CMS
Council
for Medical Schemes

ANNUAL REPORT

2011~2012

Annual Report

RP | 117/2012
ISBN | 978 0 621 40821 8

Council for Medical Schemes
Private Bag X34
Hatfield 0028
Pretoria

t | 012 431 0500
f | 012 430 7644
e | information@medicalschemes.com
w | www.medicalschemes.com

Origami /ˌeriˈgaːmi/

Origami is a modern art form that dates back hundreds of years.

Its results? Masterfully crafted little paper gems. Complex in design, beautiful to look at, fragile, yet enduring. Perfected over time, requiring utmost care and attention.

This is how the Council for Medical Schemes sees itself: caring and nurturing as it holds in its hands a delicate industry that requires as much time and attention as any origami sculpture.

Join us on a journey through our 2011-2012 financial year as we continued to serve South Africa and all its people.

Contents

Part 1: The Council for Medical Schemes 1 April 2011-31 March 2012

Part 2: The medical schemes industry in 2011

A nation's
greatest wealth
lies in its health

Corporate Overview

*"If you were born without wings,
do nothing to prevent them
from growing."*

~ Coco Chanel ~

Profile

The Council for Medical Schemes (CMS or Council) 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.

Council is an autonomous public agency funded through levies charged to medical schemes. It is accountable to the Minister responsible for national health matters.

Values

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

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

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

Vision

We strive to be a fair custodian of equitable access to medical schemes in order to support the improvement of universal access to healthcare.

Mission

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

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

Our strategic goals

Strategic goal 1

Access to good quality medical scheme cover is maximised.

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

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

Strategic goal 2

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

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

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

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

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

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

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

Strategic goal 3

Council is responsive to the needs of the environment by being an effective and efficient organisation.

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

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

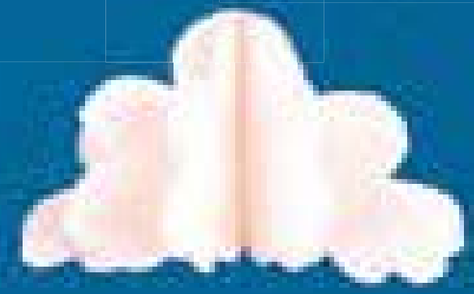
Strategic goal 4

Council provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the National Health Insurance development process.

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

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

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



Chairperson's statement

"When we look up, it widens our horizons. In the sky, there are no boundaries."

~ Julia Gregson ~

Trevor Bailey

Acting Chairperson, Council for Medical Schemes

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

Introduction

South Africa's health system is undergoing a much-needed strategic review. Both the public and the private sectors are affected. And the role of regulators remains crucial in this changing environment.

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

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

Strengthening the healthcare system

Council continued to support the Department of Health in its efforts to strategically review the entire health system of South Africa. Council provided input to the technical sub-committees of the Ministerial Advisory Committee on the proposed National Health Insurance (NHI) system, and submitted a formal document on the NHI policy paper (which is available on our website).

Ever-escalating costs in the industry, which are driven by private hospitals and medical specialists, have always been one of Council's concerns, and this financial year proved no different. This worrying trend of inflation-exceeding price increases in the private health sector has serious and negative implications for the well-being and sustainability of the entire health system. Council therefore continued to motivate for the establishment of a regulator to oversee the price determination of private healthcare provision. Council believes that a real need exists for a platform where medical schemes and healthcare providers can meet and negotiate prices for the benefit of all South African consumers.

Private healthcare providers should also be regulated, specifically the hospitals and specialists. The practice where beneficiaries are exposed to unfair billing practices must be addressed.

Putting beneficiaries first

Council continued to place beneficiaries first.

As consumers of healthcare, beneficiaries of medical schemes must get value for their hard-earned money, and must continue to enjoy protection against unpredictable, undesirable, and potentially catastrophic health events. No effort should be spared to eradicate all forms of unfair discrimination threatening the well-being of beneficiaries, however long such noble efforts may take.

The Medical Schemes Act 131 of 1998 provides a unique legislative framework aimed at providing equitable access to private healthcare on par with the best in the world. Where imperfections exist, Council continued to engage with the Ministry of Health to ensure that the necessary legislative amendments are considered, especially those meant to strengthen the protection of beneficiaries and improve the functioning of the entities that Council oversees. A regulator is only as empowered as its enabling legislation.

Guiding and working with the industry

Council is confident that the medical schemes industry of South Africa has never looked better. The financial health and long-term sustainability of medical schemes and the businesses affiliated with them remained one of Council's priorities in the year under review. Only well-managed and financially sound medical schemes, empowered and supported by good legislation and a strong regulator, can offer just and adequate protection against ill health and guarantee respect for the constitutional imperative of fair treatment for all.

Ultimately, the entire health system is better off due to the work of Council.

Mergers, liquidations, and curatorships are the natural and even expected outcomes of a healthy and robust free market economy where both consumers and service providers have rights and responsibilities. Council's efforts must be acknowledged in contributing to the fact that the medical schemes industry has never been as healthy as it is now and beneficiaries enjoy unprecedented protection of their rights and interests.

Much progress was made in efforts to distinguish and protect medical schemes from commercial health insurance without infringing on the provisions of the Medical Schemes Act when the Minister of Finance published for public comment draft Regulations on the so-called "demarcation" matter. Council trusts that legislative amendments will enhance efforts aimed at creating an ever-fairer environment for South African consumers.

Compliance with the Medical Schemes Act remains on Council's regulatory radar, especially when it comes to good governance, which is a pillar of any healthy organisation and industry. Council introduced routine inspections into medical schemes in the year under review. The accreditation standards for managed care organisations were also improved.

To become a more proactive and effective regulator, Council embarked on projects which will enable it to keep an even closer eye on the industry and serve it better. These included the Composite Risk Index (CRI) and Real-Time Monitoring (RTM) projects. The RTM initiative should allow Council to monitor the financial and non-financial indicators of medical schemes in real time: monthly at first, and daily as the project develops and is perfected. The CRI combines different types of data on medical schemes to try and predict which schemes should experience difficulties – and take regulatory action before the problem grows too big.

The Ministry of Health has put on hold efforts to develop a system of risk equalisation for the medical schemes environment. The Risk Equalisation Technical Advisory Panel (RETAP) was therefore transformed into the Industry Technical Advisory Panel (ITAP) with a broader scope than RETAP's. ITAP serves as a useful platform for Council and the industry to engage each other on practical issues, and develop and strengthen cooperation between the various stakeholder groups.

Last but not least, the year under review saw the resolution of a long-standing matter between Council and a medical scheme, which alleged that it had been defamed when Council reported on the scheme's governance problems in its Annual Report of 2004-2005. The High Court's ruling confirmed that Council has the duty and responsibility to report on matters of interest and value to members of the public affected by the behaviour of medical schemes and other entities regulated by Council. Council welcomes the High Court's recognition that Council has the right and duty to speak openly in the public interest. Council will continue to exercise this right and duty in its capacity as regulator of the medical schemes industry.

Gratitude

I am proud of the fact that the Auditor-General of South Africa has given Council its 12th unqualified audit in a row.

Such success is possible only thanks to the hard work, passion, and dedication of Council's employees. I would like to thank each and every person who contributed to making Council as trusted and respected an entity as it is today. The Registrar of Medical Schemes and Chief Executive of the Council for Medical Schemes, Dr Monwabisi Gantsho, and the Council employees are thanked for their efforts and congratulated on their achievements in the year under review. I pledge Council's continued guidance and support for their endeavours in regulating the industry.

A number of fellow Councillors left Council when their terms came to an end in October 2011, including Prof. William Pick, the former Chairperson. I thank them for everything they have done for Council and wish them well in their future endeavours. I also welcome on board the new Councillors who joined the Council family in November 2011. I look forward to working with the Councillors in advancing the causes close to Council's heart as Council continues serving beneficiaries, medical schemes, and the health sector at large.

I also wish to thank the entire industry and other stakeholders for their continued cooperation over the last financial year.

Conclusion

On behalf of Council, I pledge Council's continued commitment to strengthening Council's relationship with the Ministry of Health and the many others who are equally convinced of the need to promote equitable access to private health financing and quality care. Council stands firm in its conviction that every South African is entitled to quality healthcare.

Trevor Bailey
Acting Chairperson
Council for Medical Schemes
31 July 2012

Registrar's review

"I have walked that long road to freedom. I have tried not to falter; I have made missteps along the way. But I have discovered the secret that after climbing a great hill, one only finds that there are many more hills to climb. I have taken a moment here to rest, to steal a view of the glorious vista that surrounds me, to look back on the distance I have come. But I can only rest for a moment, for with freedom come responsibilities, and I dare not linger, for my long walk is not ended."

~ Nelson Mandela ~

Dr Monwabisi Gantsho

Registrar and Chief Executive, Council for Medical Schemes

"Council continued to place the interests of members of medical schemes first, balanced against the need to ensure the long-term financial health and sustainability of medical schemes themselves."

It gives me great pleasure to report on the activities and achievements of the Council for Medical Schemes (CMS or Council) in the 2011-2012 financial year.

In the year under review, Council continued to execute its mandate which is derived from the Medical Schemes Act 131 of 1998. We continued to place the interests of members of medical schemes first, balanced against the need to ensure the long-term financial health and sustainability of medical schemes themselves.

All our endeavours as both regulator and ombudsman stem from our belief that a strong private health financing industry contributes to the goal of universal access to quality care envisaged by the ongoing strategic review of South Africa's entire health system.

Strengthening the healthcare system

National Health Insurance (NHI)

In the financial year under review, Council continued to support efforts of the Department of Health (DoH) to strategically reform the health system of South Africa by way of the proposed system of National Health Insurance (NHI). Council staff members who serve on the technical sub-committees of the Ministerial Advisory Committee on NHI continued to provide input on the proposed strengthening of the South African health system, including a report on purchasing in an NHI environment. The DoH published the long-awaited Green Paper on NHI for public comment in August 2011. Council submitted its comments in January 2012; the submission is available on our website.

Medical Schemes Amendment Bill

The Medical Schemes Act was promulgated in 1998, and Council was established in 2000. We have been gaining considerable experience in the regulation of medical schemes and the businesses affiliated with them ever since.

Council has identified areas in the Medical Schemes Act which may require revision to ensure that we are able to discharge our duties in a more effective manner. In addition, many areas of the Medical Schemes Act need to be amended to align the Act with other pieces of legislation which have recently been amended and to which the Medical Schemes Act makes reference.

Council had a number of interactions with the Department of Health in the period under review to discuss potential amendments to the Medical Schemes Act, including amendments to strengthen the governance of medical schemes and to clarify various uncertainties in the Act which should strengthen the regulatory activities of Council.

These amendments and other legislative changes – such as the Financial Services Laws General Amendment Bill of 2012, the demarcation Regulations, the prescribed minimum benefit (PMB) Regulations, and other Regulations to be made under the amended Medical Schemes Act – would:

- provide further clarity on the demarcation between medical schemes and commercial health insurance products;
- remove conflicts of interest;
- prevent financial irregularities and mismanagement in medical schemes;
- improve the investment strategy of schemes

(including the development of appropriate integration strategies);
- improve solidarity in healthcare funding;
- prevent unfair discrimination against vulnerable members;
- improve the fairness of appeals processes;
- strengthen the regulation of healthcare brokers;
- improve the delivery of prescribed minimum benefits (PMBs); and
- lead to improved data collection on human resources in the private sector.

Demarcation between medical schemes and health insurance

The Insurance Laws Amendment Act 27 of 2008 amended the definitions of health policies in both the Long-term Insurance Act (LTIA) and the Short-term Insurance Act (STIA).

These revised definitions are contingent on Regulations which would be made in terms of Sections 72 and 70 of the LTIA and STIA respectively.

To give effect to the process of making Regulations which would clearly demarcate health insurance products from medical schemes, National Treasury established a Demarcation Workgroup in 2009, which included representatives from Council, the Financial Services Board (FSB), and the Department of Health. The Association of Savings and Investments South Africa (ASISA) and the South African Insurance Association (SAIA) were also represented on the workgroup. This consultative process was concluded at the end of 2011, and culminated in the Minister of Finance publishing draft demarcation Regulations in March 2012 for public comment.

Council supports the draft demarcation Regulations since, with their enactment, many harmful short-term insurance products should no longer be allowed to operate.

The Medical Schemes Act protects members of medical schemes through provisions on open enrolment, community rating, the prescribed minimum benefits (PMBs), and a strict governance requirement and oversight by Council. Short-term insurance products doing the business of a medical scheme are not subject to the same regulatory oversight; risk-rating is applied, and applicants can be refused cover.

Short-term insurance products may offer seemingly attractive solutions to some individuals, but these products create the opportunity for medical schemes to selectively create gaps in their benefits and in this way create low-risk pools. This leads to a situation where older and sicker individuals are forced to join medical schemes with more comprehensive coverage at much higher cost. Because short-term insurance products are attractive to the young and healthy members of society, many of them would buy down to cheaper benefit options within their medical scheme and would stop to cross-subsidise the older and sicker members in the comprehensive options. The comprehensive options would become unaffordable, and many older and sicker members of society would lose their medical scheme cover and would not be accepted by the short-term products because of their adverse risk profile.

Health quality and outcomes in medical schemes

In the financial year under review, Council published the first draft of a framework document for the measurement of health quality and outcomes in the medical schemes environment.

The document emanated from a need to begin to objectively determine the role that medical schemes occupy in the attainment of overall health system objectives.

The key objectives in producing the document are:

- Empower consumers such that they are able to compare different medical scheme products and make appropriate choices.
- Enable medical schemes and other purchasers of healthcare services to assess the performance of different providers who serve their members.
- Assist health provider facility managers with information they can use to benchmark their performance against peers.
- Enable policy makers to monitor performance of the health system from the medical schemes perspective so that they intervene in a timely manner should there be a need to do so.

The draft document was circulated to industry for comment and the process culminated in a workshop in November 2011. The next phase of the project is to pilot data collection on a selection of identified indicators. Council has teamed up with the Office of Standards Compliance at the Department of Health to collaborate on the process of piloting health quality and outcomes indicators. This work will be done in the 2012-2013 financial year.

Monitoring diagnosis coding (ICD-10)

Our role in monitoring the implementation of ICD-10 changed during the 2011-2012 financial year; this function now resides within the Department of Health (DoH) although we have retained the responsibility of preparing compliance reports.

ICD-10, or the International Classification of Diseases – 10th Revision, is a diagnosis coding standard which was developed by the World Health Organisation (WHO); it came into use in WHO member states in 1994. Adopted by the National Health Information System of South Africa (NHISSA), the standard continues to be part of the health information strategy of the DoH; it is the diagnosis coding standard of choice in both the public and the private sectors.

The Medical Schemes Act prescribes that all providers of healthcare – such as hospitals, specialists, and doctors – 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.

ICD-10 diagnosis coding is now in its seventh year of implementation in South Africa after it was introduced in the medical schemes industry in 2006.

Council has been responsible for coordinating the activities of the National Task Team (NTT) on ICD-10 implementation since the NTT's inception. At the beginning of 2011, the Director General of the DoH formally established the NTT as a structure within the DoH. This was followed by the appointment of the NTT as a Ministerial Task Team in early 2012. Coordination of all NTT activities is a function that now fully resides within the Health Information Systems chief directorate of the DoH.

A budgetary allocation was made to the NTT in the financial year under review to update the ICD-10 browser and the Master Industry Table (MIT).

Council retains the function of compiling compliance reports, which indicate that the level at which healthcare providers comply with the legal requirement to include a valid ICD-10 code when submitting their claims to medical schemes, remains above the 95% mark.

Practice Code Numbering System (PCNS)

The Medical Schemes Act 131 of 1998, and specifically Regulation 5, requires that healthcare providers include a practice code number on the invoices they submit to medical schemes. Accordingly, as the custodian and enforcer of the Medical Schemes Act, Council must ensure that a system is in place for the issuing of such practice code numbers. The Practice Code Numbering System (PCNS) remained contracted out to the Board of Healthcare Funders of Southern Africa, or the BHF, in the year under review. The BHF is a representative body for medical schemes and medical scheme administrators.

Guaranteed benefits, a pillar of the Medical Schemes Act

The Medical Schemes Act guarantees members of medical schemes access to a set of prescribed minimum benefits, commonly called the PMBs.

The purpose of PMBs cannot be overstated: PMBs are there to ensure that members are protected against health events which could otherwise ruin them financially.

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

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

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

There are medical interventions over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. Anything above PMBs is covered per your scheme's discretion.

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

Council publishes an electronic newsletter on members' rights to PMBs, called CMScript. All issues are available on our website.

High Court ruling on PMBs

The Board of Healthcare Funders of Southern Africa (BHF), the body representing a number of medical schemes and administrators, challenged Regulation 8 of the Medical Schemes Act and asked the North Gauteng High Court in Pretoria to pronounce on it. The BHF was later joined by the South African Municipal Workers' Union National Medical Scheme (SAMWUMed).

Regulation 8 states that medical schemes must pay for the diagnosis, treatment, and care of all PMB conditions in full, or at the price charged by the healthcare provider.

In a legal process that took almost a year, the BHF and SAMWUMed were seeking to have Regulation 8 interpreted to mean that schemes must pay for PMB conditions only up to the scheme tariff, effectively changing the meaning and purpose of the PMB provisions in the Medical Schemes Act.

The High Court handed down its ruling in November 2011: PMBs remain in place, and the law which prescribes them stands, both unchanged. The ruling effectively reaffirmed the need for PMBs and the protection they offer to members of medical schemes.

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

The PMB Code of Conduct, which was developed in 2010, seeks to ensure greater compliance with the PMB provisions in the Medical Schemes Act. It is available on our website.

Clarifying prescribed minimum benefits (PMBs)

Council published definitions for a number of PMB conditions where the current definitions are open to interpretation which may prejudice consumers.

These benefit definitions were developed in accordance with the requirements of the Medical Schemes Act, and serve to clarify the entitlements associated with certain PMB conditions. The definitions provide guidance on the use of Novo Seven (an expensive drug often incorrectly used in the management of uncontrollable haemorrhage), the application of health economics evaluation to PMBs, general transplants, kidney transplants, prostate cancer, and ischemic heart disease.

The benefit definitions are based on the principle that the diagnosis, treatment, and care of PMB conditions must be evidence-based and take into consideration cost-effectiveness and affordability for the medical scheme.

Reviewing PMBs

The Department of Health (DoH) is leading the review of prescribed minimum benefits (PMBs); the Medical Schemes Act prescribes that PMBs be reviewed every two years. While no formal review of PMB legislation was performed in the period under review, Council made further adjustments to its recommendations which it had presented to the DoH in 2010. We expect that the Minister of Health will publish draft amendments to the PMB Regulations soon.

The myth surrounding PMBs

PMBs are under constant attack. There are those who persistently claim that PMBs drive up the costs of medical schemes and consequently push up the monthly contributions, which in turn allegedly makes medical schemes increasingly unaffordable and the medical schemes industry unsustainable in the long run.

Such attacks, though vociferous and unrelenting, are unfounded. Council has been inviting the parties making such allegations to come forward with evidence in support of their claims, but almost 12 years later, no such evidence has ever been brought to our attention.

In fact, our research paints a very different and very positive picture of PMBs and their impact on the industry. Since PMBs were reintroduced with the Medical Schemes Act 131 of 1998, the industry has been performing better than ever and medical schemes have reached a new level of financial soundness. Industry has never been as stable and sustainable as it is now. Equally important is the fact that members of medical schemes remain protected against unforeseen and catastrophic health events.

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

Exemptions from PMB provisions

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

In the financial period under review, Council granted exemptions from provisions on PMBs to the following bargaining council schemes:

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

Creating the medical schemes industry

Status of schemes

In February 2012 we published a list of all the registered medical schemes (and their contact details) in the *Government Gazette* in accordance with Section 25 of the Medical Schemes Act.

We received no applications for the registration of a new medical scheme during the period under review.

GetMed Medical Scheme was deregistered in August 2011 because it had failed to comply with the conditions which had been set out in its registration.

The number of registered medical schemes dropped from 99 in March 2011 to 95 in March 2012.

Status of options

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

The number of registered benefit options decreased from 316 in January 2011 to 311 in March 2012. This represents a drop in the number of benefit options in open schemes from 171 to 169 between 2011 and 2012, and a drop in the number of benefit options in restricted schemes from 145 to 142 during the same period.

Table 1: Options as at 1 March 2012

Status of option	Open schemes options	Restricted schemes options	Total
Options registered in January 2011	**171**	**145**	**316**
Discontinued options	-5	0	-5
Discontinued options due to scheme mergers and combining options within schemes	-2	-2	-4
Discontinued options due to scheme liquidations	-2	-1	-3
New options	1	0	1
Options with efficiency discounts	-22	0	-22
Approved options with effect from 1 January 2012 (excl. efficiency discount options)	**141**	**142**	**283**
Options with efficiency discounts*	28	0	28
Registered options as at 1 March 2012	**169**	**142**	**311**

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

Evaluating the rules of medical schemes

Council processed 275 rule amendments during the 2011-2012 financial year. The proposed amendments included changes to contributions and benefits, the registration of new benefit options, and efficiency-discounted options.

Both Council's Appeals Committee and the independent Appeal Board upheld Council's determinations to reject the proposed eligibility criteria for restricted medical schemes. Industry does, however, persist in its efforts to restructure eligibility criteria so as to allow restricted medical schemes to avoid admitting higher-risk groups as members of such schemes.

Marketing material and application forms

We evaluated the marketing material and application forms of the following schemes:

1. AECI Medical Aid Society
2. Altron Medical Aid Scheme
3. Anglo Medical Scheme
4. Bankmed
5. Bestmed Medical Scheme
6. Bonitas Medical Fund
7. BP Medical Aid Society
8. Cape Medical Plan
9. Compcare Wellness Medical Scheme
10. De Beers Benefit Society
11. Discovery Health Medical Scheme
12. Fedhealth Medical Scheme
13. Genesis
14. Golden Arrows Employee's Medical Benefit Fund
15. Government Employees Medical Scheme (GEMS)
16. IBM (SA) Medical Scheme
17. Keyhealth
18. LA Health Medical Scheme
19. Lonmin Medical Scheme
20. Massmart Health Plan
21. MBMed
22. Medihelp
23. Medimed Medical Scheme
24. Medipos Medical Scheme
25. Medshield Medical Scheme
26. Pick & Pay Medical Scheme
27. Platinum Health
28. Profmed
29. Quantum Medical Aid Society
30. Rand Water Medical Scheme
31. Rhodes University Medical Scheme
32. SABC
33. SA Breweries Medical Aid Society
34. SAMWUMed
35. Sasolmed
36. SEDMED
37. Siemens Medical Scheme
38. South African Police Service Medical Scheme (POLMED)
39. Spectramed
40. Thebemed
41. Topmed Medical Scheme
42. Umvuzo Health Medical Scheme
43. University of the Witwatersrand Staff Medical Aid Fund
44. Wooltru Healthcare Fund
45. Xstrata Medical Aid Scheme

Section 32 of the Medical Schemes Act ensures that the rules of medical schemes are binding on them and their stakeholders. We 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 Act always takes precedence over scheme rules should the two be inconsistent.

Administrators

Council approved the accreditation of Discovery Health (Pty) Ltd on evaluation of the administrator's renewal application but as at 31 March 2012 this organisation remained unaccredited because it had not confirmed its acceptance of the suspensive conditions which Council had imposed on it.

Council approved the renewal of Medihelp's compliance with the accreditation standards for administrators applicable to self-administered medical schemes for a further three years based on an evaluation conducted by the Accreditation Unit which included confirmation of the scheme's compliance with the previous conditions imposed.

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

- Medscheme Holdings (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Metropolitan Health (Pty) Ltd
- Professional Medical Scheme Administrators (Pty) Ltd
- V Med Administrators (Pty) Ltd

The above-mentioned administrators were issued with accreditation certificates and our website, which lists the names and contact details of all the entities regulated by us, was amended accordingly.

In the period under review we conducted on-site evaluations of two self-administered medical schemes to assess their conduct and compliance with the accreditation standards for administration. Pro Sano Medical Scheme was provided with a certificate of compliance.

A number of non-compliance issues were identified during the evaluation of self-administered Food Workers Medical Benefit Fund's compliance with administration standards. Discussions with the scheme's Board of Trustees resulted in corrective action being taken by the scheme and the sourcing of a system which will enable them to comply with administration standards. The scheme will be re-evaluated once the measures have been implemented.

There were 16 third-party administrators and eight self-administered medical schemes as at 31 March 2012.

Managed care organisations

A number of new applications for accreditation as MCOs were received during the period under review but a number of them were found not to be valid as the proposed services offered by these organisations did not meet the definition of "managed healthcare" as defined in the Medical Schemes Act and Regulations, and therefore did not require Council's accreditation. The applicants were notified as such.

Council approved the following new applications of MCOs (for two years):

- Centre for Degenerative Joint Diseases (Pty) Ltd
- Dentpro (Pty) Ltd

Council approved the renewal of accreditation of the following MCOs:

- Allcare Administrators (Pty) Ltd
- Centre for Diabetes and Endocrinology (Pty) Ltd
- Dental Information Systems (Pty) Ltd
- Dental Risk Company (Pty) Ltd
- Emerging Market Healthcare (Pty) Ltd
- Enablemed (Pty) Ltd
- Independent Clinical Oncology Network (Pty) Ltd
- Medical Services Organisation SA (Pty) Ltd
- Medscheme Holdings (Pty) Ltd
- Private Health Administrators (a division of Sweiden Trust (Pty) Ltd))
- Resilience Health Services (Pty) Ltd
- Universal Care (Pty) Ltd
- Uno Healthcare (Pty) Ltd t/a One Health Managed Care

The following MCOs were deactivated on our website:

- Clicks Direct Medicines (Pty) Ltd elected not to renew their accreditation because the organisation does not offer managed care services anymore.
- The business conducted by UDIPA Holdings (Pty) Ltd, ECIPA Healthcare, Diagnostic Care (Pty) Ltd, Clinical Partners (Pty) Ltd, and Goodmed t/a Lifechoice (Pty) Ltd was re-assessed and found not to be doing the business of managed care. These entities are therefore not required to be accredited as contemplated in the Medical Schemes Act.

There were 40 managed care organisations as at 31 March 2012.

Brokers and broker organisations

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

Table 2: Broker accreditations suspended and withdrawn 2011-2012

Broker number	Action	Effective date	Reason
RA van den Berg (BR 3341)	Withdrawn	10.08.2011	The broker requested that accreditation be withdrawn since he no longer provides broker services.
LM Schietekat (BR 477)	Suspended	18.01.2012	This was a default suspension following the withdrawal of the Financial Services Provider (FSP) license number by the Financial Services Board (FSB).

Table 3: Brokerage accreditations suspended and withdrawn 2011-2012

Brokerage number	Action	Effective date	Reason
Jordaan Advisors CC (ORG 3732)	Withdrawn	18.04.2011	This organisation had shareholding and a financial interest in another broker organisation, Jurien Jordaan Advisory Services (ORG 2904). Accreditation had been granted on condition that the accreditation of ORG 2904 be withdrawn. ORG 3732 elected to withdraw its application.
Tshepang Consultants CC (ORG 3160)	Suspended	18.01.2012	This was a default suspension following the withdrawal of the Financial Services Provider (FSP) license number by the Financial Services Board (FSB).
South African Financial Management CC (ORG 350)	Withdrawn	07.02.2012	The entity sold its book to another broker organisation, namely Sasfin Financial Advisory Services (Pty) Ltd (ORG 544).

In the financial year being reviewed we received new applications from 918 brokers and 145 broker organisations, and renewal applications from 4 298 brokers and 1 171 broker organisations.

There were 7 482 brokers and 2 151 broker organisations as at 31 March 2012.

Medical schemes' sales staff

Medical schemes sought clarity on a possible accreditation process as it relates to internal marketers employed by schemes as brokers. We confirmed that internal sales employees are not required to be accredited as brokers; this is because they render sales and broker services as employees of the scheme and are therefore excluded from the definition of a broker as defined in Section 1 of the Medical Schemes Act.

Observing and working with industry

Duty to speak openly

Council managed the successful appeal to the Supreme Court of Appeal (SCA) against a judgment of the North Gauteng High Court in a defamation case involving Selfmed Medical Scheme.

The ruling of the SCA reaffirmed the obligation of the Registrar and Council to be able to report on matters affecting medical schemes and their members in an unfettered manner.

Ensuring compliance with the Medical Schemes Act

It is our duty to ensure that the entities which we regulate – medical schemes, administrators, managed care organisations, and healthcare brokers and broker organisations – comply with the Medical Schemes Act 131 of 1998 at all times. We have the expertise and mandate to monitor the behaviour of regulated entities and take corrective action where required.

The nature and extent of litigation against the Registrar and Council remained unpredictable, but these challenges were dealt with in a manner which ensured that the imperative of protecting member interests was at all times maintained. We are proud of the fact that we managed to recover monies in excess of R6.8 million arising from protracted litigation occasioned by regulatory intervention concerning Bonitas Medical Fund (Bonitas).

Our Compliance & Investigations Unit instituted inspections and investigations in terms of Section 44(4)(a) of the Medical Schemes Act into Sizwe Medical Fund (Sizwe) and Medshield Medical Scheme (Medshield).

In the year under review we also started attending the Annual General Meetings (AGMs) and Special General Meetings (SGMs) of medical schemes as observers. Concerns were raised with relevant schemes. Plans are also underway to try and improve the manner in which members meetings are conducted and to make them open and accessible to the broader membership of schemes.

Sections 57(1) and 57(4) of the Medical Schemes Act provide for the election and appointment of trustees and Principal Officers who are fit and proper. We commenced with the process of vetting (screening) trustees and Principal Officers to ensure that schemes are managed by fit and proper officers, thereby strengthening their governance structures and ensuring better protection of members' interests.

Enforcement relating to personal medical savings accounts (PMSAs)

In 2007 the High Court of South Africa ruled that funds standing to the credit of personal medical savings accounts (PMSAs) of members constitute trust money as defined in Section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001 – and as such remain the property of members. It ordered that PMSA monies must be paid out to members when their membership comes to an end or when they move to a new scheme with PMSAs.

It also ordered that interest accrued on these PMSA amounts be paid to members and that if a member could not be located, the balance be paid into the Guardians Fund.

The intention of Regulations 10(3)-10(5) in the Medical Schemes Act has always been to ring-fence savings balances and to protect them from creditors of the medical scheme. The Registrar had sought a declaratory order to confirm this interpretation of the Medical Schemes Act. The Omnihealth judgment confirmed the Registrar's interpretation of the Act and said Regulations.

In giving effect to the judgement and law, the Registrar issued Circulars 38 of 2011 and 5 of 2012 to provide guidance on the correct implementation of Regulations 10(3)-10(5). Medical schemes indicated that they would need to adjust their systems in order to comply with these provisions, so Council granted a one-year extension for implementation to those who had applied for it.

King Code and Report on Governance III

Council examined the King III Report and its possible implications for medical schemes. We engaged industry to determine the practical challenges that may be attached to the implementation of such a governance code. Many of the principles in the King III Report are already enshrined in the Medical Schemes Act and need no further clarification, but we will continue to engage with industry where necessary.

The remuneration of trustees

In 2011 we shared with industry a draft document in which we propose a framework for the remuneration of medical scheme trustees. The project arose out of a concern over a lack of uniformity in the manner in which medical schemes remunerate and reward members of their boards. The observed inconsistencies in some instances result in gross abuses of member contributions whereby some trustees become unjustly enriched. When this happens, non-health expenditure rises and governance problems emerge. Industry was invited to comment on the framework document. Council intends to formulate a comprehensive guideline for trustee remuneration with the main aim of eliminating abuses while ensuring that medical schemes are able to recruit and retain appropriately skilled individuals to serve on their boards.

Scheme amalgamations, liquidations, and curatorships

In the year being reviewed, medical schemes continued to merge, liquidate, and be placed under curatorship. We must emphasise that such developments are not undesirable but are in fact a natural response to natural market forces operating in any industry. Such occurrences therefore cannot and should not be used to argue for a negative picture of the South African medical schemes landscape; no outside intervention is required when no problem has been diagnosed.

Amalgamations

Discovery Health Medical Scheme (Discovery) and Edcon Medical Aid Scheme (Edcon) amalgamated into Discovery with effect from 1 January 2012.

Liquidations

Protea Medical Aid Society (Protea) was placed under curatorship in October 2010 after an investigation revealed irregularities relating to the running of the scheme. The curatorship was cancelled and the scheme was placed under provisional liquidation in the hands of the Master of the Western Cape High Court in April 2011.

Curatorships

Following protracted litigation between Council and Bonitas Medical Fund (Bonitas) that failed to adequately address the governance issues at the scheme, the trustees and acting Principal Officer (PO) of Bonitas were finally removed from office and South Africa's third-largest medical scheme was placed under curatorship in May 2011. The curator is expected to reintroduce proper governance structures at the scheme.

How RETAP became ITAP

Council gained capacity and knowledge during the period of developing a risk adjustment mechanism for medical schemes. But a decision was taken at policy level to no longer proceed with the implementation of a risk adjustment system in the medical schemes environment.

The Risk Equalisation Technical Advisory Panel (RETAP) had been established as a forum through which experts from the industry would provide advice and guidance in preparation for a full roll-out of risk equalisation. Council took the decision to continue convening a forum such as RETAP in an effort to enhance collaborative efforts with the industry. Industry embraced this idea and the Industry Technical Advisory Panel (ITAP) was formed in January 2012 with a mandate that is broader than that of RETAP. ITAP presents an opportunity for industry to work with Council to explore other uses of the risk measurement data and other projects.

ITAP's terms of reference are still being finalised, but some areas have already been identified on which to continue collaboration:

- Ongoing discussion on data standards and groupers
- Analysis of demographic and prevalence trends
- Analysis of utilisation and burden of disease
- Cost of prescribed minimum benefits (PMBs)
- General cost drivers in the healthcare industry

Guidance on contribution increases

In the year under review, Council analysed key economic indicators with a bearing on the private healthcare sector in order to make a recommendation to industry on reasonable cost increase assumptions when determining contribution increases for the year 2012.

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

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

Council published Circulars 29 and 54 of 2011, which are a guidance note on contribution increases and the evaluation of cost increase assumptions by medical schemes respectively. The purpose was to share with industry our view on inflation and the likely impact of the projected cost increase assumptions on contribution increases for 2012.

