



COUNCIL FOR MEDICAL SCHEMES

1267 Pretorius Street, Hadefields Block E, Hatfield, Pretoria

Private Bag X34, Hatfield 0028

Telephone: 012 431 0500 Telefax: 012 430 7644

www.medicalschemes.com



Council for Medical Schemes

ANNUAL REPORT 2004-5

Strategic Objectives

Secure an appropriate level of protection for beneficiaries of medical schemes and the public by authorising the conduct of medical schemes business and monitoring the financial performance and soundness of schemes.

Provide support and guidance to trustees and promote understanding of the medical schemes environment by trustees, beneficiaries and the public.

Foster compliance with the Act by medical schemes, administrators, managed care entities and brokers and initiate enforcement action where required.

Investigate and resolve complaints raised by beneficiaries and the public.

Monitor the impact of the Act, research developments, and recommend policy options to improve the regulatory environment.

Foster the continued development of the CMS as an employer of choice.

Develop strategic alliances nationally, regionally and internationally.

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A N N U A L R E P O R T 2 0 0 4 - 5



PREVIOUS PAGE

- A **DIVINER'S BASKET** with the objects necessary for divining and therapy to deal with illness or "re-establish order in the vital relationships between people, and between people and the spirits" (Boris Westliau quoted by Colin Richards) and comes from the Chokwe people of Angola and the Democratic Republic of Congo.

The images

The selection of images was made with the assistance of the Wits Art Gallery, to reflect notions of health and the exchange of money in many cultures in South Africa and the continent as a whole, many of which live side-by side in a setting which supports medical schemes. These two items (health and the exchange of money), very roughly mirror the business of medical schemes.

The artwork reflected in the Annual Report 2004/05 belongs to Wits University and Standard Bank Collections of Art. The Council for Medical Schemes expresses its gratitude for the use of these images and in particular for the assistance given by Julia Charlton, senior curator of the Wits Art Gallery.



—● **AIDS CLOTH** by
Noria Maswanganyi
& Florence Nobela
of the Chivurika
Embroidery Project.

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Chairperson's foreword

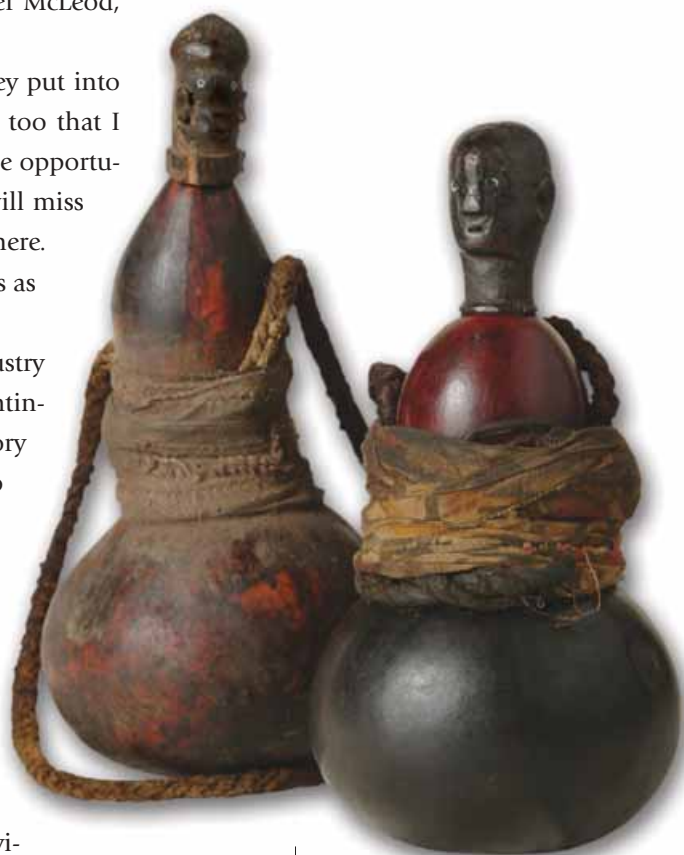
IT IS with considerable pride, but some nostalgia, that I present this foreword to the Annual Report of the Council for Medical Schemes for 2004/05, as my tenure chairing the Council draws to a close. During 2005, the terms of office of several other Council members also come to an end. They are Ms Gando Matyumza who has been an able deputy chairperson, Professor Heather McLeod, Dr Jakes Jekwa and Dr Reno Morar.

I would like to thank them for the tremendous effort they put into the work of the Council over the past five years. I am sure too that I speak for all of us when I say that we are most grateful for the opportunity afforded us to participate in the Council, and that we will miss the dynamic and rewarding interactions we have enjoyed here. We wish our successors as much fulfillment in their positions as we experienced.

Over these past five years both the regulator and the industry have experienced fundamental transformation – which continues. There is little comparison between the level of regulatory oversight exercised in the medical schemes industry prior to the creation of the new Council for Medical Schemes and Office of the Registrar in 2000, and what is now in place.

In 2000, when the current Medical Schemes Act became operational, the industry was regulated by a sub-directorate in the Department of Health. This was inadequate to regulate the then R30bn which was spent annually by some 7-million beneficiaries in the industry while, at the same time, ensuring that members and their dependants were treated fairly in terms of the law, and ensuring an environment which would function well into the future. A regulatory structure was therefore created which would have the capacity and flexibility to redirect further development of the private health funding sector in a manner consistent with national health policy being rolled out by the first democratically-elected government.

Inequities and unfair practices which had developed for members over the previous years, were now to be outlawed by the Medical Schemes Act, but this required a strong and adequate regulator to translate the law into a useful reality for members while protecting the financial security of schemes then and into the future. This, in turn, called for the overseeing of specific moves: the promotion of



● Medicine containers

These calabashes are used by ritual specialists as containers in which to store medicines.

Pare, Tanzania

Gourd, wood, fabric, fibre, beads

Standard Bank Foundation
Collection of African Art - Housed
at the University of the
Witwatersrand Art Galleries

Acquired 2004

non-discriminatory access to private health care funding; the placing of schemes on a sound financial footing; the improvement of scheme governance; and the protection of consumers.

One of our first tasks as the Council was ensuring that the new regulator itself had impeccable system of corporate governance. We therefore defined our role as Council to include:

- leading and controlling the affairs of the organization and making strategic decisions affecting the operations of the organization;
- exercising those legislative functions set aside by the Act to be exercised only by Council and taking specific decisions that are judged by the Registrar and Council to be of such significance as to require being taken by Council;
- setting appropriate policies to manage risks to the operations and achievement of Council's regulatory objectives, taking into account the nature and extent of risks facing the Council, their likelihood of crystallising, and the Council's ability to reduce the incidence and impact of risks that do materialize;
- maintaining a sound system of financial controls, taking into account the costs of particular controls relative to the benefits obtained in managing related risks; and
- maintaining high-level relations with stakeholders and other agencies, including government.

This corporate governance framework has served us well over the years, and we hope that our successors will build on it.

We also adopted a Code of Good Conduct, which is underpinned by the requirement that all Council members bring independent judgment to bear on issues of strategy, performance, resources and standards of conduct. Other important components of the Code include

access to suitable training, advice and information, supplied in a timely manner, and in a format and quality appropriate to enable Council to discharge its duties. Again we recommend this code of conduct to

the new Council and hope that the code can be improved upon as new circumstances emerge.

We have seen, over the past five years, initial resistance by some stakeholders giving way to a generally enthusiastic participation in a newly-invigorated industry which is on a much sounder footing financially and ensuring greater assistance towards its members. There is always room for improvement in any situation, but we believe that our increased regulatory capacity has translated into a more-professional and useful service matched by growing levels of cooperation and mutual respect between ourselves and industry stakeholders.

In 2000, close to 50% of members of schemes belonged to schemes with sol-



Diviner's necklace

Part of the regalia worn by a sangoma or traditional healer when consulting with and treating clients.

Wood, thread, glass beads, leather

Standard Bank Foundation Collection of African Art - Housed at the University of the Witwatersrand Art Galleries

veny levels of less than 10%. In 2000, the regular annual deficit schemes made had amounted to R1bn. I leave office with the vast majority of members in schemes which meet the statutory minimum solvency levels of 25% or more, and with the industry now regularly making large surpluses. We have achieved successes in the areas of minimum reserve requirements, more stringent financial controls within medical schemes, and closer scrutiny of the financial affairs of medical schemes. A stronger awareness of the need for good governance also exists, with participation of trustees and consumer groups in educational programmes that the Registrar has set up.

As the Council goes forward, it looks to the creation of a Risk Equalisation Fund for the industry as well as continued participation in the creation of a Social Health Insurance system.

As a Council, we were very fortunate that the Minister of Health, Dr Manto Tshabalala-Msimang took a very active interest in our work over the years. The Minister's support on key regulatory measures -- such as curbing the abuse of reinsurance, setting out appropriate requirements for prescribed minimum benefits and medical schemes governance -- has been very important to many of the seminal successes of the Council. I take this opportunity to thank the Minister for her considerable assistance and counsel to us as Council.

In closing, I would like to pay particular tribute to the Registrar, Patrick Masobe, for his leadership of the executive arm of the Council. Under his direction, a regulatory body has emerged that has demonstrated vision, the ability to be flexible under appropriate circumstances, and the tenacity to remain resolute when key issues of policy and principle are at stake. I have every confidence that the Registrar and his team will continue to build on their successes, learn from their mistakes, and boldly confront the challenges that lie ahead. I wish them well.

Prof Nicky Padayachee

Chairperson – Council for Medical Schemes



● **Isijolandi** (medicine necklace)
Zulu, South Africa
Glass beads, horns, plastic spoons
Standard Bank Foundation
Collection of African Art - Housed
at the University of the
Witwatersrand Art Galleries

Also see necklace on page 13.

Registrar's review

External developments affecting our work

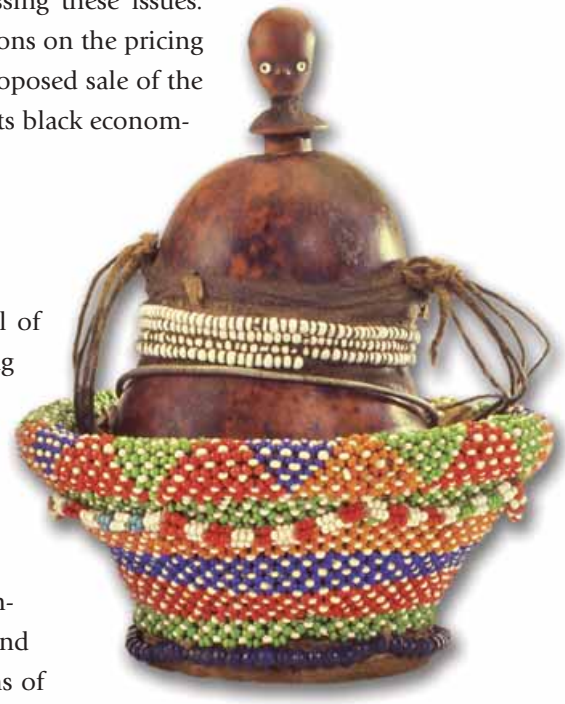
The past year has seen a number of important policy developments that, though not part of our regular agenda, have nonetheless impacted on our work. These external factors have affected the experience that beneficiaries had of their medical schemes and we have had to expend much effort on addressing these issues. Central to these has been the promulgation of the new regulations on the pricing of medicines and the Competition Tribunal hearings on the proposed sale of the Afrox hospital group to a consortium made of Mediclinic and its black economic empowerment partners.

Regulation of medicine prices

Medical schemes and their beneficiaries expressed a great deal of uncertainty over the implications of the new medicines pricing regulations in the light of legal challenges mounted against these regulations by a number of parties in the private sector. Those needing medicines for the compulsory cover of the 25 prescribed chronic conditions were faced, too, with added costs when pharmacists decided to charge "administrative" fees that were not reimbursed by medical schemes. We were, as a consequence, inundated with queries both from medical schemes and from beneficiaries expressing their anxiety over the implications of the medicine-pricing regulations. A considerable amount of our time was spent jointly with the health department responding to beneficiaries' complaints and to schemes' enquiries. While a judgement from the Constitutional Court on the legality of these regulations is still awaited, it would appear that the promise of lower medicine costs is in sight, with manufacturer prices estimated to have decreased by 21% since May 2004.

Competition Tribunal hearings and the Afrox Healthcare transaction

We were called upon to assist the Competition Tribunal in its deliberations on the likely impact of the proposed transaction on hospital costs. This was done with a submission on behalf of the Minister of Health and of the Council and then by providing expert help at the hearings. Hospital costs are the largest portion of



● **A medicine gourd, or *nhunguvana*.** "Such objects are more and less than stethoscopes or antibiotics," says Rayda Becker describing the object and its relationship to its users – and the distance from its Western observers. It rests in a beaded basket known as a *xitebana* and the *Nhlontwa*, the head on the top of the stopper (with a stirring device) has been separately created
Tsonga-Shangaan, South Africa.



● **Umdwana** (Child figure or doll). Different uses for the dolls are recorded; some related to fertility, others to ornamental or decorative purposes, and still others to identity statements.

Ndebele, South Africa

Gourd, beads, fibre

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medical scheme input costs, and our work at the Tribunal gave us an opportunity to look critically at competition in the hospital industry with an eye on the effect this has on costs to the public in general and medical schemes in particular. The outcome of the Tribunal hearings resulted in a complete restructuring in the financing of the deal in which the BEE consortium bought the interests of Afrox Healthcare from the parent group and the complete disappearance of Mediclinic.

New developments in the regulatory regime

We advanced the improvement of the medical schemes regulatory framework on a number of fronts during the year under review. In this section we report on some of the more important changes to the regulatory regime.

Mitigating against unfair discrimination in benefit design

We have found it necessary to scrutinise more thoroughly the construction of benefits and certain practices that have grown over the years in benefit design in order

REGULATING IN THE PUBLIC INTEREST: Taking stock and looking to

A Five-Year Review of the Council for Medical Schemes

AS THE Council for Medical Schemes approached the end of its fifth year of operations in 2005, the Registrar published a review and analysis of the first five years of the Council.

The review will provide a basis for critical reflection on progress and lay the platform for future actions. It will be provided to the Minister of Health for her consideration in relation to the requirement to assess Council's performance every five years.

The Council was established to protect the interests of beneficiaries of medical schemes, to ensure that medical schemes functioned in a way which complemented national health policy and to make recommendations to the

Minister of Health.

The review outlined the setting up of the Council and of the Office of the Registrar and set out the strategic objectives of the organization while assessing its accomplishments and shortcomings over the period.

Financial soundness of medical schemes formed a major focus of the early years of the regulatory effort. By 2000 an increasing annual deficit in the industry had reached R1bn. To address this, it became apparent that the growing phenomenon of the inappropriate use of reinsurance in the industry, needed to be addressed.

Other areas highlighted in the review include progress on managing rules of schemes, simplifying benefits

to allay continuing concerns of unfair discrimination against some members of schemes. This work represents, in part, our attempt to implement the recommendations made in our Fair Treatment of Members project, where members expressed their displeasure at unnecessary complexity of benefit design.

Part of the problem is manifest in the increasing trend to moving, as far as possible, benefits out of the risk pool and of forcing members to pay for increasing amounts of healthcare from medical savings accounts and the so-called annual routine benefits. Another problem relates to the differentiation of total contributions within a single-benefit option based upon variable contributions to a medical savings account.

These various configurations of medical savings accounts, annual routine benefits, thresholds and deductibles have largely had the effect of creating a de facto risk-rated contribution for out-of-hospital expenses, based on age and health status. In other words, for out-of-hospital expenses, over a period of time the actual contribution payable by a member begins to approximate the rate payable by that member based on expected claims of that member and her or his dependants, as opposed to a community-rated contribution based upon an expected average cost for the medical scheme.

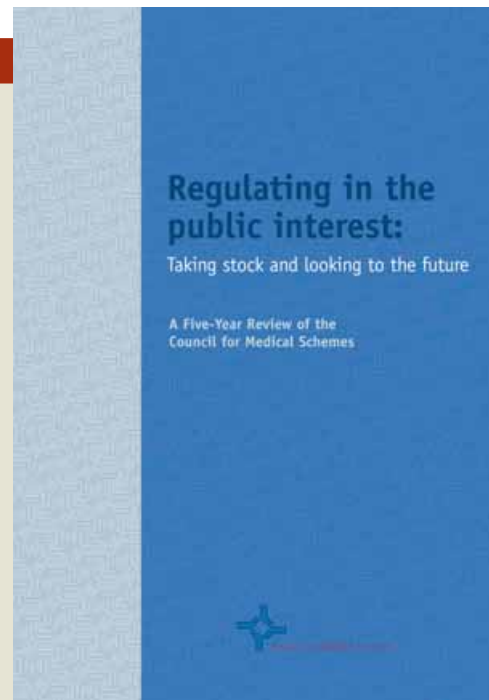
Towards the end of 2004, we informed schemes that these benefit designs were

the future

provided by schemes and constructing a compliance-based regime for the sector.

The review notes that in the past five years progress was made in promoting non-discriminatory access to private health funding. Practices of overt and direct discrimination on the basis of age and health status were largely contained – but structural problems emerged which have resulted in older and sickly members facing greater financial obstacles in gaining access to health care.

Scheme governance falls among four broad thematic concerns which the report regarded as critical factors going forward. Price-setting behaviour by schemes and providers formed a second concern; rationing in a setting



of scarce resources produces decisions which have to be made on limitations to health care; and a final concern, the report noted, is the appropriate regulation of the use of expensive technology.

neither acceptable nor legal and that they had to be ended. They result in unfair discrimination directly or indirectly against persons on grounds of state of health, contrary to section 24(2) (e) of the Medical Schemes Act, and they constitute a circumvention of the provisions of the Act.

Implementation of ICD 10 codes

The purpose of the new coding system is to standardise data collection and billing practices in order to improve efficiency. An ICD 10 implementation task team -- including department of health, medical schemes and administrators, providers and switching companies -- was formed to develop an implementation strategy for ICD 10 for medical schemes. The task team has evaluated the readiness for implementation by schemes, providers, switching companies and other relevant stakeholders. It was decided that the ICD-10 codes should be implemented on 1 July 2005.

The process of further consultation with stakeholders is continuing, with many aspects that will need to be dealt with in the course of the actual implementation after July 2005.

The 15 PMB chapters have also been coded for ICD10, and they now form the basis of our interpretation of members' entitlement to PMBs. This process, while appearing to be removed from the immediate sphere of member interest, will directly affect the way in which members are reimbursed. It will require significant effort in educating stakeholders as well as members so that the system can deliver its objective of efficiently reimbursing for conditions that are being treated and for which schemes are obliged to pay in full.

The National Health Reference Price List (NHRPL)

For the second consecutive year we have undertaken the task of compiling a reference price list of services supplied into the medical scheme environment. Although not initially a core function of the CMS, the move in the year 2003/04 to provide the list was necessitated by action taken by the Competition Commission in curtailing the annual negotiations between the medical schemes industry through the Board of Healthcare Funders and hospital and doctor groups. This move had created an impasse in the medical schemes environment and the Council stepped in to compile a reference price list that schemes could use to define their benefits should they wish.

During 2004, state hospital prices and services were included in the list at the request of the department of health. The intense level of work required on this list and the persistent nature of inquiries from stakeholders necessitated the employment of one extra staff member during the year. Some changes to the compilation of the list were reflected in the outcome of the pricing exercise. The previous approach of keeping price increases "cost neutral" was changed where necessary,

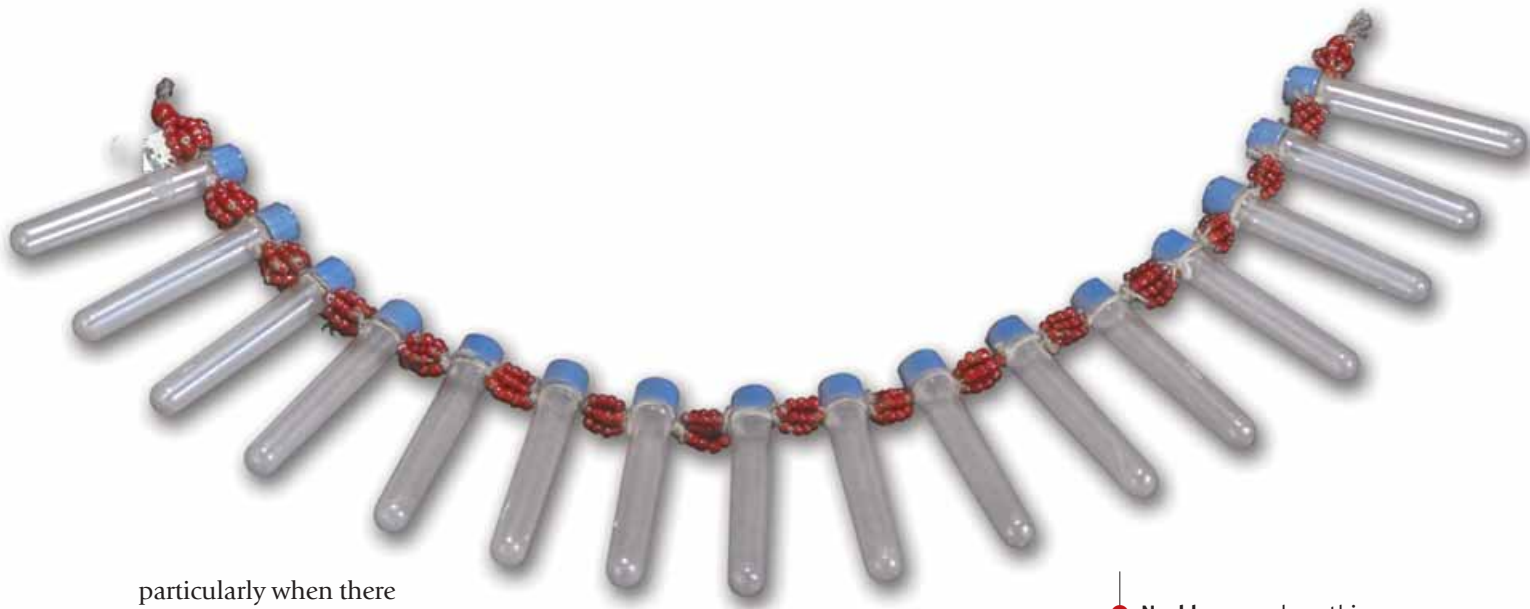


● **Katatora** (divination instrument) Divination instruments such as these are used by ritual specialists in the consultation of spirits.

Luba, Democratic Republic of Congo

Wood, beads

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particularly when there was solid evidence of higher real input costs. However in the absence of adequate justification, the year's CPIX inflation figure of 5,2% was adhered to.

Risk Equalisation

We continued to assist the department of health with the technical work on the development of policy on the Risk Equalisation Fund (REF). The Council has now been requested by the department to proceed with the testing of the REF scheme to assist government in coming to a final decision on its implementation.

A number of technical documents were completed in this regard during this year. They include:

- Methodology for the determination of REF contribution tables;
- Accounting and financial implications of the REF for medical schemes – done together with SAICA; and
- Solvency implications of the REF for medical schemes.

A reporting framework for medical schemes, including the necessary return that will allow for submission by schemes of the data required for the shadow REF run, has been finalised. We are also in the process of completing a review of the feasibility of implementation and the technological and institutional infrastructure required to operate the REF. As this report was going to press, Cabinet announced its approval of the implementation of the REF

Prescribed minimum benefits

The Minister of Health introduced amendments to the HIV/AIDS PMBs on 1 January 2005 to make provision for the payment by medical schemes of anti-retroviral therapy treatment.

Consultations on the setting up of a REF have also provided the impetus to research defining a basic benefit package that will facilitate the implementation of risk equalisation among schemes. A preliminary set of principles that will guide the process of the development of a basic benefit package has been developed. During September 2004, three members of staff who are directly involved in the project visited the Netherlands, Ireland, and the state of Oregon in the USA to learn more about developing a basic benefit package. We expect this work to gather momentum during 2005/06.

● Necklaces such as this were worn by ritual specialists, medical practitioners and their clients to store medicines and other powerful substances.
Zulu, South Africa
Umgexo (medicine necklace)
Glass beads, test tubes
Standard Bank Foundation
Collection of African Art -
Housed at the University of the
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Access to medical schemes by people with low incomes

Also as a result of the REF consultation process, and with an eye on how best to deliver less-expensive benefit options which would cover those with some income but who are presently not covered by the medical scheme industry, focus has been given to the possibility of developing a low-cost medical scheme environment.

This project, again undertaken with the industry, is reviewing issues both on the demand and on the supply side that constrain the development of low-cost options within medical schemes. We expect recommendations to be made during January 2006, and these will then be assessed for their policy implications.

Assessing the impact of chronic disease list and designated service providers.

The introduction of compulsory cover for 25 chronic conditions with arrangements made for provision of services through designated service providers has now been in effect for more than a year. We have undertaken a substantial drive to make the public aware of these arrangements. While the basic objective of ensuring that schemes provide cover for these diseases has been achieved, it became clear during the year that some schemes used this opportunity to cease covering other chronic conditions that were not included within the legislated 25. In addition, we have had to intervene in the reluctance of certain schemes to supply cover for treatments that may, for medically sound reasons, have varied from the treatment algorithm attached to the chronic conditions.

A project to monitor the impact of the legislation on designated service providers and on the chronic disease list is underway. The primary purpose is to gain an improved understanding of the impact of these new policies on a range of issues including delivery of PMBs, changes in benefit design and contributions, and the impact on schemes, beneficiaries and providers. Preliminary findings indicate that the CDL legislation has improved healthcare delivery to scheme members in respect of the 25 chronic conditions. Coverage for chronic medication increased from 86.6% in 2003 to 100% in 2004 among open schemes. 57.5% of open schemes options also provided cover for the non-statutory chronic

conditions whilst the balance only provided cover for conditions on the CDL. The cover for chronic medication in the restricted schemes environment increased from 78.4% to 100%. 71.1% of restricted scheme options also provided benefits for non-statutory chronic medication.

These preliminary results also show that that use of formularies and protocols chronic medicines has increased to 85% of open schemes from 33.6% prior to the regulations coming into force. The use of protocols also increased to 64,5% from 34,2% in restricted schemes.

Figure 1: Chronic medication coverage

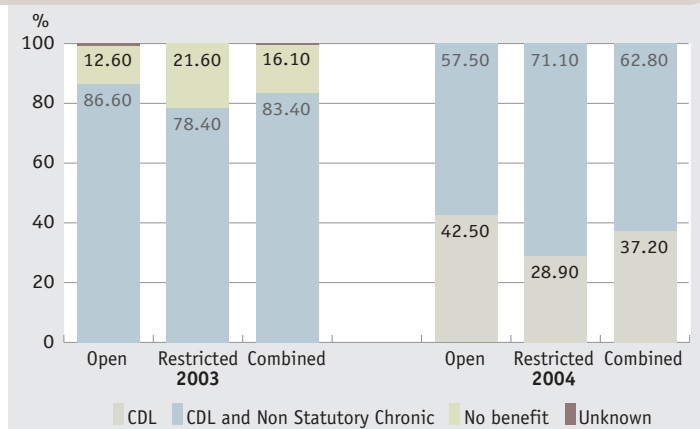
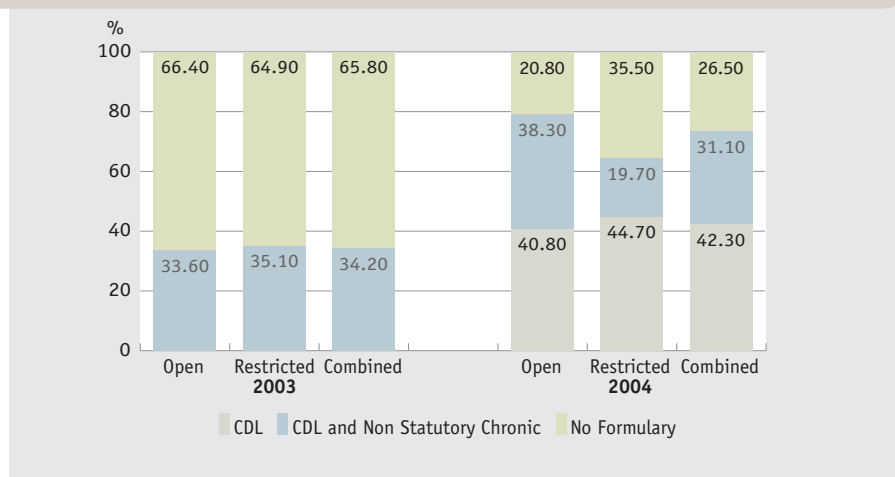


Figure 2: Changes in the use of formularies and protocols for chronic medications



Finally, our research found that a total of 78.2% of all options used DSPs in 2004, against only 45.3% in 2003. The use of DSPs in 2004 included those for the CDL and non-statutory chronic conditions. It would appear that DSP arrangements have been identified as a useful strategy for managing risk. While this increase is encouraging, neither the registered rules of the schemes nor the member communication are consistent in the identification of the DSP. The communication often just states that a DSP has to be used without stipulating who the DSP is. It was not clear whether this had been communicated to members in other ways.

The second phase of the research will be completed by October 2005, and will focus particularly on the impact on costs, beneficiaries and providers.

Medical schemes expenditure on private hospitals

Our participation in the Competition Tribunal hearings has also provided some impetus to an aspect of our investigation into the cost drivers in medical schemes. Figure 4 below shows real expenditure on private hospitals by medical schemes on a beneficiary per month, over an eight-year period. After adjusting for inflation and membership, the overall expenditure on hospitals rose by 17,3% to R186,6 per benefi-

Figure 3: Use of designated service providers in schemes

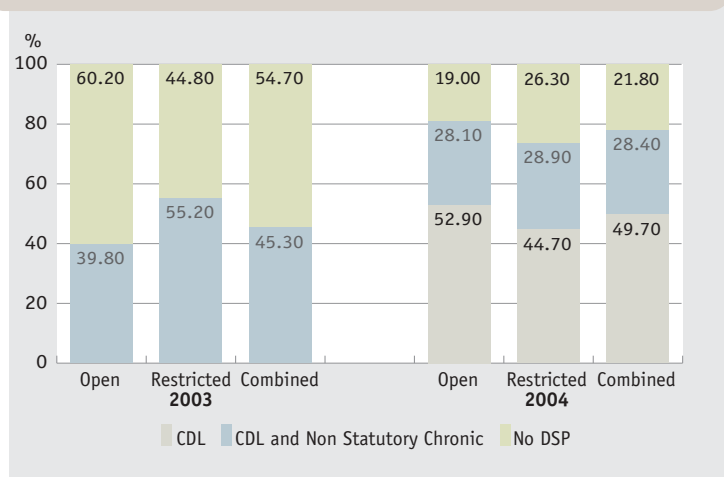
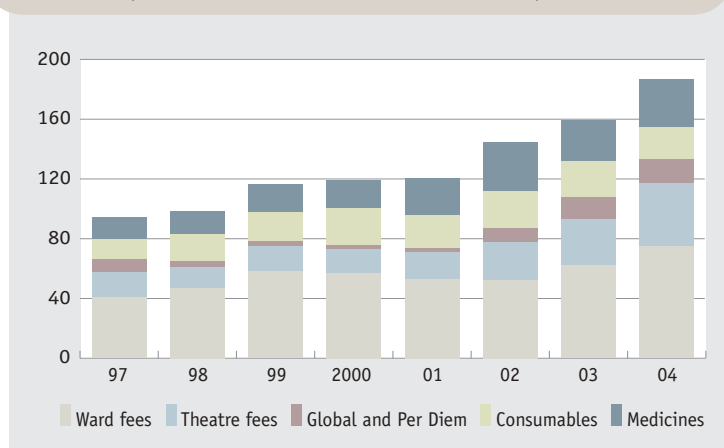


Figure 4. Real expenditure on private hospitals (per beneficiary per month in 2004 prices)



ary per month in 2004 from R159 in 2003. Ward fees increased by 20,4% to R74,8 from R62,1 in 2003. The highest increase was for theatre fees, which rose by 35,6% to R42,3 from R31,2 in 2003. Medicines increased by 16,4% to R31,6 from R27,2 in 2003.

Total private hospitals expenditure has increased by an inflation-adjusted 103,1%, since 1997. Ward fees increased by 85,8%; consumables by 63,1% and medicines by 122%. Theatre fees have risen by 172%!

Of particular concern is the fact that private hospitals are operating in a largely unregulated environment and that medical schemes provide little effective countervailing market power to that of the major hospital groups. We have therefore initiated an intensive research project on medical schemes' expenditure on private hospitals, with the following three objectives:

- To assess the impact and extent of escalating private hospital costs in relation to medical schemes expenditure;
 - To identify and evaluate the causes of current and historical rates of escalation of private hospital costs in South Africa; and
 - To identify and recommend possible remedies to reduce the rate of private hospital cost escalation, to the extent that it may be found to be inappropriate, and to mitigate the effects thereof.

This project is expected to generate a consolidated final report by March 2006.



● Katanga copper crosses,

See page 35.

Our work with regulated entities - medical schemes, administrators, managed care organisations and brokers

Risk-based regulatory framework

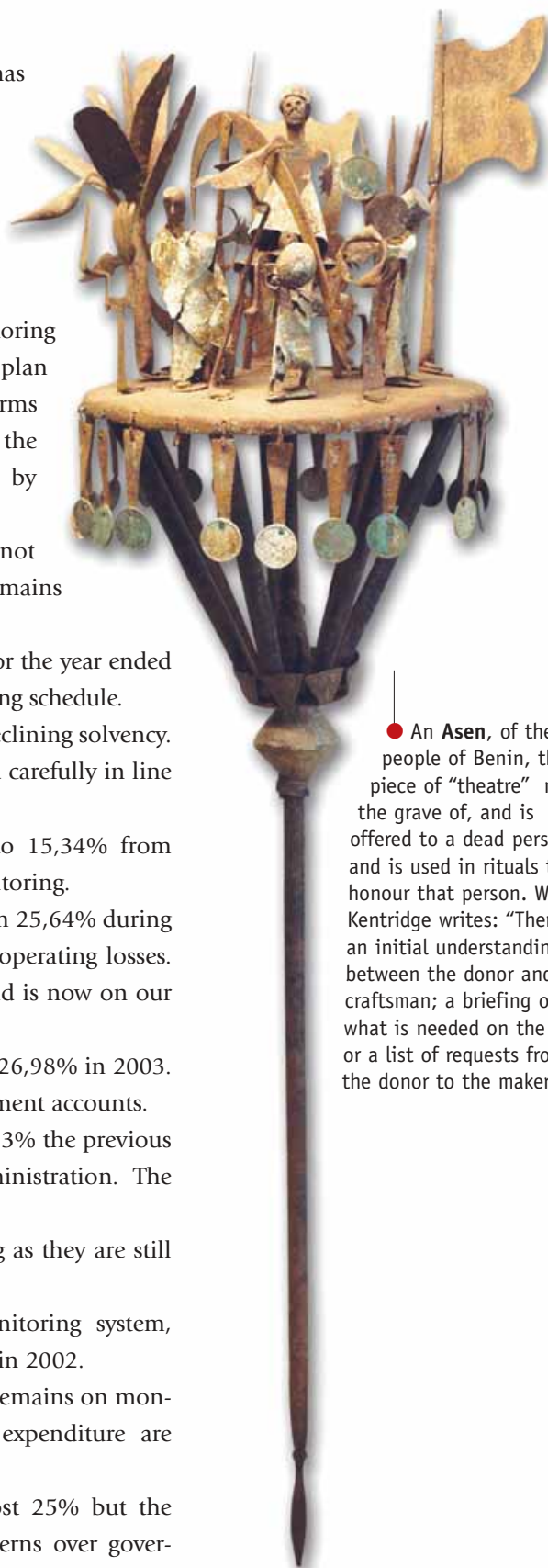
The Council takes a risk-based approach to regulation, and the intensity of our work with specific schemes depends on whether or not they are among those classified as high impact. During the year, we developed risk assessment frameworks and risk mitigation plans for a number of schemes, including Fedhealth, Bonitas, Oxygen, Discovery Health, Spectramed and Bankmed. The trustees have been briefed on our view of the risks within their schemes and measures to mitigate them. We will now monitor the implementation of specific mitigation plans while we continue to roll out the development of risk assessment and mitigation plans to other high impact schemes.

Promoting financial health of schemes – and treating their ills

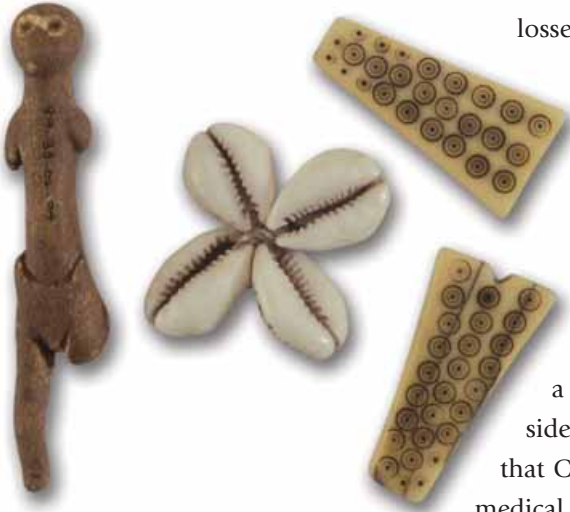
Several schemes are on our monthly monitoring programmes to assist in restor-

ing them to good financial health. Our work in this regard has focused on:

- **POLPRISMED** – we appointed a compliance officer to this scheme who was instrumental in turning its deficit position into an operating surplus by year's end. The scheme is now in the process of finalising an amalgamation with **HOSMED**.
- **LIBERTY** medical scheme remains on the monthly monitoring schedule. Monitoring of performance against a business plan agreed between the Registrar and the trustees of the scheme forms the basis for the monthly meetings. The solvency position of the scheme has improved from 10,05% in 2003 to 20,78% by December 2004.
- **PROTECTOR HEALTH** medical scheme's financial position has not improved much over the last financial year, and the scheme remains under constant watch.
- **X-PRESS's** (Renaissance Health) solvency declined to 11,52% for the year ended December 2004. The scheme has been placed on our monitoring schedule.
- **MUNIMED** incurred losses on two of its options, resulting in declining solvency. The scheme has been placed on watch and will be monitored carefully in line with the agreed business plan.
- **PHAROS** medical scheme has seen a slight improvement to 15,34% from 13,49% during 2002 in its solvency and will remain on monitoring.
- **OXYGEN** medical scheme's solvency declined to 16,25%% from 25,64% during the period under review, with a number of options making operating losses. The scheme has been instructed to redesign these options and is now on our monthly watch list.
- **GLOBAL HEALTH's** solvency declined to 20,61% in 2004 from 26,98% in 2003. The scheme has been instructed to provide monthly management accounts.
- **PROFMED** has improved solvency to 22,04% in 2004 from 8,83% the previous year after considerable restructuring of benefits and administration. The scheme remains on our monitoring programme.
- **SEDMED, NBC** and **NIMAS** have been placed under monitoring as they are still below the required 25% solvency margin.
- **DISCOVERY HEALTH** medical scheme remains on our monitoring system, though it has increased its solvency to 23,62 % from 2,58% in 2002.
- **MEDSHIELD** has reached the required 25% solvency level but remains on monitoring until concerns on high levels of non-healthcare expenditure are resolved.
- **RESOLUTION HEALTH's** solvency has also increased to almost 25% but the scheme remains on the monitoring programme until concerns over governance and high non-health expenditure have been fully dealt with.
- **FEDHEALTH, SPECTRAMED, BESTMED, SIZWE, BONITAS, MEDCOR** and **CSIR** have all reached the prescribed 25% solvency level in line with agreed business plans and are no longer on our monthly monitoring programme.



