Annual Report

2010~2011

Annual Report

2010~2011

RP | 52/2011
ISBN | 978 0 621 40011 3

Council for Medical Schemes
Private Bag X34
Hatfield 0028
Pretoria

t | + 27 (0)12 431 0500
f | + 27 (0)12 430 7644
e | information@medicalschemes.com
w | www.medicalschemes.com

The Council for Medical Schemes serves South Africa by learning from international experience – welcome to our world!

Contents

Part 1: the Council for Medical Schemes 1 April 2010-31 March 2011

Part 2: the medical schemes industry in 2010

He who has Health has Hope
he who has hope has
& Everything
Arabian proverb

Corporate overview

Profile

The Council for Medical Schemes (CMS) is the regulatory authority responsible for overseeing the medical schemes industry in South Africa. It administers and enforces the Medical Schemes Act 131 of 1998. The CMS is an autonomous public agency funded through levies charged to medical schemes. It is accountable to the Minister of Health who is responsible for national health matters.

Vision

Our vision is to regulate fairly and effectively in order to protect the interests of beneficiaries and to promote equity in access to medical schemes.

Mission

The Council for Medical Schemes will act in an administratively fair and transparent manner, with integrity and professionalism, and will achieve this by:

- *informing the public about their rights and obligations in respect of access to medical schemes;*
- *ensuring that all entities conducting the business of a medical scheme comply with the Medical Schemes Act;*
- *ensuring that complaints raised by the public are handled appropriately and speedily;*
- *contributing to the improved management and governance of medical schemes; and*
- *advising the Minister of Health of appropriate regulatory interventions that will assist in attaining national health policy objectives.*

Approach

We act in an administratively fair and transparent manner, with integrity, professionalism, and respect.

We are conscious of the need to be cost-effective in the use of our resources and those of regulated entities.

We are proportionate in our actions and recognise the responsibilities of trustees.

We are mindful not to impede innovation unduly, and focus on facilitating fair competition.

Our key strategic objectives

Strategic objective 1

We monitor the impact of the Medical Schemes Act, research developments, and recommend policy options to improve the regulatory environment.

We conduct research into the impact that the Medical Schemes Act is having on the key policy goals of reducing unfair discrimination in access to health insurance, improving access to prescribed benefits, and making information available on important trends in medical schemes.

Strategic objective 2

We secure an appropriate level of protection for beneficiaries of medical schemes and the public by authorising the conduct of medical schemes and monitoring their financial performance.

We assess the financial performance of schemes and monitor their compliance with financial management standards to contribute towards a financially sound medical schemes industry. We also ensure that all entities conducting the business of a medical scheme are appropriately licensed to do so.

Strategic objective 3

We provide support and guidance to trustees and promote understanding of the medical schemes environment among trustees, beneficiaries, and the public.

We assist with the training of trustees, provide advice, and work to improve the understanding of medical schemes among market participants. We also seek to increase our own understanding of the concerns and priorities of trustees and beneficiaries, and to be more responsive to their needs.

Strategic objective 4

We foster compliance with the Medical Schemes Act by medical schemes, administrators and brokers, and initiate enforcement action where required.

In taking vigorous and timely enforcement action, we treat all parties fairly. We act with integrity and in a consistent manner. We regard vigorous enforcement as an important deterrent to undesirable behaviour and as a key to our credibility.

Strategic objective 5

We investigate and resolve complaints raised by beneficiaries and the public.

We assist beneficiaries to achieve fair and unbiased outcomes when they lodge complaints against their medical schemes. We also contribute to the speedy resolution of appeals lodged with us or the independent Appeal Board.

Strategic objective 6

We foster the continued development of the Council for Medical Schemes as an employer of choice.

We maintain the CMS as an attractive place to work at by keenly focusing on our recruitment, remuneration, employee development, and equity strategies. We also seek to advance the values of teamwork and leadership, sharing, taking pride in our achievements, and doing things that improve people's lives. In addition, we strive to manage our financial resources in an impeccable manner and to enhance our business competence and effectiveness continuously through the use of appropriate information systems.

Strategic objective 7

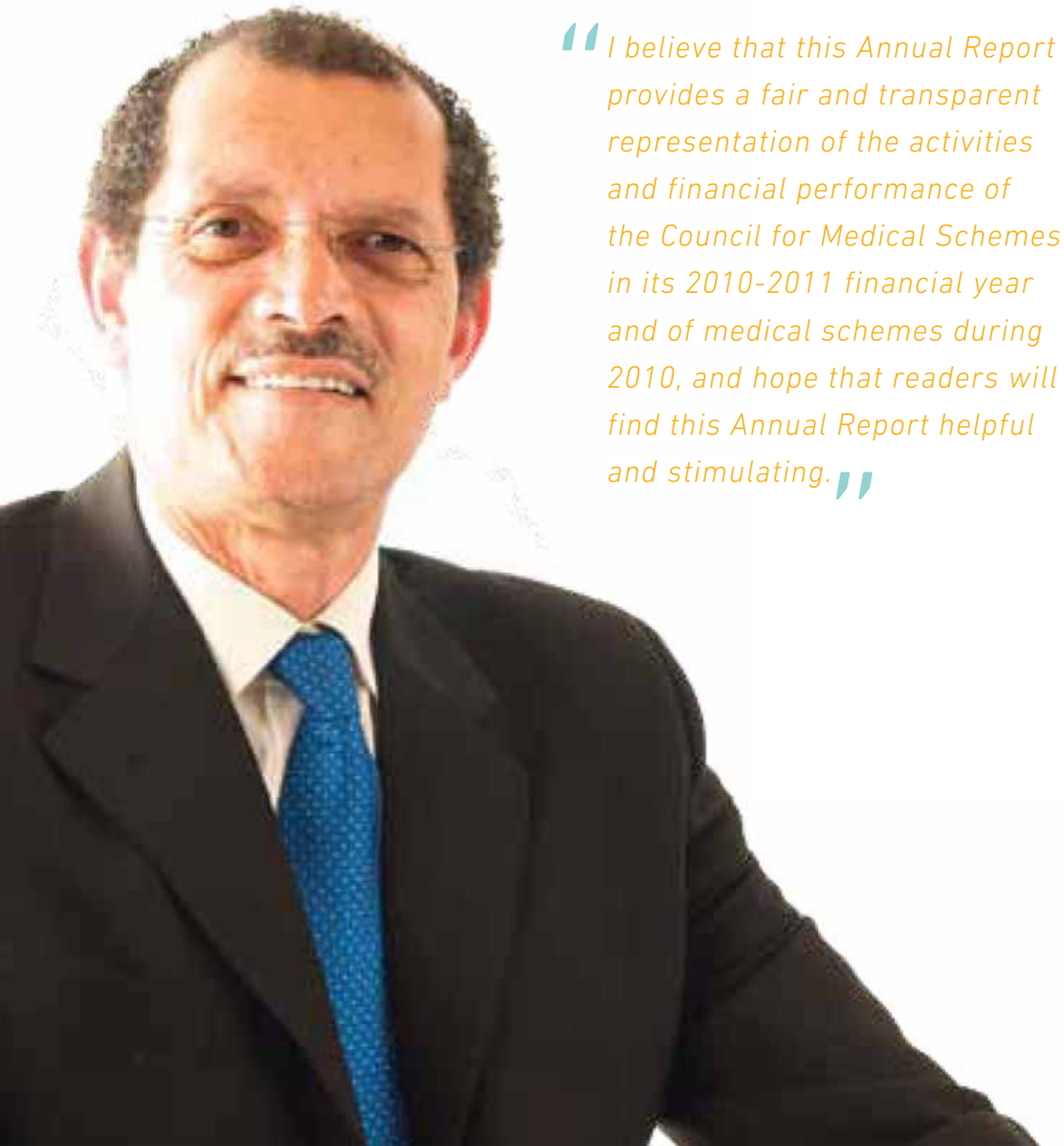
We develop strategic alliances nationally, regionally, and internationally.

We cooperate with and learn from the experiences of our regulatory counterparts at home and abroad so as to strengthen the health insurance regulatory system in South Africa.

Chairperson's statement

Professor William Pick

Chairperson, Council for Medical Schemes



"I believe that this Annual Report provides a fair and transparent representation of the activities and financial performance of the Council for Medical Schemes in its 2010-2011 financial year and of medical schemes during 2010, and hope that readers will find this Annual Report helpful and stimulating."

The Council for Medical Schemes, or CMS, continued to focus on its *raison d'être* and in so doing set itself some important objectives for the year 2010-2011.

The healthcare landscape is, however, undergoing some significant and exciting changes – changes which have implications for the way in which we regulate medical schemes and private healthcare in South Africa.

The emergence of a National Health Insurance (NHI) system and its successful implementation depend on South Africa's ability to regulate health service provision such that the interests of South Africans are both served and protected. The experience of the CMS over the past decade has emphasised the enormous challenges facing regulators in this sector. Unless the NHI is regulated efficiently and effectively, it will be yet another source of profit for a very creative, consumptive private sector, coming at the expense of the people of South Africa.

It is my hope that the experience of the Council for Medical Schemes will, in some small way, inform the national debate around regulation in an NHI system.

The year under review also saw an increase in legal challenges to the decisions of the CMS. The CMS is itself "regulated" by the Medical Schemes Act and cannot exceed the powers granted to it by the Act, and it is within the compass of these powers that the CMS addressed the issue of governance in medical schemes. The recourse to courts led to an unnecessary expenditure of members' money, and the CMS has taken note hereof. It appears that the increase in legal challenges is a reflection of the CMS's success in addressing this thorny issue. The struggle to ensure good governance of schemes will continue.

Protecting members

As indicated above, all our efforts in the period under review were aimed at making sure that members of medical schemes enjoy continued and improved protection against unpredictable and potentially catastrophic health events.

The CMS therefore continued to participate in the process aimed at demarcating medical schemes from health insurance in order to address the ever-present danger of unfair discrimination based on age and health status, and the protection of the integrity of the medical schemes industry. We also persevered in our efforts to review the regulatory framework governing the remuneration of healthcare brokers; we believe that consumers have the right to independent advice.

Protecting medical schemes

The financial sustainability of the existing medical schemes remains a priority for us. Only healthy schemes, empowered and supported by sound legislation, can offer healthy protection against ill health and guarantee respect for the constitutional imperative of fair treatment for all.

So we continued to guide and support medical schemes and the organisations affiliated with them to ensure that they are well-managed and financially sound. As mentioned above, good governance is a *sine qua non* if schemes are to serve their members. To this end governance structures must continue to be strengthened, especially in an environment as complex as healthcare, where people's health and livelihoods are at stake. Trustees responsible for the protection of their members' interests must be empowered and supported; effective trustees ease the burden on the regulator. Gaps in the legislative framework are being addressed through a comprehensive review process aimed at strengthening the provisions which speak to prospective regulation.

Medical schemes with sicker and older members are especially vulnerable to discriminatory market forces and deserve special attention. The systemic discrimination against such members in the current unequalised medical schemes environment needs resolution. The development and implementation of a system of risk adjustment remains a significant need; it will benefit all members, all schemes, all South Africans.

Strengthening the industry

For the benefit of all – members, medical schemes and society at large – certain topics remain of particular interest to us.

Cost escalation in the industry, especially among private hospitals and medical specialists, is one of them. The trend of ever-increasing healthcare prices has serious implications for the well-being and sustainability of the entire health system. In partnership with the Department of Health, a consultative process to enable collective price negotiations between medical schemes and service providers has been initiated.

The absence of effective supply-side regulation, especially in relation to private hospitals, remains a concern. Private hospital groups and specialists remain averse to contracting with medical schemes and members are being exposed to the risk of unfair billing practices. Supply-side reforms are clearly needed.

Caring about all South Africans

Our participation in regulatory and policy developments in the health and insurance industries ensures that the rights of every South African are borne in mind at all times.

All South Africans should be in a position to enjoy access to quality care.

Gratitude

I am proud of the fact that the Auditor-General has given the Council for Medical Schemes another unqualified audit for the period under review – our 11th clean audit in a row.

I thank Principal Officers, trustees, administrators, managed care organisations, brokers and other industry stakeholders for their continued cooperation over the last financial year.

My fellow Councillors are thanked for their dedication and support for the causes of this unique regulatory body.

I thank staff at the Office of the Registrar for the opportunity to report on their efforts and achievements in the period under review.

On behalf of the Council, I pledge our continued commitment to strengthening our relationships with the Ministry of Health and many others who are equally convinced of the need to promote equitable access to private health financing and quality care.

Prof. William Pick
Chairperson
Council for Medical Schemes
29 July 2011

Registrar's review

Dr Monwabisi Gantsho

Registrar & Chief Executive, Council for Medical Schemes

"The Council for Medical Schemes believes that access to quality care is the right of every South African."

In terms of Section 7 of the Medical Schemes Act 131 of 1998, there are specific functions which the Council and the Registrar of Medical Schemes are required to perform by instruction from the Executive Authority in order to provide regulatory supervision of private health financing through medical schemes.

To this end the Office of the Registrar continued to excel in the financial year 2010-2011 by using expertise in law, actuarial sciences, economics and consumer affairs as expected by the Minister of Health in terms of the Medical Schemes Act.

Section 7 of the Medical Schemes Act prescribes that the Council for Medical Schemes (CMS) shall:

- protect the interests of beneficiaries at all times;
- control and coordinate the functioning of medical schemes in a manner that is complementary with national health policy;
- 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;
- investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Medical Schemes Act;
- collect and disseminate information about private healthcare;
- make rules, not inconsistent with the provisions of the Medical Schemes Act, for the purpose of the performance of its functions and the exercise of its powers;
- advise the Minister of Health on any matter concerning medical schemes; and
- perform any other functions conferred on the Council by the Minister of Health or by the Medical Schemes Act.

Strategic objective

We monitor the impact of the Medical Schemes Act, research developments, and recommend policy options to improve the regulatory environment.

1

Strategic objective 1

We monitor the impact of the Medical Schemes Act, research developments, and recommend policy options to improve the regulatory environment.

Regulatory and policy developments

Reviewing legislation

The Council for Medical Schemes (CMS) continued to interact with the Department of Health and the Ministry on the Medical Schemes Amendment Bill to improve on current legislation where gaps have been identified.

A comprehensive legislative review process aimed at addressing shortcomings in the Medical Schemes Act was initiated in the year under review.

The areas of emphasis are:

- demarcation (defining the business of a medical scheme and distinguishing medical schemes from "traditional" insurance products);
- strengthening the framework on prescribed minimum benefits (PMBs);
- protecting members exposed to liquidations of medical schemes; and
- strengthening the governance of medical schemes.

The services of a professional drafter were engaged to facilitate this process.

Regulation 8 and the Board of Healthcare Funders of Southern Africa

Our Legal Services Unit continued to support the Office of the Registrar and the Council in ensuring that medical schemes properly comply with Regulation 8 of the Medical Schemes Act and pay in full for PMB conditions.

The Board of Healthcare Funders of Southern Africa (BHF) sought to challenge our position on Regulation 8 in the High Court. A number of interested parties showed a strong interest in the matter and indicated a desire to join the court action in support of our position.

The court postponed the matter and it is anticipated that it will be heard during the forthcoming financial year.

Rendering PMBs to members of medical schemes is a cornerstone of the protection afforded to members in terms of the Medical Schemes Act. This case is crucial in defining the scope and ambit of regulation in this regard.

Demarcation and top-up or gap cover

The Legal Services Unit continued to work closely with the Compliance Unit in its interventions to prevent insurance products doing the business of a medical scheme from continuing to operate.

As reported in the previous financial year, the Supreme Court of Appeal (SCA) ruling in the Guardrisk case saw a prohibition of top-up and gap cover products, and legal steps to curb these products have been taken during the period under review. A number of products have been identified and will be subjected to judicial scrutiny during the forthcoming financial year. The importance of acting against insurance products doing the business of a medical scheme lies in the fact that these products – while eroding the principle of risk cross-subsidisation – are not obliged to provide the protection to policy holders which medical schemes are required to furnish in terms of the Medical Schemes Act.

Consumer Protection Act

The advent of the Consumer Protection Act 68 of 2008 (CPA) which became law on 1 April 2011 has far-reaching implications for both consumers and regulatory bodies.

As the Medical Schemes Act is consumer-orientated and seeks to protect members of medical schemes, who are in essence consumers falling within the ambit of private healthcare insurance, a process was embarked upon to analyse the CPA with a view to establishing the extent to which the Medical Schemes Act was aligned with the CPA and to identify those areas where the regulatory framework required adjusting.

The process embarked upon envisaged both an evaluation of the internal processes in place at the CMS, specifically in the area of complaints adjudication, and an evaluation of the extent to which medical schemes and their rules are aligned with the requirements of the CPA.

This process gave rise to a draft exemption application wherein the Minister of Trade and Industry will be requested to exempt the CMS from certain provisions of the CPA pending the alignment of the regulatory framework with the CPA. This exemption will also allow medical schemes the opportunity to align their processes with the requirements of the CPA.

The process is ongoing and the Registrar is scheduled to meet with the Consumer Commissioner during May 2011 to discuss the proposed exemption application, the conclusion of a Memorandum of Understanding between the CMS and the Consumer Commission, and the impact of the CPA on the medical schemes environment.

Competition Act

The Competition Act 89 of 1998 makes it incumbent on the Competition Commission to enter into agreements with other regulatory bodies where their jurisdiction and roles overlap.

The respective custodians of the Competition Act and Medical Schemes Act share regulatory oversight where entities which fall within the ambit of the Medical Schemes Act – including schemes, administrators and healthcare brokerages – wish to merge or buy each other out. The Council for Medical Schemes engaged with the Commission to clarify our unique functions as regulatory bodies. A draft Memorandum of Understanding (MoU), which takes into account Section 63 of the Medical Schemes Act, was prepared and forwarded to the Commission for final input before it is expected to be signed.

Evaluating the risk profiles of schemes

The Medical Schemes Act provides for open enrolment, community rating and prescribed minimum benefits (PMBs). These three pillars of the Act control risk-rating to a large extent and protect older and sicker members against unfair discrimination in favour of younger and healthier members of medical schemes.

A system of risk adjustment is an important element required to strengthen these solidarity principles in healthcare.

There has been a focus on the development of National Health Insurance (NHI) but due to uncertainty surrounding the final details of NHI, a risk adjustment system was never implemented.

Yet it is important that the knowledge and capacity which were gained during the shadow period of developing the risk adjustment structure are maintained and that the Council for Medical Schemes (CMS) continues to collect risk profile information. This work is now being done by the Strategic Projects Unit (SPU); the Unit published the annual report on 2009 risk structure submissions and gave feedback to schemes on their 2010 submissions for the first two quarters of 2010. The annual report on risk submissions dealing with 2010 returns will be published in the next financial year.

The PMB pricing study based on data from 2005 has become outdated and the risk factors which schemes faced in 2005 may no longer be relevant. With support from technical industry experts, we collected detailed claim-level data for 2009 on 5.4 million beneficiaries. This information is being analysed to establish the cost of the PMB package and to identify the key risk factors which best predict a scheme's financial liability.

Defining PMBs

Following the review of PMB Regulations, which had started in 2008, the CMS submitted draft amendments to PMB Regulations to the Minister of Health. These draft amendments will be published for public comment soon.

In the meantime, we have started developing improved definitions for PMBs. We led a series of consultative meetings with various stakeholders to improve the benefit definitions for solid organ transplants, breast cancer, prostate cancer and gastrointestinal cancer. This initiative aims to improve on the clarity of PMBs as prescribed in Regulations.

Developing a Code of Conduct on PMBs

Subsequent to the release of Circulars 37 of 2009 *(Non-compliance by the medical schemes industry in respect of the provision and payment of prescribed minimum benefits)*, 7 of 2010 *(Extension of time to comply with Circular 37 of 2009 granted)* and 9 of 2010 *(Compliance with Circular 37 of 2009 – further extension of deadline and the establishment of a PMB Task Team)* as well as meetings with the Minister of Health and stakeholder representatives on the funding of PMBs, the Department of Health – with assistance from the CMS and Health Professions Council of South Africa (HPCSA) – held a workshop with affected parties on 11 May 2010 in Johannesburg's East Rand.

Parties to this process agreed that it is in the best interest of medical scheme members to proceed with a collaborative approach to find solutions to PMB-related problems; this led to the establishment of a representative task team.

The PMB Task Team prepared a PMB Code of Conduct during June and July 2010. The immediate objective was to ensure that PMBs are offered to members of medical schemes in compliance with current legislation.

Secondly, it was agreed that the task team will continue to exist in order to advise the Department of Health and the CMS on possible amendments to PMB Regulations.

The PMB Code of Conduct – which is available on our website (*www.medicalschemes.com*) – addresses appropriate behaviour expected of stakeholders to ensure compliance with existing PMB Regulations made in terms of the Medical Schemes Act 131 of 1998.

National Health Insurance

The Council for Medical Schemes (CMS) believes that access to quality care is the right of every South African.

The development of a National Health Insurance (NHI) system for South Africa does not fall within our mandate. The proposal to strategically reform the South African health system is being initiated and driven by the Department of Health and the Ministry, and we keenly await the publication of the official policy proposal to be able to engage with it and support the NHI process where we may be instructed to do so by the Department of Health. We should be in a better position to report on this issue in future Annual Reports.

Chairperson of Council does, however, serve on the Ministerial Advisory Committee (MAC) on NHI and two staff members serve on its technical sub-committees. The Office's knowledge and experience of medical schemes and our exposure to healthcare financing continue to provide invaluable support to this process.

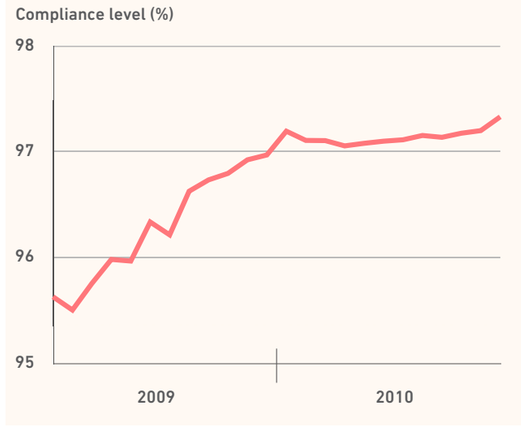
Monitoring ICD-10

The Office of the Registrar continued to monitor the implementation of the International Classification of Diseases – 10th Revision (ICD-10) codes.

ICD-10 is a diagnosis coding standard which was developed by the World Health Organisation (WHO). Adopted by the National Health Information System of South Africa (NHISSA), the standard continues to be part of the health information strategy of the Department of Health; it is the diagnosis coding standard of choice in the public and private sectors.

The Medical Schemes Act 131 of 1998 prescribes that all providers of healthcare – such as hospitals, doctors and allied professionals – are required to use ICD-10 codes when diagnosing patients and submitting claims to medical schemes. The benefits of ICD-10 coding include the standardisation of diagnosis, improved clinical and risk management by medical schemes, the speedy and appropriate reimbursement of healthcare providers, and improved access to benefits by members of medical schemes.

Figure 1: How providers comply with ICD-10 coding 2009 and 2010



Based on submissions from medical schemes, the Council for Medical Schemes (CMS) monitors the extent to which healthcare providers comply with the legal requirement to include a valid ICD-10 code when they submit claims to medical schemes. In 2009 the average level of providers submitting a valid ICD-10 code to medical schemes was 96.3%; it was 97.3% in 2010.

The Department of Health has initiated a process to create a more permanent structure to oversee ICD-10 implementation in the public and private health sectors, and to move towards the creation of a health standards body which would oversee the implementation of all coding structures in the country, including ICD-10 and procedure coding.

How members use healthcare services

This project was a continuation of our efforts to address cost escalation in the private health sector. Its overall objective was to explore the way in which members of medical schemes use healthcare services and to recommend strategies to mitigate cost escalation in the medical schemes industry.

It is important to understand the major trends in the utilisation of healthcare services so as to determine areas of potential cost flare-ups more accurately. Appropriate cost control strategies can then be designed and recommendations can be made for roll-out in the entire private health sector.
Our Research & Monitoring Unit compiled a list of 40 healthcare utilisation indicators which included in- and out-of-hospital care, specialists, diagnostic devices and medicines. The piloting exercise involved selected medical schemes, administrators and private healthcare providers, based on a non-random sampling technique.

The following key issues emerged from the analysis:

- Medical schemes use different information technology (IT) platforms to capture and interpret member information.
- There is inconsistency in how medical schemes and administrators capture ICD-10 codes. Some schemes capture only primary codes while others also include secondary codes.
- Schemes have limited access to patients' clinical notes which makes it difficult for them to collect utilisation data.
- There is inconsistent use of alternative reimbursement systems, with some medical schemes using diagnosis- related groups (DRGs) and others still on fee-for-service.
- There are vast differences in the risk-adjustment methodologies that different stakeholders use.
- There are no industry norms or standards on utilisation measures.

The next phase of this project will entail collecting actual utilisation data from medical schemes from which trends will be ascertained.

How members move between schemes and options

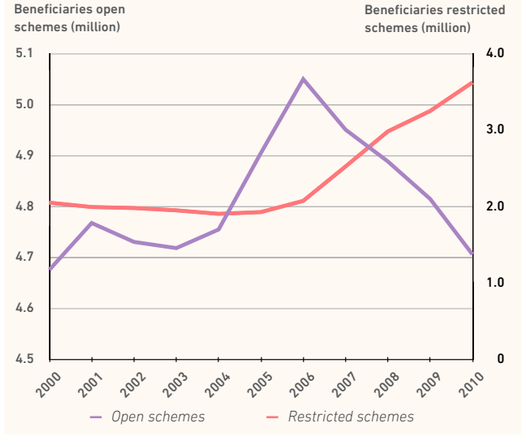
The Research & Monitoring Unit conducted a study on member movement in the medical schemes industry.

The study explored member movement at both scheme and option level. It looked at movement trends from open to restricted schemes and from high-cost to lower-cost options. The study also analysed the factors which influence members' decisions to change benefit options within their medical scheme.

The research findings confirmed a trend towards consolidation among medical schemes.

Open schemes have experienced a significant loss of membership in recent years while membership in restricted schemes has been growing; this can be explained by government employees moving from open to restricted schemes.

Figure 2: Member movement in open and restricted schemes 2000-2009



The study on member movement also revealed the effect of contribution increases on the industry and members of medical schemes when they move between benefit options within their scheme.

The nominal increase in average risk contributions per average beneficiary (as per scheme financials) in 2006/2007 was 10.0% and the comparative figure for 2009/2010 was 11.5% for open schemes; this was slightly higher than restricted schemes.

The average increase for restricted schemes in gross contributions per average beneficiary per month was 3.9% for 2006/2007 and the comparative figure for 2009/2010 was 11.6%.

The contribution increases proposed by schemes in 2009/2010 were 15.7% for open schemes (a deviation of 4.2% from the actual increase that the CMS eventually approved) and 12.7% for restricted schemes (a deviation of 1.1% from the final increase). The considerable difference between these estimated contribution increases and the actual increase in the average contribution income of medical schemes indicates that some members bought down from more comprehensive options to cheaper options with the consequent effect on contributions; this phenomenon is more pronounced in open schemes.

An online survey was conducted to understand how members of medical schemes choose or change a benefit option. This survey was part of the member movement study and was used to better understand why members move between benefit options. We asked members of a restricted scheme if they had changed benefit options in 2008 and 2009. The study revealed that the most common reason why members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options. The other common reason for changing benefit options was limited access to benefits, i.e. when members feel that they do not have adequate benefits in their current option, they seek out an option that offers the benefits that meet their needs.

Finally, this study on member movement confirmed that medical schemes do compete against one another for membership.
Very few schemes compete based on efficiency measures when purchasing healthcare for their beneficiaries. Overall, medical schemes still resort to fee-for-service measures and simply increase their contributions to accommodate the ever-increasing healthcare costs.

Practice Code Numbering System (PCNS)

Regulation 5 of the Medical Schemes Act requires suppliers of healthcare services to include a practice code number on accounts submitted to medical schemes for payment.

The CMS accordingly has the responsibility to ensure that a system is in place for the issuing of such practice code numbers.

Currently the Practice Code Numbering System (PCNS) is contracted out to the Board of Healthcare Funders of Southern Africa (BHF).

The CMS monitors on a quarterly basis the key statistical information about all providers registered in the PCNS.

Strategic objective 2

We secure an appropriate level of protection for beneficiaries of medical schemes and the public by authorising the conduct of medical schemes and monitoring their financial performance.

Strategic objective 2

We secure an appropriate level of protection for beneficiaries of medical schemes and the public by authorising the conduct of medical schemes and monitoring their financial performance.

Healthcare pricing in the private sector

In October 2010 the Department of Health (DoH), with assistance from the CMS, held a meeting with stakeholders from the private healthcare industry to discuss the possibility of introducing a multilateral tariff negotiation process into the private health insurance sector. The meeting discussed mechanisms to fill the void which arose after the High Court judgement against the Reference Price List (RPL).

In November 2010 a discussion document was published. Interested parties were invited to comment on the proposed framework and the development of a supporting legislative framework.

Various industry stakeholders submitted technical and legal comments on the proposals in the discussion document.

The Minister of Health then appointed a steering group made up of representatives from statutory organisations and other entities to oversee the review of the discussion document which must be done in consideration of the comments submitted by stakeholders.

Clinical Review Committee

The Clinical Review Committee (CRC), established in 2010, serves to consolidate the knowledge of our employees with a clinical background.

A key role of the CRC is to advise the Complaints Adjudication Unit on the clinical aspects of complaints under their consideration.

Over 700 clinical opinions were provided to the Complaints Adjudication Unit in 2010-2011.

Status of schemes

The number of registered medical schemes dropped from 105 in January 2010 to 99 in January 2011 (5.7% decrease).

The number of open schemes decreased from 30 in the year 2010 to 28 in 2011 (6.7% decrease), with the 75 restricted schemes falling to 71 in the same period (5.3% decrease). These figures include schemes which effect their contributions mid-year.

Amalgamations

The Office of the Registrar dealt with eight proposed amalgamations during the period under review. Of the eight proposals, seven were ultimately confirmed by the Registrar, namely:

- Discovery Health Medical Scheme (Discovery) and Afrisam SA Medical Scheme amalgamated into Discovery with effect from 1 June 2010.
- Discovery and Umed amalgamated into Discovery with effect from 1 July 2010.
- Momentum Health and Ingwe Health Plan amalgamated into Momentum Health with effect from 1 October 2010.
- Medshield Medical Scheme and Oxygen Medical Scheme amalgamated into Medshield with effect from 1 October 2010.
- Thebemed and Suremed Health amalgamated into Thebemed with effect from 1 October 2010. The confirmation was contested and is being reviewed.
- Moremed Medical Scheme and Clicks Group Medical Scheme amalgamated into Moremed with effect from 1 January 2011; the new scheme has been named Horizon Medical Scheme.
- Topmed Medical Scheme and the Built Environment Professional Associations Medical Scheme (B.E.P.Meds) amalgamated into Topmed with effect from 1 January 2011.

The Office did not confirm the proposed amalgamation between Sizwe Medical Fund and Gen-Health Medical Scheme because of material concerns that the amalgamation would not serve the best interests of the members of the two schemes. Gen-Health was eventually liquidated due to the persistent deterioration of its financial situation; this regulatory intervention ensured that members of the scheme were not faced with financially catastrophic consequences.

The Office does not anticipate significant consolidation in the medical schemes industry for the 2011-2012 financial year; no schemes had indicated the intention to merge as at 31 March 2011.

Liquidations

Gen-Health Medical Scheme was liquidated on 12 October 2010 after the curator appointed by the High Court failed to bring about the anticipated turnaround of the scheme. Members were given the opportunity to transfer to Medshield Medical Scheme without facing any general or condition-specific waiting periods.

Curatorships

Protea Medical Aid Society was placed under curatorship on 29 October 2010 following an investigation revealing irregularities relating to the running of the scheme. The High Court appointed a curator to ensure that the scheme remained solvent and regained its financial sustainability.

Status of options

The ongoing trend in the consolidation of medical schemes mentioned in the previous Annual Report continued to result in a decrease in the number of benefit options.

The number of registered benefit options decreased from 332 in January 2010 to 316 in January 2011. This represents a drop in the number of benefit options in open schemes from 174 to 171 between 2010 and 2011, and a drop in the number of options in restricted schemes from 158 to 145 during the same period.

Contributions

The average gross contribution increase for all medical schemes in 2011 was 9.2%.

Open schemes have always increased their contributions by more than restricted schemes have but this trend ended in the year under review. The comparative increases for open and restricted schemes were 9.1% and 9.4% respectively. We will continue to monitor contribution increases in both

Table 1: Options as at 1 January 2011			
Status of option	**Open schemes options**	**Restricted schemes options**	**Total**
Options registered in January 2010	**174**	**158**	**332**
Discontinued options	-3	-4	-7
Discontinued options due to scheme mergers and combining options within schemes	-4	-9	-13
Discontinued options due to scheme liquidations	-3	0	-3
New options	7	0	7
Options with efficiency discounts	-22	0	-22
Approved options 1 January 2011 (excluding efficiency discount options)	**149**	**145**	**294**
Options with efficiency discounts*	22	0	22
Registered options 1 January 2011	**171**	**145**	**316**

** 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 149.*

open and restricted schemes to determine whether this deviation from the norm was a once-off occurrence or the beginning of a new trend.

The observation above also highlights the fact that the average family contribution in restricted schemes is 11.5% lower than in open schemes. This substantiates the purpose of restricted schemes: they are able to provide medical scheme benefits at a more affordable level than open schemes can.

The fact that restricted schemes have, for the first time, increased their contributions by more than open schemes have is concerning because if this continues to happen, the differential between open scheme contributions and restricted scheme contributions may reduce. This in turn raises the issue whether it is preferable to have restricted schemes in an environment where the traditional advantages of lower contributions are being eroded by the various challenges facing the industry.

The gross contribution increase is based on the actual number of principal members and adult and child dependants in medical schemes. The information in this section is a summary based on medical scheme submissions in respect of the annual benefit changes and contribution increases for 2011; it is based on projections in these submissions.

The average gross contribution increase was 9.1% per principal member, 9.4% per adult dependant, and 9.1% per child dependant. In open medical schemes, it was 9.1% per principal member, 9.3% per adult dependant, and 8.3% per child dependant. In restricted medical schemes, it was 9.0% per principal member, 9.7% per adult dependant, and 9.9% per child dependant.

Risk contributions: year-on-year percentage rate changes

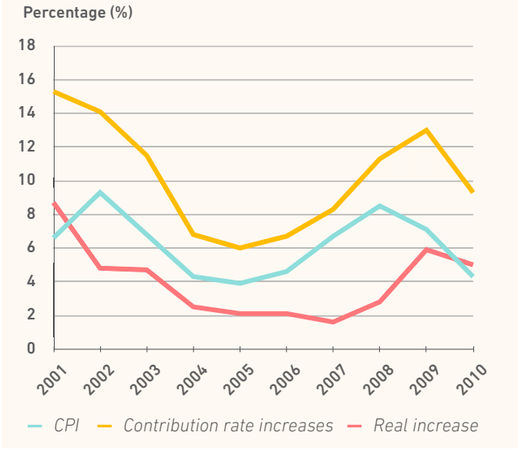
The average risk contribution increase for all medical schemes in 2011 was 9.1%. The comparative increases for open and restricted schemes were 8.7% and 9.7% respectively.

The average risk contribution increase was 8.9% per principal member, 9.5% per adult dependant and 9.0% per child dependant. The principal member, adult dependant and child dependant risk contribution percentage increases for open schemes was 8.7%, 9.2% and 8.0% respectively. The principal member, adult dependant and child dependant risk contribution percentage increases for restricted schemes was 9.3%, 10.1% and 10.1% respectively.

Contribution rates relative to general price indicators

Figure 3 shows the historical and current trends in the Consumer Price Index (CPI) (or inflation) relative to contribution rates in medical schemes between 2001 and 2010. We also incorporated the real increase in medical scheme contributions (amount by which medical contribution increases are greater than inflation).

Figure 3: Contributions and inflation 2001-2010



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

The trend noted for the past 10 years, of contribution increases in open schemes being higher than in restricted schemes, was not maintained in the period under review. It is interesting to note that the average real increase in contributions throughout the period 2001 to 2010 is in the region of 4.0%. This is higher than the CPI + 3% range recommended by the Office and has implications for the long-term affordability of the medical schemes industry as increases in salaries may not necessarily be able to keep pace with contribution increases.

From the graph we can also infer that there were two periods in which the real increase in medical scheme contributions was double the inflation rate at the time, i.e. in the years 2001 and 2010. This is worrying. As a result the contribution rate for 2011 is 48.0% higher than the 2001 contribution rate in real terms. This means that the average medical schemes contribution rate in 2011 is 48.0% higher than the 2001 contribution after the impact of inflation has been removed.

Gross contributions and risk contributions 2011

The average monthly gross contribution for 2011 per principal member, adult dependant, child dependant and family was as follows:

Monthly gross contribution in 2011	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 646	R1 449	R468	R2 707
Restricted schemes	R1 362	R1 146	R498	R2 397
All schemes	R1 467	R1 265	R463	R2 472

The average monthly risk contribution for 2011 per principal member, adult dependant, child dependant and family was as follows:

Monthly risk contribution in 2011	Principal member	Adult dependant	Child depenant	Family
Open schemes	R1 454	R1 257	R412	R2 378
Restricted schemes	R1 296	R1 091	R481	R2 287
All schemes	R1 331	R1 133	R426	R2 240

Non-health expenditure increases compared to gross contribution increases

The average increase in total non-health expenditure – which includes administration costs associated with collecting contributions and paying out benefits, printing costs associated with schemes' brochures and benefit guides, the cost of running call centres and legal costs – for all medical schemes in 2011 was 6.0%. The comparative increases for open and restricted schemes were 5.6% and 7.1% respectively.

The principal member, adult dependant and child dependant non-health cost increases for all medical schemes were 6.2%, 5.4% and 5.0% respectively.

The principal member, adult dependant and child dependant non-health cost increases for open schemes were 5.8%, 5.4% and 4.6% respectively. The principal member, adult dependant and child dependant non-health cost increases for restricted schemes were 7.4%, 5.9% and 6.0% respectively.

Restricted schemes had higher increases in the non-health component than open schemes for 2011. This requires monitoring as non-health expenditure is traditionally lower in restricted schemes than in open schemes.

Medical schemes proposed that the non-health costs per beneficiary per month (pbpm) in 2011 be R115.83 pbpm. The comparative amounts for open and restricted schemes were R156.07 pbpm and R71.58 pbpm respectively.

Evaluating other scheme rules

The Office of the Registrar evaluated a number of proposed rule amendments from medical schemes for the year 2011 and where these complied with the requisite standards, they were registered. The proposed amendments included mid-year changes to contributions and benefits, the registration of new benefit options, and efficiency-discounted options.

Medical schemes applied for amendments to their rules on the following as well:

- definitions regarding the "scheme reimbursement rate" (due to the High Court ruling on the National Health Reference Price List or NHRPL resulting in it being no longer applicable);
- eligibility criteria for membership of restricted medical schemes;
- their change in physical addresses;
- clarification of prescribed minimum benefits (PMBs) and designated service providers (DSPs) in relation to the PMB Code of Conduct;
- governance structures; and
- clarification of processes with respect to amalgamations and liquidations.

Council – the Board of the Council for Medical Schemes – granted various exemptions from provisions in the Medical Schemes Act during the period under review, including exemptions from PMB provisions for schemes which had converted from the bargaining council environment.

Benefit options of the following bargaining council schemes were granted exemptions from provisions on PMBs, as allowed by Regulation 8(h) in the Medical Schemes Act:

- Building & Construction Industry Medical Aid Fund
- Fishing Industry Medical Scheme (Fishmed)
- Food Workers Medical Benefit Fund
- Golden Arrow Employees Medical Benefit Fund
- Motohealth Care

Council also granted exemptions to schemes with options that provide for efficiency discounts based on the provider choice offered:

- Discovery Health Medical Scheme
- Keyhealth
- Momentum Health

A number of applications for rule amendments were rejected for various reasons, including:

- amendments to the eligibility clause for restricted medical schemes*;
- non-compliance with the statutory requirements on PMBs and specifically Regulation 8 of the Medical Schemes Act which instructs schemes to pay in full for the diagnosis, treatment and care of PMB conditions;
- unfairness and/or unfair discrimination of the proposed rule amendments in contravention of Sections 31(3)(a) and 29(1)(n) of the Medical Schemes Act;
- inconsistencies and ambiguity in the existing registered rules;
- poor motivation for proposed contribution changes;
- proposed rules not complying with legislation;
- unfairly high contribution increases;
- poorly defined benefits; and
- schemes limiting benefits unless members enrol on managed care or disease management programmes when the only instance in which a co-payment or limit may be applied is when a member chooses to use a non-DSP.

* The Appeals Committee upheld the Office's determinations to reject the proposed eligibility criteria for restricted schemes. Industry does, however, persist in its efforts to restructure these eligibility criteria so as to allow restricted medical schemes to avoid admitting higher-risk groups as members of such schemes. These efforts seek to infringe on the "open enrolment" requirement that is a cornerstone of the Medical Schemes Act 131 of 1998 and, if successful, will have serious and undesirable consequences for the entire health industry in South Africa. Coupled with disregard for the original intention of restricted schemes envisaged in the Medical Schemes Act, attempts to undermine the "open enrolment" principle may result in the unfair discrimination against certain sections of the industry, creating opportunities for restricted schemes to distort the underlying profile of open schemes.

Engagement with schemes

One medical scheme was registered in the period under review. Getmed Medical Scheme had submitted its application for registration in the 2009-2010 financial year but was not registered then as there were serious inconsistencies in its application that required it to resubmit certain sections of the application.

Rand Mutual Association (RMA) remains unregistered; we need further information to complete its motivation for registration. The Office is in consultation with representatives from the proposed scheme to ensure that its application for registration is adequately motivated.

Efficiency discounts

Benefit options with efficiency discounts offer members discounts where the scheme is able to obtain efficiency with a provider network. The main purpose of the discount is to offer members a more efficient choice of providers while continuing to offer contributions that are not discriminatory.

Although such options allow for differentiation in contribution structures in conflict with community-rating legislation, schemes can apply for exemption to operate these options. Efficiency-discounted options allow schemes to negotiate better reimbursement and healthcare delivery terms with healthcare providers. This arrangement normally results in cost savings for schemes.

Since efficiency-discounted benefit options were introduced in 2008, Council has allowed three schemes to operate such options by exemption from the Medical Schemes Act. Only two of these schemes have actually registered efficiency discount options.

Efficiency-discounted options may allow members to choose the contribution rate based on their choice of healthcare provider, but they are still regarded as one option. They are also reported on as one option to ensure that the risk-pooling effect is maximised at option level and reflected as such in the financial statements of the medical schemes concerned.

Marketing material and application forms

The protection and fair treatment of medical scheme members has always been and remains one of our top priorities; with this in mind, we continue to evaluate the marketing material of larger medical schemes.

In 2010-2011 we evaluated the marketing material and application forms of the following medical schemes:

- AECI Medical Aid Society
- Afrox Medical Aid Society
- Anglo Medical Scheme
- Anglovaal Group Medical Scheme
- Bankmed
- Bestmed Medical Scheme
- BMW Employees Medical Aid Society
- Bonitas Medical Fund
- Cape Medical Plan
- Compcare Wellness Medical Scheme
- De Beers Benefit Society
- Discovery Health Medical Scheme
- Edcon Medical Aid Scheme
- Fedhealth Medical Scheme
- Government Employees Medical Scheme (GEMS)
- IBM (SA) Medical Scheme
- Keyhealth
- LA-Health Medical Scheme
- Libcare Medical Scheme
- Medihelp
- Medimed Medical Scheme
- Medipos Medical Scheme
- Medshield Medical Scheme
- Metropolitan Medical Scheme
- Netcare Medical Scheme
- PG Bison Medical Aid Society
- PG Group Medical Scheme
- Pick & Pay Medical Scheme
- Platinum Health
- Protea Medical Aid Society
- Quantum Medical Aid Society
- Rand Water Medical Scheme
- Rhodes University Medical Scheme
- SA Breweries Medical Aid Society
- Sasolmed
- Siemens Medical Scheme
- South African Police Service Medical Scheme (POLMED)
- Spectramed
- Thebemed
- Tiger Brands Medical Scheme
- Topmed Medical Scheme
- Tsogo Sun Group Medical Scheme
- Umvuzo Health Medical Scheme
- University of Kwa-Zulu Natal Medical Scheme
- Xstrata Medical Aid Scheme

During our analysis, we found numerous issues, including:

- Schemes fail to indicate the non-PMB chronic conditions that are covered under the various benefit options.
- Schemes do not clarify members' entitlements to PMBs. (We did instruct them to provide their members with information that is consistent with the intentions of PMB Regulations.)
- Schemes operating programmes which contravene the definition of "the business of a medical scheme" in the Medical Schemes Act were ordered to stop operating such programmes.
- Schemes were instructed to remove the unfair and illegal provisions in their marketing materials which ask members to register in certain disease management programmes before their benefits are paid out.

Section 32 of the Medical Schemes Act ensures that the rules of medical schemes are binding on them and their stakeholders. This Office will continue to monitor the marketing material and application forms of medical schemes to ensure that they comply with their registered rules and the Medical Schemes Act – where the Medical Schemes Act always takes precedence over scheme rules should the two be inconsistent.

Clinical Unit

The Clinical Unit continued to analyse clinical complaints and provide opinions to the Clinical Review Committee (CRC). The number of complaints with a clinical component increased significantly in the year under review.

The Unit was also instrumental in the publication of CMScript, the CMS electronic newsletter on PMBs.

The Unit also participated in various training events on PMBs around the country.