The following economic indicators were reviewed to allow us to recommend a certain range for contribution increases for the year 2012:

Economic indicator	Percentage increase / decrease
CPI (bottom end – moving average for 2010-2011)	3.9%
CPI (top end – National Treasury-projected headline inflation for 2011)	4.9%
Medicine pricing: Single Exit Price (projected trend for 2012)	2.14%

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 the 2012 financial year lie between 4.3% and 5.3%.

Overall, the distribution of medical schemes cost assumptions used in determining contribution increases showed a weighted median cost increase of 8.3% – above Council's recommended maximum increase assumption of 5.3%.

As was the case in the past, cost assumptions for private hospitals and medical specialists were above CPI. Despite the increasing trend of consolidation among medical schemes, there is no evidence to suggest the strengthening of bargaining powers in tariff negotiations between schemes and administrators on the one hand, and hospitals and other healthcare providers on the other.

Medical schemes remain price takers in a market characterised by a limited degree of competition between a few hospital groups and health care providers.

Escalating costs, coupled with anomalies inherent in the private healthcare market, will continue to serve as potential barriers to access to healthcare if left unchecked. Council will continue to monitor changes in the above indicators and will publish information to enable medical schemes to factor in their pricing to guide contribution increases for the year 2013.

Contributions

The average gross contribution increase for all medical schemes in 2012 was 8.9%.

Open schemes increased their contributions by more than restricted schemes in the calendar year under review. The comparative increases for open and restricted schemes were 9.2% and 8.4% respectively. This observation highlights the fact that the average family contribution in restricted schemes is 12.0% 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 gross contribution increase is based on the actual number of principal members as well as adult and child dependants in medical schemes. The information in this section is a summary based on medical scheme submissions in respect of the annual benefit changes and contribution increases for 2012; it is based on projections in these submissions.

The average gross contribution increases for the 2011-2012 benefit and contribution review period are:

Increase in gross contributions in 2012	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.3%	9.0%	8.9%	9.2%
Restricted schemes	8.1%	9.2%	8.3%	8.4%
All schemes	**8.8%**	**9.1%**	**8.6%**	**8.9%**

Gross contributions and risk contributions

The average monthly gross contribution for 2012 per principal member, adult dependant, child dependant, and family is as follows:

Monthly gross contributions in 2012	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 803	R1 557	R510	R2 956
Restricted schemes	R1 482	R1 155	R581	R2 600
All schemes	**R1 581**	**R1 326**	**R525**	**R2 659**

The average monthly risk contribution for 2012 per principal member, adult dependant, child dependant, and family is as follows:

Monthly risk contributions in 2012	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 587	R1 342	R446	R2 585
Restricted schemes	R1 416	R1 098	R564	R2 490
All schemes	**R1 436**	**R1 183**	**R485**	**R2 411**

Risk contributions: year-on-year percentage rate changes

The average risk contribution increase for all medical schemes in 2012 was 8.8%. The comparative increases for open and restricted schemes were 9.1% and 8.5% respectively.

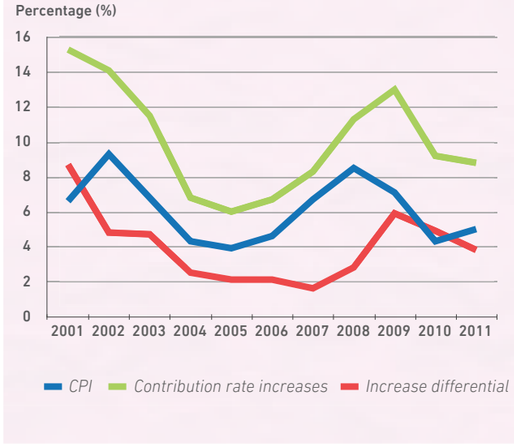
The average risk contribution increases for the 2011-2012 benefit and contribution review period are:

Increase in risk contributions in 2012	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.2%	9.0%	8.6%	9.1%
Restricted schemes	8.2%	9.2%	8.4%	8.5%
All schemes	**8.8%**	**9.1%**	**8.5%**	**8.8%**

Contribution rates relative to general price indicators

Figure 1 shows the historical and current trends in the Consumer Price Index (CPI) (or inflation) relative to contribution rates in medical schemes between 2001 and 2011. We also incorporated the amount by which medical contribution increases are greater than inflation.

Figure 1: Contributions and inflation 2001-2011



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

The average difference in the increase in contributions compared to CPI throughout the period 2001 to 2011 is in the region of 3.9%. 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.

How much members contributed and what schemes paid

In 2011, medical schemes collected a total of R107.4 billion in contributions, representing an increase of 11.3% from R96.5 billion in 2010.

Of this, schemes spent R93.2 billion on healthcare benefits, an increase of 10.0% from R84.7 billion in 2010.

(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 2011* on page 123 and in the Annexures differs from the one reported above because it includes the IBNR and the results of risk transfer arrangements.)

Figure 2 depicts the trend in healthcare benefits paid by medical schemes to different types of providers since the year 2000. The figures have been adjusted for inflation.

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

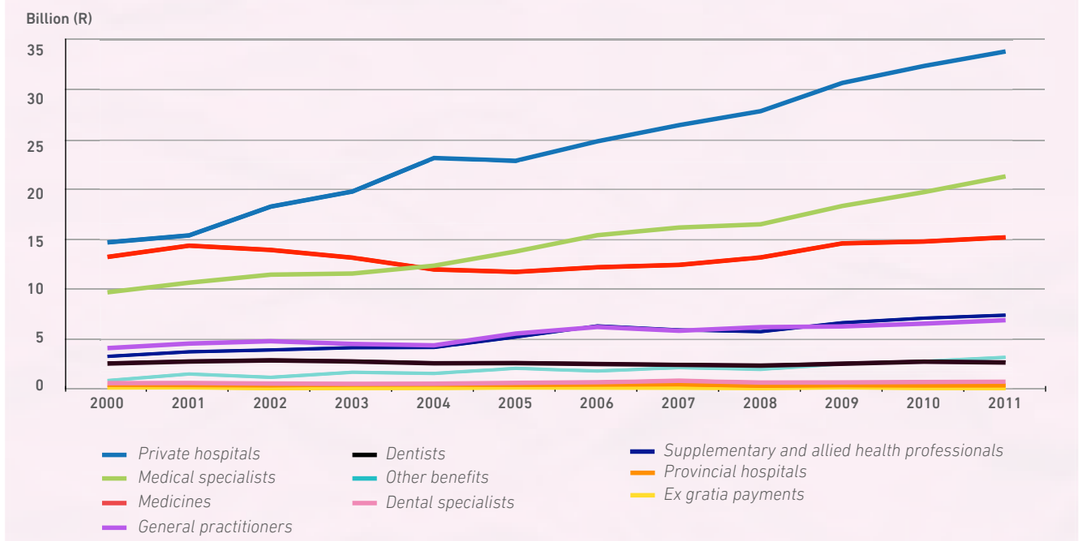
By 2011, medical schemes expenditure on private hospitals had increased in real terms by 129.9% to R33.8 billion compared to R14.7 billion in 2000.

Private hospitals expenditure accounted for 29.9% of all healthcare benefits paid by medical schemes in 2000; the comparative figure in 2001 was 28.4%. Expenditure on private hospitals appeared to decline between 2004 and 2005 but an upward trend began to emerge in 2006 and onwards such that, in 2011, private hospitals expenditure accounted for 36.3% of all healthcare benefits paid by medical schemes; this was marginally less than the 36.4% noted in 2010.

Benefits paid to medical specialists in 2011 amounted to R21.3 billion, an increase of 121.9% in real terms when compared to the R9.6 billion that was spent on this item in 2000. Expenditure on medical specialists has been increasing since 2003, where it accounted for 19.6% of all benefits paid. This increased to 22.8% in 2011.

Medical schemes spent 15.2% more on medicines in 2011 (R15.2 billion), up from R13.2 billion in 2000. As a proportion of total healthcare benefits paid, expenditure on medicines decreased from 27.0% in 2000 to 19.2% in 2004. In the years 2005-2010,

Figure 2: Total healthcare benefits paid 2000-2011: 2011 prices*



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

medicines expenditure remained stable at 17.0% relative to all benefits paid.

Total expenditure on general practitioners (GPs) amounted to R6.8 billion in 2011, which is an increase of 78.9% compared to the R3.8 billion that was spent on these healthcare providers in 2000.

There was an increase of 4.2% on healthcare benefits paid to dentists, from R2.4 billion in 2000 to R2.5 billion in 2011.

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 2012 was 6.4%. The comparative increases for open and restricted schemes were 5.4% and 9.6% respectively. This requires monitoring as non-health expenditure is traditionally lower in restricted schemes than in open schemes.

Non-health expenditure

The reduction of non-health expenditure is an area that we continued to focus on in the year under review. We made progress, through various initiatives and engagements, in encouraging trustees to take a closer look at these costs and ensure that value for money is obtained.

The non-health expenditure of medical schemes remained stable in real terms. Total non-health expenditure (i.e. administration expenses, managed healthcare: management services, broker and distribution costs, and impaired receivables) amounted to R12.1 billion in 2011, an increase of 4.8% from R11.6 billion in 2010. This is a stark contrast to the double-digit increases experienced over a decade ago.

Monitoring schemes' finances and solvency

One of our main responsibilities as regulator of the industry is to exercise oversight over the financial soundness of medical schemes.

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

Council also monitors schemes which are above the required statutory solvency of 25.0% but whose solvency is rapidly decreasing. Interventions on such schemes may include the submission of management accounts, financial review meetings with the Board of Trustees, and the submission of business plans.

Other schemes on Council's radar are those with excessive non-health expenditure and governance problems, as well as those under curatorship.

Overall, the industry remained stable in the 2011 financial year. A fair number of medical schemes improved their solvency, and the number of schemes under close monitoring (i.e. the so-called ICU schemes with a solvency below the prescribed 25.0%) dropped from 19 to 14, although this is partially due to amalgamations and liquidations. Some schemes did achieve the minimum required solvency level during the year.

There were nine (9) open and five (5) restricted medical schemes in ICU as at 31 December 2011. There were 12 open and seven (7) restricted schemes in ICU as at 31 December 2010.

Medical schemes experiencing governance problems are more likely to ultimately experience financial problems as well. Such schemes are also on close monitoring.

Table 4 shows a summary of schemes under close monitoring in terms of Regulation 29(4) of the Medical Schemes Act.

As part of our regulatory interventions, and to ensure the protection of member interests, we have asked some medical schemes with a worsening financial position to consider amalgamation. This is indicative of the general direction in which the industry is moving given the persistent challenges around continually increasing costs.

There were 97 medical schemes (26 open and 71 restricted) as at 31 December 2011, representing a total of 8 526 409 lives.

Table 4: Schemes under close monitoring

Solvency	Open schemes	Restricted schemes	Name of schemes
Solvency below 10.0%	1	2	Government Employees Medical Scheme (GEMS) Resolution Health Medical Scheme Transmed Medical Fund
Solvency of 10.0-13.5%	1	0	Thebemed
Solvency of 13.5-17.5%	2	2	Altron Medical Aid Scheme Keyhealth Pharos Medical Plan Umvuzo Health Medical Scheme
Solvency of 17.5-22.0%	2	1	Hosmed Medical Aid Scheme Minemed Medical Scheme National Independent Medical Aid Society (NIMAS)
Solvency of 22.0-25.0%	3	0	Community Medical Aid Scheme (COMMED) Discovery Health Medical Scheme Momentum Health
Solvency below 25.0%	**9**	**5**	**14**

There were 4 760 114 (2010: 4 799 915) beneficiaries in open schemes as at 31 December 2011, of which 60.0% (2010: 60.8%) found themselves in schemes who are not meeting the prescribed minimum solvency requirement. The restricted schemes market had 3 766 295 (2010: 3 515 803) beneficiaries as at 31 December 2011, of which 49.5% (2010: 47.9%) were in schemes not meeting the prescribed minimum solvency requirement.

As at 31 December 2011, 55.4% (2010: 55.3%) of beneficiaries were in schemes on close monitoring. This number would be significantly smaller if the Government Employees Medical Scheme (GEMS) and Discovery Health Medical Scheme were excluded because they represent the largest number of beneficiaries in both the restricted and open schemes market respectively.

How ICU schemes on close monitoring fared

Altron Medical Aid Scheme fell below the prescribed 25.0% solvency during 2010. At the end of December 2011, it had a solvency of 16.8%. The scheme had experienced a significant drop in membership following a relaxation of employment conditions by the employer, resulting in younger and healthier members leaving the scheme. This was subsequently corrected when the employer made membership of the scheme compulsory for all employees. Altron was placed on close monitoring in 2011. It has submitted a business plan.

Community Medical Aid Scheme (COMMED) had a solvency level of 22.0% in 2011, an improvement on the previous year. But the scheme continued to experience a decline in membership, as well as a worsening age profile. COMMED also has high non-health expenses. The scheme is under close monitoring and has submitted a business plan which was approved by the Office of the Registrar.

Discovery Health Medical Scheme ended 2011 with a solvency of 23.5%. The scheme continued to grow its membership base. The Board of Trustees introduced various initiatives to address non-health expenditure; Council is monitoring this expenditure on an ongoing basis. Discovery has submitted a business plan; there is ongoing engagement with the scheme to discuss progress against the approved plan.

As at 31 December 2011, the Government Employees Medical Scheme (GEMS) had a solvency of 8.6%. The scheme continued to grow its membership in the year under review, which put pressure on its solvency ratio. Benefit alignment continues to be an area of focus, so that utilisation and the resultant impact of claims on reserves are managed appropriately. GEMS submits monthly management accounts and quarterly financial updates for monitoring purposes. It also has an approved business plan.

Hosmed Medical Aid Scheme continued to be riddled with governance challenges in 2011. Council had difficulties obtaining the scheme's statutory submissions, which resulted in substantial statutory penalties being imposed. Hosmed ended the year with a solvency level of 18.4%.

For the year ending in December 2011, Keyhealth had a solvency of 15.6%. The scheme continued to be under pressure due to an ageing membership profile and high claims. Keyhealth is under close monitoring; it submits management accounts and we meet with its trustees regularly to monitor progress.

For Lonmin Medical Scheme the year 2011 was very successful; the scheme achieved a solvency of 32.3%, compared with 19.3% in 2010. Its claims expenditure for the year was lower than expected.

Minemed Medical Scheme had a solvency of 18.9% at year end, an improvement on 2010. The scheme experienced a lower claims ratio which resulted in its reserves building up. Minemed has an approved business plan and is submitting monthly management accounts to Council.

As at 31 December 2011, Momentum Health had a solvency of 23.9%. The scheme's performance improved compared to the previous year largely due to membership growth in the lower-cost benefit options as well as reduced claims. We are monitoring the scheme closely through monthly management accounts and quarterly meetings.

The National Independent Medical Aid Society (NIMAS) had a solvency ratio of 19.2% at year end. The scheme is gradually losing younger members which impacts on the average age of the scheme. The huge decline in membership, coupled with a reduced claims ratio, resulted in an increase in reserves. We asked NIMAS to seek an amalgamation partner and the scheme is currently at an advanced stage of engagement with another scheme in this regard. NIMAS submits monthly management accounts and attends bi-monthly meetings to discuss its financial performance.

Pharos Medical Plan experienced a decline in solvency and ended 2011 with 15.1% compared with 17.5% at the end of 2010. The scheme's high claims experience continued in the year under review, as well as a decrease in membership. Pharos continued to submit monthly management accounts and attend quarterly meetings to discuss its financial performance.

Pro Sano Medical Scheme ended the year with a solvency ratio of 25.2%.

As at 31 December 2011, Resolution Health Medical Scheme had a solvency of 9.1%, a decline from 17.6% in 2010. The Board introduced various initiatives to address non-health expenditure. The scheme continued to be monitored closely through regular meetings and the submission of monthly management accounts.

Spectramed had a solvency ratio of 32.2% in the 2011 financial year, a drastic improvement from 19.5% in 2010. This improvement in performance can be attributed to various initiatives which the scheme had engaged in over the last couple of years, including benefits realignment.

Thebemed had a solvency level of 11.0% in the year under review. The scheme's performance improved even though its membership grew substantially. This is largely due to initiatives around claims management. Thebemed is on close monitoring; the scheme submits management accounts and bi-monthly meetings have been arranged to continually discuss progress.

Transmed Medical Fund's solvency ratio continued to decline; it was 9.5% at the end of 2011. The scheme has a high age profile, and the many claims resulted in the scheme incurring large losses and a rapid decrease in its solvency. Transmed submitted a business plan, and is under close monitoring. Council has ongoing meetings with the scheme to discuss progress and ensure that its members are protected.

Umvuzo Health Medical Scheme had a solvency level of 14.9% at year end.

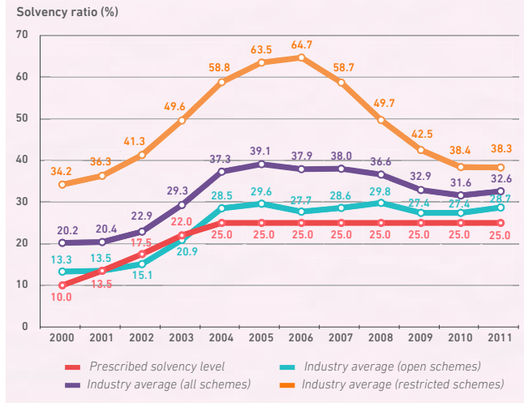
Other schemes on close monitoring

Council also pays attention to medical schemes whose solvency is above the statutory requirement but who face other challenges, including a falling solvency as a result of huge operational losses, high non-health expenditure, and/or excessively low membership, to name a few. The regulatory response to such schemes is always aligned to the severity of the problems being experienced, and may include the submission of monthly management accounts, financial review meetings, as well as reserving plans.

Solvency of the industry

The medical schemes industry remained above the required statutory solvency level of 25.0% in the year 2011.

Figure 3: Solvency levels 2000-2011



How schemes invest

Council started reviewing Annexure B of the Medical Schemes Act, read in conjunction with Regulation 30. This legislation regulates investments made by medical schemes to ensure that the spread of investments is aligned with the nature of medical scheme liabilities. We secured the services of various experts to serve on the Annexure B / Regulation 30 Technical Advisory Panel (TAP). This work is in its early stages, and industry will be engaged to provide comments in due course.

Accounting guide for medical schemes

Council worked with the South African Institute of Chartered Accountants (SAICA) Medical Schemes Project Group on the annual revision and publication of the *SAICA Accounting Guide for Medical Schemes*. The guide was published in September 2011.

Efficiency-discounted benefit options

Efficiency-discounted benefit options allow for differentiation in contribution structures in conflict with the principle that the monthly contributions may be based only on income or family size, or both. Medical schemes therefore need to apply for exemption from Section 29(1)(n) of the Medical Schemes Act to operate these options.

In 2011-2012 Council granted exemptions to three schemes – Fedhealth Medical Scheme, Liberty Medical Scheme, and Thebemed – allowing them to operate benefit options which provide efficiency discounts based on the provider choice offered. This means that, as at March 2012, there were five medical schemes with efficiency-discounted benefit options, including Discovery Health Medical Scheme and Momentum Health.

Benefit options with efficiency discounts offer members discounts where the scheme is able to obtain efficiency with a selected 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.

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.

These options were introduced in 2008. Council is in the process of monitoring their performance.

Initiatives to improve the functioning of regulated entities

Routine inspections

Council is the statutory body responsible for regulating the medical schemes industry in the country. This means that we register and regulate medical schemes, and accredit and regulate the businesses affiliated with them, namely administrators, managed care organisations (MCOs), and healthcare brokers and broker organisations.

Ensuring good governance in these regulated entities is one of our priorities. Good governance benefits all: the entities themselves, the industry as a whole, and members at large. By implication the entire health system is strengthened.

It is with the above in mind that we decided, in the year under review, to introduce routine inspections into medical schemes. Relying on Section 44(4)(b) of the Medical Schemes Act, which says that the Registrar of Medical Schemes can order an inspection into a medical scheme "or any other person" to routinely monitor their compliance with the Medical Schemes Act, our Compliance & Investigations Unit inspected Discovery Health Medical Scheme (Discovery), the Government Employees Medical Scheme (GEMS), Profmed, Witbank Coalfields Medical Aid Scheme, Bestmed Medical Scheme, and Topmed Medical Scheme.

Accreditation of MCOs

The managed care accreditation standards were revised during the year under review to include a comprehensive range of criteria within which the skills, infrastructure, capacity and clinical expertise of managed care organisations (MCOs) are measured for compliance in order to be accredited. We commenced with on-site evaluations of applicants to verify the information. Five pilot on-site evaluations were conducted at the premises of the following MCOs:

- CareCross Health (Pty) Ltd
- Centre for Diabetes and Endocrinology (Pty) Ltd
- Dental Information Systems (Pty) Ltd
- Medical Services Organisation SA (Pty) Ltd
- Mediscor PBM (Pty) Ltd

Once the pilot on-site evaluations were concluded, the managed care accreditation standards were finalised and published for public comment, and Version 4 was published on our website and introduced for evaluating all future applications. As a result, the Accreditation Unit completed two additional on-site evaluations by year-end and accredited the following entities as MCOs:

- Prime Cure Health (Pty) Ltd
- South African Oncology Consortium Limited

Collaboration with other regulatory entities

Consumer Protection Act

The Consumer Protection Act (CPA) has had a significant impact on a number of industries and their regulatory bodies, including Council. While a number of interventions provided for in the legislation, such as the strengthening of consumers' rights to receive clear and transparent communication of their contractual rights and obligations, are to be welcomed, the wide jurisdictional span of the CPA on the other hand has posed a number of technical challenges for Council, particularly in the area of complaints adjudication in view of the dual jurisdiction provided for in the legislation in this regard. A number of schemes found themselves in the position of having complaints adjudicated upon by both the Consumer Commission and Council.

Having given careful consideration to the CPA and its impact on the regulation of medical schemes, particularly in view of the complex clinical and technical nature of many of the matters which require to be adjudicated upon to give proper effect to the medical schemes regulatory framework, Council resolved to apply to the Minister of Trade and Industry for exemption from a number of the provisions of the CPA on the basis that prevailing provisions of the Medical Schemes Act provide consumers with either the same or improved protection to that contemplated by the CPA.

It bears noting that Council's application for exemption is consistent with the approach adopted by the Financial Services Board (FSB) in engaging with the CPA.

Council is confident that the positive tenets enshrined in the CPA will be effectively protected within the scope and ambit of the prevailing regulatory framework.

The determination of health prices

Subsequent to the November 2010 publication of a discussion document on the determination of health prices in the private sector by the Department of Health (DoH) and Council, Council staff members served on a task team appointed by the Minister of Health to evaluate comments on the discussion document and to advise the Minister on how to proceed with this matter.

The parliamentary Health Portfolio Committee invited Council to make a presentation to the committee in July 2011; we again proposed that a regulator be established to oversee the process of price determination in the private health sector.

In respect of private healthcare tariffs, we had numerous discussions with and provided technical support to the DoH, the Competition Commission, and the Health Professions Council of South Africa (HPCSA).

In February 2012 a Council staff member accompanied officials from the DoH and the Competition Commission to the Organisation for Economic Cooperation and Development (OECD) Working Party on competition among private hospitals.

Our "warning systems"

Statutory returns and complaints

Since the inception of Council in 2000, we have been collecting and continue to collect quarterly statutory returns. Although the numbers are unaudited, these returns serve as an early warning system for Council to consider appropriate regulatory intervention where required. The statistics that we collect on the complaints that we receive each year also serve as a way to monitor the industry and pick up problematic areas of possible non-compliance with the Medical Schemes Act.

Real-Time Monitoring (RTM) of the industry

As part of our continued efforts to monitor and ensure the financial soundness of medical schemes, we commenced with a project which seeks to collect financial and non-financial variables from all medical schemes via web services in real time, i.e. a shorter reporting period than is currently possible through other statutory reporting tools. This is the Real-Time Monitoring (RTM) system, and it will assist us in better understanding scheme profiles and risks, and allow for the requisite regulatory action to be taken more timeously. The determination of appropriate regulatory action will be an interactive one, done together with the Boards of Trustees of medical schemes. We are in the final stages of piloting the RTM system with a sample of representative schemes, both self- and third-party-administered. Once the pilot study is completed, the RTM will be rolled out to all medical schemes.

Measuring scheme risks

The Department of Health decided not to proceed with the implementation of the Risk Equalisation Fund (REF). In the meantime, Council developed a shadow system which has collected REF data from medical schemes since 2005. The information collected from medical schemes through the REF returns has strengthened our understanding of the important impact of schemes' risk profiles. REF data provides information which supports and is invaluable to the regulatory activities of Council.

Council has therefore decided to continue with the collection of scheme risk data, and will continue with the scheme risk measurement activities which are based on the former REF returns. The REF risk factor weights and the costs of PMBs were therefore estimated using a large sample obtained from medical schemes. The REF data will be linked to other routinely collected data to feed into the Composite Risk Index (CRI).

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

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

Council has consequently initiated the development of a Composite Risk Index (CRI) which ranks medical schemes in terms of the risks they face. The objective of the index is to proactively identify problematic medical schemes that may face financial difficulties.

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

Council is collaborating on the CRI with the newly established Industry Technical Advisory Panel (ITAP) to start implementing the index during the 2012-2013 financial year.

Complaints and appeals processes

Council resolves thousands of complaints every year – and this number keeps growing.

In the 2011-2012 financial year we received 6 138 complaints. This was an increase of 0.04 complaints per 1 000 beneficiaries on the previous financial year, as illustrated in Figure 4.

We resolved 5 963 complaints in the period under review.

Table 5 indicates the time it took to resolve complaints.

Complaints are currently classified under the categories listed in Table 6; the number of complaints resolved is also indicated.

Complaints of a technical or clinical nature typically involve the non-payment or short-payment of PMB-related accounts.

Examples of administrative complaints are unpaid accounts, the claw back of personal medical savings accounts, and pre-authorisation issues.

Complaints of a legal or compliance nature involve, for example, a medical scheme terminating membership due to the member's alleged non-disclosure of material information.

Figure 4: Number of complaints per 1 000 beneficiaries 2009-2010 to 2011-2012

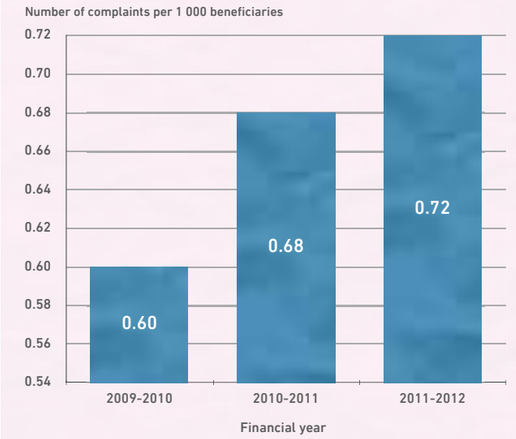


Table 5: How long it took to resolve complaints 2011-2012

	Resolution time (days)					
	0-30	31-60	61-90	91-120	120+	Total
Total complaints resolved	1 490	1 505	1 278	615	1 075	**5 963**
% of total complaints resolved	24.99%	25.24%	21.43%	10.31%	18.03%	**100%**

Table 6: Categories of complaints

Category of complaint	Number of complaints resolved
Technical / clinical	3 387
Administrative	2 060
Legal / compliance	516
Total	**5 963**

A more detailed analysis of complaints resolved shows the following:

Table 7: Categories of complaints in more detail		
Category of complaint	**Sub-category of complaint**	**Number of complaints resolved**
Technical / clinical		**4 067**
Non-payment / short-payment of benefits	Prescribed minimum benefits (PMBs)	2 370
	Non-PMBs	1 697
Administrative		**731**
Pre-authorisation		247
Increase in contributions		176
Information not received from scheme		168
Personal Medical Savings Account (PMSA)		59
Rejection of membership application		39
Other		22
Inaccessible networks		20
Legal / compliance		**504**
Membership status		260
Waiting periods		119
Unethical conduct		57
Late-joiner penalties		42
Misrepresentation		10
Governance		7
Other		5
Fraudulent assignment		4
Total on new system		**5 302**
Total on old system		**661**
Total resolved (both systems)		**5 963**

In the year under review Council's Complaints Adjudication Unit resolved 2 370 complaints relating to the funding of prescribed minimum benefits (PMBs). This was 40% of all complaints which the Unit resolved, and represents the highest category of complaints. The second-highest category of complaints was the non-payment or short-payment of non-PMBs. The total on this was 1 697 in the period under review.

The category "membership status" was the third-highest category of complaints and the total was 260.

Tables 8 and 9 and Figures 5 and 6 show the top 10 open and restricted medical schemes respectively whose members approached Council for resolution of their complaints.

Figure 5: Top 10 open schemes complained about 2010-2011 and 2011-2012

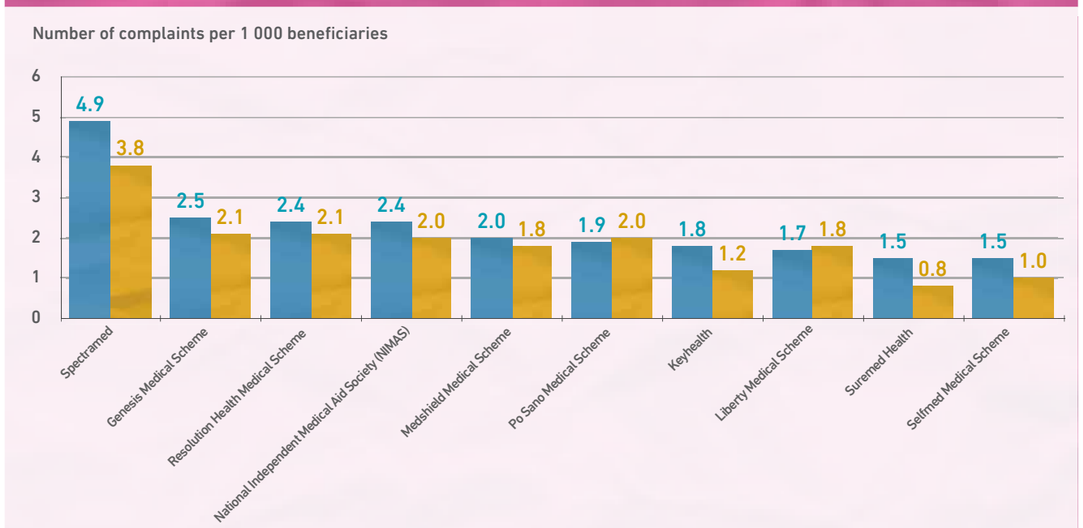


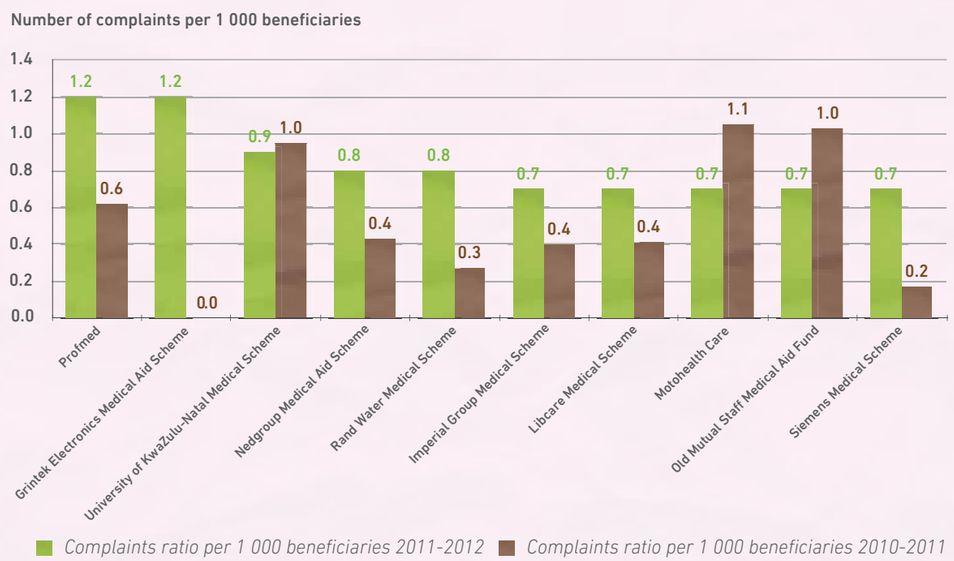
Table 8: Top 10 open schemes complained about 2011-2012

Medical scheme	Number of beneficiaries	Number of complaints received	Number of complaints per 1 000 beneficiaries
Spectramed	64 666	319	4.9
Genesis Medical Scheme	20 241	51	2.5
Resolution Health Medical Scheme	70 396	172	2.4
National Independent Medical Aid Society (NIMAS)	17 621	42	2.4
Medshield Medical Scheme	221 093	448	2.0
Pro Sano Medical Scheme	58 954	110	1.9
Keyhealth	86 351	156	1.8
Liberty Medical Scheme	134 732	227	1.7
Suremed Health	3 338	5	1.5
Selfmed Medical Scheme	16 929	25	1.5

Table 9: Top 10 restricted schemes complained about 2011-2012

Medical scheme	Number of beneficiaries	Number of complaints received	Number of complaints per 1 000 beneficiaries
Profmed	63 734	78	1.2
Grintek Electronics Medical Aid Scheme	2 592	3	1.2
University of KwaZulu-Natal Medical Scheme	7 499	7	0.9
Nedgroup Medical Aid Scheme	50 044	40	0.8
Rand Water Medical Scheme	7 653	6	0.8
Imperial Group Medical Scheme	16 188	12	0.7
Libcare Medical Scheme	12 148	9	0.7
Motohealth Care	65 061	45	0.7
Old Mutual Staff Medical Aid Fund	30 504	21	0.7
Siemens Medical Scheme	5 880	4	0.7

Figure 6: Top 10 restricted schemes complained about 2010-2011 and 2011-2012



Adjudicating appeals

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

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

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

The appeals process

If you are a member of a medical scheme and unhappy with a decision of your medical scheme, you can try to resolve the matter with your scheme or you can come directly to Council and lodge a formal complaint against your scheme in terms of Section 47(1) of the Medical Schemes Act. The Medical Schemes Act – and accordingly the rules of every registered medical scheme in the country – prescribes that schemes must establish dispute resolution committees to deal with member complaints. And while we encourage members to talk to their scheme first, nothing prevents you from coming directly to us.