● An **Asen**, of the Fon people of Benin, this piece of "theatre" marks the grave of, and is offered to a dead person and is used in rituals to honour that person. William Kentridge writes: "There is an initial understanding between the donor and the craftsman; a briefing of what is needed on the asen, or a list of requests from the donor to the maker..."



● **Divination items.** These form part of the set of items kept by a sangoma or traditional healer and used for diagnosing ailments and prescribing remedies.

Southern African
Wood, cowrie shells, ivory
Standard Bank Foundation
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Reinsurance

The financial results of schemes show that the dramatic decline in reinsurance losses has continued along with increases in solvency levels. Reinsurance losses have decreased from R297 million in 2002 when the Act was amended to require greater oversight of reinsurance, to R123 million in 2003 and now R7,8 million in the period under review.

Medical schemes auditor approvals

The process of auditor approval has been continued. We have again refined the approval process, and have now been able to ensure that a greater number of auditor approval applications are received and considered before the commencement of the statutory audit. This suggests that Council's auditor approval process is gaining in effectiveness and that medical schemes and their auditors are paying increasing attention to legislative requirements in this regard.

Medical schemes' financial performance during 2004

Part four of this annual report contains a comprehensive analysis of the financial performance of medical schemes during 2004. A brief review of these financial results shows the following points:

- During 2004, the number of principal members of medical schemes increased by 1,1% to 2.8 million members. However the ratio of dependants to members has continued a slight downward trend leaving overall beneficiaries figure unchanged at 6,9 million for the year. The dependants ratio declined to 1,45 from 1,48 the previous period.
- The proportion of pensioner members (those 65 and over) within schemes has grown to 6,7% from 6,4% in 2003.
- We have collected data for the first time on the provincial distribution of medical scheme members. These data shows that 37,3% of members are in Gauteng, while 17,3% and 14,9% are in the Western Cape and KwaZulu-Natal, respectively. The Northern Cape accounted for the least number of members of medical schemes at 2,2%.
- Gross contribution income increased by 7,4% to R52,2bn. Risk contributions were R46,7bn while medical savings accounts contributions were R5,5bn.
- Once again the industry's financial picture is in good health. Net assets rose 35,4% to R20,4bn from R15,1bn the year before. Total surplus from operations has increased steadily since 2001, and rose 17,2% to R2,8 billion from R2,4bn in 2003.
- The inclusion of investment and other income increases the overall surplus to R5,0bn, an increase of 14,1% compared to 2003. Accumulated funds grew by 34,1% to R18,9bn from R14,1bn last year.
- The solvency ratio of the industry as a whole rose to 36,6% at December 2004 from 29,3% the previous year. Open schemes grew solvency by 33,5% to

Figure 5: Solvency of open schemes

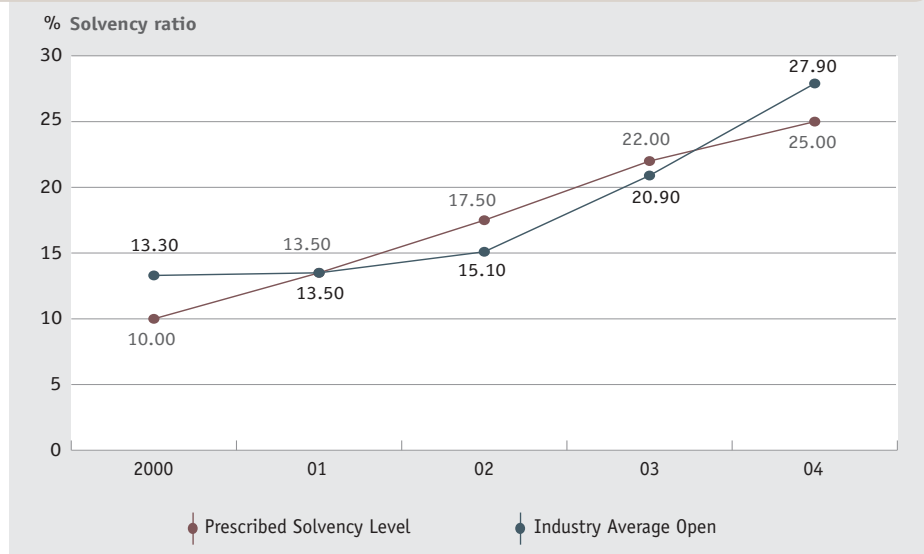
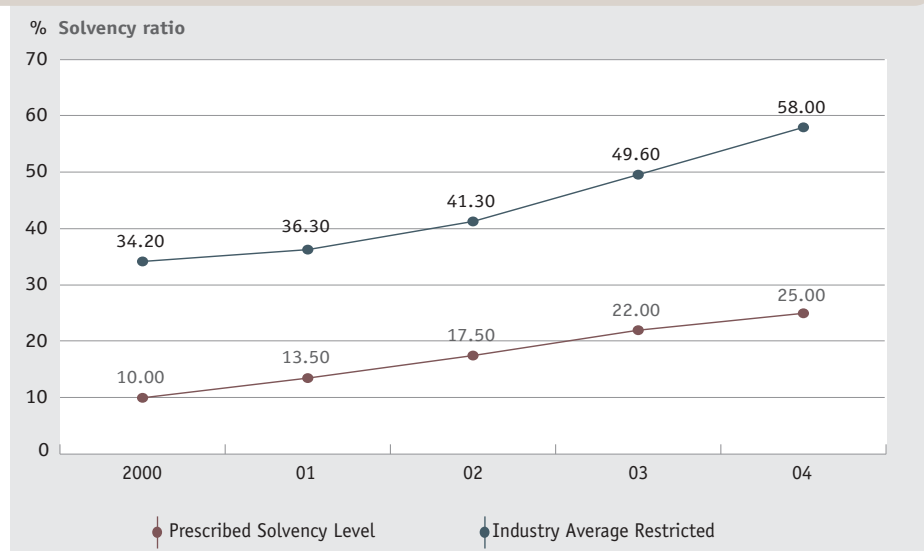


Figure 6: Solvency of restricted schemes



27,9%. Restricted schemes, on the other hand, achieved a solvency position of 58% compared to 49,3% in 2003.

- The ability of medical schemes to pay claims has increased considerably over the past three years. The number of months' claims that schemes can cover from their existing cash and cash equivalents have increased to 5,7 months from 4,2 months in 2003.
- Total expenditure on benefits increased by 7,2% to R41.5bn. The increase per beneficiary per month was 6,5%. Private hospital expenditure increased by 18,8% to R15,7bn. Spending on public hospitals increased by 5,3% to R261,9 million. Medical specialists accounted for R8,2bn, and increase of 8,4% on the previous year, while expenditure on general practitioners declined by 1,7% to R2,9bn. Expenditure on medicines, in a year that saw a great deal of activity

- around pricing in the judicial arena, decreased to R8bn from R8,6bn in 2003.
- Administration expenses increased by 10,3% to R5bn and managed care expenses rose by 12,6% to R1,3bn. These two components of non-healthcare expenditure effectively accounted for 12% of gross contribution income (11,7% in 2003).
 - The increase in broker fees of 21,1% to R704 million continues to underscore the problem of churning and inefficient utilisation of members' contributions. We intend to place firm new recommendations before the Minister in order to deal with this matter.
 - Bad debts, or "impaired receivables" amounted to R215 million in 2004, a decrease of 33,2% on 2003.
 - Total non-health expenditure rose by 7,6% to R7,1bn and accounted for 13,9% of gross contributions. Non-health expenditure per beneficiary has increased in real terms by 6,5% to R893.

Accreditation of administrators and managed healthcare entities

A lengthy process on accreditation of administrators and managed healthcare entities came close to finality in the course of 2004/05.

The Council has been working on proposals for an appropriate policy direction for the use of managed care by medical schemes. The initial phases of accrediting managed health care entities began during this period and coincided with the development of these policy proposals.

Some 47 managed care entities were accredited during the period under review. Many of these are subject to various conditions that must be complied with in order to remain accredited. These included Clinical Partners (Pty) Ltd, a company associated with the Netcare hospital group. During the year 2004/05, we asked the Competition Commission for a view on whether or not this particular arrangement of doctors associated with the hospital group, posed potential competition problems. The Commission responded that the issue could only be determined in the light of the conduct and contractual arrangements by the proposed entity. Council then decided to accredit the company as a managed healthcare organisation, subject once again to various conditions.

The need for accreditation means that the provision of managed healthcare services will be illegal if organisations offering the service are not accredited as providers. This process is intended to ensure that the provision of these services enhances the quality and efficiency of services to beneficiaries of medical schemes.

The same would apply to the accreditation of administrators – existing administrators are deemed to be accredited until the process of evaluation has been completed. During 2004/05, some 11 applications for accreditation were scrutinised and approved, subject to a number of conditions. This information has been placed on our website.

This process will have implications for those providing administration services and charging for them but who have not applied for accreditation or whose accreditation has been denied. Once again, these moves, required by statute, are

implemented to ensure that medical schemes and their beneficiaries receive adequate service in the administration of the funds intended for their health care.

Accreditation of brokers

There were 6 684 individuals accredited as health brokers during the year. We have also accredited 152 new organizations and 211 had their accreditation renewed. There were 596 accredited broker organizations on our database.

Registration of rules, new schemes and assessment of amalgamations

An important development during this period was the registration in November 2004 of the new Government Employees Medical Scheme (GEMS). The registration was subject to several conditions and much of 2005 was to be spent setting the scheme up with the involvement of the unions and other staff representatives. Some 1,5 million members could be covered by GEMS by 2009. Its appearance on the scene will have profound implications for several schemes that currently have large numbers of civil service members.

The registration of scheme rules has proceeded apace. The process was slower in the year under review partly because of difficulty by schemes in interpreting properly the requirements for designated service providers, and partly because of added scrutiny of benefit design by our team. One issue that has emerged as highly complex has been the attempt to ascertain the quantum of co-payments for prescribed minimum benefits in a setting that is not a designated service provider. Some schemes have required co-payments in excess of 80% of the cost – which we have had difficulty in approving. Nonetheless, attempts to quantify the exact amounts in order to come to a reasonable co-payment quantum have been more complex than originally contemplated.

Among the amalgamations considered during the year were those of Oxygen and Meds; PULZ and NMP (to form Momentum Health); Discovery and AngloGold and SAB and ABI. The request by IBM to amalgamate with DHMS was turned down as we believed that this will not be in the best interests of many members of IBM. The amalgamation of NMP and PULZ caused a great deal of member confusion seemingly caused by inappropriate communication. This was eventually sorted out with the help of our office.

Bargaining council medical schemes

Bargaining council medical schemes remain largely outside of the regulatory ambit of the Medical Schemes Act. The regulatory concern here is that members

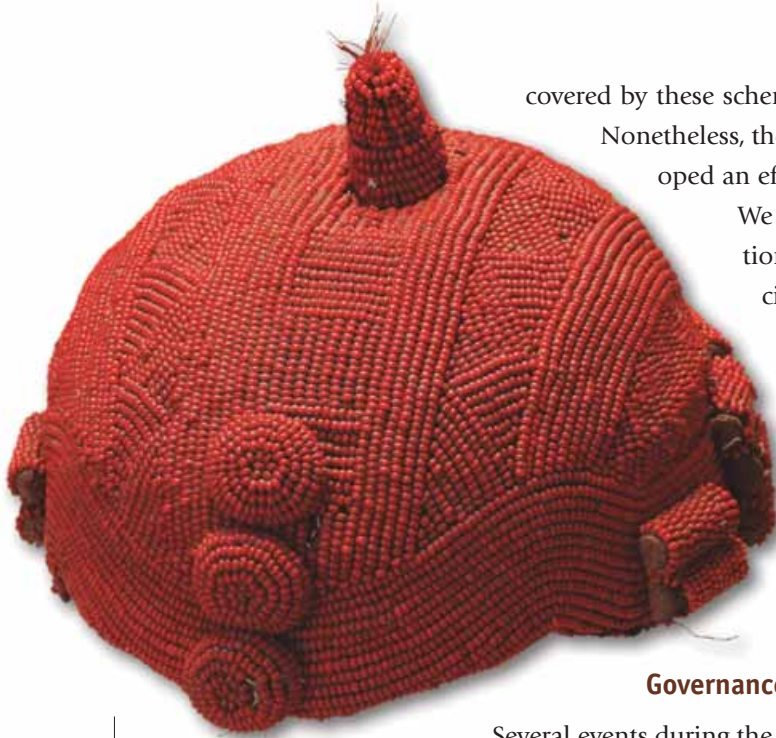


● **Diviner's necklace.** Part of the regalia worn by a sangoma or traditional healer when consulting with and treating clients.

Swazi/Tsonga-Shangaan, South Africa

Glass beads, thread, ndoro (conus shell)

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Witwatersrand Art Galleries



● **Orikogbo** – a beaded crown of the Yoruba of Nigeria.

Constructed like an English barrister's wig, it would be worn by a potentate or king wielding authority and intended, it would seem to be associated with the British legal system.. Yoruba wigs or crowns frequently drew on British colonial images.

covered by these schemes are not afforded the protections offered by the Act. Nonetheless, there is recognition that several of these entities have developed an effective mechanism for the delivery of basic health care.

We undertook a project to evaluate options for the resolution of uncertainties over the migration of bargaining council schemes to the Medical Schemes Act, as required by legislation. A situational analysis of these schemes has been undertaken, together with the Department of Labour, to gain a broader understanding of these schemes and the environment in which they operate. The findings have been discussed in workshops with bargaining councils around the country, and will lay the basis for policy on these schemes.

Governance of medical schemes

Several events during the course of 2004/05 prompted the Council to devote considerable resources to examining governance of medical schemes. One of our "theme" projects focussed on governance, in particular on identifying the causes of governance failure within schemes and recommending additional strategies to improve governance and to mitigate the risk of governance failure. Several scheme representatives, administrators and others gave their time and expertise to participate in the investigation.

Some of the preliminary findings have been interesting and pointed to some of the areas where attention could be devoted. For instance, although trustees of many of the boards of trustees showed a great range and variability in skills and experience, most schemes did not have a formal induction programme for new trustees. Induction was usually informal. Although schemes saw it as their responsibility to ensure that trustees were fit and proper to carry out their duties, few had any screening processes to ensure that trustees were, indeed, fit and proper. This is an area where the Act provides insufficient clarity. On remuneration of trustees, widely-varying practices exist on boards of trustees. This can range from large amounts for some trustees to small honoraria and some cases only certain trustees might be paid while others receive no payment at all. Problems however, arise if this information is not made properly available to scheme members for their approval at annual general meetings. While schemes reported that members had easy access to trustees, this survey did not approach members who frequently report through the media that they do not have access to trustees. Despite the obvious need for member participation and the creation of a system of governance demanding this, very few members participate through the annual general meetings. Participation rate in the schemes surveyed ranged from 5% to 17% in some closed schemes. In the examples outlined above, conflict of interest is often a problem. In the survey, it became clear that some respondents had little or no understanding of the concept. Most trustees and principal officers interviewed, however, had a reasonable understanding of what would constitute conflict of

interest in the medical scheme setting. This report is still to be elaborated upon before recommendations can be made and acted on.

Poor behaviour in governance of schemes inevitably has the result of forcing costs up for medical scheme members while reducing the overall effectiveness of the scheme. Problems have arisen in schemes that might be characterised, in extreme cases, as corruption. In other cases, questionable judgement of trustees in some of their actions has had to be dealt with at Council. In still other cases, squabbles between trustee members of boards have rendered schemes literally ungovernable, and have meant that members cannot be adequately serviced. Some boards are constituted in such a way that the member is unable to have the appropriate say in the scheme's governance as set out in the Medical Schemes Act. Council is able to take a certain amount of action when failures of governance occur in schemes.

PROSANO

For much of the year under review, Council has been in talks with Prosano's trustees on the manner in which the Board of Trustees has been constituted. Council believes the constitution of the scheme's governance structures is inconsistent with the requirements of Section 57 of the Medical Schemes Act which provides for members to be able to elect a board of trustees. Prosano members are able only to vote for regional structures but not for the main Board of Trustees. These regional representatives then vote for the national board from their own ranks. Two directives were issued by the Registrar to Prosano instructing the scheme to change its rules so as to comply with the Act, and also to cease payments of honorariums and fees to people who are not members of the Board of Trustees. Both directives were appealed by the scheme to Council, which eventually, in December, dismissed the appeal. The issue, however, has not been settled and is now before the Appeal Board. In the meanwhile, disputes between various scheme trustees continue as do differences between the board of trustees and the Office of the Registrar.

HOSMED

Trustees of the scheme were "removed" from their position as trustees by members at the scheme's annual general meeting. Interim trustees were appointed to take over the management of the scheme. Part of this dispute was manifest in legal action before the High Court intended to resolve a dispute over which administration company would administer the scheme.

The "interim trustees" then asked to meet with the Registrar, ostensibly to "present their credentials" as lawful trustees of the scheme. Acting in accordance with advice from senior counsel, the Registrar declined the meeting on the basis that the application before the High Court would resolve the dispute regarding the legitimacy of the two boards, and that the Registrar only had those powers foreshadowed in the Act and did not have the power to mediate the dispute between

the rival trustees.

The Registrar took the view that the lawful trustees of the scheme would be decided by the High court, and that once that has been done the Registrar would be in a position to act in terms of the Medical Schemes Act. Predictably perhaps, the lawyers of the so-called "interim trustees" chose to view this response as evidence of "bias" and "dereliction of duty" by the Registrar, for which they threatened to take the issue to higher levels of decision-making to act on their behalf. The Registrar joined the court action as a "friend of the court" to help the court understand the issues involved. The judge found that the removal of the trustees by the AGM was illegal and invalid, and that the appointment of the so-called interim trustees was illegal and had no legal force. The judge further ordered that all costs borne by the Registrar's office in submitting affidavits "as a friend of the court" should be repaid by the scheme.

COMMED

A similar disagreement occurred in Commed medical scheme between members of the Board of Trustees following a vote of no confidence at a Special General Meeting. A court order was eventually handed down, with three members from each "faction" taking places on the Board of Trustees and a seventh trustee being appointed by the Registrar. Despite this, the trustees were unable or unwilling to come to some arrangement to keep the scheme running and decided to take their issue to the High Court to seek a resolution to the impasse largely created by the non-appearance of one faction at meetings causing the meetings to be without a quorum. The High Court ordered all the trustees to attend the meetings, failing which any meeting held by those who attended would be deemed to be quorate. In the meanwhile, the Registrar has ordered a forensic audit of the scheme to look into possible irregular payments.

PROTECTOR HEALTH

Protector Health medical scheme approached the Registrar to seek advice on the possibility of declaring a breach of contract by its former administrator of the same name. The scheme was advised that the Registrar's office, having looked at the situation, did not believe that there was a material breach of contract. The trustees were also warned that they might, in all likelihood, expose the scheme to a damages claim should they proceed to terminate the contract on the basis of the alleged breaches. The scheme chose to ignore this advice, terminated the contract and appointed another administrator. The scheme has subsequently lost an arbitration case and has been told by the arbitrator that the termination was illegal and that the old administrator would be entitled to damages for breach of the contract. At the same time, we were concerned about the financial position of the scheme and had difficulties relying on the accounts placed before us. An inspection was ordered into the scheme in order to understand better its financial position. A plan to sort out the scheme's position has followed.

RESOLUTION HEALTH

The trustees of this scheme purported to outsource the day-to-day running of the scheme to a 'management company', whose directors consisted of some of the trustees. The Board claimed that this was not a conflict of interest but, rather, another model of governance. This was not our view and we held a number of meetings with the trustees to persuade them to change. Allied to this new model was a substantial sum of money flowing to the management company as management fees. The trustees have now agreed to wind down this 'management company' to ensure that the scheme is run by the Board of Trustees. We continue to keep a close watch on this matter.

SELFMED

We have questioned several issues concerning governance at Selfmed, including the manner in which the scheme's chairperson ostensibly appointed himself the principal officer and CEO. Also under scrutiny was the approximately R1 million level of remuneration awarded to this part-time post and other dubious appointments of family members to the scheme's executive management. This matter has not yet been resolved.

MEDSHIELD

In the previous year, we reported that MAPP, a company supplying broking services to the Medshield medical scheme, had challenged the Registrar's capacity to carry out an inspection of its premises in terms of the Medical Schemes Act and the Inspection of Financial Institutions Act, alleging that sections of both Acts were unconstitutional. The dispute had arisen from allegations of improper use of members' contributions. An interdict granted against the Registrar was due to come to a full hearing in the period under review. Late last year, however, Mapp decided to withdraw the legal challenges. It decided, too, to abandon the interdict it had received against the office and agreed to pay R200 000 towards the Registrar's legal costs in this matter. Many of the issues that had concerned the office have also been dealt with, and approximately R20 million has been paid back into the scheme.

POLPRISMED

Action was taken to beef up governance at POLPRISMED by appointing a compliance officer to assist with the governance of the scheme. A useful turnaround has since occurred and the scheme ended the year in the black. The office has nonetheless pushed hard for the trustees to take some sensible long-term decisions on the future of the scheme.



● Hakata (Divining dice). These form part of the set of items kept by a ritual specialist and are used for divination purposes.

Shona, Zimbabwe
Wood, bone

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Continuing the enforcement of the demarcation line

The enforcements actions of the Council have included the cancellation of a number of reinsurance contracts that were inconsistent with the Act.

Our focus on the demarcation between those products which do the business of a medical scheme and which, therefore, have to register with the Council for Medical Schemes and to comply with the Act, and those products which are insurance products has fallen on the short-term insurance products. We are working with the Financial Services Board to take the issue of compliance up with the Short Term Insurance Association. At the same time, we are also preparing prosecutions of some of these products.

Broker conduct – and misconduct

The absence of a code of conduct governing the behaviour of intermediaries selling medical schemes has provided for delays in disciplining brokers where complaints against them have been laid and substantiated. However, during the year two events have ensured that this can now proceed apace. The appointment in terms of the Financial Advisors and Intermediary Services Act of an Ombud with the power to resolve many of these problems and impose penalties on offenders has taken place. With the Ombud's appointment, a code of conduct is again in use. We are in the process of organising a way of working with the Ombud to ensure maximum effectiveness in sorting out problems the public faces when dealing with complex products and potential mis-selling of them.



Inspections

Six inspections were undertaken during the year to assess the level of compliance with the provisions of the law governing the payment of commission to intermediaries. A trend appears to have emerged in which a separate company or channel is set up as a "distribution channel" which is paid separately from the intermediary service itself. This is an area which deserves greater clarity to ensure that members of schemes are not being made to pay for services which should, ordinarily, be provided by brokers and paid for in the normal course of broker payments. In some cases it appears as if the mechanism has been set up purely to enable larger payments to brokers and, so, to avoid the provisions of the regulations in this regard.

Undesirable business practices

The undesirable business practice declaration in respect of the sale of the administration capacity of a scheme without fair valuation, a proper and transparent process and to officers and employees of the scheme was finalised and gazetted. This was generally very well received. In this regard, discussions with Munimed with regard to the inappropriate alienation of its administration capacity were satisfactorily completed. The medical scheme, the trust that was set up to hold the

● **Goldweights** Geometric and figurative brass weights were used in West Africa to weigh gold dust and nuggets in the production and use of gold as part of the gold trading economy

Ashante, Ghana

Goldweights

Brass

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administrator "on behalf of the members" and the office of the Registrar agreed that the administrator should be sold and the proceeds repatriated to the scheme. A potential purchaser was being sought for the purpose.

The going has been less smooth between Medihelp and the Office of the Registrar. Medihelp has been informed that we do not approve of its proposed sale of its administration capacity to a consortium including the CEO of the scheme and other officers of the scheme. The parties have been advised that such a sale would contravene the undesirable business practice declaration. Medihelp subsequently appealed against the Registrar's decision to the Council.

Trustee training

Trustee training remains an important component of Council's compliance strategy. Trustees rely heavily on the provision of training by the Council. A good deal of time and effort was expended on training on governance, financial management and clinical governance. During the course of the year, trustee training was provided in several centres around the country each month. The training programme has been developed, with the suggestions of participants, so that training appropriate for those new to the medical schemes environment can be provided at some sessions, and those with a more sophisticated understanding of the territory can develop their knowledge and understanding further. We have also included in the training specific areas that trustee may find interesting and that can be usefully delivered by experts in the field outside of the Council. This included the help of the department of health's pharmaceutical policy people when the medicines pricing began to influence the workings of schemes and benefits design.

Our work with scheme beneficiaries and the public

Consumer education

The flipside of training trustees on suitable governance practices is the need to have an informed and involved member body that can make its trustees accountable.

Our training has extended to trade union groups around the country whose members participate in medical schemes. In addition, groups of consumers have asked from time to time for the assistance of Council on specific areas in which they need training and this, too, is given. A new area that has been developed has been in the growing need for the human relations departments of various government and local authority departments to acquaint themselves with the workings of schemes, the Council and the law as it pertains to medical schemes, so that they can better assist their staff members.

Flowing from this has been the development and co-operation within the Regulators' Forum of the consumer-training divisions of various regulators and other statutory groups such as the provincial consumer departments dealing with

the Medical Schemes Act.

These aspects of our training schedule have been important and useful developments that hold out the promise that the reach of the Council can be extended to assist members well beyond our current staffing constraints.

Resolving complaints raised by members against their schemes

A major function of the office of the Registrar is the resolution of complaints that schemes have not resolved between themselves and their members or doctors. Our complaints section received 2 456 complaints for the financial year 2004/5 of which 1 848 (76,16%) were found to have been valid.

Table 1 shows the classification of complaints received for the financial year 2004/5.

Table 1: **Complaints received during 2004/05**

Type of complaint	Number	% of total	2003/04 comparatives
UNPAID ACCOUNTS	660	35.71%	795
EXCLUSION OF BENEFITS	325	17.58%	236
NON PAYMENT OF REFUND	199	10.76%	199
MISUNDERSTANDING WITH SCHEME	131	7.08%	157
UNAUTHORIZED DEDUCTIONS	110	5.95%	104
TERMINATION OF MEMBERSHIP	101	5.46%	76
EXORBITANT PREMIUMS	63	3.40%	42
LOSS DUE TO BUREAUCRATIC INEFFICIENCIES	44	2.38%	73
REVERSAL OF PAYMENT	40	2.16%	33
REFUSAL BY SCHEME TO GIVE AUTHORIZATION	32	1.73%	43
PROBLEMS WITH GOVERNANCE STRUCTURE	20	1.08%	66
MEMBER FRAUDULENTLY ASSIGNED	19	1.028%	7
SUSPENSION OF MEMBERSHIP	17	0.91%	18
WITHHOLDING OF BENEFIT INFORMATION	15	0.81%	15
UNREASONABLE WAITING PERIODS	13	0.70%	8
LATE JOINER PENALTY	12	0.64%	12
CONCERN REGARDING MANAGEMENT OF SCHEME	12	0.64%	33
EXCLUSION OF PRE-EXISTING CONDITION	6	0.32%	4
PREMIUM INCREASE WITHOUT PROPER NOTICE	6	0.32%	6
REJECTION OF APPLICATION	6	0.32%	8
UNETHICAL MARKETING PRACTICES	6	0.32%	9
REFUSAL TO PROVIDE MEMBERSHIP CERTIFICATE	6	0.32%	2
RESTRICTION OF CHANGE OF OPTION	3	0.16%	2
RESTRICTION ON CHOICE OF PROVIDER	2	0.10%	2
TOTAL	1 848	100%	1 957

We have resolved 1 682 of the 1 848 complaints found to have been valid. This is 91% of the total number of valid complaints that have been received. Many of the complaints that were not resolved related to lack of proper details and information provided by complainants. We continue to deal with these in order to ensure that they are finalised.

“Unpaid accounts” was the largest component, as it always is, of complaints, comprising more than 36% of the total. The causes of the disputes in this area are not simply the scheme as Goliath, pitted against the individual and powerless member. Much of it appears to be due to a lack of understanding of complex products and rules and the systems that have developed in individual schemes resulting, at times, in a scheme refusing to pay an account in terms of its rules.

Some of these problems might relate to inappropriate marketing material – a problem we hope to tackle in the coming year.

A few schemes have, it seems deliberately, chosen to ignore the legal requirement for the provision of alternative medication to that in formularies or algorithms when clinically necessary. But in some cases it appears, as well, that providers have not acquainted themselves adequately with the provisions in the regulations so that they may more properly assist their patients. This, too, has given rise to complaints.

Adjudication of appeals

The Council has a board sub-committee whose function is to hear appeals by those aggrieved either by a decision made by their scheme’s disputes committee or by the Registrar. Twenty appeals were heard during the year under review.

An important case before the appeals sub-committee concerned the refusal by Prosano to implement the Registrar’s directive on necessary amendments to the rules of the scheme setting out its governance structure. Section 57(2) of the Act requires that at least half of the members of a scheme’s board of trustees shall be elected from amongst the members of the scheme. Prosano had contended that the scheme’s rule in this regard were not inconsistent with this section.

In its decision, the appeals subcommittee found that the rules were, indeed, at odds with the Act insofar as a majority of persons can feasibly be trustees in terms of these rules without ever having been subject to an election by members of the scheme. A further appeal has been heard by the Appeal Board which has upheld the Registrar’s directive in its entirety.

During the course of last year, the Registrar declared certain practices to be undesirable business practices. This effectively outlawed the practice of medical schemes which were self-administered, hiving off their administration sections into a separate company, in which employees/trustees of the scheme might have a financial interest and then selling the service back to the scheme without a process of evaluating whether or not the disposal of the administration was done at fair value.

This declaration occurred at a point at which Medihelp Medical Scheme was seeking to separate its administration from the rest of the scheme and to form an administration company consisting of existing employees of the scheme. On 23 June 2004, we advised Medihelp that the proposed transfer of its administration

assets to a company called Strata would constitute an offence in that it would result in a harmful business practice declaration, in that employees of Medihelp would have a direct or indirect financial interest in Strata.

The issue came before the appeals sub-committee of the Council where Medihelp argued that Strata would be formed and assets and liabilities of the scheme would be transferred to the new company. Staff would then be transferred to the new company, and only then would the scheme enter into an administration contract with the new company. On this basis, Medihelp argued that at the time the administration contract was entered into, the persons who had an interest in the new administration company would no longer be employees of the scheme, and that the transaction would not be inconsistent with the undesirable business practice declaration. In its decision, the appeals sub-committee rejected this argument and upheld the Registrar's decision that the proposed transaction would constitute an undesirable business practice as envisaged in the declaration.

It was clearly demonstrated at the hearing that the transfer of employees could not take place until an administration agreement had been entered into. Until such time as the administration agreement was finalised, the employees would be employees of Medihelp. This would ensure that they fell foul of the Registrar's declaration.

Another case before the appeals subcommittee concerned the refusal by Discovery Health Medical Scheme to meet the costs of orthodontic treatment, the removal of wisdom teeth and maxillo-facial surgery. The appellant, KK had joined Discovery in the beginning of February 2003. He claimed that, during 2003, he was covered for hospitalisation for the removal of wisdom teeth and for maxillo-facial surgery, but that in 2004 he was informed that he was not covered for such hospitalisation. He claimed that cover for such procedures was reinstated for 2005. In his documentation when he signed up there was an exclusion for a year for maxillo-facial procedures among other conditions. This clause ensured that Discovery would not have to pay for the procedure. Dismissing the appeal, Council noted that, "In any event, even had his membership not been subject to these exclusions, Discovery Health Medical Scheme would not have been obliged to compensate the appellant. Upon joining Discovery Health, the appellant had elected to join the coastal core plan. Provision is made in this plan for a medical savings account and the member is required to choose whether or not he or she wishes to have such an account. The appellant chose not to have a medical savings account."

Mr YY at Munimed had a similar experience. He joined Munimed on 1 July 2003. At that point the benefit schedule applicable to his membership provided for unlimited orthodontic treatment. But in January 2004 the scheme restructured its benefits and imposed an annual limit of R2 000 on specialised dentistry including orthodontics.

YY's employer had directed that he could not move schemes till the following year unless he changed his job. But the member had ongoing expenses for his son's orthodontics and found himself saddled with the expenses and an inadequate benefit.

He was not granted relief by the Appeal Board as it found the scheme was entitled to change its benefits. His problem of not being able to get out of the scheme until the following year was one between his employer and himself and could not be addressed by the Council and its appeal processes.

ZZ's case however at the Appeal Board proved more successful for the appellant. ZZ had been severely assaulted in an attack and, after a stay in hospital, knew that further surgery and treatment would be required. This would involve the reconstruction of the jaw and the replacement of missing teeth with prostheses.

The Classic Priority Plan of Discovery appeared to hold out the prospect of this treatment being covered and this was contained, according to the appellant, in a section of the option's launch document dealing with major surgery – with a specific reference to trauma-related surgery.

Discovery's view was that there were several phases to the type of reconstruction surgery needed, and believed that only the first phase could be classified as trauma-related. The rest would fall under specialised dentistry.

This meant that Discovery was not prepared to go beyond the bone augmentation required in the first surgery.

The complainant took issue with the decision and it was referred to the scheme's *ex-gratia* committee, which decided to approve most of the rest of surgery – but not the cost of the dental implants and abutments. No reasons for this were given.

The member then took the issue to the scheme's disputes committee which decided that the information in the document was misleading and that a reasonable person would have believed all the surgery and follow-up treatment to be included. The disputes committee also described Discovery's documents as containing a grey area and suggested that Discovery review its policy definition and exclusions to make this clearer. It confirmed the *ex-gratia* decision – but this was still insufficient for ZZ who appealed to the Council in terms of Section 48 of the Act.

The Council agreed that the scheme's interpretation of the rules was correct – that it should only apply to the trauma-related surgery – but since both the *ex-gratia* committee and the disputes committee had agreed that an extra amount should be paid – the question that faced the Council, was "how much". The Council held that no logical basis existed for the distinction made by the *ex-gratia* committee on where it decided to cut off the funding, and ordered that the scheme should pay the costs of the further surgery because of the misunderstanding the literature had created and that the costs of the implants and abutments be included.

During this period, the High Court was asked to rule on a dispute between a



● **Izindondo** – a necklace of 12 brass beads – symbolised wealth and Zulu royal control over many aspects of life such as lobolo, agricultural labour of women and conferred social status.

medical scheme and the Council's Appeal Board. The dispute arose from the desire of the Appeal Board to hear evidence from a witness in a dispute between Profmed medical scheme and the estate of a deceased person whose membership had previously been suspended by the scheme. Much of the legal argument revolved around the differences between an appeal before the High Court and an appeal to the Appeal Board in terms of the Medical Schemes Act. In the end, the court upheld the Appeal Board's right to hear evidence, unlike the procedure when a court ruling is appealed. The scheme was ordered to pay costs as well.

Communication and other stakeholder relationships

Much of the media work was in response to public concern early in the year about increases to scheme premiums. Further into the year a robust media debate was conducted around the problems in medicine pricing particularly in respect of the medical schemes environment.

We continue to respond to the media on a number of issues and to appear frequently on the electronic media, including on issues such as the impact of the new medicines pricing structure on medical schemes and their members.

One edition of CMS News was published during the year. Our internal newsletter, Masihambisane, has continued to appear regularly and has served as a useful tool for communicating with staff on internal issues relevant to us.

The people of the council and management of other resources

The work of CMS Active – realigning people processes with our organisational strategy

Performance management

The staff coalition, called CMS Active has continued our work on realigning our business with a strategy for management of our human resources. A new performance-management system has been agreed and will come into effect during the 2005/06 financial year. The coalition has also begun discussions on a remuneration strategy with the aim of proposing policy in this regard during the new year.

Improving skills and developing career paths

We have engaged in a number of training initiatives during this period. All sixty members of staff were taken through a course on improving customer service. This culminated in a charter on customer service adopted by Council. The key challenge now is to ensure meticulous implementation of the charter. Other training initiatives have included performance evaluation, attendance at a number of conferences and seminars and development of technical skills such as conducting skills audits, effective business writing, advanced computing and managing public relations.

Figure 7: Managerial level by racial grouping

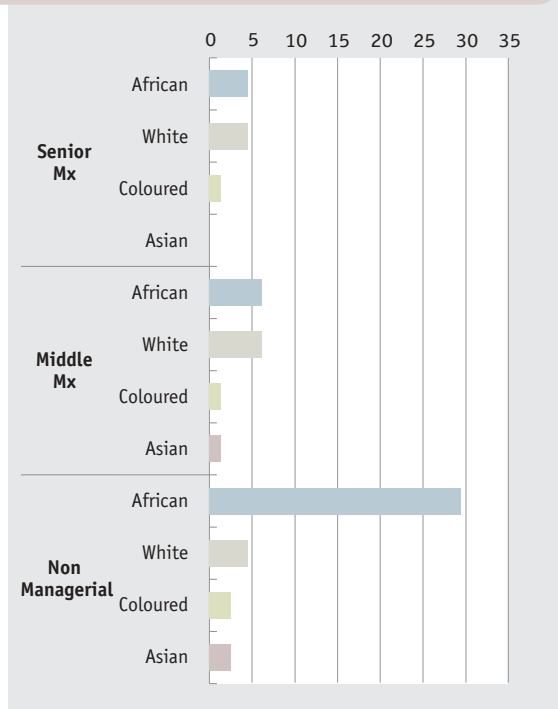
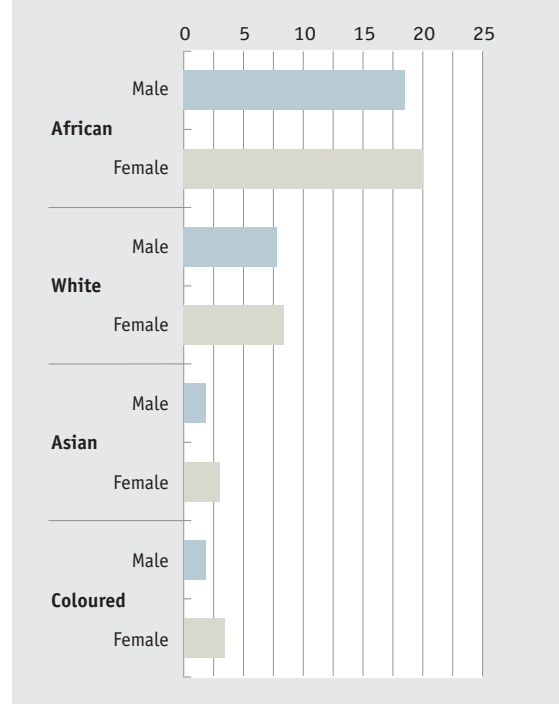


Figure 8: Racial and gender representation



Employment equity

Our employment equity profile is shown in figures 7 and 8. The Council has set up an Equity Forum in terms of the law and developed a plan to ensure that staff development takes place in terms of the Equity Act and to the benefit of the Council and its work.

We have conducted qualitative analyses of policies, procedures and practices through internal surveys and staff focus group discussions, as well as quantitative analyses of workforce profiles to identify specific areas that require our attention. We have debated employment equity barriers caused either by the lack of a policy or by a policy that may permit unfair discrimination.

Financial management and information technology

The management of Council's financial resources continues to be an important part of our work. We have ensured that we have complied fully with the requirements of the Public Finance Management Act during the year under review. Our internal auditors, GOBODO, have continued to provide good service, and internal audits were conducted in four divisions, including financial supervision, research and monitoring, compliance and the legal units. Our risk management team has continued to function, and has focused on the implementation of a fraud prevention plan at Council. The Council's audit committee met four times during the year. Two new external members also joined the audit committee during this time.

Table 2 below summarises the Council's income and expenditure for 2004/05. Staff costs have, predictably perhaps, been our main item of expenditure, accounting for 60% of total spend.

Table 2: Our income and expenditure during 2004/05

Income and expenditure analysis for 2004/2005.

