DHMS efficiency-discounted options is shown in Table 3.

Table 3: Efficiency-discounted options of Discovery Health Medical Scheme in 2009-2012

Year	2009	2010	2011	2012
	R'000	R'000	R'000	R'000
EDOs	30 820	70 779	110 068	159 410
Non-EDOs	178 941	198 558	149 859	332 515
Total	**209 761**	**269 337**	**259 927**	**491 925**

EDOs = efficiency-discounted options

The results in Table 3 demonstrate that, within the DHMS, efficiency-discounted options contributed up to 32.4% of the surplus in 2012 even though these options make up only 11.6% of the membership of the combined option.

Similar results have been observed in Momentum Health's efficiency-discounted options (Table 4).

Table 4: Efficiency-discounted options of Momentum Health in 2009-2012

Year	2009	2010	2011	2012
	R'000	R'000	R'000	R'000
EDOs	63 771	108 907	136 411	154 762
Non-EDOs	(111 018)	(80 929)	(63 689)	(50 517)
Total	**(47 247)**	**27 978**	**72 722**	**104 245**

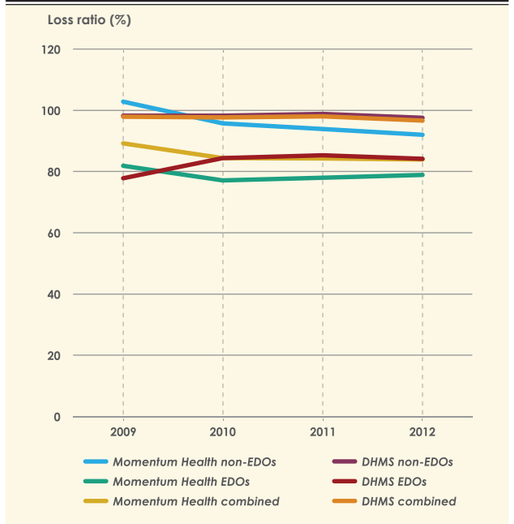
EDOs = efficiency-discounted options

The results in Table 4 show that the efficiency-discounted options in Momentum Health enabled the options to have positive net healthcare results even though they make up only 26.1% of the membership of these options.

These results have been caused by the loss ratios of efficiency-discounted options being lower than those of the main options.

Figure 1 shows the loss ratio of efficiency-discounted options versus the combined options and non-efficiency-discounted options for both Momentum Health and DHMS options.

Figure 1: The loss ratio of efficiency-discounted options in 2009-2012



EDOs = efficiency-discounted options
DHMS = Discovery Health Medical Scheme

The trend observed is that on the Momentum Health efficiency-discounted options the loss ratio has been on average 17.7% lower than on the main option and on average 7.6% lower than on the combined option.

The same trend is observed for the DHMS, with the loss ratio being 15.6% lower on average than the main option and 15.0% lower on average for the combined option.

Efficiency-discounted options contribute positively to the performance of options as a whole, and the trend has been observed since the registration of these options in 2009.

The remainder of the registered efficiency-discounted options has been in operation for a year, and the experience has not developed to the extent that a reasonable conclusion could be made; they have been excluded from this analysis.

Evaluating the rules of medical schemes

The Benefits Management Unit (BMU) at the CMS processed 280 rule amendments in the 2012-2013 financial year. These included changes to contributions and benefits, the registration of new benefit options, and the registration of new efficiency-discounted options.

Both the Appeals Committee and the Appeal Board agreed with the Office of the Registrar to reject the eligibility criteria that restricted medical schemes were proposing in an effort to avoid admitting higher-risk groups as members. It is unfortunate that restricted medical schemes continued to persist in their efforts to discriminate against older and sicker members of society in the year under review by trying to limit and even deny them access to the schemes.

The Legal Services Unit rendered close support to BMU in the year under review, particularly in the area of rule amendments, with specific emphasis on the issue of eligibility in restricted schemes.

Model rules

Model rules aim to establish a culture of industry-wide compliance with applicable legislation and so provide best practice guidance for complying with the Medical Schemes Act. They also aim to create a culture of cooperation among medical schemes and other regulated entities by standardising submissions to the CMS as they relate to matters such as governance, contributions, and benefits.

It was 2007 when the Benefits Management Unit (BMU) at the CMS first realised that the model rules (which are available on the CMS website) need to be revised. Since then BMU has been collaborating with other Units at the CMS, and workshops continue to this day.

The revision of the model rules is necessitated by the promulgation of the Consumer Protection Act 68 of 2008, Circular 28 of 2011 and Circular 5 of 2012 (on personal medical savings accounts), Circular 48 of 2011 (the King III Report on Governance and integrated sustainability reporting), the extensive amendments being proposed to the Medical Schemes Act, and related legislation.

The revised model rules are expected to be finalised in the coming financial year.

The Chief Executive & Registrar encourages all medical schemes to adopt the model rules when they prepare their annual rule amendments for registration with the CMS. Other regulated entities should be mindful of the model rules as well.

Marketing material and application forms

The CMS evaluated the marketing material and application forms of the following medical schemes in the 2012-2013 financial year:

1) AECI Medical Aid Society
2) Altron Medical Aid Scheme
3) Anglo Medical Scheme
4) Anglovaal Group Medical Scheme
5) Bankmed
6) Barloworld Medical Scheme
7) Bestmed Medical Scheme
8) BMW Employees Medical Aid Society
9) BP Medical Aid Society (2012 & 2013)
10) Cape Medical Plan
11) Eyethumed Medical Scheme (liquidated)
12) Fishing Industry Medical Scheme (Fishmed)
13) Genesis Medical Scheme
14) Golden Arrows Employees Medical Benefit Fund (2012 & 2013)
15) Government Employees Medical Scheme (GEMS)
16) Grintek Electronics Medical Aid Scheme
17) Horizon Medical Scheme
18) Hosmed Medical Aid Scheme
19) IBM (SA) Medical Scheme
20) Imperial Group Medical Scheme (2012 & 2013)
21) LA Health Medical Scheme
22) Liberty Medical Scheme
23) Lonmin Medical Scheme (2012 & 2013)
24) Malcor Medical Scheme
25) Massmart Health Plan (2012 & 2013)
26) MBMed Medical Aid Fund (2012 & 2013)
27) Medihelp
28) Medipos Medical Scheme
29) Medshield Medical Scheme
30) Metrocare
31) Momentum Health
32) Nedgroup Medical Aid Scheme
33) Parmed Medical Aid Scheme
34) Pharos Medical Plan
35) Pick & Pay Medical Scheme
36) Profmed Medical Scheme (2012 & 2013)
37) Quantum Medical Aid Society
38) Resolution Health Medical Scheme
39) SABC Medical Aid Scheme
40) South African Municipal Workers Union Medical Scheme (SAMWUMed)
41) Sasolmed
42) South African Police Service Medical Scheme (POLMED)
43) Spectramed
44) Thebemed
45) Umvuzo Health Medical Scheme
46) Witbank Coalfields Medical Aid Society (WCMAS)
47) Xstrata Medical Aid Scheme

The Medical Schemes Act (Section 32) ensures that the rules of schemes are binding on themselves as well as all their stakeholders. The CMS will continue to monitor the marketing material and application forms of schemes to ensure that they comply with their registered rules and the Medical Schemes Act (where the Act always takes precedence over scheme rules should the two be inconsistent with each other).

Administrators

No new third-party administrators applied for accreditation during the year under review.

Only Bestmed Medical Scheme, which used to be administered by a third party, became self-administered. A compliance certificate was approved by Council and issued to the scheme.

Council approved the accreditation renewal of the following third-party administrators for a period of two years:

1) Agility Global Health Solutions Africa (Pty) Ltd
2) Allcare Administrators (Pty) Ltd
3) Eternity Private Health Fund Administrators (Pty) Ltd
4) Momentum Medical Scheme Administrators (Pty) Ltd
5) Private Health Administrators (Pty) Ltd
6) Sechaba Medical Solutions (Pty) Ltd
7) Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd
8) Universal Healthcare Administrators (Pty) Ltd
9) V Med Administrators (Pty) Ltd

Council approved the renewal of compliance with administration standards in respect of the following self-administered schemes:

1) Cape Medical Plan
2) Platinum Health
3) Umvuzo Health Medical Scheme

The following on-site evaluations of third-party administrators and self-administered medical schemes were completed during the year:

1) Food Workers Medical Benefit Fund

2) South African Municipal Workers Union Medical Scheme (SAMWUMed)

The following administrator and self-administered medical scheme were deactivated on the CMS website:

1) The accreditation of Sanlam Healthcare Management (Pty) Ltd as an administrator was not renewed because the organisation lost its only client scheme and changed its administration system. Should the organisation wish to provide administration services to medical schemes again in future, a new accreditation application will have to be lodged.

2) Self-administered Pro Sano Medical Scheme amalgamated with Bonitas Medical Fund with effect from 1 January 2013 and therefore ceased to operate.

Fifteen third-party administrators and nine self-administered medical schemes were accredited as at 31 March 2013.

Managed care organisations

A number of new applications for the accreditation as MCOs were received and evaluated during the period under review. Some of them were found to be invalid as the service offering that was being proposed by these organisations could not be defined as "managed healthcare" as per the Medical Schemes Act and Regulations; accordingly, these organisations did not require to be formally accredited. The applicants were notified as such.

Council approved the accreditation of the following new applications for a period of two years:

1) Aid for Aids Management (Pty) Ltd (previously Lethimvula Healthcare (Pty) Ltd)
2) Right to Care Health Services (Pty) Ltd

Council approved the renewal of accreditation of the following MCOs:

1) Agility Global Health Solutions Africa (Pty) Ltd
2) Allcare Administrators (Pty) Ltd
3) CareCross Health (Pty) Ltd
4) Dental Risk Company (Pty) Ltd
5) Discovery Health (Pty) Ltd
6) Eternity Healthcare (Pty) Ltd
7) HIV Managed Care Solutions (Pty) Ltd t/a Careworks
8) Independent Clinical Oncology Network (Pty) Ltd
9) KwaZulu-Natal Managed Care Coalition Ltd
10) Lifesense Disease Management (Pty) Ltd
11) Managed Healthcare Systems (Pty) Ltd
12) Medicross Healthcare Group (Pty) Ltd
13) Mediscor PBM (Pty) Ltd
14) Metropolitan Health Risk Management (Pty) Ltd
15) Momentum Medical Scheme Administrators (Pty) Ltd
16) OneCare Health (Pty) Ltd
17) Performance Health (Pty) Ltd
18) Prime Cure Health (Pty) Ltd
19) Professional Medical Scheme Administrators (Pty) Ltd
20) Providence Healthcare Risk Managers (Pty) Ltd
21) RX Health (Pty) Ltd
22) Scriptpharm Risk Management (Pty) Ltd
23) South African Oncology Consortium Ltd
24) Supplementary Health Services (Pty) Ltd
25) V Med Administrators (Pty) Ltd

On-site evaluations were completed during the year under review to assess the compliance of the following MCOs with the managed care accreditation standards:

1) Agility Global Health Solutions Africa (Pty) Ltd
2) CareCross Health (Pty) Ltd
3) Dental Risk Company (Pty) Ltd
4) Discovery Health (Pty) Ltd
5) Medicross Healthcare Group (Pty) Ltd
6) OneCare Health (Pty) Ltd
7) Scriptpharm Risk Management (Pty) Ltd
8) V Med Administrators (Pty) Ltd

The following MCOs were deactivated on the CMS website:

1) The accreditation of Sanlam Healthcare Management (Pty) Ltd as a managed care organisation was not renewed because the organisation lost its only client scheme and changed its operating system. Should the organisation wish to provide managed care services again in future, a new accreditation application will have to be lodged.

2) Faranani Healthcare Management (Pty) Ltd and Emerging Market Healthcare (Pty) Ltd elected not to renew their accreditation. Faranani no longer performs managed care services.

3) The accreditation of U.D.I.P.A Holdings (Pty) Ltd and East Cape Medical Business Systems (Pty) Ltd (t/a ECIPA Healthcare) was deactivated in the year under review after a more detailed interrogation of their contracts and protocols revealed that they do not offer managed care services (as defined in the Medical Schemes Act) and therefore do not need to be accredited by the CMS. The deactivation of their accreditation is subject to them not doing "the business of a medical scheme" in future.

There were 39 managed care organisations as at 31 March 2013.

Brokers and broker organisations

The accreditation of the following brokers and broker organisations was rejected, suspended, and withdrawn during the financial year under review.

Table 5: Broker accreditation applications rejected in 2012-2013

Broker number	Action	Effective date	Reason
JN Msomi (BR 32534)	Rejected	23.07.2012	The applicant did not meet the qualification requirements.
N Premrajh (BR 32861)	Rejected	20.08.2012	The applicant did not meet the qualification requirements.
Z le Roux (BR 33097)	Rejected	31.10.2013	The applicant was insolvent.

Table 6: Broker accreditations suspended & withdrawn in 2012-2013

Broker number	Action	Effective date	Reason
RL Morris (BR 26391)	Suspended	17.07.2012	The broker failed to provide proof of his Financial Services Provider (FSP) license number issued by the Financial Services Board (FSB).
MDL Doherty- Bigara (BR 5281)	Withdrawn	31.07.2012	The broker is not providing broker services anymore.
VH Nkanyani (BR 30760)	Suspended	25.03.2013	This was a default suspension following the withdrawal of the Financial Services Provider (FSP) license number by the Financial Services Board (FSB).

Table 7: Brokerage accreditations suspended & withdrawn in 2012-2013

Broker number	Action	Effective date	Reason
Ness Consulting Services (Pty) Ltd (ORG 3350)	Withdrawn	24.04.2012	The entity is not providing broker services anymore.
Mentor Healthcare Planning (Pty) Ltd (ORG 842)	Withdrawn	12.06.2012	The entity is not providing broker services anymore.
Jacques Nel Financial Planning CC (ORG 3121)	Withdrawn	30.06.2012	The entity is not providing broker services anymore.
Marledan Financial Consultants (ORG 737)	Withdrawn	31.07.2012	The entity is not providing broker services anymore.
Gerber Botha & Gowar Brokers CC (ORG 2957)	Withdrawn	03.09.2012	The entity is not providing broker services anymore.
Sentra Makelaars CC (ORG 3964)	Withdrawn	01.11.2012	The entity chose to withdraw its application for accreditation renewal.
Kheta Insurance Brokers (Pty) Ltd (ORG 3692)	Suspended	14.03.2013	This was a default suspension following the withdrawal of the Financial Services Provider (FSP) license number by the Financial Services Board (FSB).

The Accreditation Unit processed applications from 1 461 new brokers and 141 new broker organisations, and renewal applications from 4 200 brokers and 1 035 broker organisations.

There were 8 360 brokers and 2 208 broker organisations as at 31 March 2013.

Revising how healthcare brokers and brokerages are accredited

Following the publication of the draft document for public comment, the Accreditation Unit published a final policy document on the CMS website describing the reviewed requirements and processes regarding the accreditation of healthcare brokers and broker organisations in terms of the Medical Schemes Act. Electronic links are provided in the document to the relevant detailed Circulars published in this regard.

What brokers can be paid

The Minister of Health announced an increase in the maximum amount payable to brokers in terms of Section 65 of the Medical Schemes Act, from R65.65 to R69.00 per member per month, with effect from 1 May 2012.

Monitoring and working with the industry

Ensuring compliance with the Medical Schemes Act

It is the duty of the CMS to ensure that the entities under its regulatory supervision – namely medical schemes, administrators, managed care organisations, and healthcare brokers and broker organisations – comply fully with the Medical Schemes Act 131 of 1998 at all times.

The CMS has both the mandate and the expertise to monitor the behaviour of regulated entities and take corrective action where required.

Routine inspections of medical schemes

The Compliance & Investigations Unit continued, in the year under review, with routine inspections in terms of Section 44(4)(b) to monitor schemes' compliance with the Medical Schemes Act.

More specifically, this Section prescribes that "[t]he Registrar may order an inspection [...] for purposes of routine monitoring of compliance with [the Medical Schemes Act] by a medical scheme or any other person".

The schemes that undergo routine inspections are identified using the Composite Risk Index (CRI), which ranks all the registered medical schemes in the country according to the risks they face. The index, also called the "traffic light approach" to regulating, identifies schemes which may face financial difficulties in future. Schemes are ranked on a scale from red through yellow to green. Red schemes are prioritised; green schemes require no or minimal regulatory intervention.

The following schemes were inspected in the year under review:

1) Bankmed
2) Chartered Accountants (SA) Medical Aid Fund (CAMAF)
3) Cape Medical Plan
4) Horizon Medical Scheme
5) Keyhealth
6) LA Health Medical Scheme
7) Medihelp
8) Nedgroup Medical Aid Scheme
9) Platinum Health
10) Suremed Health
11) Thebemed
12) Tsogo Sun Group Medical Scheme

Other inspections and investigations

In the year under review the Compliance & Investigations Unit instituted inspections into Selfmed Medical Scheme and Spectramed in terms of Section 44(4)(a) of the Medical Schemes Act.

The Section states that "[t]he Registrar may order an inspection [...] if he or she is of the opinion that such an inspection will provide evidence of any irregularity or of non-compliance with [the Medical Schemes Act] by any person".

Selfmed was inspected after its financial statements revealed irregularities. The CMS also received an anonymous complaint about the governance of the scheme.

Spectramed was inspected as a result of a complaint around the management of the scheme's affairs.

Trustees must be fit and proper

The poor standard of adherence to the principles of good corporate governance by the trustees in certain medical schemes continued to give cause for concern during the period under review. The Legal Services Unit worked particularly closely with Compliance & Investigations in providing the requisite legal support for compliance interventions engaged in by this Unit.

The Compliance & Investigations Unit also continued to screen and vet trustees and Principal Officers to ensure that medical schemes are managed by officials who are fit and proper to carry out these duties.

Sections 57(1) and 57(4) of the Medical Schemes Act provide for the election and appointment of fit and proper trustees and Principal Officers with a view to strengthening the governance structures of medical schemes and so ensuring better protection of members' interests.

Compliance & Investigations also monitored the election of a new Board of Trustees and Principal Officer for Bonitas Medical Fund after the curatorship of the scheme was lifted on 31 August 2012. The South Gauteng High Court in Johannesburg had placed Bonitas under curatorship in May 2011 over the CMS's concerns that the scheme's acting Principal Officer and Board at the time were not fit and proper to run the scheme. It took two years to remove the scheme's previous acting Principal Officer and Board from office and replace them by the curator. They remain banned from taking office as Principal Officers or trustees ever again.

The remuneration of trustees

A comprehensive literature study on the remuneration of trustees was conducted in the previous financial year. The project recommended that an expert entity be appointed to conduct a qualitative study on remuneration in the medical schemes environment. Budget constraints prevented this activity from taking place in the year under review, but provisions have been made for the 2013-2014 financial year. The expert entity is expected to provide guidelines as well as an implementation strategy for remunerating trustees in medical schemes.

Attending schemes' meetings

The Compliance & Investigations Unit of the CMS continued to attend the Annual General Meetings (AGMs) and Special General Meetings (SGMs) of medical schemes as observers. Concerns, where observed, were pointed out.

Plans are in the pipeline to improve the manner in which members' meetings – such as AGMs, SGMs, and trustee elections – are conducted to make them more accessible to more members.

The CMS encourages all medical scheme members to take a keener interest in the affairs of their respective schemes. The schemes, after all, belong to the members.

Litigation

The Legal Services Unit continued to provide guidance and close support to the operational Units within the CMS as well as assuming responsibility for litigation in those instances where recourse to the courts was required in discharging the regulatory mandate of the Chief Executive & Registrar as well as Council.

The nature and extent of litigation against both the Chief Executive & Registrar and Council remained unpredictable in the year under review.

The increase in the demand on the Legal Services Unit, primarily in the area of litigation, can be attributed to the increasing ability of the Compliance & Investigations Unit to conduct in-depth investigations into the functioning and governance of medical schemes.

Capacity in Legal Services was accordingly strengthened by the addition of a further Legal Advisor post. This has greatly improved the ability of the Unit to continue meeting its mandate in an exemplary fashion.

The following were among the activities engaged in by the Unit during the period under review:

1) ensuring the integrity of regulatory decisions by providing legal advice to the Office of the Chief Executive & Registrar on process and procedure;
2) furnishing written and verbal legal opinions, advice, and representations to the Office of the Chief Executive & Registrar and Council;
3) reviewing contracts, policies, and procedures of operational Units at the CMS to ensure sound contracting;
4) promoting an understanding amongst CMS staff of the legal framework within which we operate by tracking changes to complementary legislation and communicating findings via presentations to staff; and
5) providing support to the Chief Executive & Registrar and Council by furnishing advice on changes in the principles of corporate governance.

The following cases were dealt with in the period under review:

Barloworld Medical Scheme

This restricted scheme submitted a rule amendment directed at retaining pensioners belonging to a certain employer group, after the Appeal Board had ruled on the matter. The Appeal Board ruling was subsequently taken on review to the North Gauteng High Court. The court upheld the Appeal Board ruling with costs.

Bonitas Medical Fund

The long-standing curatorship of Bonitas was uplifted during August 2012 by the South Gauteng High Court. The Legal Services Unit succeeded in recovering virtually all the legal costs incurred in placing the scheme under curatorship.

Sizwe Medical Fund

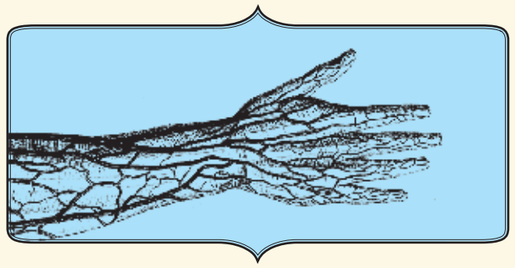
The scheme was placed under provisional curatorship by the South Gauteng High Court on 4 September 2012 on the basis of material irregularities of a governance nature which had come to the attention of the Chief Executive & Registrar. Dr Marshall N. Gobinca was appointed curator and has commenced the task of correcting the governance concerns which gave rise to the curatorship. The scheme has indicated its intention to appeal against the judgment.

Medshield Medical Scheme

The scheme was placed under provisional curatorship by the North Gauteng High Court on 2 October 2012 as a result of material concerns over the governance of the scheme. Mr Themba Langa was appointed curator and has proceeded to address and rectify the concerns raised. The scheme has signified its intention to appeal.

Daniel Pienaar v the Registrar & Council

The Chairperson of Liberty Medical Scheme, Daniel Pienaar, brought an application in the North Gauteng High Court for an interdict seeking to prevent the CMS from proceeding to invoke the provisions of Section 46 of the Medical Schemes Act to have him removed from office as trustee. The court held that there was no basis for the granting of an interdict and that the prescribed processes should continue. The matter was dismissed with costs. Daniel Pienaar has applied for leave to appeal against the judgment, and the ruling of the High Court is awaited.



Scheme amalgamations, liquidations, and curatorships

In the year under review, medical schemes continued to merge, liquidate, and be placed under curatorship. Such developments are not necessarily undesirable; they are in fact an expected response to natural market forces operating in any industry. Amalgamations, liquidations, and curatorships cannot be used to argue for a negative picture of the South African medical schemes landscape.

Amalgamations

1) Resolution Health Medical Scheme and the National Independent Medical Aid Society (NIMAS) amalgamated into Resolution Health Medical Scheme with effect from 1 August 2012.
2) Bonitas Medical Fund (Bonitas) and Pro Sano Medical Scheme amalgamated into Bonitas with effect from 1 January 2013.
3) Discovery Health Medical Scheme (DHMS) and Nampak SA Medical Scheme amalgamated into the DHMS with effect from 1 March 2013.

Liquidations

The following schemes were liquidated in the period under review:

1) Siemens Medical Scheme (12 January 2012)
2) Metrocare (1 June 2012)
3) Eyethumed Medical Scheme (31 December 2012)

Curatorships

Two schemes were placed under curatorship:

1) Sizwe Medical Fund (provisional curatorship on 4 September 2012, confirmed on 22 January 2013)
2) Medshield Medical Scheme (provisional curatorship on 2 October 2012, confirmed on 25 January 2013)

The curatorship of Bonitas Medical Fund was lifted on 31 August 2012; the scheme had been under curatorship since 27 May 2011.

ITAP

The Industry Technical Advisory Panel (ITAP) is the transformed Risk Equalisation Technical Advisory Panel (RETAP). It brings together the CMS and industry stakeholders to collaborate on projects identified by the CMS as having strategic implications for the entire industry.

Participation on ITAP is open to any stakeholder in the medical schemes industry with an interest in a specific research project indentified through the ITAP process. Those who decide to become involved in ITAP research projects are expected to submit data, and actively attend and contribute to meetings. The broader industry meetings are intended to inform the whole industry of ITAP's various activities and to report back on results.

The CMS coordinated two ITAP meetings in the year under review, on 5 July 2012 and 7 March 2013.

There are four ITAP sub-committees, each of which takes responsibility for a different project:

1) Medical Inflation & the Utilisation of Healthcare Services
2) Impact & Value of Managed Care Interventions
3) Schemes Risk Measurement (SRM) (former REF) Data & the Cost of Prescribed Minimum Benefits (PMBs)
4) Composite Risk Index (CRI)

Each sub-committee made significant progress on its respective project in the reporting period.

The Medical Inflation & the Utilisation of Healthcare Services sub-committee finalised a draft framework for measuring medical inflation; this included splitting the medical inflation index into the utilisation of healthcare and tariff components. The framework is available on the CMS website; it is an important source of information for evaluating contribution increases and improving understanding of the key drivers of medical inflation. The framework is currently being piloted on a few schemes, and the final model is expected to be concluded in the 2013-2014 financial year.

The ITAP sub-committee which seeks to measure the impact and value of managed care programmes which are purchased by medical schemes on behalf of their members, collected data on two conditions in the year under review, namely HIV/AIDS and breast cancer. The project aims to assess the value of managed care interventions based on these diseases. The specifications for collecting data on these conditions were finalised. The next phase of the project, which will be conducted during the 2013-2014 financial year, includes an evaluation of the availability and suitability of data for measuring the effectiveness of managed care on the two select conditions.

In the year under review, ITAP's SRM sub-committee provided input on the Entry & Verification Guidelines (EVGs) for identifying beneficiaries with risk factors for the latest version of the manual entitled *Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria* (available on the CMS website). This sub-committee's broader objective is to identify new risk factors in medical scheme beneficiaries, and give feedback to individual schemes and ITAP alike.

The CRI sub-committee concluded its analysis of the CRI model that can be used to profile medical schemes in terms of the financial risks they face. The index is populated for internal purposes at the CMS to identify schemes which are more likely to face financial difficulties or governance irregularities, and to take timely and appropriate action. The structure of the financial risk component is published on the CMS website.

The index has the following components:

1) financial risk (pricing risk, volatility risk, and liquidity risk)
2) change in membership profile
3) complaints received by the CMS
4) governance issues

ITAP has become an active forum for the CMS and industry to collaborate on technical discussions and analysis, and as such it is already making a valuable contribution to the industry and all beneficiaries.

A study on contributions and benefits

The Medical Schemes Act outlines legislative requirements informing the capacity of the CMS to act with regard to benefit content configuration as well as the pricing of options.

R&M conducted a study on contribution increases and benefit options in the period under review. The scope of the project was to review international experience as it relates to benefit content enhancement and/or limitations within the context of changes in contributions. The project undertook a systematic review of literature which was triangulated with the quantitative analysis of 2010-2011 annual statutory data, medical schemes cost assumptions, 2010 risk clustering data, and the CMS complaints database as well as a qualitative analysis of scheme rules to determine factors attributable to changes in benefit option design and contributions.

The study population was made up of 26 medical schemes stratified by type, size, number of benefit options, and number of beneficiaries; the sample was selected using a non-random purposive technique. The selected schemes represented 64% of the number of lives covered by medical schemes between 2010 and 2011.

The study has allowed the CMS to enhance its processes of assessing scheme rules and contribution increases.

A key finding of the study was that, when solvency levels are above the statutory requirement, schemes tend not to consider reserves-loading in their projections unless a scheme is experiencing stagnation in membership growth within an option(s) or challenges with regard to the payment of claims.

Guidance on contribution increases

In the year under review, the CMS again analysed key economic indicators with a bearing on the private healthcare sector in an effort to make a recommendation to industry on reasonable cost increase assumptions when determining contribution increases for the year 2013.

This process was again informed by the realisation that contribution increases in excess of the Consumer Price Index (CPI) have an adverse effect on the long-term sustainability of medical schemes.

Empirical evidence points to a positive correlation between contribution increases and the downward migration of beneficiaries to cheaper benefit options, or the outright deregistration of dependants. Younger and healthier beneficiaries tend to be highly sensitive to price changes and therefore more prone to the "buy-down phenomenon". Such behaviour compromises the key principle of community-rating as it is envisaged in the Medical Schemes Act.

In Circular 29 of 2012, published in July 2012, the CMS provided guidance on contribution increases for the 2013 calendar year. The Circular also informed medical schemes of the key considerations that the CMS would take into account in assessing the adequacy of cost increases for their 2013 benefit year.

The CMS advised medical schemes that they should limit the cost increase assumptions for the 2013 benefit year to 6.0% for each individual healthcare cost driver, including private hospital fees, specialist costs, and administration fees.

Schemes were also requested to submit analyses of demographic indicators and healthcare utilisation in motivating for their respective cost increase assumptions for 2013.

Analysing the assumptions on contribution increases

Every year the CMS analyses the assumptions that medical schemes had used to arrive at their respective contribution increases for a particular benefit year. Its observations for 2013 were published in the form of Circular 4 of 2013.

Cost assumptions that are used to arrive at contribution increases take into account the tariff portion (as negotiated between medical schemes and healthcare providers), the changes in beneficiary demographics, and the utilisation of healthcare services.

For the 2013 benefit year, medical schemes assumed that they would need to increase their contributions by an average of 9.6%.

The assumed increase in the tariff portion was 6.8% or 0.8% higher than the maximum tariff increase of 6.0% recommended by the CMS in its Circular 29 of 2012.

The impact of changed demographics and the utilisation of healthcare services made up the remaining 2.8% of the total assumed increase in costs for 2013.

The CMS noted that the utilisation assumptions of most medical schemes, both open and restricted, did not correlate with their improving or worsening demographic and disease profiles. The cost increase assumptions in low-risk (younger and healthier) medical schemes were slightly lower than those in high-risk (older and sicker) medical schemes, but the difference was not statistically significant.

As has been observed in the past, cost assumptions for private hospitals and medical specialists were above CPI. The cost assumptions for each were 1.0% and 0.4% above the recommended 6.0% increase respectively.

Private hospital and medical specialist costs continued to make up the most significant portion of medical scheme expenditure in the 2012 calendar year.

Circular 4 of 2013 also indicates that the size of a medical scheme does not seem to have an impact on cost assumption increases, implying that medical schemes remain price takers in the industry, with no benefits derived from economies of scale by members who belong to large medical schemes. Schemes should try to address cost factors to the best of their ability because failure to do this allows the affordability challenge in accessing healthcare to continue, which can be perceived as a threat to the long-term sustainability of the industry.

Contributions

The average gross contribution increase for all medical schemes in 2013 was 9.7%.

Open schemes increased their contributions by more than the restricted schemes did in the calendar year under review. The comparative increases for open and restricted schemes were 10.8% and 8.1% respectively.

This observation highlights the fact that the average family contribution in restricted schemes was 17.0% lower than in open schemes in the 2012 benefit year; it was 12.0% lower in 2011. This in turn points to the very purpose of restricted medical schemes: their profile and structure allows them to provide benefits at a more affordable level than open schemes can.

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants in medical schemes. The information in this section is a summary based on medical scheme submissions in respect of the annual benefit changes and contribution increases for 2013; it is based on projections in these submissions.

The average gross contribution increases for the 2012-2013 benefit and contribution review period are:

Increase in gross contributions in 2013	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.6%	10.0%	9.4%	9.7%
Restricted schemes	10.8%	10.7%	10.9%	10.8%
All schemes	**7.9%**	**8.8%**	**8.0%**	**8.1%**

Gross contributions and risk contributions

The average monthly gross contribution for 2013 per principal member, adult dependant, child dependant, and family is as follows:

Monthly gross contribution in 2013	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 700	R1 448	R542	R2 842
Restricted schemes	R2 061	R1 914	R614	R3 388
All schemes	**R1 628**	**R1 288**	**R561**	**R2 805**

The average monthly risk contribution for 2013 per principal member, adult dependant, child dependant, and family is as follows:

Monthly risk contribution in 2013	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 543	R1 295	R499	R2 576
Restricted schemes	R1 808	R1 641	R536	R2 948
All schemes	**R1 561**	**R1 234**	**R542**	**R2 693**

Risk contributions: year-on-year percentage rate changes

The average risk contribution increase for all medical schemes in 2013 was 9.7%. The comparative increases for open and restricted schemes were 10.8% and 8.4% respectively.

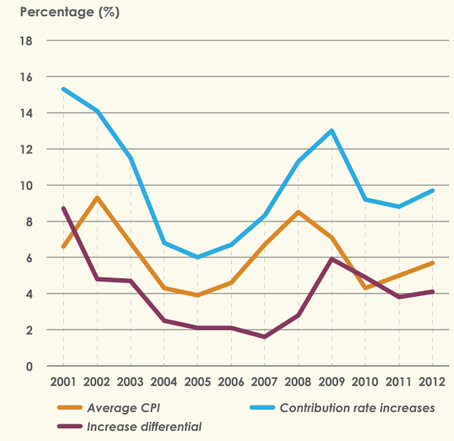
The average risk contribution increases for the 2012-2013 benefit and contribution review period are:

Increase in risk contributions in 2013	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.7%	10.0%	9.4%	9.7%
Restricted schemes	10.8%	10.7%	11.0%	10.8%
All schemes	**8.2%**	**9.0%**	**8.1%**	**8.4%**

Contribution rates relative to general price indicators

Figure 2 shows the historical and current trends in the Consumer Price Index (CPI) (or inflation) relative to contribution rates in medical schemes between 2001 and 2012. We have also incorporated the amount by which medical contribution increases are greater than inflation.

Figure 2: Contributions & inflation in 2001-2012



CPI = Consumer Price Index

Our research shows that since the year 2002, medical scheme contributions have been similar to inflation.

The average difference in the increase in contributions compared to CPI throughout 2001 to 2012 is in the region of 4.0%. This has implications for the long-term affordability of the medical schemes industry as increases in salaries may not necessarily be able to keep pace with contribution increases.

How much members contributed and what schemes paid

In the 2012 calendar year, medical schemes collected a total of R117.5 billion in contributions, representing an increase of 9.4% from R107.4 billion in 2011.

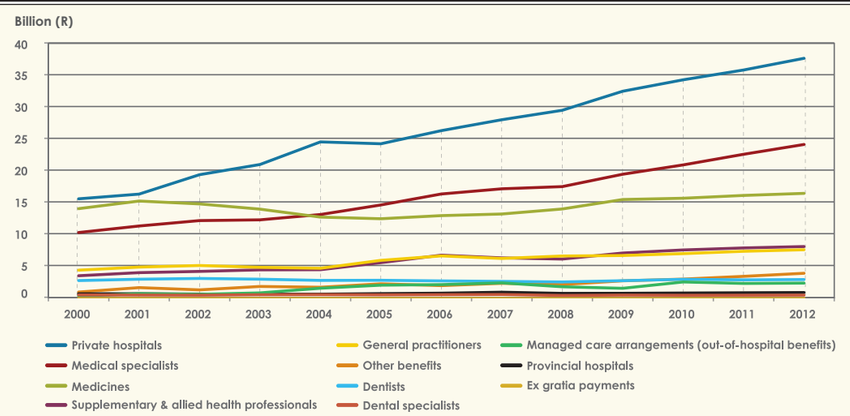
Of this, schemes paid, in nominal terms, R103.3 billion for healthcare benefits, an increase of 10.8% from the R93.2 billion in 2011.

(The figure for total gross relevant healthcare expenditure incurred by medical schemes under the heading *Contributions, relevant healthcare expenditure, and trends* in the chapter entitled *The medical schemes industry in 2012* on page 224 and in the Annexures differs from the one reported above because it includes the IBNR and the results of risk transfer arrangements.)

Figure 3 depicts the trend in healthcare benefits paid by medical schemes to different types of providers since the year 2000. The figures have been adjusted for inflation on 2012 figures, which is why the 2011 figures differ slightly from those that were provided in the previous Annual Report.

The trend is the same as in previous years, with schemes paying the largest proportion of healthcare benefits towards private hospitals, medical specialists, and medicines.

Figure 3: Total healthcare benefits paid in 2000-2012: 2012 prices*



* CPIX is the rebased Consumer Price Index (CPI) excluding interest rates on mortgage bonds.

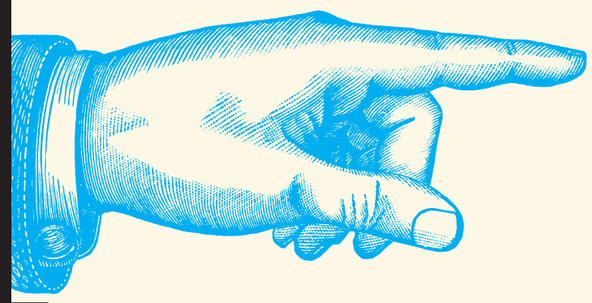
By 2012, medical schemes expenditure on private hospitals had increased in real terms by 5.3% to R37.6 billion compared to R35.7 billion in 2011.

Private hospitals expenditure accounted for 29.9% of all healthcare benefits paid by medical schemes in 2000; the comparative figure in 2006 was 34.5% which increased further to 36.4% in 2012. Figure 3 further illustrates an increase in private hospitals expenditure from R15.5 billion in 2000 to R37.6 billion in 2012. If adjusted for inflation and number of beneficiaries in the period 2000-2012, then the increase in private hospitals expenditure amounted to 88.2% between 2000 and 2012, from R2 300.5 to R4 330.0 per beneficiary per annum on 2012 prices.

Benefits paid to medical specialists in 2012 amounted to R24.0 billion, an increase of 6.7% in real terms when compared to the R22.5 billion that was spent on this item in 2011. Expenditure on medical specialists has been increasing since 2003, where it accounted for 19.6% of all benefits paid. This increased to 23.3% in 2012.

Non-diagnosing specialist providers such as anaesthetists, radiologists, and pathologists accounted for 11.1% of the 23.3% of all the benefits that were paid to specialists in 2012. If adjusted for inflation and number of beneficiaries in the period 2000-2012, then medical schemes expenditure on specialists increased by 82.9% between 2000 and 2012, from R1 513.0 to R2 768.6 per beneficiary per annum on 2012 prices.

Medical schemes spent 1.9% more on medicines in 2012 (R16.3 billion), up from R16.0 billion in 2011. As a proportion of total healthcare benefits paid, expenditure on medicines as a percentage of all benefits paid decreased from 16.3% in 2011 to 15.8% in 2012. When adjusted for inflation and number of beneficiaries between 2000 and 2012, schemes' expenditure on medicines declined by 9.1% in the 12-year period, from R2 070.7 in 2000 to R1 882.6 in 2012.



Total expenditure on general practitioners (GPs) amounted to R7.5 billion in 2012, which is an increase of 4.2% compared to the R7.2 billion that was spent on these healthcare providers in 2011. Expenditure on GPs as a proportion of all benefits paid to healthcare providers was 7.2% in 2012 compared to the 7.3% in 2011. When adjusted for inflation and number of beneficiaries, expenditure on GPs increased by 35.9% from R633.3 per beneficiary per annum in 2000 to R861.0 per beneficiary per annum in 2012.

There was an increase of 3.7% on healthcare benefits paid to dentists, from R2.7 billion in 2011 to R2.8 billion in 2012. Expenditure on dentists as a percentage of all benefits paid was 2.8% in 2011 and 2.7% in 2012. During 2000-2012, expenditure on dentists decreased by 17.7% from R389.9 per beneficiary per annum in 2000 to R320.8 per beneficiary per annum in 2012.

Non-health expenditure

The CMS continued to emphasise the effective management of non-health expenditure in the year under review.

The non-health expenditure of medical schemes – which includes fees paid to third-party administrators, trustee remuneration and other considerations as well as other general operating costs – should be maintained at acceptable levels and reduced where indicated to ensure that members of medical schemes derive more value out of every healthcare Rand they spend on their monthly contributions. In the year under review the CMS again strengthened its efforts in encouraging trustees to monitor and review these costs on an ongoing basis in the best interests of their respective members.

In their 2012 financial year, medical schemes spent a total of R13.1 billion on non-health expenditure, compared to R12.1 billion in 2011, thus representing an increase of 8.1%. Open medical schemes had an average increase of 6.5%, compared with the 12.5% increase for restricted schemes.

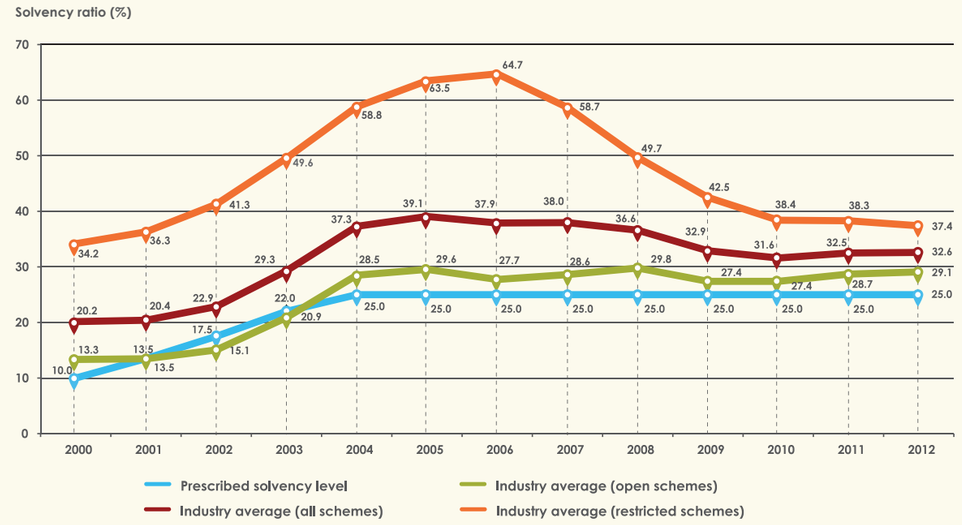
Overall, the non-health expenditure of medical schemes remained stable in real terms in the period being reviewed; this is a stark contrast to the year-on-year double-digit increases that were being experienced over a decade ago.

Keeping an eye on schemes' finances and solvency

The Medical Schemes Act 131 of 1998, and specifically Regulation 29, requires schemes to maintain accumulated funds expressed as a percentage of gross annual contributions – also called their solvency – amounting to at least 25.0%. One of the responsibilities of the CMS is ensuring that medical schemes are able to maintain this minimum statutory solvency level to remain financially sound at all times and sustainable in the long run. Schemes who fail to meet solvency requirements are expected to submit business plans and, where necessary, appropriate action plans as well.

Overall, the industry remained financially healthy and stable in 2012, its solvency staying above the minimum ratio of 25.0% prescribed by legislation.

Figure 4: Industry solvency for all schemes in 2000-2012



Schemes with a solvency below the prescribed 25.0% are termed "ICU schemes".

From a solvency point of view, the industry remained stable in the year under review. A fair number of the ICU schemes on close monitoring significantly improved their solvency; the focused efforts of their respective Boards of Trustees in this regard are commendable.

The Chief Executive & Registrar is actively engaging with schemes facing financial and other challenges to ensure that members' interests are protected at all times.

Eleven ICU medical schemes found themselves below the minimum statutory solvency requirement of 25.0% at the end of 2012, compared with 14 as at 31 December 2011. Seven of the 11 were open schemes and four were restricted; at the end of 2011 the numbers were nine open and five restricted medical schemes with a solvency below 25.0%.

Three schemes thus achieved the 25.0% solvency mark in 2012, one scheme amalgamated into another, and they were consequently taken out of the ICU categorisation as at 31 December 2012. At the end of the year, only one new scheme was added to this categorisation.

Table 8 provides an overview of medical schemes under close monitoring in 2012 in terms ofRegulation 29(4) of the Medical Schemes Act.

Table 8: Medical schemes under close monitoring in 2012

Solvency	Open schemes	Restricted schemes	Name of schemes
Solvency below 10.0%	1	1	Resolution Health Medical Scheme Government Employees Medical Scheme (GEMS)
Solvency of 10.0-13.5%	1	0	Thebemed
Solvency of 13.5-17.5%	1	2	Pharos Medical Plan Transmed Medical Fund Umvuzo Health Medical Scheme
Solvency of 17.5-22.0%	0	1	Altron Medical Aid Scheme
Solvency of 22.0-25.0%	4	0	Discovery Health Medical Scheme (DHMS) Hosmed Medical Aid Scheme Keyhealth Pro Sano Medical Scheme*
Solvency below 25.0%	**7**	**4**	**11**

* Pro Sano Medical Scheme merged with Bonitas Medical Fund with effect from 1 January 2013.

There were 93 medical schemes at the end of 2012, 25 open and 68 restricted, housing a total of 8 679 473 beneficiaries. Of these, 3 815 431 were principal members and 4 864 042 were dependants.

As at 31 December 2012, there were 4 759 994 beneficiaries in open schemes (compared to 4 760 114 as at 31 December 2011), of which 58.8% (2 796 583) were in schemes that were not meeting the prescribed minimum solvency requirement of 25.0%. The restricted schemes market had a total of 3 919 479 beneficiaries at the end of 2012 (3 766 295 as at 31 December 2011), of which 50.5% (1 978 668 beneficiaries) were in schemes not meeting the 25.0% solvency requirement.

The percentage of open scheme beneficiaries whose schemes ended 2012 with a solvency below the prescribed 25.0% would drop from the 58.8% reported above to just 6.9% if Discovery Health Medical Scheme (DHMS) were excluded from the calculations, and the percentage of restricted scheme beneficiaries would drop from the 50.5% above to only 4.3% if the Government Employees Medical Scheme (GEMS) were excluded. DHMS accounts for more than half (51.9%) of all beneficiaries in the open schemes market, and in the restricted schemes industry GEMS represents almost half (46.2%) of all beneficiaries.

The CMS also keeps a close eye on schemes whose solvency, although healthy, is decreasing rapidly as well as those with excessive non-health expenditure and governance problems, the latter being more likely to face financial problems down the line if their governance challenges go unaddressed. Medical schemes under curatorship are also carefully monitored.

How ICU schemes on close monitoring fared

At the end of the 2012 year, 11 medical schemes found themselves in ICU, or below the minimum statutory solvency requirement: seven open and four restricted. This number was 14 as at 31 December 2011 (nine open and five restricted).

Altron Medical Aid Scheme had a solvency ratio of 21.1% at the end of December 2012. This was an improvement on the previous year, suggesting that the reversal of the employer's decision to relax employment conditions by allowing employees to join other medical schemes is beginning to bear fruit. The trustees of the scheme attend quarterly monitoring meetings with the CMS and have submitted a turnaround plan.

A solvency ratio of 25.5% was attained by the Community Medical Aid Scheme (COMMED) after several years. However, the scheme continued to struggle with its membership base in 2012, and its trustees have been encouraged to review their strategies in this respect.

The 2012 year-end solvency ratio of the open Discovery Health Medical Scheme (DHMS) was slightly lower than in the previous year, at 23.4%. The scheme continued to grow its membership base, and its Board of Trustees introduced a number of initiatives, amongst them the alignment of benefits and the introduction of further compliance and risk management health expenditure, which is closely monitored by the CMS. The scheme submitted a business plan which was approved by the Office of the Chief Executive & Registrar, against which progress is tracked. The trustees attend monitoring meetings on a regular basis.

The Government Employees Medical Scheme (GEMS) had a solvency of 7.9% at the end of 2012, down from the 8.6% reported a year earlier. This is because GEMS continued to grow its membership, and also because it took on a pensioner group from another scheme. Both these factors increased the strain on its solvency ratio. GEMS submits monthly management accounts and quarterly financial updates for monitoring purposes. It also has an approved business plan to improve its solvency level.

The open Hosmed Medical Aid Scheme ended 2012 with a solvency ratio of 23.1%, an improvement on the previous year. The scheme continued to experience governance challenges, coupled with membership loss.

Keyhealth improved its financial performance in the year under review, ending 2012 with a solvency of 23.1%. But the challenges faced by this open scheme with regards to a worsening demographic profile remain. Its Board of Trustees attends monitoring meetings to discuss progress against the approved business plan.

In keeping with the previous year, 2012 saw an improved performance by Minemed Medical Scheme, with a solvency of 28.5%. The restricted scheme incurred lower claims once again, which boosted its reserves.

Momentum Health's solvency stood at 28.6% at the 2012 year-end, comfortably above the required minimum solvency of 25.0%. This open scheme had been on close monitoring for some time, with various initiatives being introduced by the trustees over the years to improve its financial performance and solvency level, in particular, creating a stable membership base.

The 2012 year-end solvency ratio of the open Pharos Medical Plan was 16.6%. The scheme continued to face a risk pool that is small, declining, and ageing. Pharos submitted a business plan and continued to submit monthly management accounts. The trustees attend quarterly meetings to discuss progress.

Pro Sano Medical Scheme, now merged into Bonitas Medical Fund, had a solvency ratio of 22.6% at the end of 2012, compared with a 25.2% solvency at the end of 2011.

Resolution Health Medical Scheme ended 2012 on a solvency of 6.1%, a marked decline from its 9.1% solvency in 2011 and 17.6% solvency in 2010. The CMS has advised the Board to seek solutions to address the sustainability of this open scheme, including amalgamation. The CMS engages with the scheme regularly to ensure that members' interests are protected at all times.

In 2012, the open Thebemed had a slightly lower solvency level than in 2011, namely of 10.6%, primarily due to expected claims and a loss of members. The CMS holds review meetings with the Board on a regular basis. Thebemed has an approved business plan to improve its financial soundness; and the scheme also submits monthly management accounts.

In comparison with 2011, 2012 was a better year for Transmed Medical Fund; its solvency ratio improved from 9.5% at the end of 2011 to 16.3% at the end of 2012. This is partly due to adjustments to its benefit design and the introduction of managed care interventions. Transmed submitted a business plan and is under close monitoring. The CMS has ongoing meetings with this restricted scheme to discuss progress against submitted turnaround plans.

Umvuzo Health Medical Scheme had a solvency level of 14.5% at 2012 year-end. This restricted scheme also introduced changes to its managed care programmes in an attempt to curb losses.

Personal medical savings accounts (PMSAs)

During 2012, the CMS made significant strides in ensuring that personal medical savings accounts (PMSAs) are treated as trust funds which medical schemes hold on behalf of their respective members. These monies must be maintained and invested separately from scheme funds, and the interest and other earnings on these funds must be allocated to members.

Medical schemes were granted an extension until the end of the 2012 calendar year to make the necessary adjustments to their systems; schemes indicated compliance effective from January 2013.

The CMS is liaising with the Master of the High Court to establish Standard Operating Procedures (SOPs) regarding the payment of unclaimed PMSA monies over into the Guardians Fund. Industry will be kept abreast of these developments.

How schemes invest

The CMS made significant progress in reviewing Annexure B of the Medical Schemes Act read in conjunction with Regulation 30. This piece of legislation regulates investments which medical schemes make to ensure that they are aligned with the nature of liabilities unique to medical schemes. Various external experts serve on the Annexure B / Regulation 30 Technical Advisory Panel (TAP), and the CMS continued to engage with them in the year under review. Once this project is completed, it will allow for better regulation of scheme investments as well as improved management of these funds, be it directly by the schemes themselves or by contracted parties. Industry will be engaged in due course to provide comments.

How schemes report

The CMS again collaborated with the Medical Schemes Project Group of the South African Institute of Chartered Accountants (SAICA) on the annual review and publication of the *SAICA Accounting Guide for Medical Schemes*. The guide was published in October 2012.

The CMS also engaged with the Independent Regulatory Board for Auditors (IRBA) on several matters during the year under review.

Our association with both these bodies is critical in ensuring that the quality of data submitted by medical schemes is of the highest standard, and in compliance with applicable accounting and auditing standards.

Collaboration with other regulatory entities

The determination of health prices

In November 2010, the Department of Health and the CMS published a discussion document on the determination of healthcare prices in the private sector, following which CMS staff members served on a task team appointed by the Minister of Health to evaluate comments on the discussion document and to advise the Minister on how to proceed with this matter.

In July 2011, the CMS again proposed that a regulator be established to oversee price determination in the private health sector when it was invited to make a presentation to the parliamentary Health Portfolio Committee.

During the year under review, the CMS held various discussions with officials in the Competition Commission, the Health Professions Council of South Africa (HPCSA) as well as the Minister of Health and the Department of Health on the determination of healthcare prices in the private sector.

Amendments to the Competition Act 89 of 1998, which were proclaimed in March 2013, now enable the Competition Commission to conduct full market enquiries into a broader range of sectors, and the CMS will collaborate with the Competition Commission during the forthcoming year on their unprecedented enquiry into the healthcare market.

The Protection of Personal Information Bill (POPI)

A task team was established to investigate the implications of the Protection of Personal Information Bill (POPI) for the CMS and the industry, with a view to ensuring that appropriate submissions are made to the Department of Justice & Constitutional Development in relation to the impact of this proposed piece of legislation on both the CMS as regulator and the industry.

Our "warning systems"

Statutory returns and complaints

The CMS has been collecting quarterly and annual statutory returns since its inception in 2000, and rolled out a Real-Time Monitoring (RTM) system in 2012. The quarterly returns, though unaudited, serve as an early warning system for the CMS to consider appropriate regulatory intervention where required.

The statistics that we collect on the complaints that we receive each year also serve as a way to monitor the industry and pick up problematic areas of possible non-compliance with the Medical Schemes Act.

Real-Time Monitoring (RTM) of the industry

As part of its regulatory mandate, the CMS monitors the financial soundness of medical schemes to ensure that they remain sustainable in the long term for the benefit of members and the national health system as a whole.

Several tools are used to support this function and collect data from medical schemes. One such tool is the Real-Time Monitoring (RTM) system which was rolled out to the industry during 2012 following the successful completion of the pilot phase in which a selected sample of medical schemes and administrators participated.

The RTM collects financial and non-financial information from medical schemes and administrators via a direct mapping process from their respective systems in real time. This timeliness of information allows for appropriate and specific regulatory interventions where indicated and always in consultation with the relevant Boards of Trustees.

Measuring the risks that schemes face

In the previous financial year the CMS reported that the Department of Health had decided not to proceed with the implementation of the much-anticipated Risk Equalisation Fund (REF) for the medical schemes industry.

In the meantime, the CMS had developed a shadow system which has been collecting REF data from schemes since 2005.

REF data has been invaluable to the regulatory activities of the CMS.

The CMS continued to collect the "former REF returns", now called Schemes Risk Measurement (SRM) data, in the year under review, as the regulator aims to further enhance its understanding of the risk profiles of medical schemes. The SRM data analysis tool was updated during the reporting period, and the Entry & Verification Guidelines (EVGs) for identifying beneficiaries with risk factors were reviewed; the latest version of the *Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria* is available on the CMS website.

Medical schemes are encouraged to continue submitting the "former REF returns" as they allow the CMS to estimate risk factor weights and costs of benefits, including the prescribed minimum benefits (PMBs).

The submission requirements were also reconsidered in the year under review in an effort to reduce the administration burden on schemes; schemes are now required to submit their REF returns annually (every April) as opposed to quarterly.

REF data, together with other routinely collected data, feeds into the Composite Risk Index (CRI).

Composite Risk Index (CRI), or the "traffic light approach" to regulating

Monitoring and measuring the risks facing medical schemes is a very important function in seeking to prospectively regulate them. A proactive approach enables the CMS to anticipate problematic areas long before they materialise, and it facilitates timely regulatory intervention, should it be required.

The Composite Risk Index (CRI) was implemented in the year under review. Also known as the "traffic light approach" to regulating, the index ranks medical schemes according to the risks they face as it aims to proactively identify schemes that may face financial and other difficulties.

The CRI relies on information such as financial indicators, demographics of beneficiaries, and the number of complaints received to rank medical schemes on a scale from red through yellow to green. Red schemes are prioritised while green schemes require no or minimal regulatory intervention.

The CMS is collaborating on the CRI with the newly established Industry Technical Advisory Panel (ITAP).

The prevalence of chronic diseases

R&M conducted a trend analysis study on chronic diseases in the private healthcare sector for the period 2006-2011. The study design was a retrospective review of the Schemes Risk Measurement prevalence database.

The top 10 chronic conditions that showed the fastest increase in the period 2006-2011, in order of their prevalence from highest to lowest in 2011, were hypertension, hyperlipidaemia, diabetes mellitus type 2, hypothyroidism, glaucoma, rheumatoid arthritis, bipolar mood disorder (BMD), Parkinson's disease, chronic renal disease, and systemic lupus erythematosus (SLE), which is an autoimmune disease.

Bipolar mood disorder experienced the fastest growth in this period.

Table 9 summarises these changing prevalence rates between 2006 and 2011.

Table 9: Top 10 chronic conditions in 2006-2011

Chronic condition	Prevalence per 1 000 beneficiaries		% increase
	2006	2011	
Hypertension	57.6	78.8	36.8%
Hyperlipidaemia	23.9	32.9	37.7%
Diabetes mellitus type 2	12.0	22.1	84.2%
Hypothyroidism	9.7	13.7	41.2%
Glaucoma	1.8	2.7	50.0%
Rheumatoid arthritis	2.0	2.6	30.0%
Bipolar mood disorder (BMD)	0.7	2.3	228.6%
Parkinson's disease	0.5	0.8	60.0%
Chronic renal disease	0.2	0.3	50.0%
Systemic lupus erythematosus (SLE)	0.16	0.22	37.5%

The prevalence of hypertension increased by 36.8% between 2006 and 2011, from 57.6 to 78.8 per 1 000 beneficiaries, making it the fastest-increasing cardiovascular condition among medical scheme beneficiaries and the most prevalent chronic disease on the PMB Chronic Diseases List (CDL).

