COUNCIL FOR MEDICAL SCHEMES
ANNUAL REPORT 2015/16

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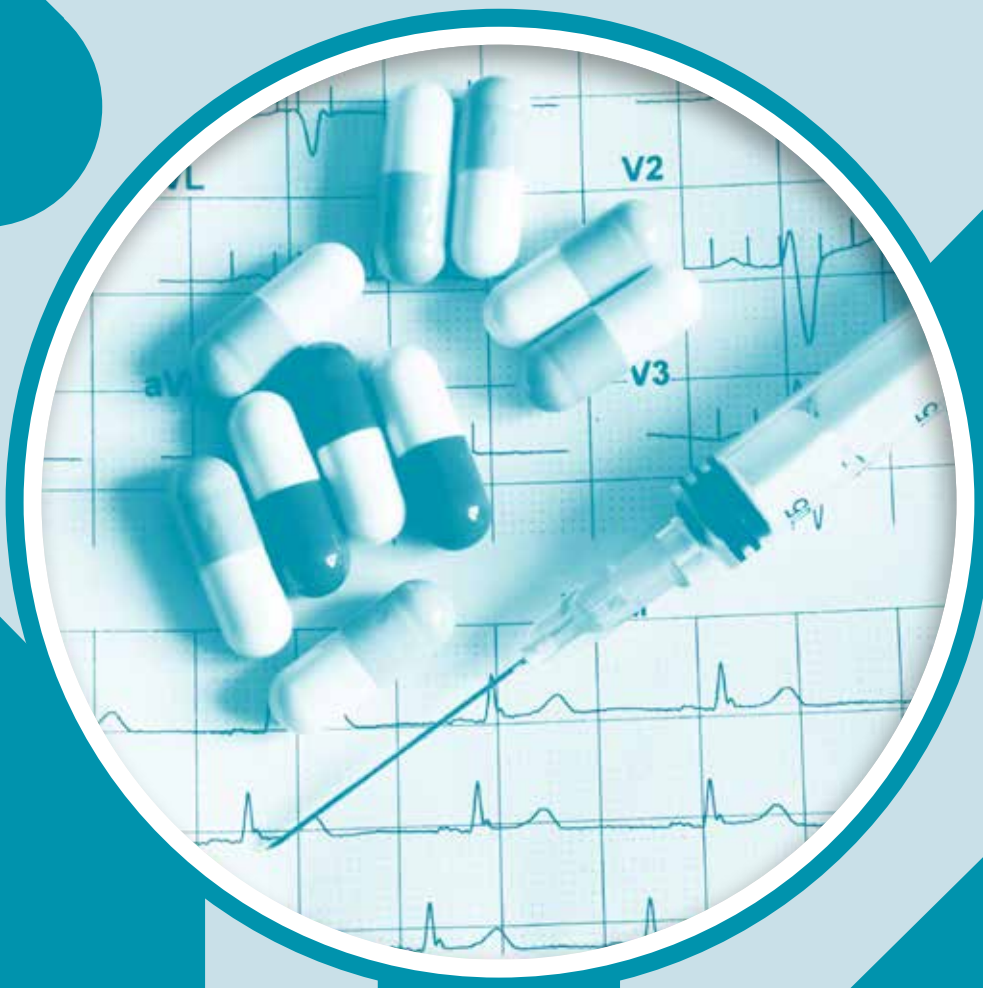


GENERAL INFORMATION ON THE COUNCIL FOR MEDICAL SCHEMES

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

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

AFS	Annual Financial Statements
A-G	Auditor-General
AGM	Annual general meeting
AGSA	Auditor-General of South Africa
AIDS	Acquired immune deficiency syndrome
APP	Annual performance plan
BEE	Black economic empowerment
Beneficiaries	Principal members + dependants (total membership of medical scheme)
BHF	Board of Healthcare Funders of Southern Africa
BMU	Benefits Management Unit
Board	Board of Trustees
CAMAF	Chartered Accountants (SA) Medical Aid Fund
CDL	Chronic disease list
CIB	Chronic illness benefit
CMS	Council for Medical Schemes
Council	Accounting Authority or the board of the Council for Medical Schemes
CPI	Consumer Price Index
CPIX	CPI excluding interest rates on mortgage bonds
CRC	Clinical Review Committee
DDDR	Dynamic Database Driven Return
DENOSA	Democratic Nursing Organisation of South Africa
Dependant	Member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
NDoH	National Department of Health
DRG	Diagnosis-related group
DRGTAP	DRG Technical Advisory Panel
DSP	Designated service provider
DTP	Diagnosis and treatment pair
EDO	Efficiency discounted option
EE	Employment equity
EMC	Executive Management Committee
EWS	Early warning system
EXCO	Executive Committee (Council sub-committee)
Executive Authority	Minister of Health
FAIS Act	Financial Advisory and Intermediary Services Act 37 of 2002
FSB	Financial Services Board
FSP	Financial service provider
FSU	Financial Supervision Unit
GAAP	Generally Accepted Accounting Principles
GAE	Gross administration expenditure
GCI	Gross contribution income
GDP	Gross Domestic Product
GP	General practitioner
GRAP	Generally Recognised Accounting Practices
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
IAS	International Accounting Standard
ICD-10	International Classification of Diseases – 10th Revision
ICON	Independent Clinical Oncology Network (Pty) Ltd
ICU	Intensive care unit
IFRS	International Financial Reporting Standards
INSETA	Insurance Sector Education and Training Authority

IRBA	Independent Regulatory Board of Auditors
ISBN	International Standard Book Number
ITAP	Industry Technical Advisory Panel
MAC	Ministerial Advisory Committee
MCO	Managed care organisation
MoU	Memorandum of Understanding
MPR	Medicine Price Registry
MRC	Medical Research Council
MRI (scan)	Magnetic resonance imaging
MSA	Member Savings Account
MSO	Medical Services Organisation (Pty) Ltd
NHC	Net healthcare
NHE	Non-healthcare expenditure
NHI	National Health Insurance
NHISSA	National Health Information System of South Africa
NHRPL	National Health Reference Price List
NPA	National Prosecuting Authority
Office	Office of the Chief Executive and Registrar (of Medical Schemes)
Pab	Per average beneficiary
Pabpa	Per average beneficiary per annum
Pabpm	Per average beneficiary per month
Pampm	Per average member per month
Pasbpm	Pabpm in respect of schemes that had savings transactions
Pb	Per beneficiary
Pbpm	Per beneficiary per month
PCNS	Practice Code Numbering System
Pensioner	Beneficiary at least 65 years old
PFMA	Public Finance Management Act 1 of 1999
PMB	Prescribed minimum benefit
Pmpm	Per member per month
Pppm	Per patient per month
PMSA	Personal medical savings account
PO	Principal Officer
PPS	Professional Provident Society
Principal member	Member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Q	Quarter
QR	Quarterly returns
RAF	Risk Assessment Framework
RCI	Risk Contribution Income
RDC	Regulatory Decisions Committee
REF	Risk Equalisation Fund
Registrar	Registrar of Medical Schemes
REMCO	Remuneration Committee of Council
R&M	Research and monitoring
RP	Government Printing Works (number)
RPL	Reference Price List
RTM	Real time monitoring system
SABC	South African Broadcasting Corporation
SABINET	Southern African Bibliographic Information Network
SAHRC	South Africa Human Rights Commission
SAICA	South African Institute of Chartered Accountants
SAMA	South African Medical Association
SAPS	South African Police Service
SCA	Supreme Court of Appeal
SEP	Single exit price
SLA	Service level agreement
SOP	Standard operating procedure
TB	Tuberculosis
Treasury	National Treasury
WHO	World Health Organization
WIP	Work in progress

PROFILE AND VISION

Profile

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

Vision

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

MISSION AND VALUES

Mission

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

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

Values

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

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

- Ubuntu – we need each other to achieve our goals.
- We strive to be consistent in our regulatory approach.
- We approach challenges with a “can do” attitude.
- We are proud of our achievements.
- We are occupied in doing something that is of value.

STRATEGIC GOALS

Strategic Goal 1

Access to good quality medical scheme cover is promoted

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

Strategic Goal 2

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

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

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

Strategic Goal 3

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

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

Strategic Goal 4

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

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

FOCUSING ON OUR MEMBERS

The work of the Council for Medical Schemes (CMS) focuses on its stakeholders. Its constitutional, legislative and policy mandates all have a singular purpose: To support the improvement of universal access to healthcare by serving as a fair custodian of equitable access to medical schemes.

As such, the CMS emphasises the correct and transparent management of member issues and complaints. It places a premium on member communication and efficient processes to ensure that members are protected, that they have access to benefits, and that complaints are dealt with effectively.

The CMS member-centric framework involves prospective, concurrent and retrospective regulation and comprises the following:

PROSPECTIVE REGULATION

ACCESS TO HEALTHCARE

Deals with registration and accreditation functions, and any other activity, which provides some form of prior approval. It seeks to prevent problems from occurring in advance. Over-regulation occurs where the activities are so onerous and poorly designed that they stifle innovation and market entry.

ACTIVITIES

Understanding member benefits

- Rules of medical schemes
- Benefit options offered to members
- Efficiency discounted options
- Member contributions to offset benefits
- Contribution rates relative to general price indicators
- Guidance on contribution increases
- Scheme marketing materials and application forms

Accreditation as a form of quality assurance

- 3rd party administrators and self-administered schemes
- Managed care organisations
- Evaluation of administrators and MCOs
- Unwarranted profit sharing incentives
- Standardised contracting & reporting of managed care services by medical schemes
- Broker and broker organisations
- Verification of qualifications
- Adjustment of broker fees

CONCURRENT REGULATION

MANAGEMENT

Focuses primarily on reporting arrangements and ongoing reviews.

ACTIVITIES

Financial supervision of medical schemes

- Development of a new auditor authorisation system
- Financial soundness of medical schemes
- Proposed amendment to solvency framework
- Healthcare utilisation data
- Scheme risk measurement
- Growing burden of chronic disease care
- Monitoring of diagnosis coding (ICD-10)
- Making OOP spending visible
- Measurement of quality of healthcare

Strengthening and monitoring of governance systems

- Inspection of regulated entities
- Governance assessment instrument
- AGM and trustee elections

Reaching out to stakeholders

- Broker training
- Induction training
- Accredited skills programme
- Consumer education
- Using social media to reach members
- Customer care

RETROSPECTIVE REGULATION

GOVERNANCE/INTERVENTION/ REFLECTION

Deals with registration and involves reactive regulatory interventions once problems become apparent. If the prospective framework is inadequate, or the concurrent framework is delayed in identifying problems, then a great, and possibly impossible, burden can be placed on these functions. Furthermore, where retrospective actions are not fully carried through or successful actions not properly communicated, the preventive or knock-on governance effects may be lost, thereby increasing the probability that those problems requiring retrospective interventions will recur.

ACTIVITIES

Complaints adjudicated

Enforcement interventions to ensure compliance

- Post-curatorship monitoring

Rulings on appeals

- Appeals committee
- Appeal board
- Topical rulings by the High Courts
- Topical rulings by the Supreme Court of Appeal
- Topical rulings by the Constitutional Court

OUR MEMBERS, OUR FOCUS

Buttressed by:
ICT
Human resources
Finance/Performance

Giving effect to our mandate

While the work of the CMS is technical and to a large extent defined by legislative and other regulatory endeavours, its scope of work has a single focus: Our members.

For this reason, we are framing the execution of our mandate in three broad pillars. The first, prospective regulation, deals with registration and accreditation functions as well as any other activity that provides some form of prior approval. It seeks to prevent problems from occurring in advance. Over-regulation occurs where the activities are so onerous and poorly designed that they stifle innovation and market entry.

Concurrent regulation – the second pillar – concerns financial management and focuses primarily on reporting arrangements and ongoing review of medical aid schemes. Financial and associated reporting, information such as solvency thresholds, and routine inspections are key elements of this type of regulation.

Retrospective regulation deals with registration and provides the platforms and avenues to follow once challenges become apparent. This pillar enables a critical look at all problems and aims to minimise – and in the long term, negate – any problem from recurring.

This framework is supported by world-class information and communications technology solutions, best practice in human resources and efficient financial services. All with the member at the centre of the CMS' mandate and business plan.

The CMS still has a lot of work ahead of us to reach our goals, but successes and highlights exist and some of these are discussed on the next pages.

LEGISLATIVE AND OTHER MANDATES

Constitutional mandates

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

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

Legislated mandates

When the medical schemes industry was deregulated in 1989, the lack of control allowed for significant problems to emerge, resulting in poor solvency levels, inadequate accountability and a lack of member participation in governance of medical schemes. This situation necessitated the promulgation of the Medical Schemes Act, 131 of 1998, which became fully operational in 2000.

The purpose of the Act is to promote non-discriminatory access to private healthcare funding and it therefore provides protection to vulnerable members who were previously often 'dumped' on the already overburdened public sector.

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

- Protect the interests of beneficiaries (of medical schemes) at all times.
- Control and coordinate the functioning of medical schemes in a manner that is complementary to national health policy.
- Make recommendations to the Minister of Health on criteria for the measurement of the quality and outcomes of relevant health services provided for by medical schemes and such other services as the Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act.
- Collect and disseminate information about private healthcare.
- Make rules, consistent with the provisions of the Act, for the purpose of performing its functions and exercising its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on Council by the Minister of Health or by the Act.

Policy mandates

The CMS, as an organ of state, is obliged to discharge its statutory mandate in a coherent manner which is consistent with national policy. The priority areas of the electoral mandate in government's Programme of Action and the Strategic Goals of the NDoH covering the period between 2014 and 2019 focuses on the following priorities:

Government's Programme of Action electoral mandate priorities for 2014–2019

- Radical economic transformation, rapid economic growth and job creation.
- Rural development, land and agrarian reform and food security.
- Ensuring access to adequate human settlements and quality basic services.
- Improving the quality of and expanding access to education and training.
- Ensuring quality healthcare and social security for all citizens.
- Fighting corruption and crime.
- Contributing to a better Africa and a better world.
- Social cohesion and nation building.

The National Department of Health Strategic Goals for 2014–2019

- Prevent disease and reduce its burden, and promote health.
- Make progress towards universal health coverage through the development of the National Health Insurance Scheme, and improve the readiness of health facilities for its implementation.
- Re-engineer primary healthcare by increasing the number of ward-based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services.
- Improve health facility planning by implementing norms and standards.
- Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms.
- Develop an efficient health management information system for improved decision-making.
- Improve the quality of care by setting and monitoring national norms and standards, improving system for user feedback, increasing safety in healthcare, and by improving clinical governance.
- Improve human resources for health by ensuring adequate training and accountability measures.

The CMS has reviewed and amended its vision, mission and strategic goals to assist in the expression of its mandate.

THE COUNCIL

Prof. Yosuf Veriava
Chairperson of Council

Dr Loyiso Mpuntsha
Vice Chairperson

Prof. Bonke Dumisa
Member

Mr Moremi Nkosi
Member

Ms Lunah Nevhutalu
Member

Adv Harshila Kooverjie
Member

Ms Mosidi Maboye
Member

Prof. Sadhasivan Perumal
Member

Mr Johan van der Walt
Member

Dr Steven Mabela
Member

OUR LEADERSHIP – THE EXECUTIVES

Mr Daniel Lehutjo
Chief Financial Officer and Acting Chief Executive & Registrar

Dr Anton de Villiers
General Manager: Research and Monitoring

Mr Stephen Mmatli
General Manager: Compliance and Investigations

Ms Lindelwa Ndziba
General Manager: Human Resources

Mr Craig Burton-Durham
General Manager: Legal Services

Ms Thembekile Phaswane
Senior Manager: Complaints Adjudication

Ms Tebogo Maziya
General Manager: Financial Supervision

Mr Jaap Kugel
Chief Information Officer

Dr Elsabé Conradie
General Manager: Stakeholder Relations

Mr Paresh Prema
General Manager: Benefits Management

Mr Danie Kolver
General Manager: Accreditation

* *Senior Strategist position vacant*

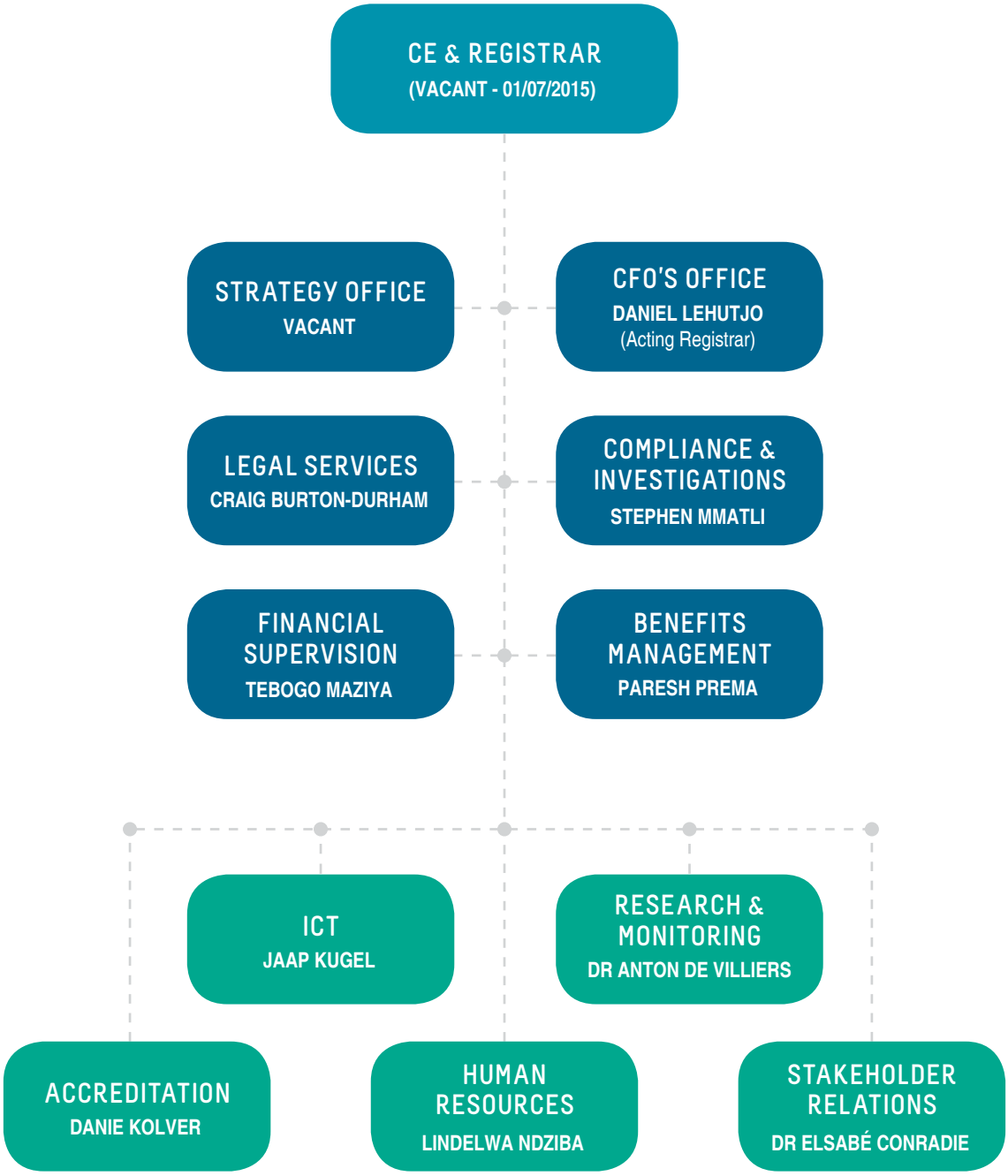
MEDICAL SCHEMES REGISTERED IN TERMS OF THE MEDICAL SCHEMES ACT

AS AT 31 MARCH 2016

Name of scheme	Type
1 AECI Medical Aid Society	Restricted
2 Alliance-Midmed Medical Scheme	Restricted
3 Anglo Medical Scheme	Restricted
4 Anglovaal Group Medical Scheme	Restricted
5 Bankmed	Restricted
6 Barloworld Medical Scheme	Restricted
7 Bestmed Medical Scheme	Open
8 BMW Employees Medical Aid Society	Restricted
9 Bonitas Medical Fund	Open
10 BP Medical Aid Society	Restricted
11 Building & Construction Industry Medical Aid Fund	Restricted
12 Cape Medical Plan	Open
13 Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Restricted
14 Community Medical Aid Scheme (COMMED)	Open
15 Compcare Wellness Medical Scheme	Open
16 De Beers Benefit Society	Restricted
17 Discovery Health Medical Scheme	Open
18 Engen Medical Benefit Fund	Restricted
19 Fedhealth Medical Scheme	Open
20 Fishing Industry Medical Scheme (Fish-Med)	Restricted
21 Food Workers Medical Benefit Fund	Restricted
22 Genesis Medical Scheme	Open
23 Glencore Medical Scheme	Restricted
24 Golden Arrow Employees' Medical Benefit Fund	Restricted
25 Government Employees Medical Scheme (GEMS)	Restricted
26 Grintek Electronics Medical Aid Scheme	Restricted
27 Horizon Medical Scheme	Restricted
28 Hosmed Medical Aid Scheme	Open
29 Impala Medical Plan	Restricted
30 Imperial Group Medical Scheme	Restricted
31 Keyhealth	Open
32 LA-Health Medical Scheme	Restricted
33 Libcare Medical Scheme	Restricted
34 Liberty Medical Scheme	Open
35 Lonmin Medical Scheme	Restricted
36 Makoti Medical Scheme	Open
37 Malcor Medical Scheme	Restricted
38 Massmart Health Plan	Restricted
39 MBMed Medical Aid Fund	Restricted
40 Medihelp	Open
41 Medimed Medical Scheme	Open
42 Medipos Medical Scheme	Restricted
43 Medshield Medical Scheme	Open
44 Metropolitan Medical Scheme	Restricted

Name of scheme	Type
45 Momentum Health	Open
46 Motohealth Care	Restricted
47 Naspers Medical Fund	Restricted
48 Nedgroup Medical Aid Scheme	Restricted
49 Netcare Medical Scheme	Restricted
50 Old Mutual Staff Medical Aid Fund	Restricted
51 Parmed Medical Aid Scheme	Restricted
52 PG Group Medical Scheme	Restricted
53 Pick n Pay Medical Scheme	Restricted
54 Platinum Health	Restricted
55 Profmed	Restricted
56 Quantum Medical Aid Society	Restricted
57 Rand Water Medical Scheme	Restricted
58 Remedi Medical Aid Scheme	Restricted
59 Resolution Health Medical Scheme	Open
60 Retail Medical Scheme	Restricted
61 Rhodes University Medical Scheme	Restricted
62 SA Breweries Medical Aid Society (SABMAS)	Restricted
63 SABC Medical Scheme	Restricted
64 Samwumed	Restricted
65 Sasolmed	Restricted
66 Sedmed	Restricted
67 Selfmed Medical Scheme	Open
68 Sisonke Health Medical Scheme	Restricted
69 Sizwe Medical Fund	Open
70 South African Police Service Medical Scheme (POLMED)	Restricted
71 Spectramed	Open
72 Suremed Health	Open
73 TFG Medical Aid Scheme	Restricted
74 Thebemed	Open
75 Tiger Brands Medical Scheme	Restricted
76 Topmed Medical Scheme	Open
77 Transmed Medical Fund	Restricted
78 Tsogo Sun Group Medical Scheme	Restricted
79 Umvuzo Health Medical Scheme	Restricted
80 University of KwaZulu-Natal Medical Scheme	Restricted
81 University of the Witwatersrand Staff Medical Aid Fund	Restricted
82 Witbank Coalfields Medical Aid Scheme	Restricted
83 Wooltru Healthcare Fund	Restricted

ORGANISATIONAL STRUCTURE



CHAIRPERSON'S REPORT

PROFESSOR YOSUF VERIAVA

It goes without saying that safeguarding the medical schemes that grow and excel under our aegis rests on the shoulders of the CMS and those who work within it. This is a leadership role and a position of trust that we do not take lightly and which we will continue to fulfil to the best of our ability and in the best interests of the South African healthcare industry.

The funding of healthcare services has not been the greatest success story of our time, especially here in South Africa where we are all too aware of our shortcomings in this arena. We are however not alone in our quest to find a workable, cost-effective healthcare funding model. Healthcare funding systems the world over have encountered several problems of their own. When studying the healthcare provision models of a number of countries throughout the world it is abundantly clear that healthcare is in crisis at a global level.

Healthcare expenditure is rising globally and has in some instances outstripped the Gross Domestic Product (GDP) of individual countries. Despite the fact that approximately 17.1% of the GDP was being spent on the provision of healthcare services in the United States (2014 figures), for example, healthcare there has become nothing short of a political hot potato.

Locally, only 16% of the South African population belong to medical schemes while the rest of the population depends on an over-burdened government sector.

It is our considered opinion that cognisance should be taken of international experience when implementing our own universal healthcare system. While these experiences do not always have relevance for local circumstances, they do highlight the possible challenges that may be faced when implementing different kinds of national health systems.

The National Health Insurance (NHI) is intended to ensure that all South African citizens will benefit from healthcare financing on an equitable basis. The CMS believes that an initiative that seeks to ensure access to quality and affordable health services for all based on their health needs, irrespective of their socio-economic status, is critical to the very future of our nation and should be supported by all South Africans. For these reasons, the CMS wholeheartedly supports the National Department of Health's (NDoH) initiative to implement a universal health insurance system that seeks to address the current inequities that exist in the all-important arenas of healthcare delivery and access.

The NHI initiative and the draft White Paper represent an unprecedented opportunity for the South African healthcare sector, and the funding industry in particular, to make a valuable contribution towards the development of a new healthcare dispensation in South Africa. It is an opportunity that the sector should grasp with both hands.

The Minister of Health, Dr Aaron Motsoaledi, has confirmed that as is the case elsewhere in the world, government does not intend limiting the choices of patients. Indeed, the Minister signals a strong future role for private healthcare and a prudent approach to government spending on NHI.

The NDoH's work towards introducing a new universal healthcare-funding framework follows on the heels of a number of reforms over the past years, which, despite some criticism at the time of their introduction, have succeeded in their goal of improving access to medicines. These reforms have included, for example, the generic substitution of medicines, and the introduction of a Single Exit Price (SEP) system, both of which have had a positive impact on our overall national health system.

The CMS has played an important supervisory and watchdog role and garnered considerable experience within the healthcare funding sector over the years. We consequently believe that the CMS has much to contribute towards the development of the NHI and a new healthcare dispensation.

We have learnt a great deal from the current health market enquiry into private healthcare, most importantly, that the era of heightened healthcare consumerism has dawned and that we must take greater heed of the needs of healthcare consumers at each and every level of the private and public healthcare sector.

The vacuum left because of no price regulation within the private healthcare sector where providers are charging above medical scheme rates, places an onerous burden on the already hard-pressed South African healthcare consumer. Hence, accessibility and affordability are more important than ever and for this industry to remain sustainable, we would have to pay more than lip service to the notion of affordability and accessibility.

The Minister of Health has often said that the effective monitoring of healthcare service delivery and overall performance of the health system requires functional health information systems capable of producing real-time information for decision-making. Globally, information and communication technology has emerged as a critical enabling mechanism to achieve this.

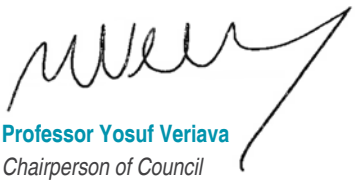
I am convinced that without managed care we would be in a much worse situation today. It has made a positive contribution to the financial sustainability of medical schemes as is evident in the data shared by some medical schemes. However, since its introduction within the private healthcare funding arena there has been much debate about whether managed care is adding value as it is supposed to do, namely to reduce healthcare expenditure while improving patient outcomes. If managed care is indeed making a difference, schemes, administrators and managed care organisations will have to improve their systems to collect relevant information demonstrating managed care's value proposition and ensuring health outcomes for beneficiaries continuously improve.

"The CMS has played an important supervisory and watchdog role and garnered considerable experience within the healthcare funding sector over the years.

In addition to already mentioned achievements, we have made considerable inroads in strengthening our industry and the financial sustainability of medical schemes. The current healthy financial state of medical schemes speaks volumes in this regard.

It is nonetheless also true that within our industry transparency and the responsibility to change rest not only on the shoulders of every medical scheme and healthcare funder but also on the shoulders of every individual who works within the industry.

We believe that South Africa, and more specifically the South African healthcare industry, stands at a critical crossroads in the history of our nation. We, however, implicitly believe in the future of both private and public healthcare. Let's work together to ensure a better, more sustainable future for our industry.



Professor Yosuf Veriava
Chairperson of Council

May 2016

OVERVIEW OF THE ACTING CHIEF EXECUTIVE & REGISTRAR

MR DANIEL LEHUTJO

It is an honour to reflect on the past year's performance by the Council for Medical Schemes (CMS).

Allow me to start off by thanking the Council and the employees of the CMS who daily make the attainment of the CMS' vision a priority in a number of ways. We do not have a big team – less than 100 people – yet without the contribution of each one, the CMS would not be making the inroads it is making towards ensuring accessible and fairly managed medical schemes and, in turn, accessible, quality healthcare.

The CMS supervises a considerable industry; there are some 83 medical schemes in this country with more than 8 800 000 beneficiaries. These schemes have a total annual contribution flow of approximately R151.6 billion.

The role of the CMS is therefore primarily one of a protector, which exists to safeguard the industry and the collateral that has been built up over the years within the healthcare-funding sector. As the CMS, we are the ombudsman of the medical schemes industry and the advocate who speaks out for those who cannot. While we jealously guard and protect the interests of our members, we are also here to ensure the sustainability of an industry that we believe in and hold dear.

Strengthening the healthcare system

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

The medical schemes industry plays an integral part in the day-to-day functioning of healthcare financing and provision to South Africans. However, as always, its role needs to be balanced against the need for a sustainable healthcare system that does not unfairly exclude vulnerable groups from cover.

The CMS plays an invaluable role in terms of affording some level of financial protection to members in areas where abuse has been identified. The CMS' vision is to ensure equitable access to medical schemes, and its mission includes protecting and informing the beneficiaries of these schemes as well as the general public about their rights. It is the CMS' role to continuously strengthen regulations that will ensure that beneficiaries remain protected and the gains to be made through the National Health Insurance (NHI) are not undermined.

The White Paper on NHI was published on the 10th of December 2015. The CMS submitted its comments to the NDoH and is committed, with the private medical scheme industry, to participate in the NHI reform. Furthermore, the private sector has gained valuable experience over the years from which the NHI process can benefit, utilising the expertise and experience available in the private sector.

The amendment of the Medical Schemes Act is another way the CMS endeavours to contribute to transformation in the private healthcare industry. The Medical Schemes Amendment Bill was submitted to the state law advisors who confirmed that the proposed amendments are constitutionally sound. A Memorandum of Objectives was prepared and submitted in support of the Bill. At the same time, the required Socio-Economic Impact Assessment was completed and submitted to the Department of Planning, Monitoring and Evaluation in the Presidency. The Bill is now with the Department of Health.

Strategic interventions enhancing member focus

Mediation

The CMS continues to refer appeals to independent mediators to try and settle these matters and restore the relationships between members and schemes. The project remains successful with high settlement rates.

Trustee remuneration

The CMS concluded the first phase of the Trustee Remuneration project to provide guidelines and to ensure that each scheme has a Trustee Remuneration policy, which has to be approved at its respective annual general meeting. The second phase has commenced during the period under review by conducting research and reviewing current legislation to assist the development of a remuneration framework and scales.

Declaration of undesirable branding practices

The CMS identified an industry trend where marketing and branding practices undertaken by third-party service providers were creating confusion within the industry. It was also noted that some third-party service providers had been using this confusion to promote their own commercial interests. During the year under review, comments from industry stakeholders were collated, and are being analysed. Depending on the outcome of the analysis, the draft declaration may be reframed and a final one published.

Declaration of undesirable electoral practices

The CMS published a notice in the Government Gazette in regard to unfair board trustee electoral processes. The due date for the submissions was 29 May 2015. Comments were received and reviewed, with further communication pending.

The amendment of the Medical Schemes Act is another way the CMS endeavours to contribute to transformation in the private healthcare industry.

Managed care theme project

This project seeks to effectively demonstrate the value of managed care rendered to beneficiaries of medical schemes. It is implemented by the CMS in collaboration with the industry.

Completed data specifications in respect of entry level criteria, process indicators and health outcomes were finalised for the following conditions:

- Asthma/chronic obstructive pulmonary disease;
- Cardiac failure, cardiomyopathy, coronary artery disease, dysrhythmias, hyperlipidaemia and hypertension;
- Chronic renal disease;
- Diabetes mellitus (types I and II);
- Hypothyroidism; and
- HIV/Aids.

Prescribed Minimum Benefits (PMB)

The PMB definitions for two medical conditions, localised and advanced breast cancer, were completed during the year under review.

A total of ten CMScripts were published to provide information on several medical conditions covered by medical schemes as part of the PMB provision.

Prospective regulation

Various regulatory interventions implemented by the CMS ensure the protection of beneficiaries, thereby enhancing the focus on members of medical schemes.

Understanding member benefits, a pillar of the Act

No entity applied to be registered as a new medical scheme during the period under review. The number of medical schemes remained at 83 in March 2016.

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

Rules of medical schemes

The CMS was established to provide for, among others, the registration and control of certain activities of medical schemes and to protect the interest of members of medical schemes. The Medical Schemes Act 131 of 1998 (the Act), which was assented to in November 1998 and commenced in February 1999, gave the CMS the powers and mandate to oversee these entities to ensure compliance with both the Act and the rules.

Medical schemes exercise their powers and perform their functions in accordance with set rules. These rules provide for the rights and responsibilities, dos and don'ts for medical schemes and all persons involved. Medical schemes found to have contravened these are deemed non-compliant and can be deregistered or not be allowed to be registered.

The Act stipulates a comprehensive process for the submission of rules by medical schemes, the approval of these as well as the process to be followed by a medical scheme in responding to a rejected submission. Apart from enhancing accountability, and promoting trust and fairness, the registered rules help other relevant units within the office of the Registrar to perform their daily functions when dealing with medical schemes and/or related parties.

To assist medical schemes, the CMS has compiled a model to follow when drafting rules. This model and the explanatory memorandum are in the final stages of completion and will be made available on the CMS' website as a reference before the end of the year. Medical schemes are encouraged to make use of the model when drafting their rules and to also contact the respective analysts where assistance is required.

The CMS processed 242 rule amendments submitted by schemes in 2015/16. These included changes to contributions and benefits, the registration of new benefit options, and the registration of new efficiency-discounted benefit options (EDOs).

Benefit options offered to members

Medical schemes continued to consolidate in 2015/16, with the number of benefit options available remaining stable over the period of review. There was no change in the number of efficiency-discounted benefit options (EDOs) registered on 31 March 2015.

The total number of registered benefit options (including EDOs) increased from 319 in March 2015 to 323 in March 2016. Benefit options in open schemes increased from 182 to 184, and restricted schemes registered options increased from 137 to 139.

TABLE 1: REGISTERED BENEFIT OPTIONS AS ON 1 MARCH 2016

Status of option	Open scheme options	Restricted scheme options	Total options
Options registered as at 31 March 2015	**182**	**137**	**319**
Less: efficiency-discounted options	-42	0	-42
Options registered as at 31 March 2015 (excluding efficiency-discounted options)	**140**	**137**	**277**
New options	2	2	4
Discontinued options	0	0	0
Discontinued options due to scheme mergers	0	0	0
Discontinued options due to scheme liquidations	0	0	0
Options registered as at 31 March 2016 (excluding efficiency-discounted options)	**142**	**139**	**281**
Options with efficiency discounts*	42	0	42
Options registered as at 31 March 2016	**184**	**139**	**323**

** These options are registered as one option but they have differing contribution tables based on the provider choice offered to members. The total number of registered options for open schemes is therefore 142.*

Efficiency-discounted options

Efficiency-discounted options (EDOs) were introduced in 2008. These benefit options are categorised as having network arrangements for healthcare provision that are more restrictive than the mainstream options. By allowing these options to better define the network arrangement, it gives schemes the ability to identify providers and networks that have proven to be more cost effective and efficient in providing healthcare services than the current provider arrangements, and allows schemes to pass on the cost efficiencies beneficiaries of medical schemes. This takes the form of monthly medical scheme contributions that are discounted on the basis of choice of network or healthcare provider that are utilised to provide benefits. This practice is in conflict with the statutory principle that contributions may be differentiated only on the basis of income or family size, or both. Schemes must therefore be exempted from section 29(1)(n) of the Medical Schemes Act before they can operate the EDOs.

In the year under review, there are eight schemes offering such options. The eight schemes are Momentum Health, Discovery Health Medical Scheme (DHMS), Fedhealth Medical Scheme, Liberty Medical Scheme, Thebemed, Compcare Wellness Medical Aid Scheme, Medihelp and Bestmed Medical Scheme.

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

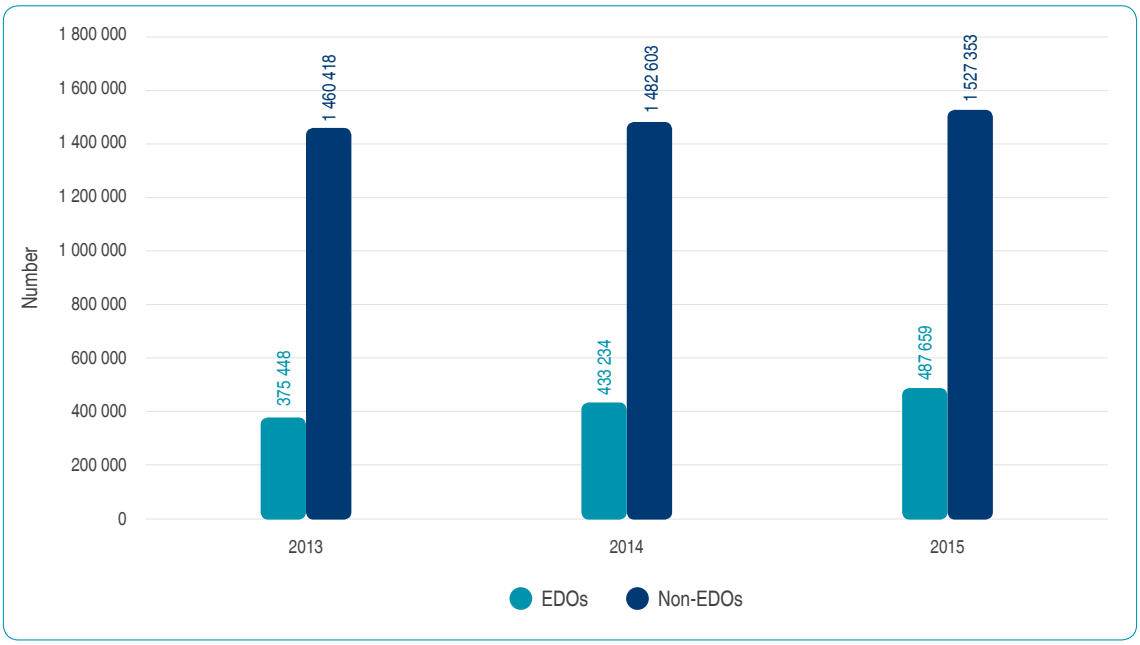
Benefit options with network arrangements offer advantages to both members and medical schemes. Members receive discounts because the scheme is able to obtain efficiency from a selected provider network. The growth in membership of the options has seen the average age of the membership of EDOs being lower than the main option. This would suggest that members who choose these options are willing to join options with restrictions on provider networks as there is a lower expectation of them needing the benefits in this age cohort. Although experience in these options has been favourable to date, the options with restricted providers should be promoted to the higher age cohort as the choice of the provider network is not only cost effective but also more efficient in providing the healthcare service, resulting in those needing care actually getting access to a better quality of care at a more efficient cost. Members' contributions are fair and non-discriminatory and they retain a measure of choice within the efficiency of the network.

Table 2 reflects the number of beneficiaries on EDOs and non-EDOs since 2013.The EDOs have evidenced consecutive above-average annual membership growth rates over the past two years. During the period under review, membership of EDOs has increased by 12.6% per annum across the eight medical schemes offering EDOs, compared to a marginal increase of 3% per annum of the non-EDOs.

TABLE 2: BENEFICIARIES ON EDO AND NON-EDO OPTIONS (2013–2015)

Type of options	2013	2014	2015
EDOs	375 448	433 234	487 659
Non-EDOs	1 460 418	1 482 603	1 527 353
Total	**1 835 866**	**1 915 837**	**2 015 012**

FIGURE 1: BENEFICIARIES ON EDO AND NON-EDO FOR 2013 TO 2015

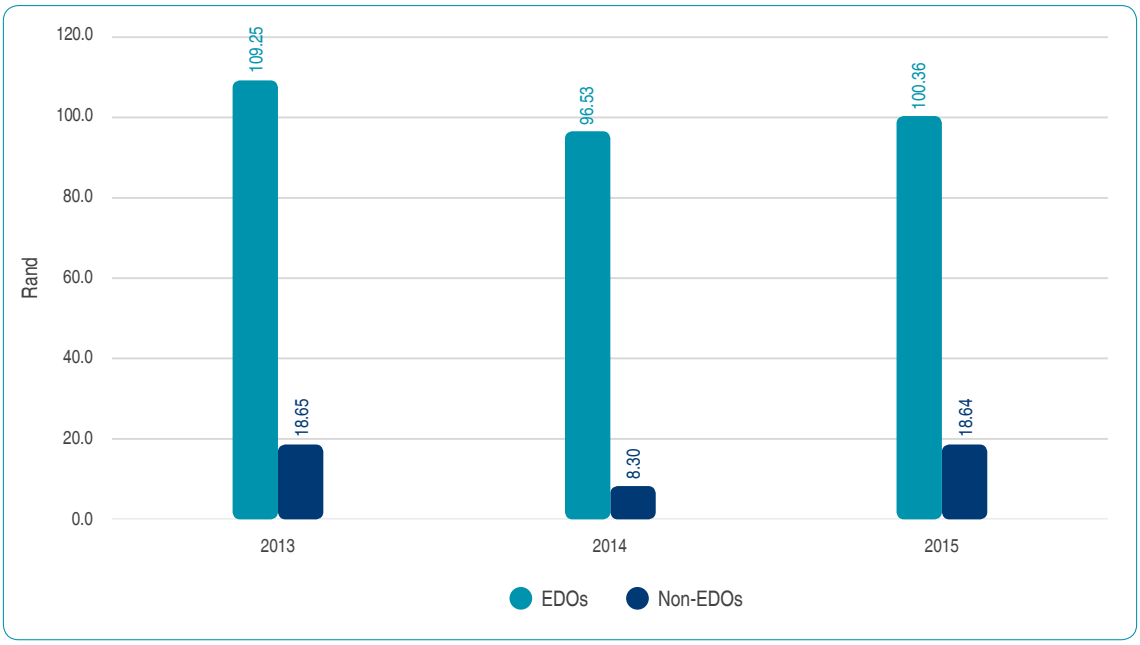


The net healthcare results of the EDOs and non-EDOs is shown in Table 3. Overall, the EDOs continue to report positive net healthcare results. During the period under review, the EDOs collectively contributed up to 63% of the total surplus, even though these options accounted for only 24% of the total membership.

TABLE 3: NET HEALTHCARE RESULTS OF EDOS AND NON-EDOS (2013–2015)

Type of options	2013 R'000	2014 R'000	2015 R'000
EDOs	492 198	501 850	587 271
Non-EDOs	326 786	147 681	341 593
Total	**818 984**	**649 531**	**928 864**

FIGURE 2: NET HEALTHCARE RESULTS (PBPM) FOR 2013 TO 2015



The age profile of the EDOs is compared to the corresponding non-EDOs in Table 4. The membership age profile has been fairly consistent across the eight medical schemes offering EDOs during the period under review. The EDO membership base reflects a favourable age profile with an average age of 30.9. As at 31 December 2015, the average EDO member is 4.6 years younger than the average member on the non-EDO.

TABLE 4: MEMBERSHIP AGE PROFILE OF EDOS AND NON-EDOS (2015)

Scheme name	Membership		Average member age	
	EDO	Non-EDOs	EDO	Non-EDOs
Bestmed Medical Scheme	2 649	69 131	30.9	31.5
Compcare Wellness Medical Scheme	5 777	21 567	32.6	36.3
Discovery Health Medical Scheme	240 342	1 137 980	30.7	35.6
Fedhealth Medical Scheme	2 100	55 879	35.0	38.0
Liberty Medical Scheme	7 670	68 899	29.6	37.3
Medihelp	33 503	117 135	28.7	34.5
Momentum Health	184 622	56 735	31.4	36.4
Thebemed	10 996	27	32.0	38.0
Total	**487 659**	**1 527 353**	**30.9**	**35.5**

The following table provides a high-level summary of the EDOs currently registered. Refer to Annexure T for detailed information on the EDOs.

TABLE 5: EDO OPTION SUMMARY AS ON 31 DECEMBER 2015

Type of option	Members	Beneficiaries	Gross contributions R'000	Net healthcare results pbpm R	Claims ratio %
EDOs	233 106	487 659	6 377 012	100.4	72.8
Non-EDOs	703 579	1 527 353	33 556 466	18.9	87.5
Total	**936 685**	**2 015 012**	**39 933 478**	**38.4**	**85.0**

Member contributions to offset benefits

The average gross contribution increase for all medical schemes in 2016 was 8.8%. On average, open schemes instituted larger increases in contributions (9.0%) than restricted schemes (8.6%).

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. The information in this section is a summary based on medical scheme submissions on benefit changes and contribution increases for 2016.

TABLE 6: AVERAGE GROSS CONTRIBUTION INCREASES FOR 2015/16 BENEFIT AND CONTRIBUTION REVIEW PERIOD

	Principal member %	Adult dependant %	Child dependant %	Family %
Open schemes	9.0	9.1	8.9	9.0
Restricted schemes	8.5	8.6	8.6	8.6
All schemes	**8.8**	**8.9**	**8.8**	**8.8**

TABLE 7: AVERAGE MONTHLY GROSS CONTRIBUTION FOR 2016

	Principal member R	Adult dependant R	Child dependant R	Family R
Open schemes	2 162	1 935	670	3 512
Restricted schemes	2 013	1 642	737	3 440
All schemes	**2 102**	**1 821**	**703**	**3 483**

The average risk contribution increase for all medical schemes in 2016 was 8.8%. The comparative increases for open and restricted schemes were 9.0% and 8.7%, respectively. The risk contribution is equal to the total contribution paid less the amount that is allocated to a savings account for a beneficiary.

During the review period the level of contribution to savings accounts as a proportion of the total contribution differed for open and restricted schemes. For all schemes, the average amount contributed to savings accounts amounted to 10.0% of total contributions. In the case of open schemes, this proportion was 13.7%, while for restricted schemes it formed 4.4% of total contributions. This reflects a difference in the benefit structures of open and restricted schemes, particularly in relation to the extent of out-of-hospital benefits and how these are split between members' savings and the risk pool.

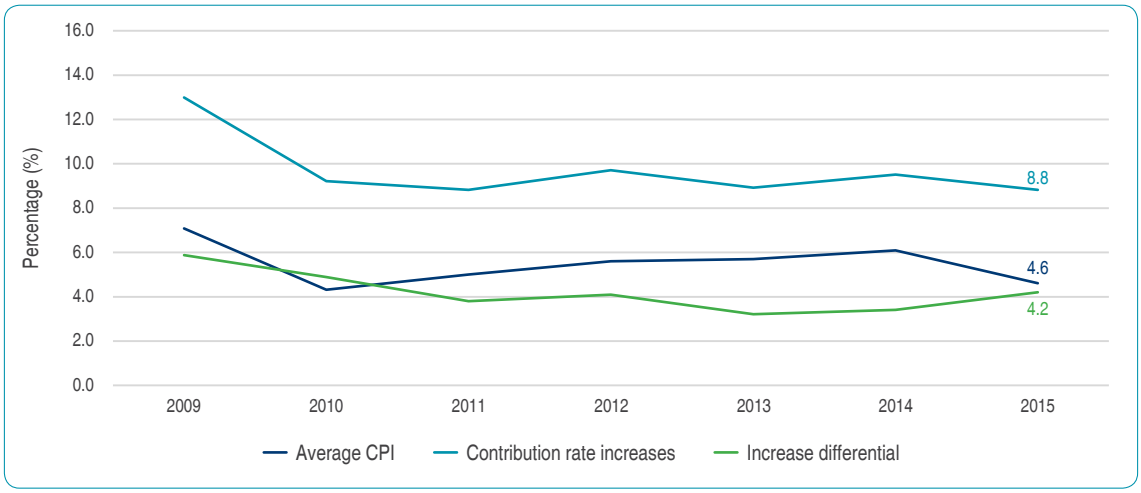
TABLE 8: AVERAGE RISK CONTRIBUTION INCREASES FOR 2015/16 BENEFIT AND CONTRIBUTION REVIEW PERIOD

	Principal member %	Adult dependant %	Child dependant %	Family %
Open schemes	9.0	9.1	9.0	9.0
Restricted schemes	8.6	8.7	8.7	8.7
All schemes	**8.8**	**9.0**	**8.9**	**8.9**

Contribution rates relative to general price indicators

Figure 3 shows historical and current inflation trends, measured by the Consumer Price Index (CPI), relative to contribution rates of medical schemes between 2009 and 2015. The graph also indicates the percentage by which the average rate of increase in medical scheme contributions exceeded inflation.

FIGURE 3: CONTRIBUTIONS AND INFLATION (2009–2015)



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

Since 2009, medical scheme contributions have followed a similar trend to inflation. However, the average difference in contribution increases relative to CPI was in the region of 3.9% between 2001 and 2015. This has implications for the long-term affordability of the medical schemes industry as increases in salaries may not keep pace with contribution increases.

Guidance on contribution increases

On an annual basis, the CMS analyses key economic indicators that have a bearing on the private healthcare sector to make a recommendation to the industry on reasonable assumptions when determining annual increases in member contributions. This process is informed by an understanding that contribution increases in excess of the Consumer Price Index (CPI) have an adverse effect on the long-term sustainability of medical schemes.

By circular, the CMS provided guidance on contribution increases for the 2016 calendar year. Medical schemes were advised that they should limit their cost increase assumptions for 2016 to 6.0% for each individual healthcare cost driver, including private hospital fees, specialist costs and administration fees. The circular also informed medical schemes of the key considerations that the CMS would take into account in assessing cost increases for 2016.

Schemes were requested to submit analyses of demographic indicators and healthcare utilisation in motivating for their cost increase assumptions for 2016.

The weighted average total assumed increase for 2016 across all medical schemes was 8.67%, slightly lower than 2015. The weighted average assumed impact of utilisation and demographic changes on contribution increases across all schemes was 3.05%. The results of the analysis were published in Circular 23 of 2016.

Parallel with this project, the CMS also did research on measuring medical scheme contribution inflation increases. A discussion document will be published for comments in 2016.

Scheme marketing materials and application forms

The CMS evaluated the marketing materials, application forms and websites of a number of medical schemes during the 2015/16 financial year.

It is concerning that schemes' brochures still do not always contain information about their dispute resolution mechanisms and/or where and how members can lodge complaints. Affected schemes have been advised to include these provisions, including CMS' contact details, in their marketing materials and websites.

As the office reviews different channels and mediums that schemes use to communicate with members, we have been on a constant drive to ensure that there is consistency in the schemes' communication with their members. One of the mediums under the CMS' spotlight are websites of medical schemes. Increasingly we find that websites of medical schemes are provided as part of the administrators' website. This is of concern to the office as these websites need to be independent of the administrator's website. We also find that schemes use their websites to communicate about peripheral products like rewards programmes that are not part of medical schemes' business. This has been brought to the attention of those schemes that have used this medium to communicate to its members and they have subsequently removed these products from their websites.

Although schemes use these portals to share information with their members, we note that not all information is easily accessible to users of these portals. Examples of information that is not easily accessible are lists of designated service providers or preferred provider networks, lists of chronic conditions covered over and above the Chronic Disease List (CDL), exclusion lists and the registered rules of medical schemes. This has been brought to the attention of schemes and also identified in the Communication Guidelines as the minimum information that must be shared with members.

The CMS will continue to monitor these channels of communication with its members to ensure that they comply with their registered rules and the Medical Schemes Act (which always takes precedence over scheme rules if there are inconsistencies).

Accreditation as a form of quality assurance

As a key component to facilitating access to quality healthcare, the CMS improves accreditation standards for the administrators of medical schemes, managed care organisations and healthcare brokers. It also regulates the broker fraternity in collaboration with the Financial Services Board.

Third-party administrators and self-administered schemes

No applications for accreditation from new entrants was received. Prime Med Administrators (Pty) Ltd applied for renewal of its accreditation in view of its change in control in accordance with Regulation 26(2) following the acquisition of its shares by another administrator. The Council declined the accreditation renewal of Strata Healthcare Management (Pty) Ltd as it failed to meet all of the key requirements for accreditation as prescribed in Regulation 17(2)(f). Sixteen third-party administrators were accredited and ten self-administered medical schemes issued with compliance certificates as at 31 March 2016.

Council approved the accreditation renewal of third-party administrators for a period of two years and the renewal of compliance certificates of self-administered schemes for a period of three years as listed in Table 9.

TABLE 9: THIRD-PARTY ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES ACCREDITATION STATUS (2015/16)

Third-party administrators' accreditation renewed for two years	Self-administered schemes' compliance certificates renewed for three years
1. Prime Med Administrators (Pty) Ltd 2. Professional Provident Society Healthcare Administrators (Pty) Ltd (formerly Professional Medical Scheme Administrators (Pty) Ltd) 3. Discovery Health (Pty) Ltd 4. Medscheme Holdings (Pty) Ltd 5. MetHealth (Pty) Ltd 6. Metropolitan Health Corporate (Pty) Ltd 7. Providence Healthcare Risk Managers (Pty) Ltd	1. Cape Medical Plan 2. Bestmed Medical Scheme 3. Platinum Health 4. Umvuzo Health Medical Scheme 5. Witbank Coalfields Medical Aid Scheme

Managed care organisations

A number of new applications for accreditation as managed care organisations (MCOs) were received and evaluated during the period under review. However, the services provided by some of these could not be defined as managed healthcare within the context of the Medical Schemes Act and Regulations. These organisations did not require to be formally accredited and were notified accordingly. The Centre for Degenerative Joint Diseases (Pty) Ltd elected not to renew its accreditation and was deactivated on the CMS website. There were 41 accredited managed care organisations on 31 March 2016.

TABLE 10: NEW AND RENEWED MCO ACCREDITATIONS

New accreditations	Renewed accreditations
1. Ulwazi Health Solutions (Pty) Ltd 2. Thebe Risk Management Services (Pty) Ltd 3. Zeal Health Innovations (Pty) Ltd	1. My Care Health Solutions (Pty) Ltd 2. Centre for Diabetes and Endocrinology (Pty) Ltd 3. Knowledge Objects Healthcare (Pty) Ltd 4. Knowledge Objects Solutions (Pty) Ltd 5. Strata Healthcare Management (Pty) Ltd 6. Dental Information Systems (Pty) Ltd 7. Enablemed (Pty) Ltd 8. Medscheme Holdings (Pty) Ltd 9. Private Health Administrators (Pty) Ltd 10. Uno Healthcare (Pty) Ltd t/a One Health Managed Care (Pty) Ltd 11. Universal Care (Pty) Ltd 12. Aid for Aids Management (Pty) Ltd 13. Sechaba Medical Solutions (Pty) Ltd

Evaluation of administrators and managed care organisations

On-site evaluation conducted at administrators and MCOs enable evaluation and assessment of infrastructure, systems, skills and resources employed to comply with accreditation standards and steps required to be taken to secure ongoing compliance. Table 11 displays the on-site evaluations of third-party administrators and self-administered medical schemes, as well as managed care organisations that were completed.

TABLE 11: ON-SITE EVALUATIONS COMPLETED DURING THE YEAR UNDER REVIEW

On-site evaluations of third-party administrators and self-administered medical schemes	On-site evaluations of compliance with the managed care accreditation standards
1. MMI Health (Pty) Ltd (formerly Momentum Medical Scheme Administrators (Pty) Ltd)	1. Rx Health (Pty) Ltd
2. Allcare Administrators (Pty) Ltd	2. Allcare Administrators (Pty) Ltd
3. Discovery Health (Pty) Ltd	3. Lifesense Disease Management (Pty) Ltd
4. MetHealth (Pty) Ltd	4. Metropolitan Health Risk Management (Pty) Ltd
5. Metropolitan Health Corporate (Pty) Ltd	

Unwarranted profit-sharing incentives

Circular 51 was published in October 2014 following concerns regarding an emerging trend among certain medical schemes and MCOs to enter into performance incentive-based or profit-sharing arrangements, provided for in the agreements. During the year under review, the CMS' managed care agreement reviews identified two such arrangements in the process of evaluating applications for renewal of accreditation. Subsequent discussion with the organisations concerned resulted in the removal of the offending clauses from the contracts prior to these coming into effect. This will ensure that members do not contribute towards untested and unjustified contractual arrangements for managed care delivery as there is a clear indication of the fee associated with the service rendered by the contracting entity.

Standardised contracting and reporting of managed care services by medical schemes

Circular 56 of 2015, published subsequent to internal CMS discussions regarding standardised contracting and reporting of managed care services, resulted in managed care expenses being suitably defined. As the cost of managed care interventions impact directly on the delivery of cost-effective and appropriate healthcare benefits to scheme beneficiaries, all expenses by medical schemes towards accredited managed care services will henceforth be recognised as 'healthcare services' in the audited financial statements and statutory returns of medical schemes.

Brokers and broker organisations

The CMS received 5 969 applications from individual brokers to either be accredited or to renew accreditation. Individuals accredited totalled 4 499, while 116 applications were incomplete and thus not accredited.

A total of 1 134 broker organisation applications were accredited and 23 applications were incomplete and not accredited.

The total number of accredited individual brokers and broker organisations on 31 March 2016 was 8 688 and 2 214, respectively.

The applications for accreditation of the following brokers were rejected and withdrawn during the financial year under review.

TABLE 12: BROKER ACCREDITATION SUSPENDED, WITHDRAWN AND REJECTED IN 2015/16

Broker number	Effective date	Reason
Broker accreditation withdrawn 2015/16		
Jan le Roux (BR 9085)	15.05.2015	The broker surrendered his status as accredited broker
Shene Annelee van Wyk (BR 34613)	24.08.2015	Broker resigned
Zandile Patricia Mthembu (BR 34612)	24.08.2015	Broker resigned
Visvanathan Pillay (BR 34826)	24.05.2015	Broker resigned
Christopher Swart (BR 35968)	14.03.2016	Unable to verify qualifications
Alfred Tonic Mohlala (BR 1735)	09.03.2016	The broker is not licenced for health service product with the FSB
Andries Stephanus Cronje (BR 5678)	18.12.2015	FSP licence withdrawn by FSB
Michael Anthony Gerber (BR 24358)	23.09.2015	Broker passed away
Nicole de Bruin (BR 35923)	24.08.2015	Broker resigned

Broker number	Effective date	Reason
New broker applications rejected 2015/16		
Nyameka Stella Booi	30.03.2015	Submitted fraudulent copy of matric certificate
Daunee Gildenhuys	29.05.2015	The applicant is an unrehabilitated insolvent
Lebogang Charlotte Thutwa	17.09.2015	Submitted fraudulent copy of matric certificate
Johan Hartzenberg	06.10.2015	The applicant is a principal officer of Alliance Midmed Medical Scheme
Patience Xoliswa Mokonotela	15.03.2016	Submitted fraudulent copy of matric certificate
Shaun Peter Stainbank	10.06.2015	Unable to verify qualifications
Toni Jayne Kinsey	21.09.2016	Unable to verify qualifications
Sandra Lin	15.09.2015	Unable to verify qualifications
Nomfusi Matsha	21.05.2015	Unable to verify qualifications
Quentin Grundlingh	04.08.2016	Unable to verify qualifications
Brokerage accreditation withdrawn 2015/16		
S & A Accounting Services CC (ORG 888)	18.12.2015	FSP licence withdrawn by FSB
FPM Administrators (Pty) Ltd (ORG 168)	03.03.2016	Business transferred to another accredited entity
Cornerstone Financial Services Group (Pty) Ltd (ORG 2483)	14.01.2016	Business transferred to another accredited entity

Verification of qualifications

Accredited healthcare brokers are required to be licensed by the Financial Services Board (FSB) as financial services providers (FSPs). In addition to the process adopted to exchange information with the FSB in this regard, the CMS has enhanced its systems to verify the academic qualifications of individuals applying for accreditation. This serves to minimise the risk of accrediting persons who fail the minimum academic qualifications and to combat fraud being perpetrated in order to be accredited. The number of applications verified in terms of the performance agreement with the service provider during the financial year totalled 1 026.

Adjustment of broker fees

The Minister of Health announced an increase in the maximum amount payable to brokers by medical schemes in respect of broker clients as members in terms of Section 65 of the Medical Schemes Act, to R80.00 per member per month, with effect from 1 January 2016.

Concurrent regulation

In the quest to provide guidance to promote stability in the medical schemes industry, the CMS continues to support efforts aimed at ensuring sustainability of the industry, with an ultimate focus on beneficiaries of the medical schemes.

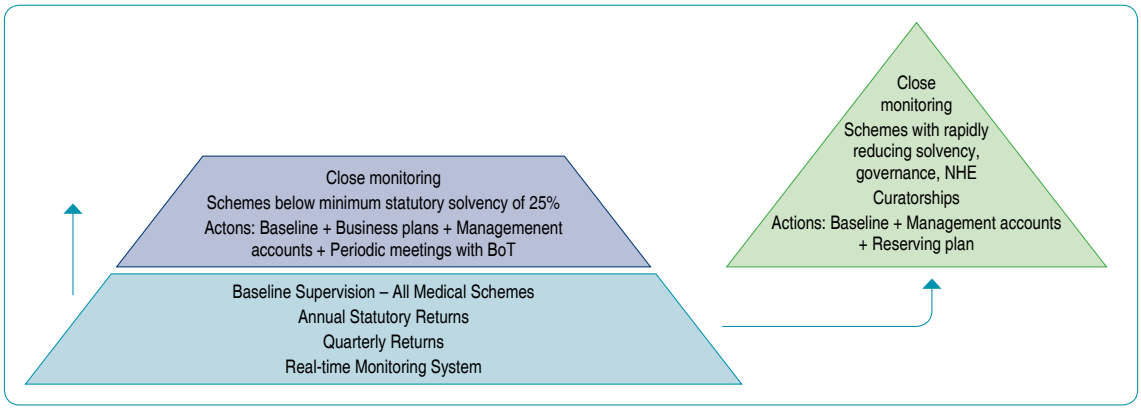
Financial supervision of medical schemes

The financial supervision and monitoring of all registered medical schemes is a core function of the CMS to ensure that medical schemes maintain a financially sound position and are able to honour their obligations when they become due. This is a significant task as members pay contributions in exchange for healthcare cover. It is therefore important that this protection of members, which is at the heart of the Medical Schemes Act, is sustained and continued, and that the industry remains stable.

There are several areas/tools that are key in the close monitoring of schemes, and they are as follows:

- The Annual Financial Statements (AFS) as per section 37 of the Medical Schemes Act: Albeit historical data, the statutory returns are an important tool for reporting on historical financial performance and position of medical schemes. Their ability to continue operating into the foreseeable future, determine trends and any emerging issues – this enables more effective decision-making and feeds directly into the various regulatory interventions catered for in the Medical Schemes Act and policy formulation. The information contained in the AFS is useful to various stakeholders, in particular members whose monies are being managed by medical schemes on their behalf. This information contained in the AFS is critical to members in determining their return on investment and value proposition offered by medical schemes to which they belong.
- Early Warning System (EWS): The EWS is mainly utilised as an alarm bell mechanism, to signal potential challenges that schemes could/are facing. It comprises several statutory tools namely:
  - Quarterly Return System: This system serves as the core of our EWS, enabling the continuous monitoring of schemes in between audit cycles. The CMS is then able to institute a suite of interactions with the management of schemes and ensure the ongoing protection of members.
  - Real-Time Monitoring (RTM) System: Over the past financial year, the CMS has made significant progress in the implementation and utilisation of the RTM by the industry. The data received through this system focuses on a few key indicators which are collected from all schemes on a monthly basis, based on which there will be interaction with the scheme. It seeks to assist in better understanding of the profiles of medical schemes, and any other matters that are unique to the respective schemes.

FIGURE 4: SUPERVISION PYRAMID



Development of a new auditor authorisation system

In ensuring that medical scheme reporting has appropriate integrity and is aligned with best practice in respect of accounting and auditing standards, Section 36 of the Medical Schemes Act requires all statutory auditors of medical schemes to be approved by the Registrar, following approval by members at Annual General Meetings or as determined by the rules. During the latter part of 2015, the CMS commenced with the development of standards to be met by auditors in order to be eligible for appointment by medical schemes as statutory auditors. The industry was invited to provide comments and this new process is now underway. It will benefit all stakeholders by enhancing the current process and providing more transparency.

Financial soundness of medical schemes

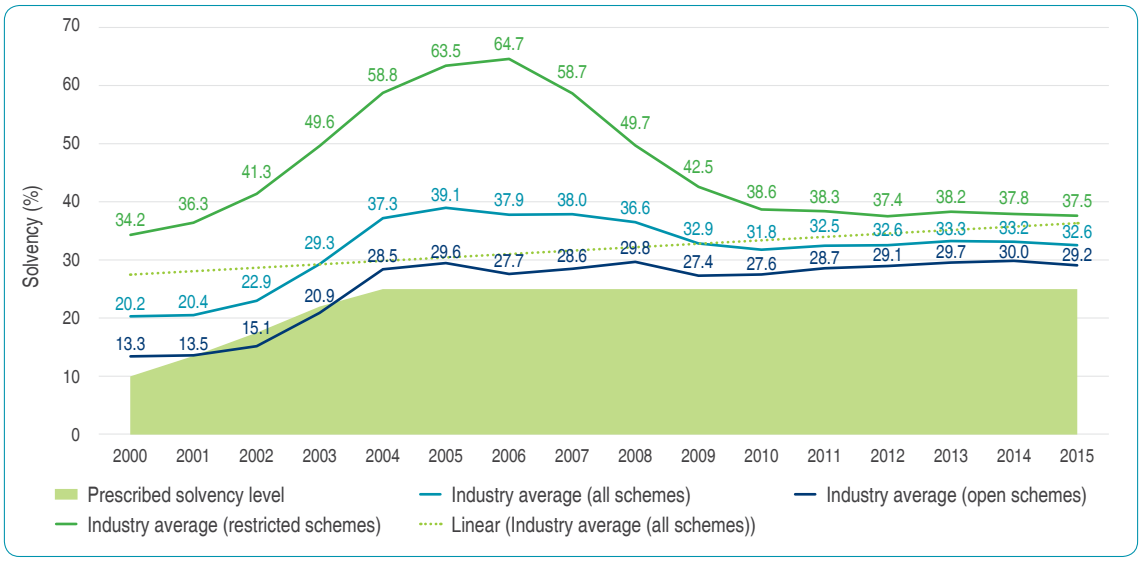
Regulation 29 of the Medical Schemes Act requires all medical schemes to maintain accumulated funds of at least 25% of gross annual contributions. Medical schemes that fall short of this requirement are required to notify the CMS of the underlying causes of failure, and corrective action to be undertaken.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

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

As at 31 December 2015, the number of schemes on close monitoring remained the same as in 2014 – four open and three restricted schemes as at 31 December 2015 (five open and two restricted as at 31 December 2014).

The solvency level for all registered schemes was 32.6% (33.2%: 31 December 2014), representing a decline of 1.8% as at December 2015.