Analysis of cash flows for the year ending march 2005

Income		29 967 786
Grant Received	584 863	
Levies Received	24 818 101	
Accreditation and Registration Fees	4 188 908	
Other Income	375 914	
Debtors		-319 777
Cash Received from clients		29 648 009
Interest Received		716 110
TOTAL CASH RECEIVED		30 364 119
Expenditure		34 889 976
Administration	2 458 820	
Appeal Board	316 698	
Accreditation Costs	540 000	
Audit Fees	296 029	
Conferences and workshops	712 833	
Consulting Fees	107 362	
Consumer Education	185 915	
Council Committees	675 430	
Depreciation	1 164 225	
HR Organisational Strategy	305 730	
Investigation Costs	647 208	
Legal costs	2 122 402	
Media & Promotion	421 774	
NRPL	562 287	
Office Rental	1 713 087	
Personnel	21 044 349	
Research Costs	577 850	
Resource Centre	126 017	
Risk-Equalisation Project	584 863	
Strengthening Dispute Resolution	99 000	
Trustee Training	228 097	
Depreciation written back		-1 164 225
Creditors		-2 766 302
Cash paid to Suppliers and Employees		30 959 449
Capital Expenditure		402 011
Computer Equipment and Software	358 223	
Office Furniture & Equipment	21 730	
Other Assets	22 058	
TOTAL CASH PAID OUT		31 361 460
NET CASH DECREASE		-997 341

The Resource Centre has seen to it that the manuals required in terms of the Promotion of Access to Information Act (POATIA) have been updated and sent to the Department of Justice. A report required by the South African Human Rights Commission in accordance with mandatory requirements on our implementation of POATIA in compliance with legislative provisions has been duly supplied.

Our Information Technology environment has continued to be fairly stable during this period. New work has included the revamping of the statutory returns, in order to enhance the return and to introduce changes made in the Accounting and Auditing Guide for Medical Schemes. We also developed the shadow risk equalisation fund return to allow schemes to submit consolidated data by chronic disease, age and gender of beneficiaries. The IT work has also included moves to a new financial management platform (Account mate), a newly-designed website and further development of a number of our critical databases, including the complaints management and accreditation databases. We also installed a comprehensive call centre solution during the year.

Conclusion

This report is characterized by actions we have taken to deliver effectively on the core responsibilities of the Council. I believe there have been a number of significant improvements on many fronts. I would like to thank trustees, administrators and others we have worked with for contributing positively to improvements in the operations of medical schemes. I would also like to thank the Minister, Dr Manto Tshabalala-Msimang, for her assistance and counsel during the year. Our Council members deserve much credit for their dedication and advice. I wish those who are not returning great success in their future endeavours. Finally, I congratulate our staff for their unstinting dedication to the work of the Council.

T. Patrick Masobe

August 2005

Brass rings, Katanga copper crosses, *izindondo* and *ndoros*.

Throughout Africa metal products were associated with supernatural powers and were highly valued, largely because of their durability and symbolic status. Brass rings and Katanga copper crosses were traded as currency items; *izindondo* (solid brass beads) were symbolic of royal Zulu power in the 19th century, and *ndoros* (shells) were used for trade, bridewealth and to display rank and wealth.

Central and East Africa

Brass rings, currency crosses, *ndoros* (conus shells)

Zulu, South Africa *izindondo* (brass bead necklace)

Brass, shell, copper

Standard Bank Foundation Collection of African Art - Housed at the University of the Witwatersrand Art Galleries





A U D I T O R - G E N E R A L

REPORT OF THE AUDITOR-GENERAL TO PARLIAMENT ON THE FINANCIAL STATEMENTS OF THE COUNCIL FOR MEDICAL SCHEMES FOR THE YEAR ENDED 31 MARCH 2005

1. AUDIT ASSIGNMENT

The financial statements as set out on pages 39 to 49, for the period ended 31 March 2005, have been audited in terms of section 188 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), read with section 4 and 20 of the Public Audit Act, 2004 (Act No. 25 of 2004) and section 13(4) of the Medical Schemes Act, 1998 (Act No. 131 of 1998). These financial statements, the maintenance of effective control measures and compliance with relevant laws and regulations are the responsibility of the Registrar. My responsibility is to express an opinion on these financial statements, based on the audit.

2. NATURE AND SCOPE

The audit was conducted in accordance with Statements of South African Auditing Standards. Those standards require that I plan and perform the audit to obtain reasonable assurance that the financial statements are free of material misstatement.

An audit includes:

- examining, on a test basis, evidence supporting the amounts and disclosures in the financial statement,
- assessing the accounting principles used and significant estimates made by management, and
- evaluating the overall financial statement presentation.

Furthermore, an audit includes an examination, on a test basis, of evidence supporting compliance in all material respects with the relevant laws and regulations which came to my attention and are applicable to financial matters.

I believe that the audit provides a reasonable basis for my opinion

3. AUDIT OPINION

In my opinion, the financial statements fairly present, in all material respects, the financial position of the Council

for Medical Schemes at 31 March 2005 and the results of its operations and cash flows for the year ended, in accordance with the Statements of Generally Accepted Accounting Practice and in the manner required by the Public Finance Management Act, 1999 (Act No. 1 of 1999).

4. APPRECIATION

The assistance rendered by the staff of the Council for Medical Schemes during the audit is sincerely appreciated.

A H Muller
for Auditor-General

Pretoria
31 July 2005

Balance sheet

OF THE COUNCIL FOR MEDICAL SCHEMES

AS AT 31 MARCH 2005

	Note	31/03/05 R	31/03/04 R
ASSETS			
Non-current assets			
Property, plant & equipment	3	1 992 939	2 755 152
Current assets			
Trade debtors and other receivables	5	725 120	405 343
Cash and cash equivalents	4	9 116 171	10 113 512
Total assets		11 834 230	13 274 007
FUNDS AND LIABILITIES			
Administration funds			
Accumulated funds		4 702 111	8 908 190
Current liabilities			
Trade creditors and other payables	6	5 868 189	2 770 440
Provisions	6	1 263 930	1 595 377
Total funds and liabilities		11 834 230	13 274 007

Mr T Patrick Masobe

Registrar of Medical Schemes

Date: 31/5/2004

INCOME STATEMENT

OF COUNCIL FOR MEDICAL SCHEMES

FOR THE YEAR ENDED 31 MARCH 2005

	Note	31/03/05 R	31/03/04 R
Revenue	7	29 967 786	29 644 910
Expenditure		34 889 976	34 299 922
Administration		2 458 820	3 222 115
Appeal Board expenses		316 698	391 354
Accreditation costs		540 000	1 200 000
Audit fees:	10	296 029	469 997
Conference, workshops & seminars		712 833	635 215
Consulting fees		107 362	170 495
Consumer education		185 915	193 912
Council Committees		675 430	651 694
Depreciation		1 164 225	1 263 695
HR/Organisational Strategy		305 730	-
Investigation costs		647 208	620 135
Irregular expenditure		-	506 195
Legal fees		2 122 402	1 713 462
Media & promotion		421 774	512 458
NRPL		562 287	-
Office rental		1 713 087	1 554 643
Personnel expenditure		21 044 349	18 895 662
Research costs		577 850	734 072
Resource centre		126 017	174 328
Risk Equalisation Project	9	584 863	1 125 386
Strengthening Dispute Resolution		99 000	-
Trustee training		228 097	265 104
Operating deficit for the year		(4 922 190)	(4 655 012)
Interest received		716 110	1 477 582
Net deficit		(4 206 080)	(3 177 430)

Statement of changes in equity

FOR THE YEAR ENDED 31 MARCH 2005

	31/03/05 R	31/03/04 R
Balance at 31/3/2004	8 908 191	12 085 620
Net deficit for the year	(4 206 080)	(3 177 430)
Balance at 31/03/ 2005	<u>4 702 111</u>	<u>8 908 190</u>

Cash flow statement

OF COUNCIL FOR MEDICAL SCHEMES

FOR THE YEAR ENDED 31 MARCH 2005

	Note	31/03/05 R	31/03/04 R
Cash flow from operating activities			
Cash receipts from debtors		29 033 988	29 966 077
Cash receipts from Department of Health		584 863	1 125 386
Cash paid to suppliers and employees		(30 930 290)	(30 336 254)
Cash utilised in operations	8	(1 311 439)	755 209
Interest received		716 110	1 477 582
<i>Net cash flows from operating activities</i>		(595 329)	2 232 791
Cash flows from investing activities			
Purchase of fixed assets		(402 012)	(682 008)
Net increase(decrease) in cash and cash equivalents		(997 341)	1 550 782
Cash and cash equivalents at the beginning of the year		10 113 512	8 562 730
Cash and cash equivalents at the end of the year	4	<u>9 116 171</u>	<u>10 113 512</u>

Notes to the financial statements

FOR THE YEAR ENDED 31 MARCH 2005

1. Legislation

- 1.1. The Council was established under the Medical Schemes Act, 1998 (Act No. 131 of 1998)
- 1.2. The Council is a listed entity under schedule 3 of the Public Finance Management Act, (Act No 1 of 1999).
- 1.3. The Council collects levies from schemes in terms of the Levies Act 2000 (Act No.58 of 2000)

2. Accounting Policies

The principal accounting policies adopted in the preparation of these financial statements are as set out below and are consistent with those of the previous year:

2.1 Basis of preparation

The financial statements are prepared under the historical cost basis and are in accordance with and comply with the South African Statements of Generally Accepted Accounting Practice.

2.2 Non current assets

All items of property plant and equipment are recognised at cost less accumulated depreciation. Depreciation is calculated on the straight line method to write off each asset over their estimated useful lives as follows:

Computer equipment	25%
Computer software	33%
Office furniture and equipment	10%
Motor vehicle	20%
Other assets	10%

Repairs and maintenance are charged to the income statement during the financial period in which they are incurred.

Expenditure that increases the original value and useful lives of property plant and equipment items are classified as assets and amortised over their useful lives on a straight line method.

Where the carrying amount of an asset is greater than its estimated recoverable amount, it is written down immediately to its recoverable amount.

Gains and losses on disposal are determined by comparing proceeds with the carrying amount and are included in the operating profit during the period in which they accrue.

2.3 Trade debtors and other receivables

Accounts receivables are carried at original invoice less provision made for impairment in value of these receivables. Where circumstances reveal doubtful recovery of amounts outstanding, a provision for impaired receivables is made and charged to the income statement.

2.4 Trade creditors and other payables

Trade and other payables are recognised at cost, comprising original debt less principal payments and amortisations.

2.5 Provisions

Provisions are recognised when there is a present legal or constructive obligation as a result of past events, it is probable that an outflow of resources will be required to settle the obligation and a reliable estimate of the amount can be made.

2.6 Revenue

The main sources of revenue of the Council are listed below.

2.6.1 Levies

Levies are the amounts paid by medical schemes based on the number of members in a scheme during the financial period. Levies are recognised on an accrual basis in accordance with the number of members in the medical scheme in the period they fall due.

2.6.2 Accreditation fees

Accreditation fees are fixed tariffs paid by brokers over two years. Accreditation fees are recognised in the financial period in which services are rendered.

2.6.3 Grants

The Council receives grants from government for specific projects. Grants are recognised in the financial period at their fair value where there is reasonable assurance that the grant will be received and the Council will comply with the attached conditions. Grants relating to future costs are deferred and recognised in the income statement over the period necessary to match them with the costs for which they are intended to compensate.

2.6.4 Registration fees

Registration fees relate to the amounts paid by schemes to register or amend their rules. Registration fees are recognised in the financial period that they fall due.

2.6.5 Interest

Interest income comprises interest received on cash and cash equivalents, and that earned on overdue levies. Interest income is recognised in the income statement for all interest bearing investments on an accrual basis using the effective yield based on the actual amount. Interest on overdue levies is calculated at the rate determined by the South African Revenue Services.

Notes to the financial statements *continued*

2.7 Cash and cash equivalents

Cash and cash equivalents are carried on the balance sheet at cost for the purpose of the cash flow statement. Cash and cash equivalents comprise cash on hand and deposits held in current and call accounts at the bank.

2.8 Financial instruments

(a) Accounting for financial instruments

Financial instruments carried on the balance sheet include cash and bank balances, investments, receivables and trade creditors. The particular recognised methods adopted are disclosed in the individual policy statements associated with each item.

(b) Financial risk management

Financial risk factors:

The Council's activities expose it to a limited degree of financial risks including interest rates and credit defaults.

Interest rate risk:

The Council's income and operating cash flows are to a large extent independent of charges in the market interest rates. The Council invests surplus cash on call accounts and its exposure to interest rate risk is limited by virtue of the limited term that surplus cash is held on call.

Credit risk:

The Council is exposed to credit risk, which is the risk that a counterpart will be unable to pay accounts in full when due. There is no significant concentration of credit risk due to a wide spread of debtors that owe amounts to the Council.

Liquidity risk:

The Council is exposed to liquidity risk by virtue of having trade creditors at year end. Liquidity risk is managed by maintaining sufficient balances on cash and cash equivalents.

2.9 Research costs

Research costs relate to work performed by the research unit. The objective of the unit is to monitor the impact of the Medical Schemes Act, 1998 (Act No. 131 of 1998), research developments and recommend policy options to improve regulatory environment. Research expenditure is recognised as an expense in the financial period in which it was incurred.

3. Property, plant and equipment

	Computer Equipment	Computer Software	Furniture & Fitting	Motor Vehicle	Other Assets	TOTAL fittings
Period ended 31 March 2004						
Opening gross carrying amount	1 142 326	976 509	1 077 193	33 295	107 516	3 336 839
Additions	204 122	388 125	81 761	-	8 000	682 008
Depreciation charge	(675 374)	(415 468)	(140 968)	(14 269)	(17 616)	(1 263 695)
Closing net carrying amount	671 074	949 166	1 017 986	19 026	97 900	2 755 152
At 31 March 2004						
Gross carrying amount	1 346 607	1 364 634	1 158 954	33 295	115 357	4 018 847
Accumulated depreciation	675 374	415 468	140 968	14 269	17 616	1 263 695
	671 233	949 166	1 017 986	19 026	97 741	2 755 152
Year ended March 2005						
Opening gross carrying amount	671 233	949 166	1 017 986	19 026	97 741	2 755 152
Additions	273 764	84 459	21 730	-	22 058	402 011
Depreciation charge	(371 571)	(615 019)	(145 489)	(14 268)	(17 877)	(1 164 224)
Closing net carrying amount	573 426	418 606	894 227	4 758	101 922	1 992 939
At 31 March 2005						
Gross carrying amount	944 997	1 033 625	1 039 716	19 026	119 799	3 157 163
Accumulated depreciation	371 571	615 019	145 489	14 268	17 877	1 164 224
Net carrying amount	573 426	418 606	894 227	4 758	101 922	1 992 939

4. Cash and cash equivalents

Note	31/03/05 R	31/03/04 R
Cash and bank	4 066 171	5 113 512
Call account	5 050 000	5 000 000
	9 116 171	10 113 512

The effective interest rate on call account deposit was 7.35% (March 05: 7%) and these deposits have an average maturity of 30 days.

Notes to the financial statements *continued*

5. Trade debtors and other receivables

Note	31/03/05 R	31/03/04 R
Accounts receivable	173 673	126 705
Provisions for Impaired Receivables	(29 158)	-
Sundry debtors	580 605	125 758
Prepaid expenses	-	152 880
	725 120	405 343

6. Trade creditors, other payables and provisions

Accounts payable	1 835 552	1 168 535
Income Received In advance	4 032 637	1 601 905
Grant received in advance	3 762 751	
Broker fees received in advance	269 886	
Accruals	557 741	-
Provisions		
Leave days	438 238	428 901
Accreditation Costs	267 951	1 166 476
	7 132 119	4 365 817

7. Revenue

Accreditation fees	3 731 281	4 656 641
Appeal fees	9 091	10 526
Grant	584 863	1 125 386
Interest on levies	1 031	15 515
Levies	24 818 101	23 125 516
Other income	365 792	526 575
Registration fees	457 627	184 751
	29 967 786	29 644 910

8. Reconciliation between net surplus and cash applied to activities

Note	31/03/05 R	31/03/04 R
	31/03/05 R	31/03/04 R
Operating surplus/(deficit)	(4 206 080)	(3 177 430)
Adjusted for:		
Depreciation	1 164 225	1 263 695
Interest received	(716 110)	(1 477 582)
Operating surplus before working capital	(3 757 965)	(3 391 317)
Decrease(Increase) in accounts receivable	(319 777)	1 446 551
(Decrease)/Increase in accounts payable	3 097 749	1 983 905
(Decrease)/Increase in provisions	(331 447)	716 070
	(1 311 440)	755 209

9. Risk Equalisation Fund

During the year the National Department of Health (NDoH) granted Council an amount of R2 800,000 in respect of the Risk Equalisation Fund Project. An amount of R584,863 was utilised during the year. The unutilised balance at 31 March 2005 has been deferred and included as income received in advance.

Deferred grant income at the beginning of the year	1 547 614	-
Grant received during the year	2 800 000	2 673 000
Utilised in project activities	(584 863)	(1 125 386)
Utilised to defer depreciation charge relating to assets acquired	-	-
Deferred grant income at the end of the year	3 762 751	1 547 614

10. Audit fees

External audit	181 029	189 052
Internal audit	115 000	280 945
	296 029	469 997

The external audit work is conducted by the Office of the Auditor-General

Notes to the financial statements *continued*

11. Going concern

The financial position of the Council is such that the Accounting Authority is of the view that its operations will continue for as long as its mandate remains.

12. Taxation

No provision for taxation is made because the Council is exempt from income tax in terms of section 10(1) (cA). of the Income Tax Act, 1962 (Act No: 58 of 1962)

13. Related party transactions

Council members appointed by the Minister of Health, control the financial and operating activities of the Council. Council members appoint the executive management which is responsible for executing Council member decisions.

The emolument paid to Council members and executive management is shown below:

31 March 2005

Council members	Fees for services	Basic salary	Bonuses	Expense allowances	Consulting Fees	Total
GN Padayachee	18 882	–	–	–	–	18 882
NNA Matyumza	17 782	–	–	–	–	17 782
R.L Morar	39 045	–	–	–	–	39 045
N Mgumane	14 870	–	–	–	–	14 870
JW Jekwa	46 812	–	–	–	–	46 812
HD Mcleod	27 536	–	–	–	380 331	407 867
S. Kariem	13 139	–	–	–	–	13 139
J. Murphy	6 215	–	–	–	–	6 215
BB Crookes	21 747	–	–	–	–	21 747
	206 027	–	–	–	380 331	586 358

Prof.Heather Mcleod who is a Council member was appointed to assist the Risk Equalisation Project task team by the Director-General of the National Department of Health. An amount of R2, 800, 000 was transferred by NDOH for the project and her consulting fees are paid from this grant.(refer Note 10)

Executive management	Fees for services	Basic salary	Bonuses	Expense allowances	Consulting Fees	Total
TP. Masobe	–	675 805	143 816	12 000	–	831 621
FFT Mothobi	–	552 167	109 099	18 000	–	679 266
CJ Burton-Durham	–	497 411	82 216	18 000	–	597 627
DG Kolver	–	473 243	78 479	18 000	–	569 722
PR Sidley	–	446 694	74 100	18 000	–	538 794
EE Theys	–	497 411	82 216	18 000	–	597 627
KP. Matshidze	–	451 836	78 480	18 000	–	548 316
	–	3 594 567	648 406	120 000	–	4 362 973

31 March 2004

Council members	235 975	–	–	–	481 679	717 654
Executive management	3 424 926	666 491	120 000	–	4 211 417	4 997 908
	235 975	3 424 926	666 491	120 000	481 679	4 929 071

The executive management are eligible for an annual performance-related bonus payment linked to the operational plans and and strategic objectives of Council. The structure of the individual bonus plan and awards is decided by the Remunerations Committee of Council.

14. Contingent liabilities

At 31 March 2005 Council had a contingent liability of R408,584 arising from a legal claim by a former employee for unfair dismissal.

Based on legal opinion, Council does not expect this liability to crystallise.

15. Operating lease commitments

Council has an operating lease for rental of the office up to 31 May 2010

The rental escalates by 7% compounded every year

Not later than one year	2 703 759	1 554 643
Later than one year and not later than 5 years	14 030 037	326 143
TOTAL	16 733 796	1 880 786

Report of the audit committee

We are pleased to present our report to the Council's Accounting Authority for the financial year ended 31 March 2005.

Audit committee members and attendance

Please note that the term of audit committee members ended in August 2004. The committee consisted of the following members:

Meetings

Meetings and attendance for the year under review:

Name of Member	Role	Number of Meetings Attended
Mr. C. Manny	(Chairperson)	2
Mr. S. Patterson	Member	2
Mr. O Thenga	Member	1
Dr. R. Morar	Member	2
Ms. G. Matyumza	Member	2

The new audit committee, which commenced its new role from September 2004, consists of the members listed hereunder and meets 4 times per annum as per its approved terms of reference.

The committee held four (4) scheduled meetings and no special meeting was called during the year under review. During these meetings the committee considered a number of issues including those discussed in the paragraphs below.

Meetings and attendance for the year under review:

Name of Member	Role	Number of Meetings Attended
Mr. Ronald Moyo	(Chairperson)	4
Mr. Alex Hill	Member	4
Dr. Reno Morar	Member	4
Ms. Gando Matyumza	Member	4

Other invitees.

Representatives of the Auditor-General, internal auditors and senior management attend these meetings as and when requested to do so.

Audit committee responsibilities

Mandate

The mandate of the audit committee is derived from Section 38 (1) (a) of the Public Finance Management Act (PFMA), and paragraph 3.1 of the Treasury Regulations.

The audit committee reports that it has complied with its responsibilities arising from section 38(1) (a) of the PFMA and Treasury Regulation 3.1.13.

The audit committee also reports that it has adopted appropriate formal terms of reference as its audit committee charter, has regulated its affairs in compliance with this charter and has discharged all its responsibilities as contained therein.

The effectiveness of internal control

The performance of an effective internal audit function is central to the proper operation of the audit committee. As part of the Council's governance structures, the audit committee has amongst others, an oversight function of ensuring that the Council's internal control policies, practices and procedures are in place, effective and adequate to safeguard the Council's resources and achieve its mission. Establishing effective internal controls involves an assessment of the risks the Council faces both from internal and external sources.

The system of internal control is effective, as the various reports of the internal and external auditors have shown. The fraud and risk prevention plans have been developed by our internal auditors.

Review of legal cases pending at financial year-end

The committee reviewed legal cases against the Council that were pending at the financial year-end so as to assess the adequate disclosure required in terms of GAAP and Treasury Regulations.

Evaluation of financial statements

The audit committee has reviewed and discussed the annual financial statements to be included in the annual report with the Auditor General and the Accounting Officer. The committee concurs with the conclusions of the Auditor General and hereby recommend the financial statements for adoption by the Council in terms of the PFMA.

Our commitment

The audit committee remains committed to working together with the Council and all stakeholders to promote sound corporate governance and to strengthen internal control procedures in the Council.

Ronald Moyo

Chairperson of the audit committee

Date 22/7/2005

Review of operations of medical schemes

Coverage by medical schemes

Number of medical schemes

Table 3 shows that there were 133 registered medical schemes operating during 2004. Forty eight (48) were open while 85 were restricted medical schemes. There were also 12 bargaining council schemes in operation during the same period.

The number of medical scheme declined to 145 from 147 in 2004. The number of open schemes remained unchanged while that of restricted schemes declined to 85 from 87. This reduction is attributable to liquidations, amalgamations and mergers between schemes.

Table 3: Distribution of medical scheme by size and type of scheme

Size of medical scheme	TYPE OF SCHEME*			
	Open	Restricted	Bargaining Council	Consolidated
Small (<6,000 members)	14 (16)	57 (58)	7 (7)	78 (81)
Medium (>6,000 members but <30,000 beneficiaries)	8 (5)	15 (16)	2 (2)	25 (23)
Large (30,000 or more beneficiaries)	26 (27)	13 (13)	3 (3)	42 (43)
Total	48 (48)	85 (87)	12 (12)	145 (147)

* Figures in brackets represent restated number of schemes in 2003

Membership of medical schemes

Table 4 shows that the total number of principal members of medical schemes increased by 1,1% to 2 833 322 during 2004. Membership of open schemes increased by 2,2%, while that of restricted schemes declined by 1,5%. Membership of bargaining council schemes increased by 2,0% to 117 058 members.

The number of dependants decreased by 1,0%. As a result the number of ben-

eficiaries declined by 0,1% to 6 915 666 from 6 924 686 in 2003. The number of dependants in restricted schemes declined by 2,9% while in open schemes there was a small decline in the number of dependants. Restricted schemes experienced a drop of 2,3% in the number of beneficiaries while a marginal increase (0,8%) was experienced in open medical schemes.

Table 4: Distribution of beneficiaries in medical schemes

Scheme type		2004	2003	% change
Registered	Members	2 716 264	2 688 055	1,05
	Beneficiaries	6 662 563	6 671 801	-0,14
Open	Members	1 924 343	1 883 728	2,16
	Beneficiaries	4 755 303	4 718 797	0,77
Restricted	Members	791 921	804 327	-1,54
	Beneficiaries	1 907 260	1 953 004	-2,34
Bargaining council	Members	117 058	114 760	2,00
Consolidated	Members	2 833 322	2 802 815	1,09
	Beneficiaries	6 915 666	6 924 686	-0,13

Age distribution of beneficiaries

Figure 9: Age distribution of medical scheme beneficiaries

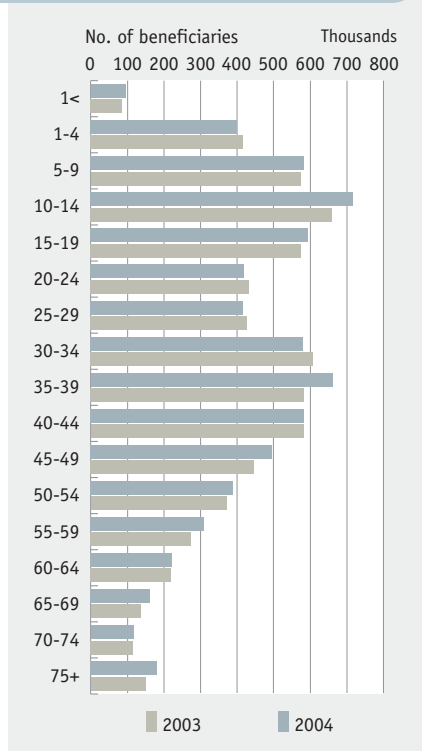


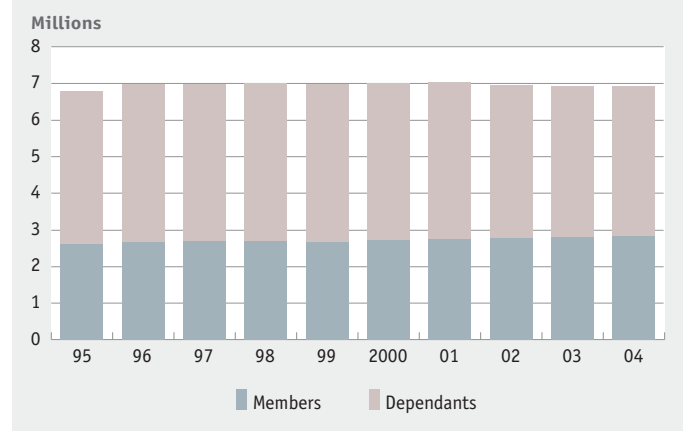
Figure 9 shows the age distribution of the medical scheme beneficiaries during 2003 and 2004. There were more beneficiaries aged between the intervals 5 and 15 years, 34 and 40 years and also those over 70 years during 2004. This reflects a slight aging of membership of schemes with the average age of medical scheme beneficiaries increasing to 32,0 years in 2004 from 31,9 years in 2003. The average age of members of restricted medical schemes was 32,6 years, while that of open schemes was 32,1 years.

Female members were generally older than males in all medical schemes. The average age of male members was 31,4 years compared to that of female members at 32,6 years. The average age of males in open schemes was 31,4 years while that of restricted schemes was 32,0 years. Among females, the average age in open schemes was 32,8 years while that of restricted schemes was 33,2 years.

Trends in membership

Figure 10 shows the trends in the number of beneficiaries of all medical schemes over the last ten years. The trend analysis shows that the number of beneficiaries has remained fairly steady at around 7 million since 1996. It is noticeable that while the number of members seem to have increased steadily overtime, the number of dependants has however been declining since 1999.

Figure 10: Trend analysis of coverage of beneficiaries



Pensioner ratio

The percentage of pensioners (beneficiaries who were 65 years or older as at 31 December 2004), increased to 6,7% from 6,4% in 2004. The percentage was higher in restricted schemes (7,8%) than in open schemes (6,3%), continuing a trend that was observed in previous years.

There were proportionately more female than male pensioners in registered schemes. Bargaining Council medical schemes were different in that they had a higher proportion of male pensioners than females.

Table 5: Pensioner ratio (>65 years) of registered schemes

Type of scheme	Gender	2004	2003
Open	male	6,00	6,40
	female	6,62	5,40
	consolidated	6,31	5,90
Restricted	male	6,94	8,80
	female	8,69	6,60
	consolidated	7,82	7,70
Registered schemes	male	6,28	7,60
	female	7,20	6,00
	consolidated	6,74	6,80
Bargaining Council*	male	7,72	3,20
	female	0,96	0,50
	consolidated	4,34	1,85
Consolidated	male	6,33	7,00
	female	6,98	5,80
	consolidated	6,66	6,40

* The 2004 results could be an indication of better reporting by bargaining council schemes.

Dependants ratio

The dependant ratio, which measures the average number of dependants per principal member of a medical scheme, declined by 2,0% to 1,44 from 1,47 in 2003.

The decline in the dependants ratio was highest in bargaining council schemes followed by open schemes. Restricted schemes on the other hand experienced the least decline in the dependants' ratio.

Table 6: Dependant ratio in medical schemes

Type of scheme	2004	2003	% change
Registered scheme	1,45	1,48	-2,03
open	1,47	1,51	-2,65
restricted	1,41	1,43	-1,40
Bargaining Council	1,16	1,20	-3,33
Consolidated	1,44	1,47	-2,04

Membership by province

Table 7 shows the provincial breakdown of membership of medical schemes. These data were collected primarily on the basis of the location of principal members. More than one third (37,3%) of the beneficiaries of schemes are based in Gauteng, 17,3% are in the Western Cape and 14,9% are in Kwazulu-Natal. The Northern Cape has the least proportion of medical scheme members at 2,2%.

Table 7: Medical scheme membership by province

Province	Members	Dependants	Beneficiaries	% of total beneficiaries
Gauteng	1 092 200	1 487 204	2 579 404	37,30
Limpopo	98 047	181 611	279 658	4,04
Mpumalanga	166 418	287 790	454 208	6,57
North West	124 799	188 131	312 930	4,52
Free State	130 568	188 254	318 822	4,61
KwaZulu Natal	417 706	610 894	1 028 600	14,87
Western Cape	508 585	685 300	1 193 885	17,26
Eastern Cape	234 735	361 091	595 826	8,62
Northern Cape	60 264	92 069	152 333	2,20
Consolidated	2 833 322	4 082 344	6 915 666	100

Benefits

Total benefits paid by medical schemes

Expenditure by medical schemes on health care benefits increased to R41,5bn in 2004, an increase of 7,2% on 2003. This represents an increase per beneficiary per month of 6,5% during 2004.

Figure 11 shows the proportions of benefits paid to hospitals, general practitioners, specialists and others. Hospital expenditure, which includes theatre fees, ward fees, consumables, medicines dispensed and global and per diem arrange-

ments, accounted for 38,0% (R15,7bn) of the R41,5bn paid to providers. This is an 18,5% increase on 2003. The increase in expenditure on private hospitals was 19,5% while that of provincial hospitals was 5,3%. Provincial hospitals accounted for 1,7% of the overall benefits paid to hospitals.

In the private hospitals, ward fees accounted for 43,8% of the total private hospital expenditure (includes global and/or per diem arrangements), theatre fees made up 24,8%, consumables were at 12,9% and medicines dispensed within hospitals accounted for 18,5%.

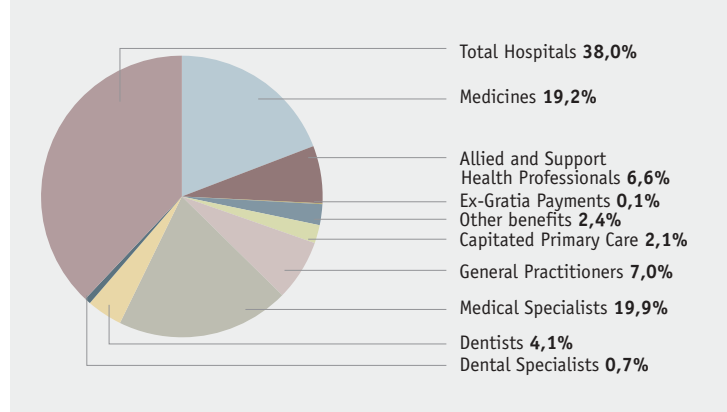
Expenditure in the provincial hospitals was dominated by ward fees which accounted for 75,3% of the total expenditure, consumables made up 12,9%, while theatre fees and medicines dispensed made up 6,7% and 5,1% respectively.

Medical specialists accounted for 19,9% of the total expenditure in 2004. Expenditure on general practitioners declined by 1,7% to R2,9bn in 2004 from R3,0bn in 2003.

Medicines dispensed by pharmacists and providers other than hospitals, accounted for 19,2% (R7,96bn) of the total benefits paid by medical schemes. Expenditure on pharmacists accounted for 82,9% of the total medicine expenditure while dispensing practitioners accounted for 16,8%.

Allied health professionals accounted for only 0,3% of the total expenditure on medicines. Expenditure on allied health professionals of increased by 2,4% to R2,74bn in 2004 from R2,67bn in 2003.

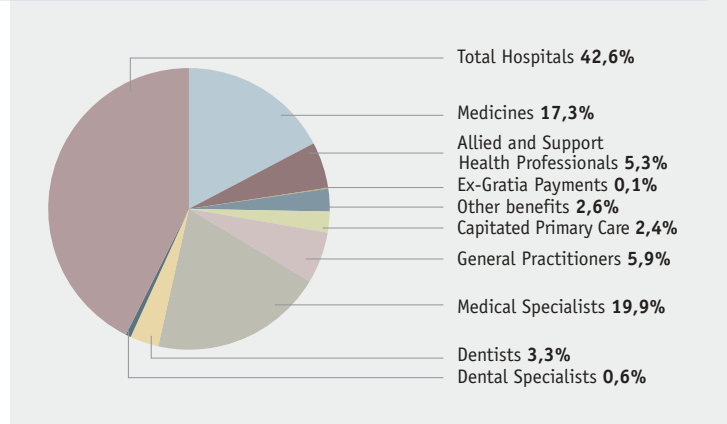
Figure 11: Total benefits paid during 2004



Benefits paid out of risk pool

Benefits paid out of the risk pool amounted to R36,8bn (88,9%) of total benefits in 2004; an increase of 6,8% from R34,5bn in 2003. Hospitals (private and provincial) accounted for 42,6% of the total risk benefits paid in 2004 compared with 38,3% in 2003. Medicines expenditure accounted for 17,3% while specialists accounted for 19,9%. General practitioners accounted for 5,9% of the total risk benefits; a drop of 7,8% to R2,2bn in 2004 from R2,4bn in 2003.

Figure 12: Benefits paid from risk pool during 2004

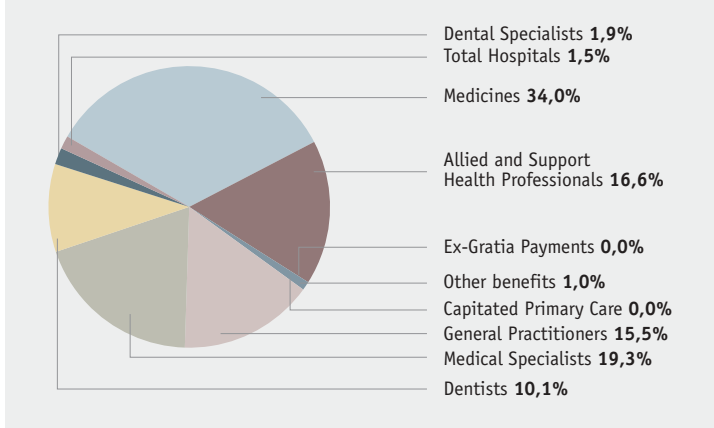


Benefits paid from medical savings accounts

Personal medical savings accounts, which are accounts set aside by a medical scheme for individual use by members and their dependants, accounted for 11,2% (R4,6bn) of the overall expenditure on benefits. This reflected an increase of 10,7% on 2003. Medicines accounted for 34,0% of benefits paid while medical specialists and general practitioners accounted for 19,3% and 15,6% respectively.

A small percentage (1,5%) of medical savings accounts money was spent on hospital services (1,5%); this reflects a 12,3% decline from R80,7m in 2003 to R70,8m in 2004.

Figure 13: Benefits paid from saving accounts in 2004



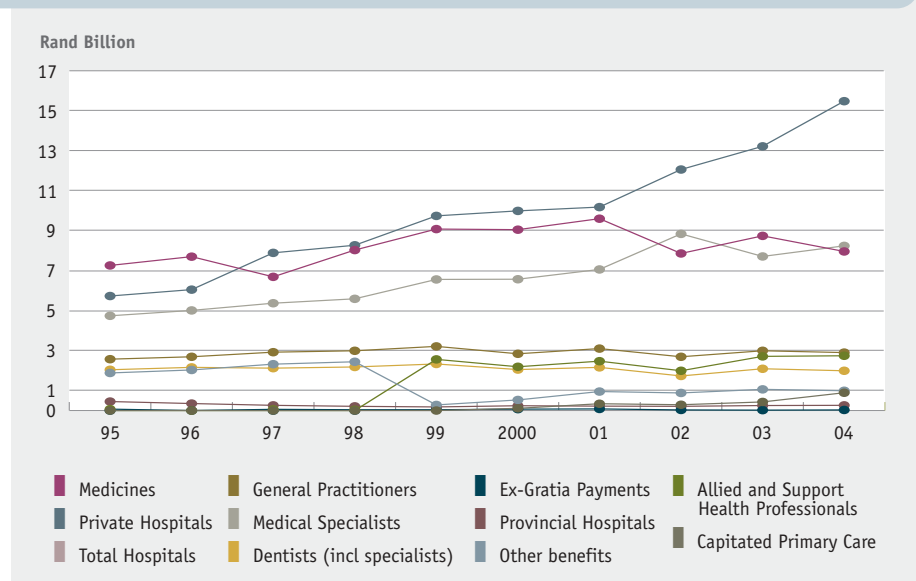
Trends in total benefits paid

Figure 14 shows the distribution of benefits to different types of providers since 1995.

The largest increase in expenditure was on hospitals, which rose by an adjusted 16,9% to R15,7bn from R13,5bn in 2003. Expenditure in private hospitals increased by 17,2% to R15,5bn from R13,2bn in 2003. Provincial hospitals increased their share by 3,8% to R248,8m from R252,3m in 2003.

In private hospitals, theatre fees increased by 35,9%, ward fees by 20,3% and medicines dispensed in hospitals by 16,3%. Consumables declined by 8,8%. In provincial hospitals, ward fees increased by 18,8%, and consumables by 2%.