Hyperlipidaemia's prevalence among beneficiaries grew from 23.9 in 1 000 beneficiaries in 2006 to 32.9 in 1 000 beneficiaries in 2011. This is most likely due to lifestyle changes.

The 84.2% increase in the prevalence of diabetes mellitus type 2 between 2006 and 2011 again points to the importance of leading a healthy lifestyle.

Over six times more female than male beneficiaries were treated for hypothyroidism between 2006 and 2011. The overall prevalence of the disease increased from 9.7 to 13.7 per 1 000 beneficiaries in that period. Its prevalence increased by 37.5% in female beneficiaries, from 16.5 per 1 000 in 2006 to 22.6 per 1 000 in 2011. The prevalence of hypothyroidism among male beneficiaries increased at a faster rate, from 2.3 per 1 000 in 2006 to 3.8 per 1 000 in 2011, an increase of 63.2%.

The prevalence of glaucoma increased from 1.8 per 1 000 beneficiaries in 2006 to 2.7 per 1 000 beneficiaries in 2011. No significant gender-related difference in prevalence was observed.

The prevalence of rheumatoid arthritis increased from 2.0 per 1 000 beneficiaries in 2006 to 2.6 per 1 000 beneficiaries in 2011, an increase of 30.0%. More female than male beneficiaries were treated for the disease during that period. The prevalence of rheumatoid arthritis among female beneficiaries increased from 2.8 to 3.8 per 1 000 in 2006-2011, compared to a change from 1.1 to 1.4 per 1 000 in male beneficiaries during the same period.

The prevalence of bipolar mood disorder (BMD) among medical scheme beneficiaries more than doubled between 2006 and 2011. The mental disease showed an increase of a staggering 228.6% during the period covered by the study, from 0.7 to 2.3 per 1 000 beneficiaries. Very few beneficiaries under the age of 14 years were treated for the disease, but the prevalence of BMD among female beneficiaries 15-39 years old increased from 1.0 per 1 000 in 2006 to 3.6 per 1 000 in 2011; for males in the same age group, the BMD prevalence was 0.5 per 1 000 in 2006 and 2.9 per 1 000 in 2011. Similar trends were observed in the older age groups (above 40 years).

Parkinson's disease became 60.0% more prevalent between 2006 and 2011, increasing from 0.5 to 0.8 per 1 000 beneficiaries. Prevalence of the disease among beneficiaries between 60 and 79 years old increased from 3.9 to 4.4 per 1 000 in the same period; the numbers were higher among beneficiaries older than 80 years, increasing from 11.0 per 1 000 in 2006 to 12.2 per 1 000 in 2011.

The prevalence of chronic renal disease increased from 0.2 per 1 000 beneficiaries in 2006 to 0.3 per 1 000 beneficiaries in 2011, an increase of 50.0%. More male than female beneficiaries were treated for the disease; in 2011, its prevalence was 0.4 per 1 000 males and 0.3 per 1 000 females.

The prevalence of systemic lupus erythematosus (SLE) increased from 0.16 per 1 000 beneficiaries in 2006 to 0.22 per 1 000 beneficiaries in 2011. SLE is more commonly found in women than in men. Compared with the year 2006, there were seven times more women than men treated for SLE in 2011.

Complaints and appeals processes

How many complaints we received

The CMS receives thousands of complaints each financial year, and 2012-2013 was no different. But for the first time in our 13-year history, the number of complaints we received actually dropped when compared to the previous financial years: by more than 200.

The CMS received 5 915 complaints in the 2012-2013 financial year, compared to the 6 138 in the previous reporting period. This was a first-ever decrease, namely of 223 complaints or 3.6 complaints per 1 000 beneficiaries.

Figure 5: Number of complaints per 1 000 beneficiaries in 2010-2011, 2011-2012 & 2012-2013

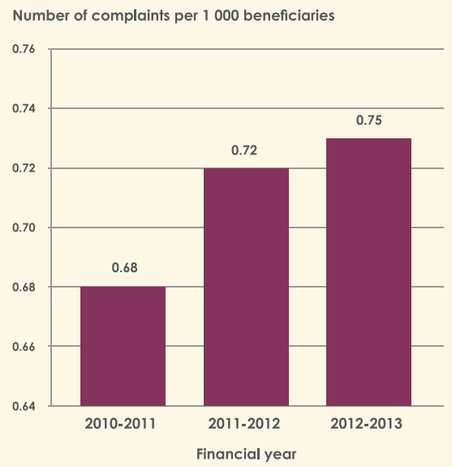
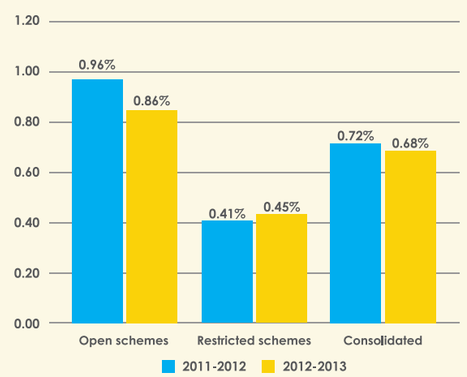


Figure 6 represents the consolidated percentages of complaints received for the 2011-2012 and 2012-2013 financial years for both open and restricted medical schemes.

Figure 6: Percentage of complaints received in 2011-2012 & 2012-2013



How many complaints we resolved

The Complaints Adjudication Unit resolved 5 253 complaints in the period under review; Table 10 indicates the time it took to resolve these complaints.

Table 10: How long it took to resolve complaints in 2012-2013

	0-30 days	31-60 days	61-90 days	91-120 days	120+ days	Total
Total complaints resolved	1 609	932	869	560	1 283	**5 253**
% of total complaints resolved	30.64%	17.75%	16.55%	10.66%	24.42%	**100%**

Which way rulings went

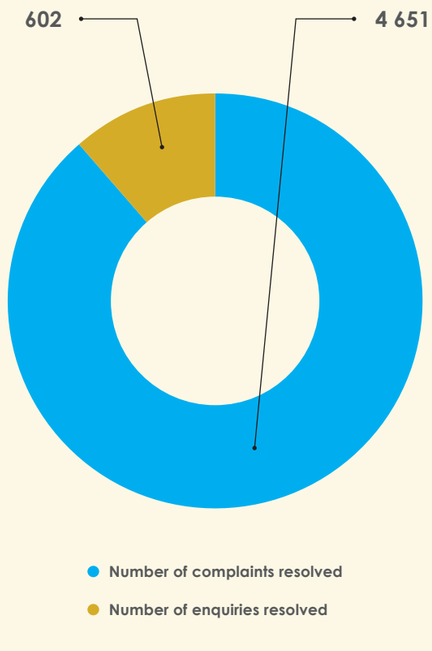
Table 11 shows which way rulings were adjudicated on. In this instance, the CMS worked on 4 651 complaints representing complaints against medical schemes, administrators, and brokers.

Table 11: Which way rulings went in 2012-2013

Type of scheme	Number of complaints	Ruled in favour of complainant	Ruled in favour of complainant & scheme	Ruled in favour of scheme
Open	3 502	1 828	273	1 401
Restricted	1 149	783	60	306
Total	**4 651**	**2 611**	**333**	**1 707**

In the same context, Figure 7 shows both the total number of complaints resolved and the total number of enquiries resolved in the 2012-2013 financial year.

Figure 7: Complaints & enquiries resolved in 2012-2013



How complaints are categorised

The complaints that the CMS receives are categorised into the groups listed in Table 12; the resolution numbers are also indicated.

Table 12: Categories of complaints

Category of complaint	Number of complaints resolved
Technical / clinical	2 717
Administrative	1 567
Legal / compliance	367
Subtotal 1	**4 651**
Invalid complaints	245
Outstanding documents*	233
Enquiries	124
Subtotal 2	**602**
Total	**5 253**

* These complaints were awaiting submission of further documents from the complainants, but no documents were forthcoming after notifications had been sent to the complainants.

The subtotal of 4 651 represents the number of valid complaints that were resolved by the Complaints Adjudication Unit in the year under review.

Only valid complaints are subject to classification in terms of the complaints system.

A breakdown of the 4 651 valid and resolved complaints as noted in Table 12 is explained in Table 13 where examples of the types of complaints that fall under each category are provided.

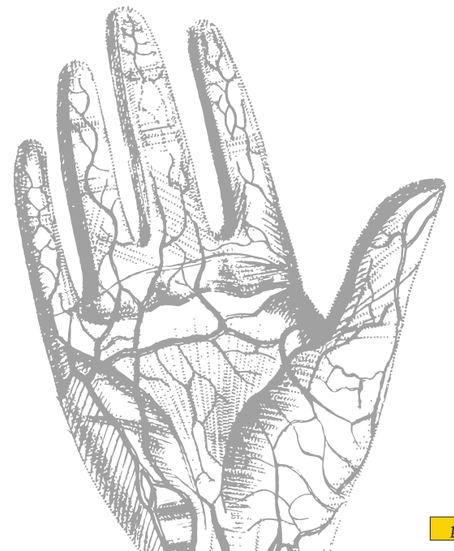
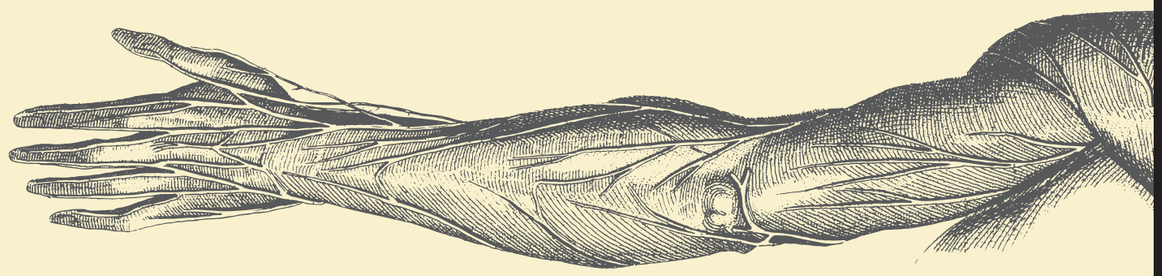


Table 13: Categories of complaints in more detail

Category description	Total amount
Technical / clinical	**2 717**
PMB accounts:	**2 411**
Non-payment	**592**
Exclusion of condition	43
Sub-limits in option	96
DSP	41
Protocols	199
Formulary	79
Provider irregular billing	2
Incorrect coding	58
Third-party claims	5
Outstanding information	62
Other	7
Short-payment	**1 814**
Sub-limits in option	117
DSP	352
Protocols	154
Formulary	94
Provider irregular billing	14
Incorrect coding	84
Outstanding information	57
Paid at scheme tariff	846
Paid from savings account	94
Other	2
Reversal	**5**
Sub-limits in option	1
Formulary	2
Incorrect coding	1
Third-party claims	1
Non-PMB accounts:	**306**
Non-payment	**180**
Exclusion of condition	69
Sub-limits in option	36
DSP	13
Protocols	35
Formulary	7
Provider irregular billing	3
Incorrect coding	12
Outstanding information	5
Short-payment	**121**
Sub-limits in option	58
DSP	24
Protocols	15
Formulary	1
Provider irregular billing	3
Incorrect coding	12
Outstanding information	8
Reversal	**5**
Sub-limits in option	3
Paid at scheme tariff	2
Administrative	**1 567**
Rejection of application for membership	**46**
Contributions	**99**
Annual increase	4
Contribution increase without prior notice	12
Incorrect contributions charged	62
Contributions misrepresented	21
Benefits	**1 027**
Benefits suspended due to non-payment of contributions	12
Non-payment of benefits	997
Limitation of benefits	17
Benefits excluded	1
Personal medical savings account	**67**
Refund not received	17
Clawback of refunds	48
Self-payment gap	2
Information not received from the scheme	**195**
Membership / tax certificate not received	14
General customer service	92
Brochures	7
Incorrect information from scheme	82
Pre-authorisation	**119**
Inaccessible networks	**14**
Provider not accessible	7
Restriction on choice of provider	7
Legal / compliance	**367**
Governance	6
Unethical conduct	11
Fraudulent assignment by broker	2
Incorrect advice by broker	1
Membership status	212
Late-joiner penalties	39
Waiting periods	96
TOTAL	**4 651**

PMB = prescribed minimum benefit
DSP = designated service provider



Funding PMBs

The CMS observed the same trend as in the last three years: more complaints were received about the manner in which medical schemes and administrators pay for prescribed minimum benefits (PMBs) than any other complaint category.

In the year under review, a total of 2 411 complaints fell inside the PMB category, of which 592 related to non-payment of PMB claims and 1 814 dealt with the short-payment of claims relating to services rendered for PMB conditions.

The highest sub-category under PMBs, which amounted to 846, related to instances where medical schemes incorrectly funded PMB claims at their respective scheme rates and not in full, leaving members to foot the outstanding balance of the bill.

The CMS noted that some medical schemes have deliberately programmed their systems to automatically fund members' PMB accounts at scheme rates and then pay the outstanding balance only after the CMS investigates a complaint alleging the short-payment of PMB accounts. The CMS is busy addressing this glaring non-compliance with the provisions of the Medical Schemes Act with the medical schemes concerned, specifically as it relates to Regulation 8 which states that PMBs must be covered in full.

The second-highest sub-category under PMBs (which amounted to a total of 393 complaints) related to instances where medical schemes short-paid claims or made no payment at all owing to the fact that members did not use the services of the designated service providers of the scheme, be it voluntarily or involuntarily.

The third-highest PMB sub-category related to the application of protocols in the treatment and management of certain PMB conditions. The CMS resolved 353 complaints which dealt with protocols. Some members did not qualify for benefits since their treatment did not form part of treatment protocols, but the CMS noted that some of these protocols were contravening the Medical Schemes Act in that they were not evidence-based. This means that members had been offered an incomplete package of care.

Funding non-PMBs

A total of 306 complaints had to do with the funding for non-PMB conditions. This category deals with members' accounts which were not paid due to members not entitled to benefits. Examples of these are where an account is initially paid and later reversed (an erroneous payment), stale claims, and exhausted benefits.

Membership

These are complaints about the suspension and termination of membership. Typically, membership is terminated because the member had failed to disclose material information about their health status when they were applying for membership. The CMS resolved 212 complaints in this category in the year under review.

Some members were found not to have provided medical schemes with true and correct information and were accepted by medical schemes without any waiting periods imposed on their membership, only to claim for funding for chronic medication, maternity benefits, and surgical procedures within months of joining the medical scheme. Investigations revealed that most members had pre-existing conditions which they failed to disclose to medical schemes at the time of applying for membership. However, there were also instances where medical schemes got it wrong as they simply terminated membership without any proof of the existence of conditions which justified disclosure, and some had no proof that members were diagnosed or received treatment during the 12 months leading up to the date of application to become members. The CMS found in favour of members in cases where there was no evidence of non-disclosure on their part.

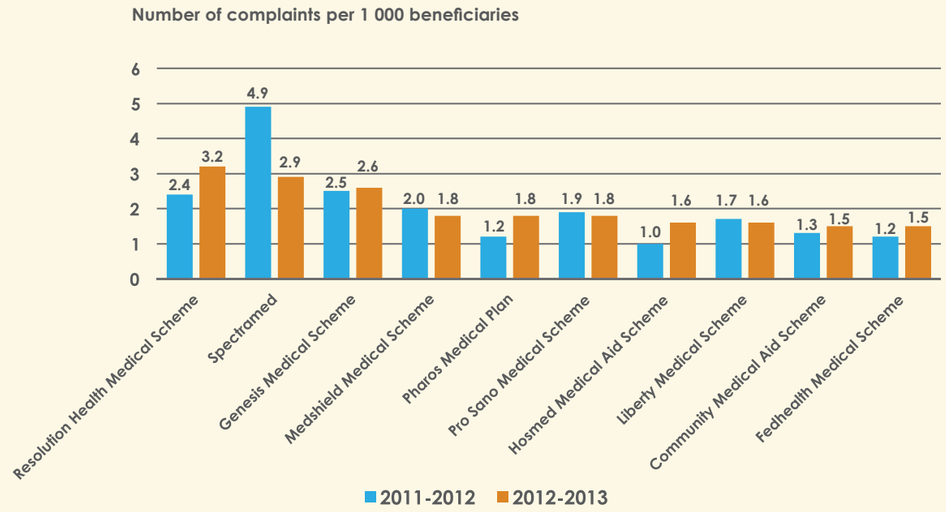
The schemes most complained about

Table 14 illustrates the top 10 medical schemes which were complained about most often in the 2011-2012 and 2012-2013 financial years compared to medical schemes of a similar size. Members who belong to these medical schemes are not necessarily faced with bigger risks, nor should the table be interpreted to mean that these medical schemes are more likely to fail.

Table 14: Top 10 schemes complained about in 2011-2012 & 2012-2013

Medical scheme	Number of beneficiaries 2012-2013	Number of complaints received per 1 000 beneficiaries 2011-2012	Number of complaints received per 1 000 beneficiaries 2012-2013
Resolution Health Medical Scheme	81 601	2.4	3.2
Spectramed	48 208	4.9	2.9
Genesis Medical Scheme	20 181	2.5	2.6
Medshield Medical Scheme	187 965	2.0	1.8
Pharos Medical Plan	13 770	1.2	1.8
Pro Sano Medical Scheme	53 327	1.9	1.8
Hosmed Medical Aid Scheme	78 130	1.0	1.6
Liberty Medical Scheme	124 056	1.7	1.6
Community Medical Aid Scheme (COMMED)	14 090	1.3	1.5
Fedhealth Medical Scheme	148 816	1.2	1.5

Figure 8: Top 10 schemes complained about in 2011-2012 & 2012-2013



The CMS collected data from all medical schemes on alternative dispute resolution processes for the first time in 2012-2013. There appears to be a strong correlation between the lack of alternative dispute resolution mechanisms within medical schemes and the number of complaints escalated to the CMS. The majority of medical schemes reflected in Table 14 did not have such mechanisms in place.

Table 15: Top 10 open schemes complained about in 2011-2012 & 2012-2013

Medical scheme	Number of beneficiaries 2012-2013	Number of complaints received per 1 000 beneficiaries 2011-2012	Number of complaints received per 1 000 beneficiaries 2012-2013
Resolution Health Medical Scheme	81 601	2.4	3.2
Spectramed	48 208	4.9	2.9
Genesis Medical Scheme	20 181	2.5	2.6
Medshield Medical Scheme	187 965	2.0	1.8
Pharos Medical Plan	13 770	1.2	1.8
Pro Sano Medical Scheme	53 327	1.9	1.8
Hosmed Medical Aid Scheme	78 130	1.0	1.6
Liberty Medical Scheme	124 056	1.7	1.6
Community Medical Aid Scheme (COMMED)	14 090	1.3	1.5
Fedhealth Medical Scheme	148 816	1.2	1.5

Figure 9: Top 10 open schemes complained about in 2011-2012 & 2012-2013

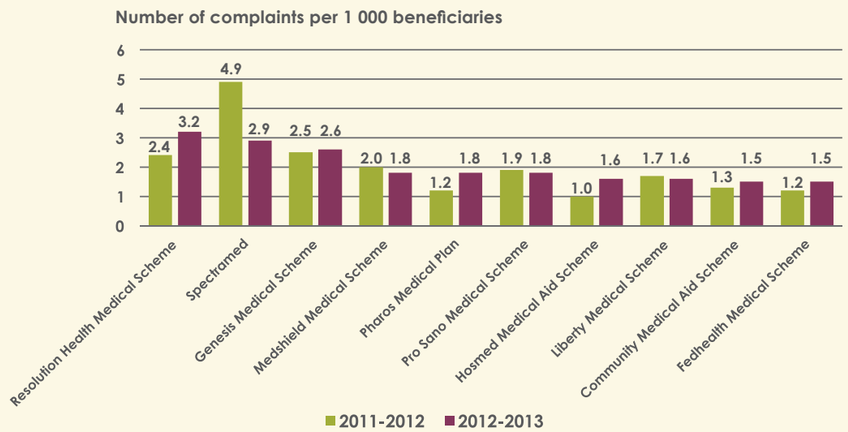
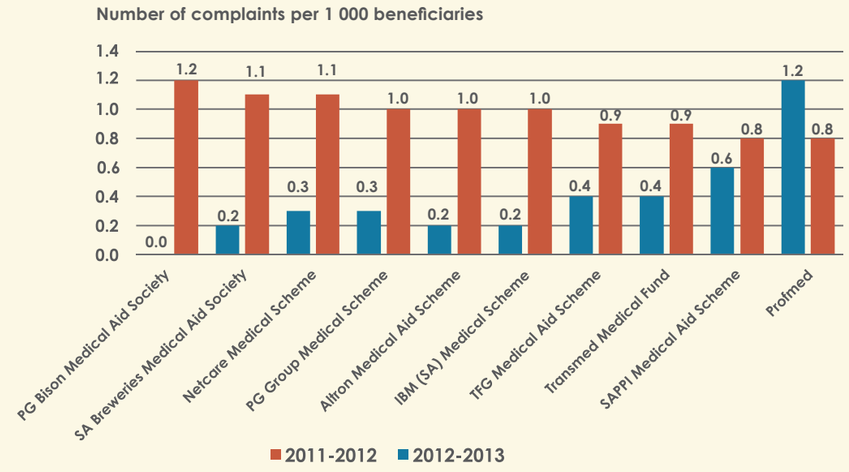


Table 16: Top 10 restricted schemes complained about in 2011-2012 & 2012-2013

Medical scheme	Number of beneficiaries 2012-2013	Number of complaints received per 1 000 beneficiaries 2011-2012	Number of complaints received per 1 000 beneficiaries 2012-2013
PG Bison Medical Aid Society	815	0.0	1.2
SA Breweries Medical Aid Society	22 265	0.2	1.1
Netcare Medical Scheme	39 885	0.3	1.1
PG Group Medical Scheme	2 774	0.3	1.0
Altron Medical Aid Scheme	8 547	0.2	1.0
IBM (SA) Medical Scheme	4 012	0.2	1.0
TFG Medical Aid Scheme	6 204	0.4	0.9
Transmed Medical Fund	111 035	0.4	0.9
SAPPI Medical Aid Scheme	7 931	0.6	0.8
Profmed	63 687	1.2	0.8

Figure 10: Top 10 restricted schemes complained about in 2011-2012 & 2012-2013



Former Judge President on the Appeal Board

The appeals framework of the CMS was strengthened in the year under review when the Minister of Health appointed former Judge President of the North Gauteng and South Gauteng High Courts, Judge Bernard M. Ngoepe, to chair the Appeal Board.

Adjudicating appeals

Members are encouraged to first approach their respective medical scheme in the event of a dispute; medical schemes are required by law to operate (effective) dispute resolution committees.

Should the member feel aggrieved by the decision of such a committee, the member should approach the CMS and lodge a complaint with our Complaints Adjudication Unit who will make a determination on behalf of the Registrar.

Appeals against decisions of the Registrar are made to the Appeals Committee of Council. Appeals against decisions of the Appeals Committee are made to the Appeal Board, and from there, appeals can be taken all the way through to the Constitutional Court in the event of a constitutional matter.

Judge Ngoepe has served as Judge for 18 years, 14 of which as Judge President. He is a Judge of the African Union's African Court for Human and People's Rights and has acted as Judge of both the Constitutional Court and the Supreme Court of Appeal (SCA). He is the Chancellor of the University of South Africa (UNISA) and has served on many other bodies. Judge Ngoepe has also recently been appointed Chairperson of the Appeals Panel of the Press Council of South Africa. He was a member of the Amnesty Committee of the Truth and Reconciliation Commission (TRC).

Judge Ngoepe was admitted as attorney of the Supreme Court of South Africa in 1976, and as advocate in 1983. He has received several awards and honours.

The appeals process

If you are a member of a medical scheme and unhappy with a decision of your medical scheme, you can try to resolve the matter with your scheme or you can come directly to Council and lodge a formal complaint against your scheme in terms of Section 47(1) of the Medical Schemes Act.

The Medical Schemes Act – and accordingly the rules of every registered medical scheme in the country – prescribes that schemes must establish dispute resolution committees to deal with member complaints. And while we encourage members to

talk to their scheme first, nothing prevents you from coming directly to us.

If you go to your scheme first and wish to appeal your scheme's decision, you should appeal to Council – and you should do so within three months. This is according to Section 48 of the Medical Schemes Act.

If you lodge a complaint with us and wish to appeal our decision (made by the Registrar's Office on behalf of Council), you should also appeal to Council – but you should do so within 30 days. This is according to Section 49 of the Medical Schemes Act.

In both Section 48 and Section 49 appeals, Council is represented by one of its sub-committees, namely the Appeals Committee.

Topical rulings

The Appeals Committee met 11 times in the year under review, and the Appeal Board once.

All judgements relevant to the CMS, including of the High Court and higher, are available on the CMS website.

Some of the more topical rulings are summarised below.

VZ v the Registrar and GEMS

This matter was heard by the Appeals Committee following an appeal by the member against the Registrar's ruling which confirmed the decision of the Government Employees Medical Scheme (GEMS) to decline payment in full for the use of a non-formulary drug, Crestor.

The member wanted the scheme to fund the full costs of Crestor for both himself and his spouse; he argued Crestor is more effective in lowering cholesterol levels than Simvastatin, the scheme's formulary drug. He also contended that the formulary drug recommended by the scheme was likely to cause him liver complications and muscle pains.

The Registrar had issued a ruling in favour of the scheme, confirming that the scheme is entitled, in terms of Regulation 8(4) of the Medical Schemes Act 131 of 1998, to use formularies and that it may impose a co-payment if a member voluntarily elects to use a non-formulary rather than an effective formulary drug.

Council's Appeals Committee upheld the Registrar's ruling and found no clinical evidence to support the allegations of an adverse reaction to Crestor by either the appellant or his spouse. The Committee also found that the superior efficacy of Crestor over Simvastatin as stated by the appellant was more perceived than actual, and could not be supported in the absence of clinical evidence.

Medshield v S

S was diagnosed with breast cancer in 2008. The condition is included in the prescribed minimum benefit (PMB) Regulations under code *950J – Cancer of breast – treatable*.

S subsequently had a left-breast mastectomy and reconstruction. There were, however, complications after the reconstruction and the prosthesis needed to be removed. A new prosthesis was inserted after tissue expansion. In May 2011, S was ready for the final stage of reconstruction, namely areola and nipple reconstruction and tattooing. She applied for authorisation and waited for feedback for almost three months, and finally decided to go ahead with the procedure without having obtained authorisation. Authorisation was declined two days before the scheduled surgery. Medshield Medical Scheme acknowledged that the mastectomy was related to the cancer but denied authorisation and funding for the areola and nipple reconstruction because the scheme was of the view that such reconstruction is not PMB level of care and excluded from the scheme's benefits.

The Registrar's Office determined that the PMB Regulations include reconstructive surgery after a mastectomy due to breast cancer, and that both areola and nipple reconstruction are part of the reconstructive process. Contour correction is also included in reconstruction surgery.

Medshield appealed the Registrar's decision that the surgery and treatment the member required constituted PMB level of care and that the scheme was liable to fund it in full.

The Appeals Committee overruled the decision of the Registrar's Office. It ruled that, even where PMBs are concerned, the Regulations do permit appropriate interventions aimed at improving the effectiveness and efficiency of healthcare provision, as provided by Regulation 8(4) of the Medical Schemes Act. Authorisation is one such intervention and a medical scheme cannot be held liable for costs incurred where authorisation had been declined. To hold otherwise, the Committee found, would render Regulation 8(4) meaningless. Medshield was, however, cautioned on its undue delay in responding to the application for authorisation.

M v Discovery Health

A member of the Discovery Health Medical Scheme appealed a decision made by the Registrar in favour of the scheme following the scheme's application of a waiting period to a pre-existing condition which the member had not disclosed to the scheme at the time of his applying for membership.

The Registrar held that the scheme had been very lenient in imposing the waiting period when the Medical Schemes Act in fact allows medical schemes to terminate membership in the event of the non-disclosure of material information.

The member applied for authorisation for the delivery of his baby three months after having joined the scheme. At the time of the membership application, his wife was 20 weeks pregnant, but he did not disclose this; the membership application form indicated that the questions relating to pregnancy and/or planned pregnancy were answered in the negative.

The member submitted that he had merely signed a membership application form which had been completed by a broker.

The Appeals Committee made important comments in respect of this matter:

1) Section 29(2)(e) of the Medical Schemes Act entitles a scheme to suspend or terminate membership on the basis of non-disclosure of material information. Material information is that which is important in enabling a medical scheme to make a fair assessment of its underwriting risk. This also guards medical schemes against anti-selection, which is when people join a scheme only to obtain funding for the treatment of a specific condition and subsequently leave the scheme having accessed benefits of medical scheme membership which exceed the monthly contributions they had made.

2) The same Section of the Medical Schemes Act does not require that material non-disclosure be intentional or fraudulent. Rather, the applicable standard is whether the applicant should reasonably have known about the condition.

3) Suspension or termination of membership does not necessarily indicate dishonesty. This is why medical schemes prefer to impose condition-specific waiting periods instead of outright termination of membership.

The Appeals Committee also noted that it can never be justification to state that the membership application form was completed by a broker and that the member merely signed the form. Each member must know and understand what s/he signs and consents to.

The Committee concluded that the scheme was entitled to information that it considered material.

The member's appeal did not succeed and the Registrar's ruling was upheld.

F v the Registrar and Discovery Health

The member submitted a complaint in respect of the scheme's refusal to fund biokinetic treatment in excess of what was allowed by the rules of the scheme. The Office of the Registrar ruled in favour of Discovery Health Medical Scheme and the aggrieved member appealed the decision.

The member had been receiving biokinetic treatment for a back condition during 2010. Discovery Health had funded all the sessions except for a few held during December 2010. The scheme indicated that the basis for its rejection of these claims was a claims audit, conducted towards the end of 2010, which had revealed a significant increase in biokinetic claims, to the extent that the scheme was now exposed to an additional risk. Discovery Health had therefore decided to

implement a managed care protocol for the funding of biokinetic sessions to ensure that the treatment sought was both medically necessary and in line with industry standards.

The new protocol was based on the billing standards published for biokineticists; it provides that after 12 biokinetic sessions motivations should be submitted for additional treatment.

Discovery Health issued a general notice to all biokineticists advising them that, starting on 1 November 2010, the new billing rule would be applied and that the scheme would require a motivation should the treatment exceed 15 sessions.

The scheme did not inform its members of these new limits, but used the above reasons to decline the appellant's claims for biokinetic sessions obtained in December 2010.

During the course of the Appeals Committee hearing, Discovery Health argued that the implementation of the new billing guidelines was a change in how the benefit would be managed as opposed to a change to the benefit structure. It was therefore unnecessary, the scheme argued, to give notice of the change to members (as is required by the Medical Schemes Act and the scheme's rules).

The scheme also argued that notifying members would be costly, and that it was in any case entitled in terms of Regulations 15D and 15H of the Medical Schemes Act to apply managed care protocols.

But the member maintained that the benefit had changed; it had, after all, been unlimited before the new billing guidelines were implemented, and now required a motivation after 15 sessions.

The Committee agreed with the member's view and held that limiting a benefit constitutes a change in the benefit.

It also held that members were entitled to a reasonable notification of the change, and that such notification had to be issued before the protocol had been implemented and not after treatment had already occurred.

The member's appeal was upheld and the ruling of the Registrar was set aside.

U v Fedhealth

It was common cause that the appellant suffered from "spinal stenosis of the lumbar spine" and that there was no spinal cord compression. The appellant, a member of Fedhealth Medical Scheme, complained of lumbar back pain going into the right leg, coupled with numbness and weakness. The MRI scan of the lumbar spine revealed a very large sequestrated L5/S1 right-sided disc prolapse with severe spinal canal stenosis, and spine degenerative problems were revealed at surgery during which the hypertrophic ligamentum flavum and bone spurs were removed.

The parties at the hearing agreed that "spinal cord compression" is an emergency medical condition as defined in Section 7 of the Regulations to the Medical Schemes Act. It was also the common understanding that "spinal cord compression" develops when there is mechanical compression on the spinal cord as a result of an underlying (causative) condition or conditions.

The merit of this appeal's success was based on the ground forwarded by the member, namely that "spinal stenosis" is a prescribed minimum benefit (PMB) as contemplated by code 941A of Annexure A with respect to the interpretation of the diagnosis terms "ishaemia or degenerative disease [not otherwise specified]".

Fedhealth argued that the meaning of "spinal cord compression" and "ishaemia or degenerative disease [not otherwise specified]" must be properly interpreted, also pointing out that the disjunctive form "or" is used in the diagnosis. Thus, the scheme argued, code 941A must be read in context. Spinal stenosis is a condition that may result in the compression of spinal nerve roots and/or the spinal cord. Code 941A is applicable when spinal stenosis results in "spinal cord compression", and that is the definitive PMB diagnosis. The member's diagnosis was not classified as a PMB under code 941A with the diagnosis statement of "[s]pinal cord compression, ishaemia or degenerative disease [not otherwise specified]".

The Appeal Board ruled that the medical scheme was not obliged to pay in full for the diagnosis, treatment, and care costs of the appellant's condition as it was not a PMB.

The Clinical Unit

The Clinical Unit, housed within the Office of the Strategist, supports the Complaints Adjudication Unit and other Units at the CMS by providing clinical opinions in instances where knowledge of clinical matter is required to make decisions.

During the 2012-2013 financial year, the Unit expected to provide an estimated 550 clinical opinions, but in fact provided 758. This represents a workload which is 38% more than expected.

Besides the unexpectedly high workload, the Clinical Unit could not fill a vacancy during the year under review. This meant that its work of a retrospective nature crowded out its prospective work.

The vacancy in the Clinical Unit is expected to be filled soon, and an additional position was approved for the coming financial year.

Complaints against brokers

The Accreditation Unit of the CMS dealt with one complaint against a broker in the 2012-2013 financial year. The member alleged that the broker had incorrectly advised her not to disclose a pre-existing condition when she was applying for membership with a new medical scheme, causing the scheme to terminate her membership due to non-disclosure of a material nature – something that medical schemes are allowed by law to do. The matter was ruled in favour of the broker because the complainant could not substantiate her allegation. The only evidence she could provide was the membership application form she had signed, in which she was declaring that the information she was providing therein was accurate and correct.

The CMS referred another complaint against a broker to the Office of the Ombud for Financial Services Providers (FAIS Ombud), which was established by the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS Act). The role of the FAIS Ombud is to resolve disputes between financial services providers and their clients in a procedurally fair, informal, economical, and expeditious manner. The jurisdiction of the FAIS Ombud is limited to violations which occurred on or after 30 September 2004 and to claims not exceeding R800 000.

Healthcare brokers are co-regulated by the Financial Services Board (FSB) and the CMS in that they are required by the FAIS Act to be accredited by the CMS before they can apply for a license with the FSB and start operating as valid businesses.

The complainant in the second matter, also a member of a medical scheme, alleged that the broker had sold him membership of a medical scheme with a recommendation to select a benefit option which did not give him access to healthcare services in the area where he lives.

The CMS referred the matter to the FAIS Ombud because the complainant was seeking a recourse that falls outside the jurisdiction of the CMS: he wanted the broker to reimburse him all the contributions he had paid to the scheme, with a claim for the pain and suffering he had endured as a result of the broker's conduct.

It should be noted that the jurisdiction of the CMS is limited when it comes to recourse against healthcare brokers and broker organisations, to either suspending or withdrawing their accreditation where wrongdoing has been established.

Alternative dispute resolution

Legal Services has assumed responsibility for a project directed at exploring the benefits inherent in alternative dispute resolution and engaged with medical schemes in this regard.

The primary purpose of the project is to establish the extent to which costs can be saved on unnecessary litigation by members against their schemes in addition to mitigating the ever-increasing volume of complaints being raised by members of medical schemes directly with the CMS. The project is currently in its pilot phase and it is anticipated that it will be rolled out substantively during the course of the coming financial year.

Engaging with stakeholders

In the financial year under review the CMS filled the newly created post of Head: Stakeholder Relations to strengthen relationships with its diverse range of stakeholders. Housing the Communications Unit, the Education & Training Unit as well as the call centre, or the Customer Care Centre (CCC), Stakeholder Relations continued to be the first line of interaction for many medical scheme beneficiaries and regulated entities alike.

The Stakeholder Relations Unit established new platforms for building and nurturing relationships with CMS stakeholders through indabas and forums, including the Boards of Trustees and Principal Officers Forums. Meetings with relevant regulators set the foundation to form collaborative relationships through the signing of memorandums of understanding between the CMS and these regulators.

New branding and awareness campaigns were launched to enhance the visibility and services of the CMS to beneficiaries and the public in general. Through radio talk shows the CMS encouraged members of medical schemes to attend their respective schemes' Annual General Meetings (AGMs).

The year under review saw our Annual Report being published before the PFMA-prescribed deadline once again. It was publicised by means of an official launch which took the form of a press conference at our premises in Hatfield, Pretoria. The report was also presented to trustees and Principal Officers in Gauteng and Cape Town; the CMS appreciates the opportunity to interact with industry leaders at a more personal level. The CMS also appreciates the ever-increasing interest in this flagship publication, as well as the positive feedback from a variety of industry players.

The regular publications of the CMS continued to be published in the year under review, including the official newsletter *CMS News* and PMB-focused *CMScript*. Media engagement continued successfully by way of press releases, a press conference, and the ongoing interaction on media enquiries. The CMS enjoyed good coverage in both print and online media, and prominence on radio reached a highlight with talk shows during Consumer Protection Month throughout March 2013.

Consumer education programmes in all nine provinces increased in number during the period under review due to the high demand by various consumer groups. A marked increase in requests for the training of employer groups ensured a full programme resulting in high numbers of trained consumers. The CMS conducted and participated in several workshops across the country and reached over 36 000 consumers. Interaction with the Consumer Protection Forum (CPF), consisting of Provincial Consumer Affairs Offices and regulatory bodies, as well as with its Consumer Education Committee continued, resulting in the CMS receiving a number of free radio slots on consumer talk shows and exposure through their various outreach and awareness programmes.

Various other initiatives by the Education & Training Unit ensured that the CMS reached out to its targeted stakeholders, including exhibitions at the Rand Show, the Soweto Show, the Operational Health Management Conference (OHMC), the Hospital Association of South Africa (HASA), and the National Consumer Forum (NCF). These sessions presented an opportunity to create awareness of the CMS and to educate consumers on their rights and responsibilities when it comes to medical schemes.

The CMS conducted two *General Induction to Trusteeship* training sessions in Gauteng and Cape Town in the year under review. The sessions are designed to educate and empower new trustees when it comes to their fiduciary roles and responsibilities. The training sessions in 2012-2013 were attended by 117 trustees.

In the year under review, the Customer Care Centre (CCC) received 36 957 calls, 10 095 less than in the previous financial year.

Table 17: How calls were handled in 2011-2012 & 2012-2013

	2011-2012	2012-2013
Calls received	47 052 (100%)	36 957 (100%)
Calls successfully handled	41 960 (89.2%)	31 922 (86.4%)
Short calls	1 753 (3.7%)	2 437 (6.6%)
Calls abandoned	3 339 (7.1%)	2 598 (7.0%)
Average waiting time	2 minutes 47 seconds	2 minutes 15 seconds
Average talk time	2 minutes 27 seconds	2 minutes 46 seconds

Table 18: Number & types of calls received in 2011-2012 & 2012-2013

Types of calls	Number of calls	
	2011-2012	2012-2013
Accreditation (administrators, MCOs*, brokers & broker organisations)	12 200	11 399
Complaints	12 475	8 800
General (incl. interpretation of the Medical Schemes Act)	1 022	3 356
Looking for other health-related entities	1 665	2 005
Rules-related queries (contributions, claims, benefits)	2 575	1 343
Prescribed minimum benefits (PMBs)	1 134	1 207
Mergers & liquidations	234	608
Calls escalated to other CMS Units	1 649	519
Waiting periods & late-joiner penalties	660	325
ICD-10** & the NHRPL***	210	165
Other	13 228	7 230
Total	**47 052**	**36 957**

* MCOs = managed care organisations
** ICD-10 = International Classification of Diseases – 10th Revision
*** NHRPL = National Health Reference Price List

Our building blocks

No organisation can function without people, money, and information and communication technology.

Three of our Units have traditionally been seen as providing crucial support to the remaining Units within the CMS and rendering the functioning of the regulator possible, namely Human Resources (HR), Internal Finance, and the Information & Communication Technology (ICT) & Knowledge Management (KM) Unit.

Everything we do, however, starts with the annual planning process.

Annual planning process

The annual planning process commenced in June 2012, after the Auditor-General of South Africa (AGSA) had presented his report to Council.

The process kicked off with a series of internal meetings which led to the development of a draft Strategic Plan (SP), Annual Performance Plan (APP), and budget of the CMS for the 2013-2014 financial year, all of which were presented to Council in August 2012.

Taking Council's guidance into consideration, the Office of the Chief Executive & Registrar made changes to the plans, and the final SP, APP, and budget for the 2013-2014 financial year were approved by Council in October 2012.

The Minister of Health has approved the 2013-2014 plans, and the Office of the Chief Executive & Registrar presented them to the Health Portfolio Committee of Parliament in March 2013.

Human Resources Unit (HR)

The Human Resources Unit (HR) at the CMS implemented its strategy for the 2012-2013 financial year through the Annual Performance Plan (APP) as it relates to matters such as remuneration and benefits, talent management and staff retention (appointments, orientation and induction, probation, and resignations), performance management, training and development, Employment Equity (EE), employee wellness, team-building, as well as personnel and related costs.

A detailed report on the HR activities can be found in the section entitled *Part D: Human Resources management* on page 160 of this Annual Report.

Internal Finance

The Internal Finance Unit, under the leadership of the Chief Financial Officer (CFO), is responsible for ensuring that the CMS has sufficient funds to be able to execute its regulatory mandate as prescribed by the Medical Schemes Act. The Unit relies on the Council for Medical Schemes Levies Act 58 of 2000 to charge an annual levy to each registered medical scheme in order to make up that year's budget of the CMS.

The Unit maintains an effective, efficient, and transparent system of financial management that complies with all applicable legislation. It maintains proper books and accounts, implements and monitors internal control procedures, and regularly updates our financial, payroll, and fixed-asset systems to keep pace with technological change.

More details on Internal Finance can be found in *Part C: Governance* on pages 144 to 159 and *Part E: Financial information* on pages 174 to 222 in this Annual Report.

ICT & KM

Our Information & Communication Technology (ICT) & Knowledge Management (KM) Unit consists of three sub-units, namely Software Development, Network Management, and Knowledge Management.

Software Development and Network Management

The ICT team successfully rolled out a new Electronic Document Management System (EDMS) to the CMS in the year under review. This document management solution has proven easy to learn and use, reliable, powerful, and secure. The solution has increased the productivity of staff without demanding a change in how they work. With this EDMS, the ICT team has improved workflow, increased information reuse, and eliminated redundancy. The team can now control content in a secure manner and avoid document duplication and data loss – all because of this single solution that integrates with Windows Explorer. The EDMS solution is also accessible from one's desktop computer, laptop, tablet, and smartphone, which makes it easier for everyone at the CMS to manage, edit, share, review, and approve content.

In the reporting period under review, ICT began to refine the Management Information System (MIS) further to incorporate the quarterly and annual return data into the Real-Time Monitoring (RTM) data that the CMS has been receiving from medical schemes in order to aid CMS management in decision-making.

The Minister of Health gave the CMS the directive to develop a transparent pricing system for the Pharmaceutical Economic Evaluation Directorate (PEED) which, once completed, will enable the directorate to comply with the provisions of Section 22G of the Medicines and Related Substances Control Act 101 of 1965. The development of this Medicines Price Registry (MPR) system started in the period under review. The MPR will ensure that the PEED conducts its day-to-day activities electronically instead of relying on the current manual process; the system will also ensure transparency in the prices of medicines, giving the general public access to authorised and up-to-date Single Exit Prices (SEPs) applicable to the South African pharmaceutical market. The Department of Health's PEED will be able to utilise the MPR system to conduct price manipulations that are expected to inform future amendments to pricing policies.

Knowledge Management (KM)

In the year under review, the KM Unit successfully responded to 394 information requests from both internal and external stakeholders, which included PAIA requests as well as requests for scholarly articles, books, and other sources of information.

PAIA

The CMS continued to comply with the Promotion of Access to Information Act 2 of 2000 (PAIA) by submitting our Section 32 report to the South African Human Rights Commission (SAHRC) and publishing our Section 15 report in the *Government Gazette* on 14 September 2012.

Records management

The project to digitise all CMS records was a success. A total of 3 413 records were scanned and imported into to the newly deployed Electronic Document Management System described above, making them electronically searchable and hence more accessible to interested parties.

Concluding thoughts

It is my strong belief that the Council for Medical Schemes (CMS) executed its mandate well in the year under review as it continued to serve the public interest by effectively regulating a complex and dynamic industry without fear or favour. I affirm our unwavering commitment to protecting and strengthening the rights-based framework contained in the Medical Schemes Act 131 of 1998 from which the CMS derives the purpose for its being.

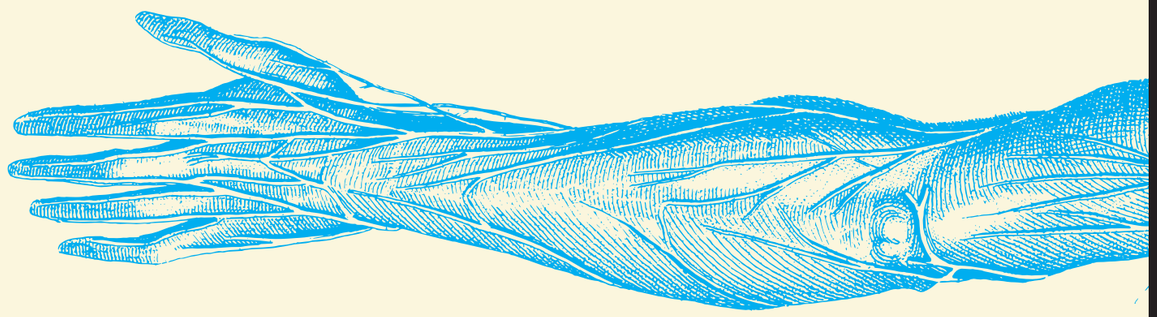
I would like to thank each and every CMS employee for their hard work and dedication in the period under review. The CMS is only as effective and efficient as its people.

I would like to extend a special word of thanks to Council members, both those who left us and those who joined us in the financial year under review. I owe much gratitude to Dr Rejoice Simelane, Chairperson of Council up to 30 June 2012, as well as to Trevor Bailey, Acting Chairperson of Council up to 27 November 2012. I would like to welcome the newly appointed Chairperson, Prof. Yosuf Veriava, to the CMS family.

As both regulator and ombudsman, the CMS always appreciates cooperation from industry. Our relations can only benefit from continuing and open dialogue.

I look forward to leading the CMS into another fruitful year as we discharge our unique mandate to protect members, guide medical schemes, and contribute to the attainment of a more equitable national health system.

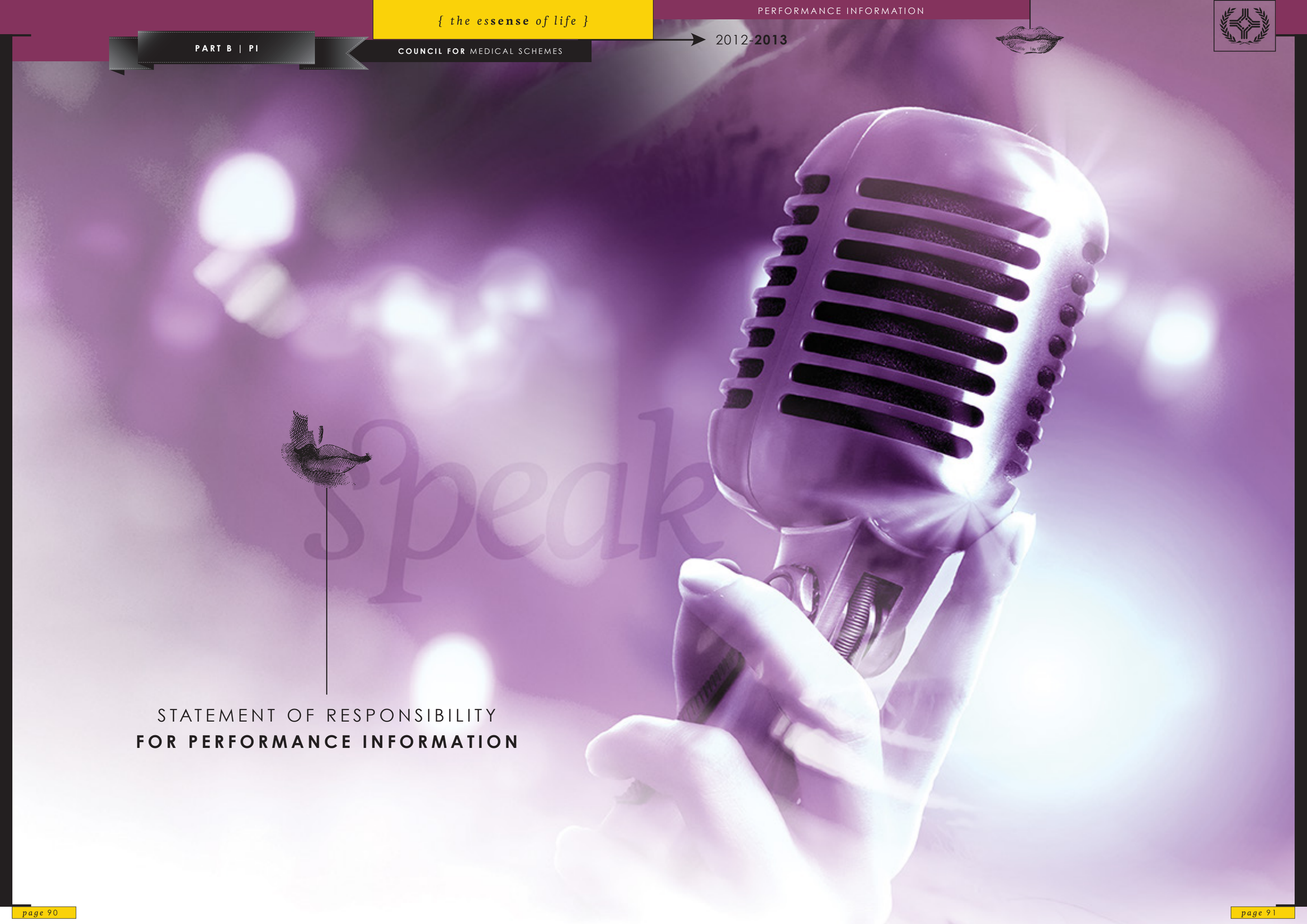
Dr Monwabisi Gantsho
Chief Executive & Registrar
Council for Medical Schemes
31 July 2013



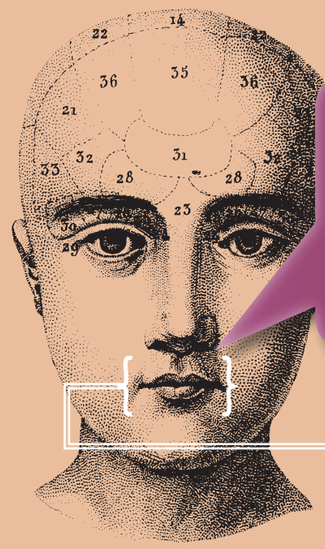
PERFORMANCE INFORMATION

"Knowing what you cannot do is more important than knowing what you can do. In fact, that's **good taste.***"*

A. C. Benson



STATEMENT OF RESPONSIBILITY
FOR PERFORMANCE INFORMATION



STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

Statement of responsibility for performance information for the financial year ended 31 March 2013

The Chief Executive & Registrar is responsible for the preparation of the performance information of the Council for Medical Schemes (CMS), and for the judgements made in this information.

The Chief Executive & Registrar is also responsible for establishing and implementing a system of internal control designed to provide reasonable assurance as to the integrity and reliability of performance information.

In my opinion, the performance information fairly reflects the actual achievements against planned objectives, indictors, and targets, as per the Strategic Plan and Annual Performance Plan of the CMS for the financial year ended 31 March 2013.

The performance information of the CMS for the financial year ended 31 March 2013 has been audited by the external auditors (the Auditor-General of South Africa).

The performance information of the CMS, as set out on pages 94-138, has been approved by Council (the Accounting Authority).

Dr Monwabisi Gantsho
Chief Executive & Registrar
Council for Medical Schemes
31 July 2013

objectives

performance

indicators

targets

"One cannot develop **taste** *from what is of average quality but only from the very best."*
Johann Wolfgang von Goethe

PERFORMANCE INFORMATION
BY PROGRAMME (UNIT)

PROGRAMME 1: OFFICE OF THE CEO

Sub-programme 1.1: Office of the CEO

• No deviation + Positive deviation - Negative deviation

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
1.1.4.1	**Develop international strategic relationships with other regulators**	Number of meetings with regulators from other countries	-	1	6	5	**Deviation** The Council for Medical Schemes (CMS) travelled to two countries in the year under review, Belgium and China. In Belgium the CMS engaged with four regional regulators, strategic partners, and stakeholders.

Purpose

The CEO is the Accounting Officer of the Council for Medical Schemes (CMS), exercising overall control over the office. As Registrar, he exercises legislated powers to regulate medical schemes, administrators, managed care organisations, as well as healthcare brokers and brokerages.

Achievement of strategic objectives

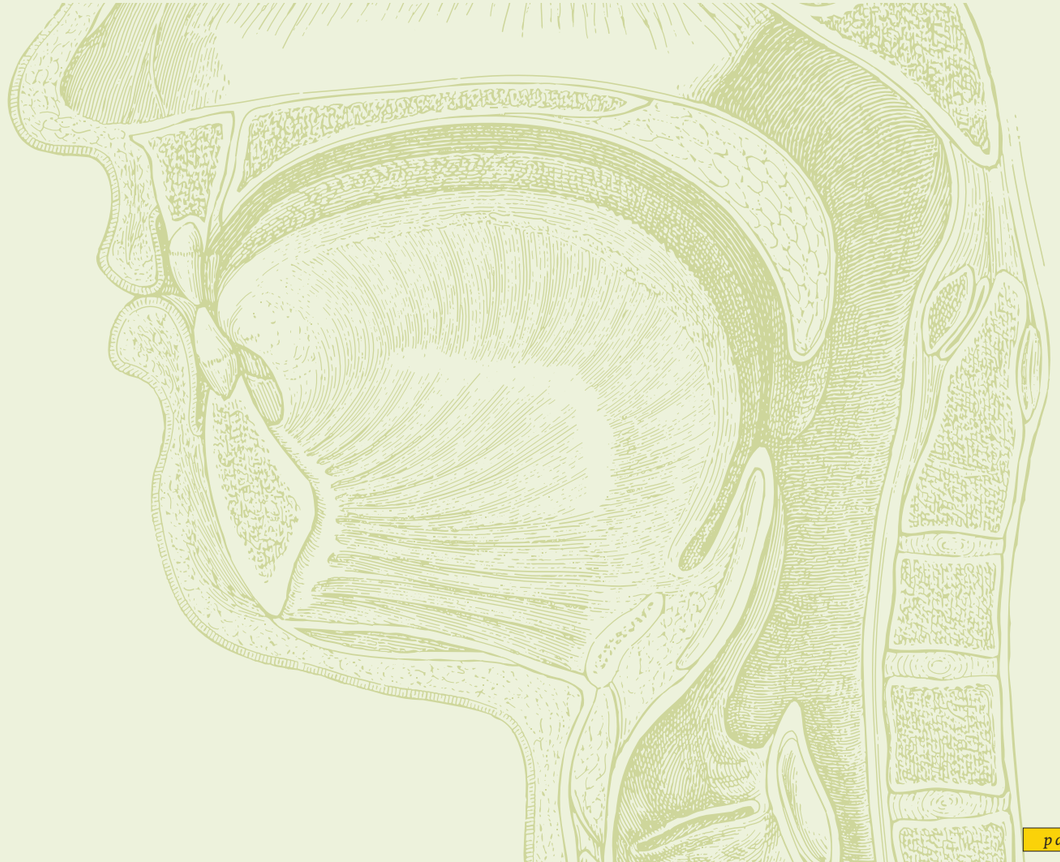
The performance of the Office of the CEO has contributed to strategic goal 4 of the CMS – "The Council for Medical Schemes provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the National Health Insurance development process." – in the context of understanding and supporting the universal access to healthcare in South Africa (NHI) by drawing from international experience.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Office of the CEO	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**177**	**154**	**23**	**124**	**169**	**(45)**
Printing and stationery	152	121	31	100	143	(43)
Refreshments	25	33	(8)	24	26	(2)
Operating expenses	**3 930**	**5 102**	**(1 172)**	**3 747**	**3 985**	**(238)**
Committee remuneration	274	261	13	54	80	(26)
Consulting fees	1 149	1 135	14	1 009	1 064	(55)
Council members fees	1 033	2 420	(1 387)	1 720	1 869	(149)
Courier and postage	87	110	(23)	58	51	7
Travel and subsistence	937	899	38	831	854	(23)
Venue and catering	450	277	173	75	67	8
Staff cost	**8 527**	**5 985**	**2 546**	**3 649**	**4 398**	**(749)**
Salaries	8 287	5 784	2 503	3 533	4 328	(795)
Staff training	240	201	39	116	70	46
Total	**12 634**	**11 241**	**1 393**	**7 520**	**8 552**	**(1 032)**



PROGRAMME 1: OFFICE OF THE CEO

Sub-programme 1.2: Strategic Projects Unit

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
1.2.1.1	**Support the prescribed minimum benefit (PMB) review conducted by the Department of Health (DoH)**	Number of recommendations to the DoH on amendments to PMB Regulations	1	-	1	1	**Deviation** No activities were planned for this indicator for the period under review. In response to a request from the DoH, minor changes were made to the draft PMB Regulations that had been previously submitted to the DoH by the CMS.
1.2.2.1	**The PMB Code of Conduct is updated**	Number of PMB Code of Conduct reports released per year	-	1	-	1	**Deviation** Management had agreed that the PMB Code of Conduct should not be updated since the publication of the draft PMB Regulations was pending.
1.2.2.2	**PMB definitions**	Number of clinical advisory committee contributions that has been incorporated in benefit definitions	5	10	-	10	**Deviation** One of the two senior clinical employees in the Clinical Unit was unable to work due to illness for the entire period and was finally boarded in November 2012. The position is yet to be filled and will be advertised shortly. There has been an increase in clinical opinions required by the Complaints Adjudication Unit; this work will only receive attention when the vacancy is filled.
1.2.2.3	**Provide clinical opinions**	Number of clinical matters reviewed by the Clinical Review Committee (CRC) per year	842	550	758	208	**Deviation** There was a change in the nature of complaints received by the office and the Unit needed to provide many more clinical opinions than expected. This extra workload has resulted therein that the PMB benefit definitions could not be developed as planned.
1.2.3.1	**Strategic Plan (SP) and Annual Performance Plan (APP)**	Annual submission of the Strategic Plan and Annual Performance Plan	2	1	1	-	**No deviation**

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
1.2.4.1	**Support universal access through recommendations made to the National Health Insurance (NHI) Ministerial Advisory Committee (MAC)**	Number of written reports submitted to the NHI MAC per year	1	1	-	1	**Deviation** This indicator is dependent on requests for information from the NHI MAC, the Department of Health, and the parliamentary Health Portfolio Committee on Health. During the reporting period, the NHI MAC did not request any input. The NHI is still at its infancy.
1.2.4.2	**Policy recommendations made to the Department of Health (DoH)**	Number of policy recommendations made to the DoH per year	1	1	1	-	**No deviation**
1.2.4.3	**The Medical Schemes Act is reviewed to protect the legislated framework**	Number of recommendations made to amend the Medical Schemes Act per year	1	-	-	-	**Deviation** No activities were planned for this indicator for the period under review.