FIGURE 5: INDUSTRY SOLVENCY FOR ALL SCHEMES (2000–2015)

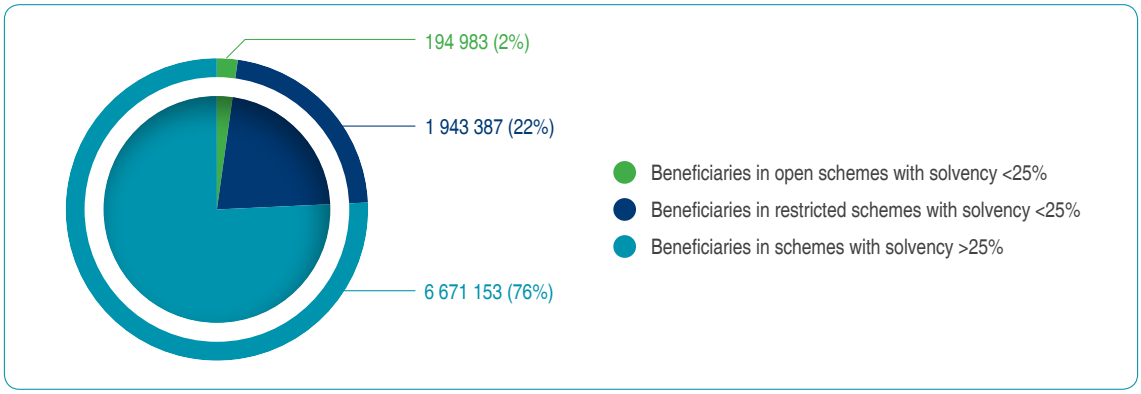


In total, there are 4 938 453 beneficiaries in the open scheme market (4 899 975: December 2014); of which 3.9% (194 983) are in schemes not meeting the prescribed minimum solvency requirement.

The solvency level for all the open schemes was 29.2% at 31 December 2015 (30.0%: 31 December 2014), representing a decrease of 2.7%.

The restricted scheme market had 3 871 070 beneficiaries (3 914 483: 31 December 2014), of which 50.2% (1 943 387) of beneficiaries are in schemes not meeting the prescribed minimum solvency requirement. The total beneficiary representation of restricted schemes below 25% excluding Government Employees Medical Scheme (GEMS) is 4.2%. In the restricted scheme industry, GEMS represents 46.0% of beneficiaries.

FIGURE 6: BENEFICIARIES BY SOLVENCY LEVEL OF THEIR MEDICAL SCHEME (2015)



Figures 7 and 8 indicate that the percentage of beneficiaries belonging to schemes that do not meet the minimum statutory solvency level has remained the same over the past two years.

FIGURE 7: COMPARISON OF BENEFICIARIES IN SCHEMES BELOW 25% SOLVENCY LEVEL (2015 AND 2014)

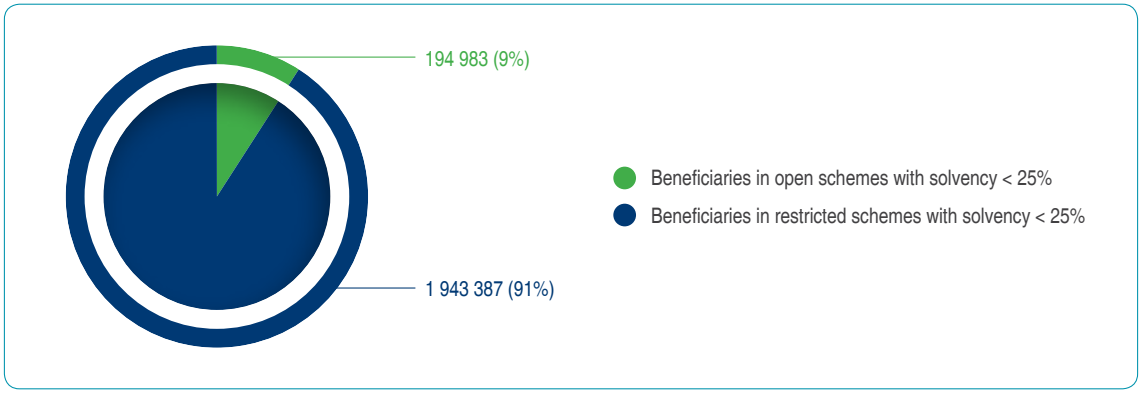
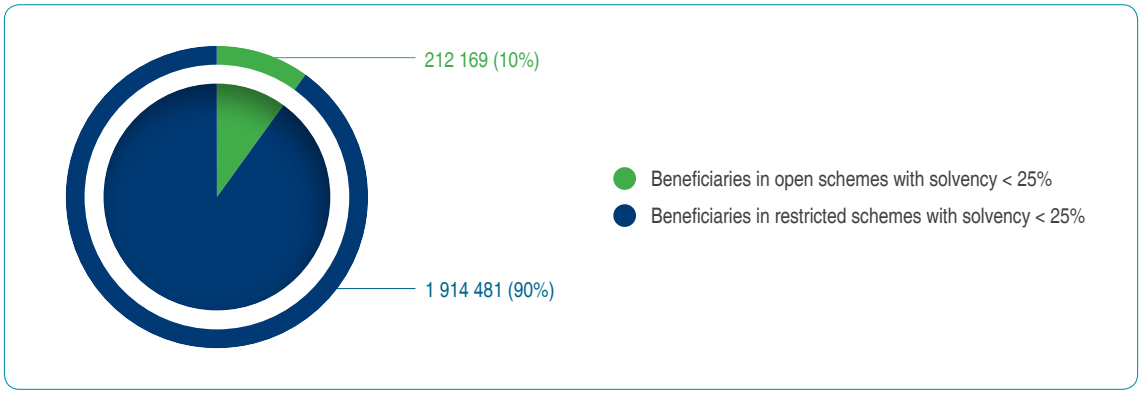


FIGURE 8: BENEFICIARIES IN SCHEMES BELOW 25% SOLVENCY (2014)



Of the seven schemes that did not meet the 25% solvency ratio:

- One had a solvency level lower than 10%;
- Two were between 10% and 13.5%;

[redacted]

- Two were between 22% and 25%.

Table 13 contains a summary of schemes on close monitoring in terms of Regulation 29 (4) of the Medical Schemes Act.

TABLE 13: SCHEMES ON CLOSE MONITORING

Open schemes			Restricted schemes		
2015	**Number of schemes**	**Comments**	**2015**	**Number of schemes**	**Comments**
Number of schemes below 25% at the beginning of 2015	5	1. Liberty Medical Scheme 2. Thebemed 3. Community Medical Aid Scheme (COMMED) 4. Suremed 5. Resolution Health Medical Scheme	Number of schemes below 25% at the beginning of 2015	2	1. Government Employees Medical Scheme (GEMS) 2. Transmed Medical Fund
Change in number of schemes	-1	Suremed reached 25% solvency level	Change in number of schemes below 25%	1	Platinum Health
Number of schemes below 25% at the end of 2015	4		Number of schemes below 25% at the end of 2015	3	
2014	**Number of schemes**	**Comments**	**2014**	**Number of schemes**	**Comments**
Number of schemes below 25% at the beginning of 2014	5	1. Liberty Medical Scheme 2. Thebemed 3. Community Medical Aid Scheme (COMMED) 4. Suremed 5. Resolution Health Medical Scheme	Number of schemes below 25% at the beginning of 2014	2	1. Government Employees Medical Scheme (GEMS) 2. Transmed Medical Fund
Change in number of schemes below 25%	0		Change in number of schemes below 25%	0	
Number of schemes below 25% at the end of 2014	5		Number of schemes below 25% at the end of 2014	2	

[redacted]

As at 31 December 2015, GEMS reported a solvency ratio of 9.5%, compared to 10.0% in 2014. The number of GEMS members has slightly decreased by 1.9% and beneficiaries decreased by 3.1% during the same period. Factors contributing to reduction in beneficiaries are increased resignations by public sector employees; termination of membership due to the scheme's debt management policy; and resignation of deceased members. Despite the drop in the solvency ratio, the scheme remains fairly stable. GEMS has an approved business plan, submit management accounts and attend quarterly monitoring meetings with the CMS.

Liberty Medical Scheme experienced a marked increase in younger and low claiming members. This has resulted in deterioration in the scheme's age profile and has led to high increases in claims. The solvency ratio of Liberty Medical Scheme dropped significantly by 26.7% from 17.2% in 2014 to 12.6% in 2015. The scheme plans to address these performance challenges through focused efforts on growth of younger members and to lower non-healthcare expenses. The scheme submits monthly management accounts and the board attends regular monitoring meetings with the CMS.

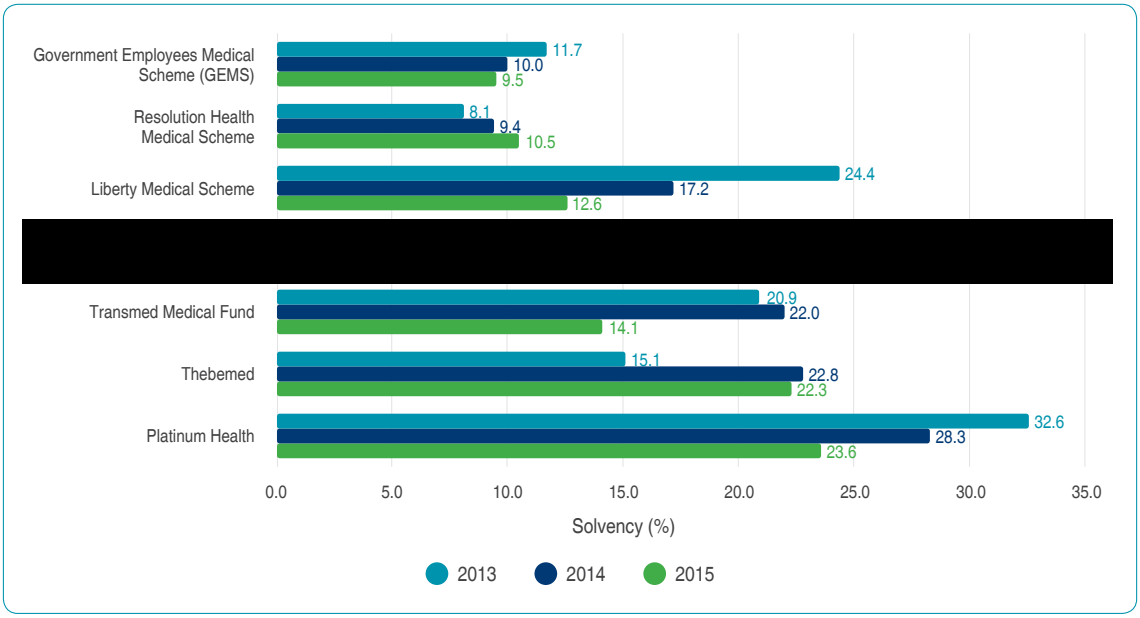
Platinum Health reported a solvency ratio of 23.6% in 2015, from 28.3% in 2014. It was noted that the scheme's membership grew by 18.7%, resulting in higher contributions while claims increased as well. This reduced solvency margins. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

Resolution Health Medical Schemes reported a solvency ratio of 10.5% in 2015, from 9.4% in 2014. The increase in solvency is mainly as a result of the significant decline in membership of 21.7% from 2014. The CMS has advised the board to seek sustainable solutions which would safeguard members' interests.

Thebemed's solvency ratio slightly decreased by 2.2% from 22.8% in 2014 to 22.3% in 2015. The decrease in solvency ratio is mainly due to membership growth. A business plan was submitted by the scheme and it was declined by CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

The solvency ratio of Transmed Medical Fund (Transmed) deteriorated significantly by 35.9% from 22.0% in 2014 to 14.1% in 2015. The drop in solvency ratio is mainly due to high claims, increased non-healthcare expenditure resulting in the scheme making huge losses, which in turn had a negative impact on the reserves. The scheme submitted a new business plan in response to a change in employer subsidies and continues to submit monthly management reports. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

FIGURE 9: SOLVENCY TRENDS FOR ALL SCHEMES BELOW 25% SOLVENCY LEVEL (2015)



The following graph depicts the solvency ratio and distribution of healthcare spend for all schemes with a statutory solvency level below 25%.

FIGURE 10: DISTRIBUTION OF HEALTHCARE SPEND FOR OPEN SCHEMES BELOW 25% SOLVENCY LEVEL (2015)

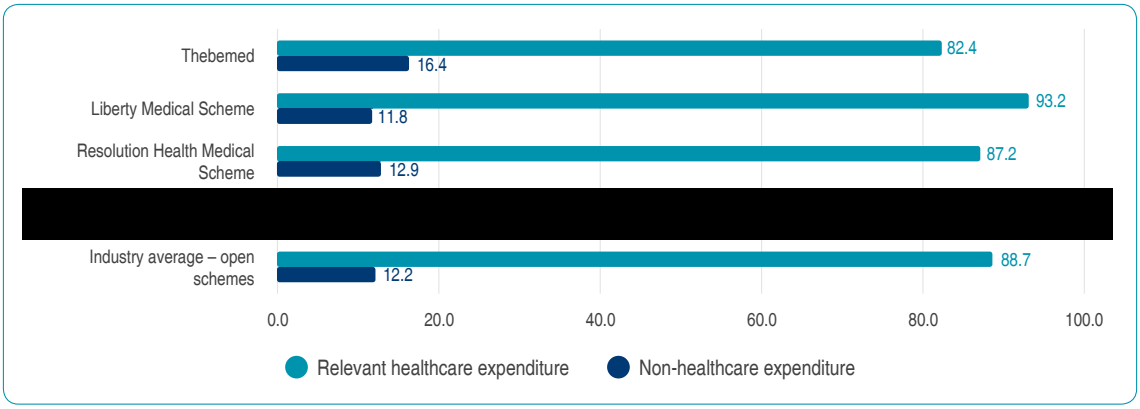
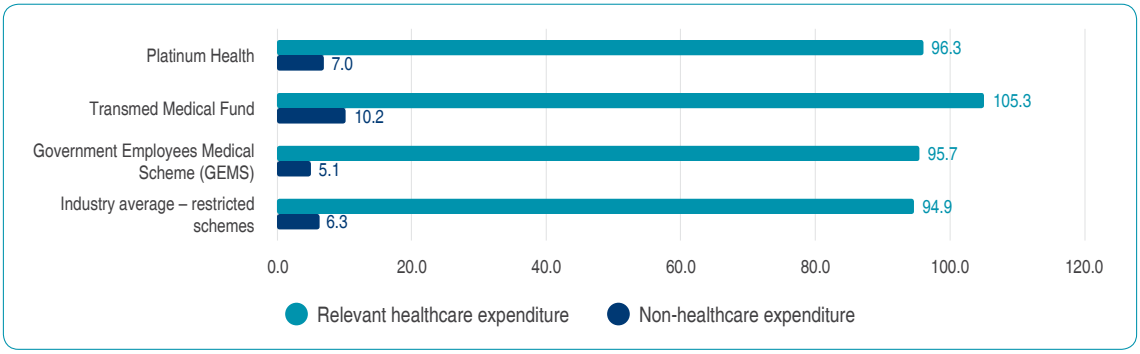


FIGURE 11: DISTRIBUTION OF HEALTHCARE SPEND FOR RESTRICTED SCHEMES BELOW 25% SOLVENCY LEVEL (2015)



Proposed amendment to solvency framework

In 2015 the CMS published a discussion document on the solvency framework with the aim of amending the current framework. The deadline for comments was extended into the new financial year to give all stakeholders enough time to submit their comments. The research on the solvency framework will continue in 2016.

Healthcare utilisation data

The CMS is in the second year of using the dynamic database driven return (DDDR) system to collect the healthcare utilisation data from the industry. The new system, which was well received by both medical schemes and administrators, eased the burden on schemes because manual submission of data is no longer applicable. For the 2015 submission, the scope of data collection was slightly expanded to collect more data on managed care, specifically health quality. A new section to collect provider information was also included. This data will be used to assist the National Department of Health (NDoH) with its analysis on resource planning for the NHI.

The CMS is optimistic about an improvement in the data quality, although there are still schemes that failed to submit quality data the first time to CMS. The CMS will continue to work with the industry through workshops and publications to improve the quality of data used in the Annual Report and research projects.

The collected data enabled the CMS to conduct research on a range of health policy issues, including trends in medical schemes' demographics; market concentration, the cost and quality of health services; healthcare utilisation patterns; medical scheme risk measurement; scheme mergers; access to healthcare services; and the possible impact of the NHI on the private medical scheme industry.

Scheme risk measurement

The CMS continued to collect the scheme risk measurement data. The data make a powerful contribution to understanding the differences in the risk profiles of medical schemes. The Competition Commission showed interest in the project and the results and relevant documentation relating to the risk measurement data were requested by the Health Market Inquiry. Medical schemes still do not compete at the same level and there are significant differences between the risk profiles of medical schemes.

The growing burden of chronic disease care

The 2015 retrospective study of the CMS' Scheme Risk Measurement Database was undertaken to establish changes in the frequency of chronic diseases among beneficiaries of medical schemes between 2008 and 2014. The study compared trends for open and restricted schemes, schemes of various sizes, and a range of benefit options.

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

The higher prevalence of beneficiaries with chronic diseases translates to an increase in visits to general practitioners and specialists, a growth in the use of medicines, and a possible rise in hospital events. Without population-wide interventions to address the root causes of these chronic diseases, the upward trend is expected to continue with increasingly severe impacts on schemes. Protection of risk pools and growth in younger, healthier beneficiaries are critical for long-term sustainability of the industry. The value proposition of managed care will become more and more important and schemes must make sure that the beneficiaries get value for money, especially if they are registered on a chronic disease programme.

Monitoring of diagnosis coding (ICD-10)

It is a statutory requirement that all healthcare providers, including doctors, hospitals and allied professionals, use the 10th revision of the International Statistical Classification of Diseases and Related Health Problems codes (ICD-10) when diagnosing patients and submitting claims to medical schemes. The CMS continued to collect ICD-10 compliance data from the industry.

The Ministerial ICD-10 Task Team is currently not active, but the CMS made a recommendation to the NDoH to revitalise the ICD-10 Task Team and to expand its mandate to start to collect similar data from the public sector.

Only one medical scheme, i.e. Makoti Medical Scheme, did not submit data for 2015. The data submitted covered about 99% of beneficiaries of the relevant medical schemes and analysis indicated that about 98.7% of paid claim lines by medical schemes complied with ICD-10 coding standards. All discipline groups had ICD-10 compliance percentages of above 85%.

The dominating error in claim lines submitted by general practitioners and medical specialists was error code R109 (ICD-10 code not applicable to procedure – clinical validation), with this error code making up 93.9% and 78.3% of rejected lines within these discipline groups, respectively. Clinical validation, however, only applies to PMBs and in cases where a medical scheme has a direct payment arrangement (in other words, a designated service provider contract) with the treating doctor.

The ICD-10 compliance report also confirmed that pharmacies and pathology laboratories still use the default Z-codes on most of their claims as they are not provided with a referral code. These disciplines rely on the treating practitioner to provide the ICD-10 referral code as they are not allowed to diagnose patients. Pathology laboratories may not receive such codes as the requested tests are mostly required to reach a diagnosis. All providers were requested to provide the applicable ICD-10 codes to prescriptions.

Making out-of-pocket spending visible

Out-of-pocket expenditure is a key indicator of members' experiences as well as their perception of the medical schemes environment. It is therefore important that it is continually monitored so that the industry can assess how well it is doing.

There is ongoing debate on what is the right or acceptable level of out-of-pocket payment. The World Health Organization's guidelines state that out-of-pocket expenditure should never exceed 15% of the total healthcare cost in any health system. For 2015 this expenditure was 18.6%. It is important to note that not all claims are submitted to schemes and administrators, and therefore the actual experience could be higher than 18.6%.

Measurement of quality of healthcare

The working group of the Industry Technical Advisory Panel (ITAP) made good progress discussing 11 of the 27 CDL conditions. As in the previous year, this panel identified minimum process and outcome indicators that are expected of managed care organisations (MCOs) when they manage these conditions. The panel further recommended that the MCOs had to collect the process and outcome indicators and have these available on request.

The CMS also adopted the same indicators identified through ITAP as the minimum standards acceptable for quality of care in the medical schemes environment. The CMS continued to further amend the data collected through the Annual Statutory Returns to incorporate these indicators.

For the first time, the CMS published a report in 2015 on measuring quality in medical schemes, based on the 2013 and 2014 data submission. The results were disappointing for a number of these indicators. A summary of the 2015 data on coverage ratios (process indicators) by medical scheme and benefit option is included in Annexure K. A more detailed report will be published in 2016.

Strengthening and monitoring of governance systems

Evaluating and exercising inspections into activities of all entities registered with the CMS are critical to ensure viability of the entities, good governance and fairness to beneficiaries of medical schemes.

Inspection of regulated entities

The CMS institutes inspections to ensure that medical schemes are compliant with the Medical Schemes Act.

During the reporting period, the CMS instituted section 44(4)(a) inspections on the following schemes:

In particular, the CMS:

- Concluded the investigation into the affairs of **Medihelp** pursuant to allegations of irregularities with regard to the sale of the administration business to Strata. The inspectors uncovered irregularities with regard to payment of broker fees and the sale of the administration component of the scheme to Strata in contravention of section 63 of the Act.

- Finalised the inspection into the affairs of **Bankmed** in December 2015 pursuant to allegations of governance irregularities. It was found that the Board of Trustees failed to avoid conflict of interest when it awarded service contracts to the wife of the Chairperson of the Board of Trustees.
- Instituted an inspection into the affairs of **Bonitas** based on allegations of governance irregularities. The scheme refused the inspectors access and subsequently lodged an appeal against the Registrar's decision to institute the inspection.
- Finalised the inspection into the affairs of **POLMED** in March 2015 pursuant to allegations of governance irregularities at the scheme. The inspectors uncovered irregular expenditure by the senior executives of the scheme, as well as abuse of scheme resources.

Section 44(4)(b) routine inspections were conducted on the following schemes:

- Randwater;
- Motohealth;
- Commed;
- Massmart;
- Quantum;
- Sisonke;
- Medimed;
- Impala;
- BP;
- Rhodes University; and
- Wits University.

Governance assessment instrument

During the reporting period, the CMS introduced a governance assessment tool in collaboration with The Global Platform for Intellectual Property to assist schemes in assessing their own governance and compliance with the Medical Schemes Act. The instrument is a self-assessment tool which CMS believes will assist schemes not only with compliance with the Act but also in strengthening their governance systems and framework.

AGM and trustee elections

The CMS identified and attended 37 Annual General Meetings (AGMs) as an observer and addressed irregularities with scheme Principal Officers. The most common issues observed during the AGMs were complaints from members in regards to partial payment of hospital bills; the schemes choosing service providers without consulting members, such as the selection of auditors; increasing salaries for the boards of trustees; inconvenient scheduling of AGMs; and late delivery of meeting packs.

Reaching out to stakeholders

Consumers, and particularly members, remain the CMS' focus. Various training and outreach programmes were offered ensuring beneficiaries of medical schemes receive fair treatment from relevant service providers.

Broker training

The CMS conducted four Continuing Professional Development (CPD) training sessions. Broker training was provided based on requests from brokers. In Gauteng, 98 brokers were trained; 44 in the Eastern Cape, 50 in the Western Cape and 67 in KwaZulu-Natal. Training sessions in the Eastern Cape, Western Cape and KwaZulu-Natal were offered for the first time and the CMS hopes to respond to the demand in other provinces as well.

Induction training

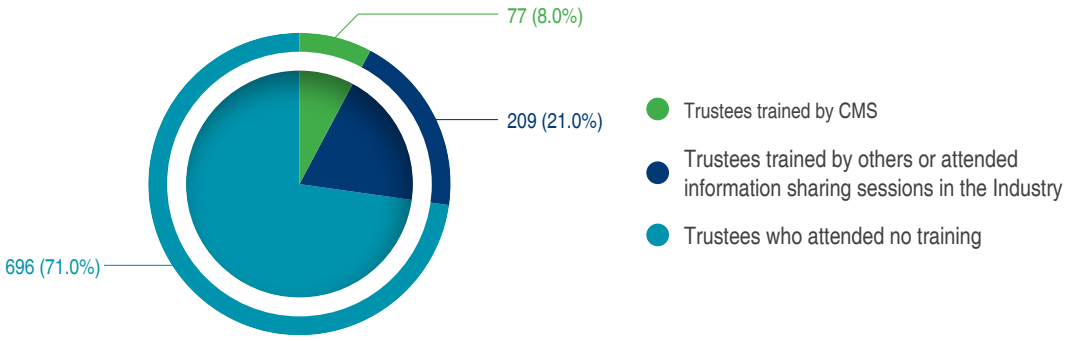
Compulsory two-day induction training sessions were held in Gauteng and the Western Cape for newly appointed trustees. During the year under review 65 trustees benefited from these sessions. However, many trustees also attended other training or information sharing sessions, such as seminars and conferences. Table 14 compares training or information sharing sessions attended during the 2014/15 and 2015/16 financial years.

TABLE 14: COMPARISON OF TRAINING OR INFORMATION SHARING SESSIONS ATTENDED

Type of session	Number of trustees		% trained	
	2014/15	2015/16	2014/15	2015/16
Trustees trained by CMS	73	77	7.0	8.0
Trustees trained by others or attended information sharing sessions in the Industry	239	209	23.0	21.0
Trustees who attended no sessions	726	696	70.0	71.0
Total number	**1 038**	**982**		

Figure 12 indicates the total number of trustees trained or who attended other types of information sharing sessions during the period under review.

FIGURE 12: TOTAL NUMBER OF TRUSTEES TRAINED OR ATTENDED INFORMATION SHARING SESSIONS (2015/16)



It should be noted that these figures are not audited and may not reflect all training attended by trustees. However, the low number of trustees attending training or information sharing sessions remains a concern. The lack of attendance at sessions where updates of industry developments or refresher courses about the fiduciary duties of trustees are given, could be a contributing factor to governance issues that some medical schemes experience.

Accredited skills programme

An accredited skills programme was offered in Gauteng and of the 33 trustees attending the programme, nine attendees were declared competent by the Insurance Seta (INSETA). A competency certificate is issued by the INSETA to trustees who have not only attended the four-day programme, but who also wrote and passed the examination. Seven of these trustees were from Medshield, one from Massmart Wealth and one from Sisonke Health. The first session of the accredited skills programme was offered to the Parmed Board of Trustees in Cape Town. The programme will be concluded in the next financial year.

Consumer education

Consumer education activities were held for general consumers, of which the majority included medical scheme members. Of the 41 sessions offered, 28 were conducted in urban and semi-urban areas and 13 in rural areas in five provinces. A total of 6 147 consumers were reached of whom 3 472 were from rural areas. Details are shown in Table 15.

TABLE 15: EDUCATION AND TRAINING SESSIONS TO CONSUMERS, TRUSTEES AND BROKERS

Province	Total number of consumers reached	Number of consumers reached in rural areas	Rural areas covered	Main languages spoken in the covered rural areas
Eastern Cape	643	598	Graaff Reinet, Matatiele	Afrikaans, isiXhosa
Free State	524	524	Sasolburg, Qwaqwa	Sesotho & English
Gauteng	1 398	-	-	
KwaZulu-Natal	1 166	800	Nqutu	IsiZulu
Limpopo	1 750	1 250	Modimolle, Marble Hall, Groblersdal, Mookgophong, Lebowakgomo	Sepedi
Mpumalanga	316	300	Hazyview	IsiSwati
Northern Cape	-		-	-
North West	-		-	-
Western Cape	350		-	-
Total	**6 147**	**3 472**		

Specific training programmes were also offered on request and 67 beneficiaries were recorded.

Using social media to reach members

In its endeavour to enhance accessibility to members of medical schemes, the CMS continues to use social media as a platform to reach out to members.

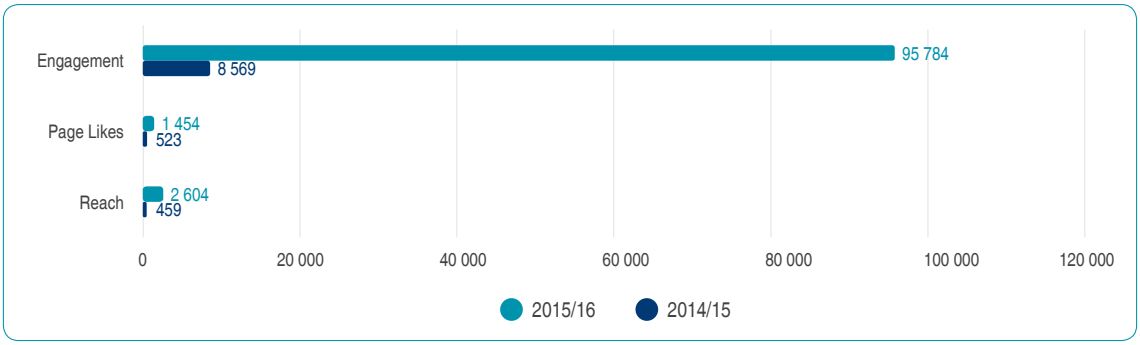
Focusing mainly on the biggest social media channel, Facebook, the organisation has seen tremendous growth in the number of page likes – 178% to be exact. The significance of this growth is that the CMS' audience count on social media at any given point is at least 1 454. Page likes can be regarded as subscriptions to receive information updates.

In proportion to this growth is the number of engagements, which has increased by 460%. Engagements include enquiries, comments and shares on the CMS' posts. Enquiries posted on the page are handed over to the relevant units for assistance. Testifying to the success of this system, is the page's response rate of 76% of enquiries per hour.

Through the audience segmentation tool, the organisation has been able to run targeted updates, reaching the particular audience most relevant to the update.

Other platforms such as Twitter, LinkedIn and Instagram have also seen increased activity – feeding off updates through linkages with the organisation's Facebook page.

FIGURE 13: OVERVIEW OF ENGAGEMENTS, LIKES AND REACH OF CMS FACEBOOK PAGE (2015/16)



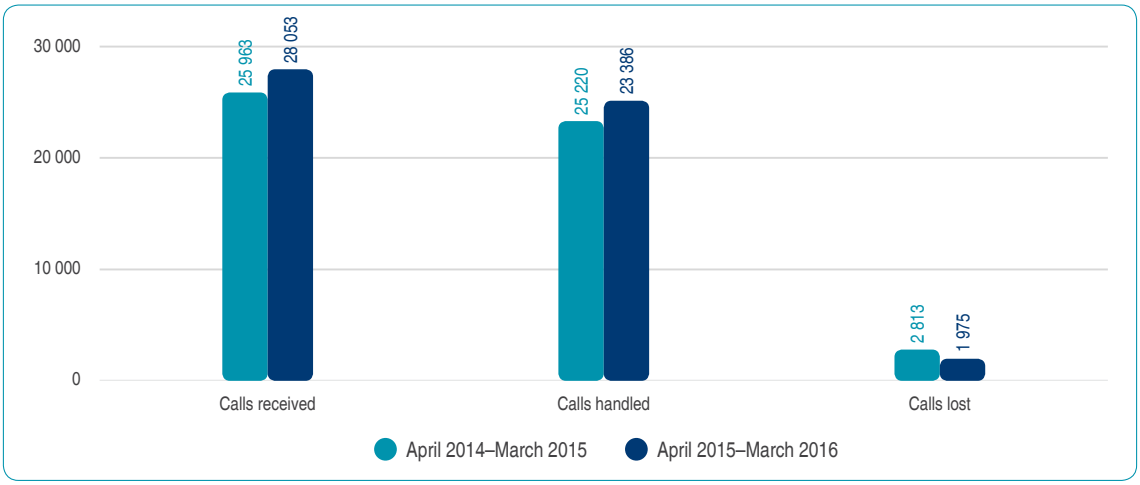
Customer care

The Customer Care Centre (CCC) continued its support to members of medical schemes and industry stakeholders by providing information and guidance geared towards solving problems and enhancing relationships.

During the period under review, the CCC received a total of 28 053 calls of which 25 220 (89.9%) were handled. This rate is more than the global metric standard which is currently 80%. As indicated in Figure 14, compared to the previous financial year (2014/15), the total number of calls has increased by 2 090 (7.4%).

The number of lost calls recorded was 2 813 (10%) for 2015/16 compared to 1 975 (7.60%) for 2014/15. The global metric standard for abandonment rate of calls by a call centre is between 5–8%. It is important to note that although the number of calls received has increased significantly, the staff complement has remained unchanged for both periods, contributing to the increased abandoned calls.

FIGURE 14: COMPARISON OF INCOMING CALLS



All 460 telephone and email clinical enquiries received by the Clinical unit through telephone calls and email during the 2015/16 period were comprehensively addressed.

Retrospective regulations

Much progress was made in efforts to distinguish and protect medical schemes in terms of legislation and other regulatory frameworks. Notable in this regard are also the CMS' efforts to improve the quality and health outcomes for all the scheme beneficiaries.

Complaints adjudicated

The CMS received 5 089 new complaints in the reporting year compared to the 3 876 complaints received in 2014/15. This represents an increase of 1 213 (12%). The total number of complaints resolved in 2015, including those carried forward from the previous year, was 7 251.

TABLE 16: NUMBER OF COMPLAINTS RECEIVED AND RESOLVED IN 2014 AND 2015

	2014	2015
Complaints carried forward from the previous year	3 777	2 162
Complaints received during current year	3 876	5 089
Total complaints	7 653	7 251
Total resolved	**5 491**	**5 794**
Closing balance as at 31 Dec 2015	2 162	1 457

TABLE 17: RESOLUTION TURN-AROUND TIMES FOR COMPLAINTS IN 2015

	Resolution turn-around time in days					
Complaints resolved	**0–30**	**31–60**	**61–90**	**91–120**	**>120**	**Total**
Number of complaints resolved	2 291	1 036	596	365	1 506	5 794
% of complaints resolved	39.5	17.9	10.3	6.3	26.0	100.0

The total of 5 794 resolved matters included invalid complaints and resolved enquiries.

TABLE 18: RULINGS ON RESOLVED COMPLAINTS AGAINST REGULATED ENTITIES IN 2015

Scheme type	Number of complaints	Ruled in favour of the complainant	Ruled in favour of both complainant and the regulated entity	Ruled in favour of the regulated entity	Invalid/ Enquiries
Open medical schemes	3 527	971	260	1 172	1 124
Restricted medical schemes	2 261	776	55	404	1 026
Brokers	6			5	1
Total	**5 794**	**1 747**	**315**	**1 581**	**2 151**

TABLE 19: NUMBER OF COMPLAINTS RESOLVED IN 2015, BY CATEGORY

Main categories	Number of complaints resolved
Valid complaints: Clinical	1 524
Valid complaints: Administrative	1 771
Valid complaints: Legal/compliance	348
Subtotal	**3 643**
Inquiries/Invalid	2 151
Total	**5 794**

TABLE 20: NUMBER OF COMPLAINTS RESOLVED BY CATEGORY (2014 AND 2015)

	2014	2015
Clinical complaints	**2 704**	**1 524**
Short-payment of PMB accounts	**1 822**	**1 050**
3rd party claim	3	0
Designated service provider	425	257
Exclusion of a condition	1	0
Formularies	72	36
Incorrect coding	120	42
Outstanding information	117	63
Paid at scheme tariff	694	387
Paid from savings account	59	41
Protocols	248	166
Provider irregular billing	12	8
Sub-limits in options	71	50
Non-payment of PMB accounts	**483**	**322**
Designated service provider	41	37
Exclusion of a condition	34	26
Formularies	45	21
Incorrect coding	29	21
Outstanding information	55	44
Paid at scheme tariff	4	2
Paid from savings account	1	0
Protocols	205	128
Provider irregular billing	4	5
Sub-limits in options	61	37
3rd party claim	4	1
Reversal (erroneous payment)	0	0
Short-payment of non-PMB accounts	**250**	**128**
Network provider	33	20
Exclusion of a condition	1	0
Formularies	5	2
Incorrect coding	20	12
Outstanding information	26	9
Protocols	66	28
Provider irregular billing	7	1
Sub-limits in options	92	56
Non-payment of non-PMBs	**149**	**24**
Administrative complaints	**2 016**	**1 767**
Benefits paid incorrectly	1 083	923
Contributions increases	146	118
General customer service	197	241
Inaccessible networks	1	2
Information/brochures not received	9	15
Medical savings account	139	144
Benefit option changes	114	24
Rejection of application for membership (due to legibility)	6	0
Pre-authorisation	321	300
Legal/Compliance	**503**	**348**
Broker conduct	5	6
Incorrect advice	2	0
Governance	11	10
Rejection of application for membership (discrimination)	33	15
Waiting periods	102	81
Late joiner penalty	46	33
Unethical conduct	0	3
Suspension and/or termination of membership	304	200

Scheme-specific performance

TABLE 21: INTERNAL DISPUTE RESOLUTION ACTIVITIES FOR THE TEN OPEN SCHEMES WITH MOST COMPLAINTS PER 1 000 BENEFICIARIES (2014 AND 2015)

Open scheme	2014 complaints per 1 000 beneficiaries	2015 complaints per 1 000 beneficiaries	Dispute Resolution Committee (DRC)	Matters served before DRC
Spectramed	2.9	5.4	Yes	None
Resolution Health Medical Scheme	2.8	2.9	Yes	None
Genesis Medical Scheme	1.0	1.2	Yes	None
Suremed	0.6	1.0	Yes	None
Keyhealth	0.6	0.8	Yes	1
Topmed Medical Scheme	0.8	0.8	No	None
Medihelp	0.8	0.9	Yes	None
Liberty Health Medical Scheme	0.5	0.7	No	None
Fedhealth Medical Scheme	0.9	0.9	No	None
Medshield	0.9	0.5	Yes	153

FIGURE 15: OPEN SCHEMES WITH MOST COMPLAINTS PER 1 000 BENEFICIARIES (2014 AND 2015)

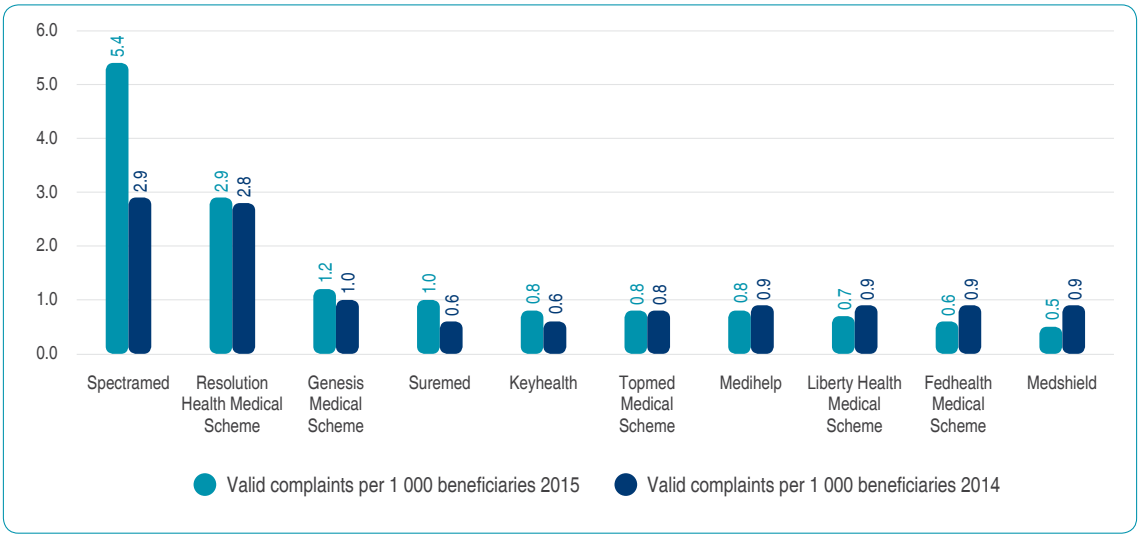
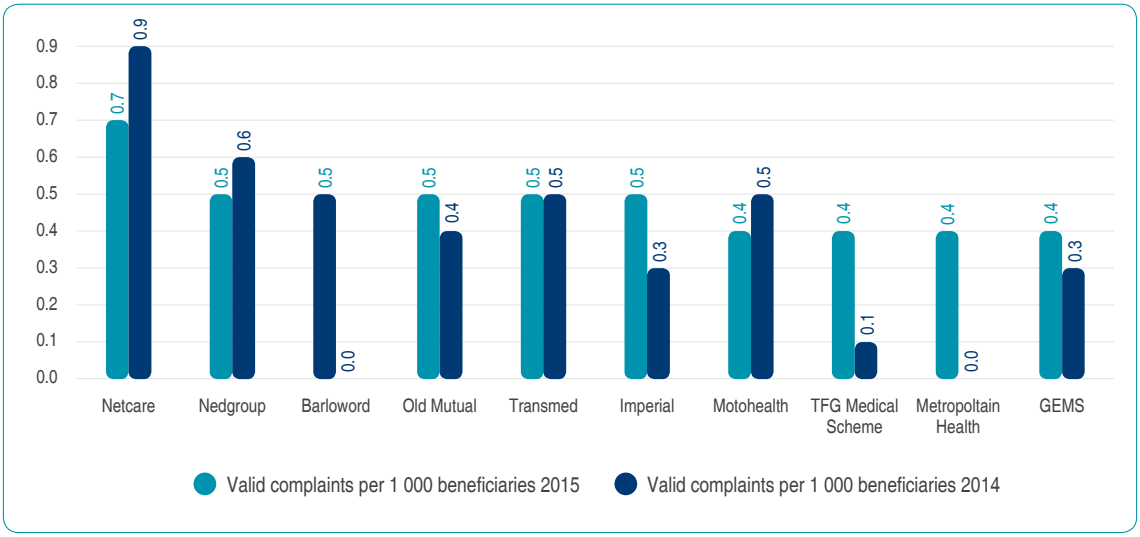


TABLE 22: INTERNAL DISPUTE RESOLUTION ACTIVITIES FOR THE TEN RESTRICTED SCHEMES WITH MOST COMPLAINTS PER 1 000 BENEFICIARIES (2014 AND 2015)

Restricted schemes	2014 complaints per 1 000 beneficiaries	2015 complaints per 1 000 beneficiaries	Dispute Resolution Committee (DRC)	Matters served before DRC
Netcare	0.9	0.7	Yes	None
Nedgroup	0.6	0.5	No	None
Barloword	0	0.5	Yes	None
Old Mutual	0.4	0.5	No	None
Transmed	0.5	0.5	Yes	None
Imperial	0.3	0.5	Yes	None
Motohealth	0.5	0.4	No	None
TFG Medical Scheme	0.1	0.4	Yes	None
Metropolitan Health	0	0.4	Yes	None
GEMS	0.3	0.4	Yes	None

FIGURE 16: RESTRICTED SCHEMES WITH MOST COMPLAINTS PER 1 000 BENEFICIARIES (2014 AND 2015)



Ten longest outstanding cases

From the complaints resolved, CMS noted a general trend that complainants, doctors and some medical schemes delay in submitting the documents required for timeous resolution of complaints. In certain instances, CMS staff also do not meet the set timeframes due to complexity of some complaints and this also results in delayed resolution of complaints. Following are examples of cases which were resolved outside the set timeframes.

VD V BESTMED

The complainant's 23-year-old daughter was diagnosed with insulin-dependent diabetes mellitus and end-stage renal failure. She reportedly had insulin-dependent diabetes mellitus since the age of 18 months. Her treating provider reported that she developed progressive microvascular complications and also has retinopathy and neuropathy. She was subsequently diagnosed with renal failure and continued to be on dialysis. The treating provider motivated for Simultaneous Pancreas and Kidney transplant (SPK), which was rejected by the scheme. The scheme's argument was that a pancreas transplant was not specified anywhere in the regulations for treatment of diabetes and thus not regarded as a PMB level of care.

The challenges involved in this matter was on the complexity of the clinical issues and the differences in interpreting the explanatory note on solid organ transplants.

Another contributor to the delays was the exchange of clinical information between the office and the complainant, who was assisted by the Wits Donald Gordon Transplant Unit. The Clinical Review Committee (CRC) had to conduct an extensive literature review on the clinical benefits of a SPK transplant versus a kidney transplant alone. The CRC also had to review a benefit definition from the South African Transplant Society submitted by the Wits Donald Gordon Transplant Unit, which purported to support a SPK transplant. Finally, the CRC had to review the public hospital clinical protocols in managing patients who presented with comparable clinical circumstances as those in this case.

The complaint involved extensive interaction between the CMS, complainant, medical scheme and Donald Gordon Transplant Unit (acting on behalf of the member). The matter was referred back to scheme for further particulars on two separate occasions. The CMS' CRC also conducted an extensive literature review of studies submitted by both the scheme and the service provider. The complaint was logged on 22 October 2014 and was resolved on 14 August 2015. It took 195 working days to be resolved.

F V BESTMED

The complaint involved a determination of a PMB liability in respect of a child initially diagnosed with Glycogen Storage Disease – Type 0 (Aglycogenosis). The 4-year-old child was diagnosed with this disease when she was 16 months old. The child's paediatric endocrinologist reported a number of clinical presentations which he said were consistent with the disease. The complainant had also submitted numerous clinical reports and genetic testing results received from a doctor in the University of Florida in the USA, but these were speculative on the actual diagnosis.

There appeared to have been uncertainty regarding where to classify the condition under the Diagnosis and Treatment Pairs (DTPs). The scheme had acknowledged that the condition may be classified under ICD 10 E74.0 but was unable to formulate a funding decision as the genetic test results were not available. Treatment, which could constitute a PMB level of care for the condition, was also unclear.

On that basis, the PMB approval could not be granted due to inconclusive test results and unconfirmed diagnosis. The scheme referred the child to a paediatric neurologist for a second opinion, who advised that Glycogen Storage Disease was likely but also indicated the possibility of a differential diagnosis of Rett's Syndrome due to stereotypic hand movements, microcephaly and scoliosis.

The matter had very complex clinical issues. There was a lengthy back and forth review of clinical reports and test results from the paediatric endocrinologist, US genetic specialist and two paediatric neurologists. The child was referred for a second opinion and that process had to be allowed to unfold. Her parents also referred her to another paediatric neurologist, whose findings were reviewed.

M V RESOLUTION HEALTH MEDICAL SCHEME

The member was diagnosed with a BRCA 1 cancer gene and the scheme declined authorising preventative bi-later mastectomy and reconstruction surgery. The CMS' CRC reported that the diagnosis code Z80.3,family history of malignant neoplasm of breast, neither falls under the PMB list or ambit, nor is listed under the DTPs, Chronic Disease List (CDL) and the emergency medical conditions. The complaint was logged on 28 April 2015 and analysed on 30 April 2015. On 12 April 2015, the complainant requested the CMS to close the complaint as they were in direct contact with the scheme and that the scheme is considering funding the surgery. However, on 20 May 2015, the complainant requested that we re-open the complaint as the matter was not resolved with the scheme. The matter was referred to our CRC for a clinical opinion and the opinion was received on 2 November 2015. The complaint was resolved on 9 November 2015.

The delay was caused by the member's request to close the complaint and also by the delayed CRC opinion. It took 135 working days to resolve this complaint.

L V FEDHEALTH

The member is an 81-year-old lady who suffers from Chronic Obstructive Pulmonary Disease. Earlier in 2015 she suffered an acute episode of chronic bronchitis and now requires 24-hours oxygen therapy. The medical scheme approved and funded an Ecomed Nidex concentrator with a backup cylinder and two refills. The member states that Ecomed Nidex is large and heavy, therefore she is unable to move around freely. She purchased a portable Imogen One G3 machine which runs on batteries and required a refund from the scheme for this machine. The CRC indicated that the scheme has discharged its mandate by funding the Ecomed Nidex concentrator on behalf of the member.

The delay was caused by the scheme's request for an extension of the due date and submitting its response long after the due date, also by the member submitting information after five months of requesting such as well as the clinical opinion that took three months to complete.

The complaint was logged on 23 December 2014 and analysed on 24 December 2014. The scheme requested an extension for response until 28 January 2015; however, a response was only sent to the CMS on 09 March 2015. The CMS requested further particulars from the complainant on 9 March 2015 for submission within 21 days. The complainant requested an extension but she never submitted information and the file was closed on 21 April 2015 due to lack of submission of missing information. On 24 August 2015, the complainant submitted outstanding information and requested that we pursue the matter further. The CMS duly referred the matter to the CRC for review of clinical records and input. The CRC finalised its opinion on 4 November 2015 and the matter was resolved on 9 November 2015. The complaint was resolved in 215 days.

M V GEMS

The matter was logged on 7 May 2015 and sent to the scheme for a response on 8 May 2015. A clinical report was requested from the complainant on 8 May 2015. The complaint related to the unpaid accounts for a physician, dermatologist and a general practitioner.

The scheme's response was received on 27 July 2015. The response was insufficiently detailed and the matter was referred back to the scheme requesting reasons why code 0199 was declined for payment. The scheme neglected to respond, and follow-ups were made on 21 October 2015 and 23 November 2015.

The scheme's response was finally received on 23 November 2015 and an apology for the delayed response as well as a confirmation that code 0199 was reviewed and processed to be paid at scheme rate. The complaint was resolved on day 139.

DS V NEDGROUP

The complaint was logged on the 15 May 2015 and sent to the scheme for comments as prescribed. The scheme response received was dated the 3rd of June 2015. Upon follow-up with the complainant on the 19th of June 2015, he stated that the dependant's Nexiam was previously funded from PMB benefits. A clinical report was requested from the complainant but the information that the treatment was based on, was for the year 2012. The CMS advised the complainant that it required the latest clinical report to enable proper investigation of the complaint. Subsequently, the complainant provided an updated clinical report on the 27th of August 2015. The case was referred to the CRC to confirm the PMB status of the dependant's condition. The committee made some recommendations

for the scheme's consideration and further follow-ups were made with the scheme in this regard as well as the 2016 funding of the dependant's Nexiam treatment and possible generic substitution. The final scheme response was received on the 30th of November 2015. The ruling was drafted and communicated to the complainant on the 1st of December 2015.

It took 138 work days to resolve this complaint. The cause of delay was the late submission of the clinical report from the complainant and the amount of correspondence between the scheme and the CMS in clarifying the funding decision.

The Clinical unit provided a total of 478 clinical opinions out of the 484 referrals from the Complaints Adjudication unit during the period under review.

Enforcement interventions to ensure compliance

Post-curatorship monitoring

SIZWE, HOSMED AND MEDSHIELD

The CMS commenced with the close monitoring of schemes that were under curatorship. The purpose of close monitoring is to ensure that the newly elected boards of trustees implement all outstanding matters that could not be finalised by the Curators at the end of their term. The monitoring is also required in terms of the court order cancelling curatorship of the schemes.

Board notice 73 of 2004

Board Notice 73 of 2004 was issued in terms of section 61(1) of the Medical Schemes Act for the purpose of ensuring that when schemes change administrators, it is done in a fair and transparent manner.

Section 43 enquiries

The CMS issued two section 43 enquiries. The purpose of these enquiries was to determine whether the schemes complied with Board Notice 73 of 2004, which requires schemes that decide to change their administrators, to do so in a fair and equitable manner. This is intended to ensure that the Boards of Trustees conduct a proper assessment of a range of administrators before deciding on the preferred one. Section 43 enquiries were issued:

- To Netcare medical scheme pursuant to Discovery Health's acquisition of Prime Med, the administrator of Netcare.
- To POLMED medical scheme pursuant to its change of administration from Metropolitan to Medscheme Holdings.

Rulings on appeals

Stability in the medical scheme industry and the overall healthcare environment is an imperative that cannot be ignored. Hence, beneficiaries and schemes not satisfied with the Registrar's opinion are offered another opportunity to raise their concerns.

Appeals Committee

An overview of some of the cases that were resolved during the year under review is provided below:

HOSMED V B

The respondent B's child suffered from Renal Tubular Acidosis, a PMB condition included in the category 903K of the Regulations to the Medical Schemes Act. The appellant declined to fund chronic medication in full as prescribed to B's child together with pathology tests. The partial payment of the accounts followed hospitalisation of B's daughter for Hypokalaemia, twice, with weight loss of more than 15 kg in a period of 8 months due to illness. The treating physician noted the condition causes severe acidosis and electrolyte disturbances, if not appropriately managed and could lead to death or irreversible kidney failure if the child dehydrates. The appellant declined to pay for the medication prescribed, arguing that the child's disease does not appear on the listing of chronic illnesses. The respondent instead offered to pay for the medication on an acute medicine basis.

The Appeals Committee found that the appellant failed to prove that Renal Tubular Acidosis did not qualify as PMB. It also looked at the particular circumstances of the child and concluded that the case was unique and deserving exception.

HOSMED V S

Mr S joined Hosmed Medical scheme for a short while and then resigned. Among the reasons for his resignation from the scheme were the failure to pay for services received from service providers and the suspension of benefits without informing him. In its correspondence with Mr S the scheme attributed the failure to pay for services to outstanding contributions on his part. The scheme claimed that it had not received a certain contribution from Mr S and therefore could not process the termination of membership. As a result of failing to terminate the membership, the scheme went on deducting contributions for five months from Mr S, even though he had tendered his resignation.

The Appeals Committee found that there was failure to communicate properly with Mr S on the part of the scheme. It found it improper for the scheme to continue to receive contributions for five months from the respondent while the membership was suspended. The behaviour of the scheme was said to be the direct cause of the resignation from the scheme. The Appeals Committee further criticised the scheme for forcing Mr S to remain longer on the scheme without any intentions of providing membership benefits to him. The scheme was ordered to refund the respondent the five months' contributions.

P V POLMED

The appellant, a medical doctor, initially complained about the practice of the scheme of paying medical scheme members who had received her services directly to them and not to her practice. The contention of the appellant was that the scheme needed to pay her practice for the services she rendered to its members, as it was difficult for her to recoup payment from the members.

The scheme argued that it had discovered anomalies in the appellant's practice profile and had informed the appellant that it would pay claims submitted by her practice directly to relevant members. The scheme argued that it had made its decision on the basis of section 59(2) of the Medical Schemes Act.

In as far as the interpretation of section 59(2), the Appeals Committee had regard to decision of the Supreme Court of Appeal in the matter between Sechaba Medical Solutions & Others v Sekete & Others (216/2014)[2015] ZACSA 8, where the court held that medical scheme members do not necessarily expect to receive a sum of money from their medical scheme for medical treatment received from service providers, but that members authorise the medical scheme to pay the service provider. The Appeals Committee therefore found that the Registrar's view that a medical scheme is not obliged to pay the service provider directly, was no longer good in law. Regarding the allegations of anomalies in the appellant's practice, the Appeals Committee referred to Regulation 6 of the Medical Schemes Act, which stipulates that a medical scheme has to inform a service provider within 30 days of receiving an account that it is erroneous or unacceptable for payment, setting out the reasons for its opinion. The Appeals Committee found that the scheme had been conducting its analysis of the appellant's accounts for a period of 18 months. The Appeals Committee held that the scheme could not "wave an indiscriminate Sword of Damocles" in the form of a never-ending analysis of the appellant's purchased medicine records. The scheme was ordered to make direct payment to the appellant of all accounts that have been submitted by the appellant.

COMMED V THE REGISTRAR

In this matter the Registrar had ordered a routine inspection into the affairs of the scheme. The scheme challenged the ordering of an inspection into its affairs by way of an appeal. The Appeals Committee noted that the inspection in question was ordered in April 2013 and has been delayed due to disputes between the scheme and the Registrar. The scheme argued that the order to institute an inspection into its affairs was a decision that could be appealed in terms of section 49(1) of the Medical Schemes Act. The Registrar argued that an order for inspection was not a decision that could be appealed as contemplated in section 49(1) of the Medical Schemes Act.

In order to decide this matter, the Appeals Committee had regard to a judgment of the Gauteng Division of the High Court in the matter between the Council for Medical Schemes and the Registrar v Bonitas Medical Scheme. The Appeals Committee highlighted certain salient points in the Bonitas decision, which dealt with the powers of the Registrar to order inspections. It held that not every expression by a functionary will constitute a decision, and that an expression of setting in motion an investigative procedure will often not constitute a decision in this context. The Appeals Committee held the view that an order for inspection could not constitute a decision that is appealable in that it would mean that a medical scheme could prevent the Registrar or the inspector from even entering the premises of the scheme by virtue of pending appeals. The Appeals Committee ruled against the scheme.

Appeal Board

An overview of some of the cases that were finalised by the Appeal Board is outlined below.

FEDHEALTH V T

This matter was ruled in favour of the member and the scheme was directed to refund the member for expenses incurred in the purchase of Humira, a drug. The scheme's contention was that the condition from which the member suffered was not a PMB and therefore refused the funding of Humira. The Appeal Board found that the condition of the member was a PMB and that he had used various drugs over the years but could not get better. It was held that where the intervention algorithm was ineffective, an exception needed to be made according to the regulations in the Medical Schemes Act.

FEDHEALTH V B

The member in this matter lodged a complaint with the Registrar which was dismissed. The member then took the matter to the Appeals Committee which ruled in his favour. The scheme appealed the ruling of the Appeals Committee with the Appeal Board which, in an unprecedented move, set aside both the ruling of the Registrar and that of the Appeals Committee. The member is diabetic, dependent on insulin. He obtained insulin on a regular basis, funded by the scheme as chronic medication. He was registered with

the Centre for Diabetes and Endocrinology (CDE), which managed his condition on a capitation arrangement. When he decided to go overseas, his membership of the CDE was terminated because his treating doctor refused to take the responsibility of managing his condition and therefore he was denied supply of insulin. The member then went ahead and bought the insulin out of his pocket while he was overseas, which cost him €1 670.41 (R25 548).

The scheme's appeal centred on Rule D3 of its rules which provides that benefits are only provided within the borders of the country. The Rule also gives the board of the scheme the absolute discretion to accord benefits. The Appeal Board held that the Appeals Committee correctly found that the scheme failed to exercise its discretion on whether or not to reimburse the member. However, it held that the Appeals Committee should have referred the matter back to the scheme after finding in favour of the member. It was held that the Appeals Committee erred in exercising a discretion that should have been exercised by the scheme's board.

BONITAS V J-S

The member in this matter suffers from cancer and needed a biologic, Herceptin. The member applied for the provision of a whole year's supply of Herceptin. The treatment would cost the scheme R558 697.07 without co-payment. The scheme's view was that there had to be a co-payment of 10% in terms of its Rules and legislation because funding was limited to R200 000 in terms of its Rules. The scheme argued that it was willing to fund Herceptin up to R200 000 with an ex gratia payment of R18 619. Beyond this point the re-imbursement for the rest of the year's treatment was declined. The Registrar ruled against the member, but the ruling was set aside by the Appeals Committee, invoking regulation 8 of the Medical Schemes Act.

The Appeal Board found the provision of the drug to be clinically appropriate and effective. It however held that, in terms of the Rules of the scheme, funding for Herceptin was indeed limited to R200 000. The benefit option of the member was also taken into consideration as a limiting factor by the Appeal Board. The ruling of the Appeals Committee was set aside.

Topical rulings by the High Courts

The CMS was engaged in a number of important court actions during the year under review. The majority of these cases were adjudicated in favour of the CMS.

CMS/SOUTH AFRICAN MEDICAL ASSOCIATION AND PASA

This matter relates to two complaint referrals about alleged price fixing by two respective groups of healthcare providers. The matter was escalated to the Competition Appeal Court which found that the CMS as a regulatory body is competent to lodge the complaints in the interest of the members of medical schemes. The matter was set down for hearing on the 13th of June 2016.

GOVERNMENT EMPLOYEES MEDICAL SCHEMES V THE APPEAL BOARD OF THE CMS, THE REGISTRAR AND MR M

The Appeal Board of the CMS confirmed a ruling made by the Registrar which stated that the scheme was not entitled to terminate the membership of the member due to allegations of fraud against him in his capacity as a service provider. The basis for the decision was that the conduct of members in their capacity as service providers was distinct from their conduct as members of a medical scheme. The Medical Schemes Act provides appropriate remedies for fraud and there were no grounds for the termination of membership in this instance. The Pretoria High Court dismissed the scheme's subsequent appeal.

GENESIS V MINISTER OF HEALTH AND CMS

Genesis lodged an application in the Western Cape High Court to have Regulation 8 struck down. Initially, only the Minister of Health, who is responsible for the promulgation of the Regulations, was cited as a respondent. The CMS and a number of industry stakeholders brought an interlocutory application to the court to be joined in the matter. This application was granted in respect of the majority of other parties. Genesis was refused leave to appeal this decision whereupon it petitioned the Supreme Court of Appeal (SCA). This petition was denied. The scheme's subsequent appeal to the Constitutional Court was also rejected. The scheme consequently withdrew the action.

Topical rulings by the Supreme Court of Appeal (SCA)

GENESIS V CMS AND THE REGISTRAR: CORRECT APPEAL PROCESS

After the Western Cape High Court ruled that section 48 of the Medical Schemes Act is the appropriate appeal provision to deal with appeals against rulings on complaints against the Registrar, the CMS petitioned the SCA for leave to appeal. The concern was that the longer process provided for in Section 49 would prejudice members of medical schemes. The SCA dismissed the petition and the CMS' subsequent appeal to the Constitutional Court was also unsuccessful. As a result of the outcome of the case, the CMS has amended its appeal procedures accordingly and all appeals relating to complaints now have to be in the form of an affidavit and lodged within three months.

GENESIS V CMS AND THE REGISTRAR: PERSONAL MEDICAL SAVINGS ACCOUNTS

This ongoing matter relates to the ownership of the funds in a member's personal savings account. The CMS relied on a prior judgment of the Gauteng North High Court in the Omnihealth matter which stated that these funds belong to members and should not form part of the funds of the scheme. Genesis, however, contended that this ruling does not apply to it for jurisdictional reasons and obtained a judgment from the Western Cape High Court in support of this position. The CMS appealed to the SCA and the matter is due to be heard on 12 May 2016.

BESTMED MEDICAL SCHEME AND TRUSTEES VS CMS AND THE REGISTRAR

An urgent interdict application was launched in the Gauteng High Court (Pretoria Division) by Bestmed and its Trustees in terms of which they sought an order suspending the effect of notices to remove certain Trustees. The CMS opposed the application and launched a counter-application to place Bestmed into curatorship and for the appointment of a Curator. The applications were heard on 4 and 5 December 2014. Both parties appealed against the judgment in terms of the application and counter-application in March 2015. The appeals were heard on 10 April 2015 and both were dismissed by the Court. A new Board has since taken over the affairs of the scheme.

BONITAS MEDICAL SCHEME

The medical scheme challenged a decision of the Registrar to launch an inspection into the affairs of the medical scheme, by lodging an appeal to the Council in terms of Section 49 (1). The effect of the appeal was, according to Bonitas, to suspend the inspection. Due to the conflicting views on the correct interpretation of Section 49 (1), the Registrar sought a declaration from the Gauteng High Court, Pretoria Division, which ruled in favour of the Registrar. The medical scheme has since appealed against the High Court Judgment to the Supreme Court of Appeal and the CMS awaits the date of the hearing of the appeal.

Topical rulings by the Constitutional Court

GENESIS V CMS, THE REGISTRAR AND JOUBERT: PMB PAYMENT

As reported in the Annual Report of 2014/15, this matter relates to the funding of prescribed minimum benefit (PMB) claims in private hospitals. The Cape High Court found that the scheme's registered rules, which stated that PMB claims will only be paid if obtained from the state sector, took precedence over the provisions of the Medical Schemes Act (the Act). This judgment was subsequently taken on appeal and overturned by the SCA which ruled in favour of the CMS. The court ruled that the Act supersedes the rules and that the intention of the legislature was to provide access to state as well as private facilities. By failing to appoint a designated service provider, the scheme was liable to fund PMB claims in full at any hospital utilised by its members. Genesis applied for leave to appeal to the Constitutional Court but the application was dismissed.

Concluding remarks

It is my strong belief that the Council for Medical Schemes executed its mandate well in the year under review. It continued to serve the public interest by effectively regulating a complex and dynamic industry in a fair manner. I affirm our unwavering commitment to protecting and strengthening the rights-based framework contained in the Medical Schemes Act 131 of 1998 from which the CMS derives the purpose for its being.

I sincerely appreciate the work done with dedication by each and every CMS employee and gratefully extend a special word of thanks to Council members for their support during the period under review.

As a regulator, the CMS always appreciates cooperation from industry. Our relations with all stakeholders can only benefit from ongoing and open dialogue.

I look forward to another fruitful year as we discharge our unique mandate to protect members, guide medical schemes, and contribute to the attainment of a more equitable national health system with a team of highly skilled employees.

May we always remember: The CMS is only as effective and efficient as its people.

Mr Daniel Lehutjo
Acting Chief Executive & Registrar

29 May 2016

PART B:
PERFOMANCE INFORMATION

STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

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

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

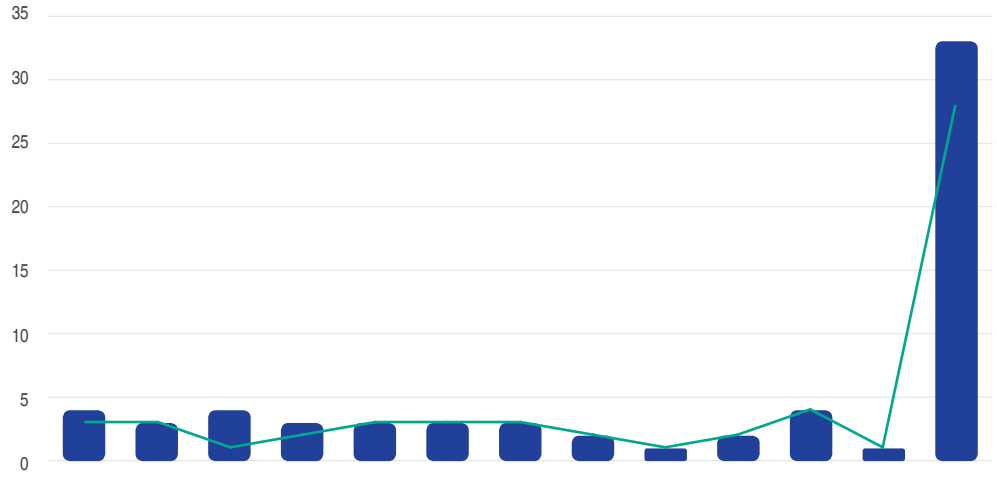
In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned objectives, indicators and targets which are set out in the strategic plan and annual performance plan of the CMS for the financial year ended 31 March 2016.

The performance information of the CMS for the financial year ended 31 March 2016 has been audited by the Auditor-General of South Africa. This information, as contained on pages 54 to 71, has also been approved by Council, which is the Accounting Authority of the CMS. Its audit report is presented on pages 91 to 92.

Mr Daniel Lehutjo
Acting Chief Executive & Registrar
Council for Medical Schemes

July 2016

Overview of CMS performance per programme 2015/16



	Sub-Prog 1.2: Office of CFO	Sub-Prog 1.3: ICT & KM	Sub-Prog 1.4: Human Resources	Prog 2: Strategy Office	Prog 3: Accreditation	Prog 4: Research & Monitoring	Prog 5: Stakeholder Relations	Prog 6: Compliance and Investigations	Prog 7: Benefit Management	Prog 8: Legal Services	Prog 9: Financial Supervision	Prog 10: Complaints Adjudication	Total number of indicators
Number of indicators per programme	4	3	4	3	3	3	3	2	1	2	4	1	33
Number of indicators achieved	3	3	1	2	3	3	3	2	1	2	4	1	28

ANNUAL PERFORMANCE INFORMATION REPORT 2015/16

Programme 1: Administration

Sub-programme 1.1: CEO and Registrar

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 1.1.4.1 – Provision of strategic leadership to the organisation and effective regulation of the industry						
1.1.4.1	Ensure that 100% of all quarterly performance indicators are met or exceeded by the units, per year	86%	100%	85%	15%	Partially achieved There were three units where deviations were noted: • Office of the CFO (1) • Human Resources (3) • Strategy Office (1)

Legend: Achieved, Not achieved, Partially achieved

Purpose

The CEO is the executive officer of the CMS and is tasked with the mandate of exercising overall management of the office and as Registrar, exercises legislated powers to regulate medical schemes, administrators, brokers, and managed care organisations.