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

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

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

Topical rulings

Council's Appeals Committee and the Appeal Board met nine and four times respectively in the financial year under review. Council's Appeals Committee adjudicated on 103 matters in the financial year under review, and the Appeal Board on six. All judgements are available on our website. Some of the more topical rulings are summarised below.

Genesis v Registrar and Others

Three members of Genesis Medical Scheme submitted complaints to the Office of the Registrar who determined each complaint in favour of the complainant. In each case the scheme was advised of its right to appeal such ruling within 30 days, as provided for in terms of Section 49 of the Medical Schemes Act.

Section 49 does not condone the late filing of an appeal so the scheme decided to lodge an appeal in terms of Section 48 instead. This was an attempt to remedy the late filing of its appeal papers. The scheme submitted a number of grounds to support its view that it was permissible to file an appeal under Section 48.

Section 48 requires appeals to be lodged within three months of the ruling being appealed against.

The question arose: under which Section should one submit an appeal against a ruling of the Registrar?

The Appeals Committee confirmed that:

- an appeal against a decision of a scheme's dispute resolution committee should be submitted in terms of Section 48 of the Medical Schemes Act (within three months); and
- an appeal against a decision of the Registrar should be submitted in terms of Section 49 of the Medical Schemes Act (within 30 days).

This is because a dispute resolution process conducted at medical scheme level is in effect equivalent to a complaint filed with Council in terms of Section 47(1) of the Medical Schemes Act. This is confirmed in schemes' rules which state that appeals against the decision of a dispute committee of a scheme should be lodged under Section 48 of the Medical Schemes Act. There is no need to repeat the complaints process under Section 47(1) if the matter was already heard by the dispute resolution committee of a scheme.

Because the Registrar's Office is involved in a Section 47 complaint, we are already familiar with the matter, and 30 days is therefore considered a reasonable amount of time within which to lodge an appeal. This is not true for matters appealed under Section 48 of the Medical Schemes Act where the Registrar and Council are not familiar with the matter.

The Appeals Committee noted that disagreement may arise about the date on which an appellant (member) received his/her scheme's ruling and that Section 48 therefore confers discretion on the Appeals Committee to condone a member's late filing of an appeal against its scheme's ruling. No such discretion is allowed under Section 49 because the Registrar's Office knows when it sent its ruling.

The Appeals Committee concluded that the legislator could not have intended to allow an appellant following the Section 47 complaints process (lodged with Council) to appeal in terms of Section 48.

Medshield v Registrar and Others

The Appeal Board, as established in terms of Section 50 of the Medical Schemes Act, ruled that obesity alone cannot prevent members from undergoing joint replacement surgery, and that your scheme cannot use your weight to deny you access to benefits.

The Appeal Board based its ruling on Regulations 15H(a) and 15H(c) of the Medical Schemes Act, which speak about managed care protocols.

Medical schemes are allowed to use managed care interventions to ensure that their members receive appropriate care within the limits of what the schemes can afford; this is why they contract with managed care organisations. Protocols are an example of a managed care intervention.

But according to Regulation 15H(a), protocols must be evidence-based. And according to Regulation 15H(c), protocols must allow for alternative treatment in exceptional circumstances where

the protocol has proven ineffective and/or harmful to the patient, without penalising the patient.

Managed care organisation Medical Services Organisation SA (Pty) Ltd (MSO) had been implementing a protocol which was denying members with a Body Mass Index (BMI) of 35 and more access to surgery for joint replacement.

The Appeal Board found that the protocol fell foul of managed care Regulations.

MSO was ordered to suspend the protocol with immediate effect and its contracted medical schemes, including Medshield, were ordered to authorise and fund joint replacement surgery where it was clinically necessary, regardless of the patient's weight.

The issue that initially arose for adjudication was the application of a protocol by Medshield and MSO where members of the scheme requiring joint replacement surgery and with a BMI of 35 and more were being denied surgery despite the fact that they were fit for it. The Registrar's Office had found that the application of the protocol in its format at the time was not acceptable and, amongst others, not evidence-based. Medshield and MSO filed an appeal against the Registrar's decision, but the Appeals Committee concurred with the finding of the Registrar's Office and ruled that the working of the protocol be suspended until such time as MSO provides adequate data to support the protocol in terms of clinical and financial risk management and improved patient outcomes.

Medshield v Registrar and B

The fact that prostate cancer is a prescribed minimum benefit (PMB) condition was never under dispute. The issue was whether Brachytherapy (a form of radiation therapy) for the treatment of prostate cancer is a PMB level of care, and whether the member was entitled to receive Brachytherapy under the rules of the scheme.

The scheme had refused funding because, it argued, Brachytherapy is not a PMB level of care as it is not available in the public sector.

At the same time the scheme was willing to fund External Beam Radiation Therapy (EBRT), which is more expensive than Brachytherapy.

The Appeals Committee ruled that the scheme had failed to consider the cost-effectiveness of the treatment being sought and its advantages for the member, and ordered the scheme to fund Brachytherapy in full.

The scheme appealed this ruling to the Appeal Board in terms of Section 50 of the Medical Schemes Act.

The Appeal Board confirmed that:

- Prostate cancer is a PMB condition.
- The member required Brachytherapy to treat his cancer.
- Brachytherapy fell outside the rules of the scheme and was not available in the public sector at the time.
- The scheme would have had to fund External Beam Radiation Therapy instead.
- The scheme should fund the cheaper of the two treatments, namely Brachytherapy.

Liberty v Registrar and K

This case was about determining which medical scheme was liable for funding claims incurred by a newborn from date of birth until the date of discharge from hospital.

The child's mother was a member of Genesis Medical Scheme; the father belonged to Liberty Medical Scheme.

The father registered the newborn as his dependant. According to the rules of Liberty, the child became one of its beneficiaries with effect from birth. The child underwent a routine medical check-up for two days immediately after birth, and a claim was submitted to Liberty. But Liberty refused to pay, citing Genesis as the responsible party.

The mother lodged a complaint with the Office of the Registrar, who ruled in her favour: the child had become a beneficiary of Liberty from the moment of its birth, and Genesis was therefore not responsible for the account.

Liberty appealed the decision, arguing that industry practice is for all routine medical check-ups of a newborn child to be included in the maternity authorisation of a member's confinement.

The Appeals Committee rejected this argument. Liberty could not prove the alleged industry practice and, more importantly, the scheme must fund the accounts of its beneficiaries.

R v Registrar and Discovery

Discovery Health Medical Scheme had correctly refused to fund the drug Novo Seven after it was used to treat coronary artery perforation which was sparked by a cardiac angioplasty.

The Registrar's Office found that the member had used the drug without obtaining pre-authorisation, as is required by the scheme rules. More importantly, the Registrar also found that Novo Seven is indicated for spontaneous and surgical bleeding in patients with haemophilia – a condition the complainant did not suffer from.

The Appeals Committee upheld the decision of the Registrar when the member appealed the ruling. The committee decided that the member was bound by the contract he had signed with the scheme; by implication he had bound himself to the rules of the scheme in as far as they (through the scheme protocol) indicate that the only condition where Novo Seven can be used is haemophilia.

A v Registrar and Liberty

The Appeals Committee instructed Liberty Medical Scheme to pay the full claim submitted by the member for the services of a psychologist after the scheme had given the member incorrect advice on the extent of her cover. The amount exceeded the limit applicable to the member's cover per year.

The scheme admitted that its call centre had given the member incorrect information as regards the level of her cover. The incorrect information had led the member to believe that she had enough cover for the treatment she was about to embark on.

The scheme's defence was that its rules "prevail above any other information the member may have received".

The Appeals Committee ruled that the scheme cannot escape liability by seeking refuge behind its rules, especially when a member had relied on its advice to her detriment and might not have incurred the expense but for the incorrect information from the scheme.

The other reason why the scheme was found liable for providing negligent advice is because its call centre agent should have had the skills and knowledge to provide accurate information and advice. Call centre agents working at medical schemes must be adequately informed and skilled to, at the very least, provide accurate advice on their respective medical schemes and their rules, including benefit option limitations. If they are not, and the member acts to her detriment based on erroneous advice, then the agents act negligently and the scheme cannot absolve itself of vicarious liability by pointing to the very rules of which its call centre agents should have been aware, blaming the member for not familiarising herself with them. It was in any event with a view to familiarising herself with the rules on her cover limits that the member did the prudent thing of contacting the call centre, as members are invited to do by the scheme.

Pro Sano v Registrar and M

The member's attorneys lodged a complaint with the Registrar's Office after Pro Sano Medical Scheme funded only five of the 12 days that the member had spent in hospital.

The initial diagnosis of acute onset of epigastric pain was updated to unstable angina after tests were done. The scheme had initially refused to

provide the hospital with pre-authorisation because the scheme does not cover admissions for investigations, observations and consultations. But after the scheme was advised that the member had been transferred to a high care ward for unstable angina, it retrospectively approved the hospitalisation and funded five days of it.

The Registrar's Office instructed the scheme to pay for the entire stay in hospital, and in full, given the fact that the member's was a medical emergency and therefore a prescribed minimum benefit (PMB) condition, and because the treatment was clinically appropriate. Pro Sano's rules also confirm that, in the event of emergencies, members can be admitted to hospital without pre-authorisation.

The scheme appealed the decision of the Registrar, arguing that it had informed the hospital many times that pre-authorisation was not approved in the absence of a confirmed diagnosis, but the Appeals Committee dismissed the scheme's appeal, stating that the member cannot be penalised for the hospital's decision over which she had no control. The declined pre-authorisation request was based on administrative and not clinical considerations, and they were found to be unreasonable. The committee also concluded that the scheme should engage the hospital for the recovery of the seven days that were not retrospectively authorised.

VHS v Registrar and Medshield

The Appeal Board found that Medshield Medical Scheme was wrong in terminating the membership of the complainant's daughter based on alleged non-disclosure of material information upon joining the scheme.

The daughter was born with a condition called Spina Bifida, which caused paraplegia (paralysis of the legs and lower body). She was treated for the condition after her birth, 25 years later, and again in 2007. When the daughter completed the scheme's application form in April 2009, she indicated that she had neither been diagnosed with a condition nor had she sought advice or treatment on a condition in the 12 months leading up to the day of her application.

The Registrar's Office ruled in the member's favour because her treatment did not fall within the 12-month period referred to in the application form. The scheme appealed the decision, saying that the member should have disclosed that she was in a wheelchair and that she received treatment in 2007.

The Appeals Committee referred the matter back to the scheme. The finding was inconclusive, so the complainant appealed to the next level, i.e. the Appeal Board.

The Appeal Board ruled that the member had provided all the information that was required in the original application form, and that there was no general clause which required a member to disclose any other additional information. There was no evidence of fraud or deliberate non-disclosure on the part of the member, and the scheme was directed to reinstate the member and fund her claims accordingly.

The Appeal Board also found that the scheme could not use Section 29(2) of the Medical Schemes Act to protect itself against its own negligence or fault. Section 29(2) lists the five instances in which a medical scheme is allowed to cancel or suspend a member's membership, namely if the member:

- fails to pay his/her monthly contribution/s, as required by the scheme's rules;
- fails to repay any debt due to his/her medical scheme;
- submits fraudulent claims;
- commits any fraudulent act; or
- fails to disclose material information.

GEMS v Omphemetse Pharmacy

The pharmacy lodged a complaint against the medical scheme because the scheme refused to pay any of the pharmacy's claims.

Government Employees Medical Scheme (GEMS) believed it had acted within its rights following allegations of fraud levelled against the pharmacy. GEMS informed Omphemetse Pharmacy in writing that the scheme would no longer pay them directly and that it had elected instead to reimburse its members after they had paid the pharmacy for services rendered. But the pharmacy continued to submit claims to the scheme.

The Office of the Registrar found that the scheme had indeed acted within its rights, but the Appeals Committee ruled that the scheme could not suspend the payment of claims pending the outcome of a criminal investigation and instructed GEMS to make direct payments to the pharmacy.

GEMS escalated the matter to the Appeal Board who upheld the appeal and set aside the Appeal Committee's judgment, thereby allowing GEMS to suspend direct payments to the pharmacy. The Appeal Board found that there was no contract between the scheme and the pharmacy, and that Section 59(2) of the Medical Schemes Act gives a scheme discretion regarding payment to a service provider (or a member) directly. There was also no evidence to the effect that any claims were submitted by members and not paid by the scheme.

B v Registrar and Discovery

The member lodged a complaint against Discovery Health Medical Scheme for unilaterally changing the status of his child dependant to that of an adult dependant without prior consultation.

The member contended that it was never his intention to cover the dependant in his adulthood as he was financially independent, asserted that Discovery had contravened its own rules and internal processes, and sought relief in the form of contributions refund from the time the dependant attained adulthood status until termination of his membership (which was at the member's instruction).

Discovery refused any refund and maintained it had acted in accordance with its rules. The scheme also argued that no express instruction was required from a member to change the status of a dependant from child to adult. When the Registrar's Office upheld Discovery's decision, the member approached the Appeals Committee. The committee found the member to have been the cause of his own predicament: he had failed to terminate the membership of his dependant when he became financially independent, and he had not read or responded to numerous communications from Discovery where the dependant's status was clearly indicated. His appeal was dismissed.

S v Registrar and Transmed

The member lodged a complaint with the Registrar's Office concerning a dispute with Transmed Medical Fund regarding the non-funding of treatment related to a prescribed minimum benefit (PMB) condition.

The member's representative stated that the member had been diagnosed with bilateral cataracts which were affecting his vision and that he, as well as other service providers, were prepared to perform cataract surgery on the member at standard rates but were aggrieved by Transmed's imposition of a 40% co-payment for the use of a non-designated service provider (non-DSP). The member believed that the co-payment should be waived due to the condition being a PMB.

Transmed maintained that the 40% co-payment was correctly imposed for the voluntary use of a non-DSP and that the services sought by the member were available at Transmed's DSP and also in the public sector.

The Registrar ruled in favour of Transmed and confirmed that the co-payment was correctly applied. The Appeals Committee held that both respondents had correctly applied the provisions of the Medical Schemes Act, and specifically Regulations 8(2) and 8(3), which allow schemes to use DSPs for PMBs and allow co-payments where members choose to use a non-DSP. The appeal was accordingly dismissed.

Clinical Review Committee (CRC)

The CRC was established in 2010 with a view to rendering expert advice on complaints of a clinical nature.

A total of 842 clinical opinions were provided to our Complaints Adjudication Unit in the period under review. This is many more than in the previous financial year. This is mainly because of our ever-stronger enforcement of PMB provisions.

Complaints against brokers

The Accreditation Unit at Council accredits the businesses affiliated with medical schemes, namely medical scheme administrators, managed care organisations (MCOs), as well as healthcare brokers and broker organisations, of which there are thousands. The Unit also investigates and adjudicates on complaints against these entities.

The Accreditation Unit dealt with three complaints against brokers in the 2011-2012 financial year, and referred one matter to the Financial Services Board (FSB), regulator of the financial non-banking sector in South Africa which includes short- and long-term insurance products. Healthcare brokers are co-regulated by the FSB and Council in that they are required by the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS) to be licensed by the FSB before they can apply for accreditation with Council and start operating as valid businesses.

The three complaints which Council resolved related to:

- A broker failed to provide the complainant (a member of a medical scheme) with the services contemplated in the service level agreement signed between the two parties.
- A brokerage continued to debit the complainant for service fees after termination of membership with the medical scheme.
- A scheme rejected a claim from the complainant's doctor for the completion of the chronic application form since the complainant was still subjected to a waiting period.

Engaging with stakeholders

Council continued to build and nurture relationships with its diverse range of stakeholders through concrete communications, consumer education, and trustee training initiatives. Our call centre, or Customer Care Centre (CCC), continued to be the first line of interaction for many members and regulated entities alike.

Our Annual Report for the preceding financial year was published early and publicised by means of an official launch which took the form of a press conference at our premises in Pretoria. The report was also presented to trustees in Johannesburg and Cape Town; we appreciate being able to interact with industry at a more personal level. Council also appreciates the ever-increasing interest in this flagship publication.

Council published various other publications in the year under review, including *CMS News* and CMScript, and engaged with the media fraternity by way of press releases, press conferences, and the ongoing interaction on media enquiries. We enjoyed prominence in the broadcasting world by making relatively frequent appearances on national television and radio, and we enjoyed good coverage in the print and online media too.

We organised consumer education programmes in all nine provinces. This included interaction with the Consumer Protection Forum (CPF), consisting of Provincial Consumer Affairs Offices and regulatory bodies, and its Consumer Education Committee. The collaboration with CPF resulted in Council receiving a number of free radio slots on consumer talk shows and exposure through their various outreach and awareness programmes.

Council's consumer education programmes target all Living Standards Measures (LSMs) and focus on capacity-building of a range of different people who regularly engage with consumers. We conducted and participated in 121 workshops across the country and reached over 40 000 consumers. Outside radio broadcasts with community radio stations and free radio talk shows on SABC radio stations further increased the number of consumers we reached this year. Various other initiatives ensured that we reached out to our targeted stakeholders, including exhibitions at the Rand Easter Show, Pretoria Show, Soweto Show, the Operational Health Management Conference (OHMC), the Hospital Association of South Africa (HASA), and the National Consumer Forum (NCF). These sessions presented an opportunity to create awareness of Council and to educate consumers on their rights and responsibilities.

Two annual return workshop sessions were conducted in Johannesburg and Cape Town. These were received in a very positive light and participants were impressed with the practical nature of the sessions. A total of 128 delegates from 38 scheme administrators attended the workshops.

We conducted two *General Induction to Trusteeship* training sessions in Gauteng and Cape Town. The sessions are designed to educate and empower new trustees when it comes to their fiduciary roles and responsibilities. The training sessions were attended by trustees from 12 restricted and 11 open schemes. These sessions largely concentrated on corporate governance (fiduciary duties of trustees) and an overview of the Medical Schemes Act and other legislation which has an impact on trusteeship.

Over and above the general sessions, three additional trustee training workshops were conducted for Boards of Trustees who had requested scheme-specific sessions. The Trustee Induction Pack (TIP) was updated with links to various new pieces of legislation which have an impact on trusteeship. TIP serves as an online guide to new trustees to better understand their roles.

Our Customer Care Centre received 47 052 calls during the year under review; only 7.1% (3 339 calls) were abandoned and 3.7 % (1 753 calls) were short calls. Overall, 89.2% (41 960 calls) were dealt with successfully. Our call handling time was on average 2 minutes 27 seconds; the average queuing time was 2 minutes 47 seconds.

Our building blocks

No organisation, public or private, can function without people, money, and information and communication technology. Three of our Units have traditionally been seen as providing crucial support to the remaining Units within Council and rendering the functioning of Council possible, namely Human Resources (HR), Internal Finance, and the Information & Communication Technology and Knowledge Management (ICT & KM) Unit.

Human Resources (HR)

Acquiring talent

The aim of our talent acquisition strategy is to identify and hire the best talent. Human Resources (HR) is responsible for the recruitment, interviewing, testing, selection, orientation, and evaluation of all employees. During the period under review, talented personnel were sourced in line with our recruitment processes and policies.

In the previous financial year four new positions were identified and approved for appointment in 2011-2012. The selection process adopted in recruiting for both current and new positions was geared to ensuring that the best and most appropriately qualified personnel was appointed. Their performance was monitored during the probation period to ensure that they met their performance targets.

All new employees who were appointed during 2011-2012 completed the mandatory probation period of six months and were subsequently confirmed as permanent employees of Council after the successful conclusion of probation reviews.

HR placed focus and emphasis on providing effective orientation, education and training throughout 2011-2012 to new 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 Policy Manual. New employees were also provided career development opportunities through the Professional Development Programme (PDP).

Reorganisation and alignment

Some Units were reorganised and realigned in the year under review to support the optimal performance of Council, for instance:

- Our medical and healthcare skills were consolidated into the Clinical Unit under the Clinical Review Committee (CRC).
- The Complaints Adjudication Unit, which consists mainly of legal skills, and the Clinical Unit were

moved to the new Strategy Unit in the Office of the Registrar to better assist in appeals processes at both Appeals Committee and Appeal Board level where matters are mainly of a legal and medical nature.
- Former Risk Equalisation Fund (REF) staff with skills in data analysis and research capabilities were placed in the Research & Monitoring Unit.

Managing performance
Our performance management system is designed to ensure that high performance is both encouraged and rewarded.

At the onset of the financial year under review, HR facilitated the drafting and conclusion of performance agreements for 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.

Two formal performance reviews were conducted in 2011-2012. Through the Moderating Committee, HR facilitated the awarding of incentive bonuses to employees who excelled in their performance and who qualified in recognition of their contribution to ensuring that Council met its strategic goals and delivered on its mandate in the year under review.

Job evaluation and salary benchmarking
HR conducted an evaluation of all positions to ensure that they are correctly graded, and undertook a salary benchmark survey to ensure that salaries are in line with the job market. Council approved the recommendations to correct misalignments, and adjustments were implemented with effect from 1 April 2012.

Training and development
Council continued to implement personal development plans identified by a skills audit concluded early in 2011. Staff members undertook various training programmes in 2011-2012. A Workplace Skills Plan and Annual Training Report was completed and submitted to the Health and Welfare Sector Education and Training Authority (HWSETA).

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

Employment Equity (EE)
Although Council has a diverse workforce, the representation of Indians, Coloureds and persons with disabilities is still below the nationally defined representation for designated groups.

Table 10: Council profile as at 31 March 2012

	Men					Women					Total
Occupational level	**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	3	0	1	4	8	2	0	0	0	2	10
Professionals	9	0	0	5	14	7	2	1	6	16	30
Skilled technical	7	1	1	1	10	16	1	1	6	24	34
Semi-skilled	1	0	0	0	1	14	2	0	0	16	17
Total permanent	**21**	**1**	**2**	**10**	**34**	**39**	**5**	**2**	**12**	**58**	**92**
People with disabilities included above	0	0	1	0	0	0	0	0	0	0	0
Grand total	**21**	**1**	**2**	**10**	**34**	**39**	**5**	**2**	**12**	**58**	**92**

Council will continue to earmark available opportunities to ensure equitable representation of all designated groups.

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

Our approach in the year under review was to proactively address and pre-empt health and social issues before they turned into bigger and costlier problems. As such, HR entered into a Service Level Agreement (SLA) with ICAS Southern Africa to provide employees with a wellbeing programme which provides a number of services that are accessible to employees and managers alike in a private and confidential manner.

Other wellness initiatives included:

- 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: presentations were facilitated to raise awareness on HIV/AIDS.
- Flu vaccinations were administered on-site to both staff and management.

Corporate social responsibility
For the first time, HR facilitated mentorship to 10 boys from Vukani-Mawethu in Mamelodi as part of our social responsibility initiatives in playing a role in building up responsible men for our future. This was in addition to another successful programme of hosting grade 11 and 12 girls on an annual basis.

Reviewing Council policies
HR reviewed Council's Sabbatical and Reward & Incentives Policies. Council also recognises that there may be times when employees wish to take extended periods of time away from work during the course of their employment with Council in order to pursue further education with international institutions. To accommodate employees in this regard, HR drafted an Australian Development Scholarship Study Policy aimed at providing employees with the opportunity of pursuing international studies, a key aspect of our retention philosophy.

Council approved amendments to both the Sabbatical and Reward & Incentives Policies and adopted the Australian Development Scholarship Study Policy.

Team building, culture, and diversity
HR facilitated workshops on diversity management as well as team-building.

Internal Finance

Managing our financial resources
Council continued to manage its finances in terms of the Public Finance Management Act 1 of 1999 (PFMA). The PFMA directs that financial management be efficient, effective, economical, and transparent. In line with this imperative, Council put in place systems of internal controls, constituted the Audit & Risk Committee, and duly appointed internal auditors.

Budget
Council submitted its projections of income and expenditure for the approval of the Minister of Health in March 2011. These projections were based on the strategic objectives and operational plans for the financial year 2011-2012. Approval was received in July 2011. On the basis of this approval, medical schemes were levied at R21.22 per member per annum in order to meet Council's operations.

Financial management
Monthly management accounts for the period under review were produced and served at relevant structures, including the Audit & Risk Committee and Council's Finance Committee. In order to monitor spending against the budget, monthly variance meetings were held with Unit Heads; these discussions are confirmed in the Strategic Management Meetings (SMMs). Cash flow was monitored through monthly cash flow projections; this was also used to monitor spending against budget.

Annual Financial Statements
Annual Financial Statements (AFS) were finalised in time to meet the statutory deadline of 31 May 2012. They were duly submitted to the Auditor-General and National Treasury. The AFS were then subjected to an external audit by the Auditor-General.

Council has received an unqualified audit opinion for the 2011-2012 financial year.

Our income and expenditure
Council's total revenue in 2011-2012 amounted to R93.7 million. Levy income accounted for R76.5 million, which accounts for 81.6% of the total income. The revenue also included an amount of R4.2 million received from the Department of Health (DoH). Other sources of revenue included accreditation and registration fees.

Our total expenses in 2011-2012 were R89.1 million, with R56.1 million allocated to staff costs. We spent R1.4 million on audit fees, R19.1 million on operating expenses, and R10.7 million on administrative expenses.

Supply chain management
Monthly supply chain reports were prepared and submitted to National Treasury, as required.

Council adjudicated over two tenders during the financial year 2011-2012: Benefit Option Registry and Supply, and the installation and maintenance of photocopier machines. The tenders were still in the process of being finalised as at the end of March 2012.

Internal audit
In terms of the internal audit process, Sizwe Ntsaluba VSP submitted their three-year rolling plan which was approved by the Audit & Risk Committee. In line with their three-year rolling plan, they have since covered the following risk assessments:

- Audit follow-up report
- Complaints Adjudication
- Enterprise Risk Management
- Information Technology
- Accreditation
- Performance Information
- Compliance
- Stakeholder Relations
- Financial Supervision
- Corporate Governance
- Financial Management
- Supply Chain Management

Risk management
Risk management continued to be our focus and a Risk Register was monitored on a monthly basis. This Risk Register is discussed at Strategic Management Meetings (SMMs), the Audit & Risk Committee, and Council's Finance Committee meetings. As a result of this instrument Council is satisfied that risk management is being monitored adequately.

Performance management
We produced quarterly performance information reports which were reviewed by the Auditor-General. The summary of the performance information is set out on pages 58 to 75.

Internal controls
Council continued to monitor its internal controls to ensure consistency and compliance with its procurement processes. The I*nternal Finance Policies and Procedures Manual* is being revised to accommodate new developments.

Information & Communication Technology (ICT) & Knowledge Management (KM)

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

Software Development
The Software Development sub-unit undertook some exciting software projects this year. One of the projects is aimed at collecting data from medical schemes on a monthly basis. This project was aptly called the Real-Time Monitoring (RTM) system. This system will assist Council in keeping a close eye on solvency ratios and the general health of medical schemes in real time. It will also be used as an "early warning system", enabling the proactive regulation of schemes. This system is still in pilot testing and will be going live during the 2012-2013 financial year.

The complaints system was revamped to allow other departments, for instance Accreditation, to lodge complaints against brokers and brokerages. The system can now be used enterprise-wide to log complaints.

The quarterly and annual financial return systems where revised and published as scheduled. This allowed schemes to submit their quarterly and annual returns online.

A new medical schemes registry was developed, using the latest Microsoft Dynamics CMS/XRM platform. The pilot phase was successfully completed and full implementation is underway.

Network Management
In order to improve on e-mail redundancy and continuity, we successfully implemented and deployed the cloud-based Mimecast e-mail archiving, continuity and security solution across the enterprise during March 2012.

In an ongoing effort to enhance network security, our firewalls were replaced with a new firewall solution based on latest technology.

Two of our older server rooms were completely revamped to ensure standards compliance.

Knowledge Management
An e-library was developed and implemented in the year under review. This system allows employees to search our Knowledge Management Centre for books, journals and other publications while also allowing us to search other online databases, such as SABINET and EBSCOHOST.

Big strides were made with the digitising of paper-based records and ensuring that such records are fully searchable, thereby unlocking and making their contents accessible to staff. This project will gather further momentum in the coming year.

The Knowledge Management Centre continued to make information available where such was requested in terms of the Promotion of Access to Information Act 2 of 2000 (PAIA).

Concluding thoughts

The Council for Medical Schemes is a unique regulator responsible for overseeing a unique industry with its own set of unique challenges.

I would like to take this opportunity to thank Council employees for their hard work and dedication to Council's causes. Without you we would not be where we are today.

I wish to extend a special word of thanks to Council members, both former and current, for leading and guiding our efforts as we strive to serve this complex and dynamic industry. Much gratitude is owed to former Council members under the leadership of Prof. William Pick, whose term came to an end in October 2011. I look forward to taking Council to new heights with the continued support from the new Council members.

Industry's cooperation is always much appreciated. It pleases me that the relations between regulator and regulated continue to improve with time as both parties gain better understanding of each other's roles and responsibilities thanks to open and constructive dialogue.

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

Dr Monwabisi Gantsho
Registrar & Chief Executive
Council for Medical Schemes
31 July 2012

Performance information

"The gladdest moment in human life, methinks, is a departure into unknown lands. The blood flows with the fast circulation of childhood."

~ Sir Richard Burton ~

Programme 1: Administration

■ No deviation ■ Positive deviation ■ Negative deviation

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Sub-programme 1: Office of the Chief Executive				
Sub-programme 2: Internal Finance				
Annual Financial Statements (AFS)	Number of accurate Annual Financial Statements (AFS) submitted using the approved template	1	1	No deviation
Budget management	Percentage of budget resources allocated to the strategic objectives that are utilised for the intended purpose	100%	100%	No deviation
Revenue	Percentage of budgeted income collected	100%	99.9%	A balance of R33 000 is still outstanding on total levies. This is due to a query from Quantum Medical Scheme. Our Legal Services and Compliance & Investigations Units are attending to the matter. This amount was paid in April 2012.
Procurement	Number of tenders adjudicated on per the supply chain management	1	2	Two (2) tenders were in the process of being adjudicated on: • Photocopiers • Benefit options registry
	Percentage of creditors paid within 30 days	100%	99.0%	There were instances where invoices had to be queried before payments could be effected. One (1) creditor (Mokoka Attorneys) is over 90 days because we have not received their tax clearance certificate yet.
Cash management	Number of cash flow projections to meet operational requirements	12	12	No deviation
Asset management	Accurate asset register maintained	100%	98.0%	During the year we changed assests bar codes for ease of counting and location. The scanners are still being programmed to be compatible with the assets register and bar codes.
Payroll management	Number of accurate payroll runs performed timeously	13	13	No deviation
Audit & Risk Committee meetings	Number of Audit & Risk Committee meetings held	4	4	No deviation

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Sub-programme 3: Information Systems and Knowledge Management				
Training & support	Number of Helpdesk incidents (cases) handled per year	800	744	The Unit deployed a password self-service system in the year under review which helped with keeping Helpdesk requests down. Most of the Helpdesk requests which were experienced during the year related to printer issues.
	Number of staff trained per year	50	31	Two (2) Chalk 'n Talk sessions were held in the year and the turnout of staff members to these sessions was lower than anticipated. There were also no new systems to introduce to staff during the financial year under review.
Operations	Number of major network-related incidents per year	4	3	Our systems are stable and reliable.
	Number of days per year where access to computer systems is totally interrupted	5	2	Our systems are stable and reliable.
Software development	Number of custom software application "bugs" (incidents) reported per year	600	173	This relates to all our internally developed systems. Due to the high incident rates on the legacy systems previously, we expected a higher "bug" rate in the year under review, but due to the continuous efforts of the software development team, the Unit managed to keep the incident rate low. Our systems are stable and reliable, and are reaching maturity.
	Number of days of interrupted access to custom-developed applications per year	4	1	There was a malfunction on one of the network switches. The firmware on the switch was old which caused the switch to stop working, and therefore no one was able to gain access to the network. A firmware upgrade was done on the switch to resolve the problem. Due to this network failure, employees were unable to connect to any computer system on the network. Our systems are stable and reliable.

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Knowledge & Records Management	Number of requests for information responded to per year	300	226	Most of the requests received related to the Promotion of Access to Information Act (PAIA). The requests were mainly for medical scheme rules and our Annual Report.
	Number of records electronically captured per year	2 000	3 192	The drive to capture electronically all information and interaction with Council centrally continues, therefore the numbers are much higher than expected.
Sub-programme 4: Human Resources				
Talent management & staff retention	Staff turnover rate	8.0%	1.1%	The low staff turnover rate is attributable to the improved implementation of our retention strategies, e.g. benefits, remuneration, and working conditions.
	Number of high-potential employees on the development programme	21	21	No deviation
Performance is maximised	Number of employees undergoing bi-annual performance reviews	172	175	New employees joined Council in the financial year under review and they had to be assessed in terms of policy.
	Percentage of employees undergoing training in accordance with a personal development plan	60.0%	66.0%	There was an improvement on the management of training objectives.
Productive work environment	Number of Health Days held	1	1	No deviation
	Number of employees attending cultural awareness session	86	81	Not all staff members were able to attend the cultural awareness session.
	Number of workshops on values and work ethics	1	1	No deviation
HR management systems & processes	Number of employees surveyed in respect of HR customer service	86	0	This process was delayed due to the office restructuring process. Surveys will be conducted during the 2012-2013 financial year.

Programme 2: Accreditation

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Broker accreditation applications processed	Number of new individual broker applications received per year	617	918	We received high volumes of individual application forms from Discovery Health Medical Scheme, Old Mutual, and Liberty Medical Scheme.
	Number of new individual brokers accredited per year	415	326	Fewer individual brokers were accredited due to applications not complying with the accreditation requirements.
	Number of individual broker renewal applications received per year	3 372	4 298	Brokers are notified of their renewal of accreditation four (4) months prior to their expiry date. A number of brokers submitted their renewal applications earlier than anticipated.
	Number of individual broker renewals accredited per year	2 920	3 722	Brokers are notified of their renewal of accreditation four (4) months prior to their expiry date. A number of brokers submitted their renewal applications earlier than anticipated, and due to this a higher volume of brokers was accredited.
	Number of new broker organisation applications received per year	122	145	During the verification of Financial Services Provider (FSP) licences on individual brokers in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS), we discovered that several broker organisations were licensed by the Financial Services Board (FSB) but not accredited by Council. Those unaccredited broker organisations then submitted their applications to be accredited by Council.
	Number of new broker organisations accredited per year	90	83	A number of applicants failed to comply with the accreditation requirements and could not be accredited.
	Number of broker organisation renewal applications received per year	880	1 171	Broker organisations are notified of their renewal of accreditation four (4) months prior to their expiry date. A number of organisations submitted their renewal applications earlier than anticipated.
	Number of broker organisation renewals accredited per year	720	1 046	Broker organisations are notified of their renewal of accreditation four (4) months prior to their expiry date. A number of organisations submitted their renewal applications earlier than anticipated, and due to this a higher volume of organisations was accredited.

