CMS
Council for Medical Schemes

# ANNUAL REPORT 2018/19

*WORKING TOGETHER TO CURB FRAUD, WASTE AND ABUSE*

Annual Report
Council for Medical Schemes

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## Working together to curb fraud, waste and abuse

The theme for this year's annual report is centred on "Fraud, Waste and Abuse". Fraud, waste and abuse have been identified as key contributors to exorbitant healthcare costs. Propelled by the transformative agenda of the United Nations' Sustainable Development Goals to be achieved by 2030, which among others focuses on addressing the social ills that many countries are grappling with, the private healthcare industry has an opportunity to do right by its members, and rid the system of the scourge of fraud, waste and abuse which is in the end detrimental to members.

The signing of the Charter on Fraud, Waste and Abuse on 1 March 2019, by role players in the medical schemes industry mapped a way for the sector to deal with prohibitive medical scheme costs as a result of fraud, waste and abuse. This imperative is in line with South Africa's National Development Plan goals to reduce inequality by 2030. As long as the escalating costs of medical schemes are left unchecked, many people will be compelled to cancel their memberships, thus compromising their ability to access quality healthcare. Working together to curb fraud, waste and abuse will help to ensure that many of South Africa's people are not marginalised and priced out of the private healthcare system as a result of the additional costs brought on by fraud, waste and abuse.

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# PART A:
## GENERAL INFORMATION

# GENERAL INFORMATION ON THE COUNCIL FOR MEDICAL SCHEMES

| | |
|---|---|
| **Name** | Council for Medical Schemes |
| **Physical address** | Block A Eco Glades 2 Office Park<br>420 Witch-Hazel Avenue<br>Eco Park<br>Centurion<br>Pretoria 0157<br>South Africa |
| **Postal address** | Private Bag X34<br>Hatfield<br>Pretoria 0028<br>South Africa |
| **Telephone number** | 012 431 0500 |
| **Customer Care Centre** | 0861 123 267<br>0861 123 CMS |
| **Fax number** | 0862 068 260 |
| **Email address** | information@medicalschemes.com |
| **Website** | www.medicalschemes.com |
| **Internal auditors** | Nexia-SAB&T |
| **External auditors** | Auditor-General of South Africa |
| **Bank** | Absa Group Limited |
| **Chairperson of Council** | Dr Clarence Mini |
| **Chief Executive and Registrar** | Dr Sipho Kabane |
| **Council Secretariat** | Mr Khayalethu Mvulo |

# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **ABET** | Adult Basic Education Training |
| **AGM** | Annual General Meeting |
| **ARC** | Audit and Risk Committee |
| **AVE** | Advertising Value Equivalent |
| **BBBEE** | Broad-Based Black Economic Empowerment |
| **CCMA** | Commission for Conciliation, Mediation and Arbitration |
| **CDL** | Chronic Disease List |
| **CISNA** | Committee of Insurance, Securities and Non-banking Financial Authorities |
| **CMS** | Council for Medical Schemes |
| **CPD** | Continuing Professional Development |
| **CPF** | Consumer Protection Forum |
| **CPI** | Consumer Price Index |
| **DDDR** | Dynamic Data Driven Return |
| **DES** | Demarcation Exemption System |
| **DMP** | Disease Management Programme |
| **DRC** | Dispute Resolution Committee |
| **DRSaaS** | Microsoft Disaster Recovery as a Service |
| **DTP** | Diagnosis and Treatment Pairs |
| **EDO** | Efficiency Discount Option |
| **EXCO** | Executive Committee |
| **FFS** | Fee for Service |
| **FPI** | Financial Planning Institute |
| **FSCA** | Financial Sector Conduct Authority |
| **GEMS** | Government Employees Medical Scheme |
| **GP** | General Practitioner |
| **HMI** | Health Market Inquiry |
| **HPCSA** | Health Professions' Council of South Africa |
| **HR** | Human Resources |
| **HRSE** | Human Resource, Social and Ethics Committee |
| **HWSETA** | Health and Welfare Sector Education and Training Authority |
| **ICT** | Information and Communication Technology |
| **IoDSA** | Institute of Directors of Southern Africa |
| **KM** | Knowledge Management |
| **LCBO** | Low-Cost Benefit Option |
| **MCO** | Managed Care Organisation |
| **MoU** | Memorandum of Understanding |
| **NDoH** | National Department of Health |
| **NHI** | National Health Insurance |
| **NomCom** | Nominations Committee |
| **PFMA** | Public Finance Management Act, No. 1 of 1999 |
| **PMB** | Prescribed Minimum Benefit |
| **RBC** | Risk-Based Capital |

# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **SADC** | Southern African Development Community |
| **SAICA** | South African Institute of Chartered Accountants |
| **SAMA** | The South African Medical Association |
| **SANCU** | South African National Consumer Union |
| **SCM** | Supply Chain Management |
| **SCR** | Scheme Community Rate |
| **SIU** | Special Investigating Unit |
| **SRM** | Scheme Risk Measurement |
| **The Act** | Medical Schemes Act, No. 131 of 1998 |

# STRATEGIC OVERVIEW

## Profile of the CMS

The Council for Medical Schemes (CMS) is a regulatory authority responsible for overseeing the medical schemes industry in South Africa. It administers and enforces the Medical Schemes Act, No. 131 of 1998.

## Vision

To promote vibrant and affordable cover for all.

## Mission

The CMS 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 Act;
- Ensuring the improved management and governance of medical schemes;
- Advising the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- Ensuring collaboration with other entities in executing the CMS' regulatory mandate.

## Values

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

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

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

# LEGISLATIVE AND OTHER MANDATES

## Constitutional mandates

The state is obliged, in terms of Section 27 of the Constitution of South Africa, to develop legislation that is geared towards the progressive realisation of the right of access to healthcare by all those living in the country. The Medical Schemes Act, No. 131 of 1998 (the Act), forms part of the country's legislation aimed at facilitating access to healthcare services. The Act aligns with the spirit and letter of the Constitution through its provision for non-discriminatory access to medical scheme membership.

## Legislated mandates

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

Significant problems emerged as a result of the deregulation of the medical schemes industry in 1989, including poor solvency levels, inadequate accountability and a lack of member participation in governance of medical schemes. The situation necessitated the promulgation of the Act, which became fully operational in 2000.

Medical schemes are essentially business entities that are registered with the Council for Medical Schemes (CMS) and, as such, now operate in a legislated environment. This environment was established to balance the rights and interests of these business entities on the one hand, with those of the public on the other. Section 36 of the Constitution addresses the limitation of the rights and sets clear criteria to be met when any right contained in the Bill of Rights is limited by law; whereas Section 22 of the Constitution guarantees freedom of trade, which may be limited by law. To bridge the gap, the Act imposes certain limitations on the medical schemes environment by confining the business of the schemes to entities that are registered by the CMS and requires that such entities comply with the provisions of the Act.

Section 7 of the Act provides for the establishment of the CMS under the oversight of the Council, which is the accounting authority or Board of the CMS and has the following functions:

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

# LEGISLATIVE AND OTHER MANDATES

## Policy mandates

The CMS is obliged to execute its statutory mandate in a way that is coherent and consistent with national policy. The priority areas of the electoral mandate in the South African Government's Programme of Action and the Strategic Goals of the National Department of Health (NDoH) are as follows:

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

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

### *The National Department of Health's strategic goals*

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

# ORGANISATIONAL STRUCTURE


Figure 1: CMS organisational structure

# STRATEGIC GOALS

## Strategic goal 1

*Access to good quality medical scheme cover is promoted*

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

## Strategic goal 2

*Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

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

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

## Strategic goal 3

*The CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

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

## Strategic goal 4

*The CMS provides strategic advice to influence and support the development and implementation of national health policy*

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

# LEADERSHIP – COUNCIL

**Dr Clarence Mini**
*Chairperson*

**Adv. Harshila Kooverjie**
*Vice Chairperson*

**Adv. Rebaone Gaoraelwe**
*Member*

**Dr Steven Mabela**
*Member*

**Ms Mosidi Maboye**
*Member*

**Mr Moerane Maimane**
*Member*

**Dr Memela Makiwane**
*Member*

**Prof. Lungile Pepeta**
*Member*

**Dr Yogan Pillay**
*Member*

**Ms Diane Terblanche**
*Member*

**Dr Aquina Thulare**
*Member*

**Mr Johan van der Walt**
*Member*

# LEADERSHIP – EXECUTIVES

**Dr Sipho Kabane**
*Chief Executive and Registrar*

**Mr Daniel Lehutjo**
*Chief Financial Officer*

**Mr Jaap Kügel**
*Chief Information Officer*

**Mr Craig Burton-Durham**
*General Manager: Legal Services*

**Mr Danie Kolver**
*General Manager: Accreditation*

**Ms Tebogo Maziya**
*General Manager: Financial Supervision*

**Mr Paresh Prema**
*General Manager: Benefits Management*

**Mr Michael Willie**
*General Manager: Research and Monitoring*

**Mr Stephen Mmatli**
*General Manager: Compliance and Investigations*

**Ms Tembi Phaswane**
*General Manager: Complaints and Adjudication*

**Ms Lindelwa Ndziba**
*General Manager: Human Resources*

**Ms Grace Khoza**
*General Manager: Stakeholder Relations*

# MEDICAL SCHEMES REGISTERED WITH THE CMS IN TERMS OF THE MEDICAL SCHEMES ACT

## AS AT 31 MARCH 2019

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

| | Scheme name | Type |
|---|---|---|
| 39 | Medihelp | Open |
| 40 | Medimed Medical Scheme | Open |
| 41 | Medipos Medical Scheme | Restricted |
| 42 | Medshield Medical Scheme | Open |
| 43 | Momentum Health | Open |
| 44 | Motohealth Care | Restricted |
| 45 | Naspers Medical Fund | Restricted |
| 46 | Nedgroup Medical Aid Scheme | Restricted |
| 47 | Netcare Medical Scheme | Restricted |
| 48 | Old Mutual Staff Medical Aid Fund | Restricted |
| 49 | Parmed Medical Aid Scheme | Restricted |
| 50 | PG Group Medical Scheme | Restricted |
| 51 | Pick n Pay Medical Scheme | Restricted |
| 52 | Platinum Health | Restricted |
| 53 | Profmed | Restricted |
| 54 | Quantum Medical Aid Society | Restricted |
| 55 | Rand Water Medical Scheme | Restricted |
| 56 | Remedi Medical Aid Scheme | Restricted |
| 57 | Retail Medical Scheme | Restricted |
| 58 | Rhodes University Medical Scheme | Restricted |
| 59 | SABC Medical Aid Scheme | Restricted |
| 60 | SAMWUMED | Restricted |
| 61 | Sasolmed | Restricted |
| 62 | SEDMED | Restricted |
| 63 | Selfmed Medical Scheme | Open |
| 64 | Sisonke Health Medical Scheme | Restricted |
| 65 | Sizwe Medical Fund | Open |
| 66 | South African Breweries Medical Aid Society | Restricted |
| 67 | South African Police Service Medical Scheme (Polmed) | Restricted |
| 68 | Suremed Health | Open |
| 69 | TFG Medical Aid Scheme | Restricted |
| 70 | Thebemed | Open |
| 71 | Tiger Brands Medical Scheme | Restricted |
| 72 | Topmed Medical Scheme | Open |
| 73 | Transmed Medical Fund | Restricted |
| 74 | Tsogo Sun Group Medical Scheme | Restricted |
| 75 | Umvuzo Health Medical Scheme | Restricted |
| 76 | University of KwaZulu-Natal Medical Scheme | Restricted |
| 77 | Witbank Coalfields Medical Aid Scheme | Restricted |
| 78 | Wooltru Healthcare Fund | Restricted |

# CHAIRPERSON'S REPORT

Dr Clarence Mini

**This is our first full financial year since we were appointed as the Council of the CMS and our confidence in leading this important regulator has grown, together with our better aligned strategic direction, focused stakeholder engagements and intentional regulatory interventions.**

In my previous address I mentioned the challenges which I saw in the industry, and subsequently put to both the Council, and management of the CMS to confront. As such, it brings me great pleasure to report that the organisation's trajectory has improved as a result of countering these challenges.

## Aligned strategic direction

It is said that good governance starts with a great governing body. As the Council, we are committed to ensuring that we provide the organisation with exemplary leadership and towards this end, the entire Council attended governance training at the Institute of Directors Southern Africa. This training emphasised the need for robust debate within the Council itself, adopting a proactive approach to understanding organisational culture, and cultivating behaviours that drive results.

One such driver of results is organisational stability. We are pleased that the long-standing instability, caused by the vacancy in the Chief Executive and Registrar position at the CMS, has been filled. After a year in an acting capacity, Dr Sipho Kabane was ultimately appointed, on the Council's recommendation, as the permanent Registrar by the Hon. Minister of Health. Dr Kabane meets his tenure with ample footing, having held the position of Senior Strategist prior to acting as Chief Executive and Registrar.

This progress allowed the Council to focus next on ensuring that the organisation is fit for purpose, with the commissioning of a diagnostic study and a review of policies and charters. The diagnostic study has provided the Council with a good view of the state of the organisation and the remedies required to ensure that the CMS is fit for purpose.

## Focused stakeholder engagements

The CMS' focused stakeholder engagements have proven to be the best opportunities to connect and demonstrate how the organisation is responsive to the legitimate needs and concerns of its key stakeholders. A case in point is the CMS road shows, which have developed with increased success, to become one of the most respected regulatory activities.

Interestingly, these road shows have also shed light on many niggling industry matters such as medical scheme fraud, waste and abuse. Discussions with medical schemes, administrators, managed-care organisations, policy makers and the public at large resulted in the CMS hosting its inaugural Fraud, Waste and Abuse (FWA) Summit, under the fitting slogan "Partnership to curb fraud, waste and abuse".

The outcomes of the summit were threefold: the establishment of standards, the signing of an industry Charter as a pledge to contribute to combating FWA, and the establishment of a structure to continuously deal with FWA post the summit.

Through stakeholder management, the CMS has strengthened its relationship with its co-regulators. The advent of greater industry collaboration has begun between the CMS and organisations such as the Health Professions Council of South Africa (HPCSA), the South African Medical Association (SAMA), and the Special Investigating Unit (SIU).

The organisation also forged agreements of cooperation between South African Development Community (SADC) groupings such as the Committee of Insurance, Securities and Non-banking Financial Authorities (CISNA).

## Intentional regulatory interventions

In our quest to ensure proper alignment with the country's health policy direction, support for our political principals has been more decisive.

The CMS is tasked with advising the Ministry of Health on national health policy issues regarding consolidation of risk pools and developing a Low Cost Benefits Option towards National Health Insurance (NHI), and ultimately realising universal health coverage for the country.

In discharging its mandate the CMS has made submissions and participated constructively at the Competition Commission's Health Market Inquiry (HMI).

## Acknowledgements and conclusion

For the Council and me, the past year has been excitingly demanding. We have learnt and grown in our new appointment. True to our values, we have approached challenges with a 'can-do' attitude, and we are proud of our achievements in this regard.

I wish to thank my Council colleagues, for their support and unwavering commitment to the task at hand. I also extend a word of appreciation to the management of the CMS, led by Dr Kabane, and staff members at all levels for their hard work and dedication.

I am convinced that the summary above supports my view that ***ithanga liphuma ezaleni*** – the circumstances of the past cannot hold us back from becoming better in the future.

**Dr Clarence Mini**

*Chairperson*
31 May 2019

*IT IS SAID THAT GOOD GOVERNANCE STARTS WITH A GREAT GOVERNING BODY. AS THE COUNCIL, WE ARE COMMITTED TO ENSURING THAT WE PROVIDE THE ORGANISATION WITH EXEMPLARY LEADERSHIP.*

# OVERVIEW OF THE CHIEF EXECUTIVE AND REGISTRAR

Dr Sipho Kabane

**The Council for Medical Schemes' (CMS) performance during the past financial year is a testament to the adage: *'Sefate se tsejwa ka ditholwana'* – a tree is known by its fruit.**

Our biggest harvest lies in the supervision of a massive and very important industry comprising 78 medical schemes, 26 administrators and 15 managed care organisations – collectively responsible for 8.92 million beneficiaries. Our biggest picking – the beneficiaries are serviced by 264 benefit options while being cushioned by over R66 billion in reserves. In 2018, over R17 billion was paid from their medical savings accounts, while they expended over R32 billion in out-of-pocket payments.

Our task is succinctly captured in Section 7 of the Medical Schemes Act, No. 131 of 1998 as the protection of the interests of scheme members and beneficiaries, and the regulation of the medical schemes industry in a manner that is complementary to national policy.

Our reaping is of great importance in achieving South Africa's socio-economic goals of poverty reduction, economic growth and eradication of inequities. I am proud to be at the helm of such an important organisation, having been permanently appointed as Chief Executive and Registrar of the CMS in February 2019. The following synopsis details our toils in ensuring that we harvest a balanced healthcare basket, for all our stakeholders.

## Regulation of the medical schemes industry

The founding legislation of the CMS discharges the role of strategic oversight and regulation concerning both the organisation, the Office of the Registrar and the medical schemes industry to the CMS. The organisation is also charged with advising the Ministry of Health on national health policy issues in the quest to realise universal health coverage for the country.

The CMS, through its work, is constantly looking for ways to improve its effectiveness and efficiency as a regulator, while making significant inputs into the National Health Policy debate. The establishment of Registrar Forums for direct engagement with industry associations such as the Board of Health Funders, Health Funders Association and other key stakeholders are examples of proactive and dialogue-seeking regulatory approaches that the CMS has been engaged in during this past year. These are beginning to bear fruit.

By 'watering the seed' of policy improvement, the organisation has participated in numerous public debates and contributed to publications on the NHI, Medical Schemes Amendment Bills and the HMI. Staying true to this focus we have engaged with the review of Prescribed Minimum Benefits in order to enrich member entitlements and ensure alignment with Universal Health Coverage.

The CMS has also issued several publications and circulars that are aimed at advancing industry debates on key regulatory issues such as:

- Consolidation of schemes with less than 6 000 members;
- Consolidation of government-funded schemes;
- Simplification and standardisation of benefit options;
- Low-Cost Benefit Options;
- Development of a preventative primary healthcare benefit as part of the Prescribed Minimum Benefits Review; and
- Central Beneficiary Registry.

The organisation also proactively seeded discussions with key stakeholders, aimed at establishing a National Coding Authority, which will act as an arbiter in disputes related to coding disputes.

To root out fraud, waste and abuse, which constitutes 15% of all medical scheme claims, the CMS hosted the inaugural Fraud, Waste and Abuse Summit. The approximate rand value associated with fraud, waste and abuse in 2018 alone, was close to R3 billion.

These resources, now lost to the health system, were rightfully destined and allocated for the provision of quality health services for scheme members and beneficiaries. The social and economic impact of these kinds of health system leaks cannot be underestimated – they eat at the beneficiaries' yield.

## Protection of the interests of beneficiaries

### *Financial capital*

In the 2018/19 financial year, the CMS had a total operating budget of R164.9 million. This was made up of levy income of R144.2 million (87.5%) received from the 3 992 102 principal medical scheme members, a grant from the National Department of Health of R5.8 million (3.5%), as well as accreditation and registration fees of R7.5 million (4.6%) from entities regulated by the CMS. Part F (Financial Information) and Part E (Human Resource Management) of this report provide detailed information on how these resources were transformed to carry out the mandate of the CMS in regulating an industry with aggregated reserves of R66.4 billion and an annual gross contribution collection of R192.3 billion (2018).

### *Human capital*

The total staff complement of the CMS was 118 by the end of the financial year. This is a skilled and competent workforce comprising 21 officials with Master's or PhD degrees; 24 officials with Honour's degrees and 22 officials with Bachelor's degrees. The organisation moved to fill several key positions including those of General Managers for the Research and Monitoring and Stakeholder Relations Units, bringing about the necessary operational stability. Additionally, the CMS improved its Employment Equity targets by a significant 16.59% during the year under review. The development and execution of an Implementation Plan, based on the recommendations of a diagnostic exercise conducted by Council, will improve organisational effectiveness and efficiency, significantly.

### *Intellectual capital*

The CMS' intellectual capital continues to rest mainly in its human resources, stakeholder relationships, and its facilities. Collectively, the high-quality skilled CMS personnel possess an aggregated work experience of over 100 years. The organisation, through its systems and operational templates developed over the years, continues to act as a repository of valuable industry data which is collected, analysed and reported on, on an ongoing basis. Working together with stakeholders and strategic partners, the CMS was involved in several key industry strategic projects during the year under review, including: the development of a Framework for Standardisation of Option, the development of a Framework for the Consolidation of Schemes with <6 000 members, the Risk-based Capital Solvency Framework, the Prescribed Minimum Benefit Review Project, the Beneficiary Registry, as well as the provision of inputs to health market inquiries.

### *Manufactured capital*

As at 31 March 2019, the CMS had a total asset value of R18.2 million, up from R15.9 million in 2017/18. An amount of R11.4 million was spent on the lease of the building currently occupied by the CMS, in Centurion.

### *Natural capital*

The CMS continued on its energy-saving trajectory. The ongoing practice of virtualising servers rather than utilising physical nodes assisted the organisation to maintain a low carbon footprint level during the year under review.

## Social and stakeholder capital

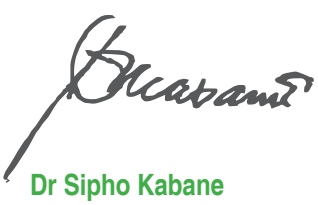
### *Social responsibility*

As a responsible corporate citizen, the CMS commemorated Nelson Mandela Day by giving back to some of the communities within which the organisation operates. This included the donation of groceries to the Rock of Hope Place of Safety, the St. Michaels and All Angels Church, the Indaba Zosindiso Orphanage, as well as school uniforms to underprivileged pupils from the Olievenhoutbosch Primary School in Pretoria.

### *Engagement with stakeholders*

In line with its objective to prioritise stakeholder engagement and as part of discharging its supervisory oversight mandate, the CMS embarked on several engagements with stakeholders across the industry. A total of 47 one-on-one visits to schemes and other regulated entities was conducted as part of road shows for medical schemes, spearheaded by the Chairperson of Council and coordinated by the office of the Registrar. A total of five broker training sessions was conducted with 141 trainees. In addition, no less than 20 radio and television interviews were granted, reaching an aggregated audience of 2 million.

The CMS achieved 85% of the objectives that it had set for itself for this financial year and has retained its record, with 18 unqualified audit outcomes now in a row. CMS staff and management have done a sterling job in ensuring that the CMS tree continues to bear fruit – and for that I am grateful.

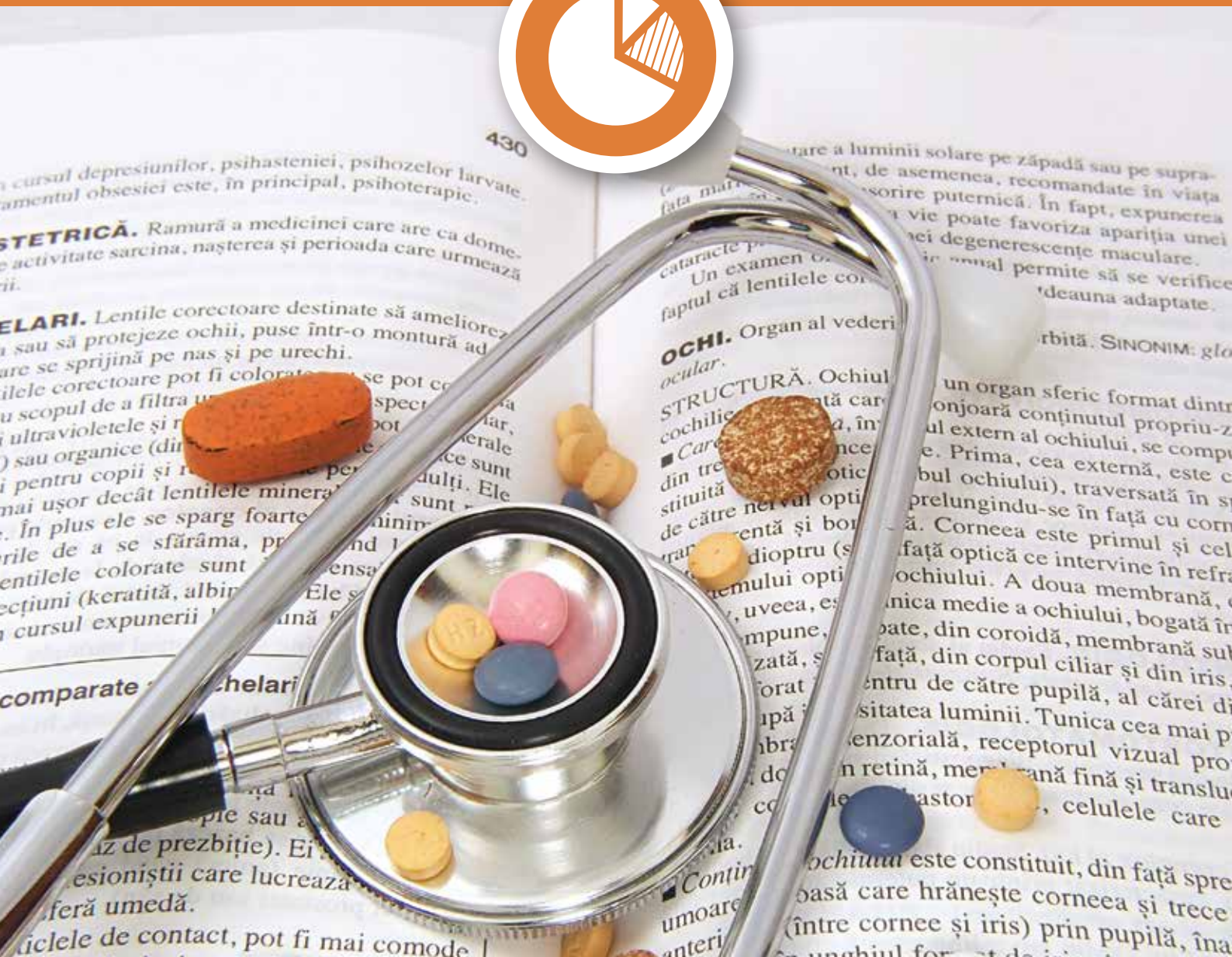


**Dr Sipho Kabane**

*Chief Executive and Registrar*

31 May 2019

# PART B:
## PERFORMANCE INFORMATION



# STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

## FOR THE YEAR ENDED 31 MARCH 2019

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

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

In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned objectives, indicators and targets which are set out in the Strategic Plan and Annual Performance Plan of the CMS for the financial year ended 31 March 2019.

The performance information of the CMS for the financial year ended 31 March 2019 has been audited by the Auditor-General of South Africa. This information, as contained on pages 28 to 53, has also been approved by Council, which is the Accounting Authority of the CMS.

**Dr Sipho Kabane**

*Chief Executive and Registrar*
Council for Medical Schemes
Date: 31 July 2019

# PERFORMANCE OVERVIEW

The CMS has achieved 98% of targets set in the Annual Performance Plan 2018/19, with 18% of the targets being partially achieved. The Financial Supervision Unit had an indicator that did not materialise during the period under review and therefore it is recorded as not applicable (2%).

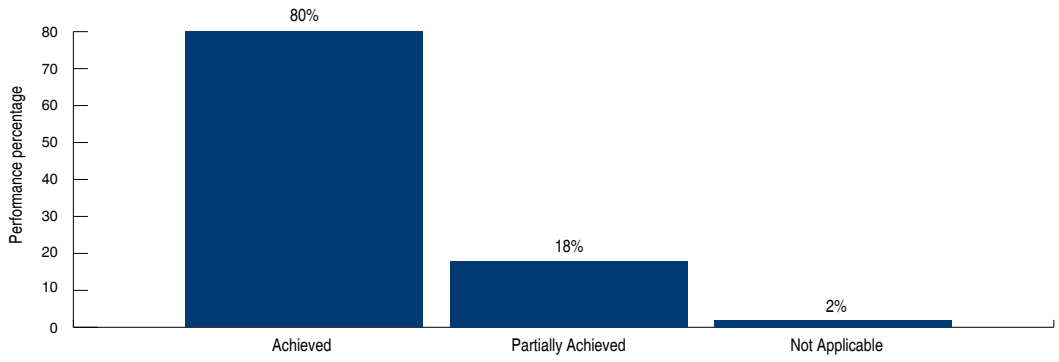



Figure 2: Overview of CMS performance

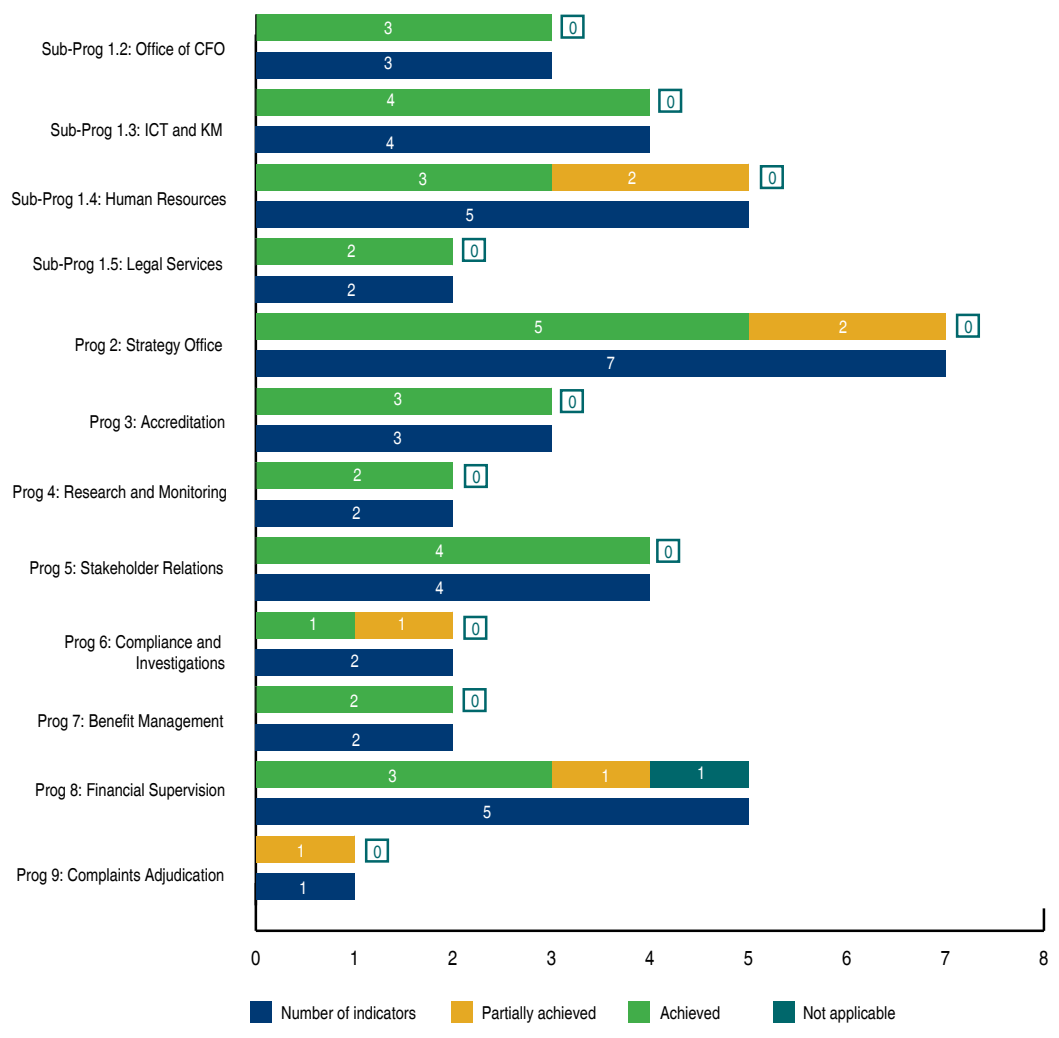



Figure 3: Annual performance information 2018/19: Overview per programme

# PERFORMANCE BY PROGRAMME

## Programme 1: Administration

The administrative programmes of the Council for Medical Schemes are effectively focused on the efficient functioning of the office and provide support to the core programmes to efficiently carry out their mandates. The programme is made up of five sub-programmes.

### *Sub-Programme 1.1: Office of the Chief Executive and Registrar*

The Chief Executive and Registrar is the executive officer of the CMS, mandated to exercise overall management of the office and, as Registrar, to exercise legislated powers to regulate medical schemes, administrators, brokers, and managed care organisations.

**Linking performance with budget**

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Sub-programme 1.1 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| General administrative expenses | - | - | - | 4 | - | 4 |
| Printing and stationery | 50 | 45 | 5 | 47 | 17 | 30 |
| Refreshments | 2 | 1 | 1 | 1 | - | 1 |
| Subscriptions | - | 4 | (4) | - | 2 | (2) |
| | 52 | 50 | 2 | 52 | 19 | 33 |
| **Operating expenses** | | | | | | |
| Committee remuneration | 90 | 128 | (38) | 197 | 152 | 45 |
| Consulting | 1 919 | 1 480 | 439 | 1 414 | 421 | 993 |
| Council member fees | 2 818 | 3 530 | (712) | 1 595 | 1 302 | 293 |
| Labour relations costs | 2 000 | 1 780 | 220 | 5 000 | 6 618 | (1 618) |
| Postage and courier | 68 | 66 | 2 | 64 | 64 | - |
| Transcription services | 113 | 223 | (110) | 82 | 148 | (66) |
| Travel and subsistence | 1 105 | 1 495 | (390) | 553 | 1 223 | (670) |
| Travel and subsistence (International) | - | - | - | 224 | - | 224 |
| Venue and catering | 485 | 747 | (262) | 278 | 377 | (99) |
| | 8 598 | 9 449 | (851) | 9 407 | 10 305 | (898) |
| **Staff costs** | | | | | | |
| Salaries | 4 584 | 2 347 | 2 237 | 6 136 | 1 932 | 4 204 |
| Staff training | 349 | 405 | (56) | 231 | 83 | 148 |
| | 4 933 | 2 752 | 2 181 | 6 367 | 2 015 | 4 352 |
| **Total** | **13 583** | **12 251** | **1 332** | **15 826** | **12 339** | **3 487** |

*Sub-Programme 1.2: Office of the CFO*

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

**Key performance indicators, planned targets and actual achievements**

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 1.2.1: Ensure effective financial management and alignment of budget allocation with strategic priorities** | | | | | | | | |
| **1.2.1.1** | An unqualified opinion issued by the Auditor-General on the annual financial statements by 31 July each year | 1 | 1 | 1 | 1 | 1 | - | CMS received an unqualified opinion on its annual financial statements for 2017/18. |
| **1.2.1.2** | Produce an annual performance information report that is reliable, accurate and complete by 31 July each year | 1 | 1 | 1 | 1 | 1 | - | CMS annual performance information report that was reliable, accurate and complete for 2017/18. |
| **Strategic Objective 1.2.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS** | | | | | | | | |
| **1.2.2.1** | Number of strategic risk register reports submitted to Council for monitoring, per year | 4 | 4 | 4 | 4 | 4 | - | Strategic risks were monitored during the year by Council. |

**Achievement of strategic objectives**

The CMS manages its finances under the direction of the Public Finance Management Act, No. 1 of 1999 (PFMA). Controls that the CMS has put in place for effective and efficient management of its finances need further improvement, especially in the area of Supply Chain Management. The Audit and Risk Committee met quarterly to provide the necessary oversight function to the CMS. The committee approved a three-year internal audit rolling plan during the year under review.

A strategic risk assessment workshop was held during the year with members of Council, the Audit and Risk Committee, and CMS management. Strategic risks were monitored by all governance structures. The CMS submitted its Annual Performance Plan for the 2018/19 financial year on 31 January 2018. Approval from the Executive Authority was received for the plans and budget for 2018/19.

Three tenders were awarded in accordance with National Treasury regulations during the year.

### Strategy to overcome areas of under-performance

There were no areas of under-performance in the sub-programme.

### Changes to planned targets

There were no changes to planned targets for the sub-programme during the year under review.

### Linking performance with budget

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Sub-programme 1.2 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Bank charges | 123 | 112 | 11 | 138 | 117 | 21 |
| Building expenses | 2 052 | 1 813 | 239 | 2 083 | 1 920 | 163 |
| General administrative expenses | 216 | 199 | 17 | 244 | 272 | (28) |
| Insurance | 530 | 523 | 7 | 454 | 481 | (27) |
| Printing and stationery | 194 | 185 | 9 | 264 | 236 | 28 |
| Refreshments | 83 | 84 | (1) | 3 | - | 3 |
| Rent | 11 375 | 11 690 | (315) | 11 527 | 11 625 | (98) |
| Rent: Operating expense | 2 320 | 2 341 | (21) | 2 138 | 2 138 | - |
| Subscriptions | 23 | 18 | 5 | 20 | 24 | (4) |
| | 16 916 | 16 965 | (49) | 16 871 | 16 813 | 58 |
| **Audit remuneration** | | | | | | |
| External audit | 900 | 740 | 160 | 886 | 697 | 189 |
| Internal audit | 1 305 | 1 873 | (568) | 700 | 779 | (79) |
| | 2 205 | 2 613 | (408) | 1 586 | 1 476 | 110 |
| **Operating expenses** | | | | | | |
| Consulting | 156 | 399 | (243) | 195 | 203 | (8) |
| Postage and courier | 44 | 14 | 30 | 42 | 3 | 39 |
| Travel and subsistence | 30 | 47 | (17) | 36 | 33 | 3 |
| Venue and catering | 35 | 104 | (69) | 35 | 65 | (30) |
| | 265 | 564 | (299) | 308 | 304 | 4 |
| **Staff costs** | | | | | | |
| Employee benefits | 2 686 | 2 846 | (160) | 2 238 | 2 405 | (167) |
| Salaries | 10 419 | 10 863 | (444) | 9 540 | 9 565 | (25) |
| Staff training | 400 | 283 | 117 | 71 | 95 | (24) |
| Workmen's compensation | 170 | 170 | - | 160 | 160 | - |
| | 13 675 | 14 162 | (487) | 12 009 | 12 225 | (216) |
| **Total** | **33 061** | **34 304** | **(1 243)** | **30 774** | **30 818** | **(44)** |

*Sub-programme 1.3: Information and Communication Technology (ICT) and Knowledge Management (KM)*

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

**Key performance indicators, planned targets and actual achievements**

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 1.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected** | | | | | | | | |
| **1.3.1.1** | Percentage of network and server uptime, per year | 99.5% | 99.7% | 99.45% | 99% | 99.41% | 0.41% | The unit was able to maintain its network and server uptimes above its set target. |
| **1.3.1.2** | Percentage of IT security incidents, per year | New indicator | 1.1% | 0.27% | 0% | 0% | - | - |
| **Strategic Objective 1.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance** | | | | | | | | |
| **1.3.2.1** | Percentage of uptime, of all installed application systems where network access exists, per year | 99% | 99.7% | 99.47% | 99% | 100% | 1% | The unit was able to maintain a 100% uptime for all application systems. |
| **Strategic Objective 1.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing** | | | | | | | | |
| **1.3.2.1** | Percentage of physical requests for information received and finalised within 30 days, per year | 350 | 98% (244/249) | 97.5% | 90% | 98.5% | 8.5% | The unit was able to exceed on its response time for request for information received. |

**Achievement of strategic objectives**

The year under review saw the unit exceeding all its planned annual targets, despite facing several challenges. In as far as ensuring an established ICT infrastructure is concerned, the sub-unit tasked with this strategic objective, focused on strengthening the CMS' cybersecurity readiness by conducting an external penetration test as well as an internal vulnerability assessment and implementing measures to overcome weaknesses identified. The sub-unit furthermore implemented encryption on all user machines and commenced with enrolment of all devices on the Microsoft Office 365 Device Management portal. As a result, no security incidents occurred during the reporting period. The sub-unit also invested in an additional physical server and switching hardware to strengthen its existing virtualised server environment and thus provide a stable hosting environment for the different application systems in use. Minor network connection issues were encountered in the third quarter of the year, as part of a project to change over from one internet service provider to another. To avoid a recurrence, any future changeovers will be performed with an existing Internet Service Provider uplink in place. A Hot Site for IT Disaster Recovery has yet to be established, because local developments such as the Microsoft Disaster Recovery as a Service (DRSaaS) made the specifications and solutions proposed in the tender documentation obsolete and non-cost effective. Going forward, the CMS will leverage its existing licensing and services model with Microsoft to enable a DRSaaS solution which will present a more cost-effective solution to the more traditional solutions proposed to date.

The Software Development Sub-Unit achieved 100% uptime for all its installed application systems where network access existed. This can be ascribed mainly to changes in the software development methods, where smaller parts of the development work are undertaken and performed better than before. This has resulted in a more stable application systems environment which is less prone to errors or 'bugs'. The sub-unit furthermore embarked on a pilot project with the Government Employees Medical Scheme (GEMS) on the beneficiary registry, and valuable lessons have been learnt in the process. Where strategic software development projects are concerned, the Single Exit Price System, which the CMS is developing for the NDoH, is still under development and although good progress has been made, it is running behind schedule. To ensure that the project is finalised, the CMS will appoint a dedicated resource to oversee its completion by the end of the 2019/20 financial year. The development of the National Beneficiary Registry has progressed steadily and the pilot project with GEMS has proven very productive and will form the basis for engaging with other schemes to participate on a voluntary basis.

The Knowledge Management Sub-Unit exceeded its planned annual target by 8.5%. This was mainly due to the availability of records online which improved response times, as retrieval online is much quicker than having to request the CMS' off site storage provider to deliver, which may sometimes take days. Improved working relations with some units, specifically the Legal Unit in terms of responding to more complex requests for information, have given the sub-unit more leverage, and thus improved the response time. The sub-unit furthermore finalised the digitisation of all paper-based records stored with the storage provider, thus ensuring that all records stored since the inception of the CMS can now be searched and retrieved electronically on the electronic document management system.

### Strategy to overcome areas of under-performance

There were no areas of under-performance in the sub-programme during the year under review.

### Changes to planned targets

There were no changes to planned target for the sub-programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Sub-programme 1.3 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| General administrative expenses | 579 | 654 | (75) | 714 | 543 | 171 |
| Printing and stationery | 18 | 13 | 5 | 13 | 13 | - |
| Refreshments | 2 | - | 2 | 4 | - | 4 |
| Rent: Copiers | 399 | 401 | (2) | 424 | 396 | 28 |
| Security | 464 | 409 | 55 | 602 | 362 | 240 |
| Subscriptions | 13 | 13 | - | - | 14 | (14) |
| Telecommunication expenses | 6 715 | 5 146 | 1 569 | 6 558 | 4 434 | 2 124 |
| | 8 190 | 6 636 | 1 554 | 8 315 | 5 762 | 2 553 |
| **Operating expenses** | | | | | | |
| Consulting | 230 | 184 | 46 | 254 | 89 | 165 |
| Knowledge management | 981 | 1 497 | (516) | 776 | 940 | (164) |
| Travel and subsistence | 75 | 89 | (14) | 42 | 37 | 5 |
| Venue and catering | 10 | 11 | (1) | 12 | 13 | (1) |
| | 1 296 | 1 781 | (485) | 1 084 | 1 079 | 5 |
| **Staff costs** | | | | | | |
| Salaries | 11 956 | 11 426 | 530 | 10 705 | 9 866 | 839 |
| SEP system expenses | - | 229 | (229) | - | 468 | (468) |
| Staff training | 170 | 139 | 31 | 163 | 177 | (14) |
| | 12 126 | 11 794 | 332 | 10 868 | 10 511 | 357 |
| **Total** | **21 612** | **20 211** | **1 401** | **20 267** | **17 352** | **2 915** |

*Sub-programme 1.4: Human Resources Management*

The purpose of the sub-programme is to provide a high quality service to internal and external customers by assessing their needs and proactively addressing those needs by developing, delivering, and continuously improving human resources programmes that promote and support the CMS mission. This service is fulfilled with professionalism, integrity, and responsiveness by:

- Treating all customers with respect;
- Providing resourceful, courteous, and effective customer service;
- Promoting teamwork, open and clear communication, and collaboration; and
- Demonstrating creativity, initiative, and optimism.

In so doing, the CMS administration and staff are supported with human resources (HR) management advice and assistance, enabling them to make decisions that maximise the most important asset of the CMS, its people. The unit continues working towards ensuring that the CMS remains an employer of choice.

**Key performance indicators, planned targets and actual achievements**

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic objective 1.4.1: Build competencies and retain skilled employees** | | | | | | | | |
| **1.4.1.1** | Minimise staff turnover rate to less than 10% per annum | 9% | 4.42% | 7.1% | <10% | 4.48% | 5.52% | CMS was able to maintain is staff turnover rate at less than 10%. |
| **1.4.1.2** | Turnaround time to fill a vacancy (Turnaround time of 120 working days to fill a vacancy that exists during the year), excluding position of CEO | There were 3 out of 9 positions that took longer than the 90 days to fill | There were 5 out of 14 positions that took longer than the 90 days to fill | There were 16 vacancies during the period, 12 were filled within 120 days, one took longer than the 120 days to fill and the recruitment process was underway for 3 | 120 days | There were 14 vacancies during the period, 9 were filled within 120 days, 3 took longer than 120 days and the recruitment process was underway for 2 | 3 took longer than 120 days to fill | The position of General Manager Research and Monitoring was delayed due to a labour dispute. The appointment of the General Manager: Stakeholder Relations was delayed as the incumbent needed to serve two months' notice. The position of Junior Developer was converted to Help Desk Technician as per ICT operational requirements which led to a delay in the filling of the vacancy. |
| **1.4.1.3** | Achievement of Employment equity targets (according to EE targets), annually | 94% | 91.45% | 79.82% | 85% | 97.12% | 12.12% | The unit exceeded on its Employment Equity targets. |

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 1.4.2: Maximise performance to improve organisational efficiency and maintain high performance culture** | | | | | | | | |
| **1.4.2.1** | 100% of employee performance agreements are signed by no later than 31 May of each year | New indicator | 100% | 86% | 100% | 100% | - | - |
| **1.4.2.2** | Percentage of employee performance assessment concluded, bi-annually* | New indicator | 100% | 100% | 100% | 93.97% | -6.03% | Seven employees' assessments could not be concluded due to incapacity, resignations and disputes. |

### Achievement of strategic objectives

A permanent Registrar was appointed bringing much-needed stability to the organisation. Several members of the executive team underwent business and organisational coaching initiatives to equip them to coach teams and with self-development. The CMS was able to maintain a staff turnover rate well below the industry average of approximately 10%. This can be attributed to initiatives taken to improve and address staff concerns regarding benefits. A major exercise is currently under way to review the existing remuneration model and performance system. Broad consultation was undertaken to ensure that the views of staff and managers were taken into account.

A further contributory factor to improved staff turnover has resulted from ensuring that the unit provides a stable and conducive work environment by dealing with employee relations matters in a manner that is not disruptive to the workplace. Labour disputes have been dealt with timeously and effectively with the result that, so far, all matters referred to the Commission for Conciliation, Mediation and Arbitration (CCMA) and concluded have been ruled in favour of the CMS. In addition, Executives and Managers have been trained on how to initiate and chair disciplinary cases, thereby empowering them to deal with labour matters in an informed manner.

Having in-sourced cleaning staff in the previous financial year, the CMS has made provision to fully subsidise their medical schemes, thereby fulfilling a key objective of being an employer of choice.

In line with the CMS' philosophy of lifelong learning, employees benefited from a range of professional development and skills training. Recognising the need to extend skills development to those members of the cleaning staff who do not have a matric qualification, the CMS registered them for Adult Basic Education Training (ABET). Cleaning staff members who already had a matric certificate were registered for tertiary education, with the result that the Cleaning Supervisor is currently registered for a Bachelor's degree in Industrial Psychology, paid for by the CMS.

### Strategy to overcome areas of under-performance

Delays in recruitment placements outside of the 120-day target were due to factors beyond the control of the unit. Three positions were affected:

- General Manager: Research and Monitoring – The delay in filling this position was due to a labour dispute flowing from disciplinary action taken against the previous GM.
- General Manager: Stakeholder Relations – The filling of this position was delayed due to the appointee needing to serve out a notice period longer than one calendar month, in line with the appointee's position and contractual obligation to their employer.
- Help Desk Technician: The filling of this position was delayed due to a change in the requirements by the ICT Unit. The position first advertised was for a Junior Developer. However, due to operational requirements, an urgent need was identified by the ICT Unit for a Help Desk technician, and this position was then given priority.

Appraisal of 93.97% of the CMS' employees was successfully undertaken; however the balance of 6.03% could not be concluded due to dismissal, early retirement, resignation, suspension and/or termination.

### Changes to planned targets

There were no changes to planned targets for the sub-programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Sub-programme 1.4 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| General administrative expenses | 98 | 104 | (6) | 103 | 56 | 47 |
| Printing and stationery | 22 | 22 | - | 21 | 15 | 6 |
| Refreshments | - | - | - | 132 | 76 | 56 |
| Subscriptions | 206 | 164 | 42 | 149 | 162 | (13) |
| **Operating expenses** | | | | | | |
| Consulting | 990 | 798 | 192 | 947 | 568 | 379 |
| Transcription services | - | 4 | (4) | - | 11 | (11) |
| Travel and subsistence | 27 | 34 | (7) | 22 | 24 | (2) |
| Venue and catering | 157 | 102 | 55 | 167 | 118 | 49 |
| | 1 174 | 938 | 236 | 1 136 | 721 | 415 |
| **Staff costs** | | | | | | |
| Employee wellness | 318 | 270 | 48 | 654 | 379 | 275 |
| Recruitment and relocation | 831 | 1 009 | (178) | 415 | 308 | 107 |
| Salaries | 4 891 | 5 114 | (223) | 4 620 | 4 923 | (303) |
| Staff training | 105 | 225 | (120) | 86 | 53 | 33 |
| Temporary staff | 3 242 | 2 716 | 526 | 666 | 791 | (125) |
| | 9 387 | 9 334 | 53 | 6 441 | 6 454 | (13) |
| **Total** | **10 887** | **10 562** | **325** | **7 982** | **7 484** | **498** |

*Sub-programme 1.5: Legal Services*

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

**Key performance indicators, planned targets and actual achievements**

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office** | | | | | | | | |
| **1.5.3.1** | Number of written and verbal legal opinions provided to internal and external stakeholders, per year | 205 | 100% (175) | 267 | 200 | 279 | 79 | The unit received more requests for verbal and written legal opinion than was initially estimated. |
| **Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar** | | | | | | | | |
| **1.5.3.2** | Percentage of court and tribunal appearances in legal matters received and handled by the unit, per year | 21 | 100% (25) | 100% (17) | 100% | 100% | - | - |



**Achievement of strategic objectives**

The unit successfully provided high quality legal opinions on a range of issues, not limited to the Medical Schemes Act. The unit received a large volume of legal enquiries from members, schemes, administrators and brokers for the provision of both verbal and written legal opinions relating to the application of Section 59 of the Act, termination of membership due to non-disclosure and the scheme's refusal to re-enrol such members upon request, as well as legal positions relating to change of scheme name, amongst others. These high volumes of queries contributed to the high numbers of verbal and written opinion provided.

The unit has noted the publication of the Medical Schemes Amendment Bill and is engaging as part of the CMS response process, in providing constructive legal advice. The implications of the Medical Schemes Amendment Bill, as published by the NDoH, pose a significant risk to the continued, effective regulation of the industry. The unit successfully collated all the comments provided by the different business units for submission.

There has been significant interaction with the Financial Sector Conduct Authority (FSCA), the Prudential Authority and National Treasury on the various amendments to the financial services legislation, notably the FSR Act and the COFI Bill, and how these impact the CMS. The challenge for the CMS has been the lack of proper engagement and consultation from other stakeholders pertinent to the promulgation of these two pieces of legislation.

In the matter of CMS vs Hosmed, the CMS brought an urgent application in the Pretoria High Court (Gauteng Division) to postpone Hosmed's Annual General Meeting (AGM), which was scheduled to take place on 20 September 2018, to the date of a duly notified and convened AGM. The court granted the application in favour of the CMS. This was crucial for the CMS to curb fraudulent and unlawful allegations from occurring against the scheme.

In the matter of Parson vs CMS, the appellant was a former member of the Board of Trustees of Medshield and brought an appeal against the decision of the Council to remove him in terms of Section 46. The Appeal Board heard the matter and issued a ruling confirming the decision of the CMS in August 2018. The Appeal Board agreed with the CMS that the trustee was required to disclose two adverse court judgments against him when he participated in the election process, but that he had failed to do so. This decision to remove was necessitated to ensure that medical schemes are led by fit and proper individuals who, in terms of their integrity, are beyond reproach.

In the case of CMS vs Ms Khosana, the CMS filed an application with the Western Cape High Court to have Ms Khosana removed as provisional curator of SAMWUMED. This application was precipitated because of information received which indicated that several corporate governance matters were threatening the survival of the scheme. Further, the CMS launched this application because of ongoing failure by the curator to respect the financial controls, policies and procedures of the scheme. In order to protect the funds of the scheme and its members, the CMS launched this application which was accepted by the court and the said provisional curator was replaced with a different curator due to the overwhelming evidence presented by the CMS. This judgment made the point that a curator is an extension of the Registrar and if the Registrar is of the view that a curator is not furthering the interest of the scheme, the Registrar is entitled to remove such a curator.

There was great support amongst team members in the unit and this enabled the unit to deliver on all its legal projects in alignment with the unit's strategic objectives. The unit applied a consistent and robust methodology and this enabled flexibility and robust performance on all legal projects.

### Strategy to overcome areas of under-performance

There were no areas of under-performance in the sub-programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the sub-programme during the year under review.



### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Sub-programme 1.5 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 10 | - | 10 | 5 | 4 | 1 |
| Refreshments | 2 | - | 2 | 1 | - | 1 |
| Subscriptions | 4 | 3 | 1 | 4 | 3 | 1 |
| | 16 | 3 | 13 | 10 | 7 | 3 |
| **Operating expenses** | | | | | | |
| Legal fees | 8 665 | 6 022 | 2 643 | 8 496 | 8 604 | (108) |
| Travel and subsistence | 93 | 83 | 10 | 31 | 33 | (2) |
| Venue and catering | 4 | 2 | 2 | 4 | 2 | 2 |
| | 8 762 | 6 107 | 2 655 | 8 531 | 8 639 | (108) |
| **Staff costs** | | | | | | |
| Salaries | 4 360 | 4 489 | (129) | 4 041 | 3 939 | 102 |
| Staff training | 115 | 108 | 7 | 83 | 69 | 14 |
| | 4 475 | 4 597 | (122) | 4 124 | 4 008 | 116 |
| **Total** | **13 253** | **10 707** | **2 546** | **12 665** | **12 654** | **11** |

## Programme 2: Strategy Office

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

### Key performance indicators planned targets and actual achievements

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 2.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected** | | | | | | | | |
| **2.1.1** | The number of benefit definitions published, per year | 12 | 10 CMS scripts 7 PMB definitions | 10 | 10 | 10 | - | - |
| **2.1.2** | Conduct a review of the prescribed minimum benefits (PMB), every two years | New indicator | New indicator | Draft costed PMB benefit package completed but not submitted to Council | 1.Submit final costed PMB benefit package to the Executive Authority 2.Once approved publish new regulations and code of conduct | A service based Preventa-tive and Primary Healthcare package and costing meth-odology report was submitted to the Executive Authority | A final costed PMB benefit package was not submitted to the Executive Authority | The service-based Preventative and Primary Healthcare package and costing methodology report was submitted to the Executive Authority, this is one of the milestones in the PMB Review process. |
| **Strategic Objective 2.2: Provide clinical opinions to resolve complaints and enquiries** | | | | | | | | |
| **2.2.1** | Percentage of category 1* clinical opinions provided within 30 working days of receipt from Complaints Adjudication | 938 | 40% | 98% | 90% | 54% | -36% | Due to increased volumes of referrals from the Complaints Adjudication Unit to the Clinical Unit, there was an increased referral work load. |
| **2.2.2** | Percentage of category 2* clinical opinions provided within 60 working days of receipt from Complaints Adjudication | New indicator | New indicator | 100% | 95% | 99% | 4% | The unit was able to provide category 2 clinical opinions within the set timeframes more efficiently. |

* *Category 1 clinical opinion will be an uncomplicated clinical opinion that will be expected to be analysed and 90% expected to be completed within 30 working days of referral/receipt from the complaints adjudication unit.*

* *Category 2 clinical opinion will be a more complex clinical opinion compared to a category 1 requiring more in-depth analysis and time less than 60 working days for full completion.*

* *Category 3 will be allocated to a clinical opinion of a very complex nature requiring extensive inputs, additional documentations and research. These will require experts/specialist consultation before a conclusion can be reached. 100% of clinical opinions of this nature will be aimed for completion within 90 days of receipt from the Complaints adjudication unit*

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **2.2.3** | Percentage of category 3* clinical opinions provided within 90 working days of receipt from Complaints Adjudication | New indicator | New indicator | 100% | 98% | 100% | 2% | The unit was able to provide category 3 clinical opinions within the set timeframes more efficiently. |
| **2.2.4** | Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days | New indicator | 99% | 99% | 96% | 98% | 2% | The unit was able to deal with enquiries within the set timeframes more efficiently. |
| **Strategic Objective 2.3: Conduct research to inform appropriate national health policy interventions** | | | | | | | | |
| **2.3.1** | Number of research projects and support projects published in support of the National Health Policy, per year | New indicator | New indicator | 11 | 5 | 11 | 6 | The unit received additional requests for research and support projects. |



### Achievement of strategic objectives

The unit undertook a variety of strategic projects during the 2018/19 financial year. The PMB Review was the flagship of these projects. The unit was able to develop a service-based Preventative and Primary Healthcare package for inclusion as the foundation of a future PMB package. This is to meet the healthcare needs of the country, address the changing pattern of diseases as well as address the hospi-centric and expensive nature of the current PMB package. The current diagnosis-driven PMBs are discriminatory in nature hence the decision to transit the future PMBs to service-based PMBs.

The PMB benefit definitions continue to define detailed funding and clinically appropriate guidelines for PMB diagnoses. These guidelines target high financial impact conditions as well as those that affect vulnerable groups of the population. Strategic prospective initiatives that were aimed at influencing healthcare policy were undertaken during the year. These include discussion documents on the Low-cost Benefit Option, Schemes Consolidation Framework, and the Benefit Option Simplification Project in conjunction with the Research and Monitoring Unit and the Office of the Senior Strategist.

The unit dealt with an increased volume of complaints that required clinical opinions in their resolution. These clinical matters had become increasingly complex and contentious in nature, requiring that some were followed up to the Appeals Committee stage. Most of these cases involve high financial and quality of life impacting conditions as well as emerging sophisticated healthcare technologies.

### Strategy to overcome areas of under-performance

The Clinical Units underperformed in resolving clinical opinions in less than 30 working days, owing to an increased volume of referrals from the Complaints Adjudication Unit following the deployment of additional resources to deal with the unit's backlog. A turnaround strategy was implemented, with temporary clinical analysts appointed. Improved results are expected in quarter one of the 2019/20 financial year.

The PMB Review Project was partially achieved as stakeholders' involvement and push back delayed the process. The project involves a major policy development process which requires the inputs and consensus of a variety of stakeholders with divergent interests that are often not aligned. The PMB Review Project has now been planned in a phased manner with:

- Phase 1: The development of a Preventative and Primary Healthcare package and a costing methodology – 2018/19;
- Phase 2: The development of the rest of the package – 2019/20; and
- Phase 3: Finalisation, approval by the executive authority, implementation and monitoring of the revised PMB package – 2020/22.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 2 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 12 | 7 | 5 | 7 | 9 | (2) |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| Subscriptions | 17 | 19 | (2) | - | 14 | (14) |
| | 31 | 26 | 5 | 10 | 23 | (13) |
| **Operating expenses** | | | | | | |
| Consulting | 928 | 2 107 | (1 179) | 875 | 1 070 | (195) |
| Travel and subsistence | 250 | 496 | (246) | 208 | 172 | 36 |
| Venue and catering | 66 | 268 | (202) | 60 | 81 | (21) |
| | 1 244 | 2 871 | (1 627) | 1 143 | 1 323 | (180) |
| **Staff costs** | | | | | | |
| Salaries | 9 825 | 10 654 | (829) | 9 103 | 10 017 | (914) |
| Staff training | 131 | 150 | (19) | 101 | 100 | 1 |
| | 9 956 | 10 804 | (848) | 9 204 | 10 117 | (913) |
| **Total** | **11 231** | **13 701** | **(2 470)** | **10 357** | **11 463** | **(1 106)** |

## Programme 3: Accreditation

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

### Key performance indicators, planned targets and actual achievements

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 3.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services** | | | | | | | | |
| **3.1.1** | Number of brokers and broker organisations accredited on receipt of complete applications and relevant information, per year | 5 634 | 4 854 | 5 500 | 4 980 | 5 030 | 50 | The unit received more applications than anticipated. |
| **Strategic Objective 3.2: Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined** | | | | | | | | |
| **3.2.1** | Number of managed care organisation applications accredited within 3 months of receipt of all relevant information | 16 | 21 | 15 | 25 | 22 | -3 | Three organisations did not renew their accreditation during the year. |
| **Strategic Objective 3.3: Accredit Administrators and issue Compliance Certificates to Self-administered schemes based on their compliance with the accreditation requirements in order to provide administration services** | | | | | | | | |
| **3.3.1** | Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information | 13 | 14 | 6 | 14 | 14 | - | - |

### Achievement of strategic objectives

On-site evaluations of managed care organisations were conducted, to verify information based on actual findings. This played an important role in assessing compliance of accredited entities with standards and requirements. The process, together with experience over time, also enabled the unit to prepare a revised and improved set of standards for accreditation. These will be introduced in the near future in respect of administrators, as well as self-administered medical schemes which render such services within their own infrastructure. The unit continues to monitor the financial soundness of risk-bearing entities which contract with medical schemes in terms of prepaid capitation fees paid based on their annual financial statements, to ensure their financial soundness. Work has similarly commenced on an analysis of organisations contracting with medical schemes based on alternative reimbursement structures, to assess the need to accredit such entities.

The unit planned to evaluate 25 applications inclusive of likely new ones applying for the first time. Three organisations which were previously accredited opted not to renew their accreditation and were accordingly not evaluated.

Similarly, on-site evaluations were also conducted of administrators and self-administered medical schemes, enabling the unit to prepare a revised and improved set of administration standards for accreditation, to be introduced in the near future.

The work done by the unit to publish a draft document for comment, regarding clarity on administration and non-healthcare expenditure, will contribute towards levelling the playing fields and comparing cost structures amongst medical schemes and contracting parties for services outsourced.

The unit ensured the verification of academic qualifications of individual brokers during the year and took action against a number of brokers who failed to meet the qualification criteria and who had previously submitted fraudulent proof of qualifications. A guide for the preparation of agreements between medical schemes and brokers or broker organisations was subsequently introduced. The unit also initiated an increase in the maximum amount to be paid by medical schemes to brokers, published by the Minister of Health in the Government Gazette. An advanced electronic system, to enable online payment of statutory fees with submission of applications for accreditation as brokers, will contribute to shorter turnaround times for accreditation and enable electronic certificates to be made available in a secure manner.

### Strategy to overcome areas of under-performance

There were no areas of under-performance in the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 3 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 30 | 22 | 8 | 35 | 28 | 7 |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| Subscriptions | 186 | 123 | 63 | 166 | 100 | 66 |
| | 218 | 145 | 73 | 204 | 128 | 76 |
| **Operating expenses** | | | | | | |
| Consulting | 150 | 102 | 48 | - | - | - |
| Travel and subsistence | 311 | 246 | 65 | 218 | 51 | 167 |
| Venue and catering | 10 | 7 | 3 | 73 | 25 | 48 |
| | 471 | 355 | 116 | 291 | 76 | 215 |
| **Staff costs** | | | | | | |
| Salaries | 8 936 | 8 445 | 491 | 8 427 | 9 032 | (605) |
| Staff training | 131 | 108 | 23 | 100 | 27 | 73 |
| | 9 067 | 8 553 | 514 | 8 527 | 9 059 | (532) |
| **Total** | **9 756** | **9 053** | **703** | **9 022** | **9 263** | **(241)** |

## Programme 4: Research and Monitoring

The purpose of the programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. This information enables the CMS to contribute to the development of policy that enhances the protection of the interests of beneficiaries and members of the public.

### Key performance indicators, planned targets and actual achievements

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 4.1: Conduct research to inform appropriate policy interventions** | | | | | | | | |
| **4.1.1** | Number of research projects and support projects finalised, per year | 10 | 10 | 9 | 8 | 14 | 6 | There were requirements during the year for additional projects. |
| **Strategic Objective 4.2: Monitoring trends to improve regulatory policy and practice** | | | | | | | | |
| **4.2.1** | Non-financial report submitted for inclusion in the annual report | 1 | 1 | 1 | 1 | 1 | - | - |

### Achievement of strategic objectives

The programme actively participated in the Health Market Inquiry and provided input to the National Health Insurance and Medical Schemes amendment bills. The Health Market Inquiry's provisional recommendations advocate increased transparency for medical scheme beneficiaries, through the reporting of healthcare indicators that measure the value of healthcare interventions. The unit concluded the very first industry-wide Patient Experience Survey Study. The study focused on how medical scheme beneficiaries experience disease management programmes (DMPs) for diabetes, and provided insight into the value of DMPs from the perspective of patients. One of the key findings was that DMPs for diabetes could certainly be improved in areas such as providing emotional support to the patient and providing support to build the self-confidence of the patient.

The unit continued to conduct research on scheme risk profiles, quality in medical schemes and chronic disease list (CDL) prevalence. This research allows schemes to understand and better manage their risk profiles. The CDL prevalence study showed an upward trend in the diagnosis and treatment of CDL conditions.

The unit also conducted research work on the value proposition of efficiency discount options (EDOs). EDOs allow for differentiated contributions within a benefit option by offering a discount to members who voluntarily choose to use more cost-efficient providers designated by the medical schemes. The intended beneficiaries of the discount are the group of beneficiaries with unfavourable health status, especially the elderly and sickly members. The key finding of the study was that savings achieved through EDO offerings are more likely attributable to the fact that they are attractive to young and healthy beneficiaries, rather than the supposed efficiency of these options.

A research study on Benefit Option Classification was conducted by the unit. The study finds itself relevantly consistent with the research questions that are being probed by the Health Market Inquiry investigation. The policy questions were whether benefit design premiums reflect the average utilisation on benefit options. In other words; are members able to predict their average utilisation, and thus choose the benefit option which optimally meets their healthcare needs? Further work in this research will include market segmentation surveys to fully understand medical scheme members' choice preferences. Finally, the unit conducted a stakeholder analysis from input received for the Draft Risk-based Capital (RBC) Solvency Framework that was published in 2015; the CMS will publish an updated framework in 2019. This will include technical detail of the calculations required and the implementation timelines/ strategy, enabling further and deeper engagement.

### Strategy to overcome areas of under-performance

There were no areas on under-performance in the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 4 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 9 | 3 | 6 | 3 | 3 | - |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| Subscriptions | 15 | 13 | 2 | 11 | 12 | (1) |
| | 26 | 16 | 10 | 17 | 15 | 2 |
| **Operating expenses** | | | | | | |
| Consulting | 141 | 207 | (66) | 94 | - | 94 |
| Travel and subsistence | 146 | 56 | 90 | 143 | 48 | 95 |
| Venue and catering | 29 | 14 | 15 | 28 | 3 | 25 |
| | 316 | 277 | 39 | 265 | 51 | 214 |
| **Staff costs** | | | | | | |
| Salaries | 6 864 | 5 929 | 935 | 6 517 | 6 261 | 256 |
| Staff training | 192 | 160 | 32 | 74 | 87 | (13) |
| | 7 056 | 6 089 | 967 | 6 591 | 6 348 | 243 |
| **Total** | **7 398** | **6 382** | **1 016** | **6 873** | **6 414** | **459** |

## Programme 5: Stakeholder Relations

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

### Key performance indicators, planned targets and actual achievements

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 5.1: Create awareness and provide training in order to enhance the visibility and reputation of CMS** | | | | | | | | |
| **5.1.1** | Percentage of member awareness of CMS resulted from survey, in alternate years | New indicator | 40.3% | n/a | 50% | 64% | 14% | The survey results show an increase in the awareness of CMS by members. |
| **5.1.2** | Number of stakeholder training and awareness sessions, per year | 46 | 55 | 59 | 45 | 85 | 40 | There was an increased number of invitations for information sessions received during the year. |
| **Strategic Objective 5.2: Communication and engagement to inform and empower stakeholders** | | | | | | | | |
| **5.2.1** | Submission of CMS Annual Report by 31 August to the Executive Authority | 1 | 1 | 1 | 1 | 1 | - | - |
| **5.2.2** | Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year | 94% | 97% | 93% | 75% | 89.7% | 14.7% | CMS achieved a total of 89.7% neutral and positive coverage from articles in the media. |

### Achievement of strategic objectives

The hosting of the Fraud, Waste and Abuse Summit from 28 February to 01 March 2019 generated significant media coverage, with a total Advertising Value Equivalent (AVE) of R5.7 million. The publicity generated during February and March 2019 (pre- and post-summit period) included coverage from Power FM, Radio 702, SAfm, Kaya FM, Cape Talk Radio, Channel Africa, SABC, City Press, Sowetan, The Star, Rapport, The Witness, Cape Argus, Daily Sun, and Daily News.

Education and Training offered a Health Professions' Council of South Africa (HPCSA) approved Continuing Professional Development (CPD) induction programme for newly appointed trustees. Institute of Directors of Southern Africa (IoDSA) and South African Institute of Chartered Accountants (SAICA) members could claim CPD points from this training. The sub-unit also engaged with stakeholders like the South African National Consumer Union (SANCU) on matters affecting consumers in general.

Advanced Broker Training was conducted in the Gauteng and Eastern Cape provinces. Delegates were awarded CPD points and points approved by the Financial Planning Institute (FPI).

For the first time, consumer education outreach engagements were conducted mostly in rural areas, with the aim of reaching more medical scheme beneficiaries, during World Consumer Rights month. The outreach programme was conducted in collaboration with Consumer Protection Forum (CPF) members in Mpumalanga, Northern Cape, Free State and the Eastern Cape, with widespread media coverage on community radio stations. Medical scheme members were informed about their rights, responsibilities and obligations. Members of schemes were empowered to make informed decisions.

The results of a Brand Awareness Study indicate that the level of awareness of the CMS ranges from extremely familiar to not at all familiar. With limited direct access to medical scheme beneficiaries, the CMS largely relies on the schemes themselves for the distribution of questionnaires to members. Only a certain percentage of participation from members can be achieved through this process. In response to the results of the study, the CMS will expand its activities during the new financial year to include more engagement with members and beneficiaries of medical schemes in order to improve their levels of brand awareness.

### Strategy to overcome areas of under-performance

There were no areas of under-performance for the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 5 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 13 | 17 | (4) | 12 | 11 | 1 |
| Subscriptions | 23 | 11 | 12 | 11 | 11 | - |
| | 36 | 28 | 8 | 23 | 22 | 1 |
| **Operating expenses** | | | | | | |
| Consulting | 328 | 92 | 236 | - | - | - |
| Exhibition costs | 112 | 103 | 9 | 100 | 38 | 62 |
| Media and promotion | 1 451 | 1606 | (155) | 1 032 | 3 434 | (2 402) |
| Postage and courier | - | 3 | (3) | 11 | 10 | 1 |
| Printing and publication | 812 | 979 | (167) | 820 | 878 | (58) |
| Travel and subsistence | 1 108 | 842 | 266 | 696 | 308 | 388 |
| Venue and catering | 1 650 | 1 875 | (225) | 318 | 340 | (22) |
| | 5 461 | 5 500 | (39) | 2 977 | 5 008 | (2 031) |
| **Staff costs** | | | | | | |
| Employee wellness | 2 | - | 2 | 7 | 8 | (1) |
| Salaries | 8 400 | 8 404 | (4) | 7 893 | 8 017 | (124) |
| Staff training | 144 | 114 | 30 | 115 | 75 | 40 |
| | 8 546 | 8 518 | 28 | 8 015 | 8 100 | (85) |
| **Total** | **14 043** | **14 046** | **(3)** | **11 015** | **13 130** | **(2 115)** |

## Programme 6: Compliance and Investigation

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

### Key performance indicators planned targets and actual achievements

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 6.2.1: Regulated entities comply with Legislation** | | | | | | | | |
| **6.2.1** | Percentage of non-compliance cases against regulated entities undertaken, per year | 82 | 100% (39) | 100% (72) | 100% | 92% | -8% | There were three matters received that could not be attended to before the end of the financial year. |
| **Strategic Objective 6.2.2: Strengthen and monitor governance systems** | | | | | | | | |
| **6.2.2** | Number of governance interventions implemented, per year | 55 | 100% (105) | 100% (108) | 85 | 116 | 31 | The unit had to undertake more governance intervention matters than was initially estimated. |



### Achievement of strategic objectives

During the period under review the unit was able to intervene timeously and appropriately in instances where the rights of members were compromised; this is supported by the fact that the unit performed over and above its set targets. The enforcement of rulings on member complaints, observation of AGMs and other governance irregularities also contributed to the attainment of the strategic outcomes.

The unit observed AGMs to ensure that medical schemes conduct their AGMs in compliance with the Medical Schemes Act as well as scheme rules. The unit's main focus during observation was on ensuring that the schemes' voting, and election processes were conducted in a fair and transparent manner for the benefit of scheme members. All medical schemes were able to convene and conclude their AGMs with the exception of three. Of these, one AGM was disrupted by disgruntled members; one scheme was placed under curatorship due to governance issues; and enforcement action is currently being undertaken against the third scheme by means of an inspection that was ordered by the Registrar in terms of Section 44(4)(b) of the Act, due to failure to hold an AGM.

The unit implemented a Demarcation Exemption System (DES) for the submission of demarcation renewal applications and exemption conditions information by insurance entities that have been exempted from doing the business of a medical scheme. The development of this system was crucial because of the volume of information regarding healthcare products that must be structured and managed to allow end-users to have complete oversight of the business of insurers, which falls in line with doing the business of a medical scheme.

The unit was also involved with the design of the demarcation website tab which was placed on the CMS' website. The purpose of the demarcation website tab is to provide details of exempted insurance products and details and contact information for entities, to facilitate the complaints process for the benefit of members. The CMS, in consultation with the FSCA, The Prudential Authority and National Treasury, formulated the renewal exemption guideline that provides the process to be followed for the extension of the current exemption timeframe of 01 April 2017 to 31 March 2019 for a further two years, to 31 March 2021. The guideline sets out the required exemption application documentation that entities should submit.

### Strategy to overcome areas of under-performance

There were no areas of under-performance reported in the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 6 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 19 | 8 | 11 | 18 | 12 | 6 |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| Subscriptions | 19 | 17 | 2 | 75 | 24 | 51 |
| | 40 | 25 | 15 | 96 | 36 | 60 |
| **Operating expenses** | | | | | | |
| Inspection costs | 2 724 | 6 824 | (4 100) | 1 994 | 16 033 | (14 039) |
| Travel and subsistence | 183 | 277 | (94) | 169 | 127 | 42 |
| Venue and catering | 20 | 3 | 17 | 16 | 3 | 13 |
| | 2 927 | 7 104 | (4 177) | 2 179 | 16 163 | (13 984) |
| **Staff costs** | | | | | | |
| Salaries | 8 774 | 9 476 | (702) | 7 415 | 7 477 | (62) |
| Staff training | 212 | 159 | 53 | 85 | 60 | 25 |
| | 8 986 | 9 635 | (649) | 7 500 | 7 537 | (37) |
| **Total** | **11 953** | **16 764** | **(4 811)** | **9 775** | **23 736** | **(13 961)** |

## Programme 7: Benefits Management

The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. All other rules are analysed and approved to ensure consistency with the Medical Schemes Act. This ensures that the beneficiaries have access to affordable and appropriate quality healthcare. By doing this the CMS ensures that the rules of medical schemes are fair to beneficiaries and are consistent with the Act.

### Key performance indicators, planned targets and actual achievements

| | Performance Indicator | Actual Achieve-ment 2015/16 | Actual Achieve-ment 2016/17 | Actual Achieve-ment 2017/18 | Planned Target 2018/19 | Actual Achieve-ment 2018/19 | Deviation from planned target to Actual Achieve-ment for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 7.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act** | | | | | | | | |
| **7.1.1** | Percentage interim rule amendments processed within 14 working days of receipt of all information, per year | New indicator | 87% (88 out of 101) | 96.3% (104/108) | 80% | 96.2% | 16.2% | The unit exceeded its target by managing its processes more efficiently. |
| **7.1.2** | Percentage of annual rule amendments processed before 31 December of each year | New indicator | 98.9% (90) | 100% (91) | 90% | 100% | 10% | The unit exceeded its target by managing its processes more efficiently. |

### Achievement of strategic objectives

The unit is responsible for registering rules of medical schemes and as such contributes to the goal of the CMS to ensure that schemes are regulated efficiently and that rules that are registered are not unfair to members and are compliant with the Act. These rules relate to the general operation of the schemes in terms of governance and also to their contribution rates and benefit provision. The unit comprises six analysts with technical expertise to assist the office of the Registrar and the CMS to achieve its mandate of protecting the interests of beneficiaries of medical schemes.

It is therefore important that the target set annually is met with great precision, consistency and commitment. The unit set itself high targets for the review period and managed to exceed these targets. The unit will endeavour to continue with this stellar performance to ensure the mandate is continuously achieved.

### Strategy to overcome areas of under-performance

There were no areas of under-performance in the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 7 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 14 | 13 | 1 | 24 | 12 | 12 |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| Subscriptions | 20 | 12 | 8 | 19 | 19 | - |
| | 36 | 25 | 11 | 46 | 31 | 15 |
| **Operating expenses** | | | | | | |
| Travel and subsistence | 25 | 21 | 4 | 20 | 11 | 9 |
| Venue and catering | - | 2 | (2) | - | 2 | (2) |
| | 25 | 23 | 2 | 20 | 13 | 7 |
| **Staff costs** | | | | | | |
| Salaries | 7 078 | 6 372 | 706 | 6 261 | 6 421 | (160) |
| Staff training | 105 | 99 | 6 | 70 | 56 | 14 |
| | 7 183 | 6 471 | 712 | 6 331 | 6 477 | (146) |
| **Total** | **7 244** | **6 519** | **725** | **6 397** | **6 521** | **(124)** |

## Programme 8: Financial Supervision

The purpose of the programme is to serve the beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, the CMS works to achieve an industry that is financially sound.

### Key performance indicators, planned targets and actual achievements

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 8.1: Monitor and promote the financial soundness of medical schemes** | | | | | | | | |
| **8.1.1** | Recommendations in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar) for 100% of business plan received, per year | 100% | 100% | 100% | 100% | 88% | -12% | There was one matter received at the end of the last quarter of the financial year that had to be carried over to the new financial year. |
| **8.1.2** | Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year | 100% | - | 100% | 100% | n/a | - | No schemes with rapidly reducing solvency were identified during the period. |
| **8.1.3** | Percentage of auditor applications authorised or rejected, per year | New indicator | New indicator | 100% | 100% | 100% | - | - |
| **8.1.4** | Number of quarterly financial return reports published (excluding quarter 4), per year | 3 | 3 | 3 | 3 | 3 | - | - |
| **8.1.5** | Number of financial sections prepared for the Annual Report | 1 | 1 | 1 | 1 | 1 | - | - |

### Achievement of strategic objectives

The programme's strategic objective is to monitor and promote the financial soundness of medical schemes. Regulation 29 of the Medical Schemes Act prescribes that the minimum accumulated funds of medical schemes should be at least 25.0% of gross contributions so as to ensure that members' interests are protected; and guarantee the continued operation of the scheme, ensuring that it is able to pay members' claims when due. The prescribed solvency also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations. The schemes that fell below the minimum required

statutory solvency level were closely monitored and required to submit business plans detailing their turnaround strategies. Regular meetings were held with the management of these schemes to monitor progress against the submitted plans.

As per Section 37 of the Act, statutory returns of annual financial statements reveal the historical financial performance and position of medical schemes and their ability to continue operating into the foreseeable future, and determine trends and emerging issues. Annual financial statements enable more effective decision-making and feed directly into the various regulatory interventions catered for in the Act, as well as policy formulation. Annual statutory returns form the basis of the financial sections prepared for the Annual Report. The programme completed the input for 2017/18 timeously. There were no significant analysis findings and the medical schemes industry remained above the statutory solvency requirement of 25% overall.

The Act requires that the annual financial statements of medical schemes are audited. The reliance that is placed on the information contained in the annual financial statements is high, and it is therefore important to ensure not only the quality of audits, but that auditors are familiar with the very complex medical schemes environment. The purpose of the auditor approval process is to assess the capability of the proposed audit firms and audit partners to be engaged in the audit assignment of medical schemes. The programme has to evaluate the quality of both the audit firm and audit partner to ensure that they are fit and proper to conduct the audit of a medical scheme. The programme engaged with applications received for the authorisation of statutory auditors and International Financial Reporting Standards as per Section 36 of the Act during the year. Several new applicants with no medical scheme experience were authorised on condition that they utilise an authorised concurrent review partner, for at least the first three years of the authorisation cycle.

The Quarterly Return System serves as the core of the Early Warning System and enables the continuous monitoring of schemes in between audit cycles. It enables the CMS to respond timeously and appropriately to changes; to interact with the management of schemes; and to ensure the ongoing protection of members.



### Strategy to overcome areas of under-performance

There were no areas of under-performance in the programme during the year under review.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 8 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 16 | 9 | 7 | 10 | 3 | 7 |
| Refreshments | 2 | - | 2 | 4 | - | 4 |
| Subscriptions | 37 | 30 | 7 | 35 | 32 | 3 |
| | 55 | 39 | 16 | 49 | 35 | 14 |
| **Operating expenses** | | | | | | |
| Consulting | - | - | - | 53 | - | 53 |
| Travel and subsistence | 40 | 22 | 18 | 38 | 15 | 23 |
| Venue and catering | 56 | 38 | 18 | 53 | 21 | 32 |
| | 96 | 60 | 36 | 144 | 36 | 108 |
| **Staff costs** | | | | | | |
| Salaries | 12 515 | 12 686 | (171) | 11 643 | 11 749 | (106) |
| Staff training | 194 | 168 | 26 | 106 | 64 | 42 |
| | 12 709 | 12 854 | (145) | 11 749 | 11 813 | (64) |
| **Total** | **12 860** | **12 953** | **(93)** | **11 942** | **11 884** | **58** |

## Programme 9: Complaints Adjudication

The purpose of the programme is to serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. This ensures that beneficiaries are treated fairly by their medical schemes.

### Key performance indicators planned targets and actual achievements

| | Performance Indicator | Actual Achievement 2015/16 | Actual Achievement 2016/17 | Actual Achievement 2017/18 | Planned Target 2018/19 | Actual Achievement 2018/19 | Deviation from planned target to Actual Achievement for 2018/19 | Comment on deviations |
|---|---|---|---|---|---|---|---|---|
| **Strategic Objective 9.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes** | | | | | | | | |
| **9.1.1** | Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per quarter | 75.31% | 84% | 68% | 83% | 55% | -28% | The backlog that accumulated in 2017/18 had a negative impact on the achievement of targets as the unit had a task of tackling the backlog as well as attending to the new complaints. |

### Achievement of strategic objectives

Despite the unit missing its annual target, it received positive feedback from some complainants who were pleased with the rulings made by the unit. One of the important functions of the CMS is to investigate complaints and settle disputes in relation to the affairs of medical schemes, and the Act sets down the process of investigation and resolution of complaints. In the investigation and disposal of complaints, the Registrar's Office acted independently, impartially and objectively in relation to all complaints that were adjudicated. Complaints adjudication involves the application of case law, consideration of registered rules and other relevant legal principles. The principles of fair administrative justice underpin the decision-making process, and the entities against which complaints were laid were afforded the opportunity to respond to complaints prior to resolution.

Of note is the fact that rulings made by the Registrar's Office in relation to complaints are appealable to the Council for Medical Schemes in terms of Section 48 of the Act, which provides for a three-month period for filing appeal papers.

Complaints form an integral part of the medical schemes' internal operations and are a good measure of the effectiveness of services rendered to members. Therefore, complaints are viewed as an early-warning tool, highlighting operational inefficiencies in systems, people and processes of regulated entities. These complaints provide insight into current and/or potential problems within the regulated entities, especially where the conduct of these entities is found to have either been unfair to members and/or contravened certain provisions of the Act.

The Registrar's Office continues to engage medical schemes and administrators where complaint trends depict unfairness of policies employed which contravene the legislation.

### Strategy to overcome areas of under-performance

The employment of additional capacity and revised targets will help alleviate the pressure faced by the unit in the 2018/19 financial year. Three positions will be filled in the 2019/20 period and the administrative function previously performed by Legal Officers will be moved to Paralegals, which will enable Legal Officers to focus on the core function of resolution, with fewer administrative tasks.

The IT infrastructure used in the adjudication of complaints has aged and is no longer performing optimally. In recent years, a need has arisen to update the database, bringing it in line with regulatory developments and ever-changing technological requirements. The unit is currently engaging different entities with a view to determining which reporting systems exist that would be suitable for

the medical schemes environment. The finalisation of the exploration exercise will enable the CMS to purchase a suitable system to enable automation of most of the adjudication functions and to improve data collection, thereby improving services.

Time-consuming administrative functions also aggravated the delay in resolving complaints and placed immense pressure on the adjudication process. The onerous and cumbersome administrative functions inherent in the complaints adjudication process were minimised after the office secured the services of temporary staff and interns, who were tasked with handling administrative responsibilities which are normally performed by Legal Adjudication Officers. The tasks performed by interns and temporary staff included the following: drafting acknowledgement and referral letters; referral of valid complaints to entities for formal responses; informing complainants of the referrals; attending to telephonic and email queries from complainants; requesting further particulars from relevant parties; attaching scheme responses to their respective files; sending responses to complainants for comments; referral of clinical complaints to the Clinical Unit for clinical opinions; and attaching clinical opinions to their respective files.

Since the unit has a high resignation rate, any vacancy that arises contributes to the partially achieved target. Once the unit is under-staffed during the vacancy, it is inevitable that the current staff are unable to resolve complaints timeously. However, there is ongoing training of staff to ensure they are up to speed with the medical schemes environment.

As more complaints are becoming complex, regular complex-complaints discussion meetings enable the team to engage robustly on those complaints, to ensure that a single view of the office is carried through in the rulings.

### Changes to planned targets

There were no changes to planned targets for the programme during the year under review.

### Linking performance with budgets

| | 2018/19 | | | 2017/18 | | |
|---|---|---|---|---|---|---|
| Programme 9 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 | Budget R'000 | Actual expenditure R'000 | (Over)/ Under expenditure R'000 |
| **Administrative expenses** | | | | | | |
| Printing and stationery | 4 | 2 | 2 | 2 | 2 | - |
| Refreshments | 2 | - | 2 | 3 | - | 3 |
| | 6 | 2 | 4 | 5 | 2 | 3 |
| **Operating expenses** | | | | | | |
| Travel and subsistence | 109 | 37 | 72 | 608 | 61 | 547 |
| Venue and catering | - | 2 | (2) | - | 2 | (2) |
| | 109 | 39 | 70 | 608 | 63 | 545 |
| **Staff costs** | | | | | | |
| Salaries | 7 244 | 6 764 | 480 | 6 649 | 6 387 | 262 |
| Staff training | 129 | 47 | 82 | 96 | 49 | 47 |
| | 7 373 | 6 811 | 562 | 6 745 | 6 436 | 309 |
| **Total** | **7 488** | **6 852** | **636** | **7 358** | **6 501** | **857** |

# PART C:
## OVERVIEW OF ACTIVITIES DURING THE 2018/19 REPORTING PERIOD

# OVERVIEW OF ACTIVITIES DURING THE 2018/19 REPORTING PERIOD

## Financial overview


Figure 4: A snapshot of the industry

### *Reserves of medical schemes in 2018*

The financial performance of medical schemes remained, on average, stable for the year ended 31 December 2018. The average solvency ratio (accumulated funds, when expressed as a percentage of gross annual contributions translate into the solvency ratio) for all medical schemes for the period was reported at 34.54%, an increase of 4.07% from 33.19% in 2017. The industry in total remained above the statutory minimum solvency requirement of 25% as required by Regulation 29 of the Medical Schemes Act, No. 131 of 1998. The reserves at the end of the financial year under review were reported at R66 billion, up from R60 billion in the previous year.

The reserves serve to protect members' interests and to guarantee the continued operation of schemes. They also serve as a buffer against unforeseen, large-scale health events or the adverse performance of medical schemes.

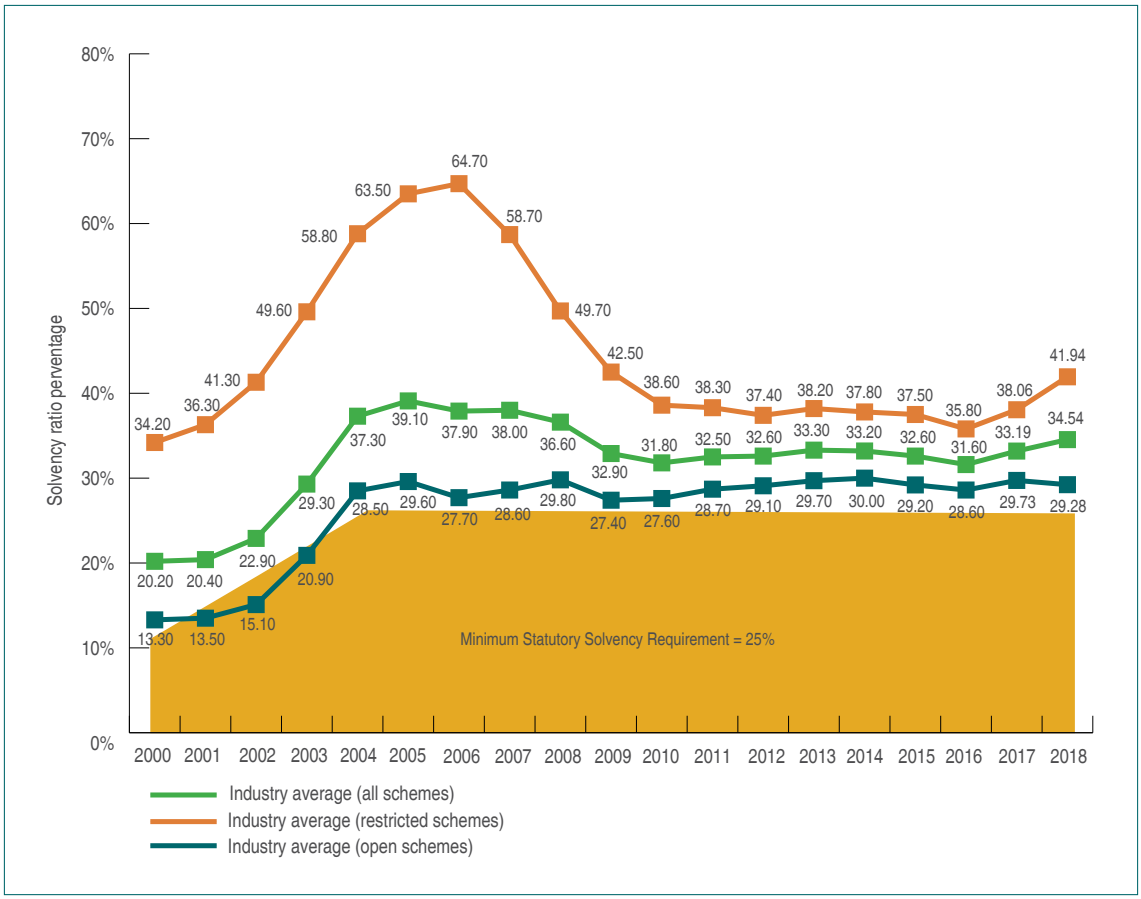



Figure 5: Industry solvency level for all medical schemes: 2000–2018



While most medical schemes experienced a worse claims experience compared to 2017, some of the larger medical schemes had a good year, which had an overall positive effect on the overall solvency of medical schemes – restricted schemes in particular had a marked improvement in solvency from 38.06% in 2017 to 41.94% in 2018, a year-on-year increase of 10.19%. This is largely attributable to the turnaround in financial performance of the largest restricted medical scheme, namely the Government Employees Medical Scheme, which reported an increase of 62.55% in solvency level, from 15.22% in 2017 to 24.74% in 2018.

The solvency of a medical scheme is underpinned by various core elements, such as the level of contributions, claims, non-healthcare expenditure and the operational results. Collectively, these are the broad determinants of performance, and as such the level of reserves and solvency reported by a medical scheme.

### *Financial performance of medical schemes*

In 2018, a total of R174 billion was collected in risk contributions[1] from members (2017: R163 billion) and expenditure on relevant healthcare services was reported at R157 billion (2017: R145 billion). R16 billion was spent on non-healthcare expenses, compared to R15 billion in 2017, an increase of 5.01%. The claims ratio as at 31 December 2018 was an increased 90.22% from a slightly lower 88.70% reported in 2017.

The higher claims ratio for 2018 was a result of various factors experienced by medical schemes such as: increased utilisation, increase in the number of high cost cases and changes in the demographic profile of others. Whilst this was the experience of most schemes, there are some schemes that had better claims ratios due to, amongst other things, improved claims management processes.

1 *Risk contributions: Gross contributions less savings contributions*

After paying for relevant healthcare services and operational expenses, medical schemes result incurred a much lower net health care result of R1.21 billion before investment income in 2018, compared to a net health care result of R3.36 billion in 2017. After investment income and consolidation adjustments, a surplus of R5.02 billion was realised, (2017: R8.93 billion) – this means that R5.02 billion of member contributions were contributed to general reserves (also known as accumulated funds) of the industry, representing a decline of 43.78% from the previous year. This is explained by the generally poorer financial performance of medical schemes in 2018, compared to 2017. See Figure 6.

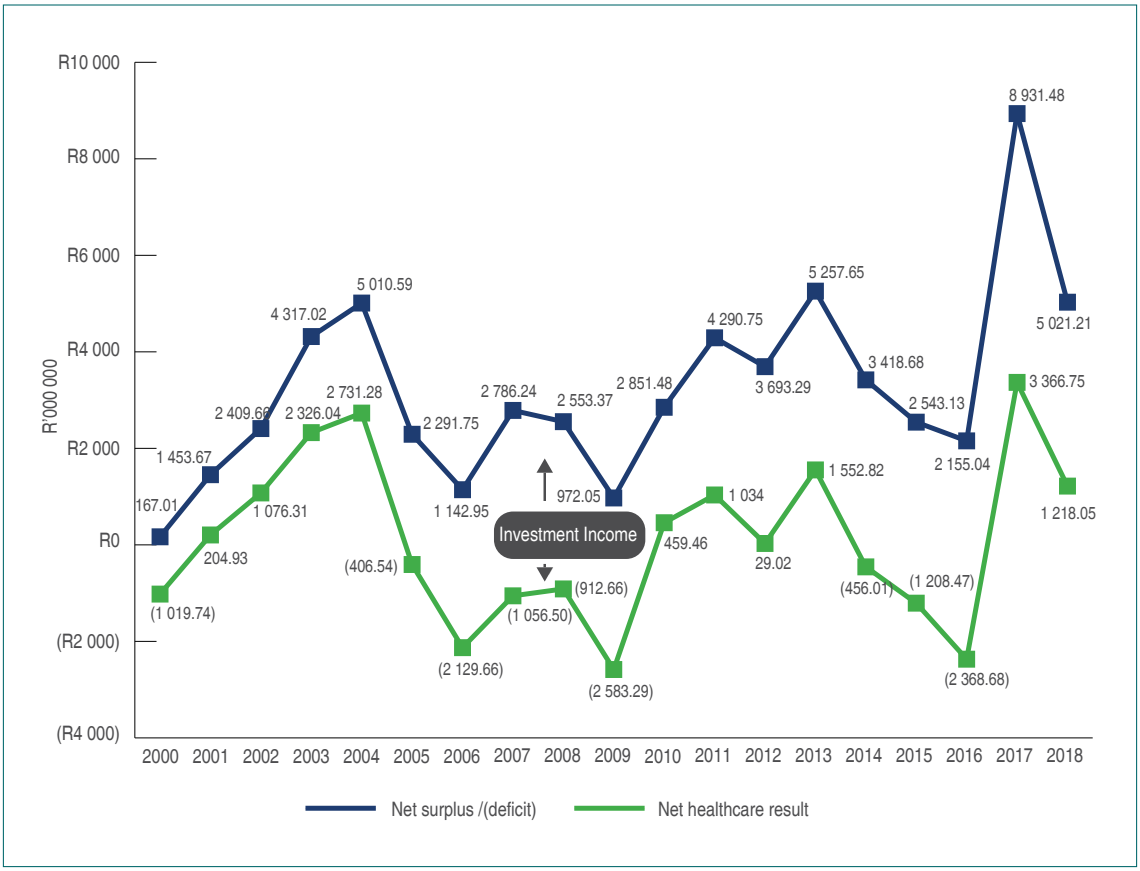



Figure 6: Net healthcare results and net results: 2000–2018

### *Schemes under close monitoring*

Medical schemes that fall short of the statutory minimum solvency level of 25% are required to notify the CMS of the underlying causes of failure, and corrective action to be undertaken. Such schemes are then closely monitored by the CMS. As at 31 December 2018, seven medical schemes were below the minimum statutory solvency requirement of 25% (ICU schemes) – four open and three restricted schemes. In total, there were 4 969 621 beneficiaries in the open scheme market (4 960 455: December 2017), of which 7.36% (365 535) were in schemes not meeting the prescribed minimum solvency requirement (15.72%: 779 925 in December 2017). The solvency ratio for all restricted schemes increased by 10.19%, from 38.06% as at 31 December 2017 to 41.94% as at 31 December 2018. The restricted scheme market had 3 947 074 beneficiaries (3 911 581: 31 December 2017) of which 48.16% (1 900 775) were in schemes not meeting the prescribed minimum solvency requirement (47.97%: 1 876 641 in December 2017), as shown in Figure 7.

Other reasons for schemes being subjected to close monitoring could include governance-related concerns or the fact that the scheme has high non-health expenditure levels.

Figure 7 depicts solvency trends for the last three years, for schemes below 25%, as at 31 December of the relevant year.

- The Government Employees Medical Scheme (GEMS) reported a solvency level of 24.74% in 2018, up from 15.22% in 2017. The revision of the scheme's underwriting policy, a tighter claims management programme, as well as other cost containment measures, have contributed to the marked improvement in the schemes' financial performance. The scheme has an approved business plan which is being monitored. The CMS also has regular meetings with the scheme to discuss progress against the business plan.

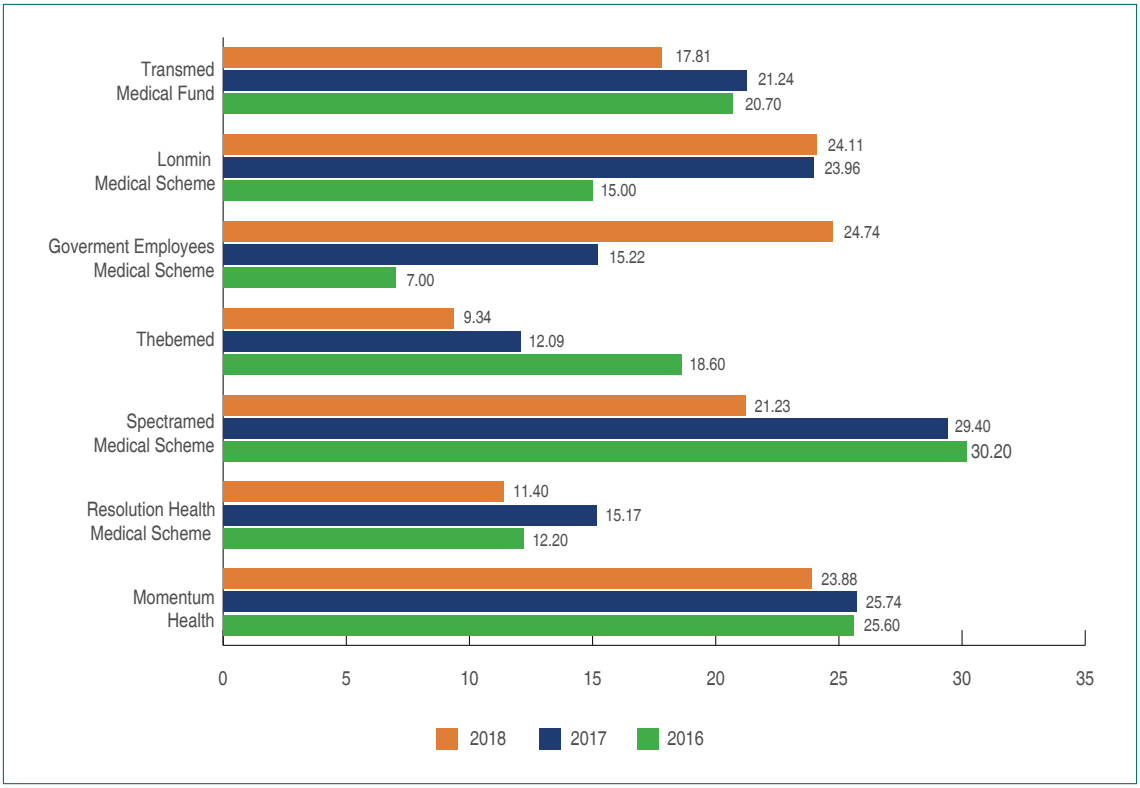



Figure 7: Schemes with solvency levels below 25%



- Lonmin Medical Scheme had a solvency ratio of 24.11% in 2018, which is a slight improvement to their solvency ratio reported in the prior year. The scheme introduced, *inter alia*, designated service provider arrangements to contain claims costs. A business plan was submitted by the scheme and was approved by the CMS. The CMS holds monitoring meetings with the Board on a regular basis. The scheme also submits monthly management accounts.
- Resolution Health Medical Scheme had a lower solvency level of 11.40% compared to 15.17% in 2017. The scheme amalgamated with Spectramed, effective 01 January 2019. The new entity is Health Squared Medical Scheme.
- Spectramed fell below the minimum statutory solvency level of 25% in 2018. The scheme reported a solvency level of 21.23%, a decrease from 29.40% in 2017. The scheme experienced a decreasing membership base as well as a worsening demographic profile. The scheme amalgamated with Resolution Health Medical Scheme, effective 01 January 2019. The new entity is Health Squared Medical Scheme.
- Momentum Health fell below the minimum statutory solvency level of 25% in 2018, with a solvency level of 23.88% from 25.74% in 2017. The scheme amalgamated with Metropolitan Health Medical Scheme in 2017, which led to an increase in membership. The scheme has submitted a business plan and the CMS holds monitoring meetings with the Board. The scheme also submits monthly management accounts.
- Thebemed's solvency ratio decrease, reported at 9.34% compared to 12.09% in 2017, is mainly due to membership growth and a worse than anticipated claims experience. The scheme has a reinsurance contract in place to mitigate some of the risk of these high costs. The CMS holds monitoring meetings with the Board on a regular basis and the scheme submits monthly management accounts.
- Transmed Medical Fund (Transmed) reported a solvency ratio of 17.81%, a decrease from 21.24% in the previous year. This decrease is attributable to, amongst other things, a steady decline in membership, coupled with a worsening demographic profile. A business plan was submitted by the scheme and approved by the CMS. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

### *Interventions to strengthen financial supervision of medical schemes*

During the course of the financial year, the Non-Healthcare Expenditure Review Project was completed. This project was carried out to further address the generally high operational costs in the medical schemes environment, some of which do not offer a discernible value add proposition, and could in some cases be deemed wasteful. One of the key findings was that the cost structure across medical schemes is not directly comparable due to differences in the classification of what is deemed to be core administration as well as supplementary services. This culminated in the publication of Circular 6 of 2019 which seeks to clarify the classification of services. The industry was engaged for comments and work is ongoing in this regard. The need for Circular 6 was further amplified by the subject-specific analysis in respect of fraud, waste and abuse during the analysis of quarterly returns, where it was found that the majority of schemes contract for fraud management services through the administrator.

The collaboration with the South African Institute for Chartered Accountants (SAICA) and the Independent Regulatory Board of Auditors (IRBA) continued in the year under review, to ensure that medical scheme reporting is aligned with international accounting and auditing standards.

The statutory reporting tools were also enhanced to encourage more transparent reporting by medical schemes.

### *Member contribution increases for 2019*

The average gross contribution increase for all medical schemes in 2019 was 8.2%. On average, restricted schemes instituted a 7.3% increase in contributions, while open schemes increased contributions by 8.8%.

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. Table 1 shows a summary based on medical scheme submissions on benefit changes and contribution increases for the 2019 calendar year.

Table 1: Average gross contribution increases for 2019

| | Principal member % | Adult dependant % | Child dependant % | Family % |
|---|---|---|---|---|
| Restricted schemes | 6.9% | 8.5% | 7.2% | 7.3% |
| Open schemes | 8.7% | 9.0% | 9.1% | 8.8% |
| **All schemes** | **8.0%** | **8.8%** | **8.1%** | **8.2%** |

Table 2: Average monthly gross contribution for 2019, as measured in Rand

| | Principal member R | Adult dependant R | Child dependant R | Family R |
|---|---|---|---|---|
| Restricted schemes | 2 555.50 | 2 129.37 | 909.52 | 4 367.74 |
| Open schemes | 2 613.83 | 2 322.84 | 855.84 | 4 194.31 |
| **All schemes** | **2 589.69** | **2 241.29** | **882.95** | **4 266.09** |

The average risk contribution increase for all medical schemes in 2019 was 8.4%. The comparative increase for open schemes was 9.2% and 7.3% for restricted schemes. The risk contribution is equal to the total contribution paid, less the amount that is allocated to a savings account for a beneficiary.

Table 3: Average risk contribution increases for the 2018/19 benefit and contribution review period

| | Principal member % | Adult dependant % | Child dependant % | Family % |
|---|---|---|---|---|
| Open schemes | 9.1% | 9.3% | 9.5% | 9.2% |
| Restricted schemes | 6.9% | 8.6% | 7.3% | 7.3% |
| **All schemes** | **8.2%** | **9.0%** | **8.3%** | **8.4%** |

### *Medical scheme contribution increases relative to inflation*

The contribution rate increases reflected in Figure 8 show that, on average, contribution rates across the industry increased by 7.2% between 2017 and 2018 and by 8.2% between 2018 and 2019. The average Consumer Price Index (CPI) increase during these periods was 4.7% for 2018 (as calculated by Statistics South Africa) and 5.2% for the 2019 period (as forecast by National Treasury Forecast for CPI for 2019).

Figure 8 also illustrates that the average difference in contribution increases relative to CPI was in the region of 4.2% between 2009 and 2019. The difference between medical scheme contribution rate increases and the average CPI increase has implications for the long-term affordability of the medical schemes industry, as increases in salaries may not necessarily keep pace with contribution increases.

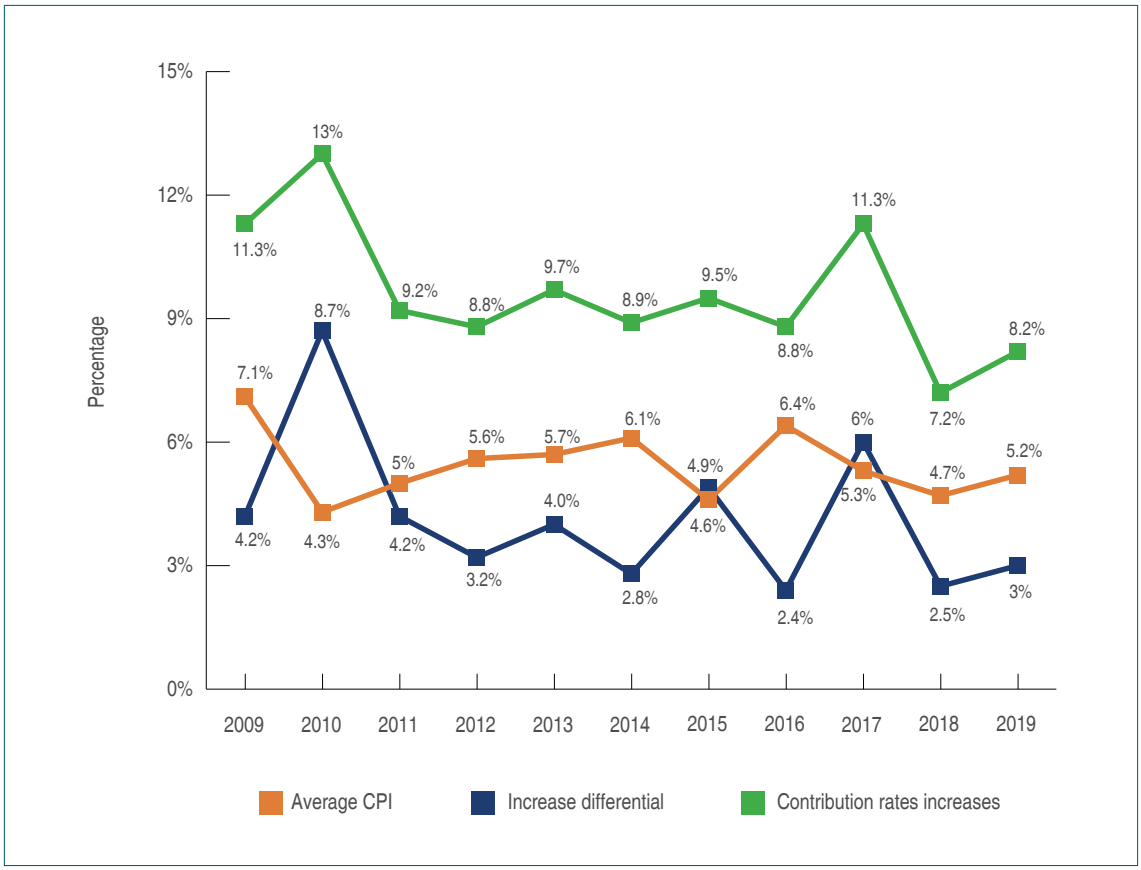



Figure 8: Medical scheme contribution increases and inflation: 2009–2019



## Medical scheme benefit options and consolidation trends

In February 2019, the CMS published a list of all 78 registered medical schemes and their contact details in the Government Gazette, as required by Section 25 of the Act. No new medical schemes were registered during the period under review.

To ensure compliance with provisions of the Act, the CMS compiled model scheme rules with an explanatory memorandum, released to industry stakeholders via Circular 36 of 2016, which medical schemes are encouraged to follow. As at 31 March 2019, the CMS had processed 102 interim rule amendments and 78 submissions for benefit and contribution changes effective 1 January 2019.