Achievement of strategic objectives

The main objective of the office of the CEO is to ensure the CMS is effectively and efficiently run as well as to regulate the industry in a fair and transparent manner. To this end the CMS achieved 85% of its indicators as set out in its annual performance plan 2015/16. The 85% achievement is in relation to the core programmes, while the 15% deviation is mainly attributed to its administrative programmes. Overall the industry was well regulated, despite the challenges the CMS has faced in the period under review. These were mainly in the regulatory arena where schemes refused to be investigated, necessitating the CMS to enforce regulatory powers through the courts and incur high legal costs. The high number of complaints received by the CMS is still a source of concern but programmes such as Complaints and Adjudication with the assistance of the clinical expertise available at CMS was able to resolve a higher percentage of these complaints.

As at 31 March 2016 CMS was still awaiting concurrence from the Minister of Finance with regard to the approval of its budget for 2016/17. The Acting Registrar has been actively following up with both Ministries in this regard. This, however, poses a challenge in that the CMS is not able to embark on its objectives at the start of its new financial year which results in variances during the year.

The Human Resources unit deviated on three of its indicators for the period under review. The staff turnover rate was at 9% at the end of the financial year (9 out of 100 employees), the higher rate was due to terminations, non-renewal of contract, non-performance, relocation and career advancement. The high staff turnover rate impacted on staff training as only 67% of the targeted 70% was achieved.

The area of filling of key vacancies is a concern for the CMS. The CMS employs highly skilled and specialised individuals due to the nature of its business. The challenge in finding the appropriate staff included, among other things, complexity in the regulatory environment and the mismatch of the skills required as well as the remuneration levels of the CMS compared to the market. The CMS conducts a salary benchmark study to ascertain that the remuneration levels are on par with the market.

The CMS' standard recruitment process did not yield prospective/successful candidates for certain key vacancies. It then explored the avenue of head hunting and approached agencies for this purpose.

The deviation in the Strategy office was in relation to the contribution the CMS has to make to the National Health Insurance (NHI) during the year, by way of reports to the Ministerial Advisory Committee (MAC). The White Paper was only released in December 2015 and the CMS will provide its comments during the 2016/17 financial year.

Changes to planned targets

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

Sub-programme budget

Sub-programme 1.1: CEO and Registrar	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**70**	**38**	**32**	**134**	**116**	**18**
General administrative expenses	4	-	4	4	-	4
Printing and stationery	42	38	4	120	100	20
Refreshments	24	-	24	10	16	(6)
Forensic investigation	**-**	**-**	**-**	**6 000**	**7 257**	**(1 257)**
Forensic investigation	-	-	-	6 000	7 257	(1 257)
Operating expenses	**4 578**	**3 259**	**1 319**	**4 887**	**4 601**	**286**
Consulting	2 253	1 794	459	2 050	2 352	(302)
Council members' fees	1 175	741	434	1 897	1 430	467
Courier and postage	58	51	7	60	55	5
Printing and publication	-	-	-	32	10	22
Transcription services	74	42	32	87	70	17
Travel and subsistence	794	448	346	579	491	88
Venue and catering	224	183	41	182	193	(11)
Staff costs	**3 513**	**2 123**	**1 390**	**3 613**	**3 416**	**197**
Salaries	3 433	2 069	1 364	3 538	3 356	182
Staff training	80	54	26	75	60	15
Total	**8 161**	**5 420**	**2 741**	**14 634**	**15 390**	**(756)**

Sub-programme 1.2: Office of the CFO

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 1.2.3.1 – An effective, efficient and transparent financial management system						
1.2.3.1	An unqualified report issued by the Auditor-General on the Annual Financial Statements by 31 July each year	1	1	1	-	Achieved
Strategic Objective 1.2.3.2 – Risk management						
1.2.3.2	Number of strategic risk register reports submitted to Council, per year	Indicator was revised	4	4	-	Achieved
Strategic Objective 1.2.3.3 – Planning and budgeting						
1.2.3.3	The budget is approved by the Executive Authority by 31 March each year	New indicator	1	-	1	Not Achieved CMS received the approval of its levies on 23 May 2016.
	An unqualified report issued by the Auditor-General on the annual performance information 31 July each year	1	1	1	-	Achieved

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the sub-programme is to serve all business units in the CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance unit also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, we help Council to be a reputable regulator.

Achievement of strategic objectives

The CMS received an unqualified audit report on its financials as well as performance information in the year under review. The unit has strengthened its supply chain management processes in the aim to avoid irregular expenditure.

The strategic and annual performance plans together with the budget for 2016/17 was submitted to the Executive Authority within the stipulated timeframes. The Executive Authority approved the CMS' strategic and annual performance plans for 2016/17. As of 31 March 2016, the CMS was still awaiting the approval of its 2016/17 budget. The CMS subsequently received the approval from the Executive Authority on 23 May 2016.

The unit procured a risk management system during the year which offers a fully integrated enterprise governance, risk and compliance solution.

Changes to planned targets

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

Sub-programme budget

Sub-programme 1.2: Office of the CFO	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**15 882**	**15 427**	**455**	**11 245**	**13 356**	**(2 111)**
Bank charges	50	55	(5)	45	46	(1)
Building expenses	2 351	2 382	(31)	2 001	1 977	24
General administrative expenses	234	152	82	286	224	62
Insurance	333	333	-	293	295	(2)
Printing and stationery	142	154	(12)	94	114	(20)
Refreshments	-	-	-	5	4	1
Rent	11 049	10 655	394	7 121	9 294	(2 173)
Rent – operating expense	1 715	1 687	28	1 394	1 393	1
Subscriptions	8	9	(1)	6	9	(3)
Auditors remuneration	**2 080**	**1 952**	**128**	**1 622**	**1 897**	**(275)**
External audit	977	969	8	721	803	(82)
Internal audit	1 103	983	120	901	1 094	(193)
Depreciation and amortisation	**3 772**	**4 019**	**(247)**	**3 321**	**3 772**	**(451)**
Depreciation and amortisation	3 772	4 019	(247)	3 321	3 772	(451)
Forensic investigation	**-**	**-**	**-**	**-**	**-**	**-**
Forensic investigation	-	-	-		-	-
Loss on disposal of asset	**-**	**254**	**(254)**	**-**	**25**	**(25)**
Loss on disposal of asset	-	254	(254)	-	25	(25)
Operating expenses	**326**	**180**	**146**	**185**	**142**	**43**
Consulting	254	135	119	100	97	3
Courier and Postage	42	15	27	55	34	21
Travel and subsistence	15	15	-	20	3	17
Venue and catering	15	15	-	10	8	2
Staff costs	**9 524**	**10 028**	**(504)**	**9 230**	**9 247**	**(17)**
Employee benefits	1 808	1 794	14	1 620	1 683	(63)
Salaries	7 361	7 833	(472)	7 277	7 280	(3)
Staff training	200	234	(34)	190	140	50
Workmen's compensation	155	167	(12)	143	144	(1)
Total	**31 584**	**31 860**	**(276)**	**25 603**	**28 439**	**(2 836)**

Sub-programme 1.3: Information and Communication Technology and Knowledge Management

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 1.3.3.1: ICT Operations & Infrastructure						
1.3.3.1	Percentage of network and server uptime, per year	97.05%	93%	99.5%	6.5%	Achieved The unit strived to ensure that server uptime was maintained throughout the year.
Strategic Objective 1.3.3.2: Software Development & Maintenance						
1.3.3.2	Percentage uptime, of custom developed application systems during working days where network access exists, per year	98.23%	99%	99.9%	0.9%	Achieved The unit strived to ensure that all custom-developed systems were accessible throughout the year.
Strategic Objective 1.3.3.3: Knowledge & Records Management						
1.3.3.3	Number of request for knowledge and records information responded to, per year	274	350	254	46	Achieved The target set was estimated figures. The unit attended to all requests received during the period.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the sub-programme is to serve the CMS' business units by providing technology enablers and making information available to stakeholders.

ICT Operations & Infrastructure

The sub-unit successfully concluded two tenders for the provisioning of new photocopiers to the CMS as well as for virtualising our existing physical server infrastructure. The new photocopiers were successfully rolled out together with secure and follow-me printing, which is aimed at reducing printing costs across the organisation. The virtualisation project has commenced and scoping workshops are underway. Apart from the above, the sub-unit also successfully expanded its local area network with the commissioning of new office space and installed and commissioned a new computer-based training facility which will in future not only be utilised by CMS staff but also by the Education and Training Sub-Unit in training trustees, brokers and other stakeholders. Apart from the above, the sub-unit also commenced with the upgrading of the core network switching infrastructure and was able to roll out an online backup solution in line with the CMS Business Continuity and Disaster Recovery Plan.

Software Development & Maintenance

Our software development efforts further exploited and expanded the Microsoft Dynamics Extensible Relationship Management (XRM) platform by integrating the CMS legacy systems into this system. The unit introduced the scheme and benefit option registries and linked other systems such as the statutory return system to these registries. A case management system was also developed on the XRM platform and is currently being prepared for testing. The utilisation part of our statutory return system was also further updated in close collaboration with schemes and administrators. This system, which utilises Extensible Markup Language (XML), allows for faster and more accurate collection of data while reducing the administrative burden on administrators. The development of the Single Exit Price (SEP) System for Medicines on behalf of the National Department of Health also progressed well and it is expected that the system will be rolled out during the course of 2016.

Knowledge Management

The CMS continued with its drive to unlock information within the organisation, thereby creating and maintaining an environment where information and knowledge becomes paramount. A crucial part of this 'unlocking' of information is the scanning of CMS records, the process of object character recognition and the storing of such records on a proper electronic document management system.

The drive to expand the electronic capturing of all CMS records continued during the reporting period and we successfully concluded a bureau scanning project whereby paper-based files stored at our off-site storage provider were successfully digitised and stored on the Electronic Document Management Solution. The unit further enhanced and integrated the electronic document management system by making it externally accessible to employees and rolling out its mobile application to IOS and Android users.

Apart from the above, the unit also further improved the E-Library by increasing access to relevant online databases to CMS staff. Finally, the unit also successfully dealt with and provided information requested by various stakeholders under the Promotion of Access to Information Act (PAIA).

Changes to planned targets

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

Sub-programme budget

Sub-programme 1.3: Information and Communication Technology and Knowledge Management	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**4 398**	**4 468**	**(70)**	**3 725**	**3 549**	**176**
General administrative expenses	530	616	(86)	376	573	(197)
Printing and stationery	11	10	1	12	9	3
Rental – copiers	264	194	70	251	248	3
Security	919	864	55	417	301	116
Telecommunication expenses	2 674	2 784	(110)	2 656	2 412	244
Operating expenses	**1 020**	**893**	**127**	**670**	**733**	**(63)**
Consulting	263	286	(23)	226	201	25
Knowledge management	686	544	142	426	508	(82)
Travel and subsistence	51	50	1	18	24	(6)
Venue and catering	20	13	7		-	-
Staff costs	**9 028**	**8 042**	**986**	**8 435**	**7 931**	**504**
Salaries	8 352	7 699	653	7 435	7 536	(101)
Staff training	180	41	139	150	107	43
Temporary staff – SEP system	496	302	194	850	288	562
Total	**14 446**	**13 403**	**1 043**	**12 830**	**12 213**	**617**

Sub-programme 1.4: Human Resource Management

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic objective 1.4.3.1: Recruitment and talent management						
1.4.3.1	Minimise staff turnover rate and maintain a turnover rate of 5% or less, annually	3.88%	5%	9%	4%	Not Achieved The high staff turnover rate was due to terminations, non-renewal of contract, non-performance, relocation and career advancement.
	Turnaround time to fill a vacancy (turnaround time of 90 days to fill a vacancy that exists during the year)	There were 7 out of 10 positions that took longer than 90 days to fill	There were 3 out of 5 positions that took longer than 90 days to fill			

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
	Senior Strategist – 3/11/2014		90 days	342 days	252 days	Not achieved The position of the Senior Strategist was advertised but could not be filled due to incumbents not meeting the minimum requirements.
	Clinical Analyst: MCO – 1/6/2015		90 days	87 days	3 days	Achieved Position successfully filled within 90 days.
	Medical Advisor: Clinical – 1/7/2015		90 days	120 days	30 days	Not Achieved The position had to be revised and re-advertised as Junior Medical Advisor when it became evident that applicants were more experienced and earning above CMS remuneration. The successful incumbent commenced duties on 1 February 2016.
	Administrator: Complaints Adjudication – 1/8/2015		90 days	41 days	49 days	Achieved Position successfully filled within 90 days.
	Senior Programmer – 1/9/2015 (New position)		90 days	118 days	28 days	Not Achieved A moratorium was put in place thus the delay in filling the newly created position. The appointment was made on 1 February 2016.
	Health Economist – 4/1/2016		90 days	61 days	29 days	Partially achieved The recruitment process for this vacancy is still underway.
	Senior Manager: Clinical – 12/1/2016		90 days	55 days	35 days	Partially achieved The recruitment process for this vacancy is still underway.
	IT Developer – 1/2/2016		90 days	41 days	49 days	Partially achieved The recruitment process for this vacancy is still underway.
	Senior Legal Adjudication Officer 1/3/2016		90 days	20 days	70 days	Partially achieved The recruitment process for this vacancy is still underway.
	Percentage of Employment equity targets achieved (85% optimal in terms of Employment Equity Act), annually	88%	85%	94%	11%	Achieved CMS achieved a higher percentage with regard to its employment equity targets set.
Strategic Objective 1.4.3.2: Performance is maximised						
1.4.3.2	Percentage of employees undergoing training in accordance with a personal development plan, annually	New indicator	70%	67%	3%	Not Achieved 70% of targeted staff training was not achieved in line with the Workplace Skills Plan (WSP), as a result of resignations.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the sub-programme is to provide a high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support the Council's vision. Through human resources management advice and assistance, the sub-programme enables the CMS to make decisions that maximise its most important asset – its people – and to continue the development of CMS as an employer of choice.

Achievement of strategic objectives

The unit continued to implement key elements contained in the organisation's HR strategy, which seeks to improve employee relations; automate the human resources processes to improve recruitment processes; and review capacity to respond to the needs of the organisation.

The unit facilitated a comprehensive review of the HR policy manual; acquired and implemented an iCloud web-based recruitment system; acquired a logical, integrated, streamlined extension of the payroll system revolving around the human resources responsibilities that improved management of employee life cycle; and acquired a comprehensive reference checking system.

The CMS staff turnover rate was higher than expected. This is related to the CMS not being as competitive in terms of remuneration and other benefits compared to other entities.

The CMS has experienced difficulties in filling key vacancies such as those of the CEO, Senior Strategist, Senior Manager Clinical and Health Economist. This is due to some applicants not meeting the minimum requirements of the position and others who earn above the package offered by CMS.

Employee training remains crucial in measuring progress in attaining the organisational objectives as well as retaining a knowledgeable workforce. However, the targeted percentage of 70% of employees undergoing training was not achieved as a result of resignations.

Performance assessments were finalised by the moderating committee and 73.20% of employees obtained a very effective performance score.

Changes to planned targets

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

Sub-programme budget

Sub-programme 1.4: Human Resource Management	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**242**	**252**	**(10)**	**145**	**145**	**-**
General administrative expenses	77	72	5	61	48	13
Printing and stationery	12	15	(3)	11	6	5
Refreshments	48	48	-	30	45	(15)
Subscriptions	105	117	(12)	43	46	(3)
Operating expenses	**682**	**668**	**14**	**469**	**342**	**127**
Consulting	513	531	(18)	311	216	95
Legal fees	-	-	-	24	16	8
Transcription services	6	6	-	-	-	-
Travel and subsistence	30	23	7	17	11	6
Venue and catering	133	108	25	117	99	18
Staff costs	**5 459**	**5 222**	**237**	**5 055**	**4 985**	**70**
Employee wellness	577	313	264	493	472	21
Recruitment and relocation	784	786	(2)	770	821	(51)
Salaries	3 716	3 836	(120)	3 401	3 390	11
Staff training	100	80	20	151	142	9
Temporary staff	282	207	75	240	160	80
Total	**6 383**	**6 142**	**241**	**5 669**	**5 472**	**197**

Programme 2: Strategy Office

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 2.2.2: Prescribed Minimum Benefits definitions						
2.2.2	The number of benefit definitions and CMS scripts published, per year	11	12	12	-	Achieved
Strategic Objective 2.2.3: Provide clinical opinions						
2.2.3	Number of clinical matters reviewed by the Clinical Review Committee (CRC), per year	623	1472	938	534	Achieved The target set was estimated. The unit cleared all back logs during the year. At the end of the financial year there were 48 cases outstanding, these were still within the unit's 30-day turnaround time as per the unit's standard operating procedures.
Strategic Objective 2.4.1: Support universal access through recommendations made to the National Health Insurance MAC committee						
2.4.1	Number of National Health Insurance (NHI) reports submitted to Ministerial Advisory Committee (MAC), per year	-	1	-	1	Not Achieved No reports were required by the National Department of Health during the year; however, the CMS is working on giving comments on the NHI White Paper.

Legend: Achieved, Not achieved, Partially achieved

Purpose

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

Achievement of strategic objectives

The unit cleared the huge backlog of clinical opinions and enquiries it had during the year. At the end of the financial year there were 48 cases outstanding, these were still within the unit's 30-day turnaround time as per the unit's standard operating procedures.

A total of ten CMS scripts and two benefit definitions were written and published during the financial year.

The unit worked on the revision of the Prescribed Minimum Benefits (PMB), it has developed a proposed preventative package which still needs to be costed. The PMB review process is currently awaiting the provision of strategic direction from the National Department of Health.

There were no reports that were required by the NDoH during the year. The White Paper was released in December 2015 and CMS is working on giving comments on this during 2016/17.

Changes to planned targets

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

Programme budget

Programme 2: Strategy Office	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**10**	**9**	**1**	**6**	**5**	**1**
Printing and stationery	10	9	1	6	5	1
Operating expenses	**501**	**241**	**260**	**105**	**25**	**80**
Consulting	330	220	110	25	-	25
Travel and subsistence	171	21	150	49	16	33
Staff costs	**6 325**	**4 361**	**1 964**	**5 613**	**4 904**	**709**
Salaries	6 145	4 322	1 823	5 490	4 786	704
Staff training	180	39	141	123	118	5
Total	**6 836**	**4 611**	**2 225**	**5 724**	**4 934**	**790**

Programme 3: Accreditation

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 3.2.1: Brokers are accredited based on their fitness and propriety and are compliant with the requirements for accreditation						
3.2.1	Number of brokers and broker organisations accredited within 30 days of receipt of complete applications, per year	5 027	5 192	5 634	442	Achieved The unit accredited a higher number of brokers and broker organisations than initially estimated.
Strategic Objective 3.2.2: Managed Care Organisations (MCOs) are evaluated and accredited for compliance with accreditation standards						
3.2.2	Number of managed care organisation applications, which meet the key requirements, accredited within 3 months of receipt, per year	26	16	16	-	Achieved
Strategic Objective 3.2.3: Administrators and self-administered schemes are evaluated and accredited for compliance with accreditation standards						
3.2.3	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt, per year	9	13	12	1	Achieved One administrator's accreditation renewal was considered by Council but not approved due to the organisation not meeting the key requirements for accreditation.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to ensure brokers and broker organisations, administrators and MCO's are accredited in line with the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skills, capacity and infrastructure, and are financially sound.

Achievement of strategic objectives

The unit ensured the evaluation, including on-site inspections of facilities and infrastructure, of administrators and managed care entities during the year. The office continued to monitor the financial soundness of risk-bearing entities based on their Annual Financial Statements to ensure their financial soundness. Two cases of unwarranted profit sharing arrangements between medical schemes and managed care organisations were discontinued following a process of contract evaluation by the office. The verification of broker qualifications resulted in a number of individuals having been refused accreditation based on false or misleading information supplied. The office finalised the managed care quality outcome measurement strategy in respect of six main categories of PMBs during the period and published a circular clarifying a separation of managed care fees from non-healthcare expenditure in the financial returns to be submitted by medical schemes.

Changes to planned targets

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

Programme budget

Programme 3: Accreditation	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**135**	**107**	**28**	**110**	**49**	**61**
Printing and stationery	50	40	10	50	44	6
Subscriptions	85	67	18	60	5	55
Operating expenses	**505**	**442**	**63**	**587**	**485**	**102**
Travel and subsistence	499	438	61	582	481	101
Venue and catering	6	4	2	5	4	1
Staff costs	**7 338**	**7 144**	**194**	**6 755**	**6 632**	**123**
Salaries	7 238	7 121	117	6 704	6 604	100
Staff training	100	23	77	51	28	23
Total	**7 978**	**7 693**	**285**	**7 452**	**7 166**	**286**

Programme 4: Research and Monitoring

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 4.2.1: Monitor compliance to Regulation 5 (e) with regards to ensuring that the practice code number of a treating provider is provided for on the billing statement to medical scheme for services rendered to the member						
4.2.1	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per year	4	4	4	-	Achieved
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions						
4.4.1	Number of research projects and specialised technical support projects finalised, per year	11	8	10	2	Achieved The unit finalised an additional two projects during the year.
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice						
4.4.2	Non-financial report submitted for inclusion in the Annual Report, per year	1	1	1	-	Achieved

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. By doing this we help the Council for Medical Schemes to contribute to development of policy that enhances the protection of the interests of beneficiaries and members of public.

Achievement of strategic objectives

The unit has exceeded the annual target of eight research and specialised technical support projects. The unit is also actively involved in the Health Market Inquiry and in various internal processes regarding participation in the proposed National Health Insurance (NHI) initiative. A first report on measuring quality in medical schemes was published by the unit and the results were presented at the Actuarial Society of South Africa's 2015 Convention in November. Utilisation data were for the first time collected by using the newly developed Dynamic Database Driven Return (DDDR) system and the results were included in the Annual Report and successfully presented at the launch of the Annual Report and road shows.

Changes to planned targets

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

Programme budget

Programme 4: Research and Monitoring	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**13**	**12**	**1**	**4**	**3**	**1**
Printing and stationery	3	2	1	3	3	-
Subscriptions	10	10	-	1	-	1
Operating expenses	**133**	**50**	**83**	**362**	**312**	**50**
Consulting	65	-	65	251	251	-
Travel and subsistence	43	36	7	80	42	38
Venue and catering	25	14	11	31	19	12
Staff costs	**6 569**	**6 731**	**(162)**	**6 357**	**5 729**	**628**
Salaries	6 409	6 609	(200)	6 115	5 599	516
Staff training	160	122	38	242	130	112
Total	**6 715**	**6 793**	**(78)**	**6 723**	**6 044**	**679**

Programme 5: Stakeholder Relations

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 5.2.1: Stakeholder awareness and training						
5.2.1.	Number of stakeholder training and awareness sessions, per year	New indicator	18	46	28	Achieved The unit held additional training and awareness sessions during the year.
Strategic Objective 5.2.2: Communication and engagement with stakeholders						
5.2.2	Publication of CMS' Annual Report by 31 August	1	1	1	-	Achieved

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 5.2.3: Stakeholder management						
5.2.3	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year	72.9%	75%	94%	19%	Achieved The initiatives taken by the unit led to an increase in the positive or neutral feedback on the CMS' reputation.

Legend: Achieved, Not achieved, Partially achieved

Purpose

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

Achievement of strategic objectives

The number of stakeholder training and awareness sessions include Continuing Professional Development (CPD) broker training sessions conducted in Gauteng, Eastern Cape, Western Cape and KwaZulu-Natal, of which training sessions in the Eastern Cape, Western Cape and KwaZulu-Natal were offered for the first time. The compulsory two-day induction training sessions for newly appointed trustees were held in Gauteng and the Western Cape. The accredited skills development programme, the highlight for the year, resulted in nine attendees being declared competent by the Insurance Seta.

Consumer education activities for general consumers and medical scheme members were conducted in the urban and semi-urban areas, covering five of the nine provinces. Of the total 6 147 consumers reached, 3 472 were from rural areas.

The CMS participated in several radio and television interviews, talk shows in various languages and a number of opinion pieces were published resulting in the continued positive reputation of the CMS for the year under review.

Changes to planned targets

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

Programme budget

Programme 5: Stakeholder Relations	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**20**	**13**	**7**	**28**	**16**	**12**
Printing and stationery	10	6	4	8	8	-
Refreshments	-	-	-	10	2	8
Subscriptions	10	7	3	10	6	4
Operating expenses	**2 392**	**2 171**	**221**	**2 538**	**2 405**	**133**
Consulting	40	33	7	75	147	(72)
Courier and Postage	10	-	10	10	9	1
Exhibition costs	100	56	44	130	87	43
Media and promotion	981	843	138	363	336	27
Printing and publication	549	571	(22)	849	811	38
Travel and subsistence	388	331	57	703	587	116
Venue and catering	324	337	(13)	408	428	(20)
Staff costs	**6 692**	**6 825**	**(133)**	**6 486**	**6 176**	**310**
Employee wellness	3	6	(3)		-	-
Salaries	6 589	6 731	(142)	6 266	5 949	317
Staff training	100	88	12	220	227	(7)
Total	**9 104**	**9 009**	**95**	**9 052**	**8 597**	**455**

Programme 6: Compliance and Investigation

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 6.2.1: Enforcement of the Act to ensure compliance						
6.2.1	Number of enforcement interventions undertaken, per year	52	45	82	37	Achieved The unit dealt with more enforcement interventions than was initially estimated during the year.
Strategic Objective 6.2.2: Strengthen and monitor governance systems						
6.2.2	Number of governance interventions implemented, per year	88	72	55	17	Achieved The target set was estimated. The unit attended to all matters that required monitoring during the period.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.

Achievement of strategic objectives

During the reporting period we introduced a governance assessment tool in collaboration with The Global Platform Intellectual Property (TGPIP) to assist schemes in assessing their own governance and compliance with the Medical Schemes Act. The instrument is a self-assessment tool which CMS believes will assist schemes not only with compliance with the Act, but also in strengthening their governance systems and framework.

The unit identified and attended 37 annual general meetings as observers and addressed irregularities that were picked up at the meetings with scheme Principal Officers.

Furthermore, the unit held a meeting with the Board of Healthcare Funders (BHF) to discuss a way forward regarding resolving the Regulation 10(6) issue which specifies that schemes should not pay for PMB-related costs from members' savings accounts.

The unit finalised the first phase of Trustee Remuneration project. This aims to ensure that each scheme has a Trustee Remuneration policy in place.

Changes to planned targets

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

Programme budget

Programme 6: Compliance and Investigation	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**2**	**2**	**-**	**4**	**1**	**3**
Printing and stationery	2	2	-	4	1	3
Operating expenses	8	11	(3)	-	-	-
Travel and subsistence	8	11	(3)		-	-
Staff costs	**5 412**	**5 215**	**197**	**4 921**	**5 009**	**(88)**
Salaries	5 262	5 179	83	4 826	4 910	(84)
Staff training	150	36	114	95	99	(4)
Total	**5 422**	**5 228**	**194**	**4 925**	**5 010**	**(85)**

Programme 7: Benefits Management

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objectives 7.2.1: Analyse scheme rule amendments						
7.2.1	Number of rule amendments analysed, per year	242	212	222	10	Achieved The unit received more amendments than initially estimated.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. We analyse and approve all other rules to ensure consistency with the Medical Schemes Act. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this we help the Council for Medical Schemes ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the Act.

Achievement of strategic objectives

The unit continues to ensure beneficiaries' protection is upheld by analysing all rule amendments to make sure that these are fair, non-discriminatory and do not undermine the policy intention of the Medical Schemes Act. The unit processed 222 rule amendments during the year.

The unit further analysed medical schemes' marketing materials and related documents and/or forms, to ensure consistency with the registered rules. Inconsistencies identified during the analyses of marketing materials were addressed by schemes and resulted in low or no inconsistencies. All rules and marketing materials deemed non-compliant were referred to the Compliance and Investigation Unit for further handling with probable penalties imposed. The unit's insistence in ensuring compliance by rejecting rules that undermine the Act, has assisted in an increased level of cooperation and compliance by schemes with more schemes accepting the reasons for the rejections. The office has also seen a decrease in the number of appeals by schemes, with regards to the rejected rules/amendments.

The review of the model rules has been finalised by the unit and will be available on the CMS website, which will form the basis for rules that are compliant with the Act by stakeholders.

Changes to planned targets

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

Programme budget

Programme 7: Benefits Management Unit	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**31**	**22**	**9**	**31**	**28**	**3**
Printing and stationery	14	12	2	17	12	5
Subscriptions	17	10	7	14	16	(2)
Operating expenses	**17**	**15**	**2**	**-**	**-**	**-**
Travel and subsistence	15	14	1		-	-
Venue and catering	2	1	1		-	-
Staff costs	**5 534**	**5 088**	**446**	**5 260**	**4 729**	**531**
Salaries	5 402	5 069	333	5 160	4 695	465
Staff training	132	19	113	100	34	66
Total	**5 582**	**5 125**	**457**	**5 291**	**4 757**	**534**

Programme 8: Legal Services

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 8.2.1: Legal advisory service for effective regulation of the industry and management of the office						
8.2.1.	Number of written and verbal legal opinions provided to internal and external stakeholders, per year	227	100	205	105	Achieved The unit provided a higher number of written and verbal legal opinions than was initially estimated.
Strategic Objective 8.2.2: Support CMS mandate by defending decisions of Council and the Registrar						
8.2.2	Number of court and tribunal appearances in legal matters handled by the unit, per year	24	20	21	1	Achieved The unit handled a higher number of court and tribunal matters than was initially estimated.

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions.

Achievement of strategic objectives

The unit continued to provide effective legal support to the various operational units located in the Office of the Registrar and the Council, ranging from legal advice on day-to-day matters, including litigation in both the High Court and the Supreme Court of Appeal on issues of critical regulatory importance. The unit was engaged in a number of important court actions as a result of interventions initiated by the Compliance and Investigations Unit. The vast majority of these cases were adjudicated in favour of the CMS. The unit provided all legal opinions and advice requested well within the prescribed time frames.

Changes to planned targets

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

Programme budget

Programme 8: Legal Services	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**13**	**8**	**5**	**10**	**9**	**1**
Printing and stationery	8	6	2	10	9	1
Subscriptions	5	2	3		-	-
Operating expenses	**8 064**	**7 554**	**510**	**8 052**	**7 724**	**328**
Courier and postage	-	-	-	2	-	2
Legal fees	7 970	7 459	511	8 000	7 683	317
Travel and subsistence	90	93	(3)	50	41	9
Venue and catering	4	2	2		-	-
Staff costs	**3 578**	**3 595**	**(17)**	**3 334**	**3 163**	**171**
Salaries	3 503	3 529	(26)	3 249	3 093	156
Staff training	75	66	9	85	70	15
Total	**11 655**	**11 157**	**498**	**11 396**	**10 896**	**500**

Programme 9: Financial Supervision

	Performance indicator	Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 9.2.1: Monitor and promote the financial soundness of medical schemes						
9.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per year	100%	100%	100%	-	Achieved
	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	New indicator	100%	100%	-	Achieved
	Number of quarterly financial return reports published (excluding quarter 4), per year	3	3	3	-	Achieved
	Number of financial sections prepared for the Annual Report	1	1	1	-	Achieved

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to serve the beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, we help the Council for Medical Schemes monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

Achievement of strategic objectives

In terms of Regulation 29 of the Medical Schemes Act requires all medical schemes to maintain accumulated funds of at least 25% of gross annual contributions. Medical schemes that fall short of this requirement must notify the CMS of the underlying causes of failure and corrective action to be taken.

The unit continued to strengthen and enhance Early Warning System (EWS) interventions. These initiatives consist of regular financial review meetings with schemes and their Boards of Trustees, submission of business plans and turn-around strategies, the quarterly returns as well as the Real-Time Monitoring (RTM) system. The quarterly return ensures that the CMS is able to undertake baseline supervision on all medical schemes and make appropriate regulatory interventions between audit cycles. Further to this, the RTM system allowed the CMS to better understand the profiles of schemes and intervene timeously to ensure the protection of members' interests.

The unit collaborates with the South African Institute of Chartered Accountants (SAICA) and the Independent Regulatory Body of Auditors (IRBA) in order to develop and publish industry standardised Accounting and Auditing Guides for Medical Schemes to help achieve uniformity in respect of proper disclosure and good financial reporting across the industry. During the period under review, we published a circular (Circular 56 of 2015) prescribing Key Audit Matters to be included in the audit reports of medical schemes – this makes the CMS one of the first regulators to do so.

Regarding the appointment of auditors, the unit commenced and concluded work relating to the development of standards for the authorisation of auditors – this will enhance the approval of auditors as required in Section 36 of the Medical Schemes Act, and make the process more transparent with criteria set out up front. These standards were published for public comment. The final set of standards and associated information technology systems will be published early in the new financial year.

The unit achieved all its strategic objectives through the above mentioned processes.

Changes to planned targets

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

Programme budget

Programme 9: Financial Supervision Unit	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**30**	**35**	**(5)**	**50**	**30**	**20**
Printing and stationery	10	7	3	17	10	7
Subscriptions	20	28	(8)	32	19	13
Operating expenses	**75**	**57**	**18**	**155**	**27**	**128**
Consulting	-	-	-	20	-	20
Travel and subsistence	25	23	2	50	27	23
Venue and catering	50	34	16	85	-	85
Staff costs	**10 196**	**10 186**	**10**	**9 809**	**9 684**	**125**
Salaries	10 008	10 035	(27)	9 569	9 505	64
Staff training	188	151	37	240	179	61
Total	**10 301**	**10 278**	**23**	**10 014**	**9 741**	**273**

Programme 10: Complaints Adjudication

Performance indicator		Actual achievement 2014/15	Planned target 2015/16	Actual achievement 2015/16	Deviation from planned target to actual achievement 2015/16	Comments
Strategic Objective 10.2.1: Complaints resolution						
10.2.1	Percentage of complaints resolved within 120 working days and in accordance with complaints procedure, per year	73%	73%	75.31%	2.31%	Achieved

Legend: Achieved, Not achieved, Partially achieved

Purpose

The purpose of the programme is to serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, we ensure that beneficiaries are treated fairly by their medical schemes.

Achievement of strategic objectives

The decisions made on resolved complaints had a positive impact on members in terms of rule amendments made. The rules which were found to contravene the Medical Schemes Act were amended and this addressed non-compliance issues which were of concern. In addition, the overall resolution rate meant the unit was able to address more complaints than anticipated.

Changes to planned targets

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

Programme budget

Programme 10: Complaints Adjudication Unit	Budget 2015/16 R'000	Actual 2015/16 R'000	(Over)/ under expenditure R'000	Budget 2014/15 R'000	Actual 2014/15 R'000	(Over)/ under expenditure R'000
Administrative expenses	**164**	**55**	**109**	**141**	**79**	**62**
Printing and stationery	52	10	42	12	10	2
Subscriptions	64	11	53	80	21	59
Telecommunication expenses	48	34	14	45	46	(1)
Operating expenses	**678**	**321**	**357**	**726**	**1 138**	**(412)**
Consulting	500	110	390	609	1 016	(407)
Courier and postage	-	-	-	1	1	-
Travel and subsistence	158	211	(53)	116	121	(5)
Venue and catering	20	-	20		-	-
Staff costs	**6 586**	**6 129**	**457**	**5 875**	**5 503**	**372**
Salaries	6 426	6 069	357	5 732	5 354	378
Staff training	160	60	100	143	149	(6)
Total	**7 428**	**6 505**	**923**	**6 742**	**6 720**	**22**

PART C:
GOVERNANCE

CORPORATE GOVERNANCE REPORT

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

Accounting authority: The Council

Section 4 of the Act empowers the Minister of Health of the Republic to appoint a Council consisting of up to 15 members. When appointing the Council, the Minister takes into consideration the interests of members and of medical schemes, expertise in law, accounting, medicine, actuarial sciences, economics and consumer affairs. Section 10(1) prescribes the minimum number of meetings that the Council may hold each year. As at 31 March 2016, the Council consisted of 10 members.

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

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

- Executive Committee;
- Human Resource Committee;
- Finance Committee;
- Audit & Risk Committee;
- ICT Governance Committee; and
- Appeals Committee.

The above-mentioned committees play a vital role in ensuring that the governance function of the Council is efficient and effective.

The role of the Council

Section 7 of the Act provides that the functions of the Council shall be to:

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

Reports to the Portfolio Committee on Health

The Council presented the following reports to the Portfolio Committee on Health:

- The CMS Strategic Plan, Annual Performance Plan and Budget for 2016/17 on 21 April 2016; and
- The Annual Report on 14 October 2015.

Reports to the Executive Authority

The Council approved and submitted four Quarterly Performance information reports on organisational performance to the Minister of Health in line with the requirements and guidelines laid down by the National Treasury. The reports were submitted on the following dates:

Quarter 1 2015/16 – 30 July 2015
Quarter 2 2015/16 – 30 October 2015
Quarter 3 2015/16 – 29 January 2016
Quarter 4 2015/16 – 29 April 2016

TABLE 23: COMPOSITION OF NEW COUNCIL AS AT 31 MARCH 2016

Name of Council member	Designation	Date appointed	Date resigned	Qualification	Area of expertise	Council committee	No. of meetings attended
Prof. Y Veriava	Chairperson	14 Nov 2014	N/A	MBBCH (Wits), Hon DSc (Wits) FCP(SA), FRCP (London)	Clinical Medicine	EXCO, HR	10
Dr L Mpuntsha	Vice Chairperson	14 Nov 2014	N/A	MBChB, MPhil	Medicine	EXCO, Appeals Committee	18
Prof. BC Dumisa	Member	14 Nov 2014	N/A	LLB, LLM, MBA, MSc, DBA	Law Management	Appeals Committee ICT Governance	13
Ms L Sibanyoni	Member	14 Nov 2014	N/A	BBusSC (Actuarial Sciences)	Actuarial Sciences	HR, Audit and Risk Committee	7
Dr S Mabela	Member	14 Nov 2014	N/A	BSc, MBA, PhD (Economics)		EXCO, HR, ICT Governance	9
Ms M Maboye	Member	14 Nov 2014	N/A	BA, Adv. Dip, Dip	Healthcare Management	EXCO, HR	8
Mr J Van der Walt	Member	14 Nov 2014	N/A	CA (SA) BCompt (Hons) MComm	Accounting Management	Audit and Risk Committee	14
Mr M Nkosi	Member	14 Nov 2014	N/A	MPH, PGD, BA	Healthcare Management	ICT Governance, Audit & Risk Committee	12
Prof. S Perumal	Member	14 Nov 2014	N/A	DComm, MSc BComm	Finance	EXCO, Audit & Risk Committee	19
Adv. H Kooverjie	Member	14 Nov 2014	N/A	BA, LLB	Law	Appeals Committee	12

TABLE 24: MEMBERSHIP OF COUNCIL COMMITTEES AS AT 31 MARCH 2016

Council committee	No. of meetings held	No. of members	Names of members
Executive Committee (EXCO)	4	5	Prof. Y Veriava Dr L Mpuntsha Prof. S Perumal Dr S Mabela Ms M Maboye
Human Resources Committee	1	4	Prof. Y Veriava Dr S Mabela Ms M Maboye Ms L Sibanyoni
Audit & Risk Committee	4	6	Mr R Nicholls (Independent non-executive member) Mrs J Naicker (Independent non-executive member) Ms P Mzizi (Independent non-executive member) Prof. S Perumal Mr M Nkosi Mr J Van der Walt
Finance Committee	6	4	Prof. S Perumal Mr M Nkosi Ms L Sibanyoni Mr J Van der Walt
Appeals Committee	9	6	Dr L Mpuntsha Prof. B Dumisa Adv. H Kooverjie Adv. V Ngalwana (Chair – external) Adv. H Maenetje (Alternate Chair – external)
Full Council	6	10	Prof. Y Veriava Dr L Mpuntsha Prof. B Dumisa Prof. S Perumal Dr S Mabela Adv. H Kooverjie Mr M Nkosi Ms L Sibanyoni Ms M Maboye Mr J Van der Walt

TABLE 25: REMUNERATION OF COUNCIL MEMBERS IN 2015/16

Name of Council member	Remuneration R'000	Total R'000
Prof. Y Veriava	110	110
Prof. BC Dumisa	96	96
Ms H Koovertjie	78	78
Ms MS Mabela	88	88
Ms M Maboye	25	25
Dr L Mpuntsha	131	131
Ms L Nevhutalu	28	28
Mr M Nkosi*	-	-
Prof. S Perumal	108	108
Mr J Van der Walt	77	77
Total	**741**	**741**

** Non-remunerated Council members*

Council Secretariat

The Council Secretariat is responsible for providing corporate governance support to the Council and its committees. The Council Secretariat is also responsible for providing guidance to Council members on their rights, responsibilities, duties and powers, both on an individual level and collectively. The Council Secretary supports Council compliance with all laws and regulations that are relevant to the CMS and the private healthcare industry. All logistical arrangements in connection with Council business are carried out by the Council Secretariat.

Internal Controls

The Office of the CFO is tasked with the responsibility for internal control to ensure the efficient management of CMS resources.

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

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

Internal audit

The CMS has established an outsourced Internal Audit function which resides under the direction of the Audit and Risk Committee. The purpose of the internal audit function is to provide an independent, objective assurance and consulting activity designed to add value and improve CMS' operations. It evaluates and provides assurance on the effectiveness of risk management, control and governance processes at CMS.

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

The internal audit charter together with the Annual Internal Audit Plan and a three year rolling plan was approved by the Audit and Risk Committee during the year. The Internal Auditors and External Auditors had several meetings during the year to ensure that there was synergy between the two assurance providers to ensure a value adding and cost effective service.

Scope of work

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

The scope of work of the outsourced Internal Audit Function is to determine whether CMS' network of risk management, control, and governance processes, as designed and represented by management, are adequate and effective to mitigate related risks.

Risk management

The CMS has matured progressively over the years in terms of its implementation of the Risk Management Framework. Risk management is fast becoming embedded in the CMS' culture; there is continuous consideration of risks during discussions around new projects, strategy, processes, and resources and in every facet of the organisation.

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

The Council is ultimately responsible for risk management in CMS and is supported by the Audit and Risk Committee, Executive Management and the Risk and Performance Manager.

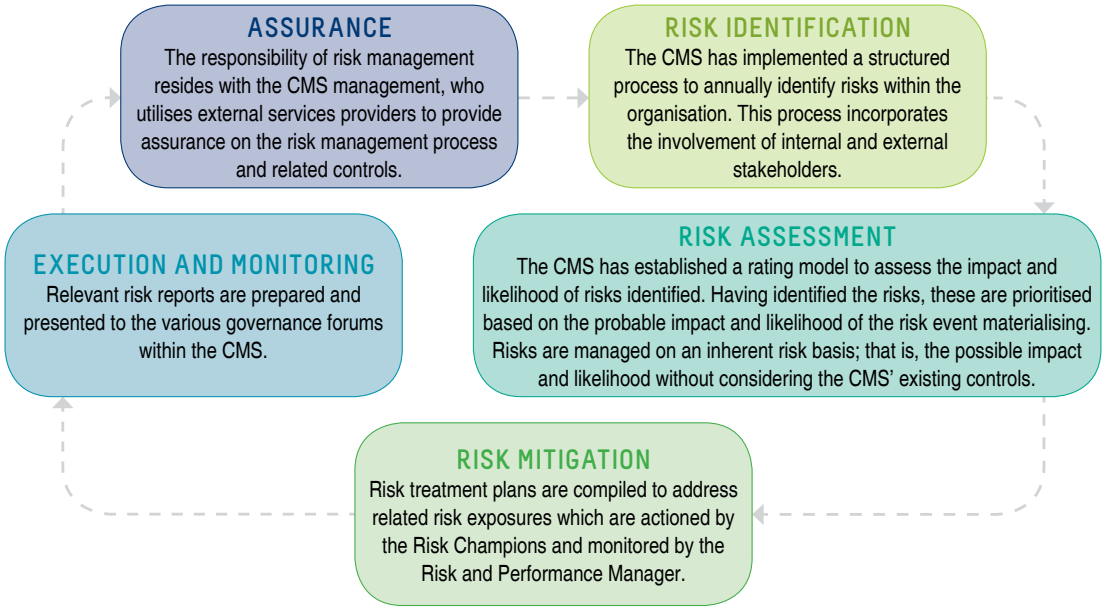
CMS Risk Assessment Process during 2015/16

There is regular and on-going identification, evaluation, management, monitoring and reporting of risks aimed at improving the ability to reduce the incidence/impact on the CMS of risks that do materialise.

Operational risks are identified by business units and these risks are raised by the Risk Champions into the various units' operational risk registers. These risks are monitored and reported on a monthly basis at the unit meetings as well as at the Risk Champions Committee meetings. Continuous monitoring of these risks are carried out by the Risk Champions and the Risk and Performance Manager.

Strategic risks are identified by Council, the Audit and Risk Committee and Executive Management while these risks are monitored and reported on at all governance structures within the CMS.

FIGURE 17: RISK ASSESSMENT PROCESS



Health, safety and environmental issues

A Health and Safety Committee was established and a Health and Safety Framework developed with the aim of protecting employees against such hazards arising out of activities at work.

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

Prevention of fraud and corruption

The CMS has adopted a Fraud and Corruption Strategy. The CMS is committed to protect its funds and other assets and as such will not tolerate corrupt or fraudulent activities emanating from either internal or external sources. Any detected corrupt activities will be investigated and, where so required, reported to the law enforcement authorities in accordance with its Fraud and Corruption Prevention Strategy.

Materiality and Significance Framework

As required by the Treasury Regulations, the Council has developed a materiality and significance framework appropriate to its size and circumstances.

Framework 2015/16 Financial Year

Levels set as per the guidance set out in the Practice Note on the PFMA and submitted to the Minister of Health for approval.

Materiality

The Council has taken into account the following factors in determining the CMS's level of materiality:

a) The nature of the CMS' business;
b) Statutory requirements affecting the CMS;
c) The inherent and control risks associated with the CMS; and
d) Quantitative and qualitative issues.

Having taken these factors into account, the Council has assessed the level of "a material loss" to be:

a) Every amount in respect of criminal conduct;
b) R30 000 and above for irregular, fruitless and wasteful expenditure involving gross negligence; and
c) R1 130 7601 and above being about 1% of income to report in terms of Subsection 55 (1)(d) regarding the fair presentation of affairs of the public entity, its business, its financial results, its performance against pre- determined objectives and its financial position as at the end of the financial year concerned.

Significance

The Council has decided that any transaction covered by Section 54(2) of the Public Finance Management Act will be reported on, being:

a) Establishment or participation in the establishment of a company;
b) Participation in a significant partnership, trust, unincorporated joint venture or similar arrangement;
c) Acquisition or disposal of a significant shareholding in a company;
d) Acquisition or disposal of a significant asset;
e) Commencement or cessation of a significant business activity; and
f) A significant change in the nature or extent of its interest in a significant partnership, trust unincorporated joint venture or similar arrangement.

REPORT OF THE AUDIT AND RISK COMMITTEE

We are pleased to present our report to the Council for Medical Schemes (CMS) Accounting Authority (Council) for the financial year ended 31 March 2016.

This report is provided by the Audit and Risk Committee of Council, appointed in respect of the 2015/16 financial year, in compliance with Section S51(1)(a)(ii) of the Public Finance Management Act, 1 of 1999, as amended (PFMA). The committee's operation is guided by a detailed charter that is informed by the PFMA and approved by Council.

Audit and Risk Committee members and meetings

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

The Committee held four scheduled meetings during the year under review. Meetings and attendance at these meetings are set out in Table 26.

1 *Based on the audited figure of income for 2013/14*

TABLE 26: MEETINGS AND ATTENDANCE OF THE AUDIT AND RISK COMMITTEE IN 2015/16

Name of member	Position of member	Date of appointment	Date of reappointment	Term end	Meetings attended			
					19 May 2015 (scheduled)	25 July 2015 (scheduled)	27 January 2016 (scheduled)	17 February 2016 (scheduled)
Mr Rowan Nicholls	Independent & non-executive and Chairperson	1 October 2009	1 November 2012	Term extended until October 2016	√	√	√	√
Josephine Naicker	Independent & non-executive	1 October 2009	1 November 2012	Term extended until October 2016	√	√	X	X
Ms Pumla Mzizi	Independent & non-executive	1 April 2015			√	√	√	√
Mr Johan van der Walt	Non-executive & Council member	14 November 2014			√	X	√	√
Mr Moremi Nkosi	Non-executive & Council member	14 November 2014			√	√	√	X
Prof. S Perumal	Non-executive & Council member	14 November 2014			√	√	X	√

√ = attended X = apology

Other invitees

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

Functions

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

- Evaluation of the effectiveness of risk management, controls, and governance processes;
- Oversight over:
  - The financial and performance reporting process;
  - The activities of the internal and external audits, and facilitation of a coordinated approach between these functions;
- Review of:
  - Provisional and year-end Financial Statements to ensure that they fairly present and are prepared in the manner required by the PFMA and the Medical Schemes Act;
  - The External Audit Plan, budget, and reports on the Annual Financial Statements;
  - The internal audit charter, Annual Audit Plan, Three-year Audit Plan, and annual budget;
  - Internal audit and risk management reports and, where relevant, recommendations made to the Board and management;
- Approval of:
  - The internal audit charter, budget, and Three-year Audit Plan;
  - Audit fees and engagement terms of the internal auditor are recommended to Council;
  - Engagement terms, plans, and budget for the Auditor-General of South Africa is recommended to Council; and
- Recommendation of the unaudited and audited Annual Financial Statements to Council for the financial year ended 31 March 2016.

Audit and Risk Committee responsibility

Mandate

The mandate of the committee is derived from Section S51(1)(a)(ii) of the PFMA and paragraph 3.1 of the Treasury Regulations. The committee reports that it has discharged its responsibilities arising the aforementioned legislation and regulations.

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

Role of the Audit and Risk Committee in CMS governance

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

Internal audit services: Three-year rolling Strategic Internal Audit Plan

The outsourced internal auditor compiled and presented its Three-year rolling Strategic Audit Plan for the review and approval of the committee. The committee approved plan after it was satisfied that the plan is in line with the requirements of the PFMA, Treasury Regulations and is risk-based, as required by Internal Auditing Standards.

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

External Audit Plan by the Auditor-General of South Africa

The committee reviewed and approved the External Audit Plan, as prepared and presented by the Auditor-General of South Africa, in terms of the Public Audit Act, for the year ended 31 March 2016. The committee confirms that this plan is in line with regulations and standards, and that it takes into consideration the CMS risk register for the year under review. The committee believes that the plan and audit fee presented was sufficient and reasonable for completion of the CMS annual audit.

Risk management and internal controls

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

The committee is satisfied that areas of improvement within the CMS risk management and internal control practices have been adequately identified and entity-wide risk management within the CMS has now been fully implemented.

Based on internal audits that were performed during the 2015/16 financial period, the overall control environment of the related processes, subject to internal audit, was found to be adequate and partially effective. Management has noted the identified control weaknesses and is in the process of addressing them.

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

The Council is currently enhancing the foundation of the control environment by embarking on a process to formally document controls through the introduction of process flows and improving narrative descriptions of relevant processes.

Review of legal cases pending at financial year-end

The committee reviewed progress reports on legal cases against the CMS as the regulator on a quarterly basis and those pending at the financial year-end so as to assess the adequacy of its disclosure in the Annual Financial Statements, as required in terms of the South African Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. No cases warrant any further mention in this report.

Evaluation of the Audit and Risk Committee

The committee is required to have its adequacy and effectiveness evaluated annually. During the year under review, management carried out a self-evaluation of the committee.

Evaluation of the Financial Statements

The committee reviewed the Annual Financial Statements of the CMS for the financial year ended 31 March 2016 and is satisfied that, in all material respects, the Financial Statements comply with the relevant provisions of the PFMA and GRAP, and fairly present the financial position of the CMS at that date, and the results of operations and cash flows for the financial year then ended.

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

The committee recommended the Financial Statements and performance information report for the year ended 31 March 2016 to Council for approval.

Our commitment

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

Mr Rowan Nicholls
Chairperson on behalf of the CMS Audit and Risk Committee

29 July 2016

PART D:
HUMAN RESOURCES MANAGEMENT

HUMAN RESOURCES MANAGEMENT

The Human Resources (HR) unit provides human resources leadership on all matters related to the employer-employee relationship so as to support and manage the organisation's people and associated processes. The unit also provides strategic direction and advice related to human resources policies and practices while ensuring that these are compliant with the applicable employment legislation and code of good practice.

Policy review

The unit met most of its performance targets as set out in the Annual Performance Plan (APP). In line with the APP, the unit has successfully benchmarked and implemented the approved compassionate leave, family responsibility leave, maternity leave, performance incentive policy, and the health and safety policy.

In the period under review, the HR function facilitated a comprehensive review of the HR policy manual, effecting HR policies that are compliant and aligned with labour legislation, and based on best practice in line with the CMS's philosophy to promote the organisation as an employer of choice. The unit is in the process of incorporating amendments into the HR policy manual. Consultations with all stakeholders will resume in May 2016.

Improved HR and recruitment processes

The unit acquired an integrated and streamlined human resources information solution with an improved management of the employee life cycle. The system integrates payroll, employee self-service, personnel and performance management, employment equity and skills development.

To improve the efficiency of the recruitment process, the unit also acquired and implemented a web-based recruitment system. Through this system, all applications are made on a portal and the entire recruitment process – starting with the advertisement and invitation to apply, and ending with the successful appointment of an applicant – is processed electronically. Added to this, the unit has further enhanced verification checks by acquiring a comprehensive reference checking system.

Improved employee and labour relations

The Human Resources unit has been working with the National Education, Health and Allied Workers Union (Nehawu) to conclude an Organisational Rights Agreement.

An intervention during 2015 addressed staff concerns impacting on morale and productivity. The outcome of the process is currently the subject of a dispute lodged by Nehawu.

During the course of 2015 and 2016, the unit represented CMS in two cases referred to the CCMA, including a dispute lodged by Nehawu over the payment of performance bonuses. The CCMA ruled that the employer had not acted unfairly and the application was dismissed.

Talent management and staff retention

Attracting and retaining talent remains a key priority for the CMS. The aim of the CMS talent acquisition strategy is to identify and hire the best talent available. During the period under review, the HR unit managed the recruitment of employees including the selection, testing and interviewing of potential employees, as well as the orientation, and performance evaluation of successfully appointed employees.

The selection process adopted is geared to ensuring that the best and most appropriately qualified personnel were appointed. Their performance is then monitored during the probation period to ensure that they meet their performance targets.

Appointments

The following seven appointments were made:

- Senior Financial Analyst;
- Accreditation Analyst: MCO;
- Health Economist;
- Clinical Analyst;
- Administrator;
- Medical Advisor; and
- Senior Developer.

Recruitment of suitable incumbents for the positions of Senior Strategist, Senior Manager, and Health Economist has been challenging. Most of the applications received were either not meeting the minimum requirements of the job or were above the remuneration package that the CMS offers for the positions.

Orientation and induction

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

Probation

Four new employees completed the mandatory probation period of six months and were confirmed as permanent employees of the CMS.

Resignations and terminations

The following nine resignations and terminations were received in the reporting period:

- Chief Executive & Registrar;
- Health Economist (2);
- Communications Manager;
- Senior Manager: Risk and Performance Management;
- Senior Legal Adjudication Officer;
- Senior Manager: Clinical;
- Accreditation Analyst: MCO; and
- Administrator.

Performance management

Performance management continued to be a high-priority area. At the beginning of the financial year under review, the HR unit facilitated the drafting and conclusion of performance agreements of all CMS employees, ensuring that the contracts correctly reflected the requirements of the CMS and captured accomplishment-based performance standards, outcomes and measures.

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

Training and development

The CMS takes pride in providing and supporting a learning culture for all its employees. During the period under review, staff participated in various training programmes identified in their personal development plans or professional development programmes. New employees were provided career development opportunities through the professional development programme.

The HR unit completed a workplace skills plan and annual training report and submitted it to the Health and Welfare Sector Education and Training Authority.

As a result of the training, a number of employees achieved academic success by completing Certificate, Diploma, Degree, Higher Degree and Master's Degree programmes. Two employees are currently undertaking PhD studies.

Due to a number of resignations as well as work commitments, 70% of targeted employee training as contained in the Workplace Skills Plan was not achieved.

Social responsibility

The organisation continued to support the less fortunate and the needy through various social and welfare causes.

The highlights include:

- Providing 60 blankets purchased by employees and donated to the homeless outside the St Michaels Church and All Angels Anglican Church in Sunnyside as part of the Nelson Mandela 67 Minutes on 17 July 2015;
- Donating tea, coffee, milk and peanut butter to St Michael Church and All Angels Anglican Church to feed the homeless; and
- Hosting 10 girls from the Olivenhoutbosch Secondary School for the annual *Cell C Take a Girl Child to Work* campaign and the *Tracker Men-in-the-Making* initiative. Both initiatives are aimed at motivating learners to achieve their dreams.

Employment Equity (EE)

When aligning employment equity goals with the new BBBEE targets, the CMS employs 100 employees, comprising:

Formula: A= B/C X D

Criteria		A	B	C	D	%
Black people with disabilities employed by the entity as a percentage of all full time employees	1	100	1.00%	4%	2	0.500
Black people employed by the entity at Senior Management level as a percentage of employees at Senior Management level	6	10	60.00%	60%	2	2.00
Black women employed by the entity at Senior Management level as a percentage of employees at Senior Management level	3	10	30.00%	30%	2	2.00
Black people employed by the entity at Professionally qualified as a percentage of employees at Professionally qualified level	33	35	94.29%	75%	2	2.51
Black women employed by the entity at Professionally qualified as a percentage of employees at Professionally qualified level	16	35	45.71%	40%	1	1.14
Black people employed by the entity at Skilled Technical & Academically qualified workers as a percentage of employees at Skilled Technical & Academically qualified level	51	52	98.08%	80%	1	1.23
Weighting points					**10**	**9.38**
Employment Equity Target Percentage						**93.83**

The CMS submitted an Employment Equity report for the year under review to the Department of Labour.

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

Employee wellness

Mainlining employee wellness is an important part of the HR function. The CMS has an outsourced employee wellness programme that provides staff members with access to guidance on work-life balance.

In addition, HR provided the following employee wellness initiatives aimed at assisting employees to manage a healthy and productive lifestyle:

- Wellness days where employees participated in a diverse range of health promotion activities;
- Subsidised health club membership;
- Screening for HCT, cancer, diabetes, blood glucose and cholesterol; counselling and testing for HIV/Aids; as well as Body Mass Index measurement; and
- On-site administration of flu vaccinations to staff and management.

HR OVERSIGHT STATISTICS

TABLE 27: PERSONNEL COSTS BY PROGRAMME/UNIT (2015/16)

Programme	Total expenditure of unit R'000	Personnel expenditure R'000	Personnel expenditure as % of total expenditure	Number of employees	Average personnel cost per employee R'000
Accreditation	7 693	7 120	92.56%	10	712.02
Benefits Management	5 125	5 069	98.92%	7	724.07
CEO & Registrar's Office	5 420	2 068	38.15%	3	690.79
Compliance & Investigations	6 505	6 067	90.48%	7	866.76
Complaints Adjudication	5 228	5 179	99.08%	8	648.46
Financial Supervision	10 278	10 033	97.63%	11	912.08
Human Resources	6 142	3 835	62.47%	5	767.05
Internal Finance	31 860	7 833	24.78%	9	870.62
ICT & KM	13 403	7 699	57.44%	11	700.53
Legal Services	11 157	3 529	31.62%	4	882.16
Research & Monitoring	6 793	6 610	97.28%	8	826.27
Stakeholder Relations	9 009	6 729	74.70%	11	610.69
Strategy Office & Clinical unit	4 611	4 321	93.73%	6	719.82
Total	**123 224**	**76 101**	**61.87%**	**100**	**761.01**

TABLE 28: PERSONNEL COSTS BY SALARY BAND (2015/16)

Level	Personnel expenditure R'000	Personnel expenditure as % of total expenditure	Number of employees at year end	Average personnel cost per employee R'000
Top management	491	0.64%	0	0
Senior management	16 282	21.39%	10	1 628
Professionals	30 277	39.79%	34	891
Skilled labour	27 999	36.79%	52	538
Semi-skilled labour	1 052	1.38%	4	263
Unskilled labour	0	0.00%	0	0
Total	**76 101**	**100.00%**	**100**	**761**

Note: The Registrar's employment ceased on 30 June 2015, before year end, thus zero occupancy in top management.

TABLE 29: PERFORMANCE REWARDS BY SALARY BAND (2015/16)

Level	Performance rewards R'000	Personnel expenditure R'000	% of performance rewards to total personnel cost	% of performance rewards to total personnel expenditure per occupational level
Top management	0	491	0.00%	0.00%
Senior management	1 032	16 282	1.36%	6.34%
Professionals	1 837	30 277	2.41%	6.07%
Skilled labour	1 578	27 999	2.07%	5.64%
Semi-skilled labour	52	1 052	0.07%	4.99%
Unskilled labour	0	0	0.00%	0.00%
Total	**4 500**	**76 101**	**5.91%**	**23.03%**

Note: 5.91% is the percentage of performance rewards to total personnel cost, whereas 23.03% is the percentage of total rewards to personnel expenditure per occupational level.

TABLE 30: TRAINING COST BY PROGRAMME (2015/16)

Programme	Personnel expenditure R'000	Training expenditure R'000	Training expenditure as % of personnel cost	Number of employees	Average training cost per employee R'000
Accreditation	7 120	23	0.32%	10	2.29
Benefits Management	5 069	19	0.37%	7	2.66
CEO & Registrar's Office	2 068	54	2.61%	3	18.10
Compliance & Investigations	6 067	60	0.99%	7	8.61
Complaints Adjudication	5 779	36	0.70%	8	4.48
Financial Supervision	10 033	151	1.51%	11	13.75
Internal Finance	3 835	80	2.09%	9	8.90
Human Resources	7 833	234	2.99%	5	46.72
ICT & KM	7 699	41	0.53%	11	3.72
Legal Services	3 529	66	1.88%	4	16.62
Research & Monitoring	6 610	122	1.84%	8	15.22
Stakeholder Relations	6 729	88	1.31%	11	7.96
Strategy Office & Clinical unit	4 321	39	0.90%	6	6.56
Total	**76 101**	**1 013**	**1.33%**	**100**	**10.13**

TABLE 31: EMPLOYMENT AND VACANCIES BY PROGRAMME/UNIT (2015/16)

Programme	Number of employees 2014/15	Approved posts 2015/16	Number of employees 2015/16	Vacancies 2015/16	% of vacancies
Accreditation	10	0	10	1	11.11%
Benefits Management	7	0	7	0	0.00%
CEO & Registrar's Office	3	0	3	1	11.11%
Compliance & Investigations	7	0	7	0	0.00%
Complaints Adjudication	10	0	8	2	22.22%
Financial Supervision	11	0	11	1	11.11%
Human Resources	5	0	5	0	0.00%
Internal Finance	10	0	9	0	0.00%
ICT & KM	11	1	11	0	0.00%
Legal Services	4	0	4	0	0.00%
Research & Monitoring	8	0	8	0	0.00%
Stakeholder Relations	11	0	11	0	0.00%
Strategy Office & Clinical unit	5	2	6	4	44.44%
Total	**102**	**3**	**100**	**9**	**100.00%**

TABLE 32: EMPLOYMENT AND VACANCIES BY SALARY LEVEL (2015/16)

Level	Number of employees 2014/15	Approved posts 2015/16	Number of employees 2015/16	Vacancies 2015/16	% of vacancies
Top management	1	0	0	1	11.11%
Senior management	10	0	10	1	11.11%
Professionals	36	3	34	5	55.56%
Skilled labour	51	0	52	2	22.22%
Semi-skilled labour	4	0	4	0	0.00%
Unskilled labour	0	0	0	0	0.00%
Total	**102**	**3**	**100**	**9**	**100.00%**

Council approved the following new positions in 2015/16 Medical Advisor, Senior Developer & Clinical Analyst. Vacancies were due to resignations and internal movement.

TABLE 33: EMPLOYMENT CHANGES BY SALARY BAND (2015/16)

Level	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	1	0	1	0
Senior management	10	0	0	10
Professionals	36	3	3	34
Skilled labour	51	2	2	52
Semi-skilled labour	4	1	1	4
Unskilled labour	0	0	0	0
Total	**102**	**6**	**7**	**100**

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

TABLE 34: REASONS FOR STAFF LEAVING (2015/16)

Reason	Number of employees	% of total number of staff leaving
Death	0	0%
Resignation	6	86%
Dismissal	0	0%
Retirement	0	0%
Ill health	0	0%
Expiry of contract	1	14%
Other	0	0%
Total	**7**	**100%**

TABLE 35: LABOUR RELATIONS – MISCONDUCT AND DISCIPLINARY ACTION (2015/16)

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

PART E:
FINANCIAL INFORMATION

COUNCIL FOR MEDICAL SCHEMES ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2016

Index

The reports and statements set out below comprise the Annual Financial Statements presented to parliament:

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY OF THE ANNUAL REPORT

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

All information and amounts disclosed in the Annual Report are consistent with the Annual Financial Statements audited by the Auditor-General.

The Annual Report is complete, accurate and free from any omissions.

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

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

The Annual Financial Statements are based on appropriate accounting policies, consistently applied and supported by reasonable and prudent judgments and estimates.

The Accounting Authority is responsible for the preparation of the Annual Financial Statements and for the judgments made in this information.

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

The Auditor-General is responsible for independently reviewing and reporting on the entity's Annual Financial Statements. The Annual Financial Statements have been examined by the Auditor-General and their report is presented on page 91.

In our opinion, the Annual Report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the entity for the financial year ended 31 March 2016.

The Annual Financial Statements set out on pages 89 to 121, which have been prepared on the going concern basis, were approved by the Council on 31 July 2016 and were signed on its behalf by:

Mr MD Lehutjo
Acting Chief Executive & Registrar

Prof. Y Veriava
Chairperson of Council

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

Report on the Financial Statements

Introduction

1. I have audited the Financial Statements of the Council for Medical Schemes, set out on pages 93 to 121, which comprise the Statement of Financial Position as at 31 March 2016, the Statement of Financial Performance, Statement of Changes in Net Assets, Cash Flow Statement and the Statement of Comparison of Budget Information with Actual Information for the year then ended, as well as the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting authority's responsibility for the Financial Statements

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

Auditor-General's responsibility

3. My responsibility is to express an opinion on these Financial Statements based on my audit. I conducted my audit in accordance with International Standards on Auditing. Those standards require that I comply with ethical requirements, and plan and perform the audit to obtain reasonable assurance about whether the Financial Statements are free from material misstatement.

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

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

Opinion

6. In my opinion, the Financial Statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2016 and its financial performance and cash flows for the year then ended, in accordance with SA standards of GRAP and the requirements of the PFMA.

Report on other legal and regulatory requirements

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

Predetermined objectives

8. I performed procedures to obtain evidence about the usefulness and reliability of the reported performance information of the following selected programmes presented in the Annual Performance Report of the public entity for the year ended 31 March 2016:

- Programme 3: Accreditation on pages 62 to 63;
- Programme 4: Research and Monitoring on pages 63 to 64;
- Programme 5: Stakeholder Relations on pages 64 to 65;

- Programme 6: Compliance and Investigation on page 66;
- Programme 7: Benefits Management unit on page 67;
- Programme 8: Legal Services on page 68;
- Programme 9: Financial Supervision unit on pages 69 to 70; and
- Programme 10: Complaints Adjudication unit on pages 70 to 71.

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

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

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

Additional matters

12. Although I identified no material findings on the usefulness and reliability of the reported performance information for the selected programmes, I draw attention to the following matters:

Achievement of planned targets

13. Refer to the Annual Performance Report on pages 53 to 71 for information on the achievement of the planned targets for the year.

Unaudited supplementary information

14. The supplementary information, set out on pages 122 to 200, does not form part of the Annual Performance Report and is presented as additional information. I have not audited these schedules and, accordingly, I do not report on them.