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Managed care organisation (MCO) accreditation applications processed	Number of MCO applications evaluated per year	21	26	Four (4) MCO accreditation renewal applications were evaluated ahead of the planned times, and two (2) new applications were received during the year under review.
	Number of MCOs accredited per year	20	15	Several MCOs were found not to be providing managed care services as defined in the Medical Schemes Act 131 of 1998 and therefore did not need accreditation. Their accreditation renewal applications were not considered for approval by Council.
Administrator accreditation applications processed, including self-administered medical schemes	Number of administrator applications evaluated per year	14	15	In terms of the Medical Schemes Act, renewal applications must be submitted at least three (3) months before the expiry of the current accreditation. This is to allow enough time for the applications to be evaluated for completeness and validity, and to then be presented to the steering committee for deliberation. Targets are set according to the expected renewal submission dates.
	Number of administrators accredited per year	8	10	Council approved two (2) administrator applications during the period under review, which would otherwise have been presented to Council in the new financial year.

Programme 3: Research & Monitoring

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Clinical support service	Number of clinical support cases completed per year	750	827	An additional Clinical Analyst was appointed with effect from January 2012; this appointment assisted with the clearing of a backlog and the resolution of more clinical complaints. Council observed a general increase in the number of complaints with a clinical dimension in the year under review, which contributed to the higher numbers.
Monitor ICD-10 compliance	Number of medical schemes complying with ICD-10 (International Classification of Diseases – 10th Revision) in the year	380 (95.0%)	359	The number of medical schemes decreased during the year under review and some schemes were excluded because they submitted incomplete data.
Practice Code Numbering System (PCNS)	A responsible entity is in place to operate the PCNS	Yes	Yes	No deviation
Research	Number of research projects finalised per year	4	5	A project that was previously classified as a "support project" became a standing project and is now reported under this objective.
Specialised technical support	Number of support projects finalised per year	4	3	Support projects are dependent on requests for statistical and research input from other Council Units. In addition, one (1) project previously classified as a "support project" is now a standing research project.
Annual Report	Number of annual analyses of non-financial data	1	1	No deviation

Programme 4: Stakeholder

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Sub-programme 1: Education & Training				
Trustee training	Number of trustees trained	100	69	The planned session for KwaZulu-Natal was cancelled due to low number of attendance.
Consumer education	Number of beneficiaries trained	30 000	40 432	The Unit received more invitations for sessions coordinated by stakeholders, and attended more outreach events during weekends.
Coordinate external training undertaken by other Council Units	Number of sessions coordinated	3	2	Three (3) administrator annual return workshops were planned for the year but only two (2) were conducted. The third was cancelled due to the low number of attendees.
Customer Care Centre	Number of calls handled per year	40 000	41 960	More members are becoming aware of Council through the efforts and initiatives of our Education & Training and Communications Units. There were influxes of calls due to the release of the Annual Report, curatorships, liquidations, radio interviews, exhibitions, and benefit option changes for 2012.
	Number of calls abandoned per year	3 200	3 339	The duration of calls was longer due to the explanations and clarifications which were given to members regarding the benefit option changes for 2012. Therefore the increase in the number of abandoned calls.

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Sub-programme 2: Communications				
Communication with stakeholders	Number of communiqués	37	37	No deviation
	Number of *CMS News*	2	1	The first issue was published in February 2012; the second issue needed to be postponed into the new financial year 2012-2013 to allow external contributors enough time to write and submit their articles (which are of a highly specialised and both technically and conceptually complex nature).
	Number of CMScript	8	7	While the final draft of issue 8 was prepared and presented for sign-off, it was not approved, and more changes were recommended. Issue 8 will therefore be published in the new financial year 2012-2013.
	Number of *Masihambisane*	12	12	No deviation
	Press conferences	2	2	No deviation
	Press releases	12	15	More issues warranted the issuing of a press release than was originally anticipated.
	Media enquiries	100%	100%	No deviation
Publication of Council's Annual Report	Production of Council's Annual Report	1	1	No deviation
	Launch of Council's Annual Report (press conference)	1	1	No deviation
	Council Annual Report road shows	3	2	Planned road shows were scheduled to take place in Gauteng, Cape Town, and Durban, but due to low numbers the road show for Durban was cancelled.
Support for other Units	Number of Circulars edited	20	54	More issues warranted the issuing of a Circular than was originally anticipated.

Programme 5: Compliance

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Enforcement of rulings and directives	Number of directives issued	20	23	The reason for the high number of directives issued was non-compliance by medical schemes pending the outcome of the Board of Healthcare Funders of Southern Africa (BHF) High Court case with regards to the interpretation of Regulation 8 of the Medical Schemes Act 131 of 1998.
	Number of directives and rulings enforced to ensure compliance	12	11	Fewer matters were received from the Complaints Adjudication Unit that required enforcement of rulings with regard to schemes not complying.
Inspection of regulated entities	Number of schemes requiring inspection actually inspected	12	10	The reason for the deviation is that the routine and commissioned inspections took longer than anticipated, which resulted in fewer schemes being inspected.
	Number of completed individual inspections	12	9	The reason for the deviation is that the routine and commissioned inspections took longer than anticipated, which resulted in fewer schemes being inspected.
	Number of Units utilising inspection reports	20	3	There were fewer Units that utilised the inspection reports.
Exemption applications	Percentage of exemption applications adjudicated upon	100%	100%	No deviation
	Percentage of recommendations in accord with Council's verdict	99.0%	99.0%	No deviation
	Number of days it takes to communicate Council decisions after receiving them	8	29	The Unit experienced delays with the communication of Council's verdicts from the Secretariat. This delay therefore affected the Unit's target negatively as the process of sending out the recommendation letter to the scheme was delayed.

Programme 6: Complaints Adjudication

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Complaints resolution service	Number of complaints received in the year	5 645	6 138	The high number of complaints received was the result of members being dissatisfied with changes to benefit options, contribution increases, exclusions, and non-payment of prescribed minimum benefits (PMBs) in full. During quarter 1 and 2 of the year under review, the IT system could not draw accurate statistics. The system was fixed during the year and the annual figures therefore reflect the true number of complaints received for the financial year under review.
	Number of complaints resolved within 30 days	1 694	1 490	There were backlogs in resolving clinical complaints due to understaffing in the Clinical Unit.
	Number of complaints resolved within 60 days	2 258	1 505	There were backlogs in resolving clinical complaints due to understaffing in the Clinical Unit.
	Number of complaints resolved within 90 days	1 016	1 278	The Unit made an effort to resolve complaints which had the potential of rolling over to the new financial year, hence the high increase in the actual complaints resolved within 90 days.
	Number of complaints resolved within 120 days	509	615	The Unit made an effort to resolve complaints which had the potential of rolling over to the new financial year, hence the high increase in the actual complaints resolved within 120 days.
	Number of complaints resolved within 120+ days	169	1 075	The Unit made an effort to resolve complaints which had the potential of rolling over to the new financial year, hence the high increase in the actual complaints resolved within 120+ days.

Programme 7: Benefit Management

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Scheme rules amendments	Number of rule amendments processed per year	310	275	The deviation is due to Council receiving fewer amendments than expected based on previous years' experience.
Monitoring scheme marketing material	Number of schemes' marketing material reviewed per year	45	45	No deviation
Registering new schemes	Number of applications considered per year	2	0	No applications for the registration of a new medical scheme were received during the year under review.
Managing scheme amalgamations	Number of amalgamations managed per year	2	1	Only one (1) amalgamation application was received during the financial year being reviewed. This was lower than expected based on previous years' experience.

Programme 8: Legal Services

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Legal advisory service	Number of written legal opinions provided to Council or business Units per year	52	61	The Unit continued to provide well-researched legal advice to both internal and external stakeholders as and when needed. Opinions were furnished in relation to the following important issues: the meaning of "immediate family", the obligation of medical schemes to remove pre-funding reserves from scheme funds, and the personal medical savings accounts (PMSAs).
Legal support service	Number of court cases where court papers are filed per year	30	20	The Unit endeavoured to save costs as far as possible by settling matters through the use of internal resources, thereby avoiding protracted court proceedings.
Secretarial support service	Number of Council meetings supported per year	4	6	Two (2) additional full Council meetings were scheduled in the year under review.
	Number of Council EXCO meetings supported per year	6	3	The EXCO meeting of 23 June 2011 was postponed due to the special Council meeting scheduled for 28 July 2011. The EXCO meeting of 29 September 2011 was moved to 30 September 2011 and changed into a full Council and SMM meeting due to the nature of matters that needed deliberation by Council.
	Number of Council Appeals Committee meetings supported per year	8	9	A special Appeals Committee meeting was scheduled for 29 September 2011 due to urgent matters that needed to be adjudicated on by the committee.
	Number of Appeal Board hearings supported per year	4	4	No deviation

Programme 9: Strategic Projects

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Maintain the REF shadow process	Number of lay articles on the Risk Equalisation Fund (REF) published per year	1	1	No deviation
	Number of REF shadow process reports published per year	5	4	A fifth report was not required as the pricing study did not result in any changes to the REF risk factors.
	Number of REF research reports published for the year	2	2	No deviation
	Number of REF IT system user requirement documents produced for the year	1	0	A formal decision was taken not to implement the REF system. The REF IT system was therefore not developed further.
Support the PMB review conducted by the Department of Health	Number of recommendations to the Department of Health on amendments to the prescribed minimum benefit (PMB) Regulations	0	1	The zero in the plan was an error. The outcome of the PMB review work completed by Council has not yet been published by the Department of Health. During the period, numerous discussions were held with the Department, and the process is still ongoing.
Update PMB Code of Conduct	Number of PMB Code of Conduct reports released per year	1	0	Due to the Board of Healthcare Funders of Southern Africa (BHF) court case, Council's management agreed that the revision of the PMB Code of Conduct should be postponed until after the court case had been heard.
PMB benefit definitions	Number of clinical advisory committee contributions incorporated in benefit definitions	10	5	The target of 10 could not be achieved due to the limited resources that were available.
Provide clinical opinions	Number of clinical matters reviewed by the Clinical Review Committee (CRC) per year	150	842	Subsequent to Council's stronger enforcement of PMB Regulations, a large increase in the number of clinical complaints was observed. This resulted in a backlog in complaints, which was resolved by the appointment of an additional Clinical Analyst in January 2012.
Submit Strategic Plan (SP) and Annual Performance Plan (APP)	Annual submission of Council's Strategic Plan (SP) and Annual Performance Plan (APP)	1	2	The APP timing for submission was incorrect. The draft APP was submitted in August 2011 and the final APP was submitted in November 2011.
	Quarterly submissions of the updated Risk Register	4	4	No deviation
Support universal access through recommendations to the National Health Insurance (NHI) Ministerial Advisory Committee (MAC)	Number of written reports submitted to the NHI MAC per year	1	1	No deviation
Make policy recommendations to the Department of Health	Number of policy recommendations made to the Department of Health per year	1	1	No deviation
Review the Medical Schemes Act to protect the legislated framework	Number of recommendations made to amend the Medical Schemes Act per year	1	1	No deviation

Programme 10: Financial Supervision

Strategic objective	Performance indicator	Annual target 2011-2012	Actual performance 2011-2012	Comments on deviations
Improve statutory returns as tools for monitoring and reporting, and publish reports on findings	Number of IT specifications produced in respect of quarterly return	1	1	No deviation
	Number of IT specifications produced in respect of annual return	1	1	No deviation
	Number of quarterly reports published	3	3	No deviation
	Number of financial sections prepared for the Annual Report	1	1	No deviation
Improve reporting by medical schemes (data quality)	Number of training sessions held in respect of reporting of financial information	2	2	No deviation
	Number of rejections due to quality of statutory returns	1	0	The quality of all submissions met the required standard.
	Number of rejections due to quality of Annual Financial Statements (AFS)	2	2	No deviation
	Number of guidelines published	6	6	No deviation
	Number of inputs prepared for the South African Institute of Chartered Accountants (SAICA) *Accounting Guide for Medical Schemes*	1	1	No deviation
	Number of inputs prepared for the Independent Regulatory Board of Auditors (IRBA) guide	1	1	No deviation
Provide specialised financial advice	100% of requests for specialised advice processed	100%	100%	No deviation
Provide financial oversight of medical schemes (close monitoring)	Number of recommendations in respect of Regulation 29 of the Medical Schemes Act (medical schemes below prescribed solvency)	5	7	Transmed Medical Scheme was granted a conditional approval for 2011 and 2012, pending a resolution of funding challenges by the employer group.
	Number of recommendations on action plans for medical schemes with a rapidly reducing solvency but above the statutory minimum (Type III schemes)	7	6	Only six (6) medical schemes fell within this category. There was an error with regard to reporting in quarter 2 and 3 where the actual number of recommendations should have reflected two (2) and one (1) respectively. Quarter 4 was reported on correctly, with the number of recommendations being three (3).
Governance & independence	Number of online auditor approval questionnaire per year	1	1	No deviation
	Audit approval letters drafted such that 100% of applications by medical schemes are responded to annually	100%	100%	No deviation
	Responses to 100% of medical schemes which submitted reinsurance applications	100%	100%	No deviation

Our Annual Financial Statements

"I love finding gems. However, I'm not talking about ludicrously expensive diamonds, or priceless sapphires. I mean the impetuous, primitive rushes of passion and love we experience so rarely that they become impossible to ignore. That overwhelming sense of selflessness and beauty. Hope and desire. Happiness and strength. These are the moments that define us as people."

~ George MacDonald ~

Statement of financial position
of the Council for Medical Schemes
as at 31 March 2012

	Notes	2012	2011
		R	R
ASSETS			
Current assets		**14,641,841**	**8,461,057**
Trade and other receivables	5	3,621,887	1,529,277
Cash and cash equivalents	6	11,019,954	6,931,780
Non-current assets		**4,825,302**	**4,973,176**
Property, plant and equipment	3	4,181,194	4,221,250
Intangible assets	4	644,108	751,926
TOTAL ASSETS		**19,467,143**	**13,434,233**
LIABILITIES			
Current liabilities		**11,586,386**	**11,214,509**
Trade and other payables	8	7,498,037	7,593,404
Provisions	9	4,088,349	3,621,105
Non-current liabilities		**398,879**	**324,522**
Operating lease payable	7	398,879	324,522
TOTAL LIABILITIES		**11,985,265**	**11,539,031**
NET ASSETS		**7,481,878**	**1,895,202**
NET ASSETS			
Reserves			
Accumulated surplus		7,481,878	1,895,202
TOTAL NET ASSETS		**7,481,878**	**1,895,202**

Trevor Bailey
Acting Chairperson
Council for Medical Schemes
31 July 2012

Statement of financial performance
of the Council for Medical Schemes
for the period ending 31 March 2012

	Notes	2012	2011
		R	R
Income		**93,725,539**	**69,167,732**
Revenue from exchange transactions	10.1	89,433,315	69,034,784
Revenue from non-exchange transactions	10.2	4,292,224	132,948
Expenditure		**89,047,064**	**82,204,138**
Administrative expenses	11	10,706,087	10,291,786
Audit fees	12	1,368,770	1,368,005
Bad debts	13	-	98,656
Operating expenses	14	19,091,043	16,848,546
Staff cost	15	56,138,761	51,557,771
Depreciation	3	1,206,328	1,191,439
Amortisation	4	536,075	847,935
Operating surplus/(deficit) for the period		**4,678,475**	**(13,036,406)**
Gain/(loss) on disposal of assets		66,822	(14,172)
Interest received		841,379	1,227,976
Surplus/(deficit) for the period		**5,586,676**	**(11,822,602)**

Statement of changes in net assets
of the Council for Medical Schemes
for the period ending 31 March 2012

	Notes	2012	2011
		R	R
Accumulated surplus as at 1 April 2011		**1,895,202**	**13,717,804**
Surplus/(deficit) for the period		5,586,676	(11,822,602)
		7,481,878	**1,895,202**
Accumulated surplus as at 31 March 2012		**7,481,878**	**1,895,202**

Cash flow statement
of the Council for Medical Schemes
for the period ending 31 March 2012

	Notes	2012	2011
		R	R
Cash flows from operating activities			
Cash receipts from customers		87,340,705	68,859,766
Cash receipts from debtors		87,340,705	68,859,766
Cash paid to suppliers and employees		(82,566,203)	(74,605,519)
Cash generated from operations	16	4,774,502	(5,745,753)
Interest received		841,379	1,227,976
Net cash flow from/(used in) operating activities		**5,615,881**	**(4,517,777)**
Cash flows from investing activities			
Acquisition of property, plant and equipment	3	(1,206,486)	(2,687,417)
Acquisition of intangible assets	4	(428,257)	(315,741)
Proceeds from sale of equipment		107,035	31,500
Net cash flow from/(used in) investing activities		**(1,527,707)**	**(2,971,659)**
Net increase in cash and cash equivalents		**4,088,174**	**(7,489,437)**
Cash and cash equivalents at beginning of the year		6,931,780	14,421,217
Cash and cash equivalents at end of the year	**6**	**11,019,954**	**6,931,780**

Notes to the financial statements
of the Council for Medical Schemes
for the period ending 31 March 2012

1. General

The Council for Medical Schemes is a listed entity under schedule 3 of the Public Finance Management Act (Act No. 1 of 1999) (PFMA) and domiciled in South Africa. The address of its registered offices 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, Council administers and enforces the Medical Schemes Act (Act No. 131 of 1998). It is accountable to the Minister responsible for national health matters. Council collects levies from medical schemes in terms of the Levies Act (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 Council. This adoption did not result in any additional disclosure or change in accounting policy.

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 adoption of the amendments to the Standards of GRAP and various interpretations of the Standards of GRAP (effective from 1 April 2011) will not have a significant effect on the financial statements.

The following Standards of GRAP have been approved by the Minister of Finance but were not adopted by Council as they are not applicable to the entity.

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 2012:

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
		This Standard will not be implemented because Council has only one segment.	Effective date:	To be determined by the Minister of Finance
GRAP 21	Impairment of non-cash generating assets	This Standard prescribes the procedures that Council applies to determine whether a non-cash generating asset is impaired and to ensure 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:	1 April 2012
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: Council has adopted GRAP 23 in full.	Effective date:	1 April 2012
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:	1 April 2012
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:	1 April 2013
GRAP 26	Impairment of cash-generating assets	This Standard prescribes the procedures to determine whether a cash-generating asset is impaired and to ensure 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:	1 April 2012

Standard	Topic	Summary and impact	Effective date	
GRAP 103	Heritage assets	This Standard prescribes the accounting treatment for heritage assets and related disclosure requirements.	ASB issued date:	July 2008
		This Standard will not be implemented because Council has no heritage assets.	Effective date:	1 April 2012
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:	1 April 2012
GRAP 105	Transfer of functions between entities under common control	This Standard establishes accounting principles for the acquirer and transferor in a transfer of functions between entities under common control.	ASB issued date:	November 2010
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	To be determined by the Minister of Finance
GRAP 106	Transfer of functions between entities not under common control	This Standard establishes accounting principles for the acquirer in a transfer of functions between entities not under common control.	ASB issued date:	November 2010
		The impact on the financial results and disclosure is considered to be minimal.	Effective date:	To be determined by the Minister of Finance
GRAP 107	Mergers	This Standard establishes accounting principles for the combined entity and combining entities in a merger. The Standard will be applied to a transaction or event where no acquirer can be identified.	ASB issued date:	November 2010
		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 Council. All amounts are stated in the 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 Council 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

Council makes estimates and assumptions which 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 circumstances. Areas which management believes require the most critical estimates and judgements are:

Useful economic lives of property, plant and equipment

Council 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 is 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 expenses 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 cash on hand and deposits held in current and call accounts at the bank.

2.6 Borrowing costs

Section 66 of the PFMA prohibits Council 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 Council 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 administrators, manage care organisations, and brokers, 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 appellants when appealing to the Appeal Board. Appeal fees are recognised in the financial period in which the appeal was raised and services were rendered.

(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 in which 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 Council is recognised as revenue when future economic benefits flow to Council and these benefits can be measured reliably.

2.7.2 Revenue from non-exchange transactions

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

(a) Government grants

Council receives grants from the Department of Health for specific projects. These grants are recognised when it is probable that future economic benefits will flow to Council 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.

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 Council; 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 Council 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 value, 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 which are directly associated with the development of identifiable software products controlled by Council, 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 the 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 and assets

A contingent liability is a possible obligation which arises form 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 Council, or a present obligation which 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.

Contingent assets usually arise from unplanned or other unexpected events that are not wholly within the control of the entity and give rise to the possibility of an inflow of economic benefits or service potential to the entity. A contingent asset is disclosed where an inflow of economic benefits or service potential is probable.

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

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

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

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

Currency risk:
Council 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:
Council 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 Council. The objective of the Unit is to monitor the impact of the Medical Schemes Act (Act No. 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 2011 to 31 March 2012. 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. GRAP 24 has not been adopted fully, as the effective date is only 1 April 2012.

2.18 Employee benefits

Short-term employee benefits
The cost of short-term employee benefits - which are 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 bonuses payable are 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	Other fixed assets	TOTAL
	R	R	R	R	R	R
For the period ending 31 March 2012						
Opening net book amount at 1 April 2011	1,334,156	835,208	1,706,350	-	345,536	4,221,250
Cost	6,366,204	2,204,788	3,624,897	139,885	552,393	12,888,167
Accumulated depreciation	(5,032,048)	(1,369,580)	(1,918,547)	(139,885)	(206,857)	(8,666,917)
Additions for the year	567,767	28,500	358,510	221,871	29,838	1,206,486
Disposals at net book value	(25,995)	-	(14,219)	-	-	(40,214)
Depreciation charge	(498,062)	(346,363)	(299,076)	(8,389)	(54,438)	(1,206,328)
Closing net carrying amount at 31 March 2012	1,377,866	517,345	1,751,565	213,482	320,937	4,181,194
Closing net carrying amount at 31 March 2012	1,377,865	517,345	1,751,565	213,482	320,937	4,181,194
Cost	6,583,802	2,233,288	3,876,729	221,871	582,231	13,497,921
Accumulated depreciation	(5,205,937)	(1,715,943)	(2,125,164)	(8,389)	(261,294)	(9,316,727)
Cost of fully depreciated property, plant and equipment still in use	4,292,976	1,214,097	1,060,274	-	41,142	6,608,489
Accumulated depreciation	(4,292,976)	(1,214,097)	(1,060,274)	-	(41,142)	(6,608,489)
Carrying amount of fully depreciated property, plant and equipment still in use	-	-	-	-	-	-
For the period ending 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	-	41,183	2,687,417
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	4,221,250
Closing net carrying amount at 31 March 2011	1,334,156	835,208	1,706,350	-	345,536	4,221,250
Cost	6,366,204	2,204,788	3,624,897	139,885	552,393	12,888,167
Accumulated depreciation	(5,032,048)	(1,369,580)	(1,918,547)	(139,885)	(206,857)	(8,666,917)
Cost of fully depreciated property, plant and equipment still in use	4,430,605	1,143,109	625,538	139,885	13,357	6,352,494
Accumulated depreciation	(4,430,605)	(1,143,105)	(625,538)	(139,885)	(13,357)	(6,352,494)
Carrying amount of fully depreciated property, plant and equipment still in use	-	-	-	-	-	-

4. Intangible assets

	Acquired software	Developed software	TOTAL
	R	R	R
For the period ending 31 March 2012			
Opening net book amount at 1 April 2011	418,085	333,841	751,926
Cost	4,389,190	920,550	5,309,740
Accumulated amortisation	(3,971,105)	(586,709)	(4,557,814)
Additions for the year	371,650	56,607	428,257
Disposals at net book value	-	-	-
Amortisation	(328,183)	(207,892)	(536,075)
Closing net carrying amount at 31 March 2012	461,552	182,556	644,108
Closing net carrying amount at 31 March 2012	461,552	182,556	644,108
Cost	4,760,840	977,157	5,737,997
Accumulated amortisation	(4,299,288)	(794,601)	(5,093,889)
Cost of fully amortised intangible assets still in use	3,775,518	345,435	4,120,954
Accumulated depreciation	(3,775,518)	(345,435)	(4,120,954)
Carrying amount of fully amortised intangible assets still in use	-	-	-
For the period ending 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)	(847,935)
Closing net carrying amount at 31 March 2011	418,085	333,841	751,926
Closing net carrying amount at 31 March 2011	418,085	333,841	751,926
Cost	4,389,190	920,550	5,309,740
Accumulated amortisation	(3,971,105)	(586,709)	(4,557,814)
Cost of fully amortised intangible assets still in use	3,065,101	351,238	3,416,339
Accumulated depreciation	(3,065,101)	(351,238)	(3,416,339)
Carrying amount of fully amortised intangible assets still in use	-	-	-

5. Trade and other receivables

	2012	2011
	R	R
Accounts receivable	445,950	15,298
Sundry debtors	2,173,910	894,751
Prepaid expenses	1,002,027	619,228
	3,621,887	1,529,277

As at 31 March 2012 the carrying amount of trade and other receivables approximates their fair values due to the short-term maturities of theses 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	1,019,954	6,931,780
Call account	10,000,000	-
	11,019,954	6,931,780

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 payables

Previous lease contract		
Opening balance as at 1 April 2010	-	73,455
Movement for the year	-	(73,455)
New lease contract		
Opening balance as at 1 April 2011	324,522	-
Movement for the year	74,357	324,522
Closing balance as at 31 March 2012	398,879	324,522

8. Trade and other payables

	2012	2011
	R	R
Accounts payable	2,456,555	4,285,899
Income received in advance	750,560	644,189
Accrual for leave pay	1,282,672	1,489,284
Other accruals	3,008,250	1,174,032
	7,498,037	7,593,404

As at 31 March 2012 the carrying amount of trade and other payables approximates their fair values due to the short-term maturities of theses 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	4,071,989	3,421,105
Opening balance	3,421,105	2,609,419
Utilisation of provision during the year	(3,421,105)	(2,609,419)
Provision made during the current year	4,071,989	3,421,105

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	16,360	200,000
Opening balance	200,000	-
Utilisation of provision during the year	(200,000)	-
Provision made during the current year	16,360	200,000

"Other provisions" relates to expenses for the International Partnership Programme for which invoices were not received.

Total	**4,088,349**	**3,621,105**

10. Revenue

10.1 Revenue from exchange transactions

BUDGET			ACTUAL		
2012	2011		Notes	2012	2011
R	R			R	R
5,500,000	5,500,000	Accreditation fees		5,709,000	4,737,000
-	-	Appeal fees		20,000	22,000
76,575,837	63,359,700	Levies income		76,534,662	63,721,098
400,000	384,000	Registration fees		371,100	417,550
-	11,500,000	Sundry income		392,728	137,136
-	-	Legal fees recovered		6,405,826	-
82,475,837	80,743,700			89,433,315	69,034,784

Legal fees were recovered on the Bonitas Medical Fund matter.

10.2 Revenue from non-exchange transactions

-	-	Government grants - Department of Health		4,194,000	-
-	-	Mandatory grants - Department of Higher Education and Training		98,224	132,948
-	-			4,292,224	132,948

Council received an unconditional grant from the Department of Health. We did not budget for this grant.

11. Administrative expenses

40,692	37,301	Bank charges		46,124	75,263
2,404,216	1,772,401	Building expenses		2,635,740	1,585,417
4,524,000	4,305,537	Rent		4,487,608	4,301,386
190,008	132,996	Courier and postage		119,957	109,026
977,920	1,278,324	General administrative expenses		1,071,136	1,350,229
139,168	121,668	Insurance		134,995	133,414
335,388	258,722	Printing and stationery		289,065	239,207
172,620	160,752	Refreshments		156,298	171,125
64,000	321,000	Rental - copiers		-	231,290
143,722	70,651	Security		145,899	65,453
105,860	96,834	Subscriptions		64,402	50,237
1,275,604	1,736,582	Telecommunication expenses		1,367,233	1,752,144
276,455	246,704	Travel		187,630	227,595
10,649,653	10,539,472			10,706,087	10,291,786

12. Audit fees

BUDGET 2012 R	BUDGET 2011 R		ACTUAL Notes	ACTUAL 2012 R	ACTUAL 2011 R
593,908	574,480	Auditors' remuneration - external audit		752,117	484,475
663,814	1,135,795	Auditors' remuneration - internal audit		616,653	883,530
1,257,722	1,710,275			1,368,770	1,368,005

13. Bad debts

-	-	Bad debts		-	98,656
-	-			-	98,656

Council accepted a lesser settlement from a former employee in respect of sabbatical leave.

14. Operating expenses

429,000	166,922	Accreditation costs		319,962	129,440
450,000	372,000	Appeal Board		228,695	388,593
368,000	194,000	Consulting fees		347,147	766,973
885,500	1,225,501	Consumer education		1,211,790	1,104,698
2,875,473	1,155,857	Committee expenses	17.1	3,585,942	1,711,543
696,000	940,000	HR/organisational strategy		435,270	494,341
750,000	500,000	Investigation costs		837,056	348,024
80,000	-	International Partnership Programme		96,360	-
419,537	267,516	Knowledge Management		383,505	244,886
6,220,845	3,700,812	Legal fees		10,388,582	9,892,398
125,440	268,000	Media and promotion		19,951	225,504
122,000	156,000	Newsletters		45,962	38,551
671,000	517,004	PMB review		495,411	299,893
140,000	115,000	Research costs		87,334	40,188
400,000	1,138,000	Strategic and operational planning		410,089	800,452
83,160	50,400	Transcription services		36,024	53,265
190,000	629,151	Trustee training		161,963	309,797
14,905,955	11,396,163			19,091,043	16,848,546

15. Staff cost

1,272,000	1,120,152	Employee benefits		1,234,920	1,081,758
397,320	342,200	Employee wellness		352,003	329,062
850,000	820,000	Recruitment and relocation		636,762	765,226
55,341,193	51,803,543	Salaries		52,409,900	47,372,114
200,000	200,000	Social contributions		65,776	200,000
1,939,476	1,673,863	Staff training		1,291,880	1,328,337
290,000	334,044	Temporary staff		147,520	481,274
60,289,989	56,293,802			56,138,761	51,557,771
		Total number of employees		92	83

16. Reconciliation between net surplus and cash applied to activities

	ACTUAL Notes	ACTUAL 2012 R	ACTUAL 2011 R
Operating surplus/(deficit)		5,586,676	(11,822,602)
Adjusted for:			
Amortisation		536,075	847,935
Depreciation		1,206,328	1,191,439
Interest received		(841,379)	(1,227,976)
Gain/(loss) on disposal of assets		(66,822)	14,172
Operating surplus/(deficit) before working capital		6,420,878	(10,997,032)
Decrease/(increase) in accounts receivable		(2,092,610)	(175,018)
(Decrease)/increase in accounts payable		(21,010)	4,414,611
(Decrease)/increase in provisions		467,244	1,011,686
Cash flows from operating activities		4,774,502	(5,745,753)

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 Council 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. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the Council for Medical Schemes.

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

	Notes	2012	2011
		R	R
Fees for services			
Bailey T		269,570	55,686
Du Plessis DJ		62,918	30,576
Dumisa BC		42,398	-
Fihlani ZL		8,106	-
Fortune T		173,183	47,969
Gwagwa T		36,670	7,462
Hoosain AK		141,286	24,513
Mjamba-Matshoba BN		43,788	-
Morata MO		48,250	-
Nevhutalu L		13,124	-
Njongwe PZ		71,796	15,437
Phadu T		108,080	19,474
Pick W		212,350	80,636
Rothberg AD		53,288	49,972
Rusconi R		-	1,530
Simelane RV		65,031	11,516
Theophanides A		17,370	-
Thompson RG		198,992	60,763
Van Gelderen CJ		207,282	31,850
Weapond JC		61,374	-
Zulu TF		9,264	-
		1,844,119	437,384

The increase in Council member fees is due to an increase in the activitities of Council. There was a need during the year to establish a Finance Committe and a special Strategic Management Team (SMT) Committee to look into the implications of National Health Insurance (NHI) for the operations of Coucil as well as to assess how Council can contribute in the development of the NHI. Council member fees were adjusted retrospectively from 1 April 2011 during the year.

17.2 Executive management

Basic salary		11,774,011	9,334,031
Bonuses		1,109,076	878,439
Expense allowances		-	354,000
		12,883,087	10,566,470

18. Operating lease commitments

18.1 Office rental

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

	Notes	2012	2011
		R	R
Not later than one year		4,590,363	4,590,363
Later than one year and not later than five years		765,061	5,355,424
		5,355,424	9,945,787

19. Change in accounting policy

19.1 Leave accrual

During the previous financial year Council 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)
Increase in trade and other payables		-	1,489,284

20. Taxation

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

	Notes	2012	2011
		R	R

21. Irregular expenditure

Opening balance	3,472,451	-
Current year	-	2,299,520
Prior year	-	1,172,931
Less: amounts condoned	-	-
Irregular expenditure awaiting condonation	**3,472,451**	**3,472,451**
Analysis of irregular expenditure awaiting condonation per age classification		
Current year	-	2,299,520
Prior year	-	1,172,931
Total	**-**	**3,472,451**

Council incurred irregular expenditure in the previous financial year when it had acquired goods without going through a competitive bidding process or sourcing three quotations. But 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 a competitive bidding process.

Council has since applied for condonation from National Treasury; no response has been received in this regard.

22. Contingent assets

Council won a court case against Selfmed Medical Scheme in the Supreme Court of Appeal that concluded in November 2011. Council won another court case against Profmed in the North Gauteng High Court that concluded in March 2012. Council, as the successful party in both cases, was awarded costs on the party and party scale. The bill of costs relating to these matters has to date not yet been approved by the Taxation Master of the North Gauteng High Court. For these reasons uncertainties exist relating to the amount and timing of the legal fees recovered.

Report of the Audit & Risk Committee

"We are tied to the ocean. And when we go back to the sea, whether it is to sail or to watch, we are going back from whence we came."

~ John F. Kennedy ~

Report of the Audit & Risk Committee

We are pleased to present our report to the Council for Medical Schemes (CMS or Council) Accounting Authority for the financial year ended 31 March 2012.