Guidance on contribution increases

During the period under review, the CMS undertook, for the first time, a process to analyse key economic indicators which have a bearing on the functioning of the private healthcare sector to recommend a range for contribution increases for the year 2011. This process was informed by the observation that contribution increases in excess of the Consumer Price Index (CPI) have a negative impact on the affordability of medical schemes.

The purpose of publishing a guidance note (Circular 46 of 2010) was to inform industry on our view on inflation and its projected impact on contribution increases for 2011.

The following economic indicators were reviewed to allow us to recommend a certain range for contribution increases for 2011:

Economic indicator	Percentage increase/decrease
CPI (average for 2009-2010)	5.2%
Exchange rates	
Rand / Dollar / Euro (average for 2009-2010)	-13.2%
Medicine pricing	
Single Exit Price (projected trend for 2011)	-1.2%

To arrive at a recommendation, we also reviewed annual statutory return data from medical schemes and analysed changes in the age profile of members, changes to the burden of disease in medical schemes, and the extent to which diagnostic technology is used. The results of the analysis led us to recommend that contribution increases for 2011 be confined within 4.9-5.2%.

The CMS will continue to monitor changes in the above indicators and will publish a Circular to guide contribution increases for the year 2012. This will be done by the end of July 2011 to enable medical schemes to factor in the guideline figures in their projections.

Monitoring the financial soundness of schemes

In 2010-2011 the Financial Supervision Unit (FSU) continued to address the challenge of ensuring that medical schemes are financially healthy, thus ensuring that members have cover when they need it most. One of the Unit's key focus areas was also continued efforts to intervene where necessary and work with Boards of Trustees in coming up with appropriate turn-around strategies.

The work around data quality continued and included liaising and collaborating with entities such as the South African Institute of Chartered Accountants (SAICA) and the Independent Regulatory Board of Auditors (IRBA) to ensure that the manner in which medical schemes report is in line with both legislation and internationally accepted standards. Good quality data will ultimately ensure that members of medical schemes and other stakeholders make the best possible decisions.

Over the years, significant strides have been made in achieving standardisation and uniformity regarding proper disclosures and good financial reporting across the entire medical schemes industry.

The annual revision and publication of the SAICA Accounting Guide proceeded smoothly; the guide was published in September 2010. FSU continued to engage with IRBA on the Auditing Guide.

FSU's primary sources of financial information are quarterly and annual statutory returns, the findings of which are published on our website *(www.medicalschemes.com)*. In both instances, the Unit publishes various guidelines and Circulars to assist industry with the completion of statutory returns.

The issues which were identified during the analysis of the above-mentioned returns, and which were communicated via Circulars to industry, included:

- in respect of reports of Boards of Trustees: disclosure on the number of trustees and various non-compliance matters;
- non-adherence to the requirements of the International Accounting Standard (IAS), International Financial Reporting Standards (IFRS) and the SAICA Accounting Guide for 2010; and
- accuracy and completeness of statutory returns.

Concerns were raised with schemes also on the following matters:

- high non-health expenditure;
- low or rapidly reducing solvency levels;
- high claims ratios; and
- failure to meet budgetary targets.

In the period under review, FSU also undertook the annual approval of auditors. This process was completed successfully. One of the issues that arose was auditors being assigned to too many medical schemes, possibly reducing their ability to pay the requisite attention to the audit, particularly for the larger and more complex schemes.

Monitoring the financial soundness of medical schemes remains core to the Unit's functions. FSU provides baseline supervision for all schemes and a heightened level of supervision and monitoring for schemes facing challenges, particularly those with solvency below the minimum statutory level of 25.0%. In this regard, we continued to interact with schemes on their business plans and turn-around strategies. We also placed particular focus on schemes with a solvency above 25.0% but where it was rapidly reducing. This drive to streamline our monitoring efforts and enhance what we call our Early Warning System (EWS) saw the development of the Real Time Monitoring System, albeit in its initial phases. This system will be an endeavour to obtain and monitor the most up-to-date financial and non-financial information from medical schemes to allow for timely and appropriate regulatory interventions.

Assessing the financial performance of schemes

As at December 2010, the number of registered medical schemes had decreased to 100 from 110 in 2009; there were 27 open schemes and 73 restricted schemes.

There were 179 registered benefit options in open schemes in 2010 (including 13 that were deregistered during the year) compared to 190 options in 2009; this represents a decrease of 5.8%. In restricted schemes, there were 159 options (including 6 that were deregistered during the year) in 2010 compared to 161 in 2009.

The number of principal members increased by 3.6% to 3 612 062 in 2010. The number of dependants rose by 2.7% to 4 703 656, which means that the total number of beneficiaries increased by 3.1% to 8 315 718.

Gross Contribution Income

The Gross Contribution Income (GCI) for all medical schemes increased by 13.7% to R96.5 billion in 2010 from R84.9 billion in 2009.

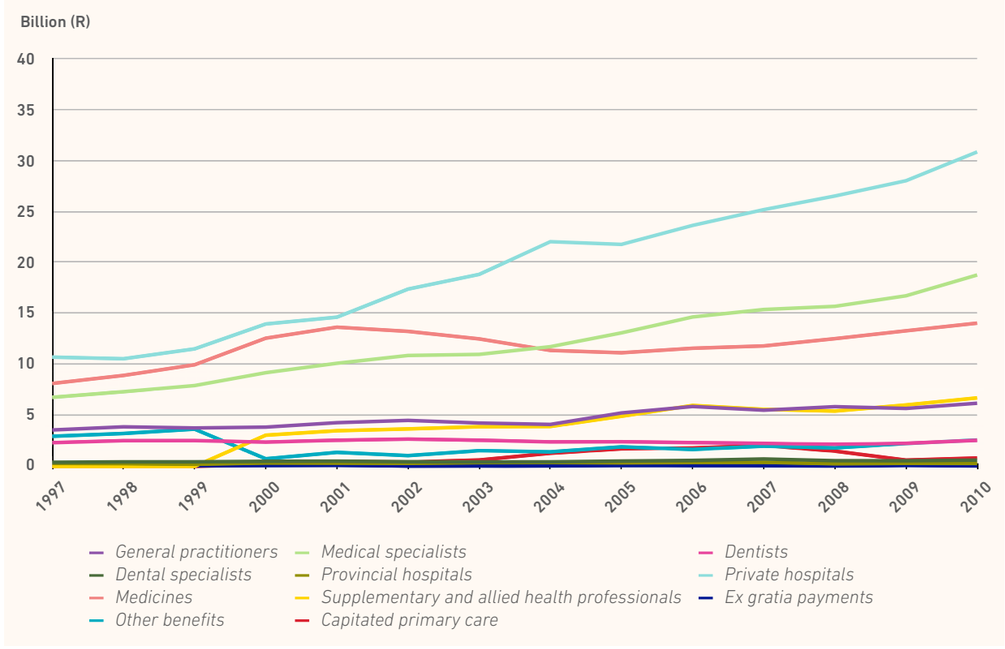
Healthcare expenditure

Scheme expenditure on healthcare benefits increased by 11.0% to R84.7 billion in 2010 from R76.3 billion in 2009. (The figure for total gross relevant healthcare expenditure incurred by medical schemes under the heading "Contributions, relevant healthcare expenditure and trends" in the section entitled *Reviewing the operations of medical schemes in 2010* includes the IBNR and the results of risk transfer arrangements.)

Hospitals accounted for R31.1 billion of the R84.7 billion paid to all healthcare providers. Medical scheme expenditure on private hospitals increased in 2010 by 10.1% to R30.8 billion compared with a 2.6% decrease in their spending on provincial hospitals (to R281.5 million).

Expenditure on medicines dispensed by pharmacists and providers other than hospitals increased to R14.0 billion in 2010, an increase of 5.6%. Payments to specialists increased by 12.2% to R18.8 billion. Expenditure on general practitioners (GPs) increased by 9.0% to R6.2 billion while payments to dentists increased by 13.2% to R2.5 billion. Expenditure on dental specialists decreased by 11.5% to R601.3 million. Expenditure on supplementary and allied health professionals increased by 11.5% to R6.7 billion in 2010.

Figure 4: Total healthcare benefits paid: 2010 prices*



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

Non-healthcare expenditure

Medical schemes spent R7.8 billion on administration in 2010 – a growth of 4.4% from R7.5 billion in 2009. Open schemes increased their administration expenditure by 1.4% from R5.5 billion to R5.6 billion. The 13.1% rise from R2.0 billion in 2009 to R2.2 billion in 2010 in restricted schemes reflects a significant growth in their membership numbers during the year under review, particularly at the Government Employees Medical Scheme (GEMS) which enrolled 27.1% more beneficiaries in 2010.

Managed healthcare management fees increased by 16.2% from R1.9 billion in 2009 to R2.3 billion in 2010. In 2010 the number of people covered by managed care organisations grew by 3.3% to 8 217 817 beneficiaries (which is 98.8% of all beneficiaries).

Broker costs for medical schemes increased by 8.9% to R1.3 billion from previous year's R1.2 billion while impaired receivables (previously known as bad debts) decreased by 4.8% to R168.2 million for the year under review from R176.6 million in 2009.

Total non-healthcare expenditure (i.e. administration fees, fees for managed healthcare, broker fees, impairments and commercial reinsurance) rose by 6.9% from R10.8 billion in 2009 to R11.6 billion in 2010.

The industry experienced a net healthcare deficit of R459.6 million in 2010 (2009: R2.6 billion), representing a substantial decrease in losses incurred at operational level.

The inclusion of investment and other income resulted in schemes making a net surplus of R2.9 billion in 2010. Net investment and other income decreased by 21.5% to R2.2 billion. This was 75.0% of net surplus, and underscores the importance of investment income for schemes that experienced a difficult operating year.

Net assets or members' funds (total assets less total liabilities) rose by 10.7% to end the year at R32.6 billion. Reserves (accumulated funds) grew by 10.4% to R30.9 billion from the R28.0 billion recorded in 2009.

The average industry solvency ratio decreased by 4.0% to 31.6% compared to 32.9% in 2009. This was still higher than the prescribed level of 25.0%. The solvency ratio of open schemes remained unchanged at 27.4% (2009: 27.4%). Restricted schemes experienced a decline of 9.7% in their solvency ratio, which reduced to 38.4% in 2010 from 42.5% in 2009. A number of both open and restricted schemes suffered severe losses in 2010, coupled with a general decline in investment returns.

Figure 5: Industry solvency trends for all schemes 2000-2010

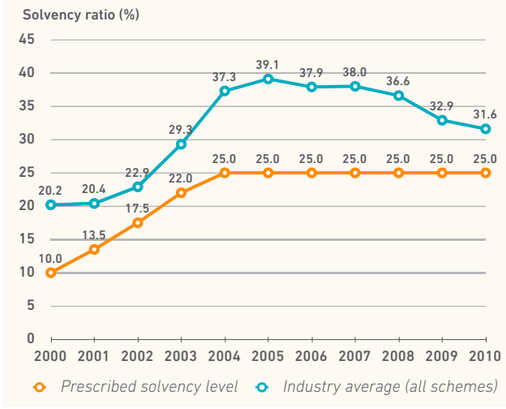


Figure 6: Industry solvency trends for open schemes 2000-2010

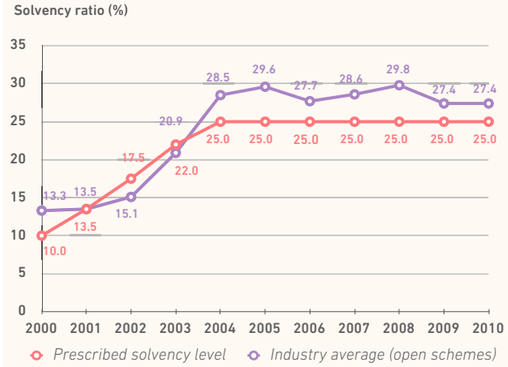
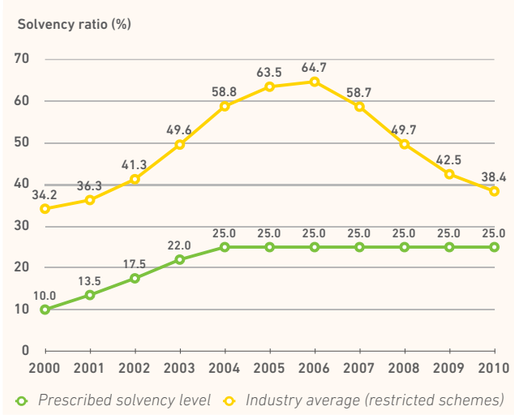


Figure 7:Industry solvency trends for restricted schemes 2000-2010



Monitoring compliance with Regulation 29: solvency

Regulation 29 of the Medical Schemes Act 131 of 1998 requires medical schemes to maintain accumulated funds expressed as a percentage of gross annual contributions of not less than 25.0% (also called solvency), for the period under review. The Office of the Registrar is responsible for ensuring that medical schemes are financially sound and able to maintain this minimum statutory solvency level. Schemes who fail to meet solvency requirements must submit business plans to this Office and, where necessary, appropriate action plans as well. We analyse the actions plans and, if they are found to be satisfactory, approve them.

The Office of the Registrar also keeps a close eye on schemes whose solvency is above 25.0% but rapidly decreasing. Interventions on such schemes may include submission of management accounts, financial review meetings with the Board of Trustees and submission of business plans. Other schemes kept on the radar are those with excessive non-health expenditure and governance problems as well as those under curatorship.

On 31 December 2010, 19 medical schemes were below the statutory solvency level of 25.0%: 12 open (2009: 16) and 7 restricted schemes (2009: 6).

The average solvency of open schemes under close monitoring was 22.1% in 2010 (2009: 15.2%). This represents a 45.4% increase on the previous year. Two additional open schemes fell below the statutory solvency requirement of 25.0%, namely Discovery Health Medical Scheme and Pro Sano Medical Scheme, and one medical scheme achieved solvency. The average solvency level of restricted schemes under close monitoring was 7.9% in 2010 (2009: 11.2%). This represents a 29.4% decrease. Two restricted schemes fell below the prescribed 25.0% solvency during 2010, namely Altron Medical Aid Scheme and Transmed Medical Fund.

Below is a summary of the schemes under close monitoring in terms of Regulation 29(4) of the Medical Schemes Act:

Solvency position	Open schemes	Restricted schemes	Names of schemes
Below 10.0%	2	1	Thebemed, GEMS, Protea Medical Aid Society
10.0% – 13.5%	1	0	Keyhealth
13.5% – 17.5%	3	3	Transmed Medical Fund, Minemed Medical Scheme, Umvuzo Health Medical Scheme, Pharos Medical Plan, BEPS, Hosmed Medical Aid Scheme
17.5% – 22.0%	5	2	Altron Medical Aid Scheme, Momentum Health, NIMAS, Spectramed, Resolution Health Medical Scheme, COMMED, Lonmin Medical Scheme
22.0% – 25.0%	2	0	Discovery Health Medical Scheme, Pro Sano Medical Scheme
Below prescribed 25.0%	**12**	**7**	**19**

As part of our regulatory interventions, and to ensure that members' interests are protected, some of the schemes with a worsening financial position were instructed to consider amalgamation. This is indicative of the general direction in which the industry is moving, given the persistent challenges around continually increasing claims costs.

In total, there were 4 799 915 beneficiaries in the open schemes market as at 31 December 2010 (2009: 4 815 334), of which 60.8% were in schemes not meeting the prescribed minimum solvency requirement (2009: 20.6%). The restricted schemes market had 3 515 803 beneficiaries as at 31 December 2010 (2009: 3 253 171), of which 47.9% were in schemes not meeting the prescribed minimum solvency requirement (2009: 38.6%).

In total, 55.3% of beneficiaries were in medical schemes on close monitoring as at 31 December 2010 (2009: 27.8%). This figure would be significantly smaller if GEMS and Discovery Health Medical Scheme were excluded.

Solvency per scheme

Altron Medical Aid Scheme fell below the prescribed 25.0% solvency during 2010, with a solvency of 19.5% at year-end. The scheme experienced a significant drop in membership after the employer relaxed employment conditions, resulting in younger and healthier members leaving the scheme and consequently worsening its demographic profile. As a result, Altron experienced high claims which led to losses and dilution of reserves. The scheme was placed on close monitoring in 2011. It has submitted a business plan.

The restricted Built Environment Professional Associations Medical Scheme (BEPS) had a solvency level of 15.9% for the period under review. Although its solvency improved, the low membership level continued to pose a threat to the sustainability of the scheme. BEPS amalgamated with Topmed Medical Scheme with effect from 1 January 2011.

Community Medical Aid Scheme (COMMED) had a solvency of 19.2% at the end of 2010. The scheme experienced a substantial decline in membership, as well as a worsening age profile. COMMED also has high non-healthcare expenses. The scheme remains under close monitoring and has submitted a business plan which was approved by the Office.

Discovery Health Medical Scheme (Discovery) had a solvency level of 24.7% for the period under review. The scheme experienced an increase in membership during the year. The Office continues to engage regularly with the scheme; Discovery also submits monthly management accounts.

The restricted Government Employees Medical Scheme or GEMS had a solvency of 7.1% in 2010. The scheme has been in operation for five years and should have attained a solvency ratio of 25.0% in its fifth year of operation. However, the scheme continued to experience substantial growth in membership. This places pressure on its solvency ratio. GEMS continued to monitor benefit design and implement measures to reduce the impact of claims on reserves. The scheme provides the Office with monthly management accounts and quarterly financial updates for monitoring purposes. It also has an approved business plan.

Gen-Health Medical Scheme (Gen-Health) was liquidated during 2010 due to excessive losses incurred. This was the result of an inappropriate pool of members being recruited onto the scheme in a short period of time, thus resulting in excessively high claims and dilution of reserves. Members were transferred to Medshield Medical Scheme.

Hosmed Medical Aid Scheme (Hosmed) continued to face governance challenges in 2010. The scheme ended the year with a solvency level of 14.8%. Its membership grew and the scheme is under close monitoring. It submits monthly management accounts and attends quarterly meetings with the Office to discuss its performance against the agreed interim solvency levels. Hosmed has an approved business plan for 2011.

Ingwe Health Plan amalgamated with Momentum Health with effect from 1 September 2010.

Keyhealth had a solvency of 12.1% in 2010. The scheme remained under pressure due to an ageing membership profile and high claims. In the year under review, the scheme undertook to revisit its benefit design and reduce non-healthcare expenditure. Keyhealth is under close monitoring; it submits management accounts and we regularly meet with its management to monitor progress.

Lonmin Medical Scheme had a solvency level of 19.3% in 2010; it was registered in 2006 and should have attained a solvency ratio of 25.0% during its fifth year of operation. But the scheme experienced increased claims from 2009, as well as membership growth. Despite the challenges, the scheme continued in its endeavours to build reserves. Lonmin is currently under close monitoring; we also meet with them regularly.

MEDCOR (the restricted Medical Scheme for the Department of Correctional Services) amalgamated into GEMS with effect from 1 January 2010.

Minemed Medical Scheme had a solvency of 16.1% at year-end, an improvement from 2009. The scheme experienced a lower claims ratio than in 2009 which resulted in its reserves increasing. We are monitoring this restricted scheme closely through monthly management accounts and quarterly meetings.

Momentum Health had a solvency of 20.2% at the end of 2010. Its membership grew because the scheme amalgamated with Ingwe Health Plan. The lower claims coupled with an increase in reserves resulted in a higher solvency level. We are monitoring the scheme closely through monthly management accounts and quarterly meetings.

The National Independent Medical Aid Society (NIMAS) ended 2010 with a solvency ratio of 18.4%. The scheme is gradually losing younger members which affects the average age of the scheme in a negative way. The huge decline in membership coupled with a reduced claims ratio resulted in an increase in its reserves. NIMAS was instructed to seek an amalgamation partner. The scheme must continue to submit monthly management accounts to this Office and attend bi-monthly meetings to discuss its financial performance and amalgamation prospects.

Oxygen Medical Scheme amalgamated with Medshield Medical Scheme with effect from 1 October 2010.

The solvency ratio of Pharos Medical Plan (Pharos) was 17.5% at year-end. The scheme experienced excessively high claims in 2010 which resulted in losses. Pharos also has high non-healthcare expenses. The scheme continues to submit monthly management accounts to this Office and attends quarterly meetings to discuss its financial performance.

Pro Sano Medical Scheme (Pro Sano) fell below the statutory solvency level of 25.0% during 2010, ending the year with a solvency ratio of 24.4%. The scheme was placed under curatorship in 2005; the curatorship was lifted in October 2010. Pro Sano's membership is ageing and contributes to the losses incurred.

Protea Medical Aid Society (Protea) fell below the minimum required solvency level of 25.0% during the course of 2009. The scheme had a solvency of 5.2% at the end of the period under review. Although Protea had restructured its benefits for 2010 in an attempt to reduce losses, the claims ratio remained high, thus the continued losses and dilution of reserves. The scheme was liquidated at the end of March 2011.

Resolution Health Medical Scheme (Resolution Health) had a solvency of 17.6% for the period under review. Its non-healthcare expenditure remains high, although it has decreased from 2009. The Board of Trustees has introduced various initiatives to address non-healthcare expenditure. We continue to monitor its costs to ensure that they reduce further and are maintained at acceptable levels. Resolution Health continues to be monitored closely through regular meetings and the submission of monthly management accounts.

Spectramed had a solvency ratio of 19.5% at year-end. We had approved its redesigned benefits for 2010 which were aimed at attracting new members, but the scheme's membership continued to decline in 2010. Spectramed then reduced its member loss risk by directing its marketing initiatives at the private sector. The non-healthcare expenditure remains high. The scheme continues to be closely monitored.

Telemed amalgamated with Bestmed Medical Scheme with effect from 1 January 2010.

Thebemed ended 2010 with a solvency level of 5.8%. Growing membership coupled with increased claims resulted in solvency being put under pressure. Thebemed is on close monitoring; the scheme submits management accounts and bi-monthly meetings have been arranged to continually discuss progress. The scheme has an approved business plan for 2011.

Transmed Medical Fund dropped below the 25.0% solvency level during 2010. The restricted scheme ended the year under review with a solvency of 14.1%. Transmed has a high age profile and the

high claims resulted in the scheme incurring large losses and a rapid decrease in its solvency. The scheme was placed under close monitoring; it has submitted a business plan.

Umvuzo Health Medical Scheme had a solvency ratio of 13.8% at the end of 2010. The scheme experienced an exceptional growth pattern in membership since its inception. Umvuzo submitted a business plan for consideration by the Office.

Other schemes on close monitoring

The Office of the Registrar pays close attention to schemes that are above the statutory solvency requirements but have other challenges, including a rapidly reducing solvency. Solvency may fall drastically due to a myriad of factors, among which may be huge operational losses, high non-health expenditure, and excessively low membership. The regulatory response to such medical schemes is aligned to the severity of the problems being experienced by the scheme, and may include the submission of monthly management accounts, financial review meetings and reserving plans.

Accrediting administrators, managed care organisations, and brokers

The public can visit our website – *www.medicalschemes.com* – to check whether the administrator of their medical scheme, managed care organisation and broker or brokerage are accredited.

Administrators

Council approved the accreditation renewal of the following third-party administrators for a further two years after the Accreditation Unit evaluated their applications and ensured that they comply with all the accreditation conditions that had been imposed on them:

- Agility Global Health Solutions Africa (Pty) Ltd
- Allcare Administrators (Pty) Ltd
- Eternity Private Health Fund Administrators (Pty) Ltd
- Momentum Administrators (Pty) Ltd
- Private Health Administrators (Pty) Ltd
- Providence Healthcare Risk Managers (Pty) Ltd
- Sanlam Healthcare Management (Pty) Ltd
- Sechaba Medical Solutions (Pty) Ltd
- Status Medical Aid Administrators (Pty) Ltd
- Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd
- Universal Healthcare Administrators (Pty) Ltd

During the period under review we conducted on-site evaluations of five self-administered medical schemes to assess their conduct and compliance with the accreditation standards for administration. The following self-administered medical schemes were provided with certificates of compliance since they complied with the conditions imposed on them:

- De Beers Benefit Society
- Rand Water Medical Scheme
- South African Municipal Workers Union Medical Scheme (SAMWUMed)
- Witbank Coalfields Medical Aid Scheme

Getmed applied for accreditation as an administrator but the application was not finalised because the applicant did not provide all the required information and did not pay the prescribed fee. The promoters also failed to secure the registration of the medical scheme concerned.

The Accreditation Unit evaluated self-administered Medshield Medical Scheme's compliance with administration standards. The evaluation was conducted during May 2010 and various issues of non-compliance were identified. This matter is under consideration by Council.

There were 16 accredited third-party administrators and eight accredited self-administered medical schemes as at 31 March 2011.

Managed care organisations

New applications for accreditation as managed care organisations (MCOs) were received in the period under review.

The application of Getmed Managed Care Solutions (Pty) Ltd was not finalised because the company failed to provide all the required information and failed to pay the prescribed application fee.

Council will consider the accreditation of Dentpro (Pty) Ltd in the next reporting period.

Council evaluated and considered the following accreditation renewal applications:

- Agility Global Health Solutions (Pty) Ltd
- Allcare Administrators (Pty) Ltd
- Care Cross (Pty) Ltd
- Dental Risk Company (Pty) Ltd
- Discovery Health (Pty) Ltd
- East Cape Medical Business Systems (Pty) Ltd (ECIPA)
- Emerging Market Healthcare (Pty) Ltd
- Eternity Healthcare (Pty) Ltd
- Faranani Healthcare Management (Pty) Ltd
- HIV Managed Care Solutions (Pty) Ltd t/a Careworks
- Independent Clinical Oncology Network (Pty) Ltd (ICON)
- KwaZulu-Natal Managed Care Coalition (Pty) Ltd
- Lifesense Disease Management (Pty) Ltd
- Medical Services Organisation (Pty) Ltd (MSO)
- Medicross (Pty) Ltd
- Mediscor (Pty) Ltd
- OneCare Health (Pty) Ltd
- Performance Health (Pty) Ltd
- Prime Cure Health (Pty) Ltd
- Professional Medical Scheme Administrators (Pty) Ltd
- Providence Healthcare Risk Managers (Pty) Ltd
- Qualsa Healthcare (Pty) Ltd
- RX Health (Pty) Ltd
- Sanlam Healthcare Management (Pty) Ltd
- South African Oncology Consortium Limited
- V Medical Aid Administrators (Pty) Ltd

The following managed care organisations were deactivated on our website:

- National Health Risk Managers (Pty) Ltd elected not to renew their accreditation because they merged with MSO as their holding company.
- The business conducted by Opticlear (Pty) Ltd and Aganang HIV Resource Centre does not fall within the legal framework of the Medical Schemes Act.
- East Cape Medical Business Systems (Pty) Ltd (ECIPA) failed to submit required information.

The following MCOs complied with conditions for accreditation which had been imposed on them:

- Care Cross (Pty) Ltd
- Centre for Diabetes and Endocrinology (Pty) Ltd
- Dental Information Systems (Pty) Ltd
- Enablemed (Pty) Ltd
- Momentum Medical Scheme Administrators (Pty) Ltd

There were 43 accredited managed care organisations as at 31 March 2011.

Brokers

In the 2010-2011 financial year we received new applications for accreditation from 964 brokers and 137 broker organisations. We received renewal applications from 3 631 brokers and 1 174 broker organisations. We accredited 591 new brokers and 90 new brokerages. We granted renewals to 2 760 brokers and 875 brokerages.

As at 31 March 2011, the end of the reporting period, there were 7 789 brokers and 2 178 brokerages accredited in South Africa.

The Accreditation Unit dealt with five complaints against brokers in 2010-2011 and referred one matter to the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS) to adjudicate on its

failure to comply with fit and proper requirements prescribed in FAIS. The four complaints which were resolved related to:

- a medical scheme terminating a client's membership because s/he had not disclosed essential information on applying for membership;
- brokers collecting professional fees from clients without their consent;
- brokers providing improper advice; and
- unlawful collection and payment of professional fees to brokers.

The accreditation of Captivest Healthcare (Pty) Ltd was withdrawn and the company was deactivated on our website because it was liquidated.

We refused to accredit three brokers and two broker organisations because we found them not to be fit and proper.

In the period under review the FSB, which co-regulates brokers with us, implemented substantial changes to the fit and proper requirements for financial service providers; these include measures to manage conflict of interest. These measures apply to healthcare brokers as well and will improve transparency and regulatory oversight in terms of how financial advisors conduct themselves.

The Accreditation Unit participated in various discussions and regulatory interventions against brokers where employers unlawfully appointed healthcare brokers, where entities were considered not fit and proper, and where other contraventions of the Medical Schemes Act took place.

Strategic objective

We provide support and guidance to trustees and promote understanding of the medical schemes environment among trustees, beneficiaries, and the public.

Strategic objective 3

We provide support and guidance to trustees and promote understanding of the medical schemes environment among trustees, beneficiaries, and the public.

Trustee training

In the year under review the Consumer Education & Trustee Training Unit conducted three *Induction to Trusteeship* training sessions in Gauteng, the Western Cape and KwaZulu-Natal. The training targeted mainly new trustees in both open and restricted medical schemes to empower them with the necessary skills and knowledge to manage their schemes. The sessions focused on corporate governance, the administration of medical schemes, complaints procedures and compliance priorities.

The Unit updated the *Trustee Training Manual* and trustee induction packs to include the principles of the King III Report. Two Unit standards were also developed based on the *Trustee Training Manual*, namely *The Medical Schemes Act and Regulations* (Unit standard 117 118) and *The Duties of Trustees* (Unit standard 123 421). These standards will be registered with the Insurance Sector Education and Training Authority (INSETA).

Consumer education and awareness

The Council for Medical Schemes (CMS) has a comprehensive consumer education and awareness programme which includes regular capacity-building workshops, radio talk shows, events at shopping malls, presentations at public events, and regular educational and awareness campaigns in newspapers and magazines.

Through workshops with healthcare organisations, case managers, hospital groups, trade union representatives, consumer groups, employee assistance practioners and provincial government staff, the Consumer Education & Trustee Training Unit seeks to expand the capacity of a range of different people who engage with consumers and/or members of medical schemes on a daily basis.

In 2010-2011 the Unit conducted 110 stakeholder workshops in all nine provinces and ensured that the CMS received media exposure of an advertising value equivalent to more than R2 million.

The Unit also successfully conducted various outreach and awareness events, and participated in the annual Rand Easter Show, Rustenburg Show, Pretoria Show, wellness events of government departments and other organisations, and conferences. Consumers were given educational material. Brochures and booklets were also distributed to medical schemes and provincial consumer affairs offices for distribution to consumers.

CMS News, CMScript and media relations

Our Annual Report 2009-2010 was published early for the third time in a row. Its official launch took the form of a press conference which was presided over by the newly appointed Registrar and Chief Executive who had joined the CMS on 1 June 2010. The Report was further publicised at road shows in Durban, Cape Town and Johannesburg where Principal Officers and trustees were given the opportunity to interact with the new Registrar and other members of staff at a more personal level.

One issue of *CMS News* was published in the period under review. The theme was "What medical schemes are all about" and the publication explored the unique principles underpinning the Medical Schemes Act, namely open enrolment, community rating, prescribed minimum benefits and governance, while acknowledging the ever-present need for a system of risk adjustment to address the unfair discrimination against members who are older and/or sicker which is currently taking place.

The e-newsletter on PMBs, CMScript, as well as the staff newsletter *Masihambisane* continued to be published.

Journalists and other media practitioners again enjoyed our special attention in the year under review. All our press releases are available on our website *(www.medicalschemes.com)*.

Our corporate identity and logo were revamped in the year under review and launched in October 2010.

4

Strategic objective

We foster compliance with the Medical Schemes Act by medical schemes, administrators and brokers, and initiate enforcement action where required.

Strategic objective 4

We foster compliance with the Medical Schemes Act by medical schemes, administrators and brokers, and initiate enforcement action where required.

Compliance with the Act

Bonitas Medical Fund

The Bonitas case – which formed the subject of an application by the Registrar to place the scheme under curatorship during the last financial year – continued to loom large, with a number of protracted interventions placing large demands on the resources of the Legal Services Unit. Among the issues which detained the Unit was an application to the High Court by the affected trustees for them to be reinstated to the Board.

In opposing this application, the Office of the Registrar simultaneously brought an application for the removal from office of the acting Principal Officer of the scheme. The Registrar also initiated a process of resolving the matter in a manner consistent with the regulatory obligations of the Council for Medical Schemes (CMS) under the Medical Schemes Act.

Hosmed Medical Aid Scheme

The Legal Services Unit continued to work closely with the Compliance Unit in ensuring that proper governance is restored to the scheme.

The Gen-Health matter

Gen-Health Medical Scheme was placed under curatorship in November 2005. Three years later assets to the value of R47 million belonging to three former officials in charge of the scheme and its administrator were seized as part of criminal proceedings against them.

At the same time the curator, pursuing his obligations, duly instituted civil proceedings against these officials to recover monies which they owed to the scheme, estimated at R160 million.

In September 2010, the civil case was about to go to trial when the scheme went into provisional liquidation. The lawyers acting for the three former officials then proposed a settlement offer of R15 million in full and final settlement of the civil case, contingent on the following:

1. both the curator acting on behalf of the scheme and the Council for Medical Schemes (CMS) will withdraw the criminal charges which they had filed with the National Prosecuting Authority (NPA) against the former officials;
2. the frozen assets of the former officials will be released;
3. the R15 million settlement will come from the frozen assets; and
4. all money owing to the scheme and all legal fees will be covered from the R15 million.

Both the curator and the liquidator – who was appointed in October 2010, shortly after this settlement was proposed – accepted the conditions and agreed to the settlement; both duly filed their affidavits in this regard.

The NPA subsequently withdrew the criminal charges against the former officials based on the settlement reached, the frozen assets were released, and the scheme received R15 million.

Gen-Health was liquidated on 12 October 2010. Medshield Medical Scheme agreed to take in its former members with effect from 13 October 2010 – and without imposing any waiting periods on them, whether general or condition-specific.

Appeals Committee

Council's Appeals Committee reviewed 98 cases in the period under review. It upheld the Registrar's ruling in 64 of these cases.

Most important were a number of cases where medical schemes were directed to recalculate members' monthly contributions and refund late-joiner penalties which had been levied on members from the date of commencement of their membership.

Regulation 13 of the Medical Schemes Act, read together with the definition of "late joiner" in Regulation 11, provides that a member who had been a member of a medical scheme before April 2001 and who had had no break in coverage exceeding three consecutive months since April 2001 is excluded from the reach of the late-joiner penalty. The Appeals Committee ruled that where a member should not have been levied a late-joiner penalty in the first place, it would have been unjust to say that the scheme can keep a penalty fee that should never have been levied against that member.

Appeal Board

The independent Appeal Board adjudicated on 21 matters in the year under review; 16 of those arose from the Appeals Committee.

Worth highlighting is a decision on the governance of medical schemes.

The Appeal Board decided that where a decision is made pursuant to the powers granted to the Council under Section 46(1) of the Medical Schemes Act, Council is entitled to act in terms of Section 46(1) if it has "sufficient reason to believe that the person concerned is not a fit and proper person to hold the office concerned".

The Appeal Board confirmed that Section 46 gives Council a wide discretion – subject to the caveat that it has to have before it reliable evidence as to the suitability or otherwise of the person concerned to hold the office concerned. The Appeal Board ruled that a trustee who accepts an office of trust and fails to disclose his/her business relationship with a supplier to the medical scheme of which s/he is to become a trustee, by such very act discloses a lack of judgment or maybe dishonesty so as to render him/her unfit to be a trustee of such a scheme.

In that particular matter the Appeal Board was concerned by the appellant's past behaviour which gave the Board "sufficient reason" to regard him as not being a fit and proper person to hold the office of trustee. Even though the appellant agreed to recuse himself from all discussions relating to the service provider whom he had a business relationship with, his relationship with the service provider's major shareholders will continue to exist and may create the perception that he is in a position to influence decisions of the Board or to pass on information to the service provider which may give them a preferential edge against other would-be suppliers to the scheme. Whether or not he would so act is irrelevant – as long as the possibility exists that he could so act.

Board Notice 73 of 2004

Years after its publication, the Notice remains valid and we continue to ensure that medical schemes comply with its directives. The Notice says that a medical scheme must follow a fair process when selecting a new administrator.

In the period under review our Compliance Unit investigated the following schemes to ascertain whether they complied with the Notice.

Spectramed complied with the Notice to a substantial degree when it awarded its administration contract to V Medical Aid Administrators (Pty) Ltd at the end of 2009 to start in the beginning of 2010. Its previous administrator was Rowan Angel (Pty) Ltd.

Remedi Medical Aid Scheme was found to have complied with the Notice when it changed its administrator from Metropolitan Health (Pty) Ltd to Discovery Health (Pty) Ltd in 2010. The scheme had been engaged in a reasonable process of evaluating a range of potential administrators best suited for its needs and ultimately awarded the contract to Discovery Health (Pty) Ltd. The decision was made taking into account considerations of, amongst others, cost, capacity, experience in administration and the financial soundness of the administrator.

Naspers Medical Fund is a self-administered scheme but it was found to have complied with the Notice when it outsourced the administration of two of its benefit options – N Option Plus and N Option Basic – to Discovery Health (Pty) Ltd with effect from 1 January 2011. The scheme had engaged in a detailed tendering process wherein candidate administrators were evaluated and shortlisted, resulting in the qualifying administrator being awarded the contract.

Our investigation into Medipos Medical Scheme is ongoing. The scheme moved its administration function from Old Mutual Healthcare (Pty) Ltd to Metropolitan Health Corporate (Pty) Ltd from 1 January 2011 as a long-term solution to its administration.

Inspections

The following schemes were investigated for alleged non-compliance with the Medical Schemes Act 131 of 1998.

An inspection into Sizwe Medical Fund uncovered that the scheme had not been complying with Regulations on prescribed minimum benefits (PMBs), that it had been operating an unregistered benefit option, and that it had an improperly constituted Board of Trustees. We applied for curatorship to protect the best interests of the members of the scheme.

Fedhealth Medical Scheme was instructed to stop offering to its members interest-free loans for cosmetic surgery and medical interventions which are excluded from its benefits as this was a contravention of the provisions of the definition of "the business of a medical scheme", as defined in the Medical Schemes Act. The scheme had also not been paying for PMB conditions in full ever since it had obtained a legal opinion which advised the scheme that "payment in full" means "payment at scheme rate" and not at cost. Fedhealth is currently contesting the validity of Regulation 8 in alignment with the recent opinion of the Board of Healthcare Funders of Southern Africa (BHF), a case before the courts.

The Compliance Unit investigated Hosmed Medical Aid Scheme for providing the Hosmed Club loyalty programme which included funeral cover, travel discounts, discounts on magazines and discounts at certain retail stores to its members. The inspection report found that the programme was a contravention of the Medical Schemes Act in that the scheme was engaged in business other than the business of a medical scheme. The new Board of Trustees subsequently withdrew the loyalty programme.

Having initially opposed our application for curatorship, Protea Medical Aid Society finally conceded to a curator, but on condition that the inspection report from an independent investigator not form the basis for the curatorship but only the fact that the reserves of the scheme had dropped below the required 25.0%. Protea was placed under curatorship in October 2010.

Community Medical Aid Scheme (COMMED) was investigated for financial irregularities that allegedly took place during the term of office of the previous Board of Trustees. The current Board reported the matter to the South African Police Service (SAPS) and will try and recover the missing funds.

The Registrar expended a remarkable amount of time and financial resources in trying to restore governance and discipline at Bonitas Medical Fund. This included enforcing the closure of Bonitas Marketing (Pty) Ltd which we had investigated for alleged contraventions of the Companies Act 71 of 2008, lack of financial controls, and conflicts between the Board of Directors and the Managing Director.

Section 43 enquiries

During the reporting period we instituted Section 43 enquiries to enforce compliance with the Medical Schemes Act; Section 43 states that the Registrar of Medical Schemes is allowed to inspect whatever and whenever he wishes subject to the Medical Schemes Act.

Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd had paid once-off fees to brokers in contravention of accreditation standards. The administrator was directed to reverse these payments.

The PO of Minemed Medical Scheme was serving as a member of the Board in contravention of Section 57 of the Medical Schemes Act. The scheme was directed to remove the PO from the Board of Trustees. It has complied with our directive.

Witbank Coalfields Medical Aid Scheme subsidises 50.0% of the contributions of "continuation members" once they retire but the law does not allow this because prefunding is not part of the business of a medical scheme. The scheme was directed to apply for an exemption and unwind this long-standing arrangement with employer groups. Witbank Coalfields were given until the end of 2011 to comply with the Medical Schemes Act.

There were alleged conflicts of interest between the Board of Medshield Medical Scheme and service providers, the soliciting of young members to the scheme, and irregular payments to brokers. We initiated an investigation into the scheme but the scheme blocked our investigation before we could conclude it. Further engagement is in order to conclude the investigation. We had, however, uncovered that the scheme paid brokers a "research fee" when they placed members below a certain age onto the scheme. We directed Medshield to stop this practice as it was discriminatory and ordered it to recover the amounts that had been paid out.

Penalties

Sizwe Medical Scheme was penalised for contravening Section 31(2) of the Medical Schemes Act by operating an unregistered benefit option. They have appealed the imposition of the penalty and the matter is ongoing.

Section 46 proceedings

In the year under review the following Section 46 proceedings were instituted against scheme trustees to remove them from office for not being fit and proper:

- Liberty Medical Scheme: the Chairperson and one trustee
- Sizwe Medical Fund: the entire Board of the scheme
- Bonitas Medical Fund: the entire Board of the scheme

Comment on governance

The CMS is not concerned with punitive measures only. In fact, we are pleased with the evidence that there is constant improvement in governance and the financial health displayed by many schemes over the years. However, the CMS wishes to make it clear that we regulate, in the first place, by supporting entities to comply with the Medical Schemes Act 131 of 1998. When regulatory actions are taken, the intention is not to reflect adversely on any entities; they merely reflect our efforts to regulate in a fair and non-discriminatory way.

5

Strategic objective

We investigate and resolve complaints raised by beneficiaries and the public.

Strategic objective 5

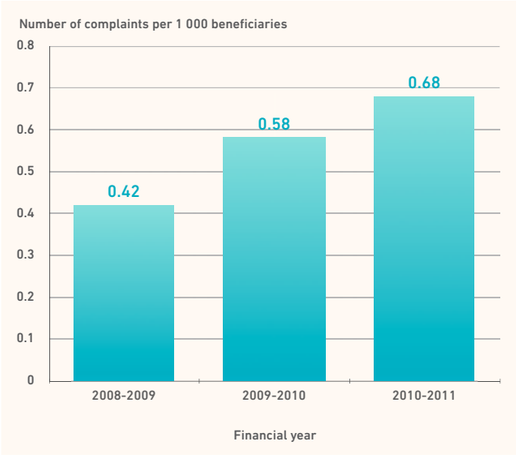
We investigate and resolve complaints raised by beneficiaries and the public.

The Complaints Adjudication Unit at the Council for Medical Schemes (CMS) serves as an early warning mechanism to serious and systemic issues in the medical schemes industry based on the thousands of individual complaints it receives every year from members of medical schemes and the general public.

Resolving complaints

The Complaints Adjudication Unit received 5 617 complaints in the year under review. This is 953 more than in the 2009-2010 financial year.

The graph below indicates the number of complaints (including valid and invalid complaints as well as enquiries) received in relation to the total number of beneficiaries in the last three financial years of the Council for Medical Schemes (CMS).



The number of complaints reaching our Complaints Adjudication Unit has been increasing with every year. In the 2008-2009 financial year, the Unit received 0.42 complaints per 1 000 beneficiaries. In 2009-2010, this number increased to 0.58 complaints per 1 000 beneficiaries. In the current reporting period, Complaints Adjudication dealt with 0.68 complaints for every 1 000 beneficiaries.

5 351 complaints were resolved in the year under review; 3 480 (65%) of these were resolved within 120 days of the date on which they were referred to the relevant medical scheme for comment.

Table 2 indicates the time it took to resolve complaints in the 2010-2011 financial year.

Table 3 shows the top 10 schemes whose members approached the CMS to have their complaints resolved. The schemes are benchmarked per 1 000 beneficiaries.

Table 2: How long it took to resolve complaints 2010-2011

	Resolution time (days)					
	0-30	31-60	61-90	91-120	120+	Total
Total complaints resolved	664	1 292	838	686	1 871	5 351
% of total complaints resolved	12.41%	24.15%	15.66%	12.82%	34.97%	100%

The number of complaints received for the entire industry in the period under review is 0.68 per 1 000 beneficiaries (as reported above), which is significantly lower than the results of the top 10 schemes.