Compliance with legislation

15. I performed procedures to obtain evidence that the public entity had complied with applicable legislation regarding financial matters, financial management and other related matters. I did not identify any instances of material non-compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA.

Internal control

16. I considered internal control relevant to my audit of the Financial Statements, Annual Performance Report and compliance with legislation. I did not identify any significant deficiencies in internal control.

Other reports

17. I draw attention to the following engagement that could potentially impact on the public entity's financial, performance and compliance-related matters. My opinion is not modified in respect of this engagement.

Investigations

18. An external forensic investigation into allegations of corruption against the former Chief Executive Officer (CEO) was undertaken in the prior financial year. The investigation was concluded in April 2015. The report on the forensic investigation was received by Council and the recommendations are in the process of being implemented. The contract of the suspended CEO ended in June 2015 and was not renewed.

Auditor - General

Pretoria
31 July 2016

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2016

	Note(s)	2016 R'000	2015 R'000
Assets			
Current Assets			
Receivables from exchange transactions	3	7 131	6 835
Cash and cash equivalents	4	24 687	10 515
		31 818	**17 350**
Non-current Assets			
Property, plant and equipment	5	17 682	16 016
Intangible assets	6	673	1 505
		18 355	17 521
Total Assets		**50 173**	**34 871**
Liabilities			
Current Liabilities			
Payables from exchange transactions	7	13 893	13 090
Unspent conditional grants and receipts	12	2 254	-
Provisions	8	257	132
		16 404	**13 222**
Non-current Liabilities			
Operating lease liability	9	6 205	3 681
Provisions	8	928	896
		7 133	**4 577**
Total Liabilities		**23 537**	**17 799**
Net Assets		**26 636**	**17 072**
Accumulated surplus		26 636	17 072

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 31 MARCH 2016

	Note(s)	2016 R'000	2015 R'000
Revenue	11	129 952	120 095
Administrative expenses	13	(20 448)	(17 389)
Audit fees	14	(1 952)	(1 897)
Operating expenses	15	(15 862)	(17 931)
Staff costs	16	(80 689)	(77 108)
Depreciation and amortisation		(4 019)	(3 772)
Forensic investigation	17	-	(7 257)
Loss on disposal of assets	18	(254)	(25)
Operating (deficit)/surplus		**6 728**	**(5 284)**
Investment revenue	19	2 836	2 209
(Deficit)/surplus for the year		**9 564**	**(3 075)**

STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED 31 MARCH 2016

	Accumulated surplus R'000	Total net assets R'000
Balance at 1 April 2014	**20 147**	**20 147**
Changes in net assets		
Surplus for the year	(3 075)	(3 075)
Total changes	(3 075)	(3 075)
Balance at 1 April 2015	**17 072**	**17 072**
Changes in net assets		
Surplus for the year	9 564	9 564
Total changes	9 564	9 564
Balance at 31 March 2016	**26 636**	**26 636**

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2016

	Note(s)	2016 R'000	2015 R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		129 205	114 351
Grants		2 710	4 856
Interest income		2 836	2 209
		134 751	121 416
Payments			
Employee costs		(80 689)	(77 108)
Suppliers		(34 778)	(41 299)
		(115 467)	(118 407)
Net cash flows from operating activities	21	**19 284**	**3 009**
Cash flows from investing activities			
Purchase of property, plant and equipment	5	(5 135)	(6 959)
Proceeds from sale of property, plant and equipment	5	(33)	33
Purchase of intangible assets	6	(12)	(653)
Proceeds from sale of intangible assets	6	68	(1)
Net cash flows from investing activities		**(5 112)**	**(7 580)**
Net increase/(decrease) in cash and cash equivalents		**14 172**	**(4 571)**
Cash and cash equivalents at the beginning of the year		10 515	15 086
Cash and cash equivalents at the end of the year	4	24 687	10 515

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2016

Budget on Cash Basis

	Approved budget R '000	Adjustments R '000	Final budget R '000	Actual amounts on comparable basis R '000	Difference between final budget and actual R '000	Reference
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees	5 876	-	5 876	6 228	352	
Appeal fees	-	-	-	10	10	
Interest received – investment	2 926	-	2 926	2 836	(90)	
Legal fees recovered	-	-	-	1 551	1 551	1
Levies income	120 107	-	120 107	120 107	-	
Registration fees	400	-	400	370	(30)	
Sundry income	-	-	-	1 230	1 230	2
Total revenue from exchange transactions	**129 309**	**-**	**129 309**	**132 332**	**3 023**	
Revenue from non-exchange transactions						
Transfer revenue						
Government transfers – Department of Health	2 556	-	2 556	302	(2 254)	3
Mandatory transfer – Department of Higher Education and Training	-	-	-	154	154	
Total revenue from non-exchange transactions	**2 556**	**-**	**2 556**	**456**	**(2 100)**	
Total revenue	**131 865**	**-**	**131 865**	**132 788**	**923**	
Expenditure						
Personnel	(86 249)	-	(86 249)	(80 689)	5 560	4
Depreciation and amortisation	(3 772)	-	(3 772)	(4 019)	(247)	
Loss on disposal of assets	-	-	-	(254)	(254)	
General expenses	(12 950)	-	(12 950)	(11 584)	1 366	5
Legal fees	(7 970)	-	(7 970)	(7 459)	511	
Rent	(11 049)	-	(11 049)	(10 655)	394	
Council members' fees	(1 175)	-	(1 175)	(741)	434	
Consulting	(4 118)	-	(4 118)	(3 054)	1 064	
Auditors' remuneration	(2 080)	-	(2 080)	(1 952)	128	
Telecommunication expenses	(2 723)	-	(2 723)	(2 817)	(94)	
Total expenditure	**(132 086)**	**-**	**(132 086)**	**(123 224)**	**8 862**	
Surplus before taxation	**(221)**	**-**	**(221)**	**9 564**	**9 785**	
Actual amount on comparable basis as presented in the Budget and Actual Comparative Statement	**(221)**	**-**	**(221)**	**9 564**	**9 785**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2016

Budget on Cash Basis

	Approved budget R '000	Adjustments R '000	Final Budget R '000	Actual amounts on comparable basis R '000	Difference between final budget and actual R '000	Reference
Statement of Financial Position						
Assets						
Non-current Assets						
Property, plant and equipment	(6 910)	-	(6 910)	(5 185)	1 725	6
Total Assets	**(6 910)**	**-**	**(6 910)**	**(5 185)**	**1 725**	
Liabilities						
Current Liabilities						
Payables from exchange transactions	-	-	-	(2 619)	(2 619)	7
Non-current Liabilities						
Operating lease liability	-	-	-	(2 566)	(2 566)	8
Total Liabilities	-	-	-	(5 185)	(5 185)	
Net Assets	(6 910)	-	(6 910)	-	6 910	
Net Assets						
Net Assets Attributable to Owners of Controlling Entity						
Reserves						
Accumulated surplus	(6 910)	-	(6 910)	-	6 910	

Note

1. *100% over-collection on legal fees recovered was due to timing of the income being unknown. Only after receiving the Tax Master's account can income be reliably estimated.*
2. *100% over-collection on sundry income was due to penalties raised due to contravention of s66(3) and s37 by medical schemes.*
3. *88% under-utilisation on grant received is due to projects, for which it was allocated, still being in progress.*
4. *6.6% under-expenditure on personnel was due to the delay in filling of positions, as well as resignations during the year.*
5. *11% under-expenditure on general expenses was due to application of the cost containment instruction measures by National Treasury.*
6. *24% under-expenditure on capital budget was due to a delay in awarding of the tender for the Virtualisation project.*
7. *100% over-expenditure on payables from exchange transactions was due to inadequate budgeting for the line item.*
8. *100% over-expenditure on the operating lease liability was due to inadequate budgeting for the line item.*

ACCOUNTING POLICIES

FOR THE YEAR ENDED 31 MARCH 2016

1. Presentation of Annual Financial Statements

The Annual Financial Statements have been prepared in accordance with the Standards of Generally Recognised Accounting Practice (GRAP), issued by the Accounting Standards Board in accordance with Section 55 of the Public Finance Management Act (PFMA), 1999 (Act No. 1 of 1999).

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

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

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

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

1.1 Presentation currency

These Annual Financial Statements are presented in South African Rand, which is the functional currency of the entity.

1.2 Going concern assumption

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

1.3 Comparative figures

Budget information, in accordance with GRAP 1 and 24, has been provided in a separate disclosure note to these Annual Financial Statements.

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

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

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

1.4 Significant judgments and sources of estimation uncertainty

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

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

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

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

Provisions

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

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

Depreciation and amortisation

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

Effective interest rate

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

Impairment testing

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

1.5 Financial instruments

Initial recognition

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

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

Initial measurement

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

Subsequent measurement

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

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

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

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

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

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

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

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

Gains and losses

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

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

Impairment

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

FINANCIAL ASSETS MEASURED AT AMORTISED COST

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

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

FINANCIAL ASSETS MEASURED AT COST

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

Derecognition

FINANCIAL ASSETS

A financial asset is derecognised at trade date, when:

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

FINANCIAL LIABILITIES

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

1.6 Property, plant and equipment

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

The cost of an item of property, plant and equipment is recognised as an asset when:

- it is probable that future economic benefits or service potential associated with the item will flow to the entity; and
- the cost of the item can be measured reliably.

Property, plant and equipment is initially measured at cost.

The cost of an item of property, plant and equipment is the purchase price and other costs attributable to bring the asset to the location and condition necessary for it to be capable of operating in the manner intended by management. Trade discounts and rebates are deducted in arriving at the cost.

Where an asset is acquired through a non-exchange transaction, its cost is its fair value as at date of acquisition.

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

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

Costs include costs incurred initially to acquire or construct an item of property, plant and equipment and costs incurred subsequently to add to, replace part of, or service it. If a replacement cost is recognised in the carrying amount of an item of property, plant and equipment, the carrying amount of the replaced part is derecognised.

The initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located is also included in the cost of property, plant and equipment, where the entity is obligated to incur such expenditure, and where the obligation arises as a result of acquiring the asset or using it for purposes other than the production of inventories.

Recognition of costs in the carrying amount of an item of property, plant and equipment ceases when the item is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Items such as spare parts, standby equipment and servicing equipment are recognised when they meet the definition of property, plant and equipment.

Property, plant and equipment is carried at cost less accumulated depreciation and any impairment losses.

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

Property, plant and equipment is carried at revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses. Revaluations are made with sufficient regularity such that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period.

Any increase in an asset's carrying amount, as a result of a revaluation, is credited directly to a revaluation surplus. The increase is recognised in surplus or deficit to the extent that it reverses a revaluation decrease of the same asset previously recognised in surplus or deficit.

Any decrease in an asset's carrying amount, as a result of a revaluation, is recognised in surplus or deficit in the current period. The decrease is debited in revaluation surplus to the extent of any credit balance existing in the revaluation surplus in respect of that asset.

The useful lives of items of property, plant and equipment have been assessed as follows:

Item	Depreciation method	Average useful life
Furniture and fittings	Straight-line	14 years
Motor vehicles	Straight-line	5 years
Computer equipment	Straight-line	7 years
Computer software	Straight-line	7 years
Leasehold improvements – work in progress (WIP)	Straight-line	10 years
Other fixed assets	Straight-line	16 years

The residual value, and the useful life and depreciation method of each asset are reviewed at the end of each reporting date. If the expectations differ from previous estimates, the change is accounted for as a change in accounting estimate.

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

Each part of an item of property, plant and equipment with a cost that is significant in relation to the total cost of the item is depreciated separately.

The depreciation charge for each period is recognised in surplus or deficit unless it is included in the carrying amount of another asset.

Items of property, plant and equipment are derecognised when the asset is disposed of or when there are no further economic benefits or service potential expected from the use of the asset.

The gain or loss arising from the derecognition of an item of property, plant and equipment is included in surplus or deficit when the item is derecognised. The gain or loss arising from the derecognition of an item of property, plant and equipment is determined as the difference between the net disposal proceeds, if any, and the carrying amount of the item.

1.7 Intangible assets

An asset is identifiable if it either:

- is separable, i.e. is capable of being separated or divided from an entity and sold, transferred, licensed, rented or exchanged, either individually or together with a related contract, identifiable assets or liability, regardless of whether the entity intends to do so; or
- arises from binding arrangements (including rights from contracts), regardless of whether those rights are transferable or separable from the entity or from other rights and obligations.

An intangible asset is recognised when:

- it is probable that the expected future economic benefits or service potential that are attributable to the asset will flow to the entity; and
- the cost or fair value of the asset can be measured reliably.

Where an intangible asset is acquired through a non-exchange transaction, its initial cost at the date of acquisition is measured at its fair value as at that date.

Intangible assets are carried at cost less any accumulated amortisation and any impairment losses.

An intangible asset is regarded as having an indefinite useful life when, based on all relevant factors, there is no foreseeable limit to the period over which the asset is expected to generate net cash inflows or service potential. Amortisation is not provided for these intangible assets, but they are tested for impairment annually and whenever there is an indication that the asset may be impaired. For all other intangible assets amortisation is provided on a straight-line basis over their useful life.

The amortisation period and the amortisation method for intangible assets are reviewed at each reporting date.

Reassessing the useful life of an intangible asset with a finite useful life after it was classified as indefinite is an indicator that the asset may be impaired. As a result the asset is tested for impairment and the remaining carrying amount is amortised over its useful life.

Internally generated brands, mastheads, publishing titles, customer lists and items similar in substance are not recognised as intangible assets.

Internally generated goodwill is not recognised as an intangible asset.

Amortisation is provided to write down the intangible assets, on a straight-line basis, to their residual values as follows:

Item	Useful life
Developed software	7 years
Acquired software	7 years

Intangible assets are derecognised:

- on disposal; or
- when no future economic benefits or service potential are expected from its use or disposal.

The gain or loss arising from the derecognition of an intangible assets is included in surplus or deficit when the asset is derecognised (unless the Standard of GRAP on leases requires otherwise on a sale and leaseback).

1.8 Impairment of non-financial assets

Cash-generating assets are assets managed with the objective of generating a commercial return. An asset generates a commercial return when it is deployed in a manner consistent with that adopted by a profit-oriented entity.

Non-cash-generating assets are assets other than cash-generating assets.

Impairment is a loss in the future economic benefits or service potential of an asset, over and above the systematic recognition of the loss of the asset's future economic benefits or service potential through depreciation/(amortisation).

Carrying amount is the amount at which an asset is recognised in the Statement of Financial Position after deducting any accumulated depreciation and accumulated impairment losses thereon.

A cash-generating unit is the smallest identifiable group of assets held with the primary objective of generating a commercial return that generates cash inflows from continuing use that are largely independent of the cash inflows from other assets or groups of assets.

Costs of disposal are incremental costs directly attributable to the disposal of an asset, excluding finance costs and income tax expense.

Depreciation/(Amortisation) is the systematic allocation of the depreciable amount of an asset over its useful life.

Fair value less costs to sell is the amount obtainable from the sale of an asset in an arm's length transaction between knowledgeable, willing parties, less the costs of disposal.

Recoverable service amount is the higher of a non-cash-generating asset's fair value less costs to sell and its value in use.

Useful life is either:

(a) the period of time over which an asset is expected to be used by the entity; or
(b) the number of production or similar units expected to be obtained from the asset by the entity.

Identification

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

The entity assesses at each reporting date whether there is any indication that a non-cash-generating asset may be impaired. If any such indication exists, the entity estimates the recoverable service amount of the asset.

Irrespective of whether there is any indication of impairment, the entity also tests a non-cash-generating intangible asset with an indefinite useful life or a non-cash-generating intangible asset not yet available for use for impairment annually by comparing its carrying amount with its recoverable service amount. This impairment test is performed at the same time every year. If an intangible asset was initially recognised during the current reporting period, that intangible asset was tested for impairment before the end of the current reporting period.

Recognition and measurement

If the recoverable service amount of a non-cash-generating asset is less than its carrying amount, the carrying amount of the asset is reduced to its recoverable service amount. This reduction is an impairment loss.

An impairment loss is recognised immediately in surplus or deficit.

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

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

After the recognition of an impairment loss, the depreciation/(amortisation) charge for the non-cash-generating asset is adjusted in future periods to allocate the non-cash-generating asset's revised carrying amount, less its residual value (if any), on a systematic basis over its remaining useful life.

Reversal of an impairment loss

The entity assesses at each reporting date whether there is any indication that an impairment loss recognised in prior periods for a non-cash-generating asset may no longer exist or may have decreased. If any such indication exists, the entity estimates the recoverable service amount of that asset.

An impairment loss recognised in prior periods for a non-cash-generating asset is reversed if there has been a change in the estimates used to determine the asset's recoverable service amount since the last impairment loss was recognised. The carrying amount of the asset is increased to its recoverable service amount. The increase is a reversal of an impairment loss. The increased carrying amount of an asset attributable to a reversal of an impairment loss does not exceed the carrying amount that would have been determined (net of depreciation or amortisation) had no impairment loss been recognised for the asset in prior periods.

A reversal of an impairment loss for a non-cash-generating asset is recognised immediately in surplus or deficit.

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

After a reversal of an impairment loss is recognised, the depreciation/(amortisation) charge for the non-cash-generating asset is adjusted in future periods to allocate the non-cash-generating asset's revised carrying amount, less its residual value (if any), on a systematic basis over its remaining useful life.

1.9 Employee benefits

Short-term employee benefits

The cost of short-term employee benefits, (those payable within 12 months after the service is rendered, such as paid vacation leave and sick leave, bonuses, and non-monetary benefits such as medical care), are recognised in the period in which the service is rendered and are not discounted.

The expected cost of compensated absences is recognised as an expense as the employees render services that increase their entitlement or, in the case of non-accumulating absences, when the absence occurs.

The expected cost of surplus sharing and bonus payments is recognised as an expense when there is a legal or constructive obligation to make such payments as a result of past performance.

Defined contribution plans

Payments to defined contribution retirement benefit plans are charged as an expense as they fall due.

Payments made to industry-managed (or state plans) retirement benefit schemes are dealt with as defined contribution plans where the entity's obligation under the schemes is equivalent to those arising in a defined contribution retirement benefit plan.

1.10 Leases

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

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

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

Finance leases – lessee

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

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

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

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

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

Operating leases – lessee

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

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

1.11 Revenue from exchange transactions

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

Recognition

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

- The entity retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.
- The amount of revenue can be measured reliably.
- It is probable that the economic benefits or service potential associated with the transaction will flow to the entity and the costs incurred or to be incurred in respect of the transaction can be measured reliably.

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

The main sources of revenue from exchange transactions are:

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

Measurement

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

1.12 Revenue from non-exchange transactions

Non-exchange transactions are defined as transactions where the entity receives value from another entity without directly giving approximately equal value in exchange.

Revenue is the gross inflow of economic benefits or service potential during the reporting period when those inflows result in an increase in net assets, other than increases relating to contributions from owners.

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

1.13 Borrowing costs

Borrowing costs are interest and other expenses incurred by an entity in connection with the borrowing of funds.

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

1.14 Translation of foreign currencies

Foreign currency transactions

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

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

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

1.15 Unauthorised expenditure

Unauthorised expenditure is expenditure that has not been budgeted for, expenditure that is not in terms of the conditions of an allocation received from another sphere of government or organ of state and expenditure in the form of a grant that is not permitted. Unauthorised expenditure is accounted for as an expense in the Statement of Financial Performance and where recovered, it is subsequently accounted for as income in the Statement of Financial Performance.

1.16 Irregular expenditure

Irregular expenditure as defined in Section 1 of the PFMA is expenditure other than unauthorised expenditure, incurred in contravention of or not in accordance with a requirement of any applicable legislation, including:

(a) This Act.
(b) The State Tender Board Act, 1968 (Act No. 86 of 1968), or any regulations made in terms of the Act.
(c) Any provincial legislation providing for procurement procedures in that provincial government.

National Treasury Practice Note No. 4 of 2008/09 which was issued in terms of Sections 76(1) to 76(4) of the PFMA requires the following (effective from 1 April 2008):

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

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

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

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

1.17 Fruitless and wasteful expenditure

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

1.18 Post-reporting date events

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

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

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

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

1.19 Related parties

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

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

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

Further details about those transactions are disclosed in the notes to the Financial Statements.

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

1.20 Transfer of functions

Between entities under common control

RECOGNITION

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

DERECOGNITION

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

MEASUREMENT

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

Between entities that are not under common control

RECOGNITION

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

DERECOGNITION

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

MEASUREMENT

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

1.21 Budget information

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

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

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

The approved budget covers the fiscal period from 01/04/2015 to 31/03/2016.

The Annual Financial Statements and the budget are not prepared on the same basis of accounting and therefore a comparison with the budgeted amounts for the reporting period have been included in the Statement of Comparison of Budget and Actual Amounts.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2016

2. New standards and interpretations

2.1 Standards and interpretations effective and adopted in the current year

In the current year, the entity has adopted the following standards and interpretations that are effective for the current financial year and that are relevant to its operations:

2.2 Standards and Interpretations early adopted

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

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

2.3 Standards and interpretations issued, but not yet effective

The entity has not applied the following standards and interpretations, which have been published but are not yet effective.

Standard/Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 32: Service Concession Arrangements: Grantor	1 April 2016	The impact of the amendment is not material.
GRAP 108: Statutory Receivables	1 April 2016	The impact of the amendment is not material.
GRAP 109: Accounting by Principals and Agents	1 April 2017	The impact of the amendment is not material.

The aggregate impact of the initial application of the statements and interpretations on the entity's Annual Financial Statements is expected to be as follows:

	2016 R'000	2015 R'000
3. Receivables from exchange transactions		
Accounts receivable	157	99
Sundry debtors	4 359	4 351
Prepaid expenses	2 615	2 385
	7 131	**6 835**
4. Cash and cash equivalents		
Cash and cash equivalents consist of:		
Cash on hand	7	3
Bank balances	1 274	2 744
Corporation for Public Deposits account	23 406	7 768
	24 687	**10 515**

5. Property, plant and equipment

	2016			2015		
	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000
Computer equipment	9 779	(5 492)	4 287	8 226	(4 956)	3 270
Computer software	1 697	(1 457)	240	2 262	(1 750)	512
Furniture and fittings	6 106	(2 400)	3 706	5 101	(2 093)	3 008
Leasehold improvements WIP	11 980	(2 798)	9 182	10 492	(1 609)	8 883
Motor vehicles	249	(191)	58	222	(142)	80
Other fixed assets	581	(372)	209	604	(341)	263
Total	**30 392**	**(12 710)**	**17 682**	**26 907**	**(10 891)**	**16 016**

Reconciliation of property, plant and equipment – 2016

	Opening balance R'000	Additions R'000	Disposals R'000	Other changes, movements R'000	Depreciation R'000	Total R'000
Computer equipment	3 270	2 282	(43)	-	(1 222)	4 287
Computer software	512	-	(17)	-	(255)	240
Furniture and fittings	3 008	1 324	(145)	-	(481)	3 706
Leasehold improvements	8 883	1 488	-	-	(1 189)	9 182
Motor vehicles	80	27	-	-	(49)	58
Other fixed assets	263	14	(16)	-	(52)	209
	16 016	**5 135**	**(221)**	**-**	**(3 248)**	**17 682**

The gross carrying amount of fully depreciated property, plant and equipment still in use amounts to R4 076 771.

Reconciliation of property, plant and equipment – 2015

	Opening balance R'000	Additions R'000	Disposals R'000	Depreciation R'000	Total R'000
Computer equipment	2 468	1 927	(27)	(1 098)	3 270
Computer software	317	576	(1)	(380)	512
Furniture and fittings	2 411	1 003	(5)	(401)	3 008
Leasehold improvements WIP	6 487	3 420	-	(1 024)	8 883
Motor vehicles	125	-	-	(45)	80
Other fixed assets	289	33	-	(59)	263
	12 097	**6 959**	**(33)**	**(3 007)**	**16 016**

6. Intangible Assets

	2016			2015		
	Cost/ Valuation R'000	Accumulated amortisation and accumulated impairment R'000	Carrying value R'000	Cost/ Valuation R'000	Accumulated amortisation and accumulated impairment R'000	Carrying value R'000
Acquired software	1 703	(1 111)	592	3 085	(1 936)	1 149
Developed software	1 145	(1 064)	81	1 477	(1 121)	356
Total	**2 848**	**(2 175)**	**673**	**4 562**	**(3 057)**	**1 505**

Reconciliation of intangible assets – 2016

	Opening balance R'000	Additions R'000	Disposals R'000	Amortisation R'000	Total R'000
Acquired software	1 149	12	(64)	(505)	592
Developed software	356	-	(4)	(271)	81
	1 505	**12**	**(68)**	**(776)**	**673**

The gross carrying amount of fully amortised intangible assets still in use amounts to R366 751.

Reconciliation of intangible assets – 2015

	Opening balance R'000	Additions R'000	Disposals R'000	Amortisation R'000	Total R'000
Acquired software	995	653	(24)	(475)	1 149
Developed software	645	-	-	(289)	356
	1 640	**653**	**(24)**	**(764)**	**1 505**

	2016 R'000	2015 R'000
7. Payables from exchange transactions		
Accounts payable	5 697	5 372
Accruals	5 786	5 309
Accrual for leave pay	1 753	1 647
Income received in advanced	657	762
	13 893	**13 090**

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

8. Provisions

Reconciliation of provisions – 2016

	Opening balance R'000	Additions R'000	Utilised during the year R'000	Total R'000
Provision for long service award	1 028	308	(151)	1 185

Reconciliation of provisions – 2015

	Opening balance R'000	Additions R'000	Utilised during the year R'000	Reversed during the year R'000	Total R'000
Provision for long service award	1 036	234	(242)	-	1 028
Provision for performance bonus	120	-	-	(120)	-
	1 156	**234**	**(242)**	**(120)**	**1 028**

	2016 R'000	2015 R'000
Non-current liabilities	928	896
Current liabilities	257	132
	1 185	**1 028**

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

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

	2016 R'000	2015 R'000

9. Operating lease liability

Non-current liabilities	(6 205)	(3 681)
Current liabilities	-	-
	(6 205)	**(3 681)**

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

	At amortised cost R'000	Total R'000
10. Financial instruments disclosure		
2016		
Financial assets		
Trade and other receivables from exchange transactions	4 516	4 516
Cash and cash equivalents	24 687	24 687
	29 203	**29 203**
Financial liabilities		
Trade and other payables from exchange transactions	13 893	13 893
2015		
Financial assets		
Trade and other receivables from exchange transactions	4 451	4 451
Cash and cash equivalents	10 515	10 515
	14 966	**14 966**
Financial liabilities		
Trade and other payables from exchange transactions	13 091	13 091

	2016 R'000	2015 R'000
11. Revenue		
Accreditation fees	6 228	5 612
Appeal fees	10	26
Government transfers: Department of Health	302	4 751
Legal fees recovered	1 551	1 153
Levies income	120 107	107 841
Mandatory transfer: Department of Higher Education and Training	154	105
Registration fees	370	336
Sundry income	1 230	271
	129 952	**120 095**
The amount included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	6 228	5 612
Appeal fees	10	26
Legal fees recovered	1 551	1 153
Levies income	120 107	107 841
Registration fees	370	336
Sundry income	1 230	271
	129 496	**115 239**
The amount included in revenue arising from non-exchange transactions is as follows:		
Taxation revenue		
Transfer revenue		
Government transfers: Department of Health	302	4 751
Mandatory transfer: Department of Higher Education and Training	154	105
	456	**4 856**

	Note(s)	2016 R'000	2015 R'000
12. Conditional grant received			
Grant received from Department of Health			
Grant received		2 556	-
Utilised		(302)	-
		2 254	**-**

The CMS received a grant to the amount of R2 556 000 in the year under review with a condition to complete:

a) Development and maintenance of a Medicines Pricing Registry; and
b) Development and maintenance of beneficiary registry for medical schemes members.

13. Administrative expenses			
Bank charges		55	46
Building expenses		2 382	1 977
General administrative expenses		840	845
Insurance		333	295
Printing and stationery		311	332
Refreshments		48	77
Rent		10 655	9 294
Rent-operating expense		1 687	1 393
Rental – Copiers		194	248
Security		864	301
Subscriptions		261	122
Telecommunication expenses		2 818	2 459
		20 448	**17 389**
14. Auditors' remuneration			
External audit		969	803
Internal audit		983	1 094
		1 952	**1 897**
15. Operating expenses			
Committee remuneration		54	59
Consulting		3 054	4 220
Council members' fees	23	741	1 430
Courier and postage		66	99
Exhibition costs		56	87
Knowledge management		544	508
Legal fees		7 459	7 699
Media and promotion		843	336
Printing and publication		571	820
Transcription services		48	70
Travel and subsistence		1 714	1 843
Venue and catering		712	760
		15 862	**17 931**

	2016 R'000	2015 R'000
16. Staff costs		
Employee benefits	1 794	1 683
Employee wellness	319	472
Recruitment and relocation	786	821
Salaries	76 101	72 056
Staff training	1 013	1 484
Temporary staff	207	160
SEP system expense	302	288
Workmen's compensation	167	144
	80 689	**77 108**
Total number of employees	100	102
17. Forensic investigation		
Forensic investigation	-	7 257
In response to serious allegations levelled against the Registrar of the CMS by the former provisional curator of Medshield, an independent forensic investigation into these allegations was instituted by Council and the Registrar was suspended. However, the contract of the Registrar was terminated on 30 June 2015.		
18. Loss on disposal of assets		
Loss on disposal of assets	254	25
CMS disposed of some assets which where no longer in use during the year and incurred a loss.		
19. Investment revenue		
Interest earned on investment	2 836	2 209
The entity earns interest from the current account as well as the CPD account.		
20. Taxation		
No provision for taxation is made because the CMS is exempt from income tax in terms of Section 10(1)(cA) of the Income Tax Act, 1962 (Act No. 58 of 1962).		
21. Cash generated from operations		
(Deficit)/Surplus	9 564	(3 075)
Adjustments for:		
Depreciation and amortisation	4 019	3 772
(Gain)/Loss on sale of assets and liabilities	254	25
Movements in operating lease assets and accruals	2 524	2 574
Movements in provisions	157	(128)
Changes in working capital:		
Receivables from exchange transactions	(291)	(1 209)
Payables from exchange transactions	803	1 050
Unspent conditional grants and receipts	2 254	-
	19 284	**3 009**

	2016 R'000	2015 R'000

22. Commitments

Operating leases – as lessee (expense)

22.1 Photocopier rental

Minimum lease payments due		
- within one year	399	120
- in second to fifth year inclusive	764	-
	1 163	**120**

The CMS entered into an operating lease agreement which commenced on 1 March 2016 for the rental of photocopiers up to 28 February 2019, with 0.0% escalation. The existing operating lease was settled in the current financial year.

22.2 Office rental

Minimum lease payments due		
- within one year	9 599	7 631
- in second to fifth year inclusive	47 278	37 588
- later than five years	32 748	39 716
	89 625	**84 935**

The CMS entered into a renewable ten year lease agreement which commenced on 1 June 2013 and will terminate on 31 May 2023 and which provides for an escalation of 8.5% per annum. In conjunction with the first lease a second lease was entered into to start in June 2014 for additional space in the existing building with the same terms as the first lease agreement. In conjunction with the first lease, a third lease was entered into to start in October 2015 for additional space in the existing building with the same terms as the first lease agreement. The CMS also contracted to have the option to purchase the office building.

23. Related parties

Relationships

Executive authority:	The Executive Authority as defined in Section 1 of the PFMA, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.
Accounting Authority:	Council, as defined in Section 49 of the PFMA, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.
Executive management:	Council members appoint the executive management team which is responsible for executing their decisions.

23. Related parties (continued)

Related party transactions

	2016 R'000	2015 R'000
Transfer paid to/(received from) related parties		
Department of Health	(2 556)	(4 751)
Mr T Bailey	-	235
Prof. BC Dumisa	96	259
Mr AK Hoosain	-	118
Adv. H Kooverjie	78	39
Dr MS Mabela	88	32
Ms M Maboye	25	27
Ms MO Morata	-	53
Dr L Mpuntsha	131	101
Ms L Nevhutalu	28	55
Prof. S Perumal	108	47
Mr T Phadu	-	11
Ms A Theophanides	-	33
Prof. CJ van Gelderen	-	113
Mr J van der Walt	77	35
Prof. Y Veriava	110	159
Adv. CJ Weapond	-	74
Mr TF Zulu	-	39
	741	**1 430**

Compensation to executive management – 2016

	Basic salary R'000	Performance bonus R'000	Acting allowance R'000	Total R'000
Chief Executive and Registrar (until 30 June 2015)	520	-	-	520
Chief Financial Officer/Acting Registrar (April 2015–March 2016)	1 494	119	585	2 198
Chief Information Officer	1 480	96	-	1 576
General Manager: Accreditation	1 439	94	-	1 533
General Manager: Benefits Management	1 368	89	-	1 457
General Manager: Compliance and Investigation	1 494	108	-	1 602
General Manager: Financial Supervision	1 494	108	-	1 602
General Manager: Human Resources	1 494	119	-	1 613
General Manager: Legal services	1 494	108	-	1 602
General Manager: Research & Monitoring	1 363	100	-	1 463
General Manager: Stakeholder Relations	1 321	97	-	1 418
Senior Manager: Complaints Adjudication	1 123	81	-	1 204
	16 084	**1 119**	**585**	**17 788**

23. Related parties (continued)

Compensation to executive management – 2015

	Basic salary R'000	Performance bonus R'000	Acting allowance R'000	Total R'000
Chief Executive and Registrar (until 31 March 2014)	1 901	-	-	1 901
Chief Financial Officer/Acting Registrar (April 2014–March 2015)	1 417	106	565	2 088
Chief Information Officer	1 430	86	-	1 516
General Manager: Accreditation	1 331	77	-	1 408
General Manager: Benefits Management	1 311	78	-	1 389
General Manager: Compliance and Investigation	1 399	106	-	1 505
General Manager: Financial Supervision	1 393	106	-	1 499
General Manager: Human Resources	1 387	86	-	1 473
General Manager: Legal Services	1 458	106	-	1 564
General Manager: Research & Monitoring	1 162	87	-	1 249
General Manager: Stakeholder Relations	1 233	92	-	1 325
Senior Strategist – resigned 31/10/2014	855	-	-	855
Senior Manager: Complaints Adjudication	1 066	65	-	1 131
	17 343	**995**	**565**	**18 903**

Compensation to executive management includes gross remuneration as well as all company contribution.

24. Contingencies

Contingent liabilities

On 17 August 2015, the CMS lost a petition to appeal in the case of Genesis v CMS section 48/49 in SCA and the CMS was also unsuccessful in petitioning the Constitutional Court on this matter. The CMS is liable for the costs of the application for condonation. The estimated financial effect is to be determined by the decision of the Taxation Master which has not yet occurred.

Contingent assets

The CMS won court cases against the following parties:

- Genesis vs CMS and Du Toit
- Genesis vs CMS and Joubert
- Hosmed (Upliftment of Curatorship)
- Government Employees Medical Fund
- Bestmend
- SAMA
- Medshield

The CMS, as the successful party in these cases, was awarded costs on the party and party scale. The bills of costs relating to these matters have, to date, not been approved by the Taxation Master of the Court. For these reasons uncertainties exist relating to the amount and timing of the legal fees recovered.

25. Risk management

Financial risk management

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

Liquidity risk

The entity's risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. The entity manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the Corporation for Public Deposits account of R23 406 312 as at 31 March 2016.

Credit risk

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

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

Market risk

Interest rate risk

The entity invests surplus funds in the Corporation for Public Deposits account. The interest rates on this account fluctuate in line with movements in money market rates. The impact on investment revenue of a percentage shift would be a maximum increase of R26 390 or decrease of R26 390 respectively.

		2016 R'000	2015 R'000
26. Irregular expenditure			
Opening balance		8 436	6 516
Current year		983	8 436
Less: Amounts not recoverable (not condoned)		-	(6 516)
		9 419	**8 436**
Analysis of expenditure awaiting condonation per age classification			
Current year		983	8 436
Details of irregular expenditure			
Incident	**Disciplinary steps taken/ criminal proceedings**		
Bid awarded without following correct procedures	Application for condonation to be made to National Treasury	983	1 094
Bid awarded without following correct procedures	Not recoverable (not condoned)/ written off by Council	-	32
Non-compliance to cost containment measures	Under investigation	-	3
Deviations incorrectly approved	Under investigation	-	7 056
Request for quotation incomplete	Under investigation	-	251
		983	**8 436**

There was no irregular expenditure identified during the year under review other than the following: In the prior financial year, non-compliance with the Preferential Procurement Policy Framework Act (PPPFA), 2000 (Act No. 5 of 2000) was identified for not awarding the contract to the tenderer who scored the highest points.

The expenditure in each subsequent financial year will also be classified as irregular expenditure.

In the prior financial year the CMS incurred irregular expenditure for staff training and temporary staffing without following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/08.

In the prior year two transactions relating to staff training to the value of R31 863 were identified.

In the prior year, non-compliance to National Treasury Instruction 01 of 2013/14 regarding Cost Containment Measures, relating to catering and events was identified and has been classified as irregular expenditure.

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

Also in the prior year, non-compliance with the PPPFA was identified for not indicating the weighting of the criterion used to evaluate functionality on a request for quotation.

	2016 R'000	2015 R'000
Details of irregular expenditure not recoverable (not condoned)		
Incident		
Approval to deviate from SCM processes not obtained	-	636
Bid awarded without following correct procedures	-	795
Deviations incorrectly approved	-	3 759
Quotations accepted based on lowest price instead of on points scored	-	503
Three quotes not obtained	-	822
	-	**6 515**

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

27. Reconciliation between Budget and Statement of Financial Performance

Reconciliation of budget surplus/deficit with the surplus/deficit in the Statement of Financial Performance:		
Net surplus/(deficit) per the Statement of Financial Performance	9 564	(3 075)
Adjusted for:		
Gain on the sale of assets	254	25
(Over)/under collection of revenue	(923)	(569)
Over/(under) budget expenditure	(9 116)	(702)
Net deficit per approved budget	**(221)**	**(4 321)**

28. Budget differences

Differences between budget and actual amounts basis of preparation and presentation

The budget and the accounting bases differ. The Annual Financial Statements are prepared on the accrual basis using a classification based on the nature of expenses in the Statement of Financial Performance. The Annual Financial Statements differ from the budget, which is approved on the cash basis.

PART F:
THE MEDICAL SCHEMES INDUSTRY IN 2015

Introduction

The CMS is in the second year of using the new Dynamic Database Driven Annual Returns System to collect the Healthcare Utilisation Returns. The aim of the new system is to ensure that healthcare utilisation measures in the Healthcare Utilisation Annual Statutory Returns (ASR) are adequately defined and not open to varying interpretations by medical schemes. In order to accommodate all administration systems, the guidelines and specification documents are deliberately targeted at the 'lowest common denominator'. The standards in the specification documents will be gradually raised to allow for the collection of healthcare indicators that are currently not available from all medical schemes. The updated guidelines and specification documents are not meant to change the definitions of healthcare utilisation indicators, but to strengthen these definitions and improve consistency. The CMS will continue to work on improving the system and will consult schemes and administrators in this process. Furthermore, the CMS will engage with medical schemes that submitted poor quality ASR data.

Gross benefits paid (benefits paid from risk pool plus savings) reported in the utilisation section of this report (pages 123 to 155 and Annexures C to K) differ slightly from gross benefits reported in the financial statutory returns section. This is a result of definitional issues and the application of accounting principles. In 2015, the financial statutory returns re-defined and standardised the various accredited managed care services. The financial statutory return was amended to reflect the standardised classification and naming conventions (also refer to CMS Circular 56 of 2015). These amendments were applied to financial years 2014 as well as 2015 data, and led to a higher upward revision of the total benefits paid amount reported in 2014.

Note that all figures reported in the utilisation section of this report (pages 123 to 155 and Annexures C to K) for the financial year 2014 have been revised and as a result may differ from the amounts reported in the previous year's Annual Report.

Demographic information

Number of schemes and benefit options

There was no change to the number of medical schemes registered in South Africa between 2014 and 2015. At the end of 2015, there were 83 medical schemes, consisting of 23 open schemes and 60 restricted schemes. The decline in the number of schemes from 2005 to 2015 is illustrated in Figure 1. There were slight changes in the number of schemes by size category. Medihelp Medical Scheme beneficiaries fell below the cut-off of 220 000 beneficiaries for the 'Very Large' category at the end of December 2015.

FIGURE 1: NUMBER OF SCHEMES 2005–2015

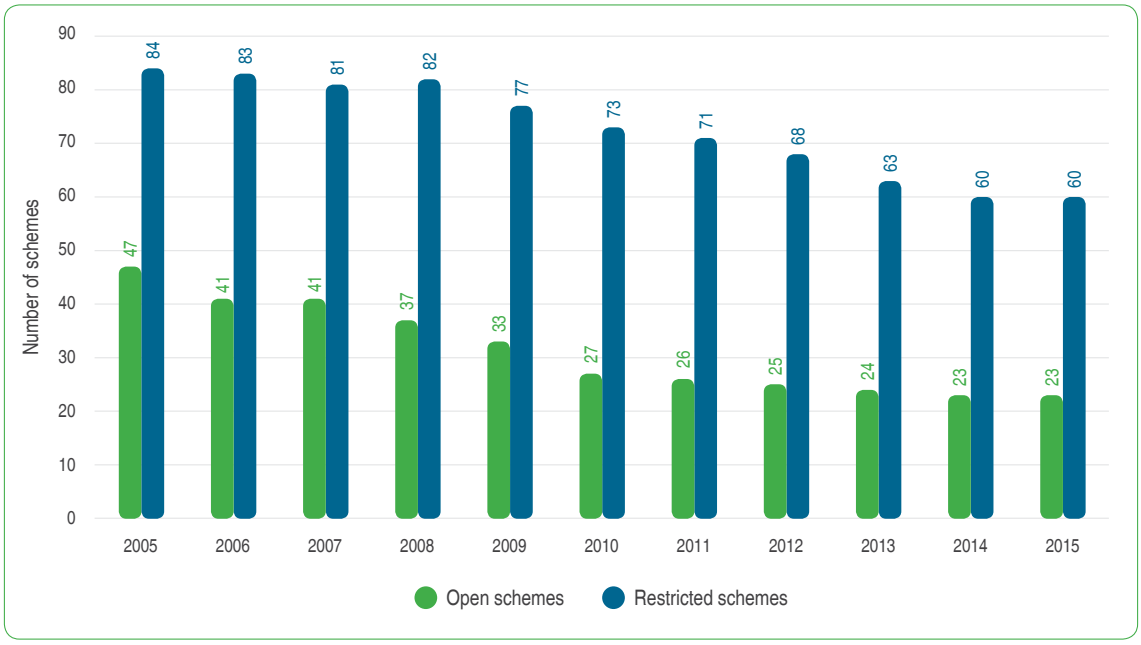


TABLE 1: NUMBER OF SCHEMES BY SIZE AND TYPE AS AT 31 DECEMBER 2014 AND 2015

Type of scheme	Size	2014	2015
Open schemes	Very Large	4	3
	Large	7	8
	Medium	6	7
	Small	6	5
Restricted schemes	Very Large	2	2
	Large	7	6
	Medium	21	23
	Small	30	29
All schemes	**Very Large**	**6**	**5**
	Large	**14**	**14**
	Medium	**27**	**30**
	Small	**36**	**34**
	Total	**83**	**83**

Very large = > 220 000 beneficiaries
Large = > 65 000 beneficiaries, but < 220 000 beneficiaries
Medium = > 15 000 beneficiaries but < 65 000 beneficiaries
Small = < 15 000 beneficiaries

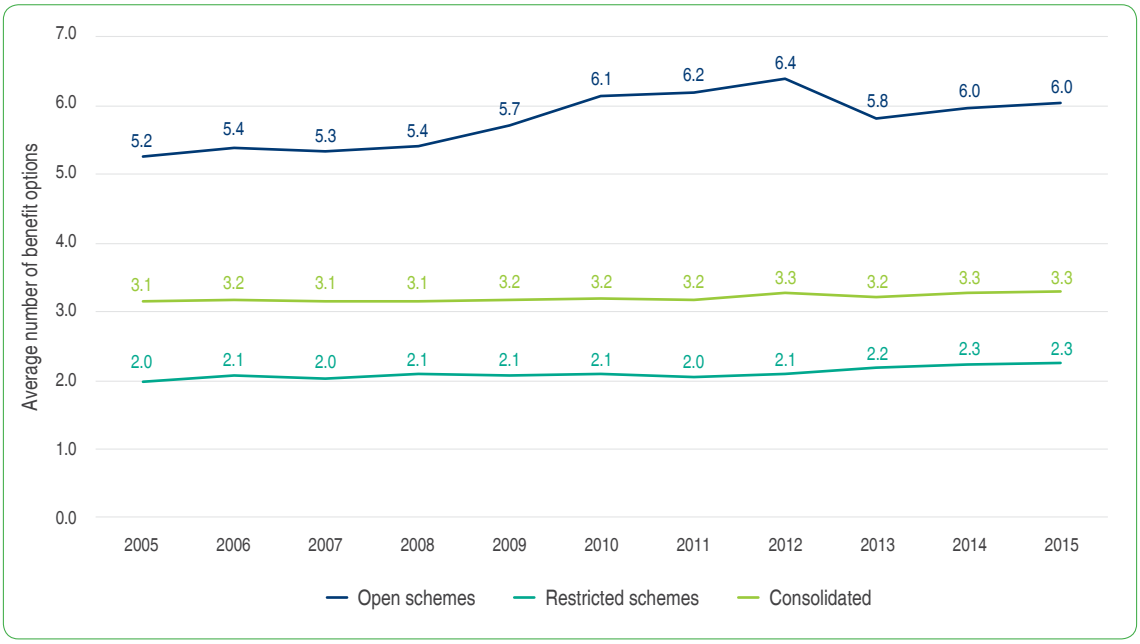
Amalgamation of schemes

There were no scheme amalgamations during this reporting period.

Trend in average number of options

Open medical schemes had, on average, six benefit options per scheme in 2015, compared to approximately two benefit options for the restricted schemes. For the industry as a whole, the average number of benefit options was three. Over time there has been a slight increase in the average number of benefit options for open schemes. The difference in the average number of benefit options between open and restricted schemes is due to differences in competition dynamics. Open medical schemes generally use benefit design as a mechanism to achieve any one of the following objectives: i) marketability and competitiveness of benefit options; ii) effective risk-pooling and iii) the mechanism through which healthcare benefits are rationed and delivered.

FIGURE 2: AVERAGE NUMBER OF OPTIONS 2005–2015



Membership of medical schemes

There was a year-on-year decrease of 0.06% in the total number of medical scheme beneficiaries, from 8.814 million in December 2014 to 8.809 million in December 2015. This decrease marks the first negative growth seen in the medical schemes industry since 2004. The total number of beneficiaries of restricted schemes showed negative growth of 1.11% compared to a 0.79% increase in the beneficiaries of open schemes.

TABLE 2: MEMBERSHIP OF SCHEMES 2014 AND 2015

Type of Scheme	Year	Members	Dependants	Beneficiaries	% change
Open schemes	2014	2 295 664	2 604 311	4 899 975	
	2015	2 327 137	2 611 316	4 938 453	0.79%
Restricted schemes	2014	1 625 568	2 288 915	3 914 483	
	2015	1 623 790	2 247 280	3 871 070	-1.11%
All schemes	2014	3 921 232	4 893 226	8 814 458	
	2015	3 950 927	4 858 596	8 809 523	-0.06%

Trends in the number of beneficiaries

Figure 3 depicts the trend in medical scheme coverage for the past 11 years. The number of beneficiaries decreased from 8.814 million in 2014 to 8.809 million in 2015. This represents a decrease of 0.06%. Beneficiaries belonging to open schemes constituted 56% of the total number of beneficiaries at the end of 2015.

FIGURE 3: NUMBER OF BENEFICIARIES 2005–2015

Average age, pensioner ratio and gender distribution

Table 3 shows the average age of beneficiaries and the proportion of pensioners (beneficiaries aged 65 years and older) by scheme type and gender. The average age of male beneficiaries is slightly lower than that of females and the pensioner ratio is also lower. The pensioner ratio increased slightly to 7.7% for the industry, with pensioner ratios for both male and female beneficiaries rising.

TABLE 3: AVERAGE AGE OF BENEFICIARIES AND PENSIONER RATIO 2013 AND 2014

Type of Scheme	Gender	Average age and Pensioner ratio	2013	2014	2015
		Average age	34.2	34.2	34.5
	Female	Pensioner ratio	9.0%	9.3%	9.7%
		Average age	32.8	32.8	33.0
	Male	Pensioner ratio	7.3%	7.6%	7.9%
		Average age	**33.5**	**33.6**	**33.8**
Open schemes	**Total**	**Pensioner ratio**	**8.2%**	**8.5%**	**8.8%**
		Average age	31.1	31.3	31.6
	Female	Pensioner ratio	6.6%	6.8%	7.0%
		Average age	28.8	28.9	29.1
	Male	Pensioner ratio	4.8%	4.9%	5.1%
		Average age	**30.0**	**30.2**	**30.5**
Restricted schemes	**Total**	**Pensioner ratio**	**5.8%**	**5.9%**	**6.1%**
		Average age	32.8	32.9	33.2
	Female	Pensioner ratio	7.9%	8.2%	8.5%
		Average age	31.0	31.1	31.3
	Male	Pensioner ratio	6.2%	6.4%	6.7%
		Average age	**31.9**	**32.1**	**32.3**
All schemes	**Total**	**Pensioner ratio**	**7.1%**	**7.3%**	**7.7%**

Figure 4 shows the age and gender distribution of medical scheme beneficiaries for 2005, 2014 and 2015. A bimodal distribution is evident, for both male and female beneficiaries. Age bands under 1 to 15–19 years featured more male beneficiaries with female beneficiaries outnumbering males in the age groups 20 years and older. In 2015, 52.61% of all beneficiaries were female and 47.39% were male.

The average age of medical scheme beneficiaries in 2015 was 32.3 years, slightly older than the 32.1 years reported in 2014. Female beneficiaries were generally older than male beneficiaries. The average age of female medical scheme beneficiaries was 33.2 years in 2015 and that of males were 31.3 years.

FIGURE 4: AGE AND GENDER DISTRIBUTION OF BENEFICIARIES 2005, 2014 AND 2015

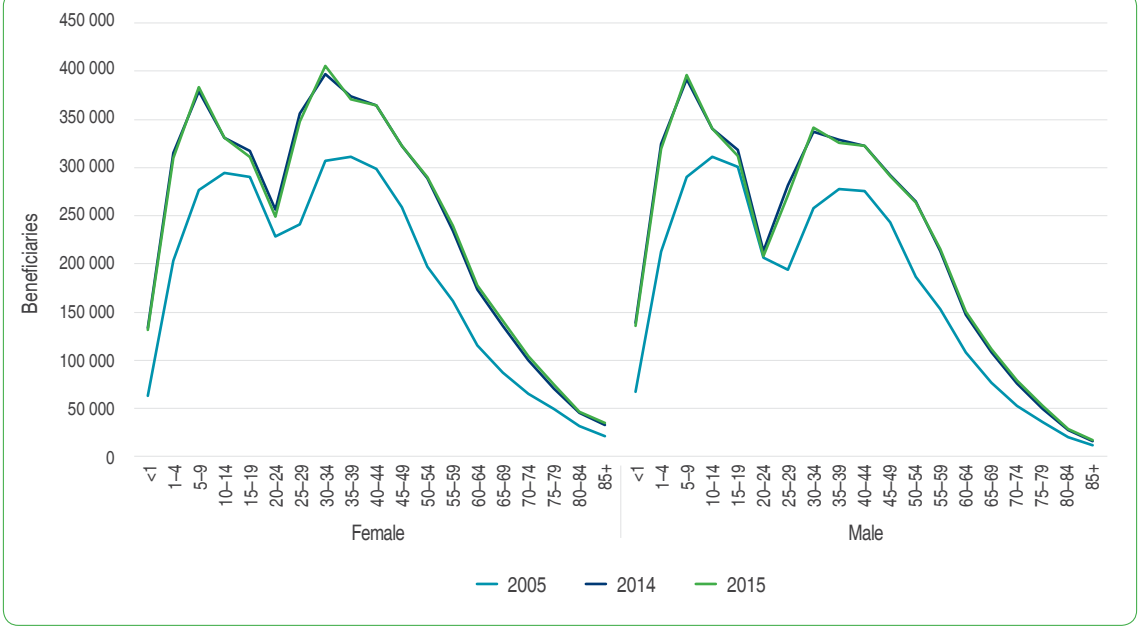


Figure 5 illustrates how the proportion of beneficiaries by age band has changed over time, from 2005 to 2015. There were proportionally more beneficiaries in the ages between 10 and 24 years, as well as between 35 and 49 years, for 2005 compared to 2015. There were proportionally less beneficiaries in 2005, for all ages under nine years as well as all ages over 50 years. The increase of members in the age bands over 50 years has greater cost implications as beneficiaries in the older age bands have higher average costs. This trend is more prominent in the open schemes and a negative change in the age distribution can have a significant impact on the cost of healthcare.

FIGURE 5: PROPORTION OF BENEFICIARIES PER AGE BAND 2005 VS 2015

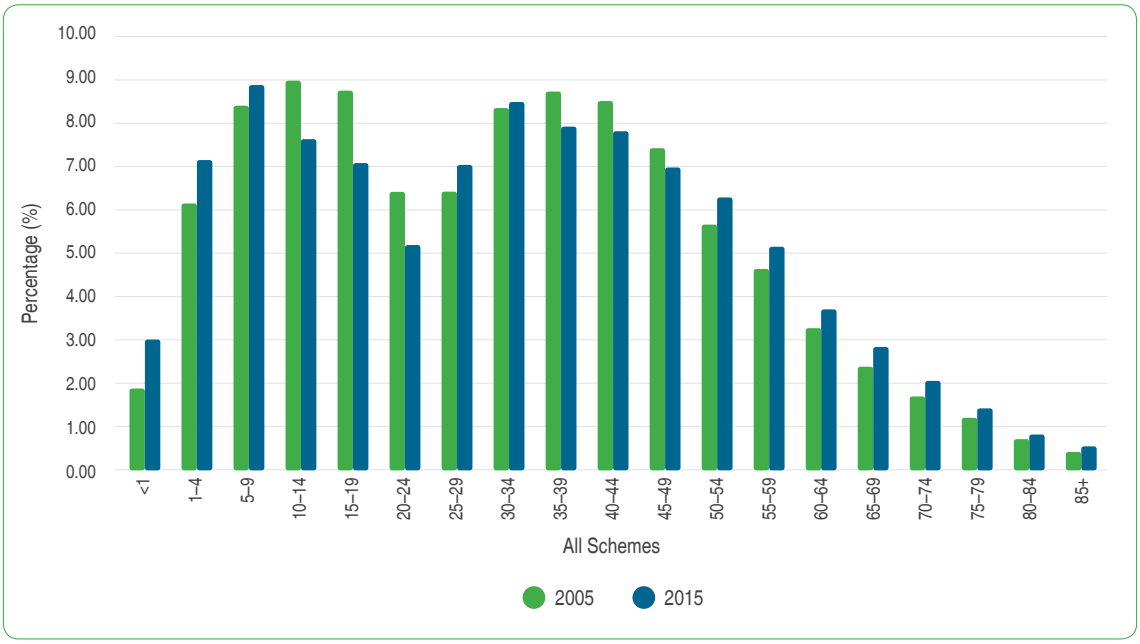
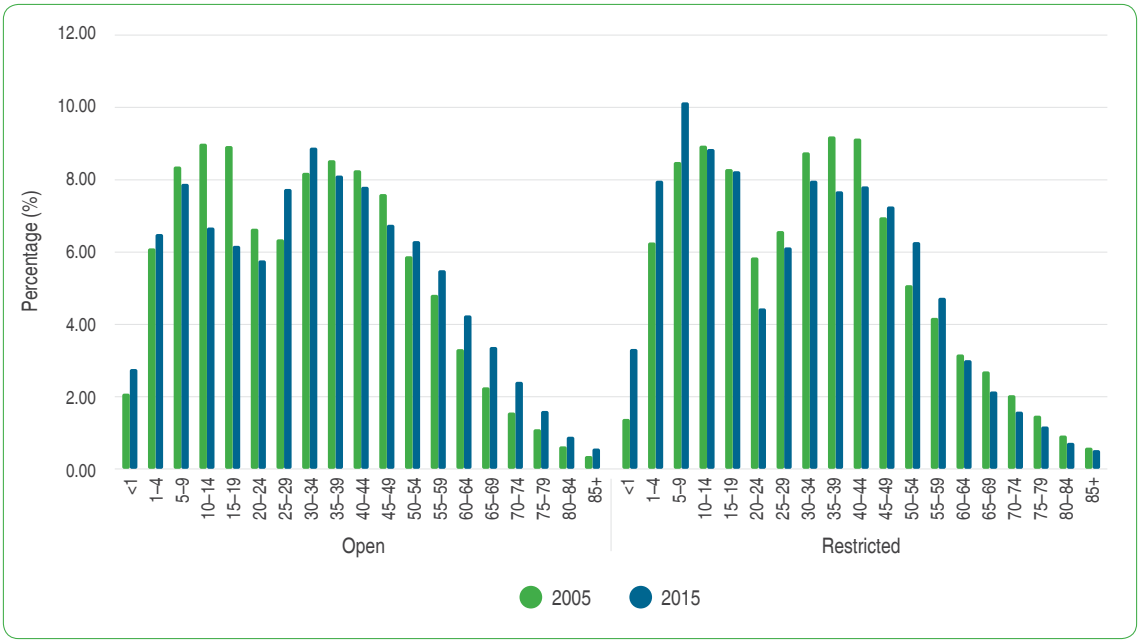


Figure 6 presents the proportion of beneficiaries per age band split between open and restricted schemes for 2005 and 2015.

FIGURE 6: PROPORTION OF BENEFICIARIES PER AGE BAND 2005 VS 2015, SPLIT BETWEEN OPEN AND RESTRICTED SCHEMES



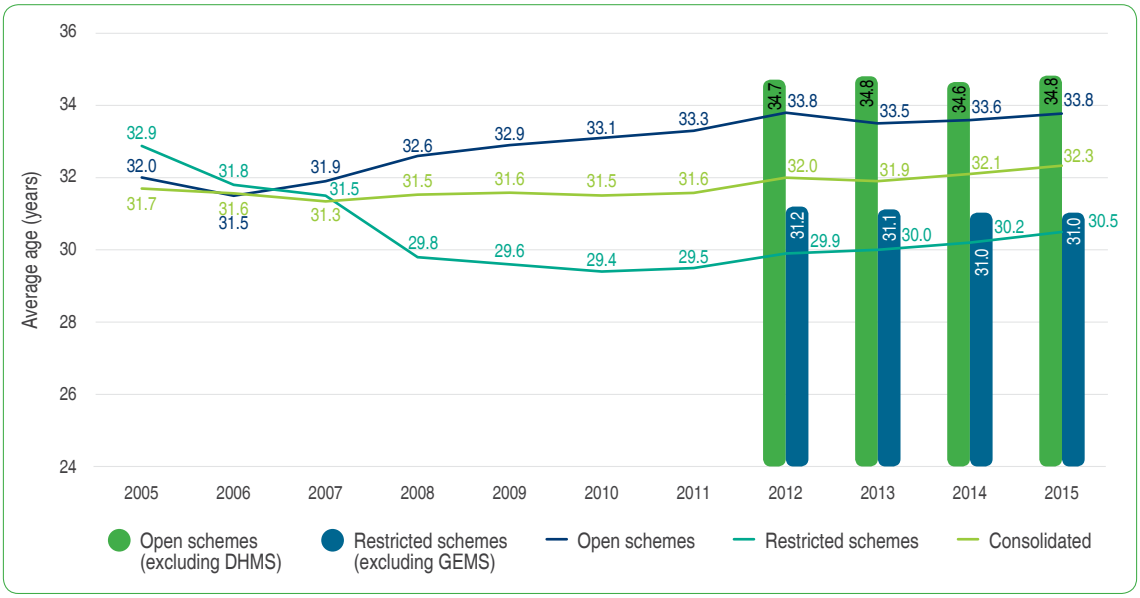
Trend in the average age of beneficiaries

Figure 7 shows the trend in the average age of beneficiaries from 2005 to 2015. Members of restricted medical schemes were older than those of open schemes until 2006. This changed in 2007, primarily due to the introduction of GEMS, when beneficiaries of restricted schemes were younger than those of open schemes.

The impact of GEMS and Discovery Health Medical Scheme (DHMS) on restricted and open schemes, respectively, is also reflected in Figure 7.

Figure 7 further illustrates that the average age of beneficiaries of open schemes in 2015 was 33.8 years (34.8 years if DHMS is excluded) while the average age of beneficiaries of restricted schemes in 2015 was 30.5 years (31 years if GEMS is excluded).

FIGURE 7: AGE OF BENEFICIARIES 2005–2015



Dependant ratio

The dependant ratio measures the average number of dependants per principal member. The dependant ratio for the entire industry decreased from 1.3 in 2014 to 1.2 in 2015. The dependant ratio for both restricted medical schemes and open medical schemes also decreased to 1.38 and 1.12, respectively. See Figure 8 for more detail.

FIGURE 8: DEPENDENT RATIO IN SCHEMES 2005–2015

Coverage by province

Figure 9 shows the distribution of beneficiaries by province in 2015. This data are collected primarily on the basis of the location of principal members. Approximately 38% of beneficiaries were located in Gauteng. The Western Cape and KwaZulu-Natal accounted collectively for approximately 2.53 million beneficiaries, comprising 29% of the total number. Table 4 and Figure 9 provide further information.

FIGURE 9: PROVINCIAL DISTRIBUTION OF BENEFICIARIES 2015

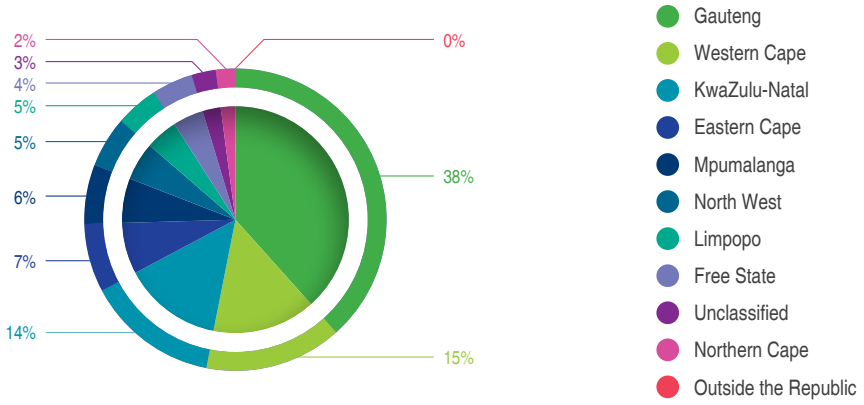


TABLE 4: PROVINCIAL CHANGES IN BENEFICIARIES BETWEEN 2014 AND 2015

Province	2015	2014	% Growth
Gauteng	3 381 051	3 341 984	1.20%
Western Cape	1 297 359	1 288 978	0.70%
KwaZulu-Natal	1 244 568	1 260 954	-1.30%
Eastern Cape	643 620	660 762	-2.60%
Mpumalanga	559 573	567 140	-1.30%
North West	480 496	485 795	-1.10%
Limpopo	405 353	419 866	-3.50%
Free State	385 224	389 156	-1.00%
Unclassified	227 824	211 547	7.70%
Northern Cape	181 608	185 213	-1.90%
Outside the Republic	2 847	3 063	-7.10%
	8 809 523	**8 814 458**	

Healthcare benefits[1]

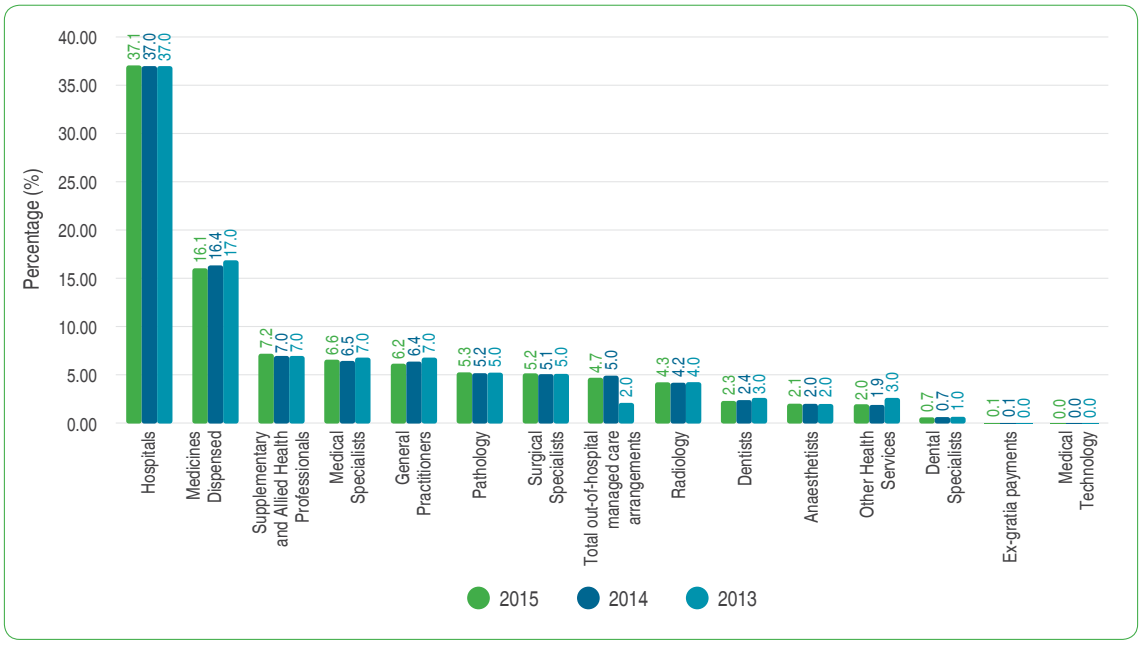
Total healthcare benefits paid

The total healthcare benefits paid is the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members. Expenditure on healthcare benefits increased (in nominal terms) by 9.0%, from R127.2 billion in 2014 to R138.6 billion in 2015.

The average amount spent per average beneficiary per annum (pabpa) increased by 9.04% in 2015, from R14 511.10 to R15 822.76. Figure 10 shows the proportions of benefit expenditure paid by medical schemes to various categories of healthcare providers for the period between 2013 and 2015.

1 *Note that gross benefits paid (benefits paid from risk pool plus savings) reported in the utilisation section of this report differ slightly from gross benefits reported in the financial statutory returns section. For more information, read notes in Annexures C to K.*

FIGURE 10: DISTRIBUTION OF HEALTHCARE BENEFITS PAID 2013, 2014 AND 2015



Total hospital expenditure by medical schemes comprised R51.4 billion or 37.1% of the R138.6 billion that medical schemes paid to all healthcare providers in 2015.

Total medical scheme expenditure on private hospitals increased by 9.36% to R51.1 billion from R46.8 billion in 2014. In-patient admissions constituted about 88% of the R51.1 billion paid to private hospitals in 2015 (same-day inpatient admissions constituted 12%). The average amount pabpa paid to private hospitals increased by 9.39%, from R5 338.19 in 2014 to R5 839.57 in 2015.

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals amounted to R22.3 billion or 16.1% of total healthcare benefits paid in 2015. This represents an increase of 7.09% compared to R20.8 billion spent in 2014.

The amount paid to supplementary and allied health professionals in 2015 increased by 12.65% from R8.9 billion in 2014 to R10 billion in 2015. This category accounted for 7.2% of all benefits paid by schemes in 2015.

Expenditure on general practitioners (GPs) amounted to R8.6 billion or 6.2% of healthcare benefits paid, representing an increase of 5.51% on the 2014 figure of R8.1 billion. Only 11.5% of the R8.6 billion paid to general practitioners in 2015 was paid to general practitioners operating in hospitals.