### *Benefit options*

The total number of registered benefit options decreased from 273 in March 2018 to 264 in March 2019. These options exclude the 65 efficiency discount options (EDO) as at March 2019 that are part of the individual options registered. The number of EDOs increased from 51 as at March 2018 to 65 as at March 2019. Benefit options in open schemes decreased from 136 to 129 while restricted schemes' registered options decreased from 137 to 135.

Table 4: Registered benefit options as at March 2019

| Classification of medical scheme | Open scheme options | Restricted scheme options | Total options |
|---|---|---|---|
| Options registered as at 31 March 2018 | 181 | 141 | 332 |
| Less: Efficiency discounted options | -46 | -6 | -47 |
| Options registered as at 31 March 2018 (excluding efficiency discounted options) | 136 | 135 | 271 |
| New options | 0 | 0 | 0 |
| Discontinued options | -6 | 0 | -6 |
| Discontinued options due to scheme mergers | -1 | -2 | -3 |
| Discontinued options due to scheme liquidations | 0 | 0 | 0 |
| Options registered as at 31 March 2019 (excluding efficiency discounted options) | 129 | 135 | 264 |
| Efficiency discount options* | 53 | 12 | 65 |
| Options registered as at 31 March 2019 | 182 | 147 | 329 |

* *Efficiency discount options have similar benefit offerings to their "non-EDO portion" except that they have discounted contribution tables based on the restricted provider network*

### *Efficiency discounted options*

In terms of Section 29(1)(n) of the Act a medical scheme may only differentiate contributions on the basis of family size and income. Hence, schemes intending to introduce EDOs must apply for exemption from this provision in the Act before they can operate EDOs. EDOs provide medical schemes with the capacity to use economies of scale on behalf of members when negotiating tariffs and fees with clinical providers.

There were 12 (nine open and three restricted) schemes offering efficiency discounted options as at 31 March 2019. The schemes include Momentum Health; Discovery Health Medical Scheme; Fedhealth Medical Scheme; Bonitas Medical Fund; Thebemed; Compcare Wellness Medical Aid Scheme; Medihelp; Bestmed Medical Scheme; Resolution Health; Government Employees Medical Scheme (GEMS), MotoHealth Care and Old Mutual Staff.

The percentage of members of EDO options, measured as a percentage of members of all options has however remained constant between 2013 and 2019. In 2013, 20.5% of members were members of EDO options and in 2019, 23.5% of members were members of EDO options.

This trend is disappointing, as analysis of the net healthcare results shows that EDO options continue to report positive results. The net healthcare result of the EDOs and non-EDOs is shown in Table 5. During the period under review, the EDOs collectively contributed up to 31.6% of the total surplus, even though these options accounted for only 23.5% of the total membership.

Table 5: Net healthcare results of EDOs and non-EDOs: 2013–2018

| Type of option | 2013 R'000 | 2014 R'000 | 2015 R'000 | 2016 R'000 | 2017 R'000 | 2018 R'000 |
|---|---|---|---|---|---|---|
| EDOs | 492 198 | 501 850 | 587 271 | 630 314 | 1 054 804 | 983 335 |
| Non-EDOs | 326 786 | 147 681 | 341 593 | (179 323) | 2 202 764 | 1 632 130 |
| **Total** | **818 984** | **649 531** | **928 864** | **450 991** | **3 257 568** | **2 615 465** |

However, one of the reasons for the better operating results of EDOs could be that the average age of beneficiaries of EDOs is younger than the average age of the scheme average. As of December 2018, the average age of EDO beneficiaries was 31.2 compared to 34.5 for non-EDOs. The claims ratio for EDOs was 79.5% compared to 89.6% for non-EDOs. (Refer to Annexure V for detailed information on EDOs).

## Accreditation of entities

### *Administrators and self-administered schemes*

Table 6: Administrators and self-administered schemes accredited – 2018/19

| Administrators and self-administered schemes accredited | | | | |
|---|---|---|---|---|
| | **New applications** | **Renewals** | **On-site evaluations** | **On-site compliance evaluations** |
| **Administrators** | National Health Group (Pty) Ltd | Agility Health (Pty) Ltd | Agility Health (Pty) Ltd | Discovery Health (Pty) Ltd |
| | | MMI Health (Pty) Ltd | | |
| | | Private Health Administrators (Pty) Ltd | | |
| | | Providence Healthcare Risk Managers (Pty) Ltd | | |
| | | Sanlam Health Administrators (Pty) Ltd | | |
| | | Sechaba Medical Solutions (Pty) Ltd | | |
| | | Universal Healthcare Administrators (Pty) Ltd | | |
| **Self-administered Schemes** | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | Bestmed Medical Scheme | De Beers Benefit Society | |
| | Medihelp | Cape Medical Plan | Medihelp | |
| | | Platinum Health | SAMWUMED | |
| | | Umvuzo Health Medical Scheme | | |

### *Third party administrators and self-administered schemes*

Applications in respect of eight (8) administrators and six (6) self-administered medical schemes were evaluated and finalised during the year. On-site evaluations were conducted in respect of one (1) administrator and three (3) self-administered medical schemes. The Accreditation Unit continued to monitor compliance by accredited entities with conditions imposed and the audited financial statements of administrators annually to ensure their financial soundness.

Work commenced towards the revision of Accreditation Standards for Administrators and Self-administered Medical Schemes and Version 6 has been prepared for consultation. Measures were introduced to extend the scope of information to be provided by accredited organisations and new applicants. Details of directors and shareholders of the applicant and all related subsidiary and holding companies need to be declared to assess and manage any conflict or likely conflict of interest in rendering accredited services. The information provided is similarly verified.

The draft document has been published for consultation which seeks to provide clarity regarding the suitable classification of bonafide administration fees and to distinguish between core and supplementary administration services. The objective is to enable the industry and the CMS to compare and manage the costs of administration amongst medical schemes and to ensure that supplementary or non-core services are not subject to accreditation and are accordingly contracted for independently.

*Managed care organisations and self-administered schemes*

Table 7: Managed care organisations and self-administered schemes accredited – 2018/19

| Managed care organisations and self-administered schemes accredited | | | | |
|---|---|---|---|---|
| | New applications | Renewals | On-site evaluations | On-site compliance evaluations |
| **Managed Care Organisations** | ICAS Managed Care (Pty) Ltd | Agility Health (Pty) Ltd | | Discovery Health (Pty) Ltd |
| | National Health Group (Pty) Ltd | Aid for Aids Management (Pty) Ltd | | |
| | | CareWorks (Pty) Ltd | | |
| | | Discovery Health (Pty) Ltd | | |
| | | Liberty Health Administration (Pty) Ltd | | |
| | | Lifesense Disease Management (Pty) Ltd | | |
| | | Mediscor PBM (Pty) Ltd | | |
| | | Metropolitan Health Risk Management (Pty) Ltd | | |
| | | MMI Health (Pty) Ltd | | |
| | | Momentum Thebe Ya Bophelo (Pty) Ltd | | |
| | | Performance Health (Pty) Ltd | | |
| | | Prime Cure Health (Pty) Ltd | | |
| | | Professional Provident Society Healthcare Administrators (Pty) Ltd | | |
| | | Rx Health (Pty) Ltd | | |
| | | Sanlam Health Managed Care (Pty) Ltd | | |
| | | Sechaba Medical Solutions (Pty) Ltd | | |
| | | Scriptpharm Risk Management (Pty) Ltd | | |
| | | South African Oncology Consortium Ltd | | |
| **Self-administered Schemes** | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | | | |
| | Medihelp | | Medihelp | |



### Managed care organisations

Applications were received and evaluated during the period under review from two (2) new managed care organisations and two (2) self-administered medical schemes. Eighteen (18) organisations applied for renewal of accreditation, and two (2) organisations elected not to apply for renewal. An on-site evaluation was conducted for one (1) self-administered medical scheme.

The Accreditation Unit continued to monitor compliance by accredited entities with conditions imposed and the financial soundness of risk-bearing entities on an annual basis to ensure their financial soundness.

Work commenced towards the Revision of Accreditation Standards for Managed Care Organisations and Version 5 has been prepared for consultation.

### Managed Care Theme Project measuring the impact of managed care interventions

The project seeks to effectively demonstrate and evaluate the value of managed care services rendered to beneficiaries of medical schemes. Eleven (11) PMB conditions were finalised in collaboration with stakeholders during the year under review with completed data specifications in respect of entry level criteria, process indicators and health outcomes having been introduced. The result is that all prescribed chronic diseases, as part of the PMBs, have now been completed through this participatory process.

*Brokers and broker organisations*

**Individual brokers and broker organisations**

Table 8: Accreditation of brokers and broker organisations

| Brokers and Brokerages Accredited | Individual Brokers | Brokerages |
|---|---|---|
| First time applications received | 982 | 108 |
| Renewal applications received | 4 260 | 1 132 |
| **Total accredited** | **3 972** | **1 061** |
| Accreditation refused due to being disqualified | 4 | - |
| Applications deferred for evaluation due to incomplete information received or additional information requested | 1 266 | 179 |

**Broker accreditation applications withdrawn or rejected**

The accreditation of three (3) individual brokers was withdrawn due to death, discontinuation of broker activities and immigration. Three individual first time applications were declined due to fraudulent academic qualifications. One application was declined due to their status as an unrehabilitated insolvent.

**Verification of academic qualifications**

The Accreditation Unit continued to verify academic qualifications of individuals applying to be accredited as brokers. The qualifications of 1 613 individuals were verified independently during the period under review.

**Guide for preparing broker agreements**

The unit prepared and concluded a consulting process and published a guideline document for the preparation of contracts between the broker fraternity and medical schemes.

**Adjustments of broker fees**

The Minister of Health announced an increase in the maximum amount payable to brokers by medical schemes in respect of broker clients who are members of medical schemes, in terms of Section 65 of the Medical Schemes Act. The amount was increased to R94.77 per member per month, with effect from 1 January 2019.

## Enforcing and encouraging compliance for a healthy industry

Legislation allows the CMS to conduct two types of inspection, Section 44(a) commissioned inspections and Section 44(b) routine inspections.

Routine inspections are conducted to ensure that medical schemes comply with the provisions of the Act, scheme rules, internal policies and procedures, and overall good governance as well as to evaluate the fitness and propriety of the Board of Trustees and principal officers. The Registrar instituted ten (10) routine inspections in terms of Section 44(4)(b) of the Medical Schemes Act during the period under review.

Inspections following allegations of irregularities:

- Discovery Health Medical Scheme – the investigation was completed. The final inspection report is being reviewed with the intention of issuing directives, where necessary;
- Government Employees Medical Scheme – the scheme's response to the draft report was received and their response is undergoing internal processes of review.
- Bonitas Medical Fund – the scheme's response to the draft inspection report is expected in the first quarter of the next reporting period.

*Exemption applications*

Schemes should comply with all the provisions of the Act and in instances where there is non-compliance a formal exemption application should be submitted for approval by the Council. The majority of the exemption applications received related to exemption from the provisions of Section 35(8) pertaining to the investment of scheme assets or the granting of loans.

*Section 45 enforcement action*

The unit received a complaint from a policyholder on Roshmed Hospital Scheme with regards to non-payment of claims. This matter was further investigated and the applicant was requested to submit information in terms of Section 45 of the Act. After analysis of the information, it was confirmed that the entity is doing the business of a medical scheme, without being registered. The entity was directed to either register as a medical scheme or cease doing business. The entity subsequently applied to be registered as a medical scheme, which application is currently under consideration.

Through social media observations, the unit noted that an entity by the name of The Medtrix Medical Fund was doing the business of a medical scheme. A Section 45 enquiry was directed to the entity and a meeting was convened wherein the contravention of the Act was discussed. The entity is currently in the process of refunding its ten members and will cease doing the business of a medical scheme.

*Annual general meetings*

During the reporting period, 34 Annual General Meetings (AGMs) were observed, to ensure that medical schemes conduct their

AGMs in compliance with the Medical Schemes Act as well as scheme rules. The main focus for observing AGMs was on ensuring that the schemes' voting, and election processes were conducted in a fair and transparent manner for the benefit of scheme members. All medical schemes were able to convene and conclude their AGMs, except for the South African Police Service Medical Scheme (Polmed), Hosmed Medical Scheme (Hosmed) and the South African Municipal Workers Union Medical Scheme (SAMWUMED).

### *Curatorship(s)*

SAMWUMED was placed under curatorship on 03 May 2018, with Ms Duduza Khosana appointed as curator. During September 2018 Mr Joe Seloane was appointed as curator and currently reports to the CMS on a regular basis.

### *Demarcation regulations*

An Exemption Framework was put in place as a transitional arrangement for a period of two (2) years, ending on 31 March 2019, to provide for an exemption for insurers and their respective financial service providers that are providers of indemnity products that meet the definition of "business of a medical scheme" in line with the Act; while a Low-Cost Benefit Option (LCBO) Guideline is being developed under the leadership of the NDoH.

In 2018/19 the CMS received two Section 50 appeals lodged as a result of Council decisions not to approve exemption applications received in terms of Section 8(h) and the Demarcation Exemption Framework, one in October 2017, and the second in June 2018.

The two Section 50 appeals, lodged by Discovery Health (Pty) Ltd and Agility Insurance Administrators (Pty) Ltd respectively, were ruled in favour of the CMS. The CMS issued Enforcement letters to the affected parties to transfer members to either a registered insurer that had been granted exemption or to a registered medical scheme.

Following delays experienced regarding the finalisation of the LCBO Guideline by 31 March 2019, the Demarcation Exemption Renewal Framework (Renewal Framework) was concluded, in consultation with the FSCA, Prudential Authority, National Treasury and the NDoH. The Renewal Framework will serve as a guideline to providers of indemnity products, whose products were granted exemption from doing the business of a medical scheme, for their application for renewal of exemption for a further period of two years, effective from 01 April 2019 until 31 March 2021, subject to certain conditions.

Stakeholders were informed of the Renewal Framework by means of Circular 30 of 2019. Renewal applications received by the CMS are currently in the process of being reviewed.

The CMS developed a system for the submission of the exemption applications, which went live on 7 June 2018. Information about insurers whose indemnity products were granted exemption from doing the business of a medical scheme, including details of the insurers' respective financial service providers' customer care numbers, is available on the CMS website.

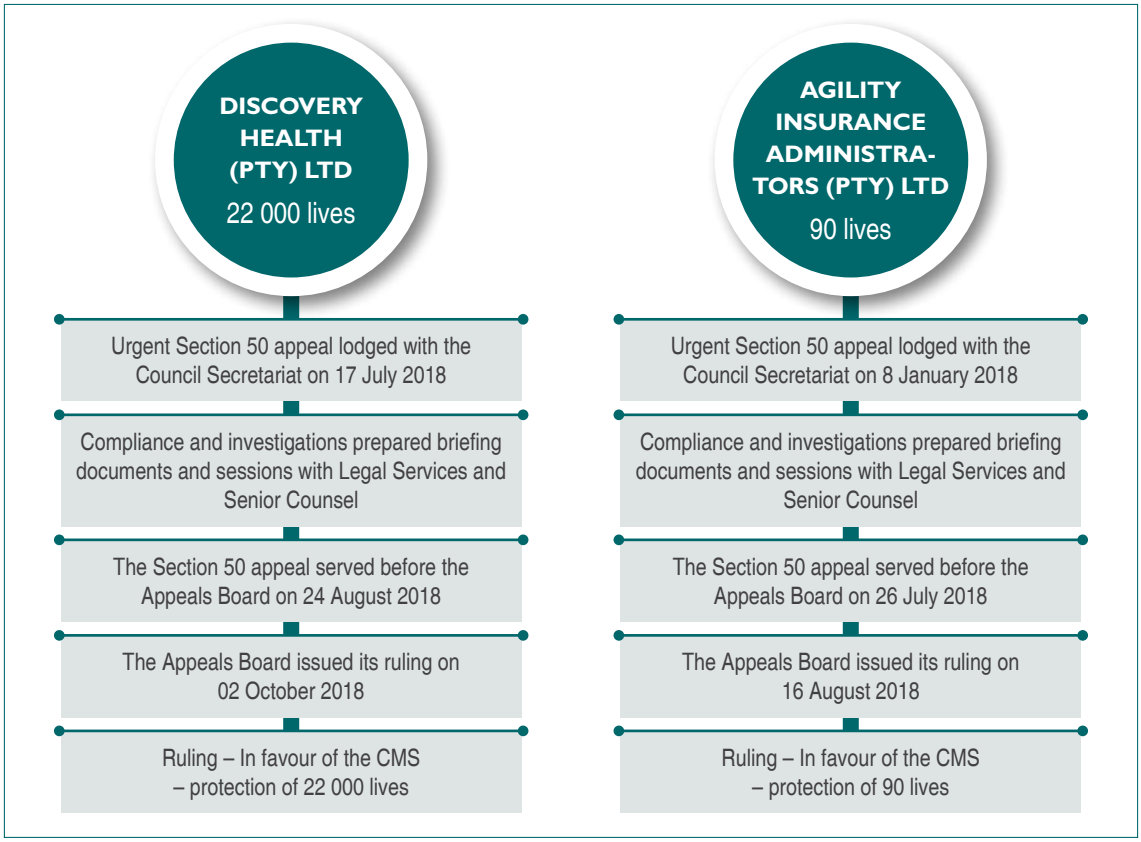



Figure 9: Discovery Health (Pty) Ltd and Agility Insurance Administrators (Pty) Ltd appeal processes

## Burden of diseases and use of healthcare services in medical schemes

### *Healthcare utilisation annual statutory returns Data Collection System*

The implementation of the Medical Schemes Act needs to be monitored regularly to evaluate its impact on the industry and beneficiaries and, where necessary, to recommend relevant legislative reforms. Good quality data is important to achieve this objective. The introduction of the Dynamic Data Driven Return (DDDR) System was accompanied by continued improvements in the data specification guidelines. To accommodate all administration systems, the guidelines and specifications are deliberately targeted at the 'lowest common denominator' that every accredited medical scheme administrator should be able to provide. The CMS has observed an improvement in the quality of healthcare data and more consistent reporting of healthcare utilisation data. One-on-one engagements with schemes and industry-wide workshops were held, aimed at improving data submitted for the annual statutory returns. The non-financial section of the Annual Reports was finalised, using the data collected through the Healthcare Utilisation Annual Statutory Returns.

### *Analysis of scheme risk measurement returns*

The CMS continued to collect Scheme Risk Measurement (SRM) data to measure and report on the risk profiles of medical schemes and benefit options. This allows schemes to better understand the impact of age and chronic disease on the beneficiaries covered by medical schemes. The findings indicate that the large degree of variation in risk between medical schemes is directly attributable to the true differences in the risk profiles of individual medical schemes. The observed increase in the industry community rate is possibly a result of a change in the risk profile of medical schemes' beneficiaries.

### *Scheme-specific reports detailing the Scheme Community Rate (SCR) by benefit option*

The CMS also continued to analyse and report on the scheme community rate. Scheme-specific reports were sent to each scheme detailing the scheme's monthly community rate in relation to the industry community rate at scheme and benefit option level. The variations observed are reported in the SRM Industry Report.

### *Prevalence of chronic diseases in the population covered by medical schemes in South Africa*

The findings of the Chronic Disease List (CDL) Prevalence Study, conducted by the Research and Monitoring Unit, showed that the upward trend in diagnosis and treatment of many conditions on the chronic disease list (CDL) was sustained. The expenditure on CDLs makes up around 20% of the expenditure on Prescribed Minimum Benefits (PMBs), which constitutes about R80 billion of total risk benefits paid in 2017. It is therefore important for schemes to efficiently manage their beneficiaries and make a concerted effort to identify and register beneficiaries on the disease management programmes they provide. It is concerning that less than 50% of beneficiaries claiming for CDL conditions are registered on a disease management programme.

### *Analysis of the utilisation statistics*

The Research and Monitoring Unit developed a database that allows for the analysis and monitoring of trends in the utilisation of healthcare services by members of medical schemes. The database allows for the disaggregation of utilisation statistics by Practice Code Numbering System discipline codes. The database is invaluable for monitoring the work of the CMS, and as a source of information for human resource planning and policy analysts in the private and public healthcare space.

### *Quality in medical schemes: analysis of process indicators*

The Research and Monitoring Unit undertook a study to determine the quality of healthcare in the medical schemes environment. The CMS collected information from the review periods 2016 and 2017, on process indicators and the limited outcome indicators of the disease management programmes (DMP) for the following 14 CDL conditions: Human Immunodeficiency Virus (HIV); diabetes mellitus types 1 and 2 (DM1 and DM2); hypertension; congestive heart failure; ischemic heart disease; chronic renal failure; asthma; chronic obstructive pulmonary disease; bipolar mood disorder; ulcerative colitis; schizophrenia; Crohn's disease; and hypothyroidism.

The study was based on beneficiaries that are registered on medical schemes' chronic disease management programmes. This understates the true number of beneficiaries with the underlying CDL conditions, as some may be receiving treatment for the condition (possibly paying for tests and treatment out of their own pockets), but not be registered for the programme. All-cause hospital admissions, re-admission rates and the number of beneficiaries with co-morbidities were also collected. The study revealed an improvement in process indicators compared to respective years for conditions such as HIV, DM1 and DM2. However, the outcomes data could not be validated nor supported by any form of intervention employed by the schemes. As a result, the notable trend could be attributed to under-reporting or other data-related issues. It is thus recommended that reporting and identification of outcomes indicators need to be improved.

Managed care services should provide the proper quality of care, leading to better quality health outcomes, which in turn will ensure that the provision of healthcare services is cost effective. If the management and treatment of patients with CDL conditions through specific intervention programmes is effective, the associated hospitalisation expenditure should decline at an increasing rate.

### *Medical schemes demographic data trend analysis*

The Research and Monitoring Unit concluded a descriptive study on demographic, geographic, utilisation, managed care and PMB data, as part of the healthcare utilisation annual statutory returns collected from medical schemes. The findings of the report are important for profiling members of medical schemes, planning purposes, making policy decisions and helping to formulate benefit packages. The data is equally important in understanding the distribution of medical scheme members for resource planning in terms of the NHI planning and implementation process, for it provides information on private sector beneficiaries. The key findings of the research are as follows:

- The medical schemes industry has experienced a significant consolidation resulting in a reduction in the number of medical schemes from 144 in 2000 to 80 in 2017;
- Medical scheme beneficiaries increased by over 2 million beneficiaries over the period 2000 to 2017. However, the proportion of South Africans covered by medical schemes has remained largely unchanged; and
- The analysis revealed a difference in the number of options between restricted and open schemes. On average, open schemes offered relatively more benefit options compared to restricted schemes, which offer on average less benefit options.

### *Customer satisfaction and complaints*

This project investigated secondary customer satisfaction data found in literature and the primary complaints data sourced from CMS annual reports. The preliminary findings of the study revealed that there is somewhat of an association between customer satisfaction and complaints. The study revealed that more than half of the valid complaints were related to non-payment of benefits. It is recommended that medical schemes need to be proactive in effectively communicating benefit entitlement to members. Furthermore, schemes are encouraged to provide feedback and explanation to their members when benefits are not paid. Training and member education on the products offered by medical schemes could improve the perceived quality of service offered by medical schemes to their members. Finally, third party contracts should be better managed where service delivery is concerned.

### *Medical scheme inflation*

Guided by regulatory provisions, an analysis of contribution increase inflation was conducted. Within this analysis, certain factors were quantified into components related to 'tariff' and 'utilisation' increases. The analysis was undertaken within the context of other research projects on contribution increase analysis. The cost of medical scheme contributions has been increasing consistently at rates above inflation. Several views and hypotheses have been put forward to explain this trend. These include the impact of changes in demographic profile; increases in the burden of disease; provider billing behaviour (within the context of principal agent relationship and information asymmetry); benefit design; health technology; anti-selection; and absence of price regulation. If not well managed, these factors will continue to affect affordability of the medical scheme cover, leading to a declining membership, which will continue to erode risk pooling within the medical scheme's environment.

## Policy research areas

### *Benefit option classification*

This project finds itself relevantly consistent with the research questions that are being probed by the Health Market Inquiry investigation. The research questions were whether benefit design premiums reflect the average utilisation of benefit options. In other words, are members able to predict their average utilisation, and thus choose the benefit option which optimally meets their healthcare needs? One would naturally assume that the affirmative inference applies in a competitive market with ample choice.

Both peer reviewed research literature, and a market segmentation analysis conducted, found that member characteristics did not fully explain member utilisation patterns between benefit options. This phenomenon is mostly explained by product complexity or member confusion as reported in the research literature.

The preliminary findings of the benefit classification project are:

- Three distinct benefit designs were identified; and
- In some instances, benefit option premiums and average utilisation within specific benefit designs overlapped with premiums and utilisation costs of other groups of benefit designs.

The absence of compact and independent groups of benefit designs suggests that there is an element of product choice complexity in the medical schemes industry. Research literature points to member confusion with product proliferation as the cause (members have too many options to choose from).

The CMS needs to conduct market segmentation surveys to fully understand medical scheme members' choice preferences. This will result in independent and more accurate benefit design clusters, which in turn will assist in developing regulatory standards for making differences between benefit options more perceptible for medical scheme beneficiaries.

### *Patient Experience Survey*

The Patient Experience Survey focused on how medical scheme beneficiaries experience disease management programmes for diabetes. The exercise is pivotal to gaining insight into the value of disease management programmes from the perspective of patients. The Health Market Inquiry's provisional recommendations advocate more transparency for medical scheme beneficiaries, through the reporting of healthcare indicators that measure the value of healthcare interventions.

This type of transparency could assist medical scheme beneficiaries by making benefit option decisions simpler, especially if beneficiaries know which options report good patient experience scores. Thus, option purchases would be based on revealed value from the perspective of beneficiaries.
The major findings of the survey were:

- Patient-reported experience measures are positively associated with patient treatment adherence;
- Poor patient experience is associated with poor performance on the patient's psychological and emotional support dimension;
- Specific areas for improvement are information provision for family support at home;
- The need for convenient access;
- Providing emotional support to the patient; and
- Providing support to build self-confidence of the patient.

Ultimately:

- Patient-reported experience scores support patient satisfaction results, in that policy makers can identify where pay-for-performance contracts can improve quality for beneficiaries;
- Patient experience results, reported on a geographical basis, suggest that regional arrangements may lock in good performance in specific geographical areas. Thus, inter-regional savings are limited by the regional footprint of provider networks;
- Poor patient experience suggests that there are inefficiencies to correct, before interventions such as risk equalisation, regional schemes and risk-based capital achieve optimal outcomes.

### *Provider Distribution Project*

The Provider Distribution Project is relevant in the current policy development discussion. Health care interventions need to be accessible, effective, and affordable.
The methodology used in the analysis identified under- and over-served areas in South African provinces, using the Gini-coefficient. It then identified areas where provider allocations were not effective due to diminishing returns in efficiency.
The findings showed that:

- The methodology is effective for conducting an economic impact evaluation on provider distribution and access;
- The model could provide a solution to the void in empirical methods to support the implementation of a certificate of needs policy;
- Regional inefficiencies in the allocation of provider resources can fuel waste and abuse on the supply-side (supply-induced demand); and
- Poor patient experience suggests that there are inefficiencies to correct, before interventions such as risk equalisation, regional schemes and risk-based capital can achieve optimal outcomes.

### *Risk-Based Capital Solvency Framework*

The discussion around the implementation of a risk-based solvency regime for the health industry in South Africa has been ongoing since as far back as 1995. Extensive work has been done in this regard. However, any change to the solvency framework for medical schemes will need to be cognisant of the changing policy environment to ensure regulatory coherence, including *inter alia* the draft Medical Schemes Amendment Bill, the outcomes of the Health Market Inquiry and the implementation of National Health Insurance. On 25 November 2015, the CMS published Circular 68 of 2015, outlining a proposal for a risk-based solvency framework that could be applied to South African medical schemes. Stakeholders were invited to comment on the technical discussion document. Nineteen submissions were received from:

- 10 medical schemes;
- 2 administrators;
- 1 hospital group; and
- 6 consulting and actuarial firms.

All respondents supported the concept of moving towards a risk-based approach to solvency but differed on some of the technical detail. It is generally agreed that the framework should be aligned with the Solvency Assessment Framework, adjusted as necessary for the medical scheme environment. The CMS will publish an updated framework in 2019 that takes into consideration the feedback received from industry. It will include technical detail of the calculations required and the implementation timeline/strategy, enabling further and deeper engagement.

### *Value proposition for Efficiency Discounted Options*

The CMS has allowed the registration of efficiency discounted options (EDOs) since January 2009 through an exemption framework. EDOs allow for differentiated contributions within a benefit option by offering a discount to members who voluntarily choose to use more cost-efficient providers designated by the medical schemes. The intended beneficiaries of the discount are a group of beneficiaries with unfavourable health status, especially the older and sicker medical scheme enrollees.

The main findings of the cross-sectional descriptive study on the value proposition of EDOs revealed that EDOs tend to attract beneficiaries who are young and have a favourable health status. This analysis suggests that savings achieved through EDO offerings are more likely attributable to the young and healthy beneficiaries, than to the supposed efficiency of these options. The proliferation of EDOs, especially when used by medical schemes as a tool to compete for favourable risk profiles, is likely to promote a 'free-rider problem' in the medical schemes system – a phenomenon typified by young and healthy beneficiaries choosing EDO options, only to switch

to more comprehensive benefit options when their health needs change. Furthermore, the reliance on fee-for-service payment arrangements for healthcare benefits significantly reduces the ability of EDOs to purchase high quality services at low cost. Nonetheless, the EDO experience has shown that it is possible to make an impact on the high cost of health by offering premium discounts to beneficiaries who voluntarily choose "more cost-efficient service provider arrangements". The proposal made in the Medical Schemes Amendment Bill 2018 to regularise the EDO arrangement in the medical scheme's environment, is a positive development.

## National Health Insurance

### *Medical schemes risk pool consolidation*

On 19 October 2018 the CMS published Circular 42, inviting stakeholders within the industry to comment on the proposed framework for medical schemes consolidation. This research was initiated after the publication of the National Health Insurance White Paper in 2017, where paragraph 322 stated the following:

"Amendments to the Medical Schemes Act will be initiated as part of the broad phased implementation. **Medical schemes will evolve and consolidate during this phase** to provide complementary cover. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme. **Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS).** The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI."

Twenty-three (23) responses from different medical schemes, administrators, research institutes and unions were received by the CMS. A variety of views was presented. These ranged from complete support for some form of risk pool consolidation within the industry, to no support at all for the proposed policy options, whilst some stakeholders preferred that the CMS should consider the Health Market Inquiry (HMI) recommendations.

This review enabled the CMS to undertake additional analysis on small schemes and on the Low-Cost Benefit Option. Circular 28 of 2019 was then published. This circular sought to enhance aspects of Circular 42 of 2018, based on comments received. The descriptive analysis presented within Circular 28 showed that membership is an insufficient metric to identify the schemes which could be considered for consolidation, even though Regulation 2 (3) of the Medical Schemes Act specifies the expected number of members.

Industry-wide analysis of all medical schemes has been recommended, based on a more holistic set of parameters and economic simulations. Given the varying characteristics of the medical schemes, from their operational to business models, and financial and clinical perspectives, the CMS recognises that certain market mechanisms within a wide range of industries can allow small players to operate sustainably, and in fact, enhance competition and innovation. This is also evidenced in the few amalgamations that have occurred between small or medium-sized schemes and large schemes.

Whilst the CMS awaits the final publication of the Health Market Inquiry Report, the Medical Schemes Amendment Bill and the NHI Bill, research and publication of outputs on risk pool consolidation will continue. In the 2018/19 financial year, the CMS will be collecting the following primary data from the industry:

- Chronicity;
- Demographic factors of beneficiaries added each month;
- Average claim sizes by the factors included in this report; and
- Information on eligibility criteria and subsidy policies.

A discussion document will also be published on benefit option standardisation and the medical schemes Umbrella Fund. Several stakeholders, through their submissions, requested that the CMS provide more detail on how an Umbrella Fund can be configured in alignment with the current national policy, whilst addressing risk pool fragmentation and barriers of entry for new medical schemes.

### *Public Sector Medical Schemes Forum*

The CMS held several meetings with public sector schemes where different issues affecting the medical schemes were discussed, including the National Health Insurance. From the meetings it was agreed that Terms of Reference for the Public Sector Medical Schemes Forum will be established and that participation in this forum will be extended to other stakeholders such as the Board of Trustees and employer's organisations.

### *Health Market Inquiry*

The CMS continued to participate in the Health Market Inquiry (HMI) process, and reviewed the Provisional Findings and Recommendations. Whilst the CMS agreed with most of the recommendations, a submission was also made on areas where there were glaring contradictions between the HMI findings and/or recommendations and the Medical Schemes Act, National Health Insurance Bill and the Medical Schemes Amendment Bill.

### *Presidential Health Summit*

The CMS was nominated by the Presidency to actively participate in the NHI and Health Systems Improvement War Room. Through this participation, the CMS has been able to assist the Presidency in organising activities for the Presidential Health Summit, particularly co-ordination of input and submissions for Pillar 9: Developing an Information System that will Guide the Health System Policies, Strategies and Investments, as well as participating in discussions around effective implementation of NHI in South Africa.

## Court rulings

Legal Services provided legal support to the CMS on a range of legal issues, with some remarkable landmark judgments and successes achieved.

Some of the topical court rulings during the period under review are reported below:

### *Hosmed*

The CMS brought an urgent application in the Pretoria High Court (Gauteng Division) to postpone Hosmed's AGM, which was scheduled to take place on 20 September 2018, to the date of a duly notified and convened AGM.

The court also amended the scheme's rules in terms of Section 51(5)(c) of the Medical Schemes Act to extend the term of office of the current Board of Trustees until 30 days after the date on which the results of the proper AGM had been announced.

The court granted the application with costs. The application was necessitated by complaints lodged against Africore, the company that won the tender to conduct the elections, which seriously questioned the integrity of the electoral process.

A certain electoral officer of Africore had been implicated in problematic elections of other medical schemes as well as the invalid elections of Hosmed in 2008. Some of the complaints against this officer included forged proxy forms; the declaration of valid proxy forms as invalid; allowing voting without ballot papers and denying members the opportunity to inspect proxies in their favour. The CMS intervened precisely to curb these fraudulent allegations.

### *Parsons vs CMS*

The appellant was a former member of the Board of Trustees of Medshield and brought an appeal against the decision of the Council to remove him in terms of Section 46. The Appeal Board heard the matter and issued a ruling confirming the decision of the CMS in August 2018. The Appeal Board agreed with the CMS that the trustee was required to disclose two adverse court judgments against him when he participated in the election process, but that he had failed to do so.

The fact that he did not see the judgments as relevant indicated that he lacks insight into the high standards of conduct and integrity set for the position of a trustee. The decision to remove was necessitated to ensure that Medical Schemes are led by fit and proper individuals who, in terms of their integrity, are beyond reproach. Any allegations of fraud, waste or abuse will be attended to by the CMS without fear, favour or prejudice.

### *The National Health Care Professionals Association, Medscheme Holdings (Pty) Ltd & Other*

The Association launched an application to review the provisions of Sections 59(1) (2) and (3) of the Act on the basis that these sections allowed schemes to abuse and act unlawfully against them amongst others. They alleged that schemes at times stopped direct payments to them; conducted unauthorised, illegal investigation into patient rooms; lacked cohesion in signing acknowledgement of debts by medical schemes to service providers; and illegally stopped payments to service providers.

Before their application could be heard, the CMS raised a *point in limin*, holding the view that this Association had no locus standi. The court agreed with the CMS and ordered the Association to pay costs of the application. The Association then appealed this finding. When the matter was discussed on appeal, the Association lost, but was successful in reversing the costs order.

The Association has since launched an appeal to the Supreme Court of Appeal and the matter will be ready for hearing in the near future. Unfortunately, the merits of the case have not been canvassed since the Association is still fighting the lack of locus standi to revive their case. Should the Association fail in the Supreme Court of Appeal, it will be the end of the case unless the Association can appeal the matter to the Constitutional Court.

At the time, the CMS had not adopted a solid approach to their complaint, but the CMS was aware of the possibility that Section 59 presents challenges to the industry, more particularly in the fraud, waste and abuse area. Until such time as the merits of this case are dealt with, the CMS will continue to closely monitor and continue the fight against fraud, waste and any other form of abuse in the industry.

### *CMS vs Ms Duduza*

The CMS filed an application with the Western Cape High Court to have Ms Duduza removed as provisional curator of SAMWUMED. This application was precipitated because of information received which indicated that several corporate governance matters were threatening the survival of the scheme. Further, there was ongoing failure by the curator to respect the financial controls, policies and procedures of the scheme. To protect the funds of the scheme and its members, the CMS launched the application which, due to the overwhelming evidence presented by the CMS, was accepted by the court and the said provisional curator was replaced with a different curator.

### *City Hospital vs CMS*

An urgent application was received from City Hospital wherein they sought payment from several medical schemes and one administrator. The relief sought from the CMS was to investigate

complaints, declare an undesirable business practice and institute inspections into the schemes listed. The Council and the Registrar lodged a counter-application in the matter together with the answering affidavit. Attorneys representing the CMS have written to City Hospital's attorneys requesting them to withdraw their case against the Council and the Registrar, and rather lodge a complaint with the Council in terms of the normal procedures. The matter is on-going.

## Complaints received

Some of the complaints handled by the CMS during the year under review are highlighted below:

### *Suspension of direct payment of claims and recovery of monies owed to medical schemes*

During the 2018/19 financial year, an increase in the volume of complaints from medical practitioners against medical schemes and administrators was noted, relating to the medical schemes' decision to withhold claim payments allegedly owed to their practices. According to the complainants, the medical schemes had arbitrarily initiated an audit of claims submitted by their practices, subsequent to which payments due to their practices were suspended without any unlawful justification.

The medical practitioners alleged, amongst other things, that:

- Medical schemes said that they had identified billing anomalies and/or suspicious claims from the practices;
- Medical schemes were conducting retrospective claims reviews and requesting information relating to consultation hours, location of the practices, proof of purchase of consumables, equipment, qualifications, names and identification numbers of locums, time spent during consultation per patient, hours worked per day, clinical notes on patients' files, and the number of practices registered by the same medical practitioner whose claims were under audit;
- In certain instances, the medical practitioners co-operated with the audit and submitted the required information, however some refused to submit information, claiming doctor-patient confidentiality, and some submitted incomplete information or refused to submit the requested information;
- Without any guilty finding against them, the complainants had received correspondence advising them that direct payment to their practices was suspended and that they owed medical schemes specific sums of money for payments previously made to their practices to which they were not entitled;
- Medical schemes were acting in contravention of Section 59(3) and Regulation 6 of the Medical Schemes Act, No. 131 of 1998 as they applied both provisions incorrectly and the medical practitioners claimed that there was no basis for withholding payment; and
- Most medical practitioners questioned the manner in which investigations were conducted whilst some called into question the qualifications of the forensic and audit teams that evaluated their claims and questioned the amounts allegedly owed by them.

In all rulings made by the Registrar's office, the CMS clarified the legality of the medical scheme's conduct in withholding claim payments and offsetting the value of the alleged irregular claims against the new ones submitted by the complainants. Where claims for which payment had been made by the medical schemes did not match the information that was subsequently submitted, and where other discrepancies were noted, the findings against the medical practitioners were confirmed. Similarly, where no information was provided, and the medical schemes could not verify the validity of claims under audit, the CMS advised that there was no basis for compelling medical schemes to release payment owing to the failure to provide information that would enable proper validation of claims.

The CMS emphasised that the decision to commence deducting the amounts allegedly owed must be preceded by a transparent and credible investigation which should be followed by a detailed report, founded on factual evidence of the irregularities and quantification of amounts allegedly owed.

Of importance is that medical schemes and administrators should not fund claims negligently where there is reasonable suspicion of irregularity, as the Board of Trustees of medical schemes has a duty to ensure that proper control systems are employed by or on behalf of the medical schemes. There is a statutory and fiduciary obligation on administrators of medical schemes to administer the business of medical schemes in accordance with the provisions of the Medical Schemes Act. This duty also applies to self-administered medical schemes. However, medical schemes and administrators were cautioned against investigating practices indefinitely and advised that such investigations must be expedited and brought to finality, and further that investigations must not be used to frustrate medical practitioners.

It is worth mentioning that some of the rulings issued were appealed by aggrieved parties who were dissatisfied by the decision that Section 59(3) is a statutory mechanism whereby medical schemes can offset any payments previously made to medical practitioners in instances where payment was made in error. The rules also provide for the implementation of fraud management policies and the implementation of sanctions that may include the recovery of losses by medical schemes. Therefore, medical schemes have an obligation to recover funds lost and by extension, prevent any further losses.

### *Suspension of membership on the basis of short-payment of monthly contributions*

Some medical schemes had policies that stated that they should liaise with employer groups for annual income verification of members but the policy was silent on direct engagement with members. The medical schemes concerned were of the view that the responsibility to update members' income rested with the employer groups. This meant that members were not

contacted regarding changes relating to their contributions, including income verification. The CMS raised concerns regarding policies that exclude members, after noting that members were never informed of the requirement for annual income verification and only became aware of the requirement once their benefits had been suspended due to delayed submission of income verification by their employers. The CMS held in the rulings that the policies were in contravention of the Medical Schemes Act as the members had a contract with the medical schemes and the medical schemes had a duty to liaise with them on any matter affecting their membership.

### *Incorrect information conveyed by Orthopaedic Surgeons to patients regarding benefit entitlement*

An increase was observed in the number of complaints from Orthopaedic Surgeons and members who demanded payment of costs related to spinal surgery in full, as they regarded spinal stenosis as a PMB condition – this despite Circular 67 of 2016, which provides information on the nature and cover of spinal stenosis. The CMS ruled against complainants as spinal stenosis is not a PMB condition if there is no compression found or where there is no pathology in the spinal cord. The claims relating to back surgery had to be funded in accordance with the limits stipulated in the rules. The Registrar's Office is in the process of engaging the Orthopaedic Society on the matter so that they, in turn, can engage with their members on the matter.

### *Payment of accounts relating to treatment of Prescribed Minimum Benefits (PMBs) from medical savings accounts*

It was noted with concern that some accounts relating to the treatment of PMB conditions were still being funded from members' medical savings accounts, despite this being prohibited by Regulation 10(6) of the Act. None of the responses pertaining to complaints about the contravention of Regulation 10(6), received from the medical schemes concerned, provided reasons why accounts were funded in contravention of the legislation. Instead, they merely advised that the accounts concerned had been reversed and reprocessed to pay from the medical schemes' risk benefit.

This conduct shows that more work needs to be done by the CMS to ensure full compliance by medical schemes and their administrators with the application of the legislation, and that there must be consequences for those entities who contravene the Act.

### *Adjudication of complaints*

The CMS implemented a complaints reduction strategy during 2018 by channelling certain service provider's complaints to medical schemes for direct engagement. This strategy proved successful as it led to a reduction in the number of complaints adjudicated by the team. A reduction of 859 was achieved in the total number of new complaints, from a total of 4 667 received in 2017 to 3 808 complaints in 2018. This translated into a reduction of l8.4%. The complaints ratio per 1 000 beneficiaries is explained in Table 9.



Table 9: Complaints ratio per 1 000 beneficiaries

| 2017 | 2018 | % change |
|---|---|---|
| 4 667 | 3 808 | - |
| 0.53 | 0.42 | -18,40% |

During the period under review, a concerted effort was made to resolve the existing backlog of complaints. This meant that a higher volume of complaints was resolved outside the set timeframe. The unit needed to juggle between new complaints received and aged ones, whilst simultaneously paying attention to clinically urgent new complaints as these always need to be prioritised. Capacity constraints within the team remained a concern and this resulted in the team working under constant pressure.

The unit received much-needed assistance in the form of interns who were able to provide administrative support to the functions inherent in the complaints adjudication process.

The total number of complaints resolved in 2018 was significantly higher compared to 2017, with an improved resolution rate of 33%. Table 10 shows the actual number of complaints received and resolved during periods 2017 and 2018.

Table 10: Number of complaints received and resolved

| | 2017 | 2018 |
|---|---|---|
| Complaints carried forward from the previous year | 1 754 | 2 842 |
| Complaints received during the year | 4 667 | 3 808 |
| **Total complaints** | **6 421** | **6 650** |
| Total complaints resolved during the year | (3 579) | (4 758) |
| Closing balance as at 31 December | 2 842 | 1 892 |

Table 11: Resolution turnaround times

| Resolution turnaround times in days | | | | | | |
|---|---|---|---|---|---|---|
| Complaints resolved in days | 0–30 | 31–60 | 61–90 | 91–120 | + 120 | **Total** |
| Total number of complaints resolved | 828 | 715 | 572 | 394 | 2 249 | **4 758** |
| % of complaints resolved | 17.40% | 15.03% | 12.02% | 8.28% | 47.27% | **100%** |

Table 12: Rulings on resolved complaints against regulated entities in 2018

| Entity Type | Number of complaints | Ruled in favour of the complainant | Ruled in favour of both | Ruled in favour of regulated entity | Enquiries / Invalid complaints |
|---|---|---|---|---|---|
| Open Medical Schemes | 2 823 | 1 146 | 326 | 1 187 | 164 |
| Restricted Medical Schemes | 1 904 | 1 081 | 232 | 491 | 100 |
| Brokers | 10 | 1 | 2 | 7 | - |
| Administrators | 21 | 6 | - | 15 | - |
| **Total** | **4 758** | **2 234** | **560** | **1 700** | **264** |

Table 13: Number of complaints resolved by category

| Main category | Number of complaints resolved |
|---|---|
| Administrative | 2 624 |
| Clinical | 1 430 |
| Legal / Compliance | 436 |
| Sub-total | 4 490 |
| Inquiries / Invalid | 268 |
| **Total** | **4 758** |

Table 14: Rulings on resolved complaints against regulated entities in 2018

| | 2018 | 2017 | % Increase / Decrease |
|---|---|---|---|
| **Administrative complaints** | **2 624** | **1 855** | **41%** |
| Benefits paid incorrectly | 1 624 | 1 086 | 50% |
| Pre-authorisation | 426 | 320 | 33% |
| General customer service | 237 | 244 | -3% |
| Medical savings account | 184 | 120 | 53% |
| Contribution increases | 116 | 69 | 68% |
| Benefit option changes | 33 | 16 | 106% |
| Information / brochures not received | 3 | 0 | 100% |
| **Clinical complaints** | **1 430** | **995** | **100%** |
| **Short-payment of PMB accounts** | **888** | **669** | **33%** |
| Paid at scheme tariff | 285 | 195 | 46% |
| Designated service provider | 106 | 154 | -31% |
| Non-designated service provider | 178 | N/A | N/A |
| Protocols | 98 | 101 | -3% |
| Sub-limits in options | 58 | 59 | -2% |
| Incorrect coding | 48 | 49 | -2% |
| Outstanding information | 53 | 49 | 8% |
| Formularies | 31 | 31 | 0% |
| Paid from savings account | 19 | 22 | -14% |
| Service provider irregular billing | 12 | 9 | 33% |
| **Non-payment of PMB accounts** | **354** | **220** | **61%** |
| Protocols | 106 | 68 | 56% |
| Sub-limit in options | 39 | 36 | 8% |
| Scheme exclusion | 22 | 19 | 16% |
| Outstanding information | 43 | 19 | 126% |
| Designated Service Provider | 53 | 29 | 83% |
| Incorrect coding | 55 | 33 | 67% |
| Formularies | 36 | 16 | 125% |
| **Short-payment of non-PMB accounts** | **133** | **92** | **45%** |
| Sub-limits in options | 39 | 38 | 3% |
| Network provider | 28 | 19 | 47% |
| Outstanding information | 13 | 7 | 86% |
| Protocols | 19 | 14 | 36% |
| Incorrect coding | 27 | 13 | 108% |
| Formularies | 2 | 0 | 100% |
| Provider irregular billing | 5 | 1 | 400% |
| **Non-payment of non-PMB accounts** | **55** | **14** | **293%** |
| **Legal / Compliance** | **436** | **273** | **60%** |
| Suspension / termination of membership | 237 | 148 | 60% |
| Waiting periods | 109 | 61 | 79% |
| Late joiner penalty | 48 | 31 | 55% |
| Rejection of application for membership (eligibility) | 14 | 10 | 40% |
| Governance | 23 | 20 | 15% |
| Broker conduct | 3 | 3 | 0% |

Table 15: Availability of internal dispute resolution for the top ten medical schemes with the most complaints per 1 000 beneficiaries

| Open schemes | 2017 Complaints per 1 000 beneficiaries | 2018 Complaints per 1 000 beneficiaries | Dispute Resolution Committee (DRC) | Number of matters served before the DRC |
|---|---|---|---|---|
| Health Squared | 4.4 | 2.8 | Yes | None |
| Genesis | 2.8 | 1.8 | Yes | None |
| Fedhealth | 1.4 | 1.4 | Yes | None |
| Resolution | 2.6 | 1.2 | Yes | None |
| Selfmed | | 1.2 | Yes | None |
| Sizwe | 1.2 | 1.0 | Yes | None |
| Hosmed | 0.9 | 1.0 | Yes | 3 matters |
| Medihelp | 1.1 | 0.9 | Yes | None |
| Medshield | | 0.8 | Yes | 124 matters |
| Keyhealth | 1.1 | 0.7 | Yes | None |

Table 15 does not imply that there are serious operational or systemic problems with these schemes or that they are about to fail. The table simply lists the top ten medical schemes with a higher number of complaints relative to other medical schemes of similar size.

## Stakeholder engagement

### *Fraud, Waste and Abuse Summit*

In line with its new trajectory of improved stakeholder engagement, the CMS continued to deepen the level of engagement with stakeholders across the industry during the year under review. Through a tripartite engagement involving two medical scheme associations, i.e. the Board of Healthcare Funders of Southern Africa, and the Health Funders Association, significant strides were made to rally stakeholders in a quest for lasting solutions to some of the challenges faced by the industry.



The collaboration culminated in the hosting of the CMS' inaugural Fraud, Waste and Abuse Summit in February 2019, where various industry stakeholders came to together to discuss solutions for dealing with the scourge of fraud, waste, and abuse in the sector. One of the key outcomes of this summit was an Industry Charter, signed by various stakeholders who pledged their commitment not only to deal with fraud, waste and abuse in their environments, but also to support industry initiatives in this regard, including sharing of information on fraud, waste and abuse activities.

### *One-on-one visits*

Under the leadership of the Chairperson of the Board and the Registrar, a total of 47 one-on-one visits were conducted during the period as part of the CMS' roadshow for medical schemes and other regulated entities. Through its Annual Report, the CMS continues to collect and disseminate valuable data on different aspects of the private healthcare sector, including information on overall industry performance. The report serves as an informative resource on key industry developments for the CMS' key stakeholders, including the Portfolio Committee on Health, broader industry stakeholders, members of medical schemes, the media, as well as research students.

### *Marketing and public relations activities*

Various marketing and public relations activities were initiated to raise awareness about the CMS brand and the services offered for members of medical schemes. Information booklets on topical medical scheme-related issues were produced and distributed as part of member awareness initiatives. The CMS also ran a campaign through the Independent Media Group of newspapers, with a significant footprint across the country, where pull-outs (newspaper inserts) provided information on how to save on annual benefits so that they do not run out before the end of the year; how to lodge a complaint on medical scheme-related issues with the CMS; and late joiner penalties, among other matters, were covered.

### *Media coverage*

Members of the public and the media were kept informed on key CMS developments through several press releases issued by the organisation; media interviews; as well as opinion pieces aimed at articulating pertinent medical scheme-related issues for members. These generated significant media coverage for the CMS during the period under review, with 89.7% of the articles receiving neutral and positive coverage, and a total Advertising Value Equivalent (AVE) of R5.7 million. Improved social media activity resulted in improved social media mentions for the CMS.

### *Member education*

Additional funding, directed towards member awareness initiatives, resulted in a significant increase in the number of awareness sessions conducted across the country. In total, 85 education, training, and awareness sessions were conducted for consumers, medical scheme trustees, as well as brokers during the year under review. Thirty-three of these sessions were conducted in rural areas of the country, across seven provinces. Through these interventions, including joint campaigns as part of the Consumer Protection Forum, a total of 7 459 consumers were reached. A significant number of 4 352 of these were from rural areas. Interviews and announcements on consumer education initiatives were conducted on various national and community radio stations, with a cumulative reach of approximately 3.5 million listeners – mainly in the Gauteng, North West, Free State, Northern Cape, Limpopo, Eastern Cape, and Mpumalanga provinces.

### *Member support*

The CMS continued to offer assistance and guidance to stakeholders who, for one reason or another, appealed for assistance through the Customer Care Service Centre care line. A total of 37 020 calls were received during the year under review. Of all calls received, 33 496 (90.48%) were handled by the Customer Care Consultants, and 3 513 (9.48%) calls were dropped by the callers due to the long wait caused by high call volumes. A total of 11 calls were received outside of working hours.

Enquiry trends, which became evident in the course of interaction with stakeholders, related to late joiner penalties; waiting periods; Prescribed Minimum Benefits (PMBs); Designated Service Providers (DSPs); Medical Service Accounts; and formularies and protocols. As part of facilitating improved customer service for members by the schemes, the issues picked up through the enquiries were addressed with scheme customer care officials during the bi-annual Customer Care Forum sessions, facilitated by the CMS.

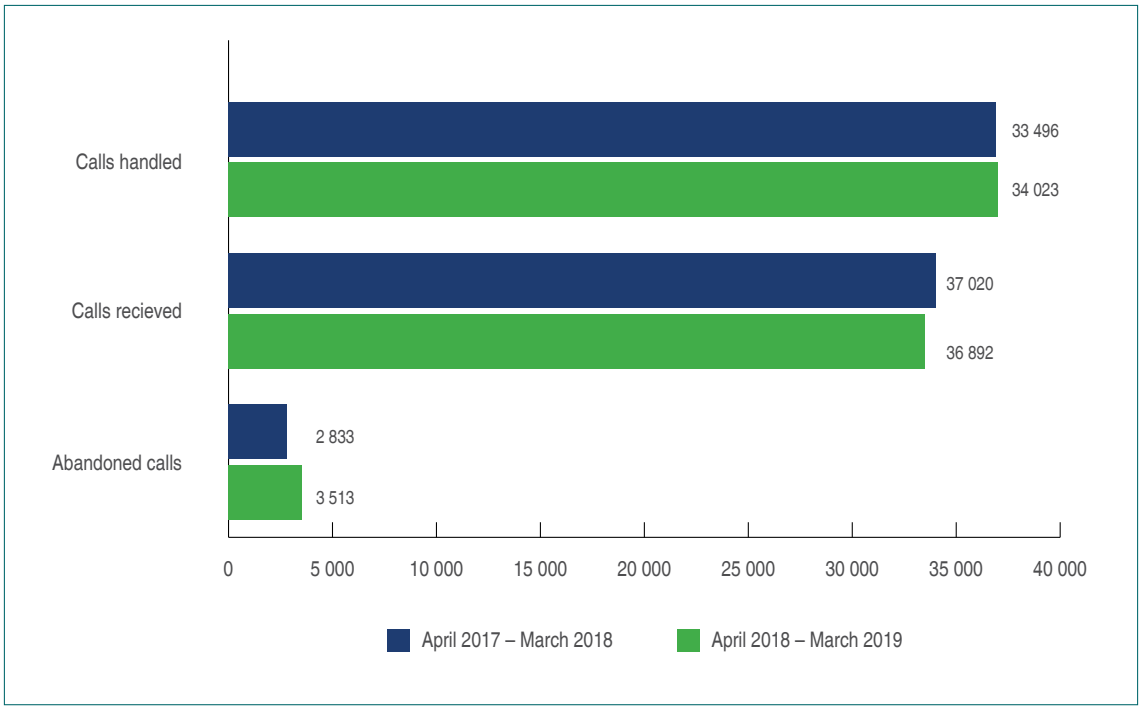



Figure 10: Calls received, handled and abandoned – 2017/18 and 2018/19

# PART D:
## GOVERNANCE

# INTRODUCTION

The Council for Medical Schemes is a body established in terms of the Medical Schemes Act, No. 131 of 1998. It is governed by a Council of up to 15 members appointed by the Minister of Health. The Executive Officer of the Council, who is also the Registrar of Medical Schemes, is also appointed by the Minister of Health. The Council has an appropriate mix of skills, competencies and talents, as members are drawn from a cross-section of society. In support of gender parity, the Council is led by the Chairperson Dr Clarence Mini, and his Deputy Chairperson, Advocate Harshilla Kooverjie (SC).

The Council subscribes to the King IV™ Code of Corporate Governance through, among others, the following governance mechanisms:

- A charter and code of conduct which regulates its functions;
- The devolution of its work into seven committees which all have charters and defined responsibilities, allowing for checks and balances;
- A system for declaration of conflicts of interests and a register;
- Regular sittings of Council up to four times per year, as provided for in the Medical Schemes Act, and additional special meetings when necessary;
- Full and unfettered access to the organisation's information including records of any nature; and
- Regular learning and development opportunities, as well as an annual evaluation including the committees.

The Medical Schemes Act outlines the Council's main and secondary responsibilities, including accountability to the Executive Authority. Among these responsibilities is the protection of beneficiaries of medical schemes, which is achieved through a responsive complaints resolution system; the supervision of financial performance of the industry; benefits management; research and monitoring; as well as a compliance and investigations function.

Over and above its statutory duties and responsibilities, the Council has traditional duties as a governing board, including:

- The evaluation and approval of the Five-Year Strategic Plan;
- The evaluation and approval of the Annual Performance Plan;
- The evaluation and approval of financial information and reporting; and
- The oversight of executive management performance.

The current corps of Council was appointed by the Minister of Health in November 2017. Initially the Minister appointed 14 members. There were two resignations during 2018 relating to Ms Angela Drescher and Shivani Ranchod. The business of Council continued with 12 members.

When the current Council was appointed it inherited an organisation that did not have a Chief Executive and Registrar. The recruitment and appointment of a permanent Chief Executive was prioritised in order to stabilise the organisation and ensure that there is a person in place to be held accountable for the direction of the CMS. The CMS was delighted to welcome its new Chief Executive and Registrar, who was appointed by the Minister of Health in February 2019. The Council remains in full support of its Chief Executive and Registrar and will continue to empower and support him during his five-year tenure.

Council prioritised governance, stakeholder engagement and ethical leadership during the year under review. To strengthen governance in the organisation, Council reviewed all internal corporate governance processes through an exercise that closely scrutinised its governance model, including the way its responsibilities are devolved into committees. The exercise resulted in Council revising its code of conduct and the charters of all its committees. A need was identified for the creation of a new committee, the Nominations Committee.

Several roadshows across the country were undertaken by the Chairperson and members of the Council to ensure that the CMS is visible to medical schemes and that challenges faced by schemes are communicated to the Chairperson directly. This proved to be a tremendous success, with schemes hailing the effort to engage by the Council. The CMS was itself pleased to meet the principal officers and members of boards of trustees of the schemes at their own premises and was able to appreciate the enormous challenges on the ground.

In order to promote ethics, integrity and clean governance, the CMS promoted ethical leadership across the organisation and set the tone. Members of Council and management attended various training sessions on ethics, leadership and governance. The CMS sees training as an investment towards a culture of ethical, clean governance. Where the organisation faced allegations of impropriety, these were dealt with swiftly in order to restore confidence and credibility.

# CORPORATE GOVERNANCE

## Council secretariat

The Council is assisted and supported by the Council Secretariat who offers guidance to members collectively and individually on their duties, responsibilities and powers. The Secretariat apprises the Council on developments in legislation, regulations, good governance, ethics and compliance. The recording of minutes of meetings, resolutions of Council, training and development, induction and annual evaluations are carried out by the Council Secretariat. The Council is satisfied that the Secretariat performed his duties satisfactorily during the reporting period and kept an arm's length relationship in so doing.

## The Appeal Board

The Appeal Board, appointed by the Minister of Health, hears Section 50 appeals that are lodged against the decisions of the Council. The Appeal Board is chaired by a retired judge of the High Court and has three members. It recently appointed an alternate member to its ranks.

# MEMBERS OF THE COUNCIL



Table 16: Composition of Council as at 31 March 2019

| Name of Council member | Field of expertise | Knowledge and experience | Qualifications | Current Council Committee seats |
|---|---|---|---|---|
| Dr Clarence Mini | • Medical<br>• Healthcare | • Medical Scheme Health Policy<br>• Clinical Governance | • Physician MB Bachelor of Medicine<br>• Postgraduate Diploma in Palliative Medicine<br>• Advanced Diploma in Negotiation Skills | • EXCO<br>• Human Resource, Social and Ethics Committee |
| Mr Johan van der Walt | • Chartered Accountancy<br>• Finance<br>• Marketing, Advertising and Branding<br>• Risk Management | • Auditing<br>• Risk Management<br>• Financial Management<br>• Corporate Governance and Compliance<br>• Internal Control Design<br>• Procurement<br>• Marketing, Advertising and Branding<br>• IT | • Master's Degree in Financial Management<br>• CA(SA)<br>• B.Compt | • Audit and Risk Committee<br>• Finance Committee<br>• Information Communications and Technology Strategic Committee |
| Adv. Harshila Khoosal Kooverjie | • Legal | • Public Law<br>• Administrative Law<br>• Constitutional Law<br>• Financial Sector and Financial Markets<br>• Commercial Lax<br>• Tax | • BA<br>• LLB | • Appeals Committee<br>• EXCO |

| Name of Council member | Field of expertise | Knowledge and experience | Qualifications | Current Council Committee seats |
|---|---|---|---|---|
| Ms Mosidi Maboye | • Healthcare<br>• Nursing<br>• Midwifery<br>• Regulatory | • Healthcare<br>• Nursing<br>• Midwifery | • Post graduate in Healthcare Management<br>• BA in Nursing Science<br>• Occupational Health Nursing<br>• Advanced Diploma in Nursing | • Nominations Committee.<br>• Human Resource, Social and Ethics Committee<br>• Appeals Committee |
| Ms Diane Reinette Terblanche | • Legal<br>• Corporate Governance | • Legislative Government Policy | • BA(LAW)<br>• LLB<br>• LLM | • Nominations Committee<br>• EXCO<br>• Appeals Committee |
| Mr Moerane Marokane Maimane | • General Management<br>• Healthcare<br>• Finance<br>• Operations | • General Management<br>• Human Resources<br>• Economics<br>• Finance<br>• Marketing | • MBA<br>• BPA (Hons)<br>• Diploma in Public Administration<br>• B. Admin (Accounting) | • Human Resource, Social and Ethics Committee<br>• Nominations Committee |
| Adv. Rebaone Gaoraelwe | • Legal | • Corporate Governance<br>• Corporate Legal Services<br>• Governance Audits<br>• Regulatory Policy and Strategy | • BProc<br>• LLB<br>• LLM<br>• Higher Diploma Company Law<br>• Certificate in Public Sector Governance and Strategy | • Appeals Committee<br>• Information Communications and Technology Strategic Committee |
| Prof. Lungile Pepeta | • Healthcare<br>• Paediatrics<br>• Paediatric Cardiology<br>• Higher Education and Training | • Child Healthcare<br>• Paediatrics<br>• Paediatric Cardiology<br>• Higher Education and Training In Health Sciences | • MBChB<br>• DCH (SA)<br>• FC Paed (SA)<br>• Cert Cardiology (SA)<br>• MMed (Wits)<br>• FSCAI | • Appeals Committee |
| Dr Yogan Pillay | • Healthcare<br>• Policy | • Public Health<br>• Health Policy | • Bachelor's Degree in physiology, biochemistry and psychology<br>• PhD in health policy and planning | • EXCO |
| Dr Aquina Thulare | • Healthcare<br>• Paediatrics | • Health Economics | • MBA<br>• BSc MedS (Hons)<br>• Bachelor's Degree in Medicine and Surgery (MBChB) | • Information Communications and Technology Strategic Committee<br>• Audit and Risk Committee |
| Dr Memela M Makiwane | • Healthcare<br>• Clinical Pharmacology<br>• Pharmaceutical Regulatory Affairs | • Health Risk Management<br>• Public Health Management | • Master of Medicine (MMed)<br>• Bachelor's Degree in Medicine and Surgery (MBChB)<br>• Diploma in HIV Management (Dip HIV Man)<br>• Post Graduate Diploma in Pharmaceutical Medicine (PGDip PharmMed)<br>• Fellowship of the College of Clinical Pharmacologists (FCCP) | • Appeals Committee<br>• Information Communication and Technology Strategic Committee |

| Name of Council member | Field of expertise | Knowledge and experience | Qualifications | Current Council Committee seats |
|---|---|---|---|---|
| Dr Matlodi Steven Mabela | • Economics | • Economics<br>• Corporate Strategy and Operations<br>• Corporate Governance and Compliance | • PhD Economics<br>• MBA<br>• Bachelor of Science | • EXCO<br>• Human Resource, Social and Ethics Committee |

Table 17: Remuneration of Council members from 01 April 2018 – 31 March 2019

| Name of Council member | Remuneration 2019 R'000 | Other allowances/ reimbursement/s R'000 | Total Remuneration 2019 R'000 |
|---|---|---|---|
| Prof. BC Dumisa | - | - | - |
| Ms A Dresher | - | - | - |
| Adv. R Gaoraelwe | 268 | - | 268 |
| Adv. H Koorvertjie | 376 | - | 376 |
| Dr MS Mabela | 137 | - | 137 |
| Ms M Maboye | 579 | - | 579 |
| Mr M Maimane | 650 | - | 650 |
| Dr M Makhiwane | 230 | - | 230 |
| Dr C Mini | 557 | - | 557 |
| Dr L Mpuntsha | - | - | - |
| Ms L Nevhutalu | - | - | - |
| Prof. L Pepeta | 47 | - | 47 |
| Prof. S Perumal | - | - | - |
| Ms S Ranchod | 47 | - | 47 |
| Ms Terblanche | 461 | - | 461 |
| Mr J van der Walt | 178 | - | 178 |
| Prof. Y Veriava | - | - | - |
| **Total** | **3 530** | **-** | **3 530** |

# COMMITTEES OF THE COUNCIL

The Council is supported by seven Committees.

Table 18: Committees of the Council

## Council

The Council is the governing body of the CMS. It exercises oversight over the entity. The Act sets out the objectives of the Council, which include financial accountability as well as the strategic direction of the organisation.

| Executive Committee (EXCO) | Human Resource, Social and Ethics Committee (HRSE) | Finance Committee | Audit and Risk Committee (ARC) | Information Commu-nications and Technology Strategic Committee | Appeals Committee | Nominations Committee (NomCom) |
|---|---|---|---|---|---|---|
| 5 members | 5 members | 3 members | 4 Council members<br>3 independent members | 3 members | 6 members | 3 members |
| Chaired by the Chairperson of the Council and responsible for day-to-day tasks of the Council. | Responsible for all human resource and remuneration matters in the organisation. | Reviews the CMS' financial policies, strategies and capital structure and takes such action and makes such reports and rec-ommendations to the Audit and Risk Committee and Council as it deems advisable. | The ARC assists Council in fulfilling its oversight responsibility which includes responsibilities regarding the safeguarding of assets, operating effective systems of control and preparing annual financial statements as required by the PFMA, Treasury Regulations, as well as risk management and internal audit oversight. | Responsible for information and communications governance in the organisation, in line with the Corporate Governance of ICT Policy Framework. | Responsible for the resolution of disputes between beneficiaries and medical schemes. | NomCom monitors the transparent nomination and appointment of members of the committees of Council, ensuring the necessary knowledge, skills, experience, balance of power and diversity of gender and race.<br><br>NomCom's holistic view of the composition of Council committees facilitates independence of judgement, promotes effective collaboration between committees, and ensures minimal overlap and fragmentation by encouraging integrated thinking. |

Table 19: Members of Council committees and meetings attended – 2019

| Council Member | Full Council 10 Meetings | Ad Hoc Committee 2 Meetings | EXCO 8 Meetings | HRSE 12 Meetings | Finance Committee 3 Meetings | ARC 5 Meetings | ICT Strategic Committee 3 Meetings | Appeals Committee | NomCom 3 Meetings |
|---|---|---|---|---|---|---|---|---|---|
| Dr Clarence Mini | 10 | | 8 | 12 | | 3 | | | |
| Adv. Harshila Kooverjie | 5 | | 7 | | | | | 8 | |
| Mr Moerane Maimane | 10 | 2 | | 12 | | | | 12 | 3 |
| Dr Steven Mabela | 3 | | 5 | 8 | | | | | |
| Ms Mosidi Maboye | 9 | 1 | | 11 | | | | 17 | 3 |
| Prof. Lungile Pepeta | 7 | | | | | | | | |
| Mr Johan Van Der Walt | 8 | 1 | | | 3 | 5 | 3 | | |
| Adv. Rebaone Gaoraelwe | 9 | 1 | | | | | 3 | 10 | |
| Ms Diane Terblanche | 8 | 1 | 7 | | | | | 14 | 3 |
| Dr Yogan Pillay | 2 | | 6 | | | | | | |
| Dr Aquina Thulare | 4 | | | | 2 | 1 | 1 | | |
| Dr Memela Makiwane | 9 | 1 | | | | 1 | 3 | 6 | |
| Ms Shivani Ranchod (Resigned 23/8/18) | 4 | | | | | | | | |

# INTERNAL CONTROL

The Office of the CFO is tasked with the responsibility for internal control to ensure the efficient management of CMS resources in line with the Public Finance Management Act (PFMA) and Treasury Regulations. The Regulations require that an entity takes reasonable steps to prevent irregular, fruitless and wasteful expenditure.

## Budget management

Section 53 (1) of the PFMA requires that public entities submit a budget of estimated revenue and expenditure for approval six months prior to commencement of each new financial year. The CMS complied with this provision, submitting a budget that is in line with its strategic and annual performance plan. Approval of the 2018/19 budget by the Executive Authority was received on 05 April 2018. During the year the budget is monitored to ensure that expenditure is in line with the performance of the organisation.

## Financial management

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

- An effective, efficient and transparent system of financial management;
- Reliability of financial and management reports;
- Compliance with applicable laws and regulations; and
- Adequacy of procedures to safeguard assets.

CMS noted instances of non-compliance with policies which led to the entity having an emphasis of matter in the audit report. This area therefore requires much attention in the ensuing financial years. The CMS has received an unqualified audit report from the Auditor General of South Africa (AGSA) for 2018/19. Whilst we are satisfied with the systems of internal controls, the supply chain management (SCM) area has been identified as a component of financial management that requires focused attention. The CMS has taken measures to improve in the area of SCM with a view to establishing a centralised system of SCM and moving to automation of the procurement process. Where irregular and fruitless and wasteful expenditure has been identified, CMS will establish and investigation committee in collaboration with internal auditors as required by the Supply Chain Management Framework.

Where irregular, fruitless and wasteful expenditure have been identified, the CMS will establish an investigation committee, in collaboration with the internal auditors, as required by the Supply Chain Management Framework.

## Materiality

As required in terms of Treasury Regulations, the Council has developed a Materiality and Significance Framework appropriate to its size and circumstances. The Council has taken into account the following factors in determining the CMS' level of materiality:

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

Taking these factors into account, the Council has assessed the level of 'a material loss' to be:

- Every amount in respect of criminal conduct;
- R30 000 and above for irregular, fruitless and wasteful expenditure involving gross negligence; and
- R1 360 750 and above, being about 1% of income to report in terms of Subsection 55(1)(d) regarding the fair presentation of affairs of the public entity, its business, its financial results, its performance against pre-determined objectives and its financial position as at the end of the financial year concerned.

## Significance

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

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

# INTERNAL AUDIT

The internal audit function of the CMS is an outsourced function. To ensure that it maintains its independence the function reports administratively to the Registrar and functionally to the Audit and Risk Committee. The purpose of the internal audit function is to provide independent assurance that the risk management, governance and internal control processes are operating effectively, as well as to add value and improve the CMS' operations.

The annual Internal Audit Plan and a Three-Year Rolling Plan were approved by the Audit and Risk Committee during the year. Audit scopes are based on management's assessment of the risks related to the core business of the CMS. The audit coverage focussed on high-risk areas identified in consultation with the Audit and Risk Committee and management. Management has developed a plan to address the gaps identified by internal audit during the year.

In line with the combined assurance model, the internal and external auditors held several meetings during the year to ensure a more streamlined alignment of audit work.

## Risk management

The Council, through its Audit and Risk Committee, is responsible for overall oversight of risk management practices and processes. The responsibility for risk management implementation resides with management at all levels. The CMS Enterprise Risk Management Framework and Policy was updated and approved by Council during 2018. A strategic risk assessment workshop was held with Council, the Audit and Risk Committee and management on 23 August 2018.

Council continues to discharge its responsibility through its Audit and Risk Committee and ensures that risk management is a standing item for discussion at each scheduled Council meeting.



## Risk Governance

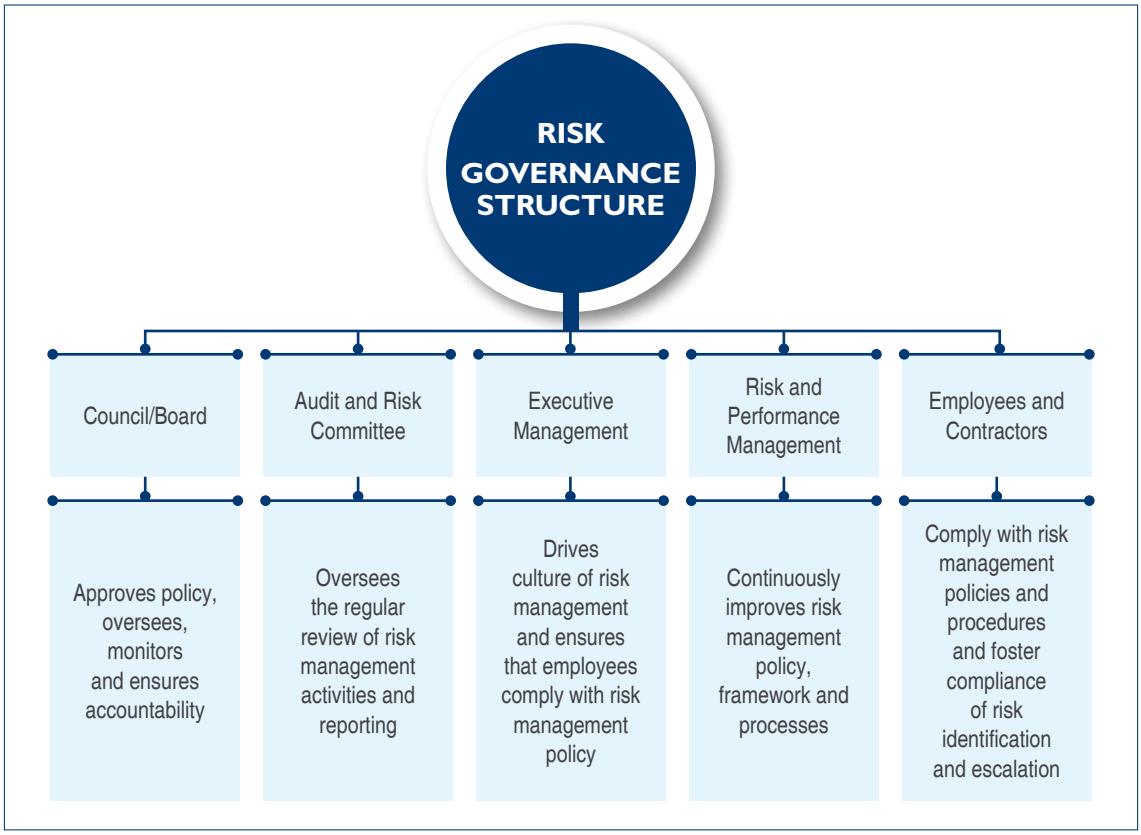



Figure 11: Risk governance structure

## Risk assessment

The CMS manages all categories of risk associated with its business operations as depicted in the figure following.

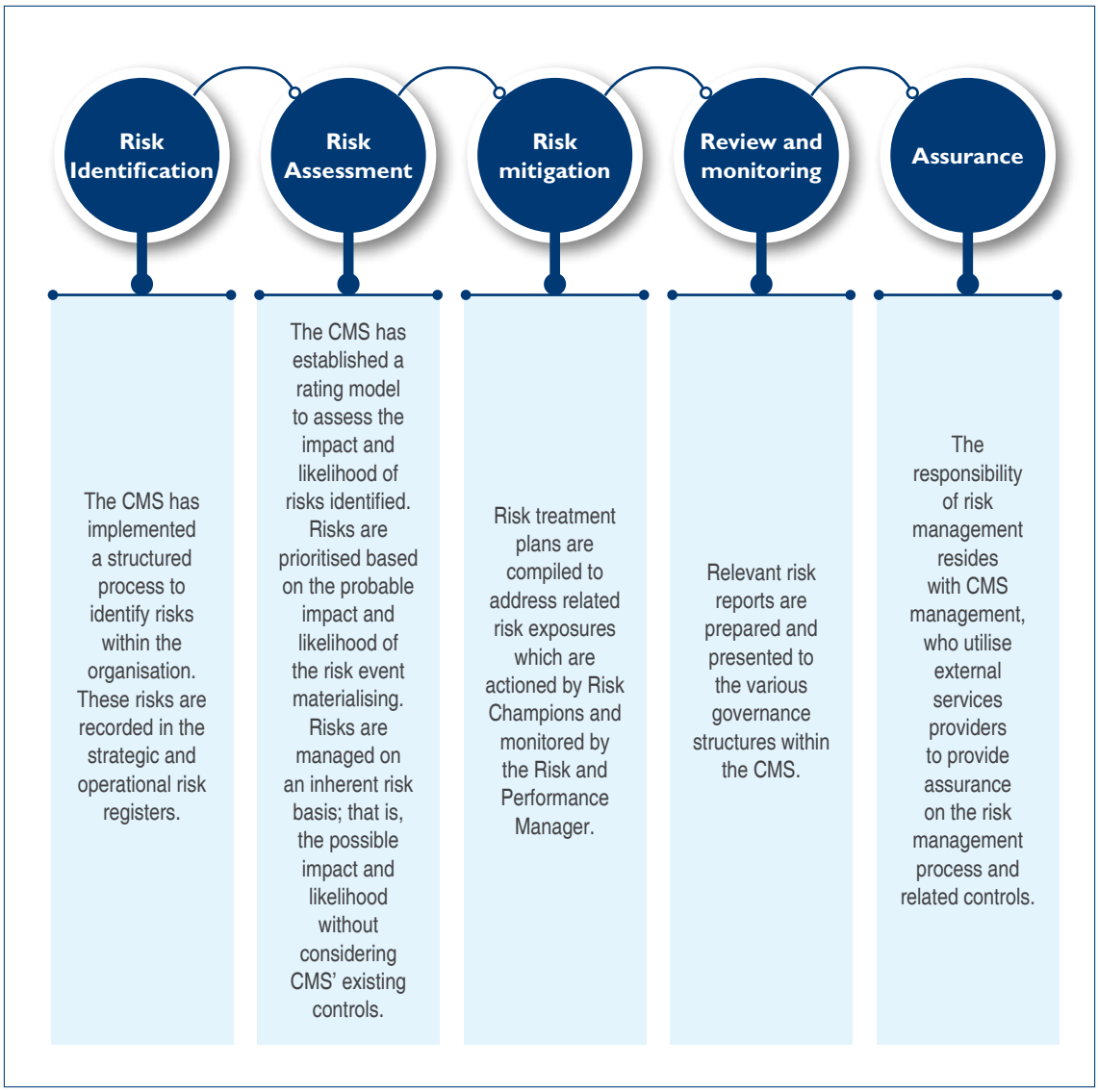



Figure 12: Risk assessment process

## Prevention of fraud and corruption

The CMS is committed to protecting its funds and other assets and as such has adopted a zero tolerance to fraudulent activities emanating from either internal or external sources. Any detected corrupt activities are investigated and, where so required, reported to the law enforcement authorities in accordance with Treasury Regulation 31 and the Fraud and Corruption Prevention Strategy.

## CMS Hotline

The CMS has an established Hotline for the reporting of any suspicious or fraudulent activity. To report suspected fraud against an employee or member of the Council for Medical Schemes, whistle-blowers are requested to use the contacts provided below:

**Toll free number:** 0800 867 423
**Free Fax:** 0800 00 77 88
**Email address:** cms@behonest.com

## Health, safety and environmental issues

A Health and Safety Committee was established and a Health and Safety Framework developed with the aim of protecting employees against the hazards to health and safety arising out of activities at work. The Council considers that reasonable precautions have been taken to ensure a safe working environment. The CMS conducts its business with due regard for environmental concerns.

# REPORT OF THE AUDIT AND RISK COMMITTEE

We are pleased to present our report to the Council for Medical Schemes (CMS) Accounting Authority (Council) for the financial year ended 31 March 2019.

This report is provided by the Audit and Risk Committee of Council, appointed in respect of the 2018/19 financial year of the CMS, in compliance with Section 51(1)(a)(ii) of the Public Finance Management Act 1 of 1999, as amended (PFMA). A detailed Charter that is informed by the PFMA guides the operations of the Committee.

## Audit and Risk Committee members and meetings

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

The Committee held four scheduled meetings and an additional ad hoc meeting during the year under review. Meetings and attendance at these meetings were as follows in Table 20.

Table 20: Meetings and attendance of the Audit and Risk Committee in 2018/19

| Name of member | Position of member | Date of appointment | Term end | Meetings attended | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 24 May 2018 (scheduled) | 26 July 2018 (scheduled) | 07 Nov 2018 (ad hoc) | 20 Nov 2018 (scheduled) | 23 Jan 2019 (scheduled) |
| Mr Kariem Hoosain | Independent non-executive and Chairperson | 18 Jan 2017 | | √ | √ | √ | √ | √ |
| Mrs Marianna Strydom | Independent non-executive | 18 Nov 2016 | | √ | √ | √ | √ | √ |
| Ms Michelle Pillay | Independent non-executive | 26 Nov 2018 | | - | - | - | - | √ |
| Dr Aquina Thulare | Non-executive Council member | May 2017 | | √ | X | X | X | X |
| Mr Johan van der Walt | Non-executive Council member | 14 Nov 2014 | | √ | √ | √ | √ | √ |
| Mrs Shivani Ranchod | Non-executive Council member | 15 Nov 2017 | Resigned Aug 2018 | √ | √ | - | - | - |
| Dr Memela Makiwane | Council Member | | | - | - | - | - | √ |

√ = attended

X = apology

## Other invitees

The internal and external auditors attended all the meetings of the Committee as permanent invitees. The Chief Executive and Registrar and Chief Financial Officer attended meetings ex-officio, and other senior managers attended for agenda items relevant to them. The Chairperson of Council also attended three meetings by invitation.

## 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 and performance reporting process
  - the activities of the internal and external audits and facilitation of a coordinated approach between these functions
- Review of:
  - provisional and year-end financial statements to ensure that they fairly present and are prepared in the manner required by the PFMA and the Medical Schemes Act
  - the external audit plan, budget and reports on the Annual Financial Statements
  - the internal audit charter, annual audit plan, three-year audit plan and annual budget
  - internal audit and risk management reports and, where relevant, recommendations made to the Council and Management
- Approval of:
  - the internal audit charter, budget and three-year audit plan
  - audit fees and engagement terms of the internal auditor are recommended to Council
  - engagement terms, plans, and budget for the Auditor-General of South Africa is reviewed and recommended to Council
- Recommendation of the audited Annual Financial Statements and Annual Performance Report to Council for the financial year ended 31 March 2019.

## Audit and Risk Committee responsibility

### *Mandate*

The mandate of the Committee is derived from Section 51(1)(a)(ii) of the PFMA and Treasury Regulations 27.

The Committee reports that it has discharged its responsibilities arising from Section 51(1)(a)(ii) of the PFMA and Treasury Regulation 27.

The Committee further reports that it has adopted appropriate formal terms of reference, authorised by Council, as it's 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. At the end of the current year, Council also added the mandate of the Finance Committee to that of the Audit and Risk Committee, although the Audit and Risk Committee were respectful of the opinion that both the CMS and the Audit and Risk Committee would benefit most through the continuation of the Finance Committee. The charter will be amended to take this into consideration.

## Role of the Audit and Risk Committee on CMS governance

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

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

The Committee acknowledges that an effective internal audit function is central to the proper operation of the Committee. The outsourced internal auditor of the CMS, compiled and presented its three-year rolling strategic plan for the review and approval of the Committee. The plan was approved by the Committee after it was satisfied that the plan is in line with the requirements of the PFMA, Treasury Regulations and is risk-based, as required by Internal Auditing Standards.

The Committee satisfied itself regarding the objectivity and independence of the CMS internal audit function and the continued appropriateness of the internal audit charter.

## External audit plan by the Auditor-General of South Africa

The Committee reviewed the external audit plan for the financial year under review as prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act for the year ended 31 March 2019. The Committee confirms that this plan is in line with Regulations and standards, and that the plan takes into consideration the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented was sufficient and reasonable for completion of the CMS annual audit.

## Risk management and internal controls

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

Based on internal audits that were performed during the 2018/19

financial period, the overall control environment of the related processes subject to internal audit was found to be adequate and partially effective. There is a generally sound system of internal controls, designed to meet the organisation's objectives and are generally being applied consistently. As in the previous financial year, some weakness in relation to the inconsistent application of Supply Chain Management controls put the achievement of Supply Chain Management objectives at risk. One of the key risks identified relates to the bypassing of the normal Supply chain management processes. Council has asked that this be addressed urgently.

The Committee noted with concern continued Irregular Expenditure for the 2018/19 financial year. The Committee therefore requested the Council to determine accountability for this continuous breach of Internal Controls and consider and implement appropriate corrective and disciplinary measures, where necessary.

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

## Review of legal cases pending at financial year-end

The Committee reviewed progress reports on legal cases involving the CMS as the regulator on a quarterly basis and those pending at the financial year-end so as to assess the adequacy of its disclosure in the Annual Financial Statements as required in terms of the Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. Details in terms of legal cases that warrant noting can be found on page 135 note 23 of the annual financial statements.

## Evaluation of the Audit and Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually. During the year under review a self-evaluation was carried out by the Committee.

## Evaluation of financial statements and annual performance report

The Committee reviewed the annual financial statements and annual performance report of the CMS for the financial year ended 31 March 2019 and is satisfied that, in all material respects, the financial statements and annual performance report comply with the relevant provisions of the PFMA, GRAP including any interpretations, guidelines and directives issued by the Accounting Standards Board and fairly present the financial position and performance of the CMS at that date and the results of operations and cash flows for the financial year then ended.

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

The Committee recommended the financial statements and performance report for the year ended 31 March 2019 to Council for approval.

## Our commitment

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

*Chairperson on behalf of the Audit and Risk Committee*
**Council for Medical Schemes**
31 July 2019

# PART E:
## HUMAN RESOURCES MANAGEMENT

# HUMAN RESOURCES MANAGEMENT

The Human Resources (HR) Unit ensures that its programmes and services align with the organisation's strategic goal of being "… responsive to the environment by being a fair, transparent, effective and efficient organisation". During the 2018/19 reporting year, the unit focused on the strategic priorities outlined below:

## Remuneration philosophy

The unit appointed a service provider through a tender process to develop a remuneration philosophy and benchmark its remuneration against public services and state-owned entities. The appointment was made in December 2018.

## Performance management

Job and competency profiling workshops to enhance the performance management system were facilitated between October and November 2018. Job profiles of all employees were revised to ensure alignment with the purpose of the job and to inform the performance management and remuneration philosophy projects.

Performance management continued to be a high-priority area. At the beginning of the period under review, employees signed performance agreements with their supervisors. In line with HR policies, two formal performance reviews were concluded. Through a Moderating Committee, consisting of Executive Management Committee and trade union representative, the unit facilitated the awarding of incentive bonuses to employees for their contribution to the achievement of the CMS' overall strategic objectives.

## Policy review

In the period under review, the HRSE Committee of Council embarked on a comprehensive review of the HR Policy Manual to ensure that HR policies are compliant and aligned with labour legislation and based on codes of good practice in line with the CMS' philosophy of promoting the organisation as an employer of choice.

## Employee relations

During the reporting period, five unfair labour disputes and one case of unfair dismissal were referred and heard at the CCMA. Four of the five unfair labour disputes were ruled in favour of the CMS. The unfair dismissal matter as well as one of the unfair labour practice matters have been referred for arbitration while the other matter is still ongoing.

The HR Unit facilitated training for general managers and managers on initiating and chairing disciplinary hearings to empower staff members and to curb costs in appointing external service providers for the chairing of certain disciplinary hearings.

## Employee wellness

Two employees were referred for occupational health assessments as part of ongoing performance management. One employee was approved for permanent medical boarding while the other application is still under review.

Maintaining a healthy workforce is an important part of the HR function. The CMS has an outsourced Employee Wellness Programme that provides staff members with access to guidance on work-life balance.

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

- Wellness days, where employees participated in a diverse range of health promotion activities including HIV testing and counselling; screening for cancer, diabetes, blood glucose and cholesterol; as well as Body Mass Index measurement; and
- Subsidised health club membership.

To promote the CMS as an employer of choice, the Council approved a medical scheme subsidy for cleaning staff effective from 01 April 2019.

## Social responsibility

The unit, in collaboration with the Social Events Committee participated in the Mandela Day celebrations on 18 July 2018 by donating groceries and baby formula to Rock of Hope Place of Safety; groceries to St Michael and All Angels Church for the homeless, Indaba Zosindiso orphanage and school uniforms (jerseys, shoes, and socks) to the underprivileged pupils at Olivenhoutbosch Primary School.

## Workforce planning

The Minister of Health appointed a permanent Chief Executive and Registrar of the CMS on 20 February 2019.

## Other vacancies

Vacancies are filled in line with the CMS recruitment and selection policy. In the 2018/19 review period fourteen (14) positions were filled. Three (3) of the executive appointments are for a five-year fixed term period, while the remaining eleven (11) are permanent positions. The CMS continued to support government's call to develop the skills of qualified graduates by training twenty-four (24) interns during the review period.

The staff turnover rate decreased from 7.1% to 5.08% during the current financial year. There were six (6) terminations during the year: four (4) due to career advancement, one (1) due to misconduct, and one (1) due to ill-health.

## Skills training

Since incorporation into the permanent structure of the CMS, a process has been initiated for members of the cleaning staff to receive ABET training on numeracy and literacy as part of their development. Five cleaners completed the ABET assessment on 22 March 2019 and will commence with training in the next reporting period. A notable achievement in this regard relates to one of the cleaning ladies who is on the brink of completing her studies towards a bachelor's degree in Public Administration, with the University of South Africa (Unisa). The CMS is proud of her level of dedication and would like to encourage all employees to reach for their full potential in personal development.

## Learning and development

The CMS has a Professional Development Programme providing employees with opportunities to develop new knowledge and skills so that they are equipped to perform their tasks and to contribute to achieving organisational objectives. At the beginning of each financial year, a Workplace Skills Plan is developed to identify specific training needs in view of the skills requirements of the CMS, and this is reported on in the Annual Training Report 2018/19, submitted to the Health and Welfare Sector Education and Training Authority (HWSETA).

## Diversity and inclusion

The HR Unit is in the process of sourcing an external service provider to facilitate a diversity and inclusion workshop following the results of the climate survey, including other issues identified as barriers in the employment equity plan.

## Employment equity

Employment equity remains a major focus for the CMS as it strives to build and maintain an environment that provides equal opportunity to all its employees, with special consideration for previously disadvantaged groups at all occupational levels. New members were appointed to the Employment Equity Forum and provided with training.

The CMS is fairly aligned with the Broad-Based Black Economic Empowerment (BBBEE) scorecard. Although the CMS made good progress in achieving employment equity targets, there was an increase in the employment equity target percentage from 79.82% in the 2017/18 financial year, to 96.41% in 2018/19. Attracting and appointing individuals with disabilities remains a challenge. Currently, the organisation is at 0% to reach the national target of 2% for individuals with disabilities, as illustrated in Table 21.

Table 21: BBBEE scorecard

| Criteria | | A* | B* | C* | D* | % | Achievement/ Challenge |
|---|---|---|---|---|---|---|---|
| Black people with disabilities employed by the entity as a percentage of all full-time employees | 0 | 118 | 0.00% | 4% | 2 | 0.00 | 2.00 |
| Black people employed by the entity at Senior Management level as a percentage of employees at Senior Management level | 10 | 13 | 76.92% | 60% | 2 | 2.56 | -0.56 |
| Black women employed by the entity at Senior Management level as a percentage of employees at Senior Management level | 4 | 13 | 30.77% | 30% | 2 | 2.05 | -0.05 |
| Black people employed by the entity at the Professionally qualified level as a percentage of employees at the Professionally qualified level | 33 | 35 | 94.29% | 75% | 2 | 2.51 | -0.51 |
| Black women employed by the entity at the Professionally qualified level as a percentage of employees at the Professionally qualified level | 18 | 35 | 51.43% | 40% | 1 | 1.29 | -0.29 |
| Black people employed by the entity at the Skilled Technical and Academically qualified workers level as a percentage of employees at the Skilled Technical and Academically qualified level | 50 | 51 | 98.04% | 80% | 1 | 1.23 | -0.23 |
| Weighting points | | | | | 10 | 9.64 | 0.36 |
| Employment Equity Target Percentage | | | | | | 96.41 | |

**Key*

*Measurement of the employment equity criteria*

*The different indicators of employment equity in the scorecard are calculated on the following basis:*

*Formula: A= B/C X D*

*A is the score achieved in respect of any given criteria as referred to paragraph 5.1.1 to 5.1.6*

*B is the percentage of category of black people being measured*

*C is the percentage compliance target in respect of that criteria*

*D is the weighing points allocated to the applicable criteria being measured*

# HR OVERSIGHT STATISTICS

Table 22: Personnel costs per programme

| Business unit | Total expenditure of unit (R'000) | Personnel expenditure (R'000) | Personnel expenditure as % of total expenditure | Number of employees as at year end | Average personnel cost per employee (R'000) |
|---|---|---|---|---|---|
| Programme 1 – Administration | | | | | |
| Sub-programme 1.1 – Office of the Chief Executive and Registrar | 12 251 | 2 347 | 19.16% | 4 | 586.75 |
| Sub-programme 1.2 – Office of the CFO | 34 304 | 10 863 | 31.67% | 19 | 571.74 |
| Sub-programme 1.3 – ICT and Knowledge Management | 20 211 | 11 426 | 56.53% | 13 | 878.92 |
| Sub-programme 1.4 – Human Resources | 10 562 | 5 114 | 48.42% | 5 | 1 022.80 |
| Sub-programme 1.5 – Legal Services | 10 707 | 4 489 | 41.93% | 4 | 1 122.25 |
| Programme 2 – Strategy Office | 13 701 | 10 654 | 77.76% | 10 | 1 065.40 |
| Programme 3 – Accreditation | 9 053 | 8 445 | 93.28% | 9 | 938.33 |
| Programme 4 – Research and Monitoring | 6 382 | 5 929 | 92.90% | 7 | 847.00 |
| Programme 5 – Stakeholder Relations | 14 046 | 8 404 | 59.83% | 11 | 764.00 |
| Programme 6 – Compliance and Investigation | 16 764 | 9 476 | 56.53% | 9 | 1 052.89 |
| Programme 7 – Benefit Management | 6 519 | 6 372 | 97.75% | 7 | 910.29 |
| Programme 8 – Financial Supervision | 12 953 | 12 686 | 97.94% | 11 | 1 153.27 |
| Programme 9 – Complaints Adjudication | 6 852 | 6 764 | 98.72% | 9 | 751.56 |
| **Total** | **174 305** | **102 969** | **59.07%** | **118** | **872.62** |

Table 23: Personnel costs per salary band

| Level | Personnel expenditure (R'000) | Personnel expenditure as % of total expenditure | Number of employees as at year end | Average personnel cost per employee (R'000) |
|---|---|---|---|---|
| Top management | - | 0.00% | - | - |
| Senior management | 22 571 | 21.92% | 13 | 1 736.23 |
| Professionals | 42 692 | 41.46% | 39 | 1 094.67 |
| Skilled technical and academically qualified | 35 543 | 34.52% | 54 | 658.20 |
| Semi-skilled labour | 1 349 | 1.31% | 3 | 449.67 |
| Unskilled labour | 814 | 0.79% | 9 | 90.44 |
| **Total** | **102 969** | **100.00%** | **118** | **872.62** |

Table 24: Performance rewards

| Level | Personnel expenditure (R'000) | Personnel expenditure as % of total expenditure | Number of employees as at year end | Average personnel cost per employee (R'000) |
|---|---|---|---|---|
| Top management | - | 0.00% | - | - |
| Senior management | 1 589 | 19.73% | 13 | 122.23 |
| Professionals | 3 633 | 45.11% | 39 | 93.15 |
| Skilled technical and academically qualified | 2 674 | 33.20% | 54 | 49.52 |
| Semi-skilled labour | 93 | 1.15% | 3 | 31.00 |
| Unskilled labour | 65 | 0.81% | 9 | 7.22 |
| **Total** | **8 054** | **100.00%** | **118** | **68.25** |

Table 25: Training costs per programme

| Business unit | Personnel expenditure (R'000) | Training expenditure (R'000) | Training expenditure as % of total expenditure | Number of employees | Average training cost per employee (R'000) |
|---|---|---|---|---|---|
| Programme 1 – Administration | | | | | |
| Sub-programme 1.1 – Office of the Chief Executive and Registrar | 2 347 | 405 | 17.26% | 4 | 101.25 |
| Sub-programme 1.2 – Office of the CFO | 10 863 | 283 | 2.61% | 19 | 14.89 |
| Sub-programme 1.3 – ICT and Knowledge Management | 11 426 | 139 | 1.22% | 13 | 10.69 |
| Sub-programme 1.4 – Human Resources | 5 114 | 225 | 4.40% | 5 | 45.00 |
| Sub-programme 1.5 – Legal Services | 4 489 | 108 | 2.41% | 4 | 27.00 |
| Programme 2 – Strategy Office | 10 654 | 150 | 1.41% | 10 | 15.00 |
| Programme 3 – Accreditation | 8 445 | 108 | 1.28% | 9 | 12.00 |
| Programme 4 – Research and Monitoring | 5 929 | 160 | 2.70% | 7 | 22.86 |
| Programme 5 – Stakeholder Relations | 8 404 | 114 | 1.36% | 11 | 10.36 |
| Programme 6 – Compliance and Investigation | 9 476 | 159 | 1.68% | 9 | 17.67 |
| Programme 7 – Benefit Management | 6 372 | 99 | 1.55% | 7 | 14.14 |
| Programme 8 – Financial Supervision | 12 686 | 168 | 1.32% | 11 | 15.27 |
| Programme 9 – Complaints Adjudication | 6 764 | 47 | 0.69% | 9 | 5.22 |
| **Total** | **102 969** | **2 165** | **2.10%** | **118** | **311.36** |

Table 26: Employment and vacancies per programme

| Programme | 2017/18 number of employees | Approved posts 2018/19 | 2018/19 number of employees | 2018/19 vacancies | % of vacancies |
|---|---|---|---|---|---|
| Programme 1 – Administration | | | | | |
| Sub-programme 1.1 – Office of the Chief Executive and Registrar | 3 | 1 | 4 | 1 | 7.69% |
| Sub-programme 1.2 – Office of the CFO | 16 | 2 | 19 | 2 | 15.38% |
| Sub-programme 1.3 – ICT and Knowledge Management | 12 | - | 13 | 1 | 7.69% |
| Sub-programme 1.4 – Human Resources | 6 | - | 5 | 1 | 7.69% |
| Sub-programme 1.5 – Legal Services | 4 | - | 4 | - | 0.00% |
| Programme 2 – Strategy Office | 10 | - | 10 | - | 0.00% |
| Programme 3 – Accreditation | 10 | - | 9 | 1 | 7.69% |
| Programme 4 – Research and Monitoring | 6 | - | 7 | 2 | 15.38% |
| Programme 5 – Stakeholder Relations | 10 | - | 11 | 1 | 7.69% |
| Programme 6 – Compliance and Investigation | 8 | - | 9 | 1 | 7.69% |
| Programme 7 – Benefit Management | 7 | - | 7 | - | 0.00% |
| Programme 8 – Financial Supervision | 11 | - | 11 | 1 | 7.69% |
| Programme 9 – Complaints Adjudication | 10 | - | 9 | 2 | 15.38% |
| **Total** | **113** | **3** | **118** | **13** | **100.00%** |

Table 27: Employment and vacancies per salary band

| Level | 2017/18 number of employees | Approved posts 2018/19 | 2018/19 number of employees | 2018/19 vacancies | % of vacancies |
|---|---|---|---|---|---|
| Top management | 0 | - | 1 | - | 0.00% |
| Senior management | 11 | 1 | 12 | 2 | 13.33% |
| Professionals | 38 | - | 39 | 3 | 20.00% |
| Skilled technical and academically qualified | 52 | 1 | 54 | 7 | 46.67% |
| Semi-skilled labour | 5 | - | 3 | 1 | 6.67% |
| Unskilled labour | 7 | 1 | 9 | 2 | 13.33% |
| **Total** | **113** | **3** | **118** | **15** | **100.00%** |

Table 28: Employment changes per salary band

| Level | Employment at beginning of period | Appointments | Terminations | Employment at end of period |
|---|---|---|---|---|
| Top management | - | 1 | - | 1 |
| Senior management | 11 | 3 | 3 | 12 |
| Professionals | 38 | 2 | 2 | 39 |
| Skilled technical and academically qualified | 52 | 5 | 6 | 54 |
| Semi-skilled labour | 5 | 1 | 2 | 3 |
| Unskilled labour | 7 | 3 | 2 | 9 |
| **Total** | **113** | **15** | **15** | **118** |

Table 29: Reasons for staff leaving

| Reason | Number of employees | % of total number of staff leaving |
|---|---|---|
| Death | - | 0.00% |
| Resignations | 11 | 73.33% |
| Dismissal | 3 | 20.00% |
| Retirement | - | 0.00% |
| Ill health | 1 | 6.67% |
| Expiry of contract | - | 0.00% |
| Other | - | 0.00% |
| **Total** | **15** | **100.00%** |

Table 30: Labour relations: misconduct and disciplinary actions

| Reason | Number of occurances |
|---|---|
| Verbal warning | 0 |
| Written warning | 0 |
| Final written warning | 0 |
| Dismissal | 3 |
| **Total** | **3** |

# PART F:
## FINANCIAL INFORMATION

Council for Medical Schemes

# STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY OF THE ANNUAL REPORT AS AT 31 MARCH 2019

To the best of our knowledge and belief, we confirm the following:

All information and amounts disclosed in the Annual Report are consistent with the annual financial statements audited by the Auditor-General of South Africa.

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

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

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

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

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

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

The Auditor-General of South Africa is responsible for independently auditing and reporting on the CMS' annual financial statements. The annual financial statements have been audited by the Auditor-General of South Africa and their report is presented on pages 103 to 106.

In our opinion, the Annual Report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the CMS for the financial year ended 31 March 2019.

The annual financial statements set out on pages 107 to 138, which have been prepared on the going concern basis, were approved by the Council on 31 May 2019 and were signed on its behalf by:

**Dr S Kabane**
Chief Executive and Registrar

**Dr CM Mini**
Chairperson of Council

Council for Medical Schemes

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

## Report on the audit of the financial statements

### *Opinion*

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 103 to 138, which comprise the statement of financial position as at 31 March 2019, the statement of financial performance, statement of changes in net assets, and statement of cash flows and the statement of comparison of budget information with actual information for the year then ended, as well as the notes to the financial statements, including a summary of significant accounting policies.

2. 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 2019, and its financial performance and cash flows for the year then ended in accordance with the South African Standards of Generally Recognised Accounting Practice (SA GRAP) and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA).

### *Basis for opinion*

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the auditor-general's responsibilities for the audit of the financial statements section of this auditor's report.

4. I am independent of the entity in accordance with sections 290 and 291 of the International Ethics Standards Board for Accountants' *Code of ethics for professional accountants* (IESBA code), parts 1 and 3 of the *International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards)* and the ethical requirements that are relevant to my audit in South Africa. I have fulfilled my other ethical responsibilities in accordance with these requirements and the IESBA codes.

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

### *Emphasis of matter*

6. I draw attention to the matter below. My opinion is not modified in respect of this matter.

**Restatement of corresponding figures**

7. As disclosed in notes 25 and 28 to the financial statements, the corresponding figures for 31 March 2019 were restated as a result of an error in the financial statements of the entity at, and for the year ended, 31 March 2019.

### *Responsibilities of the accounting authority for the financial statements*

8. The accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with SA 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.

9. In preparing the financial statements, the accounting authority is responsible for assessing the Council for Medical Scheme's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless the appropriate governance structure either intends to liquidate the entity or to cease operations, or has no realistic alternative but to do so.

### *Auditor-General's responsibilities for the audit of the financial statements*

10. My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

11. A further description of my responsibilities for the audit of the financial statements is included in the annexure to this auditor's report.

Council for Medical Schemes

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

## Report on the audit of the annual performance report

*Introduction and scope*

12. In accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA) and the general notice issued in terms thereof, I have a responsibility to report material findings on the reported performance information against predetermined objectives for selected programmes presented in the annual performance report. I performed procedures to identify findings but not to gather evidence to express assurance.

13. My procedures address the reported performance information, which must be based on the approved performance planning documents of the entity. I have not evaluated the completeness and appropriateness of the performance indicators included in the planning documents. My procedures also did not extend to any disclosures or assertions relating to planned performance strategies and information in respect of future periods that may be included as part of the reported performance information. Accordingly, my findings do not extend to these matters.

14. I evaluated the usefulness and reliability of the reported performance information in accordance with the criteria developed from the performance management and reporting framework, as defined in the general notice, for the following selected programmes presented in the annual performance report of the entity for the year ended 31 March 2019:

| Programmes | Pages in the annual performance report |
|---|---|
| Programme 2 – Strategy Office | 38 to 40 |
| Programme 3 – Accreditation Unit | 41 to 42 |
| Programme 6 – Compliance and Investigation | 47 to 48 |
| Programme 8 – Financial Supervision Unit | 51 to 52 |
| Programme 9 – Complaints and Adjudication | 53 to 54 |

15. I performed procedures to determine whether the reported performance information was properly presented and whether performance was consistent with the approved performance planning documents. I performed further procedures to determine whether the indicators and related targets were measurable and relevant, and assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.

16. I did not raise any material findings on the usefulness and reliability of the reported performance information for these programmes.

*Other matter*

17. I draw attention to the matter below.

### Achievement of planned targets

18. Refer to the annual performance report on pages 28 to 54 for information on the achievement of planned targets for the year and explanations provided for the under/ over achievement of a significant number of targets.

### Adjustment of material misstatements

19. I identified material misstatements in the annual performance report submitted for auditing. These material were on the usefulness and reliability of the reported performance information on Programme 2 – Strategy Unit and Programme 8 – Financial Supervision Unit. As management subsequently corrected the misstatements, I did not raise any material findings on the usefulness and reliability of the reported performance information.

## Report on the audit of compliance with legislation

*Introduction and scope*

20. In accordance with the PAA and the general notice issued in terms thereof, I have a responsibility to report material findings on the compliance of the public entity with specific matters in key legislation. I performed procedures to identify findings but not to gather evidence to express assurance.

21. The material findings on compliance with specific matters in key legislations are as follows:

### Annual financial statements

22. The financial statements submitted for auditing were not prepared in accordance with the prescribed financial reporting framework as required by section 55(1)(a) and (b) of the Public Finance Management Act.

23. Material misstatements in expenditure identified by the auditors in the submitted financial statement were corrected resulting in the financial statements receiving an unqualified audit opinion.

Council for Medical Schemes

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

**Procurement and contract management**

24. Some of the goods and services with a transaction value below R500 000 were procured without obtaining the required price quotations, as required by treasury regulation 16A6.1.

## Other information

25. The accounting authority is responsible for the other information. The other information comprises the information included in the annual report. The other information does not include the financial statements, the auditor's report and those selected programmes presented in the annual performance report that have been specifically reported in this auditor's report.

26. My opinion on the financial statements and findings on the reported performance information and compliance with legislation do not cover the other information and I do not express an audit opinion or any form of assurance conclusion thereon.

27. In connection with my audit, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and the selected programmes presented in the annual performance report, or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

28. I have not yet received the annual report. When I do receive this information, if I conclude that there is a material misstatement therein, I am required to communicate the matter to those charged with governance and request that the other information be corrected. If the other information is not corrected I may have to re-issue my auditor's report amended as appropriate.

## Internal control deficiencies

29. I considered internal control relevant to my audit of the financial statements, reported performance information and compliance with applicable legislation; however, my objective was not to express any form of assurance on it. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on the annual performance report and the findings on compliance with legislation included in this report.

30. Leadership did not exercise oversight responsibility regarding financial reporting and compliance as well as related internal controls.

31. Management did not review and monitor compliance with applicable legislation.

32. Management did not prepare accurate and complete financial reports that are supported and evidenced by reliable information.

## Other reports

33. I draw attention to the engagement to be conducted by the accounting authority of the entity that could have, an impact on the matters reported in the entity's financial statements, compliance with applicable legislation and other related matters. The investigation did not form part of my opinion on the financial statements or my findings on compliance with legislation.

34. As disclosed in note 26 to the financial statements, an investigation will be conducted by the accounting authority, relating to the possible cover quoting identified in the procurement process which could result in financial misconduct or irregular expenditure. The investigation will be covering the period 1 April 2018 to 31 March 2019. The proceedings to initiate the investigation were in progress at the date of this auditor's report.

Auditor - General

Pretoria
31 July 2019

AUDITOR-GENERAL SOUTH AFRICA

*Auditing to build public confidence*

Council for Medical Schemes

# ANNEXURE – AUDITOR-GENERAL'S RESPONSIBILITY FOR THE AUDIT

1. As part of an audit in accordance with the ISAs, I exercise professional judgement and maintain professional scepticism throughout my audit of the financial statements, and the procedures performed on reported performance information for selected programmes and on the public entity's compliance with respect to the selected subject matters.

## Financial statements

2. In addition to my responsibility for the audit of the financial statements as described in this auditor's report, I also:

- identify and assess the risks of material misstatement of the financial statements whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control
- obtain an understanding of internal control relevant to the audit 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 public entity's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the accounting authority
- conclude on the appropriateness of the accounting authority's use of the going concern basis of accounting in the preparation of the financial statements. I also conclude, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Council for Medical Schemes ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements about the material uncertainty or, if such disclosures are inadequate, to modify the opinion on the financial statements. My conclusions are based on the information available to me at the date of this auditor's report. However, future events or conditions may cause a public entity to cease continuing as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation

## Communication with those charged with governance

3. I communicate with the accounting authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

4. I also confirm to the accounting authority that I have complied with relevant ethical requirements regarding independence, and communicate all relationships and other matters that may reasonably be thought to have a bearing on my independence and, where applicable, related safeguards.