Purpose

The purpose of the Strategic Projects Unit, which houses the Clinical Unit and the Complaints Adjudication Unit, is to execute projects to provide information to the Ministry of Health on strategic health reform matters to achieve government's objective of an equitable and sustainable healthcare financing system in support of universal access, to support the CMS in its strategic and operational planning, and to provide support to the CMS on clinical matters.

Achievement of strategic objectives

The inability of this Unit to complete the PMB definitions as planned results therein that members of medical schemes are not optimally protected in respect of PMBs. The long delay in the completion of the PMB review further leaves members vulnerable. Many of the treatments in the current PMB treatment algorithms have become outdated, and members therefore do not benefit from advances in the treatment of chronic conditions.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Strategic Projects Unit	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**7**	**-**	**7**	**6**	**-**	**6**
Refreshments	3	-	3	3	-	3
Printing and stationery	4	-	4	3	-	3
Operating expenses	**6**	**2**	**4**	**676**	**497**	**179**
Consulting fees	-	-	-	16	12	4
Travel and subsistence	6	2	4	82	58	24
Venue and catering	-	-	-	578	427	151
Staff cost	**75**	**51**	**24**	**5 600**	**1 696**	**3 904**
Salaries	-	-	-	5 487	1 625	3 862
Staff training	75	51	24	113	71	42
Total	**88**	**53**	**35**	**6 282**	**2 193**	**4 089**

{ the essense of life }

PROGRAMME 1: OFFICE OF THE CEO

Sub-programme 1.3: Complaints Adjudication

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
1.3.2.1	**Complaints resolution**	Number of complaints received	6 138	6 875	5 915	960	**Deviation** These figures are estimated as the trend in the industry is continuously changing and therefore difficult to predict.
		Number of complaints resolved	5 963	6 679	5 253	1 426	**Deviation** Capacity constraints in the Complaints Adjudication Unit hindered the performance of the team. Additional workload was allocated to the remaining team members and they were unable to resolve the higher volume of complaints speedily. The issue of under-performance is being addressed by the appointment of additional staff members. The additional staff members will enable the Unit to resolve more complaints and this will improve the resolution rate.
		Number of complaints resolved within 30 working days	1 490	1 669	1 609	60	**Deviation** Capacity constraints in the Complaints Adjudication Unit hindered the performance of the team. This resulted in a lower resolution rate than predicted. The issue of under-performance is being addressed by the appointment of additional staff members. The additional staff members will enable the Unit to resolve more complaints and this will improve the resolution rate.

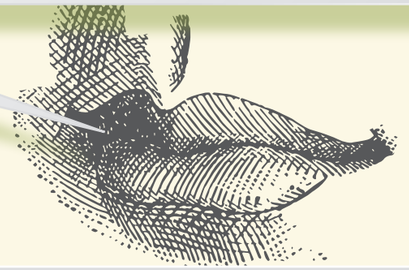
Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
		Number of complaints resolved within 60 working days	1 505	1 686	932	754	**Deviation** Capacity constraints in the Complaints Adjudication Unit hindered the performance of the team. This resulted in a lower resolution rate than predicted. The issue of under-performance is being addressed by the appointment of additional staff members. The additional staff members will enable the Unit to resolve more complaints and this will improve the resolution rate.
		Number of complaints resolved within 90 working days	1 278	1 431	869	562	**Deviation** Capacity constraints in the Complaints Adjudication Unit hindered the performance of the team. This resulted in a lower resolution rate than predicted. The issue of under-performance is being addressed by the appointment of additional staff members. The additional staff members will enable the Unit to resolve more complaints and this will improve the resolution rate.
		Number of complaints resolved within 120 working days	615	689	560	129	**Deviation** Capacity constraints in the Complaints Adjudication Unit hindered the performance of the team. This resulted in a lower resolution rate than predicted. The issue of under-performance is being addressed by the appointment of additional staff members. The additional staff members will enable the Unit to resolve more complaints and this will improve the resolution rate.
		Number of complaints resolved within 120+ working days	1 075	1 205	1 283	78	**Deviation** The Complaints Adjudication Unit strived, as far as possible, to resolve complaints that were long outstanding, hence more complaints were resolved than predicted.

Purpose

The Complaints Adjudication Unit serves the beneficiaries of medical schemes and the general public by investigating and resolving complaints in an effective, efficient, and fair manner.

Achievement of strategic objectives

Even though the Unit did not resolve the exact number of complaints predicted (6 679), the effort put in by a team of five Legal Adjudication Officers in resolving 5 253 complaints is commendable. The total number of complaints resolved showed that the Unit strived, under difficult circumstances, to achieve the strategic goal of the organisation, since a sizable number of complaints were still resolved. Two vacancies arose during the course of the year which had to be filled and the existing staff members had to perform additional tasks and were also expected to resolve complaints received by the Unit.



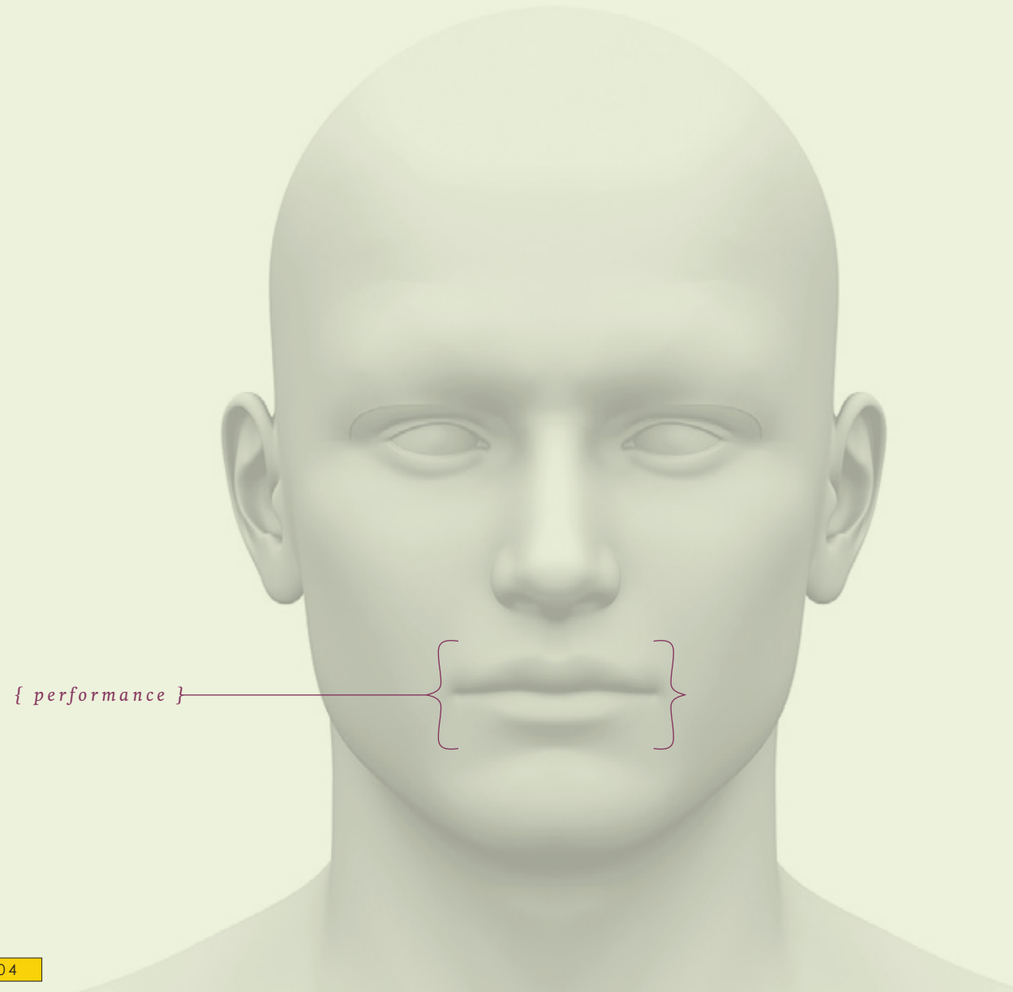
Changes to planned targets

The Annual Performance Plan 2012-2013 (APP) submitted to the Executive Authority and National Treasury included only one indicator for the Complaints Adjudication Unit. Management decided that the indicator, as stated in the table below, did not truly represent the function of the Unit appropriately and resolved to include further indicators. The changes to the indicators were submitted to the Executive Authority and National Treasury on 31 August 2012.

Strategic objective		Audited / actual performance			Estimated performance	Medium-term targets		
		2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
Strategic goal 2: Medical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected.								
Strategic objective 1.3.2.1: Complaints resolution								
1.3.2.1	**Number of complaints resolved within 120 days**	529 out of 1 020 complaints (51.9%)	1 059 out of 2 434 complaints (43.5%)	961 out of 2 707 complaints (35.5%)	1 113 out of 2 757 complaints (40.4%)	1 820 out of 3 033 complaints (60.0%)	2 085 out of 3 336 complaints (62.5%)	2 385 out of 3 670 complaints (65.0%)

Unit budget

Complaints Adjudication	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**11**	**5**	**6**	**18**	**8**	**10**
Refreshments	5	3	2	4	4	-
Printing and stationery	6	2	4	14	4	10
Operating expenses	**40**	**36**	**4**	**43**	**23**	**20**
Travel and subsistence	33	30	3	43	23	20
Venue and catering	7	6	1	-	-	-
Staff cost	**4 021**	**3 996**	**25**	**3 881**	**3 663**	**218**
Salaries	3 937	3 951	(14)	3 755	3 599	156
Staff training	84	45	39	126	64	62
Total	**4 072**	**4 037**	**35**	**3 942**	**3 694**	**248**



PROGRAMME 2: CORPORATE SERVICES
Sub-programme 2.1: Internal Finance Unit

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
2.1.3.1	**Annual Financial Statements**	Number of GRAP-compliant Annual Financial Statements submitted by 31 May each year	1	1	1	-	**No deviation**
		An unqualified audit opinion	-	1	1	-	**No deviation**
2.1.3.2	**Budget management**	Number of budget reports produced to ensure budgeted resources allocated to the strategic objectives are utilised for the intended purpose	-	12	12	-	**No deviation**
2.1.3.3	**Revenue**	Percentage of budgeted income collected	99.9%	100%	100%	-	**No deviation**
2.1.3.4	**Procurement**	Number of tenders adjudicated during the year	2	1	2	1	**Deviation** Two tenders were adjudicated upon during the period under review: • lease of building tender • internal audit services tender
		Percentage of creditors paid within 30 days	99%	100%	98%	2%	**Deviation** During quarter 2 of the financial year there was an invoice from a service provider, but the service provider did not submit their tax clearance certificate together with the invoice, as payment was over R30 000. Payment to the provider was made once the CMS received the certificate. During quarter 3 there were invoices from two service providers that needed to be queried. The service providers were paid once the queries on the invoices were resolved.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
2.1.3.5	**Cash management**	Number of cash flow projections to meet operational requirements	12	12	12	-	**No deviation**
2.1.3.6	**Asset management**	Number of asset register updates during the year	-	12	12	-	**No deviation**
2.1.3.7	**Payroll management**	Number of payrolls produced in the financial year	13	13	13	-	**No deviation**
2.1.3.8	**Internal controls**	Number of Audit & Risk Committee meetings held in a year	4	4	4	-	**No deviation**
		Number of Finance Committee meetings held in a year	-	4	7	3	**Deviation** A Finance Committee meeting took place on 14 August 2012 to discuss the draft budget for 2013/2014. A further meeting had to be set up for 10 October 2012 for the finalisation of the budget. As these are going to be scheduled meetings, the targets will be corrected to reflect this going forward. An ad hoc Finance Committee meeting had to be scheduled for 4 March 2013 to deal with matters around the lease agreement.
		Percentage of internal audit reports as per audit plan	-	100%	98%	2%	**Deviation** The following audit reports were still being finalised by the internal auditors at year-end: • Legal Services Unit • quarter 3 audit on performance objectives • supply chain management The delay was due to the audit plan of the internal auditors not being approved in the first quarter of the period. Management will ensure that the internal audit plans are thoroughly reviewed by management before being submitted to the Audit & Risk Committee for approval.
2.1.3.9	**Risk management**	Number of risk register updates	-	4	4	-	**No deviation**
2.1.3.10	**Performance management**	Number of Strategic and Annual Performance Plans submitted to the Executive Authority	-	1	2	1	**Deviation** A draft Strategic and Annual Performance Plan was submitted to the Executive Authority in August 2012 and a final plan was submitted in November 2012. When setting the targets for this indicator, the Internal Finance Unit did not take into account the draft submission. This will be corrected going forward.
		Number of PFMA reports submitted to the Executive Authority	-	4	4	-	**No deviation**

Purpose

The Internal Finance Unit serves all Units within the CMS, the senior management team, and Council by maintaining an efficient, effective, and transparent system of financial management that complies with applicable legislation. The Unit also serves the Audit & Risk Committee, internal auditors, Department of Health, National Treasury, and the Auditor-General of South Africa by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the Unit helps the CMS to be a reputable regulator.

Achievement of strategic objectives

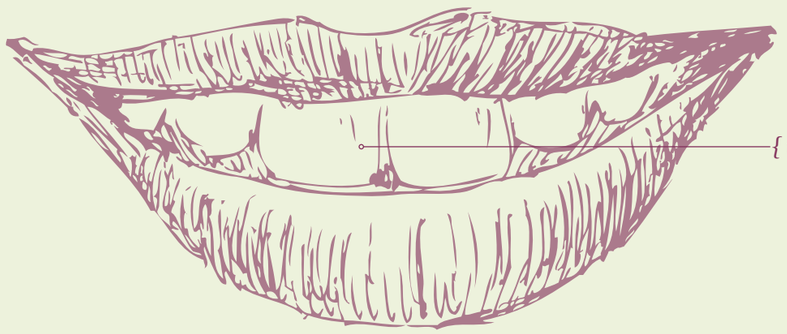
The Unit achieved an unqualified audit opinion, thereby confirming that as an organisation the CMS has proper internal controls and measures that are working. This also means that the financial resources of the CMS are used in a most cost-effective and efficient manner, as required by the Public Finance Management Act 1 of 1999. In this regard other Units are also able to achieve the stated objectives in an efficient manner.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Internal Finance Unit	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**9 782**	**8 631**	**1 151**	**8 641**	**8 921**	**(280)**
Bank charges	43	40	3	41	46	(5)
Cleaning and gardening	677	606	71	628	541	87
External audit fees	630	627	3	594	752	(158)
General expense admin	165	167	(2)	203	194	(9)
Insurance	150	176	(26)	139	135	4
Internal audit fees	788	1 052	(264)	664	617	47
Refreshments	10	17	(7)	10	12	(2)
Rent	5 234	4 485	749	4 524	4 488	36
Rental other assets	14	12	2	16	13	3
Repairs and maintenance office	1 041	274	767	784	1 146	(362)
Printing and stationery	31	45	(14)	31	29	3
Subscriptions	7	5	2	15	0	15
Water & electricity, rates & levies	992	1 125	(133)	992	949	43
Operating expenses	**147**	**183**	**(36)**	**137**	**248**	**(111)**
Consulting fees	72	112	(40)	58	184	(126)
Courier and postage	50	34	16	55	54	1
Travel and subsistence	25	37	(12)	24	10	14
Staff cost	**8 096**	**7 957**	**139**	**5 999**	**6 027**	**(28)**
Employee benefits	1 328	1 349	(21)	1 272	1 235	37
Salaries	6 318	6 127	191	4 223	4 536	(313)
Staff training	250	341	(91)	304	190	114
Workmen's compensation	200	140	60	200	66	134
Amortisation	**848**	**942**	**(94)**	**1 224**	**792**	**432**
Depreciation	**1 191**	**1 861**	**(670)**	**1 296**	**1 653**	**(357)**
Total	**20 064**	**19 574**	**490**	**17 298**	**17 641**	**(344)**



PROGRAMME 2: CORPORATE SERVICES

Sub-programme 2.2: Information and Communication Technology (ICT) and Knowledge Management (KM)

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
2.2.3.1	**Training & support**	Number of Helpdesk incidents / cases handled per year	744	500	646	146	**Deviation** The year under review saw more Helpdesk incidents being reported than the anticipated target. This constituted a negative increase. The increase in Helpdesk calls can be ascribed mainly to issues related to the deployment of new photocopier machines and a centralised printer accounting system. The deployment of a new mail archiving system and end-user requests related to the retrieval of e-mail on the new system also contributed to an increase in the actual number of Helpdesk calls received. The Unit constantly monitors issues being reported and depending on the issues being experienced, "Chalk and Talk" training sessions are set up to assist staff, focusing on those specific areas of concern.
		Number of staff trained per year	31	60	38	22	**Deviation** The year under review saw fewer staff members attending the "Chalk and Talk" training sessions than anticipated. Although staff members are encouraged on an ongoing basis to attend the "Chalk and Talk" sessions, further measures will be put in place to ensure better staff attendance. One such measure will be to hold competitions and the handing out of prizes at the training sessions.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
		Number of major network-related incidents per year	3	3	5	2	**Deviation** The year under review saw five major network incidents being reported, two more than the target of three. The core IT infrastructure at the current CMS premises in Hatfield is more than six years old. Due to the age of the infrastructure, some of the core switches failed. As a result of a 4-hour switch replacement service level agreement (SLA) with our suppliers, these switches were replaced and the network restored within four hours. The CMS will be relocating to its new premises on 17 May 2013. A new infrastructure and a total reconfiguration of our switches should ensure that future network interruptions are reduced to a minimum.
2.2.3.2	**Operations**	Number of days per year where access to computer systems is totally interrupted	2	3	5	2	**Deviation** The year under review saw five major network incidents being reported, two more than the target of three. The core IT infrastructure at the current CMS premises in Hatfield is more than six years old. Due to the age of the infrastructure, some of the core switches failed. As a result of a 4-hour switch replacement service level agreement (SLA) with our suppliers, these switches were replaced and the network restored within four hours. The CMS will be relocating to its new premises on 17 May 2013. A new infrastructure and a total reconfiguration of our switches should ensure that future network interruptions are reduced to a minimum.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
2.2.3.3	**Software development**	Number of custom software application "bugs"/ incidents reported per year	173	400	120	280	**Deviation** The year under review saw 280 fewer "bugs" being reported related to our custom-developed software applications. This deviation is positive as all custom software applications have been operating efficiently. It is also indicative of a higher software application development maturity level.
		Number of days interrupted access to custom-developed applications per year	1	3	3.05	0.05	**Deviation** The year under review saw a total of 3.05 days where access to our custom-developed applications was interrupted. This constituted half a day more than the target. These interruptions were also due to the network-related incidents mentioned above.
2.2.3.4	**Knowledge & Records Management**	Number of requests for information responded to per year	226	350	394	44	**Deviation** The year under review saw the number of requests for information directed to our Resource Centre exceed the target by 44 requests. This positive deviation was mainly due to requests relating to the approval of new scheme rules, requests for research articles by members of staff, as well as requests for case law information. The increase is also indicative of an increased awareness among staff of the services rendered by the Resource Centre.
		Number of records electronically captured per year	3 192	3 000	3 413	413	**Deviation** The year under review saw the target for the number of electronic records captured exceeded by 413 records. This positive deviation is related to our drive to digitise all paper-based records on our new Electronic Document Management System (EDMS). This drive was further enhanced by a need to digitise as much as possible paper-based records in anticipation of the pending relocation of the offices to Centurion.

Purpose

The purpose of the Information and Communication Technology (ICT) and Knowledge Management (KM) Unit is to serve the other CMS Units by providing technology enablers and making information available to stakeholders.

Achievement of strategic objectives

The Unit was able to further consolidate and improve the stability of the CMS internally developed software application systems. This resulted in Units being able to better capture, collect, analyse, and disseminate data related to their areas of expertise, and allowed them to improve their service offering to our various stakeholders, such as members of medical schemes, administrators, managed care organisations, and healthcare brokers and brokerages.

The Unit successfully deployed a new Electronic Document Management System (EDMS) and exceeded its target in digitising the CMS paper-based records to the new system. This resulted in information becoming more accessible and retrievable, in turn improving our ability to serve our stakeholders better.

The Unit was able to increase its response rate to the number of requests for information related to medical scheme rules and case law, thus allowing various stakeholders to make better-informed choices.

The Unit was further able to train CMS staff members in the use of key ICT systems, and although fewer staff members attended these training sessions than targeted, the training interventions still proved valuable. The Unit will endeavour to improve participation by introducing innovative interventions to promote such training events.

The Unit was able to successfully respond to 646 Helpdesk requests during the year. Although these requests were more than the Unit had anticipated, the Unit was able to assist staff in using newly introduced technology such as a new central printer accounting and secure print system as well as a new mail archiving system. This in turn led to an increase in productivity and an opportunity for face-to-face end-user training.

Finally, despite a higher than anticipated number of network infrastructure outages, the Unit was able to rebuild and improve its ageing switching environment, thereby contributing to a more stable ICT environment wherein staff could function productively.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Information and Communication Technology (ICT) and Knowledge Management (KM)	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**2 538**	**2 276**	**262**	**1 885**	**1 930**	**(44)**
Computer expenses	114	103	11	90	113	(22)
Copy costs	159	247	(88)	150	237	(87)
External storage	228	242	(14)	215	186	29
Internet expenses	357	342	15	362	319	43
Printing and stationery	20	6	14	19	8	11
Refreshments	18	12	6	18	12	6
Rental: copiers	180	120	60	64	-	64
Security	295	52	243	144	146	(2)
Software license subscription	485	341	144	311	306	5
Telephone and fax	684	813	(129)	513	604	(91)
Operating expenses	**714**	**514**	**200**	**605**	**549**	**56**
Consulting fees	210	56	154	170	162	8
Knowledge management	487	446	41	420	384	36
Travel and subsistence	16	10	7	16	3	12
Venue and catering	-	2	(2)	-	-	-
Staff cost	**6 749**	**7 069**	**(320)**	**5 537**	**5 594**	**(57)**
Salaries	6 559	6 495	64	5 411	5 471	(60)
SEP system expenses	-	478	(478)	-	-	-
Staff training	190	96	94	125	122	3
Total	**10 001**	**9 859**	**141**	**8 027**	**8 072**	**(45)**

PROGRAMME 2: CORPORATE SERVICES

Sub-programme 2.3: Human Resources management

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
2.3.3.1	**Talent management & staff retention**	Staff turnover rate	1.11%	5%	3.19%	1.81%	**Deviation** To date the total turnover for 2012-2013 is 3.19% against the target of 5% envisaged.
		Number of high-potential individuals engaged and developed for strategic positions	21	21	-	21	**Deviation** The succession planning project undertaken by the Unit was planned to be phased in over three years. The fourth quarter of the period was mainly focused on sourcing the appropriate service providers. The performance target set was in anticipation of a service provider being appointed during the fourth quarter of the financial year.
2.3.3.2	**Performance is maximised**	Number of employees undergoing bi-annual performance reviews	175	89	272	183	**Deviation** The appraisals for 2011/2012 were only concluded in quarter one of 2012/2013 and the actual for this had to be reported in the period. The annual target should have been recorded as 178, to include the bi-annual performance reviews, but was erroneously recorded at 89.
		Percentage of employees undergoing training in accordance with a personal development plan	66%	60%	83%	23%	**Deviation** The staff complement at the CMS increased from 89 to 94 during the period, therefore the total number of staff undergoing training increased.
2.3.3.3	**A productive work environment**	Number of health days held	1	1	3	2	**Deviation** Due to a high interest expressed in health matters the Unit was able to provide additional health awareness programmes.
		Number of employees attending a cultural awareness session	81	89	74	15	**Deviation** A cross-functional workshop to celebrate cultural awareness was held during the year under review. Ten staff members could not attend due to operational matters and five were on maternity leave.
		Number of workshops on values and work ethics	1	1	1	-	**No deviation**
2.3.3.4	**Human Resources management systems and processes**	Number of employees surveyed in respect of HR customer service	-	89	92	3	**Deviation** Three new staff members took part in the survey during the year under review.

Purpose

The Human Resources Unit (HR) is committed to providing high-quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support the vision of the CMS.

The Unit fulfils this mission with professionalism, integrity, and responsiveness by:

- treating all its customers with respect;
- providing resourceful, courteous, and effective customer service;
- promoting teamwork, open and clear communication, and collaboration; and
- demonstrating creativity, initiative, and optimism.

By doing this the HR Unit helps the CMS by supporting its administration and staff through human resources management advice and assistance, enabling them to make decisions that maximise its most important asset: its people, and continues the development of the CMS as an employer of choice.

Achievement of strategic objectives

The overall performance of the organisation was closely monitored through performance agreements, thereby enabling the organisation to reach its strategic goals. Staff members who performed at above-par levels received recognition for their performance in the form of an incentive bonus. Performance was further enhanced through interventions provided by the Unit geared at addressing health and welfare issues in the workplace, values and ethics, as well as culture and diversity. Lastly, as a result of our multi-pronged retention strategy, we continued to have a lower than expected turnover rate, and the organisation benefited from a stable workforce able to provide continuity in the delivery of key strategic goals.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Human Resources management	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**166**	**159**	**7**	**171**	**152**	**19**
Donations	6	4	3	6	7	(0)
Motor vehicle - expenses	21	20	1	20	12	8
Refreshments	85	84	1	80	74	6
Printing and stationery	8	11	(3)	32	21	12
Subscriptions	45	41	5	33	39	(6)
Operating expenses	**1 012**	**1 180**	**(168)**	**772**	**681**	**91**
Consulting fees	525	665	(140)	172	96	76
Travel and subsistence	208	193	15	112	250	(138)
Venue and catering	279	322	(43)	488	335	153
Staff cost	**4 717**	**4 499**	**218**	**4 428**	**4 134**	**294**
Employee wellness	421	442	(21)	397	352	45
Recruitment and relocation	718	580	138	850	637	213
Salaries	3 062	3 101	(39)	2 741	2 856	(115)
Staff training	162	167	(5)	150	142	8
Temporary services	354	209	145	290	148	142
Total	**5 895**	**5 838**	**57**	**5 371**	**4 967**	**404**

Programme 3: Accreditation

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
3.2.1	**Broker accreditation applications processed**	Number of broker applications processed during the year	-	4 425	6 837	2 412	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of new individual broker applications received per year	918	950	1 461	511	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of new individual broker applications accredited per year	326	790	1 180	390	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of individual broker renewal applications received per year	4 298	2 530	4 200	1 670	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of individual broker renewal applications accredited per year	3 722	2 756	2 957	201	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of new broker organisations applications received per year	145	120	141	21	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of new broker organisations applications accredited per year	83	109	122	13	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry. There were instances where organisations were not accredited due to them not complying with accreditation requirements.
		Number of broker organisations renewal applications received per year	1 171	825	1 035	210	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.
		Number of broker organisations renewals applications processed per year	-	755	915	160	**Deviation** The targets set are estimated figures and are dependent on the trend in the industry.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
3.2.2	**Managed care organisations (MCOs) accreditation applications processed**	Number of MCO applications processed per year	26	24	29	5	**Deviation** Two applications which were scheduled to be finalised in quarter one of 2013/2014 were processed during the year under review. There were a further three new MCO applications which were received and processed during the year under review.
		Number of MCO applications accredited per year	15	25	28	3	**Deviation** Two applications which were scheduled to be finalised in quarter one of 2013/2014 were processed during the period under review. One MCO was accredited after expiry of its interim accreditation.
3.2.3	**Administrator accreditation applications processed**	Number of applications from administrators and self-administered medical schemes evaluated	15	15	12	3	**Deviation** The target set is based on the expected number of administrators that are due to be accredited for the year. There was one application that was received and processed during the previous financial year. Two applications were not received during the year under review due to one self-administered scheme no longer being self-administered and one third-party administrator not renewing its accreditation after losing its only client and changing its administration system.
		Number of applications from administrators and self-administered medical schemes accredited	10	15	14	1	**Deviation** The target set is based on the expected number of administrators to be renewed as well as likely new applicants which are due to be accredited during the year.

Purpose

The purpose of the Accreditation Unit is to ensure that administrators, managed care organisations, and healthcare brokers and brokerages are assessed and accredited to the extent to which they meet the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure, and are financially sound.

Achievement of strategic objectives

The Unit introduced measures, processes, and systems to enhance accreditation processes and related procedures in strengthening the objective to improve governance and securing institutional safety within the medical schemes industry.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

	2012/2013			2011/2012		
Accreditation	**Budget**	**Actual expenditure**	**(Over-) / under-expenditure**	**Budget**	**Actual expenditure**	**(Over-) / under-expenditure**
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**70**	**65**	**5**	**70**	**67**	**3**
Refreshments	5	7	(2)	5	4	1
Stationery	65	58	7	65	63	2
Operating expenses	**401**	**289**	**112**	**333**	**321**	**12**
Travel and subsistence	401	289	112	333	321	12
Staff cost	**5 563**	**5 407**	**156**	**5 092**	**4 966**	**127**
Salaries	5 501	5 366	135	5 008	4 911	97
Staff training	62	41	21	85	55	30
Total	**6 034**	**5 761**	**273**	**5 495**	**5 353**	**142**

Programme 4: Research & Monitoring

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
4.1.1	**Maintain the Schemes Risk Measurement (SRM) process**	Number of lay articles on the SRM published per year	-	1	-	1	**Deviation** The article was mainly targeted to report to members about the SRM process. The objectives of the project changed, thus this activity could not be implemented.
		Number of SRM process reports published per year	-	5	2	3	**Deviation** These are SRM activities mainly on the maintenance of the SRM system and progress reports for the Chief Executive & Registrar, but the objective of the project has since changed. The two process reports concluded relate to the entry and verification guidelines. The deviation is attributed to the change in the objective of the project. The target for this indicator will be corrected to reflect change in the objectives.
		Number of SRM research reports published for the year	-	2	1	1	**Deviation** During the Industry Technical Advisory Panel (ITAP) meeting in July 2012, a resolution was taken that schemes should submit their SRM data only once a year. The submission of SRM data has been changed from quarterly to annual.
		Number of SRM IT system user requirement documents produced for the period	-	1	-	1	**Deviation** The project was deferred due to confidentiality and budget constraints.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
4.2.2	**Monitor compliance with the International Classification of Diseases – 10th Revision (ICD-10)**	Number of schemes complying with ICD-10 in the year	359	95	90	5	**Deviation** The number of schemes registered in 2012 reduced to 93. The deviation in this regard was attributed to schemes that were amalgamated and liquidated during the review period. Also schemes that submitted incomplete data were excluded. The target for the year was based on the number of schemes in the industry. Monitoring ICD-10 compliance is done every quarter for all schemes. The actual for the year should have been averaged to give a more accurate reflection of the Unit's achievement compared against the target set. The calculation method for the annual target was not correctly specified, therefore the actual and targets for the quarters had to be added. The target for this indicator will be corrected to reflect the average over the year.
4.2.3	**Practice Code Numbering System (PCNS)**	Ensure that an approved entity is contracted with to manage the PCNS at all times	Yes	Yes	Yes	-	**No deviation**
4.4.1	**Research**	Number of research projects finalised per year	5	4	4	-	**No deviation**
4.4.2	**Specialised technical support**	Number of support projects finalised per year	3	4	4	-	**No deviation**
4.4.3	**Annual Report**	Number of annual analyses of non-financial data	1	1	1	-	**No deviation**

Purpose

The Research & Monitoring Unit serves the beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate, and report on trends in medical schemes, investigate clinical aspects of complaints, and develop recommendations to improve the regulatory policy and practice.

By doing this the Unit helps the CMS to contribute to the development of policy that enhances the protection of the interests of beneficiaries and members of the public.

Achievement of strategic objectives

Strategic goal 2 of the CMS is aimed at ensuring that medical schemes are properly governed and responsive to the environment, and that beneficiaries are informed and protected. The Research & Monitoring Unit supports this strategic goal by monitoring the implementation of the Medical Schemes Act.

Regulation 5(f) states that all registered providers of health services must submit diagnostic codes on all invoices submitted to schemes for reimbursement; this Regulation is monitored.

The Unit continued to monitor the International Classification of Diseases – 10th Revision (ICD-10) compliance data through the analysis and publication of quarterly reports.

The Unit supported strategic goal 2 of the CMS by ensuring that there is an approved entity to administer the Practice Code Numbering System (PCNS) as per the provisions of the Medical Schemes Act.

One of the strategic goals of the CMS is to ensure that access to good quality medical scheme cover is maximised. The Unit supported this objective through the maintenance of the Schemes Risk Measurement (SRM) system, and by reporting on risk profiles in medical schemes. Through this specific activity, the Unit was able to identify high- to low-risk schemes. This outcome was imperative for the Composite Risk Index (CRI) which is a regulatory tool that was implemented by the CMS to proactively identify schemes with potential financial and governance irregularities.

The CMS also provides influential strategic advice and support for the development and implementations of strategic health policy. The analyses of the non-financial information for the Annual Report, various research projects concluded, and specialised technical support reports remain a key performance area for the Unit. The research project on health quality outcomes supports Section 7(c) of the Medical Schemes Act, which is one of the key functions of the CMS. Another research project concluded by the Unit, on models for integrating the finances and delivery of health services, was also key strategic advice and support to the recently published regulations by the Health Professions Council of South Africa (HPCSA) prohibiting the employment of doctors. The technical support project on the comprehensive inflation guidance framework for the medical schemes industry supports the approval and registration and of benefit option changes and contribution increases by the CMS.

Changes to planned targets

The targets for three performance indicators were changed due to a resolution taken by the oversight Committee. Explanations are provided in the comments column. The target indicator for actual performance of monitoring the ICD-10 compliance (4.2.2) does not correctly reflect the number of schemes registered with the CMS. This target indicator will be corrected to be comparable with the number of registered medical schemes. Computation in now based on the average number of schemes that submitted compliance reports per year. This computation enables a direct comparison between the planned target and the number of registered schemes with the CMS.

Unit budget

	2012/2013			2011/2012		
Research & Monitoring	**Budget**	**Actual expenditure**	**(Over-) / under-expenditure**	**Budget**	**Actual expenditure**	**(Over-) / under-expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Administrative expenses	**7**	**7**	**0**	**7**	**5**	**2**
Refreshments	4	4	0	4	4	0
Printing and stationery	3	3	0	-	1	(1)
Subscriptions	-	-	-	3	0	3
Operating expenses	**165**	**152**	**13**	**160**	**88**	**72**
Consulting fees	125	115	10	9	6	3
Travel and subsistence	35	31	3	142	76	66
Venue and catering	6	6	-	9	6	3
Staff cost	**5 545**	**5 546**	**(1)**	**4 025**	**4 582**	**(557)**
Salaries	5 429	5 416	13	3 833	4 427	(594)
Staff training	116	130	(14)	191	155	36
Total	**5 718**	**5 705**	**12**	**4 192**	**4 676**	**(484)**

Programme 5: Stakeholder Relations

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
5.2.4	**Communication with stakeholders**	Number of communiqués	37	36	42	6	**Deviation** The total number of communiqués is the sum of the communication initiatives listed below, i.e. *CMS News, CMScript, Masihambisane,* press conferences, and press releases. More initiatives took place than was originally anticipated.
		• Number of *CMS News*	1	2	1	1	**Deviation** The delay in the publication of the first issue was caused by some external authors requesting more time to submit their articles, and by both internal and external authors submitting their articles late. The timely publication of *CMS News* is dependent on internal and, where applicable, external stakeholders appreciating deadlines, be it for submission of material or approval.
		• Number of *CMScript*	7	8	8	-	**No deviation**
		• Number of *Masihambisane*	12	12	12	-	**No deviation**
		• Press conferences	2	2	1	1	**Deviation** The first press conference took place on 4 September 2012 (launch of the Annual Report 2011-2012), as scheduled. The need for a press conference is dependent on the issues that justify enough media attention for the CMS to hold a press conference, therefore the target set is only an estimate.
		• Press releases	15	12	20	8	**Deviation** More matters warranted the issuing of a press release than was originally anticipated.
		• Media enquiries	100%	100%	100%	-	**No deviation**
5.2.5	**Publication of the CMS Annual Report**	Managing the production process of CMS Annual Report	1	1	1	-	**No deviation**
		Organising launch of CMS Annual Report (press conference)	1	1	1	-	**No deviation**
		Organising CMS Annual Report road shows	2	2	2	-	**No deviation**
5.2.6	**Support for other Units**	Number of Circulars drafted and edited	54	20	52	32	**Deviation** More matters warranted the issuing of a Circular than was originally anticipated.
5.2.7	**Customer Care Centre**	Number of calls handled per year	41 960	42 000	31 922	10 078	**Deviation** The number of calls is an estimate and is dependent on the changes taking place in the medical schemes industry.
		Number of calls abandoned per year	3 339	3 000	2 598	402	**Deviation** Fewer calls were abandoned due to the strict management of calls.
4.1.1	**Trustee training**	Number of trustees trained	69	80	117	37	**Deviation** There was a high demand for trustee training due to new appointments and requests for scheme-specific training.

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
4.1.2	**Consumer education**	Number of beneficiaries who receive consumer education	40 432	25 000	36 551	11 551	**Deviation** The demand from consumer groups for training of members on medical scheme matters increased as more members became aware of the CMS.
4.1.3	**Coordinate external training undertaken by other CMS Units**	Number of sessions coordinated	2	2	1	1	**Deviation** Only one Administrator Workshop was held in the period under review. The Education & Training Unit and the Financial Supervision Unit (FSU) jointly coordinated the programme. As per a directive from FSU, only one workshop per annum is required to inform medical schemes what is required for their submission of annual returns. The target will be reduced going forward.

Purpose

The Stakeholder Relations Unit – which houses Communications, Education & Training, and the Customer Care Centre – is there to create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, the media, Council members as well as CMS staff, through communications, education, training, and customer care interventions.

Achievement of strategic objectives

In the Communications Unit more activities took place than anticipated, and compliments were received from industry stakeholders for the quality of communication initiatives.

The Customer Care Centre received fewer calls than the target, which by implication means that fewer members and brokers lodged complaints. While the CMS wants to reduce calls relating to complaints, it wants to increase the number of calls from the general public to ask more questions about their rights as members of medical schemes and to ask for information about the CMS.

It is anticipated that the increased number of requests for consumer training might influence the statistics of the Customer Care Centre. Although consumer training is encouraged, care is taken to rather provide quality training to bigger groups, thereby enhancing the cost-effectiveness of consumer training.

Two industry Indabas and the first round of forums for Boards of Trustees and Principal Officers of medical schemes took place and proved to be a huge success.

The Healthcare Regulator Forum was scheduled for June 2013, and meetings with the Financial Services Board (FSB), the Public Protector South Africa, the National Prosecuting Authority of South Africa (NPA), and others commenced to discuss details of a Memorandum of Understanding (MoU) with the relevant stakeholders.

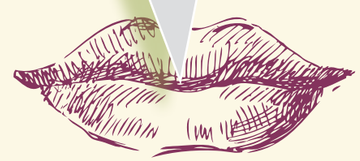
The Unit participated in the demarcation project and attended meetings with the FSB and the Department of Health (DoH). The Unit also participated in the Composite Risk Index (CRI) project and represented the executive management team on the Industry Technical Advisory Panel (ITAP). These initiatives and others will continue as described in the operational plan of the Unit.

Functions of the National Press Club (NPC) were attended continuously to build relationships with journalists, and breakfast meetings were arranged to be continued with pertinent journalists.

Participation in the Relocation Committee continued and advice was specifically provided for the correct branding and signage in the new building.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.



Unit budget

Stakeholder Relations	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**8**	**7**	**1**	**10**	**7**	**3**
Refreshments	2	2	-	3	-	3
Stationery	5	4	1	6	6	-
Subscriptions	1	1	-	1	1	0
Operating expenses	**1 886**	**1 899**	**(13)**	**1 795**	**1 829**	**(34)**
Courier and postage	14	14	-	15	15	-
Exhibition cost	290	302	(12)	455	622	(167)
Media and promotion	211	171	40	125	20	105
Printing and publication	491	438	53	446	363	83
Travel and subsistence	622	719	(97)	625	674	(49)
Venue and catering	258	255	3	129	135	(6)
Staff cost	**5 360**	**5 131**	**229**	**3 678**	**3 868**	**(190)**
Salaries	5 198	5 011	187	3 556	3 787	(231)
Staff training	162	120	42	123	81	42
Total	**7 254**	**7 037**	**217**	**5 484**	**5 704**	**(220)**

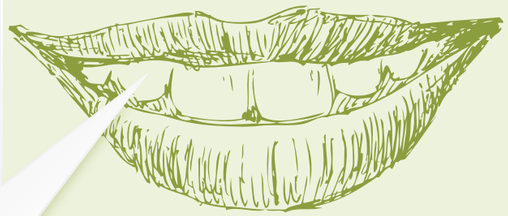
PERFORMANCE INFORMATION

Programme 6: Compliance

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
6.2.1	**Enforcement of rulings and directives**	Number of directives issued	23	20	23	3	**Deviation** We received more matters that needed enforcement than we had anticipated.
6.2.2	**Inspection of regulated entities**	Number of inspections or investigations conducted	10	12	16	4	**Deviation** The Unit managed to complete some inspections timeously, and due to this the Unit was able to conduct more inspections.
6.2.3	**Exemption applications**	Number of exemption applications prepared for adjudication by the Council	-	20	25	5	**Deviation** Exemptions are by nature unpredictable and one cannot foresee how many medical schemes will be applying to be exempted from complying with certain Sections of the Medical Schemes Act. The target given is an estimate based on the trend observed from the past.

Purpose

The purpose of the Compliance Unit is to serve members of medical schemes and the public in general by analysing, reviewing, and investigating information on possible transgressions of the Medical Schemes Act, and taking appropriate actions to enforce compliance with the Act. By doing this the Unit helps the CMS foster compliance with the Medical Schemes Act and take proportionate actions to promote a culture of compliance with legislation.



Achievement of strategic objectives

By timeously intervening in instances of non-compliance and conducting both routine and commissioned inspections into the affairs of medical schemes, the Unit contributed to the strategic outcomes of the CMS in fostering compliance with the Medical Schemes Act.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Compliance	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**1**	**22**	**(6)**	**17**	**15**	**2**
Refreshments	4	3	1	3	3	-
Printing and stationery	10	11	(1)	10	10	-
Subscriptions	2	8	(5)	4	2	2
Operating expenses	**655**	**322**	**333**	**810**	**891**	**(81)**
Consulting fees	288	126	162	730	815	(85)
Travel and subsistence	367	196	171	80	76	4
Staff cost	**4 556**	**4 620**	**(64)**	**4 186**	**4 131**	**55**
Salaries	4 431	4 522	(91)	4 091	4 059	31
Staff training	125	98	27	95	72	23
Total	**5 227**	**4 964**	**263**	**5 013**	**5 037**	**(24)**

Programme 7: Benefits Management Unit

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
7.2.1	**Scheme rule amendments**	Number of rule amendments processed per year	275	314	280	34	**Deviation** The rule amendments submitted to the CMS are based on decisions made by the Boards of the schemes that are registered. Therefore the targets are only an estimate of the number of amendments expected for the year.
7.2.2	**Monitor scheme marketing material**	Number of scheme marketing material reviewed per year	45	45	54	9	**Deviation** The objective of this activity is to analyse marketing material in conjunction with the registered rules, and monitor whether there are any inconsistencies between them. During the period under review the Unit exceeded its target of 45 scheme marketing materials to be monitored.
7.2.3	**Registration of new schemes**	Number of applications for new schemes considered per year	-	1	-	1	**Deviation** No new applications were received during the year for registration of a new medical scheme.
7.2.4	**Management of scheme amalgamations**	Number of scheme amalgamations managed per year	1	3	5	2	**Deviation** The Unit managed a larger number of scheme amalgamations during the year than targeted. The process of amalgamation is not under the control of this Unit, hence it is dependent on the experience in the industry.

PERFORMANCE INFORMATION

Purpose

The purpose of the Benefits Management Unit (BMU) is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The Unit analyses and approves all other rules to ensure consistency with the Medical Schemes Act. This ensures that beneficiaries have access to affordable and appropriate quality healthcare. By doing this the Unit helps the CMS to ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the Medical Schemes Act.

Achievement of strategic objectives

The Unit continued in its responsibility in ensuring that strategic goal 2 – "[m]edical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected" – is supported.

The Unit ensures that this strategic goal is achieved by ensuring that rule amendments are fair and consistent with the Medical Schemes Act. The Unit also ensures that beneficiaries are informed and not misled by marketing materials of medical schemes, as the Unit is responsible for the analysis of schemes' marketing materials.

The Unit's responsibility to manage the amalgamations of medical schemes also contributes to the organisation's responsibility to protect the beneficiaries of medical schemes.

Changes to planned targets

The target for strategic objective 7.2.4 was corrected to reflect the target of "3" and to be in line with the annual target in the Annual Performance Plan 2012-2013 (APP). The corrections were submitted to the Executive Authority on 31 August 2012.

Unit budget

Benefits Management Unit	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**55**	**38**	**17**	**53**	**39**	**13**
Printing and stationery	25	19	6	23	19	4
Refreshments	10	6	4	10	8	2
Subscriptions	20	13	7	20	13	7
Operating expenses	**11**	**-**	**11**	**12**	**-**	**12**
Travel	11	-	11	12	-	12
Staff cost	**4 695**	**4 310**	**385**	**4 573**	**3 866**	**707**
Salaries	4 545	4 163	382	4 339	3 754	585
Staff training	150	147	3	234	112	121
Total	**4 761**	**4 345**	**413**	**4 638**	**3 906**	**732**

Programme 8: Legal Services Unit

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
8.2.1	**Legal advisory service**	Number of written legal opinions provided to the CMS or Units per year	61	66	118	52	**Deviation** The Unit continued to provide well-researched legal advice to both internal and external stakeholders as and when required. Stakeholders are becoming more and more aware of the CMS and they are asking a lot more questions with regard to their benefits, and the Unit is receiving more queries than in previous years.
8.2.2	**Legal support service**	Number of court cases where court papers are filed	20	36	23	13	**Deviation** The Unit, in an effort to save costs, endeavoured, to the extent possible, to settle matters without resorting to litigation.
8.2.3	**Secretarial support service**	Number of Council meetings supported per year	6	4	5	1	**Deviation** A special Council meeting had to be set up in the latter part of the year to deal with urgent matters.
		Number of EXCO meetings supported per year	3	6	6	-	**No deviation**
		Number of Appeals Committee meetings supported per year	9	10	11	1	**Deviation** Due to a backlog with Appeals Committee matters, a special Appeals Committee meeting had to be set up to deal with the backlog.
		Number of Appeal Board hearings supported per year	4	4	1	3	**Deviation** The Chairperson of the Appeal Board was appointed as a Judge and could no longer act as the Chairperson of the Appeal Board. The process of appointing the Chairperson of the Appeal Board is dependent on the Minister of Health. Submissions were made to the Ministry in November 2012. Judge Bernard M. Ngoepe was appointed but was only available from 1 November 2012 to start.

Purpose

The purpose of the Legal Services Unit is to provide legal advice and representation to the CMS and other Units to ensure the integrity of regulatory decisions.

Achievement of strategic objectives

The CMS as well as the Chief Executive & Registrar are required to function in an environment where their decisions are free from risk of legal challenges. In cases where they could be challenged, this has an adverse impact on the CMS meeting its regulatory mandate, strategic outcomes, and goals. The Legal Services Unit ensured that sound legal advice was provided to all operational Units in the Office of the Chief Executive & Registrar, and was successful in all litigation. By so doing it ensured that the integrity of the regulatory process is protected.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Legal Services Unit	2012/2013 Budget	2012/2013 Actual expenditure	2012/2013 (Over-) / under-expenditure	2011/2012 Budget	2011/2012 Actual expenditure	2011/2012 (Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**23**	**21**	**2**	**17**	**13**	**4**
Refreshments	6	6	-	4	4	0
Printing and stationery	17	15	2	13	9	3
Operating expenses	**5 359**	**9 499**	**(4 140)**	**6 620**	**10 669**	**(4 049)**
Consulting fees	372	89	283	200	182	18
Courier and postage	10	9	1	20	15	5
Legal fees	4 793	9 305	(4 512)	6 221	10 389	(4 168)
Transcription services	59	46	13	83	36	47
Travel and subsistence	112	47	65	82	38	44
Venue and catering	13	3	10	14	9	5
Staff cost	**3 091**	**3 279**	**(188)**	**2 157**	**2 141**	**15**
Salaries	3 002	3 204	(202)	2 081	2 129	(48)
Staff training	89	75	14	76	13	63
Total	**8 473**	**12 799**	**(4 326)**	**8 793**	**12 823**	**(4 030)**

Programme 9: Financial Supervision Unit

Strategic objective		Performance indicator	Actual achievement 2011/2012	Planned target 2012/2013	Actual achievement 2012/2013	Deviation from planned target to actual achievement 2012/2013	Comment on deviation
9.2.1	**Improve statutory returns as tools for monitoring and reporting, and publish reports on findings**	Number of IT specifications produced in respect of quarterly returns	1	1	1	-	**No deviation**
		Number of IT specifications produced in respect of annual returns	1	1	1	-	**No deviation**
		Number of quarterly reports published	3	3	3	-	**No deviation**
		Number of financial sections prepared for the Annual Report	1	1	1	-	**No deviation**
9.2.2	**Improve reporting by medical schemes (data quality)**	Number of training sessions held in respect of reporting of financial information	2	1	1	-	**No deviation**
		Number of rejections due to quality of statutory returns	-	1	1	-	**No deviation**
		Number of rejections due to quality of Annual Financial Statements	2	2	3	-	**No deviation**
		Number of guidelines published	6	6	6	-	**No deviation**
		Number of inputs prepared for the *SAICA Accounting Guide for Medical Schemes*	1	1	1	-	**No deviation**
		Number of inputs prepared for the IRBA guide	1	1	-	1	**Deviation** Input to IRBA on the audit guide occurs as and when it is required; no input was required in the period under review.
9.2.3	**Provide specialised financial advice**	100% of requests for specialised advice processed	100%	100%	100%	-	**No deviation**
9.2.4	**Provide financial oversight of medical schemes / close monitoring**	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan submissions received	7	100%	100%	-	**No deviation**
		Recommendations on action plans for schemes with rapidly reducing solvency but above the statutory minimum for 100% of schemes identified	6	100%	100%	-	**No deviation**
9.2.5	**Governance and independence**	Number of online auditor approval questionnaires per year	1	1	1	-	**No deviation**
		Audit approval letters drafted such that 100% of applications by schemes are responded to annually	100%	100%	100%	-	**No deviation**
		Responses to 100% of schemes that submitted reinsurance applications	100%	100%	100%	-	**No deviation**

Purpose

The Financial Supervision Unit (FSU) serves the beneficiaries of medical schemes, the Office of the Chief Executive & Registrar, and trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Medical Schemes Act. By doing this, the Unit helps the CMS monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

Achievement of strategic objectives

The Unit continued its collaboration with the South African Institute of Chartered Accountants (SAICA) and the Independent Regulatory Board of Auditors (IRBA), ensuring that data submitted by medical schemes is of the highest standard and complies with relevant accounting and auditing standards. The quality of data collected has a direct impact on regulatory interventions, which need to be appropriate to ensure protection of members at all times. The work done by the Unit in ensuring that schemes handle personal medical savings accounts (PMSAs) as trust monies, separate from scheme assets, went a long way in ensuring that member interests are protected.

In support of efforts to strengthen the governance structures of medical schemes, the Unit engaged with trustees, encouraging them to review the manner in which they contract for services, such that value is added and non-health expenditure is reduced and maintained at acceptable levels. This also impacts on the affordability of medical schemes.

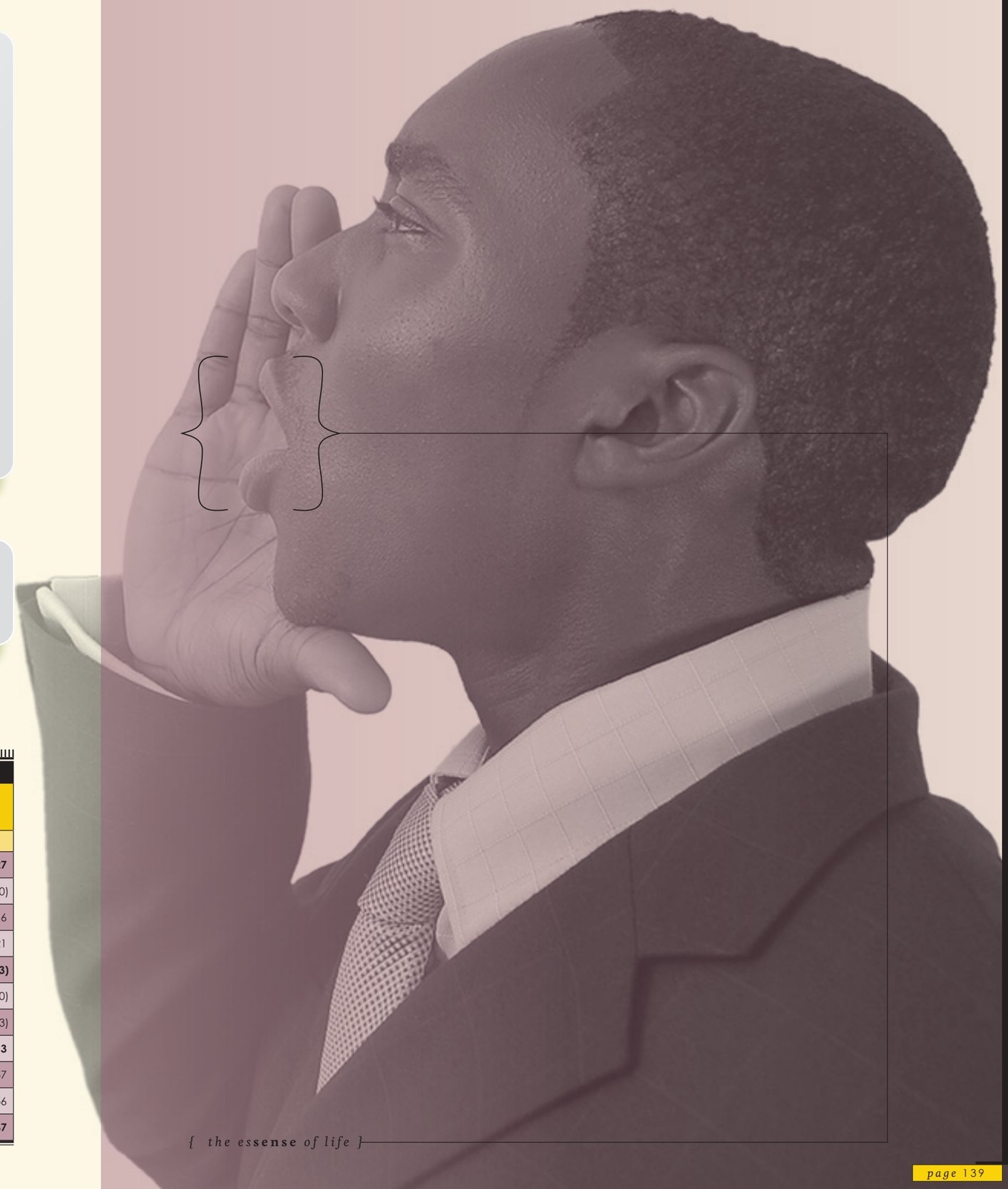
In improving oversight and securing the interest of members, the Unit participated in the development of the Real-Time Monitoring (RTM) system, which will allow for more frequent monitoring of schemes to ensure they maintain financial soundness. This, together with the ongoing improvement to the statutory tools, strengthens our early-warning systems and consequently the concurrent regulatory function of the CMS.