Table 3: Top 10 schemes complained about 2010-2011

Medical scheme	Number of complaints received	Number of beneficiaries	Number of complaints per 1 000 beneficiaries
Spectramed	322	85 858	3.75
Protea Medical Aid Society	11	5 818	2.20
Resolution Health	130	62 157	2.10
Genesis Medical Scheme	41	20 283	2.05
Pro Sano Medical Scheme	135	67 091	2.01
NIMAS	38	19 743	2.00
Liberty Medical Scheme	284	158 656	1.80
Medshield Medical Scheme	461	261 805	1.77
Cape Medical Plan	22	14 461	1.57
Gen-Health Medical Scheme	42	30 460	1.40

Figure 8: Top 10 schemes complained about 2009-2010 and 2010-2011

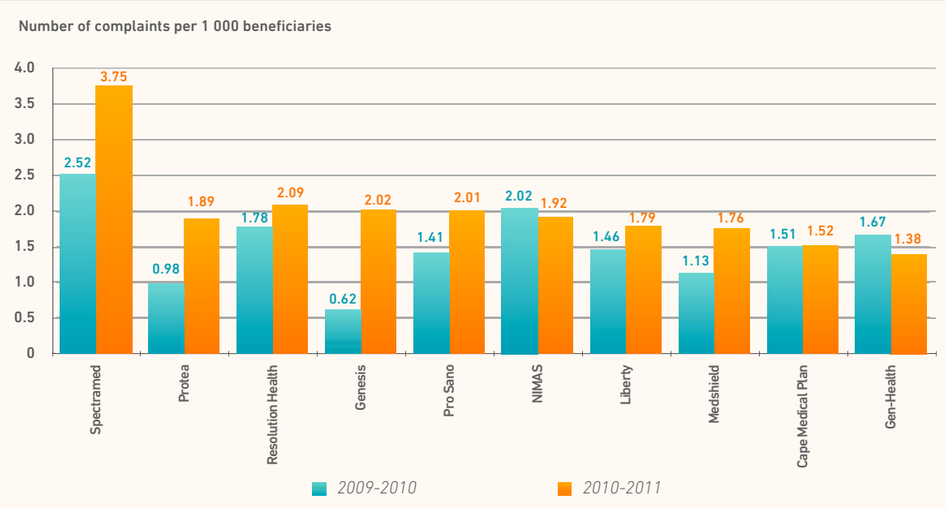


Figure 8 compares the number of complaints received in the 2009-2010 financial year with the number of complaints received against the same medical schemes in the financial year under review.

Adjudicating appeals

The Appeals Committee of Council adjudicated on a number of disputes in 2010-2011. Some of the more topical ones are summarised below.

Medshield v TA

Medshield Medical Scheme appealed the ruling of the Registrar in which it was directed to settle outstanding accounts that were submitted to its former service provider, Calabash Health Solutions (Pty) Ltd, within four months of the date of treatment. Calabash is a managed care organisation whose functions included accepting claims risk from various medical schemes on a capitation basis.

Medshield declined to pay the accounts in question because they had not been resubmitted to the scheme directly after the services of Calabash had been terminated. The scheme indicated that it had sent out notifications to all its members informing them that all accounts which were previously submitted to Calabash and for which payment was not received, had to be resubmitted to the scheme directly within a specified time frame.

The member submitted her accounts to the scheme after service providers notified her of the outstanding amounts but Medshield declined payment on the grounds that the accounts were being resubmitted to the scheme too late, i.e. after the cut-off date indicated in the notice to members. The member claimed that she had never received the said notification.

The Registrar had ruled that Medshield were still liable for the accounts and that the member could not be prejudiced as a result of the termination of a contract between the scheme and Calabash. The Registrar relied on Regulation 15E(1)(a) of the Medical Schemes Act which provides that "the medical scheme is not absolved from its responsibility towards its members if any other party is in default to provide any service in terms of such contract".

The Appeals Committee dismissed Medshield's appeal and directed the scheme to pay the outstanding accounts of R3 753.72 as well as the legal fees which the member had incurred (R10 000).

DB v Compcare

This matter dealt with the scheme's refusal to pay for the costs of a stem cell transplant that was performed to the member's 25-year-old dependant after the dependant was diagnosed with Acute Lymphoblastic Leukemia.

The member found a donor in the USA after all attempts to find a match in South Africa had failed. The member settled all the costs relating to the search, harvesting and transportation of the stem cells from abroad and requested that the scheme pay for the transplant costs.

Compcare Wellness Medical Scheme declined on the grounds that the donor was not a family member and that the patient was a high-risk patient who was unlikely to benefit from a bone marrow transplant. The Office of the Registrar confirmed that the scheme had acted in accordance with the legislative criteria set out in Annexure A(4)(ii) to the Regulations of the Medical Schemes Act which provides that "allogeneic bone marrow transplantation should only be considered where there is an HLA matched family donor".

The Appeals Committee decided to refer the matter to the Board of Trustees to consider an ex gratia payment. It also recommended that Annexure A be revisited by the relevant authorities to incorporate international best practice and remove what seems to be an unfortunate and rigid categorisation.

Discovery v OC

The member was diagnosed with Ulcerative Colitis in 2003. He was using medication to treat the condition but his condition deteriorated and he was hospitalised on a number of occasions between July and September 2009. Discovery Health Medical Scheme was requested to fund the drug Revellex from his Chronic Illness Benefit (CIB) as an alternative drug since the other medications used were ineffective, but the scheme declined this request as it was of the view that Revellex does not form part of the algorithm for Ulcerative Colitis.

Regulation 15I(c) in the Medical Schemes Act provides that "[i]f managed health care entails the use of a formulary or restricted list of drugs, provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary".

Although Revellex is not indicated in the PMB algorithm for Ulcerative Colitis, the Office of the Registrar advised the scheme that Revellex does fall within the ambit of the section entitled *Review for further medication or surgery* of the Chronic Diseases List (CDL) algorithm for the treatment of the condition. And Regulation 8 clearly states that any benefit option which is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of PMB conditions.

In its appeal Discovery indicated that Revellex is not readily available in the public sector and that it would be unaffordable for the scheme to fund the drug but it produced no evidence to support its second point.

The Appeals Committee emphasised that Revellex is not a first-line drug for the treatment of Ulcerative Colitis but based its ruling on the interpretation of Regulation 15H. The fact that the drug is not readily available for the treatment of Ulcerative Colitis at public hospitals does not mean that its unavailability is because of its alleged unaffordability. The Appeals Committee also indicated that the scheme had failed to satisfactorily address Regulation 15H(c) in the circumstances of this case, namely that since all the formulary drugs had been exhausted and proven ineffective, "appropriate exceptions" in the form of non-formulary drugs or surgery was the answer. It is for these reasons that the appeal was dismissed.

LD v Golden Arrow

The member appealed against the ruling of the Registrar which had found that Golden Arrow Employees Medical Benefit Fund had acted in terms of its registered rules when the scheme had refused to pay for hospital stay where his hospital benefit had been exhausted.

The member was admitted to hospital with the necessary authorisation from the scheme. After being discharged, he was held liable for the funding of the hospital's account. His daughter indicated that she had contacted the scheme about the unpaid accounts and was told that the scheme had informed the member's wife, two days after he was discharged from hospital, that his funds were exhausted and the scheme would not cover the outstanding claims. The daughter was of the opinion that the family would have moved her father to another facility had they been timeously informed that his benefits had been exhausted. The scheme indicated that it had informed the hospital that the member's funds were exhausted.

The Appeals Committee ruled that the scheme had a responsibility to ensure that the member's hospital benefit was enough to cover his stay. This is not to say that pre-authorisation constitutes a guarantee that there is enough cover available for hospital stay. Rather, the scheme (or its agent) had failed in its duty to keep the member informed of available benefits and could not expect the member to pay for its own fault.

The Appeals Committee ruled in favour of the member.

AE v Discovery

The member contested the ruling of the Registrar's Office which supported the scheme's refusal to refund claims which had been incurred at a drug rehabilitation facility in circumstances where the service provider's account did not contain a practice number or ICD-10 codes.

The appellant had paid directly to the service provider and submitted an account to Discovery Health Medical Scheme for a refund.

The Registrar had based his decision on the fact that the claims lacked the requisite particulars stipulated in Regulation 5 of the Medical Schemes Act and found that the scheme had acted in accordance with legislation and its rules when declining a refund. Regulation 5 of the Medical Schemes Act, read with Section 59 of that Act, requires that service providers' accounts contain, among other things, "the relevant diagnostic and such other item code numbers that relate to such relevant health service".

The appellant argued that her child's admission and treatment at the facility had been pre-authorised by the scheme and that the scheme should therefore be held liable for the account in question. The Appeals Committee indicated that pre-authorisation is no guarantee that the scheme will pay; pre-authorisation only means

that the admission and procedure accord with the scheme's funding protocol.

The Appeals Committee dismissed the appeal and upheld the Registrar's ruling.

WE and VA v Medshield

These two matters were dealt with as one appeal because both dealt with the Registrar's ruling directing Medshield Medical Scheme to fund in full post-mastectomy reconstructive breast surgery following radiotherapy and chemotherapy for the treatment of breast cancer.

Medshield did not dispute the fact that breast cancer and mastectomy are PMB conditions. They gave three reasons for refusing to fund the reconstructive surgery:

1. It was a cosmetic procedure which is a scheme exclusion.
2. Post-mastectomy breast reconstructive surgery is not listed as part of the recommended breast cancer treatment under code 950J of the PMB Diagnosis and Treatment Pairs (DTPs); the treatment prescribes only radiotherapy and chemotherapy.
3. The fact that the surgery is offered in some public sector hospitals for teaching purposes does not automatically qualify it as a PMB level of care for breast cancer.

The Office of the Registrar took the view that post-mastectomy breast reconstruction surgery forms part of the standard of care for the treatment of breast cancer; it relied on Explanatory Note 2 of PMB Regulations in Annexure A of the Medical Schemes Act which stipulates that "surgical management" and "medical management" should be interpreted as referring to "prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition".

The note enjoins us to consider the practice in both private and public sectors when interpreting the meaning of "surgical management" for the treatment of breast cancer under PMBs. The view of the Registrar's Office was supported by a medical practitioner who works at a public and private hospital. She confirmed that reconstructive surgeries are performed as a norm at the Gauteng public hospital every week.

The Appeals Committee also pointed out that only where there are significant differences between the private and public sectors should one construe "surgical management" to mean "predominant public hospital practice" in the treatment of breast cancer.

The committee concluded on the strength of evidence before it that there appear to be no significant differences between standard practice in the private and public sectors. But it pointed out that it is not necessary to consider the prevailing public sector practice alone and it would seem that post-mastectomy breast reconstruction in public hospitals is the norm rather than the exception.

The Registrar's rulings in both matters were upheld. A cautionary note was pointed out by the committee to indicate that this ruling does not set a precedent for all post-mastectomy breast reconstruction cases and that it was only on the basis of the evidence before it that the committee had arrived at this conclusion. A similar case argued differently may result in a different outcome.

The GEMS matter

The Office of the Registrar instructed the restricted Government Employees Medical Scheme (GEMS) to change its eligibility criteria because they give the Board discretion to determine whether a particular employer or group is allowed join the scheme or not. The Office discovered that GEMS had been using these criteria to unfairly deny entry to potentially high-risk groups which would otherwise have been eligible to join GEMS or an open medical scheme of their choice; this behaviour amounts to unfair discrimination in order to deny access to a medical scheme in contravention of the Medical Schemes Act and has serious implications for industry at large.

GEMS may be a restricted medical scheme but the principle of open enrolment enshrined in law – which provides that a medical scheme must accept anyone who may wish to join that scheme – applies to those members of GEMS who would otherwise have been eligible in terms of its rules and in this case the very reason why the scheme was registered in the first place: to provide a medical scheme for government employees who render services in the public interest.

GEMS submitted a proposed amendment to its eligibility criteria; it proposed that the Board no longer be required to decide which groups to accept and which to deny membership. But the Office determined that the revised eligibility criteria would in practice effectively exclude certain groups which the Office believes should be allowed to join the scheme; our concerns had not been addressed. The proposed amendment was rejected and the scheme appealed the decision of the Office by approaching Council's Appeals Committee; the committee upheld the ruling of the Office. The scheme then decided to take the matter further by appealing the decision of the Appeals Committee with the independent Appeal Board. The outcome of that process is expected in the new financial year. The decision on how GEMS is allowed to accept and reject member groups is of strategic importance and needs to be settled.

GEMS is the fastest-growing scheme in South Africa; this is because it attracts members from open schemes as well as previously uncovered lives (virgin medical scheme members). The influx of members into GEMS has resulted in open schemes ageing and restricted schemes becoming younger as a whole. If GEMS is allowed to continue with its drive to craft its eligibility criteria so as to exclude certain groups, this may result in certain vulnerable groups (from both restricted and open schemes) being forced into the open schemes environment; this would ultimately cause the risk profile of open schemes to deteriorate and reduce the affordability of medical schemes for all members and South Africans.

Profmed

Profmed has always been a restricted medical scheme for professionals with a tertiary degree of at least four years who are also members of the Professional Provident Society (PPS). But Section 21A(3) of the Medical Schemes Act prescribes that "[i]t is an offence to market, advertise or in any other way promote a medical scheme in a manner likely to create the impression that membership of such medical scheme is conditional upon an applicant purchasing or participating in any product, benefit or service provided by a person other than the medical scheme in terms of its rules".

Profmed was therefore requested to remove the requirement that its prospective members belong to PPS in order to be allowed to join the scheme. It was asked to replace this condition with the requirement of a four-year degree or equivalent professional qualification. In fulfilling this request, the scheme tried to amend its rules to broaden its eligibility criteria to allow access to students completing their tertiary qualification as well as support staff of its existing members. The Office of the Registrar rejected the proposed amendment because it sought to broaden the eligibility criteria which the scheme was originally intended for and as defined in the Medical Schemes Act. Had the proposed amendment been accepted, it may have led to instances where the scheme would cherry-pick and operate like an open medical scheme under the guise of a restricted scheme. The Office recommended numerous alternatives to the proposed rule amendment; we even suggested that Profmed consider morphing into an open medical scheme.

The scheme has lodged an appeal against the decision of the Registrar with Council's Appeals Committee.

Barloworld Medical Scheme

The Registrar rejected the scheme's proposal to amend its eligibility criteria which sought to allow its unbundled subsidiaries to continue to be eligible for membership of the scheme. The independent Appeal Board upheld the Registrar's decision. The Office is pleased with this ruling because it further strengthens our stance on restricted schemes seeking to reformulate their criteria in a manner which is contrary to the originally defined purpose for a particular restricted scheme.

Discovery

Discovery Health Medical Scheme refused membership to an applicant arguing that his joining the scheme would create a dangerous precedent resulting in open medical schemes having no choice but to accept high-risk members. The applicant lodged a complaint with the Office of the Registrar and a ruling was made in his favour; the principle of open enrolment in the Medical Schemes Act clearly stipulates that schemes are not allowed to reject applicants on any arbitrary grounds, including their age and health status. Discovery has appealed the ruling of the Registrar with the Appeals Committee and the case has been set down for the new financial year.

Implementing the new complaints database

Our complaints database was improved in the year under review. We are now able to resolve complaints more speedily and we can also track our own performance and efficiency. We should be able to offer improved customer care to the thousands of complainants who contact us each year.

6

Strategic objective

We foster the continued development of the Council for Medical Schemes as an employer of choice.

Strategic objective 6

We foster the continued development of the Council for Medical Schemes as an employer of choice.

Human Resources

Talent management

The Human Resources (HR) Unit continued with its three-year project on talent management which entails the strategic management of the flow of talent through an organisation. The purpose of the project is to ensure that the Council for Medical Schemes (CMS) has an available supply of talent that can be aligned with the right jobs at the right time based on the CMS strategic objectives.

In 2010-2011, the Unit identified people and positions that are critical to this organisation. The identified employees were placed on a leadership and high-potential employee development assessment programme; this work is ongoing.

The integration and alignment of the following policies was achieved as part of the broader talent management strategy.

- Recruitment: Through well-structured recruitment processes and practices HR ensured that the right people were appointed.
- Retention: HR implemented practices which support and reward our employees, e.g. flexible office hours, enhanced staff benefits, and funding for professional development, including the attendance of local and international seminars and conferences.
- Employee development: Opportunities were provided to staff for continuous informal and formal learning and development which was managed by HR through a training plan approved and adopted for the year under review.
- Performance management: Ongoing support was provided to the various Units at the CMS aimed at improving performance, including feedback and measurement.
- Workforce planning: HR conducted a work study to assess both current and future skills shortages at the CMS. Council approved eight new positions to be filled in 2011-2012.
- Culture: The development of a positive, progressive and high-performance "way of operating" continued to be inculcated at every level of the organisation. From an HR perspective, this approach was brought into the interviewing and selection processes.

Performance management

Performance was successfully managed during the course of 2010-2011.

At the onset of the financial year under review, HR facilitated the drafting and conclusion of performance agreements for our employees, making sure that the contracts correctly reflected requirements and accomplishment-based performance standards, outcomes and measures. We also ensured that each job was clearly described.

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

All the new employees who were appointed during 2010-2011 and who completed the mandatory probationary period of six months were confirmed as permanent employees of the CMS after the probationary confirmation process was concluded between HR and the relevant supervisors.

HR placed focus and emphasis on providing effective orientation, education and training throughout 2010-2011 to all employees. Within their first week of appointment, HR provided new employees with in-depth and comprehensive orientation on the structure and function of the organisation, our terms and conditions of service, and all policies, including the HR Manual. Support was provided for career development opportunities through the Professional Development Programme (PDP).

HR provided assistance and guidance to management regarding the ongoing coaching and feedback on their staff, in some instances implementing poor performance interventions where management had identified concerns.

At the end of 2010-2011, following two formal review processes, HR facilitated through the Moderating Committee the awarding of incentive bonuses to those employees who qualified for their contributions to ensuring that the CMS met its strategic goals and delivered on its mandate in the year under review.

Training and development

Staff members undertook various training programmes in 2010-2011. HR completed and submitted a Workplace Skills Plan and Annual Training Report to the Health and Welfare Sector Education and Training Authority (HWSETA) who gave us a grant of R99 286.27.

Recruitment and workforce planning

During 2010-2011, HR successfully addressed both current and future human resource requests by assessing which skills, knowledge, predispositions and abilities are required for the CMS to accomplish its strategic goals and by sourcing the best talent. The turnaround time for the filling of vacancies from the date of advertising to appointment was two months.

Table 4: CMS staff profile as at 31 March 2011

Occupational level	Men					Women					Total
	A	C	I	W	Total	A	C	I	W	Total	
Top management	1	0	0	0	**1**	0	0	0	0	**0**	**1**
Senior management	2	0	0	4	**6**	2	0	0	0	**2**	**8**
Professionals	5	0	1	4	**10**	7	2	0	5	**14**	**24**
Skilled technical	10	1	1	2	**14**	19	2	3	6	**30**	**44**
Semi-skilled	1	0	0	0	**1**	4	1	0	0	**5**	**6**
Total permanent	**19**	**1**	**2**	**10**	**32**	**32**	**5**	**3**	**11**	**51**	**83**
People with disabilities included above	0	0	1	0	**1**	0	0	0	0	**0**	**1**
Grand total	**19**	**1**	**2**	**10**	**32**	**32**	**5**	**3**	**11**	**51**	**83**

Employee wellness

The wellness of our employees remained a priority for HR and a key strategic objective for ensuring staff retention and improving productivity.

Our approach this year was to proactively address and pre-empt health and social issues before they turned into bigger and costlier problems.

HR hosted a successful corporate wellness programme based on three areas:

- Promoting fitness and healthy habits: All staff members were provided with a subsidised health club membership. Free health screenings were offered for high blood pressure, elevated cholesterol and other health ailments.
- On-site health education on HIV/AIDS and TB: Presentations were facilitated to raise awareness on HIV/AIDS and tuberculosis.
- Free counselling: This service was made available to staff to assist them in coping with matters related to stress, family, psychological and financial issues, and any other matter which has or may have an impact on their productivity.

Managing our financial resources

The Council for Medical Schemes (CMS) is an entity listed under schedule 3A of the Public Finance Management Act 1 of 1999 (PFMA). The PFMA is therefore the basis for the manner in which we manage our financial affairs.

The CMS has put in place good systems of internal control in order to effectively and efficiently manage its financial matters. This is evidenced by the fact that we have received unqualified audit reports for 11 successive years; we pride ourselves in this regard.

Budget

The CMS submitted its proposed budget for 2010-2011 to the Executive Authority for approval during March 2010. We received approval from the Minister of Health in concurrence with the Minister of Finance during July 2010.

Accordingly, medical schemes were levied at R18.29 per principal member per annum to allow us to meet our regulatory mandate.

Budget variance reports are tabled every month in strategic management meetings to track expenditure against operational objectives.

Legal fees

The Legal Services Unit was extraordinarily active during the period under review in providing legal support to the various compliance functions of the CMS.

Most notable among the matters dealt with was the Bonitas Medical Fund case wherein the Registrar and Council had, prior to the financial year under review, applied for the scheme to be placed under curatorship due to material concerns regarding its governance. The trustees of the scheme, after initially signifying an intention to comply with the proposed course of action, subsequently elected to resist the intervention, thereby resulting in a phase of protracted litigation being entered into which spanned a period of almost two and a half years. The financial burden posed by the ongoing litigation in this matter resulted in the Unit budget coming under undue strain.

Financial management

Management accounts were produced every month. They served in strategic management meetings (monthly), meetings of the Audit & Risk Committee (quarterly) as well and Council meetings (quarterly). Cash flow was monitored by monthly cash flow projections to estimate our ability to meet our operational objectives.

Financial statements for the year ending 31 March 2011

Our financial statements for the year ending 31 March 2011 were finalised in time to comply with the PFMA deadline of 31 May 2011. They were then duly submitted to the Auditor-General (AGSA) and National Treasury; the AGSA audited them and we are pleased to report that we once again received an unqualified audit opinion for the 2010-2011 financial year. Our financial statements for the year ending 31 March 2011 are included in this Annual Report in the section *Our Annual Financial Statements* (page 120-141).

Supply chain management

Monthly supply chain management reports were submitted to Treasury, as required by the PFMA.

During the year under review we advertised for a tender of travel management services. The tender was adjudicated and awarded to XL Nexus Travel, a BEE-compliant entity.

Internal audits

Our internal auditors, Sizwe Ntsaluba Inc., performed the internal audit function in line with their three-year rolling plan. In the period under review they presented 10 audit reports to the Audit & Risk Committee. We are satisfied with the value-adding services we receive from the internal auditors.

Risk management

The Risk Management Committee continued to monitor real and potential risks in the CMS and advised management on the appropriate mitigating measures. The Internal Finance Unit prepared a risk register every month and presented it at strategic management meetings and to the Audit & Risk Committee.

Performance information

As required by the PFMA, we produced a performance information report for the period under review; it was reviewed by the Auditor-General. The report is set out in the section *Performance information: performance v targets* on page 84-119 of this Annual Report.

In the year under review the AGSA did, however, identify some gaps on our performance report which needed improvements. We consequently worked very hard with the Technical Advisory Unit (TAU) of Treasury to perfect our performance information format. We are pleased that our performance information report will meet all the required standards going forward.

Information Systems & Knowledge Management

Software development and reporting

The year under review saw ongoing refinements being done to the online financial return as well as auditor approval systems. Quarterly and annual financial returns were released on time for completion by medical schemes, as directed by our Financial Supervision Unit (FSU).

We were very proud to release our new website in line with our revised corporate identity and logo. The new website was designed to enhance the end-user experience and friendliness, and conforms to the latest in web standards. The website can be accessed at *www.medicalschemes.com*.

Complaints are now processed faster and more efficiently thanks to system enhancements performed on the complaints database. The enhancements include improved inter-departmental communication features, standardising on the Portable Document Format (PDF) standard, and performance-based reporting whereby we can measure our own efficiency and effectiveness in resolving complaints speedily.

In an effort to improve customer care, an interim call ticketing system was written for our Customer Care Centre and successfully deployed. All calls are now logged on the system and where escalation is required, progress is monitored.

We also added auto-feedback functionality to our complaints and accreditation systems, which ensures that stakeholders receive recognition of receipt following their initiation of contact with this Office.

In the context of contributing to national health policy and objectives, we assisted the Department of Health (DoH) by developing an interim Mini Single Exit Price (Mini-SEP) system followed by a fully functional system. The site can be accessed at *www.mpr.gov.za* (Medicine Price Registry).

We refined our management reporting as part of an ongoing effort to provide business intelligence to aid in management decision-making.

Finally, our software development division focused on Microsoft Dynamics Customer Relationship Management (CRM / XRM) as the basis for all future return systems and for the development and hosting of the various registries which the Council for Medical Schemes (CMS) will require in future to fulfil its mandate. To this end, a feasibility study and specifications for the first phase of the registries, being a medical schemes registry, were developed and signed off.

Network administration and IT Helpdesk

During the year under review, our Network Administration function was responsible for the commissioning and installation of a new Internet line connection. Our previous connection solution of 1Mbps was replaced with a 4Mbps direct line of sight microwave link. This increased bandwidth and aided in improving the browsing experience to the different portals on our website which our stakeholders access on a daily basis.

We successfully installed a new Storage Area Network (SAN) and a new database cluster. The combination of SAN, together with new server platforms and the latest database software, now provides us with 99.9% up-time and major speed enhancements in data management.

In response to being able to recover from a possible disaster, our weekly backup tapes are now also securely stored offsite. To ease the process of password changes which our security policy demands, we successfully rolled out a password reset self-help system. This greatly reduced the strain on our Helpdesk and makes it easier for users to manage their accounts.

The year under review saw our IT Helpdesk attending to 1 016 support requests. The Helpdesk also successfully hosted six bimonthly "Chalk and Talk" sessions with internal staff during which induction and training were conducted on the various technology platforms in use at the CMS. In order to gauge end-user satisfaction with IT service delivery, two surveys were conducted and, where appropriate, adjustments were made to the support function.

Knowledge and records management

Our Resource Centre continued with its mandate to enhance knowledge and information sharing within the organisation. Members of staff were assisted with their information requests, specifically on governance, health economics and policy as well as legal matters.

We continued to comply with our obligations in terms of the Promotion of Access to Information Act 2 of 2000 (PAIA). We managed to submit our Section 32 report to the South African Human Rights Commission (SAHRC). The relevant material in terms of Section 15 of PAIA was submitted to the Department of Justice and Constitutional Development. The report was published in *Government Gazette 33350* on 9 July 2010.

As far as records management goes, the following was achieved in our 2010-2011 financial year:

- A project was undertaken in August and September 2010 to realign paper-based records within the CMS.
- 12 181 paper-based files were re-indexed at our off-site facility.
- 683 paper-based postal items were registered, scanned and routed to the in-trays of our different departments.
- 339 new off-site storage boxes were prepared and taken to off-site storage.
- 22 archived files were requested from off-site storage.
- 770 new accreditation applications were scanned to the accreditation repository.
- National Archives approved the CMS file plan.

Customer Care Centre

Our Customer Care Centre received 47 573 calls during the financial year under review, of which only 6.4% was abandoned; 42 976 calls were thus handled and dealt with successfully. Our call handling time was 2 minutes 36 seconds; the average queuing time was 2 minutes 21 seconds.

Strategic objective

7

We develop strategic alliances nationally, regionally, and internationally.

Strategic objective 7

We develop strategic alliances nationally, regionally, and internationally.

We continued to build and strengthen strategic relationships with other regulators and various industry stakeholders. We interacted with the Competition Commission on a formal approach to price negotiations in the private health sector; we engaged with the Financial Services Board (FSB) on a number of regulatory matters; the Health Professions Council of South Africa (HPCSA) co-led the industry workshop on PMBs with us.

We look forward to further engagement with decision-makers in the South African health system and international counterparts.

Conclusion

The year under review proved challenging but successful.

I would like to thank Council for their continued guidance and support in standing by the Office as it fulfils its mandate to regulate in a fair and transparent manner.

I also thank the management team and all staff for their excellent work and dedication in the period under review. The CMS is only as strong as its people.

I look forward to leading the Council for Medical Schemes as it continues to play a crucial role in the South African health system.

Dr Monwabisi Gantsho
Registrar & Chief Executive
Council for Medical Schemes
29 July 2011

Performance information: performance v targets

Strategic objective 1

We monitor the impact of the Medical Schemes Act, research developments, and recommend policy options to improve the regulatory environment.

Key performance indicator	Target	Actual performance	Reason for deviation
Monitor impact of Medical Schemes Act and trends in private health finance			
Analyse non-accounting data – including demographics, utilisation of healthcare services, burden of disease and geographic distribution of membership – for quarterly and annual statutory returns	Submission of annual report by end of August 2010	Data analysis on *Reviewing the operations of medical schemes 2010* section of Annual Report was concluded on schedule, and the required Annexures on non-financial data and benefit section	No deviation
Develop strategies to improve quality of non-financial information	Ongoing	Research & Monitoring (R&M) liaised with Information Technology and Financial Supervision on a continuous basis to implement rule validation and testing of part 2 and 3 of the annual statutory return	No deviation
Research developments and recommend policy options to improve regulatory environment			
Understand utilisation of healthcare services in medical schemes to develop more appropriate strategies to mitigate cost-escalation in the environment	Final report on utilisation determinants by 31 March 2011	Report was completed, presenting a framework for strengthening the collection of utilisation information; report incorporates input from Strategic Projects Unit	No deviation
Develop policy framework for registration of scheme contributions	Report on price indicators by 28 February 2011	Target not achieved	Staff member executing the project left on a long-term study leave and it was not possible to secure a replacement timeously
Factors impacting on member movement across benefit options	Final report by end of February 2011	Report detailing factors which impact on member movement in medical schemes was completed on schedule	No deviation
Monitor ICD-10 implementation	Quarterly monitoring of compliance by schemes and other stakeholders	Aggregate compliance statistics and results were produced for each quarter	No deviation
	Quarterly meetings of National Task Team on ICD-10 implementation	All quarterly meetings were convened; CMS hosted one of them	No deviation
Pricing analysis based on revised PMB package	Participate in process to specify data requests to medical schemes by May 2010	Strategic Projects Unit published report on cost estimates for selected PMB conditions on schedule	No deviation
Provide statistical and research support to other Units	Ongoing project to respond to ad hoc requests for analytical assistance from internal and external clients	Research & Monitoring Unit assisted with the following requests: • Submission of a research article to the *World Medical Journal* • Input into a survey tool developed by Nkonki & Nkonki for the medical schemes industry • Input into *CMS News* articles R&M Unit also published an inflation guidance note that informed rule changes and benefit design for 2011	No deviation

Strategic objective 2

We secure an appropriate level of protection for beneficiaries of medical schemes and the public by authorising the conduct of medical schemes and monitoring their financial performance.

Key performance indicator	Target	Actual performance	Reason for deviation
Ensure fair treatment of beneficiaries and the public by ensuring compliance with registered scheme rules			
Monitor marketing material and all application forms of high-impact schemes to assess consistency with registered rules and as identified through complaints/clinical analysts	3 schemes per analyst per quarter for 3 quarters (June, September and March of each year)	Target achieved (47 schemes' marketing material and application forms analysed over the reporting period)	No deviation
Ensure compliance by all schemes in their rules with the Medical Schemes Act, amended Regulations and revised model rules			
Circulate to schemes the dates for submission of contribution and benefit changes; advise schemes that marketing of contributions and benefits prior to their approval is at the scheme's risk	Circular outlining revised process for submission of contribution and benefit changes by June 2010	Circular 35 of 2010 sent out on 25 June 2010	No deviation
Ensure submission by schemes of Appendix 1A, 1B and C and Annexes A and B on contribution and benefit changes	Online submission of contribution on Appendix 1A, 1B and C and benefit schedules by 1 October 2010	100% received on or before 1 October 2010 for schemes with changes effective from 1 January 2011	Only schemes with amendments taking effect from 1 January 2011 must comply
Review and approve contribution and benefit changes	Recommendations to Unit Head on annual contribution and benefit changes for each scheme; final decisions on 2011 contribution and benefit changes by end of December 2010	Completed within prescribed timeframes	Only schemes with amendments taking effect from 1 January 2011 must comply
	Publish list of approved open scheme options on website by no later than 2nd week in November 2010 and of approved restricted scheme options in mid-December 2010	Circular 63 of 2010 published on 15 November 2010; Circular 69 of 2010 published on 22 December 2010	No deviation
Monitor interim contribution and benefit changes; analyse and recommend rule amendments for approval	Analyse applications within 7 days of receiving all information; submit recommendations within 10 days to Registrar	Target achieved (130 changes monitored)	No deviation
Communicate reasons for not registering rules to schemes	Letters compiled and sent to schemes within 7 days of analysing their rules and after all information received	Target achieved (7 letters)	No deviation
Make available information on approved and rejected rules to internal staff	Publish information on SharePoint once Registrar has taken a decision	Registered rules published on MOSS database once decision taken	No deviation
Make available scanned version of latest registered/amended rules to key internal staff	Update rules database with all registered rules in force; all scheme rules scanned by 30 June 2010	Target achieved (100% of rules scanned)	No deviation
Interpret model rules and guide stakeholders on them	Communicate to stakeholders, as required	Not applicable	No deviation
Analyse applications for registration of new schemes	Report with recommendation to Registrar within 14 days of receiving application and all information	Target achieved (1 case)	No deviation
Analyse applications for registration of new and restructured benefit options	Report with recommendations to Head within 10 days of receiving application and all information	Target achieved (3 cases)	No deviation
Monitor conditions imposed on schemes during the rule amendment process; this includes monitoring in terms of Section 33 and Regulation 29(4)	Monthly review of schemes' reports for compliance with conditions; submit recommendations to Head within 7 days of receipt	Target achieved (7 schemes monitored for compliance)	No deviation
Publish in *Government Gazette* a notification of the registration of medical schemes	February of each year	*Government Gazette* published on 11 February 2011	No deviation
Maintenance and upkeep of scheme master database	As and when required	Database is up to date	No deviation
Manage amalgamations in compliance with approved exposition and prevailing legislation	Prepare a report based on amalgamation documents with recommendations to Registrar for approval and confirmation within 21 days of receiving all information	Target achieved (8 documents)	No deviation
Manage liquidation procedures with Financial Supervision in compliance with prevailing legislation	Recommendations to Registrar regarding approval of liquidator	Not applicable (0 voluntary liquidations in reporting period)	No deviation
Render legal advice on rule amendments, amalgamations, liquidations and curatorships in accordance with Medical Schemes Act	Within 1 week of request or sooner when required	Completed within prescribed timeframes	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Evaluate curators' reports; provide feedback to curators	Monthly	Curators' reports were evaluated; feedback was provided to curators	No deviation
Participate in finalisation of the review of model rules	Internal workshops on revised model rules as and when required	No activities for period under review	No deviation
Register scheme rules in respect of contributions and benefits			
Engage in assessment of contribution and benefit changes with Benefits Management Unit (BMU) and Research & Monitoring (R&M)	Final decisions on 2011 contribution and benefit changes by end of December 2010	Target achieved	No deviation
Alert other Units to relevant decisions having an impact on registration of scheme rules	Within 1 week of ruling becoming available	BMU was alerted on all matters where decisions had impact on registration of rules	No deviation
Assist in ensuring that medical schemes' benefit options are financially sound			
Assess financial impact of new benefit options and material restructuring of existing options to ensure that options are financially sound and self-supporting	Within 4 weeks after all information has been received	Target achieved	No deviation
Analyse and improve statutory returns as tools for monitoring and reporting			
Develop Quarterly Returns (QR)	Quarterly Returns (QR) IT specifications by January 2011	Target achieved	No deviation
	2010 QR IT development starts in March 2010 and is finalised by end of May 2010	Target achieved	
	2011 QR IT development starts in March 2011 and is finalised by end of May 2011	2011 QR project underway; to be finalised in May 2011	
Develop 2010 annual return	Finalise by end of February 2011	Target achieved	No deviation
Disseminate 2010 online quarterly statutory returns	Quarterly returns available for completion beginning of June 2010	Target achieved	No deviation
Disseminate 2010 online annual statutory returns	Annual returns available for completion beginning of March 2010	Target achieved	No deviation
Analyse 2010 quarterly returns	Publication of reports: Quarter 1 – beginning of September 2010; Quarter 2 – beginning of October 2010; Quarter 3 – end of January 2011	Target achieved; Quarter 1 report was published on 16 September 2010; Quarter 2 report was published on 4 November 2010; Quarter 3 report was published on 27 January 2011	No deviation
Analyse 2009 annual returns	Financial analyses of annual returns by end of June 2010	Target achieved	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Monitor the financial soundness of medical schemes			
Identify schemes who do not comply with Regulation 29 on solvency (using the returns)	Quarterly reports: Quarter 1 – end of September 2010; Quarter 2 – end of October 2010; Quarter 3 – end of January 2011; for Annual Report – end of July 2010	Target achieved; reports for each quarter completed on time	No deviation
Identify schemes who comply with Regulation 29 on solvency but are experiencing rapid decreases (using the returns)	Quarterly reports: Quarter 1 – end of September 2010; Quarter 2 – end of October 2010; Quarter 3 – end of January 2011; for Annual Report – end of July 2010	Target achieved; reports for each quarter completed on time	No deviation
Examine and evaluate structure and elements of Regulation 29(4) business plans to assess true financial position and performance of medical schemes	6 weeks after receiving the completed business plan	Analysed and completed as and when submissions were made by schemes	No deviation
Monitor schemes' compliance with agreed action plan	Quarterly reports: Quarter 1 – end of September 2010; Quarter 2 – end of October 2010; Quarter 3 – end of January 2011	Target achieved; reports for each quarter completed on time	No deviation
Research the impact of Omni-Health judgement on management of savings plan monies and its effect on solvency	End of March 2011	Completed within prescribed timeframes	No deviation
Ensure that financial guidelines used by the Council for Medical Schemes are updated			
Review auditor approval process	End of April 2010	Target achieved	No deviation
Review the following standard documentation: business plans, management accounts, reinsurance guidelines, Board of Trustees (BoT) manual	End of March 2011	Target achieved	No deviation

Strategic objective 3

We provide support and guidance to trustees and promote understanding of the medical schemes environment among trustees, beneficiaries, and the public.

Key performance indicator	Target	Actual performance	Reason for deviation
Promote sound corporate governance of medical schemes			
Trustee training: promote understanding of the Medical Schemes Act by Boards of Trustees to ensure sound corporate governance of medical schemes			
Conduct general trustee training to improve governance and decision-making on Boards	Induction trustee training session in March 2011	Target achieved; conducted 3 general induction training sessions (Cape Town, KwaZulu-Natal and Gauteng)	No deviation
Participate in trustee training and education on Medical Schemes Act, responsibilities as trustees, and principles of good governance	As per targets set by Education & Training Unit	Participated in all 3 sessions, as scheduled by Education & Training Unit	No deviation
Assess fitness and propriety of trustees and conduct skills audit	Ongoing	Target not achieved	Categorisation of schemes not yet finalised
In-house trustee training and involvement of external experts to provide training, as per training needs analysis of schemes (red schemes)	Ongoing; trustee training is provided based on scheme's needs	Target partly achieved; held in-house training for Pro Sano and GEMS	Categorisation of schemes not yet finalised
Continue to identify service providers to contract with; establish relationships with accredited training service providers	Develop a Memorandum of Understanding (MoU) with service providers by March 2011	Target partly achieved; drafted MoU for 1 service provider	No deviation
Finalise Trustee Training Manual and Trustee Induction Pack (TIP) in line with Medical Schemes Amendment Bill	Produce online training manual by March 2011	Target partly achieved; updated the manual and TIP	Awaiting Units' input into Trustee Training Manual
Conduct annual training audit to enhance quality of data submitted by schemes; ensure efficient use of resources by CMS and external parties	Consolidate training data by March 2011	Target partly achieved; consolidated data for 3 induction training sessions	Categorisation of schemes not yet finalised
Support from BMU and Complaints Adjudication Unit by their participating in BoT training workshops on scheme rules, the Medical Schemes Act and/or Regulations	As and when required, by the Education & Training Unit	No training sessions attended over reporting period	Requirement to attend training is as and when required; no requests for training were received over reporting period
Financial Supervision supports Education & Training Unit by participating in BoT training on financial issues	Present modules on financial management of schemes to BoTs, as and when required	Target achieved	No deviation
Research & Monitoring participates in training of providers, administrators, schemes' administrative and clinical personnel, medical advisors and other stakeholders	Presentations on PMBs at 30 sessions	Various training sessions were conducted during the 2010-2011 financial year, except in the last quarter during which no sessions took place	No deviation
Obtain feedback from Education & Training on corporate governance	Quarterly or sooner if indicated	Feedback received and processed accordingly	No deviation
Ensure that appointed and elected trustees are "fit and proper"	By June 2010	Completed within prescribed timeframes	No deviation
Consumer education			
"Train the trainer" education: provide training on Consumer Open Day to trade unions, employer groups, health organisations, healthcare providers and consumer groups	20 sessions for trade unions	Target partly achieved; conducted 6 sessions	Education & Training Officer vacated position; Unit was understaffed; due to the civil servants strike a number of planned sessions were cancelled
	10 sessions for employer groups/EAPs	Target achieved; conducted 14 sessions	No deviation
	20 sessions for health organisations	Target partly achieved; conducted 8 sessions	Education & Training Officer vacated position; Unit was understaffed
	25 sessions for healthcare providers/case managers	Target partly achieved; conducted 13 sessions	Education & Training Officer vacated position; Unit was understaffed
	20 sessions for consumer groups	Target achieved; conducted 35 sessions	No deviation
Drive outreach and awareness initiatives to increase consumer awareness of our role as regulator	Participate in consumer-focused media programmes	Target achieved; conducted radio interviews	No deviation
	Participate in selected target-specific outside broadcasts	Target achieved	No deviation
	Use the media to inform of new trends and educate the public	Target achieved; placed educational articles in various newspapers and magazines	No deviation
	Exhibitions	Target achieved; exhibited at Rand Show, Rustenburg Show, Pretoria Show, SAMA conference, BHF conference and IPM	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Participate in joint national activities with the NCF, other regulators, provincial consumer affairs offices etc.	4 campaigns; 3 town meetings	Target partly achieved; participated in 4 campaigns with stakeholders (Savings Month, Spending Patterns, Consumer Month, WCRD)	No deviation; no invitation received from the NCF for town meetings
Participate in Consumer Month activities	March 2011	Target achieved; participated in Gauteng, Northern Cape, North West and KZN; Consumer Rights Day activities	No deviation
Liaise with internal stakeholders	Bi-annual meetings to establish trends that infringe on consumer rights (consumer alerts)	Target achieved; held 2 meetings with Customer Care Centre and Complaints Adjudication Unit	No deviation
Liaise with external stakeholders	Participate in Consumer Protection Forum and National Consumer Education Committee activities	Target achieved; attended 3 Consumer Protection Forum meetings and 3 National Consumer Education Committee meetings	No deviation
Formalise relationships with key stakeholders (e.g. regulators and consumer protection offices)	Develop Memorandum of Understanding (MoU)	Target achieved; MoUs were developed	No deviation
Use various communication tools to convey key messages to stakeholders			
Publish and publicise Annual Report 2009-2010	Publish Annual Report 2009-2010 by 1 September 2010	Target achieved; Annual Report 2009-2010 was published on 26 August 2010	No deviation
	Launch Annual Report 2009-2010 by 10 September 2010	Target achieved; launch took place on 2 September 2010	No deviation
	Road shows (Durban, Cape Town, Johannesburg) by 17 September 2010	Target achieved; road shows took place 7-9 September 2010	No deviation
	Participation in road shows by other Units	Target achieved	No deviation
Address key issues in *CMS News*, CMScript and *Masihambisane*	Publish 3 issues of *CMS News*; publish 12 issues of CMScript; publish 12 issues of *Masihambisane*	Target partly achieved; 1 issue of *CMS News* was published; 9 issues of CMScript were published; 12 issues of *Masihambisane* were published	Unavailability of resources
Publish circulars, editorials, opinion pieces and press releases on key issues	Publish Circulars, editorials, opinion pieces and press releases at least once a month	Target achieved	No deviation

Strategic objective 4

We foster compliance with the Medical Schemes Act by medical schemes, administrators and brokers, and initiate enforcement action where required.