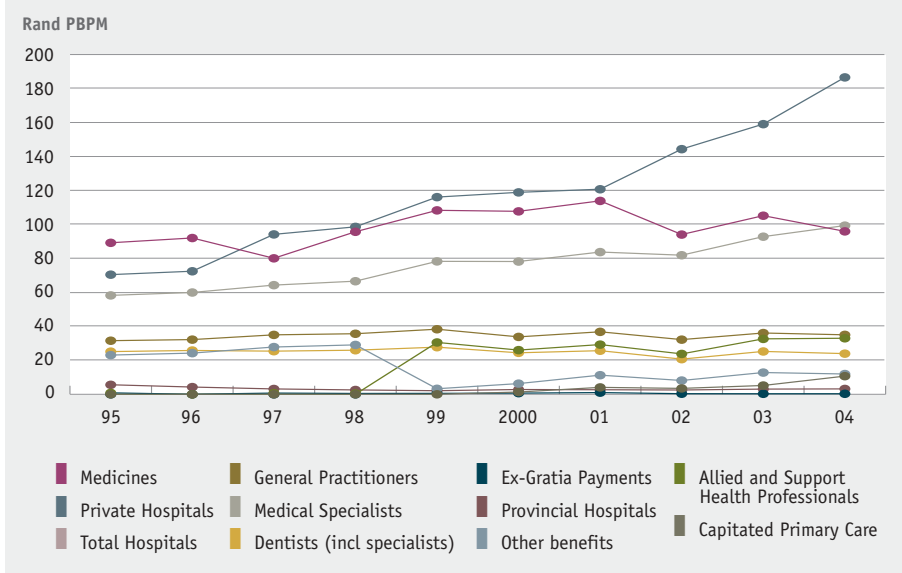
Figure 14: Total benefits paid, 2004 prices



Theatre fees and medicines dispensed in hospitals declined by 27,5% and 50,3% respectively.

Expenditure on medical specialists increased by 6,9% to R8,2bn from R7,7bn in 2003. General practitioners expenditure, on the other hand, declined by 3,1% to R2,9bn from R3bn in 2003. Expenditure on medicines declined by 8,9% to R8bn from R8,7bn in 2003. A similar trend was noted on dentists, including dental specialists where expenditure declined by 5,2% to R2bn from R2,1bn in 2003. There was a significant increase in expenditure on capitated primary care in which rose by 106,1% to R886,4m from R430m in 2003. Expenditure on allied and support health professionals increased marginally by 1,0% from R2,7bn in 2003.

Figure 15: Total benefits paid per beneficiary per annum, 2004 prices



Total benefits paid per beneficiary

Figure 15 shows the overall increase per beneficiary in expenditure. Expenditure on hospitals increased by 17,1% to R189,7 per beneficiary per month from R162,1 in 2003. The increase in private hospitals was 17,3% while that of provincial hospitals was comparatively lower at 4,0%.

Expenditure on medical specialists increased by 7,0% to R99,3 from R92,8 in 2003. General practitioners' share of expenditure declined by 3,0% to R35 from R36,1 in 2003. A similar trend was noted among dentists and dental specialists where expenditure declined by 5,1% to R23,9 from R25,2 in 2003.

Expenditure on medicines, when adjusted for inflation and membership, declined by 8,8% to R95,9 from R105,2 in 2003. The most significant increase in per beneficiary expenditure was that of capitated primary care which rose by 106,4% to R10,7 from R5,2 in 2003. Expenditure on allied and health professionals increased marginally by 1,1% to R33,0 from R32,6 in 2003.

Utilisation of health services

The utilisation levels of primary healthcare services in registered schemes, particularly general practitioners, declined from an average of 803,8 per 1000 beneficiaries in 2003 to 740,5 per 1000 beneficiaries in 2004.

Admissions to both public and private hospitals were also lower than in the previous year. Private hospital admissions declined to 197,9 per 1000 beneficiaries from 243,5 in 2003. Public hospital admission declined to 11,5 admissions per 1000 beneficiaries from 24,1 in 2003. On the whole, utilisation levels were higher in restricted than open schemes, particularly for primary care services and admissions to hospitals.

Table 8: Utilisation of services

Provider group	Open schemes	Restricted schemes	Consolidated 2004	Consolidated 2003
	per 1000 Beneficiaries			
PRIVATE PROVIDERS				
Number of beneficiaries visiting a GP at least once a year	710,99	811,31	740,46	803,76
Number of beneficiaries visiting a dentist at least once a year	260,65	335,59	282,66	301,02
Number of beneficiaries visiting a private nurse at least once a year	4,91	8,15	5,87	9,63
PRIVATE FACILITIES				
Number of admissions to hospitals	190,43	216,04	197,95	243,49
PUBLIC FACILITIES				
Number of admissions to hospitals	9,23	17,09	11,54	24,31

Average utilisation of services

The average number of visits to a general practitioner per beneficiary was 3,3 in 2004; a slight decline from 3,4 in 2003. The visits were higher for restricted schemes (3,9 visits per annum) compared to open schemes (3,0 visits per annum).

The average length of stay in private hospitals was 1,1 in 2004. This was higher for restricted schemes (2,4 days per annum) compared to open schemes (0,5 days per annum). The length of stay in provincial hospital was lower (0,1) than in private hospitals.

Table 9: Average utilisation of services

Average utilisation of services	Open schemes	Restricted schemes	Consolidated 2004	2003
Visits to a general practitioner per year	3,03	3,93	3,30	3,44
Visits to a dentist per year	0,54	0,63	0,57	0,67
Visits to a private nurse per year	0,01	0,03	0,02	-
Length of stay in private hospital	-	2,36	1,06	-
Length of stay in provincial hospitals	-	0,06	0,05	-

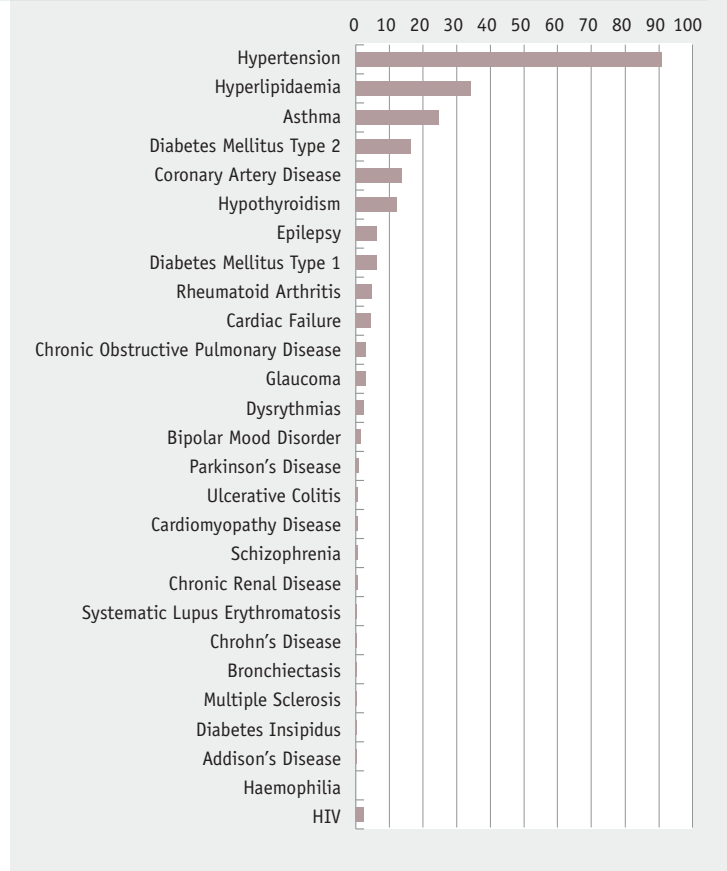
In general, there has been a decline in the level of utilisation of services of medical specialists and allied health professionals. There was however a noticeable increase in the level of utilization of other benefits such as appliances, prostheses and ambulance services (Annexure G).

Burden of disease

A new set of 25 legislated chronic conditions was introduced in the medical schemes environment in January 2004. The regulations required that these 25 prescribed chronic conditions should be covered in all medical schemes benefit options. Figure 16 shows the prevalence of these chronic conditions. The data represents 77,4% of schemes and 76,7% of beneficiaries. Schemes that did not submit any data on chronic conditions were excluded from the analysis as were schemes that submitted poor quality data. The analysis showed that the most prevalent condition in medical schemes is hypertension (91 cases/1000 beneficiaries), followed by hyperlipidaemia (34 cases/1000 beneficiaries) and asthma (25 cases/1000) beneficiaries.

Generally, the prevalence of chronic conditions in registered schemes was higher in restricted than in open medical schemes. The higher prevalence in restricted schemes may be related to the higher age profile of these schemes compared with that of open schemes.

Figure 16: Prevalence of chronic conditions in registered schemes



Contributions, claims and trends during 2004

Total contributions and claims during 2004

Total contributions for all schemes increased on average by 7,4% to R52,2 bn from R48,6bn in 2003. Total gross claims incurred went up 7,0% to R41,4bn from R38,7bn in 2003. Gross contributions attributable to registered schemes only (excluding bargaining council schemes) grew by 7,1% per beneficiary per month to R645 from R602 in 2003, while gross claims per beneficiary per month jumped 6,7% to R511 from R479.

Risk contributions and claims for registered schemes

Risk contributions (net of savings contributions) increased by 7,2% to R46bn from R42,9bn in 2003. The comparable increase between 2002 and 2003 was 11,4%. Risk contributions per beneficiary per month increased to R577 from R539, an increase of 7,1% (2003: 13,2%).

Risk claims increased by 6,5% to R36,2bn from R34,0bn (2003: 7,6%). Risk claims per beneficiary went up to R453 per month from R426, an increase of 6,3%. (2003: 9,0%).

Medical savings accounts contributions and claims

Contributions to medical savings accounts increased by 9,9% to R5,5bn from R5,0bn the year before. (2003: 19,0%). The increase per average beneficiary was 9,5% from R63 to R69 (2003: 21,2%).

Claims paid from savings accounts increased by 9,5% to R4,6bn from R4,2bn. (2003: 16,7%). Claims per beneficiary were also 9,4% higher in 2004, from R53 to R58. The comparable increase between 2002 and 2003 was 17,8%.

Medical savings accounts claims as a percentage of total net claims incurred went up from 10,9% in 2003 to 11,4% in 2004. The same figure increased to 13,1% from 12,7%

when viewed on a beneficiary basis. This would indicate a move towards benefit designs requiring a greater proportion of benefits to be funded out of a member's savings rather than from the general risk pool.

Contributions and claims by open and restricted membership schemes

Table 10 and figures 18 and 19 show the contributions and claims per beneficiary per month for open and restricted schemes.

Beneficiaries of restricted schemes saw lower gross contribution increases of 6,9% compared with the 7,4% for those in open scheme. Claims costs were higher in the restricted schemes than in the open ones. The risk claims ratio for open schemes declined to 76,2% from 77,3% in 2003. The ratio for restricted schemes increased to 84,3% from 83,6%.

Figure 11 shows that open schemes are increasingly paying claims out of medical savings accounts; with 13% of all claims paid out of medical savings accounts compared with 12,3% in 2003. Put another way, the claims ratio of medical savings accounts in open schemes increased to 85,1% in 2004 from 82,6% in 2003.

Figure 17: Risk and savings contributions and claims for registered schemes

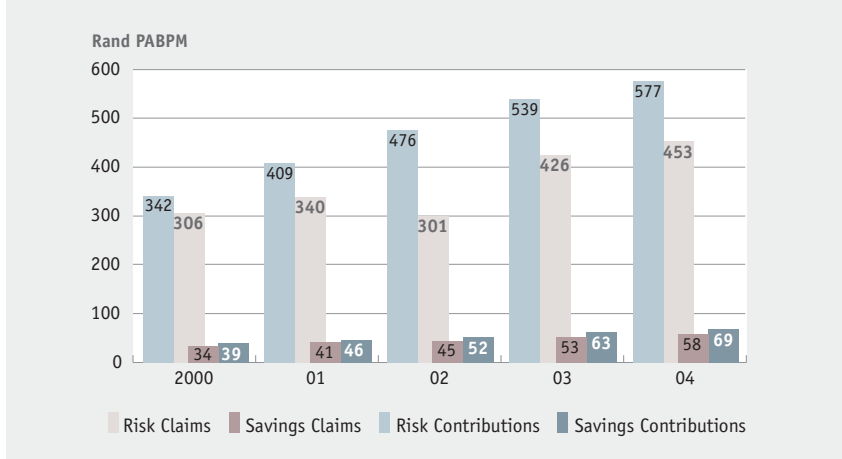


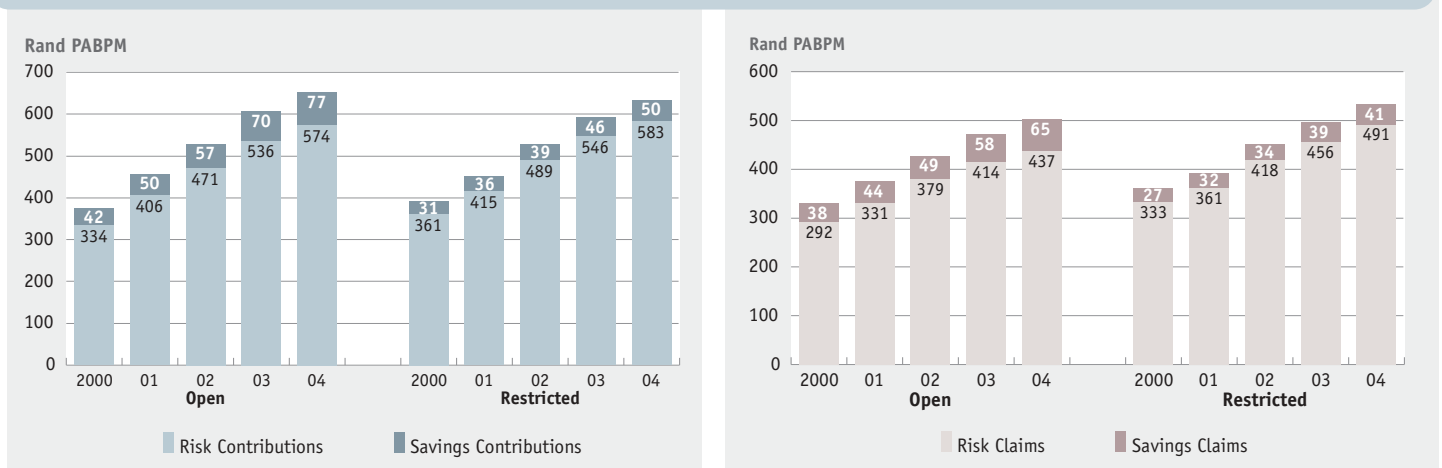
Table 10: Contributions and claims per average beneficiary per month for open and restricted schemes

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	PABPM R	% Change	PABPM R	% Change	PABPM R	% Change	PABPM R	% Change
OPEN								
2000	334		42		292		38	
2001	406	21,8%	50	18,7%	331	13,3%	44	17,6%
2002	471	15,8%	57	14,2%	379	14,4%	49	10,8%
2003	536	13,8%	70	23,6%	414	9,1%	58	18,6%
2004	574	7,2%	77	8,8%	437	5,7%	65	11,9%
RESTRICTED								
2000	361		31		333		27	
2001	415	15,0%	36	14,6%	361	8,3%	32	17,6%
2002	489	17,8%	39	9,8%	418	15,8%	34	4,9%
2003	546	11,6%	46	17,1%	456	9,1%	39	15,3%
2004	583	6,8%	50	9,1%	491	7,7%	41	5,4%

*PABPM = per average beneficiary per month

Growth in restricted schemes claims paid out of medical savings accounts slowed to 7,7% in 2004 from 7,9% the year before. Medical savings accounts claims ratio for restricted schemes declined to 82,1%, down from 85,0% in 2003.

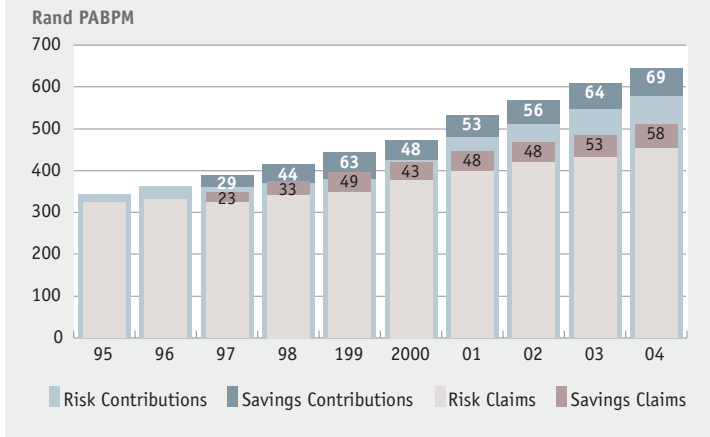
Figures 18 & 19: Risk and savings contributions and claims per average beneficiary per month for open and restricted schemes



Trends in contributions and claims since introduction of medical savings accounts

Figure 20 illustrates the increased utilisation of medical savings accounts in the benefit design of all registered schemes since 1997 when schemes first started using these. Risk contributions have increased by 60,5% and claims incurred have gone up by 39,3% since 1997. Contributions to and claims from medical savings accounts, on the other hand, have increased by 133,9% and 153,4% respectively. This suggests that schemes are increasingly shifting benefits from the

Figure 20: Risk and savings contributions and claims, 2004 prices



risk pool into the medical savings account. In other words, it would appear that members are effectively funding more benefits out of their own pockets rather than being funded within the risk pool.

Claims ratio for risk benefits

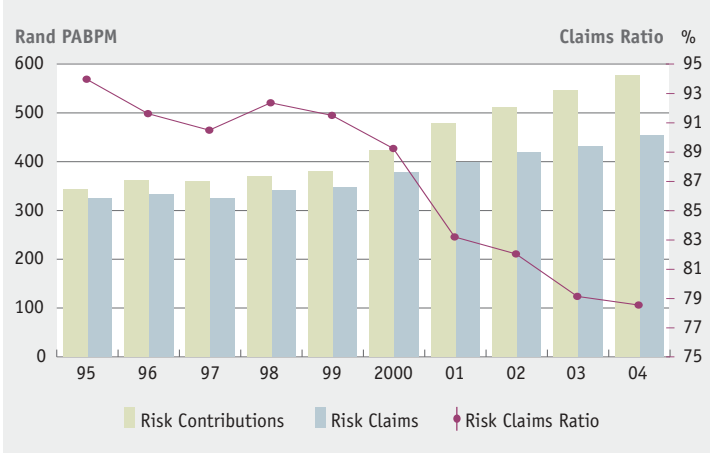
Figure 21 shows the relationship between risk contributions and claims paid over the past decade, adjusted for inflation. The claims ratio, which is the percentage of contributions paid out in claims, declined at a slower rate in 2004 compared to the last few years. The claims ratio

decreased to 78,6% from 79,2% in 2003 (claims ratio was over 90% before 1999). The claims ratio effectively translates into medical schemes paying 78,6% (2003: 79,2%) of contributions towards benefits, leaving 21,4% (2003: 20,8%) of contributions to non-health expenditure and reserves

(future benefits). As reserves for most schemes are at the prescribed level, more of members' contributions should in future be utilised towards benefits. Trustees should ensure that benefits are not substituted by high levels of non-health expenditure.

Figures 22 and 23 shows the levels of claims and non-health care expenditure after adjusting contributions by removing the percentage earmarked for reserves. The two figures show that the claims ratios reduces by 5,8% compared to non-health ratio which only reduces by 1%.

Figure 21: Risk claims ratio for all schemes since 1995 adjusted for inflation, 2004 prices



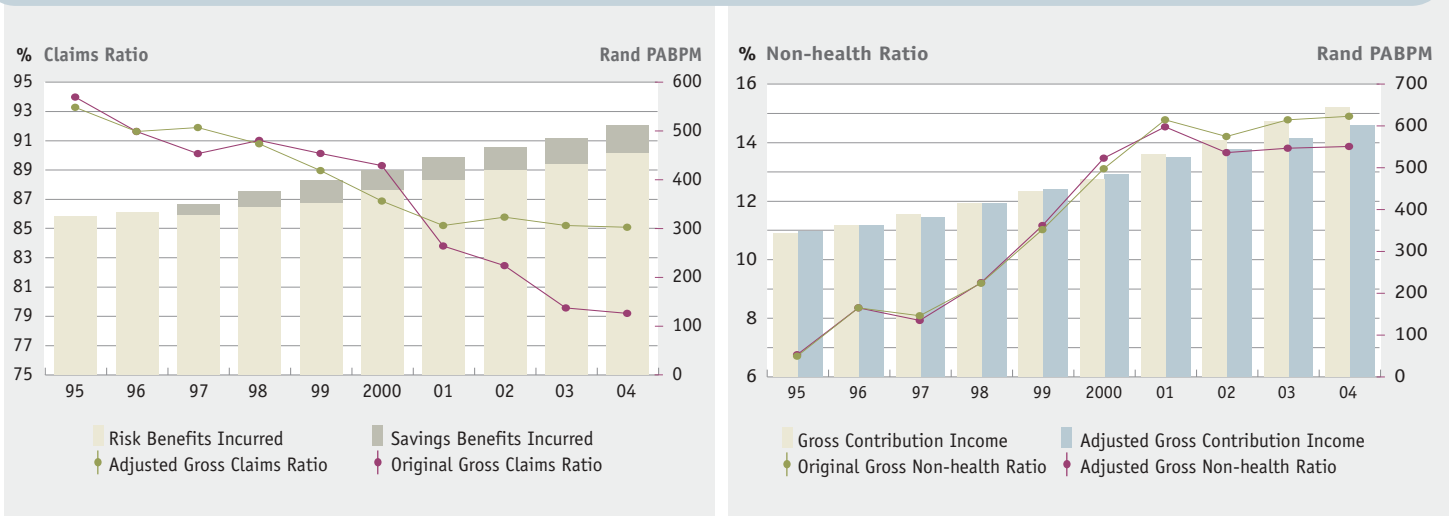
Non-health expenditure

Medical schemes' non-health expenditure consists of administration, brokers fees, impaired receivables (bad debts), reinsurance results and expenditure associated with managed care.

Administration expenditure

Administration expenditure in registered medical schemes grew 10,5% to R5bn from R4,5bn in 2003. Open scheme expenditure was R4bn, an increase of 12,1% from R3,5bn in 2003. Restricted schemes raised their expenditure by a more modest 5,0% to R1,0bn from R978m.

Figures 22 & 23: Claims ratio, non-health ratio and contributions since 1995 adjusted for reserve building and inflation, 2004 prices



Administration fees paid to administrators made up R3,7bn of the total (73,7%). Staff remuneration and marketing expenses accounted for 10,2%, respectively. Trustee remuneration represented 0,7% of gross administration expenditure whilst principal officer fees represented 0,6%. Annexure O provides full details of these expenditure items for each scheme.

Table 11: Total administration fees paid to third party administrators

	Open schemes			Restricted schemes		
	PABPM			PABPM		
	2004 R	2003 R	% Variance	2004 R	2003 R	% Variance
Direct administration fees	48,70	44,23	10,11%	33,83	31,79	6,42%
Co-administration fees	1,18	0,54	118,52%	0,50	0,55	-9,09%
Indirect expenses paid	0,81	0,80	1,25%	0,23	0,28	-17,86%
Total	50,68	45,57	11,24%	34,56	32,62	5,95%

*PABPM = per average beneficiary per month

Table 11 shows gross administration fees paid to third-party administrators which comprises of direct administration fees, co-administration fees and indirect expenses. The table shows that beneficiaries in open schemes paid on average 46,6% more for gross administration fees than restricted schemes in 2004 (2003: 39,7%).

Open schemes experienced an increase of 11,2% in the total administration fees paid to third-party administrators; this increase is slightly lower than the overall increase in administration expenditure of 12,1% for open schemes. Restricted schemes experienced an increase of 6,0% in the total administration fees paid to third-party administrators; this increase is one percentage point higher than the overall increase in administration expenditure of 5,0% for restricted schemes from 2003 to 2004.

In 2004, principal officer fees represented 0,6% of gross administration expenditure for open schemes compared to 1,1% in restricted medical schemes. This translated into R0,43 per average beneficiary in the open scheme market (for those schemes paying principal-officer fees), and R0,76 per average beneficiary in the restricted scheme market; a difference of 76,7%.

Marketing and advertising fees represented 3,3% of gross administration expenditure in respect of all registered schemes. Open schemes paid R0,93 per average beneficiary per month for marketing and advertising, where as restricted schemes paid R0,97 per average beneficiary per month, based on the number of schemes that paid marketing and advertising expenditure. Interesting to note that restricted schemes paid more towards marketing and advertising on an average beneficiary level than open schemes.

Administration expenditure represented 69,8% (2003: 67,9%) of total non-health expenditure.

Expenditure associated with management of benefits

Managed healthcare expenditure also jumped to R1,2bn from R1,1bn, an increase of 11,8% from 2003. The average number of members covered by these interventions grew by 1,2%. Managed care tools were used by 114 schemes during 2004 (2003: 109 schemes), and by 6 462 862 (97,1%) of beneficiaries (2003: 96,0%). However, it should be noted that not all beneficiaries mentioned above are covered by managed care due to some of the options not having managed care interventions.

Administration and managed-care expenditure jointly accounted for 12,1% (2003: 11,7%) of gross contribution income, higher than the broad guideline of 10% that Council has established. Our analysis shows that there were 33 open schemes, representing 2 992 999 beneficiaries, and 20 restricted schemes, representing 279 835 beneficiaries, whose overall administration expenditures were still above the 10% level.

Table 12 shows administration and managed care expenditure for open and restricted schemes by type of scheme administration. There were 7 self-administered open schemes (2003: 9 schemes), representing 479 083 beneficiaries (2003: 511 885) and 42 third-party administered open schemes (2003: 40 schemes), representing 4 238 353 beneficiaries (2003: 4 181 457).

Self-administered open schemes grew their expenditure by 10,9% to R77 pbpm from R69 pbpm in 2003. Open schemes administered by third parties saw a rise of 12,0% to R88 pbpm from R78 pbpm. The latter schemes spend 14,4% more on administration and managed care expenditure than self-administered open schemes.

There were also 13 self-administered restricted schemes (2003: 13 schemes), representing 238 744 beneficiaries (2003: 247 264) and 74 third party administered restricted schemes (2003: 75 schemes), representing 1 697 094 beneficiaries (2002: 1 711 556). Self-administered restricted schemes paid on average R43 pbpm compared with the R59 pbpm spent by restricted schemes administered by third parties. The expenditure by the latter schemes was 36,5% higher than the former.

Table 12: Gross administration expenditure and managed care expenditure in respect of open and restricted schemes

	OPEN SCHEMES				RESTRICTED SCHEMES			
	Self-administered		Third Party		Self-administered		Third Party	
	PABPM R	% Change	PABPM R	% Change	PABPM R	% Change	PABPM R	% Change
2000	37,50	-	48,66	-	24,69	-	38,26	-
2001	62,83	67,5%	62,70	28,8%	31,26	26,6%	41,49	8,4%
2002	55,80	-11,2%	69,81	11,4%	37,31	19,4%	49,27	18,8%
2003	69,17	24,0%	78,38	12,3%	32,95	-11,7%	55,76	13,2%
2004	76,72	10,9%	87,78	12,0%	43,25	31,3%	59,02	5,9%

*PABPM = per average beneficiary per month

Self-administered open schemes spent 77,4% more pbpm compared with self-administered restricted schemes. Open schemes administered by third parties paid on average 48,7% more pbpm than third-party administered restricted schemes. This may be explained by the fact that:

- Restricted schemes usually have simpler benefit designs and fewer benefit options, all of which results in simpler administration;
- Collection of contributions and credit control is much simpler for restricted schemes; and
- Sometimes the employer group associated with a restricted scheme makes a contribution to some of the capital and salary expenditure.

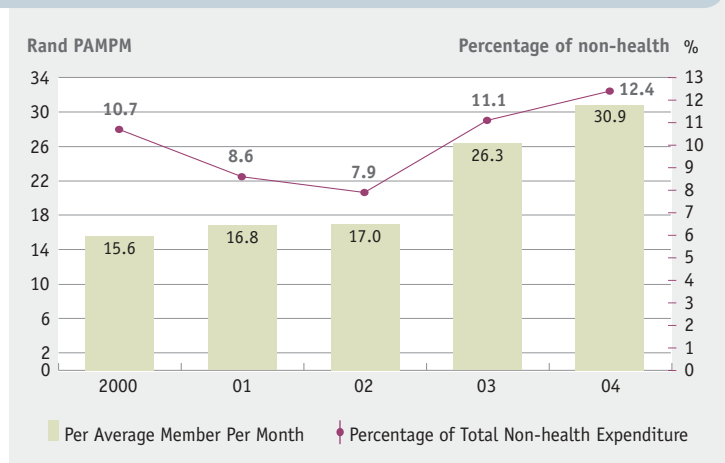
Fees paid to healthcare brokers

Commission fees paid to healthcare brokers again rose sharply to R704m from R581m in 2003, an increase of 21,1%. Virtually all commission payments (99,7%) were made by open schemes. Those schemes that paid broker commissions have seen this expenditure increase as a percentage of gross contribution income to 1,9% from 1,7% in 2003. When expressed as a percentage of total non-health expenditure, broker fees increased to 12,2% from 11,0% for those schemes that paid broker fees.

Figure 24 shows trends in payments made to brokers since 2000, as well as the percentage of total non-health expenditure that these commissions have accounted for.

In the restricted schemes market, only four schemes reported any commission payments (three in 2003). However, these schemes paid R2,2m in commission, up 107,3% from 2003. Data from these four schemes shows that only 5 318 new members joined the schemes in 2004. The three schemes that paid broker commission in 2003 had seen 10 495 new members joining, which suggests that the

Figure 24: Trends in broker fees for the open scheme market



number joining in 2004 has gone down by 49,3% in spite of the substantial increases in commission payments.

The 47 open schemes that paid broker fees during 2004 indicated that 390 873 new members joined the schemes during 2004, a decrease of 9,8% from the 433 904 new members that joined the open schemes that paid broker fees in 2003.

Data from open schemes shows that 168 767 people were introduced to medical schemes for the first time in 2004, compared with 215 845 in 2003. This is a decline of 21,8%. Restricted schemes, on the other hand, saw 52 982 newly-introduced members, a decrease of 35,3% on 2003. The increase in broker fees of 21,1% is therefore not related to the introduction of members.

Broker commission per member per month

Figure 25 illustrates the actual broker fees per member per month (based on the industry's overall average principal members) compared with a fee per member per month that includes broker fees, marketing expenditure as well as advertising expenditure.

Marketing and advertising expenditure have gone up year on year, without any perceptible increase in many new members joining.

Schemes that had the highest increase in broker fees pmpm and a decrease in the number of members joining between 2003 and 2004, are shown in table 13.

Figure 26 excludes from the analysis the top three schemes in table 13, and illustrates the trends in broker fee pmpm since 2000. The information is based only on the average number of members of those schemes that paid broker fees.

The actual broker fee per average member per month for the open industry market escalated by approximately 17,2% between 2003 and 2004. However, should the three outliers be removed, this increase to 7,5%, hence the broker fee per average member per month would reduce from R31 per average member per month to R25.

Figure 25: Costs incurred in sourcing membership

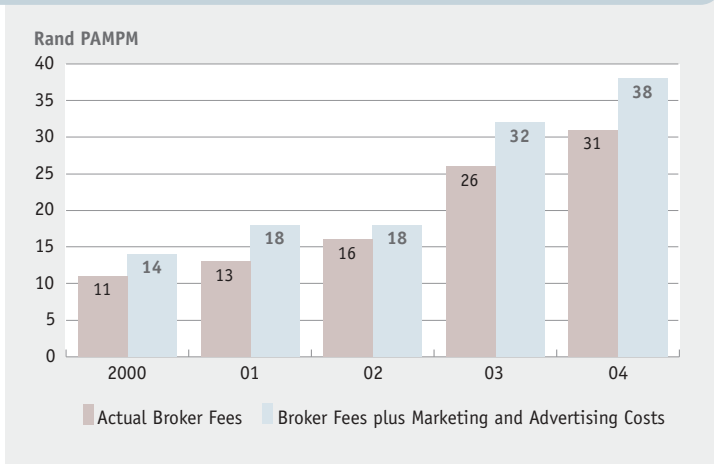


Figure 26: Broker fees excludes the top three outliers

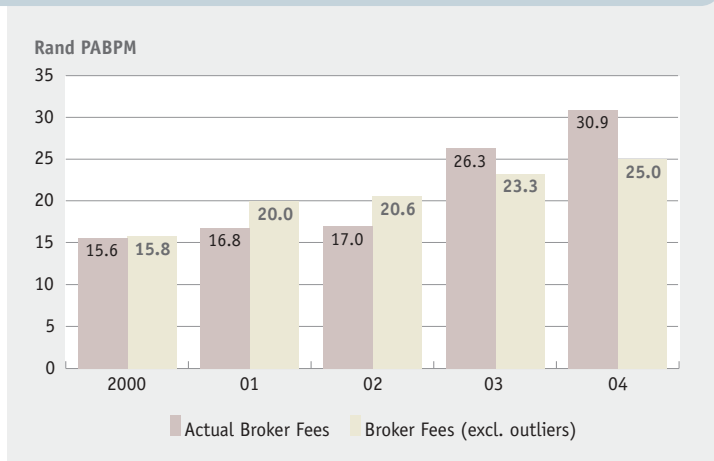


Table 13: Schemes with the largest increases in broker commission between 2003 and 2004

Scheme name	Type	Broker fees paid			Number of members joining the scheme		
		PAMPM 2004 R	PAMPM 2003 R	% Change	2004	2003	% Change
Built Environment Professional Associations	Restricted	48,72	10,51	363,66%	378	1 173	-67,77%
Profimed	Restricted	1,76	0,69	156,80%	2 542	4 029	-36,91%
Global Health	Open	4,44	2,89	53,33%	2 152	13 298	-83,82%
Community Medical Aid Scheme (COMMED)	Open	12,76	8,83	44,45%	0	1 526	-100,00%
Topmed Medical Scheme	Open	39,13	27,74	41,06%	1 357	1 520	-10,72%
Hosmed Medical Aid Scheme	Open	7,65	5,67	34,87%	0	4 830	-100,00%
Discovery Health Medical Scheme	Open	41,69	32,72	27,42%	139 898	171 065	-18,22%
Medihelp	Open	10,16	8,02	26,72%	9 055	9 589	-5,57%
Bestmed Medical Scheme	Open	34,46	27,45	25,55%	9 095	11 376	-20,05%
SAMWUMED	Restricted	0,19	-	N/A	2 398	5 293	-54,69%

*PAMPM = per average member per month

Reinsurance results

The number of reinsurance contracts entered into by schemes declined to 5 during 2004 from 10 the year before. Other reinsurance entries in a few schemes related to prior year adjustments. The net effect was a decrease in the reinsurance deficit of 93,7%, decreasing to a deficit of R7,8m from R123m in 2003.

Impaired receivables

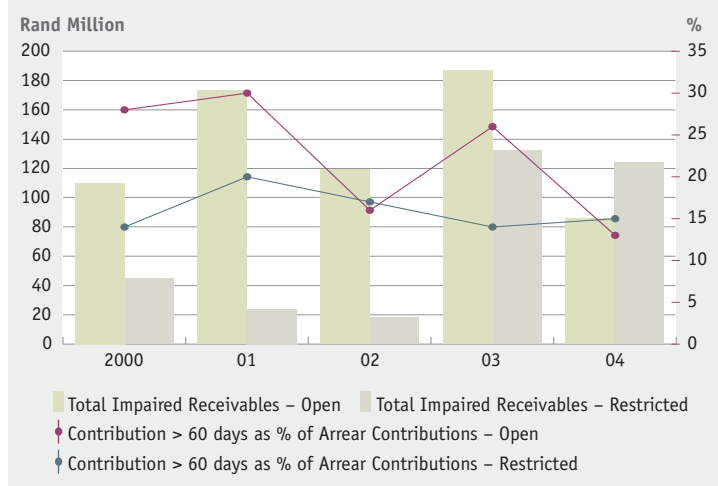
The total impaired receivables (previously known as bad debts) for the year under review amounted to R211m compared to R321m in 2003, which is a decrease of 34,3%. This movement resulted from the net effect of the following three categories:

- The increase in impaired receivables written off of approximately 45,2%.
- The increase in impaired receivables of approximately 79,9%.
- The decrease in the provision for impaired receivables of approximately 118,1%.

Impaired receivables for 2004 represented 3,0% of total non-health expenditure compared to 4,8% in 2003.

There is some concern that medical schemes have seen a 45,2% increase in impaired receivables written off. This is espe-

Figure 27: Impaired receivables



cially so because the administration fee associated with the contributions being provided for impaired receivable purposes is not recovered by schemes. The fluctuation in impaired receivables over the years could be due to ineffective debt collection systems and inappropriate manner of debtors ageing; currently 13,5% of arrear contributions are over 60 days old (2003: 24,7%).

Medical schemes typically collected contributions within 9,3 days during 2004, a decrease of 22,3% from 12 days in 2003. Though this is an improvement from the prior period it is still a concern as Section 26(7) requires that all contributions should be paid to a medical scheme not later than three days after payment is due. The associated risk of not collecting contributions timely is the possible impairment of the debtor and paying claims were contributions have not been received.

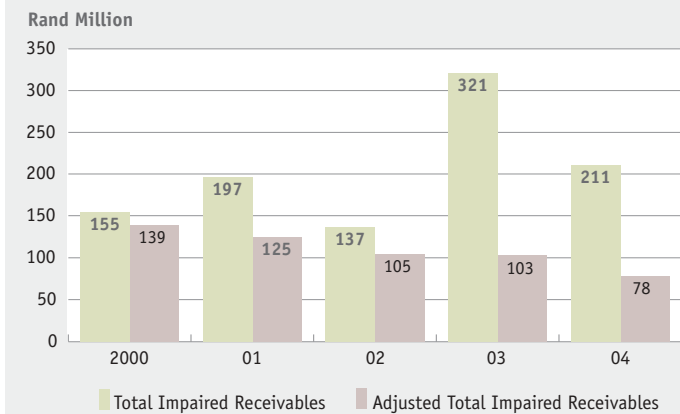
Table 14: Impaired receivables: open vs restricted schemes since 2000

Year	Total impaired receivables		Total impaired receivables as % of non health expenditure		Contribution over 60 days as % of arrear contributions	
	Open R'000	Restricted R'000	Open	Restricted	Open	Restricted
2004	86 865	124 559	1,5%	8,6%	13,3%	14,6%
2003	188 582	132 657	3,6%	9,6%	26,4%	13,9%
2002	118 922	17 914	2,5%	1,6%	16,3%	17,4%
2001	172 872	23 754	4,0%	2,4%	29,5%	20,1%
2000	110 417	44 917	3,7%	4,5%	27,9%	14,2%

Table 14 shows that, in 2004, total impaired receivables were higher for restricted schemes than for open schemes. As a general trend, however, the impairments for restricted schemes are lower than for open schemes. Impaired receivables as a percentage of non-health expenditure were 8,6% for restricted schemes (2003: 9,6%) and 1,5% for open schemes (2003: 3,6%).

Figure 28 shows the trends in impaired receivables over the last five years. The figure shows the actual amounts incurred and an adjustment for the four outlier schemes

Figure 28: Actual impaired receivables compared to the impaired receivables after the removal of the outliers



which had the highest variances for the periods. The trend over the five years looks more consistent with the adjusted amounts. The full details on impaired receivables are contained in Annexure R.

Table 15 shows total impaired receivables per administrator as well as outstanding contribution debtors over 60 days as a percentage of total contribution debtors.