Council for Medical Schemes

# STATEMENT OF FINANCIAL POSITION

## AS AT 31 MARCH 2019

| | Note(s) | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|---|
| **Assets** | | | |
| **Current assets** | | | |
| Receivables from exchange transactions | 3 | 3 708 | 10 576 |
| Cash and cash equivalents | 4 | 26 631 | 32 372 |
| | | **30 339** | **42 948** |
| **Non-current assets** | | | |
| Property, plant and equipment | 5 | 15 225 | 17 130 |
| Intangible assets | 6 | 1 003 | 1 084 |
| | | **16 228** | **18 214** |
| **Total assets** | | **46 567** | **61 162** |
| **Liabilities** | | | |
| **Current liabilities** | | | |
| Payables from exchange transactions | 7 | 23 852 | 27 806 |
| Unspent conditional grants and receipts | 12 | 2 574 | 2 803 |
| Provisions | 8 | 179 | 311 |
| | | **26 605** | **30 920** |
| **Non-current liabilities** | | | |
| Operating lease liability | 9 | 9 732 | 9 442 |
| Provisions | 8 | 1 804 | 1 527 |
| | | **11 536** | **10 969** |
| **Total liabilities** | | **38 141** | **41 889** |
| **Net assets** | | **8 426** | **19 273** |
| Accumulated surplus/(deficit) | | 8 426 | 19 273 |

Council for Medical Schemes

# STATEMENT OF FINANCIAL PERFORMANCE

## FOR THE YEAR ENDED 31 MARCH 2019

| | Note(s) | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|---|
| Revenue | 11 | 163 566 | 160 791 |
| Administrative expenses | 13 | (24 249) | (23 199) |
| Audit fees | 14 | (2 613) | (1 476) |
| Operating expenses | 15 | (35 066) | (43 783) |
| Staff costs | 16 | (112 372) | (101 099) |
| Depreciation and amortisation | | (4 598) | (4 906) |
| Gain/(loss) on disposal of assets | 17 | 7 | 9 |
| **Operating deficit** | | **(15 325)** | **(13 662)** |
| Interest received | | 4 478 | 4 744 |
| **(Deficit)/surplus for the year** | | **(10 847)** | **(8 918)** |



Council for Medical Schemes

# STATEMENT OF CHANGES IN NET ASSETS

## FOR THE YEAR ENDED 31 MARCH 2019

| | | Accumulated surplus/(deficit) R'000 | Total net assets Restated R'000 |
|---|---|---|---|
| Opening balance as previously reported | | 28 191 | 28 191 |
| **Restated* Balance at 01 April 2017** | | **28 191** | **28 191** |
| Total recognised income and expenses for the year | | (8 918) | (8 918) |
| Deficit for the year | | (4 560) | (4 560) |
| Correction of errors | | (4 358) | (4 358) |
| **Balance at 01 April 2018** | | **19 273** | **19 273** |
| Deficit for the year | | (10 847) | (10 847) |
| **Balance at 31 March 2019** | | **8 426** | **8 426** |

Council for Medical Schemes

# CASH FLOW STATEMENT

## FOR THE YEAR ENDED 31 MARCH 2019

| | Note(s) | 2019 R'000 | 2018 R'000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| **Receipts** | | | |
| Proceeds from levies and fees | | 157 582 | 145 746 |
| Transfers | | 5 774 | 5 536 |
| Interest received | | 4 478 | 4 744 |
| **Total receipts** | | **167 834** | **156 026** |
| **Payments** | | | |
| Employee costs | | (104 276) | (96 263) |
| Suppliers | | (66 678) | (59 956) |
| Total payments | | **(170 954)** | **(153 219)** |
| **Net cash flows from operating activities** | 20 | **(3 120)** | **2 807** |
| **Cash flows from investing activities** | | | |
| Purchases of property, plant and equipment | 5 | (2 305) | (2 941) |
| Proceeds from sale of property, plant and equipment | 5 | 12 | 36 |
| Purchase of intangible assets | 6 | (328) | - |
| **Net cash flows from investing activities** | | **(2 621)** | **(2 905)** |
| **Net decrease in cash and cash equivalents** | | **(5 741)** | **(98)** |
| Cash and cash equivalents at the beginning of the year | | 32 372 | 32 470 |
| **Cash and cash equivalents at the end of the year** | 4 | **26 631** | **32 372** |

Council for Medical Schemes

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

## FOR THE YEAR ENDED 31 MARCH 2019

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| | Approved budget R'000 | Adjustments R'000 | Final budget R'000 | Actual amounts on comparable basis R'000 | Difference between final budget and actual R'000 | Reference |
| **Statement of Financial Performance** | | | | | | |
| **Revenue** | | | | | | |
| ***Revenue from exchange transactions*** | | | | | | |
| Accreditation fees, registration, appeal fees and inspections fees recovered | 7 560 | 995 | 8 555 | 11 775 | 3 220 | 1 |
| Interest received | 4 483 | - | 4 483 | 4 478 | (5) | |
| Levies income | 144 246 | - | 144 246 | 144 980 | 734 | 2 |
| Revenue other than sale of goods and services | 1 416 | - | 1 416 | 422 | (994) | |
| Sundry income | 1 416 | (850) | 566 | 405 | (161) | |
| **Total revenue from exchange transactions** | **159 121** | **145** | **159 266** | **162 060** | **2 794** | |
| ***Revenue from non-exchange transactions*** | | | | | | |
| **Transfer revenue** | | | | | | |
| Government transfers | 5 815 | (145) | 5 670 | 5 774 | 104 | |
| **Total revenue** | **164 936** | **-** | **164 936** | **167 834** | **2 898** | |

Council for Medical Schemes

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| | Approved budget R'000 | Adjustments R'000 | Final budget R'000 | Actual amounts on comparable basis R'000 | Difference between final budget and actual R'000 | Reference |
| **Expenditure** | | | | | | |
| Personnel | (103 846) | (2 002) | (105 848) | (101 270) | 4 578 | 3 |
| Social contributions | (170) | - | (170) | (160) | 10 | |
| Advertising | (813) | (750) | (1 563) | (1 566) | (3) | |
| Agency and support/outsourced services | (68) | (44) | (112) | (238) | (126) | |
| Audit costs | (900) | - | (900) | (740) | 160 | |
| Board costs | (1 776) | (1 132) | (2 908) | (3 542) | (634) | |
| Bank charges | (100) | (23) | (123) | (108) | 15 | |
| Building expenses | (1 911) | 73 | (1 838) | (1 670) | 168 | |
| Communication | (6 072) | 71 | (6 001) | (4 534) | 1 467 | 4 |
| Consultants | (6 427) | 280 | (6 147) | (5 549) | 598 | |
| Contractors | (322) | (2 920) | (3 242) | (2 581) | 661 | |
| Investigation fees | (1 230) | (1 494) | (2 724) | (8 060) | (5 336) | 5 |
| Legal fees | (8 980) | (1 685) | (10 665) | (8 142) | 2 523 | 6 |
| Non life insurance | (380) | (150) | (530) | (124) | 406 | |
| Postage | (112) | - | (112) | (84) | 28 | |
| Printing and stationary | (1 206) | (17) | (1 223) | (1 264) | (41) | |
| Rental of buildings and office equipment | (14 111) | - | (14 111) | (14 158) | (47) | |
| Repairs and maintenance | (964) | (8) | (972) | (836) | 136 | |
| Security costs | (464) | - | (464) | (409) | 55 | |
| Training and development | (1 557) | (820) | (2 377) | (1 998) | 379 | |
| Subscription and publication | (600) | 37 | (563) | (411) | 152 | |
| Travel and subsistence local | (2 519) | (984) | (3 503) | (3 226) | 277 | |
| Venues and facilities | (976) | (1 546) | (2 522) | (2 839) | (317) | |
| Other unclassified goods and services | (2 965) | (100) | (3 065) | (4 599) | (1 534) | 7 |
| Employee benefits | (2 686) | - | (2 686) | (2 846) | (160) | |
| **Total expenditure** | **(161 155)** | **(13 214)** | **(174 369)** | **(170 954)** | **3 415** | |
| **Surplus/(deficit) for the year** | **3 781** | **(13 214)** | **(9 433)** | **(3 120)** | **6 313** | |
| **Actual amount on comparable basis as presented in the budget and actual comparative statement** | **3 781** | **(13 214)** | **(9 433)** | **(3 120)** | **6 313** | |

Council for Medical Schemes

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| | Approved budget R'000 | Adjustments R'000 | Final budget R'000 | Actual amounts on comparable basis R'000 | Difference between final budget and actual R'000 | Reference |
| **Reconciliation** | | | | | | |
| **Basis of accounting difference** | | | | | | |
| Depreciation and amortisation | | | | (4 598) | | |
| Gain/(loss) on sale of assets | | | | 7 | | |
| Movement in operating lease | | | | (290) | | |
| **Movement in provisions** | | | | | | |
| Movement in provisions | | | | (145) | | |
| Change in receivables from exchange transactions | | | | (6 884) | | |
| Change in payables from exchange transactions | | | | 3 954 | | |
| Change in unspent conditional transfer | | | | 229 | | |
| **Actual amount in the statement of financial performance** | | | | **(10 847)** | | |

Council for Medical Schemes

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| | Approved budget R'000 | Adjustments R'000 | Final budget R'000 | Actual amounts on comparable basis R'000 | Difference between final budget and actual R'000 | Reference |
| **Statement of Financial Performance** | | | | | | |
| **Assets** | | | | | | |
| ***Current assets*** | | | | | | |
| Cash and cash equivalents | - | 16 017 | 16 017 | 5 741 | (10 276) | |
| ***Non-current assets*** | | | | | | |
| Property, plant and equipment | (3 871) | - | (3 781) | (2 293) | 1 488 | |
| Intangible assets | - | - | - | (328) | (328) | |
| | (3 781) | - | (3 781) | (2 621) | 1 160 | |
| **Total assets** | **(3 781)** | **16 017** | **12 236** | **3 120** | **(9 116)** | |
| **Liabilities** | | | | | | |
| ***Current liabilities*** | | | | | | |
| Unspent conditional grants and receipts | - | 2 803 | 2 803 | - | (2 803) | |
| **Total liabilities** | **-** | **2 803** | **2 803** | **-** | **(2 803)** | |
| **Net assets** | **(3 781)** | **13 214** | **9 433** | **3 120** | **(6 313)** | |
| **Net assets** | | | | | | |
| ***Net assets attributable to owners of controlling entity*** | | | | | | |
| *Format and classification difference* | | | | | | |
| Accumulated surplus/(deficit) | (3 781) | 13 214 | 9 433 | 3 120 | (6 313) | |

Council for Medical Schemes

# NOTES TO THE STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

## FOR THE YEAR ENDED 31 MARCH 2019

Basis of accounting: The approved budget is based on a cash basis, thus recognising transactions and other events only when cash is received or paid. The actual amounts were based on an accrual basis of accounting and were adjusted to be comparable to the budget which is on the cash basis.

Classification basis: The classification basis adopted in the approved budget is according to the economic classification as per the National Treasury ENE database.

Period of the approved budget: 01 April 2018 to 31 March 2019.

The approval of budget: The 2018/19 budget was approved in terms of section 2(4) of the Council for Medical Schemes Levies Act, 2000 (Act No. 58 of 2000) by the Minister of Health with the concurrence of the Finance Minister on the 05 April 2018.

Budget adjustments: Approval by the Acting Deputy Director-General: Public Finance was granted on 19 October 2018. CMS to retain cash surplus for the 2017/18 financial year. Mid-term budget review was also done during October 2018 to reallocate funds between units.

Calculated materiality and significance value as determined in terms of Treasury Regulation 28.3.1 amount to R1 299 million. Positive and negative differences above the calculated materiality are explained in this statement below:

1. The variance relates to inspection fees recovered which were not budgeted for based on the recovery of inspection costs in terms of the Inspection of Financial Institutions Act (Act No. 80 of 1998) section 11.
2. Levy on medical schemes is based on the number of principal memberships. The actual number of members as furnished by schemes to the Registrar was higher than the estimated number of members at the point of budget planning.
3. The position of the Registrar was still vacant until 19 February 2019. Other vacancies were not filled within the prescribed estimated time frames of 120 days.
4. The strategic approach towards the Disaster Recovery Project changed and as such costs related to this project did not materialised.
5. On 01 April 2018, The Inspection of Financial Institutions Act (Act No. 80 of 1998) was repealed which allowed the Registrar to recover inspection costs in terms of section 11. For that reason, in the 2018/19 financial year, CMS had to bear all the costs of inspections which were not budgeted for.
6. Legal fees expenditure is by nature unpredictable as this industry is very litigious and as such there is always a buffer on this item for any eventualities.
7. The variance is due to the recruitment costs of senior officials at CMS incurred to the recruitment agencies as well as additional subscriptions which were not budgeted for.

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019

### 1. Presentation of annual financial statements

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

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

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

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

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

#### *1.1 Presentation currency*

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

#### *1.2 Going concern assumption*

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

#### *1.3 Comparative figures*

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

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

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

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

#### *1.4 Significant judgments and sources of estimation uncertainty*

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

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

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

**Provisions**

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

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

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### Depreciation and amortisation

At the end of each financial year, management assesses whether there is any indication that the CMS' expectations about the residual value and the useful life of assets included in the property, plant and equipment have changed since the preceding reporting date. If any such indication exists, the change has been accounted for as a change in accounting estimate in accordance with Standards of GRAP on Accounting Policies, Changes in Accounting Estimates and Errors.

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

### Effective interest rate

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

### Impairment testing

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

### *1.5 Financial instruments*

### Classification

***Initial recognition and measurement***

Financial instruments are recognised initially when the entity becomes a party to the contractual provisions of the instruments. The entity classifies financial instruments, or their component parts, on initial recognition as a financial asset, a financial liability. Financial instruments are measured initially at fair value.

***Subsequent measurement***

Financial instruments at fair value through surplus or deficit are subsequently measured at fair value, with gains and losses arising from changes in fair value being included in surplus or deficit for the period.

Gains and losses arising from changes in fair value are recognised in equity until the asset is disposed of or determined to be impaired.

Financial liabilities at amortised cost are subsequently measured at amortised cost, using the effective interest method.

***Impairment of financial assets***

At each end of the reporting period the entity assesses all financial assets, other than those at fair value through surplus or deficit, to determine whether there is objective evidence that a financial asset or group of financial assets has been impaired.

Impairment losses are recognised in surplus or deficit.

***Receivables from exchange transactions***

Trade receivables are measured at initial recognition at fair value, and are subsequently measured at amortised cost using the effective interest rate method. Appropriate allowances for estimated irrecoverable amounts are recognised in surplus or deficit when there is objective evidence that the asset is impaired. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 30 days overdue) are considered indicators that the trade receivable is impaired. The allowance recognised is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the effective interest rate computed at initial recognition.

The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the deficit is recognised in surplus or deficit within operating expenses. When a trade receivable is uncollectible, it is written off against the allowance account for trade receivables. Subsequent recoveries of amounts previously written off are credited against operating expenses in surplus or deficit.

Trade and other receivables are classified as loans and receivables.

***Payables from exchange transactions***

Trade payables are initially measured at fair value, and are subsequently measured at amortised cost, using the effective interest rate method.

*Cash and cash equivalents*

Cash and cash equivalents comprise cash on hand and demand deposits, and other short-term highly liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. These are initially and subsequently recorded at fair value.

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### *1.6 Property, plant and equipment*

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

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

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

Property, plant and equipment is initially measured at cost.

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

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

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

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

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

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

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

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

| Item | Depreciation method | Average useful life |
|---|---|---|
| Furniture and fittings | Straight-line | 14 years |
| Motor vehicle | Straight-line | 5 years |
| Computer equipment | Straight-line | 7 years |
| Computer software | Straight-line | 7 years |
| Leasehold improvements | Straight-line | Over the lease period |
| Other fixed assets | Straight-line | 16 years |

The depreciable amount of an asset is allocated on a systematic basis over its useful life.

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

The depreciation method used reflects the pattern in which the asset's future economic benefits or service potential are expected to be consumed by the entity. The depreciation method applied to an asset is reviewed at least at each reporting date and, if there has been a significant change in the expected pattern of consumption of the future economic benefits or service potential embodied in the asset, the method is changed to reflect the changed pattern. Such a change is accounted for as a change in an accounting estimate.

The entity assesses at each reporting date whether there is any indication that the entity expectations about the residual value and the useful life of an asset have changed since the preceding reporting date. If any such indication exists, the entity revises the expected useful life and/or residual value accordingly. The change is accounted for as a change in an accounting estimate.

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

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

The entity separately discloses expenditure to repair and maintain property, plant and equipment in the notes to the financial statements (see note 13).

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### *1.7 Intangible assets*

An asset is identifiable if it is either:

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

An intangible asset is recognised when:

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

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

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

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

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

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

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

| Item | Average useful life |
|---|---|
| Developed software | 7 years |
| Acquired software | 7 years |

Intangible assets are derecognised:

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

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

### *1.8 Leases*

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

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

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

**Finance leases – lessee**

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

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

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

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

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

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

### Operating leases – lessor

Operating lease revenue is recognised as revenue on a straight-line basis over the lease term.

Initial direct costs incurred in negotiating and arranging operating leases are added to the carrying amount of the leased asset and recognised as an expense over the lease term on the same basis as the lease revenue.

The aggregate cost of incentives is recognised as a reduction of rental revenue over the lease term on a straight-line basis.

The aggregate benefit of incentives is recognised as a reduction of rental expense over the lease term on a straight-line basis.

Income for leases is disclosed under revenue in statement of financial performance.

### Operating leases – lessee

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

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

### *1.9 Revenue from exchange transactions*

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

### Recognition

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

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

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

The main sources of revenue from exchange transactions are:

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

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

**Measurement**

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

*1.10 Revenue from non-exchange transactions*

Revenue comprises gross inflows of economic benefits or service potential received and receivable by an entity, which represents an increase in net assets, other than increases relating to contributions from owners.

Conditions on transferred assets are stipulations that specify that the future economic benefits or service potential embodied in the asset is required to be consumed by the recipient as specified or future economic benefits or service potential must be returned to the transferor.

Control of an asset arise when the entity can use or otherwise benefit from the asset in pursuit of its objectives and can exclude or otherwise regulate the access of others to that benefit.

Exchange transactions are transactions in which one entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value (primarily in the form of cash, goods, services, or use of assets) to another entity in exchange.

Fines are economic benefits or service potential received or receivable by entities, as determined by a court or other law enforcement body, as a consequence of the breach of laws or regulations.

Non-exchange transactions are transactions that are not exchange transactions. In a non-exchange transaction, an entity either receives value from another entity without directly giving approximately equal value in exchange, or gives value to another entity without directly receiving approximately equal value in exchange.

Restrictions on transferred assets are stipulations that limit or direct the purposes for which a transferred asset may be used, but do not specify that future economic benefits or service potential is required to be returned to the transferor if not deployed as specified.

Stipulations on transferred assets are terms in laws or regulation, or a binding arrangement, imposed upon the use of a transferred asset by entities external to the reporting entity.

Transfers are inflows of future economic benefits or service potential from non-exchange transactions, other than taxes.

**Services in-kind**

Except for financial guarantee contracts, the entity recognise services in-kind that are significant to its operations and/or service delivery objectives as assets and recognise the related revenue when it is probable that the future economic benefits or service potential will flow to the entity and the fair value of the assets can be measured reliably.

Where services in-kind are not significant to the entity's operations and/or service delivery objectives and/or do not satisfy the criteria for recognition, the entity disclose the nature and type of services in-kind received during the reporting period.

*1.11 Irregular expenditure*

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

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

National Treasury Practice Note no. 4 of 2008/09 which was issued in terms of sections 76(1) to 76(4) of the PFMA requires the following (effective from 01 April 2008):

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

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

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

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

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

### *1.12 Fruitless and wasteful expenditure*

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

### *1.13 Post-reporting date events*

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

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

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

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

### *1.14 Related parties*

A related party is a person or an entity with the ability to control or jointly control the other party, or exercise significant influence over the other party, or vice versa, or an entity that is subject to common control, or joint control.

Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities.

Related party transaction is a transfer of resources, services or obligations between the reporting entity and a related party, regardless of whether a price is charged.

Significant influence is the power to participate in the financial and operating policy decisions of an entity, but is not control over those policies.

Management are those persons responsible for planning, directing and controlling the activities of the entity, including those charged with the governance of the entity in accordance with legislation, in instances where they are required to perform such functions.

Close members of the family of a person are considered to be those family members who may be expected to influence, or be influenced by, that management in their dealings with the entity.

The entity is exempt from disclosure requirements in relation to related party transactions if that transaction occurs within normal supplier and/or client/recipient relationships on terms and conditions no more or less favourable than those which it is reasonable to expect the entity to have adopted if dealing with that individual entity or person in the same circumstances and terms and conditions are within the normal operating parameters established by that reporting entity's legal mandate.

Where the entity is exempt from the disclosures in accordance with the above, the entity discloses narrative information about the nature of the transactions and the related outstanding balances, to enable users of the entity's financial statements to understand the effect of related party transactions on its annual financial statements.

### *1.15 Budget information*

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

Council for Medical Schemes

# ACCOUNTING POLICIES

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

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

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

The approved budget covers the fiscal period from 01/04/2018 to 31/03/2019.

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

### *1.16 Provisions and contingencies*

Provisions are recognised when:

- the entity has a present obligation as a result of a past event;
- it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; and
- a reliable estimate can be made of the obligation.

The amount of a provision is the best estimate of the expenditure expected to be required to settle the present obligation at the reporting date.

Where the effect of time value of money is material, the amount of a provision is the present value of the expenditures expected to be required to settle the obligation.

The discount rate is a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the liability.

Where some or all of the expenditure required to settle a provision is expected to be reimbursed by another party, the reimbursement is recognised when, and only when, it is virtually certain that reimbursement will be received if the entity settles the obligation. The reimbursement is treated as a separate asset. The amount recognised for the reimbursement does not exceed the amount of the provision.

Provisions are reviewed at each reporting date and adjusted to reflect the current best estimate. Provisions are reversed if it is no longer probable that an outflow of resources embodying economic benefits or service potential will be required, to settle the obligation.

Where discounting is used, the carrying amount of a provision increases in each period to reflect the passage of time. This increase is recognised as an interest expense.

A provision is used only for expenditures for which the provision was originally recognised.

Provisions are not recognised for future operating surplus (deficit).

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note 23.

### *1.17 Segment information*

A segment is an activity of an entity:

- that generates service potential (including service potential relating to transactions between activities of the same entity);
- whose results are regularly reviewed by management to make decisions about resources to be allocated to that activity and in assessing its performance; and
- for which separate financial information is available.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019

## 2. New standards and interpretations

### *2.1 Standards and interpretations issued, but not yet effective*

The entity has not applied the following standards and interpretations, which have been published and are mandatory for the entity's accounting periods beginning on or after 01 April 2019 or later periods:

| Standard/Interpretation | Effective date: Years beginning on or after | Expected impact |
|---|---|---|
| Guideline: Accounting for Arrangements Undertaken in terms of the National Housing Programme | 01 April 2019 | Unlikely there will be material impact |
| GRAP 32: Service Concession Arrangements: Grantor | 01 April 2019 | Unlikely there will be material impact |
| GRAP 108: Statutory Receivables | 01 April 2019 | Not expected to impact results but may result in additional disclosure |
| GRAP 109: Accounting by Principals and Agents | 01 April 2019 | Unlikely there will be material impact |
| IGRAP 17: Service Concession Arrangements where a Grantor Controls a Significant Residual Interest in an Asset | 01 April 2019 | Unlikely there will be material impact |
| IGRAP 18: Interpretation of the Standard of GRAP on Recognition and Derecognition of Land | 01 April 2019 | Unlikely there will be material impact |
| IGRAP 19: Liabilities to Pay Levies | 01 April 2019 | Unlikely there will be material impact |

## 3. Receivables from exchange transactions

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Accounts receivable | 39 | 75 |
| Sundry debtors | 2 050 | 8 995 |
| Prepaid expenses | 1 619 | 1 506 |
| | **3 708** | **10 576** |

| Receivables ageing | Current | 30 days | 60 days | 90 days | 120 days | Over 120 |
|---|---|---|---|---|---|---|
| Accounts receivable | - | - | 2 | - | 6 | 31 |
| Subtotal | - | - | 2 | - | 6 | 31 |
| | - | - | 2 | - | 6 | 31 |

Part of the receivables from exchange transactions are the following:

R39 194 is interest receivable and employees' advances which are both current and

R2 010 362 is the sundry debtor of inception costs recoverable from medical aid schemes which were under inspection. It is recoverable on the finalisation of the inspection report.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 4. Cash and cash equivalents

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Cash and cash equivalents consist of: | | |
| Bank balances | 2 207 | 4 222 |
| CPD account | 24 424 | 28 150 |
| | **26 631** | **32 372** |

### 5. Property, plant and equipment

| | 2019 | | | 2018 | | |
|---|---|---|---|---|---|---|
| | Cost/ Valuation R'000 | Accumulated depreciation and accumulated impairment R'000 | Carrying value R'000 | Cost/ Valuation R'000 | Accumulated depreciation and accumulated impairment R'000 | Carrying value R'000 |
| Computer equipment | 14 099 | (9 622) | 4 477 | 12 460 | (7 739) | 4 721 |
| Computer software | 2 163 | (1 879) | 284 | 2 163 | (1 649) | 514 |
| Furniture and fittings | 8 369 | (3 820) | 4 549 | 7 820 | (3 170) | 4 650 |
| Leasehold improvements | 11 980 | (6 621) | 5 359 | 11 980 | (5 346) | 6 634 |
| Motor vehicles | 470 | (232) | 238 | 470 | (138) | 332 |
| Other fixed assets | 731 | (413) | 318 | 647 | (368) | 279 |
| **Total** | **37 812** | **(22 587)** | **15 225** | **35 540** | **(18 410)** | **17 130** |

*Reconciliation of property, plant and equipment – 2019*

| | Opening balance R'000 | Additions R'000 | Disposals R'000 | Other changes, movements R'000 | Depreciation R'000 | Total R'000 |
|---|---|---|---|---|---|---|
| Computer equipment | 4 721 | 1 672 | (21) | - | (1 895) | 4 477 |
| Computer software | 514 | - | - | - | (230) | 284 |
| Furniture and fittings | 4 650 | 549 | - | - | (650) | 4 549 |
| Leasehold improvements | 6 634 | - | - | - | (1 275) | 5 359 |
| Motor vehicles | 332 | - | - | - | (94) | 238 |
| Other fixed assets | 279 | 84 | - | - | (45) | 318 |
| **Total** | **17 130** | **2 305** | **(21)** | **-** | **(4 189)** | **15 225** |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

*Reconciliation of property, plant and equipment – 2018*

| | Opening balance R'000 | Additions R'000 | Disposals R'000 | Depreciation R'000 | Total R'000 |
|---|---|---|---|---|---|
| Computer equipment | 5 078 | 1 607 | (3) | (1 961) | 4 721 |
| Computer software | 791 | - | - | (277) | 514 |
| Furniture and fittings | 4 011 | 1 272 | (24) | (609) | 4 650 |
| Leasehold improvements | 7 908 | - | - | (1 274) | 6 634 |
| Motor vehicles | 426 | - | - | (94) | 332 |
| Other fixed assets | 262 | 62 | - | (45) | 279 |
| **Total** | **18 476** | **2 941** | **(27)** | **(4 260)** | **17 130** |

## 6. Intangible assets

| | 2019 | | | 2018 | | |
|---|---|---|---|---|---|---|
| | Cost/ Valuation R'000 | Accumulated amortisation and accumulated impairment R'000 | Carrying value R'000 | Cost/ Valuation R'000 | Accumulated amortisation and accumulated impairment R'000 | Carrying value R'000 |
| Acquired software | 2 449 | (2 215) | 234 | 2 424 | (1 940) | 484 |
| Other fixed assets | 2 098 | (1 329) | 769 | 1 795 | (1 195) | 600 |
| **Total** | **4 547** | **(3 544)** | **1 003** | **4 219** | **(3 135)** | **1 084** |

*Reconciliation of intangible assets – 2019*

| | Opening balance R'000 | Additions R'000 | Amortisation R'000 | Total R'000 |
|---|---|---|---|---|
| Acquired software | 484 | 25 | (275) | 234 |
| Developed software | 600 | 303 | (134) | 769 |
| **Total** | **1 084** | **328** | **(409)** | **1 003** |

*Reconciliation of intangible assets – 2018*

| | Opening balance R'000 | Additions R'000 | Total R'000 |
|---|---|---|---|
| Acquired software | 976 | (492) | 484 |
| Developed software | 753 | (153) | 600 |
| **Total** | **1 729** | **(645)** | **1 084** |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 7. Payables from exchange transactions

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Accounts payable | 9 502 | 10 684 |
| Accruals | 10 917 | 13 081 |
| Accrual for leave pay | 2 214 | 2 806 |
| Income received in advanced | 1 219 | 1 235 |
| | **23 852** | **27 806** |

| Payables ageing | Current | 30 days | 60 days | 90 days | 120 days | Over 120 |
|---|---|---|---|---|---|---|
| Payables from exchange transactions | 6 572 | - | 15 | 10 | - | 17 |
| Payables from non-exchange transaction | 2 888 | - | - | - | - | - |
| Subtotal | 9 460 | - | 15 | 10 | - | 17 |

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

### 8. Provisions

*Reconciliation of provisions – 2019*

| | Opening balance R'000 | Additions R'000 | Utilised during the year R'000 | Reversed during the year R'000 | Total R'000 |
|---|---|---|---|---|---|
| Provision for long service award | 1 838 | 497 | (311) | (41) | 1 983 |

*Reconciliation of provisions – 2018*

| | Opening balance R'000 | Additions R'000 | Utilised during the year R'000 | Total R'000 |
|---|---|---|---|---|
| Provision for long service award | 1 691 | 458 | (311) | 1 838 |

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Non-current liabilities | 1 804 | 1 527 |
| Current liabilities | 179 | 311 |
| | **1 983** | **1 838** |

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

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 9. Operating lease liability

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Non-current liabilities | 9 732 | 9 442 |

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

### 10. Financial instruments disclosure

*Categories of financial instruments*

| | 2019 | |
|---|---|---|
| | At amortised cost R'000 | Total R'000 |
| **Financial assets** | | |
| Trade and other receivables from exchange transactions | 2 089 | 2 089 |
| Cash and cash equivalents | 26 631 | 26 631 |
| | **28 720** | **28 720** |
| **Financial liabilities** | | |
| Trade and other payables from exchange transactions | 23 852 | 23 852 |

| | 2018 | |
|---|---|---|
| | At amortised cost R'000 | Total R'000 |
| **Financial assets** | | |
| Trade and other receivables from exchange transactions | 9 070 | 9 070 |
| Cash and cash equivalents | 32 369 | 32 369 |
| | **41 439** | **41 439** |
| **Financial liabilities** | | |
| Trade and other payables from exchange transactions | 23 261 | 23 261 |

| Payables ageing | Current | 30 days | 60 days | 90 days |
|---|---|---|---|---|
| Payables from exchange transactions | 6 573 | - | - | - |
| Payables from non- exchange transaction | 2 888 | - | - | - |
| Subtotal | 9 460 | - | - | - |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 11. Revenue

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Accreditation fees | 7 787 | 8 182 |
| Inspection fees recovered | 3 491 | 9 085 |
| Government transfers: Department of Health | 5 899 | 5 964 |
| Legal fees recovered | 418 | 906 |
| Levies income | 144 980 | 135 663 |
| Mandatory transfer: Department of Higher Education and Training | 104 | 40 |
| Registration fees | 456 | 402 |
| Sundry income | 431 | 549 |
| | **163 566** | **160 791** |

The amount included in revenue arising from exchanges of goods or services are as follows:

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Accreditation fees | 7 787 | 8 182 |
| Inspection fees recovered | 3 491 | 9 085 |
| Legal fees recovered | 418 | 906 |
| Levies income | 144 980 | 135 663 |
| Registration fees | 456 | 402 |
| Sundry income | 431 | 549 |
| | **157 563** | **154 787** |

The amount included in revenue arising from non-exchange transactions is as follows:

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Transfer revenue** | | |
| Government transfers: Department of Health | 5 899 | 5 965 |
| Mandatory transfer: Department of Higher Education and Training | 104 | 40 |
| | **6 003** | **6 004** |

**Nature and type of services in-kind are as follows:**

The CMS awarded Board of Healthcare Funders (BHF) a contract on 14 December 2009 to administer the Practice Code Numbering System (PCNS) in terms of Regulation 1 of the Medical Schemes Act (Act No. 131 of 1998). The CMS does not charge any fee to BHF for the administration of the PCNS. BHF only has to submit quarterly report to CMS for purposes of research work.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 12. Unspent conditional grants and receipts

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Grant received from Department of Health** | | |
| Opening balance | 2 803 | 3 272 |
| Utilised during the year | (229) | (469) |
| | **2 574** | **2 803** |

The CMS received a grant to the amount of R2 556 000 in 2015/16 and R1 613 000 in 2016/17 financial years with a condition to complete:

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

### 13. Administrative expenses

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Bank charges | 112 | 117 |
| Building expenses | 1 813 | 1 920 |
| General administrative expenses | 957 | 871 |
| Insurance | 523 | 481 |
| Printing and stationery | 346 | 364 |
| Refreshments | 84 | 76 |
| Rent | 11 690 | 11 625 |
| Rent-operating expense | 2 341 | 2 138 |
| Rental – copiers | 401 | 396 |
| Security | 409 | 362 |
| Subscriptions | 427 | 417 |
| Telecommunication expenses | 5 146 | 4 434 |
| | **24 249** | **23 201** |

Included in the administrative expenses above is the repairs and maintenance cost with the amount disclosed below:

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Repairs and maintenance** | | |
| Repairs and maintenance costs | 697 | 837 |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 14. Auditors' remuneration

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| External audit | 740 | 697 |
| Internal audit | 1 873 | 779 |
| | **2 613** | **1 476** |

### 15. Operating expenses

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Committee remuneration | 128 | 152 |
| Consulting | 5 368 | 2 350 |
| Council members' fees | 3 530 | 1 302 |
| Exhibition costs | 103 | 38 |
| Inspection costs | 6 824 | 16 033 |
| Knowledge management | 1 498 | 940 |
| Labour relations costs | 1 780 | 6 618 |
| Legal fees | 6 022 | 8 604 |
| Media and promotion | 1 606 | 3 434 |
| Postage and courier | 83 | 77 |
| Printing and publication | 979 | 878 |
| Transcription services | 226 | 160 |
| Travel and subsistence | 3 744 | 2 141 |
| Venue and catering | 3 175 | 1 053 |
| | **35 066** | **43 780** |

Inspection costs relate to costs incurred on the commissioned inspections to various medical schemes by the Compliance and Investigation Unit during the current financial year. These inspections were outsourced.

### 16. Staff costs

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Employee benefits | 2 846 | 2 405 |
| Employee wellness | 270 | 387 |
| Recruitment and relocation | 1 009 | 308 |
| Salaries | 102 967 | 95 585 |
| Staff training | 2 165 | 995 |
| Temporary staff | 2 716 | 791 |
| SEP system expense | 229 | 468 |
| Workmen's compensation | 170 | 160 |
| | **112 372** | **101 099** |
| | | |
| Total number of employees | 118 | 113 |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 17. Gain/ (Loss) on disposal of assets

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Gain/(loss) on disposal of assets | 7 | 9 |

The CMS disposed of some assets which where no longer in use during the year with a gain of R7 000.

### 18. Interest received

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Interest earned on investment | 4 478 | 4 744 |

The CMS earns interest from the current account as well as the CPD account.

### 19. Taxation

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

### 20. Cash (used in)/generated from operations

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| (Deficit)/Surplus | (10 847) | (8 918) |
| **Adjustment for:** | | |
| Depreciation and amortisation | 4 598 | 4 906 |
| (Gain)/Loss on sale of assets and liabilities | (7) | (9) |
| Movements in operating lease assets and accruals | 290 | 1 211 |
| Movements in provisions | 145 | 147 |
| **Changes in working capital:** | | |
| Receivables from exchange transactions | 6 884 | (4 542) |
| Payables from exchange transactions | (3 954) | 10 480 |
| Unspent conditional grants and receipts | (229) | (468) |
| | **(3 120)** | **2 807** |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 21. Commitments

Operating leases – as lessee (expense)

*20.1 Photocopier rental*

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Minimum lease payments due** | | |
| - within one year | - | 369 |

The CMS entered into an operating lease agreement which commenced on 01 March 2016 for the rental of photocopiers up to 28 February 2019, with 0.0% escalation. The existing operating lease was settled in the current financial period.

*20.2 Office rental*

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Minimum lease payments due** | | |
| - within one year | 12 368 | 11 399 |
| - in second to fifth year inclusive | 46 455 | 56 145 |
| - later than five years | - | 2 678 |
| | **58 823** | **70 222** |

The CMS entered into a renewable 10 year lease agreement which commenced on 01 June 2013 and will terminate on 31 May 2023 and which provides for an escalation of 8.5% per annum. In conjunction with the first lease a second lease was entered into to start in June 2014 for additional space in the existing building with the same terms as the first lease agreement. In conjunction with the first lease, a third lease was entered into to start in October 2015 for additional space in the existing building with the same terms as the first lease agreement. The CMS also contracted to have the option to purchase the office building.

### 22. Related parties

*Relationships*

| | |
|---|---|
| Executive authority: | The Executive authority as defined in Section 1 of the PFMA, is the Minister of Health,as the CMS falls under the portfolio of the Department of Health. |
| Accounting authority: | Council, as defined in Section 49 of the PFMA, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of CMS. |
| Executive management: | Executive management is appointed by the Council and Registrar is appointed by the Minister of Health. |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

*Related party transactions*

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| **Transfer paid to (received from) related parties** | | |
| Department of Health | (5 670) | (5 496) |
| | | |
| Prof. BC Dumisa | - | 143 |
| Ms A Dresher | - | 13 |
| Adv. R Gaoraelwe | 268 | 18 |
| Adv. H Koorvertjie | 376 | 117 |
| Dr MS Mabela | 137 | 79 |
| Ms M Maboye | 579 | 151 |
| Mr M Maimane | 650 | 18 |
| Dr M Makhiwane | 230 | 18 |
| Dr C Mini | 557 | 64 |
| Dr L Mpuntsha | - | 193 |
| Ms L Nevhutalu | - | 47 |
| Prof. L Pepeta | 47 | 11 |
| Prof. S Perumal | - | 77 |
| Ms S Ranchod | 47 | 21 |
| Ms Terblanche | 461 | 11 |
| Mr J van der Walt | 178 | 147 |
| Prof. Y Veriava | - | 173 |
| | **3 530** | **1 301** |

Council is the governing body of the CMS and as such it exercises oversight over the entity. Council members' fees increased in the current year by 167% due to an increased number of meetings, refer to Part D (Governance) for a detailed report on Council's activities.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

| | 2019 | | | |
|---|---|---|---|---|
| | Basic salary R'000 | Performance management R'000 | Acting allowance and other R'000 | Total R'000 |
| **Compensation to executive management** | | | | |
| Chief Executive and Registrar (from 20 February 2019) (Acting from April 2018 – 19 February 2019) | 1 973 | 197 | 355 | 2 525 |
| Chief Financial Officer | 1 846 | 203 | (27) | 2 022 |
| Chief Information Officer | 1 811 | 163 | 45 | 2 019 |
| General Manager: Accreditation | 1 778 | 178 | 4 | 1 960 |
| General Manager: Benefits Management | 1 704 | 188 | 4 | 1 896 |
| General Manager: Compliance and Investigation | 1 846 | - | 5 | 1 851 |
| General Manager: Complaints and Adjudication | 1 510 | 125 | (22) | 1 613 |
| General Manager: Financial Supervision | 1 846 | 185 | 5 | 2 036 |
| General Manager: Human Resources | 1 846 | 166 | (43) | 1 969 |
| General Manager: Legal Services | 1 846 | 185 | 5 | 2 036 |
| General Manager: Research and Monitoring | 810 | - | 32 | 842 |
| General Manager: Stakeholder Relations (from 13 August 2018) | 1 284 | - | (6) | 1 278 |
| Executive Manager: Office of the Chief Executive and Registrar | 237 | - | - | 237 |
| | **20 337** | **1 590** | **357** | **22 284** |

The position of the Chief Executive and Registrar has been vacant up to the 19 February 2019. The Senior Strategist acted in this position. Other benefits include acting allowance, movement in leave provision and movement in long service award.

| | 2018 | | | |
|---|---|---|---|---|
| | Basic salary R'000 | Performance management R'000 | Acting allowance and other R'000 | Total R'000 |
| **Compensation to executive management** | | | | |
| Chief Financial Officer | 1 730 | 159 | 36 | 1 925 |
| Chief Information Officer | 1 714 | - | (3) | 1 711 |
| General Manager: Accreditation | 1 666 | 125 | 39 | 1 830 |
| General Manager: Benefits Management | 1 598 | 147 | 32 | 1 777 |
| General Manager: Compliance and Investigation | 1 730 | 159 | 48 | 1 937 |
| General Manager: Complaints and Adjudication | 1 415 | 118 | 33 | 1 566 |
| General Manager: Financial Supervision | 1 730 | 159 | 50 | 1 939 |
| General Manager: Human Resources | 1 730 | 157 | 24 | 1 911 |
| General Manager: Legal Services | 1 730 | 145 | 66 | 1 941 |
| General Manager: Research and Monitoring | 1 526 | 140 | 28 | 1 694 |
| General Manager: Stakeholder Relations | 1 174 | - | 293 | 1 467 |
| Senior Strategist/Acting Registrar (April 2017 – March 2018) | 1 526 | 140 | 576 | 2 242 |
| | **19 269** | **1 449** | **1 222** | **21 940** |

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 23. Contingencies

*Contingent liabilities*

On the 01 September 2016, the CMS lost an urgent application by Commed in a case of Commed v CMS in the Gauteng High Court. CMS as the respondent was ordered to pay the costs of the application, including the costs of the two sets of counsels. The estimated financial effect is to be determined by the decision of the Tax Master, however the taxed amount is estimated to be equal or less than R300 000.

Dr MA Mazibuko v CMS and Government Employees Medical Schemes case:

On 30 May 2017, the CMS was ordered by the High Court of South Africa Gauteng Division, Pretoria to provide Dr MA Mazibuko with the ruling and/or decision of the complaint lodged with the CMS in terms of the Medical Schemes Act (Act No. 131 of 1998), by Friday 2 June 2017. The costs of this application were reserved. The estimated taxed amount of costs on this case are equal or less than R180 000.

On 4 March 2019, the CMS approved a settlement offer of four months in an unfair dismissal dispute of the General Manager which is currently at the CCMA. The estimated amount of the settlement offer of the dispute is R542 612.

*Contingent assets*

The CMS won court cases against the following parties:

- Commed Medical Aid Schemes and CMS (Curatorship/liquidation)
- CMS and SAMWUMED Curatorship application
- Mr E Sibanda v Registrar and Commed
- Hosmed vs CMS

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

### 24. Risk management

*Financial risk management*

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

*Liquidity risk*

The CMS' risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. The CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account of R24 423 697 as at 31 March 2019.

*Credit risk*

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

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

*Market risk*

**Interest rate risk**

The CMS invests surplus funds in the CPD account. The interest rates on this account fluctuate in line with movements in money market rates. The impact on investment revenue of a percentage shift would be a maximum increase of R42 733 or decrease of R42 733 respectively.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 25. Irregular expenditure

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Opening balance | 28 255 | 10 787 |
| Add: Irregular expenditure – current year | 16 168 | 15 387 |
| Add: Irregular expenditure incurred in the prior years but identified in 2018 financial year | - | 2 081 |
| | **44 423** | **28 255** |

The cause of the irregular expenditure was investigated and the assessment was that the entity did not suffer any loss as the expenditure was incurred in pursuance of the operations of CMS. This irregular expenditure was due to non-compliance with procurement processes. The process of application for condonation of this irregular expenditure is still underway.

Prior year irregular expenditure was restated by R109 875 to correct a prior year misstatement. This amount was duplicated in the 2017/18 financial year.

Analysis of expenditure awaiting condonation per age classification:

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Current year | 16 168 | 17 468 |
| Prior years | 28 255 | 10 787 |
| | **44 423** | **28 255** |

The CMS incurred irregular expenditure during the current year of R781 441 due to extending the scope of work by more than 15% without prior approval from National Treasury. CMS also incurred an irregular expenditure of R10 320 009. In establishing a panel of inspectors, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS also incurred irregular expenditure of R4 654 279. In establishing a panel of lawyers, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS incurred irregular expenditure of R367 804 as the CMS did not apply the preference point system in awarding the bid. The CMS incurred irregular expenditure of R44 194 by sourcing services without going through a competitive quotation process.

In the prior year, the CMS incurred irregular expenditure of R1 884 705 due to not inviting written price quotations for procurements up to an estimated value of R500 000 although CMS sourced these services from its panel of legal service providers. The CMS also incurred irregular expenditure of R11 843 285, in establishing a panel of inspectors, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS also incurred irregular expenditure of R1 769 005 as the CMS did not apply the preference point system correctly as in some cases bids were not awarded to service providers with the highest points.

The CMS incurred irregular expenditure of R2 081 317 in the prior financial years identified during the prior years audit, where the CMS did not establish its panel of inspectors through a bidding process as required for all procurements above R500 000.

In the prior years, the CMS incurred irregular expenditure of R1 064 915, which was as a result of a calculation error on the application of the 80/20 preferential point system on procurement of transaction above R30 000 but below R500 000, however, bids were awarded to the cheapest quotation but not the highest scoring bidder. This resulted in non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA).

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

In the prior years, the CMS incurred irregular expenditure of R99 326 by not following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/2008. In the prior year, the CMS also incurred irregular expenditure of R204 000 due to non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) for not awarding the contract to the bidder who scored the highest points which occurred in prior years: See below.

In the prior years, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified to the amount of R982 906 for not awarding the contract to the bidder who scored the highest points.

*Details of irregular expenditure*

| | 2019<br>R'000 | 2018<br>Restated<br>R'000 |
|---|---|---|
| **Incident** | | |
| Bid awarded without following correct procedures | 412 | 3 654 |
| Bid awarded to inspectors whose panel was not established through bidding process | 10 321 | 13 814 |
| More than 15% extension of the scope of work without prior National Treasury approval | 781 | - |
| Bid awarded to lawyers whose panel was not established through bidding process | 4 654 | - |
| | **16 168** | **17 468** |

In the prior years, the CMS incurred irregular expenditure to the value of R1 094 000 for non-compliance with the Preferential Procurement Policy Framework Act (PPPFA), 2000 (Act No.5 of 2000) for not awarding the contract to the tenderer who scored the highest points.

In the prior financial years, the CMS incurred irregular expenditure to the value of R31 863 for staff training and temporary staffing without following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/08.

In the prior years, non-compliance to National Treasury Instruction 01 of 2013/14 regarding Cost Containment Measures, relating to catering was identified and was classified as irregular expenditure to the value of R3 000.

In the prior years, the CMS incurred irregular expenditure of R7 056 000 by acquiring services without going through a competitive quotation process or without going through a competitive bidding process to appoint a service provider. However, the reasons for this deviation were recorded and approved by the Acting Chief Executive and Registrar for the quotations, and the deviation for the bidding process were recorded and approved by the Council. In both instances, the reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/08 of National Treasury, which allows for deviation from a competitive quotation and bidding process.

Also in the prior years, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not indicating the weighting of the criterion used to evaluate functionality on a request for quotation which amounted to R251 000.

All the irregular expenditure incurred by the CMS has been submitted to National Treasury for condonation.

### 26. Matters under investigation

1. During the current year's audit, there was an audit finding relating to cover quoting by suppliers which may result in financial misconduct or irregular expenditure. Management will undertake a further internal investigation to determine if there was possible financial misconduct relating to the matter of cover quoting by suppliers.
2. During the current year's audit, auditors identified possible irregular expenditure of R193 233 which is still under investigation by management.

Council for Medical Schemes

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## FOR THE YEAR ENDED 31 MARCH 2019 (CONTINUED)

### 27. Fruitless and wasteful expenditure

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Opening balance | 7 | - |
| Incurred during the year | 30 | 7 |
| | **37** | **7** |

During the year expenditure of R25 750 was incurred for a venue which was never utilised. R4 445 overpayment of the leave gratuity was incurred during the current financial year.

### 28. Prior period errors

A prior period error was identified in relation to transactions accounted for in the 2018/19 financial year where the activities occurred in the 2017/18 financial year.

| | 2019 R'000 | 2018 Restated R'000 |
|---|---|---|
| Increase in legal fees recovered-revenue 31 March 2018 | - | (186) |
| Increase in legal fees recoverable (Receivable) 31 March 2018 | - | 186 |
| Increase in accruals 31 March 2018 | - | (4 277) |
| Decrease in inspection costs 31 March 2018 | - | 4 277 |
| Increase in accruals 31 March 2018 | - | (249) |
| Decrease in legal fees-expense 31 March 2018 | - | 249 |
| Increase in accruals 31 March 2018 | - | (18) |
| Decrease in subscription expense 31 March 2019 | - | 2 |
| Decrease in travel-expense 31 March 2018 | - | 16 |

### 29. Segment information

*General information*

**Identification of segments**

The entity is organised and reports to management on the basis of its core mandated business as set out in the Medical Schemes Act, Act 131 of 1998. The function of the mandate is to regulate the medical schemes industry. Due to the nature and service of the organisation, management reviews and evaluates the entity as a whole, as all risks, resources and financial matters of the entity are directed to deliver its core mandate.

The entity's operations are located in Centurion, its only office in the country. Although the office services the public of South Africa, its risk and financial costs are limited to this single location.

It is on this basis that management views the entity as a single segment to which adequate disclosure has been made in these Annual Financial Statement.

# PART G:
## THE MEDICAL SCHEMES INDUSTRY IN 2018

# THE MEDICAL SCHEMES PROFILE IN 2018

## Introduction

Gross benefits paid (benefits paid from risk pool plus savings) reported in the utilisation section of this report (pages 140 to 214 and Annexures C to M) differ slightly from gross benefits reported in the financial statutory returns section. This is a result of definitional issues and the application of accounting principles. Thus figures reported in the utilisation section of this report (pages 140 to 214 and Annexures C to M) for the financial year 2017 have been revised, and therefore may differ from the amounts reported in the previous year's annual report.

## Number of schemes and benefit options

The medical schemes industry has seen consolidation in terms of the number of registered schemes over the past 18 years as depicted in Figure 13. The figure shows that the number of medical schemes has declined significantly from 144 in 2000, to 79 in 2018. The decline was more pronounced between 2008 and 2010 when the industry lost almost 20 schemes over a period of two years through mergers, deregistrations and liquidations. The rate of consolidation has, however, slowed down in the past five years, with the industry only losing four schemes. In 2018, the number of medical schemes declined to 79, consisting of 21 open schemes and 58 restricted schemes.



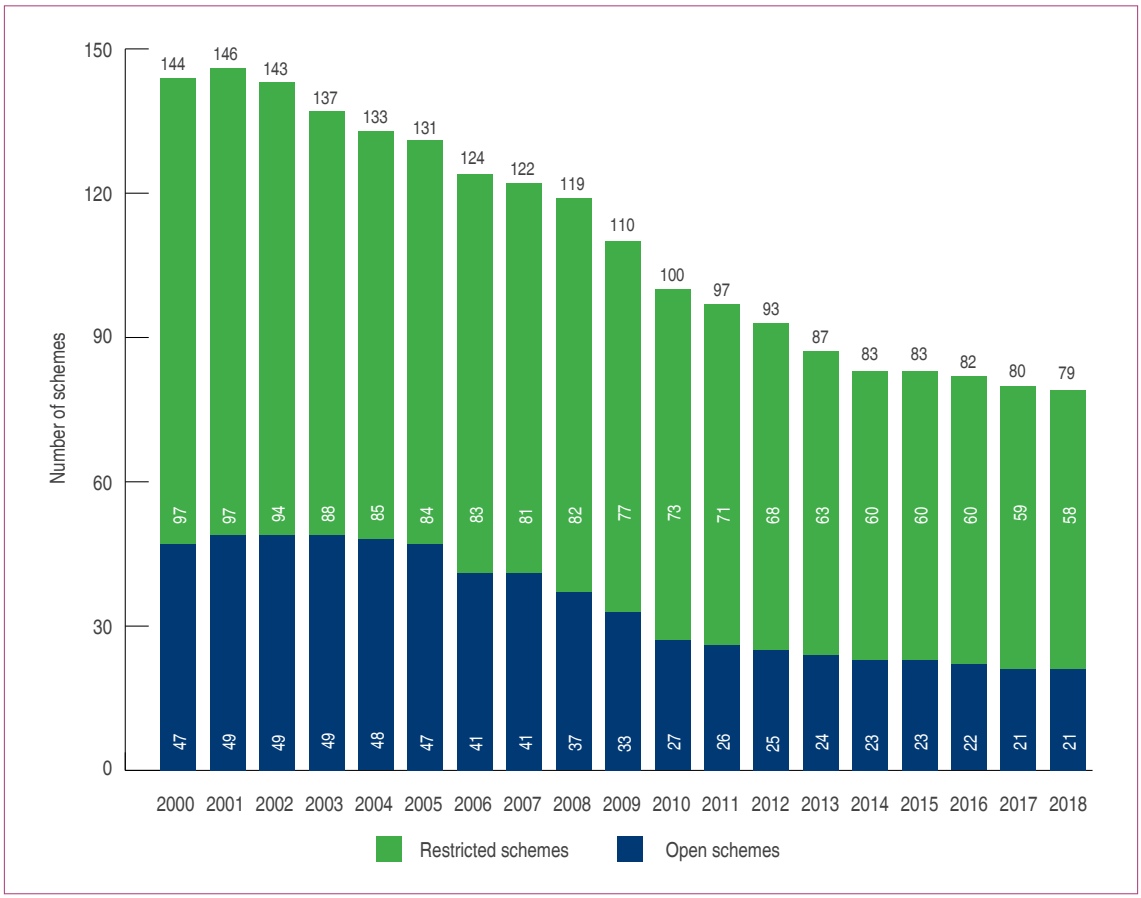
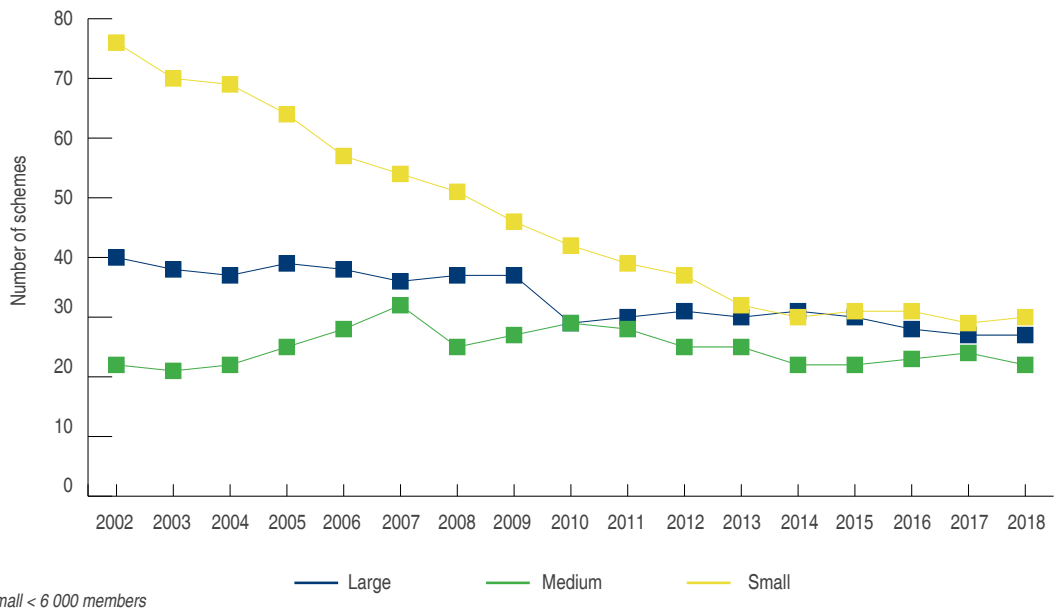



Figure 13: Number of schemes 2000–2018

Figure 14 demonstrates trends in the distribution of schemes by size from 2002 to 2018. In this period, the number of schemes classified as 'small' decreased at a faster rate than those classified as 'medium' and 'large'. Large and medium schemes remained generally stable during that period. However, a sharp decline in medium schemes occurred between 2007 and 2008, due to liquidation and deregistration of schemes.




*Small < 6 000 members*

*Medium => 6 000 members but < 30 000 beneficiaries*

*Large => 30 000 beneficiaries*

Figure 14: Number of schemes by size 2002–2018



Figure 15 reflects the contribution of open schemes in the consolidation of schemes by size between 2002 and 2018. The figure shows an upward trend in medium schemes from 2005 to 2007 as opposed to a downward trend in large schemes in the same period. In general, open schemes experienced a decrease in number, with small schemes contributing significantly to this decrease.

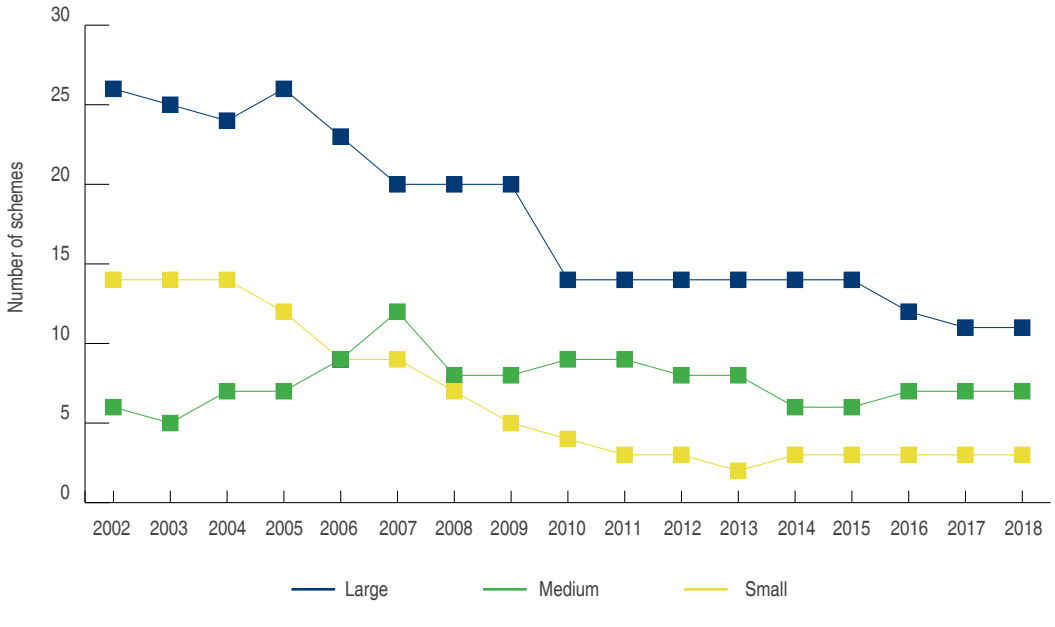



Figure 15: Number of open schemes by size and type 2002–2018

Among restricted schemes, the small schemes had a significant drop in 2003 (see Figure 16), although the decrease was generally consistent between 2002 and 2014. Small schemes decreased at a faster rate than medium and large schemes. The decrease in the number of schemes remained steady between 2014 and 2018.

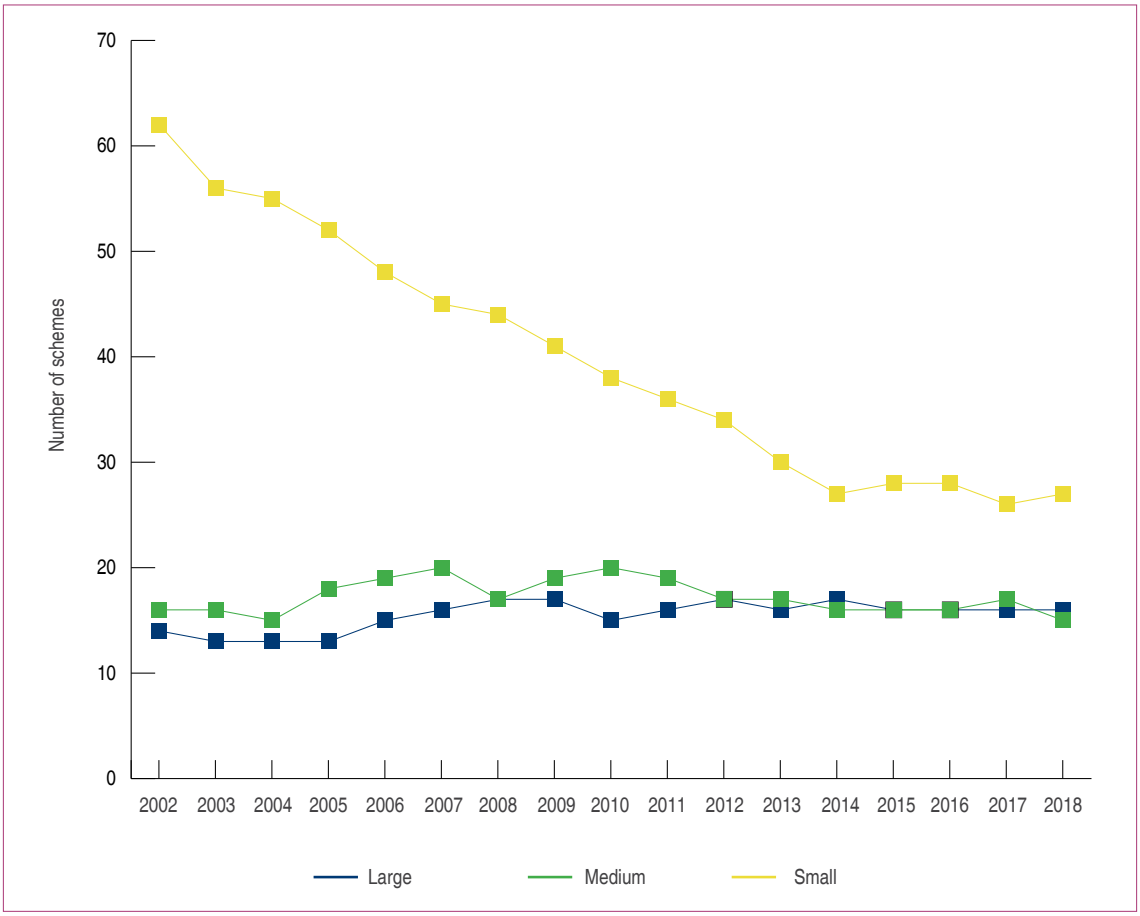



Figure 16: Number of restricted schemes by size and type 2002–2018

Figure 17 illustrates the average number of benefit options per scheme type. Overall, the number of benefit options available in open schemes has remained consistently above the industry average while those in restricted schemes have remained below average. Between 2012 and 2013, the average number of benefit options in open schemes decreased significantly from 6.40 to 5.80. The average number of benefit options per scheme for the industry decreased marginally to 3.43 in 2018 from 3.48 in 2017. In 2018, the average number of benefit options in restricted medical schemes declined to 2.33 from 2.39 in 2017 while in open schemes the average number of options declined to 6.48 from 6.52.

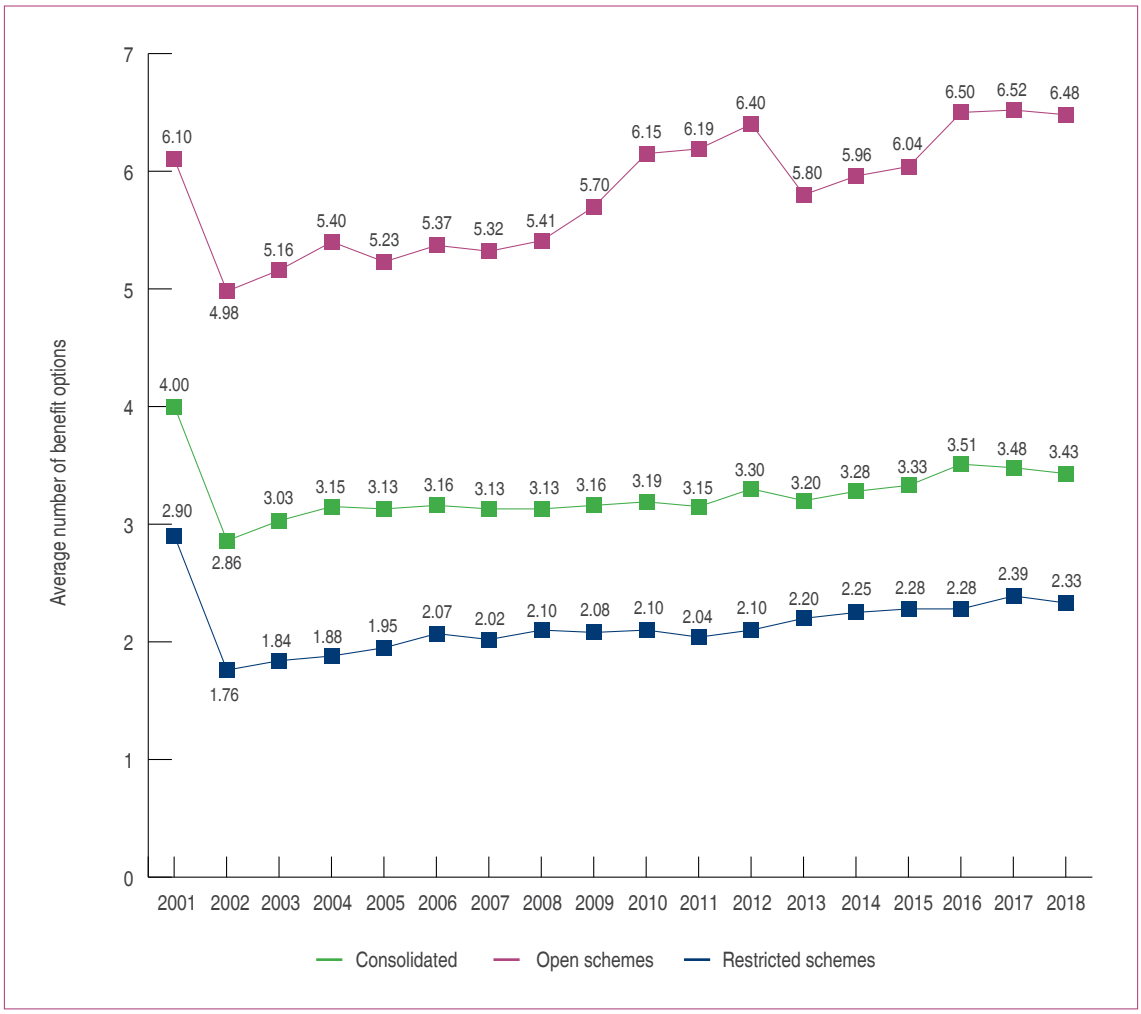



Figure 17: Average number of benefit options 2001–2018

# DEMOGRAPHIC INFORMATION

Table 31 illustrates the number of beneficiaries covered by medical schemes in 2017 and 2018. Medical scheme beneficiaries increased marginally by 0.5% in 2017/18 as compared to a decline of 0.07% in 2016/17. The increase in beneficiaries is attributed to the growth of Makoti (27.9%), LA-Health (13.7%), GEMS (1.8%) and Discovery Health (1.5%). The number of beneficiaries covered by medical schemes increased from 8.872 million at the end of December 2017 to 8.916 million in December 2018. The largest proportion of medical scheme beneficiaries is covered by open medical schemes. The number of beneficiaries in restricted schemes increased by 0.91% between 2017 and 2018 while open scheme beneficiaries increased by 0.18% in the same period.

Table 31: Beneficiaries of medical schemes in 2017 and 2018

| Type of scheme | Year | Members | Dependants | Beneficiaries | % Change |
|---|---|---|---|---|---|
| Open | 2017 | 2 366 197 | 2 594 258 | 4 960 455 | |
| | 2018 | 2 382 924 | 2 586 697 | 4 969 621 | 0.18% |
| Restricted | 2017 | 1 646 525 | 2 265 056 | 3 911 581 | |
| | 2018 | 1 656 781 | 2 290 293 | 3 947 074 | 0.91% |
| All Schemes | 2017 | 4 012 722 | 4 859 314 | 8 872 036 | |
| | 2018 | 4 039 705 | 4 876 990 | 8 916 695 | 0.50% |

Table 32 provides statistics of the top ten medical schemes, classified according to the number of beneficiaries. The top ten medical schemes account for 80.1% of the medical scheme population, with 61.5% covered by open schemes and 38.5% covered by restricted schemes. Among the top ten medical schemes, open schemes presented the highest number of options with a maximum of 17 options as compared to six in restricted schemes. Five schemes had more than six benefit options, accounting for 93.2% of beneficiaries in open schemes and one scheme had six options with 6.8% of the beneficiaries. Among restricted schemes there were a maximum of six options and a minimum of two.

Table 32: Statistics on top ten medical schemes 2018 (Excl. sub-options/EDOs)

| Scheme type | Number of schemes | Min. number of options | Max. number of options | Members | Adult dependants | Child dependants | Beneficiaries |
|---|---|---|---|---|---|---|---|
| **Open** | **6** | **6** | **17** | **2 106 784** | **960 180** | **1 325 558** | **4 392 522** |
| ≤6 Options | 1 | 6 | 6 | 156 555 | 66 688 | 75 923 | 299 166 |
| 6> Options | 5 | 7 | 17 | 1 950 229 | 893 492 | 1 249 635 | 4 093 356 |
| **Restricted** | **4** | **2** | **6** | **1 064 980** | **498 667** | **1 186 274** | **2 749 921** |
| ≤6 Options | 4 | 2 | 6 | 1 064 980 | 498 667 | 1 186 274 | 2 749 921 |
| 6> Options | - | - | - | - | - | - | - |
| **All Schemes** | **10** | **2** | **17** | **3 171 764** | **1 458 847** | **2 511 832** | **7 142 443** |

The industry grew from 6.73 million beneficiaries in 2000 to 8.92 million beneficiaries in 2018. The proportion of beneficiaries covered by medical schemes, expressed as a proportion of the population in the country, declined during the period under review – from 16.5% in 2000 to 15.4% in 2018. The industry experienced negative growth in 2002, 2003, 2004, 2015 and 2017 after many years of sustained growth as shown in Figure 18.

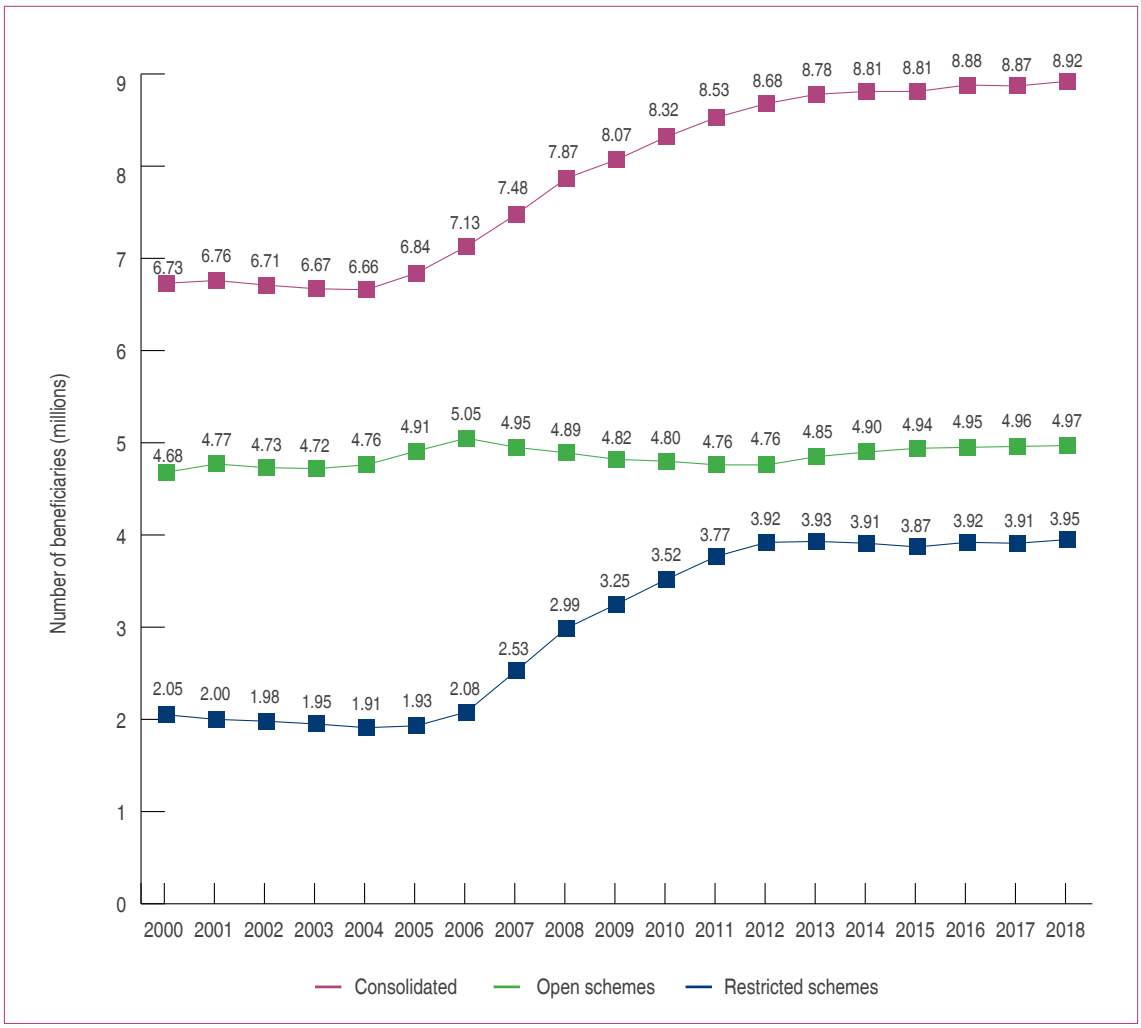



Figure 18: Number of beneficiaries 2000–2018

Figure 19 depicts membership and dependant growth in restricted and open schemes. The year 2007 experienced a significant increase in the number of beneficiaries in restricted schemes as compared to open schemes. This is largely attributable to the introduction of GEMS which enrolled a significant number of Persal employees, some of whom were previously not covered by medical schemes. The rate of growth in the number of beneficiaries has declined since 2014. The marginal growth in principal members was accompanied by a slight decline in dependant beneficiaries in open schemes in 2018.

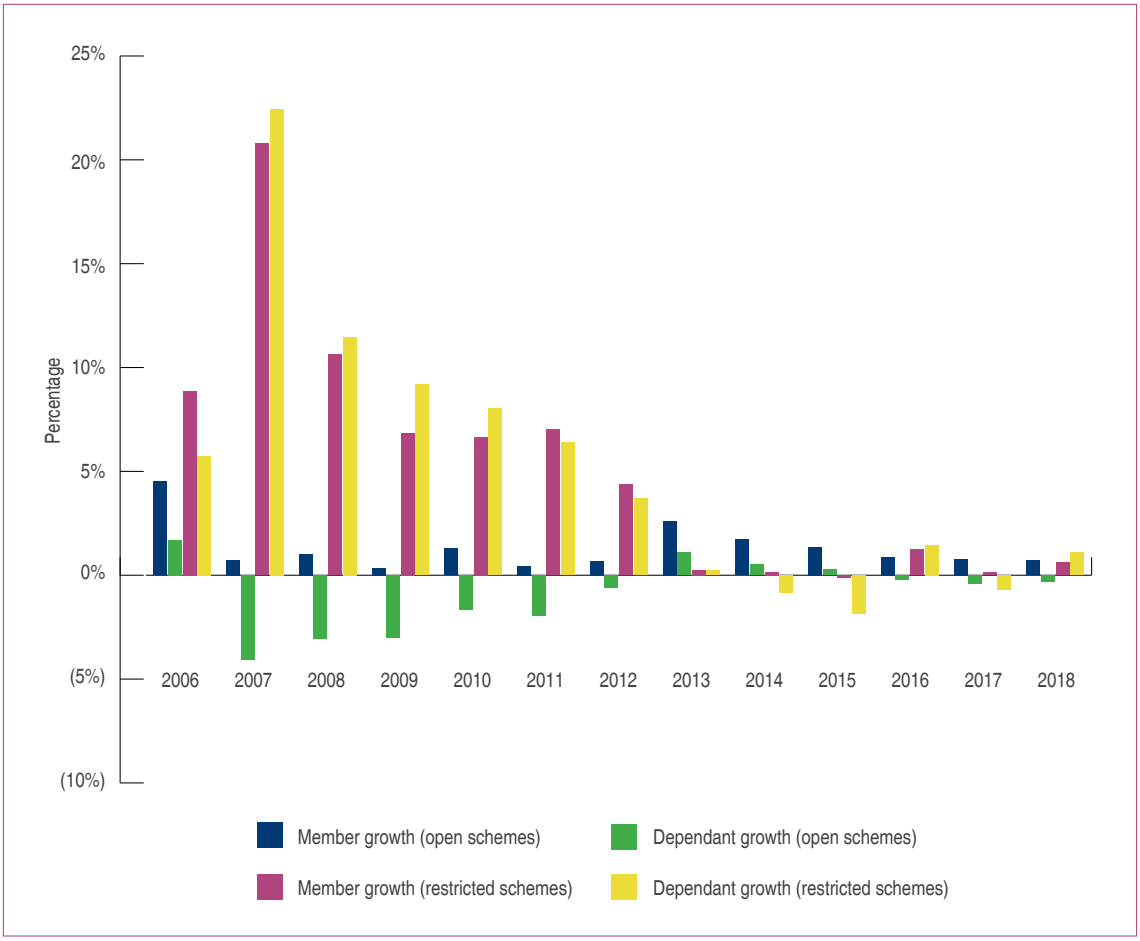



Figure 19: Membership changes by beneficiary type in open and restricted schemes

The dependant ratio measures the average number of dependants per principal member. Figure 20 shows that the dependant ratio remained unchanged between 2017 and 2018 at 1:1.21. The dependant ratio in open schemes decreased by a margin of 1:0.01 between 2017 and 2018, while in restricted schemes saw no change. The findings indicate that overall, there has been a decrease in the size of families covered between 2008 and 2018.

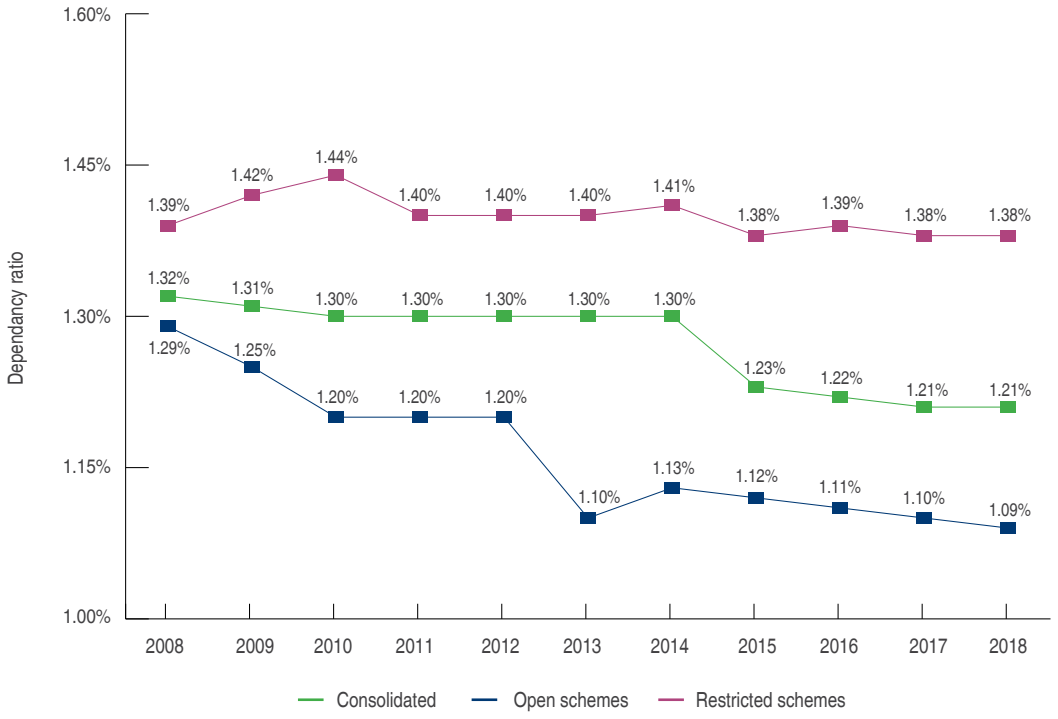



Figure 20: Dependant ratio in schemes 2008–2018

Table 33 outlines the average age of beneficiaries and the proportion of pensioners (beneficiaries aged 65 and older) by scheme type and gender. The age profile of the medical scheme population is important when analysing the burden of diseases and projecting the cost of healthcare. The average age of beneficiaries, industry-wide, increased slightly by 0.2 from 32.6 years in 2017 to 32.8 years in 2018. Female beneficiaries were on average older than male beneficiaries for the period 2015 to 2018. The proportion of pensioners increased to 9.0% in 2018 from 8.4% in 2017. The average age of 34.4 years in open schemes was higher than the industry average age of 32.8 years in 2018 while in restricted schemes it was lower at 30.8 years.

Table 33: Average age, pensioner ratio, and gender distribution

| Type of Scheme | Gender | Average age (years) and pensioner ratio (%) | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|
| Open Schemes | Female | Average age | 34.5 | 34.7 | 34.9 | 35.2 |
| | | Pensioner ratio | 9.7% | 10.1% | 10.9% | 11.6% |
| | Male | Average age | 33.0 | 33.2 | 33.3 | 33.5 |
| | | Pensioner ratio | 7.9% | 8.2% | 8.9% | 9.6% |
| | Total | Average age | 33.8 | 34.0 | 34.1 | 34.4 |
| | | Pensioner ratio | 8.8% | 9.2% | 10.0% | 10.7% |
| Restricted Schemes | Female | Average age | 31.6 | 31.9 | 31.8 | 32.1 |
| | | Pensioner ratio | 7.0% | 7.1% | 7.4% | 7.9% |
| | Male | Average age | 29.0 | 29.1 | 28.9 | 29.3 |
| | | Pensioner ratio | 5.1% | 5.2% | 5.4% | 5.8% |
| | Total | Average age | 30.5 | 30.6 | 30.5 | 30.8 |
| | | Pensioner ratio | 6.1% | 6.3% | 6.5% | 6.9% |
| All Schemes | Female | Average age | 33.0 | 33.4 | 33.5 | 33.8 |
| | | Pensioner ratio | 8.5% | 8.8% | 9.3% | 9.9% |
| | Male | Average age | 31.3 | 31.5 | 31.4 | 31.7 |
| | | Pensioner ratio | 6.7% | 7.0% | 7.4% | 7.9% |
| | Total | Average age | 32.3 | 32.5 | 32.6 | 32.8 |
| | | Pensioner ratio | 7.7% | 7.9% | 8.4% | 9.0% |

Figure 21 outlines the age and gender composition of medical scheme beneficiaries for 2008, 2017 and 2018. The trend is similar across all the years, with some minor differences in the year 2008, when there were more young beneficiaries (aged 5 to 9); less older beneficiaries (85+); and more beneficiaries in the age band 35 to 39. The overall number of beneficiaries starts to drop from the age band 35 to 39 until the age band 80+, and the pattern is similar for both males and females, except in 2008 where the numbers dropped from the age band 40 to 44.

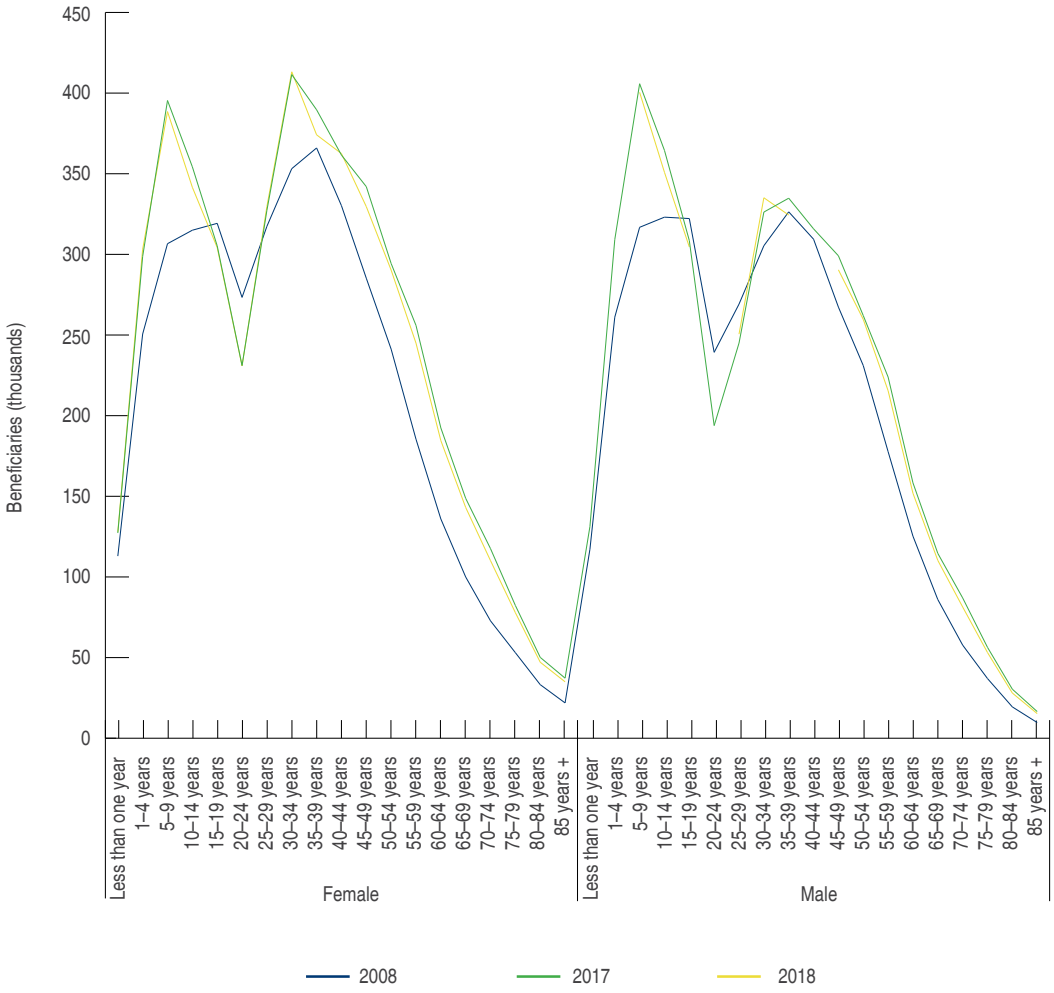



Figure 21: Age and gender distribution of beneficiaries 2008, 2017 and 2018

The population pyramid in Figure 22 illustrates the age and gender structure of medical scheme beneficiaries for 2017 and 2018. Large proportions of beneficiaries are found in the age bands 5 to 9, 10 to 14 and 35 to 39 years for both males and females. The figure shows the population shrinkage between the ages of 20 to 24 followed by an increase in the proportion of adults in age bands 25 to 29. Males outnumbered females in the under one age band in both years, whereas in the age bands 30 to 34 and 40 to 44 females outnumbered males.

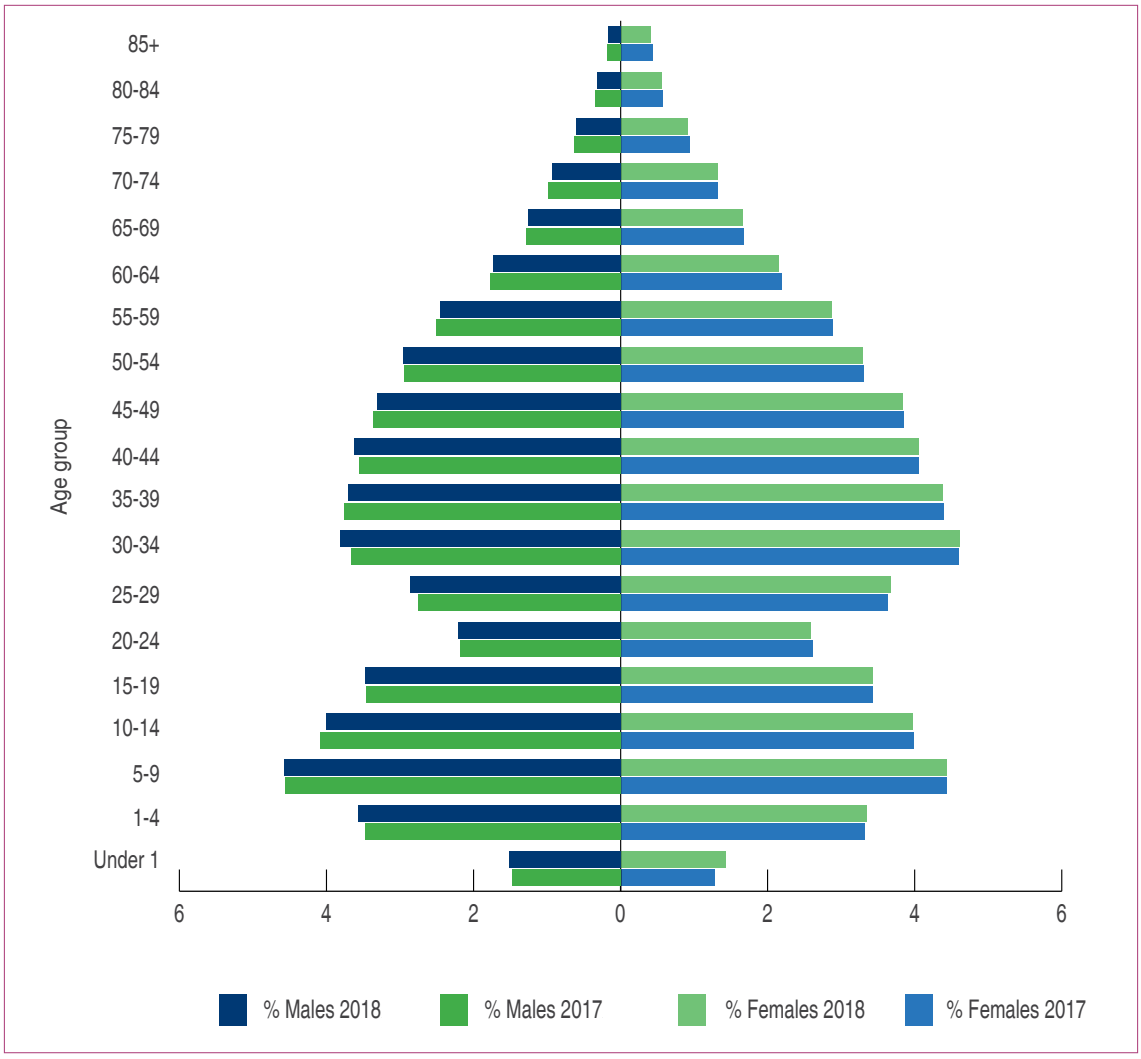



Figure 22: Age and gender distribution of beneficiaries 2017 and 2018

Figure 23 shows the variation in the average age of beneficiaries between 2004 and 2018. The average age of beneficiaries of restricted schemes was above industry average age from 2004 to 2006 and declined between 2006 and 2007. Since 2006 open medical schemes have had older beneficiaries than those in restricted schemes. The trends depict the impact of the Government Employees Medical Scheme (GEMS) and Discovery Medical Scheme (DHMS) on the demographics of medical scheme populations, particularly age. In 2018, the average age of beneficiaries in restricted schemes was 30.9 years excluding GEMS and 35.0 years in open schemes (excluding DHMS).

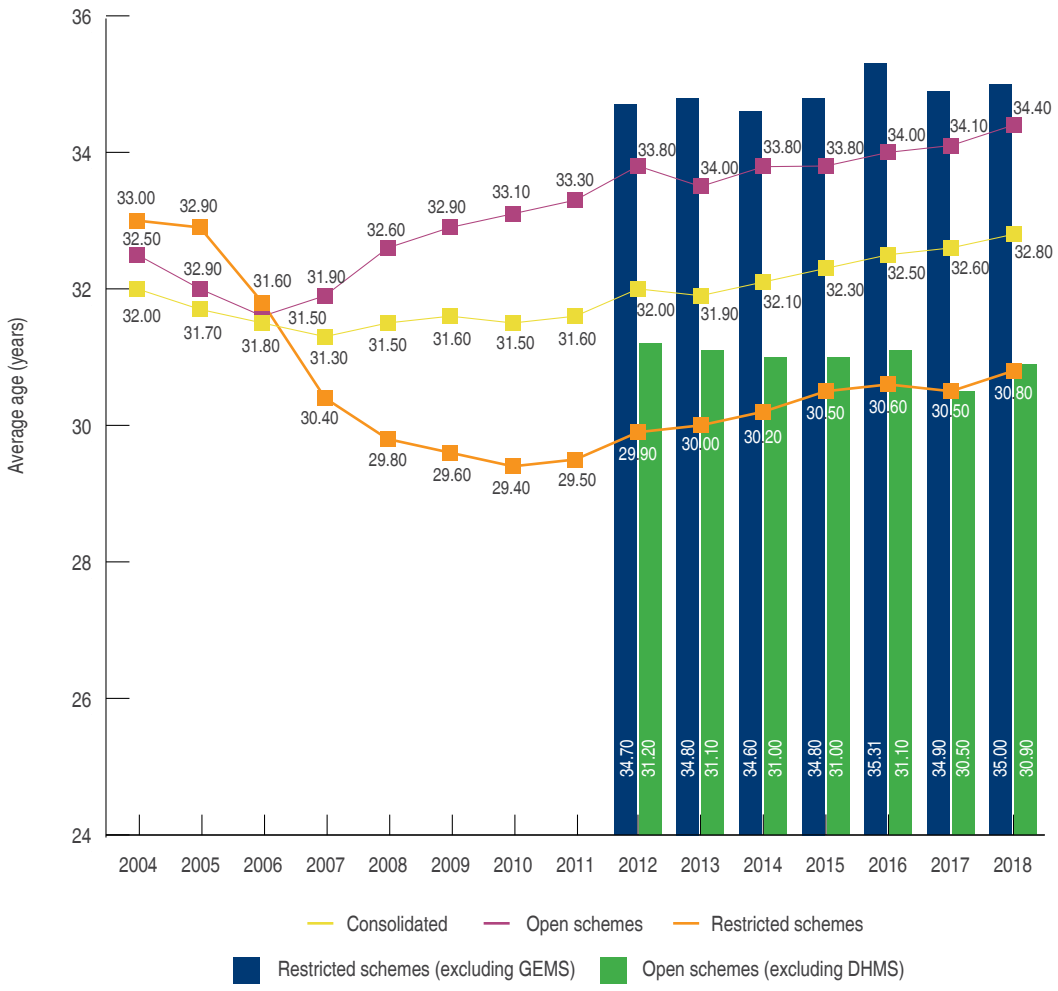



Figure 23: Age of beneficiaries 2004–2018

The map in Figure 24 depicts the geographic distribution of beneficiaries per province. The province of residence data is primarily based on the principal member's address. Most of the medical scheme's beneficiaries are in Gauteng with a total of 3 543 351 beneficiaries followed by Western Cape and KwaZulu-Natal with 1 327 573 and 1 256 360, respectively. The province with the least beneficiaries was Northern Cape with 2% of the total beneficiaries.

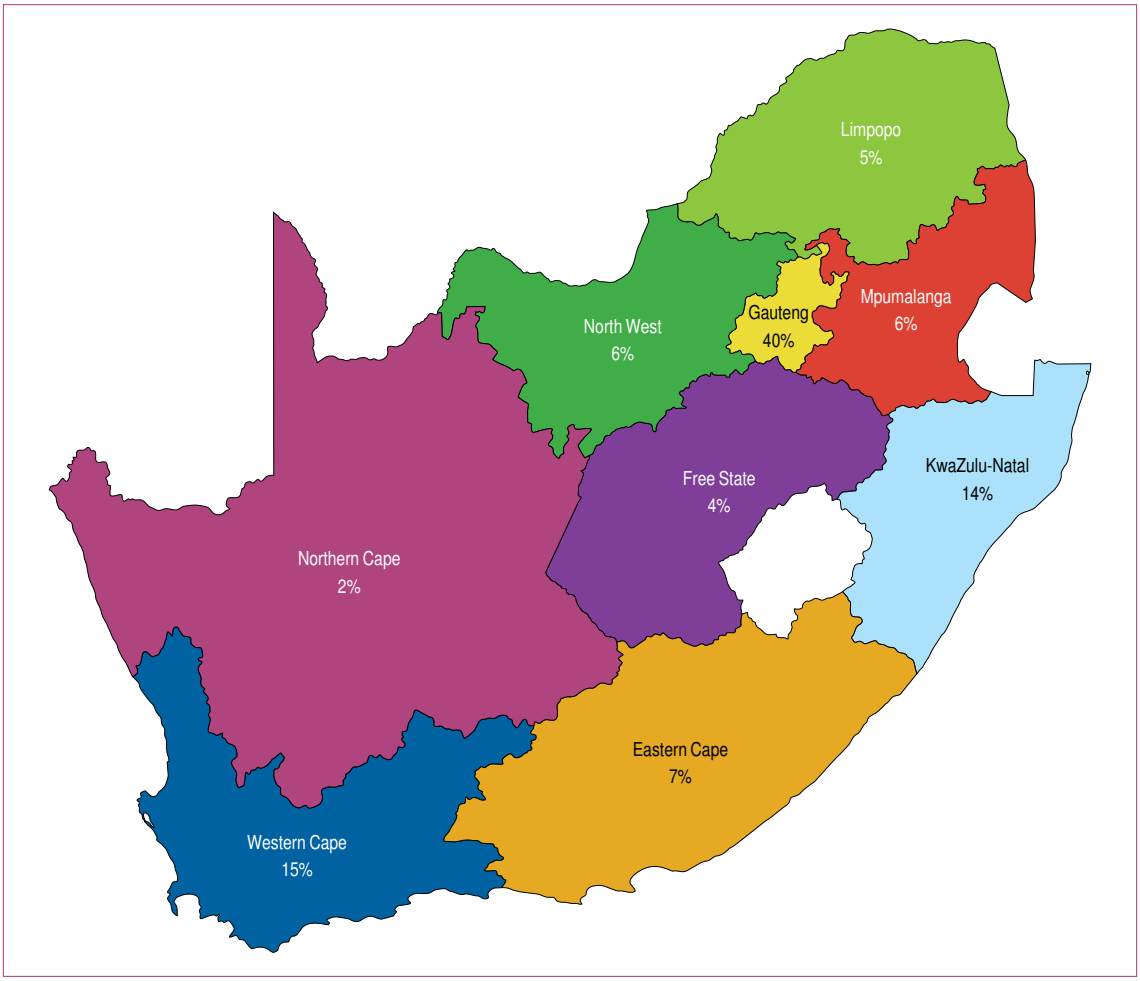



Figure 24: Distribution of beneficiaries by province in 2018

Table 34 shows that the number of beneficiaries grew in all provinces except Mpumalanga, where a decline of 0.8% was experienced in 2018 compared 2017. Overall, the industry grew by 0.5% in 2018, an improvement from a decline of 0.07% in 2017. The number of beneficiaries outside the Republic increased significantly from 1 619 in 2017 to 4 768 in 2018.

Table 34: Distribution of beneficiaries by province 2017 and 2018

| Province | 2017 | 2018 | % change |
|---|---|---|---|
| Gauteng | 3 530 204 | 3 543 351 | 0.4% |
| Western Cape | 1 307 019 | 1 327 573 | 1.6% |
| KwaZulu-Natal | 1 232 181 | 1 256 360 | 2.0% |
| Eastern Cape | 625 276 | 637 847 | 2.0% |
| Mpumalanga | 551 688 | 547 402 | -0.8% |
| North West | 457 333 | 485 044 | 6.1% |
| Limpopo | 410 439 | 433 881 | 5.7% |
| Free State | 381 721 | 389 600 | 2.1% |
| Northern Cape | 181 511 | 187 573 | 3.3% |
| Unclassified | 193 045 | 103 296 | -46.5% |
| Outside the Republic | 1 619 | 4 768 | 194.5% |
| **All provinces** | **8 872 036** | **8 916 695** | **0.5%** |

Table 35 illustrates changes in the number of beneficiaries between 2014 and 2018 according to scheme type and province. For the period 2014 to 2018, Gauteng Province gained beneficiaries in both the restricted and open schemes. Among the restricted schemes, Limpopo Province had the highest growth of 8.1%, however it lost beneficiaries in open schemes with a decrease of 6.7%. Mpumalanga showed negative growth in both the open and restricted schemes, with a decline of 3.1% and 3.8% respectively. The negative growth trend was similar in the Eastern Cape, with a decline of 2.9% in open schemes and 3.9% in restricted schemes.

Table 35: Beneficiary growth per province

| Scheme type | Province | 2014 | 2018 | Percentage change |
|---|---|---|---|---|
| Open | Eastern Cape | 299 538 | 290 877 | -2.9% |
| | Free State | 152 769 | 159 008 | 4.1% |
| | Gauteng | 2 268 280 | 2 389 006 | 5.3% |
| | KwaZulu-Natal | 654 604 | 675 327 | 3.2% |
| | Limpopo | 135 024 | 125 947 | -6.7% |
| | Mpumalanga | 269 639 | 261 231 | -3.1% |
| | Northern Cape | 77 535 | 74 379 | -4.1% |
| | North West | 175 374 | 161 027 | -8.2% |
| | Western Cape | 746 232 | 800 876 | 7.3% |
| Restricted | Eastern Cape | 361 224 | 346 970 | -3.9% |
| | Free State | 236 387 | 230 592 | -2.5% |
| | Gauteng | 1 073 704 | 1 154 345 | 7.5% |
| | KwaZulu-Natal | 606 350 | 581 033 | -4.2% |
| | Limpopo | 284 842 | 307 934 | 8.1% |
| | Mpumalanga | 297 501 | 286 171 | -3.8% |
| | Northern Cape | 107 678 | 113 194 | 5.1% |
| | North West | 310 421 | 324 017 | 4.4% |
| | Western Cape | 542 746 | 526 697 | -3.0% |

# HEALTHCARE BENEFITS

## Total healthcare benefits paid

Total healthcare expenditure on benefits paid in 2018 amounted to R173.3 billion, an increase of 8.0% from the 2017 reported amount of R160.5 billion. Ninety percent of these benefits were paid from risk benefits and 10% from medical savings accounts. Average claims paid per beneficiary per annum (pabpa) increased by 6.6% to R19 549.00. Risk benefits paid per beneficiary increased by 6.7% to R17 607.91, and the average spent from medical savings accounts pabpa, increased by 5.5% to R1 941.06.

Expenditure on hospital services accounted for 37.12% of total benefits paid, followed by medicine dispensed at 15.56%, and then supplementary and allied health professionals at 7.5%. These proportions are similar for risk benefits paid, with hospital expenditure taking up just over 41%, medicine dispensed accounting for 13.21% and supplementary and allied health professionals being 6.4% of risk benefits paid.

Approximately 77% of healthcare expenditure from medical savings accounts was paid towards medicines dispensed, supplementary and allied health professionals, general practitioners and dentists, consisting of 36.85%, 17.66%, 13.94% and 8.05% respectively. Just 1.52% or R261.1 million of benefits paid from medical savings accounts was paid towards hospital services. These proportions highlight how benefit options are designed and are graphically presented in Figure 25.

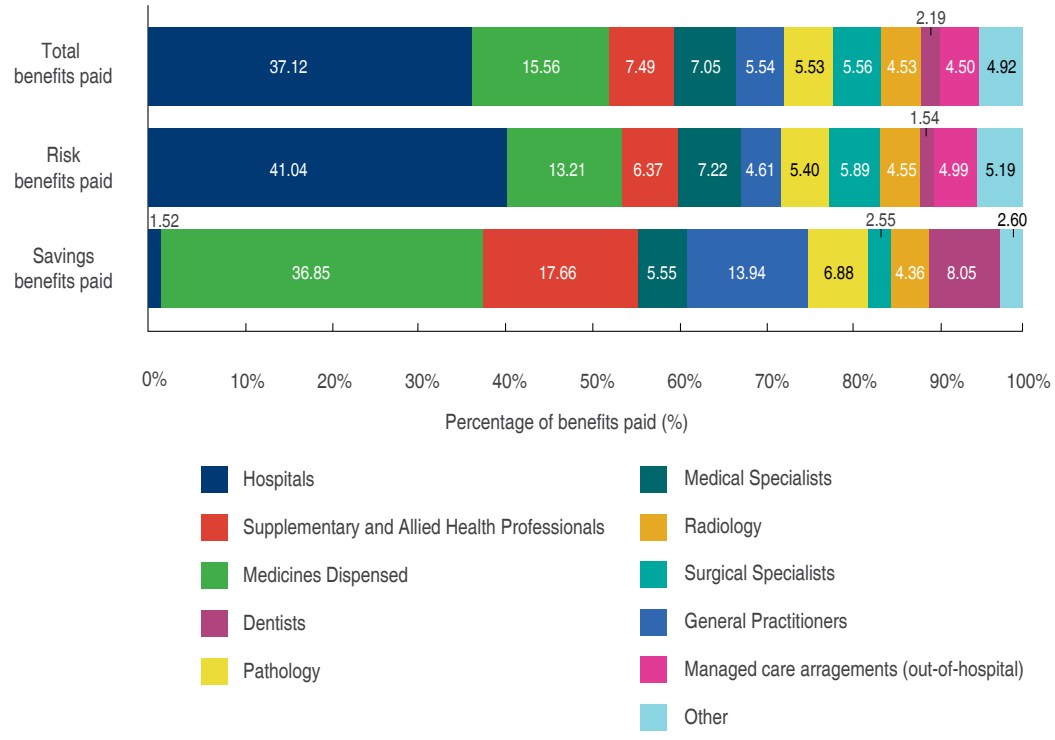



Figure 25: Distribution of healthcare benefits paid 2018

**Other consists of anaesthetists, other health services, dental specialists, ex-gratia payments and other unspecified benefits*

The distribution of benefits paid by open and restricted medical schemes did not vary much in 2018. Minor differences are noted in Figure 26, where open medical schemes paid 1.9% more benefits towards hospital services than restricted medical schemes, and restricted schemes paid more benefits towards medicines dispensed than open schemes at 16.8% and 14.7% respectively. Open schemes paid 0.8% more benefits towards managed care arrangements than restricted schemes.

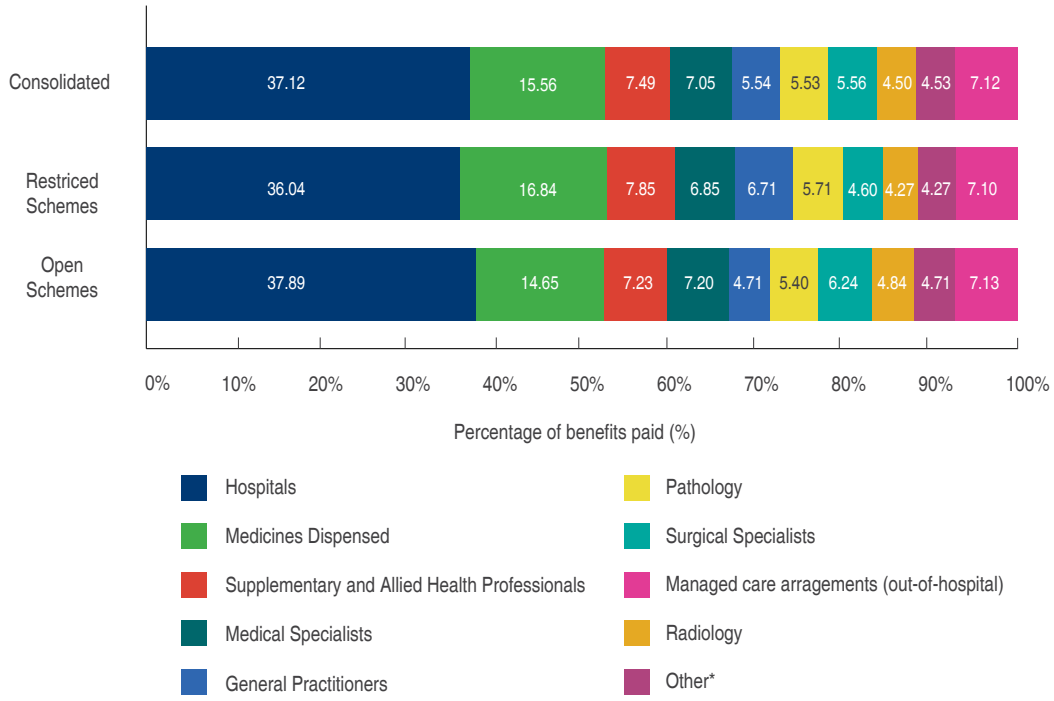



Figure 26: Distribution of healthcare benefits paid 2018 by scheme type

**Other consists of dentists, anaesthetists, other health services, dental specialists, ex-gratia payments and other unspecified benefits*

Total hospital expenditure amounted to R64.3 billion of the R173.3 billion (37.1%) that medical schemes paid to all healthcare providers in 2018. A larger percentage of benefits was paid towards hospital services by open schemes at 37.9% compared to 36.0% by restricted schemes. The average amount paid per beneficiary for hospital services increased by 7.0% to R7 256.42, with expenditure towards private hospitals making up 93.1% of total hospital expenditure at R6 757.56.

## Total healthcare benefits paid for hospital services by reimbursement method

Approximately 29% of expenditure on hospital services was paid towards fee for service (FFS) ward fees, which amounted to R18.8 billion in 2018, representing an increase of 8.18%, and averaging at R2 120.40 pabpa.

FFS consumables increased by 8.86% to R13.4 billion and FFS theatre fees at R9.6 billion, accounting for 21% and 15%, respectively. Medicine expenditure in hospital accounted for 8% of total hospital expenditure at R5.3 billion.

