THE COUNCIL FOR MEDICAL SCHEMES

ANNUAL REPORT 2014/15

15 YEARS ON THE PULSE

ANNUAL REPORT
COUNCIL FOR MEDICAL SCHEMES

RP91/2014
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GENERAL INFORMATION

GENERAL INFORMATION OF THE COUNCIL FOR MEDICAL SCHEMES

Name	Council for Medical Schemes
Physical address	Block A Eco Glades 2 Office Park 420 Witch-Hazel Avenue Eco Park Centurion Pretoria 0157 South Africa
Postal address	Private Bag X34 Hatfield Pretoria 0028 South Africa
Contact details	
Telephone number	012 431 0500
Customer Care Centre	0861 123 267 0861 123 CMS
Fax number	0862 068 260
Email address	information@medicalschemes.com
Website	www.medicalschemes.com
Internal auditors	Sekela Xabiso
External auditors	Auditor-General of South Africa
Bank	Absa Group Limited
Chairperson of Council	Professor Yosuf Veriava
Acting Chief Executive & Registrar	Mr Daniel Lehutjo
Council Secretariat	Mr Khayalethu Mvulo

A
CMS
Council
for Medical Schemes

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

AFS	Annual financial statements
A-G	Auditor-General
AGM	Annual general meeting
AGSA	Auditor-General of South Africa
AIDS	Acquired immune deficiency syndrome
APP	Annual performance plan
ASR	Annual Statutory Returns
BEE	Black economic empowerment
Beneficiaries	Principal members + dependants (total membership of medical scheme)
BHF	Board of Healthcare Funders of Southern Africa
BMU	Benefits Management Unit
Board	Board of trustees
CDL	Chronic disease list
CIB	Chronic illness benefit
CMS	Council for Medical Schemes
Council	Accounting Authority or the board of the Council for Medical Schemes
CPI	Consumer Price Index
CPIX	CPI excluding interest rates on mortgage bonds
CRC	Clinical Review Committee
DENOSA	Democratic Nursing Organisation of South Africa
Dependant	Member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DoH	Department of Health
DRG	Diagnosis-related group
DRGTAP	DRG Technical Advisory Panel
DSP	Designated service provider
DTP	Diagnosis and treatment pair
EDO	Efficiency discounted option
EE	Employment equity
EMC	Executive Management Committee
EWS	Early warning system
EXCO	Executive Committee (Council sub-committee)
Executive Authority	Minister of Health
FAIS Act	Financial Advisory and Intermediary Services Act 37 of 2002
FMPPI	Framework for managing programme performance information
FSB	Financial Services Board
FSU	Financial Supervision Unit
GAAP	Generally Accepted Accounting Principles
GAE	Gross administration expenditure
GCI	Gross contribution income
GP	General practitioner
GRAP	Generally Recognised Accounting Practices
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
IAS	International Accounting Standard
ICD-10	International Classification of Diseases – 10th Revision
ICON	Independent Clinical Oncology Network (Pty) Ltd
ICU	Intensive care unit
IFRS	International Financial Reporting Standards
INSETA	Insurance Sector Education and Training Authority
IRBA	Independent Regulatory Board of Auditors
ISBN	International Standard Book Number
ITAP	Industry Technical Advisory Panel
LCBO	Low cost benefit option
MAC	Ministerial Advisory Committee
MCO	Managed care organisation
MoU	Memorandum of understanding

MPR	Medicine Price Registry
MRC	Medical Research Council
MRI (scan)	Magnetic resonance imaging
MSO	Medical Services Organisation (Pty) Ltd
NDP	National development plan
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
NPA	National Prosecuting Authority
Pab	Per average beneficiary
Pabpa	Per average beneficiary per annum
Pabpm	Per average beneficiary per month
Pampm	Per average member per month
Pb	Per beneficiary
Pbpm	Per beneficiary per month
Pppm	Per patient per month
PCNS	Practice Code Numbering System
Pensioner	Beneficiary at least 65 years old
PFMA	Public Finance Management Act 1 of 1999
PMB	Prescribed minimum benefit
Pmpm	Per member per month
PMSA	Personal medical savings account
PO	Principal officer
PPS	Professional Provident Society
Principal member	Member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Q	Quarter
QR	Quarterly returns
RAF	Risk Assessment Framework
RCI	Risk Contribution Income
RDC	Regulatory Decisions Committee
REF	Risk Equalisation Fund
Registrar	Registrar of Medical Schemes
REMCO	Remuneration Committee of Council
R&M	Research and monitoring
RP	Government Printing Works (number)
RPL	Reference Price List
SABC	South African Broadcasting Corporation
SABINET	Southern African Bibliographic Information Network
SAHRC	South African Human Rights Commission
SAICA	South African Institute of Chartered Accountants
SAMA	South African Medical Association
SAPS	South African Police Service
SCA	Supreme Court of Appeal
SEP	Single exit price
SLA	Service level agreement
SOP	Standard operating procedure
TB	Tuberculosis
Treasury	National Treasury
WHO	World Health Organisation

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PROFILE

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

The CMS 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 CMS regulates the medical schemes industry in a fair and transparent manner and achieves this by:

- Protecting members of 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.
- Advising the Minister of Health on appropriate regulatory and policy interventions that will assist in attaining national health policy objectives.

VALUES

The values of the CMS stem from those underpinning the Constitution of South Africa and from the specific vision and mission of the CMS.

As 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 for all employees of the CMS:

- 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 in doing something that is of value.
- .

STRATEGIC GOALS

STRATEGIC GOAL 1

Access to good quality medical scheme cover is maximised

The CMS strives to achieve this goal primarily through activities centred on strengthening the system of prescribed minimum benefits (PMBs). It provides technical support for the PMB review undertaken by the Department of Health (DoH) and is responsible for the revision of regulations related to PMBs.

STRATEGIC GOAL 2

Medical schemes are properly governed, are responsive to the environment and beneficiaries are informed and protected

The CMS is able to impact positively on the governance and responsiveness of schemes in a number of ways, including:

- The processes of registering all medical schemes and accrediting brokers, managed care organisations (MCOs) and scheme administrators and the periodic renewal of registration or accreditation.
- Monitoring compliance with a number of statutory provisions, ranging from the governance of schemes and the content of their marketing materials, to the filing of quarterly reports by schemes and the use of practice codes by health professionals servicing beneficiaries.
- Investigating and resolving complaints by beneficiaries and service providers in an efficient and effective manner.
- Building the capacity of trustees of medical schemes to fulfil their fiduciary role.
- Undertaking consumer education and increasing beneficiaries' awareness of their rights, responsibilities and channels of redress.
- Publishing information about the performance of schemes and their compliance with statutory obligations.
- Enforcing rulings and directives made by the Registrar and Council.
- Undertaking close monitoring of schemes where financial reserves fall below the specified level.

STRATEGIC GOAL 3

The CMS is responsive to the needs of the environment by being an effective and efficient organisation

The CMS places a premium on good management, from well-considered planning to effective performance measurement. Achievement of this goal rests to a large extent on sound financial and human resources management and the effective use of information technology to support business processes and the interface with stakeholders.

STRATEGIC GOAL 4

The CMS provides influential strategic advice and support for the development and implementation of strategic health policy, including support for the national health insurance (NHI) development process

The CMS, with its unique access to detailed information on the private healthcare sector, is able to make an informed contribution to national policy. The data collected by the CMS through reports submitted by schemes is supplemented by dedicated research in areas such as the burden of disease and the impact of PMBs in terms of quality of healthcare and the health status of beneficiaries. Areas on which the CMS provides specific advice to the DoH and the Minister of Health include the development of NHI and periodic reviews of and amendments to the Medical Schemes Act.

15 YEARS ON THE PULSE

The Council for Medical Schemes (CMS) has a healthy beating pulse as can be seen over the 15 years of operation. Key milestones and highlights of the dynamic changes the CMS brought to the medical schemes industry, despite legal and other challenges and some resistance to change, are reflected in this timeline.

2000

- The Council for Medical Schemes is formally established on 2 May 2000
- Statutory minimum solvency requirements are introduced

2001

Introduction of amendments to section 20 of Medical Schemes Act – reinsurance requirements

2002

Introduction of online statutory returns

2003

- The National Health Act is promulgated
- Prescribed Minimum Benefits (PMBs) are expanded to include 25 chronic conditions

2004

- Ruling by Competition Commission prohibits tariff setting between schemes and healthcare groups
- Single exit price (SEP) is introduced to keep medicine costs down
- Amendments to PMBs and Chronic Disease List
- Regulations are amended to require minimum solvency of 25%

2005

- GEMS is established as a restricted scheme and is currently the second largest medical scheme
- Online auditor approval questionnaire is introduced

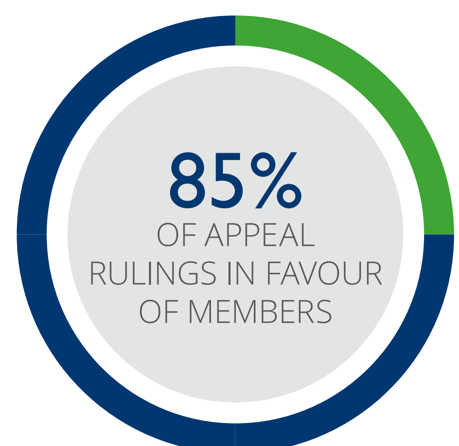
2006

- CMS publishes the National Health Reference Price List (NHRPL) as a guideline for healthcare service tariffs

2007

Strengthening the capacity of the CMS to manage the required data of the Risk Equalisation Fund (REF) by introducing the REF shadow returns

IN THE PAST 15 YEARS



STAKEHOLDER RELATIONS est 2012

To create and promote optimal awareness and understanding of the medical schemes environment

- 2012 – Inaugural CMS Indaba is held
- 2013 – The first Stakeholder Forum is held
- 2014 – New trustee training programmes are introduced
- 2015 – Accredited training programme commences

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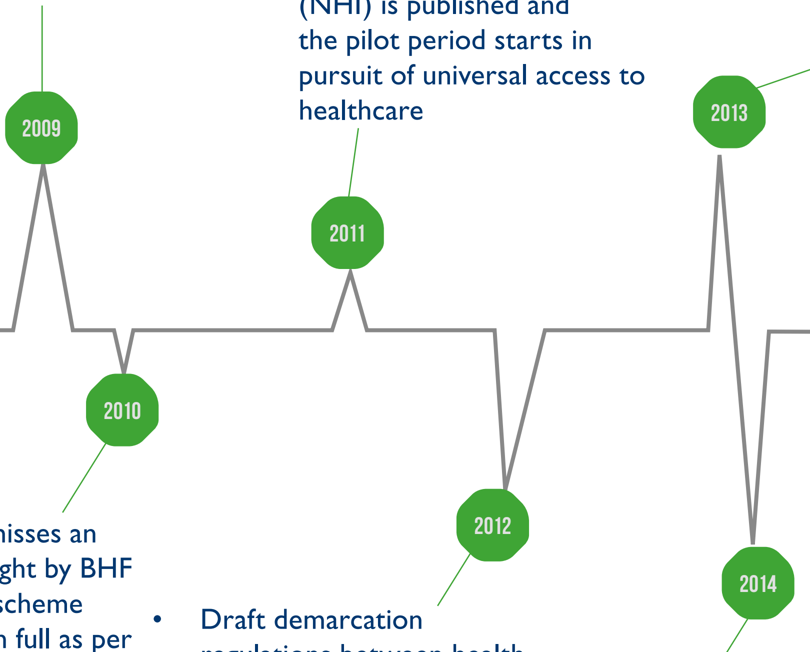


2009

Medical schemes industry incurs biggest losses since 2000

2010

- High Court dismisses an application brought by BHF to pay PMBs at scheme rate instead of in full as per legislation
- High Court renders NHRPL invalid and sets it aside
- A code of conduct is published to address issues surrounding PMBs

2011

- The Consumer Protection Act (CPA) is promulgated
- The Green Paper on National Health Insurance (NHI) is published and the pilot period starts in pursuit of universal access to healthcare

2012

- Draft demarcation regulations between health insurance policies and medical schemes are published by National Treasury
- Medical deductions are converted into medical tax credits
- Introduction of real-time monitoring system for medical schemes

2013

- Trustee remuneration project begins
- CMS moves from Hatfield into new offices in Centurion, hosting the first Indaba at the premises

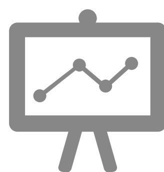
2014

- Low cost benefit options introduced
- Private healthcare is investigated by the Competition Commission through a market inquiry
- Beneficiary registry consultation begins
- New system to collect utilisation data developed

2015

- Benefit registry development starts
- The Council for Medical Schemes celebrates 15 years on the pulse

102 EMPLOYEES



8 573 BROKERS ACCREDITED

8.8 MILLION BENEFICIARIES

140.2 BILLION CONTRIBUTIONS

THE COUNCIL

Adv Harshila Kooverjie
Member

Ms Maboye Mosidi
Member

Prof Sadhasivan Perumal
Member

Mr Johan van der Walt
Member

Dr Matlodi Steven Mabela
Member

OUR LEADERSHIP THE EXECUTIVES

Chief Financial Officer and Acting Chief Executive & Registrar

General Manager: Research and Monitoring

General Manager: Compliance and Investigations

General Manager: Human Resources

General Manager: Legal Services

Senior Manager: Complaints Adjudication

General Manager: Financial Supervision

Chief Information Officer

General Manager: Stakeholder Relations

Senior Strategist until October 2014

General Manager: Benefits Management Unit

General Manager: Accreditation

LEGISLATIVE AND OTHER MANDATES

Constitutional mandates

Section 27 of the Constitution obliges the state to develop legislation to progressively realise the right of access to healthcare. The Medical Schemes Act, 131 of 1998, is one of several laws that facilitate access to healthcare. It does so by creating a framework for non-discriminatory access to medical schemes.

Section 36 of the Constitution deals with the limitation of rights and sets clear criteria to be met when any right contained in the Bill of Rights is limited by law. Section 22 of the Constitution guarantees freedom of trade, which may be limited by law. The Medical Schemes Act imposes certain limitations in the medical schemes environment by confining the business of schemes to entities that are registered by the CMS and requiring that such entities comply with provisions of the Medical Schemes Act.

Legislated mandates

When the medical schemes industry was deregulated in 1989, the lack of control allowed for significant problems to emerge, resulting in poor solvency levels, inadequate accountability and a lack of member participation in governance of medical schemes. This situation necessitated the promulgation of the Medical Schemes Act, 131 of 1998, which became fully operational in 2000. The purpose of the Act is to promote non-discriminatory access to private healthcare funding and it therefore provides protection to vulnerable members who were previously often "dumped" on the already overburdened public sector.

Section 7 of the Medical Schemes Act provided for the establishment of the CMS under the oversight of the Council, which is the accounting authority or board of the CMS and has the following functions:

- Protect the interests of beneficiaries (of medical schemes) at all times.
- Control and coordinate the functioning of medical schemes in a manner that is complementary to national health policy.
- Make recommendations to the Minister of Health on criteria for the measurement of the quality and outcomes of relevant health services provided for by medical schemes and such other services as the Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act.
- Collect and disseminate information about private healthcare.
- Make rules, not inconsistent with the provisions of the Act, for the purpose of performing its functions and exercising its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on Council by the Minister of Health or by the Act.

Policy mandates

The CMS, as an organ of state, is obliged to discharge its statutory mandate in a coherent manner which is consistent with national policy. The 10 priority areas in government's Programme of Action and the 10-Point Plan of the NDoH covering the period 2009 – 2014 remained unchanged for the 2014/2015 financial year. The following were still of particular significance:

Government's Programme of Action for 2009 – 2014: 10 priority areas

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

The Department of Health 10-Point Plan for 2009 – 2014

- Provide strategic leadership and create a social compact for better health outcomes.
- Implement a national health insurance (NHI) plan.
- Improve the quality of healthcare services.
- Overhaul the healthcare system and improve its management.
- Improve human resources planning, development and management.
- Revitalise healthcare infrastructure.
- Accelerate implementation of the HIV/AIDS and STIs National Strategic Plan and increase the focus on TB and other communicable diseases.
- Undertake mass mobilisation in support of better health across the population.
- Review the drug policy.
- Strengthen research and development.

Developments in relation to NHI

The expected White Paper on NHI is a fundamental policy document that will outline the set of interrelated health system changes, all of them directed at moving the country towards the vision of universal health coverage as contained in the National Development Plan. To achieve this goal the White Paper must adequately address the health system's imbalances, taking bold and decisive steps that will offer the entire population improved prospects of living a long and healthy life.

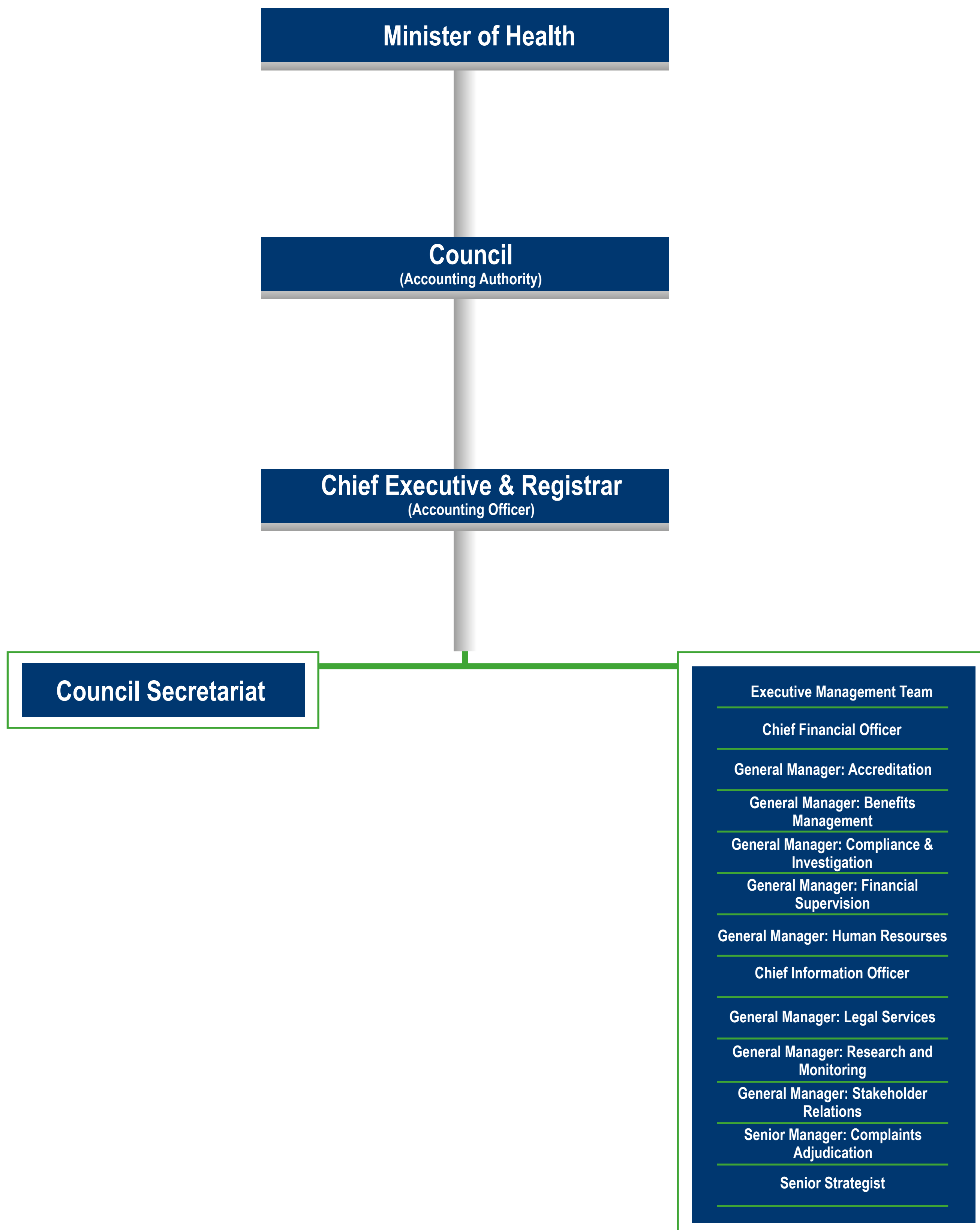
While the White Paper on NHI is still awaited, the DoH has continued with the NHI pilot projects in 10 health districts. The department has also continued consultation with other departments, including talks with National Treasury focusing on the cost of NHI. However, as the DoH has indicated, it is extremely difficult to determine in advance what NHI will cost. This has been one of several considerations in government's decision to implement NHI in a phased manner.

MEDICAL SCHEMES REGISTERED IN TERMS OF THE MEDICAL SCHEMES ACT AS AT FEBRUARY 2015

No	Scheme Name	Type
1	AECI Medical Aid Society	Restricted
2	Alliance-Midmed Medical Scheme	Restricted
3	Anglo Medical Scheme	Restricted
4	Anglovaal Group Medical Scheme	Restricted
5	Bankmed	Restricted
6	Barloworld Medical Scheme	Restricted
7	Bestmed Medical Scheme	Open
8	BMW Employees Medical Aid Society	Restricted
9	Bonitas Medical Fund	Open
10	BP Medical Aid Society	Restricted
11	Building & Construction Industry Medical Aid Fund	Restricted
12	Cape Medical Plan	Open
13	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Restricted
14	Community Medical Aid Scheme (COMMED)	Open
15	Compcare Wellness Medical Scheme	Open
16	De Beers Benefit Society	Restricted
17	Discovery Health Medical Scheme	Open
18	Engen Medical Benefit Fund	Restricted
19	Fedhealth Medical Scheme	Open
20	Fishing Industry Medical Scheme (FISH-MED)	Restricted
21	Food Workers Medical Benefit Fund	Restricted
22	Genesis Medical Scheme	Open
23	Glencore Medical Scheme	Restricted
24	Golden Arrows Employees' Medical Benefit Fund	Restricted
25	Government Employees Medical Scheme (GEMS)	Restricted
26	Grintek Electronics Medical Aid Scheme	Restricted
27	Horizon Medical Scheme	Restricted
28	Hosmed Medical Aid Scheme	Open
29	Impala Medical Plan	Restricted
30	Imperial Group Medical Scheme	Restricted
31	Keyhealth	Open
32	LA-Health Medical Scheme	Restricted
33	Libcare Medical Scheme	Restricted
34	Liberty Medical Scheme	Open
35	Lonmin Medical Scheme	Restricted
36	Makoti Medical Scheme	Open
37	Malcor Medical Scheme	Restricted
38	Massmart Health Plan	Restricted
39	MBMED Medical Aid Fund	Restricted
40	Medihelp	Open
41	Medimed Medical Scheme	Open
42	Medipos Medical Scheme	Restricted
43	Medshield Medical Scheme	Open
44	Metropolitan Medical Scheme	Restricted
45	Momentum Health	Open
46	Motohealth Care	Restricted
47	Naspers Medical Fund	Restricted
48	Nedgroup Medical Aid Scheme	Restricted
49	Netcare Medical Scheme	Restricted
50	Old Mutual Staff Medical Aid Fund	Restricted
51	Parmed Medical Aid Scheme	Restricted

No	Scheme Name	Type
52	PG Group Medical Scheme	Restricted
53	Pick n Pay Medical Scheme	Restricted
54	Platinum Health	Restricted
55	Profmed	Restricted
56	Quantum Medical Aid Society	Restricted
57	Rand Water Medical Scheme	Restricted
58	Remedi Medical Aid Scheme	Restricted
59	Resolution Health Medical Scheme	Open
60	Retail Medical Scheme	Restricted
61	Rhodes University Medical Scheme	Restricted
62	SA Breweries Medical Aid Society (SABMAS)	Restricted
63	SABC Medical Scheme	Restricted
64	Samwumed	Restricted
65	Sasolmed	Restricted
66	Sedmed	Restricted
67	Selfmed Medical Scheme	Open
68	Sisonke Health Medical Scheme	Restricted
69	Sizwe Medical Fund	Open
70	South African Police Service Medical Scheme (POLMED)	Restricted
71	Spectramed	Open
72	Suremed Health	Open
73	TFG Medical Aid Scheme	Restricted
74	Thebemed	Open
75	Tiger Brands Medical Scheme	Restricted
76	Topmed Medical Scheme	Open
77	Transmed Medical Fund	Restricted
78	Tsogo Sun Group Medical Scheme	Restricted
79	Umvuzo Health Medical Scheme	Restricted
80	University of KwaZulu-Natal Medical Scheme	Restricted
81	University of the Witwatersrand Staff Medical Aid Fund	Restricted
82	Witbank Coalfields Medical Aid Scheme	Restricted
83	Wooltru Healthcare Fund	Restricted

ORGANISATIONAL STRUCTURE



CHAIRPERSON'S REPORT

Chairperson's REPORT

Professor Yosuf **VERIAVA**

During the 15 years of its existence, the Council for Medical Schemes (CMS) has built a proud culture of protecting beneficiaries of medical schemes by enforcing compliance with the provisions of the Medical Schemes Act. Requirements for open enrolment, community rating and prescribed minimum benefits are the main pillars of the Act and are linked with the principle of protecting beneficiaries against discrimination based on health status and other arbitrary grounds.

The introduction of legislated prescribed minimum benefits (PMBs) in January 2004 was designed to satisfy the constitutional obligation of ensuring that every South African has access to basic and adequate healthcare. PMBs ensure that all essential, non-discretionary benefits are covered by medical schemes. However, the PMB package was not designed to operate in an environment where there is no price regulation. Many medical scheme beneficiaries are left unprotected due to the 2010 high court judgment, which set aside the National Health Reference Price List (NHRPL) regulations, leaving a void in the regulation of healthcare prices. Controversial as they are, PMBs remain the perfect mechanism to link a future health insurance (NHI) system with the private healthcare financing industry.

The CMS supports the national Department of Health (DoH) in the development of an alternative mechanism for the determination of private healthcare prices. The ongoing market inquiry by the Competition Commission will also potentially provide insight into some of the structural challenges faced by the industry.

Council discharges its mandate in an increasingly litigious healthcare environment. Governance of medical schemes continues to be a challenge within the regulatory framework. In order to stabilise governance of medical schemes, where necessary, Council applies to the courts for the appointment of curators for schemes, manages insolvent schemes and institutes other legal proceedings to ensure that beneficiaries are protected. These interventions, while critical in protecting the CMS mandate, incur high legal costs and increase the cost of regulation.

In the ensuing period, Council plans to strengthen regulation by way of amending the Medical Schemes Act. This process is at an advanced stage as proposed amendments have already been submitted to the DoH.

During the year under review the CMS contributed to the draft demarcation regulations published by National Treasury and the Financial Services Board (FSB). This development partly led to the low-cost benefit options initiative. Council has approved the proposal that the CMS should consult with industry and develop a framework to guide medical schemes that may be interested in applying for these types of options.

As an institution that strives continuously to support beneficiaries of medical schemes, it is gratifying that the industry is financially healthy despite the low growth in membership (0.4%) and legislation challenges that have resulted in high private healthcare costs. The average age of beneficiaries, at 32.1 years, has remained almost unchanged in the last three years. However, membership growth in the younger age groups would contribute to keeping costs down.

The average cost of total benefits utilised by beneficiaries has increased by 10% and the amount for PMBs by 13.4%. It is interesting to note that PMBs constitute 52.5% of all risk benefits. Therefore schemes are still offering a significant proportion of risk benefits (47.5%) which are not PMBs.

Although the PMB benefit design is, in general, more hospital-centric, it is a concern that over 37% of all benefits paid were for hospitalisation. The CMS is in the process of including more preventive and primary care benefits in the PMB package and day hospitals could potentially play an important role in providing these services.

The CMS endeavours are not confined purely to issues relating to the medical schemes industry and its beneficiaries. It also has a strong commitment to the strengthening of the overall healthcare system and ensuring the provision of services that will make healthcare accessible to all citizens in the country.

The South African healthcare delivery system has two functionally separate and distinct components – the public sector component which serves 83% of the population and the private sector component, which is better-resourced, but only serves 17% of the population. Interaction between these two systems is negligible. Both systems are predominantly involved in the provision of curative services. Although curative services are important, preventive interventions and primary healthcare require significantly more attention.

The suboptimal health status of the population is a matter of serious concern. There has been significant improvement in South Africa's health indices in the democratic era, but the challenge of improving the health status of the population as a whole remains. This is evident in current health indices and our failure, as a country, to meet the Millennium Development Goals for health. In the World Health Organisation (WHO) survey of good health, equity and responsiveness, South Africa was ranked 175th out of 195 member states.

The mismatch of resources in the public and private health sectors and inefficiencies in the use of available resources have, to some extent, contributed to the poor health status of South Africans. However, the provision of curative services alone cannot improve the health of a population. The late Gavin Mooney, a health economist, commented in relation to South Africa: "The health problems are enormous. Of course they can be ameliorated through better healthcare. But the fundamental pointers remain the two key social determinants of health or ill health – poverty and inequality."

It is noteworthy that the present approach to population health is focused on the social determinants of health. The final report of the WHO Commission on Social Determinants of Health, "Closing the gap in a generation", and the United Nations' "Health in the post-2015 development agenda" promote the adoption of such an approach on a global scale.

Our essential focus both in the public and private sectors, as we provide curative services, should also consider population health. This approach is embedded in the National Development Plan (NDP). The main objectives of the plan are to: address social determinants of health; reduce disease burden to manageable levels; build human resources; strengthen the National Health System; and implement NHI. The NDP has set a number of goals for 2030. These are: life expectancy of 70 years; a generation largely free of HIV in the under

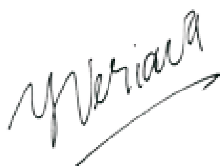
20 year group; infant mortality of less than 20/1 000 live births; maternal mortality of less than 100/100 000 live births; all HIV-positive people on treatment; a reduction of 28% in non-communicable diseases; and a 50% reduction in deaths from drug abuse, road accidents and violence.

The achievement of these goals will reflect in a healthier population. Some of the key ingredients for the successful implementation of the NDP are the active involvement of all South Africans, leadership from all sectors of society, and strong collaboration between the public and private healthcare sectors. An integrated approach between these two sectors is an essential factor in achieving universal coverage through NHI.

A quote from the NDP is worth mentioning: “Underpinning the National Health System policy are two interlinked ideas: the equalising principles of primary healthcare and the decentralised area-based, people-centred approach of the district health system.”

Finally, despite the challenges in the industry, I pledge my full support to all future endeavours by CMS staff as outlined in the strategic plans. Under the guidance of the Acting Registrar, Mr Daniel Lehutjo, the staff has continued undeterred with its organisational functioning, acting in the best interest of CMS stakeholders and members of medical schemes. The suspension of the Registrar was announced by the Minister of Health during the previous financial year while the investigation by Edward Nathan and Sonnenbergs Forensics (ENS) continued. The investigation was completed towards the end of the 2014/2015 financial year and the report issued in April 2015. The Minister announced that the contract of the Registrar expiring at the end of June 2015 would not be renewed.

In closing, I extend my thanks and appreciation to my colleagues serving on Council and to the Acting Registrar and his team for their continued focus on the CMS mandate as entrenched in the Medical Schemes Act. I also wish to thank those in the industry who continued to serve the industry and its nearly nine million medical scheme members.



Professor Yosuf Veriava
Chairperson of Council

June 2015

OVERVIEW OF THE ACTING CHIEF EXECUTIVE & REGISTRAR

Acting Chief Executive & REGISTRAR

Daniel **LEHUTJO**

I am especially pleased to present the Annual Report of the Council for Medical Schemes for the financial year 1 April 2014 to 31 March 2015, as we celebrate 15 years of protecting the interests of beneficiaries, while ensuring that administrators, managed care organisations and intermediaries serving schemes perform well in the regulated environment.

The Council for Medical Schemes (CMS) has kept its finger firmly on the pulse of the medical schemes industry for the past 15 years, taking special care in educating and informing beneficiaries of schemes of their rights and responsibilities and providing guidance to the industry. The CMS has recorded numerous achievements over the years but ultimately the benefits experienced by beneficiaries of medical schemes are the most important yardstick of our success.

This overview of the organisation's performance highlights the commitment of Council, executive management and our employees to uphold the mandate of the CMS, as set out in the Medical Schemes Act, 131 of 1998. It considers operational issues and also reflects the CMS' contribution to advising government on the quality and outcomes of health services provided through medical scheme cover, thereby contributing to the development of health policy as envisaged in section 7(b) of the Medical Schemes Act.

Key industry developments

In our efforts to advance access to quality and affordable healthcare, the CMS developed a proposal to introduce low cost benefit options to people who can otherwise not afford current medical scheme coverage.

The imminent promulgation of regulations demarcating health insurance and medical scheme cover and their implementation during 2015 will create a gap in the market in terms of access to private healthcare. This, together with the estimated cost of the prescribed minimum benefits (PMB) package for 2014 – R552.3 per beneficiary per month compared to R508.2 the previous year – will leave many low-income consumers without affordable cover.

The framework will focus on the protection of risk pools, benefit option design, ensuring continuity of healthcare, protecting solvency, reducing non-healthcare expenses, marketing and underwriting. It will provide an opportunity for schemes to be responsive to the needs of the environment, while at the same time ensuring that the policy objectives of open enrolment, community rating, consumer protection, non-discrimination and expanding risk-pooling are demonstrably furthered where exemptions are sought.

The proposal received widespread support from government and industry. It provided for a framework and detailed guidelines on low cost benefit options (LCBOs) and for exemptions to be granted from compliance with certain sections of the Medical Schemes Act. The proposal was also prompted by several appeals by the Minister of Health for medical schemes to find innovative ways of providing affordable benefits and to focus on primary and preventive healthcare.

The CMS looks forward to further engagement with industry and to publish the framework in respect of LCBOs in 2015.

The demarcation debate continued and the CMS is eagerly awaiting final publication of the regulations.

The Minister of Health tasked the CMS with establishing a central repository – a Beneficiary Registry – containing records of all funded patients in South Africa, which will further enhance the efforts of the DoH on resource planning for an inclusive healthcare system for South Africa. The aim is to have the Beneficiary Registry developed by the end of the 2015/2016 financial year.

A project to review the current solvency framework for medical schemes commenced during the period under review and will continue as a priority project. The industry will be invited to comment on a proposed framework in 2015/16.

The CMS has initiated a project to redesign and enhance the system used to collect healthcare utilisation data with the purpose of improving the quality of data submitted by all registered medical schemes. This new system, which was well received by both medical schemes and administrators, eases the burden on schemes because manual submission of data is no longer applicable.

Data received through the enhanced Annual Statutory Returns (ASR) system will enable the CMS to conduct research on a range of health policy issues, including trends in medical schemes' demographics; the cost and quality of health services; healthcare utilisation patterns; medical scheme risk measurement; and access to healthcare interventions.

Little progress was made this year on the Medical Schemes Amendment Bill and PMB review. The CMS continued engaging with the DoH and met the State Law Advisor at the end of 2014 to resolve concerns about the Amendment Bill. The CMS completed final technical work on the Bill in the last quarter of 2014 and it is hoped that the Bill will be presented to Cabinet during 2015 and subsequently made available for public comment.

Benefits and costs

Three PMB benefit definitions were published in the year under review. These documents sought to clarify PMB entitlements of certain conditions. The definitions provide guidance to the healthcare industry on funding of PMBs with the resultant effect of minimising complaints regarding these conditions.

The quality of the definitions was appraised by industry stakeholders for comments and approval. These are considered living documents and therefore refinements are anticipated to deal with evolving clinical practice. The CMS will continue to engage with relevant stakeholders regarding drafting of future benefit definitions.

The growing burden of chronic disease care

The 2014 retrospective study of the CMS' Scheme Risk Measurement (SRM) Database was undertaken to establish changes in the frequency of chronic diseases among beneficiaries of medical schemes between 2008 and 2013. The study compared trends for open and restricted schemes, schemes of various sizes, and a range of benefit options.

The main finding was that there has been a sustained upward trend in diagnosis and treatment of many conditions on the chronic disease list (CDL). While the study could not isolate specific reasons for this increase in chronic diseases, the trend could be generally attributed to improved data management systems of medical schemes and administrators, the deteriorating disease profile and higher average age of beneficiaries, increased beneficiary awareness of entitlements, and changes in care-seeking behaviour.

The findings of the 2014 prevalence study are summarised in Table 1.

Table 1: Prevalence of chronic conditions among medical scheme beneficiaries: 2008 – 2013

Rank (2012)	Condition	Type	Prevalence (cases/1 000 beneficiaries)			Change** (%)		Average annual growth rate (%)
			2008	2012	2013	2012 vs 2013	2008 vs 2013	2008 vs 2013
1 (1)	Hypertension (HYP)	Total	65.51	86.16	87.2	1.2	33.1	5.9
		Open	61.92	86.92	87.62	0.8	41.5	7.2
		Restricted	65.99	85.3	86.68	1.6	31.4	5.6
2 (2)	Hyperlipidaemia (HYL)	Total	27.71	35.58	34.78	-2.2	25.5	4.6
		Open	33.54	40.5	39.64	-2.1	18.2	3.4
		Restricted	27.20	30.03	28.87	-3.9	6.1	1.2
3 (3)	Diabetes mellitus type 2 (DM2)	Total	16.03	25.66	26.91	4.9	67.9	10.9
		Open	14.75	23.01	24.14	4.9	63.7	10.4
		Restricted	18.07	28.65	30.28	5.7	67.5	10.9
4 (6)	HIV/AIDS (Receiving ARVs)	Total	6.60	14.57	17.41	19.5	163.7	21.4
		Open	6.07	8.53	10.24	20.0	68.6	11.0
		Restricted	6.95	21.39	26.12	22.1	275.9	30.3
5 (4)	Asthma (AST)	Total	13.00	15.77	15.79	0.1	21.5	4.0
		Open	13.00	15.78	16.02	1.5	23.2	4.3
		Restricted	13.75	15.77	15.51	-1.6	12.8	2.4
6 (5)	Hyperthyroidism (TDH)	Total	11.48	14.7	14.45	-1.7	25.9	4.7
		Open	11.03	15.23	14.97	-1.7	35.7	6.3
		Restricted	11.79	14.09	13.83	-1.8	17.3	3.2
7 (7)	Ischaemic heart disease (IHD)	Total	6.58	7.3	6.87	-5.9	4.4	0.9
		Open	6.87	8.35	7.78	-6.8	13.2	2.5
		Restricted	5.58	6.11	5.77	-5.6	3.5	0.7
8 (8)	Epilepsy (EPL)	Total	3.49	4.24	4.26	0.5	22.1	4.1
		Open	3.53	4.44	4.47	0.7	26.5	4.8
		Restricted	3.35	4.01	3.99	-0.5	19.0	3.5
9 (9)	Cardiomyopathy (CMY & CHF)	Total	3.96	4.17	4.22	1.2	6.5	1.3
		Open	3.95	4.03	4.07	1.0	3.1	0.6
		Restricted	3.41	4.34	4.39	1.2	28.6	5.2
10 (11)	Rheumatoid arthritis (RHA)	Total	2.09	2.93	2.96	1.0	41.7	7.2
		Open	1.99	2.84	2.87	1.1	44.4	7.6
		Restricted	2.05	3.03	3.08	1.7	50.4	8.5

* *Note the prevalence used in this table is SRM prevalence entry and verification (E&V) criteria*
** *Note the change is the percentage change in the cases per 1 000 beneficiaries from year to year*

Table 1 depicts the trends in the 10 most commonly diagnosed and treated conditions from 2008 to 2013. The ranking of most of these conditions remained unchanged over this period.

The higher prevalence of beneficiaries with chronic diseases translates to an increase in visits to general practitioners and specialists, a growth in the use of medicines, and a possible rise in hospital events. Without population-wide interventions to address the root causes of these chronic diseases the upward trend is expected to continue with increasingly severe impacts on schemes. Protection of risk pools and growth in younger, healthier beneficiaries are critical for long-term sustainability of the industry.

Member contributions

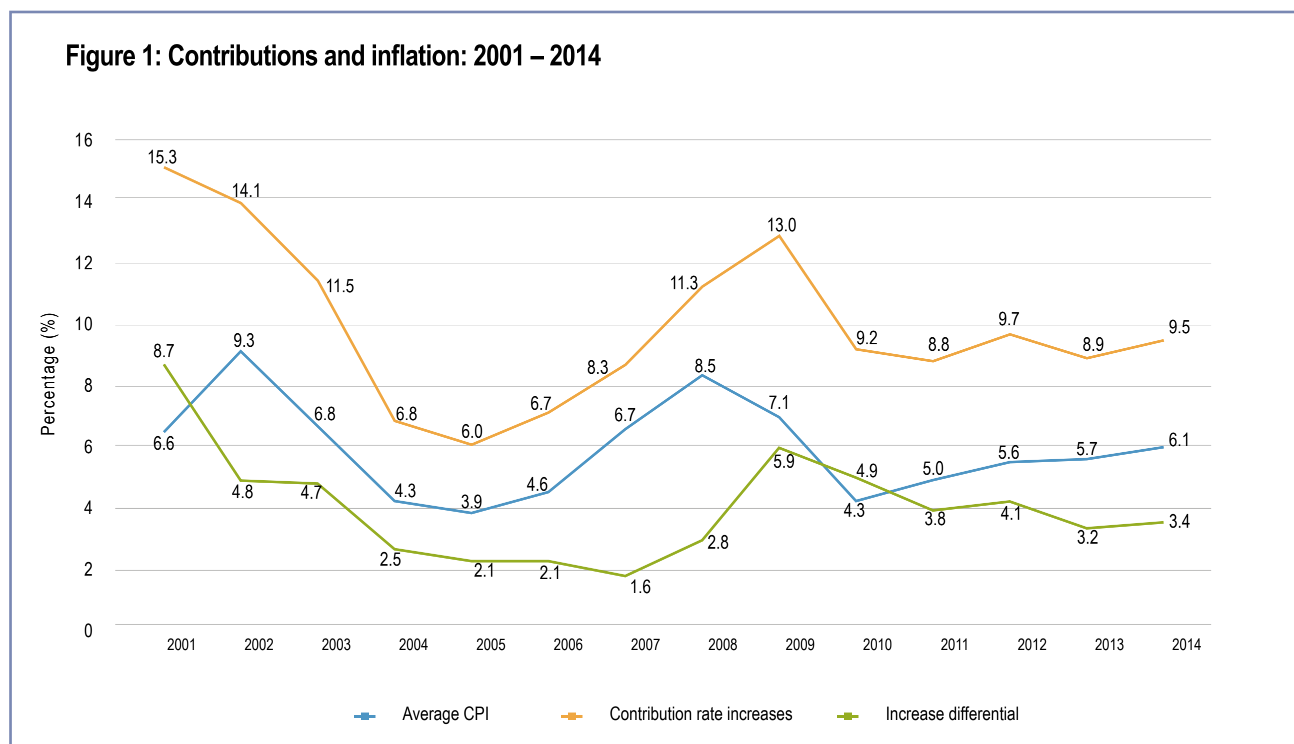
The 83 registered medical schemes had a combined total of 8.8 million members in December 2014, comprising of 3 921 232 main members and 4 893 226 dependants.

The average gross contribution increase[1] for all medical schemes in 2014 was 9.5%, slightly higher than the assumed or estimated increase of 9.2%. The overall cost consumption increase was 9.2%, which is inclusive of 2.9% for utilisation. On average open schemes instituted larger increases in contributions (9.8%) than restricted schemes (9.2%).

1. *The gross contribution increase is based on the actual number of principal members as well as adult and child dependants.*

Figure 1 shows historical and current inflation trends, measured by the Consumer Price Index (CPI), relative to contribution rates of medical schemes between 2001 and 2014. The graph also indicates the percentage by which the average rate of increase in medical scheme contributions exceeded inflation.

Figure 1: Contributions and inflation: 2001 – 2014



Average CPI = Average change in the Consumer Price Index year-on-year

Since 2002 medical scheme contributions have followed a similar trend to inflation. However, the average difference in contribution increases relative to CPI was in the region of 4.0% between 2001 and 2014. This has implications for the long-term affordability of the medical schemes industry as increases in salaries may not keep pace with contribution increases.

Member out-of-pocket spending

Out-of-pocket expenditure is a key indicator of members' experiences and their perceptions of the medical schemes environment. It is therefore important that it is continuously monitored.

There is ongoing debate on what is the right or acceptable level of out-of-pocket payment. The World Health Organisation (WHO) guidelines state that out-of-pocket expenditure should not exceed 15% of the total healthcare cost in any health system. During the last financial year the CMS published a report which highlighted the fact that out-of-pocket expenditure of South African medical scheme members was at least 18% of the total healthcare cost – well above the WHO guideline.

The report indicated a need for the CMS to report more proactively on the quantum of out-of-pocket payments. Accordingly, the CMS is delighted to include a new section on out-of-pocket expenditure in Chapter 2 of this report, indicating improved data collection and analysis. In previous years out-of-pocket data was only collected at scheme level, while in the 2014/2015 financial year this data was collected at option level as well, which facilitated more in-depth analysis.

The CMS analysis of out-of-pocket expenditure shows that the level of out-of-pocket expenditure is influenced by benefit design. Beneficiaries do not claim when they realise their schemes will not be paying for their claim. Out-of-pocket spending by beneficiaries who are on an option with member savings plus threshold averaged almost R6 000 per beneficiary per annum. Due to benefit design these members would typically claim for nearly all their health costs, as they aim to reach those benefit thresholds.

Benefit options: offerings to members

Medical schemes continued to consolidate in 2014/2015, with the number of benefit options available remaining stable over the period of review. There was an increase in efficiency-discounted benefit options (EDOs), from 40 such options on 31 March 2014 to 42 a year later.

The total number of registered benefit options (including EDOs) increased from 317 in March 2014 to 319 in March 2015. The increase in benefit options in open schemes was from 177 to 182, while the decrease in restricted schemes was from 140 to 137.

Table 2: Options as at 31 March 2015

Status of option	Open scheme options	Restricted scheme options	Total
Options registered as at 31 March 2014	**177**	**140**	**317**
Less: efficiency-discounted options (EDOs)	-40	0	-40
Options registered as at 31 March 2014 (excluding efficiency-discounted options)	**137**	**140**	**277**
New options	+5	+2	+7
Discontinued options	-2	-3	-5
Discontinued options due to scheme mergers	0	-2	-2
Discontinued options due to scheme liquidations	0	0	0
Options registered as at 31 March 2015 (excluding efficiency-discounted options)	**140**	**137**	**277**
Options with efficiency discounts*	+42	0	+42
Options registered as at 31 March 2015	**182**	**137**	**319**

* *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 140.*

Efficiency-discounted options

EDOs are benefit options with network arrangements for healthcare provision. They were introduced in 2008 and allow monthly medical scheme contributions to be differentiated on the basis of healthcare providers that are utilised to provide benefits. This practice is in conflict with the statutory principle that contributions may be differentiated only on the basis of 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 EDOs.

In the year under review, Council allowed Bestmed Medical Scheme to introduce EDOs, bringing the total number of schemes offering such options to nine at the end of March 2015. The other eight are: Momentum Health, Discovery Health Medical Scheme (DHMS), Fedhealth Medical Scheme, Liberty Medical Scheme, Thebemed, Compcare Wellness Medical Aid Scheme, Medihelp and Hosmed Medical Aid Scheme.

Only open medical schemes have elected to offer EDOs to date. Refer to Annexure R for detailed information on the EDOs.

Benefit options with network arrangements offer advantages to both members and medical schemes. Members receive discounts because the scheme is able to obtain efficiency from a selected provider network. Members' contributions are fair and non-discriminatory and they retain a measure of choice within the efficiency of the network. Medical schemes also achieve cost savings because network arrangements allow schemes to negotiate better reimbursement and healthcare delivery terms.

Demand for such options is expected to continue growing as schemes and members experience benefits from such arrangements.

Table 3 provides a high level summary of the EDO options currently registered.

Table 3: EDO option summary as at 31 December 2014

Type of option	Members	Beneficiaries	Gross contributions R'000	Net healthcare results pbpm	Claims ratio %
EDOs	207 779	433 234	5 174 829	95.53	68.2
Non-EDOs	673 188	1 482 603	30 288 547	8.30	85.2
Total	**880 967**	**1 915 837**	**35 463 376**	**28.25**	**82.6**

Monitoring of diagnosis coding (ICD-10)

It is a statutory requirement that all healthcare providers, including doctors, hospitals and allied professionals, use the International Classification of Diseases, 10th Revision (ICD-10) codes when diagnosing patients and submitting claims to medical schemes. The CMS continued to provide ICD-10 compliance data to the DoH Director-General.

The Ministerial ICD-10 Task Team revised data specifications for quarterly submissions from medical schemes in the year under review. The revised data specification requires medical schemes to submit ICD-10 compliance data every six months.

The 2014 ICD-10 submissions were based on the revised data specification and the results were reasonable. Only two medical schemes

(Makoti and Spectramed) did not submit data. The data submitted covered about 99% of beneficiaries of the relevant medical schemes and analysis indicated that about 98.7% of paid claim lines by medical schemes complied with ICD-10 coding standards.

The ICD-10 compliance report also confirmed that pharmacies and pathology laboratories still use the default Z-codes on most of their claims as they are not provided with a referral code.

The value of managed care

A research project which involved qualitative assessment of HIV and AIDS disease management programmes within the medical schemes industry was undertaken in 2014. It also involved a review of international experience of disease management programmes, exploring their structure, key components and measurement of effectiveness. For the local experience, this research project used information provided by key stakeholders to understand contextual factors influencing managed care services and arrangements for managing HIV and AIDS within the medical schemes industry.

The primary objective of this study was to provide support to the Industry Technical Advisory Panel (ITAP) managed care project. A mixed-method approach was used to facilitate data collection and analysis. This included a review of literature on disease management programmes, key informant interviews and qualitative assessment of clinical protocols and disease programmes.

The research helped to identify specific issues relating to HIV and AIDS healthcare provision from the MCOs' perspective. These included the role of factors such as:

- The influence of medical schemes' contracting and funding models.
- The identification data required for monitoring health outcomes in respect of HIV and AIDS.
- Benefit option design and content.
- The effect of scheme rules on facilitating access to care within each option.
- The role of ex gratia payments in facilitating access to required care for low options.

All these factors provide detailed contextual understanding of managed care services and managed care arrangements within the medical schemes industry.

The following were key findings of the research project:

- While medical schemes may differ in their managed care business models, a holistic approach to disease management through innovative contracting is the preferred model since it is likely to have a major impact on health outcomes. This approach should be supported by innovative reimbursement models to reward good performance by service providers. This approach should also identify areas requiring specific focus and corrective interventions by medical schemes. Medical schemes and their MCOs would then be in a better position to demonstrate value for money spent on managed care services and interventions which are clinically justified.
- Where medical schemes have multiple contracts with different MCOs, schemes need to facilitate sharing of data in an electronic format at beneficiary level between contracted entities, which will enable cost effective management of drug interactions, side effects and complications.
- Process and outcomes data available within MCOs should be consistently shared with the medical schemes to enable better monitoring and evaluation of health outcomes by the medical schemes. Such information would supplement financial performance information currently shared by most MCOs with medical schemes.
- The use of innovative means to identify patients eligible for the programmes through profiling pathology results and/or hospital admissions data is considered by MCOs as a successful intervention for cost-effective management of conditions. Such an approach is encouraged, especially as HIV and AIDS are under-reported in the industry.

Measuring the quality of healthcare

During the past financial year substantial progress was made on this key objective. The CMS adopted the indicators identified through the ITAP working group as the minimum standards for quality of care in the medical schemes environment. The CMS then amended the data collected through the Annual Statutory Returns to incorporate these indicators and investigated ways of analysing such data. A report was prepared on the analytical methodology and the drawing of inferences on quality of care.

The CMS is pleased that, as a regulator, it has managed to collect data that will help answer the critical question of quality of care in the medical schemes environment. The results of the analysis of this first set of data will be made available in a separate report once the analysis is concluded.

A stable industry

No entity applied to be registered as a new medical scheme during the period under review. The number of medical schemes decreased from 85 in March 2014 to 83 in March 2015.

In February 2015 the CMS published a list of all registered medical schemes and their contact details in the *Government Gazette*, as required by section 25 of the Medical Schemes Act.

Scheme amalgamations and liquidations

In the year under review, medical schemes continued to merge while no schemes were liquidated. Such developments are an expected response to market forces and are not necessarily a negative development or an indication of instability in the South African medical schemes environment. The mergers listed below involved the absorption of schemes into larger entities and resulted in greater risk pooling.

Table 4: Amalgamations during 2014/2015

Scheme name	Scheme amalgamated with	Date
Afrox Medical Aid Society	Discovery Health Medical Scheme	1 April 2014
PG Bison Medical Aid Society	Discovery Health Medical Scheme	1 May 2014

Analysis of market structure

An understanding of market concentration and its impact on the medical scheme environment is critical to healthcare policy reforms. Over the past year the CMS has done research on measuring market concentration among medical schemes, benefit options, administrators and provider groups.

The preliminary research findings were welcomed by the Competition Commission (CC) and the CMS will continue its research on market structure in the next financial year.

Monitoring the financial soundness and viability of schemes

Over the last 15 years, the CMS has consistently strengthened its systems and processes for the close monitoring of schemes in order to ensure their financial soundness and viability.

One of the most important developments was the introduction of online submission of statutory returns which resulted in improved reporting and accuracy due to in-built system validation rules. An online system was also instituted to facilitate the annual approval of auditors appointed by schemes.

Enhancement of the early warning system (EWS)[2] proved to be crucial. Interventions that have been introduced over the years include regular financial review meetings with schemes and their boards of trustees, submission of business plans and turn-around strategies.

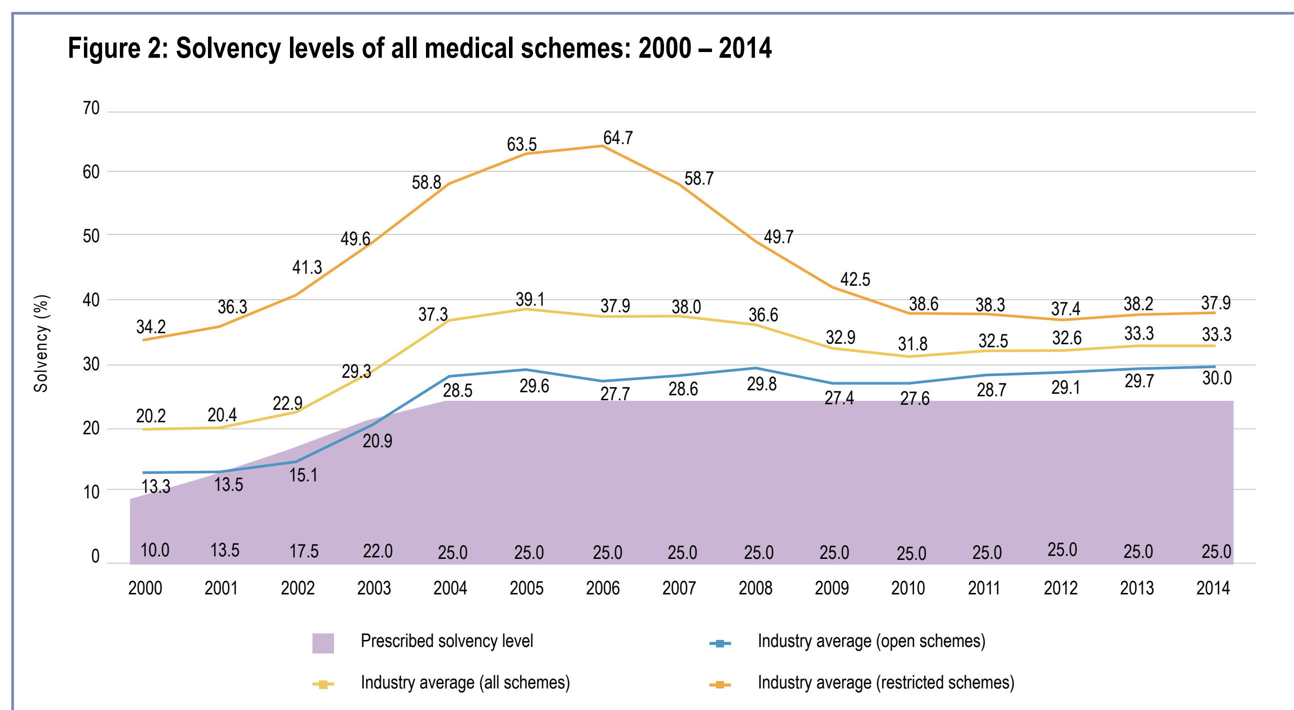
A key area of focus has been the monitoring of non-healthcare expenditure and continued interaction with trustees to ensure value add for members.

The development of the quarterly return was a significant measure in ensuring that the CMS is able to undertake baseline supervision on all medical schemes and make appropriate regulatory interventions between audit cycles. Further to this, the Real Time Monitoring (RTM) System was introduced to improve the ongoing monitoring of schemes by collecting a defined and limited data set on a monthly basis. This allows the CMS to better understand the profiles of schemes and intervene timeously to ensure the protection of members' interests.

A significant amount of work has gone into improving the quality of reporting by medical schemes. This has entailed collaboration with the South African Institute of Chartered Accountants (SAICA) and the Independent Regulatory Body of Auditors (IRBA). These partnerships resulted in the publication of Accounting and Auditing Guides for Medical Schemes which help achieve standardisation and uniformity in respect of proper disclosure and good financial reporting across the industry.

Financial soundness of medical schemes

Figure 2: Solvency levels of all medical schemes: 2000 – 2014



2. *The early warning system is a term that the CMS uses for the collective of regulatory statutory interventions that occur in between accounts. These include statutory quarterly returns, management accounts, financial review meetings and real time monitoring.*

Regulation 29 of the Medical Schemes Act requires all medical schemes to maintain accumulated funds of at least 25% of gross annual contributions. Medical schemes that fall short of this requirement are required to notify the CMS of the underlying causes of failure and corrective action to be taken. Such schemes are then placed on close monitoring by the CMS.

Schemes that have solvency levels above the required level of 25%, but have reserves that are rapidly diminishing are also monitored. Interventions in relation to such schemes may include submission of management accounts, financial review meetings with the board of trustees and even submission of business plans to address the situation. Other schemes kept on the CMS radar are those that have governance problems, are under curatorship or record excessive non-healthcare expenditure.

In the last 15 years, the collective efforts of the CMS and boards of trustees of medical schemes have been somewhat successful in stabilising non-healthcare expenditure in real terms, albeit off a high base. However, there are individual schemes that continue to have challenges and the CMS regularly engages them in an effort to reduce non-healthcare expenditure to acceptable levels.

In 2000, there were 15 open schemes and 14 restricted schemes below the prescribed solvency level. In the last 15 years, the total number of schemes in the industry has fallen mainly due to amalgamations and liquidations. As a result, the number of schemes under close monitoring has also reduced significantly. Furthermore, some schemes which were on close monitoring have since attained solvency and have been removed from close monitoring.

As at 31 December 2014, there were seven medical schemes (nine at 31 December 2013) below the minimum statutory solvency requirement of 25%. Five of these were open schemes and two restricted. A year earlier six open and three restricted schemes were being closely monitored. The seven schemes on close monitoring at the end of 2014 covered 24.1% of all medical schemes beneficiaries – 4.3% of open scheme beneficiaries and 48.9% of restricted scheme beneficiaries.

When excluding the Government Employees Medical Scheme (GEMS), which accounts for 47.0% of the restricted scheme market, the proportion of restricted scheme beneficiaries belonging to schemes with reserves below the minimum statutory solvency level falls to 1.9% (2013: 3.6%).

In the course of 2014:

- Pharos Medical Plan amalgamated with Topmed Medical Scheme with effect from 01 January 2014.
- DHMS, which accounts for 53.8% of the open scheme market, attained a solvency ratio above 25% for the year under review.

Figure 3: Beneficiaries by solvency level of their medical scheme: 2014

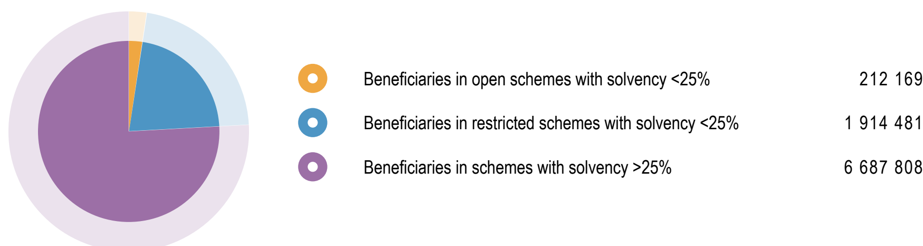
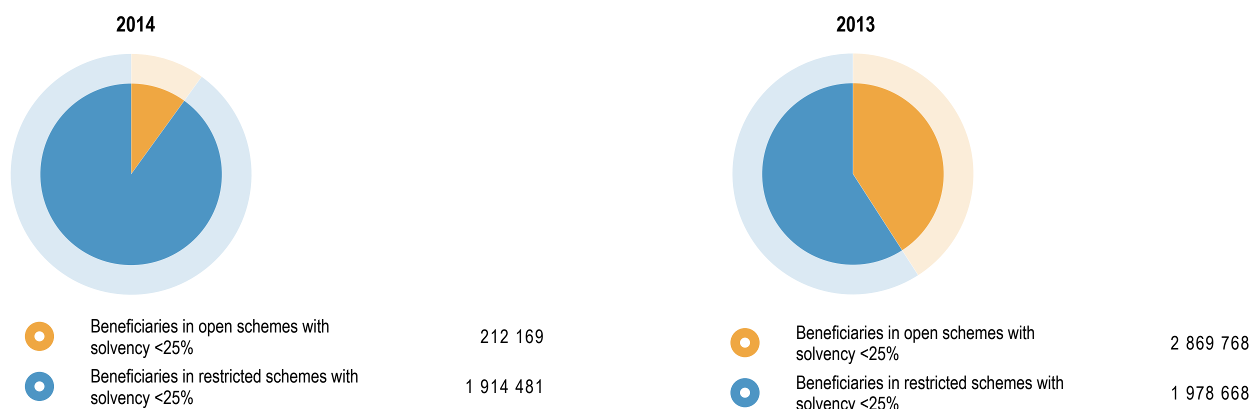


Figure 4: Comparison of beneficiaries in schemes below 25% solvency level: 2013 and 2014



Figures 3 and 4 indicate that the percentage of beneficiaries belong to schemes that do not meet the minimum statutory solvency level has reduced sharply in open schemes due to DHMS reaching solvency.

Table 5 contains a summary of schemes on close monitoring in terms of Regulation 29 (4) of the Medical Schemes Act.

Table 5: Schemes below solvency level of 25%: 2014

Solvency level	Open schemes	Restricted schemes	Name of scheme
Below 10%	1	0	Resolution Health Medical Scheme
From 10% – 13,5%	0	1	Government Employees Medical Scheme
From 13,5% – 17,5%	1	0	Liberty Medical Scheme
From 17,5% – 22%	2	0	Community Medical Aid Scheme, Suremed Health
From 22% – 25%	1	1	Thebemed Transmed Medical Fund
Total	**5**	**2**	

Community Medical Aid Scheme (COMMED) reported a solvency ratio of 21.4% for 2014, which is a 16.4% decrease compared to the ratio of 25.6% achieved in 2013. It was further noted that membership increased by 12.7% and claims grew by 4.0% during the same period. The scheme's non-healthcare expenditure has increased and this has contributed to the overall losses incurred by the scheme. The scheme has been placed on close monitoring and is submitting monthly management accounts.

DHMS ended 2014 with a solvency ratio of 25.8%, which represents a 6.2% increase on the 2013 ratio of 24.3%. The scheme fell below the required solvency level in 2010 due to membership growth and a subsequent deterioration in the pensioner ratio and chronic disease profile of the scheme. The minimum solvency requirement was attained due to scheme management and trustees implementing interventions such as adjustments to contributions, benefits and non-healthcare expenditure and focusing on forensic and fraud management. The scheme had also diversified its investments in recent years and this resulted in higher returns. Collectively these factors boosted the scheme's reserves in 2014.

As at 31 December 2014, GEMS reported a solvency ratio of 10.0%, compared to 11.7% in 2013. The scheme had contributions in significant variance from their budgeted results for 2014. The number of GEMS beneficiaries has increased over the years, putting pressure on the scheme's reserves. However, during 2014 beneficiaries actually decreased by 0.8%. Factors contributing to this reduction in beneficiaries were resignations by public sector employees; termination of membership due to the scheme's debt management policy; and resignation of deceased members. The drop in the solvency ratio in 2014 was mainly due to the claims ratio being higher than anticipated. The scheme has implemented measures to minimise the impact of this. GEMS has an approved business plan, submits management accounts to the CMS, and attends quarterly monitoring meetings with the CMS.

Hosmed Medical Aid Scheme reached a solvency ratio of 25.5% at the end of 2014 (2013: 24.5%). The scheme has experienced significant governance challenges in the past, resulting in the appointment of a curator in April 2014. In addition, membership losses of 2.1% were incurred during 2014. The curator attends monthly meetings with the CMS and the scheme is submitting monthly management accounts.

Liberty Medical Scheme experienced a marked decrease in younger and low-claiming members. This change in the scheme's age profile led to high increases in claims. The solvency ratio of Liberty Medical Scheme dropped significantly (29.5%), from 24.4% in 2013 to 17.2% in 2014. The scheme plans to address these performance challenges through efforts focused on the growth of younger members and lowering non-healthcare expenses. The scheme submits monthly management accounts and the board attends regular monitoring meetings with the CMS.

Resolution Health Medical Scheme reported a solvency ratio of 9.4% in 2014, slightly up from 8.1% in 2013. While this was partly due to a small increase in reserves, it was mainly as a result of the significant (21.7%) decline in membership from 2013. The CMS has advised the board to seek sustainable solutions, which would safeguard members' interests.