Trends in total non-health expenditure

Total non-healthcare expenditure for registered schemes rose by approximately 7,6% to R7,1bn in 2004 from R6,6bn in 2003. As explained earlier,

Table 15: Impaired receivables per administrator

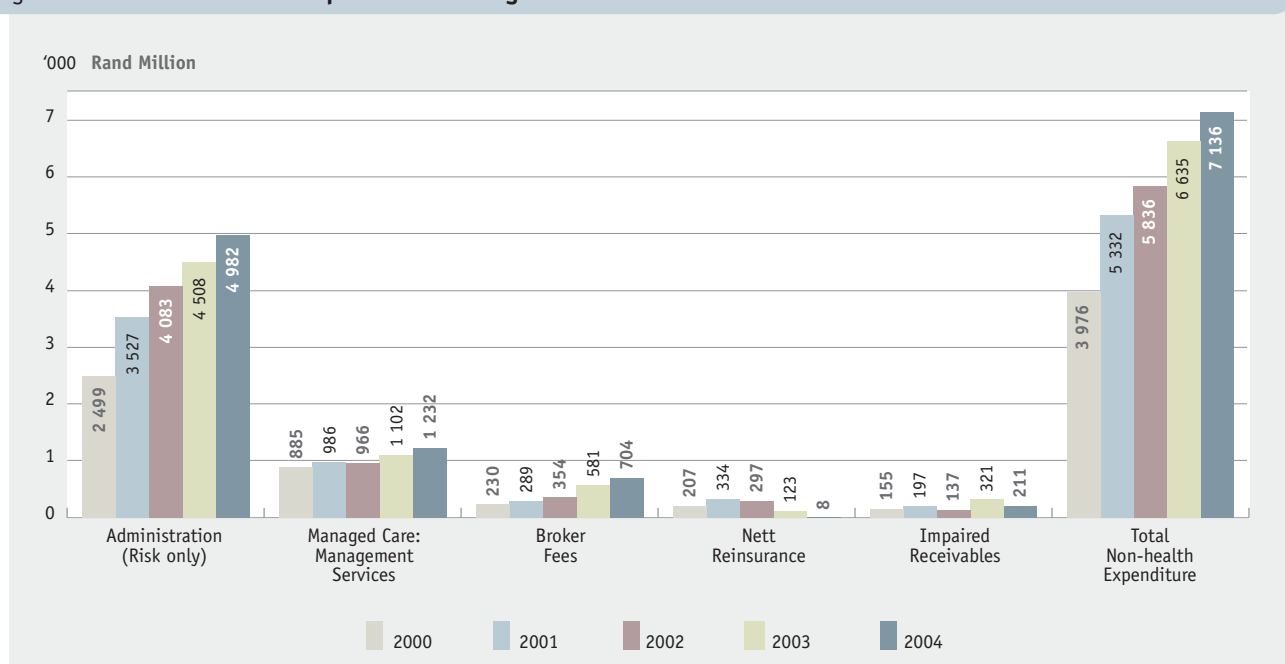
Administrator	Number of schemes	Total impaired receivables	Outstandings contributions > 60 days as % of arrear contributions	Number of schemes	Total impaired receivables	Outstanding contributions > 60 days as % of arrear contributions
	2004	2004 R'000	2004 %	2003	2003 R'000	2003 %
Medscheme (Pty) Ltd	22	17 277	30,07%	21	28 119	45,06%
Self-administered	19	10 589	20,97%	19	14 875	18,09%
Metropolitan Health Corporate (Pty) Ltd	16	4 313	17,79%	16	87 255	70,01%
Old Mutual Healthcare (Pty) Ltd	11	5 546	26,88%	13	(802)	15,78%
Sovereign Health -Division of Medscheme Holdings	11	(400)	1,99%	11	589	0,21%
Status Medical Aid Administrators (Pty) Ltd	9	(91)	1,81%	9	3 144	3,29%
Allcare Administrators (Pty) Ltd	8	12 240	7,48%	7	1 032	6,19%
Discovery Health (Pty) Ltd	8	20 428	-0,91%	10	(1 772)	-1,11%
Mx Network Systems (Pty) Ltd	3	113 942	82,91%	3	122 163	83,74%
Other	26	27 581	26,72%	28	66 635	31,51%
Total	133	211 424	13,54%	137	321 239	24,65%

*The figures in brackets are credits

administration expenditure increased by 10,5%, managed care by 11,8%, broker fees rose by 21,1% and impaired receivables decreased by 34,2%. There was a decrease of 93,6% in reinsurance losses.

Figure 29 shows the trends in total non-health expenditure since 2000. Total non-health expenditure has increased by approximately 79,5% over the five year period. Administration expenditure rose by 99,3%; managed care by 39,1%; bro-

Figure 29: Total non-health expenditure for registered schemes



ker fees by 206,4%, and impaired receivables by 36,1%. Net reinsurance losses have decreased by 96,2%. Total non-health expenditure rose to 13,9% (2003: 13,8%) of contributions in 2004.

Figure 30 shows further that non-health expenditure per beneficiary increased to R1 045 from R981 in 2003, an increase of 6,5% in real terms. The downward sloping claims ratio decreased, on the other hand, to 79,2% from 79,6% in 2003. Total non-health expenditure was fairly stable in 2001 and 2003, but has increased considerably in 2004. This increase in non-health expenditure was mainly due to the 19,6% increase in broker fees to R102 per beneficiary from R85.

Given the reduction in the proportion of claims being paid to 79,2% from 79,6% in 2003, it would seem that claims are not necessarily putting upwards pressure on contributions. The increase in contributions (6,0% in 2004) continue

to finance higher non-health expenditure.

Figure 31 depicts the information on risk contributions, risk benefits, administration costs and annual surpluses/(deficits) discussed previously on a beneficiary per month basis. From the figure, it is clear that the rate of increase on administration expenditure per beneficiary has declined, while the rate of growth of member surpluses has increased considerably. The implication is that, unlike in previous years when gross administration expenses per beneficiary were growing at the expense of the beneficiary surpluses, this pattern has now started to reverse.

The figure also shows that the growing divergence in contributions and claims per member per month has not levelled off (as shown by increases in rate of contribution changes accompanied by declines in claims ratios).

Figure 30: Real non-health expenditure per beneficiary, 2004 prices

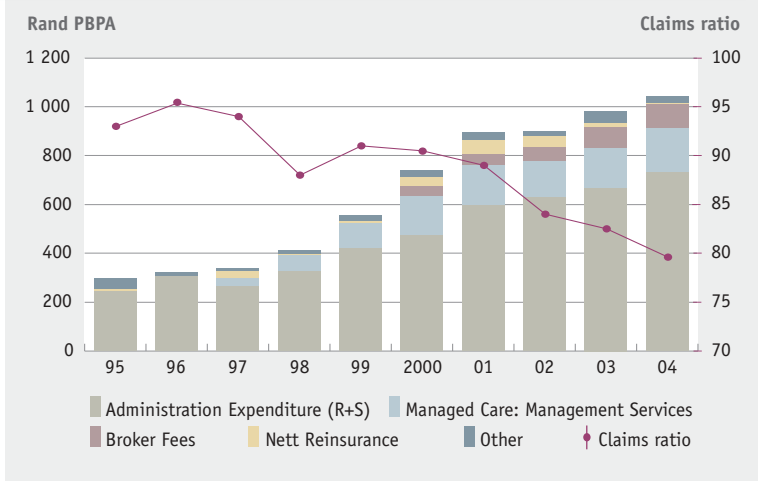
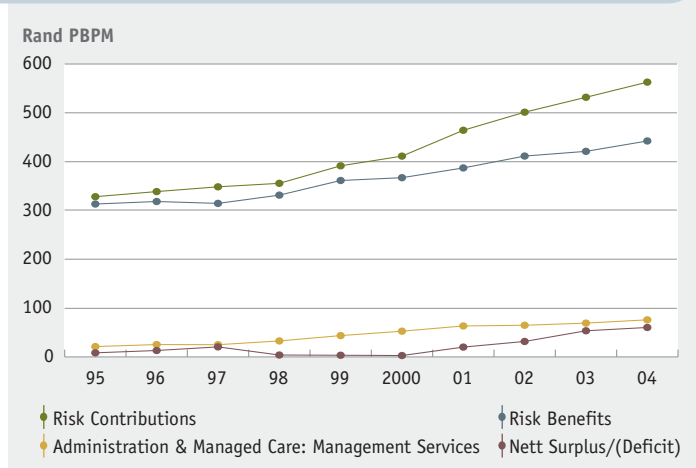


Figure 31: Contributions, benefits and non-health expenditure, 2004 prices



Operating results during 2004 and changes over the last five years

Total surplus from operations for all schemes has increased steadily since 2001, and increased again to R2,8bn from R2,4bn in 2003, a growth of 17,2%. Operating surpluses had grown by a dramatic 547,4% and 114,5% during 2002 and 2003, respectively. The 2004 increase, though not as dramatic, is still significant and may be an indication of a possible stabilisation of the industry. The industry net surplus grows to R5bn when investments and other income are taken into account, an increase of 14,1% compared to 2003.

Investments

Net investment and other income decreased as a percentage of net surplus to 44,8% from 46,3%. The decrease has largely mirrored changes in interest rates.

Figure 33 provides information on the composition of investments of medical schemes during 2004. In open schemes, a greater proportion (67,1%) of investments was held in cash and cash equivalents. Bonds accounted for 21,5%, equities accounted for 5,9%, insurance policies for 3,7%, properties for 1,2% and 0,6% for other investments.

Figure 32: Operating results

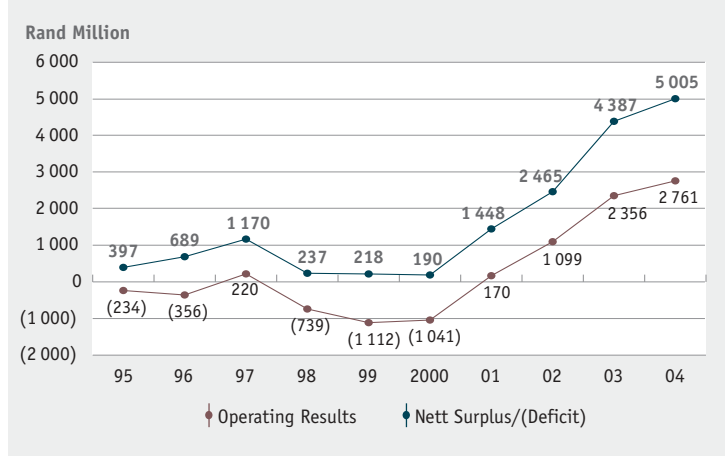


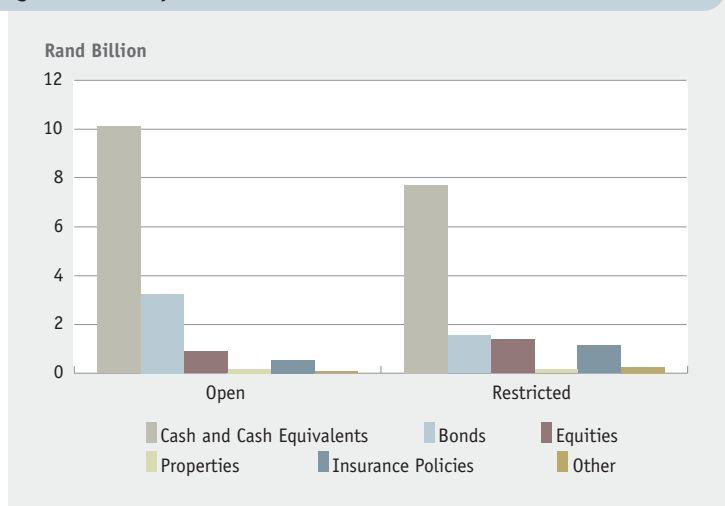
Table 16: Operating results for all schemes since introduction of the new Medical Schemes Act

Year	Surplus/(Deficit) from operations R'000	Net investment and other income R'000	Net surplus/(deficit) R'000	% Growth
2000	(1 040 566)	1 230 398	189 832	
2001	169 725	1 278 153	1 447 878	662,7
2002	1 098 795	1 366 273	2 465 068	70,3
2003	2 356 497	2 030 368	4 386 865	78,0
2004	2 761 092	2 243 551	5 004 643	14,1

Restricted schemes also held a larger proportion of their investments, 63,4%, in cash and cash equivalents. Bonds accounted for 12,7%, equities and insurance policies made up 11,4% and 9,3%, respectively. Other investments and property accounted for smaller proportions; each represented 2,0% and 1,3% respectively of total investments made by restricted schemes.

The primary obligation of a medical scheme is to ensure that it has built up sufficient assets to pay benefits due to members as they fall due. Asset management must therefore be structured to the demands, nature and timing of the expected liabilities of the scheme. A medical scheme should spread its assets in such a manner that it matches its liabilities and minimum accumulated funds at any point in time. Hence, trustees need to monitor investments more closely to ensure not only compliance with Annexure B, but also that appropriate diversification of risk is achieved.

Figure 33: Composition of scheme investments

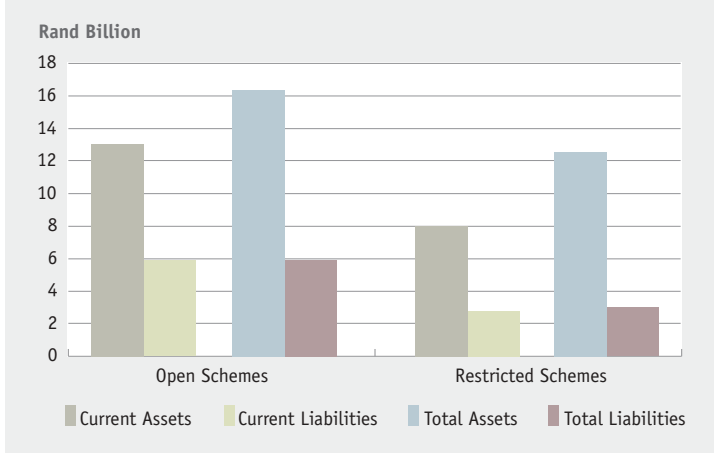


Matching assets and liabilities

The difference between the schemes total assets and its total liabilities represents the liquidity gap. A positive difference indicates that the scheme has sufficient assets to meet its liabilities, while a negative one indicates illiquidity. However, it is key to consider not only the total asset and liability position but also the periods within which liabilities must be paid and assets can be converted to cash flows. This is where the financing risks must be matched.

Figure 34 compares the matching of assets and liabilities in open and restricted schemes. The current assets:current liabilities ratio for open schemes was 2,21, and 2,88 for restricted schemes. The total asset: total liability ratios were 2,76 and 4,17 for open and restricted schemes respectively.

Figure 34: Matching of assets and liabilities



Medical schemes were required to implement accounting standard AC133, with a further requirement during 2004 of preparing a risk management report. This report assesses the various risks that a medical scheme may be exposed to over the short, medium and long term, including the risk to liquidity.

The liquidity analyses were done for periods up to 1 month; 1-3 months and 3-12 months. The quality of the data was in some cases unreliable, with total figures in the liquidity reports not reconciling to the balance sheet. This is dis-

appointing as these are supposedly audited figures. We observed the following with regard to those schemes with a quick ratio (current assets: current liabilities) below 2:

- Generally, these schemes held a high proportion of their total investments in cash;
- For the period up to 3 months, some open schemes had low cash holding, low claims paying ability yet had very high exposures to equity. This is a fairly risky strategy, especially for schemes with no excess reserves. Restricted schemes generally had excess reserves and had low cash holdings, coupled with high exposure to bonds and insurance policies. While the investment strategies were not so conservative, this was buttressed by the existence of excess reserves;
- However, in those cases where the bulk of a medical scheme's investments are held through insurance policies, trustees must consider whether such policies are suitable given the scheme's financial position and short term nature of its liabilities. In this regard, it is also important for trustees to ensure that the investment mandate and policy of the scheme are not only compliant with the requirements of Annexure B of the Act, but also allow for easy cashing in of investments; and
- Similar trends were observed for period up to 1 year both restricted and open schemes. Some schemes had low cash and near cash holdings and more exposure to bonds and equity, and lower than average claims paying ability. In such

cases, trustees must be mindful of the volatility and short-term performance of equities, and the possible capital loss in the case of bond holdings. This is especially critical for the schemes sampled above, whose liquidity ratio was below industry average of 2.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Trustees should guard against longer-term and riskier investment when the scheme's liquidity is well below the industry average.

Net assets, accumulated funds and solvency

The required "minimum accumulated funds" established by Regulation 29 of the Medical Schemes Act increased to 25% of gross contributions at year end December 2004. These "minimum accumulated funds" are more commonly referred to as the "reserves" of a scheme. When expressed as a percentage of gross contributions they reflect the solvency level of the scheme.

Net assets, defined as total assets less total liabilities, rose 35,4% to R20,0bn in 2004 from R14,7bn in 2003 in respect of registered medical schemes. Reserves grew concomitantly by 34,5% to R18,5bn from R13,7bn the year before.

The overall industry average solvency increased as a result, to 36,6% as at December 2004 from 29,3% as at December 2003. This level was more than the prescribed solvency level of 25%. The solvency ratio of open schemes was 27,9% compared with 20,9% in 2003. Restricted schemes continued their high performance and achieved a solvency ratio of 58% compared to 49,6% in 2003. On an industry basis, restricted scheme members have a higher average reserve position per member than members of open schemes. Full details of the solvency levels of the various schemes are detailed in Annexure K and L.

Figures 35, 36 and 37 show the changes in solvency for all schemes, open and restricted schemes respectively, since the implementation of the new Medical Schemes Act. All three figures reflect improvements in the solvency ratios since 2000, with the overall ratio for all registered schemes now exceeding the prescribed minimum 25% level.

Figure 35: Solvency position of all registered schemes

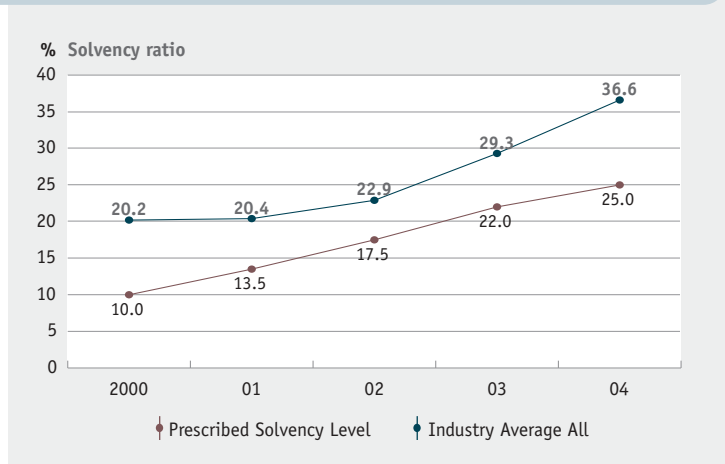


Figure 36: Solvency trends since 2000 for open schemes

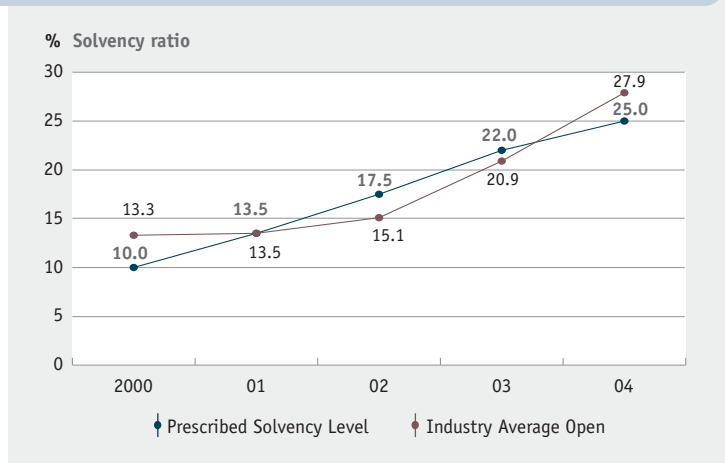


Figure 37: Solvency trends since 2000 for restricted schemes

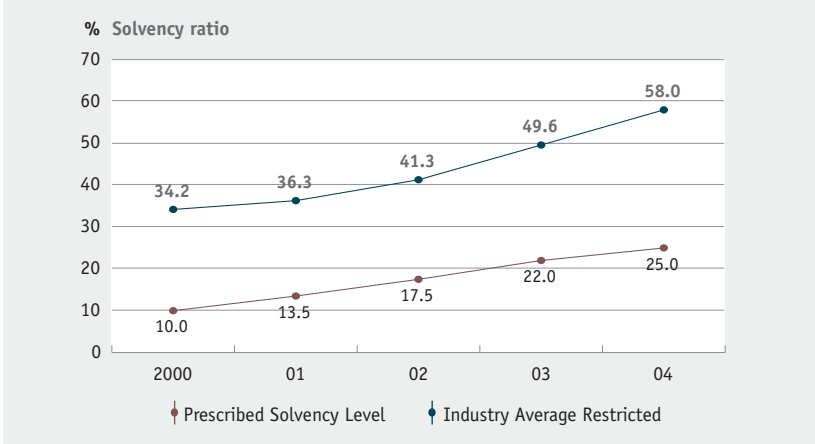


Table 17 shows, for open and restricted schemes, the number of members in the schemes that failed to meet the prescribed solvency level compared to the number of members in schemes that attained the solvency level. The relevant prescribed solvency levels used in the table are 10%, 13,5%, 17,5%, 22% and 25% for 2000, 2001, 2002, 2003 and 2004 respectively.

Table 17: Prescribed solvency levels and number of members

		Open schemes		Restricted schemes	
		Below	Above	Below	Above
		Prescribed Level		Prescribed Level	
Number of medical schemes	2000	15	33	15	86
	2001	19	29	11	83
	2002	24	25	7	86
	2003	19	29	7	80
	2004	18	30	4	81
Membership	2000	2 385 051 (51%)	2 291 048	839 029 (41%)	1 214 412
	2001	2 650 934 (56%)	2 117 142	576 462 (29%)	1 419 862
	2002	3 519 329 (74%)	1 211 882	251 050 (13%)	1 731 873
	2003	3 426 988 (73%)	1 291 809	222 430 (11%)	1 730 574
	2004	2 534 273 (53%)	2 221 030	80 160 (4%)	1 827 100

Table 17 and figure 38 illustrates that, for open schemes, the greater part of members (53%) were in the 18 schemes that failed to meet the prescribed solvency level in 2004 when compared to the number of members in the 30 open schemes that attained the prescribed solvency level of 25%. This figure is skewed considerably by the results of Discovery Health medical scheme. Should this largest open scheme be removed from the analysis, only 20% of the members will be in the group below the prescribed solvency level compared to 53% before. It should also be noted that Discovery has also increased its solvency to over 23%, just below the required 25%. These findings show that today more members of these schemes enjoy greater solvency protection than ever before.

Restricted schemes, on the other hand, had the majority (only 4 of the 85 restricted schemes were below 25%) of their members within those schemes that met the prescribed solvency level.

The Council has also instituted an early-warning system on financial soundness made up of quarterly returns and a review of monthly management accounts in some instances. This early-warning system is intended to enable the Registrar and trustees

to take proactive steps to resolve financial difficulties when they occur. Table 18 compares solvency levels reported in the 2004 final quarterly returns with the solvency as reported in the audited statutory return as at December 2004. We also compared these figures with budgeted estimates provided as part of the quarterly returns. Overall, there were no significant variations between the quarterly and audited results on an industry wide basis. At the level of individual schemes, material changes were generally linked to adjustments made in respect of provisions for outstanding claims and provisions for impaired receivables.

Table 19 represents the budget estimates, the quarterly and audited annual results. Monitoring

Figure 38: Prescribed solvency levels and number of members

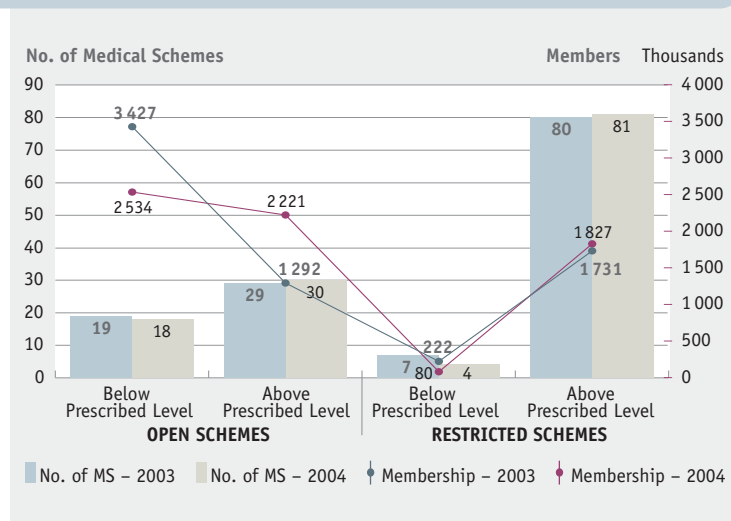


Table 18: Solvency comparison between quarterly, audited annual and budget reports

	Unaudited Actuals 2003	Audited Actuals 2003	% Variance	Budget 2004	Audited Actuals 2004	Unaudited Actuals 2004	Audited vs Unaudited % Variance	Audited vs Budget % Variance
Open schemes	20,96%	20,88%	-0,4%	25,30%	27,63%	27,94%	1,1%	10,4%
Restricted schemes	49,86%	49,57%	-0,6%	50,97%	57,22%	57,95%	1,3%	13,7%
Total Registered schemes	29,40%	29,30%	-0,4%	32,21%	36,17%	36,61%	1,2%	13,7%

Table 19: Comparison of selected indicators

	Budget 2004 PAMPM	Unaudited actuals 2004 PAMPM	Audited actuals 2004 PAMPM	Audited vs Budget % Variance	Audited vs Unaudited % Variance
OPEN SCHEMES					
Gross Contributions	R1 689	R1 607	R1 615	-4.4%	0.5%
Nett Claims Incurred	R1 166	R1 087	R1 085	-7.0%	-0.1%
Total Non-health Expenditure	R248	R244	R249	-0.5%	2.0%
Nett claims ratio	77,09%	76,68%	76,19%	-1.2%	-0.6%
Non-health as a % of GCI	14,68%	15,20%	15,44%	5.2%	1.6%
Average Members	1 958 828	1 912 063	1 900 692	-3.0%	-0.6%
RESTRICTED SCHEMES					
Gross Contributions	R1 791	R1 506	R1 530	-14.6%	1.6%
Nett Claims Incurred	R1 448	R1 178	R1 187	-18.0%	0.8%
Total Non-health Expenditure	R169	R150	R151	-10.4%	0.5%
Nett claims ratio	87,52%	84,87%	84,26%	-3.7%	-0.7%
Non-health as a % of GCI	9,41%	9,98%	9,87%	4.9%	-1.1%
Average Members	680 064	812 825	801 044	17.8%	-1.5%

*PAMPM = per average member per month

the accuracy of the budgeting process is crucial in ensuring that a scheme remains financially viable, and any variance should be closely investigated.

Solvency, claims and non-health expenditure

Table 20 and figure 39 depict the relationships between the solvency position, gross claims ratio and gross non-health expenditure of open schemes since 2000.

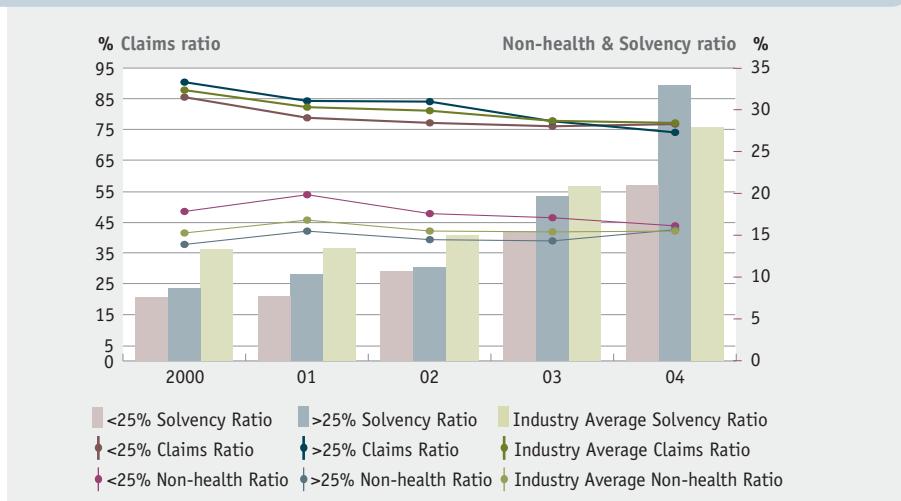
The table shows the results of schemes that were below 25% as at December 2004, and under our close monitoring programme and those that attained 25% after being on close monitoring. New schemes that are below their respective required phase-in solvency levels and schemes that amalgamated during the five-year period were removed from the group for the sake of comparison.

Table 20: Solvency, claims ratio and non-health expenditure in open schemes

	Solvency ratio			Claims ratio			Non-health ratio		
	Industry average	< 25%	> 25%	Industry average	< 25%	> 25%	Industry average	< 25%	> 25%
2000	13,35%	7,62%	8,70%	87,88%	85,59%	90,46%	15,27%	17,84%	13,90%
2001	13,47%	7,73%	10,35%	82,35%	78,90%	84,37%	16,81%	19,84%	15,49%
2002	15,05%	10,74%	11,16%	81,20%	77,26%	84,15%	15,50%	17,58%	14,47%
2003	20,88%	15,53%	19,69%	77,91%	76,15%	77,78%	15,40%	17,09%	14,32%
2004	27,89%	21,03%	32,87%	77,24%	76,86%	74,17%	15,49%	16,12%	15,66%

Table 20 and figure 39 shows that, for schemes under close monitoring, solvency improved by 35,4% during 2004. However, non-health expenditure per beneficiary was 10% higher than the industry average and benefits were below the industry average. These schemes are in some cases only starting now to address the high levels of non-health expenditure and increasing benefits to the open scheme industry average.

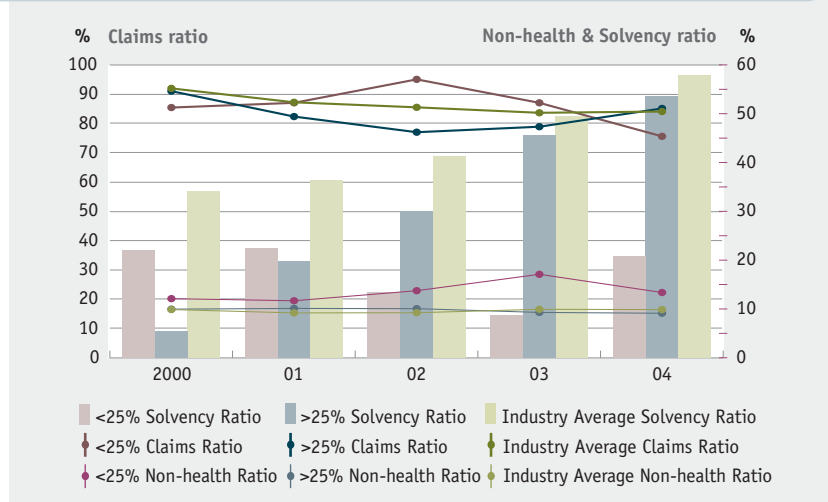
Figure 39: Solvency, claims and non-health expenditure ratios in open schemes



In the case of the 12 schemes which were previously under close monitoring but have now achieved the 25% reserve level, average solvency improved by 277,8% to 32,9% from 8,7% in 2000. Non-health expenditure per beneficiary was 9,4% lower than the industry average while benefits were 14% below the industry average.

Figure 40 depicts the same relationships for restricted schemes and shows that claims ratios in the restricted schemes under close monitoring are generally higher than that of open schemes, although there has been a tendency to reduce benefits instead of non-health expenditure in order to increase solvency. These schemes should pay more attention to reducing non-health expenditure, which is currently still above the restricted scheme industry average.

Figure 40: Solvency, claims and non-health in restricted schemes



Risk assessment framework, high impact medical schemes and solvency

The risk assessment regulatory framework that was adopted in 2003 has allowed us to categorize schemes into three impact bands – low, medium and high – on the basis of the systemic impact that a scheme’s failure might have on Council’s goals and the industry.

Table 21 below shows the solvency position of the 25 schemes categorised as high impact. Three (3) high impact schemes had solvency below 15% (2003: 5); five showed solvency between 15% and 22% (2003: 7); while the remaining 17 schemes were above the 25% prescribed solvency (2003: 13).

Table 21: High-impact schemes per type

Type of scheme	Average beneficiaries		Contributions PABPM		Gross claims ratio		Gross non-health ratio		Solvency ratio	
	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003
Open	4 040 067	4 022 084	R662	R616	77,19%	77,69%	15,23%	15,35%	26,95%	19,52%
Restricted	870 035	861 658	R621	R585	85,52%	82,17%	9,77%	10,26%	49,26%	42,43%
Total	4 910 102	4 883 742	R654	R610	78,59%	78,45%	14,31%	14,49%	30,78%	23,49%

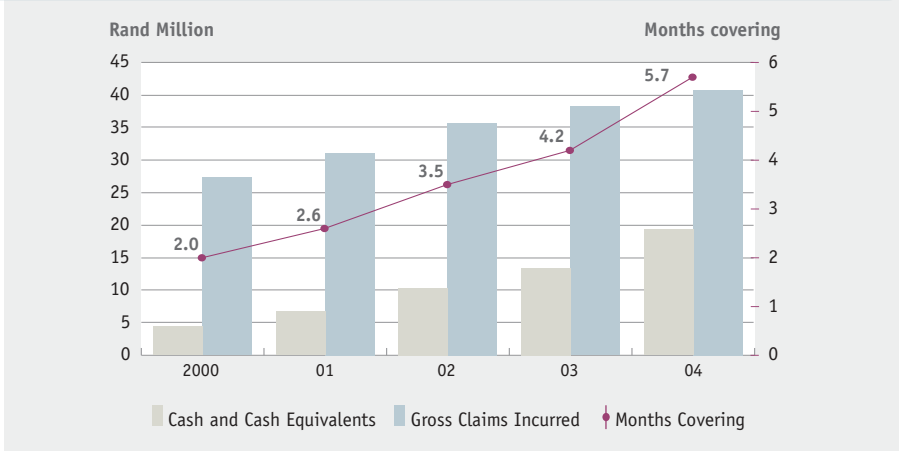
*PABPM = per average beneficiary per month

Claims paying ability of medical schemes

A scheme’s financial soundness is also measured by its ability to pay claims from cash and cash equivalents in the immediate future. Figure 41 depicts the claims paying ability of schemes measured in months of cover. This is the number of months’ claims that the scheme is able to cover from its existing cash and cash equivalents. The cash coverage improved by 35,7% to 5,7 from 4,2 months in 2004, implying that schemes in general have improved their claims paying ability.

Schemes’ payment cycles reflect a similar trend of 22,9 days compared to the 22,4

Figure 41: Average gross claims covered by cash and cash equivalents



days in 2003. The provision for outstanding claims, in terms of months' coverage, has improved from 0,9 month to 0,8 months. The reduction in the provision for unpaid claims reflects an improvement in schemes ability to pay claims more timely. Details of individual scheme's claims paying ability are outlined in Annexure N.

Medical schemes benefit options during 2004

There were 420 (2003: 415) benefit options in registered medical schemes during 2004. Open schemes accounted for 260 (61,9%) of benefit options (2003: 253 options or 61,0%). Restricted membership schemes had 160 (38,1%) of all registered options (2003: 162 options or 39,0%). Open schemes had, on average, 5,4 options per scheme with an average membership of 7 400 per option. Restricted schemes had an average of 1,9 options per schemes with an average membership

Table 22: Benefit options for open and restricted schemes

	Open schemes	Restricted schemes	Total
All benefit options			
Number of options	260 (61,9%)	160 (38,1%)	420 (100%)
Membership representing	1 924 343 (70,9%)	791 921 (29,1%)	2 716 264 (100%)
Number of Schemes	48 (36,1%)	85 (63,9%)	133 (100%)
Surplus from operations pmpm	R89,88	R69,76	R84,01
Average GCI pbpm	R642,42	R630,50	R639,02
Options with members > 2 500	42,3%	45,6%	43,6%
Number of options	110 (60,1%)	73 (39,9%)	183 (100%)
Membership representing	1 800 525 (71,8%)	706 145 (28,2%)	2 506 670 (100%)
Number of Schemes	38 (41,3%)	54 (58,7%)	92 (100%)
Surplus from operations pmpm	R95,82	R68,64	R88,16
Average GCI pbpm	R638,12	R628,52	R635,47
Options with members < 2 500	57,7%	54,4%	56,4%
Number of options	150 (63,3%)	87 (36,7%)	237 (100%)
Membership representing	123 818 (59,1%)	85 776 (40,9%)	209 594 (100%)
Number of Schemes	42 (43,8%)	54 (56,2%)	96 (100%)
Surplus from operations pmpm	R3,46	R79,01	R34,38
Average GCI pbpm	R710,77	R647,49	R684,57

*GCI pbpm = Gross contribution income per beneficiary per month

*PMPM = per member per month

of 4 950 per option.

The number of benefit options with fewer than 2 500 members increased to 56,4% (237 options in 2004) from 55,4% (230) the year before. There were 150 (57,7%) open schemes benefit options with less than 2 500 members and 87 (54,4%) restricted schemes options with less than 2 500 members.

One hundred (42,2%) of options with less than 2,500 members incurred operating losses in 2004 compared with 74 options (32,2%) in 2003.

The remaining 183 options (2003:185) had more than 2 500 members per option - averaging 13 698 members per option. Of these, 70 options representing 38,3% incurred operating losses (2003: 56 options representing 30,3%).

It would thus appear that options with less than 2 500 members are more likely to incur operating losses. They also have higher contributions and attract higher administration costs than other options.

Table 23: Results of loss-making options

	Open schemes	Restricted schemes	Total
Loss making options			
Representing of total options	43,9%	35,0%	40,5%
Number of options	114 (67,1%)	56 (32,9%)	170 (100%)
Membership representing	522 474 (67,3%)	253 458 (32,7%)	775 932 (100%)
Number of schemes	42 (54,6%)	35 (45,4%)	77 (100%)
Deficit from operations pmpm	(R126,05)	(R95,91)	(R116,20)
Average GCI pbpm	R773,90	R648,66	R734,84
Loss making options with member < 2 500			
Number of options	69 (69,0%)	31 (31,0%)	100 (100%)
Membership representing	52 810 (67,5%)	25 453 (32,5%)	78 263 (100%)
Number of schemes	34 (61,8%)	21 (38,2%)	55 (100%)
Deficit from operations pmpm	(R193,87)	(R206,28)	(R197,91)
Average GCI pbpm	R854,61	R727,53	R812,38
Loss making options with member > 2 500			
Number of options	45 (64,3%)	25 (35,7%)	70 (100%)
Membership representing	469 664 (67,3%)	228 005 (32,7%)	697 669 (100%)
Number of schemes	27 (61,4%)	17 (38,6%)	44 (100%)
Deficit from operations pmpm	(R118,42)	(R83,59)	(R107,04)
Average GCI pbpm	R765,51	R639,56	R726,51

*GCI pbpm = Gross contribution income per beneficiary per month

*PMPM = per member per month

Of the 420 benefit options within registered schemes during 2004, 170 (40,5%) incurred operating losses. 114 (67,1%) of the loss making options were in open schemes and 56 (32,9%) were in restricted membership schemes. The options with less than 2,500 members realised an average R198 pmpm operating loss. Those with more than 2 500 members made an average operating loss of R107 pmpm, or a loss 1,85 times lower than the former options.

Table 24: Comparison of profit and loss-making options' results

	Open schemes			Restricted schemes		
	Profit making options	Loss making options	% variance	Profit making options	Loss making options	% variance
Number of options	146	114		104	56	
Representing	56,1%	43,9%		65,0%	35,0%	
Average GCI pbpm	R597,46	R773,90	-22,8%	R623,16	R648,66	-3,9%
Claims ratio	68,44%	93,08%	-26,5%	79,07%	96,86%	-18,4%
Administration ratio	11,19%	9,73%	15,0%	7,00%	6,91%	1,3%

*GCI PBPM = gross contribution income per beneficiary per month

Table 24 illustrates that open schemes had a higher prevalence of loss making options compared to restricted medical schemes. Many of the open scheme options were also more expensive while offering fewer benefits.