Key performance indicator	Target	Actual performance	Reason for deviation
Ensure compliance by all schemes in their rules with the Medical Schemes Act, amended Regulations and revised model rules			
Analyse non-compliance reports submitted by various Units	Reports were analysed within 1 month of receipt; recommendations for regulatory intervention were included where required	Completed within prescribed timeframes	No deviation
Render reports of non-compliance by regulated entities to Compliance Unit	As and when necessary	Reports were submitted quarterly, as requested	No deviation
Monitor, investigate and/or inspect schemes to ensure good governance and appropriate non-health expenditure	Report/memorandum with recommendations compiled within 1 month after completion of investigation or inspection	Completed within prescribed timeframes	No deviation
Identify criminal charges; prepare statements and documents regarding criminal charges	Within 20 days after Council's decision in terms of Section 16(b) of the Medical Schemes Act	Completed within prescribed timeframes	No deviation
Participate in administrator accreditation review processes, including evaluation of reports	Attend all Accreditation Sub-committee meetings as and when convened by Accreditation Unit	Performed within timeframes prescribed by Accreditation Unit	No deviation
Advise Legal Services of persistent non-adherence to Office directives for possible court action	Provide memo to Legal Services within 7 days of investigation to institute legal proceedings	Completed within prescribed timeframes	No deviation
Implement enforcement processes to ensure compliance with directives/rulings	Within 1 week of notification of non-compliance with directive/ruling	Completed within prescribed timeframes	No deviation
Prepare exemption applications with recommendations for consideration by Registrar	7 days before RDC meeting; 7 days before Council meeting	Completed within prescribed timeframes	No deviation
Group contraventions of Medical Schemes Act into categories according to similarity of enforcement approaches	Prepare documents categorising contraventions by end of June 2010	Completed within prescribed timeframes	No deviation
For each category, develop procedure detailing processes for investigation with regard to: • Determining whether an infraction has occurred • Enforcement measures to remedy infraction	Table enforcement manual at Council by August 2010 Publish relevant parts of manual on website by end of October 2010	Completed within prescribed timeframes Target not achieved	No deviation Discussed and agreed to by Registrar that manual be further refined before publishing on website

Key performance indicator	Target	Actual performance	Reason for deviation
Implement applicable programmes and decisions of Regulatory Decisions Committee (RDC) on demarcation and other priorities of the Council for Medical Schemes	Within 7 days of the resolution of RDC	Completed within prescribed timeframes	No deviation
Support RDC	Within 7 days of decisions (or sooner, depending on urgency)	Completed within prescribed timeframes	No deviation
Ensure compliance with financial aspects of the Medical Schemes Act			
Analyse auditor approval applications	End of September 2010	Target achieved	No deviation
Analyse reinsurance contracts	Reply to schemes within 30 days of receiving application; report within 4 weeks of receiving all information	Target achieved	No deviation
Analyse exemptions	Report within 4 weeks of receiving all information	Target achieved	No deviation
Analyse new schemes	Report within 4 weeks of receiving all information	Target achieved	No deviation
Analyse amalgamations	Report within 4 weeks of receiving all information	Target achieved	No deviation
Identify schemes who do not comply on investments, i.e. Annexure B read in conjunction with Regulation 30	End of July 2010	Target achieved	No deviation
Update internal investments manual as new products and data become available	March 2011	Target achieved	No deviation
Accreditation of administrators			
Manage accreditation of new administrators and prepare findings reports	Applications assessed within 2 months of receiving all information; evaluation reports prepared, considered by Steering Committee and finalised for submission to EXCO within 3 months after evaluation	Getmed Fund Administrators application form was received but administrator failed to pay the applicable application fees and did not submit all the required documentation; no evaluation report was prepared	No deviation
Manage renewals of administrator accreditation, taking into account contract reviews, assessment of financial soundness and on-site evaluations (where appropriate)	Reports prepared within 3 months of receiving all information or on conclusion of further analysis in the event of an on-site evaluation, as may be required	Target achieved	No deviation
	5 renewal evaluations completed and findings reports prepared by May 2010, 6 by September 2010, 9 by January 2011, 10 by March 2011	11 completed	No deviation
Evaluation of compliance by self-administered medical schemes with administration standards			
Conduct on-site evaluations of self-administered medical schemes to evaluate compliance of their resources, systems, skills and capacity with relevant administration standards	1 evaluation completed and findings report prepared by June 2010, 2 by September 2010, 3 by December 2010, 4 by March 2011	5 completed; 4 submitted at EXCO meeting for approval; 1 submitted at Steering Committee meeting and not submitted at EXCO meeting	No deviation
	Evaluation reports prepared, considered by Steering Committee and finalised for submission to Council within 3 months after evaluation	Target achieved	No deviation
Participate in meetings of EXCO to consider evaluations	Reports for meetings 2 weeks in advance	Target achieved	No deviation
Accreditation of managed care organisations			
Perform accreditation evaluations of new managed care organisations and prepare findings reports	Reports prepared within 2 months of receiving all information	Getmed Managed Care Solutions (Pty) Ltd, Dentpro (Pty) Ltd	No deviation
Manage accreditation renewal of previously accredited managed care organisations by means of desk-based analysis, contract reviews and assessment of financial soundness	7 evaluations completed and findings reports prepared by August 2010, 19 by November 2010, 30 by March 2011	30 renewal evaluations were completed	No deviation
Participate in meetings of EXCO to consider applications	Reports for meetings 2 weeks in advance	Target achieved	No deviation
Monitor compliance with imposed conditions; make recommendations on continued accreditation status	Report to Registrar within 1 month of receiving all information or on conclusion of further analysis in the event of a follow-up on-site evaluation, as may be required	Status reports submitted to monthly Strategic Management Meetings (SMMs)	No deviation
Accreditation of brokers			
Review and process applications for accreditation of brokers and broker organisations	80% of new applicants accredited and accreditation renewed within 14 days of receiving all information; 100% accredited within 30 days of receiving all information	Processed: 681 new applications accredited; 3 635 renewal applications accredited	No deviation
Verify licence status of applicants in terms of FAIS with Financial Services Board (FSB)	Ongoing	Target achieved	No deviation
Maintain database for broker accreditation	Complete records are maintained	Ongoing; target achieved	No deviation
Send renewal notifications to brokers before expiry of accreditation	Notification sent at least 120 days before expiry of accreditation	1 091 individual renewal notifications were sent by SMS; 164 broker organisation renewal notifications were sent by post	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Provide legal advice and support to operational Units in Office of the Registrar and Council			
Review contracts, policies and procedures of Units	Within 7 days of request (or sooner, depending on urgency)	Completed within prescribed timeframes	No deviation
Render support to Accreditation Unit in implementing the guideline document on the process required for suspension/ withdrawal of accredited entities/persons	By March 2010	Completed within prescribed timeframes	No deviation
Provide legal advice to Registrar and Council			
Render prompt, reliable internal legal opinions	Within 30 days of request (or sooner, depending on urgency)	Completed within prescribed timeframes	No deviation
Take responsibility for litigation against Registrar and Council; brief Council and drive legal processes	As and when required	Completed within prescribed timeframes	No deviation
Render support to Council and EXCO			
Provide secretarial and corporate governance support to Council and EXCO	Within 14 days of meeting	Secretarial support rendered on all 4 Council meetings and 6 EXCO meetings held during the period under review	No deviation
Promote understanding of the legal framework in which we operate			
Track changes to complementary laws and case law	Three presentations: June 2010, September 2010, March 2011	Completed within prescribed timeframes	No deviation
Support passage of the Medical Schemes Amendment Bill			
Liaise with stakeholders in support of the promulgation of the Medical Schemes Amendment Bill	As and when required	The process of amending the Medical Schemes Act and Regulations is still ongoing and is expected to be finalised by the end of the next financial year	No deviation

Strategic objective 5

We investigate and resolve complaints raised by beneficiaries and the public.

Key performance indicator	Target	Actual performance	Reason for deviation
Investigate complaints raised by beneficiaries			
Analyse complaints raised by beneficiaries as required by Section 47 of the Medical Schemes Act	Analysis done within 4 days of receiving complaint from administrator	Analysis of complaints not always done within 4 days, as targeted	Capacity in Unit not adequate to deal with increased volume of complaints
Send correspondence to schemes for comments, as prescribed	Send correspondence on day of analysis	Correspondence sent on day of analysis	No deviation
Send correspondence to complainant advising of status of complaint	Send correspondence on day of analysis	Correspondence acknowledging complaint sent on day of analysis	No deviation
Resolving complaints: analyse responses from schemes to make a decision/ruling; apply relevant legal principles to complaints	Rulings to be made within 120 days of the date on which a complaint was referred to a medical scheme	5 617 complaints received; 5 351 complaints resolved – 3 480 (65%) were resolved within 120 days of the date on which they were referred to relevant medical schemes; 35% took longer than 120 days to resolve	Capacity in Unit not adequate to deal with increased volume of complaints; backlog was further compounded by non-performance of a staff member; there was a delay in filing of responses by some medical schemes
Adjudicating on complaints: investigate and resolve complaints raised by beneficiaries and the public	Written clinical input provided within 7 days	7-day turn-around time was not always maintained	A backlog accumulated during the financial year due to a combination of factors, including an increase in number of complaints and inadequate capacity
Render support to Complaints Adjudication Unit to ensure legally sound and enforceable rulings			
Render advice on complaints of a complex legal nature	As and when required	Advice was rendered as required	No deviation
Develop a decisions register; publish rulings as per complaints classification	By September 2010	Decisions were published on website; decisions register is an ongoing process to be completed by September 2011	System still being developed by IT Unit
Work with Council's Appeals Committee and the Appeal Board to set down appeals	Within 60 days of receipt	11 sittings of Appeals Committee and 5 sittings of Appeal Board were scheduled	No deviation
Render secretarial support to Appeals Committee and the Appeal Board	As per meetings scheduled by Appeals Committee and the Appeal Board	Support was rendered for all 16 meetings, as scheduled	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Handle appeals in terms of Section 49 of the Medical Schemes Act			
Refer notices of appeals to secretariat of Appeals Committee; appear before Appeals Committee; provide information when an obligation to provide information arises	Within 1 week of receiving notice of an appeal from the appellant	Target achieved; papers of appeals were submitted to secretariat within 1 week of receipt; 51 appeals were held: 30 April 2010: Venter v Bankmed, Fedhealth v De Vries, Sussman v DHMS, Bower v DHMS, Muller v DHMS 29 June 2010: Van Deventer v Spectramed, Fedhealth v Swanepoel, Pienaar v POLMED, Merrifield v DHMS, Genesis v Du Toit, Oxygen v Staessen, Genesis v Joubert 29 July 2010: Resolution Health v Nelson, Smith v Medshield, Jacobs v Keyhealth, Essa v Medshield 30 August 2010: Medshield v Mogale, Armbuster v Bestmed, Cronje v Bestmed, Van Zyl v Profmed, Van Dijk v Profmed, SAMWUMed v Puterman, Puterman v Cape Medical Plan, Spectramed v Hedington, Cape Medical Plan v Niewoudt 30 September 2010: Omphemetse v GEMS, Hunter v GEMS, Pro Sano v Moopanar, Pro Sano v Hassan, Nefdt v Fedhealth, Van der Merwe v Fedhealth 2 November 2010: Joubert v DHMS, Verwey v DHMS, Van der Walt v DHMS, Fedhealth v Van Goeverden, Calvete v Oxygen, Spectramed v Hughes, Botha v DHMS 10 February 2011: DHMS v Osborn, Leendertz v Golden Arrow, DHMS v Von Rudiger, Cook v Resolution Health, Buttress v Selfmed, Allie v DHMS, Treast v DHMS, Mileti v DHMS, Medshield v Terblanche, Oxygen v Westwood & Van Eyk, Medshield v Frankental, Sizwe v Pooe, Meyer v Naspers	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Participate on envisaged amendments to appeals processes currently in place			
Identify practical problems with current appeals process; provide recommendations for amendments	Upon establishment of Committee	Comments provided on impediments regarding current appeals process	No deviation
Participate in the improvement of complaints database			
Key complaints areas for compliance action: a detailed analysis of key problem areas identified through the complaints database	Comprehensive report by 30 September 2010	Report giving comprehensive analysis of key problem areas in terms of complaints received was completed on schedule	No deviation
Provide data and regular assistance to Research & Monitoring Unit to improve quality of reports produced by complaints database (coding of complaints)	Provide input before and during development of new database, as and when required	Unit participated and provided input to Committee comprised of Research & Monitoring and IT Unit on data specifications for new complaints database	No deviation
Develop an integrated complaints system to categorise coding standards	Complaints system by end of May 2010	New complaints system was developed and implemented in November 2011	System was delivered 5 months later than originally anticipated because the changes required were far more complex than had originally been communicated; these included PDF editing, integrating with SharePoint and complete workflow rebuilds

Strategic objective 6

We foster the continued development of the Council for Medical Schemes as an employer of choice.

Key performance indicator	Target	Actual performance	Reason for deviation
Human Resources			
Talent management: produce and manage an established talent management strategy to assure that the CMS has an available supply of talent that can be aligned with the right jobs at the right time based on the CMS's strategic objectives through the strategic management of talent flow through the organisation	Define core competencies/talent domains of individuals; align talent strategy with recruitment and selection strategies to clearly identify talent and high potential; conduct talent assessment programmes so that employees understand their talent zones; link talent process to succession and career strategies; enhance employee engagement and retain high-potential individuals; link personal developmental objectives to training programmes	Employees (people and positions) critical to this organisation were identified; employees were placed on a leadership and "high-potential employee" development assessment programme; talent management strategy aligned with: • Recruitment processes: through well-structured recruitment processes and practices, people with right talent, skills and competencies were appointed • Retention strategies: employees were rewarded for high performance and enjoyed benefits such as flexi-time and funding for professional development, including attendance of local and international seminars and conferences • Employee development: opportunities were provided to staff for continuous informal and formal learning and development managed by HR through a training plan • Performance management: ongoing support was provided to Units aimed at improving performance, including feedback/measurement • Workforce planning: HR conducted a work study to assess current/future skills shortages, the results of which were Council approving 8 new positions to be filled in 2011-2012 • Culture: development of a positive, progressive and high-performance "way of operating" continued to be inculcated at every level; this was brought into the interview and selection process	No deviation
Recruitment: hire and retain high-quality talent	Turn-around time of 2 months to fill vacancies from date of advertisement to appointment	Current and new resource requests were successfully filled by sourcing the best talent after carefully assessing which skills, knowledge, predisposition and ability were required for the CMS to accomplish its strategic goals	No deviation
Employee wellness: enhance life quality of employees; alleviate impact of personal and family problems on their work	Promote fitness and healthy habits; provide on-site health education on HIV/AIDS and TB; free counselling services: provide confidential assistance and/or short-term counselling to those experiencing personal or work-related problems	Subsidised health club membership provided to staff; free health screenings for high blood pressure, elevated cholesterol and other ailments; presentations to raise awareness on issues relating to HIV/AIDS and TB; free counselling service to assist staff to cope with matters related to stress, family, psychological and financial issues and any matter that has or may have an impact on their productivity	No deviation
Implement Affirmative Action and Employment Equity in line with national policy			
Implement Employment Equity Plan for 2010-2011	Set equity goals and targets to inform recruitment targets	• Registrar approved Employment Equity Report (form EEA2) and income differential statements (form EEA4) for 1 April 2010-31 March 2011 • Progress report submitted to Department of Labour by October 2010 • Quarterly reports on EE data submitted to SMM	No deviation
Manage performance			
Successfully manage performance in 2010-2011	Manage performance by: • ensuring all employees conclude performance contracts • providing performance documentation • providing support to employees and managers • implementing interventions to deal with poor performance • collating and tabling results to Moderating Committee	• Facilitated drafting and conclusion of performance agreements for employees, ensuring that requirements and accomplishment-based performance standards, outcomes and measures were correctly reflected in performance agreements, and ensuring that each job has a clear job description • First performance review process extended to November 2010 • Second performance review process conducted in March 2011 • Finalised performance appraisals returned to HR at end of March 2011 • Scores were collated and submitted to Moderating Committee • Moderating Committee moderated scores and those who qualified received bonuses	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Organisational training and development			
Provide opportunities to staff for continuous informal and formal learning and development managed by HR through a training plan	• Review training and development plan for 2009-2010 • Assess effectiveness of training plan; table report to SMM • Identify training priorities highlighted in career and succession strategy • Implement new training plan for 2010-2011 • Prepare report on training interventions for submission to HWSETA	• Report on effectiveness of training tabled to SMM; concerns raised at SMM addressed • Facilitated implementation of appropriate learning interventions in line with training policy; completed Workplace Skills Plan (WSP) and Annual Training Report for 2010-2011 and submitted them to HWSETA by 30 June 2010 • Facilitated staff registration at various institutions for professional development courses, workshops, conferences and seminars; total cost of training amounted to R1 328 337	No deviation
Internal Finance			
Ensure financial management in a manner that is consistent with the Public Finance Management Act and other applicable legislation			
Financial records: keep full and proper records of the financial affairs of the CMS as required by PFMA Section 55(1)(a)	Transactions are processed daily in various books of first entry within the accounting system	Target achieved; internal control processes developed to ensure all transactions are processed on a daily basis within the accounting system	No deviation
	Presentation of monthly management accounts to various structures within CMS (SMM, Council and Audit & Risk Committee)	Target achieved; monthly management accounts presented to SMM and other structures, as required	No deviation
Prepare Annual Financial Statements in accordance with Generally Accepted Accounting Principles (GAAP) and applicable Generally Recognised Accounting Practices (GRAP); submit to relevant stakeholders, as prescribed by PFMA	Draft Annual Financial Statements by 30 April 2010	Target achieved; final and approved Annual Financial Statements were submitted on 31 May 2010 to all relevant institutions and on the prescribed basis/templates; we are pleased to report that we have received an unqualified audit opinion for the 2009-2010 financial year	No deviation
	Management comments on Auditor-General's management letter within 7 working days		
	Draft Annual Financial Statements to various structures for approval		
	Final financial statements to Auditor-General by 31 May 2010		
Maintain and communicate effective and efficient internal controls within organisation	Review finance policy and procedure manual in October each year	Finance policies and procedures manual was reviewed in November 2010	No deviation
	Present to full staff in Aprileach year	Internal office memo on control weaknesses was communicated to all staff on 8 April 2010; weaknesses were also presented to staff on 3 May 2010	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Constitute and ensure functioning of Audit & Risk Committee as prescribed by PFMA and in terms of their approved audit charter	Audit & Risk Committee meetings are held quarterly	Target achieved; quarterly meetings were held	No deviation
	Communicate Audit & Risk Committee recommendations to relevant structures within CMS	Target achieved	No deviation
	Audit & Risk Committee to review audit charter annually	Target achieved	No deviation
Budget management: allocate budgeted resources to attain strategic objectives of CMS	A consolidated budget of estimated revenue and expenditure is submitted to Executive Authority 6 months before financial year or another period agreed to	Target achieved; consolidated budget in respect of the 2010-2011 financial year was submitted to Executive Authority on 12 March 2010	No deviation
	Budget variances are discussed with Heads of Units prior to discussion at SMM	Target achieved; monthly budget discussion meetings held with SMM members	No deviation
	Mid-year review of budget to ensure consistency with approved operational plans and projected cash flow	Target achieved	No deviation
Revenue management: schemes are levied to fund operations of CMS	Imposition notice is published in *Government Gazette* for 30 days after receiving approval from Executive Authority	Target achieved; proposed notice was published in *Government Gazette* on 15 March 2010; imposition notice received on 9 June 2010 – started to invoice medical schemes on 10 June 2010	No deviation
	Ensure improved debtors collection system is maintained	Target achieved; 100% of levies were collected by end of September 2010	No deviation
Performance management: monitor effectiveness and efficiency of CMS	Preparation of quarterly reports on performance of Unit; facilitation and consolidation of performance information report	Target achieved; quarterly submissions to Department of Health and annual submission of performance information report submitted to Auditor-General on 31 May 2010, as prescribed	No deviation
Procurement: tenders are issued in line with Supply Chain Management (SCM) guidelines	Review Tender Committee guidelines annually; issue a standard request for proposal with each tender	In July 2010 we renewed our lease agreement with our current landlord for another 3 years; in the year under review we advertised for a tender of travel management services; the tender was adjudicated and awarded to XL Nexus Travel, a BEE-compliant entity	No deviation
Cash management: ensure compliance with Treasury Regulations and implement proper cash management controls	Cash flow reports are prepared monthly	Target achieved	No deviation
	Invest surplus funds in high-interest earning accounts	Target achieved	No deviation
	Maintain EFT system to ensure payments are made to approved service providers	Target achieved	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Risk management: maintain an effective, efficient and transparent system of risk management	Consolidated risk register discussed and updated with SMM on a monthly basis; risk register updated with internal audit reports	Target partly achieved; risk register was maintained for the first three quarters of the financial year and discussed with SMM during this period	Discussions with Unit Heads did not take place as planned
Information Systems & Knowledge Management			
Render an effective and efficient IT Helpdesk support service			
Log all calls on Helpdesk support system	Conduct IT survey every quarter	Most calls logged have been attended to successfully; 2 surveys were conducted in 2010-2011	No deviation
	Establish SLAs with each Unit for each category	SLAs not signed	No need for SLAs; standards are monitored with AdventNet Helpdesk System
	Replace/upgrade policy	Not revised; PCs replaced in line with SMM directive to replace all machines older than 4 years	Current 3-year replacement policy to be reviewed as part of the overall adoption of new IT policies and procedures in the new financial year
Respond to all logged calls within 30 minutes	All calls were responded to within 30 minutes	Average response time of 23 minutes 57 seconds; received 1 018 calls; 1 016 were successfully closed; 2 calls remain open	No deviation
Ensure all printers and photocopy machines function optimally	Reduce downtime on printers and photocopy machines	We started a process of preventative maintenance on our photocopiers; this reduced downtime substantially; we replaced old and redundant printers with new units	No deviation
Ensure end-user desktop PCs function optimally	Minor issues = 30 minutes; major issues = 4 hours; vendor intervention = 48 hours	We have not been able to accurately measure the stated response times per urgency of issue (i.e. minor, major or vendor intervention) but we have achieved an average response time of 23 minutes 57 seconds; we conducted IT customer satisfaction surveys to gauge satisfaction levels; responses were positive	AdventNet Helpdesk System was not configured properly; it will be reconfigured to provide accurate statistics
Conduct regular "Chalk and Talk" sessions with staff	Monthly	We were able to conduct "Chalk and Talk" sessions every 2 months	Due to busy schedules it remains a challenge to attract the required numbers to monthly "Chalk and Talk" sessions
Helpdesk survey	Quarterly	We conducted 2 surveys for Helpdesk and a general survey for IS & KM; we received an overall rating of 75%	Surveys were synchronised with the bi-annual performance management system

Key performance indicator	Target	Actual performance	Reason for deviation
Regularly test and maintain LAN infrastructure and related components (telephony and "server farm")			
Test and maintain LAN infrastructure and related components such as switches and firewalls	LAN infrastructure updated when necessary with latest firmware, as and when released	No firmware was released for our Nortell switches; the switches are fully updated with latest available firmware; stable uptime of LAN was assured	No deviation
Ensure disaster recovery and data backup procedures are in place			
Perform daily, weekly and monthly differential and full backups; ensure emergency electrical supply is maintained; ensure environmental monitoring systems in server rooms function optimally	Data restored on a monthly basis to test success of backups; UPS, GENSET and EMS systems maintained and serviced as per SLA schedules	UPS and GENSET services provided on 24/7 basis; several successful failovers achieved during power outages; all UPS, EMS and GENSET services maintained through established SLAs and regularly tested; weekly and monthly backups of data performed; weekly and monthly backup tapes taken offsite for storage	No deviation
Ensure Internet connectivity is monitored and optimally running at 100%			
Install and monitor backup line with a different network	Backup line on a different network installed by end of June 2010	We changed our Internet service provider from IS to Vox in August 2010; this resulted in an increased uncontested bandwidth of 4MB	It took time to cancel our contract with IS on the ADSL backup line solution; we could terminate the contract in March 2011
Ensure adequate domain security measures are in place			
Test and regularly check security infrastructure for vulnerabilities; fine-tune Group Policy; deploy anti-virus (AV) measures	Logs are monitored every week for possible intrusion attempts, virus outbreak and data security, and to perform a controlled penetration	We performed an external security assessment with SensePost; they identified loopholes and guidelines on how to solve them; we corrected the shortcomings found and a follow-up audit was performed; Group Policy and AV logs are checked every week	No deviation
	Account management self-service by end of June 2010	A new self-service utility was installed; users were trained; this was achieved by end of March 2011; this resulted in overall logon experience improving	Project was completed but not on time because most of our budget-dependent projects were delayed due to the late approval of our budget and delayed levy income during 2010; it also took a considerable time to obtain the necessary licenses from the provider
	Ancillary systems logon experience improved by August 2010	Ancillary systems, such as the new complaints system, were integrated with AD to improve user logon experience	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Redefine the three-year IT hardware replacement policy			
Rework replacement policy	Policy document by June 2010; approval from Council by August 2010	New replacement policy was drafted but still needs to be discussed by the IT Steering Committee; as the IT Steering Committee could not approve the policy, it did not serve before Council	There were delays in setting up and properly constituting the IT Steering Committee
Upgrade the "server farm" from Windows 2003 to 2008			
Upgrade servers to 2008	June 2010	We upgraded our domain controllers to 2008 by June 2010; project completed	No deviation
Introduce a Storage Area Network (SAN) and a remotely-hosted disaster recovery site			
Implement a SAN solution	May 2010	New SAN solution and clustered SQL solution was installed in January 2011 and commissioned in March 2011	SAN project was completed but delayed due to late approval of CMS budget; it also took considerable time to agree on configuration of SAN
Investigate remotely-hosted site	August 2010	We were not able to commission a remotely-hosted disaster recovery site	This project needed to be shifted to the new financial year (2011-2012) due to budget constraints
Introduce unified communications			
Install a network card to the PABX and reconfigure exchange for unified communications	September 2010	Target not achieved	Project suspended; value-add to CMS was minimal given our size and we already have Live Communications Server 2005; LCS 2005 will be revived in 2011-2012
Improve server facilities			
Upgrade server rooms	December 2010	Target not achieved	Quotations obtained for the revamping of our old server facilities were substantially higher than what we had budgeted; we had to move this project to the new financial year 2011-2012
Improve line access speed			
Upgrade network lines	May 2010	A new, faster Internet link was established in August 2010 using microwave technology (4Mbps)	Project was completed but not by target date because CMS budget was approved late

Key performance indicator	Target	Actual performance	Reason for deviation
Assist Financial Supervision in monitoring the financial performance and soundness of medical schemes			
Assist with maintenance and query handling for online return systems			
Render telephonic and written assistance to internal and external stakeholders on queries related to submission of online returns; maintain current systems to function optimally	Quarter 1 by May 2010; Quarter 2 by August 2010; Quarter 3 by October 2010; Quarter 4 by January 2011; annual by February 2011	Implemented on time; continuous support rendered	No deviation
Maintain the online auditor approval questionnaire for 2010			
Amend online auditor approval questionnaire; improve associated reports; render telephonic and written assistance to internal and external stakeholders on queries related to submission of online auditor approval questionnaire	Deliver online auditor approval questionnaire by June 2010	Implemented on time; continuous support rendered	No deviation
Assist the Council for Medical Schemes in exposing information to stakeholders			
Develop new website			
Assist with development testing and deployment of all components of new website	Functional website by May 2010	New website developed and deployed in September 2010; completed all bug fixes by March 2011; website workflow developed and is under testing by service provider	Project completed but 3 months late; this was mainly due to late approval of CMS budget and the fact that time schedule for development of CI Manual took longer than expected; another factor that delayed the project was its prioritisation by service provider
Develop and maintain self-service portals			
Develop and test all new and existing components for new website	Broker portal – August 2010; brokerage portal – September 2010; statutory returns – October 2010; managed care portal – November 2010; administrator portal – December 2010; medical schemes portal – January 2011; access to information portal – February 2011; conference portal – March 2011	Conference portal not done	Reassessment of conference portal determined that the value-add would not outweigh the support which CMS currently renders to Department of Health on mini-SEP system
Publish and maintain content on website and related portals			
Publish and maintain content on website as requested by Units; administrate current and new website	Content published within 24 hours of receiving a finalised publication request	All requests to publish material to website were processed within 24 hours	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Establish online payment facility on website			
Develop and implement payment facility and interface on website	Functional online payment system	Pay facility service provider selected; project not implemented due to unavailability of funds for bank administration charges; project discontinued until funds are made available	Internal Finance did not provide budget for bank administration charges which will be incurred should an online payment facility be implemented
Assist the Council for Medical Schemes in effective control of tangible and intangible assets			
Link new asset managing system to AdventNet System			
Assets to appear in new asset managing system	Systems linked by June 2010	We were able to successfully import all assets into the AdventNet Asset System but could not link Pastel's Asset Management System to Helpdesk as planned	Software provider of Asset Management System (Pastel) uses a proprietary database and is unwilling to share connection and database structures with CMS; licensing and budgetary constraints prevent us from linking all assets in this system
Gather requirements and develop a self-service budget control system			
Liaise with relevant parties to maintain requirements and develop the self-service budget control system	Effective budget control system by January 2011	Target not achieved	As with the Asset Management System, CMS uses a proprietary financial management system (Account-mate); the database structure of this software has been encoded and is not accessible; this makes it impossible to develop an interface that provides the necessary reporting capabilities
Assist the Council for Medical Schemes in implementing enterprise solutions			
Investigate and advise on installation and configuration of SQL server in a clustered environment	Database running on SAN solution by July 2010	We successfully configured a clustered SQL solution linked to our new SAN by March 2011; all SQL databases were successfully ported to the new environment	Budget constraints mid-2010 delayed hardware implementation; hardware and software technology was more thoroughly investigated and revised which further delayed our project but resulted in a better solution at the end
Investigate and procure BI solution according to needs of CMS	BI solution by July 2010	Back-end tool (SQL server 2008 enterprise R2) procured and implemented	No deviation
Investigate, procure and customise an issue tracking system	Deploy system by September 2010	Interim issue tracking system developed in September 2010 and deployed in March 2011; Customer Care Centre is currently issuing tickets to employees; management reports have been created	Considerable time was taken to consult with Unit Heads on time frames to which they would be bound by the new issue tracking system
Design and develop partial API into a Proof of Concept	Proof of Concept by March 2011	We procured Microsoft CRM 2011; this system is undergoing testing on our development servers; Microsoft CRM 2011 will be integrated with all our systems as the new API	No deviation
Liaise with relevant parties to gather and develop a functional and usable MIS system; deploy on a Unit-by-Unit basis	7 Units by March 2011	Implemented and training provided to members of SMM	No deviation
Integrate and automate feedback to various stakeholders	Automated feedback in systems by May 2010	Automated feedback implemented on all systems by May 2010	No deviation
Train end users on new systems	As and when necessary	Ad hoc training was performed as necessitated by the release of new systems	No deviation
Develop new mini-SEP system and deploy to Department of Health	June 2010	Completed by end of July 2010; delivered for final sign-off to Department of Health in mid-August 2010	Department of Health's internal approval and consulting process took longer than expected; this contributed to the project being delayed by a month
Develop new SEP system and deploy to Department of Health	March 2011	Fully functional SEP system developed using old system and reverse-engineering it; this system is currently with Department of Health for testing and bug-fixing	Factors which contributed to delay of mini-SEP system had a minor contribution to delay of final SEP system; other factors included time taken to acquire hardware needed to run SEP, internal approval process and staff consultation at Department of Health, and investigation of the already developed SEP system before restoration
Develop Proof of Concept for quarterly return system GRP and deploy for UAT	November 2010	Project replaced by development of Schemes Registry on CRM; quarterly return system was further refined and bugs have been reduced to a minimum	Microsoft CRM and development of Registries need to take place first before GRP can be built on the same platform
Develop and deploy new quarterly and annual return system GRP module	May 2011	Project depends on previous project that was moved out	See above
Investigate REF registry and plan implementation	March 2011	Target achieved	No deviation
Act as intermediary between the Council for Medical Schemes and our stakeholders by providing relevant guidance and advice, thus rendering excellent customer service			
Ensure call waiting time is reduced in Inter-reactive Voice Recording (IVR)	Ongoing	02:21 seconds	No deviation
Ensure call abandon rate is reduced	Below 10%	6.43%	No deviation
Ensure all calls are wrapped up on time	Should not exceed an average of 10 seconds	10 seconds	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Conduct review study on benchmarking criteria for handling calls in regulatory industry by looking at call waiting times, call handling and call wrapping	Project scope by end of July 2010; research and consulting by end of September 2010; draft report by end of December 2010; final report by end of March 2011	Project is at fact-finding phase with other stakeholders	Delays in establishing exact scope for this project caused it to run over to new financial year
Educate staff on importance of Customer Care Centre by conducting presentations and writing feature articles	Once per quarter	Presentation at full staff meeting; article in *Masihambisane*	No deviation; target achieved but not on quarterly basis
Respond to all queries received by phone and via support and information e-mail platforms as they come; where information is needed from other Units, escalate or channel such enquiries using call ticketing system	Ongoing	Attended to approximately 2 000 e-mail queries	No deviation
Negotiate, agree and enter into SLAs with all operating Units	Negotiations by end of June 2010; agreements disseminated to Units by end of July 2010; agreements signed by end of August 2010; implementation to coincide with call ticketing system in September 2010	Only one Unit signed SLA; call ticketing system implemented; it enforces set time frames for responding to customer enquiries	No deviation; target partly achieved
Develop and arrange annual training programme for Customer Care Centre consultants with relevant Units	Training programme by end of April 2010; training once a month	Training in the form of brainstorming sessions was held twice a month	No deviation; target achieved
Knowledge management			
Internet and online database searching, proactively providing Current Awareness Services (CAS)	Ongoing, as and when information is required; provide CAS in terms of information updates	Online information searches for the following projects were completed: • Universal mandatory health insurance in the Netherlands • Information on health insurance regulators in the Netherlands, Germany, Ghana, Brazil, Peru • Utilisation of health services • Healthcare cost drivers • Income insurance and technology • Benefit design in healthcare reforms • Dealing with missing data • Mortality on hospital profiles • Measurement of general wards, ICU and high care • Trends in hospital services provision • Community-based health insurance for rural and informal settlements • Body Mass Index (BMI) as predictor of outcome in total knee replacement	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
		• Developmental psychology and child neurology • Effect of obesity on mid-term survival and clinical outcome of cementless total hip replacement • Remuneration of trustees • Trusts and trustees • Utilisation of critical care units	
Contribute article about daily operations of Resource Centre in *Masihambisane*	Give detail once a month on our online subscription databases, inter-library loans, SABINET and how Resource Centre can contribute to the overall organisational information needs	Resource Centre contributed the following information in *Masihambisane*: 1. King III report 2. Companies Act 3. Book *Redefining Healthcare: Creating Value-based Competition* 4. Article *The ABC of the Knowledge Management Centre* The following publications were reviewed as part of informing staff members of latest publications in Resource Centre during October – December 2010: 1. *Redefining health policy* 2. *Health policy in global world* A guide to the Consumer Protection Act was published	No deviation
Receive and respond to queries; prepare statistical information; PAIA Manual in terms of legislation	Respond to request within 30 days Statistics (Section 15 & 32) prepared by 15 April 2010 and submitted to Department of Justice and Constitutional Affairs by 30 April 2010 Prepare PAIA Manual in 3 languages by 20 August 2010 and submit to South African Human Rights Commission (SAHRC) by 31 August 2010	Section 15 & 32 reports were prepared and submitted to SAHRC and Department of Justice and Constitutional Affairs; *Government Gazette* was published to that effect CMS manual was forwarded to SAHRC, as per legislation requirement Ongoing: responding to PAIA requests as and when received	No deviation
Develop a file plan	Submit draft document file plan to National Archives by 31 March 2010; get it approved by National Archivist by 30 April 2010	CMS file plan was approved by National Archives; a certificate was issued	No deviation
Develop a retention and disposal policy	Prepare draft document by 21 May 2010 and submit for approval by SMM by 31 May 2010	Policy was approved by EXCO	No deviation
Link document content types defined in document centre with the approved file plan structure	Ongoing: as and when a document becomes passive and out of use, it is classified as a record and is filed accordingly	Target not achieved	Delays in approving CMS file plan by National Archives pushed this project into late in the financial year; uncertainty with MOSS as a platform casted doubt on whether this work should proceed; this project will have to be attended to in the 2011-2012 financial year

Key performance indicator	Target	Actual performance	Reason for deviation
Bar-code all physical files (records)	By 4 June 2010: installation of software for bar-coding; training of records officer on how to utilise the software By 22 June 2010: records officer begins to place barcodes on files in preparation for scanning	Target not achieved	Scanning of physical files to records centre took more effort and time than had been anticipated; it currently takes up most of the time of records officer; a motivation was made to appoint an additional resource but due to budget constraints this was deferred to 2011-2012; this project will have to stand over till then or all files in filing room need to be bureau-scanned
Scan physical files to records centre	By 1 May 2010: investigate different scanners available in market with assistance from IT Helpdesk officer By 21 May 2010: decide which scanner to purchase and use By 1 July 2010: start scanning paper files into system; continue as and when files become available for scanning purposes	Scanner acquired and installed, and records officer trained in its use by end of June 2010 Scanning of all incoming files commenced on 1 July 2010 The following physical files were scanned to MOSS: 1. Accreditation: 832 physical files (applications) were scanned into the accreditation database for record purposes 2. Postal/registered mail: 651 registered and normal letters were scanned and routed into different Units' in-trays	No deviation
Perform unplanned activities as may be required from time to time			
Offsite files storage (registry)	Ongoing: send file boxes to Metrofile as and when required	57 new boxes were sent to Metrofile: BMU – 12 boxes; Registrar – 10 boxes; Legal Services – 3 boxes; Accreditation – 32 boxes; FSU – 2 boxes	No deviation
Re-index all CMS files kept at Metrofile	26 August 2010 to 30 September 2010	Target achieved	No deviation
Financial Services Board (FSB) web service	August 2010	Web service developed and implemented timeously	No deviation
Real-time monitoring (RTM) web service	February 2011	Web service, RTM Manual and specifications developed by February 2011; key indicator definitions being determined before pilot testing will commence	No deviation

Risk Equalisation Fund (REF)

Key performance indicator	Target	Actual performance	Reason for deviation
Risk Equalisation Fund (REF) project: maintain capacity to evaluate risk profiles of medical schemes for the purpose of risk adjustment			
Establish techniques to evaluate REF submissions through more research on scheme-specific expected values			
Calculate scheme-specific expected values for 2009 and 2010 submissions	Complete scheme-specific expected rates for all schemes for analysis April and August 2010	Expected values for 2009 established	No deviation
Prepare revised REF weighting tables and Entry & Verification (E&V) criteria guidelines			
Review E&V criteria guidelines for 2011	Publish E&V criteria guidelines by August 2010	No comments on E&V criteria received	15 March 2011: E&V will not be updated because no concerns were raised with existing version
Review REF weighting tables and expected count table for 2011	Publish REF weighting tables and count table for 2011 by September 2010	Awaiting response from industry actuaries; 15 March 2011: this was not followed up; will receive attention now	8 April 2011: this work was delayed due to work on Strategic Plan, price determination project and NHI purchasing work; will be completed in May 2011
REF risk factor and pricing analysis based on revised PMBs			
Identify and cost REF risk factors informed by PMB review project	Publish weighting and count tables by March 2011	Permission given by schemes representing almost 6 million lives; confidentiality agreements signed; Metropolitan data tests fine; awaiting only Discovery data; 15 March 2011: all data collected and analysed; for discussion with RETAP on 23 March 2011	Work was delayed due to sheer volume of data that was analysed
Review E&V criteria guidelines on new REF risk factors	Publish E&V criteria guidelines by March 2011	Target not achieved	REF risk factor study must be completed before this work can start
Migrate to new IT systems for collecting, storing and evaluating REF submissions			
Prepare front-end system to evaluate REF submissions	Do preparatory work by March 2011 to ensure a document can be distributed to schemes by April 2011	Will submit only user requirements by April 2011; recommendations received from Ethica; Council has indicated that more work on REF will not continue, instead a beneficiary register will be developed	Mistake in original target; revised strategy by Council will lead to a re-design of system (to commence in 2011-2012)
Prepare systems for schemes to perform bulk uploads of beneficiary data; prepare system to store data submissions	Do preparatory work by March 2011 to ensure a functional REF IT system can be in place by June 2011	Will submit only user requirements by April 2011; 15 March 2011: work not commenced due to other priorities; development of scheme and option registries by IT takes priority	Change in priorities; REF will not be implemented but a beneficiary registry will be developed

Key performance indicator	Target	Actual performance	Reason for deviation
Analyse REF returns			
Q1 to Q4 of 2009: annual report	Publish annual report 2009 by July 2010	Data collected; analysis nearly complete; report published 10 August 2010; Circular sent out on completion of report; RETAP meeting 17 September 2010	No deviation
Q1 and Q2 of 2010: limited feedback	Publish reports to schemes by December 2010	15 March 2011: reports published on website	Delayed due to focus on Strategic Plan, Annual Performance Plan and budget
Q1 to Q4 of 2010: annual report	Do preparatory work by March 2011 to ensure annual report for 2010 is published by July 2011	15 March 2011: data cleansing process underway	No deviation
Communicate to industry on REF process			
Publish report to industry on REF process	Publish by August 2010	22 Feb 2011: article submitted for *CMS News*	Delayed but completed
PMB review project: establish areas that must be reviewed, consult, and recommend changes to Regulations			
Continue with consultative process and make recommendations to Department of Health on changes to PMB Regulations			
Prioritise conditions for review inclusive of consultative process	Conclude retrospective analysis by April 2010	Not started; PMB Code of Conduct completed	Must await publication of draft Regulations submitted to Minister of Health on 5 March 2010 before further work can commence; PMB Code of Conduct makes provision for benefit definitions; project underway Completed: • rFVIIa guidelines Final drafts: • Organ transplants • Liver transplant • Kidney transplant • Breast cancer • Prostate cancer First drafts: • GIT cancer Meeting only: • Cardiovascular DTPs
Establish clinical advisory committees	Establish clinical advisory committees by June 2010	Circulars 45 and 47 of 2010 sent out; consultative process underway	No deviation
Complete costing of current PMB package	Costing report by September 2010		See comments on pricing study
Complete costing of revised benefit structure	Costing report by February 2011		See comments on pricing study
Recommend changes to PMB Regulations	Draft Regulations by February 2011		See comments on pricing study
Participate in legal review of PMB Regulations	As per targets set by PMB review project	Participated in legal reviews, as required	No deviation

Key performance indicator	Target	Actual performance	Reason for deviation
Clinical Review Committee (CRC): consolidate clinical capacity			
Establish collaborative clinical function across Units			
Establish Clinical Review Committee (CRC)	Establish by April 2010	Committee established; ToR agreed; still requires process improvements; assistance from IT requested on database; SOPs finalised, currently being implemented; assistance from analyst in Accreditation Unit	No deviation
Diagnosis-Related Groups (DRGs): consider objectives and system options, and make recommendations			
Institute consultative process and make recommendations to Department of Health on the use of DRGs in South African private and public healthcare sectors			
International review and operational applicability in developing countries; workshop with local experts	Consultation document by June 2010	Project plan agreed to by DoH; first workshop scheduled for 24 May 2010; target date will not be met	DoH had to attend to the World Cup Nerve Centre
Establish DRG Technical Advisory Panel (DRGTAP); define objectives	Establish advisory committee by April 2010	Target not achieved	DoH had to attend to the World Cup Nerve Centre; policy draft in third iteration, for discussion with DoH
Prepare recommendations to DoH	Final recommendations by August 2010	Target not achieved; no further interaction with DoH in this respect	22 February 2011: project will be addressed in 2011-2012 at request of DoH
Health professionals HR capacity: standardise existing databases and develop capacity to report on health professionals in South Africa			
Assess existing HR capacity in South African health system			
Have discussions with BHF and DoH	Discussions by April 2010	Resistance from BHF; legal letter sent; Discovery approached for alternative data source (R&M)	Decision not to pursue legal route to obtain this information from BHF; instead this work will commence after contract with BHF expires
Transform PCNS data to PERSAL	Transform systems by June 2010		Decision not to pursue legal route to obtain this information from BHF; instead this work will commence after contract with BHF expires
Maintenance and updating of database; fully integrated database (incremental)	Ongoing		Decision not to pursue legal route to obtain this information from BHF; instead this work will commence after contract with BHF expires

Key performance indicator	Target	Actual performance	Reason for deviation
National Health Insurance (NHI) support: support Department of Health on costing and development of an NHI package			
Determine comprehensive package of services to be offered in NHI environment			
Initial investigation of possible package and costing	Recommendations to NHI Ministerial Advisory Committee (MAC) in accordance with their requirements	Attended meetings on 10 April 2010, 22 April 2010, 7 & 8 June 2010; meeting on 19 October 2010 in Cape Town; working on second report; 22 February 2011: final report for discussion on 7 & 8 March 2011; 15 March 2011: more work needs to be done on this report	No deviation
Cost the delivery model which will be used to deliver health services in NHI environment			
Cost package informed by REF pricing study	Recommendations to NHI MAC in accordance with their requirements	Information submitted to MAC	No deviation
Legislative agenda: collaborate with Department of Health on legislative reform where required			
Support Department of Health in preparing legislation for healthcare reform initiatives			
Participate in policy development processes	Recommendations to DoH in accordance with their requirements	• Received no response to input on legislative amendments • Poor progress on demarcation with Treasury task team; considering alternate routes with assistance from DoH • Released discussion document on tariff negotiations in healthcare; comments by 15 December 2010 15 March 2011: held 2 meetings with steering group; currently engaging with comments and preparing a response	No deviation (under control of DoH)

Key performance indicator	Target	Actual performance	Reason for deviation
Compliance with prescribed minimum benefits (PMBs) project			
Coordinate PMB compliance project across Units			
Update PMB ICD-10 code list	Publish list by June 2010	Target achieved	No deviation
Prepare specifications document on payment of PMBs by schemes	Document by August 2010	Initial planning now subject to PMB task team recommendations; industry workshop held and task team established on 11 May 2010; first meeting on 25 May 2010; problems in agreement to ToR on 4 June 2010; target to establish PMB Code of Conduct by 15 July 2010; PMB Code of Conduct completed 30 July 2010	Adjustments made in accordance with developments following compliance Circulars and meetings with Ministry, DoH and stakeholders
Identify PMB-related matters for reporting in annual statutory returns	Communicate data specifications to schemes with annual statutory returns specifications by October 2010	Target not achieved	Pricing study took precedence

Our Annual Financial Statements

Statement of financial position
of the Council for Medical Schemes
as at 31 March 2011

	Notes	2011	2010
		R	R
ASSETS			
Non-current assets		**4,973,174**	**4,055,062**
Property, plant and equipment	3	4,221,249	2,770,942
Intangible assets	4	751,925	1,284,120
Current assets		**8,461,057**	**15,775,476**
Trade and other receivables	5	1,529,277	1,354,259
Cash and cash equivalents	6	6,931,780	14,421,217
TOTAL ASSETS		**13,434,231**	**19,830,537**
LIABILITIES			
Non-current liabilities		**324,522**	**73,455**
Operating lease payable	7	324,522	73,455
Current liabilities		**11,214,509**	**6,039,277**
Trade and other payables	8	7,593,404	3,429,858
Provisions	9	3,621,105	2,609,419
TOTAL LIABILITIES		**11,539,031**	**6,112,732**
NET ASSETS		**1,895,201**	**13,717,805**
NET ASSETS			
Reserves			
Accumulated surplus		1,895,201	13,717,805
TOTAL NET ASSETS		**1,895,201**	**13,717,805**

Prof. William Pick
Chairperson
Council for Medical Schemes
28 July 2011

Statement of financial performance
of the Council for Medical Schemes
for the year ended 31 March 2011

BUDGET			Notes	ACTUAL	
2011	2010			2011	2010
R	R			R	R
80,743,698	**60,046,397**	**Revenue**		**69,167,732**	**64,939,465**
80,743,698	60,046,397	Revenue from exchange transactions	10.1	69,034,784	61,074,465
-	-	Revenue from non-exchange transactions	10.2	132,948	4,039,307
82,620,968	**69,013,022**	**Expenditure**		**82,204,139**	**63,834,335**
10,539,472	9,004,037	Administrative expenses	11	10,291,786	7,587,442
1,710,275	920,000	Audit fees	12	1,368,005	1,110,054
-	-	Bad debts	13	98,656	-
11,240,163	9,635,497	Operating expenses	14	16,848,545	10,326,925
56,293,802	48,267,488	Staff cost	15	51,557,772	42,400,659
1,400,004	840,000	Depreciation	3	1,191,439	1,246,902
1,281,252	180,000	Amortisation	4	847,936	1,162,352
(1,877,270)	**(8,966,625)**	**Operating surplus/(deficit) for the period**		**(13,036,407)**	**1,105,130**
-	-	Gain/(loss) on disposal of assets		(14,172)	(2,095)
1,000,000	1,400,000	Interest received		1,227,976	1,659,465
(877,270)	**(7,566,625)**	**Surplus/(deficit) for the period**		**(11,822,603)**	**2,762,500**

Statement of changes in net assets
of the Council for Medical Schemes
for the year ended 31 March 2011

	Notes	2011	2010
		R	R
Accumulated surplus as at 1 April 2010		**13,717,805**	**7,820,713**
Change in accounting policy with respect to government grants		-	3,655,527
Accumulated surplus as at 1 April 2010 - restated reported		**13,717,804**	**11,476,240**
Surplus/(deficit) for the period		(11,822,603)	2,762,501
Accumulated surplus as at 31 March 2011 - previously reported		**1,895,201**	**14,238,741**
Prior period error with respect to legal fees	20	-	(520,936)
Accumulated surplus as at 31 March 2011		**1,895,201**	**13,717,805**

Cash flow statement
of the Council for Medical Schemes
for the year ended 31 March 2011

	Notes	2011	2010
		R	R
Cash flows from operating activities			
Cash receipts from customers		68,859,766	63,882,482
Cash receipts from debtors		68,859,766	59,843,175
Cash receipts from grant		-	4,039,307
Cash paid to suppliers and employees		(74,605,518)	(63,767,562)
Cash generated from operations	16	(5,745,752)	114,920
Interest received		1,227,976	1,659,465
Net cash flow from/(used in) operating activities		**(4,517,776)**	**1,774,385**
Cash flows from investing activities			
Acquisition of property, plant and equipment	3	(2,687,418)	(863,326)
Acquisition of intangible assets	4	(315,741)	(842,345)
Proceeds from sale of equipment		31,500	24,116
Net cash flow from/(used in) investing activities		**(2,971,659)**	**(1,681,554)**
Net increase in cash and cash equivalents		**(7,489,437)**	**92,831**
Cash and cash equivalents at beginning of the year		14,421,217	14,328,386
Cash and cash equivalents at end of the year		**6,931,780**	**14,421,217**

Notes to the financial statements
of the Council for Medical Schemes
for the year ended 31 March 2011

1. General

The Council for Medical Schemes (CMS) is an entity listed under schedule 3A of the Public Finance Management Act, Act No. 1 of 1999, and domiciled in South Africa. The address of the CMS's place of business is Block E, Hadefields Office Park, 1267 Pretorius Street, Hatfield, Pretoria.