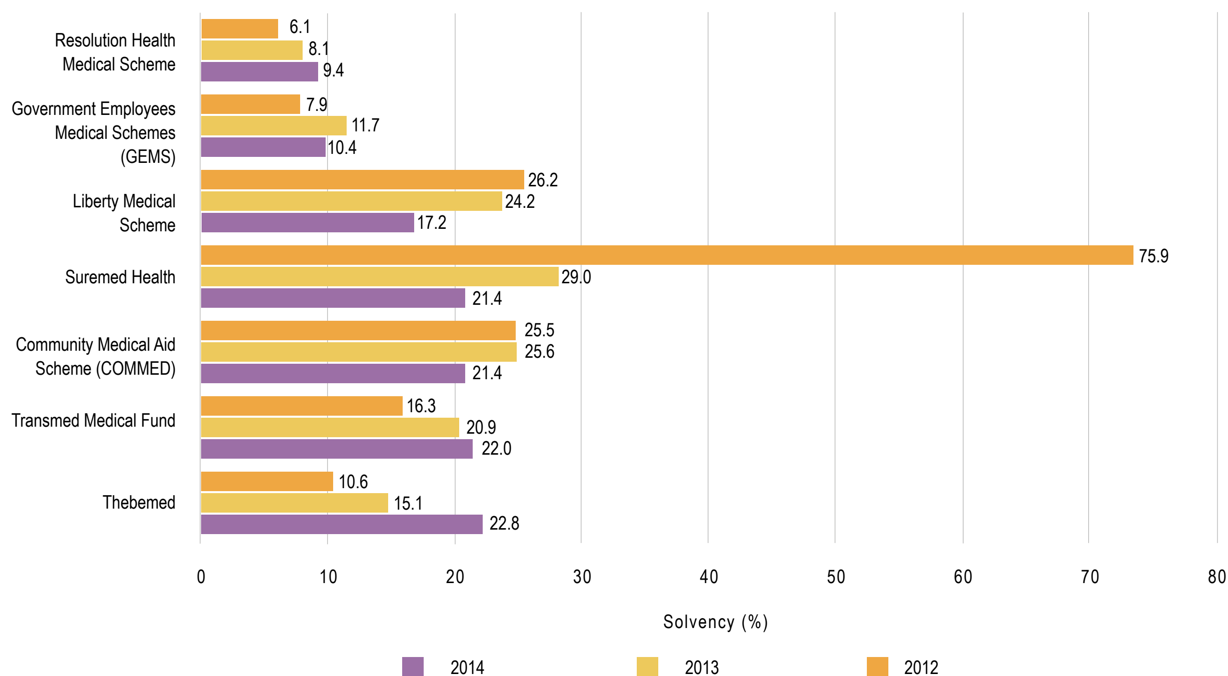
Suremed Health incurred a significant drop in solvency from 29.0% in 2013 to 21.4% in 2014. This was attributable to a significant increase in membership from a certain employer group, which had a significant impact on the demographic profile of the scheme. This in turn presented difficulties in pricing contributions and benefits accurately and appropriately, leading to the scheme incurring net deficits in both 2013 and 2014. The scheme is under close monitoring and is submitting monthly management accounts.

Thebemed reached a solvency ratio of 22.8% in 2014, which is 50.9% higher than the 2013 solvency ratio of 15.1%. The improved solvency ratio was mainly due to measures including tighter management of non-healthcare expenditure and utilisation and conclusion of a reinsurance contract in order to manage the risk of high hospital claims. A business plan was submitted by the scheme and the CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

The solvency ratio of Transmed Medical Fund (Transmed) improved by 5.3% from 20.9% in 2013 to 22.0% in 2014. This was the result of a decrease in beneficiaries of 13.5%, which in turn impacted on overall contribution income. The scheme submitted a new business plan in response to a change in employer subsidies and continues to submit monthly management reports. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

Umvuzo Health Medical Scheme had a solvency level of 21.3% at the end of 2013 and this improved significantly (20.2%) in the year under review to 25.6% as at December 2014. The scheme performed better in 2014 mainly due to claims being lower than anticipated, resulting in growth in reserves. Umvuzo has an approved business plan and submits monthly management accounts.

Figure 5: Solvency trends for all schemes below 25% solvency level: 2014



Quality control through accreditation

Since its inception, the CMS has improved standards for accrediting administrators of medical schemes, MCOs and brokers.

Further, the CMS – together with the Financial Services Board (FSB) – co-regulates the broker fraternity.

During the year under review the CMS continued to accredit and monitor administrators of medical schemes, MCOs and brokers operating in the industry. It also ensured that self-administered medical schemes complied with statutory requirements.

Third-party administrators, self-administered schemes and managed care organisations

A total of 17 third-party administrators had been accredited and 11 self-administered medical schemes issued with compliance certificates as at 31 March 2015. Refer to Annexure Z for details on the administrators.

There were 39 accredited MCOs as at 31 March 2015. Refer to Annexure Z for a list of accredited MCOs.

Unwarranted performance or profit sharing incentives

Circular 51 was published in October 2014 following concerns regarding an emerging trend amongst certain medical schemes and MCOs to enter into agreements featuring performance incentive-based or profit-sharing arrangements. Six such arrangements were disclosed and evaluated, and five of these were found to be unwarranted. The parties were instructed to terminate the arrangements.

Brokers and broker organisations

The accreditation of several brokers and broker organisations was rejected, suspended or withdrawn during the financial year under review. The affected parties are listed in Table 6.

Table 6: Broker accreditation suspended, withdrawn and rejected in 2014/2015

Broker name and number	Action	Effective date	Reason
Broker accreditation suspended and withdrawn in 2014/2015			
C Grigor (BR 9974)	Withdrawn	18.12.2014	The broker was no longer deemed fit and proper to act as an accredited healthcare broker.
Brokerage accreditation suspended and withdrawn in 2014/2015			
Verso Health (Pty) Ltd (ORG 1667)	Withdrawn	30.06.2014	The entity discontinued its business.
Thethani Financial Services (Pty) Ltd (ORG3996)	Suspended	12.03.2015	Licence suspended by the Financial Services Board.
Brokerage accreditation rejected in 2014/2015			
Juntos Brokers (Pty) Ltd (ORG 45)	Renewal of accreditation refused	25.02.2015	The applicant was no longer deemed fit and proper to act as a broker organisation.
Charmier Consultants cc (ORG 2638)	Renewal of accreditation refused	31.07.2014	The brokerage was no longer deemed fit and proper to act as a broker organisation.

A process of verifying the academic qualifications submitted by individuals in order to mitigate the risk of granting accreditation to unqualified applicants was introduced. A contract was entered into with a third party to perform this function.

The Minister of Health announced an increase in the maximum amount payable to brokers in terms of section 65 of the Medical Schemes Act. The amount increased from R71.07 to R75.00 per member per month, with effect from 1 February 2014.

Investigation and resolution of complaints

The decrease in the number of new complaints which we observed in 2013 continued in 2014. Figure 6 represents the number of complaints received per 1 000 beneficiaries.

During 2014, 3 876 new complaints were received, bringing the total number of complaints to be resolved to 7 653.

Figure 6: Number of complaints received per 1 000 beneficiaries: 2014

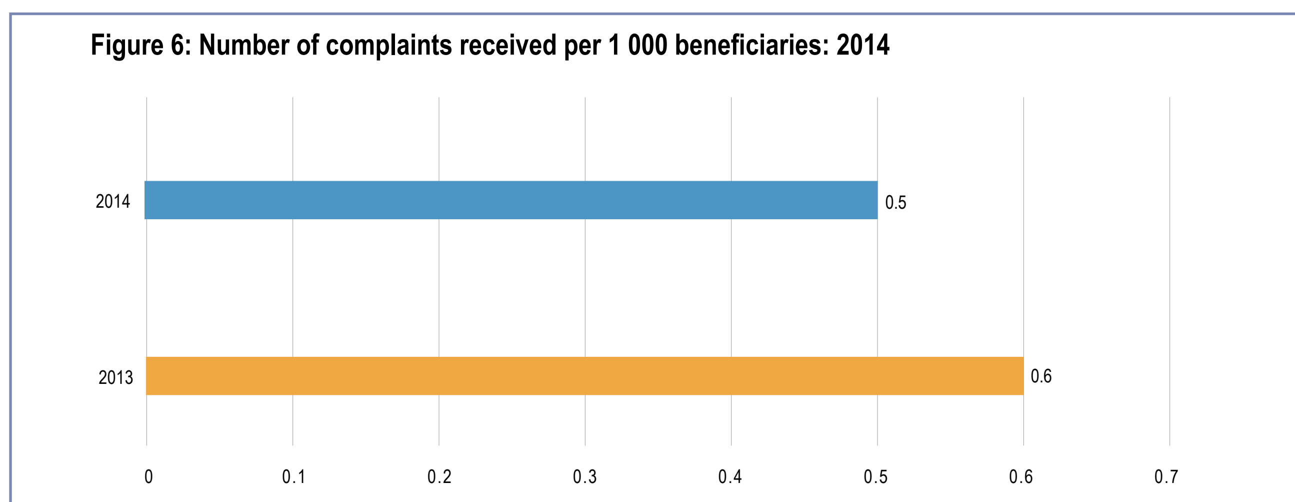


Table 7 below indicates the volume of complaints handled.

Table 7: Number of complaints received and resolved: 2013 and 2014

	2014	2013
Complaints carried forward from previous year	3 777	3 641
Complaints received during current year	3 876	5 609
Total complaints	7 653	9 250
Total resolved	**5 491**	**5 473**
Closing balance as at 31 Dec 2014	2 162	3 777

The report on complaints resolved during 2014 takes account of a substantial number of complaints that had not been resolved in previous reporting periods mainly due to the increasing complexity of complaints.

Table 8: Resolution turn-around time for complaints: 2014

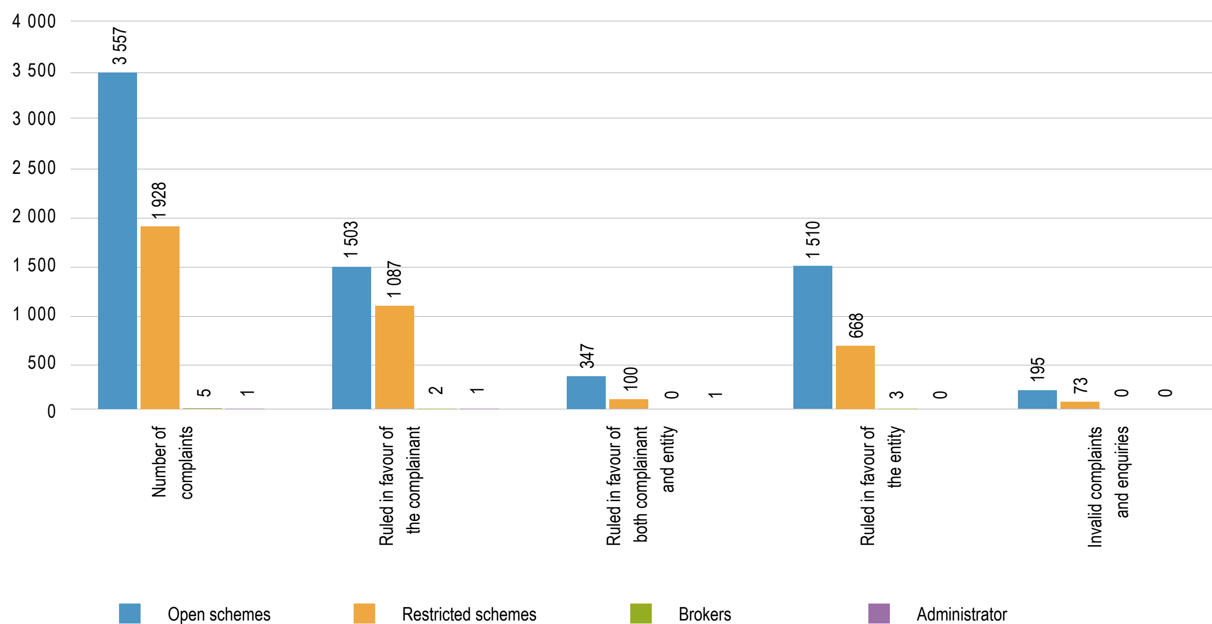
	Resolution turn-around time in days					
Complaints resolved	**0-30**	**>30-60**	**>60-90**	**>90-120**	**>120**	**Total**
Number of complaints resolved	1 607	1 064	516	518	1 786	**5 491**
% of complaints resolved	29.3	19.4	9.4	9.4	32.5	**100.0**

Figure 7: Number of complaints resolved and inquiries/invalid complaints dealt with: 2014

A total of 5 223 complaints were classified as valid complaints. These were referred to medical schemes, administrators and brokers for comment and were resolved after receipt of responses from these parties. Calls and mails which were classified as enquiries were resolved internally without being referred to the medical schemes, administrators and brokers for comment.

The rulings made in relation to complaints that were resolved in 2014 are summarised in Figure 8.

Figure 8: Rulings on complaints against medical schemes resolved: 2014



The types of complaints that were resolved are summarised in Table 9.

Table 9: Number of complaints resolved by category: 2013 and 2014

Main categories	Number of complaints resolved	
	2014	2013
Clinical	2 705	3 078
Administrative	2 015	1 521
Legal/compliance	503	409
Subtotal 1	**5 223**	**5 008**
Enquiries and invalid complaints	268	465
Total	**5 491**	**5 473**

	2014	2013	% change
Clinical complaints	**2 704**	**3 078**	**(12.2)**
Short-payment of PMB accounts	**1 822**	**2 116**	**(13.9)**
3rd party claim	3	5	
Designated service provider	425	416	
Exclusion of a condition	1	2	
Formularies	72	82	
Incorrect coding	120	114	
Outstanding information	117	50	
Paid at scheme tariff	694	1027	
Paid from savings account	59	68	
Protocols	248	223	
Provider irregular billing	12	22	
Sub-limits in options	71	107	
Non-payment of PMB accounts	**483**	**620**	**(22.1)**
Designated service provider	41	43	
Exclusion of a condition	34	45	
Formularies	45	64	
Incorrect coding	29	63	
Outstanding information	55	67	
Paid at scheme tariff	4	42	
Paid from savings account	1	14	
Protocols	205	200	
Provider irregular billing	4	1	
Sub-limits in options	61	68	
3rd party claim	4	11	
Reversal (erroneous payment)	0	2	
Short-payment of non-PMB accounts	**250**	**179**	**39.7**
Network provider	33	30	
Exclusion of a condition	1	3	
Formularies	5	1	
Incorrect coding	20	25	
Outstanding information	26	11	
Protocols	66	25	
Provider irregular billing	7	5	
Sub-limits in options	92	79	

	2014	2013	% change
Non-payment of non-PMBs	**149**	**163**	**(8.6)**
Administrative complaints	**2 016**	**1 521**	**32.5**
Benefits paid incorrectly	1083	960	
Contributions increases	146	122	
General customer service	197	74	
Inaccessible networks	1	10	
Information/brochures not received	9	73	
Medical savings account	139	70	
Benefit option changes	114	0	
Rejection of application for membership (due to legibility)	6	16	
Pre-authorisation	321	196	
Legal/compliance	**503**	**409**	**23.0**
Broker conduct	5	8	
Incorrect advice	2	6	
Governance	11	14	
Rejection of application for membership (discrimination)	33	22	
Waiting periods	102	74	
Late joiner penalty	46	39	
Suspension and/or termination of membership	304	246	

Scheme-specific performance

Tables 10 and 11 list medical schemes that attracted the highest rates of complaints. The fact that medical schemes appear on these lists does not necessarily mean that their members face bigger risks or that these schemes are likely to fail.

Table 10: Ten open schemes with most complaints per 1 000 beneficiaries: 2013 and 2014

Open schemes	2014 complaints per 1000 beneficiaries	2013 complaints per 1 000 beneficiaries	Dispute resolution committee (DRC)	Matters served before the DRC
Spectramed	2.9	2.6	Yes	None
Resolution Health Medical Scheme	2.8	3.5	Yes	1
Community Medical Aid Scheme (COMMED)	2.0	0.5	Yes	None
Genesis Medical Scheme	1.0	1.6	Yes	None
Medshield Medical Scheme	0.9	1.6	No	None
Fedhealth Medical Scheme	0.9	1.0	No	None
Momentum Health Medical Scheme	0.9	1.0	Yes	None
Medihelp	0.9	0.8	Yes	None
Topmed Medical Scheme	0.8	1.1	No	None
Hosmed	0.7	1.2	No	None

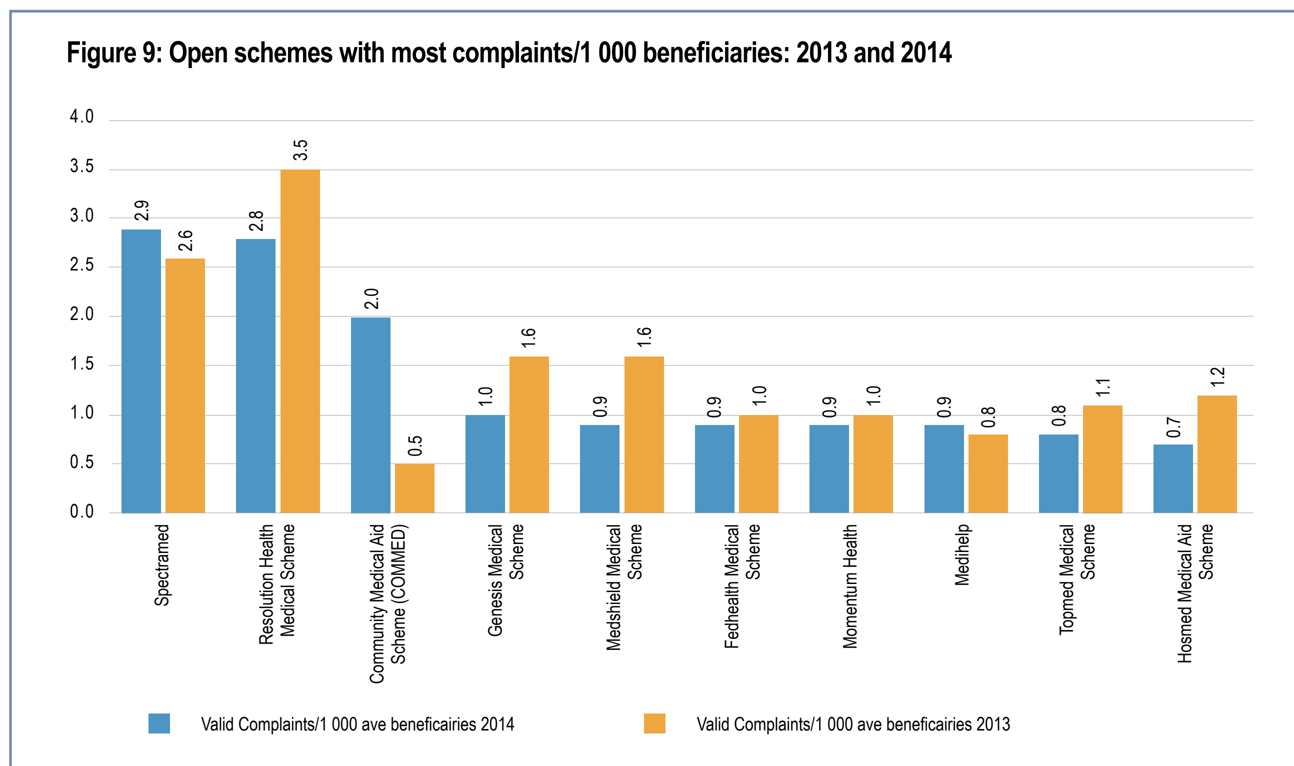


Table 11: Ten restricted schemes with most complaints per 1 000 beneficiaries: 2013 and 2014

Restricted schemes	2014 complaints per 1 000 beneficiaries	2013 complaints per 1 000 beneficiaries	Dispute resolution committee (DRC)	Matters served before the DRC
University of Witwatersrand Medical Scheme	0.9	0.7	Yes	None
Netcare Medical Scheme	0.9	1.0	Yes	None
Horizon Medical Scheme	0.9	0.0	No	None
Grintek Electronics Medical Scheme	0.6	1.9	No	None
Nedgroup Medical Aid Scheme	0.6	0.4	No	None
Profmed	0.6	0.6	Yes	None
Anglovaal Group Medical Scheme	0.5	0.1	No	None
Motohealth	0.5	0.7	No	None
Engen Medical Benefit Fund	0.5	0.4	No	No
Bankmed	0.5	0.8	No	None

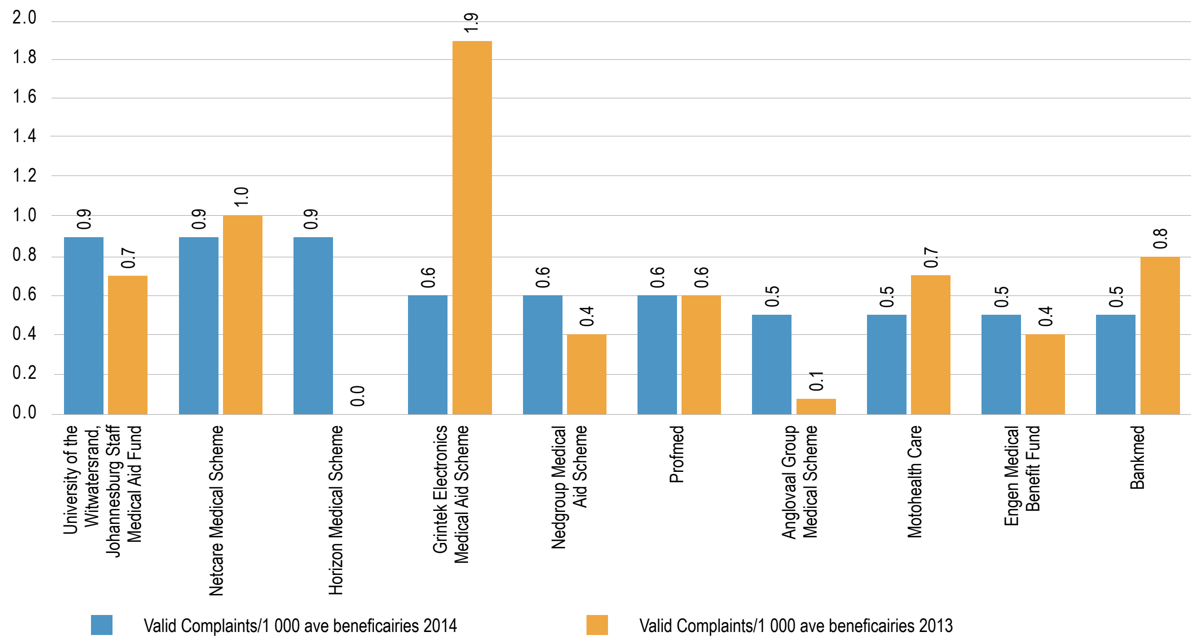


Figure 10: Closed schemes with most complaints/1 000 beneficiaries: 2013 and 2014

Topical rulings

Discovery Health v the Registrar and G

The scheme appealed against the ruling of the Registrar in favour of member G. The Registrar had held that the scheme incorrectly declined funding for the member's hospitalisation on the basis that her treatment was linked to a 12-month condition-specific waiting period imposed on her membership for hypertension and related complications. The related complications included conditions such as stroke and hypertensive heart and renal disease.

During June 2013 the member was admitted in hospital for myocardial infarction. The doctor indicated that the member had never received treatment for the condition but accepted that she had been treated for hypertension which was controlled. The doctor further indicated that she had a family history of angina, and had several risk factors which included her hypertensive condition, her family history, a history of smoking and hyperlipidaemia.

Despite the aforesaid, the member had never experienced angina before her admission. In the days before her admission she had symptoms which led to her admission to hospital. Her troponin levels were elevated while in hospital.

The Registrar based his decision on the view of the Clinical Review Committee of the CMS that the member had several risk factors for myocardial infarction and it could not be concluded that the condition for which she was admitted was solely due to hypertension.

The scheme contended that the Registrar's ruling was incorrect for two reasons:

- The Medical Schemes Act does not preclude a medical scheme imposing a waiting period for a related condition, provided that the primary and related conditions are rationally related.
- The procedure the member underwent was a consequence of treating the primary and/or related condition, hypertension.
- The scheme submitted that intellectually and in the abstract hypertension and heart disease disorders of blood vessels are correlated. It further stated that, whenever a claim is submitted by a member, before applying the condition-specific waiting period exclusion it seeks to determine if a factual and/or causal nexus exists between the primary condition and the treatment of related conditions. This depends on the facts of each case.

The scheme concluded that its approach to imposing and applying waiting periods, and consequently denying the member's claim for treatment of a related condition, had been based on a proper construction of the Act. A clear intellectual, scientific and clinical basis existed for connecting the primary and related condition and there was a factually-based causal connection between the primary and related condition.

The scheme had concluded that given the risk factors of the member, hypertension was a major risk for coronary artery disease which manifested itself clinically in the member as myocardial infarction.

In its ruling the Appeals Committee noted that the scheme did not provide any evidence in support of its argument that the primary condition had been causally linked to the myocardial infarction on the basis of the facts

of this case. In its decision to refuse funding, the scheme had relied on the fact that hypertension is a major risk factor for coronary artery disease. The scheme did not apply factual evidence to exclude the presence and influence of any other possible risk factors.

The Appeals Committee was further of the view that the scheme failed to apply its own test before imposing a waiting period. The scheme, by its own admission, indicated it required a factual investigation of the correlation between the primary condition and the condition for which the member was treated.

The Appeals Committee noted that because a condition-specific waiting period imposed in terms of the Act excluded medical cover, it should be strictly – or even restrictively – interpreted. Its application should be based on the facts of the individual case and not merely on scientific probabilities. In a case such as member G's, where other risk factors were present, scientific probabilities were even more unreliable and could have an unfair outcome for the member especially in the absence of a clear factual basis to correlate the primary condition and the treated condition.

The scheme's appeal was dismissed.

In closing, the Appeals Committee noted that the ruling did not finally determine whether it was permissible to apply a condition-specific waiting period to a related condition in order to exclude liability to fund treatment or in which circumstances this would be allowed. It had not been necessary to determine this in the present case, since the scheme failed its own test.

Bestmed v the Registrar and M

The scheme appealed the Registrar's decision that the scheme's refusal to fund in full the cost of harvesting a kidney from a living non-member donor for purposes of a kidney transplant to a dependant member of the scheme constituted an unlawful restriction of access to benefits that are guaranteed in terms of the Medical Schemes Act and its regulations.

The scheme advanced the following grounds of appeal:

- The funding of the non-member's medical costs (in addition to the cost of harvesting the kidney from a cadaver donor) would be in contravention of several rules of the scheme.
- Because the non-member had no contractual relationship with the scheme, he had no rights to claim from the scheme and the scheme had no obligation to him.
- The Registrar's ruling was in conflict with regulations made in terms of the Medical Schemes Act.
- No limitation had been placed on the quantum that the non-member could claim from the scheme.
- No limitation had been placed on the time during which the non-member could claim from the scheme.
- The Registrar's ruling militated against general medical insurance principles in that it compelled the scheme to assume the liability of settling the non-member's medical costs without the quid pro quo of a premium.

The Appeals Committee held that all the above grounds were misplaced. The Committee noted that the third ground failed to identify the regulations allegedly contravened by the Registrar's ruling and the Committee itself was aware of none. The other grounds hinged on the incorrect assumption that the non-member had lodged the complaint at his own instance and not on behalf of the member.

The Committee further observed that the scheme had invoked clause 15 of the regulations in putting the proposition that "there is no cost-effectiveness as far as the donor is concerned". It countered that cost-effectiveness was not a relevant consideration in declining to fund in full the cost of harvesting an organ from a living non-member donor for implantation to a member in order to treat a PMB condition. "What the exclusion does is to deny the member a PMB benefit in clear contravention of regulation 8(1) which provides that any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions."

The Committee also noted that, on the facts of this appeal, none of the other provisions under regulation 8 was applicable.

It was not disputed that the member's condition was a PMB condition. Moreover, it was clear from the provision of paragraph 5 of the explanatory note to Annexure A of the Medical Schemes Act regulations that a kidney transplant was a PMB condition.

Paragraph 5 which deals with "solid organ transplants" states: "The prescribed minimum benefits Annexure includes solid organ transplants (liver, kidney and heart) only where these are provided by public hospitals in accordance with public sector protocols and subject to public sector waiting lists."

The Committee took the view that there could be no transplant without the harvesting of the organ from a donor. It must therefore follow that the costs of such harvesting (together with incidental costs of care for the donor, if living) were also included as part of the PMB.

The Committee also concluded that the provision did not limit the benefit to member donors or exclude the cost of harvesting the organ from non-member donors and costs incidental thereto. The only stricture was that the procedure must be available at public hospitals, although it need not necessarily be performed there.

The scheme's appeal was dismissed.

Dr M vs GEMS

This was an appeal against a ruling of the Registrar which affirmed that GEMS had acted in accordance with its rules and the Medical Schemes Act when it stopped direct payments to Dr M, a specialist obstetrician and gynaecologist, due to the institution of fraud investigations against him by the Health Professions Council of South Africa (HPCSA). The scheme had given notice to Dr M's practice that it would no longer pay claims to the practice and that it would pay any benefit owing directly to its members. Dr M's practice would need to recover payment directly from the members.

The appellant then made a formal request to the scheme for reinstatement to the "direct payment list". The scheme refused the doctor's request. The HPCSA's investigation concluded without proving charges of fraud against the doctor but the scheme still refused to restore the doctor to the "direct payment list". It was this post-investigation refusal that formed the basis of his complaint to the Registrar's Office.

The Registrar ruled that the scheme had acted in accordance with the provisions of section 59 of the Medical Schemes Act and also within its own rules by paying members directly as direct payment to members is provided for in the Act.

The Appeals Committee held that this case was similar to the other cases adjudicated by the Committee, the High Court and the Supreme Court of Appeal wherein it was held that there was no automatic contractual relationship between a medical scheme and a service provider entitling a service provider to direct payment. It was the member and not the medical scheme that was indebted to the service provider. Therefore, in the absence of a contract between a service provider and a medical scheme, there exists no legal basis for a service provider to enforce direct payment from a medical scheme. The Appeals Committee indicated that it was bound by the previous decisions in so far as they related to the application of section 59 of the Medical Schemes Act and dismissed the appeal.

Dr B obo JS vs Bonitas Medical Scheme and the Registrar

Bonitas had approved the funding of Mrs JS's Herceptin, but limited the monetary fee to the oncology specialised drug benefit of R200 000 per annum and made this subject to a 10% co-payment which it funded from ex-gratia benefits. The R200 000 was a benefit available on the member's benefit option. The issue arose when the doctor applied for further funding of the drug after the member depleted her annual specialised drug benefit limit.

The scheme indicated that its limitation of funding was based on the fact that 12 months' Herceptin treatment was not a PMB level of care as the treatment was not a predominant public hospital treatment for breast cancer. Secondly, its managed care protocol in respect of the treatment of HER2NEU breast cancer was based on international guidelines and it supported the funding of 12 months' Herceptin for early diagnosed HERNEU2 breast cancer but limited this to the R200 000 annual specialised drug limit with 10% co-payment.

The CMS Clinical Review Committee confirmed that the 12-month Herceptin treatment in respect of the member's HER2NEU breast cancer did not form part of the PMB level of care due to the treatment not being predominant public hospital practice. Furthermore, due to the cost vs survival rate, the 12-month Herceptin treatment was not cost-effective for medical schemes. Consequently, the Registrar found that Bonitas had acted in accordance with the provisions of Regulation 8 of the Act and also within its own scheme rules.

On appeal by the doctor, the Appeals Committee stated that the issue in dispute was whether the imposition of an annual limit and a co-payment was permissible within a proper construction of the provisions of the Medical Schemes Act and regulations.

The argument by the scheme that Herceptin was not a PMB level of care – by reason of its unavailability in state hospitals – was not upheld as the scheme had not provided any evidence of significant differences between public and private hospitals in the prevailing treatment regime for breast cancer. It was further noted that the scheme had not questioned the clinical appropriateness of Herceptin for the treatment of breast cancer. The Committee found in favour of the appellant and instructed the scheme to fund in full the 12-month course of Herceptin.

The Appeals Committee found that the scheme's limitation of benefits relating to the medical management of a PMB condition on the member's benefit option and the application of the 10% co-payment was a direct contravention of regulation 8(1). This states: "Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions."

Bonitas Medical Fund subsequently filed a section 50 appeal and the matter will be heard by the Appeal Board.

G v Nedgroup Medical Scheme

This was an appeal against a ruling by the Registrar's Office which upheld the scheme's decision to fund the account of a specialist who was not a designated service provider (DSP) for treatment of a PMB condition at 100% of the medical scheme rates. The beneficiary had planned surgery and his treating doctor charged more than three times the rates of his medical scheme. The scheme funded the claim at 100% medical scheme rates and this resulted in an outstanding balance payable by the beneficiary. The Registrar's office held that regulation 8(2)(a) and (b) of the Medical Schemes Act stated that a scheme was only liable to pay the treatment of a PMB condition in full if the services were obtained from a DSP of the scheme or involuntarily from a non-DSP. Consequently, the scheme had not contravened any of its rules or the Act in funding at 100% of its rates the services rendered by a non-DSP.

The beneficiary alleged that he had been misled by the scheme that it would fund the costs of the specialist in full. He was aggrieved that the Scheme had not informed him that the treating specialist was not a DSP and that the specialist's rates were more than three times the medical scheme rates.

The scheme had received an authorisation request from the treating doctor's practice. The authorisation letter sent to the beneficiary contained a disclaimer that stated that *"this authorisation is not a guarantee of payment and will depend on your scheme benefits and rules . . . the claims would be paid at scheme rates or negotiated tariffs. If any of the information in this letter is unclear, please contact your customer service department".* The authorisation letter provided a contact number, should the beneficiary require additional information or assistance.

The beneficiary confirmed that he had not attempted to contact the scheme to check whether his treating doctor was a DSP of the scheme despite the disclaimer on the authorisation letter.

The Appeal Committee confirmed the Registrar's decision and dismissed the appeal.

Fedhealth Medical Scheme v Ms L

Fedhealth appealed against a ruling of the Registrar that the Scheme was liable to fund in full the prosthesis of Ms L. (The scheme accepted the part of the ruling that found the member was liable to fund the balance of the claim for the use of a non-DSP.)

Ms L lodged a complaint with the Registrar in respect of Fedhealth's refusal to fund in full a total shoulder replacement procedure. The basis for declining funding in full was that the procedure was not a PMB level of care and the member had failed to utilise the scheme's DSP.

The two issues on appeal were whether the prosthesis constituted a PMB level of care and, if so, whether Fedhealth was liable to fund the cost of the prosthesis in full or by co-payment.

Fedhealth contended that the shoulder replacement was not a PBM level of care. It argued that a PMB level of care for the injury that Ms L suffered was a reduction and relocation, and not a replacement. Fedhealth contended further that, even if the shoulder replacement was a PMB level of care, the scheme was entitled to impose a co-payment because the treatment or procedure was not an emergency, as contemplated in Regulation 8(3).

Ms L, on the other hand, contended that it was a PMB level of care because the doctor said that nothing short of a shoulder replacement would work. She also disputed the application of a co-payment.

The Appeals committee held that:

- Code 902H in Annexure A which deals with the "musculoskeletal system; trauma nos" and, specifically, "closed fractures/dislocations of limb bones/epiphysi, excluding fingers and toes" states the level of treatment to be "reduction/relocation". Code 900H dealing specifically with "open fractures/dislocation of bones or joints" states the level of treatment to be "reduction/relocation; medical and surgical management". Neither of these codes indicated that the level of care includes shoulder replacement, or replacement simpliciter.
- The injury that Ms L suffered fell under code 902H which does not include replacement as a PMB level of care.

The Appeals Committee accepted Fedhealth's contention that the shoulder replacement procedure, in respect of which the Scheme refused to make full payment of the costs, was not a PMB level of care for the injury in question. Fedhealth was entitled to refuse to pay the shortfall in respect of the procedure.

Appeal against legal interpretation

The Food and Allied Workers Union (FAWU) challenged the provisions of regulation 28(7) of the Medical Schemes Act which provides a member or an employer (in the case of an employer group) the right to terminate the services of a broker providing services to the relevant member(s) upon receipt of a notice of termination of services. It also provides that the scheme should discontinue payment to a broker whose services have been terminated in this manner.

FAWU contended that trade unions should also be recognised as an agent with the right to appoint a broker on behalf of its members, particularly since workers often approach unions when they experience difficulties with medical schemes.

FAWU appealed the Registrar's decision that regulation 28(7) does not recognise that unions may act as their members' agents in appointing brokers, and that the legislation gives such right to members and employers, in the case of employer groups. FAWU challenged the constitutionality of regulation 28(7) and argued that the provision was unconstitutional as it infringed employees' rights to freedom of association under section 18 of the Constitution. The trade union further requested Council to approach the Labour Court or High Court for a declaratory order on the interpretation of regulation 28(7).

The Appeals Committee had to adjudicate the interpretation of regulation 28(7) and pronounce on the constitutional challenge to this regulation.

The challenge on the constitutionality of the regulation was dismissed on the basis that only the courts have jurisdiction to determine the constitutionality of the provision. With regard to the declaratory relief sought from Council, it was held that our courts do not offer legal opinions on questions of law and that a remedy could be found elsewhere. The appeal was dismissed.

Except for constitutional matters, the **Supreme Court of Appeal** (SCA) is the highest court of appeal. The following matters served before the SCA in 2014/2015 or were pending:

Barnard v CMS and Registrar

The matter was heard on 20 August 2014 after 10 former trustees who were removed by way of curatorship in 2012 were granted leave to appeal. The former trustees contended that the Registrar could have used a lesser sanction than curatorship to deal with his regulatory concerns. A bench of six judges found that the material irregularities at the scheme justified the appointment of a curator and that this measure was in the interests of the beneficiaries of the scheme. The removal of trustees in terms of section 46 of the Medical Schemes Act would have been too time-consuming and would not have been an effective alternative remedy in a situation where the majority of trustees were implicated. The court confirmed that Judge Murphy had correctly granted the interim and final orders of curatorship in the North Gauteng High Court. The appeal was dismissed with costs.

The appellate ruling in favour of the CMS in this matter has provided clarity on major issues that the CMS is frequently required to address with schemes and trustees.

Genesis v CMS and the Registrar: correct appeal process

The Medical Schemes Act provides two distinct provisions for dealing with appeals. In this review application Genesis argued that the CMS had been using the incorrect appeal provisions. It contended that section 48 was the applicable provision where appeals were lodged against rulings by the Registrar on the resolution of complaints. The CMS held

the position that section 49 of the Act was the applicable provision. The Western Cape High Court upheld Genesis' appeal and the CMS applied for leave to appeal to the SCA. The court denied the application for leave to appeal and the CMS subsequently petitioned the SCA to have the matter heard as it believes there to be a reasonable prospect of the SCA overturning the judgment and that this would be in the best interests of members.

The matters summarised below served before the **High Court** in 2014/2015 or were pending:

Genesis v the CMS, Registrar and Joubert: PMB payment

This matter has been previously reported and relates to the short-payment of PMB claims after a member sustained injuries in a motor vehicle accident. The Western Cape High Court made a judgment in favour of Genesis based on the limitations contained in the registered rules of the scheme. The court granted the CMS leave to appeal and the record has been filed in the SCA. The CMS was awaiting a hearing date at the close of 2014/2015. There are strong prospects of success for the CMS to succeed in its leave to appeal.

Genesis v CMS and the Registrar: savings accounts

On 24 December 2014 the Western Cape High Court set aside the Registrar's decision to reject the annual financial statements and return of Genesis Medical Scheme. The Registrar rejected these records on the basis of a judgment by the North Gauteng High Court in a separate matter (Omnihealth) which held that the funds in a member's personal medical savings account constituted trust money and did not form part of the assets of the scheme.

The Western Cape Division, however, rejected this view and found that these funds formed part of the assets of the medical schemes and should be reflected as such in the scheme's financial reports. The judge held that the Omnihealth judgment was wrong in law and that the decision of the Registrar to reject Genesis' financial reports was also an error in law because it was predicated directly and exclusively on the Omnihealth judgment. The court upheld Genesis' application with costs. The Cape High Court granted the CMS leave to appeal to the SCA.

Bestmed v CMS and the Registrar

On 4 and 5 December 2014 the North Gauteng High Court heard an application by Bestmed in terms of which they sought an order suspending the effect of notices issued by the CMS in terms of section 46 of the Medical Schemes Act. These notices removed nine members of the board of trustees on the basis of allegations of misappropriation of scheme funds. The CMS lodged a counter application to place the scheme under curatorship due to the fact that it was without an effective management structure. The three remaining trustees conducted their own elections to fill the vacancies pending the finalisation of the court application.

The court dismissed both applications finding that the new trustees were validly appointed and that there was therefore no need for curatorship. It also confirmed the CMS submission that the removal of the nine trustees could not be suspended pending a section 50 appeal. Both parties applied for leave to appeal the judgment, but it was uncertain at the end of the financial year whether the case would be brought before the SCA.

Mediation of disputes and legal assistance

The CMS continued its efforts to provide cost-effective and user-friendly ways for members of schemes to have their disputes resolved. The voluntary mediation project was positively received by both members and medical schemes during the period under review. The Appeals Committee of the CMS identified a number of cases to be referred for mediation before they proceeded to a formal appeal hearing and 71% of these cases were settled through the mediation of an independent service provider. This has achieved substantial cost savings, not only for the parties to the dispute, but also for the CMS. It has also appeared to salvage relationships between the parties.

The partnership between ProBono.Org and the CMS, which ensures that members of schemes have access to legal representation at hearings before the Appeals Committee and Appeal Board, continued throughout 2014/2015.

Focus on good governance

The CMS continued protecting members' interests by focusing on good governance of medical schemes and close monitoring of compliance with the Medical Schemes Act. During the period under review no schemes were placed under curatorship.

Curatorships

The curatorship of Sizwe was lifted on 15 December 2014 by the North Gauteng High Court. During the period of curatorship the scheme managed to appoint trustees with professional expertise. Members of the board of trustees conducted the election of office bearers under the supervision of KPMG and appointed members of its Clinical, Investment, Audit and Risk, Complaints and Disputes, and Remuneration committees. All governance concerns had been addressed by the curator. Where funds had been misappropriated or unlawfully paid, appropriate steps were taken to recover these funds.

In the Medshield case, new trustees were elected at a special general meeting on 2 August 2014. Various sub-committees were introduced to enhance governance in the areas of audit, risk and compliance, finance, investment and operations, human resources and remuneration, marketing, product review and pricing, clinical governance and disputes and ex gratia payments. A study was conducted to benchmark trustee remuneration. At the annual general meeting (AGM) members approved amendments to rules of the scheme in order to ensure that trustee remuneration remains within reasonable levels and increases in line with general inflation. Scheme rules were further amended to provide for the management of conflicts of interest in procurement. A procurement committee was also formed. The broker contract with Saplings was terminated. The scheme initiated legal proceedings to recover the R10 million paid to acquire the trademark "Medshield".

Annual general meetings and trustee elections

The CMS attended the AGMs of 28 schemes as observers and addressed irregularities that were noted at the meetings with the respective principal officers. The most commonly observed issues arising at scheme AGMs were complaints from members about partial payment of hospital bills, the scheme choosing service providers (such as auditors) without consulting members, increasing salaries for trustees, holding AGMs at inconvenient times and late delivery of meeting packs.

Board Notice 73 of 2004

Board Notice 73 of 2004 requires schemes to engage in fair and reasonable evaluation of a range of potential service providers when selecting an administrator. Spectramed moved its administration contract from V-med to Agility following a tender process. The CMS reviewed the tender process in relation to Board Notice of 2004 and an inspection was pending at the end of the reporting period.

Inspection of regulated entities

The CMS is entitled to undertake inspections in terms of the Medical Schemes Act. Section 44(4)(a) inspections are undertaken where the CMS is of the opinion that there may be evidence of irregularities or non-compliance. The CMS instituted section 44(4)(a) inspections of the following schemes:

- Medihelp: An anonymous tip-off alleging misconduct and various irregularities.
- Bankmed: Received allegations of misconduct, procurement irregularities and conflicts of interest.
- Bonitas Medical Fund: Information relating to allegations of governance irregularities was obtained.
- South African Police Medical Scheme (Polmed): The inspection was based on information received about alleged governance irregularities.

Section 44(4)(b) inspections are of a more routine nature. The CMS instituted section 44(4)(b) inspections on the following schemes: Parmed Medical Aid Scheme, Compcare Wellness Medical Scheme, SABC Medical Aid Scheme, Building & Construction Industry Medical Aid Fund, TFG Medical Aid Scheme (Foschini Group), Umvuzo Health Medical Scheme and Fedhealth Medical Scheme.

Branding and the declaration of undesirable practices

During the year under review, the CMS focused on the marketing and branding practices of medical schemes' third-party service providers. Some of these providers have created confusion by making it difficult to distinguish between the business of a medical scheme and the business of a third-party service provider contracted to a medical scheme. The uncertainty arises mainly because some medical schemes share their brand identity with their third-party service providers. The service providers then use this common brand identity to market their services more generally to clients beyond the medical schemes environment. These services do not constitute the business of a medical scheme and their broader application therefore creates confusion. To address the matter, the Registrar published his intention to declare certain marketing and branding practices as undesirable in *Government Gazette* No 38545 of 13 March 2015.

Interface with stakeholders

The CMS embarked on developing a set of guidelines for communication to beneficiaries within the private healthcare industry and these were published on 8 July 2014. The overall aim of the guidelines is to clarify the minimum required information to be disseminated to beneficiaries and service providers and the optimum way of sharing it. The communication guidelines include the format to be used, the level of information required, and the channels of communication to be used in communication to members and providers.

The communication guidelines seek to clarify the obligation of medical schemes in terms of section 57 of the Medical Schemes Act. They will also ensure that members are aware of legislation which accords them the right of access to information regarding their entitlements, including PMBs and use of designated service providers (DSPs) and other benefit offerings.

The CMS commenced a project to review exclusion list annexures to the rules of all 83 medical schemes before the rules could be registered for the 2015 benefit year. The objective of the project is to ensure that medical schemes do not exclude certain benefits to which members are entitled.

To foster cooperation among medical schemes and other regulated entities by standardising submissions to the CMS on matters such as governance, contributions and benefits, revision of model rules proceeded during the 2014/2015 period.

The marketing materials and application forms of a number of medical schemes during the 2014/2015 financial year were evaluated. It has become increasingly concerning that schemes' brochures still do not always contain information about schemes' dispute resolution mechanisms and/or where and how members can lodge complaints. The CMS will continue to monitor the marketing materials and application forms of schemes.

Fair treatment of beneficiaries

Medical schemes are required in terms of section 29 of the Medical Schemes Act to make rules on matters dealt with in this section to ensure that beneficiaries are treated fairly and protected. Despite this provision, fair treatment of beneficiaries by their medical schemes remains a challenge, as is often reflected in the complaints received by the CMS.

Protection of beneficiaries is one of the basic functions of the CMS as provided for in section 7(a) of the Medical Schemes Act. Guidelines will be developed as a follow up to the initial Fair Treatment Project launched by the CMS in February 2004.

Industry engagement

The forums and Indabas established by the CMS for direct engagement with stakeholders continued to be valuable platforms for discussing and addressing pertinent issues in the industry.

A new Customer Care Forum was introduced during the year under review as a means to engage more directly with the frontline customer care centres of schemes and administrators.

The CMS offered capacity-building workshops, induction training for newly appointed trustees, broker training and scheme-specific training.

In the year under review the CMS was able for the first time to offer a trustee skills programme accredited by the South African Qualifications Authority (SAQA). The skills programme has been quality assured by the Insurance Sectoral Education and Training Authority (INSETA) and consists of unit standards registered on the National Qualifications Framework (NQF).

The following table reflects the status of trustees across the industry in terms of training they have received.

Table 12: Total number of trustees trained by 2014/2015

	Number	% of all trustees
CMS-trained	73	7
Other training	239	23
No training received	726	70
Total	**1 038**	**100**

Table 12 indicates that only 7% of trustees have been trained by the CMS while 23% have attended other training programmes and the majority of trustees (70%) have not received any training. This lack of training could be a factor contributing to governance issues that some medical schemes experience.

Collaboration with other entities

Engagement with the CC on the market inquiry into the private healthcare sector continued during the year under review, with the CMS supplying data and clarifying matters related to the functioning of entities in the sector. The CMS acted on behalf of medical schemes to obtain an extension of the tight deadline within which schemes were required to submit extensive data sets.

The IT systems of the CMS

Since the inception of the CMS, information and communication technology (ICT) has been a vital tool in ensuring that the overall strategic objectives and business goals of the organisation were met.

The CMS focused its efforts on establishing a robust ICT network and server infrastructure, on the one hand, and specialised software applications, on the other.

Some of the applications which were developed over time include:

- An accreditation system which allowed the office to accredit brokers, broker organisations and MCOs.
- A complaints adjudication system for the registering and management of complaints.
- An online Financial Statutory Return system which expedited the submission of quarterly and annual financial data by schemes.
- An auditor approval questionnaire which facilitated the CMS' approval of scheme auditors.
- A website with interactive portals serving various CMS stakeholders.
- A system for collection of real-time key indicator data from schemes.

The ICT support system makes it possible for the CMS to sustain an effective mobile workforce, which is especially important for those officials whose duties demand that they work away from the office.

During 2014/2015, the CMS focused on establishing an effective ICT Governance Framework to ensure strategic alignment between other business units and ICT.

The latest software development intervention for the period under review focused on the development of the Dynamic Database Driven Annual Return (DDDR) system for the collection of utilisation data. This new system makes use of web services instead of the more traditional web-based return system, allowing schemes and administrators to fully automate their submission processes.

In its aim to become a paperless working environment the CMS continued with the scanning and digitising of paper-based files.

CMS support to the national Department of Health

The CMS, continues to support the Department of Health (DoH) through participation in relevant ministerial committees including the Health Data Advisory and Coordination Committee (HDACC), Essential Medicines Committee and the ICD-10 Task Team. Involvement in these committees has added value to the output of the CMS. Ongoing support has also been provided to the Office of Health Standards Compliance (OHSC), a new regulator of healthcare establishments.

The CMS was requested by the Health Minister's office to provide technical advice on analysing and interpreting data the DoH intended to include in its submission on the market inquiry being conducted by the Competition Commission, as well as data required by the World Health Organisation (WHO).

OVERVIEW OF THE CHIEF EXECUTIVE & REGISTRAR (CONTINUED)

Strategic planning processes of the CMS

The annual planning process commenced in June 2014 with a series of internal meetings with executive management and the Chair of Council. The final plans and budget for 2015/2016 were submitted to the Executive Authority and National Treasury in January 2015 and approved.

Concluding thoughts

I would like to thank colleagues for their hard work and stellar efforts of keeping CMS on the pulse over the past 15 years. The contribution of the Council is also appreciated.

The CMS is poised to achieve even greater success during 2015/2016 as it continues to inform and protect members, assist medical schemes and strive towards the attainment of an effective national health system.

CMS – maintaining a healthy heartbeat!

Mr Daniel Lehutjo

Acting Chief Executive & Registrar
29 May 2015

PERFORMANCE INFORMATION

PART B: PERFORMANCE INFORMATION

Statement of responsibility for performance information for the year ended 31 March 2015

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

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

In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned objectives, indicators and targets which are set out in the strategic plan and annual performance plan of the CMS for the financial year ended 31 March 2015.

The performance information of the CMS for the financial year ended 31 March 2015 has been audited by the Auditor-General of South Africa. This information, as contained on pages 59 to 80, has also been approved by Council, which is the Accounting Authority of the CMS. Their audit report is presented on pages 104 to 106.

Daniel Lehutjo
Acting Chief Executive & Registrar
Council for Medical Schemes
31 July 2015

Programme 1: Office of the CEO & Registrar

This programme comprises three sub-programmes:

- The CEO & Registrar.
- The Strategy Office.
- Complaints Adjudication Unit.

Sub-programme 1.1: CEO & Registrar

Legend: *Positive deviation* *Negative deviation* ***No deviation*** *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 1.1.4.1 – Provision of strategic leadership to the organisation and effective regulation of the industry					
1.1.4.1	Ensure that 100% of quarterly performance indicators are met or exceeded by the units	100%	86%	14%	**Deviation** This was due to some targets not being met in the following units: • Strategy Office • Complaints Unit • ICT&KM • Human Resources

Purpose

The CEO of the CMS holds responsibility for overall management of the organisation and, as Registrar, exercises legislated powers to regulate medical schemes, administrators, brokers and managed care organisations (MCOs).

Achievement of strategic objectives

The CMS has managed to stabilise governance within medical schemes despite some serious challenges from the industry. There were a number of inspections undertaken, however some schemes have resisted these interventions.

During the year, the CMS uplifted curatorship of two schemes – Bonitas and Medihelp – and both schemes are now stable. Hosmed, however, is still under curatorship and the Office is confident that the scheme will be stabilised soon.

The CMS has performed extremely well in terms of achieving its objectives for the year. There were challenges related to capacity requirements for the organisation and the ageing IT infrastructure of CMS.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**134**	**116**	**18**	**143**	**138**	**4**
Donations	4	–	4	–	–	–
Printing and stationery	120	100	20	117	126	(9)
Refreshments	10	16	(6)	26	12	13
Forensic investigation	**6 000**	**7 257**	**(1 257)**	**–**	**–**	**–**
Operating expenses	**4 887**	**4 601**	**286**	**5 040**	**5 934**	**(894)**
Committee remuneration	48	59	(11)	63	100	(37)
Consulting fees	2 002	2 293	(291)	1 545	1 623	(78)
Council members' fees	1 897	1 430	467	1 800	2 317	(517)
Courier and postage	60	55	5	83	124	(41)
Printing and publication	32	10	22	–	–	–
Transcription services	87	70	17	69	109	(40)
Travel and subsistence	579	491	88	756	860	(104)
Venues and catering	182	193	(11)	724	801	(77)
Staff costs	**3 613**	**3 415**	**198**	**3 446**	**3 447**	**(1)**
Salaries	3 538	3 355	183	3 308	3 255	53
Staff training	75	60	15	138	192	(54)
Total	**14 634**	**15 389**	**(755)**	**8 629**	**9 519**	**(891)**

Sub-programme 1.2: Strategy Office

Legend: *Positive deviation* *Negative deviation* ***No deviation*** ***Deviation outside control of CMS***

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 1.2.2.2 – Develop benefit definitions for prescribed minimum benefits (PMBs)					
1.2.2.2	Number of benefit definitions and editions of *CMScript* published	11	12	1	**Deviation** An additional edition of CMScript was produced.
Strategic objective 1.2.2.3 – Provide clinical opinions					
1.2.2.3	Number of clinical matters reviewed by the Clinical Review Committee (CRC)	960	623	337	**Deviation** There was a large backlog to be cleared during the year, as well as new matters to be dealt with. The unit cleared much of the backlog.
Strategic objective 1.2.4.1: Support universal access through recommendations made to the Ministerial Advisory Committee (MAC) on National Health Insurance					
1.2.4.1	Number of national health insurance reports submitted to Ministerial Advisory Committee (MAC)	1	–	1	**Deviation** No reports were required by the Department of Health (DoH) during the period under review.

Purpose

The purpose of the Strategy Office is to engage in projects to provide information to the Ministry of Health on strategic health reform related to government's objective of an equitable and sustainable healthcare financing system in support of universal access. The Strategy Office also provides support to the Office on clinical matters. The purpose of the Clinical Unit is to ensure that access to good quality medical scheme cover is maximised and that regulated entities are properly governed, through prospective and retrospective regulation.

Achievement of strategic objectives

The Clinical Unit reduced the number of outstanding clinical opinions to the lowest it has been in many years. This has helped boost staff morale. The unit adopted "block week" system allowing clinical analysts to work away from the office for one week each month and concentrate on clearing the backlog.

The highest risk faced by the Clinical Unit is its inability to keep up with the demand for increasingly complex clinical opinions, not only from the Complaints Adjudication Unit but other stakeholders, while maintaining an acceptable level of quality. It became evident that additional human resources would be required in order to manage the balance between quantity and quality of work. This would also avoid the need to shift tasks from the PMB Benefit Definitions Project team, as occurred in the past. Additional positions for a Clinical Analyst and a Junior Medical Advisor were therefore created for the 2015/16 year. A specialist medical professional was also sourced to assist with complex clinical complaints.

The unit commenced development of a knowledge management system to assist with linking and archiving supporting documentation relating to clinical opinions.

The unit reached the target of producing three benefit definitions and one extra edition CMScript. These activities are part of prospective regulation as they are intended to reduce complaints. The topics for CMScript were selected on the basis of prevalence of cases.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**6**	**5**	**1**	**6**	**4**	**2**
Printing and stationery	6	5	1	3	2	1
Refreshments	–	–	–	3	2	1
Operating expenses	**105**	**25**	**80**	**70**	**25**	**45**
Consulting fees	25	–	25	–	–	–
Travel and subsistence	49	16	33	70	25	45
Venues and catering	31	9	22	–	–	–
Staff costs	**5 613**	**4 904**	**709**	**4 799**	**3 793**	**1 006**
Salaries	5 490	4 786	704	4 611	3 645	966
Staff training	123	118	5	188	148	40
Total	**5 724**	**4 934**	**790**	**4 875**	**3 822**	**1 053**

Sub-programme 1.3: Complaints Adjudication Unit

Legend: *Positive deviation* *Negative deviation* ***No deviation*** *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 1.3.2.1 – Complaints resolution					
1.3.2.1	Percentage of complaints resolved within 120 days and in accordance with complaints procedure	93%	73%	20%	**Deviation** Great efforts were made by the unit to meet the target, however complex complaints took longer than 120 days to resolve.

Purpose

The Complaints Adjudication Units serves beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, the unit ensures that beneficiaries are treated fairly by their medical schemes.

Achievement of strategic objectives

The unit compiled trend reports after noting many similar complaints at particular schemes which suggested systemic problems at scheme level. The root causes of complaints were noted and remedial action was agreed with affected schemes and other relevant parties. The resolution of systemic problems will not only benefit beneficiaries but will also reduce the number of complaints referred to the CMS.

The unit reviewed complaints received with a view to ensuring compliance of scheme rules with the Medical Schemes Act. It identified rules which were inconsistent with the Act and rules that were unfair to beneficiaries. Clauses in the rules of a number of medical schemes were escalated to the Benefits Management Unit and recommendations were made on amendments.

The unit made presentations to a number of medical schemes, administrators and brokers in order to improve understanding and application of certain provisions of the Act.

Judgments delivered by Council's Appeals Committee confirmed a majority of rulings made by the unit and indicated it was interpreting the Act correctly.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**4**	**1**	**3**	**11**	**7**	**4**
Printing and stationery	4	1	3	6	2	4
Refreshments	–	–	–	5	5	–
Operating expenses	**–**	**–**	**–**	**27**	**15**	**12**
Travel and subsistence	–	–	–	22	12	10
Venues and catering	–	–	–	5	3	2
Staff costs	**4 921**	**5 009**	**(88)**	**4 568**	**4 414**	**154**
Salaries	4 826	4 910	(84)	4 496	4 388	108
Staff training	95	99	(4)	72	26	46
Total	**4 925**	**5 010**	**(85)**	**4 606**	**4 436**	**170**

Programme 2: Corporate Services

Programme 2 comprises three sub-programmes:

- Internal Finance.
- Information and Communication Technology and Knowledge Management.
- Human Resources Management.

Sub-programme 2.1: Internal Finance Unit

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 2.1.3.1: An effective, efficient and transparent financial management system					
2.1.3.1	An unqualified report on the annual financial statements issued by the Auditor-General by 31 July each year	1	1	–	No deviation
Strategic objective 2.1.3.2 – Risk management					
2.1.3.2	Annual approval of risk management framework by Council by September each year	1	1	–	No deviation
Strategic objective 2.1.3.3 – Planning and budgeting					
2.1.3.3	Submission of final annual performance plans and budget to Executive Authority for approval by November each year	1	1	–	No deviation
	An unqualified report on annual performance information issued by the Auditor-General by 31 July each year	1	1	–	No deviation

Purpose

This programme serves all business units in the CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance Unit also serves the Audit and Risk Committee, internal auditors, DoH, National Treasury and the Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the unit helps Council to maintain its reputation.

Achievement of strategic objectives

The CMS manages its finances in accordance with the Public Finance Management Act (PFMA) and has put in place adequate systems of internal control to manage its affairs effectively and efficiently. The Internal Finance Unit plays an important role in ensuring that internal controls are applied consistently in order to achieve good financial governance. The internal auditors continue to provide risk assurance reports in line with their three-year rolling plan, thus strengthening internal control measures.

The Auditor-General issued an unqualified audit report on the CMS for the financial year 2013/14. This was the CMS's 14th consecutive unqualified audit report.

The unit has strengthened its supply chain management processes. A supply chain officer was appointed during the year. A new electronic supplier database system was developed and implemented. While a new procurement workflow system was initiated this could not be fully implemented due to development issues. The system will be fully implemented during 2015/16.

The unit submitted its strategic plan for 2015-2020 and annual performance plan to the Executive Authority in accordance with the National Treasury framework. Quarterly performance information reports were submitted to the Executive Authority within stipulated timeframes.

The risk management framework and policy for 2014/15 were approved by Council. Risk management has now been fully implemented within the CMS. Risk identification and evaluation are performed regularly with the risk champions of the organisation. Controls were put in place for all risks identified and these were monitored on an ongoing basis. Strategic risk reports were submitted to both the Audit and Risk Committee and Council for monitoring purposes.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**11 245**	**13 356**	**(2 110)**	**9 919**	**10 274**	**(358)**
Bank charges	45	46	(1)	50	41	9
Cleaning and gardening	751	756	(4)	657	741	(85)
General expenditure admin	272	213	59	475	471	4
Insurance	293	295	(2)	159	274	(115)
Printing and stationery	94	114	(20)	31	24	7
Refreshments	5	4	1	13	8	5
Rent	7 121	9 294	(2 173)	6 420	6 319	100
Rent – operating costs	1 394	1 393	1	948	948	–
Rental other assets	14	11	3	25	6	18
Repair and maintenance	200	144	56	227	285	(58)
Subscriptions	6	9	(3)	6	5	1
Water and electricity	1 050	1 077	(27)	908	1 152	(244)
Audit fees	**1 622**	**1 897**	**(276)**	**1 530**	**1 601**	**(71)**
External audit fees	721	803	(83)	680	806	(126)
Internal audit fees	901	1 094	(193)	850	795	55
Operating expenses	**185**	**142**	**43**	**486**	**522**	**(36)**
Consulting fees	100	97	3	353	405	(52)
Courier and postage	55	34	21	44	48	(4)
Travel and subsistence	20	3	17	26	17	9
Venues and catering	10	8	2	63	52	11
Depreciation and amortisation	**3 321**	**3 772**	**(451)**	**2 411**	**2 637**	**(225)**
Amortisation	748	765	(17)	1 205	895	310
Depreciation	2 573	3 007	(434)	1 206	1 742	(535)
Penalties waived	**–**	**–**	**–**	**–**	**310**	**(310)**
Loss on disposal of assets	**–**	**25**	**(25)**	**–**	**176**	**(176)**
Staff costs	**9 230**	**9 247**	**(17)**	**7 972**	**7 779**	**193**
Employee benefits	1 620	1 683	(63)	1 587	1 462	125
Salaries	7 277	7 280	(3)	6 146	6 072	74
Staff training	190	140	50	115	125	(10)
Workmen's Compensation Fund	143	144	(1)	124	120	4
Total	**25 603**	**28 389**	**(2 836)**	**22 318**	**23 299**	**(983)**

Sub-programme 2.2: Information and Communication Technology and Knowledge Management

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation from planned target 2013/14	Comments on deviation
Strategic objective 2.2.3.1 – ICT operations and infrastructure					
2.2.3.1	Percentage of network and server uptime per quarter	99%	97.05%	1.95%	**Deviation** Electricity supply interruptions and ageing infrastructure had a negative impact on the network and server uptime.
Strategic objective 2.2.3.2 – Software development and maintenance					
2.2.3.2	Percentage uptime (during working days) for custom-developed application systems	99%	98.23%	0.77%	**Deviation** Due to electricity supply interruptions the systems were not always available for use.
Strategic objective 2.2.3.3 – Knowledge and records management					
2.2.3.3	Estimated number of requests for information and records responded to	350	274	76	**Deviation** The target was based on estimated figures. The unit attended to all requests that were received. The CMS has improved the quantity and quality of information on its externally facing website and most material is accessible to external stakeholders. Due to the special project to digitise CMS records, members of staff also have access to organisational records in full text through the M-files content management system. Both these factors have led to a decrease in requests for information.

Purpose

The unit serves CMS business units by providing technology enablers and making information available to stakeholders.

Achievement of strategic objectives

During the past year the CMS introduced a number of systems and control measures to ensure the stability of CMS systems and business continuity. These included a more stable and reliable Symantec back-up solution and AppAssure which allows for real-time back-ups and standby servers, should one of the servers go offline.

The unit is constantly improving system stability and reliability as well as ease of use. A new utilisation statutory return system, Project Lion, was successfully deployed and is utilised by all schemes.

The unit continued to make records available in electronic medium and this led to fewer requests for information.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenditure	**3 725**	**3 549**	**176**	**3 099**	**3 244**	**(146)**
Computer expenses	81	67	14	120	79	41
Copy cost	168	279	(111)	159	236	(77)
External storage	208	294	(86)	228	275	(47)
Internet expenses	233	294	(61)	151	330	(180)
Printing and stationery	12	9	3	20	9	11
Refreshments	13	6	7	18	6	12
Rental: copiers	251	248	3	280	244	36
Repairs and maintenance	510	412	98	–	–	–
Security	417	301	116	290	368	(79)
Software licence subscriptions	1 107	1 010	97	898	815	83
Telephone and fax	725	629	96	935	882	54
Operating expenses	**670**	**733**	**(63)**	**697**	**583**	**115**
Consulting fees	226	201	25	150	51	99
Knowledge management	426	508	(82)	531	527	4
Travel and subsistence	18	24	(6)	16	5	12
Staff costs	**8 435**	**7 931**	**504**	**8 198**	**7 416**	**986**
Salaries	7 435	7 536	(101)	6 858	6 960	102
SEP system expenses	850	288	562	1 200	308	892
Staff training	150	107	43	140	148	(8)
Total	**12 830**	**12 213**	**617**	**11 994**	**11 243**	**955**

Sub-programme 2.3: Human Resources Management

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

	Performance indicator	Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 2.3.3.1 – Recruitment and talent management					
2.3.3.1	Maximum staff turnover rate	5%	3.88%	1.12%	**Deviation** The office maintained a staff turnover rate of less than the targeted 5%. There were four resignations during the period under review.
	Turnaround time to fill a vacancy				
	Marketing Analyst – new position created in 2013/14	90 days	720 days	630 days	**Deviation** The new position of Technical Market Analyst was advertised and interviews were held but no suitable candidate could be appointed. The responses received to date have not yielded any satisfactory candidates. Management will reassess the need for this position.
	Communications Manager – 1 March 2014	90 days	150 days	60 days	**Deviation** The delay was due to the unit having to prioritise the finalisation of the annual report.
	Senior Investigator – 1 April 2014	90 days	90 days	–	No deviation
	Senior Researcher – 1 April 2014	90 days	90 days	–	No deviation
	Senior Researcher – 1 April 2014	90 days	120 days	30 days	**Deviation** The selected candidate declined a job offer in May 2014 and a second round of interviews was held before a successful candidate was appointed.
	Accreditation Analyst – 1 April 2014	90 days	120 days	30 days	**Deviation** The successful candidate was appointed from 1 August 2014.
	Supply Chain Management Officer – 1 April 2014	90 days	120 days	30 days	**Deviation** The successful candidate was appointed from 1 October 2014.
	Legal Advisor – 1 June 2014	90 days	120 days	30 days	**Deviation** The successful candidate was appointed from 1 August 2014.
	Senior Investigator – 1 September 2014	90 days	90 days	–	No deviation
	Senior Strategist – 1 November 2014	90 days	150 days	60 days	**Deviation** Interviews were held in February 2015. The selected candidate declined the job offer and no other candidate interviewed was suitable.
	Percentage of employee feedback from annual satisfaction survey	54%	54%	–	No deviation
	Percentage of employment equity targets achieved	85%	88%	3%	**Deviation** Eight staff appointments were in accordance with equity targets.