This report is provided by the Audit & Risk Committee of Council, appointed in respect of the 2011-2012 financial year of Council in compliance with Section 51(1)(a)(ii) of the Public Finance Management Act 1 of 1999 (PFMA), as amended. The Committee's operation is guided by a detailed charter which is informed by the PFMA and approved by Council.

Audit & Risk Committee members and meetings

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

The Committee held three scheduled meetings and one special meeting during the year under review.

Meetings and attendance at these meetings was as follows:

Name of member	Date of appointment	Date term ended	Meetings attended			
			19.05.2011 (scheduled)	26.07.2011 (special)	20.10.2011 (scheduled)	15.03.2012 (scheduled)
Charles Mazhindu	1 October 2009		√	√	√	√
Rowan Nicholls	1 October 2009		√	√	√	√
Josephine Naicker	1 October 2009		√	√	√	√
Kariem A Hoosain	28 May 2009		√	X	√	√
Dr Zola P Njongwe	1 September 2005	Term ended October 2011	√	√	X	-
Prof. Dion J du Plessis	1 October 2010	Resigned October 2011	√	√	√	-
Thabani F Zulu	1 November 2011		-	-	-	√
Zola L Fihlani	1 November 2011		-	-	-	X

√ = attended X = apology - = not a member at the time of the meeting

Other invitees

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

Functions

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

- Evaluation of the effectiveness of risk management, controls, and governance processes
- Oversight of:
  - ✦ the financial reporting process
  - ✦ the activities of the internal and external audits and facilitation of a coordinated approach between these functions
- Review of:
  - ✦ provisional and year-end financial statements to ensure that they are fairly presented and prepared in the manner required by the PFMA and 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 2012

Audit & Risk Committee responsibility

Mandate

The mandate of the Committee is derived from Section 51(1)(a)(ii) of the PFMA and paragraph 3.1 of Treasury Regulations.

The Committee reports that it has discharged its responsibilities arising from Section 51(1)(a)(ii) of the PFMA and Treasury Regulation 3.1.13.

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

Role of the Audit & Risk Committee on Council governance

The Committee continued to discharge its mandate as part of Council's governance structures and enhanced its oversight function as follows:

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

Council's outsourced internal auditor Sizwe Ntsaluba VSP compiled and presented its three-year rolling strategic plan for the review and approval of the 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 Council's 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 2012.

The Committee confirms that this plan is in line with Regulations and standards, and that the plan takes into consideration Council's risk register for the year under review.

The Committee believes that the plan and audit fee presented are adequate for completion of Council's annual audit.

Risk management and internal controls

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

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

Both internal and external audits identified information technology (IT) 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 the top strategic risks that would have been identified and approved by Council. The Committee recommended to Council that it identify the role of combined assurance providers as a top strategic risk together with the reporting requirements to provide comfort to Council on the effectiveness of Council's risk management framework, and recommends Council's risk register as prepared by management for adoption by Council.

Reviewing legal cases pending at financial year-end

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

Evaluating the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually.

During the year under review, the Committee was not evaluated by Council.

Evaluating financial statements

The Committee:

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

The Committee concurs with and accepts the Auditor-General's conclusion on the Annual Financial Statements, and recommends that the audited financial statements be accepted by Council and read together with the report from the Auditor-General.

The Committee reviewed Council's Annual Financial Statements for the year ended 31 March 2012 and is satisfied that they comply with the relevant provisions of the PFMA, and GRAP, in all material respects and fairly present Council's financial position at that date as well as its results of operations and cash flows for the year then ended.

Our commitment

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

Charles Mazhindu
Chairperson
Audit & Risk Committee
31 July 2012

Members of the Audit & Risk Committee

Charles Mazhindu:
independent & non-executive; Chairperson

Rowan Nicholls:
independent & non-executive

Josephine Naicker:
independent & non-executive

Kariem A Hoosain:
non-executive & Council member

Dr Zola P Njongwe:
non-executive & Council member (term ended 31 October 2011)

Prof. Dion J du Plessis:
non-executive & Council member (resigned 31 October 2011)

Thabani F Zulu:
non-executive & Council member (appointed 31 October 2011)

Zola L Fihlani:
non-executive & Council member (appointed 31 October 2011)

Report of the Auditor-General

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

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 76 to 98, which comprise the statement of financial position as at 31 March 2012, the statement of financial performance, statement of changes in net assets and the cash flow statement for the year then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting authority's responsibility for the financial statements

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

Auditor-General's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the General Notice issued in terms thereof and International Standards on Auditing.

Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2012, and its financial performance and cash flows for the year then ended in accordance with SA Standards of GRAP and the requirements of the PFMA.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

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

Predetermined objectives

8. I performed procedures to obtain evidence about the usefulness and reliability of the information in the annual performance report as set out on pages 58 to 75 of the annual report.

9. The reported performance against predetermined objectives was evaluated against the overall criteria of usefulness and reliability. The usefulness of information in the annual performance report relates to whether it is presented in accordance with the National Treasury annual reporting principles and whether the reported performance is consistent with the planned objectives. The usefulness of information further relates to whether indicators and targets are measurable (i.e. well-defined, verifiable, specific, measurable and time-bound) and relevant as required by the National Treasury Framework for managing programme performance information.

   The reliability of the information in respect of the selected programmes is assessed to determine whether it adequately reflects the facts (i.e. whether it is valid, accurate and complete).

10. There were no material findings on the annual performance report concerning the usefulness and reliability of the information.

Additional matter

11. I draw attention to the following matter below. This matter does not have an impact on the predetermined objectives audit findings reported above.

Material adjustments to the annual performance information report

12. Material misstatements in the annual performance report were identified during the audit, all of which were corrected by management.

Compliance with laws and regulations

13. I did not identify any instances of material non-compliance with specific matters in key applicable laws and regulations as set out in the General Notice issued in terms of the PAA.

Internal control

14. I did not identify any deficiencies in internal control which I considered sufficiently significant for inclusion in this report.

Pretoria
31 July 2012

Reviewing the operations of medical schemes in 2011

"The use of travelling is to regulate imagination by reality, and instead of thinking how things may be, to see them as they are."

~ Samuel Johnson ~

Reviewing the operations of medical schemes in 2011

Number of schemes and options

The declining trend in the total number of medical schemes continued during 2011.

At the end of 2011, there were 97 medical schemes registered in South Africa, compared to 100 schemes at the end of 2010. This reflects a 3.0% reduction in the overall number of registered medical schemes. The number consists of 26 open and 71 restricted medical schemes.

One open and two restricted schemes disappeared in the year under review. These figures indicate a 3.7% decrease in the number of open schemes (from 27 to 26), and a 2.7% decrease in the number of restricted schemes (from 73 to 71). Overall, the number of all registered medical schemes decreased by 3.0% compared to the 9.1% decline in 2010.

Table 11: Number of schemes by size and type as at December 2011

Size of scheme	Type of scheme	2010	2011
Large (≥ 30 000 beneficiaries)	Open	14	14
	Restricted	15	16
	Consolidated	29	30
Medium (≥ 6 000 members but < 30 000 beneficiaries)	Open	9	9
	Restricted	20	19
	Consolidated	29	28
Small (< 6 000 members)	Open	4	3
	Restricted	38	36
	Consolidated	42	39
Total number of schemes	**Open**	**27**	**26**
	Restricted	**73**	**71**
	Consolidated	**100**	**97**

Open schemes had 161 registered benefit options in 2011 compared to 166 options in 2010. This translates into a decline of 3.0% in 2011 compared to the 11.7% decrease observed in 2010. In the restricted schemes environment, there were 145 benefit options compared to the 153 options in 2010. This represents a decrease of 5.2% which is slightly higher than the 4.4% decrease observed in 2010.

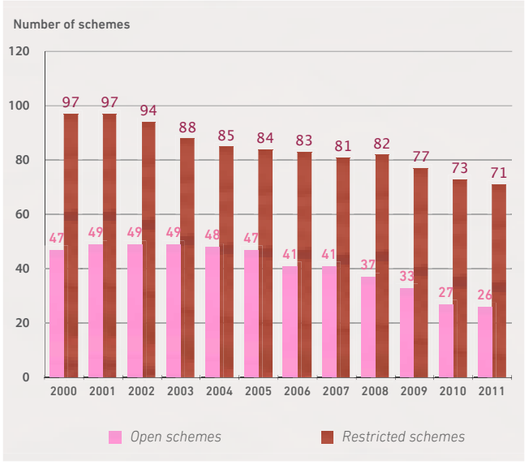
The average number of benefit options in 2011 was 6.2 in open schemes (similar to what was observed in 2010); the average number of options in restricted schemes relative to 2011 declined slightly to 2.0 (compared to 2.1 in 2010). Overall, the average number of benefit options in all medical schemes remained unchanged at 3.2 in 2011.

Trend in the number of schemes

Figure 7 depicts the trend in the number of registered medical schemes from 2000 to 2011.

Open schemes decreased by 44.7% from 47 in 2000 to 26 in 2011. Similarly, the restricted schemes environment experienced a slump in the number of schemes, from 97 in 2000 to 71 in 2011, translating into a 26.8% decrease.

Figure 7: Number of schemes 2000-2011



Overall, a downward trend in the number of registered schemes can be observed during the 12-year period between 2000 and 2011. The trend can largely be explained by market consolidation through liquidations and mergers.

The overall number of schemes decreased from 144 in 2000 to 97 in 2011, translating into an average rate of decline of four medical schemes per year over a period of 12 years.

Trend in the number of schemes by size

Figure 8 depicts the trend in the number of registered medical schemes by size from 2001 to 2011.

The Figure indicates a trend whereby a number of smaller schemes were consolidated into large schemes, particularly between 2001 and 2005. From 2005, additional competition in the sector altered the trend to some extent as several open schemes tried to consolidate their market size in response to the emergence of the Government Employees Medical Scheme (GEMS). This resulted in the number medium-sized schemes beginning to increase.

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 6.2 in 2011, as illustrated in Figure 9.

The average number of benefit options in restricted schemes increased from 1.8 in 2002 to 2.0 in 2011.

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 2011.

Figure 8: Number of schemes by size 2001-2011

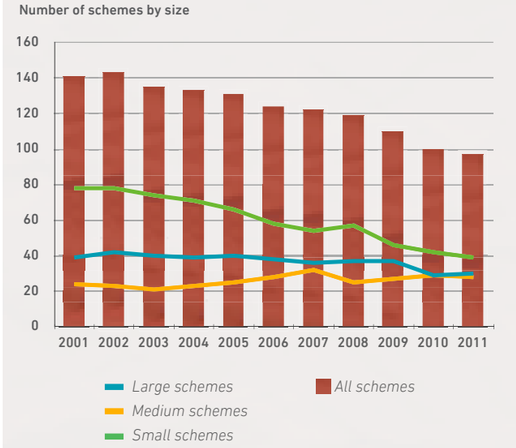
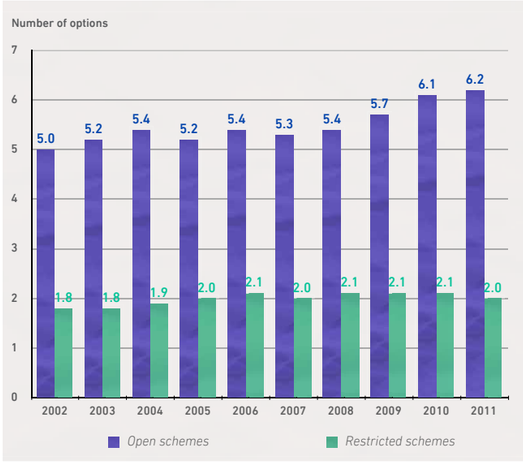


Figure 9: Number of options 2002-2011



Membership of medical schemes

The growth trend in the number of principal members slowed to 3.3% in 2011, down from 3.6% in 2010. This translates into a total of 3 730 565 principal members in 2011 compared to 3 612 062 in 2010. The number of dependants rose by 2.0% to 4 795 844; the number of beneficiaries increased by 2.5% to 8 526 409.

Open schemes experienced a 0.5% increase in the number of principal members; the number of principal members in restricted schemes rose by 7.5%. The coverage of beneficiaries in open schemes declined marginally by 1.9% but there was an increase of 6.8% in restricted schemes. See Table 12.

Trend in the number of beneficiaries

Figure 10 depicts the trend in medical scheme coverage from 2000 to 2011.

The number of beneficiaries increased to 8.5 million in 2011 from 6.7 million in 2000; this represents an increase of 26.9%. The number of beneficiaries in open schemes was 4.7 million in 2000 and 4.8 million in 2011. The number of beneficiaries in restricted schemes was 2.1 million in 2000 and 3.7 million in 2011. This means an increase of 2.1% and 76.2% respectively over the 12-year period.

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. A noteworthy feature in the data presented in Figure 10 is that since 2006, restricted schemes membership grew by 1.6 million beneficiaries, which is significant compared to the 2000-2005 period.

Table 12: Membership of schemes 2010 and 2011

Type of scheme	Type of membership	2010	2011	% change
Open schemes	Principal members	2,172,723	2,182,562	0.5
	Dependants	2,627,192	2,577,552	-1.9
	Beneficiaries	4,799,915	4,760,114	-0.8
Restricted schemes	Principal members	1,439,339	1,548,003	7.5
	Dependants	2,076,464	2,218,292	6.8
	Beneficiaries	3,515,803	3,766,295	7.1
Total schemes	**Principal members**	**3,612,062**	**3,730,565**	**3.3**
	Dependants	**4,703,656**	**4,795,844**	**2.0**
	Beneficiaries	**8,315,718**	**8,526,409**	**2.5**

Figure 10: Number of beneficiaries 2000-2011

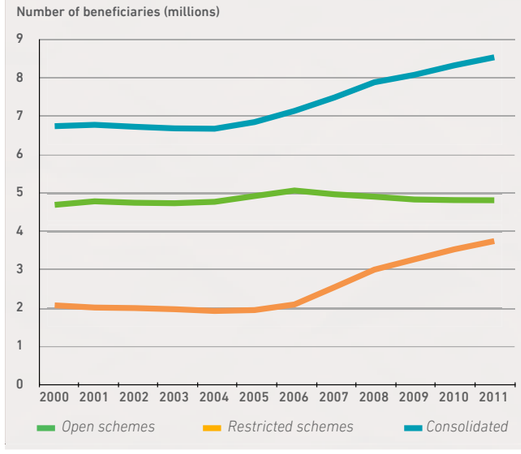
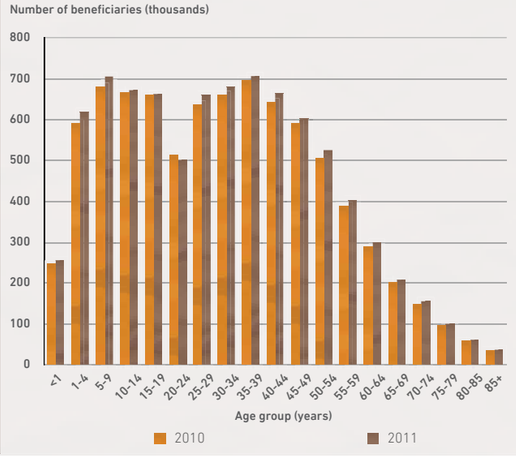


Figure 11: Age distribution of beneficiaries 2010 and 2011



Age distribution of beneficiaries

Figure 11 shows the age distribution of beneficiaries for 2010 and 2011.

A bimodal distribution was again evident.

Increases in the number of beneficiaries were seen in most of the age bands. The only age band which experienced a decline compared to the previous year was the age band 20-24, declining by 2.3% from 514 000 beneficiaries in 2010 to 502 000 beneficiaries in 2011. The average age of beneficiaries was 31.6 years in 2011, slightly older than the 31.5 years reported in 2010.

Trend in the average age of beneficiaries

Figure 12 depicts the trend in the average age of beneficiaries from 2004 to 2011.

The Figure illustrates that, until 2006, restricted schemes had an older age profile than open schemes. This changed in 2007; restricted schemes started to have a younger age profile 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.

Gender distribution of beneficiaries

Figure 13 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, medical schemes beneficiaries in 2011 consisted of proportionately more females than males at 52.2% (52.3% in 2010) and 47.8% (47.7% in 2010) respectively. Female beneficiaries were generally older than male beneficiaries; the average age of females belonging to a medical scheme in 2011 was 32.4 years (32.3 in 2010) and that of males remained unchanged over the two years at 30.7.

Figure 12: Age of beneficiaries 2004-2011

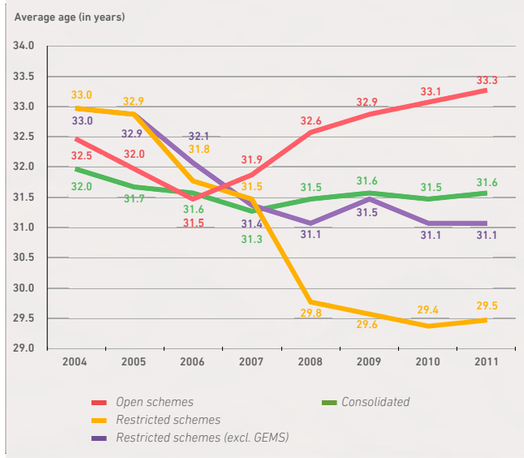
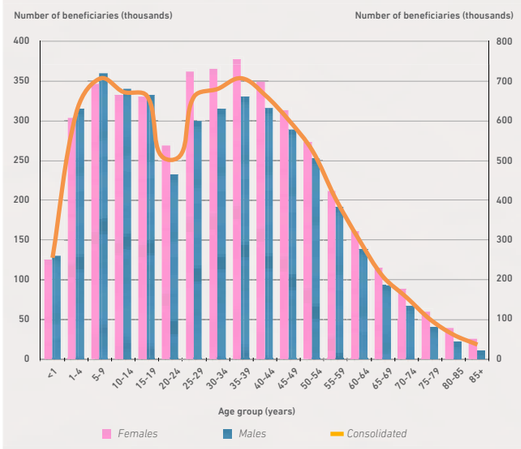


Figure 13: Age and gender distribution of beneficiaries 2011



Pensioner ratio

Table 13 shows that the proportion of pensioners (beneficiaries 65 years old or older) increased marginally, from 6.5% in 2010 to 6.6% in 2011. Open schemes had a higher pensioner ratio (7.8%) than restricted schemes (5.1%). There were more female (7.4%) than male (5.8%) pensioners.

Dependant ratio

The dependant ratio measures the average number of dependants per principal member; it remained unchanged at 1.3 in 2011. The dependant ratio for both open and restricted schemes remained unchanged at 1.2 and 1.4 respectively. Figure 14 shows that the overall dependant ratio has declined steadily between 2000 and 2011.

Figure 14 also illustrates that the dependant ratio in restricted schemes started overtaking the ratio in open schemes after the introduction of GEMS in 2006, illustrating a trend whereby members of GEMS generally cover more dependants compared to other medical schemes.

Coverage by province

Figure 15 shows the distribution of beneficiaries by province.

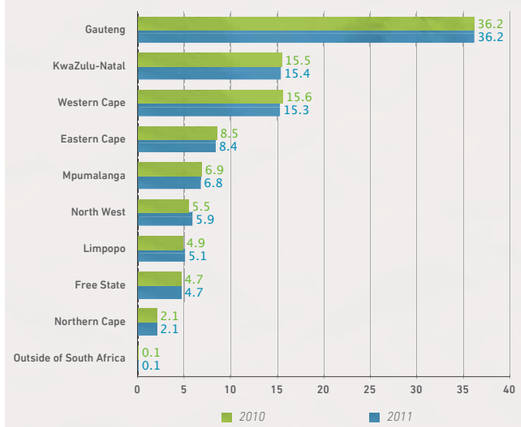
This data was collected primarily on the basis of the location of principal members. More than one third of beneficiaries (36.2%) were located in Gauteng in 2011. A slight growth in the number of beneficiaries in KwaZulu-Natal was noted, up to 15.4% of all beneficiaries, and as a result this province overtook the Western Cape in the year under review. The Western Cape took 15.3% of all beneficiaries in 2011, followed by the Eastern Cape with 8.4% of beneficiaries.

Table 13: Pensioner ratio in schemes 2010 and 2011 (%)

Type of scheme	Gender	2010	2011
Open schemes	Female	8.4	8.8
	Male	6.6	6.8
	All	7.5	7.8
Restricted schemes	Female	5.7	5.7
	Male	4.5	4.4
	All	5.1	5.1
Total schemes	**Female**	**7.3**	**7.4**
	Male	**5.7**	**5.8**
	All	**6.5**	**6.6**

Figure 14: Dependant ratio in schemes 2000-2011

Figure 15: Distribution of beneficiaries by province 2011 (%)



Healthcare benefits

Total healthcare benefits paid

Medical schemes spent 10.0% more on healthcare benefits in 2011; this expenditure increased to R93.2 billion from R84.7 billion in 2010.

Figure 16 shows the proportions of benefits which schemes paid to the various categories of providers in 2011.

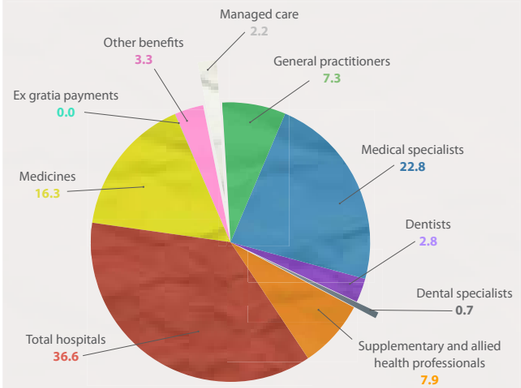
Medical scheme expenditure on hospitals – which includes ward fees, theatre fees, consumables, medicines, and per diem arrangements – consumed R34.1 billion or 36.6% of the R93.2 billion paid to all providers. Expenditure on private hospitals increased by 9.7% to R33.8 billion from R30.8 billion in 2010; expenditure on provincial hospitals decreased by 8.0% to R304.1 million from R281.5 million spent in 2010.

Payments to medical specialists amounted to R21.3 billion or 22.8% of total healthcare benefits paid in 2011; this is an increase of 13.5% on 2010.

Benefits which schemes paid for medicines dispensed by pharmacists and providers other than hospitals amounted to R15.2 billion or 16.3% of total benefits paid. This reflects an increase of 8.6% when compared to the R14.0 billion spent in 2010.

Expenditure on general practitioners (GPs) amounted to R6.8 billion or 7.3% of benefits paid, representing an increase of 9.7% from 2010's R6.2 billion. Dentists accounted for R2.6 billion in medical scheme expenditure, an increase of 1.7% on 2010. Expenditure on dental specialists accounted for 0.7% of benefits paid. Benefits paid to supplementary and allied health professionals came to R7.3 billion; they were R6.7 billion in 2010. The proportion of benefits spent on managed care in 2011 was 2.2% (R2.1 billion), a decline from the 2.2 billion that was paid in 2010.

Figure 16: Total healthcare benefits paid in 2011 (%)

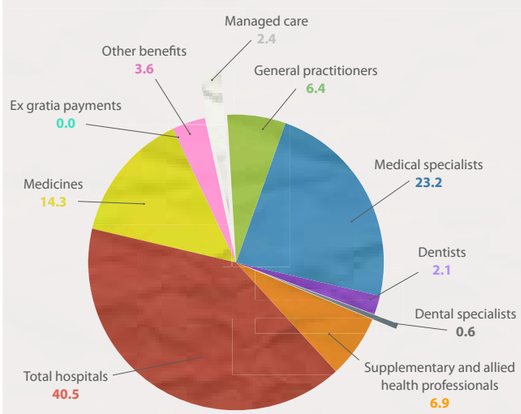


Healthcare benefits paid from risk pool

Healthcare benefits which medical schemes covered from their risk pools amounted to R84.0 billion; this was 90.1% of the total benefits they paid in 2011 and reflects an increase of 9.9% on the R76.4 billion paid in 2010.

Hospital expenditure accounted for 40.5% of risk benefits paid in 2011. Expenditure on medical specialists accounted for 23.2% of total risk pool benefits; medicines took up 14.3%. Expenditure on GPs was R5.3 billion; this represents 6.4% of risk pool benefits.

Figure 17: Healthcare benefits paid from risk pool in 2011 (%)

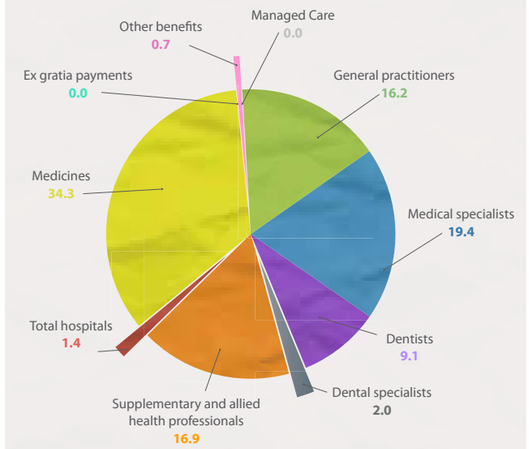


Healthcare benefits paid from medical savings accounts

Healthcare benefits paid from medical savings accounts amounted to R9.2 billion (9.9%) of total benefits in 2011.

Figure 18 show that medicines took up the largest share of medical savings accounts expenditure in 2011 (34.3%). Medical specialists accounted for 19.4% and GPs for 16.2%. Supplementary healthcare providers took 16.9% 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 (1.4% and 2.0% respectively).

Figure 18: Healthcare benefits paid from savings accounts in 2011 (%)



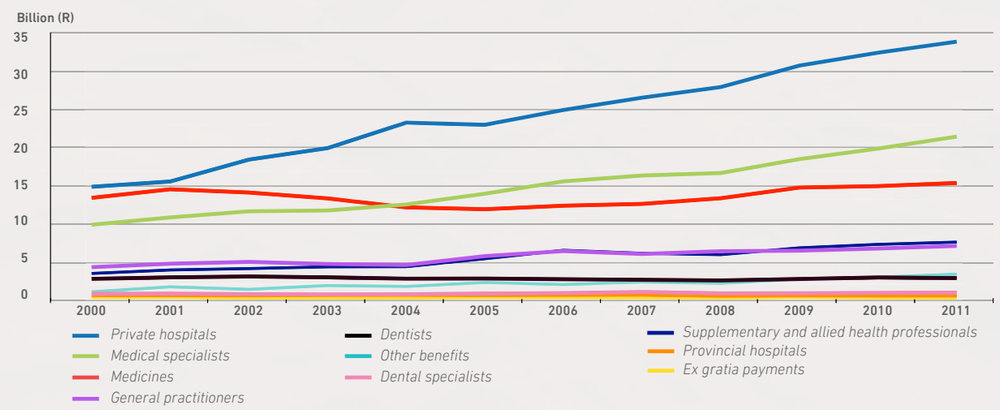
Trends in total healthcare benefits paid

Figure 19 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 2011, medical scheme expenditure on private hospitals had increased in real terms by 129.9% to R33.8 billion compared to R14.7 billion in 2000 (see Figure 19). Private hospital expenditure accounted for 29.9% of all healthcare benefits paid in 2000; the comparative figure in 2001 was 28.4% (see Figure 20). Expenditure on private hospitals appeared to decline between 2004 and 2005, but an upward trend began to emerge in 2006, such that in 2011 private hospital expenditure accounted for 36.3% of all healthcare benefits paid by medical schemes; this was marginally less than the 36.4% noted in 2010.

Benefits paid to medical specialists in 2011 amounted to R21.3 billion, an increase of 121.9% in real terms when compared to the R9.6 billion that was spent on this item in 2000 (see Figure 19). Expenditure on medical specialists has been increasing since 2003, where it accounted for 19.6% of all benefits paid; this increased to 22.8 % in 2011 (see Figure 20).

Figure 19: Total healthcare benefits paid 2000-2011: 2011 prices*



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

Expenditure on medicines increased by 15.2% to R15.2 billion in 2011 from R13.2 billion in 2000 (see Figure 19). As a proportion of total healthcare benefits, it decreased from 27.0% in 2000 to 19.2% in 2004 (see Figure 20). In 2005-2010, medicines expenditure remained consistent at 17.0% relative to all benefits paid (see Figure 20).

Total expenditure on GPs amounted to R6.8 billion in 2011, which is an increase of 78.9% 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 2011.

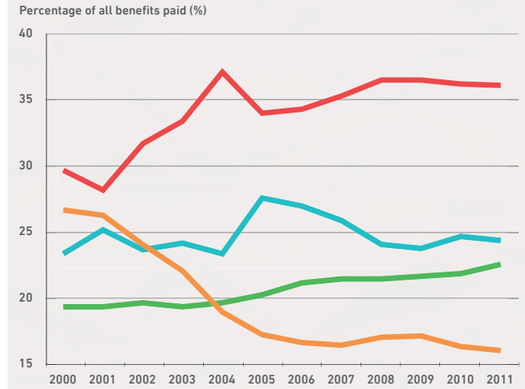
Healthcare benefits paid per beneficiary

Figure 21 shows the changes in healthcare expenditure per beneficiary per month (pbpm) from 2000 to 2011.

When adjusted for inflation and membership, expenditure on private hospitals increased by 82.2% from R181.5 pbpm in 2000 to R330.7 pbpm in 2011. An upward trend could be observed between 2000 and 2004, followed by a slight decline in 2004-2005. From 2005, private hospitals experienced an increasing expenditure trend pbpm until 2011.

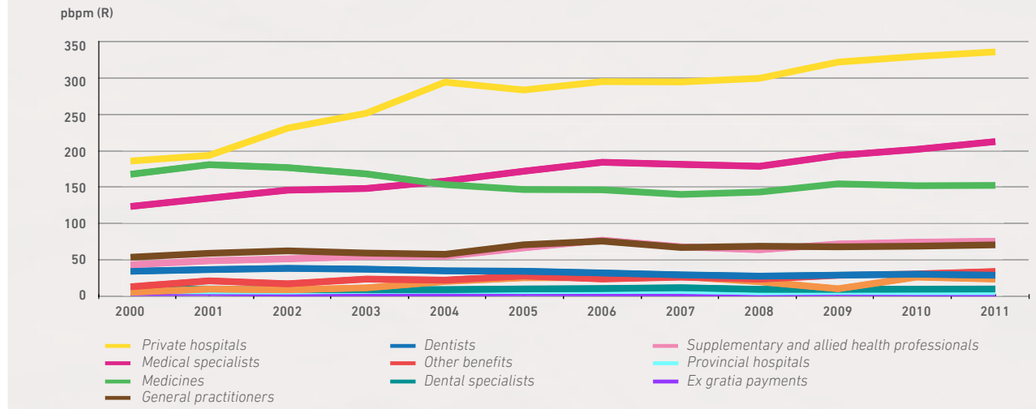
After peaking in 2001, expenditure on medicines continued to decline until 2007. It was R165.4 pbpm in 2000 and declined by 10.4% to R148.2 pbpm in 2011.

Figure 20: Cost determinants as a percentage of all benefits paid 2000-2011



Per-beneficiary expenditure on medical specialists increased by 74.3% over the 12-year period from 2000 to 2011, from R119.4 pbpm to R208.1 pbpm respectively; that on GPs increased by 34.1% from R49.9 pbpm in 2000 to R66.9 pbpm in 2011. Medical schemes spent 19.8% less on dentists; they paid R30.8 pbpm in 2000 and R24.7 pbpm in 2011. Spending on dentists declined by 17.9% from R30.0 pbpm in 2000 to R25.3 pbpm in 2011; that on dental specialists increased by 1.6% from R6.4 pbpm in 2000 to R6.5 pbpm in 2011. Medical scheme expenditure on supplementary and allied health professionals increased by 80.9% – from R39.7 pbpm in 2000 to R71.8 pbpm in 2011.

Figure 21: Total healthcare benefits paid per beneficiary per month 2000-2011: 2011 prices*



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

Utilisation of services

Primary healthcare services

The data presented in this section should be interpreted with caution due to definition- and underreporting-related issues; in some cases respective years' data maybe be incomparable.

The number of beneficiaries who visited GPs and private nurses at least once in 2011 was 768.6 and 12.6 per 1 000 average beneficiaries respectively. The respective figures for the previous year were 774.7 and 13.4 per 1 000 average beneficiaries. The number of beneficiaries visiting a dentist at least once in 2011 decreased to 227.6 from 233.2 per 1 000 average beneficiaries in 2010.

Visits to GPs and dentists

The average number of visits to a GP per average beneficiary per annum (pabpa) was 3.0 in 2011, unchanged compared to 2010. The average number of visits in open schemes was 2.8 per year; the average number of visits in restricted medical schemes was 3.4 pabpa.

The average number of visits to a dentist in 2011 was at 0.4 pabpa, also unchanged from 2010. For open and restricted schemes the numbers were 0.4 and 0.5 visits pabpa respectively.

Private hospital services

Figure 22 illustrates the distribution of beneficiaries admitted in private hospitals by age band. The number of beneficiaries admitted in private hospitals increased by 5.3% from 169.7 in 2010 to 178.81 in 2011 per 1 000 beneficiaries.

Figure 23 depicts the number of beneficiaries admitted in private hospitals stratified by gender; this is to further illustrate the impact of maternity in the reproductive years. The admission rates for female beneficiaries compared to males were higher in the age bands 15-19 until 55-59. Admissions for male beneficiaries were higher in age bands <1 until 10-14. From age band 60-64 the admission rates were higher in male beneficiaries than females.

Table 14: Utilisation of primary healthcare services 2010 and 2011 (per 1 000 beneficiaries)

	Open schemes	Restricted schemes	Consolidated	Consolidated
Number of beneficiaries visiting a private provider at least once in 2011			2011	2010*
General practitioner	746.7	780.3	760.8	739.9
Dentist	216.9	247.9	229.9	225.7
Private nurse	8.3	10.1	9.0	8.8

** The 2010 figures have been restated.*

Table 15: Utilisation of healthcare services 2010 and 2011 (per average beneficiary per annum)

	Open schemes	Restricted schemes	Consolidated	Consolidated
	2011			2010*
Visits to a GP	2.8	3.4	3.0	3.0
Visits to a dentist	0.4	0.5	0.4	0.4
Visits to a private nurse**	-	-	-	-

** The 2010 figures have been restated.*
*** The numbers were too insignificant to be reflected.*

Length of stay in private hospitals

In 2011, medical scheme beneficiaries spent an average of 3.2 days in private hospitals; the comparative figure for 2010 was 3.0 days (where the figures for 2010 have been restated).

Figure 24 illustrates an average length of stay of nearly five days and an average length of stay of nearly six days in hospitals.