The fundamental policies underpinning the Medical Schemes Act are community rating of contributions, cross subsidisation by different risk profiles and open enrolment. The proliferation of benefit options cuts across and undermines these principles by reducing the size of the risk pools and may well result in a new form of risk rating. Members requiring specialised and chronic cover may well be herded onto more expensive benefit options, which end up with smaller risk pools and invariably incur losses.

Administrator market in 2004

Figure 42 illustrates the market share of administrators as well as self-administered schemes, based on the number of beneficiaries administered at December 2004.

Figure 42: Market share based on the number of beneficiaries

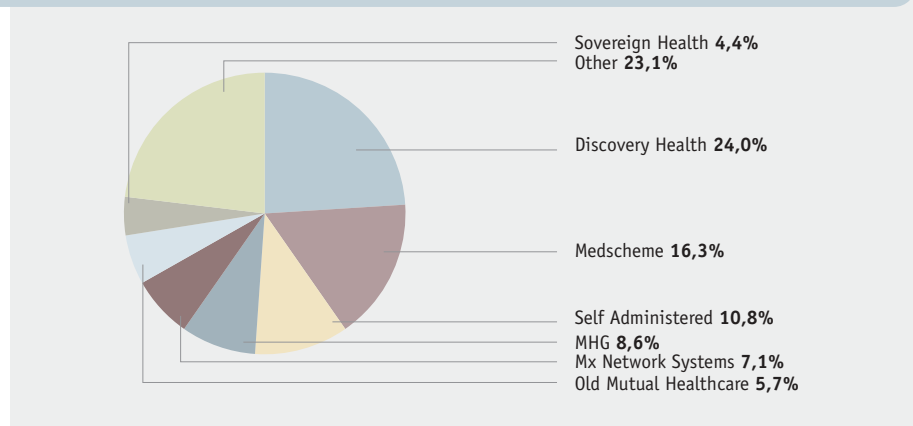


Figure 43 depicts the changes in the market share since 2000 for all schemes based on the number of beneficiaries as administered by the various parties at December of each year.

The market is dominated by five large administrators who, together, hold 66% of the market. Sovereign Health was owned by Medscheme Holdings at end of the year under review.

Figures 44 and 45 indicate the change in market shares for the five largest administrators based on beneficiaries of open and restricted schemes, respectively. Discovery Pty (Ltd) has increased its share of the open scheme market to 30% in 2004 from 15% in 2000. The large drop in market share of Medscheme in the restricted market in 2002 was due to the movement of one scheme.

Figure 43: Market share of all administrators based on the number of beneficiaries

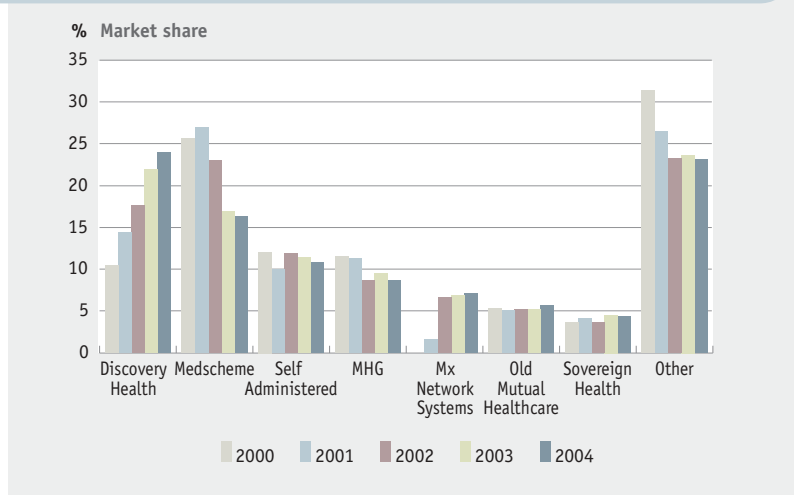


Figure 44: Market share of five largest administrators in the open schemes market

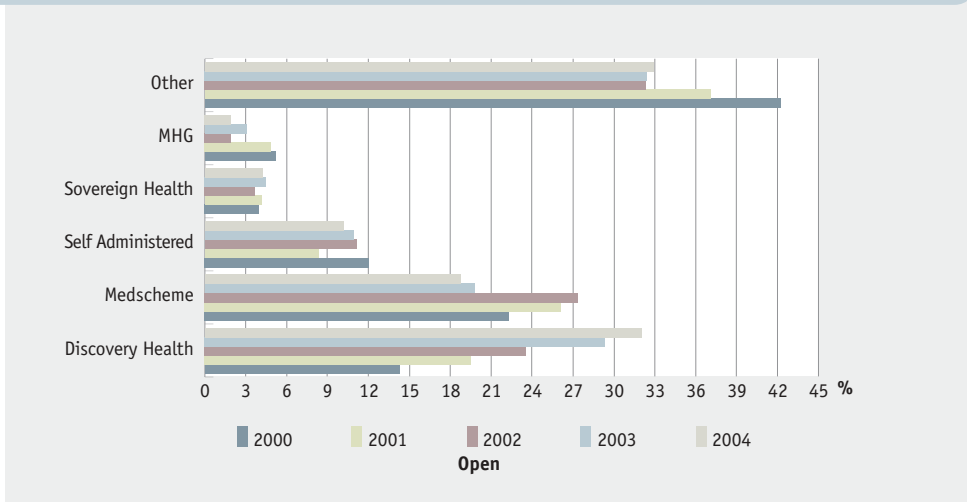
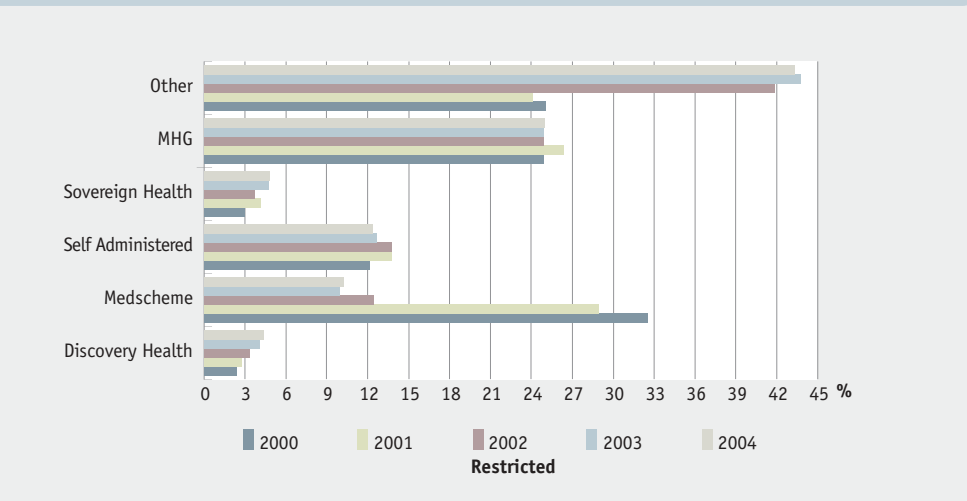


Figure 45: Market share of five largest administrators in the restricted schemes market



Despite the concentration of market power in the large administrators, there appears to be little or no economies of scale reflected in the level of administration fees. Administration fees paid by open schemes to the five largest administrators were between 20% and 40% higher than the average for open scheme market. Fees paid by restricted schemes were 30% to 50% higher than the market aver-

Table 25: Administrator market share since 2000 based number of beneficiaries – open schemes

Name of Administrator	No of Schemes	Beneficiaries Market Share 2004 %	Gross Administration Costs		Fees paid to administrators		Gross Contributions	Risk Claims Ratio
			PABPM 2004 R	As % of GCI 2004 %	PABPM 2004 %	As % of GCI 2004 R	PABPM 2004 %	2004
Discovery Health (Pty) Ltd	1	32,02%	84,72	11,84%	68,78	9,62%	715,26	68,67%
Medscheme (Pty) Ltd	4	18,77%	51,99	8,68%	39,09	6,53%	598,97	78,75%
Self administered	7	10,16%	65,65	7,77%	-	0,00%	845,29	86,26%
Old Mutual Healthcare (Pty) Ltd	4	5,09%	61,68	11,85%	50,97	9,79%	520,47	83,98%
Exclusive Health (Pty) Ltd	1	4,63%	89,51	17,17%	56,90	10,91%	521,42	58,26%
Sovereign Health - Division of Medscheme Holdings	4	4,22%	62,02	8,40%	54,23	7,35%	738,28	81,55%
Allcare Administrators (Pty) Ltd	3	3,86%	58,43	12,43%	50,23	10,69%	469,92	82,03%
Rowan Angel (Pty) Ltd	1	3,74%	54,25	11,13%	46,82	9,61%	487,37	68,16%
Sizwe Medical Services (Pty) Ltd	1	3,32%	66,29	10,50%	53,53	8,48%	631,30	70,10%
Multimed	1	2,48%	63,24	8,77%	46,77	6,48%	721,35	87,43%
Sigma Health Fund Managers (Pty) Ltd	1	2,48%	57,80	9,48%	30,72	5,04%	609,92	92,50%
Metropolitan Health Corporate (Pty) Ltd	2	1,92%	74,86	10,96%	39,99	5,85%	683,34	88,40%
Medical Aid Administration Experts (Pty)Ltd	1	1,43%	123,91	25,94%	49,84	10,43%	477,76	54,97%
Amanzi Health Administrators (Pty) Ltd	1	1,32%	63,40	9,92%	50,14	7,84%	639,30	91,86%
Status Medical Aid Administrators (Pty) Ltd	5	1,27%	73,66	10,54%	65,00	9,30%	699,14	82,92%
Prosperity Health Corporate Fund Managers (Pty)Ltd	2	0,87%	63,48	16,62%	43,40	11,36%	381,94	79,04%
African Life Health (Pty) Ltd	1	0,64%	52,24	14,21%	23,85	6,49%	367,51	75,72%
Definiti Medical Fund Managers (Pty) Ltd	1	0,48%	62,61	16,39%	54,44	14,25%	381,90	74,64%
Private Health Administrators	1	0,38%	99,00	15,88%	57,60	9,24%	623,54	79,94%
Hall Adminstrator cc	1	0,32%	114,88	25,12%	74,95	16,39%	457,38	63,48%
Integrated Healthcare (Pty) Ltd	1	0,27%	41,13	8,83%	36,71	7,88%	465,60	72,64%
Benmed Medical Scheme Administrators (Pty) Ltd	1	0,15%	92,81	15,66%	58,19	9,82%	592,47	69,93%
Supreme Health Administrators (Pty) Ltd	1	0,08%	8,12	12,96%	7,85	12,54%	62,64	96,04%
Thebe ya Bophelo Healthcare Administration	1	0,06%	39,78	13,76%	31,80	11,01%	288,97	61,87%
Mx Network Systems (Pty) Ltd	1	0,05%	106,34	26,07%	18,66	4,57%	407,91	59,94%
Active Health	1	0,01%	37,95	10,11%	24,59	6,55%	375,28	85,13%
Average			70,17	10,79%	48,70	7,49%	650,57	76,19%

age for restricted schemes.

The open scheme market has shown a significant swing from self-administration to the large third party administrators, while restricted schemes have not seen the same movement from self administered towards the large third party administrators.

Tables 25 and 26 illustrates the market share based on the number of beneficiaries to whom services are being delivered by third party administrators as well as those beneficiaries of self administered schemes, and the average cost of administration. Gross administration costs comprise administration costs charged both to the risk pool and to the savings accounts. The administration fee includes co-administration fees as well. It should also be noted that although Sovereign Health was a division of Medscheme, its results have been disclosed separately.

Table 26: Administrator market share since 2000 based number of beneficiaries – restricted schemes

Name of Administrator	No of Schemes	Beneficiaries Market Share 2004 %	Gross Administration Costs		Fees paid to administrators		Gross Contributions	Risk Claims Ratio
			PABPM 2004 R	As % of GCI 2004 %	PABPM 2004 %	As % of GCI 2004 R	PABPM 2004 %	2004
Metropolitan Health Corporate (Pty) Ltd	14	24,97%	45,19	7,17%	35,67	5,66%	630,67	88,22%
Mx Network Systems (Pty) Ltd	2	24,38%	36,52	5,93%	31,23	5,07%	616,07	80,31%
Self administered	13	12,33%	36,52	6,47%	0,97	0,17%	564,26	85,88%
Medscheme (Pty) Ltd	18	10,19%	41,60	5,61%	33,84	4,57%	740,92	82,50%
Old Mutual Healthcare (Pty) Ltd	9	7,25%	38,01	6,59%	43,50	7,54%	577,15	95,19%
Sovereign Health -Division of Medscheme Holdings	7	4,80%	58,33	7,84%	51,06	6,86%	743,91	80,03%
Discovery Health (Pty) Ltd	8	4,39%	55,63	9,72%	46,61	8,14%	572,48	84,02%
PPS Insurance Co Ltd	1	3,63%	63,68	10,85%	54,86	9,34%	587,16	74,79%
Providence Healthcare Risk Managers (Pty) Ltd	2	1,91%	54,74	8,43%	46,71	7,19%	649,38	70,25%
Eternity Private Health (Pty) Ltd	1	1,73%	93,85	11,41%	82,28	10,01%	822,22	82,24%
Allcare Administrators (Pty) Ltd	5	1,63%	64,51	9,48%	57,37	8,43%	680,69	95,07%
Status Medical Aid Administrators (Pty) Ltd	4	1,53%	42,39	6,82%	35,43	5,71%	621,09	88,05%
Mpumalanga Managed Health Care (Pty) Ltd	1	0,78%	34,93	4,71%	-	0,00%	741,68	89,85%
Amanzi Health Administrators (Pty) Ltd	1	0,36%	78,06	11,88%	65,63	9,99%	657,14	85,52%
Integrated Healthcare (Pty) Ltd	1	0,10%	64,96	9,43%	57,86	8,40%	689,16	69,64%
Average			44,24	6,99%	33,83	5,34%	632,94	84,26%

Compliance

with submission of audited financial statements and statutory returns

Section 37 of the Act requires that every medical scheme submit to the Registrar its audited annual financial statements and statutory returns by 30 April in respect of its financial year. A number of faulty or incomplete returns have once again delayed the processing of the data. Better co-operation from the schemes in this regard will be appreciated.

The following medical schemes submitted their documentation after the deadline required by the Act. Section 66(3) requires that penalties be imposed on such schemes unless good cause can be shown for the late submission of the returns.

1. Baymed (auditor's management report + investment schedule)
2. Bestmed (auditor's management report)
3. Bonitas (auditor's management report + BOT report)
4. Commed (all required returns)
5. Eclipse (auditor's management report)
6. Free State (auditor's management report)
7. Hosmed (all required returns)
8. Ingwe (auditor's management report)
9. Liberty (all required returns)
10. Lifemed (all required returns)
11. Munimed (all required returns)
12. Protector (all required returns)
13. Thebemed (AFS, BOT report & auditor's management report)
14. ABI (auditor's management report)
15. AECI (auditor's management report)
16. Aranda (all required returns)
17. CAMAF (all required returns)
18. Mascom (auditor's management report)
19. Moremed (all required returns)
20. Naspers (all required returns)
21. Old Mutual Staff (BoT Report)
22. Parmed (auditor's management report)
23. Profmed (auditor's management report)
24. Randwater (all required returns)
25. Polmed (auditor's management report)
26. Transmed (auditor's management report)
27. Umed (auditor's management report)
28. Umvuzo (auditor's management report)
29. Polprised (all required returns)

The following schemes' financial statements and/or returns were initially rejected in terms of Section 38. The necessary changes have been made by the schemes and revised financial statements have been submitted.

Ref no.	Name
1589	Baymed
1121	Klerksdorp Medical Benefit Society (KDM)
1214	Old Mutual Staff Medical Aid Scheme
1587	Pathfinder Medical Scheme
1454	Pro Sano Medical Scheme
1196	Protea Medical Aid Society
1575	Resolution Health Medical Scheme
1531	Sedmed
1544	Tiger Brands Medical Scheme
1582	Transmed Medical Fund

The following schemes' financial statements and/or returns were rejected. The necessary changes have been made in accordance with the Registrar's interpretation of the events. The revised financial statements have not yet been resubmitted by the schemes at time of printing.

Ref no.	Name
1170	NBC Medical Scheme
1158	Cawmed Medical Scheme
1561	Gen-Health Medical Scheme
1149	Medihelp
1557	Samancor Health Plan
1147	Telemed
1486	Sizwe Medical Fund
1565	Venda Police and Prisons Medical Scheme (Polprised)

Composition of the Council during 2004-5

The composition of Council was as follows during the year under review:

Chairperson

Dr Nicky Padayachee, Formerly Dean of the Faculty of Health Sciences, University of Cape Town.

Deputy Chairperson

Ms. Gando Matyumza, General Manager, Eskom KZN.

Dr. Siva Pillay, Medical Practitioner in Uitenhage, Eastern Cape until 30 July 2004.

Professor Heather McLeod, Associate Professor of Actuarial Science, University of Cape Town

Dr. Reno Morar, Director, Cape Clothing Benefit Fund

Dr. Kamy Chetty, Deputy-Director-General, National Department of Health.

Dr. Jakes Jekwa, Medical Practitioner, East London

Mr. Barry Crookes, Formerly CEO of Old Mutual Employee Benefits division, Retired Actuary

Mr. Boissie Mbha, Attorney in private practice and Acting Judge of the High Court – until May 2004.

Ms. Nomonde Mgumane, Senior Consultant in mediation and arbitration.

Mr John Murphy, Acting Judge of the Labour Court and former Pension Funds Adjudicator

Dr. MS Kariem, Chief Operations Officer, Groote Schuur Hospital, University of Cape Town

Consolidated balance sheet as at 31 December 2004

	REGISTERED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			Per Average Member			Per Average Beneficiary		
	2004	2003	%	2004	2003	%	2004	2003	%	2004	2003	%	2004	2003	%
	R'000	R'000	Change	R'000	R'000	Change	R'000	R'000	Change	R	R	Change	R	R	Change
ASSETS															
Non-current Assets	7 900 570	7 048 090	12,10	19 100	257 153	-92,57	7 919 670	7 305 242	8,41	2 812,75	2 645,84	6,31	1 148,09	1 065,61	7,74
Property, Plant and Equipment	229 520	119 808	91,57	5 082	5 486	-7,37	234 601	125 293	87,24	83,32	45,38	83,61	34,01	18,28	86,08
Investments	7 665 749	6 928 282	10,64	14 018	251 667	-94,43	7 679 767	7 179 949	6,96	2 727,54	2 600,46	4,89	1 113,32	1 047,33	6,30
Other Non-current Assets	5 302	-	N/A	-	-	0,00	5 302	-	N/A	1,88	-	N/A	0,77	-	N/A
Current Assets	21 033 245	15 798 664	33,13	525 719	193 467	171,74	21 558 964	15 992 130	34,81	7 656,87	5 792,10	32,20	3 125,35	2 332,75	33,98
Inventories	19 111	2 427	687,55	961	1 003	-4,12	20 073	3 429	485,33	7,13	1,24	473,98	2,91	0,50	481,71
Accounts Receivable	1 734 324	2 355 331	-26,37	78 396	59 427	31,92	1 812 720	2 414 758	-24,93	643,80	874,59	-26,39	262,79	352,24	-25,40
Cash and Cash Equivalents	19 279 809	13 440 906	43,44	446 362	133 037	235,52	19 726 171	13 573 943	45,32	7 005,94	4 916,27	42,51	2 859,65	1 980,02	44,43
Total Assets	28 933 815	22 846 753	26,64	544 819	450 619	20,90	29 478 634	23 297 373	26,53	10 469,62	8 437,94	24,08	4 273,44	3 398,36	25,75
FUNDS AND LIABILITIES															
Members' Funds	19 999 605	14 774 711	35,36	439 379	367 329	19,61	20 438 984	15 142 040	34,98	7 259,10	5 484,21	32,36	2 962,98	2 208,75	34,15
Accumulated Funds	18 232 507	13 426 416	35,80	438 741	366 690	19,65	18 671 248	13 793 106	35,37	6 631,27	4 995,64	32,74	2 706,72	2 011,99	34,53
Revaluation Reserve - Investments	703 037	417 895	68,23	326	326	0,00	703 362	418 221	68,18	249,81	151,47	64,92	101,96	61,01	67,14
Revaluation Reserve - Property, Plant and Equipment	20 878	6 399	226,25	-	-	0,00	20 878	6 399	226,25	7,41	2,32	219,92	3,03	0,93	224,23
Reserves Set Aside for Specific Purposes	550 375	487 562	12,88	-	-	0,00	550 375	487 562	12,88	195,47	176,59	10,69	79,79	71,12	12,19
Other Reserves	492 808	436 439	12,92	313	313	0,00	493 121	436 752	12,91	175,14	158,18	10,72	71,49	63,71	12,21
Non-current Liabilities	268 564	194 739	37,91	2 911	2 293	26,94	271 475	197 032	37,78	96,42	71,36	35,11	39,35	28,74	36,93
Borrowings	85 700	49 219	74,12	-	129	-100,00	85 700	49 348	73,66	30,44	17,87	70,29	12,42	7,20	72,59
Other Non-current Liabilities	182 864	145 520	25,66	2 911	2 164	34,52	185 775	147 684	25,79	65,98	53,49	23,35	26,93	21,54	25,02
Current Liabilities	8 665 646	7 877 303	10,01	102 529	80 997	26,58	8 768 175	7 958 300	10,18	3 114,10	2 882,37	8,04	1 271,10	1 160,87	9,50
Savings Plan Liability	3 697 416	3 063 866	20,68	361	797	-54,71	3 697 777	3 064 663	20,66	1 313,30	1 109,97	18,32	536,06	447,04	19,91
Accounts Payable	2 505 498	2 200 648	13,85	51 966	36 475	42,47	2 557 463	2 237 123	14,32	908,31	810,25	12,10	370,75	326,33	13,61
Provision for Outstanding Claims	2 462 732	2 612 788	-5,74	50 202	43 726	14,81	2 512 934	2 656 514	-5,40	892,49	962,15	-7,24	364,29	387,50	-5,99
Total Funds and Liabilities	28 933 815	22 846 753	26,64	544 819	450 619	20,90	29 478 634	23 297 373	26,53	10 469,62	8 437,94	24,08	4 273,44	3 398,36	25,75

Consolidated income statement for the year ended 31 December 2004

	REGISTERED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			PAMP			PABPM		
	2004 R'000	2003 R'000	% Change	2004 R'000	2003 R'000	% Change	2004 R'000	2003 R'000	% Change	2004 R	2003 R	% Change	2004 R	2003 R	% Change
Gross Contribution Income (Savings Contribution Income)	51 531 439	48 031 615	7,29	679 478	603 622	12,57	52 210 917	48 635 237	7,35	1 545,27	1 467,91	5,27	630,74	591,20	6,69
(Net Claims Incurred)	(5 498 064)	(5 044 339)	8,99	(543)	(757)	-28,28	(5 498 607)	(5 045 095)	8,99	-162,74	-152,27	6,88	-66,43	-61,33	8,32
Own Facility Surplus/(Deficit)	(36 166 094)	(34 026 289)	6,29	(545 486)	(485 267)	12,41	(36 711 580)	(34 511 556)	6,37	-1 086,54	-1 041,63	4,31	-443,50	-419,51	5,72
	(9 075)	(2 198)	312,84	(19 883)	(18 115)	9,76	(28 958)	(20 313)	42,56	-0,86	-0,61	39,79	-0,35	-0,25	41,68
Gross Underwriting Results (Administration Expenditure)	9 858 205	8 958 790	10,04	113 566	99 483	14,16	9 971 771	9 058 273	10,08	295,13	273,40	7,95	120,47	110,11	9,40
(Managed care: Management Services)	(4 981 554)	(4 507 526)	10,52	(50 703)	(56 854)	-10,82	(5 032 257)	(4 564 379)	10,25	-148,94	-137,76	8,11	-60,79	-55,48	9,57
(Broker Fees)	(1 231 543)	(1 101 548)	11,80	(20 056)	(9 648)	107,87	(1 251 599)	(1 111 196)	12,64	-37,04	-33,54	10,45	-15,12	-13,51	11,94
Nett Re-insurance Surplus/(Deficit)	(704 102)	(581 304)	21,12	-	-	0,00	(704 102)	(581 304)	21,12	-20,84	-17,54	18,78	-8,51	-7,07	20,38
	(7 825)	(123 335)	-93,66	-	-	0,00	(7 825)	(123 335)	-93,66	-0,23	-3,72	-93,78	-0,09	-1,50	-93,69
Nett Underwriting Results (Impaired Receivables Written Off)	2 933 181	2 645 077	10,89	42 808	32 981	29,79	2 975 989	2 678 058	11,12	88,08	80,83	8,97	35,95	32,55	10,44
(Increase)/Decrease in Provision for Impaired Receivables	(246 822)	(1 69 993)	45,20	-	(60)	100,00	(246 822)	(1 70 053)	45,14	-7,31	-5,13	42,33	-2,98	-2,07	44,25
	7 239	4 024	79,88	-	-	0,00	7 239	4 024	79,88	0,21	0,12	76,39	0,09	0,05	78,76
	28 159	(155 270)	118,14	(3 473)	(262)	1224,11	24 686	(155 532)	115,87	0,73	-4,69	115,56	0,30	-1,89	115,77
Surplus/(Deficit) from Operations Other Income/(Expenditure)	272 1757	2 323 838	17,12	39 335	32 659	20,44	2 761 092	2 356 497	17,17	81,72	71,12	14,90	33,36	28,64	16,45
Nett Investment Income	247 037	213 794	15,55	399	(525)	175,90	247 435	213 269	16,02	7,32	6,44	13,77	2,99	2,59	15,30
Unrealised Gains/(Losses) on Re-measurement of Financial Instruments and Investment Properties	1 492 868	1 620 621	-7,88	30 932	37 739	-18,04	1 523 800	1 658 359	-8,11	45,10	50,05	-9,90	18,41	20,16	-8,68
Realised Gains/(Losses) on Disposal of Financial Instruments and Investment Properties	223 793	155 739	43,70	3 406	-	N/A	227 199	155 739	45,88	6,72	4,70	43,05	2,74	1,89	44,98
Surplus/(Deficit) on Sale of Property, Plant and Equipment	37 994	(1 433)	2751,49	-	(64)	100,00	37 994	(1 497)	2637,41	1,12	-0,05	2588,19	0,46	-0,02	2621,72
(Impairment Losses on Financial Instruments and Property Plant and Equipment)	198 207	(11 166)	1875,03	-	-	0,00	198 207	(11 166)	1875,03	5,87	-0,34	1840,60	2,39	-0,14	1864,06
Reversal of Previous Recognised Impairment Losses on Financial Instruments and Property, Plant and Equipment	9 279	22 067	-57,95	-	-	0,00	9 279	22 067	-57,95	0,27	0,67	-58,77	0,11	0,27	-58,21
	(161)	7 612	-102,12	162	34	380,35	0	7 645	-100,00	0,00	0,23	-100,00	0,00	0,09	-100,00
	(363)	(14 918)	-97,56	-	-	0,00	(363)	(14 918)	-97,56	-0,01	-0,45	-97,61	-0,00	-0,18	-97,58
	-	871	-100,00	-	-	0,00	-	871	-100,00	-	0,03	-100,00	-	0,01	-100,00
NETT SURPLUS/(DEFICIT)	4 930 410	4 317 023	14,21	74 233	69 842	6,29	5 004 643	4 386 865	14,08	148,12	132,40	11,87	60,46	53,33	13,38

Notes:

- PAMP = per average member per month
- PABPM = per average beneficiary per month

Consolidated statement of changes in funds and reserves for the year ended 31 December 2004

	REGISTERED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			Per Average Member			Per Average Beneficiary			
	2004	2003	%	2004	2003	%	2004	2003	%	2004	2003	%	2004	2003	%	
	R'000	R'000	Change	R'000	R'000	Change	R'000	R'000	Change	R	R	Change	R	R	Change	
ACCUMULATED FUNDS																
Balances at the Beginning of the Year	13 449 766	9 269 332	45.10	364 682	300 136	21.51	13 814 448	9 569 468	44.36	4 906	3 466	41.56	2 003	1 396	43.47	
- As Previously Reported	13 426 416	9 229 085	45.48	366 690	299 469	22.45	13 793 106	9 528 554	44.76	4 899	3 451	41.95	2 000	1 390	43.86	
- Prior Year Adjustment	23 350	441	5 199.05	(2 008)	667	-400.00	21 343	1 108	1826.36	8	0	1789.00	3	0	1814.46	
- AC 133 Transition Adjustment	-	39 806	-100.00	-	-	0.00	-	39 806	-100.00	-	14	-100.00	-	6	-100.00	
Nett Surplus/(Deficit) for the Year	4 930 410	4 317 023	14.21	74 233	69 842	6.29	5 004 643	4 386 865	14.08	1 777	1 589	11.87	726	640	13.38	
Unrealised Gains/(Losses) on Re-measurement of Financial Instruments and Investment Properties	(2 383)	(3 510)	-32.12	-	-	0.00	(2 383)	(3 510)	-32.12	-1	-1	-33.43	-0	-1	-32.54	
Transfer to/(from) Accumulated Funds	(56 466)	(42 323)	33.42	-	(3 202)	100.00	(56 466)	(45 526)	24.03	-20	-16	21.63	-8	-7	23.26	
- Due to Amalgamation	7 349	(4 772)	253.99	0	(251)	100.00	7 349	(5 023)	246.30	3	-2	243.46	1	-1	245.39	
- Due to Re-measurement of Financial Instruments and Investment Properties	(8 581)	(52 349)	-83.61	-	-	0.00	(8 581)	(52 349)	-83.61	-3	-19	-83.93	-1	-8	-83.71	
- Other Transfers	(55 233)	14 798	-473.25	(0)	(2 951)	-100.00	(55 233)	11 847	-566.23	-20	4	-557.19	-8	2	-563.35	
Other	(88 820)	(114 106)	-22.16	(175)	(85)	104.20	(88 994)	(114 191)	-22.07	-32	-41	-23.58	-13	-17	-22.55	
Balances at the End of the Year	18 232 507	13 426 416	35.80	438 741	366 690	19.65	18 671 248	13 793 106	35.37	6 631	4 996	32.74	2 707	2 012	34.53	
REVALUATION RESERVE (INVESTMENTS)																
Balances at the Beginning of the Year	417 405	217 908	91.55	326	326	0.00	417 731	218 234	91.41	148	79	87.70	61	32	90.23	
- As Previously Reported	417 895	248 514	68.16	326	326	0.00	418 221	248 839	68.07	149	90	64.81	61	36	67.03	
- Prior Year Adjustment	(490)	67	-834.59	-	-	0.00	(490)	67	-834.59	-0	0	-820.35	-0	0	-830.05	
- AC 133 Transition Adjustment	-	(30 672)	100.00	-	-	0.00	-	(30 672)	100.00	-	-11	100.00	-	-4	100.00	
Unrealised Gains/(Losses) on Re-measurement of Investments	328 984	218 272	50.72	-	-	0.00	328 984	218 272	50.72	117,00	79	47.80	48	32	49.79	
Transfer (to)/from Income Statement on Disposal of Investments	(16 527)	(4 398)	275.78	-	-	0.00	(16 527)	(4 398)	275.78	-6	-2	268.49	-2	-1	273.46	
Transfer (to)/from Reserves	1 485	(1 886)	178.72	-	-	0.00	1 485	(1 886)	178.72	1	-1	177.19	0	-0	178.23	
Other	(28 311)	(12 000)	135.92	-	-	0.00	(28 311)	(12 000)	135.92	-10	-4	131.35	-4	-2	134.47	
Balances at the End of the Year	703 037	417 895	68.23	326	326	0.00	703 362	418 221	68.18	250	151	64.92	102	61	67.14	
REVALUATION RESERVE (PROPERTY, PLANT AND EQUIPMENT)																
Balances at the Beginning of the Year	13 853	7 329	89.02	-	-	0.00	13 853	7 329	89.02	5	3	85.36	2	1	87.86	
- As Previously Reported	6 399	7 329	-12.68	-	-	0.00	6 399	7 329	-12.68	2	3	-14.37	1	1	-13.22	
- Prior Year Adjustment	7 453	-	N/A	-	-	0.00	7 453	-	N/A	3	-	N/A	1	-	N/A	
Unrealised Gains/(Losses) on Re-measurement of Property Plant and Equipment	12 637	(929)	1459.85	-	-	0.00	12 637	(929)	1459.85	4	-0	1433.47	2	-0	1451.44	
Transfer (to)/from Income Statement on Disposal of Property Plant and Equipment	-	-	0.00	-	-	0.00	-	-	0.00	-	-	0.00	-	-	0.00	
Transfer (to)/from Reserves	-	-	0.00	-	-	0.00	-	-	0.00	-	-	0.00	-	-	0.00	
Other	(5 612)	-	N/A	-	-	0.00	(5 612)	-	N/A	-2	-	N/A	-1	-	N/A	
Balances at the End of the Year	20 878	6 399	226.25	-	-	0.00	20 878	6 399	226.25	7	2	219.92	3	1	224.23	
RESERVES SET ASIDE FOR SPECIFIC PURPOSES																
Balances at the Beginning of the Year	487 562	441 524	10.43	-	-	0.00	487 562	441 524	10.43	173	160	8.29	71	64	9.74	
- As Previously Reported	487 562	438 709	11.14	-	-	0.00	487 562	438 709	11.14	173	159	8.98	71	64	10.45	
- Prior Year Adjustment	-	2 815	-100.00	-	-	0.00	-	2 815	-100.00	-	1	-100.00	-	0	-100.00	
Transfer (to)/from Reserves	(4 398)	(33 831)	-87.00	-	-	0.00	(4 398)	(33 831)	-87.00	-2	-12	-87.25	-1	-5	-87.08	
Other	67 211	79 869	-15.85	-	-	0.00	67 211	79 869	-15.85	24	29	-17.48	10	12	-16.37	
Balances at the End of the Year	550 375	487 562	12.88	-	-	0.00	550 375	487 562	12.88	195	177	10.69	80	71	12.19	

Consolidated statement of changes in funds and reserves for the year ended 31 December 2004

	REGISTERED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			Per Average Member			Per Average Beneficiary		
	2004 R'000	2003 R'000	% Change	2004 R'000	2003 R'000	% Change	2004 R'000	2003 R'000	% Change	2004 R	2003 R	% Change	2004 R	2003 R	% Change
OTHER RESERVES															
Balances at the Beginning of the Year	409 420	364 382	12,36	313	313	0,00	409 733	364 695	12,35	146	132	10,17	59	53	11,66
- As Previously Reported	436 439	364 382	19,78	313	313	0,00	436 752	364 695	19,76	155	132	17,44	63	53	19,02
- Prior Year Adjustment	(27 019)	-	N/A	-	-	0,00	(27 019)	-	N/A	-10	-	N/A	-4	-	N/A
Transfer (to)/from Reserves	55 832	14 839	276,24	-	-	0,00	55 832	14 839	276,24	20	5	268,94	8	2	273,91
Other	27 557	57 218	-51,84	-	-	0,00	27 557	57 218	-51,84	10	21	-52,77	4	8	-52,14
Balances at the End of the Year	492 808	436 439	12,92	313	313	0,00	493 121	436 752	12,91	175	158	10,72	71	64	12,21

Consolidated membership analysis as at 31 December 2004

	MEMBERS		DEPENDANTS		BENEFICIARIES	
	2004	2003 % Change	2004	2003 % Change	2004	2003 % Change
Registered Schemes						
- Open Schemes	2 716 264	2 688 055	3 946 299	3 983 746	6 662 563	6 671 801
- Restricted Schemes	1 924 343	1 883 728	2 830 960	2 835 069	4 755 303	4 718 797
	791 921	804 327	1 115 339	1 148 677	1 907 260	1 953 004
Bargaining Council Schemes	1 170 58	114 760	136 045	138 125	253 103	252 885
TOTAL MEMBERSHIP	2 833 322	2 802 815	4 082 344	4 121 871	6 915 666	6 924 686
Registered Schemes						
- Open Schemes	2 701 736	2 665 280	3 951 538	3 986 882	6 653 275	6 652 162
- Restricted Schemes	1 900 692	1 859 816	2 816 744	2 833 526	4 717 436	4 693 342
	801 044	805 464	1 134 795	1 153 356	1 935 838	1 958 820
Bargaining Council Schemes	1 13 900	95 747	130 932	107 562	244 832	203 309
AVERAGE MEMBERSHIP	2 815 636	2 761 027	4 082 470	4 094 445	6 898 107	6 855 471
MEMBERSHIP PER PROVINCE as at December						
Gauteng	1 092 200	38,55%	1 487 204	36,43%	2 579 404	37,30%
Limpopo	980 47	3,46%	1 81 611	4,45%	279 658	4,04%
Mpumalanga	1 664 18	5,87%	2 87 790	7,05%	454 208	6,57%
North West	1 247 99	4,40%	1 88 131	4,61%	312 930	4,52%
Free State	1 305 68	4,61%	1 88 254	4,61%	318 822	4,61%
Kwa-Zulu Natal	417 706	14,74%	610 894	14,96%	1 028 600	14,87%
Western Cape	508 585	17,95%	685 300	16,79%	1 193 885	17,26%
Eastern Cape	234 735	8,28%	361 091	8,85%	595 826	8,62%
Northern Cape	60 264	2,13%	92 069	2,26%	152 333	2,20%
Average No of Dependents per Member	1,45	1,48				
Overall Pensioner Ratio	6,66%	5,90%				
Average Age	32,02					