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 2.3.3.2 – Maximisation of performance					
2.3.3.2	Percentage of staff members attaining a very effective level of performance (rating of 4)	75%	94%	19%	**Deviation** Of the 89 employees who underwent performance appraisal, 31 obtained a very effective rating.
	Percentage of employees undergoing training in accordance with a personal development plan annually	68%	78%	10%	**Deviation** 80 employees underwent training in accordance with personal development plans.

Purpose

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

The unit fulfils this mission with professionalism, integrity and responsiveness by:
- Treating all our customers with respect.
- Providing resourceful, courteous and effective customer service.
- Promoting teamwork, open and clear communication, and collaboration.
- Demonstrating creativity, initiative and optimism.

The unit assists management and staff of the CMS by providing advice and assistance in the area of HR, thus enabling them to make decisions that maximise the organisation's human resource capacity and contribute to positioning the CMS as an employer of choice.

Achievement of strategic objectives

Talent management and staff retention

During the period under review talented personnel were sourced in line with our recruitment policies and processes. The selection process in recruiting for existing and new positions was geared to ensuring that the most appropriate personnel were appointed. Their performance was monitored during a probation period to ensure that they met their performance targets.

An orientation programme was provided to new employees, providing in-depth information on the structure and functions of the CMS, terms and conditions of service, and all policies, including HR policies.

Performance management

Performance management continued to be a high priority area for the HR Unit. At the beginning of the financial year under review, the unit facilitated the drafting and conclusion of performance agreements for 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 2014/15 reporting period. Through the Moderating Committee, the HR Unit facilitated the awarding of incentive bonuses to those employees who excelled.

Training and development

Staff undertook various training programmes identified in their personal development plans or professional development programmes. The HR Unit completed a workplace skills plan and annual training report and submitted these to the Health and Welfare Sector Education and Training Authority (HWSETA).

The HR Unit takes pride in encouraging a learning culture for all CMS employees. A number of employees completed certificate, diploma and degree courses, including post-graduate degrees. Two employees are currently undertaking PhD studies.

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

Employment equity

Currently the CMS employs 102 employees of whom 79.41% are black and 61.76% are female. The CMS continues to recruit and appoint employees from previously disadvantaged groups.

The employment equity forum continued to monitor 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 Indian and coloured employees and persons with disabilities remained below the nationally defined benchmark for designated groups. The CMS will continue to strive for equitable representation of all designated groups.

Policy reviews

The following policies were reviewed during the period under review: eligibility to participate in the performance management and incentive system, maternity and paternity leave, study leave, and family responsibility and compassionate leave.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**145**	**145**	**–**	**177**	**194**	**(16)**
Donations	29	20	9	7	7	–
Motor vehicle expenses	32	28	4	22	23	(1)
Printing and stationery	11	6	5	10	10	–
Refreshments	30	45	(15)	90	111	(21)
Subscriptions	43	46	(3)	48	43	6
Operating expenses	**469**	**342**	**126**	**1 015**	**1 090**	**(75)**
Consulting fees	311	216	94	546	596	(50)
Legal fees	24	16	8	91	111	(20)
Travel and subsistence	17	11	6	17	14	3
Venue and catering	117	99	18	361	369	(8)
Staff costs	**5 055**	**4 985**	**68**	**5 245**	**5 243**	**2**
Employee wellness	493	472	20	446	480	(34)
Recruitment and relocation	770	821	(51)	1 070	1 092	(22)
Salaries	3 401	3 390	10	3 350	3 243	107
Staff training	151	142	9	125	127	(2)
Temp services	240	160	80	254	301	(47)
Total	**5 669**	**5 472**	**194**	**6 437**	**6 527**	**(89)**

Programme 3: Accreditation

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2013/14	Comments on deviation
Strategic objective 3.2.1 – Broker applications accredited					
3.2.1	Number of brokers and broker organisations accredited within 21 working days of receipt of complete applications	4 964	5 027	63	**Deviation** The planned target was based on estimated figures. The unit attended to all requests that were received. There were more brokers accredited than anticipated.
Strategic objective 3.2.2 – Managed care organisation (MCO) applications accredited					
3.2.2	Number of MCOs accredited within three months of receipt of application	27	26	1	**Deviation** The planned target was based on estimated figures. The unit attended to all requests that were received. Right to Care did not apply to renew its accreditation.
Strategic objective 3.2.3 – Administrator applications accredited					
3.2.3	Number of administrators and self-administered schemes accredited within three months of receipt of application	7	9	2	**Deviation** The planned target was based on estimated figures. The unit attended to all requests that were received. One renewal application was brought forward as the company had to apply anew for accreditation following a change in control of the administrator. One application was received early and was accredited during the period under review.

Purpose

To ensure brokers and broker organisations, administrators and MCOs are accredited in line with the requirements of the Medical Schemes Act. The Act requires applicants to be fit and proper, have the necessary resources, skills, capacity, and infrastructure, and be financially sound.

Achievement of strategic objectives

Third-party administrators and self-administered schemes

No new third-party administrators were accredited during the year under review. One application was received but accreditation was not approved as the applicant did not meet the requirements for accreditation.

Selfmed medical scheme was issued with a compliance certificate following its first on-site evaluation of compliance with administration standards.

The Accreditation Unit completed the evaluation of six renewal applications which were approved by Council for a period of two years. It also undertook five on-site evaluations of third-party administrators and self-administered medical schemes.

A total of 17 third-party administrators were accredited and 11 self-administered medical schemes issued with compliance certificates as at 31 March 2015.

Managed care organisations

A number of new applications for accreditation as MCOs were evaluated but found not to be valid as the services provided did not meet the requirements for accreditation as set out in the Medical Schemes Act and regulations. These organisations did not require formal accreditation and were advised accordingly.

The Accreditation Unit completed detailed evaluations in respect of 24 renewal applications which were approved by Council for a period of two years. In addition, the unit conducted on-site evaluations of compliance with accreditation standards for eight MCOs.

There were 39 accredited MCOs as at 31 March 2015.

Managed care project
The unit participated in a joint project which seeks to demonstrate the value of managed care in terms of its health impact. The definitions of a number of medical conditions were finalised during the year by developing the required indicators and minimum data specifications for measuring managed care services delivered.

Unwarranted performance or profit-sharing incentives
Circular 51 was published in October 2014 because of concerns about several medical schemes and MCOs entering into agreements based on performance-based incentives or profit-sharing arrangements. Six such arrangements were evaluated and five were found to be unwarranted. In the latter cases, parties were instructed to terminate the arrangements.

Brokers and broker organisations
Accreditation of brokers is undertaken by the unit in collaboration with the Financial Services Board which determines whether the fit and proper requirements have been met.

The unit instituted action against a broker for misconduct and Council concurred, withdrawing accreditation of the individual for a period of three years. The names of four entities were removed from the database for various reasons. The unit introduced a system to verify the academic qualifications of individuals applying for accreditation.

There were 8 573 brokers and 2 207 broker firms accredited as at 31 March 2015.

Appeal against legal interpretation
A trade union unsuccessfully lodged an appeal with the Appeals Committee against the Office's interpretation of Regulation 28(7) and Circular 20 of 2010. The ruling confirmed the position in law that a member or employee is not entitled to appoint any person or party as an agent with a view to appointing a broker for that member. It follows that only a member, or employer in certain circumstances, may appoint or terminate the services of an accredited broker to provide services to any employee as a member of a medical scheme.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**110**	**49**	**61**	**78**	**63**	**14**
Printing and stationery	50	44	6	70	60	10
Refreshments	–	–	–	8	3	4
Subscriptions	60	5	55	–	–	–
Operating expenses	**587**	**485**	**102**	**406**	**245**	**161**
Travel and subsistence	582	481	101	398	240	158
Venues and catering	5	4	1	8	5	3
Staff costs	**6 755**	**6 632**	**124**	**5 313**	**5 807**	**(494)**
Salaries	6 704	6 604	101	5 156	5 751	(595)
Staff training	51	28	23	157	56	101
Total	**7 452**	**7 166**	**287**	**5 797**	**6 115**	**(319)**

Programme 4: Research and Monitoring

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 4.2.1 – Monitor compliance with Regulation 5 (f) to ensure that relevant diagnostic and other code numbers are provided in billing statements sent to medical schemes					
4.2.1	Number of reports produced on provider compliance according to the International Classification of Diseases (ICD-10)	4	1	3	**Deviation** The Ministerial Task Team decided to produce only one report for the year.
Strategic objective 4.2.2 – Monitor compliance with Regulation 5 (e) to ensure that practice code numbers of healthcare providers appear in billing statements sent to medical schemes					
4.2.2	Number of quarterly reports received from the Practice Code Numbering System (PCNS) service provider reflecting active practice code numbers	4	4	–	No deviation
Strategic objective 4.4.1 – Conduct research to inform appropriate policy interventions					
4.4.1	Number of research projects and specialised technical support projects finalised	8	11	3	**Deviation** There were additional research projects required by the office during the period under review.
Strategic objective 4.4.2 – Monitoring trends to improve regulatory policy and practice					
4.4.2	Non-financial reports submitted for inclusion in the annual report	1	1	–	No deviation

Purpose

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

Achievement of strategic objectives

The Research and Monitoring Unit continued to provide ICD-10 compliance data to the DoH Chief Directorate for Health Information Systems. The data specification document was revised by the Ministerial Task Team and schemes began using the new data specification. As agreed with the Ministerial Task Team, one report was produced by the unit.

Use of practice code numbers

The PCNS contract with the Board of Healthcare Funders (BHF) has been extended until such time as the court processes relating to the conclusion of a new contract have been finalised. The unit had various discussions with the BHF to improve the quality of data and reports submitted to the CMS. The unit received the required quarterly reports from the BHF.

Policy-related research

The unit exceeded the target of eight research and specialised projects. A total of 11 research and specialised reports were finalised in the areas described below:

- Prevalence of chronic diseases in medical schemes: 2008 – 2013.
- Composite Risk Index.
- A comprehensive guidance framework on inflation for use by the medical schemes industry in Contribution Assumption Increases.
- Assessing the value of managed healthcare.

- Health and outcomes measurement in medical schemes.
- The impact of market structure on the quality of the community rating environment.
- Out-of-pocket payments by medical scheme members.
- Scheme risk measurement system.
- Competition Commission (CC) submission and technical engagement with the technical advisory panel of the CC.
- Statistical report on circumcision as at November 2014 for the DoH.
- Annual Statutory Returns: utilisation data specification.

The unit arranged and participated in a full meeting of the Industry Technical Advisory Panel (ITAP) held on 27 March 2015. Feedback was given to the industry on all ITAP-related projects. Significant progress was made on measuring health quality outcomes.

Monitoring to improve regulatory policy and practice

The unit completed the analysis and write-up of the non-financial section of the annual report. After consultation with the industry, the unit finalised a new data specification document to collect utilisation statistics (part of the annual statutory returns). The ICT unit developed a new IT system to collect the data. It is envisaged that this process will, over time, improve the quality of utilisation data, strengthen monitoring of utilisation trends and inform recommendations regarding regulatory policy.

Changes to planned targets

Number of ICD-10 compliance reports: due to changes in the data specification it was agreed with the task team to finalise only one report for the period under review and to produce two ICD-10 compliance reports in 2015/16. These changes were approved by the Ministerial Task Team.

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**4**	**3**	**1**	**10**	**7**	**3**
Printing and stationery	3	3	–	3	2	1
Refreshments	–	–	–	5	5	–
Subscriptions	1	–	1	2	–	2
Operating expenses	**362**	**312**	**50**	**474**	**420**	**54**
Consulting fees	251	251	–	400	397	3
Travel and subsistence	80	42	38	55	18	37
Venues and catering	31	19	12	19	5	14
Staff costs	**6 357**	**5 729**	**628**	**5 972**	**5 256**	**716**
Salaries	6 115	5 599	516	5 788	5 085	704
Staff training	242	130	112	184	171	12
Total	**6 723**	**6 044**	**679**	**6 456**	**5 683**	**773**

Programme 5: Stakeholder Relations

Legend: *Positive deviation* *Negative deviation* ***No deviation*** *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 5.2.1 – Stakeholder awareness and training					
5.2.1	Quality of information provided at training sessions, measured through training feedback questionnaires	90%	92.5%	2.5%	**Deviation** The Education & Training Sub-unit managed the evaluation of presenters and training material so that feedback was obtained from almost all attendees. Their high ratings led to the target being exceeded.
Strategic objective 5.2.2 – Communication and engagement with stakeholders					
5.2.2	Publication of CMS Annual Report by 31 August	1	1	–	No deviation
Strategic objective 5.2.3 – Stakeholder management					
5.2.3	Percentage of positive feedback on CMS reputation as measured through a media monitoring tool	70%	72.9%	2.9%	**Deviation** After negative publicity in quarter one, the Stakeholder Relations Unit presented positive content to the media and this resulted in favourable coverage exceeding the target.

Purpose

The purpose of the unit is to create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, the media, Council members and staff, through communication, education, training and customer care interventions.

Achievement of strategic objectives

The unit managed to improve the reputation of the CMS at no direct cost by securing positive news articles in various media and a three-page feature in *Business Report*.

Analysis by media monitoring specialists Ornico reflected 100% positive media reporting on the CMS for a period of six months after the negative reporting in the first quarter.

The Contact Centre has seen continual improvement in its operations since the installation of the new telephone system during quarter three. Abandoned calls decreased progressively to only 7.76% in the final quarter.

The Customer Care Forum which commenced meeting in quarter three has been very successful. It led to Contact Centre management receiving several technical training requests and these were directed to the Education and Training Sub-unit for intervention.

Forums and Indabas held during the period under review were attended by an increasingly large number of delegates and these engagement events appeared to be a huge success in terms of sharing information and building relationships with schemes.

The CC congratulated the CMS on feedback on submissions made by industry role players to its market inquiry into private healthcare. The commission also appreciated the additional information and data the CMS provided to assist it with the market inquiry.

The Education and Training Sub-unit continued to provide training sessions, which were all evaluated positively. The INSETA-accredited skills programme for trustees was well received.

Consumer education continued and outreach programmes into rural areas in various provinces took place. The CMS participated in several radio talk shows to educate members about their rights.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**28**	**16**	**12**	**17**	**16**	**1**
Printing and stationery	8	8	–	8	8	–
Refreshments	10	2	8	8	8	–
Subscriptions	10	6	4	1	–	1
Operating expenses	**2 538**	**2 405**	**133**	**2 396**	**2 435**	**(39)**
Consulting fees	75	147	(72)	82	82	–
Courier and postage	10	9	1	10	10	–
Exhibition	130	87	43	252	251	1
Media and promotion	363	336	27	416	455	(39)
Printing and publication	849	811	38	842	835	7
Travel and subsistence	703	587	116	546	551	(5)
Venues and catering	408	428	(20)	248	251	(3)
Staff costs	**6 486**	**6 176**	**310**	**5 873**	**5 219**	**654**
Salaries	6 266	5 949	317	5 713	5 089	624
Staff training	220	227	(7)	160	130	30
Total	**9 052**	**8 597**	**455**	**8 286**	**7670**	**616**

Programme 6: Compliance

Legend: *Positive deviation* *Negative deviation* ***No deviation*** *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 6.2.1 – Enforcement of the Medical Schemes Act to ensure compliance					
6.2.1	Estimated number of enforcement interventions undertaken	48	52	4	**Deviation** There were more matters than expected that required enforcement interventions during the period under review.
Strategic objective 6.2.2 – Strengthening and monitoring governance systems					
6.2.2	Number of governance interventions implemented	69	88	19	**Deviation** There were more matters than expected that required governance interventions during the period under review.

Purpose

The unit serves members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.

Achievement of strategic objectives

The unit embarked on a new project of vetting scheme officers. This had a major impact on the unit's targets as 45 scheme officers were vetted with follow-up action where governance intervention was required.

The unit continued to monitor curatorships of Hosmed, Selfmed and Sizwe to ensure that the schemes were being managed efficiently. The unit successfully concluded the election processes for boards of trustees of Sizwe and Medshield, thereby placing both schemes in a position where their curatorship would be lifted.

Annual general meetings and election processes of schemes were monitored to ensure that trustees were elected fairly and in line with regulations under the Medical Schemes Act.

The Compliance and Investigations Unit continued to enforce compliance with the Medical Schemes Act. In instances where trustees of schemes were found to be unfit and improper, the removal of trustees in terms of section 46(1) was effected.

During the reporting, period five routine inspections and five commissioned inspections were conducted. The unit uncovered two instances of non-compliance and governance failure and, in both instances, the unit issued directives to the schemes to correct the governance lapses and improve compliance.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**141**	**79**	**62**	**108**	**70**	**38**
Cellphone contracts	45	46	(1)	30	19	11
Printing and stationery	12	10	2	22	12	10
Refreshments	4	2	2	4	4	–
Subscriptions	80	21	59	52	35	17
Operating expenses	**726**	**1 138**	**(412)**	**639**	**385**	**254**
Consulting fees	609	1 016	(407)	322	218	104
Courier and postage	1	1	–	–	–	–
Travel and subsistence	116	121	(5)	197	147	50
Venues and catering	–	–	–	120	20	100
Staff costs	**5 875**	**5 503**	**372**	**5 402**	**4 853**	**549**
Salaries	5 732	5 354	378	5 282	4 747	535
Staff training	143	149	(6)	120	106	14
Total	**6 742**	**6 720**	**(22)**	**6 149**	**5 308**	**841**

Programme 7: Benefits Management Unit

Legend: *Positive deviation* *Negative deviation* ***No deviation*** *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objectives 7.2.1 – Analyse scheme rule amendments					
7.2.1	Estimated number of rule amendments analysed	280	242	38	**Deviation** The rule amendments submitted to this office are based on decisions by the boards of medical schemes. The number received is not within the CMS's control.

Purpose

The purpose of this programme 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 scheme rules to ensure consistency with the Medical Schemes Act. This contributes to beneficiaries having access to affordable and appropriate quality healthcare and helps the CMS ensure that the rules of medical schemes are fair to beneficiaries and consistent with the Act.

Achievement of strategic objectives

The unit has continued to support the goals of ensuring that medical schemes are properly governed and responsive to the environment, and that beneficiaries are informed and protected. It ensures that rule amendments are fair and consistent with the Medical Schemes Act. By analysing the marketing materials of schemes, the unit also ensures that beneficiaries are honestly informed and not misled by marketing materials.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**31**	**28**	**3**	**50**	**36**	**14**
Printing and stationery	17	12	5	25	19	6
Refreshments	–	–	–	5	2	3
Subscriptions	14	16	(2)	20	15	5
Operating expenses	**–**	**–**	**–**	**26**	**1**	**25**
Consulting fees	–	–	–	20	–	20
Travel and subsistence	–	–	–	6	1	5
Staff costs	**5 260**	**4 730**	**530**	**4 819**	**4 537**	**282**
Salaries	5 160	4 695	465	4 659	4 373	286
Staff training	100	35	66	160	164	(4)
Total	**5 291**	**4 758**	**533**	**4 895**	**4 574**	**321**

Programme 8: Legal Services

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 8.2.1 – Legal advisory service for effective regulation of the industry and management of the Office					
8.2.1.	Estimated number of written and verbal legal opinions provided to internal and external stakeholders	60	227	167	**Deviation** The planned target is based on past experience but cannot be accurately anticipated. The unit experienced unusually high demand for legal opinions on a range of issues during 2014/2015.but was able to meet the demand within specified timeframes.
Strategic objective 8.2.2 – Support CMS mandate by defending decisions of Council and the Registrar					
8.2.2	Estimated number of legal matters handled by the unit	20	24	4	**Deviation** There were more matters than anticipated handled during the period under review.

Purpose

The unit provides legal advice and representation to the CMS and its business units to ensure the integrity of regulatory decisions.

Achievement of strategic objectives

The unit experienced a high demand for support and advice of a legal nature during the period under review. A marked increase in requests for legal opinions was generated by the activities of the various units, and particularly by the Compliance and Investigations Unit.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**10**	**9**	**1**	**17**	**14**	**3**
Printing and stationery	10	9	1	11	8	3
Refreshments	–	–	–	6	6	–
Operating expenses	**8 052**	**7 724**	**328**	**7 987**	**9 476**	**(1 489)**
Courier and postage	2	–	2	–	–	–
Legal fees	8 000	7 683	317	7 950	9 438	(1 488)
Transcription services	–	–	–	1	–	1
Travel and subsistence	50	41	9	36	38	(2)
Staff costs	**3 334**	**3 163**	**171**	**3 122**	**3 210**	**(88)**
Salaries	3 249	3 093	156	3 027	3 097	(70)
Staff training	85	70	15	95	113	(18)
Total	**11 396**	**10 896**	**500**	**11 126**	**12 700**	**(1 574)**

Programme 9: Financial Supervision Unit

Legend: *Positive deviation* *Negative deviation* *No deviation* *Deviation outside control of CMS*

Performance indicator		Planned target 2014/15	Actual achievement 2014/15	Deviation from planned target 2014/15	Comments on deviation
Strategic objective 9.2.1 – Monitor and promote the financial soundness of medical schemes					
9.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plans received	100%	100%	–	No deviation
	Number of quarterly financial return reports published (excluding quarter four)	3	3	–	No deviation
	Number of financial sections prepared for the annual report	1	1	–	No deviation

Purpose

The unit serves the beneficiaries and trustees of medical schemes and the Registrar's Office by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, the unit helps the CMS achieve an industry that is financially sound.

Achievement of strategic objectives

The unit's achievements included analysis of the 2013 Annual Returns and preparing the financial sections for the annual report during the period under review. The annual report incorporated a review of medical schemes' operations and their solvency for the 2013/14 financial year. Leading up to the analysis of schemes annual financials, the unit analysed schemes' quarterly financial returns and published these reports on the CMS website. This quarterly analysis is an important part of the unit's early warning system, which enables the CMS to take appropriate and timeous regulatory action.

Throughout the year the unit assessed the viability of schemes' business plans and management accounts. The business plan for Liberty medical scheme was rejected as it did not appear to have reasonable and attainable targets: The scheme was requested to submit a revised business plan. Two other schemes, Suremed and Topmed, were placed on close monitoring mainly because of their rapidly declining solvency and their operating losses.

Changes to planned targets

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

Unit budget

Expenditure	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/under expenditure R'000	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000
Administrative expenses	**50**	**30**	**20**	**56**	**38**	**18**
Printing and stationery	17	10	7	19	13	6
Refreshments	1	1	–	7	7	–
Subscriptions	32	19	13	30	18	12
Operating expenses	**155**	**27**	**128**	**220**	**83**	**137**
Consulting fees	20	–	20	20	–	20
Travel and subsistence	50	27	23	55	19	36
Venues and catering	85	–	85	145	64	81
Staff costs	**9 809**	**9 684**	**125**	**9 471**	**8 695**	**776**
Salaries	9 569	9 505	64	9 209	8 431	778
Staff training	240	179	61	262	264	(2)
Total	**10 014**	**9 741**	**273**	**9 747**	**8 816**	**931**

GOVERNANCE

PART C: GOVERNANCE

Council is the governing body of the CMS and, as such, it exercises oversight over the entity in accordance with the Medical Schemes Act, 131 of 1998, the Public Finance Management Act, 1 of 1999 (as amended), Treasury Regulations and the corporate governance principles set out in the King III Code of Governance Principles. Council is also guided by other relevant laws in the execution of its oversight responsibility.

Accounting Authority: Council

Section 4 of the Medical Schemes Act empowers the Minister of Health to appoint a Council consisting of up to 15 members. When appointing Council, the Minister takes into consideration the interests of members and medical schemes, and expertise in law, accounting, medicine, actuarial sciences, economics and consumer affairs. As at 31 March 2015 Council consisted of 10 members.

Section 10(1) of the Act prescribes the minimum number of meetings that Council must hold each year.

As a governing board, Council provides strategic direction and maintains effective control of the organisation. In respect of its governance responsibility Council reports to the Minister of Health and Parliament. As with all public entities, Council reports in respect of its financial performance and service delivery obligations.

In order to exercise its oversight role effectively, Council has delegated its functions to the following subcommittees in terms of Section 9(1)(a)-(b):

- Executive Committee
- Human Resources Committee
- Finance Committee
- Audit & Risk Committee
- ICT Governance Committee
- Appeals Committee.

These committees play a vital role in ensuring that the governance function of the Council is efficient and effective.

The role of Council

Section 7 of the Act provides that the functions of Council are to:

- Protect the interests of medical schemes beneficiaries at all times.
- Control and coordinate the functioning of medical schemes in a manner that is complementary to national health policy.
- Make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of relevant health services provided for by medical schemes, and such other services as Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act.
- Collect and disseminate information about private healthcare.
- Make rules, not inconsistent with the provisions of the Act, for the purpose of performing its functions and exercising its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on Council by the Minister of Health or by the Act.

Reports to the Portfolio Committee on Health

Council presented the following reports to the Portfolio Committee on Health during the 2014/2015 year:

- The CMS strategic plan, annual performance plan and budget for 2014/2015 on 30 July 2014.
- The Annual Report on 30 September 2014.

Reports to the Executive Authority

Council approved and submitted four quarterly performance information reports to the Minister of Health in line with the requirements and guidelines of National Treasury. The reports were submitted on the following dates:

- 30 July 2014
- 30 October 2014
- 30 January 2015
- 30 April 2015.

Table 13: Composition of Council as at 31 March 2015

Name of Council member	Designation	Date appointed	Date resigned	Qualifications	Area of expertise	Council committees	Number of meetings attended
Prof Y Veriava	**Chairperson**	14 Nov 2014	N/A	MBBCH (Wits), Hon DSc (Wits), FCP (SA), FRCP (London)	Clinical medicine	EXCO and HR	17
Dr L Mpuntsha	**Vice-Chairperson**	14 Nov 2014	N/A	MBChB, MPhil	Medicine	EXCO and Appeals	15
Prof BC Dumisa	**Member**	14 Nov 2014	N/A	LLB, LLM, MBA, MSc, DBA	Law Management	Appeals, ICT and Governance	20
Ms L Nevhutalu	**Member**	14 Nov 2014	N/A	BbusSc (Actuarial Sciences)	Actuarial sciences	HR and Audit & Risk	8
Dr S Mabela	**Member**	14 Nov 2014	N/A	BSc, MBA, PhD (Economics)	Economics	EXCO, HR, ICT and Governance	7
Ms M Maboye	**Member**	14 Nov 2014	N/A	BA, Adv Dip Nursing, Dip Nursing	Healthcare Management	EXCO and HR	7
Mr J Van der Walt	**Member**	14 Nov 2014	N/A	CA (SA), BCompt (Hons), MComm	Accounting Management	Audit & Risk	4
Mr M Nkosi	**Member**	14 Nov 2014	N/A	BA, MPH, PGD,	Healthcare Management	Governance, ICT and Audit & Risk	4
Prof S Perumal	**Member**	14 Nov 2014	N/A	BComm, DComm, MSc	Finance	EXCO and Audit & Risk	6
Adv H Kooverjie	**Member**	14 Nov 2014	N/A	BA, LLB	Law	Appeals	9

Composition of Council as at 30 October 2014

Name of Council member	Designation	Date appointed	Date resigned	Qualifications	Area of expertise	Council committees	Number of meetings attended
Prof Y Veriava	**Chairperson**	28 Nov 2012	N/A	MBBCH (Wits), Hon DSc (Wits), FCP (SA), FRCP (London)	Clinical medicine	EXCO and HR	11
Mr T Bailey	**Vice-Chairperson**	28 Oct 2011	30 Oct 2014	BA, LLB, LLM	Law	EXCO and Appeals	9
Prof BC Dumisa	**Member**	28 Oct 2011	30 Oct 2014	LLB, LLM, MBA, MSc, DBA	Law Management	Appeals	14
Mr ZL Fihlani	**Member**	28 Oct 2011	30 Oct 2014	CA (SA), MComm (Tax)	Tax	Finance and Audit & Risk	3
Mr K Hoosain	**Member**	28 Oct 2011	30 Oct 2014	CA (SA), MBA	Accounting Management	EXCO, Finance and Audit & Risk	3
Ms MO Morata	**Member**	28 Oct 2011	30 Oct 2014	BProc, PostGradDip (Drafting of Contracts)	Law	Remuneration and Appeals	3
Dr L Mpuntsha	**Member**	29 Oct 2012	30 Oct 2014	MBChB, MPhil	Medicine	HR and Appeals	12
Ms L Nevhutalu	**Member**	28 Oct 2011	30 Oct 2014	BbusSc (Acturial Sciences)	Acturial sciences	HR	5
Mr T Phadu	**Member**	28 Oct 2011	30 Oct 2014	MSc (London), Senior Diploma (Political Economy) (Moscow)	Policy	HR and Remuneration	2
Dr A Pillay	**Member**	28 Oct 2011	30 Oct 2014	BPharm, MSc, PhD (Australia)	Medicine Management	EXCO	3
Ms A Theophanides	Member	28 Oct 2011	30 Oct 2014	BCom Honours (Actuarial Sciences)	Actuarial sciences	EXCO, HR and Remuneration	
Prof CJ Van Gelderen	Member	28 Oct 2011	30 Oct 2014	MBChB, Dip Mid COG (SA), MRCOG, FRCOG, FCOG (SA)	Medicine	EXCO, HR and Appeals	
Adv CJ Weapond	Member		30 Oct 2014	Bluris, BPol, LLB, MTech	Law	Appeals	
Mr T Zulu	Member		30 Oct 2014	CA (SA)	Accounting	Finance and Audit & Risk	

Table 14: Membership of Council Committees as at 31 March 2015

Council Committee	Number of meetings held	Number of members	Names of members
Executive Committee (EXCO)	2	5	Prof Y Veriava Dr L Mpuntsha Prof S Perumal Dr Steven Mabela Ms M Maboye
Human Resources Committee	1	4	Prof Y Veriava Dr Steven Mabela Ms M Maboye Ms L Nevhutalu
Audit & Risk Committee	4	5	Mr Charles Mazhindu (resigned 20 July 2014) (Chairperson and independent non-executive member) Mr Rowan Nicholls (Chairperson and independent non-executive member) Mrs Josephine Naicker (Independent non-executive member) Prof S Perumal (appointed 14 November 2014) Mr M Nkosi (appointed 14 November 2014) Mr J Van der Walt (appointed 14 November 2014)
Finance Committee	4	4	Prof S Perumal (appointed 14 November 2014) Mr M Nkosi (appointed 14 November 2014) Ms L Nevhutalu (appointed 14 November 2014) Mr J Van der Walt (appointed 14 November 2014)
Appeals Committee	4	6	Dr L Mpuntsha Prof B Dumisa Adv H Kooverjie Adv V Ngalwana (Chair – external) Adv H Maenetje (Alternate Chair – external)

Council committees as at 30 Oct 2014

Council Committee	Number of meetings held	Number of members	Names of members
Executive Committee (EXCO)	5	6	Prof Y Veriava Mr T Bailey Mr K Hoosain Dr A Pillay Ms A Theophanides Mr T Phadu
Human Resources Committee	2	6	Prof Y Veriava Dr L Mpuntsha Ms L Nevhutalu Mr T Phadu Ms A Theophanides Prof CJ Van Gelderen
Audit & Risk Committee	4	6	Mr Charles Mazhindu (resigned 20 July 2014) (Chairperson and independent non-executive member) Mr Rowan Nicholls (Independent non-executive member) Mrs Josephine Naicker (Independent non-executive member) Mr Kariem A Hoosain (term ended 31 October 2014) Mr Thabani F Zulu (term ended 31 October 2014) Mr Zola L Fihlani (term end 31 October 2014)
Finance Committee	4	3	Mr Kariem A Hoosain (term ended 31 October 2014) Mr Thabani F Zulu (term ended 31 October 2014) Mr Zola L Fihlani (term ended 31 October 2014)
Appeals Committee	13	8	Mr T Bailey Prof B Dumisa Ms MO Morata Prof CJ Van Gelderen Dr L Mpuntsha Adv H Maenetje (Chair – external) Adv V Ngalwana (Chair – external) Adv CJ Weapond (Alternate chair – external)

Table 15: Remuneration of Council members in 2014/15

Name of Council member	Remuneration R'000	Other allowance/s R'000	Other reimbursement/s R'000	Total R'000
Prof Y Veriava	159	–	–	159
Mr T Bailey	235	–	–	235
Prof BC Dumisa	259	–	–	259
Mr AK Hoosain	118	–	–	118
Ms H Koovertjie	39	–	–	39
Ms MS Mabela	32	–	–	32
Ms M Maboye	27	–	–	27
Ms MO Morata	53	–	–	53
Dr L Mpuntsha	101	–	–	101
Ms L Nevhutalu	55	–	–	55
Mr M Nkosi*	–	–	–	–
Prof S Perumal	47	–	–	47
Dr A Pillay*	–	–	–	–
Mr T Phadu	11	–	–	11
Ms A Theophanides	33	–	–	33
Prof CJ van Gelderen	113	–	–	113
Mr J van der Walt	35	–	–	35
Adv CJ Weapond	74	–	–	74
Mr TF Zulu	39	–	–	39
Total	**1 430**	**–**	**–**	**1 430**

* *Non-remunerated Council members*

Council Secretariat

The Council Secretariat is responsible for providing support and advice on corporate governance to Council and its committees. The Council Secretariat provides guidance to Council members on their rights, responsibilities, duties and powers at an individual level and collectively. The Council Secretary promotes compliance with all laws and regulations which are relevant to the CMS and the medical schemes industry. In addition to this, the Council Secretary services Council meetings, attending to the logistical arrangements and ensuring that proper minutes are taken and kept. Council resolutions are communicated by the Council Secretary to all affected parties.

Internal Finance Unit and internal controls

The Internal Finance Unit is tasked with development and maintenance of internal controls to ensure the efficient management of CMS resources. Financial policies and procedures were updated in 2014/2015, in order to align with National Treasury's cost-containment measures.

Management implements and maintains a system of internal control that ensures the attainment of major objectives, such as:

- Effectiveness and efficiency of operations.
- Reliability of financial and management reports.
- Compliance with applicable laws and regulations.
- Adequacy of procedures to safeguard assets.

Internal audit

The CMS has outsourced its internal audit function which is performed under the direction of the Audit & Risk Committee. The purpose of the internal audit function is to provide an independent, objective assurance of sound financial practices and to advise the CMS on how to improve its operations. The internal auditors evaluate and provide assurance of the effectiveness of risk management, control and governance processes at the CMS.

In undertaking their audit work, the internal auditors complied with the Standards for the Professional Practice of Internal Auditing and Code of Ethics of the Institute of Internal Auditors and other relevant guidelines laid down by appropriate bodies.

The internal audit charter, annual internal audit plan and a three-year rolling plan were approved by the Audit & Risk Committee during the year. The internal auditors and external auditors held several meetings to ensure that there was synergy between them and cost-effectiveness in the services provided.

Scope of work

The audit scope was based on management's assessment of risks relating to the core business of CMS. It focused on high-risk areas identified in consultation with the Audit & Risk Committee, Executive Management and the Risk and Performance Manager.

The internal auditor's scope of work is to determine whether CMS's network of risk management, control and governance processes are adequate and effective in mitigating risks.

Risk management

The CMS has matured over the past two years in terms of its implementation of the risk management framework. Risk management is fast becoming embedded in the CMS's culture and there is continuous consideration of risks during discussions about new projects, strategy, processes and resources, and in every facet of the organisation.

It is the policy of the CMS to manage all categories of risk associated with its business operations through the development and maintenance of a formal risk policy framework and to acknowledge its responsibility to ensure that the CMS has and maintains an effective, efficient and transparent system of risk management. The CMS has committed the entity to a process of risk management that is aligned to the principles of the PFMA, Treasury Regulations and King III Report.

Council is ultimately responsible for risk management in the CMS and is supported by the Audit & Risk Committee, Executive Management and the Risk and Performance Manager. The risk management framework was revised and approved during March 2015.

CMS risk assessment process during 2014/2015

There is regular and ongoing identification, evaluation, management, monitoring and reporting of risks. This process is aimed at improving the organisation's ability to reduce the incidence of risk and its impact on the CMS.

The risk management process involves:

- Strategy: The CMS assesses the risks arising from its strategic objectives and the risks which could prevent the CMS from achieving its strategic objectives.
- Risk champions: Risk champions are an integral part of risk management process at the CMS. Individuals who have been identified in each business unit have undergone extensive training on the risk management process and their responsibilities.
- Risk identification: The CMS has implemented a structured process to identify risks within the organisation annually. This process involves internal and external stakeholders.
- Risk assessment: CMS has established a rating model to assess the likelihood of risks that have been identified actually occurring and their probable impact. This assists the organisation to prioritise its risks and manage them on the basis of their inherent risk, without considering the CMS's existing controls.
- Risk mitigation: Risk treatment plans are compiled to address relevant risk exposures and these are actioned by the risk champions and monitored by the Risk and Performance Manager.
- Execution and monitoring: Relevant risk reports are prepared and presented to various governance forums of the CMS.
- Assurance: The responsibility of risk management resides with the CMS management team which utilises external service providers to provide assurance on the risk management process and related controls.

The CMS risk management process:

Materiality framework

As required by Treasury Regulations, Council has developed a materiality and significance framework appropriate to its size and circumstances. The approach to this framework for 2014/2015 is outlined below:

Levels of materiality were set in accordance with guidance contained in the Practice Note on the PFMA and submitted to the Minister of Health for approval. Council took the following into account in determining the CMS's level of materiality:

- The nature of the CMS's business.
- Statutory requirements affecting the CMS.
- Inherent and control risks associated with the CMS.
- Quantitative and qualitative issues.

In the light of the above, Council assessed the level of "a material loss" to be:

- Every amount in respect of criminal conduct.
- R30 000 and above for irregular, fruitless and wasteful expenditure involving gross negligence.
- R1 130 760[1] and above – about 1% of income – for reporting in terms of subsection 55 (1)(d) of the PFMA which deals with the fair presentation of the affairs of a public entity, its business, its financial results, its performance and its financial position as at the end of the financial year.

Council decided that any transaction covered by section 54(2) of the PFMA would be reported as significant changes, namely:

- Establishment of or participation in the establishment of a company.
- Participation in a significant partnership, trust, unincorporated joint venture or similar arrangement.
- Acquisition or disposal of a significant shareholding in a company.
- Acquisition or disposal of a significant asset.
- Commencement or cessation of a significant business activity.
- A significant change in the nature or extent of its interest in a significant partnership, trust, joint venture or similar arrangement

Health, safety and environmental issues

A Health and Safety Committee was established and a health and safety framework was developed with the aim of protecting employees against hazards which might arise from activities at work.

Council ensures that reasonable precautions are taken to ensure a safe working environment and the CMS conducts its business with due regard for environmental concerns. The organisation held two emergency evacuation drills during the reporting period.

Prevention of fraud and corruption

The CMS is committed to protecting its funds and other assets and will not tolerate corrupt or fraudulent activities emanating from internal or external sources. The CMS has adopted a fraud and corruption strategy which requires that any corrupt activities that are detected must be investigated and, where appropriate, reported to the law enforcement authorities.

1. Based on the audited figure of income for 2013/2014

Report of the Audit & Risk Committee

We are pleased to present our report for the financial year ended 31 March 2015 to Council, the accounting authority of the Council for Medical Schemes (CMS).

This report is provided by the Audit & Risk Committee of Council, appointed in respect of the 2014/2015 financial year, in compliance with section S51(1)(a)(ii) of the Public Finance Management Act, 1 of 1999 (PFMA), as amended. The Committee's operation is guided by a detailed charter that is informed by the PFMA and has been 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 Chairperson, Mr Charles Mazhindu, resigned from the Committee on 20 July 2014 due to his increased professional commitments.

The Committee held three scheduled meetings and one special meeting during the year under review. The dates of these meetings and attendance at them are reflected in Table A.

Table A: Meetings of the Audit & Risk Committee in 2014/2015 and members' attendance

Name of member	Position of member	Date of appointment	Date of re-appointment	Term end	Meetings attended			
					22 May 2014 (scheduled)	24 July 2014 (special)	21 October 2014 (scheduled)	19 February 2015 (scheduled)
Charles Mazhindu	Independent and non-executive Chairperson	1 October 2009	1 November 2012	Resigned as Chairperson 20 July 2014	X	–	–	–
Rowan Nicholls	Independent and non-executive Chairperson from 24 July 2015	1 October 2009	1 November 2012		√	√	√	√
Josephine Naicker	Independent and non-executive	1 October 2009	1 November 2012		X	√	√	√
Kariem A Hoosain	Council member and non-executive	28 May 2009	28 October 2011	31 October 2014	√	√	√	Term ended 31 October 2014
Thabani F Zulu	Council member and non-executive	1 November 2011	N/A	31 October 2014	√	√	√	Term ended 31 October 2014
Zola L Fihlani	Council member and non-executive	1 November 2011	N/A	31 October 2014	X	X	X	Term ended 31 October 2014

Table B: Members appointed on 14 November 2014 and their attendance at meetings

Name of member	Position of member	Date of appointment	Date of re-appointment	Term end	Meetings attended			
					22 May 2014 (scheduled)	24 July 2014 (special)	21 October 2014 (scheduled)	19 February 2015 (scheduled)
Johan van der Walt	Council member and non-executive	14 November 2014			–	–	–	√
Sadhasivan Perumal	Council member and non-executive	14 November 2014			–	–	–	√
Moremi Nkosi	Council members and non-executive	14 November 2014			–	–	–	√

√ = attended
X = apology

Other invitees

The internal and external auditors of the CMS attended all meetings of the Committee as permanent invitees. The Acting Chief Executive & Registrar/Chief Financial Officer attended meetings ex officio and other senior managers attended for agenda items relevant to them.

Functions

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 fairly present the position of the CMS and are 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, which are recommended to Council.
  - Engagement terms, plans and budget for the Auditor-General of South Africa, which are also recommended to Council.
- Recommendation of the unaudited and audited Annual Financial Statements to council for the financial year ended 31 March 2015.

Audit & Risk Committee's responsibility

Mandate

The mandate of the Committee is derived from section S51(1)(a)(ii) of the PFMA and paragraph 3.1.13 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, which have been authorised by Council, as its charter. It has regulated its affairs in compliance with this charter and has discharged all responsibilities required by the charter.

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 in relation to CMS governance

As part of the CMS's governance structures, the Committee continued to discharge its mandate and, among other activities, performed its oversight function as follows:

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

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

The Committee satisfied itself of the objectivity and independence of the CMS internal audit function and the continued appropriateness of the internal audit charter. The Committee acknowledges that an effective internal audit function is central to the proper operation of the Committee.

External audit plan by the Auditor-General of South Africa

The Committee reviewed and approved the external audit plan for the financial year ended 31 March 2015 which was prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act. The Committee confirmed that this plan was in line with regulations and standards, and that the plan took into consideration the CMS risk register for the year under review. The Committee considered 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, ensuring that they are effective and adequate to safeguard the CMS's resources and promote the achievement of its mission. The Committee continued to report on the establishment of effective internal controls, which require periodic identification, and the 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 have been adequately identified and entity-wide risk management within the CMS has now been fully established.

Based on internal audits during 2014/2015, the overall control environment of processes subject to internal audit was found to be partially adequate and partially effective. Several control weaknesses were noted that require management's immediate attention.

Council continues in its effort to improve and enhance the system of internal control with its focus on governance, people, methods and practices. Inherent to this process is the embedding of governance structures that integrate independence, industry knowledge, professional accreditation and experience. This is further supported by partnerships with key assurance providers and management.

Council is currently strengthening the foundations of the control environment by embarking on a process to formally document the system of controls, utilising process flows and improving narrative descriptions of relevant processes.

The audit by the Auditor-General identified weaknesses relating to supply chain management and information technology governance. 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 quarterly progress reports on legal cases brought against the CMS in its role as regulator and those cases pending at the financial year-end. This was in order to assess the adequacy of disclosure in the Annual Financial Statements, as required in terms of the South African Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. No cases warrant any further mention in this report.

Evaluation of the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually. During the year under review such an evaluation took place as part of a broader evaluation of Council.

Evaluation of Annual Financial Statements

The Committee reviewed the Annual Financial Statements of the CMS for the financial year ended 31 March 2015 and is satisfied that, in all material respects, the financial statements comply with the relevant provisions of the PFMA, GRAP and fairly present the financial position of the CMS at that date and the results of operations and cash flows for the financial year then ended.

The Committee reviewed and discussed the CMS Annual Financial Statements to be included in this Annual Report with the Auditor-General of South Africa and the Accounting Officer of the CMS. The Committee concurs with and accepts the conclusion of the Auditor-General of South Africa on the CMS Annual Financial Statements.

The Committee recommended the financial statements and performance information report for the year ended 31 March 2015 to Council for approval.

Other matters

During the period under review the Chief Executive Officer and Registrar was suspended following allegations of corruption. A forensic investigation was instituted to look into these allegations. The report of the investigation was finalised in April 2015 and recommendations of the report have since been implemented. The allegations did not relate to any internal financial irregularities.

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 in full compliance with its legal and Charter mandate.

Rowan Nicholls
Chairperson

On behalf of the Audit & Risk Committee
Council for Medical Schemes

30 July 2015

HUMAN RESOURCES MANAGEMENT

PART D: HUMAN RESOURCES MANAGEMENT

Over the past 15 years, the Human Resources (HR) Unit has been responsible for providing focused leadership in relation to organisational development and career and succession planning. In terms of succession planning, critical positions have been identified and the HR Unit has facilitated competency assessments to assist staff to identify areas for development in line with the organisation's succession plan. Emphasis has also been placed on performance management and strategies on remuneration and incentives to ensure market-related remuneration of CMS staff.

The CMS remuneration strategy is benchmarked against best practice and salary surveys are conducted every two years. This has contributed to a relatively high retention rate of 96.08% among key staff.

Performance management is a strategic imperative for the CMS and in 2004 the organisation implemented a performance management system focusing on the recognition of high performers. The result is that high performance has been maintained and the turnover of high performers has been effectively managed. Performance management consists of two performance reviews each year and monthly performance assessments.

The HR Unit has also been responsible for the "people" side of change processes, including the relocation of the office from Hatfield, Pretoria to Centurion. No resignations were attributed to the move.

In addition to the succession planning framework, initiatives aimed at staff retention include a flexi-time policy, sabbatical leave, business coaching and the enhancement of several employee benefits. The HR Unit also runs a comprehensive wellness programme, guided by a Wellness Committee. This includes subsidised gym membership, annual health screening tests, cancer awareness education programmes, HIV and AIDS education programmes, financial wellness, employee counselling and monthly health bulletins. Absenteeism rates are monitored and reported to the executive management team.

Implementation of the CMS's human resources strategy for the 2014/2015 financial year is outlined below. The report deals with remuneration and benefits, talent management and staff retention, performance management, training and development, employment equity and personnel-related costs.

The HR Unit's strategic objective is to help the CMS be responsive to the medical schemes environment by operating effectively and efficiently.

The HR Unit strives to provide the highest level of service to internal and external customers by assessing their needs and proactively addressing these through human resources programmes that promote and support the CMS's vision.

Policy review

The HR Unit reviewed the policy pertaining to study leave, maternity and paternity leave, and compassionate leave. It also reviewed the performance and incentives policy and the disclosure of interests and acceptance of gifts policy. A health and safety policy was adopted by Council.

Recruitment and talent management

Recruitment processes have been enhanced in respect of verification checks relating to candidates' qualifications, previous employment, criminal offences and credit records.

In this financial year the following eight vacant positions were filled:

- Senior Researchers (2);
- Senior Investigators (2);
- Accreditation Analyst;
- Communications Manager;
- Supply Chain Management Officer; and
- Legal Advisor.

Unfortunately, one candidate declined the CMS job offer and that position is still in the process of being filled.

The following resignations were received:

- Senior Strategist;
- Senior Investigator;
- Senior Researcher; and
- Legal Advisor.

The HR Unit provides new employees with in-depth and comprehensive orientation within their first week at the CMS. This includes information on the structure and function of the organisation, the CMS terms and conditions of service, and all policies. Career development opportunities are offered through the Professional Development Programme (PDP). Seven of the eight employees appointed during 2014/2015 completed the mandatory probationary period of six months and were confirmed as permanent employees.

Managing performance

Over the course of the year the HR Unit facilitated the drafting and conclusion of performance agreements for employees, making sure that all contracts correctly reflected job requirements and accomplishment-based performance standards, outcomes and measures.

Two formal performance reviews were conducted during the reporting period. Through the Moderating Committee, incentive bonuses were awarded to those employees who qualified.

Job grading and evaluations

The HR Unit conducted job grading and evaluations during 2014/2015 to ensure that salaries were in line with market rates. Recommendations from the job evaluation exercise were presented to Council which resolved to consider them once the CMS budget was approved by National Treasury.

Training and development

The CMS continued to implement personal development plans identified by an earlier skills audit. Employees undertook various training programmes in 2014/2015. A workplace skills plan and annual training report were completed and submitted to the Health and Welfare Sector Education Training Authority (HWSETA).

During 2014/2015 several employees completed certificate programmes, diploma courses and degrees.

Employment equity

The representation of Indian and coloured employees and persons with disabilities is still below the nationally defined norms for these groups. In 2014/15 the CMS focused on hiring qualified candidates from these categories, as far as possible. New appointees comprised an African female, an Indian female, a coloured male and four African males.

Table 16: Appointments made in 2014/2015 by race, gender and nationality

Appointments 2014/15	Males				Females				Foreign nationals		Total
Occupational level	A	C	I	W	A	C	I	W	M	F	
Top management	0	0	0	0	0	0	0	0	0	0	0
Senior management	0	0	0	0	0	0	0	0	0	0	0
Professionals	4	1	0	0	0	0	0	0	1	0	6
Technicians and associated professionals	0	0	0	0	1	0	1	0	0	0	2
Clerks	0	0	0	0	0	0	0	0	0	0	0
Total permanent	4	1	0	0	1	0	1	0	1	0	8
Non-permanent employees	0	0	0	0	0	0	0	0	0	0	0
Grand total	**4**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**8**

Health and safety

A Health and Safety Committee was established and a health and safety framework developed with the aim of protecting employees against the hazards of health and safety arising from activities at work. The office held two evacuation drills during the reporting period.

Employee wellness

The CMS renewed its service-level agreement with ICAS Southern Africa to provide employee wellbeing programmes. The HR Unit hosted wellness events focusing on voluntary HIV testing and counselling, screening for cancer and diabetes, and flu prevention vaccinations.

Corporate social responsibility

This year the CMS hosted 10 girls from Vukani-Mawethu High School for the Cell C "Take a Girl Child to Work" initiative and 10 boys from Olienvenhoutbosch Secondary School as part of the Tracker "Men in the Making" programme.

Through the generosity employees, the CMS was able to donate school shoes and uniforms for 129 underprivileged students at Vukani-Mawethu High School and contribute towards the renovation and decoration of a children's oncology ward at Steve Biko Academic Hospital. The latter donation by CMS sparked contributions from other organisations towards the renovation and decoration of the remaining rooms in the oncology unit for children.

Teambuilding, culture and diversity

The HR Unit facilitated quarterly motivational talks for employees to assist in improving staff morale.

Human Resources Oversight Report

Table 17: Personnel costs by programme/unit 2014/2015

Programme/Unit	Total expenditure of unit R'000	Personnel expenditure R'000	Personnel expenditure as percentage of total expenditure %	Number of employees	Average personnel cost per employee R'000
Accreditation	7 166	6 604	92.16	10	660
Benefits Management	4 758	4 695	98.68	7	671
Complaints Adjudication	5 010	4 910	98.00	9	546
Compliance & Investigations	6 720	5 354	79.67	7	765
Financial Supervision	9 741	9 505	97.58	11	864
Human Recources	5 472	3 390	61.95	5	678
ICT & KM	12 213	7 536	61.70	11	685
Internal Finance	28 439	7 280	25.60	9	809
Legal Services	10 896	3 093	28.39	4	773
CEO & Registrar's Office	15 389	3 355	21.80	4	839
Strategy Office & Clinical unit	4 934	4 786	97.00	6	798
Research & Monitoring	6 044	5 599	92.64	8	700
Stakeholder Relations	8 597	5 949	69.20	11	541
Total	**125 379**	**72 056**	**57.47**	**102**	**706**

Table 18: Personnel costs by salary band 2014/2015

Level	Personnel expenditure R'000	Percentage of total personnel expenditure %	Number of employees	Average personnel cost per employee R'000
Top management	1 911	2.65	1	1 911
Senior management	15 936	22.12	10	1 594
Professionals	28 235	39.18	36	784
Skilled labour	24 934	34.60	51	489
Semi-skilled labour	1 040	1.44	4	260
Unskilled labour	0	0.00	0	0
Total	**72 056**	**100.00**	**102**	**706**

Table 19: Performance reward costs by salary band 2014/2015

Level	Performance rewards R'000	Personnel expenditure R'000	Performance rewards as percentage of total personnel cost %	Performance rewards as percentage of total personnel expenditure per occupational level %
Top management	0	1 911	0.00	0.00
Senior management	930	15 936	1.29	5.84
Professionals	1 601	28 235	2.22	5.67
Skilled labour	1 361	24 934	1.89	5.46
Semi-skilled labour	43	1 040	0.06	4.13
Unskilled labour	0	0	0.00	0.00
Total	**3 935**	**72 056**	**5.46**	**21.10**

Note: 5.46% is the percentage of performance rewards to total personnel cost, whereas, 21.10% is the percentage of total rewards to personnel expenditure per occupational level.

Table 20: Training cost by programme/unit 2014/2015

Programme/Unit	Personnel expenditure R'000	Training expenditure R'000	Training expenditure as percentage of personnel cost %	Number of employees	Average training cost per employee R'000
Accreditation	6 604	28	0.42	10	2.80
Benefits Management	4 695	35	0.75	7	4.92
Complaints Adjudication	4 910	99	2.02	9	10.97
Compliance & Investigations	5 354	149	2.78	7	21.28
Financial Supervision	9 505	179	1.88	11	16.31
Human Resources	3 390	142	4.19	5	28.39
ICT & KM	7 536	107	1.42	11	9.69
Internal Finance	7 280	140	1.92	9	15.58
Legal Services	3 093	70	2.26	4	17.49
CEO & Registrar's Office	3 355	60	1.79	4	15.04
Strategy Office & Clinical unit	4 786	118	2.47	6	19.72
Research & Monitoring	5 599	130	2.32	8	16.24
Stakeholder Relations	5 949	227	3.82	11	20.66
Total	**72 056**	**1 484**	**2.06**	**102**	**14.55**

Table 21: Employment and vacancies by programme/unit 2014/2015

Programme/Unit	Number of employees 2013/2014	Approved posts 2014/2015	Number of employees 2014/2015	Vacancies 2014/2015	Percentage of total vacancies (%)
Accreditation	9	1	10	0	0.00
Benefits Management	7	0	7	0	0.00
Complaints Adjudication	9	0	9	0	0.00
Compliance & Investigations	6	1	7	1	16.67
Financial Supervision	11	0	11	0	0.00
Human Resources	5	0	5	0	0.00
ICT & KM	11	0	11	0	0.00
Internal Finance	9	1	8	0	0.00
Legal Services	4	0	4	1	16.67
CEO & Registrar's Office	4	0	4	0	0.00
Strategy Office & Clinical unit	6	0	7	1	16.67
Research & Monitoring	7	0	8	2	33.33
Stakeholder Relations	10	1	11	1	16.67
Total	**98**	**4**	**102**	**6**	**100.00**

Table 22: Employment and vacancies by salary level 2014/2015

Level	Number of employees 2013/14	Approved posts 2014/15	Number of employees 2014/15	Vacancies 2014/15	Percentage of total vacancies (%)
Top management	1	0	1	0	0.00
Senior management	11	0	10	1	16.67
Professionals	33	1	36	5	83.33
Skilled labour	40	3	51	0	0.00
Semi-skilled labour	13	0	4	0	0.00
Unskilled labour	0	0	0	0	0.00
Total	**98**	**4**	**102**	**6**	**100.00**

Council approved the following new positions in 2014/2015: Senior Investigator, Accreditation Analyst: MCO, Supply Chain Management Officer and Senior Researcher. Vacancies were due to resignations and internal movement.

Table 23: Employment changes by salary band 2014/2015

Level	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	1	0	0	1
Senior management	11	0	1	10
Professionals	33	6	3	36
Skilled labour	40	11	0	51
Semi-skilled labour	13	0	9	4
Unskilled labour	0	0	0	0
Total	**98**	**17**	**13**	**102**

Vacancies between appointments and terminations were due to resignations and internal alignment of jobs within the Patterson grading system.

Table 24: Reasons for staff leaving 2014/2015

Reason	Number of employees	Percentage of total number of staff leaving (%)
Death	0	0
Resignation	4	100
Dismissal	0	0
Retirement	0	0
Ill health	0	0
Expiry of contract	0	0
Other	0	0
Total	**4**	**100**

Table 25: Labour relations: misconduct and disciplinary action 2014/2015

Reason	Number of occurrences
Verbal warning	0
Written warning	0
Final written warning	1
Dismissal	0
Total	**1**

FINANCIAL INFORMATION

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY FOR THE ANNUAL REPORT

To the best of my knowledge and belief, I confirm the following:

All information and amounts disclosed in the annual report are consistent with the annual financial statements audited by the Auditor-General.

The annual report is complete, accurate and free from any omissions.

The annual report has been prepared in accordance with the guidelines on the annual report as issued by National Treasury.

The annual financial statements have been prepared in accordance with Standards of Generally Recognised Accounting Practice (GRAP) including any interpretations, guidelines and directives issued by the Accounting Standards Board.

The annual financial statements are based on appropriate accounting policies, consistently applied and supported by reasonable and prudent judgments and estimates.

The Accounting Authority is responsible for the preparation of the annual financial statements and for the judgments made in this information.

The Accounting Authority is responsible for establishing and implementing a system of internal control which has been designed to provide reasonable assurance of the integrity and reliability of the performance information, the human resources information and the annual financial statements.

The external auditors are responsible for independently reviewing and reporting on the entity's annual financial statements. The annual financial statements have been examined by the entity's external auditors and their report is presented on pages 104 to 106.

In our opinion, the annual report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the entity for the financial year ended 31 March 2015.

The annual financial statements set out on pages 108 to 134, which have been prepared on the going concern basis, were approved by the Council on 31 July 2015 and were signed on its behalf by:

Mr MD Lehutjo

Acting Chief Executive & Registrar

Prof Y Veriava

Chairperson of Council

REPORT OF THE AUDITOR GENERAL

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 108 to 134, which comprise the statement of financial position as at 31 March 2015, the statement of financial performance, statement of changes in net assets, cash flow statement and the statement of comparison of budget information with actual information for the year then ended, as well as 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 South African standards of General Recognised Accounting Practice (SA standards of GRAP) and the requirements of the Public Finance Management Act, 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 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 2015 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.

Report on other legal and regulatory requirements

7. In accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) and the general notice issued in terms thereof, I have a responsibility to report findings on the reported performance information against predetermined objectives for selected programmes presented in the annual performance report, non-compliance with legislation and internal control. The objective of my tests was to identify reportable findings as described under each subheading but not to gather evidence to express assurance on these matters. Accordingly, I do not express an opinion or conclusion on these matters.

Predetermined objectives

8. I performed procedures to obtain evidence about the usefulness and reliability of the reported performance information for the following selected programmes presented in the annual performance report of the public entity for the year ended 31 March 2015:
    - Programme 3: Accreditation on pages 70 to 71
    - Programme 4: Research and monitoring on pages 72 to 73
    - Programme 5: Stakeholder relations on pages 74 to 75
    - Programme 6: Compliance unit on pages 75 to 76
    - Programme 7: Benefit management unit on page 77
    - Programme 8: Legal support unit on page 78
    - Programme 9: Financial supervision on pages 79 to 80

9. I evaluated the reported performance information against the overall criteria of usefulness and reliability.

10. I evaluated the usefulness of the reported performance information to determine whether it was presented in accordance with the National Treasury's annual reporting principles and whether the reported performance was consistent with the planned programmes. I further performed tests to determine whether indicators and targets were well defined, verifiable, specific, measurable, time bound and relevant, as required by the National Treasury's Framework for managing programme performance information (FMPPI).

11. I assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.

12. I did not identify any material findings on the usefulness and reliability of the reported performance information for the selected programmes.

Additional matters

13. Although I did not identify any material findings on the usefulness and reliability of the reported performance information for the selected programmes, I draw attention to the following matters:

Achievement of planned targets

14. Refer to the annual performance report on pages 58 to 80 for information on the achievement of the planned targets for the year.

Unaudited supplementary information

15. The supplementary information set out on pages 135 to 208 does not form part of the annual performance report and is presented as additional information. I have not audited this information and, accordingly, I do not report thereon.

Compliance with legislation

16. I performed procedures to obtain evidence that the public entity had complied with applicable legislation regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA, are as follows:

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

Procurement and contract management

17. Quotations were awarded to bidders who did not submit a declaration on whether they are employed by the state or connected to any person employed by the state, which is prescribed in order to comply with Treasury regulation 16A8.3.

18. One contract with a transaction value above R500 000 was procured without inviting a competitive bid, as required by Treasury Regulations 16A6.1. A deviation was approved by the accounting authority even though it was not impractical to invite competitive bids, in contravention of Treasury Regulation 16A6.4.

Expenditure management

19. The accounting authority did not take effective steps to prevent irregular expenditure as required by section 51(1)(b)(ii) of the PFMA.

Internal control

20. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with legislation. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on non-compliance with legislation included in this report.

Financial and performance management

21. The internal control systems designed and implemented by management did not prevent or detect irregular expenditure, in certain instances, due to incorrect interpretation of legislation.

Other reports

Investigations

22. An external forensic investigation into allegations of corruption against the suspended Chief Executive Officer (CEO) was undertaken during the year under review. The investigation was concluded in April 2015. The recommendations of the forensic report are in the process of being implemented. The contract of the suspended CEO ended in June 2015 and was not renewed.

Auditor - General

Pretoria

31 July 2015

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2015

	Note(s)	2015 R'000	2014 R'000
Assets			
Current assets			
Receivables from exchange transactions	3	**6 836**	5 627
Cash and cash equivalents	4	**10 515**	15 086
		17 351	20 713
Non-current assets			
Property, plant and equipment	5	**16 016**	12 097
Intangible assets	6	**1 505**	1 640
		17 521	13 737
Total assets		**34 872**	34 450
Liabilities			
Current liabilities			
Payables from exchange transactions	7	**13 091**	12 040
Provisions	8	**132**	362
		13 223	12 402
Non-current liabilities			
Operating lease liability	9	**3 681**	1 107
Provisions	8	**896**	794
		4 577	1 901
Total liabilities		**17 800**	14 303
Net assets		**17 072**	20 147
Accumulated surplus		**17 072**	20 147

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 31 MARCH 2015

	Note(s)	2015 R'000	2014 R'000
Revenue	11	**120 095**	113 077
Administrative expenditure	12	**(17 389)**	(14 108)
Audit fees	13	**(1 897)**	(1 601)
Operating expenses	14	**(17 931)**	(21 213)
Staff cost	15	**(77 108)**	(69 669)
Depreciation and amortisation		**(3 772)**	(2 637)
Forensic investigation	16	**(7 257)**	–
Penalties waived	17	**–**	(310)
Loss on disposal of asset		**(25)**	(176)
Operating (deficit) surplus		**(5 284)**	3 363
Investment revenue		**2 209**	1 965
(Deficit) surplus for the year		**(3 075)**	5 328

STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED 31 MARCH 2015

	Accumulated surplus R'000	Total net assets R'000
Balance at 01 April 2013	**14 819**	**14 819**
Changes in net assets		
Surplus for the year	5 328	5 328
Total changes	5 328	5 328
Balance at 01 April 2014	**20 147**	**20 147**
Changes in net assets		
Surplus for the year	(3 075)	(3 075)
Total changes	(3 075)	(3 075)
Balance at 31 March 2015	**17 072**	**17 072**

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2015

	Note(s)	**2015 R'000**	2014 R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		**114 351**	105 806
Grants		**4 856**	4 935
Interest income		**2 209**	1 965
		121 416	112 706
Payments			
Employee costs		**(77 108)**	(69 667)
Suppliers		**(41 299)**	(42 970)
		(118 407)	(112 637)
Net cash flows from operating activities	19	**3 009**	69
Cash flows from investing activities			
Purchase of property, plant and equipment	5	**(6 959)**	(1 772)
Proceeds from sale of property, plant and equipment	5	**33**	73
Purchase of intangible assets	6	**(653)**	(185)
Proceeds from sale of intangible assets	6	**(1)**	–
Net cash flows from investing activities		**(7 580)**	(1 884)
Net increase/(decrease) in cash and cash equivalents		**(4 571)**	(1 815)
Cash and cash equivalents at the beginning of the year		**15 086**	16 901
Cash and cash equivalents at the end of the year	4	**10 515**	15 086

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2015

Budget on Cash Basis

	Approved budget R '000	Adjustment R '000	Final Budget R '000	Actual amounts on comparable basis R '000	Difference between final budget and actual R '000	Note
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees	5 500	–	5 500	5 612	112	
Appeal fees	24	–	24	26	2	
Interest received	2 286	–	2 286	2 209	(77)	
Legal fees recovered	830	–	830	1 153	323	1
Levies income	107 841	–	107 841	107 841	–	
Registration fees	380	–	380	336	(44)	
Sundry income	83	–	83	271	188	2
Total revenue from exchange transactions	**116 944**	**–**	**116 944**	**117 448**	**504**	
Revenue from non-exchange transactions						
Government transfers: Department of Health	4 751	–	4 751	4 751	–	
Mandatory transfer: Department of Higher Education & Training	40	–	40	105	65	
Total revenue from non-exchange transactions	**4 791**	**–**	**4 791**	**4 856**	**65**	
Total revenue	**121 735**	**–**	**121 735**	**122 304**	**569**	
Expenditure						
Personnel	(80 743)	–	(80 743)	(77 108)	3 635	3
Depreciation and amortisation	(3 321)	–	(3 321)	(3 772)	(451)	
Loss on disposal of assets	–	–	–	(25)	(25)	
General expenses	(10 778)	–	(10 778)	(9 970)	808	
Legal fees	(8 024)	–	(8 024)	(7 699)	325	
Rent	(7 372)	–	(7 372)	(9 542)	(2 170)	4
Council members' fees	(1 896)	–	(1 896)	(1 430)	466	
Consulting	(3 599)	–	(3 599)	(4 220)	(621)	
Auditors' remuneration	(1 622)	–	(1 622)	(1 897)	(275)	
Forensic investigation	(6 000)	–	(6 000)	(7 257)	(1 257)	5
Telecommunication expenses	(2 701)	–	(2 701)	(2 459)	242	
Total expenditure	**(126 056)**	**–**	**(126 056)**	**(125 379)**	**677**	
Surplus for the year	**(4 321)**	**–**	**(4 321)**	**(3 075)**	**1 246**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2015

Budget on Cash Basis

	Approved budget R'000	Adjustment R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Note
Statement of financial position						
Assets						
Non-current assets						
Property, plant and equipment	7 094	–	7 094	6 956	(138)	
Intangible assets	70	–	70	653	583	
	7 164	**–**	**7 164**	**7 609**	**445**	
Total assets	**7 164**	**–**	**7 164**	**7 609**	**445**	6
Liabilities						
Non-Current Liabilities						
Operating lease liability	–	–	–	2 574	2 574	7
Total liabilities	**–**	**–**	**–**	**2 574**	**2 574**	
Net assets	**7 164**	**–**	**7 164**	**5 035**	**(2 129)**	
Net assets						
Net assets attributable to owners of controlling entity						
Reserves						
Accumulated surplus	7 164	–	7 164	5 035	(2 129)	8

Note

1. *38.9% Over-collection on legal fees recovered was due to timing of the income being unknown. Only after receiving the Tax Master's account can income be reliably estimated.*
2. *226.5% Over-collection on sundry income was due to the hosting of an accredited trustee workshop for which medical schemes paid for the trustees to attend.*
3. *4.5% Under-expenditure on personnel was due to the delay in filling of new positions, as well as resignations during the year.*
4. *29.4% Over-expenditure on rent was due to the straight line of the lease over the term of the lease agreement.*
5. *20.9% Over-expenditure on the forensic investigation was due to the extent and duration of the investigation.*
6. *6.2% Over-expenditure on the capital budget was due to the capitalisation of the workflow system being utilised in the current year.*
7. *100.00% Over-expenditure on the operating lease liability was due to inadequate budgeting for the line item.*
8. *29.7% Overall under-expenditure of surplus funds allocated to the current year's budget was due to saving, as well as additional income.*

1. Presentation of Annual Financial Statements

The annual financial statements have been prepared in accordance with the Standards of Generally Recognised Accounting Practice (GRAP), issued by the Accounting Standards Board in accordance with Section 55 of the Public Finance Management Act (Act 1 of 1999).