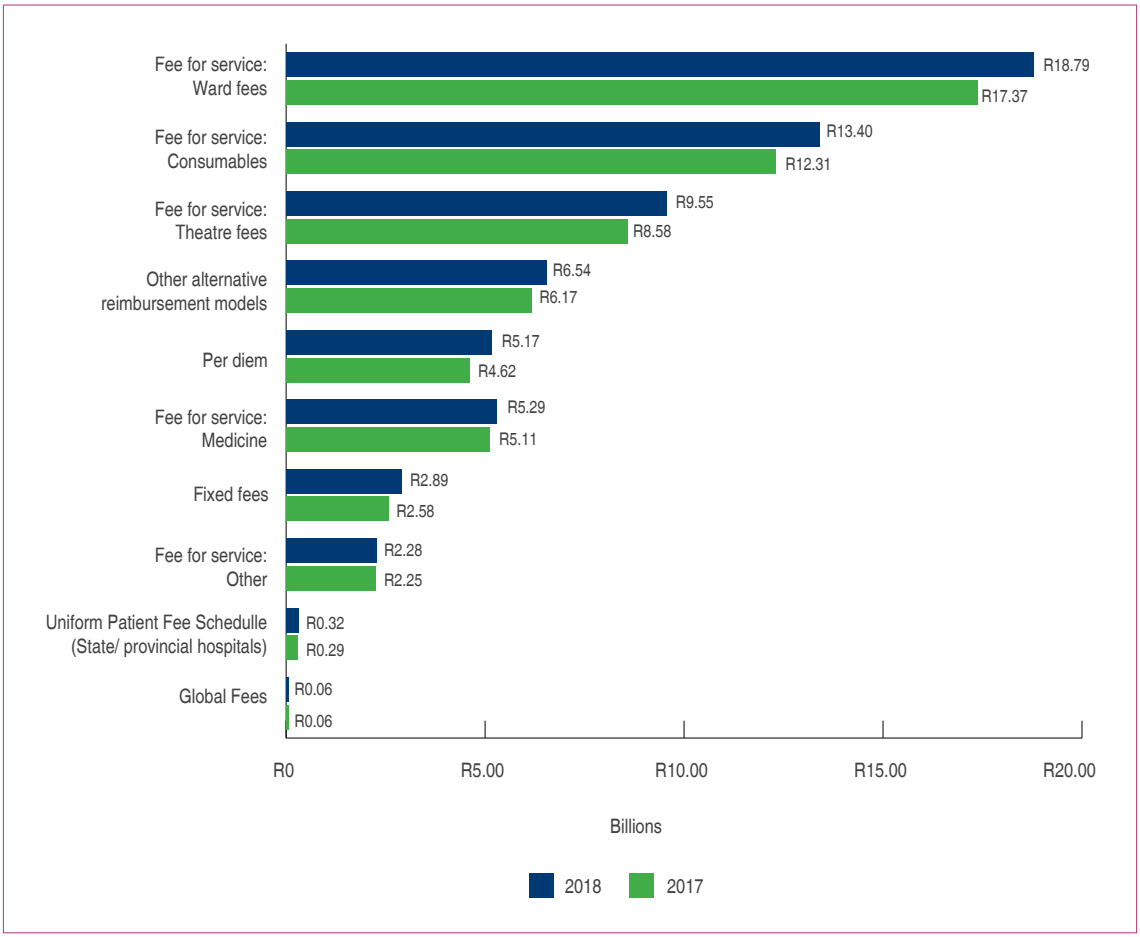



Figure 27: Healthcare benefits paid for hospital services in 2017 and 2018

## Total healthcare benefits paid for medicines dispensed

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals amounted to approximately R27.0 billion or 15.6% of total healthcare benefits paid. This represents an increase of 4.7% compared to the R25.8 billion spent in 2017. Pharmacies were paid R23.9 billion or 88.7% of all benefits paid towards medicines dispensed in 2018. General practitioners accounted for 5.0% of medicines dispensed, with all other providers making up 6.7%. Other key observations include the shifts in Diagnostic Radiology (38) and Speech Therapy and Audiology (82) which increased in both relative terms and as a proportion of benefits paid. Table 36 lists the top ten dispensing providers. The significant increase in Speech Therapy and Audiology (82) was attributed to a large scheme reporting expenditure under the medicines and consumables category, which was previously reported under the Supplementary and Allied Health Professionals category.

Table 36: Benefits paid for medicines dispensed – Top ten disciplines

| Discipline | 2018 R'000 | % of 2018 total | 2017 R'000 | % of 2017 total | % change |
|---|---|---|---|---|---|
| Pharmacies (60) | R23 904.14 | 88.7% | R22 850.74 | 88.7% | 4.6% |
| General Medical Practice (14) | R1 243.97 | 4.6% | R1 283.06 | 5.0% | -3.0% |
| Clinical Services (90) | R457.07 | 1.7% | R432.27 | 1.7% | 5.7% |
| Ophthalmology (26) | R348.43 | 1.3% | R322.94 | 1.3% | 7.9% |
| Diagnostic Radiology (38) | R249.29 | 0.9% | R211.54 | 0.8% | 17.8% |
| Independent Practice Specialist Radiation Oncology (40) | R158.17 | 0.6% | R148.15 | 0.6% | 6.8% |
| Registered Nurses (88) | R70.74 | 0.3% | R64.54 | 0.3% | 9.6% |
| Speech Therapy and Audiology (82) | R62.63 | 0.2% | R16.50 | 0.1% | 279.5% |
| Surgery Independent Practice Specialist (42) | R55.29 | 0.2% | R45.69 | 0.2% | 21.0% |
| Clinical Technology (75) | R50.04 | 0.2% | R49.17 | 0.2% | 1.8% |
| Other | R364.49 | 1.4% | R326.66 | 1.3% | 11.6% |
| **Total medicine dispensed** | **R26 964.28** | **100.0%** | **R25 751.26** | **100.0%** | **4.7%** |



## Total healthcare benefits paid per event (visit)

The amount paid to supplementary and allied health professionals in 2018 increased by 9.4% from R11.9 billion in 2017 to R13.0 billion in 2018, accounting for 7.5% of all benefits paid in 2018. Open medical schemes paid slightly more benefits towards supplementary and allied health professionals than restricted schemes at R7.33 billion compared to R5.64 billion respectively. Seventy-one percent of benefits paid to this category of disciplines were towards out-of-hospital visits at an average of R1 445.01 per visit, and in-hospital visits averaging at R2 551.26 per visit.

Expenditure on general practitioners (GPs) amounted to R9.6 billion or 5.5% of healthcare benefits paid, representing an increase of 4.9% on the 2017 figure of R9.1 billion. Thirteen percent of benefits paid to GPs in 2018 were for hospital visits, averaging R887.68 per visit, with the average per out-of-hospital visit being R384.22 (Figure 16).

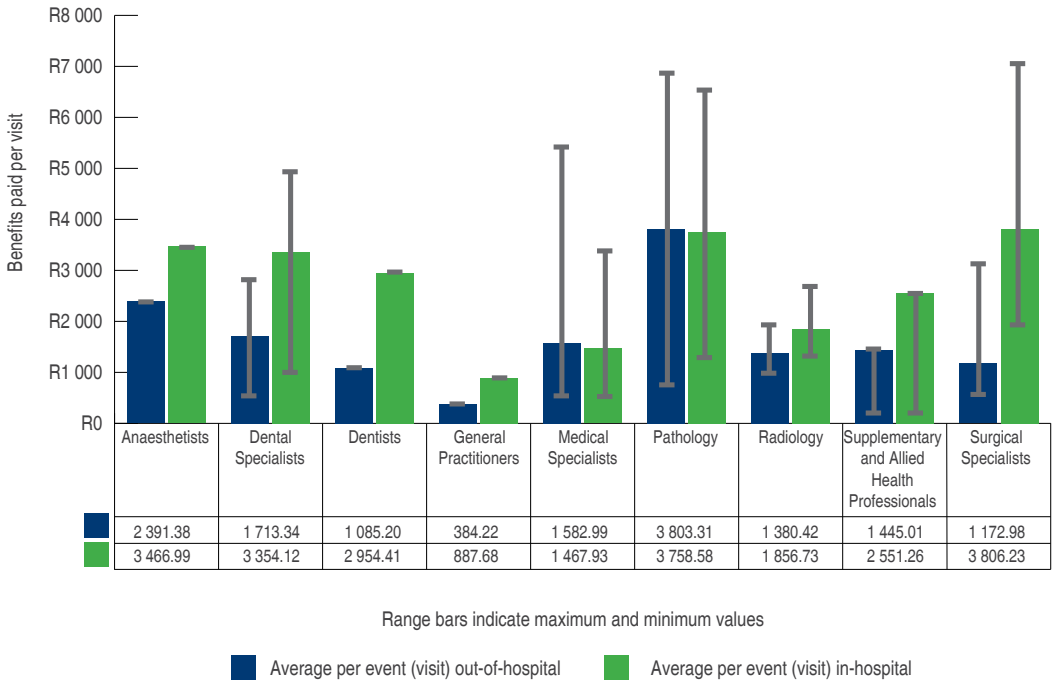
Payments to all specialists (anaesthetists, medical specialists, pathology services, radiology services and surgical specialists) amounted to R43.0 billion, which increased by 11.3% from the 2017 total of R38.7 billion and accounts for 24.8% of total healthcare benefits paid in 2018.

Payments to medical specialists amounted to R12.2 billion or 7.1% of total healthcare benefits paid in 2018. About 62.3% of the total paid to medical specialists in 2018 was paid to medical specialists operating in hospitals, with an average amount of R1 467.93 per visit. Out-of-hospital visits amounted to R1 582.99.

Total expenditure on pathology amounted to R9.5 billion or 5.5% of total healthcare expenditure, with 53.7% spent in-hospital at an average of R3 758.58 per event, and R3 803.31 per event out-of-hospital.

Surgical specialists were paid R9.6 billion or 5.6% of total healthcare benefits paid, at an average of R3 806.23 per in-hospital event and R1 172.98 per out-of-hospital event, while benefits paid to anaesthetists averaged R3 466.99 per in-hospital event, and R2 391.28 per out-of-hospital event.

Figure 28 shows benefits paid to different disciplines per event (visit) both in and out of hospital. Total benefits paid per event are calculated as total benefits paid (from risk and savings) divided by the number of visits to the provider. The cost (or benefits paid) per event should be interpreted with caution as the calculation does not consider other factors such as the number of hours spent per event, etc. Events paid in-hospital from medical savings accounts of beneficiaries make up a very small part of the expenditure and mainly relate to dentist and dental specialist visits.




| | Anaesthetists | Dental Specialists | Dentists | General Practitioners | Medical Specialists | Pathology | Radiology | Supplementary and Allied Health Professionals | Surgical Specialists |
|---|---|---|---|---|---|---|---|---|---|
| Average per event (visit) out-of-hospital | 2 391.38 | 1 713.34 | 1 085.20 | 384.22 | 1 582.99 | 3 803.31 | 1 380.42 | 1 445.01 | 1 172.98 |
| Average per event (visit) in-hospital | 3 466.99 | 3 354.12 | 2 954.41 | 887.68 | 1 467.93 | 3 758.58 | 1 856.73 | 2 551.26 | 3 806.23 |

Figure 28: Benefits paid per event (visit) 2018

## Trends in total healthcare benefits paid at constant prices

Figure 29 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2007. These figures have been adjusted for inflation with 2018 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2018 prices.

Expenditure on private hospitals increased by 3.51% in real terms from R61.8 billion in 2017 to R64.0 billion in 2018. The increasing trend in expenditure on private hospitals, from R33.5 billion in 2007 to R64.0 billion in 2018, translates into an annualised increase of 6.07% over the period and is illustrated in Figure 29. The proportion of benefits paid towards private hospitals in 2007 was 34.52% and has only slightly increased to 36.92% of total benefits paid in 2018.

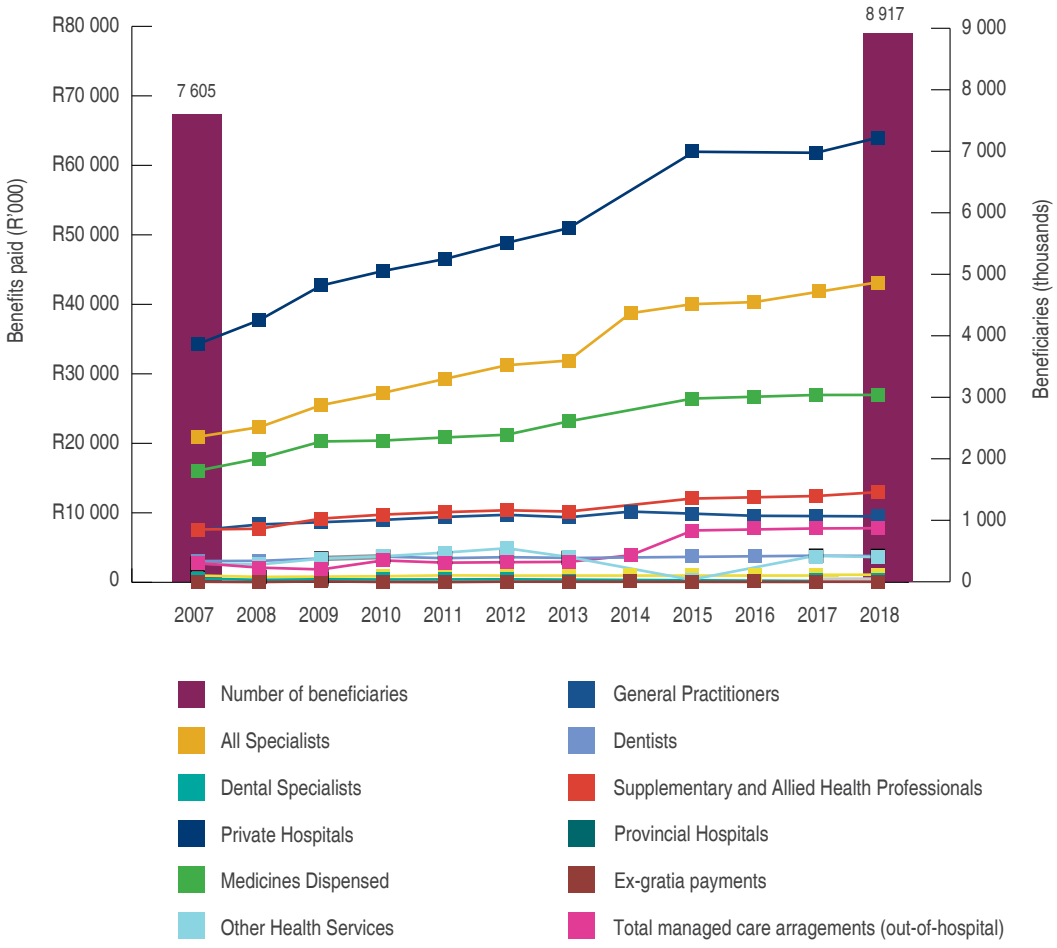



Figure 29: Total healthcare benefits paid 2007–2018 (2018 prices*)

** All values are adjusted for inflation using the Consumer Price Index (CPI) for 2018 as a base period.*

*** Historical values are revised when the base period changes and will not correspond to the values reported in the previous annual reports.*

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2018 amounted to R43.0 billion in real terms, an increase of 6.31% in real terms when compared to 2017 and a 6.86% annualised increase over the period 2007 to 2018.

It should be noted that the annual growth in membership must be factored in when considering changes in the total expenditure of medical schemes.

## Healthcare benefits paid per beneficiary

Figure 30 shows the changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2007 to 2018 in real terms (at 2018 prices). The amount paid in real terms on private hospitals increased by 2.21% from R7 061.86 pabpa in 2017 to R7 218.20 pabpa in 2018.

The amount spent on specialists increased in real terms from R4 625.79 pabpa in 2017 to R4 855.84 pabpa in 2018, an annual increase of 4.97%. There was a slight decrease of 1.24% in real terms for the benefits paid for medicines dispensed.

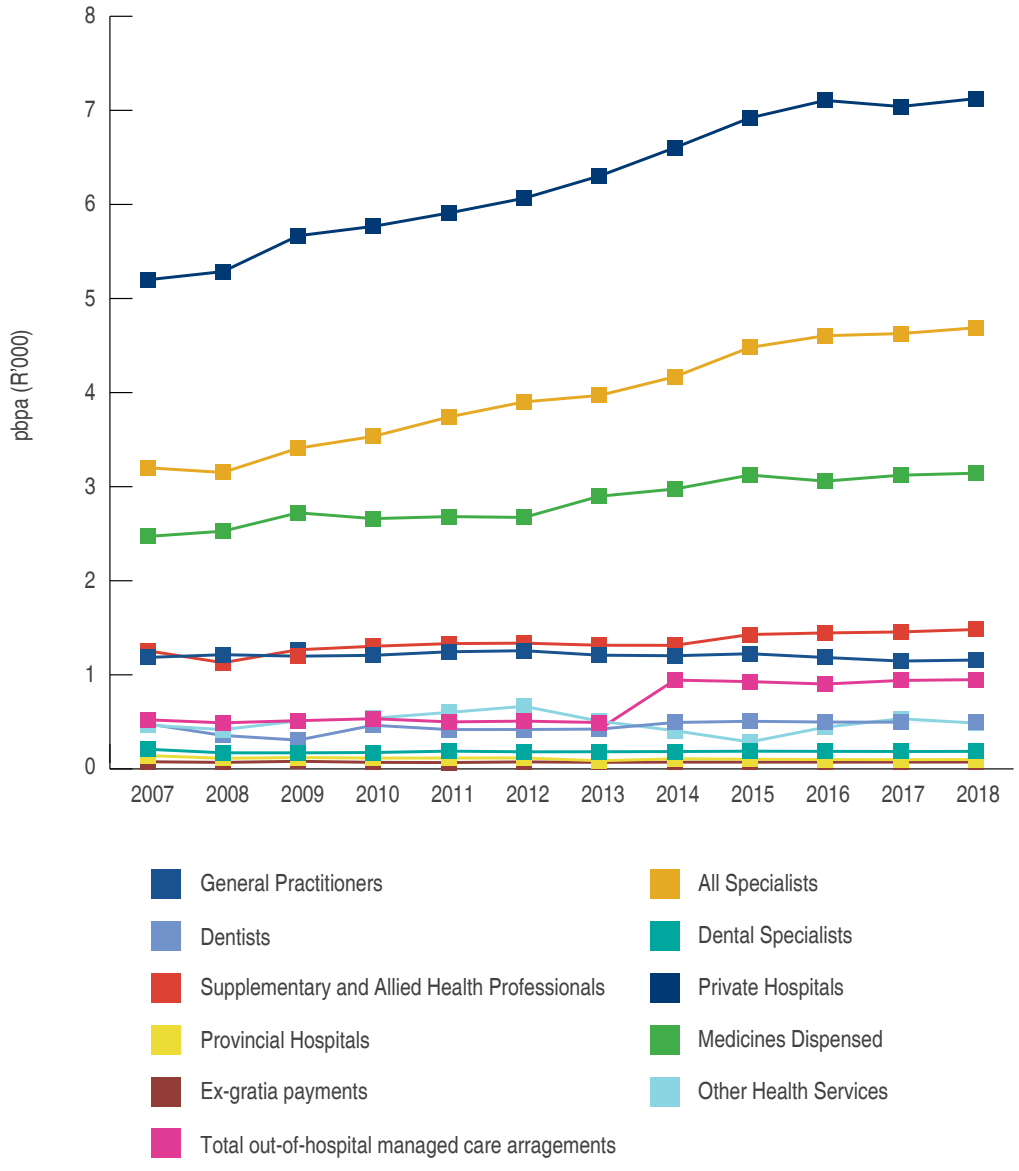



Figure 30: Total healthcare benefits paid pabpa 2007–2018 (2018 prices*)

** All values are adjusted for inflation using the Consumer Price Index (CPI) for 2018 as a base period.*

*** Historical values are revised when the base period changes and will not correspond to the values reported in the previous annual reports.*

## Healthcare benefits paid by age

Figure 31 shows the per capita healthcare expenditure across healthcare services by age group. The expenditure for beneficiaries under 45 years of age, with the exclusion of beneficiaries less than one year of age, falls below the industry average expenditure of R19 549.00 per beneficiary. Healthcare expenditure per beneficiary older than 45 years increases rapidly and ranged from around R20 736.85 to over R70 784.23 per beneficiary.

Sixty-three percent of expenditure on beneficiaries less than one year old, goes towards hospital services, with expenditure on medical specialists a distant second at 14%, medicine dispensed at 5% and support specialists (anaesthetists, pathology and radiology) at 8%. Total benefits paid for beneficiaries 85 years and older consist of 49% paid towards hospital services, 13% on medicines dispensed and 12% towards support specialists.

Expenditure on primary healthcare providers, general medical practitioners and dentists continue to be overshadowed by expenditure on specialists.

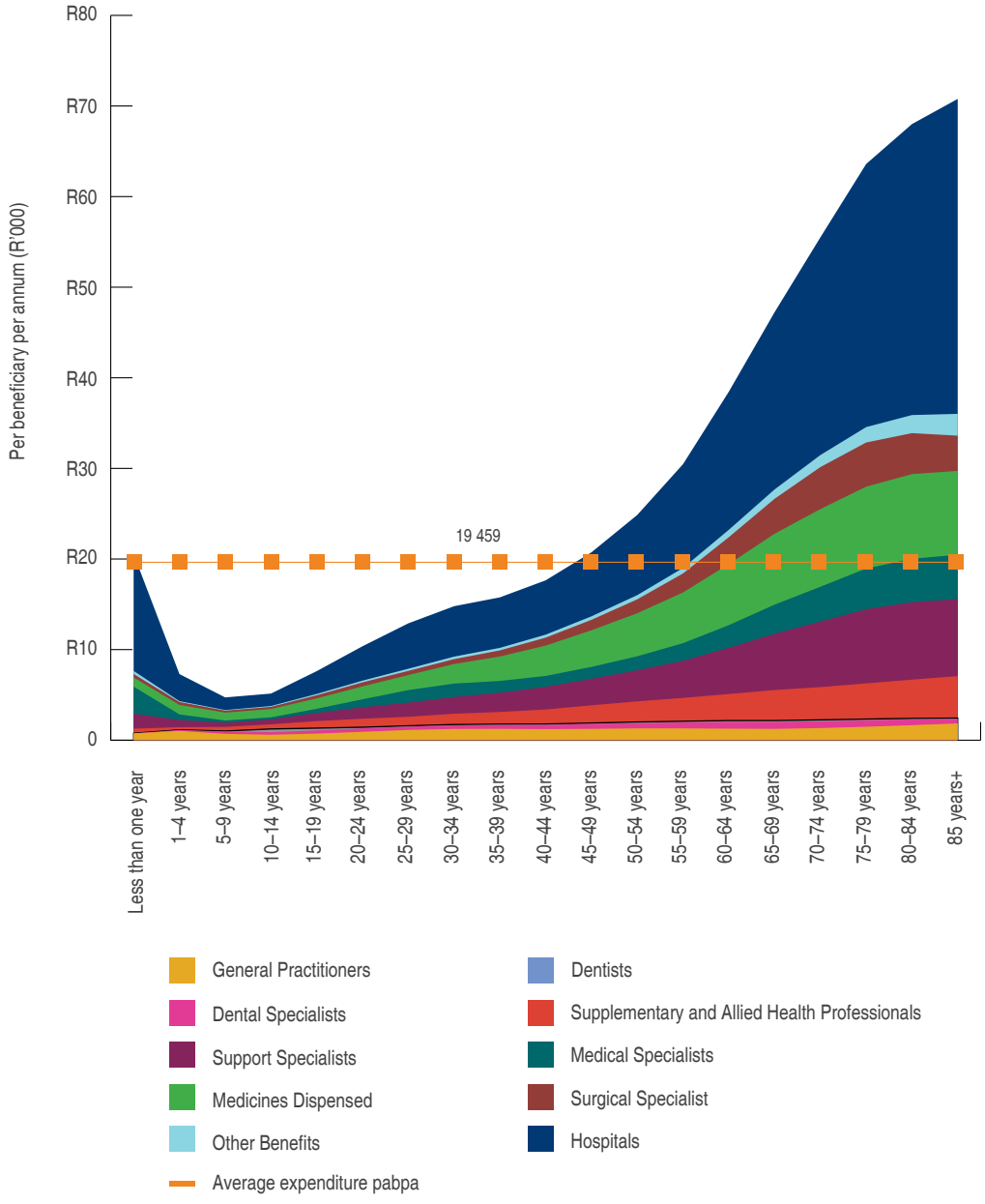



Figure 31: Expenditure per capita by age band 2018

Figure 32 highlights the differences observed in the expenditure of benefits paid by age band and the changes in the medical scheme population from December 2017 to December 2018. Expenditure for beneficiaries over 79 years of age decreased slightly, by 1.33% for beneficiaries in the age band 80–84 years and by 5.18% for beneficiaries 85 years and older. Decreases were observed for age bands 10–14 years of 6.93% and 20–24 years of 6.46%. The largest increase of 3.31% was observed for the age band 50–54 years. Figure 32 further depicts the number of beneficiaries in 2018 against the average amount paid for benefits for each of the age bands.

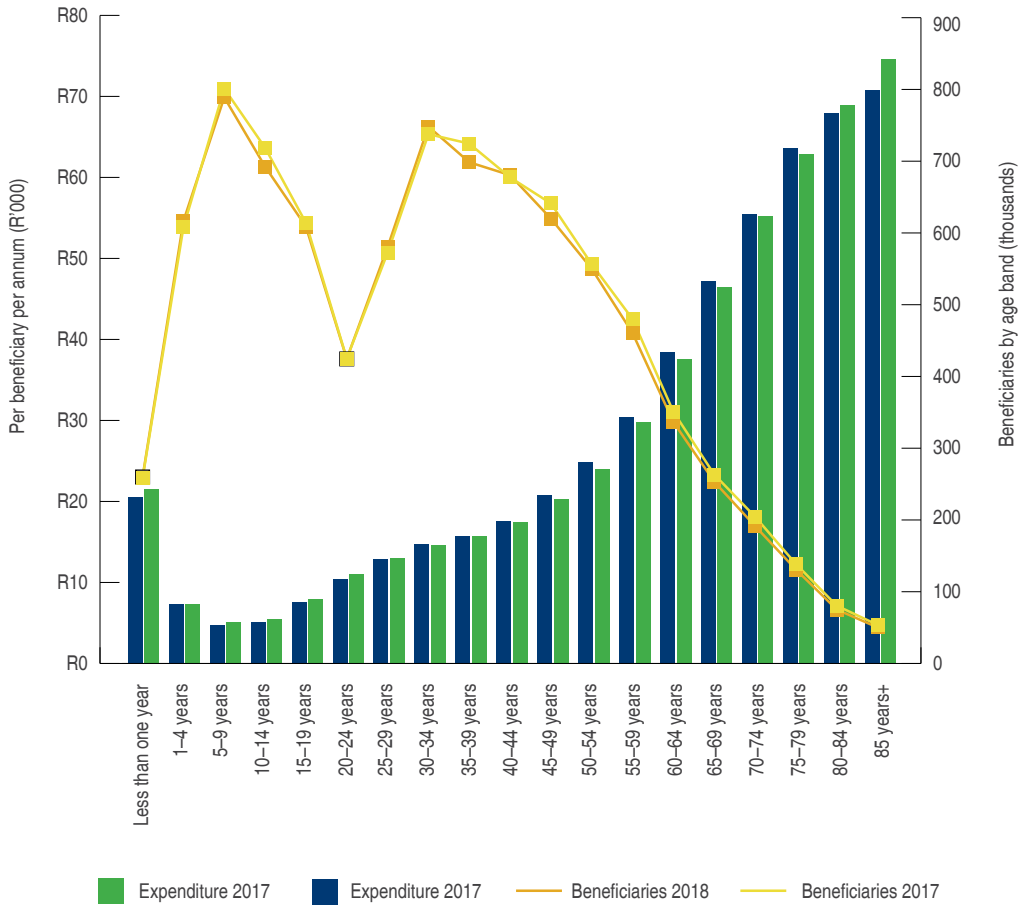



Figure 32: Healthcare expenditure by age band 2017 and 2018

Proportionally more benefits were paid towards beneficiaries 65 years and older, as seen in Figure 33. In 2018, 25.37% of total healthcare expenditure was paid towards these beneficiaries who comprise 8.32% of the medical scheme population. Beneficiaries less than one year old makeup 2.9% of the population but consume around 3.22% of total benefits paid, and beneficiaries between 35 and 64 years makeup 38.51% of the population and consume 47.61% of total benefits paid. This analysis shows the positive effect of the principle of community rating, one of the social solidarity pillars of the medical schemes act, without which healthcare would be unaffordable and inaccessible for older and sickly beneficiaries.

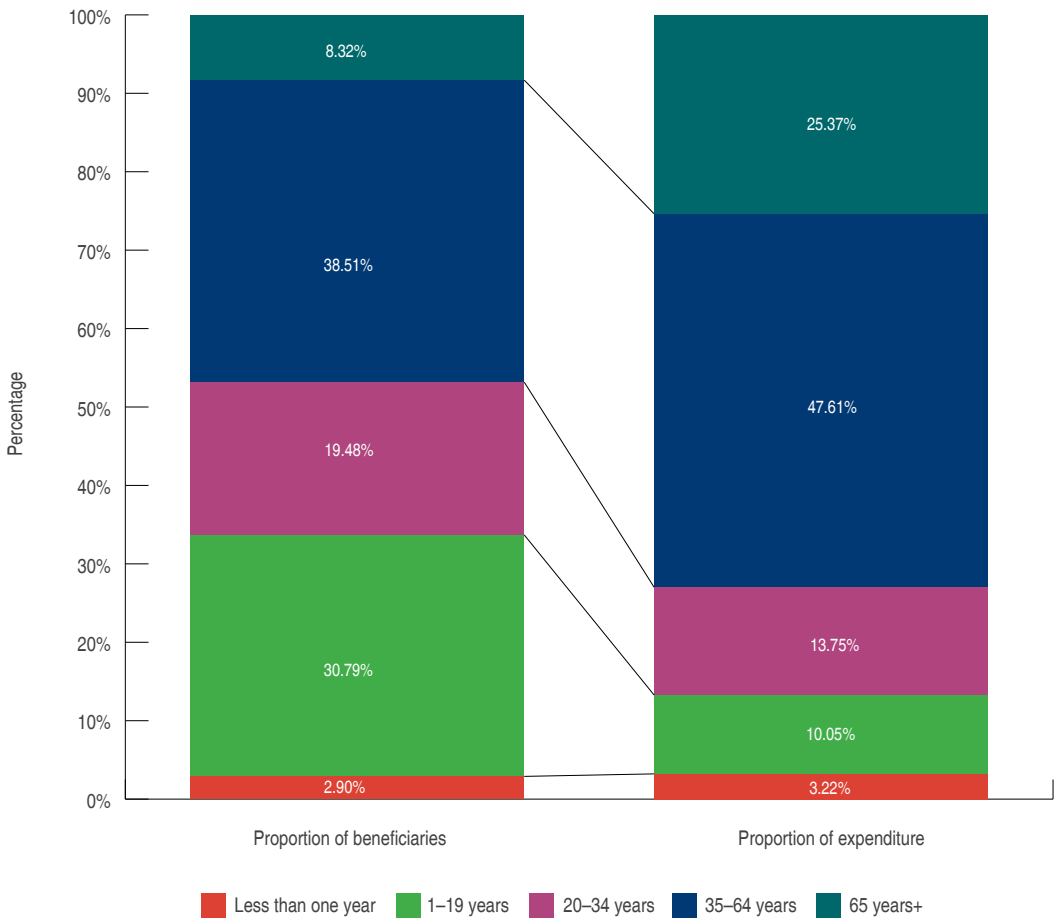



Figure 33: Proportion of total healthcare expenditure by age group

# OUT-OF-POCKET PAYMENTS

Out-of-pocket payments have been calculated as the difference between the claim amount billed and the amount that was paid from medical scheme risk, including the amount paid from the medical savings account. This is an understatement of the true out-of-pocket expenditure incurred by medical scheme members, since not all out-of-pocket claims are submitted to the medical scheme. In 2018, the total out-of-pocket expenditure amounted to R32.9 billion – up from the R31.8 billion in 2017. This represents 19.0% of the total benefits paid.

Figure 34 shows the split of out-of-pocket expenditure for 2018. It is clear that the largest component of out-of-pocket expenditure is attributable to medicines dispensed.

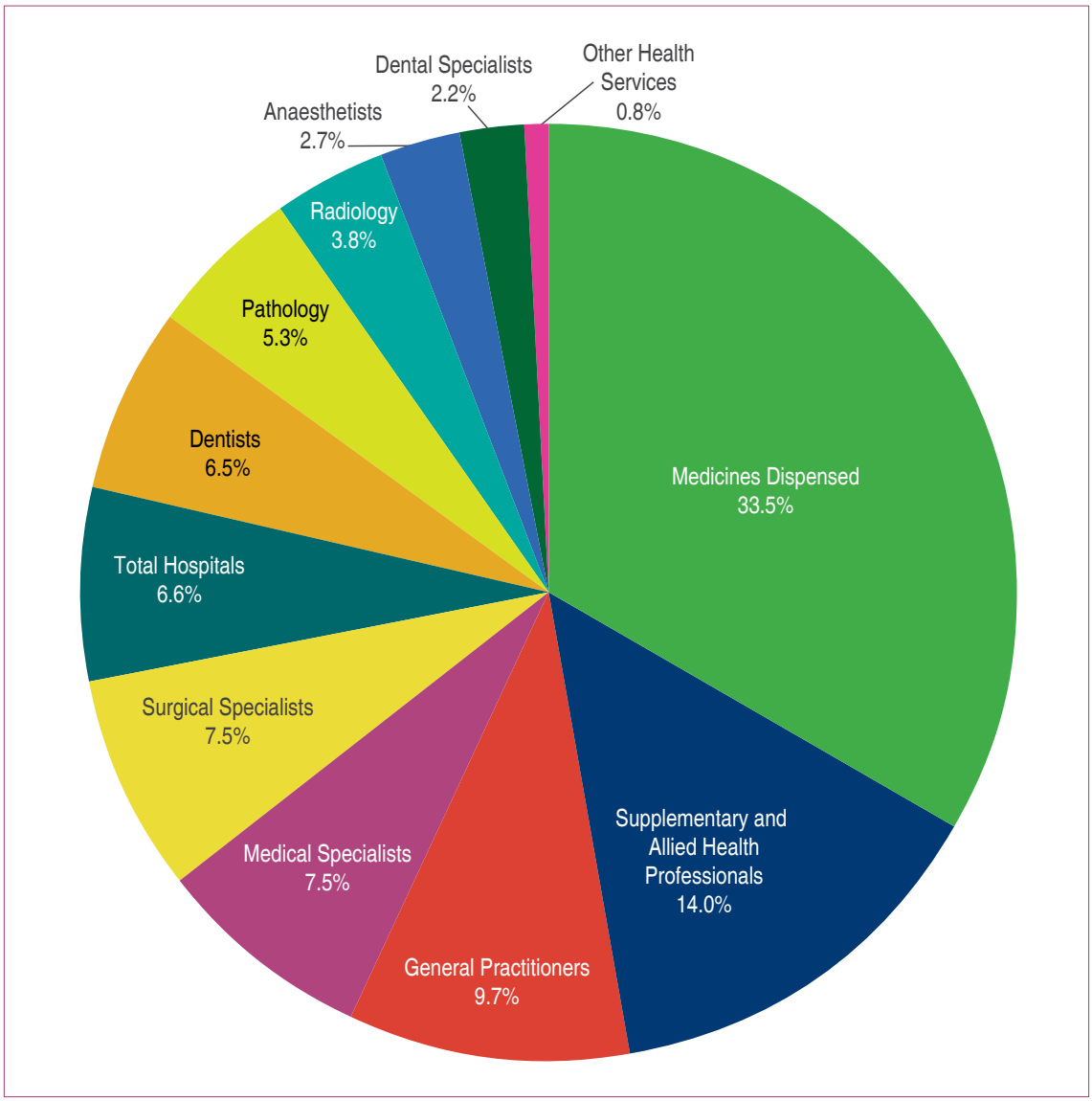



Figure 34: Out-of-pocket-payments by type 2018

Figure 35 splits the out-of-pocket expenditure, as defined in Figure 34, into the proportion paid from the medical savings account (Paid from MSA), and that not covered by any medical scheme contribution or risk (Paid by member).

Figure 35 illustrates that the bulk of medical savings is used on medicines, supplementary and allied health professionals and general practitioners. This is naturally a function of the medical scheme benefit design.

When it comes to 'Paid by member' expenditure is largely on medicines dispensed, surgical specialists and total hospitals. This is partly as a result of surgical specialists costs and hospital bills being more than the scheme rate (on average).

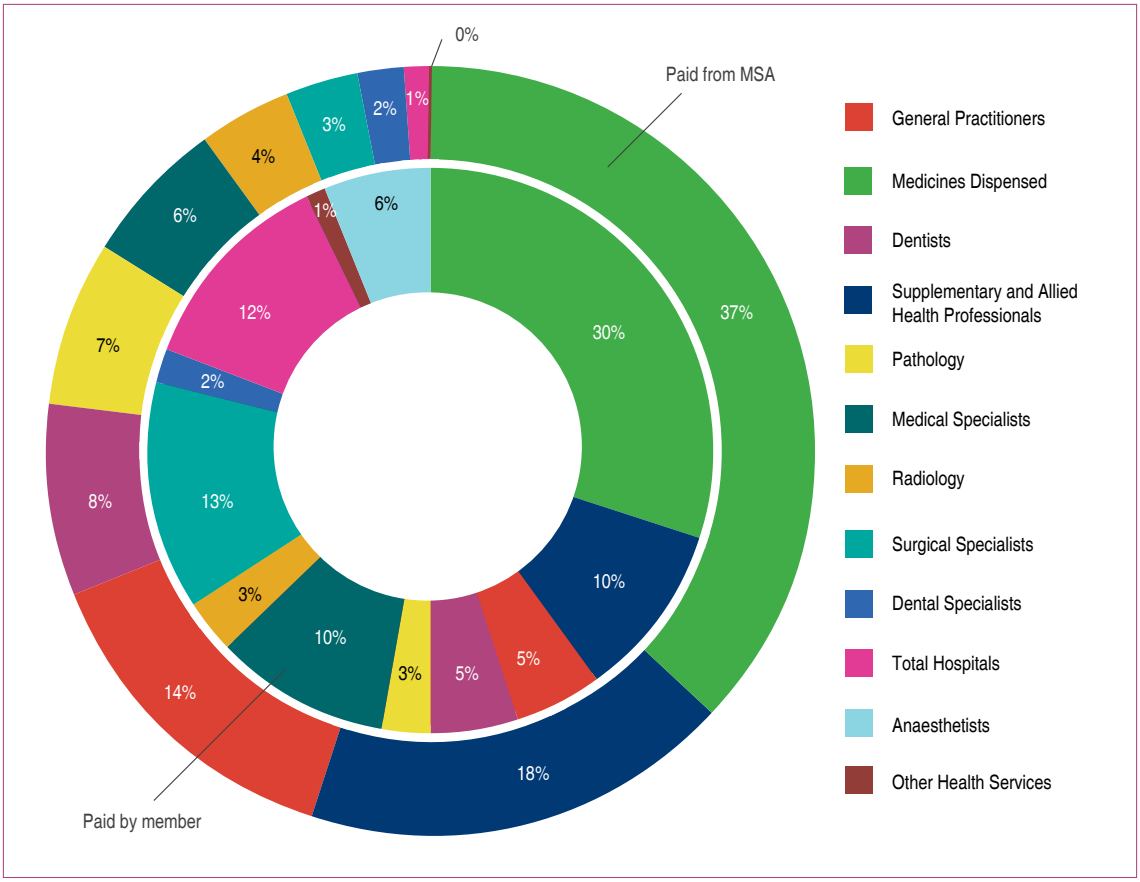



Figure 35: Out-of-pocket-payments by source 2018

Figure 36 shows the trend in out-of-pocket payments from 2014 to 2018. Overall, there has been an increasing upward trend in the out-of-pocket payments across the industry. The figure also illustrates that the out-of-pocket expenditure is lower on restricted schemes. This is largely as a function of the benefit design and richness of restricted schemes – which tend to be more comprehensive than those of open schemes.

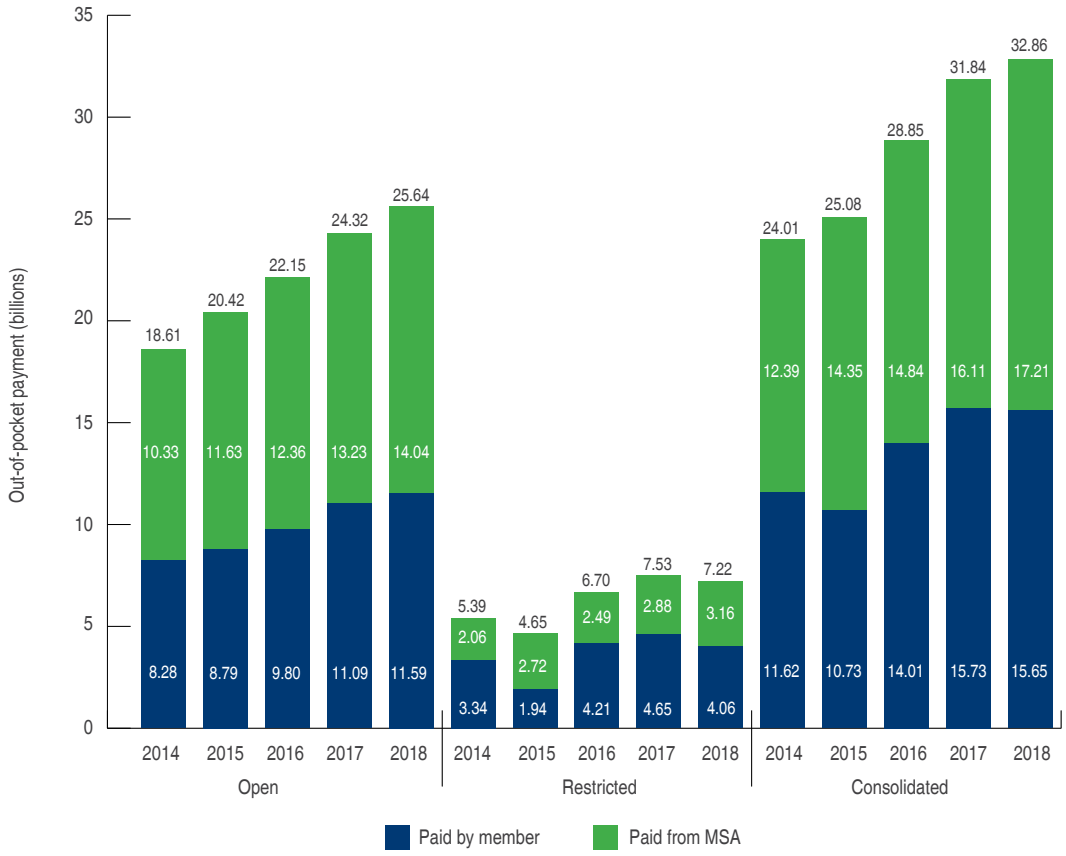



Figure 36: Trend in out-of-pocket payments 2014–2018

# PRESCRIBED MINIMUM BENEFITS

The total expenditure on prescribed minimum benefits (PMBs) by medical schemes amounted to R87.8 billion in 2018. The total benefits paid in 2018 was R173.3 billion. Therefore, PMBs constituted 50.7% of total benefits paid. Expenditure on PMBs for 2018 was R821 per beneficiary per month (pbpm), representing an 11.2% increase from the recalculated figure of R738 for the 2017 financial year.

Figure 37 depicts the differences in PMB expenditure by scheme. The variation is due to several factors such as different risk profiles and efficiency within the schemes. It could also be attributable to non-compliance in terms of either payment of PMBs or improper reporting on the level of PMBs.

Nine schemes, comprising six open schemes and three restricted schemes, reported PMB expenditure below R300 pbpm. As in 2017, average PMB costs were higher in open schemes than in restricted schemes, which may be indicative of the worsening risk profile in open schemes.

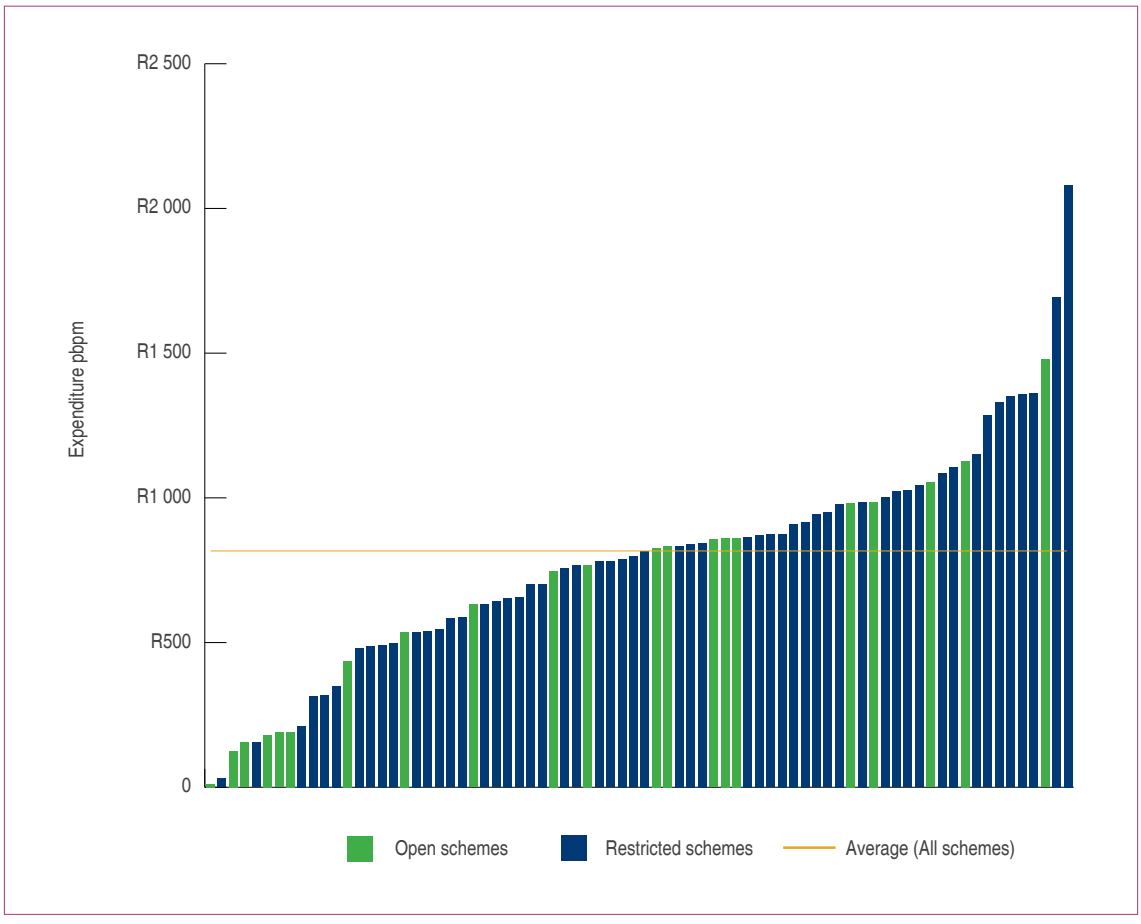



Figure 37: PMB expenditure by scheme for 2018

Medical scheme expenditure on PMBs is monitored from year to year and is mainly driven by a combination of the following:

- Beneficiary profile, which speaks to the level of cross-subsidisation between the young and the old and the sick and the healthy;
- Prevalence of chronic conditions and disease burden; and
- Expenditure on treatment, which is strongly linked to contracting between schemes and providers.

Figure 38 depicts the relationship between medical schemes' expenditure on PMBs and the beneficiary profile. Expenditure on PMBs generally increases with age. In ages above 45, expenditure on PMBs is higher than the industry average of R821 pbpm. PMB expenditure for beneficiaries aged one year or less is significantly more than the industry average. In the ages from one to 44 years, PMB expenditure is below the industry average. To maintain reasonable PMB expenditure increases from year to year, membership growth in the age bands encompassing 1 to 44-year olds should be higher than the growth in age ranges with PMB costs above the average of R821 pbpm (beneficiaries aged one year or less, and those older than 45).

As shown in the Figure 38, this has not been the case. There has been much higher growth in the age bands above 44 years.

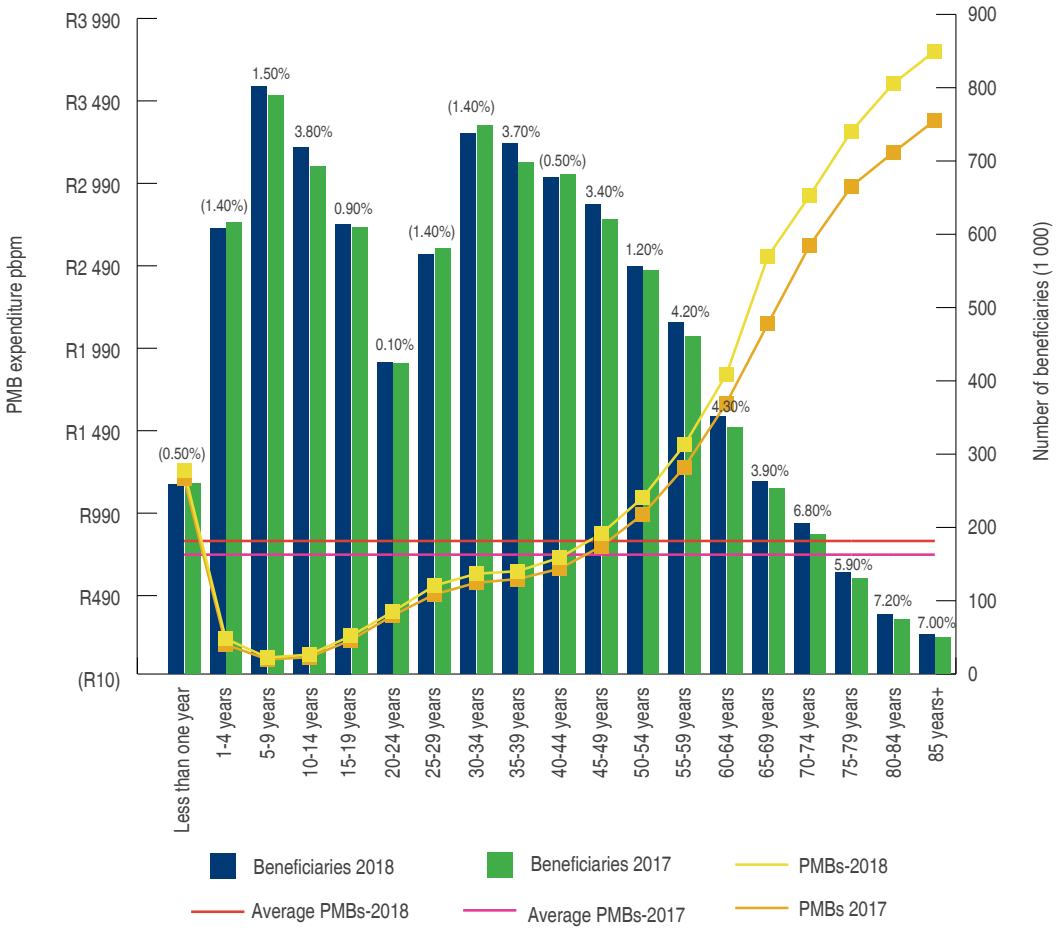



Figure 38: PMB expenditure by age band for 2017 and 2018

# CHRONIC CONDITION BENEFITS

Figure 39 shows the proportion of beneficiaries registered on schemes' disease management programme.

Hypertension remains the most prevalent condition on the CDL among medical schemes. In 2018, the number of beneficiaries registered for hypertension was 143.72 per 1 000 beneficiaries. This is also the most expensive condition on a pbpm basis and in 2018, medical schemes spent R24.98 pbpm on hypertension. The high per beneficiary per month expenditure on hypertension is due to its high prevalence in the population covered by medical schemes.

Hyperlipidaemia is the second most prevalent condition, with a prevalence of 77.91 per 1 000 beneficiaries, followed by Diabetes Mellitus Type 2 – with a prevalence of 50.26 per 1 000 beneficiaries. The decline in the number of registrations for HIV, asthma, rheumatoid arthritis and diabetes mellitus type 1 is due to the marginal decline in the number of beneficiaries diagnosed with these conditions.

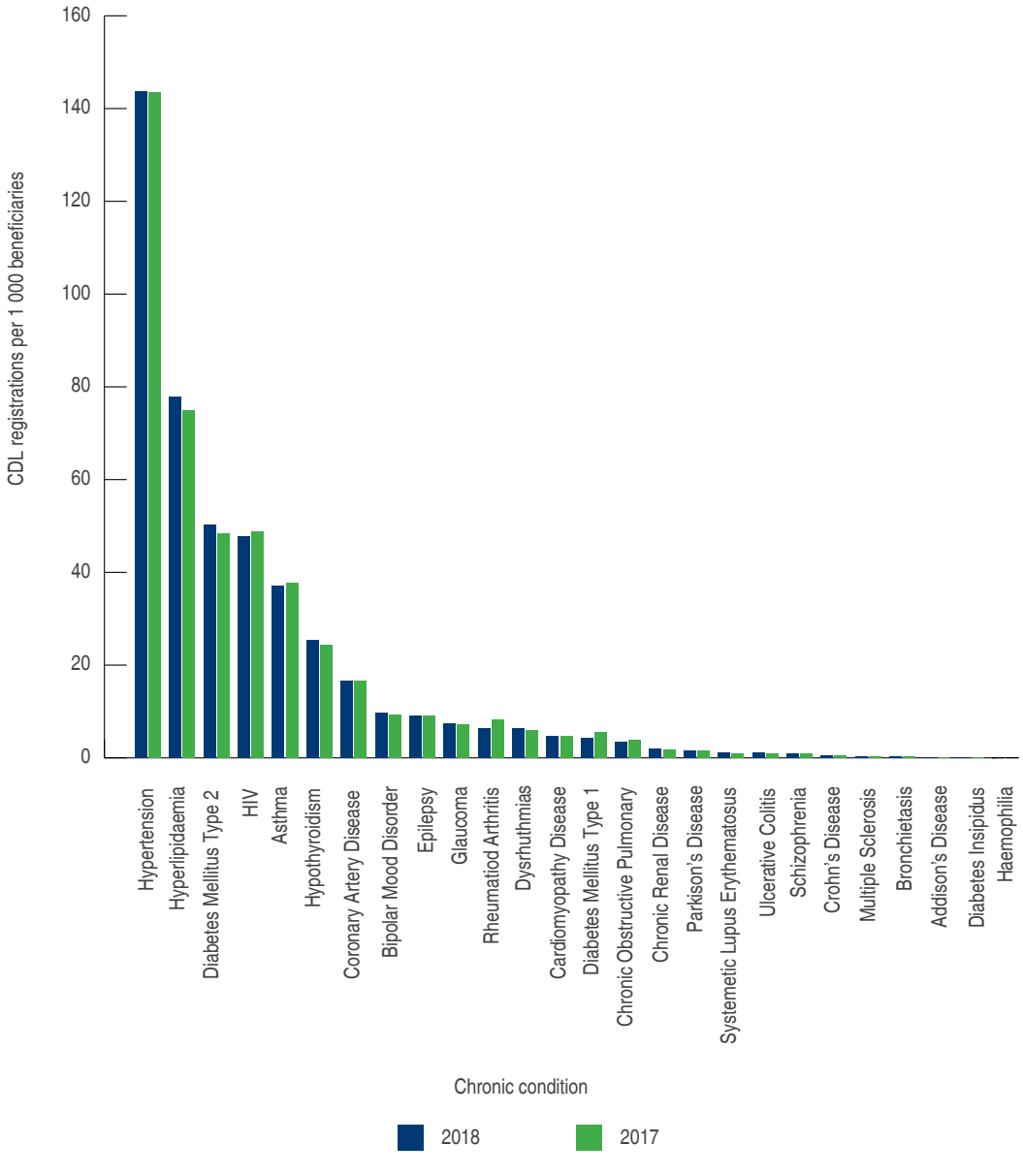



Figure 39: Proportion of beneficiaries registered on a chronic disease management programme in 2017 and 2018

Figure 40 shows expenditure per patient per month (pppm) on chronic conditions in 2017 and 2018, and compares it to the prevalence of the chronic conditions.

Haemophilia had the highest expenditure per patient registered, followed by Chronic Renal Disease and Multiple Sclerosis. In 2018, schemes spent R26 158 pppm on Haemophilia compared to R24 626 pppm in 2017. The 2017 amounts have been restated due to the reclassification of the data. That said, haemophilia has a very low prevalence (0.04 per 1 000 beneficiaries) so even though it is costly per patient, it does not contribute the most in terms of the overall cost to the scheme.

For most conditions, the increase in the number of registered patients from 2017 to 2018 was greater than the increase in the expenditure, resulting in a decrease in the average pppm cost.

The pppm expenditure is much lower than the estimated Scheme Risk Measurement (SRM) cost per patient for most of the CDLs. This may either be due to under-reporting of expenditure by schemes, or a reflection of the quality of care provided by the medical schemes. The latter possibility is consistent with the data submitted on the quality of care.

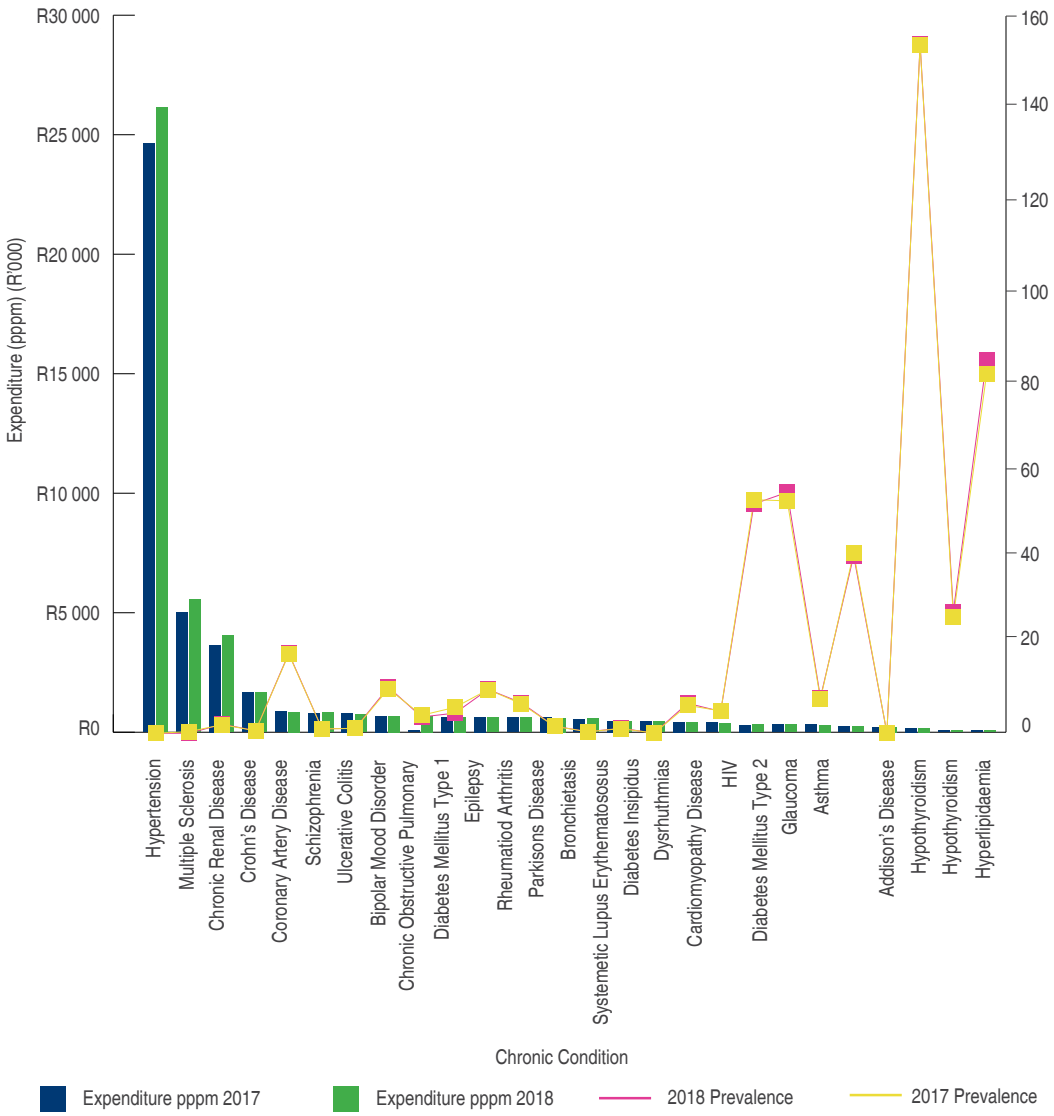



Figure 40: Expenditure pppm on chronic conditions in 2017 and 2018, compared to prevalence

# DIAGNOSIS AND TREATMENT PAIR BENEFITS

Diagnosis and treatment pairs (DTPs) are a set of procedures and treatments linked to certain Prescribed Minimum Benefit (PMB) conditions. Figure 41 depicts expenditure by medical schemes on DTPs for 2017 and 2018. Most of the DTP expenditure is in-hospital.

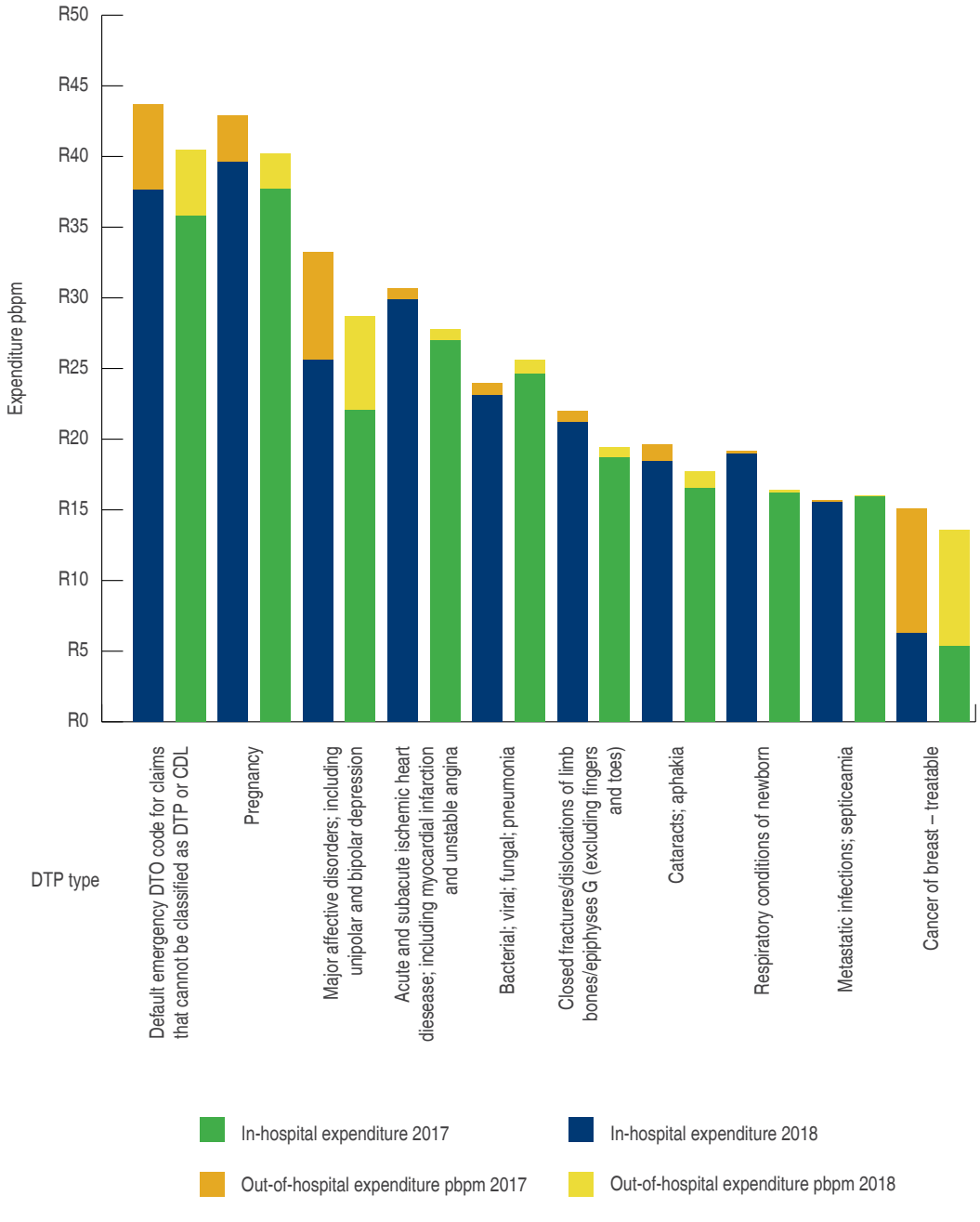



Figure 41: Top ten DTPs by expenditure pbpm

The default emergency conditions category was the most expensive DTP in 2018, with schemes spending R37.62 pbpm in-hospital. The composition of the top ten DTP conditions was the same as that of 2017.

Treatable breast cancer and major affective disorders (including unipolar and bipolar depression) accrued the highest expenditures outside hospital, amounting to R8.82 and R7.57 pbpm respectively.

Table 37: Top ten diagnosis and treatment pair (DTP) conditions

| DTP Diagnosis | Total expenditure on DTP conditions (R million) |
|---|---|
| Default emergency DTP code for claims that cannot be classified as DTP or CDL | 4 671 |
| Pregnancy | 4 584 |
| Major affective disorders; including unipolar and bipolar depression | 3 548 |
| Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina | 3 278 |
| Bacterial; viral; fungal pneumonia | 2 562 |
| Closed fractures/ dislocations of limb bones / epiphyses (excluding fingers and toes) | 2 352 |
| Cataract; aphakia | 2 096 |
| Respiratory conditions in newborns | 2 051 |
| Metastatic infections; septicaemia | 1 675 |
| Cancer of breast – treatable | 1 612 |
| **Total cost** | **28 428** |

The top ten DTP conditions cost R28.4 billion in 2018 compared to R25.9 billion in 2017.

# QUALITY OF CARE

When it comes to establishing the value of healthcare services, not only is the cost important, but also the quality of the services provided, and their respective outcomes. Demonstrating the value of managed care can prove challenging, but the coverage ratios for those beneficiaries registered on the various chronic programmes can provide some insight. Annexure F shows the coverage ratios for 14 CDL conditions, by scheme and benefit option.

Figures 42 and 43 illustrate the coverage ratios for hypertension and Diabetes Mellitus Type 2, the most prevalent, and third most prevalent chronic conditions respectively. These are conditions whose prevalence could be drastically reduced with improved lifestyle changes. Hyperlipidaemia is the second most prevalent chronic condition amongst medical scheme beneficiaries. Although hypertension is the most prevalent chronic condition, Figure 42 shows that the coverage ratios of some of the monitoring tests remain low.

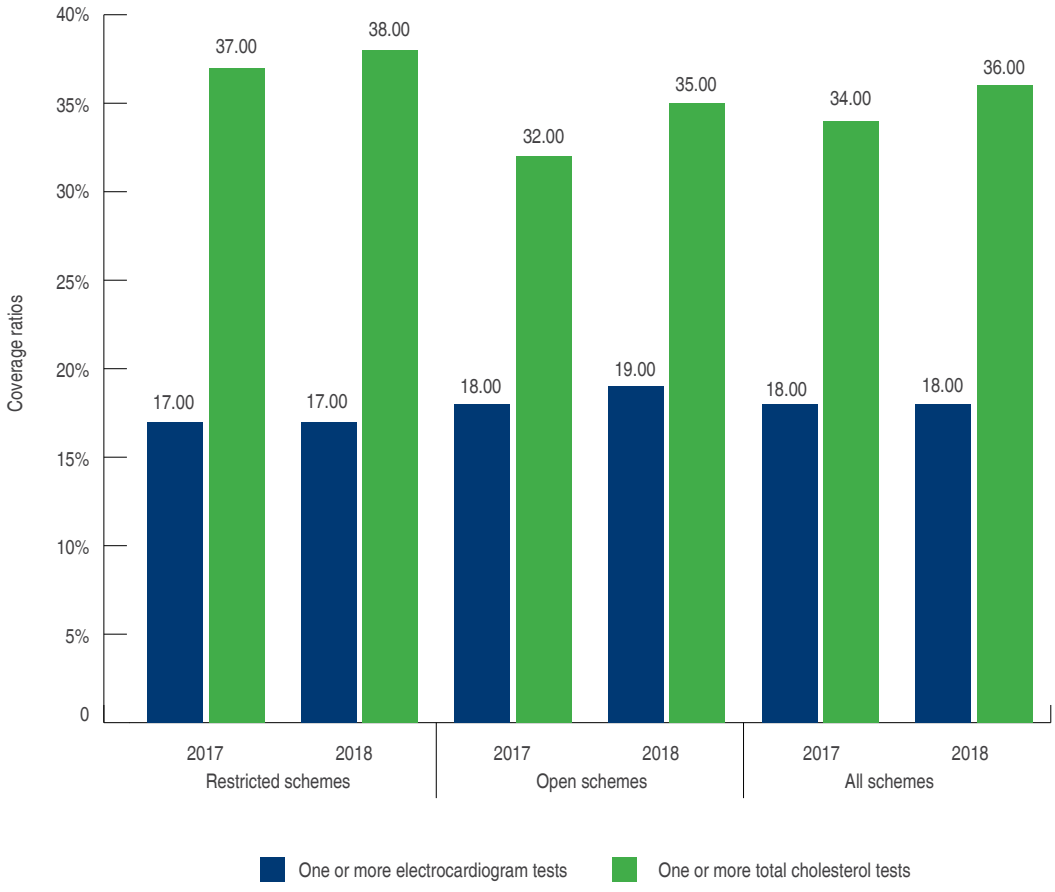



Figure 42: Hypertension coverage ratios

Similarly, as can be seen in Figure 43, the coverage ratios for Diabetes Mellitus Type 2 appear low.

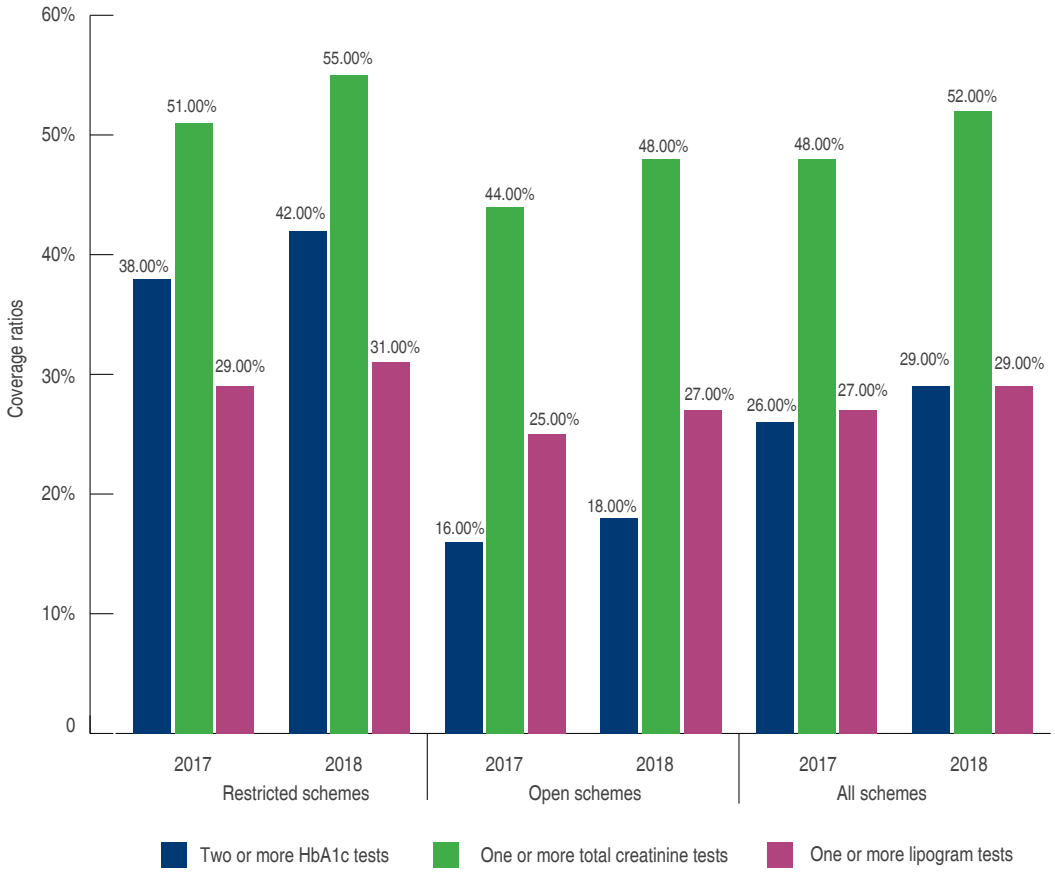



Figure 43: Diabetes Mellitus Type 2 coverage ratios

Figure 44 shows that the coverage ratios for HIV are quite high but have not yet reached the target of 90%. It is also worth looking at the coverage ratios for HIV, to see how these compare with the 2020 development goals, mainly the 90-90-90 Strategy. The 90-90-90 Clinical Cascades is a concept introduced as a set of goals by the United Nation's programme on HIV/AIDS in 2013. The idea is that by 2020, 90% of people who are HIV infected will be diagnosed, 90% of people who are diagnosed will be on antiretroviral treatment and 90% of those who receive antiretrovirals will be virally suppressed.

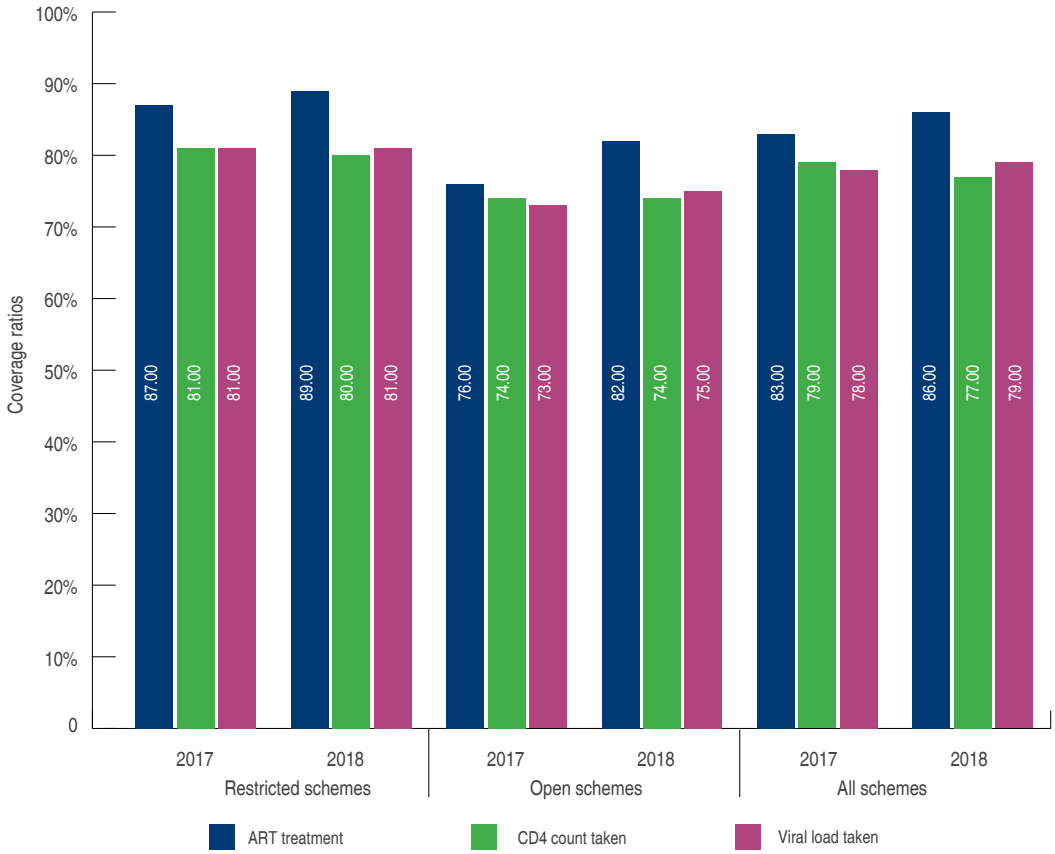



Figure 44: Human Immunodeficiency Virus (HIV)

# UTILISATION OF HEALTHCARE SERVICES

## Utilisation of general practitioner (GP) health services

The proportion of medical scheme beneficiaries visiting a GP at least once a year reduced slightly to 81.6% in 2018 from 82.0% in 2017, as shown in Figure 45. The number of beneficiaries visiting a GP was higher in the restricted schemes for both 2018 and 2017 than in open schemes. Both restricted and open schemes reported a slight decline in the percentage of beneficiaries visiting a GP during the period under review. The average number of GP visits per patient decreased from 3.3 in 2017 to 3.2 in 2018. The average number of visits to the GP remained unchanged at 3.1 for open schemes, while restricted schemes reported a reduction from 3.4 in 2017 to 3.3 in 2018. Overall, the percentage of patients consulting with a GP in a hospital setting increased from 10.1% in 2017 to 10.8% in 2018. The in-hospital GP visits were higher in restricted medical schemes compared to open schemes.

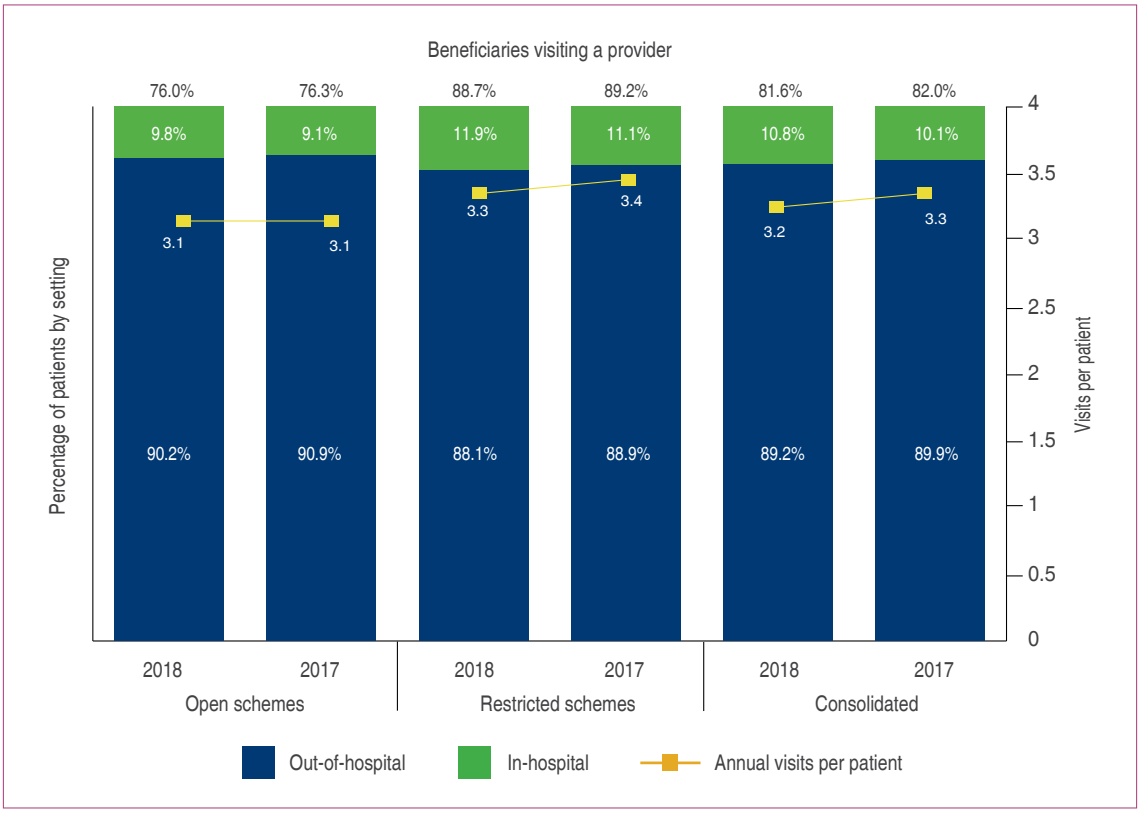



Figure 45: Utilisation of general medical practitioner health services in 2018 and 2017

Consolidated out-of-hospital consultations amounted to 87.9% of all expenditure to GPs in 2017, and decreased to 86.9% in 2018, as depicted in Figure 46. Both open and restricted schemes reported an increase in the number of beneficiaries visiting a GP a least once during the year in a hospital setting. In 2018, 13.1% of all expenditure to GPs was claimed for 10.8% of patients. A slightly higher proportion of in-hospital expenditure was observed in 2017 compared to the percentage of beneficiaries consulting in the same setting (12.1% vs 10.1%). These trends must be monitored, as an increase in the occurrence of unnecessary in-hospital consultations may be indicative of wasteful use of healthcare resources, an ineffective managed care framework or poor benefit design.

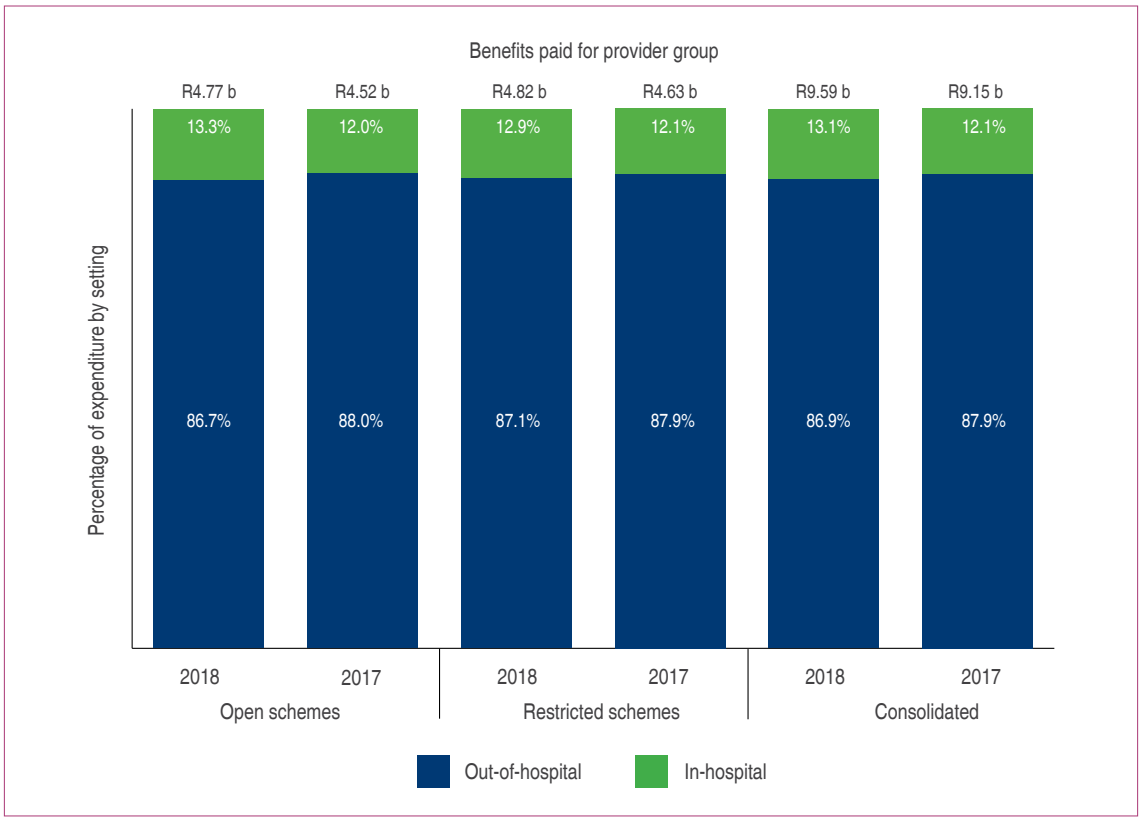



Figure 46: Out-of-hospital and in-hospital expenditure distribution for general medical practitioners in 2018 and 2017

Figure 47 depicts the utilisation of GPs by beneficiary age band. Utilisation rates were high across all age bands in 2018, ranging from 68% in the 15 to 19 year age band to 100% in the age bands 80 years and above.

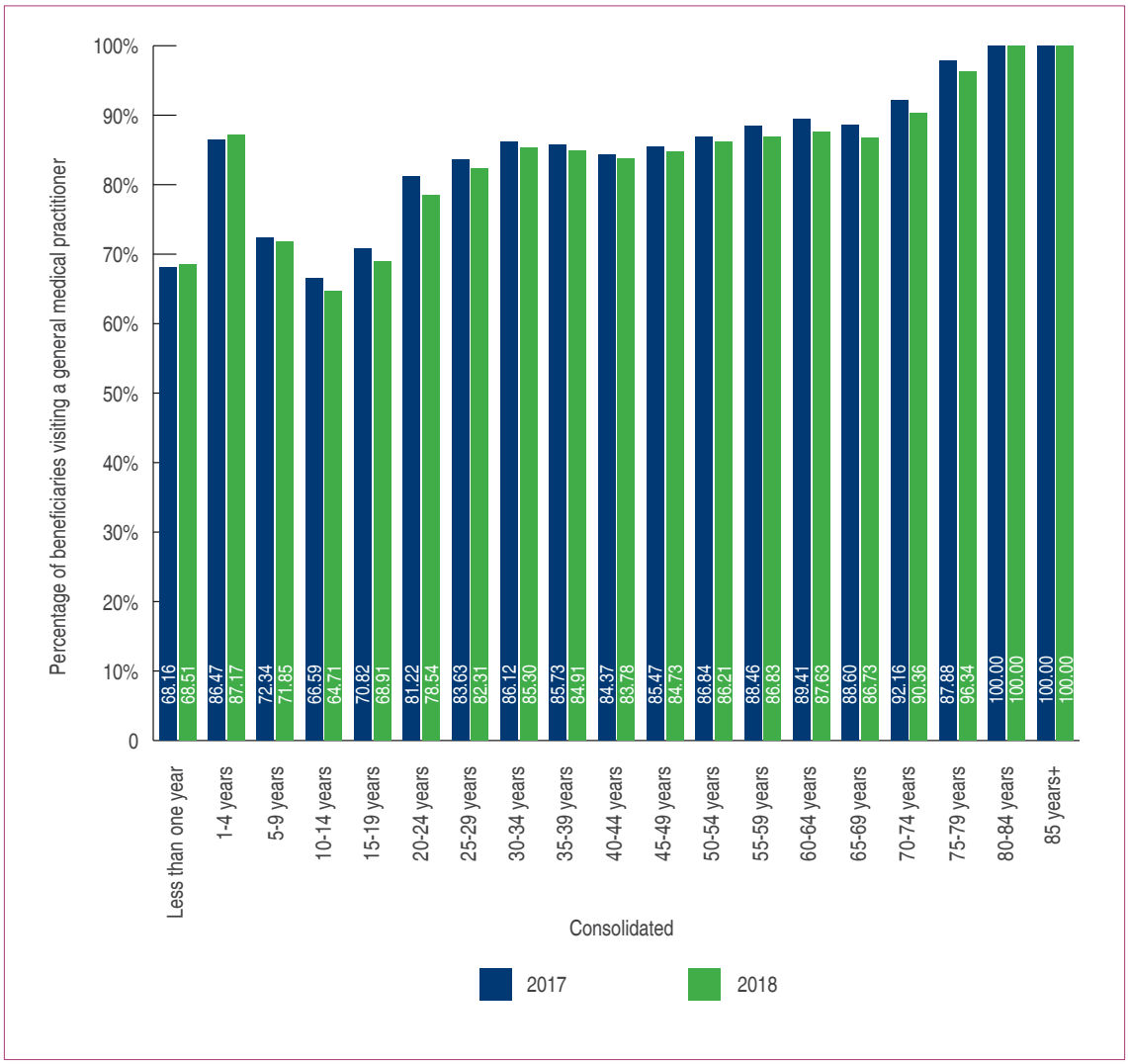



Figure 47: Beneficiaries consulting general medical practitioners by age band

## Utilisation of general dental practitioner health services

The number of covered medical scheme beneficiaries visiting a dental practitioner at least once during the year reduced slightly from 21.8% in 2018 to 21.7% in 2018 as shown in Figure 48. More beneficiaries in restricted schemes (24.4%) had at least one dentist consultation in 2018 compared to those in open schemes (19.6%). Similar trends were observed in 2017. The average number of visits to dental practitioners remained largely unchanged at about 1.8 visits per patient in both open and restricted schemes. Nearly all dental practitioner consultations took place in out-of-hospital settings.

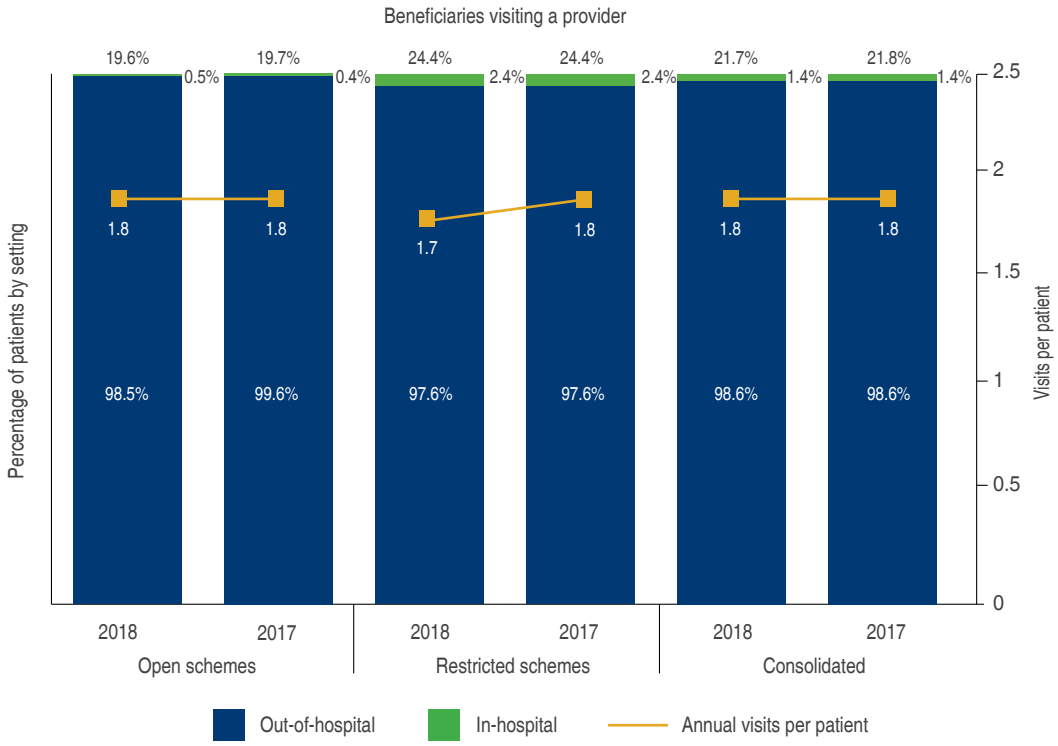



Figure 48: Utilisation of general dental practitioner health services in 2018 and 2017

Figure 49 demonstrates the proportion of expenditure on dental practitioners for both in- and out-of-hospital settings. The largest proportion of expenditure for dental practitioners (96.8% for all schemes) occurred in out-of-hospital settings, in line with the proportion of beneficiaries receiving dental care in out-of-hospital settings.

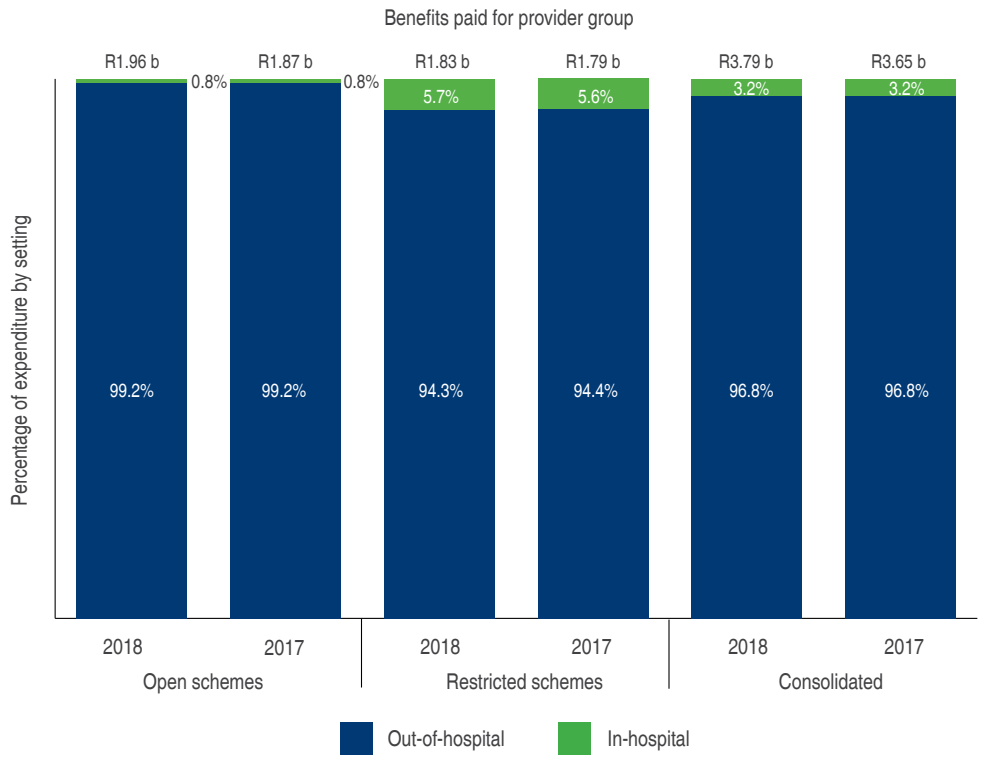



Figure 49: Out-of-hospital and in-hospital expenditure distribution for general dental practitioners in 2018 and 2017

The utilisation of dentists was low, at less than 30% of all covered beneficiaries across all age bands in both the 2017 and 2018 financial years, as depicted in Figure 50. This is far below the recommended frequency of at least one visit to the dentist per beneficiary per year and has serious implications for the dental quality of care funded by medical schemes.

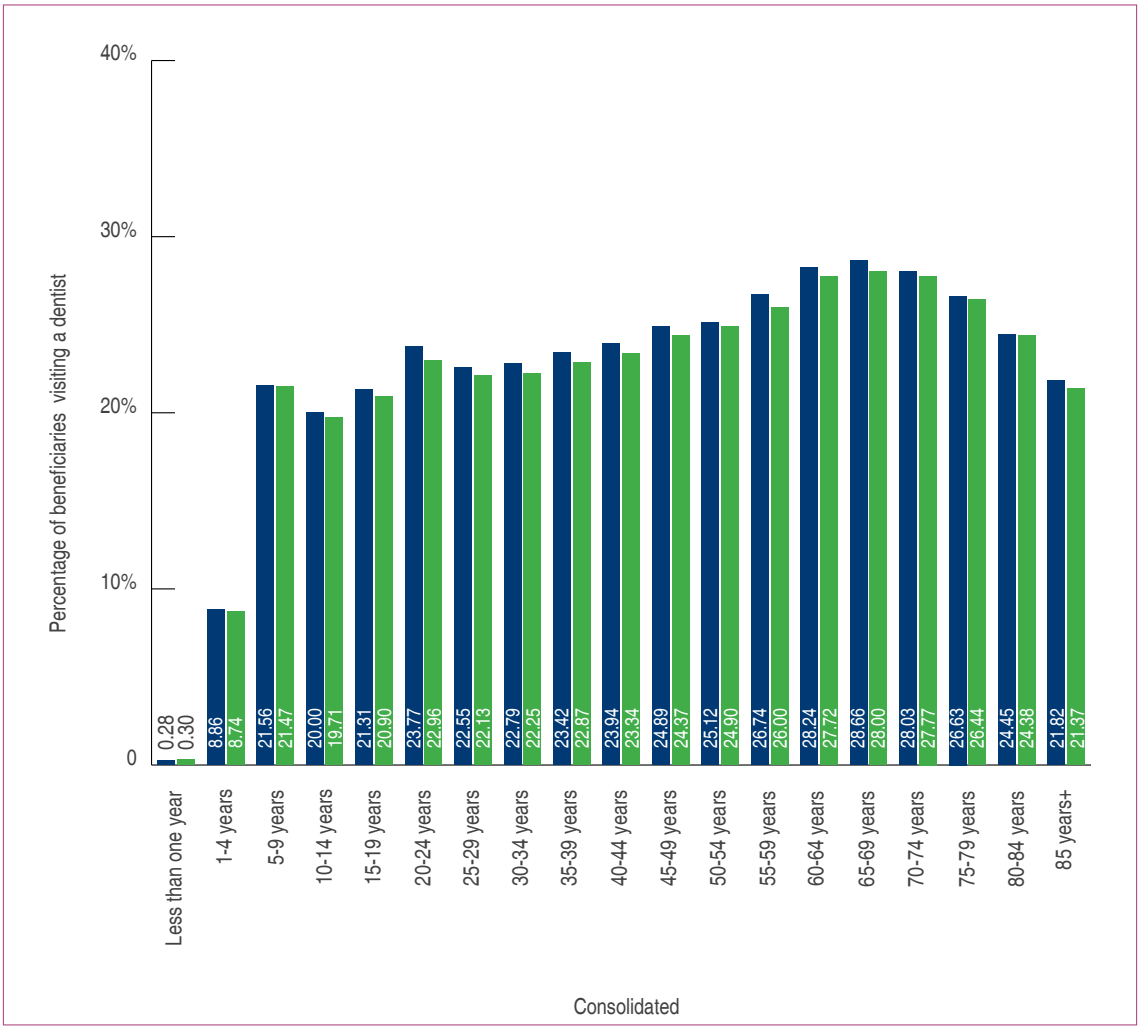



Figure 50: Beneficiaries consulting general dental practitioners by age

## Utilisation of dental specialist health services

A slight increase in the number of medical scheme beneficiaries visiting a dental specialist at least once during the year was observed, from 4.2% in 2017 to 4.3% in 2018 as shown in Figure 51. As observed with dental practitioners, a higher proportion of beneficiaries in restricted schemes (5.6%) had at least one dental specialist consultation in 2018 compared to those in open schemes (3.3%). The average number of visits to dental specialists remained largely unchanged at about 1.9 visits per patient during the period under review for beneficiaries in both open and restricted schemes. Nearly all dental specialist consultation took place in out-of-hospital settings.

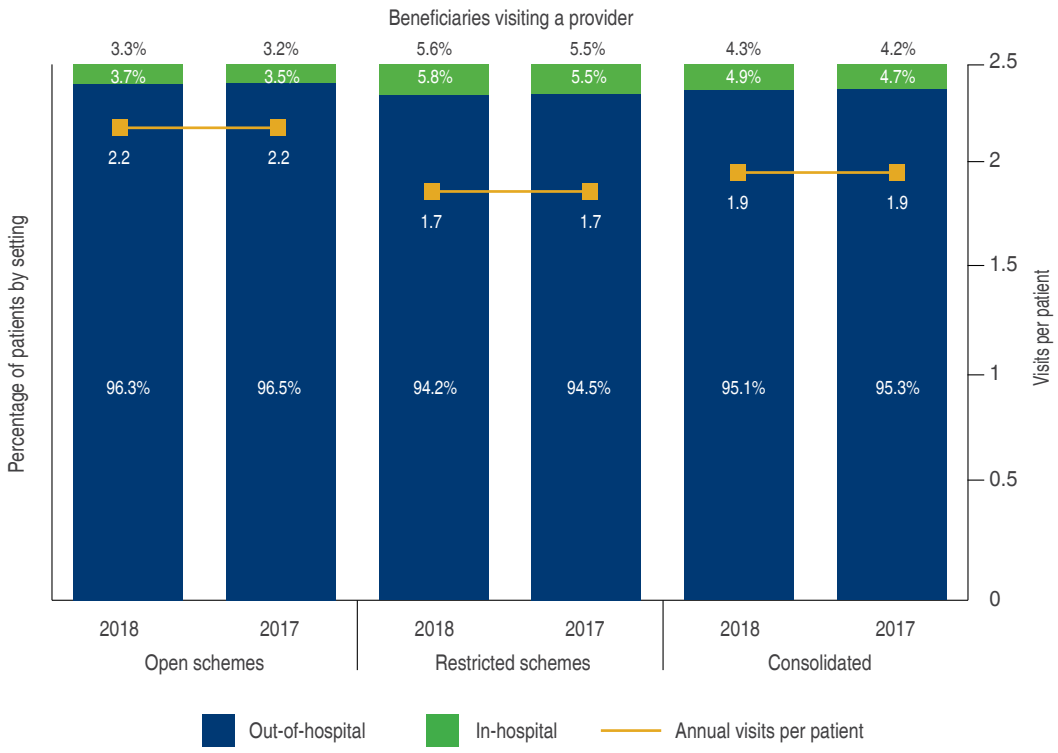



Figure 51: Utilisation of dental specialist health services in 2018 and 2017

About 4.9% of beneficiaries were responsible for 9.0% of expenditure on dental specialists in 2018. This observation is explained by the higher cost associated with in-hospital provider consultations. These trends must be monitored, as an increase in the occurrence of unnecessary in-hospital consultations may be indicative of wasteful use of healthcare resources, an ineffective managed care framework or poor benefit design.

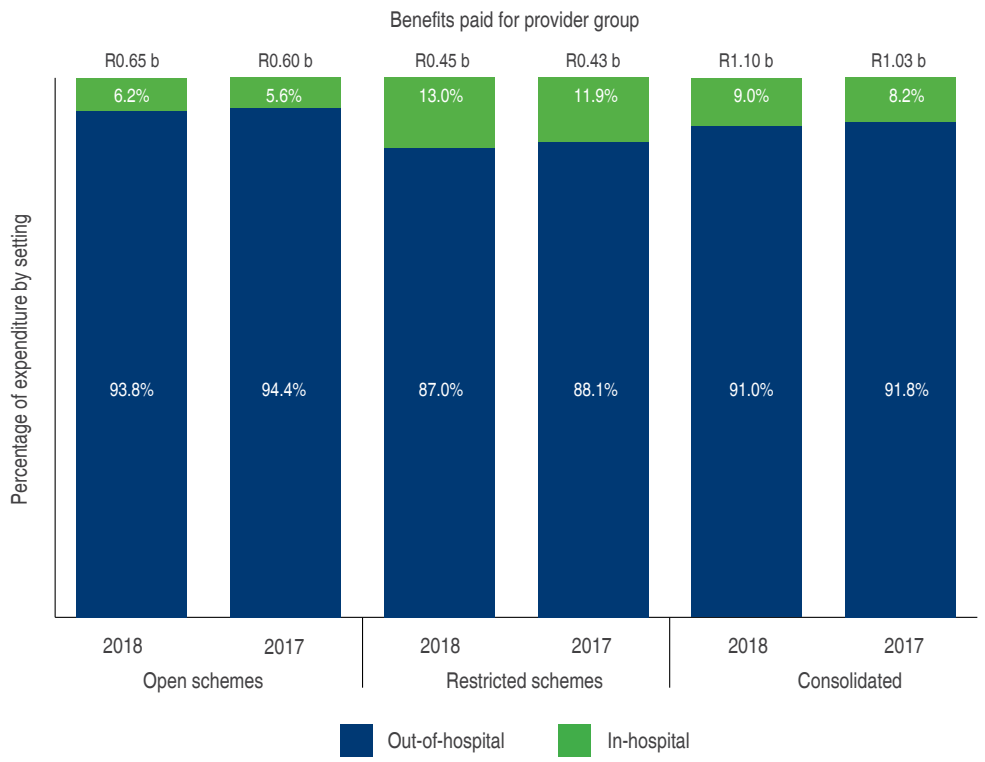



Figure 52: Out-of-hospital and in-hospital expenditure distribution for dental specialists in 2018 and 2017

## Utilisation of medical specialist health services

During the period under review, approximately 37% of beneficiary consultations with medical specialists occurred in in-hospital settings and 63% in out-of-hospital settings (Figure 53). In restricted and open schemes combined, 35.2% of beneficiaries consulted with a medical specialist in 2018 compared with 34.5% in 2017. The average annual number of consultations per patient remained largely unchanged at between 3.2 and 3.4.

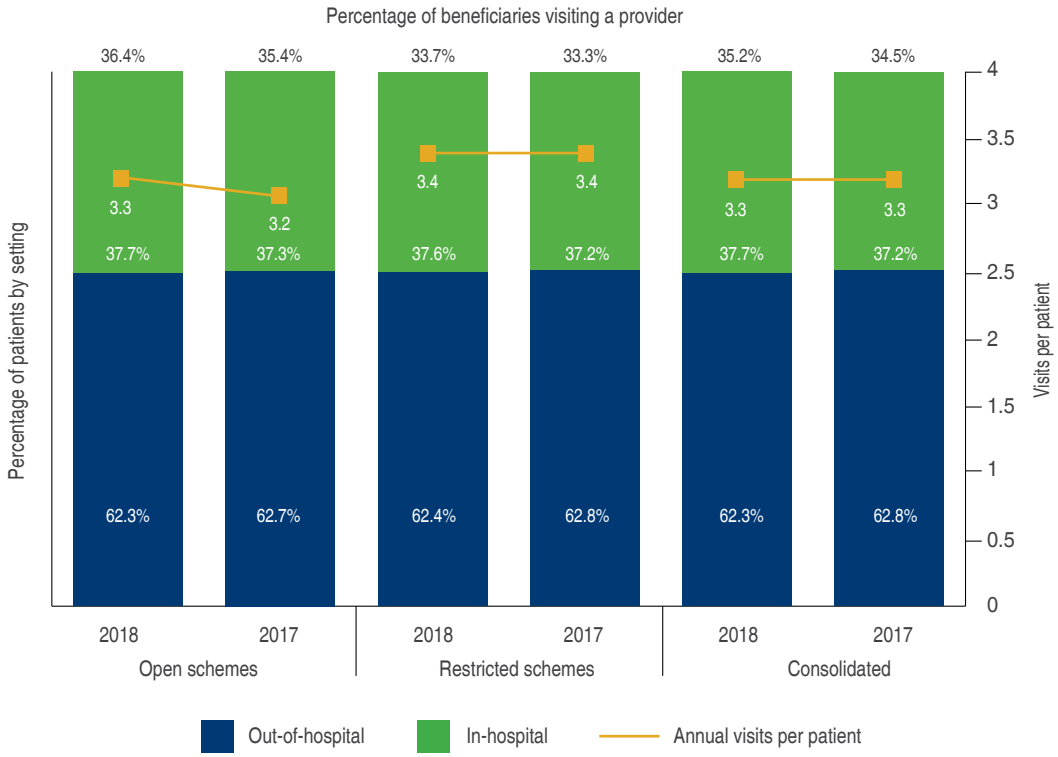



Figure 53: Utilisation of medical specialist health services in 2018 and 2017

The split in the expenditure on medical specialist healthcare services was reversed when compared to the proportion of beneficiaries visiting a medical specialist in either an in-hospital or out-of-hospital setting. More than 60% of expenditure was associated with in-hospital consultations compared to 37% of beneficiary consultations in the same setting (Figure 54). These trends may be indicative of wasteful use of healthcare resources, an ineffectively managed care framework, poor benefit design or the preference of the healthcare provider. A detailed expenditure analysis per medical specialist provider type is contained in Annexure G.

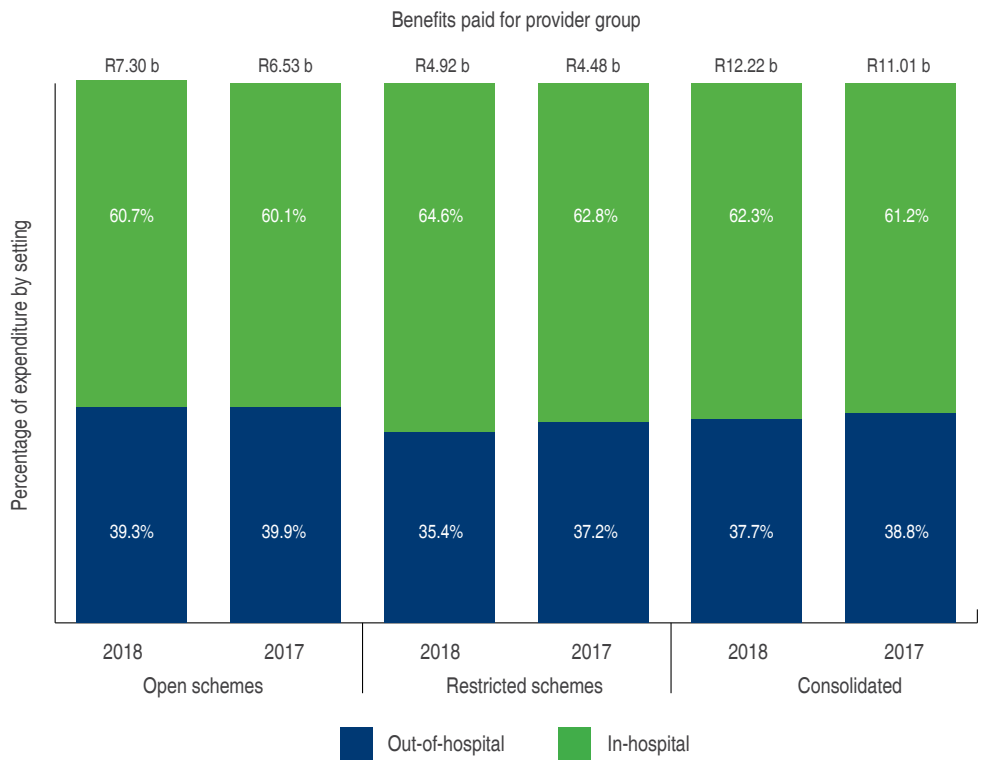



Figure 54: Out-of-hospital and in-hospital expenditure distribution for medical specialist services in 2018 and 2017

Figure 55 depicts the utilisation of medical specialists by age band. Visits to medical specialists were high for infants, peaking at rates over 70% for covered infants. Utilisation declined to levels below 30% for children between the ages of 1 and 15 years. The rise in utilisation to over 30% of covered beneficiaries in the 20 to 40 year age bands may be explained by an increase in the utilisation of maternal health services by female beneficiaries. Beneficiaries using medical specialists steadily rose from over 30% in the 40 to 45 year age band to over 80% in the 85+ age band.