There is a strong negative correlation between the proportion of benefits paid to general practitioners and the proportion of benefits paid to hospitals. Medical schemes that have a high proportion of benefits paid to GPs tend to have a lower proportion of benefits paid to hospitals, while schemes that have a low proportion of benefits paid to GPs tend to have a higher proportion of benefits paid to hospitals. The results show the importance of primary healthcare interventions in bringing down the high cost associated with hospitalisation.

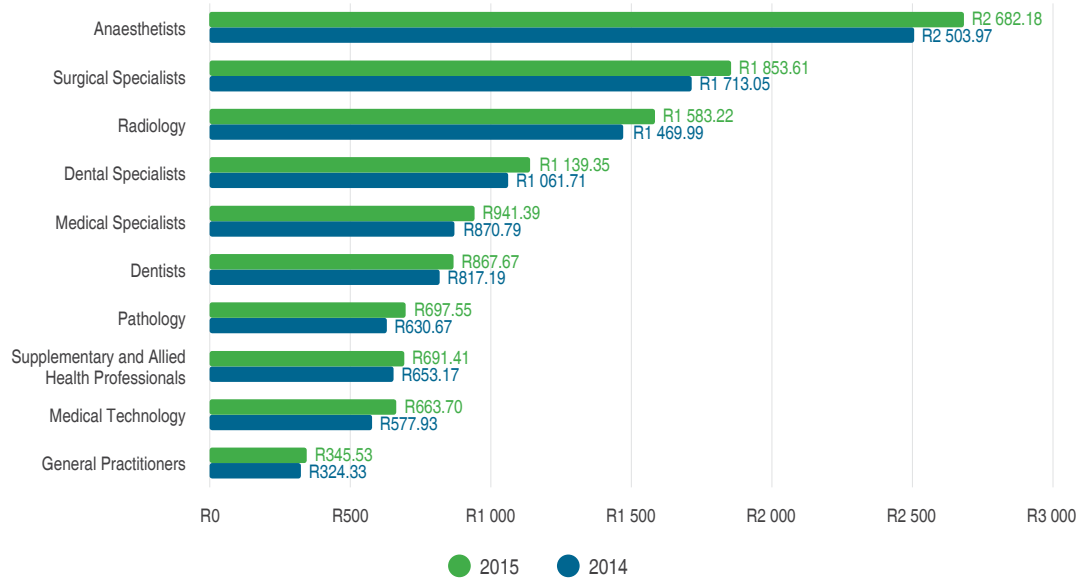
Payments to all specialists (anaesthetists, medical specialists, pathology services, radiology services and surgical specialists) amounted to R32.5 billion or 23.5% of total healthcare benefits paid in 2015. This amount increased by 10.90% from R29.3 billion paid in 2014.

Payments to medical specialists amounted to R9.1 billion or 6.6% of total healthcare benefits paid in 2015. About 55% of the R9.1 billion paid to medical specialists in 2015 was paid to medical specialists operating in hospitals. Expenditure on pathology services amounted to R7.3 billion or 5.3% of healthcare benefits paid while expenditure on surgical specialists and radiology services amounted R7.2 billion and R5.9 billion respectively.

Figure 11 shows benefits paid to different disciplines per event (visit). Total benefits paid per event is calculated as total benefits paid (from risk + savings) divided by the number of visits to a provider. Notice that the cost (or benefits paid) per event must be interpreted with caution as the calculation does not take into account other factors such as the number of hours spent per event, etc. In 2015, benefits paid to anaesthetists averaged at R2 682.18 per event (visit). This represented an increase of 7.12% from the 2014 figure of R2 503.97 and was the highest average paid per event in the industry, but in total, anaesthetists consumed less than 3% of all benefits paid. The amount paid to surgical specialists was R1 853.61 per event.

General practitioners[2] (GPs) were paid the lowest amount at an average of R345.53 per event. This represented an increase of 6.53% from the 2014 figure of R324.33. The average amount per event paid to GPs operating in hospitals was R649.27, which was almost double the average amount per event paid to GPs that do not operate in a hospital (R325.39).

FIGURE 11: TOTAL BENEFITS PAID PER EVENT (VISIT) 2015



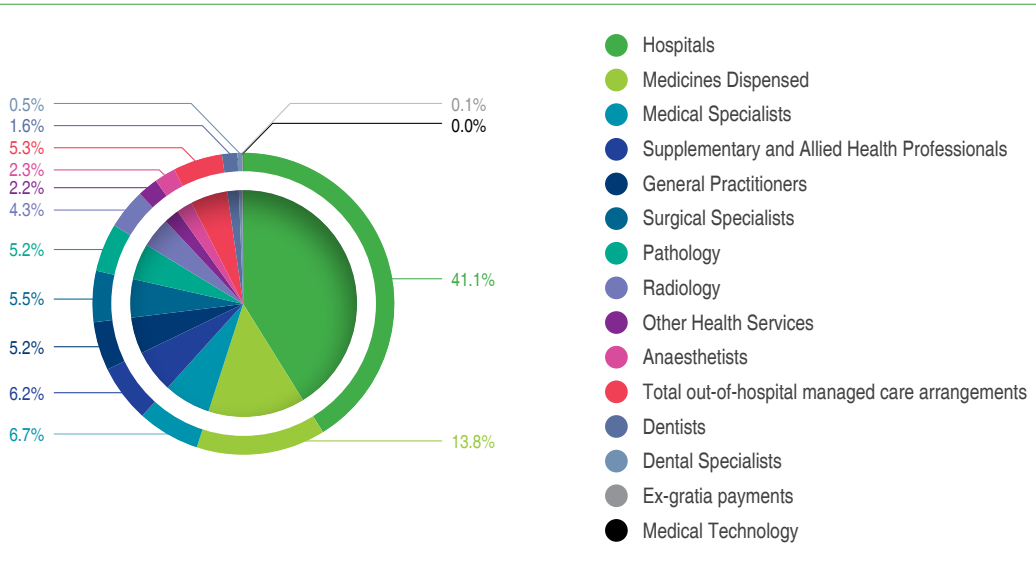
Healthcare benefits paid from risk pool

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 12.

Healthcare benefits which medical schemes covered from their risk pools amounted to R124.6 billion in 2015 compared to R114.8 billion in 2014, an increase of 8.53%. The average risk amount pabpa increased by 8.57% to R14 220.80 in 2015 compared to R13 098.36 in 2014.

Hospital expenditure accounted for 41.1% of risk benefits paid in 2015. Expenditure on medicines accounted for 13.8% of total risk pool benefits. Medical specialists consumed 6.7% of the pie, while risk pool expenditure on GPs was R6.4 billion or 5.2% of total risk pool benefits.

FIGURE 12: DISTRIBUTION OF HEALTHCARE BENEFITS PAID FROM RISK POOL 2015



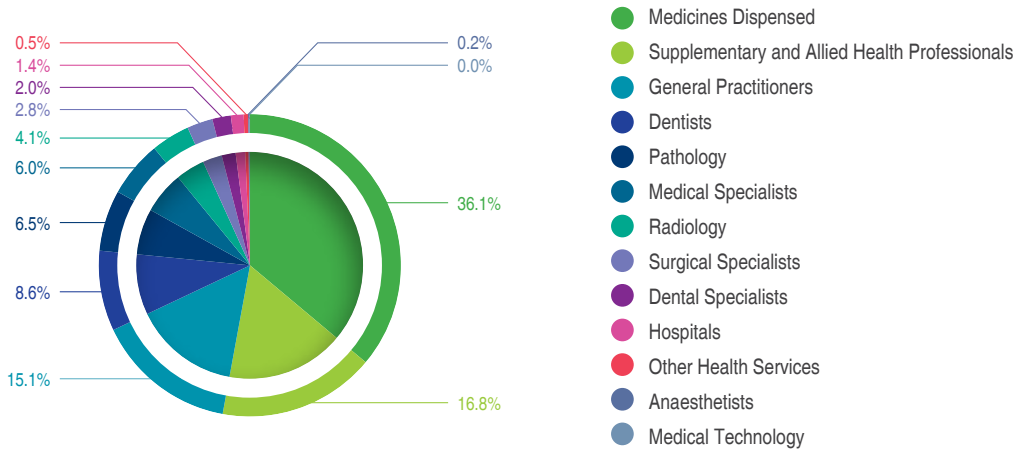
2 *Note that the amount reported for benefits paid per visit is different from the amounts reported in Tables 6–10. Tables 6–10 focus on primary healthcare and as a result only include out of hospital benefits while Figure 11 includes total benefits paid which includes both in-hospital and out-of-hospital payments.*

Healthcare benefits paid from savings

Of total healthcare benefits paid, medical schemes paid R14.0 billion (10%) from beneficiaries' personal medical savings accounts in 2015. Figure 13 shows that medicines absorbed the largest share of savings accounts expenditure in 2015 (36.1%). Supplementary and allied health professionals took up 16.8% of healthcare benefits paid from savings accounts.

General practitioners accounted for 15.1% and dentists for 8.6%, while pathology services and medical specialists absorbed 6.5% and 6.0% of healthcare benefits paid from savings accounts respectively.

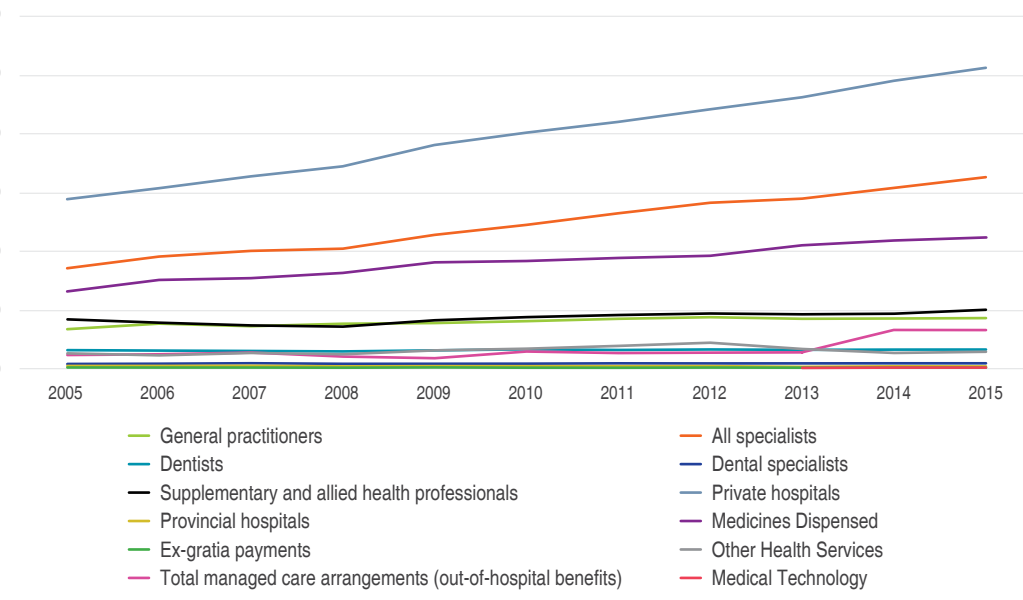
FIGURE 13: DISTRIBUTION OF HEALTHCARE BENEFITS PAID FROM SAVINGS 2015



Trends in total healthcare benefits paid[3]

Figure 14 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2005. These figures have been adjusted for inflation with 2015 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data have been adjusted to 2015 prices.

FIGURE 14: TOTAL HEALTHCARE BENEFITS PAID 2005–2015 (2015 PRICES*)



* *All values are adjusted for inflation using the Consumer Price Index (CPI) for 2015 as a base period.*
** *Historical values are revised when the base period changes and will not correspond to the values reported in the 2014 Annual Report.*

3 *Note that historical (pre-2014) provider classifications have been used in order to create continuity and preserve historical data. The groupings differ slightly with provider classifications used in other sections of the report.*

Medical schemes' expenditure on private hospitals increased in real terms by 4.55% to R51.1 billion in 2015, compared to R48.9 billion in 2014. The sustained increase in expenditure on private hospitals, rising from R28.6 billion in 2005 to R51.1 billion in 2015, is illustrated in Figure 14.

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2015 amounted to R32.5 billion in real terms, an increase of 6.03% in real terms when compared to the R30.7 billion spent on this item in 2014.

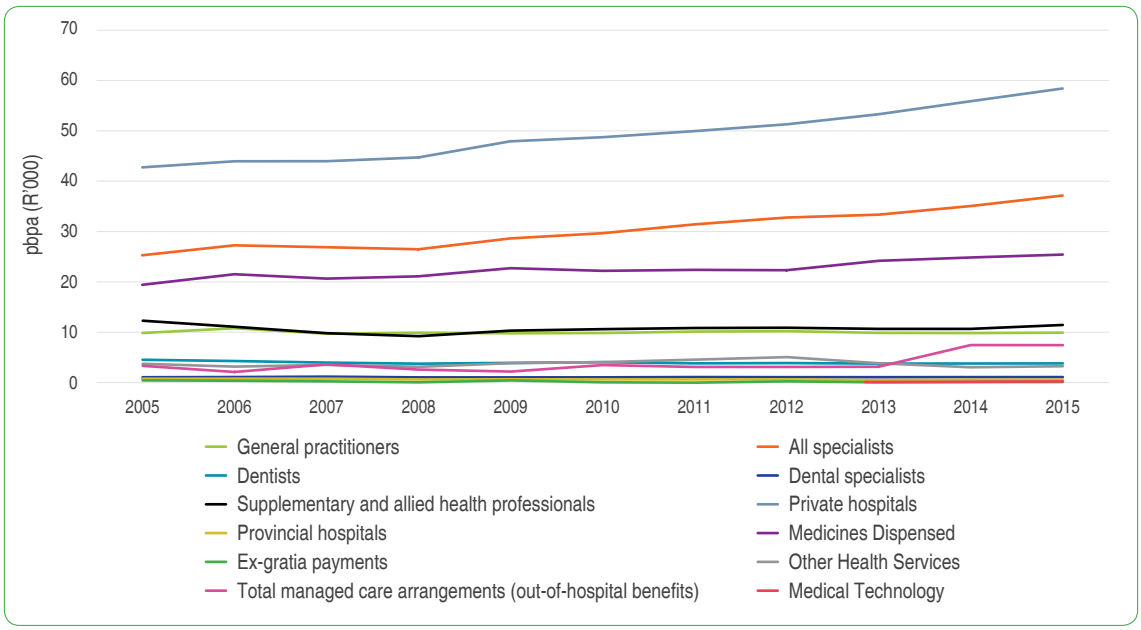
It should be noted that the annual growth in membership must be taken into account when considering changes in the total expenditure of medical schemes.

Healthcare benefits paid per beneficiary

Figure 15 shows the changes in healthcare expenditure pabpa from 2005 to 2015 in real terms (at 2015 prices). The amount paid in real terms on private hospitals increased by 4.58% from R5 584 pabpa in 2014 to R5 840 pabpa in 2015.

The amount spent on specialists increased in real terms from R3 505 pabpa in 2014 to R3 718 pabpa in 2015, an annual increase of 6.06%. There was an increase of 2.42% in real terms for the benefits paid on medicines dispensed.

FIGURE 15: TOTAL HEALTHCARE BENEFITS PAID PABPA 2005–2015 (2015 PRICES*)



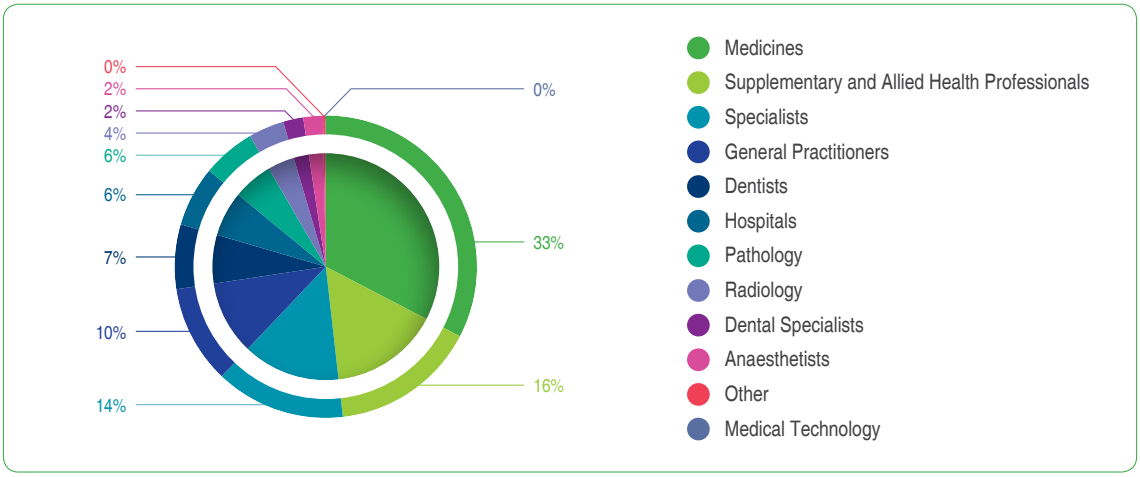
* *All values are adjusted for inflation using the CPI for 2015 as a base period.*
** *Historical values are revised when the base period changes and will not correspond to the values reported in the 2014 Annual Report.*

Out-of-pocket payments

The out-of-pocket (OOP) is calculated as the difference between the total amounts claimed less the total risk benefits paid by medical schemes. In 2014, the level of OOP payments was estimated to be at least 18% of total healthcare expenditure (R24.0 billion in nominal terms) among medical scheme beneficiaries. In nominal terms, the estimated OOP in 2015 grew by 13.4% to R27.2 billion compared to 2014. This represents 18.6% of total healthcare expenditure for beneficiaries.

The bulk of OOP was for medicine claims which constituted 33% of total OOP expenditure. The next highest expenditure was towards Supplementary and Allied Health Professionals which amounted to 16% of total OOP expenditure. OOP expenditure for medicines may be largely as a result of over-the-counter and non-formulary medicines. OOP is low for hospitals since most schemes cover hospitalisation in full. The CMS will continue to monitor trends in OOP and associated factors.

FIGURE 16: 2015 OUT-OF-POCKET EXPENDITURE BREAKDOWN



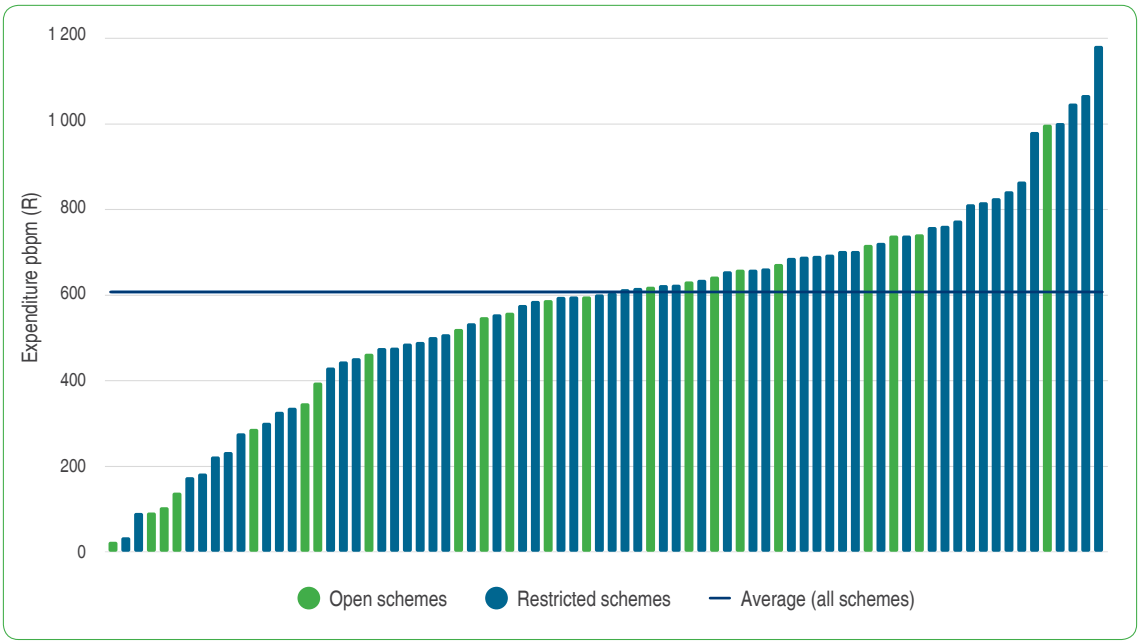
Prescribed Minimum Benefits

The total expenditure on prescribed minimum benefits (PMBs) for medical schemes amounted to R64.2 billion in 2015. The total risk benefits paid in 2015 was R124.7 billion. Therefore, the expenditure on PMB-related healthcare benefits constituted 51% of total risk benefits paid. In 2014 PMBs constituted 52% of total risk benefits paid.

The expenditure for PMBs for 2015 was R608 per beneficiary per month (pbpm) representing a 9.4% increase from the recalculated figure of R556 for the 2014 financial year. The expected cost of PMBs for 2015 from the scheme risk measurement (SRM) data was estimated at R608 pbpm, exactly the same as the actual expenditure from the annual returns data.

The expenditure on PMB benefits varies from scheme to scheme and the differences can be seen in Figure 17. The variation is due to a number of factors which include different risk profiles and efficiency within the schemes. The other reason for variation, which is of concern, could be non-compliance in terms of either payment of PMB benefits or improper reporting on the level of PMB benefits.

FIGURE 17: SCHEME COMMUNITY RATE FOR 2015



Eight schemes reported PMB costs below R200 pbpm – four open schemes and four restricted schemes. The open schemes seem to have lower costs of PMBs on average with only 25% of them in the upper quarter.

The cost of PMB benefits for the industry is monitored from year to year. The cost of PMBs is mainly driven by a combination of the following:

- Scheme demographic profile which impacts on the level of cross subsidisation between the young and the old; the healthy and the sick;
- Burden of disease; and
- Cost of treatment which is strongly linked to contracting between schemes and providers.

Beneficiary profile in relation to cost of PMBs

Figure 18 depicts the relationship between expenditure on PMB healthcare benefits and age. The expenditure for PMBs generally increases with age. In ages above 45, the PMBs expenditure is higher than the industry average of R608 pbpm. The under one age group expenditure was significantly more than the industry average. The ages from one year up to 44 years of age have PMB expenditure below the industry average. To maintain a reasonable PMB expenditure increase from year to year, the membership growth in the age ranges from one year olds to 44 year olds should be higher than the growth in age ranges with PMB expenditure above the average of R608 pbpm, i.e. under ones and those older than 45.

Comparing 2014 and 2015, the beneficiaries in the age range one year to 44 years reduced by about 45 000 beneficiaries while the membership in below one and above 45 years of age grew by almost 39 000. This unfavourable change in beneficiary profile is one of the factors contributing to the escalation in expenditure for PMBs during the reporting period.

FIGURE 18: PRESCRIBED MINIMUM BENEFITS EXPENDITURE BY AGE BAND FOR 2014 AND 2015

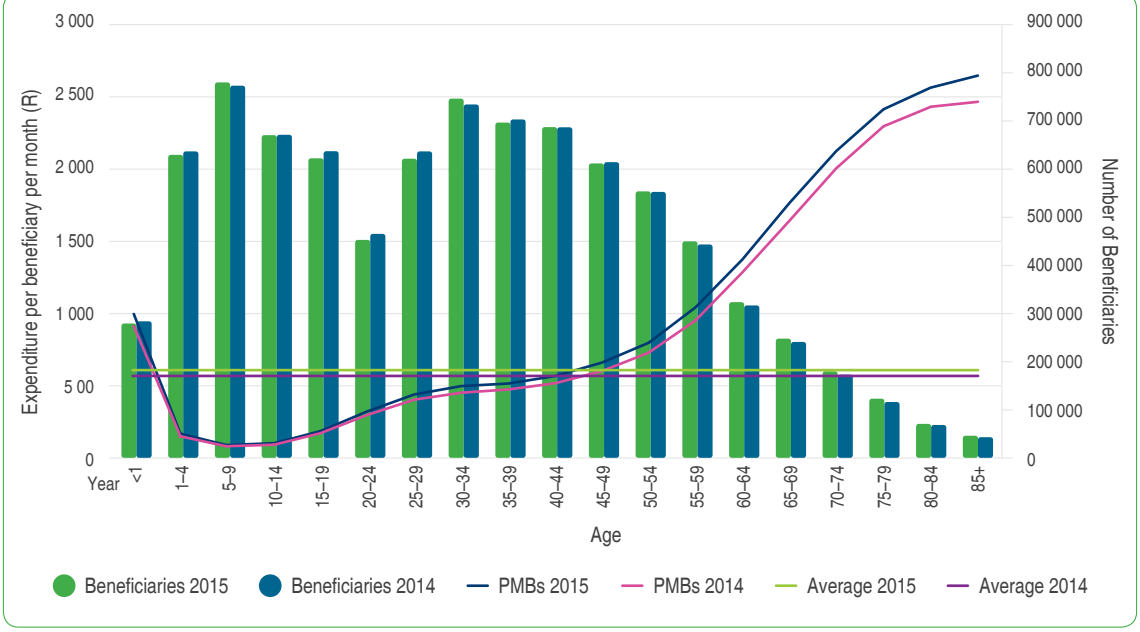


Figure 19 shows the expenditure and prevalence of Chronic Disease List (CDL) conditions. Generally, the more prevalent a condition is, the higher its expenditure pbpm.

Hypertension remains the most prevalent CDL condition among medical scheme beneficiaries. The prevalence of hypertension increased from 147.56 per 1 000 beneficiaries in 2014 to 152.82 per 1 000 beneficiaries in 2015. The expenditure on hypertension has also increased from R20.67 pbpm to R22.05 pbpm from 2014 to 2015. This was the most expensive CDL condition on a per beneficiary per month basis in 2015.

Diabetes Mellitus 2, ranked third by prevalence, recorded a significant year-on-year increase in the expenditure compared to other CDL conditions. The expenditure on this condition was R11.79 pbpm in 2014 and increased by 19% to R14.03 pbpm in 2015.

Chronic renal disease has a comparatively lower prevalence yet the expenditure of the condition is comparable to Diabetes Mellitus 2 on a pbpm basis.

FIGURE 19: EXPENDITURE AND PREVALENCE OF CHRONIC CONDITIONS

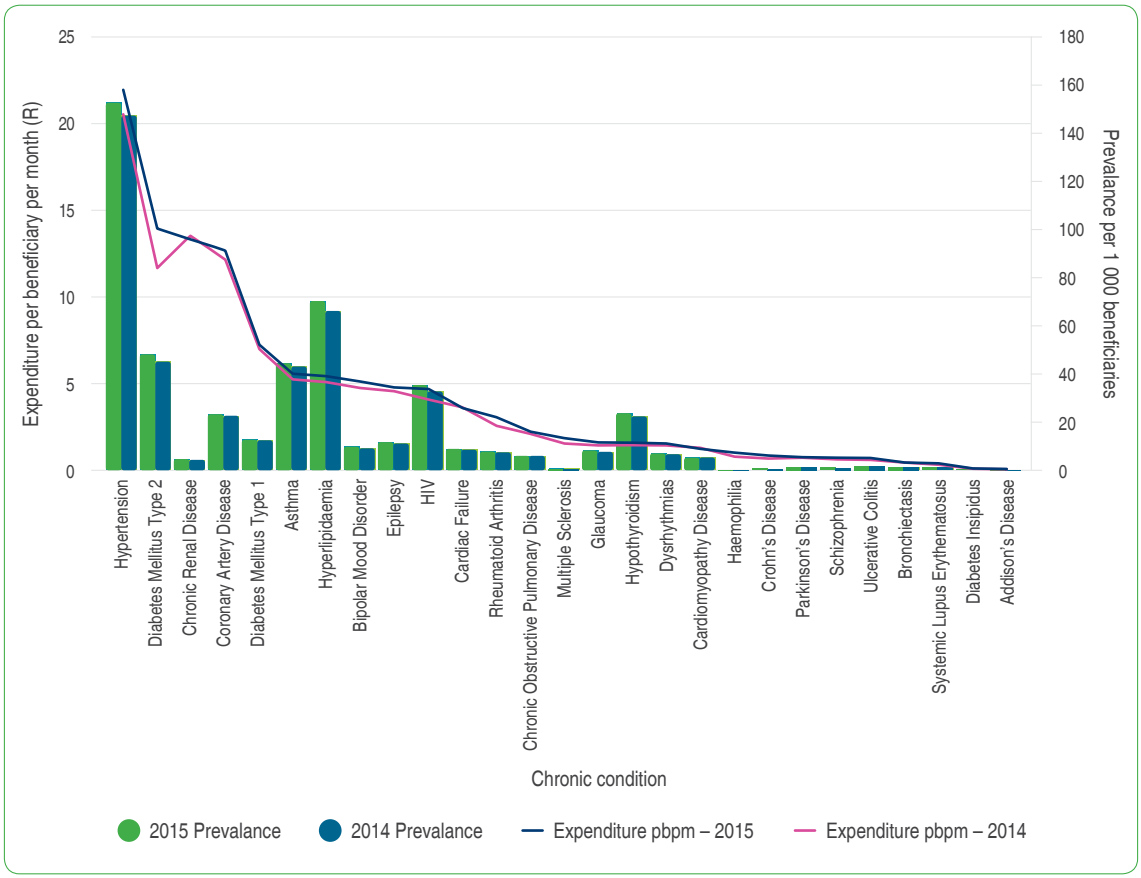


Figure 20 below demonstrates the expenditure on treatment as measured by the average expenditure per patient per month for each CDL condition. Haemophilia is still the most expensive CDL to treat per patient. In 2015, expenditure on haemophilia was R18 666 per patient per month (pppm) compared to R14 486 pppm in 2014. Multiple Sclerosis and Chronic Renal Diseases expenditure was R3 797 pppm and R2 938 pppm in 2015. These three conditions are relatively very expensive to treat on a per patient per month basis. The expenditure on chronic renal disease fell from R3 234 in 2014 to R2 938 in 2015.

The expenditure per patient per month is much lower than the SRM estimated cost per patient for most of the CDLs. This may be due to either under reporting of the PMB expenditure by schemes or a reflection of the poor quality of care received by medical scheme beneficiaries.

FIGURE 20: EXPENDITURE ON CHRONIC CONDITIONS IN 2014 AND 2015

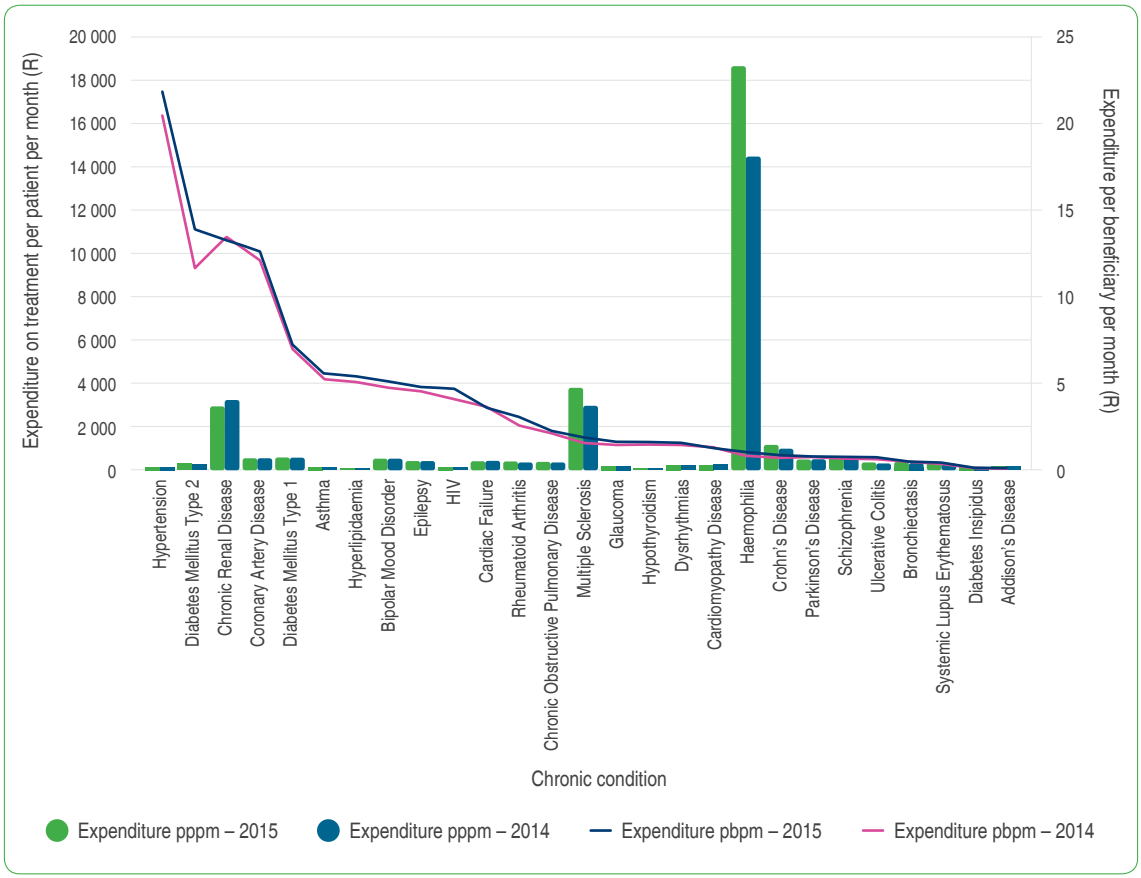


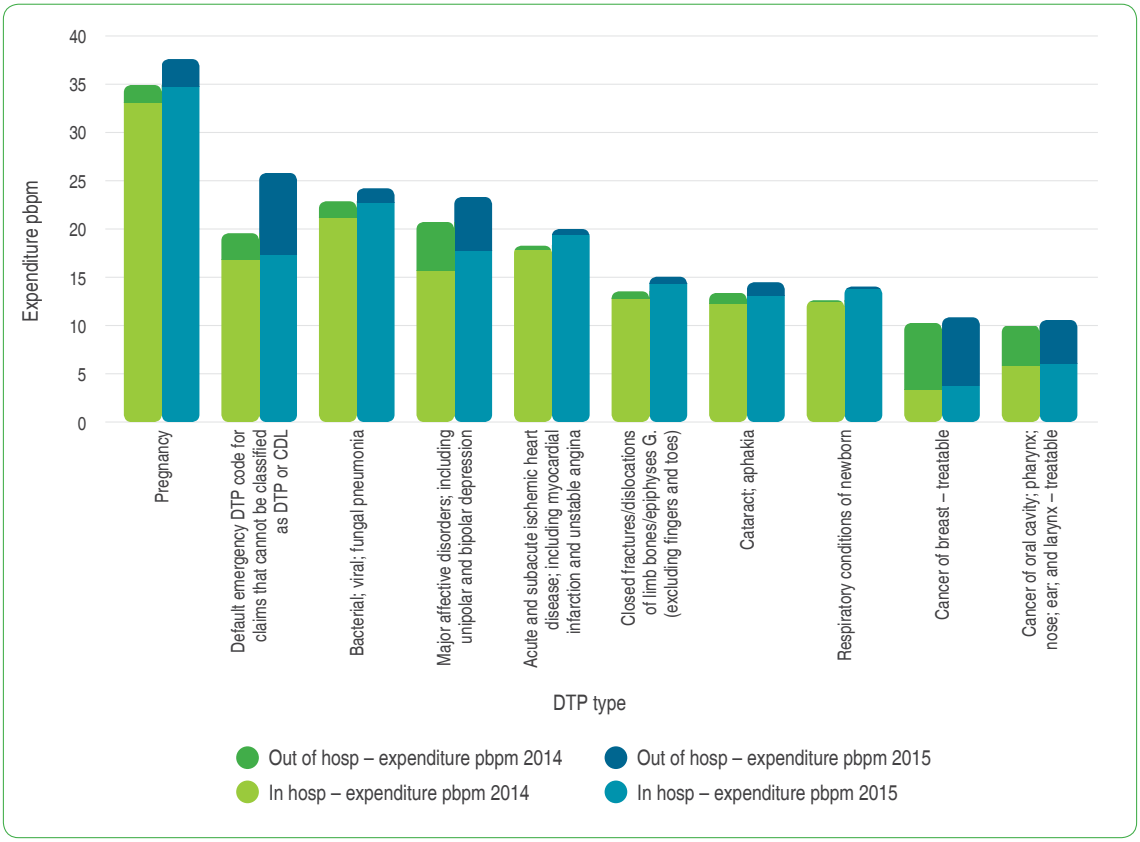
Figure 21 depicts the expenditure on Disease Treatment Pairs (DTPs) conditions for 2014 and 2015 financial years. Care for most of the DTPs is largely hospital based.

Pregnancy remains as the most expensive DTP with expenditure of R36 pbpm – this cost is inclusive of all beneficiaries. The composition of the top 10 DTP conditions has changed compared to 2014 with default emergency conditions joining the top 10 and becoming the second most expensive condition in 2015 with expenditure of R26 pbpm.

Treatable breast cancer and treatable cancer of the oral cavity, pharynx, nose, ear and larynx are among the top 10 DTPs in 2015. These were not part of the top 10 DTPs in 2014.

Default emergency conditions and major affective disorders, including unipolar and bipolar depression, had the highest expenditure outside hospital amounting to R8.41 pbpm and R5.50 pbpm, respectively.

FIGURE 21: TOP 10 DISEASE TREATMENT PAIRS BY EXPENDITURE PER BENEFICIARY PER MONTH



The top 10 DTP conditions had a combined expenditure of R20.7 billion in 2015, as shown in Table 5.

TABLE 5: TOP 10 DTP CONDITIONS

DTP Diagnosis	Total expenditure on DTP conditions (R billion)
Pregnancy	3 964
Default emergency DTP code for claims that cannot be classified as DTP or CDL	2 719
Bacterial; viral; fungal pneumonia	2 552
Major affective disorders; including unipolar and bipolar depression	2 457
Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina	2 107
Closed fractures/dislocations of limb bones/epiphyses G. (excluding fingers and toes)	1 593
Cataract; aphakia	1 527
Respiratory conditions of new born	1 480
Cancer of breast – treatable	1 143
Cancer of oral cavity, pharynx, nose, ear, and larynx – treatable	1 113
Total Cost	**20 655**

Managed care

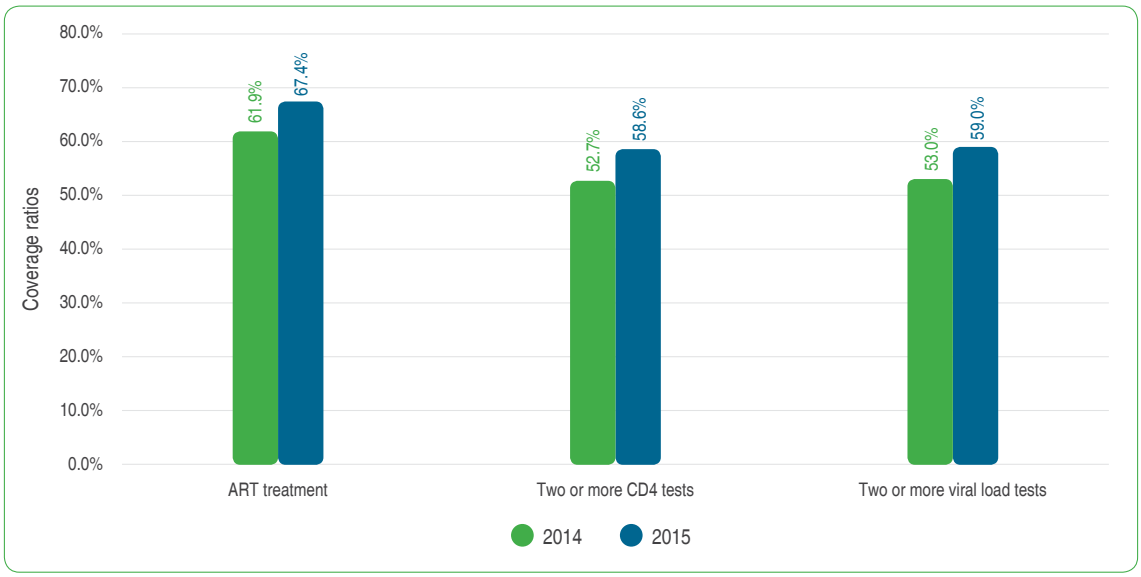
The CMS is excited to include a new section in the annual report that focuses on quality of care across medical schemes. The CMS embarked on an industry wide consultative process to establish the best standard of care that is clinically appropriate and cost effective in medical schemes. This process identified appropriate process and outcome indicators for the management of the CDL conditions. Process indicators assess what the provider did for the patient and how well it was done. Process indicators relate to a series of inter-related activities undertaken to achieve objectives. Outcome indicators are states of health or events that follow care, and that may be affected by healthcare. An ideal outcome indicator would capture the effect of care processes on the health and wellbeing of patients and populations.

The work to improve the measurement of quality of care across medical schemes is ongoing. The CMS has collected data on nine of the 26 CDL conditions and more will be collected in the future. The data collected include the number of beneficiaries with a CDL condition receiving appropriate care. The coverage ratios for these conditions are listed in Annexure K by scheme and benefit option. Coverage ratio denotes to the proportion of beneficiaries registered for a chronic programme receiving the appropriate level of care.

HIV is the best managed CDL condition in the industry with coverage ratios as high as 60%, as shown in Figure 22. The coverage ratios are disappointing for other chronic conditions. There is also wide variation of coverage ratios if one compares benefit options and ultimately the managed care organisations.

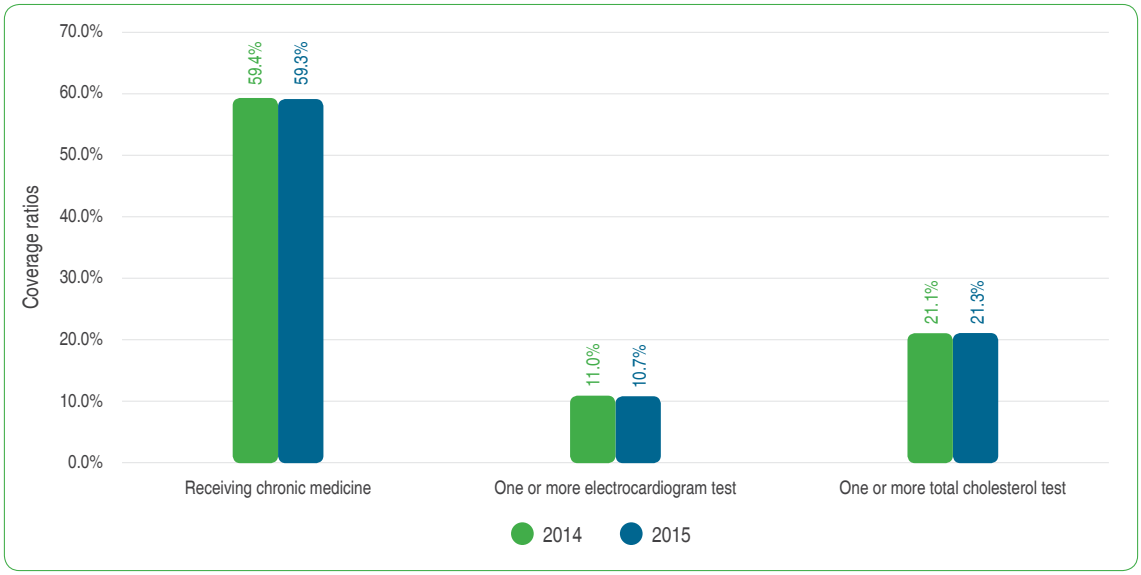
The proportion of HIV beneficiaries receiving Antiretroviral Therapy (ART) is 67.4% in 2015, up from 61.9% in 2014. The coverage of HIV monitoring tests has also increased significantly with increases from 53% in 2014 to 59% in 2015 for both viral load tests and the CD4 counts.

FIGURE 22: HIV – COVERAGE RATIOS



About 59.3% of hypertensive patients are receiving hypertension treatment as shown in Figure 23. The coverage ratios of monitoring hypertensive patient management are very low. The coverage for the electrocardiogram test fell slightly from 11.0% in 2014 to 10.7% in 2015. The coverage of the total cholesterol test was 21.1% in 2014, increasing marginally to 21.3% in 2015. Note that hypertension is the most prevalent chronic condition across medical scheme beneficiaries.

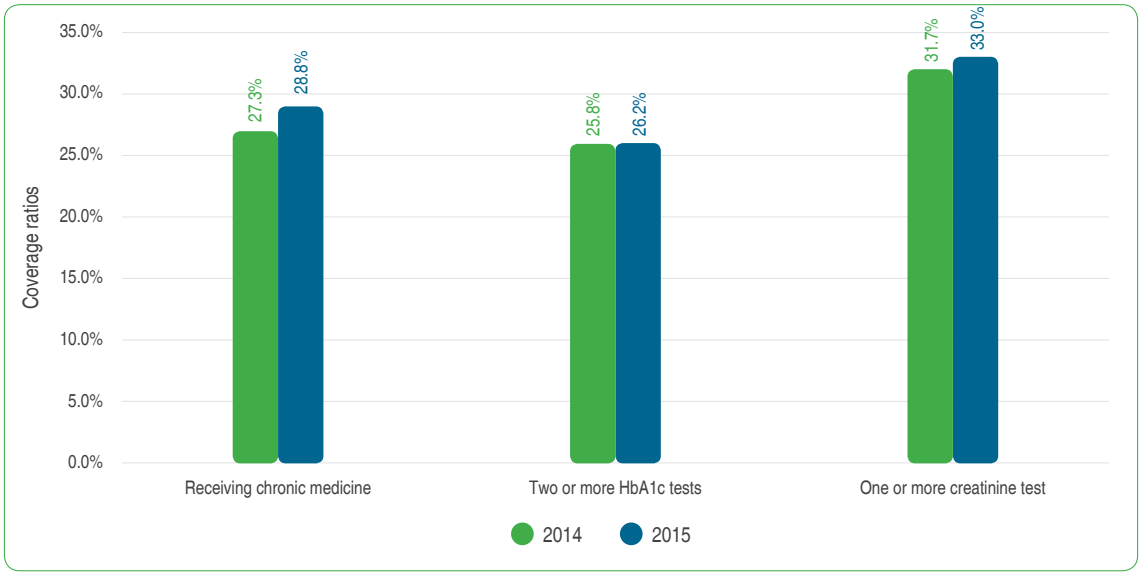
FIGURE 23: HYPERTENSION – COVERAGE RATIOS



Considering this data alone, it appears that the registration of hypertensive patients on the CDL management programme is more concerned with providing access to drugs rather than the holistic management of the patients' health.

The coverage ratios for Diabetes Mellitus Type 2 (DM Type 2) are depicted in Figure 24. DM Type 2 is increasingly more prevalent in the industry. The coverage ratios are very low, with the coverage of monitoring tests, such as the creatinine test, being 33% in 2015, while the HbA1c test was 26.2%. In 2014 the coverage of these tests was at similar levels. The proportion of DM Type 2 patients claiming for chronic disease medicine was 28.8% in 2015, a slight increase from 2014.

FIGURE 24: DIABETES MELLITUS 2 – COVERAGE RATIOS



Utilisation of healthcare services

Primary healthcare services

Primary healthcare providers act as a first point of contact and are responsible for the patients' continuing care. Ideally, the primary healthcare providers (medical, dental or nurse practitioners) should also be responsible for the coordination of specialist care that the patient may need. This is not always the case in the South African medical schemes environment. Patients are free to enter the healthcare system at any point in the system.

A visit in this report is defined as an actual valid beneficiary consultation with a service provider or an event leading to submission of a valid claim.

Table 6 and Table 7 show patterns in the out-of-hospital utilisation of primary healthcare providers by type of scheme.

The number of medical schemes' beneficiaries visiting GPs at least once a year was 738.48 per 1 000 beneficiaries for 2015 and 736.49 for 2014. The overall rate of GP consultations has therefore remained unchanged during the period under review. The number of beneficiaries visiting GPs was higher in the restricted schemes for both 2015 and 2014 financial years compared to open schemes.

Visits to general dental practitioners (dentists) remained largely unchanged between 2015 and 2014, at 214.24 and 214.51 per 1 000 beneficiaries, respectively. More beneficiaries in restricted schemes (236.49 per 1 000) had at least one dentist consultation in 2015 compared to those in open schemes (197.15 per 1 000).

Visits to registered nurses (nurses) increased from a revised 9.22 per 1 000 beneficiaries in 2014 to 12.39 per 1 000 beneficiaries in the 2015 financial year. Consultations with a nurse was slightly higher in restricted schemes compared to those of open schemes. The high cost per visit for the registered nurses came as a surprise and is probably a result of specialised services in the private medical scheme industry.

The frequency of GP, dentist and nurse visits per beneficiary remained unchanged at about four, two and three times per year, respectively, during the period under review.

The amount paid to primary health care providers is higher for dentists compared to both GPs and nurses. Moreover, a large portion of dental care is paid for from the Member Savings Account (MSA). Beneficiaries without MSA or whose MSA is exhausted are likely to self-fund or forego most of the dental care.

TABLE 6: UTILISATION OF PRIMARY HEALTHCARE SERVICES IN 2014 AND 2015

Discipline	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Provider utilisation per 1 000 beneficiaries						
General Medical Practice	681.94	814.05	738.48	683.57	805.37	736.49
General Dental Practice	197.15	236.49	214.24	197.48	236.07	214.51
Registered nurses	11.77	13.20	12.39	8.80	9.76	9.22
Provider utilisation per patient						
General Medical Practice	3.47	3.73	3.59	3.52	3.79	3.65
General Dental Practice	2.10	1.80	1.95	2.11	1.80	1.96
Registered nurses	2.32	2.83	2.56	2.58	2.97	2.76
Average amount paid to provider per visit (Risk benefit)						
General Medical Practice	R179.16	R290.96	R233.91	R178.71	R276.22	R226.82
General Dental Practice	R323.48	R799.78	R533.80	R318.83	R760.91	R516.00
Registered nurses	R204.92	R320.39	R264.11	R186.57	R313.28	R250.15
Average amount paid to provider per visit (MSA)						
General Medical Practice	R139.74	R41.20	R91.48	R121.84	R35.02	R79.00
General Dental Practice	R537.62	R67.37	R329.98	R489.64	R58.97	R297.55
Registered nurses	R138.64	R19.02	R77.33	R140.28	R17.84	R78.84
Average amount paid to provider per visit (Total)						
General Medical Practice	R318.90	R332.15	R325.39	R300.55	R311.23	R305.82
General Dental Practice	R861.10	R867.15	R863.77	R808.46	R819.87	R813.55
Registered nurses	R343.57	R339.41	R341.44	R326.85	R331.12	R328.99

Table 7 demonstrates the statistical distribution of the number of beneficiaries utilising healthcare services and amounts paid to primary health providers in 2015. The large variation in the utilisation statistics is indicative of varying levels of benefit depth between medical schemes and benefit options. This is largely a function of benefit design, demographic profile of risk pools and the associated burden of disease. Hospital plans will mostly have very low utilisation of primary healthcare services while the opposite is true for comprehensive plans.

The amount paid for a small number of events or visits is influenced by reversals or claim rejections in the year subsequent to the date of event or visit. Therefore, the minimum amounts paid are likely not to be the actual amounts paid by the scheme per visit.

The analysis of other providers who play a role in the provision of primary health are presented in Annexure E.

TABLE 7: STATISTICAL DISTRIBUTION OF THE NUMBER OF BENEFICIARIES, VISITS AND AMOUNTS PAID TO PRIMARY HEALTH PROVIDERS IN 2015

Discipline	Indicator	Minimum	25th percentile	50th percentile	75th percentile	Maximum
General medical practice						
	Utilisation per 1 000 beneficiaries	76.64	542.90	748.87	828.84	954.11
	Utilisation per patient	1.92	2.94	3.51	4.05	18.34
	Risk amount paid per visit	R21.33	R153.17	R264.40	R316.81	R386.09
	MSA amount paid per visit	R0.00	R0.00	R28.84	R170.89	R331.01
	Total amount paid per visit	R199.52	R293.47	R327.30	R350.44	R404.14
General dental practice						
	Utilisation per 1 000 beneficiaries	0.09	154.65	238.63	303.51	432.89
	Utilisation per patient	0.94	1.74	1.91	2.11	192.97
	Risk amount paid per visit	R0.00	R241.42	R621.93	R873.15	R1 164.56
	MSA amount paid per visit	R0.00	R0.00	R29.12	R323.36	R772.64
	Total amount paid per visit	R4.99	R701.86	R844.71	R968.36	R1 182.60
Registered nurses						
	Utilisation per 1 000 beneficiaries	0.10	3.84	8.15	13.00	49.77
	Utilisation per patient	1.00	2.30	3.11	4.60	12.80
	Risk amount paid per visit	R46.80	R201.04	R247.45	R346.62	R579.44
	MSA amount paid per visit	R0.00	R0.00	R4.16	R54.88	R286.20
	Total amount paid per visit	R46.80	R231.91	R282.64	R386.68	R744.11

Utilisation of specialist healthcare services

Table 8 depicts the utilisation and average cost of specialist healthcare services by scheme type for the 2015 and 2014 financial years, in- and out-of-hospital combined. Medical specialists are used more frequently than all the other specialities. The utilisation of anaesthetists, pathology and radiology services, all support specialists, are to a large extent dependent on the activity of medical and surgical specialists.

The detailed analysis is shown in the annexures.

TABLE 8: UTILISATION OF SPECIALIST HEALTHCARE SERVICES IN 2014 AND 2015

Specialist Group	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Utilisation per 1 000 beneficiaries						
Medical Specialists	343.18	316.33	331.35	336.27	315.71	327.10
Surgical Specialists	253.10	200.41	229.88	249.10	196.61	225.68
Dental Specialists	32.47	55.73	42.72	32.33	56.67	43.19
Anaesthetists	98.16	73.06	87.10	95.98	71.91	85.24
Pathology	451.14	416.66	435.95	447.00	402.40	427.10
Radiology	271.15	241.13	257.92	264.23	237.03	252.10
Utilisation per patient						
Medical Specialists	3.25	3.48	3.35	3.20	3.36	3.27
Surgical Specialists	1.88	1.95	1.91	1.87	1.92	1.89
Dental Specialists	2.41	1.97	2.16	2.41	1.98	2.16
Anaesthetists	1.37	1.39	1.38	1.37	1.37	1.37
Pathology	2.71	2.81	2.75	2.72	2.92	2.80
Radiology	1.62	1.68	1.65	1.62	1.67	1.64
Risk amount paid per visit/event						
Medical Specialists	R861.49	R840.67	R852.39	R801.20	R773.84	R789.09
Surgical Specialists	R1 870.53	R1 572.18	R1 753.35	R1 719.57	R1 471.26	R1 621.52
Dental Specialists	R768.55	R824.95	R798.11	R743.37	R772.53	R759.01
Anaesthetists	R2 857.86	R2 330.95	R2 662.10	R2 657.98	R2 196.32	R2 484.23
Pathology	R552.78	R687.09	R610.50	R512.94	R607.22	R554.23
Radiology	R1 433.70	R1 418.55	R1 427.33	R1 336.79	R1 331.27	R1 334.43
MSA amount paid per visit/event						
Medical Specialists	R134.36	R30.55	R88.99	R125.02	R27.20	R81.70
Surgical Specialists	R140.41	R38.17	R100.26	R128.15	R35.41	R91.53
Dental Specialists	R647.89	R62.88	R341.23	R590.82	R53.60	R302.70
Anaesthetists	R23.91	R13.61	R20.08	R23.59	R13.37	R19.74
Pathology	R133.63	R25.25	R87.06	R115.84	R25.87	R76.44
Radiology	R245.64	R32.42	R155.90	R216.53	R27.05	R135.55
Total amount paid per visit/event						
Medical Specialists	R995.85	R871.22	R941.39	R926.22	R801.05	R870.79
Surgical Specialists	R2 010.94	R1 610.34	R1 853.61	R1 847.72	R1 506.67	R1 713.05
Dental Specialists	R1 416.44	R887.83	R1 139.35	R1 334.19	R826.13	R1 061.71
Anaesthetists	R2 881.78	R2 344.55	R2 682.18	R2 681.57	R2 209.69	R2 503.97
Pathology	R686.41	R712.34	R697.55	R628.78	R633.09	R630.67
Radiology	R1 679.34	R1 450.97	R1 583.22	R1 553.32	R1 358.32	R1 469.99

Table 9 demonstrates the statistical distribution of the number of beneficiaries utilising healthcare services and amounts paid to specialist health providers in 2015. The large variation in the utilisation statistics is indicative of varying levels of benefit depth between medical schemes and benefit options. This is largely a function of benefit design, demographic profile of risk pools and the burden of disease.

TABLE 9: STATISTICAL DISTRIBUTION OF THE NUMBER OF BENEFICIARIES, VISITS AND AMOUNTS PAID TO SPECIALIST PROVIDERS IN 2015

Specialist Group	Indicator	Minimum	25th percentile	50th percentile	75th percentile	Maximum
Medical Specialists						
	Utilisation per 1 000 beneficiaries	33.33	126.25	173.36	261.88	628.68
	Utilisation per patient	1.78	2.09	2.47	4.65	9.23
	Risk amount paid per visit	R295.19	R759.33	R857.23	R997.74	R3 221.30
	MSA amount paid per visit	R0.01	R4.08	R37.71	R185.46	R607.99
	Total amount paid per visit	R402.95	R835.36	R960.94	R1 064.48	R3 222.08
Surgical Specialists						
	Utilisation per 1 000 beneficiaries	30.91	99.62	130.86	166.61	277.18
	Utilisation per patient	1.24	1.5	1.64	2.18	4.62
	Risk amount paid per visit	R119.01	R500.51	R769.44	R2 539.29	R4 751.93
	MSA amount paid per visit	R0.01	R11.02	R81.64	R210.31	R603.81
	Total amount paid per visit	R438.62	R680.23	R887.27	R2 586.98	R4 755.88
Dental Specialists						
	Utilisation per 1 000 beneficiaries	0.2	5.08	21.56	41.88	109.22
	Utilisation per patient	0.68	1.1	1.8	2.36	6.23
	Risk amount paid per visit	R0.83	R544.80	R861.59	R3 195.43	R5 864.99
	MSA amount paid per visit	R0.08	R86.22	R245.46	R467.99	R1 051.18
	Total amount paid per visit	R183.69	R964.31	R1 148.18	R3 400.90	R5 891.10
Anaesthetists						
	Utilisation per 1 000 beneficiaries	1.39	4.5	30.22	91.37	116.8
	Utilisation per patient	0.1	1.08	1.23	1.38	7.44
	Risk amount paid per visit	R78.52	R833.07	R2 046.80	R2 568.17	R4 128.67
	MSA amount paid per visit	R0.00	R8.93	R33.61	R120.49	R1 866.62
	Total amount paid per visit	R206.95	R1 232.31	R2 121.64	R2 599.14	R4 139.31
Pathology						
	Utilisation per 1 000 beneficiaries	5.58	148.18	267.04	370	449.18
	Utilisation per patient	1.58	1.97	2.31	3.29	5.28
	Risk amount paid per visit	R0.93	R426.07	R719.55	R871.32	R1 637.02
	MSA amount paid per visit	R0.04	R1.37	R21.56	R185.65	R404.87
	Total amount paid per visit	R170.05	R652.35	R759.41	R883.68	R1 637.17
Radiology						
	Utilisation per 1 000 beneficiaries	5.15	102.36	147.28	215.05	290.43
	Utilisation per patient	1.19	1.41	1.66	1.9	6.44
	Risk amount paid per visit	R280.72	R1 156.87	R1 475.05	R1 753.26	R3 501.98
	MSA amount paid per visit	R0.00	R2.70	R37.02	R182.99	R665.20
	Total amount paid per visit	R494.94	R1 343.22	R1 584.70	R1 802.02	R3 857.57

Utilisation of hospital services

Table 10 provides details of the utilisation of private hospital services for same-day and inpatient admissions by hospital category. Same-day cases in the report refers to a hospital confinement that ends within 24 hours, while inpatient admission refers to a hospital confinement longer than 24 hours. Work with the industry is ongoing to improve the definitions and coding of hospital data. Inpatient admissions have largely remained unchanged during the period under review. Most hospital admission statistics were higher for open schemes, except for maternity admissions. Admissions to provincial hospitals where significantly lower than the admissions to private hospitals. This may be due to benefit design, patient choice or the difficulty of provincial hospitals to successfully submit claims for payment to medical schemes or administrators. The analysis also shows the low usage of sub-acute facilities and day clinics. The use of the aforementioned facilities could have a positive impact the reduction of hospital costs.

TABLE 10: UTILISATION OF HOSPITAL FACILITIES IN 2014 AND 2015 (ADMISSION RATES)

Admission Type	2015			2014		
Hospital Category	Open	Restricted	All	Open	Restricted	All
Same-day inpatient admissions per 1 000 beneficiaries						
Sub-Acute Facilities	0.06	0.14	0.10	0.06	0.16	0.10
Provincial Hospitals	1.02	28.85	13.09	1.31	32.44	14.96
Private Hospitals ('A' - Status)	9.85	20.69	14.55	9.91	18.53	13.69
Private Hospitals ('B' - Status)	64.83	102.18	81.03	66.05	102.24	81.92
Private Hospitals ('A' & 'B' - Status)	74.68	122.87	95.58	75.96	120.77	95.61
Private Rehab Hospital (Acute)	0.01	0.01	0.01	0.01	0.00	0.01
Unattached Operating Theatres	0.06	0.06	0.06	0.08	0.05	0.07
Approved Day Clinics	12.85	8.45	10.95	11.56	7.57	9.81
Inpatient admissions per 1 000 beneficiaries						
Drug & Alcohol Rehab	1.06	0.78	0.94	1.05	0.74	0.91
Sub-Acute Facilities	2.35	3.02	2.64	2.25	3.24	2.68
Mental Health Institutions	4.22	4.05	4.15	3.83	3.91	3.86
Provincial Hospitals	1.16	3.59	2.21	1.09	4.59	2.62
Private Hospitals ('A' - Status)	18.46	26.64	22.01	17.31	29.15	22.50
Private Hospitals ('B' - Status)	154.03	137.46	146.84	150.27	138.51	145.11
Private Hospitals ('A' & 'B' - Status)	172.49	164.10	168.85	167.58	167.66	167.62
Private Rehab Hospital (Acute)	0.34	0.25	0.30	0.37	0.25	0.32
Hospices	0.27	0.23	0.25	0.29	0.26	0.28

Table 11 illustrates the average number of hospital days per year for different categories of hospital facilities. The average length of stay for private hospitals has remained under 4.5 days for the period under review, well below the international norms. This suggests that patients of low acuity are being systematically admitted to hospital. The average length of stay as reported by medical schemes for provincial hospitals is significantly higher than expected. This is likely to be more of a data quality issue that the actual practice. The other contributing factor is the low usage of provincial hospitals by beneficiaries. In 2015, there were 19 061 provincial hospital admissions compared to 1 456 877 in private hospitals ('A' and 'B' status). The provincial hospitals admissions data should therefore be interpreted with caution.

TABLE 11: UTILISATION OF HOSPITAL FACILITIES IN 2014 AND 2015: AVERAGE LENGTH OF STAY (ALOS)

Hospital Category	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Drug & Alcohol Rehab	11.76	14.74	12.83	11.81	15.90	13.27
Mental Health Institutions	10.89	11.72	11.24	11.29	12.22	11.70
Sub-Acute Facilities	10.04	9.76	9.91	9.30	9.11	9.20
Provincial hospitals	6.55	11.51	10.04	7.21	16.37	14.24
Private Hospitals ('A' - Status)	3.76	4.02	3.89	3.79	3.95	3.88
Private Hospitals ('B' - Status)	4.10	4.52	4.27	4.18	4.60	4.36
Private Hospitals ('A' & 'B' - Status)	4.07	4.44	4.22	4.14	4.49	4.29
Hospices	7.64	29.49	16.21	5.90	36.27	18.41

Table 12 and Table 13 illustrate the average length of stay and admission rates per year for different admission categories across hospital facilities. The admission rate and average length of stay for all hospitals, though slightly higher when compared to statistics for facilities listed in Table 10, are consistent with the previously reported figures.

TABLE 12: INPATIENT (≥ 24 HOURS) ACROSS ALL HOSPITAL TYPES BY ADMISSION CATEGORY IN 2014 AND 2015

Hospital Admission Category	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Inpatient admissions for medical cases						
Admission rate per 1 000 beneficiaries	114.32	149.84	129.75	109.07	153.99	128.86
Average Length of Stay	4.82	4.97	4.89	4.82	5.43	5.15
Inpatient admissions for surgical cases						
Admission rate per 1 000 beneficiaries	68.23	15.33	45.26	65.06	16.87	43.84
Average Length of Stay	3.96	3.99	3.96	3.88	3.78	3.86
Inpatient admissions for maternity cases						
Admission rate per 1 000 female beneficiaries	27.42	26.60	27.06	27.02	30.11	28.42
Average Length of Stay	2.73	2.63	2.69	2.73	2.69	2.71
Inpatient admissions for all hospital cases						
Admission rate per 1 000 beneficiaries	196.41	179.26	188.96	187.76	186.79	187.33
Average Length of Stay	4.37	4.70	4.51	4.34	5.05	4.65

TABLE 13: SAME-DAY INPATIENT (< 24 HOURS) ACROSS ALL HOSPITAL TYPES BY ADMISSION CATEGORY IN 2014 AND 2015

Hospital Admission Category	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Admission rate per 1 000 beneficiaries						
Ambulatory cases	3.22	1.98	2.68	3.15	2.05	2.66
Emergency room visits	8.73	8.84	8.78	8.44	8.65	8.53
Medical cases	18.68	140.28	71.50	18.20	144.91	74.01
Surgical cases	66.51	16.46	44.77	64.73	13.69	42.25
Maternity cases	0.44	1.60	0.96	0.40	0.73	0.55
All same-day inpatient cases	85.42	157.58	116.76	83.13	158.99	116.54

Table 14 illustrates the average length of stay and admission rates per year level of care across hospital facilities. As expected, admissions to the general ward were the highest, remaining largely unchanged between 2014 and 2015, at 169.80 and 170.75 per 1 000 beneficiaries, respectively.

The median number of hospital admissions in respect of PMB conditions remained unchanged between 2014 and 2015 at about 102 per 1 000 beneficiaries. The accuracy of PMB admissions data is a major challenge as scheme rules and systems are not set up to separate PMB from non-PMB admissions. The logic generally advanced by medical schemes is that there is no business incentive to identify claims related to PMBs when the rules of the scheme provide for the payment of all authorised hospital admissions, PMB or not. Work to improve the quality of PMB admissions data is ongoing.

About 22% of beneficiaries who were admitted to hospital during the period under review get re-admitted within 90 days of the first admission. The re-admission is not necessarily related to the first admission. The repeat admission rate is an important indicator of quality in hospital care services.

Death statistics is another area that needs improvement. The number of deaths decreased to 10.71 in 2015 from 12.79 in 2014. Currently, it is not possible to collect data on deaths that occur shortly after the patient is discharged from hospital. The CMS will work with the medical schemes to improve the quality of data related to deaths.