These annual financial statements have been prepared on an accrual basis of accounting and are in accordance with historical cost convention as the basis of measurement, unless specified otherwise.

In the absence of an issued and effective Standard of GRAP, accounting policies for material transactions, events or conditions were developed in accordance with paragraphs 8, 10 and 11 of GRAP 3 as read with Directive 5.

Assets, liabilities, revenues and expenses were not offset, except where offsetting is either required or permitted by a Standard of GRAP.

The principal accounting policies applied in the preparation of these annual financial statements are set out below. These accounting policies are consistent with those applied in the preparation of the prior year annual financial statements, unless specified otherwise.

1.1 Presentation currency

These annual financial statements are presented in South African Rand, which is the functional currency of the entity.

1.2 Going concern assumption

These annual financial statements have been prepared based on the expectation that the entity will continue to operate as a going concern for at least the next 12 months.

1.3 Comparative figures

Budget information, in accordance with GRAP 1 and 24, has been provided in a separate disclosure note to these annual financial statements.

When the presentation or classification of items in the annual financial statements is amended, prior period comparative amounts are also reclassified and restated, unless such comparative reclassification and/or restatement is not required by a Standard of GRAP. The nature and reason for such reclassifications and restatements are also disclosed.

Where material accounting errors, which relate to prior periods, have been identified in the current year, the correction is made retrospectively as far as is practicable and the prior year comparatives are restated accordingly. Where there has been a change in accounting policy in the current year, the adjustment is made retrospectively as far as is practicable and the prior year comparatives are restated accordingly.

The presentation and classification of items in the current year is consistent with prior periods.

1.4 Significant judgments and sources of estimation uncertainty

The use of judgment, estimates and assumptions is inherent to the process of preparing annual financial statements. These judgments, estimates and assumptions affect the amounts presented in the annual financial statements. Uncertainties about these estimates and assumptions could result in outcomes that require a material adjustment to the carrying amount of the relevant asset or liability in future periods.

In the process of applying these accounting policies, management has made the following judgments that may have a significant effect on the amounts recognised in the financial statements.

Estimates are informed by historical experience, information currently available to management, assumptions, and other factors that are believed to be reasonable under the circumstances. These estimates are reviewed on a regular basis. Changes in estimates that are not due to errors are processed in the period of the review and applied prospectively.

In the process of applying the entity's accounting policies the following estimates, were made:

Provisions

Provisions are measured as the present value of the estimated future outflows required to settle the obligation. In the process of determining the best estimate of the amounts that will be required in future to settle the provision, management considers the weighted average probability of the potential outcomes of the provisions raised. This measurement entails determining what the different potential outcomes are for a provision as well as the financial impact of each of those potential outcomes. Management then assigns a weighting factor to each of these outcomes based on the probability that the outcome will materialise in future. The factor is then applied to each of the potential outcomes and the factored outcomes are then added together to arrive at the weighted average value of the provisions.

Additional disclosure of these estimates of provisions is included in note 8 – Provisions.

Depreciation and amortisation

Depreciation and amortisation recognised on property, plant and equipment and intangible assets are determined with reference to the useful lives and residual values of the underlying items. The useful lives of assets are based on management's estimation of the asset's condition, expected condition at the end of the period of use, its current use, expected future use and the entity's expectations about the availability of finance to replace the asset at the end of its useful life. In evaluating the condition and use of the asset, which informs the useful life, management considers the impact of technology and minimum service requirements of the asset.

Effective interest rate

The entity uses an appropriate interest rate, taking into account guidance provided in the standards, and applying professional judgment to the specific circumstances, to discount future cash

flows. The entity used the prime interest rate to discount future cash flows.

Impairment testing

In testing for and determining the value-in-use of non-financial assets, management is required to rely on the use of estimates about the asset's ability to continue to generate cash flows (in the case of cash-generating assets). For non-cash-generating assets, estimates are made regarding the depreciated replacement cost, restoration cost, or service units of the asset, depending on the nature of the impairment and the availability of information.

1.5 Financial instruments

Initial recognition

The entity recognises a financial asset or a financial liability in its Statement of Financial Position when, and only when, the entity becomes a party to the contractual provisions of the instrument. This is achieved through the application of trade date accounting.

Upon initial recognition, the entity classifies financial instruments or their component parts as a financial liabilities, financial assets or residual interests in conformity with the substance of the contractual arrangement and to the extent that the instrument satisfies the definitions of a financial liability, a financial asset or a residual interest.

Initial measurement

When a financial instrument is recognised, the entity measures it initially at its fair value plus (in the case of a financial asset or a financial liability not subsequently measured at fair value), transaction costs that are directly attributable to the acquisition or issue of the financial asset or financial liability.

Subsequent measurement

The entity measures all financial assets and financial liabilities after initial recognition using the following categories:

- Financial instruments at fair value.
- Financial instruments at amortised cost.
- Financial instruments at cost.

All financial assets measured at amortised cost, or cost, are subject to an impairment review.

Financial instruments at fair value comprise financial assets or financial liabilities that are:

- Derivatives.
- Combined instruments that are designated at fair value.
- Instruments held for trading. A financial instrument is held for trading if:
  - It is acquired or incurred principally for the purpose of selling or repurchasing it in the near-term.
  - On initial recognition, it is part of a portfolio of identified financial instruments that are managed together and for which there is evidence of a recent actual pattern of short term profit-taking.
  - Non-derivative financial assets or financial liabilities with fixed or determinable payments that are designated at fair value at initial recognition.
  - Financial instruments that do not meet the definition of financial instruments at amortised cost or financial instruments at cost.

Financial instruments at amortised cost are non-derivative financial assets or non-derivative financial liabilities that have fixed or determinable payments, excluding those instruments that the entity designates at fair value at initial recognition or are held for trading.

Financial instruments at cost are investments in residual interests that do not have a quoted market price in an active market, and whose fair value cannot be reliably measured.

The entity assesses which instruments should be subsequently measured at fair value, amortised cost or cost, based on the definitions of financial instruments at fair value, financial instruments at amortised cost or financial instruments at cost as set out above.

Gains and losses

A gain or loss arising from a change in the fair value of a financial asset or financial liability measured at fair value is recognised in surplus or deficit.

For financial assets and financial liabilities measured at amortised cost or cost, a gain or loss is recognised in surplus or deficit when the financial asset or financial liability is derecognised or impaired, or through the amortisation process.

Impairment

All financial assets measured at amortised cost, or cost, are subject to an impairment review. The entity assesses at the end of each reporting period whether there is any objective evidence that a financial asset or group of financial assets is impaired.

Financial assets measured at amortised cost:
If there is objective evidence that an impairment loss on financial assets measured at amortised cost has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows (excluding future credit losses that have not been incurred) discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced directly OR through the use of an allowance account. The amount of the loss is recognised in surplus or deficit.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed directly OR by adjusting an allowance account. The reversal does not result in a carrying amount of the financial asset that exceeds what the amortised cost would have been had the impairment not been recognised at the date the impairment is reversed. The amount of the reversal is recognised in surplus or deficit.

Financial assets measured at cost:
If there is objective evidence that an impairment loss has been incurred on an investment in a residual interest that is not measured at fair value because its fair value cannot be measured reliably, the amount of the impairment loss is measured as the difference between the carrying amount of the financial asset and the present value of estimated future cash flows discounted at the current market rate of return for a similar financial asset. Such impairment losses are not reversed.

Derecognition

Financial assets

A financial asset is derecognised at trade date, when:

a) The cash flows from the asset expire, are settled or waived.
b) Significant risks and rewards are transferred to another party.
c) Despite having retained significant risks and rewards, the entity has transferred control of the asset to another entity.

Financial liabilities

A financial liability is derecognised when the obligation is extinguished. Exchanges of debt instruments between a borrower and a lender are treated as the extinguishment of an existing liability and the recognition of a new financial liability. Where the terms of an existing financial liability are modified, it is also treated as the extinguishment of an existing liability and the recognition of a new liability.

Policies relating to specific financial instruments

Investments

Investments, which include fixed deposits and short-term deposits invested in registered commercial banks, are categorised as financial instruments at amortised cost and are subsequently measured at amortised cost.

Where investments have been impaired, the carrying value is adjusted by the impairment loss, which is recognised as an expense in the period that the impairment is identified.

On disposal of an investment, the difference between the net disposal proceeds and the carrying amount is charged or credited to the Statement of Financial Performance.

Cash and cash equivalents

Cash and cash equivalents are measured at amortised cost. Cash includes cash on hand and cash with banks. Cash equivalents are short-term highly liquid investments that are held with registered banking institutions with maturities of three months or less and are subject to an insignificant risk of change in value.

For the purposes of the Cash Flow Statement, cash and cash equivalents comprise cash on hand and deposits held on call with banks.

Trade and other receivables

Trade and other receivables are initially recognised at fair value plus transaction costs that are directly attributable to the acquisition and subsequently stated at amortised cost, less provision for impairment. All trade and other receivables are assessed at least annually for possible impairment. Impairments of trade and other receivables are determined in accordance with the accounting policy for impairments. Impairment adjustments are made through the use of an allowance account.

Bad debts are written off in the year in which they are identified as irrecoverable. Amounts receivable within 12 months from the reporting date are classified as current.

Trade payables

Trade payables are initially measured at fair value plus transaction costs that are directly attributable to the acquisition and are subsequently measured at amortised cost using the effective interest rate method.

1.6 Property, plant and equipment

Initial recognition and measurement

Property, plant and equipment are tangible non-current assets (including infrastructure assets) that are held for use in the production or supply of goods or services, rental to others, or for administrative purposes, and are expected to be used during more than one year.

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 entity.
- The cost of the item can be measured reliably.

Items of property, plant and equipment are initially recognised as assets on acquisition date and are initially recorded at cost where acquired through exchange transactions. However, when items of property, plant and equipment are acquired through non-exchange transactions, those items are initially measured at their fair values as at the date of acquisition.

The cost of an item of property, plant and equipment is the purchase price and other costs attributable to bring 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.

Where an asset is acquired through a non-exchange transaction, its cost is its fair value as at date of acquisition. Where an item of property, plant and equipment is acquired in exchange for a non-monetary asset or monetary assets, or a combination of monetary and non-monetary assets, the asset acquired is initially measured at fair value (the cost). If the acquired item's fair value was not determinable, deemed cost is the carrying amount of the asset(s) given up.

When significant components of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment. These major components are depreciated separately over their useful lives.

Subsequent to initial recognition, items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses.

Depreciation

Property, plant and equipment are depreciated on the straight line basis over their expected useful lives to their estimated residual value.

Property, plant and equipment are carried at cost less accumulated depreciation and any impairment losses. The useful lives of items of property, plant and equipment have been assessed as follows:

Item	Average useful life
Furniture and fittings	14 years
Motor vehicles	5 years
Computer equipment	7 years
Computer software	7 years
Leasehold improvements	10 years
Other fixed assets	16 years

Impairments

The entity tests for impairment where there is an indication that an asset may be impaired. An assessment of whether there is an indication of possible impairment is done at each reporting date. Where the carrying amount of an item of property, plant and equipment is greater than the estimated recoverable amount (or recoverable service amount), it is written down immediately to its recoverable amount (or recoverable service amount) and an impairment loss is charged to the Statement of Financial Performance.

Reviewing the useful life of an asset on an annual basis does not require the entity to amend the previous estimate unless expectations differ from the previous estimate.

An impairment is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined had no impairment been recognised. A reversal of the impairment is recognised in the Statement of Financial Performance.

Derecognition

Items of property, plant and equipment are derecognised when the asset is disposed of or when there are no further economic benefits or service potential expected from the use of the asset. The gain or loss arising on the disposal or retirement of an item of property, plant and equipment is determined as the difference between the sales proceeds and the carrying value and is recognised in the Statement of Financial Performance.

1.7 Intangible assets

Initial recognition and measurement

An intangible asset is an identifiable non-monetary asset without physical substance. The entity recognises an intangible asset in its Statement of Financial Position only when it is probable that the expected future economic benefits or service potential that are attributable to the asset will flow to the entity and the cost or fair value of the asset can be measured reliably.

Internally generated intangible assets are subject to strict recognition criteria before they are capitalised. Research expenditure is never capitalised, while development expenditure is only capitalised to the extent that:

- The entity intends to complete the intangible asset for use or sale.
- It is technically feasible to complete the intangible asset.
- The entity has the resources to complete the project.
- It is probable that the entity will receive future economic benefits or service potential.
- The entity has the ability to measure reliably the expenditure during development.

Intangible assets are initially recognised at cost.

Where an intangible asset is acquired by the entity for no or nominal consideration (that is, a non-exchange transaction), the cost is deemed to be equal to the fair value of that asset on the date acquired.

Where an intangible asset is acquired in exchange for a non-monetary asset or monetary assets or a combination of monetary and non-monetary assets, the asset acquired is initially measured at fair value (the cost). If the acquired item's fair value is not determinable, its deemed cost is the carrying amount of the asset(s) given up.

The cost of an intangible asset is amortised over the useful life where that useful life is finite. The amortisation expense on intangible assets with finite lives is recognised in the Statement of Financial Performance in the expense category consistent with the function of the intangible asset.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually, either individually or at the cash-generating unit level. The assessment of indefinite life is reviewed annually to determine whether the indefinite life assumption continues to be supportable. If not, the change in useful life from indefinite to finite is made on a prospective basis.

Following initial recognition of the development expenditure as an asset, the cost model is applied requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses. Amortisation of the asset begins when development is complete and the asset is available for use. It is amortised over the period of expected future benefit. Amortisation is recorded in Statement of Financial Performance in the expense category consistent with the function of the intangible asset. During the period of development, the asset is tested for impairment annually.

Amortisation and impairment

Amortisation is charged to write off the cost of intangible assets over their estimated useful lives using the straight-line method.

Item	Useful life
Developed software	7 years
Acquired software	7 years

The amortisation period, the amortisation method and residual value for intangible assets with finite useful lives are reviewed at each reporting date and any changes are recognised as a change in accounting estimate in the Statement of Financial Performance.

Impairments

The entity tests intangible assets with finite useful lives for impairment where there is an indication that an asset may be impaired. An assessment of whether there is an indication of possible impairment is performed at each reporting date. Where the carrying amount of an item of an intangible asset is greater than the estimated recoverable amount (or recoverable service amount), it is written down immediately to its recoverable amount (or recoverable service amount) and an impairment loss is charged to the Statement of Financial Performance.

Derecognition

Intangible assets are derecognised when the asset is disposed of or when there are no further economic benefits or service potential expected from the asset. The gain or loss arising on the disposal or retirement of an intangible asset is determined as the difference between the sales proceeds and the carrying value and is recognised in the Statement of Financial Performance.

1.8 Impairment of non-financial assets

Recognition

The entity assesses at each reporting date whether there is an indication that an asset may be impaired. Where the carrying amount of an asset exceeds its recoverable amount (or recoverable service amount in the case of non-cash-generating assets), the asset is considered impaired and is written down to its recoverable amount (or recoverable service amount). An assets recoverable amount (or recoverable service amount) is the higher of the fair value less costs to sell, and the value-in-use of the asset.

Measurement

An asset's recoverable amount (or recoverable service amount) is the higher of an asset's or cash-generating unit's fair value less costs to sell and its value-in-use. This recoverable amount (or recoverable service amount) is determined for individual assets, unless those individual assets are part of a larger cash-generating unit, in which case the recoverable amount (or recoverable service amount) is determined for the whole cash generating unit.

An asset is part of a cash-generating unit where that asset does not generate cash inflows that are largely independent of those from other assets or group of assets.

In determining the recoverable amount (or recoverable service amount) of an asset the entity evaluates the assets to determine whether the assets are cash-generating assets or non-cash-generating assets.

For cash-generating assets the value in use is determined as a function of the discounted future cash flows from the asset.

Where the asset is a non-cash-generating asset the value in use is determined through one of the following approaches:

- Depreciated replacement cost approach: The current replacement cost of the asset is used as the basis for this value. This current replacement cost is depreciated for a period equal to the period that the asset has been in use so that the final depreciated replacement cost is representative of the age of the asset.
- Restoration cost approach: Under this approach, the present value of the remaining service potential of the asset is determined by subtracting the estimated restoration cost of the asset from the current cost of replacing the remaining service potential of the asset before impairment.
- Service units approach: The present value of the remaining service potential of the asset is determined by reducing the current cost of the remaining service potential of the asset before impairment, to conform with the reduced number of service units expected from the asset in its impaired state.

The decision as to which approach to use is dependent on the nature of the identified impairment.

In assessing value-in-use for cash-generating assets, the estimated future cash flows are discounted to their present value using a discount rate that reflects current market assessments of the time value of money and the risks specific to the asset. In determining fair value less costs to sell, other fair value indicators are used.

Impairment losses of continuing operations are recognised in the Statement of Financial Performance in those expense categories consistent with the function of the impaired asset.

An assessment is made at each reporting date as to whether there is any indication that previously recognised impairment losses may no longer exist or may have decreased. If such indication exists, the entity makes an estimate of the assets or cash-generating unit's recoverable amount.

Reversal of impairment losses

A previously recognised impairment loss is reversed only if there has been a change in the assumptions used to determine the asset's recoverable amount since the last impairment loss was recognised. The reversal is limited so that the carrying amount of the asset does not exceed its recoverable amount, nor exceed the carrying amount that would have been determined, net of depreciation, had no impairment loss been recognised for the asset in prior years. Such reversal is recognised in the Statement of Financial Performance unless the asset is carried at a revalued amount, in which case the reversal is treated as a revaluation increase.

Identification

When the carrying amount of a non-cash-generating asset exceeds its recoverable service amount, it is impaired.

The entity 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 entity estimates the recoverable service amount of the asset.

Irrespective of whether there is any indication of impairment, the entity also test 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 was tested for impairment before the end of the current reporting period.

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.

Any impairment loss of a revalued non-cash-generating asset is treated as a revaluation decrease. When the amount estimated for an impairment loss is greater than the carrying amount of the non-cash-generating asset to which it relates, the entity recognises a liability only to the extent that is a requirement in the Standards of GRAP.

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 non-cash-generating asset's revised carrying amount, less its residual value (if any), on a systematic basis over its remaining useful life.

Reversal of an impairment loss

The entity 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 entity 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 asset's recoverable service amount 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.

Any reversal of an impairment loss of a revalued non-cash-generating asset is treated as a revaluation increase.

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 non-cash-generating asset's revised carrying amount, less its residual value (if any), on a systematic basis over its remaining useful life.

1.9 Employee benefits

Short term employee benefits

Short-term employee benefits encompass all those benefits that become payable in the short term, that is within a financial year or within 12 months after the financial year. Therefore, short-term employee benefits include remuneration, compensated absences and bonuses.

Short-term employee benefits are recognised in the Statement of Financial Performance as services rendered, except for non-accumulating benefits, which are recognised when the specific event occurs. These short term employee benefits are measured at their undiscounted costs in the period the employee renders the related service or the specific event occurs.

Defined contribution plans

Contributions made towards the fund are recognised as an expense in the Statement of Financial Performance in the period that such contributions become payable. This contribution expense is measured at the undiscounted amount of the contribution paid or payable to the fund. A liability is recognised to the extent that any of the contributions have not yet been paid. Conversely an asset is recognised to the extent that any contributions have been paid in advance.

1.10 Leases

Leases are classified as finance leases where substantially all the risks and rewards associated with ownership of an asset are transferred to the entity through the lease agreement. Assets subject to finance leases are recognised in the Statement of Financial Position at the inception of the lease, as is the corresponding finance lease liability.

Assets subject to operating leases, that is those leases where substantially all of the risks and rewards of ownership are not transferred to the lessee through the lease, are not recognised in the Statement of Financial Position. The operating lease expense is recognised over the course of the lease arrangement.

The determination of whether an arrangement is, or contains, a lease is based on the substance of the arrangement at inception date; namely whether fulfillment of the arrangement is dependent on the use of a specific asset or assets or the arrangement conveys a right to use the asset.

Finance leases – lessee

Assets subject to a finance lease, as recognised in the Statement of Financial Position, are measured (at initial recognition) at the lower of the fair value of the assets and the present value of the future minimum lease payments. Subsequent to initial recognition these capitalised assets are depreciated over the contract term.

The finance lease liability recognised at initial recognition is measured at the present value of the future minimum lease payments. Subsequent to initial recognition this liability is carried at amortised cost, with the lease payments being set off against the capital and accrued interest. The allocation of the lease payments between the capital and interest portion of the liability is effected through the application of the effective interest method.

The finance charges resulting from the finance lease are expensed, through the Statement of Financial Performance, as they accrue. The finance cost accrual is determined using the effective interest method.

Any contingent rents are expensed in the period in which they are incurred.

The finance lease liabilities are derecognised when the entity's obligation to settle the liability is extinguished. The assets capitalised under the finance lease are derecognised when the entity no longer expects any economic benefits or service potential to flow from the asset.

Operating leases – lessee

The lease expense recognised for operating leases is charged to the Statement of Financial Performance on a straight-line basis over the term of the relevant lease. To the extent that the straight-lined lease payments differ from the actual lease payments the difference is recognised in the Statement of Financial Position as either lease payments in advance (operating lease asset) or lease payments payable (operating lease liability) as the case may be. This resulting asset and/or liability is measured as the undiscounted difference between the straight-line lease payments and the contractual lease payments.

The operating lease liability is derecognised when the entity's obligation to settle the liability is extinguished. The operating lease asset is derecognised when the entity no longer anticipates economic benefits to flow from the asset.

1.11 Revenue from exchange transactions

Revenue from exchange transactions refers to revenue that accrues to the entity directly in return for services rendered or goods sold, the value of which approximates the consideration received or receivable, excluding indirect taxes, rebates and discounts.

Recognition

Revenue from exchange transactions is only recognised once all of the following criteria have been satisfied:

- The entity retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.
- 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 entity and the costs incurred or to be incurred in respect of the transaction can be measured reliably.

Fair value is the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

The main sources of revenue from exchange transactions are:

- **Accreditation fees:** Accreditation fees are fixed tariffs paid by administrators, managed care organisations, and brokers, over two years. Accreditation fees are recognised in the financial period in which services are rendered.
- **Appeal fees:** Appeal fees are fixed tariffs paid by appellants when appealing to the Appeal Board. Appeal fees are recognised in the financial period in which the appeal was raised and services were rendered.
- **Levies income:** Levies are the amounts paid by medical schemes based on the number of principal members in a medical scheme during the financial period. Levies are recognised on an accrual basis in accordance with the number of principal members in the medical scheme in the period in which they fall due.
- **Registration fees:** Registration fees relate to the amounts paid by medical schemes to register or amend their rules. Registration fees are recognised in the financial period in which they fall due.
- **Sundry income:** All other income received not in the normal operations of CMS is recognised as revenue when future economic benefits flow to the CMS and these benefits can be measured reliably.

Measurement

Revenue is measured at the fair value of the consideration received or receivable, net of trade discounts and volume rebates.

1.12 Revenue from non-exchange transactions

Non-exchange transactions are transactions that are not exchange transactions.

Revenue from non-exchange transaction arises when the 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.

Revenue from non-exchange transactions is generally recognised to the extent that the related receipt or receivable qualifies for recognition as an asset and there is no liability to repay the amount.

Grants, transfers and donations received or receivable are recognised when the resources that have been transferred meet the criteria for recognition as an asset and there is not a corresponding liability in respect of related conditions.

An asset that is recognised as a result of a non-exchange transaction is recognised at its fair value at the date of the transfer. Consequently, revenue arising from a non-exchange transaction is measured at the fair value of the asset received, less the amount of any liabilities that are also recognised due to conditions that must still be satisfied.

Where there are conditions attached to a grant, transfer or donation that gave rise to a liability at initial recognition, that liability is transferred to revenue as and when the conditions attached to the grant are met.

Grants without any conditions attached are recognised as revenue in full when the asset is recognised at an amount equalling the fair value of the asset received.

1.13 Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

1.14 Translation of foreign currencies

Foreign currency transactions

Transactions in foreign currencies are initially accounted for at the rate of exchange ruling on the date of the transaction. Exchange differences arising on the settlement of creditors or on reporting of creditors at rates different from those at which they were initially recorded are expensed.

Transactions in foreign currency are accounted for at the spot rate of the exchange ruling on the date of the transaction.

Gains and losses arising on the translation are dealt with in the Statement of Financial Performance in the year in which they occur.

1.15 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 or organ of state and expenditure in the form of a grant that is not permitted. Unauthorised expenditure is accounted for as an expense in the Statement of Financial Performance and where recovered, it is subsequently accounted for as income in the Statement of Financial Performance

1.16 Irregular expenditure

Irregular expenditure as defined in section 1 of the Public Finance Management Act (PFMA) is expenditure other than unauthorised expenditure, incurred in contravention of or not in accordance with a requirement of any applicable legislation, including:

(a) This Act.

(b) The State Tender Board Act, 1968 (No 86 of 1968), or any regulations made in terms of the Act.

(c) Any provincial legislation providing for procurement procedures in that provincial government.

National Treasury Practice Note No 4 of 2008/2009 which was issued in terms of sections 76(1) to 76(4) of the PFMA requires the following (effective from 1 April 2008):

Irregular expenditure that was incurred and identified during the current financial year and which was condoned before year end and/or before finalisation of the financial statements must also be recorded appropriately in the irregular expenditure register. In such an instance, no further action is required with the exception of updating the note to the financial statements.

Irregular expenditure that was incurred and identified during the current financial year and for which condonement is being awaited at year end must be recorded in the irregular expenditure register. No further action is required with the exception of updating the note to the financial statements.

Where irregular expenditure was incurred in the previous financial year and is only condoned in the following financial year, the register and the disclosure note to the financial statements must be updated with the amount condoned.

Irregular expenditure that was incurred and identified during the current financial year and which was not condoned by the National Treasury or the relevant authority must be recorded appropriately in the irregular expenditure register. If liability for the irregular expenditure can be attributed to a person, a debt account must be created if such a person is liable in law. Immediate steps must thereafter be taken to recover the amount from the person concerned. If recovery is not possible, the accounting officer or accounting authority may write off the amount as debt impairment and disclose such in the relevant note to the financial statements. The irregular expenditure register must also be updated accordingly. If the irregular expenditure has not been condoned and no person is liable in law, the expenditure related thereto must remain against the relevant programme/expenditure item, be disclosed as such in the note to the financial statements and updated accordingly in the irregular expenditure register.

1.17 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is expenditure that was made in vain and would have been avoided had reasonable care been exercised. Fruitless and wasteful expenditure is accounted for as expenditure in the Statement of Financial Performance and where recovered, it is subsequently accounted for as revenue in the Statement of Financial Performance.

1.18 Post-reporting date events

Events after the reporting date are those events, both favourable and unfavourable, that occur between the reporting date and the date when the financial statements are authorised for issue. Two types of events can be identified:

- Those that provide evidence of conditions that existed at the reporting date (adjusting events after the reporting date).
- Those that is indicative of conditions that arose after the reporting date (non-adjusting events after the reporting date).

The entity will adjust the amounts recognised in the financial statements to reflect adjusting events after the reporting date once the event occurred.

The entity will disclose the nature of the event and an estimate of its financial effect or a statement that such estimate cannot be made in respect of all material non-adjusting events, where non-disclosure could influence the economic decisions of users taken on the basis of the financial statements.

1.19 Related parties

The entity has processes and controls in place to aid in the identification of related parties. A related party is a person or an entity with the ability to control or jointly control the other party, or exercise significant influence over the other party, or vice versa, or an entity that is subject to common control, or joint control. Related party relationships where control exists are disclosed regardless of whether any transactions took place between the parties during the reporting period.

Where transactions occurred between the entity and one or more related parties, and those transactions were not within:

- Normal supplier and/or client/recipient relationships on terms and conditions no more or less favourable than those which it is reasonable to expect the entity to have adopted if dealing with that individual entity or person in the same circumstances.
- Terms and conditions within the normal operating parameters established by the reporting entity's legal mandate;

Further details about those transactions are disclosed in the notes to the financial statements.

Only transactions with related parties not at arm's length or not in the ordinary course of business are disclosed.

1.20 Transfer of functions

Between entities under common control

Recognition

The receiving entity recognises the assets and liabilities acquired through a transfer of functions on the effective date of the transfer. All income and expenses that relate to the functions transferred are also recognised from the effective date of the transfer. The recognition of these income and expenses is governed by the accounting policies related to those specific income and expenses and accordingly this policy does not provide further guidance thereon.

Derecognition

The transferring entity derecognises the assets and liabilities on the effective date of the transfer of functions. These transferred assets and liabilities are measured at their carrying values upon derecognition. The resulting difference between the carrying value of the assets and liabilities transferred and any consideration received for the assets and liabilities transferred is recognised in accumulated surplus or deficit.

Measurement
Assets and liabilities acquired by the receiving entity through a transfer of functions, are measured at initial recognition at the carrying value that they were transferred. The difference between the carrying value of the assets and liabilities transferred and any consideration paid for the assets and liabilities transferred is recognised in accumulated surplus or deficit. The carrying value at which the assets and liabilities are initially recognised is therefore the deemed cost thereof. Subsequent measurement of these assets and liabilities will be done according to the accounting policies relevant to those assets and liabilities. Accordingly, this accounting policy does not provide additional guidance on the subsequent measurement of the transferred assets and liabilities.

Between entities that are not under common control

Recognition
The receiving entity recognises the assets and liabilities acquired through a transfer of functions on the effective date of the transfer. All income and expenses that relate to the functions transferred are also recognised from the effective date of the transfer. The recognition of these income and expenses is governed by the accounting policies related to those specific income and expenses and accordingly this policy does not provide further guidance thereon.

Derecognition
The transferring entity derecognises the assets and liabilities on the effective date of the transfer of functions. These transferred assets and liabilities are measured at their fair values upon derecognition. The resulting difference between the fair value of the assets and liabilities transferred and any consideration received for the assets and liabilities transferred is recognised in accumulated surplus or deficit.

Measurement
Assets and liabilities acquired by the receiving entity through a transfer of functions are measured at initial recognition at the fair value that they were transferred. The difference between the fair value of the assets and liabilities transferred and any consideration paid for the assets and liabilities transferred is recognised in accumulated surplus or deficit. The fair value of these assets and liabilities is therefore the deemed cost of thereof. Subsequent measurement of these assets and liabilities will be done according to the accounting policies relevant to those assets and liabilities. Accordingly, this accounting policy does not provide additional guidance on the subsequent measurement of the transferred assets and liabilities.

1.21 Budget information

Entities are typically subject to budgetary limits in the form of appropriations or budget authorisations (or equivalent) which is given effect through authorising legislation, appropriation or similar.

General purpose financial reporting by the entity shall provide information on whether resources were obtained and used in accordance with the legally adopted budget.

The approved budget is prepared on a cash basis and presented by economic classification linked to performance outcome objectives.

The approved budget covers the fiscal period from 01/04/2014 to 31/03/2015.

The annual financial statements and the budget are not on the same basis of accounting and therefore a comparison with the budgeted amounts for the reporting period have been included in the statement of comparison of budget and actual amounts.

2. New standards and interpretations

2.1 Standards and interpretations early adopted

The entity has chosen to early adopt the following standards and interpretations:

Standard/interpretation:	Effective date: Year beginning on or after	Expected impact
GRAP 20: *Related parties*	1 April 2016	The impact of the amendment is not material

2.2 Standards and interpretations issued but not yet effective

The entity has not applied the following standards and interpretations which have been published and are mandatory for the entity's accounting periods beginning on or after 01 April 2015 or later periods:

Standard/interpretation:	Effective date: Year beginning on or after	Expected impact
GRAP 108: *Statutory receivables*	1 April 2016	The impact of the amendment is not material
DIRECTIVE 11: *Changes in measurement bases following the initial adoption of Standards of GRAP*	1 April 2016	The impact of the amendment is not material

	2015 R'000	2014 R'000
3. Receivables from exchange transactions		
Accounts receivable	**100**	401
Prepaid expenses	**2 385**	2 057
Sundry debtors	**4 351**	3 169
	6 836	5 627
4. Cash and cash equivalents		
Cash and cash equivalents consist of:		
Cash on hand	**3**	6
Bank balances	**2 744**	3 277
CPD account	**7 768**	11 803
	10 515	15 086

5. Property, plant and equipment

	2015			2014		
	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Computer equipment	**8 226**	**(4 956)**	**3 270**	6 333	(3 865)	2 468
Computer software	**2 262**	**(1 750)**	**512**	1 718	(1 401)	317
Furniture and fittings	**5 101**	**(2 093)**	**3 008**	4 107	(1 696)	2 411
Leasehold improvements	**10 492**	**(1 609)**	**8 883**	7 071	(584)	6 487
Motor vehicles	**222**	**(142)**	**80**	222	(97)	125
Other fixed assets	**604**	**(341)**	**263**	571	(282)	289
Total	**26 907**	**(10 891)**	**16 016**	20 022	(7 925)	12 097

Reconciliation of property, plant and equipment – 2015

	Opening balance	Additions	Disposals	Reclassification of leasehold improvement	Depreciation	Total
Computer equipment	**2 468**	**1 927**	**(27)**	**–**	**(1 098)**	**3 270**
Computer software	**317**	**576**	**(1)**	**–**	**(380)**	**512**
Furniture and fittings	**2 411**	**1 003**	**(5)**	**–**	**(401)**	**3 008**
Leasehold improvements	**6 487**	**3 420**	**–**	**–**	**(1 024)**	**8 883**
Motor vehicles	**125**	**–**	**–**	**–**	**(45)**	**80**
Other fixed assets	**289**	**33**	**–**	**–**	**(59)**	**263**
	12 097	**6 959**	**(33)**	**–**	**(3 007)**	**16 016**

Reconciliation of property, plant and equipment – 2014

	Opening balance	Additions	Disposals	Reclassification of leasehold improvement	Depreciation	Total
Computer equipment	2 170	947	(37)	18	(630)	2 468
Computer software	674	–	(5)	–	(352)	317
Furniture and fittings	1 530	646	(126)	439	(78)	2 411
Leasehold improvements	7 421	107	–	(457)	(584)	6 487
Motor vehicles	169	–	–	–	(44)	125
Other fixed assets	322	72	(52)	–	(53)	289
	12 286	1 772	(220)	–	(1 741)	12 097

	2015			2014		
	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value

6. Intangible assets

	Cost/ Valuation 2015	Accumulated amortisation and accumulated impairment 2015	Carrying value 2015	Cost/ Valuation 2014	Accumulated amortisation and accumulated impairment 2014	Carrying value 2014
Acquired software	**3 085**	**(1 936)**	**1 149**	4 390	(3 395)	995
Developed software	**1 477**	**(1 121)**	**356**	1 571	(926)	645
Total	**4 562**	**(3 057)**	**1 505**	5 961	(4 321)	1 640

Reconciliation of intangible assets – 2015

	Opening balance	Additions	Disposals	Amortisation	Total
Acquired software	**995**	**653**	**(24)**	**(475)**	**1 149**
Developed software	**645**	**–**	**–**	**(289)**	**356**
	1 640	**653**	**(24)**	**(764)**	**1 505**

Reconciliation of intangible assets – 2014

	Opening balance	Additions	Disposals	Amortisation	Total
Acquired software	1 445	185	(23)	(612)	995
Developed software	935	–	(6)	(284)	645
	2 380	185	(29)	(896)	1 640

7. Payables from exchange transactions

	2015 R'000	2014 R'000
Accounts payable	**5 373**	5 527
Accruals	**5 309**	4 025
Accrual for leasehold improvement	**–**	270
Accrual for leave pay	**1 647**	1 440
Income received in advance	**762**	778
	13 091	12 040

Included in *Payables from exchange transactions* is an accrual for leave pay. Employees' entitlement to annual leave is recognised when it accrues to the employee. An accrual is recognised for the estimated liability for annual leave due as a result of service rendered by employees up to the reporting date.

8. Provisions

Reconciliation of provisions – 2015

	Opening balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	**1 036**	**234**	**(242)**	**–**	**1 028**
Provision for performance bonus	**120**	**–**	**–**	**(120)**	**–**
	1 156	**234**	**(242)**	**(120)**	**1 028**

Reconciliation of provisions – 2014

	Opening balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	964	376	(304)	–	1 036
Provision for performance bonus	–	120	–	–	120
	964	496	(304)	–	1 156

	2015 R'000	2014 R'000
Non-current liabilities	**896**	794
Current liabilities	**132**	362
	1 028	1 156

Employees receive long service awards in intervals of 10 years. The provision for long service award represents management's best estimate of the entity's liability at year end for current employees in service. The calculation is based on the current employee's salary factored by the number of years in service until the award falls due. This is also factored by the expectancy rate of employees being in service after 10 years, based on historic information.

The provision for performance bonus was done at year end in March 2014, with information available to management. In the current period due to reassessment the provision was reversed.

9. Operating lease liability

	2015	2014
Non-current liabilities	**(3 681)**	(1 107)
Current liabilities	**–**	–
	(3 681)	(1 107)

CMS entered into an office agreement which contains an escalation of 8.5% p.a., which resulted in the difference between the actual lease payment and the straight-lined amount.

10. Financial instruments disclosure

	At amortised cost	Total
Categories of financial instruments		
2015		
Financial assets		
Trade and other receivables from exchange transactions	**4 451**	**4 451**
Cash and cash equivalents	**10 515**	**10 515**
	14 966	**14 966**
Financial liabilities		
Trade and other payables from exchange transactions	**13 091**	**13 091**
2014		
Financial assets		
Trade and other receivables from exchange transactions	3 571	3 571
Cash and cash equivalents	15 087	15 087
	18 658	18 658
Financial liabilities		
Trade and other payables from exchange transactions	12 036	12 036

11. Revenue

	2015 R'000	2014 R'000
Accreditation fees	**5 612**	6 264
Appeal fees	**26**	2
Government transfers: Department of Health	**4 751**	4 525
Legal fees recovered	**1 153**	2 058
Levies income	**107 841**	99 177
Mandatory transfer: Department of Higher Education & Training	**105**	410
Registration fees	**336**	394
Sundry income	**271**	247
	120 095	113 077
The amounts included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	**5 612**	6 264
Appeal fees	**26**	2
Legal fees recovered	**1 153**	2 058
Levies income	**107 841**	99 177
Registration fees	**336**	394
Sundry income	**271**	247
	115 239	108 142
The amounts included in revenue arising from non-exchange transactions are as follows:		
Transfer revenue		
Government transfers: Department of Health	**4 751**	4 525
Mandatory transfer: Department of Higher Education & Training	**105**	410
	4 856	4 935

	Note(s)	2015 R'000	2014 R'000
12. Administrative expenses			
Bank charges		**46**	41
Building expenses		**1 977**	2 178
General administrative expenses		**845**	1 018
Insurance		**295**	274
Printing and stationery		**332**	297
Refreshments		**77**	178
Rent		**9 294**	6 319
Rent – operating expense		**1 393**	948
Rental – copiers		**248**	244
Security		**301**	368
Subscriptions		**122**	117
Telecommunication expenses		**2 459**	2 126
		17 389	14 108
13. Auditors' remuneration			
External audit		**803**	806
Internal audit		**1 094**	795
		1 897	1 601
14. Operating expenses			
Committee remuneration		**59**	100
Consulting		**4 220**	3 371
Council members' fees	21	**1 430**	2 317
Courier and postage		**99**	182
Exhibition costs		**87**	251
Knowledge management		**508**	527
Legal fees		**7 699**	9 549
Media and promotion		**336**	455
Printing and publication		**820**	835
Transcription services		**70**	109
Travel and subsistence		**1 843**	1 948
Venue and catering		**760**	1 569
		17 931	21 213
15. Staff costs			
Employee benefits		**1 683**	1 462
Employee wellness		**472**	480
Recruitment and relocation		**821**	1 092
Salaries		**72 056**	64 136
Staff training		**1 484**	1 770
Temporary staff		**160**	301
Temporary staff – SEP system		**288**	308
Workmen's compensation		**144**	120
		77 108	69 669
Total number of employees		**102**	98

	2015 R'000	2014 R'000

16. Forensic investigation

	2015 R'000	2014 R'000
Forensic investigation	**7 257**	–

In response to serious allegations levelled against the Registrar of CMS by the former provisional curator of Medshield, an independent forensic investigation into these allegations was instituted by Council and the Registrar was suspended.

17. Penalties waived

	2015 R'000	2014 R'000
Penalties waived	**–**	310

The Registrar imposed a penalty on a medical scheme in December 2011 for non-compliance with Regulation(8) of the Medical Schemes Act. The medical scheme finally settled the member's PMB claim on which the penalty was imposed. The Registrar decided to waive this penalty.

18. 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.

19. Cash generated from operations

	2015 R'000	2014 R'000
(Deficit)/surplus	**(3 075)**	5 328
Adjustments for:		
Depreciation and amortisation	**3 772**	2 637
Loss/(gain) on sale of assets and liabilities	**25**	176
Debt impairment	**–**	310
Movements in operating lease assets and accruals	**2 574**	1 040
Movements in provisions	**(128)**	192
Changes in working capital:		
Receivables from exchange transactions	**(1 209)**	(1 889)
Sundry debtors	**–**	(310)
Payables from exchange transactions	**1 050**	(7 415)
	3 009	69

20. Commitments

Operating leases – as lessee (expense)

20.1 Photocopier rental

	2015 R'000	2014 R'000
Minimum lease payments due		
– within one year	**120**	250
– in second to fifth year inclusive	**–**	137
	120	387

The CMS has operating leases for the rental of photocopiers up to 30 September 2015, with 0.0% escalation. The first operating lease's terms have been adjusted as the photocopiers were only delivered in October 2012 and not in August 2012 as initially agreed upon. The second operating lease was settled in the current financial period.

20.2 Office rental

	2015 R'000	2014 R'000
Minimum lease payments due		
– within one year	**7 631**	7 122
– in second to fifth year inclusive	**37 588**	34 643
– later than five years	**39 716**	50 292
	84 935	92 057

The CMS entered into a renewable 10-year lease agreement which commenced on 1 June 2013 and will terminate on 31 May 2023 and which provides for an escalation of 8.5% per annum. In conjunction with the first lease a second lease was entered into to start in June 2014 for additional space in the existing building with the same terms as the first lease agreement. The CMS also contracted to have the option to purchase the office building.

21. Related parties

Relationships

Executive authority: The Executive Authority as defined in Section 1 of the PFMA, 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 PFMA, 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.

	2015 R'000	2014 R'000
Related party transactions		
Transfer paid to/(received from) related parties		
Department of Health	**(4 751)**	(4 525)
Compensation to accounting authority/non-executive council members:		
Mr T Bailey	**235**	355
Prof BC Dumisa	**259**	293
Mr ZL Fihlani	**–**	44
Mr AK Hoosain	**118**	165
Ms H Koovertjie	**39**	–
Ms MS Mabela	**32**	–
Ms M Maboye	**27**	–
Ms MO Morata	**53**	196
Dr L Mpuntsha	**101**	171
Ms L Nevhutalu	**55**	15
Prof S Perumal	**47**	–
Mr T Phadu	**11**	109
Ms A Theophanides	**33**	125
Prof CJ van Gelderen	**113**	246
Mr J van der Walt	**35**	–
Prof Y Veriava	**159**	265
Adv CJ Weapond	**74**	282
Mr TF Zulu	**39**	51
	1 430	2 317

21. Related parties (continued)

Compensation to executive management:	Basic salary	Performance bonus	Acting allowance	Total
2015				
Chief Executive & Registrar	**2 021**	**(120)**	**–**	**1 901**
Chief Financial Officer	**1 417**	**106**	**565**	**2 088**
Chief Information Officer	**1 430**	**86**	**–**	**1 516**
General Manager: Accreditation	**1 331**	**77**	**–**	**1 408**
General Manager: Benefits Management	**1 311**	**78**	**–**	**1 389**
General Manager: Compliance and Investigation	**1 399**	**106**	**–**	**1 505**
General Manager: Financial Supervision	**1 393**	**106**	**–**	**1 499**
General Manager: Human Resources	**1 387**	**86**	**–**	**1 473**
General Manager: Legal Services	**1 458**	**106**	**–**	**1 564**
General Manager: Research & Monitoring	**1 162**	**87**	**–**	**1 249**
General Manager: Stakeholder Relations	**1 233**	**92**	**–**	**1 325**
Senior Strategist – resigned 31/10/2014	**855**	**–**	**–**	**855**
Senior Manager: Complaints Adjudication	**1 066**	**65**	**–**	**1 131**
	17 463	**875**	**565**	**18 903**

Compensation to executive management:	Basic salary	Performance bonus	Long service award	Total
2014				
Chief Executive & Registrar	1 818	120	–	1 938
Chief Financial Officer	1 354	85	–	1 439
Chief Information Officer	1 294	69	–	1 363
General Manager: Accreditation	1 302	–	–	1 302
General Manager: Benefits Management	1 206	70	–	1 276
General Manager: Compliance and Investigation	1 306	77	–	1 383
General Manager: Financial Supervision	1 326	77	–	1 403
General Manager: Human Resources	1 341	78	109	1 528
General Manager: Legal Services	1 328	85	–	1 413
Acting General Manager: Research & Monitoring – replaced 30/09/2013	436	–	–	436
Acting General Manager: Research & Monitoring – appointed 01/10/2013	596	54	–	650
General Manager: Stakeholder Relations	1 176	61	–	1 237
Senior Strategist – resigned 31/07/2013	468	–	–	468
Senior Strategist – appointed 01/12/2013	372	–	–	372
Senior Manager: Complaints Adjudication	982	58	–	1 040
	16 305	834	109	17 248

Compensation to executive management includes gross remuneration as well as all company contribution, including leave accrual.

A performance bonus provision was made at year end in March 2014, with information available to management. In the current period due to reassessment the provision was reversed.

22. Contingencies

Contingent assets

The CMS won court cases against the following parties:

- Medshield – Curatorship application
- Medshield – Upliftment of curatorship
- Sizwe – Removal of curator
- Sizwe – Upliftment of curatorship
- Genesis vs CMS and du Toit
- Genesis vs CMS and Joubert

The CMS as the successful party in these cases, was awarded costs on the party and party scale. The bills of costs relating to these matters have 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. Risk management

Financial risk management

The entity's activities expose it to a variety of financial risks: liquidity risk, credit risk and market risk (including cash flow interest rate risk).

Liquidity risk

The entity's risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account.

Credit risk

Credit risk consists mainly of cash deposits, cash equivalents and trade debtors. The entity only deposits cash with major banks with high quality credit standing and limits exposure to any one counter-party.

Trade receivables comprise a widespread customer base. Management evaluated credit risk relating to customers on an ongoing basis.

Market risk:

Interest rate risk

The entity invests surplus funds in the CPD account. The interest rates on this account fluctuate in line with movements in money market rates.

24. Irregular expenditure

	2015 R'000	2014 R'000
Opening balance	**6 516**	3 826
Current year	**8 436**	1 416
Prior years	**–**	1 274
Less: Amounts not recoverable (not condoned)	**(6 516)**	–
	8 436	6 516
Analysis of expenditure awaiting condonation per age classification		
Current year	**8 436**	1 416
Prior years	**–**	5 100
	8 436	6 516

24. Irregular expenditure (continued)

Details of irregular expenditure

Incident	Disciplinary steps taken/criminal proceedings	2015 R'000	2014 R'000
Bid awarded without following correct procedures	Application for condonation to be made to National Treasury	**1 094**	795
Quotations accepted based on lowest price instead of on points scored	Not recoverable (not condoned)/written off by Council	**–**	206
Three quotes not obtained	Not recoverable (not condoned)/written off by Council	**32**	415
Non-compliance to cost containment measures	Under investigation	**3**	–
Deviations incorrectly approved	Under investigation	**7 056**	–
Request for quotation incomplete	Under investigation	**251**	–
		8 436	1 416

In the prior financial year, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not awarding the contract to the tenderer who scored the highest points. The expenditure in each subsequent financial year will also be classified as irregular expenditure.

In the prior financial year, 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.

In the prior financial year CMS incurred irregular expenditure for staff training and temporary staffing without following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/2008. In the current year two transactions relating to staff training to the value of R31 863 were identified.

In the current year, non-compliance to National Treasury Instruction 01 of 2013/2014 regarding Cost Containment Measures, relating to catering and events was identified that and has been classified as irregular expenditure.

In the current year, CMS incurred irregular expenditure that it had acquired services without going through a competitive quotation process or without going through a competitive bidding process to appoint a service provider. However, the reasons for the deviation were recorded and approved by the Acting Chief Executive & Registrar for the quotations, and the deviation for the bidding process were recorded and approved by the Council. In both instances, the reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/08 of National Treasury, which allows for deviation from a competitive quotation and bidding process.

Also in the current financial year, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not indicating the weighting of the criterion used to evaluate functionality on a request for quotation.

	2015 R'000	2014 R'000
Details of irregular expenditure not recoverable (not condoned)		
Incident		
Approval to deviate from SCM processes not obtained	**636**	–
Bid awarded without following correct procedures	**795**	–
Deviations incorrectly approved	**3 759**	–
Quotations accepted based on lowest price instead of on points scored	**503**	–
Three quotes not obtained	**822**	–
	6 516	–

An unsuccessful application for condonation was made to National Treasury during the year under review. An internal analysis was concluded and revealed that no official was liable in law for the irregular expenditure. The Council consented to the de-recognition of the irregular expenditure as per National Treasury's Guideline on Irregular Expenditure.

	2015 R'000	2014 R'000
25. Reconciliation between budget and statement of financial performance		
Reconciliation of budget surplus/deficit with the surplus/deficit in the statement of financial performance:		
Net (deficit)/surplus per the statement of financial performance	**(3 075)**	5 328
Adjusted for:		
Impairments recognised/reversed	**–**	310
(Gain)/loss on the sale of assets	**25**	176
(Over)/under collection of revenue	**(569)**	(3 468)
Over/(under) budget expenditure	**(702)**	(2 087)
Net (deficit)/surplus per approved budget	**(4 321)**	259

26. Budget differences

Differences between budget and actual amounts basis of preparation and presentation
The budget and the accounting bases differ. The annual financial statements are prepared on the accrual basis using a classification based on the nature of expenses in the statement of financial performance. The annual financial statements differ from the budget, which is approved on the cash basis.

THE MEDICAL SCHEMES INDUSTRY IN 2014

CHAPTER 2: THE MEDICAL SCHEMES INDUSTRY IN 2014

The CMS has completed a project to redesign and enhance the system it uses to collect healthcare utilisation data. The purpose of the project was to improve the quality of data submitted by medical schemes as well as reduce the burden to schemes that the manual submission process represented.

The new data collection system will ensure that healthcare utilisation measures in the Annual Statutory Returns (ASR) on healthcare utilisation are adequately defined and are not open to varying interpretations by medical schemes. In order to accommodate all administration systems, the guidelines and specification documents are deliberately targeted at the "lowest common denominator". The standards in the specification documents will gradually be raised to allow for the collection of healthcare indicators that are currently not available from all medical schemes. The updated guidelines and specification documents are not meant to change the definitions of healthcare utilisation indicators, but to strengthen these definitions and improve consistency.

The data reported in this chapter constitute the first batch collected by means of the Annual Statutory Returns Healthcare Utilisation System, which was well received by medical schemes and administrators. The CMS will continue to work on improving the system and will consult schemes and administrators in this process. Furthermore, the CMS will engage with medical schemes that submit poor quality ASR data.

Gross benefits paid (benefits paid from the risk pool plus savings) reported in the utilisation section of this report (pages 156 to 158 and annexures D to H) differ from gross benefits reported in the financial statutory returns section. This is a result of definitional issues, treatment of payment reversals and the time of the actual data extraction. In the financial statutory returns, payment reversals are deducted from the reported totals due to accounting principles.

Number of schemes and benefit options

The downward trend in the total number of medical schemes that has been noted for several years continued in 2014. In December 2014, there were 83 medical schemes registered in South Africa, compared to 87 at the end of 2013. The number of open schemes decreased by one, to 23 schemes, and the number of restricted schemes declined by three, to 60 schemes. The decline in the number of schemes is illustrated in Figure 11 below.

Figure 11: Number of schemes 2005 – 2014

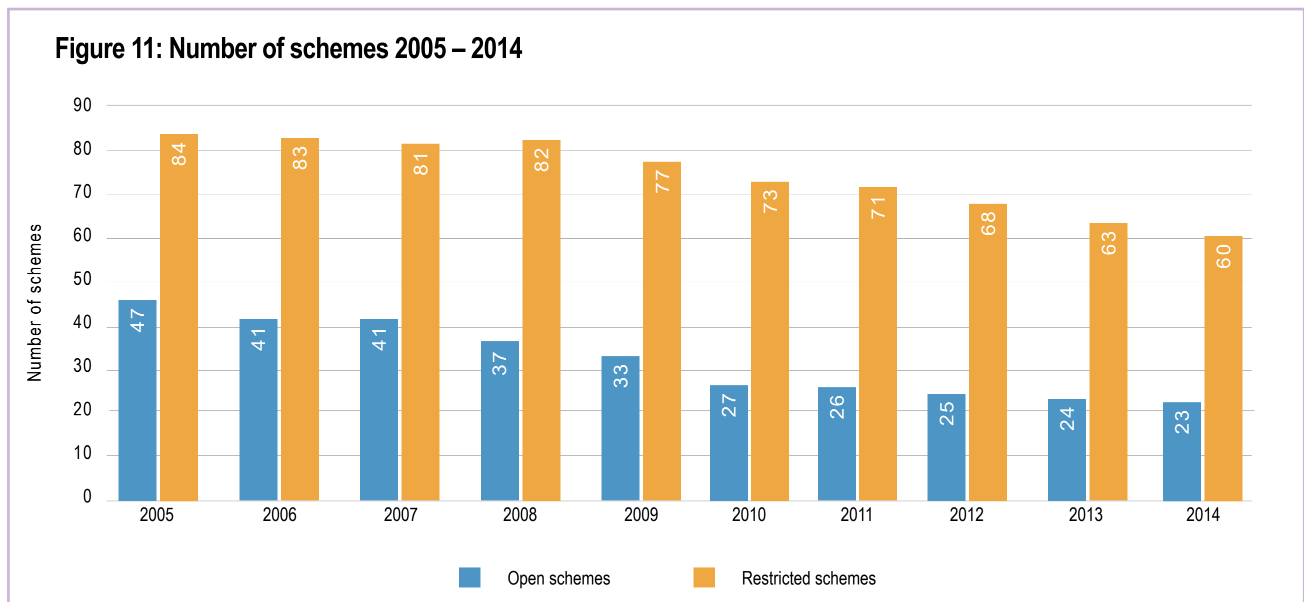


Table 26: Number of schemes by size and type as at 31 December 2013 and 2014

Type of scheme	Size	2013	2014
Open schemes	Very large	3	4
	Large	9	7
	Medium	5	6
	Small	7	6
Restricted schemes	Very large	2	2
	Large	6	7
	Medium	24	21
	Small	31	30
All schemes	**Very large**	**5**	**6**
	Large	**15**	**14**
	Medium	**29**	**27**
	Small	**38**	**36**
	Total	**87**	**83**

Very large = > 220 000 beneficiaries
Large => 65 000 beneficiaries, but < 220 000 beneficiaries
Medium = > 15 000 beneficiaries but < 65 000 beneficiaries
Small < 15 000 beneficiaries

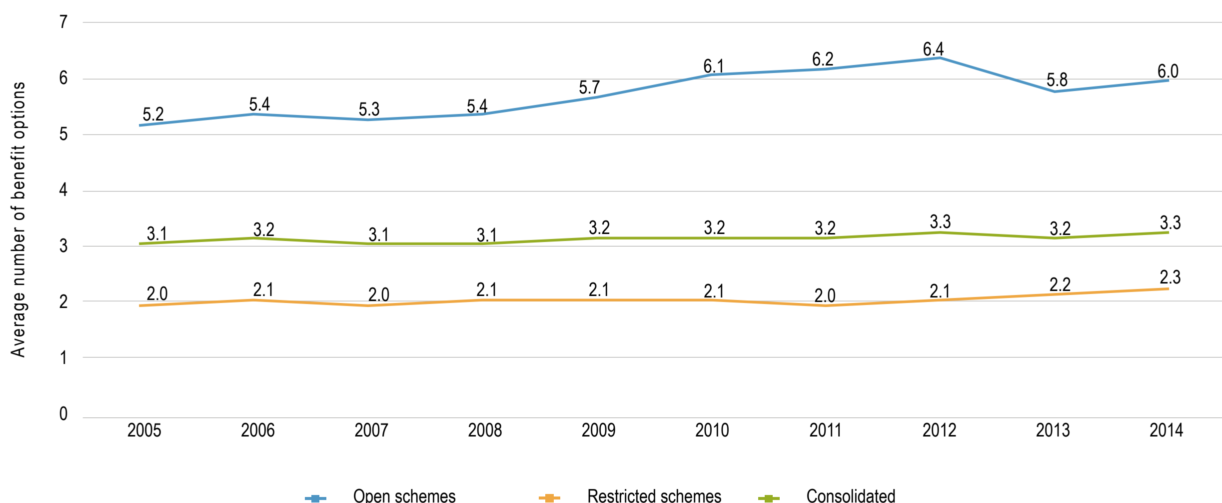
Amalgamation of schemes

One open scheme, Pharos Medical Plan, amalgamated with Topmed Medical Scheme while three restricted schemes, Altron Medical Aid Scheme, Afrox Medical Scheme and PG Bison Medical Aid Society, amalgamated with Discovery Health Medical Scheme (DHMS).

Trend in average number of options

Open medical schemes had, on average, six benefit options per scheme in 2014, compared to approximately two benefit options for restricted schemes. For the industry as a whole the average number of benefit options was about three. Over time there has been a slight increase in the average number of benefit options for open schemes. The difference between open and restricted schemes is probably a result of competition in the open medical schemes market.

Figure 12: Average number of options 2005 – 2014



Membership

Membership of medical schemes

There was a year-on-year increase of 0.4% in the total number of medical scheme beneficiaries, from 8.78 million in December 2013 to 8.81 million in December 2014. This increase of 0.4% confirms a steady slowing in the annual growth of medical schemes beneficiaries, from a peak of 5.3% in 2008, down to 2.5% in 2011 and only 1.1% in 2013.

The total number of beneficiaries of restricted schemes showed negative growth of 0.4% compared to a 1.1% increase in the beneficiaries of open schemes.

Table 27: Membership of schemes 2013 and 2014

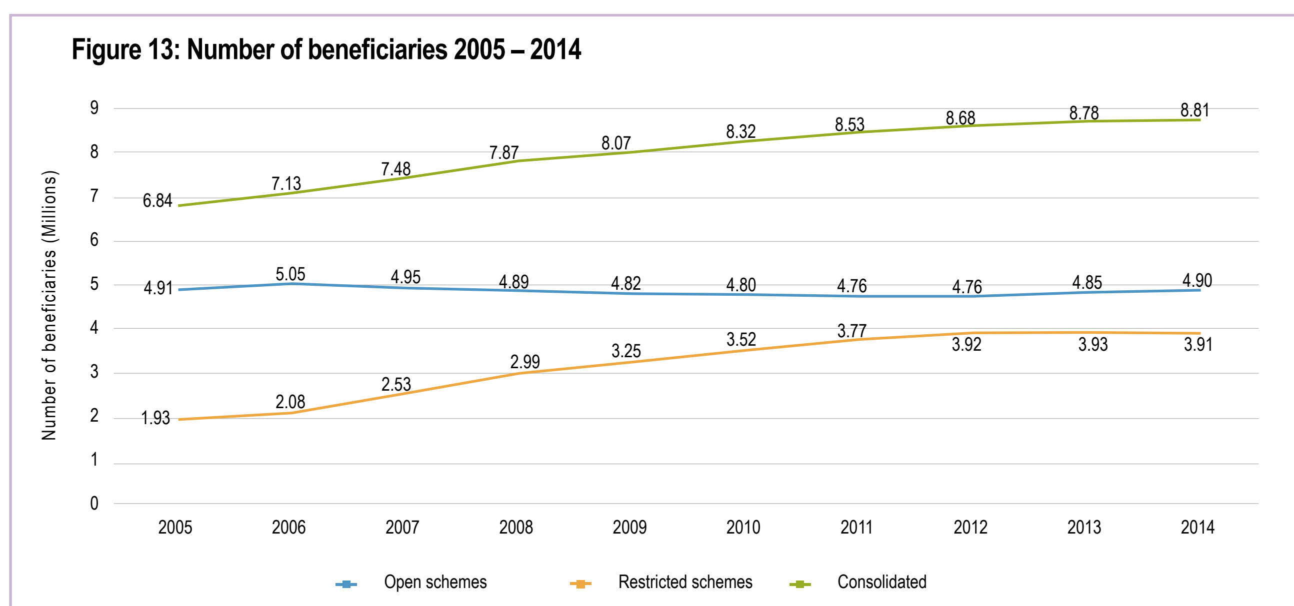
Type of scheme	Year	Members	Dependants	Beneficiaries	% change
Open schemes	2013	2 256 168	2 590 741	4 846 909	
	2014	2 295 664	2 604 311	4 899 975	1.1%
Restricted schemes	2013	1 623 005	2 308 394	3 931 399	
	2014	1 625 568	2 288 915	3 914 483	(0.4%)
All schemes	2013	3 879 173	4 899 135	8 778 308	
	2014	3 921 232	4 893 226	8 814 458	0.4%

Trends in the number of beneficiaries

Figure 13 depicts the trend in medical scheme coverage for the past 10 years. The number of beneficiaries increased to 8.81 million in 2014 from 6.84 million in 2005. This represents an increase of 28.8% over the course of a decade. Beneficiaries belonging to open schemes constituted 55.6% of the total number of beneficiaries at the end of 2014.

There was a noticeable increase in beneficiaries of restricted schemes from 2006/7, but this was off a low base relative to open schemes. The growth in beneficiaries belonging to restricted schemes really started with the inception of the Government Employees Medical Scheme (GEMS), but it appears that membership of GEMS has started to stabilise, resulting in slower growth for the restricted scheme market as a whole. In 2014, GEMS beneficiaries decreased to 1.83 million from 1.85 million (in 2013) contributing to the -0.4% decline in beneficiaries experienced by restricted schemes.

Figure 13: Number of beneficiaries 2005 – 2014



Average age, pensioner ratio and gender distribution

Table 28 shows the average age of beneficiaries and the proportion of pensioners (beneficiaries aged 65 years and older) by scheme type and gender. The average age of male beneficiaries is slightly lower than that of females and the pensioner ratio is also lower. The pensioner ratio increased slightly to 7.3% for the industry, with pensioner ratios for both male and female beneficiaries rising.

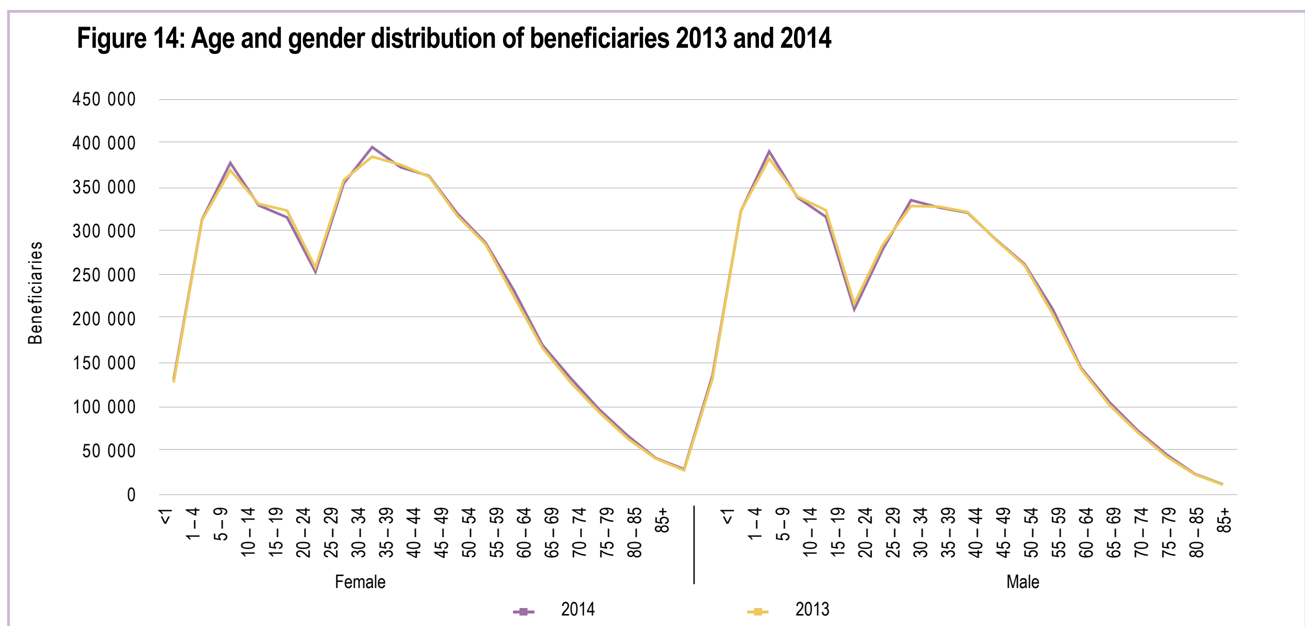
Table 28: Average age of beneficiaries and pensioner ratio 2013 and 2014

Type of scheme	Gender	Average age of beneficiaries and pensioner ratio	2013	2014
Open schemes	Female	Average age in years	34.2	34.2
		Pensioner ratio (%)	9.0	9.3
	Male	Average age in years	32.8	32.8
		Pensioner ratio (%)	7.3	7.6
	Total	**Average age in years**	**33.5**	**33.6**
		Pensioner ratio (%)	**8.2**	**8.5**
Restricted schemes	Female	Average age in years	31.1	31.3
		Pensioner ratio (%)	6.6	6.8
	Male	Average age in years	28.8	28.9
		Pensioner ratio (%)	4.8	4.9
	Total	**Average age in years**	**30**	**30.2**
		Pensioner ratio (%)	**5.8**	**5.9**
All schemes	Female	Average age in years	32.8	32.9
		Pensioner ratio (%)	7.9	8.2
	Male	Average age in years	31.0	31.1
		Pensioner ratio (%)	6.2	6.4
	Total	**Average age in years**	**31.9**	**32.1**
		Pensioner ratio (%)	**7.1**	**7.3**

Figure 14 shows the age and gender distribution of medical scheme beneficiaries for 2013 and 2014. A bimodal distribution is evident, for both male and female beneficiaries. Age bands <1 to 15 – 19 years featured more male beneficiaries while female beneficiaries outnumbered males in the age groups 20 years and older. In 2014, across all age groups, 52.5% of all beneficiaries were female and 47.5% male.