	UTILISATION		UTILISATION		UTILISATION		UTILISATION		UTILISATION		UTILISATION		UTILISATION		UTILISATION			
	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries	OPEN per 1000 Beneficiaries	RESTRICTED per 1000 Beneficiaries	CONSOLIDATED per 1000 Beneficiaries
PRIVATE FACILITIES	PRIVATE PROVIDERS																	
Number of:	Beneficiaries visiting a provider at least once a year																	
Admissions to Hospitals	190.43	216.04	197.95	710.99	811.31	740.46	15.81	9.85	18.19	167.16	187.08	159.22	6.43	5.97	6.61	0.12	0.06	0.10
Admissions for PMB in hospitals	26.69	33.57	28.71	35.63	5.01	47.78	6.43	5.97	6.61	167.16	187.08	159.22	6.43	5.97	6.61	19.26	34.10	24.56
Admissions to day clinics and operating theatres	7.64	27.52	13.48	2.38	5.01	3.13	85.84	82.70	87.09	85.84	82.70	87.09	85.84	82.70	87.09	1.04	1.78	1.31
Beneficiaries admitted to ICU	7.85	5.47	7.15	2.78	5.23	3.48	9.37	8.97	9.52	9.37	8.97	9.52	9.37	8.97	9.52	0.22	0.35	0.27
Beneficiaries admitted to high care ward	12.00	7.78	10.76	4.70	10.37	6.33	0.25	0.20	0.27	0.25	0.20	0.27	0.25	0.20	0.27	3.07	7.01	4.48
Beneficiaries admitted to general ward	67.33	108.33	79.37	4.91	8.15	5.87	29.07	28.30	29.38	29.07	28.30	29.38	29.07	28.30	29.38	0.60	0.73	0.65
Pregnancies	6.78	6.59	6.72	14.69	30.26	19.16	6.47	5.95	6.67	5.45	5.69	5.35	5.45	5.69	5.35	2.30	3.96	2.89
Births	7.79	5.12	7.01	35.63	77.94	47.78	9.37	8.97	9.52	8.63	8.64	8.62	8.63	8.64	8.62	0.46	0.53	0.48
Live births	5.06	2.47	4.30	2.38	5.01	3.13	6.47	5.95	6.67	5.45	5.69	5.35	5.45	5.69	5.35	4.11	30.78	13.64
Caesarean sections	5.61	5.59	5.60	2.78	5.23	3.48	5.45	5.69	5.35	8.63	8.64	8.62	8.63	8.64	8.62	0.26	0.30	0.27
Beneficiaries admitted for dialysis	0.55	0.41	0.51	4.70	10.37	6.33	0.00	0.00	0.00	10.20	7.94	11.10	10.20	7.94	11.10	0.06	0.19	0.11
Selected medical investigations	Chronic Conditions																	
Number of:	Allied and Support Health Professionals																	
Beneficiaries receiving MRI and CT scans	9.82	13.35	10.86	35.63	77.94	47.78	0.00	0.00	0.00	7.55	5.45	8.38	7.55	5.45	8.38	0.00	0.00	0.00
MRI and CT scans administered	15.66	20.00	16.94	27.11	60.48	36.70	0.00	0.00	0.00	0.02	0.06	0.00	0.02	0.06	0.00	0.00	0.03	0.03
Beneficiaries receiving PET Scans	0.00	0.61	0.18	4.70	10.37	6.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PET Scans administered	0.00	1.34	0.40	9.19	17.36	11.54	0.00	0.00	0.00	0.02	0.00	0.03	0.02	0.00	0.03	0.00	0.03	0.03
Beneficiaries receiving Angiograms	2.97	2.60	2.86	6.04	17.13	9.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Angiograms administered	6.18	5.67	6.03	4.68	10.95	6.48	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Preventative Health	Other																	
Number of:	Total number of visits to a provider																	
Mammograms administered	4.37	6.07	4.87	22.42	47.64	29.67	54.58	30.34	47.67	15.14	13.33	14.63	20.169	233.04	210.62	47.67	14.63	14.63
Pap smears administered	47.69	20.97	39.84	1.46	2.97	1.89	15.14	13.33	14.63	20.169	233.04	210.62	20.169	233.04	210.62	41.405	430.28	418.68
Mortality	Physiotherapist																	
Number of deaths	1.35	2.02	1.55	41.75	88.81	55.27	0.40	0.29	0.36	39.54	26.86	35.93	0.40	0.29	0.36	0.40	0.29	0.36
PUBLIC FACILITIES	Speech Therapist																	
Number of:	Psychologist																	
Admissions to hospitals	9.23	17.09	11.54	151.13	320.20	199.71	134.26	120.57	130.36	53.64	41.04	50.05	16.67	23.88	18.73	0.54	0.63	0.57
Admissions for PMB in hospitals	0.66	3.43	1.48	94.57	208.32	127.26	2.77	6.06	3.71	1.78	8.13	9.17	1.78	8.13	9.17	0.01	0.03	0.02
Beneficiaries admitted to ICU	0.03	0.11	0.05	4.48	10.26	6.14	0.20	1.02	0.43	2.103	19.43	20.58	2.103	19.43	20.58	0.01	0.03	0.02
Beneficiaries admitted to high care ward	0.04	0.03	0.03	0.07	0.12	0.09	0.00	0.00	0.00	0.00	0.03	0.01	0.00	0.01	0.01	0.01	0.03	0.06
Beneficiaries admitted to general ward	3.21	7.15	4.37	0.89	2.28	1.29	0.00	0.00	0.00	0.00	0.03	0.01	0.00	0.01	0.01	0.01	0.01	0.01
Pregnancies	0.07	0.12	0.09	0.57	1.58	0.86	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Births	0.13	0.10	0.12	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Live births	0.02	0.06	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01

Utilisation of services for the year ended 31 December 2004

	UTILISATION		UTILISATION	UTILISATION		UTILISATION	UTILISATION		NUMBER OF CASES
	OPEN Beneficiaries per 1000	RESTRICTED Beneficiaries per 1000		CONSOLIDATED Beneficiaries per 1000	OPEN Beneficiaries per 1000		RESTRICTED Beneficiaries per 1000	CONSOLIDATED Beneficiaries per 1000	
Caesarean sections Beneficiaries admitted for dialysis	0,08	0,15	0,10						
Selected medical investigations									
Number of:									
Beneficiaries receiving MRI and CT scans administered	0,12	0,34	0,18	Total number of visits to a provider	49,80	50,14	49,90		
Beneficiaries receiving PET Scans	0,00	0,01	0,00	Medical Specialists	196,47	208,71	199,98	Other Benefits	
Beneficiaries receiving PET Scans administered	0,00	0,01	0,00	Dermatologist	17,58	18,57	17,86	Appliances	30,34
Beneficiaries receiving Angiograms	0,01	0,10	0,03	Gynaecologist	174,97	237,35	192,89	Prostheses	17,03
Angiograms administered	0,01	0,23	0,08	Physician	12,90	13,86	13,17	Ambulance Service	6,11
				Gastroenterologist	21,00	24,22	21,93	Other	29,20
				Neurologist	42,20	45,49	43,14		
				Cardiologist	49,65	74,97	56,93		
				Psychiatrist	8,21	6,31	7,66		
				Medical Oncologist	23,00	28,65	24,62		
				Neuro-Surgeon	3,55	3,03	3,40		
				Nuclear Medicine	67,04	73,96	69,03		
				Ophthalmologist	83,97	95,06	87,15		
				Orthopaedic Surgeon	57,88	62,25	59,13		
				Otorhinolaryngologist	162,22	167,21	163,65		
				Paediatrician	2,89	2,47	2,77		
				Paediatric Cardiologist	0,94	1,43	1,08		
				Specialist Physical Medicine	8,95	8,79	8,91		
				Plastic Reconstructive Surgeon	94,25	109,96	98,76		
				Surgeon	9,04	11,05	9,62		
				Thoracic Surgeon	41,36	47,29	43,06		
				Urologist					
				Clinical Support Specialists					
				Anaesthetist	108,10	120,87	111,77		
				Pathologist	737,14	877,01	777,33		
				Radiologist	325,18	361,37	335,58		
				Radiotherapist	41,49	45,72	42,70		
				Laboratory Technologist	1,86	2,42	2,02		
				Other	5,72	34,02	13,85		
				Dental Specialists					
				Maxilla, Facial & Oral Surgeon	15,92	16,72	16,15		
				Oral Pathologist	0,14	0,14	0,14		
				Orthodontist	58,19	60,18	58,76		
				Periodontist	5,93	4,69	5,58		
				Prosthodontist	3,87	7,07	4,79		
Mortality									
Number of deaths	0,03	0,51	0,17						

Notes:

- Chronic conditions:
 - 76,7% of medical schemes have submitted data representing 82,0% of beneficiaries
- Utilisation of health care services:
 - 78,9% of medical schemes have submitted data representing 85,0% of beneficiaries
- Exclusions:
 - schemes that did not submit the data were excluded from the analysis
 - schemes with poor quality data were also excluded from the analysis

Analysis of all benefits paid for the year ended 31 December 2004

	OPEN SCHEMES			RESTRICTED SCHEMES			OPEN SCHEMES			RESTRICTED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			PABPM		
	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change
TOTAL HOSPITALS	10 989 839	38,61	4 529 998	36,33	9 105 319	3 996 439	18,5	224 135	41,11	181 586	23,4	15 743 973	37,96	13 283 344	18,5	190 20	161,47	17,8	190 20	161,47	17,8
PRIVATE HOSPITALS	9 966 935	35,02	3 979 647	31,92	8 131 406	3 539 130	19,5	213 387	39,13	176 967	20,6	14 159 969	34,14	11 847 504	19,5	171 06	144,02	18,8	171 06	144,02	18,8
Ward Fees	4 180 983	14,69	1 835 304	14,72	3 345 476	1 586 045	22,0	189 022	34,67	157 378	20,1	6 205 309	14,96	5 088 898	21,9	74 96	61,86	21,2	74 96	61,86	21,2
Theatre Fees	2 666 856	9,37	829 857	6,66	1 801 238	748 695	37,1	12 940	2,37	5 429	138,3	3 509 652	8,46	2 555 363	37,3	42 40	31,06	36,5	42 40	31,06	36,5
Consumables	1 460 934	5,13	357 445	2,87	1 574 912	400 999	-8,0	2 459	0,45	1 576	56,0	1 820 837	4,39	1 977 487	-7,9	22 00	24,04	-8,5	22 00	24,04	-8,5
Medicines dispensed	1 658 162	5,83	957 042	7,68	1 409 780	803 391	18,2	8 966	1,64	12 584	-28,8	2 624 170	6,33	2 225 755	17,9	31 70	27,06	17,2	31 70	27,06	17,2
Global / per diem fee	910 134	3,20	407 685	3,27	847 411	339 638	11,0	4 276	0,78	-	N/A	1 322 096	3,19	1 187 049	11,4	15 97	14,43	10,7	15 97	14,43	10,7
PROVINCIAL HOSPITALS	1 112 770	0,40	142 666	1,14	126 502	117 671	4,6	6 472	1,19	4 619	40,1	261 908	0,63	248 792	5,3	3 16	3,02	4,6	3 16	3,02	4,6
Ward Fees	87 958	0,31	104 926	0,84	97 965	63 634	19,4	4 295	0,79	3 649	17,7	197 179	0,48	165 248	19,3	2 38	2,01	18,6	2 38	2,01	18,6
Theatre Fees	4 981	0,02	11 499	0,09	8 495	15 216	-30,5	987	0,18	218	352,7	17 468	0,04	23 929	-27,0	0 21	0 29	-27,5	0 21	0 29	-27,5
Consumables	9 942	0,03	23 209	0,19	9 397	23 041	2,2	666	0,12	403	65,4	33 817	0,08	32 841	3,0	0 41	0 40	2,3	0 41	0 40	2,3
Medicines dispensed	9 889	0,03	3 033	0,02	10 645	15 780	-51,1	523	0,10	349	49,9	13 445	0,03	26 774	-49,8	0 16	0 33	-50,1	0 16	0 33	-50,1
MEDICINES	5 201 125	18,27	2 674 301	21,45	6 064 263	2 470 515	-7,7	83 923	15,39	82 316	2,0	79 593 499	19,19	86 17 094	-7,6	96 15	104,75	-8,2	96 15	104,75	-8,2
Medicines dispensed by Pharmacists	4 333 929	15,23	2 200 921	17,65	4 849 359	1 839 434	-2,3	64 355	11,80	58 516	10,0	6 599 204	15,91	6 747 309	-2,2	79 72	82,02	-2,8	79 72	82,02	-2,8
Medicines dispensed by Practitioners	852 057		465 106		1 197 071	616 568	-27,4	19 514	3,58	23 753	-17,8	1 336 677	3,22	1 837 393	-27,3	16 15	22,33	-27,7	16 15	22,33	-27,7
Medicines dispensed by Allied and Support Health Professionals	15 140	0,05	8 274	0,07	17 833	14 513	-27,6	54	0,01	46	17,3	23 468	0,06	32 392	-27,6	0 28	0 39	-28,0	0 28	0 39	-28,0
EX-GRATIA PAYMENTS	12 084	0,04	13 750	0,11	9 744	12 485	16,2	182	0,03	2 087	-91,3	26 015	0,06	24 315	7,0	0 31	0 30	6,3	0 31	0 30	6,3
OTHER BENEFITS	537 971	1,89	444 656	3,57	467 539	577 663	-6,0	7 596	1,39	2 700	181,3	990 223	2,39	1 047 902	-5,5	11 96	12,74	-6,1	11 96	12,74	-6,1
Appliances (supplied outside hospitals excl. prosthesis)	108 388	0,38	60 003	0,48	130 670	44 556	-3,9	215	0,04	15	1292,3	1 68 606	0,41	175 242	-3,8	2 04	2,13	-4,4	2 04	2,13	-4,4
Prostheses	141 741	0,50	97 429	0,78	124 900	94 807	8,9	213	0,04	899	-76,3	239 382	0,58	220 606	8,5	2 89	2,68	7,8	2 89	2,68	7,8
Ambulance Services	52 598	0,18	11 832	0,09	47 328	9 252	13,9	1 242	0,23	923	34,5	65 671	0,16	57 504	14,2	0 79	0 70	13,5	0 79	0 70	13,5
Other	235 245	0,83	275 393	2,21	164 641	429 047	-14,0	5 926	1,09	862	587,3	516 563	1,25	594 550	-13,1	6 24	7,23	-13,7	6 24	7,23	-13,7
CAPITATED PRIMARY CARE	741 400	2,61	144 999	1,16	292 388	129 290	110,2	-	0,00	2 406	-100,0	886 399	2,14	424 084	109,0	10 71	5,16	107,7	10 71	5,16	107,7
TOTAL BENEFITS	28 460 575	100	12 467 702	100	26 686 058	11 528 234	7,1	545 262	100	482 811	12,9	41 473 538	100	38 697 103	7,17	501 03	470,39	6,5	501 03	470,39	6,5

Notes:

- PABPM = per average beneficiary per month

Analysis of risk benefits paid for the year ended 31 December 2004

	OPEN SCHEMES			RESTRICTED SCHEMES			OPEN SCHEMES			RESTRICTED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			PABPM					
	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R'000	% of total	% Change	R	% Change	R	% Change		
TOTAL HOSPITALS	10929417	44.12	4519608	39.26	9074696	18.6	3946352	41.18	181586	23.4	15673161	42.56	13202634	18.7	189334	16049	18.0	189334	16049	18.0	189334	16049	18.0	
PRIVATE HOSPITALS	9909179	40.00	3970880	34.49	8103130	19.6	3499457	39.21	176967	20.6	14093446	38.27	11779554	19.6	17026	43,19	18.9	17026	43,19	18.9	17026	43,19	18.9	
Ward Fees	4170963	16.84	1833386	15.93	3338639	22.1	1578094	34.73	157378	20.1	6193371	16.82	5074110	22.1	7482	61,68	21.3	7482	61,68	21.3	7482	61,68	21.3	
Theatre Fees	2635992	10.64	828203	7.19	1789103	36.8	743751	2.38	5429	138.3	3477135	9.44	2538283	37.0	42,01	30,85	36.1	42,01	30,85	36.1	42,01	30,85	36.1	
Consumables	1452902	5.86	355951	3.09	1572865	-7.9	390751	2.459	1576	56.0	1811311	4.92	1965192	-7.8	2,188	23,89	-8.4	2,188	23,89	-8.4	2,188	23,89	-8.4	
Medicines dispensed	1649323	6.66	953340	8.28	1402523	786861	18.9	8966	1.65	12584	-28.8	2611628	7.09	2201968	18.6	31,55	26,77	17.9	31,55	26,77	17.9	31,55	26,77	17.9
Global / per diem fee	910134	3.67	407685	3.54	847411	339638	11.0	4276	0.79	N/A	1322096	3.59	1187049	11.4	15,97	14,43	10.7	15,97	14,43	10.7	15,97	14,43	10.7	
PROVINCIAL HOSPITALS	110104	0.44	141043	1.23	124155	107257	8.5	6472	1.19	4619	40.1	257619	0.70	236031	9.1	3,11	2,87	8.5	3,11	2,87	8.5	3,11	2,87	8.5
Ward Fees	85757	0.35	103531	0.90	96182	63306	18.7	4295	0.79	3649	17.7	193583	0.53	163136	18.7	2,34	1,98	17.9	2,34	1,98	17.9	2,34	1,98	17.9
Theatre Fees	4915	0.02	11472	0.10	8421	15194	-30.6	987	0.18	218	352.7	17374	0.05	23832	-27.1	0,21	0,29	-27.6	0,21	0,29	-27.6	0,21	0,29	-27.6
Consumables	9743	0.04	23092	0.20	9040	13479	45.8	666	0.12	403	65.4	33501	0.09	22923	46.1	0,40	0,28	45.2	0,40	0,28	45.2	0,40	0,28	45.2
Medicines dispensed	9689	0.04	2948	0.03	10512	15279	-51.0	523	0.10	349	49.9	13161	0.04	26140	-49.7	0,16	0,32	-50.0	0,16	0,32	-50.0	0,16	0,32	-50.0
MEDICINES	4011826	16.19	2284526	19.84	4781306	82316	-8.5	83923	15.42	82316	2.0	6380276	17.32	6963145	-8.4	77,08	84,64	-8.9	77,08	84,64	-8.9	77,08	84,64	-8.9
Medicines dispensed by Pharmacists	3322643	13.41	1871236	16.25	3696177	1557231	-1.1	64355	11.82	58516	10.0	5258234	14.28	5311925	-1.0	63,52	64,57	-1.6	63,52	64,57	-1.6	63,52	64,57	-1.6
Medicines dispensed by Practitioners	677802	2.74	406518	3.53	1073074	529581	-32.3	19514	3.59	23753	-17.8	1103834	3.00	1626408	-32.1	13,33	19,77	-32.6	13,33	19,77	-32.6	13,33	19,77	-32.6
Medicines dispensed by Allied and Support Health Professionals	11381	0.05	6772	0.06	12055	12711	-26.7	54	0.01	46	17.3	18207	0.05	24812	-26.6	0,22	0,30	-27.1	0,22	0,30	-27.1	0,22	0,30	-27.1
EX-GRATIA PAYMENTS	12053	0.05	13732	0.12	9732	12481	16.1	182	0.03	2087	-91.3	25967	0.07	24300	6.9	0,31	0,30	6.2	0,31	0,30	6.2	0,31	0,30	6.2
OTHER BENEFITS	501662	2.03	435208	3.78	444818	570006	-7.7	7596	1.40	2700	181.3	944466	2.56	1017524	-7.2	11,41	12,37	-7.8	11,41	12,37	-7.8	11,41	12,37	-7.8
Appliances (supplied outside hospitals excl. prosthesis)	80371	0.32	57801	0.50	113670	42254	-11.4	215	0.04	15	1292.3	138387	0.38	155939	-11.3	1,67	1,90	-11.8	1,67	1,90	-11.8	1,67	1,90	-11.8
Prostheses	140706	0.57	96038	0.83	123125	93595	9.2	213	0.04	899	-76.3	236957	0.64	217619	8.9	2,86	2,65	8.2	2,86	2,65	8.2	2,86	2,65	8.2
Ambulance Services	52520	0.21	11706	0.10	47293	9099	13.9	1242	0.23	923	34.5	65468	0.18	57315	14.2	0,79	0,70	13.5	0,79	0,70	13.5	0,79	0,70	13.5
Other	228064	0.92	269664	2.34	160730	425058	-15.0	5926	1.09	862	587.3	503654	1.37	586650	-14.1	6,08	7,13	-14.7	6,08	7,13	-14.7	6,08	7,13	-14.7
CAPITATED PRIMARY CARE	741400	2.99	144999	1.26	292388	129290	110.2	-	0.00	2406	-100.0	886399	2.41	424084	109.0	10,71	5,16	107.7	10,71	5,16	107.7	10,71	5,16	107.7
TOTAL RISK BENEFITS	2477338	100	11512432	100	23408869	10611056	6.7	544284	100	482536	12.8	3683053	100	34502461	6.75	44493	419,40	6.1	44493	419,40	6.1	44493	419,40	6.1

Notes:

- PABPM = per average beneficiary per month

Analysis of savings benefits paid for the year ended 31 December 2004

	OPEN SCHEMES			RESTRICTED SCHEMES			RESTRICTED SCHEMES			OPEN SCHEMES			RESTRICTED SCHEMES			BARGAINING COUNCIL SCHEMES			CONSOLIDATED			PABPM		
	2004		% of total	2004		% of total	2003		% of total	2003		% of total	2004		% of total	2003		% of total	2004		% of total	2003		% Change
	R'000	%		R'000	%		R'000	%		R'000	%		R'000	%		R'000	%		R'000	%		R'000	%	
TOTAL HOSPITALS	60 421	1,64	10 390	1,09	30 624	50 087	-12,3	-	0,00	-	0,00	70 812	1,52	80 710	-12,3	0,86	0,98	-12,8	0,86	0,98	-12,8	0,86	0,98	-12,8
PRIVATE HOSPITALS	57 755	1,57	8 768	0,92	28 277	39 673	-2,1	-	0,00	-	0,00	66 523	1,43	67 950	-2,1	0,80	0,83	-2,7	0,80	0,83	-2,7	0,80	0,83	-2,7
Ward Fees	10 020	0,27	1 918	0,20	6 837	7 951	-19,3	-	0,00	-	0,00	11 938	0,26	14 788	-19,3	0,14	0,18	-19,8	0,14	0,18	-19,8	0,14	0,18	-19,8
Theatre Fees	30 864	0,84	1 653	0,17	12 136	4 944	90,4	-	0,00	-	0,00	32 517	0,70	17 080	90,4	0,39	0,21	89,2	0,39	0,21	89,2	0,39	0,21	89,2
Consumables	8 032	0,22	1 494	0,16	2 047	10 248	-22,5	-	0,00	-	0,00	9 526	0,21	12 295	-22,5	0,12	0,15	-23,0	0,12	0,15	-23,0	0,12	0,15	-23,0
Medicines dispensed	8 840	0,24	3 702	0,39	7 257	16 530	-47,3	-	0,00	-	0,00	12 542	0,27	23 787	-47,3	0,15	0,29	-47,6	0,15	0,29	-47,6	0,15	0,29	-47,6
Global / per diem fee	-	0,00	-	0,00	-	-	0,0	-	0,00	-	0,00	-	0,00	-	-	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	
PROVINCIAL HOSPITALS	2 201	0,06	1 394	0,15	1 783	10 413	-66,4	-	0,00	-	0,00	4 289	0,09	12 761	-66,4	0,05	0,16	-66,6	0,05	0,16	-66,6	0,05	0,16	-66,6
Ward Fees	67	0,00	27	0,00	74	328	70,3	-	0,00	-	0,00	3 596	0,08	2 111	70,3	0,04	0,03	69,3	0,04	0,03	69,3	0,04	0,03	69,3
Theatre Fees	198	0,01	117	0,01	357	9 561	-3,1	-	0,00	-	0,00	94	0,00	97	-3,1	0,00	0,00	-3,7	0,00	0,00	-3,7	0,00	0,00	-3,7
Consumables	199	0,01	85	0,01	133	501	-55,2	-	0,00	-	0,00	284	0,01	634	-55,2	0,00	0,01	-55,5	0,00	0,01	-55,5	0,00	0,01	-55,5
Medicines dispensed	1 189 299	32,25	389 775	40,80	1 282 957	370 992	-4,5	-	0,00	-	0,00	1 579 074	34,01	1 653 949	-4,5	19,08	20,10	-5,1	19,08	20,10	-5,1	19,08	20,10	-5,1
Medicines dispensed by Pharmacists	1 011 285	27,43	329 685	34,51	1 153 182	282 203	-6,6	-	0,00	-	0,00	1 340 970	28,88	1 435 385	-6,6	16,20	17,45	-7,2	16,20	17,45	-7,2	16,20	17,45	-7,2
Medicines dispensed by Practitioners	1 74 256	4,73	58 587	6,13	1 23 997	86 987	10,4	-	0,00	-	0,00	232 843	5,01	210 984	10,4	2,81	2,56	9,7	2,81	2,56	9,7	2,81	2,56	9,7
Medicines dispensed by Allied and Support Health Professionals	3 758	0,10	1 502	0,16	5 778	1 802	-30,6	-	0,00	-	0,00	5 260	0,11	7 580	-30,6	0,06	0,09	-31,0	0,06	0,09	-31,0	0,06	0,09	-31,0
EX-GRATIA PAYMENTS	31	0,00	17	0,00	12	3	208,5	-	0,00	-	0,00	48	0,00	16	208,5	0,00	0,00	206,6	0,00	0,00	206,6	0,00	0,00	206,6
OTHER BENEFITS	36 309	0,98	9 448	0,99	22 721	7 657	50,6	-	0,00	-	0,00	45 758	0,99	30 378	50,6	0,55	0,37	49,7	0,55	0,37	49,7	0,55	0,37	49,7
Appliances (supplied outside hospitals excl prosthesis)	28 017	0,76	2 202	0,23	17 000	2 303	56,6	-	0,00	-	0,00	30 219	0,65	19 303	56,6	0,37	0,23	55,6	0,37	0,23	55,6	0,37	0,23	55,6
Prostheses	1 035	0,03	1 391	0,15	1 775	1 212	-18,8	-	0,00	-	0,00	2 426	0,05	2 987	-18,8	0,03	0,04	-19,3	0,03	0,04	-19,3	0,03	0,04	-19,3
Ambulance Services	77	0,00	126	0,01	35	154	7,8	-	0,00	-	0,00	204	0,00	189	7,8	0,00	0,00	7,1	0,00	0,00	7,1	0,00	0,00	7,1
Other	7 180	0,19	5 729	0,60	3 911	3 989	63,4	-	0,00	-	0,00	12 909	0,28	7 899	63,4	0,16	0,10	62,4	0,16	0,10	62,4	0,16	0,10	62,4
CAPITATED PRIMARY CARE	-	0,00	-	0,00	-	-	0,0	-	0,00	-	0,00	-	0,00	-	-	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00
TOTAL SAVINGS BENEFITS	3 687 237	100	955 270	100	3 277 189	9 178	10,7	979	100	275	255,8	4 643 485	100	4 194 642	10,70	56,10	50,99	10,0	56,10	50,99	10,0	56,10	50,99	10,0

Notes:

- Global / per diem hospital fee and capitated primary care are not applicable in this schedule
- PABPM = per average beneficiary per month

Detailed financial results: registered schemes for the year ended 31 December 2004

Ref. No.	Name of Medical Scheme	Members	Beneficiaries	No. of Dependents per Member	Gross Contributions		Gross Administration Expenses (RISK +PMSA)		Managed Care: Management Services		Broker Fees	Net Reinsurance Results	Net Claims Incurred: Net Contributions	Gross Underwriting Results	Net Underwriting Results	Surplus/ (Deficit) from Operations	Net Surplus/ (Deficit)	Net-Assets (Members Funds per BS)	Net Assets per Regulation 29	Solvency Ratio
					R'000	PABPM R	R'000	As % of PABPM GCI	R'000	As % of PABPM GCI										
1434	Unmed Scheme	9 580	31/12/04 24 754	1,59	223 624	747	12 592	5,63	4 098	1,83	-	-	81,75	40 051	23 362	23 102	37 111	1 444 400	142 797	63,86
1597	Umvuzo Health Medical Scheme	2 283	5 815	1,75	8 966	152	1 296	14,45	284	3,16	-	-	69,70	2 530	951	939	940	940	940	10,48
1520	University of Natal Medical Scheme	3 196	7 085	1,20	55 480	657	6 590	11,88	-	0,00	-	-	85,52	6 045	(546)	(548)	1 688	32 674	27 346	49,29
1282	University of the Witwatersrand Staff Medical Aid Scheme	2 984	6 694	1,25	59 407	733	3 569	6,01	2 186	3,68	-	-	80,73	11 450	5 695	6 362	1 1168	50 127	50 127	84,38
1565	Venda Police and Prisons Medical Scheme (Polprismed)	2 641	6 693	1,59	24 328	336	4 876	20,04	285	1,17	864	-	85,60	3 502	(2 523)	(2 467)	(431)	(431)	(431)	-1,77
1291	Witbank Coalfields Medical Aid Scheme	5 679	15 135	1,65	133 531	742	6 290	4,71	902	0,68	-	-	89,85	9 841	2 650	2 563	18 800	157 744	145 042	108,62
1293	Wooltru Healthcare Fund	8 382	18 369	1,20	113 740	520	11 755	10,33	2 019	1,77	-	-	84,67	16 577	2 804	2 786	12 838	942 14	93 788	82,46
1253	Xstrata Medical Aid Scheme	3 961	11 640	1,91	66 402	487	4 310	6,49	2 783	4,19	-	-	75,93	15 983	8 891	9 018	11 934	33 668	33 641	50,66
SUB-TOTAL -	Registered Restricted Schemes	791 921	1 907 260	1,41	1 470 319	633	1 027 675	6,99	2 982 270	2,03	13	2 183	811	2 122 413	795 662	671 103	1 846 963	9 547 423	8457 824	57,95
TOTAL REGISTERED SCHEMES		2 716 264	6 662 563	1,45	5 153 439	645	5 000 174	9,70	63 123 154	2,39	15	704 102	(7825)	9 858 205	2 933 181	2 721 757	4 930 410	19 999 605	18 502 620	36,61

Notes:

- Draft Annual Financial Statements were submitted.
- An encumbered asset was excluded in the calculation of the solvency ratio.
- A subordinated loan was included in the calculation of the solvency ratio.
- The solvency ratio has been restated by removing the inclusion of the special government subsidised pensioner group contributions.
- The scheme was registered during 2000, and a phase-in solvency ratio of 22% applies.
- The scheme was registered during 2001, and a phase-in solvency ratio of 17,5% applies.
- The scheme was registered during 2002, and a phase-in solvency ratio of 13,5% applies.
- The scheme was registered during 2003, and a phase-in solvency ratio of 10% applies.
- The scheme was registered during 2004, and a phase-in solvency ratio of 10% will apply to the scheme from December 2005.
- Myhealth amalgamated with Oxygen with effect from 1 July 2004.
- AngloGold amalgamated with Discovery Health with effect from 1 June 2004.
- Billmed amalgamated with Samancor Health Plan with effect from 1 July 2004.

- PMSA = Personal Medical Savings Account
- GCI = Gross Contribution Income
- PABPM = Per Average Beneficiary Per Month
- BS = Balance Sheet

Detailed financial information: registered schemes for the year ended 31 December 2004

- e The solvency ratio has been restated by removing the inclusion of the special government subsidized pensioner group contributions.
 - f The scheme was registered during 2000, and a phase-in solvency ratio of 22% applies.
 - g The scheme was registered during 2001, and a phase-in solvency ratio of 17,5% applies.
 - h The scheme was registered during 2002, and a phase-in solvency ratio of 13,5% applies.
 - i The scheme was registered during 2003, and a phase-in solvency ratio of 10% applies.
 - j The scheme was registered during 2004, and a phase-in solvency ratio of 10% will apply to the scheme from December 2005.
 - k Myhealth amalgamated with Oxygen with effect from 1 July 2004.
 - l Anglogold amalgamated with Discovery Health with effect from 1 June 2004.
 - m Billmed amalgamated with Samancor Health Plan with effect from 1 July 2004.
- PMSA = Personal Medical Savings Account
 - GCI = Gross Contribution Income
 - PABPM = Per Average Beneficiary Per Month
 - PB = Per Beneficiary

- There are no 2004 figures for the colour coded schemes due to:
 - Schemes liquidating during the year (Highveld furnished the Office with management accounts for the 2003 financial year).

The following schemes amalgamated in 2004:

- Allcare with NBC with effect from 1 January 2004.
- Anglogold with Discovery Health with effect from 1 June 2004.
- Myhealth with Oxygen with effect from 1 July 2004.
- Billmed with Samancor with effect from 1 July 2004.

- There are no 2003 figures for the colour coded schemes due to:
 - Schemes registering during 2004. The solvency ratio is not directly comparable to that of other schemes.

Detailed financial results: registered schemes as at 31 December 2004

Ref. No.	Name of Medical Scheme	Accounts Receivable		Contribution Debtors		Accounts Payable		Outstanding Claims Provision		Investments				Gross Claims Incurred Cash and Cash Equivalents Coverage	
		R'000	Days Outstanding	R'000	Days Outstanding	R'000	Days Outstanding	R'000	Months	R'000	R'000	R'000	R'000		R'000
REGISTERED SCHEMES – OPEN															
I589	Baymed	1 336	27,10	1 336	27,10	1 213	25,61	637	N/A	183	-	-	-	-	0,13
I252	Bestmed Medical Scheme	5 998	3,40	781	0,44	48 193	37,09	12 900	72,62	302 937	7 484	3 957	7 462	545	7,80
I512	Bonitas Medical Aid Fund	65 225	6,13	91 856	8,63	310 688	37,72	177 249	114,08	1 120 484	220 138	453 601	28 056	64 651	5 378
I034	Cape Medical Plan	4 504	25,01	86	0,48	3 014	16,10	5 000	119,98	49 185	27 643	66 457	16 530	-	1 230
I048	Commercial and Industrial Medical Aid Society (CIMAS)	7 603	34,06	6 041	27,06	6 367	31,40	2 500	92,16	91 595	1 659	15 870	682	11 672	14,06
I552	Community Medical Aid Scheme (COMMED)	5 277	8,66	6 819	11,19	14 590	30,23	12 000	103,95	87 560	34 407	43 086	-	306	144
I491	Compare Medical Scheme	10 717	14,73	9 566	13,15	16 424	29,12	10 599	103,66	128 676	-	984	2 388	-	7,50
I125	Discovery Health Medical Scheme	602 559	16,96	521 896	14,69	358 489	13,80	403 508	111,28	2 140 174	2 019 169	-	-	-	5,27
I596	Eclipse Medical Scheme	52	6,56	52	6,56	335	51,97	455	N/A	865	-	-	-	-	4,39
I202	Fedhealth	67 758	21,50	72 160	22,90	15 277	6,38	61 985	112,94	324 128	71 569	50 227	1 108	238 795	12
I501	Free State Medical Aid Scheme	31	5,66	-	0,00	119	22,73	105	0,00	900	554	-	-	-	2
I554	Genesis Medical Scheme	161	0,56	33	0,12	9 264	41,44	7 051	93,29	84 994	-	-	-	-	12,50
I561	Gen-Health Medical Scheme	6 859	30,63	6 443	28,77	6 245	42,70	4 544	53,33	57 845	-	3 457	-	-	685
I162	Global Health	28 625	21,85	29 303	22,37	25 637	21,43	18 000	111,34	81 608	5 386	-	5 039	79 105	1 027
I466	Good Hope Medical Aid Society	415	5,67	-	0,00	1 789	27,31	630	32,66	29 101	-	143	-	6 923	2,39
I537	Hosmed Medical Aid Scheme	19 936	12,17	14 169	8,65	29 264	21,39	86 476	117,58	277 737	-	-	-	-	14,60
I577	Ingwe Health Plan	3 855	10,62	1 354	3,73	12 050	44,18	5 145	103,93	59 625	-	-	-	-	286
I556	KwaZulu-Natal Medical Aid Scheme	496	2,76	2 451	13,62	10 216	71,29	6 900	95,18	84 636	-	5 318	-	-	68
I576	Liberty Medical Scheme	4 286	2,05	4 098	1,96	12 579	7,88	36 000	89,22	172 867	98 563	9 080	-	-	4,08
I536	Lifemed Medical Scheme	5 717	22,91	5 556	22,27	4 847	23,54	4 017	106,00	30 583	-	3 659	1 074	-	4,88
I142	Medical Expenses Distribution Society (MEDS)	14 612	24,12	13 701	22,62	2 296	4,52	8 000	104,93	33 136	38 996	28 824	-	-	1,34
I549	Medicover 2000	23 350	14,83	95	0,06	9 834	8,78	26 132	87,22	606 107	20 255	14 564	33 231	-	3 553
I149	Midhep	141 379	19,57	28 571	3,96	115 443	18,35	65 520	98,60	586 157	-	23 785	17 992	-	24 433
I506	Medimed Medical Scheme	4 658	24,19	4 330	22,49	2 245	15,51	3 609	86,21	34 454	-	-	-	-	22
I140	Medshield Medical Scheme	27 827	7,44	34 809	9,31	170 095	71,20	41 096	97,21	696 705	39 833	21 307	-	126 214	19
I021	Meridian Health	2 284	15,43	1 978	13,36	985	8,04	3 155	93,39	11 295	20 942	21 307	-	-	10,14
I087	Munimed	14 795	5,33	6 963	2,51	48 045	20,02	34 000	104,17	93 198	33 681	65 766	18 659	15 538	3,03
I166	National Independent Medical Aid Society (NIMAS)	10 145	14,30	6 285	8,86	10 878	17,50	25 100	45,97	93 366	182	3 971	-	-	797
I167	National Medical Plan (NMP)	18 651	5,27	14 867	4,20	24 782	8,56	83 419	97,62	359 013	227 489	-	-	32 613	2,37
I170	NBC Medical Scheme	9 128	16,10	9 858	17,39	1 258	2,80	13 500	102,25	52 686	-	-	-	-	3,86
I139	Omnihealth	15 454	14,83	22 323	21,42	19 495	20,97	13 500	99,22	42 204	-	2 446	-	-	1,49
I560	Openplan Medical Scheme	4 254	4,29	4 281	4,32	22 095	25,68	14 021	97,91	156 275	55 008	32	490	-	1 650
I215	Oxygen	5 086	1,96	7 138	2,75	59 726	27,47	52 300	138,06	109 202	213 521	-	2 537	-	1,45
I587	Pathfinder Medical Scheme	229	6,80	737	21,88	3 153	162,65	644	47,52	4 629	-	-	-	-	64
I546	Pharos Medical Plan	3 464	9,49	3 023	8,28	3 260	11,14	9 507	98,52	30 702	-	-	-	-	3,45
I454	Pro Sano Medical Scheme	17 602	7,51	25 418	10,85	66 368	32,11	37 000	114,98	591 336	125	2 010	39 984	-	3715
I196	Protea Medical Aid Society	3 252	31,13	3 021	28,92	726	7,20	3 115	99,08	18 059	2 930	984	-	-	0,64
I285	Protector Health	14 763	9,51	11 509	7,42	22 895	16,08	19 000	104,52	44 566	3 527	12 257	-	22	1,39
I595	Pulz Medical Scheme	20 695	82,64	2 330	9,30	26 078	178,58	6 112	117,86	30 478	-	-	-	-	6,86
I575	Resolution Health Medical Scheme	3 443	3,26	2 080	1,97	3 980	6,97	13 410	100,24	134 808	-	-	-	-	2,10
I446	Selfmed Medical Scheme	2 018	2,84	1 203	1,70	16 600	28,25	14 500	92,25	101 708	29 914	25 842	3 066	-	127
I486	Sizwe Medical Fund	69 559	21,38	73 123	22,47	33 611	14,73	50 000	94,11	357 460	39 863	33 453	-	-	2 060
I141	Spectramed	44 161	15,64	20 650	7,31	19 663	10,11	67 053	0,00	348 594	-	-	8 140	-	194
I464	Suremed Health	984	7,31	1 170	8,69	5 910	63,01	4 950	92,38	18 479	-	-	-	-	5,90
I147	Telemed	12 157	6,55	10 113	5,45	45 510	4,18	45 510	90,37	224 158	-	-	6 455	-	6,48
I592	Thebemed	298	11,69	367	14,43	360	22,84	1 695	N/A	3 655	-	-	-	-	4,21