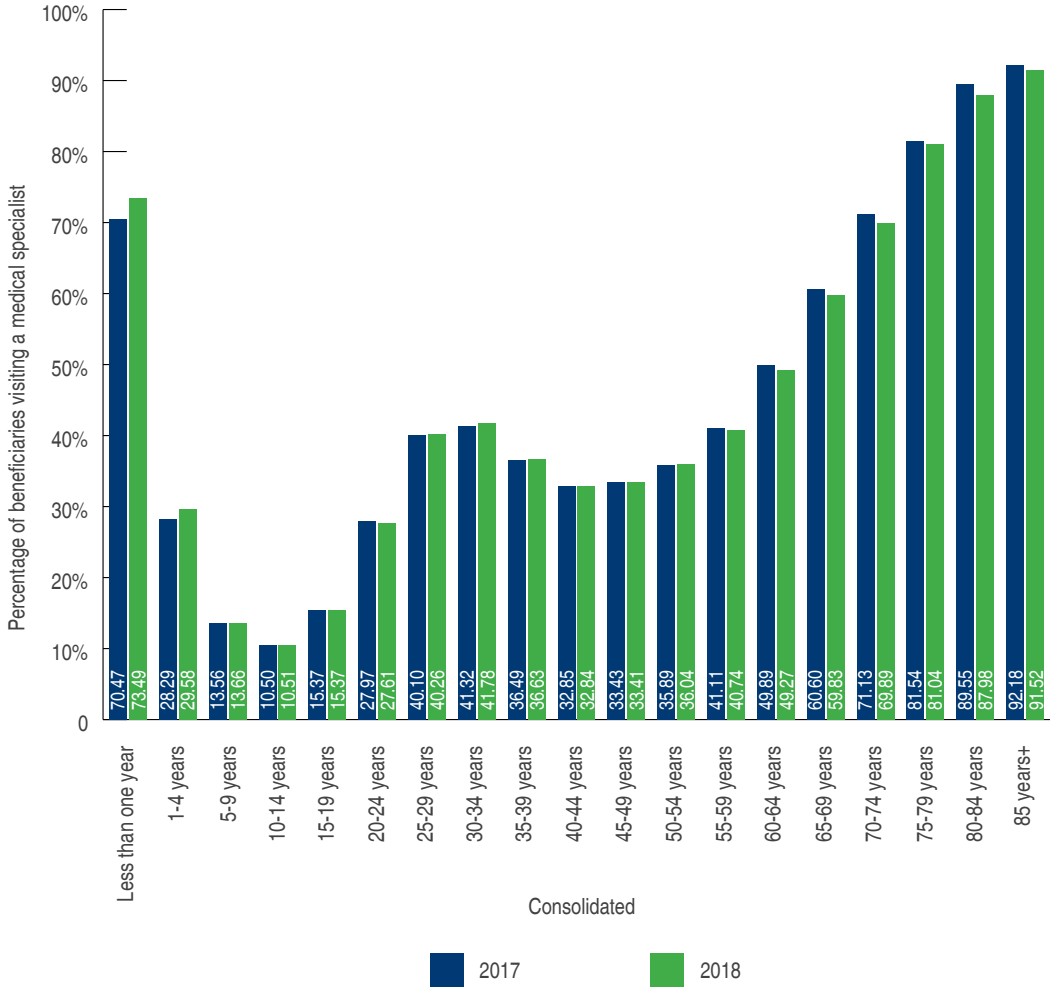



Figure 55: Beneficiaries consulting medical specialists by age

## Utilisation of surgical specialist health services

The proportion of medical scheme beneficiaries consulting with a surgical specialist at least once a year rose slightly to 23.5% from 23.0% in 2017 (Figure 56). The number of surgical specialist consultations was higher in open schemes in both the 2018 and 2017 financial years when compared to restricted schemes. The annual average number of repeat consultations per patient was 1.9 across the medical schemes industry during the period under review. Overall, the percentage of patients consulting with a surgical specialist in a hospital setting increased slightly from 46.4% in 2017 to 47.2% in 2018. The in-hospital surgical specialist visits were higher in open medical schemes than in restricted schemes. Restricted schemes seem to have more control in the utilisation of expensive providers than open schemes.

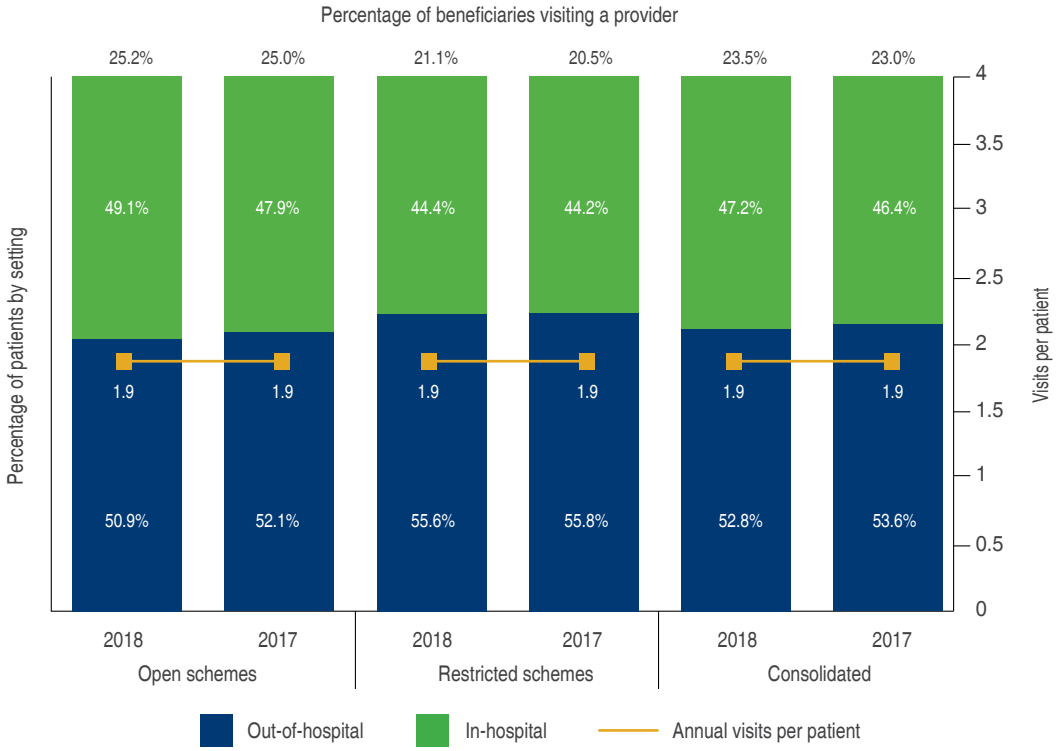



Figure 56: Utilisation of surgical specialist health services in 2018 and 2017

Consolidated in-hospital consultations amounted to 82.1% of all expenditure on surgical specialists in 2017, and increased to 83.9% in 2018, as depicted in Figure 57. This is significantly higher than the proportion of beneficiaries making in-hospital consultations. The detailed expenditure analysis per surgical specialist provider type is contained in Annexure G. Surgical specialist consultations are mostly associated with expensive hospital admissions of patients. Failure to manage and control utilisation will lead to an increase in the occurrence of unnecessary in-hospital consultations and an increase in the wasteful use of healthcare resources, an ineffective managed care framework and/or poor benefit design.

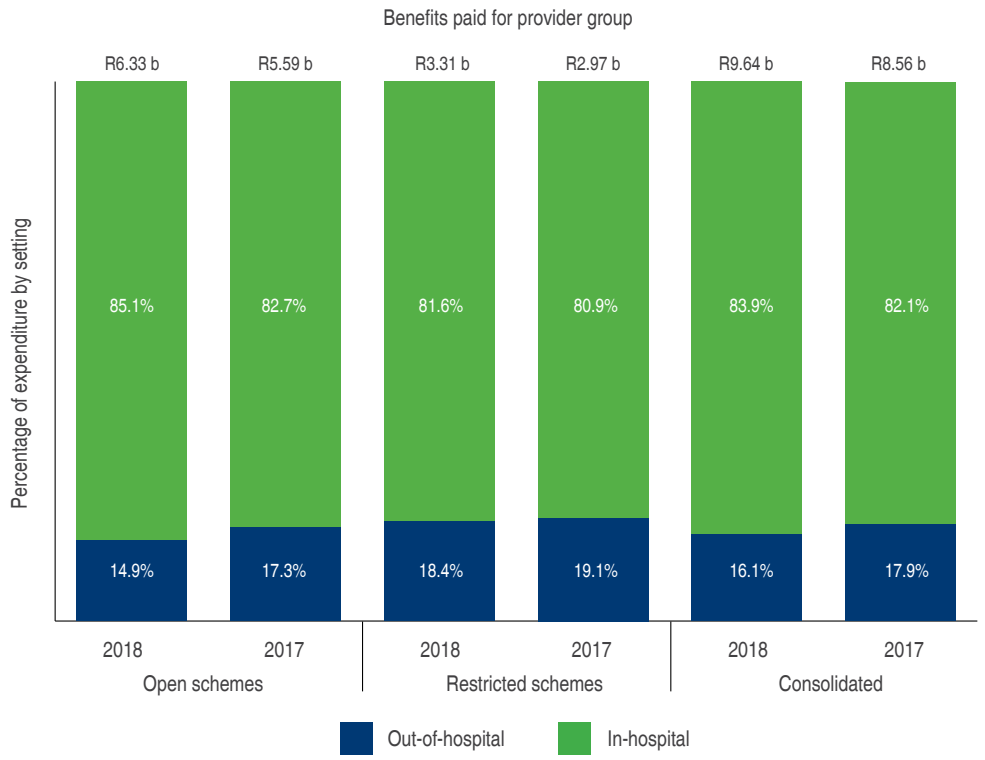



Figure 57: Out-of-hospital and in-hospital expenditure distribution for surgical specialists in 2018 and 2017

Figure 58 depicts the utilisation of surgical specialists by age band. Utilisation rose steadily from about 10% in the youngest beneficiaries to more than 80% in the 75 to 84 year age bands. The utilisation of surgical specialists is strongly associated with admissions to acute hospitals.

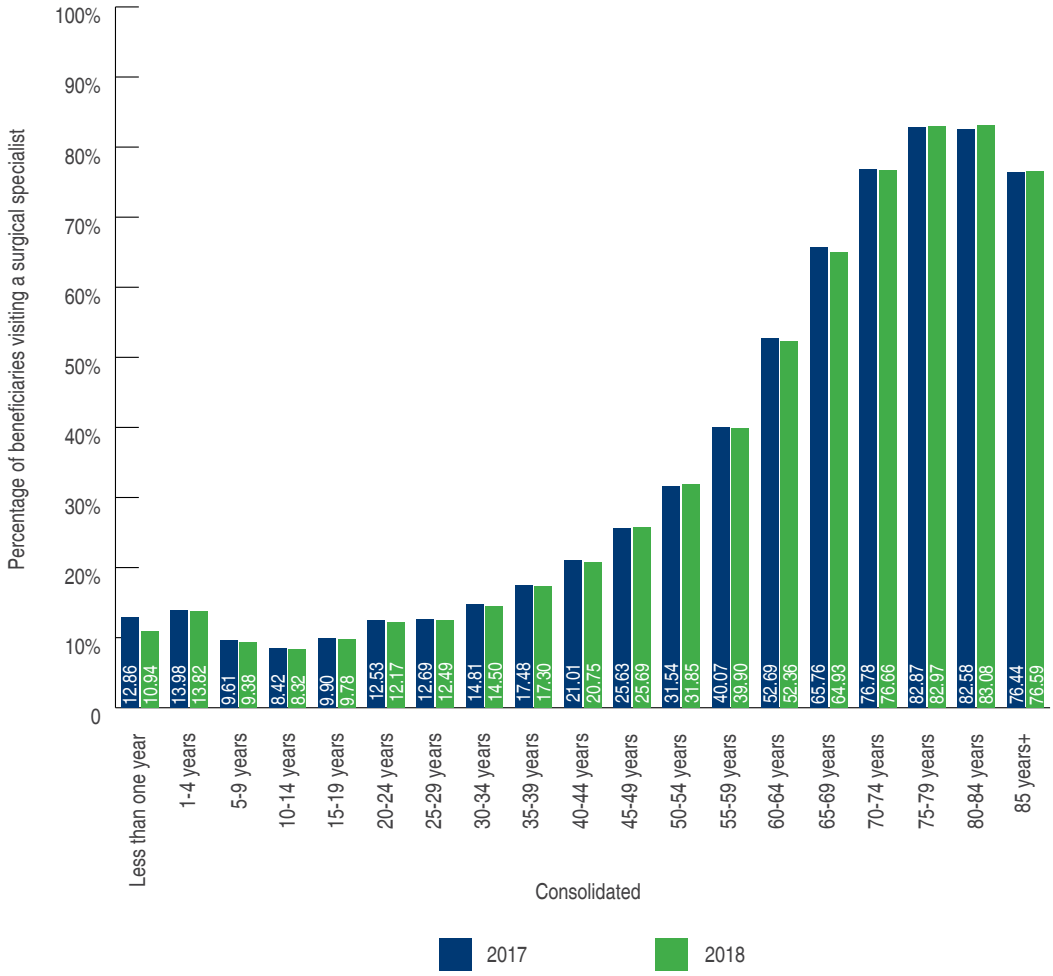



Figure 58: Beneficiaries consulting medical specialists by age

## Utilisation of anaesthetist health services

About 90% of all anaesthetist consultations took place in hospital settings, as shown in Figure 59. A slight increase in the number of medical scheme beneficiaries consulting with anaesthetists at least once during the year was observed, from 8.7% in 2018 to 9.0% in 2018. A higher proportion of beneficiaries in open schemes (10.2%) had at least one anaesthetist consultation in 2018 compared to those in restricted schemes (7.5%). The average number of visits to anaesthetists remained unchanged at about 1.4 visits per patient during the period under review for beneficiaries in both open and restricted schemes.

The proportion of benefits paid for in-hospital anaesthetist consultations is slightly higher than that of beneficiaries visiting anaesthetists in the same setting across all scheme types (94.9% and 91.5% in 2018).

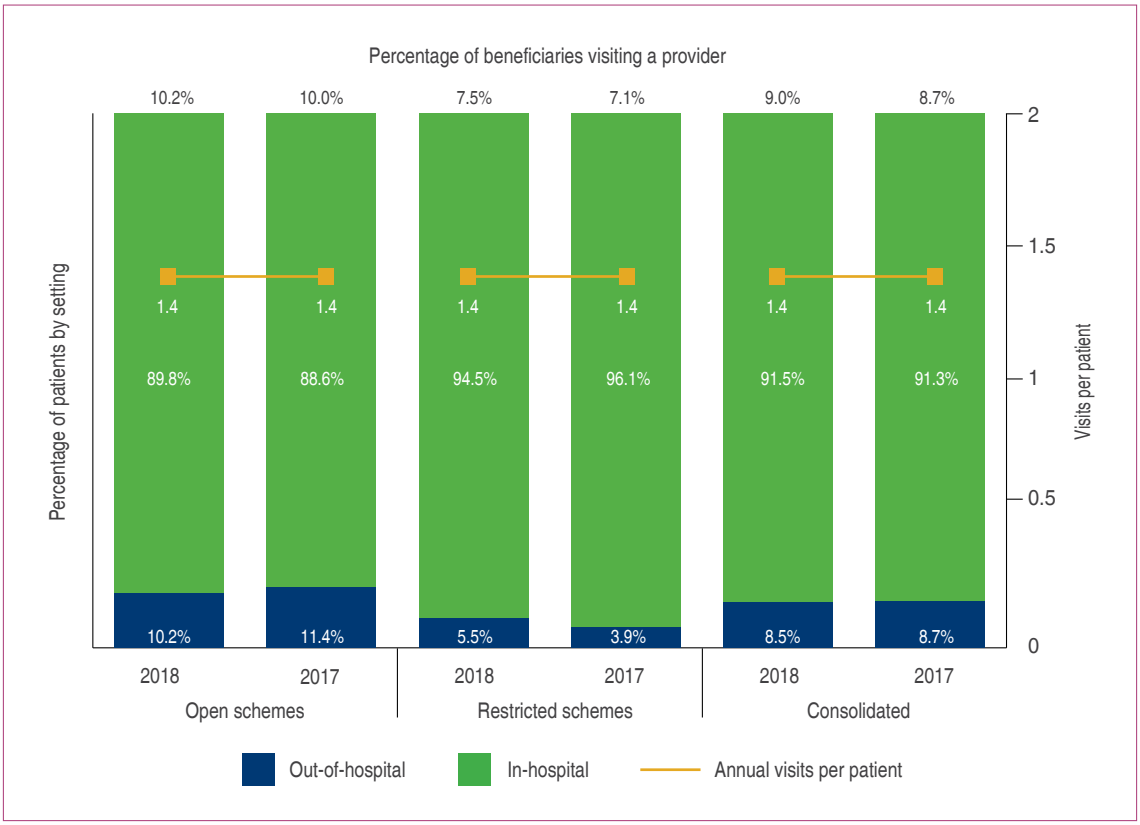



Figure 59: Utilisation of anaesthetist health services in 2018 and 2017

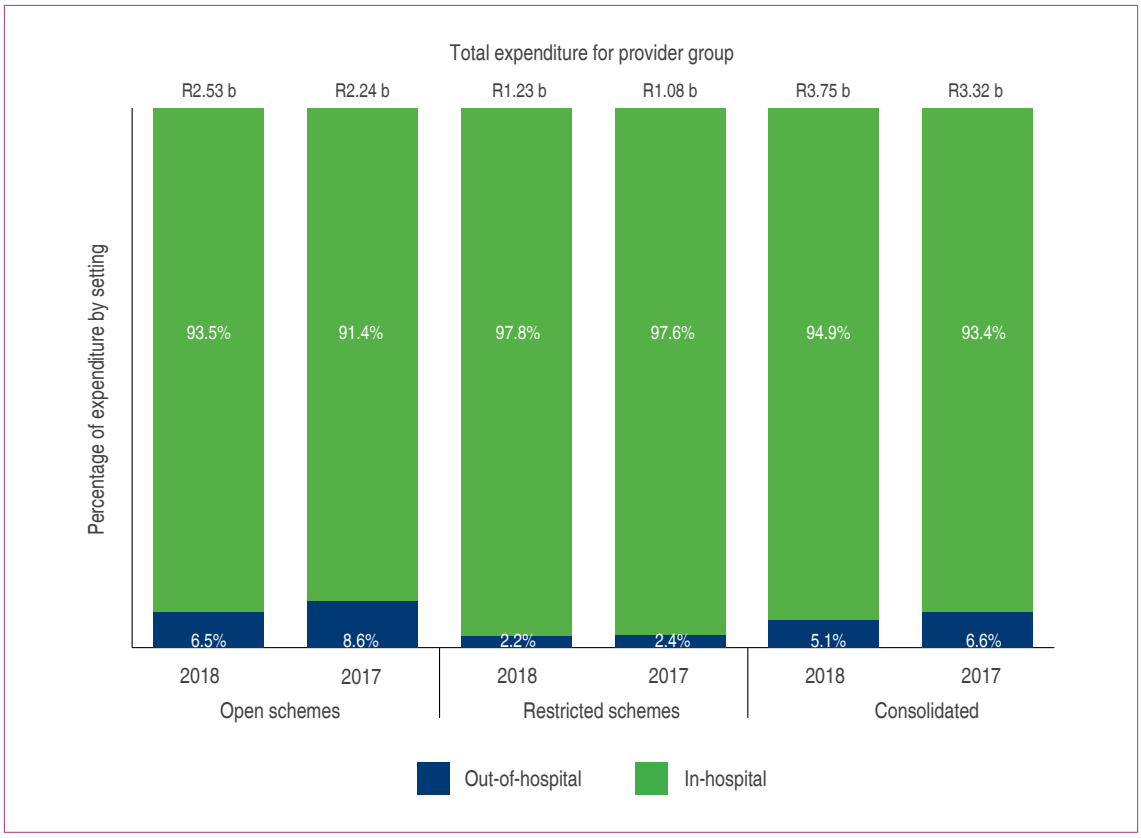



Figure 60: Out-of-hospital and in-hospital expenditure distribution on anaesthetist services in 2018 and 2017

## Utilisation of pathologist health services

The percentage of beneficiaries on whose behalf at least one claim for pathology services was made, showed a marginal increase from an average of 44.4% in 2017 to 45.2% in 2018 across all schemes, as depicted in Figure 61. About 31% of all claims for pathology services originated in the hospital setting. The average number of repeat claims for pathology services remained unchanged at 2.5 per patient across all schemes during the period under review.

In 2018, pathology claims originating in the hospital setting accounted for about 53% of all the expenditure as shown in Figure 62. Similar trends were observed in both open and restricted schemes for the period under review.

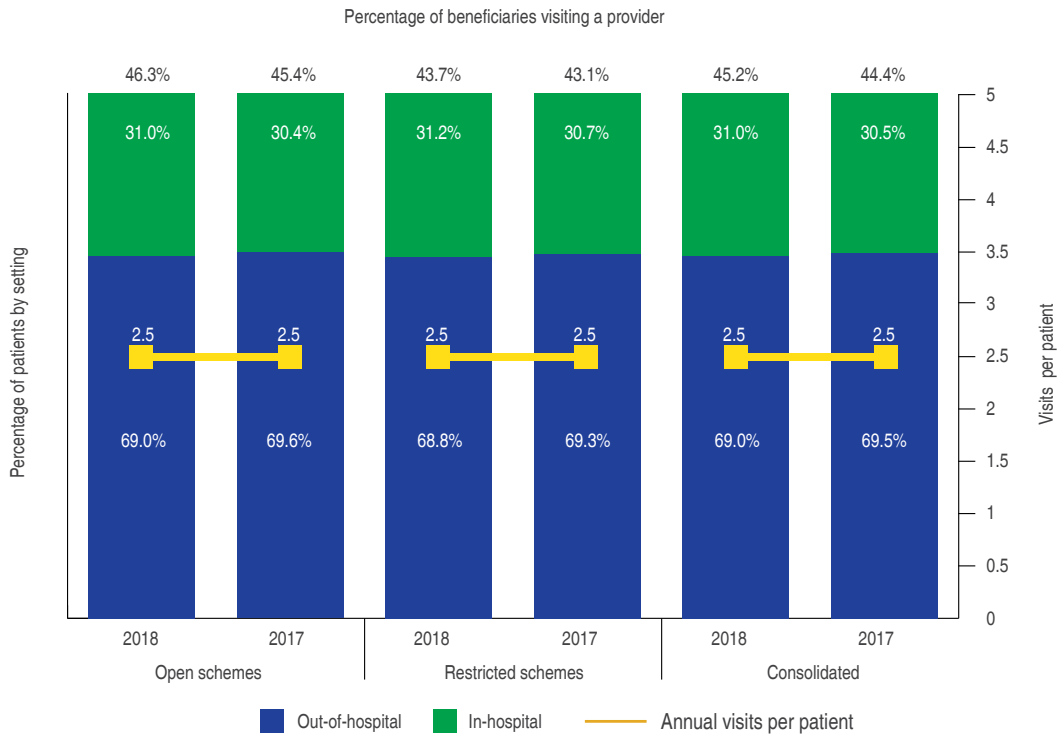



Figure 61: Utilisation of pathologist health services in 2018 and 2017

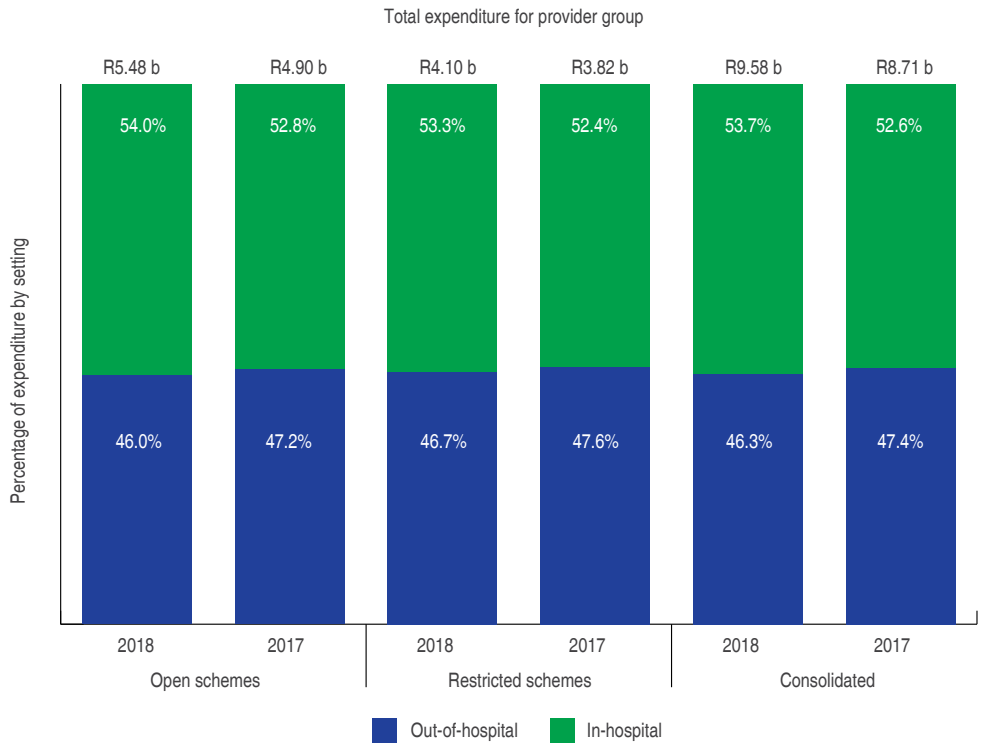



Figure 62: Out-of-hospital and in-hospital expenditure distribution for pathologists in 2018 and 2017

## Utilisation of radiologist health services

The percentage of beneficiaries on whose behalf at least one claim for radiology services was made, showed a marginal increase from an average of 26.7% in 2017 to 27.7% in 2018 across all schemes as depicted in Figure 63. At least 35% of all claims for radiology services originated in the hospital setting. The average number of repeat claims for radiology services remained unchanged at 1.6 per patient across all schemes during the period under review.

In 2018, radiology claims originating in the hospital setting accounted for 52.4% of all the expenditure as shown in Figure 64. Similar trends were observed in both open and restricted schemes for the period under review.

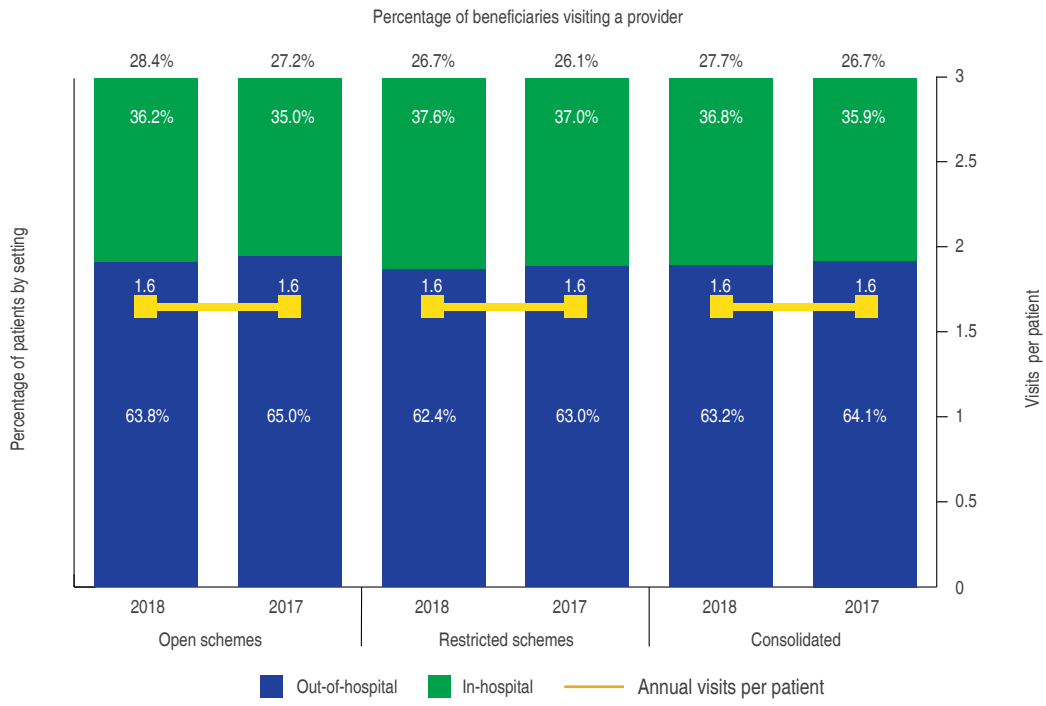



Figure 63: Utilisation of radiologist health services in 2018 and 2017

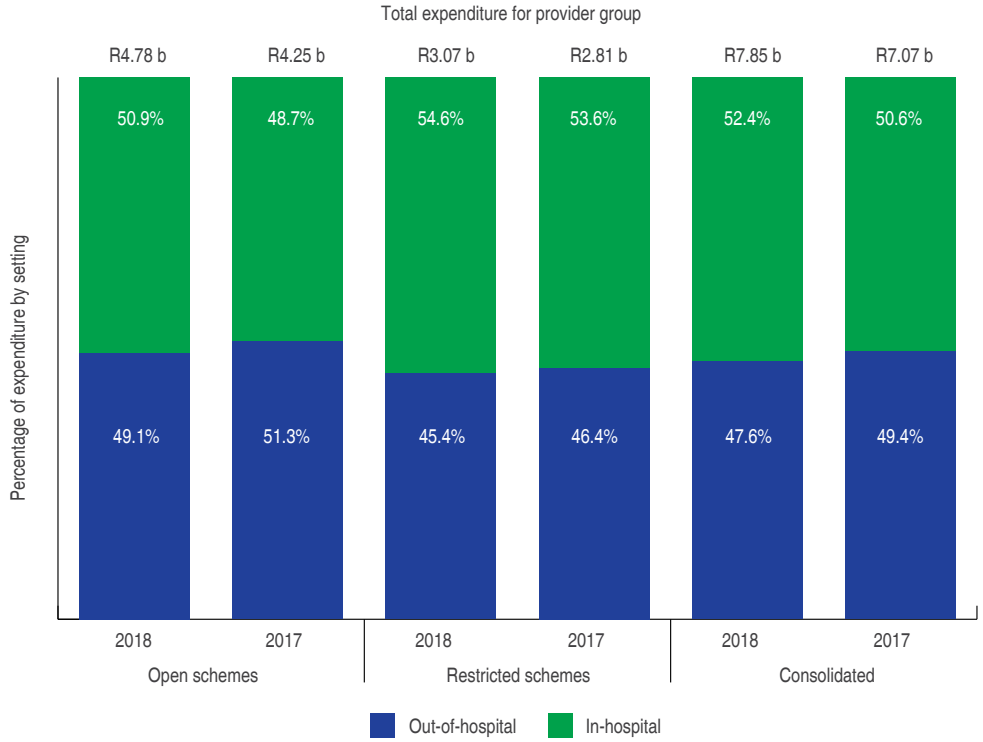



Figure 64: Out-of-hospital and in-hospital expenditure distribution on radiologists in 2018 and 2017

## Utilisation of supplementary and allied health professional services

The proportion of medical scheme beneficiaries consulting with a supplementary and allied health professional at least once a year was 50.3% in 2018 vs 49.3% in 2017 (Figure 65). The number of beneficiary surgical specialist consultations was higher in the open schemes for both the 2018 and 2017 financial years when compared to open schemes. The annual average number of repeat consultations per patients was about three across the medical schemes industry during the period under review. Overall, the percentage of patients consulting with a supplementary and allied health professional in a hospital setting decreased slightly from 19.9% in 2017 to 19.8% in 2018.

The consolidated in-hospital consultations amounted to 29.1% of all expenditure to supplementary and allied health professionals in 2017, and increased to 29.4% in 2018, as depicted in Figure 66. The detailed expenditure analysis per supplementary and allied health professional provider type is contained in Annexure G.

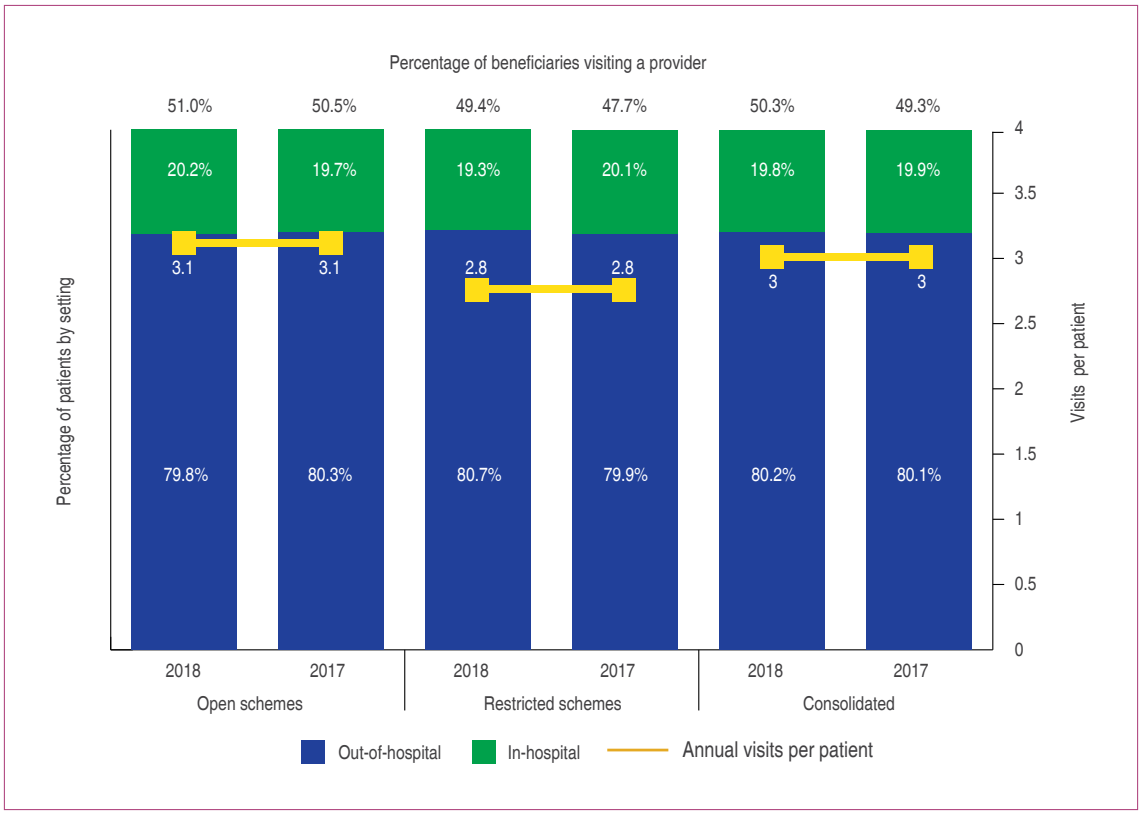



Figure 65: Utilisation of supplementary and allied health professional services in 2018 and 2017

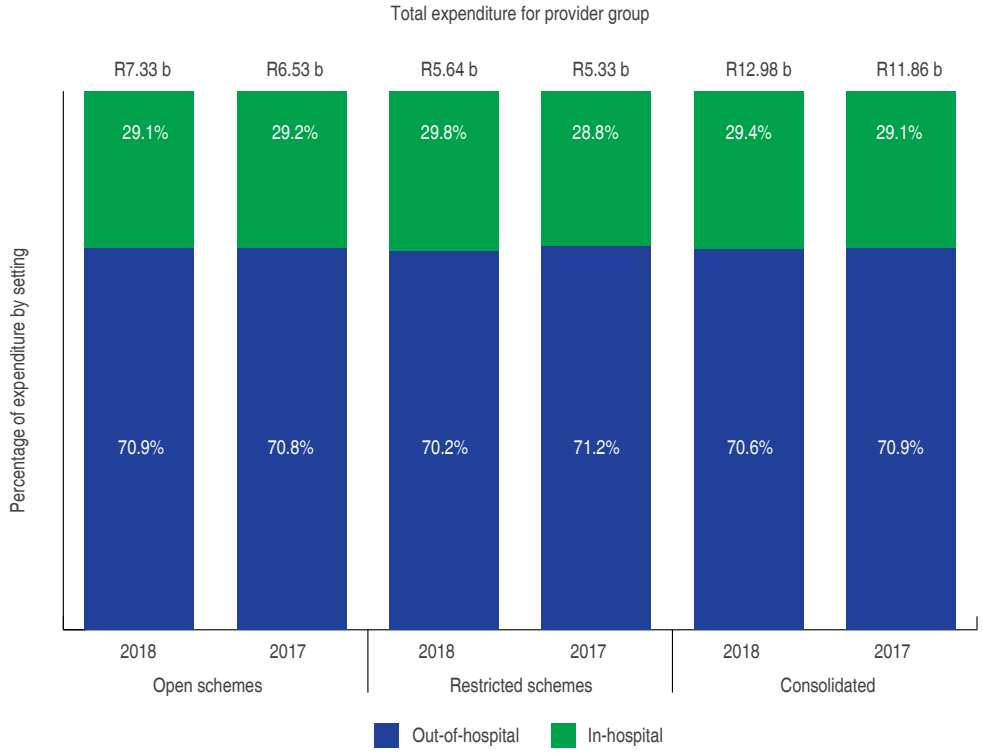



Figure 66: Out-of-hospital and in-hospital expenditure distribution for supplementary and allied health professionals in 2018 and 2017

# UTILISATION OF HOSPITAL SERVICES

## Analysis of admissions to hospitals

Tables 38 to 40 provide details of the utilisation of hospital services for both same day and inpatient admissions combined by hospital category.

The number of beneficiaries admitted to private acute hospitals ('A' & 'B' - status) decreased by 0.5% to 267.69 per 1 000 in 2018 from 269.05 in 2017 for beneficiaries in both open and restricted schemes as shown in Table 38. The average age of beneficiaries admitted to acute hospitals was 39.5 years for all schemes in 2018. Beneficiaries covered by open schemes were much older than those covered by restricted schemes at admission, 41.7 vs 36.9 years. A slight increase in average age of admitted beneficiaries for both open and restricted schemes was observed in 2018. The disaggregated inpatient same-day and overnight admissions are shown in Table 39 and Table 40 The average length of stay for overnight inpatient admissions increased by 1.5% from 4.42 in 2017 to 4.48 days in 2018 as shown in Table 39.

Admissions to provincial hospitals were 15.85 and 16.90 per 1 000 beneficiaries in 2018 and 2017, respectively. Beneficiaries admitted in public hospitals were generally older than those admitted to private hospitals in 2018, 42.3 vs 39.5 years. The average length of stay for overnight inpatient admissions decreased by 28.7% from 7.43 in 2017 to 5.30 days in 2018 as shown in Table 39. The average length of stay for a public hospital is generally higher than that of private hospitals. This may be explained by the significantly older beneficiaries admitted in public hospitals and possibly the admission of high-acuity patients.

Beneficiaries treated in day clinics and sub-acute facilities in 2018 had an average age of 40.0 and 61.7 years, respectively. Less than 20 in 1 000 beneficiaries were treated in day-clinics or sub-acute facilities across all medical schemes for the period under review. Medical scheme beneficiaries are more likely to be admitted to acute hospitals than to day clinics.

The number of beneficiaries admitted to mental health institutions showed an increase of 7.9% to 5.55 in 2018 from 5.15 admitted beneficiaries in 2017. The average length of stay of overnight inpatient admissions was 11.5 and 11.4 days in 2018 and 2017, respectively, as shown in Table 39.

Less than 2 in 1 000 beneficiaries were admitted to rehabilitation hospitals and hospices in 2018 and 2017 as shown in Table 38. The consolidated average length of stay in a rehabilitation hospital or hospice remained unchanged at about 19.4 days in 2018 and 2017 as shown in Table 39.

Table 38: Analysis of all (same-day and overnight inpatient) admissions to hospitals in 2018 and 2017

| Hospital group (PCNS) | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| **Private hospital (57/58)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 266.18 | 268.14 | -0.7 | 269.58 | 270.23 | -0.2 | 267.69 | 269.05 | -0.5 |
| Average length of stay (days) | 2.99 | 2.85 | 5.0 | 3.01 | 2.99 | 0.6 | 3.00 | 2.91 | 3.0 |
| Number of admissions per patient | 1.32 | 1.31 | 0.3 | 1.32 | 1.30 | 1.2 | 1.32 | 1.31 | 0.7 |
| Average age (years) | 41.65 | 41.40 | 0.6 | 36.87 | 36.85 | 0.0 | 39.52 | 39.39 | 0.3 |
| **Provincial hospitals (56)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 1.98 | 2.36 | -16.1 | 33.34 | 35.57 | -6.3 | 15.85 | 16.90 | -6.2 |
| Average length of stay (days) | 2.34 | 2.20 | 6.3 | 0.58 | 0.85 | -32.1 | 0.70 | 0.95 | -26.8 |
| Number of admissions per patient | 1.40 | 1.46 | -4.3 | 2.30 | 2.23 | 3.2 | 2.20 | 2.14 | 2.8 |
| Average age (years) | 41.18 | 41.03 | 0.4 | 42.45 | 41.86 | 1.4 | 42.31 | 41.76 | 1.3 |
| **Day clinics (76/77)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 20.13 | 18.44 | 9.2 | 11.68 | 10.83 | 7.9 | 16.40 | 15.11 | 8.5 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.20 | 1.19 | 1.1 | 1.20 | 1.17 | 2.3 | 1.20 | 1.19 | 1.5 |
| Average age (years) | 40.04 | 39.56 | 1.2 | 39.89 | 37.62 | 6.0 | 39.99 | 38.95 | 2.7 |
| **Sub-acute facilities (49)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 3.19 | 3.13 | 1.9 | 3.18 | 3.71 | -14.4 | 3.18 | 3.38 | -5.9 |
| Average length of stay (days) | 10.47 | 9.99 | 4.7 | 10.34 | 10.46 | -1.1 | 10.41 | 10.22 | 1.9 |
| Number of admissions per patient | 1.19 | 1.19 | -0.4 | 1.20 | 1.18 | 2.2 | 1.19 | 1.18 | 0.8 |
| Average age (years) | 65.59 | 63.84 | 2.7 | 56.73 | 54.03 | 5.0 | 61.71 | 59.10 | 4.4 |
| **Mental health institutions (55)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 5.62 | 5.18 | 8.6 | 5.47 | 5.12 | 6.9 | 5.55 | 5.15 | 7.9 |
| Average length of stay (days) | 10.82 | 10.71 | 1.1 | 12.15 | 11.52 | 5.5 | 11.40 | 11.06 | 3.1 |
| Number of admissions per patient | 1.20 | 1.21 | -0.7 | 1.13 | 1.13 | 0.1 | 1.17 | 1.18 | -0.4 |
| Average age (years) | 38.09 | 38.29 | -0.5 | 38.26 | 38.43 | -0.4 | 38.17 | 38.35 | -0.5 |
| **Rehabilitation hospitals (47/59/79)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 1.94 | 1.79 | 8.4 | 1.40 | 1.41 | -1.1 | 1.70 | 1.62 | 4.6 |
| Average length of stay (days) | 16.49 | 14.66 | 12.5 | 18.39 | 19.32 | -4.8 | 17.18 | 16.43 | 4.6 |
| Number of admissions per patient | 1.52 | 1.54 | -1.1 | 1.31 | 1.24 | 5.6 | 1.44 | 1.41 | 2.0 |
| Average age (years) | 49.10 | 47.70 | 2.9 | 44.54 | 43.15 | 3.2 | 47.28 | 45.74 | 3.4 |

Table 39: Analysis of overnight inpatient admissions to hospitals in 2018 and 2017

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Hospital group (PCNS) | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| **Private hospital (57/58)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 184.20 | 184.27 | 0.0 | 172.11 | 167.85 | 2.5 | 178.86 | 177.08 | 1.0 |
| Average length of stay (days) | 4.32 | 4.14 | 4.2 | 4.71 | 4.81 | -2.1 | 4.48 | 4.42 | 1.5 |
| Number of admissions per patient | 1.37 | 1.36 | 0.6 | 1.39 | 1.37 | 1.4 | 1.38 | 1.36 | 0.9 |
| Average age (years) | 42.20 | 42.09 | 0.3 | 38.42 | 38.46 | -0.1 | 40.60 | 40.59 | 0.0 |
| **Provincial hospitals (56)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 0.88 | 0.95 | -6.9 | 3.61 | 3.73 | -3.4 | 2.09 | 2.17 | -3.7 |
| Average length of stay (days) | 5.24 | 5.48 | -4.3 | 5.32 | 8.07 | -34.1 | 5.30 | 7.43 | -28.7 |
| Number of admissions per patient | 1.42 | 1.42 | 0.0 | 1.51 | 1.49 | 1.0 | 1.49 | 1.48 | 0.8 |
| Average age (years) | 39.56 | 39.11 | 1.2 | 46.53 | 45.40 | 2.5 | 44.81 | 43.80 | 2.3 |
| **Day clinics (76/77)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 0.94 | 1.07 | -11.5 | 1.06 | 0.55 | 93.4 | 0.99 | 0.84 | 18.6 |
| Average length of stay (days) | 2.49 | 2.69 | -7.4 | 2.87 | 5.69 | -49.6 | 2.67 | 3.55 | -24.8 |
| Number of admissions per patient | 1.10 | 1.11 | -1.0 | 1.22 | 1.20 | 1.5 | 1.15 | 1.13 | 1.6 |
| Average age (years) | 53.08 | 51.42 | 3.2 | 43.22 | 39.22 | 10.2 | 48.68 | 48.12 | 1.2 |
| **Sub-acute facilities (49)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 2.91 | 2.86 | 1.8 | 2.85 | 3.25 | -12.4 | 2.88 | 3.03 | -4.9 |
| Average length of stay (days) | 11.47 | 10.93 | 4.9 | 11.53 | 11.94 | -3.4 | 11.50 | 11.40 | 0.8 |
| Number of admissions per patient | 1.19 | 1.19 | 0.0 | 1.19 | 1.17 | 2.3 | 1.19 | 1.18 | 1.1 |
| Average age (years) | 65.55 | 63.48 | 3.2 | 57.74 | 54.82 | 5.3 | 62.13 | 59.37 | 4.7 |
| **Mental health institutions (55)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 5.39 | 4.98 | 8.3 | 5.42 | 4.87 | 11.2 | 5.40 | 4.93 | 9.6 |
| Average length of stay (days) | 11.29 | 11.14 | 1.4 | 12.27 | 12.10 | 1.4 | 11.73 | 11.56 | 1.5 |
| Number of admissions per patient | 1.19 | 1.19 | -0.5 | 1.13 | 1.13 | 0.1 | 1.16 | 1.17 | -0.3 |
| Average age (years) | 38.04 | 38.24 | -0.5 | 38.26 | 38.38 | -0.3 | 38.14 | 38.31 | -0.4 |
| **Rehabilitation hospitals (47/59/79)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 1.74 | 1.55 | 12.0 | 1.22 | 1.15 | 5.5 | 1.51 | 1.38 | 9.5 |
| Average length of stay (days) | 18.36 | 16.87 | 8.9 | 21.11 | 23.65 | -10.7 | 19.34 | 19.35 | -0.1 |
| Number of admissions per patient | 1.48 | 1.47 | 0.2 | 1.31 | 1.24 | 5.4 | 1.41 | 1.38 | 2.4 |
| Average age (years) | 47.87 | 46.16 | 3.7 | 43.89 | 42.79 | 2.6 | 46.34 | 44.79 | 3.5 |

Table 40: Analysis of same-day inpatient admissions to hospitals in 2018 and 2017

| Hospital group (PCNS) | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| **Private hospital (57/58)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 81.98 | 83.87 | -2.2 | 97.47 | 102.38 | -4.8 | 97.47 | 102.38 | -4.8 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.21 | 1.21 | -0.3 | 1.21 | 1.21 | 0.2 | 1.21 | 1.21 | 0.2 |
| Average age (years) | 40.54 | 40.05 | 1.2 | 34.46 | 34.52 | -0.2 | 34.46 | 34.52 | -0.2 |
| **Provincial hospitals (56)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 1.10 | 1.42 | -22.3 | 29.73 | 31.83 | -6.6 | 29.73 | 31.83 | -6.6 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.38 | 1.49 | -7.3 | 2.45 | 2.36 | 3.9 | 2.45 | 2.36 | 3.9 |
| Average age (years) | 42.44 | 42.37 | 0.2 | 41.65 | 41.20 | 1.1 | 41.65 | 41.20 | 1.1 |
| **Day clinics (76/77)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 19.19 | 17.38 | 10.4 | 10.62 | 10.28 | 3.3 | 10.62 | 10.28 | 3.3 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.21 | 1.20 | 1.1 | 1.20 | 1.17 | 2.3 | 1.20 | 1.17 | 2.3 |
| Average age (years) | 39.33 | 38.78 | 1.4 | 39.56 | 37.54 | 5.4 | 39.56 | 37.54 | 5.4 |
| **Sub-acute facilities (49)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 0.28 | 0.27 | 3.8 | 0.33 | 0.46 | -28.6 | 0.33 | 0.46 | -28.6 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.11 | 1.16 | -3.9 | 1.27 | 1.24 | 2.3 | 1.27 | 1.24 | 2.3 |
| Average age (years) | 66.06 | 67.52 | -2.2 | 47.36 | 48.07 | -1.5 | 47.36 | 48.07 | -1.5 |
| **Mental health institutions (55)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 0.23 | 0.20 | 16.7 | 0.05 | 0.25 | -78.0 | 0.05 | 0.25 | -78.0 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 1.67 | 1.88 | -11.0 | 1.25 | 1.15 | 8.8 | 1.25 | 1.15 | 8.8 |
| Average age (years) | 39.78 | 40.12 | -0.9 | 38.45 | 39.28 | -2.1 | 38.45 | 39.28 | -2.1 |
| **Rehabilitation hospitals (47/59/79)** | | | | | | | | | |
| Number of admissions per 1 000 lives | 0.20 | 0.23 | -15.7 | 0.18 | 0.26 | -30.4 | 0.18 | 0.26 | -30.4 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |
| Number of admissions per patient | 2.01 | 2.12 | -5.0 | 1.35 | 1.26 | 7.4 | 1.35 | 1.26 | 7.4 |
| Average age (years) | 63.77 | 62.37 | 2.3 | 49.10 | 44.76 | 9.7 | 49.10 | 44.76 | 9.7 |

## Analysis of admissions to private hospitals

Figure 67 demonstrates admission rates by age for different hospital groups. Private acute hospitals show an expected pattern with high admission rates for infants, high admission rates for female beneficiaries in the reproductive age range and very high admission rates for elderly beneficiaries. The increase in utilisation by the 20 to 40 year age groups may be explained by an increase in the utilisation of maternal health services by female beneficiaries.

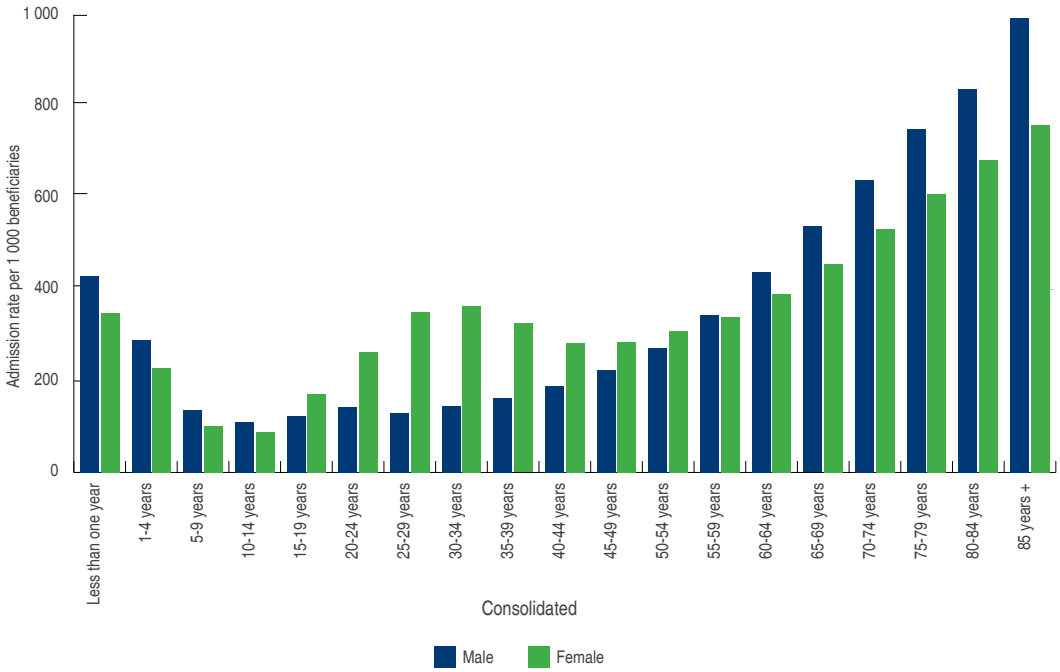



Figure 67: Admission rates (per 1 000 beneficiaries) for private hospitals (57/58)

Figure 68 demonstrates the average length of stay for beneficiaries admitted to acute private hospitals. The average increased with age for both 2018 and 2017. The overall average length of stay increased only marginally for the period under review. However, the increase was significant in the older beneficiaries, especial in the 85 years and above age band. Older beneficiaries stayed longer in hospital in 2018 compared to 2017.

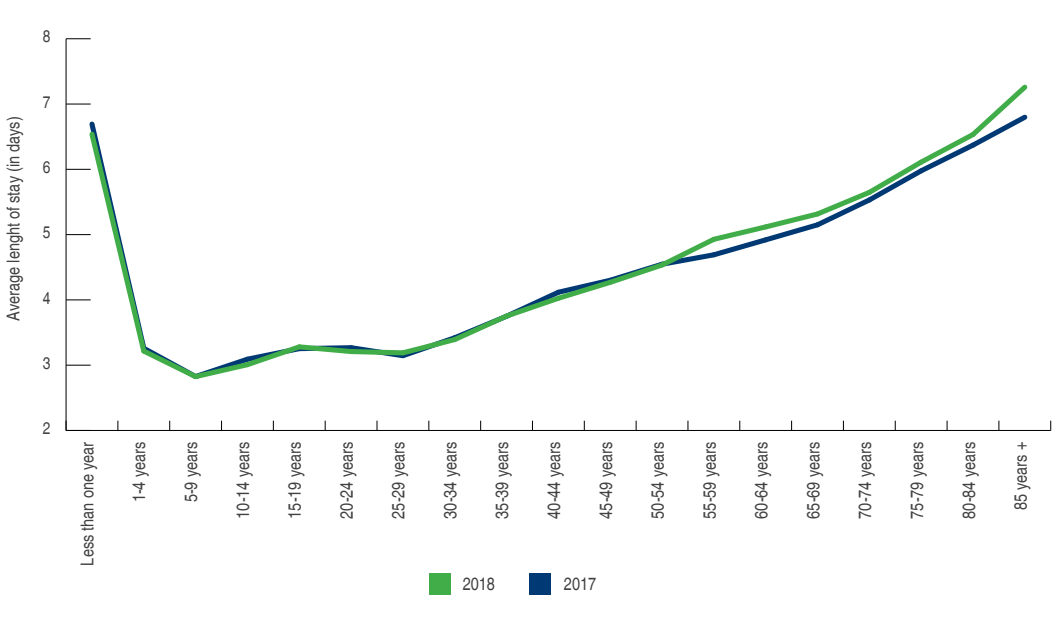



Figure 68: Overnight-inpatient admissions average length of stay for private hospital (57/58)

## Analysis of admissions to public hospitals

Age analysis of public hospitals shows that, in addition to lower admission rates, older beneficiaries in benefit options that have the state facility as the designated service provider are far more likely to be admitted to hospital as overnight inpatient cases than younger beneficiaries in the same plan as demonstrated in Figure 69. Like private hospitals, an increase in the utilisation of hospital services by female beneficiaries in the 20 to 40 year age group bands was observed, which may also be explained by an increase in the utilisation of maternal health services by female beneficiaries. Additionally, more male compared to female beneficiaries in the older age bands (> 55 years) were admitted to public hospitals.

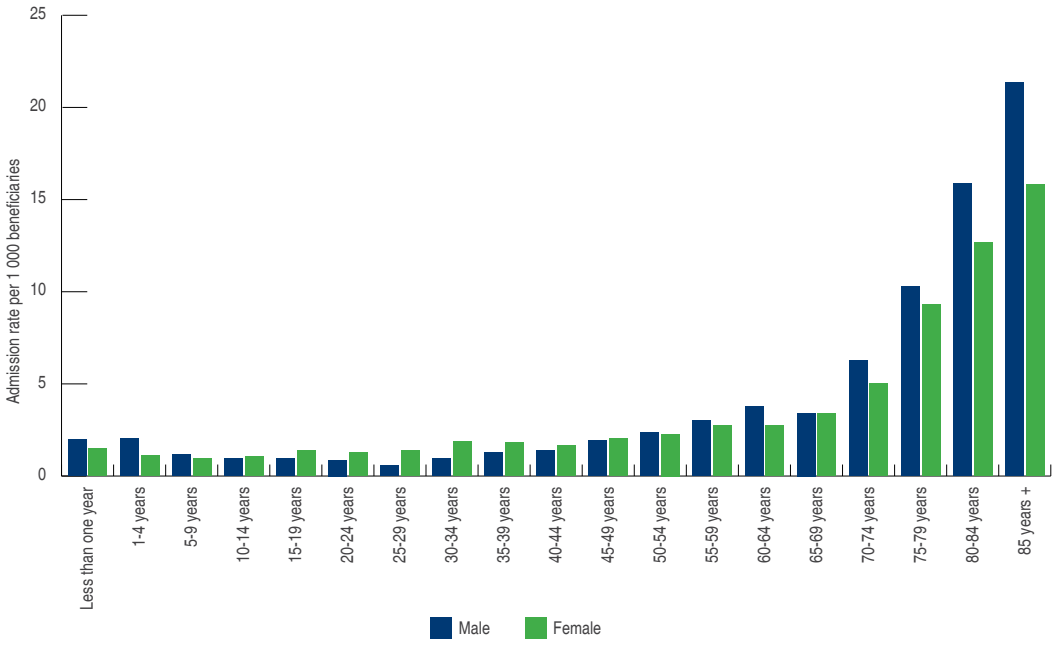



Figure 69: Admission rates (per 1 000 beneficiaries) for provincial hospitals (56)

## Analysis of admissions to day clinics

Figure 70 depicts the analysis of beneficiary admissions to day clinics. Day hospitals offer opportunities to improve the efficiency of the private hospital sector. The use of day hospitals has cost benefits for both beneficiaries and medical schemes. Less than 30 in 1 000 beneficiaries in the 1 to 4 year age band were admitted to day clinics, declining to levels around 10 in 1 000 beneficiaries between the 5 to 59 year age band and then rising steadily to 70 in 1 000 in the 75 to 79 year age band, before declining to under 60 in 1 000 beneficiaries in 2018.

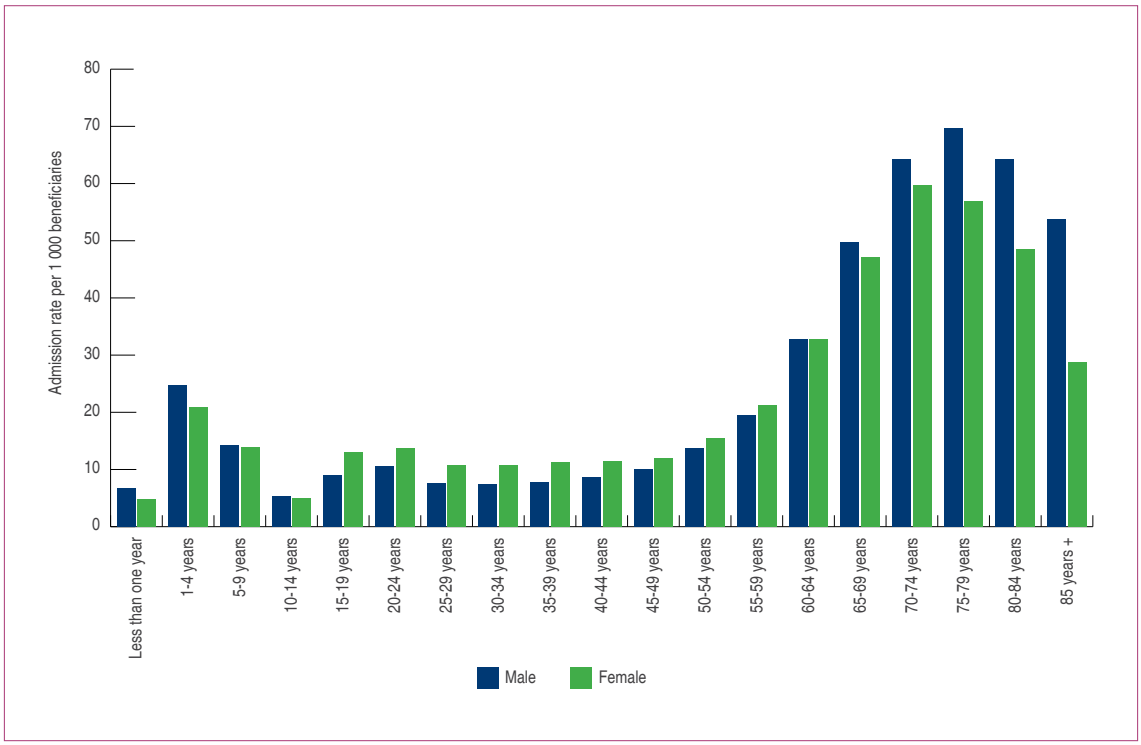



Figure 70: Admission rates (per 1 000 beneficiaries) for day clinics (76/77)

## Analysis of admissions to mental health institutions

Figure 71 demonstrates the admission of beneficiaries to mental health institutions by age. Proportionally more female compared to male beneficiaries were admitted to mental health institutions across all age groups. The excess of female mental health institution admissions is consistent with the high prevalence of psychiatric conditions in the female medical schemes population.

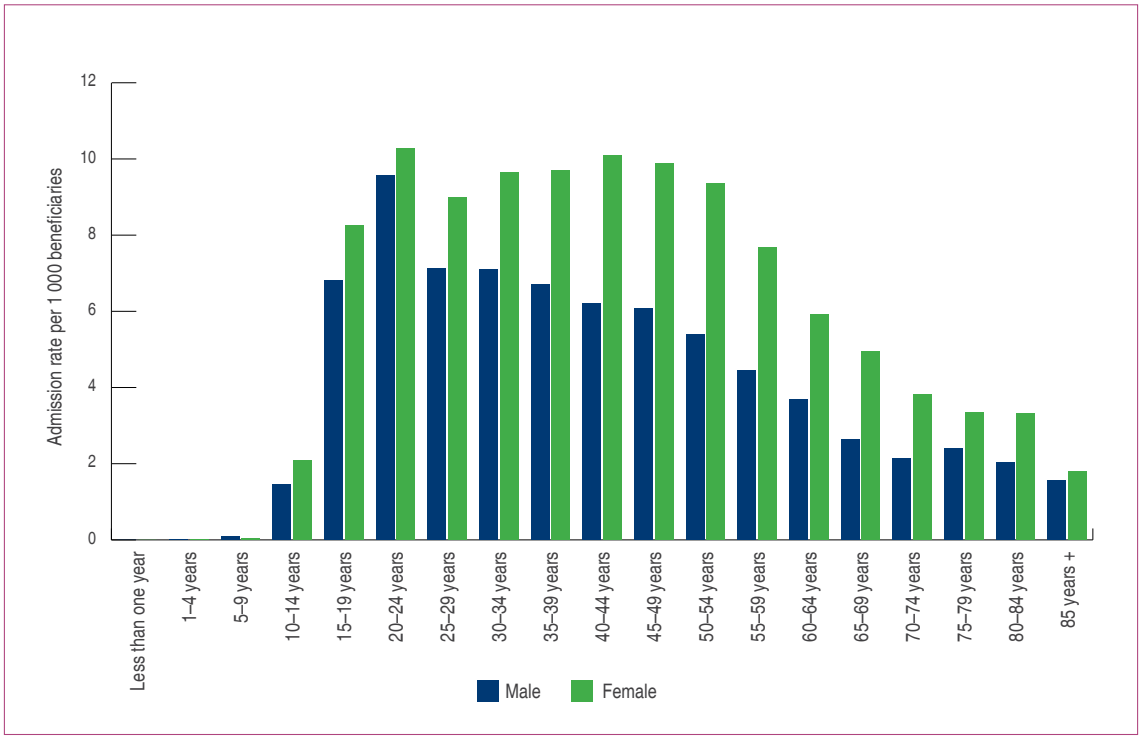



Figure 71: Admission rates (per 1 000 beneficiaries) for mental health institutions (55)

# HOSPITAL ADMISSIONS BY LEVEL OF CARE

Tables 41 to 48 illustrate the average length of stay and admission rates per year by level of care across hospital facilities.

## General ward admissions

General ward admissions decreased by 3.4% to 171.32 per 1 000 beneficiaries in 2018 from 177.30 per 1 000 beneficiaries in 2017. The number of inpatient days per general ward admission was 3.27 days in 2018 and 3.19 days in 2017.

Table 41: General ward admissions in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 156.25 | 165.02 | -5.3 | 190.33 | 193.05 | -1.4 | 171.32 | 177.30 | -3.4 |
| Average length of stay (days) | 3.26 | 3.09 | 5.5 | 3.28 | 3.30 | -0.6 | 3.27 | 3.19 | 2.5 |

## High care unit admissions

Admissions to a high care unit declined by 3.9% from 26.91 per 1 000 beneficiaries in 2017 to 25.86 in 2018. The length of stay in high care units increased slightly from 3.08 days in 2016 to 3.29 days in 2018.

Table 42: High care unit admissions in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 26.21 | 28.49 | -8.0 | 25.43 | 24.87 | 2.2 | 25.86 | 26.91 | -3.9 |
| Average length of stay (days) | 3.12 | 2.84 | 9.9 | 3.51 | 3.43 | 2.6 | 3.29 | 3.08 | 7.0 |

## Intensive care unit

Admissions to intensive care units (ICU) decreased by 9.3% from 12.10 per 1 000 beneficiaries in 2017 to 11.19 per 1 000 beneficiaries in 2018. The length of stay in ICU increased slightly from 4.52 days in 2017 to 4.95 days in 2018.

Table 43: Intensive care unit admissions in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 11.14 | 12.68 | -12.1 | 11.25 | 11.36 | -0.9 | 11.19 | 12.10 | -7.5 |
| Average length of stay (days) | 4.93 | 4.30 | 14.7 | 4.97 | 4.85 | 2.5 | 4.95 | 4.52 | 9.3 |

## Same-day admissions

Same-day admissions to all hospitals declined by 9.3% to 41.32 per 1 000 beneficiaries in 2018 from 45.58 per 1 000 beneficiaries in 2017 across all scheme types.

Table 44: Same-day admissions in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 39.89 | 42.61 | -6.4 | 43.13 | 49.38 | -12.7 | 41.32 | 45.58 | -9.3 |
| Average length of stay (days) | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 | 1.00 | 1.00 | 0.0 |

## Outpatient hospital visits

Outpatient hospital visits declined by 13.9% between 2017 (166.59 per 1 000 beneficiaries) and 2018 (143.50 per 1 000 beneficiaries). Outpatient visits are normally associated with a beneficiary's need for emergency treatment in the hospital setting that may not lead to hospitalisation.

Table 45: Outpatient hospital visits in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 176.35 | 217.36 | -18.9 | 102.04 | 101.41 | 0.6 | 143.50 | 166.59 | -13.9 |



## Hospital admissions in respect of PMB conditions

The average number of hospital admissions in respect of PMB conditions remained unchanged between 2018 and 2017 at 64.43 and 64.03 per 1 000 beneficiaries, respectively. The accuracy of PMB admissions data is a major challenge as scheme rules and systems are not set up to separate PMB from non-PMB admissions. The logic generally advanced by medical schemes is that there is no business incentive to identify claims related to PMBs when the rules of the scheme provide for the payment of all authorised hospital admissions, PMB or not.

Table 46: Hospital admissions for Prescribed Minimum Benefits in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of admissions per 1 000 beneficiaries | 49.04 | 51.26 | -4.3 | 83.86 | 80.43 | 4.3 | 64.43 | 64.03 | 0.6 |

## Repeat admissions

Repeat admissions within ninety days of the first admission decreased to 13.77 from 14.07 per 1 000 admissions in 2018 and 2017, respectively. A very large difference was noted between the 2017 repeat admissions reported in the 2018 and restated in the 2019 Annual Statutory returns was noted, pointing to data quality challenges for some of the data elements. Re-admission to hospital within 90 days of the first admission is not necessarily related to the first admission, however the repeat admission rate is an important indicator of the quality of in-hospital care services.

Table 47: Repeat admissions (within 90 days) in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Repeat admissions (within 90 days) % | 21.36 | 24.45 | -12.6 | 27.68 | 32.59 | -15.3 | 13.77 | 14.07 | -2.1 |

## Deaths related to hospitalisation

Recording and collections of death statistics in the medical schemes' environment is an area of healthcare utilisation that needs improvement. This information is important because of its use in measuring health quality outcomes and costs associated with a death event. Very few medical schemes can collect data on deaths that occur shortly after the patient is discharged from hospital. The CMS will continue to work with medical schemes to improve the quality of this indicator. For the period under review, deaths related to hospitalisation declined by 17.1% from 10.61 in 2017 to 8.80 per 1 000 admissions in 2018.

Table 48: Hospital deaths related to hospitalisation in 2017 and 2018

| | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| Level of care | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| Number of deaths per 1 000 admissions | 10.89 | 12.47 | -12.7 | 12.64 | 13.94 | -9.3 | 8.80 | 10.61 | -17.1 |

# ANALYSIS OF ADMISSIONS BY SELECTED CASE TYPES

Tables 49 to 52 show admission rates, average length of stay and expenditure across 32 case types and the rate of change between 2017 and 2018. Admission rates were generally higher in open than restricted schemes. The observed changes between 2017 and 2018 are consistent with the expenditure and demographic changes.

## Medical inpatient admissions rates

There was generally an increase of at least 10% in the admission rates for most of the medical inpatient medical case types. The decline from 76.36 per 10 000 beneficiaries in 2017 to 68.78 per 10 000 beneficiaries for 2018 in the admission rate for pneumonia cases was the most significant medical inpatient admission type. The decline in admissions for pneumonia was observed in most medical schemes, with the significant decline of 22% recorded by a large restricted scheme. The decline in the admissions for pneumonia may represent progress towards a reduction in infectious disease associated burden. The limited data reported on immunisation coverage (Annexure M) shows very low rates for flu vaccinations, which is estimated to reduce infections by 50%.

The average length of stay for inpatient medical case types ranged from 2.14 days for normal deliveries to 5.83 days for malignant neoplasm of the bronchus and lung as shown in Table 20. Malignant neoplasm showed the highest increase (16.8%) in the length of stay during the period under review. The average length of stay for pneumonia admissions showed a marginal decline of 2% from 4.53 days in 2017 to 4.44 days in 2018.



Expenditure by cost types, disaggregated by the hospital claims and related fees, are shown in Table 52. The medical-inpatient case type with the highest average amount paid in 2018 was acute myocardial infarction with the average cost being R107 228.14 (R74 934.03 attributable to the hospital account and R32 294.13 other expenditure). The expenditure for normal deliveries was the lowest (R23 980.65) of the selected medical-inpatient cost types. The hospital component of the admission account forms the most significant portion of the total expenditure for all the medical case types.

## Surgical inpatient admission rates

Surgical inpatient admissions showed an increase in the number of selected case types. Caesarean section admissions increased by 5.1% during the period under review. In 2018, 76.91 per 10 000 beneficiaries were admitted for caesarean section births compared to 73.15 per 10 000 beneficiaries in 2017. Caesarean births in medical schemes are more than three times higher in the public sector and out of sync with some of the highly developed countries. Endarterectomy, litigation and stripping of varicose veins – lower limb and tonsillectomy and/or adenoidectomy recorded a decrease of between 3.8% and 6.5%.

Peripheral vascular bypass recorded a significant increase in the average length of stay. Observed increases and decreases for other surgical case types were only marginal. Coronary artery bypass graft had the highest length of stay, down from 12.07 days in 2017 to 11.06 days in 2018.

Surgical case types with the highest average amount paid in 2018 were coronary artery bypass graft (R385 117.82), peripheral vascular bypass (R169 644.13), colorectal resection (R143 234.98), hip replacement (R138 267.26) and knee replacement (R131 914.76). The observations are consistent with the 2016 Organisation for Economic Co-operation and Development and World Health Organization study (Lorenzoni and Roubal, 2016) on the international comparison of South African private hospital price levels.

## Day surgery admission rates

The increase in tonsillectomy and/or adenoidectomy day cases during the period under review was significant and was accompanied by the decline in the inpatient cases.

The average expenditure for each of the selected case types was significantly lower when treated as day-surgery cases rather than inpatient-surgery cases. This strengthens the evidence which suggests that healthcare costs can be reduced significantly when treatment is delivered in appropriate settings. The total expenditure for lens and cataract procedures was R23 927.07 compared to R27 769.46 if treatment had been delivered via inpatient admission. The difference in the two settings in as far as the lens and cataract procedure is concerned is explained by the lower fees for the amount paid for pharmaceuticals and healthcare professionals.

Table 49: Admission rates (per 10 000 beneficiaries) and average rate of change by case type

| | Open | Restricted | Consolidated | | |
|---|---|---|---|---|---|
| Case type | 2018 | 2018 | 2018 | 2017 | % change |
| **Medical inpatient** | | | | | |
| M01 Acute myocardial infarction | 15.72 | 7.38 | 10.38 | 9.25 | 12.2 |
| M02 Angina pectoris | 67.32 | 34.15 | 46.07 | 42.09 | 9.5 |
| M03 Cholelithiasis | 4.90 | 2.43 | 3.81 | 3.81 | 0.2 |
| M04 Heart failure | 25.92 | 23.27 | 24.74 | 21.93 | 12.8 |
| M05 Malignant neoplasm of bronchus and lung | 2.59 | 2.64 | 2.61 | 2.33 | 12.0 |
| M06 Normal deliveries | 20.07 | 22.46 | 21.13 | 21.49 | -1.7 |
| M07 Pneumonia | 61.91 | 77.42 | 68.78 | 76.36 | -9.9 |
| **Surgical inpatient** | | | | | |
| S01 Appendectomy | 9.70 | 8.59 | 9.21 | 9.09 | 1.3 |
| S02 Caesarean section | 80.08 | 72.94 | 76.91 | 73.15 | 5.1 |
| S03 Cholecystectomy | 11.93 | 10.93 | 11.49 | 11.13 | 3.2 |
| S04 Colorectal resection | 2.04 | 1.07 | 1.61 | 1.47 | 9.7 |
| S05 Coronary artery bypass graft | 1.32 | 1.31 | 1.32 | 1.30 | 1.3 |
| S06 Discectomy | 1.35 | 1.57 | 1.44 | 1.38 | 4.4 |
| S07 Endarterectomy | 0.47 | 0.27 | 0.38 | 0.41 | -5.8 |
| S08 Hip replacement: total and partial | 8.92 | 6.29 | 7.75 | 7.39 | 4.8 |
| S09 Hysterectomy – abdominal or vaginal | 13.07 | 14.78 | 13.83 | 13.31 | 3.9 |
| S10 Knee replacement | 13.02 | 11.44 | 12.31 | 11.27 | 9.3 |
| S11 Mastectomy | 2.42 | 2.23 | 2.33 | 2.12 | 9.8 |
| S12 Open prostatectomy | 1.49 | 0.85 | 1.22 | 1.30 | -6.5 |
| S13 Percutaneous transluminal coronary angioplasty | 5.03 | 10.12 | 5.31 | 4.87 | 9.0 |
| S14 Peripheral vascular bypass | 0.66 | 0.47 | 0.58 | 0.52 | 9.7 |
| S15 Repair of inguinal hernia | 9.65 | 4.25 | 7.26 | 7.18 | 1.2 |
| S16 Thyroidectomy | 2.60 | 1.81 | 2.25 | 2.17 | 3.6 |
| S17 Transurethral resection of prostate | 2.53 | 3.30 | 2.88 | 2.61 | 10.3 |
| S18 Arthroscopic excision of meniscus of knee | 8.83 | 3.97 | 6.68 | 6.49 | 2.9 |
| S19 Lens and cataract procedures | 66.00 | 16.88 | 44.69 | 42.64 | 4.8 |
| S20 Ligation and stripping of varicose veins – lower limb | 1.65 | 1.16 | 1.43 | 1.51 | -4.8 |
| S21 Tonsillectomy and/or adenoidectomy | 27.40 | 11.40 | 20.29 | 21.09 | -3.8 |
| **Day surgery** | | | | | |
| S18 Arthroscopic excision of meniscus of knee | 5.90 | 3.54 | 4.22 | 3.39 | 24.5 |
| S19 Lens and cataract procedures | 104.62 | 62.14 | 74.33 | 69.30 | 7.3 |
| S20 Ligation and stripping of varicose veins – lower limb | 0.46 | 0.20 | 0.28 | 0.34 | -18.6 |
| S21 Tonsillectomy and/or adenoidectomy | 18.35 | 22.70 | 21.43 | 20.23 | 5.9 |

Table 50: Average length of stay by medical case type

| Case type | Open 2018 | Restricted 2018 | Consolidated 2018 | Consolidated 2017 | Consolidated % change |
|---|---|---|---|---|---|
| M01 Acute myocardial infarction | 4.98 | 4.88 | 4.93 | 4.84 | 1.9 |
| M02 Angina pectoris | 2.95 | 3.02 | 2.98 | 3.03 | -1.7 |
| M03 Cholelithiasis | 3.72 | 3.38 | 3.63 | 3.5 | 3.7 |
| M04 Heart failure | 5.75 | 5.81 | 5.78 | 5.89 | -1.9 |
| M05 Malignant neoplasm of bronchus and lung | 6.24 | 5.34 | 5.83 | 4.99 | 16.8 |
| M06 Normal deliveries | 2.06 | 2.24 | 2.14 | 2.2 | -2.7 |
| M07 Pneumonia | 4.17 | 4.71 | 4.44 | 4.53 | -2.0 |

Table 51: Average length of stay by inpatient surgical case type

| Case type | Open 2018 | Restricted 2018 | Consolidated 2018 | Consolidated 2017 | Consolidated % change |
|---|---|---|---|---|---|
| S01 Appendectomy | 2.53 | 3.17 | 2.79 | 2.82 | -1.1 |
| S02 Caesarean section | 2.96 | 3.41 | 3.15 | 3.12 | 1.0 |
| S03 Cholecystectomy | 2.90 | 2.83 | 2.87 | 2.60 | 10.4 |
| S04 Colorectal resection | 8.28 | 9.85 | 8.73 | 8.31 | 5.1 |
| S05 Coronary artery bypass graft | 9.66 | 12.89 | 11.06 | 12.07 | -8.4 |
| S06 Discectomy | 5.43 | 4.13 | 4.85 | 4.85 | 0.0 |
| S07 Endarterectomy | 5.32 | 6.17 | 5.57 | 5.71 | -2.5 |
| S08 Hip replacement: total and partial | 5.3 | 5.69 | 5.44 | 5.79 | -6.0 |
| S09 Hysterectomy – abdominal or vaginal | 2.87 | 3.31 | 3.07 | 3.13 | -1.9 |
| S10 Knee replacement | 4.37 | 5.24 | 4.73 | 4.98 | -5.0 |
| S11 Mastectomy | 2.37 | 3.48 | 2.83 | 3.01 | -6.0 |
| S12 Open prostatectomy | 3.85 | 5.28 | 4.28 | 4.51 | -5.1 |
| S13 Percutaneous transluminal coronary angioplasty | 2.83 | 1.86 | 2.73 | 4.38 | -37.7 |
| S14 Peripheral vascular bypass | 8.01 | 10.32 | 8.81 | 6.22 | 41.6 |
| S15 Repair of inguinal hernia | 1.63 | 1.52 | 1.60 | 1.60 | 0.0 |
| S16 Thyroidectomy | 2.12 | 2.54 | 2.27 | 2.34 | -3.0 |
| S17 Transurethral resection of prostate | 2.76 | 3.44 | 3.11 | 3.28 | -5.2 |
| S18 Arthroscopic excision of meniscus of knee | 1.19 | 1.35 | 1.23 | 1.09 | 12.8 |
| S19 Lens and cataract procedures | 0.86 | 1.03 | 0.89 | 0.87 | 2.3 |
| S20 Ligation and stripping of varicose veins – lower limb | 1.21 | 1.71 | 1.39 | 1.35 | 3.0 |
| S21 Tonsillectomy and/or adenoidectomy | 0.93 | 1.22 | 1.01 | 1.02 | -1.0 |

Table 52: Average hospital expenditure (in Rand) by case type, 2018

| Case type | Open | Restricted | Consolidated | | |
|---|---|---|---|---|---|
| | Total amount paid per admission R | Total amount paid per admission R | Hospital amount paid per admission R | Other[2] amount paid per admission R | Total amount paid per admission R |
| **Medical inpatient** | | | | | |
| M01 Acute myocardial infarction | 109 537.14 | 104 460.00 | 74 934.01 | 32 294.13 | 107 228.14 |
| M02 Angina pectoris | 61 672.14 | 55 075.50 | 40 071.98 | 18 468.64 | 58 540.62 |
| M03 Cholelithiasis | 51 997.26 | 31 933.03 | 30 132.58 | 16 248.83 | 46 381.42 |
| M04 Heart failure | 53 204.76 | 48 294.74 | 35 587.74 | 15 571.01 | 51 158.75 |
| M05 Malignant neoplasm of bronchus and lung | 29 600.23 | 35 733.40 | 19 360.13 | 13 033.76 | 32 393.89 |
| M06 Normal deliveries | 24 195.06 | 23 739.76 | 17 561.81 | 6 418.84 | 23 980.65 |
| M07 Pneumonia | 24 798.66 | 31 222.76 | 18 966.35 | 9 035.96 | 28 002.31 |
| **Surgical inpatient** | | | | | |
| S01 Appendectomy | 37 009.83 | 41 026.58 | 24 897.04 | 13 773.73 | 38 670.77 |
| S02 Caesarean section | 40 161.11 | 41 091.53 | 28 260.89 | 12 292.33 | 40 553.21 |
| S03 Cholecystectomy | 47 206.38 | 53 742.00 | 35 189.29 | 14 771.96 | 49 961.26 |
| S04 Colorectal resection | 133 248.60 | 167 697.52 | 99 457.29 | 43 777.69 | 143 234.98 |
| S05 Coronary artery bypass graft | 369 892.85 | 402 804.25 | 232 359.28 | 151 758.54 | 384 117.82 |
| S06 Discectomy | 139 619.45 | 118 457.04 | 86 408.14 | 43 770.53 | 130 178.67 |
| S07 Endarterectomy | 131 728.10 | 113 863.92 | 85 376.30 | 41 141.41 | 126 517.71 |
| S08 Hip replacement: total and partial | 136 878.44 | 140 729.39 | 92 309.36 | 45 957.90 | 138 267.26 |
| S09 Hysterectomy – abdominal or vaginal | 46 449.29 | 49 336.27 | 33 574.11 | 14 243.64 | 47 817.75 |
| S10 Knee replacement | 131 184.37 | 132 954.91 | 89 417.87 | 42 496.89 | 131 914.76 |
| S11 Mastectomy | 42 582.96 | 56 484.73 | 30 023.56 | 18 378.57 | 48 402.13 |
| S12 Open prostatectomy | 68 009.70 | 91 543.63 | 52 400.87 | 22 663.97 | 75 064.84 |
| S13 Percutaneous transluminal coronary angioplasty | 126 942.34 | 120 168.38 | 100 765.47 | 25 483.72 | 126 249.19 |
| S14 Peripheral vascular bypass | 153 298.18 | 200 919.38 | 110 582.50 | 59 061.63 | 169 644.13 |
| S15 Repair of inguinal hernia | 39 069.89 | 33 440.40 | 27 434.97 | 10 174.30 | 37 609.27 |
| S16 Thyroidectomy | 47 953.37 | 46 559.60 | 33 614.58 | 13 841.40 | 47 455.98 |
| S17 Transurethral resection of prostate | 42 179.74 | 47 169.55 | 29 528.04 | 15 239.68 | 44 767.72 |
| S18 Arthroscopic excision of meniscus of knee | 33 473.95 | 34 298.68 | 21 274.58 | 12 417.52 | 33 692.10 |
| S19 Lens and cataract procedures | 27 663.41 | 28 310.63 | 11 371.44 | 16 398.02 | 27 769.46 |
| S20 Ligation and stripping of varicose veins – lower limb | 32 349.12 | 33 745.28 | 22 589.76 | 10 255.94 | 32 845.70 |
| S21 Tonsillectomy and/or adenoidectomy | 14 391.83 | 16 771.38 | 9 650.62 | 5 335.20 | 14 985.82 |
| **Day surgery** | | | | | |
| S18 Arthroscopic excision of meniscus of knee | 22 914.12 | 24 654.67 | 15 790.06 | 8 162.97 | 23 953.04 |
| S19 Lens and cataract procedures | 23 448.13 | 24 251.59 | 11 967.06 | 11 960.01 | 23 927.07 |
| S20 Ligation and stripping of varicose veins – lower limb | 20 532.36 | 19 854.70 | 14 692.63 | 5 497.47 | 20 190.11 |
| S21 Tonsillectomy and/or adenoidectomy | 11 095.03 | 12 625.17 | 8 495.01 | 3 747.62 | 12 242.64 |

2 *Other amount paid includes radiology, pathology, pharmaceuticals, professional and other unspecified fees*

# UTILISATION OF MEDICAL TECHNOLOGY

Table 53 provides an overview of the utilisation of medical technology, which remained largely unchanged during the period under review. The utilisation of MRI scans, angiograms, bone density scans, and dialysis services were generally higher in open medical schemes than in restricted schemes. The utilisation of healthcare technology was stable during the period under review. The changes observed may be explained by changes in the demographic characteristics of beneficiaries over time.

## Computerised tomography scans

The use of computerised tomography (CT) scans increased by 4.3%, from 42.47 in 2017 to 44.28 per 1 000 beneficiaries in 2018 as shown in Table 53. The number of beneficiaries receiving CT scans was high in open schemes when compared to restricted schemes. The frequency of CT scans per patient was less than 1.2 for 2017 and 2018.

## Magnetic Resonance Imaging

The number of beneficiaries utilising magnetic resonance imaging (MRI) scans increased by 5.7% during the period under review. About 27 in 1 000l beneficiaries received an MRI scan during 2018 financial year. Proportionally more beneficiaries received MRI scans compared to restricted schemes. The frequency of MRI scans per patient was less than 1.2 for 2017 and 2018.

## Renal dialysis

The number of beneficiaries receiving renal dialysis increased by 6.5% between 2017 and 2018. Overall, 10.59 patients per 1 000 beneficiaries received renal dialysis in 2018. Proportionally more beneficiaries in restricted schemes received renal dialysis when compared to open schemes.

## Bone density scans

The number of bone density scans increased marginally from 5.62 in 2017 to 5.81 per 1 000 beneficiaries in 2018.

## Angiograms

A very small number of beneficiaries received an angiogram during the 2017 and 2018 financial years – 2.08 in 2017 and 2.30 per 1 000 beneficiaries in 2018.

## Positron emission tomography

Positron emission tomography (PET) scans were performed in less than 1 per 1 000 beneficiaries in both the 2017 and 2018 financial years. The difference in the use of PET scans in the open and restricted schemes was not significant.

Table 53: Utilisation of medical technology

| Healthcare technology | Open | | | Restricted | | | Consolidated | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2017 | % change | 2018 | 2017 | % change | 2018 | 2017 | % change |
| **CT scans** | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 48.85 | 47.00 | 3.9 | 38.50 | 36.65 | 5.1 | 44.28 | 42.47 | 4.3 |
| Number of tests per patient | 1.20 | 1.20 | 0.0 | 1.17 | 1.10 | 6.4 | 1.19 | 1.16 | 2.2 |
| **MRI** | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 30.84 | 29.27 | 5.4 | 22.30 | 20.89 | 6.8 | 27.06 | 25.60 | 5.7 |
| Number of tests per patient | 1.13 | 1.12 | 0.8 | 1.09 | 1.05 | 3.7 | 1.11 | 1.09 | 1.8 |
| Renal dialysis | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 7.57 | 7.64 | -0.9 | 14.40 | 12.92 | 11.5 | 10.59 | 9.95 | 6.5 |
| **Bone density scans** | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 6.85 | 6.70 | 2.3 | 4.49 | 4.25 | 5.9 | 5.81 | 5.62 | 3.3 |
| Number of tests per patient | 1.09 | 1.04 | 4.1 | 1.07 | 1.08 | -1.1 | 1.08 | 1.06 | 2.3 |
| Angiograms | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 2.76 | 2.56 | 8.1 | 1.71 | 1.48 | 15.7 | 2.30 | 2.08 | 10.3 |
| Number of tests per patient | 1.31 | 1.22 | 7.1 | 1.24 | 1.20 | 3.8 | 1.28 | 1.21 | 6.0 |
| **PET** | | | | | | | | | |
| Number of patients per 1 000 beneficiaries | 0.89 | 0.67 | 33.3 | 0.83 | 0.72 | 15.1 | 0.86 | 0.69 | 25.0 |
| Number of tests per patient | 1.65 | 1.44 | 14.6 | 1.35 | 1.21 | 11.9 | 1.52 | 1.33 | 14.2 |

# UTILISATION OF MATERNAL AND REPRODUCTIVE HEALTHCARE SERVICES

This section gives an account of the utilisation of screening, child, maternal, and reproductive health services. The utilisation of maternal and reproductive healthcare services was stable during the period under review. The changes observed may be explained by changes in the demographic characteristics of beneficiaries and improvements in the quality of data over time. The number of caesarean sections performed per 1 000 birth admissions was a significant observation. According to the data received from medical schemes, more than 75% of all births were by caesarean section in 2018. The true rate is likely to be significantly higher than the reported figures. Efforts to improve maternal health data will continue in the current financial year.

Table 54: Utilisation of maternal and reproductive healthcare services

| | 2018 | | | 2017 | |
|---|---|---|---|---|---|
| Maternal health indicators | Open | Restricted | Consolidated | Consolidated | % change |
| Birth admissions (per 1 000 female beneficiaries) | 32.53 | 27.23 | 30.15 | 30.75 | -2.0 |
| Number of live births (per 1 000 birth admissions) | 967.37 | 976.99 | 971.19 | 977.27 | -0.6 |
| Caesarean sections performed (per 1 000 birth admissions) | 778.74 | 751.35 | 768.34 | 756.03 | -1.6 |
| Birth admissions of women under 15 years (per 1 000 female beneficiaries aged under 15 years) | 3.89 | 8.50 | 7.00 | 6.85 | 2.2 |
| Birth admissions of women between 15–19 years (per 1 000 female beneficiaries aged 15–19 years) | 12.85 | 24.35 | 20.56 | 19.16 | 7.3 |
| Mammograms (per 1 000 female beneficiaries aged 50–69 years) | 363.63 | 275.45 | 326.76 | 309.64 | 5.5 |
| Pap smears (per 1 000 female beneficiaries aged 15–69 years) | 172.90 | 143.12 | 159.90 | 162.62 | -1.7 |
| Intra uterine contraceptive devices (IUCD) inserted into a woman aged 15–49 years (per 1 000 female beneficiaries aged 15–49 years) | 13.48 | 9.17 | 11.57 | 12.05 | -4.0 |
| Live births in health facilities – weighing less than 2 500g (per 1 000 live births) | 12.64 | 29.67 | 19.38 | 18.26 | 6.1 |
| Surgical procedures to protect women from further pregnancy (per 1 000 female beneficiaries aged 15–49 years) | 3.83 | 1.00 | 3.15 | 3.26 | -3.3 |
| Surgical procedures to prevent men from being fertile (per 1 000 male beneficiaries aged 15–49 years) | 8.00 | 2.73 | 5.86 | 5.82 | 0.8 |
| Subdermal contraceptive implant inserted just under the skin of female beneficiaries aged 15–49 years – upper arm (per 1 000 female beneficiaries aged 15–49 years) | 0.79 | 1.26 | 1.19 | 60.38 | -98.0 |
| Termination of pregnancy in the first 12 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations) | 327.99 | 641.89 | 505.08 | 600.47 | -15.9 |
| Termination of pregnancy at 13–20 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations) | 415.45 | 163.59 | 278.85 | 273.73 | 1.9 |
| Termination of pregnancy performed under safe conditions in a health facility (per 1 000 female beneficiaries) | 1.07 | 1.18 | 1.12 | 1.10 | 1.5 |
| Women using contraceptives (per 1 000 female beneficiaries aged 15–49 years) | 209.22 | 194.29 | 202.46 | 195.48 | 3.6 |

# TRENDS IN CONTRIBUTIONS RECEIVED AND CLAIMS PAID ON BEHALF OF MEMBERS

## Contributions

The gross contribution received from members of medical schemes in 2018 was R192.28 billion compared to R179.82 billion in December 2017. This is an increase of 6.93% from the prior year.

Risk contributions (gross contributions excluding personal medical savings account contributions) increased by 6.81% to R173.96 billion from R162.87 billion in 2017. The equivalent increase from 2016 to 2017 was 10.42%.

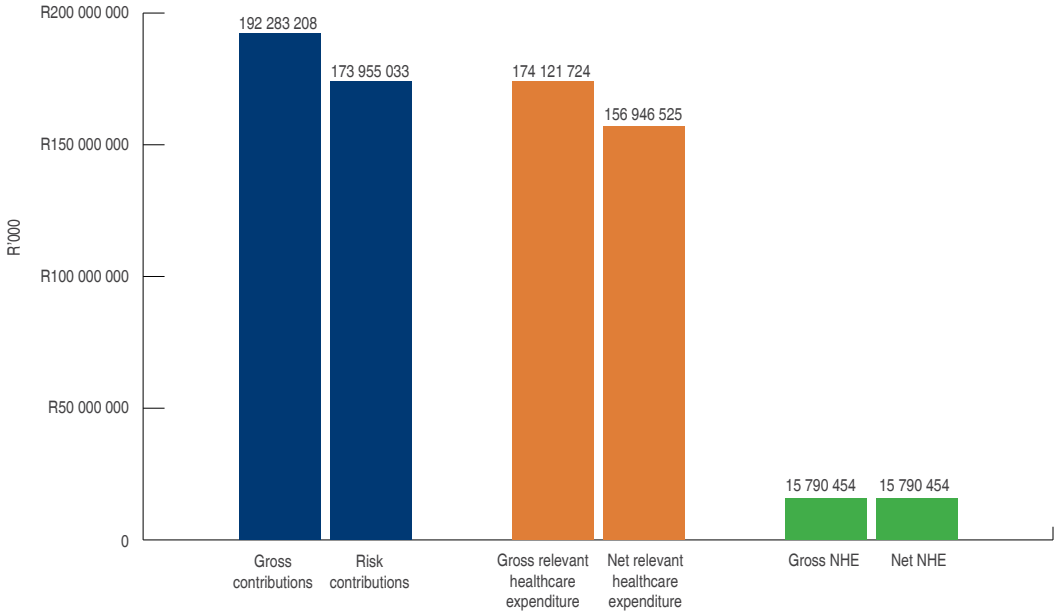



Figure 72: Gross contributions, relevant healthcare expenditure and non-healthcare expenditure (NHE) (2018)

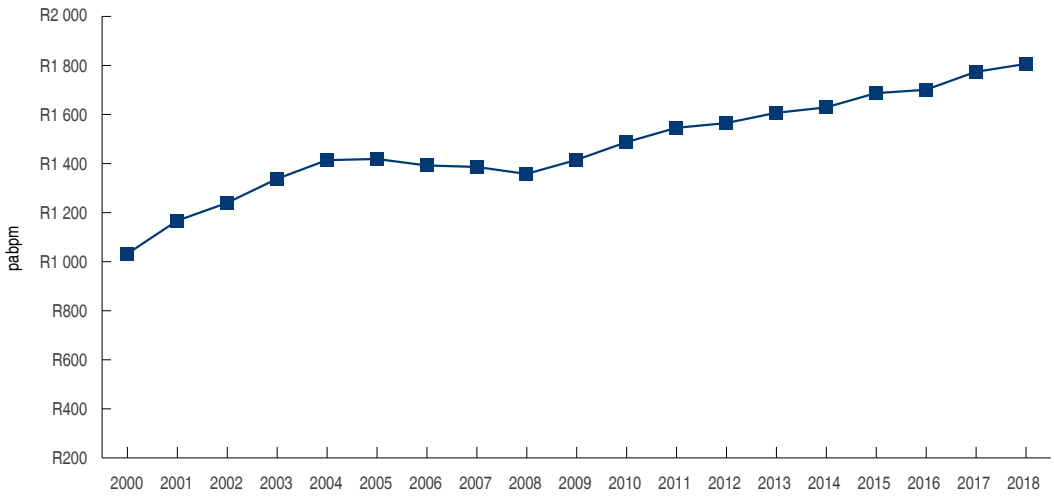



Figure 73: Gross contribution per average beneficiary per month (2000–2018) in 2018 prices

Gross contributions, adjusted for lives covered (per average beneficiary per month)[1] (pabpm) have increased by 75.08% between 2000 and 2018, while gross relevant healthcare expenditure increased by 77.65% (Figure 73).

Gross contributions pabpm rose by 6.54% to R1 806.06 from R1 695.14 in 2017. After adjusting for inflation, this growth was 1.80%.

The increase in risk contributions pabpm was 6.42%, rising to R1 633.91 from R1 535.36. The 2017 increase was 10.40%.

Contributions to medical savings accounts increased by 8.13% to R18.33 billion from R16.95 billion (2017: 4.91% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, and adjusted for inflation, the increase was 1.21% – from R200.63 to R203.05. During 2017 the increase was 2.66% in real terms.

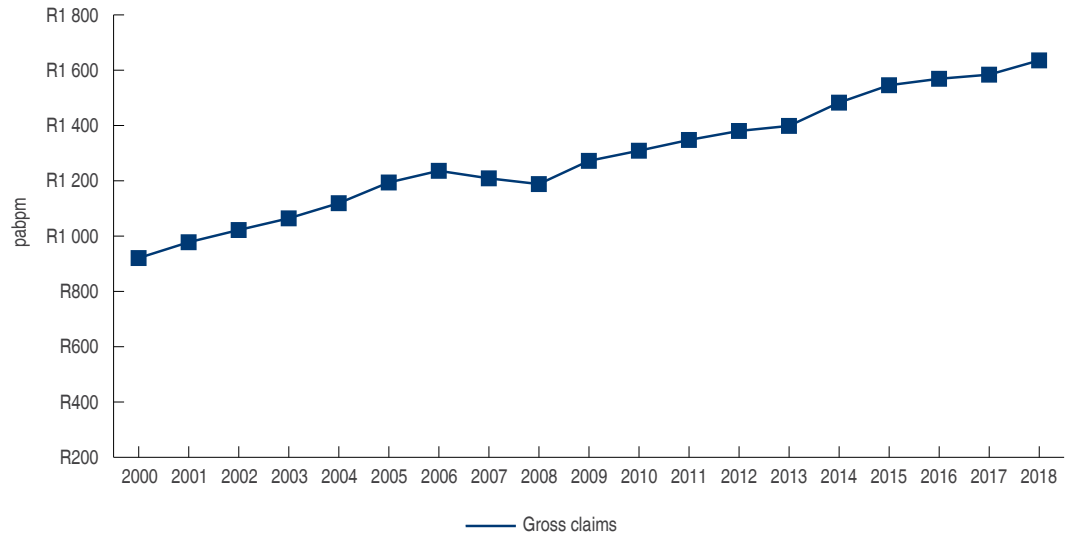
Investment income and reserves have assisted medical schemes to reduce the burden of increasing healthcare costs, maintain reserves and retain members. Factors such as increasing claims, technology costs, members getting sicker and older, and stagnant growth in members, have had a collective negative impact on available reserves.

The total gross relevant healthcare expenditure incurred by medical schemes increased by 8.46% to R174.12 billion in 2018 from R160.53 billion in 2017.

Risk claims increased by 8.64% to R156.95 billion from R144.46 billion in 2017.



1 *Reflected in 2018 prices*




*pabpm = per average beneficiary per month*

Figure 74: Gross relevant healthcare expenditure (2000–2018) in 2018 prices

The total gross relevant healthcare expenditure incurred pabpm increased by 8.07% to R1 635.47 from R1 513.34 in 2017. Risk claims pabpm rose by 8.25% to R1 474.15 from R1 361.86 in 2017.

A combination of factors has impacted on the claims experience of medical schemes over time, more so in recent years. These include changing benefit design, demographic profiles, increased utilisation of benefits in some schemes and a higher number of high cost cases. Some medical schemes were also affected by widespread fraud and abuse of benefits, as well as wastage of resources. The industry trend in claims experience deteriorated in 2018 compared to 2017, with the majority of schemes experiencing claims that were worse than expected in the year under review. The change in Value Added Tax also had an impact on claims costs.

Figures 75 and 76 depict the medical schemes that had the highest increases in claims ratios, from 2017 to 2018.

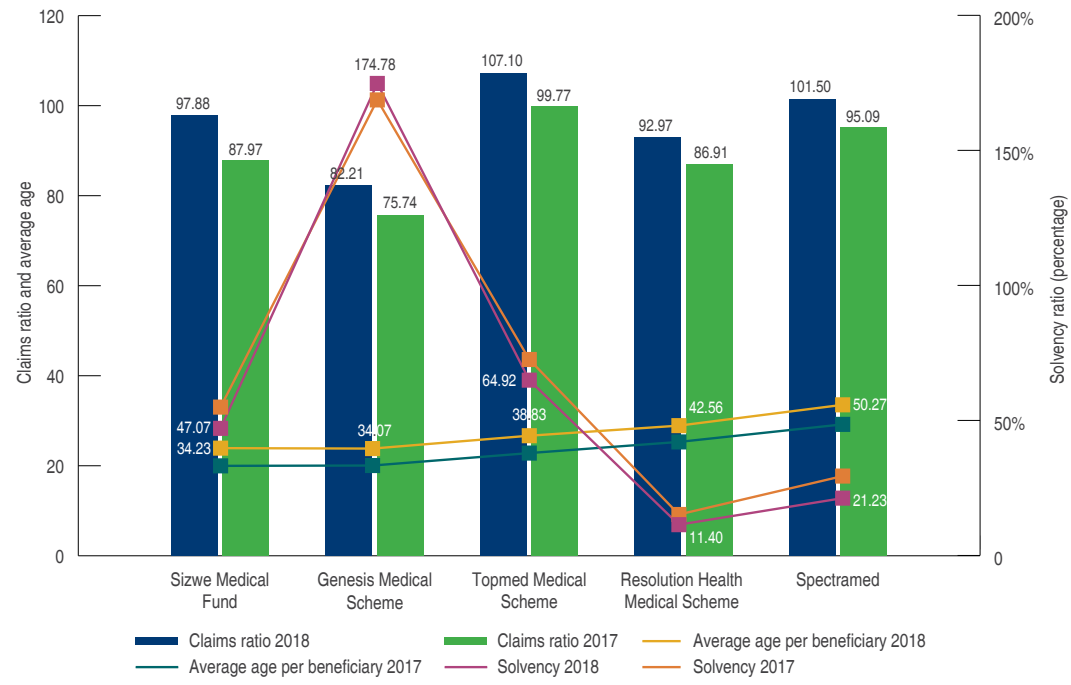



Figure 75: Open schemes with a claims ratio increase greater than 4.00%

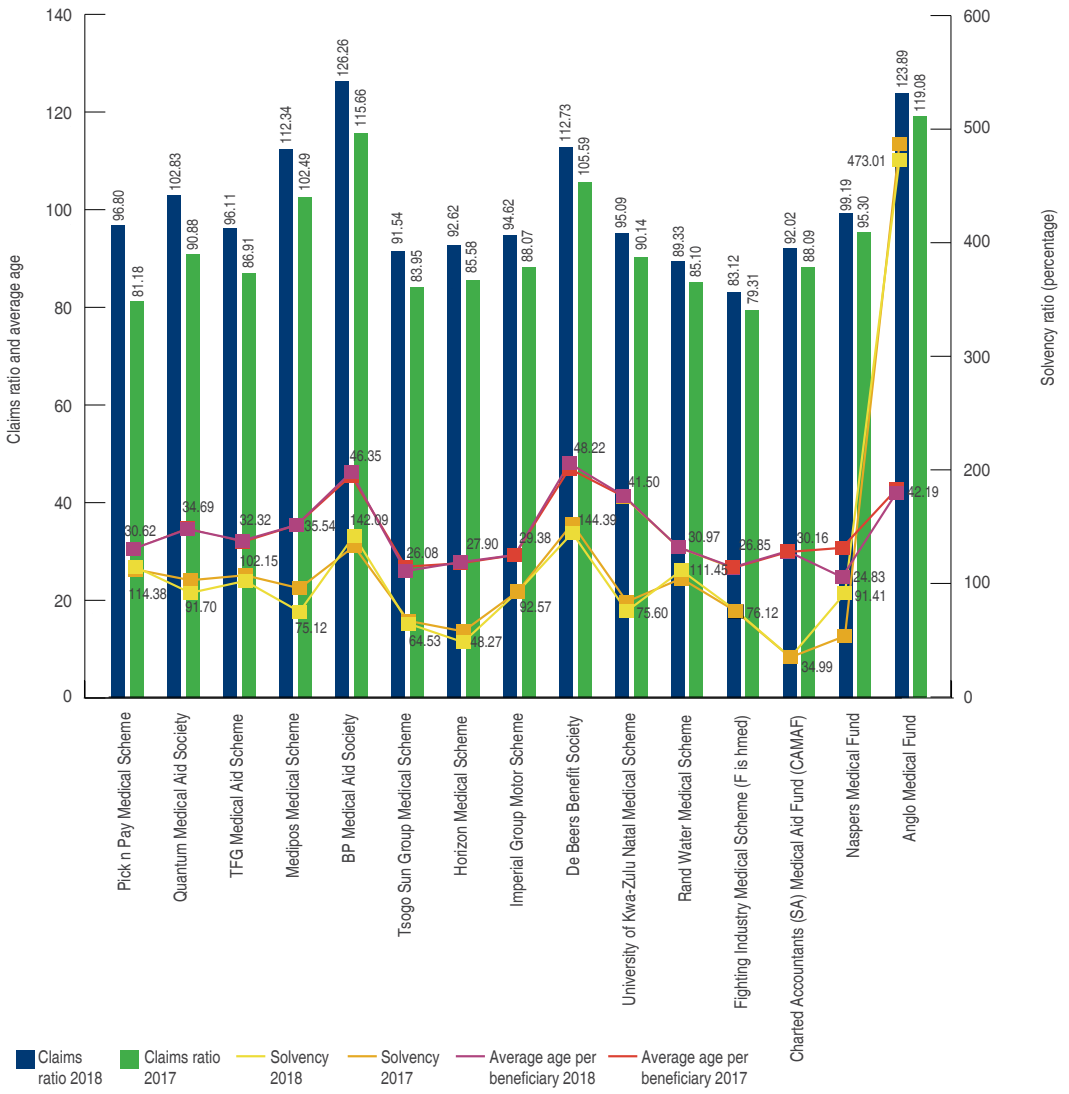



Figure 76: Restricted schemes with a claims ratio increase greater than 4.00%

The majority of open schemes and all restricted schemes where claims ratios increased by more than 4.00% have solvency ratios that are above the minimum required statutory level of 25.00%, suggesting that they could be utilising reserves to cushion members from high contribution increases. Whilst the utilisation of reserves to cushion members against increasing costs is an appropriate strategy for medical schemes, there are schemes that appear to be deliberately under-pricing, some with poorer than average risk profiles. In those cases, caution should be exercised to ensure that financial sustainability is maintained.

Table 55: Open scheme deviation from industry average (2018 and 2017)

| Ref. no. | Name of medical scheme | % change in claims ratio | % deviation from average claims ratio of 89.84% 2018 | % deviation from average claims ratio of 87.20% 2017 |
|---|---|---|---|---|
| 1486 | Sizwe Medical Fund | 11.27 | 8.95% | 0.88% |
| 1554 | Genesis Medical Scheme | 8.54 | -8.49% | -13.14% |
| 1422 | Topmed Medical Scheme | 7.35 | 19.21% | 14.42% |
| 1575 | Resolution Health Medical Scheme | 6.97 | 3.48% | -0.33% |
| 1141 | Spectramed | 6.74 | 12.98% | 9.05% |

Table 55 shows the percentage deviation of the open schemes, with a claims ratio increase greater than 4.00% from 2017 to 2018, from the industry average of 89.84% and 87.20% for 2018 and 2017 respectively.

Table 56: Top ten open scheme claims ratios (2018 and 2017)

| Ref. no. | Name of medical scheme | Claims ratio 2018 | Claims ratio 2017 | Average age per beneficiary 2018 | Average age per beneficiary 2017 | Solvency ratio 2018 | Solvency ratio 2017 |
|---|---|---|---|---|---|---|---|
| 1422 | Topmed Medical Scheme | 107.10 | 99.77 | 38.83 | 37.91 | 64.92 | 72.56 |
| 1034 | Cape Medical Plan | 103.69 | 104.10 | 39.57 | 38.87 | 99.82 | 112.31 |
| 1446 | Selfmed Medical Scheme | 103.58 | 103.65 | 46.32 | 46.15 | 80.77 | 92.40 |
| 1141 | Spectramed | 101.50 | 95.09 | 50.27 | 48.54 | 21.23 | 29.40 |
| 1486 | Sizwe Medical Fund | 97.88 | 87.97 | 34.23 | 33.18 | 47.07 | 54.94 |
| 1140 | Medshield Medical Scheme | 95.50 | 97.85 | 37.16 | 37.57 | 37.87 | 44.63 |
| 1149 | Medihelp | 93.25 | 90.65 | 37.03 | 36.95 | 28.65 | 29.56 |
| 1491 | Compcare Wellness Medical Scheme | 93.16 | 90.32 | 38.43 | 37.68 | 25.10 | 26.56 |
| 1575 | Resolution Health Medical Scheme | 92.97 | 86.91 | 42.56 | 42.04 | 11.40 | 15.17 |
| 1512 | Bonitas Medical Fund | 91.12 | 88.05 | 34.60 | 33.30 | 25.16 | 24.46 |

The top ten schemes with the highest claims ratios for both open and restricted schemes in 2018 are shown in the Tables 56 and 58. The increase in claims ratios has had the expected adverse impact on solvency (albeit it that it was off-set to some extent by membership losses). This phenomenon is heightened by the fact that the returns from investments were poorer in 2018 than in 2017.