The average age of medical scheme beneficiaries in 2014 was 32.1 years, slightly older than the 31.9 years reported in 2013. Female beneficiaries were generally older than male beneficiaries. The average age of female medical scheme beneficiaries was 32.9 years in 2014 and that of males 31.1 years.

Figure 14: Age and gender distribution of beneficiaries 2013 and 2014

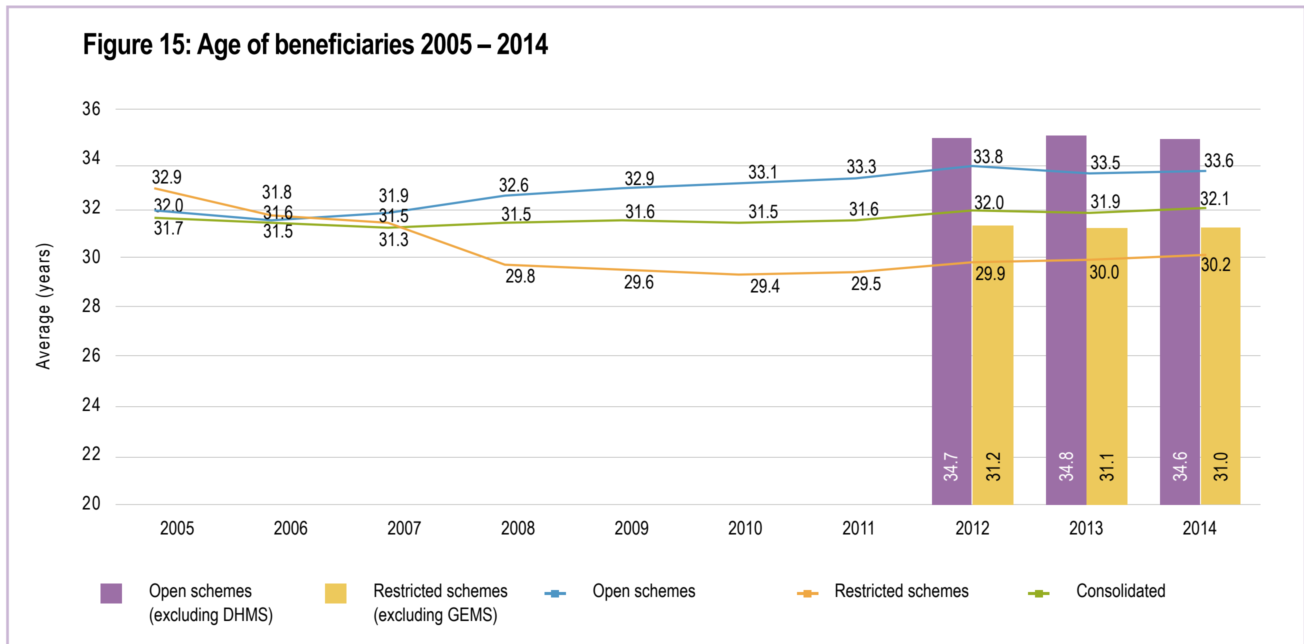


Trend in the average age of beneficiaries

Figure 15 shows the trend in the average age of beneficiaries from 2005 to 2014. Members of restricted medical schemes were older than those of open schemes until 2006. This changed in 2007, primarily due to the introduction of GEMS, when beneficiaries of restricted schemes were suddenly younger than those of open schemes.

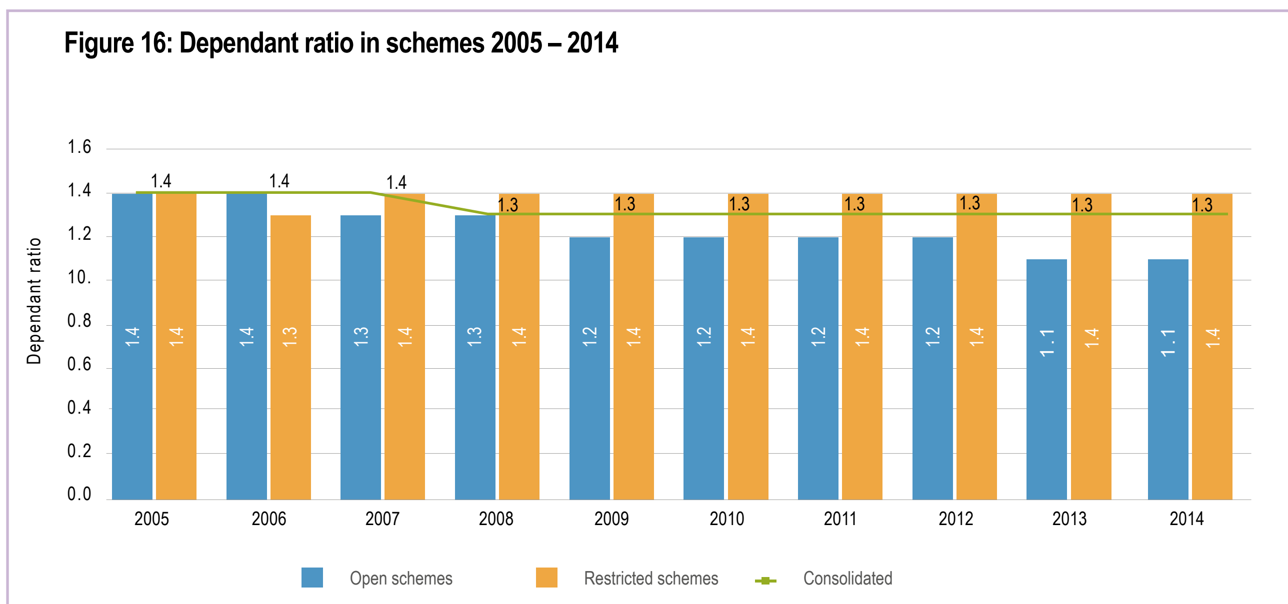
The impact of GEMS and DHMS on restricted and open schemes respectively is also reflected in Figure 15.

Figure 5 further illustrates that the average age of beneficiaries of open schemes in 2014 was 33.6 years (and would have been 34.4 years if DHMS was excluded) while the average age of beneficiaries of restricted schemes in 2014 was 30.2 years (and would have been 31 years if GEMS was excluded).



Dependant ratio

The dependant ratio measures the average number of dependants per principal member. The dependant ratio for the entire industry remained constant at 1.3 in 2014. The dependant ratio for both restricted medical schemes and open medical schemes also remained unchanged. See Figure 16 for more detail.



Coverage by province

Figure 17 shows the distribution of beneficiaries by province in 2014. This data is collected primarily on the basis of the location of principal members. Approximately 34% of beneficiaries – some 3 million – were located in Gauteng. The Western Cape and KwaZulu-Natal accounted collectively for approximately 2.6 million beneficiaries, comprising 30% of the total number. Table 29 and Figure 17 provide further detailed information.

Figure 17: Provincial distribution of beneficiaries by Province 2014

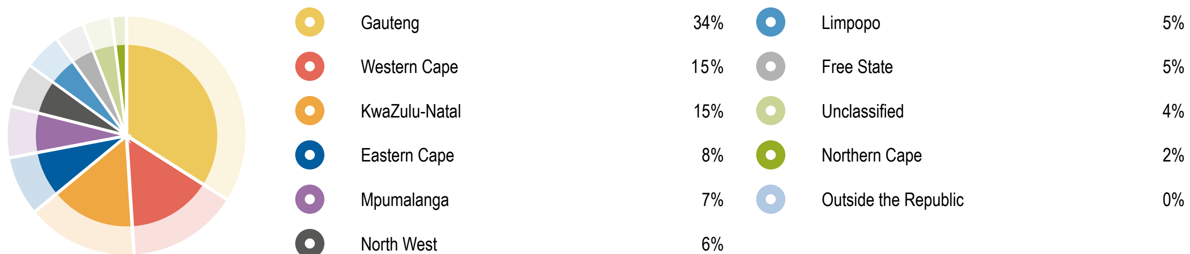


Table 29: Provincial changes in beneficiaries between 2013 and 2014

Province	2013*	2014	% growth
Northern Cape	189 264	192 409	1.7
Limpopo	433 220	437 906	1.1
Gauteng	2 952 924	2 982 814	1.0
Western Cape	1 299 153	1 310 998	0.9
KwaZulu-Natal	1 293 764	1 301 813	0.6
Mpumalanga	588 386	589 900	0.3
North West	524 408	524 879	0.1
Free State	404 691	402 672	(0.5)
Eastern Cape	703 895	697 125	(1.0)
Unclassified	383 963	369 718	(3.7)
Outside the Republic	4 640	4 224	(9.0)
Total	**8 778 308**	**8 814 458**	**0.4**

* *The provincial distribution of beneficiaries for 2013 has been restated.*

Classification of benefit options and movement of beneficiaries

Benefit options have been classified on the basis of the nature of benefits offered, benefit financing and delivery of benefits.

- Any option that has a member savings account has been classified as a savings option. This implies an option with both a savings account and day-to-day benefits paid from risk has been classified as a savings account option. Traditional options provide day-to-day benefits which are paid from risk. These have no members' savings accounts at all.
- Hybrid options consist of a primary registered option and an efficiency discount option (EDO). Data was not collected on the EDO.
- Designated service provider (DSP) refers to the delivery mode. Options in this category have a network provider.

Table 30: Definition of benefit option types

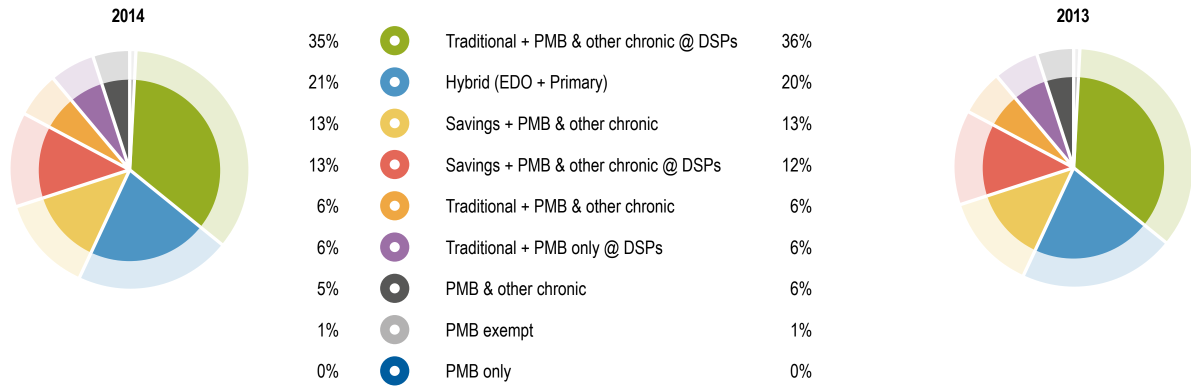
Key	Summary of major benefits
PMB exempt	These options are exempt from paying for the full PMB package.
PMB only	There are no day-to-day benefits provided on these plans. Only PMBs are offered.
PMB & other chronic	These options provide chronic cover for PMBs and other chronic conditions and no day-to-day benefits.
Traditional & PMB only @ DSPs	These options provide day-to-day benefits financed from risk, with chronic cover for PMB conditions only. There are network arrangements for hospitalisation.
Savings + PMB & other chronic @ DSPs	These options provide day-to-day benefits financed from the member savings account, chronic cover for PMBs and other chronic conditions. There are network arrangements for hospitalisation.
Traditional + PMB & other chronic @ DSPs	These options provide day-to-day benefits financed from risk, chronic cover for PMBs and other chronic conditions. There are network arrangements for hospitalisation.
Savings + PMB & other chronic	These options provide day-to-day benefits financed from the member savings account, chronic cover for PMBs and other chronic conditions.
Traditional + PMB & other chronic	These options provide day-to-day benefits financed from risk, chronic cover for PMBs and other chronic conditions.
Hybrid (EDO + primary)	Has a primary option and efficiency discount option.

Table 31: Definition of benefit options

	Open schemes	Restricted schemes	All schemes
PMB exempt	–	9	9
PMB only	3	2	5
PMB & other chronic	23	9	32
Traditional & PMB only @ DSPs	7	10	17
Savings + PMB & other chronic @ DSPs	38	40	78
Traditional + PMB & other chronic @ DSPs	34	59	93
Savings + PMB & other chronic	12	1	13
Traditional + PMB & other chronic	1	5	6
Hybrid (EDO + primary)	19	–	19
Total	**137**	**135**	**272**

The most common type of option offered by the schemes is the traditional plus PMB & other chronic with DSP arrangements. The second most popular was the savings plus PMB & other chronic with DSP arrangements. Both these options offer chronic benefits for PMB conditions and supplementary chronic conditions.

Figure 18: Distribution beneficiaries by benefit option type

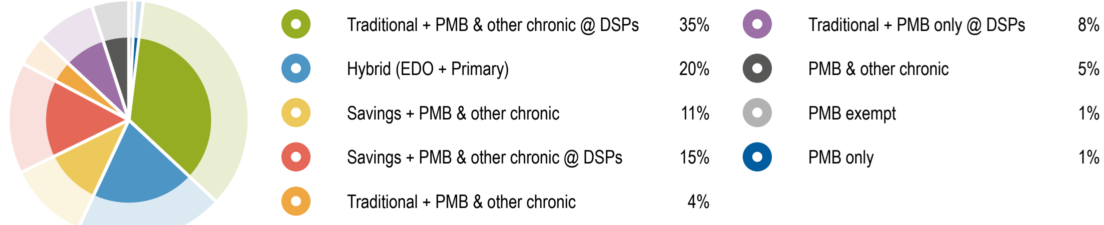


The graphs above show the distribution of beneficiaries across benefit options in 2013 and 2014. The pattern was very similar. The number of beneficiaries in the category, traditional plus PMB and other chronic cover at DSPs dropped by 1% while the hybrid type of option increased by a similar margin.

It appears that most beneficiaries opted to be limited to a provider network. They also prefer to have day-to-day benefits, especially if they are paid from the risk pool. At least half of the beneficiaries are on options with DSP arrangements for PMBs and other chronic conditions. This proportion could be higher as a significant number in hybrid options could also be in DSP arrangements.

About 23% of beneficiaries do not have access to day-to-day benefits.

Figure 19: Beneficiaries changing/joining an option in 2014



About 50% of the beneficiaries choosing a benefit option selected opted for the traditional plus PMBs and other chronic conditions with DSP arrangements or the hybrid type of benefit option. The PMB only benefit options received the least new members, followed by PMB-exempt options.

Most members preferred to have access to chronic benefits in addition to PMBs, with a significant proportion selecting day-to-day benefits.

How did member movement impact the options?

This section considers the profile of beneficiaries leaving a benefit option, beneficiaries joining a benefit option as well as beneficiaries who did not change their benefit option.

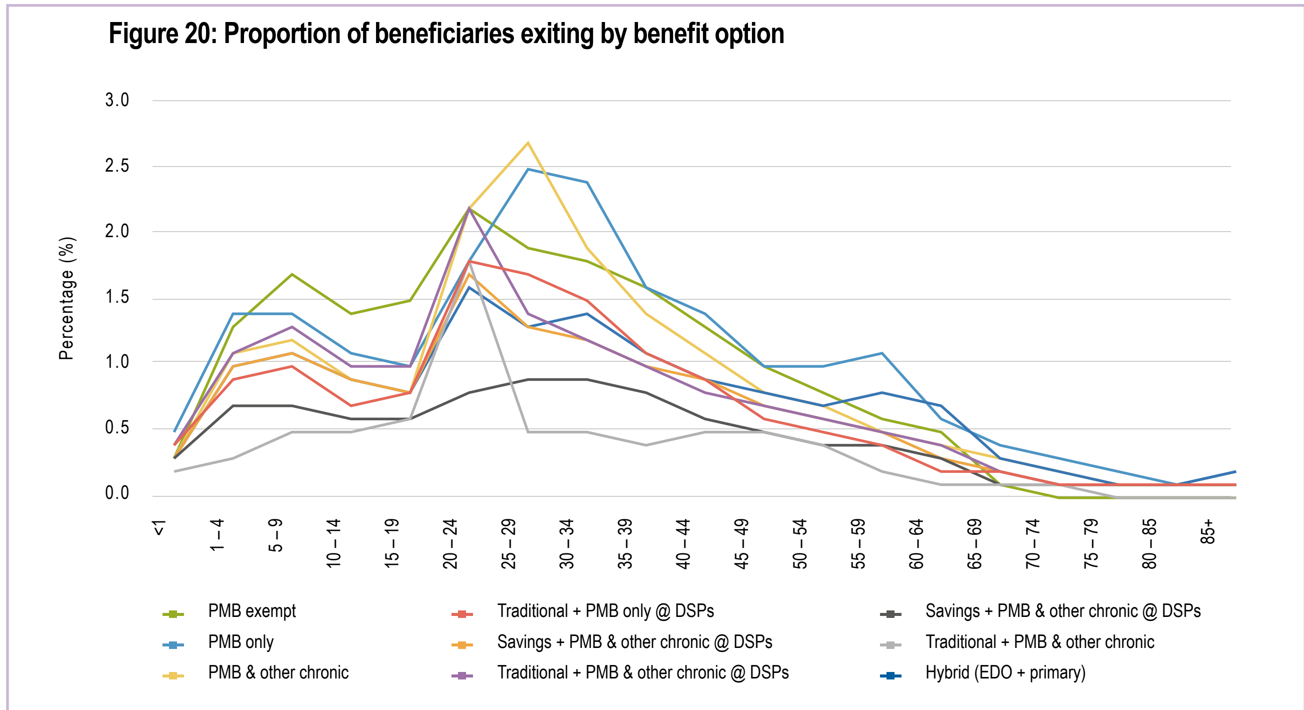


Figure 20: Proportion of beneficiaries exiting by benefit option

The loss of membership has been mostly among members under the age of 35 years and it peaks in the age band 20 to 29 years. Lack of employment may be a major factor contributing to this. The loss in membership appears relatively consistent across all benefit option types although options with comprehensive benefits are experiencing much lower levels of loss in membership across all ages.

The less comprehensive benefit options experienced a significant loss in membership from ages 30 upwards. Contributions of members on these options tend to cost less, and the losses may be a reflection of members having increased income as they grow older and being able afford more comprehensive health cover. Alternatively beneficiaries may be realising their need for more cover and buying-up into the comprehensive options.

The more comprehensive benefit options (savings or traditional options plus PMBs and other chronic cover) lost fewer members in the age groups from 30 years upwards. This could be a reflection of affordability: parents on these options may subsidise their children while they are studying or seeking employment.

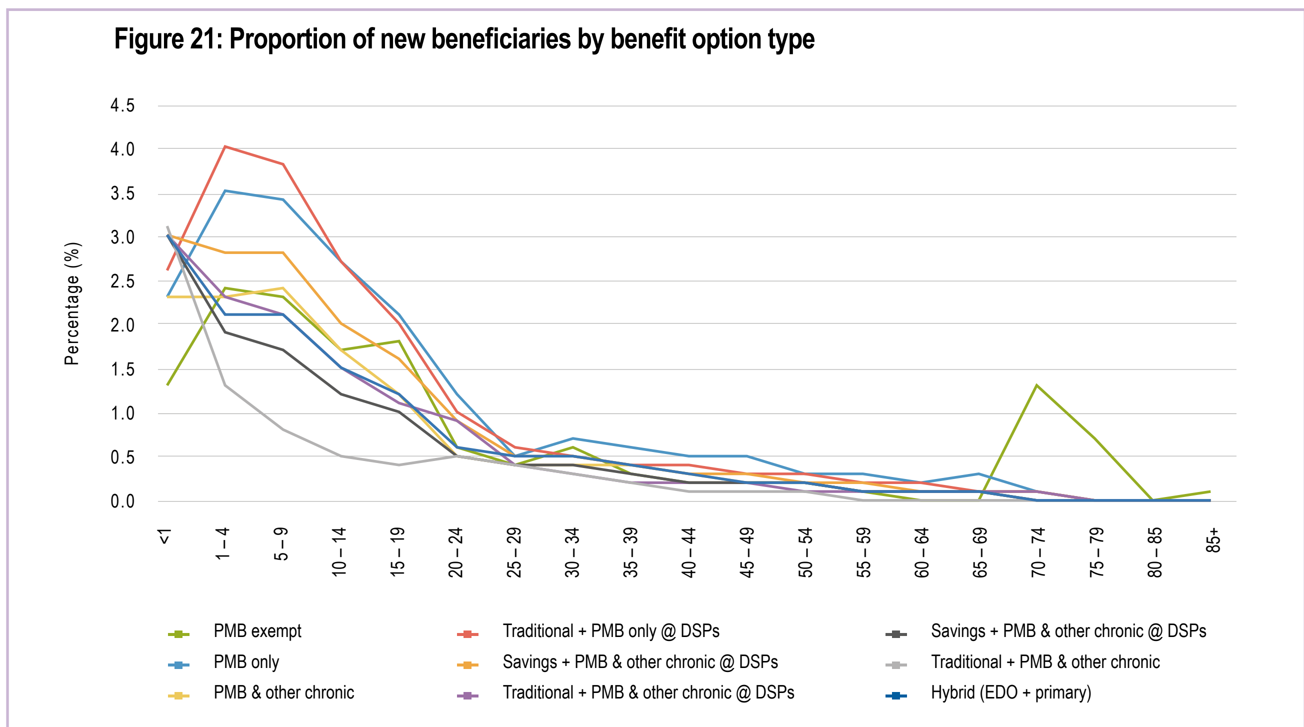
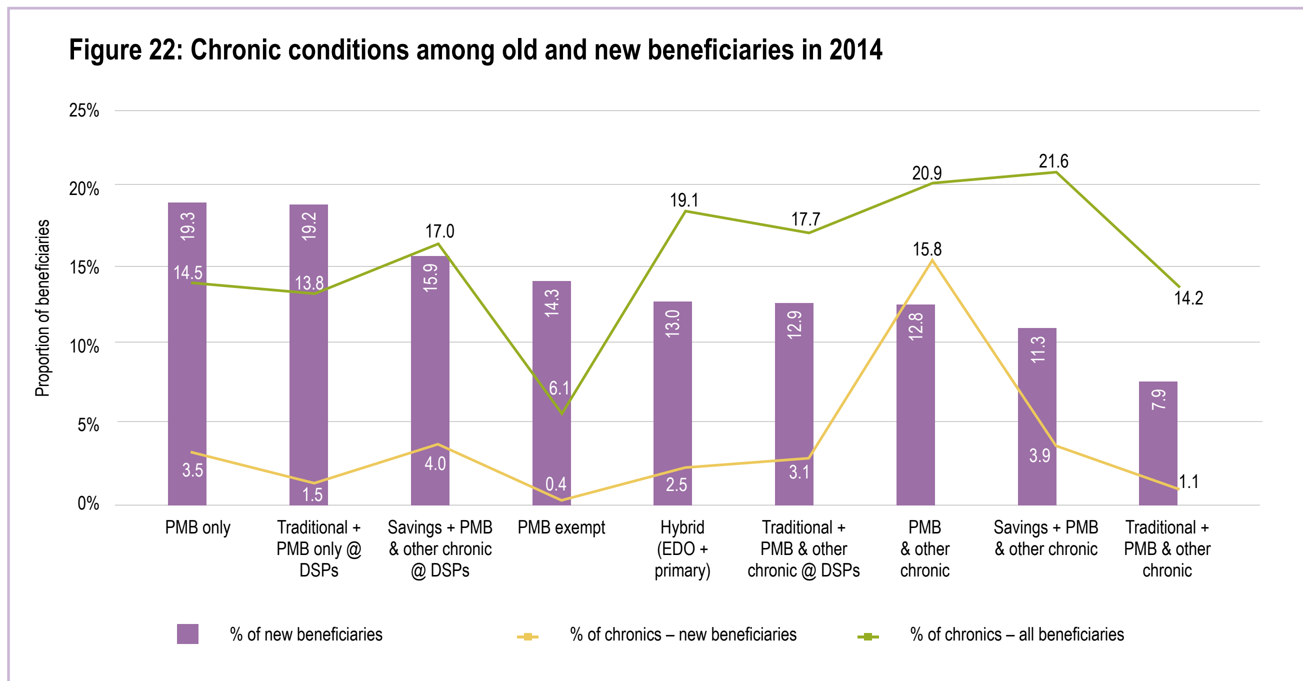


Figure 21: Proportion of new beneficiaries by benefit option type

Most beneficiaries join benefit options at an early age – mostly before nine years of age. Member behaviour looks generally consistent across options with the PMB-exempt type presenting a major exception in terms of 1% of its membership joining after turning 70. This is probably a data issue.

The options that offer comprehensive benefits have the highest proportion of beneficiaries joining at less than one year of age. It appears that beneficiaries maintain comprehensive benefits while they are having babies and downgrade once this phase is over. This may explain why the peak joining age for less comprehensive benefit options is between one and nine years of age. The comprehensive options show their highest membership growth in the under ones and this growth reduces consistently with age.

Figure 22: Chronic conditions among old and new beneficiaries in 2014



The PMB-only plans and the traditional plus PMB and other chronic cover (with DSP arrangements) had the highest proportion of new beneficiaries. The prevalence of chronic conditions among beneficiaries of these options was just below 15%. Members who moved to these options had a much lower prevalence of chronic conditions – only 3.5% for those joining PMBs only option and 1.5% for the traditional plus PMBs and other chronic cover with DSP arrangements. It appears there was significant improvement in the risk profile of these options due to these new members. Overall, the risk profile of the beneficiaries who were new to each option was better than the existing risk pool. Most beneficiaries with chronic conditions remained on their existing options.

The above data suggest that the movement of members is complex and more analysis needs to be carried out to understand what drives member behaviour.

Healthcare benefits

Total healthcare benefits paid

Total healthcare benefits paid are the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members. Medical schemes spent 11.1% more on healthcare benefits in 2014 than in 2013. This expenditure increased (in nominal terms) to R124.1 billion in 2014 from R111.7 billion in 2013.

The average amount spent per beneficiary per annum (pabpa) went up by 10% in 2014, from R12 892.6 to R14 185.5. Figure 23 shows the proportions of benefit expenditure paid by medical schemes to various categories of healthcare providers in 2014 and 2013.

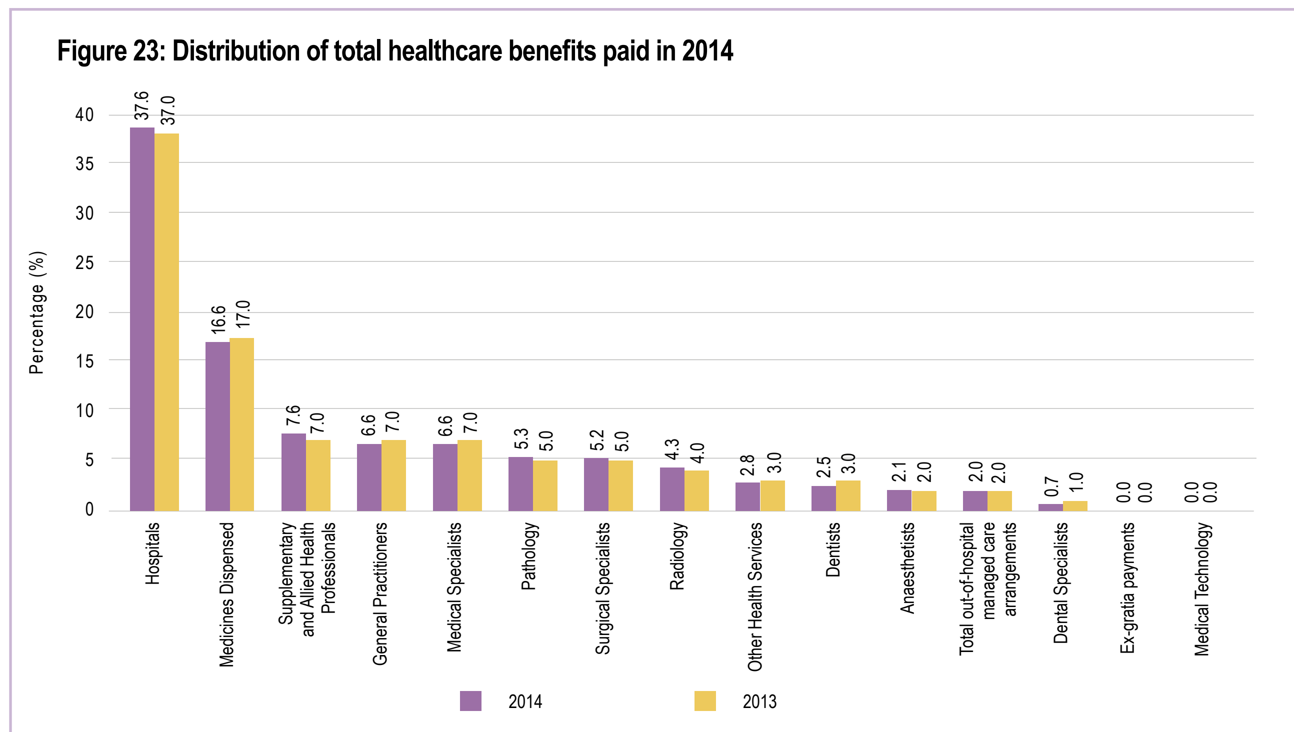


Figure 23: Distribution of total healthcare benefits paid in 2014

Total hospital expenditure by medical schemes – which includes ward fees, theatre fees, consumables, medicines and per diem arrangements – consumed R46.6 billion or 37.6% of the R124.1 billion that medical schemes paid to all healthcare providers in 2014.

Total medical scheme expenditure on private hospitals increased by 11.6% to R46.4 billion from R41.6 billion in 2013. In-patient admissions constituted 88% of the R46.4 billion paid to private hospitals in 2014 (same-day in-patient admissions constituted 12%). The average amount paid pabpa to private hospitals increased by 10.6%, from R4 799.38 in 2013 to R5 306.96 in 2014.

Medical scheme payments for medicines dispensed by pharmacists and providers other than hospitals amounted to R20.5 billion or 16.6% of total healthcare benefits paid. This was an increase of 8.9% compared to the R18.9 billion spent in 2013.

The most significant increase in benefits paid in 2014 was in respect of supplementary and allied health professionals. The amount increased by 14.5% from R8.2 billion in 2013 to R9.4 billion in 2014. This category accounted for 7.6% of all benefits paid by schemes in 2014.

Expenditure on general practitioners (GPs) amounted to R8.2 billion or 6.6% of healthcare benefits paid, representing an increase of 7.6% on the 2013 figure of R7.6 billion. Only 10.9% of the R8.2 billion paid to GPs in 2014 was paid to those operating in hospitals.

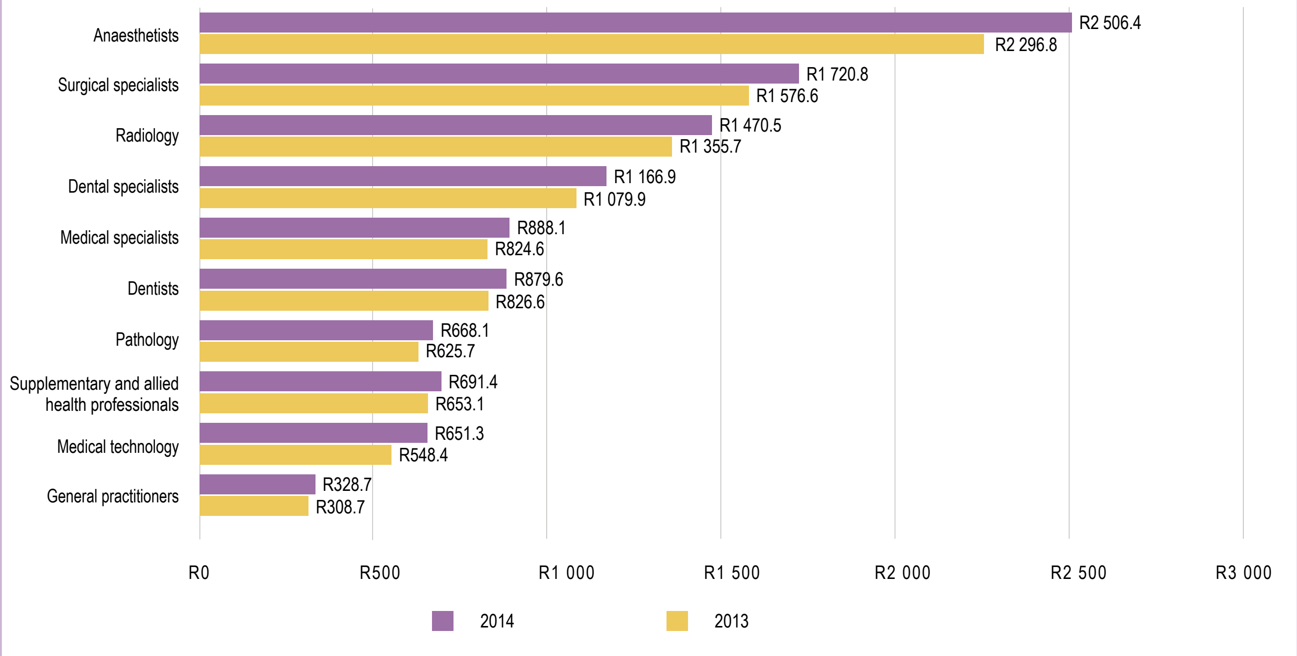
There is a strong negative correlation between the proportion of benefits paid to GPs and the proportion of benefits paid to hospitals. Medical schemes that have a high proportion of benefits paid to GPs tend to have a lower proportion of benefits paid to hospitals, while schemes that have a low proportion of benefits paid to GPs tend to have a higher proportion of benefits paid to hospitals. This negative correlation may be caused by medical schemes' benefit option designs.

It is worth noting that the category comprising all specialists (previously reported as medical specialists) has been disaggregated into five categories (anaesthetists, medical specialists, pathologists, radiologists and surgical specialists). Payments to all specialists amounted to R29.1 billion or 23.5% of total healthcare benefits paid in 2014. This amount increased by 12% from R26.0 billion paid in 2013.

Payments to medical specialists amounted to R8.2 billion or 6.6% of total healthcare benefits paid in 2014. About 54% of the R8.2 billion paid to medical specialists in 2014 was paid to those operating in hospitals. Expenditure on pathology amounted to R6.6 billion or 5.3% of healthcare benefits paid while expenditure on surgical specialists and radiology services amounted R6.4 billion and R5.3 billion respectively.

Figure 24 show benefits paid to different disciplines per event (visit). Total benefits paid per event is calculated as total benefits paid (from the risk pool and members' savings) divided by the number of visits to a provider. In 2014, benefits paid to anaesthetists averaged at R2 506.4 per event. This represented an increase of 9.1% on the 2013 figure of R2 296.8 and was the highest average benefit paid by the industry. The average amount paid to surgical specialists was R1 720.8 per event, while GPs were paid the lowest amount at an average of R328.7 per event.

Figure 24: Total benefits paid per event (visit) 2014



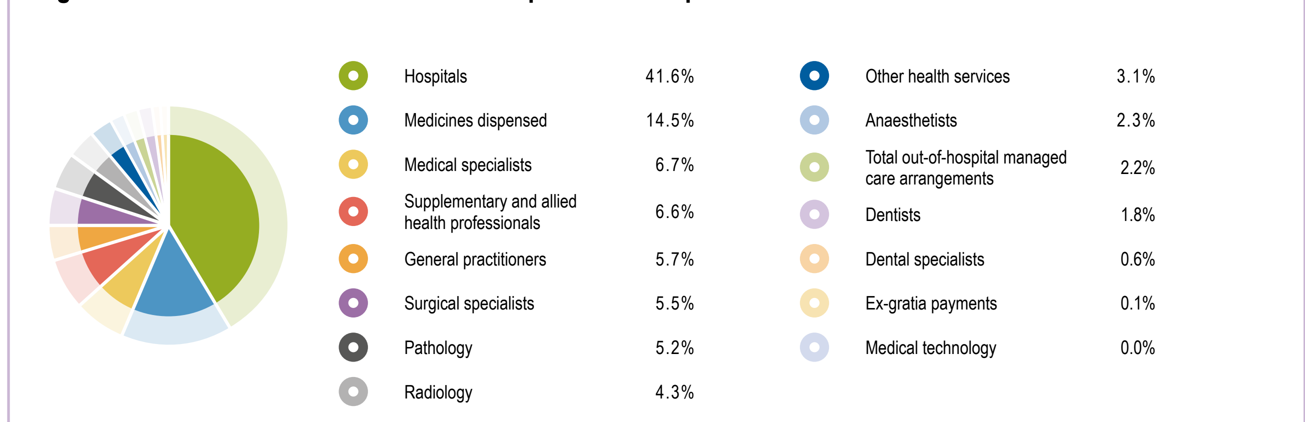
Healthcare benefits paid from risk pools

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 25.

Healthcare benefits which medical schemes covered from their risk pools amounted to R111.8 billion in 2014 compared to R100.7 billion in 2013, an increase of 11.1%. The average risk amount pabpa increased by 10.1% to R12 783.6 in 2014 from R11 616.4 in 2013.

Hospital expenditure accounted for 41.6% of risk benefits paid in 2014. Expenditure on medicines accounted for 14.5% of total risk pool benefits. Medical specialists consumed 6.7% of the pie, while risk pool expenditure on GPs was R6.3 billion or 5.7% of total risk pool benefits.

Figure 25: Distribution of healthcare benefits paid from risk pool 2014

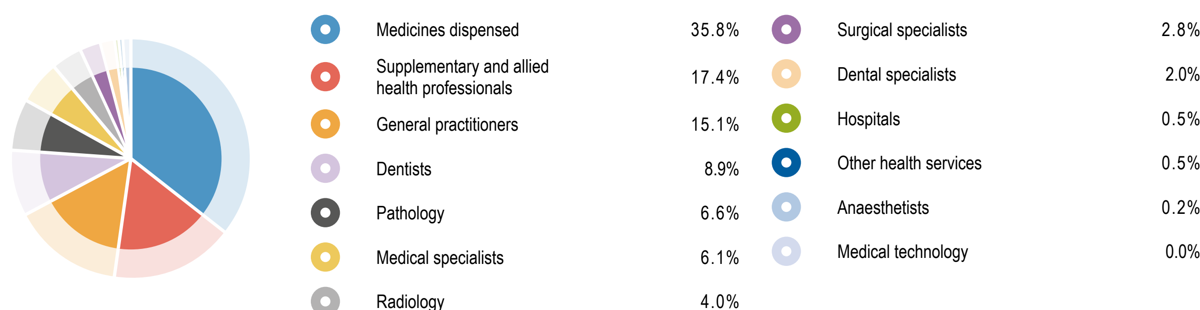


Healthcare benefits paid from savings

Of total healthcare benefits paid, medical schemes paid R12.2 billion (9.9%) from beneficiaries' personal medical savings accounts in 2014. Figure 26 shows that medicines absorbed the largest share of savings account expenditure in 2014 (35.8%). Supplementary and allied health professionals received 17.4% of healthcare benefits paid from savings accounts.

General practitioners accounted for 15.1% and dentists for 8.9% while pathology services and medical specialists absorbed 6.6% and 6.1% of healthcare benefits paid from savings accounts respectively.

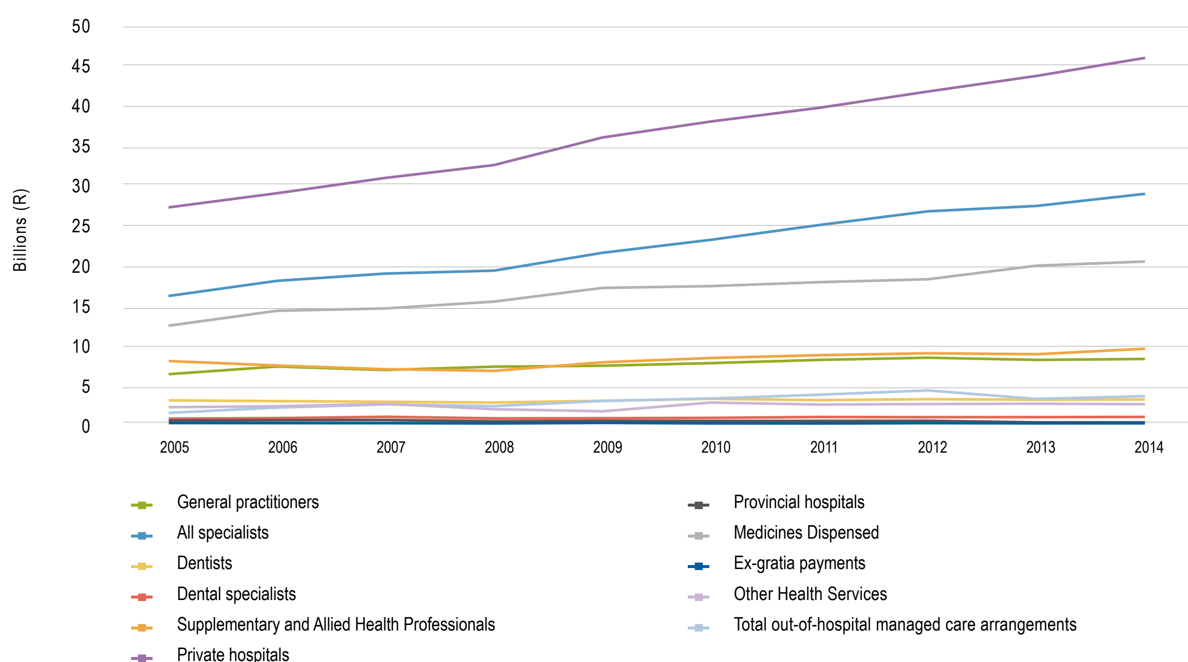
Figure 26: Distribution of healthcare benefits paid from savings 2014



Trends in total healthcare benefits paid[1]

Figure 27 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2005. These figures have been adjusted for inflation with 2014 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2014 prices.

Figure 27: Total healthcare benefits paid 2005 – 2014: (2014 prices*)



* *All values are adjusted for inflation using the Consumer Price Index (CPI) for 2014 as a base period.*
** *Historical values are revised when the base period changes and will not correspond to the values reported in the 2013 annual report.*

[1] *Note that historical (pre-2014) provider classifications have been used in order to create continuity and preserve historical data. The groupings differ slightly with provider classifications used in other sections of the report.*

Medical schemes' expenditure on private hospitals increased in real terms by 5.2% to R46.4 billion in 2014, compared to R44.1 billion in 2013. The sustained increase in expenditure on private hospitals, rising from R27.4 billion in 2005 to R46.4 billion in 2014, is illustrated in Figure 28.

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2014 amounted to R29.1 billion in real terms, an increase of 5.6% in real terms when compared to the R27.6 billion spent on this item in 2013.

It should be noted that the annual growth in membership must be taken into account when considering changes in the total expenditure of medical schemes.

Healthcare benefits paid per beneficiary

Figure 28 shows changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2005 to 2014 in real terms (at 2014 prices). The amount paid in real terms on private hospitals increased by 4.2% from R5 092 pabpa in 2013 to R5 307 pabpa in 2014.

The amount spent on specialists increased in real terms from R3 189 pabpa in 2013 to R3 335 pabpa in 2014, an annual increase of 4.6%. There was an increase of 7% in real terms for the benefits paid to supplementary and allied health professionals.

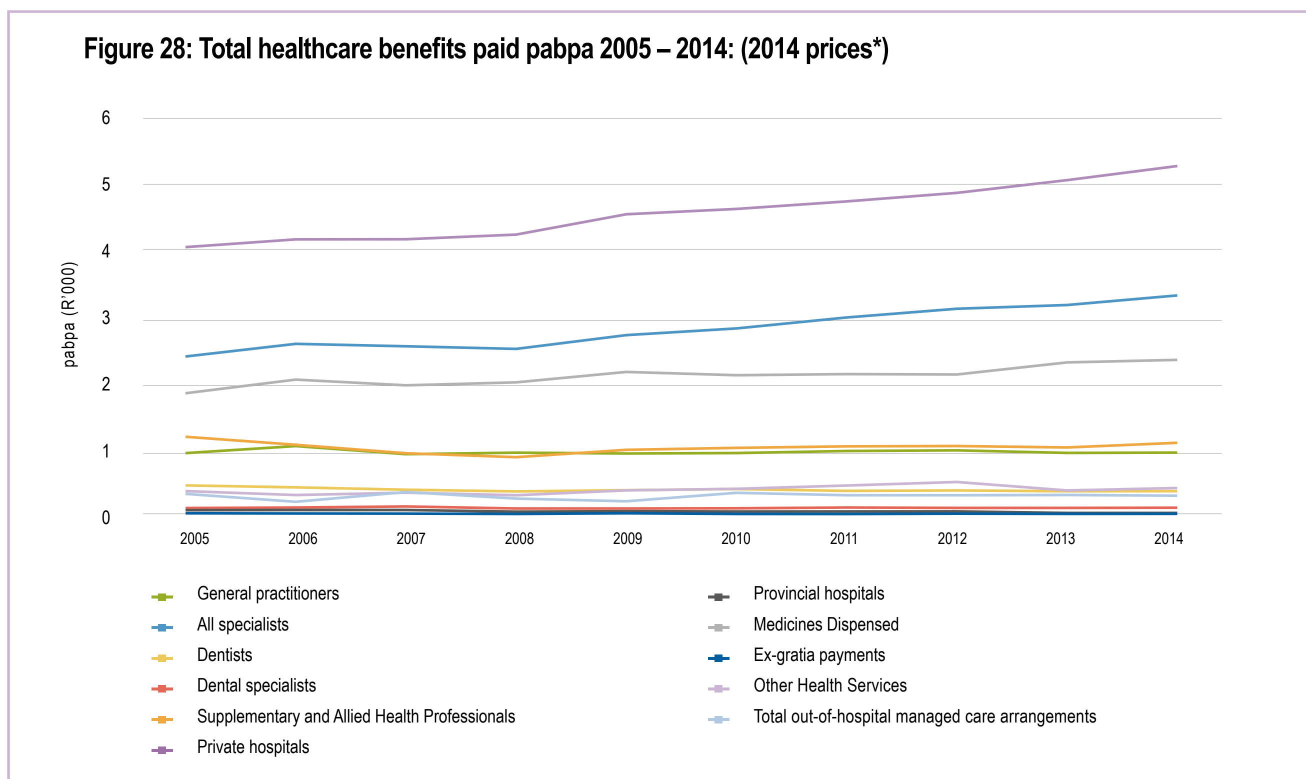


Figure 28: Total healthcare benefits paid pabpa 2005 – 2014: (2014 prices*)

* *All values are adjusted for inflation using the Consumer Price Index (CPI) for 2014 as a base.*
** *Historical values are revised when the base changes and will not correspond to the values reported in the 2013 annual report.*

Prescribed minimum benefits

Data on PMBs

This was the second year that the CMS collected data on the cost of PMBs through the annual returns of medical schemes. But it was the first time the new reporting system was used and there were some data challenges. Largely inaccurate data from 19 schemes – covering approximately 780 000 beneficiaries – was excluded. However, accurate data from the remaining schemes remained available and this allowed sound analysis based on a significant number of beneficiaries. These data challenges explain the difference in the PMB cost pbpm between this report and the previous one.

The total cost of PMBs for the schemes included in this analysis amounted to R53.7 billion. For these same schemes, R102.2 billion was paid from the risk pool for all benefits including PMBs. This means PMBs constituted 52.5% of the total risk benefits.

Cost drivers of PMB benefits

In the previous report, it was calculated that the PMB cost pbpm was R512 in 2013. When analysis was limited to those schemes for which data was utilised for the purposes of this report, the PMB cost was R500 pbpm for 2013. Besides the data issue discussed above, this difference could be partly due to the inclusion of payments from members' savings accounts in the 2013 figures (although PMB benefits should not be paid from the savings accounts). An amount of R11 pbpm was paid from members savings accounts in 2013.

The cost of PMBs for 2014 was R567 pbpm, representing a 13.4% increase from the recalculated figure of R500. The expected cost of PMBs from the Scheme Risk Measurement (SRM) data was R552 pbpm – very close to the R567 pbpm from the annual returns data.

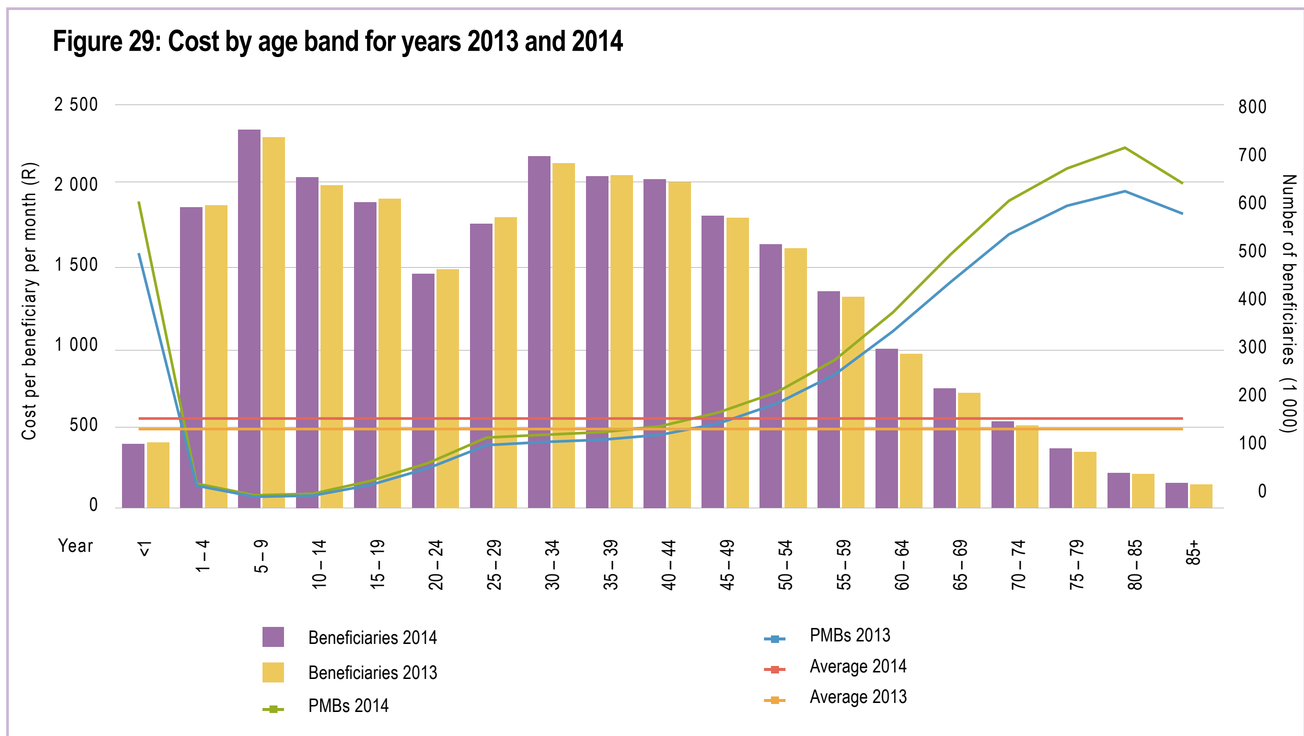
The cost of PMBs is mainly driven by:

- The beneficiary profile, which speaks to the level of cross-subsidisation between young and old beneficiaries, the sick and the healthy.
- The cost of treatment, which is strongly linked to contracting between schemes and providers.
- The prevalence of chronic conditions and disease burden.

Beneficiary profile

Figure 29 indicates how the beneficiary profile of schemes is affecting the cost of PMBs.

Figure 29: Cost by age band for years 2013 and 2014



The cost of PMBs increased by 13.4% from R500 pbpm in 2013 to R567 pbpm in 2014. This is a significant increase in a single year. The two straight lines on the graph show the average cost of PMBs pbpm in 2013 and 2014, while the curving lines indicate how the costs of PMBs change according to the age of beneficiaries.

If an age band lies where the curving lines are above the straight lines, beneficiaries in the age band (on average) cost more than the industry average for treatment of PMBs. If an age band lies where the curving lines fall below the straight lines, beneficiaries in the age bands are cheaper to treat for PMBs than the industry average. Therefore if membership increases in age bands between one and 40 years, the overall cost of PMBs pbpm would fall, all other things being equal. The converse is also true.

Membership growth has been higher for older age bands and this largely explains the 13.4% increase in cost of PMBs. From age 40 upwards, there has been an increase of 68 100 beneficiaries. In the younger age groups, below 40 years, there has been only slight growth of 1 300 beneficiaries.

The effect of the change in membership profile can best be analysed by looking at PMB treatment costs for certain ages. For beneficiaries above 45 years, it costs more than the industry average to treat each beneficiary. The cost rose to a peak of R2 300 pbpm (more than four times the average) for beneficiaries aged 80 to 84 years in 2014. A small increase in the number of beneficiaries in this age band would increase the cost of PMBs by a significant margin. The corresponding growth in younger membership would have to be more than five times the growth in older age bands to keep costs level.

If the rise in numbers of older members is sustained, the increase in the costs of PMBs is likely to continue. Membership growth in the younger age groups would help keep costs down. The industry needs to find a way of retaining membership in the age bands 19 to 29 years. This would help contain the cost of PMBs as well as other healthcare benefits.

Burden of disease: chronic conditions

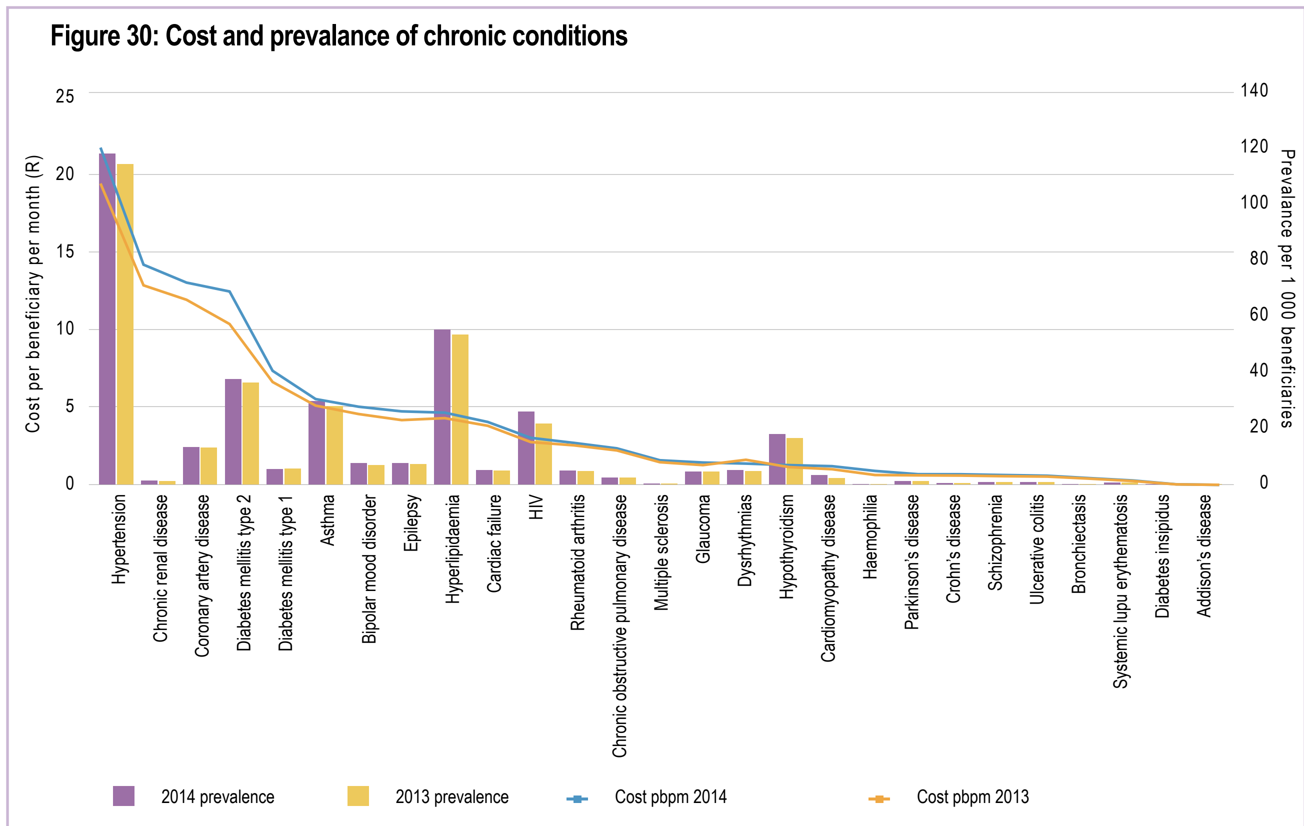


Figure 30: Cost and prevalance of chronic conditions

The prevalence of chronic diseases has increased from 2013 to 2014. This is consistent with a rise in the number of older beneficiaries. Hypertension remains the most prevalent chronic condition and was the most expensive condition on a pbpm basis in 2014. Although hypertension is relatively very cheap to treat, costing only R179 pppm, the fact that it is very common makes it the most costly condition on a pbpm basis.

Chronic renal disease has very low prevalence – 1.37 per 1 000 beneficiaries in 2014 – yet it was the second most expensive condition on a pbpm basis. This is explained by the high average cost of treatment of this condition per patient per month (pppm). Pppm refers to the average monthly cost of treating patients with specific CDL conditions. Figure 31 shows how treatment cost varies by CDL condition.

Cost of treatment

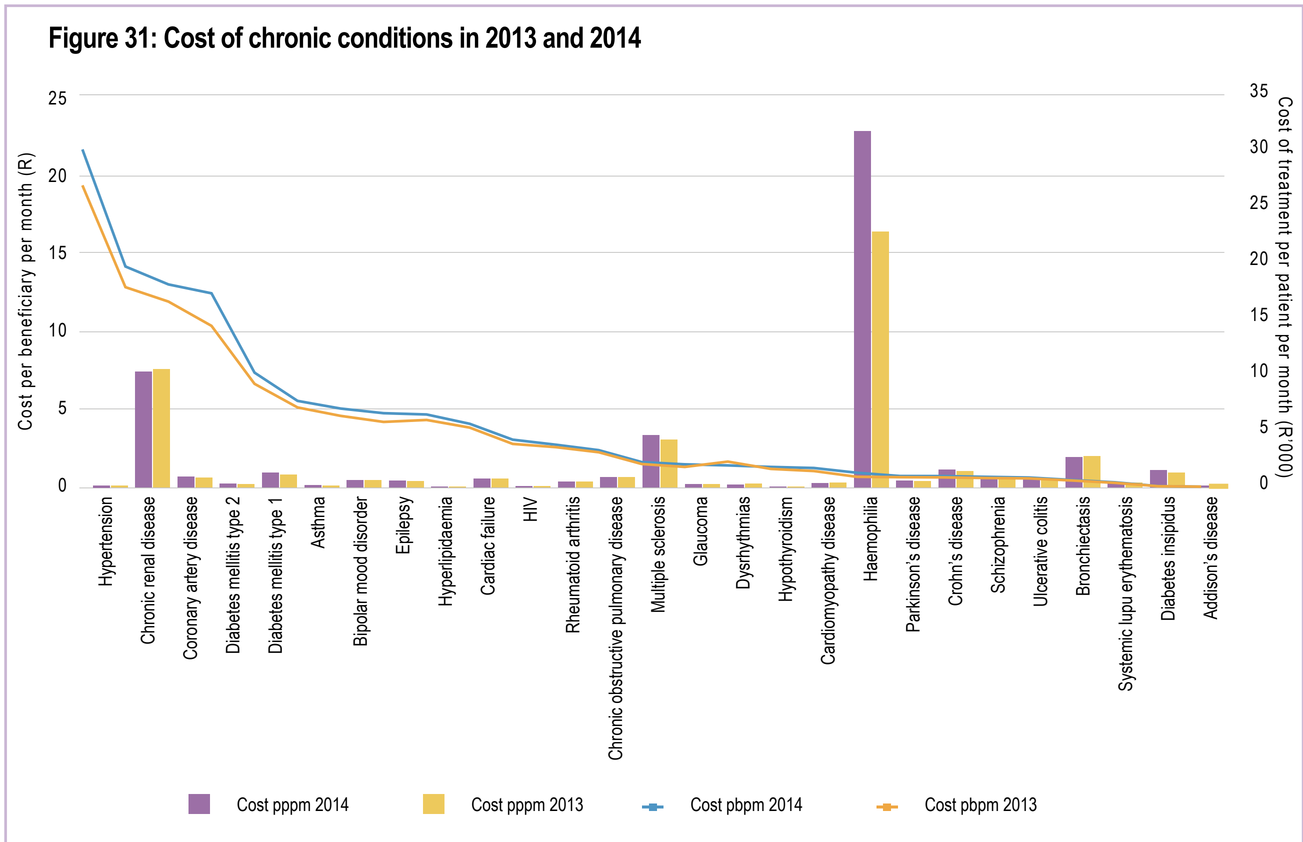


Figure 31: Cost of chronic conditions in 2013 and 2014

Haemophilia was the most expensive condition to treat per patient. There was a sharp increase in treatment cost, from R22 900 to R31 900 pppm between 2013 and 2014. Since this condition is rare, the overall pbpm cost to schemes was low, at only 92 cents in 2014.

Chronic renal disease cost R10 400 pppm in 2014, down from R10 600 pppm in the previous year.

Disease treatment plans

There was not much change in respect of disease treatment plans (DTPs). The top 10 conditions in 2014 are very similar to the top 10 in 2013, as indicated by Figure 32. The only change is that “cancer of breast (treatable)” drops out of the top 10 and is replaced by “obstruction of the urogenital tract; regardless of cause”.

There was a significant increase in the overall cost of DTPs – from R269 to R308 pbpm, representing an annual increase of 14.2%.

The level of in-hospital and out-of-hospital costs of DTPs was very comparable for 2013 and 2014. Most expenditure on DTP conditions was in-hospital. “Major affective disorders, including unipolar and bipolar depression” had the highest out-of-hospital expenditure at R6.20 pbpm.

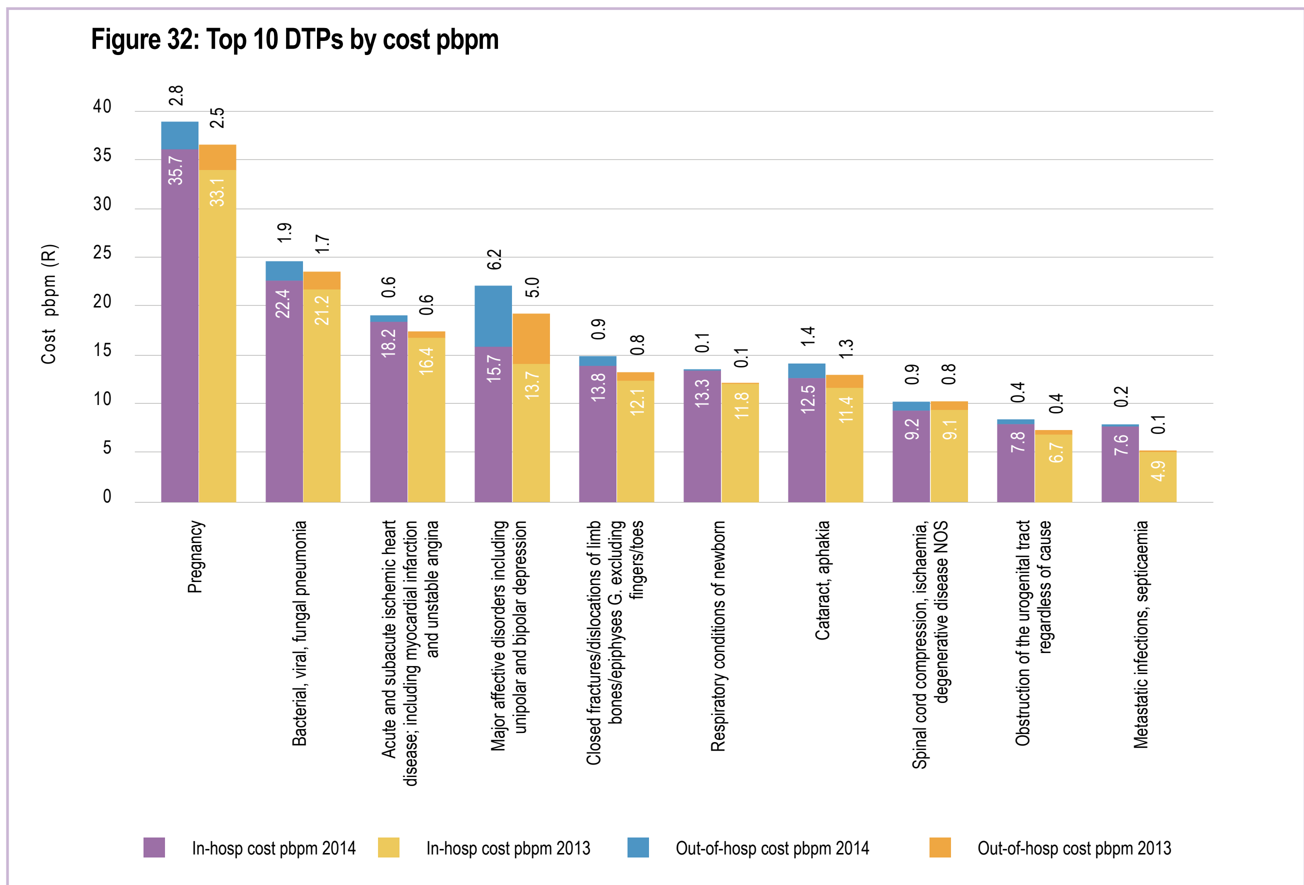
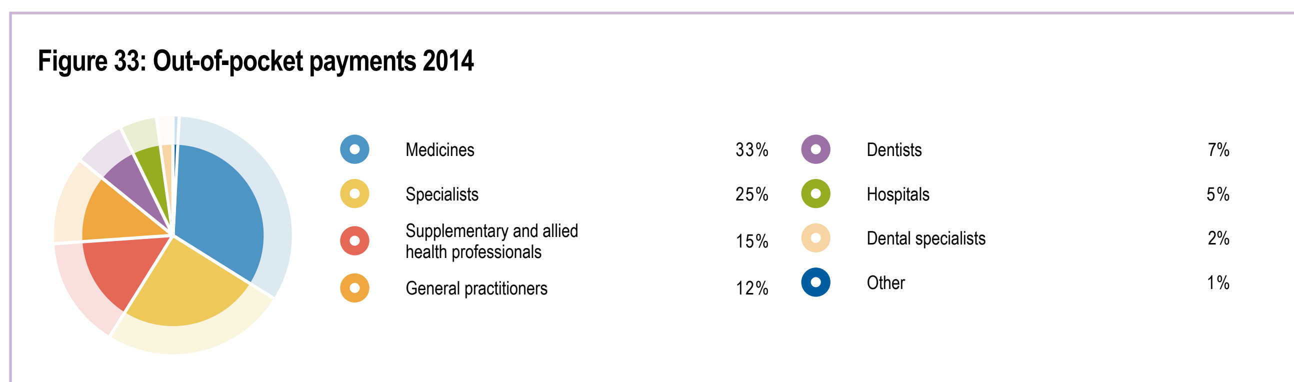


Figure 32: Top 10 DTPs by cost pbpm

Out-of-pocket payments

The term out-of-pocket payments, as it is used in this section, refers to the amounts beneficiaries paid using their own resources, including payments from their medical scheme savings accounts. Essentially it comprises all healthcare costs paid by beneficiaries and not covered from the risk pool.