TABLE 14: HOSPITAL ADMISSIONS BY LEVEL OF CARE AND OTHER OUTCOMES 2014 AND 2015

	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Average number of General Ward admissions (per 1 000 beneficiaries)	170.57	170.97	170.75	171.94	167.12	169.80
Average length of stay for General Ward admissions	3.78	4.13	3.93	3.80	4.12	3.94
Average number of High Care admissions (per 1 000 beneficiaries)	25.15	20.09	22.92	24.31	19.11	22.00
Average length of stay for High Care admissions	3.47	3.96	3.66	3.50	3.98	3.68
Average number of ICU admissions (per 1 000 beneficiaries)	10.80	9.32	10.15	10.62	8.28	9.58
Average length of stay for ICU admissions	5.08	5.04	5.06	5.08	5.69	5.31
Average number of hospital outpatient visits (per 1 000 beneficiaries)	122.66	102.42	113.75	118.31	94.54	107.75
Median number of PMB related admissions (per 1 000 beneficiaries)	104.51	99.58	101.92	96.24	104.19	101.97
Average number of repeat admissions (90 days) (per 1 000 beneficiaries)	297.52	115.27	220.99	289.08	113.91	214.93
Number of hospital deaths (per 1000 beneficiaries)	10.10	11.54	10.71	11.18	14.98	12.79

Utilisation of medical technology

Table 15 provides an overview of the utilisation of medical technology. The numbers remained largely unchanged during the period under review. The utilisation of MRI scans, angiograms, bone density scans and dialysis services is generally higher in open medical schemes than in restricted schemes. The restating of the 2014 figures of the utilisation of medical technology statistics nearly doubled the number of beneficiaries receiving computed tomography (CT) scans. This trend is maintained in 2015. The trend in the utilisation of CT scans will be monitored to confirm the correctness of the data.

TABLE 15: UTILISATION OF MEDICAL TECHNOLOGY IN 2014 AND 2015

	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Number of utilising beneficiaries per 1 000 beneficiaries						
PET scans	0.41	0.20	0.32	0.34	0.19	0.27
Angiograms	1.76	0.71	1.31	1.64	0.61	1.19
Renal dialysis services	6.42	3.95	5.38	5.53	3.65	4.73
Bone density scans	7.38	4.29	6.01	7.32	4.32	5.96
MRI scans	28.49	19.01	24.28	26.24	17.91	22.49
CT scans	48.67	33.71	42.02	45.95	32.19	39.74

Utilisation of screening, preventative, child, maternal and reproductive healthcare services

This section gives an account on the utilisation of screening, child, maternal and reproductive health services. Most of the indicators in this section were introduced as a new data part for the first time in the 2015 Healthcare Utilisation Annual Statutory Returns. This data therefore has many data quality shortcomings as a significant number of schemes were not able to adjust their systems to submit this data to the CMS by the due date. These results must be interpreted with caution. The aim of the data part is to align indicators collected by the CMS with those collected by the National Department of Health. This will allow for the benchmarking in the level of access and quality of care received by beneficiaries of medical schemes.

Table 16 illustrates preventive services for female beneficiaries. The number of birth admissions dropped from the restated 27.1 per 1 000 female beneficiaries in 2014 to 26.4 per 1 000 female beneficiaries in 2015. Birth admissions were equally distributed between open and restricted schemes in 2015.

The number of live births showed a marginal drop in 2015 to about 880.27 per 1 000 birth admissions.

Caesarean sections performed increased from restated 667.46 in 2014 to 674.81 per 1 000 birth admissions in 2015. The number of caesarean section procedures performed was slightly higher in restricted schemes compared to open schemes.

The number of births to female beneficiaries under 15 years of age remained unchanged at 0.6 per 1 000 female beneficiaries in this age group. Medical schemes previously reported a rate of 2.0 per female beneficiaries in the under 15 years of age group.

The number of births to female beneficiaries between 15 and 19 years of age decreased from 14.63 per 1 000 female beneficiaries in 2013 to 13.50 in 2014. There were 17.33 and 9.43 births per 1 000 female beneficiaries aged between 15 and 19 years in restricted and open schemes, respectively, for 2015.

The number of mammograms that medical schemes paid for in respect of female beneficiaries aged 50 to 69 years decreased marginally from 286.98 to 286.59 per 1 000 female beneficiaries in this age group from 2014 to 2015, respectively.

The number of pap smear procedures paid for in 2014 was 161.58 per 1 000 female beneficiaries aged 15 to 69 years compared to 166.00 in the previous year. Open schemes reported higher rates of utilisation for pap smear procedures than restricted schemes.

TABLE 16: MATERNAL HEALTH COVERAGE

	2015			2014		
	Open	Restricted	All	Open	Restricted	All
Number of birth admissions (per 1 000 female beneficiaries)	26.32	26.62	26.46	26.8	27.47	27.10
Total number of live births (per 1 000 births)	839.42	931.90	880.27	846.00	945.47	890.65
Number of caesarean sections performed (per 1 000 female beneficiaries)	646.91	708.49	674.81	642.17	697.00	667.46
Number of birth admissions to women under 15 years (per 1 000 female beneficiaries aged under 15 years)	0.56	0.59	0.58	0.48	0.62	0.55
Number of birth admissions to women between 15–19 years (per 1 000 female beneficiaries aged 15–19 years)	9.43	17.33	13.50	9.78	19.07	14.63
Number of mammograms paid (per 1 000 female beneficiaries aged 50–69 years)	320.43	237.14	286.59	313.45	248.07	286.98
Number of pap smears paid for (per 1 000 female beneficiaries aged 15–69 years)	172.25	147.88	161.58	175.41	154.08	166.00
Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15–49 years (per 1 000 female beneficiaries aged 15–49 years)	7.98	6.7	7.41	7.78	6.88	7.37
Surgical procedure to protect a woman from further pregnancy (count)	6 939	2 178	9 117	6 651	2 412	9 063
Surgical procedure to prevent a man from being fertile (count)	4 723	1 420	6 143	4 383	1 474	5 857
Subdermal contraceptive implant inserted just under the skin of a woman aged 15–49 years' upper arm (per 1 000 female beneficiaries aged 15–49 years)	0.07	0.15	0.11	0.12	0.2	0.16

Trends in the contraceptive, child health services, immunisation, eye care, mental health, cancer care, HIV and TB care and malaria care coverage are shown in Annexure E. A relatively small number of schemes was able to submit adequate data for these indicators. These results should therefore be interpreted with caution.

Resources

The distribution and availability of human resources is the cornerstone of health policy in the South African policy context. One of the policy issues identified by the Draft National Health Insurance (NHI) white paper, is the impact that the distribution of human resources for health has on access to quality healthcare for all. The availability or lack of health resources where people live and work, can either improve or impair access to appropriate care when it is needed.

In the NHI environment there is a role for public-private partnerships, and participating private providers will have to register with the Office of Health Standards and Compliance. It is within this context that the distribution of healthcare providers in the private sector becomes more important for the future health policy environment. The distribution of human resources for healthcare also has implications for provincial trends in healthcare utilisation within the current private medical schemes industry.

This section provides a high-level description of the availability of different types of healthcare providers, and their distribution across the provinces of South Africa.

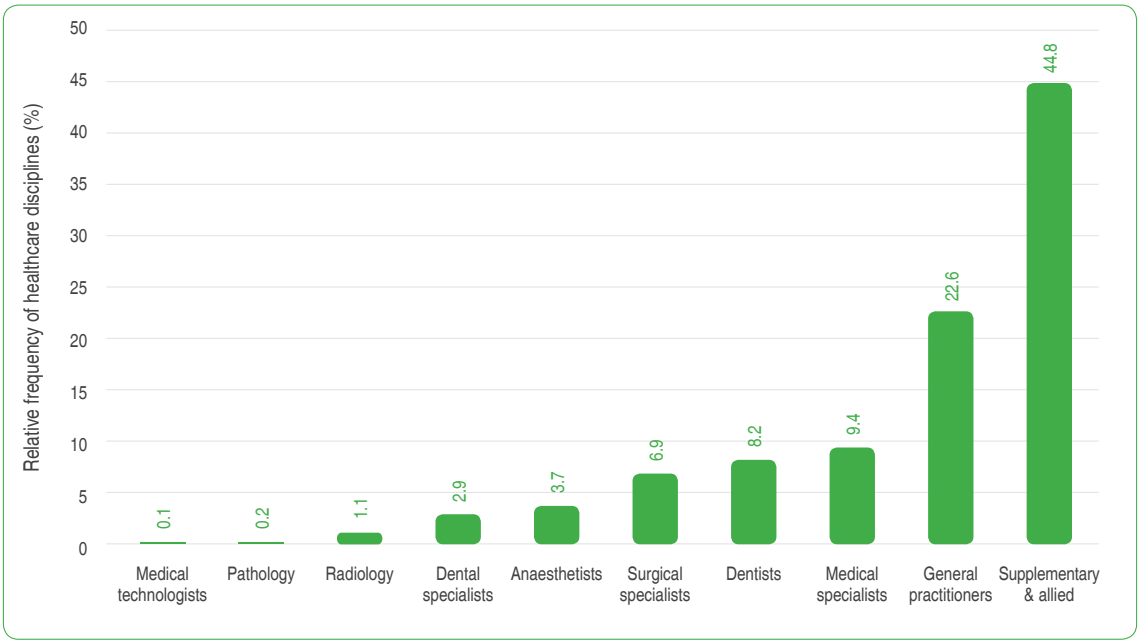
The provider data presented are sourced from annual healthcare utilisation statutory return. The data on private sector providers are based on providers who have claimed from medical schemes in 2015. Thus the counts do not reflect the full population of private sector health resources. For the first time, the CMS has collected data on claiming provider practices. Some schemes were not able to provide Health Professional Council of South Africa (HPCSA) practice numbers. With time, this should improve. The number of general practitioners per 10 000 beneficiaries (Table 28) are based on practice number counts and not HPCSA numbers per discipline.

Private sector

The structure of human resources for health

Figure 25 shows the make-up of human resources for health that claimed from medical schemes in 2015. Out of all health disciplines, supplementary and allied health professionals are the most prevalent (44.8%). They are followed by general practitioners at 22.6%. The third largest group are medical specialists at 9.4%. Surgical specialists make up 6.9% of all healthcare professionals in the private sector. Anaesthetists are the sixth largest group and make up 3.7% of all human health resources.

FIGURE 25: RELATIVE FREQUENCY OF HEALTHCARE DISCIPLINES (2015)



Provincial distribution of beneficiaries and healthcare disciplines

Figures 26 to 35 describe the provincial distribution of beneficiaries relative to healthcare disciplines that claimed from medical schemes in 2015. A common feature in these figures is that Gauteng, KwaZulu-Natal and the Western Cape share a high proportion of claiming healthcare disciplines, relative to their proportion of beneficiaries.

FIGURE 26: RELATIVE DISTRIBUTION OF REGISTERED NURSES AND BENEFICIARIES (2015)

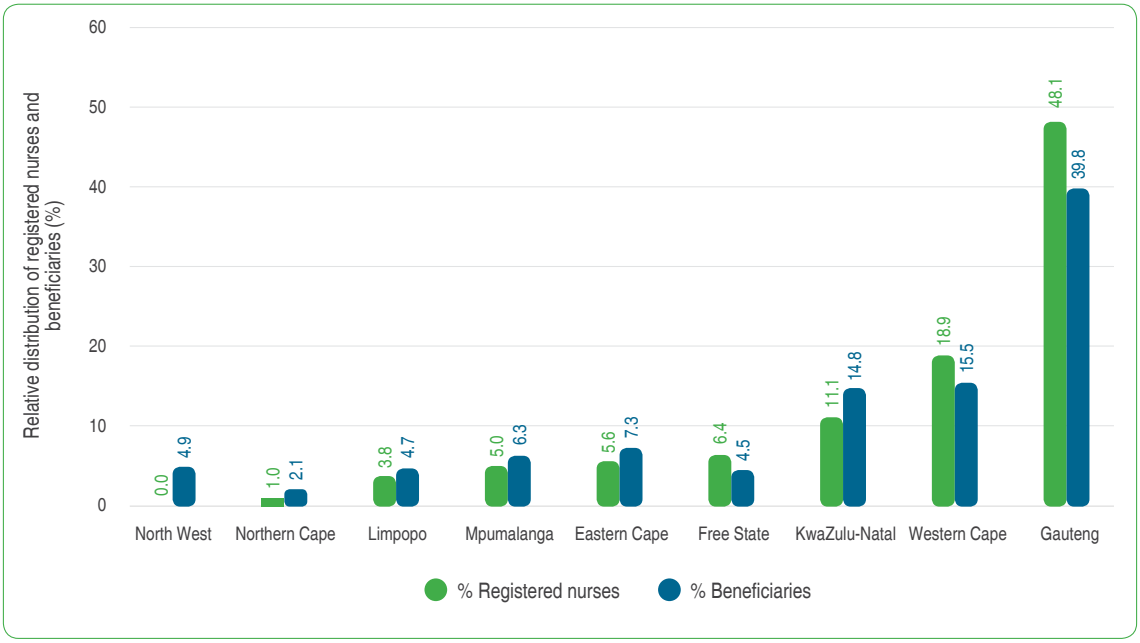


FIGURE 27: RELATIVE DISTRIBUTION OF SUPPLEMENTARY AND ALLIED HEALTH PROFESSIONALS AND BENEFICIARIES (2015)

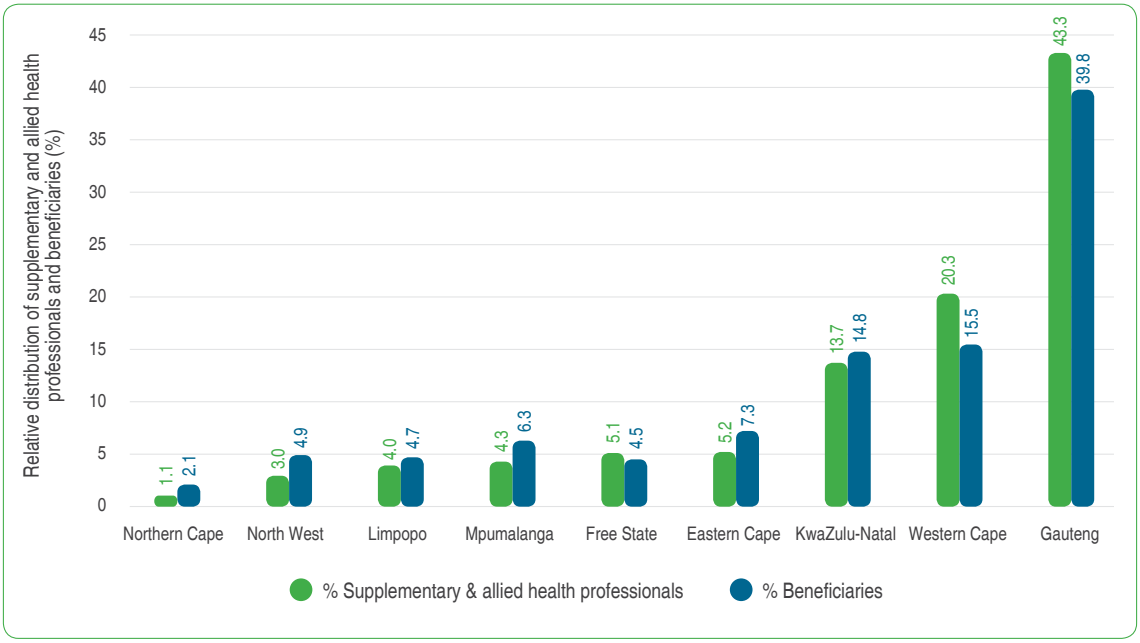


FIGURE 28: RELATIVE DISTRIBUTION OF AUDIOLOGISTS AND SPEECH THERAPISTS AND BENEFICIARIES (2015)

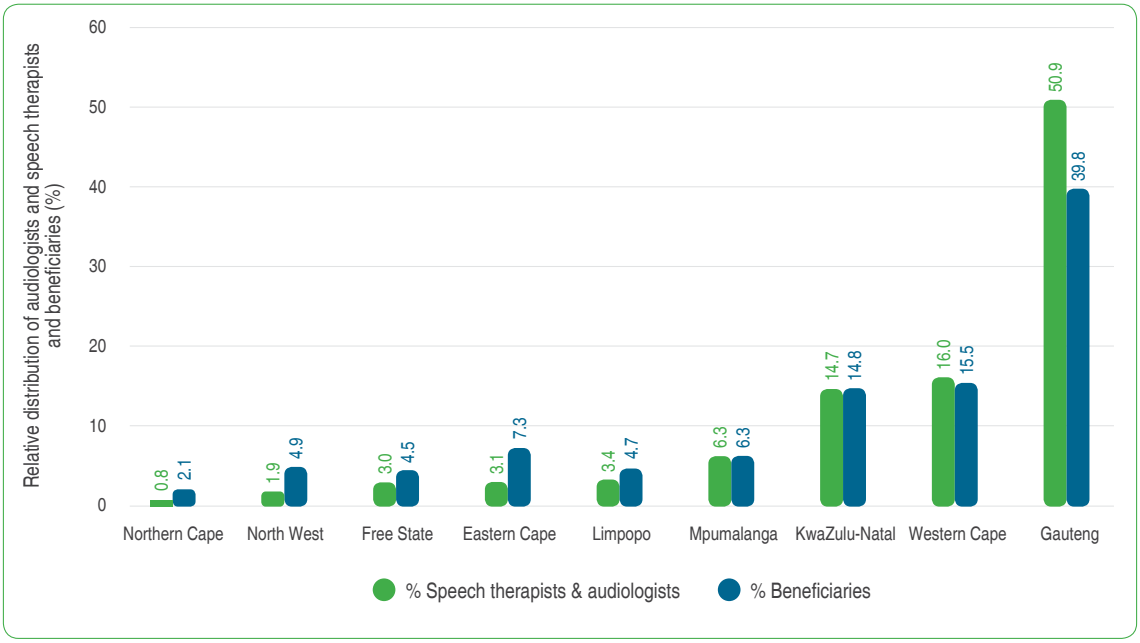


FIGURE 29: RELATIVE DISTRIBUTION OF OCCUPATIONAL THERAPISTS AND BENEFICIARIES (2015)

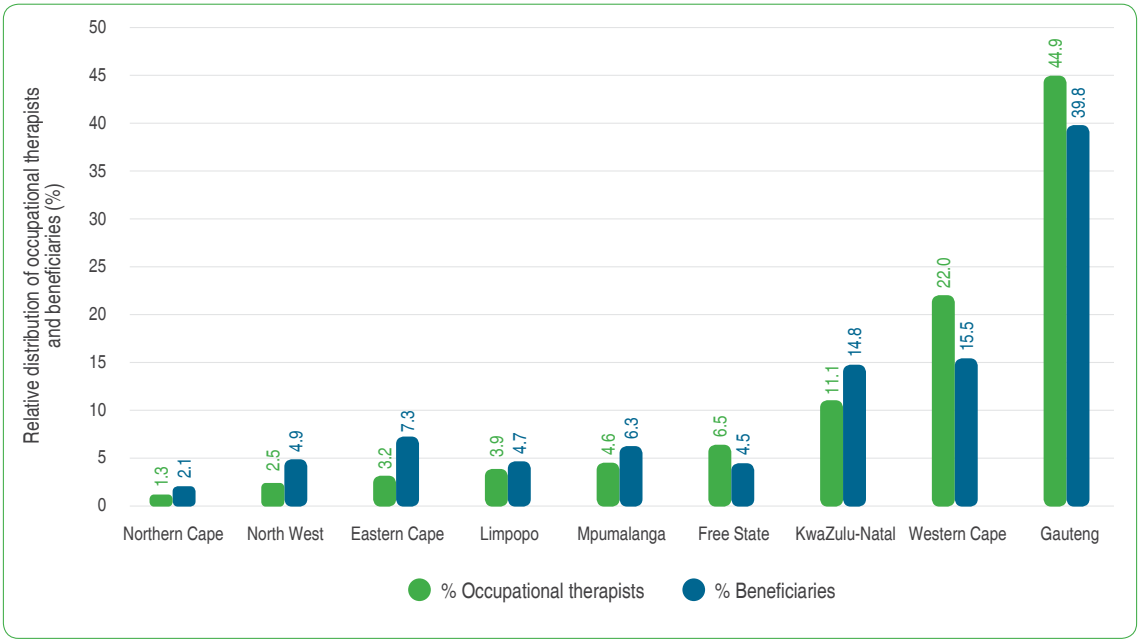


FIGURE 30: RELATIVE DISTRIBUTION OF GPS AND BENEFICIARIES (2015)

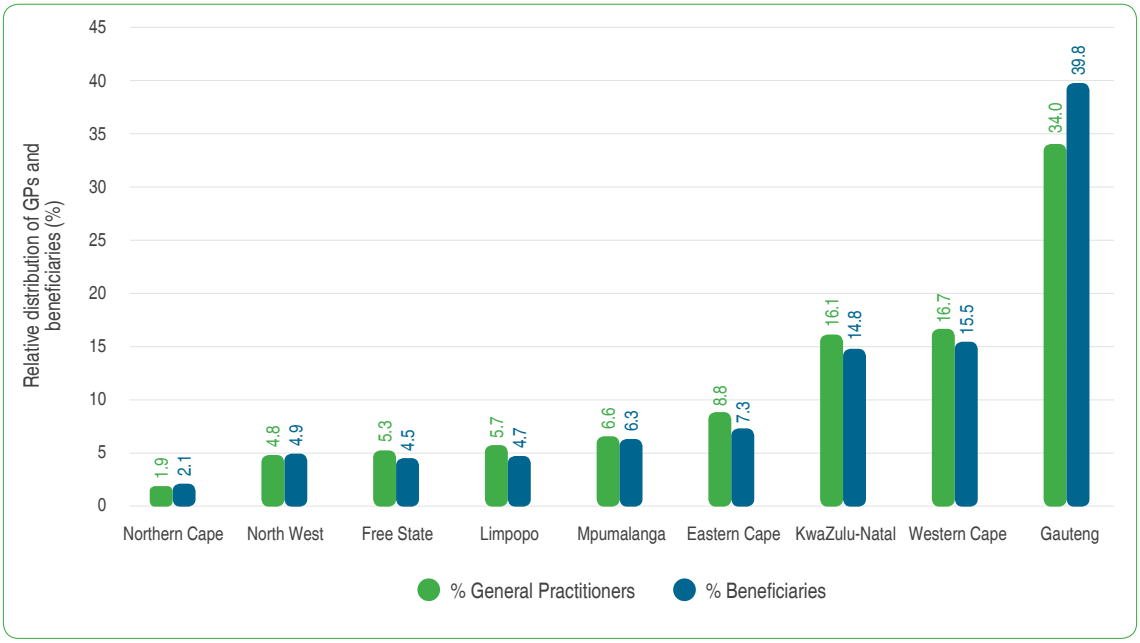


Table 17 shows the count of GPs and their availability per 10 000 beneficiaries across the nine provinces. The highest count GP practices are in Gauteng (4 246), with 13 GP practices per 10 000 beneficiaries. There are 14 GP practices per 10 000 beneficiaries in the total medical schemes industry.

TABLE 17: GENERAL PRACTITIONERS PER 10 000 BENEFICIARIES (2015)

Province	GP headcount	GPs per 10 000 beneficiaries
Eastern Cape	1 008	16
Free State	649	17
Gauteng	4 248	13
KwaZulu-Natal	1 806	15
Limpopo	740	18
Mpumalanga	812	15
Northern Cape	223	12
North West	548	11
Western Cape	1 934	15
Total	**11 966**	**14**

FIGURE 31: RELATIVE DISTRIBUTION OF MEDICAL SPECIALISTS AND BENEFICIARIES (2015)

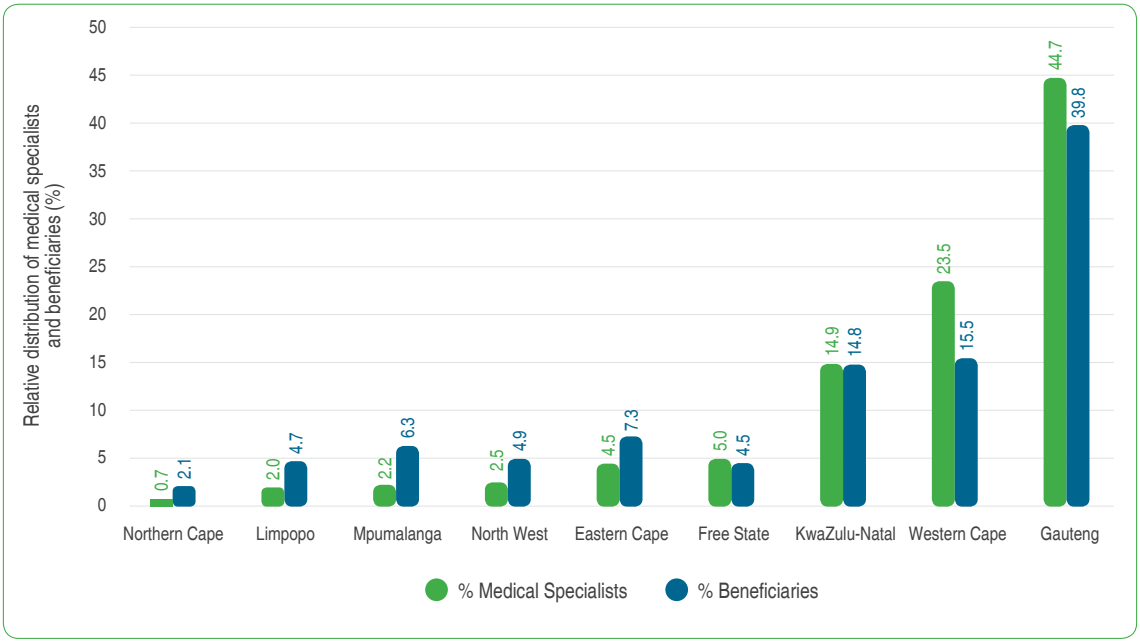


FIGURE 32: RELATIVE DISTRIBUTION OF SURGICAL SPECIALISTS AND BENEFICIARIES (2015)

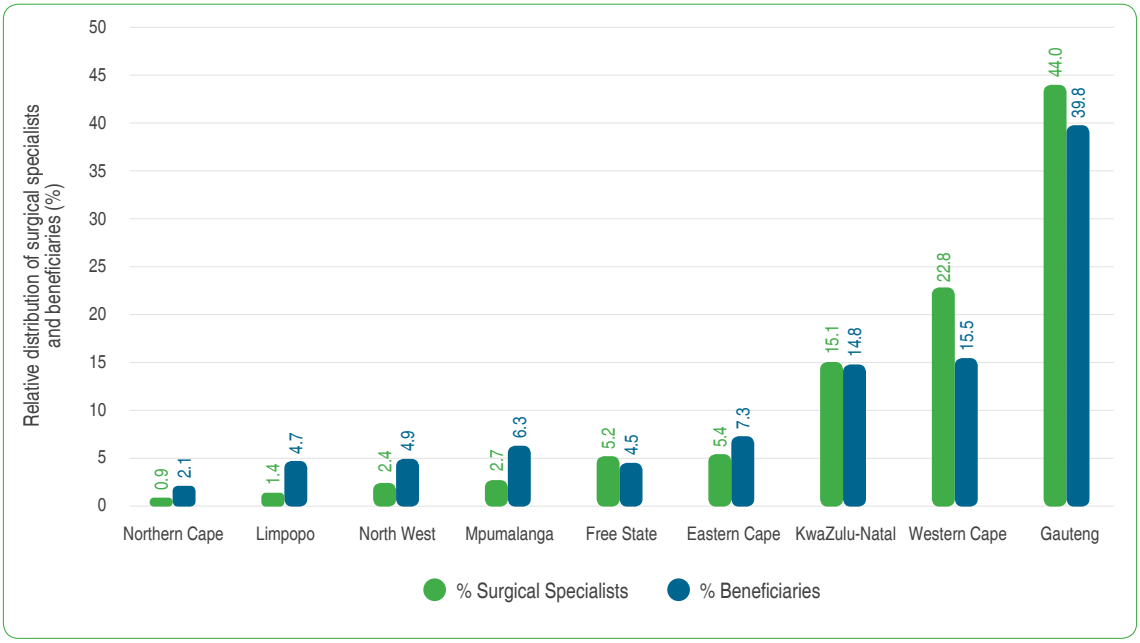


FIGURE 33: RELATIVE DISTRIBUTION OF RADIOLOGISTS AND BENEFICIARIES (2015)

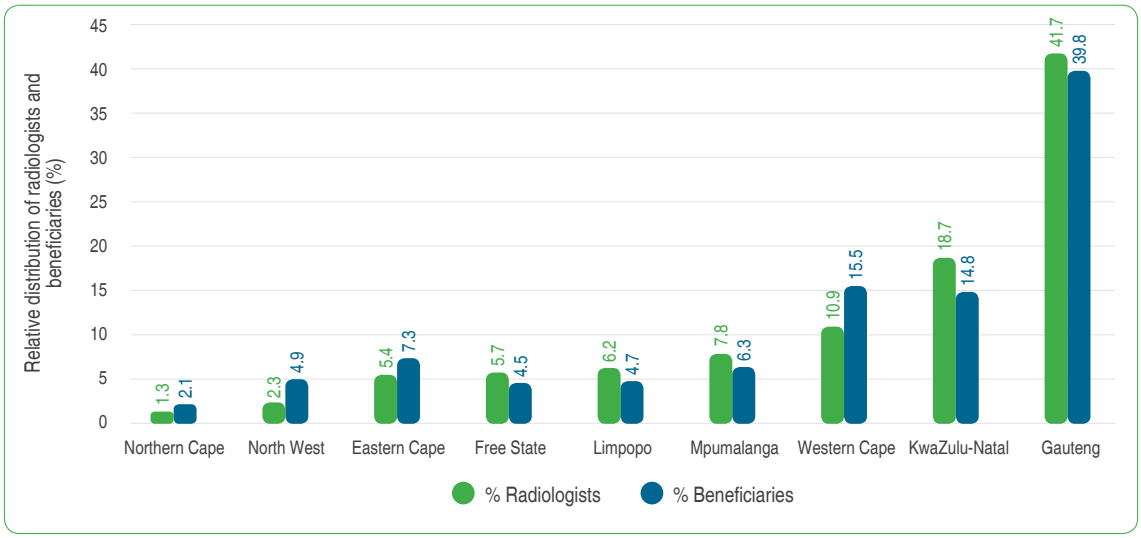


FIGURE 34: RELATIVE DISTRIBUTION OF PATHOLOGISTS AND BENEFICIARIES (2015)

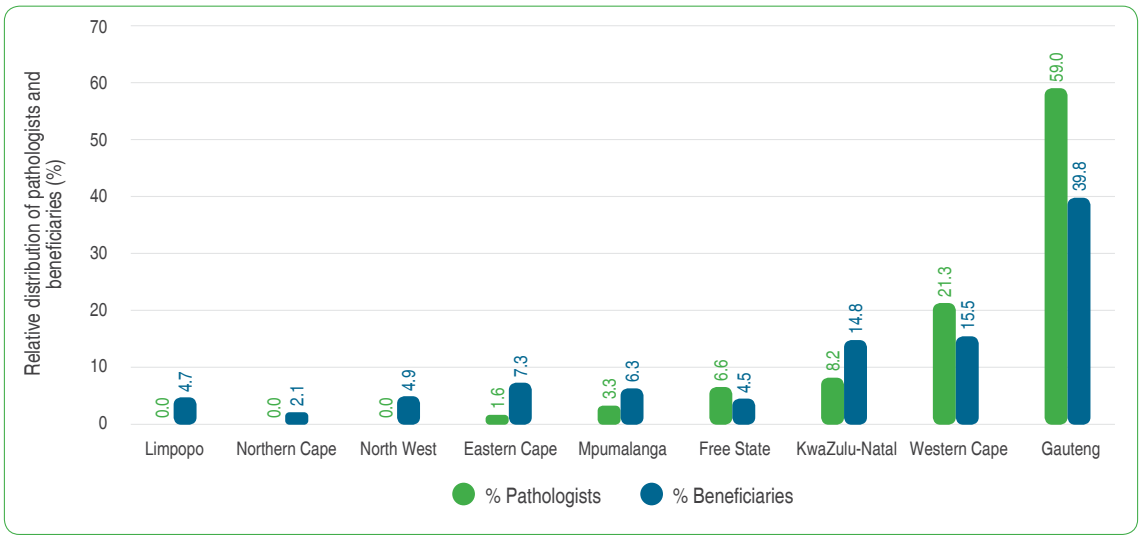
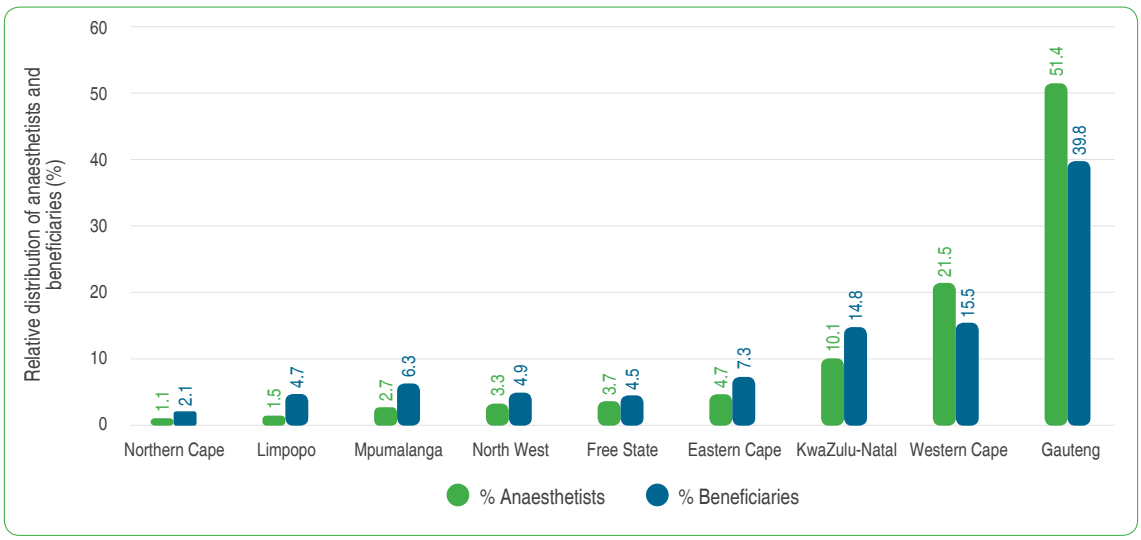


FIGURE 35: RELATIVE DISTRIBUTION OF ANAESTHETISTS AND BENEFICIARIES (2015)



Significant observations

Some provinces have higher proportions of healthcare providers than their proportion of beneficiaries in the medical schemes industry. Although this is largely co-dependent on the distribution of medical scheme membership across provinces, it may have a negative impact on the ability to access services in other provinces.

This is significant in the light of the Draft NHI White Paper recommendations. The policy seeks to enable equal access to health services to all South Africans. Central to its policy is its Human Resources for Health Strategy. It intends to augment resource deficiencies through innovative contracting arrangements with the private sector. This will no doubt have an impact on the availability of private sector health resources for primary healthcare.

An example of this is the NHI's primary healthcare re-engineering platform which focuses on access to registered nurses at ward level. This will also include better access to audiologists and speech therapists through the Integrated School Health Programme.

This may have an implication on funding vested in secondary and tertiary healthcare interventions. Utilisation will be shifted from some levels of health delivery to other points of healthcare contact.

Future healthcare policy interventions will have implications on the access and distribution of primary healthcare resources in the private sector, and the scope of complementary services provided by medical schemes.

As we approach the implementation phases of NHI, the following will become relevant:

- The distribution of primary care healthcare professionals as private providers seek to participate in the NHI; and
- The need for medical schemes to have provider networks spread evenly to reduce hurdles to accessing complementary benefits.

The global picture

Table 18 provides indicators of physician availability per 10 000 population reported in the World Health Statistics Report 2015. The global ratio of physicians per 10 000 population is 13.9. South Africa's ratio is less than that of other BRIC countries. This continues to raise concerns about the overall health system's performance and equity objectives, especially within the current context of health systems reforms for the NHI implementation.

TABLE 18: GLOBAL COMPARISON OF PHYSICIANS PER 10 000 POPULATION (2015)

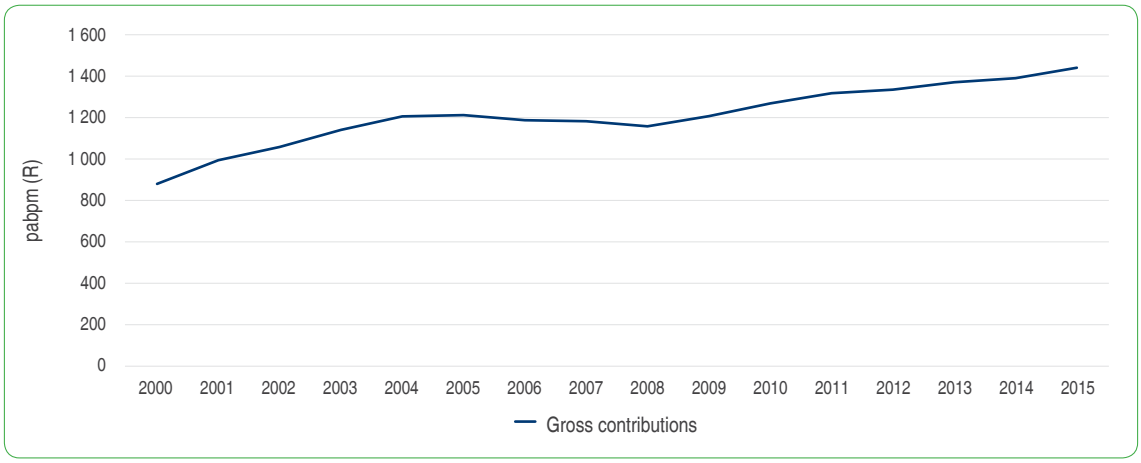
Global trends	Physicians per 10 000 population
Global	13.9
Upper middle income countries	16.1
BRICS countries:	
South Africa	7.8
India	7.0
China	14.9
Brazil	18.9
Russia	Not available
African region	2.7

Source: World Health Statistics Report 2015.
Note: Physician in this context means all medically trained doctors (professional qualification) regardless of specialisation.

Contributions, relevant healthcare expenditure[4] and trends

Contributions

FIGURE 36: GROSS CONTRIBUTIONS 2000–2015 (2015 PRICES)



pabpm = per average beneficiary per month

Since 2000, gross contributions per average beneficiary per month[5] (pabpm) have increased by 63.5%, as depicted in Figure 36, while gross relevant healthcare expenditure increased by 67.8% – see Figure 37. This has assisted the industry to cover increasing healthcare costs, build reserves and retain members. However, increasing costs have also had the impact on affordability of medical schemes.

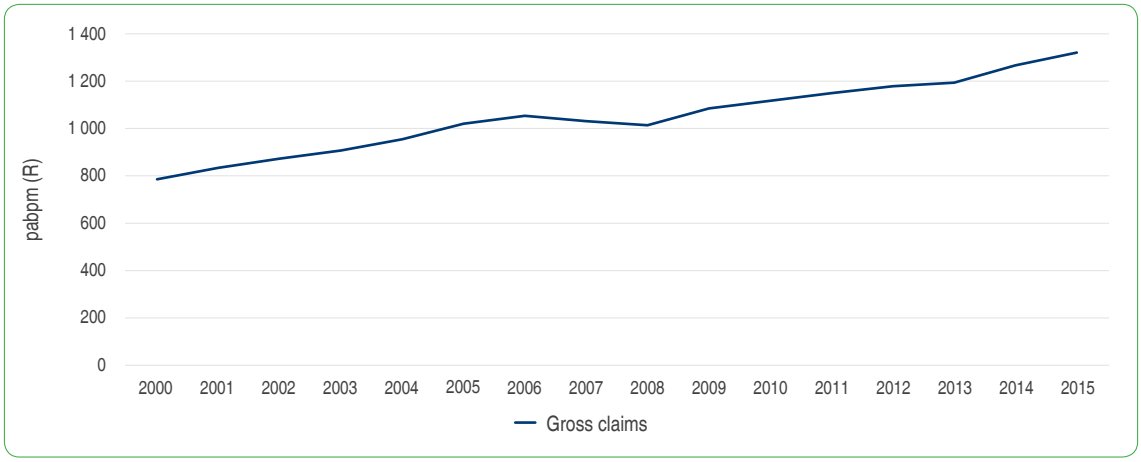
Scheme contributions increased by 8.1% to R151.6 billion as at December 2015 from R140.2 billion in December 2014. Gross contributions pabpm rose by 8.3% to R1 439.8 from R1 329.8 in 2014.

Risk contributions (excluding medical savings accounts contributions) increased by 7.7% to R136.7 billion from R126.9 billion in 2014. The equivalent increase from 2013 to 2014 was 7.8%. The increase in risk contributions pabpm was 7.9%, rising to R1 298.5 from R1 203.9. The 2014 increase was 7.4%.

Contributions to medical savings accounts increased by 12.1% to R14.9 billion from R13.3 billion (2014: 10.1% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 9.8% – from R150.4 to R165.2. During 2014 the increase was substantially higher at 30.6%; a number of schemes introduced savings on existing options.

Relevant healthcare expenditure

FIGURE 37: GROSS RELEVANT HEALTHCARE EXPENDITURE 2000–2015 (2015 PRICES)



pabpm = per average beneficiary per month

4 *All references to claims and benefits indicate relevant healthcare expenditure.*

5 *Adjusted for inflation, 2015 prices.*

The total gross relevant healthcare expenditure incurred by medical schemes increased by 8.9% to R138.9 billion[6] from R127.6 billion in 2014. The total gross relevant healthcare expenditure incurred pabpm increased by 9.0% to R1 319.2 from R1 210.3 in 2014. It should be noted that this year's claims figures as well as the comparative figure for 2014 include accredited managed care services as stipulated in Circular 56 of 2015.

Risk claims increased by 8.4% to R125.0 billion from R115.3 billion in 2014. Risk claims pabpm rose by 8.5% to R1 186.6 from R1 093.5.

Claims paid from medical savings accounts increased by 13.4% to R14.0 billion from R12.3 billion (2014: 10.4% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 32.6% to R155.0 from R116.9 (2014: 9.7% increase). The higher increase, together with the increase experienced in contributions to savings accounts, seem to suggest a move towards benefit designs which requires a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Table 19 and Figures 38 and 39 show contributions and claims for open and restricted schemes pabpm.

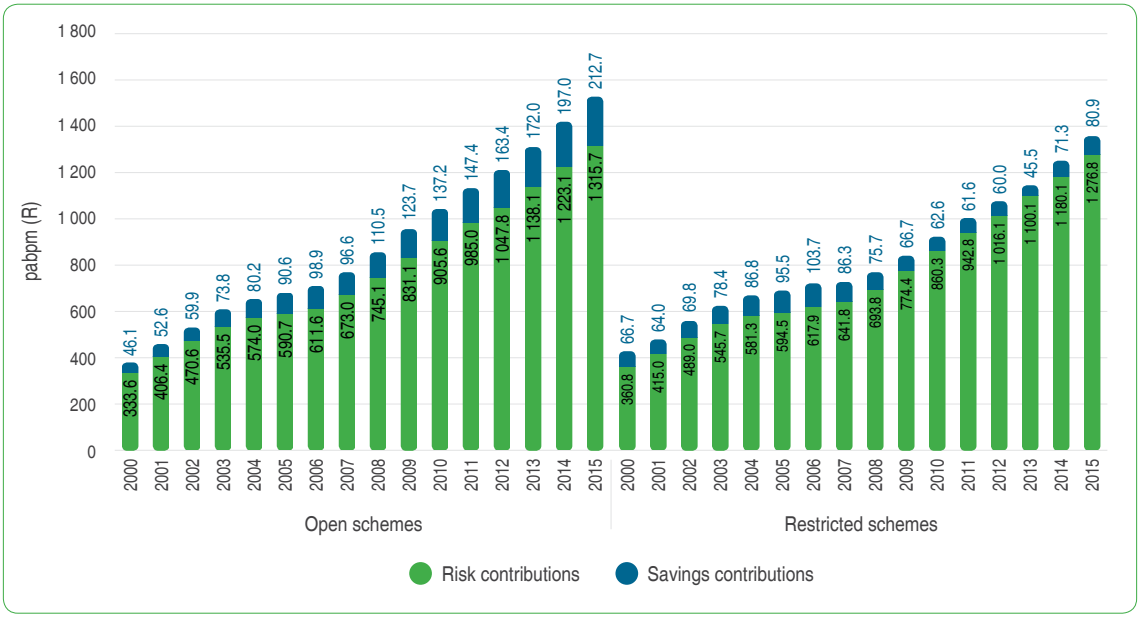
TABLE 19: CONTRIBUTIONS AND RELEVANT HEALTHCARE EXPENDITURE PABPM 2000–2015

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	333.6		46.1		292.4		41.3	
2001	406.4	21.8	52.6	14.1	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	13.9	379.3	14.5	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.8	77.5	13.6
2006	611.6	3.5	98.9	9.2	522.9	8.0	95.9	23.7
2007	673.0	10.0	96.6	-2.3	562.1	7.5	91.6	-4.5
2008	745.1	10.7	110.5	14.4	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
2011	985.0	8.8	147.4	7.4	831.8	8.4	139.8	6.9
2012	1 047.8	6.4	163.4	10.9	884.9	6.4	153.6	9.9
2013	1 138.1	8.6	172.0	5.3	953.2	7.7	160.5	4.5
2014	1 223.1	7.5	197.0	14.5	1 073.5	12.6	175.8	9.5
2015	1 315.7	7.6	212.7	8.0	1 167.4	8.7	202.4	15.1
Restricted schemes								
2000	360.8		66.7		333.1	8.3	58.8	
2001	415.0	15.0	64.0	-4.0	360.9		57.9	-1.5
2002	489.0	17.8	69.8	9.1	417.9	15.8	60.3	4.1
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.4
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.7
2005	594.5	2.3	95.5	10.0	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.2
2007	641.8	3.9	86.3	-16.8	595.7	2.3	75.7	-18.4
2008	693.8	8.1	75.7	-12.3	638.0	7.1	66.2	-12.5
2009	774.4	11.6	66.7	-11.9	727.3	14.0	61.7	-6.8
2010	860.3	11.1	62.6	-6.1	785.1	7.9	57.5	-6.8
2011	942.8	9.6	61.6	-1.6	842.0	7.2	55.6	-3.3
2012	1 016.1	7.8	60.0	-2.6	932.8	10.8	53.6	-3.6
2013	1 100.1	8.3	45.5	-24.2	988.8	6.0	40.6	-24.3
2014	1 180.1	7.3	71.3	56.7	1 118.3	13.1	43.8	7.9
2015	1 276.8	8.2	80.9	13.5	1 211.1	8.3	70.9	61.9

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

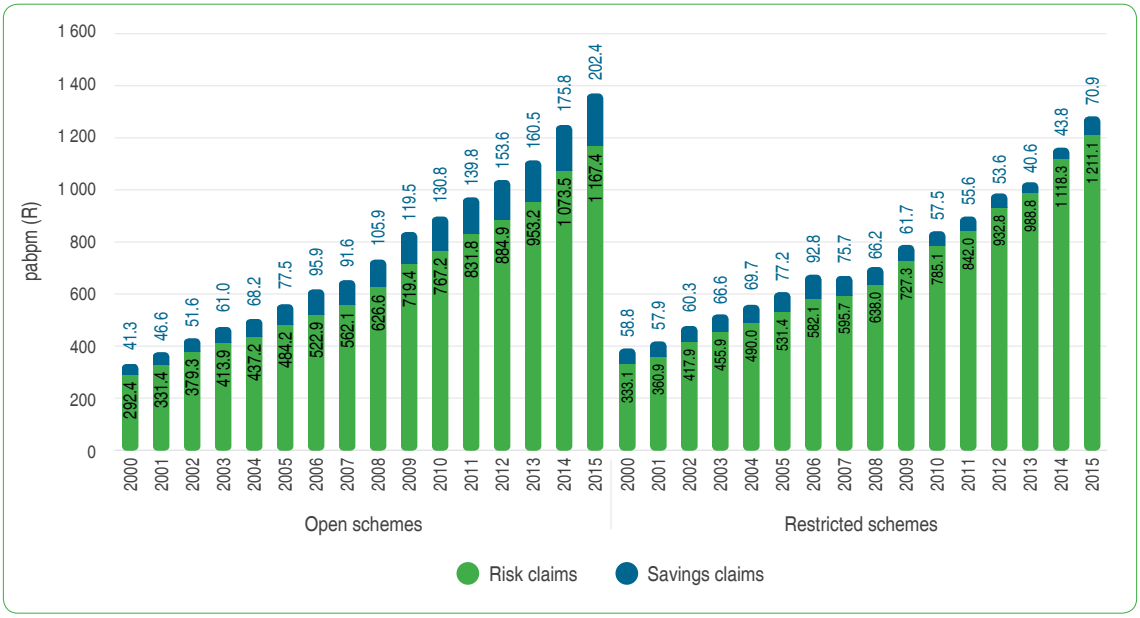
6 *This number differs from the R124.1 billion reported above as "benefits paid" include IBNR and the results of risk transfer arrangements in this section.*

FIGURE 38: RISK AND SAVINGS CONTRIBUTIONS PABPM 2000–2015



pabpm = per average beneficiary per month

FIGURE 39: RISK AND SAVINGS CLAIMS PABPM 2000–2015



pabpm = per average beneficiary per month

On average, increases in risk contributions and claims pabpm were slightly lower in restricted schemes than in open schemes over the past 15 years. This is partly because restricted schemes generally have higher reserve levels compared to open schemes, thus availing resources for cushioning of increasing healthcare costs. The risk claims ratio in open schemes increased to 88.7% in 2015 from 87.8% in 2014; in restricted schemes it increased to 94.9% from 94.8% in 2014.

Circular 56 of 2015 clarified that all accredited managed healthcare services (as specified in Circular 13 of 2014) should be included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate (evidence-based medicine) healthcare benefits to beneficiaries of medical schemes. This resulted in schemes restating their 2014 figures:

- The open schemes' risk ratio increased from 85.0% to 87.8%;
- The restricted scheme industry average increased from 92.4% to 94.8%; and
- The total schemes' risk ratio increased from 88.2% to 90.8%.

FIGURE 40: RISK AND MEDICAL SAVINGS ACCOUNTS CONTRIBUTIONS AND CLAIMS PABPM 2000–2015

pabpm = per average beneficiary per month

Figure 40 and Table 20 show that between 2003 and 2006 medical savings account contributions and claims increased at greater rates than those recorded for the risk components.

But the figures for the period 2007–2013 appear to reflect a change in this trend. In 2000, savings contributions made up 12.8% of gross contributions. At the end of 2013, savings had declined to 9.3% of gross contributions. The decrease is partly attributable to a decision of the CMS not to allow variable savings rates on an option, which resulted in a number of medical schemes no longer offering savings plan accounts.

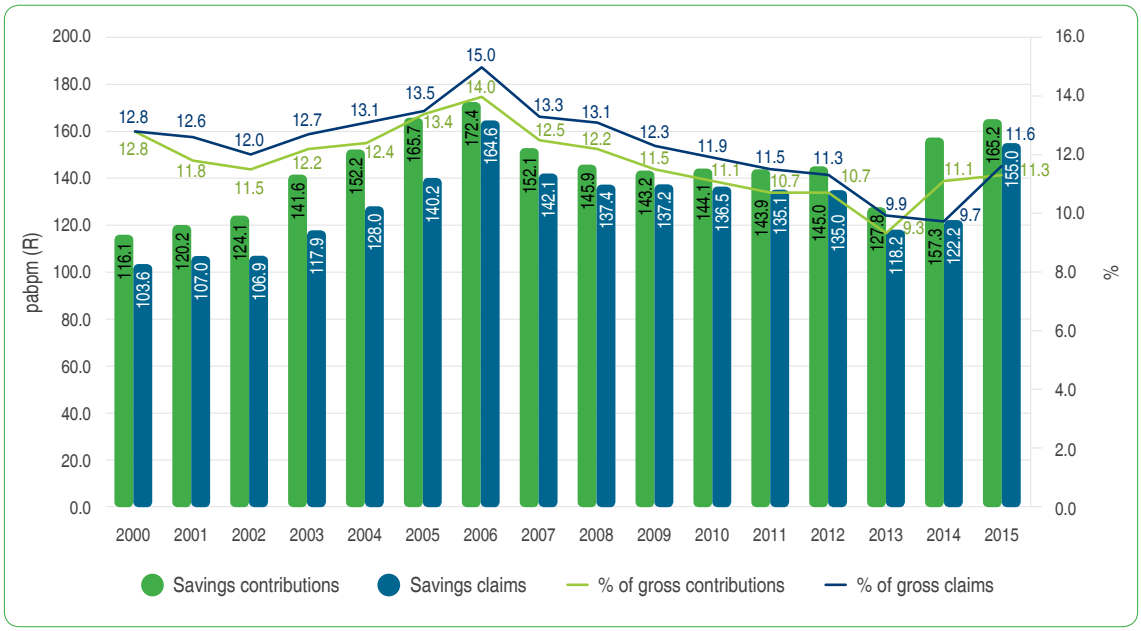
Savings contributions experienced a large increase in 2014 of 23.1% and savings claims a large increase of 26.8% in 2015. This is partly due to a number of schemes introducing savings on existing options, and is indicative of a move towards benefit designs which requires a greater proportion of benefits to be funded out of members' personal savings accounts than from the general risk pool of the scheme.

TABLE 20: CONTRIBUTIONS AND RELEVANT HEALTHCARE EXPENDITURE PABPM 2000–2015: 2015 PRICES

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
2000	791.6		116.1		706.5		103.6	
2001	895.3	13.1	120.2	3.5	744.9	5.4	107.0	3.3
2002	954.5	6.6	124.1	3.2	783.0	5.1	106.9	-0.1
2003	1 020.9	7.0	141.6	14.1	808.2	3.2	117.9	10.3
2004	1 076.2	5.4	152.2	7.5	845.5	4.6	128.0	8.6
2005	1 070.7	-0.5	165.7	8.9	900.4	6.5	140.2	9.5
2006	1 059.6	-1.0	172.4	4.0	932.1	3.5	164.6	17.4
2007	1 068.6	0.8	152.1	-11.8	924.9	-0.8	142.1	-13.7
2008	1 050.4	-1.7	145.9	-4.1	912.4	-1.4	137.4	-3.3
2009	1 096.7	4.4	143.2	-1.9	979.6	7.4	137.2	-0.1
2010	1 153.4	5.2	144.1	0.6	1 007.3	2.8	136.5	-0.5
2011	1 197.3	3.8	143.9	-0.1	1 035.9	2.8	135.1	-1.0
2012	1 212.2	1.2	145.0	0.8	1 062.9	2.6	135.0	-0.1
2013	1 243.4	2.6	127.8	-11.9	1 075.2	1.2	118.2	-12.4
2014	1 258.8	1.2	157.3	23.1	1 143.3	6.3	122.2	3.4
2015	1 298.5	3.2	165.2	5.0	1 186.6	3.8	155.0	26.8

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

FIGURE 41: MEDICAL SAVINGS ACCOUNTS CONTRIBUTIONS AND CLAIMS PABPM 2004–2015: 2015 PRICES



pabpm = per average beneficiary per month

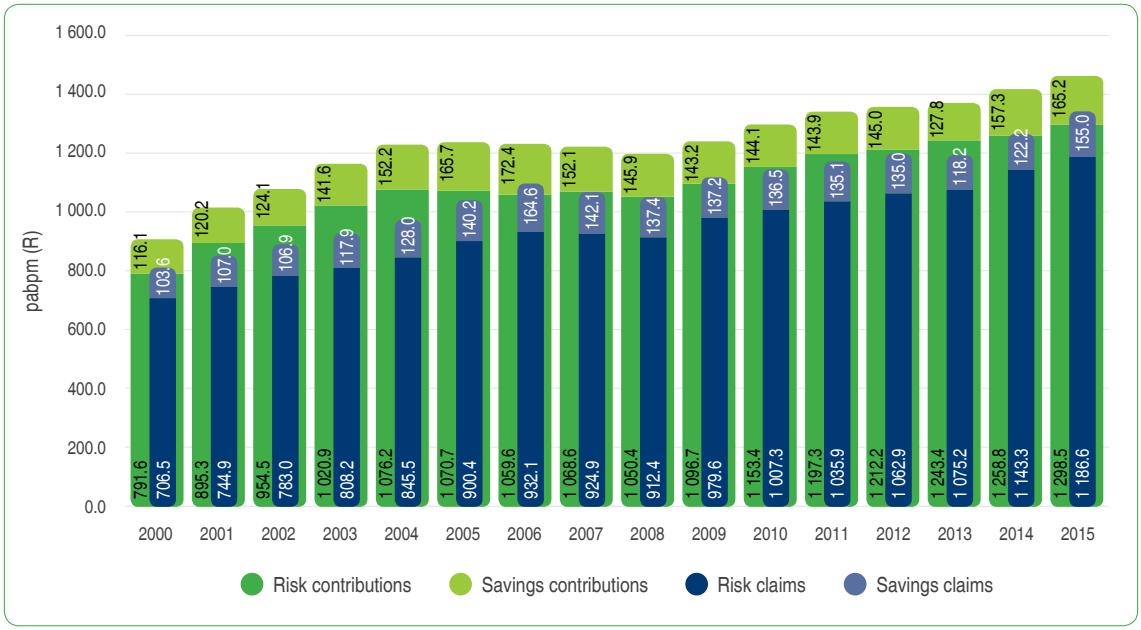
The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure dropped slightly to 9.7% in 2014 but again increased to 11.6% in 2015, as shown in Figure 41.

For open schemes, the proportion of claims paid from medical savings accounts increased from 14.1% in 2014 to 14.8% in 2015; the medical savings accounts claims ratio increased to 95.2% from 89.2% in 2014.

For restricted schemes, the proportion of claims paid from medical savings accounts increased from 3.8% in 2014 to 5.5% in 2015. The medical savings accounts claims ratio increased to 87.6% from 61.4% in 2014.

Figure 42 shows the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 64.0% and 68.0% respectively, on a pabpm basis. In addition, medical savings account contributions and claims have risen by 42.3% and 49.6% respectively.

FIGURE 42: RISK AND MEDICAL SAVINGS ACCOUNTS CONTRIBUTIONS AND CLAIMS PABPM 2000–2015 (2015 PRICES)



pabpm = per average beneficiary per month

Figure 43 shows the relationship between risk contributions and claims paid over the past decade. All figures have been adjusted for inflation.

FIGURE 43: RISK CLAIMS RATIO FOR ALL SCHEMES 2000–2015 (2015 PRICES)

pabpm = per average beneficiary per month

After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised to 86.6% in 2007 and 86.9% in 2008. There was an increase in 2009, followed by a decrease over the next two years to 86.5% in 2011. In 2012 there was a slight increase from the previous year, with medical schemes paying out 87.7% of risk contributions in benefits. In 2013 the claims ratio decreased to 86.5%, and has since risen again in 2014 to 90.8% and in 2015 to 91.4%.

FIGURE 44: SEASONALITY OF CLAIMS PER MONTH IN 2015

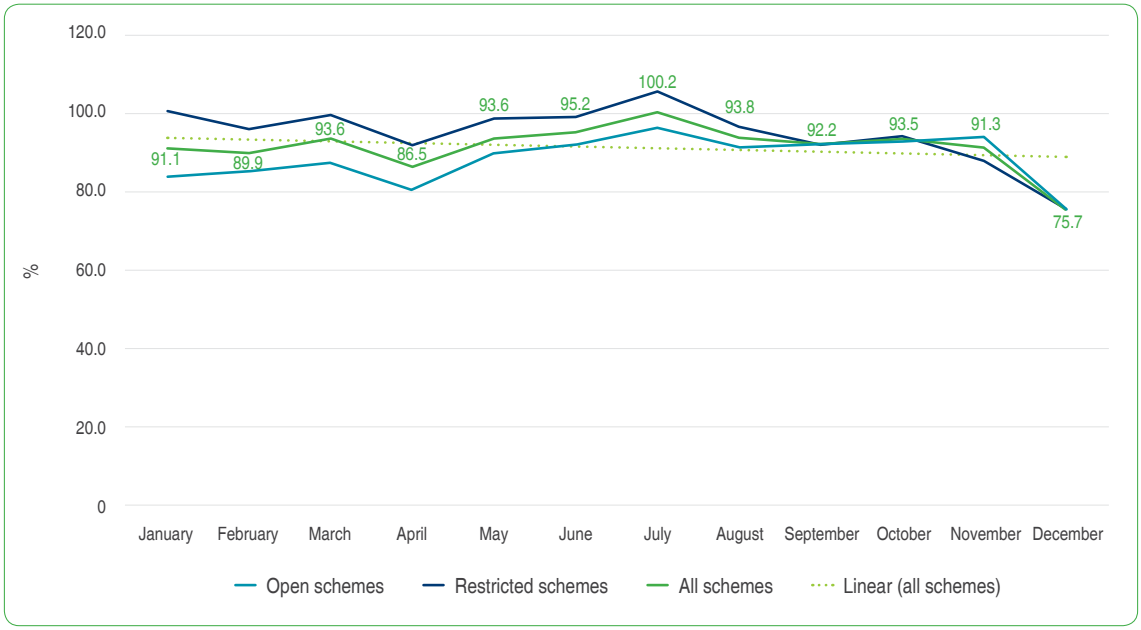


Figure 44 shows the seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2015. Both open and restricted schemes follow the same general trend: an increase in claims in the first quarter of the year as members gain access to new benefits, increases in claims over the winter months, and a downward trend in the last quarter of the year.

Risk transfer arrangements

Over the past few years, medical schemes have increasingly resorted to risk transfer arrangements to manage their insurance risks. Table 21 reflects the main components of such arrangements:

- The capitation fees which schemes paid to third parties to manage their risks.
- The estimated costs which schemes would have incurred had they not used risk transfer arrangements.
- The net effect thereof.

The 'net income/(expense)' column reflects the value derived from the risk transfer arrangement. (Annexure Z provides further details.)

TABLE 21: SIGNIFICANT RISK TRANSFER ARRANGEMENTS 2014 AND 2015

	Capitation fees			Estimated recoveries			Net income/(expense)*		
	2015 R'000	2014 R'000	% growth	2015 R'000	2014 R'000	% growth	2015 R'000	2014 R'000	% growth
Open schemes	2 035 516	2 001 917	1.7	1 900 516	1 883 763	0.9	(133 453)	(89 922)	-48.4
Restricted schemes	1 040 302	1 036 582	0.4	1 180 012	1 221 269	-3.4	145 371	191 448	-24.1
All	**3 075 818**	**3 038 498**	**1.2**	**3 080 528**	**3 105 032**	**-0.8**	**11 918**	**101 526**	**-88.3**

** The net income/(expense) on risk transfer arrangements includes an amount of R7.2 million in respect of profit- and loss-sharing agreements.*

Table 22 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 23 details the 10 benefit options which reported the greatest losses.

TABLE 22: SCHEMES WITH HIGHEST RISK TRANSFER ARRANGEMENT LOSSES 2015

Ref. no.	Name of medical scheme	Beneficiaries 31 Dec 2015	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	654 384	764 795	650 233	(115 304)	-15.1
1486	Sizwe Medical Fund	125 366	59 112	7 207	(51 906)	-87.8
1167	Momentum Health	248 172	298 810	247 057	(51 281)	-17.2
1087	Keyhealth	76 210	73 809	66 649	(7 776)	-10.5
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	45 897	22 124	17 597	(4 528)	-20.5
1583	Platinum Health	98 919	16 519	13 785	(2 734)	-16.6
1422	Topmed Medical Scheme	51 113	23 534	21 218	(2 315)	-9.8
1430	Remedi Medical Aid Scheme	46 815	9 813	7 774	(2 039)	-20.8
1293	Wooltru Healthcare Fund	19 520	22 573	20 499	(1 787)	-7.9
1039	MBMed Medical Aid Fund	9 721	9 443	7 672	(1 771)	-18.8

TABLE 23: OPTIONS WITH HIGHEST RISK TRANSFER ARRANGEMENT LOSSES 2015

Ref. no.	Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2015	Average age per beneficiary Years	Capitation fees R'000	Estimated recoveries R'000	Profit/(loss) sharing R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	Standard	320 896	33.0	518 041	442 843	(516)	(75 713)	-14.6
1167	Momentum Health	Custom	105 189	31.0	99 391	40 703	151	(58 537)	-58.9
1125	Discovery Health Medical Scheme	Classic Comprehensive	376 774	38.7	126 167	72 133	-	(54 034)	-42.8
1486	Sizwe Medical Fund	Gomomo Care Option	11 240	27.9	59 112	7 207	-	(51 906)	-87.8
1167	Momentum Health	Ingwe	43 343	26.8	82 805	65 266	132	(17 407)	-21.0
1512	Bonitas Medical Fund	Bonsave	72 764	27.4	58 344	41 043	-	(17 302)	-29.7
1512	Bonitas Medical Fund	Primary	157 835	27.4	127 289	113 555	(225)	(13 958)	-11.0
1125	Discovery Health Medical Scheme	Essential Comprehensive	40 810	43.1	13 327	7 386	-	(5 941)	-44.6
1512	Bonitas Medical Fund	Boncap	59 492	32.8	20 623	14 788	-	(5 835)	-28.3
1125	Discovery Health Medical Scheme	Executive	25 149	41.6	9 876	5 836	-	(4 040)	-40.9

Bonitas Medical Fund is listed in both Tables 22 and 23 as the biggest loss-maker.

The Sizwe Medical Fund Gomomo Care option suffered the biggest loss in terms of the percentage of capitation fees paid (87.8%) followed by the Custom option from Momentum Health (58.9%), as shown in Table 23.

Accredited managed healthcare services (no transfer of risk)

Accredited managed healthcare services increased by 7.3% to R3.5 billion in 2015 from R3.3 billion in 2014. In 2015, 8 698 133 beneficiaries (or 98.7% of all beneficiaries) were covered by these managed healthcare arrangements.

TABLE 24: ACCREDITED MANAGED HEALTHCARE SERVICE FEES (NO TRANSFER OF RISK) FOR OPTIONS WITH A CLAIMS RATIO ABOVE 100% (2015)

Scheme type	Accredited managed healthcare services fees (no transfer of risk)		Risk claims		Beneficiaries	Number of options
	R'000	pmpm	R'000	% of RCI		
Open schemes	104 989	75.5	4 594 127	114.9	210 264	22
Restricted schemes	164 205	70.4	9 113 017	115.9	383 229	35
All schemes	**269 194**	**72.3**	**13 707 144**	**115.5**	**593 493**	**57**

pmpm = per member per month
RCI = risk contribution income

Table 24 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare services. There were 57 options in this category, and they accounted for 6.8% of beneficiaries in respect of whom such expenditure was incurred.

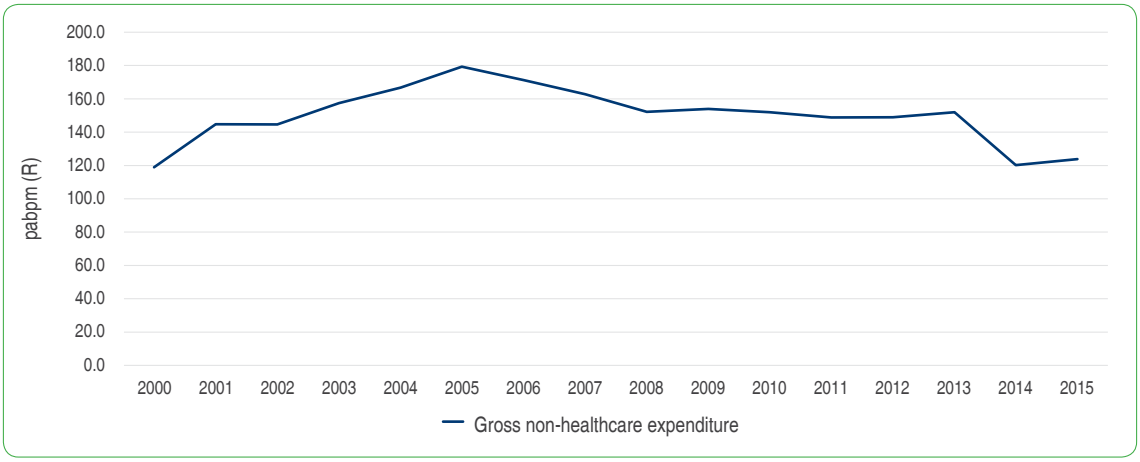
TABLE 25: ACCREDITED MANAGED HEALTHCARE SERVICES (NO TRANSFER OF RISK) OF 10 LARGEST SCHEMES (2015)

Ref. no.	Name of medical scheme	Type	Average beneficiaries	Claims ratio	Accredited managed healthcare services as % of RCI
1125	Discovery Health Medical Scheme	Open	2 663 054	86.1	3.3
1598	Government Employees Medical Scheme (GEMS)	Restricted	1 771 786	95.7	2.3
1512	Bonitas Medical Fund	Open	654 190	94.1	2.9
1580	South African Police Service Medical Scheme (POLMED)	Restricted	492 221	95.4	1.7
1167	Momentum Health	Open	240 822	86.2	2.6
1279	Bankmed	Restricted	210 929	96.4	2.4
1149	Medihelp	Open	203 659	88.5	2.0
1252	Bestmed Medical Scheme	Open	196 466	91.3	2.5
1140	Medshield Medical Scheme	Open	159 452	94.7	1.9
1202	Fedhealth Medical Scheme	Open	144 054	91.2	2.3

Table 25 depicts the 10 largest schemes (by number of average beneficiaries) and shows their total expenditure on managed healthcare services. The industry average was 2.6% of risk contribution income.