As the regulatory authority responsible for overseeing the medical schemes industry in South Africa, the CMS administers and enforces the Medical Schemes Act 131of 1998. It is accountable to the Minister responsible for national health matters. The CMS collects levies from schemes in terms of the Levies Act 2000 (Act No. 58 of 2000).

2. Accounting policies

The specific principles, bases, conventions, rules and practices applied in preparing and presenting these financial statements are set out below and are consistent with those of the previous year, unless explicitly stated.

2.1 Basis of preparation

These general purposes financial statements are prepared and presented under the accrual basis of accounting in accordance with the Standards of Generally Recognised Accounting Practices (GRAP), including any interpretations, guidelines and directives issued by the Accounting Standards Board.

Effect of Standards of GRAP

The following effective Standards of GRAP have been adopted by the CMS. This adoption did not result in any additional disclosure or change in accounting policies.

Standard	Topic
GRAP 1	Presentation of financial statements
GRAP 2	Cash flow statements
GRAP 3	Accounting policies, changes in accounting estimates and errors
GRAP 4	The effects of changes in foreign exchange rates
GRAP 5	Borrowing costs
GRAP 9	Revenue from exchange transactions
GRAP 13	Leases
GRAP 14	Events after the reporting date
GRAP 17	Property, plant and equipment
GRAP 19	Provisions, contingent liabilities and contingent assets
GRAP 102	Intangible assets
IPSAS 20	Related party disclosure

Accounting policies for material transactions, events or conditions not covered by the GRAP reporting framework, as detailed above, have been developed in accordance with paragraphs 7, 11 and 12 of GRAP 3 and the hierarchy approved in Directive 5 issued by the Accounting Standards Board.

The following Standards of GRAP have been effected by the Minister of Finance but were not adopted by the CMS as they are not applicable to the entity's operations.

Standard	Topic
GRAP 6	Consolidated and separate financial statements
GRAP 7	Investments in associates
GRAP 8	Interests in joint ventures
GRAP 10	Financial reporting in hyperinflationary economies
GRAP 11	Construction contracts
GRAP 12	Inventories
GRAP 16	Investment property
GRAP 100	Non-current assets held for sale and discontinued operations
GRAP 101	Agriculture

Standards and amendments to Standards issued but not effective

The following Standards and amendments to Standards have been issued but are not effective as at 31 March 2011:

Standard	Topic	Summary and impact	Effective date	
GRAP 18	Segment reporting	This Standard establishes principles for reporting financial information by segments. The impact on the financial results and disclosure is considered to be minimal.	ASB issued date:	March 2005
		The CMS does not apply this Standard as the impact on the financial results and disclosure is considered to be minimal.	Effective date:	to be determined by the Minister of Finance
GRAP 21	Impairment of non-cash-generating assets	This Standard prescribes the procedures that the CMS applies to determine whether a non-cash-generating asset is impaired, and ensures that impairment losses are recognised.	ASB issued date:	March 2009
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	to be determined by the Minister of Finance
GRAP 23	Revenue from non-exchange transactions (taxes and transfers)	This Standard prescribes the requirements for the financial reporting of revenue from non-exchange transactions (grants and transfer payments).	ASB issued date:	February 2008
		Early adoption of Standard: the CMS adopted GRAP 23 in full as it materially affected the financial statements as disclosed in note 18.1.	Effective date:	to be determined by the Minister of Finance
GRAP 24	Presentation of budget information in the financial statements	This Standard requires a comparison of budget and actual amounts and an explanation for material differences.	ASB issued date:	November 2007
		The impact on the financial results is considered to be minimal, but the impact on disclosure is significant.	Effective date:	to be determined by the Minister of Finance
GRAP 25	Employee benefits	The Standard prescribes the accounting treatment and disclosure for employee benefits.	ASB issued date:	November 2009
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	to be determined by the Minister of Finance
GRAP 26	Impairment of cash-generating assets	This Standard prescribes the procedures to determine whether a cash-generating asset is impaired, and ensures that impairment losses are recognised.	ASB issued date:	March 2009
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	to be determined by the Minister of Finance
GRAP 104	Financial instruments	This Standard establishes the principles for recognising, measuring, presenting and disclosing financial instruments.	ASB issued date:	October 2009
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	to be determined by the Minister of Finance

2.2 Presentation currency

(a) Functional and presentation currency

All amounts have been presented in the currency of South African Rand which is the functional currency of the CMS. All amounts are stated in nearest Rand.

(b) Transactions

Foreign currency transactions are translated into the functional currency using the exchange rate prevailing at the dates of the transactions.

2.3 Going concern assumption

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

2.4 Critical accounting estimates and judgements

The CMS makes estimates and assumptions that affect the reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Areas which management believes require the most critical estimates and judgements are:

Useful economic lives of property, plant and equipment

The CMS estimates the useful lives of property, plant and equipment based on the period over which the assets are expected to be available for use. The estimated useful lives of property, plant and equipment are reviewed periodically and are updated if expectations differ from previous estimates due to physical wear and tear, technical or commercial obsolescence, and legal or other limits on the use of the relevant assets. In addition, the estimation of the useful lives of property, plant and equipment are based on internal evaluation and experience with similar assets. It is possible, however, that future results of operations could be materially affected by changes in the estimates brought about by changes in the factors mentioned above. The amounts and timing of recorded espenses for any period would be affected by changes in these factors and circumstances. A reduction in the estimated useful lives of property, plant and equipment would increase the recorded expenses and decrease the non-current assets.

2.5 Cash and cash equivalents

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

2.6 Borrowing costs

Section 66 of the PFMA prohibits the CMS from borrowing unless such borrowing has been effected through the Minister of Finance. Borrowing costs incurred other than on qualifying assets are recognised as an expense in surplus or deficit in the period to which they relate.

2.7 Revenue

Revenue is recognised when it is probable that future economic benefits or service potential will flow to the entity and these benefits can be measured reliably.

2.7.1 Revenue from exchange transactions

"Revenue from exchange" transactions are transactions in which the CMS receives assets or services, or has liabilities extinguished, and directly gives approximately equal value exchange. The main sources of revenue from exchange transactions are:

(a) Accreditation fees

Accreditation fees are fixed tariffs paid by brokers, administrators and managed care organisations, over two years. Accreditation fees are recognised in the financial period in which services are rendered.

(b) Appeal fees

Appeal fees are fixed tariffs paid by an appellant when appealing to the Appeal Board. Appeal fees are recognised in the financial period in which the appeal was raised and services were rendered.

(c) Levies

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

(d) 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.

(e) Sundry income

All other revenue received not in the normal operations of the CMS is recognised as revenue when future economic benefits flow to the CMS and these benefits can be measured reliably.

2.7.2 Revenue from non-exchange transactions

"Revenue from non-exchange" transactions are transactions that are not exchange transactions. The main sources of revenue from non-exchange transactions are:

(a) Government grants

The CMS receives grants from the Department of Health for specific projects. These grants are recognised when it is probable that the future economic benefits will flow to the CMS and when the amount can be measured reliably. Revenue recognised as a consequence of a transfer is measured at the fair value of the assets recognised as at the date of recognition. A grant is recognised as non-exchange revenue to the extent that there is no further obligation arising from the receipt of the transfer payment.

(b) Mandatory grants

The Council receives a mondatory grant from HWSETA in accordance with the Skills Development Act (No 1 of 1999). Revenue recognised as a consequence of a transfer are measured at the fair value of the assets recognised as at the date of recognition. A grant is recognised as non-exchange revenue to the extent that there is no further obligation arising from the receipt of the transfer payment.

2.8 Operating lease

Payments made under operating leases (leases other than finance leases) are charged to the statement of financial performance on a straight-line basis over the period of the lease. When an operating lease is terminated before the lease period has expired, any payment required to be made to the lessor by way of a penalty is recognised as an expense in the period in which termination takes place.

2.9 Property, plant and equipment

Narrative description

Property, plant and equipment are tangible non-current assets that are held for use in the supply of goods or services, and are expected to be used during more than one year.

Assets embodying service potential but not necessarily generating economic benefits also qualify for recognition as property, plant and equipment.

Initial recognition

All items of property, plant and equipment are recognised at cost when:

(i) it is probable that future economic benefits associated with the item will flow to the CMS; and

(ii) the cost of the item can be measured reliably.

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, on the same basis. The carrying amount of the replaced part is derecognised. All other repairs and maintenance are charged to the statement of performance during the financial period in which they are incurred.

Subsequent measurement

Subsequent to recognition, property, plant and equipment are stated at cost less accumulated depreciation and any accumulated impairment losses.

Depreciation

All items of property, plant and equipment are depreciated when they are available for use and the CMS continues to depreciate these items until they are derecognised.

Depreciation is provided for on a straight-line basis to write off the cost of each asset to its residual value over the estimated useful life. The estimated useful life of assets is as follows:

Category of asset	Estimated useful life
Computer equipment	4 years
Computer software	3 years
Furniture and fittings	10 years
Motor vehicle	5 years
Other fixed assets	10 years

The residual values, useful life and depreciation method of all items of property, plant and equipment are reviewed at each financial year-end to ensure that the amount, method and period of depreciation are consistent with previous estimates and the expected pattern of consumption of the future economic benefits embodied in the items of property, plant and equipment.

Impairment of assets

The carrying amounts of assets are reviewed at each reporting date to determine whether there is any indication of impairment. Where the carrying amount of an asset is greater than its estimated recoverable amount, it is written down immediately to its recoverable amount. These impairment losses are recognised in surplus or deficit in the period in which they arise.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no future economic benefits are expected from its use or disposal. The difference between the net disposal proceeds, if any, and the net carrying amount is recognised in the statement of financial performance.

2.10 Intangible assets

Narrative description

An intangible asset is an identifiable non-monetary asset without physical substance and includes acquired computer software and developed software.

Initial recognition

(a) Acquired software

Acquired computer software is capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

(b) Developed software

Costs that are directly associated with the development of identifiable software products controlled by the CMS and which will probably generate economic benefits exceeding costs beyond one year, are recognised as intangible assets.

Amortisation

Amortisation is provided for on a straight-line basis to write off the cost of each asset over the estimated useful life. The annual amortisation rates are based on the following estimated useful lives:

Category of asset	Estimated useful life
Acquired software	3 years
Developed software	3 years

The useful life and amortisation method of all items of intangible assets are reviewed at each financial year-end to ensure that the amount, method and period of amortisation are consistent with previous estimates and the expected pattern of consumption of the future economic benefits embodied in the items of intangible assets.

Impairment of assets

The carrying amounts of assets are reviewed at each reporting date to determine whether there is any indication of impairment. Where the carrying amount of an asset is greater than its estimated recoverable amount, it is written down immediately to its recoverable amount. These impairment losses are recognised in surplus or deficit in the period in which they arise.

Derecognition

An item of intangible assets is derecognised upon disposal or when no future economic benefits are expected from its use or disposal. The difference between the net disposal proceeds, if any, and the net carrying amount is recognised in the statement of financial performance.

Judgements used for recognition of internally generated intangible assets

The recognisable cost of internally developed software is estimated to be the number of days spent on development multiplied by the relevant rate per day of the IT personnel involved in the development.

2.11 Provisions

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

2.12 Contingent liabilities

A contingent liability is a possible obligation that arises from past events, and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CMS, or a present obligation that arises from past events but is not recognised because:

(i) it is not probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; or

(ii) the amount of the obligation cannot be measured with sufficient reliability.

2.13 Financial instruments

Accounting for financial instruments

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

Financial risk management

Financial risk factors:

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

Interest rate risk:

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

Credit risk:

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

Liquidity risk:

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

Currency risk:

The CMS is exposed to currency risk which is the risk that arises as a result of changes in exchange rates. The exposure to currency risk is limited by virtue of the limited transactions with suppliers from outside the country.

Investment risk:

The CMS is exposed to investment risk by virtue of having short-term investments of surplus cash on call and fixed deposit accounts. The investment risk is limited by virtue of the limited term that surplus cash is held on call and fixed deposit.

2.14 Trade and other receivables

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

2.15 Trade and other payables

Trade and other payables are recognised at cost less principal payments and amortisations.

2.16 Research costs

Research costs relate to work performed by the Research & Monitoring Unit of the CMS. The objective of the Unit is to monitor the impact of the Medical Schemes Act 131 of 1998, research developments, and recommend policy options to improve the regulatory environment. Research expenditure is recognised as an expense in the financial period in which it was incurred.

2.17 Budget information

The approved budget covers the fiscal period from 1 April 2010 to 31 March 2011. Budget resources were obtained and used in accordance with the legally adopted budget. Except for non-exchange revenue, both the financial statements and the annual budget adopt the accrual basis of accounting.

2.18 Employee benefits

Short-term employee benefits

The cost of short-term employee benefits - those payable within 12 months after the services are rendered, such as paid vacation leave and bonuses - is recognised in the period in which the service is rendered.

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

3. Property, plant and equipment

	Computer equipment	Computer software	Furniture and fittings	Motor vehicle	Library books	Other fixed assets	TOTAL
	R	R	R	R	R	R	R
For the year ended 31 March 2011							
Opening net book amount at 1 April 2010	840,715	120,933	1,433,669	14,334		361,292	2,770,943
Cost	5,533,790	1,289,907	3,150,400	139,885	-	533,305	10,647,287
Accumulated depreciation	(4,693,075)	(1,168,974)	(1,716,731)	(125,551)	-	(172,013)	(7,876,344)
Additions for the year	1,156,318	914,881	575,035	(0)		41,183	2,687,418
Disposals at net book value	(25,359)	-	(15,653)	-		(4,660)	(45,672)
Depreciation charge	(637,519)	(200,606)	(286,702)	(14,334)		(52,279)	(1,191,439)
Closing net carrying amount at 31 March 2011	1,334,155	835,208	1,706,350	-		345,536	4,221,249
Closing net carrying amount at 31 March 2011	1,334,155	835,208	1,706,350	-		345,536	4,221,249
Cost	6,366,204	2,204,788	3,624,897	139,885	-	552,393	12,888,166
Accumulated depreciation	(5,032,048)	(1,369,580)	(1,918,547)	(139,885)	-	(206,857)	(8,666,917)
Gross carrying amount of fully depreciated property, plant and equipment	4,430,605	1,143,109	625,538	139,885	-	13,357	6,352,494
For the year ended 31 March 2010							
Opening net book amount at 1 April 2009	1,276,424	202,289	1,370,491	42,311	0	289,215	3,180,730
Cost	5,300,217	1,214,097	2,859,252	139,885	42,014	412,556	9,968,021
Accumulated depreciation	(4,023,793)	(1,011,808)	(1,488,761)	(97,574)	(42,014)	(123,341)	(6,787,292)
Additions for the year	276,851	75,810	389,916	-	-	120,749	863,326
Disposals at net book value	-	-	(26,211)	-	-	-	(26,211)
Depreciation charge	(712,560)	(157,167)	(300,527)	(27,977)	-	(48,671)	(1,246,902)
Closing net carrying amount at 31 March 2010	840,715	120,932	1,433,669	14,334	-	361,292	2,770,942
Closing net carrying amount at 31 March 2010	840,715	120,932	1,433,669	14,333	-	361,292	2,770,942
Cost	5,533,790	1,289,907	3,150,400	139,885	42,014	533,305	10,689,300
Accumulated depreciation	(4,693,075)	(1,168,974)	(1,716,731)	(125,551)	(42,014)	(172,013)	(7,918,359)
Gross carrying amount of fully depreciated property, plant and equipment still in use	2,368,405	748,850	121,275	-	42,014	-	3,280,544

4. Intangible assets

	Acquired software	Developed software	TOTAL
	R	R	R
For the year ended 31 March 2011			
Opening net book amount at 1 April 2010	953,179	330,941	1,284,120
Cost	4,269,025	724,974	4,993,999
Accumulated amortisation	(3,315,846)	(394,033)	(3,709,879)
Additions for the year	120,165	195,576	315,741
Disposals at net book value	-	-	-
Amortisation	(655,259)	(192,676)	(847,936)
Closing net carrying amount at 31 March 2011	418,084	333,841	751,925
Closing net carrying amount at 31 March 2011	418,084	333,841	751,925
Cost	4,389,190	920,550	5,309,740
Accumulated amortisation	(3,971,105)	(586,709)	(4,557,815)
Gross carrying amount of fully amortised intangible assets still in use	3,065,101	351,238	3,416,339
For the year ended 31 March 2010			
Opening net book amount at 1 April 2009	1,489,974	114,154	1,604,127
Cost	3,775,518	376,136	4,151,654
Accumulated amortisation	(2,285,544)	(261,982)	(2,547,527)
Additions for the year	493,507	348,838	842,345
Disposals at net book value	-	-	-
Amortisation	(1,030,302)	(132,051)	(1,162,352)
Closing net carrying amount at 31 March 2010	953,179	330,941	1,284,120
Closing net carrying amount at 31 March 2010	953,179	330,941	1,284,120
Cost	4,269,025	724,974	4,993,999
Accumulated amortisation	(3,315,846)	(394,033)	(3,709,879)
Gross carrying amount of fully amortised intangible assets still in use	1,410,809	-	1,410,809

5. Trade and other receivables

	2011	2010
	R	R
Accounts receivable	15,298	15,632
Sundry debtors	894,751	708,028
Prepaid expenses	619,228	630,599
	1,529,277	1,354,259

As at 31 March 2011, the carrying amount of trade and other receivables approximates their fair values due to the short-term maturities of these assets. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

6. Cash and cash equivalents

Cash and bank	6,931,780	4,421,217
Fixed deposit	-	10,000,000
	6,931,780	14,421,217

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes. Cash and cash equivalents have a maturity of less than three months and insignificant risk of changes in fair value.

7. Operating lease commitments

Previous lease contract		
Opening balance as at 1 April 2010	73,455	378,489
Movement for the year	(73,455)	(305,034)
New lease contract		
Opening balance as at 1 April 2010	-	-
Movement for the year	324,522	
Closing balance as at 31 March 2011	324,522	73,455

8. Trade and other payables

	2011	2010
	R	R
Accounts payable	4,285,900	1,294,957
Income received in advance	644,189	546,279
Accrual for leave pay	1,489,284	1,117,028
Other accruals	1,174,032	471,594
	7,593,404	3,429,858

As at 31 March 2011, the carrying amount of trade and other payables approximates their fair values due to the short-term maturities of these liabilities.

Included in trade and other payables 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 reporting date.

9. Provisions

Performance bonuses	3,421,105	2,609,419
Opening balance	2,609,419	2,257,343
Utilisation of provision during the year	(2,609,419)	(2,257,343)
Provision made during the current year	3,421,105	2,609,419

A performance bonus is the reward for outstanding performance of employees who performed well during the financial year. Performance bonuses are provided in terms of our Performance Management Policy and are payable by no later than 30 June each year.

Other provisions	200,000	-
Opening balance	-	837,916
Utilisation of provision during the year	-	(547,331)
Reversal of unused provision	-	(356,947)
Provision made during the current year	200,000	66,362

"Other provisions" is in relation to the assessment in terms of Section 83(2) of the Compensation for Occupational Injuries and Diseases Act,1993. The Council for Medical Schemes did not receive this assessment for the year under review.

TOTAL	**3,621,105**	**2,609,419**

BUDGET 2011 R	BUDGET 2010 R		ACTUAL 2011 R	ACTUAL 2010 R
		10. Revenue		
		10.1 Revenue from exchange transactions		
5,500,000	5,500,000	Accreditation fees	4,737,000	5,960,000
-	-	Appeal fees	22,000	22,000
63,359,698	48,846,397	Levies income	63,721,098	52,218,581
384,000	400,000	Registration fees	417,550	391,950
11,500,000	5,300,000	Sundry income	137,136	2,307,627
80,743,698	60,046,397		69,034,784	61,074,465
		10.2 Revenue from non-exchange transactions		
-	10,527,527	Government grants	-	3,865,000
-	-	Mandatory grants	132,948	174,307
-	10,527,527		132,948	3,865,000
		11. Administrative expenses		
37,301	36,000	Bank charges	75,263	36,051
1,772,401	2,228,706	Building expenses	1,585,417	2,247,932
4,305,537	2,362,450	Rent	4,301,386	2,155,021
132,996	154,000	Courier and postage	109,026	117,749
1,278,324	364,376	General administrative expenses	1,350,229	426,440
121,668	163,500	Insurance	133,414	124,845
258,722	332,610	Printing and stationery	239,207	283,393
160,752	137,844	Refreshments	171,125	104,009
321,000	300,000	Rental - copiers	231,290	243,770
-	237,224	Repairs and maintenance	-	183,444
70,651	254,589	Security	65,453	124,323
96,834	47,084	Subscriptions	50,237	14,783
1,736,582	2,113,326	Telecommunication expenses	1,752,144	1,401,981
246,704	272,328	Travel	227,595	123,702
10,539,472	9,004,037		10,291,786	7,587,443
		12. Audit fees		
574,480	470,000	Auditors' remuneration - external audit	484,475	723,397
1,135,795	450,000	Auditors' remuneration - internal audit	883,530	386,656
1,710,275	920,000		1,368,005	1,110,054

BUDGET 2011 R	BUDGET 2010 R		ACTUAL 2011 R	ACTUAL 2010 R
		13. Bad debts		
		Bad debts	98,656	-
			98,656	-
		The CMS has accepted a lesser settlement from a former employee in respect of sabbatical leave.		
		14. Operating expenses		
166,922	180,000	Accreditation costs	129,440	154,508
-	115,720	Administrator training	-	54,479
372,000	360,000	Appeal Board	388,593	84,407
194,000	556,000	Consulting fees	766,973	438,249
1,225,501	657,900	Consumer education	1,104,698	748,859
1,155,857	743,877	Committee expenses	1,711,543	1,062,979
940,000	610,000	HR/organisational strategy	494,341	523,742
500,000	650,000	Investigation costs	348,024	378,431
267,516	243,000	Knowledge management	244,886	235,301
3,700,812	3,175,000	Legal fees	9,892,398	4,802,735
268,000	667,500	Media and promotion	225,504	542,166
156,000	166,000	Newsletters	38,551	103,161
517,004	330,000	PMB review	299,893	204,253
115,000	72,500	Research costs	40,188	41,310
1,138,000	658,000	Strategic and operational planning	800,452	549,504
50,400	66,000	Transcription services	53,265	23,872
629,151	550,000	Trustee training	309,797	378,969
11,396,163	9,801,497		16,848,545	10,326,925
		15. Staff cost		
1,120,152	987,540	Employee benefits	1,081,758	927,084
342,200	192,000	Employee wellness	329,062	201,901
820,000	840,000	Recruitment and relocation	765,226	789,518
51,803,543	43,879,210	Salaries	47,372,114	38,938,609
200,000	200,000	Social contributions	200,000	28,075
1,673,863	1,876,738	Staff training	1,328,337	1,206,256
334,044	292,000	Temporary staff	481,274	309,216
56,293,802	48,267,488		51,557,772	42,400,659
		Total number of employees	83	77

16. Reconciliation between net surplus and cash applied to activities

	Notes	2011	2010
		R	R
Operating surplus/(deficit)		(11,822,603)	2,762,501
Adjusted for:			
Amortisation		847,936	1,162,352
Depreciation		1,191,439	1,246,902
Interest received		(1,227,976)	(1,659,465)
Gain/(loss) on disposal of assets		14,172	2,095
Operating surplus/(deficit) before working capital		(10,997,032)	3,514,386
Decrease/(increase) in accounts receivable		(175,018)	(1,231,290)
(Decrease)/increase in accounts payable		5,531,640	(535,651)
(Decrease)/increase in accounts provisions		(105,343)	(1,632,525)
Cash flows from operating activities		(5,745,752)	114,920

17. Related parties

Executive Authority

The Executive Authority, as defined in Section 1 of the Public Finance Management Act, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.

Accounting Authority

The Council, as defined in Section 49 of the Public Finance Management Act, is the controlling body of the Council for Medical Schemes (CMS). Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.

Executive management

Council members appoint the executive management team which is responsible for executing their decisions.

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

17.1 Council members

	ACTUAL	
Notes	2011	2010
	R	R
Fees for services		
Bailey T	55,686	13,995
Bolani TA	-	3,960
Du Plessis DJ	30,576	-
Fortune T	47,969	41,441
Gwagwa T	7,462	7,785
Hoosain AK	24,513	14,749
Njongwe PZ	15,437	5,580
Palane LA	-	13,860
Pick W	80,636	36,326
Rothberg AD	49,972	27,171
Rusconi R	1,530	6,975
Simelane RV	11,516	8,010
Van Gelderen CJ	31,850	-
Phadu T	19,474	-
Thompson G	60,763	-
	437,384	179,852

17.2 Executive management

Basic salary	9,334,031	5,697,453
Bonuses	878,439	465,971
Expense allowances	354,000	121,500
	10,566,470	6,284,924

18. Operating lease commitments

18.1 Office rental

The CMS has an operating lease for rental of the offices up to 31 May 2013. The rental escalates by 9.0% compounded every year.

Not later than one year	4,590,363	514,263
Later than one year and not later than five years	5,355,424	-
	9,945,787	514,263

18.2 Photocopiers

The CMS has an operating lease contract for the rental of copiers. The contract is for the colour photocopiers and seven black and white copiers. This contract expires in 2011, with rental payments based on prime plus 0.0% escalation.

Not later than one year	-	240,338
Later than one year and not later than five years	-	-
	-	240,338

19. Change in accounting policy

19.1 Grants received

IFRS 20, *Accounting for government grants*, is in conflict with GRAP 23, *Revenue from non-exchange transactions*, therefore early adoption of GRAP 23 was applied in 2010. This constitutes a change in accounting policy with respect to the treatment of government grants. This change in accounting policy has been accounted for retrospectively. The comparative statements for 2009 have been restated to conform to the changed policy. The effect of the change is:

	ACTUAL	
Notes	2011	2010
	R	R
Decrease in revenue from non-exchange transaction	-	(5,271,748)
Increase in opening surplus - transactions before 2009	-	-

19.2 Library books

During the period under review the accounting policy with regard to library books was reviewed. We are no longer capitalising library books but we expense them off in the period that the transaction is incurred. The aggregated value of library books is insiginificant for recognition as property, plant and equipment.

Decrease in library books - accumulated depreciation	-	(42,014)
Decrease in library books - cost price	-	42,014

19.3 Leave accrual

During the year the CMS changed its accounting policy to categorise outstanding leave as a leave *accrual* instead of a leave *provision*. Management is of the opinion that the new category of disclosure will result in a fairer presentation of the financial statements, as the existence, amount and timing of the liability is an absolute certainty. The effect of this change in accounting policy is as follows:

Decrease in provisions	(1,489,284)	(1,117,028)
Increase in trade and other payables	1,489,284	1,117,028

20. Prior period error

This constitutes invoices which were classified under invoices whose payments were to be recovered from Bonitas Medical Fund for an inspection according to a court order. It was later discovered that they were not part of the court order ruling; they were actually legal fees, hence the adjustment.

(Decrease) in sundry debtors	-	(520,936)
Decrease in net surplus for the year	-	520,936

21. Contingent liability

As at 31 March 2011, the CMS had a contingent liability arising from a legal claim by a former employee for unfair dismissal. Based on the legal opinion received, the estimated legal claim amounts to R579 593.

22. 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 No. 58 of 1962.

23. Irregular expenditure

	ACTUAL
Notes	2011
	R
Opening balance	-
Current year	2,299,520
Prior year	1,172,931
Less: amounts condoned	-
Irregular expenditure awaiting condonation	**3,472,451**
Analysis of expenditure awaiting condonation per age classification	
Current year	2,299,520
Prior year	1,172,931
Total	**3,472,451**
Details of irregular expenditure not recoverable (not condoned) - current year	
Progress: in process of condonation	
Incident 1: Dell Computers (Pty) Ltd	1,620,973
Incident 2: Dimension Data	1,832,486
Incident 3: In Living Colour	18,992
Total	**3,472,451**

The CMS incurred an irregular expenditure in that it had acquired goods without going through a competitive bidding process or sourcing three quotations. However, the reasons for this deviation were recorded and approved by the Registrar. The reasons advanced do not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/2008 of National Treasury, which allows for deviation from competitive bidding process.

We have since applied for condonation from National Treasury and are awaiting a response.

Report of the Audit & Risk Committee

Report of the Audit & Risk Committee

We are pleased to present our report to the Council for Medical Schemes (CMS) Accounting Authority for the financial year ended 31 March 2011.

This report is provided by the Audit & Risk Committee of Council, appointed in respect of the 2010-2011 financial year of the CMS in compliance with Section 38(1)(a) of the Public Finance Management Act 1 of 1999 (PFMA), as amended. The Committee's operation is guided by a detailed charter which is informed by the PFMA and approved by Council.

Audit & Risk Committee members

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

The membership of the Audit & Risk Committee as at 31 March 2011 was as follows:

Name	Role	Date of appointment
Mr Charles Mazhindu	Independent; Chairperson	1 October 2009
Mr Rowan Nicholls	Independent member	1 October 2009
Ms Josephine Naicker	Independent member	1 October 2009
Dr Zola Njongwe	Council member	7 March 2008
Mr Kariem Hoosain	Council member	28 May 2009
Prof. Dion du Plessis	Council member	1 October 2010

Purpose

The purpose of the Committee is to:

- assist the CMS in discharging its duties by using effective governance and risk mitigation relating to the safeguarding of assets, the operation of adequate systems, control and reporting processes, and the preparation of accurate reporting information and financial statements in compliance with applicable legal requirements and accounting standards;
- provide independent assurance on the adequacy of the risk management framework and associated control environment;
- provide independent scrutiny of the CMS's financial and non-financial performance to the extent that it affects the CMS's exposure to risk and weakens the control environment;
- oversee the financial reporting process;
- oversee the activities of internal and external audits and ensure coordination between these activities;
- receive and deal with any complaints concerning accounting practices, the internal audit, or the content and audit of its financial statements or related matters;
- conduct annual reviews of the Committee's work and terms of reference, and report to Council on the reviews; and
- perform duties that are assigned to it by the PFMA, and as governed by other legislative requirements.

Meetings

The Committee held four scheduled meetings during the year under review. Scheduled meetings and attendance at these meetings was as follows:

Name of member	Date of appointment	Meetings attended			
		21 May 2010	23 July 2010*	18 November 2010	31 March 2011
Mr Charles Mazhindu	1 October 2009	√	√	√	√
Mr Rowan Nicholls	1 October 2009	√	√	√	√
Mrs Josephine Naicker	1 October 2009	√	X	√	X
Dr Zola Njongwe	7 March 2008	√	X	X	√
Mr Kariem Hoosain	28 May 2009	√	√	X	X
Prof. Dion du Plessis	1 October 2010	-	-	X	√

** Special Audit & Risk Committee meeting – recommendation of audited Annual Financial Statements*

Other invitees

The internal and external auditors attended all the meetings of the Committee in their respective capacities as CMS auditors. The Chief Executive Officer, Chief Financial Officer and Deputy Chief Financial Officer as well as relevant senior managers attended meetings by invitation.

Audit & Risk Committee responsibility

Mandate

The mandate of the Committee is derived from Section 38(1)(a) of the Public Finance Management Act 1 of 1999 (PFMA) and paragraph 3.1 of Treasury Regulations.

The Committee reports that it has discharged its responsibilities arising from Section 38(1)(a) of the PFMA and Treasury Regulation 3.1.13.

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

Functions

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

- Evaluation of the effectiveness of risk management, controls, and governance processes
- Oversight of:
  - the financial reporting process
  - activities of the internal and external audits and facilitation of a coordinated approach between these functions
- Review of:
  - provisional and year-end financial statements to ensure that they are fairly presented and prepared in the manner required by the PFMA and 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 being made to the board

- Approval of:
  - the internal audit charter, budget, and three-year audit plan
  - audit fees and engagement terms of the internal auditor
  - engagement terms, plans and budget for the Auditor-General
- Recommendation of the unaudited and audited Annual Financial Statements to Council for the year ended 31 March 2011

Role of Audit & Risk Committee on CMS governance

The Committee continued to discharge its mandate as part of the governance structures of the CMS and enhanced its oversight function as follows.

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

The CMS's outsourced internal auditor Sizwe Ntsaluba VSP compiled and presented its three-year rolling strategic plan for the review and approval of the Audit & Risk Committee.

The Committee approved the plan after satisfying itself that the plan is both in line with Regulations and risk-based, as required by standards.

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

External audit plan by the Auditor-General

The Committee reviewed and approved the audit plan for the year under review as prepared and presented by the Auditor-General in terms of the Public Audit Act for the year ended 31 March 2011. The Committee confirms that this plan is in line with Regulations and standards, and that the plan takes into consideration the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented are adequate for the completion of the CMS annual audit.

Risk management and internal controls

The Committee continued to ensure that the CMS risk management practices and internal policies and procedures are effective and adequate to safeguard CMS resources and promote the achievement of its mission.

The Committee continued to contribute to the establishment of effective internal controls, which requires the periodic identification and assessment of risks facing the CMS from both internal and external sources. The Committee is satisfied that areas of improvement within the CMS risk management and internal control practices are being adequately identified, and entity-wide risk management within the CMS has now been formalised. The Committee appreciates that an effective internal audit function is central to its proper operation.

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

The Committee recommends that Council review and approve the risk register and derive its own top strategic risks together with an action plan to mitigate them. The Committee recommended to Council that it identify the role of combined assurance providers as a top strategic risk together with reporting requirements to provide comfort to Council on the effectiveness of the CMS risk management framework, and recommends the CMS risk register as prepared by management for adoption by Council.

Reviewing legal cases pending at financial year-end

The Committee reviewed progress reports on legal cases against the CMS which were pending at the end of the financial year so as to assess the adequate disclosure required in terms of Generally Recognised Accounting Practices (GRAP) and Treasury Regulations. The Committee found no significant cases which warrant any mention in this report.

Evaluating the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated on an annual basis.

During the year under review, the Committee was independently evaluated by the Auditor-General as part of their annual audit of the CMS. The results of this evaluation were reported to Council and, where applicable, were included in audit findings for follow-up towards positive change.

Evaluating financial statements

The Committee:

- reviewed and discussed, with both management and the Auditor-General, the impact on the CMS Annual Financial Statements of compliance with new accounting and financial reporting pronouncements for the year under review, and is satisfied that the CMS Annual Financial Statements were prepared in line with relevant accounting standards and financial reporting framework;
- reviewed and discussed the CMS Annual Financial Statements included in this Annual Report with the Auditor-General and the Accounting Officer of the CMS; and
- reviewed the report of the Auditor-General and concurs with its findings.

The Committee reviewed the Annual Financial Statements of the CMS for the year ended 31 March 2011 and is satisfied that they comply with relevant provisions of the PFMA and International Financial Reporting Standards (IFRS) in all material respects and fairly present the financial position of the CMS at that date as well as its results of operations and cash flows for the financial year then ended. The Committee has also satisfied itself on the integrity of the remainder of the integrated report and has recommended both the financial statements and the integrated report for the year ended 31 March 2011 to Council for approval.

Our commitment

The Committee remains committed to working together with Executive Council and all stakeholders to promote sound corporate governance and to strengthen both risk management practices and internal control procedures at the CMS.

Mr Charles Mazhindu
Chairperson
Audit & Risk Committee
26 July 2011

Members of the Audit & Risk Committee

Mr Charles Mazhindu – *independent & non-executive; Chairperson*
Mr Rowan Nicholls – *independent & non-executive*
Mrs Josephine Naicker – *independent & non-executive*
Dr Zola Njongwe – *non-executive & Council member*
Mr Kariem Hoosain – *non-executive & Council member*
Prof. Dion du Plessis – *non-executive & Council member*

Report of the Auditor-General

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

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the accompanying financial statements of the Council for Medical Schemes, which comprise the statement of financial position as at 31 March 2011, the statement of financial performance, the statement of changes in net assets and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory information, as set out on pages 120 to 141.

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 the South African Standards of Generally Recognised Accounting Practice (SA Standards of GRAP) and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA), and for such internal control as management 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. As required by Section 188 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) and Section 4 of the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), my responsibility is to express an opinion on these financial statements based on my audit.

4. I conducted my audit in accordance with International Standards on Auditing and General Notice *1111 of 2010* issued in Government Gazette *33872 of 15 December 2010.* 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.

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

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

Opinion

7. 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 2011, 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

8. In accordance with the PAA and in terms of *General notice 1111 of 2010* issued in *Government Gazette 33872 of 15 December 2010,* I include below my findings on the annual performance report as set out on pages 84 to 119 and material non-compliance with laws and regulations applicable to the Council for Medical Schemes.

Predetermined objectives

Usefulness of information

9. The reported performance information was deficient in respect of the following criteria:

   - **Consistency:** The reported objectives, indicators and targets are not consistent with the approved annual performance plan.
   - **Measurability:** The targets are not specific, measurable, and time-bound.

10. The following audit findings relate to the above criteria:

Reported targets are not complete when compared with the planned targets

11. The actual achievements with regard to 40% of all planned targets specified in the annual performance plan for the year under review were not included in the report on predetermined objectives submitted for audit purposes.

Planned and reported targets are not specific, measurable and time-bound

12. For all objectives, 37% of the planned and reported targets were not:

   - specific in clearly identifying the nature and the required level of performance
   - measurable in identifying the required performance
   - time-bound in specifying the time period or deadline for delivery

Reported performance is not consistent when compared with planned targets

13. The actual achievements with regard to 24% of all planned targets specified in the annual performance plan for the year under review do not relate to the planned targets.

Changes to planned indicators and targets are not approved

14. Different indicators were reported on as opposed to the approved annual performance plan. These different objectives and targets represent 28% of the total reported indicators and targets.

Reliability of information

15. The reported performance information was deficient in respect of the following criteria:

   - **Validity:** The reported performance did not occur and does not pertain to the entity.
   - **Accuracy:** The amounts, numbers and other data relating to reported actual performance have not been recorded and reported appropriately.

- **Completeness:** All actual results and events that should have been recorded have not been included in the reported performance information.

16. The following audit findings relate to the above criteria:

The validity, accuracy and completeness of reported performance against targets could not be confirmed as inadequate supporting source information was provided

17. For the following material reported target, the validity, accuracy and completeness of the reported target could not be established as relevant source documentation could not be provided:

- Review and process applications for accreditation of brokers and broker organisations – 80% of new applicants accredited or accreditation renewed within 14 days of receipt of all relevant information and 100% accredited within 30 days of receipt of all relevant information

Reported performance against targets is not valid and accurate when compared to source information

18. The following material reported targets were not valid and accurate based on the source information or evidence provided:

- Monitoring, investigation or inspection of schemes to ensure good governance and appropriate non-healthcare expenditure – Report/memorandum with recommendations, compiled within one month of completion of the investigation or inspection
- Prepare exemption applications with recommendations for consideration by the Registrar – Seven days before RDC meeting and seven days before Council meeting

Compliance with laws and regulations

Strategic planning

19. Contrary to the requirements of Treasury Regulation (TR) 30.1.3, the strategic plan of the Council was prepared for one year and did not covera three-year period.

Annual financial statements

20. The financial statements submitted for audit did not comply with Section 40(1)(c)(i) of the PFMA. Material misstatements were identified during the audit. These were corrected by management.

Procurement and contract management

21. In certain instances, the accounting authority did not take effective and appropriate steps to prevent and detect irregular expenditure as per the requirements of Section 51(1)(b) of the PFMA. The reasons for the irregular expenditure are disclosed in note 23 to the financial statements (page 141) .

22. For the instances referred to above, goods and services with a transaction value of over R500 000 were not procured by means of a competitive bidding process as per the requirements of TR 16A6.1, TR 16A6.4 and National Treasury Practice Notes 6 and 8 of 2007/08.

INTERNAL CONTROL

23. In accordance with the PAA and in terms of *General notice 1111 of 2010* issued in *Government Gazette 33872 of 15 December 2010,* I considered internal control relevant to my audit, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters reported below are limited to the significant deficiencies that resulted in the findings on the annual performance report and the findings on compliance with laws and Regulations included in this report.

Leadership

- Policies and procedures were not developed and implemented to support the recording and reporting of performance against predetermined objectives.

Financial and performance management

- Internal controls in place were not adequate to prevent and detect irregular expenditure.
- Internal controls were not adequately designed and implemented to support the reporting of predetermined objectives.

Auditor - General

Pretoria
29 July 2011

AUDITOR-GENERAL SOUTH AFRICA
Auditing to build public confidence

Reviewing the operations of medical schemes in 2010

Reviewing the operations of medical schemes in 2010

Number of schemes and options

There were 100 medical schemes registered in South Africa at the end of 2010 compared to 110 schemes at the end of 2009. The number consists of 27 open and 73 restricted medical schemes.

The number of open schemes declined at a more significant rate than restricted schemes: 18.2% or from 33 in 2009 to 27 in 2010. Restricted schemes also experienced a decline, of 5.2% from 77 in 2009 to 73 in 2010. Overall, the number of all registered medical schemes decreased by 9.1% compared to the 7.6% decline in 2009.

Table 5: Number of schemes by size and type as at December 2010

Size of scheme	Type of scheme	2009	2010
Large (≥ 30 000 beneficiaries)	Open	20	14
	Restricted	17	15
	Consolidated	37	29
Medium (≥ 6 000 members but < 30 000 beneficiaries)	Open	8	9
	Restricted	19	20
	Consolidated	27	29
Small (< 6 000 members)	Open	5	4
	Restricted	41	38
	Consolidated	46	42
Total	**Open**	**33**	**27**
	Restricted	**77**	**73**
	Consolidated	**110**	**100**

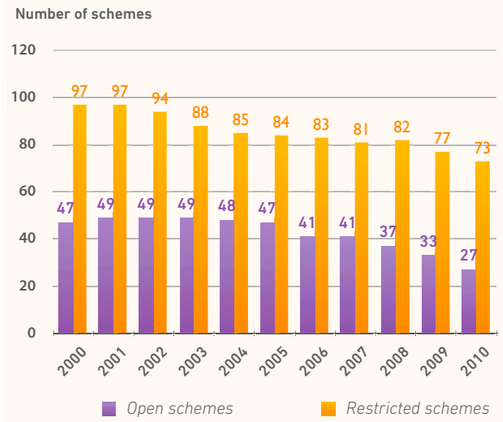
Open schemes had 166 registered benefit options in 2010 compared to 188 options in 2009. This translates into a decline of 11.7% in 2010 compared to the 6.4% decrease experienced in 2009. In the restricted schemes environment, there were 153 benefit options compared to the 160 options in 2009. This represents a decrease of 4.4% which is smaller than the 7.5% decrease observed in 2009.