Figure 33: Out-of-pocket payments 2014



The data indicate that the distribution of out-of-pocket expenditure across disciplines has not changed from 2013 to 2014. Medicines and specialists still account for the bulk of out-of-pocket expenditure. In absolute terms, out-of-pocket expenditure increased by 11.9% from R18.5 billion in 2013 to R20.7 billion in 2014.

These figures are an understatement of the true extent of out-of-pocket expenditure as beneficiaries do not claim for all out-of-pocket spending on healthcare.

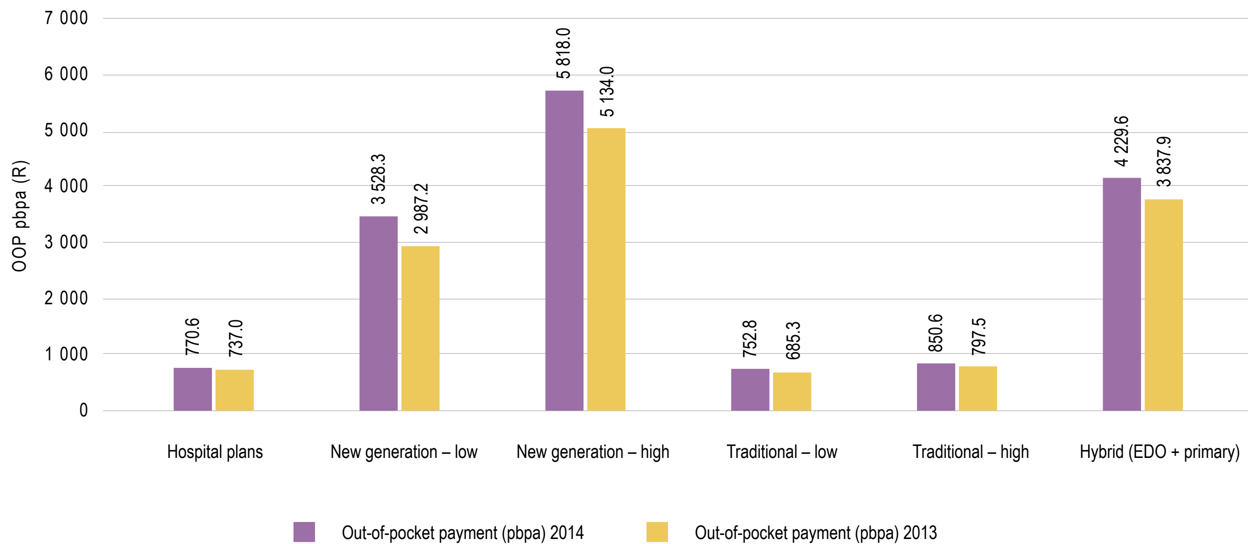
To help understand out-of-pocket expenditure, an analysis was done on how out-of-pocket payments vary according to type of benefit option. Table 32 contains a brief summary of how benefit option types have been classified for this exercise.

Table 32: Benefit Option types

Key	Summary of major benefits
Hospital plans	There are no day-to-day benefits provided. Only PMBs are covered out of hospital.
New generation – low	Day-to-day benefits are paid from members' savings accounts and there is no threshold.
New generation – high	Day-to-day benefits are paid from members' savings accounts and there is a threshold.
Traditional – low	Day-to-day benefits are paid from the risk pool with lower annual limits for day-to-day benefits.
Traditional – high	Day-to-day benefits are paid from the risk pool with high annual limits for day to day benefits.
Hybrid (EDO + primary)	There is a primary option and an EDO.

Figure 34 presents average out-of-pocket payments pbpa by benefit option type.

Figure 34: Out-of-pocket payments by benefit option type 2013 and 2014



Beneficiaries on hospital plans and traditional plans reported the lowest out-of-pocket expenditure in 2014, at approximately R830 pbpa. Hospital plans do not provide any day-to-day benefits, therefore members do not claim for such services and medicines from medical schemes. Members simply pay for these services out-of-pocket. However, these payments will most likely not be reported or captured and will not reflect in the data. In reality, hospital plan type benefit options are expected to have the highest out of pocket expenditure, more in line with new generation high options.

Members on traditional plans claim in the same way as members on hospital plans. Their day-to-day benefits are paid from the risk pool and once these are exhausted they stop claiming. This explains why they have similar levels of out-of-pocket payments as hospital plan beneficiaries. In fact, members on hospital plans should experience higher out-of-pocket payments as they have no day-to-day benefits at all.

New generation low options have day-to-day benefits paid from members' savings accounts. Member savings account payments fall within the definition of out-of-pocket expenditure. Only once members exhaust their savings, do they cease to claim for day-to-day benefits. This explains the higher out-of-pocket payments recorded for beneficiaries on these types of benefit options compared to traditional plans and hospital plans.

The new generation high options have the highest out-of-pocket payments. These options have a threshold, implying members on these options claim for almost all, if not all, of their out-of-pocket healthcare costs. Members tend to claim for all health needs because they know if they reach their threshold they will not have to pay from their own resources. The reported out-of-hospital healthcare out-of-pocket costs of these beneficiaries are about R6 000 pbpa. Assuming the health needs of beneficiaries on new generation high options apply to all beneficiaries, this figure serves as a more realistic indication of the extent of out-of-pocket payments for beneficiaries on all options.

Most of the hybrid options have member savings accounts – therefore the level of out-of-pocket payments observed on these options is expected to be in line with the new generation low options.

Utilisation of healthcare services

Primary healthcare services

The utilisation of healthcare services is shown in Table 32 below. The number of medical schemes beneficiaries visiting GPs at least once a year was 763.1 per 1 000 beneficiaries for 2014 and 763.6 for 2013 respectively. The overall rate of GP consultations has therefore remained unchanged. The rate of beneficiaries visiting GPs in 2014 was higher by about 113 per 1 000 beneficiaries in restricted schemes compared to open schemes.

The number of beneficiaries visiting dentists increased from 210.6 per 1 000 beneficiaries in 2013 to 213.0 in 2014. More beneficiaries in restricted schemes (233.4 per 1 000) had at least one dentist consultation in 2014 compared to those in open schemes (196.7 per 1 000).

The number of beneficiaries consulting private nurses increased from 10.6 to 12.0 per 1 000 beneficiaries between 2013 and 2014. Nearly twice as many beneficiaries of restricted schemes consulted a private nurse (16.1 per 1 000) compared to those of open schemes (8.8 per 1 000).

The average number of GP and dentist visits per beneficiary remained unchanged at 3.7 and 1.4 respectively during the period under review. There was a slight decrease in the average number of visits to a private nurse, from 3.7 in 2013 to 3.3 in 2014.

Table 32: Utilisation of primary healthcare services 2013 and 2014

	2014			2013*
	Open schemes	Restricted schemes	All schemes	All schemes
Per 1 000 beneficiaries				
Beneficiaries visiting GP at least once a year	712.7	825.9	763.1	763.6
Beneficiaries visiting dentist at least once a year	196.7	233.4	213.0	210.6
Beneficiaries visiting nurse at least once a year	8.8	16.1	12.0	10.6
Per beneficiary				
Average number of visits to GPs	3.5	4.0	3.7	3.7
Average number of visits to dentists	1.5	1.3	1.4	1.4
Average number of visits to nurses	2.6	3.8	3.3	3.7

* *The 2013 figures have been restated.*

Preventive services

Table 33 illustrates preventive services for female beneficiaries. The number of birth admissions dropped from 28.7 per 1 000 female beneficiaries in 2013 to 26.4 per 1 000 female beneficiaries in 2014. There were more birth admissions in restricted schemes (29.4 per 1 000) compared to open schemes (23.2 per 1 000) in 2014. Medical schemes' data on birth admissions is still not at an acceptable level. The CMS will continue to work with schemes to improve data quality on birth admissions and birth outcomes.

Caesarean sections increased from 674.7 per 1 000 pregnant female beneficiaries in 2013 to 707.7 in 2014. The number of caesarean sections was slightly higher in open schemes than in restricted schemes, at 708.1 and 707.4 per 1 000 pregnant female beneficiaries respectively.

The number of births to female beneficiaries under 15 years of age remained unchanged at 2.0 per 1 000 female beneficiaries in this age group. Proportionally more births in this age group occurred in beneficiaries covered by open schemes (3.3 per 1 000 female beneficiaries aged under 15 years).

The number of births to female beneficiaries between 15 – 19 years of age increased from 15.1 per 1 000 female beneficiaries aged 15 – 19 years in 2013 to 15.9 in 2014. There were 21.1 and 10.3 births per 1 000 female beneficiaries aged between 15 – 19 years in restricted and open schemes respectively.

The number of mammograms that medical schemes paid for in respect of female beneficiaries aged 50 to 69 years decreased marginally from 292.0 to 292.3 per 1 000 female beneficiaries in this age group from 2013 to 2014. More mammogram procedures were paid for in open schemes than in restricted schemes (329.0 compared to 238.8 per 1 000 female beneficiaries) in 2014.

The number of pap smear procedures funded in 2014 was 167.9 per 1 000 female beneficiaries aged 15 to 69 years compared to compared to 166.1 in the previous year. Open schemes reported higher rates of utilisation for pap smear procedures than restricted schemes.

Table 33: Utilisation of preventive services by female beneficiaries

	2014			2013*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of birth admissions (per 1 000 female beneficiaries)	23.9	29.4	26.4	28.7
Number of caesarean sections performed (per 1 000 birth admissions)	708.1	707.4	707.7	674.7
Number of birth admissions to women under 15 years (per 1 000 female beneficiaries under 15 years of age)	3.3	0.8	2.0	2.0
Number of birth admissions to women between 15 – 19 years (per 1 000 female beneficiaries aged 15 – 19 years)	10.3	21.1	15.9	15.1
Number of mammograms paid for (per 1 000 female beneficiaries aged 50 – 69 years)	329.0	238.8	292.3	292.0
Number of pap smears paid for (per 1 000 female beneficiaries aged 15 – 69 years)	180.9	151.5	167.9	166.1

* *The 2013 figures have been restated.*

Table 34 below shows the number of male circumcision procedures paid for in respect of male beneficiaries aged 15 – 49 years. The number of circumcision procedures paid for in 2014 was 9.1 per 1 000 male beneficiaries aged 15 – 49 years, compared to 10.7 the previous year. Restricted schemes reported higher utilisation of circumcision procedures than restricted schemes.

Table 34: Utilisation of preventive services by male beneficiaries

	2014			2013*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of circumcisions (per 1 000 male beneficiaries 15 – 49 years old)	6.1	13.2	9.1	10.7

* *The 2013 figures have been restated.*

Private hospital services

Table 35 provides details of the utilisation of private hospital services. In-patient admissions have remained largely unchanged during the period under review. Most hospital admission statistics were higher for open schemes, except for maternity admissions. There were 26.9 maternity admissions per 1 000 female inpatient admissions for open schemes in 2014 compared to 29.5 for restricted schemes.

Table 35: Utilisation of private hospital services in 2013 and 2014

	2014			2013*
	Open schemes	Restricted schemes	All schemes	All schemes
Total number of outpatient visits (per 1 000 beneficiaries)	93.8	53.6	75.9	74.4
Private hospital (PCNS: 057, 058) inpatient admissions >24 hours (per 1 000 beneficiaries)	194.8	185.9	190.8	191.0
Private hospital (PCNS: 057, 058) inpatient same-day admissions (per 1 000 beneficiaries)	86.0	63.3	75.9	75.8
Ambulatory admissions (per 1 000 beneficiaries)	3.6	3.4	3.6	3.7
Emergency room admissions (per 1 000 admissions)	10.9	8.1	10.4	9.8
Total number of in-patient admissions (> 24 hours) for maternity cases (per 1 000 female beneficiaries)	26.9	29.5	28.1	28.0
Total number of in-patient admissions (< 24 hours) for maternity cases (per 1 000 female beneficiaries)	0.6	0.8	0.7	1.0
Total number of in-patient admissions (> 24 hours) for medical cases (per 1 000 beneficiaries)	104.9	89.8	101.9	100.1
Total number of in-patient admissions (< 24 hours) for medical cases (per 1 000 female beneficiaries)	69.2	28.4	61.2	67.4
Total number of in-patient admission (> 24 hours) for surgical cases (per 1 000 beneficiaries)	68.1	54.1	65.3	64.0
Total number of in-patient admissions (< 24 hours) for surgical cases (per 1 000 beneficiaries)	61.5	52.4	59.7	59.7

* *The 2013 figures have been restated.*

Utilisation of medical technology

Table 36 provides an overview of the utilisation of medical technology which remained largely unchanged during the period under review. The utilisation of MRI scans, angiograms and bone density scans was significantly higher in open medical schemes.

Table 36: Utilisation of medical technology in 2013 and 2014

	2014			2013*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of beneficiaries receiving MRI scans (per 1 000 beneficiaries)	23.4	16.5	20.3	19.1
Number of beneficiaries receiving CT scans (per 1 000 beneficiaries)	26.7	26.6	26.6	25.1
Number of beneficiaries receiving PET scans (per 1 000 beneficiaries)	0.3	0.2	0.2	0.2
Number of beneficiaries receiving angiograms (per 1 000 beneficiaries)	1.6	0.4	1.1	1.1
Number of beneficiaries receiving bone density scans (per 1 000 beneficiaries)	7.3	4.2	5.9	6.0

* *The 2013 figures have been restated.*

Resources

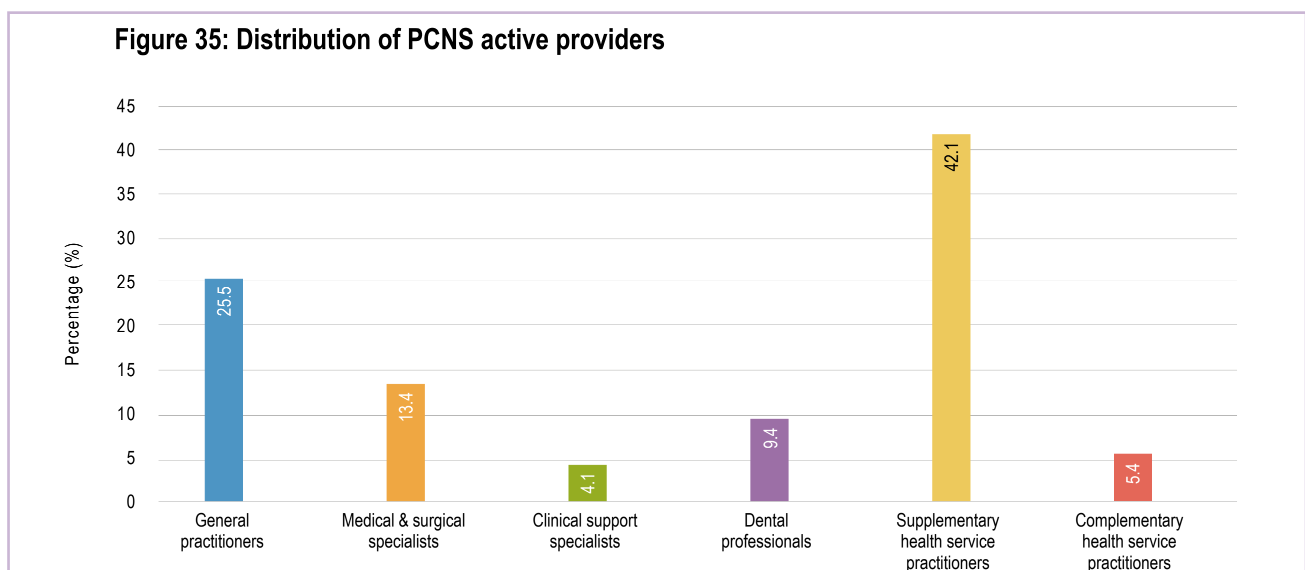
South Africa has a major challenge in terms of the shortage of human resources for healthcare and there is a skewed distribution of health professionals across provinces and between the public and private sectors. In order to improve equity, access to care, coverage and quality health outcomes, in-depth information is required on the availability of health professionals. Currently there are multiple data sources on human resources which can be used to inform policy changes, including the Health Professions Council of South Africa (HPCSA) and the Practice Code Numbering System (PCNS) administered by the Board of Healthcare Funders (BHF). Each has its own limitations and strengths.

This section provides a high-level overview of the distribution of selective disciplines within the medical schemes industry. This analysis is drawn from PCNS statistics on all active providers in quarter four of 2014, as well as the distribution of disciplines by provinces. All sub-disciplines have been aggregated within the discipline codes.

Private sector

Figure 35 shows that at the end of 2014, 42% of active health professionals registered on PCNS were supplementary health service practitioners, while GPs constituted 26% of the total and medical and surgical specialists 13%.

Figure 35: Distribution of PCNS active providers



Notes: *Active disciplines, excludes all facilities and different types of group practices.*

General practitioners

Figure 36 shows the distribution of GPs by province and this is compared to medical scheme membership per province. A total of 70.3% of PCNS-registered GPs are servicing KwaZulu-Natal, the Western Cape and Gauteng beneficiaries, with Gauteng absorbing the highest number of GPs. The remaining 29.7% of GPs are spread across the other six provinces, with the Eastern Cape accounting for 8.5% of GPs and the other provinces sharing the remainder.

Figure 36 also indicates that the provinces of Gauteng, the Western Cape and KwaZulu-Natal have a greater share of the pool of PCNS-registered GPs than their share of medical schemes beneficiaries. Mpumalanga, the Northern Cape and the North West are the only provinces that have a higher share of the South Africa's medical schemes beneficiaries than they have of PCNS-registered GPs.

Figure 36: Provincial distribution of membership and GPs: 2014

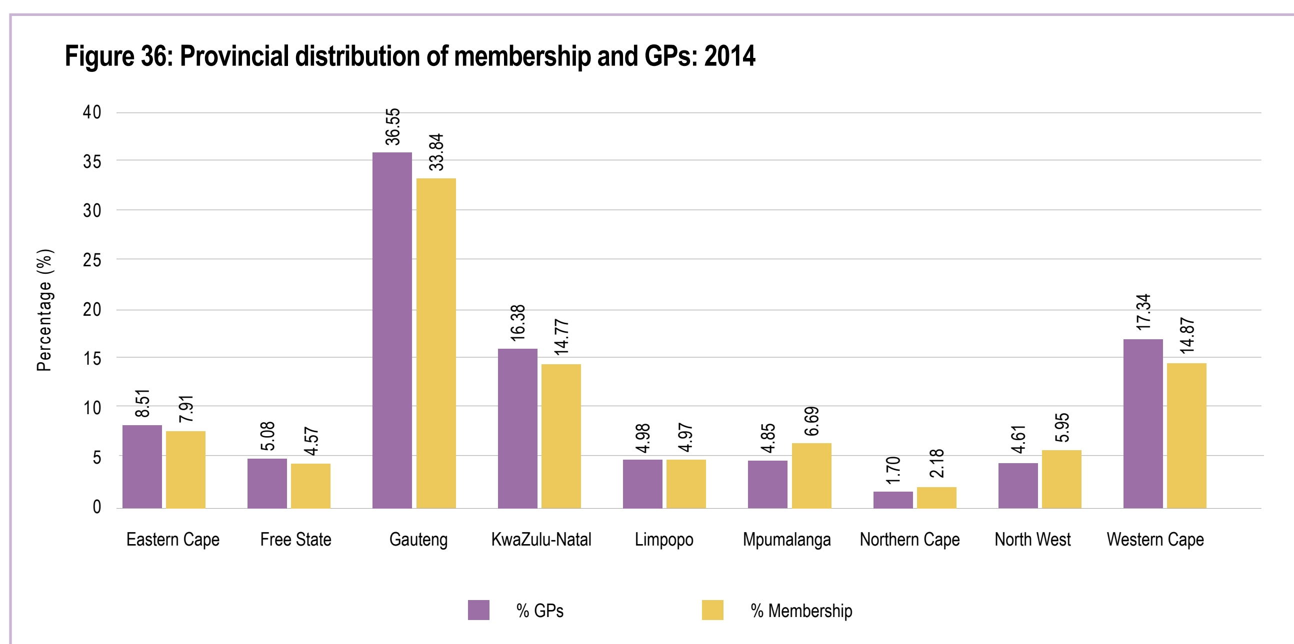


Table 37 shows the number of GPs per 10 000 medical scheme population beneficiaries. These figures confirm the pattern of inequity in the distribution of GPs, with Mpumalanga, Northern Cape and the North West provinces emerging as the least resourced.

Table 37: General practitioners per 10 000 medical schemes population

	GP headcount	GPs per 10 000 population
Eastern Cape	978	14
Free State	584	15
Gauteng	4 201	14
KwaZulu-Natal	1 883	14
Limpopo	573	13
Mpumalanga	558	9
Northern Cape	195	10
North West	530	10
Western Cape	1 993	15
Total	**11 495**	**13.6**

Note:
- *GP headcount includes GPs who are active and registered on the PCNS database.*
- *Excludes GPs not registered with PCNS but are providing healthcare to medical schemes population or are suspended from PCNS database.*
- *Annexure I (includes all clinical support specialists by province, sub disciplines aggregated to disciplines).*

Specialists

Figures 37 to 42 show the provincial distribution of various medical specialists in relation medical scheme membership in each province. They indicate that specialists are highly concentrated in Gauteng, KwaZulu-Natal and the Western Cape. Such a skewed distribution has the potential of entrenching unfairness and this might lead to a market structure that limits access to private healthcare for some members of medical schemes.

Figure 37: Provincial distribution of memberships and medical specialists: 2014

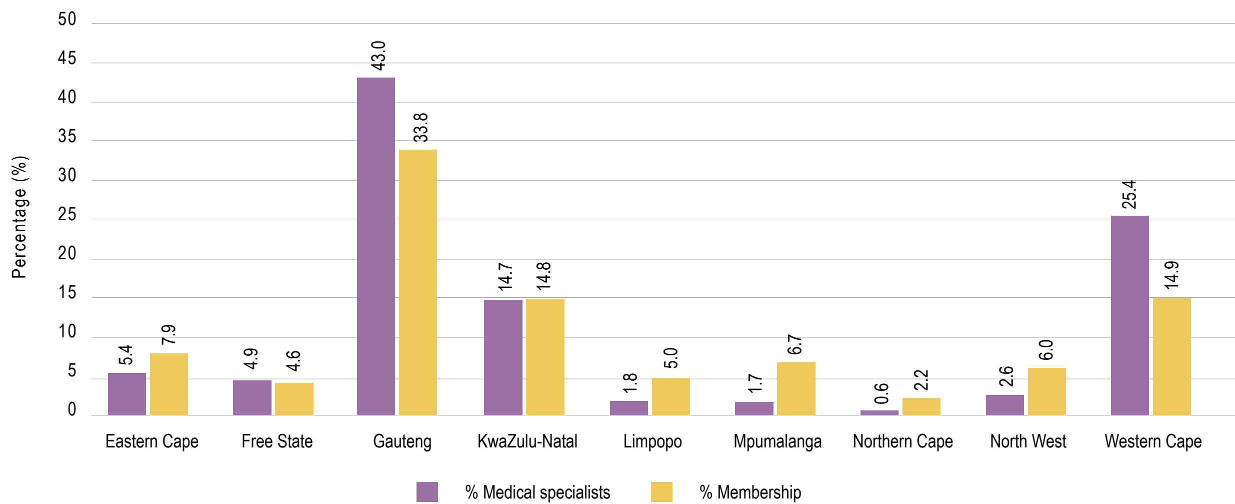


Figure 38: Provincial distribution of membership and surgical specialists

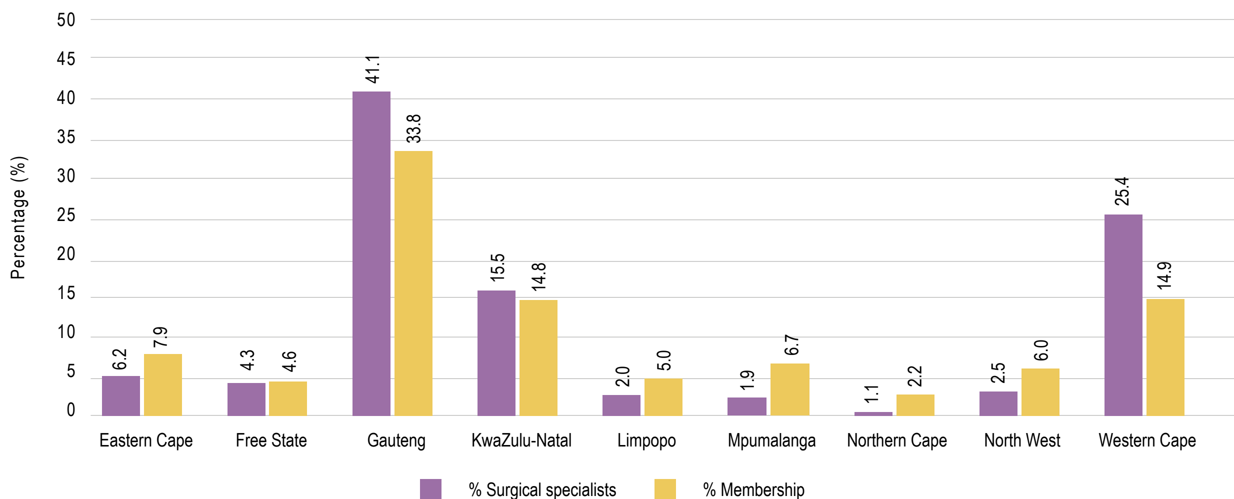


Figure 39: Provincial distribution of membership and clinical support specialists: 2014

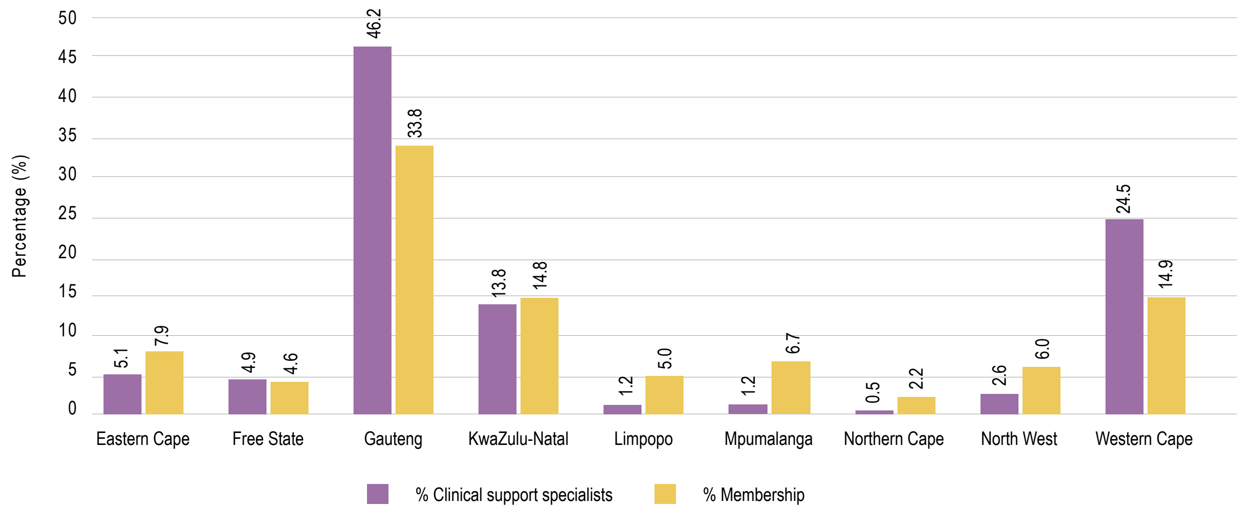
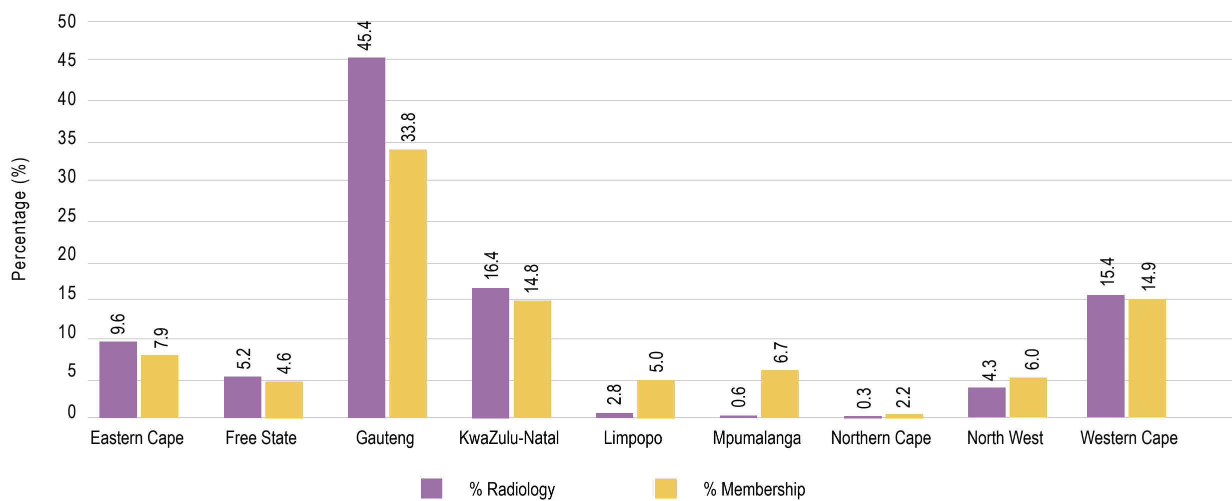
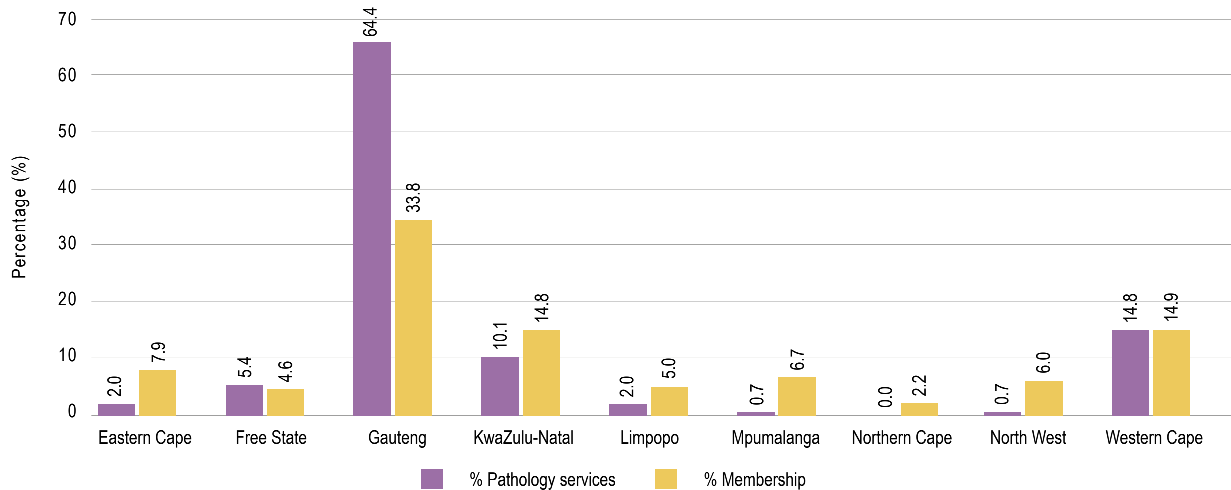
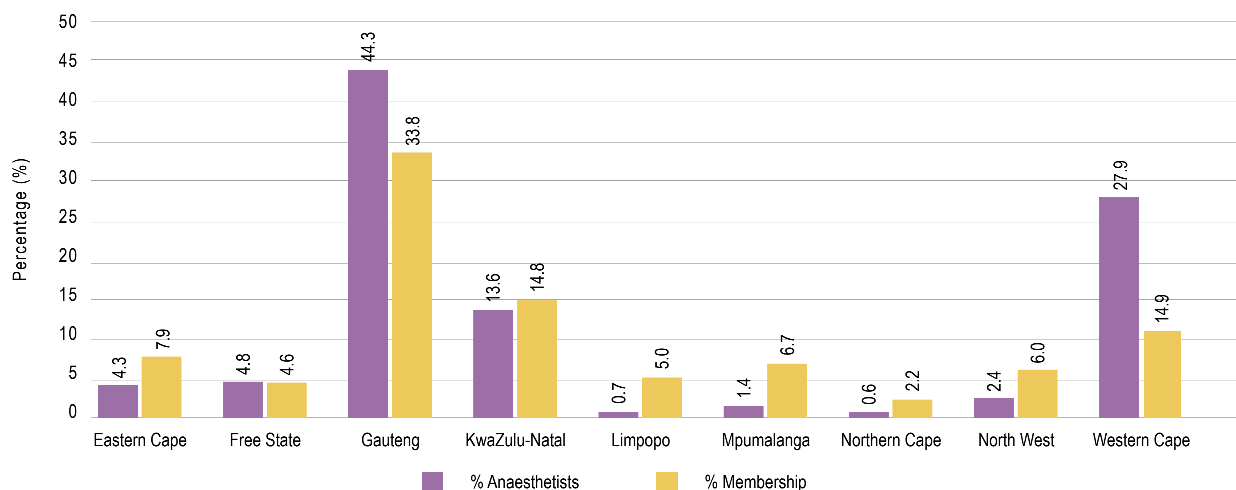


Figure 40: Provincial distribution of membership and radiology services: 2014







Despite a high number of GPs relative to specialists (Figure 35), healthcare benefits paid by medical schemes to healthcare providers continue to be skewed towards hospital and specialist care, limiting the role played by primary healthcare practitioners. This is a result of benefit design. It is expected that this situation might change in the near future due to the strengthening of managed care interventions, innovative contracting within the context of coordinated care, the low-cost benefit options market, and the inclusion of preventive and primary care benefits in the PMB package.

The global picture

A key indicator of any country's health system performance is the ratio of health professionals to the population served.

According to the 2014 World Health Report, the supply of physicians/doctors per 10 000 population globally was 14.1 and it was 15.5 for upper middle income countries. This ratio varied from 7.0 to 43.1 within BRICS countries, with India and South Africa having the lowest proportion of doctors and Russia the highest (WHO 2014). These ratios included doctors practising in the public and private healthcare sectors.

Table 38: Global trend: Physician per 10 000 population

Global trends	Physician per 10 000 population
Global	14.1
Upper middle income countries	15.5
BRICS countries	
South Africa	7.8
India	7.0
China	14.6
Brazil	18.9
Russia	43.1
Africa Region	2.6

Source: *World Health Statistics (2014)*

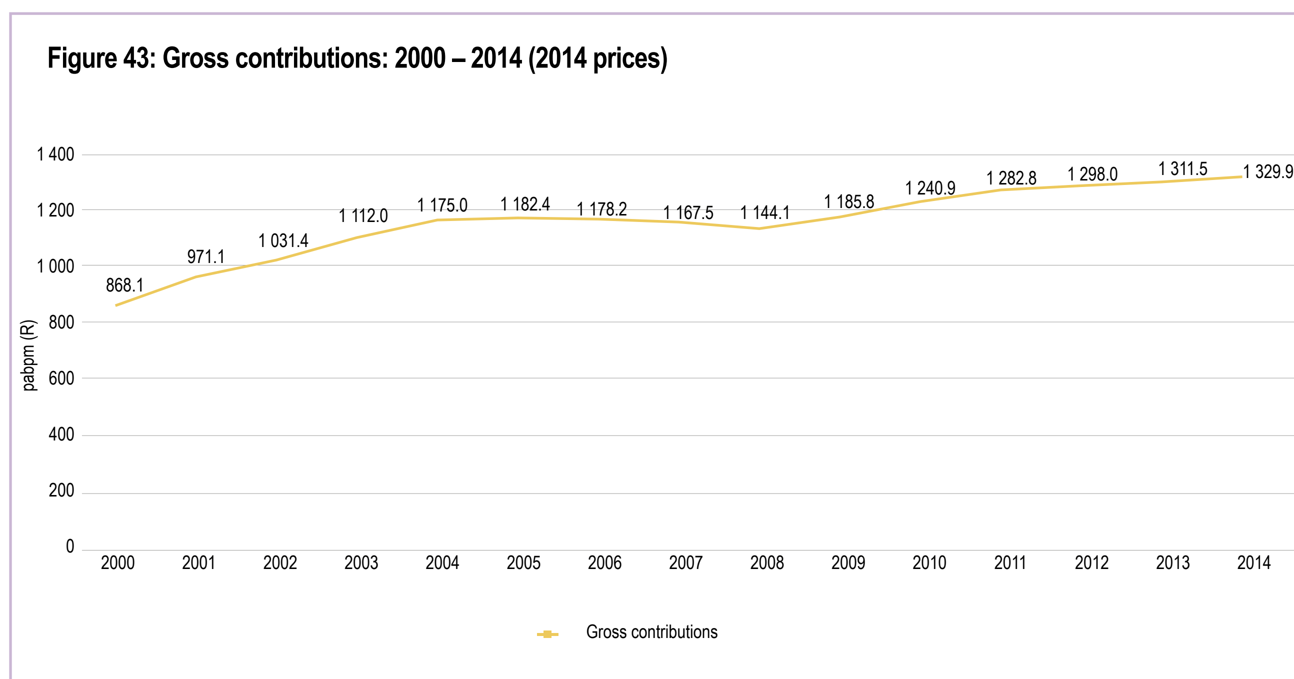
- *Physicians in this context mean all medically trained doctors (professional qualification) regardless of specialisation.*

In South Africa, the ratio of 13.6 GPs per 10 000 beneficiaries in the medical scheme industry compares well with the global ratio of 14.1 physicians per 10 000 population. Unfortunately, the ratio of 7.8 physicians per 10 000 population for South Africa as a whole raises concerns about our overall health system performance and equity objectives. It indicates why the strengthening of human resources in the public healthcare sector is a priority for the national Department of Health.

Contributions, relevant healthcare expenditure[1] and trends

Contributions

Figure 43: Gross contributions: 2000 – 2014 (2014 prices)



1. *All references to claims and benefits indicate relevant healthcare expenditure.*

Since 2000, gross contributions per average beneficiary per month[2] (pabpm) have increased by 53.2%, as depicted in Figure 36, while gross relevant healthcare expenditure increased by 52.2% (Figure 37). This has assisted the industry to cover increasing healthcare costs, build reserves and retain members.

Scheme contributions increased by 8.0% to R140.2 billion as at December 2014 from R129.8 billion in December 2013. Gross contributions pabpm rose by 7.6% to R1 329.8 from R1 235.7 in 2013.

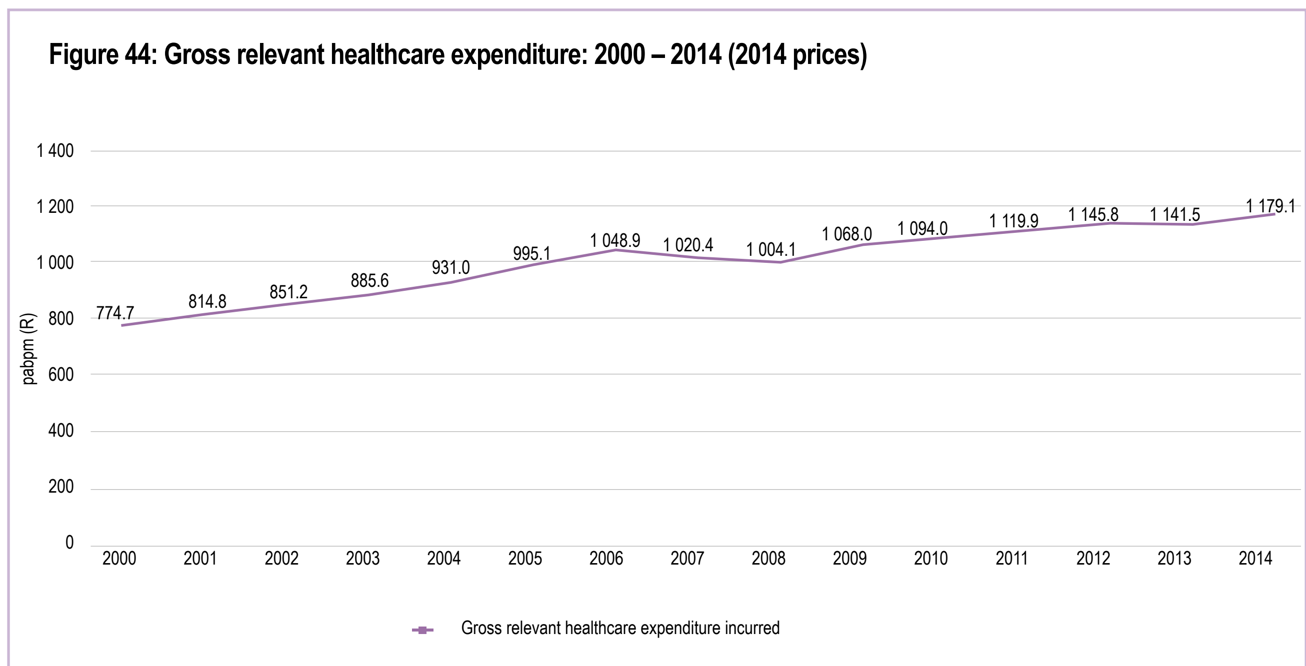
Risk contributions (gross contributions minus medical savings accounts contributions) increased by 7.8% to R126.9 billion in 2014 from R117.8 billion in 2013. The equivalent increase from 2012 to 2013 was 10.3%. The 2014 increase in risk contributions pabpm was 7.4% (2013: 8.4%), rising to R1 203.9 from R1 120.9 a year earlier.

Contributions to medical savings accounts increased by 10.1% to R13.3 billion in 2014 from R12.1 billion (2013: 11.6% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 9.4% – from R115.2 to R126.0 (2013: 6.8% decrease).

Relevant healthcare expenditure

Figure 44 shows the trend in gross relevant healthcare expenditure over time. In the last 15 years expenditure pabpm has increased by 52.2%.

Figure 44: Gross relevant healthcare expenditure: 2000 – 2014 (2014 prices)



The total gross relevant healthcare expenditure incurred by medical schemes in 2014 increased by 10.0% to R124.3 billion[3] from R113.0 billion in 2013. The total gross relevant healthcare expenditure incurred pabpm increased by 9.6% to R1 179.0 from R1 075.5 in 2013.

Risk claims increased by 10.0% to R112.0 billion in 2014 from R101.8 billion in 2013 (2013: 8.8%). Risk claims pabpm rose by 9.6% in 2014 to R1 062.2 from R969.3 (2013: 7.0%).

Claims paid from medical savings accounts increased by 10.4% to R12.3 billion in 2014 from R11.2 billion (2013: 10.8% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 9.6% in 2014 to R116.9 from R106.6 the previous year (2013: 7.4% decrease).

2. Adjusted for inflation, 2014 prices.
3. This number differs from the R124.1 billion reported above as "benefits paid" include incurred but not reported and the results of risk transfer arrangements in this section.

Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Table 39 and Figures 45 and 46 show contributions and claims for open and restricted schemes pabpm.

Table 39: Contributions and relevant healthcare expenditure pabpm: 2000 – 2014

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% Change	pasbpm R	% Change	pabpm R	% Change	pasbpm R	% Change
Open								
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	163.4	10.8	884.9	6.4	153.6	9.9
2013	1 138.1	8.6	172.0	5.3	953.2	7.7	160.5	4.5
2014	1 223.1	7.5	187.3	8.9	1 039.0	9.0	175.8	9.5
Restricted								
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	1 016.1	7.8	60.0	(2.7)	932.8	10.8	53.6	(3.5)
2013	1 100.1	8.3	45.5	(24.1)	988.8	6.0	40.6	(24.4)
2014	1 180.1	7.3	49.8	9.3	1 091.0	10.3	43.8	7.8

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of those schemes that had savings transactions

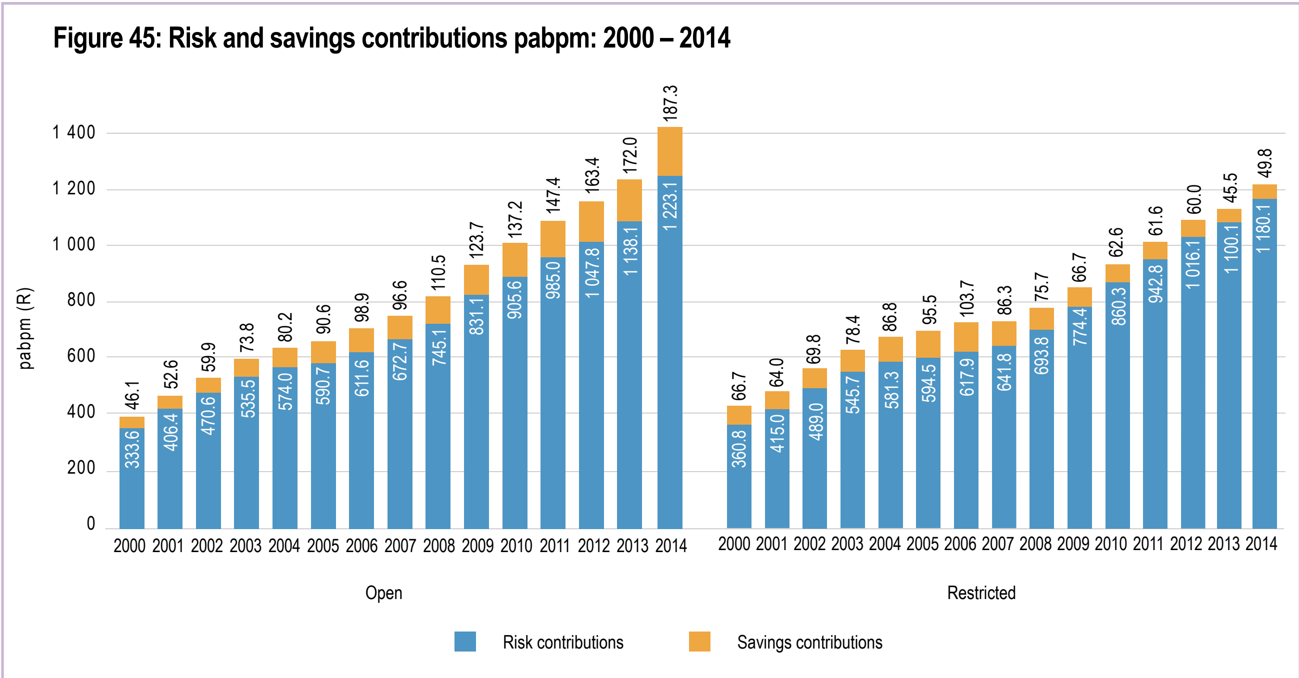


Figure 45: Risk and savings contributions pabpm: 2000 – 2014

pabpm = per average beneficiary per month

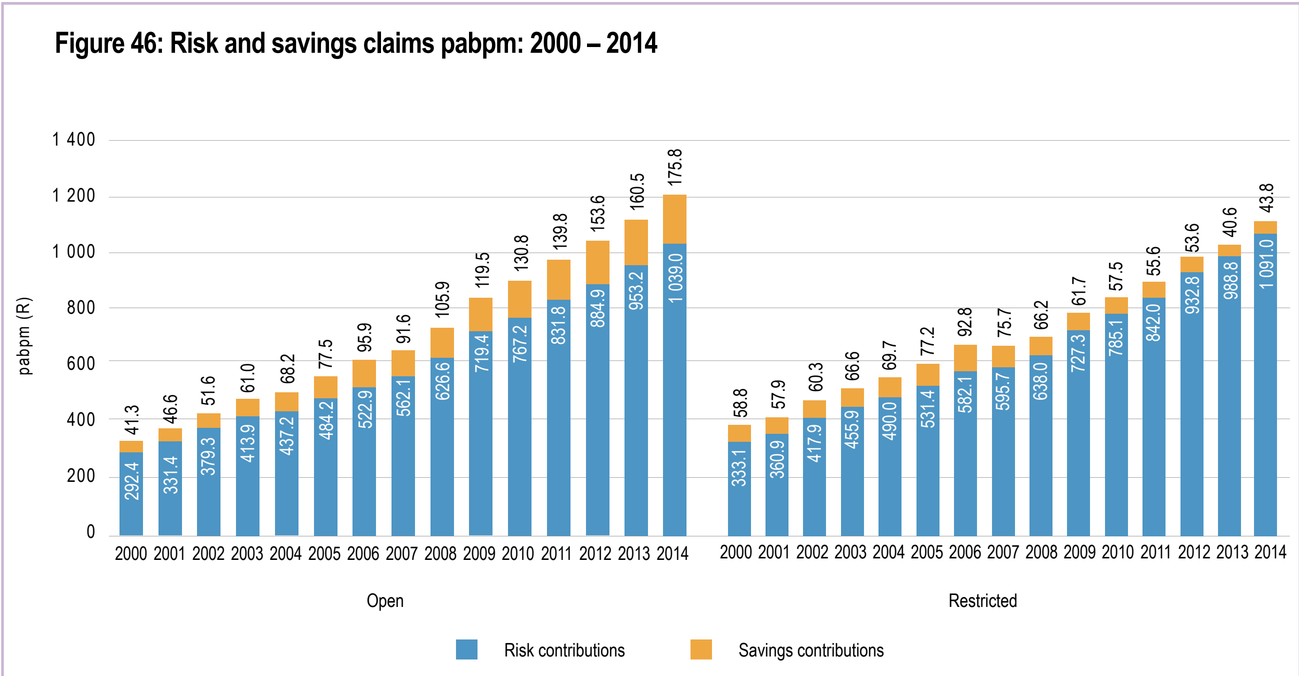


Figure 46: Risk and savings claims pabpm: 2000 – 2014

pabpm = per average beneficiary per month

On average, increases in risk contributions and claims pabpm were slightly lower in restricted schemes than in open schemes over the last 15 years. From 2008 to 2013, restricted schemes experienced decreases in claims from members' medical savings accounts while open schemes incurred increases. The risk claims ratio in open schemes increased to 85.0% in 2014 from 83.8% in 2013. In restricted schemes it increased to 92.4% from 89.9% in 2013.

Figure 47: Risk and medical savings accounts contributions and claims pabpm: 2000 – 2014

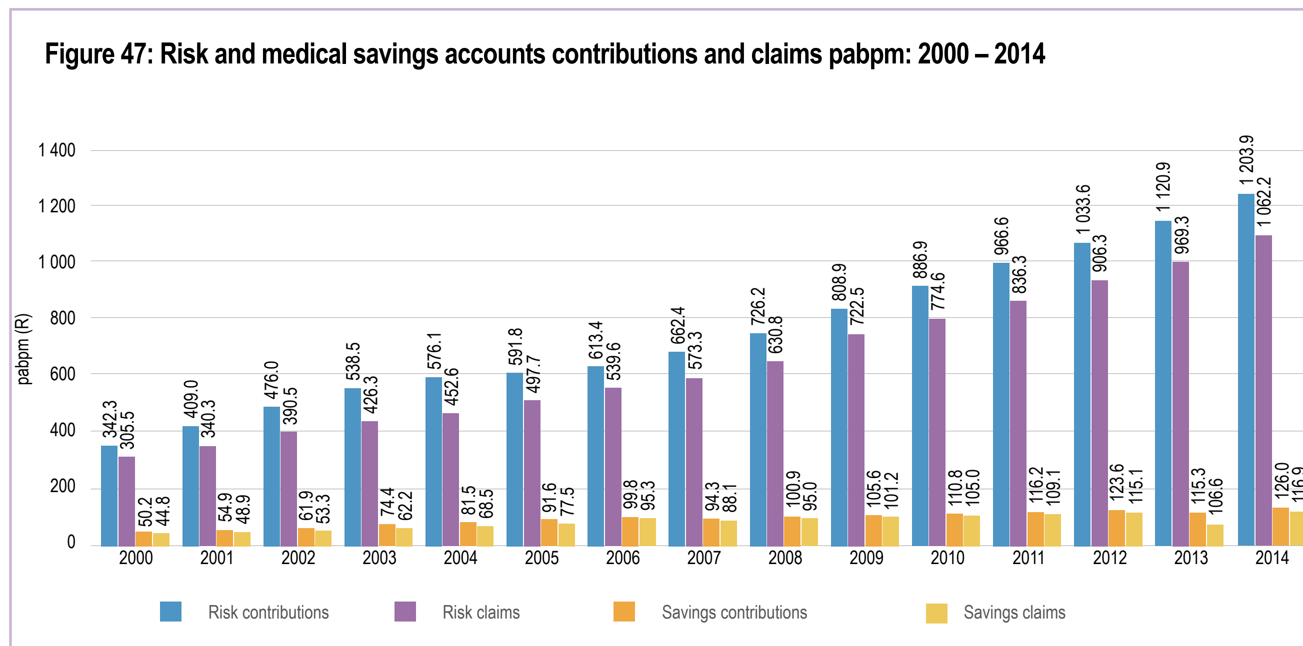


Figure 47 and Table 40 show that between 2003 and 2006 medical savings account contributions and claims increased at greater rates than those recorded for the risk components. This indicates a move towards benefit designs which require a greater proportion of benefits to be funded from members' personal medical savings accounts than from the general risk pool of the scheme.

But the figures for the period 2007 – 2014 appear to reflect a change in this trend. In 2000, savings contributions made up 12.8% of gross contributions. At the end of 2014, savings had declined to 9.5% of gross contributions. 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 savings plan accounts.

Table 40: Contributions and relevant healthcare expenditure pabpm: 2000-2014 (2014 prices)

	Risk contributions		Savings contributions		Risk claims		Savings claims	
All schemes	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
2000	757.1		111.0		675.8		99.0	
2001	856.2	13.1	114.9	3.5	712.5	5.4	102.4	3.5
2002	912.8	6.6	118.6	3.3	749.0	5.1	102.2	(0.1)
2003	976.4	7.0	135.5	14.2	772.9	3.2	112.7	10.2
2004	1 029.3	5.4	145.7	7.5	808.6	4.6	122.4	8.6
2005	1 024.0	(0.5)	158.4	8.8	861.1	6.5	134.0	9.5
2006	1 013.4	(1.0)	164.8	4.0	891.5	3.5	157.4	17.5
2007	1 022.0	0.9	145.5	(11.7)	884.5	(0.8)	135.9	(13.7)
2008	1 004.6	(1.7)	139.6	(4.1)	872.7	(1.3)	131.4	(3.3)
2009	1 048.9	4.4	136.9	(1.9)	936.8	7.4	131.2	(0.2)
2010	1 103.1	5.2	137.9	0.7	963.4	2.8	130.6	(0.5)
2011	1 145.1	3.8	137.6	(0.2)	990.7	2.8	129.3	(1.0)
2012	1 159.3	1.2	138.6	0.7	1 016.6	2.6	129.2	(0.1)
2013	1 189.2	2.6	122.3	(11.8)	1 028.3	1.2	113.1	(12.4)
2014	1 203.9	1.2	126.0	3.1	1 062.2	3.3	116.9	3.3

pabpm = per average beneficiary per month.
pasbpm = pabpm in respect of schemes which had savings transactions.

Table 40 indicates the changes in contributions and claims after adjusting for inflation.

Over the last few years, medical schemes generally experienced increases in risk contributions and claims pabpm, and a notable decrease in savings contributions and claims.

Savings contributions and claims have shown a downward trend from 2007. There was a further sharp decline in 2013 due to a number of schemes no longer utilising personal medical savings accounts in the benefit designs. Savings contributions and claims experienced a slight increase in 2014 of 3.1% and 3.3% respectively.

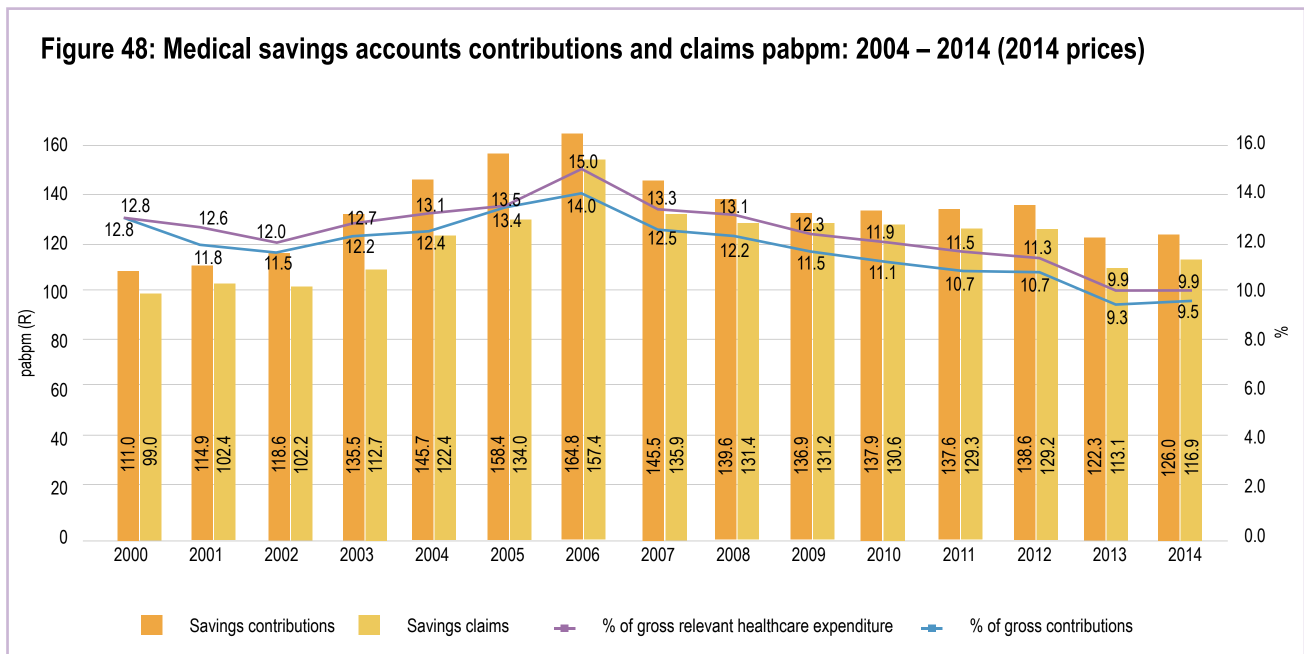


Figure 48: Medical savings accounts contributions and claims pabpm: 2004 – 2014 (2014 prices)

The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure remained stable at 9.9% during the review period (2013: 9.9%), as shown in Figure 48.

For open schemes, the proportion of claims paid from medical savings accounts increased from 14.4% in 2013 to 14.5% in 2014. The medical savings accounts claims ratio increased to 93.8% from 93.3% in 2013.

For restricted schemes, the proportion of claims paid from medical savings accounts remained stable in 2014 at 3.9% (2013: 3.9%). The medical savings accounts claims ratio decreased to 87.9% from 89.1% in 2013.

Figure 49 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 59.0% and 57.2% respectively on a pabpm basis. Medical savings account contributions and claims have risen by 13.6% and 18.1% respectively.

Figure 49: Risk and medical savings accounts contributions and claims pabpm: 2000 – 2014 (2014 prices)

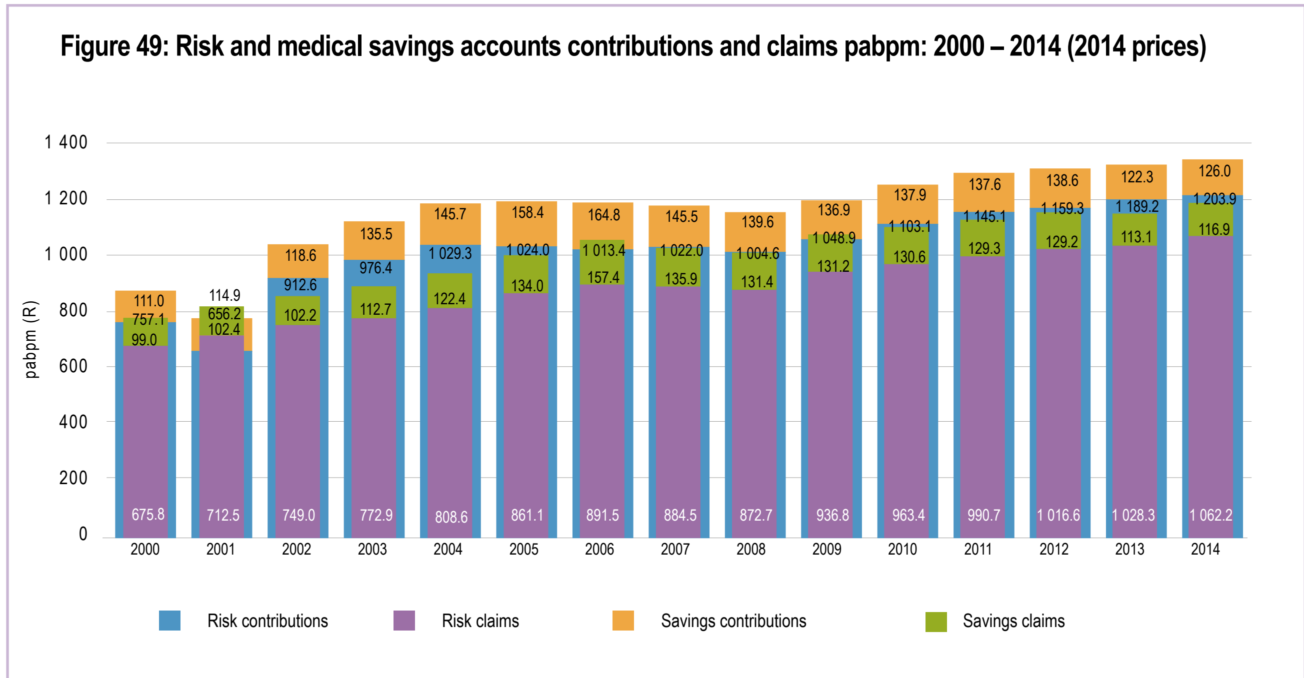
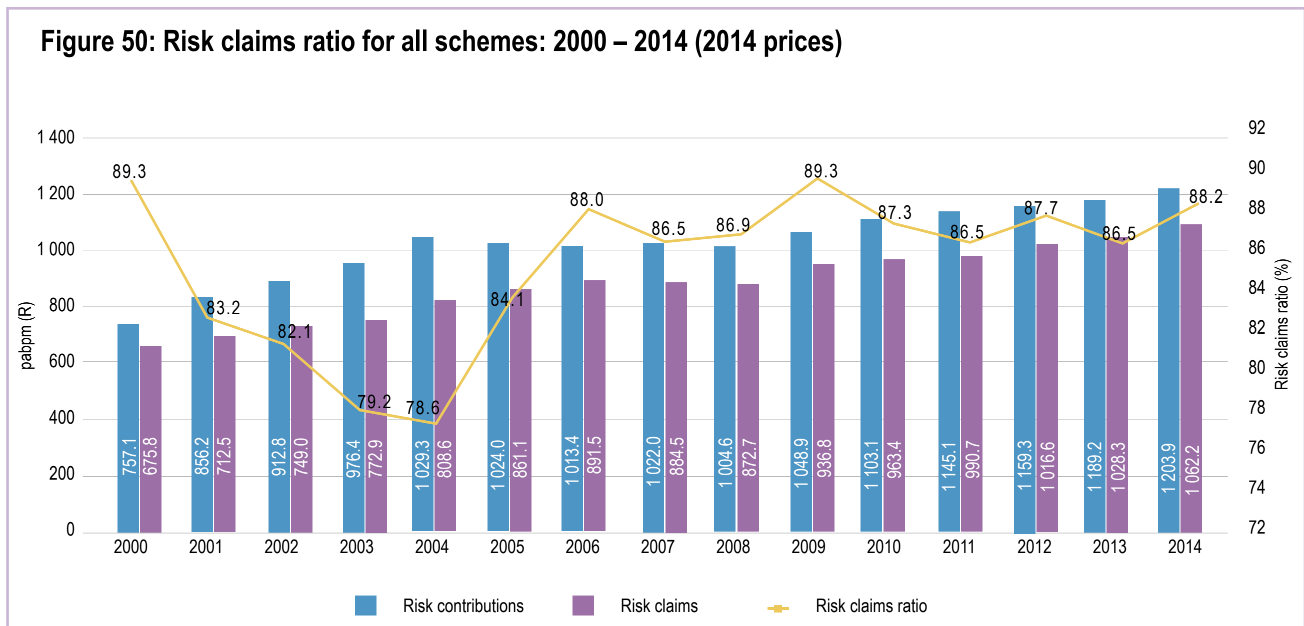


Figure 50 shows the relationship between risk contributions and claims paid over the past decade. All figures have been adjusted for inflation.

Figure 50: Risk claims ratio for all schemes: 2000 – 2014 (2014 prices)



After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised at 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. In 2012 there was a slight increase from the previous year, with medical schemes paying out 87.7% of risk contributions in benefits. In 2013 the claims ratio decreased to 86.5%, and has since risen again in 2014 to 88.2%. Thus between 2006 and 2014, claims ratios remained in a range between 86.5% and 88.2%, with the exception of 2009 when the ratio peaked at 89.3%.