Figure 22: Beneficaries admitted in private hospitals 2011

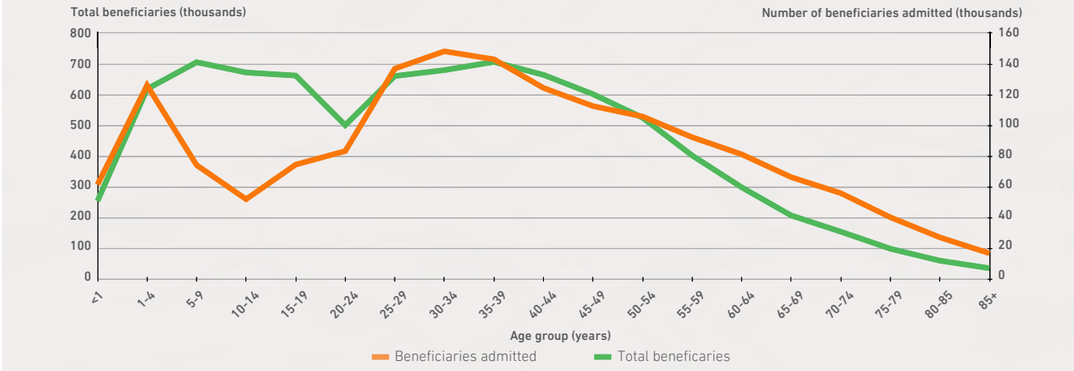


Figure 23: Beneficiaries admitted in private hospitals by age and gender 2011

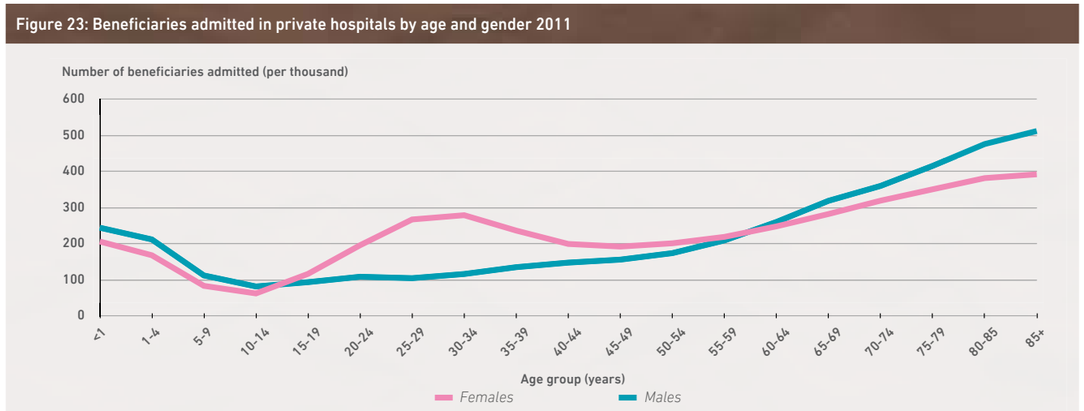
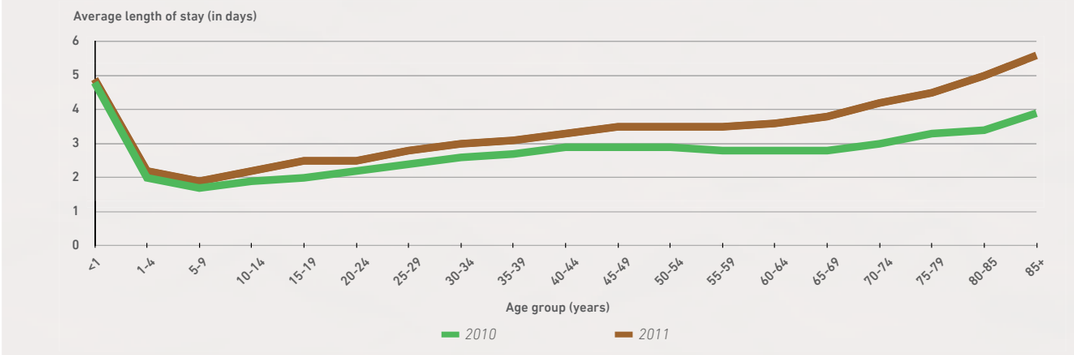


Figure 24: Average length of stay in private hospitals by age groups 2010 and 2011



Public hospital facilities

Table 16 depicts the utilisation of public hospitals per 1 000 average beneficiaries.

The number of beneficiaries admitted was higher in restricted schemes compared to open schemes, at 18.8 compared to 2.8 per 1 000 average beneficiaries. The number of beneficiaries admitted for prescribed minimum benefits (PMBs) declined slightly from 5.2 in 2010 to 5.0 per 1 000 average beneficiaries in 2011.

Length of stay in public hospitals

In 2011, medical scheme beneficiaries stayed an average of 1.5 days in public hospitals; this was slightly lower than the 1.6 days observed in 2010. As with private hospitals, the average length of stay in public hospitals for restricted scheme beneficiaries was higher than that for open schemes, at 1.6 days and 1.3 days respectively.

Burden of disease

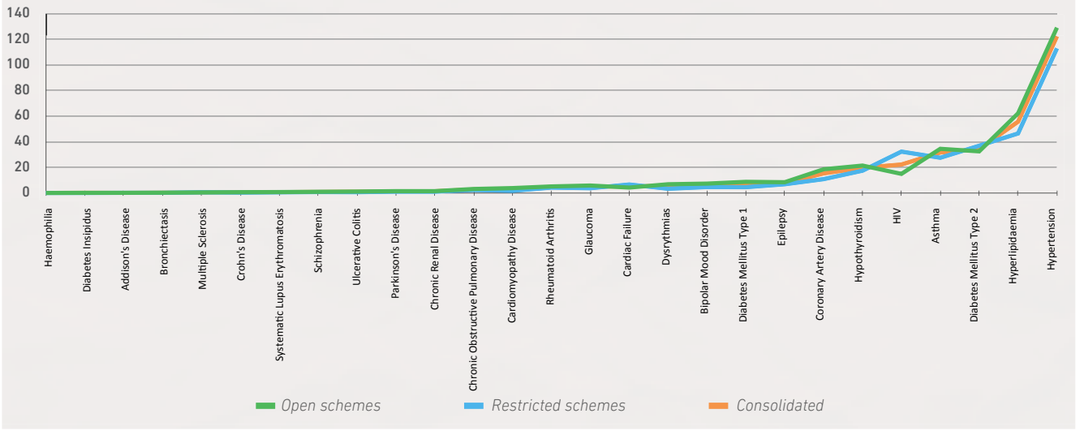
Figure 25 shows the prevalence of the PMB chronic conditions which medical schemes are required by law to cover in full on all their benefit options. The data is for 2010 and 2011. Schemes who did not submit data on chronic conditions were excluded from the analysis.

Table 16: Utilisation of public hospitals 2010 and 2011 (per 1 000 average beneficiaries per annum)

	Open schemes	Restricted schemes	Consolidated 2011	Consolidated 2010*
Beneficiaries admitted to hospital*	2.8	18.8	9.7	9.9
Admissions**	4.3	4.5	4.4	6.2
Same-day admissions	0.8	35.7	16.0	13.0
Total admissions	5.1	40.2	20.4	19.2
Beneficiaries admitted to hospital for PMBs	2.3	8.6	5.0	5.2

PMBs = prescribed minimum benefits
** Number of beneficiaries admitted per 1 000 average beneficiaries – unique admissions*
*** Number of admissions per 1 000 average beneficiaries – all admissions*

Figure 25: Chronic conditions in schemes 2010 and 2011 (per 1 000 average beneficiaries)



Despite all the difficulties with the data quality from medical schemes, Council took every care to ensure that the data is complete and accurate. The number of schemes considered for this section represents 91.8% of schemes that submitted data; these covered 96.3% of beneficiaries.

The analysis for 2011 showed that the most prevalent PMB chronic condition in medical schemes was hypertension at 122.4 cases per 1 000 average beneficiaries per annum (115.0 in 2010), followed by hyperlipidaemia at 55.7 (52.1 in 2010), diabetes mellitus type 2 at 34.3 (31.8 in 2010), and asthma at 31.6 (28.8 per 1 000 average beneficiaries in 2010).

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.

The prevalence of cardiac failure, HIV, diabetes mellitus type 2, and multiple sclerosis was higher in restricted schemes. Data in this section, and in particular HIV prevalence, should be interpreted with caution due to definition- and underreporting-related issues.

Contributions, relevant healthcare expenditure[1], and trends

Scheme contributions increased by 11.3% to R107.4 billion as at December 2011 from R96.5 billion in December 2010. Total gross relevant healthcare expenditure incurred by medical schemes increased by 10.3% to R93.6 billion[2] from R84.9 billion[2] in 2010.

Gross contributions per average beneficiary per month (pabpm) grew by 9.1% to R1 063.9 from R975.3 in 2010. Total gross relevant healthcare expenditure incurred pabpm increased by 8.1% to R927.7 from R858.4 in 2010.

Risk contributions and relevant healthcare expenditure

Risk contributions (net of medical savings accounts contributions) increased by 11.2% to R97.6 billion from R87.7 billion in 2010; the increase from 2009 to 2010 was 13.7%. The increase in risk contributions pabpm was 9.0% to R966.6 from R886.9 (2010: 9.6%).

Risk claims increased by 10.1% to R84.4 billion from R76.6 billion in 2010 (2010: 11.2%). Risk claims pabpm rose by 8.0% to R836.3 from R774.6 (2010: 7.3%).

Medical savings accounts contributions and relevant healthcare expenditure

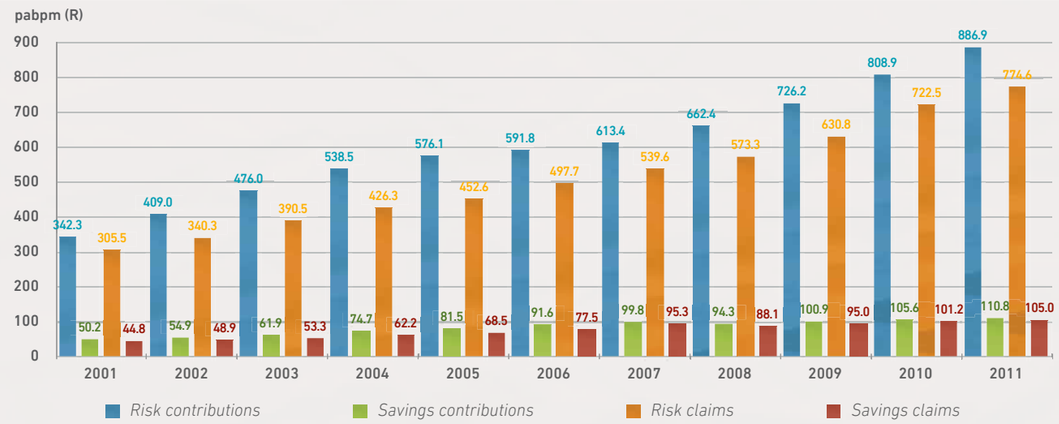
Contributions to medical savings accounts increased by 12.3% to R9.8 billion from R8.7 billion (2010: 13.2% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 4.8% – from R110.8 to R116.2 (2010: 5.0% increase).

Claims paid from medical savings accounts increased by 11.0% to R9.2 billion from R8.3 billion (2010: 12.0% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 4.0% to R109.1 from R105.0 (2010: 3.8% increase).

Figure 26 shows that up to 2006, medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components. This indicates a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

1 All references to claims and benefits indicate relevant healthcare expenditure.
2 These numbers differ from the R93.2 billion and R84.7 billion reported under the heading "Total healthcare benefits paid" on page 117 because here we have included IBNR and the results of risk transfer arrangements.

Figure 26: Risk and medical savings accounts contributions and claims pabpm 2001-2011



pabpm = per average beneficiary per month

Table 17: Contributions and relevant healthcare expenditure pabpm 2000-2011

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	333.6	-	46.1	-	292.4	-	41.3	-
2001	406.4	21.8	52.6	13.9	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	14.0	379.3	14.4	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.7	77.5	13.6
2006	611.6	3.5	98.9	9.1	522.9	8.0	95.9	23.6
2007	672.7	10.0	96.6	(2.3)	562.1	7.5	91.6	(4.4)
2008	745.1	10.8	110.5	14.3	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
2011	985.0	8.8	147.4	7.5	831.8	8.4	139.8	6.8
Restricted schemes								
2000	360.8	-	66.7	-	333.1	-	58.8	-
2001	415.0	15.0	64.0	(4.0)	360.9	8.3	57.9	(1.5)
2002	489.0	17.8	69.8	9.0	417.9	15.8	60.3	4.2
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.5
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.6
2005	594.5	2.3	95.5	10.1	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.3
2007	641.8	3.9	86.3	(16.8)	595.7	2.3	75.7	(18.4)
2008	693.8	8.1	75.7	(12.3)	638.0	7.1	66.2	(12.5)
2009	774.4	11.6	66.7	(11.9)	727.3	14.0	61.7	(6.9)
2010	860.3	11.1	62.6	(6.1)	785.1	8.0	57.5	(6.7)
2011	942.8	9.6	61.6	(1.7)	842.1	7.2	55.6	(3.4)

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

But the lower figures in 2007-2011 appear to reflect a change in this trend. The decrease is also partly attributable to Council's decision not to allow variable savings rates on an option, which resulted in a number of schemes no longer offering any savings plan accounts.

Contributions and relevant healthcare expenditure by type of scheme

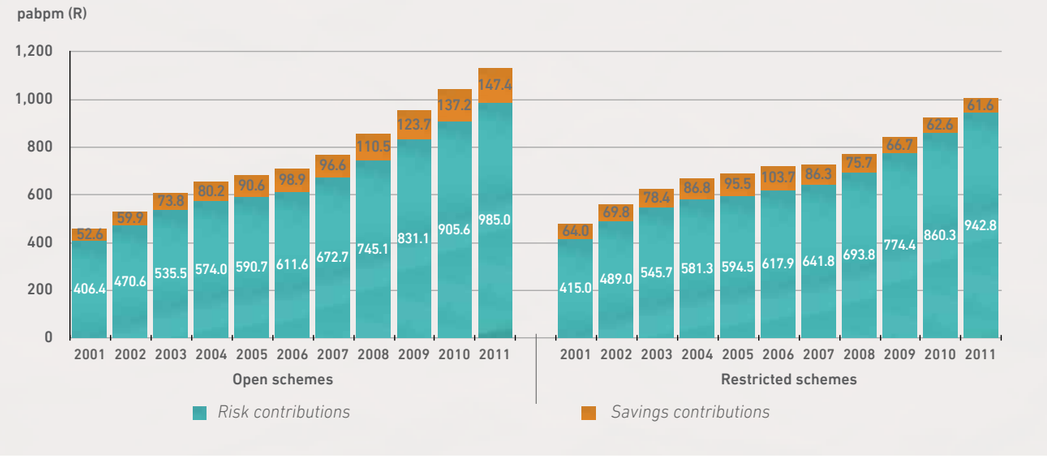
Table 17 and Figures 27 and 28 show contributions and claims for open and restricted schemes pabpm.

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 84.4% in 2011 from 84.7% in 2010; in restricted schemes it decreased to 89.3% from 91.3% in 2010.

Figure 27: Risk and savings contributions pabpm 2001-2011



pabpm = per average beneficiary per month

Figure 28: Risk and savings claims pabpm 2001-2011

pabpm = per average beneficiary per month

Table 18 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 few years, it appears that the rate of decrease is slowing down.

The proportion of claims paid from medical savings accounts decreased to 11.5% during the review period from 11.9% in 2010, as shown in Figure 29.

For open schemes, the proportion of claims paid from medical savings accounts decreased from 14.6% in 2010 to 14.4% in 2011; the medical savings accounts claims ratio decreased to 94.8% from 95.4% in 2010.

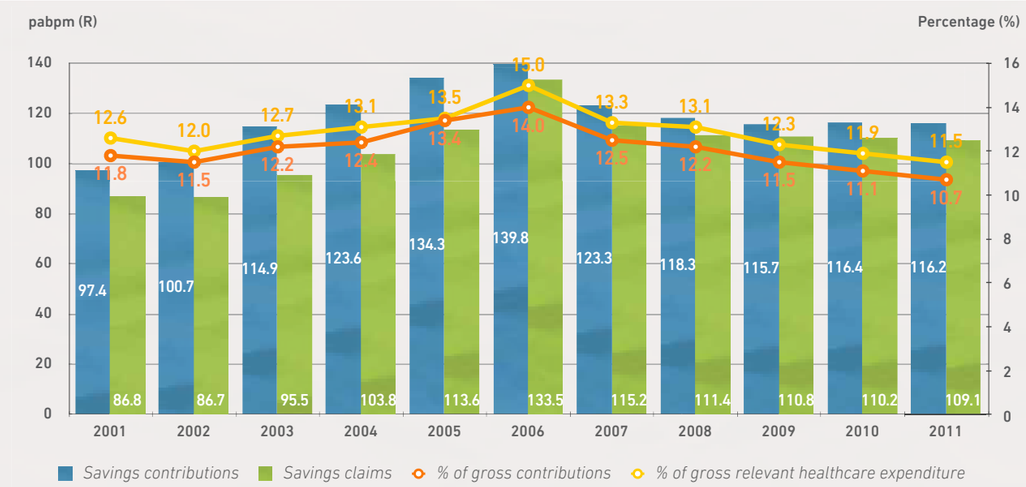
For restricted schemes, the proportion of claims paid from medical savings accounts decreased from 6.8% in 2010 to 6.2% in 2011. The medical savings accounts claims ratio decreased to 90.3% from 91.9% in 2010.

Table 18: Contributions and relevant healthcare expenditure pabpm 2000-2011: 2011 prices

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
All schemes								
2000	642.5	-	94.2	-	573.4	-	84.0	-
2001	725.7	13.0	97.4	3.4	603.9	5.3	86.8	3.3
2002	774.3	6.7	100.7	3.4	635.4	5.2	86.7	(0.1)
2003	827.9	6.9	114.9	14.2	655.3	3.1	95.5	10.2
2004	873.1	5.5	123.6	7.5	685.9	4.7	103.8	8.7
2005	867.7	(0.6)	134.3	8.7	729.7	6.4	113.6	9.4
2006	859.6	(0.9)	139.8	4.1	756.2	3.6	133.5	17.6
2007	866.2	0.8	123.3	(11.8)	749.6	(0.9)	115.2	(13.8)
2008	851.8	(1.7)	118.3	(4.1)	740.0	(1.3)	111.4	(3.3)
2009	885.9	4.0	115.7	(2.3)	791.3	6.9	110.8	(0.6)
2010	931.3	5.1	116.4	0.6	813.5	2.8	110.2	(0.5)
2011	966.6	3.8	116.2	(0.2)	836.3	2.8	109.1	(1.0)

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

Figure 29: Medical savings accounts contributions and claims pabpm 2001-2011: 2011 prices



pabpm = per average beneficiary per month

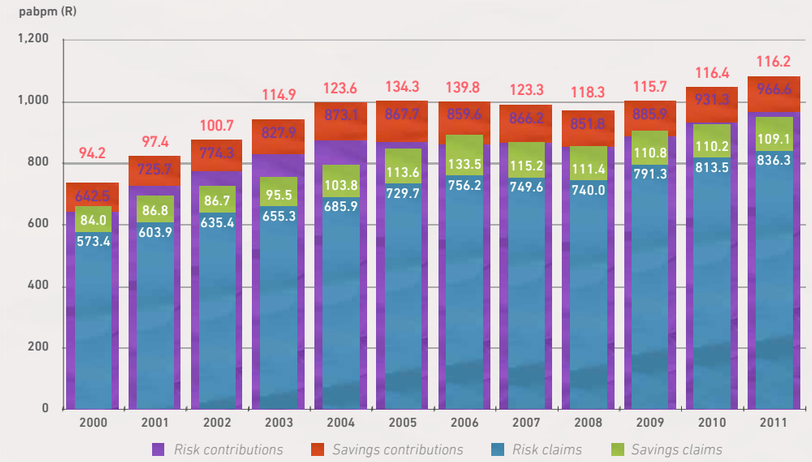
Contributions and relevant healthcare expenditure since 2000

Figure 30 tracks the use of medical savings accounts in the benefit designs of schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 50.4% and 45.8% respectively; medical savings accounts contributions and claims have risen by 23.4% and 29.9% respectively.

Figure 31 shows the relationship between risk contributions and claims paid over the past decade, after adjusting for inflation.

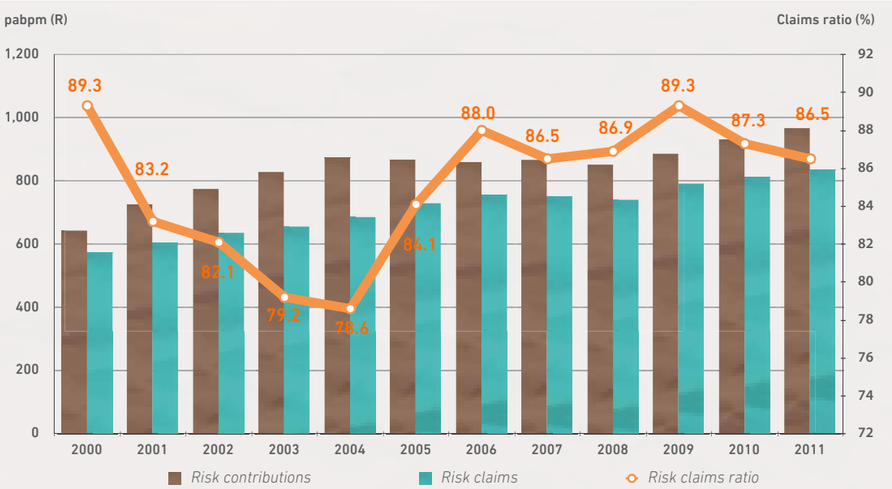
After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised to 86.5% in 2007 and 86.9% in 2008. It then increased further to 89.3% in 2009, before declining to 87.3% in 2010 and further down to 86.5% in 2011. This means that medical schemes paid out 86.5% of risk contributions in benefits in 2011.

Figure 30: Risk and medical savings accounts contributions and claims pabpm 2000-201: 2011 prices



pabpm = per average beneficiary per month

Figure 31: Risk claims ratio for all schemes 2000-2011: 2011 prices



pabpm = per average beneficiary per month

Figure 32 shows the seasonality of claims per month in 2011. Both open and restricted schemes follow the same general trend: an increase in the first quarter of the year as members gain access to new benefits for the year, increases in claims over the winter months, and a general downward trend in the last quarter of the year when benefits are depleted.

Risk transfer arrangements

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

Table 19 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 20 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 21 details the 10 biggest loss-making benefit options.

Bonitas Medical Fund is listed in both Tables 20 and 21 as the biggest loss-maker.

The Extender State & Any Hospital benefit option on Momentum Health suffered the biggest loss in terms of the percentage of capitation fees paid (96.4%), followed by its Incentive State & Associated Hospital benefit option (93.5%) and its Incentive State & Any Hospital benefit option (92.8%), as shown in Table 21.

Figure 32: Claims seasonality per month 2011

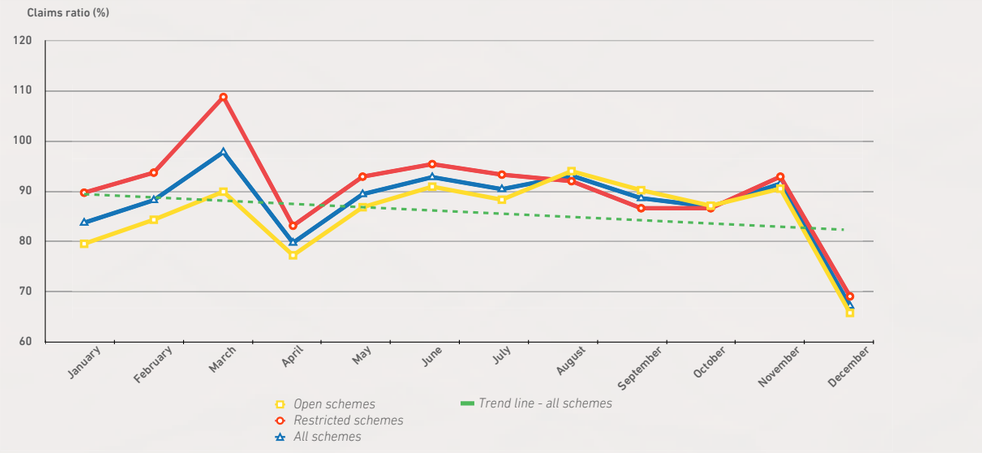


Table 19: Significant risk transfer arrangements 2010 and 2011

	Capitation fees			Estimated recoveries			Net income/(expense)		
	2011 R'000	2010 R'000	% growth	2011 R'000	2010 R'000	% growth	2011 R'000	2010 R'000	% growth
Open schemes	2 125 839	2 133 933	(0.4)	2 061 305	2 108 397	(2.2)	(55 683)	(20 336)	173.8
Restricted schemes	985 817	925 005	6.6	1 049 316	988 988	6.1	64 900	64 949	(0.1)
All schemes	**3 111 656**	**3 058 938**	**1.7**	**3 110 621**	**3 097 385**	**0.4**	**9 217**	**44 613**	**79.3**

Table 20: Schemes with highest risk transfer arrangement losses 2011

Ref. no.	Name of medical scheme	Beneficiaries	Capitation fees	Estimated recoveries	Net income/ (expense)	Net income/(expense) as % of capitation fees
		As at 31.12.2011	R'000	R'000	R'000	%
1512	Bonitas Medical Fund	609 211	917 225	772 605	(139 915)	(15.3)
1537	Hosmed Medical Aid Scheme	85 073	133 908	94 104	(39 805)	(29.7)
1149	Medihelp	242 203	294 132	274 311	(19 822)	(6.7)
1167	Momentum Health	186 959	201 971	188 688	(13 283)	(6.6)
1580	South African Police Service Medical Scheme (POLMED)	483 379	138 227	128 804	(9 423)	(6.8)
1598	Government Employees Medical Scheme (GEMS)	1 663 075	39 343	31 957	(7 386)	(18.8)
1575	Resolution Health Medical Scheme	70 396	17 871	12 382	(5 488)	(30.7)
1087	Keyhealth	86 351	64 430	55 217	(5 066)	(7.9)
1597	Umvuzo Health Medical Scheme	44 145	81 220	77 128	(4 092)	(5.0)
1582	Transmed Medical Fund	136 588	42 628	39 092	(3 536)	(8.3)

Table 21: Options with highest risk transfer arrangement losses 2011

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 31.12.2011	Years	R'000	R'000	R'000	R'000	%
1167	Momentum Health	Extender State & Any Hospital	5 754	30.0	8 051	290	-	(7 761)	(96.4)
1167	Momentum Health	Incentive State & Associated Hospital	19 100	30.4	15 624	1 023	-	(14 601)	(93.5)
1167	Momentum Health	Incentive State & Any Hospital	20 503	31.0	16 937	1 211	-	(15 726)	(92.8)
1167	Momentum Health	Custom State & Associated Hospital	31 380	28.3	12 280	1 723	-	(10 557)	(86.0)
1149	Medihelp	Unify	11 405	24.9	54 848	28 841	-	(26 008)	(47.4)
1537	Hosmed Medical Aid Scheme	Step	13 280	33.2	102 039	57 314	-	(44 725)	(43.8)
1512	Bonitas Medical Fund	Primary	124 882	27.2	79 265	57 257	1 145	(20 862)	(26.3)
1512	Bonitas Medical Fund	Standard	360 707	32.7	492 873	406 323	3 560	(82 990)	(16.8)
1512	Bonitas Medical Fund	Boncap	55 119	34.9	290 146	261 578	-	(28 568)	(9.8)
1580	South African Police Service Medical Scheme (POLMED)	Higher Plan	318 041	28.2	122 522	113 077	-	(9 445)	(7.7)

pb = per beneficiary

Non-healthcare expenditure

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

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

Administration expenditure

Administration expenditure in all medical schemes had grown by 4.7% to R8.2 billion by the end of December 2011 from R7.8 billion in 2010. Open schemes increased their administration expenditure by 3.0% to R5.8 billion from R5.6 billion in 2010. The 9.1% increase from R2.2 billion in 2010 to R2.4 billion in 2011 in restricted schemes reflects the significant increase in their membership numbers during the year under review. GEMS alone experienced a 17.6% increase in the number of their average beneficiaries.

Nine open schemes (representing 3.0% of all average beneficiaries) and 10 restricted schemes (representing 1.5% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of Gross Contribution Income (GCI) in 2011.

Table 22 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 23 shows high-impact open schemes with administration expenditure above the open schemes industry average of R101.4 pabpm. (When excluding self-administered schemes, this average increases to R103.6 pabpm.) Relative to the open schemes industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

Table 24 shows the gross administration fees paid to third-party administrators as well as administration expenditure incurred in respect of self-administered medical schemes. These fees are the sum of administration fees, co-administration fees, and other indirect expenses.

Table 22: High-impact open schemes with administration expenditure above 10.0% of GCI (2011)

Name of medical scheme	Average beneficiaries	Administration expenditure as % of GCI
Resolution Health Medical Scheme	67 299	14.5
Selfmed Medical Scheme	17 443	11.3
Spectramed	73 834	10.2

GCI = Gross Contribution Income

Table 23: High-impact open schemes with administration expenditure above open schemes industry average of R101.4 pabpm (2011)

Name of medical scheme	Average beneficiaries	Administration expenditure pabpm (R)
Selfmed Medical Scheme	17 443	145.6
Bestmed Medical Scheme	147 863	127.2
Spectramed	73 834	124.3
Fedhealth Medical Scheme	153 488	118.5
Resolution Health Medical Scheme	67 299	113.8
Keyhealth	88 212	109.1
Medihelp	244 750	108.0
Discovery Health Medical Scheme	2 302 343	106.1
Liberty Medical Scheme	142 948	103.7

pabpm = per average beneficiary per month

3 Refer to the write-up on the Risk Assessment Framework (RAF) on page 146.

On average, third party-administered open schemes spent 111.0% more on gross administration fees than third party-administered restricted schemes (2010: 99.7%).

Administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE); they grew by 4.3% to R6.2 billion in 2011 from R5.9 billion in the previous year. These fees represented 83.0% of GAE in 2011 (2010: 83.2%).

Expenditure on management of benefits: managed healthcare fees

Managed healthcare management fees increased by 8.3% to R2.4 billion in 2011 from R2.3 billion in 2010. In 2011, the number of members covered by these managed healthcare interventions increased by 2.5% to 8 421 284 beneficiaries (or 98.8% of all beneficiaries).

Table 25 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare management fees. There were 52 options in this category, and they accounted for 6.2% of beneficiaries in respect of whom such expenditure was incurred.

Table 24: Gross administration fees paid to third-party administrators pabpm 2010 and 2011

	Open schemes			Restricted schemes		
	pabpm	pabpm		pabpm	pabpm	
	2011 R	2010 R	% change	2011 R	2010 R	% change
Third-party administrators						
Direct administration fees	88.7	83.7	6.0	42.2	42.1	0.2
Co-administration fees	10.3	6.8	51.3	4.8	-	-
Indirect expenses paid	-	1.8	(100.0)	0.3	0.3	3.3
Total: third-party administrators	**89.1**	**84.1**	**5.9**	**42.2**	**42.1**	**0.2**
Self-administered medical schemes						
Direct administration fees	-	22.8	(100.0)	-	33.5	(100.0)
Co-administration fees	-	-	-	-	-	-
Indirect expenses paid	-	-	-	-	-	-
Total: self-administered schemes	**-**	**22.8**	**(100.0)**	**-**	**-**	**-**

pabpm = per average beneficiary per month

Table 25: Managed healthcare: management fees in respect of options with a claims ratio above 100.0% (2011)

	Managed care management services		Gross healthcare result*		Beneficiaries	Number of options
	R'000	pbpm	R'000	pbpm		
Open schemes	48 441	21.7	(417 316)	(186.5)	186 442	24
Restricted schemes	80 737	20.2	(526 459)	(131.5)	333 529	28
All schemes	**129 178**	**20.7**	**(943 775)**	**(151.3)**	**519 971**	**52**

pbpm = per beneficiary per month
** Gross healthcare result = contributions less claims*

Fees of trustees and Principal Officers

Remuneration and other considerations of trustees and Principal Officers rated 0.7% and 0.9% of GAE respectively. In 2011, the fees of Principal Officers came to 0.7% of GAE in open schemes (2010: 0.6%); they came to 1.5% in restricted schemes (2010: 1.5%).

Table 26 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 2011 at 67.6% (2010: 67.6%). Managed healthcare management fees made up 20.1% of non-healthcare expenditure (2010: 19.5%).

Administration expenditure and managed healthcare management fees effectively accounted for 9.9% of GCI in 2011 (2010: 10.4%).

Table 27 shows administration and managed healthcare expenditure by type of scheme administration.

Table 26: Top 10 trustee fees (2011)

Name of medical scheme	Trustee remuneration and other considerations		
	R'000	Number of trustees	Average fee per trustee R'000
Liberty Medical Scheme	6 330	9	703
Medshield Medical Scheme	4 646	11	422
Fedhealth Medical Scheme	3 566	12	297
Government Employees Medical Scheme (GEMS)	3 516	15	234
Bestmed Medical Scheme	3 465	20	173
Discovery Health Medical Scheme	2 312	9	257
Spectramed	2 278	6	380
Sizwe Medical Fund	2 144	13	165
LA Health Medical Scheme	2 103	15	140
South African Police Service Medical Scheme (POLMED)	1 861	16	116

Table 27: Gross Administration Expenditure (GAE) and managed healthcare expenditure 2000-2011

	Open schemes				Restricted schemes			
	Self-administered		Third party-administered		Self-administered		Third party-administered	
	pabpm R	% change	pabpm R	% change	pabpm R	% change	pabpm R	% change
2000	37.5	-	48.7	-	24.7	-	38.3	-
2001	62.8	67.5	62.7	28.9	31.3	26.6	41.5	8.4
2002	55.8	(11.2)	69.8	11.3	37.3	19.4	49.3	18.8
2003	69.2	24.0	78.4	12.3	33.0	(11.7)	55.8	13.2
2004	75.9	9.8	86.1	9.8	43.3	31.4	59.1	6.1
2005	80.8	6.4	91.9	6.8	41.8	(3.5)	67.8	14.7
2006	84.1	4.1	96.9	5.4	39.0	(6.7)	67.2	(0.9)
2007	89.8	6.8	101.8	5.0	41.3	6.0	65.8	(2.0)
2008	96.5	7.5	108.5	6.6	41.8	1.3	65.5	(0.5)
2009	109.8	13.8	118.6	9.3	45.1	7.8	71.9	9.7
2010	106.2	(3.3)	124.4	4.9	54.6	21.0	74.2	3.3
2011	107.1	0.8	132.5	6.5	56.3	3.1	75.6	1.9

pabpm = per average beneficiary per month

During 2011, there were six self-administered open schemes (2010: 6), representing 595 578 average beneficiaries (2010: 555 064), and 20 third party-administered open schemes (2010: 24), representing 4 153 454 average beneficiaries (2010: 4 282 646).