Table 57: Restricted scheme deviation from industry average (2018 and 2017)

| Ref. no. | Name of medical scheme | % change in claims ratio | % deviation from average claims ratio of 90.71 2018 | % deviation from average claims ratio of 90.62 2017 |
|---|---|---|---|---|
| 1563 | Pick n Pay Medical Scheme | 19.24 | 6.71 | -10.42 |
| 1516 | Quantum Medical Aid Society | 13.15 | 13.36 | 0.29 |
| 1578 | TFG Medical Aid Scheme | 10.59 | 5.95 | -4.09 |
| 1548 | Medipos Medical Scheme | 9.61 | 23.85 | 13.10 |
| 1237 | BP Medical Aid Society | 9.16 | 39.19 | 27.63 |
| 1579 | Tsogo Sun Group Medical Scheme | 9.00 | 0.92 | -7.33 |
| 1566 | Horizon Medical Scheme | 8.23 | 2.11 | -5.56 |
| 1559 | Imperial Group Medical Scheme | 7.44 | 4.31 | -2.81 |
| 1068 | De Beers Benefit Society | 6.76 | 24.28 | 16.52 |
| 1520 | University of KwaZulu-Natal Medical Scheme | 5.49 | 4.83 | -0.53 |
| 1201 | Rand Water Medical Scheme | 4.97 | -1.52 | -6.09 |
| 1271 | Fishing Industry Medical Scheme (FISH-MED) | 4.80 | -8.37 | -12.48 |
| 1043 | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | 4.46 | 1.44 | -2.79 |
| 1241 | Naspers Medical Fund | 4.08 | 9.35 | 5.16 |
| 1012 | Anglo Medical Scheme | 4.04 | 36.58 | 31.41 |

Table 57 shows the percentage deviation of the restricted schemes with a claims ratio increase of 4.00% and more from 2017 to 2018, from the industry average of 90.71% and 90.62% for 2018 and 2017 respectively. When compared to open schemes, a greater number of restricted schemes had higher increases in their claims ratios; restricted schemes have significantly larger reserves and are better able to absorb these increases.

Table 58: Top ten restricted scheme claims ratios (2018 and 2017)

| Ref. no. | Name of medical scheme | Claims ratio 2018 | Claims ratio 2017 | Average age per beneficiary 2018 | Average age per beneficiary 2017 | Solvency ratio 2018 | Solvency ratio 2017 |
|---|---|---|---|---|---|---|---|
| 1270 | Golden Arrow Employees' Medical Benefit Fund | 141.01 | 144.40 | 34.67 | 34.39 | 209.18 | 183.39 |
| 1237 | BP Medical Aid Society | 126.26 | 115.66 | 46.35 | 45.69 | 142.09 | 132.67 |
| 1012 | Anglo Medical Scheme | 123.89 | 119.08 | 42.19 | 42.90 | 473.01 | 487.14 |
| 1068 | De Beers Benefit Society | 112.73 | 105.59 | 48.22 | 47.11 | 144.39 | 152.59 |
| 1548 | Medipos Medical Scheme | 112.34 | 102.49 | 35.54 | 35.53 | 75.12 | 95.70 |
| 1507 | Barloworld Medical Scheme | 105.82 | 101.76 | 32.90 | 32.87 | 74.64 | 82.54 |
| 1516 | Quantum Medical Aid Society | 102.83 | 90.88 | 34.69 | 34.92 | 91.70 | 102.82 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 102.12 | 99.88 | 27.60 | 27.32 | 43.15 | 46.42 |
| 1531 | Sedmed | 102.09 | 109.13 | 44.56 | 43.76 | 36.78 | 33.78 |
| 1441 | Parmed Medical Aid Scheme | 101.35 | 107.55 | 50.39 | 49.50 | 64.66 | 72.27 |

## Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Claims paid from medical savings accounts increased by 6.88% to R17.18 billion (2017: R16.07 billion and 5.92% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings account claims increased by 4.70% to R190.28 (2017: R181.74 and 9.16% increase).

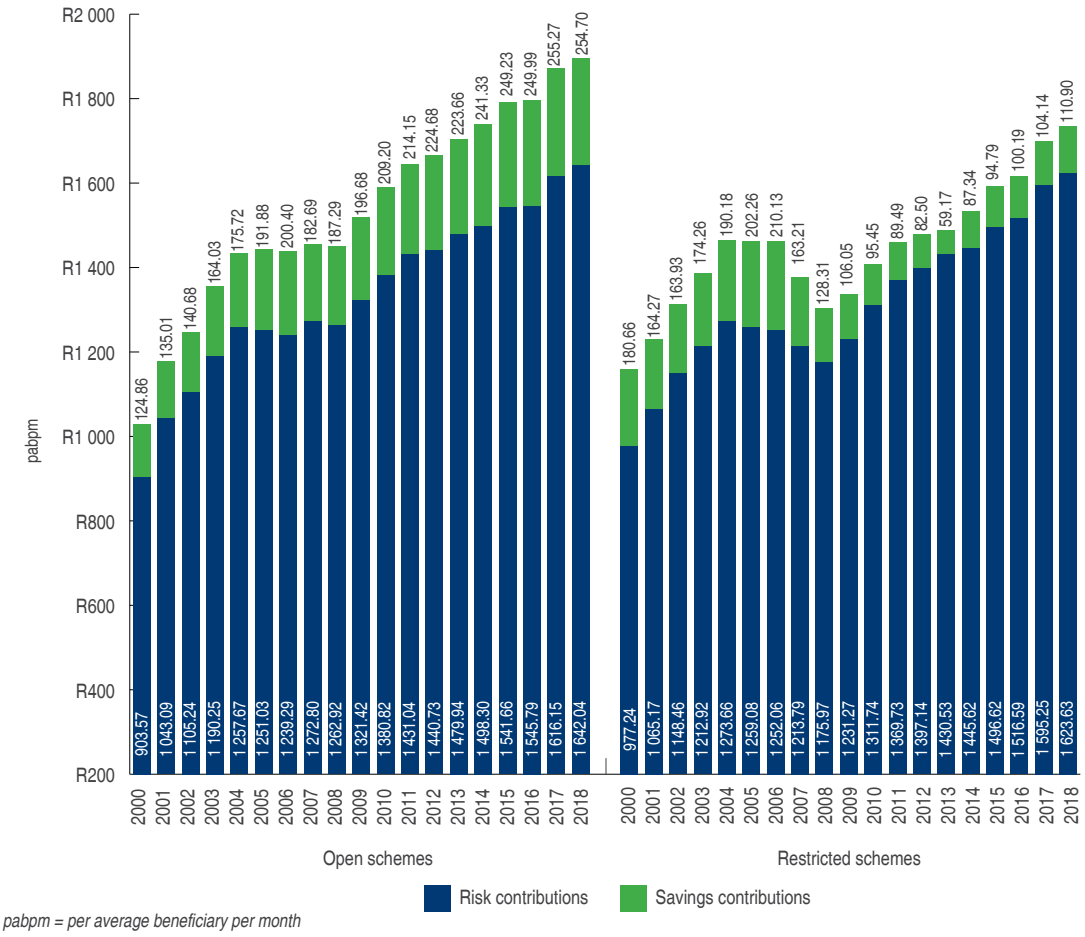
Table 59 and Figure 77 and 78 show contributions and claims for open and restricted schemes pabpm.

Table 59: Contributions and relevant healthcare expenditure pabpm (2000–2018) in 2018 prices

| | Risk contributions | | Savings contributions | | Risk claims | | Savings claims | |
|---|---|---|---|---|---|---|---|---|
| | pabpm R | % change | pasbpm R | % change | pabpm R | % change | pasbpm R | % change |
| **Open schemes** | | | | | | | | |
| 2000 | 903.57 | 15.44 | 124.86 | 8.13 | 791.98 | 7.40 | 111.86 | 6.93 |
| 2001 | 1 043.09 | | 135.01 | | 850.59 | | 119.61 | |
| 2002 | 1 105.24 | 5.96 | 140.68 | 4.20 | 890.82 | 4.73 | 121.19 | 1.32 |
| 2003 | 1 190.25 | 7.69 | 164.03 | 16.60 | 919.97 | 3.27 | 135.58 | 11.87 |
| 2004 | 1 257.67 | 5.66 | 175.72 | 7.13 | 957.93 | 4.13 | 149.43 | 10.22 |
| 2005 | 1 251.03 | -0.53 | 191.88 | 9.20 | 1 025.48 | 7.05 | 164.14 | 9.84 |
| 2006 | 1 239.29 | -0.94 | 200.40 | 4.44 | 1 059.56 | 3.32 | 194.32 | 18.39 |
| 2007 | 1 272.80 | 2.70 | 182.69 | -8.84 | 1 063.06 | 0.33 | 173.24 | -10.85 |
| 2008 | 1 262.92 | -0.78 | 187.29 | 2.52 | 1 062.07 | -0.09 | 179.50 | 3.61 |
| 2009 | 1 321.42 | 4.63 | 196.68 | 5.01 | 1 143.82 | 7.70 | 190.00 | 5.85 |
| 2010 | 1 380.82 | 4.50 | 209.20 | 6.37 | 1 169.79 | 2.27 | 199.44 | 4.97 |
| 2011 | 1 431.04 | 3.64 | 214.15 | 2.37 | 1 208.46 | 3.31 | 203.11 | 1.84 |
| 2012 | 1 440.73 | 0.68 | 224.68 | 4.92 | 1 216.74 | 0.69 | 211.20 | 3.98 |
| 2013 | 1 479.94 | 2.72 | 223.66 | -0.45 | 1 239.50 | 1.87 | 208.71 | -1.18 |
| 2014 | 1 498.30 | 1.24 | 241.33 | 7.90 | 1 315.04 | 6.09 | 215.36 | 3.19 |
| 2015 | 1 541.66 | 2.89 | 249.23 | 3.27 | 1 367.30 | 3.97 | 237.16 | 10.12 |
| 2016 | 1 545.79 | 0.27 | 249.99 | 0.30 | 1 380.35 | 0.95 | 237.64 | 0.20 |
| 2017 | 1 616.15 | 4.55 | 255.27 | 2.11 | 1 409.26 | 2.09 | 244.17 | 2.75 |
| 2018 | 1 642.04 | 1.60 | 254.70 | -0.22 | 1 475.20 | 4.68 | 241.78 | -0.98 |
| **Restricted schemes** | | | | | | | | |
| 2000 | 977.24 | 9.00 | 180.66 | -9.07 | 902.22 | 2.67 | 159.26 | -6.69 |
| 2001 | 1 065.17 | | 164.27 | | 926.31 | | 148.61 | |
| 2002 | 1 148.46 | 7.82 | 163.93 | -0.21 | 981.47 | 5.95 | 141.62 | -4.70 |
| 2003 | 1 212.92 | 5.61 | 174.26 | 6.30 | 1 013.32 | 3.25 | 148.03 | 4.53 |
| 2004 | 1 273.66 | 5.01 | 190.18 | 9.14 | 1 073.62 | 5.95 | 152.72 | 3.17 |
| 2005 | 1 259.08 | -1.14 | 202.26 | 6.35 | 1 125.44 | 4.83 | 163.50 | 7.06 |
| 2006 | 1 252.06 | -0.56 | 210.13 | 3.89 | 1 179.52 | 4.81 | 188.04 | 15.01 |
| 2007 | 1 213.79 | -3.06 | 163.21 | -22.33 | 1 126.60 | -4.49 | 143.17 | -23.86 |
| 2008 | 1 175.97 | -3.12 | 128.31 | -21.38 | 1 081.39 | -4.01 | 112.21 | -21.62 |
| 2009 | 1 231.27 | 4.70 | 106.05 | -17.35 | 1 156.39 | 6.94 | 98.10 | -12.57 |
| 2010 | 1 311.74 | 6.54 | 95.45 | -10.00 | 1 197.08 | 3.52 | 87.67 | -10.63 |
| 2011 | 1 369.73 | 4.42 | 89.49 | -6.24 | 1 223.28 | 2.19 | 80.78 | -7.86 |
| 2012 | 1 397.14 | 2.00 | 82.50 | -7.81 | 1 282.60 | 4.85 | 73.70 | -8.76 |
| 2013 | 1 430.53 | 2.39 | 59.17 | -28.28 | 1 285.80 | 0.25 | 52.79 | -28.37 |
| 2014 | 1 445.62 | 1.05 | 87.34 | 47.61 | 1 369.92 | 6.54 | 53.66 | 1.65 |
| 2015 | 1 496.08 | 3.49 | 94.79 | 8.53 | 1 419.44 | 3.61 | 83.08 | 54.83 |
| 2016 | 1 516.59 | 1.37 | 100.19 | 5.70 | 1 450.56 | 2.19 | 88.18 | 6.14 |
| 2017 | 1 595.25 | 5.19 | 104.14 | 3.94 | 1 445.58 | -0.34 | 94.72 | 7.42 |
| 2018 | 1 623.63 | 1.78 | 110.90 | 6.49 | 1 472.82 | 1.88 | 98.34 | 3.82 |

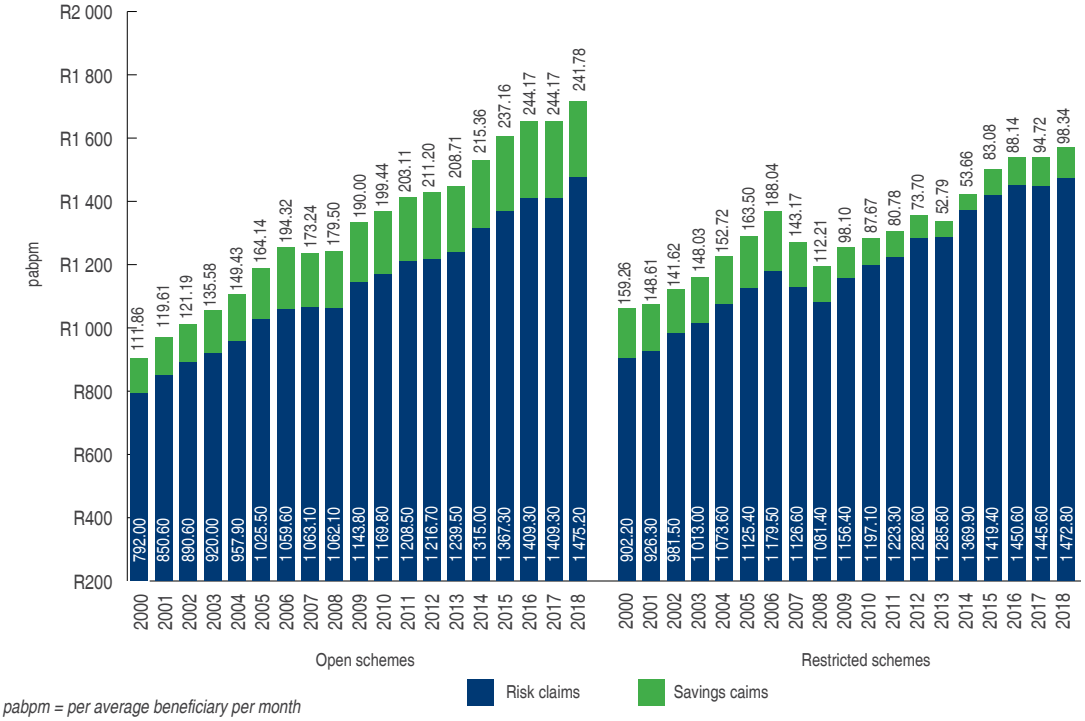
*pabpm = per average beneficiary per month*

*pasbpm = pabpm in respect of schemes which had savings transactions*




*pabpm = per average beneficiary per month*

Figure 77: Risk and savings contributions pabpm (2000–2018) in 2018 prices




*pabpm = per average beneficiary per month*

Figure 78: Risk and savings claims pabpm (2000–2018) in 2018 prices

Figures 77 and 78 show the relationship between contributions and claims for both the risk and savings pool in the open and restricted schemes. The risk claims ratio increased in 2018 from 2017 for both open and restricted schemes to 89.84% and 90.71% respectively. For the savings pool, 94.93% of the contributions received from members of open schemes was paid out in claims, compared with 88.67% for restricted schemes.

The contributions and expenditure on savings in open schemes is much higher than it is in restricted schemes. This could be partially due to the nature of benefit design. Restricted schemes generally have more traditional and richer options.

Table 60 shows that between 2003 and 2006 medical savings account contributions and claims increased at greater rates than those recorded for the risk components. The figures for the period 2007–2012 appear to reflect a change in this trend. In 2000, savings contributions made up 12.79% of gross contributions. At the end of 2012, savings had declined to 10.68% of gross contributions. The decrease is partly attributable to a decision by the CMS not to allow variable savings rates on an option, which resulted in a number of medical schemes no longer offering savings plan accounts.

The subsequently higher increases in the savings components are partly due to a number of schemes introducing savings on existing options, and are indicative of a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal savings accounts than from the general risk pool of the scheme.

Table 60: Contributions and relevant healthcare expenditure pabpm (2000–2018) in 2018 prices

| | Risk contributions | | Savings contributions | | Risk claims | | Savings claims | |
|---|---|---|---|---|---|---|---|---|
| | pabpm R | % change | pasbpm R | % change | pabpm R | % change | pasbpm R | % change |
| 2000 | 927.13 | 13.23 | 135.97 | 3.63 | 827.46 | 5.60 | 121.34 | 3.44 |
| 2001 | 1 049.77 | | 140.91 | | 873.44 | | 125.51 | |
| 2002 | 1 117.93 | 6.49 | 145.38 | 3.17 | 917.12 | 5.00 | 125.18 | -0.26 |
| 2003 | 1 196.91 | 7.06 | 166.03 | 14.20 | 947.53 | 3.30 | 138.25 | 10.44 |
| 2004 | 1 262.27 | 5.46 | 178.57 | 7.55 | 991.67 | 4.70 | 150.09 | 8.56 |
| 2005 | 1 253.36 | -0.71 | 194.00 | 8.64 | 1 054.07 | 6.30 | 164.14 | 9.36 |
| 2006 | 1 242.94 | -0.83 | 202.23 | 4.24 | 1 093.40 | 3.70 | 193.11 | 17.65 |
| 2007 | 1 252.75 | 0.79 | 178.34 | -11.81 | 1 084.24 | -0.80 | 166.62 | -13.72 |
| 2008 | 1 230.89 | -1.74 | 171.02 | -4.10 | 1 069.19 | -1.40 | 161.02 | -3.36 |
| 2009 | 1 286.13 | 4.49 | 167.90 | -1.82 | 1 148.75 | 7.40 | 160.91 | -0.07 |
| 2010 | 1 352.30 | 5.14 | 168.94 | 0.62 | 1 181.07 | 2.80 | 160.10 | -0.50 |
| 2011 | 1 404.31 | 3.85 | 168.82 | -0.07 | 1 215.00 | 2.90 | 158.50 | -1.00 |
| 2012 | 1 421.20 | 1.20 | 169.95 | 0.67 | 1 246.16 | 2.60 | 158.26 | -0.15 |
| 2013 | 1 457.58 | 2.56 | 178.54 | 5.05 | 1 260.44 | 1.10 | 165.54 | 4.60 |
| 2014 | 1 474.78 | 1.18 | 184.24 | 3.19 | 1 339.54 | 6.30 | 171.87 | 3.82 |
| 2015 | 1 521.50 | 3.17 | 193.57 | 5.06 | 1 390.27 | 3.80 | 181.64 | 5.68 |
| 2016 | 1 533.01 | 0.76 | 195.43 | 0.96 | 1 411.32 | 1.50 | 183.51 | 1.03 |
| 2017 | 1 606.91 | 4.82 | 200.63 | 2.66 | 1 425.33 | 1.00 | 190.21 | 3.65 |
| 2018 | 1 633.91 | 1.68 | 203.05 | 1.21 | 1 474.15 | 3.40 | 190.28 | 0.04 |

*pabpm = per average beneficiary per month*

*pasbpm = pabpm in respect of schemes which had savings transactions*

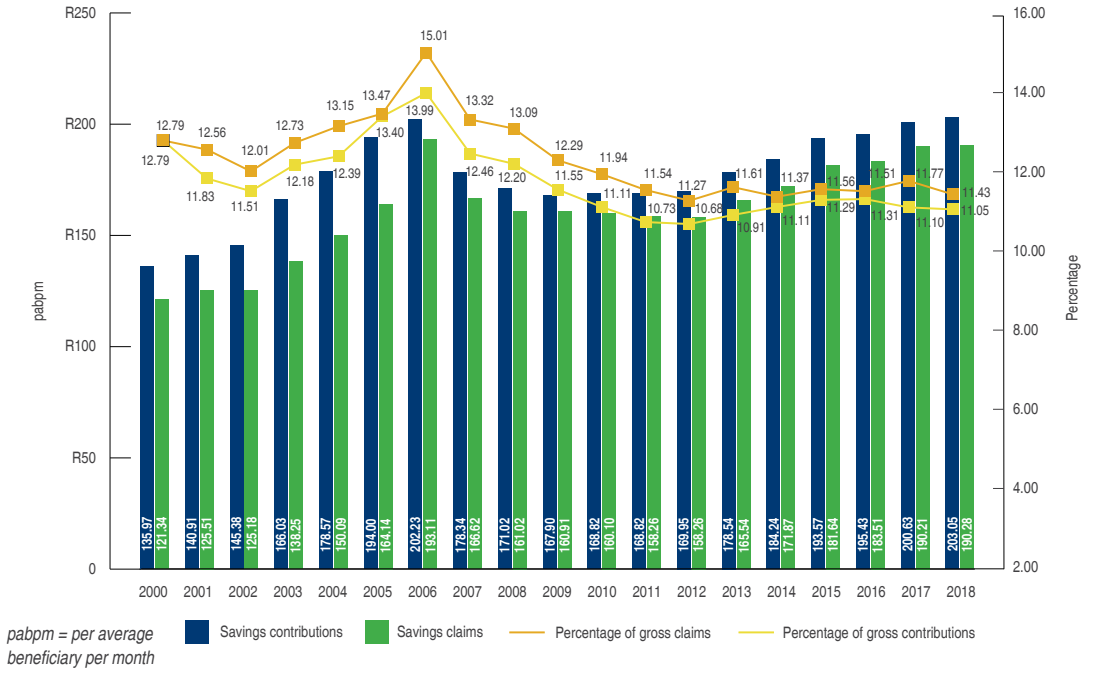



Figure 79: Medical savings account contributions and claims pabpm (2000–2018) in 2018 prices

The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure decreased slightly to 11.51% in 2016 but increased again to 11.77% in 2017, as shown in Figure 79. There was a slight decrease again in 2018 to 11.43%. For open schemes, the proportion of claims paid from medical savings accounts increased from 14.77% in 2017 to 14.08% in 2018; the medical savings account claims ratio decreased to 94.93% from 95.65% in 2017. For restricted schemes, the proportion of claims paid from medical savings accounts increased from 6.15% in 2017 to 6.26% in 2018. The medical savings account claims ratio decreased to 88.67% from 90.95% in 2017. Figure 80 shows the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 76.23% and 78.15% respectively on a pabpm basis; medical savings account contributions and claims have risen by 49.33% and 56.82% respectively.



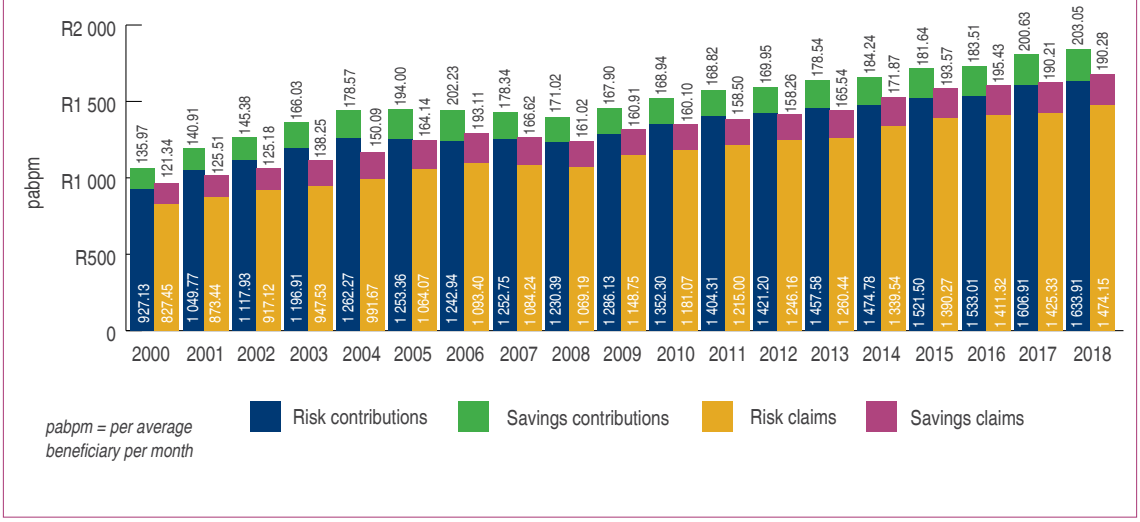



Figure 80: Risk and medical savings accounts contributions and claims pabpm (2000–2018) in 2018 prices

Figure 81 shows the relationship between risk contributions and claims paid over the last 19 years. All figures have been adjusted for inflation.

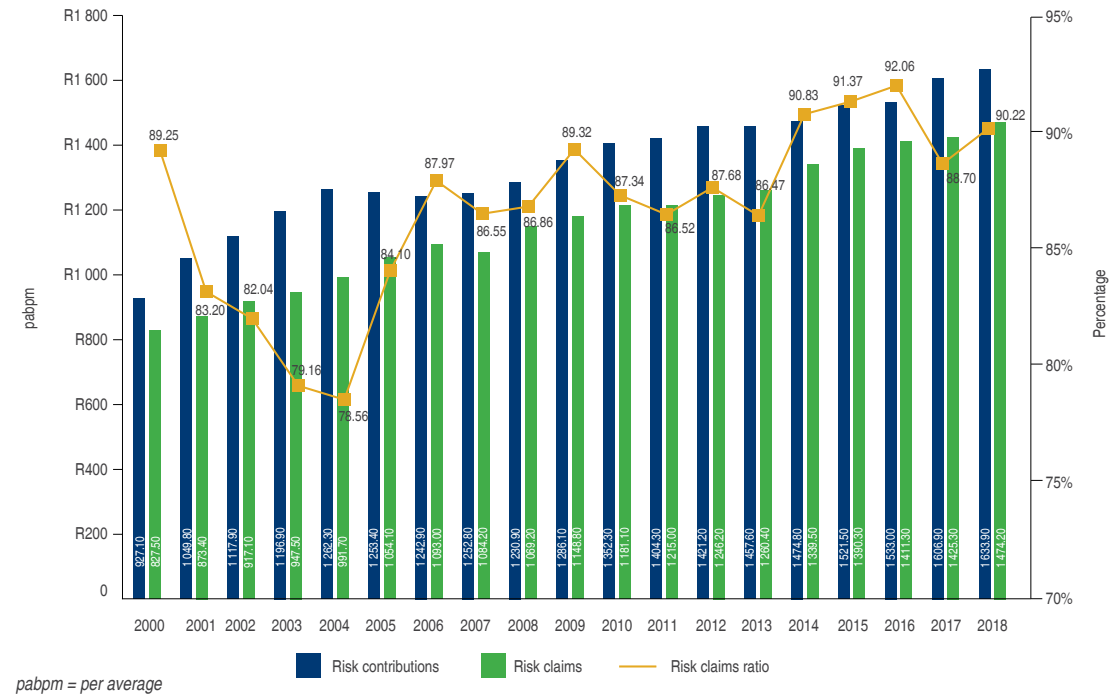



Figure 81: Risk claims ratio for all schemes (2000–2018) in 2018 prices

After an initial decline, the claims ratio increased to 87.97% in 2006 and stabilised at 86.86% in 2008. There was an increase in 2009, followed by a decrease over the next two years to 86.52% in 2011. In 2012, there was a slight increase from the previous year, with medical schemes paying out 87.68% of risk contributions in benefits. In 2013, the claims ratio decreased to 86.47%, and rose again to 92.06% in 2016. There was an increase in the claims ratio in 2018 to 90.22% from 88.7% in 2017.

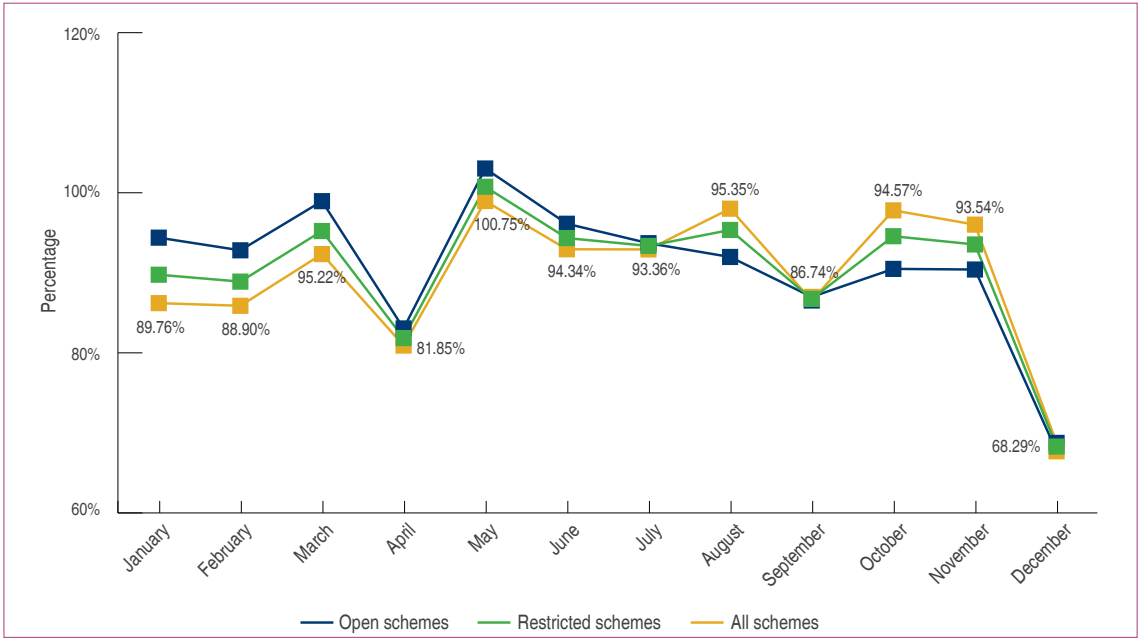



Figure 82: Seasonality of claims per month in 2018



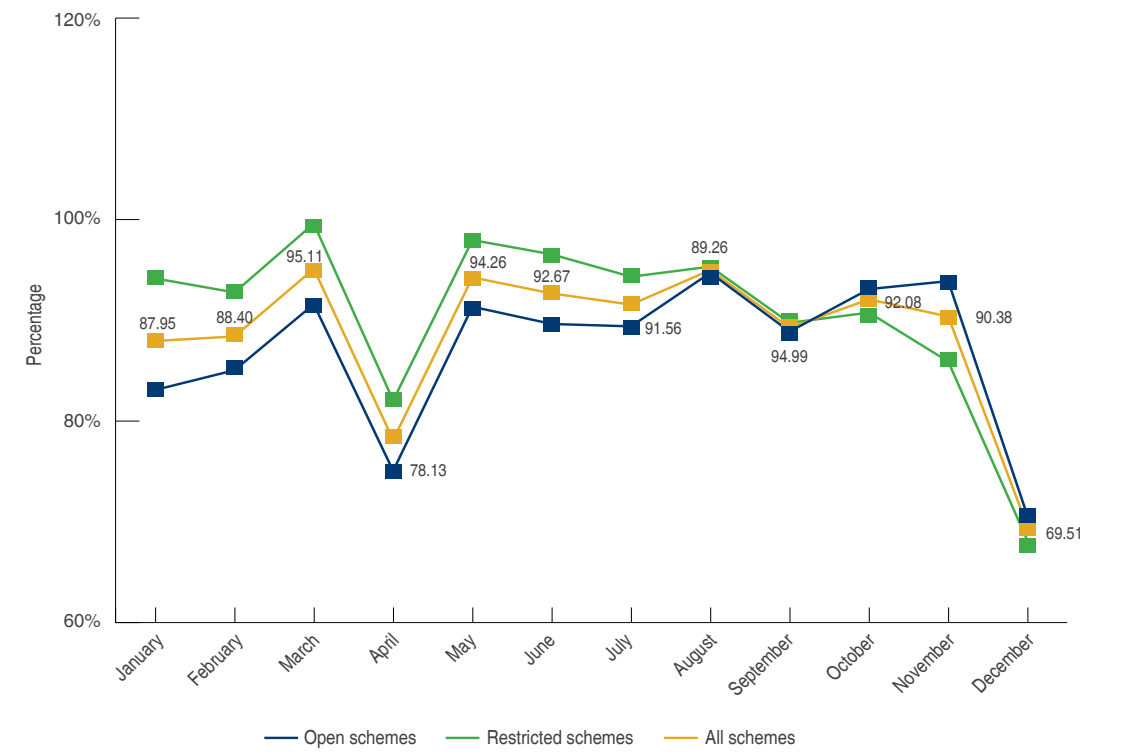



Figure 83: Seasonality of claims per month in 2017

Figures 82 and 83 show the seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2018 and 2017 respectively. Both open and restricted schemes follow the same general trend; an increase in claims in the first quarter of the year as members gain access to new benefits, increases in claims over the winter months, and a downward trend in the last quarter of the year.

On average, the claims experience per month was higher in 2018 compared to 2017.

## Risk transfer arrangements

Over the last few years, medical schemes have increasingly undertaken risk transfer arrangements to manage their insurance risks. Table 61 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 AB provides further details).

During the year under review it was noted that, in the case of a number of schemes, the estimated recovery cost calculation did not represent the cost that the scheme would have incurred should the arrangement not have been in place, as is required per International Financial Reporting Standards, but rather the cost to the provider. The CMS will be engaging further with technical experts to ensure a consistent method of calculation for the industry in future periods.

Table 61: Significant risk transfer arrangements (2017 and 2018)

| | Capitation fees | | | Estimated recoveries | | | Net income/(expense)* | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 R'000 | 2017 R'000 | % growth | 2018 R'000 | 2017 R'000 | % growth | 2018 R'000 | 2017 R'000 | % growth |
| Open schemes | 2 155 736 | 2 128 985 | 1.26 | 2 231 470 | 2 185 270 | 2.11 | 79 442 | 59 873 | 32.68 |
| Restricted schemes | 1 307 398 | 1 190 139 | 9.85 | 1 406 941 | 1 385 813 | 1.52 | 101 184 | 201 783 | -49.86 |
| All | 3 463 134 | 3 319 124 | 4.34 | 3 638 411 | 3 571 083 | 1.89 | 180 626 | 261 656 | -30.97 |

** The net income/(expense) on risk transfer arrangements includes an amount of R5.4 million in respect of profit- and loss-sharing agreements*

Table 62 lists the ten schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 63 details the ten benefit options which reported the greatest losses.

Table 62: Schemes with the highest risk transfer arrangement losses (2018)

| Ref. no. | Name of medical scheme | Beneficiaries 31 Dec 2018 | Capitation fees R'000 | Estimated recoveries R'000 | Net income/ (expense) R'000 | Net income/ (expense) as % of capitation fees % |
|---|---|---|---|---|---|---|
| 1167 | Momentum Health | 299 166 | 429 933 | 349 266 | (80 667) | -18.76 |
| 1486 | Sizwe Medical Fund | 111 522 | 62 952 | 49 300 | (13 652) | -21.69 |
| 1087 | Keyhealth | 68 831 | 73 230 | 67 095 | (6 356) | -8.68 |
| 1591 | Impala Medical Plan | 25 778 | 163 614 | 158 620 | (4 994) | -3.05 |
| 1039 | MBMed Medical Aid Fund | 9 962 | 7 159 | 2 831 | (4 327) | -60.45 |
| 1422 | Topmed Medical Scheme | 35 540 | 12 080 | 8 665 | (3 415) | -28.27 |
| 1145 | LA-Health Medical Scheme | 187 442 | 21 354 | 18 020 | (3 334) | -15.61 |
| 1271 | Fishing Industry Medical Scheme (FISH-MED) | 4 047 | 15 828 | 12 894 | (2 835) | -17.91 |
| 1466 | Makoti Medical Scheme | 7 281 | 58 700 | 55 997 | (2 703) | -4.60 |
| 1537 | Hosmed Medical Aid Scheme | 58 530 | 28 769 | 26 888 | (1 881) | -6.54 |

Table 63: Options with the highest risk transfer arrangement losses (2018)

| Ref. no. | Name of medical scheme | Name of benefit option | Benefi-ciaries 31 Dec 2018 | Average age per beneficiary Years | Capitation fees R'000 | Estimated recoveries R'000 | Profit/ (loss) sharing R'000 | Net income/ (expense) R'000 | Net income/ (expense) as % of capitation fees % |
|---|---|---|---|---|---|---|---|---|---|
| 1167 | Momentum Health | Custom | 158 199 | 31.73 | 178 971 | 76 527 | - | (102 444) | -57.24 |
| 1167 | Momentum Health | Ingwe | 54 782 | 27.21 | 134 018 | 118 342 | - | (15 676) | -11.70 |
| 1125 | Discovery Health Medical Scheme | Classic Compre-hensive | 297 212 | 41.18 | 145 231 | 130 183 | - | (15 047) | -10.36 |
| 1486 | Sizwe Medical Fund | Gomomo Care Option | 11 926 | 30.95 | 62 952 | 49 300 | - | (13 652) | -21.69 |
| 1466 | Makoti Medical Scheme | Makoti Primary | 4 828 | 32.94 | 17 782 | 8 444 | - | (9 338) | -52.51 |
| 1512 | Bonitas Medical Fund | Bonsave | 82 115 | 30.78 | 76 540 | 68 445 | - | (8 095) | -10.58 |
| 1279 | Bankmed | Bankmed Basic | 40 316 | 24.03 | 127 672 | 121 422 | - | (6 250) | -4.90 |
| 1149 | Medihelp | Dimension Prime 1 | 55 034 | 32.59 | 10 364 | 3 843 | 1 046 | (5 475) | -52.83 |
| 1591 | Impala Medical Plan | Impala Medical Plan | 25 778 | 30.21 | 163 614 | 158 620 | - | (4 994) | -3.05 |
| 1039 | MBMed Medical Aid Fund | MBMed | 9 962 | 29.33 | 7 159 | 2 831 | - | (4 327) | -60.45 |
| 1145 | LA-Health Medical Scheme | LA Focus | 36 171 | 25.51 | 10 263 | 6 709 | - | (3 554) | -34.63 |
| 1125 | Discovery Health Medical Scheme | Essential Smart | 25 872 | 32.81 | 3 810 | 614 | - | (3 195) | -83.88 |

Momentum Health is listed in both Tables 62 and 63 as the biggest loss-maker.

The Essential Smart option of Discovery Health Medical Scheme suffered the biggest loss in terms of the percentage of capitation fees paid (83.88%) followed by MBMed (60.45%), as shown in Table 63.

Table 64 lists the ten contracts on which schemes incurred the biggest losses in respect of their significant risk transfer arrangements, with comparative 2017 figures. Two MMI Health contracts feature on this list, as well as two Dental Risk Company contracts.

Table 64: Contracts with the highest risk transfer losses (2017 and 2018)

| Ref. no. | Name of medical scheme | Contract name | 2018 | | | | | 2017 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Capitation fees | Estimated recoveries | Profit/(loss) sharing | Net income/ (expense) | Net income/ (expense) as % of capitation fees | Capitation fees | Estimated recoveries | Profit/(loss) sharing | Net income/ (expense) expense | Net income/ (expense) as % of capitation fees |
| | | | R'000 | R'000 | R'000 | R'000 | % | R'000 | R'000 | R'000 | R'000 | % |
| 1167 | Momentum Health | MMI Health (Pty) Ltd | 266 463 | 204 192 | - | (62 271) | (23.37) | 230 697 | 189 367 | - | (41 330) | (17.92) |
| 1125 | Discovery Health Medical Scheme | Centre for Diabetes And Endocrinology (Pty) Ltd | 172 143 | 154 341 | - | (17 802) | (10.34) | 164 561 | 148 843 | - | (15 718) | (9.55) |
| 1167 | Momentum Health | MMI Health (Pty) Ltd | 266 463 | 204 192 | - | (62 271) | (23.37) | 230 697 | 189 367 | - | (41 330) | (17.92) |
| 1087 | Keyhealth | Dental Information Systems (Pty) Ltd | 63 184 | 56 176 | (222) | (7 230) | (11.44) | 62 313 | 56 768 | (290) | (5 836) | (9.37) |
| 1486 | Sizwe Medical Fund | IHAMCO (Previously known as UDIPA) | 40 527 | 34 577 | - | (5 950) | (14.68) | 43 445 | 39 374 | - | (4 071) | (9.37) |
| 1591 | Impala Medical Plan | Impala Medical Services | 163 614 | 158 620 | - | (4 994) | (3.05) | 149 554 | 152 249 | - | 2 694 | 1.80 |
| 1486 | Sizwe Medical Fund | East Cape Medical Business Systems (Pty) Ltd | 10 515 | 5 835 | - | (4 680) | (44.51) | 9 190 | 8 130 | - | (1 060) | (11.53) |
| 1039 | MBMed Medical Aid Fund | Preferred Provider Negotiators (Pty) Ltd | 5 639 | 970 | - | (4 669) | (82.80) | 5 443 | 1 368 | - | (4 075) | (74.87) |
| 1145 | LA-Health Medical Scheme | Dental Risk Company (Pty) Ltd | 13 611 | 9 875 | - | (3 735) | (27.44) | 11 691 | 8 398 | - | (3 294) | (28.17) |
| 1125 | Discovery Health Medical Scheme | Dental Risk Company (Pty) Ltd | 130 452 | 126 964 | - | (3 488) | (2.67) | 122 895 | 120 283 | - | (2 612) | (2.13) |

## Accredited managed healthcare services (no transfer of risk)

Accredited managed healthcare services increased by 7.06% to R4.33 billion in 2018 from R4.04 billion in 2017. In 2018, 8 807 190 average beneficiaries (or 98.77% of beneficiaries) were covered by these managed healthcare arrangements.

Table 65: Accredited managed healthcare service fees (no transfer of risk) for options with a claims ratio above 100.00% (2018)

| | Accredited managed healthcare services fees (no transfer of risk) | | Risk claims | | Beneficiaries | Number of options |
|---|---|---|---|---|---|---|
| | R'000 | pmpm | R'000 | % of RCI | | |
| Open schemes | 592 321 | 98.62 | 22 504 827 | 106.03 | 933 416 | 39 |
| Restricted schemes | 327 975 | 76.87 | 21 061 773 | 107.09 | 862 303 | 47 |
| All schemes | 920 296 | 89.58 | 43 566 600 | 106.54 | 1 795 719 | 86 |

*pmpm = per member per month*

*RCI = Risk Contribution Income*

Table 65 shows the number of benefit options with claims ratios greater than 100.00% and their expenditure on managed healthcare services. There were 86 options in this category, which accounted for 20.39% of beneficiaries in respect of whom such expenditure was incurred.

Table 66: Accredited managed healthcare services (no transfer of risk) of the ten largest schemes (2018)

| Ref. no. | Name of medical scheme | Type | Average beneficiaries | Claims ratio | Accredited managed healthcare services as % of RCI |
|---|---|---|---|---|---|
| 1125 | Discovery Health Medical Scheme | Open | 2 792 583 | 88.43 | 3.13 |
| 1598 | Government Employees Medical Scheme (GEMS) | Restricted | 1 813 320 | 85.64 | 2.04 |
| 1512 | Bonitas Medical Fund | Open | 713 190 | 91.12 | 3.06 |
| 1580 | South African Police Service Medical Scheme (POLMED) | Restricted | 502 996 | 102.12 | 1.51 |
| 1167 | Momentum Health | Open | 298 071 | 87.32 | 2.70 |
| 1279 | Bankmed | Restricted | 219 948 | 94.83 | 2.75 |
| 1149 | Medihelp | Open | 201 944 | 93.25 | 1.46 |
| 1252 | Bestmed Medical Scheme | Open | 197 088 | 89.06 | 2.39 |
| 1145 | LA-Health Medical Scheme | Restricted | 182 286 | 82.68 | 2.31 |
| 1140 | Medshield Medical Scheme | Open | 164 774 | 95.50 | 1.69 |

*RCI = Risk Contribution Income*

Table 66 depicts the ten largest schemes (by number of average beneficiaries) and shows their total expenditure on accredited managed healthcare services. The industry accredited managed healthcare services average was 2.50% of Risk Contribution Income (RCI).

# NON-HEALTHCARE EXPENDITURE

Non-healthcare expenditure refers to all other expenditure incurred by medical schemes that is not related to relevant healthcare services i.e. claims. It consists mainly of administration expenditure, broker costs and impaired receivables.

Curbing of increasing costs, elimination of fraud, waste and abuse as well as affordability of medical schemes have increasingly become an important consideration in the private healthcare sector. When medical schemes determine contributions, factors such as the claims experience of the scheme, operational costs and the level of reserving required, are taken into consideration. It is therefore essential to ensure that monies collected from members are directed at the appropriate interventions and expenditure, and that non-healthcare expenditure is managed judiciously.

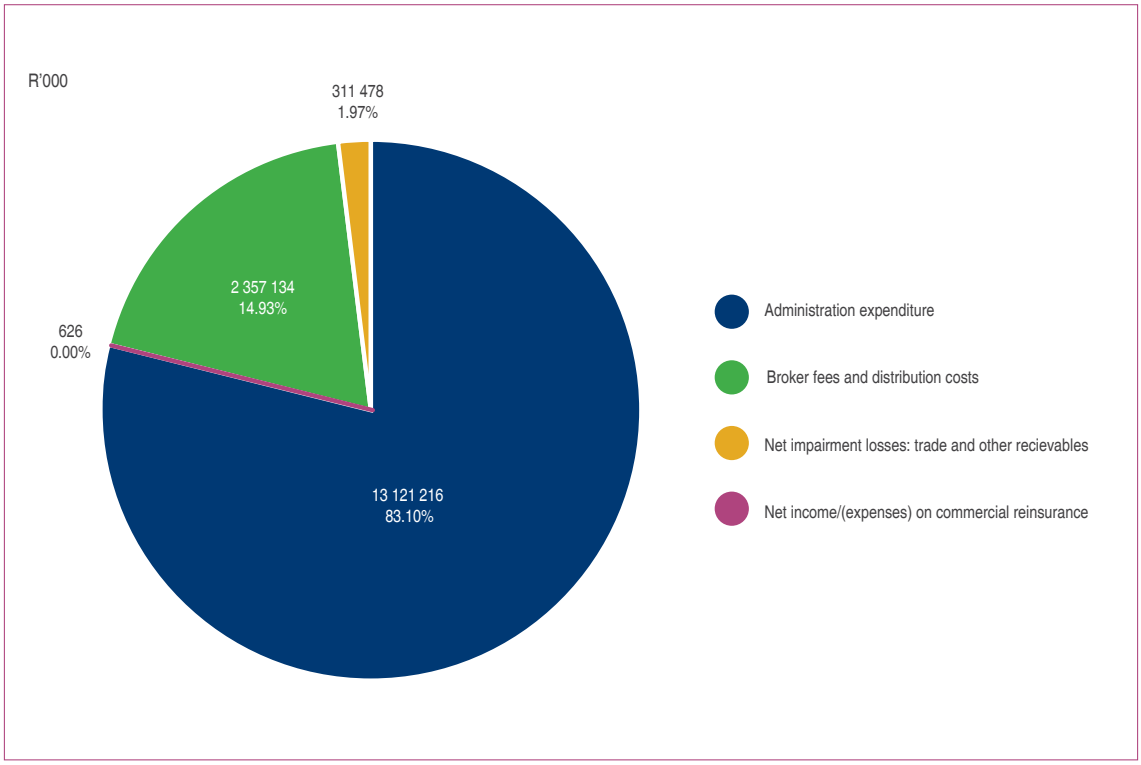



Figure 84: Distribution of non-healthcare expenditure of medical schemes

The gross non-healthcare expenditure for all medical schemes at the end of 2018 was reported at R15.79 billion, an increase of 5.01% from R15.04 billion in 2017.

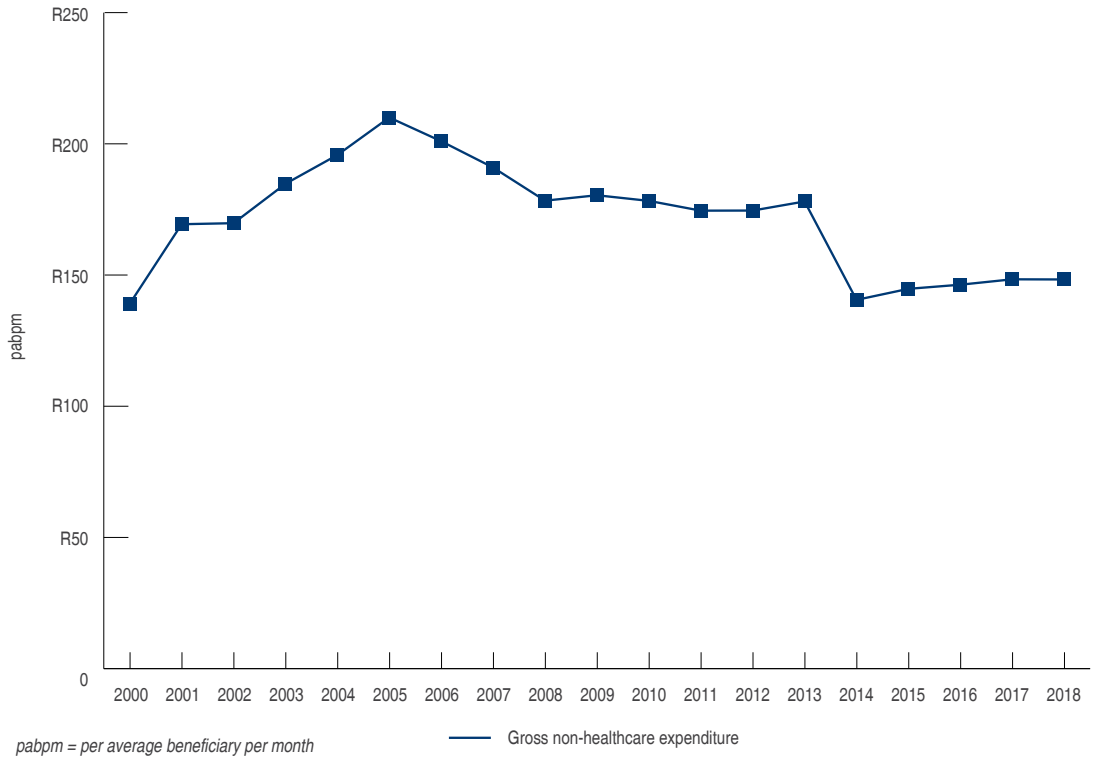



Figure 85: Gross non-healthcare expenditure (2000–2018) in 2018 prices



The rate of increase in non-healthcare expenditure has generally displayed a downward trend since 2005. In earlier years, this expenditure increased at rates that exceeded the rate of increase in contributions. In real terms, non-healthcare expenditure has reduced compared to earlier periods. There are, however, still individual schemes and components of non-healthcare expenditure – such as advertising and marketing, consulting and legal fees, and trustee remuneration – that continue to show marked increases that are higher than inflation and thus require attention. In recent years, the remuneration of trustees and Principal Officers of medical schemes has come under the spotlight, as well as the expenditure on Annual General Meetings (AGMs). There are instances where such expenditure can be deemed to be wastage of resources. In the interests of member protection, it is important that such expenditure is associated with a discernible value proposition.

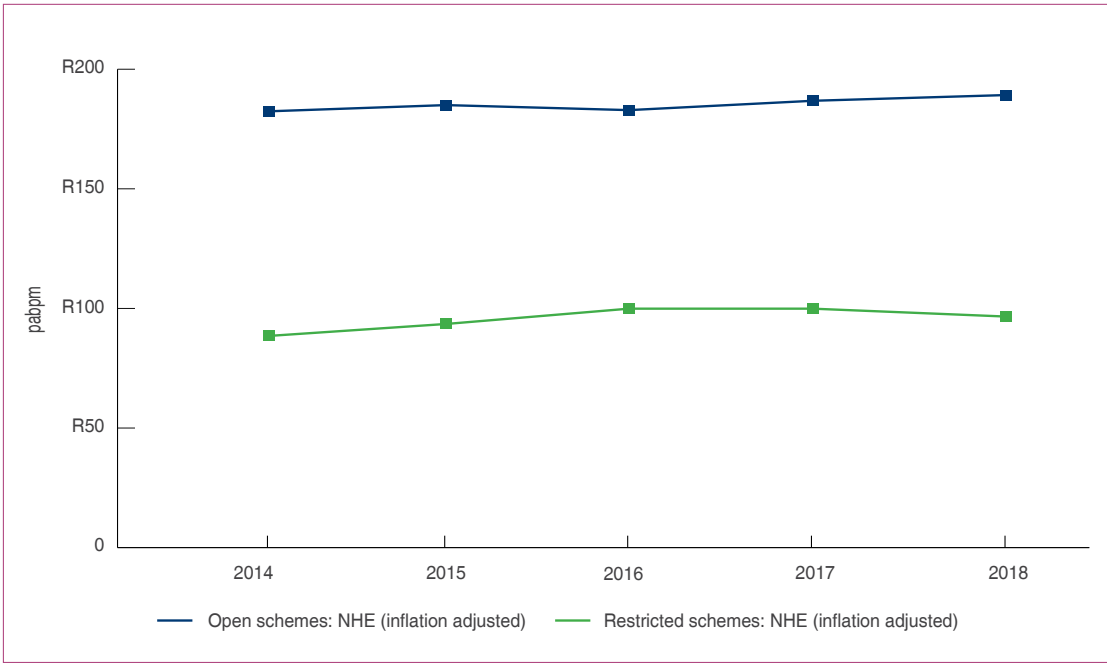



Figure 86: Non-healthcare expenditure in open and restricted schemes (2014–2018) in 2018 prices

Based on Figure 86, which shows a comparison of non-healthcare expenditure between open and restricted schemes, it is evident that expenditure in restricted schemes is much lower than in open schemes on a pabpm basis. This is partly because restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

## Administration expenditure

Administration expenditure, being the largest component of non-healthcare expenditure in all medical schemes, grew by 4.25% to R13.12 billion from R12.59 billion between December 2017 and December 2018. Open schemes increased their administration expenditure by 5.80% to R8.83 billion from R8.34 billion in 2017. Administration expenditure in restricted schemes increased by 1.18% from R4.24 billion in 2017 to R4.29 billion in 2018. A sharp decrease (up to just over 40.00%) in the expenditure of some restricted schemes was noted. The underlying reasons for this include changes in membership base.

Nine open schemes (representing 4.77% of all average beneficiaries) and eight restricted schemes (representing 4.75% of all average beneficiaries) had an overall administration expenditure greater than 10.00% of Gross Contribution Income (GCI) in 2018.

Tables 67 and 68 show the ten open schemes with the highest administration expenditure pabpm and pampm. A high cost per life covered is sometimes the function of a low average of beneficiaries rather than high absolute administration costs. Schemes need to be operating with a certain number of lives in order for the average operational costs to be lower and make the business more profitable and sustainable into the long term.

Table 67: Ten open schemes with the highest administration expenditure above industry average of R148.49 pabpm (2018)

| Ref. no. | Name of scheme | Name of administrator | Average beneficiaries | Administration expenditure | | |
|---|---|---|---|---|---|---|
| | | | | R'000 | pabpm R | % of GCI |
| 1141 | Spectramed | Agility Health (Pty) Ltd | 18 923 | 72 903 | 321.05 | 12.72 |
| 1446 | Selfmed Medical Scheme | Self-administered | 13 612 | 41 292 | 252.79 | 12.52 |
| 1575 | Resolution Health Medical Scheme | Agility Health (Pty) Ltd | 26 214 | 67 217 | 213.68 | 10.74 |
| 1486 | Sizwe Medical Fund | Sechaba Medical Solutions (Pty) Ltd | 112 201 | 269 445 | 200.12 | 11.54 |
| 1202 | Fedhealth Medical Scheme | Medscheme Holdings (Pty) Ltd | 143 200 | 338 925 | 197.23 | 9.54 |
| 1464 | Suremed Health | Momentum Thebe Ya Bophelo (Pty) Ltd | 2 449 | 5 585 | 190.04 | 10.10 |
| 1034 | Cape Medical Plan | Self-administered | 10 427 | 22 407 | 179.08 | 12.23 |
| 1087 | Keyhealth | Professional Provident Society Healthcare Administrators (Pty) Ltd | 69 569 | 149 343 | 178.89 | 7.01 |
| 1491 | Compcare Wellness Medical Scheme | Universal Healthcare Administrators (Pty) Ltd | 21 932 | 46 216 | 175.60 | 9.31 |
| 1554 | Genesis Medical Scheme | Self-administered | 21 837 | 40 185 | 153.35 | 12.13 |

*GCI = Gross Contribution Income*

*pabpm = per average beneficiary per month*

Table 68: Ten open schemes with the highest administration fees pampm (2018)

| Ref. no. | Name of scheme | Name of administrator | Average members | Administration fee pampm R |
|---|---|---|---|---|
| 1486 | Sizwe Medical Fund | Sechaba Medical Solutions (Pty) Ltd | 46 850 | 322.70 |
| 1125 | Discovery Health Medical Scheme | Discovery Health (Pty) Ltd | 1 335 093 | 304.33 |
| 1202 | Fedhealth Medical Scheme | Medscheme Holdings (Pty) Ltd | 72 286 | 282.09 |
| 1575 | Resolution Health Medical Scheme | Agility Health (Pty) Ltd | 14 116 | 245.69 |
| 1167 | Momentum Health | MMI Health (Pty) Ltd | 156 761 | 220.57 |
| 1491 | Compcare Wellness Medical Scheme | Universal Healthcare Administrators (Pty) Ltd | 13 906 | 219.36 |
| 1512 | Bonitas Medical Fund | Medscheme Holdings (Pty) Ltd | 331 955 | 202.98 |
| 1464 | Suremed Health | Momentum Thebe Ya Bophelo (Pty) Ltd | 1 210 | 201.35 |
| 1087 | Keyhealth | Professional Provident Society Healthcare Administrators (Pty) Ltd | 33 503 | 198.95 |
| 1141 | Spectramed | Agility Health (Pty) Ltd | 10 646 | 190.40 |

*pampm = per average member per month*

Tables 69 and 70 show the ten restricted schemes with the highest administration expenditure pabpm and pampm.



Table 69: Ten restricted schemes with the highest administration expenditure above industry average of R91.33 pabpm (2018)

| Ref. no. | Name of scheme | Name of administrator | Average beneficiaries | Administration expenditure | | |
|---|---|---|---|---|---|---|
| | | | | R'000 | pabpm R | % of GCI |
| 1043 | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | Sanlam Health Administrators (Pty) Ltd | 46 706 | 132 115 | 235.72 | 10.68 |
| 1194 | Profmed | Professional Provident Society Healthcare Administrators (Pty) Ltd | 71 042 | 192 546 | 225.86 | 11.54 |
| 1068 | De Beers Benefit Society | Self-administered | 9 977 | 21 783 | 181.94 | 7.09 |
| 1441 | Parmed Medical Aid Scheme | Medscheme Holdings (Pty) Ltd | 4 691 | 9 348 | 166.07 | 3.73 |
| 1523 | Grintek Electronics Medical Aid Scheme | Universal Healthcare Administrators (Pty) Ltd | 1 695 | 3 291 | 161.80 | 7.72 |
| 1237 | BP Medical Aid Society | MMI Health (Pty) Ltd | 3 669 | 6 648 | 151.00 | 7.04 |
| 1571 | Anglovaal Group Medical Scheme | Discovery Health (Pty) Ltd | 5 107 | 9 149 | 149.29 | 7.00 |
| 1012 | Anglo Medical Scheme | Discovery Health (Pty) Ltd | 18 466 | 31 535 | 142.31 | 5.96 |
| 1241 | Naspers Medical Fund | Discovery Health (Pty) Ltd | 8 613 | 14 567 | 140.94 | 7.98 |
| 1582 | Transmed Medical Fund | MMI Health (Pty) Ltd | 41 589 | 70 069 | 140.40 | 9.43 |

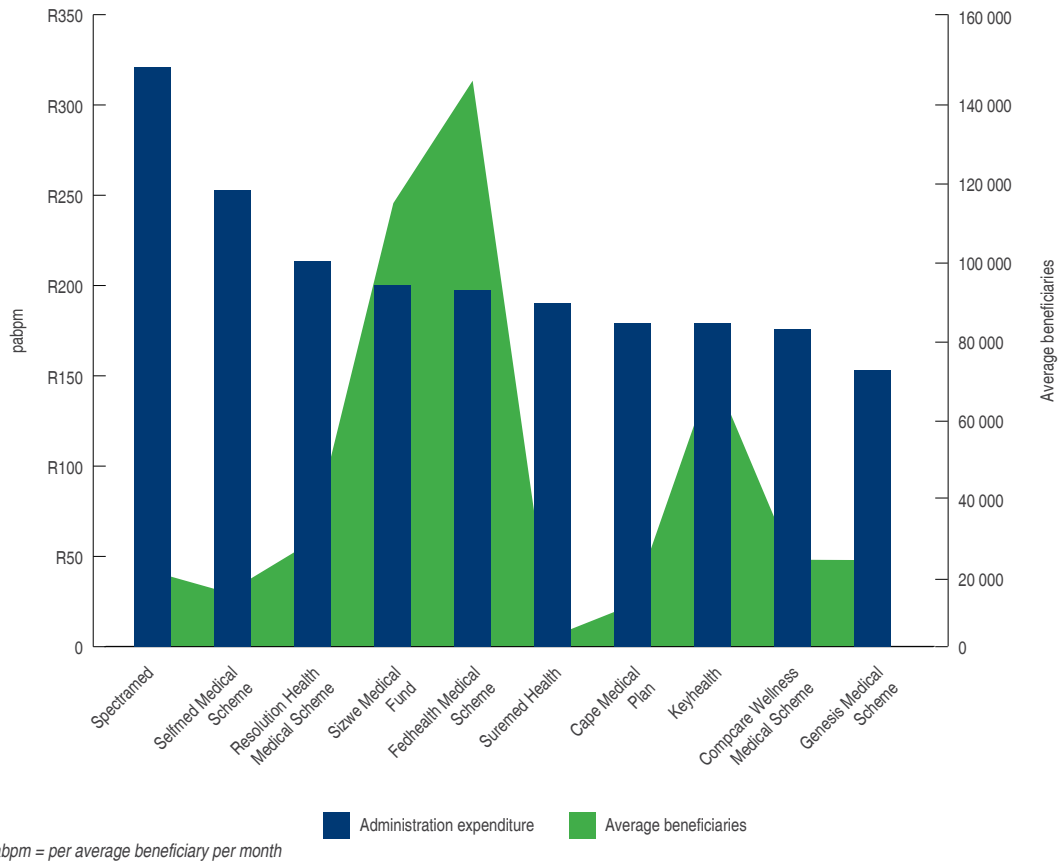
*GCI = Gross Contribution Income*

*pabpm = per average beneficiary per month*

Relative to the open and restricted schemes industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

Table 70: Ten restricted schemes with the highest administration fees pampm (2018)

| Ref. no. | Name of Scheme | Name of administrator | Average members | Administration fee pampm R |
|---|---|---|---|---|
| 1145 | LA-Health Medical Scheme | Discovery Health (Pty) Ltd | 74 124 | 292.39 |
| 1194 | Profmed | Professional Provident Society Healthcare Administrators (Pty) Ltd | 33 221 | 292.07 |
| 1043 | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | Sanlam Health Administrators (Pty) Ltd | 25 218 | 278.63 |
| 1520 | University of KwaZulu-Natal Medical Scheme | Discovery Health (Pty) Ltd | 3 445 | 269.41 |
| 1571 | Anglovaal Group Medical Scheme | Discovery Health (Pty) Ltd | 2 559 | 255.66 |
| 1523 | Grintek Electronics Medical Aid Scheme | Universal Healthcare Administrators (Pty) Ltd | 757 | 251.29 |
| 1241 | Naspers Medical Fund | Discovery Health (Pty) Ltd | 4 139 | 246.54 |
| 1441 | Parmed Medical Aid Scheme | Medscheme Holdings (Pty) Ltd | 2 362 | 242.23 |
| 1572 | Engen Medical Benefit Fund | Discovery Health (Pty) Ltd | 3 346 | 238.60 |
| 1590 | Building & Construction Industry Medical Aid Fund | Universal Healthcare Administrators (Pty) Ltd | 4 846 | 232.47 |




*pabpm = per average beneficiary per month*

Figure 87: Ten open schemes with the highest administration expenditure above industry average of R148.49 pabpm (2018)

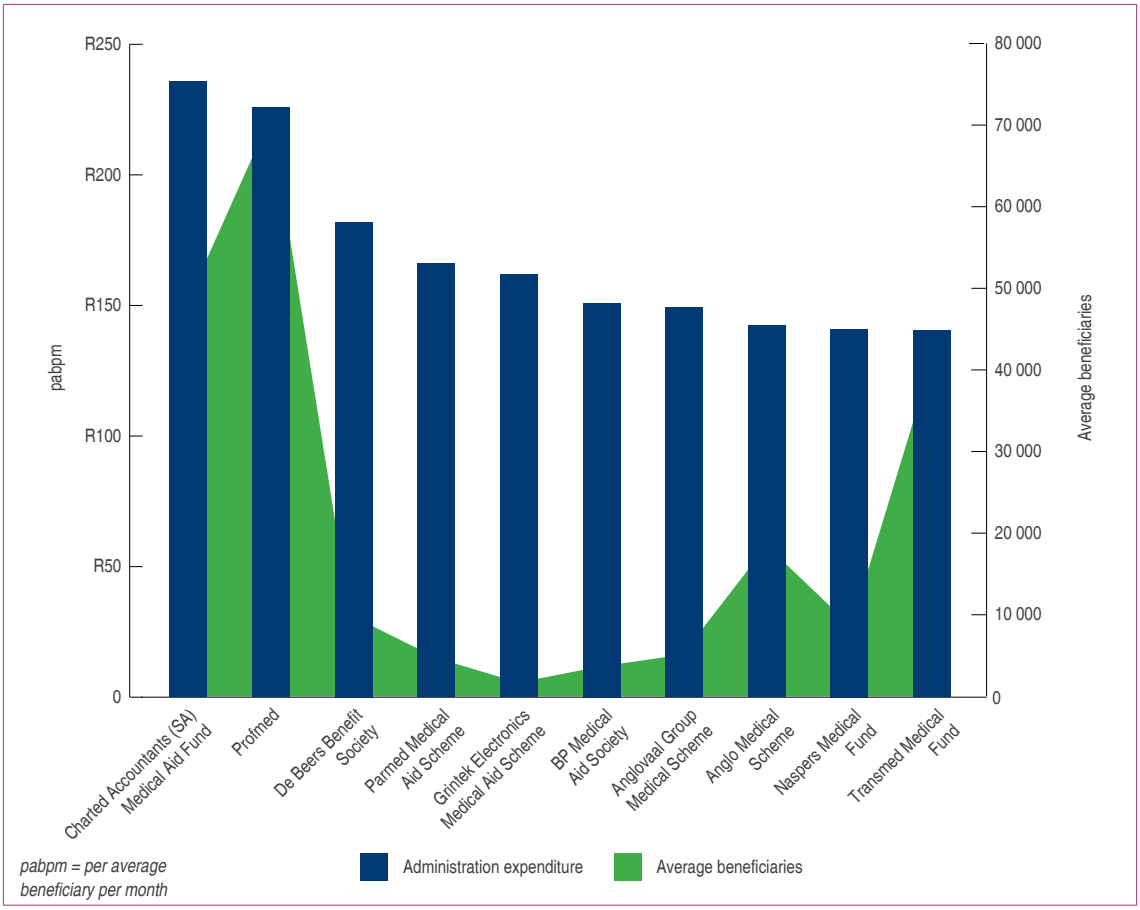



Figure 88: Ten restricted schemes with the highest administration expenditure above industry average of R91.33 pabpm (2018)

A complexity in the environment currently is that the definition of services provided by medical scheme administrators is not standardised. The bouquet of services offered by the administrators as both core and non-core administration services and related cost structures differs across entities. As such, these are not directly comparable. Circular 6 of 2019, published by the CMS, is an initial attempt to address this issue. The industry will be continually engaged.

However, based on the data submitted, whilst the services provided by the various administrators of schemes as well as the benefit option design may be variable, it was noted that there does not seem to be any correlation between the scheme size and the administration fees charged in the restricted scheme environment.

Table 71 shows the gross administration fees paid to third-party administrators. These fees are the sum of administration fees, co-administration fees, and other indirect fees paid to the administrator.

Table 71: Administration fees paid to third-party administrators pabpm (2017 and 2018)

| | Open schemes | | | Restricted schemes | | |
|---|---|---|---|---|---|---|
| | 2018 | 2017 | | 2018 | 2017 | |
| | pabpm R | pabpm R | % variance | pabpm R | pabpm R | % variance |
| Third party | | | | | | |
| Administration fees | 131.21 | 123.23 | 6.48 | 55.41 | 53.65 | 3.28 |
| Co-administration fees | - | - | - | 15.41 | 18.47 | -16.57 |
| **Total** | **131.21** | **123.23** | **6.48** | **63.14** | **62.89** | **0.40** |

On average, third-party-administered open schemes spent 107.81% more per beneficiary on administration fees than third-party-administered restricted schemes (2017: 95.95%). Administration and co-administration fees paid to third-party administrators were the main component of gross administration expenditure (GAE). They grew by 4.96% to R9.57 billion in 2018 from R9.12 billion in the previous year. These fees represented 70.45% of GAE in 2018 (2017: 80.97 %).

## Governance-related expenditure

Remuneration and other considerations of trustees and principal officers accounted for 0.67% of GAE. Table 72 and Figure 89 show the ten schemes with the highest average trustee fees. Figure 90 then shows the breakdown of trustee remuneration for the ten schemes with the highest remuneration. More details are contained in Annexure X.

Table 72: Ten schemes with highest trustee fees (2018)

| Ref. no. | Name of medical scheme | Type | Trustee remuneration and other considerations | | No. of trustees | | Average fee per trustee | |
|---|---|---|---|---|---|---|---|---|
| | | | 2018 | 2017 | | | 2018 | 2017 |
| | | | R'000 | R'000 | 2018 | 2017 | R'000 | R'000 |
| 1125 | Discovery Health Medical Scheme | Open | 9 756 | 7 834 | 8 | 10 | 1 220 | 783 |
| 1598 | Government Employees Medical Scheme (GEMS) | Restricted | 7 271 | 8 729 | 14 | 12 | 519 | 727 |
| 1580 | South African Police Service Medical Scheme (POLMED) | Restricted | 5 617 | 5 982 | 20 | 19 | 281 | 315 |
| 1486 | Sizwe Medical Fund | Open | 4 945 | 4 259 | 10 | 16 | 494 | 266 |
| 1140 | Medshield Medical Scheme | Open | 4 517 | 4 269 | 10 | 13 | 452 | 328 |
| 1537 | Hosmed Medical Aid Scheme | Open | 4 394 | 3 589 | 11 | 11 | 399 | 326 |
| 1194 | Profmed | Restricted | 4 298 | 3 870 | 14 | 13 | 307 | 298 |
| 1512 | Bonitas Medical Fund | Open | 4 079 | 4 495 | 10 | 13 | 408 | 346 |
| 1202 | Fedhealth Medical Scheme | Open | 3 958 | 3 637 | 9 | 10 | 440 | 364 |
| 1087 | Keyhealth | Open | 3 622 | 3 303 | 14 | 11 | 259 | 300 |

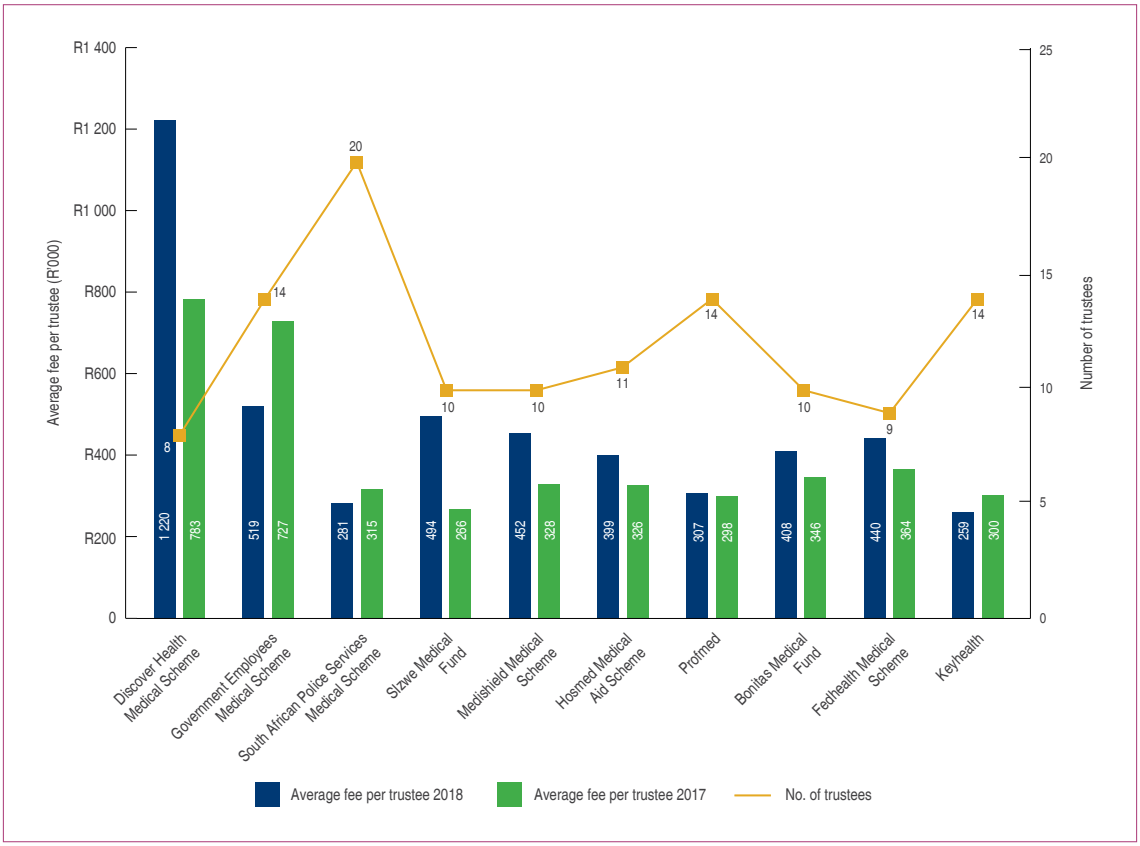



Figure 89: Average trustee fees of the ten schemes with the highest trustee fees (2017 and 2018)

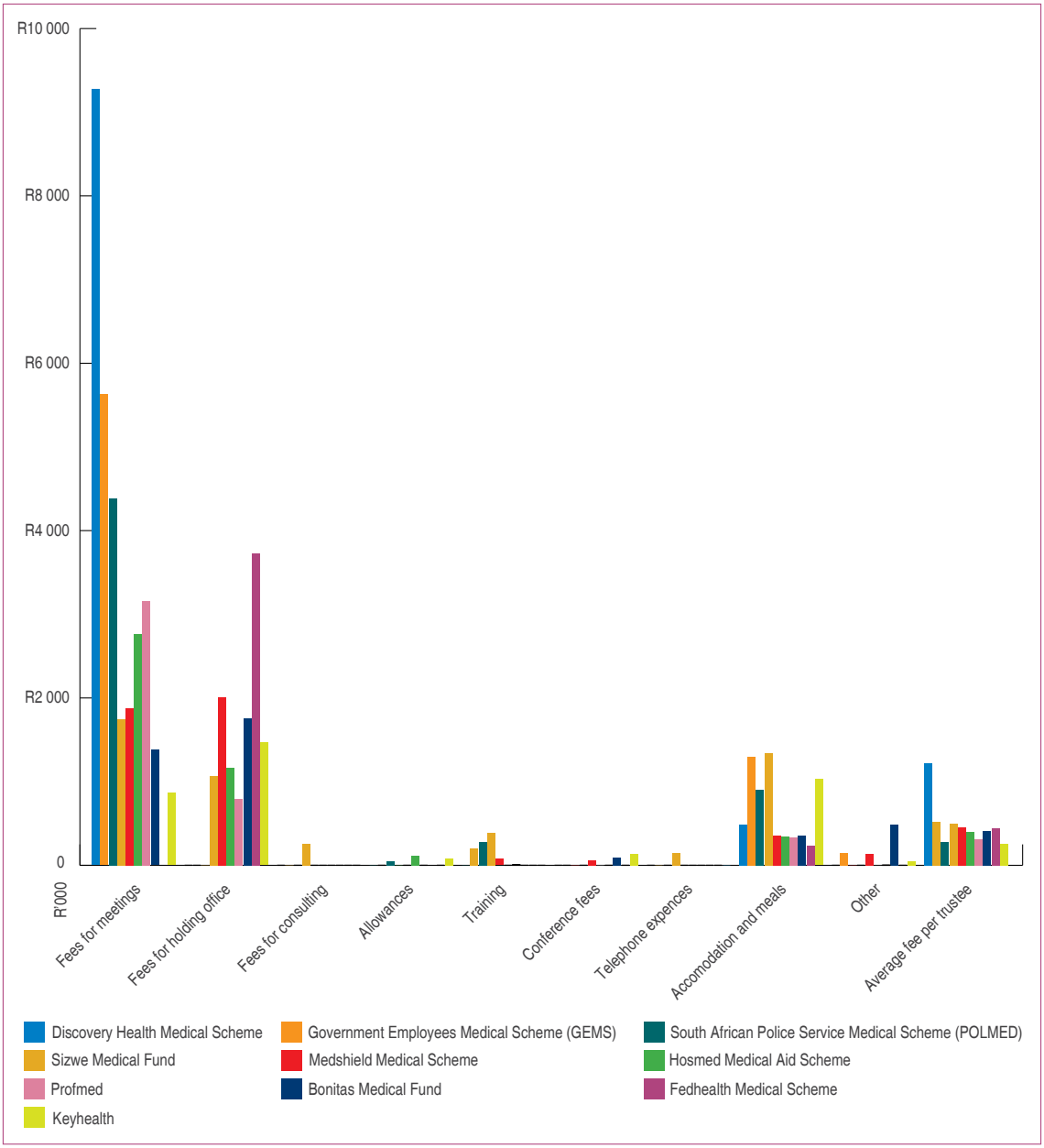



Figure 90: Composition of trustee remuneration for the ten schemes with the highest remuneration in 2018

The remuneration of principal officers of medical schemes amounted to 0.91% of GAE in 2018, and the fees of principal officers amounted to 0.58% of GAE in open schemes (2017: 0.69%) and 1.57% in restricted schemes (2017: 1.41%).

Table 73: Ten schemes with the highest remuneration for principal officers in 2018

| Ref. no. | Name of medical scheme | Average beneficiaries | Principal Officer remuneration | | |
|---|---|---|---|---|---|
| | | | 2018 R'000 | 2017 R'000 | % change |
| 1125 | Discovery Health Medical Scheme | 2 792 583 | 7 639 | 6 931 | 10.22 |
| 1598 | Government Employees Medical Scheme (GEMS) | 1 813 320 | 5 820 | 4 258 | 36.67 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 502 996 | 5 193 | 4 254 | 22.08 |
| 1512 | Bonitas Medical Fund | 713 190 | 5 113 | 4 993 | 2.40 |
| 1252 | Bestmed Medical Scheme | 197 088 | 5 038 | 11 907 | -57.69 |
| 1038 | SAMWUMed* | 75 554 | 4 412 | 2 541 | 73.63 |
| 1582 | Transmed Medical Fund | 41 589 | 4 113 | 3 931 | 4.62 |
| 1597 | Umvuzo Health Medical Scheme | 62 246 | 3 927 | 3 705 | 6.00 |
| 1145 | LA-Health Medical Scheme | 182 286 | 3 721 | 3 418 | 8.86 |
| 1194 | Profmed | 71 042 | 3 661 | 3 269 | 11.99 |

**Principal Officer remuneration includes curator fees*

Bestmed Medical Scheme's Principal Officer remuneration for 2017 included a severance payment of R6.5 million to the previous Principal Officer.

Table 74: Top ten open schemes with the highest governance-related* expenditure in 2018 (pabpm)

| Ref. no. | Name of medical scheme | Average beneficiaries | PO fees R'000 | Legal fees R'000 | Consulting fees R'000 | Trustee remunera-tion R'000 | Investiga-tion fees (fraud and other) R'000 | Total governance-related expenditure pabpm |
|---|---|---|---|---|---|---|---|---|
| 1464 | Suremed Health | 2 449 | 604 | - | - | 1 046 | - | 56.15 |
| 1446 | Selfmed Medical Scheme | 13 612 | 1 816 | - | 1 844 | 1 298 | - | 30.35 |
| 1575 | Resolution Health Medical Scheme | 26 214 | 3 625 | - | 194 | 1 886 | - | 18.13 |
| 1491 | Compcare Wellness Medical Scheme | 21 932 | 1 700 | - | 219 | 2 676 | - | 17.46 |
| 1554 | Genesis Medical Scheme | 21 837 | 2 449 | 134 | 1 369 | 452 | - | 16.81 |
| 1141 | Spectramed | 18 923 | 1 113 | - | 984 | 1 343 | - | 15.15 |
| 1537 | Hosmed Medical Aid Scheme | 61 759 | 2 921 | 901 | 3 008 | 4 394 | - | 15.15 |
| 1034 | Cape Medical Plan | 10 427 | 1 074 | 209 | 18 | 411 | - | 13.68 |
| 1466 | Makoti Medical Scheme | 6 641 | 325 | - | - | 556 | - | 11.06 |
| 1486 | Sizwe Medical Fund | 112 201 | 2 700 | 1 641 | 2 147 | 4 945 | 728 | 9.03 |

** For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in "governance-related expenditure".*

Table 75: Top ten restricted schemes with the highest governance related* expenditure in 2018 (pabpm)

| Ref. no. | Name of medical scheme | Average beneficiaries | PO fees R'000 | Legal fees R'000 | Consulting fees R'000 | Trustee remuneration R'000 | Investigation fees (fraud and other) R'000 | Total governance-related expenditure pabpm |
|---|---|---|---|---|---|---|---|---|
| 1237 | BP Medical Aid Society | 3 669 | 698 | 421 | - | 372 | - | 33.87 |
| 1012 | Anglo Medical Scheme | 18 466 | 2 184 | 2 109 | - | 1 198 | - | 24.78 |
| 1441 | Parmed Medical Aid Scheme | 4 691 | 921 | - | 10 | 32 | 71 | 18.37 |
| 1568 | Sisonke Health Medical Scheme | 18 251 | 2 473 | 1 277 | - | 109 | - | 17.62 |
| 1186 | PG Group Medical Scheme | 3 111 | 631 | - | - | - | - | 16.89 |
| 1547 | Malcor Medical Scheme | 11 463 | 524 | 1 602 | - | 46 | - | 15.79 |
| 1068 | De Beers Benefit Society | 9 977 | 1 271 | 62 | 98 | 412 | - | 15.40 |
| 1579 | Tsogo Sun Group Medical Scheme | 11 265 | - | 1 925 | - | - | - | 14.24 |
| 1038 | SAMWUMed | 75 554 | 4 412 | - | 2 941 | 593 | 3 733 | 12.88 |
| 1571 | Anglovaal Group Medical Scheme | 5 107 | - | 764 | - | - | - | 12.47 |

** For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in "governance related expenditure"*



Table 76: Ten schemes with the highest Annual General Meeting costs in 2018

| Ref. no. | Name of medical scheme | Average members | | Annual General Meeting Costs | | | |
|---|---|---|---|---|---|---|---|
| | | 2018 | 2017 | 2018 R'000 | 2017 R'000 | 2018 pampm R | 2017 pampm R |
| 1537 | Hosmed Medical Aid Scheme | 23 052 | 24 403 | 7 653 | 528 | 27.66 | 1.80 |
| 1125 | Discovery Health Medical Scheme | 1 335 093 | 1 305 219 | 4 271 | 9 989 | 0.27 | 0.64 |
| 1512 | Bonitas Medical Fund | 331 955 | 339 003 | 3 547 | 1 772 | 0.89 | 0.44 |
| 1486 | Sizwe Medical Fund | 46 850 | 48 489 | 2 349 | 4 632 | 4.18 | 7.96 |
| 1038 | SAMWUMed | 33 644 | 36 396 | 1 037 | 997 | 2.57 | 2.28 |
| 1598 | Government Employees Medical Scheme (GEMS) | 695 531 | 690 072 | 1 026 | - | 0.12 | - |
| 1140 | Medshield Medical Scheme | 81 456 | 77 008 | 778 | 2 245 | 0.80 | 2.43 |
| 1252 | Bestmed Medical Scheme | 93 635 | 94 751 | 731 | 893 | 0.65 | 0.79 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 175 954 | 175 609 | 669 | 950 | 0.32 | 0.45 |
| 1149 | Medihelp | 92 884 | 91 665 | 544 | 623 | 0.49 | 0.57 |

## Broker costs

Broker costs include all broker service fees (or broker commissions) and other distribution costs. Broker costs increased by 8.32% from R2.18 billion in 2017 to R2.36 billion in 2018 (2017: 9.6%). Broker costs represented 14.93% of total non-healthcare expenditure in 2018, while accounting for 14.47% in 2017.

For schemes that pay broker service fees, the amounts paid on a per average member per month (pampm) basis increased to R72.75 pampm in 2018 from R68.09 pampm in 2017, representing an increase of 6.84%. Broker service fees as a percentage of GCI increased slightly from 1.21% in 2017 to 1.23% in 2018.

Figure 91 shows annual broker service fees paid by open schemes since 2000, as well as their percentage of total non-healthcare expenditure.

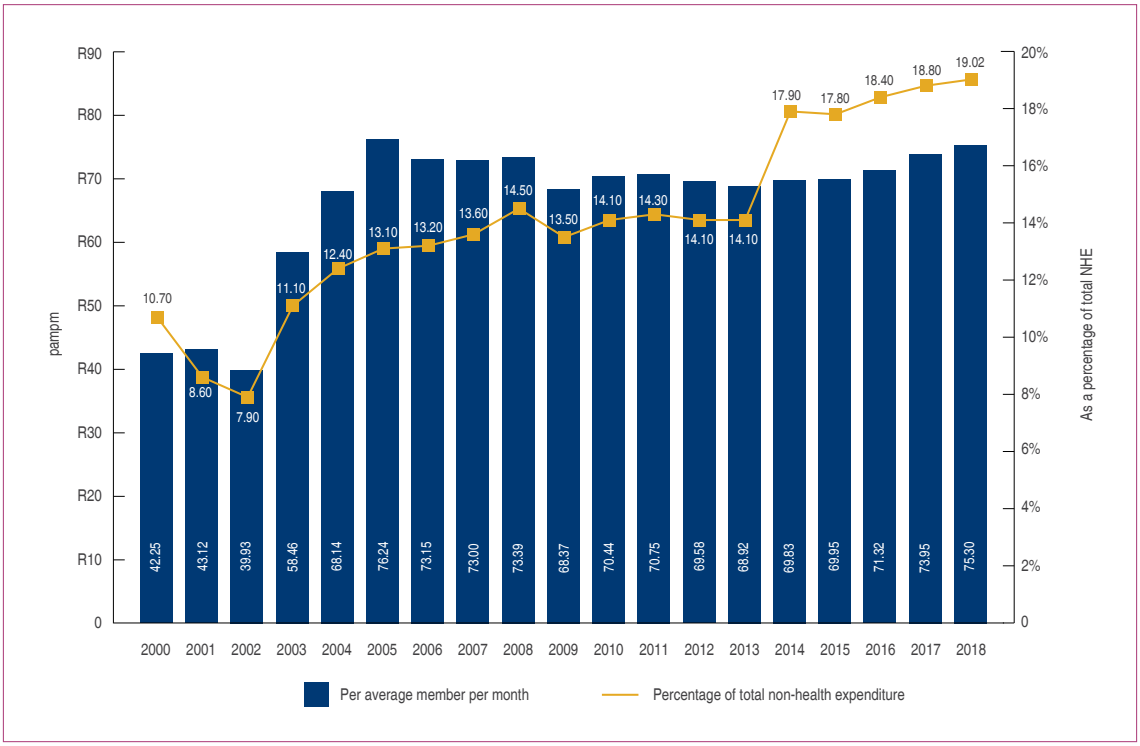



Figure 91: Broker service fees – open schemes (2000–2018)

Figure 92 illustrates the increase in broker service fees relative to the number of members of schemes that pay brokers.

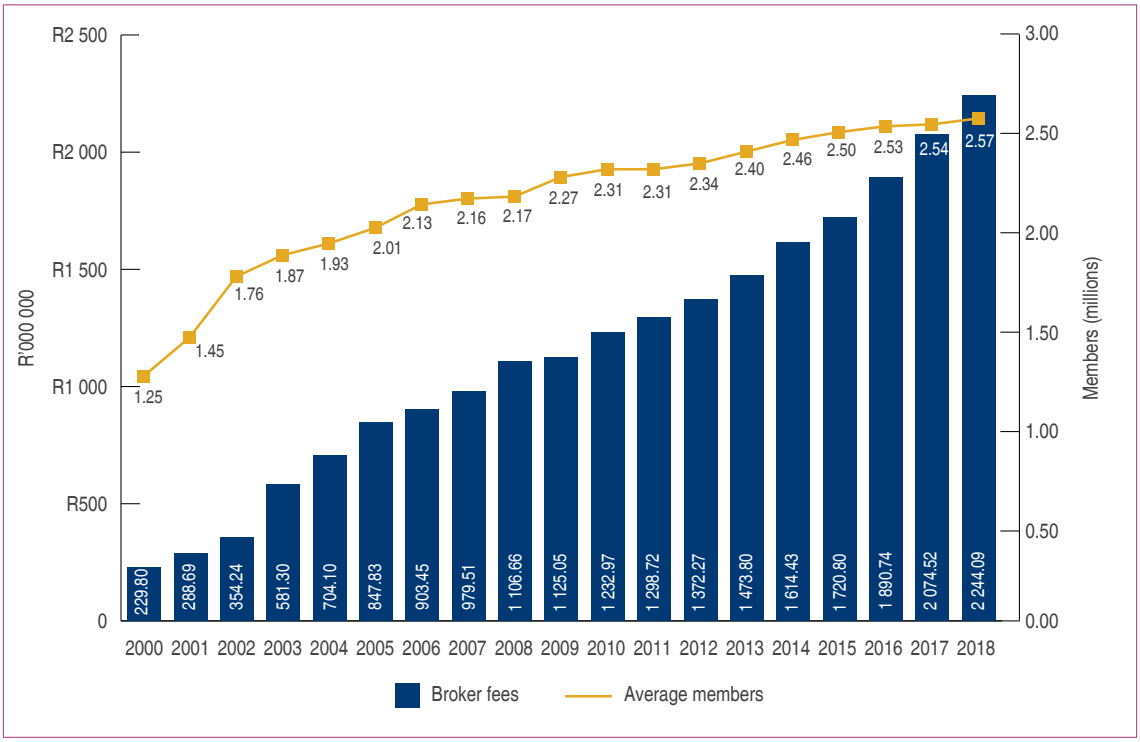



Figure 92: Broker service fees and scheme membership (2000–2018)

Table 77 illustrates the schemes which had broker service fees that were higher than the industry average of R72.75 pampm during 2018 (2017: R68.09 pampm). These five schemes (2017: 6) represented 70.46% (2017: 70.28%) of total membership that paid for broker service fees, and 77.99% (2017: 78.21%) of total broker service fees paid. One of these schemes paid at a level of 21.50% greater than the industry average.

Table 77: Schemes with broker fees above the industry average of R72.75 pampm (2018 and 2017)

| | | | Broker service fees* | | | Other distribution fees | | |
|---|---|---|---|---|---|---|---|---|
| Ref. no. | Name of medical scheme | Type | 2018 pampm R | 2017 pampm R | % change | 2018 pampm R | 2017 pampm R | % change |
| 1537 | Hosmed Medical Aid Scheme | Open | 88.39 | 80.25 | 10.14 | - | - | - |
| 1145 | LA-Health Medical Scheme | Restricted | 82.86 | 77.17 | 7.37 | - | - | - |
| 1125 | Discovery Health Medical Scheme | Open | 82.00 | 77.52 | 5.78 | - | - | - |
| 1486 | Sizwe Medical Fund | Open | 75.96 | 71.24 | 6.63 | - | - | - |
| 1512 | Bonitas Medical Fund | Open | 74.21 | 69.13 | 7.35 | - | - | - |

*pampm = per average member per month*

**Excluding distribution costs*

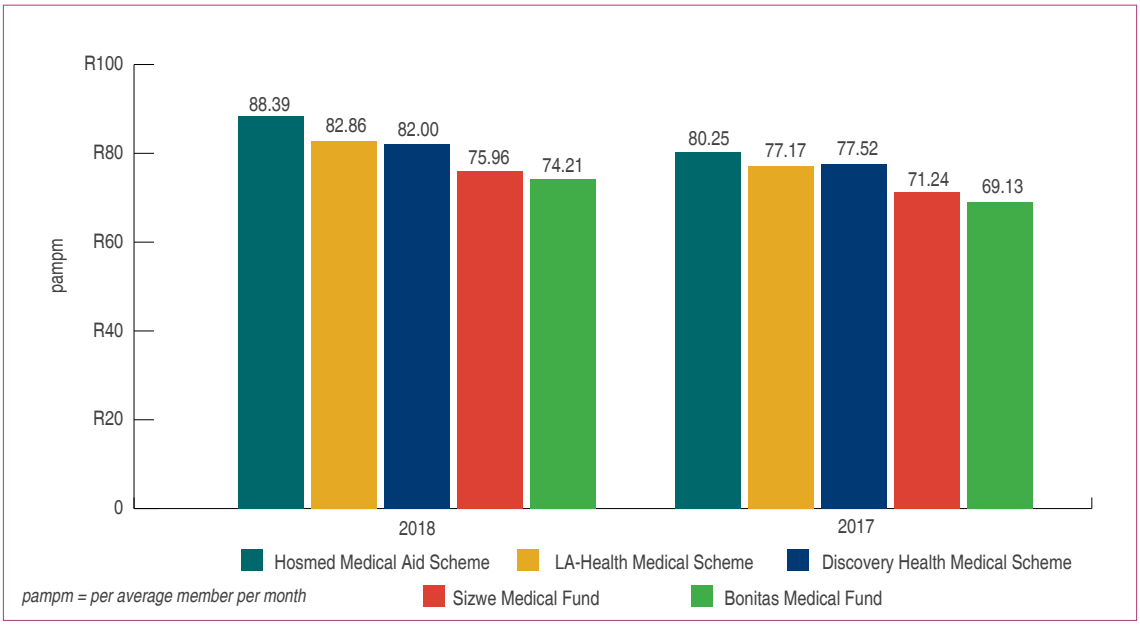



Figure 93: Schemes with broker fees above the industry average of R72.75 pampm (2018 and 2017)

## Reinsurance results

There were no schemes with reinsurance contracts in place in 2017. There was however one scheme, Thebemed, which had a reinsurance contract in place from 1 July 2018.

## Impaired receivables

Impaired receivables increased by 13.35% to R311.48 million for the year under review from R274.80 million in 2017. This represents 1.97% of total non-healthcare expenditure (1.83% in 2017).

It took schemes an average of 10.33 days to collect debts (contributions from their members) in 2018, a deterioration of 29.61% from 7.97 days in 2017. This equates to two days, meaning that it took medical schemes two days longer in 2018 to collect from members than it did in 2017. This collection period falls well outside the legal provisions which require that members pay all contributions to their medical schemes 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 94 shows the trend in impaired receivables over the past 19 years, also expressed as a percentage of total non-healthcare expenditure.

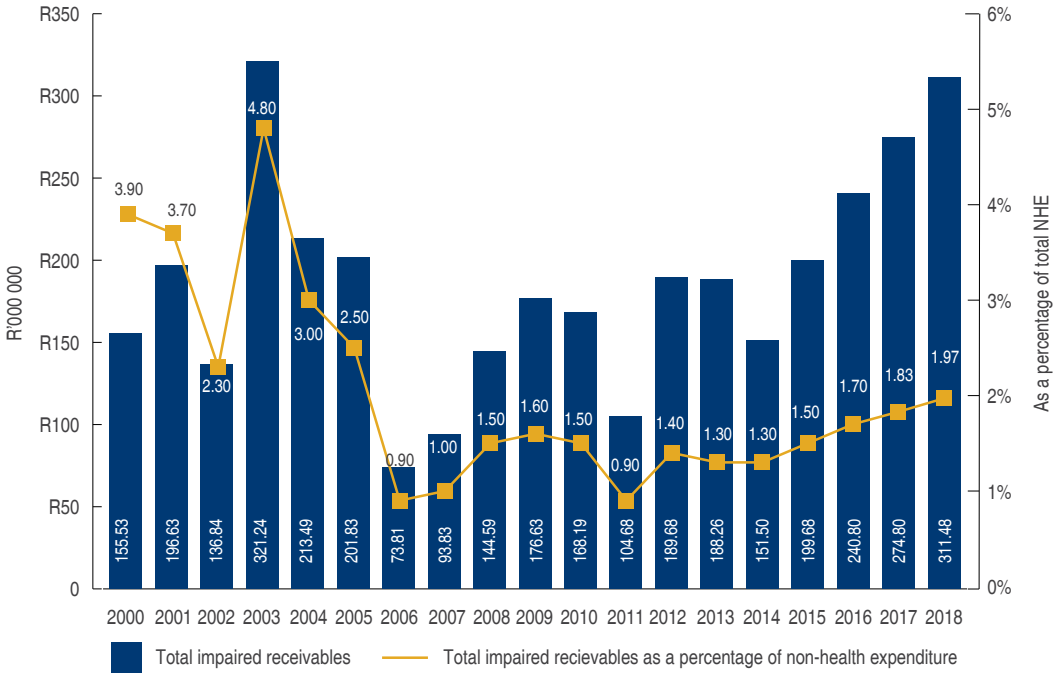



Figure 94: Impaired receivables (2000–2018)

## Fraud detection and prevention

Fraud, waste and abuse of resources is a perennial challenge in many sectors, including the healthcare sector. It is an area that has recently come under the spotlight, particularly against the backdrop of increasing costs.

Table 78 depicts monies spent by open and restricted schemes in respect of their fraud interventions, including investigating and identifying fraudulent claims as well as recoveries; and recovery administration fees paid to third parties. It should however be noted that a significant number of medical schemes have such fees included in the composite administration fee paid to third party administrators.

Table 78: Expenditure on fraud detection and prevention

| | Investigation fees (fraud) R'000 | Forensic recoveries R'000 | Third party recovery administration fees R'000 |
|---|---|---|---|
| Open schemes | (13 401) | 58 648 | (47 327) |
| Restricted schemes | (30 655) | 123 758 | (8 828) |
| **All schemes** | **(44 056)** | **182 406** | **(56 155)** |

## Trends in non-healthcare expenditure

Administration expenditure, which includes administration fees, trustee fees, principal officer fees and other operational expenditure incurred by medial schemes, was the main component of non-healthcare expenditure in 2018 at 83.10% (2017: 83.70%).

Administration expenditure accounted for 6.82% of GCI in 2018 (2017: 7.00%). Table 79 shows administration expenditure by type of scheme administration.

Table 79: Gross administration expenditure (GAE) (2000–2018) in 2018 prices

| | Open schemes | | | | Restricted schemes | | | |
|---|---|---|---|---|---|---|---|---|
| | Self -administered | | Third party | | Self -administered | | Third party | |
| | pabpm R | % change | pabpm R | % change | pabpm R | % change | pabpm R | % change |
| 2000 | 85.32 | 55.83 | 100.49 | 26.43 | 59.86 | 13.63 | 70.96 | 9.95 |
| 2001 | 132.95 | | 127.05 | | 68.02 | | 78.03 | |
| 2002 | 112.97 | -15.03 | 132.69 | 4.44 | 78.68 | 15.67 | 90.89 | 16.49 |
| 2003 | 132.47 | 17.27 | 140.25 | 5.69 | 67.12 | -14.68 | 96.24 | 5.89 |
| 2004 | 143.08 | 8.00 | 151.18 | 7.79 | 81.95 | 22.08 | 99.25 | 3.13 |
| 2005 | 145.50 | 1.69 | 158.84 | 5.07 | 76.03 | -7.22 | 113.52 | 14.37 |
| 2006 | 142.65 | -1.96 | 159.67 | 0.52 | 65.86 | -13.38 | 107.19 | -5.57 |
| 2007 | 143.73 | 0.76 | 155.27 | -2.76 | 68.27 | 3.67 | 97.78 | -8.78 |
| 2008 | 137.46 | -4.36 | 149.16 | -3.94 | 56.44 | -17.33 | 84.07 | -14.02 |
| 2009 | 143.73 | 4.56 | 152.64 | 2.33 | 60.26 | 6.76 | 85.22 | 1.37 |
| 2010 | 133.11 | -7.39 | 149.12 | -2.30 | 70.14 | 16.39 | 83.56 | -1.95 |
| 2011 | 124.94 | -6.14 | 150.51 | 0.93 | 69.30 | -1.20 | 80.78 | -3.33 |
| 2012 | 136.95 | 9.61 | 149.60 | -0.61 | 73.84 | 6.55 | 80.03 | -0.93 |
| 2013 | 141.35 | 3.21 | 147.59 | -1.34 | 72.69 | -1.55 | 81.14 | 1.40 |
| 2014 | 135.98 | -3.80 | 147.25 | -0.23 | 86.98 | 19.65 | 84.28 | 3.87 |
| 2015 | 150.33 | 10.56 | 147.76 | 0.35 | 79.21 | -8.93 | 90.81 | 7.75 |
| 2016 | 147.92 | -1.60 | 145.50 | -1.53 | 82.78 | 4.51 | 95.57 | 5.24 |
| 2017 | 144.30 | -4.02 | 148.18 | 0.29 | 82.08 | 3.63 | 95.75 | 5.44 |
| 2018 | 139.29 | -3.47 | 149.78 | 1.08 | 88.56 | 7.89 | 91.56 | -4.38 |

*pabpm = per average beneficiary per month*



Table 79 also shows that self-administered open schemes paid 57.28% (2017: 75.79%) more pabpm for administration expenditure than self-administered restricted schemes. Third-party-administered open schemes paid 63.59% (2017: 54.75%) more pabpm for administration expenditure than third-party-administered restricted schemes.

The variance in the GAE pabpm incurred by third-party and self-administered schemes is not significant in the restricted scheme industry. Third party administered open schemes, however, incurred 7.53% more GAE pabpm than their self-administered counterparts in 2018.

### *Open schemes*

During 2018, there were 6 self-administered open schemes (2017: 6), representing 609 682 average beneficiaries (2017: 603 767), and 15 third-party-administered open schemes (2016: 15), representing 4 343 974 average beneficiaries (2017: 4 327 146).

Self-administered open schemes experienced a real decrease of 3.47% in spending on administration expenditure (from R144.30 pabpm in 2017 to R139.29 pabpm in 2018) while third-party-administered open schemes increased their expenditure by 1.08% in real terms to R149.78 pabpm from R148.18 pabpm in 2017. Third-party-administered open schemes paid 7.53% more for administration expenditure than self-administered open schemes. The figure was 2.69% more in 2018.

### *Restricted schemes*

During 2018, there were 8 self-administered restricted schemes (2017: 8), representing 300 059 average beneficiaries (2017: 300 591), and 50 third-party-administered restricted schemes (2017: 52), representing 3 618 434 average beneficiaries (2017: 3 608 388).

Third-party-administered restricted schemes spent on average 3.39% more on administration expenditure at R91.56 pabpm compared to the R88.56 pabpm of self-administered restricted schemes (2017: 16.65%).

The GAE pabpm in the open scheme industry is however significantly higher than that of the restricted scheme industry. This is also reflected in the comparison between third party administered and self-administered schemes in the two industries. This is partly due to the fact that restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

Table 80 indicates the ten schemes with the highest marketing, advertising, and broker costs. The majority of these are open medical schemes. The table shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 0.71% from 2017 to 2018 (2016 to 2017: 1.15%). Member growth in this instance is not confined to new members who were not previously covered by a scheme as it includes members who moved from other schemes.

Figure 95 illustrates the information contained in Table 80.