Non-healthcare expenditure

FIGURE 45: GROSS NON-HEALTHCARE EXPENDITURE: 2015 PRICES



pabpm = per average beneficiary per month

The non-healthcare[7] expenditure of medical schemes consists mainly of administration expenditure, commissions and service fees paid to brokers, other distribution costs and impaired receivables.

Given the substantial increases in non-healthcare expenditure observed between 2000 and 2005 (which exceeded the rate of increase in contributions), non-healthcare spending has consistently been a key focus for the CMS. Overall these costs have reduced in real terms but there are still individual schemes and particular non-health spending items – such as advertising and marketing, consulting and legal fees, and trustee remuneration – that continue to show upward trends and thus require attention. In recent years, the remuneration of trustees and Principal Officers of medical schemes, has come under the spotlight, with increases being significantly higher than inflation, as well as the expenditure on Annual General Meeting (AGM) costs. In the interests of member protection, it is important that such expenditure is associated with a discernible value proposition.

7 *Prior to Circular 56 of 2015 and the subsequent restatement of the 2014 and 2015 figures, non-healthcare expenditure also included managed healthcare management services (fees for managing health benefits). Non-accredited services have subsequently been included in administration expenditure as administration expenditure: benefit management services.*

Administration expenditure

Administration expenditure, being the largest component of non-healthcare expenditure in all medical schemes, grew by 7.4% to R11.0 billion between December 2014 (when it stood at R10.2 billion) and December 2015. Open schemes increased their administration expenditure by 6.7% to R7.4 billion from R7.0 billion in 2014. Administration in restricted schemes increased by 9.0% from R3.4 billion in 2014 to R3.6 billion in 2015.

Ten open schemes (representing 4.1% of all average beneficiaries) and nine restricted schemes (representing 6.3% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of Gross Contribution Income (GCI) in 2015.

Table 26 shows 'high-impact'[8] open schemes with administration expenditure greater than 10% of GCI. A high percentage is sometimes the function of a low average contribution rather than high absolute administration costs.

TABLE 26: HIGH-IMPACT OPEN SCHEMES WITH ADMINISTRATION EXPENDITURE ABOVE 10% OF GCI (2015)

Ref. no.	Name of scheme	Average number of beneficiaries	Administration expenditure as % of GCI
1141	Spectramed	33 062	12.8
1446	Selfmed Medical Scheme	13 638	10.7
1575	Resolution Health Medical Scheme	45 575	10.3

GCI = Gross Contribution Income

Table 27 shows high-impact open schemes with administration expenditure above the open schemes industry average of R126.3 pabpm. When excluding self-administered schemes, this average increases to R127.3 pabpm. In some instances, high percentage increases may be the result of low average contributions. Relative to the open schemes industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

TABLE 27: HIGH-IMPACT OPEN SCHEMES WITH ADMINISTRATION EXPENDITURE ABOVE THE OPEN SCHEMES' INDUSTRY AVERAGE FOR 2015

Ref. no.	Name of scheme	Average beneficiaries	Administration expenditure pabpm R
1141	Spectramed	33 062	223.7
1446	Selfmed Medical Scheme	13 638	190.6
1149	Medihelp	203 659	154.8
1202	Fedhealth Medical Scheme	144 054	151.5
1087	Keyhealth	75 724	151.4
1575	Resolution Health Medical Scheme	45 575	149.8
1576	Liberty Medical Scheme	113 063	143.8
1486	Sizwe Medical Fund	126 822	141.7
1537	Hosmed Medical Aid Scheme	72 242	135.0

pabpm = per average beneficiary per month

Table 28 shows the gross administration fees paid to third-party administrators as well as administration fees paid by self-administered medical schemes. These fees are the sum of administration fees, co-administration fees, and other indirect fees paid to the administrator.

8 *Refer to the section on the Risk Assessment Framework (RAF) on p. xxx*

TABLE 28: ADMINISTRATION FEES PAID TO THIRD-PARTY ADMINISTRATORS PABPM 2014 AND 2015

Administration fees	Open schemes			Restricted schemes		
	2015 pabpm R	2014 pabpm R	% variance	2015 pabpm R	2014 pabpm R	% variance
Third party						
Administration fees	114.5	103.8	10.3	50.1	46.4	8.0
Co-administration fees	-	-	-	8.2	6.5	26.2
Total	**114.5**	**103.8**	**10.3**	**54.2**	**49.6**	**9.3**
Self administered						
Administration fees	-	-	-	-	-	-
Co-administration fees	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

pabpm = per average beneficiary per month

On average, third-party-administered open schemes spent 111.3% more per beneficiary on administration fees than third-party-administered restricted schemes (2014: 109.3%).

Administration and co-administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE). They grew by 6.9% to R8.3 billion in 2015 from R7.7 billion in the previous year. These fees represented 83.8% of GAE in 2015 (2014: 82.3%).

Fees of trustees and principal officers

Remuneration and other considerations of trustees and principal officers accounted for 0.6% and 0.9% of GAE respectively. In 2015, the fees of principal officers amounted to 0.6% of GAE in open schemes (2014: 0.6%) and 1.4% in restricted schemes (2014: 1.4%).

Table 29 and Figure 46 shows the 10 schemes with the highest average fees for trustees. More details are contained in Annexure V. Figure 47 then shows the breakdown of trustee remuneration for the 10 schemes with the highest remuneration.

Table 30 shows the 10 schemes with the highest principal officer fees. More details are contained in Annexure V.

TABLE 29: TEN SCHEMES WITH HIGHEST TRUSTEE FEES (2015)

Ref. no.	Name of medical scheme	Type	Trustee remuneration and other considerations		No. of trustees		Average fee per trustee		% change
			2015 R'000	2014 R'000	2015	2014	2015 R'000	2014 R'000	2015_ 2014
1598	Government Employees Medical Scheme (GEMS)	Restricted	7 161	8 924	12	17	597	525	13.7
1125	Discovery Health Medical Scheme	Open	4 037	3 717	6	6	673	619	8.6
1140	Medshield Medical Scheme	Open	3 810	225	7	6	544	38	1 351.4
1512	Bonitas Medical Fund	Open	3 524	3 869	10	9	352	430	-18.0
1202	Fedhealth Medical Scheme	Open	3 457	3 610	11	13	314	278	13.2
1486	Sizwe Medical Fund	Open	3 431	248	11	10	312	25	1 160.3
1491	Compcare Wellness Medical Scheme	Open	3 405	2 197	8	10	426	220	93.7
1194	Profmed	Restricted	2 861	2 400	10	10	286	240	19.2
1576	Liberty Medical Scheme	Open	2 684	2 928	8	8	335	366	-8.3
1279	Bankmed	Restricted	2 599	2 448	14	13	186	188	-1.4

FIGURE 46: AVERAGE TRUSTEE FEES: TEN SCHEMES WITH HIGHEST TRUSTEE FEES 2014 AND 2015

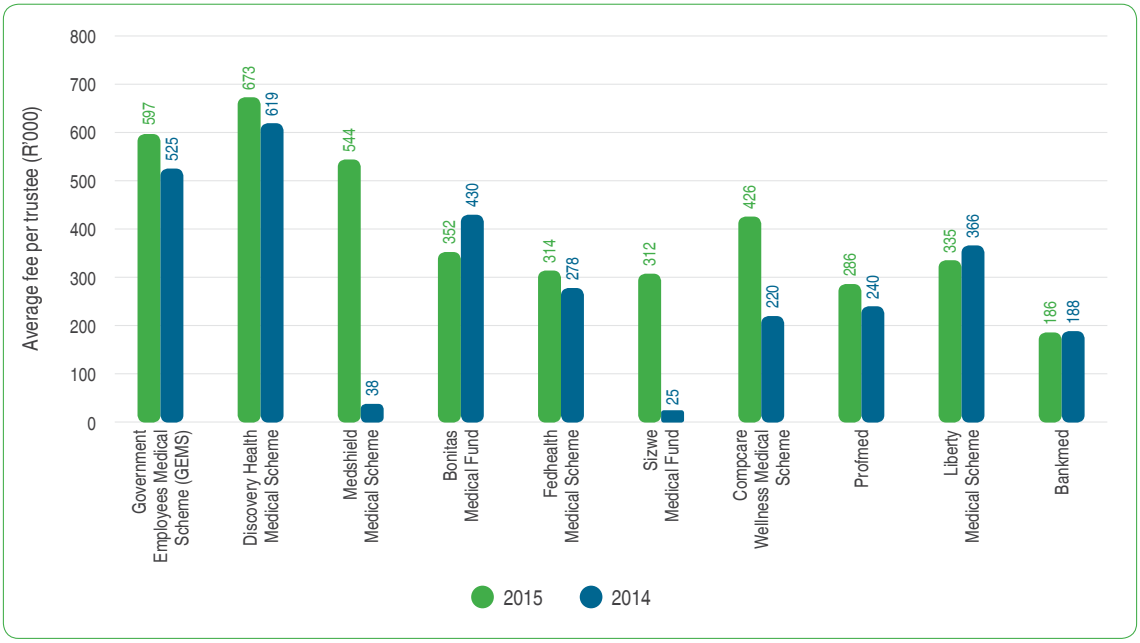


FIGURE 47: COMPOSITION OF TRUSTEE REMUNERATION FOR 10 SCHEMES WITH HIGHEST REMUNERATION IN 2015

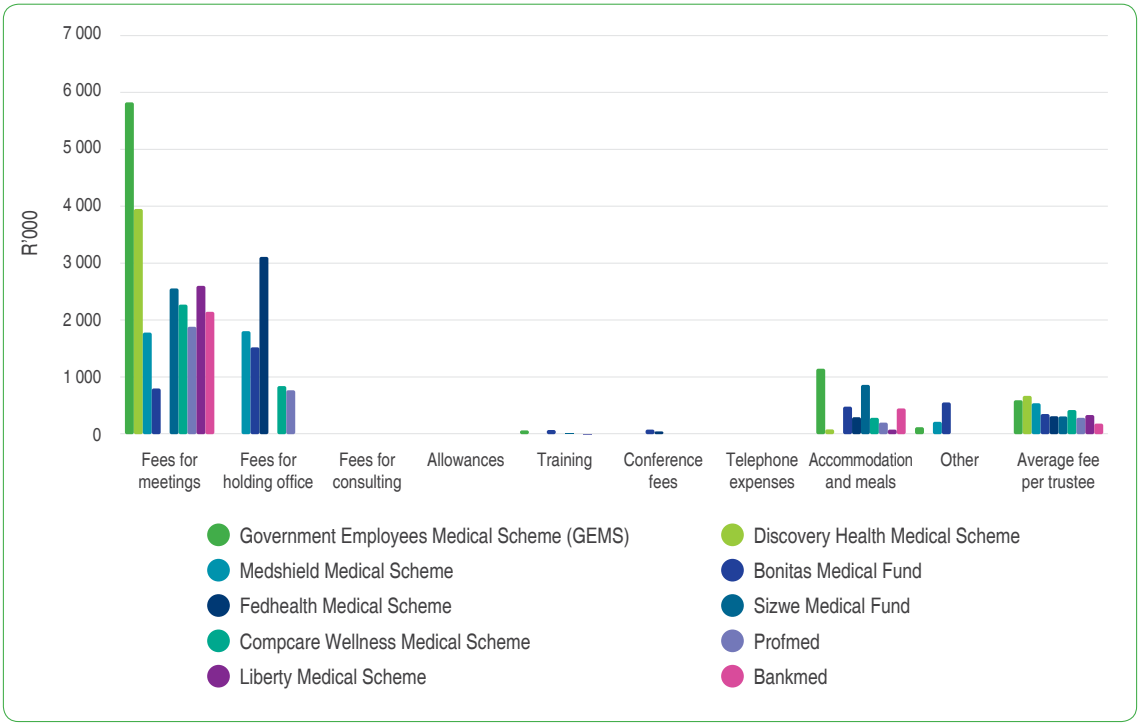


TABLE 30: TEN SCHEMES WITH HIGHEST REMUNERATION FOR PRINCIPAL OFFICERS IN 2015

Ref. no.	Name of medical scheme	Average beneficiaries	Principal Officer remuneration		
			2015 R'000	2014 R'000	% change
1580	South African Police Service Medical Scheme (POLMED)	492 221	5 744	5 365	7.1
1125	Discovery Health Medical Scheme	2 663 054	5 126	4 816	6.5
1598	Government Employees Medical Scheme (GEMS)	1 771 786	4 223	3 759	12.4
1252	Bestmed Medical Scheme	196 466	3 752	4 152	-9.6
1512	Bonitas Medical Fund	654 190	3 523	3 220	9.4
1576	Liberty Medical Scheme	113 063	3 484	4 072	-14.4
1582	Transmed Medical Fund	68 008	3 345	3 147	6.3
1597	Umvuzo Health Medical Scheme	56 369	3 267	3 075	6.2
1486	Sizwe Medical Fund	126 822	3 152	3 513	-10.3
1537	Hosmed Medical Aid Scheme	72 242	2 981	2 492	19.6

** Principal Officer remuneration includes curator fees*

TABLE 31: TEN SCHEMES WITH HIGHEST ANNUAL GENERAL MEETING COSTS IN 2015

Name of medical scheme	Average members		Annual General Meeting costs R'000		Annual General Meeting costs pabpm		AGM membership attendance per scheme*	
	2015	2014	2015	2014	2015	2014	2015	2014
Discovery Health Medical Scheme	1 250 194	1 210 702	3 218	1 993	0.2	0.1	229	141
Bonitas Medical Fund	295 462	295 064	2 477	1 651	0.7	0.5	204	58
SAMWUMed	38 664	40 553	1 632	1 113	3.5	2.3	65	54
Bestmed Medical Scheme	93 066	90 269	1 149	1 616	1.0	1.5	145	191
Sizwe Medical Fund	52 767	52 360	770	93	1.2	0.1	233	126
Medihelp	94 316	101 085	691	869	0.6	0.7	31	59
Motohealth Care	25 677	26 807	519	299	1.7	0.9	42	26
South African Police Service Medical Scheme (POLMED)	172 039	174 395	277	204	0.1	0.1	187	206
Nedgroup Medical Aid Scheme	28 565	27 825	270	-	0.8	0.0	17	17

** Source: CMS AGM attendance records*

Broker costs

Broker costs, which include all commissions, service fees and other distribution costs, increased by 5.8% from R1 707.1 million in 2014 to R1 806.4 million in 2015 (2014: 8.1%).

Broker costs represented 13.9% of total non-healthcare expenditure in 2015, while they accounted for 14.1% in 2014.

For schemes that pay broker commissions, the amounts paid on a per-average member per month (pampm) basis increased to R57.4 pampm in 2015 from R54.7 pampm in 2014, representing an increase of 5.0%.

Broker commissions as a percentage of GCI decreased slightly to 1.2% in 2015 from 1.2% in 2014.

Figure 48 shows annual broker service fees paid by open schemes since 2000, as well as their percentage of total non-healthcare expenditure.

FIGURE 48: BROKER SERVICE FEES (OPEN SCHEMES) 2000–2015

Figure 49 illustrates the increase in broker fees relative to the number of members of schemes that pay brokers.

FIGURE 49: BROKER FEES AND SCHEME MEMBERSHIP 2000–2015

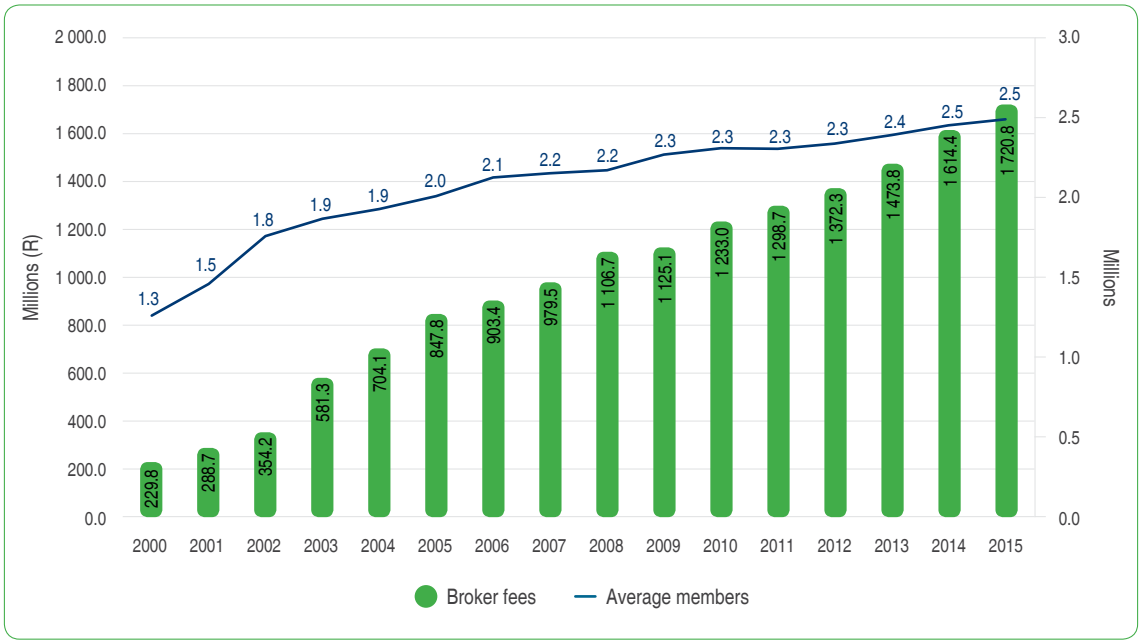


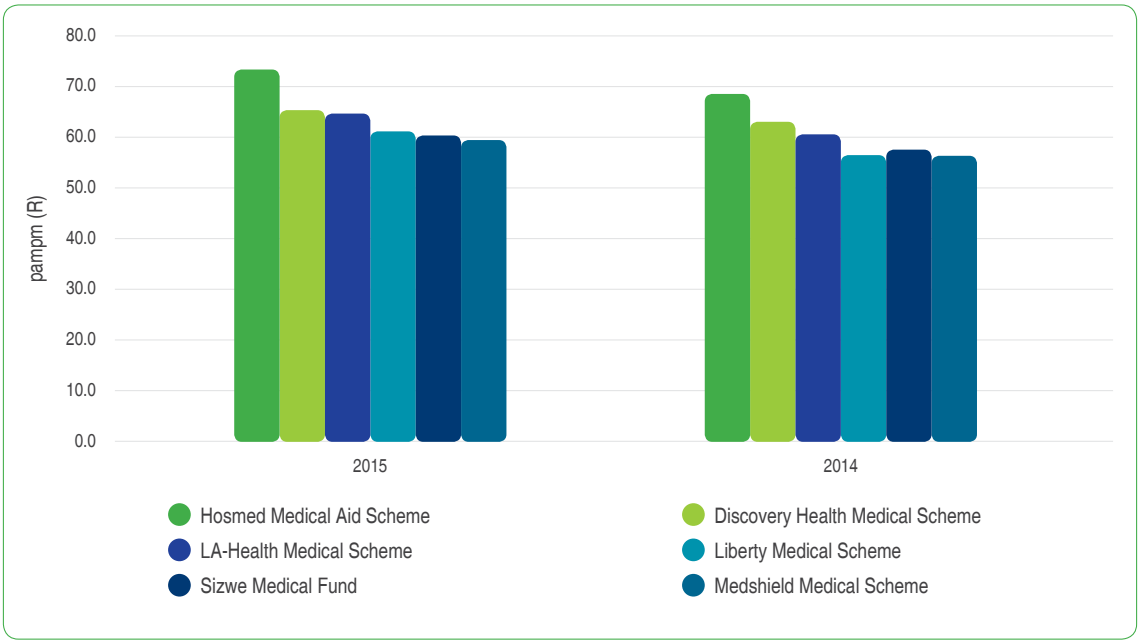
Table 32 illustrates the schemes which had broker service fees that were higher than the industry average of R57.4 pampm during 2015 (2014: R54.7 pampm). These six schemes (2014: six) represented 60.8% (2014: 60.1%) of total membership that paid for broker service fees, and 68.8% (2014: 68.5%) of total broker service fees paid. One of these schemes paid at a level of 20.0% greater than the industry average.

TABLE 32: SCHEMES WITH BROKER FEES ABOVE THE INDUSTRY AVERAGE IN 2014 AND 2015

Ref. no.	Name of medical scheme	Type	Broker fees*			Other distribution fees		
			2015 pampm R	2014 pampm R	% change	2015 pampm R	2014 pampm R	% change
1537	Hosmed Medical Aid Scheme	Open	73.5	68.7	7.0	-	-	-
1125	Discovery Health Medical Scheme	Open	65.5	63.2	3.6	-	-	-
1145	LA-Health Medical Scheme	Restricted	64.8	60.7	6.8	-	-	-
1576	Liberty Medical Scheme	Open	61.3	56.6	8.3	-	-	-
1486	Sizwe Medical Fund	Open	60.5	57.7	4.9	-	-	-
1140	Medshield Medical Scheme	Open	59.6	56.5	5.5	-	-	-

pampm = per average member per month
** Excluding distribution costs*

FIGURE 50: SCHEMES WITH BROKER FEES ABOVE THE INDUSTRY AVERAGE OF R54.7 PAMPM 2014 AND 2015



pampm = per average member per month

Reinsurance results

There were no schemes with reinsurance contracts in place in 2015. Only one medical scheme had a reinsurance contract in 2014.

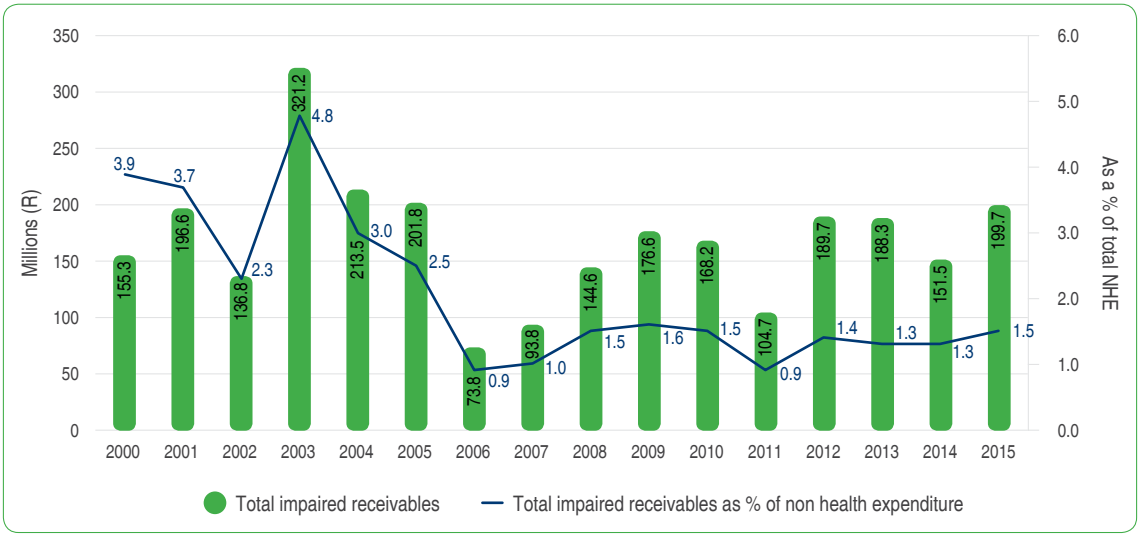
Impaired receivables

Impaired receivables increased by 31.8% to R200.0 million for the year under review from R151.5 million in 2014. They represented 1.5% of total non-healthcare expenditure (1.3% in 2014).

It took schemes an average of 9.7 days to collect debts (contributions from their members) in 2015. This was an improvement of 2.8% from 10.0 days in 2014. This collection period still falls well outside the legal provisions which require that members pay all contributions to their medical scheme not later than three days after the payment is due. The associated risks of not paying and collecting contributions timeously are the possible impairment of the debtor and paying claims when contributions have not been received.

Figure 51 shows the trend in impaired receivables over the past 16 years, also expressed as a percentage of total non-healthcare expenditure.

FIGURE 51: IMPAIRED RECEIVABLES 2000–2015



Trends in non-healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2015 at 84.6% (2014: 84.7%).

Administration expenditure accounted for 7.3% of GCI in 2015 (2014: 7.3%). Table 33 shows administration expenditure by type of scheme administration.

TABLE 33: GROSS ADMINISTRATION EXPENDITURE (GAE) 2000–2015

	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	31.5		37.1		22.1		26.2	
2001	51.8	64.4	49.5	33.4	26.5	19.9	30.4	16.0
2002	48.1	-7.1	56.5	14.1	33.5	26.4	38.7	27.3
2003	59.6	23.9	63.1	11.7	30.2	-9.9	43.3	11.9
2004	65.3	9.6	69.0	9.4	37.4	23.8	45.3	4.6
2005	68.7	5.2	75.0	8.7	35.9	-4.0	53.6	18.3
2006	70.4	2.5	78.8	5.1	32.5	-9.5	52.9	-1.3
2007	76.0	8.0	82.1	4.2	36.1	11.1	51.7	-2.3
2008	81.1	6.7	88.0	7.2	33.3	-7.8	49.6	-4.1
2009	90.4	11.5	96.0	9.1	37.9	13.8	53.6	8.1
2010	87.3	-3.4	97.8	1.9	46.0	21.4	54.8	2.2
2011	86.0	-1.5	103.6	5.9	47.7	3.7	55.6	1.5
2012	99.6	15.8	108.8	5.0	53.7	12.6	58.2	4.7
2013	108.7	9.1	113.5	4.3	55.9	4.1	62.4	7.2
2014	111.0	2.1	120.2	5.9	71.0	27.0	68.8	10.3
2015	115.0	3.6	127.3	5.9	79.2	11.5	76.0	10.5

pabpm = per average beneficiary per month

Table 33 shows that self-administered open schemes paid 45.2% (2014: 56.3%) more pabpm for administration expenditure than self-administered restricted schemes. Third-party-administered open schemes paid 67.5% (2014: 74.7%) more pabpm for administration expenditure than third-party-administered restricted schemes.

During 2015, there were five self-administered open schemes (2014: 5), representing 403 016 average beneficiaries (2014: 403 786), and 18 third-party-administered open schemes (2014: 18), representing 4 509 467 average beneficiaries (2014: 4 461 943).

Self-administered open schemes experienced an increase of 3.6% in spending on administration expenditure (from R111.0 pabpm in 2014 to R115.0 pabpm in 2015), while third-party-administered open schemes increased their expenditure by 5.9% to R127.3 pabpm from R120.2 pabpm in 2014. Third-party-administered open schemes paid 10.7% more for administration expenditure than self-administered open schemes. The figure was 8.3% in 2014.

During 2015, there were eight self-administered restricted schemes (2014: 8), representing 308 300 average beneficiaries (2014: 295 510), and 53 third-party-administered restricted schemes (2014: 54), representing 5 326 621 average beneficiaries (2014: 5 462 603).

Third-party-administered restricted schemes spent on average 4.0% less on administration expenditure at R76.0 pabpm compared to the R79.2 pabpm of self-administered restricted schemes (2014: 3.1%).

Table 34 indicates the ten schemes with the highest marketing, advertising and broker costs. The majority of these are open medical schemes. The table shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 1.4% from 2014 to 2015 (2013 to 2014: 1.8%). Member growth in this instance is not confined to new members who were not previously covered by a scheme as it includes members who moved from other schemes.

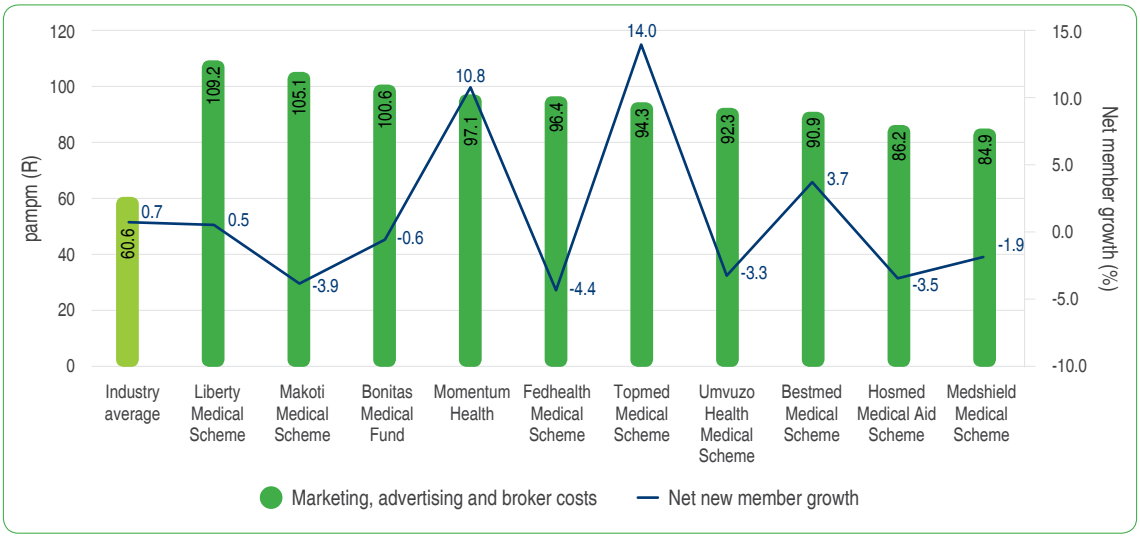
Figure 52 illustrates the information contained in Table 34.

TABLE 34: TEN SCHEMES WITH HIGHEST MARKETING, ADVERTISING AND BROKER COSTS (2015)

Ref. no.	Name of medical scheme	Marketing, advertising and broker costs pampm	Net new member growth %
	Industry average	60.6	0.7
1576	Liberty Medical Scheme	109.2	0.5
1466	Makoti Medical Scheme	105.1	-3.9
1512	Bonitas Medical Fund	100.6	-0.6
1167	Momentum Health	97.1	10.8
1202	Fedhealth Medical Scheme	96.4	-4.4
1422	Topmed Medical Scheme	94.3	14.0
1597	Umvuzo Health Medical Scheme	92.3	-3.3
1252	Bestmed Medical Scheme	90.9	3.7
1537	Hosmed Medical Aid Scheme	86.2	-3.5
1140	Medshield Medical Scheme	84.9	-1.9

pampm = per average member per month

FIGURE 52: TEN SCHEMES WITH HIGHEST MARKETING, ADVERTISING AND BROKER COSTS (2015)



pampm = per average member per month

Tables 35 and 36 show open and restricted schemes with the highest marketing and advertising expenditure.

TABLE 35: OPEN SCHEMES WITH THE HIGHEST MARKETING AND ADVERTISING EXPENDITURE (2015)*

Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider	% of total fees
	2015 pampm	2014 pampm	% change	2015 pampm	2014 pampm	% change	2015	2014	% change		R'000	
Liberty Medical Scheme	47.9	89.8	-46.7	61.3	56.6	8.3	55 995	56 379	-0.7	V Medical Solutions (Pty) Ltd	31 659	98.3
										Ad hoc expenditure	546	1.7
Makoti Medical Scheme	61.6	71.2	-13.5	43.5	38.8	12.1	2 436	2 600	-6.3	SuperSport United Football Club (Pty) Ltd	1 248	69.3
										Various suppliers	553	30.7
Bonitas Medical Fund	43.4	37.8	14.8	57.2	53.1	7.7	295 462	295 064	0.1	Bonitas Marketing (Pty) Ltd	153 704	100.0
Momentum Health	-	-	-	97.1	91.6	6.0	126 070	115 149	9.5	Not applicable	-	-
Fedhealth Medical Scheme	43.2	44.5	-2.9	53.2	49.8	6.8	71 900	74 519	-3.5	The Cheese Has Moved (Pty) Ltd	37 292	100.0
Topmed Medical Scheme	39.1	19.2	103.6	55.2	51.8	6.6	24 088	21 634	11.3	O'Donoghue	4 575	40.4
										Fastpulse	4 478	39.6
										2Cana	507	4.5
										Private Health Administrators	258	2.3
										Aerios	244	2.2
										8Creative	233	2.1
										Vine Promotion	207	1.8
										Mtech	160	1.4
										Eight Creative	142	1.3
										Various	506	4.5
Bestmed Medical Scheme	28.2	29.5	-4.4	62.7	57.5	9.0	93 066	90 269	3.1	The Old Shanghai Fire Cracker Factory	5 526	17.5
										RMS Media	4 611	14.6
										ASG Event Solutions (Pty) Ltd	4 102	13.0
										Prosort Data Laser Print	2 701	8.6
										Various small providers	2 642	8.4
										Tukssport University of Pretoria	2 530	8.0
										Three Hill	1 885	6.0
										Inkonde Projects	1 725	5.5
										Interbrand Sampson	1 321	4.2
										Cycle Labuschagne Brothers	992	3.1
										AGE Business Solutions	795	2.5
										Nelson Mandela Metropolitan University	626	2.0
										P and P Promotions CC T A P and P Communications	597	1.9
										Seriti Printing	571	1.8
										De Villiers Cycling Events	370	1.2
										Google	360	1.1
										Media Mark	144	0.5
										Brandman Business Development	-	-
										ASG Sport Solutions (Pty) Ltd	11	-

Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
	2015 pampm	2014 pampm	% change	2015 pampm	2014 pampm	% change	2015	2014	% change			
Hosmed Medical Aid Scheme	12.7	11.9	6.7	73.5	68.7	7.0	26 206	27 331	-4.1	Ad hoc expenditure	2 553	63.9
										DDB South Africa (Pty) Ltd	1 445	36.1
Medshield Medical Scheme	25.3	17.6	43.8	59.6	56.5	5.5	75 679	78 357	-3.4	Spacegrow Media	8 790	38.2
										Saints Brand and Design	5 215	22.7
										Ntsumi Telecommunications	3 283	14.3
										Other Marketing	2 395	10.4
										Hi Performance Supplies	1 212	5.3
										Peakin Blu Staff Marketing	1 137	4.9
										Wellness Odessey	480	2.1
										Specialist Research	403	1.8
										Milk Brand	59	0.3
										Maverick Digital Labs	24	0.1
Medihelp	38.2	33.9	12.7	46.0	45.8	0.4	94 316	101 085	-6.7	Strata Healthcare Management	25 615	59.3
										Various small contracts	5 516	12.8
										Moputso Consulting (Pty) Ltd	3 966	9.2
										Sportsvendo	2 577	6.0
										Starbright Solutions	2 371	5.5
										Blue Bulls co	855	2.0
										Mediamark	701	1.6
										Brandinc	611	1.4
										Solidarity	547	1.3
										Theatre on Track	343	0.8
										Healthcare Wellness	77	0.2
Open scheme industry average**	**24.3**	**14.2**	**71.1**	**62.8**	**60.4**	**4.0**	**2 304 852**	**2 263 722**	**1.8**			

pampm = per average member per month

* *Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*

** *The industry averages are based only on those schemes which incurred the specific type of expenditure.*

TABLE 36: RESTRICTED SCHEMES WITH THE HIGHEST MARKETING AND ADVERTISING EXPENDITURE (2015)

Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
	2015 pampm	2014 pampm	% change	2015 pampm	2014 pampm	% change	2015	2014	% change			
Umvuzo Health Medical Scheme	47.5	43.6	8.9	44.8	44.1	1.6	27 113	27 360	-0.9	Rain Catchers (Pty) Ltd	15 460	100.0
LA-Health Medical Scheme	0.8	1.0	-20.0	64.8	60.7	6.8	55 712	51 095	9.0	Ad hoc expenditure	525	100.0
Profmed	36.2	33.5	8.1	22.3	21.7	2.8	29 982	28 356	5.7	Ebony and Ivory	11 007	84.6
										Cyberkinetics	872	6.7
										Other	729	5.6
										Epic Communications	393	3.0
										Newsclip	9	0.1

Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
	2015 pampm	2014 pampm	% change	2015 pampm	2014 pampm	% change	2015	2014	% change			
Government Employees Medical Scheme (GEMS)	21.3	18.5	15.1	-	-	-	671 215	685 135	-2.0	Pinnacle Health Solutions (Pty) Ltd	67 015	39.1
										Other (Advertising and marketing)	55 908	32.6
										Teledirect (Pty) Ltd	48 669	28.4
SAMWUMed	14.2	5.1	178.4	6.8	5.7	19.3	38 664	40 553	-4.7	Ad hoc expenditure	6 609	100.0
Motohealth Care	9.5	12.9	-26.4	10.7	13.9	-23.0	25 677	26 807	-4.2	Various Other Companies	1 729	59.2
										Dimage	1 194	40.8
Witbank Coalfields Medical Aid Scheme	17.9	15.7	14.0	0.7	0.6	16.7	9 898	10 349	-4.4	Amadwala Group Benefits	2 123	100.0
Alliance Midmed Medical Scheme	10.4	0.4	2 500.0	-	-	-	1 726	1 713	0.8	Insight Innovative	112	52.4
										Private Health Administrators	76	35.5
										Middleburg Country Club	13	5.9
										Various	13	6.2
Sisonke Health Medical Scheme	7.3	3.5	108.6	-	-	-	8 201	8 159	0.5	Ad hoc expenditure	718	100.0
Restricted scheme industry average**	**13.2**	**12.1**	**9.1**	**30.9**	**28.3**	**9.2**	**1 412 268**	**1 346 939**	**4.9**			

pampm = per average member per month

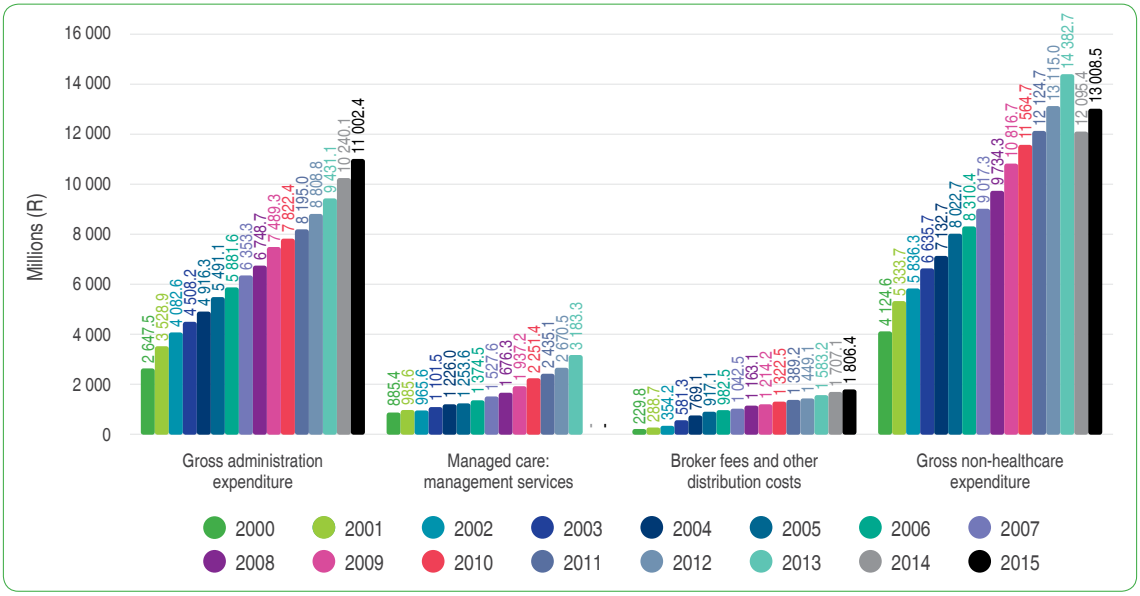
** Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*

*** The industry averages are based only in respect of those schemes which incurred the specific expenditure.*

Figure 53 shows the changes in the major categories of non-healthcare expenditure for the past 15 years.

Total net non-healthcare expenditure rose by 7.5% from R12.1 billion in 2014 to R13.0 billion in 2015.

FIGURE 53: CHANGES IN NON-HEALTHCARE EXPENDITURE 2000–2015



pabpm = per average beneficiary per month

Total gross non-healthcare expenditure has increased by 215.4% since 2000. This was driven by a 315.6% upswing in administration expenditure and an increase of 686.1% in broker costs.

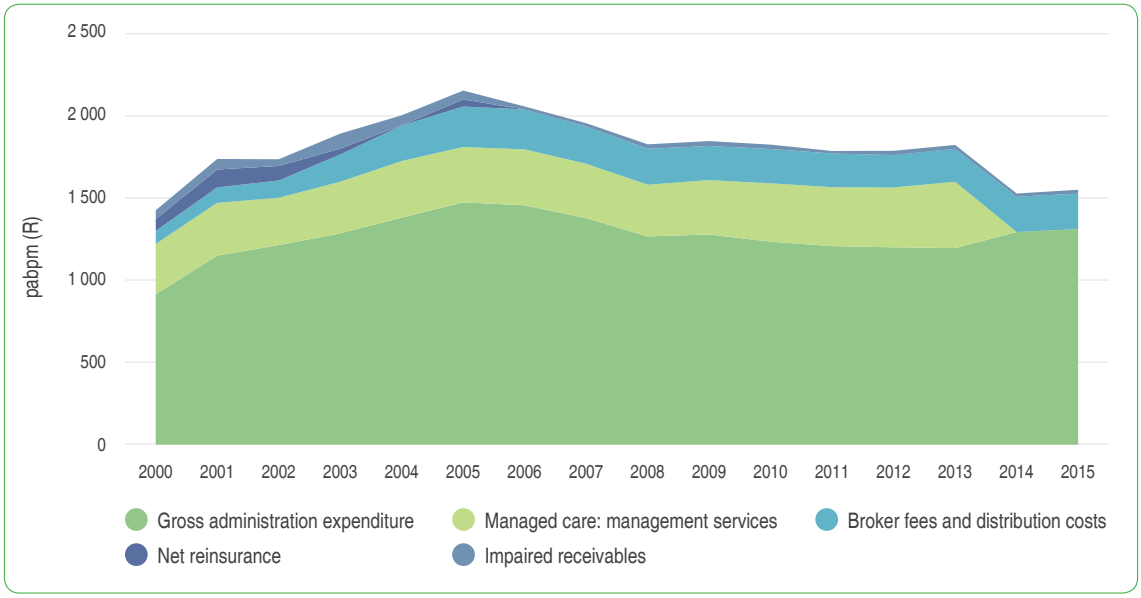
By comparison, gross claims have risen by 408.8% (not adjusted for inflation) since 2000.

As illustrated in Figures 54 and 55 together with Table 37, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI) prior to 2006. The rate of increase was reversed in 2006[9] and since then there has been a real decrease[10] in non-healthcare expenditure, from R2 153.1 pabpa in 2005 to R1 549.9 pabpa 2015 (prices adjusted to 2015 prices).

Circular 56 of 2015 resulted in the 2014 non-healthcare expenditure decreasing by 21.5% from R1 943.9 pabpa to R1 526.9 pabpa (in real terms). This can be clearly observed in Figure 54.

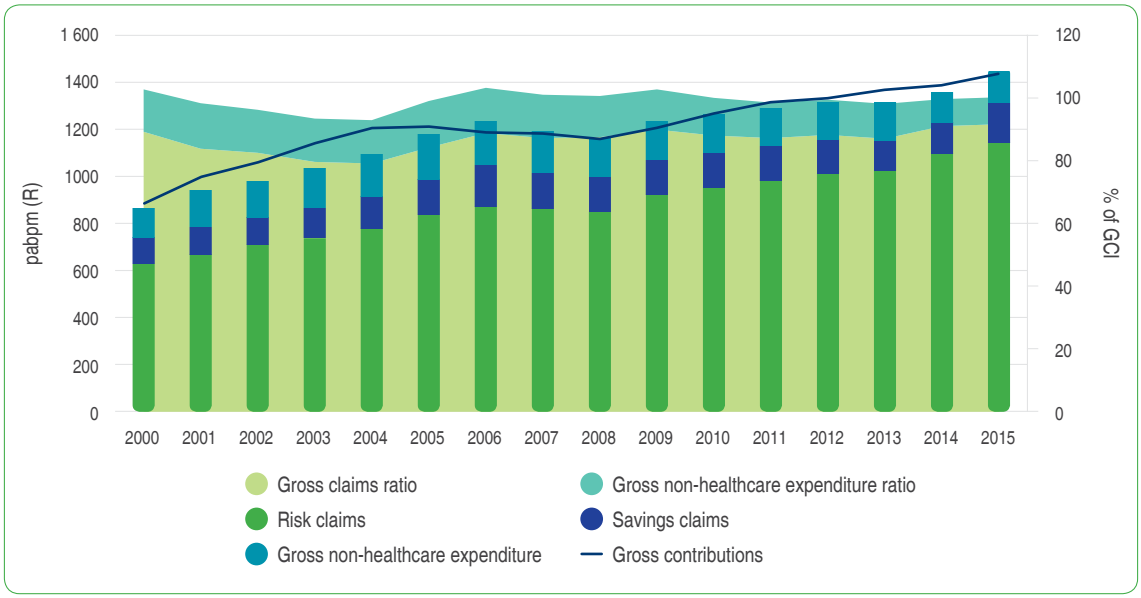
It increased marginally (by 1.5%) to R1 1549.7 in 2015 from R1 1526.7 in 2014. The net claims ratio also increased, to 91.4% in 2015 from 90.8% in 2014.

FIGURE 54: NON-HEALTHCARE EXPENDITURE PABPA 2000–2015: 2015 PRICES



pabpa = per average beneficiary per annum

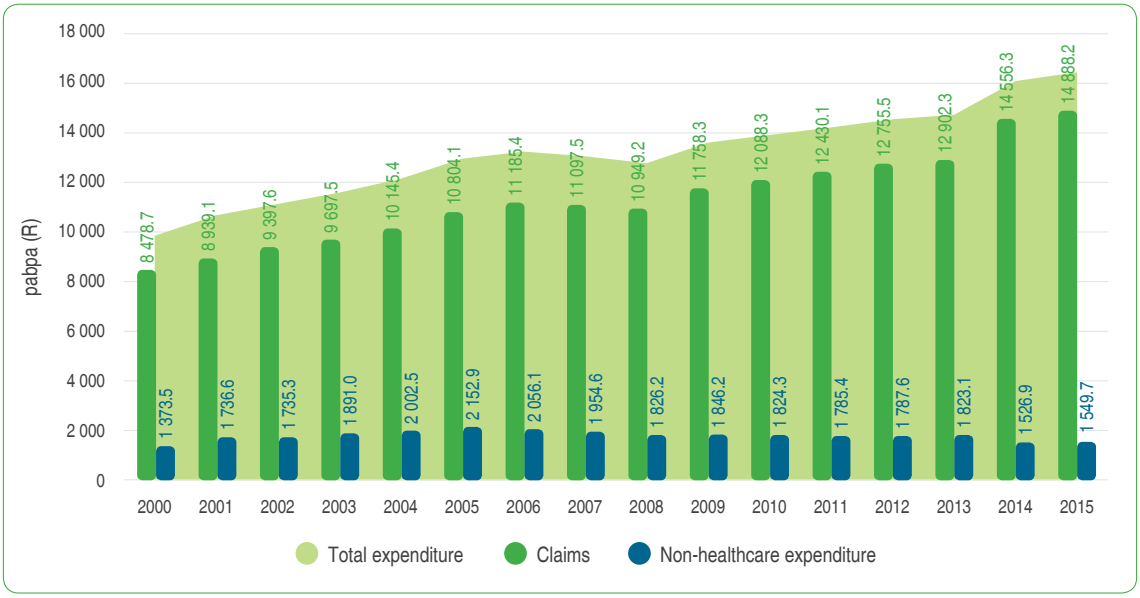
FIGURE 55: CLAIMS AND NON-HEALTHCARE EXPENDITURE PABPM 2004–2015: 2015 PRICES



9 *This can partly be explained by GEMS starting to operate in 2006.*

10 *The decrease in the current financial year is partially due to the reclassification of accredited managed healthcare services.*

FIGURE 56: CLAIMS AND NON-HEALTHCARE EXPENDITURE PABPA 2000–2015: 2015 PRICES



pabpm = per average beneficiary per month
GCI = Gross Contribution Income
pabpa = per average beneficiary per annum

TABLE 37: TRENDS IN CONTRIBUTIONS, CLAIMS AND NON-HEALTHCARE EXPENDITURE 2000–2015 (2015 PRICES*)

	Gross contributions		Gross claims		Gross non-healthcare expenditure	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	10 568.9		9 432.1		1 424.7	
2001	11 940.7	13.0	10 007.2	6.1	1 737.2	21.9
2002	12 698.5	6.3	10 471.1	4.6	1 735.3	-0.1
2003	13 689.0	7.8	10 892.9	4.0	1 891.2	9.0
2004	14 466.0	5.7	11 448.9	5.1	2 002.7	5.9
2005	14 543.7	0.5	12 238.3	6.9	2 153.1	7.5
2006	14 243.1	-2.1	12 645.3	3.3	2 056.2	-4.5
2007	14 190.7	-0.4	12 374.5	-2.1	1 954.6	-4.9
2008	13 902.8	-2.0	12 166.6	-1.7	1 826.2	-6.6
2009	14 478.2	4.1	13 017.3	7.0	1 846.0	1.1
2010	15 220.4	5.1	13 395.3	2.9	1 824.4	-1.2
2011	15 814.4	3.9	13 788.5	2.9	1 785.6	-2.1
2012	16 018.4	1.3	14 127.2	2.5	1 786.7	0.1
2013	16 449.2	2.7	14 316.2	1.3	1 822.5	2.0
2014	16 685.1	1.4	15 186.2	6.1	1 439.4	-21.0
2015	17 278.0	3.6	15 830.4	4.2	1 482.3	3.0
since 2000	**63.5**		**67.8**		**4.0**	

pabpa = per average beneficiary per annum
** The values were adjusted for CPI for 2000–2015.*

Figure 56 and Table 37 also show how non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.0% per annum from 1999 to 2001 before stabilising.

Table 38 shows the ten open schemes with non-healthcare expenditure greater than both the industry average of R157.9 pabpm and the open schemes average of 12.0% when expressed as a percentage of Risk Contribution Income (RCI).

Table 39 shows the ten restricted schemes with non-healthcare expenditure greater than both the industry average of R79.8 pabpm and the restricted schemes average of 6.3% when expressed as a percentage of RCI.

TABLE 38: TRENDS IN CLAIMS, NON-HEALTHCARE EXPENDITURE, AND RESERVE-BUILDING AS PERCENTAGE OF CONTRIBUTIONS AMONG OPEN SCHEMES (2014 AND 2015)

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building	
		2015 pabpm	2014 pabpm	2015 As % of RCI	2014 As % of RCI	2015 As % of RCI	2014 As % of RCI	2015 As % of RCI	2014 As % of RCI
1141	Spectramed	288.0	274.5	98.0	88.4	19.9	20.8	-17.8	-9.2
[redacted]									
1446	Selfmed Medical Scheme	198.2	202.3	90.3	93.6	11.2	12.2	-1.4	-5.8
1464	Suremed Health	182.2	122.2	84.7	94.6	13.4	12.6	1.9	-7.2
1149	Medihelp	181.0	169.2	88.5	93.1	11.6	12.3	-	-5.4
1491	Compcare Wellness Medical Scheme	180.9	176.7	92.7	90.0	13.6	13.9	-6.3	-3.8
1202	Fedhealth Medical Scheme	179.9	170.7	91.2	92.5	11.3	11.7	-2.5	-4.2
1575	Resolution Health Medical Scheme	178.7	157.1	87.2	87.4	12.9	13.1	-0.1	-0.5
1087	Keyhealth	176.0	168.3	93.9	88.4	9.2	9.0	-3.1	2.5
1576	Liberty Medical Scheme	174.0	181.6	93.2	94.5	11.8	13.5	-5.0	-8.0
	Industry average – open schemes	**157.9**	**148.9**	**88.7**	**87.8**	**12.0**	**12.2**	**-0.7**	**0.1**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

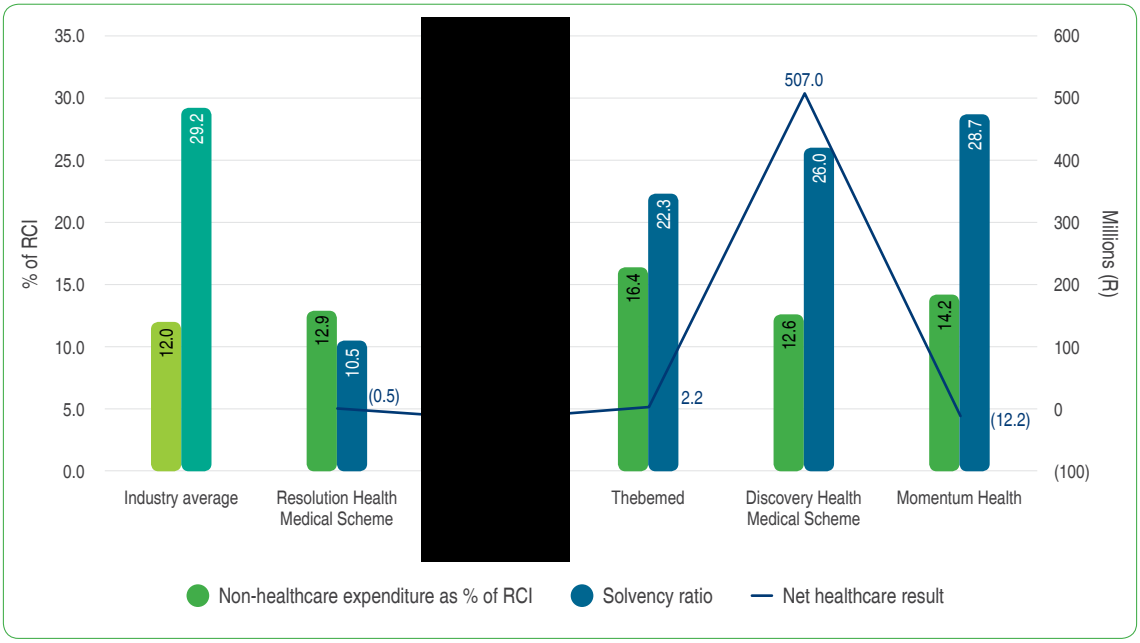
TABLE 39: TRENDS IN CLAIMS, NON-HEALTHCARE EXPENDITURE, AND RESERVE-BUILDING AS PERCENTAGE OF CONTRIBUTIONS AMONG RESTRICT SCHEMES (2014 AND 2015)

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building	
		2015 pabpm	2014 pabpm	2015 As % of RCI	2014 As % of RCI	2015 As % of RCI	2014 As % of RCI	2015 As % of RCI	2014 As % of RCI
1194	Profmed	191.5	167.5	90.0	86.7	12.6	11.8	-2.6	1.5
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	183.8	174.7	94.5	90.6	11.6	11.4	-6.1	-2.0
1441	Parmed Medical Aid Scheme	152.7	156.8	93.6	90.7	4.3	4.7	2.1	4.6
1068	De Beers Benefit Society	150.0	127.2	95.9	98.4	7.6	6.9	-3.4	-5.3
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund	139.8	128.7	93.2	89.8	6.5	6.1	0.2	4.1
1145	LA-Health Medical Scheme	138.3	133.2	82.6	80.5	11.7	11.7	5.7	7.8
1523	Grintek Electronics Medical Aid Scheme	127.6	118.1	103.9	104.4	8.4	8.6	-12.3	-13.0
1012	Anglo Medical Scheme	122.7	134.6	124.6	113.8	7.7	8.7	-32.4	-22.5
1571	Anglovaal Group Medical Scheme	122.6	119.8	92.8	99.4	8.7	9.3	-1.5	-8.7
1241	Naspers Medical Fund	117.3	110.7	89.5	87.0	9.6	9.7	0.9	3.4
	Industry average – restricted schemes	**79.8**	**72.3**	**94.9**	**94.8**	**6.3**	**6.1**	**-1.1**	**-0.9**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

Figure 57 shows the schemes in Tables 38 and 39 that had a solvency ratio below the open schemes' average of 29.2%. It is concerning that some of these medical schemes fall below the 25.0% solvency target yet exhibit very high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

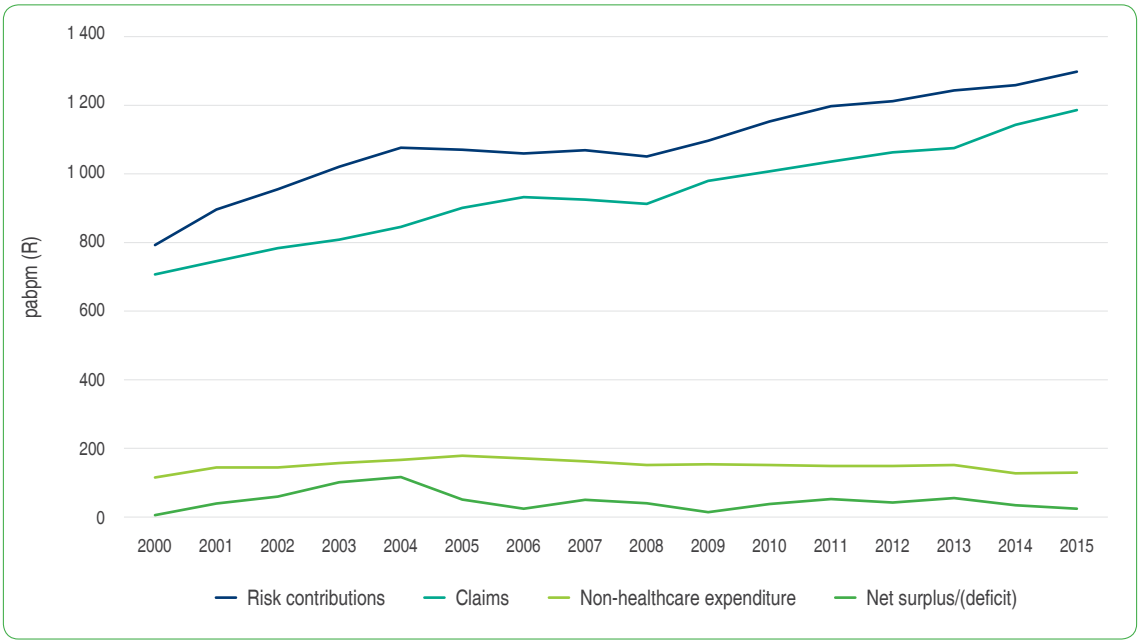
FIGURE 57: OPEN SCHEMES WITH HIGH NON-HEALTHCARE EXPENDITURE AND SOLVENCY RATIO BELOW AVERAGE (2015)



RCI = Risk Contribution Income

Figure 58 depicts information on contributions, benefits, non-healthcare expenditure, and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm had been growing since 2000 but it decreased in 2003, almost levelling out in 2004. Although this gap has since grown wider, it seems to have stabilised in the past few years.

FIGURE 58: RISK CONTRIBUTIONS, CLAIMS, NON-HEALTHCARE EXPENDITURE, AND OPERATING SURPLUSES 2000–2015: 2015 PRICES



pabpm = per average beneficiary per month
** The values were adjusted for CPI for 2000–2014.*

Benefit options

At the end of 2015 there were 276 registered benefit options (2014: 272) operating in 83 medical schemes.

Open schemes accounted for 50.4% or 139 of the registered benefit options at the end of 2015 (2014: 50.4% or 137 options). Restricted schemes had 137 options at year end, representing 49.6% of all options (2014: 136 options or 49.6%).

On average, open schemes had 6.0 options per scheme (2014: 6.0) and an average of 16 742 members per option at year-end (2014: 16 757). Restricted schemes had an average of 2.3 options per scheme (2014: 2.3), with an average of 11 852 members per option as at 31 December 2015 (2014: 12 041).

Of the 276 benefit options at year end, 95 (34.4%) had fewer than 2 500 members per option (2014: 94 or 34.6%). Of these 95 options, 49 (51.6%) incurred net healthcare losses in 2015. In 2014, 56 options (59.6%) incurred losses.

The remaining 181 options (2014: 178) had more than 2 500 members per option. Of these, 55.8% or 101 options incurred net healthcare losses (2014: 50.0% or 89 options).

TABLE 40: RESULTS OF BENEFIT OPTIONS 2015

	Open schemes	% representing	Restricted schemes	% representing	Total
All options					
Number of options	139	50.4	137	49.6	276
Members represented	2 327 137	58.9	1 623 790	41.1	3 950 927
Number of schemes	23	27.7	60	72.3	83
Net healthcare result (R'000)	(565 627)		(653 780)		(1 219 407)
Gross non-healthcare as % of GCI	10.4		6.0		8.6
Gross claims ratio (%)	89.6		94.6		91.6
Gross claims incurred pbpm	1 358.0		1 258.2		1 314.1
GCI pbpm	1 515.5		1 330.7		1 434.3
Options with members >= 2 500					
Number of options	94	51.9	87	48.1	181
Members represented	2 278 706	59.2	1 567 612	40.8	3 846 318
Net healthcare result (R'000)	(492 040)		(486 676)		(978 716)
Gross non-healthcare as % of GCI	10.4		6.0		8.6
Gross claims ratio (%)	89.5		94.3		91.4
Gross claims incurred pbpm	1 348.4		1 242.3		1 302.0
GCI pbpm	1 506.8		1 317.0		1 423.9
Options with members < 2 500					
Number of options	45	47.4	50	52.6	95
Members represented	48 431	46.3	56 178	53.7	104 609
Net healthcare result (R'000)	(74 084)		(167 103)		(241 188)
Gross non-healthcare as % of GCI	8.4		6.5		7.4
Gross claims ratio (%)	94.2		100.2		97.3
Gross claims incurred pbpm	1 839.1		1 800.4		1 818.5
GCI pbpm	1 951.6		1 796.4		1 868.9

GCI = Gross Contribution Income
pbpm = per beneficiary per month

At the end of 2015, there were 45 options in open schemes with fewer than 2 500 members (2014: 42). They had an average of 1 076.2 members per option (2014: 1 145.5) and represented 32.4% (2014: 30.7%) of all open schemes options.

Restricted schemes had 50 options with fewer than 2 500 members (2014: 52). The average number of members per option was 1 123.6 (2014: 1 182.1) and these options represented 36.5% (2014: 38.5%) of all restricted schemes options.

TABLE 41: RESULTS OF LOSS-MAKING BENEFIT OPTIONS 2015

	Open schemes	% representing	Restricted schemes	% representing	Total
Total loss making options					
% of total options	58.3		51.1		54.7
Number of options	80	53.6	70	46.4	150
Members represented	1 312 960	54.7	1 085 705	45.3	2 398 665
Net healthcare result (R'000)	(3 215 211)		(2 266 099)		(5 481 311)
Gross non-healthcare as % of GCI	9.8		5.2		7.6
Gross claims ratio (%)	95.6		99.3		97.4
Gross claims incurred pbpm	1 501.8		1 490.4		1 496.3
GCI pbpm	1 570.6		1 500.8		1 536.7
Loss making options with members > =2 500					
Number of options	59	58.4	42	41.6	101
Members represented	1 287 645	55.0	1 052 531	45.0	2 340 176
Net healthcare result (R'000)	(3 072 002)		(2 010 227)		(5 082 229)
Gross non-healthcare as % of GCI	9.9		5.2		7.7
Gross claims ratio (%)	95.4		98.9		97.1
Gross claims incurred pbpm	1 487.4		1 469.2		1 478.6
GCI pbpm	1 558.6		1 485.0		1 523.0
Loss making options with members < 2 500					
Number of options	21	42.9	28	57.1	49
Members represented	25 315	43.3	33 174	56.7	58 489
Net healthcare result (R'000)	(143 209)		(255 873)		(399 082)
Gross non-healthcare as % of GCI	7.4		5.5		6.4
Gross claims ratio (%)	103.0		109.4		106.6
Gross claims incurred pbpm	2 329.7		2 308.8		2 317.5
GCI pbpm	2 261.2		2 110.5		2 173.3

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 276 benefit options registered and operating at the end of 2015 (2014: 272), 150 (54.7%) incurred net healthcare losses. In 2014, 145 options (53.3%) incurred net healthcare losses. In the year under review, 80 options (2014: 80), representing 53.6% of loss-making options (2014: 58.4%), were in open schemes and 70 (2014: 65), representing 46.4% of loss-making options (2014: 48.1%), were in restricted schemes.

Net healthcare losses pmpm in options with fewer than 2 500 members were 3.1 times greater (2014: 3.2) than those for options with more than 2 500 members – an average of R568.6 pmpm compared to R181.0 pmpm (2014: R501.5 pmpm and R158.9 pmpm respectively).

Benefit options with fewer than 2 500 members generally have higher contributions and claims than other options and also attract higher non-healthcare costs as they are shared across a smaller base. Table 42 shows option results by demographics.

TABLE 42: DEMOGRAPHICS OF REGISTERED OPTIONS AT YEAR-END: 2015

	Open	Restricted	Total
Average age pb	**33.8**	**30.5**	
Net healthcare result pb	**-9.5**	**-14.1**	
Number of options with average age greater than or equal to the industry average	84	74	158
Number of options incurring net healthcare results better or equal to the industry average	33	23	56
Number of options incurring net healthcare results worse than the industry average	51	51	102
Number of options with average age below the industry average	55	63	118
Number of options incurring net healthcare results better or equal to the industry average	29	49	78
Number of options incurring net healthcare results worse than the industry average	26	14	40

pb = per beneficiary

There were 84 options with an average age above the 33.8 years for options in open schemes, and 55 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 74 benefit options had beneficiaries with an average age higher than the 30.5 years for all options in restricted schemes. A total of 63 options had younger beneficiaries. As expected, options covering older and sicker lives incurred greater deficits.

Net healthcare results and trends

The net healthcare result of a medical scheme indicates its position after benefits and non-healthcare expenditure are deducted from contribution income.

The net healthcare result for all medical schemes combined reflected a deficit of R1 219.4 million in 2015 (2014: R456.0 million). Open schemes incurred a total deficit of R565.6 million (2014: R37.4 million surplus), and restricted schemes generated a combined deficit of R653.8 million (2014: R493.4 million). This deterioration is mainly due to the worsening claims ratios of all schemes from 90.8% in 2014 to 91.4% in 2015.

Figure 59 and Table 43 show the impact of the increases in claims costs and non-healthcare expenditure on the net healthcare result.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 59.