The average number of benefit options in 2010 was 6.1 in open schemes (5.7 in 2009); the average number of options in restricted schemes relative to 2009 remained unchanged at 2.1. Overall, the average number of options in all medical schemes was 3.2 in 2010.

Trend in the number of schemes

Figure 9 depicts the trend in the number of registered medical schemes from 2000 to 2010.

Figure 9: Trend in number of schemes 2000-2010



The number of registered open schemes decreased by 38.6% – from 47 in 2000 to 27 in 2010. Similarly, the restricted schemes environment experienced a drop in the number of schemes from 97 in 2000 to 73 in 2010, translating into a 24.8% decrease.

Overall, a downward trend in the number of registered schemes can be observed during the 11-year period. The trend can largely be explained by market consolidation through liquidations and mergers.

The overall number of schemes decreased from 144 in 2000 to 100 in 2010, translating into an average rate of decline of four medical schemes per year over a period of 11 years.

Trend in the number of schemes by size

Figure 10 depicts the trend in the number of registered medical schemes by size from 2001 to 2010.

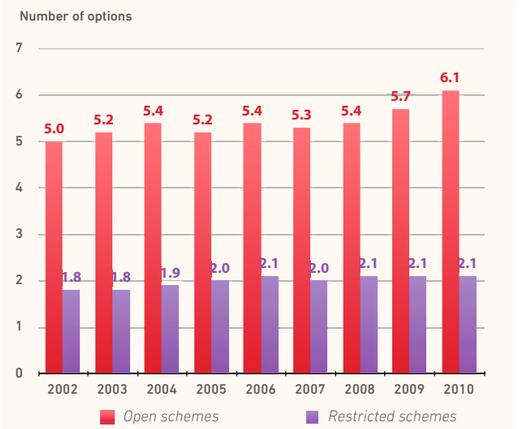
The Figure suggests that there was consolidating restructuring between small and large medical schemes in 2001-2005. But additional competition in 2005 and 2006 destabilised the constant trend among large schemes as small and medium schemes tried to consolidate their market size in response to the emergence of the Government Employees Medical Scheme (GEMS).

Trend in the number of options

In contrast to the decrease in the number of registered medical schemes, the average number of benefit options in open schemes increased from 5.0 in 2002 to 6.1 in 2010, as illustrated in Figure 11. The number of benefit options in restricted schemes increased from an average of 1.8 in 2002 to 2.1 in 2010. Overall, the average number of benefit options in medical schemes demonstrates an upward trend from 2.9 in 2002 to 3.2 benefit options per scheme in 2010.

Figure 10: Trend in number of schemes by size 2001-2010

Figure 11: Trend in number of options 2002-2010



Membership of medical schemes

The number of principal members increased at the slightly faster rate of 3.6% in 2010 compared to the 2.9% increase experienced in 2009. This translates into a total of 3 612 062 principal members in 2010 compared to 3 488 009 in 2009. The number of dependants rose by 2.7% to 4 703 656; the number of beneficiaries increased by 3.1% to 8 315 718.

Open schemes experienced a 1.3% increase in the number of principal members; the number of principal members in restricted schemes rose by 7.1%.

The coverage of beneficiaries in open schemes declined marginally by 0.3% but there was an increase of 8.1% in restricted schemes. See Table 6.

Trend in the number of beneficiaries

Figure 12 depicts the trend in medical scheme coverage from 2000 to 2010.

The number of beneficiaries increased to 8.3 million in 2010 from 6.7 million in 2000; this represents an increase of 23.9%. The number of beneficiaries in open schemes was 4.7 million in 2000 and 4.8 million in 2010. The number of beneficiaries in restricted schemes was 2.1 million in 2000 and 3.5 million in 2010. This means an increase of 2.1% and 66.7% respectively.

The increase in restricted schemes cover may appear dramatic but it is off a low base compared to open schemes. It is also important to note that the increase in beneficiaries belonging to restricted schemes really started in 2006, which coincides with the inception of GEMS.

Table 6: Membership of schemes 2009 and 2010

Type of scheme	Type of membership	2009	2010	% change
Open schemes	Principal members	2 144 369	2 172 723	1.3
	Dependants	2 670 965	2 627 192	-1.6
	Beneficiaries	4 815 334	4 799 915	-0.3
Restricted schemes	Principal members	1 343 640	1 439 339	7.1
	Dependants	1 909 531	2 076 464	8.7
	Beneficiaries	3 253 171	3 515 803	8.1
Total	**Principal members**	**3 488 009**	**3 612 062**	**3.6**
	Dependants	**4 580 496**	**4 703 656**	**2.7**
	Beneficiaries	**8 068 505**	**8 315 718**	**3.1**

Figure 12: Trend in number of beneficiaries 2000-2010

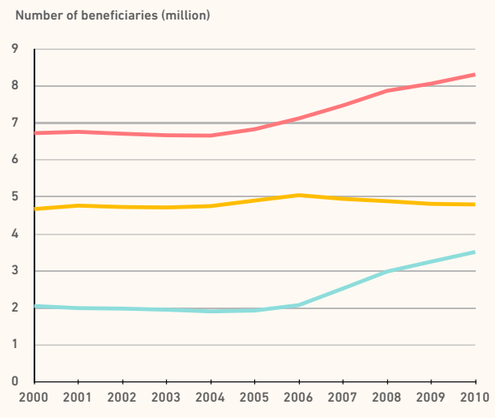
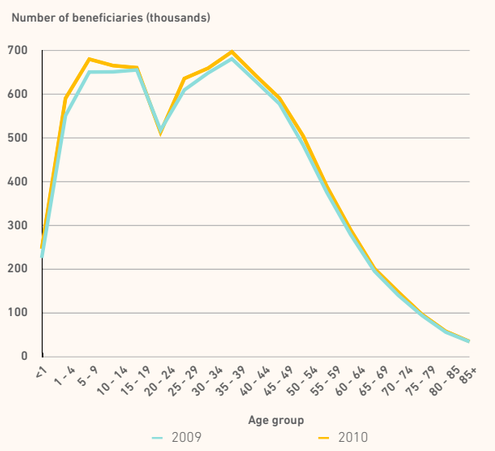


Figure 13: Age distribution of beneficiaries 2009 and 2010



Age distribution of beneficiaries

Figure 13 shows the age distribution of beneficiaries for 2009 and 2010.

A bimodal distribution was again evident.

Increases in the number of beneficiaries were seen from age bands 1-4 to 25-29 as well as from age bands 45-49 to age band 85+. A decline was observed in the number of beneficiaries in age bands <1 and from 30-34 to 40-44.

The average age of beneficiaries was 31.5 in 2010, slightly younger than the 31.6 reported in 2009.

Trend in the average age of beneficiaries

Figure 14 depicts the trend in the average age of beneficiaries from 2004 to 2010.

The Figure illustrates that, until 2006, restricted schemes had an older age profile than open schemes. This changed in 2007; restricted schemes were now younger than open schemes, largely due to the introduction of GEMS. The unique impact of GEMS on the age profile of medical schemes in South Africa is also reflected in the graph. The same trend is true for the pensioner ratio.

Figure 14: Trend in age of beneficiaries 2004-2010

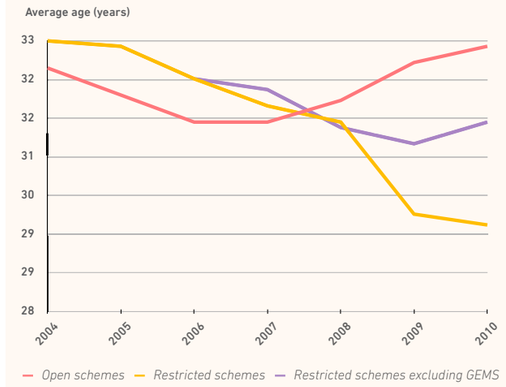
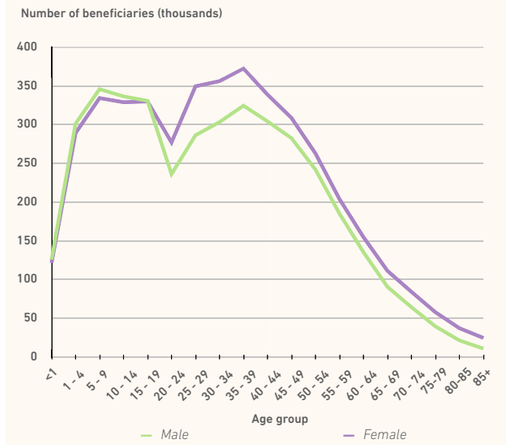


Figure 15: Age and gender distribution of beneficiaries 2010



Gender distribution of beneficiaries

Figure 15 shows the distribution of beneficiaries by gender.

Age bands <1 to 15-19 attracted more male beneficiaries but there were more female beneficiaries from the age group of 20 and older.

As a result, the beneficiaries of medical schemes were made up of proportionately more females than males at 52.3% and 47.7% respectively.

Female beneficiaries were generally older than male beneficiaries; the average age of females belonging to a medical scheme in 2010 was 32.3 years and that of males was 30.7 years.

Pensioner ratio

Table 7 shows that the proportion of pensioners (beneficiaries 65 years old or older) remained unchanged compared to the previous year at 6.5%. Open schemes had a higher pensioner ratio (7.5%) than restricted schemes (5.1%). There were more female (7.3%) than male (5.7%) pensioners. GEMS has improved the overall age profile in restricted schemes while open schemes are now older.

Table 7: Pensioner ratio in schemes 2009 and 2010 (%)

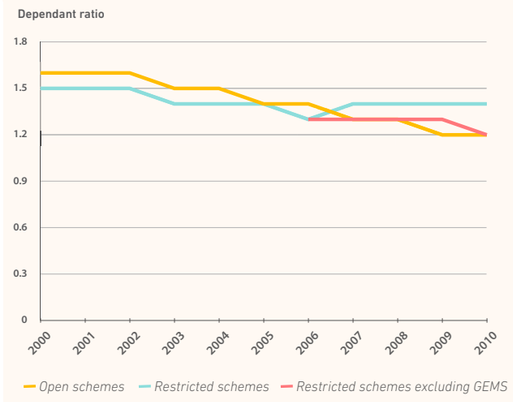
Type of scheme	Gender	2009	2010
Open	Female	8.0	8.4
	Male	6.5	6.6
	All	7.3	7.5
Restricted	Female	6.0	5.7
	Male	4.7	4.5
	All	5.3	5.1
Total	**Female**	**7.2**	**7.3**
	Male	**5.7**	**5.7**
	All	**6.5**	**6.5**

Dependant ratio

The dependant ratio measures the average number of dependants per principal member; it remained unchanged at 1.3 in 2010. The dependant ratio for both open and restricted schemes remained unchanged at 1.2 and 1.4 respectively. Figure 16 shows that the overall dependant ratio declined steadily between 2000 and 2010.

Figure 16 also illustrates that the dependant ratio in restricted schemes started overtaking the ratio in open schemes after the introduction of GEMS in 2006. This implies that more dependants are obtaining cover through GEMS when compared to other medical schemes.

Figure 16: Dependant ratio in schemes 2000-2010

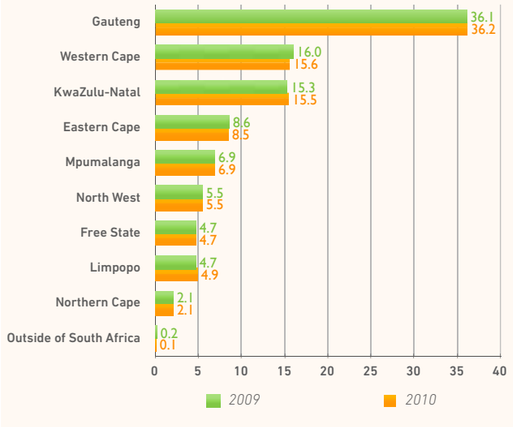


Coverage by province

Figure 17 shows the distribution of beneficiaries by province.

This data was collected primarily on the basis of the location of principal members. More than one third of beneficiaries (36.2%) were located in Gauteng, 15.6% in the Western Cape and 15.5% in KwaZulu-Natal.

Figure 17: Distribution of beneficiaries by province 2010 (%)



Healthcare benefits

Total healthcare benefits paid

Medical schemes spent 11.0% more on healthcare benefits in 2010; this expenditure increased to R84.7 billion from R76.3 billion in 2009.

Figure 18 shows the proportions of benefits which schemes paid to the various categories of providers.

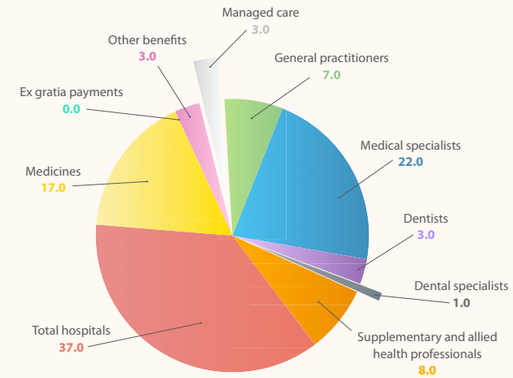
Medical scheme expenditure on hospitals – which includes ward fees, theatre fees, consumables, medicines and per diem arrangements – consumed R31.1 billion or 37.0% of the R84.7 billion paid to all providers. Expenditure on private hospitals increased by 10.0% to R30.8 billion from R28.0 billion in 2009; expenditure on provincial hospitals decreased by 3.0% to R281.5 million from R288.9 million spent in 2009.

Payments to medical specialists amounted to R18.8 billion or 22.0% of total healthcare benefits paid in 2010; this is an increase of 12.0% on 2009.

Benefits which schemes paid for medicines dispensed by pharmacists and providers other than hospitals amounted to R14.0 billion or 17.0% of total benefits paid. This reflects an increase of 5.3% when compared to the R13.3 billion spent in 2009.

Expenditure on general practitioners (GPs) amounted to R6.2 billion or 7.0% of benefits paid, representing an increase of 8.8% from 2009's R5.7 billion. Dentists accounted for R2.5 billion in medical scheme expenditure, an increase of 13.0% on 2009. Expenditure on dental specialists accounted for 1.0% of benefits paid. Benefits paid to supplementary and allied health professionals came to R6.7 billion. The proportion of benefits spent on managed care in 2010 was 3.0% (R2.2 billion), almost double the 1.6% (R1.2 billion) proportion that was paid in 2009.

Figure 18: Total healthcare benefits paid 2010 (%)

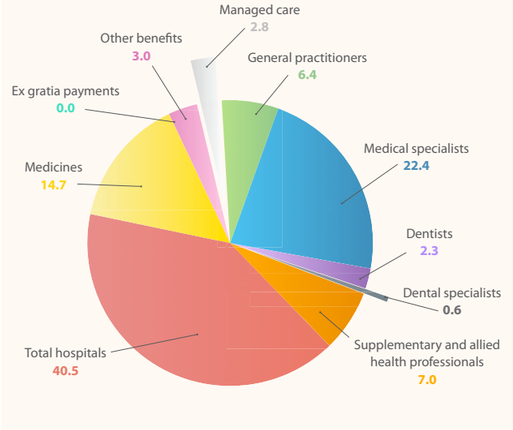


Healthcare benefits paid from risk pool

Healthcare benefits which medical schemes covered from their risk pools amounted to R76.4 billion; this was 90.0% of the total benefits they paid in 2010 and reflects an increase of 10.9% on the R68.9 billion paid in 2009.

Hospital expenditure accounted for 40.5% of risk benefits paid in 2010. Expenditure on medical specialists accounted for 22.4% of total risk pool benefits; medicines took up 14.7%. Expenditure on GPs was R4.9 billion; this represents 6.4% of risk pool benefits.

Figure 19: Healthcare benefits paid from risk pool 2010 (%)



Healthcare benefits paid from medical savings accounts

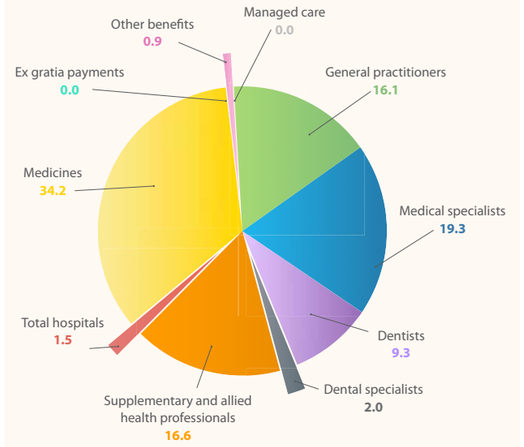
Healthcare benefits paid from medical savings accounts amounted to R8.3 billion (10.0%) of total benefits in 2010.

Figure 20 shows that medicines took up the largest share of medical savings accounts expenditure in 2010 (34.2%). Medical specialists accounted for 19.3% and GPs for 16.1%.

Supplementary healthcare providers took 16.6% of benefits paid from medical savings accounts.

As in previous years, expenditure on hospitals and dental specialists accounted for a comparatively small proportion of benefits paid from medical savings accounts (1.5% and 2.0% respectively).

Figure 20: Healthcare benefits paid from savings accounts 2010 (%)



Trends in total healthcare benefits paid

Figure 21 shows the distribution of healthcare benefits paid by medical schemes to different types of providers since 2000. These figures have been adjusted for inflation.

By 2010, medical scheme expenditure on private hospitals had increased in real terms by 121.6% to R30.8 billion compared to R13.9 billion in 2000. Private hospital expenditure accounted for 29.9% of all healthcare benefits paid in 2000; the comparative figure in 2001 was 28.4%.

Expenditure on private hospitals appeared to stabilise between 2004 and 2005 but a steep upward trend began to emerge in 2006 onwards such that in 2010 private hospital expenditure accounted for 36.4% of all healthcare benefits paid by medical schemes; this was slightly less than the 36.7% noted in 2009.

Benefits paid to medical specialists in 2010 amounted to R18.8 billion, an increase of 104.4% in real terms when compared to the R9.2 billion that was spent on this item in 2000. While expenditure on medical specialists has been increasing steadily since 2000, a trend-break occurred in 2004 with expenditure on specialists starting to increase at a much higher rate.

Expenditure on medicines increased by 11.1% to R14.0 billion in 2010 from R12.6 billion in 2000 but as a proportion of total healthcare benefits, it decreased from 27.0% in 2000 to 19.0% in 2004. In 2005-2010, medicines expenditure remained consistently at 17.0% relative to all benefits paid.

Total expenditure on GPs amounted to R6.2 billion in 2010, which is an increase of 63.2% compared with the R3.8 billion spent in 2000. There was an increase of 4.2% on benefits paid to dentists, from R2.4 billion in 2000 to R2.5 billion in 2010.

Healthcare benefits paid per beneficiary

Figure 22 shows the changes in healthcare expenditure per beneficiary per month (pbpm) from 2000 to 2010.

When adjusted for inflation and membership, expenditure on private hospitals increased by 78.4% from R172.8 pbpm in 2000 to R308.3 pbpm in 2010. An upward trend could be observed between 2000 and 2004 followed by slight stabilisation in 2004-2005. From 2005 the trend in private hospitals expenditure per beneficiary per month started accelerating remarkably and the steep upward trend continued in 2010.

After peaking in 2001, expenditure on medicines continued to decline until 2007. It was R155.6 pbpm in 2000 and declined by 10.0% to R140.0 pbpm in 2009.

Per-beneficiary expenditure on medical specialists increased by 65.0% over the 11-year period from 2000 to 2010, from R113.7 pbpm to R187.6 pbpm respectively; that on GPs increased by 30.1% from R47.6 pbpm in 2000 to R61.9 pbpm in 2010. Medical schemes spent 13.3% less on dentists; they paid R29.3 pbpm in 2000 and R25.4 pbpm in 2010. Spending on dental specialists also declined, namely by 1.6% from R6.1 pbpm in 2000 to R6.0 pbpm in 2010. Medical scheme expenditure on supplementary and allied health professionals increased by 77.5% – from R37.8 pbpm in 2000 to R67.1 pbpm in 2010.

Figure 21: Total healthcare benefits paid: 2010 prices*

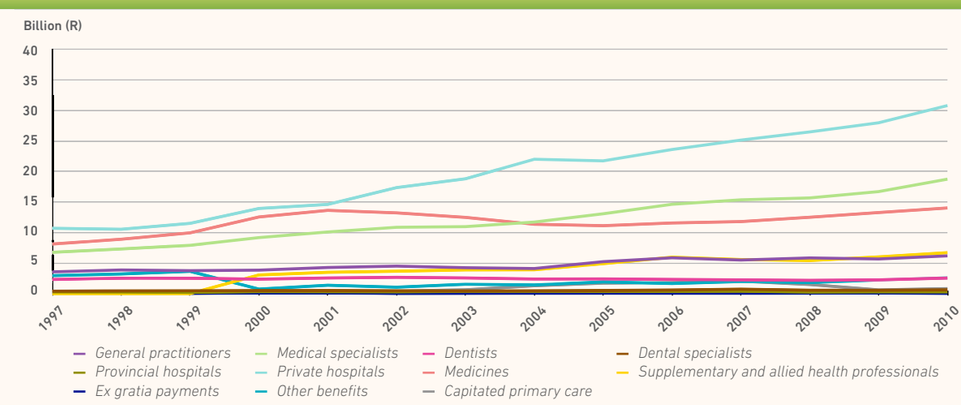
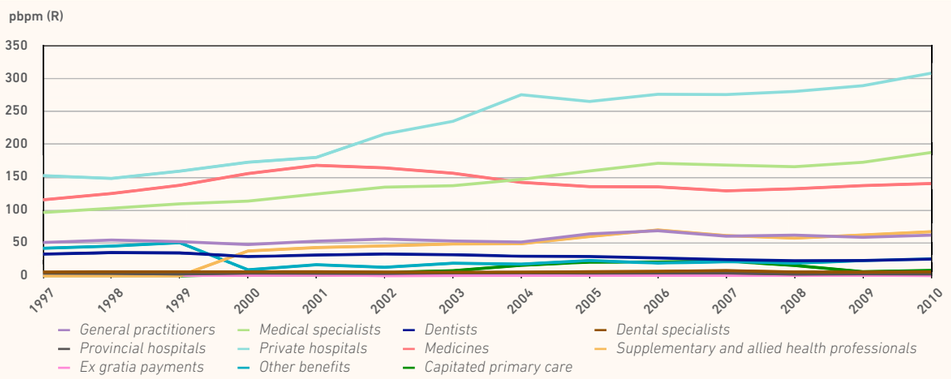


Figure 22: Total healthcare benefits paid per beneficiary per month: 2010 prices*



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

Utilisation of services

The number of beneficiaries who visited GPs and private nurses at least once in 2010 were 760.8 and 9.0 per 1 000 beneficiaries respectively. This is an increase of 9.0% for GP utilisation and an increase of 5.9% for private nurse utilisation. The number of beneficiaries visiting a dentist at least once in 2010 increased to 229.9 from 225.7 per 1 000 in 2009.

The number of beneficiaries admitted to private hospitals decreased to 184.6 per 1 000 in 2010 from 193.2 per 1 000 beneficiaries in 2009.

The number of beneficiaries admitted to public hospitals increased to 9.6 per 1 000 in 2009 from 9.5 per 1 000 beneficiaries in 2009.

The number of beneficiaries admitted to private hospitals for prescribed minimum benefits (PMBs) decreased to 95.3 in 2010 from 96.5 in 2009 per 1 000 beneficiaries, and the number of beneficiaries admitted to public hospitals for PMB conditions remained unchanged at 5.1 per 1 000 beneficiaries.

Table 8: Utilisation of healthcare services 2010 (per 1 000 beneficiaries)

	Open schemes	Restricted schemes	Consolidated	Consolidated	
		2010		2009	% change
Number of beneficiaries visiting a private provider at least once in 2010					
General practitioner	746.7	780.3	760.8	739.9	9.0
Dentist	216.9	247.9	229.9	225.7	8.0
Private nurse	8.3	10.1	9.0	8.8	5.9
Number of beneficiaries visiting a private facility at least once in 2010					
Beneficiaries admitted to hospital*	195.5	169.6	184.6	193.2	-4.5
Beneficiaries admitted for emergency	44.6	42.2	43.6	NC	NC
Admissions**	239.4	194.8	220.6	NC	NC
Same-day admissions	18.4	72.4	41.2	NC	NC
Total admissions	257.8	267.3	261.8	280.4	-6.6
Beneficiaries admitted to hospital for PMBs	96.3	93.8	95.3	96.5	-1.3
Number of beneficiaries visiting a public facility at least once in 2010					
Beneficiaries admitted to hospital*	4.5	16.7	9.6	9.5	1.1
Beneficiaries admitted for emergency	0.1	1.2	0.6	0.6	15
Admissions**	6.9	5.2	6.2	NC	NC
Same-day admissions	0.2	28.9	12.3	NC	NC
Total admissions	7.2	34.1	18.5	NC	NC
Beneficiaries admitted to hospital for PMBs	3.2	7.7	5.1	5.1	NC

** Number of beneficiaries admitted per 1 000 beneficiaries – unique admissions*
*** Number of admissions per 1 000 beneficiaries – all admissions*

Figure 23 depicts the utilisation of private hospitals, including day clinics, per 1 000 beneficiaries in 2010.

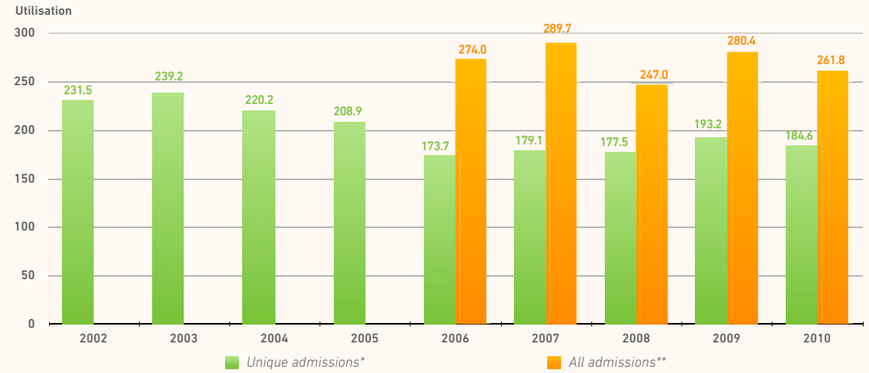
The number of beneficiaries admitted to private hospitals decreased from 193.2 in 2009 to 184.6 per 1 000 beneficiaries in 2010. The number of total admissions declined from 280.4 admissions in 2009 to 261.8 admissions per 1 000 beneficiaries in 2010. The utilisation of private nurse services increased between 2009 and 2010, as reflected in Table 9.

Visits to GPs and dentists

The average number of visits to a GP per beneficiary per annum decreased slightly from 3.0 in 2009 to 2.9 in 2010; the average number of visits in restricted medical schemes was 3.3 per beneficiary per annum and in open schemes the average number of visits was 2.7 per year.

The average number of visits to a dentist remained unchanged at 0.5 per beneficiary per year. For open and restricted schemes the numbers were 0.4 and 0.5 visits per beneficiary per year respectively.

Figure 23: Utilisation of private hospitals 2002-2010 (per 1 000 beneficiaries)



** Unique admissions – number of beneficiaries admitted*
*** All admissions – number of admissions*

Table 9: Utilisation of healthcare services 2009 and 2010 (per beneficiary per annum)

	Open schemes	Restricted schemes	Consolidated	Consolidated
		2010		2009
Visits to a GP	2.7	3.3	2.9	3.0
Visits to a dentist	0.4	0.5	0.5	0.5
Visits to a private nurse*	0.0	0.0	0.0	0.0

The 2009 figures have been restated.
** The numbers were too insignificant to be reflected.*

Length of stay in hospital

In 2010, medical scheme beneficiaries spent an average of 3.3 days in private hospitals; the comparative figure for 2009 was 3.2 days (where the figures for 2009 have been restated). The average length of stay for restricted scheme beneficiaries was significantly higher than that for open schemes, at 4.4 and 2.4 days respectively.

Beneficiaries stayed an average of 1.6 days in public hospitals; this was slightly lower than the 1.7 days observed in 2009. As with private hospitals, the average length of stay for restricted scheme beneficiaries was higher than that for open schemes, at 1.8 days and 0.1 days respectively.

Burden of disease

Figure 24 shows the prevalence of the PMB chronic conditions that medical schemes are required by law to cover in full on all their benefit options. The data is for 2009 and 2010. Schemes who did not submit data on chronic conditions were excluded from the analysis. And despite all the difficulties with the quality of the data that schemes had submitted, the CMS took every care to ensure that the data is complete and accurate.

For 2010, the data represented 95.1% of schemes (97.3% in 2009) and 99.8% of beneficiaries (99.5% in 2009). The analysis for 2010 showed that the most prevalent PMB chronic condition in medical schemes was hypertension at 112.5 cases per 1 000 beneficiaries (97.4 in 2009), followed by hyperlipidaemia at 50.9 (44.1 in 2009), Diabetes Mellitus Type 2 at 31.2 (26.2 in 2009) and asthma at 27.9 (24.1 in 2009).

The prevalence of chronic conditions was higher in open schemes than in restricted schemes; this is in line with the fact that open schemes have an older membership compared to restricted schemes.

Contributions, healthcare expenditure[1] and trends

Medical scheme contributions increased by 13.7% to R96.5 billion as at December 2010 from R84.9 billion in December 2009. Total gross relevant healthcare expenditure incurred by medical schemes increased by 11.3% to R84.9 billion[2] from R76.3 billion in 2009.

Gross contributions per average beneficiary per month (pabpm) grew by 9.6% to R975.3 from R890.0 in 2009. Total gross relevant healthcare expenditure incurred pabpm increased by 7.3% to R858.4 from R800.2 in 2009.

Risk contributions and relevant healthcare expenditure

Risk contributions (net of medical savings accounts contributions) increased by 13.7% to R87.7 billion from R77.1 billion in 2009; the increase from 2008 to 2009 was 14.8%. The increase in risk contributions pabpm was 9.6% to R886.9 from R808.9 (2009: 11.4%).

Risk claims increased by 11.2% to R76.6 billion from R68.9 billion in 2009 (2009: 18.1%). Risk claims pabpm rose by 7.2% to R774.6 from R722.5 (2009: 14.6%).

Medical savings accounts contributions and relevant healthcare expenditure

Contributions to medical savings accounts increased by 13.2% to R8.7 billion in 2010 from R7.7 billion (2009: 11.7% increase). When measured on a pabpm basis in respect of only those schemes who had savings transactions, the increase was 4.9% – from R105.7 to R110.8 (2009: 4.7% increase).

Claims paid from medical savings accounts increased by 12.0% to R8.3 billion from R7.4 billion (2009: 13.5% increase). On a pabpm basis for schemes who had savings transactions, medical savings accounts claims increased by 3.7% to R105.0 from R101.2 (2009: 6.5% increase).

Figure 25 shows that up to 2006, medical savings accounts contributions and claims increased at greater rates than those recorded for the risk component. This indicates a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

But the lower figures in 2007-2010 appear to reflect a change in this trend. This is partly attributable to the decision of the Council for Medical Schemes (CMS) not to allow variable savings rates on an option, which resulted in a number of schemes no longer offering any savings plan accounts.

Figure 24: Chronic conditions in schemes 2009 and 2010 (per 1 000 beneficiaries)

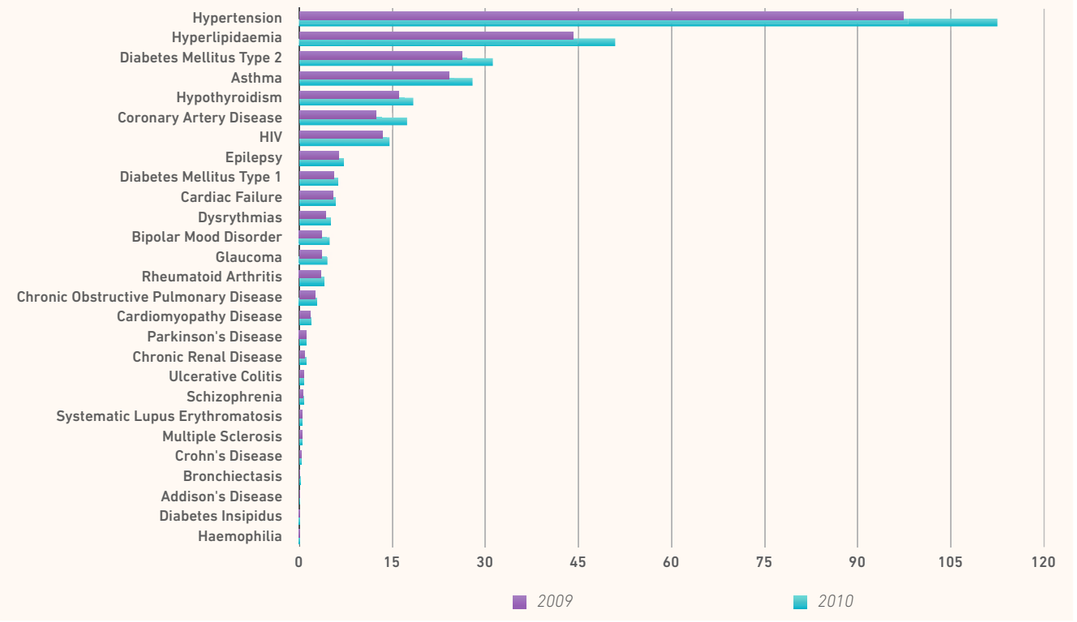
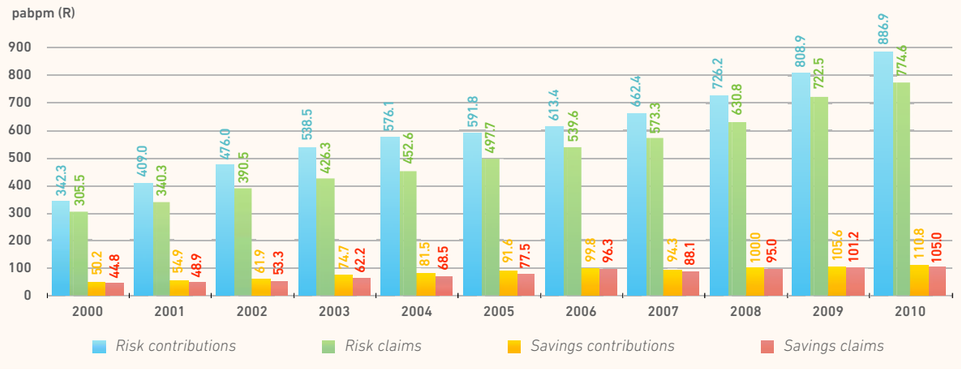


Figure 25: Risk and medical savings accounts contributions and claims pabpm 2000-2010



pabpm = per average beneficiary per month

1 All references to claims and benefits indicate relevant healthcare expenditure.
2 This number differs from the R84.7 billion reported elsewhere as "benefits paid" because we have included the IBNR and the results of risk transfer arrangements.

Contributions and relevant healthcare expenditure by type of scheme

Table 10 and Figures 26 and 27 show contributions and claims for open and restricted schemes pabpm.

Increases in risk claims pabpm were generally slightly lower in restricted schemes than in open schemes. From 2008 onwards, restricted schemes experienced decreases in claims from members' medical savings accounts while open schemes incurred an increase.

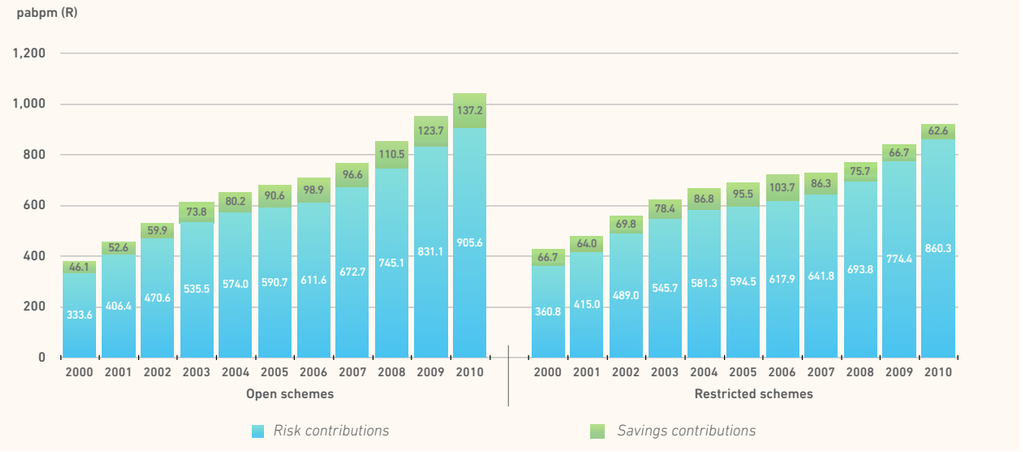
The risk claims ratio in open schemes decreased to 84.7% in 2010 from 86.6% in 2009; in restricted schemes it decreased to 91.3% from 93.9% in 2009.

Table 10: Contributions and relevant healthcare expenditure pabpm 2000-2010

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	333.6	-	46.1	-	292.4	-	41.3	-
2001	406.4	21.8	52.6	13.9	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	14.0	379.3	14.4	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.7	77.5	13.6
2006	611.6	3.5	98.9	9.1	522.9	8.0	95.9	23.6
2007	672.7	10.0	96.6	(2.3)	562.1	7.5	91.6	(4.4)
2008	745.1	10.8	110.5	14.3	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
Restricted schemes								
2000	360.8	-	66.7	-	333.1	-	58.8	-
2001	415.0	15.0	64.0	(4.0)	360.9	8.3	57.9	(1.5)
2002	489.0	17.8	69.8	9.0	417.9	15.8	60.3	4.2
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.5
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.6
2005	594.5	2.3	95.5	10.1	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.3
2007	641.8	3.9	86.3	(16.8)	595.7	2.3	75.7	(18.4)
2008	693.8	8.1	75.7	(12.3)	638.0	7.1	66.2	(12.5)
2009	774.4	11.6	66.7	(11.9)	727.3	14.0	61.7	(6.9)
2010	860.3	11.1	62.6	(6.1)	785.1	8.0	57.5	(6.7)

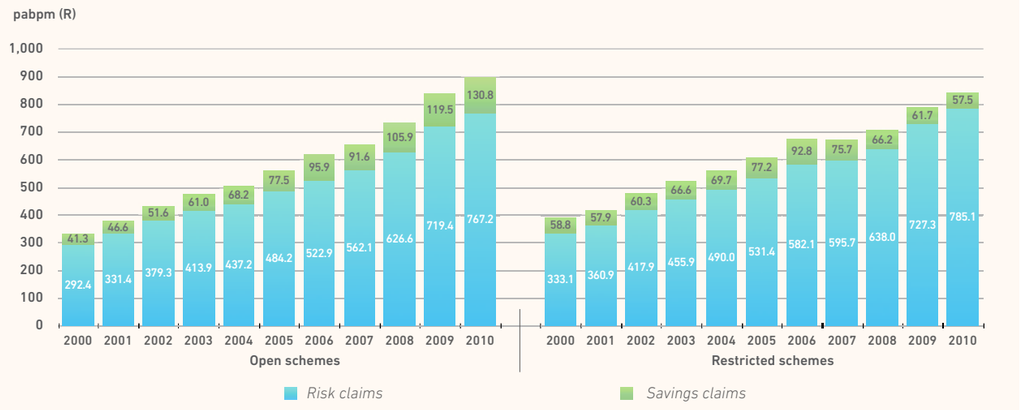
pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes who had savings transactions

Figure 26: Risk and savings contributions pabpm 2000-2010



pabpm = per average beneficiary per month

Figure 27: Risk and savings claims pabpm 2000-2010



pabpm = per average beneficiary per month

Table 11 indicates the changes in contributions and claims after adjusting for inflation. Medical schemes experienced increases in risk contributions and claims pabpm, and a noted decrease in savings contributions and claims. Even though savings contributions and claims have decreased over the last three years, it appears that the rate of decrease is slowing down.

The proportion of claims paid from medical savings accounts decreased to 11.9% during the review period from 12.3% in 2009, as shown in Figure 28.

For open schemes, the proportion of claims paid from medical savings accounts increased from 14.2% in 2009 to 14.6% in 2010; the medical savings accounts claims ratio decreased to 95.4% from 96.6%.

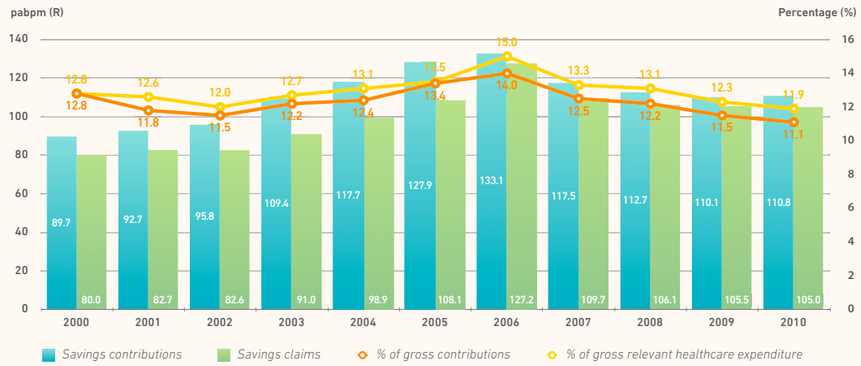
For restricted schemes, the proportion of claims paid from medical savings accounts decreased from 7.8% in 2009 to 6.8% in 2010. The medical savings accounts claims ratio decreased to 91.9% from 92.5% in 2009.

Table 11: Contributions and relevant healthcare expenditure pabpm 2000-2010: 2010 prices

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
All schemes								
2000	611.8	-	89.7	-	546.1	-	80.0	-
2001	691.1	13.0	92.7	3.4	575.1	5.3	82.7	3.3
2002	737.4	6.7	95.8	3.4	605.0	5.2	82.6	(0.1)
2003	788.4	6.9	109.4	14.2	624.0	3.1	91.0	10.2
2004	831.4	5.5	117.7	7.5	653.1	4.7	98.9	8.7
2005	826.3	(0.6)	127.9	8.7	694.9	6.4	108.1	9.4
2006	818.6	(0.9)	133.1	4.1	720.1	3.6	127.2	17.6
2007	824.9	0.8	117.5	(11.8)	713.9	(0.9)	109.7	(13.8)
2008	811.1	(1.7)	112.7	(4.1)	704.6	(1.3)	106.1	(3.3)
2009	843.6	4.0	110.1	(2.3)	753.5	6.9	105.5	(0.6)
2010	886.9	5.1	110.8	0.6	774.6	2.8	105.0	(0.5)

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes who had savings transactions

Figure 28: Medical savings accounts contributions and claims pabpm 2000-2010: 2010 prices



pabpm = per average beneficiary per month

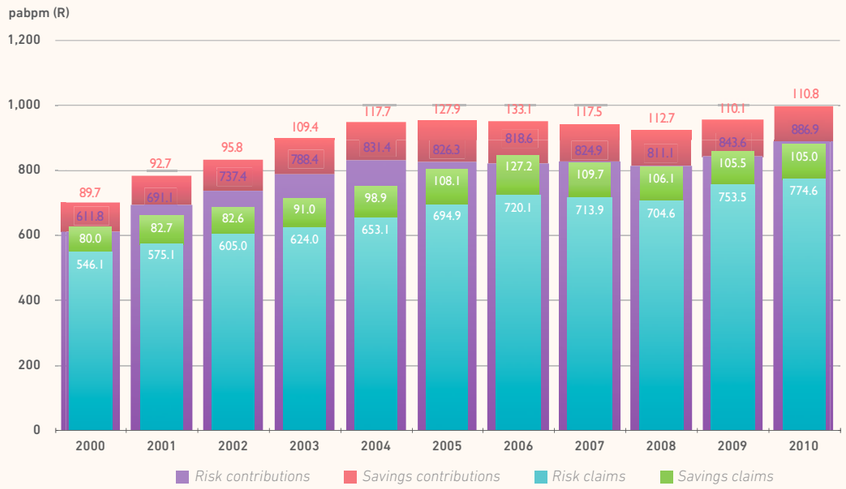
Contributions and relevant healthcare expenditure since 2000

Figure 29 tracks the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims increased by 45.0% and 41.9% respectively; medical savings accounts contributions and claims rose by 23.6% and 31.2% respectively.

Figure 30 shows the relationship between risk contributions and claims paid over the past decade, after adjusting for inflation.

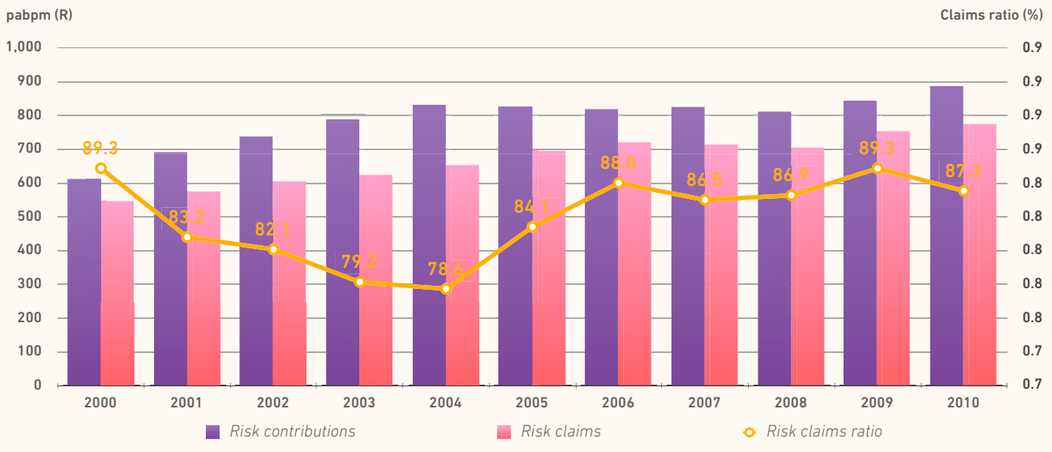
After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised to 86.5% in 2007 and 86.9% in 2008. It then increased further to 89.3% in 2009 before declining to 87.3% in 2010. This means that medical schemes paid out 87.3% of contributions in benefits.