Table 80: Ten schemes with highest marketing, advertising and broker costs (2018)

| Ref. no. | Name of medical scheme | Marketing, advertising and broker costs pampm | Net new member growth* % |
|---|---|---|---|
| | Industry average | 60.05 | 0.53 |
| 1167 | Momentum Health | 118.32 | 1.50 |
| 1537 | Hosmed Medical Aid Scheme | 88.39 | -7.30 |
| 1145 | LA-Health Medical Scheme | 82.87 | 12.40 |
| 1125 | Discovery Health Medical Scheme | 82.02 | 2.10 |
| 1486 | Sizwe Medical Fund | 76.33 | -1.30 |
| 1512 | Bonitas Medical Fund | 74.21 | -2.30 |
| 1140 | Medshield Medical Scheme | 71.82 | 4.10 |
| 1202 | Fedhealth Medical Scheme | 71.73 | 1.20 |
| 1422 | Topmed Medical Scheme | 68.64 | -10.40 |
| 1252 | Bestmed Medical Scheme | 66.83 | -1.40 |

*pampm = per average member per month*

**Net new member growth is calculated as the number of members at year-end compared to that of the previous year*

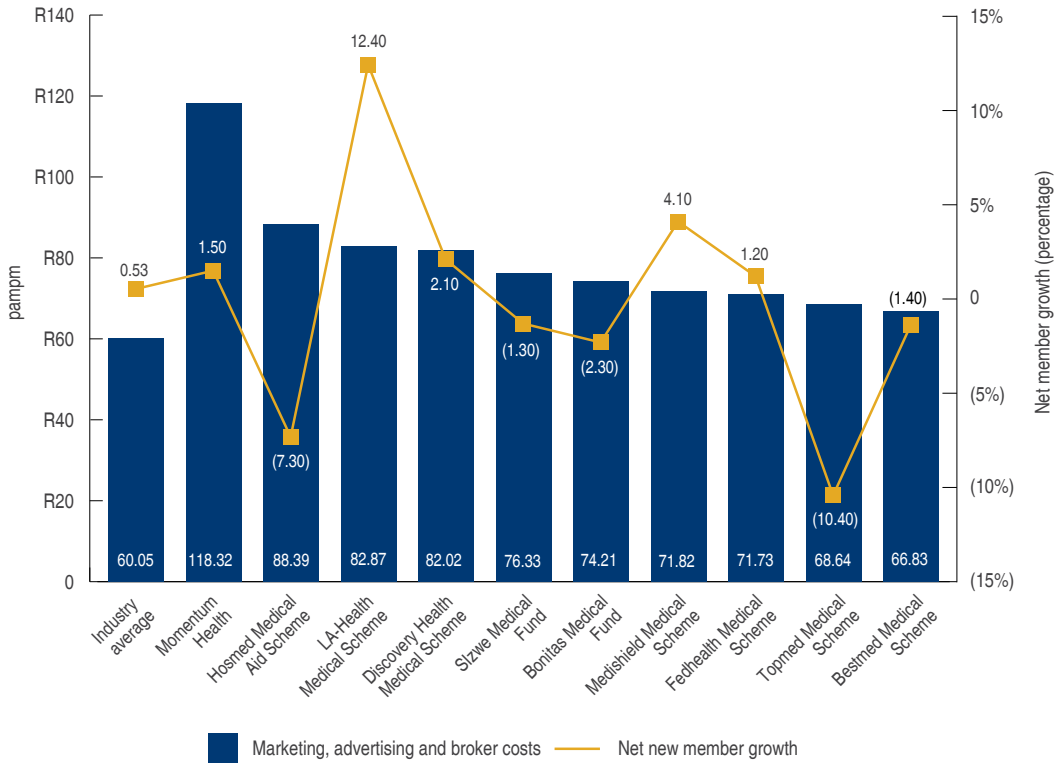



Figure 95: Ten schemes with the highest marketing, advertising and broker costs (2018) (pampm)

Tables 81 and 82 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 81: Open schemes with the highest marketing, advertising and broker expenditure (2018)*

| Ref. no. | Name of medical scheme | Marketing expenditure (including advertising) | | | Broker costs paid | | | Average members | | | Name of main advertising and marketing provider(s) | Expenditure per provider R'000 | % of total fees |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 pampm | 2017 pampm | % change | 2018 pampm | 2017 pampm | % change | 2018 | 2017 | % change | | | |
| 1167 | Momentum Health | - | - | - | 118.32 | 110.58 | 7.00 | 156 761 | 149 816 | 4.64 | *Ad hoc* expenditure | - | 0.00% |
| 1537 | Hosmed Medical Aid Scheme | 19.94 | 24.06 | -17.12 | 88.39 | 80.25 | 10.14 | 23 052 | 24 403 | -5.54 | *Ad hoc* expenditure | 235 | 4.26% |
| | | | | | | | | | | | Moralo Business Enterprise | 2 697 | 48.89% |
| | | | | | | | | | | | Kashan Advertising | 289 | 5.25% |
| | | | | | | | | | | | Print Joint | 2 295 | 41.60% |
| 1125 | Discovery Health Medical Scheme | 21.30 | 20.16 | 5.65 | 82.00 | 77.52 | 5.78 | 1 335 093 | 1 305 219 | 2.29 | Discovery Health (Pty) Ltd | 341 302 | 100.00% |
| 1486 | Sizwe Medical Fund | 56.09 | 35.81 | 56.63 | 75.96 | 71.24 | 6.63 | 46 850 | 48 489 | -3.38 | Ingenious Marketing | 9 140 | 28.99% |
| | | | | | | | | | | | Sechaba Medical Solutions (Pty) Ltd | 17 250 | 54.70% |
| | | | | | | | | | | | *Ad hoc* expenditure | 5 143 | 16.31% |
| 1512 | Bonitas Medical Fund | 41.76 | 40.82 | 2.30 | 74.21 | 69.13 | 7.35 | 331 955 | 339 003 | -2.08 | Afrocentric Distribution Services (Pty) Ltd | 165 355 | 99.41% |
| | | | | | | | | | | | *Ad hoc* expenditure | 982 | 0.59% |
| 1140 | Medshield Medical Scheme | 30.04 | 34.44 | -12.78 | 71.38 | 66.50 | 7.34 | 81 456 | 77 008 | 5.78 | Wellness Odyssey | 451 | 1.54% |
| | | | | | | | | | | | Bakubung (SABC Healthtalk) | 1 800 | 6.13% |
| | | | | | | | | | | | Meltwater and Stone Consulting | 503 | 1.71% |
| | | | | | | | | | | | Hi Performance Supplies | 3 213 | 10.94% |
| | | | | | | | | | | | Saints Brand and Design | 1 828 | 6.23% |
| | | | | | | | | | | | *Ad hoc* expenditure | 1 327 | 4.52% |
| | | | | | | | | | | | Kaya FM | 1 186 | 4.04% |
| | | | | | | | | | | | Wink Promotions | 1 360 | 4.63% |
| | | | | | | | | | | | Spacegrow Media | 8 767 | 29.86% |
| | | | | | | | | | | | Kaizer Chiefs | 3 895 | 13.26% |
| | | | | | | | | | | | Specialist Research | 2 533 | 8.62% |
| | | | | | | | | | | | Ntsumi Telecommunications | 2 477 | 8.43% |
| | | | | | | | | | | | Maverick Digital Labs | 25 | 0.08% |

| Ref. no. | Name of medical scheme | Marketing expenditure (including advertising) | | | Broker costs paid | | | Average members | | | Name of main advertising and marketing provider(s) | Expenditure per provider R'000 | % of total fees |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 pampm | 2017 pampm | % change | 2018 pampm | 2017 pampm | % change | 2018 | 2017 | % change | | | |
| 1202 | Fedhealth Medical Scheme | 78.30 | 56.24 | 39.22 | 71.39 | 65.14 | 9.59 | 72 286 | 72 203 | 0.11 | The Cheesed Has Moved (Pty) Ltd | 67 921 | 100.00% |
| 1422 | Topmed Medical Scheme | 50.36 | 40.17 | 25.37 | 68.34 | 65.74 | 3.95 | 19 414 | 21 093 | -7.96 | Fastpulse | 5 148 | 43.88% |
| | | | | | | | | | | | Intellegent Internet Solutions | 179 | 1.53% |
| | | | | | | | | | | | Med Aid Quote (Pty) Ltd | 317 | 2.71% |
| | | | | | | | | | | | *Ad hoc* expenditure | 1 171 | 9.98% |
| | | | | | | | | | | | Jellyfish Online Marketing SA (Pty) Ltd | 2 499 | 21.30% |
| | | | | | | | | | | | Hippo Comparision Services (Pty) Ltd – name changed from Digital Comparison Services | 2 416 | 20.60% |
| 1252 | Bestmed Medical Scheme | 31.15 | 24.08 | 29.36 | 66.60 | 61.97 | 7.47 | 93 635 | 94 751 | -1.18 | Accommodation Options Events | 1 430 | 4.09% |
| | | | | | | | | | | | University of Pretoria | 3 482 | 9.95% |
| | | | | | | | | | | | University of the Western Cape | 130 | 0.37% |
| | | | | | | | | | | | Baviaans to Bay Adventures T/A St Francis Sport | 100 | 0.29% |
| | | | | | | | | | | | Blue Stream Research | - | 0.00% |
| | | | | | | | | | | | Active Brands Communication | 230 | 0.66% |
| | | | | | | | | | | | ASG Event Solutions | 4 965 | 14.18% |
| | | | | | | | | | | | MPJ Stationery Supplies and Projects | 1 781 | 5.09% |
| | | | | | | | | | | | Promo Distributors | 626 | 1.79% |
| | | | | | | | | | | | Tuks Sport | 817 | 2.33% |
| | | | | | | | | | | | Independent Agency Search and Selection Company (IAS) | 492 | 1.41% |
| | | | | | | | | | | | Nelson Mandela Metropolitan University | 955 | 2.73% |
| | | | | | | | | | | | Brandman Business Development | 1 047 | 2.99% |

| Ref. no. | Name of medical scheme | Marketing expenditure (including advertising) | | | Broker costs paid | | | Average members | | | Name of main advertising and marketing provider(s) | Expenditure per provider R'000 | % of total fees |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 pampm | 2017 pampm | % change | 2018 pampm | 2017 pampm | % change | 2018 | 2017 | % change | | | |
| 1252 | Bestmed Medical Scheme | 31.15 | 24.08 | 29.36 | 66.60 | 61.97 | 7.47 | 93 635 | 94 751 | -1.18 | BTI Branding Solutions - Rand Trust | 574 | 1.64% |
| | | | | | | | | | | | LJ van Zyl | 409 | 1.17% |
| | | | | | | | | | | | Promise Brand Specialists | 6 087 | 17.39% |
| | | | | | | | | | | | Signage Production Studio | 1 096 | 3.13% |
| | | | | | | | | | | | The Cycle Labuschagne Brothers | 608 | 1.74% |
| | | | | | | | | | | | The Old Shanghai Fire Cracker Company | 722 | 2.06% |
| | | | | | | | | | | | *Ad hoc* expenditure | 9 452 | 27.00% |
| 1575 | Resolution Health Medical Scheme | 56.11 | 45.21 | 24.11 | 61.15 | 61.19 | -0.07 | 14 116 | 14 758 | -4.35 | Agility Channel | 7 422 | 78.09% |
| | | | | | | | | | | | *Ad hoc* expenditure | 1 938 | 20.39% |
| | | | | | | | | | | | Martina Nicholson | 145 | 1.52% |
| | | | | | | | | | | | National Positions | - | 0.00% |
| 1592 | Thebemed | 44.49 | 25.64 | 73.52 | 60.06 | 55.15 | 8.90 | 11 549 | 11 287 | 2.32 | Momentum Thebe Ya Bophelo | 2 750 | 44.60% |
| | | | | | | | | | | | *Ad hoc* expenditure | 3 416 | 55.40% |
| | Open scheme industry average** | - | - | - | 79.30 | 74.30 | 6.73 | 2 371 521 | 2 345 402 | 1.11 | | | |

*pampm = per average member per month*

** Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees*

*** The industry averages are based only on those schemes which incurred the specific type of expenditure*

Table 82: Restricted schemes with the highest marketing, advertising and broker expenditure (2018)

| Ref. no. | Name of medical scheme | Marketing expenditure (including advertising) | | | Broker costs paid | | | Average members | | | Name of main advertising and marketing provider(s) | Expenditure per provider R'000 | % of total fees |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 pampm | 2017 pampm | % change | 2018 pampm | 2017 pampm | % change | 2018 | 2017 | % change | | | |
| 1145 | LA-Health Medical Scheme | 44.25 | 9.07 | 387.87 | 82.86 | 77.17 | 7.37 | 74 124 | 66 079 | 12.17 | *Ad hoc* expenditure | 491 | 1.25% |
| | | | | | | | | | | | Discovery Health (Pty) Ltd | 38 866 | 98.75% |
| 1597 | Umvuzo Health Medical Scheme | 60.53 | 55.54 | 8.98 | 58.52 | 47.79 | 22.45 | 29 391 | 27 666 | 6.24 | Rain Catchers | 21 348 | 100.00% |
| | | | | | | | | | | | *Ad hoc* expenditure | - | 0.00% |
| 1194 | Profmed | 55.55 | 45.24 | 22.79 | 26.63 | 25.68 | 3.70 | 33 221 | 32 665 | 1.70 | *Ad hoc* expenditure | 1 201 | 5.42% |
| | | | | | | | | | | | Condriac Digital | 1 912 | 8.63% |
| | | | | | | | | | | | EOH Mthombo | 361 | 1.63% |
| | | | | | | | | | | | Epic Communications | 612 | 2.76% |
| | | | | | | | | | | | ROI Africa | 126 | 0.57% |
| | | | | | | | | | | | YKnot Online | 275 | 1.24% |
| | | | | | | | | | | | *Ad hoc* expenditure | - | 0.00% |
| | | | | | | | | | | | StorkBrands | 635 | 2.87% |
| | | | | | | | | | | | Ebony and Ivory | 12 477 | 56.34% |
| | | | | | | | | | | | Faith and Fear | 4 548 | 20.54% |
| 1547 | Malcor Medical Scheme | 1.87 | 1.76 | 6.25 | 16.04 | 12.74 | 25.90 | 4 758 | 5 078 | -6.30 | *Ad hoc* expenditure | 107 | 100.00% |
| 1600 | Motohealth Care | 2.76 | 7.76 | -64.43 | 13.10 | 7.47 | 75.37 | 21 530 | 22 993 | -6.36 | *Ad hoc* expenditure | 713 | 100.00% |
| 1038 | SAMWUMed | 11.60 | 8.44 | 37.44 | 5.15 | 9.93 | -48.14 | 33 644 | 36 396 | -7.56 | *Ad hoc* expenditure | 4 683 | 100.00% |
| 1590 | Building & Construction Industry Medical Aid Fund | 19.93 | 15.06 | 32.34 | 3.06 | 0.73 | 319.18 | 4 846 | 4 643 | 4.37 | *Ad hoc* expenditure | 1 159 | 100.00% |
| | Restricted scheme industry average** | 0.10 | 22.40 | -99.55 | 44.20 | 37.70 | 17.24 | 906 548 | 885 958 | 2.32 | | | |

*pampm = per average member per month*

** Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees*

***The industry averages are based only in respect of those schemes which incurred the specific expenditure*

Table 83: Schemes paying marketing fees to administrator – five largest percentages

| Ref. no. | Name of medical scheme | Marketing component of administration fee | | Total marketing, advertising and broker costs |
|---|---|---|---|---|
| | | % | pampm | pampm |
| 1145 | LA-Health Medical Scheme | 14.94 | 43.68 | 82.87 |
| 1486 | Sizwe Medical Fund | 9.51 | 30.69 | 76.33 |
| 1125 | Discovery Health Medical Scheme | 7.00 | 21.30 | 82.02 |
| 1599 | Lonmin Medical Scheme | 3.00 | 1.90 | - |
| 1012 | Anglo Medical Scheme | 1.00 | 1.82 | - |

*pampm = per average member per month*

Figure 96 shows changes in the major categories of non-healthcare expenditure for the past 19 years. Total net non-healthcare expenditure rose by 5.01% from R15.04 billion in 2017 to R15.79 billion in 2018.

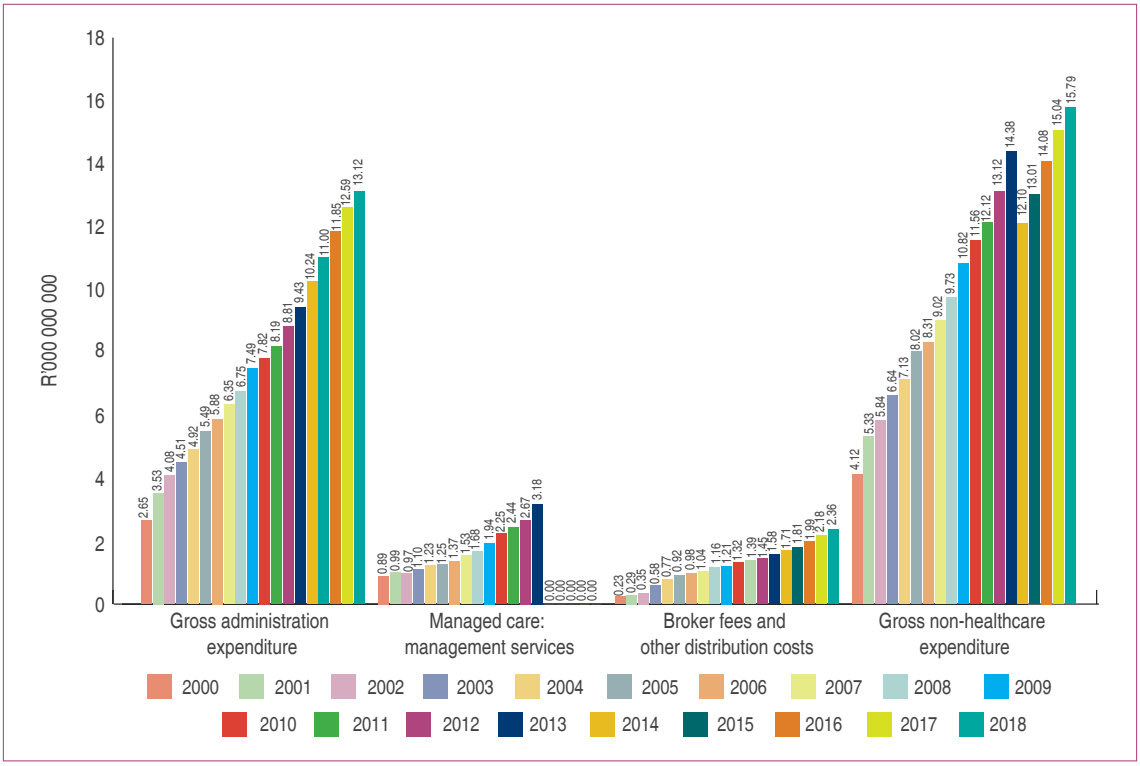



Figure 96: Changes in main components of non-healthcare expenditure (2000–2018)

Total gross non-healthcare expenditure has increased by 282.83% since 2000. This was driven by a 395.61% upswing in administration expenditure and an increase of 925.74% in broker costs.

By comparison, gross claims have risen by 537.67% (not adjusted for inflation) since 2000.

As illustrated in Figures 96 and 97 together with Table 84, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI) prior to 2006. The rate of increase was reversed in 2006[3] and since then there has been a real decrease[4] in non-healthcare expenditure, from R2 520.48 pabpa in 2005 to R1 779.78 pabpa 2018 (prices adjusted to 2018 prices).

In 2016, a circular was issued by the CMS in respect of reclassification of managed care i.e. all managed care services, with and without risk transfer, were reclassified as part of claims. Only the benefit management services of a non-healthcare nature are included in non-healthcare expenditure. This has had the effect of reducing non-healthcare expenditure, as can be clearly observed in Figure 97.

Non-healthcare expenditure decreased marginally (by 0.03%) to R1 779.78 pabpa in 2018 from R1 780.40 pabpa in 2017. The non-healthcare ratio (as a % of RCI) also decreased, from 9.23% in 2017, to 9.08% in 2018.

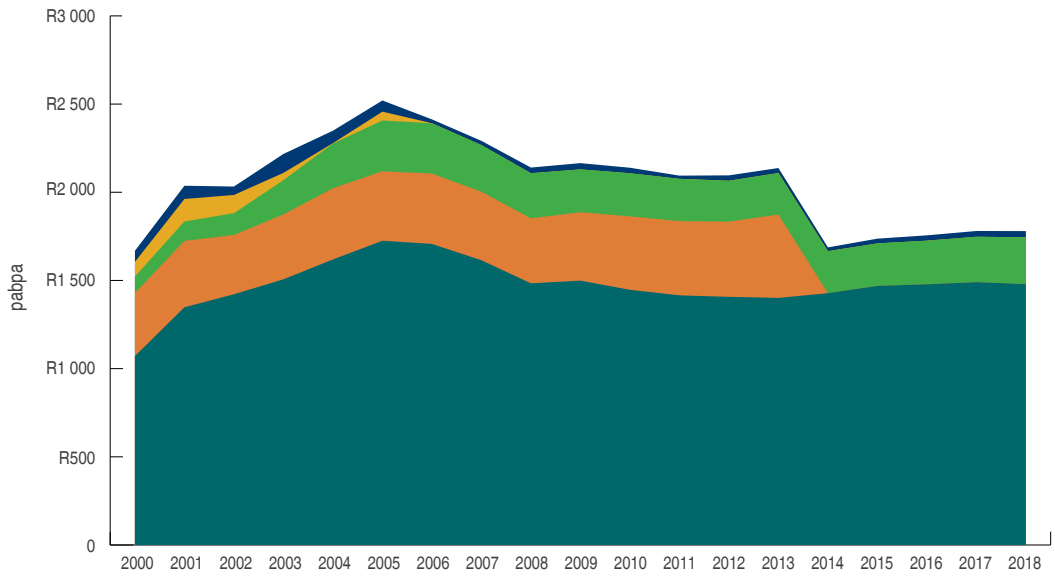



Figure 97: Non-healthcare expenditure pabpa (2000–2018) in 2018 prices

No significant changes were observed in the composition of NHE over the last three years. Administration expenditure is the biggest component of NHE (83.10%), followed by broker fees and other distribution costs (14.93%) and impaired receivables (1.97%).



3 *This can partly be explained by GEMS starting to operate in 2006.*

4 *The decrease between 2013 and 2014 is partially due to the reclassification of accredited managed healthcare services.*

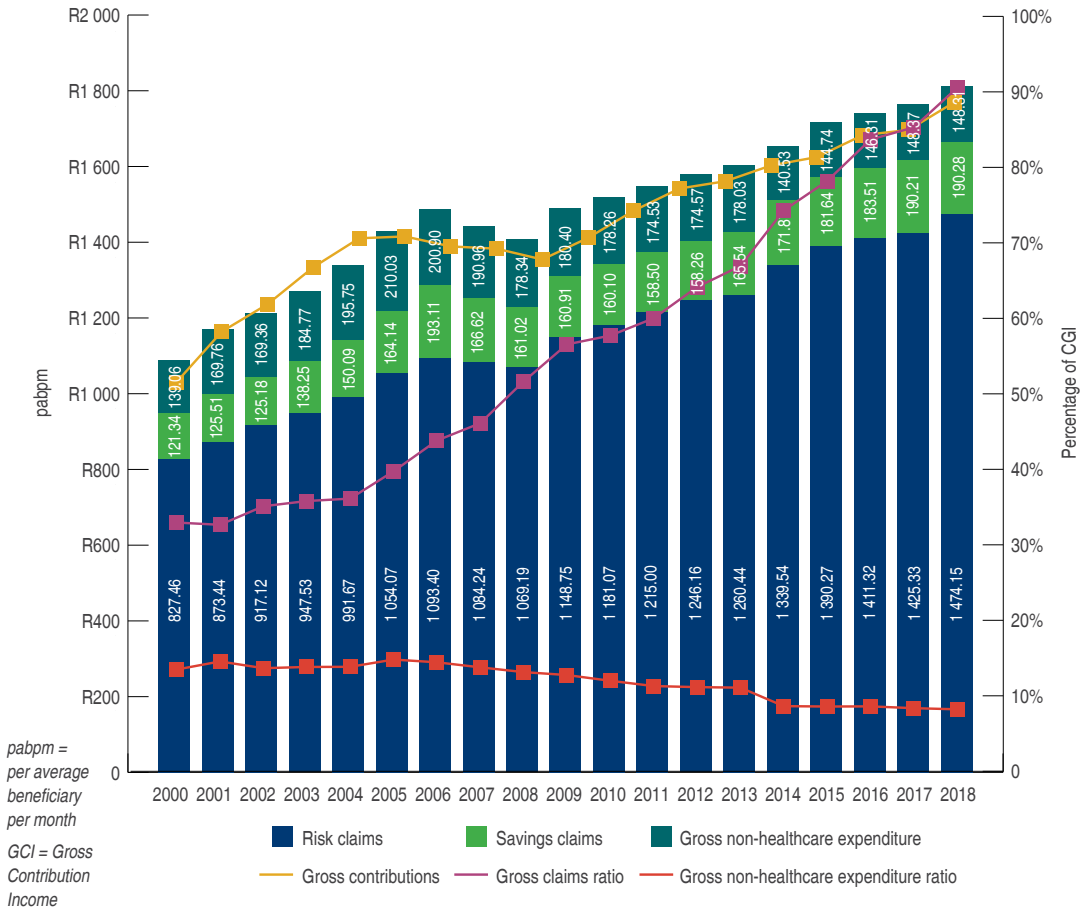



Figure 98: Claims and non-healthcare expenditure pabpm (2000–2018) in 2018 prices

Table 84: Trends in contributions, claims and non-healthcare expenditure (2000–2018) in 2018 prices*

| | Gross contributions | | Gross claims | | Gross non-healthcare expenditure | |
|---|---|---|---|---|---|---|
| | pabpa R | % growth | pabpa R | % growth | pabpa R | % growth |
| 2000 | 12 378.95 | 13.11 | 11 047.46 | -5.60 | 1 668.73 | 22.07 |
| 2001 | 14 001.22 | | 10 428.42 | | 2 036.98 | |
| 2002 | 14 872.79 | 6.22 | 12 263.92 | 17.60 | 2 032.39 | -0.23 |
| 2003 | 16 048.76 | 7.91 | 12 770.63 | 4.13 | 2 217.17 | 9.09 |
| 2004 | 16 967.10 | 5.72 | 13 428.38 | 5.15 | 2 348.95 | 5.94 |
| 2005 | 17 025.54 | 0.34 | 14 326.81 | 6.69 | 2 520.48 | 7.30 |
| 2006 | 16 707.67 | -1.87 | 14 833.42 | 3.54 | 2 411.95 | -4.31 |
| 2007 | 16 636.21 | -0.43 | 14 507.04 | -2.20 | 2 291.39 | -5.00 |
| 2008 | 16 292.03 | -2.07 | 14 257.39 | -1.72 | 2 140.06 | -6.60 |
| 2009 | 16 978.95 | 4.22 | 15 265.65 | 7.07 | 2 164.85 | 1.16 |
| 2010 | 17 845.59 | 5.10 | 15 705.67 | 2.88 | 2 139.04 | -1.19 |
| 2011 | 18 548.81 | 3.94 | 16 172.64 | 2.97 | 2 094.36 | -2.09 |
| 2012 | 18 780.09 | 1.25 | 16 562.86 | 2.41 | 2 094.79 | 0.02 |
| 2013 | 19 282.57 | 2.68 | 16 782.24 | 1.32 | 2 136.40 | 1.99 |
| 2014 | 19 548.30 | 1.38 | 17 792.11 | 6.02 | 1 686.41 | -21.06 |
| 2015 | 20 245.36 | 3.57 | 18 547.69 | 4.25 | 1 736.92 | 3.00 |
| 2016 | 20 410.26 | 0.81 | 18 827.32 | 1.51 | 1 755.72 | 1.08 |
| 2017 | 21 289.63 | 4.31 | 19 006.41 | 0.95 | 1 780.40 | 1.41 |
| 2018 | 21 672.68 | 1.80 | 19 625.65 | 3.26 | 1 779.78 | -0.03 |
| Since 2000 | | 75.08 | | 77.65 | | 6.65 |

*pabpa = per average beneficiary per annum, * The values were adjusted for CPI for 2000–2017*

Table 84 also shows how non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.00% per annum from 1999 to 2001 before stabilising.

Table 85 shows the top ten open schemes with non-healthcare expenditure greater than both the industry average of R189.23 pabpm and the open schemes average of 11.52% when expressed as a percentage of Risk Contribution Income (RCI).

Table 85: Trends in claims, non-healthcare expenditure, and reserve-building as a percentage of contributions among open schemes (2017 and 2018)

| | | Net non-healthcare expenditure | | Net claims incurred | | Net non-healthcare expenditure | | Reserve-building | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 | 2017 | 2018 | 2017 | 2018 | 2017 | 2018 | 2017 | % |
| Ref. no. | Name of medical scheme | pabpm | pabpm | As % of RCI | As % of RCI | As % of RCI | As % of RCI | As % of RCI | As % of RCI | change |
| 1141 | Spectramed | 330.90 | 239.95 | 101.50 | 95.09 | 15.30 | 12.47 | -16.80 | -7.56 | -122.22 |
| 1446 | Selfmed Medical Scheme | 260.98 | 235.67 | 103.58 | 103.65 | 12.93 | 12.29 | -16.51 | -15.95 | -3.51 |
| 1575 | Resolution Health Medical Scheme | 259.52 | 233.96 | 92.97 | 86.91 | 13.51 | 12.83 | -6.48 | 0.27 | -2 500.00 |
| 1486 | Sizwe Medical Fund | 242.81 | 206.11 | 97.88 | 87.97 | 14.00 | 12.20 | -11.88 | -0.17 | -6 888.24 |
| 1202 | Fedhealth Medical Scheme | 240.44 | 209.58 | 89.40 | 86.88 | 13.29 | 12.18 | -2.68 | 0.94 | -385.11 |
| 1464 | Suremed Health | 214.15 | 199.40 | 80.58 | 87.57 | 12.29 | 12.34 | 7.13 | 0.09 | 7 822.22 |
| 1087 | Keyhealth | 206.54 | 203.08 | 88.88 | 86.80 | 8.65 | 9.10 | 2.47 | 4.09 | -39.61 |
| 1491 | Compcare Wellness Medical Scheme | 202.35 | 196.76 | 93.16 | 90.32 | 11.95 | 12.46 | -5.11 | -2.78 | -83.81 |
| 1125 | Discovery Health Medical Scheme | 192.85 | 181.54 | 88.43 | 85.72 | 12.23 | 12.29 | -0.67 | 1.99 | -133.67 |
| 1537 | Hosmed Medical Aid Scheme | 183.06 | 198.30 | 87.21 | 86.20 | 9.41 | 11.17 | 3.38 | 2.63 | 28.52 |
| | **Industry average – open schemes** | **189.23** | **178.49** | **89.84** | **87.20** | **11.52** | **11.56** | **-1.36** | **1.24** | **-209.68** |

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

Table 86 shows the top ten restricted schemes with non-healthcare expenditure greater than both the industry average of R96.59 pabpm and the restricted schemes average of 5.95% when expressed as a percentage of Risk Contribution Income (RCI).

Table 86: Trends in claims, non-healthcare expenditure, and reserve-building as a percentage of contributions among restricted schemes (2017 and 2018)

| Ref. no. | Name of medical scheme | Net non-healthcare expenditure | | Net claims incurred | | Net non-healthcare expenditure | | Reserve-building | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2018 pabpm | 2017 pabpm | 2018 As % of RCI | 2017 As % of RCI | 2018 As % of RCI | 2017 As % of RCI | 2018 As % of RCI | 2017 As % of RCI | % change |
| 1194 | Profmed | 238.37 | 218.38 | 89.86 | 90.88 | 12.18 | 12.02 | -2.04 | -2.91 | 29.90 |
| 1043 | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | 236.72 | 207.51 | 92.02 | 88.09 | 11.63 | 10.76 | -3.64 | 1.16 | -413.79 |
| 1068 | De Beers Benefit Society | 182.61 | 156.83 | 112.73 | 105.59 | 7.11 | 6.64 | -19.84 | -12.23 | -62.22 |
| 1441 | Parmed Medical Aid Scheme | 173.40 | 160.65 | 101.35 | 107.55 | 3.90 | 4.16 | -5.25 | -11.71 | 55.17 |
| 1145 | LA-Health Medical Scheme | 167.54 | 156.20 | 82.68 | 81.33 | 12.51 | 11.91 | 4.82 | 6.75 | -28.59 |
| 1523 | Grintek Electronics Medical Aid Scheme | 162.34 | 151.18 | 97.98 | 99.50 | 7.74 | 8.11 | -5.73 | -7.62 | 24.80 |
| 1237 | BP Medical Aid Society | 151.59 | 136.45 | 126.26 | 115.66 | 7.07 | 6.39 | -33.33 | -22.05 | -51.16 |
| 1571 | Anglovaal Group Medical Scheme | 151.27 | 139.88 | 95.28 | 97.93 | 8.86 | 8.73 | -4.13 | -6.66 | 37.99 |
| 1012 | Anglo Medical Scheme | 148.15 | 123.31 | 123.89 | 119.08 | 7.39 | 6.61 | -31.28 | -25.69 | -21.76 |
| 1597 | Umvuzo Health Medical Scheme | 146.35 | 131.39 | 84.11 | 86.59 | 11.48 | 11.41 | 4.41 | 2.00 | 120.50 |
| | **Industry average – restricted schemes** | **96.59** | **95.42** | **90.71** | **90.62** | **5.95** | **6.26** | **3.34** | **3.12** | **7.05** |

*pabpm = per average beneficiary per month*

*RCI = Risk Contribution Income*

Non-healthcare expenditure for open schemes with a solvency ratio below the open scheme average (29.28%) are shown in Figure 99, while Figure 100 shows restricted schemes with a solvency ratio below the restricted scheme average (41.94%). It is concerning that some of these medical schemes fall below the 25.0% solvency target yet exhibit very high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

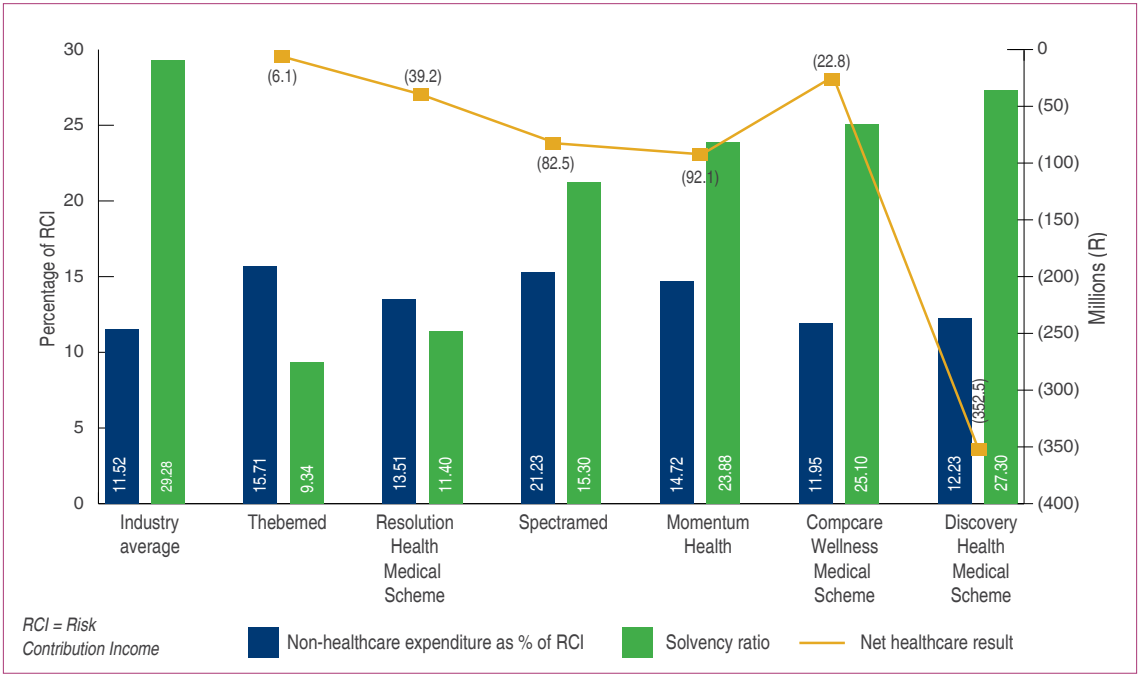



Figure 99: Open schemes with high non-healthcare expenditure and solvency ratios below average (2018)

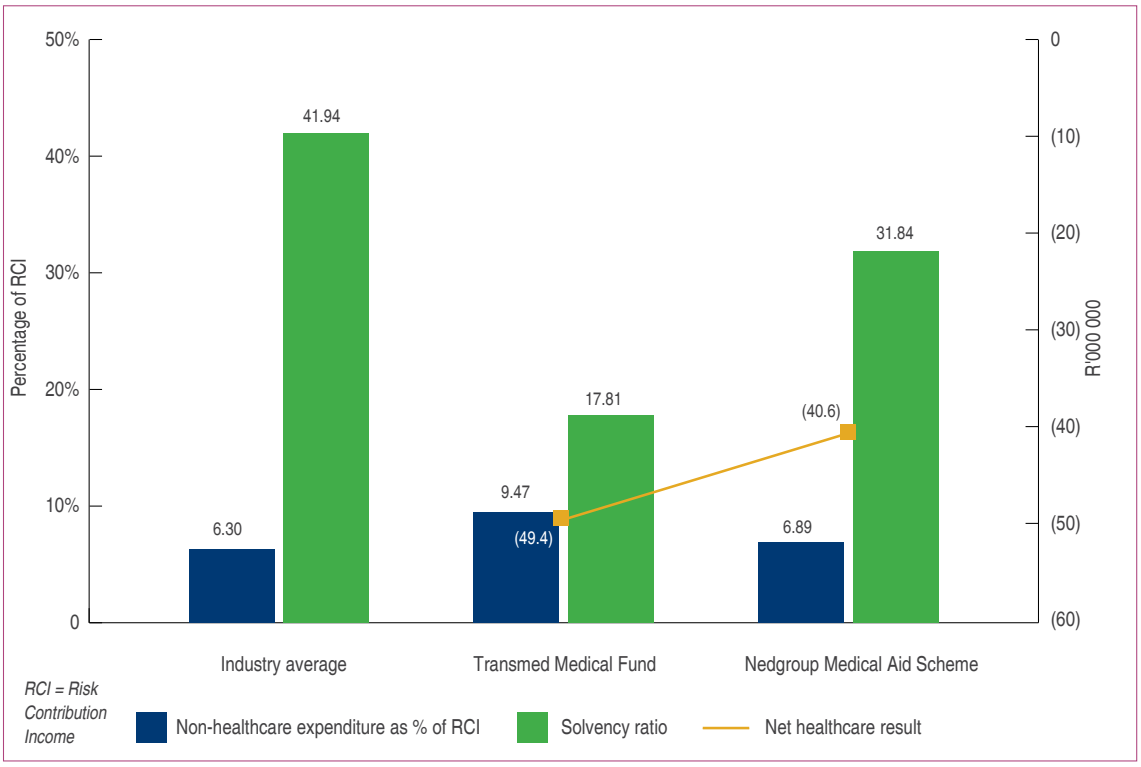
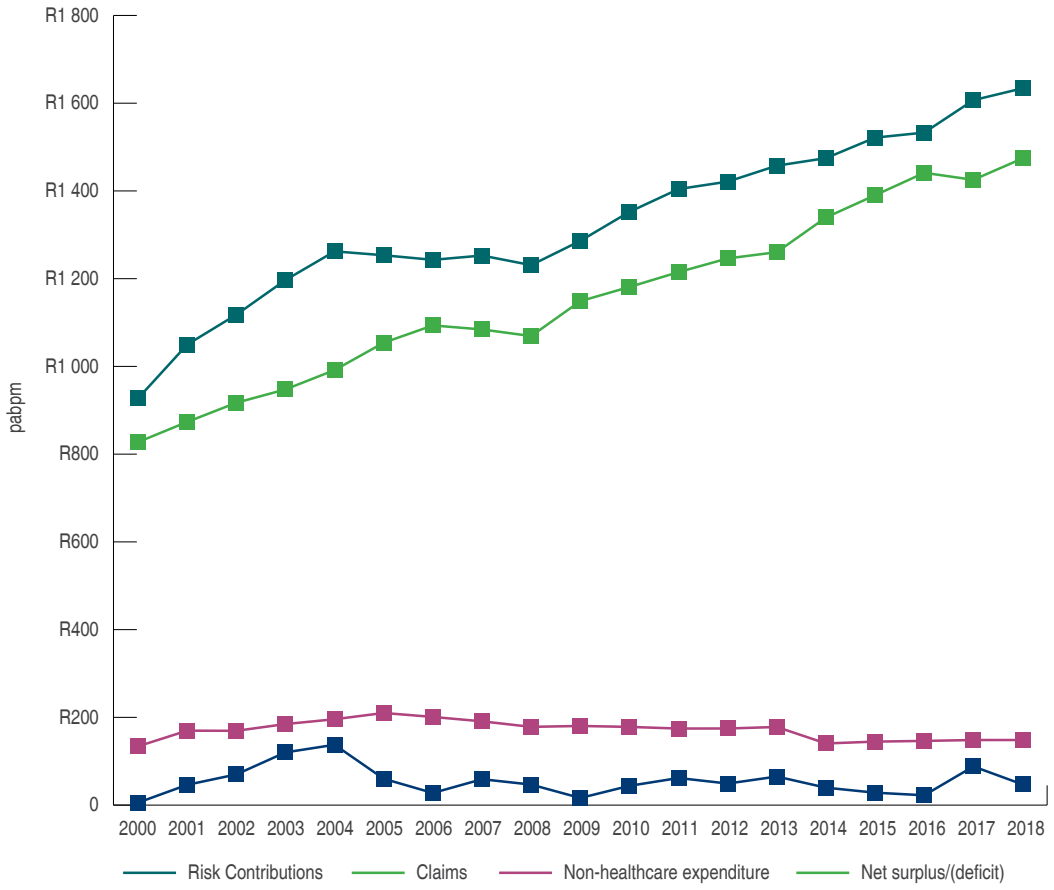



Figure 100: Restricted schemes with high non-healthcare expenditure and solvency ratios below average (2018)

Figure 101 depicts information on contributions, benefits, non-healthcare expenditure, and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm had been growing since 2000 but decreased in 2003, almost levelling out in 2004. Although this gap has since grown wider, it seems to have stabilised in the last few years.




*pabpm = per average beneficiary per month*

** The values were adjusted for CPI for 2000–2017*

Figure 101: Risk contributions, claims, non-healthcare expenditure, and net surpluses 2000–2018 (2018 prices*)

# BENEFIT OPTIONS

During 2018 there were 271 registered benefit options (2017: 278) operating in 79 medical schemes (2017: 81).

Open schemes accounted for 50.18% or 136 of the registered benefit options during 2018 (2017: 49.28% or 137 options). On average, open schemes had 6.48 options per scheme (2017: 6.52) and an average of 17 522 members per option at year-end (2017: 17 272).

Restricted schemes had 135 options during the year (excluding University of the Witwatersrand, Johannesburg Staff Medical Aid Fund which amalgamated on 1 January 2018 with Discovery Health Medical Scheme), representing 49.82% of all options (2017: 141 options or 50.72%). Restricted schemes had an average of 2.29 options per scheme (2017: 2.35), with an average of 12 272 members per option as at 31 December 2018 (2017: 11 677).

Table 87: Results of benefit options (2018)

| | Open schemes | % representing | Restricted schemes | % representing | Total |
|---|---|---|---|---|---|
| **All options** | | | | | |
| Number of options | 136 | 50.18 | 135 | 49.82 | 271 |
| Members represented | 2 382 924 | 58.99 | 1 656 781 | 41.01 | 4 039 705 |
| Number of schemes | 21 | 26.25 | 59 | 73.75 | 80 |
| Net healthcare result (R'000) | (1 331 499) | | 2 549 553 | | 1 218 054 |
| Gross non-healthcare as % of GCI | 10.01 | | 5.68 | | 8.21 |
| Gross claims ratio (%) | 90.51 | | 90.62 | | 90.55 |
| Gross claims incurred pbpm | 1 705.02 | | 1 529.44 | | 1 627.30 |
| GCI pbpm | 1 883.84 | | 1 687.74 | | 1 797.03 |
| **Options with members > 2 500** | | | | | |
| Number of options | 86 | 50.59 | 84 | 49.41 | 170 |
| Members represented | 2 327 066 | 59.22 | 1 602 226 | 40.78 | 3 929 292 |
| Net healthcare result (R'000) | (1 103 978) | | 2 777 400 | | 1 673 422 |
| Gross non-healthcare as % of GCI | 10.02 | | 5.67 | | 8.22 |
| Gross claims ratio (%) | 90.34 | | 90.23 | | 90.29 |
| Gross claims incurred pbpm | 1 692.93 | | 1 510.16 | | 1 612.30 |
| GCI pbpm | 1 874.03 | | 1 673.69 | | 1 785.65 |
| **Options with members < 2 500** | | | | | |
| Number of options | 50 | 49.50 | 51 | 50.50 | 101 |
| Members represented | 55 858 | 50.59 | 54 555 | 49.41 | 110 413 |
| Net healthcare result (R'000) | (227 398) | | (227 040) | | (454 438) |
| Gross non-healthcare as % of GCI | 9.74 | | 6.07 | | 7.95 |
| Gross claims ratio (%) | 96.84 | | 101.33 | | 99.03 |
| Gross claims incurred pbpm | 2 262.32 | | 2 219.87 | | 2 240.92 |
| GCI pbpm | 2 336.20 | | 2 190.68 | | 2 262.84 |

*GCI = Gross Contribution Income*

*pbpm = per beneficiary per month*

Of the 271 benefit options during the year, 101 (37.27%) had fewer than 2 500 members per option (2017: 104 or 37.41%). Of these 101 options, 63 (62.38%) incurred net healthcare losses in 2018, compared to 68 of these options (65.38%) incurring losses in 2017.

At the end of 2018, there were 50 options in open schemes with fewer than 2 500 members (2017: 48). They had an average of 1 117.16 members per option (2017: 1 078.88) and represented 36.76% (2017: 35.04%) of all open scheme options.

Restricted schemes had 51 options with fewer than 2 500 members (2017: 56). The average number of members per option was 1 069.71 (2017: 1 042.77) and these options represented 37.78% (2017: 39.72%) of all restricted scheme options.

The remaining 170 options (2017: 174) had more than 2 500 members per option. Of these, 55.29% or 94 options incurred net healthcare losses (2017: 44.25% or 77 options).

Table 88: Results of loss-making benefit options (2018)

| | Open schemes | % representing | Restricted schemes | % representing | Total |
|---|---|---|---|---|---|
| **Total loss making options** | | | | | |
| % of total options | 62.50 | | 53.33 | | 57.93 |
| Number of options | 85 | 54.14 | 72 | 45.86 | 157 |
| Members represented | 1 219 561 | 70.79 | 503 145 | 29.21 | 1 722 706 |
| Net healthcare result (R'000) | (4 331 872) | | (2 483 010) | | (6 814 882) |
| Gross non-healthcare as % of GCI | 9.71 | | 4.99 | | 8.14 |
| Gross claims ratio (%) | 97.31 | | 103.29 | | 99.30 |
| Gross claims incurred pbpm | 1 868.39 | | 2 060.22 | | 1 930.50 |
| GCI pbpm | 1 920.10 | | 1 994.51 | | 1 944.19 |
| **Loss making options with members >=2 500** | | | | | |
| Number of options | 53 | 56.38 | 41 | 43.62 | 94 |
| Members represented | 1 183 890 | 71.66 | 468 207 | 28.34 | 1 652 097 |
| Net healthcare result (R'000) | (4 027 577) | | (2 178 835) | | (6 206 412) |
| Gross non-healthcare as % of GCI | 9.73 | | 4.95 | | 8.19 |
| Gross claims ratio (%) | 97.05 | | 102.92 | | 98.94 |
| Gross claims incurred pbpm | 1 841.69 | | 2 002.08 | | 1 892.49 |
| GCI pbpm | 1 897.72 | | 1 945.30 | | 1 912.79 |
| **Loss making options with members < 2 500** | | | | | |
| Number of options | 32 | 50.79 | 31 | 49.21 | 63 |
| Members represented | 35 671 | 50.52 | 34 938 | 49.48 | 70 609 |
| Net healthcare result (R'000) | (304 173) | | (303 368) | | (607 540) |
| Gross non-healthcare as % of GCI | 9.25 | | 5.44 | | 7.28 |
| Gross claims ratio (%) | 103.92 | | 107.59 | | 105.81 |
| Gross claims incurred pbpm | 2 854.03 | | 3 013.81 | | 2 935.66 |
| GCI pbpm | 2 746.51 | | 2 801.14 | | 2 774.42 |

*GCI = Gross Contribution Income*
*pbpm = per beneficiary per month*

Of the 271 benefit options registered and operating during 2018 (2017: 278), 157 (57.93%) incurred net healthcare losses. In 2017, 145 options (52.16%) incurred net healthcare losses.

In the year under review, 85 options (2017: 72), representing 54.14% of loss-making options (2017: 49.66%), were in open schemes and 72 (2017: 73), representing 45.86% of loss-making options (2017: 50.34%), were in restricted schemes.

Net healthcare losses pbpm in options with fewer than 2 500 members were 2.29 times greater (2017: 1.70) than those for options with more than 2 500 members – an average of -R717.02 pbpm compared to -R313.06 pbpm (2017: -R544.85 pbpm and -R320.55 pbpm respectively).

Benefit options with fewer than 2 500 members generally have higher contributions and claims than other options and also attract higher non-healthcare costs as they are shared across a smaller base.

Table 89 shows option results by demographics.

Table 89: Demographics of registered options at year-end (2018)

| | Open | Restricted | Total |
|---|---|---|---|
| Average age pb | 34.76 | 30.98 | |
| Net healthcare result pb | -22.33 | 53.83 | |
| Number of options with average age greater than or equal to the industry average | 86 | 70 | 156 |
| Number of options incurring net healthcare results better or equal to the industry average | 22 | 11 | 33 |
| Number of options incurring net healthcare results worse than the industry average | 64 | 59 | 123 |
| Number of options with average age below the industry average | 50 | 65 | 115 |
| Number of options incurring net healthcare results better or equal to the industry average | 14 | 29 | 43 |
| Number of options incurring net healthcare results worse than the industry average | 27 | 36 | 63 |

*pb = per beneficiary*

There were 86 options with an average age above the 34.76 years for options in open schemes, and 50 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 70 benefit options had beneficiaries with an average age higher than the 30.98 years for all options. A total of 65 benefit options had younger beneficiaries. As expected, benefit options covering older and sicker lives incurred greater deficits.

# NET HEALTHCARE RESULTS AND TRENDS

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

The net healthcare result for all medical schemes combined reflected a surplus of R1.21 billion in 2018 (2017: R3.37 billion surplus). Open schemes incurred a net healthcare deficit of R1.33 billion (2017: R1.13 billion surplus), and restricted schemes generated a combined net healthcare surplus of R2.55 billion (2017: R2.23 billion surplus). The deterioration is mainly due to the higher claims ratios of open schemes, from 87.20% in 2017 to 89.84% in 2018. Restricted schemes experienced a minimal increase in the claims ratio.

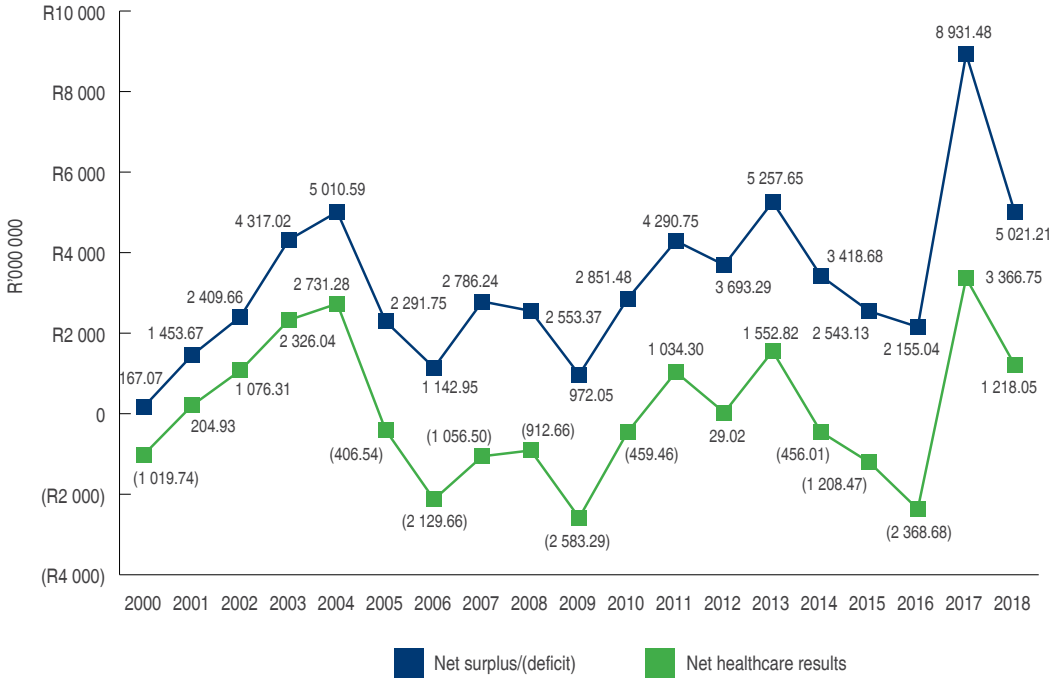



Figure 102: Net healthcare results (2000–2018)

Table 90 shows the 20 schemes with the largest net healthcare deficits; they represent 89.15% of all beneficiaries of schemes that suffered operating deficits. (Annexure Y has more details on this.) Investment income would generally have boosted the performance of these schemes by larger margins but due to poor performance on investment returns during 2018, the majority of the schemes experienced a drop in their net results and solvency levels.

Table 90: 20 schemes with the largest net healthcare deficits (2017 and 2018)

| Ref. no. | Name of medical scheme | Type | Net healthcare result | | | Solvency ratio | |
|---|---|---|---|---|---|---|---|
| | | | 2018 R'000 | 2017 R'000 | % growth | 2018 % | 2017 % |
| 1580 | South African Police Service Medical Scheme (POLMED) | Restricted | (548 191) | (344 192) | -59.27 | 43.15 | 46.42 |
| 1125 | Discovery Health Medical Scheme | Open | (352 461) | 967 953 | -136.41 | 27.30 | 27.44 |
| 1486 | Sizwe Medical Fund | Open | (277 406) | (4 081) | -6 698.17 | 47.07 | 54.94 |
| 1140 | Medshield Medical Scheme | Open | (197 158) | (256 764) | 23.21 | 37.87 | 44.63 |
| 1012 | Anglo Medical Scheme | Restricted | (139 008) | (108 375) | -28.27 | 473.01 | 487.14 |
| 1422 | Topmed Medical Scheme | Open | (127 248) | (81 161) | -56.79 | 64.92 | 72.56 |
| 1548 | Medipos Medical Scheme | Restricted | (106 621) | (43 503) | -145.09 | 75.12 | 95.70 |
| 1149 | Medihelp | Open | (99 206) | 8 136 | -1 319.29 | 28.65 | 29.56 |
| 1167 | Momentum Health | Open | (92 067) | (18 454) | -398.90 | 23.88 | 25.74 |
| 1202 | Fedhealth Medical Scheme | Open | (83 477) | 27 985 | -398.29 | 31.42 | 32.09 |
| 1141 | Spectramed | Open | (82 517) | (39 754) | -107.57 | 21.23 | 29.40 |
| 1512 | Bonitas Medical Fund | Open | (71 662) | 345 854 | -120.72 | 25.16 | 24.46 |
| 1068 | De Beers Benefit Society | Restricted | (60 977) | (36 227) | -68.32 | 144.39 | 152.59 |
| 1446 | Selfmed Medical Scheme | Open | (54 434) | (50 649) | -7.47 | 80.77 | 92.40 |
| 1582 | Transmed Medical Fund | Restricted | (49 430) | (54 991) | 10.11 | 17.81 | 21.24 |
| 1043 | Chartered Accountants (SA) Medical Aid Fund (CAMAF) | Restricted | (41 576) | 12 532 | -431.76 | 34.99 | 34.94 |
| 1469 | Nedgroup Medical Aid Scheme | Restricted | (40 551) | (58 227) | 30.36 | 31.84 | 32.19 |
| 1575 | Resolution Health Medical Scheme | Open | (39 167) | 1 682 | -2 428.53 | 11.40 | 15.17 |
| 1507 | Barloworld Medical Scheme | Restricted | (35 511) | (22 433) | -58.30 | 74.64 | 82.54 |
| 1194 | Profmed | Restricted | (34 003) | (44 574) | 23.72 | 49.36 | 52.45 |

A total of 71.43% (or 15 of 21) of the open schemes and 67.24% (39 of 58) of the restricted schemes showed net healthcare deficits during the year.

The net surplus of all schemes combined, after investment income and consolidation adjustments was R5.02 billion (2017: R8.93 billion). Net investment and other income, as well as expenditure, decreased by 31.66% from R5.56 billion in 2017 to R3.80 billion in 2018. Open schemes made a R0.82 billion (2017: R4.05 billion) surplus and restricted schemes a surplus of R4.20 billion (2017: R4.88 billion).

Figures 102 and 103 show the impact of the increases in claims costs and non-healthcare expenditure on the NHC result. The NHC and net results of all schemes since 2000 are reflected in Figure 102.

Figure 103 shows the schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 34.54% (Annexure Y provides more details).

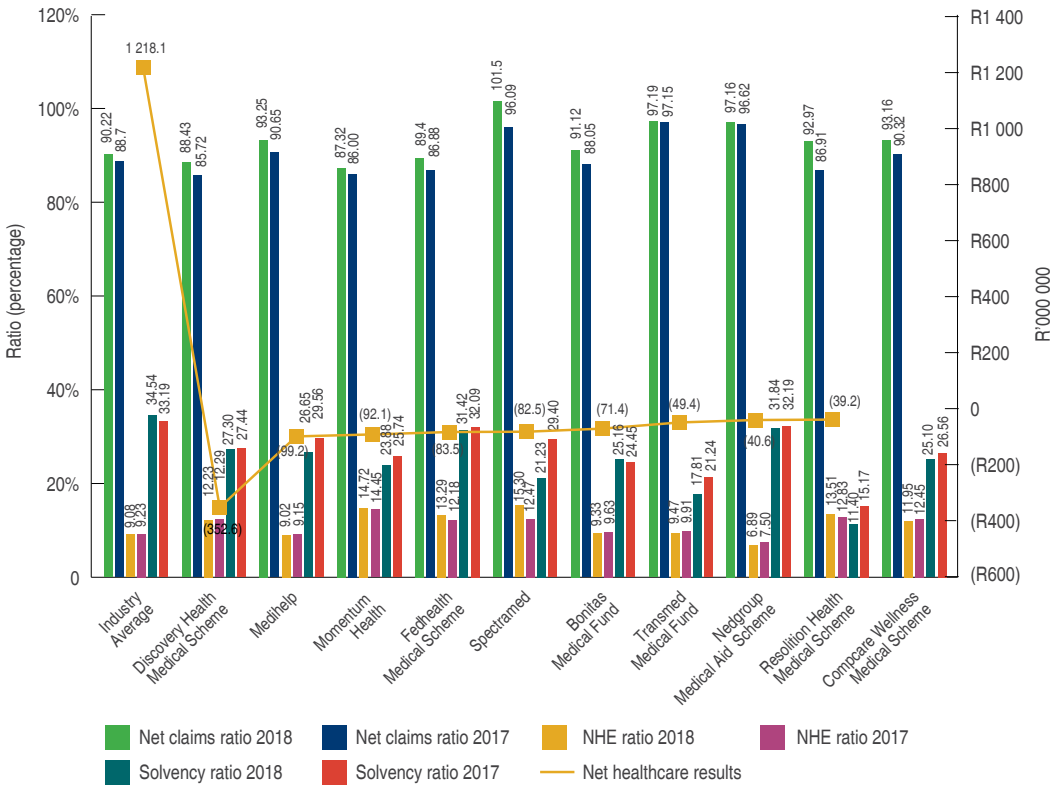



Figure 103: Schemes with the largest net healthcare deficits and solvency levels below the industry average of 34.54% (2018)

# ACCUMULATED FUNDS, SOLVENCY AND SOLVENCY TRENDS

Figure 104 shows that all medical schemes incurred a surplus of R5.0 billion compared to R8.9 billion in 2017, representing a decrease of 43.8%. The net assets in terms of Regulation 29 of the Medical Schemes increased by 11.3% from R59.7 billion in 2017 to a reported R66.4 billion in 2018.

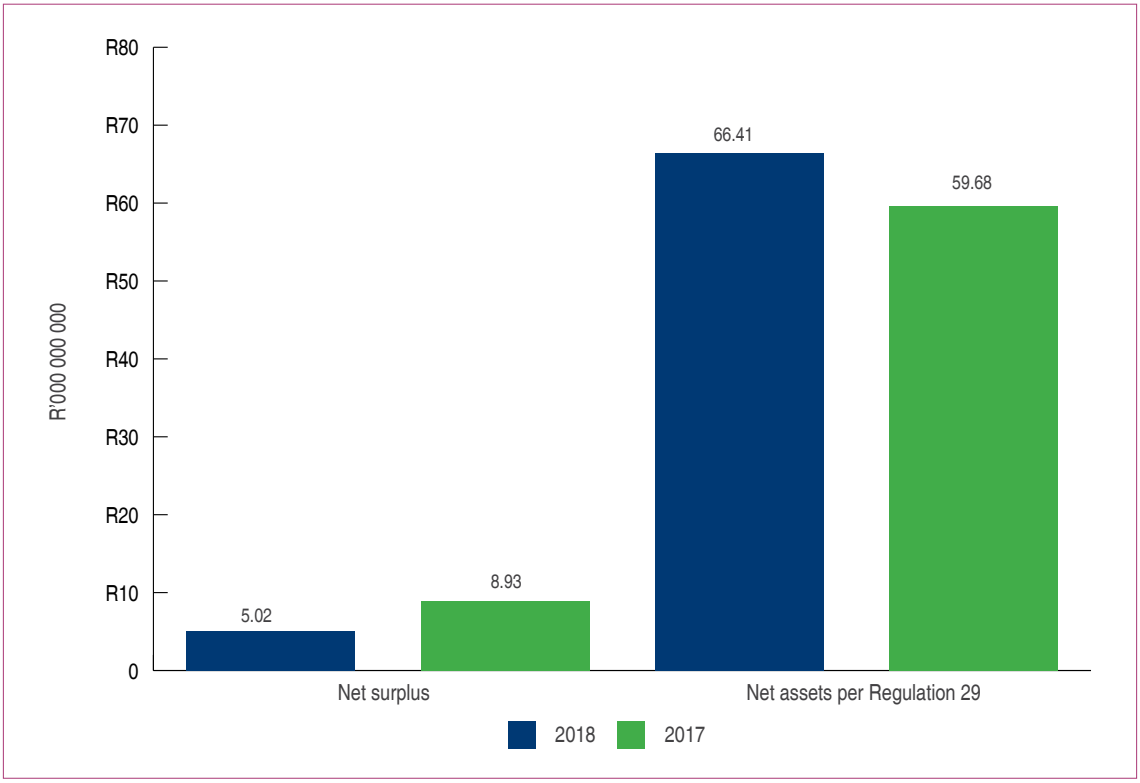



Figure 104: Net surplus and net assets per Regulation 29

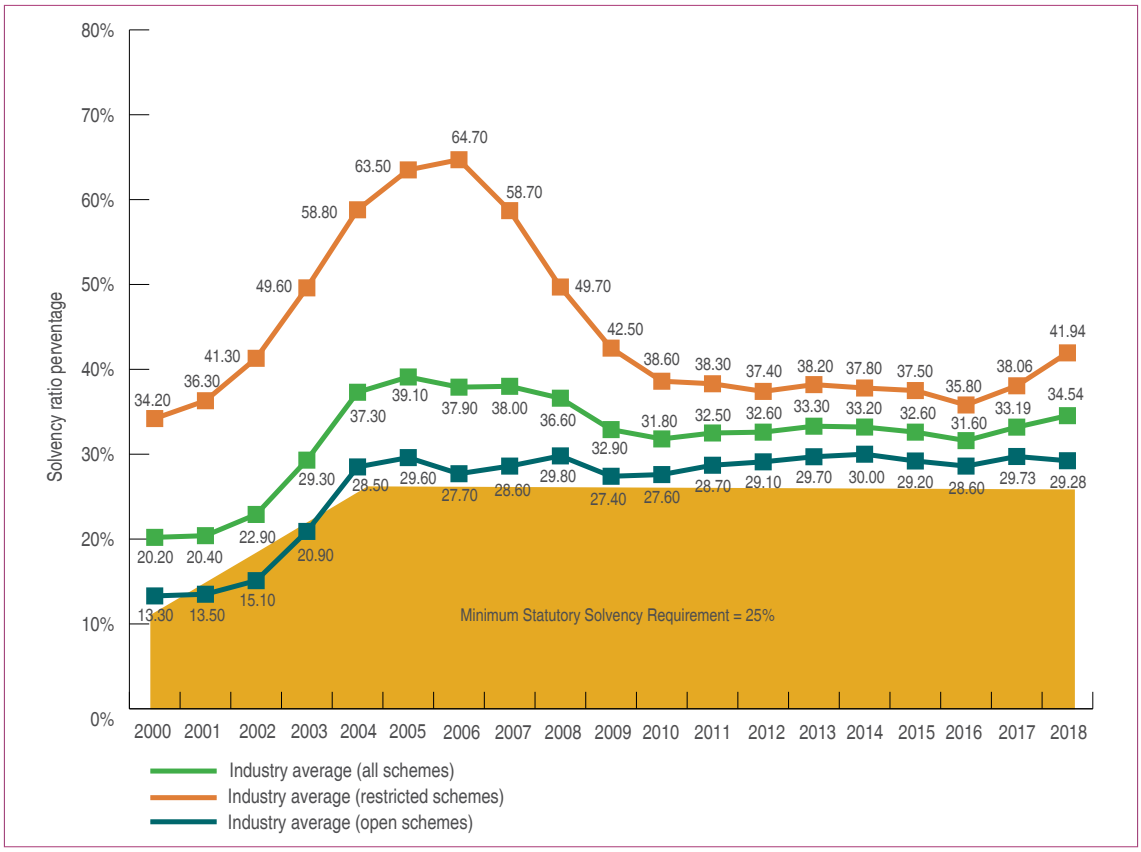



Figure 105: Industry solvency for all schemes (2000–2018)



Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes.

Accumulated funds mean the net asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable profits. The accumulated funds must at all times be maintained at a minimum level of 25.00% of gross contributions, except in the case of new medical schemes where phase-in solvency ratios apply. The phase-in solvency ratio is 10.00% during the first year of operation, 13.50% during the second year, 17.50% during the third year and not less than 22.00% during the fourth year.

These minimum accumulated funds are more commonly called the "reserves" of a scheme. When expressed as a percentage of gross contributions, they become known as the "solvency ratio" of a scheme.

A prescribed solvency ratio serves both to protect members' interests and to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations.

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, non-compliance with Regulation 29 does not necessarily mean that the scheme is in financial difficulties.

### *Factors that affect solvency*

The most important factors affecting solvency are, inter alia:

- Membership growth;
- The performance of the medical scheme, that is, claims and non-healthcare expenditure;
- Utilisation of benefits; and
- Investment income.

The membership profile of a medical scheme further affects its solvency. The membership profile includes variables such as the average age of beneficiaries, the proportion of pensioners, the relative number of male and female dependants, and the dependant ratio. All of these affect the frequency and extent of claims.

Net assets per Regulation 29 rose by 11.29% in 2018 at R66.41 billion. Accumulated funds grew by 9.99% to R67.67 billion from the R61.52 billion recorded in 2017.

The industry average solvency ratio increased to 34.54% in 2018 from 33.19% in 2017.

The solvency ratio of open schemes declined by 1.51% to 29.28% in 2018 (2017: 29.73%). Restricted schemes experienced an increase of 10.19% in their solvency ratio, 41.94% from 38.06% in 2017.

The overall industry average solvency ratio increased consistently from 2000 to 2005. Schemes were required to have reached the 25.00% solvency ratio in 2005.

As indicated in Figure 106, the open industry remained fairly constant between 2004 and 2018, slightly above the 25.00% solvency ratio prescribed by the Medical Schemes Act.

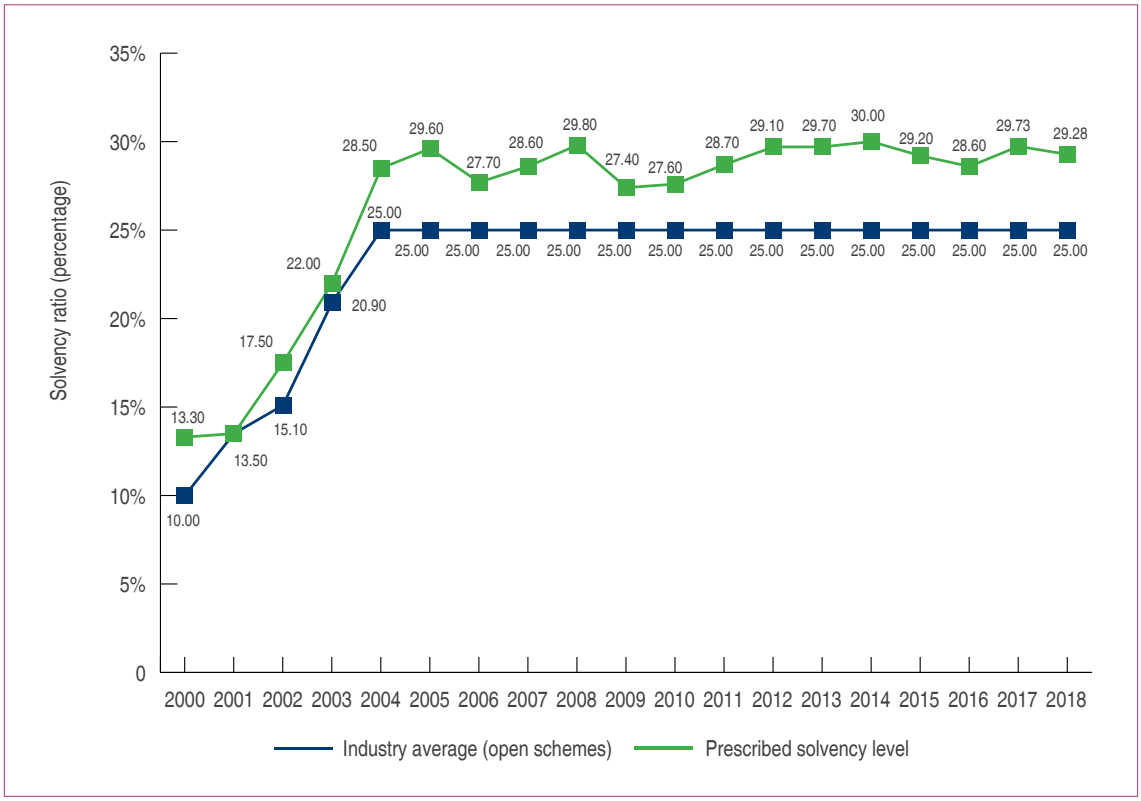



Figure 106: Industry solvency for open schemes (2000–2018)

As indicated in Figure 107, the restricted industry was at its peak in 2006 and declined from 2007 onwards. This is mostly due to the denominator that is used in the solvency calculation (gross contributions), which is affected by membership growth. The Government Employee Medical Scheme (GEMS), which is the largest restricted scheme, experienced exceptional membership growth following its registration, resulting in an overall deterioration in the solvency level of the restricted schemes industry. This subsequently improved between 2016 and 2018, largely due to the turnaround in financial performance of GEMS, which reported an increase of 62.55% in solvency level in 2018, from 15.22% in 2017 to 24.74% in 2018. The growth in GEMS has since stabilised as much of its target market is covered. As such, the overall restricted scheme market reported an improved solvency of 41.94% in 2018, from 38.06% in 2017.

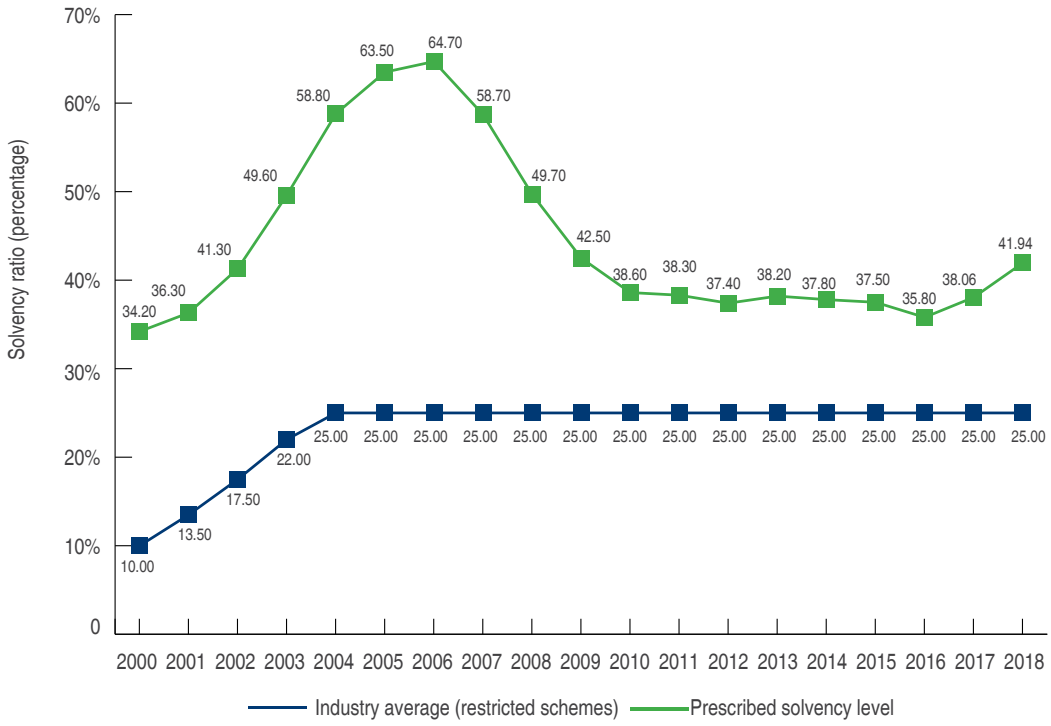



Figure 107: Industry solvency for restricted schemes (2000–2018)

Table 91: Risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions (1999–2018)

| | Risk claims % of RCI | Non-healthcare expenditure % of RCI | Reserve-building % of RCI |
|---|---|---|---|
| 1999 | 91.50 | 12.70 | -4.20 |
| 2000 | 89.30 | 14.50 | -3.70 |
| 2001 | 83.20 | 16.20 | 0.60 |
| 2002 | 82.10 | 15.20 | 2.80 |
| 2003 | 79.20 | 15.40 | 5.40 |
| 2004 | 78.60 | 15.50 | 5.90 |
| 2005 | 84.10 | 16.80 | - |
| 2006 | 88.00 | 16.20 | -4.10 |
| 2007 | 86.50 | 15.20 | -1.80 |
| 2008 | 86.90 | 14.50 | -1.40 |
| 2009 | 89.30 | 14.00 | -3.30 |
| 2010 | 87.30 | 13.20 | -0.50 |
| 2011 | 86.50 | 12.40 | 1.10 |
| 2012 | 87.70 | 12.30 | - |
| 2013 | 86.50 | 12.20 | 1.30 |
| 2014 | 90.80 | 9.50 | -0.40 |
| 2015 | 91.40 | 9.50 | -0.90 |
| 2016 | 92.10 | 9.50 | -1.60 |
| 2017 | 88.70 | 9.23 | 2.07 |
| 2018 | 90.22 | 9.08 | 0.70 |

*RCI = Risk Contribution Income*

Table 91 illustrates the relationship between risk claims, non-healthcare expenditure and reserve building. Risk claims appear to have more impact on reserve building than non-healthcare expenditure. During periods of high claims the industry has experienced a reduction in reserves while in periods with lower claims the reserves have increased. In 1999 the industry experienced risk claims of 91.50% expressed as a percentage of contributions, and reserves decreased by 4.20%, while in 2004 risk claims amounted to 78.60% and reserves increased by 5.90%.

Total risk claims fell between 2000 and 2004 and the ratio of contributions to reserves improved during this period from -3.70% to 5.90%. Non-healthcare expenditure grew during this period, largely at the expense of claims. Risk claims were at their lowest in 2004 and then started to increase in 2005, reaching 92.10% in 2016. In this respect it is important to note that the 2014 and 2015 risk claims ratios have been restated to include accredited managed healthcare services as per the requirements of Circular 56 of 2016; whilst it had been excluded from the non-healthcare expenditure ratio. Contributions to reserves were negative during this time, which was consistent with the fact that most medical schemes had attained the prescribed solvency ratio of 25.00% and did not need to grow their reserves any further. 2017 saw a reduction in the claims ratio to 88.70%, whilst positive reserve building of 2.07% occurred. The maintenance of reserves as a protection for members should be considered against the backdrop of increasing claims costs, changing demographic profiles and increasing burden of disease. In 2018, reserve building was positive however it declined in comparison to 2017 due to claims ratios increasing to 90.22%.

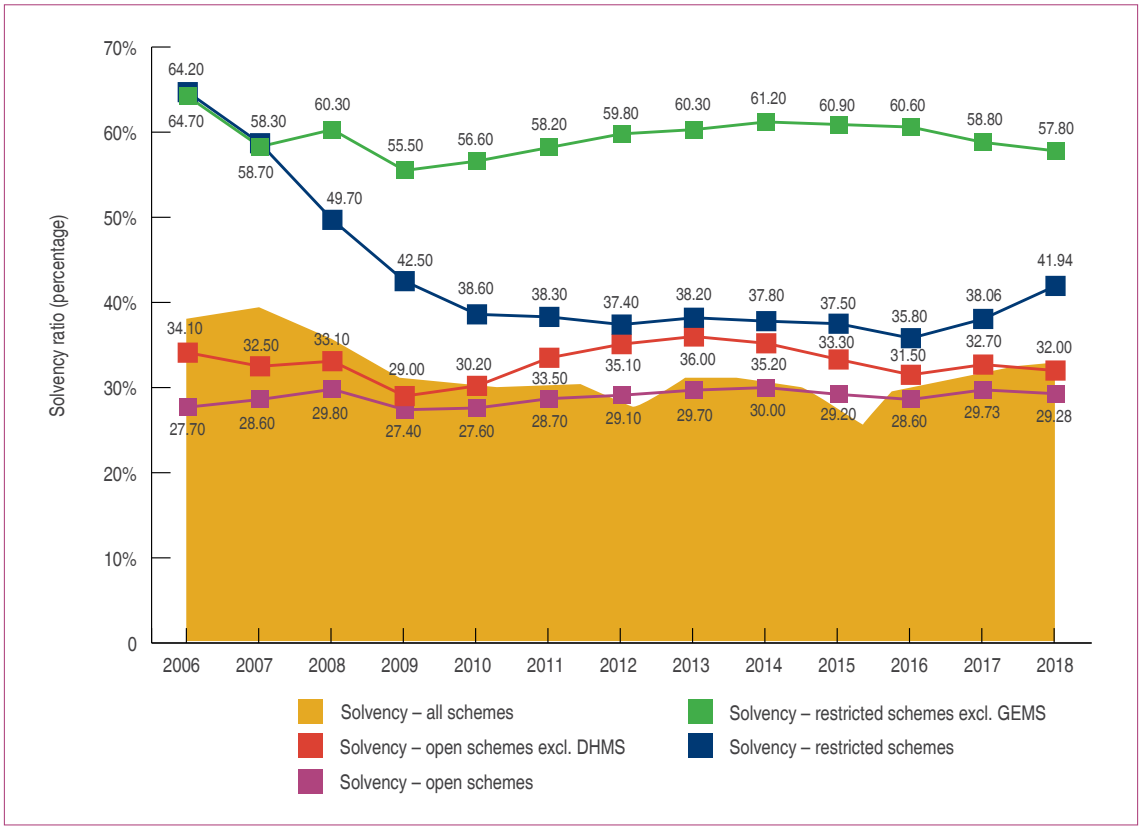



Figure 108: Industry solvency ratios excluding GEMS and DHMS

Excluding GEMS, the restricted schemes industry solvency ratio decreased in 2009 to 55.50% and then increased from 2010 onwards to 60.60% in 2016, with a subsequent reduction to 57.80% in 2018. The solvency ratio of the restricted schemes industry is much lower when GEMS results are included. This indicates the significant impact of GEMS on the restricted schemes industry.

In comparison, Discovery Health Medical Scheme (DHMS) has a lesser impact on the open schemes industry. Excluding DHMS, the 2018 open industry solvency ratio increases to 32.00% (from 29.28%).

Medical schemes should be careful of the so-called “death spiral”. A scheme with a disadvantageous, high-claiming membership profile may need to adjust its contributions and/or benefits. Options with older and sicker members, that are highly priced, may cause the younger, and lower-claiming, members to move to other, less expensive options, or even other medical schemes. This results in the scheme losing the cross-subsidy provided by the younger members and leads to an increase in losses, resulting in even higher contribution increases and/or reductions in benefits.

*Beneficiaries of schemes which failed to reach the 25.00% solvency level*

Table 92 and Figure 109 show the number of medical schemes which have yet to attain the prescribed solvency ratio of 25.00% and the number of beneficiaries in those schemes.

Table 92: Prescribed solvency levels and number of beneficiaries with solvency below 25% (2000–2018)

| | Number of open schemes | | Number of restricted schemes | |
|---|---|---|---|---|
| Year | Below prescribed level | Above prescribed level | Below prescribed level | Above prescribed level |
| 2000 | 15 | 33 | 15 | 86 |
| 2001 | 19 | 29 | 11 | 83 |
| 2002 | 24 | 25 | 7 | 86 |
| 2003 | 19 | 29 | 7 | 80 |
| 2004 | 18 | 30 | 4 | 81 |
| 2005 | 17 | 29 | 4 | 79 |
| 2006 | 18 | 23 | 4 | 79 |
| 2007 | 18 | 23 | 7 | 74 |
| 2008 | 14 | 21 | 8 | 71 |
| 2009 | 16 | 17 | 3 | 71 |
| 2010 | 12 | 15 | 7 | 66 |
| 2011 | 9 | 17 | 5 | 66 |
| 2012 | 7 | 18 | 4 | 63 |
| 2013 | 6 | 18 | 3 | 60 |
| 2014 | 5 | 18 | 2 | 58 |
| 2015 | 3 | 19 | 3 | 57 |
| 2016 | 3 | 18 | 3 | 57 |
| 2017 | 3 | 18 | 3 | 56 |
| 2018 | 4 | 17 | 3 | 55 |

| | Number of beneficiaries in open schemes | | | Number of beneficiaries in restricted schemes | | |
|---|---|---|---|---|---|---|
| | Below prescribed level | | Above prescribed level | Below prescribed level | | Above prescribed level |
| Year | At end | % | At end | At end | % | At end |
| 2000 | 2 385 051 | 51.01 | 2 291 048 | 839 029 | 40.86 | 1 214 412 |
| 2001 | 2 650 934 | 55.60 | 2 117 142 | 576 462 | 28.88 | 1 419 862 |
| 2002 | 3 519 329 | 74.39 | 1 211 882 | 251 050 | 12.66 | 1 731 873 |
| 2003 | 3 426 988 | 72.62 | 1 291 809 | 222 430 | 11.39 | 1 730 574 |
| 2004 | 2 534 273 | 53.29 | 2 221 030 | 80 160 | 4.20 | 1 827 100 |
| 2005 | 2 783 108 | 56.73 | 2 122 444 | 36 359 | 1.88 | 1 893 710 |
| 2006 | 3 218 382 | 63.72 | 1 832 056 | 145 369 | 7.00 | 1 931 536 |
| 2007 | 3 139 176 | 63.40 | 1 812 141 | 689 865 | 25.99 | 1 964 054 |
| 2008 | 1 076 450 | 22.02 | 3 812 456 | 981 977 | 32.89 | 2 003 943 |
| 2009 | 992 523 | 20.61 | 3 822 811 | 1 254 151 | 38.55 | 1 999 020 |
| 2010 | 2 918 055 | 60.79 | 1 881 860 | 1 684 682 | 47.92 | 1 831 121 |
| 2011 | 2 855 072 | 59.98 | 1 905 042 | 1 865 313 | 49.53 | 1 900 982 |
| 2012 | 2 796 583 | 58.75 | 1 963 411 | 1 978 668 | 50.45 | 1 943 538 |
| 2013 | 2 860 768 | 59.02 | 1 986 141 | 1 994 813 | 50.74 | 1 936 586 |
| 2014 | 212 169 | 4.33 | 4 687 806 | 1 914 481 | 48.91 | 2 000 002 |
| 2015 | 177 807 | 3.61 | 4 743 470 | 1 943 387 | 50.20 | 1 927 683 |
| 2016 | 811 038 | 16.42 | 4 129 033 | 1 908 478 | 48.62 | 2 016 423 |
| 2017 | 779 925 | 15.72 | 4 180 530 | 1 876 641 | 47.98 | 2 034 940 |
| 2018 | 365 535 | 7.36 | 4 604 086 | 1 900 775 | 48.16 | 2 046 299 |

**Community Medical Aid Scheme (COMMED) was excluded from this table for the 2015–2017 years*

The total number of schemes below 25.00% has declined since 2003. Although there have been numerous amalgamations, the reduction in schemes below 25.00% was not mainly due to amalgamation but also due to schemes attaining the minimum solvency ratio.

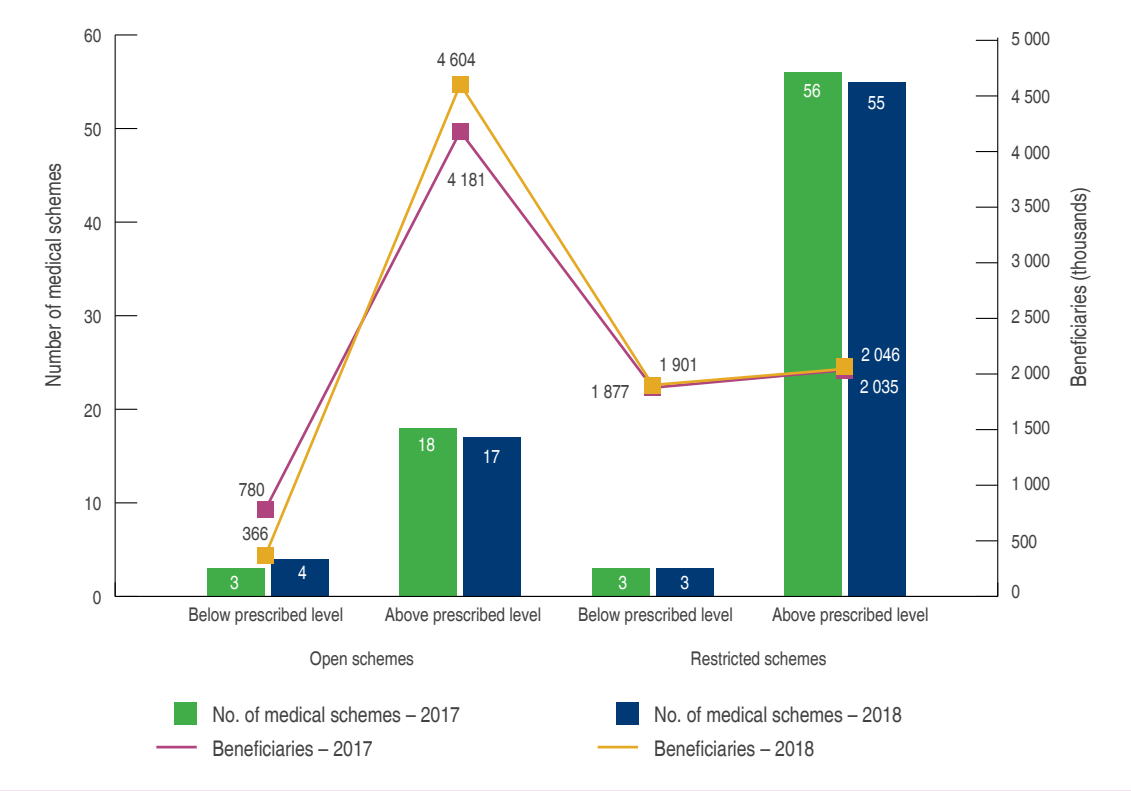



Figure 109: Prescribed solvency and number of beneficiaries (2017 and 2018)



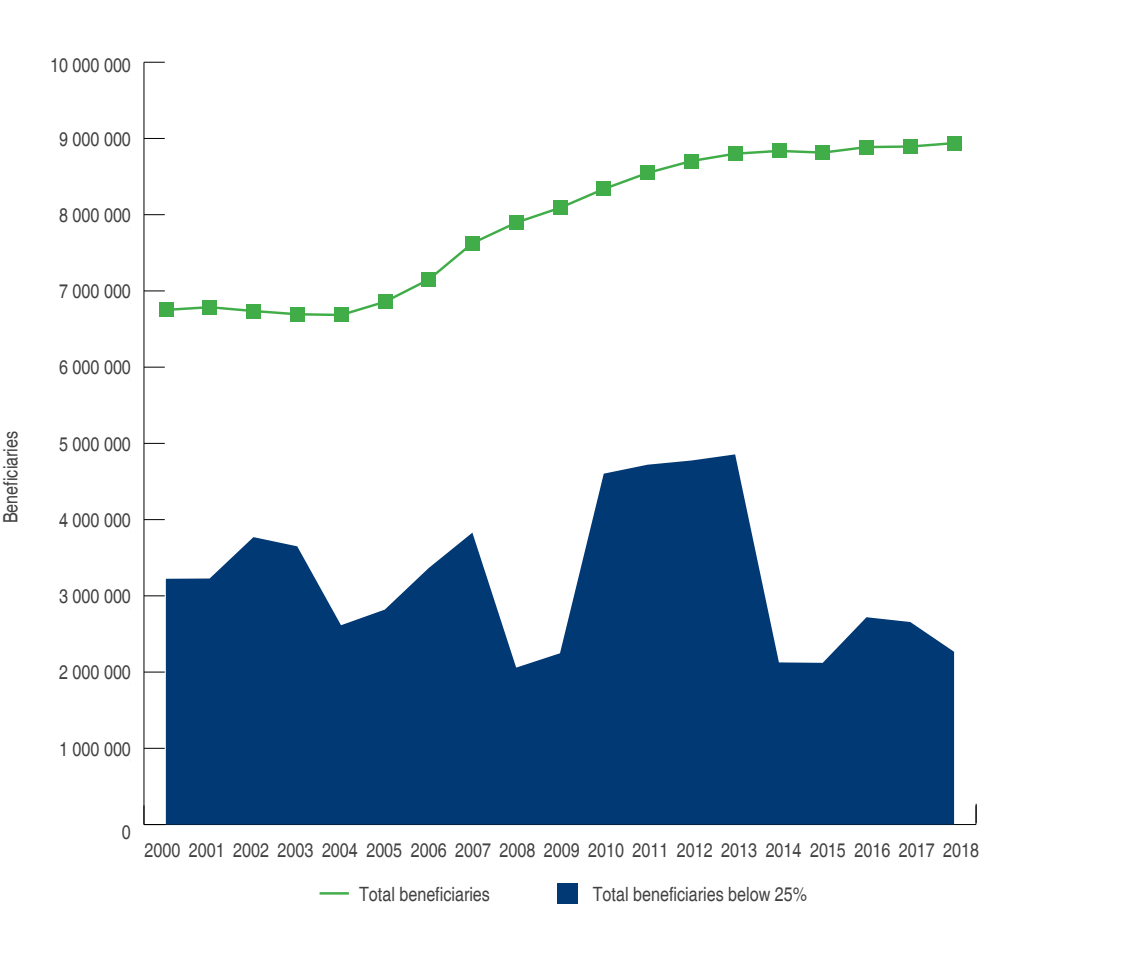



Figure 110: Beneficiaries in schemes with solvency below 25% (2000–2018)

A total of 7.36% beneficiaries in open schemes (2017: 15.72%) were covered by the four open schemes (2017: three) which failed to meet the prescribed solvency level in 2018. The remaining beneficiaries belonged to the other 17 open schemes (2017: 18) which had attained the prescribed solvency level of 25.00%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25.00%. This was mainly due to DHMS, the biggest scheme in South Africa, failing to attain the minimum prescribed solvency ratio. When DHMS reached the solvency ratio of 25.00% – in 2008, 2009, 2014, 2015, 2016, 2017 and 2018 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015 this figure was a mere 3.61% compared to 59.02 % in 2013. In 2016, Bonitas Medical Fund fell below 25.00%, increasing the percentage again to 16.42%.

Of the 58 restricted schemes at the end of 2018, only three had solvency ratios below 25.00%. These three, however, accounted for 48.16% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory solvency level of 25.00% and this accounts for 96.76% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

Table 93 below provides a summary of performance of schemes that were below the required statutory minimum solvency of 25.00% as at 31 December 2018.

Table 93: Summary of performance of schemes below 25% solvency (2018)

| Ref. no. | Name of scheme | Average beneficiaries 2018 | Average age pb* 2018 years | Pensioner ratio 2018 % | Net claims ratio 2018 % | Net claims ratio 2017 % | Net surplus/ (deficit) 2018 R'000 | Net surplus/ (deficit) 2017 R'000 | Solvency ratio 2018 % | Solvency ratio 2017 % |
|---|---|---|---|---|---|---|---|---|---|---|
| 1592 | Thebemed | 23 948 | 27.79 | 0.48 | 86.43 | 89.15 | (6 091) | (12 496) | 9.34 | 12.09 |
| 1575 | Resolution Health Medical Scheme | 26 214 | 42.56 | 18.41 | 92.97 | 86.91 | (39 167) | 1 682 | 11.40 | 15.17 |
| 1582 | Transmed Medical Fund | 41 589 | 54.71 | 44.50 | 97.19 | 97.15 | (49 430) | (54 991) | 17.81 | 21.24 |
| 1141 | Spectramed | 18 923 | 50.27 | 30.51 | 101.50 | 95.09 | (82 517) | (39 754) | 21.23 | 29.40 |
| 1167 | Momentum Health | 298 071 | 32.99 | 8.41 | 87.32 | 86.00 | (92 067) | (18 454) | 23.88 | 25.74 |
| 1599 | Lonmin Medical Scheme | 22 665 | 37.28 | 0.07 | 92.82 | 93.79 | 2 859 | (969) | 24.11 | 23.96 |
| 1598 | Government Employees Medical Scheme (GEMS) | 1 813 320 | 30.73 | 6.24 | 85.64 | 86.00 | 3 472 650 | 2 877 730 | 24.74 | 15.22 |

**pb = per beneficiary*

The CMS closely monitors schemes below the 25.00% solvency ratio by having regular meetings with them in order to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes environment and the progress that schemes have made thus far in moving towards the prescribed solvency levels, but much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

# INVESTMENTS

Figure 111 provides information on the investments of medical schemes as at the end of the years 2017 and 2018.

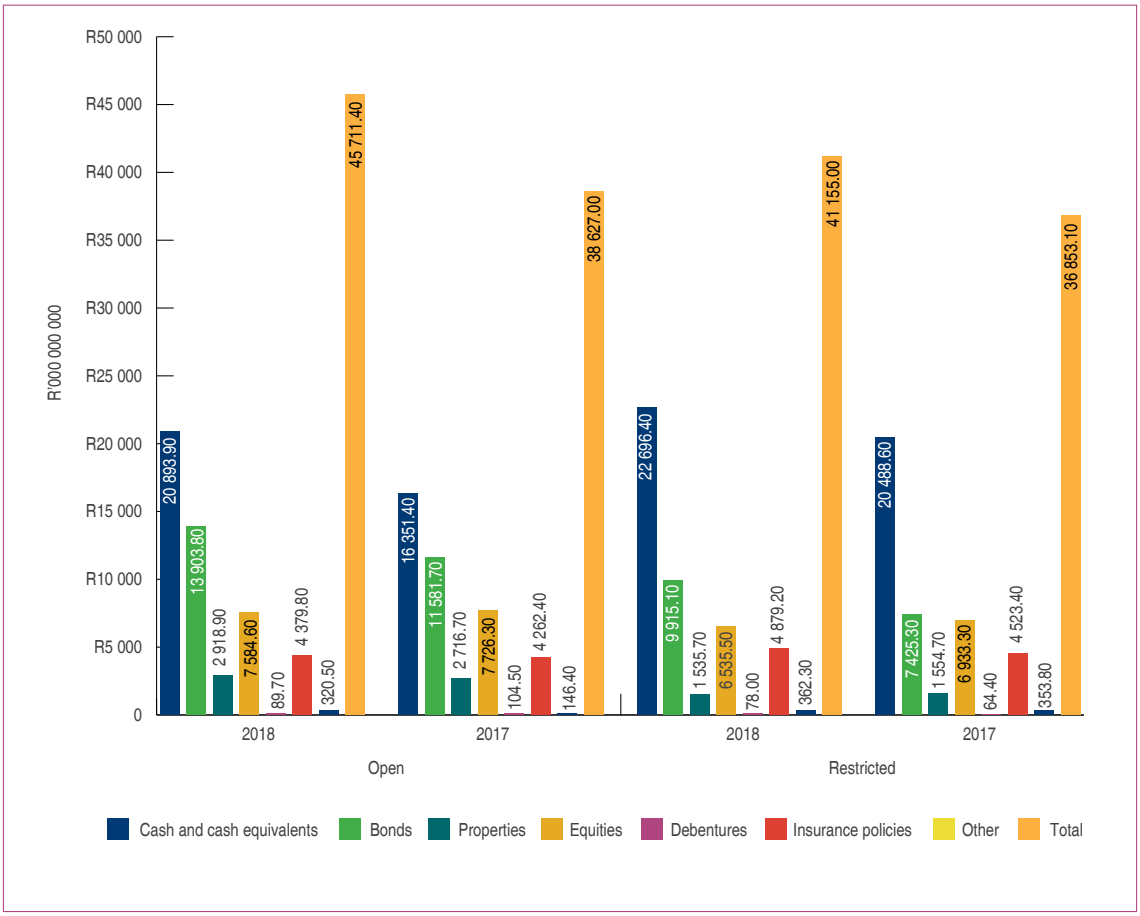



Figure 111: Scheme investments (2017 and 2018)

In open schemes, 45.71% of investments (2017: 42.33%) were held in cash or cash equivalents. Bonds accounted for 30.42% (2017: 29.98%), debentures for 0.20% (2017: 0.27%), equities for 16.59% (2017: 20.00%), non-linked insurance policies for 0.00% (2017: 0.00%), properties for 6.39% (2017: 7.03%), and other investments for 0.70% (2017: 0.38%).

Restricted schemes also held a large proportion of their investments (55.15%) in cash or cash equivalents (2017: 55.60%). Their bonds accounted for 24.09% (2017: 20.15%) and debentures for 0.19% (2017: 0.17%). Equities made up 15.88% (2017: 18.81%), non-linked insurance policies 0.08% (2017: 0.09%), properties 3.73% (2017: 4.22%), and other investments 0.88% (2017: 0.96%).

The following tables list the asset distribution of the ten largest schemes by asset base per asset category listed under Annexure B of the Regulations, as well split by local and foreign, and investment income.

Table 94: Asset distribution ten largest schemes by asset base (2018)

| Ref. no. | Name of medical scheme | Average beneficiaries | Total investable assets* R'million | Category*** 1 % | 2 % | 3 % | 4 % | 5 % | 6** % | 7 % |
|---|---|---|---|---|---|---|---|---|---|---|
| 1125 | Discovery Health Medical Scheme | 2 792 583 | 26 460.48 | 43.01 | 33.81 | 7.58 | 14.80 | 0.20 | 1.21 | 0.60 |
| 1598 | Government Employees Medical Scheme (GEMS) | 1 813 320 | 11 704.76 | 72.14 | 16.18 | 3.89 | 6.29 | 0.00 | 0.00 | 1.50 |
| 1512 | Bonitas Medical Fund | 713 190 | 5 493.97 | 48.19 | 30.92 | 4.84 | 15.75 | 0.21 | 4.65 | 0.10 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 502 996 | 4 690.52 | 45.66 | 44.79 | 4.18 | 5.07 | 0.00 | 0.00 | 0.29 |
| 1012 | Anglo Medical Scheme | 18 466 | 3 000.53 | 24.55 | 33.66 | 2.79 | 38.16 | 0.00 | 0.00 | 0.85 |
| 1279 | Bankmed | 219 948 | 2 969.91 | 49.46 | 28.95 | 3.59 | 14.79 | 1.01 | 0.00 | 2.21 |
| 1140 | Medshield Medical Scheme | 164 774 | 1 908.38 | 43.25 | 22.08 | 5.22 | 28.73 | 0.22 | 29.71 | 0.54 |
| 1252 | Bestmed Medical Scheme | 197 088 | 1 875.60 | 39.30 | 31.56 | 5.36 | 19.73 | 0.16 | 38.24 | 3.89 |
| 1149 | Medihelp | 201 944 | 1 775.63 | 63.55 | 9.24 | 1.91 | 24.33 | 0.00 | 12.87 | 0.97 |
| 1145 | LA-Health Medical Scheme | 182 286 | 1 770.63 | 99.63 | 0.06 | 0.29 | 0.00 | 0.00 | 0.00 | 0.01 |

**Total investable assets represents the total amount available for investment, excluding encumbered assets.*

***Category 6 investments' underlying assets were also included in the relevant categories.*

****Categories are as referred to in Annexure B of the Act, read in conjunction with Regulation 30.*

Table 95: Local and foreign asset distribution of the largest ten schemes by asset base (2018)

| Ref. no. | Name of medical scheme | Average beneficiaries | Total investable assets* R'million | Local** % | Foreign** % |
|---|---|---|---|---|---|
| 1125 | Discovery Health Medical Scheme | 2 792 583 | 26 460.48 | 96.84 | 3.16 |
| 1598 | Government Employees Medical Scheme (GEMS) | 1 813 320 | 11 704.76 | 97.86 | 2.14 |
| 1512 | Bonitas Medical Fund | 713 190 | 5 493.97 | 96.05 | 3.95 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 502 996 | 4 690.52 | 100.00 | 0.00 |
| 1012 | Anglo Medical Scheme | 18 466 | 3 000.53 | 96.67 | 3.33 |
| 1279 | Bankmed | 219 948 | 2 969.91 | 93.24 | 6.76 |
| 1140 | Medshield Medical Scheme | 164 774 | 1 908.38 | 92.85 | 7.19 |
| 1252 | Bestmed Medical Scheme | 197 088 | 1 875.60 | 93.94 | 6.06 |
| 1149 | Medihelp | 201 944 | 1 775.63 | 100.00 | 0.00 |
| 1145 | LA-Health Medical Scheme | 182 286 | 1 770.63 | 100.00 | 0.00 |

**Total investable assets represent the total amount available for investment, excluding encumbered assets.*

***The definitions of local and foreign assets make reference to investments made within the Republic and outside the Republic as referred to in Annexure B of the Act, read in conjunction with Regulation 30 .*

Table 96: Investment income of the largest ten schemes by asset base (2018)

| Ref. no. | Name of medical scheme | Average beneficiaries | Total investable assets* | Net investment income** | |
|---|---|---|---|---|---|
| | | | R'million | R'million | % of investable assets |
| 1125 | Discovery Health Medical Scheme | 2 792 583 | 26 460.48 | 1 324.42 | 5.01 |
| 1598 | Government Employees Medical Scheme (GEMS) | 1 813 320 | 11 704.76 | 532.38 | 4.55 |
| 1512 | Bonitas Medical Fund | 713 190 | 5 493.97 | 175.39 | 3.19 |
| 1580 | South African Police Service Medical Scheme (POLMED) | 502 996 | 4 690.52 | 236.61 | 5.04 |
| 1012 | Anglo Medical Scheme | 18 466 | 3 000.53 | (9.89) | -0.33 |
| 1279 | Bankmed | 219 948 | 2 969.91 | 86.45 | 2.91 |
| 1140 | Medshield Medical Scheme | 164 774 | 1 908.38 | 96.80 | 5.07 |
| 1252 | Bestmed Medical Scheme | 197 088 | 1 875.60 | 150.79 | 8.04 |
| 1149 | Medihelp | 201 944 | 1 775.63 | 102.47 | 5.77 |
| 1145 | LA-Health Medical Scheme | 182 286 | 1 770.63 | 121.04 | 6.84 |

**Total investable assets represents the total amount available for investment, excluding encumbered assets*

***Net investment income represents investment income after taking into account asset management fees*

The following table illustrates the total net investment income of the industry split between open and restricted schemes.

Table 97: Asset base and investment income (2017 and 2018)

| | Total investable assets* | | | Net investment income** | | | Net investment income as % of total investable assets | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 R'million | 2017 R'million | % growth | 2018 R'million | 2017 R'million | % growth | 2018 % | 2017 % | % growth |
| Open schemes | 45 711.40 | 38 627.00 | 18.34 | 2 253.03 | 3 386.00 | -33.46 | 4.93 | 8.77 | -43.79 |
| Restricted schemes | 41 155.00 | 36 853.10 | 11.67 | 1 584.74 | 2 570.46 | -38.35 | 3.85 | 6.97 | -44.76 |
| All schemes | 86 866.40 | 75 480.10 | 15.09 | 3 837.77 | 5 956.46 | -35.57 | 4.42 | 7.89 | -43.98 |

**Total investable assets represents the total amount available for investment, excluding encumbered assets*

***Net investment income represents investment income after taking into account asset management fees*

As can be seen from Table 97, whilst overall net investment income remained positive, there was a significant decline compared to 2017, which affected open and restricted schemes alike. The primary reason for this is the sharp decline in listed equity and property values towards the end of 2018. The JSE All-Share Index declined by over 11.86% during 2018.

The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number, on the other hand, indicates that the scheme has greater liabilities than assets and is therefore technically insolvent and in breach of section 35(3) of the Medical Schemes Act.

Schemes should pay attention to more than just their total asset and liability positions; they should also consider the periods in which liabilities must be paid and in which assets can be converted into cash flows.

Figure 112 compares the matching of assets and liabilities in open and restricted schemes.

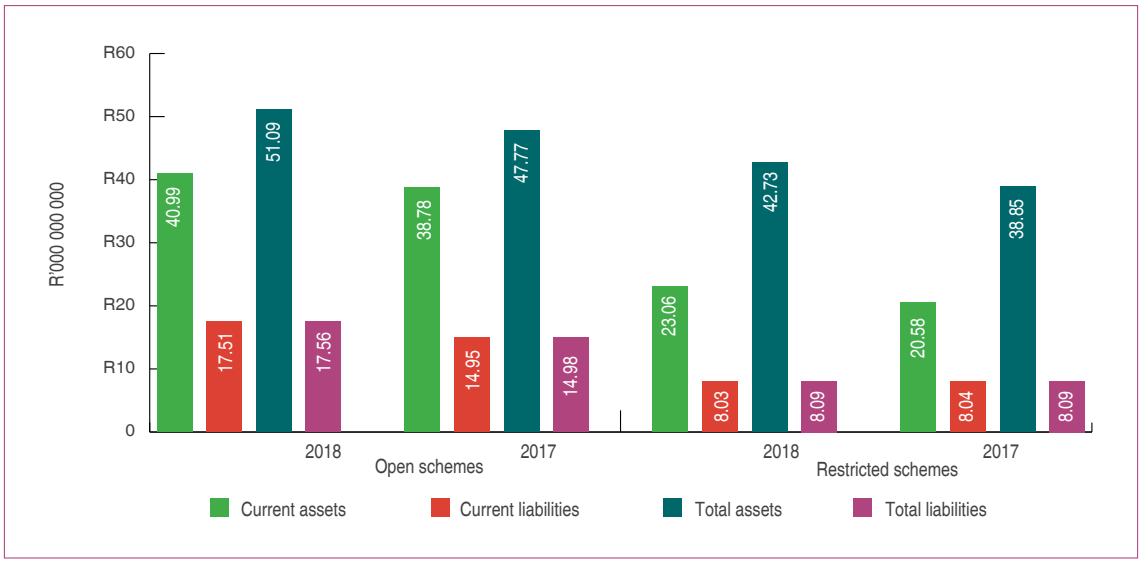



Figure 112: Matching of assets and liabilities (2017 and 2018)

The current-assets-to-current-liabilities ratio in open schemes was 2.3:1 in 2018 (2.6:1 in 2017). It was 2.9:1 in restricted schemes in 2018 (2017: 2.6:1). The total-asset-to-total-liability ratio for open and restricted schemes in 2018 was 2.9:1 (2017: 3.2:1) and 5.3:1 (2017: 4.8:1) respectively.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, a quick ratio below 2.0) is lower than the industry average of 3.9 months, boards of trustees must guard against longer-term, riskier investments. Although such investments may offer the prospect of higher returns, they may prove detrimental to the scheme should it experience a liquidity crunch.

# CLAIMS-PAYING ABILITY OF SCHEMES

The financial soundness of a medical scheme is also measured by its ability to pay claims from cash and cash equivalents. Figure 113 depicts the claims-paying ability of schemes, measured in months of cover. This is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

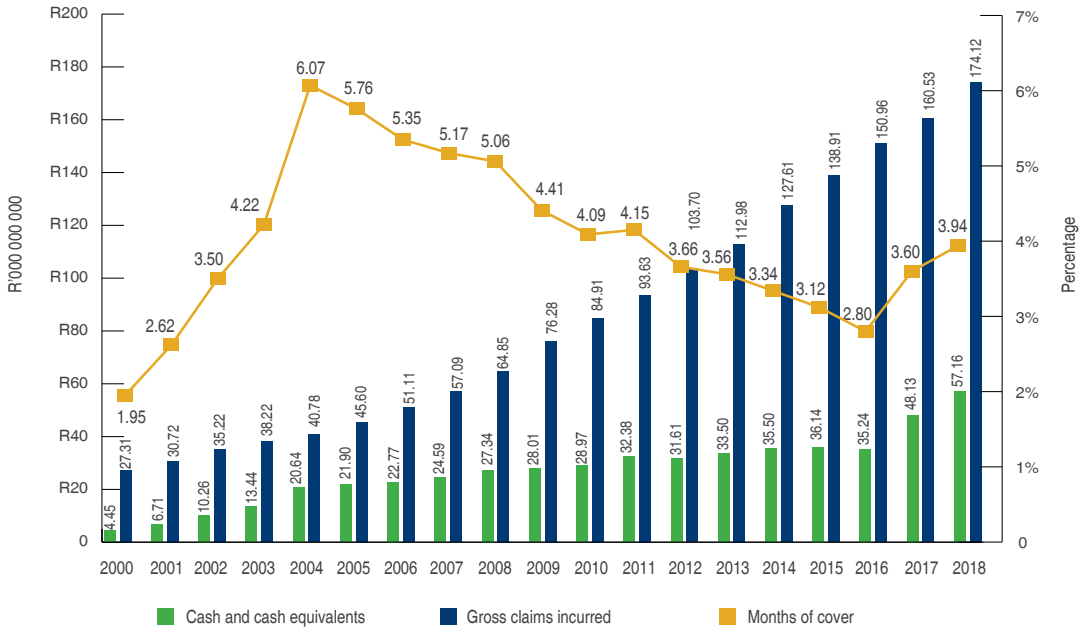



Figure 113: Average gross claims covered by cash and cash equivalents (2000–2018)

The length of cash coverage improved from 3.60 months in 2017 to 3.94 months in 2018. Payment cycles of medical schemes in 2018 were an average of 19.16 days compared with 18.30 days in 2017.

# ADMINISTRATOR MARKET

Figure 114 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 2018[4].

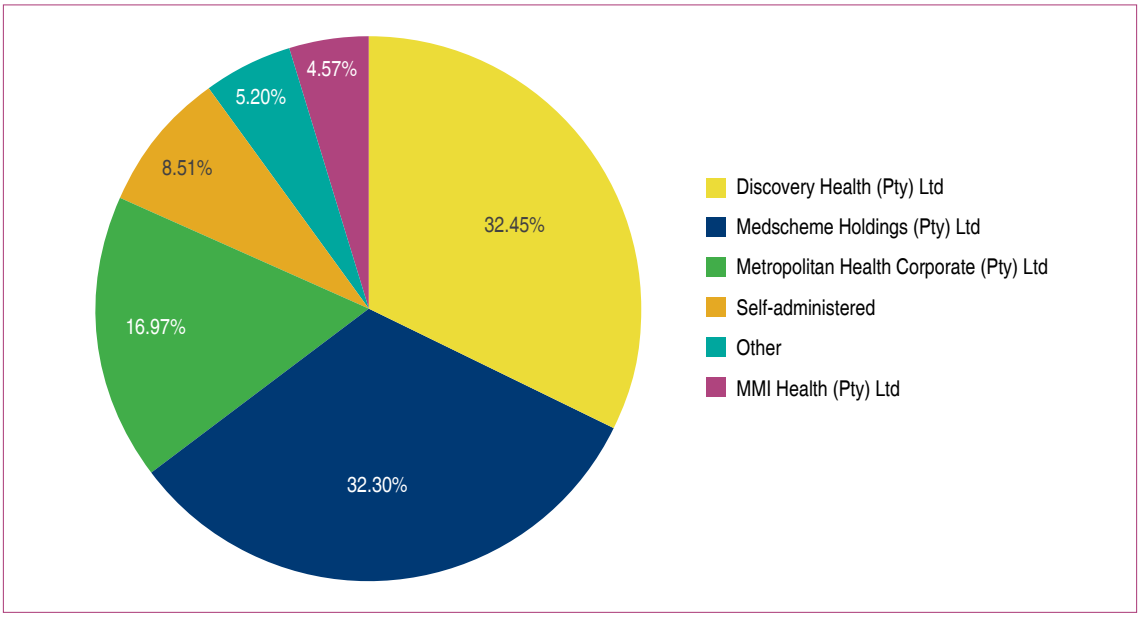



Figure 114: Administrator market share at the end of 2018

Figure 115 depicts the changes in market share of all medical schemes over the last nine years, based on the average number of beneficiaries administered by the various parties at the end of each year.

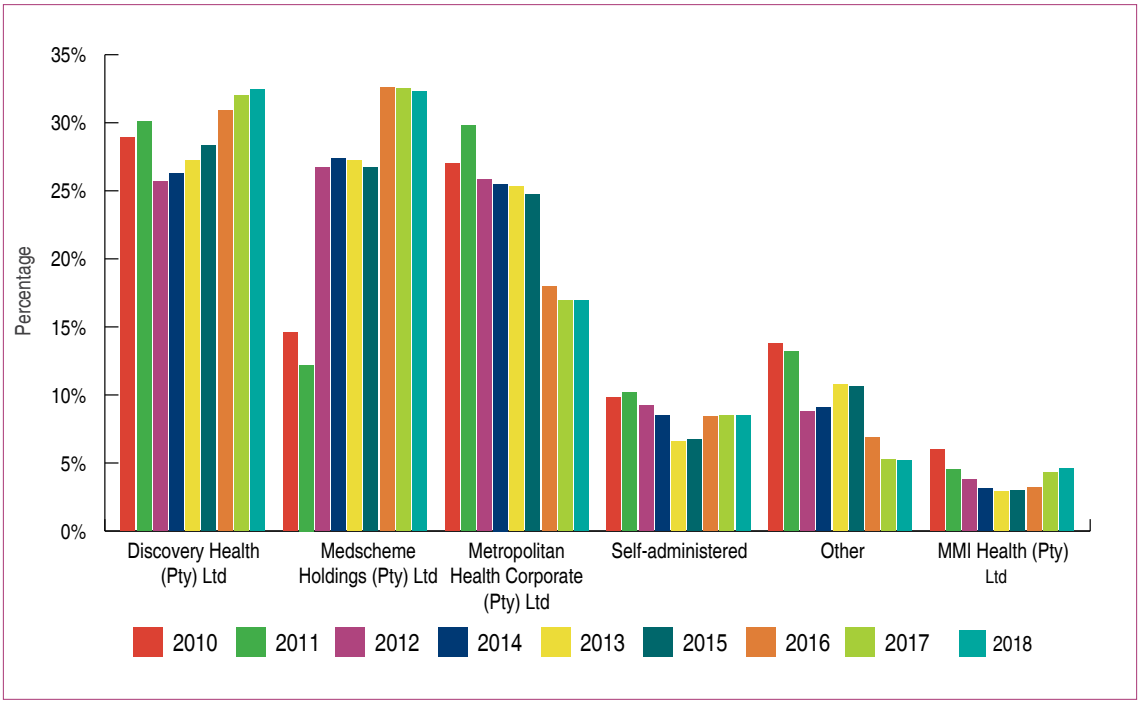



Figure 115: Market share of largest administrators based on average number of beneficiaries (2010–2018)*

* *The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AF)*

Four third-party administrators continued to dominate the market in 2018, namely (in order of market share):

- Discovery Health (Pty) Ltd 32.45%
- Medscheme Holdings (Pty) Ltd 32.30%
- Metropolitan Health Corporate (Pty) Ltd 16.97%
- MMI Health (Pty) Ltd 4.57%

Collectively the above companies administer 86.29% of the market (excluding self-administered medical schemes).[5]

Table 98 indicates the change in administrator market share between 2010 and 2018.