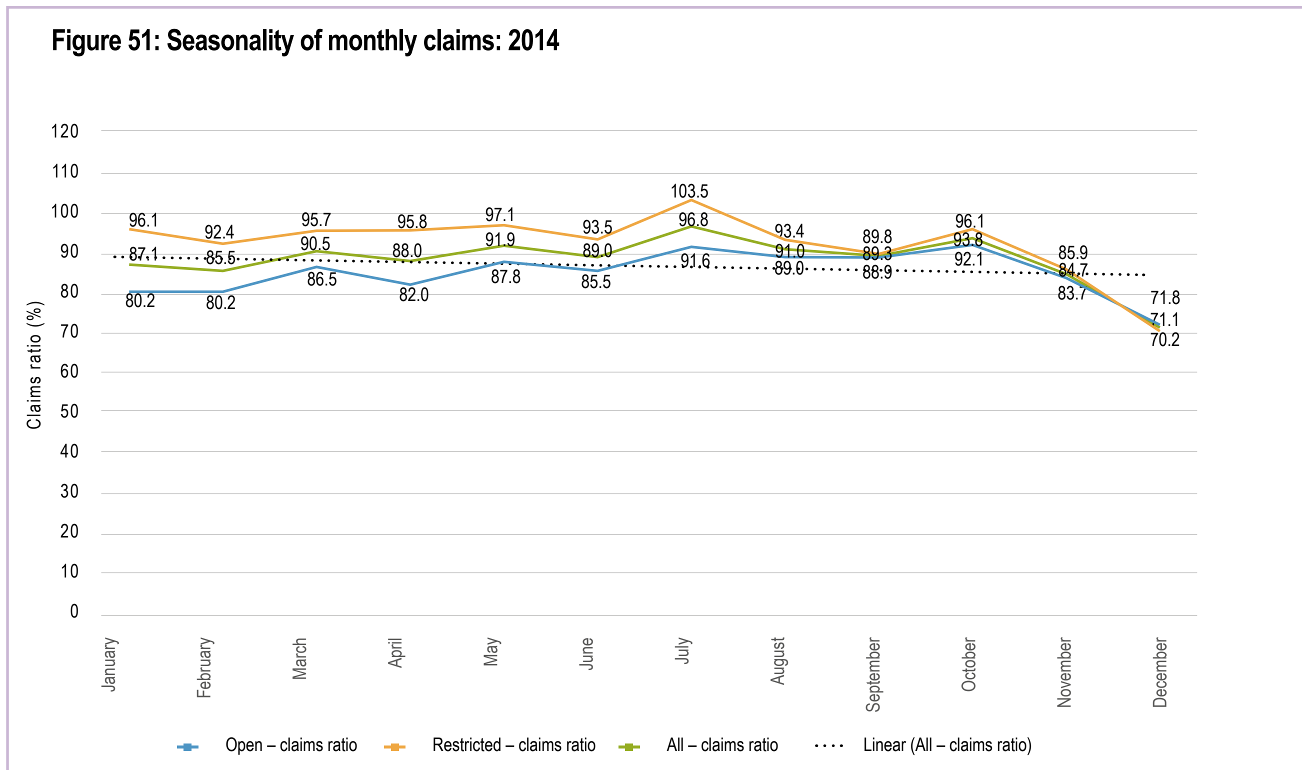


Figure 51 shows a clear seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2014. Both open and restricted schemes follow the same general trend: an increase in claims in the first quarter of the year as members gain access to new benefits, increases in claims over the winter months, and a 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 41 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.
- The net effect thereof.

The "net income/(expense)" column reflects the value derived from the risk transfer arrangement. (Annexure W provides further details.)

Table 41: Significant risk transfer arrangements 2013 and 2014

	Capitation fees			Estimated recoveries			Net income/(expense)*		
Scheme category	2014 R'000	2013 R'000	% growth	2014 R'000	2013 R'000	% growth	2014 R'000	2013 R'000	% growth
Open	2 001 917	1 881 332	6.4	1 906 845	1 705 147	11.8	(89 922)	(173 937)	(48.3)
Restricted	1 036 582	1 054 765	(1.7)	1 221 269	1 213 541	0.6	191 448	160 363	19.4
All	**3 038 498**	**2 936 097**	**3.5**	**3 128 114**	**2 918 688**	**7.2**	**101 526**	**(13 574)**	**848.0**

* *The net income/(expense) on risk transfer arrangements includes an amount of R11.9 million in respect of profit- and loss-sharing agreements.*

Table 42 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements and Table 43 details the 10 benefit options which reported the greatest losses.

Table 42: Schemes with highest risk transfer arrangement losses: 2014

Ref no	Name of medical scheme	Beneficiaries 31 Dec 2014	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	656 527	771 675	659 875	(111 800)	(14.5)
1167	Momentum Health	226 487	271 200	225 019	(46 448)	(17.1)
1087	Keyhealth	74 722	69 902	64 544	(5 293)	(7.6)
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	46 355	20 328	16 555	(3 773)	(18.6)
1583	Platinum Health	84 771	30 725	27 453	(3 273)	(10.7)
1506	Medimed Medical Scheme	14 069	9 377	6 917	(2 460)	(26.2)
1149	Medihelp	223 131	262 746	258 258	(1 730)	(0.7)
1293	Wooltru Healthcare Fund	18 699	21 241	18 325	(1 632)	(7.7)
1270	Golden Arrow Employees' Medical Benefit Fund	6 104	21 070	19 548	(1 522)	(7.2)
1145	LA-Health Medical Scheme	125 638	8 637	7 492	(1 145)	(13.3)

Table 43: Options with highest risk transfer arrangement losses: 2014

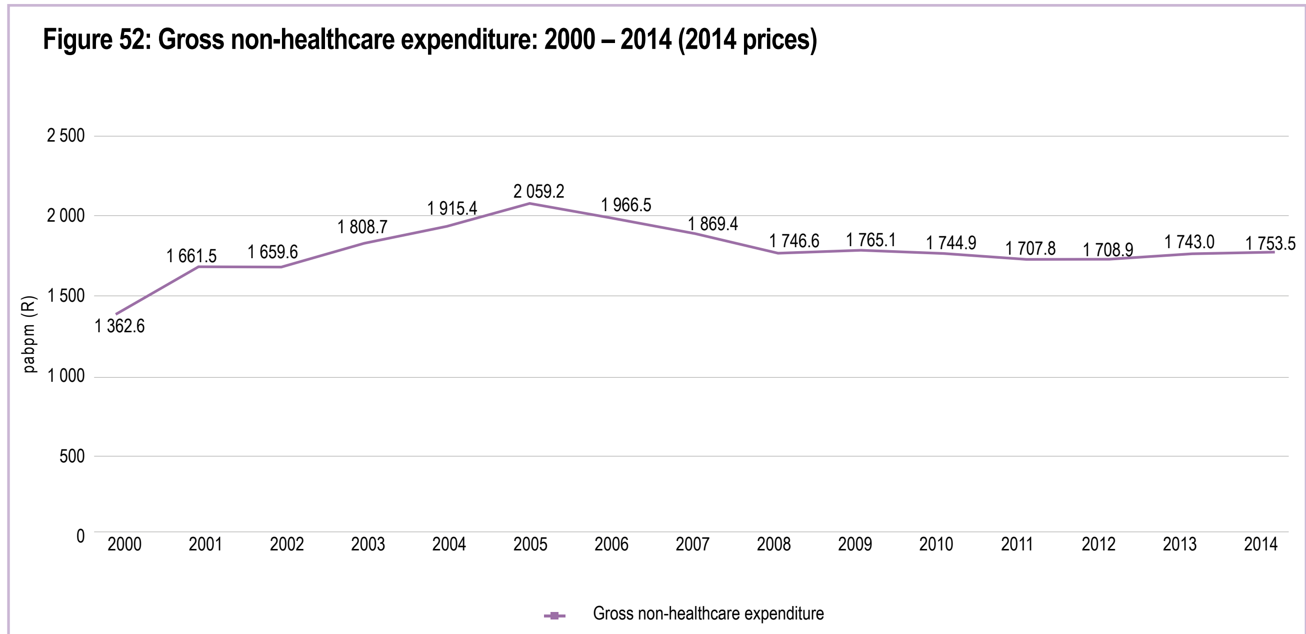
Ref No		Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2013	Average age of beneficiaries Years	Capitation fees R'000	Estimated recoveries R'000	Profit/(loss) sharing R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	1894	Bonitas Medical Fund	Standard	330 505	32.7	544 797	475 669	–	(69 128)	(12.7)
1167	2049	Momentum Health	Custom	89 198	30.9	83 417	34 089	(90)	(49 418)	(59.2)
1512	1895	Bonitas Medical Fund	Bonsave	70 369	27.2	52 163	36 295	–	(15 868)	(30.4)
1149	2294	Medihelp	Unify	9 591	26.5	53 965	40 753	(1 657)	(14 869)	(27.6)
1512	1896	Bonitas Medical Fund	Primary	147 816	27.3	116 936	103 450	–	(13 486)	(11.5)
1125	1790	Discovery Health Medical Scheme	Classic Comprehensive	401 095	38	125 594	112 624	–	(12 970)	(10.3)
1167	2263	Momentum Health	Ingwe	36 013	27.2	69 868	58 502	(78)	(11 444)	(16.4)
1552	2108	Community Medical Aid Scheme (COMMED)	Fundamental	2 071	36.2	13 200	4 034	–	(9 166)	(69.4)
1512	6070	Bonitas Medical Fund	BonClassic	26 615	44.7	39 392	32 178	–	(7 215)	(18.3)
1167	2053	Momentum Health	Incentive	78 220	36.1	78 676	73 445	(94)	(5 325)	(6.8)

pb = per beneficiary

Bonitas Medical Fund is listed in both Table 42 and 43 as the biggest loss-maker.

The Commed Fundamental option suffered the biggest loss in terms of the percentage of capitation fees paid (69.4%) followed by the Custom option from Momentum Health (59.2%), as shown in Table 43.

Non-healthcare expenditure



Given the substantial increases in non-healthcare expenditure observed between 2000 and 2005 (which exceeded the rate of increase in contributions), non-healthcare spending has consistently been a key focus for the CMS. Overall these costs have reduced in real terms but there are still individual schemes and particular non-healthcare items – such as advertising and marketing, consulting and legal fees, and trustee remuneration – that continue to show upward trends and thus require attention. In the interests of member protection, it is important that such expenditure can demonstrate clear value.

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, being the largest component of non-healthcare expenditure in all medical schemes, grew by 7.1% to R10.1 billion between December 2013 (when it stood at R9.4 billion) and December 2014. Open schemes increased their administration expenditure by 6.5% to R6.9 billion from R6.5 billion in 2013. Administration spending in open schemes increased by 8.6% from R2.9 billion in 2013 to R3.2 billion in 2014.

Ten open schemes (representing 6.0% of all average beneficiaries) and 10 restricted schemes (representing 2.1% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of gross contribution income (GCI) in 2014.

Table 44 shows "high-impact"[4] open schemes with administration expenditure greater than 10% of GCI. A high percentage is sometimes the function of a low average contribution rather than high absolute administration costs.

Table 44: High-impact open schemes with administration expenditure above 10% of GCI: 2014

Name of scheme	Average number of beneficiaries	Administration expenditure as % of GCI
Liberty Medical Scheme	116 522	10.3
Medihelp	220 374	10.1
Resolution Health Medical Scheme	57 978	11.1
Selfmed Medical Scheme	13 950	11.9
Spectramed	38 228	11.9

GCI = gross contribution income

4. Refer to the section on the Risk Assessment Framework (RAF) on page 192.

Table 45 shows high-impact open schemes with administration expenditure above the open schemes industry average of R118.7 pabpm. When excluding self-administered schemes, this average increases to R119.7 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 45: High-impact open schemes with administration expenditure above open schemes average for 2014

Name of scheme	Average beneficiaries	Administration expenditure pabpm R
Fedhealth Medical Scheme	148 836	144.1
Keyhealth	74 933	133.3
Liberty Medical Scheme	116 522	152.9
Medihelp	220 374	142.8
Resolution Health Medical Scheme	57 978	136.0
Selfmed Medical Scheme	13 950	196.7
Sizwe Medical Fund	124 626	132.0
Spectramed	38 228	189.9

pabpm = per average beneficiary per month

Table 46 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.

Table 46: Gross administration fees paid to third-party administrators pabpm: 2013 and 2014

	Open schemes			Restricted schemes		
	pabpm 2014 R	pabpm 2013 R	Variance %	pabpm 2014 R	pabpm 2013 R	Variance %
Third party						
Administration fees	103.8	97.8	6.2	46.4	43.6	6.3
Co-administration fees	–	–	–	6.5	5.8	11.8
Total – third party	**103.8**	**97.8**	**6.2**	**49.6**	**46.5**	**6.7**
Self-administered						
Administration fees	–	–	–	–	–	–
Co-administration fees	–	–	–	–	–	–
Total – self-administered	**–**	**–**	**–**	**–**	**–**	**–**

pabpm = per average beneficiary per month

On average, third-party-administered open schemes spent 109.1% more on gross administration fees than third-party-administered restricted schemes (2013: 109.0%).

Administration fees paid to third-party administrators were the main component of gross administration expenditure (GAE). They grew by 11.0% to R7.7 billion in 2014 from R6.9 billion in the previous year. These fees represented 82.3% of GAE in 2014 (2013: 82.4%).

Fees of trustees and principal officers

Remuneration and other considerations of trustees and principal officers accounted for 0.6% and 0.9% of GAE respectively. In 2014, the fees of principal officers amounted to 0.6% of GAE in open schemes (2013: 0.7%) and 1.5% in restricted schemes (2013: 1.5%).

Table 47 shows the 10 schemes with the highest average fees for trustees. More details are contained in Annexure T.

Table 48 shows the 10 schemes with the highest principal officer fees. More details are contained in Annexure T.

Figure 53 provides a breakdown of trustee remuneration for the 10 schemes with the highest remuneration.

Table 47: Ten schemes with highest trustee fees: 2014

Name of medical scheme	Type	Trustee remuneration and considerations R'000		Number of trustees		Average fee per trustee R'000	
		2014	2013	2014	2013	2014	2013
Government Employees Medical Scheme (GEMS)	Restricted	8 924	7 951	17	14	525	568
Bonitas Medical Fund	Open	3 869	3 730	9	10	430	373
Discovery Health Medical Scheme	Open	3 717	3 178	6	8	619	397
Fedhealth Medical Scheme	Open	3 610	3 703	13	12	278	309
Liberty Medical Scheme	Open	2 928	2 774	8	9	366	308
LA-Health Medical Scheme	Restricted	2 798	2 459	16	16	175	154
Spectramed	Open	2 787	2 135	8	6	348	356
Bankmed	Restricted	2 448	1 722	13	14	188	123
Profmed	Restricted	2 400	2 705	10	12	240	225
Bestmed Medical Scheme	Open	2 349	2 170	22	13	107	167

Figure 53: Composition of trustee remuneration for 10 schemes with highest remuneration: 2014

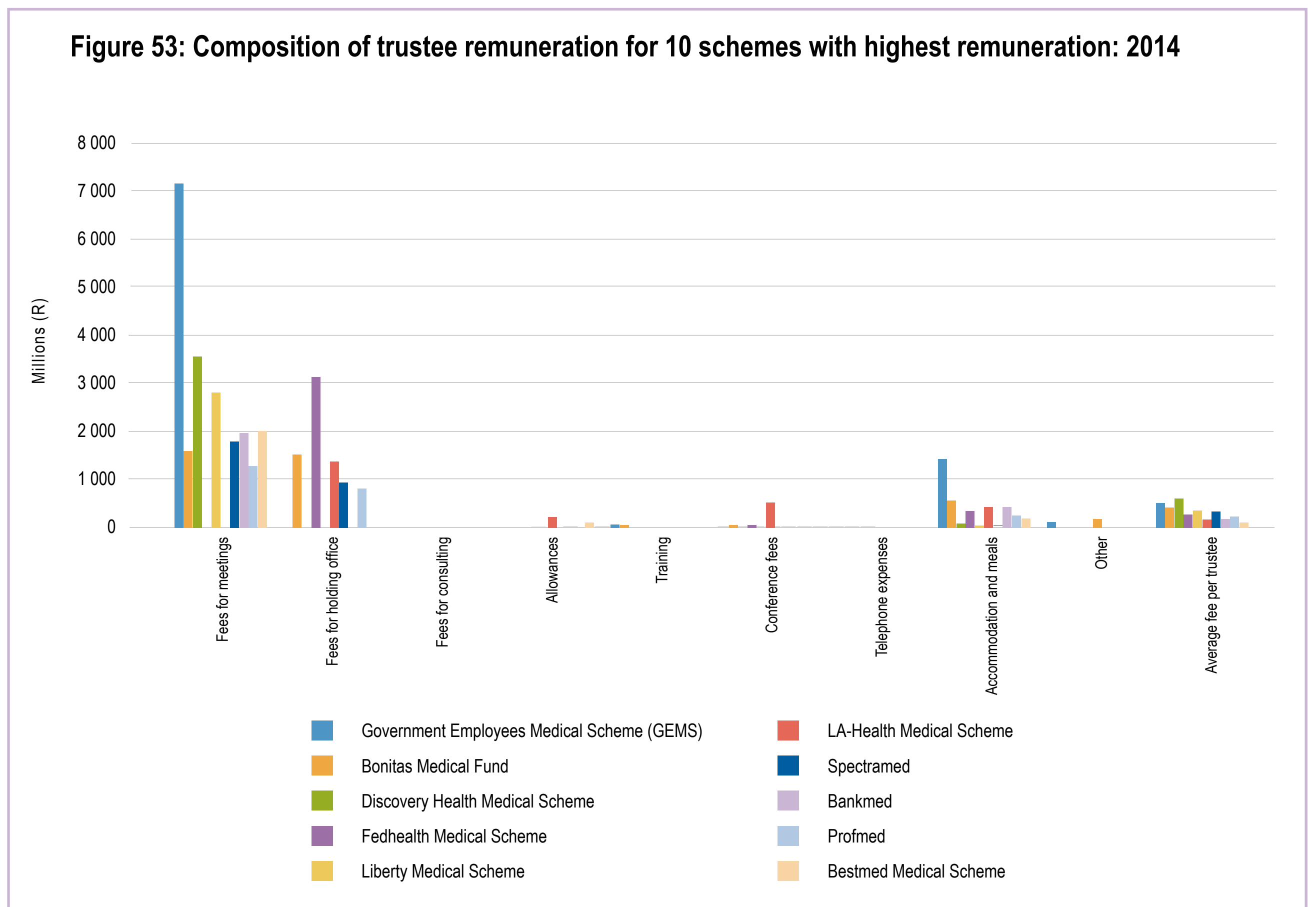


Table 48: Ten schemes with highest remuneration for principal officers: 2014

Name of medical scheme	Average number of beneficiaries	Principal officer remuneration R'000 2014	2013	% change
South African Police Service Medical Scheme (POLMED)	497 068	5 365	5 204	3.1
Discovery Health Medical Scheme	2 598 577	4 816	5 399	(10.8)
Bestmed Medical Scheme	190 272	4 152	5 684	(27.0)
Liberty Medical Scheme	116 522	4 072	3 993	2.0
Government Employees Medical Scheme (GEMS)	1 837 809	3 759	2 989	25.8
Sizwe Medical Fund*	124 626	3 513	2 539	38.3
Bonitas Medical Fund	652 602	3 220	2 863	12.5
Transmed Medical Fund	81 042	3 147	2 916	7.9
Umvuzo Health Medical Scheme	55 743	3 075	2 706	13.6
Profmed	65 137	2 599	2 426	7.1

* *Amounts include curator fees.*

Expenditure on benefits management: managed healthcare fees

Managed healthcare management fees increased by 8.1% to R3.4 billion in 2014 from R3.2 billion in 2013. In 2014 the number of beneficiaries covered by these managed healthcare interventions increased by 0.4% to 8 723 447 beneficiaries or (99% of all beneficiaries).

Table 49 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare management fees. There were 52 options in this category, and they accounted for 5.6% of beneficiaries in respect of whom such expenditure was incurred.

Table 49: Managed healthcare management fees for options with a claims ratio above 100%: 2014

	Managed care costs R'000	Managed care costs pbpm	Gross healthcare result* R'000	Gross healthcare result* pbpm	Beneficiaries	Number of options
Open schemes	82 828	37.5	(502 034)	(227.6)	183 831	20
Restricted schemes	131 353	35.8	(967 442)	(263.5)	305 977	32
All schemes	**214 181**	**36.4**	**(1 469 477)**	**(250.0)**	**489 808**	**52**

pbpm = per beneficiary per month
* *Gross healthcare result = contributions less claims*

Broker costs

Broker costs, which include all commissions, service fees and other distribution costs, increased by 8.1% from R1 583.2 million in 2013 to R1 711.3 million in 2014 (2013: 9.3%).

Broker costs represented 11.1% of total non-healthcare expenditure in 2014, while they accounted for 11.0% in 2013.

For schemes that pay broker commissions, the amounts paid on a per average member per month (pampm) basis increased to R54.7 in 2014 from R51.2 in 2013, representing an increase of 6.8%.

Broker commissions as a percentage of GCI remained at 1.2% in 2014.

Figure 54 shows annual broker service fees paid by open schemes since 2000, as well as their percentage of total non-healthcare expenditure.

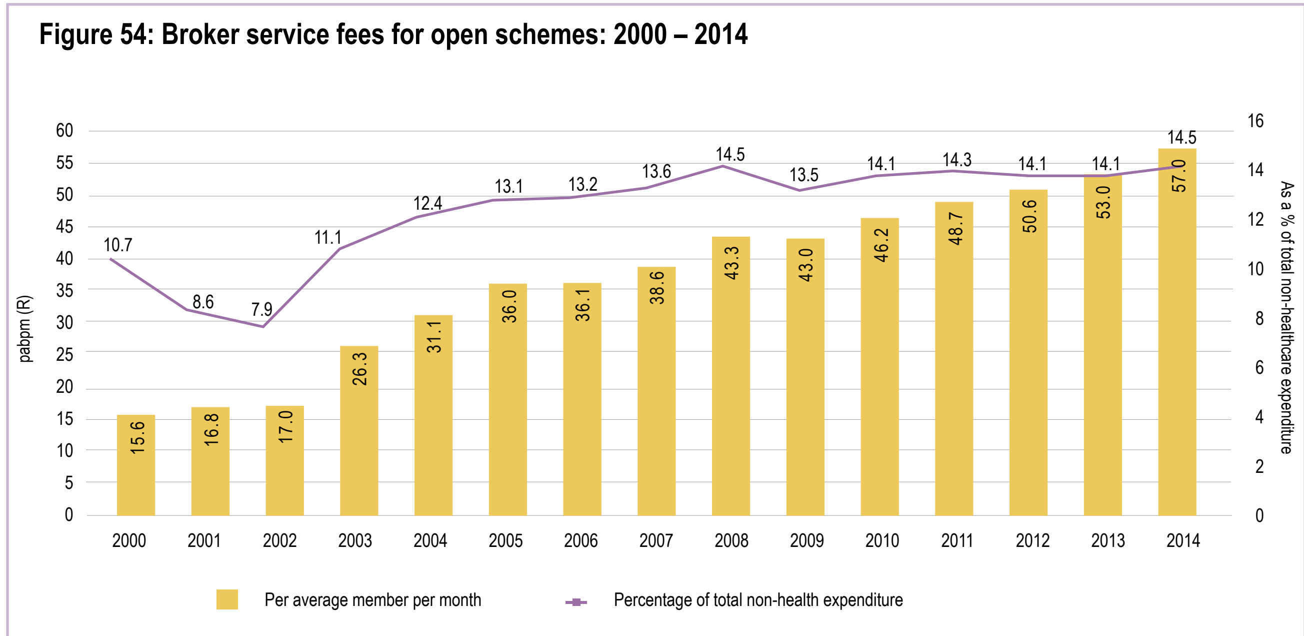


Figure 55 illustrates the increase in broker fees relative to the number of members of schemes that pay brokers.

Table 50 illustrates the schemes which had broker service fees that were higher than the industry average of R54.7 pampm during 2014 (2013: R51.2 pampm). These six schemes (2013: eight) represented 60.1% (2013: 60.8%) of total membership that paid for broker service fees, and 68.5% (2013: 69.1%) of total broker service fees paid. Two of these schemes paid at levels 15.0% greater than the industry average.

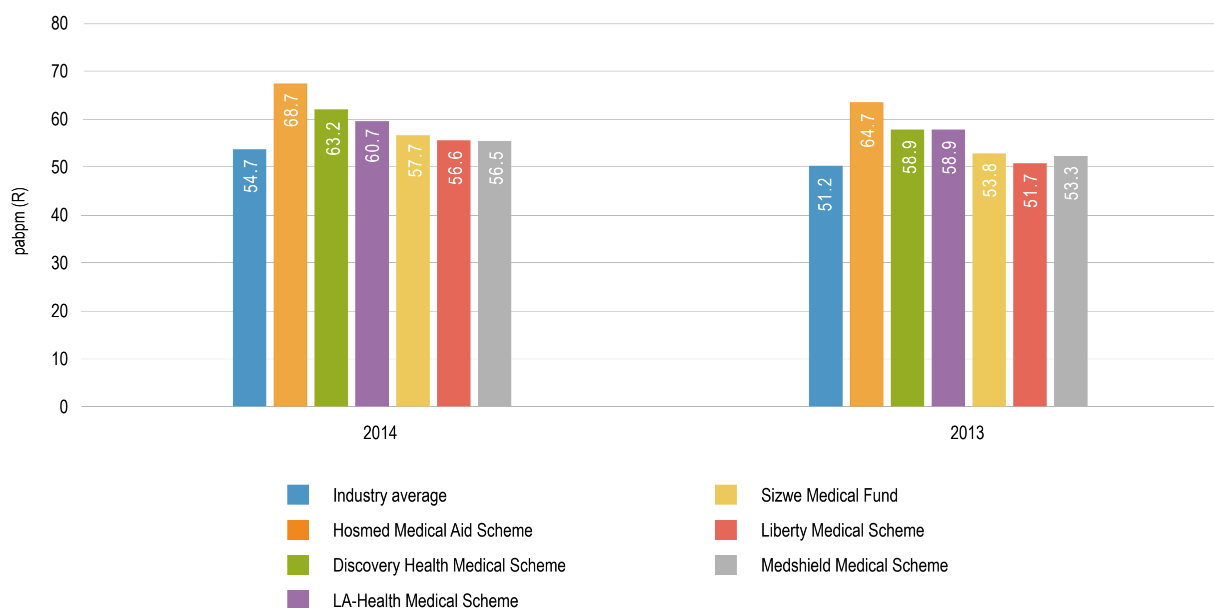
It is a matter of concern that some of the schemes which paid broker commission pampm exceeding the industry average also incurred additional distribution fees in respect of their broker network.

Table 50: Schemes with broker fees above the industry average of R54.7: 2013 and 2014

		Broker fees*			Other distribution fees		
		2014	2013		2014	2013	
		pampm	pampm	%	pampm	pampm	%
Name of medical scheme	Type	R'000	R'000	change	R'000	R'000	change
Hosmed Medical Aid Scheme	Open	68.7	64.7	6.1	–	–	0
Discovery Health Medical Scheme	Open	63.2	58.9	7.4	–	–	0
LA-Health Medical Scheme	Restricted	60.7	58.9	3.0	–	–	0
Sizwe Medical Fund	Open	57.7	53.8	7.3	–	–	0.0
Liberty Medical Scheme	Open	56.6	51.7	9.4	–	–	0
Medshield Medical Scheme	Open	56.5	53.3	6.0	5.1	17.4	-70.6

pampm = per average member per month
**excluding distribution costs*

Figure 56: Schemes with broker fees above the industry average of R54.7 pampm: 2013 and 2014



pampm = per average member per month

Reinsurance results

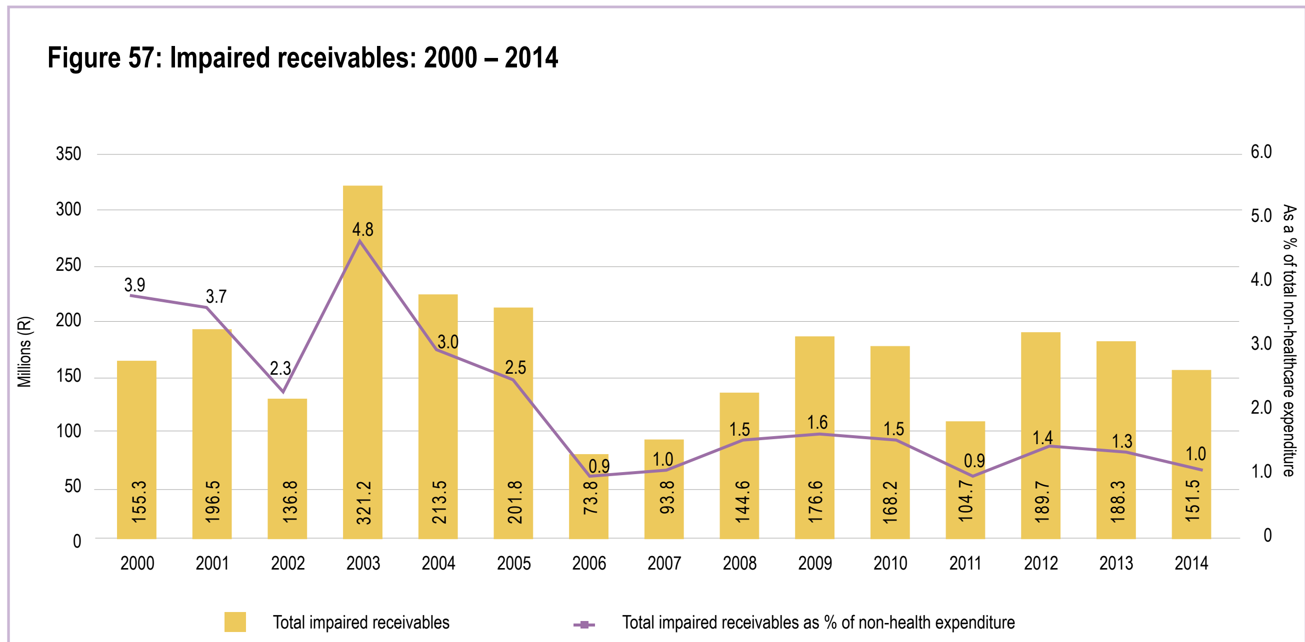
As in 2013, only one medical scheme had a reinsurance contract in 2014. The scheme made a net healthcare surplus of R13.4 million with a net reinsurance surplus of R3.3 million.

Impaired receivables

Impaired receivables decreased by 19.5% to R151.5 million for the year under review from R188.3 million in 2013. They represented 1.0% of total non-healthcare expenditure (1.3% in 2013).

It took schemes an average of 10.0 days to collect debts (contributions from their members) in 2014. This was an improvement of 4.0% from 10.4 days in 2013. 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 57 shows the trend in impaired receivables over the past 15 years, also expressed as a percentage of total non-healthcare expenditure.



Trends in non-healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2014 at 65.6% (2013: 65.6%). Managed healthcare management fees made up 22.3% of non-healthcare expenditure (2013: 22.1%).

Administration expenditure and managed healthcare management fees effectively accounted for 9.7% of GCI in 2014 (2013: 9.7%).

Table 51 shows administration and managed healthcare expenditure by type of scheme administration.

Table 51: Gross administration expenditure and managed healthcare expenditure: 2000 – 2014

	Open schemes				Restricted schemes			
	Self-administered		Third party		Self-administered		Third party	
	pabpm Rand	% change	pabpm Rand	% change	pabpm Rand	% change	pabpm Rand	% 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
2013	132.2	3.0	147.8	6.3	66.0	5.1	90.5	13.3
2014	130.6	(1.2)	156.0	5.5	69.9	5.9	99.2	9.6

pabpm = per average beneficiary per month

During 2014 there were five self-administered open schemes (2013: 6), representing 403 786 average beneficiaries (2013: 617 791), and 18 third-party-administered open schemes (2013: 18), representing 4 461 943 average beneficiaries (2013: 4 187 671).

Self-administered open schemes experienced a decrease of 1.2% in spending on administration and managed healthcare services (from R132.2 pabpm in 2013 to R130.6 pabpm in 2014) while third-party-administered open schemes increased their expenditure on these items by 5.5% to R156.0 pabpm from R147.8 pabpm in 2013. Third-party-administered open schemes paid 19.4% more for administration and managed healthcare services than self-administered open schemes. The difference was 11.8% in 2013.

During 2014, there were eight self-administered restricted schemes (2013: 8), representing 295 510 average beneficiaries (2013: 283 524), and 54 third-party-administered restricted schemes (2013: 59), representing 3 624 794 average beneficiaries (2013: 3 665 319). Third-party-administered restricted schemes spent on average 41.9% more on administration and managed healthcare management fees at R99.2 pabpm compared to the R69.9 pabpm of self-administered restricted schemes (2013: 37.1%).

Table 51 also shows that self-administered open schemes paid 86.8% (2013: 100.3%) more pabpm for administration and managed healthcare expenditure than self-administered restricted schemes. Third-party-administered open schemes paid 57.3% (2013: 63.3%) more pabpm for administration and managed healthcare expenditure than third-party-administered restricted schemes.

Table 52 selects 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 7.2% for gross administration and 9.7% for gross administration plus managed healthcare, calculated as a percentage of gross administration expenditure (2013: 7.3% and 9.7%).

Table 52: Gross administration expenditure and managed healthcare expenditure of 10 largest schemes: 2014

Name of medical scheme	Type	Average number of beneficiaries	GAE as % of GCI	GAE + managed healthcare expenditure as % of GCI
Discovery Health Medical Scheme	Open	2 598 577	8.2	10.9
Government Employees Medical Scheme (GEMS)	Restricted	1 837 809	4.5	7.2
Bonitas Medical Fund	Open	652 602	8.0	10.8
South African Police Service Medical Scheme (POLMED)	Restricted	497 068	4.4	6.4
Momentum Health	Open	221 571	8.7	10.9
Medihelp	Open	220 374	10.1	12.1
Bankmed	Restricted	202 576	6.3	9.0
Bestmed Medical Scheme	Open	190 272	6.5	7.9
Medshield Medical Scheme	Open	166 216	7.4	9.4
Fedhealth Medical Scheme	Open	148 836	9.3	11.7

GAE = gross administration expenditure
GCI = gross contribution income

Table 53 indicates the 10 schemes with the highest marketing, advertising and broker costs. The majority of these are open medical schemes. The table also shows the expenditure incurred by schemes when recruiting new members. It should 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 1.8% from 2013 to 2014 (2012 to 2013: 2.7%). Member growth in this instance is not confined to new members who were not previously covered by a scheme; it includes members who moved from other schemes.

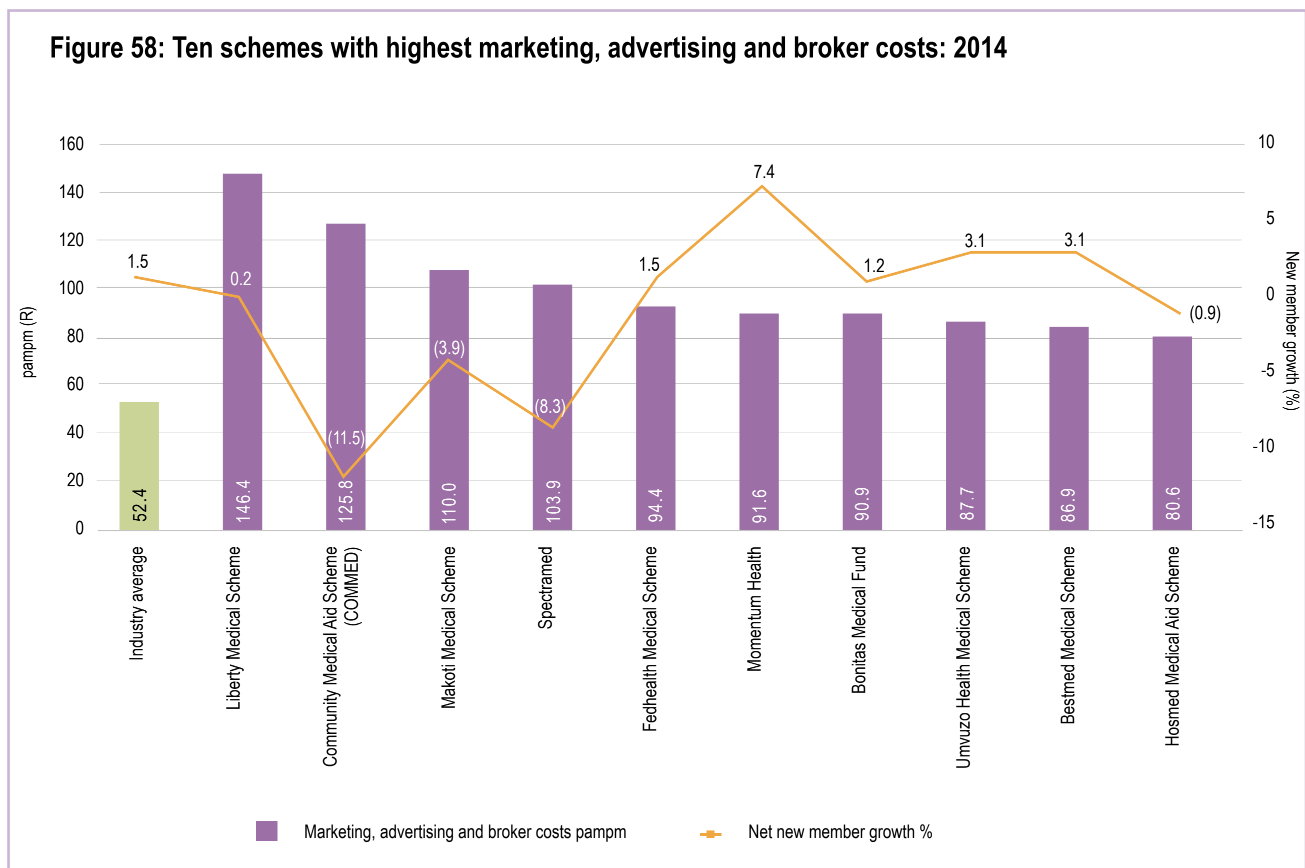
Figure 58 illustrates the information contained in Table 52.

Table 53: Ten schemes with highest marketing, advertising and broker costs: 2014

Name of medical scheme	Marketing, advertising and broker costs pampm	New member growth %
Industry average	52.4	1.5
Liberty Medical Scheme	146.4	0.2
Community Medical Aid Scheme (COMMED)	125.8	(11.5)
Makoti Medical Scheme	110.0	(3.9)
Spectramed	103.9	(8.3)
Fedhealth Medical Scheme	94.4	1.5
Momentum Health	91.6	7.4
Bonitas Medical Fund	90.9	1.2
Umvuzo Health Medical Scheme	87.7	3.1
Bestmed Medical Scheme	86.9	3.1
Hosmed Medical Aid Scheme	80.6	(0.9)

pampm = per average member per month

Figure 58: Ten schemes with highest marketing, advertising and broker costs: 2014



Tables 54 and 55 show open and restricted schemes respectively with the highest marketing and advertising expenditure.

Table 54: Open schemes with the highest marketing and advertising expenditure: 2014*

Name of scheme	2014 Advertising & marketing pampm R'000	2013 Advertising & marketing pampm R'000	% change	2014 Broker fees paid pampm R'000	2013 Broker fees paid pampm R'000	% change	2014 Average members	2013 Average members	% change	Name of main advertising and marketing provider(s)	Marketing and advertising expenditure per provider	% of total fees
Community Medical Aid Scheme (COMMED)	109.5	49.6	120.7	16.4	17.3	(5.5)	6 113	7 207	(15.2)	Allcare Administrators (Pty) Ltd	8 029	100.0
Liberty Medical Scheme	89.8	113.8	(21.1)	56.6	51.7	9.4	56 379	55 882	0.9	LMS Management and Auxilliary Services (Pty) Ltd	33 781	55.6
										V Medical Solutions (Pty) Ltd	26 965	44.4
Makoti Medical Scheme	71.2	54.7	30.2	38.8	40.1	(3.2)	2 600	2 512	3.5	Various suppliers	974	43.8
										SuperSport United Football Club (Pty) Ltd	1 248	56.2
Fedhealth Medical Scheme	44.5	35.1	26.8	49.8	49.8	0.2	74 519	73 439	1.5	The Cheese Has Moved (Pty) Ltd	39 834	100.0
Selfmed Medical Scheme	42.3	36.6	15.4	10.8	11.5	(6.7)	7 859	8 299	(5.3)	Google: Pay per click	1 392	34.9
										Lift Marketing	1 031	25.9
										Media 24	522	13.1
										SABC	210	5.3
										New Media	160	4.0
										Other providers	671	16.8
Bonitas Medical Scheme	37.8	38.1	(0.8)	53.1	48.5	9.6	295 064	294 329	0.2	Bonitas Marketing (Pty) Ltd	133 730	100.0
Open scheme industry average**	**32.5**	**31.4**	**3.3**	**60.5**	**57.1**	**6.0**	**2 275 407**	**2 232 727**	**1.9**			

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 55: Restricted schemes with the highest marketing and advertising expenditure: 2014

Name of scheme	2014 Advertising & marketing pampm R'000	2013 Advertising & marketing pampm R'000	% change	2014 Broker fees paid pampm R'000	2013 Broker fees paid pampm R'000	% change	2014 Average members	2013 Average members	% change	Name of main advertising and marketing provider(s)	Marketing and advertising expenditure per provider	% of total fees
Umvuzo Health Medical Scheme	43.6	38.2	14.1	44.1	41.5	6.2	27 360	26 193	4.5	Rain Catchers (Pty) Ltd	14 312	100.0
Profmed	33.5	26.0	29.1	21.7	21.5	0.9	28 356	27 270	4.0	Ebony and Ivory	9 431	82.7
										Cyberkinetics	668	5.9
										Newsclip	7	0.1
										Epic Communications	368	3.2
										Other provider(s)	933	8.2
Government Employees Medical Scheme (GEMS)	18.5	14.3	29.4	–	–	–	685 135	676 068	1.3	Other provider(s)	41 284	27.2
										Pinnacle Health Solutions (Pty) Ltd	63 918	42.1
										Teledirect (Pty) Ltd	46 705	30.7
Witbank Coalfields Medical Aid Scheme	15.7	–	100.0	0.6	–	100.0	10 349	10 457	(1.0)	Amadwala Group Benefits	1 955	100.0
Motohealth Care	13.8	26.9	(48.7)	13.9	13.8	0.9	26 807	28 099	(4.6)	Dimage	1 120	25.2
										Other provider(s)	3 316	74.8
Restricted scheme industry average**	**12.1**	**10.3**	**18.0**	**28.6**	**28.6**	**(0.2)**	**1 625 439**	**1 631 422**	**(0.4)**			

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.*

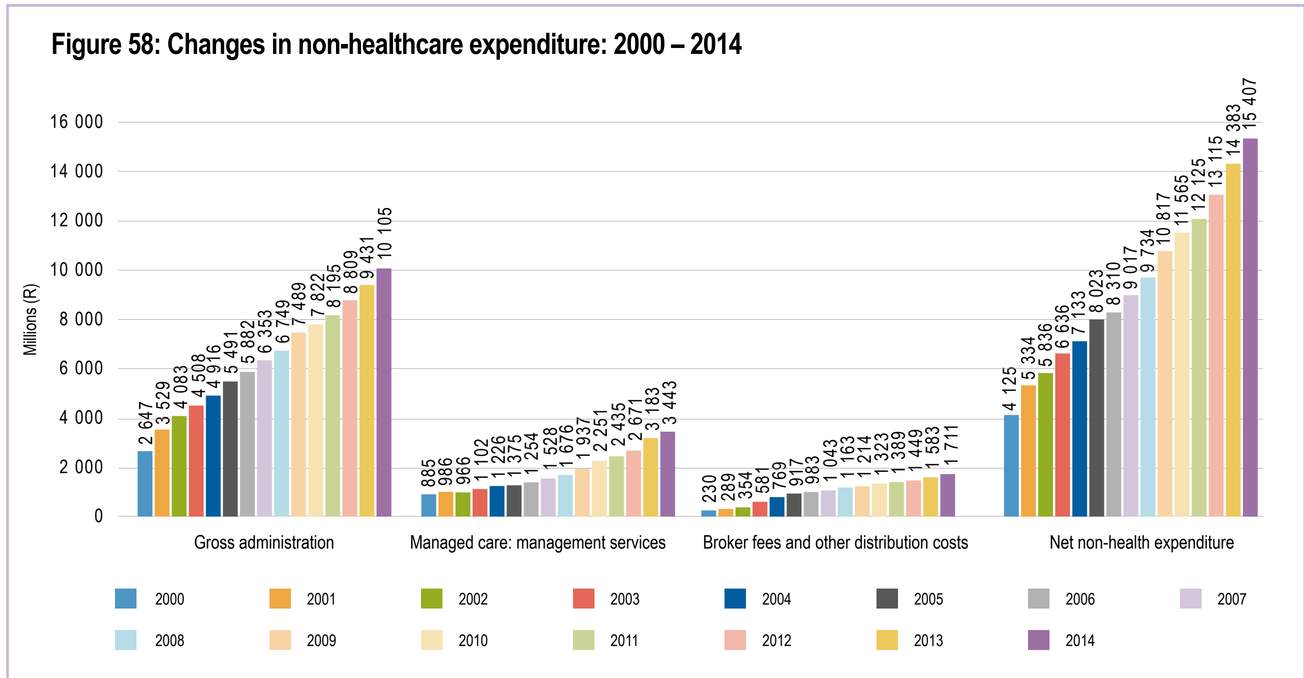
Figure 58 shows changes in the major categories of non-healthcare expenditure for the past 15 years.

Total net non-healthcare expenditure rose by 7.1% from R14.4 billion in 2013 to R15.4 billion in 2014.

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 R2 059.2 in 2005 to R1 753.5 per average beneficiary per annum in 2014 (prices adjusted to 2014 prices).

5. *This can partly be explained by GEMS starting to operate in 2006.*

Figure 58: Changes in non-healthcare expenditure: 2000 – 2014



Total gross non-healthcare expenditure has increased by 273.5% 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 281.7% upswing in administration expenditure, a 288.8% rise in fees paid for managed healthcare, and an increase of 644.7% in broker costs.

By comparison, gross claims have risen by 355.2% (not adjusted for inflation) since 2000.

Figures 59 and 60 together with Table 56 show that, after adjusting for inflation, gross non-healthcare expenditure per average beneficiary per annum (pabpa) has decreased in real terms since 2005. It increased marginally (by 0.6%) to R1 753.5 in 2014 from R1 743.0 in 2013. The net claims ratio also increased, to 88.2% in 2014 from 86.5% in 2013.

Figure 59: Non-healthcare expenditure pabpa: 1998 – 2014 (2014 prices)

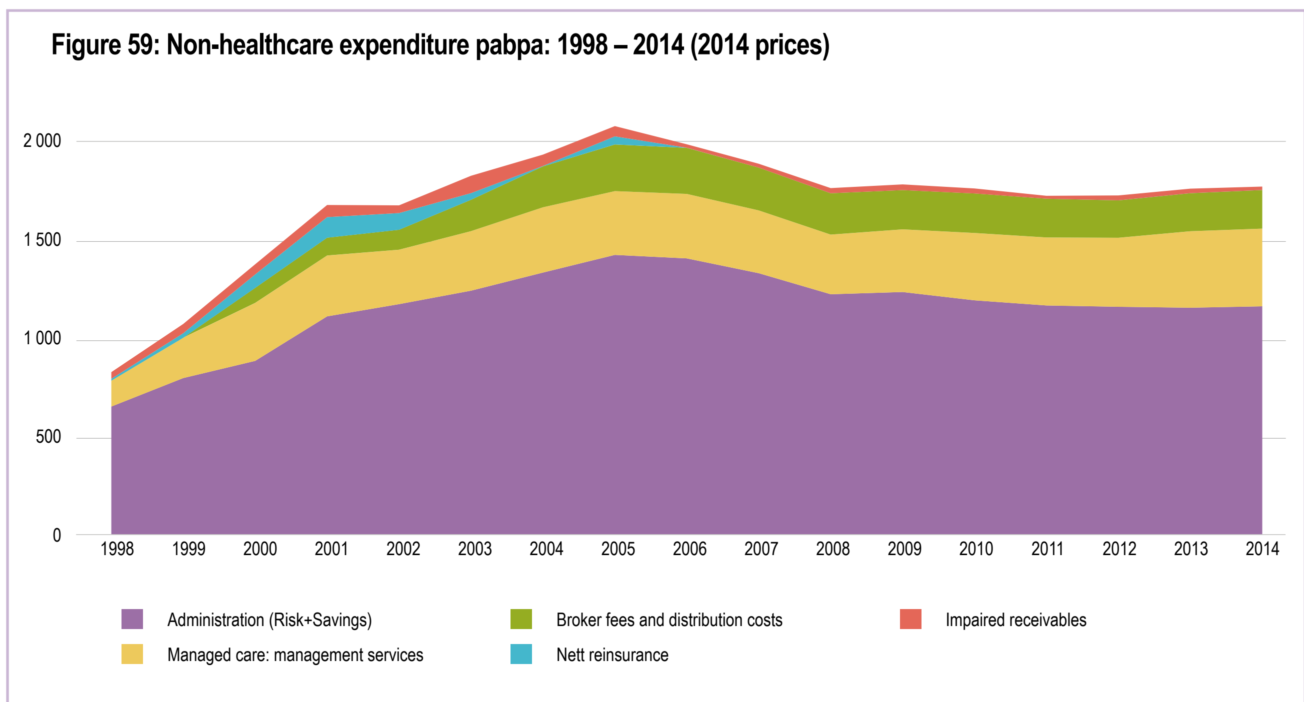
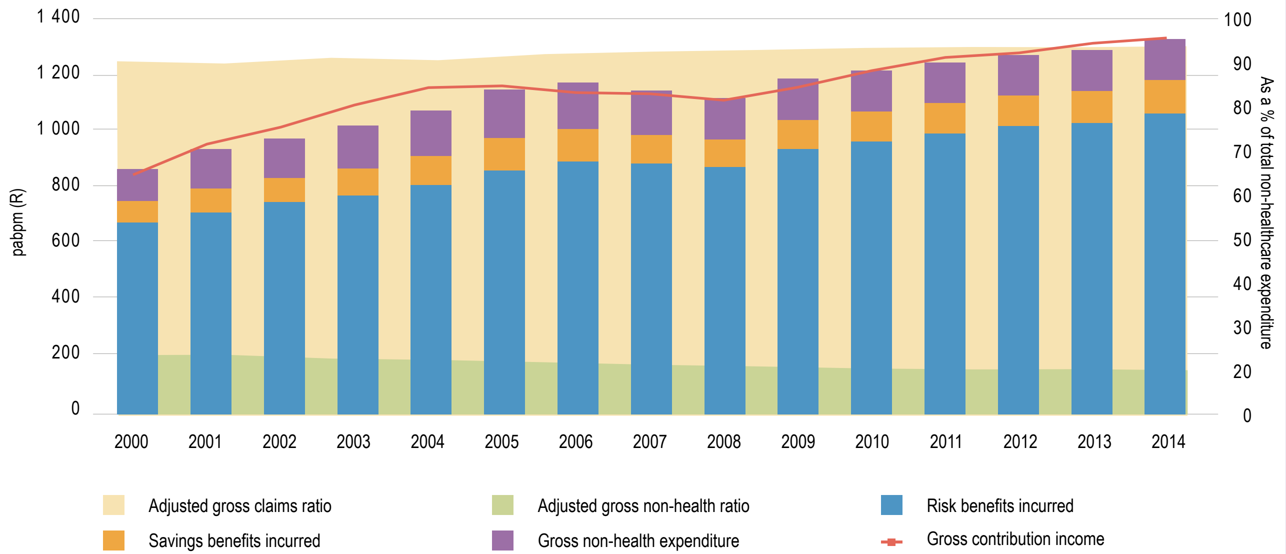


Figure 60: Claims and non-healthcare expenditure pabpm: 2004 – 2014 (2014 prices*)



pabpm = per average beneficiary per month
GCI = gross contribution income
* *The values were adjusted for CPI for 2000 – 2013.*

Figure 61: Claims and non-healthcare expenditure pabpa: 1998 – 2014 (2014 prices)

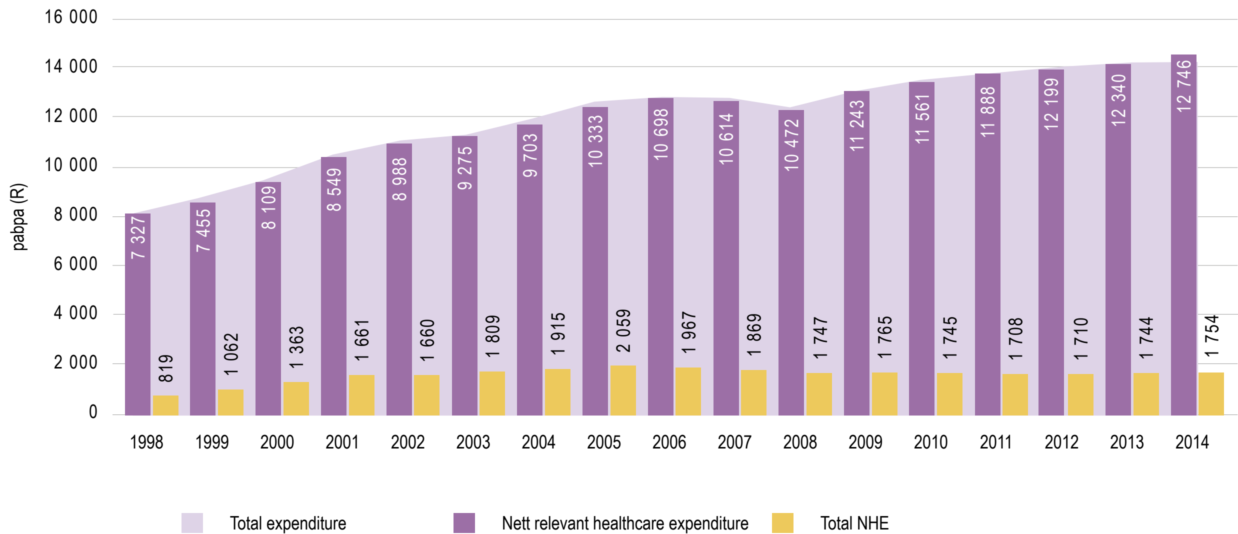


Table 56: Trends in contributions, claims and non-healthcare expenditure: 2000 – 2014 (2014 prices*)

	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa		pabpa		pabpa	
Expenditure	R	% growth	R	% growth	R	% growth
2000	10 108.2	6.4	9 020.9	6.1	1 362.6	28.2
2001	11 420.1	13.0	9 570.9	6.1	1 661.5	21.9
2002	12 145.0	6.3	10 014.6	4.6	1 659.6	(0.1)
2003	13 092.3	7.8	10 418.1	4.0	1 808.7	9.0
2004	13 835.4	5.7	10 949.8	5.1	1 915.4	5.9
2005	13 909.7	0.5	11 704.9	6.9	2 059.2	7.5
2006	13 622.2	(2.1)	12 094.1	3.3	1 966.5	(4.5)
2007	13 572.1	(0.4)	11 835.1	(2.1)	1 869.4	(4.9)
2008	13 296.8	(2.0)	11 641.4	(1.6)	1 746.6	(6.6)
2009	13 848.3	4.1	12 451.4	7.0	1 765.1	1.1
2010	14 556.9	5.1	12 811.4	2.9	1 744.9	(1.1)
2011	15 125.1	3.9	13 187.5	2.9	1 707.8	(2.1)
2012	15 320.1	1.3	13 511.4	2.5	1 708.9	0.1
2013	15 732.1	2.7	13 692.2	1.3	1 743.0	2.0
2014	15 957.8	1.4	14 148.3	3.3	1 753.5	0.6
Since 2000		**57.9**		**56.8**		**28.7**

pabpa = per average beneficiary per annum
* *The values were adjusted for CPI for 2000 – 2013.*

Figure 60 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 six open schemes with non-healthcare expenditure greater than both the industry average of R183.4 pabpm and the open schemes average of 15.0% when expressed as a percentage of Risk Contribution Income (RCI).

Table 58 shows the 10 restricted schemes with non-healthcare expenditure greater than both the industry average of R99.9 pabpm and the restricted schemes average of 8.5% when expressed as a percentage of RCI.

Table 57: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions among open schemes: 2013 and 2014

	Net non-healthcare expenses – pabpm		Net claims incurred		Net non-healthcare expenses		Reserve-building	
	R	R	% of RCI	% of RCI	% of RCI	% of RCI	% of RCI	% of RCI
Name of open medical scheme	2014	2013	2014	2013	2014	2013	2014	2013
Community Medical Aid Scheme (COMMED)	398.0	323.5	85.4	82.3	22.1	20.1	(7.5)	(2.4)
Spectramed	298.1	276.7	82.3	80.0	22.6	22.5	(4.9)	(2.5)
Compcare Wellness Medical Scheme	228.6	217.3	87.8	80.9	17.9	16.9	(5.7)	2.2
Liberty Medical Scheme	216.7	210.7	86.1	88.8	16.1	17.2	(2.2)	(6.0)
Resolution Health Medical Scheme	188.9	173.1	82.2	88.7	15.8	16.3	2.0	(5.0)
Discovery Health Medical Scheme	188.1	179.2	80.7	81.8	16.2	16.7	3.1	1.5
Industry average – open Schemes	**183.4**	**174.0**	**85.0**	**83.8**	**15.0**	**15.3**	**0.1**	**1.0**

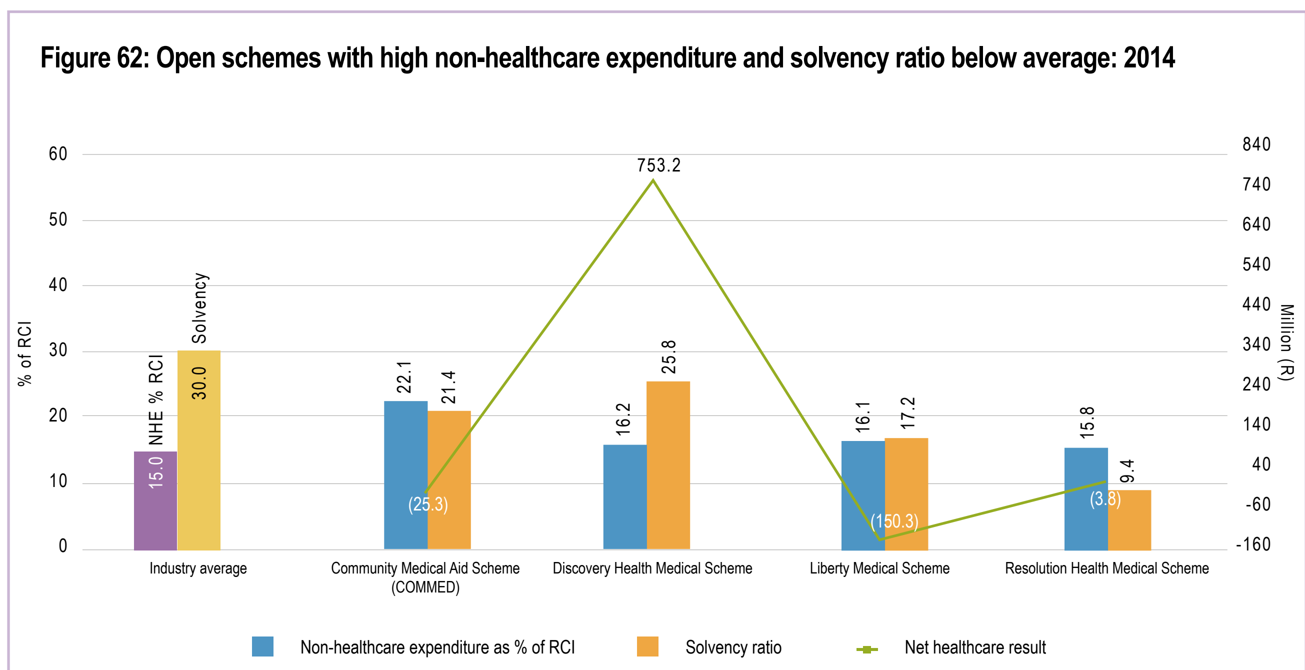
pabpm = per average beneficiary per month
RCI = risk contribution income

Table 58: Trends in claims, non-healthcare expenditure and reserve-building as percentage of contributions among restricted schemes: 2013 and 2014

Name of open medical scheme	Net non-healthcare expenses – pabpm R 2014	R 2013	Net claims incurred % of RCI 2014	% of RCI 2013	Net non-healthcare expenses % of RCI 2014	% of RCI 2013	Reserve-building % of RCI 2014	% of RCI 2013
Chartered Accountants (SA) Medical Aid Fund (CAMAF)	208.6	190.4	88.4	85.4	13.6	13.1	(2.0)	1.5
Anglo Medical Scheme	174.2	143.0	111.3	106.5	11.2	9.8	(22.5)	(16.3)
Afrox Medical Aid Society	163.3	115.6	128.2	103.4	13.3	9.4	(41.5)	(12.8)
LA-Health Medical Scheme	158.5	150.6	78.2	78.2	13.9	14.0	7.9	7.8
Grintek Electronics Medical Aid Scheme	151.1	142.6	102.0	87.5	11.0	10.9	(13.0)	1.6
Anglovaal Group Medical Scheme	148.3	144.2	97.2	96.3	11.5	11.7	(8.7)	(8.0)
Engen Medical Benefit Fund	146.5	126.2	95.6	97.2	8.7	8.1	(4.3)	(5.3)
Horizon Medical Scheme	136.0	127.6	84.0	75.2	18.7	18.9	(2.7)	5.9
Libcare Medical Scheme	133.1	132.0	83.3	79.2	10.3	10.6	6.4	10.2
Bankmed	132.5	123.8	93.7	90.4	10.4	10.4	(4.1)	(0.8)
Industry average – restricted schemes	**99.9**	**91.8**	**92.4**	**89.9**	**8.5**	**8.3**	**(0.9)**	**1.8**

Figure 62 shows the schemes in Table 57 that had a solvency ratio below the open schemes average of 30.0%. 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.

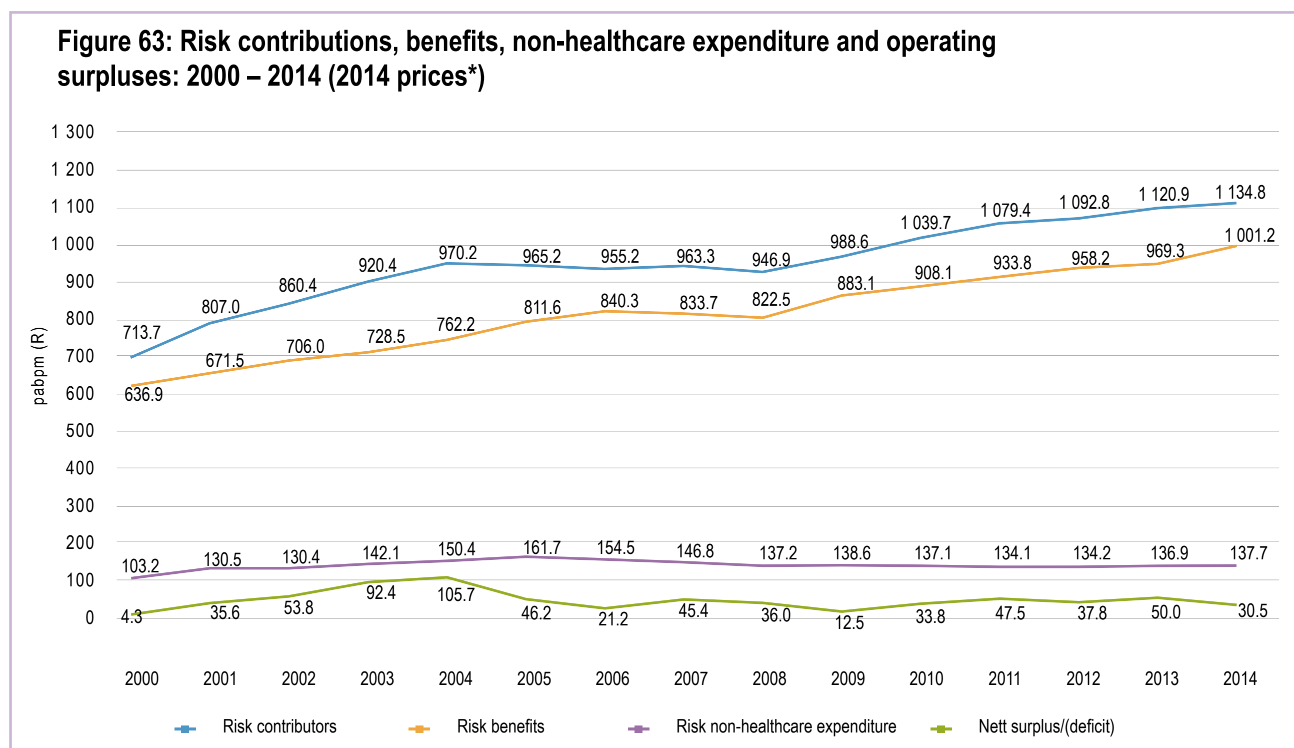
Figure 62: Open schemes with high non-healthcare expenditure and solvency ratio below average: 2014



RCI = risk contribution income

Figure 63 depicts information on contributions, benefits, non-healthcare expenditure and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm had been growing since 2000 but it decreased in 2003, almost levelling out in 2004. Although this gap has since grown wider, it seems to have stabilised in the last few years.

Figure 63: Risk contributions, benefits, non-healthcare expenditure and operating surpluses: 2000 – 2014 (2014 prices*)



pabpm = per average beneficiary per month

* *The values were adjusted for CPI for 2000 – 2013.*

Benefit options

At the end of 2014 there were 272 registered benefit options (2013: 279) operating in 85 medical schemes.

Open schemes accounted for 50.4% or 137 of the registered benefit options at the end of 2014 (2013: 50.2% or 140 options). Restricted schemes had 136 options at year end, representing 49.6% of all options (2013: 139 options or 49.8%).

On average, open schemes had 6.0 options per scheme (2013: 5.8) and an average of 16 757 members per option at year-end (2013: 16 115). Restricted schemes had an average of 2.3 options per scheme (2013: 2.2), with an average of 12 041 members per option as at 31 December 2014 (2013: 11 754).

Of the 272 benefit options at year end, 94 (34.6%) had fewer than 2 500 members per option (2013: 96 or 34.4%). Of these 94 options, 56 (59.6%) incurred net healthcare losses in 2014. In 2013, 59 options (61.5%) incurred losses.

The remaining 178 options (2013: 182) had more than 2 500 members per option. Of these, 50.0% or 89 options incurred net healthcare losses (2013: 40.7% or 74 options).

Table 59: Results of benefit options: 2014

	Open schemes	% of total	Restricted schemes	% of total	Total
All options					
Number of options	137	50.4	135	49.6	272
Membership represented	2 295 664	58.5	1 625 568	41.5	3 921 232
Number of schemes	23	27.7	60	72.3	83
Net healthcare result (R'000)	37 653		(487 186)		(449 533)
Gross non-healthcare as % of GCI	13.0		8.1		11.0
Gross claims ratio (%)	86.1		92.2		88.7
Gross claims incurred pbpm	1 206.3		1 135.3		1 174.8
GCI pbpm	1 400.5		1 230.8		1 325.1
Options with members >= 2 500					
Number of options	95	53.4	83	46.6	178
Membership represented	2 247 552	59.0	1 564 097	41.0	3 811 649
Net healthcare result (R'000)	156 723		(366 295)		(209 572)
Gross non-healthcare as % of GCI	13.1		8.1		11.0
Gross claims ratio (%)	85.9		92.1		88.4
Gross claims incurred pbpm	1 197.1		1 119.8		1 163.0
GCI pbpm	1 393.3		1 216.4		1 315.3
Options with members < 2 500					
Number of options	42	44.7	52	55.3	94
Membership represented	48 112	43.9	61 471	56.1	109 583
Net healthcare result (R'000)	(119 070)		(120 892)		(239 962)
Gross non-healthcare as % of GCI	10.3		8.2		9.1
Gross claims ratio (%)	94.6		96.3		95.5
Gross claims incurred pbpm	1 671.2		1 620.2		1 642.6
GCI pbpm	1 766.2		1 682.2		1 719.2

GCI = gross contribution income
pbpm = per beneficiary per month

At the end of 2014, there were 42 options in open schemes with fewer than 2 500 members (2013: 45). They had an average of 1 145.5 members per option (2013: 1 088.1) and represented 30.7% (2013: 32.1%) of all open schemes options.