Figure 29: Risk and medical savings accounts contributions and claims pabpm 2000-2010: 2010 prices



pabpm = per average beneficiary per month

Figure 30: Risk claims ratio for all schemes 2000-2010: 2010 prices



pabpm = per average beneficiary per month

Risk transfer arrangements

Over the last few years, schemes have increasingly resorted to risk transfer arrangements to try and manage their insurance risks.

Table 12 reflects the main components of such arrangements:

- the capitation fees which schemes paid to third parties to manage their risks;
- the estimated costs which schemes would have incurred had they not used risk transfer arrangements; and
- the net effect thereof.

The "net income/(expense)" column reflects the value derived from the risk transfer arrangement. (Annexure T provides further details.)

Table 13 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 14 details the 10 biggest loss-making benefit options in 2010.

Discovery Health Medical Scheme (Discovery) is listed in both Tables 13 and 14 as the biggest loss-maker. The Incentive Any GP / Pharmacy & Any Hospital benefit option on Momentum Health suffered the biggest loss in terms of the percentage of capitation fees paid (107.1%), followed by Discovery's KeyCare Plus option (70.5%) and Impala Medical Plan which has a single option (40.3%) (see Table 14).

Table 12: Significant risk transfer arrangements 2009 and 2010

	Capitation fees			Estimated recoveries			Net income/(expense)		
	2010 R'000	2009 R'000	% growth	2010 R'000	2009 R'000	% growth	2010 R'000	2009 R'000	% growth
Open schemes	2 133 933	2 016 246	5.8	(2 105 757)	(1 892 337)	11.3	(7 839)	(63 410)	(87.6)
Restricted schemes	925 005	1 019 859	(9.3)	(988 988)	(1 034 151)	(4.4)	(966)	(6 575)	(85.3)
All schemes	**3 058 938**	**3 036 104**	**0.8**	**(3 094 746)**	**(2 926 488)**	**5.7**	**(8 805)**	**(69 985)**	**(87.4)**

Table 13: Schemes with highest risk transfer arrangement losses 2010

Ref. no.	Name of medical scheme	Beneficiaries	Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Net income/ (expense)	Net income/ (expense) as % of capitation fees
		As at 31.12.2010	R'000	R'000	R'000	R'000	%
1125	Discovery Health Medical Scheme	2 244 894	169 965	(218 889)	-	(48 923)	-28.78
1537	Hosmed Medical Aid Scheme	95 735	118 198	(153 132)	-	(34 935)	-29.56
1149	Medihelp	246 106	383 856	(409 009)	-	(25 153)	-6.55
1591	Impala Medical Plan	18 008	56 657	(79 495)	-	(22 837)	-40.31
1576	Liberty Medical Scheme	158 656	69 034	(91 650)	-	(22 616)	-32.76
1598	Government Employees Medical Scheme (GEMS)	1 458 437	85 608	(105 043)	-	(19 434)	-22.70
1279	Bankmed	202 189	83 050	(97 362)	-	(14 313)	-17.23
1600	Motohealth Care	70 419	50 594	(62 496)	-	(11 902)	-23.52
1599	Lonmin Medical Scheme	17 248	39 568	(51 434)	-	(11 866)	-29.99
1466	Goodhope Medical Aid Society	7 137	34 343	(42 163)	-	(7 821)	-22.77

Table 14: Options with highest risk transfer arrangement losses 2010

Ref. no.	Name of medical scheme	Name of benefit option	Beneficiaries	Average age pb	Capitation fees	Estimated recoveries	Profit/ (loss) sharing	Net income/ (expense)	Net income/ (expense) as % of capitation fees
			As at 31.12.2010	Years	R'000	R'000	R'000	R'000	%
1125	Discovery Health Medical Scheme	KeyCare Plus	313 112	26.4	81 647 949	139 194 100	-	(57 546 151)	-70.5
1598	Government Employees Medical Scheme (GEMS)	Emerald	1 153 199	26.1	67 291 920	82 568 308	-	(15 276 388)	-22.7
1537	Hosmed Medical Aid Scheme	Step	19 637	33.2	86 629 168	118 272 559	-	(31 643 391)	-36.5
1591	Impala Medical Plan*	Impala Medical Plan	18 008	29.0	56 657 106	79 494 570	-	(22 837 464)	-40.3
1576	Liberty Medical Scheme	Corporate Network	11 129	30.3	31 250 618	42 892 557	-	(11 641 939)	-37.3
		Bona Plus	17 595	30.4	30 574 858	40 826 246	-	(10 251 388)	-33.5
1599	Lonmin Medical Scheme*	Lonmin Medical Scheme Benefit Plan	17 248	36.0	39 567 811	51 434 302	-	(11 866 491)	-30.0
1149	Medihelp	Necesse	39 433	29.0	119 418 540	148 262 753	-	(28 844 213)	-24.2
		Dimension Prime 3	58 796	31.4	62 522 021	73 640 991	-	(11 118 970)	-17.8
1167	Momentum Health	Incentive Any GP / Pharmacy & Any Hospital	27 358	41.2	21 629 000	44 797 000	-	(23 168 000)	-107.1

pb = per beneficiary
** Scheme with one benefit option*

Non-healthcare expenditure

The non-healthcare expenditure of medical schemes consists mainly of:

- administration expenditure;
- managed healthcare: management services (fees for managing health benefits);
- commissions and service fees paid to brokers;
- other distribution costs; and
- impaired receivables.

Administration expenditure

Administration expenditure in all medical schemes grew by 4.4% to R7.8 billion by the end of December 2010 from R7.5 billion in 2009. Open schemes increased their administration expenditure by 1.4% to R5.6 billion from R5.5 billion in 2009. The 13.1% increase from R2.0 billion in 2009 to R2.2 billion in 2010 in restricted schemes reflects the significant increase in their membership numbers during the year under review. (GEMS alone experienced a 34.7% increase in the number of average beneficiaries.)

A total of 14 open schemes (representing 5.6% of all average beneficiaries) and 13 restricted schemes (representing 2.7% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of Gross Contribution Income (GCI) in 2010.

Table 15 shows "high-impact"[3] open schemes with administration expenditure greater than 10.0% of GCI. A high percentage is sometimes the function of a low average contribution rather than high absolute administration costs.

Table 16 shows high-impact open schemes with administration expenditure above the open schemes industry average of R96.6 pabpm; when excluding self-administered schemes, this average increases to R97.8 pabpm. As mentioned, high percentages may be the result of low average contributions, but we are concerned that, relative to the open schemes industry average, some of these schemes have high administration costs as a percentage of GCI and on a pabpm basis.

Table 15: High-impact open schemes with administration expenditure above 10.0% of GCI (2010)

Name of medical scheme	Average beneficiaries	Administration expenditure as % of GCI
Hosmed Medical Aid Scheme	97 741	12.0
Resolution Health Medical Scheme	65 282	10.7
Selfmed Medical Scheme	20 234	13.6
Spectramed	95 146	10.2
Profmed	62 454	17.8

GCI = Gross Contribution Income

Table 16: High-impact open schemes with administration expenditure above the open schemes industry average of R96.6 pabpm (December 2010)

Name of medical scheme	Average beneficiaries	Administration expenditure pabpm R
Bestmed Medical Scheme	141 759	113.2
Discovery Health Medical Scheme	2 171 742	105.0
Fedhealth Medical Scheme	172 030	100.5
Keyhealth	97 898	104.4
Medihelp	237 282	105.5
Pro Sano Medical Scheme	68 541	100.5
Resolution Health Medical Scheme	65 282	107.6
Selfmed Medical Scheme	20 234	135.6
Spectramed	95 146	116.7

pabpm = per average beneficiary per month

3 Refer to the section on the Risk Assessment Framework (RAF).

Table 17 shows the gross administration fees paid to third-party administrators as well as administration expenditure incurred in respect of self-administered schemes. These fees are the sum of administration fees, co-administration fees and other indirect expenses.

On average, third party-administered open schemes spent 99.7% more on gross administration fees than third party-administered restricted schemes (2009: 89.3%).

Administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE); they grew by 6.5% to R5.9 billion in 2010 from R5.6 billion in the previous year. These fees represented 83.2% of GAE in 2010 (2009: 82.3%).

Expenditure on management of benefits: managed healthcare fees

Managed healthcare management fees increased by 16.2% to R2.3 billion in 2010 from R1.9 billion in 2009. In 2010, the number of members covered by these managed healthcare interventions increased by 3.3% to 8 217 817 beneficiaries (or 98.8% of all beneficiaries).

Table 18 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare management fees. There were 66 options in this category, and they accounted for 6.9% of beneficiaries in respect of whom such expenditure was incurred.

Table 17: Gross administration fees paid to third-party administrators 2009 and 2010

	Open schemes			Restricted schemes		
	pabpm	pabpm		pabpm	pabpm	
	2010 R	2009 R	% variance	2010 R	2009 R	% variance
Third-party administrators						
Direct administration fees	83.7	79.7	5.1	42.1	42.1	0.1
Co-administration fees	6.8	0.4	1 419.0	0	0	0
Indirect expenses paid	1.8	0	100	0.3	0.3	(4.3)
Total: third-party administrators	**84.1**	**79.7**	**5.6**	**42.1**	**42.1**	**0.1**
Self-administered medical schemes						
Direct administration fees	22.8	10.7	113.8	33.5	26.8	24.9
Co-administration fees	-	-	-	5.1	4.7	9.6
Indirect expenses paid	-	-	-	-	-	-
Total: self-administered medical schemes	**22.8**	**10.7**	**113.8**	**9.4**	**8.1**	**16.6**

pabpm = per average beneficiary per month

Table 18: Managed healthcare management fees in respect of options with a claims ratio above 100.0% (2010)

	Managed care costs	Managed care costs	Gross healthcare result*	Gross healthcare result*	Beneficiaries	Number of options
	R'000	pbpm	R'000	pbpm		
Open schemes	52 158	24.0	(456 601)	(210.4)	180 872	28
Restricted schemes	93 291	20.3	(588 797)	(128.0)	383 321	38
All schemes	**145 449**	**21.5**	**(1 045 397)**	**(154.4)**	**564 193**	**66**

pbpm = per beneficiary per month
** Gross healthcare result = contributions less claims*

Fees of trustees and Principal Officers

Remuneration and other considerations of trustees and Principal Officers rated 0.7% and 0.9% of GAE respectively.

As in 2009, the fees of Principal Officers came to 0.6% of GAE in open schemes; they came to 1.5% in restricted schemes, slightly less than the 1.6% in 2009.

Table 19 shows the 10 schemes with the highest average fees of trustees.

More details are contained in Annexure Q.

Trends in administration and managed healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2010 at 67.6% (2009: 69.2%). Managed healthcare management fees made up 19.5% of non-healthcare expenditure in 2010 (2009: 17.9%).

Administration expenditure and managed healthcare management fees effectively accounted for 10.4% of GCI in 2010 (2009: 11.1%).

Table 20 shows administration and managed healthcare expenditure by type of scheme administration.

Table 19: Top 10 trustee fees (2010)

Name of medical scheme	Trustee remuneration and other considerations		
	R'000	Number of trustees	Average fee per trustee R'000
Liberty Medical Scheme	4 536	11	412
Medshield Medical Scheme	3 794	13	292
Bestmed Medical Scheme	3 630	22	165
Fedhealth Medical Scheme	3 548	13	273
Government Employees Medical Scheme (GEMS)	2 769	16	173
Bonitas Medical Fund	2 585	10	259
Chartered Accountants (SA) Medical Aid Fund (CAMAF)	2 302	11	209
LA-Health Medical Scheme	1 927	15	128
Spectramed	1 785	5	357
Profmed	1 694	11	154

Table 20: GAE and managed healthcare expenditure 2000-2010

	Open schemes				Restricted schemes			
	Self-administered		Third-party		Self-administered		Third-party	
	pabpm R	% change	pabpm R	% change	pabpm R	% change	pabpm R	% change
2000	37.5	-	48.7	-	24.7	-	38.3	-
2001	62.8	67.5	62.7	28.9	31.3	26.6	41.5	8.4
2002	55.8	(11.2)	69.8	11.3	37.3	19.4	49.3	18.8
2003	69.2	24.0	78.4	12.3	33.0	(11.7)	55.8	13.2
2004	75.9	9.8	86.1	9.8	43.3	31.4	59.1	6.1
2005	80.8	6.4	91.9	6.8	41.8	(3.5)	67.8	14.7
2006	84.1	4.1	96.9	5.4	39.0	(6.7)	67.2	(0.9)
2007	89.8	6.8	101.8	5.0	41.3	6.0	65.8	(2.0)
2008	96.5	7.5	108.5	6.6	41.8	1.3	65.5	(0.5)
2009	109.8	13.8	118.6	9.3	45.1	7.8	71.9	9.7
2010	106.2	(3.3)	124.4	4.9	54.6	21.1	74.2	3.3

GAE = Gross Administration Expenditure
pabpm = per average beneficiary per month

During 2010, there were 6 self-administered open schemes (2009: 5) representing 555 064 average beneficiaries (2009: 479 803) and 24 third party-administered open schemes (2009: 28) representing 4 282 646 average beneficiaries (2009: 4 350 837).

Self-administered open schemes experienced a decrease of 3.3% from R109.8 pabpm to R106.2 pabpm while third party-administered open schemes increased their expenditure by 4.9% to R124.4 pabpm from R118.6 pabpm in 2009. Third party-administered open schemes paid 17.1% more for administration and managed healthcare services than self-administered open schemes; the proportion was 8.0% in 2009.

In 2010 there were 9 self-administered restricted schemes (2009: 10) representing 248 948 beneficiaries (2009: 260 657) and 66 third party-administered restricted schemes (2009: 67) representing 3 156 869 beneficiaries (2009: 2 854 921). Third party-administered restricted schemes spent on average 35.9% more on administration and managed healthcare management fees at R74.2 pabpm compared to the R54.6 pabpm of self-administered restricted schemes.

Table 20 also shows that self-administered open schemes paid 94.4% (2009: 143.5%) more pabpm for administration and managed healthcare expenditure than self-administered restricted schemes. Third party-administered open schemes paid 67.6% (2009: 65.0%) more pabpm for administration and managed healthcare expenditure than third party-administered restricted schemes.

Table 21 takes the 10 largest schemes by number of average beneficiaries and shows their total expenditure on administration and managed healthcare management fees. The industry averages were 8.1% for gross administration and 10.5% for gross administration plus managed healthcare as a percentage of Gross Contribution Income (GCI).

Table 21: Administration expenditure of 10 largest schemes (2010)

Name of medical scheme	Type	Average beneficiaries	GAE as % of GCI	GAE + managed healthcare expenditure as % of GCI
Discovery Health Medical Scheme	Open	2 171 742	9.9	12.7
Government Employees Medical Scheme (GEMS)	Restricted	1 335 772	4.7	6.7
Bonitas Medical Fund	Open	628 542	8.6	11.5
South African Police Service Medical Scheme (POLMED)	Restricted	475 882	4.3	6.4
Medihelp	Open	237 282	7.9	9.4
Bankmed	Restricted	201 250	7.2	9.4
Medshield Medical Scheme	Open	193 636	6.6	8.7
Fedhealth Medical Scheme	Open	172 030	8.6	10.6
Liberty Medical Scheme	Open	170 008	9.7	12.4
Momentum Health	Open	168 060	8.7	11.1

GAE = Gross Administration Expenditure
GCI = Gross Contribution Income

Table 22 shows the 10 schemes with the highest marketing, advertising and broker costs; they are all open medical schemes. This also shows the expenditure they incurred when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 1.3% from 2009 to 2010.

The member growth shown in Table 22 does not necessarily indicate new members whose lives were not previously covered but rather members who moved from other schemes.

Broker costs

Broker costs include all commissions, service fees and other distribution costs.

Broker costs increased with 8.9% from R1.2 billion in 2009 to R1.3 billion in 2010. They represented 11.4% of total non-healthcare expenditure in 2010; broker costs as a percentage of total non-healthcare expenditure was 11.2% in 2009.

For schemes that pay broker commissions, the amounts paid on a "per average member per month" (pampm) basis increased to R44.4 pampm in 2010 from R41.2 pampm in 2009, representing an increase of 7.7%. Broker commissions as a percentage of GCI remained stable at 2.0%.

Figure 31 shows annual broker service fees since 2000 as well as their percentage shares of total non-health expenditure.

Figure 32 illustrates the increase in broker fees relative to membership of schemes who pay brokers.

Broker service fees have been rising sharply over the past few years, resulting in their rates of increase now far exceeding the increases in number of members. For those schemes who paid brokers, broker service fees pampm increased by 190.3% since 2000 compared with an 84.8% net increase in the average number of members. The substantial increases in broker service fees are not proportional to the increase in new members.

Table 23 illustrates the schemes with broker service fees higher than the industry average of R44.4 pampm (2009: R41.2 pampm). These 11 schemes (2009: 12) represented 66.3% (2009: 53.5%) of total membership that paid for broker service fees and 77.4% (2009: 64.5%) of total broker service fees paid. Three of these schemes paid at levels 20.0% greater than the industry average.

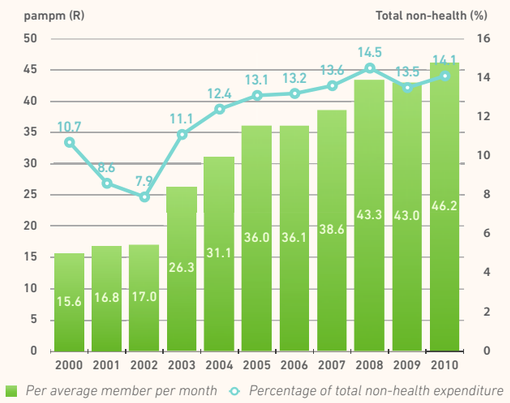
It is of concern that even while some of these schemes' broker commission pampm exceeded the industry average, they also incurred additional distribution fees in respect of their broker network.

Table 22: Top 10 schemes with highest marketing, advertising and broker costs (2010)

Name of medical scheme	Marketing, advertising and broker costs	New member growth
	pampm	%
Pharos Medical Plan	121.9	21.5
Medshield Medical Scheme*	90.5	79.4
Fedhealth Medical Scheme	87.8	13.5
Bestmed Medical Scheme	79.7	89.6
Liberty Medical Scheme*	79.2	104.5
Keyhealth	77.0	4.5
Resolution Health Medical Scheme	75.9	16.5
Bonitas Medical Fund	75.1	13.0
Spectramed	69.4	10.6
Momentum Health	69.0	40.0

pampm = per average member per month
** Schemes which had mergers in 2010*

Figure 31: Broker service fees (open schemes) 2000-2010



pampm = per average member per month

Figure 32: Broker fees and scheme membership 2000-2010

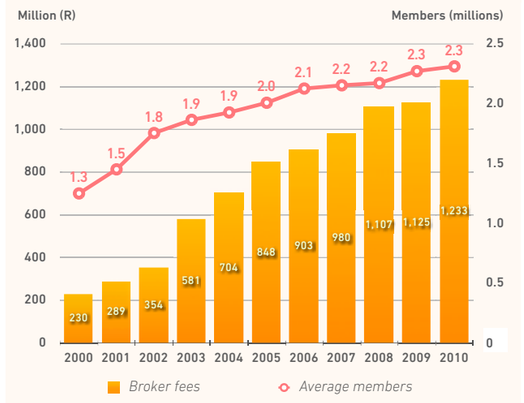
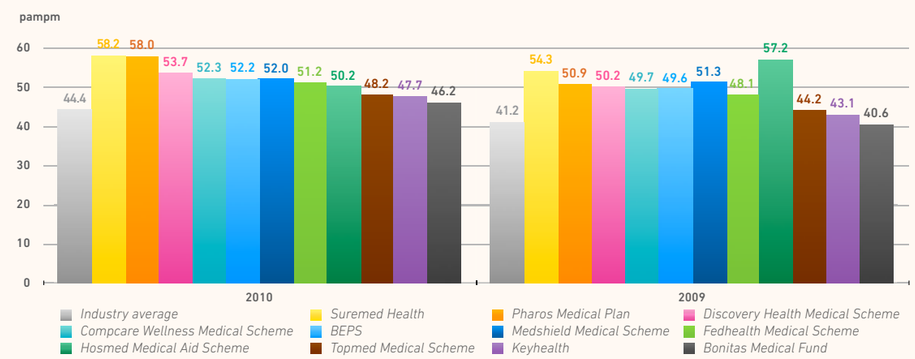


Table 23: Schemes with broker fees above industry average of R44.4 pampm 2009 and 2010

Name of medical scheme	Type	Broker fees			Distribution fees		
		2010 pampm R	2009 pampm R	% change	2010 pampm R	2009 pampm R	% change
Suremed Health	Open	58.2	54.3	7.3	6.8	9.4	-27.5
Pharos Medical Plan	Open	58.0	50.9	13.8	0.0	0.0	0.0
Discovery Health Medical Scheme	Open	53.7	50.2	6.9	0.0	0.0	0.0
Compcare Wellness Medical Scheme	Open	52.3	49.7	5.1	0.0	0.0	0.0
Built Environment Professional Associations Medical Scheme (BEPS)	Restricted	52.2	49.6	5.2	0.0	0.0	0.0
Medshield Medical Scheme	Open	52.0	51.3	1.3	29.4	29.7	-1.3
Fedhealth Medical Scheme	Open	51.2	48.1	6.5	10.6	16.0	-33.6
Hosmed Medical Aid Scheme	Open	50.2	57.2	-12.3	0.0	0.0	0.0
Topmed Medical Scheme	Open	48.2	44.2	9.2	0.0	0.0	0.0
Keyhealth	Open	47.7	43.1	10.5	0.0	15.3	-100.0
Bonitas Medical Fund	Open	46.2	40.6	13.9	0.0	0.0	0.0

pampm = per average member per month

Figure 33: Schemes with broker fees above industry average of R44.4 pampm 2009 and 2010



pampm = per average member per month

Reinsurance results

Two medical schemes had reinsurance contracts in 2010 (2009: 3). They made a net healthcare deficit of R19.1 million; their net reinsurance result was a deficit of R200 000.

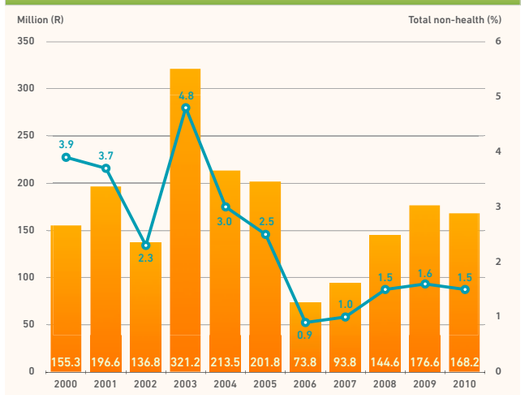
Impaired receivables

Impaired receivables (previously known as bad debts) decreased by 4.8% to R168.2 million for the year under review from R176.6 million in 2009. They represented 1.5% of total non-healthcare expenditure (1.6% in 2009).

It took schemes an average of 11.6 days to collect debts (contributions from their members) in 2010; this is an increase of 2.0% from 11.4 days in 2009. This 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 34 shows the trend in impaired receivables over the past 10 years, also expressed as a percentage of total non-healthcare expenditure.

Figure 34: Impaired receivables 2000-2010



Trends in non-healthcare expenditure

Total net non-healthcare expenditure rose by 6.9% from R10.8 billion in 2009 to R11.6 billion in 2010. Before 2006, the increase in non-healthcare expenditure was consistently higher than CPI. The rate of increase seems to have stabilised in the last few years.

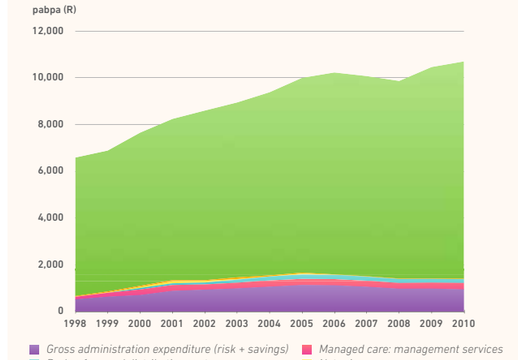
Figure 35 shows the changes in the major categories of non-healthcare expenditure for the past 11 years.

Total gross non-healthcare expenditure has increased by 180.4% since 2000. (Gross non-administration costs equate to net administration costs as no administration costs were paid in relation to savings accounts from 2007 onwards.) This was driven by a 195.5% upswing in administration expenditure, a 154.3% rise in fees paid for managed healthcare, and an increase of 475.5% in broker costs.

By comparison, gross claims have risen by 211.0% since 2000.

Figure 36 and Table 24 show that, after adjusting for inflation, gross non-healthcare expenditure per average beneficiary per annum (pabpa) decreased by 1.2% to R1 402.9 in 2010 from R1 419.7 in 2009. The net claims ratio decreased to 87.3% in 2010 from 89.3% in 2009.

Figure 36: Non-healthcare expenditure pabpa 1998-2010: 2010 prices



pabpa = per average beneficiary per annum

Figure 35: Changes in non-healthcare expenditure 2000-2010

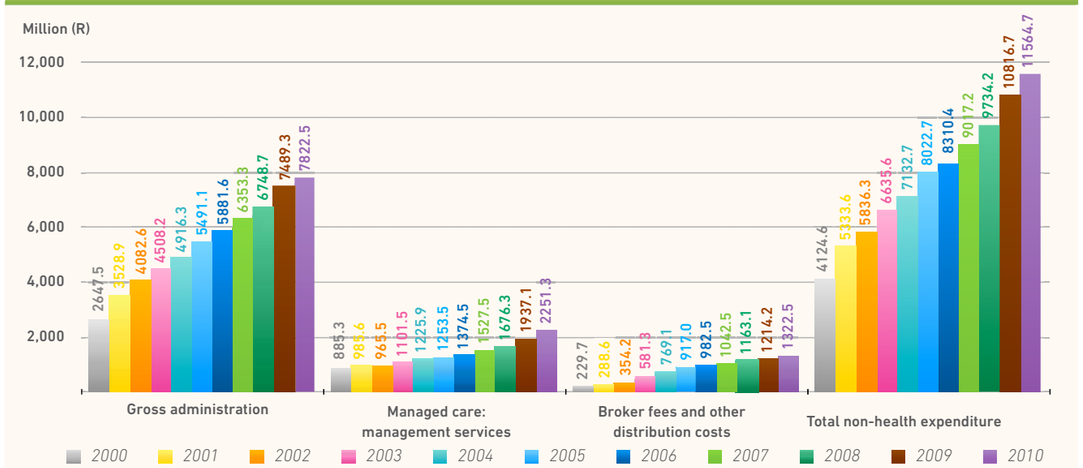


Table 24: Trends in contributions, claims and non-healthcare expenditure 2000-2010: 2010 prices

	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	8 168.1	6.4	7 290	6.1	1 101.1	28.2
2001	9 218.2	12.9	7 726	6.0	1 341.1	21.8
2002	9 810.8	6.4	8 090	4.7	1 340.7	0.0
2003	10 570.4	7.7	8 411	4.0	1 460.3	8.9
2004	11 175.5	5.7	8 845	5.2	1 547.1	5.9
2005	11 224.4	0.4	9 445	6.8	1 661.7	7.4
2006	11 003.6	-2.0	9 769	3.4	1 588.5	-4.4
2007	10 954.0	-0.5	9 552	-2.2	1 508.7	-5.0
2008	10 736.6	-2.0	9 400	-1.6	1 410.3	-6.5
2009	11 138.4	3.7	10 015	6.5	1 419.7	0.7
2010	11 703.9	5.1	10 300	2.9	1 402.9	-1.2
Since 2000		**43.3**		**41.3**		**27.4**

pabpa = per average beneficiary per annum

Figure 36 and Table 24 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 25 shows the six open medical schemes with non-healthcare expenditure greater than both the industry average of R147.1 pabpm and the open schemes average of 16.2% when expressed as a percentage of Risk Contribution Income (RCI).

Figure 37 shows the medical schemes in Table 25 that had a solvency ratio below the open schemes average of 27.4%. We are concerned that some of these 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 assessed continually and reviewed to ensure efficiencies.

Figure 38 depicts information on contributions, benefits, non-healthcare expenditure and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm has been growing since 2000 but it decreased in 2003, almost levelling out in 2004. This gap has since grown again.

Net healthcare results and trends

The net healthcare result of a medical scheme illustrates its position after benefits and non-healthcare expenditure are deducted from contribution income.

The net healthcare result for all schemes combined was a deficit of R459.6 million in 2010 (2009: R2.6 billion). Open schemes incurred deficits of R0.5 billion (2009: R1.7 billion) and restricted schemes generated surpluses of R43.5 million (2009: R918.8 million deficit). Overall, the year-on-year financial performance of both open and restricted schemes has improved. However, medical schemes had difficulty coping with increased claims costs (net relevant healthcare expenditure), which increased by 11.2% 2010.

The inclusion of investment and other income resulted in schemes making a net surplus of R2.9 billion in 2010. Net investment and other income increased by 5.4% to R3.6 billion. This was 368.5% of net surplus and underscores the importance of investment income for schemes who experience a difficult operating year.

Table 26 lists the 20 schemes with the highest net healthcare deficits. Investment income has resulted in a number of these schemes not experiencing major drops in their solvency levels.

Thirty-three per cent of open schemes (or 10 of 30) and 20.0% of restricted schemes (15 of 75) made net deficits after investment income.

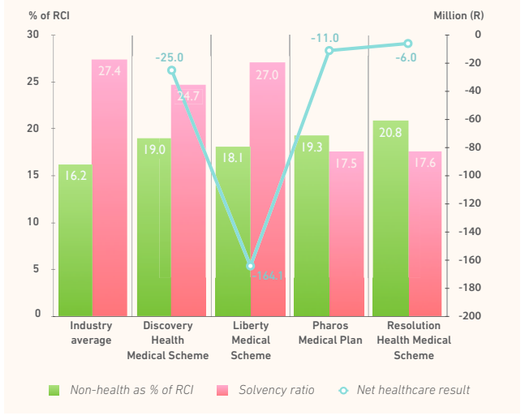
The net surplus after investment income and consolidation adjustments of all medical schemes combined was R2.9 billion (2009: R1.0 billion).

Open schemes made a R1.3 billion surplus (2009: R0.3 billion) and restricted schemes a surplus of R1.6 billion (2009: R0.7 billion). Net investment and other income increased by 5.4% to R3.6 million in 2010.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 39.

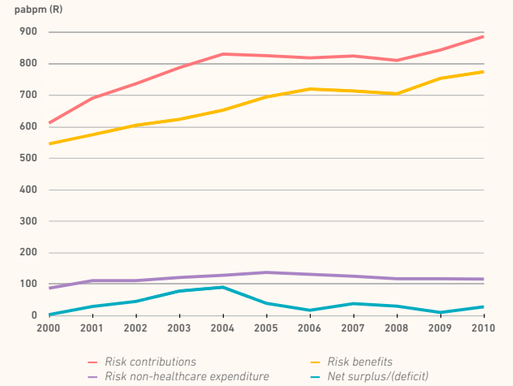
Referring to Figure 38 and 39, one can see the impact of the increases in claims costs on the net healthcare result.

Figure 37: Open schemes with high non-healthcare expenditure and solvency ratio below average for 2010



RCI = Risk Contribution Income

Figure 38: Risk contributions, benefits, non-healthcare expenditure and operating surpluses 2000-2010: 2010 prices



pabpm = per average beneficiary per month

Table 25: Trends in claims, non-healthcare expenditure and reserve-building as percentage of contributions (open schemes) 2009 and 2010

Name of medical scheme	Net non-healthcare expenses		Net claims incurred		Net non-healthcare expenses		Reserve-building	
	pabpm 2010 R	pabpm 2009 R	As % of RCI 2010	As % of RCI 2009	As % of RCI 2010	As % of RCI 2009	As % of RCI 2010	As % of RCI 2009
Discovery Health Medical Scheme	161.0	154.4	81.1	80.1	19.0	19.4	(0.1)	0.5
Liberty Medical Scheme	152.3	141.1	91.5	90.4	18.1	16.4	(9.6)	(6.7)
Pharos Medical Plan	209.2	180.6	85.8	78.8	19.3	18.2	(5.0)	3.1
Resolution Health Medical Scheme	153.7	163.4	80.3	77.1	20.8	26.2	(1.1)	(3.3)
Suremed Health	205.7	153.0	87.8	87.2	22.4	18.1	(10.1)	(5.3)
Topmed Medical Scheme	151.4	148.3	91.1	89.0	16.4	17.3	(7.4)	(6.3)
Industry average: open schemes	**147.1**	**140.4**	**84.7**	**86.6**	**16.2**	**16.9**	**(0.9)**	**(3.5)**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

Figure 39: Net healthcare results 2000-2010

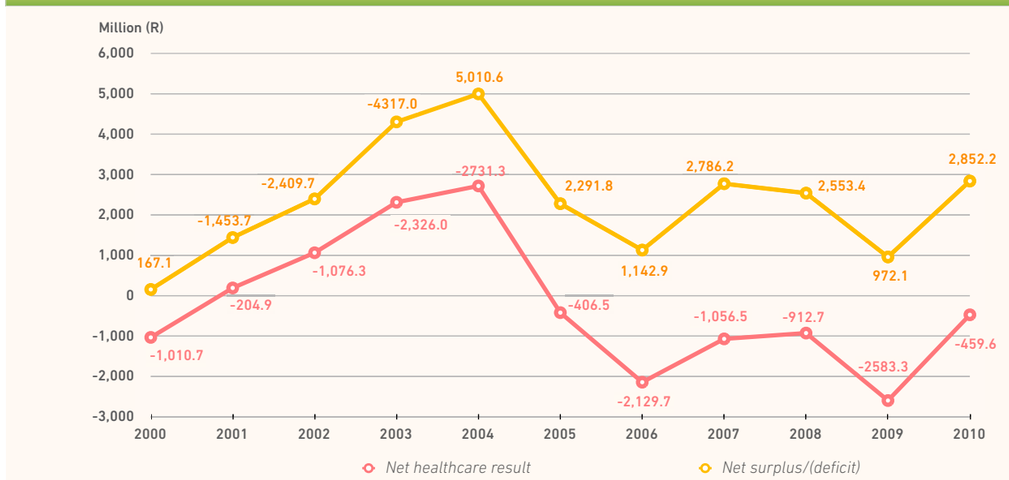


Table 26: 20 schemes with largest net healthcare deficits 2009 and 2010

Name of medical scheme	Type	Net healthcare result 2010 R'000	Net healthcare result 2009 R'000	% growth	Solvency ratio 2010 %	Solvency ratio 2009 %
Transmed Medical Fund	Restricted	(221 745)	(217 710)	(1.9)	14.1	28.9
Government Employees Medical Scheme (GEMS)	Restricted	(204 277)	180 868	(212.9)	7.1	11.1
Liberty Medical Scheme	Open	(164 186)	(66 229)	(147.9)	27.0	19.5
Gen-Health Medical Scheme	Open	(112 714)	(55 609)	(102.7)	-	21.5
Sizwe Medical Fund	Open	(96 442)	(65 191)	(47.9)	32.1	38.3
Keyhealth	Open	(89 660)	(104 707)	14.4	12.1	14.4
Medshield Medical Scheme	Open	(80 090)	(137 619)	41.8	52.5	52.0
Anglo Medical Scheme	Restricted	(55 295)	(35 701)	(54.9)	460.2	458.5
Medihelp	Open	(54 478)	(186 201)	70.7	27.4	31.5
Nedgroup Medical Aid Scheme	Restricted	(49 252)	(49 380)	0.3	41.6	45.1
Pro Sano Medical Scheme	Open	(41 904)	(108 365)	61.3	24.4	28.5
Netcare Medical Scheme	Restricted	(35 832)	1 630	(2 298.9)	41.0	54.0
Spectramed	Open	(29 779)	(17 898)	(66.4)	19.5	17.0
Discovery Health Medical Scheme	Open	(24 889)	94 849	(126.2)	24.7	25.5
Malcor Medical Scheme	Restricted	(22 744)	(19 682)	(15.6)	25.1	29.5
Umed	Restricted	(20 803)	(6 072)	(242.6)	-	46.6
Topmed Medical Scheme	Open	(20 067)	(17 245)	(16.4)	34.1	37.0
Cape Medical Plan	Open	(19 793)	(14 852)	(33.3)	130.1	129.8
Golden Arrow Employees Medical Benefit Fund	Restricted	(18 829)	(16 658)	(13.0)	88.2	99.8
Nampak SA Medical Scheme	Restricted	(18 650)	(12 139)	(53.6)	53.8	64.7

Table 27 shows the 20 schemes with the largest net healthcare deficits by the Risk Assessment Framework (RAF) classification; they represent 89.0% of all average beneficiaries who suffered operating deficits. (Annexure M has more details on this.)

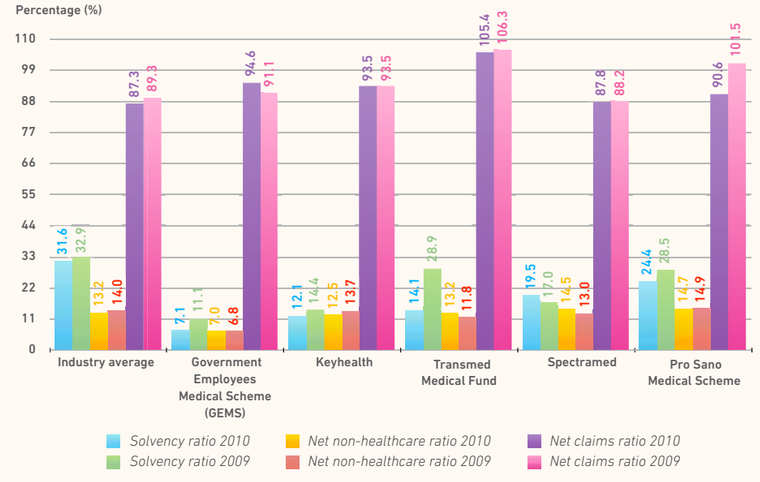
Figure 40 shows the high-impact schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 31.6%. (Annexure N provides more details.)

Table 27: 20 schemes with largest net healthcare deficits by RAF classification 2009 and 2010

Name of medical scheme	Type	Net healthcare result 2010 R'000	Net healthcare result 2009 R'000	% growth	RAF classification
Transmed Medical Fund	Restricted	(221 745)	(217 710)	(1.9)	High
Government Employees Medical Scheme (GEMS)	Restricted	(204 277)	180 868	(212.9)	High
Liberty Medical Scheme	Open	(164 186)	(66 229)	(147.9)	High
Gen-Health Medical Scheme	Open	(112 714)	(55 609)	(102.7)	Low
Sizwe Medical Fund	Open	(96 442)	(65 191)	(47.9)	High
Keyhealth	Open	(89 660)	(104 707)	14.4	High
Medshield Medical Scheme	Open	(80 090)	(137 619)	41.8	High
Anglo Medical Scheme	Restricted	(55 295)	(35 701)	(54.9)	Medium
Medihelp	Open	(54 478)	(186 201)	70.7	High
Nedgroup Medical Aid Scheme	Restricted	(49 252)	(49 380)	0.3	Medium
Pro Sano Medical Scheme	Open	(41 904)	(108 365)	61.3	High
Netcare Medical Scheme	Restricted	(35 832)	1 630	(2,298.9)	Medium
Spectramed	Open	(29 779)	(17 898)	(66.4)	High
Discovery Health Medical Scheme	Open	(24 889)	94 849	(126.2)	High
Malcor Medical Scheme	Restricted	(22 744)	(19 682)	(15.6)	Medium
Umed	Restricted	(20 803)	(6 072)	(242.6)	Low
Topmed Medical Scheme	Open	(20 067)	(17 245)	(16.4)	Medium
Cape Medical Plan	Open	(19 793)	(14 852)	(33.3)	Medium
Golden Arrow Employees Medical Benefit Fund	Restricted	(18 829)	(16 658)	(13.0)	Medium
Nampak SA Medical Scheme	Restricted	(18 650)	(12 139)	(53.6)	Medium

RAF = Risk Assesment Framework

Figure 40: High-impact schemes with largest net healthcare deficits and solvency levels below industry average of 31.6%



Accumulated funds, solvency and solvency trends

Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes. Accumulated funds, meaning the net asset value of the scheme excluding inter alia funds set aside for specific purposes and unrealised non-distributable profits, must at all times be maintained at a minimum level of 25.0% of gross contributions. These minimum accumulated funds are more commonly called the "reserves" of a scheme. When expressed as a percentage of gross contributions, they become known as the "solvency ratio" of a scheme.

Solvency levels provide an indication of the financial soundness and sustainability of a medical scheme and, in effect, represent a buffer against unforeseen and adverse fluctuations.

Net assets or members' funds (total assets less total liabilities) rose by 10.7% to end the year at R32.6 billion. Reserves (accumulated funds) grew by 10.4% to R30.9 billion from the R28.0 billion recorded in 2009.

The average industry solvency ratio decreased by 4.0% to 31.6% compared to 32.9% in 2009. This was still higher than the prescribed level of 25.0%. The solvency ratio of open schemes remained unchanged at 27.4% (2009: 27.4%); restricted schemes experienced a decline of 9.7% in their solvency ratio, which reduced to 38.4% in 2010 from 42.5% in 2009. It should, however, be noted that GEMS also experienced a decrease in its solvency. Table 26 lists the schemes who experienced the largest net healthcare deficits. Full details of the solvency ratios of all medical schemes are contained in Annexures K, L and M.

Figures 41, 42 and 43 show the changes in solvency ratios in all schemes, open schemes and restricted schemes respectively. The three Figures reflect improvement in solvency since 2001 when the Medical Schemes Act 131 of 1998 was implemented. The solvency of restricted schemes has, however, been declining since 2006.

Figure 41: Industry solvency trends for all schemes 2000-2010

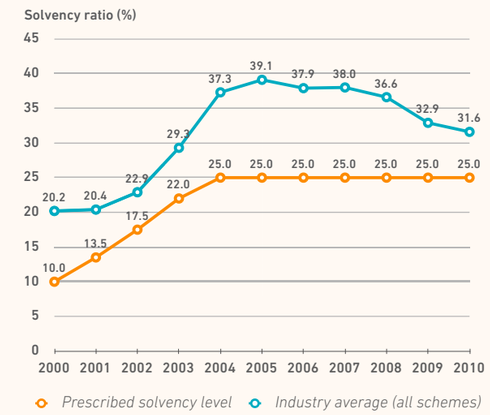


Figure 42: Industry solvency trends for open schemes 2000-2010

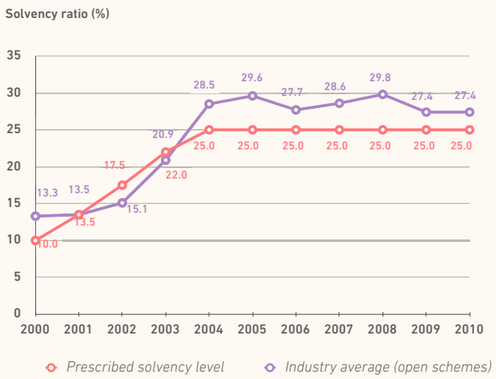
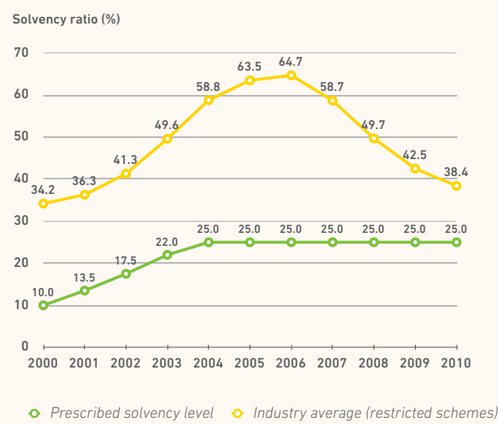


Figure 43: Industry solvency trends for restricted schemes 2000-2010



Factors that affect solvency

The most important factors which have an impact on solvency are:

- the pricing of contributions relative to benefits provided, including whether such benefits are provided from the risk pool of the scheme or from members' savings monies;
- non-healthcare expenditure; and
- investment income.

The membership profile of a scheme further affects its solvency; it includes the average age of its beneficiaries, pensioner ratio, number of male versus female dependants, and dependent ratio (i.e. the number of single members). The membership profile affects the frequency and extent of claims.

Table 28 looks at non-healthcare expenditure, claims and contributions relative to reserves.