Changes to planned targets

No changes were made to the performance indicators or targets during the period under review.

Unit budget

Financial Supervision Unit	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
Administrative expenses	**44**	**32**	**12**	**53**	**26**	**27**
Refreshments	5	4	1	5	5	(0)
Printing and stationery	19	16	3	18	12	6
Subscriptions	20	12	8	30	9	21
Operating expenses	**70**	**42**	**28**	**31**	**34**	**(3)**
Consulting fees	20	7	13	1	1	(0)
Travel	50	35	15	30	33	(3)
Staff cost	**8 082**	**7 962**	**120**	**7 484**	**7 071**	**413**
Salaries	7 788	7 764	24	7 284	6 927	357
Staff training	294	198	96	200	144	56
Total	**8 196**	**8 036**	**160**	**7 568**	**7 131**	**437**



SUMMARY OF FINANCIAL INFORMATION

Summary of financial information

Revenue collection

Sources of revenue	2012/2013			2011/2012		
	Estimate	Actual amount collected	(Over-) / under-collection	Estimate	Actual amount collected	(Over-) / under-collection
	R'000	R'000	R'000	R'000	R'000	R'000
Levies income	92 687	90 775	1 912	76 575	76 534	41
Accreditation fees	4 700	5 497	(797)	5 500	5 709	(209)
Registration fees	400	376	24	400	371	29
Appeal fees	0	10	(10)	0	20	(20)
Sundry income	0	538	(538)	0	462	(462)
Legal fees recovered	0	763	(763)	0	6 405	(6 405)
Government transfer: Department of Health	0	4 310	(4 310)	0	4 194	(4 194)
Mandatory transfer: Department of Higher Education & Training	0	30	(30)	0	98	(98)
Interest received	1 200	1 440	(240)	900	841	59
Total	**98 987**	**103 739**	**(4 752)**	**83 375**	**94 634**	**(11 259)**

Programme (Unit) expenditure

Sources of revenue	2012/2013			2011/2012		
	Budget	Actual expenditure	(Over-) / under-expenditure	Budget	Actual expenditure	(Over-) / under-expenditure
	R'000	R'000	R'000	R'000	R'000	R'000
1.1 Office of the CEO	12 634	11 241	1 393	7 520	8 552	(1 032)
1.2 Strategic Projects Unit	88	53	35	6 282	2 193	4 089
1.3 Complaints Adjudication	4 072	4 037	35	3 942	3 698	248
2.1 Internal Finance Unit	20 065	19 574	491	17 298	17 642	(344)
2.2 Information and Communication Technology (ICT) and Knowledge Management (KM)	10 001	9 859	142	8 027	8 072	(45)
2.3 Human Resources management	5 895	5 838	57	5 371	4 967	404
3. Accreditation Unit	6 034	5 761	273	5 495	5 353	142
4. Research & Monitoring Unit	5 718	5 705	13	4 192	4 676	(484)
5. Stakeholder Relations Unit	7 254	7 037	217	5 484	5 704	(220)
6. Compliance	5 227	4 964	263	5 013	5 034	(24)
7. Benefits Management Unit	4 761	4 348	413	4 638	3 906	732
8. Legal Services Unit	8 473	12 799	(4 326)	8 793	12 823	(4 030)
9. Financial Supervision Unit	8 196	8 036	160	7 568	7 131	437
Total	**98 418**	**99 252**	**(834)**	**89 623**	**89 750**	**(127)**

{ performance }

GOVERNANCE

"Observe, record, tabulate, communicate. Use your five senses. Learn to see, learn to hear, learn to feel, **learn to smell**, *and know that by practice alone you can become expert."*

William Osler

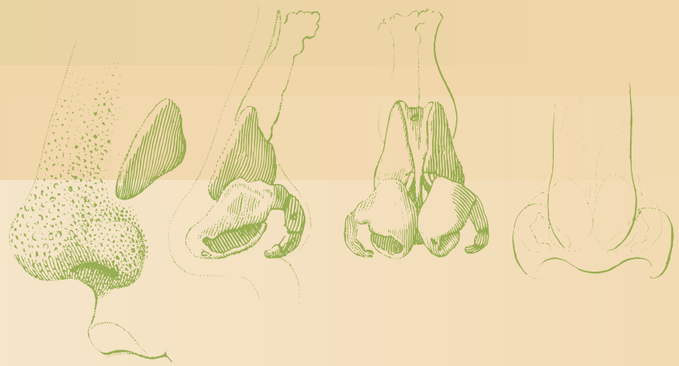
GOVERNANCE

The Accounting Authority or Board of the Council for Medical Schemes (CMS) is the Council.

The Medical Schemes Act 131 of 1998 states that Council can consist of up to 15 members, who are appointed by the Minister of Health. The Minister also appoints a Council member as the Chairperson of Council, but Council members elect from amongst themselves a Vice-Chairperson. Council members can serve a maximum of two terms, three years each.

Council consistently applies sound governance principles to policies and procedures in order to fully comply with the objective of good governance at all times. In this regard Council subscribes to the principles of good governance as envisaged in the King Report on Corporate Governance, the Public Finance Management Act, the Companies Act, the Medical Schemes Act, and Treasury Regulations.

Council has an Executive Committee (EXCO), a Human Resources Committee, a Remuneration Committee, a Finance Committee, an Audit & Risk Committee, as well as an Appeals Committee. All these Committees play a vital role in ensuring that the sound governance of Council and the CMS is maintained.



{ *"Memories, imagination, old sentiments, and associations are more readily reached through the* **sense of smell** *than through any other channel."* **Oliver Wendell Holmes** }

PORTFOLIO COMMITTEE ON HEALTH
THE EXECUTIVE AUTHORITY: THE MINISTER OF HEALTH
THE ACCOUNTING AUTHORITY OR BOARD: COUNCIL
COUNCIL SECRETARIAT
INTERNAL FINANCE UNIT AND INTERNAL CONTROLS
INTERNAL AUDIT
COMPLIANCE WITH LAWS AND REGULATIONS
FRAUD AND CORRUPTION
SOCIAL RESPONSIBILITY
REPORT OF THE AUDIT & RISK COMMITTEE

PORTFOLIO COMMITTEE ON HEALTH

The CMS made presentations to the parliamentary Portfolio Committee on Health four times in the year under review, namely as follows:

Topic of presentation	Date of presentation
The CMS Strategic Plan, Annual Performance Plan & budget for the 2013-2014 financial year	2 May 2012
The CMS Annual Report 2011-2012	12 October 2012
Briefing on medical tariffs	31 October 2012
The CMS Strategic Plan, Annual Performance Plan & budget for the 2013-2014 financial year	20 March 2013

THE EXECUTIVE AUTHORITY: THE MINISTER OF HEALTH

In complying with guidelines published by National Treasury, the CMS submitted performance information reports to the Minister of Health on a quarterly basis. The exact dates were as follows:

Quarterly performance information reports submitted to the Minister of Health	
Quarter 1 (April-June 2012)	31 July 2012
Quarter 2 (July-September 2012)	30 October 2012
Quarter 3 (October-December 2012)	31 January 2013
Quarter 4 (January-March 2013)	30 April 2013

The CMS submitted its Strategic Plan 2011/2012-2014/2015 (SP), Annual Performance Plan 2012-2013 (APP) and budget for the financial year under review to the Minister of Health on 21 November 2011.

THE ACCOUNTING AUTHORITY OR BOARD: COUNCIL

On 31 March 2013, Council consisted of 14 members who had been appointed by the Minister of Health for a three-year renewable term.

In order to fulfil its statutory obligations, Council is expected to provide strategic direction and leadership to the CMS owing to its role as the Accounting Authority or Board of this regulatory entity. Council is ultimately accountable for the performance of the CMS and therefore needs to ensure that the CMS is executing its mandate at all times – and in a fair and transparent manner, as envisaged in its mission statement.

The role of Council

The role of Council is captured in Section 7 of the Medical Schemes Act 131 of 1998.

It provides that "[t]he functions of the Council shall be to:

(a) protect the interests of the [medical scheme] beneficiaries at all times;

(b) control and coordinate the functioning of medical schemes in a manner that is complementary with the national health policy;

(c) make recommendations to the Minister [of Health] on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;

(d) investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this [Medical Schemes] Act;

(e) collect and disseminate information about private healthcare;

(f) make rules, not inconsistent with the provisions of this Act, for the purpose of the performance of its functions and the exercise of its powers;

(g) advise the Minister [of Health] on any matter concerning medical schemes; and

(h) perform any other functions conferred on the Council by the Minister [of Health] or by this [Medical Schemes] Act."

Board charter

Council operates in terms of the Medical Schemes Act 131 of 1998 and has no charter in place. However, a charter is being developed.

Table 19: Composition of Council as at 31 March 2013

Name of Council member	Designation	Date appointed	Date resigned	Qualifications	Area of expertise	Council Committee	No. of meetings attended
Prof. Y Veriava	Chairperson	28 November 2012	N/A	MBBCh (Wits), Hon DSc (Wits), FCP (SA), FRCP (London)	Clinical medicine	EXCO, HR	4
Mr T Bailey	Vice-Chairperson	28 October 2011	N/A	BA, LLB, LLM	Law	EXCO, Appeals Committee	18
Prof. BC Dumisa	Member	28 October 2011	N/A	LLB, LLM, MBA, MSc, DBA	Law, management	Appeals Committee	18
Mr ZL Fihlani	Member	28 October 2011	N/A	CA (SA), MComm (Tax)	Tax, accounting	Finance, Audit & Risk	8
Mr AK Hoosain	Member	28 October 2011	N/A	CA (SA), MBA	Accounting, management	EXCO, Finance, Audit & Risk	13
Ms MO Morata	Member	28 October 2011	N/A	BProc, PostGradDip (Drafting of Contracts)	Law	Remuneration, Appeals Committee	18
Dr L Mpuntsha	Member	28 October 2011	N/A	MBChB, MPhil	Medicine	HR, Appeals Committee	9
Ms L Nevhutalu	Member	28 October 2011	N/A	BBusSc (Actuarial Sciences)	Actuarial Sciences	HR	7
Mr T Phadu	Member	28 October 2011	N/A	MSc (London), Senior Diploma (Political Economy) (Moscow)	Policy	HR, Remuneration	8
Dr A Pillay*	Member	28 October 2011	N/A	BPharm, MSc, PhD (Australia)	Health, management	EXCO	5
Ms A Theophanides	Member	28 October 2011	N/A	BCom Honours (Actuarial Sciences)	Actuarial Sciences	EXCO, HR, Remuneration	9
Prof. CJ van Gelderen	Member	28 October 2011	N/A	MBChB, Dip Mid COG (SA), MRCOG, FRCOG, FCOG (SA)	Medicine	EXCO, HR, Appeals Committee	18
Adv. CJ Weapond	Member	28 October 2011	N/A	Biuris, BPol, LLB, MTech	Law, consulting	Appeals Committee	18
Mr TF Zulu	Member	28 October 2011	N/A	CA (SA)	Accounting	Finance, Audit & Risk	8

* Non-remunerated Council member

Table 20: Council Committees as at 31 March 2013

Council Committee	No. of meetings held	No. of members	Names of members
Executive Committee (EXCO)	6	6	Prof. Y Veriava Mr T Bailey Mr AK Hoosain Dr A Pillay* Ms A Theophanides Prof. CJ van Gelderen
Human Resources Committee	3	6	Prof. Y Veriava Dr L Mpuntsha Ms L Nevhutalu Mr T Phadu Ms A Theophanides Prof. CJ van Gelderen
Remuneration Committee	2	3	Mrs MO Morata Mr T Phadu Ms A Theophanides
Finance Committee	7	3	Mr AK Hoosain Mr ZL Fihlani Mr TF Zulu
Audit & Risk Committee	4	6	Mr C Mazhindu Mr R Nicholls Mrs J Naicker Mr AK Hoosain Mr TF Zulu Mr ZL Fihlani
Appeals Committee	6	8	Mr T Bailey Prof. BC Dumisa Adv. H Maenetje (external alternate Chairperson of the Appeals Committee) Mrs MO Morata Dr L Mpuntsha Adv. V Ngalwana (external alternate Chairperson of the Appeals Committee) Prof. CJ van Gelderen Adv. CJ Weapond

* Non-remunerated Council member

Table 21: Remuneration of Council members in 2012-2013

Name of Council member	Remuneration	Other allowance/s	Other reimbursement/s	Total
Prof. Y Veriava	R102 782	N/A	N/A	R102 782
Mr T Bailey	R389 277	N/A	N/A	R389 277
Prof. BC Dumisa	R278 894	N/A	N/A	R278 894
Mr ZL Fihlani	R102 934	N/A	N/A	R102 934
Mr AK Hoosain	R244 568	N/A	N/A	R244 568
Ms MO Morata	R253 023	N/A	N/A	R253 023
Dr L Mpuntsha	R63 690	N/A	N/A	R63 690
Ms L Nevhutalu	R80 288	N/A	N/A	R80 288
Mr T Phadu	R174 279	N/A	N/A	R174 279
Dr A Pillay*	N/A	N/A	N/A	N/A
Dr RV Simelane	R16 368	N/A	N/A	R16 368
Ms A Theophanides	R143 785	N/A	N/A	R143 785
Prof. CJ van Gelderen	R257 462	N/A	N/A	R257 462
Adv. CJ Weapond	R196 088	N/A	N/A	R196 088
Mr TF Zulu	R116 958	N/A	N/A	R116 958

* Non-remunerated Council member

COUNCIL SECRETARIAT

In the year under review, the Council Secretariat continued to offer good governance advice and support to both Council and its various Sub-Committees. The Council Secretariat makes all effort to provide Council members with guidance on their rights, responsibilities, duties, and powers, both on an individual level and collectively. The Council Secretariat also ensures that Council complies with all applicable laws and Regulations which have a bearing on the CMS and the industry which it regulates. In addition to this, the Council Secretariat services Council meetings and attends to the day-to-day logistical arrangements of such meetings, and ensures that proper minutes are taken and kept. Council resolutions are communicated by the Council Secretariat to all affected parties.

INTERNAL FINANCE UNIT AND INTERNAL CONTROLS

The CMS has an Internal Finance Unit which takes responsibility for internal controls.

Internal controls remain a key pillar for the efficient management of CMS resources. The *Internal Finance Policies & Procedures Manual* was revised and approved by Council during the year under review.

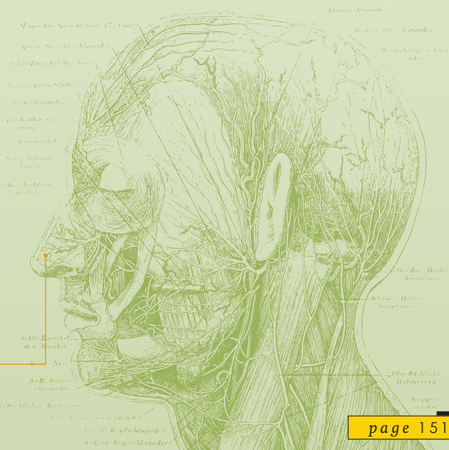
INTERNAL AUDIT

The scope of the annual internal audit of the CMS is always based on management's assessment of the risks facing the organisation. The internal audit conducted during the 2012-2013 financial year thus focused on high-risk areas identified by management in consultation with the Audit & Risk Committee of Council.

The contract of the internal auditors, SizweNtsalubaGobodo, expired in October 2012 and was extended, with Council's approval, to May 2013 to allow the tender process to be concluded. The tender process was concluded during June 2013, and the new service provider, SekelaXabiso (Pty) Ltd, was appointed with effect from 1 July 2013.

SizweNtsalubaGobodo performed risk assessments of the following during the period under review:

- follow-up report on their own findings from the previous financial year;
- follow-up report on the findings of the Auditor-General from the previous financial year;
- audit of predetermined objectives (for quarters 2 and 3 of 2012-2013);
- supply chain management;
- lease tender;
- risk management process;
- Accreditation Unit;
- Human Resources Unit;
- Legal Services Unit; and
- Research & Monitoring Unit.



COMPLIANCE WITH LAWS AND REGULATIONS

The CMS reviews its internal policies on an annual basis; they are signed off by Council. This ensures that compliance with relevant legislation is maintained.

FRAUD AND CORRUPTION

The CMS has a fraud and corruption prevention strategy in place which includes a whistle-blowing policy.

In order to remain compliant with the Protected Disclosures Act 26 of 2000, the CMS remained committed to the protection of its employees who disclose information in good faith, using the appropriate channels. The CMS recognises that the decision to report a concern can be a difficult one to make.

The CMS remains committed to high standards and good practice, and aims to be supportive of its employees.

In 2011 the CMS appointed Deloitte to manage its Tip-offs Anonymous hotline.

Employees who may wish to make confidential disclosures about suspected fraud and/or corruption activities at the CMS are able and in fact encouraged to call the hotline anonymously.

Cases involving CMS employees are reported directly to the CMS internal auditors as well as the Chairperson of Audit & Risk Committee for further investigation.

Users of the Tip-offs Anonymous service can report their disclosures using any one of the following mediums of communications:

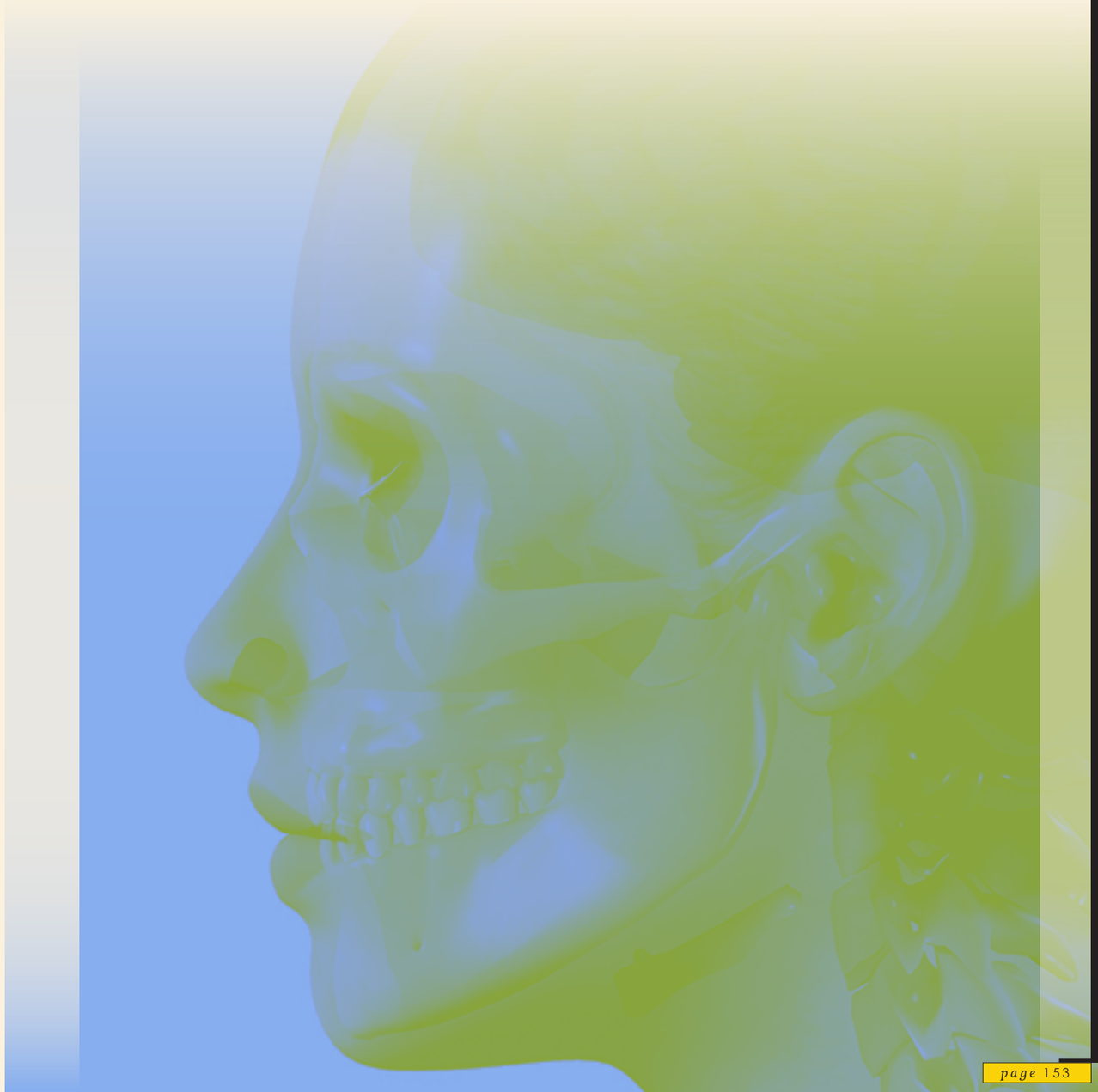
- a dedicated FreeCall number (0800 867 423)
- one unique e-mail address (cms@tip-offs.com)
- FreePost address (KZN 138, Umhlanga Rocks, 4320)
- FreeFacsimile (0800 00 77 88)

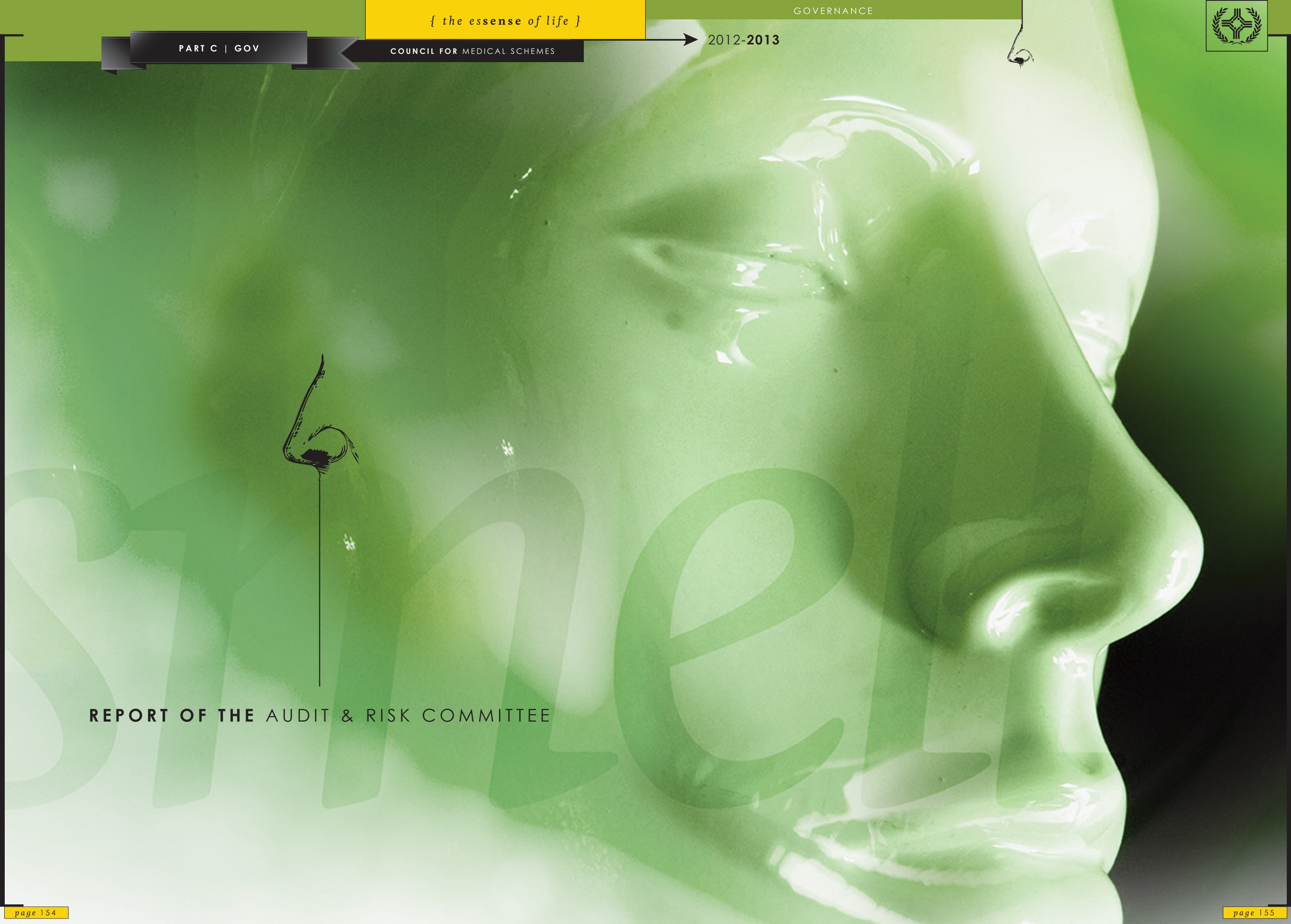
To ensure that the strategy remains sustainable, the Internal Finance Unit embarked on an awareness campaign during the year under review. A presentation on the fraud and corruption prevention strategy and whistle-blowing policy was made to all staff members, and promotional items with details of the Tip-offs Anonymous hotline were handed out to staff as well as CMS service providers. Articles on fraud and corruption were published in the official internal newsletter of the CMS, *Masihambisane*, on a monthly basis. Information on the Tip-offs Anonymous hotline is also published on the CMS intranet together with the strategy and policy document.

SOCIAL RESPONSIBILITY

The HR Unit facilitated mentorship to 10 girls from the Vukani-Mawethu High School in Mamelodi, north-east of Pretoria, in a social responsibility effort to play a role in building up responsible women for the future of our country. The CMS donated sanitary towels to the school, and again sponsored school uniforms to 123 underprivileged learners. These 123 learners were taken to the Moretele Park Recreation Resort for a day of fun and laughter.

The CMS also participated in the annual Nelson Mandela 67 Minutes Campaign this year by donating 85 pairs of school shoes to the same school.





REPORT OF THE AUDIT & RISK COMMITTEE

REPORT OF THE AUDIT & RISK COMMITTEE

We are pleased to present our report to the Council for Medical Schemes (CMS) Accounting Authority (Council) for the financial year ended 31 March 2013.

This report is provided by the Audit & Risk Committee of Council, appointed in respect of the 2012-2013 financial year of the CMS, in compliance with Section S51(1)(a)(ii) of the Public Finance Management Act 1 of 1999, as amended (PFMA). The Committee's operation is guided by a detailed charter that is informed by the PFMA and approved by Council.

Audit & Risk Committee members and meetings

The Committee is composed of three independent non-Council members and three non-executive members of Council.

The Committee held three scheduled meetings and one special meeting during the year under review. Meetings and attendance at these meetings was as follows in Table 22.

Other invitees

The internal and external auditors attended all the meetings of the Committee as invitees. The Chief Executive & Registrar and the Chief Financial Officer attended meetings by invitation, and other senior managers attended for agenda items relevant to them.

Functions

The functions discharged by the Committee, in accordance with its charter, included the following:

- Evaluation of the effectiveness of risk management, controls, and governance processes
- Oversight of:
  - the financial and performance reporting process
  - the activities of the internal and external audits, and facilitation of a coordinated approach between these functions
- Review of:
  - provisional and year-end financial statements to ensure that they are fairly presented and prepared in the manner required by the PFMA and the Medical Schemes Act
  - the external audit plan, budget, and reports on the Annual Financial Statements
  - the internal audit charter, annual audit plan, three-year audit plan, and annual budget
  - internal audit and risk management reports and, where relevant, recommendations made to the Board and management
- Approval of:
  - the internal audit charter, budget, and three-year audit plan
  - audit fees and engagement terms of the internal auditor
  - engagement terms, plans, and budget for the Auditor-General of South Africa
- Recommendation of the unaudited and audited Annual Financial Statements to Council for the year ended 31 March 2013

Table 22: Meetings & attendance of the Audit & Risk Committee in 2012-2013

Name of member	Position of member	Date of appointment	Date of reappointment	Meetings attended			
				24.05.2012 (scheduled)	25.07.2012 (special)	08.11.2012 (scheduled)	21.02.2013 (scheduled)
Charles Mazhindu	Independent & non-executive; Chairperson	1 October 2009	1 November 2012	✓	✓	✓	✓
Rowan Nicholls	Independent & non-executive	1 October 2009	1 November 2012	✓	✓	✓	✓
Josephine Naicker	Independent & non-executive	1 October 2009	1 November 2012	X	✓	X	✓
Kariem A Hoosain	Non-executive & Council member	28 May 2009	28 October 2011	X	X	✓	✓
Thabani F Zulu	Non-executive & Council member	1 November 2011	N/A	X	✓	✓	✓
Zola L Fihlani	Non-executive & Council member	1 November 2011	N/A	X	✓	X	✓

✓ = attended X = apology

Audit & Risk Committee responsibility

Mandate

The mandate of the Committee is derived from Section S51(1)(a)(ii) of the PFMA and paragraph 3.1 of Treasury Regulations.

The Committee reports that it has discharged its responsibilities arising from Section S51(1)(a)(ii) of the PFMA and Treasury Regulation 3.1.13.

The Committee further reports that it has adopted appropriate formal terms of reference, authorised by Council, as its Audit & Risk Committee charter, that it has regulated its affairs in compliance with this charter, and that it has discharged all its responsibilities as contained therein. The charter is reviewed annually, as required by the PFMA, and any changes are authorised by Council before they become effective.

Role of the Audit & Risk Committee on CMS governance

As part of the CMS governance structures, the Committee continued to discharge its mandate and, amongst others, performed its oversight function as follows:

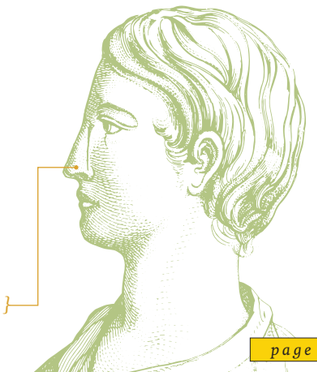
Internal audit services: three-year rolling strategic internal audit plan

The outsourced internal auditor of the CMS, SizweNtsalubaGobodo, compiled and presented its three-year rolling strategic plan for the review and approval of the Committee. The plan was approved by the Committee after it was satisfied that the plan is in line with Regulations and risk-based, as required by standards.

The Committee satisfied itself regarding the objectivity and independence of the CMS internal audit function and the continued appropriateness of both the Audit & Risk Committee charter and the internal audit charter.

External audit plan by the Auditor-General of South Africa

The Committee reviewed and approved the external audit plan for the year under review as prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act for the year ended 31 March 2013. The Committee confirms that this plan is in line with Regulations and standards, and that the plan takes into consideration the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented were adequate for completion of the CMS annual audit.



Risk management and internal controls

The Committee continued to review and to report on CMS risk management practices, internal policies, and procedures that they are effective and adequate to safeguard the CMS resources and promote the achievement of its mission. The Committee continued to report on the establishment of effective internal controls, which requires a periodic identification and assessment of risks faced by the CMS, from both internal and external sources.

The Committee is satisfied that areas of improvement within the CMS risk management and internal control practices are being adequately identified and entity-wide risk management within the CMS has now been formalised. The Committee acknowledges that an effective internal audit function is central to the proper operation of the Committee.

Both internal and external audits identified information technology as an area requiring enhancement towards effectiveness and greater control. The CMS responded by formulating an enhancement plan which is currently being implemented.

Review of legal cases pending at financial year-end

The Committee reviewed progress reports on legal cases against the CMS that were pending at the financial year-end so as to assess the adequate disclosure in the Annual Financial Statements required in terms of the South African Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. Other pending legal cases were disclosed as either contingent assets or contingent liabilities in the Annual Financial Statements.

Evaluation of the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually. During the year under review, the Committee was not evaluated by Council.

Evaluation of financial statements

The Committee:

- reviewed and discussed with management and the Auditor-General of South Africa the impact on the CMS Annual Financial Statements of compliance with new accounting and financial reporting pronouncements for the year under review, and is satisfied that the CMS Annual Financial Statements were prepared in line with relevant accounting standards and financial reporting framework;
- reviewed and discussed the CMS Annual Financial Statements to be included in this Annual Report with the Auditor-General of South Africa and the Chief Executive & Registrar of the CMS; and
- reviewed the *Report of the Auditor-General of South Africa*.

The Auditor's report

The Committee concurs with and accepts the opinion of the Auditor-General of South Africa on the CMS Annual Financial Statements, and recommends that the audited financial statements be accepted by Council.

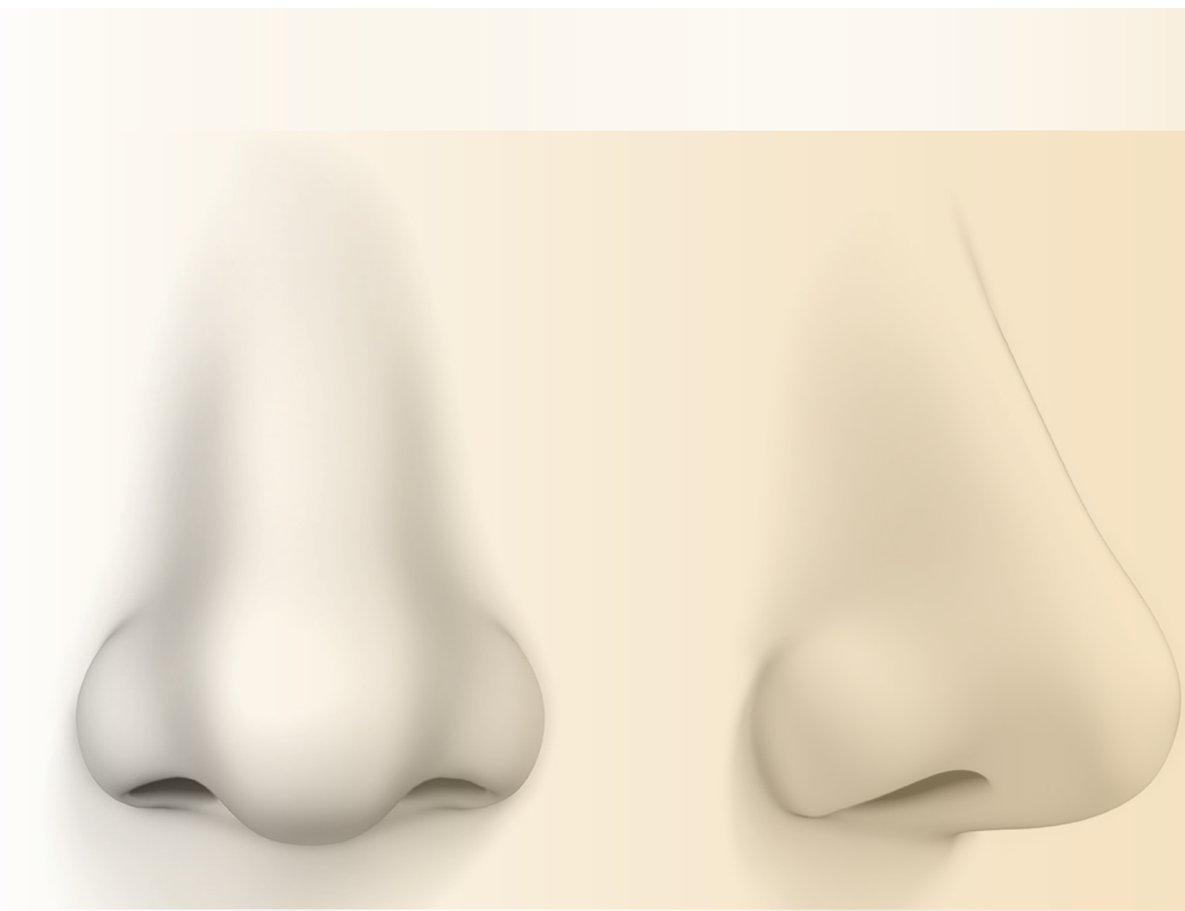
Although every effort was made to resolve the previous year's audit findings, not all the audit findings were resolved.

The Committee reviewed the Annual Financial Statements of the CMS for the year ended 31 March 2013 and is satisfied that, in all material respects, the financial statements comply with the relevant provisions of the PFMA, GRAP, and International Financial Reporting Standards (IFRS), and fairly present the financial position of the CMS at that date and the results of operations and cash flows for the year then ended. The Committee recommended the financial statements and performance information report for the year ended 31 March 2013 to Council for approval.

Our commitment

The Committee remains committed to working together with Council and all stakeholders to promote sound corporate governance and to strengthen both the risk management practices of the CMS and its internal control procedures towards the effective regulation of medical schemes.

Charles Mazhindu
Chairperson
Audit & Risk Committee
Council for Medical Schemes
31 July 2013



HUMAN RESOURCES MANAGEMENT

"People love to talk but hate to listen. **Listening** *is not merely not talking, though even that is beyond most of our powers; it means taking a vigorous, human interest in what is being told us. You can listen like a blank wall or like a splendid auditorium where every sound comes back fuller and richer."*

Alice Duer Miller

HUMAN RESOURCES MANAGEMENT

What follows is an overview of the activities of the Human Resources (HR) Unit at the Council for Medical Schemes (CMS) during the 2012-2013 reporting period.

The information relates to the implementation of an HR strategy for the 2012-2013 financial year through the Annual Performance Plan (APP) as it relates to matters such as remuneration and benefits, talent management and staff retention, performance management, training and development, Employment Equity (EE), as well as personnel and related costs.

- HR STRATEGY
- REMUNERATION AND BENEFITS
- TALENT MANAGEMENT AND STAFF RETENTION
- EMPLOYER OF CHOICE: EMPLOYEE ENGAGEMENT SURVEY
- PERFORMANCE MANAGEMENT
- TRAINING AND DEVELOPMENT
- EMPLOYMENT EQUITY (EE)
- EMPLOYEE WELLNESS
- POLICY REVIEWS
- TEAM-BUILDING, CULTURE, AND DIVERSITY
- HR OVERSIGHT STATISTICS

"The voice of the intellect is a soft one, but it does not rest until it has gained a **hearing**.*"*
Sigmund Freud

HR STRATEGY

HR's strategic objectives address the broader strategic goal of the CMS to be responsive to the needs of the environment by being an effective and efficient organisation.

REMUNERATION AND BENEFITS

An extensive and comprehensive job grading and evaluation exercise was conducted during 2012-2013 to review all the existing positions at the CMS to ensure that the respective roles are clearly defined and appropriately graded.

Management and staff were consulted throughout the process through the provision of workshops regarding the purpose of the exercise, as well as individually at Unit level where each staff member was given the opportunity to participate in the development of their job profile.

This job grading and evaluation exercise included a comparison (market positioning) of all CMS positions to similar positions in the healthcare industry and the national All Industries market to ensure that the remuneration of CMS positions remains competitive.

TALENT MANAGEMENT AND STAFF RETENTION

The aim of the CMS talent acquisition strategy is to identify and hire the best talent available. HR manages and participates in the recruitment, interviewing, testing, selection, orientation, and evaluation of all employees.

During the period under review, talented personnel were sourced in line with our recruitment policies and processes.

The selection process which was adopted in recruiting for both existing and new positions was geared to ensuring that the best and most appropriately qualified personnel was appointed. Their performance was monitored during the probation period to ensure that they met their performance targets.

Appointments

Eight appointments were made in the financial year under review:

- Financial Analysts (x 2)
- Accreditation Analyst
- Legal Adjudication Officer
- Legal Advisor
- Head: Stakeholder Relations
- Executive Assistant & Administrator
- Clinical Analyst

Orientation and induction

A comprehensive orientation programme was provided to new employees, with in-depth information on the structure and functions of the CMS, our terms and conditions of service, and all policies, including the *HR Policy Manual*. Orientation and induction exercises greatly enhance the ability of new employees to function effectively within a short period of time.

Probation

Six of the seven new employees completed the mandatory probation period of six months and were confirmed as permanent employees of the CMS after the successful conclusion of their respective probation reviews.

Resignations

The following four resignations were received in the reporting period:

- Head: Research & Monitoring
- Clinical Health Economist
- Clinical Analyst
- Council Secretariat

EMPLOYER OF CHOICE: EMPLOYEE ENGAGEMENT SURVEY

HR completed the consulting process on the "Employer of Choice" employee engagement survey which aimed to help improve HR services to CMS employees. Issues that were raised in the survey are being addressed by management with a view of further engagement with staff on an ongoing basis.

PERFORMANCE MANAGEMENT

The CMS performance management system is designed to ensure that high performance is both encouraged and rewarded.

At the beginning of the financial year under review, HR facilitated the drafting and conclusion of performance agreements of all CMS employees, ensuring that the contracts correctly reflected the requirements of the CMS and captured accomplishment-based performance standards, outcomes, and measures.

In line with HR policies, two formal performance reviews were conducted in the 2012-2013 reporting period. Through the Moderating Committee, HR facilitated the awarding of incentive bonuses to those employees who excelled in their performance and so were recognised for their contribution to ensuring that the CMS met its strategic goals and delivered on its mandate in the year under review.

TRAINING AND DEVELOPMENT

Staff undertook various training programmes identified in their Personal Development Plans or Professional Development Programmes (PDPs). HR completed a Workplace Skills Plan and Annual Training Report and submitted it to the Health and Welfare Sector Education and Training Authority (HWSETA).

HR takes pride in providing and supporting a learning culture for all CMS employees. A number of employees achieved academic success by completing Certificate, Diploma, Degree, Higher Degree, and Masters Degree programmes. Two senior managers are currently undertaking PhD studies.

New employees were provided career development opportunities through the professional development programme.

EMPLOYMENT EQUITY (EE)

A new Employment Equity Forum as well as a Training Committee were appointed in the year under review, and an EE Plan for 2012-2015 was finalised and approved by the Chief Executive & Registrar. HR submitted an EE report for the year under review to the Department of Labour.

The EE Forum continued to monitor the implementation of equity targets when new appointments were made, and held awareness and feedback sessions for both management and staff during the period under review.

The CMS has a diverse workforce, but the representation of Indians, Coloureds, and persons with disabilities remained below the nationally defined benchmark for designated groups in the reporting period. The CMS will continue to earmark available opportunities to ensure equitable representation of all designated groups.

EMPLOYEE WELLNESS

Employee wellness remained a priority for HR and a key strategic objective for ensuring staff retention and improving productivity.

In the year under review, HR proactively addressed and therefore pre-empted a diverse range of health and social issues before they turned into bigger and costlier problems for the CMS. The services of ICAS Southern Africa – one of the world's leading providers of employee assistance, wellness, and wellbeing programmes – were again contracted to provide interested employees with access to professional assistance programmes that is both private and confidential.

Other HR wellness initiatives included:

- the promotion of fitness and healthy habits (all staff members were provided with a subsidised health club membership);
- free health screenings for high blood pressure, elevated cholesterol, and other health ailments;
- on-site health education on HIV/AIDS (presentations and on-site testing were facilitated to raise awareness of HIV/AIDS);
- on-site flu vaccinations;
- an awareness campaign on women empowerment and gender equity;
- a cancer awareness campaign;
- the commemoration of World AIDS Day;
- the celebration of Human Rights Day; and
- a TB awareness campaign.

POLICY REVIEWS

The following policies were reviewed during the period under review:

- Employee Benefits Policy
- Performance Appraisal Dispute Resolution Policy
- Remuneration Philosophy and the Value Proposition Policy
- Grievance Procedures Policy

TEAM-BUILDING, CULTURE, AND DIVERSITY

HR facilitated management engagement workshops, cross-functional team-building sessions, and cultural awareness presentations for all the CMS Units during the period being reviewed.

HR OVERSIGHT STATISTICS

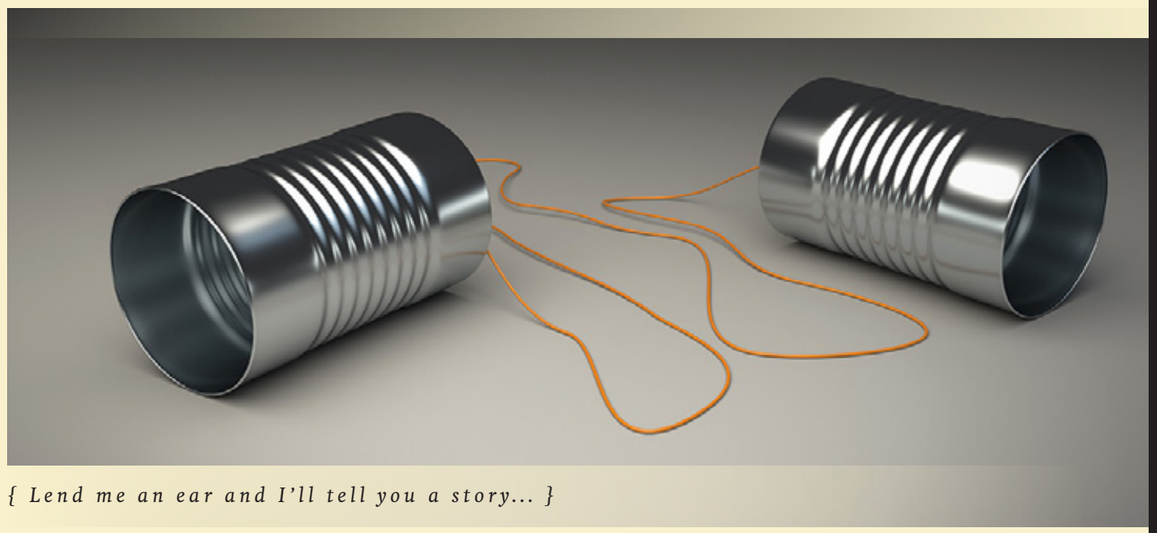
TABLE 23: PERSONNEL COST BY PROGRAMME (UNIT)

Programme (Unit)	Total expenditure for the CMS (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees	Average personnel cost per employee (R'000)
Accreditation	5 761	5 366	93.14%	9	596
Benefits Management	4 348	4 162	95.72%	7	595
Complaints Adjudication	4 037	3 951	97.87%	8	494
Compliance & Investigations	4 964	4 522	91.10%	6	754
Financial Supervision	8 036	7 764	96.62%	10	776
Human Resources	5 838	3 101	53.12%	5	620
ICT & KM*	9 859	6 495	65.88%	11	590
Internal Finance	19 574	6 130	31.32%	9	681
Legal Services	12 799	3 204	25.03%	4	801
Office of the Chief Executive & Registrar	11 241	5 784	51.45%	6	964
Office of the Strategist (incl. the Clinical Unit)**	53	-	-	-	-
Research & Monitoring	5 705	5 416	94.93%	8	677
Stakeholder Relations	7 037	5 011	71.21%	11	456
Total	**99 252**	**60 906**	**61.37%**	**94**	**648**

* Information & Communication Technology and Knowledge Management
** The Office of the Strategist, which includes the Clinical Unit, has been incorporated into the Office of the Chief Executive & Registrar for the reporting period.

TABLE 24: PERSONNEL COST BY SALARY BAND

Level	Personnel expenditure (R'000)	% of personnel expenditure to total personnel cost	Number of employees	Average personnel cost per employee (R'000)
Top management	1 707	2.80%	1	1 707
Senior management	13 274	21.79%	10	1 327
Professionals	22 057	36.21%	28	788
Skilled labour	18 144	29.79%	37	490
Semi-skilled labour	5 724	9.40%	18	318
Unskilled labour	N/A	N/A	N/A	N/A
Total	**60 906**	**100%**	**94**	**648**



{ Lend me an ear and I'll tell you a story... }

TABLE 25: PERFORMANCE REWARDS

Level	Performance rewards (R'000)	Personnel expenditure (R'000)	% of performance rewards to total personnel cost
Top management	183	1 707	10.72%
Senior management	938	13 274	7.07%
Professionals	1 845	22 057	8.36%
Skilled labour	1 334	18 144	7.35%
Semi-skilled labour	429	5 724	7.49%
Unskilled labour	N/A	N/A	N/A
Total	**4 729**	**60 906**	**7.76%**

TABLE 26: TRAINING COSTS

Programme (Unit)	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel cost	Number of employees trained	Average training cost per employee
Accreditation	5 366	42	0.78%	6	6 958
Benefits Management	4 162	147	3.53%	5	29 381
Complaints Adjudication	3 951	45	1.14%	6	7 559
Compliance & Investigations	4 522	98	2.17%	6	16 311
Financial Supervision	7 764	198	2.55%	10	19 825
Human Resources	3 101	167	5.39%	4	41 814
ICT & KM*	6 495	96	1.48%	8	11 942
Internal Finance	6 130	340	5.55%	8	42 580
Legal Services	3 204	75	2.34%	4	18 704
Office of the Chief Executive & Registrar	5 784	252	4.36%	6	41 920
Office of the Strategist (incl. the Clinical Unit)**	-	-	-	-	-
Research & Monitoring	5 416	130	2.40%	7	18 671
Stakeholder Relations	5 011	120	2.39%	8	14 944
Total	**60 906**	**1 710**	**2.81%**	**78**	**21 925**

* Information & Communication Technology and Knowledge Management
** The Office of the Strategist, which includes the Clinical Unit, has been incorporated into the Office of the Chief Executive & Registrar for the reporting period.

TABLE 27: EMPLOYMENT & VACANCIES BY PROGRAMME (UNIT)

Programme (Unit)	2011/2012 number of employees	2012/2013 approved posts	2012/2013 number of employees	2012/2013 vacancies	% of vacancies
Accreditation	9	0	9	1	9.09%
Benefits Management	7	1	7	1	9.09%
Complaints Adjudication	8	0	8	1	9.09%
Compliance & Investigations	6	0	6	0	-
Financial Supervision	9	0	10	2	18.18%
Human Resources	5	0	5	0	-
ICT & KM	10	0	11	0	-
Internal Finance	9	0	9	0	-
Legal Services	4	1	4	1	9.09%
Office of the Chief Executive & Registrar	2	0	2	0	-
Office of the Strategist (incl. the Clinical Unit)	6	0	4	2	18.18%
Research & Monitoring	8	0	8	1	9.09%
Stakeholder Relations	9	2	11	2	18.18%
Total	**92**	**4**	**94**	**11**	**100%**

TABLE 28: EMPLOYMENT & VACANCIES BY LEVEL

Programme (level)	2011/2012 number of employees	2012/2013 approved posts	2012/2013 number of employees	2012/2013 vacancies	% of vacancies
Top management	1	0	1	0	-
Senior management	10	1	10	2	18.18%
Professionals	29	1	28	2	18.18%
Skilled labour	35	1	37	6	54.55%
Semi-skilled labour	17	1	18	1	9.09%
Unskilled labour	N/A	N/A	N/A	N/A	N/A
Total	**92**	**4**	**94**	**11**	**100%**

Council approved the newly created positions of Marketing Analyst, Legal Advisor, Executive Assistant & Administrator as well as Head of Stakeholder Relations in the period under review.

Vacancies within the CMS were the result of resignations and ill health.

TABLE 29: EMPLOYMENT CHANGES

Salary band	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	1	0	0	1
Senior management	10	1	1	10
Professionals	29	1	2	28
Skilled labour	35	5	1	37
Semi-skilled labour	17	1	0	18
Unskilled labour	N/A	N/A	N/A	N/A
Total	**92**	**8**	**4**	**94**

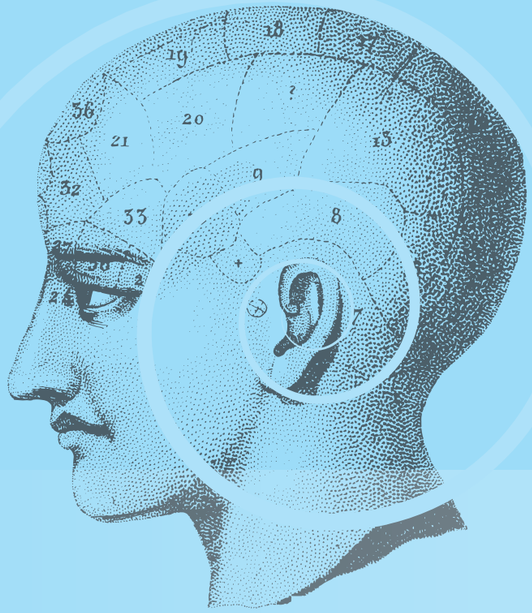
At the beginning of 2012/2013, 11 positions were approved. Eight of these were filled in the year under review. Four new positions were created in the reporting period, three of which were filled.

TABLE 30: REASONS FOR STAFF LEAVING

Reason	Number of employees	% of total number of staff leaving
Death	0	-
Resignation	3	75%
Dismissal	0	-
Retirement	0	-
Ill health	1	25%
Expiry of contract	0	-
Other	0	-
Total	4	100%

TABLE 31: LABOUR RELATIONS: MISCONDUCT & DISCIPLINARY ACTION

Nature of disciplinary action	Number of occurrences
Verbal warning	0
Written warning	1
Final written warning	0
Dismissal	0
Total	1



Sound advice.

TABLE 32: EQUITY TARGET & EMPLOYMENT EQUITY STATUS

In addition to the current workforce profile, the CMS plans to increase its personnel with additional numbers indicated under the target columns below.

Level	Male							
	African		Coloured		Indian		White	
	Current	Target	Current	Target	Current	Target	Current	Target
Top management	1	+1	0	-	0	-	0	-
Senior management	2	+1	0	-	1	-	4	-
Professionals	8	-	0	+1	0	+1	5	-
Skilled labour	8	-	2	-	1	-	1	-
Semi-skilled labour	1	-	0	-	0	-	0	-
Unskilled labour	0	-	0	-	0	-	0	-
Total	20	2	2	1	2	1	10	-

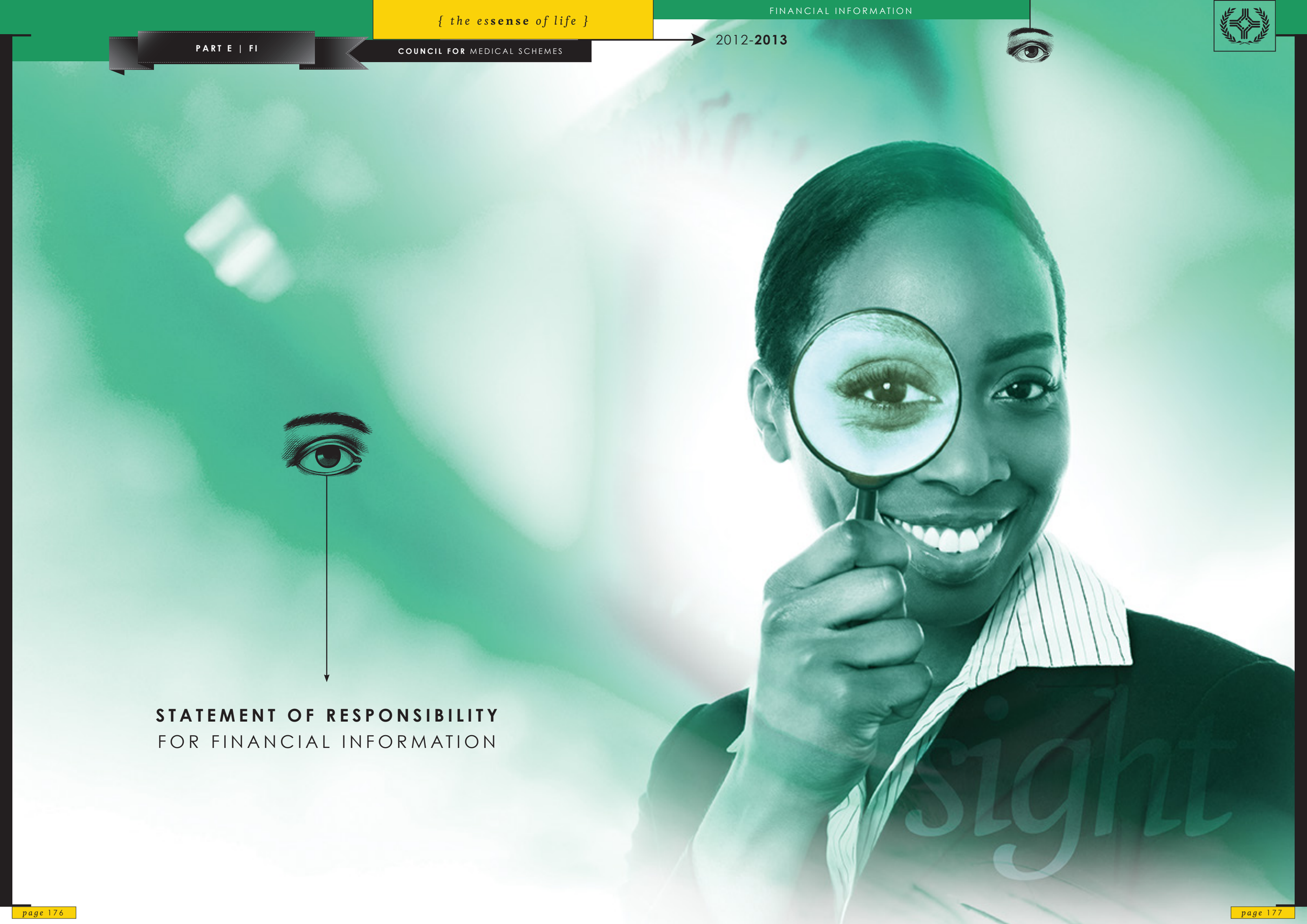
Level	Female							
	African		Coloured		Indian		White	
	Current	Target	Current	Target	Current	Target	Current	Target
Top management	0	-	0	-	0	-	0	-
Senior management	2	-	0	-	0	-	1	-
Professionals	6	-	2	-	1	-	6	+1
Skilled labour	17	+2	1	+1	1	-	6	+2
Semi-skilled labour	15	-	2	-	0	-	0	-
Unskilled labour	0	-	0	-	0	-	0	-
Total	40	2	5	1	2	-	13	3

Level	Disabled staff			
	Male		Female	
	Current	Target	Current	Target
Top management	0	-	0	-
Senior management	0	-	0	+1
Professionals	0	+1	0	-
Skilled labour	1	-	0	+1
Semi-skilled labour	0	-	0	-
Unskilled labour	0	-	0	-
Total	1	1	0	2

FINANCIAL INFORMATION

*"**Never lose sight** of the fact that the most important yardstick of your success will be how you treat other people - your family, friends, and co-workers, and even strangers you meet along the way."*

Barbara Bush



STATEMENT OF RESPONSIBILITY
FOR FINANCIAL INFORMATION

STATEMENT OF RESPONSIBILITY FOR FINANCIAL INFORMATION

Statement of responsibility for the Annual Financial Statements of the Council for Medical Schemes for the financial year ended 31 March 2013

The Accounting Authority (Council) is responsible for the preparation of the Annual Financial Statements of the Council for Medical Schemes (CMS), and for the judgements made in this information.