Detailed financial results: registered schemes as at 31 December 2004

Ref. No.	Name of Medical Scheme	Accounts Receivable		Contribution Debtors		Accounts Payable		Outstanding Claims Provision		Investments			Insurance Policy	Other	Gross Claims Incurred Cash and Cash Equivalents Coverage	
		R'000	Days Outstanding	R'000	Days Outstanding	R'000	Days Outstanding	R'000	Months	R'000	R'000	R'000				R'000
I422	Topmed Medical Scheme	4883	5,44	1,40	1,40	16878	22,90	19011	0,98	156602	25174	-	-	-	8,02	
I586	X-Press Care Medical Scheme	2928	8,74	3,756	11,22	6619	25,48	8991	1,15	32912	-	-	-	-	3,78	
	SUB-TOTAL – Registered Open Schemes	1333468	13,22	1088952	10,79	1607204	20,62	1539540	0,75	1097626	3238012	891079	184754	551889	83177	4,94
	REGISTERED SCHEMES – RESTRICTED															
I553	ABI Medical Scheme	88	0,70	65	0,52	508	6,27	1704	75,21	45765	-	-	-	-	18,58	
I005	AECI Medical Aid Society	7668	15,47	7646	15,42	3540	7,52	13738	0,96	38423	19137	66564	-	-	2,81	
I567	Afrox Medical Aid Society	16343	38,00	12376	28,78	4471	12,34	6298	0,66	48481	9401	-	-	-	3,90	
I436	Alliance Midmed Medical Scheme	2817	24,26	2206	19,00	255	3,29	2435	1,45	29375	3925	-	-	-	14,11	
I534	Altron Medical Aid Scheme	2745	7,73	2588	7,29	1620	5,43	9345	99,13	79339	8316	-	391	-	7,43	
I012	Anglo American Corporation Medical Scheme (AACMED)	10152	12,62	8382	10,42	1663	2,47	17574	73,24	114847	241449	590410	2089	46471	5,62	
I571	Anglovaal Group Medical Scheme	4889	15,72	3568	11,47	2753	10,84	4600	105,36	59255	12930	25797	156	-	7,67	
I013	Aranda Medical Scheme	400	9,42	358	5,58	229	7,75	942	65,90	9681	-	-	-	-	10,77	
I279	Bankmed	7759	1,95	3396	0,85	184698	51,92	44777	94,38	524315	327314	108550	21957	-	6,67	
I507	Barloworld Medical Scheme	2263	4,74	222	0,47	3644	7,97	12303	103,25	109346	-	-	-	-	7,86	
I115	Biz Health Medical Scheme	4031	40,36	2377	23,80	3627	38,72	300	111,02	20748	274	913	-	-	0,87	
I526	BMW Employees Medical Aid Society	447	2,72	71	0,43	1134	8,26	3100	86,42	49428	-	-	6814	-	11,84	
I237	BPSA Medical Scheme	141	1,23	132	1,15	2441	18,48	2256	98,89	7805	13242	15033	4198	-	1,27	
I590	Building & Construction Industry Medical Aid Fund	290	3,53	118	1,44	307	5,15	2400	90,22	21567	-	969	-	0	11,88	
I593	Built Environment Professional Associations Medical Scheme (BEPS)	1574	24,01	1202	18,33	171	3,03	1766	102,83	3043	-	-	-	-	1,77	
I158	Cawmed Medical Scheme	1403	85,55	-	0,00	135	3,96	1350	0,00	8946	13421	13146	-	-	0,98	
I043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	11320	12,47	1100	12,23	5171	6,99	26000	102,22	67486	24859	17823	4985	67963	3,00	
I521	Clicks Group Medical Scheme	971	18,12	575	10,74	1388	27,45	1900	106,78	8682	-	-	-	-	5,64	
I570	CSIR Medical Scheme	682	4,17	45	0,27	2016	15,14	3232	0,00	27222	-	-	-	-	6,72	
I039	DCMed Medical Aid Fund	1862	8,39	822	3,70	1290	7,27	4082	92,40	35516	-	3585	-	-	6,58	
I068	De Beers Benefit Society	4285	7,18	-	0,00	29143	59,77	18937	82,19	221499	-	-	-	5103	14,93	
I484	Edcon Medical Aid Scheme	686	4,36	245	1,55	1804	14,76	3900	81,02	31670	-	143	-	-	8,55	
I513	Ellerines Holdings Medical Aid Society	206	5,55	66	1,79	98	3,44	600	93,97	12280	-	-	-	-	14,13	
I572	Engen Medical Benefit Fund	488	2,43	25	0,13	2633	15,97	3231	104,32	50561	1038	-	-	-	8,21	
I585	Eyethumed Medical Scheme	1123	12,76	323	3,67	2982	47,00	1300	76,52	20317	4380	-	-	-	5,85	
I271	Fishing Industry Medical Scheme (Fishmed)	373	37,97	453	46,04	312	59,37	130	93,46	2876	484	-	-	-	7	
I086	Food Workers Medical Benefit Fund	1435	42,12	1314	38,55	382	21,78	-	N/A	8543	4096	11962	3207	590	19,59	
I578	Foschini Group Medical Aid Scheme	3468	34,47	2938	29,21	866	11,25	1078	91,77	29636	-	-	-	-	12,65	
I082	G5Med	4976	28,23	4028	22,85	963	7,50	2700	107,75	54811	477	6112	114	-	13,76	
I270	Golden Arrow Employees Medical Benefit Fund	2129	36,68	1901	32,75	1559	37,96	996	101,39	7942	362	-	-	-	6,65	
I523	Grintek Electronics Medical Aid Scheme	2192	31,69	1762	25,48	2134	38,75	400	107,71	27391	1143	-	-	-	14,64	
I487	Holcim South Africa Medical Scheme	431	4,77	22	0,24	1476	17,54	1408	99,25	23427	-	143	-	520	4,15	
I111	IBM (SA) Medical Aid Society	3579	40,36	2472	27,88	1997	24,94	1300	72,53	16521	-	-	-	144380	6,78	
I591	Impala Medical Plan	8	0,13	-	0,00	2002	34,22	-	N/A	6509	-	-	-	-	3,66	
I559	Imperial Group Medical Scheme	3309	11,25	3923	13,34	1675	7,28	5000	87,65	52108	-	-	32257	-	7,45	

Detailed financial results: registered schemes as at 31 December 2004

Ref. No.	Name of Medical Scheme	Accounts Receivable		Contribution Debtors		Accounts Payable		Outstanding Claims Provision		Investments			Insurance Policy	Other	Gross Claims Incurred Cash and Cash Equivalents Coverage		
		R'000	Days Outstanding	R'000	Days Outstanding	R'000	Days Outstanding	R'000	Months	R'000	R'000	R'000				R'000	
I121	Klerksdorp Medical Benefit Society (KDM)	28 547	73,43	3 114	8,01	46 275	114,05	5 700	88,77	0,46	10 441	-	189	75 890	-	42 105	0,85
I145	Lamaf Medical Scheme	20 419	15,39	18 006	13,57	9 847	8,91	25 000	94,56	0,86	185 832	4 970	2 452	5 415	-	445	5,60
I197	Libcare Medical Scheme	2 912	10,44	3 141	11,26	648	3,07	5 000	94,86	0,06	37 722	76 891	7 960	-	-	-	7,78
I547	Malcor Medical Scheme	131	0,59	39	0,18	1 259	5,51	7 566	0,00	1,10	29 472	-	18 141	-	-	-	0,87
I042	Mascom Medical Scheme	49	0,71	44	0,64	1 561	24,45	1 307	63,19	0,83	33 795	-	2 619	-	-	-	1,62
I495	Massmart Health Plan	451	4,64	44	0,45	464	6,63	1 500	92,08	0,88	25 448	1 004	-	-	-	-	9,47
I588	MEDCOR	3 908	1,66	440	0,19	78 840	51,33	33 454	91,41	0,72	302 823	-	-	-	-	274	6,48
I548	Medipos Medical Scheme	23 755	46,33	17 115	33,38	7 450	14,84	9 900	105,18	0,81	64 147	2 605 950	4 989	-	116	-	4,20
I568	Medisense Medical Scheme	12 045	28,64	10 932	25,99	8 107	27,31	5 400	95,91	0,86	127 035	-	-	-	-	-	14,07
I535	Metrocare	5 520	31,08	5 213	29,35	1 039	7,17	3 500	92,41	0,79	37 662	-	-	-	24 884	-	8,54
I105	Metropolitan Medical Scheme	122	0,45	-	0,00	3 499	15,87	4 298	101,16	0,64	10 887	-	-	-	60 483	-	1,62
I569	Minedmed Medical Scheme	1 287	3,47	73	0,20	1 318	4,77	7 500	64,68	0,89	63 161	-	-	-	10 110	-	7,52
I566	Moremed Medical Scheme	1 493	38,68	1 817	47,09	1 306	46,23	400	122,33	0,48	7 642	2 144	4 242	58	-	-	2,22
I208	Mutual & Federal Medical Aid Fund	1 119	7,30	413	2,69	684	5,12	4 000	89,65	1,02	36 713	-	-	-	-	-	9,02
I154	Nampak Group Medical Aid	10 758	29,95	9 457	26,33	9 735	32,59	7 664	87,64	0,96	105 279	-	-	-	-	-	11,59
I241	Naspers Medical Fund	1 193	4,05	607	2,06	5 370	23,03	5 021	92,20	0,79	72 464	-	25 298	-	-	-	10,22
I469	Nedcor Medical Aid Scheme	7 474	9,35	5 315	6,65	27 588	35,80	15 400	109,68	0,67	22 929	-	-	-	720 685	-	0,98
I584	Nectare Medical Scheme	4 278	7,63	3 341	5,96	956	2,04	10 700	97,94	0,90	113 440	-	-	-	-	-	7,96
I214	Old Mutual Staff Medical Aid Scheme	3 436	6,64	2 137	4,13	5 665	11,62	11 300	120,05	0,83	22 585	137 935	5 437	-	10 734	-	0,96
I441	Parmed Medical Aid Scheme	1 396	5,89	3 307	13,96	4 824	23,98	5 490	102,32	0,90	22 340	20 360	9 321	-	-	-	3,65
I515	PG Bison Medical Aid Society	324	6,92	241	5,14	106	2,65	1 564	0,00	1,29	12 931	-	-	-	-	-	10,68
I186	PG Group Medical Scheme	2 094	23,79	1 931	21,93	1 891	27,43	1 266	98,99	0,81	36 654	-	-	-	-	-	17,48
I563	Pick & Pay Medical Scheme	740	2,85	496	1,91	2 601	12,69	2 796	98,35	0,63	51 999	17 867	39 154	152	-	-	1,45
I583	Platinum Health	18 970	45,66	1 167	4,84	8 222	18,76	12 307	104,90	0,94	60 502	-	-	-	142	-	4,54
I194	Profmed	1 053	0,78	1 443	1,06	11 893	11,72	5 832	0,00	1,93	162 927	-	46 292	-	185	-	5,28
I516	Quantum Medical Aid Society	4 376	12,93	3 746	11,07	3 540	13,33	4 500	50,15	0,72	52 412	20 324	47 861	13 173	-	9 581	1,26
I201	Rand Water Medical Scheme	1 655	9,43	1 655	8,57	6 049	11,69	6 950	98,07	1,61	51 637	-	-	-	-	-	11,99
I430	Remedi Medical Aid Scheme	8 194	11,73	6 266	8,97	6 049	11,39	7 071	96,11	0,52	173 798	-	-	-	-	-	10,76
I176	Retail Medical Scheme	281	1,33	-	0,00	7 760	50,56	3 300	63,12	0,84	29 798	14 841	-	-	15 330	-	9,56
I209	SA Breweries Medical Aid Society	1 551	5,57	731	2,63	425	2,05	8 574	93,14	1,49	77 770	-	-	-	-	-	12,34
I424	SABC Medical Aid Scheme	1 763	7,60	313	1,35	746	3,76	4 338	115,31	0,85	86 028	99	-	-	-	-	14,26
I557	Samancor Health Plan	7 492	33,12	3 623	16,02	1 449	5,46	7 700	84,04	0,95	112 854	-	-	-	-	-	13,99
I038	SAMWUMed	13 815	33,76	12 827	31,34	7 661	25,83	15 402	102,58	1,71	143 150	3 474	4 680	9 051	8 531	2 263	14,81
I527	Sappi Medical Aid Scheme	2 706	10,04	2 043	7,58	2 506	10,68	4 500	90,01	0,77	49 597	-	-	-	-	-	6,95
I234	Sasolmed	5 520	3,88	26	0,02	7 633	7,05	22 496	86,85	0,69	102 183	112 750	-	-	58 241	-	3,10
I531	Sedmed	-	-	-	0,00	596	27,53	653	0,00	0,99	2 327	-	-	-	-	-	3,53
I243	Siemens Medical Scheme	1 615	8,47	601	3,15	506	3,38	3 000	109,58	0,78	38 699	-	-	-	15 962	-	8,49
I580	South African Police Service Medical Scheme (POLMED)	38 282	5,31	6 123	0,85	262 125	42,68	146 304	72,30	0,78	1 510 440	94 802	-	-	33 925	576	7,73
I254	Stocksmed	712	17,35	199	4,86	311	10,32	708	80,00	0,99	29 486	-	-	-	-	-	32,17
I544	Tiger Brands Medical Scheme	5 400	15,24	4 737	13,37	2 591	8,02	9 650	99,37	0,98	91 913	-	12 171	-	-	-	9,35
I582	Transmed Medical Fund	27 879	8,65	1 355	0,42	38 162	13,08	190 867	30,24	2,33	1 90 644	-	-	-	240	-	13,42
I579	Tsogo Sun Group Medical Scheme	1 394	13,87	1 221	12,15	1 588	20,22	1 300	96,92	0,71	34 541	2 208	-	-	-	-	15,38
I434	Umed	7 902	12,90	2 577	4,21	22 113	44,10	16 848	94,55	1,13	173 369	-	5 004	-	-	158	11,37
I597	Umvuzo Health Medical Scheme	1 062	21,80	612	12,56	1 138	35,92	670	N/A	0,69	2 153	-	-	-	203	-	2,22
I520	University of Natal Medical Scheme	707	4,65	103	0,68	2 611	21,94	1 530	97,30	0,51	25 917	-	20 146	-	-	1 482	5,67
I282	University of the Witwatersrand Staff Medical Aid Scheme	1 090	6,70	41	0,25	779	5,93	3 436	98,31	0,86	53 252	-	-	-	-	-	13,32
I565	Venda Police and Prisons Medical Scheme (Polprised)	41	0,62	-	0,00	1 887	33,07	2 151	99,07	1,24	3 565	-	-	-	-	-	2,05

Detailed financial results: registered schemes as at 31 December 2004

Ref. No.	Name of Medical Scheme	Accounts Receivable		Contribution Debtors		Accounts Payable		Outstanding Claims Provision		Investments			Gross Claims Incurred Cash and Cash Equivalents Coverage		
		R'000	Days Outstanding	R'000	Days Outstanding	R'000	Days Outstanding	R'000	Months	Cash and Cash Equivalents	Bonds and Debentures	Equities		Properties	Insurance Policy
I291	Witbank Coalfields Medical Aid Scheme	5 801	15,86	4 409	12,05	6 714	21,37	6 000	84,57	68 018	26 562	11 244	24 615	718	5,04
I293	Wooltru Healthcare Fund	255	0,82	162	0,52	3 604	13,75	5 146	95,01	46 011	66 306	-	-	-	2,26
I253	Xstrata Medical Aid Scheme	1 351	7,43	559	3,07	1 913	13,85	2 700	113,30	25 819	537	-	10 573	-	6,15
SUB-TOTAL – Registered Restricted Schemes		400 856	9,95	225 210	5,59	898 294	26,52	923 192	73,35	7 707 573	1 540 514	1 381 443	1 127 843	238 511	7,34
TOTAL REGISTERED SCHEMES		1 734 324	12,28	1 314 162	9,31	2 505 498	22,41	2 462 732	89,47	17 805 199	4 778 526	2 272 522	1 679 733	321 688	5,67

Notes:

- a Draft Annual Financial Statements were submitted.
- The denominator is gross contribution income in respect of accounts receivable outstanding days and contribution debtors.
 - The denominator is gross claims incurred in respect of accounts payable outstanding days.
 - In respect of prior year claims provision utilised = prior year payments / provision at the beginning of the year.
 - In respect of outstanding claims provision covering net claims = provision at end of year / net claims incurred.
 - In respect of Gross claims cash coverage = short term investments / gross claims incurred.
 - Please take note that in respect of the Prior year claims provision utilised:
 - If it is above 100%, the scheme under provided in the prior year.
 - If it is below 100%, the scheme over provided in the prior year.
 - If equal to zero, no information was submitted.
 - Please take note that each type of asset class includes both long-term and short-term as well as those inside the Republic and outside the Republic.

Detailed financial results: registered schemes for the year ended 31 December 2004

Ref. No.	Name of Medical Schemes	Gross Contributions		Gross Claims Incurred		Gross Claims Incurred: Gross Contributions		Gross Non-Health Expenditure		Gross Non-Health Expenditure: Gross Contributions		Surplus/(Deficit) from Operations		Surplus/(Deficit) from Operations: Gross Contributions	
		2004 PABPM R	% Growth	2004 PABPM R	% Growth	2004 %	2003 %	2004 PABPM R	% Growth	2004 %	2003 %	2004 R	% Growth	2004 %	2003 %
1154	Nampak Group Medical Aid	715	12.78	595	13.47	83.16	82.66	63	58	8.70	9.08	-3.62	40	1.56	5.63
1241	Naspers Medical Fund	753	15.14	596	1.87	79.09	89.39	65	55	19.86	8.34	4.10	66	-1	8.71
1469	Nedcor Medical Aid Scheme	569	5.59	549	4.96	10.70	96.38	33	49	-33.35	5.76	-1.09	30	-1	8.71
1584	Netcare Medical Scheme	718	9.06	600	1.63	83.58	78.49	75	68	9.78	10.40	0.66	34	62	-1.09
1214	Old Mutual Staff Medical Aid Scheme	507	4.75	689	4.13	15.63	94.17	55	49	11.61	10.84	0.38	41	-36	4.74
1441	Parmed Medical Aid Scheme	1259	1.57	1069	1.69	84.89	81.58	71	54	30.76	5.63	20.11	119	159	9.48
1515	PG Bison Medical Aid Society	843	7.27	716	6.34	84.98	87.28	67	68	-1.46	7.95	-15.06	60	24	7.07
1186	PG Group Medical Scheme	1135	10.25	889	18.37	78.34	73.24	70	78	-9.73	6.18	-18.43	141	148	14.43
1563	Pick & Pay Medical Scheme	636	12.99	503	4.45	13.00	79.06	66	58	13.11	10.32	0.10	51	52	8.05
1583	Platinum Health	358	3.29	889	3.77	347	105.47	15	11	32.41	4.09	3.37	21.60	3	0.97
1194	Profmed	587	4.83	21.64	4.39	74.73	87.08	76	77	-0.29	13.00	15.85	68	-17	4.99
1516	Quantum Medical Aid Society	617	13.37	484	4.49	78.48	82.56	73	77	-6.33	11.76	-17.38	48	10	7.72
1201	Rand Water Medical Scheme	809	6.68	653	6.12	6.66	80.65	21	24	-11.30	2.59	-26.76	136	33	16.76
1430	Remedi Medical Aid Scheme	762	7.00	8.95	5.80	5.33	76.03	51	49	4.95	6.70	6.96	110	100	10.29
1176	Retail Medical Scheme	742	6.79	9.30	5.41	5.63	-3.92	93	30	21.46	12.54	4.40	184.97	90	18.41
1209	SA Breweries Medical Aid Society	629	8.50	8.59	4.69	74.50	78.57	57	54	5.19	8.99	9.28	102	68	16.20
1424	SABC Medical Aid Scheme	792	7.14	10.88	6.76	559	20.86	53	48	10.58	6.67	6.69	-0.27	-1	-0.17
1557	Samancor Health Plan	567	5.08	11.56	6.64	497	33.57	62	47	31.95	11.03	9.33	18.29	-160	-37
1038	SAMWUmed	258	2.17	18.80	1.48	26.00	72.46	30	23	29.48	11.48	10.54	8.99	34	3.4
1527	Sappi Medical Aid Scheme	788	6.88	4.61	6.86	6.31	8.81	55	43	29.18	7.04	6.24	12.72	30	8
1234	Sasolmed	726	6.29	15.51	5.53	500	10.55	59	54	7.73	8.07	8.66	-6.73	113	73
1531	Sedmed	390	2.51	55.27	3.96	297	33.44	5	5	4.65	1.40	2.08	-32.60	-11	-5.1
1243	Siemens Medical Scheme	871	8.04	8.37	6.85	559	22.52	70	69	1.37	8.07	8.63	-6.46	8	80
1580	South African Police Service Medical Scheme (POLMED)	595	6.04	-1.42	507	4.85	4.65	51	56	-9.13	8.51	9.23	-7.82	37	63
1254	Stocksmed	810	7.37	9.89	5.94	530	12.12	74	68	9.00	9.16	9.24	-0.81	68	72
1544	Tiger Brands Medical Scheme	767	7.23	6.12	700	6.59	6.12	53	44	20.64	6.90	6.07	13.68	14	19
1582	Transmed Medical Fund	562	5.49	2.48	508	3.95	28.75	62	59	4.68	11.05	10.81	2.15	-13	93
1579	Tsogo Sun Group Medical Scheme	663	6.48	2.18	518	4.62	12.09	96	115	-16.60	14.43	17.68	-18.38	25	47
1434	Umed	747	6.60	13.24	6.12	6.11	0.11	57	49	14.62	7.58	7.49	1.22	77	-1
1597	Umvuzo Health Medical Scheme	305	N/A	N/A	198	N/A	N/A	54	N/A	N/A	N/A	N/A	32	N/A	N/A
1520	University of Natal Medical Scheme	657	5.21	26.16	5.14	415	23.83	78	60	30.98	11.88	11.45	3.82	-6	-8
1282	University of the Witwatersrand Staff Medical Aid Scheme	733	6.84	7.19	592	5.47	8.15	63	69	-8.46	8.56	10.03	-14.59	79	68
1565	Venda Police and Prisons Medical Scheme (Polprismsed)	336	2.85	18.03	288	2.27	26.69	83	122	-31.98	24.77	42.98	-42.37	-35	-65
1291	Witbank Coalfields Medical Aid Scheme	742	6.80	9.03	637	5.97	6.69	40	28	43.60	5.45	4.14	31.71	14	11
1293	Wooltru Healthcare Fund	520	4.66	11.55	437	4.01	9.04	63	64	-1.78	12.13	13.77	-11.95	13	4
1253	Xstrata Medical Aid Scheme	487	4.65	4.71	370	3.43	7.72	51	47	9.70	10.49	10.01	4.76	66	75
SUB-TOTAL - Registered Restricted Schemes		633	5.92	6.99	532	4.95	7.53	62	59	6.41	9.87	9.93	-0.54	29	31
TOTAL REGISTERED SCHEMES		645	6.02	7.27	511	4.79	6.75	90	83	7.81	13.88	13.82	0.50	34	29

Notes:

- a Draft annual financial statements were submitted for 2004.
 - The Surplus/(deficit) from operations represents the risk portion only, whereas all the other items include savings amounts.
 - PABPM = Per Average Beneficiary Per Month
 - There are no 2004 figures for the color coded schemes due to:
 - Schemes liquidating during the year (Highveld furnished the Office with management accounts for the 2003 financial year).
- The following schemes amalgamated in 2004, and in 2003
- Allcare with NBC with effect from 1 January 2004.
 - AngloGold with Discovery Health with effect from 1 June 2004.
 - MyHealth with Oxygen with effect from 1 July 2004.
 - Billmed with Samancor with effect from 1 July 2004.
 - Jomed with Lamaf with effect from 1 September 2003.
 - Pretmed with Global Health with effect from 1 October 2003.
- There are no 2003 figures for the color coded schemes due to:
- Schemes registering during 2004.

Notes:

- Ingwe Med (Pty) Ltd changed its name to African Life Health (Pty) Ltd
- Health Management Institute (Pty) Ltd changed its name to MX Network Systems (Pty) Ltd
- Average beneficiaries for the year were used.
- Comparative figures were restated
- PABPM = Per Average Beneficiary Per Month
- B and M Medical Scheme Administrators (Pty) Ltd changed its name to Benmed Medical Scheme Administrators (Pty) Ltd
- Where schemes amalgamated during the year, the results were included in the administrator as at year-end.

Impaired receivables: 2004 registered schemes for the year ended 31 December 2004

Ref. No.	Name of Medical Scheme	2004										2003										2002										2001										2000									
		Impaired Receivables Written Off	Impaired Receivables Recovered	(Increase)/Decrease in Provision for Impaired Receivables	Total Impaired Receivables	% Non-Expenditure	Contributions for More than 60 Days as of Arrar	Impaired Receivables Written Off	Impaired Receivables Recovered	(Increase)/Decrease in Provision for Impaired Receivables	Total Impaired Receivables	% Non-Expenditure	Contributions for More than 60 Days as of Arrar	Impaired Receivables Written Off	Impaired Receivables Recovered	(Increase)/Decrease in Provision for Impaired Receivables	Total Impaired Receivables	% Non-Expenditure	Contributions for More than 60 Days as of Arrar	Impaired Receivables Written Off	Impaired Receivables Recovered	(Increase)/Decrease in Provision for Impaired Receivables	Total Impaired Receivables	% Non-Expenditure	Contributions for More than 60 Days as of Arrar	Impaired Receivables Written Off	Impaired Receivables Recovered	(Increase)/Decrease in Provision for Impaired Receivables	Total Impaired Receivables	% Non-Expenditure	Contributions for More than 60 Days as of Arrar																				
1434	Umed	(260)	-	(260)	1,54	12,98	(122)	-	(82)	(204)	1,35	20,06	(177)	-	(177)	1,25	13,93	(398)	8	126	(265)	2,10	51,62	(125)	-	(17)	(142)	1,50	8,97																						
1597	Unwuzo Health Medical Scheme	-	-	(12)	0,73	9,56	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A																						
1520	University of Natal Medical Scheme	(0)	-	(2)	0,04	0,00	(18)	-	(26)	(44)	0,88	0,00	(52)	-	(52)	4,84	0,00	(0)	-	-	(0)	0,00	0,00	-	-	-	-	0,00	0,00																						
1282	University of the Witwatersrand Staff Medical Aid Scheme	(147)	-	814	668,13,12	55,44	(283)	15	273	4	-0,08	-106,65	(13)	1	(7)	19	0,41	76,33	(267)	0	483	2,15	4,98	38,22	-	0	(207)	(206)	6,35	15,09																					
1565	Venda Police and Prisons Medical Scheme (Polprismed)	-	-	-	0,00	N/A	-	-	-	-	0,00	0,00	-	-	-	0,00	0,00	-	-	-	-	0,00	0,00	-	-	-	-	0,00	0,00																						
1291	Witbank Coalfields Medical Aid Scheme	(87)	0	-	(87)	1,20	0,00	(84)	4	-	1,14	0,00	(74)	19	-	(55)	0,67	0,00	(58)	4	(350)	(404)	7,19	0,00	(111)	3	-	(108)	2,46	0,00																					
1293	Wooltru Healthcare Fund	(37)	0	18	(18)	0,13	0,00	(14)	0	8	0,05	0,00	(77)	1	83	6	-0,05	4,36	(363)	14	605	2,57	2,65	100,00	(111)	-	(753)	(864)	9,62	0,00																					
1253	Xstraa Medical Aid Scheme	(40)	-	167	127	-1,82	1,12	(6)	-	99	-1,47	3,17	(99)	-	(90)	(189)	3,11	1,30	(77)	-	(85)	(162)	3,50	0,88	-	-	(146)	(146)	3,63	4,01																					
SUB-TOTAL -	Registered Restricted Schemes	(121599)	1443	(4402)	(124559)	8,58	14,60	(125136)	634	(7950)	(132452)	9,67	13,93	(17879)	220	2,554	(15106)	1,34	18,01	(7830)	1288	(16360)	(22902)	2,35	21,02	(20718)	870	(16114)	(35962)	3,91	17,63																				
TOTAL REGISTERED SCHEMES		(246822)	7239	28159	(211424)	2,96	13,54	(169771)	4024	(153862)	(319610)	4,84	24,70	(104532)	2368	(31595)	(133759)	2,32	16,52	(121802)	12081	(84535)	(194256)	3,68	28,16	(77582)	10948	(79060)	(145694)	3,80	25,89																				

Notes:

a Draft annual financial statements were submitted for 2004.

- The comparative figures were only included for those schemes that were in operation during 2004.

The following schemes amalgamated in the 2004 year:

- Allcare with NBC with effect from 1 January 2004.
- Anglogold with Discovery Health with effect from 1 June 2004.
- Myhealth with Oxygen with effect from 1 July 2004.
- Billmed with Samancor with effect from 1 July 2004.

- There are no comparative figures for the color coded schemes due to:
 - Schemes were registered during the 2004 year.

Detailed financial results: bargaining council schemes for the year ended 31 December 2004

Ref. No.	Name of Medical Scheme	Members' 31/12/04	Beneficiaries 31/12/04	No. of Dependents per Member	Gross Contributions		Gross Administration Expenses (RISK + PMSA)		Managed Care: Management Services		Net Reinsurance R'000	Net Claims Incurred: Results %	Gross Underwriting Net R'000	Net Underwriting Results R'000	Surplus/ (Deficit) Results R'000	Net Surplus/ (Deficit) from Operations R'000	Net Assets (Members' (Deficit) R'000	Net Assets Per Funds per BS) R'000	Solvency Ratio Regulation 29 %
					R'000	PABPM R	R'000	As % of GCI	R'000	As % of GCI									
3456	Autoworkers Medical Aid Fund (Automated)	27 222	68 303	1.51	155 738	202	13 452	8.64	17	0.00	-	83.72	25 357	11 906	10 243	21 355	157 414	157 310	101.01
3514	Bargaining Council for the Building Industry (Kimberly)	146	209	0.43	1 035	380	554	53.52	203	0.00	-	24.73	779	225	225	353	2 114	2 114	204.17
3322	Building Industry Medical Aid Fund (Eastern Cape)	671	1 776	1.65	4 060	179	883	21.74	39	0.00	-	75.46	996	114	114	133	12	12	0.30
3302	Building Industry Medical Aid Fund (Western Cape)	3 398	11 580	2.41	12 074	87	2 678	22.18	19	0.00	-	65.24	4 197	1 518	1 518	1 874	3 672	3 672	30.41
3304	Clothing Industry Health Care Fund (Cape Town)	35 229	91 062	1.58	29 094	28	10 014	34.42	10	9 880	33.96	5.21	9 521	(10 373)	(11 677)	(6 018)	27 480	24 180	83.11
3327	Clothing Industry Medical Benefit Scheme (Free State & Northern Cape)	543	543	-	263	41	48	18.24	7	0.00	-	86.99	37	(11)	(11)	53	528	505	191.78
3339	Clothing Industry Medical Benefit Society (Northern Areas)	6 330	6 330	-	3 936	52	741	18.82	10	0.00	-	82.82	676	(64)	(64)	144	2 165	2 165	55.00
3318	Clothing Industry Sick Benefit Fund (Natal)	16 689	16 689	-	11 312	56	3 969	35.09	20	0.00	-	35.72	5 498	1 529	1 522	2 587	14 017	14 017	123.92
3419	Knitting Industry Medical Benefit Society (Northern Areas)	428	533	0.25	251	39	52	20.63	8	0.00	-	58.17	50	(1)	(1)	204	2 183	2 100	838.28
3324	Motor Industry Medical Aid Fund (MIMED)	24 214	53 824	1.22	459 141	711	17 245	3.76	27	10 176	2.22	85.75	65 368	37 947	37 447	53 307	226 840	226 840	49.41
3479	Natal Furniture Workers Sick Benefit Society	1 466	1 466	-	2 086	119	1 052	50.46	60	0.00	-	47.60	1 093	40	40	284	2 444	2 119	101.59
3314	Natal Hairdressers Sick Benefit Fund	722	788	0.09	488	52	15	3.06	2	0.00	-	101.46	(7)	(22)	(43)	510	510	104.56	
TOTAL BARGAINING COUNCIL SCHEMES		117 058	253 103	1.16	679 478	224	50 703	7.46	17	20 056	2.95	80.34	113 566	42 808	39 335	74 233	439 379	435 544	64.10

Notes:

a An encumbered asset was excluded in the 2004 calculation of the solvency ratio.

- PMSA = Personal Medical Savings Account
- GCI = Gross Contribution Income
- PABPM = Per Average Beneficiary Per Month
- BS = Balance Sheet
- No broker fees were paid by the schemes

Detailed financial results: bargaining council schemes for the year ended 31 December 2004

Ref. No.	Name of Medical Scheme	Beneficiaries		Gross Contribution Income (GCI)			Nett Claims Incurred (incl PMSA Claims)			Gross Administration Expenses (incl PMSA & Managed Care)			Reserve Position (per Regulation 29)			Solvency Ratio											
		Average 2004	Average 2003	2004 R'000	% Growth	PABPM 2004 R	PABPM 2003 R	% Growth	2004 R'000	% Growth	PABPM 2004 R	PABPM 2003 R	% Growth	2003 R'000	% Growth	PB 2004 R	PB 2003 R	% Growth	2004 %	2003 %							
3456	Autoworkers Medical Aid Fund (Auromed)	64 324	62 513	3	155 738	11 831 9	32	202	158	28	169	146	15	13 452	13 303	1	17	18	-2	573 10	137 914	14	2 303	2 146	7	101,01	116,56
3514	Bargaining Council for the Building Industry (Kimberly)	227	188	21	1 035	741	40	380	329	15	94	104	-10	554	675	-18	203	300	-32	2 114	1 766	20	10 113	13 584	-26	204,17	238,29
3322	Building Industry Medical Aid Fund (Eastern Cape)	1 893	2 177	-13	4 060	3 610	12	179	138	29	135	121	11	883	908	-3	39	35	12	12	(12,1)	110	7	-66	110	0,30	-3,36
3302	Building Industry Medical Aid Fund (Western Cape)	11 580	961	1105	12 074	10 447	16	87	906	-90	57	764	-93	2 678	2 807	-5	19	243	-92	3 672	1 798	104	317	166	91	30,41	17,21
3304	Clothing Industry Health Care Fund (Cape Town)	86 499	53 482	62	29 094	28 571	2	28	45	-37	1	2	-37	19 894	17 609	13	19	27	-30	24 180	33 656	-28	266	370	-28	83,11	117,80
3327	Clothing Industry Medical Benefit Scheme (Free State & Northern Cape)	539	499	8	263	264	0	41	44	-8	35	38	-8	48	32	52	7	5	40	505	439	15	930	821	13	191,78	166,34
3339	Clothing Industry Medical Benefit Society (Northern Areas)	6 327	7 271	-13	3 936	4 346	-9	52	50	4	43	37	15	741	623	19	10	7	37	2 165	2 248	-4	342	307	11	55,00	51,73
3318	Clothing Industry Sick Benefit Fund (Natal)	16 826	16 803	0	11 312	10 532	7	56	52	7	20	28	-27	3 969	3 515	13	20	17	13	14 017	11 522	22	840	654	29	123,92	109,40
3419	Knitting Industry Medical Benefit Society (Northern Areas)	539	814	-34	251	369	-32	39	38	2	49	23	-23	52	54	-5	8	6	44	2 100	1 860	13	3 941	2 831	39	838,28	503,35
3324	Motor Industry Medical Aid Fund (MIMED)	53 824	50 178	7	459 141	423 638	8	711	704	1	610	584	5	27 421	26 259	4	42	44	-3	226 840	173 534	31	4 214	3 458	22	49,41	40,96
3479	Natal Furniture Workers Sick Benefit Society	1 466	7 635	-81	2 086	2 066	1	119	23	426	56	10	457	1 052	414	154	60	5	1 223	2 119	1 835	15	1 445	240	501	101,59	88,82
3314	Natal Hairdressers Sick Benefit Fund	788	788	0	488	718	-32	52	76	-32	495	44	19	15	302	-95	2	32	-95	510	553	-8	648	702	-8	104,56	77,03
TOTAL BARGAINING COUNCIL SCHEMES		244 832	203 309	20	679 478	603 622	13	231	247	-7	186	199	-7	70 758	66 502	6	24	27	-12	435 544	367 003	19	1 721	1 451	19	64,10	60,80

Notes:

- PMSA = Personal Medical Savings Account
- GCI = Gross Contribution Income
- PABPM = Per Average Beneficiary Per Month
- PB = Per Beneficiary

- The following medical schemes changed their names during 2004:

Ref no.	New name	Old name	With effect from
1487	The Holcim South Africa Medical Scheme	Alpha Group Medical Scheme	2-Feb-04
1042	Mascom Medical Scheme	Chamber of Mines Medical Aid Society	1-Jul-04
1115	Biz Health Medical Scheme	Johannesburg Metropolitan Chamber of Commerce	1-Jul-04
1579	Southern Sun Medical Aid Scheme	Tsogo Sun Group Medical Scheme	1-Sep-04
1589	Baymed	Co-ordinated Health Plan	24-Nov-04

- The following amalgamations took place during 2004:

Ref no.	Name	Scheme amalgamated with	Ref no:	With effect from
1496	Allcare Medical Aid Scheme	NBC Medical Scheme	1170	1-Jan-04
1503	Anglogold Medical Scheme	Discovery Health Medical Scheme	1125	1-Jun-04
1148	Myhealth Medical Scheme	Oxygen	1215	1-Jul-04
1089	Billmed Medical Scheme	Samancor Health Plan	1557	1-Jul-04

- The following medical schemes were wound up during 2004:

Ref no.	Name
1177	Highveld Medical Scheme

- The following medical schemes began operations during 2004:

Ref no.	Name	With effect from
1596	Eclipse Medical Scheme	1-Apr-04
1597	Umvuzo Health Medical Scheme	1-Jul-04
1589	Baymed (registered in 2001)	1-Nov-04

- The following schemes submitted draft financial statements:

Ref no.	Name
1537	Hosmed Medical Aid Scheme
3456	Autoworkers Medical Aid Fund (Automed)
3514	Bargaining Council for the Building Industry (Kimberly)
3304	Clothing Industry Health Care Fund (Cape Town)
3327	Clothing Industry Medical Benefit Scheme (Free State & Northern Cape)
3339	Clothing Industry Medical Benefit Society (Northern Areas)
3318	Clothing Industry Sick Benefit Fund (Natal)
3419	Knitting Industry Medical Benefit Society (Northern Areas)
3479	Natal Furniture Workers Sick Benefit Society
3314	Natal Hairdressers Sick Benefit Fund

- Projections were made in respect of the non-financial data with regards to the following schemes:

Ref no. Name

3456	Autoworkers Medical Aid Fund (Automed)
3302	Building Industry Medical Aid Fund (Western Cape)
3318	Clothing Industry Sick Benefit Fund (Natal)
3324	Motor Industry Medical Aid Fund (MIMED)
3479	Natal Furniture Workers Sick Benefit Society
3314	Natal Hairdressers Sick Benefit Fund

- The 2003 comparative figures have been restated for the following schemes as a result of:

Ref no.	Name	Reason
1534	Altron Medical Aid Scheme	Specific reserves transferred to accumulated funds
1012	Anglo American Corporation Medical Scheme (AACMED)	Reclassification
1593	Built Environment Professional Associations Medical Scheme (BEPS)	Reclassification
1202	Fedhealth	Reclassification
1086	Food Workers Medical Benefit Fund	Change in accounting policy
1162	Global Health	Reclassification
1559	Imperial Group Medical Scheme	Specific reserves transferred to accumulated funds
1576	Liberty Medical Scheme	Reclassification
1495	Massmart Health Plan	Reclassification
1560	Openplan Medical Scheme	Reclassification
1583	Platinum Health	Reclassification
1454	Pro Sano Medical Scheme	Consolidation
1516	Quantum Medical Aid Society	Change in accounting policy
1430	Remedi Medical Aid Scheme	Reclassification
1209	SA Breweries Medical Aid Society	Reclassification
1531	Sedmed	Restatement
1422	Topmed Medical Scheme	Reclassification
1582	Transmed Medical Fund	Reclassification
1291	Witbank Coalfields Medical Aid Scheme	Reclassification
1293	Wooltru Healthcare Fund	Specific reserves transferred to accumulated funds

Although Klerksdorp Medical Benefit Society (KDM) submitted consolidated accounts for 2004, the 2003 comparatives were not restated.

- Please take note that the figures were rounded off in the report; hence the percentage variance will be different to that in the Annexures
- Bargaining Council Schemes were formerly known as Exempt Schemes



COUNCIL FOR MEDICAL SCHEMES

Produced by the Council for Medical Schemes,
Designed by Shahn Irwin