Self-administered open schemes experienced a slight increase of 0.8% from R106.2 pabpm to R107.1 pabpm while third party-administered open schemes increased their expenditure by 6.5% to R132.5 pabpm from R124.5 pabpm in 2010. Third party-administered open schemes paid 23.7% more for administration and managed healthcare services than self-administered open schemes; the proportion was 17.1% in 2010.

During 2011, there were eight self-administered restricted schemes (2010: 9), representing 258 458 beneficiaries (2010: 248 948), and 63 third party-administered restricted schemes (2010: 66), representing 3 403 220 beneficiaries (2010: 3 156 869). Third party-administered restricted schemes spent on average 34.3% more on administration and managed healthcare management fees at R75.6 pabpm compared to the R74.2 pabpm of self-administered restricted schemes.

Table 27 also shows that self-administered open schemes paid 90.2% (2010: 94.5%) more pabpm for administration and managed healthcare expenditure than self-administered restricted schemes. Third party-administered open schemes paid 75.3% (2010: 67.7%) more pabpm for administration and managed healthcare expenditure than third party-administered restricted schemes.

Table 28 takes the 10 largest schemes by number of average beneficiaries, and shows their total expenditure on administration and managed healthcare management fees. The industry averages were 7.6% for gross administration and 9.8% for gross administration expenditure plus managed healthcare as a percentage of Gross Contribution Income (GCI).

Table 28: Gross Administration Expenditure (GAE) and managed care management services fees incurred by 10 largest schemes (2011)

Name of medical scheme	Type of medical scheme	Average beneficiaries	GAE as % of GCI	GAE + managed healthcare expenditure as % of GCI
Discovery Health Medical Scheme	Open	2 302 343	9.4	12.2
Government Employees Medical Scheme (GEMS)	Restricted	1 570 922	4.3	6.1
Bonitas Medical Fund	Open	603 422	8.6	11.4
South African Police Service Medical Scheme (POLMED)	Restricted	482 197	4.2	6.3
Medihelp	Open	244 750	7.7	9.4
Medshield Medical Scheme	Open	236 789	5.8	7.7
Bankmed	Restricted	201 380	6.9	9.1
Momentum Health	Open	183 379	8.6	11.1
Sizwe Medical Fund	Open	156 350	9.3	11.4
Fedhealth Medical Scheme	Open	153 488	9.1	11.3

GCI = Gross Contribution Income

Table 29 indicates the top 10 schemes with the highest marketing, advertising, and broker costs, all of which are open medical schemes. The Table shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 0.5% from 2010 to 2011. The member growth shown in the Table is not necessarily that of new members whose lives were not previously covered but also includes members who moved from other schemes.

Broker costs

Broker costs include all commissions, service fees, and other distribution costs.

Broker costs increased with 5.0% from R1.3 billion in 2010 to R1.4 billion in 2011.

Broker costs represented 11.5% of total non-healthcare expenditure in 2011; broker costs as a percentage of total non-healthcare expenditure was 11.4% in 2010.

For schemes that pay broker commissions, the amounts paid on a per average member per month (pampm) basis increased to R46.8 pampm in 2011 from R44.4 pampm in 2010, representing an increase of 5.4%. Broker commissions as a percentage of GCI remained stable at 2.0%.

Figure 33 shows annual broker service fees since 2000, as well as their percentage shares of total non-healthcare expenditure.

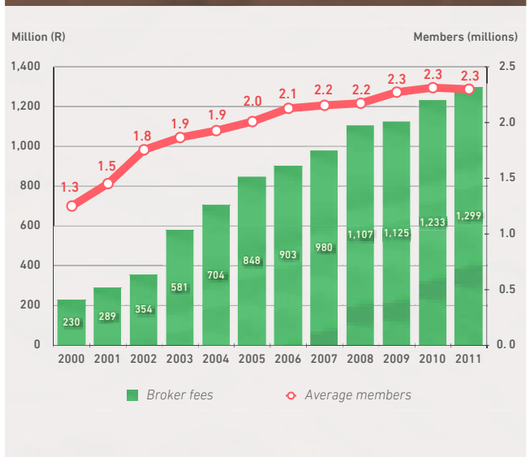
Table 29: Top 10 schemes with highest marketing, advertising, and broker costs (2011)

Name of medical scheme	Marketing, advertising, and broker costs	New member growth
	pabpm	%
Pharos Medical Plan	125.5	15.5
Liberty Medical Scheme	95.2	6.8
Bestmed Medical Scheme	93.1	21.7
Keyhealth	85.1	3.6
Fedhealth Medical Scheme	84.2	13.3
Resolution Health Medical Scheme	81.8	49.4
Topmed Medical Scheme*	79.3	34.3
Medshield Medical Scheme	79.1	3.5
Bonitas Medical Fund	77.6	18.0
Community Medical Aid Scheme (COMMED)	70.7	3.9

pabpm = per average beneficiary per month
** Schemes which had mergers in 2011*

Figure 33: Broker service fees (open schemes) 2000-2011

Figure 34: Broker fees and scheme membership 2000-2011



pampm = per average member per month

Figure 34 illustrates the increase in broker fees relative to membership of schemes that 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 that paid brokers, broker service fees pampm increased by 206.3% since 2000 compared with an 84.5% net increase in the average number of members. The substantial increases in broker service fees are not proportional to the increase in new members.

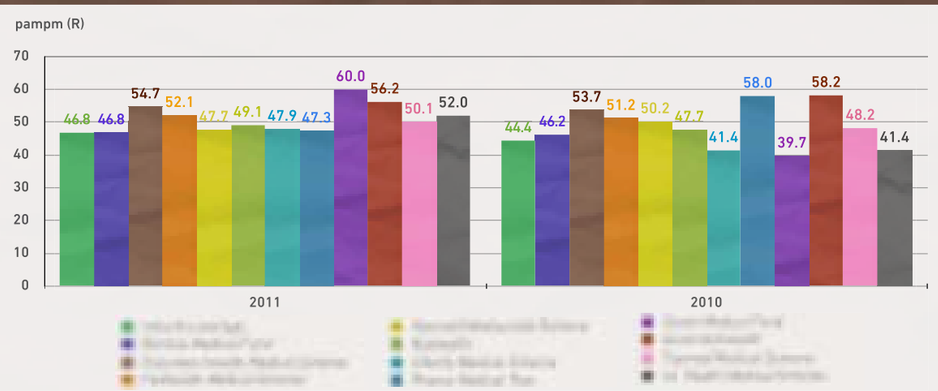
Table 30 illustrates the schemes which had broker service fees at levels higher than the industry average of R46.8 pampm (2010: R44.4 pampm). These 11 schemes (2010: 14) represented 71.3% (2010: 66.3%) of total membership that paid for broker service fees, and 80.5% (2010: 77.4%) of total broker service fees paid. Two 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 30: Schemes with broker fees above industry average of R46.8 pampm 2010 and 2011

Name of medical scheme	Type of medical scheme	Broker fees			Distribution fees		
		2011 pampm (R)	2010 pampm (R)	% change	2011 pampm (R)	2010 pampm (R)	% change
Bonitas Medical Fund	Open	46.8	46.2	1.3	-	-	0.0
Discovery Health Medical Scheme	Open	54.7	53.7	2.0	-	-	0.0
Fedhealth Medical Scheme	Open	52.1	51.2	1.8	-	10.6	-100.0
Hosmed Medical Aid Scheme	Open	47.7	50.2	-4.9	-	-	0.0
Keyhealth	Open	49.1	47.7	2.9	-	-	0.0
Liberty Medical Scheme	Open	47.9	41.4	15.7	-	-	0.0
Pharos Medical Plan	Open	47.3	58.0	-18.5	10.3	-	100.0
Sizwe Medical Fund	Open	60.0	39.7	51.2	-	-	0.0
Suremed Health	Open	56.2	58.2	-3.4	8.9	6.8	30.1
Topmed Medical Scheme	Open	50.1	48.2	3.8	8.8	-	100.0
LA Health Medical Scheme	Restricted	52.0	41.4	25.6	-	-	0.0

pampm = per average member per month

Figure 35: Schemes with broker fees above industry average of R46.8 pampm 2010 and 2011



pampm = per average member per month

Reinsurance results

Only one medical scheme had a reinsurance contract in 2011 (2010: 2). It made a net healthcare deficit of R20.4 million; its net reinsurance result was a deficit of R707 000.

Impairment losses

Impairment losses on receivables (previously known as "bad debts") decreased by 37.8% to R104.7 million for the year under review from R168.2 million in 2010. They represented 0.9% of total non-healthcare expenditure (1.5% in 2010).

It took schemes an average of 12.5 days to collect debts (contributions from their members) in 2011; this is an increase of 7.9% from 11.6 days in 2010. This collection period still falls well outside the legal provisions which require that members pay all contributions to their 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 36 shows the trend in impairment losses on receivables over the past 12 years, also expressed as a percentage of total non-healthcare expenditure.

Trends in non-healthcare expenditure

Total net non-healthcare expenditure rose by 4.8% from R11.6 billion in 2010 to R12.1 billion in 2011.

Before 2006, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index, or CPI. The rate of increase was reversed in 2006 and since then there has been a real decrease in non-healthcare expenditure, from R1 745 in 2005 to R1 441 per average beneficiary per year in 2011.

Figure 36: Impairment losses on receivables 2000-2011

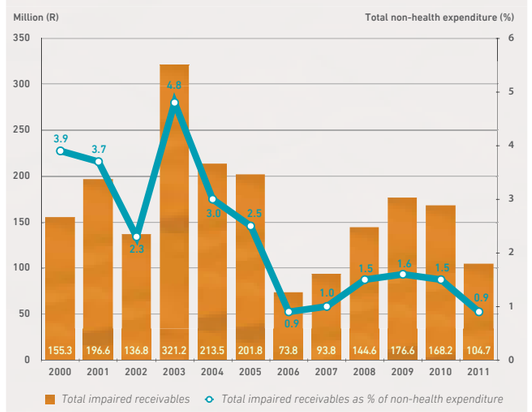


Figure 37 shows the changes in the major categories of non-healthcare expenditure for the past 12 years.

Total gross non-healthcare expenditure has increased by 193.9% since 2000. (Gross non-administration costs equate to net administration costs as no administration costs were paid in relation to savings accounts from 2007 onwards.) This was driven by a 209.4% upswing in administration expenditure, a 175.4% rise in fees paid for managed healthcare services, and an increase of 504.5% in broker costs.

By comparison, gross claims have risen by 242.9% (not adjusted for inflation) since 2000.

Figure 38 and Table 31 show that, after adjusting for inflation, gross non-healthcare expenditure per average beneficiary per annum (pabpa) decreased by 2.2% to R1 441.5 in 2011 from R1 473.2 in 2010. The net claims ratio decreased to 86.5% in 2011 from 87.3% in 2010.

Figure 37: Changes in non-healthcare expenditure 2000-2011

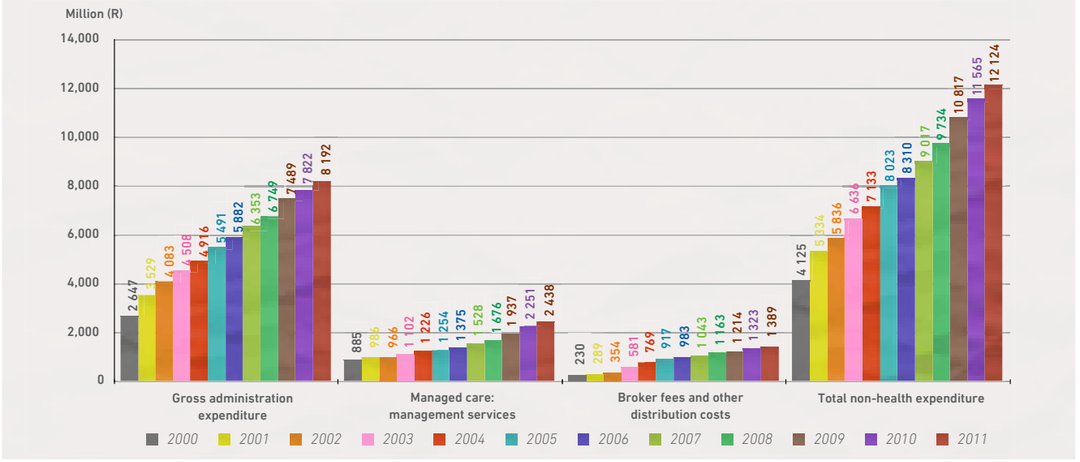


Figure 38: Non-healthcare expenditure pabpa 1998-2011: 2011 prices*

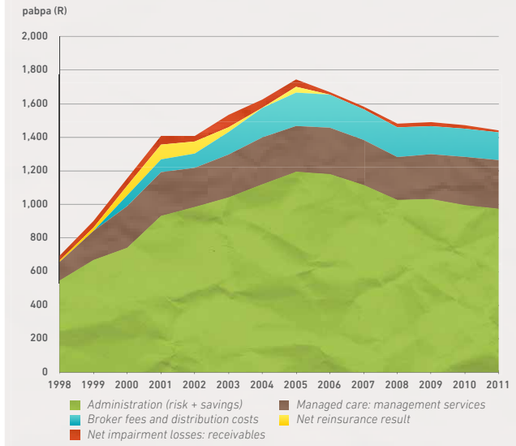


Figure 39: Claims and non-healthcare expenditure pabpa 1998-2011: 2011 prices*

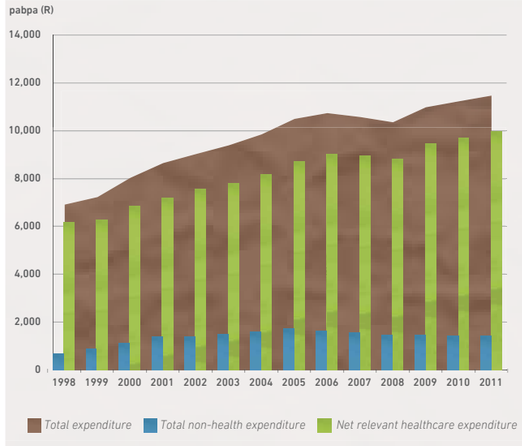


Table 31: Trends in contributions, claims, and non-healthcare expenditure 2000-2011: 2011 prices*

	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa R	% change	pabpa R	% change	pabpa R	% change
2000	8 578	6.4	7 655	6.1	1 156	28.2
2001	9 680	12.9	8 113	6.0	1 408	21.8
2002	10 303	6.4	8 495	4.7	1 408	0.0
2003	11 100	7.7	8 833	4.0	1 534	8.9
2004	11 736	5.7	9 288	5.2	1 625	5.9
2005	11 787	0.4	9 919	6.8	1 745	7.4
2006	11 555	-2.0	10 259	3.4	1 668	-4.4
2007	11 503	-0.5	10 031	-2.2	1 584	-5.0
2008	11 275	-2.0	9 871	-1.6	1 481	-6.5
2009	11 697	3.7	10 517	6.5	1 491	0.7
2010	12 291	5.1	10 817	2.9	1 473	-1.2
2011	12 767	3.9	11 132	2.9	1 441	-2.2
Since 2000		**48.8**		**45.4**		**24.7**

pabpa = per average beneficiary per annum
** The values were adjusted for CPI for 2000-2011.*

Figure 38 and Table 31 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 32 shows the six open schemes with non-healthcare expenditure greater than both the industry average of R154.1 pabpm and the open schemes average of 15.6% when expressed as a percentage of Risk Contribution Income (RCI).

Figure 40 shows the schemes in Table 32 that had a solvency ratio below the open schemes average of 28.6%. It is concerning 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 continually assessed and reviewed to ensure efficiencies.

Figure 41 depicts information on contributions, benefits, non-healthcare expenditure, and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm was growing since 2000 but it decreased in 2003, almost levelling out in 2004. This gap has since grown again.

Net healthcare results and trends

The net healthcare operating result of a medical scheme illustrates its position after benefits and non-healthcare expenditure are deducted from contribution income.

The net healthcare result for all medical schemes combined was a surplus of R1.0 billion in 2011 (2010: R459.5 million deficit). Open schemes incurred deficits of R47.6 million (2010: R0.5 billion) and restricted schemes generated surpluses of R1.1 billion (2010: R43.6 million surplus). Overall, the year-on-year financial performance of both open and restricted schemes has improved.

The inclusion of investment and other income resulted in schemes making a net surplus of R4.3 billion in 2011. Net investment and other income decreased by 1.8% to R3.4 billion.

Table 33 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.

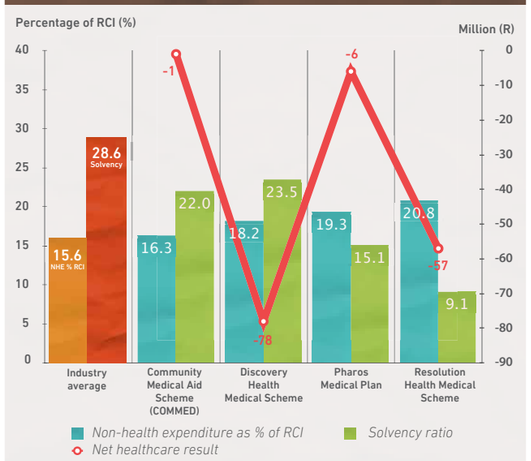
57.7% (or 15 of 26) of open schemes and 46.5% (33 of 71) of restricted schemes made net deficits after investment income.

The net surplus after investment income and consolidation adjustments of all schemes combined was R4.3 billion (2010: R2.9 billion). Open schemes made a R2.0 billion (2010: R1.3 billion) surplus and restricted schemes a surplus of R2.3 billion (2010: R1.6 billion).

Referring to Figures 41 and 42, one can see the impact of the increases in claims costs on the net healthcare result over the past few years.

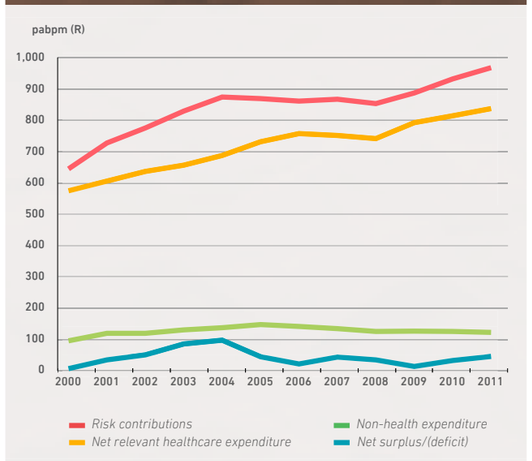
The net healthcare and net results of all schemes since 2000 are reflected in Figure 42.

Figure 40: Open schemes with high non-healthcare expenditure and solvency ratio below average (2011)



RCI = Risk Contribution Income

Figure 41: Risk contributions, benefits, non-healthcare expenditure, and operating surpluses 2000-2011: 2011 prices*



pabpm = per average beneficiary per month
** The values were adjusted for CPI for 2000-2011.*

Table 32: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions (open schemes) 2010 and 2011

Name of medical scheme	Net non-healthcare expenses		Net claims incurred		Net non-healthcare expenses		Reserve-building	
	2011 pabpm (R)	2010 pabpm (R)	2011 As % of RCI	2010 As % of RCI	2011 As % of RCI	2010 As % of RCI	2011 As % of RCI	2010 As % of RCI
Community Medical Aid Scheme (COMMED)	224.7	175.2	83.9	88.6	16.3	15.3	(0.3)	(3.9)
Compcare Wellness Medical Scheme	199.6	185.2	82.0	83.6	16.0	16.1	2.0	0.4
Discovery Health Medical Scheme	164.4	161.0	82.1	81.1	18.2	19.0	(0.3)	(0.1)
Pharos Medical Plan	228.5	209.2	83.6	85.8	19.3	19.3	(2.9)	(5.0)
Resolution Health Medical Scheme	163.9	153.7	88.2	80.3	20.8	20.8	(9.0)	(1.1)
Suremed Health	174.9	205.7	84.5	87.8	18.0	22.4	(2.5)	(10.1)
Industry average: open schemes	**154.1**	**147.1**	**84.7**	**86.6**	**16.2**	**16.9**	**(0.9)**	**(3.5)**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

Figure 42: Net healthcare results 2000-2011

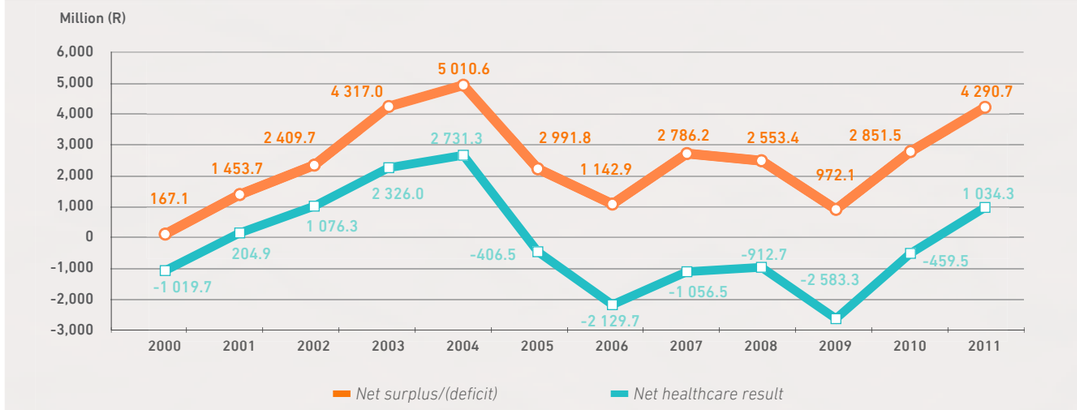


Table 33: 20 schemes with largest net healthcare deficits 2010 and 2011

Name of medical scheme	Type of medical scheme	Net healthcare result			Solvency ratio	
		2011 R'000	2010 R'000	% change	2011 %	2010 %
Medshield Medical Scheme	Open	(98 450)	(80 090)	(22.9)	36.6	52.5
Sizwe Medical Fund	Open	(90 499)	(96 442)	6.2	27.0	32.1
Discovery Health Medical Scheme	Open	(77 600)	(24 889)	(211.8)	23.5	24.7
Liberty Medical Scheme	Open	(73 361)	(164 186)	55.3	27.9	27.0
Resolution Health Medical Scheme	Open	(57 366)	(6 353)	(803.0)	9.1	17.6
Bankmed	Restricted	(56 154)	40 943	(237.2)	50.2	51.2
Anglo Medical Scheme	Restricted	(55 331)	(55 295)	(0.1)	464.7	460.2
Transmed Medical Fund	Restricted	(51 803)	(221 745)	76.6	9.5	14.1
Nedgroup Medical Aid Scheme	Restricted	(46 270)	(49 252)	6.1	36.8	41.6
Netcare Medical Scheme	Restricted	(44 515)	(35 832)	(24.2)	29.8	41.0
Topmed Medical Scheme	Open	(29 136)	(20 067)	(45.2)	169.2	34.1
Bonitas Medical Fund	Open	(28 218)	84 650	(133.3)	37.3	36.5
Witbank Coalfields Medical Aid Scheme	Restricted	(27 843)	(17 655)	(57.7)	102.0	109.9
Malcor Medical Scheme	Restricted	(20 400)	(22 744)	10.3	27.7	25.1
Golden Arrows Employees Medical Benefit Fund	Restricted	(16 306)	(18 829)	13.4	95.0	88.2
Afrox Medical Aid Society	Restricted	(15 827)	(14 553)	(8.8)	112.0	131.6
Metrocare	Restricted	(14 219)	(8 895)	(59.8)	230.4	192.2
BP Medical Aid Society	Restricted	(14 081)	(13 316)	(5.7)	91.8	87.2
Nampak SA Medical Scheme	Restricted	(13 518)	(18 650)	27.5	50.5	53.8
Quantum Medical Aid Society	Restricted	(12 409)	(6 098)	(103.5)	112.2	120.7

Table 34 shows the 20 schemes with the largest net healthcare deficits by the Risk Assessment Framework (RAF) classification; they represent 90.2% of all average beneficiaries that suffered operating deficits. (Annexure M has more details on this.)

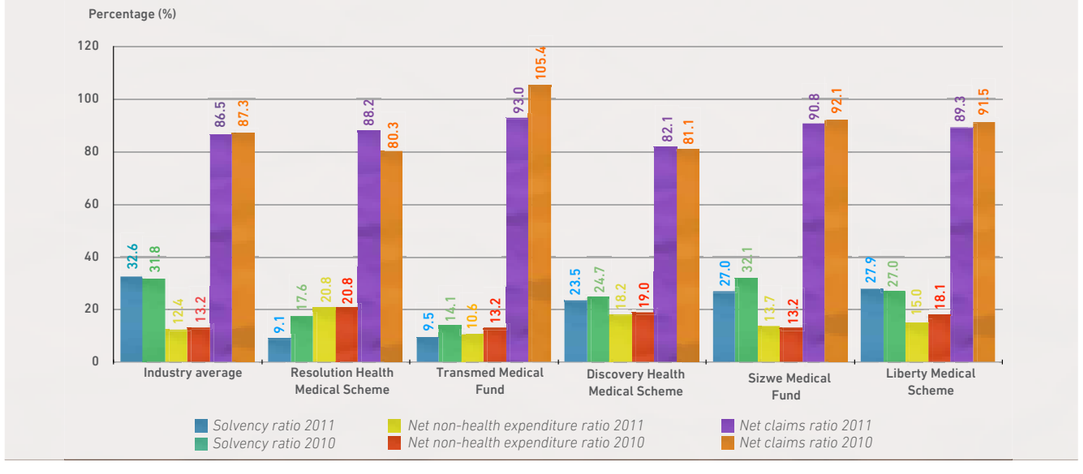
Figure 43 shows the high-impact schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 32.6%. (Annexure N provides more details.)

Table 34: 20 schemes with largest net healthcare deficits by RAF classification 2010 and 2011

Name of medical scheme	Type of medical scheme	Net healthcare result			
		2011 R'000	2010 R'000	% change	RAF classification
Medshield Medical Scheme	Open	(98 450)	(80 090)	(22.9)	High
Sizwe Medical Fund	Open	(90 499)	(96 442)	6.2	High
Discovery Health Medical Scheme	Open	(77 600)	(24 889)	(211.8)	High
Liberty Medical Scheme	Open	(73 361)	(164 186)	55.3	High
Resolution Health Medical Scheme	Open	(57 366)	(6 353)	(803.0)	High
Bankmed	Restricted	(56 154)	40 943	(237.2)	High
Anglo Medical Scheme	Restricted	(55 331)	(55 295)	(0.1)	Medium
Transmed Medical Fund	Restricted	(51 803)	(221 745)	76.6	High
Nedgroup Medical Aid Scheme	Restricted	(46 270)	(49 252)	6.1	High
Netcare Medical Scheme	Restricted	(44 515)	(35 832)	(24.2)	Medium
Topmed Medical Scheme	Open	(29 136)	(20 067)	(45.2)	Medium
Bonitas Medical Fund	Open	(28 218)	84 650	(133.3)	High
Witbank Coalfields Medical Aid Scheme	Restricted	(27 843)	(17 655)	(57.7)	Medium
Malcor Medical Scheme	Restricted	(20 400)	(22 744)	10.3	Medium
Golden Arrows Employees Medical Benefit Fund	Restricted	(16 306)	(18 829)	13.4	Medium
Afrox Medical Aid Society	Restricted	(15 827)	(14 553)	(8.8)	Medium
Metrocare	Restricted	(14 219)	(8 895)	(59.8)	Low
BP Medical Aid Society	Restricted	(14 081)	(13 316)	(5.7)	Medium
Nampak SA Medical Scheme	Restricted	(13 518)	(18 650)	27.5	Medium
Quantum Medical Aid Society	Restricted	(12 409)	(6 098)	(103.5)	Medium

RAF = Risk Assesment Framework

Figure 43: High-impact schemes with largest net healthcare deficits and solvency levels below industry average of 32.6%



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 13.0% to end the year 2011 at R36.8 billion. Regulation 29 reserves grew by 13.9% to R35.0 billion from the R30.7 billion recorded in 2010.

The industry average solvency ratio increased by 2.5% to 32.6% compared to 31.8% in 2010. This was higher than the prescribed level of 25.0%.

The solvency ratio of open schemes increased by 3.6% to 28.6% in 2011 (2010: 27.6%). Restricted schemes experienced a decline of 0.8% in their solvency ratio, which reduced to 38.3% in 2011 from 38.6% in 2010.

Table 33 lists the schemes that 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 44, 45, and 46 show the changes in solvency ratios in all schemes, open schemes, and restricted schemes respectively. The three Figures reflect improvements in solvency ratios since 2000 when the Medical Schemes Act was implemented. The solvency of restricted schemes has, however, been declining since 2006.

Figure 44: Industry solvency for all schemes 2000-2011

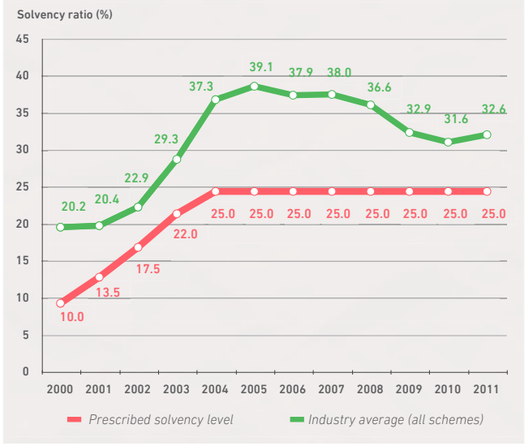


Figure 45: Industry solvency for open schemes 2000-2011

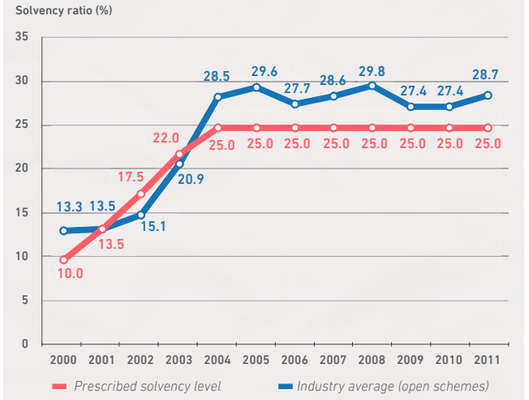
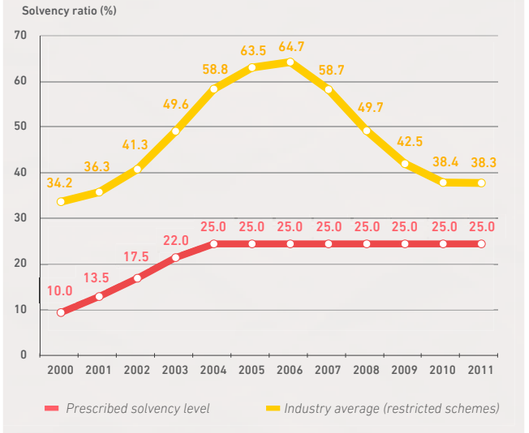


Figure 46: Industry solvency for restricted schemes 2000-2011



Factors that affect solvency

The most important factors impacting 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 dependant ratio (i.e. the number of dependants per member). The membership profile affects the frequency and extent of claims.

Table 35 looks at non-healthcare expenditure, claims, and contributions relative to reserves.

Total risk claims fell between 2000 and 2004. 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 86.5% in 2011. 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 claim costs to ensure that members are at all times protected.

Investment income also has an important role to play, especially if a scheme experiences net healthcare losses.

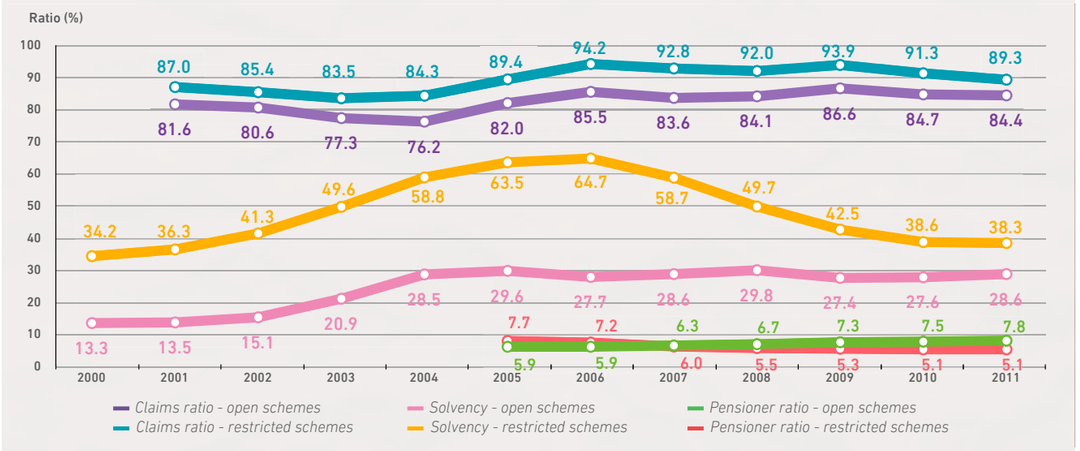
Figure 47 illustrates the impact of GEMS on all medical schemes. (The scheme was registered on 1 January 2005 but only started with operations on 1 January 2006.)