The Accounting Authority is also responsible for establishing and implementing a system of internal control designed to provide reasonable assurance as to the integrity and reliability of the Annual Financial Statements.

In our opinion, the Annual Financial Statements fairly reflect the operations of the CMS for the financial year ended 31 March 2013.

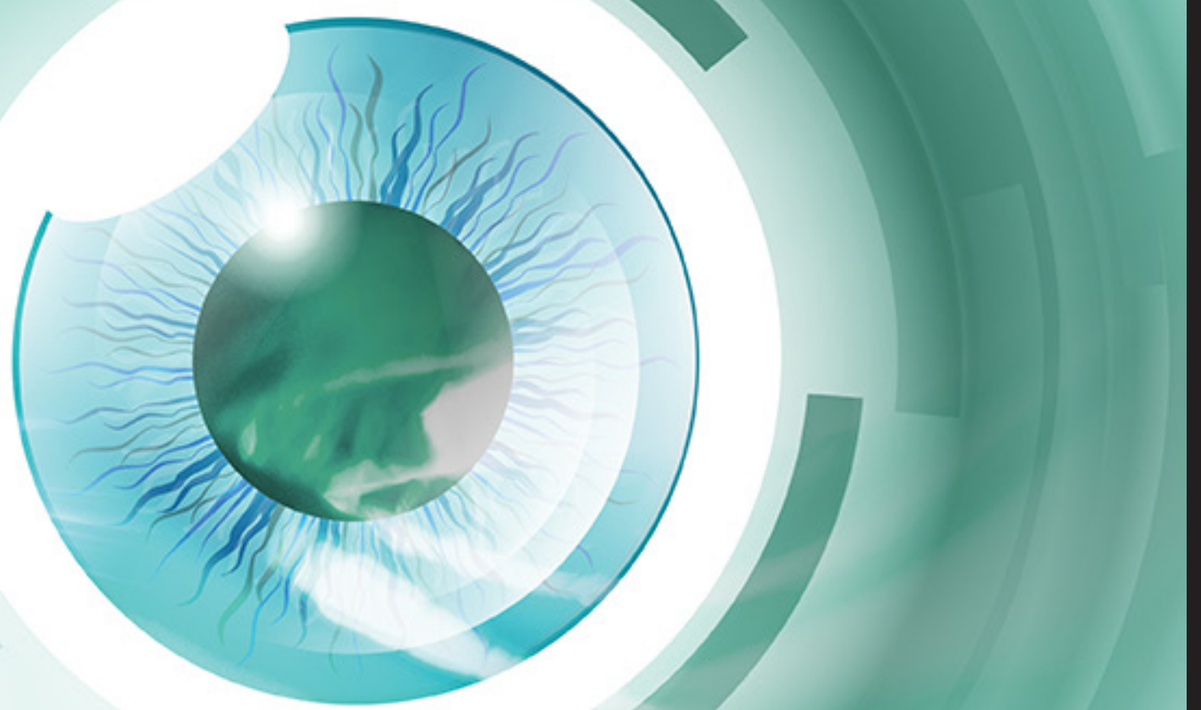
The Annual Financial Statements of the CMS for the financial year ended 31 March 2013 have been audited by the external auditors (the Auditor-General of South Africa); their report is presented on pages 186-191.

The Annual Financial Statements of the CMS, as set out on pages 192-222, have been approved.

Prof. Yosuf Veriava
Chairperson of Council
Council for Medical Schemes
31 July 2013

Dr Monwabisi Gantsho
Chief Executive & Registrar
Council for Medical Schemes
31 July 2013

"Circumstances may cause interruptions and delays, but never lose **sight** *of your goal."*
Mario Andretti



REPORT OF THE CHIEF EXECUTIVE & REGISTRAR

REPORT OF THE CHIEF EXECUTIVE & REGISTRAR

The Council for Medical Schemes (CMS) is proud of the fact that it continues to receive unqualified audit opinions in successive years from the Auditor-General of South Africa (AGSA). This is primarily because of the internal controls that have been put in place over the years. These internal controls apply to every person in the organisation without exception and are reviewed from time to time.

A general financial review of the CMS follows.

Revenue

The operations of the CMS are funded by revenue from exchange transactions and government transfers.

The main source of revenue is the levies on medical schemes collected in terms of the Council for Medical Schemes Levies Act 58 of 2000.

Revenue from exchange transactions

Revenue from exchange transactions is primarily comprised of levies income, registration fees, accreditation fees, appeal fees, as well as legal fees recovered.

During the financial year under review, the revenue from exchange transactions increased from R89.4 million to R97.9 million.

The levies income increased from R76.5 million to R90.7 million.

Government grants

During the financial year under review, the CMS received government grants amounting to R4.3 million (2011-2012: R4.2 million). Included is an amount regarding a mandatory grant received from the Department of Higher Education & Training from the Skills Development Levy.

Expenses

Expenditure of the CMS increased to R99.2 million from R89.7 million in the previous financial year, representing an increase of 11.0%. The employment cost increased by 18.0% as a result of an average salary increase and new vacancies.

In the year under review the CMS experienced a sharp increase in its legal fees expenditure. This is attributed to the many challenges the CMS faces from the industry. But the CMS emerges victorious in most of these matters, with costs awarded by the courts for legal expenses incurred by the CMS.

Assets

Limited replacement was done for property, plant, and equipment, and the decrease in net assets is therefore due to the depreciation for the year. The intangible assets increased.

For the period under review, assets were revalued, thereby increasing accumulated surplus, and thus the balance of the carrying value of assets was restated.

At year-end, the work in progress regarding the lease hold improvements was classified as a non-current asset after deliberation with National Treasury regarding the liability.

A major portion of current assets is comprised of cost and cash equivalents.

The cash balance increased to R16.9 million from R11.0 million in the previous financial year mainly due to the savings in cost in the year under review. The savings will be utilised for the tenant installation cost at the newly leased premises, payable in the new financial year.

Liabilities

Non-current liabilities include the operating lease payments of the previous office building, accounted for lease instalments on the straight-line basis.

Payables from exchange transactions consist primarily of trade payables, income received in advance, and accruals, including an accrual for leave pay. Included is the amount payable regarding the tenant installation at the new offices.

Capacity constraints and challenges

The CMS experiences capacity constraints; it is not able to employ new staff members to deliver on the objectives because of the limited budget.

One of the challenges experienced by the CMS is the legal matters which often take a long time to resolve in courts and thus result in high legal expenses.

Requests for rollover of funds

At the end of the financial year the CMS had surplus funds of about R16.0 million. The CMS applied for the retention of the cash amount of R11.0 million in order to meet operational requirements.

Supply chain management

During the reporting period, monthly supply chain management reports were submitted to National Treasury, as required.

The CMS adjudicated over two tenders in the period under review, namely for the lease of office accommodation and the provision of internal audit services.

The CMS will have relocated to new buildings in Centurion during the 2013-2014 financial year.

The CMS keeps abreast of developments in the area of financial management as it relates to accounting standards and requirements of the Public Finance Management Act 1 of 1999 (PFMA).

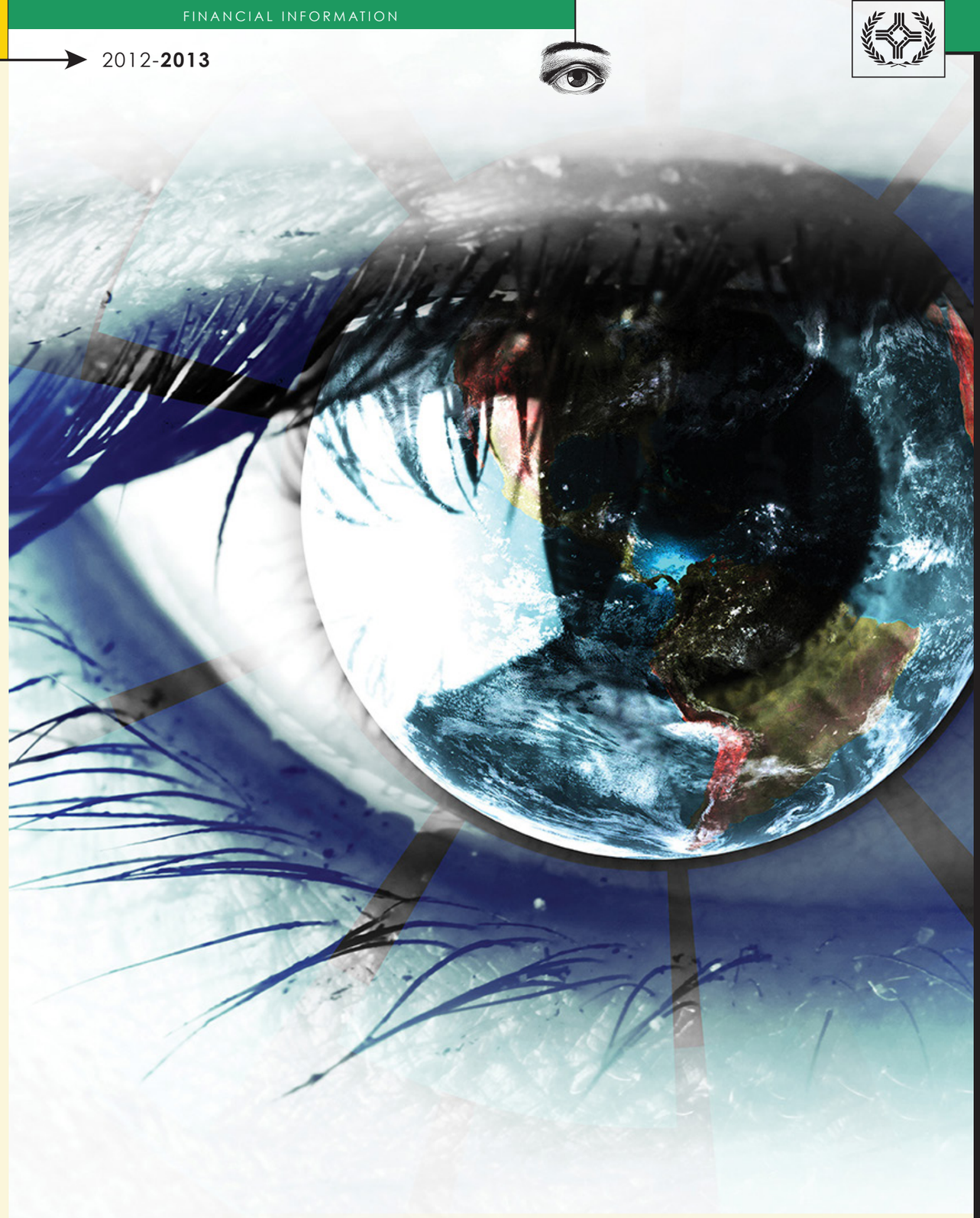
Audit report matters from the previous year

Matters reported on in the previous Annual Report have been followed up and although every effort was made to resolve the previous year's audit findings, not all the audit findings were resolved.

Appreciation

I wish to express my sincere appreciation to Council and all employees of the CMS for the sterling work they performed during the period under review.

Dr Monwabisi Gantsho
Chief Executive & Registrar
Council for Medical Schemes
31 July 2013



REPORT OF THE AUDITOR-GENERAL
TO PARLIAMENT
ON THE COUNCIL FOR MEDICAL SCHEMES

REPORT OF THE AUDITOR-GENERAL TO PARLIAMENT ON THE COUNCIL FOR MEDICAL SCHEMES

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 194 to 222, which comprise the statement of financial position as at 31 March 2013, the statement of financial performance, statement of changes in net assets and the cash flow statement for the year then ended, and the notes comprising a summary of significant accounting policies and other explanatory information.

Accounting authority's responsibility for the financial statements

2. The accounting authority is responsible for the preparation and fair presentation of these financial statements in accordance with South African Standards of Generally Recognised Accounting Practice (SA Standards of GRAP) and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA), and for such internal control as the accounting authority determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-General's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the General Notice issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2013, and its financial performance and cash flows for the year then ended in accordance with SA Standards of GRAP and the requirements of the PFMA.

Emphasis of matter

7. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Restatement of corresponding figures

8. As disclosed in note 10.2 to the financial statements, the corresponding figures for 31 March 2012 have been restated as a result of an error discovered during the current year in the financial statements of the council.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

9. In accordance with the PAA and the General Notice issued in terms thereof, I report the following findings relevant to performance against predetermined objectives, compliance with laws and regulations and internal control, but not for the purpose of expressing an opinion.

Predetermined objectives

10. I performed procedures to obtain evidence about the usefulness and reliability of the information in the annual performance report, as set out on pages 96 to 138 of the annual report.

11. The reported performance against predetermined objectives was evaluated against the overall criteria of usefulness and reliability. The usefulness of information in the annual performance report relates to whether it is presented in accordance with the National Treasury annual reporting principles and whether the reported performance is consistent with the planned objectives. The usefulness of information further relates to whether indicators and targets are measurable (i.e. well defined, verifiable, specific, measurable and time bound) and relevant, as required by the National Treasury Framework for managing programme performance information.

12. The reliability of the information in respect of the selected programmes is assessed to determine whether it adequately reflects the facts (i.e. whether it is valid, accurate and complete).

13. There were no material findings on the annual performance report concerning the usefulness and reliability of the information.

Additional matter

14. Although no material findings concerning the usefulness and reliability of the performance information were identified in the annual performance report, I draw attention to the following matter.

Material adjustments to the annual performance information report

15. Material misstatements in the annual performance report were identified during the audit, all of which were corrected by management.

Compliance with laws and regulations

16. I performed procedures to obtain evidence that the entity has complied with applicable laws and regulations regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key applicable laws and regulations, as set out in the *General Notice* issued in terms of the PAA, are as follows:

Annual financial statements, annual and performance reports

17. The financial statements submitted for auditing were not prepared in accordance with the prescribed financial reporting framework, as required by section 55(1)(a) of the PFMA.

    Material misstatements of non-current assets, liabilities, accumulated surplus, expenditure and disclosures identified by the auditors in the submitted financial statements were subsequently corrected, resulting in the financial statements receiving an unqualified audit opinion.

Procurement and contract management

18. The preference point system was not applied in all procurement of goods and services above R30 000 and below R500 000 through the quotation process, as required by section 2(a) of the Preferential Procurement Policy Framework Act and Treasury Regulation 16A6.3(b).

Internal control

19. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with laws and regulations. The matters reported below under the fundamentals of internal control are limited to the significant deficiencies that resulted in the basis for the findings on the annual performance report and the findings on compliance with laws and regulations included in this report.

Financial and performance management

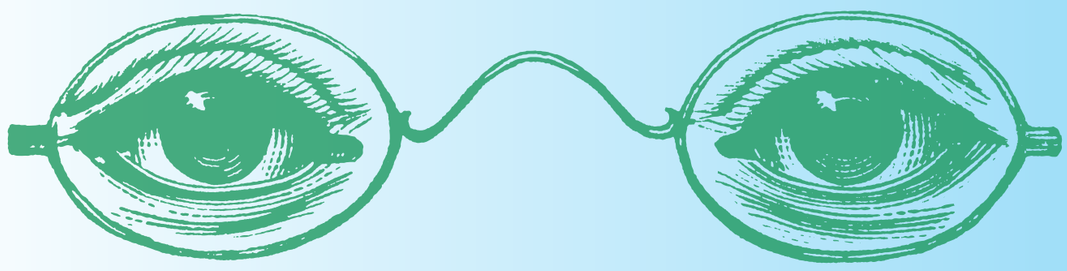
20. The financial statements and the annual performance report were not adequately reviewed to identify and correct any potential non-compliance with the accounting framework.

21. Management did not properly implement the preference points system for procurement of goods and services above R30 000 and below R500 000 through the quotation process due to a misinterpretation of legislation. Compliance monitoring systems did not identify the non-compliance.

Auditor - General

Pretoria
31 July 2013

AUDITOR-GENERAL SOUTH AFRICA
Auditing to build public confidence



ANNUAL FINANCIAL STATEMENTS OF
THE COUNCIL FOR MEDICAL SCHEMES

STATEMENT OF FINANCIAL POSITION
of the Council for Medical Schemes
as at 31 March 2013

	Notes	2013	2012
		R	R
ASSETS			
Current assets		**20 638 943**	**14 641 843**
Receivables from exchange transactions	5	3 737 447	3 621 889
Cash and cash equivalents	6	16 901 496	11 019 954
Non-current assets		**14 665 277**	**8 641 515**
Property, plant and equipment	3	12 285 804	6 147 316
Intangible assets	4	2 379 473	2 494 200
TOTAL ASSETS		**35 304 220**	**23 283 359**
LIABILITIES			
Current liabilities		**19 518 483**	**11 918 471**
Payables from exchange transactions	7	19 451 688	11 570 027
Provisions	8	-	16 360
Operating lease payable	9	66 795	332 084
Non-current liabilities		**-**	**66 795**
Operating lease payable	9	-	66 795
TOTAL LIABILITIES		**19 518 483**	**11 985 266**
NET ASSETS		**15 785 737**	**11 298 092**
NET ASSETS			
Reserves			
Accumulated surplus		15 785 737	11 298 092
TOTAL NET ASSETS		**15 785 737**	**11 298 092**

Prof. Yosuf Veriava
Chairperson of Council
Council for Medical Schemes
31 July 2013

STATEMENT OF FINANCIAL PERFORMANCE
of the Council for Medical Schemes
for the year ending 31 March 2013

	Notes	2013	2012
		R	R
Income		**102 282 273**	**93 725 539**
Revenue from exchange transactions	11.1	97 941 704	89 433 315
Revenue from non-exchange transactions	11.2	4 340 569	4 292 224
Expenditure		**99 251 917**	**89 749 533**
Administrative expenses	12	9 706 744	9 948 897
Audit fees	13	1 678 369	1 368 770
Operating expenses	14	19 250 209	19 848 233
Staff cost	15	65 813 728	56 138 761
Depreciation	3	1 861 056	1 653 020
Amortisation	4	941 811	791 852
Operating surplus for the year		**3 030 356**	**3 976 006**
Gain on disposal of assets		17 482	66 822
Interest received		1 439 807	841 379
Surplus for the year		**4 487 645**	**4 884 207**

STATEMENT OF CHANGES IN NET ASSETS
of the Council for Medical Schemes
for the year ending 31 March 2013

	Notes	2013	2012
		R	R
Restated accumulated surplus as at 1 April 2012	10	**11 298 092**	**6 413 885**
Surplus for the year		4 487 645	4 884 207
Accumulated surplus as at 31 March 2013		**15 785 737**	**11 298 092**

CASH FLOW STATEMENT
of the Council for Medical Schemes
for the year ending 31 March 2013

	Notes	2013	2012
		R	R
Cash flows from operating activities			
Cash receipts from customers		102 166 715	91 632 928
Cash receipts from debtors		97 826 146	87 340 704
Cash receipts from transfers		4 340 569	4 292 224
Cash paid to suppliers and employees		(88 915 834)	(86 858 426)
Cash generated from operations	17	13 250 881	4 774 502
Interest received		1 439 807	841 379
Net cash flow from / (used in) operating activities		**14 690 688**	**5 615 881**
Cash flows from investing activities			
Acquisition of property, plant and equipment	3	(8 030 567)	(1 206 487)
Acquisition of intangible assets	4	(827 084)	(428 257)
Proceeds from sale of equipment		48 505	107 037
Net cash flow from / (used in) investing activities		**(8 809 146)**	**(1 527 707)**
Net increase in cash and cash equivalents		**5 881 542**	**4 088 174**
Cash and cash equivalents at the beginning of the year		11 019 954	6 931 780
Cash and cash equivalents at the end of the year		**16 901 496**	**11 019 954**

ACCOUNTING POLICIES
of the Council for Medical Schemes
for the year ending 31 March 2013

1. Presentation of Annual Financial Statements

The Annual Financial Statements have been prepared in accordance with the effective Standards of Generally Recognised Accounting Practice (GRAP), including any interpretations, guidelines, and directives issued by the Accounting Standards Board (ASB) in accordance with Section 55 of the Public Finance Management Act 1 of 1999.

Accounting policies for material transactions, events, or conditions not covered by the GRAP reporting framework have been developed in accordance with paragraphs 7, 11, and 12 of GRAP 3 and the hierarchy approved in Directive 5 issued by the Accounting Standards Board.

Assets, liabilities, revenues, and expenses have not been offset except where offsetting is required or permitted by a Standard of GRAP.

These Annual Financial Statements have been prepared on the accrual basis of accounting and are in accordance with historical cost convention unless specified otherwise. They are presented in South African Rand.

These accounting policies are consistent with the previous period. A summary of the significant accounting policies is disclosed below.

1.1 Going concern assumption

These Annual Financial Statements have been prepared on the assumption that the Council for Medical Schemes (CMS) will continue to operate as a going concern for at least the next 12 months.

1.2 Comparative information

When the presentation or classification of items in the Annual Financial Statements is amended, prior period comparative amounts are restated. The nature and reason for the reclassification is disclosed. Where accounting errors have been identified in the current period, the correction is made retrospectively as far as is practicable, and the prior period comparatives are restated accordingly. Where there has been a change in accounting policy in the current period, the adjustment is made retrospectively as far as is practicable, and the prior year comparatives are restated accordingly.

1.3 Significant judgement and sources of estimation uncertainty

In preparing the Annual Financial Statements, management is required to make estimates and assumptions that affect the amounts represented in the Annual Financial Statements and related disclosures. Use of available information and the application of judgement are inherent in the formation of estimates. Actual results in the future could differ from these estimates, which may be material to the Annual Financial Statements. Significant judgements include:

Impairment testing

The recoverable amounts of individual assets have been determined based on the higher of value-in-use calculations and fair values less costs to sell. These calculations require the use of estimates and assumptions.

The CMS reviews and tests the carrying value of assets when events or changes in circumstances suggest that the carrying amount may not be recoverable. If there are indications that impairment may have occurred, estimates are prepared of expected future cash flows for each group of assets.

Useful lives and residual values

The CMS reassesses the useful lives of property, plant and equipment on an annual basis. In reassessing the useful lives of property, plant and equipment, management considers the condition and use of the individual assets to determine the remaining period over which the asset can and will be used.

Management has always considered using the property, plant and equipment over the entire economic life span of the individual assets, and has estimated that the residual values of property, plant and equipment are insignificant.

1.4 Property, plant and equipment

Property, plant and equipment are tangible non-current assets that are held for use in the supply of goods or services or for administrative purposes, and are expected to be used during more than one period.

The cost of an item of property, plant and equipment is recognised as an asset when:
- it is probable that future economic benefits or service potential associated with the item will flow to the CMS; and
- the cost or fair value of the item can be measured reliably.

The cost of an item of property, plant and equipment is the purchase price and other costs attributable to bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended by management. Trade discounts and rebates are deducted in arriving at the cost.

The initial estimate of the costs, if any, of dismantling and removing the item and restoring the site on which it is located is also included in the cost of property, plant and equipment, where the CMS is obligated to incur such expenditure and where the obligation arises as a result of acquiring the asset or using it for purposes other than the production of inventories.

Recognition of costs in the carrying amount of an item of property, plant and equipment ceases when the item is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Subsequent to the initial measurement, property, plant and equipment are depreciated on the straight-line basis over their expected useful lives to their estimated residual values. Assets held under finance leases are depreciated over their expected useful lives on the same basis as owned assets or, where shorter, the term of the relevant lease.

Subsequent to the initial measurement, property, plant and equipment are carried at cost less accumulated depreciation and any accumulated impairment losses.

Depreciation commences when the asset is ready for its intended use. The annual depreciation rates are based on the following estimated average asset lives:

Item	Average useful life
Computer equipment	7 years
Computer software	7 years
Furniture and fittings	14 years
Leasehold improvements	10 years
Motor vehicle	5 years
Other fixed assets	16 years

The residual value, useful life, and depreciation method for each asset are reviewed at the end of each reporting date. If the expectations differ from previous estimates, the change is accounted for as a change in accounting estimate in the statement of financial performance.

The gain or loss arising from the derecognition of an item of property, plant and equipment is determined as the difference between the net disposal proceeds, if any, and the carrying amount of the item. Such difference is recognised in the surplus or deficit when the item is derecognised.

Compensation from third parties for an item of property, plant and equipment that was impaired, lost, or given up is recognised in the surplus or deficit when the compensation becomes receivable.

1.5 Intangible assets

An asset is identified as an intangible asset when it:
- is capable of being separated or divided from the CMS and sold, transferred, licensed, rented, or exchanged, either individually or together with a related contract, asset, or liability; or
- arises from contractual rights or other legal rights, regardless whether those rights are separate or transferable from the CMS, or from other rights and obligations.

An intangible asset is recognised when:
- it is probable that future economic benefits or service potential attributable to the asset will flow to the CMS; and
- the cost or fair value of the asset can be measured reliably.

Intangible assets are initially measured at cost.

Where an intangible asset is acquired at no cost or for a nominal cost, its cost is its fair value as at the date of acquisition.

An intangible asset arising from development (or from the development phase of an internal project) is recognised when:
- it is technically feasible to complete the asset so that it will be available for use or sale;
- there is an intention to complete and use or sell it;
- there is an ability to use or sell it;
- it will generate probable future economic benefits or service potential;
- technical, financial, and other resources are available to complete the development and to use or sell the asset; and
- the expenditure attributable to the asset during its development can be measured reliably.

Subsequent to the initial measurement, intangible assets are carried at cost less any accumulated amortisation and any accumulated impairment losses.

An intangible asset is regarded as having an indefinite useful life when, based on all relevant factors, there is no foreseeable limit to the period over which the asset is expected to generate net cash inflows or service potential. Amortisation is not provided for such intangible assets, but they are tested for impairment annually and whenever there is an indication that the assets may be impaired. For all other intangible assets amortisation is provided on a straight-line basis over their expected useful lives to their estimated residual values.

The amortisation period, residual value (if any), and amortisation method for intangible assets are reviewed at the end of each reporting date. If the expectations differ from previous estimates, the change is accounted for as a change in accounting estimate in the statement of financial performance.

Reassessing the useful life of an intangible asset with a finite useful life after it was classified as indefinite is an indicator that the asset may be impaired. As a result the asset is tested for impairment, and the remaining carrying amount is amortised over its useful life.

Amortisation commences when the asset is ready for its intended use. The annual amortisation rates are based on the following estimated average asset lives:

Item	Average useful life
Acquired software	7 years
Developed software	7 years

Intangible assets are derecognised on disposal, or when no future economic benefits or service potential is expected from their use or disposal.

The gain or loss arising from the derecognition of an intangible asset is determined as the difference between the net disposal proceeds, if any, and the carrying amount of the intangible asset. Such difference is recognised in the surplus or deficit when the intangible asset is derecognised.

1.6 Financial instruments

Initial recognition and measurement

Financial instruments are recognised when the CMS becomes a party to the contractual provisions of the relevant instrument, and are initially measured at fair value. Subsequent to initial recognition, these instruments are measured as set out below.

Receivables

Receivables are stated at amortised cost, which, due to their short-term nature, closely approximates their fair value.

Other receivables

Other receivables consists of prepaid expenses and deposits relating to the provision of electricity and leasing of the premises. These receivables are stated at cost.

Cash and cash equivalents

Cash and cash equivalents comprise cash at the bank and deposits held on call, and are stated at amortised cost, which, due to their short-term nature, closely approximates their fair value.

Payables

Payables are stated at amortised cost, which, due to their short-term nature, closely approximates their fair value.

Financial risk management

(i) Financial risk:

The activities of the CMS expose it to a limited degree of financial risk, including interest rates and credit defaults.

(ii) Interest rate risk:

The income and operating cash flows of the CMS are to a large extent independent of changes in the market interest rate. The CMS invests surplus cash-on-call accounts, and its exposure to interest rate risk is limited by virtue of the limited term that surplus cash is held on call.

(iii) Credit risk:

The CMS is exposed to credit risk, which is the risk that a counterpart will be unable to pay accounts in full when due. There is no significant concentration of credit risk due to a wide spread of debtors that owe amounts to the CMS.

(iv) Liquidity risk:

The CMS is exposed to liquidity risk by virtue of having trade creditors at year-end. Liquidity risk is managed by maintaining sufficient balances on cash and cash equivalents.

(v) Currency risk:

The CMS is exposed to currency risk, which is the risk that arises as a result of changes in exchange rates. The exposure to currency risk is limited by virtue of the limited transactions with suppliers from outside the country.

(vi) Investment risk:

The CMS is exposed to investment risk by virtue of having short-term investments of surplus cash on call and fixed-deposit accounts. The investment risk is limited by virtue of the limited term that surplus cash is held on call and fixed deposit.

1.7 Leases

A lease is classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership. A lease is classified as an operating lease if it does not transfer substantially all the risks and rewards incidental to ownership.

Finance leases

Finance leases are recognised as assets and liabilities in the statement of financial position at amounts equal to the fair value of the leased property or, if lower, the present value of the minimum lease payments. The corresponding liability to the lessor is included in the statement of financial position as a finance lease obligation.

The discount rate used in calculating the present value of the minimum lease payments is the interest rate implicit in the lease.

Lease payments are apportioned between the finance charge and reduction of the outstanding liability. The finance charge is allocated to each period during the lease term so as to produce a constant periodic rate on the remaining balance of the liability.

Assets held under finance leases are depreciated over their expected useful lives on the same basis as owned assets or, where shorter, the term of the relevant lease.

Any contingent rents are expensed in the period in which they are incurred.

The determination of whether an arrangement is or contains a lease is based on the substance of the arrangement at inception date of whether the fulfilment of the arrangement is dependent on the use of a specific asset or assets, or whether the arrangement conveys a right to use the asset. The classification of the lease is determined using GRAP 13 – Leases.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. The difference between the amounts recognised as an expense and the contractual payments is recognised as an operating lease asset or liability.

The aggregate benefit of incentives is recognised as a reduction of rental expense over the lease term on a straight-line basis over the lease term.

Any contingent rent is recognised separately as an expense when paid or payable, and is not straight-lined over the lease term.

1.8 Impairment of non-cash-generating assets

Cash-generating assets are those assets held by the CMS with the primary objective of generating a commercial return. When an asset is deployed in a manner consistent with that adopted by a profit-oriented entity, it generates a commercial return.

Non-cash-generating assets are assets other than cash-generating assets.

Identification

The CMS assesses at each reporting date whether there is any indication that a non-cash-generating asset may be impaired. If any such indication exists, the CMS estimates the recoverable service amount of the asset.

The recoverable service amount is the higher of the fair value of a non-cash-generating asset less costs to sell and its value in use.

When the carrying amount of a non-cash-generating asset exceeds its recoverable service amount, it is impaired.

Irrespective of whether there is any indication of impairment, the CMS also tests a non-cash-generating intangible asset with an indefinite useful life or a non-cash-generating intangible asset not yet available for use for impairment annually by comparing its carrying amount with its recoverable service amount. This impairment test is performed at the same time every year. If an intangible asset was initially recognised during the current reporting period, that intangible asset is tested for impairment before the end of the current reporting period.

Value in use

Value in use of an asset is the present value of the remaining service potential of the asset.

The present value of the remaining service potential of an asset is determined using the depreciated replacement cost approach, whereby the present value of the remaining service potential of a non-cash-generating asset is determined as the depreciated replacement cost of the asset. The replacement cost of an asset is the cost to replace the gross service potential of the asset.
This cost is depreciated to reflect the asset in its used condition. An asset may be replaced either through the reproduction (replication) of the existing asset or through the replacement of its gross service potential. The depreciated replacement cost is measured as the reproduction or replacement cost of the asset, whichever is lower, less accumulated depreciation calculated on the basis of such cost, to reflect the already consumed or expired service potential of the asset.

The replacement cost or reproduction cost of an asset is determined on an "optimised" basis. The rationale is that the CMS would not replace or reproduce the asset with a like asset if the asset to be replaced or reproduced were an overdesigned or overcapacity asset.

Overdesigned assets contain features which are unnecessary for the goods or services the asset provides. Overcapacity assets have a greater capacity than is necessary to meet the demand for goods or services the asset provides.

The determination of the replacement cost or reproduction cost of an asset on an optimised basis thus reflects the service potential required of the asset.

Recognition and measurement

If the recoverable service amount of a non-cash-generating asset is less than its carrying amount, the carrying amount of the asset is reduced to its recoverable service amount. This reduction is an impairment loss.

An impairment loss is recognised immediately in surplus or deficit.

After the recognition of an impairment loss, the depreciation (amortisation) charge for the non-cash-generating asset is adjusted in future periods to allocate the revised carrying amount of the non-cash-generating asset less its residual value (if any) on a systematic basis over its remaining useful life.

Reversal of an impairment loss

The CMS assesses at each reporting date whether there is any indication that an impairment loss recognised in prior periods for a non-cash-generating asset may no longer exist or may have decreased. If any such indication exists, the CMS estimates the recoverable service amount of that asset.

An impairment loss recognised in prior periods for a non-cash-generating asset is reversed if there has been a change in the estimates used to determine the recoverable service amount of that asset since the last impairment loss was recognised.
The carrying amount of the asset is increased to its recoverable service amount. The increase is a reversal of an impairment loss. The increased carrying amount of an asset attributable to a reversal of an impairment loss does not exceed the carrying amount that would have been determined (net of depreciation or amortisation) had no impairment loss been recognised for the asset in prior periods.

A reversal of an impairment loss for a non-cash-generating asset is recognised immediately in surplus or deficit.

After a reversal of an impairment loss is recognised, the depreciation (amortisation) charge for the non-cash-generating asset is adjusted in future periods to allocate the revised carrying amount of the non-cash-generating asset less its residual value (if any) on a systematic basis over its remaining useful life.

1.9 Employee benefits

Short-term employee benefits

The cost of short-term employee benefits (i.e. those payable within 12 months after the service is rendered, such as paid vacation leave and bonuses) is recognised in the period in which the service is rendered and is not discounted.

The expected cost of compensated absences is recognised as an expense because the employees render services that increase their entitlement or, in the case of non-accumulating absences, when the absence occurs.

The expected cost of bonus payments is recognised as an expense when there is a legal or constructive obligation to make such payments as a result of past performance.

Retirement benefits

The CMS contributes to a retirement fund.
The retirement fund is a defined contribution plan. Contributions in terms of defined contribution plans are charged against income as incurred.

1.10 Provisions and contingencies

Provisions are recognised when:
- the CMS has a present obligation as a result of a past event;
- it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; and
- a reliable estimate can be made of the obligation.

The amount of a provision is the best estimate of the expenditure expected to be required to settle the present obligation at the reporting date.

Where the effect of time value of money is material, the amount of a provision is the present value of the expenditure expected to be required to settle the obligation.

The discount rate is a rate that reflects current market assessments of the time value of money and the risks specific to the liability.

Where some or all of the expenditure required to settle a provision is expected to be reimbursed by another party, the reimbursement is recognised when, and only when, it is virtually certain that reimbursement will be received if the CMS settles the obligation. The reimbursement is treated as a separate asset. The amount recognised for the reimbursement does not exceed the amount of the provision.

Provisions are reviewed at each reporting date and adjusted to reflect the current best estimate. Provisions are reversed if it is no longer probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation.

Where discounting is used, the carrying amount of a provision increases in each period to reflect the passage of time. This increase is recognised as an interest expense.

A provision is used only for expenditures for which the provision was originally recognised.

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed (in note 22) unless the possibility of an inflow / outflow of resources embodying economic benefits is remote.

1.11 Revenue from exchange transactions

Exchange transactions are transactions in which one entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value (primarily in the form of cash, goods, services, or use of assets) to another entity in exchange.

Measurement

Revenue is measured at the fair value of the consideration received or receivable, net of trade discounts, and volume rebates.

Rendering of services

When the outcome of a transaction involving the rendering of services can be estimated reliably, revenue associated with the transaction is recognised by reference to the stage of completion of the transaction at the reporting date. The outcome of a transaction can be estimated reliably when all the following conditions are satisfied:
- the amount of revenue can be measured reliably;
- it is probable that the economic benefits or service potential associated with the transaction will flow to the CMS;
- the stage of completion of the transaction at the reporting date can be measured reliably; and
- the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

When the outcome of a transaction involving the rendering of services cannot be estimated reliably, revenue is recognised only to the extent of the expenses recognised that are recoverable.

Service revenue is recognised by reference to the stage of completion of the transaction at the reporting date. Stage of completion is determined by services performed to date as a percentage of total services to be performed.

1.12 Revenue from non-exchange transactions

Non-exchange transactions are transactions that are not exchange transactions. In a non-exchange transaction, an entity either receives value from another entity without directly giving approximately equal value in exchange, or gives value to another entity without directly receiving approximately equal value in exchange.

Recognition

An inflow of resources from a non-exchange transaction recognised as an asset is recognised as revenue, except to the extent that a liability is also recognised in respect of the same inflow.

As the CMS satisfies a present obligation recognised as a liability in respect of an inflow of resources from a non-exchange transaction recognised as an asset, it reduces the carrying amount of the liability recognised and recognises an amount of revenue equal to that reduction.

Measurement

Revenue from a non-exchange transaction is measured at the amount of the increase in net assets recognised by the CMS.

When, as a result of a non-exchange transaction, the CMS recognises an asset, it also recognises revenue equivalent to the amount of the asset measured at its fair value as at the date of acquisition, unless it is also required to recognise a liability. Where a liability is required to be recognised, it will be measured as the best estimate of the amount required to settle the obligation at the reporting date and the amount of the increase in net assets, if any, recognised as revenue. When a liability is subsequently reduced, because a taxable event occurs or a condition is satisfied, the amount of the reduction in the liability is recognised as revenue.

1.13 Conditional transfer and receipts

Revenue received from a conditional transfer, donations, and funding are recognised as revenue to the extent that the CMS has complied with any of the conditions embodied in the agreement. To the extent that the conditions have not been met, a liability is recognised.

1.14 Interest income

Interest income is accrued on a time-proportioned basis, taking into account the principal outstanding and the effective interest rate over the period to maturity.

1.15 Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

1.16 Unauthorised expenditure

Unauthorised expenditure is expenditure that has not been budgeted for, expenditure that is not in terms of the conditions of an allocation received from another sphere of government, entity, or organ of state, and expenditure in the form of a grant that is not permitted in terms of the Public Finance Management Act 1 of 1999.

All expenditure relating to unauthorised expenditure is recognised as an expense in the statement of financial performance in the period in which the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and, where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

1.17 Irregular expenditure

Irregular expenditure, as defined in Section 1 of the Public Finance Management Act 1 of 1999, is expenditure other than unauthorised expenditure, incurred in contravention of or not in accordance with a requirement of any applicable legislation, including:

(a) the Public Finance Management Act 1 of 1999;
(b) the State Tender Board Act 86 of 1968, or any of its Regulations; and
(c) the supply chain management policy of the CMS.

All expenditure relating to irregular expenditure is recognised as an expense in the statement of financial performance in the period in which the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and, where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

1.18 Fruitless and wasteful expenditure

Fruitless expenditure is expenditure that was made in vain and that would have been avoided had reasonable care been exercised.

All expenditure relating to fruitless and wasteful expenditure is recognised as an expense in the statement of financial performance in the period in which the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and, where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

1.19 Budget information

The CMS is subject to budgetary limits in the form of appropriations or budget authorisations (or the equivalent), which are given effect through authorising legislation, appropriation, or similar authorisations. A reconciliation between budget and actual information has been included in the notes to the Annual Financial Statements, and both are prepared on the same basis of accounting (refer to note 23 - *Reconciliation from budget to actual information*).

1.20 Related parties

The CMS, an autonomous regulatory authority, operates in an economic sector which is dominated by entities directly or indirectly owned by the South African government. As a consequence of the constitutional independence of the three spheres of government in South Africa, only entities within the national sphere of government are considered to be related parties.

Management is defined as individuals with the authority and responsibility for planning, directing, and controlling the activities of the CMS, including those charged with the governance of the CMS in accordance with applicable legislation in instances where they are required to perform such functions. The CMS regards all individuals at senior management level as key management per the definition of the financial reporting standard.

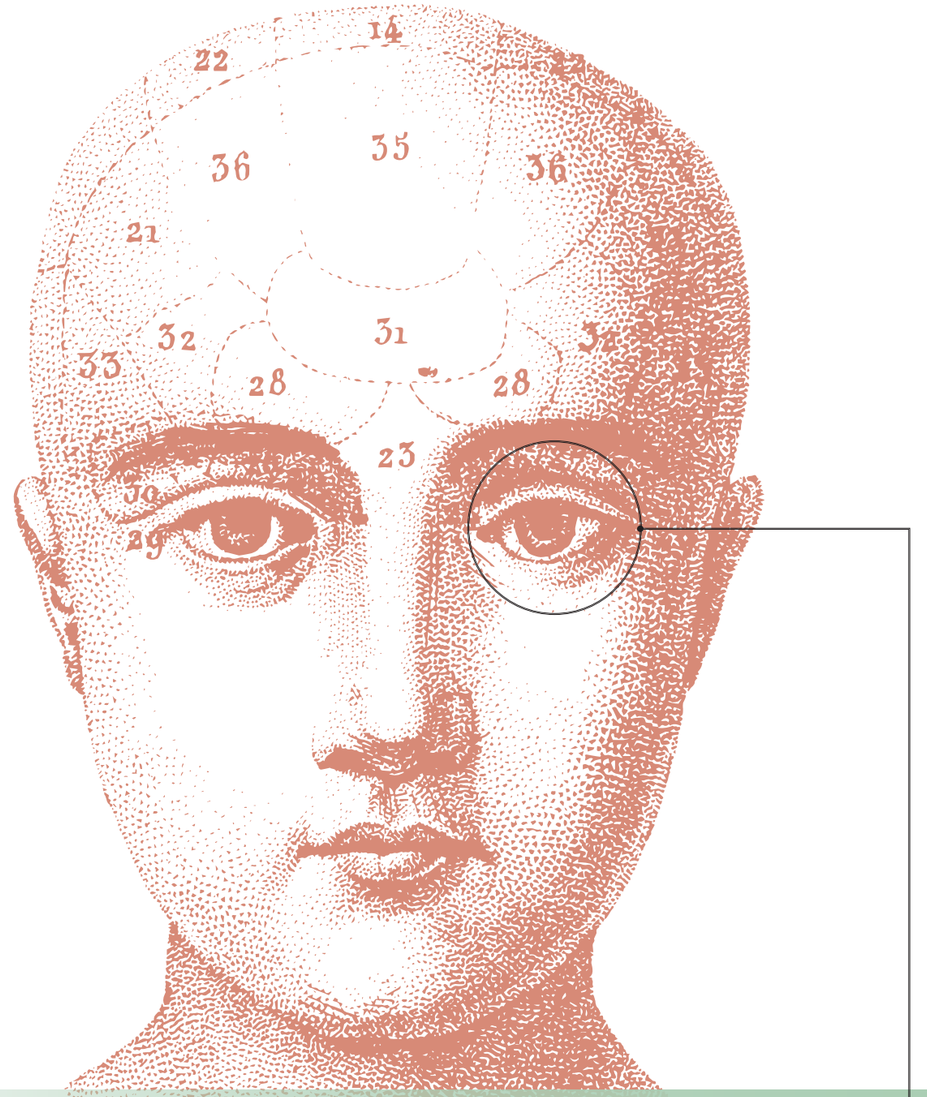
Close family members of key management personnel are those family members who may be expected to influence, or be influenced by, key management in their dealings with the CMS.

Only transactions with related parties which are not at arm's length or not in the ordinary course of business are disclosed.

Related party disclosure for transactions between government entities which took place on terms and conditions that are considered at arm's length is not required in accordance with IPSAS 20, *Related Party Disclosure*.

1.21 Research costs

Research costs relate to work performed by the Research & Monitoring Unit (R&M) of the CMS. The objective of R&M is to monitor the impact of the Medical Schemes Act 131 of 1998, research developments, and recommend policy options to improve the regulatory environment. Research expenditure is recognised as an expense in the financial period in which it was incurred.



NOTES TO THE FINANCIAL STATEMENTS
of the Council for Medical Schemes
for the year ending 31 March 2013

2. New standards and interpretations

Standards not applicable to the operations of the CMS

The following Standards of GRAP have been approved by the Minister of Finance but are not applicable to the operations of the CMS:

Standard
GRAP 6 - Consolidated and separate financial statements
GRAP 7 - Investments in associates
GRAP 8 - Interests in joint ventures
GRAP 10 - Financial reporting in hyperinflationary economies
GRAP 11 - Construction contracts
GRAP 12 - Inventories
GRAP 16 - Investment property
GRAP 26 - Impairment of cash-generating assets
GRAP 100 - Non-current assets held for sale and discontinued operations
GRAP 101 - Agriculture
GRAP 103 - Heritage assets

Improvement to the Standards of GRAP

Improvements have been made to the following Standards of GRAP: GRAP 1-4, 9-14, 16-17, 19, and 100 as part of the improvement project of the Accounting Standards Board.

The adoption of the amendments to the Standards of GRAP and various interpretations of the Standards of GRAP will not have a significant effect on the financial statements of the CMS.

Standards and interpretations issued but not yet effective

The CMS has not applied the following Standards and interpretations, which have been published and are mandatory for the accounting periods beginning on or after 1 April 2012:

Standard	Topic	Summary and impact	Effective date
GRAP 18	Segment reporting	This Standard establishes principles for reporting financial information by segments. This Standard will not be implemented, as the CMS has only one segment.	ASB issued date: March 2005 Effective date: to be determined
GRAP 25	Employee benefits	This Standard prescribes the accounting treatment and disclosure for employee benefits. The impact on the financial results and disclosure is considered to be minimal.	ASB issued date: November 2009 Effective date: 1 April 2013
GRAP 105	Transfer of functions between entities under common control	This Standard establishes accounting principles for the acquirer and transferor in a transfer of functions between entities under common control. This Standard will not be applicable, and therefore it will have no impact on the CMS.	ASB issued date: November 2010 Effective date: to be determined
GRAP 106	Transfer of functions between entities not under common control	This Standard establishes accounting principles for the acquirer in a transfer of functions between entities not under common control. This Standard will not be applicable, and therefore it will have no impact on the CMS.	ASB issued date: November 2010 Effective date: to be determined
GRAP 107	Mergers	This Standard establishes accounting principles for the combining and combined entities in a merger. This Standard will not be applicable, and therefore it will have no impact on the CMS.	ASB issued date: November 2010 Effective date: to be determined

3. Property, plant and equipment

	Notes	Computer equipment	Computer software	Leasehold improvements WIP*	Furniture and fittings	Motor vehicle	Other fixed assets	TOTAL
		R	R	R	R	R	R	R
For the year ending 31 March 2013								
Opening net book amount as at 1 April 2012		2 617 520	955 263	-	2 026 336	213 482	334 715	6 147 316
Cost		6 583 803	2 233 288	-	3 876 729	221 871	582 231	13 497 922
Accumulated depreciation		(3 966 283)	(1 278 025)	-	(1 850 393)	(8 389)	(247 516)	(7 350 606)
Additions for the year		428 613	3 330	7 421 064	96 296	-	81 264	8 030 567
Disposals at net book value		(10 098)	-	-	(20 895)	-	(30)	(31 023)
Depreciation charge		(865 980)	(284 762)	-	(571 508)	(44 374)	(94 432)	(1 861 056)
Closing net carrying amount as at 31 March 2013		2 170 055	673 831	7 421 064	1 530 229	169 108	321 517	12 285 804
Closing net carrying amount as at 31 March 2013		2 170 055	673 831	7 421 064	1 530 229	169 108	321 517	12 285 804
Cost		6 547 918	2 236 618	7 421 064	3 873 259	221 871	661 914	20 962 644
Accumulated depreciation		(4 377 863)	(1 562 787)	-	(2 343 030)	(52 763)	(340 397)	(8 676 840)
Carrying amount of fully depreciated property, plant and equipment still in use		-	-	-	-	-	-	-
Cost of fully depreciated property, plant and equipment still in use		-	-	-	-	-	-	-
Accumulated depreciation		-	-	-	-	-	-	-

* Work In Progress

	Notes	Computer equipment	Computer software	Leasehold improvements WIP*	Furniture and fittings	Motor vehicle	Other fixed assets	TOTAL
For the year ending 31 March 2012								
Opening net book amount as at 1 April 2011		2 867 038	1 374 630	-	2 030 745	-	361 650	6 634 063
Cost		6 366 204	2 204 788	-	3 624 896	139 885	552 393	12 888 166
Useful life re-estimation prior to 1 April 2011	10	1 532 882	539 422	-	324 396	-	16 114	2 412 814
Accumulated depreciation		(5 032 048)	(1 369 580)	-	(1 918 547)	(139 885)	(206 857)	(8 666 917)
Additions for the year		567 767	28 500	-	358 510	221 871	29 839	1 206 487
Disposals at net book value		(25 995)	-	-	(14 219)	-	-	(40 214)
Depreciation charge		(791 290)	(447 867)	-	(348 700)	(8 389)	(56 774)	(1 653 020)
Closing net carrying amount as at 31 March 2012		2 617 520	955 263	-	2 026 336	213 482	334 715	6 147 316
Closing net carrying amount as at 31 March 2012		2 617 520	955 263	-	2 026 336	213 482	334 715	6 147 316
Cost		6 583 803	2 233 288	-	3 876 729	221 871	582 231	13 497 922
Accumulated depreciation		(3 966 283)	(1 278 025)	-	(1 850 393)	(8 389)	(247 516)	(7 350 606)
Carrying amount of fully depreciated property, plant and equipment still in use		-	-	-	-	-	-	-
Cost of fully depreciated property, plant and equipment still in use		-	-	-	-	-	-	-
Accumulated depreciation		-	-	-	-	-	-	-

4. Intangible assets

	Notes	Acquired software	Developed software	TOTAL
		R	R	R
For the year ending 31 March 2013				
Opening net book amount as at 1 April 2012		1 964 744	529 456	2 494 200
Cost		4 760 840	977 157	5 737 997
Accumulated amortisation		(2 796 096)	(447 701)	(3 243 797)
Additions for the year		161 626	665 458	827 084
Disposals at net book value		-	-	-
Amortisation		(681 336)	(260 475)	(941 811)
Closing net carrying amount as at 31 March 2013		1 445 034	934 439	2 379 473
Closing net carrying amount as at 31 March 2013		1 445 034	934 439	2 379 473
Cost		4 922 466	1 642 615	6 565 081
Accumulated amortisation		(3 477 432)	(708 176)	(4 185 608)
Carrying amount of fully amortised intangible assets ready for disposal		-	-	-
Cost of fully amortised intangible assets		-	-	-
Accumulated amortisation		-	-	-

	Notes	Acquired software	Developed software	TOTAL
For the year ending 31 March 2012				
Opening net book amount as at 1 April 2011		2 317 890	539 905	2 857 795
Cost		4 389 190	920 550	5 309 740
Useful life re-estimation prior to 1 April 2011	10	1 899 805	206 064	2 105 869
Accumulated amortisation		(3 971 105)	(586 709)	(4 557 814)
Additions for the year		371 650	56 607	428 257
Disposals at net book value		-	-	-
Amortisation		(724 796)	(67 056)	(791 852)
Closing net carrying amount as at 31 March 2012		1 964 744	529 456	2 494 200
Closing net carrying amount as at 31 March 2012		1 964 744	529 456	2 494 200
Cost		4 760 840	977 157	5 737 997
Accumulated amortisation		(2 796 096)	(447 701)	(3 243 797)
Carrying amount of fully amortised intangible assets ready for disposal		-	-	-
Cost of fully amortised intangible assets		-	-	-
Accumulated amortisation		-	-	-

5. Receivables from exchange transactions

	Notes	2013	2012
		R	R
Financial assets at amortised cost			
Accounts receivable		683 608	411 411
Sundry debtors		2 181 823	2 208 451
Other receivables			
Prepaid expenses		872 016	1 002 027
		3 737 447	**3 621 889**

6. Cash and cash equivalents

Cash and cash equivalents consist of the following:

Financial assets			
Cash and bank		5 710 880	1 019 954
Call account		11 190 616	10 000 000
		16 901 496	**11 019 954**

7. Payables from exchange transactions

Financial assets			
Accounts payable		4 349 365	2 456 556
Accrual for leave pay		1 523 579	1 282 672
Accruals		5 356 303	7 080 239
Accrual for leasehold improvements WIP*		7 421 064	-
Income received in advance		801 377	750 560
		19 451 688	**11 570 027**

Included in *Payables from exchange transactions* is an accrual for leave pay. Employees' entitlement to annual leave is recognised when it accrues to the employees. An accrual is recognised for the estimated liability for annual leave due as a result of services rendered by employees up to reporting date.

Also included in *Payables from exchange transactions* is accrual for performance bonuses. This item has been reclassified from *Provisions* to *Accruals* during the current financial year.

The leasehold improvements WIP* relating to the new office lease was accounted for at year-end. Refer to note 18.2.

* Work In Progress

8. Provisions

	Notes	2013	2012
		R	R
Other		-	16 360
Opening balance		16 360	200 000
Utilisation of provision during the year		-	(200 000)
Provision made during the year		-	16 360
Provision reversed during the year		(16 360)	-
Total		**-**	**16 360**

9. Operating lease payable

Opening balance as at 1 April 2012	398 879	324 522
Movement during the year	(332 084)	74 357
Closing balance as at 31 March 2013	**66 795**	**398 879**
Classified as:		
Current liabilities	66 795	332 084
Non-current liabilities	-	66 795
	66 795	**398 879**

	Notes	2013	2012
		R	R

10. Prior period changes

10.1 Change in classification

During the year the CMS reclassified the operating lease payable from non-current to current. Management is of the opinion that the new classification will result in a fairer presentation of the financial statements. The effect of this change is as follows:

Increase in *Current liabilities*		-	332 084
Decrease in *Non-current liabilities*		-	(332 084)

During the year the CMS reclassified performance bonuses from provisions to accruals. Management is of the opinion that the new classification will result in a fairer presentation of the financial statements, as the existence, amount, and timing of the liability is an absolute certainty. The effect of this change is as follows:

Decrease in *Provisions*		-	(4 071 989)
Increase in *Payables from exchange transactions*		-	4 071 989

During the year the CMS reclassified certain expenses from function to nature. Management is of the opinion that the new classification will result in a fairer presentation of the financial statements. The effect of this change is as follows (on the statement of financial performance):

Decrease in *Administrative expenses*		-	757 190
Increase in *Operating expenses*		-	(757 190)

	Notes	2013	2012
		R	R

10.2 Prior period error

During the year the CMS adjusted the property, plant and equipment, as well as the intangible assets, for the useful life re-estimation.

The effect of the prior period error is as follows:

Accumulated surplus as at 1 April 2011		-	1 895 202
Useful life re-estimation of property, plant and equipment		-	2 412 818
Useful life re-estimation of intangible assets		-	2 105 869
Revised accumulated surplus as at 1 April 2011		-	6 413 889
Accumulated depreciation as at 1 April 2012		-	8 666 917
Useful life re-estimation of property, plant and equipment		-	(2 412 814)
Revised accumulated depreciation as at 1 April 2012		-	6 254 103
Accumulated amortisation as at 1 April 2012		-	4 557 814
Useful life re-estimation of intangible assets		-	(2 105 869)
Revised accumulated amortisation as at 1 April 2012		-	2 451 945
Change in depreciation expense		-	446 692
Change in amortisation expense		-	255 777
Revised surplus for the period 2012		-	4 884 207

11. Revenue

11.1 Revenue from exchange transactions

BUDGET 2013 R	BUDGET 2012 R		Notes	ACTUAL 2013 R	ACTUAL 2012 R
4 700 000	5 500 000	Accreditation fees		5 497 000	5 709 000
-	-	Appeal fees		10 000	20 000
92 687 409	76 575 837	Levies income		90 775 193	76 534 662
400 000	400 000	Registration fees		376 650	371 100
-	-	Sundry income		519 472	392 728
-	-	Legal fees recovered		763 389	6 405 825
97 787 409	**82 475 837**			**97 941 704**	**89 433 315**

11.2 Revenue from non-exchange transactions

-	-	Government transfer - Department of Health		4 310 000	4 194 000
-	-	Mandatory transfer - Department of Higher Education & Training		30 569	98 224
-	**-**			**4 340 569**	**4 292 224**

The CMS received an unconditional transfer from the Department of Health. Council decided to utilise this transfer for the shortfall in legal fees as well as the development of the Single Exit Price (SEP) system for the Department of Health.