FIGURE 59: NET HEALTHCARE RESULTS 2000–2015

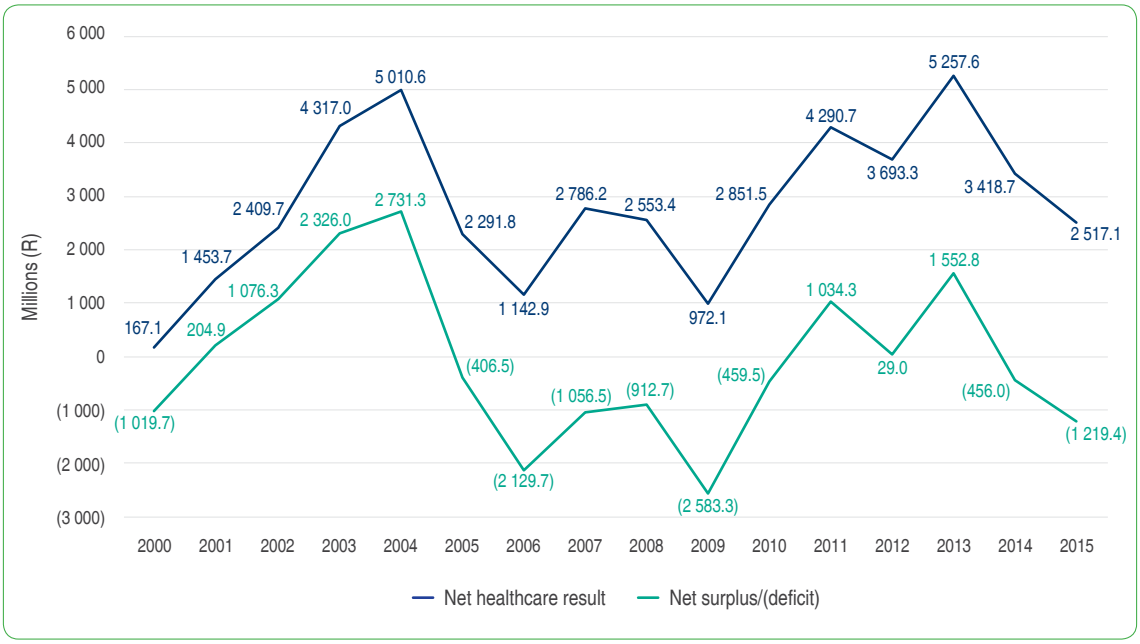


Table 43 shows the 20 schemes with the largest net healthcare deficits by the Risk Assessment Framework (RAF) classification; they represent 73.3% of all beneficiaries of schemes that suffered operating deficits (Annexure W provides more details). Investment income has boosted the performance of a number of these schemes, thus not experiencing major drops in their solvency levels.

TABLE 43: 20 SCHEMES WITH LARGEST NET HEALTHCARE DEFICITS 2014 AND 2015

Ref. no.	Name of medical scheme	Type	Net healthcare result			Solvency ratio		RAF classification
			2015 R'000	2014 R'000	% growth	2015 %	2014 %	
1512	Bonitas Medical Fund	Open	(494 277)	(247 544)	-99.7	26.1	30.7	High
1598	Government Employees Medical Scheme (GEMS)	Restricted	(205 108)	(465 927)	56.0	9.5	10.0	High
1279	Bankmed	Restricted	(150 265)	(127 956)	-17.4	42.5	46.0	High
1582	Transmed Medical Fund	Restricted	(131 947)	(26 939)	-389.8	14.1	22.0	High
1012	Anglo Medical Scheme	Restricted	(119 407)	(83 137)	-43.6	505.2	514.4	Medium
1140	Medshield Medical Scheme	Open	(113 897)	(77 284)	-47.4	53.2	53.6	High
1141	Spectramed	Open	(102 555)	(55 711)	-84.1	37.0	46.6	High
1576	Liberty Medical Scheme	Open	(99 825)	(150 279)	33.6	12.6	17.2	High
1202	Fedhealth Medical Scheme	Open	(67 785)	(110 191)	38.5	35.7	37.2	High
1422	Topmed Medical Scheme	Open	(66 291)	(51 431)	-28.9	86.4	90.2	Medium
1087	Keyhealth	Open	(53 437)	42 456	-225.9	32.9	32.2	High
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Restricted	(53 343)	(17 376)	-207.0	36.8	39.9	Medium
1252	Bestmed Medical Scheme	Open	(39 691)	(26 865)	-47.7	25.6	27.0	High
1583	Platinum Health	Restricted	(34 548)	(7 281)	-374.5	23.6	28.3	High
1194	Profmed	Restricted	(31 404)	17 188	-282.7	53.0	54.9	High
1253	Glencore Medical Scheme	Restricted	(31 064)	12 418	-350.2	43.9	53.5	Medium
1548	Medipos Medical Scheme	Restricted	(29 818)	(18 483)	-61.3	120.6	130.5	Medium
1469	Nedgroup Medical Aid Scheme	Restricted	(28 441)	(67 414)	57.8	35.1	32.3	High
1491	Compcare Wellness Medical Scheme	Open	(28 223)	(16 063)	-75.7	30.6	37.2	Medium
1563	Pick n Pay Medical Scheme	Restricted	(28 197)	(19 585)	-44.0	98.1	97.1	Medium

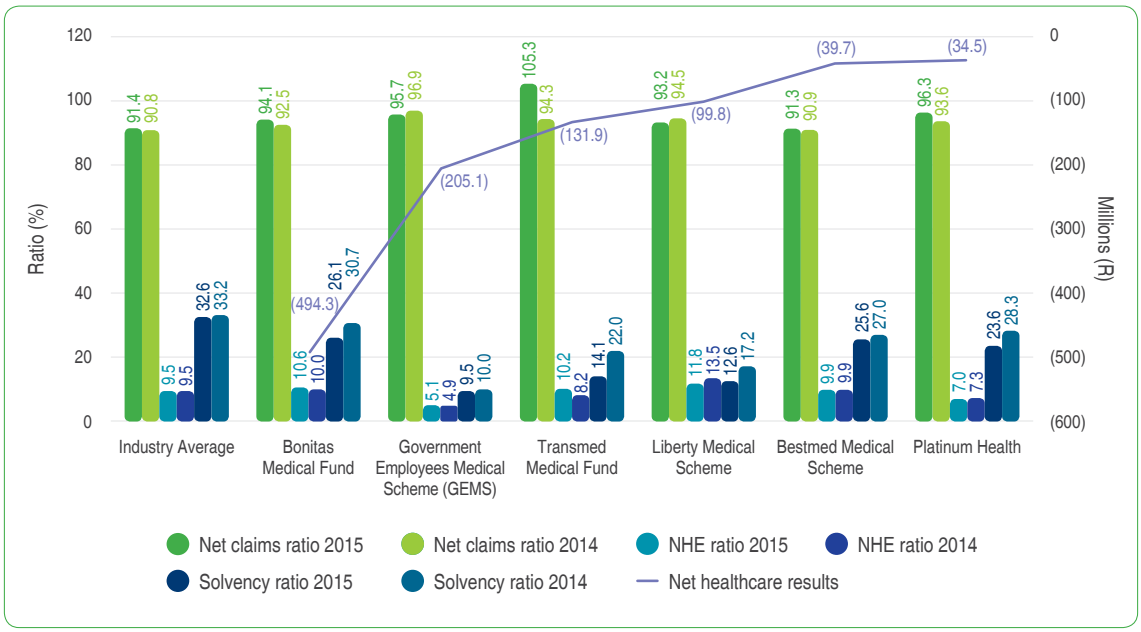
RAF = Risk Assessment Framework

A total of 65.2% (or 15 of 23) of open schemes and 56.7% (34 of 60) of restricted schemes showed net healthcare deficits during the year.

The net surplus of all schemes combined, after investment income and consolidation adjustments, was R2.5 billion (2014: R3.4 billion). Net investment and other income as well as expenditure decreased by 3.6% to R3.7 billion. Open schemes made a R1.4 billion (2014: R2.0 billion) surplus and restricted schemes a surplus of R1.2 billion (2014: R1.4 billion).

Figure 60 shows the high-impact schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 32.6%. (Annexure W provides more details.)

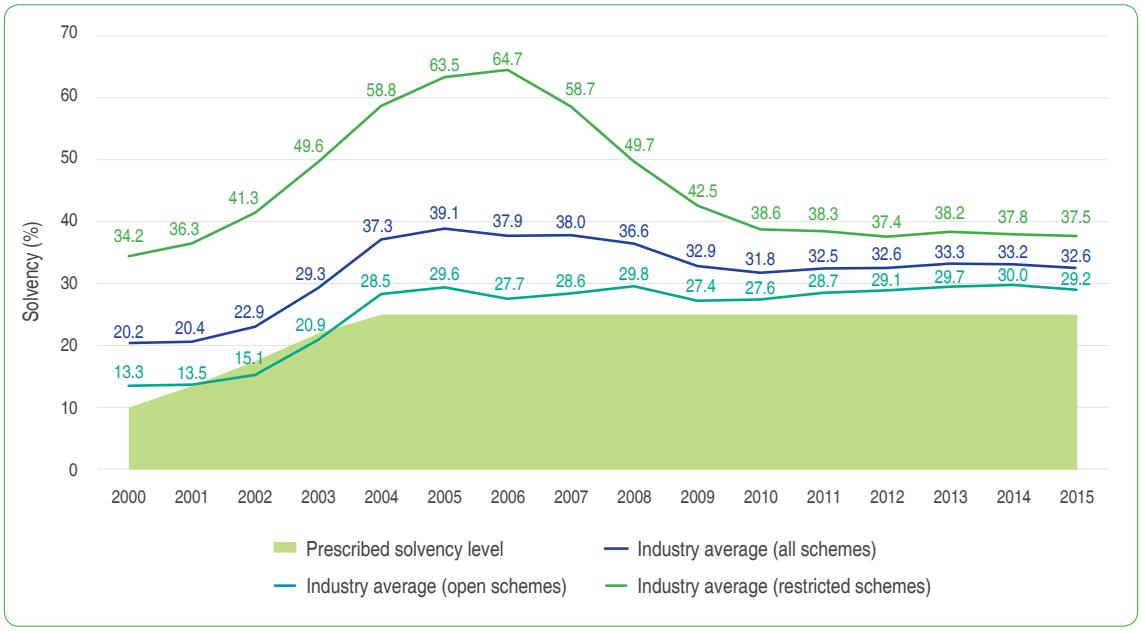
FIGURE 60: HIGH-IMPACT SCHEMES WITH LARGEST NET HEALTHCARE DEFICITS AND SOLVENCY LEVELS BELOW THE INDUSTRY AVERAGE OF 32.6% (2015)



NHE = Non-healthcare expenditure

Accumulated funds, solvency and solvency trends

FIGURE 61: INDUSTRY SOLVENCY FOR ALL SCHEMES 2000–2015



Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes.

'Accumulated funds' means the net asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable profits. The accumulated funds must at all times be maintained at a minimum level of 25.0% of gross contributions except for new medical schemes, in which case phase-in solvency ratios will apply. The phase-in solvency ratio is 10% during the first year of operation, 13.5% during the second year, 17.5% during the third year and not less than 22% during the fourth year.

These minimum accumulated funds are more commonly called the 'reserves' of a scheme. When expressed as a percentage of gross contributions, they become known as the 'solvency ratio' of a scheme.

A prescribed solvency ratio serves both to protect members' interests as well as to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio, this serves as a warning of a medical scheme's possible inability to meet its obligations.

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, non-compliance with Regulation 29 does not necessarily mean that the scheme is in financial difficulties.

Factors that affect solvency

The most important factors affecting solvency are:

- Membership growth;
- The performance of the medical scheme in relation to claims and non-healthcare expenditure; and
- Investment income.

The membership profile of a medical scheme further affects its solvency. Membership includes variables such as the average age of beneficiaries, the proportion of pensioners, the relative number of male and female dependants, and the dependant ratio. All of these affect the frequency and extent of claims.

Net assets or members' funds (total assets minus total liabilities) rose by 4.0% to end 2015 at R52.1 billion. Accumulated funds grew by 5.3% to R50.3 billion from the R47.7 billion recorded in 2014.

The industry average solvency ratio decreased to 32.6% in 2015 from 33.2% in 2014.

The solvency ratio of open schemes decreased by 2.7% to 29.2% in 2015 (2014: 30.0%). Restricted schemes experienced a decrease of 0.8% in their solvency ratio, 37.5% from 37.8% in 2014.

Overall industry average solvency ratio increased consistently from 2000 to 2005. Schemes were required to have reached the 25% solvency ratio in 2005.

As indicated in Figure 63, the restricted industry was at its peak in 2006 and declined from 2007 onwards. This is mostly due to the denominator that is used in the solvency calculation (gross contributions), which is affected by membership growth. The Government Employee Medical Scheme (GEMS), which is the largest restricted scheme, has shown exceptional membership growth since registration and this resulted in deterioration in the solvency level of the restricted schemes industry. The growth in GEMS has since slowed down as much of its target market is covered.

The open industry remained fairly constant between 2004 and 2015, slightly above the 25.0% solvency ratio prescribed by the Medical Schemes Act.

FIGURE 62: INDUSTRY SOLVENCY FOR OPEN SCHEMES 2000–2015

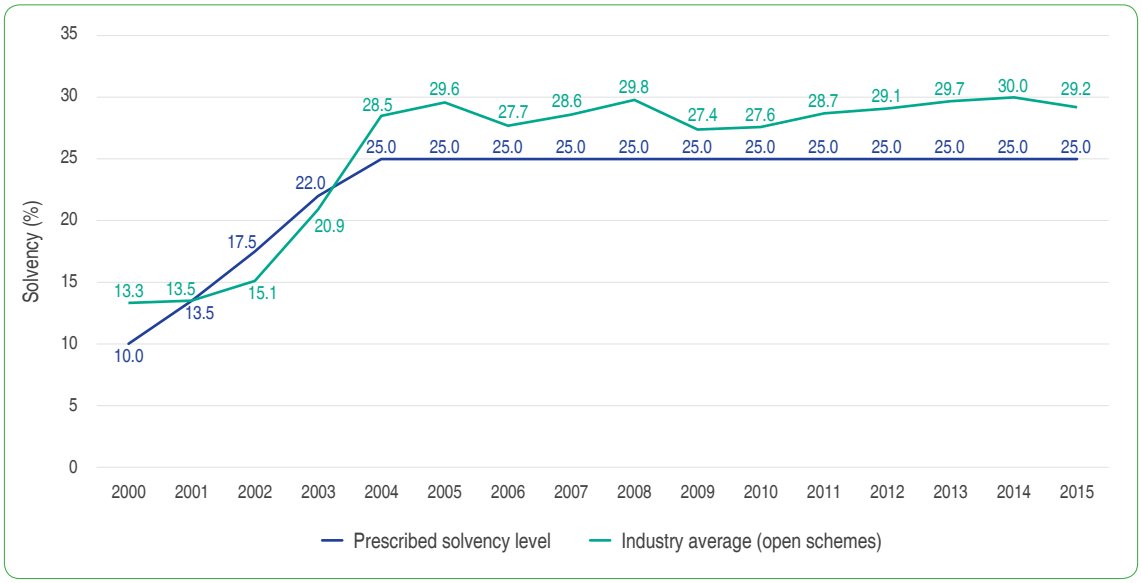


FIGURE 63: INDUSTRY SOLVENCY FOR RESTRICTED SCHEMES 2000–2015

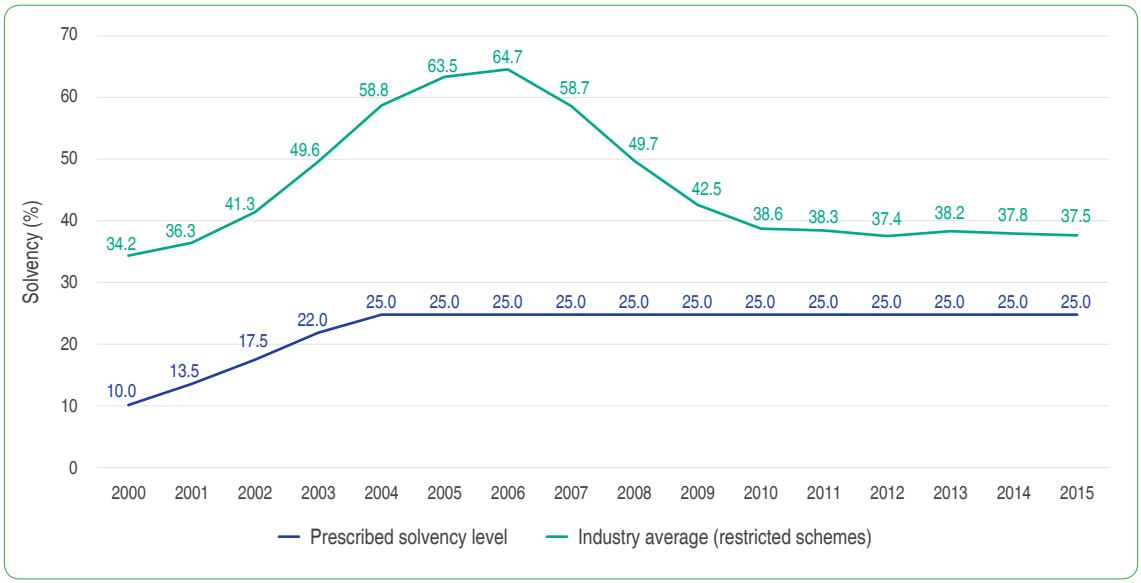


TABLE 44: RISK CLAIMS, NON-HEALTHCARE EXPENDITURE AND RESERVE-BUILDING AS A PERCENTAGE OF CONTRIBUTIONS 1999–2015

	Risk claims % of RCI	Non-healthcare expenditure % of RCI	Reserve-building % of RCI
1999	91.5	12.7	-4.2
2000	89.3	14.5	-3.7
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	-
2006	88.0	16.2	-4.1
2007	86.5	15.2	-1.8
2008	86.9	14.5	-1.4
2009	89.3	14.0	-3.3
2010	87.3	13.2	-0.5
2011	86.5	12.4	1.1
2012	87.7	12.3	-
2013	86.5	12.2	1.3
2014	90.8	9.5	-0.4
2015	91.4	9.5	-0.9

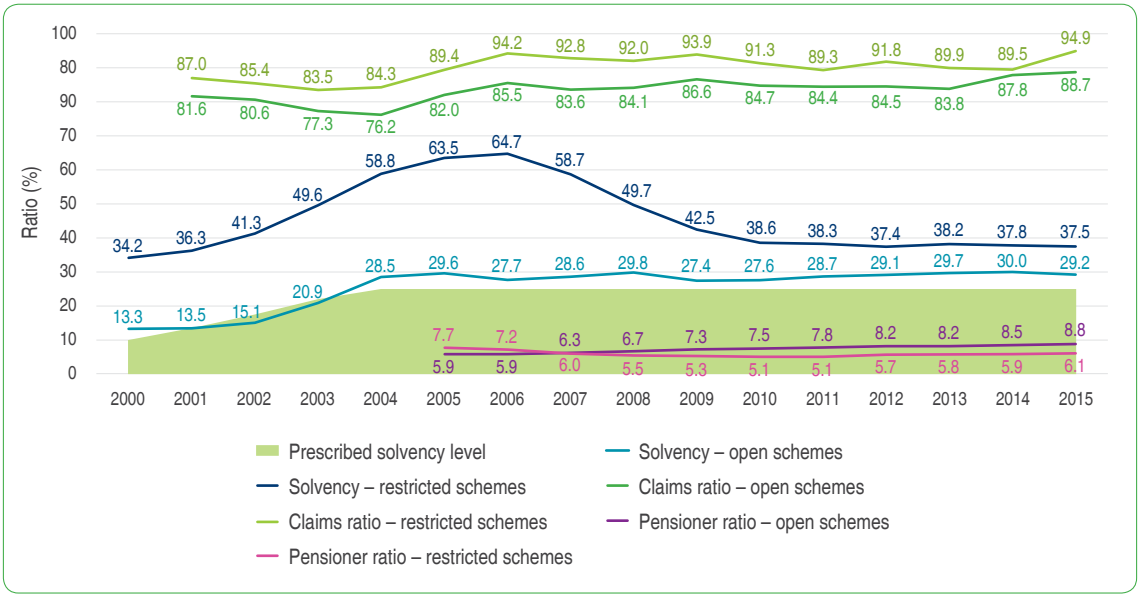
RCI = risk contribution income

Table 44 illustrates the relationship between risk claims, non-healthcare expenditure and reserve building. Risk claims appear to have more of an impact on reserve building than non-healthcare expenditure. During periods of high claims, the industry experienced a reduction in reserves, while during periods with lower claims, the reserves increased. In 1999 the industry experienced risk claims of 91.5% and reserves decreased by 4.2%, while in 2004 risk claims amounted to 78.6% and reserves increased by 5.9%.

Total risk claims fell between 2000 and 2004 and the ratio of contributions to reserves improved during this period from -3.7% to 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. Risk claims were at their lowest in 2004 and then started to increase in 2005, reaching 91.4% in 2015. In this respect it is important to note that the 2014 and 2015 risk claims ratios have been restated to include accredited managed healthcare services, while it had been excluded from the non-healthcare expenditure ratio. Contributions to reserves were negative during this time, which was consistent with the fact that most medical schemes had attained the prescribed solvency ratio of 25.0% and did not need to grow their reserves any further. The maintenance of reserves as a protection for members should be considered against the backdrop of increasing claim costs.

Figure 64 illustrates the impact of GEMS on all medical schemes. This restricted scheme was registered on 1 January 2005 but started with operations only on 1 January 2006.

FIGURE 64: IMPACT OF GEMS 2006–2015*

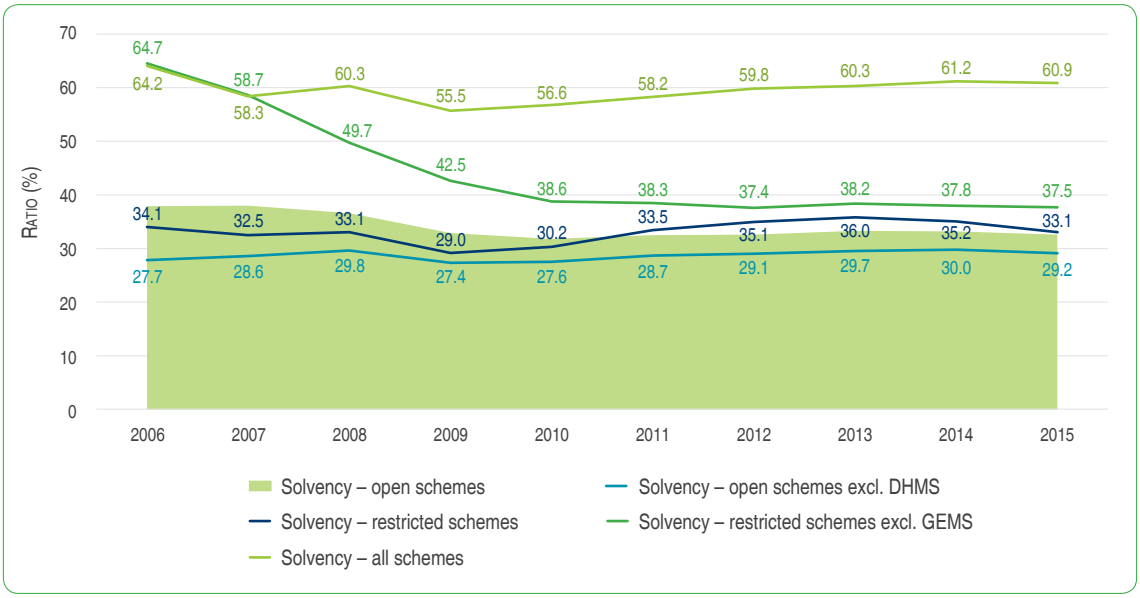


** Claims data per industry were available only from 2001 onwards and pensioner ratios from 2005 onwards.*

GEMS initially had a positive effect on the solvency levels of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who have steadily left them to join GEMS. The reserves which these members had accumulated over the years in open schemes were not transferred to GEMS.

A negative impact was subsequently experienced on some of these open schemes' claiming patterns as the members who left them to join GEMS tended to be young and healthy, and they were not necessarily replaced by members of a similar profile.

FIGURE 65: INDUSTRY SOLVENCY RATIOS EXCLUDING GEMS AND DHMS



Excluding GEMS, the restricted industry solvency ratio decreased in 2009 to 55.5% and then increased from 2010 onwards to 60.9% in 2015. The solvency ratio of the restricted scheme industry is much lower when GEMS results are included. This indicates the significant impact of GEMS on the restricted schemes industry.

In comparison, DHMS has a lesser impact on the open scheme industry. Excluding DHMS, the 2015 open industry solvency ratio increases to 33.1% (from 29.2%).

Medical schemes should be careful of the so-called 'death spiral'. A scheme with a disadvantageous, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members being highly priced, causing the younger and lower-claiming members to move to other, less expensive options, or even other medical schemes. This results in the scheme losing the cross-subsidy provided by these younger members and therefore to an increase in losses, resulting in even higher contribution increases and/or reductions in benefits.

Beneficiaries of schemes which failed to reach the 25.0% solvency

Table 45 and Figure 66 show the number of medical schemes which have yet to attain the prescribed solvency ratio of 25.0% and the number of beneficiaries in those schemes.

TABLE 45: PRESCRIBED SOLVENCY AND NUMBER OF BENEFICIARIES 2000–2015

Year	Number of open schemes		Number of restricted schemes	
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
2000	15	33	15	86
2001	19	29	11	83
2002	24	25	7	86
2003	19	29	7	80
2004	18	30	4	81
2005	17	29	4	79
2006	18	23	4	79
2007	18	23	7	74
2008	14	21	8	71
2009	16	17	3	71
2010	12	15	7	66
2011	9	17	5	66
2012	7	18	4	63
2013	6	18	3	60
2014	5	18	2	58
2015	4	19	3	57

Year	Number of beneficiaries in open schemes			Number of beneficiaries in restricted schemes		
	Below prescribed level		Above prescribed level	Below prescribed level		Above prescribed level
	At end	%	At end	At end	%	At end
2000	2 385 051	51.0	2 291 048	839 029	40.9	1 214 412
2001	2 650 934	55.6	2 117 142	576 462	28.9	1 419 862
2002	3 519 329	74.4	1 211 882	251 050	12.7	1 731 873
2003	3 426 988	72.6	1 291 809	222 430	11.4	1 730 574
2004	2 534 273	53.3	2 221 030	80 160	4.2	1 827 100
2005	2 783 108	56.7	2 122 444	36 359	1.9	1 893 710
2006	3 218 382	63.7	1 832 056	145 369	7.0	1 931 536
2007	3 139 176	63.4	1 812 141	689 865	26.0	1 964 054
2008	1 076 450	22.0	3 812 456	981 977	32.9	2 003 943
2009	992 523	20.6	3 822 811	1 254 151	38.6	1 999 020
2010	2 918 055	60.8	1 881 860	1 684 682	47.9	1 831 121
2011	2 855 072	60.0	1 905 042	1 865 313	49.5	1 900 982
2012	2 796 583	58.8	1 963 411	1 978 668	50.4	1 943 538
2013	2 860 768	59.0	1 986 141	1 994 813	50.7	1 936 586
2014	212 169	4.3	4 687 806	1 914 481	48.9	2 000 002
2015	194 983	3.9	4 743 470	1 943 387	50.2	1 927 683

The total number of schemes below 25% has declined since 2001. Although there have been numerous amalgamations, the reduction in schemes below 25% was not mainly due to amalgamation but also due to schemes attaining the minimum solvency ratio.

FIGURE 66: PRESCRIBED SOLVENCY AND NUMBER OF BENEFICIARIES 2014 AND 2015

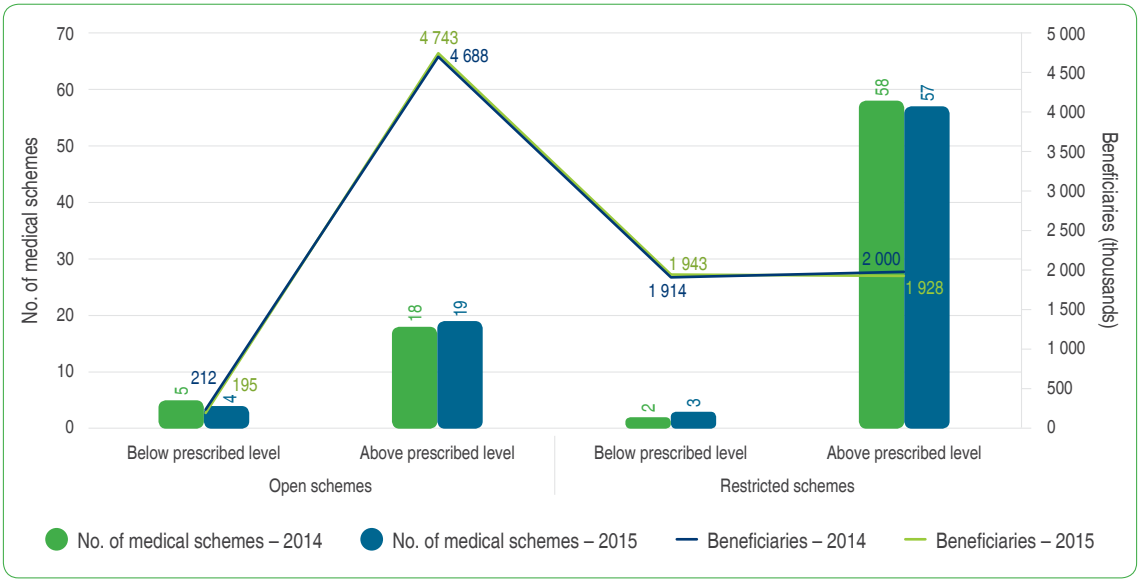


TABLE 46: SCHEMES ON CLOSE MONITORING IN THE PAST FIVE YEARS

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments
2010	12				7			
2011	9	-3	0	Protea Medical Aid Society liquidated Pro Sano Medical Scheme reached 25% Spectramed reached 25%	5	-1	-1	Lonmin Medical Scheme reached 25% Built Environment Professional Associations Medical Scheme (BEPS) amalgamated with Topmed Medical Scheme
2012	7	-1	-1	National Independent Medical Aid Society (NIMAS) amalgamated with Resolution Health Medical Scheme Community Medical Aid Scheme (COMMED) reached 25% Momentum Health reached 25% Pro Sano Medical Scheme fell below 25%	4	-1	0	Minemed Medical Scheme reached 25%
2013	6	0	-1	Pro Sano Medical Scheme amalgamated with Bonitas Medical Fund Keyhealth reached 25% Liberty Medical Scheme dropped below 25%	3	-1	0	Altron Medical Aid Scheme reached 25%

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments
2014	5	0	-1	Pharos Medical Plan amalgamated with Topmed Medical Scheme	2	-1	0	Umvuzo Health Medical Scheme reached 25%
				Discovery Health Medical Scheme reached 25%				
				Hosmed Medical Aid Scheme reached 25%				
				Community Medical Aid Scheme (COMMED) fell below 25%				
				Suremed Health fell below 25%				
2015	4	-1	0	Suremed Health reached 25%	3	1	0	Platinum Health dropped below 25%.

A total of 3.9% beneficiaries in open schemes (2014: 4.3%) were covered by the four open schemes (2014: five) that failed to meet the prescribed solvency level in 2015. The remaining beneficiaries belonged to the other 19 open schemes (2014: 18) that had attained the prescribed solvency level of 25%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25%. This was mainly due to DHMS, the biggest scheme in South Africa, failing to attain the minimum prescribed solvency ratio. When DHMS reached the solvency ratio of 25% – in 2008, 2009, 2014 and 2015 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015 this figure was a mere 3.9% compared to 4.31% in 2014 and 59.0% in 2013.

Of the 60 restricted schemes, only three had solvency ratios below 25%. These three, however, accounted for 50.2% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory solvency level of 25% and this accounts for 91.7% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

The CMS closely monitors schemes below the 25% solvency ratio by having regular meetings with them in order to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes' environment and the progress that schemes have made thus far in moving towards the prescribed solvency levels, but much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

Risk Assessment Framework and high-impact schemes

The Risk Assessment Framework (RAF) is a regulatory tool adopted by the CMS to identify both scheme-specific and cross-cutting risks related to the medical schemes environment. The RAF enables the CMS to identify high-impact schemes which would have a major effect on the entire industry if they were to fail financially or in some other way. The classification as high-impact does not necessarily mean that the identified scheme represents an actual risk or that it is experiencing problems.

Table 47 shows that the average contributions of high-impact open schemes were 3.1% higher than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that was 6.4% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of Risk Contribution Income (RCI) of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 101.7%.

TABLE 47: HIGH-IMPACT SCHEMES BY TYPE 2014 AND 2015

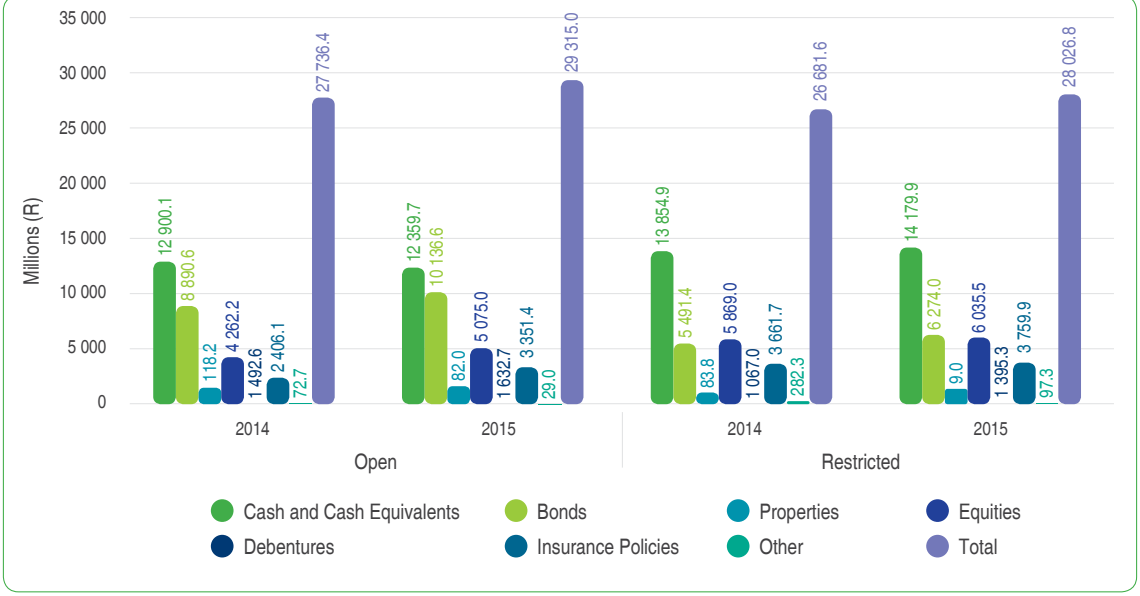
	Average beneficiaries		Net contributions pabpm (R)		Net claims ratio (%)		Net non-healthcare ratio (%)		Solvency ratio (%)	
	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Open schemes	4 741 823	4 699 870	1 323.8	1 229.2	88.7	87.7	11.9	12.1	28.0	28.8
Restricted schemes	3 136 776	3 190 195	1 283.9	1 183.6	94.8	95.0	5.9	5.8	26.1	26.2
Total schemes	**7 878 599**	**7 890 065**	**1 307.9**	**1 210.8**	**91.1**	**90.6**	**9.6**	**9.6**	**27.3**	**27.9**

pabpm = per average beneficiary per month

Investments

Figure 67 provides information on the investments of medical schemes as at the end of the years 2014 and 2015.

FIGURE 67: SCHEME INVESTMENTS 2014 AND 2015



In open schemes, 42.2% of investments (2014: 46.5%) were held in cash or cash equivalents. Bonds accounted for 34.6% (2014: 32.1%), debentures for 0.3% (2014: 0.4%), equities for 17.3% (2014:15.4%), non-linked insurance policies for 0.0% (2014: 0.0%), properties for 5.6% (2014: 5.4%), and other investments for 0.1% (2014: 0.3%).

Restricted schemes also held a large proportion of their investments (50.6%) in cash or cash equivalents (2014: 51.6%). Their bonds accounted for 22.4% (2014: 20.6%) and debentures for 0.0% (2014: 0.3%). Equities made up 21.5% (2014: 22.0%), non-linked insurance policies 0.1% (2014: 0.1%), properties 5.0% (2014: 4.0%), and other investments 0.3% (2014: 1.1%).

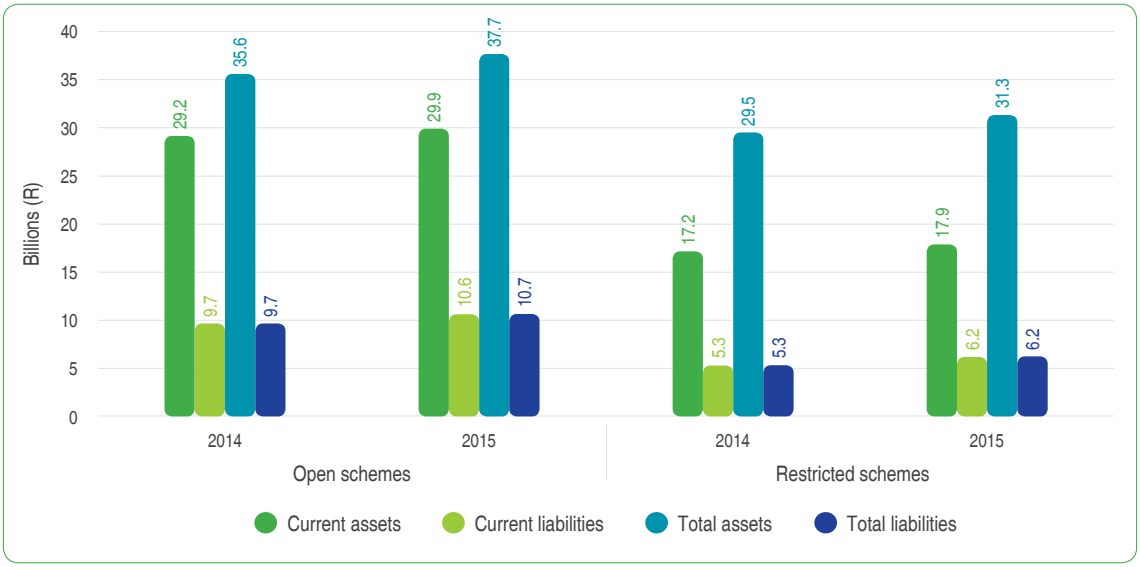
The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number indicates that the scheme has greater liabilities than assets and is therefore technically insolvent and in breach of section 35(3) of the Medical Schemes Act.

Schemes should pay attention to more than just their total asset and liability positions; they should also consider the periods in which liabilities must be paid and in which assets can be converted into cash flows.

Figure 68 compares the matching of assets and liabilities in open and restricted schemes.

FIGURE 68: MATCHING OF ASSETS AND LIABILITIES 2014 AND 2015



The current-assets-to-current-liabilities ratio in open schemes was 2.8:1 in 2015 (3.0:1 in 2014) and it was 2.9:1 (2014: 3.2:1) in restricted schemes. The total-asset-to-total-liability ratio for open and restricted schemes in 2014 was 3.5:1 (2014: 3.7:1) and 5.0:1 (2014: 5.5:1) respectively.

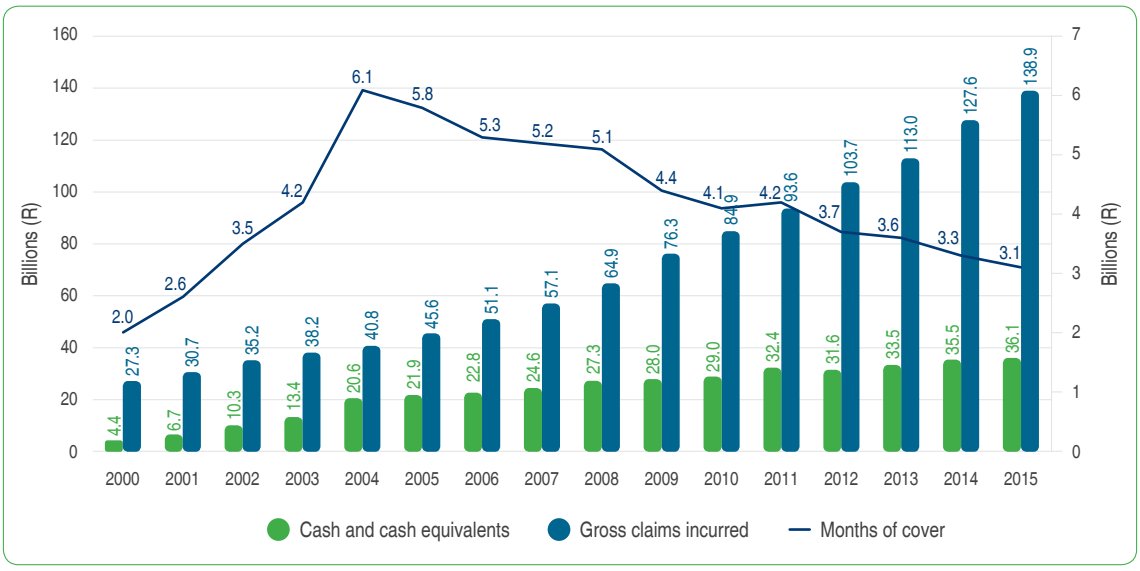
The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, a quick ratio below 2.0) is lower than the industry average of 3.1 months, boards of trustees must guard against longer-term, riskier investments. Although such investments may offer the prospect of higher returns, they may prove detrimental to the scheme should it experience a liquidity crunch.

Claims-paying ability of schemes

The financial soundness of a medical scheme is also measured by its ability to pay claims from cash and cash equivalents.

Figure 69 depicts the claims-paying ability of schemes measured in months of cover. This is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

FIGURE 69: AVERAGE GROSS CLAIMS COVERED BY CASH AND CASH EQUIVALENTS 2000–2015



The length of cash coverage declined from 3.3 months in 2014 to 3.1 months in December 2015. Payment cycles of medical schemes in 2015 were an average of 12.2 days compared with the 11.1 days in 2014.

Administrator market

Figure 70 shows the market share of medical scheme administrators as well as self-administered medical schemes based on the average number of beneficiaries administered at the end of 2015[11].

FIGURE 70: ADMINISTRATOR MARKET SHARE AT THE END OF 2015

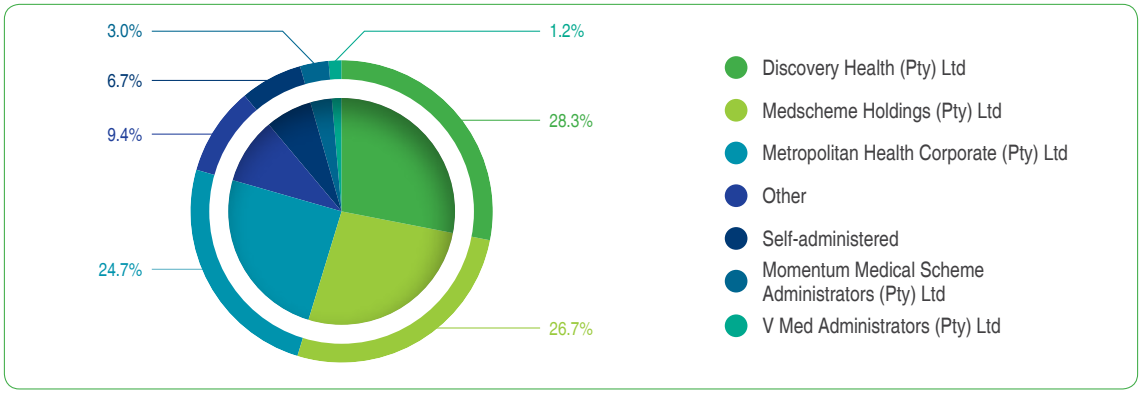
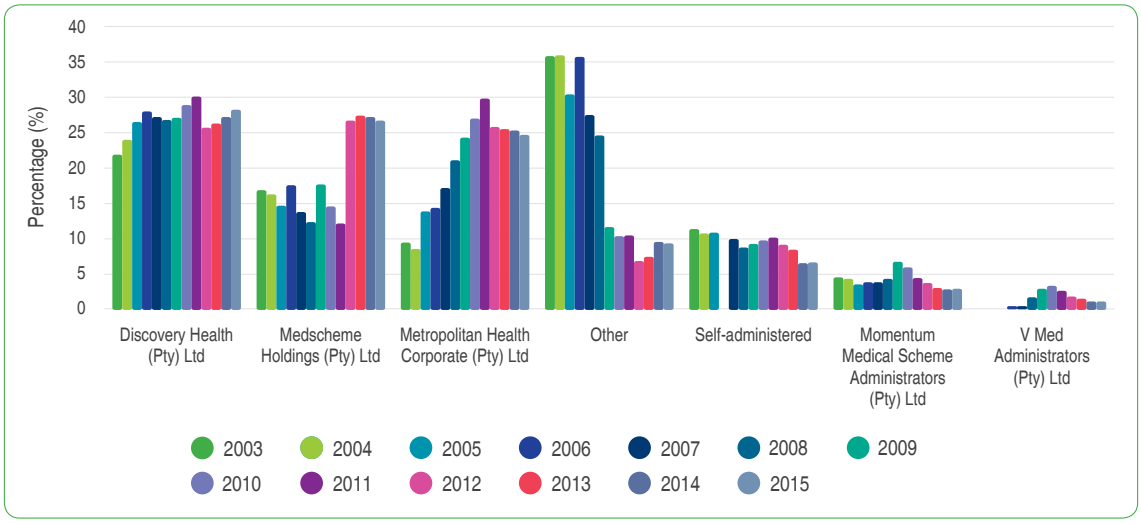


Figure 71 depicts the changes in market share of all medical schemes over the past 13 years based on the average number of beneficiaries administered by the various parties at the end of each year.

FIGURE 71: MARKET SHARE OF LARGEST ADMINISTRATORS BASED ON AVERAGE NUMBER OF BENEFICIARIES 2003–2015*



** The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AC).*

Five third-party administrators continued to dominate the market in 2015, namely:

- Discovery Health (Pty) Ltd;
- Metropolitan Health Corporate (Pty) Ltd;
- Medscheme Holdings (Pty) Ltd;
- Momentum Medical Scheme Administrators (Pty) Ltd; and
- V Med Administrators (Pty) Ltd.

Collectively, these companies administer 83.9% of the market (excluding self-administered medical schemes).[12]

Table 48 indicates the change in administrator market share between 2010 and 2015.

11 *The data presented here differ from Annexure AC, which is based on the average membership administered during the year.*

12 *The Government Employees Medical Scheme (GEMS) had a joint administrator contract in place in 2013. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The membership was included for both administrators.*

TABLE 48: ADMINISTRATOR MARKET SHARE 2010–2015

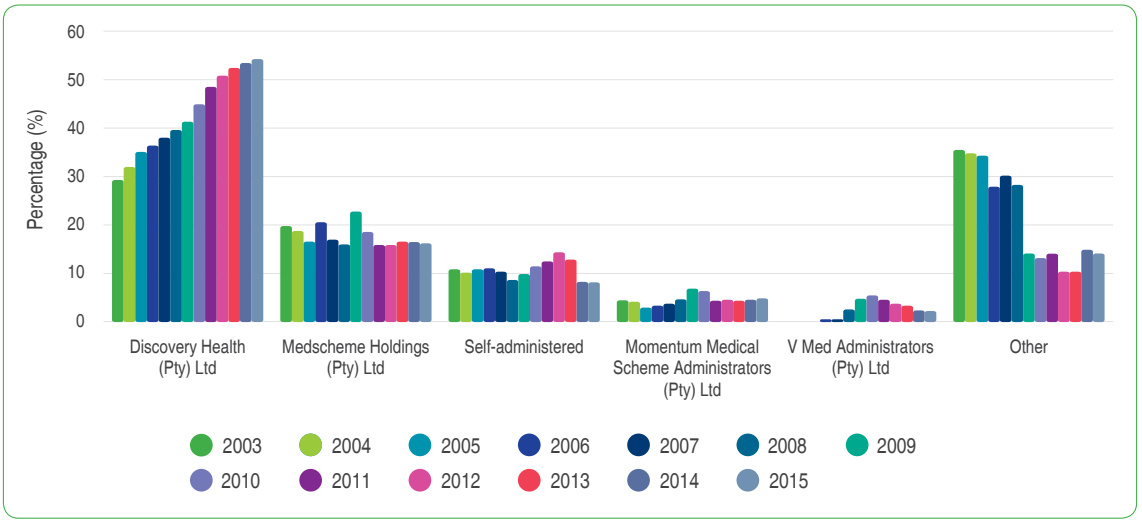
Largest market share – all schemes	2010 %	2011 %	2012 %	2013 %	2014 %	2015 %	% change: 2010–2015
Discovery Health (Pty) Ltd	28.9	30.1	25.7	26.3	27.2	28.3	-2.1
Medscheme Holdings (Pty) Ltd	14.6	12.2	26.7	27.4	27.2	26.7	82.9
Metropolitan Health Corporate (Pty) Ltd	27.0	29.8	25.8	25.5	25.3	24.7	-8.5
Other	10.4	10.5	6.9	7.5	9.6	9.4	-9.6
Self-administered	9.8	10.2	9.2	8.5	6.6	6.7	-31.6
Momentum Medical Scheme Administrators (Pty) Ltd	6.0	4.5	3.8	3.1	2.9	3.0	-50.0
V Med Administrators (Pty) Ltd	3.4	2.7	1.9	1.6	1.2	1.2	-64.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

Largest market share – open schemes	2010 %	2011 %	2012 %	2013 %	2014 %	2015 %	% change: 2010–2015
Discovery Health (Pty) Ltd	44.9	48.5	50.8	52.4	53.4	54.2	20.7
Medscheme Holdings (Pty) Ltd	18.6	15.9	15.9	16.6	16.5	16.2	-12.6
Self-administered	11.5	12.5	14.4	12.9	8.3	8.2	-28.7
Momentum Medical Scheme Administrators (Pty) Ltd	6.4	4.4	4.6	4.4	4.6	4.9	-23.4
V Med Administrators (Pty) Ltd	5.5	4.6	3.8	3.4	2.4	2.3	-58.2
Other	13.2	14.1	10.4	10.4	14.9	14.1	7.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

Largest market share – restricted schemes	2010 %	2011 %	2012 %	2013 %	2014 %	2015 %	% change: 2010–2015
Metropolitan Health Corporate (Pty) Ltd	64.9	67.8	47.4	46.7	46.6	46.2	-28.8
Medscheme Holdings (Pty) Ltd	8.9	7.3	35.9	36.3	36.3	35.8	302.8
Self-administered	7.3	7.1	4.8	4.9	5.1	5.5	-25.1
Discovery Health (Pty) Ltd	6.2	6.4	4.4	4.6	5.1	5.7	-7.5
Momentum Medical Scheme Administrators (Pty) Ltd	5.4	4.7	3.0	2.1	1.4	1.4	-73.5
Other	7.4	6.7	4.4	5.4	5.4	5.3	-28.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

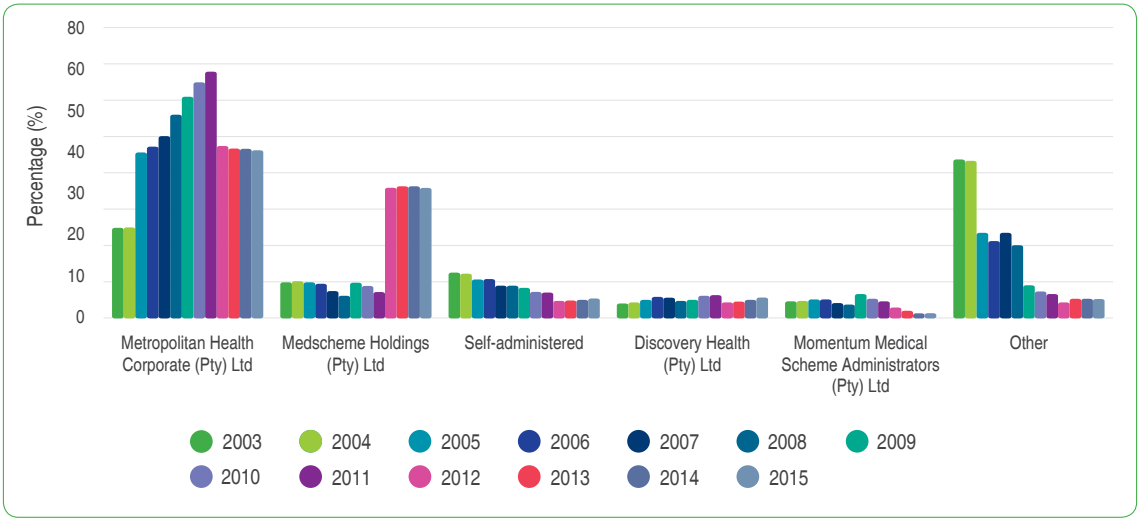
Figures 72 and 73 indicate the changes in administrator market share over the past 13 years for open and restricted medical schemes, respectively.

FIGURE 72: OPEN SCHEMES MARKET SHARE OF LARGEST ADMINISTRATORS BASED ON AVERAGE NUMBER OF BENEFICIARIES 2003–2015*



* *The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AC).*

FIGURE 73: RESTRICTED SCHEMES MARKET SHARE OF LARGEST ADMINISTRATORS BASED ON AVERAGE NUMBER OF BENEFICIARIES 2003–2015*



* *The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AC).*

Discovery Health (Pty) Ltd's share of the open schemes market increased to 54.2% (2014: 53.4%) and its share in the restricted schemes market increased to 5.7% (2014: 5.1%).

Medscheme Holdings (Pty) Ltd has the second-biggest share in both the open and restricted schemes administration market at 16.2% (2014: 16.5%) and 35.8% (2014: 36.3%), respectively. Medscheme Holdings (Pty) Ltd has been responsible for GEMS' contribution and debt management as well as correspondence services since 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the biggest share of the restricted schemes market at 46.2% (2014: 46.6%).

Table 49 shows the five administrators who had higher administration costs and fees than the industry average of administrators handling open schemes.

TABLE 49: PERCENTAGE DEVIATION FROM INDUSTRY AVERAGE: OPEN SCHEMES

	Gross administration costs %	Administration fees paid* %	Fees paid to administrators %
Allcare Administrators (Pty) Ltd	84.7	23.4	36.5
Strata Healthcare Management (Pty) Ltd	22.6	32.5	31.8
Discovery Health (Pty) Ltd	-0.9	20.3	19.6
V Med Administrators (Pty) Ltd	13.9	-4.6	17.9
Universal Healthcare Administrators (Pty) Ltd	17.5	5.5	4.8

* *Excluding co-administration fees*

Table 50 shows the two administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

TABLE 50: PERCENTAGE DEVIATION FROM INDUSTRY AVERAGE: RESTRICTED SCHEMES

	Gross administration costs %	Administration fees paid* %	Fees paid to administrators %
Eternity Private Health Fund Administrators (Pty) Ltd	74.5	65.8	65.8
Professional Provident Society Healthcare Administrators (Pty) Ltd	72.6	19.5	19.5

* *Excluding co-administration fees*

Administrators often provide call centre and marketing services, among others. Expenditure related to these were included in the 'fees paid to administrators' figures.

Tables 51 and 52 show administrator market share based on the average number of beneficiaries to whom services are being delivered by third-party administrators and medical schemes under self-administration. The tables also show the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure AC.)

TABLE 51: ADMINISTRATOR MARKET SHARE 2015 (OPEN SCHEMES)

Name of administrator	No. of schemes	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Agility Global Health Solutions Africa (Pty) Ltd	2	1.6	180.9	11.4	95.6	6.0	95.6	6.0	1 581.0	91.8
[redacted]										
Discovery Health (Pty) Ltd	1	54.2	125.2	8.0	121.3	7.8	121.3	7.8	1 557.1	86.1
Medscheme Holdings (Pty) Ltd	2	16.2	121.8	8.3	83.9	5.7	84.0	5.7	1 469.4	93.5
Momentum Medical Scheme Administrators (Pty) Ltd	1	4.9	99.4	8.7	94.0	8.2	94.0	8.2	1 145.7	86.2
Private Health Administrators (Pty) Ltd	1	1.0	114.0	8.6	80.3	6.0	80.3	6.0	1 329.5	97.4
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.5	151.4	7.4	89.8	4.4	89.8	4.4	2 040.7	93.9
Providence Healthcare Risk Managers (Pty) Ltd	2	0.4	89.3	8.3	63.5	5.9	63.5	5.9	1 081.3	89.2
Sechaba Medical Solutions (Pty) Ltd	1	2.6	141.7	9.4	99.7	6.6	99.7	6.6	1 514.4	88.3
Self-Administered	5	8.2	115.0	7.3	-	-	-	-	1 582.9	92.3
Strata Healthcare Management (Pty) Ltd	1	4.1	154.8	9.8	133.6	8.4	133.6	8.4	1 587.1	88.5
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	1.9	127.1	9.9	74.1	5.8	74.1	5.8	1 287.6	87.4
Universal Healthcare Administrators (Pty) Ltd	2	0.7	148.4	11.1	106.3	8.0	106.3	8.0	1 287.6	87.4
V Med Administrators (Pty) Ltd	1	2.3	143.8	8.8	96.2	5.9	119.5	7.3	1 637.0	93.2
Average	23	100.0	126.3	8.3	100.8	6.6	101.4	6.7	1 523.5	88.7

* *Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

TABLE 52: ADMINISTRATOR MARKET SHARE 2015 (RESTRICTED SCHEMES)

Name of administrator	No. of schemes	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Allcare Administrators (Pty) Ltd	0	-	-	-	-	-	-	-	-	-
Discovery Health (Pty) Ltd	14	5.7	101.5	7.2	89.0	6.3	89.0	6.3	1 406.4	91.4
Eternity Private Health Fund Administrators (Pty) Ltd	1	0.8	183.4	10.6	148.2	8.5	148.2	8.5	1 734.7	94.5
Medscheme Holdings (Pty) Ltd**	11	35.8	18.3	1.4	9.5	0.7	16.7	1.2	1 351.7	13.1
METHEALTH (Pty) Ltd	4	0.9	103.8	7.5	83.4	6.0	83.4	6.0	1 390.0	102.7
Metropolitan Health Corporate (Pty) Ltd	9	46.2	62.5	14.5	37.6	8.7	37.6	8.7	1 351.5	95.9
Momentum Medical Scheme Administrators (Pty) Ltd	3	1.4	92.5	7.2	72.2	5.6	73.7	5.8	1 281.8	95.1
Prime Med Administrators (Pty) Ltd	1	0.7	68.8	4.3	60.7	3.8	60.7	3.8	1 614.3	98.6
Private Health Administrators (Pty) Ltd	1	0.1	89.3	5.8	63.0	4.1	63.0	4.1	1 536.1	94.9
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.2	181.4	11.9	106.8	7.0	106.8	7.0	1 521.3	90.0
Providence Healthcare Risk Managers (Pty) Ltd	3	0.8	56.1	6.7	40.1	4.8	40.1	4.8	833.9	92.3
Self-Administered	8	5.5	67.6	6.6	-	-	-	-	1 020.8	88.5
Universal Healthcare Administrators (Pty) Ltd	4	0.7	87.2	7.0	74.7	6.0	74.7	6.0	1 244.7	90.1
V Med Administrators (Pty) Ltd	1	0.2	105.1	6.3	89.4	5.3	89.4	5.3	1 677.7	86.5
Average	61	100.0	52.6	5.8	31.6	3.5	34.2	3.7	914.2	94.9

pabpm = per average beneficiary per month
GCI = Gross Contribution Income
** Excluding co-administration fees*
*** The GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included.*

Table 53 indicates the total fees paid to the top four third-party administrators in terms of market share for all schemes, as well as the schemes falling under their administration.

Table 54 shows market share of administrators including accredited managed healthcare services.

Table 55 shows the six administrators who had the highest deviation from the 2015 industry average of R89.0 pabpm in respect of total fees received by administrators.

TABLE 53: TOTAL FEES PAID TO ADMINISTRATORS (EXCLUDING ACCREDITED MANAGED HEALTHCARE SERVICES) – DEVIATION FROM AVERAGE PER ADMINISTRATOR: 2015

Ref. no.	Name of medical scheme	Name of administrator	Average beneficiaries	Total other fees paid to administrators (incl. administration and co-administration fees) R'000	As % of GAE	Total other fees pabpm R	Total other fees pampm R	Average per administrator pabpm R	% deviation from average per administrator pabpm
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	2 663 054	3 874 897	96.8	121.3	258.3	117.8	3.0%
1145	LA-Health Medical Scheme		135 287	162 968	91.9	100.4	243.8		-14.7%
1430	Remedi Medical Aid Scheme		46 166	42 357	91.0	76.5	171.4		-35.0%
1599	Lonmin Medical Scheme		20 156	11 164	87.1	46.2	54.2		-60.8%
1012	Anglo Medical Scheme		19 322	17 265	60.6	74.5	156.7		-36.7%
1176	Retail Medical Scheme		19 041	22 218	94.8	97.2	172.8		-17.5%
1241	Naspers Medical Fund		16 352	19 531	85.2	99.5	188.6		-15.5%
1547	Malcor Medical Scheme		12 135	11 069	80.4	76.0	180.7		-35.5%
1516	Quantum Medical Aid Society		10 714	11 336	85.4	88.2	181.6		-25.1%
1579	Tsogo Sun Group Medical Scheme		10 273	9 835	80.7	79.8	174.4		-32.2%
1526	BMW Employees Medical Aid Society		7 652	6 040	85.9	65.8	153.7		-44.1%
1571	Anglovaal Group Medical Scheme		7 404	9 472	86.8	106.6	215.0		-9.5%
1520	University of Kwa-Zulu Natal Medical Scheme		6 988	7 882	87.8	94.0	196.1		-20.2%
1578	TFG Medical Aid Scheme		6 177	6 462	90.1	87.2	187.4		-26.0%
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund		5 446	7 573	87.6	115.9	217.4		-1.6%
1598	Government Employees Medical Scheme (GEMS)	Medscheme Holdings (Pty) Ltd	1 771 786	173 764	12.9	8.2	21.6	35.7	-77.0%
1512	Bonitas Medical Fund		654 190	604 349	66.8	77.0	170.5		115.8%
1202	Fedhealth Medical Scheme		144 054	200 244	76.5	115.8	232.1		224.5%
1234	Sasolmed		76 228	60 309	87.4	65.9	176.6		84.7%
1469	Nedgroup Medical Aid Scheme		51 874	58 647	87.0	94.2	171.1		164.0%
1214	Old Mutual Staff Medical Aid Fund		32 860	37 390	87.8	94.8	174.8		165.7%
1253	Glencore Medical Scheme		30 329	15 844	81.3	43.5	134.5		21.9%
1005	AECI Medical Aid Society		14 701	15 967	89.2	90.5	182.4		153.6%

Ref. no.	Name of medical scheme	Name of administrator	Average beneficiaries	Total other fees paid to administrators (incl. administration and co-administration fees) R'000	As % of GAE	Total other fees pabpm R	Total other fees pampm R	Average per administrator pabpm R	% deviation from average per administrator pabpm
1507	Barloworld Medical Scheme		12 844	12 880	85.0	83.6	184.1		134.3%
1424	SABC Medical Aid Scheme		10 632	10 179	78.6	79.8	172.7		123.6%
1039	MBMed Medical Aid Fund		9 674	7 869	88.6	67.8	163.8		90.0%
1441	Parmed Medical Aid Scheme		5 029	7 510	77.2	124.4	256.2		248.6%
1566	Horizon Medical Scheme		3 960	4 229	76.2	89.0	144.3		149.4%
1598	Government Employees Medical Scheme (GEMS)	Metropolitan Health Corporate (Pty) Ltd	1 771 786	639 578	47.6	30.1	79.4	37.6	-19.9%
1580	South African Police Service Medical Scheme (POLMED)		492 221	218 875	60.6	37.1	106.0		-1.3%
1279	Bankmed		210 929	205 256	75.2	81.1	163.6		115.8%
1582	Transmed Medical Fund		68 008	64 290	74.4	78.8	131.9		109.7%
1548	Medipos Medical Scheme		25 482	21 419	86.6	70.0	142.8		86.3%
1559	Imperial Group Medical Scheme		17 557	12 171	58.4	57.8	132.1		53.8%
1572	Engen Medical Benefit Fund		7 810	6 736	81.6	71.9	154.4		91.4%
1270	Golden Arrow Employees' Medical Benefit Fund		6 185	4 260	87.1	57.4	128.2		52.8%
1271	Fishing Industry Medical Scheme (Fishmed)		2 941	1 024	57.8	29.0	68.8		-22.8%
1167	Momentum Health	Momentum Medical Scheme Administrators (Pty) Ltd	240 822	271 533	94.6	94.0	179.5	88.5	6.2%
1600	Motohealth Care		56 024	47 388	77.4	70.5	153.8		-20.3%
1209	South African Breweries Medical Aid Scheme (SABMAS)		21 793	21 191	84.3	81.0	182.2		-8.5%
1186	PG Group Medical Scheme		2 896	2 820	87.0	81.1	173.1		-8.4%

GAE = Gross administration expenditure

TABLE 54: MARKET SHARE OF ADMINISTRATORS: INCLUDING ACCREDITED MANAGED HEALTHCARE SERVICES

Name of administrator	No. of schemes	Beneficiaries	Total fees paid to administrators (various services)*	Net relevant healthcare expenditure incurred	Accredited managed healthcare services (no transfer of risk) received*	Accredited managed healthcare services (risk transfer arrangement): capitation fee received*	Total fees received*
		Market share %	pabpm R	pabpm R	pabpm R	pabpm R	pabpm R
Agility Global Health Solutions Africa (Pty) Ltd	2	0.7	188.8	1 297.5	-	-	95.6
Discovery Health (Pty) Ltd	15	28.3	250.6	1 083.5	39.9	-	157.7
Eternity Private Health Fund Administrators (Pty) Ltd	1	0.4	271.9	1 501.2	36.7	-	185
Medscheme Holdings (Pty) Ltd**	13	26.7	75.0	1 325.6	22.7	-	53.3
METHEALTH (Pty) Ltd	4	0.5	173.8	1 305.9	30.8	93.9	140.2
Metropolitan Health Corporate (Pty) Ltd	9	24.7	110.5	1 243.6	8.6	41.6	55.3
Momentum Medical Scheme Administrators (Pty) Ltd	4	3.0	175.5	953.1	22.4	-	111.2
Prime Med Administrators (Pty) Ltd	1	0.4	133.1	1 352.9	33.9	-	94.6
Private Health Administrators (Pty) Ltd	2	0.5	160.0	1 162.3	-	-	78.9
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	1.3	211.6	1 595.0	21.0	-	108.9
Providence Healthcare Risk Managers (Pty) Ltd	5	0.6	102.2	783.6	26.6	-	63.6
Sechaba Medical Solutions (Pty) Ltd	1	1.2	239.7	1 337.8	26.4	-	126.2
Self-Administered	13	6.7	-	1 119.1	16.2	-	4.5
Strata Healthcare Management (Pty) Ltd	1	1.9	288.5	1 383.4	30.7	-	164.3
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	0.9	195.2	1 125.6	-	-	74.1
Universal Healthcare Administrators (Pty) Ltd	6	0.7	169.5	1 101.2	9.0	-	90.2
V Med Administrators (Pty) Ltd	2	1.2	236.6	1 355.5	34.0	-	150.4
Average	**84**	**100.0**	**85.7**	**1 186.6**	**30.1**	**45.8**	**89.0**

* *Excluding co-administration fees*

** *Only the GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included.*

TABLE 55: TOTAL FEES PAID TO ADMINISTRATORS (INCLUDING ACCREDITED MANAGED HEALTHCARE SERVICES) – DEVIATION FROM INDUSTRY AVERAGE (2015)

	Total fees paid to administrators (various services)* %	Accredited managed healthcare services (no transfer of risk) received* %	Accredited managed healthcare services (risk transfer arrangement): capitation fee received* %	Total fees received* %
Eternity Private Health Fund Administrators (Pty) Ltd	217.3	21.9	-100.0	107.9
Strata Healthcare Management (Pty) Ltd	236.6	2.0	-100.0	84.6
Discovery Health (Pty) Ltd	192.4	32.6	-100.0	77.2
V Med Administrators (Pty) Ltd	176.1	13.0	-100.0	69.0
METHEALTH (Pty) Ltd	102.8	2.3	105.0	57.5

* *Excluding co-administration fees*

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