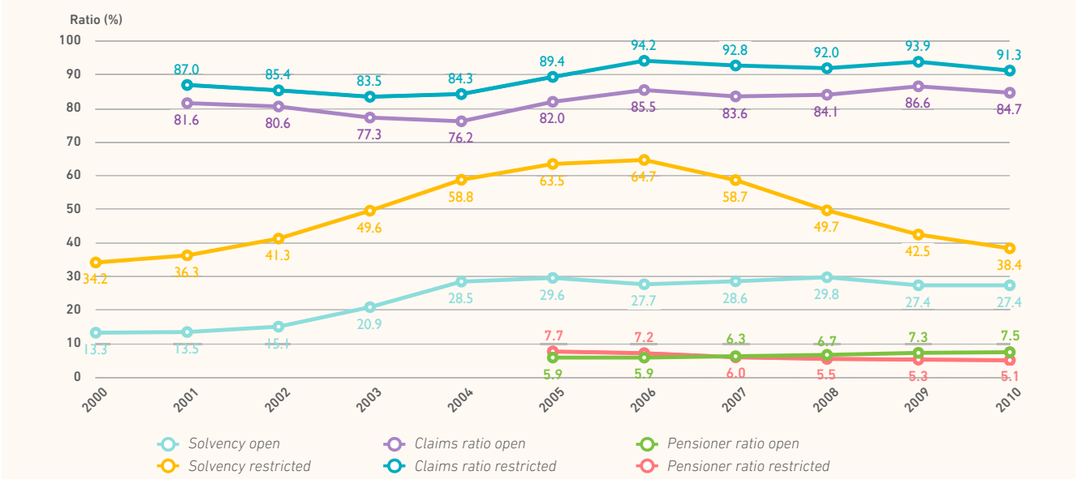
Total risk claims fell between 2000 and 2004 but the ratio of contributions to reserves improved during this period from a negative 3.7% to a positive 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. The claims ratio then started to increase in 2005 and reached 87.3% in 2010. Contributions to reserves were again negative during this time, which is consistent with the fact that most medical schemes have attained the prescribed solvency ratio of 25.0% and do not need to grow their reserves any further. However, the maintenance of reserves should be considered against the backdrop of increasing claims costs to ensure that members are protected at all times.

Investment income also plays an important role, especially when a scheme experiences net healthcare losses.

Table 28: Trends in risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions 1999-2010 (%)

	Risk claims	Non-healthcare expenditure	Reserve-building
1999	91.5	12.7	(4.2)
2000	89.3	14.5	(3.7)
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	(0.0)
2006	88.0	16.2	(4.1)
2007	86.5	15.2	(1.8)
2008	86.9	14.5	(1.4)
2009	89.3	14.0	(3.3)
2010	87.3	13.2	(0.5)

Figure 44: The impact of GEMS 2006-2010*



** Claims data was available only from 2001 onwards and pensioner ratios from 2004 onwards.*

Figure 44 illustrates the impact of GEMS on all medical schemes. (This restricted scheme was registered on 1 January 2005 but started with operations on 1 January 2006.)

GEMS has had a positive effect on the solvency of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who are now steadily leaving to join GEMS. The reserves which these members had accumulated over the years of their membership with open schemes were not transferred to GEMS. But there was a negative impact on these schemes' claiming patterns because the members who are leaving them and joining GEMS tend to be young and healthy.

Schemes should also beware of the so-called "death spiral". A medical scheme with a bad, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members being over-priced, causing the younger and lower-claiming members to move to other, less expensive benefit options, or even other schemes. This means that the scheme loses the cross-subsidy provided by these younger members and experiences an increase in losses, which in turn results in even higher contribution increases and/or the lowering of benefits.

Beneficiaries of schemes who failed to reach 25.0% solvency

Table 29 shows both the number of schemes which have yet to attain the prescribed solvency ratio of 25.0% and the number of beneficiaries in those schemes; these numbers are also shown in Figure 45.

Table 29: Prescribed solvency and number of beneficiaries 2000-2010

	Open schemes		Restricted schemes		
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level	
Number of schemes					
2000	15	33	15	86	
2001	19	29	11	83	
2002	24	25	7	86	
2003	19	29	7	80	
2004	18	30	4	81	
2005	17	29	4	79	
2006	18	23	4	79	
2007	18	23	7	74	
2008	14	21	8	71	
2009	16	17	6	71	
2010	12	15	7	66	
Beneficiaries	**At end of year**	**%**	**At end of year**	**At end of year**	**%**	**At end of year**
2000	2 385 051	51.0	2 291 048	839 029	40.9	1 214 412
2001	2 650 934	55.6	2 117 142	576 462	28.9	1 419 862
2002	3 519 329	74.4	1 211 882	251 050	12.7	1 731 873
2003	3 426 988	72.6	1 291 809	222 430	11.4	1 730 574
2004	2 534 273	53.3	2 221 030	80 160	4.2	1 827 100
2005	2 783 108	56.7	2 122 444	36 359	1.9	1 893 710
2006	3 218 382	63.7	1 832 056	145 369	7.0	1 931 536
2007	3 139 176	63.4	1 812 141	689 865	26.0	1 964 054
2008	1 076 450	22.0	3 812 456	981 977	32.9	2 003 943
2009	992 523	20.6	3 822 811	1 254 151	38.6	1 999 020
2010	2 918 055	60.8	1 881 860	1 684 682	47.9	1 831 121

Table 29 and Figure 45 show prescribed solvency levels and beneficiary representation in schemes that are both below and above the prescribed solvency of 25.0%; 60.8% beneficiaries in open schemes (2009: 20.6%) were covered by the 12 schemes (2009: 16) which failed to meet the prescribed solvency level in 2010.

The remaining beneficiaries belonged to the other 15 open schemes (2009: 17) which had attained the prescribed solvency level of 25.0%.

The increase in the number of beneficiaries belonging to open schemes who have yet to achieve the prescribed solvency is primarily attributable to Discovery Health Medical Scheme – the largest open scheme in South Africa based on the number of beneficiaries in December 2010 – dropping slightly below the prescribed solvency in the period under review.

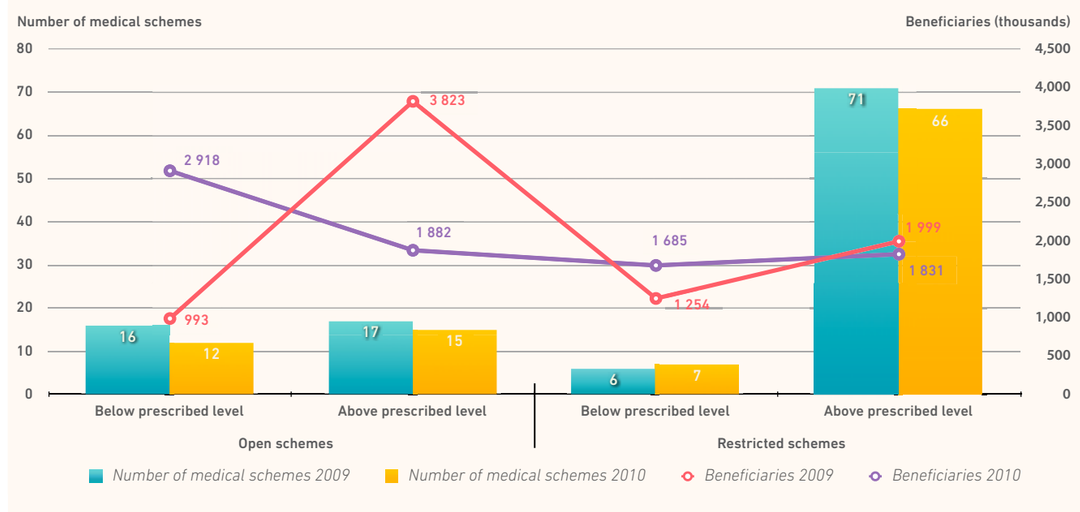
The number of beneficiaries in restricted schemes who have yet to attain the 25.0% solvency has also increased. This is largely because GEMS, the biggest restricted scheme based on the number of beneficiaries in 2010, increased its membership base during the year under review. GEMS is yet to attain the statutory solvency level of 25.0%.

Much work continues to be done to ensure that all medical schemes achieve statutory solvency levels.

Most beneficiaries in restricted schemes found themselves in schemes that were meeting the prescribed solvency level; of the 73 restricted schemes, only 7 had a solvency below 25.0%. These 7, however, constitute 47.9% of all beneficiaries in restricted schemes.

GEMS still finds itself below the statutory phase-in solvency level of 25.0% and this accounts for 86.6% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

Figure 45: Solvency and number of beneficiaries 2009 and 2010



RAF and high-impact schemes

The Risk Assessment Framework (RAF) initiative that was started in 2003 allows the CMS to better identify schemes which may have the biggest systemic impact on our goals and industry were they to fail; RAF enables us to identify high-impact schemes. Those are schemes whose failure, financial or other, would have a major impact on the industry; the classification does not necessarily mean that the scheme is a big-risk scheme or that it is experiencing problems.

Of the 26 schemes classified as high-impact in 2010 (2009: 29), only 1 (2009: 2) had a solvency ratio below 10.0%, 3 (2009: 2) had a solvency ratio of 10.0-15.0%, 2 (2009: 5) of 15.0-20.0%, and 3 (2009: 1) of 20.0-25.0%. The remaining 17 high-impact schemes (2009: 19) had met the prescribed solvency of 25.0% by the end of 2010.

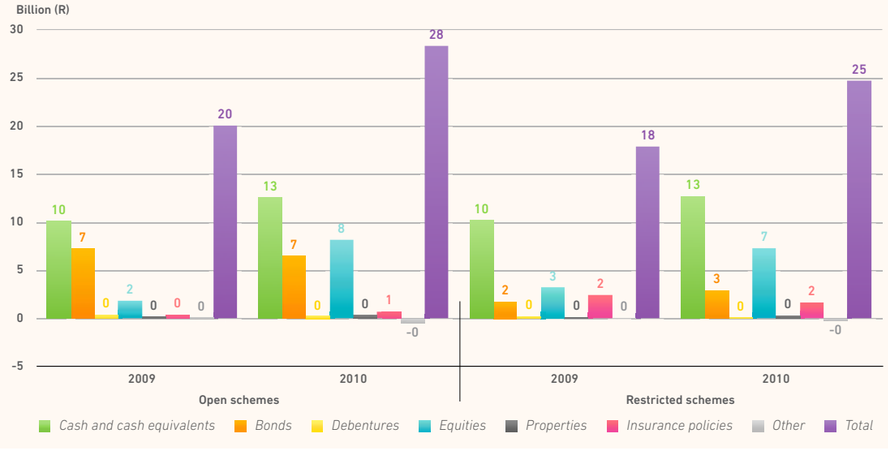
Table 30 shows that the average contributions of high-impact open schemes were 7.9% higher than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that is 7.2% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of RCI of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 102.4%. This tendency allowed restricted schemes to attain higher reserves than open schemes.

Table 30: High-impact schemes by type 2009 and 2010

	Average beneficiaries		Net contributions pabpm (R)		Net claims ratio (%)		Net non-healthcare ratio (%)		Solvency ratio (%)	
	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009
Open schemes	4 489 654	4 236 908	917.4	831.7	84.4	86.0	16.3	17.1	27.6	27.5
Restricted schemes	2 576 062	2 238 547	850.4	759.2	90.9	93.4	8.1	8.4	24.2	27.1
All schemes	**7 065 716**	**6 475 455**	**893.0**	**806.7**	**86.7**	**88.4**	**13.4**	**14.3**	**26.5**	**27.4**

pabpm = per average beneficiary per month

Figure 46: Scheme investments 2009 and 2010



Investments

Figure 46 provides information on the investments of medical schemes as at the end of 2009 and 2010.

In open schemes, 44.4% of investments were held in cash or cash equivalents (2009: 50.4%). Bonds accounted for 23.0% (2009: 36.1%), debentures for 0.1% (2009: 1.9%), equities for 28.9% (2009: 9.3%), insurance policies for 2.5% (2009: 1.9%), properties for 1.3% (2009: 0.1%) and other investments for 0.2% (2009: 0.4%).

Restricted schemes also held a large proportion of their investments (51.3%) in cash or cash equivalents (2009: 57.2%). Their bonds accounted for 11.8% (2009: 9.7%) and debentures for 0.0% (2009: 1.2%). Equities made up 29.6% (2009: 17.8%), insurance policies 6.8% (2009: 13.7%), properties 1.3% (2009: 0.1%) and other investments 0.8% (2009: 0.3%).

The shift in equities held by both open and restricted schemes is largely due to schemes which have the prescribed reserves and seek higher investment returns.

The primary obligation of a medical scheme is to ensure it has sufficient assets to pay benefits to its members when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number, on the other hand, indicates that the scheme has greater liabilities than assets.

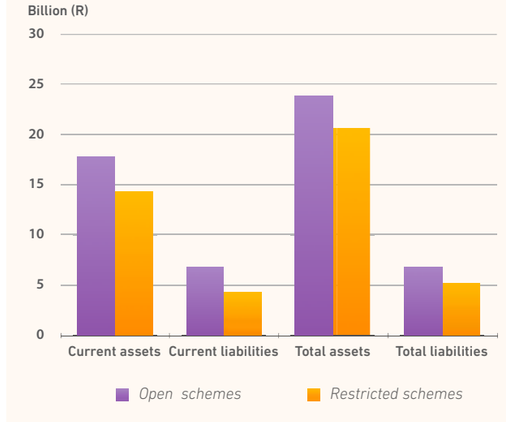
But schemes should pay attention to more than just their total asset and liability positions; they should also give thought to the periods in which liabilities must be paid and in which assets can be converted into cash flows. This is where financing risks must be matched.

Figure 47 compares the matching of assets and liabilities in open and restricted schemes.

The current-assets-to-current-liabilities ratio in open schemes was 2.7:1 in 2010 (2.7:1 in 2009 as well); it was 3.3:1 in restricted schemes (2009: 3.5:1). The total-asset-to-total-liability ratio for open and restricted schemes was 3.5:1 (2009: 3.4:1) and 4.0:1 (2009: 4.0:1 as well) respectively.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of schemes with low liquidity (i.e. a quick ratio below 2.0) is lower than the industry average of 4.1 months, Boards of Trustees must guard against longer-term and, therefore, riskier investments. Even though such investments may offer the expectancy of higher returns, they may prove detrimental to the scheme should it experience a liquidity crunch.

Figure 47: Matching assets and liabilities 2010

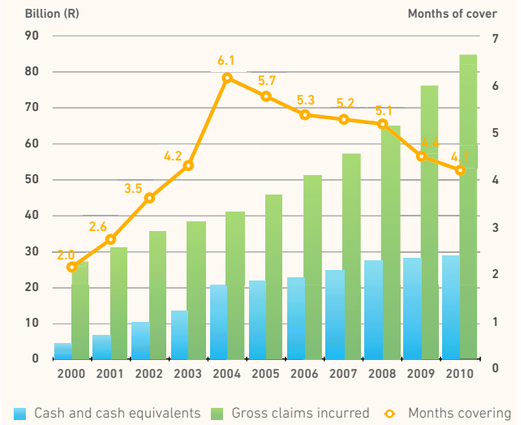


Claims-paying ability of schemes

The financial soundness of a medical scheme is also measured by its ability to pay claims from cash and cash equivalents.

Figure 48 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 48: Average gross claims covered by cash and cash equivalents 2000-2010



The cash coverage declined from 4.4 months in 2009 to 4.1 months as at December 2010 but the payment cycles of schemes reflect an average of 16.0 days compared with the 15.2 days reported in 2009.

Benefit options

The year 2010 ended with 338 benefit options (2009: 354), including those that were discontinued during the year.

As at the end of 2010, there were 100 registered medical schemes in South Africa.

(There were 110 schemes in 2009, including Telemed, Medicover, Oxygen Medical Schemes, Afrisam SA Medical Scheme, Umed, Ingwe Health Plan and MEDCOR which amalgamated with other schemes, as well as Purehealth Medical Scheme, Stocksmed and Gen-Health Medical Scheme which liquidated during the year under review.)

Open schemes accounted for 53.0% or 179 options in 2010 (2009: 54.0% or 191 options). Restricted schemes had 159 options, representing 47.0% of all benefit options (2009: 163 options or 46.0%).

On average, open schemes had 6.6 options per scheme (2009: 5.8) and an average of 12 138 members per option (2009: 11 227). Restricted schemes had an average of 2.2 options per scheme (2009: 2.1), with an average of 9 052 members per option (2009: 8 243).

Of the 338 benefit options, 149 (44.1%) had fewer than 2 500 members per option (2009: 154 or 43.5%). Of these 149 options, 97 (63.7%) incurred net healthcare losses in 2010. In 2009, 93 options (60.4%) had incurred losses. The remaining 189 options had more than 2 500 members per option (2009: 200). Of these, 50.0% or 95 options incurred net healthcare losses (2009: 130 options or 65.0%).

At the end of 2010, there were 81 options in open schemes with fewer than 2 500 members (2009: 85) at an average of 947 members per option (2009: 966), representing 45.3% of all open scheme options (2009: 44.5%).

Restricted schemes had 68 options with fewer than 2 500 members (2009: 69), with an average of 1 033 members per option (2009: 1 048), representing 42.8% of all restricted schemes options (2009: 42.3%).

Table 31: Results of benefit options 2010

	Open schemes	% representing	Restricted schemes	% representing	Total
All benefit options					
Number of options	179	53.0	159	47.0	338
Membership represented	2 172 723	60.2	1 439 339	39.8	3 612 062
Number of schemes	27	27.0	73	73.0	100
Net healthcare result	(506 505)	-	43 294	-	(463 211)
Gross non-healthcare as % of GCI	14.3	-	8.2	-	12.0
Gross claims ratio (%)	86.0	-	91.3	-	88.0
Gross claims incurred pbpm	889.3	-	798.6	-	850.9
GCI pbpm	1034.3	-	874.7	-	966.8
Options with >= 2 500 members					
Number of options	98	51.9	91	48.1	189
Membership represented	2 096 012	60.5	1 369 050	39.5	3 465 062
Number of schemes	23	30.3	53	69.7	76
Net healthcare result	(244 105)	-	207 572	-	(36 533)
Gross non-healthcare as % of GCI	14.4	-	8.1	-	12.0
Gross claims ratio (%)	85.6	-	90.9	-	87.6
Gross claims incurred pbpm	866.1	-	781.2	-	830.4
GCI pbpm	1 012.3	-	859.8	-	948.2
Options with < 2 500 members					
Number of options	81	54.4	68	45.6	149
Membership represented	76 711	52.2	70 289	47.8	147 000
Number of schemes	27	38.6	43	61.4	70
Net healthcare result	(262 400)	-	(164 277)	-	(426 678)
Gross non-healthcare as % of GCI	13.6	-	9.2	-	11.8
Gross claims ratio (%)	93.3	-	98.0	-	95.2
Gross claims incurred pbpm	1 552.2	-	1 182.4	-	1 373.3
GCI pbpm	1 663.5	-	1 206.2	-	1 442.1

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Table 32: Results of loss-making benefit options 2010					
	Open schemes	% representing	Restricted schemes	% representing	Total
All loss-making options					
% of total options	60.3		52.8		
Number of options	108	56.3	84	43.8	192
Membership represented	1 123 774	57.9	817 485	42.1	1 941 259
Number of schemes	30	35.3	55	64.7	85
Net healthcare result	(2 461 498 793)		(1 420 912 890)		(3 882 411 683)
Gross non-healthcare as % of GCI	13.4		7.6		11.0
Gross claims ratio (%)	93.7		98.6		95.7
Gross claims incurred pbpm	1 011.5		895.5		959.3
GCI pbpm	1 079.4		908.6		1 002.6
Loss-making options with >= 2 500 members					
Number of options	56	58.9	39	41.1	95
Membership represented	1 074 273	58.2	771 912	41.8	1 846 185
Number of schemes	23	41.1	33	58.9	56
Net healthcare result	(2 114 565 895)		(1 201 402 625)		(3 315 968 520)
Gross non-healthcare as % of GCI	13.4		7.5		11.0
Gross claims ratio (%)	93.1		98.1		95.1
Gross claims incurred pbpm	982.0		870.7		932.2
GCI pbpm	1 054.8		888.0		980.1
Loss-making options with < 2 500 members					
Number of options	52	53.6	45	46.4	97
Membership represented	49 501	52.1	45 573	47.9	95 074
Number of schemes	23	40.4	34	59.6	57
Net healthcare result	(346 932 898)		(219 510 265)		(566 443 163)
Gross non-healthcare as % of GCI	13.6		8.9		11.6
Gross claims ratio (%)	102.6		105.2		103.7
Gross claims incurred pbpm	1 682.4		1 373.1		1 530.8
GCI pbpm	1 640.1		1 304.9		1 475.8

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 338 benefit options within schemes in the year 2010 (2009: 354), 192 (56.8%) incurred net healthcare losses; in 2009, 223 options (63.0%) incurred net healthcare losses.

In the year under review, 108 options (2009: 121), representing 56.3% (2009: 54.3%) of the loss-making options, were in open schemes and 84 (2009: 102), representing 43.8% (2009: 45.7%), were in restricted schemes.

The net healthcare losses per member per month (pmpm) in options with fewer than 2 500 members were 3.6 times greater (2009: 2.7) than in options with more than 2 500 members: R496.5 pmpm compared to R149.7 pmpm (2009: R478.2 pmpm against R176.7 pmpm).

It appears that loss-making benefit options with fewer than 2 500 members generally have higher contributions and claims than other options and also attract higher non-healthcare costs.

Table 33 shows option results by demographics. There were 96 options with an average age above the average 33.1 years for options in open schemes, and 83 benefit options with beneficiaries younger than the average in open schemes.

In the restricted market, 95 options had beneficiaries with an average age higher than the 29.4 years for all options in restricted schemes. Sixty-four options had younger beneficiaries.

As expected, benefit options covering older and sicker lives incurred greater deficits.

Table 33: Number of benefit options by demographics 2010			
	Open schemes	Restricted schemes	Total
Options >= 33.1 years (average age in open schemes); >= 29.4 years (average age in restricted schemes)			
Number of options >= 33.1 years (open); >= 29.4 years (restricted)	96	95	191
NHC results pbpm >= -8.7 (open); NHC results pbpm >= 1.0 (restricted)	32	32	64
NHC results pbpm < -8.7 (open); NHC results pbpm < 1.0 (restricted)	64	63	127
Options < 33.1 years (average age in open schemes); < 29.4 years (average age in restricted schemes)			
Number of options < 33.1 years (open); < 29.4 years (restricted)	83	64	147
NHC results pbpm >= -8.7 (open); NHC results pbpm >= 1.0 (restricted)	39	43	82
NHC results pbpm < -8.7 (open); NHC results pbpm < 1.0 (restricted)	44	21	65

NHC = Net Healthcare
pbpm = per beneficiary per month
pb = per beneficiary
Average age pb open options = 33.1 years
Average age pb restricted options = 29.4 years
NHC results pb open options = -R8.7
NHC results pb restricted options = R1.0

Administrator market

Figure 49 shows the market share of third-party medical scheme administrators as well as self-administered medical schemes based on the average number of beneficiaries administered at the end of 2010.

Figure 50 depicts the changes in market share of all medical schemes over the last 10 years based on the average number of beneficiaries administered by the various parties at the end of each year.

The following five third-party administrators continued to dominate the market in 2010:

- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Medscheme Holdings (Pty) Ltd
- Momentum Medical Scheme Administrators (Pty) Ltd
- V Med Administrators (Pty) Ltd

Together, these five administrators administer 88.5% of the market (excluding the self-administered schemes).

Figures 51 and 52 indicate the changes in market share over the last 10 years for open and restricted schemes respectively, based on the average number of beneficiaries.

The market share of administrator Discovery Health (Pty) Ltd of the open schemes market increased to 44.9% in 2010 (2009: 41.3%); its share in the restricted schemes market increased to 6.2% (2009: 5.1%).

Medscheme Holdings (Pty) Ltd had the second-biggest share of the market in both open and restricted schemes administration at 18.6% (2009: 22.8%) and 8.9% (2009: 9.8%) respectively. Medscheme acquired Lethimvula Healthcare (Pty) Ltd in 2009; the latter had earlier acquired the business of Old Mutual Healthcare (Pty) Ltd.

Metropolitan Health Corporate (Pty) Ltd had the biggest share of the restricted schemes market in 2010 at 64.9% (2009: 60.9%).

Despite their dominance in the market and the inherent benefits of economies of scale, the larger administrators do not appear to offer any cost advantages over their smaller rivals. Perhaps their size makes them less efficient and less responsive to clients' needs?

Figure 49: Administrator market share 2010

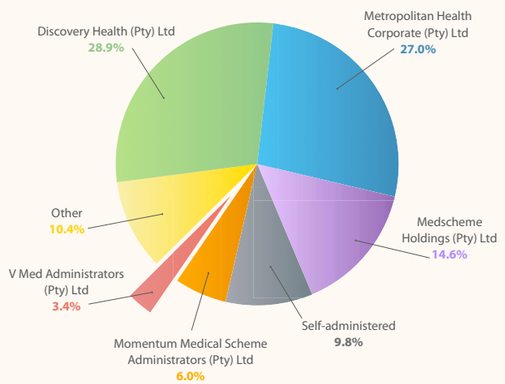


Figure 50: Market share of largest administrators based on average number of beneficiaries 2001-2010

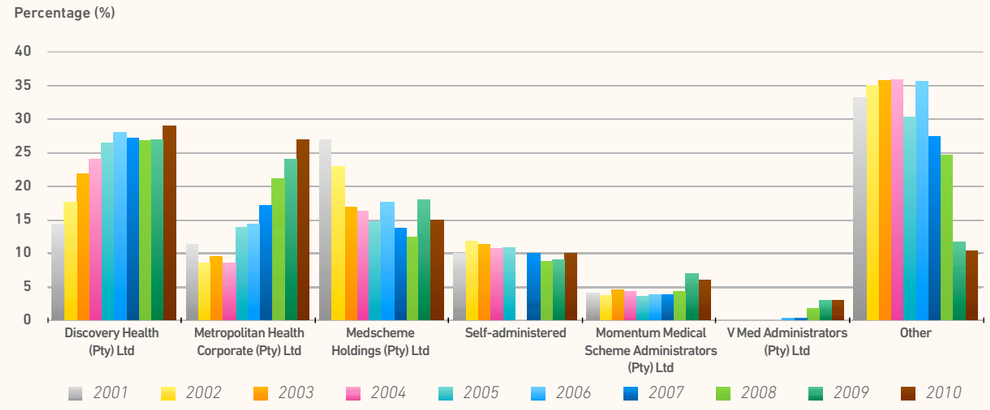


Figure 51: Open market share of largest administrators based on average number of beneficiaries 2001-2010

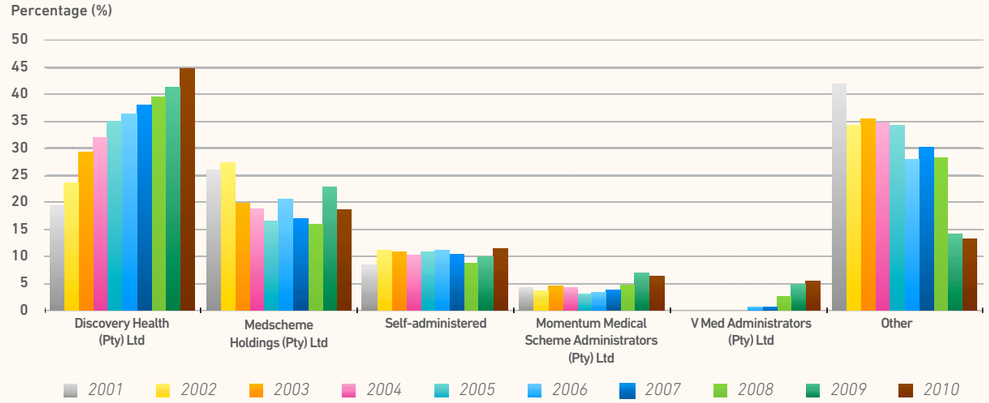


Figure 52: Restricted market share of largest administrators based on average number of beneficiaries 2001-2010

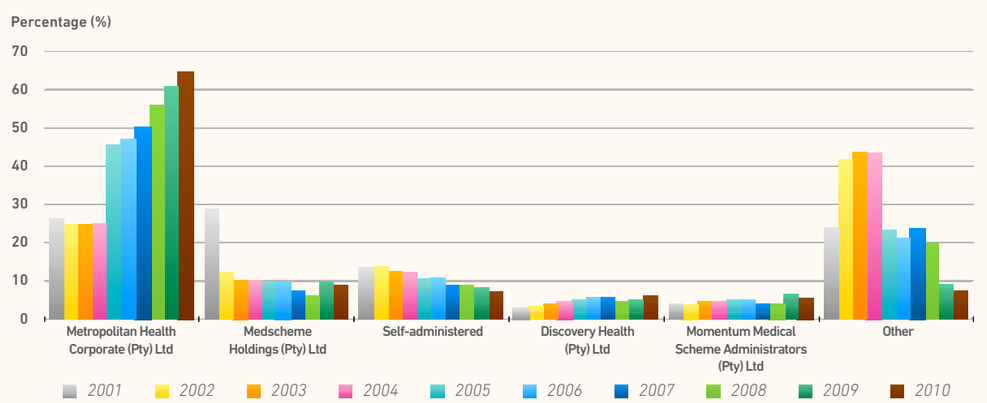


Table 34 shows the five administrators with higher administration costs and fees than the industry average of administrators handling open schemes.

As for restricted schemes, Table 35 shows the five administrators with higher administration costs and fees than the industry average for restricted schemes.

Medical scheme administrators and the businesses associated with them often provide managed healthcare services. In many instances, these services are merely additional layers of administration costs with questionable benefits for the schemes themselves; we have included these in the "fees paid to administrators" figures where they were paid to the administrator or to any company in the administrator group.

Co-administration fees were excluded from "fees paid to administrators" as these fees could not be allocated to the administrators.

Tables 36 and 37 show administrator market share based on the average number of beneficiaries to whom services are being delivered by third-party administrators and medical schemes under self-administration. We also show the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure U.)

Table 34: Percentage deviation from industry average: open schemes (%)

	Gross administration costs	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Discovery Health (Pty) Ltd	8.7	23.4	29.4
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	65.9	25.3	21.8
Sanlam Healthcare Management (Pty) Ltd	17.2	3.6	8.8
Agility Global Health Solutions Africa (Pty) Ltd	11.4	(8.6)	(6.2)
Momentum Medical Scheme Administrators (Pty) Ltd	(5.9)	(7.8)	(7.3)

** Excluding co-administration fees*

Table 35: Percentage deviation from industry average: restricted schemes (%)

	Gross administration costs	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Eternity Private Health Fund Administrators (Pty) Ltd	154.8	178.6	213.3
V Med Administrators (Pty) Ltd	53.6	64.8	118.1
Allcare Administrators (Pty) Ltd	75.8	108.1	111.3
Discovery Health (Pty) Ltd	47.9	59.1	92.2
Professional Medical Scheme Administrators (Pty) Ltd	90.2	66.7	77.8

** Excluding co-administration fees*

Table 36: Administrator market share: open schemes 2010

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	1	1.3	107.6	14.2	75.8	10.0	96.1	12.7	755.3	80.3
Allcare Administrators (Pty) Ltd	2	2.5	99.3	10.9	75.0	8.2	89.3	9.8	913.3	83.8
Discovery Health (Pty) Ltd	1	44.9	105.0	9.9	102.3	9.6	132.6	12.5	1 061.0	81.1
Eternity Private Health Fund Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Medscheme Holdings (Pty) Ltd	2	18.6	81.6	8.7	59.5	6.3	83.4	8.8	942.9	83.8
Metropolitan Health (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Metropolitan Health Corporate (Pty) Ltd	1	0.4	72.5	6.5	54.9	4.9	54.9	4.9	1 110.5	88.8
Momentum Medical Scheme Administrators (Pty) Ltd	3	6.4	90.9	8.6	76.4	7.2	95.0	9.0	1 060.3	87.4
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	1	0.3	160.3	14.4	103.9	9.3	124.8	11.2	1 111.8	85.8
Professional Medical Scheme Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Prosperity Health Managers (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Providence Healthcare Risk Managers (Pty) Ltd	2	0.3	79.7	10.2	46.9	6.0	56.5	7.2	784.4	84.3
Sanlam Healthcare Management (Pty) Ltd	1	2.9	113.2	8.8	85.9	6.7	111.5	8.7	1 281.6	85.5
Sechaba Medical Solutions (Pty) Ltd	1	4.0	85.2	9.6	58.0	6.5	73.6	8.3	885.8	96.6
Self-administered medical schemes	6	11.5	87.3	8.1	22.8	2.1	15.0	1.2	1 080.1	90.4
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	1	0.4	64.8	12.8	49.6	9.8	66.0	13.1	504.6	85.6
Universal Healthcare Administrators (Pty) Ltd	3	0.9	105.4	10.5	86.3	8.6	86.6	8.6	1 008.1	85.1
V Med Administrators (Pty) Ltd	2	5.5	100.1	10.0	57.2	5.7	71.1	7.1	997.2	89.9
Average	**27**	**100**	**96.6**	**9.4**	**82.9**	**8.1**	**102.5**	**9.9**	**96.6**	**84.7**

** Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Table 37: Administrator market share: restricted schemes 2010

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	-	-	-	-	-	-	-	-	-	-
Allcare Administrators (Pty) Ltd	2	0.4	95.2	8.2	87.6	7.5	97.0	8.3	1 163.8	104.3
Discovery Health (Pty) Ltd	11	6.2	80.1	8.0	67.0	6.6	88.2	8.8	1 007.1	86.7
Eternity Private Health Fund Administrators (Pty) Ltd	1	1.2	138.0	10.7	117.3	9.1	143.8	11.1	1 292.4	83.5
Medscheme Holdings (Pty) Ltd	19	8.9	67.6	6.2	58.1	5.3	81.1	7.4	1 094.4	91.6
Metropolitan Health (Pty) Ltd	4	1.2	68.2	7.1	57.0	6.0	60.4	6.3	956.6	94.5
Metropolitan Health Corporate (Pty) Ltd	10	64.9	45.8	5.2	33.2	3.8	33.2	3.8	872.5	92.0
Momentum Medical Scheme Administrators (Pty) Ltd	8	5.4	70.7	7.0	56.5	5.6	73.6	7.3	1 005.1	95.3
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	-	-	-	-	-	-	-	-	-	-
Professional Medical Scheme Administrators (Pty) Ltd	1	1.8	103.0	10.1	70.2	6.9	81.6	8.0	1 016.5	83.6
Prosperity Health Managers (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Providence Healthcare Risk Managers (Pty) Ltd	4	1.6	50.3	6.6	52.9	5.4	76.1	7.8	758.1	88.0
Sanlam Healthcare Management (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Sechaba Medical Solutions (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Self-administered medical schemes	9	7.3	46.0	6.7	9.4	1.3	7.6	1.0	685.5	88.0
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Universal Healthcare Administrators (Pty) Ltd	3	0.8	61.8	7.2	53.7	6.3	53.9	6.3	857.5	90.4
V Med Administrators (Pty) Ltd	1	0.4	83.2	7.1	69.4	5.9	100.1	8.5	1 178.9	87.8
Average	**73**	**100**	**54.2**	**6.0**	**41.3**	**4.5**	**45.9**	**5.0**	**903.0**	**91.3**

** Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Annexures

Annexures can be found on the provided disc.

Please note that all the Annexures are available on a disc at the back of this Annual Report.

The disc contains:

* all the Annexures in a digital PDF format
* a readme file containing important information about viewing the digital PDF
* a copyright warning and disclaimer applicable to the entire Annual Report
* the latest Council for Medical Schemes (CMS) video

To view the files stored on this disc, please insert it into your PC.

List of Annexures: the medical schemes industry in 2010

List of Tables

List of Figures

Glossary, acronyms & abbreviations

A:	African
Act:	Medical Schemes Act 131 of 1998
ad hoc:	formed, arranged or done for a particular purpose only
ADSL:	Asymmetric Digital Subscriber Line
Afrisam:	Afrisam SA Medical Scheme
AFS:	Annual Financial Statements
A-G:	Auditor-General
AGM:	Annual General Meeting
AIDS:	Acquired Immune Deficiency Syndrome
Altron:	Altron Medical Aid Scheme
ANC:	African National Congress
APP:	Annual Performance Plan
Apr:	April
AV:	anti-virus
Barloworld:	Barloworld Medical Scheme
BEE:	Black Economic Empowerment
beneficiaries:	principal members + dependants (total membership of medical scheme)
B.E.P.Meds/BEPS:	Built Environment Professional Associations Medical Scheme
Bestmed:	Bestmed Medical Scheme
BHF:	Board of Healthcare Funders of Southern Africa
BHP:	Broken Hill Proprietary Company (Australia)
BI:	Business Intelligence
BMI:	Body Mass Index
BMU:	Benefits Management Unit
BMW:	Bayerische Motoren Werke AG (Germany)
Board:	Board of Trustees
bona fide:	genuine; real
Bonitas:	Bonitas Medical Fund
BoT:	Board of Trustees
BP:	British Petroleum (United Kingdom)
Bpk:	Beperk
C:	Coloured
Calabash:	Calabash Health Solutions (Pty) Ltd
CAMAF:	Chartered Accountants (SA) Medical Aid Fund
CAS:	Current Awareness Services
CC:	Closed Corporation
CDL:	Chronic Diseases List
CEO:	Chief Executive Officer
CI:	Corporate Identity
CIB:	Chronic Illness Benefit
Clicks:	Clicks Group Medical Scheme
CMS:	Council for Medical Schemes
COMMED:	Community Medical Aid Scheme
Companies Act:	Companies Act 71 of 2008
Compcare:	Compcare Wellness Medical Scheme
Competition Act:	Competition Act 89 of 1998
Council:	Council members (the Board of the Council for Medical Schemes)
CPA:	Consumer Protection Act 68 of 2008
CPI:	Consumer Price Index
CPIX:	CPI excluding interest rates on mortgage bonds
CRC:	Clinical Review Committee
CRM:	Customer Relationship Management
CT (scan):	Computerised Tomography
Dec:	December
de facto:	in fact, whether by right or not
DENOSA:	Democratic Nursing Organisation of South Africa
dependant:	member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DHMS:	Discovery Health Medical Scheme
Discovery:	Discovery Health Medical Scheme
DoH:	Department of Health
Dr:	Doctor
DRG:	Diagnosis-Related Group
DRGs:	Diagnosis-Related Groups
DRGTAP:	DRG Technical Advisory Panel
DSP:	designated service provider
DSPs:	designated service providers
DTP:	Diagnosis and Treatment Pair
DTPs:	Diagnosis and Treatment Pairs
e:	e-mail
ECIPA:	East Cape Medical Business Systems (Pty) Ltd
Edms:	Eiendoms
EE:	Employment Equity
e.g.:	*exempli gratia* (for example)
EMS:	Environmental Monitoring Systems
etc.:	et cetera (and other similar things; and so on)
E&V:	Entry & Verification
EWS:	Early Warning System
excl.:	excluding
EXCO:	Executive Committee (Council sub-committee)
Executive Authority:	Minister of Health
f:	fax
FAIS:	Financial Advisory and Intermediary Services Act 37 of 2002
Fedhealth:	Fedhealth Medical Scheme
Fishmed:	Fishing Industry Medical Scheme
FSB:	Financial Services Board
FSU:	Financial Supervision Unit
GAAP:	Generally Accepted Accounting Principles
GAE:	Gross Administration Expenditure
GCI:	Gross Contribution Income
GEMS:	Government Employees Medical Scheme
Genesis:	Genesis Medical Scheme
Gen-Health:	Gen-Health Medical Scheme
Golden Arrow:	Golden Arrow Employees Medical Benefit Fund

GP:	general practitioner
GPs:	general practitioners
GRAP:	Generally Recognised Accounting Practices
HIV:	Human Immunodeficiency Virus
Hosmed:	Hosmed Medical Aid Scheme
HPCSA:	Health Professions Council of South Africa
HR:	Human Resources
HWSETA:	Health and Welfare Sector Education and Training Authority
I:	Indian
IAS:	International Accounting Standard
IBM:	International Business Machines Company (USA)
IBNR:	Incurred But Not Reported
ICD-10:	International Classification of Diseases – 10th Revision
ICON:	Independent Clinical Oncology Network (Pty) Ltd
ICU:	Intensive Care Unit
i.e.:	*id est* (that is to say)
IFRS:	International Financial Reporting Standards
Inc.:	Incorporated
incl.:	including
Ingwe:	Ingwe Health Plan
INSETA:	Insurance Sector Education and Training Authority
inter alia:	among other things
IRBA:	Independent Regulatory Board of Auditors
IS:	Information Systems
ISBN:	International Standard Book Number
IS & KM:	Information Systems & Knowledge Management
IT:	Information Technology
IVR:	Inter-reactive Voice Recording
Jan:	January
Jul:	July
Jun:	June
KM:	Knowledge Management
KZN:	KwaZulu-Natal
LAN:	Local Area Network
LCS:	Live Communications Server
Liberty:	Liberty Medical Scheme
Lonmin:	Lonmin Medical Scheme
Ltd:	Limited
MAC:	Ministerial Advisory Committee
Mar:	March
MB:	megabyte
Mbps:	megabit per second
MCO:	managed care organisation
MCOs:	managed care organisations
MEDCOR:	Medical Scheme for the Department of Correctional Services
Medipos:	Medipos Medical Scheme
Medscheme:	Medscheme Holdings (Pty) Ltd
Medshield:	Medshield Medical Scheme
memo:	memorandum
Metropolitan:	Metropolitan Health Corporate (Pty) Ltd
Minemed:	Minemed Medical Scheme
Moremed:	Moremed Medical Scheme
MOSS:	Microsoft Office SharePoint
MoU:	Memorandum of Understanding
MPR:	Medicine Price Registry
Mr:	Mister
MRC:	Medical Research Council
MRI (scan):	Magnetic Resonance Imaging
Mrs:	Missus
Ms:	Miss
MSO:	Medical Services Organisation (Pty) Ltd
Naspers:	Naspers Medical Fund
NC:	Not Comparable
NCF:	National Consumer Forum
NGO:	non-governmental organisation
NHC:	Net Healthcare
NHE:	Non-Healthcare Expenditure
NHI:	National Health Insurance
NHISSA:	National Health Information System of South Africa
NHRPL:	National Health Reference Price List
NIMAS:	National Independent Medical Aid Society
no.:	number
NPA:	National Prosecuting Authority
NPC:	Non-Profit Consortium
Oct:	October
Office:	Office of the Registrar (of Medical Schemes)
Oxygen:	Oxygen Medical Scheme
pab:	per average beneficiary
pabpa:	per average beneficiary per annum
pabpm:	per average beneficiary per month
PAIA:	Promotion of Access to Information Act 2 of 2000
pampm:	per average member per month
pasbpm:	pabpm in respect of schemes who had savings transactions
pb:	per beneficiary
pbpm:	per beneficiary per month
PC:	personal computer
PCNS:	Practice Code Numbering System
PCs:	personal computers
PDF:	Portable Document Format
PDP:	Professional Development Programme
pensioner:	beneficiary at least 65 years old
PET (scan):	Positron Emission Tomography
PFMA:	Public Finance Management Act 1 of 1999
Pharos:	Pharos Medical Plan
PMB:	prescribed minimum benefit
PMBs:	prescribed minimum benefits
pmpm:	per member per month
PMSA:	Personal Medical Savings Account

PO:	Principal Officer
POATIA:	Promotion of Access to Information Act
POLMED:	South African Police Service Medical Scheme
PPS:	Professional Provident Society
principal member:	member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Prof.:	Professor
Pro Sano:	Pro Sano Medical Scheme
Protea:	Protea Medical Aid Society
Pty:	Proprietary
Q:	Quarter
QR:	Quarterly Returns
R:	Rand (South African currency)
RAF:	Risk Assessment Framework
RCI:	Risk Contribution Income
RDC:	Regulatory Decisions Committee
Ref.:	Reference
REF:	Risk Equalisation Fund
Registrar:	Registrar of Medical Schemes
Remedi:	Remedi Medical Aid Scheme
Resolution Health:	Resolution Health Medical Scheme
RETAP:	Risk Equalisation Technical Advisory Panel
R&M:	Research & Monitoring
RMA:	Rand Mutual Association
RP:	Government Printing Works (number)
RPL:	Reference Price List
RTM:	real-time monitoring
SA:	South Africa(n)
SABC:	South African Broadcasting Corporation
SABINET:	Southern African Bibliographic Information Network
SAHRC:	South Africa Human Rights Commission
SAICA:	South African Institute of Chartered Accountants
SAMA:	South African Medical Association
SAMWUMed:	South African Municipal Workers Union Medical Scheme
SAN:	Storage Area Network
SAPS:	South African Police Service
SCA:	Supreme Court of Appeal
SCM:	Supply Chain Management
Selfmed:	Selfmed Medical Scheme
Sep:	September
SEP:	Single Exit Price
Sizwe:	Sizwe Medical Fund
SLA:	Service Level Agreement
SLAs:	Service Level Agreements
SMM:	Strategic Management Meeting
SMMs:	Strategic Management Meetings
SMS:	Short Message Service
SOP:	Standard Operating Procedure
SOPs:	Standard Operating Procedures
SP:	Strategic Plan
SPU:	Strategic Projects Unit
t:	telephone
t/a:	trading as
TAU:	Technical Advisory Unit
TB:	tuberculosis
Thebe Ya Bophelo:	Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd
TIP:	Trustee Induction Pack
Topmed:	Topmed Medical Scheme
ToR:	Terms of Reference
Transmed:	Transmed Medical Fund
Treasury:	National Treasury
UAT:	User Acceptance Testing
UJ:	University of Johannesburg
UK:	United Kingdom
Umvuzo:	Umvuzo Health Medical Scheme
UPS:	Uninterrupted Power Supply
USA:	United States of America
v:	versus
V Med:	V Medical Aid Administrators (Pty) Ltd
w:	website
W:	White
WHO:	World Health Organisation
Witbank Coalfields:	Witbank Coalfields Medical Aid Scheme
Wits:	University of the Witwatersrand
WSP:	Workplace Skills Plan
XRM:	eXtended Relationship Management

Photographs for sections *Corporate overview, Registrar's review, Performance information: performance v targets, Report of the Auditor-General* and *Reviewing the operations of medical schemes in 2010* courtesy of Missing Planet (www.missingplanet.co.za)

This report is printed on environmentally friendly paper.

Drawn in the studios of
ChiMO.co.za