12. Administrative expenses

43 134	40 692	Bank charges		39 545	46 124
2 710 015	2 404 216	Building expenses		2 005 050	2 635 740
593 779	609 683	General administrative expenses		690 623	647 551
150 032	139 168	Insurance		176 368	134 995
313 035	335 388	Printing and stationery		279 098	289 065
181 072	172 620	Refreshments		180 552	156 298
5 234 447	4 524 000	Rent		4 484 853	4 487 608
179 840	64 000	Rental - copiers		119 702	-
294 532	143 722	Security		51 604	145 899
95 068	105 860	Subscriptions		80 366	64 402
1 639 300	1 275 604	Telecommunication expenses		1 598 983	1 341 215
11 434 254	**9 814 953**			**9 706 744**	**9 948 897**

13. Audit fees

BUDGET 2013 R	BUDGET 2012 R		Notes	ACTUAL 2013 R	ACTUAL 2012 R
629 542	593 908	Auditors' remuneration - external audit		626 578	752 117
788 212	663 814	Auditors' remuneration - internal audit		1 051 791	616 653
1 417 754	**1 257 722**			**1 678 369**	**1 368 770**

14. Operating expenses

273 945	54 165	Committee remuneration		261 211	80 461
2 760 890	2 927 179	Consulting fees		2 303 159	2 936 447
1 033 295	1 719 616	Council members fees	19.1	2 420 396	1 868 944
160 333	147 790	Courier and postage		167 113	135 057
290 210	455 229	Exhibition cost		302 496	622 972
487 376	419 537	Knowledge management		446 382	383 505
4 793 000	6 220 845	Legal fees		9 304 908	10 388 582
211 544	125 440	Media and promotion		170 976	19 951
542 785	445 800	Printing and publication		470 412	397 185
58 592	83 160	Transcription services		45 657	36 024
2 823 295	2 409 519	Travel and subsistence		2 486 647	2 415 616
1 012 373	732 374	Venue and catering		870 850	563 488
14 447 637	**15 740 655**			**19 250 209**	**19 848 233**

15. Staff cost

1 327 968	1 272 000	Employee benefits		1 349 136	1 234 920
421 159	397 320	Employee wellness		441 881	352 003
718 000	850 000	Recruitment and relocation		580 164	636 762
64 058 366	55 341 193	Salaries		60 905 762	52 409 900
1 998 870	1 939 476	Staff training		1 710 148	1 291 880
354 400	290 000	Temporary staff		208 606	147 520
-	-	Temporary staff - SEP system		478 075	-
200 000	200 000	Workmen's compensation		139 955	65 776
69 078 763	**60 289 989**			**65 813 728**	**56 138 761**
		Total number of employees		94	92

16. Taxation

No provision for taxation is made because the CMS is exempt from income tax in terms of Section 10(1)(cA) of the Income Tax Act 58 of 1962.

17. Reconciliation between net surplus and cash applied to activities

	Notes	2013	2012
		R	R
Operating surplus		4 487 645	4 884 207
Adjusted for:			
Amortisation		941 811	791 852
Depreciation		1 861 056	1 653 020
Interest received		(1 439 807)	(841 379)
(Gain) on disposal of assets		(17 482)	(66 822)
Operating surplus before working capital		5 833 223	6 420 878
(Increase) in accounts receivable		(115 558)	(2 092 611)
Increase in accounts payable		7 482 782	629 875
Increase / (decrease) in accounts provisions		50 435	(183 640)
Cash flows from operating activities		13 250 881	4 774 502

18. Commitments

18.1 Operating leases - photocopier rental

The CMS has an operating lease for the rental of photocopiers up to 30 November 2015, with 0.0% escalation. The terms have been adjusted as the photocopiers were only delivered in October 2012 and not in August 2012 as initially agreed upon.

	Notes	2013	2012
		R	R
Minimum lease payments due			
Not later than one year		239 404	-
Later than one year and not later than five years		359 105	-
		598 509	**-**

18.2 Operating leases - office rental

The CMS had an operating lease for the rental of its office and committed to a new non-cancellable operating lease. The previous operating lease was for 2 489m^2 and the new operating lease is for 3 696m^2, with additional parking, which falls due as follows:

	Notes	2013	2012
		R	R
Minimum lease payments due			
Not later than one year		6 746 559	4 922 447
Later than one year and not later than five years		27 366 772	831 855
Later than five years		50 983 898	-
		85 097 229	**5 754 302**

The CMS entered into a new, renewable 10-year lease agreement, which will commence on 1 June 2013 and terminate on 31 May 2023, and which provides for an escalation of 8.5% per annum. The previous lease agreement will terminate on 31 May 2013; it had provided for an escalation of 9.0% per annum. The CMS also contracted to have the option to purchase the new office building.

19. Related parties

Executive Authority

The Executive Authority, as defined in Section 1 of the Public Finance Management Act 1 of 1999, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.

Accounting Authority

Council, as defined in Section 49 of the Public Finance Management Act 1 of 1999, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.

Executive management

Council members appoint the executive management team which is responsible for executing their decisions.The emolument paid to Council members and the executive management team is shown below:

19.1 Council members - fees for services

	Notes	2013	2012
		R	R
Bailey T		389 277	269 570
Du Plessis DJ		-	62 918
Dumisa BC		278 894	42 398
Fihlani ZL		102 934	8 106
Fortune T		-	173 183
Gwagwa T		-	36 670
Hoosain AK		244 568	152 214
Mjamba B		-	43 788
Morata MO		253 023	48 250
Mpuntsha L		63 690	-
Nevhutalu L		80 288	13 124
Njongwe PZ		-	71 796
Phadu T		174 279	108 080
Pick W		-	212 350
Pillay A*		-	-
Rothberg AD		-	53 288
Simelane RV		16 368	65 031
Theophanides A		143 785	17 370
Thompson G		-	198 992
Van Gelderen CJ		257 462	207 282
Veriava Y		102 782	-
Weapond CJ		196 088	61 374
Zulu TF		116 958	23 160
		2 420 396	**1 868 944**

* Non-remunerated Council member

The increase year to year is attributed to the increased number of meetings, as reported in the *Part C: Governance* section. However, the rates for Council members attending Council meetings did not increase in the financial year under review.

19.2 Executive management

	Notes	2013	2012
		R	R
Basic salary		15 516 443	11 774 011
Bonuses		1 016 212	1 109 076
		16 532 655	**12 883 087**

20. Irregular expenditure

Opening balance	3 472 451
Current year	-
Prior years	353 055
Less: amounts condoned	-
Irregular expenditure awaiting condonation	**3 825 506**
Analysis of irregular expenditure awaiting condonation per age classification	
Current year	-
Prior years	3 825 506
Total	**3 825 506**

The CMS incurred an irregular expenditure in the prior financial years in that it had acquired goods without going through a competitive bidding process or sourcing three quotations. However, the reasons for this deviation were recorded and approved by the Chief Executive & Registrar. The reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/2008 of National Treasury, which allows for deviation from a competitive bidding process.

The CMS has applied for condonation from National Treasury but it has not yet been granted. This matter was also discussed at the Standing Committee on Public Accounts (SCOPA) in February 2012.

The CMS incurred an irregular expenditure in the prior financial year identified during the audit of the finanical year under review in that it had acquired goods with invalid deviation motivations. The reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/2008 of National Treasury, which allows for deviation from a competitive bidding process.

During the audit of the financial year under review, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not applying the preference points for procurements above R30 000 but below R500 000. Management will investigate the extent of the possible irregular expenditure and report on it in the next financial year.

21. Events after the reporting date

The Accounting Authority is not aware of any matters or circumstances arising since the end of the financial year under review to the date of this Annual Report in respect of matters which would require adjustments to or disclosure in the Annual Financial Statements.

22. Contingent assets

The CMS won court cases against the following parties:

- Barloworld Medical Scheme
- Board of Healthcare Funders of Southern Africa (BHF)
- Gen-Health Medical Scheme
- Liberty Medical Scheme
- Profmed
- Pro Sano Medical Scheme
- Sizwe Medical Fund
- Suremed Health

The CMS, as the successful party, was awarded costs on the party and party scale. The bill of costs relating to these matters has to date not been approved by the Taxation Master of the Court. For these reasons uncertainties exist relating to the amount and timing of the legal fees recovered.

23. Comparison of results with the approved budget

	No. of comment	Original budget	Actual outcome	Variance	Actual outcome as % of budget
		2012~2013	2012~2013	2012~2013	2012~2013
		R	R	R	%
Income		**97 787 409**	**102 282 273**	**(4 494 864)**	**-4.6%**
Revenue from exchange transactions		97 787 409	97 941 704	(154 295)	-0.2%
Revenue from non-exchange transactions		-	4 340 569	(4 340 569)	0.0%
Expenditure		**98 417 782**	**99 251 917**	**(834 135)**	**-0.8%**
Administrative expenses:					
Building expenses	**1**	2 710 015	2 005 050	704 965	26.0%
Rent	**2**	5 234 447	4 484 853	749 594	14.3%
Security	**3**	294 532	51 604	242 928	82.5%
Other administrative expenses		3 195 260	3 165 237	30 023	0.9%
Audit fees	**4**	1 417 754	1 678 369	(260 615)	-18.4%
Operating expenses					
Consulting fees	**5**	2 760 890	2 303 159	457 731	16.6%
Council members fees	**6**	1 033 295	2 420 396	(1 387 101)	-134.2%
Legal fees	**7**	4 793 000	9 304 908	(4 511 908)	-94.1%
Operating expenses		5 860 452	5 221 746	638 706	10.9%
Staff cost					
Salaries	**8**	64 058 366	60 905 762	3 152 604	4.9%
Temporary staff - SEP system	**9**	-	478 075	(478 075)	-100.0%
Recruitment and relocation	**10**	718 000	580 164	137 836	19.2%
Other staff cost		4 302 398	3 849 726	452 672	10.5%
Depreciation		1 191 437	1 861 056	(669 619)	-56.2%
Amortisation		847 936	941 811	(93 875)	-11.1%
Operating surplus / (deficit) for the year		**(630 373)**	**3 030 356**	**(3 660 729)**	**580.7%**
Gain on disposal of assets		-	17 482	(17 482)	0.0%
Interest received		1 200 000	1 439 807	(239 807)	-20.0%
Interest paid		-	-	-	0.0%
Surplus / (deficit) for the year		**569 627**	**4 487 645**	**(3 918 018)**	**-687.8%**
Capital expenditure					
Leasehold improvements	**11**	-	7 421 064	(7 421 064)	-100.0%
Property, plant and equipment	**12**	2 609 000	1 436 587	1 172 413	44.9%
		2 609 000	**8 857 651**	**(6 248 651)**	**-239.5%**

Comments on note 23:

1	In building expenses, an amount was budgeted for expansion in the current office park. These additional expenses were not incurred due to the relocation to new offices in 2013/2014.
2	In rent, an amount was budgeted for expansion in the current office park. This additional space was not taken up due to the relocation to new offices in 2013/2014.
3	Included in security was an amount for a new security system. This upgrade was put on hold due to the relocation to new offices in 2013/2014.
4	The internal audit fees exceeded the budget amount as more reports regarding performance information, the information technology audit, and the office lease tender were required by management.
5	Consulting was under-spent because: - The relocation to new offices hindered the virtualisation as well as the wireless network project. - There was a delayed appointment of the Chairperson of the Appeal Board by the Minister of Health. - Inspections and investigations into some medical schemes were delayed due to non-cooperation by schemes.
6	The increase year to year is attributed to the increased number of meetings, as reported in the *Part C: Governance* section. However, the rates for Council members attending Council meetings did not increase in the financial year under review.
7	The expense exceeded the initial approved budgeted amount due to the increased number of legal proceedings, but Council appropriated a portion of the unconditional transfer from the Department of Health to fund this expense.
8	Underspending on salaries was due to a delay in the filling of new positions during the financial year under review because of office space constraints. The position of Head of Stakeholder Relations was only filled in August 2012. The positions of Deputy Registar, Marketing Analyst, and Accreditation Analyst were not filled. The positions of Head of Research & Monitoring and Clinical Economist which became vacant during the year were also not filled.
9	The Department of Health requested the CMS to develop a Single Exit Price (SEP) system for their use. This request was made after the CMS budget for 2012/2013 had been approved. A portion of the unconditional transfer from the Department of Health was used to fund this expense.
10	Recruitment and relocation was under-spent due to office space constraints, and as a result the filling of positions was delayed.
11	Leasehold improvements were not originally budgeted for in 2012/2013. As expansion in the current office park could not take place, Council approved a tendering process whereby a new leased office space was acquired. Council also approved that the savings of the current budget as well as accumulated funds could be utilised for the leasehold improvements.
12	Some capital expenditure was not executed due to the relocation to new offices.

CHAPTER 2

THE MEDICAL SCHEMES INDUSTRY IN 2012

"Take up one idea. Make that one idea your life - think of it, dream of it, live on that idea.
Let the brain, *muscles, nerves, every part of your body, be full of that idea, and just leave every other idea alone. This is the way to success."*
Swami Vivekananda

CHAPTER 2: THE MEDICAL SCHEMES INDUSTRY IN 2012

Number of schemes and options

The declining trend in the total number of medical schemes continued in 2012; it was noted mostly among medium- and small-sized schemes.

At the end of 2012, there were 92 medical schemes registered in South Africa, compared to the 97 schemes at the end of 2011. This reflects a reduction of five schemes.

A more significant decline was noted in restricted schemes. In 2012, open schemes reduced by one scheme to 25 (26 open schemes in 2011), and restricted schemes reduced by four schemes to 67 (71 restricted schemes in 2011). Over the past 10 years the industry has been losing an average of five medical schemes per year through mergers and liquidations.

Table 33 further illustrates that medium and small schemes experienced a significant decline in numbers, which reduced by 10.7% and 7.7% respectively. Medium schemes decreased from 28 in 2011 to 25 in 2012; small schemes decreased from 39 in 2011 to 36 in 2012.

Xstrata Alloys Medical Aid Scheme was classified as a medium scheme in 2011, but its membership grew by 11.4% to more than 30 000 beneficiaries in 2012 and as a result the scheme was classified as a large scheme in 2012.

Table 33: Number of schemes by size & type as at December 2012

Type of scheme	Size of scheme	2011	2012
Open schemes	Large*	14	14
	Medium**	9	8
	Small***	3	3
Restricted schemes	Large*	16	17
	Medium**	19	17
	Small***	36	33
All schemes	**Large***	**30**	**31**
	Medium**	**28**	**25**
	Small***	**39**	**36**

* Large scheme = ≥ 30 000 beneficiaries
** Medium scheme = ≥ 6 000 members but < 30 000 beneficiaries
*** Small scheme = < 6 000 members

Open schemes had 158 registered benefit options in 2012 compared to 161 options in 2011. This translates into a decline of 1.8% in 2012 compared to the 3.0% decrease that was observed in 2011.

The number of benefit options in the restricted schemes environment remained unchanged at 145.

Overall, the number of benefit options reduced by 0.9% between 2011 and 2012.

The average number of options increased from 6.2 to 6.3 in open schemes and from 2.0 to 2.2 in restricted schemes.

Overall, the average number of options in all medical schemes increased from 3.2 to 3.3 in 2012.

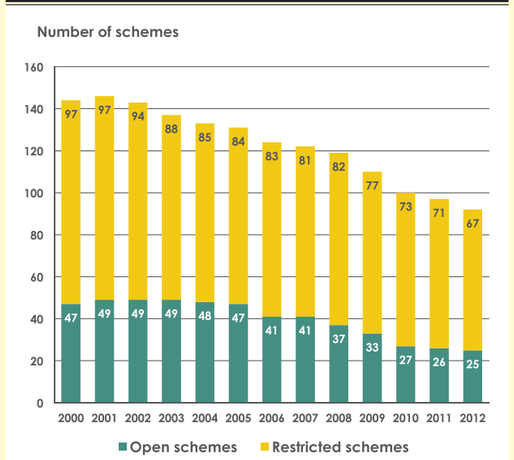
Trend in the number of schemes

Figure 11 depicts the trend in the number of registered medical schemes from 2000 to 2012.

Open schemes decreased by 46.8% from 47 in 2000 to 25 in 2012. Similarly, the restricted schemes environment experienced a slump in the number of schemes, from 97 in 2000 to 67 in 2012, translating into a 30.9% decrease.

Overall, a downward trend in the number of registered medical schemes can be observed during the 13-year period starting in 2000. The number of schemes decreased from 144 in 2000 to 92 in 2012, translating into a decline of 36.1%.

Figure 11: Number of medical schemes in 2000-2012



Trend in the number of schemes by size

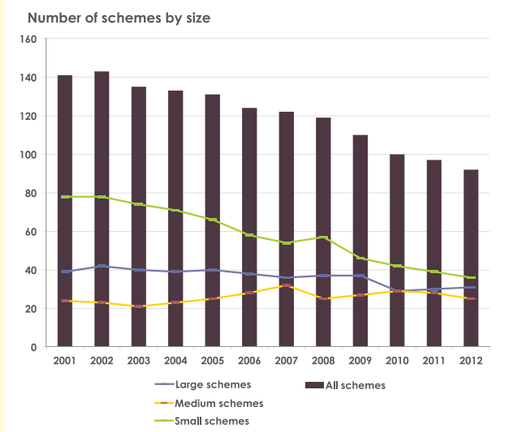
Figure 12 depicts the trend in the number of registered medical schemes by size from 2001 to 2012. A number of smaller schemes were consolidated into large schemes, particularly between 2001 and 2005. From 2005, additional competition in the industry altered this trend to some extent as several open medical schemes tried to consolidate their market size in response to the emergence of the Government Employees Medical Scheme (GEMS). This resulted in the number medium-sized schemes beginning to increase.

An analysis of the period 2001-2006 compared to 2007-2012 revealed that the number of large medical schemes declined by 2.6% and 13.9% respectively during the two periods.

An increasing trend in medium-sized schemes was noted from 2001 until 2007. Then the number of medium schemes declined significantly, from 32 in 2007 to 25 in 2008. This number has remained unchanged ever since; there were 25 medium-sized schemes at the end of 2012.

Overall, a declining trend was noted in the number of all medical schemes; they declined by 25.6% in the period 2001-2006 compared to 33.3% in the period 2007-2012.

Figure 12: Number of medical schemes by size in 2001-2012

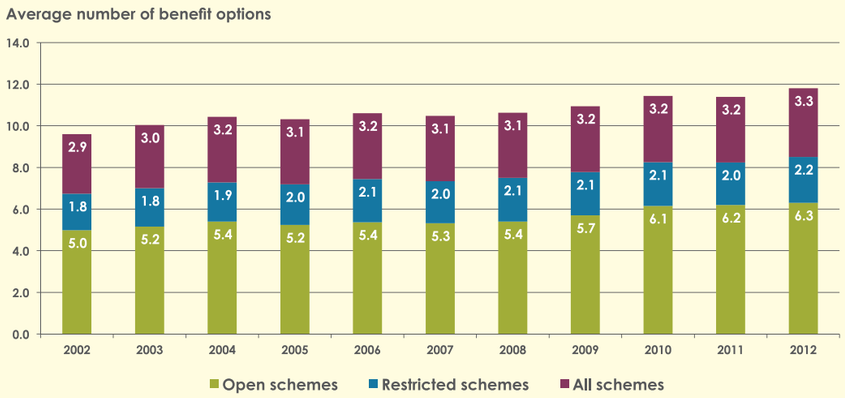


Trend in the average number of options

In contrast to the decrease in the number of both open and restricted medical schemes, the average number of benefit options in open schemes increased from 5.0 in 2002 to 6.3 in 2012, while the average number of benefit options in restricted schemes increased from 1.8 to 2.2 during the same period, as illustrated in Figure 13.

The overall average number of benefit options in medical schemes demonstrates an upward trend from 2.9 in 2002 to 3.3 benefit options per scheme in 2012.

Figure 13: Average number of benefit options in 2002-2012



Membership of medical schemes

The number of principal members increased by 2.3% in 2012, by slightly less than the increase of 3.3% observed in 2011. This translates into a total of 3 815 431 principal members in 2012 compared to 3 730 565 in 2011. The number of dependants rose by 1.4% from 4 795 844 to 4 864 042. Therefore the total number of medical scheme beneficiaries increased by 1.8% from 8 526 409 to 8 679 473 in the 2012 benefit year.

Open schemes experienced a 0.7% increase in the number of principal members; the number of principal members in restricted schemes rose by 4.5%.

The coverage of beneficiaries in open schemes declined marginally (by less than 0.5%) but there was a beneficiaries increase of 4.1% in restricted schemes. (See Table 34 for more details.)

Table 34: Membership of schemes in 2011 & 2012

Type of scheme	Year	Members	Dependants	Beneficiaries	% change
Open schemes	2011	2 182 562	2 577 552	4 760 114	
	2012	2 197 454	2 562 540	4 759 994	0.0
Restricted schemes	2011	1 548 003	2 218 292	3 766 295	
	2012	1 617 977	2 301 502	3 919 479	4.1
All schemes	**2011**	**3 730 565**	**4 795 844**	**8 526 409**	
	2012	**3 815 431**	**4 864 042**	**8 679 473**	**1.8**

Trend in the number of beneficiaries

Figure 14 depicts the trend in medical scheme coverage from 2000 to 2012.

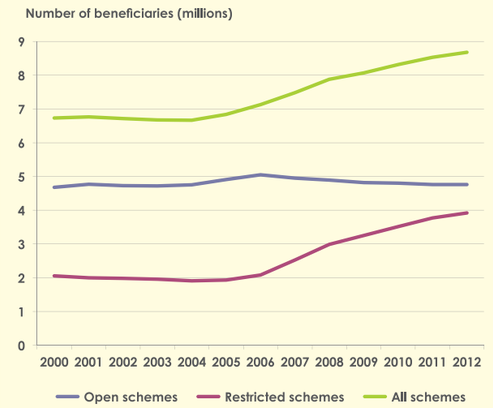
The number of beneficiaries increased to 8.7 million in 2012 from 6.7 million in 2000; this represents an increase of 22.9%.

The number of beneficiaries in open medical schemes was 4.7 million in 2000 and 4.8 million in 2012. The number of beneficiaries in restricted medical schemes was 2.1 million in 2000 and 3.9 million in 2012.

This means an increase of 2.1% and 85.7% respectively over the 13-year period.

The increase in restricted schemes cover may appear dramatic but it is off a low base compared to open schemes. Also, the growth in beneficiaries belonging to restricted schemes really started in 2006, which coincides with the inception of GEMS. A noteworthy feature presented in Figure 14 is that, since 2006, the membership of restricted schemes grew by 1.6 million beneficiaries, which is significant compared to the preceding period of 2000-2005.

Figure 14: Number of beneficiaries in 2000-2012



Age and gender distribution of beneficiaries

Figure 15 shows the age and gender distribution of medical scheme beneficiaries for 2011 and 2012. A bimodal distribution was again evident, for both male and female beneficiaries.

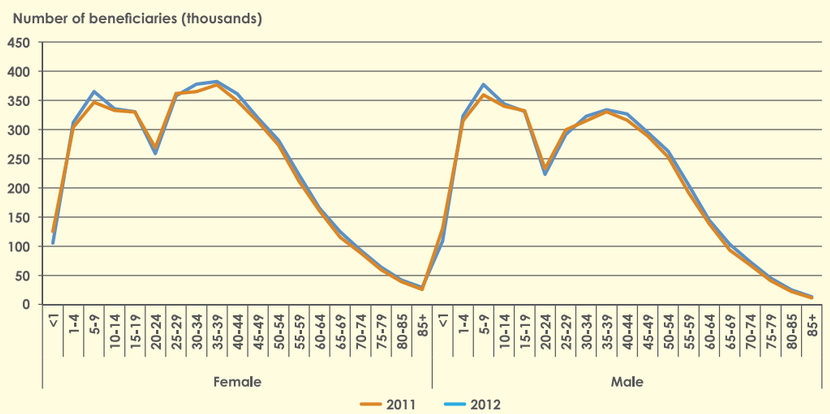
Age bands <1 to 15-19 attracted more male beneficiaries but there were more female beneficiaries in the age group of 20 and older. As a result, medical scheme beneficiaries in 2012 consisted of proportionately more females compared to males, at 52.2% and 47.8% respectively.

Overall, increases in the number of beneficiaries were seen in most of the age bands. The only age bands which experienced a drop in beneficiaries compared to the previous year were <1, 15-19, 20-24, and 25-29 years.

Figure 15 further illustrates that among female beneficiaries a decline was noted in age bans <1, 20-24, and 25-29. Among male beneficiaries a decline was noted in age bands <1, 15-19, 20-24, and 25-29.

The average age of medical scheme beneficiaries in 2012 was 32.0, slightly older than the 31.6 years reported in 2011. Female beneficiaries were generally older than male beneficiaries in 2012;

Figure 15: Age & gender distribution of beneficiaries in 2011 & 2012



the average age of females belonging to a medical scheme was 32.8 years (32.4 years in 2011) and that of males was 32.1 years compared to 30.7 years in 2011.

Trend in the average age of beneficiaries

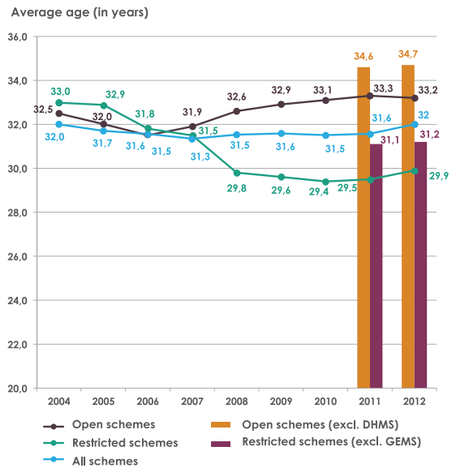
Figure 16 depicts the trend in the average age of beneficiaries from 2004 to 2012.

The Figure illustrates that, until 2006, restricted medical schemes were older than open schemes. This changed in 2007; restricted schemes were suddenly younger than open schemes, primarily due to the introduction of GEMS.

The impact of GEMS and Discovery Health Medical Scheme (DHMS) on restricted and open schemes respectively is also reflected in Figure 16.

It further illustrates that the average age of open schemes in 2012 was 33.7 years (34.7 years if the DHMS is excluded); the average age of restricted schemes in 2012 was 29.8 years (31.3 years excluding GEMS).

Figure 16: Age of beneficiaries in 2004-2012



DHMS = Discovery Health Medical Scheme
GEMS = Government Employees Medical Scheme

Pensioner ratio

Table 35 shows that the proportion of pensioners (beneficiaries 65 years old and older) increased marginally in 2012, to 7.1% from 6.6% in 2011. Open schemes had more pensioners (8.2%) than restricted schemes (5.7%). There were more female (7.8%) than male (6.3%) pensioners.

Table 35: Pensioner ratio in schemes in 2011 & 2012 (%)

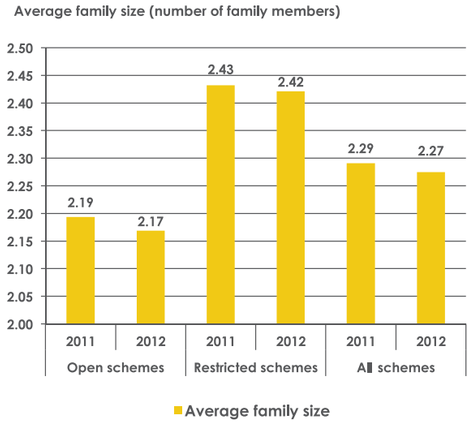
Type of scheme	Gender	2011	2012
Open schemes	Female	8.8	8.9
	Male	6.8	7.5
	All	7.8	8.2
Restricted schemes	Female	5.7	6.5
	Male	4.4	4.7
	All	5.1	5.7
All schemes	**Female**	**7.4**	**7.8**
	Male	**5.8**	**6.3**
	All	**6.6**	**7.1**

Family size

Restricted medical schemes had, on average, bigger families as beneficiaries than open medical schemes did, which were 2.42 family members (2.43 in 2011) and 2.17 family members (2.19 in 2011) respectively.

Overall, the average family size in all medical schemes declined slightly to 2.27 in 2012 compared to 2.29 in 2011.

Figure 17: Average family size in 2011 & 2012

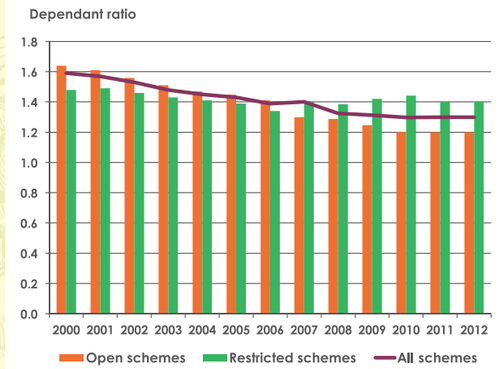


Dependant ratio

The dependant ratio measures the average number of dependants per principal member. It remained unchanged in 2012, at 1.3. The dependant ratio for both open and restricted schemes also remained unchanged, at 1.2 and 1.4 respectively.

Figure 18 illustrates that the overall dependant ratio has declined steadily between 2000 and 2012.

Figure 18: Dependant ratio in schemes in 2000-2012

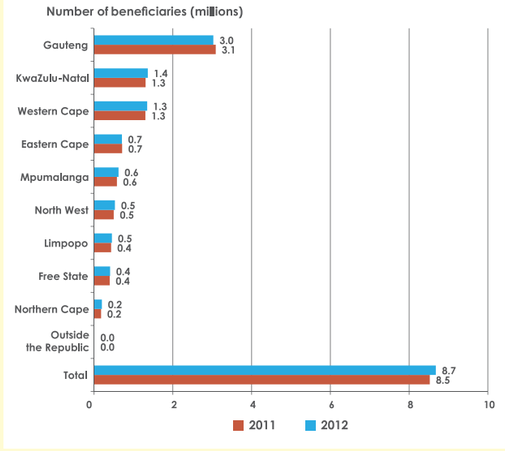


Coverage by province

Figure 19 shows the distribution of beneficiaries by province.

This data was collected primarily on the basis of the location of principal members. More than one third of beneficiaries (34.5%) were located in Gauteng, with 3.0 million beneficiaries that were registered with medical schemes. KwaZulu-Natal was the second province, with 1.4 million beneficiaries accounting for 16.1% of all the beneficiaries in 2012. A total of 1.3 million beneficiaries were located in the Western Cape, representing 14.9% of the 8.7 million beneficiaries. The remaining six provinces and residents outside the Republic accounted for 3.0 million beneficiaries, representing 34.5% of the 8.7 million beneficiaries that belonged to medical schemes in 2012.

Figure 19: Distribution of beneficiaries by province in 2011 & 2012



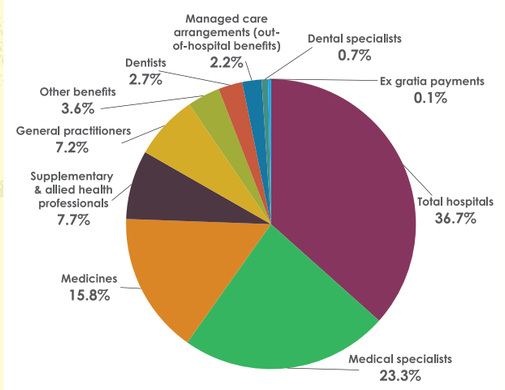
Healthcare benefits

Total healthcare benefits paid

Medical schemes spent 10.8% more on healthcare benefits in 2012. This expenditure increased (in nominal terms) to R103.3 billion from R93.2 billion in 2011.

Figure 20 shows the proportions of benefits which schemes paid to the various categories of healthcare providers in 2012.

Figure 20: Total healthcare benefits paid in 2012



Medical scheme expenditure on hospitals – which includes ward fees, theatre fees, consumables, medicines, and per diem arrangements – consumed R37.9 billion or 36.7% of the R103.3 billion that medical schemes paid to all healthcare providers in 2012. Expenditure on private hospitals increased by 11.1% to R37.6 billion from R33.8 billion in 2011, and expenditure on provincial hospitals decreased by 10.1% to R334.7 million from the R304.1 million that was spent on this item in 2011.

Payments to medical specialists amounted to R24.0 billion or 23.3% of total healthcare benefits paid in 2012; this is an increase of 12.9% on 2011.

Healthcare benefits which medical schemes paid for medicines dispensed by pharmacists and providers other than hospitals amounted to R16.3 billion or 15.8% of total healthcare benefits paid. This is an increase of 7.8% when compared to the R15.2 billion that was spent in 2011.

Expenditure on general practitioners (GPs) amounted to R7.5 billion or 7.2% of healthcare benefits paid, representing an increase of 9.2% from 2011's R6.8 billion.

Dentists accounted for R2.8 billion in medical scheme expenditure in 2012, an increase of 10.1% on 2011. Like in 2011, expenditure on dental specialists accounted for 0.7% of healthcare benefits paid.

Supplementary and allied health professionals received R7.9 billion from medical schemes in 2012; they had received R7.3 billion in 2011.

The proportion of healthcare benefits spent on managed care (out-of-hospital benefits) in 2012 was 2.2% (R2.2 billion), an increase from the R2.1 billion that was paid in 2011.

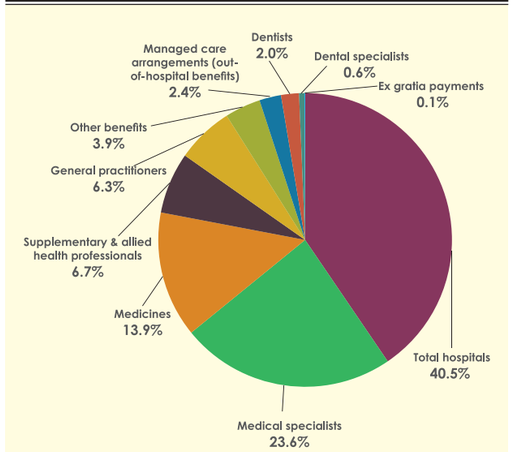
Healthcare benefits paid from risk pools

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 21.

Healthcare benefits which medical schemes covered from their risk pools amounted to R93.3 billion in 2012; this was 90.3% of the total healthcare benefits they paid in 2012 and reflects an increase of 11.5% on the R83.6 billion that was paid from risk pools in 2011.

Hospital expenditure accounted for 40.5% of risk benefits paid in 2012. Expenditure on medical specialists accounted for 23.6% of total risk pool benefits. Medicines took up 13.9% of the pie. Expenditure on GPs was R5.8 billion from risk pools; this represents 6.3% of risk pool benefits.

Figure 21: Healthcare benefits paid from risk pool in 2012

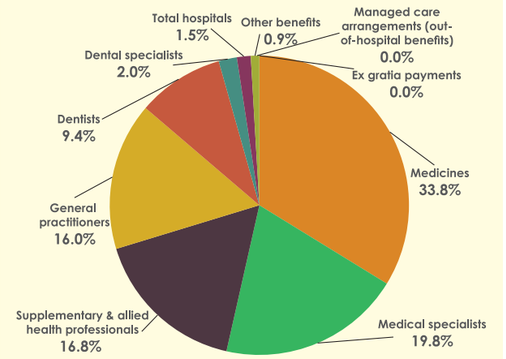


Healthcare benefits paid from personal medical savings accounts

Of total healthcare benefits paid, medical schemes paid R10.0 billion (9.7%) for healthcare benefits from personal medical savings accounts in 2012.

Figure 22 shows that medicines again took up the largest share of savings accounts expenditure in 2012 (33.8%). Medical specialists accounted for 19.8% and GPs for 16.0%. Supplementary and allied health professionals took 16.8% of healthcare benefits paid from savings accounts. And as in previous years, expenditure on hospitals and dental specialists accounted for a comparatively small proportion of healthcare benefits paid from savings accounts (1.5% and 2.0% respectively).

Figure 22: Healthcare benefits paid from savings accounts in 2012

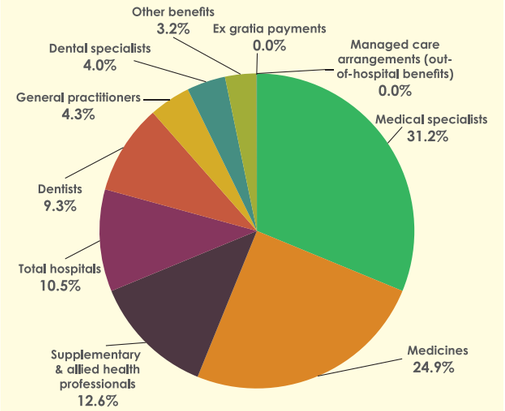


Healthcare benefits paid out of pocket

Out-of-pocket payment data is a challenge to collect due to under-reporting by both members and medical schemes. Figure 23 should therefore be interpreted with caution.

Medical scheme members made out-of-pocket payments to medical specialists (31.2% of all benefits paid by members), for medicines (24.9%), and to supplementary and allied health professionals, hospitals, and dentists (12.6%, 10.5%, and 9.3% of expenditure by members respectively).

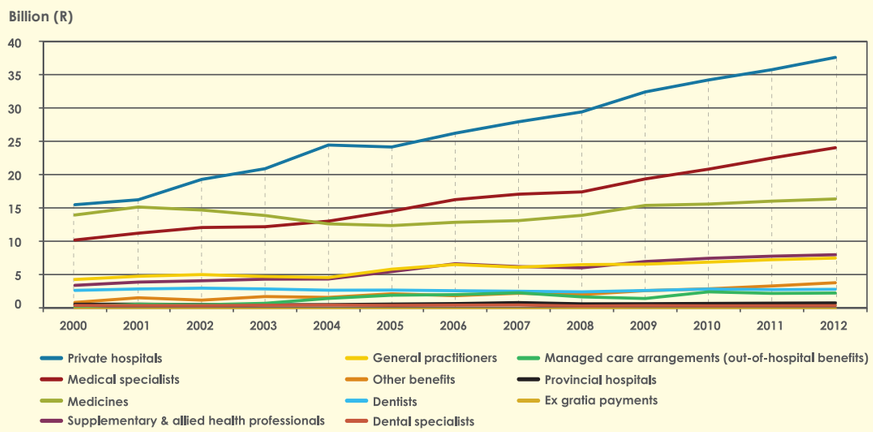
Figure 23: Healthcare benefits paid out of pocket in 2012



Trends in total healthcare benefits paid

Figure 24 shows the distribution of healthcare benefits that medical schemes paid to different types of service providers since 2000. These figures have been adjusted for inflation.

Figure 24: Total healthcare benefits paid in 2000-2012: 2012 prices*



* CPIX is the rebased Consumer Price Index (CPI) excluding interest rates on mortgage bonds.

Medical schemes expenditure on private hospitals increased in real terms by 5.3% to R37.6 billion in 2012 compared to R35.7 billion in 2011. Private hospitals expenditure accounted for 29.9% of all healthcare benefits paid by medical schemes in 2000; the comparative figure in 2006 was 34.5% which increased further to 36.4% in 2012. Figure 24 further illustrates an increase in private hospitals expenditure from R15.5 billion in 2000 to R37.6 billion in 2012.

Benefits paid to medical specialists in 2012 amounted to R24.0 billion, an increase of 6.7% in real terms when compared to the R22.5 billion that was spent on this item in 2011. Expenditure on medical specialists has been increasing since 2003, where it accounted for 19.6% of all benefits paid. This increased to 23.3% in 2012.

Non-diagnosing specialist providers such as anaesthetists, radiologists, and pathologists accounted for 11.1% of the 23.3% of all the benefits that were paid to specialists in 2012.

Medical schemes spent 1.9% more on medicines in 2012 (R16.3 billion), up from the R16.0 billion that was recorded in 2011. As a proportion of total healthcare benefits paid, expenditure on medicines as a percentage decreased from 16.3% in 2011 to 15.8% in 2012.

Total expenditure on GPs amounted to R7.5 billion in 2012, which is an increase of 4.2% on the R7.2 billion that was spent on these healthcare providers in 2011. Expenditure on GPs as a proportion of all benefits paid to healthcare providers was 7.2% in 2012 compared to the 7.3% in 2011.

There was an increase of 3.7% on healthcare benefits paid to dentists, from R2.7 billion in 2011 to R2.8 billion in 2012. Expenditure on dentists as a percentage of all benefits paid was 2.8% in 2011 and 2.7% in 2012.

Healthcare benefits paid per beneficiary

Figure 25 shows the changes in healthcare expenditure per beneficiary per annum (pbpa) from 2000 to 2012.

By 2012, medical schemes expenditure on private hospitals had increased in real terms by 5.3% to R37.6 billion compared to R35.7 billion in 2011. Private hospitals expenditure increased by 88.2% between 2000 and 2012, from R2 300.5 to R4 330.0 pbpa on 2012 prices.

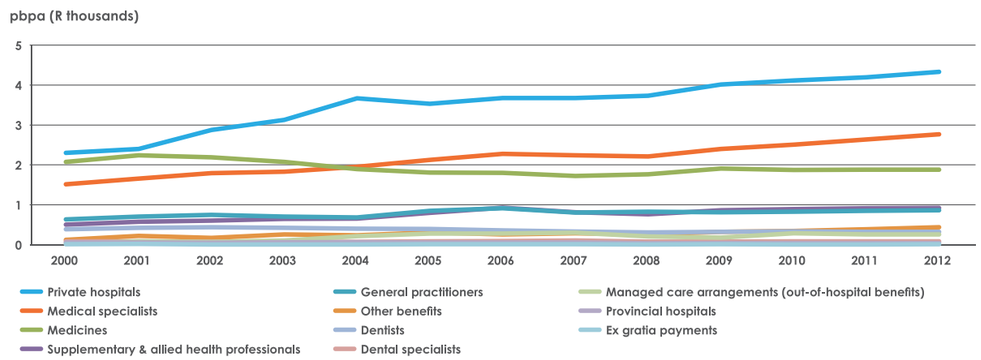
Medical schemes expenditure on specialists increased by 82.9% from R1 513.0 in 2000 to R2 768.6 pbpa on 2012 prices.

Expenditure on medicines declined by 9.1% in the same 13-year period, from R2 070.7 in 2000 to R1 882.6 pbpa in 2012.

Expenditure on primary healthcare services such as GPs increased by 35.9% from R633.3 pbpa in 2000 to R861.0 pbpa in 2012.

During 2000-2012, medical schemes expenditure on dentists decreased by 17.7% from R389.9 pbpa in 2000 to R320.8 pbpa in 2012.

Figure 25: Total healthcare benefits paid per beneficiary per annum in 2000-2012: 2012 prices*



* CPIX is the rebased Consumer Price Index (CPI) excluding interest rates on mortgage bonds.

Utilisation of healthcare services

Preventative services

Table 36 illustrates preventative benefits adjusted for female beneficiaries.

The number of mammograms that medical schemes paid for per 1 000 female beneficiaries aged 50 to 69 increased from 85.5 in 2011 to 86.7 in 2012. More mammograms were paid for in open schemes than in restricted schemes, at 94.6 compared to 74.5 per 1 000 female beneficiaries respectively.

The number of pap smears paid for in 2012 was 44.4 compared to 54.0 per 1 000 female beneficiaries in the age bands 15-69 years. Open schemes again reported higher utilisation rates than restricted schemes.

Table 36: Utilisation of preventative services (females) in 2011 & 2012

	2012			2011*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of mammograms paid for (per 1 000 females aged 50-69)	94.6	74.5	86.7	85.5
Number of pap smears paid for (per 1 000 females aged 15-69)	48.3	39.5	44.4	54.0

* The 2011 figures have been restated.

Primary healthcare services: visits to GPs and dentists

Data presented in this section should be interpreted with caution due to definition-related issues and in some instances due to under-reporting by medical schemes.

The number of visits to a GP and private nurse in 2012 was 3.8 and 3.3 visits per beneficiary respectively. The respective figures for the previous year were 3.9 and 3.1 per beneficiary.

The number of visits to a dentist in 2012 remained unchanged at 1.9 visits per beneficiary.

Table 37: Utilisation of primary healthcare services in 2011 & 2012 (per 1 000 beneficiaries)

	2012			2011*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of GP visits	3.6	4.1	3.8	3.9
Number of dentist visits	2.0	1.8	1.9	1.9
Number of nurse visits	2.8	3.8	3.3	3.1

* The 2011 figures have been restated.

Private hospital services

Table 38 illustrates the utilisation of private hospital services. It is important to note that the indicators presented were introduced in 2012. It is equally important to note that the data presented also took into account input received in response to Circular 39 of 2012.

The data presented in Table 38 is thus only for 2012, and prior year figures have not been reported.

Despite challenges with definitions and the quality of the data that medical schemes had submitted, the CMS took every care to ensure that the data is complete and accurate.

Restricted schemes had more outpatient visits than open schemes, with 81.4 and 50.2 per 1 000 beneficiaries respectively. Overall there were 67.4 outpatient visits per 1 000 beneficiaries in the year under review.

The number of admissions for medical cases in restricted schemes should be interpreted with caution due to under-reporting by GEMS, the largest restricted scheme in the country.

The number of beneficiaries' surgical cases was higher in open schemes at 435.6 compared to 367.2 surgical cases per 1 000 admissions in restricted schemes. Overall, 406.5 per 1 000 admissions were for surgical cases.

Restricted schemes reported higher rates of admissions compared to open schemes, at 88.7 and 67.7 per 1 000 admissions respectively.

The number of admissions for cathlabs was slightly higher in open schemes than in restricted schemes, at 23.5 compared to 20.6 per 1 000 admissions respectively.

Table 38: Utilisation of private hospital services in 2011 & 2012

	2012			2011*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of outpatient visits (per 1 000 beneficiaries)	81.38	50.23	67.43	
Number of same-day inpatients (per 1 000 beneficiaries admitted as inpatients)	399.92	493.75	437.92	
Number of inpatient admissions for surgical cases (per 1 000 inpatient admissions)	435.60	367.24	406.48	
Number of inpatient admissions for maternity cases (per 1 000 inpatient admissions)	67.84	88.69	76.72	
Number of inpatient admissions for cathlab cases (per 1 000 inpatient admissions)	23.51	20.58	22.26	
Number of beneficiaries admitted as inpatients (per 1 000 beneficiaries)	149.87	125.79	139.09	NI**
Number of beneficiaries admitted at day clinics / unattached operating theatres (per 1 000 beneficiaries)	6.82	6.80	6.81	7.48

* The 2011 figures have been restated.
** NI = New Indicator; introduced in 2012
Admissions for medical cases have been excluded due to data issues at GEMS.

Average age of beneficiaries admitted by administrators

Table 39 depicts the average age of beneficiaries that were admitted to private hospitals, stratified by administrator, for both 2011 and 2012.

The average age of beneficiaries increased slightly from 36.9 to 38.2 years during 2012. But if the administrators Agility Global Health Solutions Africa (Pty) Ltd and Medscheme Holdings (Pty) Ltd are excluded from the calculations, the average age of beneficiaries admitted to private hospitals in 2012 becomes 41.9 compared to 40.7 observed in 2011.

A noteworthy feature of the data was that Medscheme Holdings (Pty) Ltd depicted a declining trend in the average age of its beneficiaries admitted to private hospitals, and the data of Agility Global Health Solutions Africa (Pty) Ltd varied significantly between 2011 and 2012.

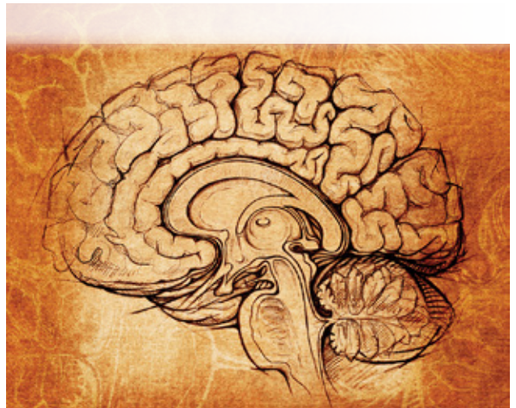


Table 39: Average age of beneficiaries admitted to private hospitals in 2011 & 2012

Name of administrator	Year	Number of schemes administered	Average age of beneficiaries admitted to private hospitals (in years)
Agility Global Health Solutions Africa (Pty) Ltd	2011*	1	34.89
	2012	1	41.18
Allcare Administrators (Pty) Ltd	2011*	4	35.41
	2012	4	37.62
Discovery Health (Pty) Ltd	2011*	13	37.30
	2012	12	37.55
Eternity Private Health Fund Administrators (Pty) Ltd	2011*	1	33.28
	2012	1	33.14
Medscheme Holdings (Pty) Ltd	2011*	20	39.86
	2012	18	37.26
METHEALTH (Pty) Ltd	2011*	1	31.27
	2012	1	33.97
Metropolitan Health Corporate (Pty) Ltd	2011*	13	32.22
	2012	13	35.27
Momentum Medical Scheme Administrators (Pty) Ltd	2011*	10	41.15
	2012	9	42.57
Private Health Administrators	2011*	1	41.45
	2012	1	45.88
Professional Medical Scheme Administrators (Pty) Ltd	2011*	1	43.39
	2012	1	45.33
Providence Healthcare Risk Managers (Pty) Ltd	2011*	6	36.84
	2012	6	37.98
Sechaba Medical Solutions (Pty) Ltd	2011*	1	37.48
	2012	1	38.90
Self-administered medical schemes	2011*	14	42.16
	2012	15	42.73
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2011*	1	33.43
	2012	1	32.80
Universal Healthcare Administrators (Pty) Ltd	2011*	4	45.24
	2012	4	46.61
V Med Administrators (Pty) Ltd	2011*	3	40.82
	2012	3	44.95

* The 2011 figures have been restated.

Burden of disease

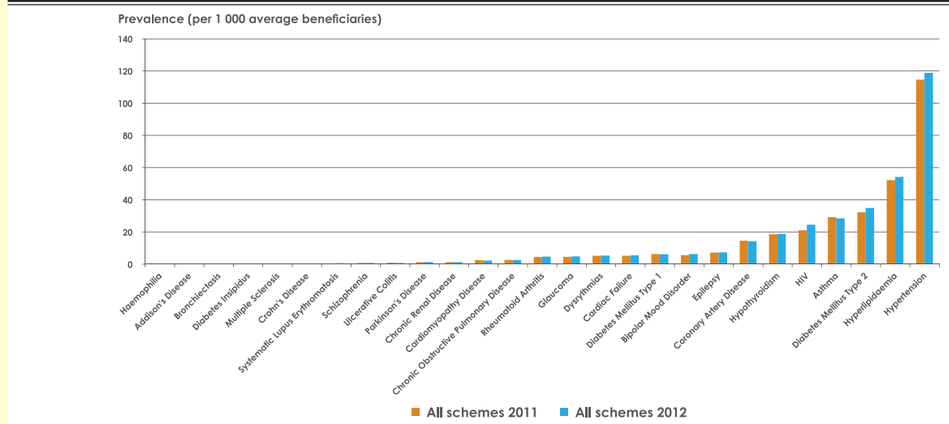
Figure 26 shows the prevalence of the prescribed minimum benefit (PMB) chronic conditions which medical schemes are required by law to cover in full on all their benefit options.

The prevalence was defined by counting every beneficiary who has any of the chronic conditions. Prior year figures have been restated due to a much more rigorous process that was implemented by some administrators to ensure a consistent and quality delivery of statutory annual returns. This was noted in all 14 medical schemes which are administered by Discovery Health (Pty) Ltd.

The analysis for 2012 showed that the most prevalent PMB chronic condition in medical schemes was hypertension at 118.8 cases per 1 000 beneficiaries (114.6 in 2011), followed by hyperlipidaemia at 54.2 (52.2 in 2011), diabetes mellitus type 2 at 34.9 (32.3 in 2011), and asthma at 28.4 (29.3 in 2011).

The prevalence of PMB chronic conditions was higher in open schemes, but cardiac failure, HIV, diabetes mellitus type 2, and multiple sclerosis were more prevalent in restricted schemes.

Figure 26: PMB chronic conditions in schemes in 2011 & 2012



Contributions, relevant healthcare expenditure[1], and trends

Scheme contributions increased by 9.4% to R117.5 billion as at December 2012, from R107.4 billion in December 2011. The total gross relevant healthcare expenditure incurred by medical schemes increased by 10.7% to R103.7 billion[2] from R93.6 billion in 2011.

Gross contributions per average beneficiary per month (pabpm) grew by 7.0% to R1 138.1 from R1 063.9 in 2011. The total gross relevant healthcare expenditure incurred pabpm increased by 8.2% to R1 003.7 from R927.7 in 2011.

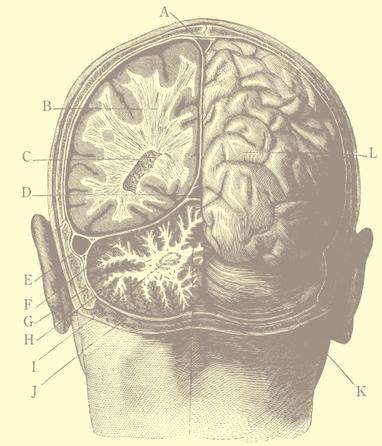
[1] All references to claims and benefits indicate relevant healthcare expenditure.
[2] This number differs from the R93.3 billion reported above as "benefits paid" because we have included IBNR and the results of risk transfer arrangements in this section.

Risk contributions and relevant healthcare expenditure

Risk contributions (net of medical savings accounts contributions) increased by 9.4% to R106.7 billion from R97.6 billion in 2011; the increase from 2010 to 2011 was 11.2%. The increase in risk contributions pabpm was 6.9% to R1 033.5 from R966.6 (2011: 9.0%).

Risk claims increased by 10.9% to R93.6 billion from R84.4 billion in 2011 (2011: 10.1%). Risk claims pabpm rose by 8.4% to R906.3 from R836.3 (2011: 8.0%).

Medical savings accounts contributions and relevant healthcare expenditure



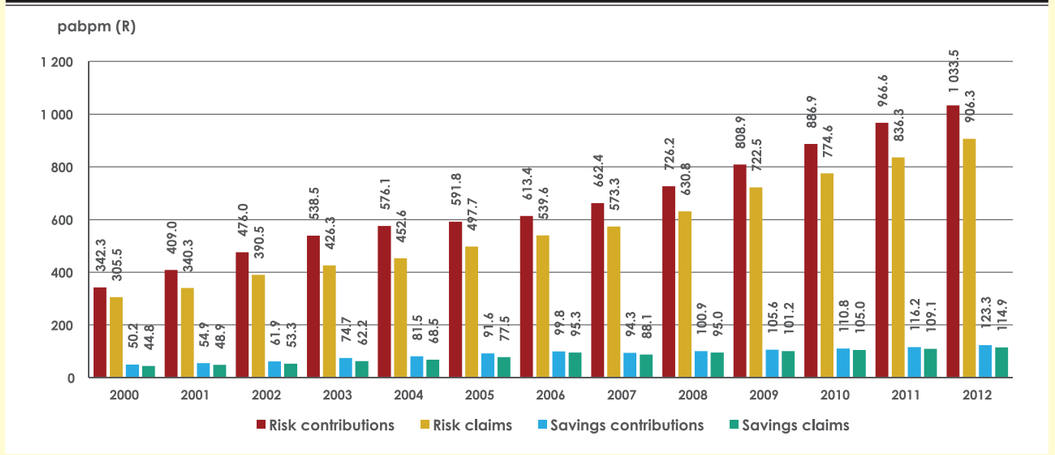
Contributions to medical savings accounts increased by 10.0% to R10.8 billion from R9.8 billion (2011: 12.3% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 6.1% – from R116.2 to R123.3 (2011: 4.8% increase).

Claims paid from medical savings accounts increased by 9.1% to R10.1 billion from R9.2 billion (2011: 11.3% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 5.3% to R114.9 from R109.1 (2011: 3.9% increase).

Figure 27 and Table 41 show that between 2003 and 2006, medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components. This indicates a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

But the lower figures in 2007-2012 appear to reflect a change in this trend. The decrease is partly attributable to a decision of the CMS not to allow variable savings rates on an option, which resulted in a number of medical schemes no longer offering any savings plan accounts.

Figure 27: Risk & medical savings accounts contributions & claims pabpm in 2000-2012



pabpm = per average beneficiary per month

Contributions and relevant healthcare expenditure by type of scheme

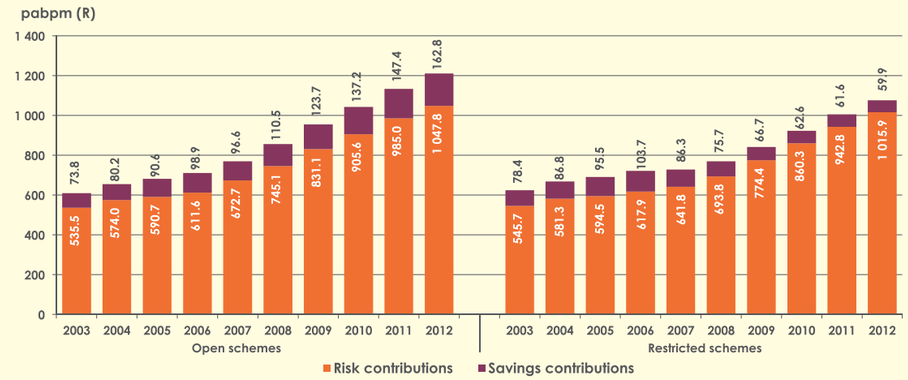
Table 40 and Figures 28 and 29 show contributions and claims for open and restricted schemes pabpm.