Restricted schemes had 52 options with fewer than 2 500 members (2013: 52). The average number of members per option was 1 182.1 (2013: 1 092.8) and these options represented 38.5% (2013: 38.2%) of all restricted schemes options.

Table 60: Results of loss-making benefit options: 2014

	Open	% of total	Restricted	% of total	Total
Total loss making options					
% of total options	58.4		48.1		53.3
Number of options	80	55.2	65	44.8	145
Membership represented	1 179 656	51.4	1 116 779	48.6	2 296 435
Net healthcare result (R'000)	(2 631 340)		(2 019 721)		(4 651 062)
Gross non-healthcare as % of GCI	12.6		7.4		10.0
Gross claims ratio (%)	92.5		97.1		94.8
Gross claims incurred pbpm (R)	1 326.1		1 269.3		1 296.4
GCI pbpm (R)	1 433.3		1 307.6		1 367.4
Loss making options with members > =2 500					
Number of options	53	59.6	36	40.4	89
Membership represented	1 148 032	51.5	1 082 163	48.5	2 230 195
Net healthcare result (R'000)	(2 459 486)		(1 792 921)		(4 252 408)
Gross non-healthcare as % of GCI	12.7		7.4		10.0
Gross claims ratio (%)	92.2		96.7		94.5
Gross claims incurred pbpm (R)	1 313.6		1 252.4		1 281.6
GCI pbpm (R)	1 424.0		1 295.2		1 356.5
Loss making options with members < 2 500					
Number of options	27	48.2	29	51.8	56
Membership represented	31 624	47.7	34 616	52.3	66 240
Net healthcare result (R'000)	(171 854)		(226 800)		(398 654)
Gross non-healthcare as % of GCI	10.8		7.2		8.9
Gross claims ratio (%)	101.1		107.5		104.5
Gross claims incurred pbpm (R)	1 822.8		1 911.3		1 870.1
GCI pbpm (R)	1 803.1		1 778.2		1 789.8

GCI = gross contribution income
pbpm = per beneficiary per month

Of the 272 benefit options registered and operating at the end of 2014 (2013: 279), 145 (53.3%) incurred net healthcare losses. In 2013, 133 options (47.7%) incurred net healthcare losses. In the year under review, 80 options (2013: 75), representing 58.4% of loss-making options (2013: 56.8%), were in open schemes and 65 (2013: 58), representing 48.1% of loss-making options (2013: 43.6%), were in restricted schemes.

Net healthcare losses pmpm in options with fewer than 2 500 members were 3.2 times greater (2013: 2.4) than those for options with more than 2 500 members – an average of R501.5 pmpm compared to R158.9 pmpm (2013: R442.8 pmpm and R182.0 pmpm respectively).

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 across a smaller base.

Table 61 shows option net healthcare results by age demographics of schemes.

There were 86 options with an average age above the 33.6 years for open schemes, and 51 benefit options with beneficiaries younger than the average in open schemes.

Table 61: Number of options by age demographics: 2014

	Open	Restricted	Total
Average age of beneficiaries	33.6 years	30.2 years	
Average NHC results pbpm	**0.7**	**-10.7**	
Number of options with average age of beneficiaries above or equal to average for all options in type of scheme	86	74	160
Number of above options with NHC results pbpm above or equal to average NHC results	33	30	63
Number of above options with NHC results pbpm below average NHC results	53	44	97
Number of options with average age of beneficiaries below average for all options in type of scheme	51	61	112
Number of above options with NHC results pbpm above or equal to average NHC results	23	46	69
Number of above options with NHC results pbpm below average NHC results	28	15	43

NHC = net healthcare result
pbpm = per beneficiary per month

In the restricted schemes market, 74 benefit options had beneficiaries with an average age higher than the average of 30.2 years for all options in restricted schemes. A total of 61 options had younger beneficiaries. As expected, options covering older and sicker lives incurred greater deficits.

Net healthcare results and trends

The net healthcare result of a medical scheme indicates its position after benefits and non-healthcare expenditure are deducted from contribution income.

The net healthcare result for all medical schemes combined reflected a deficit of R464.5 million in 2014 (2013: R1 552.8 million surplus). Open schemes incurred a total surplus of R40.1 million (2013: R630.7 million surplus), and restricted schemes generated a combined deficit of R504.6 million (2013: R922.2 million surplus). This deterioration is mainly due to the worsening claims ratios of all schemes from 86.5% to 88.2%.

Figure 64: Net healthcare results: 2000 – 2014

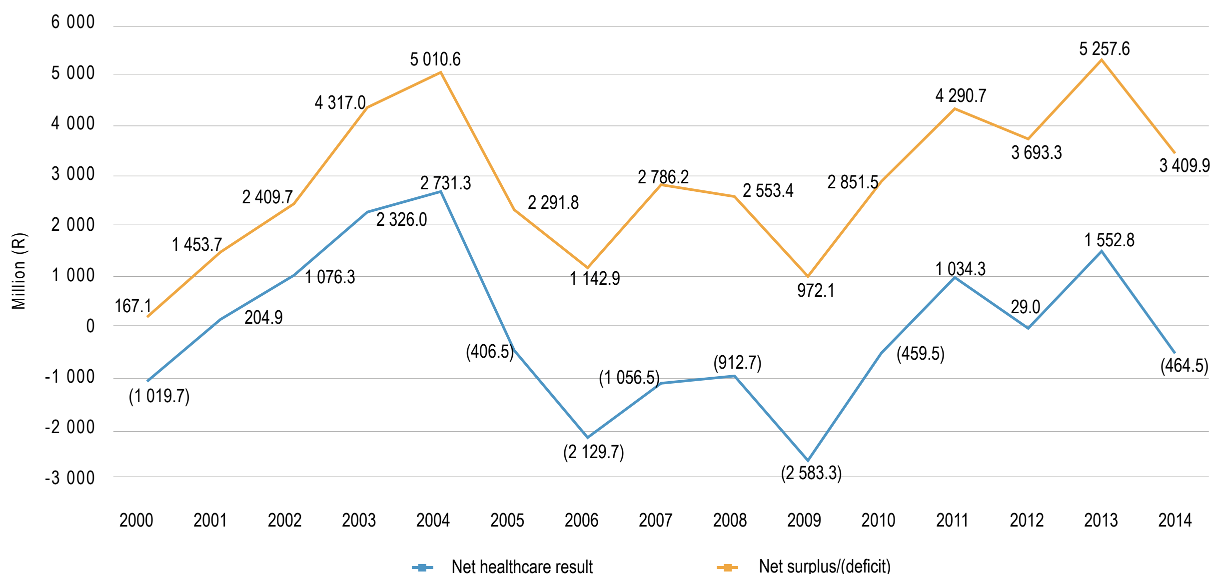


Table 62 is based on the 20 schemes with the highest net healthcare deficits. Investment income has resulted in a number of these schemes not experiencing major drops in their solvency levels.

Table 62: 20 schemes with largest net healthcare deficits: 2013 and 2014

Name of medical scheme	Type	NHC result 2014 R'000	NHC result 2013 R'000	Growth %	Solvency ratio 2014 %	Solvency ratio 2013 %	RAF classification
Government Employees Medical Scheme (GEMS)	Restricted	(465 927)	776 935	(160.0)	10.0	11.7	High
Bonitas Medical Fund	Open	(247 544)	(111 095)	(122.8)	30.7	33.3	High
Medihelp	Open	(196 991)	(143 090)	(37.7)	27.9	30.4	High
Liberty Medical Scheme	Open	(150 279)	(57 728)	(160.3)	17.2	24.4	High
Bankmed	Restricted	(127 956)	(20 942)	(511.0)	46.0	49.7	High
Fedhealth Medical Scheme	Open	(110 191)	(54 858)	(100.9)	37.2	40.2	High
Anglo Medical Scheme	Restricted	(83 137)	(58 559)	(42.0)	530.5	526.3	Medium
Medshield Medical Scheme	Open	(77 282)	787	(9,925.4)	53.6	52.2	High
Nedgroup Medical Aid Scheme	Restricted	(67 414)	(35 022)	(92.5)	32.3	35.6	High
Spectramed	Open	(55 711)	(30 498)	(82.7)	46.6	48.4	High
Topmed Medical Scheme	Open	(51 431)	(68 389)	24.8	90.2	123.8	Medium
Motohealth Care	Restricted	(36 780)	(12 224)	(200.9)	53.5	54.4	High
South African Police Service Medical Scheme (POLMED)	Restricted	(32 763)	38 166	(185.8)	50.7	48.9	High
Transmed Medical Fund	Restricted	(26 939)	(14 810)	(81.9)	22.0	20.9	High
Bestmed Medical Scheme	Open	(26 865)	(28 008)	4.1	27.0	29.2	High
Malcor Medical Scheme	Restricted	(25 518)	(21 415)	(19.2)	25.0	25.0	Medium
Community Medical Aid Scheme (COMMED)	Open	(25 344)	(13 814)	(83.5)	21.4	25.6	Medium
Cape Medical Plan	Open	(20 915)	(26 408)	20.8	127.9	133.1	Medium
Wooltru Healthcare Fund	Restricted	(20 419)	(5 851)	(249.0)	71.8	83.5	Medium
Golden Arrow Employees' Medical Benefit Fund	Restricted	(19 684)	(18 877)	(4.3)	141.4	128.5	Medium

RAF = Risk Assessment Framework

A total of 65.2% (or 15 of 23) of open schemes and 54.8% (34 of 62) of restricted schemes incurred net healthcare deficits during the year.

The net surplus of all schemes combined, after investment income and consolidation adjustments, was R3.4 billion (2013: R5.3 billion). Net investment and other income as well as expenditure increased by 0.6% to R3.9 billion. Open schemes made a R2.0 billion (2013: R2.3 billion) surplus and restricted schemes a surplus of R1.4 billion (2013: R2.9 billion).

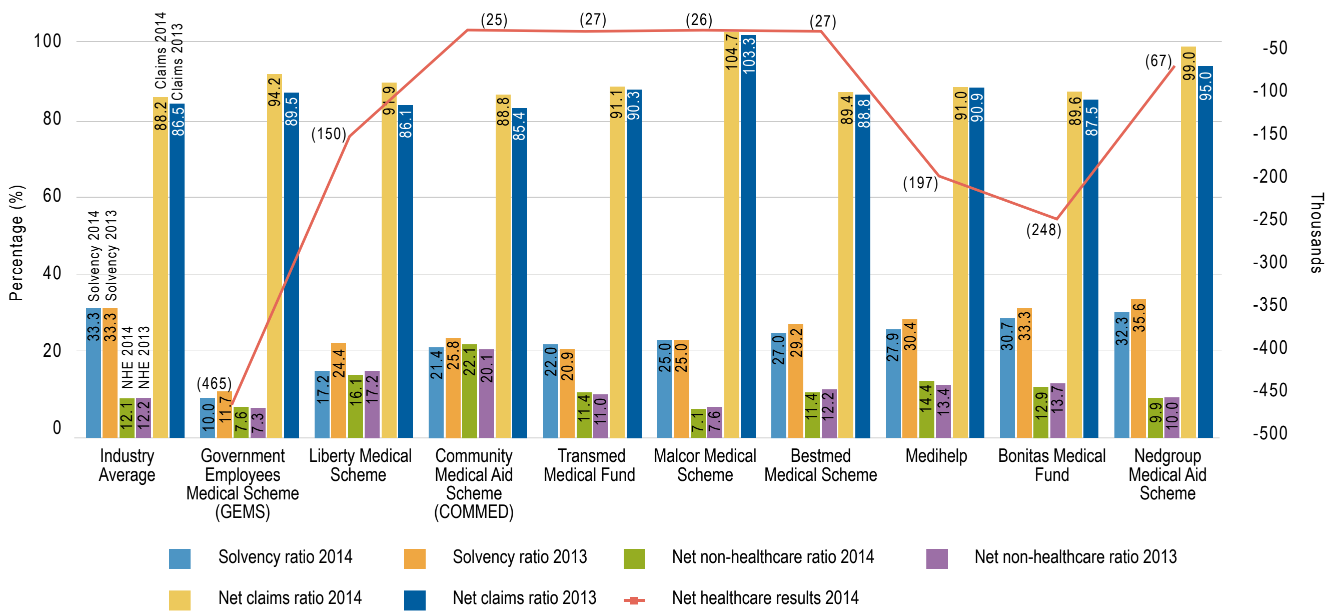
Figures 63 and 64 show the impact of the increases in claims costs and non-healthcare expenditure on the NHC result.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 64.

Table 62 shows the 20 schemes with the largest NHC deficits by the Risk Assessment Framework (RAF) classification. They represent 89.8% of all beneficiaries of schemes that suffered operating deficits. (Annexure W has more details on this.)

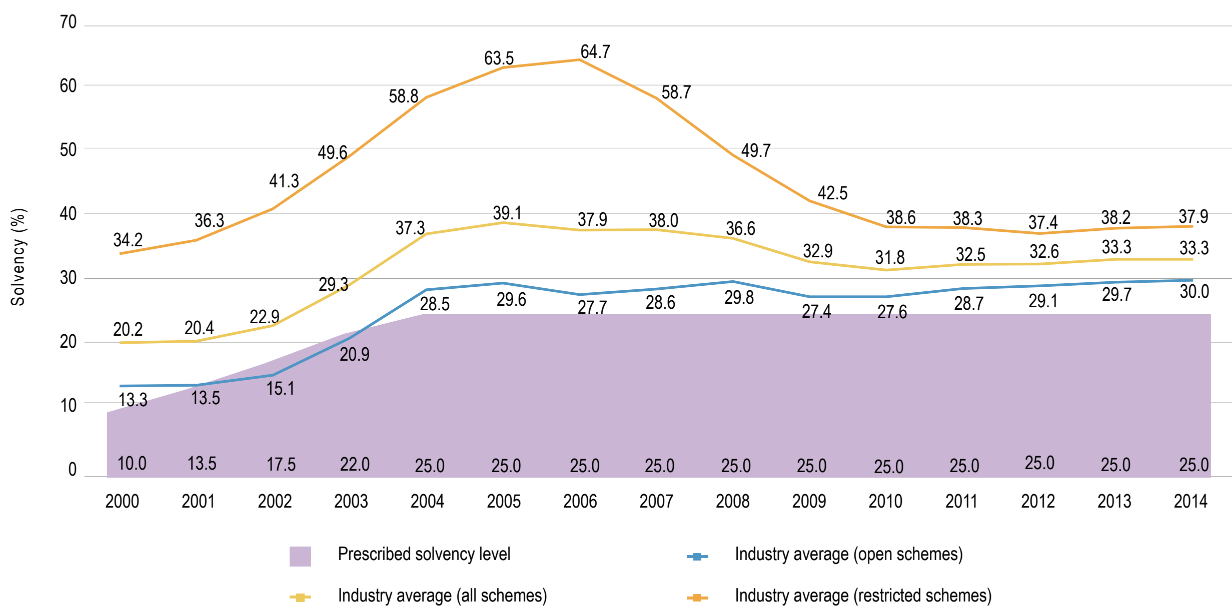
Figure 59 shows high-impact schemes with the largest NHC deficits and with solvency levels below the industry average of 33.3%. (Annexure U provides more details.)

Figure 65: High-impact schemes with largest net healthcare deficits and solvency levels below the industry average of 33.3%: 2014



Accumulated funds, solvency and solvency trends

Figure 66: Industry solvency for all schemes: 2000 – 2014



Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes.

Accumulated funds means the net asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable profits. The accumulated funds must at all times be maintained at a minimum level of 25.0% of gross contributions except for new medical schemes in which case phase-in solvency ratios will apply. The phase-in solvency ratio is 10% during the first year of operation, 13.5% during the second year, 17.5% during the third year and not less than 22% during the fourth year.

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.

A prescribed solvency ratio serves both to protect members' interests as well as to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations.

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, non-compliance with Regulation 29 does not necessarily mean that the scheme is in financial difficulties.

Factors that affect solvency

The most important factors affecting solvency are:

- Membership growth.
- The performance of the medical scheme, that is, claims and non-healthcare expenditure.
- Investment income.

The membership profile of a medical scheme further affects its solvency. Membership includes variables such as the average age of beneficiaries, the proportion of pensioners, the relative number of male and female dependants, and the dependant ratio. All of these affect the frequency and extent of claims.

Net assets or members' funds (total assets minus total liabilities) rose by 7.9% to end 2014 at R50.0 billion. Accumulated funds grew by 7.8% to R47.7 billion from the R44.3 billion recorded in 2013.

The industry average solvency ratio remained stable at 33.3% between 2013 and 2014.

The solvency ratio of open schemes increased by 1.0% to 30.0% in 2014 (2013: 29.7%). Restricted schemes experienced a decrease of 0.8% in their solvency ratio, 37.9% from 38.2% in 2013.

Overall industry average solvency ratio increased consistently from 2000 to 2005. Schemes were required to have reached the 25% solvency ratio in 2005.

As indicated in Figure 68, the restricted industry was at its peak in 2006 and declined from 2007 onwards. This is mostly due to the denominator that is used in the solvency calculation (gross contributions), which is affected by membership growth. The Government Employee Medical Scheme (GEMS), which is the largest restricted scheme, has shown exceptional membership growth since registration and this resulted in deterioration in the solvency level of the restricted schemes industry. The growth in GEMS has since slowed down as much of its target market is covered.

The open industry remained fairly constant between 2004 and 2014, slightly above the 25.0% solvency ratio prescribed by the Medical Schemes Act.

Figure 67: Industry solvency for open schemes: 2000 – 2014

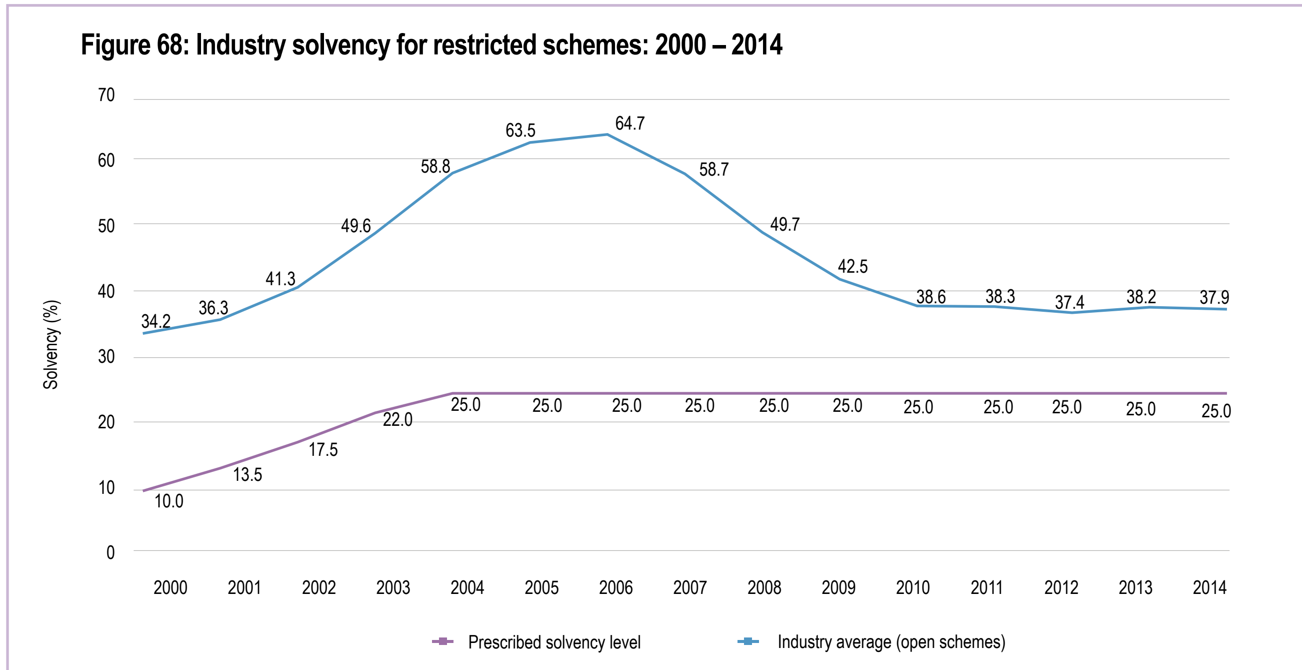


Table 63: Risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions: 1999 – 2014

	Risk claims % of RCI	Non-healthcare expenditure % of RCI	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	–
2013	86.5	12.2	1.3
2014	88.2	12.1	(0.3)

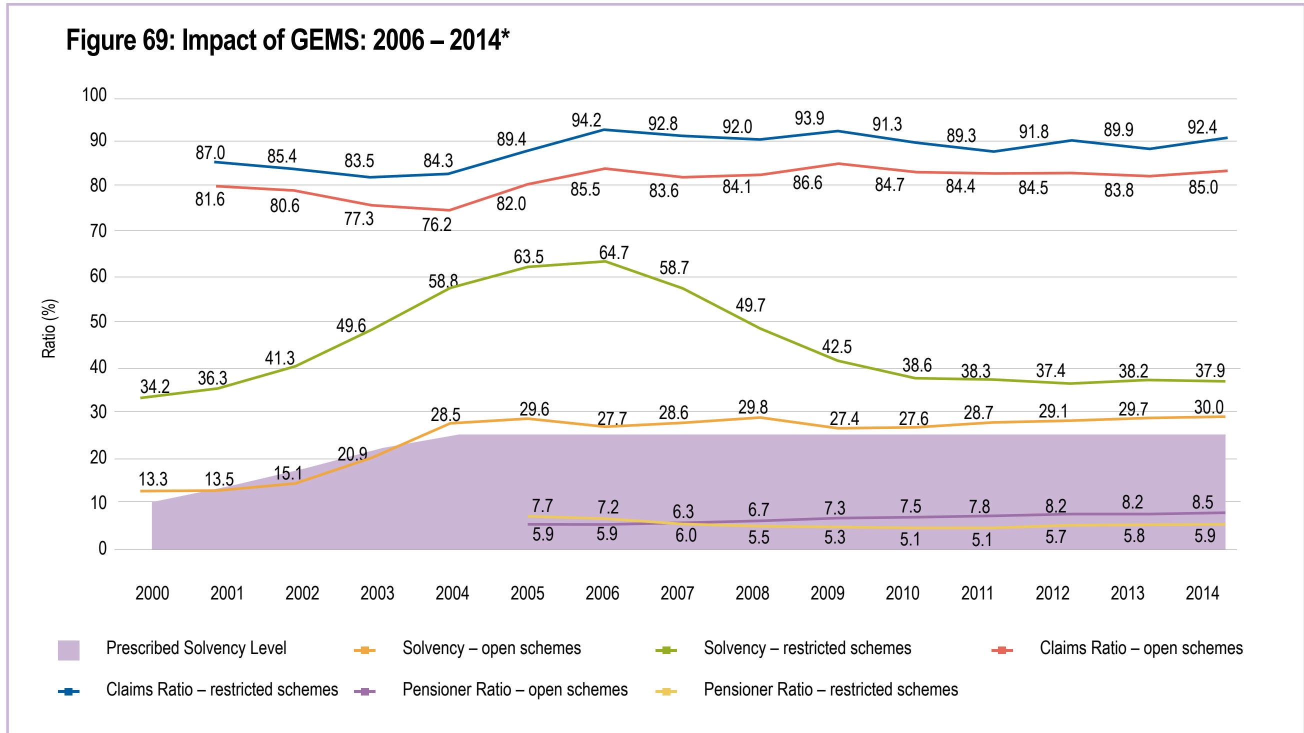
RCI = risk contribution income

The table above illustrates the relationship between risk claims, non-healthcare expenditure and reserve building. Risk claims appear to have more of an impact on reserve building than non-healthcare expenditure. During periods of high claims the industry experienced a reduction in reserves while during periods with lower claims reserves increased. In 1999 the industry experienced risk claims of 91.5% and reserves decreased by 4.2%, while in 2004 risk claims amounted to 78.6% and reserves increased by 5.9%.

Total risk claims fell between 2000 and 2004 and the ratio of contributions to reserves improved during this period from -3.7% to 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. Risk claims were at their lowest in 2004 and then started to increase in 2005, reaching 88.2% in 2014. Contributions to reserves were negative during this time, which was consistent with the fact that most medical schemes had attained the prescribed solvency ratio of 25.0% and did not need to grow their reserves any further. The maintenance of reserves as a protection for members should be considered against the backdrop of increasing claim costs.

Figure 69 illustrates the impact of GEMS on all medical schemes. This restricted scheme was registered on 1 January 2005 but started operations only on 1 January 2006.

Figure 69: Impact of GEMS: 2006 – 2014*

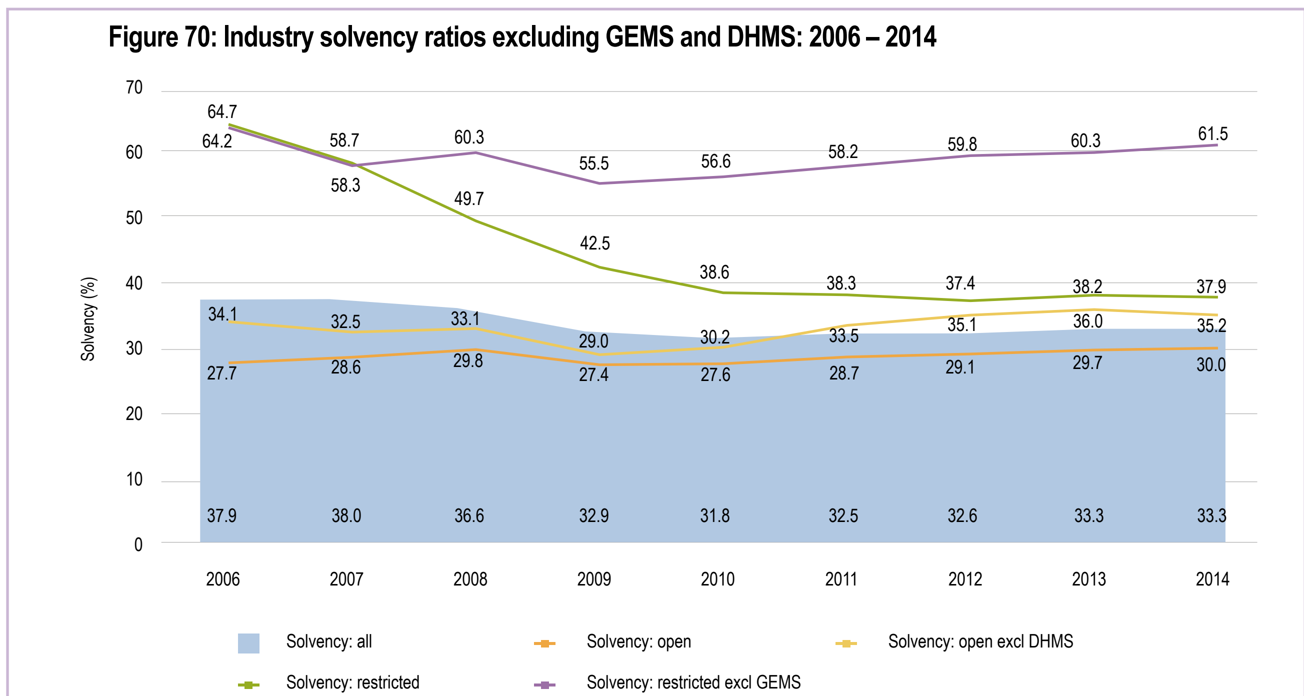


Claims data per industry was available only from 2001 onwards and pensioner ratios from 2005 onwards.

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 have steadily left them to join GEMS. The reserves which these members had accumulated over the years in open schemes were not transferred to GEMS.

A negative impact was subsequently experienced on some of these open schemes' claiming patterns as the members who left them to join GEMS tended to be young and healthy, and they were not necessarily replaced by members of a similar profile.

Figure 70: Industry solvency ratios excluding GEMS and DHMS: 2006 – 2014



Excluding GEMS, the restricted industry solvency ratio decreased in 2009 to 55.5% and then increased from 2010 onwards to 61.5% in 2014. The solvency ratio of the restricted scheme industry is much lower when GEMS results are included. This indicates the significant impact of GEMS on the restricted schemes industry.

In comparison, (DHMS has a lesser impact on the open scheme industry. Without DHMS, the open industry solvency ratio decreased in 2014 to 30.0% and it increased to 35.2% when DHMS was excluded.

Medical schemes should be careful of the so-called "death spiral". A scheme with a disadvantageous, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members being highly 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 therefore to an increase in losses, resulting in even higher contribution increases and/or reductions in benefits.

Beneficiaries of schemes which failed to reach the 25% solvency

Table 63 and Figure 71 show the number of medical schemes which have yet to attain the prescribed solvency ratio of 25% and the number of beneficiaries in those schemes.

Table 63: Prescribed solvency and number of beneficiaries: 2000 – 2013

Year	Number of open schemes		Number of restricted schemes	
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
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	3	71
2010	12	15	7	66
2011	9	17	5	66
2012	7	18	4	63
2013	6	18	3	60
2014	5	18	2	58

Year	Number of beneficiaries of open schemes			Number of beneficiaries in restricted schemes		
	Below prescribed level		Above prescribed level	Below prescribed level		Above prescribed level
	At end 2014	%	At end 2014	At end 2014	%	At end 2014
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	50.4	1 943 538
2013	2 860 768	59.0	1 986 141	1 994 813	50.7	1 936 586
2014	212 169	4.3	4 687 806	1 914 481	48.9	2 000 002

The total number of schemes below 25% has declined since 2001. Although there have been numerous amalgamations, the reduction in schemes below 25% was not mainly due to amalgamation but also due to schemes attaining the minimum solvency ratio.

Figure 71: Prescribed solvency and number of beneficiaries: 2013 and 2014

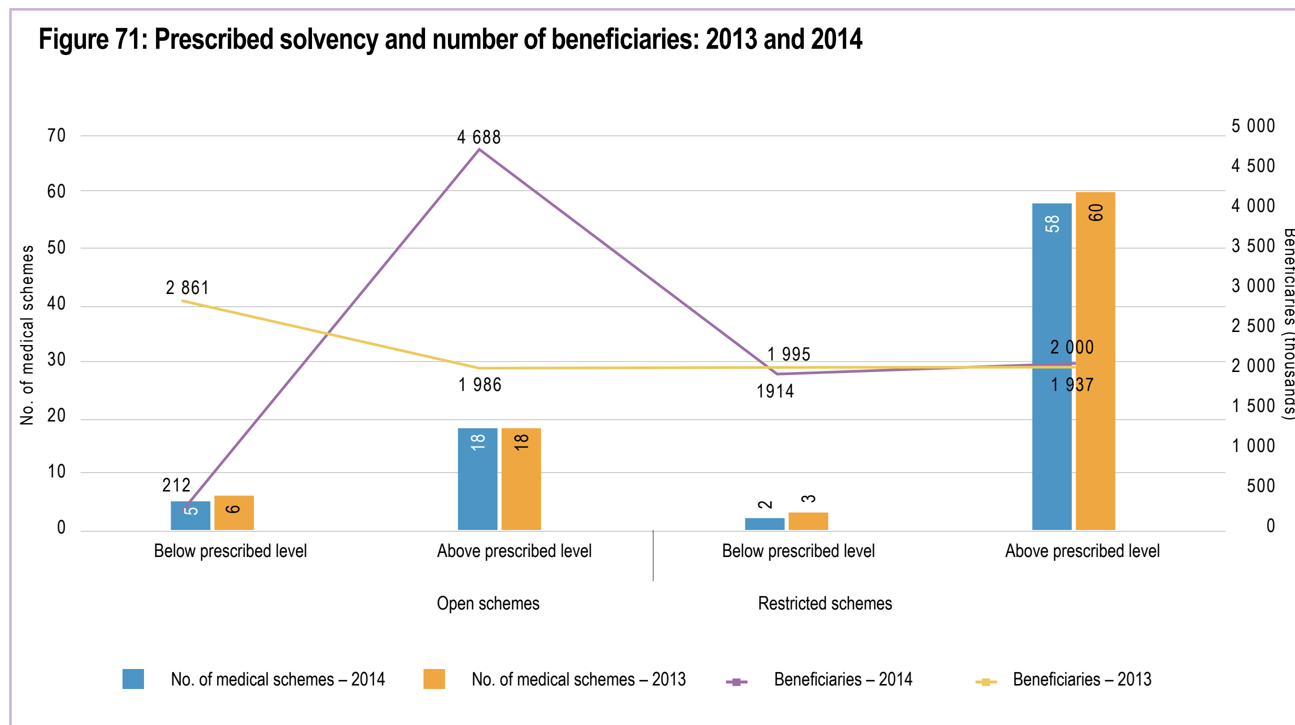


Table 64: Schemes on close monitoring in the last five years

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgam-ation	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalga-mation	Comments
2010	12				7			
2011	9	(3)	0	1) Protea liquidated 2) Prosano reached 25% 3) Spectramed reached 25%	5	(2)	1	1) Clicks amalgamated with Moremed 2) BEPS amalgamated with Topmed
2012	7	(2)	1	1) NIMAS amalgamated with Resolution 2) Commed reached 25% 3) Momentum reached 25% 4) Pro Sano dropped below 25%	4	(1)	0	1) Edcon amalgamated with DHMS 2) Siemens liquidated 3) Metrocare liquidated 4) Eyethumed liquidated

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalga-mation	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalga-mation	Comments
2013	6	(1)	1	1) ProSano amalgamated with Bonitas 2) Keyhealth reached 25% 3) Liberty dropped below 25%	3	(1)	0	1) Minemed amalgamated with Bestmed 2) IBM amalgamated with DHMS 3) Sappi amalgamated with Bestmed 4) Nampak amalgamated with DHMS 5) Altron reached 25%
2014	5	(1)	1	1) Pharos amalgamated with Topmed	2	(1)	0	1) Altron amalgamated with DHMS 2) Afrox amalgamated with DHMS 3) PG Bison amalgamated with DHMS 4) Umvuzo reached 25%

A total of 4.3% of beneficiaries in open schemes (2013: 59.0%) were covered by the five open schemes (2013: six) which failed to meet the prescribed solvency level in 2014. The remaining beneficiaries belonged to the other 18 open schemes (2013: 18) which had attained the prescribed solvency level of 25%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25%. This was mainly due to DHMS, the biggest scheme in South Africa, failing to attain the minimum prescribed solvency ratio. Whenever DHMS reached the solvency ratio of 25% – in 2008, 2009 and 2014 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2014 this figure was a mere 4.3% compared to 59.0% in 2013.

Of the 60 restricted schemes, only two had a solvency ratios below 25%. These two, however, accounted for 48.9% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory solvency level of 25% and this accounts for 96.0% of beneficiaries in schemes which did not achieve the prescribed solvency ratio.

The CMS closely monitors schemes below the 25% solvency ratio by having regular meetings with them in order to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes environment and 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.

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. The RAF enables the CMS to identify high-impact schemes which would have a major effect on the entire industry if they were to fail financially or in some other way. Classification as high-impact does not necessarily mean that the identified scheme represents an actual risk or that it is experiencing problems.

Table 62 shows that the average contributions of high-impact open schemes were 3.8% higher than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that was 8.5% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of RCI of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 84.7%.

Table 65: High-impact schemes by type: 2013 and 2014

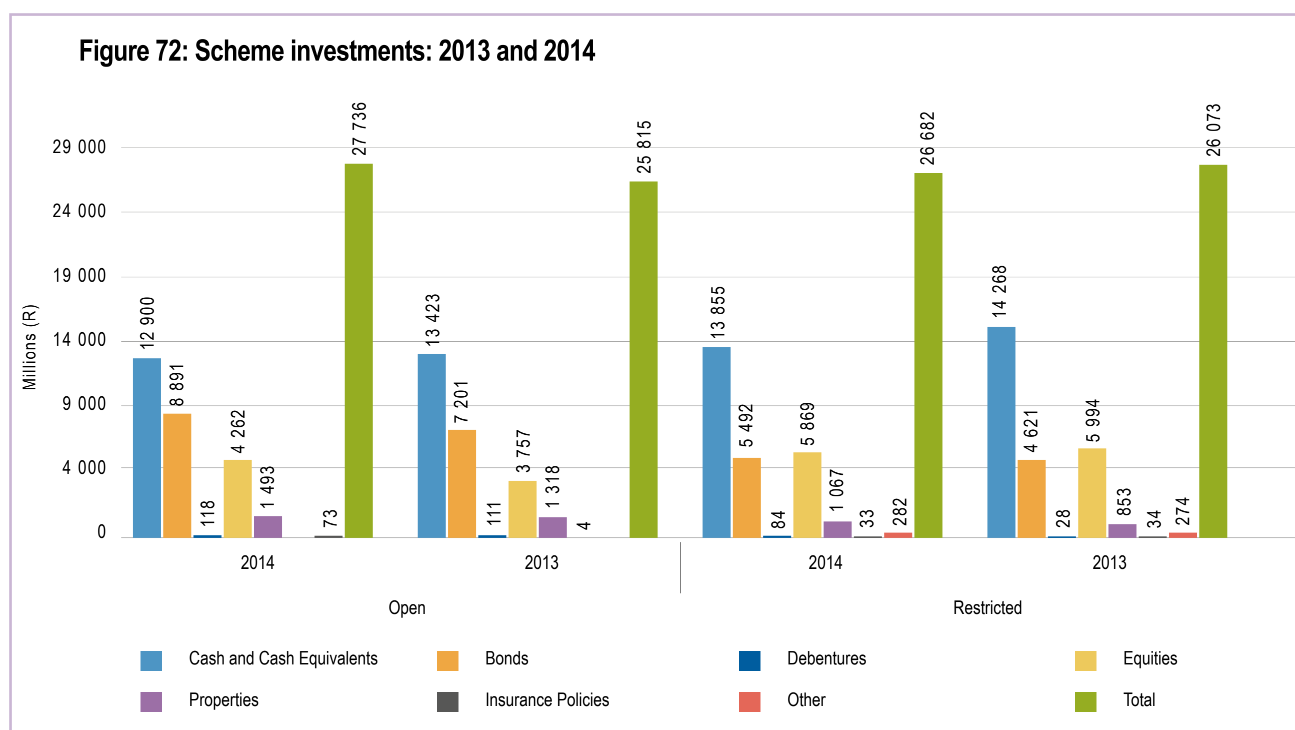
	Average beneficiaries		Net contributions pabpm (R)		Net claims ratio (%)		Net non-healthcare ratio (%)		Solvency ratio (%)	
	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013
Open	4 699 870	4 641 548	1 229.2	1 143.3	84.9	83.6	15.0	15.2	28.8	28.5
Restricted	3 190 195	3 182 705	1 183.6	1 104.7	92.7	90.1	8.1	8.0	26.2	26.6
Total	**7 890 065**	**7 824 253**	**1 210.8**	**1 127.6**	**88.0**	**86.2**	**12.3**	**12.3**	**27.9**	**27.8**

pabpm = per average beneficiary per month.

Investments

Figure 72 provides information on the investments of medical schemes as at the end of 2013 and 2014.

Figure 72: Scheme investments: 2013 and 2014



In open schemes, 46.5% of investments (2013: 52.0%) were held in cash or cash equivalents. Bonds accounted for 32.1% (2013: 27.9%), debentures for 0.4% (2013: 0.4%), equities for 15.4% (2013: 14.6%), non-linked insurance policies for 0.0% (2013: 0.0%), properties for 5.4% (2012: 5.1%), and other investments for 0.3% (2013: 0.0%).

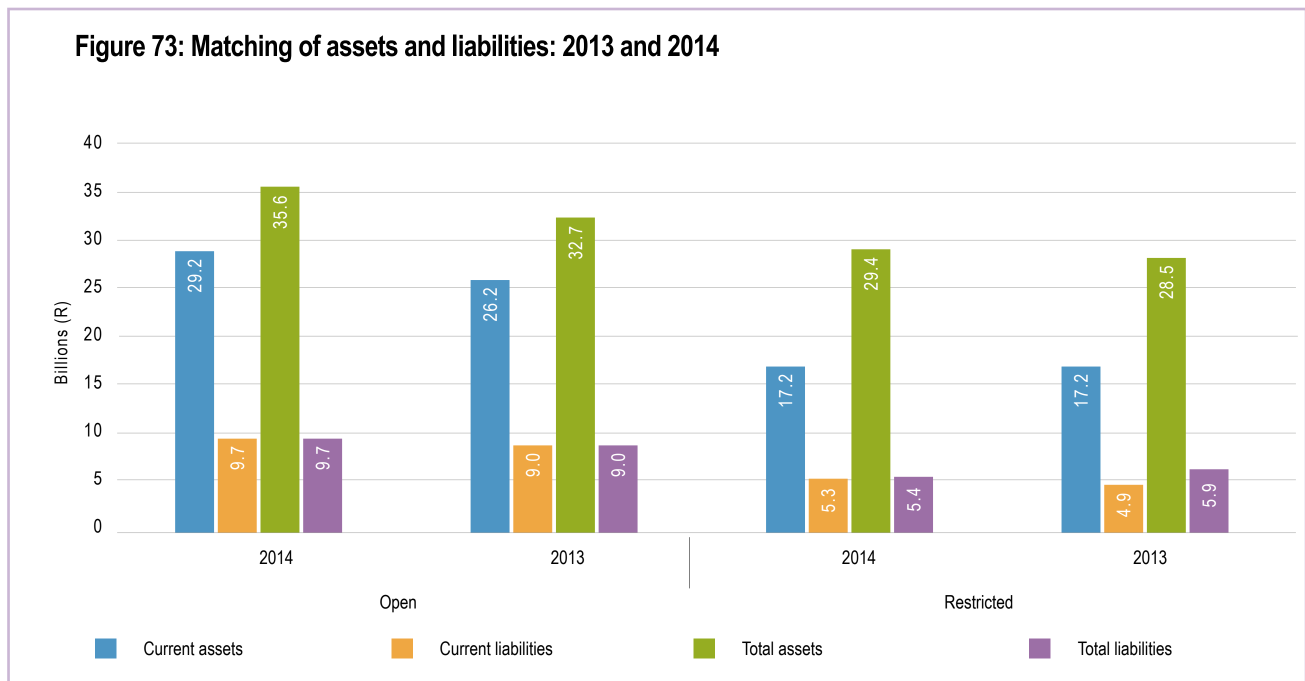
Restricted schemes also held a large proportion of their investments (51.9%) in cash or cash equivalents (2013: 54.8%). Bonds accounted for 20.6% (2013: 17.8%) and debentures for 0.3% (2013: 0.1%). Equities made up 22.0% (2013: 23.0%), non-linked insurance policies 0.1% (2013: 0.1%), properties 4.0% (2013: 3.3%), and other investments 1.1% (2013: 1.1%).

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 enable the scheme to meet its liabilities and retain 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 of 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 consider the periods in which liabilities must be paid and in which assets can be converted into cash flows.

Figure 73 compares the matching of assets and liabilities in open and restricted schemes.



The current-assets-to-current-liabilities ratio in open schemes was 3.0:1 in 2014 (2.9:1 in 2013) and it was 3.7:1 (2013: 3.6:1) in restricted schemes. The total-asset-to-total-liability ratio for open and restricted schemes in 2014 was 3.7:1 (2013: 3.6:1) and 5.5:1 (2013: 4.8:1) respectively.

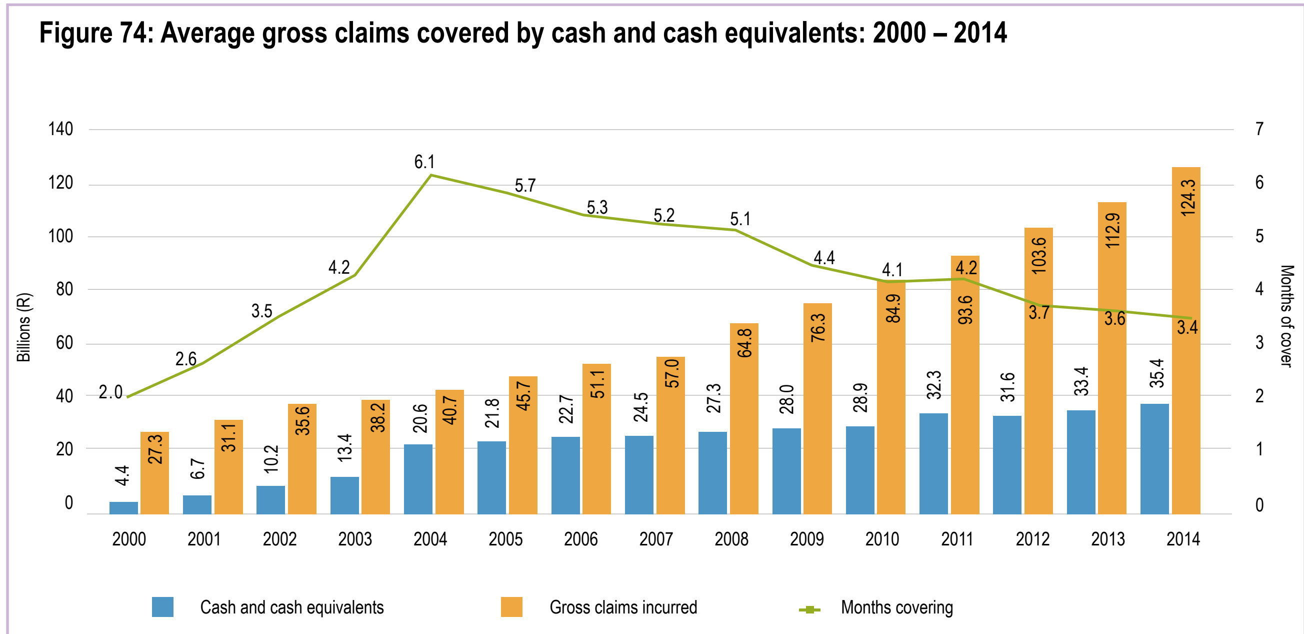
The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, a quick ratio below 2.0) is lower than the industry average of 3.6 months, boards of trustees must guard against longer-term, riskier investments. Although such investments may offer the prospect 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 74 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 74: Average gross claims covered by cash and cash equivalents: 2000 – 2014

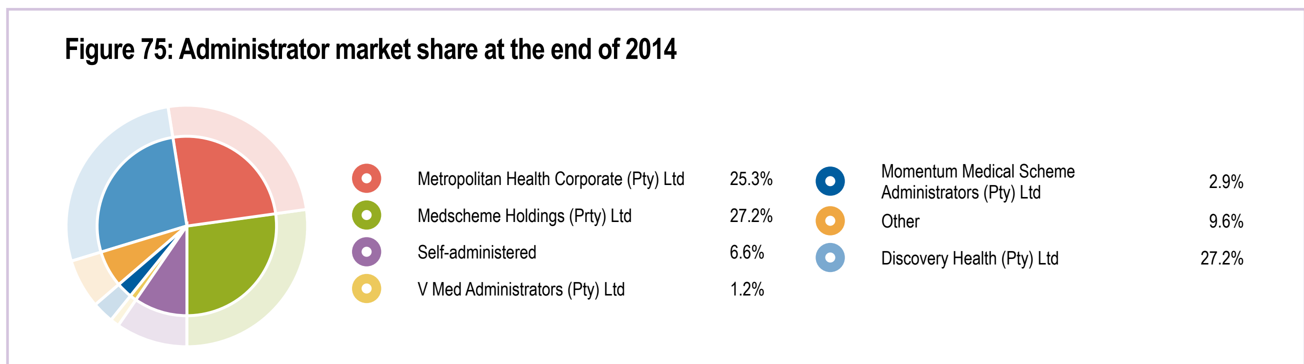


The length of cash coverage declined from 3.6 months in 2013 to 3.4 months in December 2014. Payment cycles of medical schemes in 2014 were an average of 11.4 days compared with the 12.2 days in 2013.

Administrator market

Figure 75 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 2014[6].

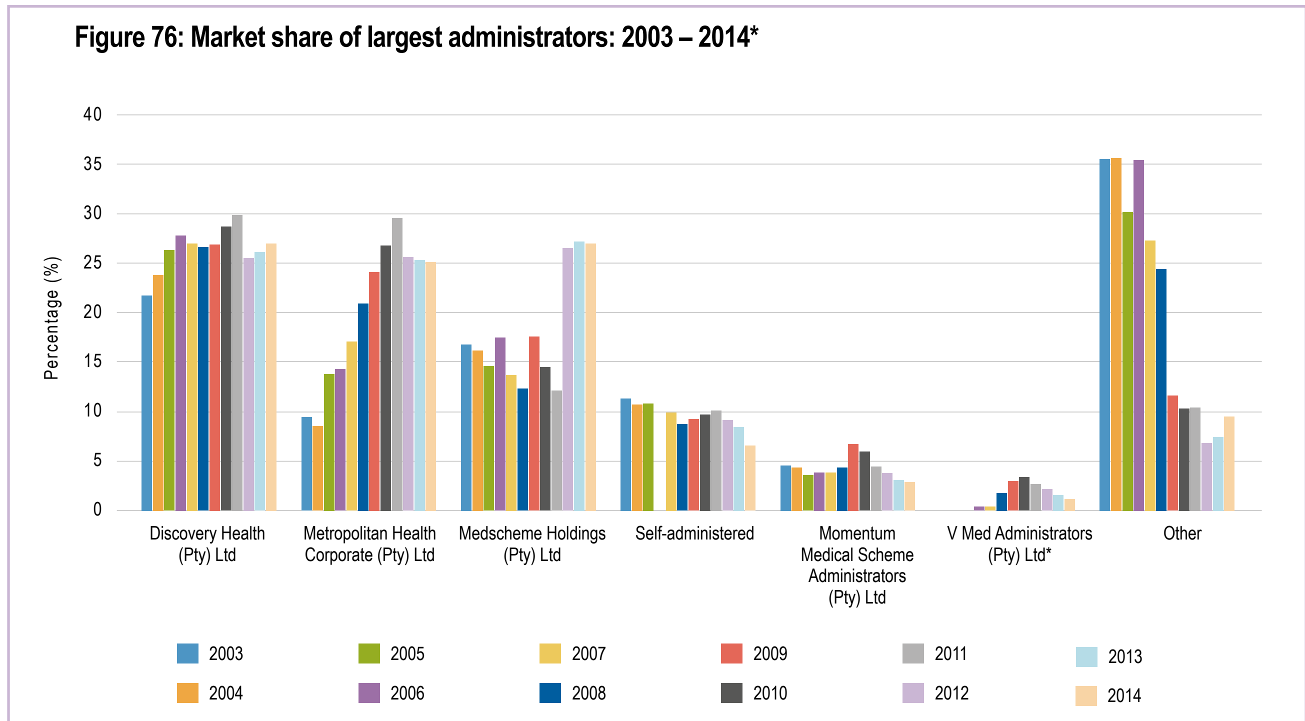
Figure 75: Administrator market share at the end of 2014



6. The data that is presented here differs from Annexure Y which is based on the average membership administered during the year.

Figure 76 depicts the changes in market share of major administrators of all medical schemes over the last 12 years based on the average number of beneficiaries in schemes they administered at the end of each year.

Figure 76: Market share of largest administrators: 2003 – 2014*



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 Y).

Five third-party administrators continued to dominate the market in 2014, 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.

Collectively the above companies administer 83.8% of the market (excluding self-administered medical schemes).[7]

Table 66 indicates the change in administrator market share between 2010 and 2014.

Table 66: Administrator market share: 2010 – 2014

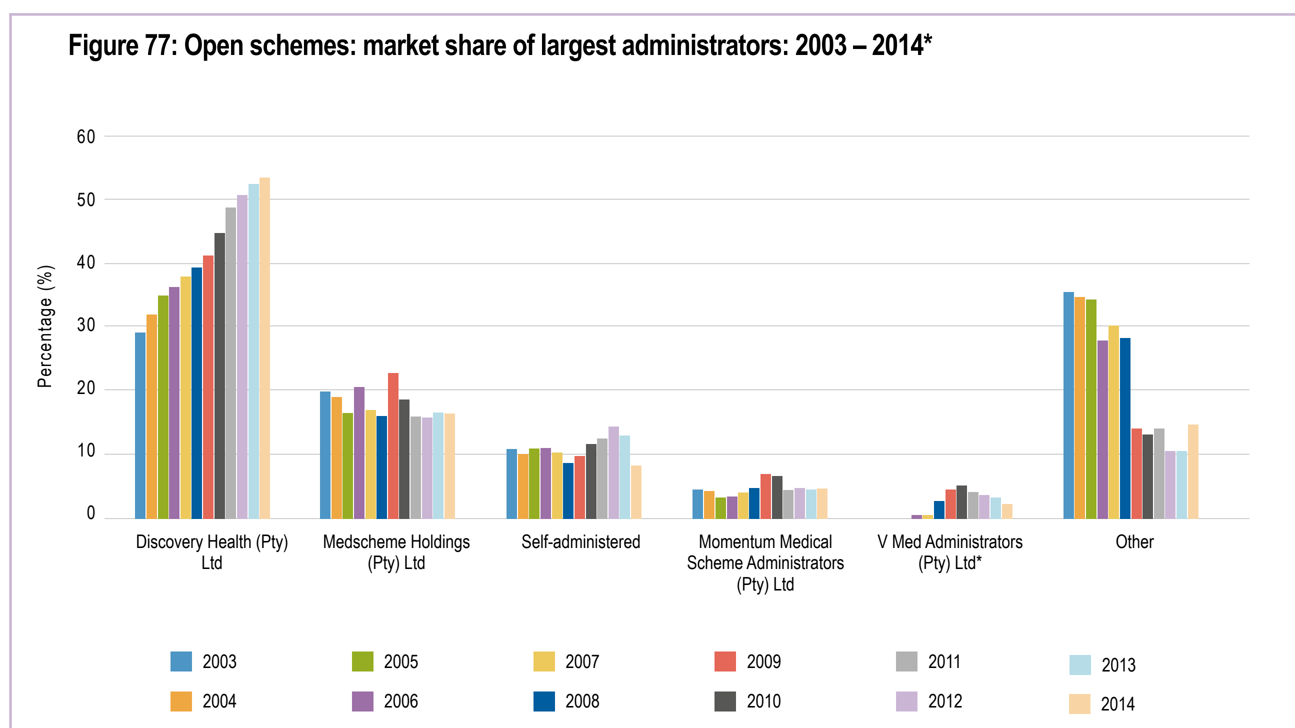
Largest market share – all schemes	2010	2011	2012	2013	2014	Change 2010 – 2014 %
Discovery Health (Pty) Ltd	28.9	30.1	25.7	26.3	27.2	-5.7
Metropolitan Health Corporate (Pty) Ltd	27.0	29.8	25.8	25.5	25.3	-6.6
Medscheme Holdings (Pty) Ltd	14.6	12.2	26.7	27.4	27.2	86.8
Self-administered	9.8	10.2	9.2	8.5	6.6	-32.5
Momentum Medical Scheme Administrators (Pty) Ltd	6.0	4.5	3.8	3.1	2.9	-52.1
V Med Administrators (Pty) Ltd	3.4	2.7	1.9	1.6	1.2	-63.8
Other	10.4	10.5	6.9	7.5	9.6	-7.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

7. GEMS had a joint administrator contract in place in 2013. 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 management services as well as the provision of financial and operational information. GEMS membership was included for both administrators.

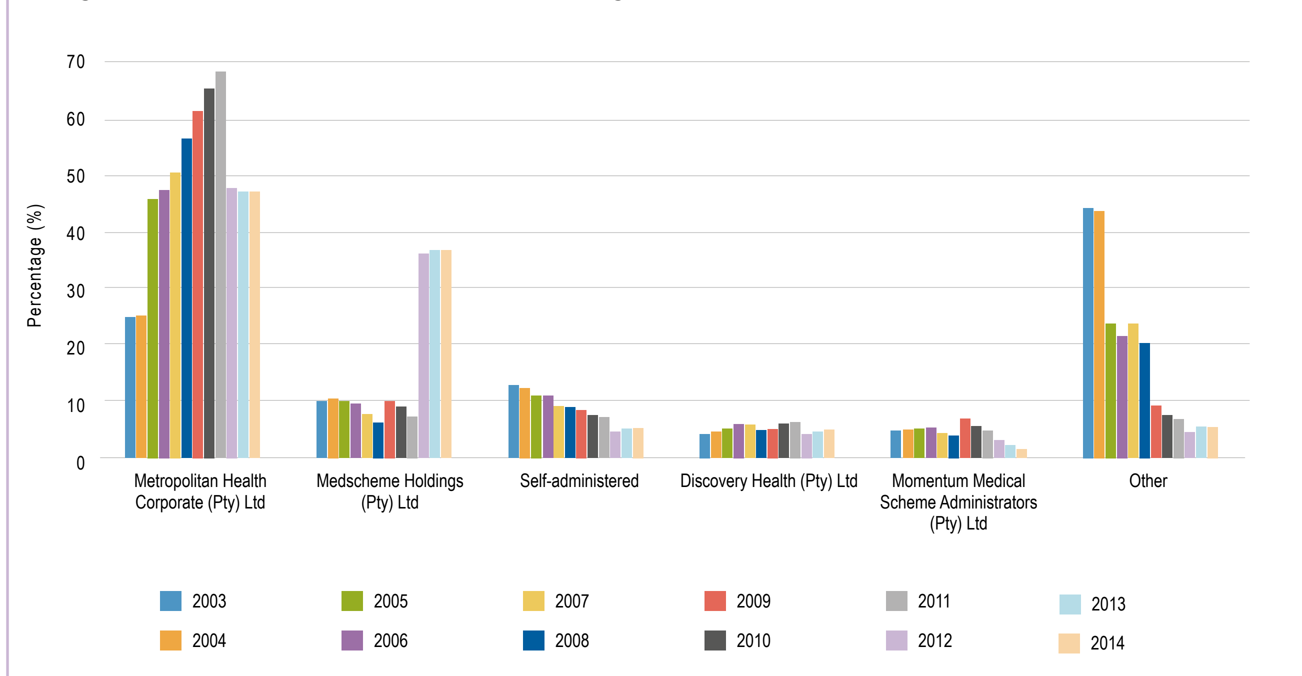
Largest market share – all schemes	2010	2011	2012	2013	2014	Change 2010 – 2014 %
Largest market share in open medical schemes						
Discovery Health (Pty) Ltd	44.9	48.5	50.8	52.4	53.4	19.0
Medscheme Holdings (Pty) Ltd	18.6	15.9	15.9	16.6	16.5	-11.4
Self-administered	11.5	12.5	14.4	12.9	8.3	-27.7
Momentum Medical Scheme Administrators (Pty) Ltd	6.4	4.4	4.6	4.4	4.6	-28.6
V Med Administrators (Pty) Ltd	5.5	4.6	3.8	3.4	2.4	-56.3
Other	13.2	14.1	10.4	10.4	14.9	12.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	
Largest market share in restricted medical schemes						
Metropolitan Health Corporate (Pty) Ltd	64.9	67.8	47.4	46.7	46.6	-28.1
Medscheme Holdings (Pty) Ltd	8.9	7.3	35.9	36.3	36.3	309.3
Self-administered	7.3	7.1	4.8	4.9	5.1	-29.8
Discovery Health (Pty) Ltd	6.2	6.4	4.4	4.6	5.1	-17.0
Momentum Medical Scheme Administrators (Pty) Ltd	5.4	4.7	3.0	2.1	1.4	-73.4
Other	7.4	6.7	4.4	5.4	5.4	-26.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

Figures 77 and 78 indicate the changes in administrator market share over the last 12 years for open and restricted medical schemes respectively.

Figure 77: Open schemes: market share of largest administrators: 2003 – 2014*



* *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 Y).*



* *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 Y).*

Discovery Health (Pty) Ltd's share of the open schemes market increased to 53.4% (2013: 52.4%) and its share of the restricted schemes market increased to 5.1% (2013: 4.6 %).

Medscheme Holdings (Pty) Ltd has the second-biggest share in both the open and restricted schemes administration market at 16.5% (2013: 16.6%) and 36.3% (2013: also 36.3%) respectively. 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 46.6% (2013: 46.7%).

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 three administrators which had higher administration costs and fees than the industry average for administrators handling open schemes.

Table 67: Open scheme administrators' costs – deviation from industry average: 2014

	Gross administration costs %	Administration fees paid* %	Fees paid to administrators (administration + managed care)* %
Discovery Health (Pty) Ltd	(0.3)	10.8	15.5
Strata Healthcare Management (Pty) Ltd	20.3	19.8	10.9
Allcare Administrators (Pty) Ltd	198.0	17.3	3.8

* *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: Restricted scheme administrators' costs – deviation from industry average: 2014

	Gross administration costs	Administration fees paid*	Fees paid to administrators (administration + managed care)*
	%	%	%
Eternity Private Health Fund Administrators (Pty) Ltd	126.6	155.0	128.5
V Med Administrators (Pty) Ltd	39.7	66.5	73.4
Discovery Health (Pty) Ltd	43.8	72.0	69.2
Professional Medical Scheme Administrators (Pty) Ltd	121.5	96.6	65.8
Methealth (Pty) Ltd	42.9	57.4	40.8
Momentum Medical Scheme Administrators (Pty) Ltd	28.7	40.8	32.5
Prime Med Administrators (Pty) Ltd	(3.8)	14.8	28.9
Universal Healthcare Administrators (Pty) Ltd	20.1	37.3	27.2
Private Health Administrators (Pty) Ltd	10.6	18.7	5.1

* *Excluding co-administration fees.*

Administrators and businesses associated with administrators often provide managed healthcare services. In some instances, the value proposition of such services to members is less than demonstrable, and these services could merely add additional layers of administration costs. They were included in the "fees paid to administrators" figures where they were paid to the administrator or to any company in the administrator group.

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. The tables 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 Y.)

Table 69: Market share of administrators in open schemes industry: 2014

	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid		Total fees paid to administrators		Gross contributions	Risk claims ratio
Name of administrator		% market share	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	%
Discovery Health (Pty) Ltd	1	53.4	118.4	8.2	115.0	8.0	153.5	10.7	1 440.1	81.7
Strata Healthcare Management (Pty) Ltd	1	4.5	142.8	10.1	124.4	8.8	147.4	10.4	1 415.4	91.0
Allcare Administrators (Pty) Ltd	1	0.2	353.8	19.0	121.8	6.5	137.9	7.4	1 866.7	88.8
Universal Healthcare Administrtors (Pty) Ltd	2	0.7	143.4	11.3	102.5	8.1	132.6	10.4	1 271.7	86.4
Sechaba Medical Solutions (Pty) Ltd	1	2.6	132.0	9.0	95.9	6.6	122.4	8.4	1 462.2	79.9
V Med Administrators (Pty) Ltd	1	2.4	152.9	10.3	89.3	6.0	119.3	8.0	1 490.8	91.9
Medscheme Holdings (Pty) Ltd	2	16.5	111.5	8.3	79.4	5.9	115.1	8.6	1 343.0	89.7
Agility Global Health Solutions Africa (Pty) Ltd	2	2.0	157.4	11.4	90.2	6.6	110.5	8.0	1 376.4	85.5

Name of administrator	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid		Total fees paid to administrators		Gross contributions	Risk claims ratio
		% market share	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	%
Momentum Medical Scheme Administrators (Pty) Ltd	1	4.6	95.6	8.7	91.2	8.3	110.3	10.0	1 102.8	82.0
Professional Medical Scheme Administrators (Pty) Ltd	1	1.5	133.3	6.7	84.0	4.2	103.1	5.2	1 986.8	87.2
Private Health Administrators (Pty) Ltd	1	0.9	102.5	7.9	75.1	5.8	96.5	7.4	1 304.0	93.9
Providence Healthcare Risk Managers (Pty) Ltd	2	0.5	81.3	8.5	63.7	6.6	86.6	9.0	958.0	88.5
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	2.0	105.9	8.9	64.6	5.4	67.7	5.7	1 184.8	84.4
Self-administered	5	8.3	107.9	7.3	–	–	20.9	1.2	1 473.5	89.8
Prime Med Administrators (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Total/ average	**23**	**100.0**	**118.7**	**8.4**	**103.8**	**7.4**	**132.9**	**9.4**	**1 410.4**	**85.0**

* *Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = gross contribution income

Table 70: Market share of administrators in the restricted schemes industry: 2014

Name of administrator	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid		Total fees paid to administrators		Gross contributions	Risk claims ratio
		% market share	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	%
Eternity Private Health Fund Administrators (Pty) Ltd	2	1.0	152.8	9.3	125.7	7.7	156.3	9.5	1 637.2	91.6
V Med Administrators (Pty) Ltd	1	0.2	94.2	5.9	82.1	5.2	118.6	7.5	1 588.9	83.3
Discovery Healthy (Pty) Ltd	12	5.1	97.0	7.4	84.8	6.5	115.7	8.9	1 306.1	85.7
Professional Medical Scheme Administrators (Pty) Ltd	1	1.1	149.4	10.5	96.9	6.8	113.4	8.0	1 422.5	85.2
Methealth (Pty) Ltd	4	0.9	96.4	7.7	77.6	6.2	96.3	7.7	1 256.8	98.2
Momentum Medical Scheme Administrators (Pty) Ltd	3	1.4	86.8	7.2	69.4	5.8	90.6	7.5	1 207.1	92.5
Prime Med Administrators (Pty) Ltd	1	0.7	64.9	4.3	56.6	3.7	88.2	5.8	1 509.3	94.7
Universal Healthcare Administrators (Pty) Ltd	4	0.6	81.0	6.5	67.7	5.5	87.0	7.0	1 238.4	87.2

	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid		Total fees paid to administrators		Gross contributions	Risk claims ratio
Name of administrator		% market share	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	As % of GCI	pabpm Rand	%
Private Health Administrators (Pty) Ltd	1	0.1	74.6	5.3	58.5	4.2	71.9	5.2	1 394.4	98.8
Allcare Administrators (Pty) Ltd	–	0.0	122.1	25.8	53.9	11.4	53.9	11.4	474.0	151.4
Providence Healthcare Risk Managers (Pty) Ltd	3	0.7	53.8	6.8	38.2	4.8	52.7	6.7	787.0	90.4
Metropolitan Health Corporate (Pty) Ltd	9	46.6	39.4	10.0	34.7	8.8	44.9	11.4	393.4	94.1
Medscheme Holdings (Pty) Ltd	12	36.3	34.7	2.8	14.5	1.2	30.6	2.5	1 235.4	90.5
Self-administered	8	5.1	58.5	6.2	–	–	9.3	0.9	948.8	85.9
Total/average	**37**	**100.0**	**67.5**	**5.5**	**49.6**	**4.0**	**68.4**	**5.5**	**1 229.8**	**92.4**

* *Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = gross contribution income