Table 35: Risk claims, non-healthcare expenditure, and reserve-building as a percentage of contributions 1999-2011 (% of RCI)

	Risk claims	Non-healthcare expenditure	Reserve-building
1999	91.5	12.7	(4.2)
2000	89.3	14.5	(3.7)
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	(0.0)
2006	88.0	16.2	(4.1)
2007	86.5	15.2	(1.8)
2008	86.9	14.5	(1.4)
2009	89.3	14.0	(3.3)
2010	87.3	13.2	(0.5)
2011	86.5	12.4	1.1

RCI = Risk Contribution Income

Figure 47: Impact of GEMS 2006-2011*



** Claims data per industry was available only from 2001 onwards and pensioner ratios from 2005 onwards.*

GEMS has had a positive effect on the solvency levels of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who are now steadily leaving them to join GEMS. The reserves which these members had accumulated over the years of their membership of these open schemes, were not transferred to GEMS. However, there was a negative impact on these schemes' claiming patterns as the profile of members who left them and went to GEMS tended to be young and healthy.

Furthermore, schemes should be careful 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 options, or even other schemes. This results in the scheme losing the cross-subsidy provided by these younger members and hence an increase in losses, resulting in even higher contribution increases and/or the lowering of benefits.

Beneficiaries of schemes which failed to reach 25.0% solvency

Table 36 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 48.

Table 36: Prescribed solvency and number of beneficiaries 2000-2011

	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	7	71
2010	12	15	7	66
2011	9	17	5	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
2011	2 855 072	60.0	1 905 042	1 865 313	49.5	1 900 982

Table 36 and Figure 48 show prescribed solvency levels and beneficiary representation in schemes which are both below and above the prescribed solvency level.

A total of 60.0% of beneficiaries in open schemes (2010: 60.8%) were covered by the nine schemes (2010: 12) which failed to meet the prescribed solvency level in 2011. The remaining beneficiaries belonged to the other 17 open schemes (2010: 15) which had attained the prescribed solvency level of 25.0%.

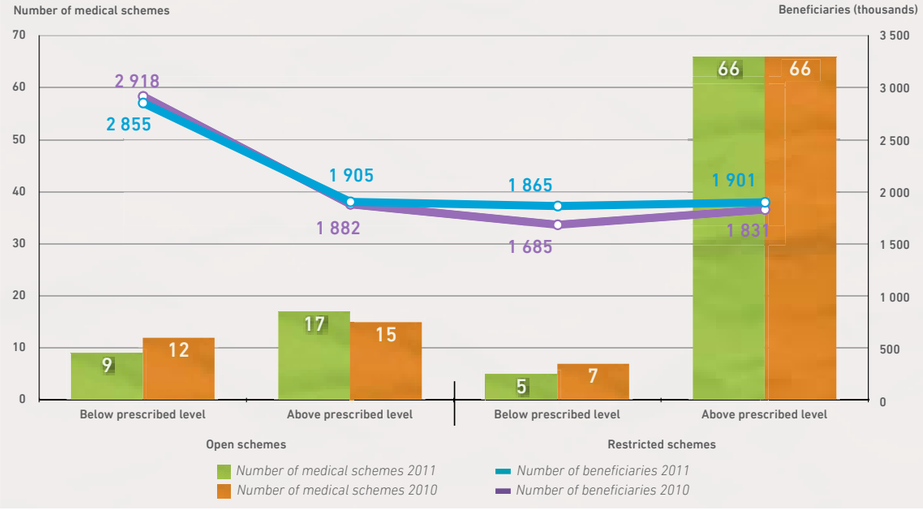
The increase in the number of beneficiaries belonging to open schemes which have yet to achieve the prescribed solvency in 2010 is primarily attributable to Discovery Health Medical Scheme – the largest open scheme in South Africa based on the number of beneficiaries in December 2011 – dropping slightly below solvency during that period.

The number of beneficiaries in restricted schemes which have yet to attain a solvency of 25.0% has also increased. This is largely due to GEMS, the biggest restricted scheme based on the number of beneficiaries for 2011, increasing 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 schemes achieve statutory solvency levels.

Most beneficiaries in restricted schemes found themselves in schemes which were meeting the prescribed solvency level; of the 71 restricted schemes, only five had a solvency below 25.0%. These five, however, constitute 49.5% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory phase-in solvency level of 25.0% and this accounts for 89.2% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

Figure 48: Prescribed solvency and number of beneficiaries 2010 and 2011



RAF and high-impact schemes

The Risk Assessment Framework (RAF) initiative that was started in 2003 allows the Office of the Registrar to better identify schemes which may have the biggest systemic impact on the goals of Council and industry were they to fail; RAF enables us to identify high-impact schemes. These are schemes whose failure, financial or other, would have a major impact on industry; the classification does not necessarily mean that the scheme is a big-risk scheme or that it is experiencing problems.

Of the 28 schemes classified as high impact in 2011 (2010: 26), three (2010: 1) had a solvency ratio below 10.0%, none (2010: 3) had a solvency ratio of 10.0-15.0%, two (2010: 2) of 15.0-20.0%, and two (2010: 3) of 20.0-25.0%. The remaining 21 high-impact schemes (2010: 17) had met the prescribed solvency of 25.0% by the end of 2011.

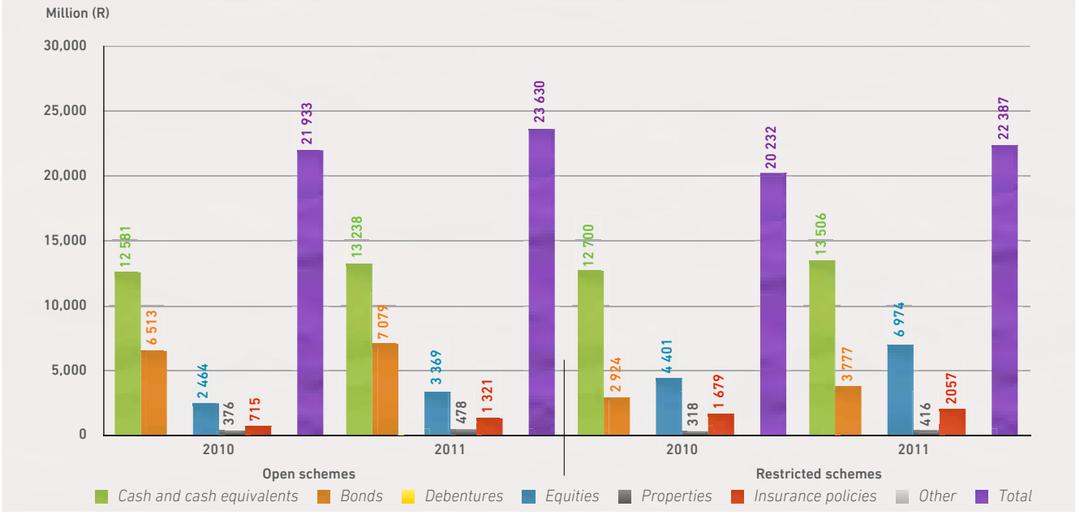
Table 37 shows that the average contributions of high-impact open schemes were 8.7% lower than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that is 5.2% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of RCI of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 107.1%. This tendency allowed restricted schemes to attain higher reserves than open schemes.

Table 37: High-impact schemes by type 2010 and 2011

	Average beneficiaries		Net contributions pabpm (R)		Net claims ratio (%)		Non-healthcare expenditure (% of RCI)		Solvency ratio (%)	
	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010
Open schemes	4 569 069	4 489 654	986.6	917.4	84.4	84.4	15.7	16.3	27.3	27.6
Restricted schemes	2 903 334	2 576 062	934.3	850.4	89.0	90.9	7.6	8.1	25.6	24.2
All schemes	**7 472 403**	**7 065 716**	**966.2**	**893.0**	**86.2**	**86.7**	**12.6**	**13.4**	**26.7**	**26.5**

pabpm = per average beneficiary per month
RCI = Risk Contribution Income

Figure 49: Scheme investments 2010 and 2011



Investments

Figure 49 provides information on the investments of medical schemes as at the end of the years 2010 and 2011.

In open schemes, 56.0% of investments (2010: 57.2%) were held in cash or cash equivalents. Bonds accounted for 30.0% (2010: 29.6%), debentures for 0.2% (2010: 0.1%), equities for 11.6% (2010: 11.2%), insurance policies for 5.6% (2010: 3.3%), properties for 2.0% (2010: 1.7%), and other investments for 0.2% (2010: -0.2%).

Restricted schemes also held a large proportion of their investments (64.3%) in cash or cash equivalents (2010: 62.8%). Their bonds accounted for 16.9% (2010: 14.5%) and debentures for 0.1% (2010: 0.0%). Equities made up 20.4% (2010: 21.8%), insurance policies 9.2% (2010: 8.3%), properties 1.9% (2010: 1.6%), and other investments 0.4% (2010: -1.0%).

The primary obligation of a medical scheme is to ensure that 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 and is therefore technically insolvent.

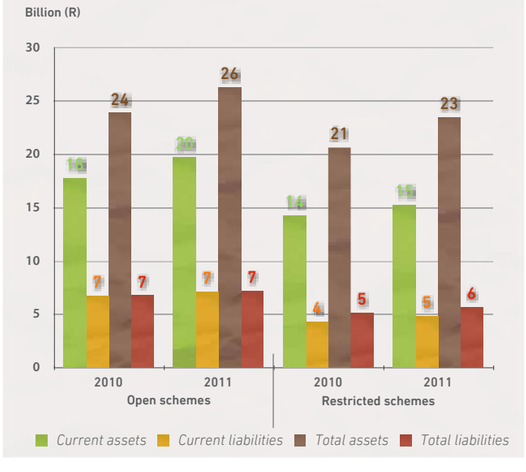
Schemes should pay attention to more than just their total asset and liability positions; they should also give thought to the periods in which liabilities must be paid and in which assets can be converted into cash flows. This is where financing risks must be matched.

Figure 50 compares the matching of assets and liabilities in open and restricted schemes.

The current-assets-to-current-liabilities ratio in open schemes was 2.8:1 in 2011 (2.7:1 in 2010); it was 4.4:1 (2010: 3.3:1) in restricted schemes. The total-asset-to-total-liability ratio for open and restricted schemes was 3.7:1 (2010: 3.5:1) and 4.1:1 (2010: 4.0:1) 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 current ratio below 1:1) is lower than the industry average of 4.0 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 50: Matching assets and liabilities 2010 and 2011



Claims-paying ability of schemes

The financial soundness of a scheme is also measured by its ability to pay claims from cash and cash equivalents.

Figure 51 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.

The cash coverage declined from 4.1 months in 2010 to 4.0 months as at December 2011, but the payment cycles of schemes reflect an average of 15.2 days compared with the 16.0 days reported in 2010.

Benefit options

The year 2011 saw 306 benefit options (2010: 338) in 97 medical schemes (excluding Protea Medical Aid Society which was liquidated with effect from 19 April 2011), including those options that were discontinued during the year.

As at the end of 2011, there were 97 registered medical schemes in South Africa. There were 100 schemes at the end of 2010.

Open schemes accounted for 52.6% or 161 benefit options in 2011 (2010: 53.0% or 179 options).

Restricted schemes had 145 options, representing 47.4% of all options (2010: 159 options or 47.0%).

At the end of the year, open schemes had an average of 6.2 options per scheme (2010: 6.6) and an average of 13 556 members per option (2010: 12 138). Restricted schemes had an average of 2.0 options per scheme (2010: 2.2), with an average of 10 676 members per option (2010: 9 052).

Of the 306 benefit options, 124 (40.5%) had fewer than 2 500 members per option (2010: 149 or 44.1%). Of these 124 options, 74 (59.7%) incurred net healthcare losses in 2011. In 2010, 149 options (63.7%) incurred losses.

The remaining 182 options (2010: 189) had more than 2 500 members per option. Of these, 45.0% or 82 options incurred net healthcare losses (2010: 95 options or 50.0%).

At the end of 2011, there were 68 options in open schemes with fewer than 2 500 members (2010: 81) at an average of 1 170.5 members per option (2010: 947), representing 42.2% (2010: 45.3%) of all open schemes options.

Restricted schemes had 56 options with fewer than 2 500 members (2010: 68), with an average of 1 297.5 members per option (2010: 1 033), representing 38.6% (2010: 42.8%) of all restricted schemes options.

Figure 51: Average gross claims covered by cash and cash equivalents 2000-2011

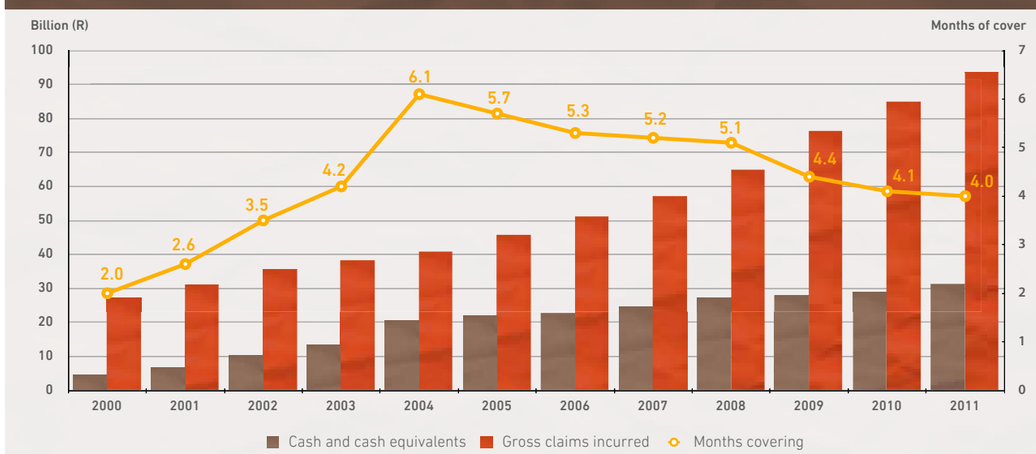


Table 38: Results of benefit options 2011

	Open schemes	% representing	Restricted schemes	% representing	Total
All benefit options					
Number of schemes	26	26.8	71	73.2	**97**
Number of options	161	52.6	145	47.4	**306**
Membership represented	2 182 562	58.5	1 548 003	41.5	**3 730 565**
Net healthcare result (R'000)	(48 311)	-	1 081 942	-	**1 033 632**
Gross non-healthcare as % of GCI	13.7	-	7.7	-	**11.3**
Gross claims ratio (%)	85.7	-	89.4	-	**87.2**
Gross claims incurred pbpm	961.4	-	856.5	-	**915.1**
GCI pbpm	1 121.5	-	958.5	-	**1 049.5**
Options with >= 2 500 members					
Number of options	93	51.1	89	48.9	**182**
Membership represented	2 102 966	58.8	1 475 342	41.2	**3 578 308**
Net healthcare result (R'000)	48 790	-	1 224 492	-	**1 273 283**
Gross non-healthcare as % of GCI	13.8	-	7.7	-	**11.3**
Gross claims ratio (%)	85.5	-	88.9	-	**86.9**
Gross claims incurred pbpm	953.5	-	839.8	-	**903.4**
GCI pbpm	1 115.1	-	944.7	-	**1 040.0**
Options with < 2 500 members					
Number of options	68	54.8	56	45.2	**124**
Membership represented	79 596	52.3	72 661	47.7	**152 257**
Net healthcare result (R'000)	(97 101)	-	(142 550)	-	**(239 651)**
Gross non-healthcare as % of GCI	12.3	-	8.5	-	**10.5**
Gross claims ratio (%)	90.8	-	97.4	-	**93.9**
Gross claims incurred pbpm	1 175.1	-	1 251.8	-	**1 211.5**
GCI pbpm	1 294.6	-	1 285.6	-	**1 290.3**

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Table 39: Results of loss-making benefit options 2011					
	Open schemes	% representing	Restricted schemes	% representing	Total
All loss-making options					
% of total options	56.5	-	44.8	-	**-**
Number of options	91	58.3	65	41.7	**156**
Membership represented	1 033 214	73.9	364 430	26.1	**1 397 644**
Net healthcare result (R'000)	(2 217 884)	-	(1 081 794)	-	**(3 299 677)**
Gross non-healthcare as % of GCI	12.9	-	7.8	-	**11.5**
Gross claims ratio (%)	93.6	-	101.1	-	**95.7**
Gross claims incurred pbpm	1 057.5	-	1 198.5	-	**1 094.5**
GCI pbpm	1 129.5	-	1 185.6	-	**1 144.2**
Loss-making options with >= 2 500 members					
Number of options	51	62.2	31	37.8	**82**
Membership represented	986 878	75.4	321 822	24.6	**1 308 700**
Net healthcare result (R'000)	(2 014 011)	-	(864 002)	-	**(2 878 013)**
Gross non-healthcare as % of GCI	12.9	-	7.9	-	**11.7**
Gross claims ratio (%)	93.3	-	100.3	-	**95.0**
Gross claims incurred pbpm	1 041.7	-	1 148.1	-	**1 067.9**
GCI pbpm	1 116.9	-	1 144.2	-	**1 123.6**
Loss-making options with < 2 500 members					
Number of options	40	54.1	34	45.9	**74**
Membership represented	46 336	52.1	42 608	47.9	**88 944**
Net healthcare result (R'000)	(203 873)	-	(217 792)	-	**(421 665)**
Gross non-healthcare as % of GCI	12.3	-	7.3	-	**9.7**
Gross claims ratio (%)	100.0	-	105.3	-	**102.7**
Gross claims incurred pbpm	1 416.7	-	1 564.4	-	**1 491.4**
GCI pbpm	1 416.6	-	1 485.7	-	**1 451.5**

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 306 benefit options within schemes in the year 2011 (2010: 338), 156 (51.0%) incurred net healthcare losses; in 2010, 192 options (56.8%) incurred net healthcare losses. In the year under review, 91 (2010: 108), representing 56.5% (2010: 56.3%) of the loss-making options, were in open schemes and 65 (2010: 84), representing 44.8% (2010: 43.8%), were in restricted schemes.

The net healthcare losses per member per month (pmpm) in options with fewer than 2 500 members were 2.2 times greater (2010: 3.6) than in options with more than 2 500 members: R395.1 pmpm compared to R183.3 pmpm (2010: R495.5 pmpm against R149.7 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 40 shows option results by demographics.

There were 92 options with an average age above the 33.3 years for options in open schemes, and 69 benefit options with beneficiaries younger than the average in open schemes.

In the restricted market, 92 options had beneficiaries with an average age higher than the 29.5 for all options in restricted schemes. Fifty-three options had younger beneficiaries.

As expected, options covering older and sicker lives incurred greater deficits.

Table 40: Number of options by demographics 2011			
	Open schemes	Restricted schemes	Total
Options >= 33.3 years (open); 29.5 years (restricted)			
Number of options >= 33.3 years (open); 29.5 years (restricted)	92	92	**184**
NHC results pbpm >= -0.8 (open); NHC results pbpm >= 23.9 (restricted)	31	25	**56**
NHC results pbpm < -0.8 (open); NHC results pbpm < 23.9 (restricted)	61	67	**128**
Options <=33.3 years (open); 29.5 years (restricted)			
Number of options <= 33.3 years (open); 29.5 years (restricted)	69	53	**122**
NHC results pbpm >= -0.8 (open); NHC results pbpm >= 23.9 (restricted)	39	34	**73**
NHC results pbpm < -0.8 (open); NHC results pbpm < 23.9 (restricted)	30	19	**49**

NHC = Net Healthcare
pbpm = per beneficiary per month
Average age per beneficiary open options = 33.3 years
Average age per beneficiary restricted options = 29.5 yeras
NHC result pbpm open options = -R0.8
NHC result pbpm restricted options = R23.9

Administrator market

Figure 52 shows the market share of medical scheme administrators as well as self-administered medical schemes based on the average number of beneficiaries administered at the end of 2011.

Figure 53 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.

Five third-party administrators dominate the market:

- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Medscheme Holdings (Pty) Ltd
- Momentum Medical Scheme Administrators (Pty) Ltd
- V Med Administrators (Pty) Ltd

Together, they administer 79.3% of the market (excluding the self-administered medical schemes).

Figures 54 and 55 indicate the changes in administrator market share over the last 11 years for open and restricted schemes respectively.

The share of administrator Discovery Health (Pty) Ltd of the open schemes market increased to 48.5% (2010: 44.9%); its share in the restricted schemes market remained at 6.2%. Medscheme Holdings (Pty) Ltd has the second-biggest share in both the open and restricted schemes administration market at 15.9% (2010: 18.6%) and 7.3% (2010: 8.9%) respectively. Medscheme Holdings (Pty) Ltd acquired Lethimvula Healthcare (Pty) Ltd in 2009; the latter had earlier acquired the business of Old Mutual Healthcare (Pty) Ltd. Metropolitan Health Corporate (Pty) Ltd has the biggest share of the restricted schemes market at 67.8% (2010: 64.9%).

Despite their market dominance and the inherent benefits of economies of scale, the larger administrators do not appear to offer any cost advantages over their smaller rivals.

Perhaps their size makes them less efficient and less responsive to clients' needs?

Figure 52: Administrator market share 2011

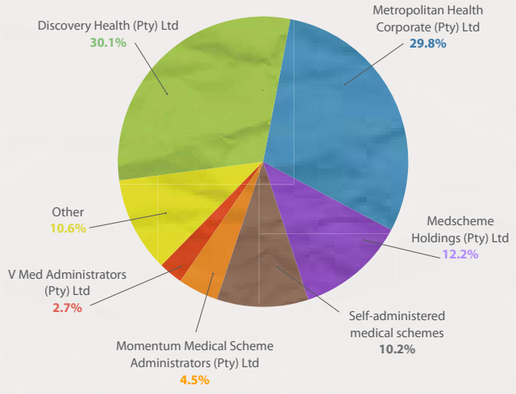
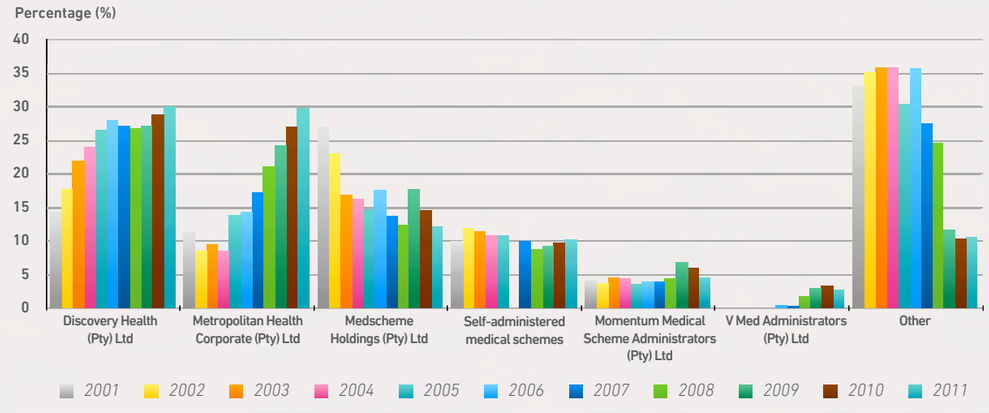
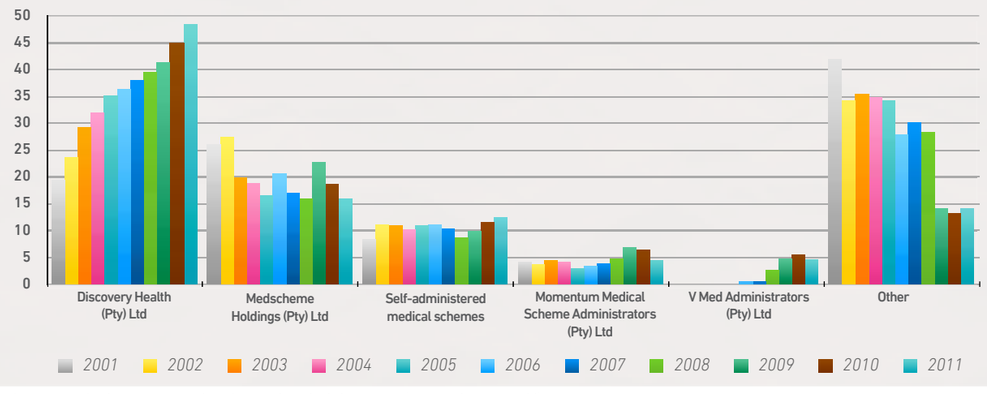


Figure 53: Market share of largest administrators based on average number of beneficiaries 2001-2011*



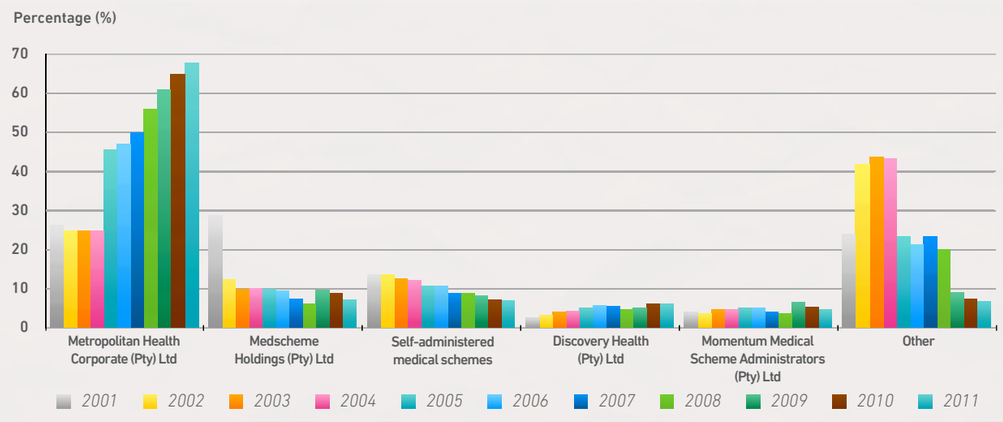
** This does not take into account the change in administrators (as per Annexure V).*

Figure 54: Open schemes market share of largest administrators based on average number of beneficiaries 2001-2011*



** This does not take into account the change in administrators (as per Annexure V).*

Figure 55: Restricted schemes market share of largest administrators based on average number of beneficiaries 2001-2011*



** This does not take into account the change in administrators (as per Annexure V).*

Table 41 shows the five administrators who had higher administration costs and fees than the industry average of administrators handling open schemes.

As for restricted schemes, Table 42 shows the five administrators with higher administration costs and fees than the industry average for restricted schemes.

Administrators and businesses associated with administrators often provide managed healthcare services. In many instances, these services are merely additional layers of administration costs with questionable benefits for the medical schemes themselves; we have included them in the "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 a specific administrator.

Tables 43 and 44 show administrator market share at year-end 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 expenditure are costs charged to both risk pools and savings accounts. (Details per individual administrator for services delivered during the year are outlined in Annexure V.)

Table 41: Percentage deviation from industry average: open schemes (%)

	Gross administration expenditure	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	73.9	29.3	26.6
Discovery Health (Pty) Ltd	4.6	16.3	23.8
Sanlam Healthcare Management (Pty) Ltd	25.5	(0.4)	4.3
Allcare Administrators (Pty) Ltd	73.0	13.9	2.6
Momentum Medical Scheme Administrators (Pty) Ltd	(14.2)	(9.8)	(5.4)

** Excluding co-administration fees*

Table 42: Percentage deviation from industry average: restricted schemes (%)

	Gross administration expenditure	Administration fees paid*	Fees paid to administrators (administration + managed care)*
Eternity Private Health Fund Administrators (Pty) Ltd	163.4	192.2	165.7
V Med Administrators (Pty) Ltd	52.6	68.0	79.8
Allcare Administrators (Pty) Ltd	76.8	114.5	77.7
Discovery Health (Pty) Ltd	54.2	74.9	74.7
Professional Medical Scheme Administrators (Pty) Ltd	104.1	80.8	56.6

** Excluding co-administration fees*

Table 43: Administrator market share: open schemes 2011

Name of administrator	Number of schemes at year-end	Beneficiaries	Gross administration expenditure		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	1.4	113.8	14.5	76.6	9.7	97.3	12.4	787.1	88.2
Allcare Administrators (Pty) Ltd	1	0.4	175.4	12.2	101.5	7.1	112.4	7.8	1 433.9	83.9
Discovery Health (Pty) Ltd	1	48.5	106.1	9.4	103.6	9.2	135.6	12.0	1 129.0	82.1
Eternity Private Health Fund Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Medscheme Holdings (Pty) Ltd	2	15.9	92.2	8.7	66.0	6.3	93.5	8.9	1 056.5	85.7
METHEALTH (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Metropolitan Health Corporate (Pty) Ltd	1	0.4	83.0	6.6	59.9	4.7	75.6	6.0	1 265.5	91.2
Momentum Medical Scheme Administrators (Pty) Ltd	2	4.4	87.0	8.7	80.4	8.0	103.6	10.3	1 003.1	81.6
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	1	0.3	176.3	14.5	115.2	9.5	138.6	11.4	1 218.8	83.6
Professional Medical Scheme Administrators (Pty) Ltd	1	1.9	109.1	7.0	71.7	4.6	85.1	5.5	1 549.2	85.7
Providence Healthcare Risk Managers (Pty) Ltd	2	0.3	72.3	8.8	49.4	6.0	60.2	7.3	825.1	84.5
Sanlam Healthcare Management (Pty) Ltd	1	3.1	127.2	9.1	88.7	6.3	114.2	8.1	1 401.1	85.2
Sechaba Medical Solutions (Pty) Ltd	1	3.3	99.1	9.3	69.0	6.5	89.8	8.5	1 060.2	90.8
Self-administered medical schemes	6	12.5	86.0	7.3	-	-	11.0	0.8	1 179.1	88.7
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	2.3	93.0	10.2	67.6	7.4	83.6	9.1	915.8	81.5
Universal Healthcare Administrators (Pty) Ltd	2	0.6	115.0	9.8	94.7	8.1	94.7	8.1	1 174.8	82.9
V Med Administrators (Pty) Ltd	2	4.6	110.7	9.7	61.9	5.4	77.5	6.8	1 137.5	85.4
Average	**26**	**100.0**	**101.4**	**9.0**	**89.1**	**8.0**	**109.5**	**9.7**	**101.4**	**84.4**

** Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Table 44: Administrator market share: restricted schemes 2011

Name of administrator	Number of schemes at year-end	Beneficiaries	Gross administration expenditure		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	0.3	97.1	7.7	90.5	7.2	101.1	8.0	1 259.7	101.6
Discovery Health (Pty) Ltd	12	6.2	84.7	7.7	73.8	6.7	99.4	9.1	1 096.0	82.4
Eternity Private Health Fund Administrators (Pty) Ltd	1	1.2	144.7	10.4	123.3	8.8	151.2	10.8	1 397.0	82.4
Medscheme Holdings (Pty) Ltd	16	7.3	69.4	5.8	60.4	5.0	85.6	7.1	1 198.5	91.4
METHEALTH (Pty) Ltd	4	1.2	71.0	6.8	60.6	5.8	74.8	7.2	1 038.4	94.4
Metropolitan Health Corporate (Pty) Ltd	12	67.8	46.3	4.8	33.2	3.5	47.3	4.9	961.6	89.7
Momentum Medical Scheme Administrators (Pty) Ltd	7	4.7	74.2	6.7	57.9	5.2	75.4	6.8	1 110.9	95.5
Private Health Administrators (a division of Sweidan Trust (Pty) Ltd)	-	-	-	-	-	-	-	-	-	-
Professional Medical Scheme Administrators (Pty) Ltd	1	1.7	112.1	9.8	76.3	6.7	89.1	7.8	1 140.1	82.3
Providence Healthcare Risk Managers (Pty) Ltd	4	1.5	55.2	6.7	39.4	4.8	55.6	6.8	819.0	88.7
Sanlam Healthcare Management (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Sechaba Medical Solutions (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Self-administered medical schemes	8	7.1	47.7	6.7	-	-	3.4	0.4	717.0	85.7
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	-	-	-	-	-	-	-	-	-	-
Universal Healthcare Administrators (Pty) Ltd	3	0.7	67.4	7.3	57.9	6.3	58.1	6.3	925.6	89.9
V Med Administrators (Pty) Ltd	1	0.3	83.8	6.4	70.9	5.4	102.3	7.8	1 319.1	86.1
Average	**71**	**100.0**	**54.9**	**5.6**	**42.2**	**4.2**	**56.9**	**5.7**	**985.9**	**89.3**

** Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

List of Annexures

A: Compliance with submission of audited Annual Financial Statements, statutory return, and audit management letter
B: Council and Council Committees – composition, meetings, and attendance 1 April 2011-31 March 2012
C: Statement of financial position as at 31 December 2011
D: Statement of comprehensive income for the year ended 31 December 2011
E: Consolidated statement of changes in funds and reserves for the year ended 31 December 2011
F: Consolidated membership analysis for the year ended 31 December 2011
G: Utilisation of services for the year ended 31 December 2011
H: Total benefits paid for the year ended 31 December 2011
I: Benefits paid from risk pool for the year ended 31 December 2011
J: Benefits paid from savings accounts for the year ended 31 December 2011
K: Income statement details: registered schemes for the year ended 31 December 2011
L: Balance sheet details: registered schemes as at 31 December 2011
M: Detailed financial information: registered schemes for the years ended 31 December 2010-2011
N: Detailed financial ratios: registered schemes for the years ended 31 December 2010-2011
O: Detailed financial information per option: registered schemes for the year ended 31 December 2011
P: Fees paid to administrators: registered schemes for the years ended 31 December 2010-2011
Q: Selected non-healthcare expenditure: registered schemes for the years ended 31 December 2010-2011
R: Operating results and solvency: registered schemes for the years ended 31 December 2010-2011
S: Demographic profile: registered schemes for the years ended 31 December 2010-2011
T: Significant risk transfer arrangements (excl. commercial reinsurance) per option: registered schemes for the year ended 31 December 2011
U: Seasonality of claims: registered schemes for the year ended 31 December 2011
V: Administrator market share and relevant cash flows under their administration for the years ended 31 December 2010-2011

Explanatory notes to the Annexures for the year ended 31 December 2011

Annexures

All the 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 printable PDF format and, for the first time, also in Excel
* a readme file containing important information about viewing the PDF and Excel files
* a copyright warning and disclaimer applicable to the entire Annual Report

To view the files stored on this disc, please insert it into your PC or MAC.

The password to open the Excel information is **annual2011**

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)
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 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
DoH:	Department of Health
Dr:	Doctor
DRG:	Diagnosis-Related Group
DRGTAP:	DRG Technical Advisory Panel
DSP:	designated service provider
DTP:	Diagnosis and Treatment Pair
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 Arrows:	Golden Arrows Employees Medical Benefit Fund
GP:	general practitioner
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
IT:	Information Technology
ITAP:	Industry Technical Advisory Panel
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
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
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
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
SMM:	Strategic Management Meeting
SMS:	Short Message Service
SOP:	Standard Operating Procedure
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

www.medicalschemes.com