Table 40: Contributions & relevant healthcare expenditure pabpm in 2000-2012

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	333.6		46.1		292.4		41.3	
2001	406.4	21.8	52.6	13.9	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	14.0	379.3	14.4	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.7	77.5	13.6
2006	611.6	3.5	98.9	9.1	522.9	8.0	95.9	23.6
2007	672.7	10.0	96.6	(2.3)	562.1	7.5	91.6	(4.4)
2008	745.1	10.8	110.5	14.3	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
2011	985.0	8.8	147.4	7.5	831.8	8.4	139.8	6.8
2012	1 047.8	6.4	162.8	10.4	884.9	6.4	153.1	9.5
Restricted schemes								
2000	360.8		66.7		333.1		58.8	
2001	415.0	15.0	64.0	(4.0)	360.9	8.3	57.9	(1.5)
2002	489.0	17.8	69.8	9.0	417.9	15.8	60.3	4.2
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.5
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.6
2005	594.5	2.3	95.5	10.1	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.3
2007	641.8	3.9	86.3	(16.8)	595.7	2.3	75.7	(18.4)
2008	693.8	8.1	75.7	(12.3)	638.0	7.1	66.2	(12.5)
2009	774.4	11.6	66.7	(11.9)	727.3	14.0	61.7	(6.9)
2010	860.3	11.1	62.6	(6.1)	785.1	8.0	57.5	(6.7)
2011	942.8	9.6	61.6	(1.7)	842.0	7.2	55.6	(3.4)
2012	1 015.9	7.8	59.9	(2.8)	932.7	10.8	53.6	(3.6)

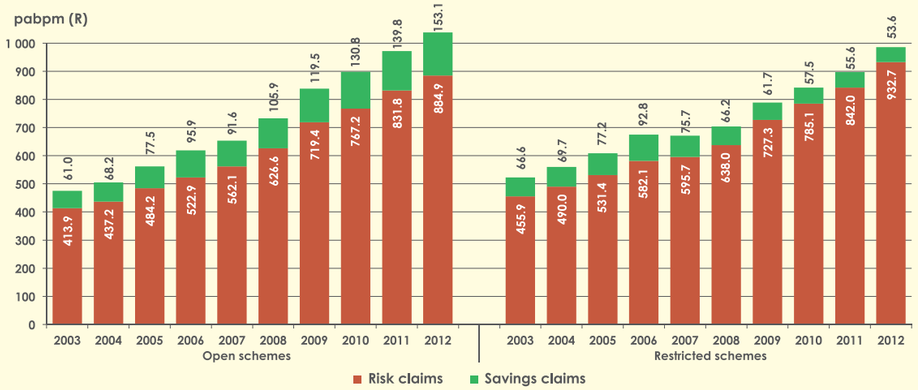
pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

Figure 28: Risk & savings contributions pabpm in 2003-2012



pabpm = per average beneficiary per month

Figure 29: Risk & savings claims pabpm in 2003-2012



pabpm = per average beneficiary per month

On average, increases in risk claims and contributions pabpm were generally slightly lower in restricted schemes than in open schemes over the last 10 years. From 2008 onwards, restricted schemes experienced decreases in claims from members' medical savings accounts while open schemes incurred an increase. The risk claims ratio in open schemes increased to 84.5% in 2012 from 84.4% in 2011; in restricted schemes it increased to 91.8% from 89.3% in 2011.

Table 41: Contributions & relevant healthcare expenditure pabpm in 2000-2012: 2012 prices

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
All schemes								
2000	678.7		99.5		605.7		88.7	
2001	766.6	13.0	102.9	3.4	637.9	5.3	91.7	3.3
2002	817.9	6.7	106.3	3.4	671.1	5.2	91.6	(0.1)
2003	874.5	6.9	121.4	14.2	692.2	3.1	100.9	10.2
2004	922.2	5.5	130.5	7.5	724.5	4.7	109.7	8.7
2005	916.6	(0.6)	141.8	8.7	770.8	6.4	120.0	9.4
2006	908.0	(0.9)	147.7	4.1	798.8	3.6	141.1	17.6
2007	914.9	0.8	130.3	(11.8)	791.8	(0.9)	121.7	(13.8)
2008	899.7	(1.7)	125.0	(4.1)	781.6	(1.3)	117.7	(3.3)
2009	935.8	4.0	122.2	(2.3)	835.8	6.9	117.0	(0.6)
2010	983.7	5.1	123.0	0.6	859.2	2.8	116.4	(0.5)
2011	1 021.0	3.8	122.7	(0.2)	883.3	2.8	115.2	(1.0)
2012	1 033.5	1.2	123.3	0.5	906.3	2.6	114.9	(0.3)

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

Table 41 indicates the changes in contributions and claims after adjusting for inflation.

Medical schemes experienced increases in risk contributions and claims pabpm, and a noted decrease in savings contributions and claims.

Even though savings contributions and claims have decreased from 2007, it appears that the rate of decrease is slowing down.

Figure 30: Medical savings accounts contributions & claims pabpm in 2003-2012: 2012 prices

pabpm = per average beneficiary per month

The proportion of claims paid from medical savings accounts decreased to 11.3% during the review period, from 11.5% in 2011, as shown in Figure 30.

For open schemes, the proportion of claims paid from medical savings accounts increased from 14.4% in 2011 to 14.8% in 2012; the medical savings accounts claims ratio decreased to 94.0% from 94.8% in 2011.

For restricted schemes, the proportion of claims paid from medical savings accounts decreased from 6.2% in 2011 to 5.4% in 2012. The medical savings accounts claims ratio decreased to 89.5% from 90.3% in 2011.

Contributions and relevant healthcare expenditure since 2000

Figure 31 tracks the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 52.3% and 49.6% respectively; medical savings accounts contributions and claims have risen by 23.9% and 29.5% on a pabpm basis respectively.

Figure 31: Risk & medical savings accounts contributions & claims pabpm in 2000-2012: 2012 prices

pabpm = per average beneficiary per month

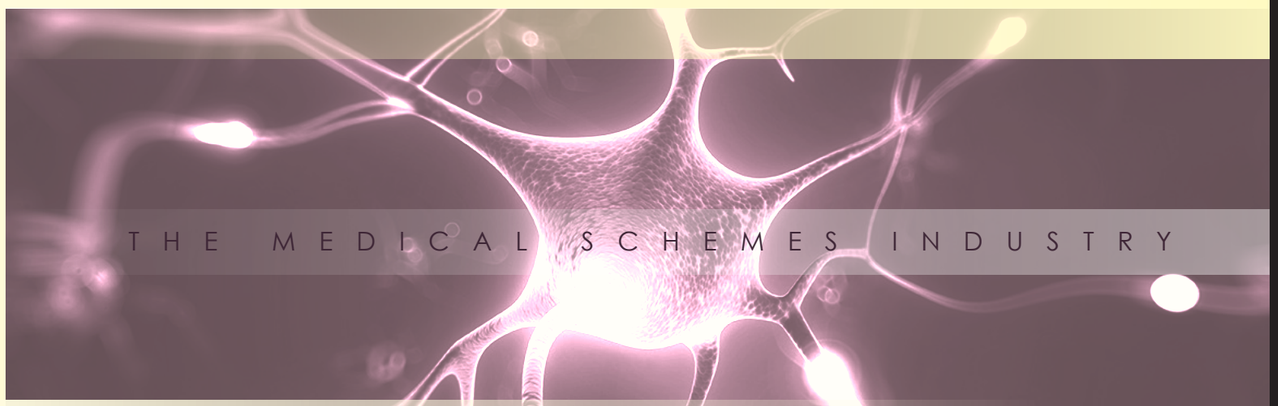
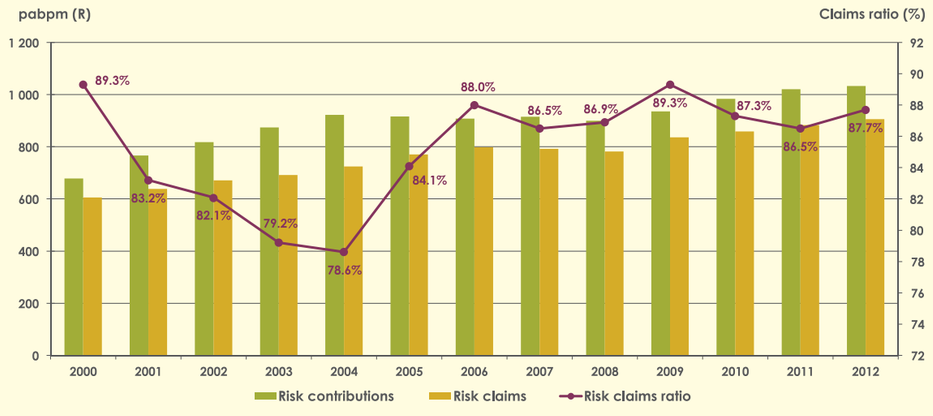


Figure 32 shows the relationship between risk contributions and claims paid over the past decade, after adjusting for inflation.

Figure 32: Risk claims ratio for all schemes in 2000-2012: 2012 prices



pabpm = per average beneficiary per month

After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised to 86.5% in 2007 and 86.9% in 2008. There was an increase in 2009, followed by a decrease over the next two years to 86.5% in 2011. For the year ended 31 December 2012, there was a slight increase from the previous year, with medical schemes paying out 87.7% of risk contributions in benefits.

Figure 33: Claims seasonality per month in 2012

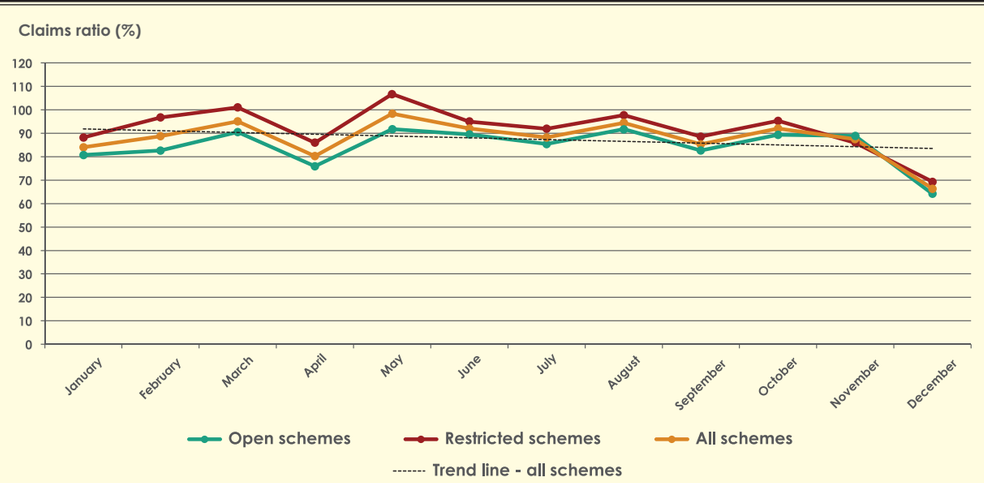


Figure 33 shows the seasonality of claims per month in 2012.

Both open and restricted schemes follow the same general trend: an increase in claims in the first quarter of the year as members gain access to new benefits, increases in claims as a proportion of contribution increases over the winter months, and a general downward trend in the last quarter of the year.

Risk transfer arrangements

Over the last few years, medical schemes have increasingly resorted to risk transfer arrangements to manage their insurance risks.

Table 42 reflects the main components of such arrangements:

- the capitation fees which schemes paid to third parties to manage their risks;
- the estimated costs which schemes would have incurred had they not used risk transfer arrangements; and
- the net effect thereof.

The "net income/(expense)" column reflects the value derived from the risk transfer arrangement. (Annexure S provides further details.)

Table 42: Significant risk transfer arrangements in 2011 & 2012

	Capitation fees			Estimated recoveries			Net income/(expense)*		
	2012 R'000	2011 R'000	% growth	2012 R'000	2011 R'000	% growth	2012 R'000	2011 R'000	% growth
Open schemes	2 192 757	2 124 457	3.2	1 809 451	2 061 305	(12.2)	(379 650)	(55 533)	583.7
Restricted schemes	1 051 761	945 935	11.2	1 097 887	1 017 359	7.9	48 854	72 825	(32.9)
All schemes	**3 244 518**	**3 070 392**	**5.7**	**2 907 338**	**3 078 665**	**(5.6)**	**(330 796)**	**7 293**	**2 012.9**

* The net income/(expense) on risk transfer arrangements also includes an amount of R6.4 million in respect of profit- and loss-sharing agreements.

Table 43 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 44 details the 10 biggest loss-making benefit options.

Table 43: Schemes with highest risk transfer arrangement losses in 2012

Ref. no.	Name of medical scheme	Beneficiaries	Capitation fees	Estimated recoveries	Net income/ (expense)	Net income/ (expense) as % of capitation fees
		As at 31.12.2012	R'000	R'000	R'000	%
1512	Bonitas Medical Fund	601 861	1 020 721	594 093	(426 628)	-41.8
1149	Medihelp	216 215	265 175	243 497	(19 755)	-7.4
1580	South African Police Service Medical Scheme (POLMED)	494 411	173 110	154 750	(18 359)	-10.6
1167	Momentum Health	200 062	218 457	202 501	(16 728)	-7.7
1486	Sizwe Medical Fund	148 544	41 508	29 399	(12 109)	-29.2
1597	Umvuzo Health Medical Scheme	47 025	88 374	78 495	(9 879)	-11.2
1087	Keyhealth	79 703	68 661	58 085	(8 069)	-11.8
1252	Bestmed Medical Scheme	152 499	84 651	78 916	(5 735)	-6.8
1537	Hosmed Medical Aid Scheme	78 130	36 504	31 373	(5 131)	-14.1
1575	Resolution Health Medical Scheme	81 601	22 593	17 801	(4 792)	-21.2

Table 44: Options with highest risk transfer arrangement losses in 2012

Ref. no.	Name of medical scheme	Name of benefit option	Beneficiaries	Average age pb	Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Net income/ (expense)	Net income/ (expense) as % of capitation fees
			As at 31.12.2012	R'000	R'000	R'000	R'000	R'000	%
1512	Bonitas Medical Fund	Boncap	50 974	33.8	374 314	104 110	-	(270 204)	(72.2)
1512	Bonitas Medical Fund	Standard	349 395	33.6	513 508	393 499	-	(120 009)	(23.4)
1149	Medihelp	Unify	10 803	25.5	52 009	28 425	(3 333)	(26 917)	(51.8)
1512	Bonitas Medical Fund	Primary	126 346	26.8	87 127	62 289	-	(24 838)	(28.5)
1167	Momentum Health	Incentive State & Any Hospital	20 189	31.0	17 683	963	(68)	(16 788)	(94.9)
1167	Momentum Health	Incentive State & Associated Hospital	20 106	30.4	17 532	950	(66)	(16 648)	(95.0)
1167	Momentum Health	Custom State & Associated Hospital	40 618	28.4	14 993	1 793	(123)	(13 323)	(88.9)
1512	Bonitas Medical Fund	Bonsave	62 306	26.7	40 299	28 950	-	(11 349)	(28.2)
1167	Momentum Health	Extender State & Any Hospital	4 392	31.0	7 387	194	(15)	(7 208)	(97.6)
1486	Sizwe Medical Fund	Sizwe Affordable	56 525	32.6	17 852	12 545	-	(5 307)	(29.7)

pb = per beneficiary

Bonitas Medical Fund is listed in both Table 43 and 44 as the biggest loss-maker.

The Extender State & Any Hospital benefit option on Momentum Health suffered the biggest loss in terms of the percentage of capitation fees paid (97.6%), followed by its Incentive State & Associated Hospital benefit option (95.0%) and its Incentive State & Any Hospital benefit option (94.9%), as shown in Table 44.

Non-healthcare expenditure

The non-healthcare expenditure of medical schemes consists mainly of:

- administration expenditure;
- managed healthcare: management services (fees for managing health benefits);
- commissions and service fees paid to brokers;
- other distribution costs; and
- impaired receivables.

Administration expenditure

Administration expenditure in all medical schemes had grown by 7.5% to R8.8 billion by the end of December 2012 from R8.2 billion in 2011. Open schemes increased their administration expenditure by 6.1% to R6.1 billion from R5.8 billion in 2011. The 10.8% increase from R2.4 billion in 2011 to R2.7 billion in 2012 in restricted schemes reflects the significant growth in their membership numbers during the year under review. GEMS alone experienced an 11.5% increase in the number of their average beneficiaries.

Eleven open schemes (representing 4.2% of all average beneficiaries) and 10 restricted schemes (representing 2.2% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of Gross Contribution Income (GCI) in 2012.

Table 45 shows "high-impact"[3] open schemes with administration expenditure greater than 10.0% of GCI. A high percentage is sometimes the function of a low average contribution rather than high absolute administration costs.

Table 45: High-impact open schemes with administration expenditure above 10.0% of GCI in 2012

Name of medical scheme	Average beneficiaries	Administration expenditure as % of GCI
Liberty Medical Scheme	126 720	10.3
Resolution Health Medical Scheme	76 091	13.3
Selfmed Medical Scheme	16 240	10.8
Spectramed	52 921	10.7

GCI = Gross Contribution Income

Table 46 shows high-impact open schemes with administration expenditure above the open schemes industry average of R107.7 pabpm. (When excluding self-administered schemes, this average increases to R108.8 pabpm.) In some instances high percentage increases may be the result of low average contributions. Relative to the open schemes industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

Table 46: High-impact open schemes with administration expenditure above the open schemes industry average of R107.7 pabpm in 2012

Name of medical scheme	Average beneficiaries	Administration expenditure pabpm (R)
Bestmed Medical Scheme	152 888	130.9
Discovery Health Medical Scheme	2 414 467	108.8
Fedhealth Medical Scheme	152 070	127.8
Keyhealth	81 073	114.0
Liberty Medical Scheme	126 720	125.9
Medihelp	222 014	111.0
Pro Sano Medical Scheme	56 106	128.0
Resolution Health Medical Scheme	76 091	121.7
Selfmed Medical Scheme	16 240	146.0
Spectramed	52 921	146.6

pabpm = per average beneficiary per month

Table 47 shows the gross administration fees paid to third-party administrators as well as administration fees paid by self-administered medical schemes. These fees are the sum of administration fees, co-administration fees, and other indirect fees paid to the administrator.

[3] Refer to the section on the Risk Assessment Framework (RAF) on pages 267-268.

Table 47: Gross administration fees paid to third-party administrators pabpm in 2011 & 2012

	Open schemes			Restricted schemes		
	pabpm	pabpm		pabpm	pabpm	
	2012 R	2011 R	% variance	2012 R	2011 R	% variance
Third-party administrators						
Administration fees	92.9	88.7	4.7	44.5	42.2	5.5
Co-administration fees	2.1	10.3	(79.6)	-	4.7	(100.0)
Total: third-party administrators	**93.0**	**89.1**	**4.4**	**44.5**	**42.2**	**5.5**
Self-administered medical schemes						
Administration fees	-	-	-	-	-	-
Co-administration fees	1.7	-	100.0	-	-	-
Total: self-administered medical schemes	**1.7**	**-**	**100.0**	**-**	**-**	**-**

pabpm = per average beneficiary per month

On average, third party-administered open schemes spent 109.0% more on gross administration fees than third party-administered restricted schemes (2011: 111.0%).

Administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE); they grew by 5.9% to R6.5 billion in 2012 from R6.2 billion in the previous year. These fees represented 82.6% of GAE in 2012 (2011: 83.0%).

Expenditure on benefits management: managed healthcare fees

Managed healthcare management fees increased by 9.6% to R2.7 billion in 2012 from R2.4 billion in 2011. In 2012, the number of beneficiaries covered by these managed healthcare interventions increased by 1.3% to 8 534 940 beneficiaries (or 98.3% of all beneficiaries).

Table 48 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare management fees. There were 53 options in this category, and they accounted for 4.7% of beneficiaries in respect of whom such expenditure was incurred.

Table 48: Managed healthcare management fees in respect of options with a claims ratio above 100% in 2012

	Managed care costs	Managed care costs	Gross healthcare result*	Gross healthcare result*	Beneficiaries	Number of options
	R'000	pbpm	R'000	pbpm		
Open schemes	41 296	26.4	(359 826)	(230.1)	130 325	25
Restricted schemes	62 775	19.5	(777 642)	(241.7)	268 137	28
All schemes	**104 070**	**21.8**	**(1 137 468)**	**(237.9)**	**398 462**	**53**

pbpm = per beneficiary per month
* Gross healthcare result = contributions less claims

Fees of trustees and Principal Officers

Remuneration and other considerations of trustees and Principal Officers rated 0.7% and 0.9% of GAE respectively. In 2012, the fees of Principal Officers came to 0.7% of GAE in open schemes (2011: 0.7%); they came to 1.5% in restricted schemes (2011: 1.5%).

Table 49 shows the 10 schemes with the highest average fees of trustees. More details are contained in Annexure P.

Table 49: Top 10 trustee fees in 2012

Name of medical scheme	Trustee remuneration and other considerations		
	R'000	Number of trustees	Average fee per trustee R'000
Government Employees Medical Scheme (GEMS)	6 535	12	545
Fedhealth Medical Scheme	3 552	11	323
Liberty Medical Scheme	3 339	10	334
Bestmed Medical Scheme	2 934	18	163
Medshield Medical Scheme	2 849	17	168
Discovery Health Medical Scheme	2 817	7	402
Spectramed	2 647	6	441
LA-Health Medical Scheme	2 418	18	134
Profmed	2 074	13	160
Medihelp	1 925	7	275

Trends in administration and managed healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2012 at 67.2% (2011: 67.6%). Managed healthcare management fees made up 20.4% of non-healthcare expenditure (2011: 20.1%).

Administration expenditure and managed healthcare management fees effectively accounted for 9.8% of GCI in 2012 (2011: 9.9 %).

Table 50 shows administration and managed healthcare expenditure by type of scheme administration.

Table 50: Gross Administration Expenditure (GAE) & managed healthcare expenditure in 2000-2012

	Open schemes				Restricted schemes			
	Self-administered		Third party-administered		Self-administered		Third party-administered	
	pabpm R	% change	pabpm R	% change	pabpm R	% change	pabpm R	% change
2000	37.5	-	48.7	-	24.7	-	38.3	-
2001	62.8	67.5	62.7	28.9	31.3	26.6	41.5	8.4
2002	55.8	(11.2)	69.8	11.3	37.3	19.4	49.3	18.8
2003	69.2	24.0	78.4	12.3	33.0	(11.7)	55.8	13.2
2004	75.9	9.8	86.1	9.8	43.3	31.4	59.1	6.1
2005	80.8	6.4	91.9	6.8	41.8	(3.5)	67.8	14.7
2006	84.1	4.1	96.9	5.4	39.0	(6.7)	67.2	(0.9)
2007	89.8	6.8	101.8	5.0	41.3	6.0	65.8	(2.0)
2008	96.5	7.5	108.5	6.6	41.8	1.3	65.5	(0.5)
2009	109.8	13.8	118.6	9.3	45.1	7.8	71.9	9.7
2010	106.2	(3.3)	124.4	4.9	54.6	21.0	74.2	3.3
2011	107.1	0.8	132.5	6.5	56.3	3.1	75.6	1.9
2012	128.4	19.9	139.0	4.9	62.8	11.5	79.9	5.7

pabpm = per average beneficiary per month

During 2012, there were seven self-administered open schemes (2011: 6), representing 606 932 average beneficiaries (2011: 595 578), and 19 third party-administered open schemes (2011: 21), representing 4 826 500 average beneficiaries (2011: 4 153 454).

Self-administered open schemes experienced a large increase of 19.9% in administration and managed healthcare services from R107.1 pabpm to R128.4 pabpm while third party-administered open schemes increased their expenditure by 4.9% to R139.0 pabpm from R132.5 pabpm in 2011. Third party-administered open schemes paid 8.3% more for administration and managed healthcare services than self-administered open schemes; the proportion was 23.7% in 2011.[4]

During 2012, there were eight self-administered restricted schemes (2011: 8), representing 272 933 beneficiaries (2011: 258 458), and 61 third party-administered restricted schemes (2011: 63), representing 3 581 754 beneficiaries (2011: 3 403 220). Third party-administered restricted schemes spent on average 27.2% more on administration and managed healthcare management fees at R79.9 pabpm compared to the R62.8 pabpm of self-administered restricted schemes.

Table 50 also shows that self-administered open schemes paid 104.5% (2011: 90.2%) more pabpm for administration and managed healthcare expenditure than self-administered restricted schemes. Third party-administered open schemes paid 74.0% (2011: 75.3%) more pabpm for administration and managed healthcare expenditure than third party-administered restricted schemes.

Table 51 takes the 10 largest schemes by number of average beneficiaries, and shows their total expenditure on administration and managed healthcare management fees. The industry averages were 7.5% for gross administration and 9.8% for gross administration plus managed healthcare as a percentage of Gross Contribution Income (GCI).

[4] Bestmed Medical Scheme became self-administered with effect from 1 July 2012.

Table 51: Gross Administration Expenditure (GAE) & managed healthcare expenditure of the 10 largest schemes in 2012

Name of medical scheme	Type of medical scheme	Average beneficiaries	GAE as % of GCI	GAE + managed healthcare expenditure as % of GCI
Discovery Health Medical Scheme	Open	2 414 467	9.0	11.8
Government Employees Medical Scheme (GEMS)	Restricted	1 752 033	4.2	6.0
Bonitas Medical Fund	Open	602 415	9.1	11.7
South African Police Service Medical Scheme (POLMED)	Restricted	491 472	4.4	6.4
Medihelp	Open	222 014	8.5	10.5
Medshield Medical Scheme	Open	201 746	6.0	7.9
Bankmed	Restricted	199 123	6.7	8.9
Momentum Health	Open	195 235	8.4	10.6
Bestmed Medical Scheme	Open	152 888	8.8	10.4
Fedhealth Medical Scheme	Open	152 070	9.2	11.2

GAE = Gross Administration Expenditure
GCI = Gross Contribution Income

Table 52 indicates the top 10 schemes with the highest marketing, advertising, and broker costs, the majority of which are open medical schemes. The table shows the expenditure incurred by schemes when recruiting new members. It should, however, be noted that this table reflects only those expenses that were paid directly by the scheme, and does not apportion administration fees where applicable. The membership statistics show that the number of principal members in open schemes increased by 0.7% from 2011 to 2012. The member growth shown in the table is not necessarily that of new members whose lives were not previously covered but also includes members who moved from other schemes.

Table 52: Top 10 schemes with the highest marketing, advertising & broker costs in 2012

Name of medical scheme	Marketing, advertising, and broker costs	New member growth
	pampm	%
Liberty Medical Scheme	126.8	9.6
Pharos Medical Plan	109.6	9.9
Makoti Medical Scheme	100.0	15.5
Bonitas Medical Fund	86.6	13.6
Topmed Medical Scheme	86.2	25.0
Fedhealth Medical Scheme	85.6	20.7
Medshield Medical Scheme	83.8	3.1
Bestmed Medical Scheme	81.0	18.7
Momentum Health	74.4	43.9
Umvuzo Health Medical Scheme	74.2	19.6

pampm = per average member per month

Tables 53 and 54 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 53: Open schemes with the highest marketing & advertising expenditure in 2012*

Name of medical scheme	2012 advertising & marketing pampm	2011 advertising & marketing pampm	% change	2012 broker fees paid	2011 broker fees paid	% change	2012 average members	2011 average members	% change	Name of main advertising & marketing provider(s)	% of total fees
Liberty Medical Scheme	78.4	47.3	65.7	48.4	47.9	1.2	58 780	65 335	(10.0)	Management and Auxiliary Services (Pty) Ltd	63.7
										V Medical Solutions (Pty) Ltd	36.3
Makoti Medical Scheme	63.9	14.0	355.8	36.1	31.4	14.9	2 525	3 015	(16.3)	SuperSport United Football Club (Pty) Ltd	16.1
Pharos Medical Plan	54.1	68.0	(20.5)	55.6	57.5	(3.5)	6 460	6 991	(7.6)	Pharadigm	49.1
Community Medical Aid Scheme (COMMED)	43.9	42.6	3.2	13.3	28.1	(52.7)	7 535	8 536	(11.7)	Allcare Administrators (Pty) Ltd	100.0
Selfmed Medical Scheme	41.8	45.1	(7.3)	11.5	12.0	(3.5)	8 601	8 834	(2.6)	Lift Marketing	32.6
Bonitas Medical Fund	39.1	30.8	27.0	47.5	46.8	1.5	273 285	267 071	2.3	Bonitas Marketing (Pty) Ltd	100.0
Open schemes industry average**	**28.6**	**23.3**	**22.7**	**53.5**	**52.2**	**2.4**	**2 190 872**	**2 165 218**	**1.2**		

pampm = per average member per month
* Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.
** The industry averages are based only in respect of those schemes which incurred the specific expenditure.

Table 54: Restricted schemes with the highest marketing & advertising expenditure in 2012*

Name of medical scheme	2012 advertising & marketing pampm	2011 advertising & marketing pampm	% change	2012 broker fees paid	2011 broker fees paid	% change	2012 average members	2011 average members	% change	Name of main advertising & marketing provider(s)	% of total fees
Motohealth Care	47.5	34.1	39.0	3.3	3.1	4.7	28 745	29 658	(3.1)	Thethani	64.6
Umvuzo Health Medical Scheme	34.1	30.1	13.4	40.0	31.3	28.0	23 738	21 721	9.3	Rain Catchers (Pty) Ltd	100.0
Profmed	25.8	18.1	42.5	19.7	17.7	11.1	26 565	25 991	2.2	Ebony and Ivory	100.0
Restricted schemes industry average**	**11.0**	**12.2**	**(9.7)**	**25.3**	**21.0**	**20.8**	**1 592 119**	**1 505 777**	**5.7**		

pampm = per average member per month
* Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.
**The industry averages are based only in respect of those schemes which incurred the specific expenditure.

Broker costs

Broker costs include all commissions, service fees, and other distribution costs.

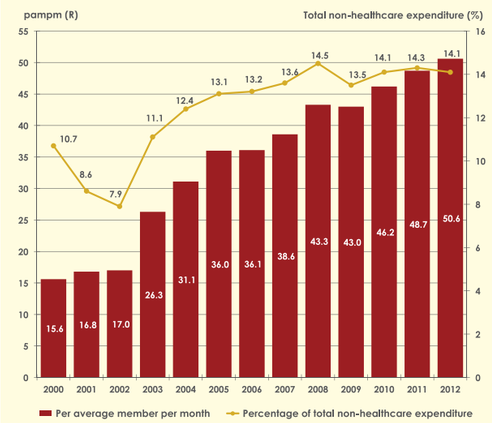
Broker costs increased with 4.3% from R1 389.2 million in 2011 to R1 449.1 million in 2012.

Broker costs represented 11.1% of total non-healthcare expenditure in 2012; broker costs as a percentage of total non-healthcare expenditure was 11.5% in 2011.

For schemes that pay broker commissions, the amounts paid on a per average member per month (pampm) basis increased to R48.8 pampm in 2012 from R46.8 pampm in 2011, representing an increase of 4.2%. Broker commissions as a percentage of GCI remained stable at 1.2%.

Figure 34 shows annual broker service fees since 2000, as well as their percentage shares of total non-healthcare expenditure.

Figure 34: Broker service fees (open schemes) in 2000-2012



pampm = per average member per month

Figure 35 illustrates the increase in broker fees relative to membership of schemes that pay brokers.

Figure 35: Broker fees & scheme membership in 2000-2012

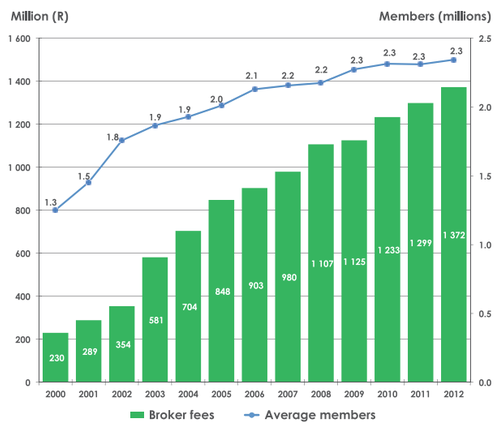


Table 55 illustrates the schemes which had broker service fees at levels higher than the industry average of R48.8 pampm (2011: R46.8 pampm). These 10 schemes (2011: 11) represented 62.5% (2011: 71.3%) of total membership that paid for broker service fees, and 71.2% (2011: 80.5%) of total broker service fees paid. Three of these schemes paid at levels 15.0% greater than the industry average.

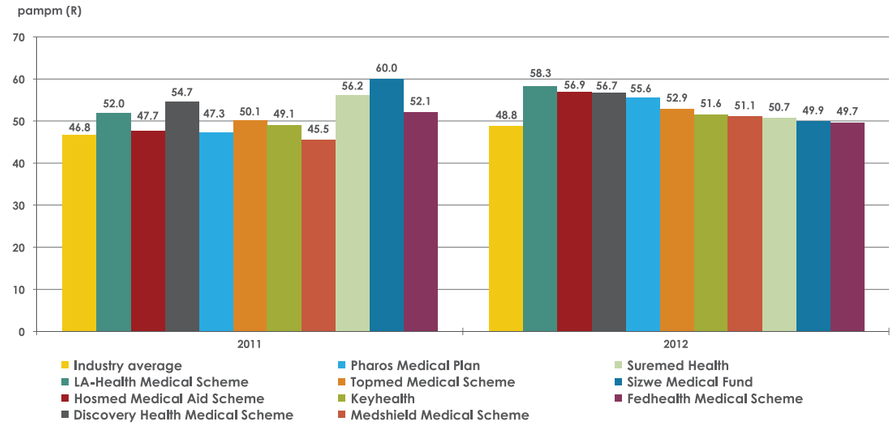
It is of concern that even while some of these schemes' broker commission pampm exceeded the industry average, they also incurred additional distribution fees in respect of their broker network.

Table 55: Schemes with broker fees above the industry average of R48.8 pampm in 2011 & 2012

Name of medical scheme	Type of medical scheme	Broker fees			Distribution fees		
		2012 pampm (R)	2011 pampm (R)	% change	2012 pampm (R)	2011 pampm (R)	% change
LA-Health Medical Scheme	Restricted	58.3	52.0	12.2%	-	-	0.0%
Hosmed Medical Aid Scheme	Open	56.9	47.7	19.3%	-	-	0.0%
Discovery Health Medical Scheme	Open	56.7	54.7	3.5%	-	-	0.0%
Pharos Medical Plan	Open	55.6	47.3	17.6%	-	10.3	-100.0%
Topmed Medical Scheme	Open	52.9	50.1	5.6%	13.0	8.8	47.8%
Keyhealth	Open	51.6	49.1	5.2%	-	-	0.0%
Medshield Medical Scheme	Open	51.1	45.5	12.3%	22.9	26.3	-13.2%
Suremed Health	Open	50.7	56.2	-9.8%	11.2	8.9	26.0%
Sizwe Medical Fund	Open	49.9	60.0	-16.9%	-	-	0.0%
Fedhealth Medical Scheme	Open	49.7	52.1	-4.7%	-	-	0.0%

pampm = per average member per month

Figure 36: Schemes with broker fees above the industry average of R48.8 pampm in 2011 & 2012



pampm = per average member per month

Reinsurance results

Two medical schemes had reinsurance contracts in 2012 (2011: 1). The two schemes made net healthcare deficits of R19.9 million with a net reinsurance surplus of R3.1 million.

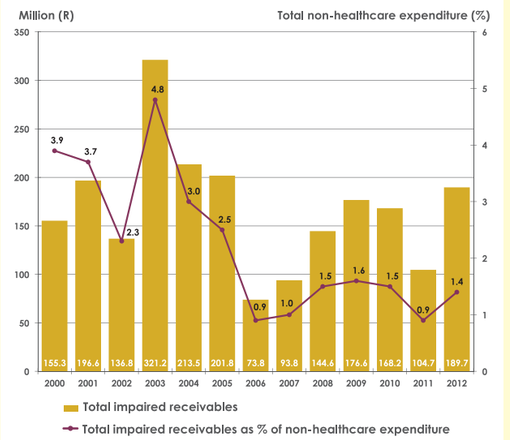
Impaired receivables

Impaired receivables increased by 81.2% to R189.7 million for the year under review from R104.7 million in 2011. They represented 1.4% of total non-healthcare expenditure (0.9% in 2011).

It took schemes an average of 10.9 days to collect debts (contributions from their members) in 2012; this is a decrease of 12.5% from 12.5 days in 2011. This collection period still falls well outside the legal provisions which require that members pay all contributions to their medical scheme not later than three days after the payment is due. The associated risks of not paying and collecting contributions timeously are the possible impairment of the debtor and paying claims when contributions have not been received.

Figure 37 shows the trend in impaired receivables over the past 13 years, also expressed as a percentage of total non-healthcare expenditure.

Figure 37: Impaired receivables in 2000-2012



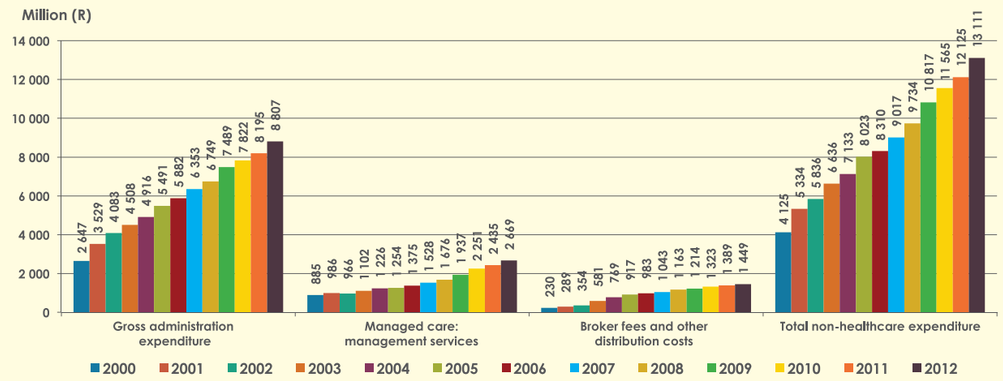
Trends in non-healthcare expenditure

Total net non-healthcare expenditure rose by 8.1% from R12.1 billion in 2011 to R13.1 billion in 2012.

Before 2006, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI). The rate of increase was reversed in 2006[5] and since then there has been a real decrease in non-healthcare expenditure, from R1 843.2 in 2005 to R1 523.6 per average beneficiary per year in 2012.

Figure 38 shows the changes in the major categories of non-healthcare expenditure for the past 13 years.

Figure 38: Changes in non-healthcare expenditure in 2000-2012



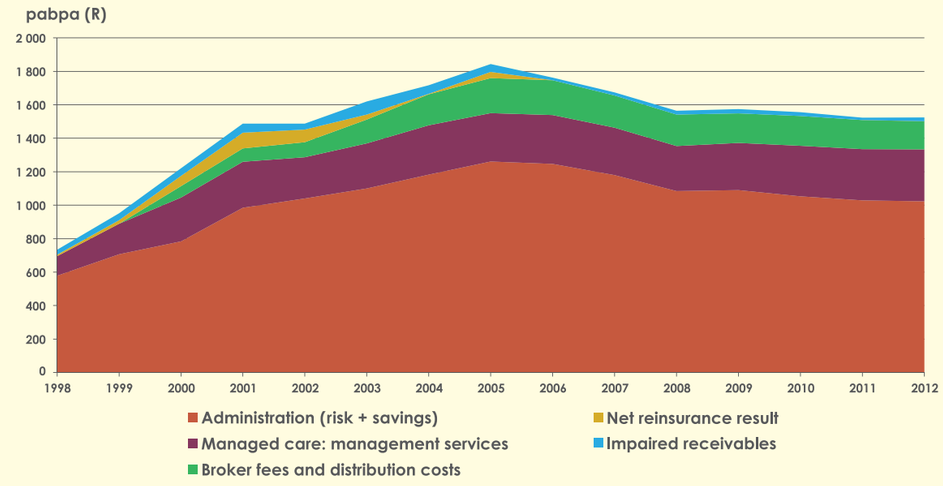
Total gross non-healthcare expenditure has increased by 217.9% since 2000. (Gross non-administration costs equate to net administration costs as no administration costs were paid in relation to savings accounts from 2007 onwards.) This was driven by a 232.7% upswing in administration expenditure, a 201.4% rise in fees paid for managed healthcare, and an increase of 530.6% in broker costs.

By comparison, gross claims have risen by 279.6% (not adjusted for inflation) since 2000.

Figures 39 and 40 as well as Table 56 show that, after adjusting for inflation, gross non-healthcare expenditure per average beneficiary per annum (pabpa) decreased in real terms since 2005. It increased marginally (by 0.1%) to R1 523.6 in 2012 from R1 522.7 in 2011. The net claims ratio also increased, to 87.7% in 2012 from 86.5% in 2011.

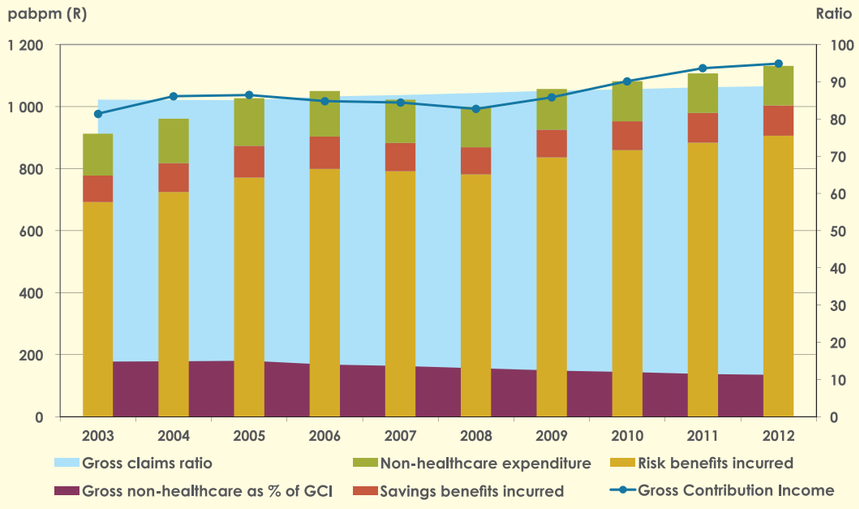
[5] This can partly be explained by GEMS starting to operate in 2006.

Figure 39: Non-healthcare expenditure pabpa in 1998-2012: 2012 prices



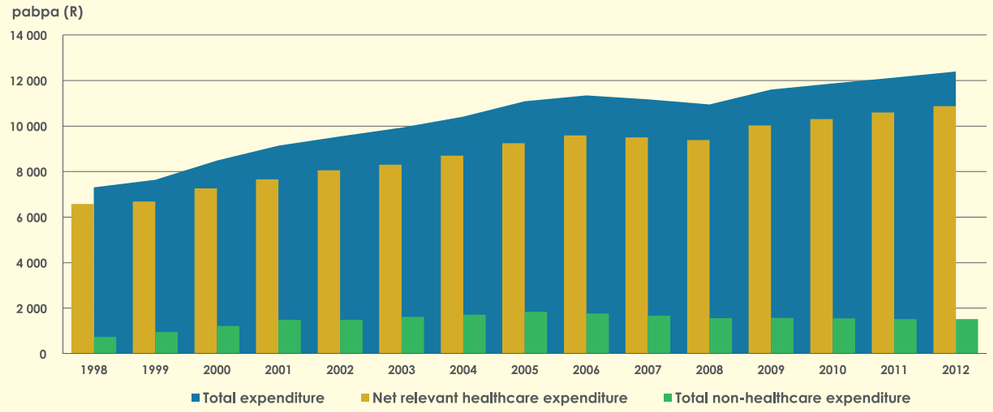
pabpa = per average beneficiary per annum

Figure 40: Gross claims & gross non-healthcare expenditure pabpm in 2003-2012: 2012 prices



pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Figure 41: Claims & non-healthcare expenditure pabpa in 1998-2012: 2012 prices



pabpa = per average beneficiary per annum

Table 56: Trends in contributions, claims & non-healthcare expenditure in 2000-2012: 2012 prices*

	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa R	% change	pabpa R	% change	pabpa R	% change
2000	9 060.2	6.4	8 085.7	6.1	1 221.4	28.2
2001	10 225.1	12.9	8 569.4	6.0	1 487.6	21.8
2002	10 882.3	6.4	8 973.4	4.7	1 487.1	0.0
2003	11 725.0	7.7	9 330.0	4.0	1 619.8	8.9
2004	12 396.1	5.7	9 810.7	5.2	1 716.1	5.9
2005	12 450.3	0.4	10 476.8	6.8	1 843.2	7.4
2006	12 205.5	-2.0	10 836.3	3.4	1 762.0	-4.4
2007	12 150.4	-0.5	10 595.3	-2.2	1 673.5	-5.0
2008	11 909.3	-2.0	10 426.6	-1.6	1 564.4	-6.5
2009	12 354.9	3.7	11 108.8	6.5	1 574.8	0.7
2010	12 982.2	5.1	11 425.5	2.9	1 556.1	-1.2
2011	13 485.7	3.9	11 758.2	2.9	1 522.7	-2.1
2012	13 657.1	1.3	12 044.8	2.4	1 523.6	0.1
Since 2000		**50.7**		**49.0**		**24.7**

pabpa = per average beneficiary per annum
* The values were adjusted for CPI for 2000-2012.

Figure 40 and Table 56 also show how non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.0% per annum from 1999 to 2001 before stabilising.

Table 57 shows the eight open schemes with non-healthcare expenditure greater than both the industry average of R164.0 pabpm and the open schemes average of 15.6% when expressed as a percentage of Risk Contribution Income (RCI).

Table 57: Trends in claims, non-healthcare expenditure & reserve-building as a percentage of contributions (open schemes) in 2011 & 2012

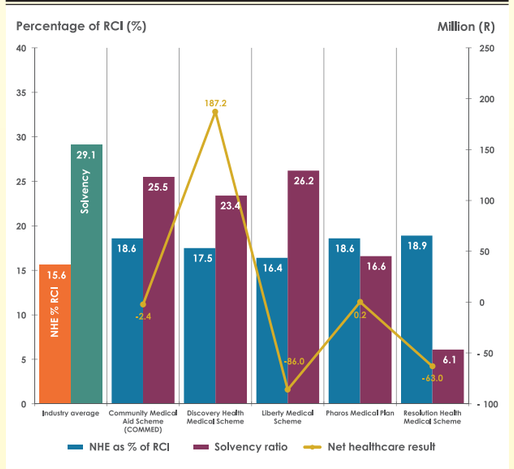
Name of medical scheme	Net non-healthcare expenses		Net claims incurred		Net non-healthcare expenses		Reserve-building	
	pabpm 2012 (R)	pabpm 2011 (R)	As % of RCI 2012	As % of RCI 2011	As % of RCI 2012	As % of RCI 2011	As % of RCI 2012	As % of RCI 2011
Community Medical Aid Scheme (COMMED)	287.9	224.7	82.3	83.9	18.6	16.3	(0.9)	(0.3)
Compcare Wellness Medical Scheme	202.3	199.6	80.9	82.0	16.2	16.0	2.9	2.0
Discovery Health Medical Scheme	170.7	164.4	81.8	82.1	17.5	18.2	0.7	(0.3)
Liberty Medical Scheme	180.2	147.7	88.8	89.3	16.4	15.0	(5.1)	(4.3)
Pharos Medical Plan	238.3	228.5	81.3	83.6	18.6	19.3	0.1	(2.9)
Resolution Health Medical Scheme	171.7	163.9	88.7	88.2	18.9	20.8	(7.6)	(9.0)
Spectramed	193.6	152.4	80.0	77.8	17.3	15.3	2.7	6.9
Suremed Health	175.2	175.6	78.9	84.5	16.6	18.0	4.5	(2.5)
Industry average: open schemes	**164.0**	**154.1**	**84.5**	**84.4**	**15.6**	**15.6**	**(0.1)**	**(0.1)**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

Figure 42 shows the schemes in Table 57 that had a solvency ratio below the open schemes average of 29.1%. It is concerning that some of these medical schemes fall below the 25.0% solvency target yet exhibit very high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

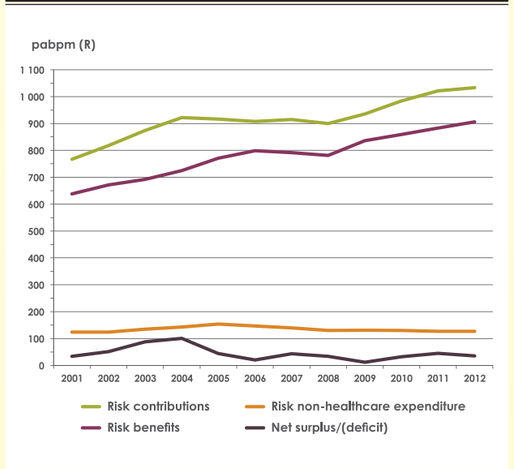
Figure 43 depicts information on contributions, benefits, non-healthcare expenditure, and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm was growing since 2000 but it decreased in 2003, almost levelling out in 2004. Although this gap has since grown again, it seems to have stabilised in the last few years.

Figure 42: Open schemes with high non-healthcare expenditure & solvency ratio below average in 2012



RCI = Risk Contribution Income
NHE = non-healthcare expenditure

Figure 43: Risk contributions, benefits, non-healthcare expenditure & operating surpluses in 2001-2012: 2012 prices*



pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2001-2012.

Net healthcare results and trends

The net healthcare result of a medical scheme illustrates its position after benefits and non-healthcare expenditure are deducted from contribution income.

The net healthcare result for all medical schemes combined was a surplus of R25.7 million in 2012 (2011: R1.0 billion surplus). Open schemes incurred deficits of R61.1 million (2011: R47.6 million), and restricted schemes generated surpluses of R86.8 million (2011: R1.1 billion surplus). Due to mainly the increased claims costs (net relevant healthcare expenditure), which increased by 10.9% in 2012, the year-on-year financial performance of both open and restricted schemes has deteriorated.

Figure 44: Net healthcare results in 2000-2012

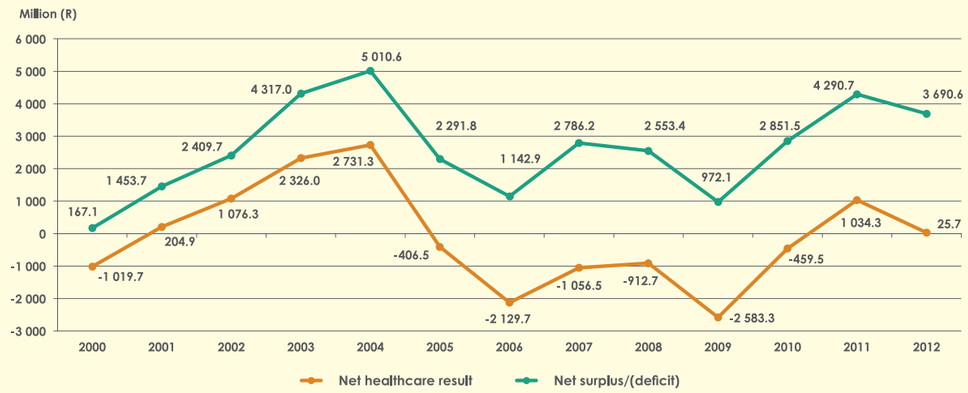


Table 58 lists the 20 schemes with the highest net healthcare deficits. Investment income has resulted in a number of these schemes not experiencing major drops in their solvency levels.

Table 58: 20 schemes with the largest net healthcare deficits in 2011 & 2012

Name of medical scheme	Type of medical scheme	Net healthcare result			Solvency ratio	
		2012 R'000	2011 R'000	% change	2012 %	2011 %
Bonitas Medical Fund	Open	(184 477)	(28 218)	(553.8)	35.5	37.3
Medihelp	Open	(164 123)	84 537	(294.1)	32.4	29.3
Government Employees Medical Scheme (GEMS)	Restricted	(144 662)	464 219	(131.2)	7.9	8.6
Liberty Medical Scheme	Open	(86 040)	(73 361)	(17.3)	26.2	27.9
Bankmed	Restricted	(79 097)	(56 154)	(40.9)	48.5	50.2
Resolution Health Medical Scheme	Open	(63 037)	(57 366)	(9.9)	6.1	9.1
Sizwe Medical Fund	Open	(57 433)	(90 499)	36.5	25.4	26.9
Anglo Medical Scheme	Restricted	(52 435)	(55 331)	5.2	472.3	464.7
Topmed Medical Scheme	Open	(49 300)	(29 136)	(69.2)	152.3	169.2
Pro Sano Medical Scheme	Open	(36 058)	(11 653)	(209.4)	22.6	25.2
Nedgroup Medical Aid Scheme	Restricted	(29 137)	(46 270)	37.0	36.1	36.8
Quantum Medical Aid Society	Restricted	(25 755)	(12 409)	(107.6)	98.6	112.2
Sasolmed	Restricted	(21 166)	6 639	(418.8)	46.5	48.9
Selfmed Medical Scheme	Open	(21 065)	11 763	(279.1)	116.2	114.5
Bestmed Medical Scheme	Open	(21 049)	(8 386)	(151.0)	28.5	30.2
Afrox Medical Aid Society	Restricted	(20 872)	(15 827)	(31.9)	97.6	112.0
Malcor Medical Scheme	Restricted	(19 525)	(20 400)	4.3	26.1	27.7
Platinum Health	Restricted	(19 524)	74 672	(126.1)	34.7	35.5
Golden Arrow Employees Medical Benefit Fund	Restricted	(16 258)	(16 306)	0.3	112.1	95.0
BP Medical Aid Society	Restricted	(15 257)	(14 081)	(8.3)	99.1	91.8

A total of 53.9% (or 14 of 26) of open schemes and 44.8% (30 of 67[6]) of restricted schemes made net healthcare deficits.

The net surplus after investment income and consolidation adjustments of all schemes combined was R3.7 billion (2011: R4.3 billion). Net investment and other income and expenditure increased by 12.5% to R3.6 billion. Open schemes made a R1.6 billion (2011: R2.0 billion) surplus and restricted schemes a surplus of R2.0 billion (2011: R2.3 billion).

Figures 43 and 44 show the impact of the increases in claims costs on the net healthcare result.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 44.

Table 59 shows the 20 schemes with the largest net healthcare deficits by the Risk Assessment Framework (RAF) classification; they represent 90.6% of all average beneficiaries that suffered operating deficits. (Annexure L has more details on this.)

[6] Alliance Midmed Medical Scheme and Metrocare did not submit any financial information and were therefore omitted from this analysis.

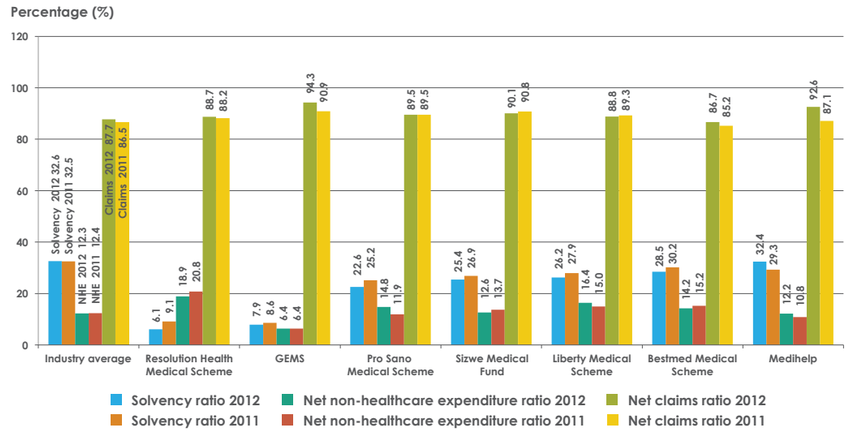
Table 59: 20 schemes with the largest net healthcare deficits by RAF classification in 2011 & 2012

Name of medical scheme	Type of medical scheme	Net healthcare result			
		2012 R'000	2011 R'000	% change	RAF classification
Bonitas Medical Fund	Open	(184 477)	(28 218)	(553.8)	High
Medihelp	Open	(164 123)	84 537	(294.1)	High
Government Employees Medical Scheme (GEMS)	Restricted	(144 662)	464 219	(131.2)	High
Liberty Medical Scheme	Open	(86 040)	(73 361)	(17.3)	High
Bankmed	Restricted	(79 097)	(56 154)	(40.9)	High
Resolution Health Medical Scheme	Open	(63 037)	(57 366)	(9.9)	High
Sizwe Medical Fund	Open	(57 433)	(90 499)	36.5	High
Anglo Medical Scheme	Restricted	(52 435)	(55 331)	5.2	Medium
Topmed Medical Scheme	Open	(49 300)	(29 136)	(69.2)	Medium
Pro Sano Medical Scheme	Open	(36 058)	(11 653)	(209.4)	High
Nedgroup Medical Aid Scheme	Restricted	(29 137)	(46 270)	37.0	High
Quantum Medical Aid Society	Restricted	(25 755)	(12 409)	(107.6)	Medium
Sasolmed	Restricted	(21 166)	6 639	(418.8)	High
Selfmed Medical Scheme	Open	(21 065)	11 763	(279.1)	High
Bestmed Medical Scheme	Open	(21 049)	(8 386)	(151.0)	High
Afrox Medical Aid Society	Restricted	(20 872)	(15 827)	(31.9)	Medium
Malcor Medical Scheme	Restricted	(19 525)	(20 400)	4.3	Medium
Platinum Health	Restricted	(19 524)	74 672	(126.1)	High
Golden Arrow Employees Medical Benefit Fund	Restricted	(16 258)	(16 306)	0.3	Medium
BP Medical Aid Society	Restricted	(15 257)	(14 081)	(8.3)	Medium

RAF = Risk Assessment Framework

Figure 45 shows the high-impact schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 32.6%. (Annexure M provides more details.)

Figure 45: High-impact schemes with the largest net healthcare deficits & solvency levels below the industry average of 32.6% in 2012



NHE = non-healthcare expenditure
GEMS = Government Employees Medical Scheme

Accumulated funds, solvency, and solvency trends

Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes.

Accumulated funds, meaning the net asset value of the medical scheme excluding inter alia funds set aside for specific purposes and unrealised non-distributable profits, must at all times be maintained at a minimum level of 25.0% of gross contributions. These minimum accumulated funds are more commonly called the "reserves" of a scheme. When expressed as a percentage of gross contributions, they become known as the "solvency ratio" of a scheme.

The purpose of a regulatory solvency level is to act as a warning mechanism to indicate a medical scheme's potential inability to meet its obligations. A solvency margin serves both to protect members' interests as well as to guarantee the continued operation of the scheme, ensuring that it is able to meet the members' claims as they arise. It also acts as a buffer against unforeseen and adverse experiences, whether from claims, assets, liabilities, or expenses.

Net assets or members' funds (i.e. total assets minus total liabilities) rose by 10.9% to end the year 2012 at R40.9 billion. Accumulated funds as defined (Regulation 29 reserves) grew by 9.6% to R38.3 billion from the R34.9 billion recorded in 2011.

The industry average solvency ratio increased by 0.3% to 32.6% compared to 32.5% in 2011.

The solvency ratio of open schemes increased by 1.4% to 29.1% in 2012 (2011: 28.7%). Restricted schemes experienced a decline of 2.3% in their solvency ratio, which reduced to 37.4% in 2012 from 38.3% in 2011.

Table 58 lists the schemes which experienced the largest net healthcare deficits. Full details of the solvency ratios of all medical schemes are contained in Annexures J, K, and L.

Figures 46, 47 and 48 show the changes in solvency ratios in all schemes, open schemes, and restricted schemes respectively. The three figures reflect improvements in solvency ratios since 2001 when the Medical Schemes Act was implemented.

The solvency of restricted schemes has, however, been declining since 2006. This is mostly due to the denominator that is used in the solvency calculation, which is affected by membership growth. GEMS had shown exceptional membership growth since registration, and that resulted in the deterioration of the solvency level of the restricted schemes industry.

Figure 46: Industry solvency for all schemes in 2000-2012

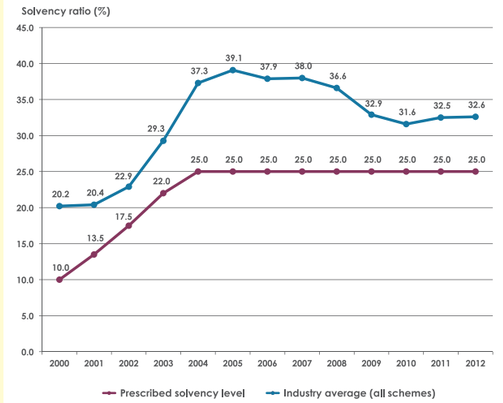


Figure 47: Industry solvency for open schemes in 2000-2012

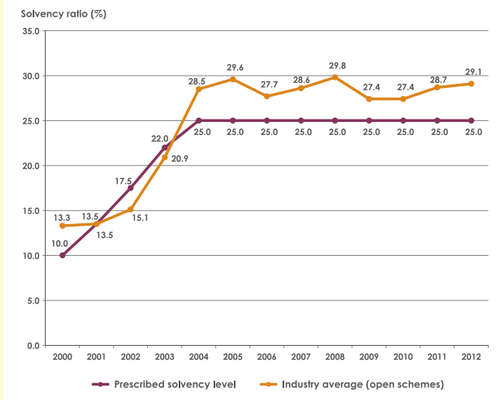
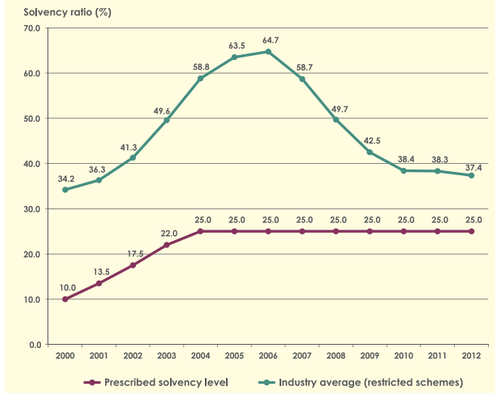


Figure 48: Industry solvency for restricted schemes in 2000-2012



Factors that affect solvency

The most important factors impacting on solvency are:

- the pricing of contributions relevant to benefits provided, including whether such benefits are provided from the risk pool of the scheme or from members' savings monies;
- non-healthcare expenditure; and
- investment income.

The membership profile of a medical scheme further affects its solvency; it includes the average age of its beneficiaries, its pensioner ratio, number of male versus female dependants, and dependant ratio. The membership profile affects the frequency and extent of claims.

Table 60 looks at risk claims, non-healthcare expenditure, and contributions relative to reserves between 1999 and 2012.

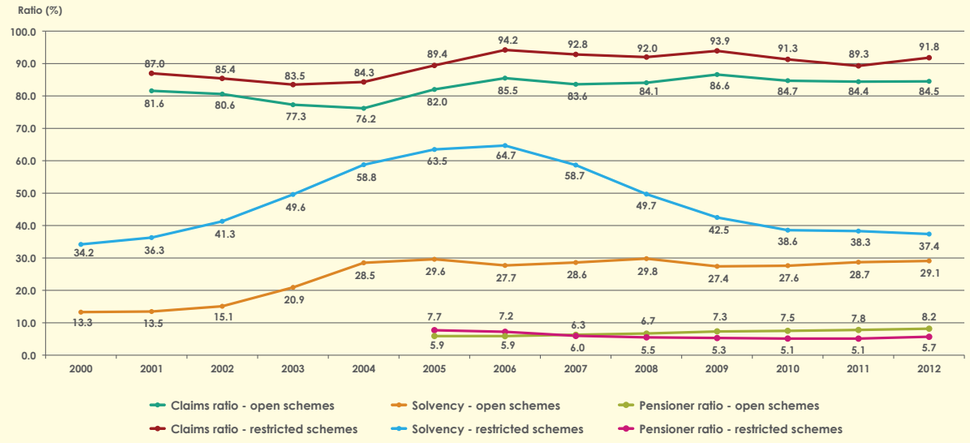
Table 60: Risk claims, non-healthcare expenditure & reserve-building as a percentage of contributions in 1999-2012 (%)

	Risk claims	Non-healthcare expenditure	Reserve-building
1999	91.5	12.7	(4.2)
2000	89.3	14.5	(3.7)
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	(0.0)
2006	88.0	16.2	(4.1)
2007	86.5	15.2	(1.8)
2008	86.9	14.5	(1.4)
2009	89.3	14.0	(3.3)
2010	87.3	13.2	(0.5)
2011	86.5	12.4	1.1
2012	87.7	12.3	-

Total risk claims fell between 2000 and 2004, but the ratio of contributions to reserves improved during this period from a negative 3.7% to a positive 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. The claims ratio then started to increase in 2005 and reached 87.7% in 2012. Contributions to reserves were negative during this time, which is consistent with the fact that most medical schemes have attained the prescribed solvency ratio of 25.0% and do not need to grow their reserves any further. The maintenance of reserves should be considered against the backdrop of increasing claim costs to ensure that members are protected at all times.

Figure 49 illustrates the impact of GEMS on all medical schemes. (This restricted scheme was registered on 1 January 2005 but started with operations only on 1 January 2006.)

Figure 49: The impact of GEMS in 2006-2012*

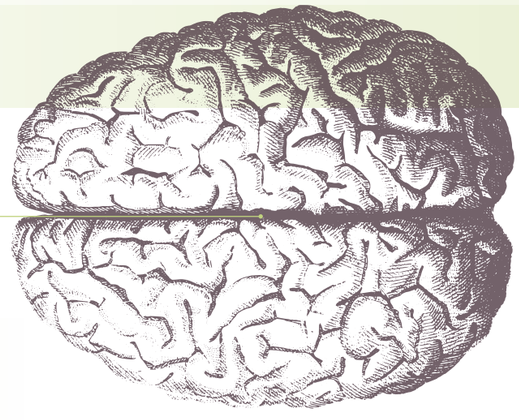


* Claims data per industry was available only from 2001 onwards and pensioner ratios from 2005 onwards.

GEMS initially had a positive effect on the solvency levels of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who are now steadily leaving them to join GEMS. The reserves which these members had accumulated over the years of their membership of these open schemes were not transferred to GEMS.

A negative impact was subsequently experienced on some of these open schemes' claiming patterns as the profile of members who left them to join GEMS tended to be young and healthy, and was not necessarily replaced by members of a similar profile.

Medical schemes should be careful of the so-called "death spiral". A scheme with a bad, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members being over-priced, causing the younger and lower-claiming members to move to other, less expensive options, or even other medical schemes. This results in the scheme losing the cross-subsidy provided by these younger members and hence an increase in losses, resulting in even higher contribution increases and/or the lowering of benefits.



Beneficiaries of schemes which failed to reach the 25.0% solvency

Table 61 shows both the number of medical schemes which have yet to attain the prescribed solvency ratio of 25.0% and the number of beneficiaries in those schemes; these numbers are also shown in Figure 50.

Table 61: Prescribed solvency & number of beneficiaries in 2000-2012

	Open schemes		Restricted schemes	
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
Number of medical schemes				
2000	15	33	15	86
2001	19	29	11	83
2002	24	25	7	86
2003	19	29	7	80
2004	18	30	4	81
2005	17	29	4	79
2006	18	23	4	79
2007	18	23	7	74
2008	14	21	8	71
2009	16	17	7	71
2010	12	15	7	66
2011	9	17	5	66
2012 [7]	7	18	4	63

Number of beneficiaries	At end of year	%	At end of year	At end of year	%	At end of year
2000	2 385 051	51.0	2 291 048	839 029	40.9	1 214 412
2001	2 650 934	55.6	2 117 142	576 462	28.9	1 419 862
2002	3 519 329	74.4	1 211 882	251 050	12.7	1 731 873
2003	3 426 988	72.6	1 291 809	222 430	11.4	1 730 574
2004	2 534 273	53.3	2 221 030	80 160	4.2	1 827 100
2005	2 783 108	56.7	2 122 444	36 359	1.9	1 893 710
2006	3 218 382	63.7	1 832 056	145 369	7.0	1 931 536
2007	3 139 176	63.4	1 812 141	689 865	26.0	1 964 054
2008	1 076 450	22.0	3 812 456	981 977	32.9	2 003 943
2009	992 523	20.6	3 822 811	1 254 151	38.6	1 999 020
2010	2 918 055	60.8	1 881 860	1 684 682	47.9	1 831 121
2011	2 855 072	60.0	1 905 042	1 865 313	49.5	1 900 982
2012	2 796 583	58.8	1 963 411	1 978 668	50.5	1 940 811

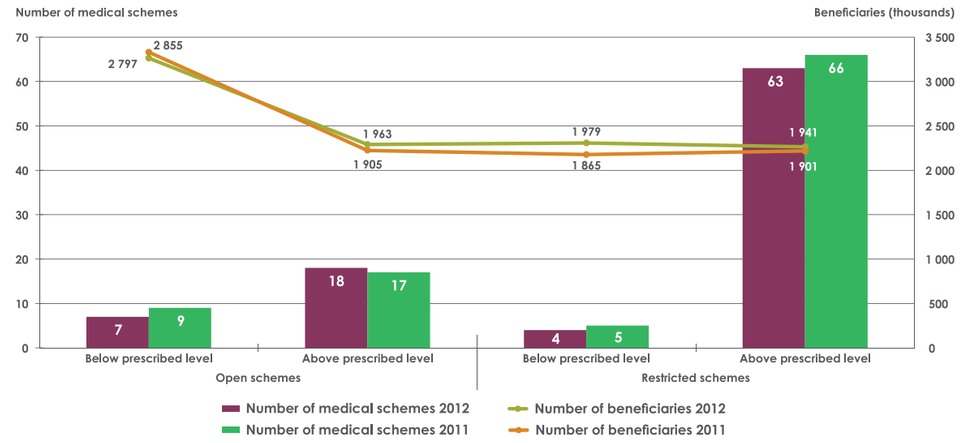
Table 61 and Figure 50 show prescribed solvency levels and beneficiary representation in medical schemes which are both below and above the prescribed solvency level.

A total of 58.8% of beneficiaries in open schemes (2011: 60.0%) were covered by the seven schemes (2011: 9) which failed to meet the prescribed solvency level in 2012. The remaining beneficiaries belonged to the other 18 open schemes (2011: 17) which had attained the prescribed solvency level of 25.0%.

Most beneficiaries belonging to open schemes which have yet to achieve the prescribed solvency are beneficiaries of Discovery Health Medical Scheme, the largest open scheme in South Africa based on the number of beneficiaries in December 2012.

[7] Alliance Midmed Medical Scheme did not submit any financial information and was therefore omitted from this analysis.

Figure 50: Prescribed solvency & number of beneficiaries in 2011 & 2012



Of the 67 restricted schemes, only four had a solvency below 25.0%. These four, however, constitute 50.5% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory phase-in solvency level of 25.0% and this accounts for 91.6% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

The CMS is cognisant of the structural challenges facing the medical schemes environment and aware of the progress that schemes have made thus far in moving towards the prescribed solvency levels, but much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

The Risk Assessment Framework and high-impact schemes

The Risk Assessment Framework (RAF) is a regulatory tool adopted by the CMS to identify both scheme-specific and cross-cutting risks related to the medical schemes environment as a whole. It assists in identifying those medical schemes which may have the biggest systemic impact on the goals of the CMS and industry if they were to fail; RAF enables the CMS to identify high-impact schemes. These are schemes whose failure, financial or other, would have a major impact on the industry; the classification does not necessarily mean that the identified scheme is a big-risk scheme or that it is experiencing problems.

Of the 28 schemes classified as high impact in 2012 (2011: 28), two (2011: 3) had a solvency ratio below 10.0%, none (2011: 0) had a solvency ratio of 10.0-15.0%, one (2011: 2) of 15.0-20.0%, and four (2011: 2) of 20.0-25.0%. The remaining 21 high-impact schemes (2011: 21) had met the prescribed solvency of 25.0% by the end of 2012.

Table 62 shows that the average contributions of high-impact open schemes were 4.3% higher than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that was 8.6% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of Risk Contribution Income (RCI) of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 106.9%.

Table 62: High-impact schemes by type in 2011 & 2012

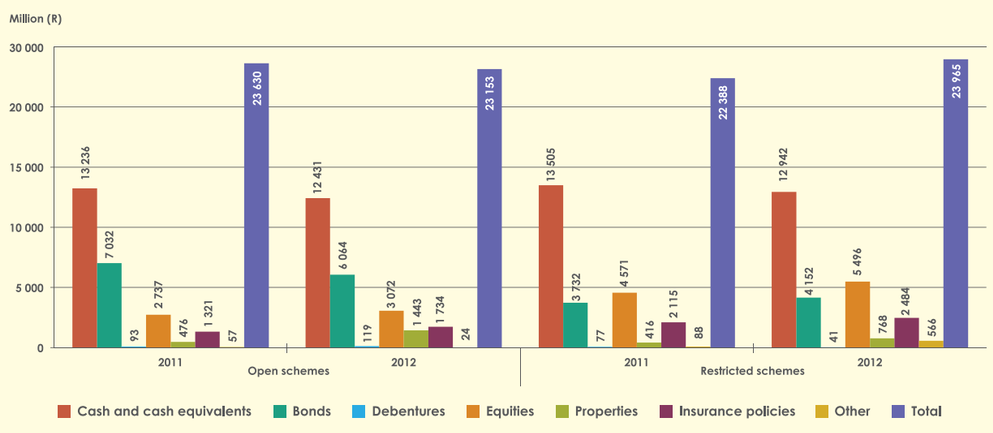
	Average beneficiaries		Net contributions pabpm (R)		Net claims ratio (%)		Net non-healthcare ratio (%)		Solvency ratio (%)	
	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011
Open schemes	4 580 290	4 569 069	1 051.6	986.6	84.4	84.4	15.6	15.7	27.8	27.3
Restricted schemes	3 098 959	2 903 334	1 008.7	934.3	92.4	89.0	7.6	7.6	24.8	25.6
All schemes	**7 679 249**	**7 472 403**	**1 034.3**	**966.2**	**87.5**	**86.2**	**12.5**	**12.6**	**26.7**	**26.7**

pabpm = per average beneficiary per month

Investments

Figure 51 provides information on the investments of medical schemes as at the end of the years 2011 and 2012.

Figure 51: Scheme investments in 2011 & 2012



In open schemes, 53.7% of investments (2011: 56.0%) were held in cash or cash equivalents. Bonds accounted for 26.2% (2011: 29.8%), debentures for 0.5% (2011: 0.4%), equities for 13.3% (2011: 11.6%), insurance policies for 7.5% (2011: 5.6%), properties for 6.2% (2011: 2.0%), and other investments for 0.1% (2011: 0.2%).

Restricted schemes also held a large proportion of their investments (54.0%) in cash or cash equivalents (2011: 60.3%). Their bonds accounted for 17.3% (2011: 16.7%) and debentures for 0.2% (2011: 0.1%). Equities made up 22.9% (2011: 20.4%), insurance policies 10.4% (2011: 9.4%), properties 3.2% (2011: 1.9%), and other investments 2.4% (2011: 0.4%).

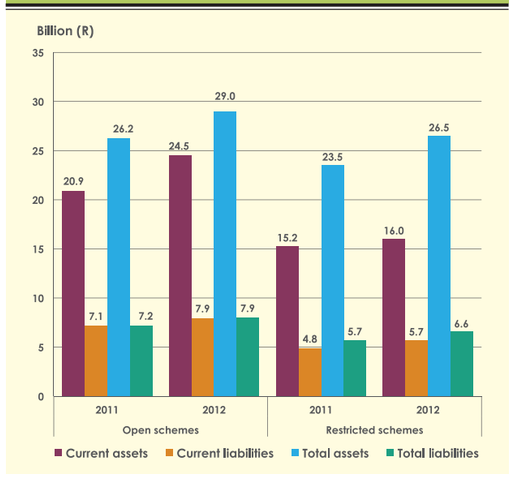
The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number, on the other hand, indicates that the scheme has greater liabilities than assets and is therefore technically insolvent and in breach with Section 35(3) of the Medical Schemes Act.

Schemes should pay attention to more than just their total asset and liability positions; they should also give thought to the periods in which liabilities must be paid and in which assets can be converted into cash flows. This is where financing risks must be matched.

Figure 52 compares the matching of assets and liabilities in open and restricted schemes.

Figure 52: Matching assets & liabilities in 2011 & 2012



The current-assets-to-current-liabilities ratio in open schemes was 3.1:1 in 2012 (2.9:1 in 2011); it was 2.8:1 (2011: 3.2:1) in restricted schemes. The total-asset-to-total-liability ratio for open and restricted schemes was 3.6:1 (2011: 3.7:1) and 4.0:1 (2011: 4.1:1) respectively.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (i.e. a quick ratio below 2.0) is lower than the industry average of 3.7 months, Boards of Trustees must guard against longer-term and, therefore, riskier investments. Even though such investments may offer the expectancy of higher returns, they may prove detrimental to the scheme should it experience a liquidity crunch.

Claims-paying ability of schemes

The financial soundness of a medical scheme is also measured by its ability to pay claims from cash and cash equivalents.

Figure 53 depicts the claims-paying ability of schemes measured in months of cover. This is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

Figure 53: Average gross claims covered by cash & cash equivalents in 2000-2012

The cash coverage declined from 4.2 months in 2011 to 3.7 months as at December 2012, but the payment cycles of medical schemes reflect an average of 15.3 days compared with the 15.1 days reported in 2011.

Benefit options

The year 2012 saw 311 benefit options (2011: 309) in 93 medical schemes, including those options that were discontinued during the year.

Open schemes accounted for 52.7% or 164 benefit options in 2012 (2011: 53.7% or 166 options). Restricted schemes had 147 options, representing 47.3% of all options (2011: 145 options or 46.9%).

On average, open schemes had 6.3 options per scheme (2011: 6.2) and an average of 13 399 members per option at year-end (2011: 13 556). Restricted schemes had an average of 2.1 options per scheme (2011: 2.0), with an average of 11 158 members per option[8] as at 31 December 2012 (2011: 10 676).

For the purposes of this report the benefit options of Alliance Midmed Medical Scheme and Metrocare were excluded as the schemes submitted no data for the 2012 year. Protea Medical Scheme was excluded from the 2011 data.

Of the 309 benefit options, 123 (39.8%) had fewer than 2 500 members per option (2011: 124 or 40.5%). Of these 123 options, 64 (52.0%) incurred net healthcare losses in 2012. In 2011, 74 options (59.7%) incurred losses.

The remaining 186 options (2011: 182) had more than 2 500 members per option. Of these, 43.5% or 81 options incurred net healthcare losses (2011: 45.0% or 82 options).

[8] Alliance Midmed Medical Scheme was excluded from the calculation of the average number of members per restricted scheme option.

Table 63: Results of benefit options in 2012

	Open schemes	% representing	Restricted schemes	% representing	Total
All benefit options					
Number of schemes	25	27.0	68	73.0	93
Number of options	164	53.1	145	46.9	309
Membership represented	2 197 454	57.6	1 617 977	42.4	3 815 431
Net healthcare result (R'000)	(62 104)		86 808		24 705
Gross non-healthcare as % of GCI	13.6		7.7		11.2
Gross claims ratio (%)	85.7		91.7		88.2
Gross claims incurred pbpm	1 027.9		955.5		995.2
GCI pbpm	1 199.7		1 041.9		1 128.4
Options with >= 2 500 members					
Number of options	96	51.6	90	48.4	186
Membership represented	2 127 194	57.8	1 555 544	42.2	3 682 738
Net healthcare result (R'000)	15 525		193 367		208 893
Gross non-healthcare as % of GCI	13.7		7.7		11.2
Gross claims ratio (%)	85.5		91.5		88.0
Gross claims incurred pbpm	1 016.9		940.1		982.3
GCI pbpm	1 189.5		1 027.8		1 116.6
Options with < 2 500 members					
Number of options	68	55.3	55	44.7	123
Membership represented	70 260	52.9	62 433	47.1	132 693
Net healthcare result (R'000)	(77 629)		(106 559)		(184 188)
Gross non-healthcare as % of GCI	11.9		7.9		10.0
Gross claims ratio (%)	90.5		96.7		93.3
Gross claims incurred pbpm	1 376.2		1 404.4		1 389.5
GCI pbpm	1 520.7		1 452.9		1 488.8

GCI = Gross Contribution Income
pbpm = per beneficiary per month

At the end of 2012, there were 68 options in open schemes with fewer than 2 500 members (2011: 68) at an average of 1 033.2 members per option (2011: 1 170.5), representing 41.5% (2011: 42.2%) of all open schemes options.

Restricted schemes had 55 options with fewer than 2 500 members (2011: 56), with an average of 1 135.2 members per option (2011: 1 297.5), representing 37.9% (2011: 38.6%) of all restricted schemes options.

Table 64: Results of loss-making benefit options in 2012

	Open schemes	% representing	Restricted schemes	% representing	Total
All loss-making benefit options					
Number of options	80	55.2	65	44.8	145
% of total options	48.8		44.8		46.9
Membership represented	1 145 476	55.7	912 076	44.3	2 057 552
Net healthcare result (R'000)	(2 294 386)		(1 422 093)		(3 716 479)
Gross non-healthcare as % of GCI	12.7		6.8		10.1
Gross claims ratio (%)	92.6		97.6		94.9
Gross claims incurred pbpm	1 169.5		1 082.3		1 127.3
GCI pbpm	1 263.2		1 108.9		1 188.5
Loss-making options with >= 2 500 members					
Number of options	46	56.8	35	43.2	81
Membership represented	1,112,960	56.0	876,169	44.0	1,989,129
Net healthcare result (R'000)	(2,107,218)		(1,239,753)		(3,346,971)
Gross non-healthcare as % of GCI	12.8		6.8		10.1
Gross claims ratio (%)	92.2		97.2		94.5
Gross claims incurred pbpm	1,152.6		1,062.5		1,109.2
GCI pbpm	1,249.7		1,092.6		1,174.0
Loss-making options with < 2 500 members					
Number of options	34	53.1	30	46.9	64
Membership represented	32,516	47.5	35,907	52.5	68,423
Net healthcare result (R'000)	(187,168)		(182,340)		(369,508)
Gross non-healthcare as % of GCI	11.2		7.4		9.2
Gross claims ratio (%)	102.0		104.6		103.4
Gross claims incurred pbpm	1,803.7		1,649.3		1,719.0
GCI pbpm	1,768.2		1,576.8		1,663.2

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 309 benefit options within schemes in the year 2012 (2011: 306), 145 (46.9%) incurred net healthcare losses; in 2011, 156 options (51.0%) incurred net healthcare losses. In the year under review, 80 (2011: 91), representing 55.2% (2011: 58.3%) of the loss-making options, were in open schemes and 65 (2011: 65), representing 44.8% (2011: 41.7%), were in restricted schemes.

The net healthcare losses per member per month (pmpm) in options with fewer than 2 500 members were 3.2 times greater (2011: 2.2) than in options with more than 2 500 members: R450.0 pmpm compared to R140.2 pmpm (2011: R395.1 pmpm against R183.3 pmpm).

Benefit options with fewer than 2 500 members generally have higher contributions and claims than other options and also attract higher non-healthcare costs as they are shared amongst a smaller base.

Table 65 shows option results by demographics.

There were 93 options with an average age above the 33.8 years for options in open schemes, and 71 benefit options with beneficiaries younger than the average in open schemes.

Table 65: Number of benefit options by demographics in 2012

	Open schemes	Restricted schemes	Total
Options >= 33.8 years (open); 29.9 years (restricted)			
Number of options >= 33.8 years (open); 29.9 years (restricted)	93	87	**180**
NHC results pbpm >= -1.1 (open); NHC results pbpm >= 1.8 (restricted)	42	36	**78**
NHC results pbpm < -1.1 (open); NHC results pbpm < 1.8 (restricted)	51	51	**102**
Options <=33.8 years (open); 29.9 years (restricted)			
Number of options <= 33.8 years (open); 29.9 years (restricted)	71	58	**129**
NHC results pbpm >= -1.1 (open); NHC results pbpm >= 1.1 (restricted)	46	42	**88**
NHC results pbpm < -1.1 (open); NHC results pbpm < 1.8 (restricted)	25	16	**41**

NHC = Net Healthcare
pbpm = per beneficiary per month

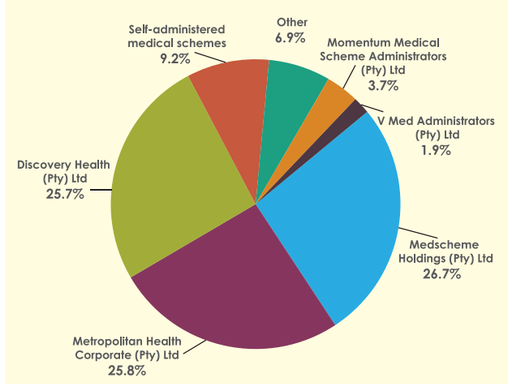
In the restricted schemes market, 87 benefit options had beneficiaries with an average age higher than the 29.9 years for all options in restricted schemes. A total of 58 options had younger beneficiaries.

As expected, options covering older and sicker lives incurred greater deficits.

Administrator market

Figure 54 shows the market share of medical scheme administrators as well as self-administered medical schemes based on the average number of beneficiaries administered at the end of 2012[9].

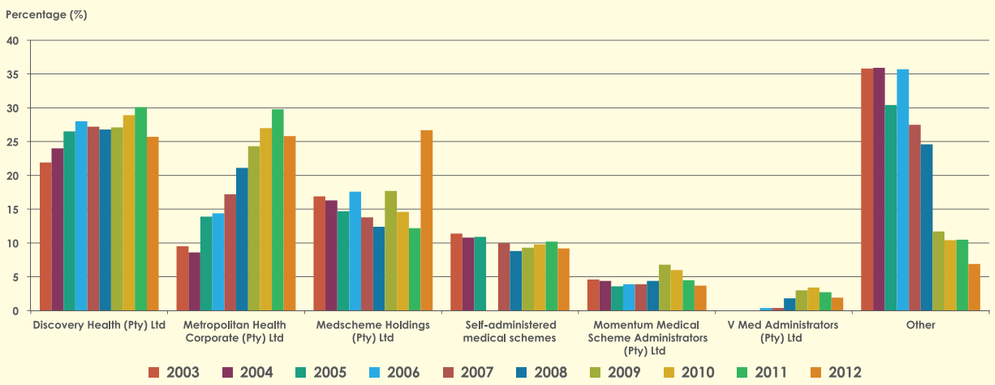
Figure 54: Administrator market share at the end of 2012



[9] The data that is presented here differs from Annexure U which is based on the average membership administered during the year.

Figure 55 depicts the changes in market share of all medical schemes over the last 10 years based on the average number of beneficiaries administered by the various parties at the end of each year.

Figure 55: Market share of largest administrators based on average number of beneficiaries in 2003-2012*



* The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure U).

Five third-party administrators continued to dominate the market in 2012, namely:

- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Medscheme Holdings (Pty) Ltd
- Momentum Medical Scheme Administrators (Pty) Ltd
- V Med Administrators (Pty) Ltd

Together, they administer 83.8% of the market (excluding the self-administered medical schemes).[10]

Table 66 indicates the change in administrator market share between 2008 and 2012.

[10] The Government Employees Medical Scheme (GEMS) had a joint administrator contract in place in 2012. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims services as well as the provision of financial and operational information. The membership was included for both administrators.

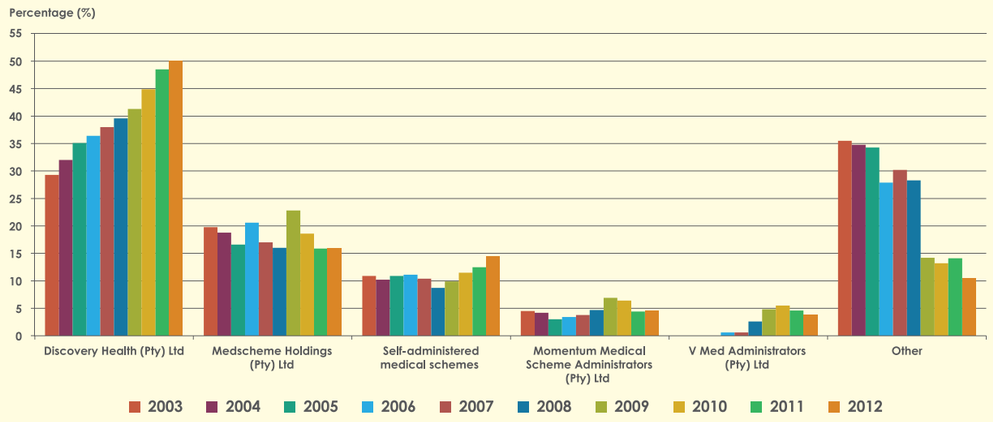
Table 66: Administrator market share in 2008-2012

	2008	2009	2010	2011	2012	% change over five years
Discovery Health (Pty) Ltd	26.8%	27.1%	28.9%	30.1%	25.7%	-4.1%
Metropolitan Health Corporate (Pty) Ltd	21.1%	24.3%	27.0%	29.8%	25.8%	22.3%
Medscheme Holdings (Pty) Ltd	12.4%	17.7%	14.6%	12.2%	26.7%	115.3%
Self-administered medical schemes	8.8%	9.3%	9.8%	10.2%	9.2%	4.5%
Momentum Medical Scheme Administrators (Pty) Ltd	4.4%	6.8%	6.0%	4.5%	3.7%	-15.9%
V Med Administrators (Pty) Ltd*	1.8%	3.0%	3.4%	2.7%	1.9%	5.6%
Other	24.6%	11.7%	10.4%	10.5%	6.9%	-72.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Largest market share in open medical schemes						
Discovery Health (Pty) Ltd	39.6%	41.3%	44.9%	48.5%	50.8%	28.3%
Medscheme Holdings (Pty) Ltd	16.0%	22.8%	18.6%	15.9%	15.9%	-0.6%
Self-administered open medical schemes	8.7%	9.9%	11.5%	12.5%	14.4%	65.5%
Momentum Medical Scheme Administrators (Pty) Ltd	4.7%	6.9%	6.4%	4.4%	4.6%	-2.1%
V Med Administrators (Pty) Ltd*	2.6%	4.8%	5.5%	4.6%	3.8%	46.2%
Other	28.3%	14.2%	13.2%	14.1%	10.5%	-62.9%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Largest market share in restricted medical schemes						
Metropolitan Health Corporate (Pty) Ltd	56.0%	60.9%	64.9%	67.8%	47.4%	-15.4%
Medscheme Holdings (Pty) Ltd	6.2%	9.8%	8.9%	7.3%	35.9%	479.0%
Self-administered restricted medical schemes	9.0%	8.4%	7.3%	7.1%	4.9%	-45.6%
Discovery Health (Pty) Ltd	4.8%	5.1%	6.2%	6.4%	4.4%	-8.3%
Momentum Medical Scheme Administrators (Pty) Ltd	3.8%	6.7%	5.4%	4.7%	3.0%	-21.1%
Other	20.1%	9.1%	7.4%	6.7%	4.4%	-78.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

* V Med Administrators (Pty) Ltd began operating in 2006.

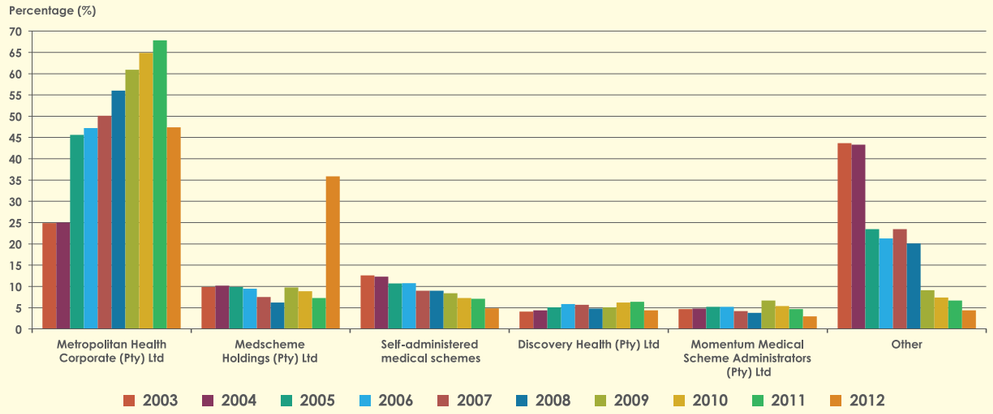
Figures 56 and 57 indicate the changes in administrator market share over the last 10 years for open and restricted medical schemes respectively.

Figure 56: Open schemes market share of largest administrators based on average number of beneficiaries in 2003-2012*



* The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure U).

Figure 57: Restricted schemes market share of largest administrators based on average number of beneficiaries in 2003-2012*



* The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure U).

The share of administrator Discovery Health (Pty) Ltd of the open schemes market increased to 50.8% (2011: 48.5%); its share in the restricted schemes market decreased to 4.4%.

Medscheme Holdings (Pty) Ltd has the second-biggest share in both the open and restricted schemes administration market at 15.9% (2011: also 15.9%) and 35.9% (2011: 7.3%) respectively.

Medscheme Holdings (Pty) Ltd acquired Lethimvula Healthcare (Pty) Ltd in 2009; the latter had earlier acquired the business of Old Mutual Healthcare (Pty) Ltd. Medscheme Holdings (Pty) Ltd has been responsible for GEMS's contribution and debt management as well as correspondence services since 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the biggest share of the restricted schemes market at 47.4% (2011: 67.8%).

Despite their market dominance and the inherent benefits of economies of scale, the larger administrators do not appear to offer any cost advantages over their smaller rivals. Perhaps their size makes them less efficient and less responsive to clients' needs?

Table 67 shows the five administrators who had higher administration costs and fees than the industry average of administrators handling open schemes.

Table 67: Percentage deviation from industry average: open schemes (%)

	Gross administration costs	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Private Health Administrators (Pty) Ltd	69.3	36.7	32.0
Allcare Administrators (Pty) Ltd	110.2	45.2	29.1
Discovery Health (Pty) Ltd	1.2	16.8	23.9

* Excluding co-administration fees

Table 68 shows the five administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

Table 68: Percentage deviation from industry average: restricted schemes (%)

	Gross administration costs	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Eternity Private Health Fund Administrators (Pty) Ltd	164.1	189.4	158.9
V Med Administrators (Pty) Ltd	56.8	63.4	73.6
Discovery Health (Pty) Ltd	51.0	74.2	71.1
Professional Medical Scheme Administrators (Pty) Ltd	111.9	86.1	58.5
Allcare Administrators (Pty) Ltd	45.4	70.3	41.8

* Excluding co-administration fees

Administrators and the businesses associated with administrators often provide managed healthcare services. In many instances, these services are merely additional layers of administration costs with questionable benefits for the medical schemes themselves; we have included them in the "[f]ees paid to administrators" figures where they were paid to the administrator or to any company in the administrator group.

Co-administration fees were excluded from "[f]ees paid to administrators" as these fees could not be allocated to specific administrators.

Tables 69 and 70 show administrator market share based on the average number of beneficiaries to whom services are being delivered by third-party administrators and medical schemes under self-administration. We also show the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure U.)

Table 69: Administrator market share in 2012: open schemes

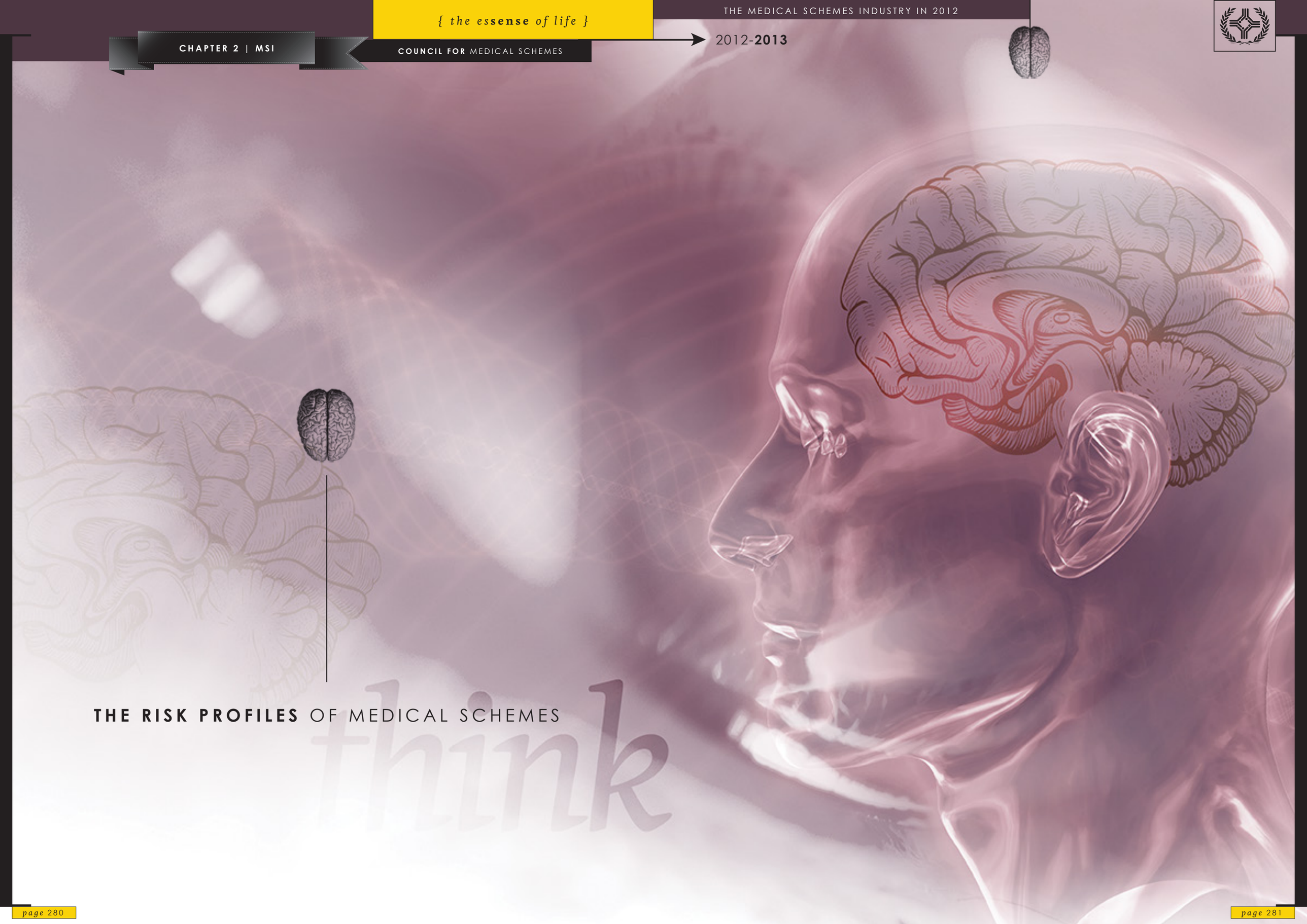
Name of administrator	No. of schemes at year-end	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators*		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Agility Global Health Solutions Africa (Pty) Ltd	1	1.6	121.7	13.3	86.5	9.4	110.4	12.0	917.7	88.7
Allcare Administrators (Pty) Ltd	1	0.3	226.0	14.0	132.4	8.2	146.7	9.1	1 618.7	82.3
Discovery Health (Pty) Ltd	1	50.8	108.8	9.0	106.5	8.8	140.7	11.6	1 214.7	81.8
Eternity Private Health Fund Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Medscheme Holdings (Pty) Ltd	2	15.9	103.3	9.1	70.9	6.3	98.3	8.7	1 130.4	86.8
METHEALTH (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Metropolitan Health Corporate (Pty) Ltd	-	0.3	68.6	8.4	52.2	6.4	65.9	8.1	815.0	92.3
Momentum Medical Scheme Administrators (Pty) Ltd	2	4.6	88.4	8.4	82.0	7.8	100.8	9.6	1 051.1	80.7
Private Health Administrators (Pty) Ltd	1	0.3	182.0	13.8	124.7	9.5	150.0	11.4	1 317.3	81.3
Professional Medical Scheme Administrators (Pty) Ltd	1	1.7	114.0	6.6	71.1	4.1	87.4	5.1	1 727.6	84.6
Providence Healthcare Risk Managers (Pty) Ltd	2	0.3	76.0	8.6	54.0	6.2	67.5	7.7	878.2	84.9
Sanlam Healthcare Management (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Sechaba Medical Solutions (Pty) Ltd	1	3.1	107.1	9.0	82.5	6.9	105.2	8.8	1 194.3	90.1
Self-administered open medical schemes	7	14.4	104.4	8.2	-	-	29.2	2.1	1 273.5	88.9
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	2.2	90.3	9.1	59.6	6.0	62.6	6.3	994.9	83.2
Universal Healthcare Administrators (Pty) Ltd	2	0.6	124.1	9.8	88.2	7.0	110.2	8.7	1 262.4	81.9
V Med Administrators (Pty) Ltd	2	3.8	132.0	10.4	67.2	5.3	85.7	6.8	1 263.5	86.2
Average	**25**	**100.0**	**107.5**	**8.9**	**91.2**	**7.6**	**113.6**	**9.4**	**107.5**	**84.5**

* Excluding co-administration fees
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Table 70: Administrator market share in 2012: restricted schemes

Name of administrator	No. of schemes at year-end	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators*		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Agility Global Health Solutions Africa (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Allcare Administrators (Pty) Ltd	2	0.2	84.2	6.2	75.8	5.6	86.5	6.4	1 358.5	105.3
Discovery Health (Pty) Ltd	12	4.4	87.4	7.6	77.5	6.8	104.4	9.1	1 144.1	83.4
Eternity Private Health Fund Administrators (Pty) Ltd	1	0.8	152.9	10.4	128.8	8.7	157.9	10.7	1 474.0	84.6
Medscheme Holdings (Pty) Ltd	15	35.9	14.4	1.4	13.2	1.3	27.3	2.6	1 045.1	91.1
METHEALTH (Pty) Ltd	3	0.6	79.6	7.1	66.3	5.9	79.9	7.1	1 121.0	93.5
Metropolitan Health Corporate (Pty) Ltd	12	47.4	45.1	12.1	31.8	8.5	41.7	11.2	373.9	92.9
Momentum Medical Scheme Administrators (Pty) Ltd	7	3.0	81.8	6.8	61.1	5.1	77.7	6.5	1 202.2	93.4
Private Health Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Professional Medical Scheme Administrators (Pty) Ltd	1	1.1	122.7	10.1	82.8	6.8	96.7	7.9	1 220.4	86.3
Providence Healthcare Risk Managers (Pty) Ltd	4	1.0	56.7	6.4	41.6	4.7	58.3	6.6	881.0	84.8
Sanlam Healthcare Management (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Sechaba Medical Solutions (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Self-administered restricted medical schemes	8	4.9	53.8	7.0	-	-	7.2	0.9	770.1	92.6
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Universal Healthcare Administrators (Pty) Ltd	3	0.4	68.8	7.0	58.4	6.0	58.7	6.0	981.1	90.1
V Med Administrators (Pty) Ltd	1	0.2	90.8	6.4	72.7	5.1	105.9	7.4	1 421.2	80.8
Average	**69**	**100.0**	**57.9**	**5.5**	**44.5**	**4.1**	**61.0**	**5.7**	**1 059.4**	**91.8**

* Excluding co-administration fees
pabpm = per average beneficiary per month
GCI = Gross Contribution Income



THE RISK PROFILES OF MEDICAL SCHEMES

The risk profiles of medical schemes

The CMS continues to collect risk profile data from medical schemes in the same format as it did for the Risk Equalisation Fund (REF) shadow process.

The objective of this exercise is to continue measuring and reporting on schemes' risk profiles.

The purpose of this section is to provide a high-level report on the analysis of the Schemes Risk Measurement (SRM) returns that were submitted to the CMS for the 2012 benefit year, and in particular on how data quality affects community-rate estimates. A comprehensive report on the SRM returns will also be released; it will include further details regarding methods, the data collection process, and a full set of results.

Industry and scheme community rates are computed using former REF contribution tables to the expected universe of beneficiaries, and former REF contribution tables to scheme members respectively. The risk profile of a particular medical scheme is the difference between the scheme's community rate and the industry community rate.

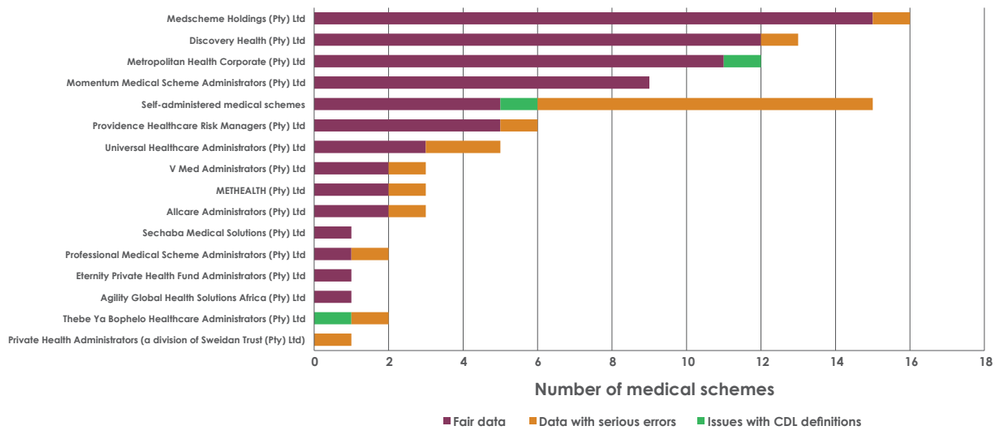
Quality of SRM data

Figure 58 shows SRM data quality evaluation by administrator as at December 2012.

Many medical scheme administrators administrate at least one medical scheme which has serious data errors. A large proportion of schemes with data errors were self-administered. Self-administered schemes and small administrators are responsible for most of the schemes reporting poor-quality data.

As at December 2012, two-thirds of self-administered schemes submitted data with many errors. Self-administered schemes provided cover to 913 748 (or 10.6%) of all medical scheme beneficiaries as at December 2012.

Figure 58: Data quality groups by administrator



CDL = Chronic Diseases List

A total of 92 medical schemes were included in the analysis for March 2012, 91 for June 2012, and 90 for both September 2012 and December 2012.

Table 71 illustrates an increasing trend of the industry community rate. The data reveals that, as at December 2012, the industry community rate was R492.13.

The data also illustrates a higher variation in schemes risk. This may be attributed to the fact that the PMB-exempted medical schemes were included in the analysis. Schemes with data concerns can skew the data even further.

Table 71 shows that an anomaly occurred in the December 2012 data, and in particular, the minimum risk rate for December 2012 is not comparable to other data points.

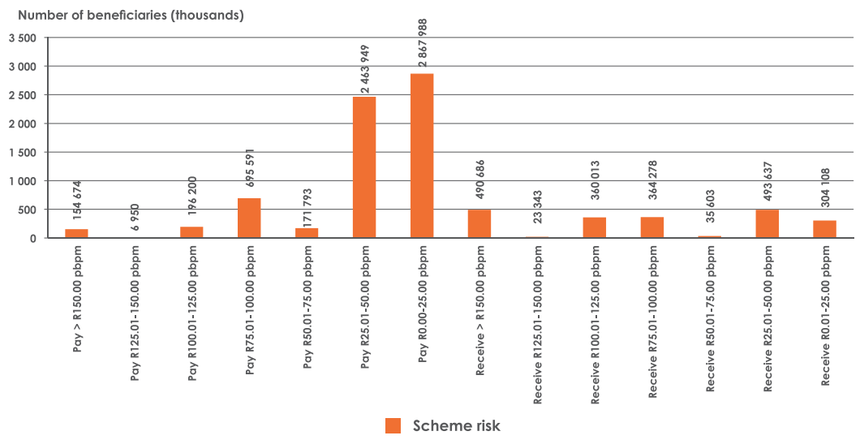
One of the schemes that reported inconsistent data was noted with a scheme community rate of R1 965.38; the scheme was classified as a Category 9 scheme. Schemes in Category 9 are defined by a combination of factors which relate to data quality, including fair data, poor data, and instances where definitions of the Chronic Diseases List (CDL) are not applied consistently by both medical schemes and administrators. Poor data quality can have a significant impact on the scheme and industry community rates, resulting in incorrect risk profiling of a scheme.

Table 71: Risk rates per month

	Full contribution table			
	March 2012	June 2012	September 2012	December 2012
Industry community rate	R480.61	R485.82	R488.71	R492.13
Minimum risk rate	R-392.26	R-411.50	R-408.72	R-1 473.25
Maximum risk rate	R235.91	R250.11	R248.41	R251.53
Standard deviation	R152.48	R153.11	R152.82	R215.94

Figure 59 illustrates December 2012 data: the risk profile for 357 824 beneficiaries was more than R100 per beneficiary per month (pbpm) below the industry community rate, while for 874 042 beneficiaries the risk profile was more than R100 pbpm above the industry community rate. The number of beneficiaries in medical schemes with a risk profile of R100 or more has increased by 18.2% since 2006.

Figure 59: Number of beneficiaries by payment band as at December 2012



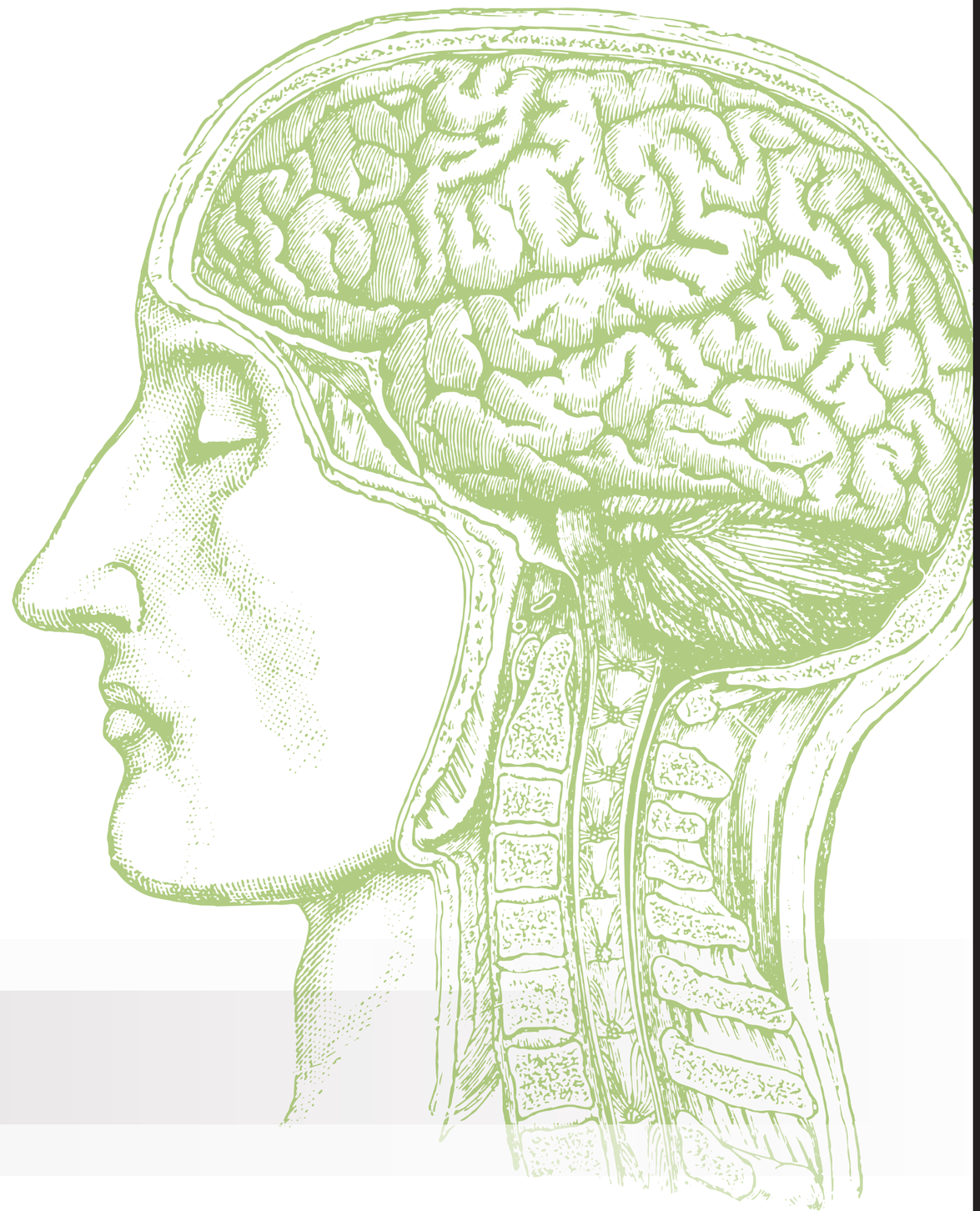
pbpm = per beneficiary per month

Notwithstanding the improvement in the quality of the SRM data over the past five years, between 12.0% and 22.0% of medical schemes remain in Category 9.

The risk profiles of medical schemes will be better understood if schemes and administrators alike submit data of an improved quality.

ANNEXURES

{ All the Annexures can be found on the provided disc. }



Please note that all the Annexures are available on the disc at the back of this Annual Report, in Excel format and printable PDFs.

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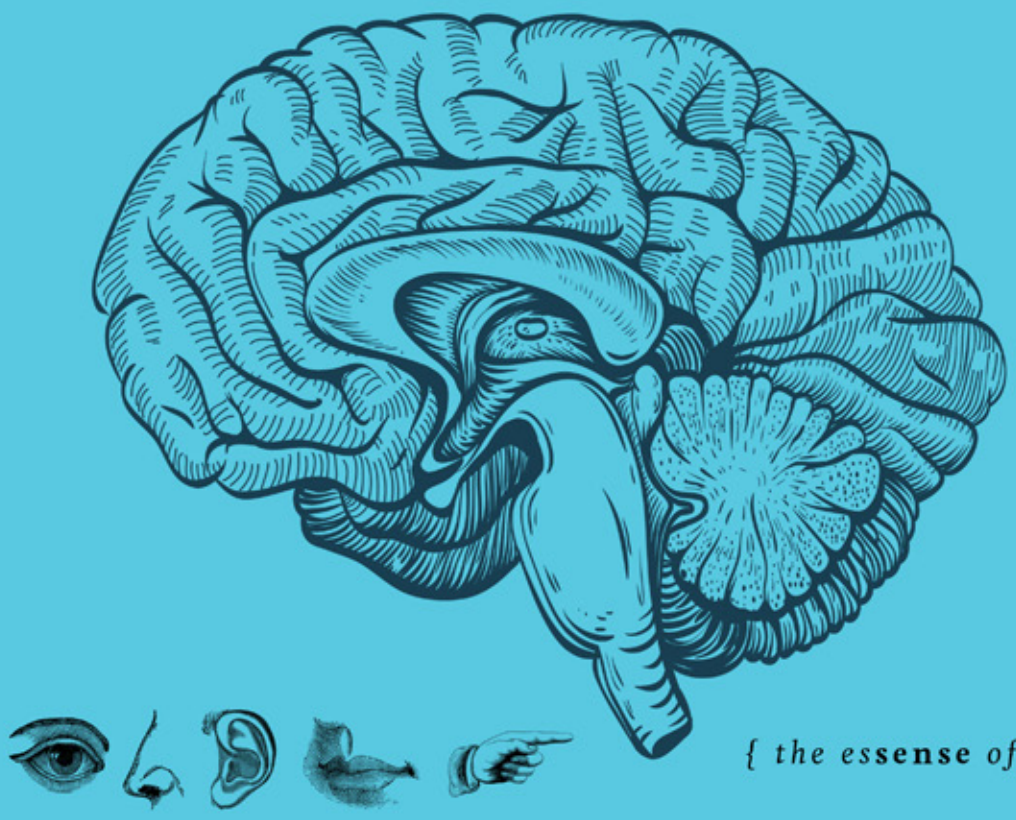
Malcolm Forbes }



{ *the* **essense** *of life* }

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