Figure 116 shows the change in market share for the administrators with the largest share of the market for all schemes, between 2010 and 2018. The administrator with the highest growth in market share is Medscheme Holdings (Pty) Ltd which grew by 121.23% over that time period with a market share of 32.30%. Discovery Health (Pty) Ltd is however now the largest administrator, with a market share of 32.45%.

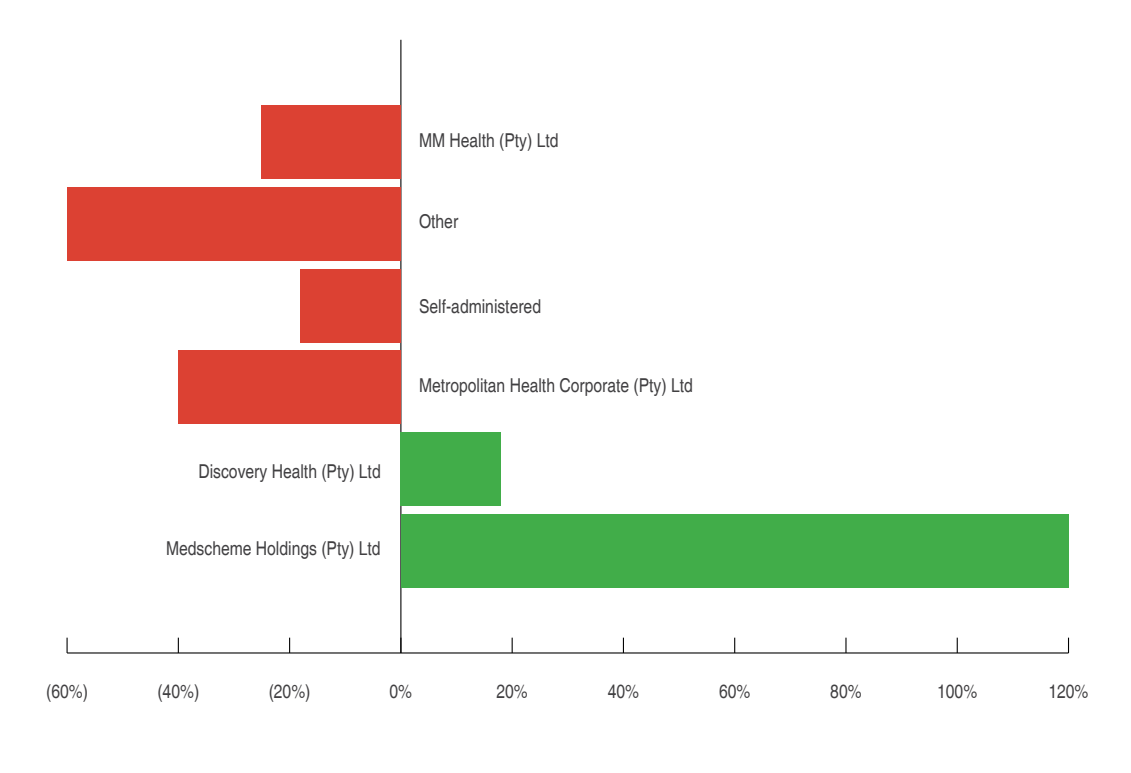



Figure 116: Percentage change in administrators with largest market share for all schemes (2010–2018)



5 *The Government Employees Medical Scheme (GEMS) has had a joint administrator contract in place since 2012. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The membership was included for both administrators.*

Table 98: Administrator market share (2010–2018)

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | % change: 2010–18 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Largest market share – open schemes** | | | | | | | | | | |
| Discovery Health (Pty) Ltd | 44.90% | 48.50% | 50.80% | 52.40% | 53.40% | 54.20% | 54.80% | 55.73% | 56.37% | 25.55% |
| Medscheme Holdings (Pty) Ltd | 18.60% | 15.90% | 15.90% | 16.60% | 16.50% | 16.20% | 18.80% | 19.08% | 18.53% | -0.38% |
| Self-administered | 11.50% | 12.50% | 14.40% | 12.90% | 8.30% | 8.20% | 12.10% | 12.24% | 12.31% | 7.04% |
| Other | 18.70% | 18.70% | 14.20% | 13.80% | 17.30% | 16.50% | 9.10% | 7.18% | 6.77% | -63.80% |
| MMI Health (Pty) Ltd | 6.40% | 4.40% | 4.60% | 4.40% | 4.60% | 4.90% | 5.20% | 5.77% | 6.02% | -5.94% |
| Total | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| **Largest market share – restricted schemes** | | | | | | | | | | |
| Medscheme Holdings (Pty) Ltd | 8.90% | 7.30% | 35.90% | 36.30% | 36.30% | 35.80% | 44.70% | 44.06% | 44.21% | 396.74% |
| Metropolitan Health Corporate (Pty) Ltd | 64.90% | 67.80% | 47.40% | 46.70% | 46.60% | 46.20% | 33.70% | 31.59% | 31.64% | -51.25% |
| Discovery Health (Pty) Ltd | 6.20% | 6.40% | 4.40% | 4.60% | 5.10% | 5.70% | 10.20% | 11.51% | 11.77% | 89.84% |
| Self-administered | 7.30% | 7.10% | 4.80% | 4.90% | 5.10% | 5.50% | 5.30% | 5.26% | 5.23% | -28.36% |
| Other | 7.40% | 6.70% | 4.40% | 5.40% | 5.40% | 5.32% | 4.70% | 3.58% | 3.83% | -48.24% |
| MMI Health (Pty) Ltd | 5.40% | 4.70% | 3.00% | 2.10% | 1.40% | 1.40% | 1.40% | 4.00% | 3.32% | -38.52% |
| Total | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| **Largest market share – all schemes** | | | | | | | | | | |
| Discovery Health (Pty) Ltd | 28.90% | 30.10% | 25.70% | 26.30% | 27.20% | 28.30% | 30.90% | 31.99% | 32.45% | 12.28% |
| Medscheme Holdings (Pty) Ltd | 14.60% | 12.20% | 26.70% | 27.40% | 27.20% | 26.70% | 32.60% | 32.49% | 32.30% | 121.23% |
| Metropolitan Health Corporate (Pty) Ltd | 27.00% | 29.80% | 25.80% | 25.50% | 25.30% | 24.70% | 18.00% | 16.96% | 16.97% | -37.15% |
| Self-administered | 9.80% | 10.20% | 9.20% | 8.50% | 6.60% | 6.70% | 8.40% | 8.50% | 8.51% | -13.16% |
| Other | 13.80% | 13.20% | 8.80% | 9.10% | 10.80% | 10.60% | 6.90% | 5.24% | 5.20% | -62.32% |
| MMI Health (Pty) Ltd | 6.00% | 4.50% | 3.80% | 3.10% | 2.90% | 3.00% | 3.20% | 4.82% | 4.57% | -23.83% |
| Total | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |

Figures 117 and 119 indicate the changes in administrator market share over the last nine years for open and restricted medical schemes respectively.

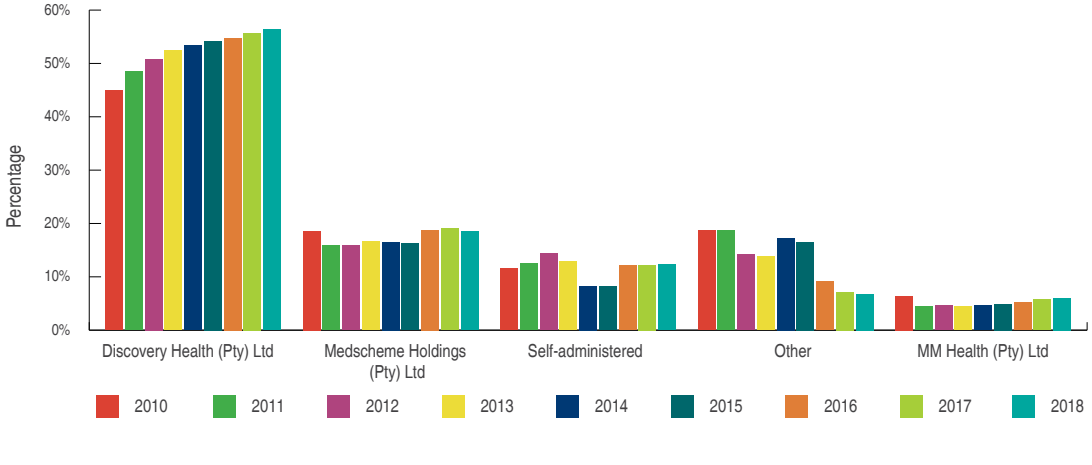



Figure 117: Open schemes market share of largest administrators based on average number of beneficiaries (2010–2018)*

* *The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AF)*

Figures 118 and 120 indicate the percentage growth or decline in market share between 2010 and 2018 for open and restricted medical schemes respectively.



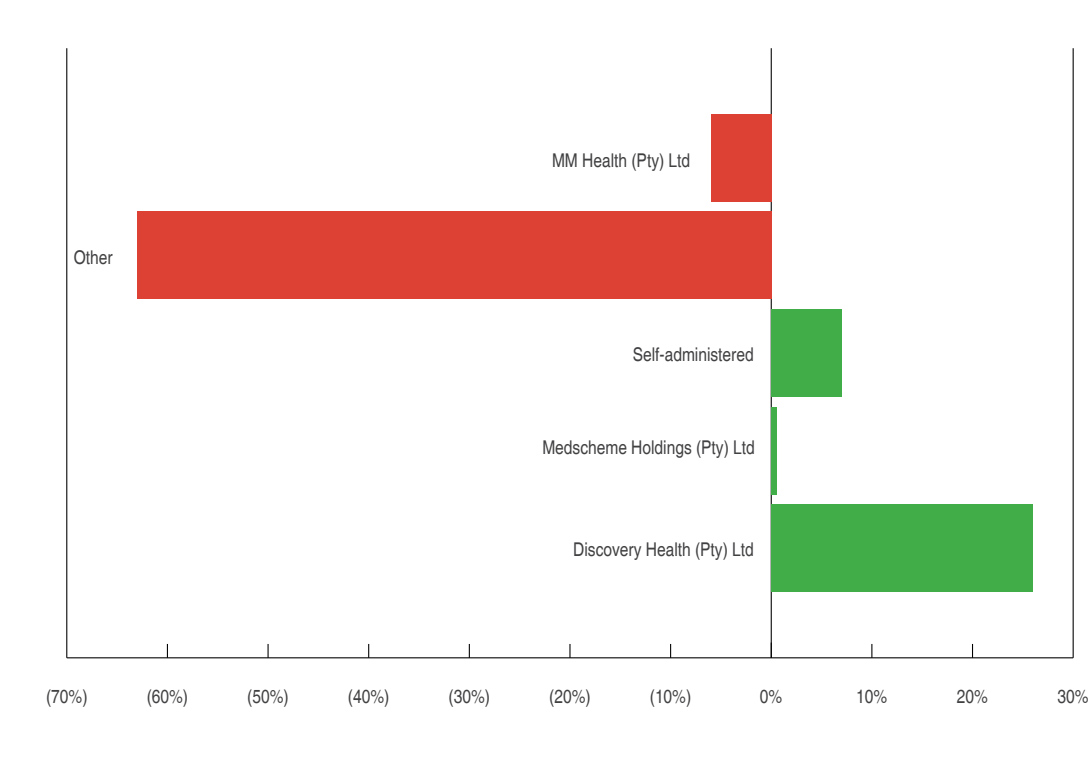



Figure 118: Percentage change in administrators with largest market share for open schemes (2010–2018)

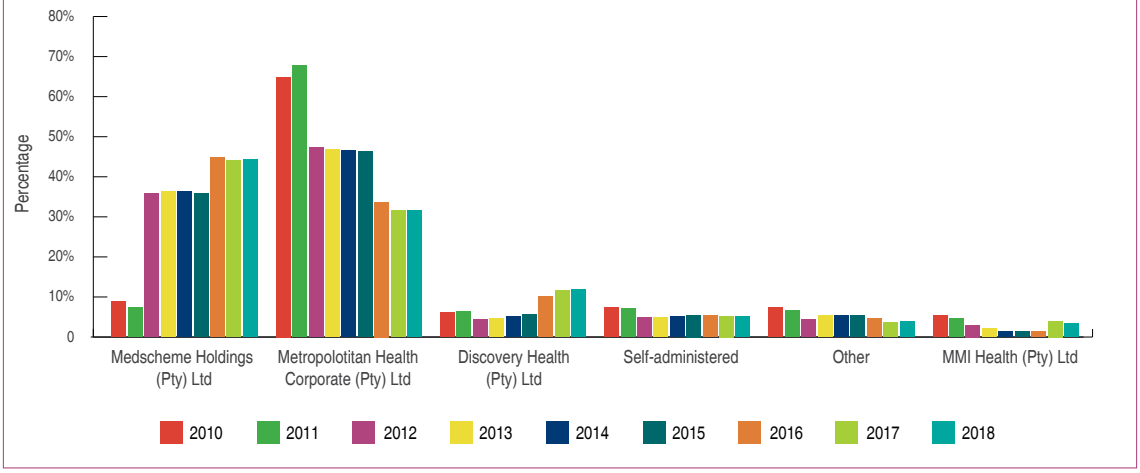



Figure 119: Restricted schemes market share of largest administrators based on average number of beneficiaries (2010–2018)*

* *The membership is based on the medical schemes administered at the end of the period and was not adjusted to reflect changes in administrators during the year (as per Annexure AF)*

Discovery Health (Pty) Ltd's share of the open schemes market increased to 56.37% (2017: 55.73%) and its share in the restricted schemes market increased to 11.77% (2017: 11.51%).

Medscheme Holdings (Pty) Ltd has the second-largest share in the open schemes administration market at 18.53% (2017: 19.08%) and the largest share in the restricted schemes administration market at 44.21% (2017: 44.06%). Medscheme Holdings (Pty) Ltd has been responsible for the GEMS contribution and debt management as well as correspondence services since 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the second-largest share of the restricted schemes market at 31.64% (2017: 31.59%).



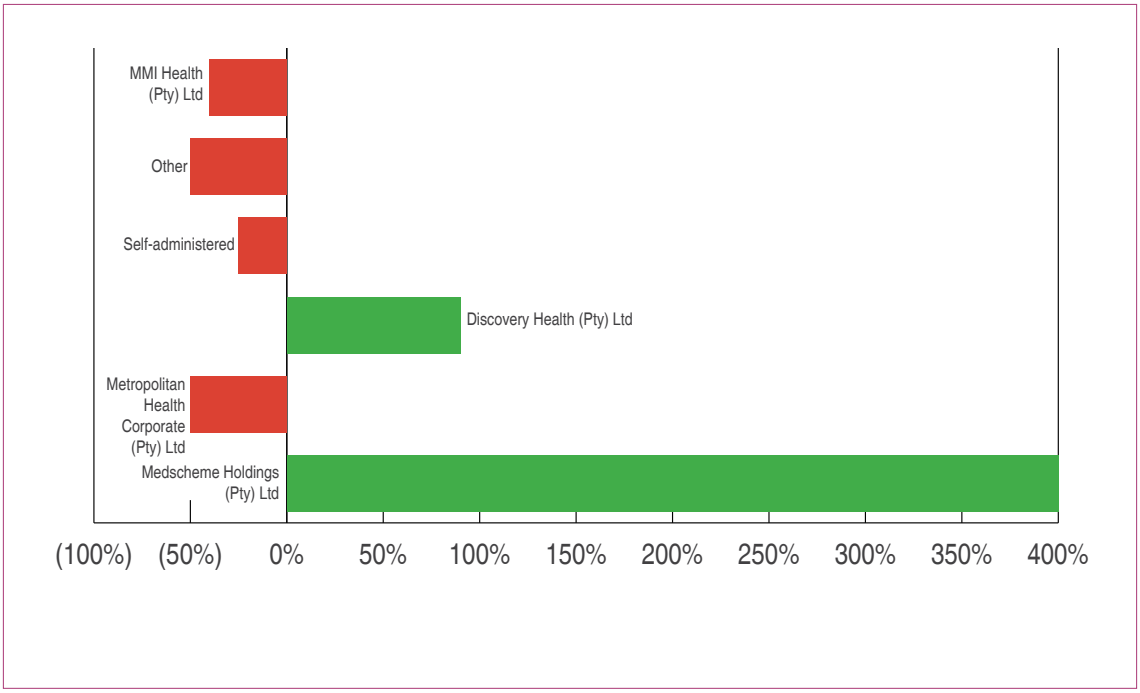



Figure 120: Percentage change in administrators with the largest market share for restricted schemes (2010–2018)

Table 99 shows the five administrators who had higher administration costs and fees than the industry average of administrators handling open schemes.

Table 99: Percentage deviation from industry average: open schemes

| | Market share % | Gross administration costs % | Administration fees paid* % | Fees paid to administrators % |
|---|---|---|---|---|
| Discovery Health (Pty) Ltd | 56.37 | 1.40 | 26.57 | 26.57 |
| Sechaba Medical Solutions (Pty) Ltd | 2.27 | 34.77 | 17.21 | 17.21 |
| Agility Health (Pty) Ltd | 0.91 | 74.21 | 5.90 | 5.90 |
| Universal Healthcare Administrators (Pty) Ltd | 0.58 | 6.94 | 5.14 | 5.14 |
| MMI Health (Pty) Ltd | 6.02 | -17.65 | 0.90 | 0.90 |

** Excluding co-administration fees*

Table 100 shows the seven administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

Table 100: Percentage deviation from industry average: restricted schemes

| | Market share % | Gross administration costs % | Administration fees paid* % | Fees paid to administrators % |
|---|---|---|---|---|
| Sanlam Health Administrators (Pty) Ltd | 0.81 | 277.51 | 330.57 | 277.80 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 1.24 | 261.72 | 290.90 | 242.99 |
| Liberty Health Administration (Pty) Ltd | 0.23 | 77.83 | 168.55 | 135.64 |
| Universal Healthcare Administrators (Pty) Ltd | 0.78 | 77.15 | 163.17 | 130.91 |
| Discovery Health (Pty) Ltd | 11.77 | 66.02 | 155.61 | 124.28 |
| MMI Health (Pty) Ltd | 3.32 | 85.30 | 150.89 | 120.14 |
| Momentum Thebe Ya Bophelo (Pty) Ltd | 0.82 | -0.05 | 23.41 | 8.29 |

** Excluding co-administration fees*

Administrators often provide other services such as call centre fees and marketing expenditure. These were included in the "fees paid to administrators" figures.

Tables 101 and 102 show administrator market share based on the average number of beneficiaries to whom services are being delivered by third-party administrators and medical schemes under self-administration. The tables also show the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure AF).

Table 101: Administrators with administration fees higher than the average of R223.37 pampm for all administrators

| Administrator | No. of medical schemes | Average members | Average beneficiaries | Market share % | Administration fees pampm |
|---|---|---|---|---|---|
| Sechaba Medical Solutions (Pty) Ltd | 1 | 46 850 | 112 201 | 1.05 | 322.70 |
| Discovery Health (Pty) Ltd | 19 | 1 649 728 | 3 467 223 | 32.45 | 282.81 |
| Sanlam Health Administrators (Pty) Ltd | 1 | 25 218 | 46 706 | 0.44 | 278.63 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 2 | 66 724 | 140 611 | 1.32 | 245.31 |

*pampm = per average member per month*

Table 102: Administrator market share 2018: open schemes

| Name of administrator | No. of schemes | Beneficiaries | Gross administration costs | | Administration fees paid* | | Total fees paid to administrators** | | Gross contributions | Risk claims ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Market share % | pabpm R | As % of GCI | pabpm R | As % of GCI | pabpm R | As % of GCI | pabpm R | % |
| Agility Health (Pty) Ltd | 2 | 0.91 | 258.69 | 11.68 | 121.74 | 5.50 | 121.74 | 5.50 | 2 213.94 | 96.80 |
| Discovery Health (Pty) Ltd | 1 | 56.37 | 150.57 | 7.80 | 145.50 | 7.54 | 145.50 | 7.54 | 1 929.19 | 88.43 |
| Medscheme Holdings (Pty) Ltd | 3 | 18.53 | 144.45 | 7.48 | 99.33 | 5.14 | 99.33 | 5.14 | 1 931.20 | 90.58 |
| MMI Health (Pty) Ltd | 1 | 6.02 | 122.28 | 9.16 | 116.00 | 8.69 | 116.00 | 8.69 | 1 335.36 | 87.32 |
| Momentum Thebe Ya Bophelo (Pty) Ltd | 3 | 0.85 | 113.28 | 10.02 | 76.61 | 6.77 | 76.61 | 6.77 | 1 130.89 | 86.66 |
| Private Health Administrators (Pty) Ltd | 1 | 0.76 | 138.28 | 7.93 | 91.63 | 5.26 | 91.63 | 5.26 | 1 742.88 | 107.10 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 1 | 1.40 | 178.89 | 7.01 | 95.81 | 3.75 | 95.81 | 3.75 | 2 552.50 | 88.88 |
| Sechaba Medical Solutions (Pty) Ltd | 1 | 2.27 | 200.12 | 11.54 | 134.74 | 7.77 | 134.74 | 7.77 | 1 734.55 | 97.88 |
| Self-administered | 6 | 12.31 | 139.29 | 7.25 | - | - | - | - | 1 921.50 | 92.50 |
| Universal Healthcare Administrators (Pty) Ltd | 2 | 0.58 | 158.80 | 9.71 | 120.87 | 7.39 | 120.87 | 7.39 | 1 635.28 | 92.88 |
| **Average** | **21** | **100.00** | **148.49** | **7.86** | **114.96** | **6.08** | **114.96** | **6.08** | **1 889.91** | **89.84** |

**Excluding co-administration fees*

***Administration fees including co-administration fees*

*pabpm = per average beneficiary per month*

*GCI = Gross Contribution Income*

*pampm = per average member per month*

Table 103: Administrator market share 2018: restricted schemes

| Name of administrator | No. of schemes | Beneficiaries | Gross administration costs | | Administration fees paid* | | Total fees paid to administrators** | | Gross contributions | Risk claims ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Market share % | pabpm R | As % of GCI | pabpm R | As % of GCI | pabpm R | As % of GCI | pabpm R | % |
| Discovery Health (Pty) Ltd**** | 18 | 11.77 | 103.66 | 5.94 | 89.31 | 5.12 | 89.31 | 5.12 | 1 745.36 | 92.31 |
| Liberty Health Administration (Pty) Ltd | 1 | 0.23 | 111.04 | 5.39 | 93.83 | 4.55 | 93.83 | 4.55 | 2 060.43 | 100.74 |
| Medscheme Holdings (Pty) Ltd** | 11 | 44.21 | 31.60 | 1.82 | 49.81 | 0.81 | 25.19 | 1.45 | 1 737.81 | 89.63 |
| Metropolitan Health Corporate (Pty) Ltd*** | 1 | 31.64 | 67.53 | 3.84 | 34.76 | 1.97 | 34.76 | - | 1 760.51 | 85.64 |
| MMI Health (Pty) Ltd**** | 11 | 3.32 | 115.70 | 7.33 | 87.66 | 5.55 | 87.66 | 5.55 | 1 579.21 | 99.09 |
| Momentum Thebe Ya Bophelo (Pty) Ltd | 3 | 0.82 | 62.41 | 6.35 | 43.12 | 4.39 | 43.12 | 4.39 | 983.19 | 95.67 |
| Private Health Administrators (Pty) Ltd | 1 | 0.07 | 108.91 | 5.57 | 79.55 | 4.07 | - | - | 1 954.34 | 100.64 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 1 | 1.24 | 225.86 | 11.54 | 136.58 | 6.98 | 136.58 | 6.98 | 1 957.12 | 89.86 |
| Sanlam Health Administrators (Pty) Ltd | 1 | 0.81 | 235.72 | 10.68 | 150.44 | 6.82 | 150.44 | 6.82 | 2 206.48 | 92.02 |
| Self-administered | 8 | 5.23 | 88.56 | 6.81 | - | - | - | - | 1 301.33 | 91.16 |
| Universal Healthcare Administrators (Pty) Ltd | 4 | 0.78 | 110.61 | 7.42 | 91.95 | 6.17 | 91.95 | 6.17 | 1 490.82 | 89.99 |
| **Average** | **60** | **100.12** | **62.44** | **5.37** | **34.94** | **3.01** | **39.82** | **3.43** | **1 162.22** | **90.71** |

**Excluding co-administration fees*

***Administration fees including co-administration fees*

*pabpm = per average beneficiary per month*

*GCI = Gross Contribution Income*

***The GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included*

****The GEMS administration fee was included in the cash flows under administration; the GEMS GCI was included*

*****Engen Medical Benefit Fund changed its administrator from MMI Health (Pty) Ltd to Discovery Health (Pty) Ltd on 1 July 2018. Its membership was included in both administrators to represent the market share during the year*

Table 104 indicates the total fees paid to the top four third-party administrators in terms of market share for all schemes, as well as the schemes falling under their administration.

Table 104: Total fees paid to administrators (excluding accredited managed healthcare services) – deviation from average per administrator (2018)

| Ref. no. | Name of medical scheme | Name of administrator | Average members | Total fees paid to administrators | | Average per administrator | Average per administrator |
|---|---|---|---|---|---|---|---|
| | | | | pampm R | As % of GAE | pampm R | % |
| 1125 | Discovery Health Medical Scheme | Discovery Health (Pty) Ltd | 1 335 093 | 304.33 | 96.63 | 282.81 | 7.61 |
| 1145 | LA-Health Medical Scheme | | 74 124 | 292.39 | 93.41 | | 3.39 |
| 1520 | University of KwaZulu-Natal Medical Scheme | | 3 445 | 269.41 | 100.00 | | -4.74 |
| 1571 | Anglovaal Group Medical Scheme | | 2 559 | 255.66 | 85.81 | | -9.60 |
| 1241 | Naspers Medical Fund | | 4 139 | 246.54 | 84.06 | | -12.82 |
| 1572 | Engen Medical Benefit Fund | | 3 346 | 238.60 | 86.85 | | -15.63 |
| 1578 | TFG Medical Aid Scheme | | 2 960 | 222.71 | 87.80 | | -21.25 |
| 1516 | Quantum Medical Aid Society | | 4 174 | 216.29 | 85.32 | | -23.52 |
| 1579 | Tsogo Sun Group Medical Scheme | | 5 110 | 207.72 | 81.63 | | -26.55 |
| 1430 | Remedi Medical Aid Scheme | | 20 897 | 202.51 | 92.57 | | -28.39 |
| 1176 | Retail Medical Scheme | | 12 276 | 199.38 | 95.40 | | -29.50 |
| 1547 | Malcor Medical Scheme | | 4 758 | 186.92 | 78.39 | | -33.91 |
| 1526 | BMW Employees Medical Aid Society | | 3 441 | 184.12 | 91.80 | | -34.90 |
| 1012 | Anglo Medical Scheme | | 8 926 | 181.83 | 61.76 | | -35.71 |
| 1209 | South African Breweries Medical Aid Scheme (SABMAS) | | 10 430 | 180.82 | 72.11 | | -36.06 |
| 1253 | Glencore Medical Scheme | | 9 105 | 157.76 | 93.85 | | -44.22 |
| 1584 | Netcare Medical Scheme | | 18 214 | 154.17 | 92.12 | | -45.49 |
| 1279 | Bankmed | | 108 669 | 145.65 | 78.52 | | -48.50 |
| 1599 | Lonmin Medical Scheme | | 18 024 | 63.21 | 88.69 | | -77.65 |
| 1202 | Fedhealth Medical Scheme | Medscheme Holdings (Pty) Ltd | 72 286 | 282.09 | 72.20 | 110.61 | 155.03 |
| 1441 | Parmed Medical Aid Scheme | | 2 362 | 242.23 | 73.45 | | 118.99 |
| 1507 | Barloworld Medical Scheme | | 5 221 | 221.57 | 84.05 | | 100.32 |
| 1424 | SABC Medical Aid Scheme | | 4 621 | 204.85 | 75.54 | | 85.20 |
| 1512 | Bonitas Medical Fund | | 331 955 | 202.98 | 70.19 | | 83.51 |
| 1005 | AECI Medical Aid Society | | 6 818 | 201.84 | 86.97 | | 82.48 |
| 1214 | Old Mutual Staff Medical Aid Fund | | 18 207 | 200.99 | 86.30 | | 81.71 |
| 1234 | Sasolmed | | 29 453 | 197.37 | 79.52 | | 78.44 |
| 1039 | MBMed Medical Aid Fund | | 4 028 | 195.06 | 80.46 | | 76.35 |
| 1566 | Horizon Medical Scheme | | 3 442 | 174.18 | 82.67 | | 57.47 |
| 1469 | Nedgroup Medical Aid Scheme | | 28 702 | 161.55 | 82.21 | | 46.05 |
| 1537 | Hosmed Medical Aid Scheme | | 23 052 | 148.88 | 40.93 | | 34.60 |
| 1580 | South African Police Service Medical Scheme (POLMED) | | 175 954 | 92.85 | 57.84 | | -16.06 |
| 1598 | Government Employees Medical Scheme (GEMS) | | 695 531 | 90.62 | 41.91 | | -18.07 |
| 1598 | Government Employees Medical Scheme (GEMS) | Metropolitan Health Corporate (Pty) Ltd | 695 531 | 90.62 | 41.91 | 90.62 | - |
| 1167 | Momentum Health | MMI Health (Pty) Ltd | 156 761 | 220.57 | 94.87 | 201.45 | 9.49 |
| 1186 | PG Group Medical Scheme | | 1 451 | 206.53 | 73.72 | | 2.52 |
| 1563 | Pick n Pay Medical Scheme | | 7 205 | 204.61 | 78.61 | | 1.57 |
| 1293 | Wooltru Healthcare Fund | | 9 810 | 199.30 | 82.01 | | -1.07 |
| 1600 | Motohealth Care | | 21 530 | 186.18 | 80.32 | | -7.58 |
| 1548 | Medipos Medical Scheme | | 13 729 | 169.77 | 84.66 | | -15.73 |
| 1559 | Imperial Group Medical Scheme | | 7 721 | 157.68 | 60.28 | | -21.73 |
| 1582 | Transmed Medical Fund | | 26 448 | 156.73 | 70.99 | | -22.20 |
| 1270 | Golden Arrow Employees' Medical Benefit Fund | | 2 789 | 156.10 | 86.86 | | -22.51 |
| 1237 | BP Medical Aid Society | | 1 808 | 153.48 | 50.09 | | -23.81 |
| 1271 | Fishing Industry Medical Scheme (FISH-MED) | | 1 761 | 84.09 | 62.58 | | -58.26 |

*GAE = Gross Administration Expenditure*

*pampm = per average member per month*

Table 105 shows market share of administrators including accredited managed healthcare services.

Table 105: Market share of administrators (including accredited managed healthcare services)

| Name of administrator | No. of schemes | Beneficiaries Market share % | Total fees paid to administrators (various services)* pabpm R | Net relevant healthcare expenditure incurred pabpm R | Accredited managed healthcare services (no transfer of risk) received* pabpm R | Accredited managed healthcare services (risk transfer arrangement): capitation fee received* pabpm R | Total fees received* pabpm R |
|---|---|---|---|---|---|---|---|
| Agility Health (Pty) Ltd | 2 | 0.42 | 121.74 | 1 957.80 | 53.56 | - | 175.31 |
| Discovery Health (Pty) Ltd | 19 | 32.45 | 134.57 | 1 395.46 | 47.05 | 54.39 | 185.07 |
| Liberty Health Administration (Pty) Ltd | 1 | 0.12 | 93.83 | 1 713.93 | 41.61 | - | 135.44 |
| Medscheme Holdings (Pty) Ltd** | 14 | 32.30 | 44.91 | 1 657.77 | 29.34 | - | 73.73 |
| Metropolitan Health Corporate (Pty) Ltd | 1 | 16.97 | 34.76 | 1 470.14 | 1.81 | - | 36.57 |
| MMI Health (Pty) Ltd | 12 | 4.57 | 104.97 | 1 239.43 | 29.46 | 117.92 | 225.86 |
| Momentum Thebe Ya Bophelo (Pty) Ltd | 6 | 0.83 | 58.98 | 919.79 | 26.63 | - | 77.74 |
| Private Health Administrators (Pty) Ltd | 2 | 0.39 | 90.41 | 1 650.61 | 30.95 | 17.77 | 137.34 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 2 | 1.32 | 116.41 | 1 938.46 | 33.23 | - | 149.64 |
| Sanlam Health Administrators (Pty) Ltd | 1 | 0.44 | 150.44 | 1 873.62 | 49.77 | - | 200.21 |
| Sechaba Medical Solutions (Pty) Ltd | 1 | 1.05 | 134.74 | 1 697.77 | 31.85 | - | 166.60 |
| Self-administered | 14 | 8.51 | - | 1 478.31 | 22.82 | - | 10.35 |
| Universal Healthcare Administrators (Pty) Ltd | 6 | 0.69 | 103.20 | 1 309.82 | 34.72 | - | 134.79 |
| **Average** | **81** | **100.06** | **100.28** | **1 474.15** | **37.26** | **90.46** | **108.88** |

*The table reflects market share based on the number of beneficiaries administered during the year (i.e. it includes mid-year administrator changes)*

**Excluding co-administration fees*

***Only the GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included*

*pabpm = per average beneficiary per month*

Table 106 shows the nine administrators that had the highest deviation from the 2018 industry average of R100.28 pabpm in respect of total fees received by administrators.

Table 106: Total fees paid to administrators (including accredited managed healthcare services) – deviation from industry average (2018)

| Name of administrator | Total fees paid to administrators (various services)* % | Accredited managed healthcare services (no transfer of risk) received* % | Accredited managed healthcare services (risk transfer arrangement): capitation fee received* % | Total fees received* % |
|---|---|---|---|---|
| MMI Health (Pty) Ltd | 4.68 | -20.93 | 30.36 | 107.44 |
| Sanlam Health Administrators (Pty) Ltd | 50.02 | 33.57 | -100.00 | 83.88 |
| Discovery Health (Pty) Ltd | 34.19 | 26.27 | -39.87 | 69.98 |
| Agility Health (Pty) Ltd | 21.40 | 43.75 | -100.00 | 61.01 |
| Sechaba Medical Solutions (Pty) Ltd | 34.36 | -14.52 | -100.00 | 53.01 |
| Professional Provident Society Healthcare Administrators (Pty) Ltd | 16.08 | -10.82 | -100.00 | 37.44 |
| Private Health Administrators (Pty) Ltd | -9.84 | -16.94 | -80.36 | 26.14 |
| Liberty Health Administration (Pty) Ltd | -6.43 | 11.67 | -100.00 | 24.39 |
| Universal Healthcare Administrators (Pty) Ltd | 2.91 | -6.82 | -100.00 | 23.80 |

** Excluding co-administration fees*

# PART H:
## HUMAN RESOURCES FOR HEALTH

# HUMAN RESOURCES FOR HEALTH

## Policy context

The CMS mandate with regards to medical scheme beneficiaries, lies in ensuring that health financing is spent on efficiently allocated health resources across geographic markets. Further to this, the Health Market Inquiry's (HMI) provisional recommendations, finds it important that a supply-side regulator coordinates and enables efficiencies in the private healthcare delivery system. This will aid in reducing supply-induced demand (SID), or practices associated with fraud, waste and abuse. Greater social benefit can be realised with the reallocation of healthcare resources to geographic areas that are not so concentrated.

The NHI White Paper's Primary Healthcare (PHC) Re-engineering has provided general practitioners (GPs) from historically disadvantaged groups, with the opportunity to participate in what was a diminishing proportion of private healthcare expenditure. In addition, delivery networks should be encouraged in underserved areas with high patient loads (inverse of density ratios). Inequality can thus be reduced by a PHC system that increases access to effective care for all vulnerable groups.

Health system strengthening and implementation of appropriate supply-side resource allocations can incentivise behaviour that improves market conduct. The following gives an account of access and efficiency of GP allocations in South Africa.

## Data sources and methods

The number of private sector GPs were sourced from a dataset derived from the CMS annual utilisation returns. The private sector GP data are based on medical practitioner claims for 2018. Discipline codes were used to uniquely identify claiming GPs. Numbers for the public sector GP resources were sourced from the South African Health Review (SAHR) 2018 appendix. The GP figures from the SAHR (2018) are derived by subtracting medical practitioner numbers from medical practitioners who are specialists.

The equality indicators used in this analysis are Gini-coefficients. This is how to interpret Gini-coefficients:

- Gini-coefficients range from 0 to 1 with 0 being the lowest and 1 being the highest inequality. The thresholds for the state of inequality described by the Gini-Coefficient ratio are:
  - Gini-coefficient of 0 = perfect equality;
  - Gini-coefficient of 0.2 = low inequality;
  - Gini-coefficient of 0.25 = moderate inequality;
  - Gini-coefficient of 0.35 = high inequality; and
  - Gini-coefficient of 0.5 = extreme inequality.

The Hoover or Robin Hood Index is used to assess the quantum of GPs required to be redistributed to underserved areas, before perfect equality can be reached. This is a convenient index for quantifying the degree of intervention required to attain equal access to healthcare resources.

The state of inequality within provinces is illustrated using Lorenz curves. The quintiles are derived from ranking and stratifying per capita healthcare utilisation costs on GPs, across 5 strata. Quintile 1 being the lowest and quintile 5 being the highest ranked in terms of per capita healthcare utilisation. The distribution of expenditure relative to beneficiaries is cumulative on the Lorenz curves. The cumulative distribution on the Lorenz curves applies to: i) Figure 124, ii) Figure 127, iii) Figure 130, and iv) Figure 133.

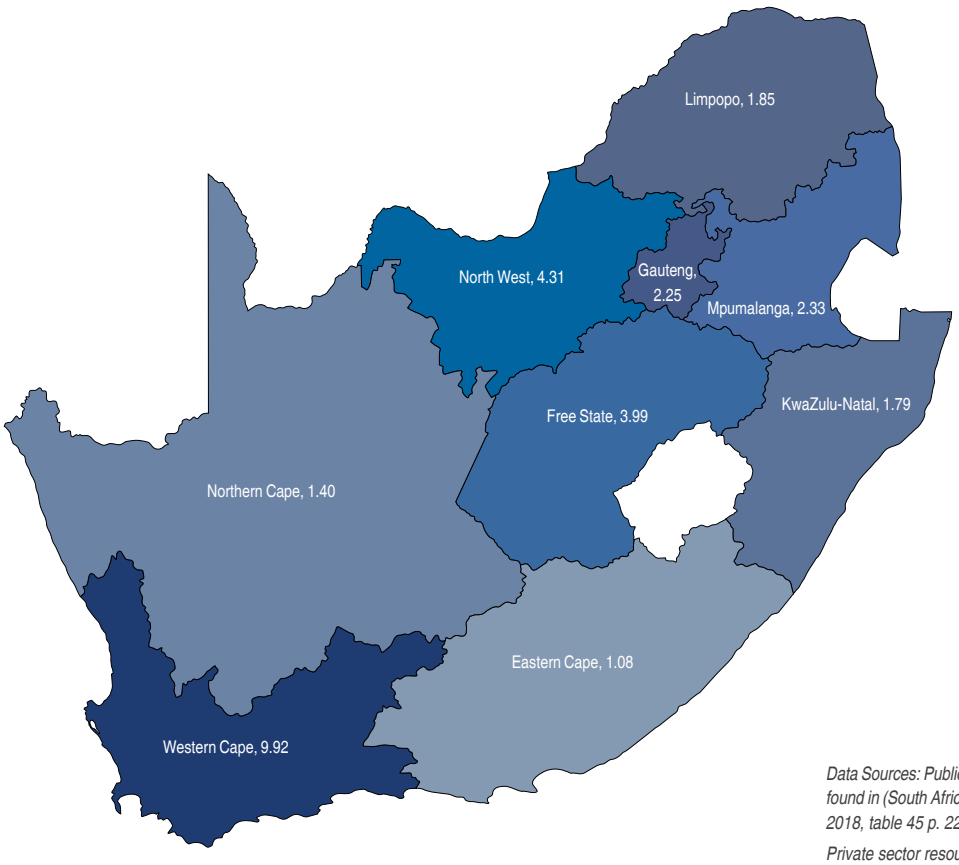
Input and output optimisation methods were applied to GP counts and GP visits, respectively. The returns to scale explain healthcare resource allocation outcomes in terms of returns to GP visits (outcome maximisation), and number of GPs (input minimisation). Differences between quintiles in provinces are adjusted for, before comparing efficiency outcomes across intra-provincial quintiles. That said, the data are not adjusted for morbidity.

## Private vs public resource allocation

Figure 121 reports GP availability ratios per province, reflected as the number of private sector GPs relative to public sector private sector GPs. The overall ratio for South Africa is 2.35 GPs per public sector GP. The private-public sector GP composition ratios for each province is described as follows (see Figure 121):

- Eastern Cape – 1.08:1;
- Free State – 3.99:1;
- Gauteng – 2.25:1;
- KwaZulu-Natal – 1.79:1;
- Limpopo – 1.85:1;
- Mpumalanga – 2.33:1;
- Northern Cape – 1.40:1;
- North West – 4.31:1; and
- Western Cape a staggering – 9.92:1.

Western Cape has an extraordinarily high ratio of GPs in the private sector relative to the public sector.




*Data Sources: Public sector resources found in (South African Health Review 2018, table 45 p. 220).*

*Private sector resource sourced from CMS annual utilisation returns.*

Figure 121: Geospatial map of Private-Public sector GP availability ratio

## Equality of resource allocation

Achieving accessible and effective healthcare for all, and especially vulnerable groups, requires careful consideration:

- The geographic sparsness of resources in re-imbursement mechanisms (Figure 121) as suggested by the Resource Allocation Working Party(RAWP) for the UK National Health System
- Whether health providers are equally distributed around where beneficiaries live;
- What impact inequality in provider distribution has on patient loads (patients per practice), and the potential competitive effect this has on provider behaviour in geographic areas in which they are concentrated in space and numbers; and
- How all these considerations impact the state of inequality and whether it can be measured in order to find and monitor policy solutions.

From the intra-provincial analysis, shown in Figure 121, the disparities between provinces can be seen. These disparities are also caused by the maldistribution of resources between the private and public sectors.

The purpose of this section is to provide a situational analysis of the problem on an intra-provincial basis. The analysis provides an empirical descriptive analysis of the problem in four provinces, namely the Eastern Cape, Gauteng, KwaZulu-Natal and the Western Cape.

Figure 122, Figure 125, Figure 128 and Figure 131 describe the proportional percentage of medical scheme beneficiaries per quintile, relative to the available GPs that claimed for services rendered per quintile, accrued in 2018. The figures describe summary statistics at provincial level for: i) the Eastern Cape (Figure 122), ii) Gauteng (Figure 125), iii) KwaZulu-Natal (Figure 128), and iv) Western Cape (Figure 131).

Figure 123, Figure 126, Figure 129 and Figure 132 report the patient loads (number of beneficiaries) per GP practice in 2018. The patient loads are reported at quintile level. The figures describe summary statistics at provincial level, i) Eastern Cape (Figure 123), ii) Gauteng (Figure 126), iii) KwaZulu-Natal (Figure 129), and iv) the Western Cape (Figure 132).

Figure 124, Figure 127, Figure 130, and Figure 133 are Lorenz curves. The Lorenz curves expresses cumulative shares of GP utilisation expenditure for beneficiaries from quintile 1 to quintile 5. The orange 45-degree line represents equal GP expenditure allocations across the quintiles. The blue curve represents the actual cumulative GP healthcare utilisation share by beneficiaries from quintile 1 to quintile 5. The area between the orange line and blue curve represents the concentration of inequality in a province. The reported Lorenz curves are for: i) Eastern Cape (Figure 124), ii) Gauteng (Figure 127), iii) KwaZulu-Natal (Figure 130), and iv) Western Cape (Figure 133).

### *Equality of Access: Eastern Cape*

Figure 122 describes the relationship between GP allocation and the proportional distribution of beneficiaries in the Eastern Cape for 2018:

- Quintile 1 – there are 8% of GPs relative to 17% of beneficiaries;
- Quintile 2 – there are 19% of GPs relative to 23% of beneficiaries;
- Quintile 3 – there are 17% of GPs relative to 20% of beneficiaries;
- Quintile 4 – there are 16% of GPs relative to 19% of beneficiaries; and
- Quintile 5 – there are 40% of GPs relative to 21% of beneficiaries.

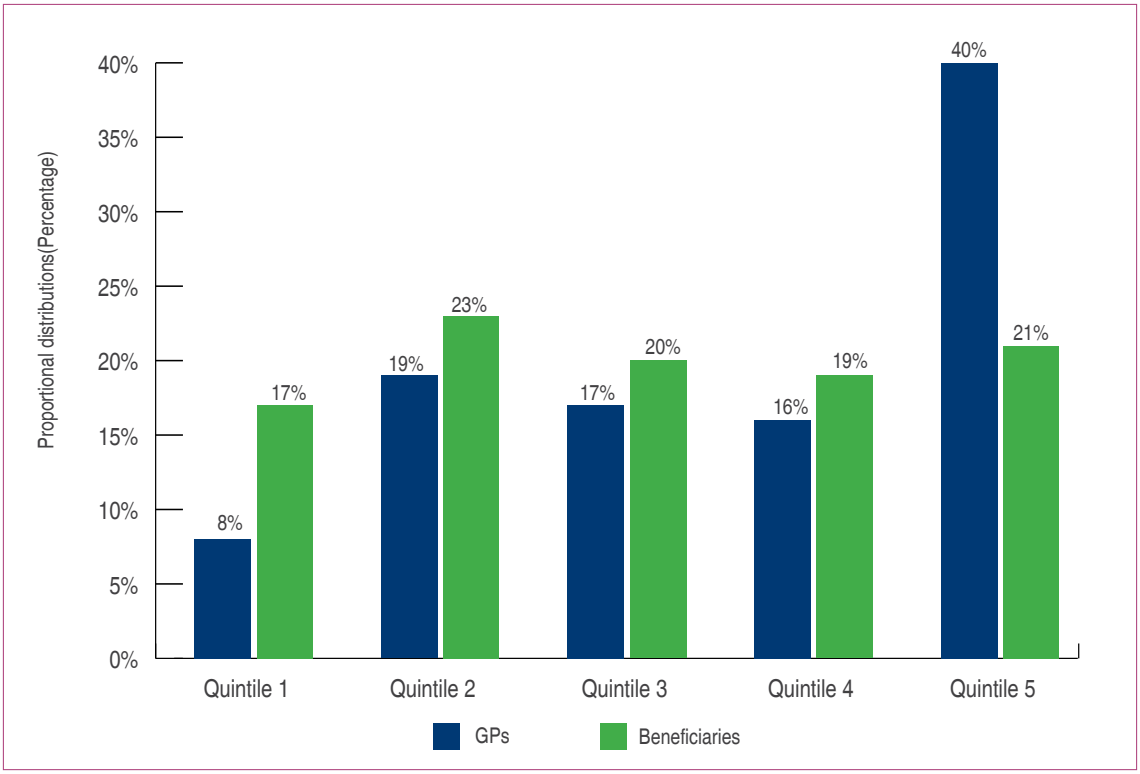



Figure 122: GPs and beneficiaries per quintile in the Eastern Cape

Figure 123 reports the patient loads per quintile in the Eastern Cape in 2018. The number of beneficiaries per GP practice are:

- Quintile 1 = 785 beneficiaries;
- Quintile 2 = 430 beneficiaries;
- Quintile 3 = 418 beneficiaries;
- Quintile 4 = 423 beneficiaries; and
- Quintile 5 = 191 beneficiaries.

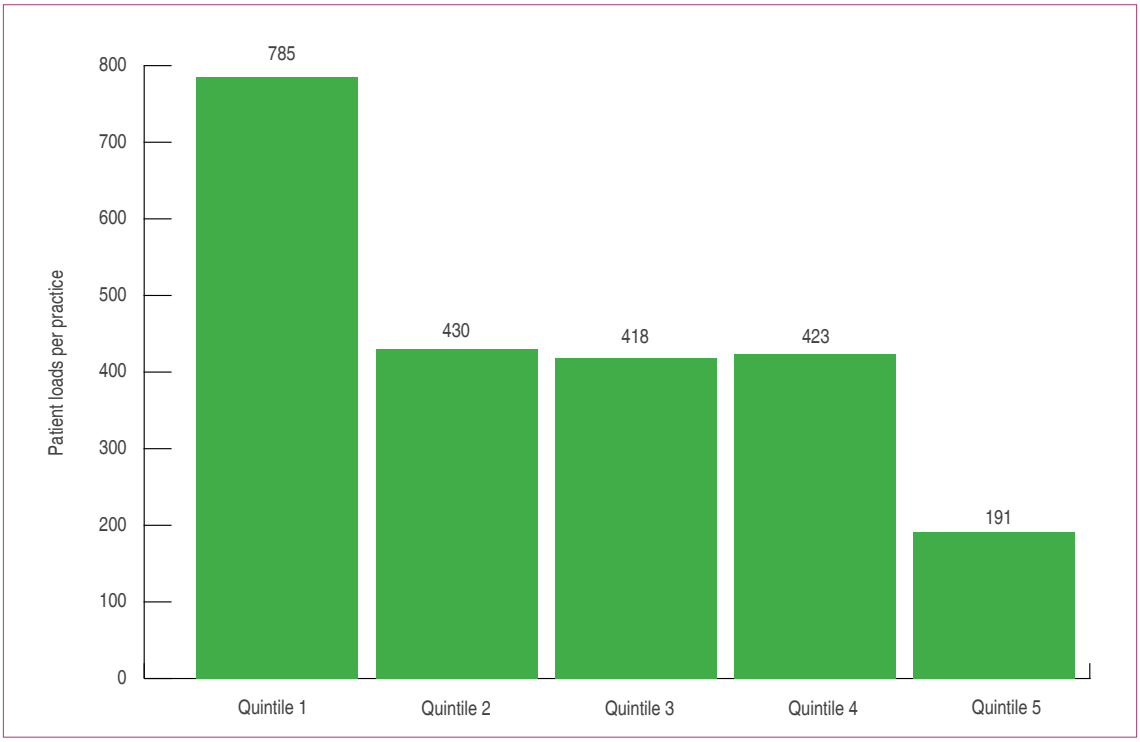



Figure 123: Patient loads per GP practice by quintile in the Eastern Cape

Figure 124 describes the inequality in GP allocations in the Eastern Cape in 2018. The Gini-coefficient in the Eastern Cape is 0.46, which means that there is a high inequality in the allocation of GPs. The Hoover index suggests that 36% of GPs should be re-allocated before perfect equality can be attained in the Eastern Cape.

The cumulative share of healthcare expenditure spent by beneficiaries on GP services across the quintiles is as follows:

- Beneficiaries in quintile 1 spent 2% of the total share;
- Beneficiaries in quintile 2 spent 8% of the total share;
- Beneficiaries in quintile 3 spent 10% of the total share;
- Beneficiaries in quintile 4 spent 30% of the total share; and
- Beneficiaries in quintile 5 spent 50% of the total share

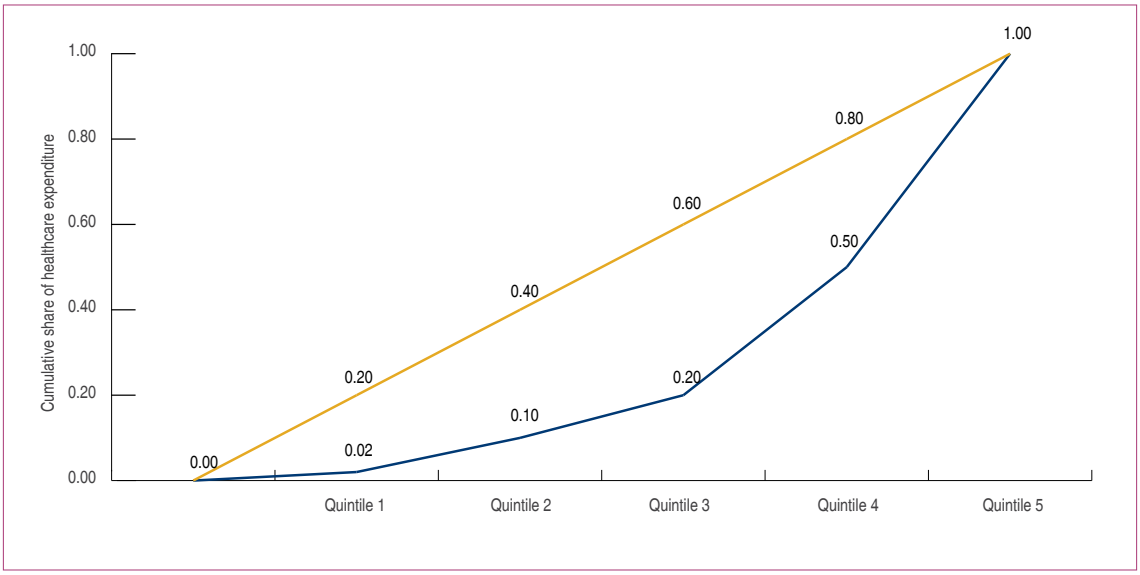



Figure 124: Lorenz curve – cumulative share of expenditure by quintile in Eastern Cape

*Equality of Access: Gauteng*

Figure 125 describes the relationship between GP allocation and the proportional distribution of beneficiaries in Gauteng for 2018:

- Quintile 1 – there are 4% of GPs relative to 13% of beneficiaries;
- Quintile 2 – there are 8% of GPs relative to 27% of beneficiaries;
- Quintile 3 – there are 11% of GPs relative to 20% of beneficiaries;
- Quintile 4 – there are 17% of GPs relative to 20% of beneficiaries; and
- Quintile 5 – there are 61% of GPs relative to 20% of beneficiaries.

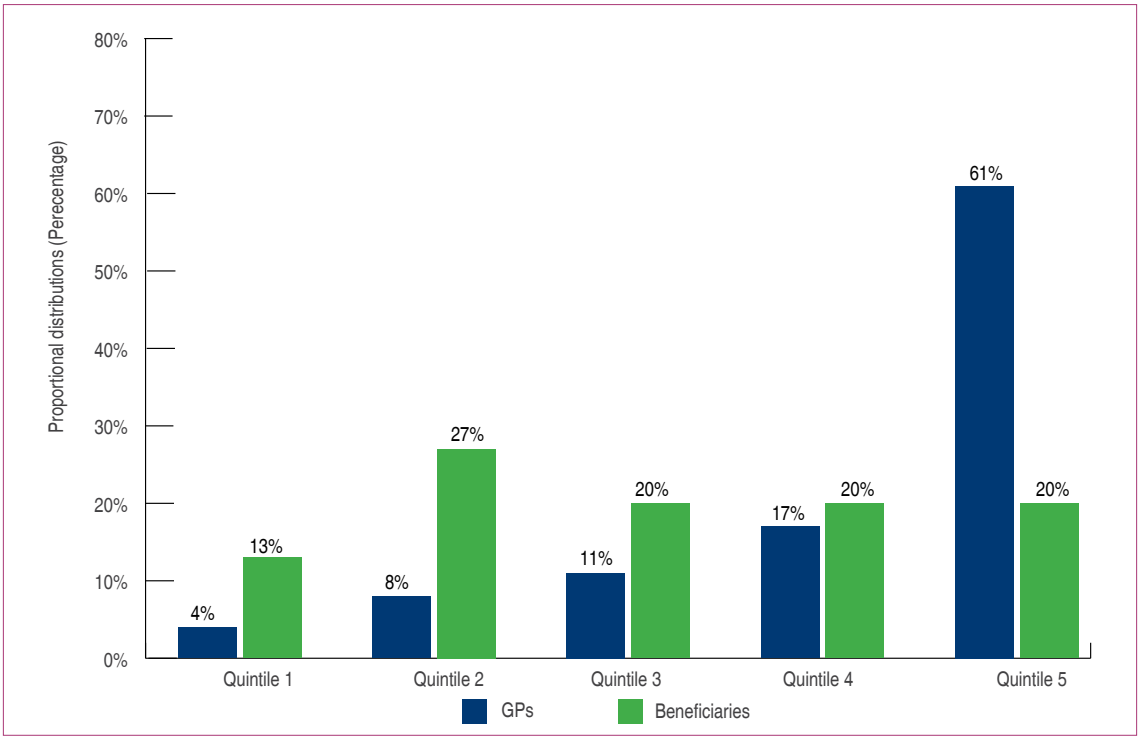



Figure 125: GPs and beneficiaries per quintile in Gauteng

Figure 126 reports the patient loads per quintile in Gauteng in 2018. The number of beneficiaries per GP practice are:

- Quintile 1 = 1 400 beneficiaries;
- Quintile 2 = 1 362 beneficiaries;
- Quintile 3 = 692 beneficiaries;
- Quintile 4 = 462 beneficiaries; and
- Quintile 5 = 128 beneficiaries.

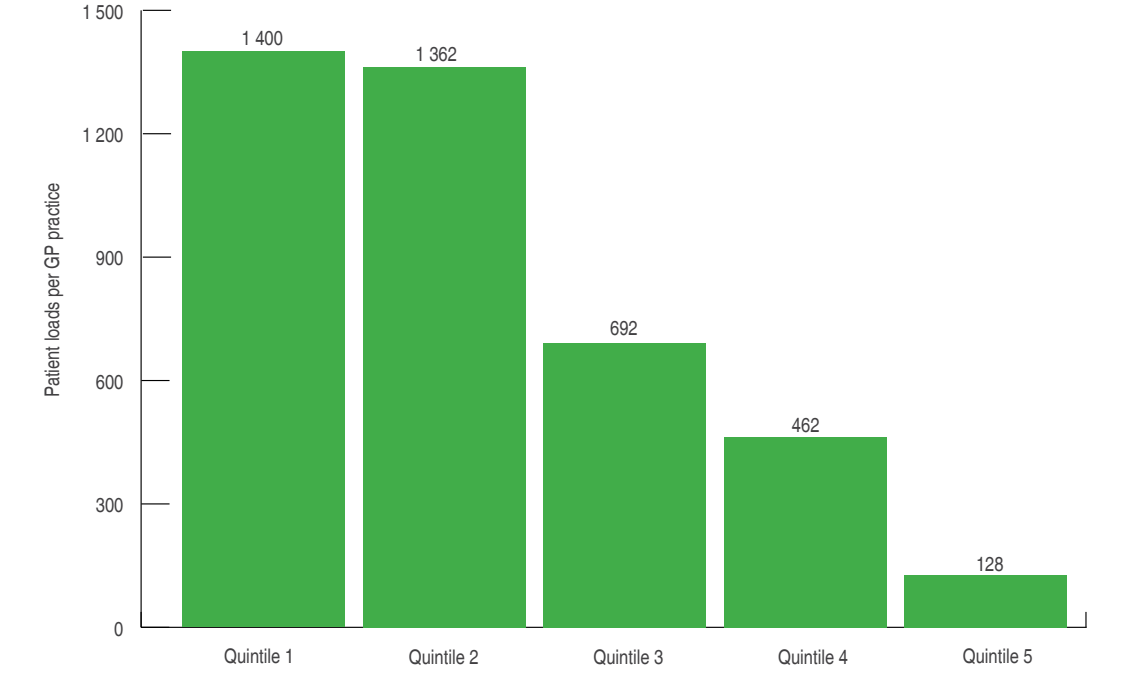



Figure 126: Patient loads per GP practice by quintile in Gauteng

Figure 127 describes the inequality in GP allocations in Gauteng in 2018. The Gini-coefficient in Gauteng is 0.62, which means that there is extreme inequality in the allocation of GPs. The Hoover index suggests that 55% of GPs should be re-allocated before perfect equality can be attained in Gauteng.

The cumulative share of healthcare expenditure spent by beneficiaries on GP services across the quintiles is as follows:

- Beneficiaries in quintile 1 spent 1% of the total share;
- Beneficiaries in quintile 2 spent 4% of the total share;
- Beneficiaries in quintile 3 spent 5% of the total share;
- Beneficiaries in quintile 4 spent 10% of the total share; and
- Beneficiaries in quintile 5 spent 80% of the total share.

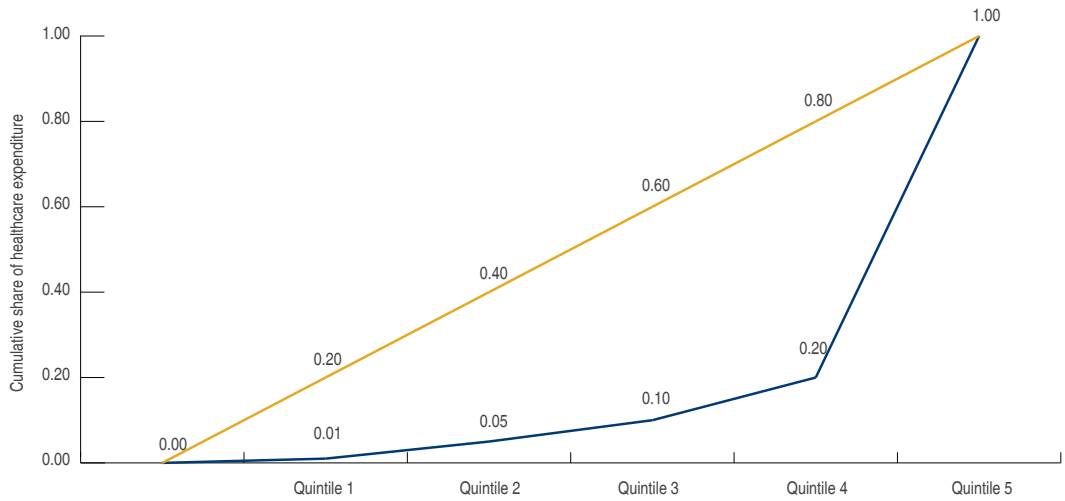



Figure 127: Lorenz curve – cumulative share of expenditure by quintile in Gauteng

*Equality of Access: KwaZulu-Natal*

Figure 128 describes the relationship between GP allocation and the proportional distribution of beneficiaries in KwaZulu-Natal for 2018:

- Quintile 1 – there are 13% of GPs relative to 20% of beneficiaries;
- Quintile 2 – there are 16% of GPs relative to 19% of beneficiaries;
- Quintile 3 – there are 15% of GPs relative to 19% of beneficiaries;
- Quintile 4 – there are 24% of GPs relative to 22% of beneficiaries; and
- Quintile 5 – there are 32% of GPs relative to 20% of beneficiaries.

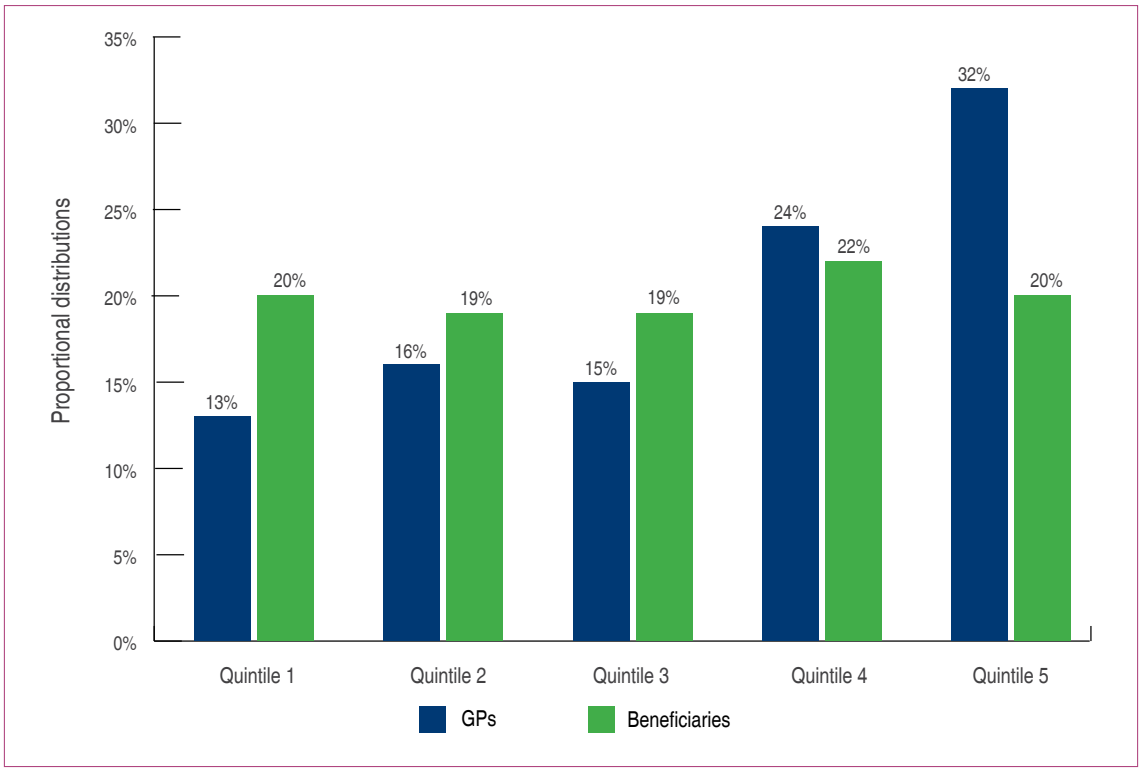



Figure 128: GPs and beneficiaries per quintile in KwaZulu-Natal

Figure 129 reports the patient loads per quintile in KwaZulu-Natal for 2018. The number of beneficiaries per GP practice are:

- Quintile 1 = 507 beneficiaries;
- Quintile 2 = 407 beneficiaries;
- Quintile 3 = 435 beneficiaries;
- Quintile 4 = 326 beneficiaries; and
- Quintile 5 = 217 beneficiaries.

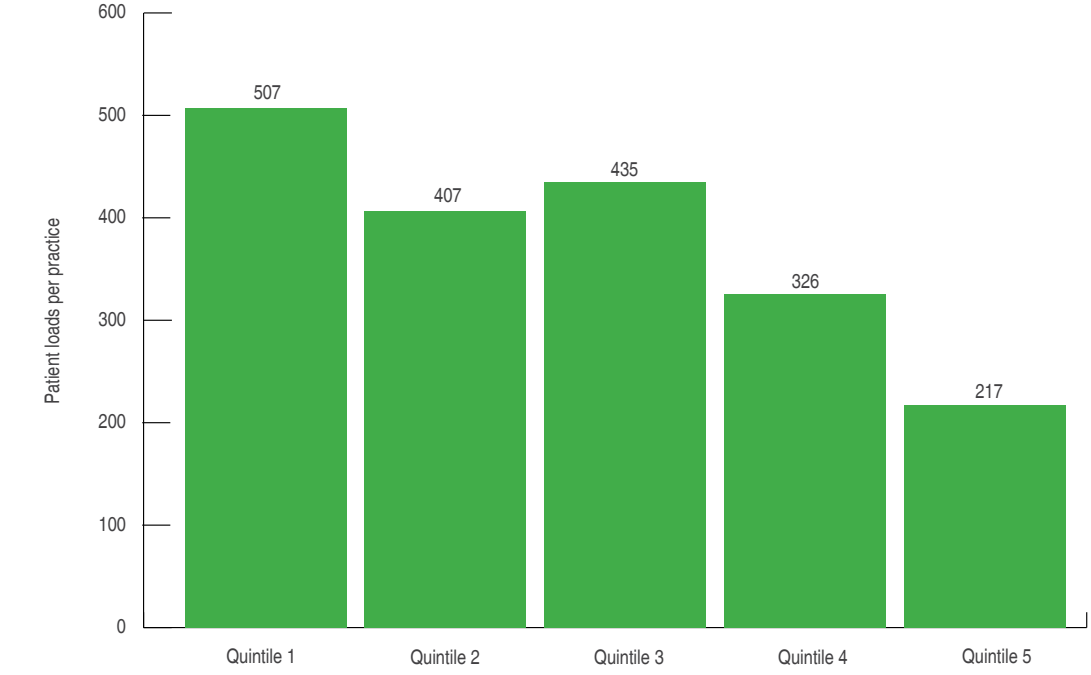



Figure 129: Patient loads per GP practice by quintile in KwaZulu-Natal

Figure 130 describes the inequality in GP allocations in KwaZulu-Natal for 2018. The Gini-coefficient in KwaZulu-Natal is 0.38, which means that there is a high inequality in the allocation of GPs. The Hoover index suggests that 27% of GPs should be re-allocated before perfect equality can be attained in KwaZulu-Natal.

The cumulative share of healthcare expenditure spent by beneficiaries on GP services across the quintiles is as follows:

- Beneficiaries in quintile 1 spent 4% of the total share;
- Beneficiaries in quintile 2 spent 6% of the total share;
- Beneficiaries in quintile 3 spent 20% of the total share;
- Beneficiaries in quintile 4 spent 30% of the total share; and
- Beneficiaries in quintile 5 spent 40% of the total share.

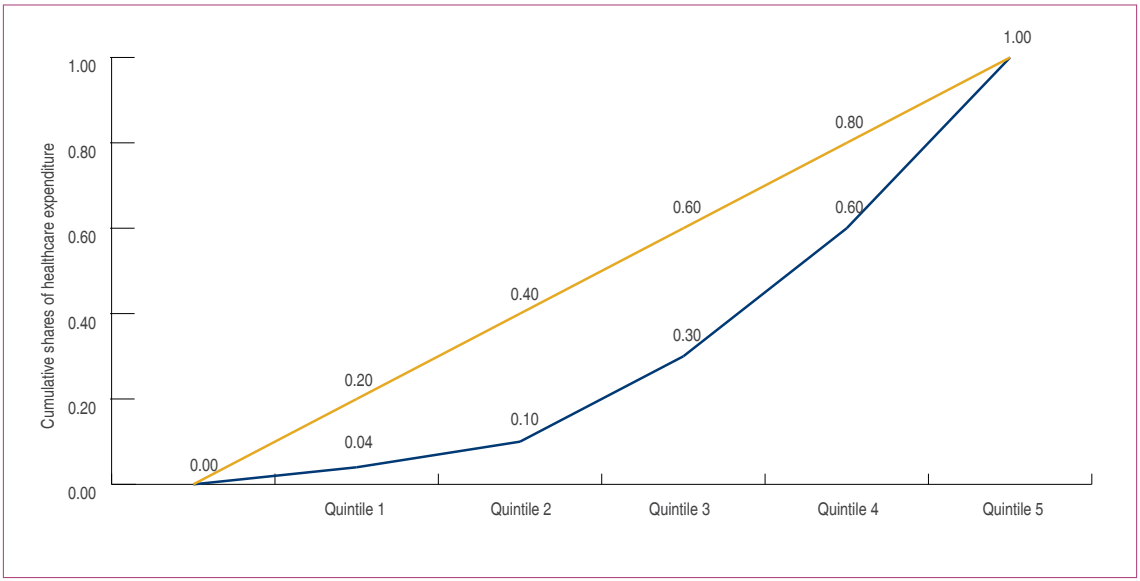



Figure 130: Lorenz curve – cumulative share of expenditure by quintile in KwaZulu-Natal

*Equality of Access: Western Cape*

Figure 131 describes the relationships between GP allocation and the proportional distribution of beneficiaries in the Western Cape for 2018:

- Quintile 1 – there are 8% of GPs relative to 20% of beneficiaries;
- Quintile 2 – there are 10% of GPs relative to 18% of beneficiaries;
- Quintile 3 – there are 17% of GPs relative to 22% of beneficiaries
- Quintile 4 – there are 19% of GPs relative to 20% of beneficiaries; and
- Quintile 5 – there are 46% of GPs relative to 20% of beneficiaries.

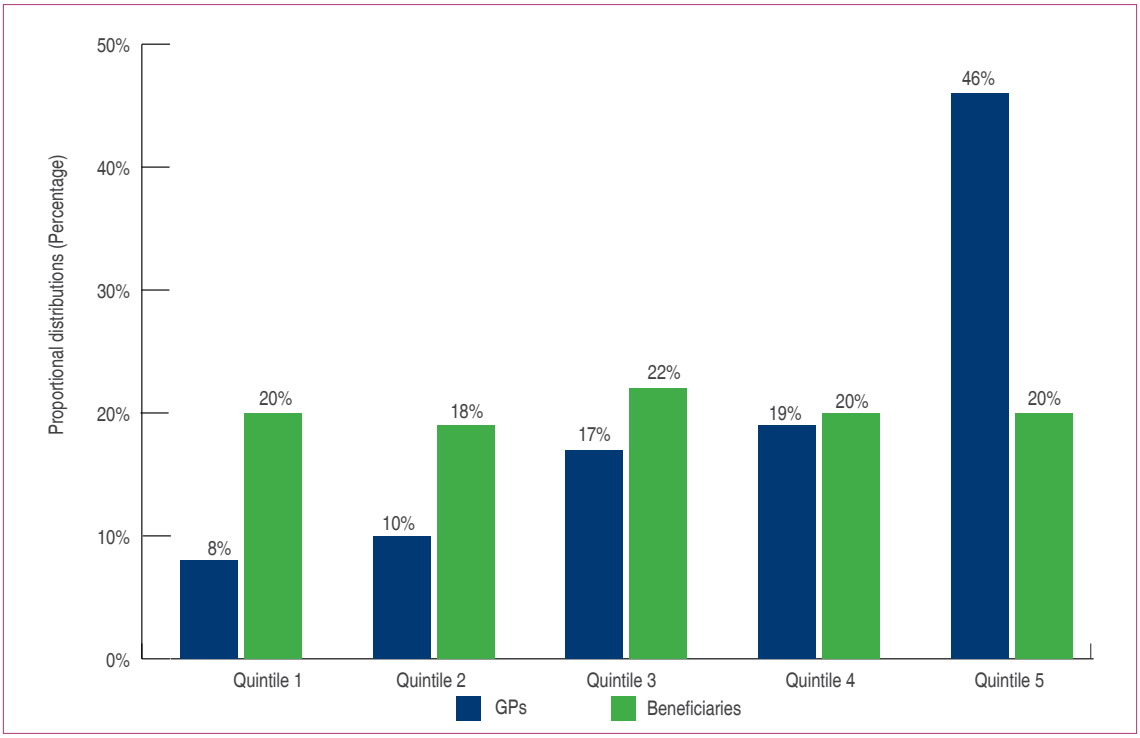



Figure 131: GPs and beneficiaries per quintile in the Western Cape

Figure 132 reports the patient loads per quintile in the Western Cape for 2018. The number of beneficiaries per GP practice are:

- Quintile 1 = 909 beneficiaries;
- Quintile 2 = 655 beneficiaries;
- Quintile 3 = 489 beneficiaries;
- Quintile 4 = 399 beneficiaries; and
- Quintile 5 = 169 beneficiaries.

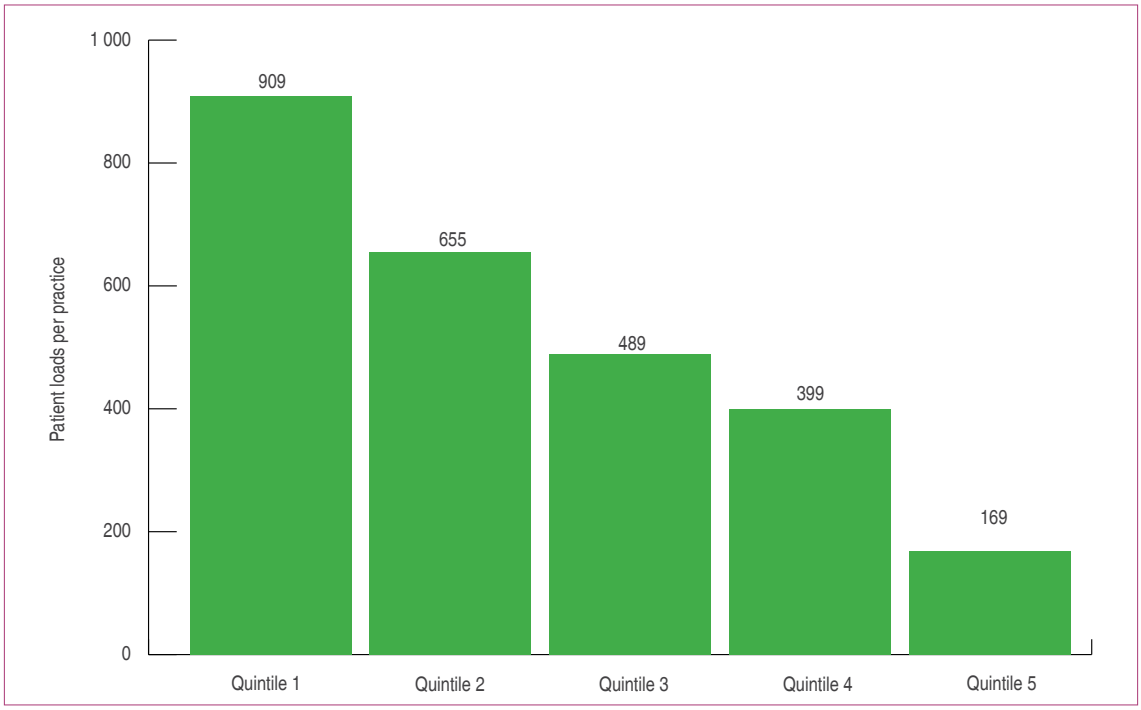



Figure 132: Patient loads per GP practice by quintile in the Western Cape

Figure 133 describes the inequality in GP allocations in the Western Cape for 2018. The Gini-coefficient in the Western Cape is 0.46, which means that there is a high inequality in the allocation of GPs. The Hoover index suggests that 35% of GPs should be re-allocated before perfect equality can be attained in the Western Cape.

The cumulative share of healthcare expenditure spent by beneficiaries on GP services across the quintiles is as follows:

- Beneficiaries in quintile 1 spent 4% of the total share;
- Beneficiaries in quintile 2 spent 6% of the total share;
- Beneficiaries in quintile 3 spent 20% of the total share;
- Beneficiaries in quintile 4 spent 10% of the total share; and
- Beneficiaries in quintile 5 spent 60% of the total share.

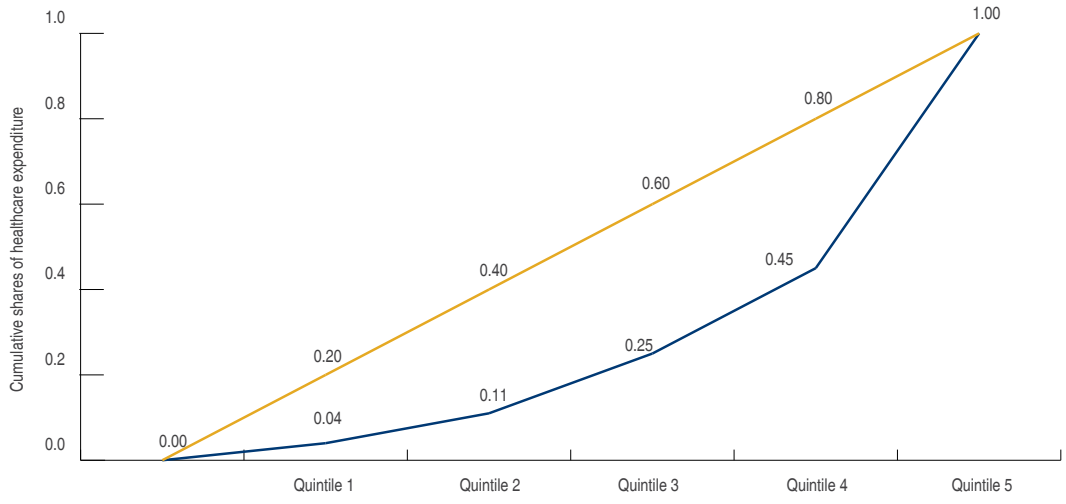



Figure 133: Lorenz curve – cumulative share of expenditure by quintile in the Western Cape

## Efficiency of resource allocation

When geographic areas have sparsely populated healthcare resources which are, these areas are not able to achieve economies of scale in the production of healthcare (National Centre for Rural Health and Care, 2019, p. 2 ). This makes it difficult for inhabitants in these areas to benefit from technical efficiencies that produce effective quality of care.

If beneficiaries find themselves in underserved areas, this may result in beneficiaries not benefiting as equally as beneficiaries in areas with a high concentration of GPs. The NHI White Paper's problem statement refers to this as healthcare financing and delivery systems that are anti-poor.

The purpose of this section is to assess the technical efficiency of GP allocations across the quintiles of provinces. The provinces that are analysed are: i) Eastern Cape, ii) Gauteng; iii) KwaZulu-Natal, and iv) the Western Cape. The questions of interest in this analysis are the following:

- What the behaviour of GP visits is relative to the proportion of GPs found across the quintiles;
- Whether GP visits increase as concentration levels increase; and
- Whether additional GP visits will move to or away from optimal efficiency.

### *Efficiency Allocation: Eastern Cape*

Figure 134 shows that GP visits increase as the proportion of GPs increase across the quintiles in the Eastern Cape.

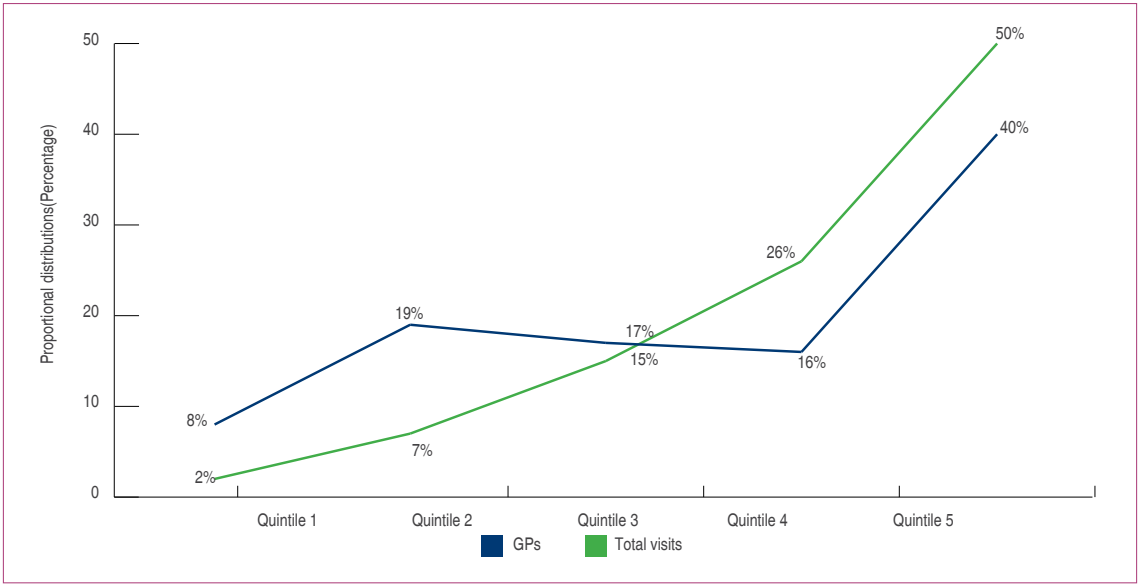



Figure 134: GPs and total visits per quintile in the Eastern Cape

Figure 135 shows that the rate of increase in scale efficiency decreases as GP visits increase from quintile 2 to 5 in the Eastern Cape.

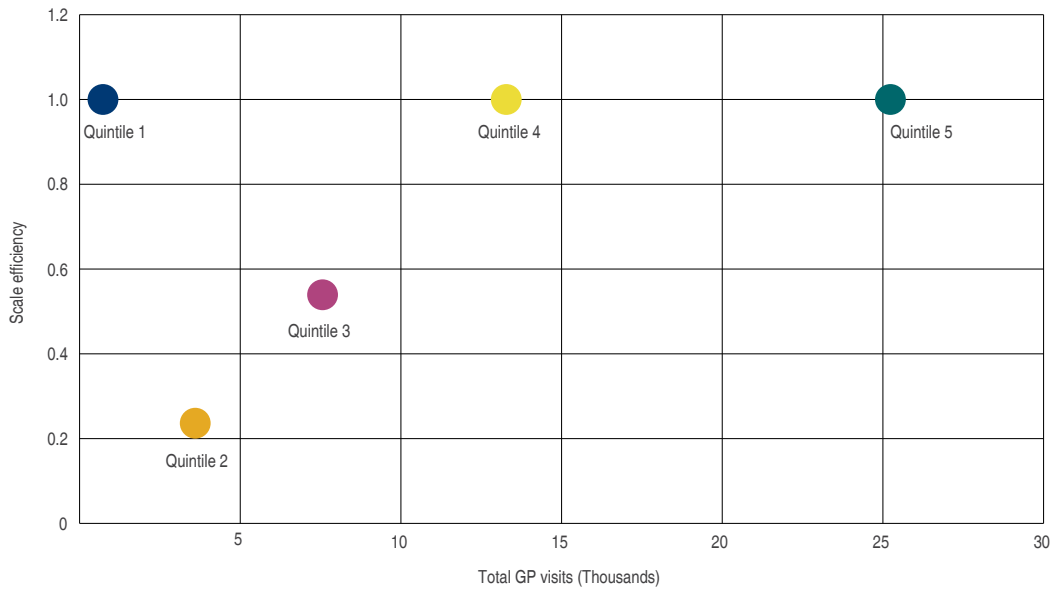



Figure 135: Scale efficiency of GP visits in the Eastern Cape (output optimisation)

Figure 136 doesn't show any clear patterns of scale efficiency in relation to the allocation of GPs in the Eastern Cape.

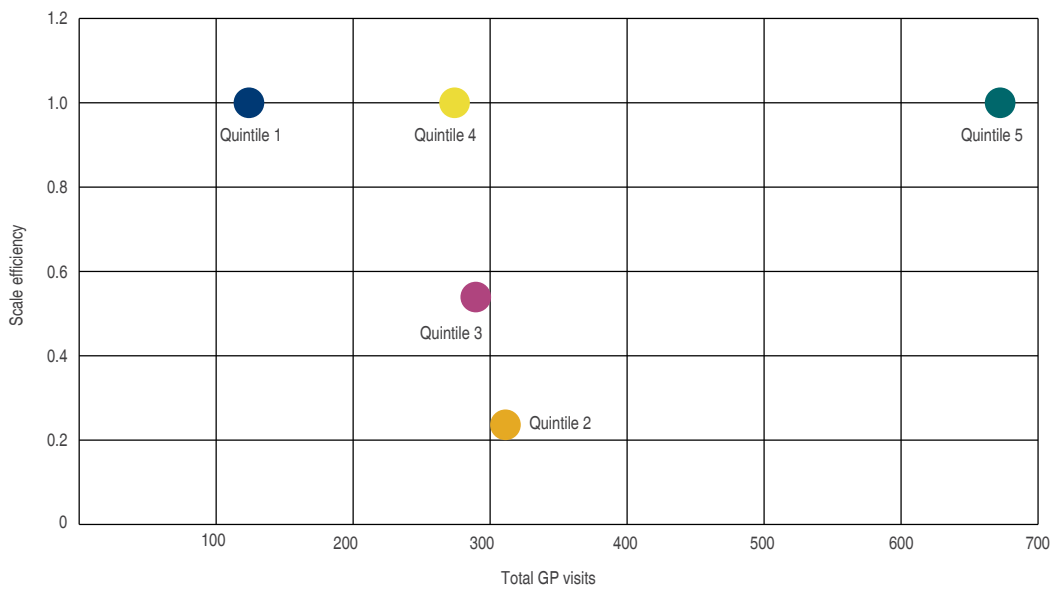



Figure 136: Scale efficiency of total GPs in the Eastern Cape (input optimisation)

*Efficiency Allocation: Gauteng*

Figure 137 shows that GP visits increase as the proportion of GPs increase across the quintiles in Gauteng.

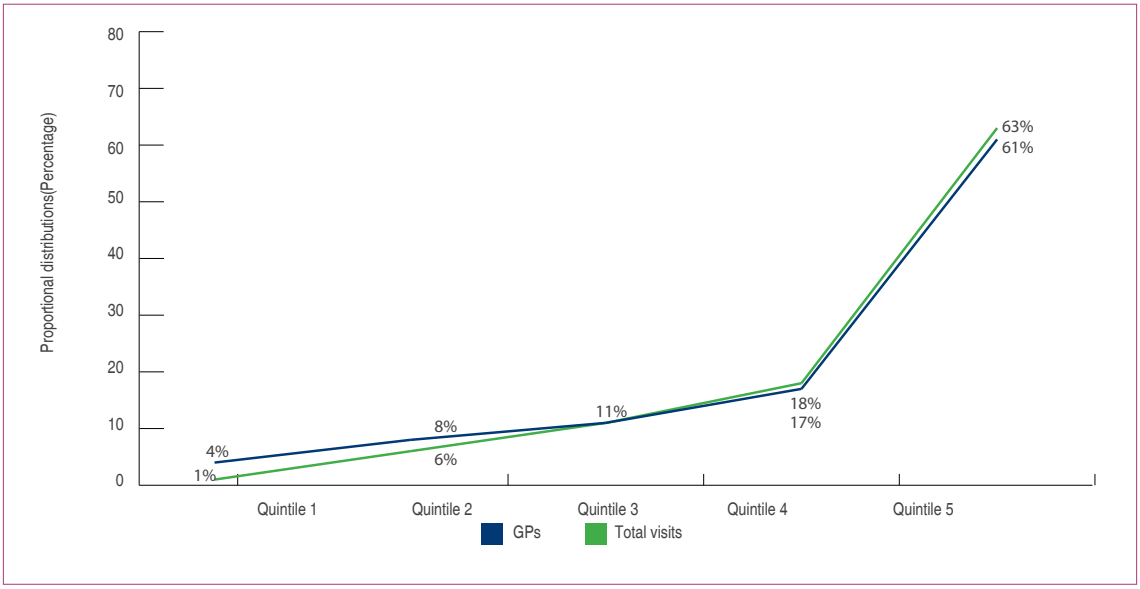



Figure 137: GPs and total visits per quintile in Gauteng

Figure 138 shows that the rate of increase in scale efficiency decreases as GP visits increase from quintile 1 to 5 in Gauteng.

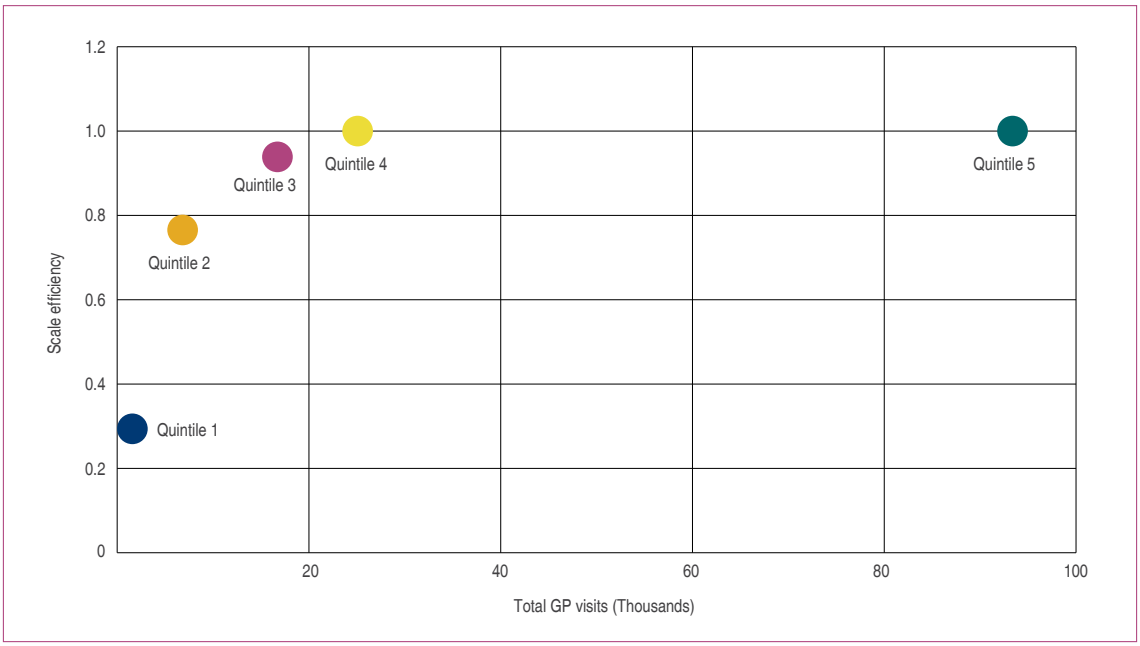



Figure 138: Scale efficiency of GP visits in Gauteng (output optimisation)

Figure 139 shows that the rate of increase in scale efficiency decreases as the number of GPs increases from quintile 1 to 5 in Gauteng.

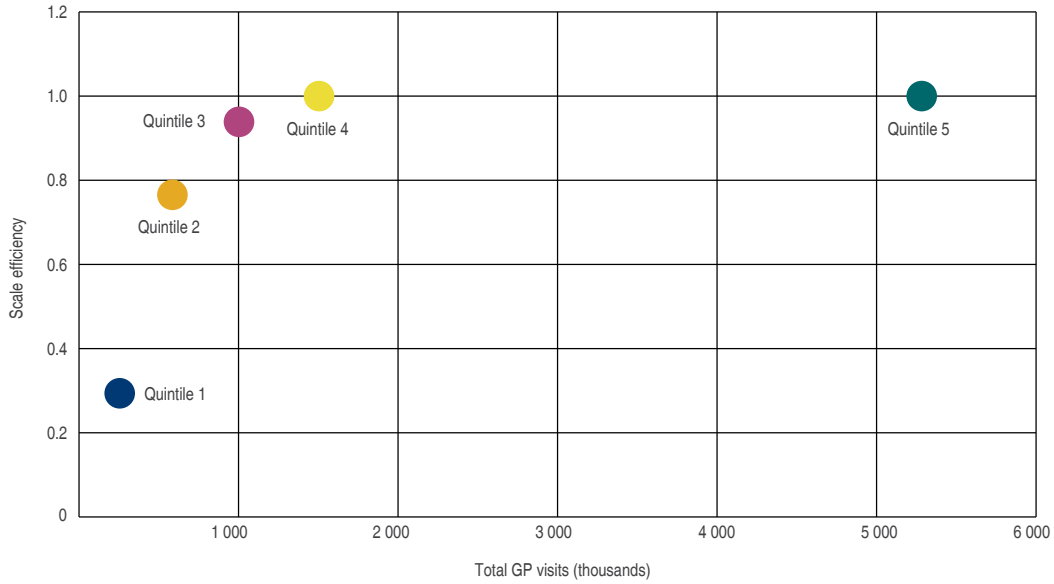



Figure 139: Scale efficiency of total GPs in Gauteng (input optimisation)

*Efficiency Allocation: KwaZulu-Natal*

Figure 140 shows that GP visits increase as the proportion of GPs increase across the quintiles in KwaZulu-Natal.

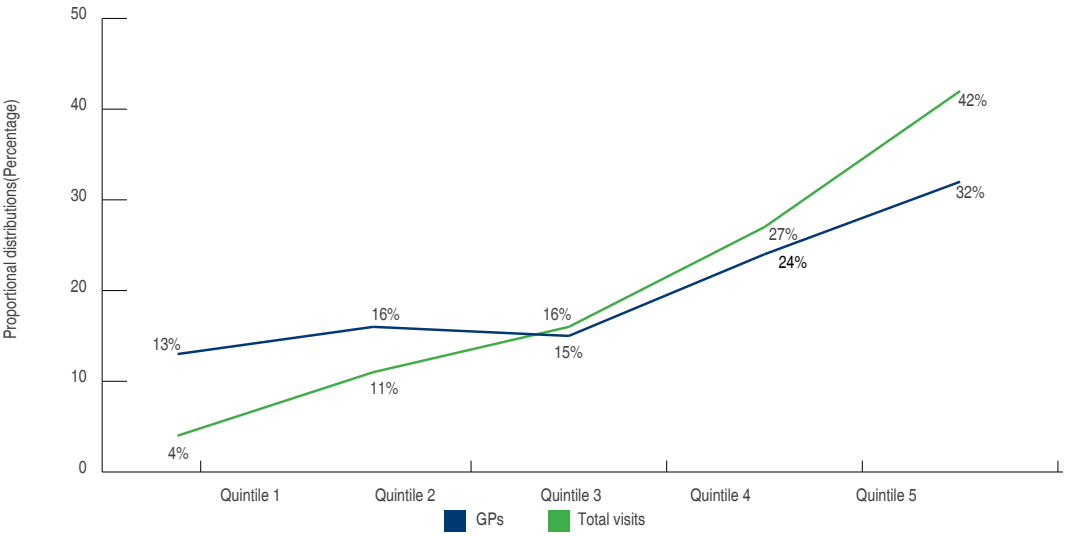



Figure 140: GPs and total visits per quintile in KwaZulu-Natal

Figure 141 shows that the rate of increase in scale efficiency decreases as GP visits increase from quintile 1 to 5 in KwaZulu-Natal.

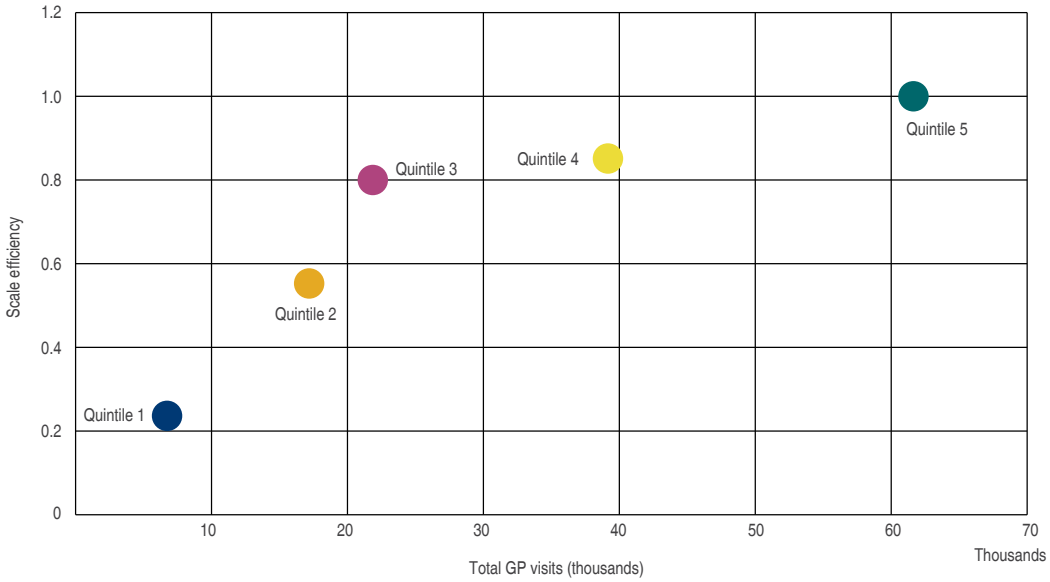



Figure 141: Scale efficiency of GP visits in KwaZulu-Natal (output optimisation)

Figure 142 shows that the rate of increase in scale efficiency decreases as the number GPs increases, from quintile 1 to 5 in KwaZulu-Natal.

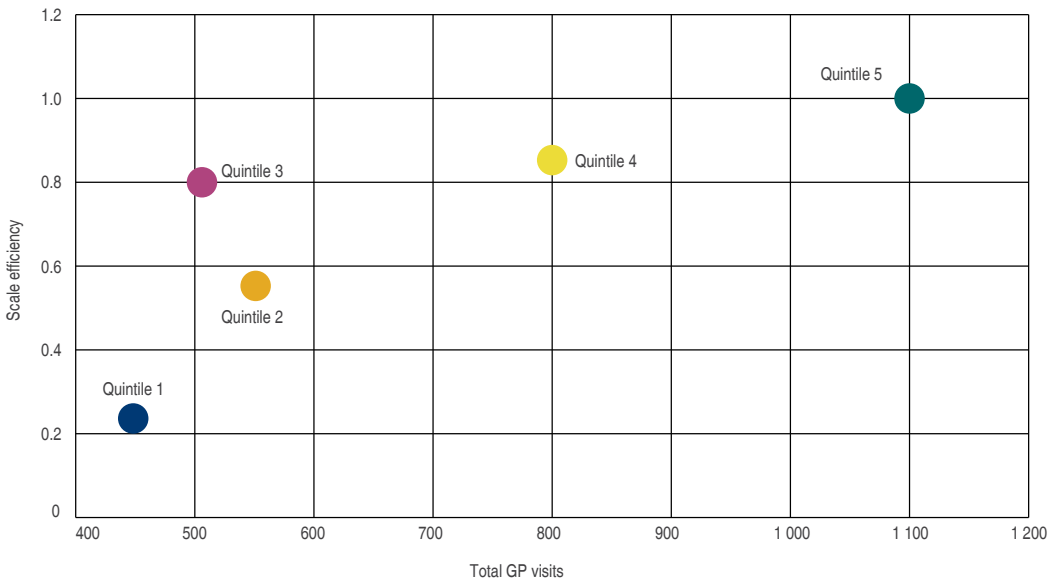



Figure 142: Scale efficiency of total GPs in KwaZulu-Natal (input optimisation)

*Efficiency Allocation: Western Cape*

Figure 143 shows that GP visits increase as the proportion of GPs increase across all quintiles in the Western Cape.

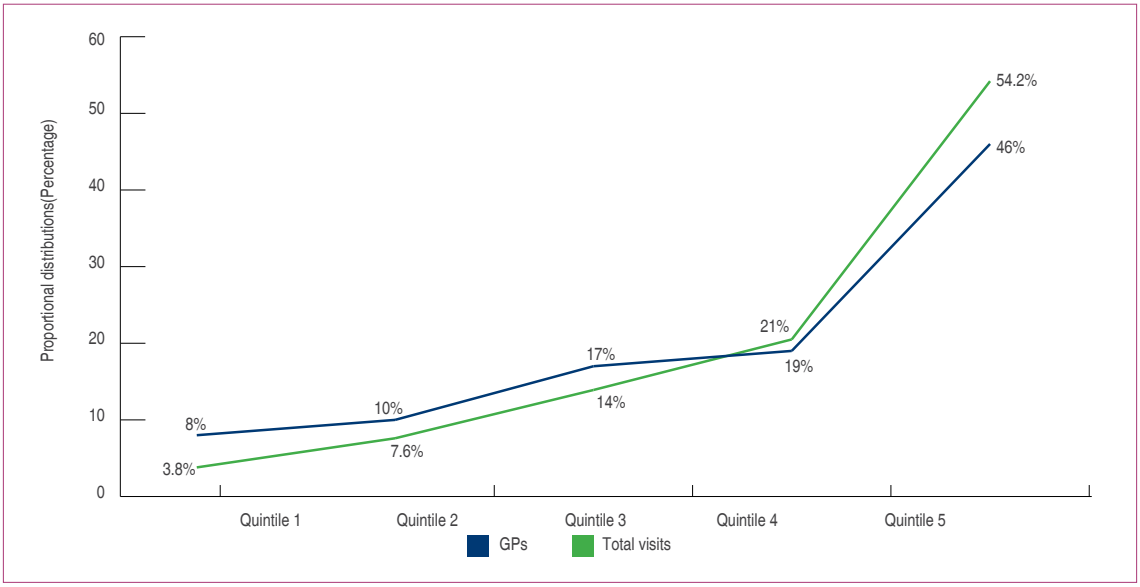



Figure 143: GPs and total visits per quintile in the Western Cape

Figure 144 shows that the rate of increase in scale efficiency decreases as GP visits increase from quintile 1 to 5 in the Western Cape.

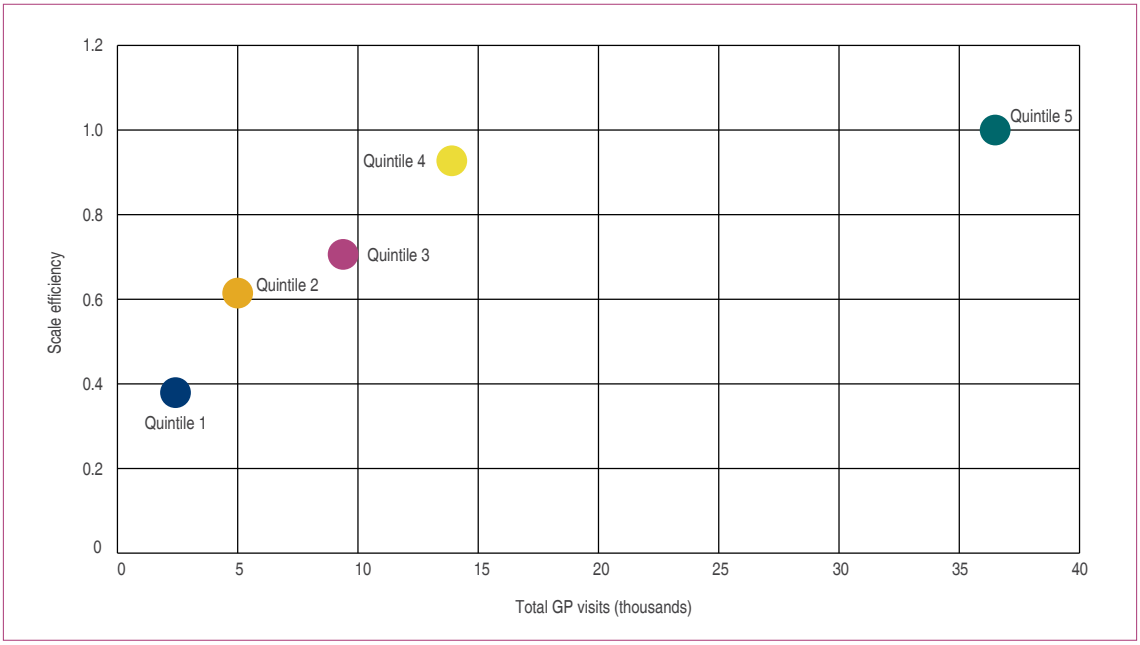



Figure 144: Scale efficiency of GP visits in the Western Cape (output optimisation)

Figure 145 shows that the rate of increase in scale efficiency decreases as the number of GPs increases from quintile 1 to 5 in the Western Cape.

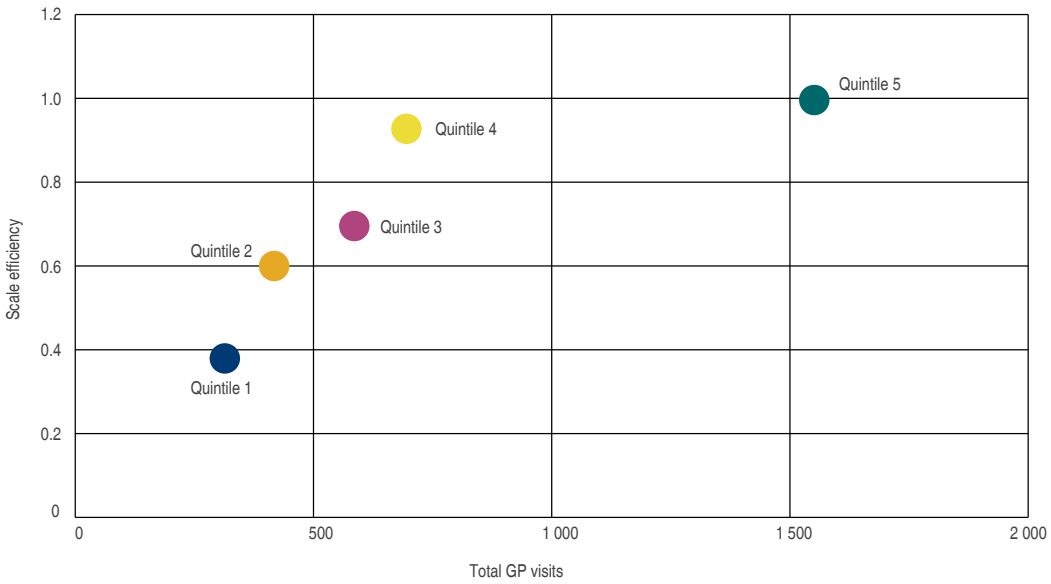



Figure 145: Scale efficiency of total GPs in the Western Cape (input optimisation)

## General findings and recommendations

### *On the disparities in private-public sector GP ratios*

There are disparities in the number of private GPs and public GPs between different provinces. Preferential re-imbursement mechanisms across geographic healthcare markets could be used to defuse potential wasteful over-servicing in geographic centres where GP numbers are higher.

The Resource Allocation Working Party (RAWP), when reviewing the United Kingdom's National Health Service system, found that re-imbursement methods could be used to neutralise perverse supply-side market factors and behaviours. An example would be the adjustment of re-imbursement to deal with differences in the depravity index between Northern Ireland and London.

Aside from cross subsidising the needs of the vulnerable and the deprived, re-imbursement mechanisms could help mitigate the effects of cherry-picking behaviour associated with health service contracting arrangements. This means that relatively older and sicker risk groups could access cost effective services outside urban areas. For example, Efficiency Discount Options (EDOs) that might not penetrate peri-urban and/or rural healthcare markets could through re-imbursement mechanisms, adjust the concentration and prevalence of SID in urban areas. By extension, this would be a health financing and delivery system that does not punish the poor.

In terms of the NHI public-private partnership agenda for PHC re-engineering, high private-public sector GP ratios suggest synergies in leveraging private sector resources. This was found to be feasible in the Western Cape, particularly for the management of non-communicable diseases (chronic conditions).

### *On the equality of GP allocations*

There are inequalities in the distribution of GPs across all quintiles of the provinces analysed.

Sparse allocations of GPs in the first and second quintiles has had an impact on patient loads per GP practice with relatively higher patient loads in these quintiles. There is a higher concentration of healthcare resources in the fifth quintiles of all provinces with relatively lower patient loads

The higher numbers of GPs in the fifth quintiles is of concern as beneficiaries are equally distributed across all five quintiles. Therefore, GPs are likely to be inundated with work in quintiles one and two while GPs in the fifth quintile are likely to compete for beneficiaries and potentially be more incentivised to over-service giving rise to SID or fraud, waste and abuse.

### *On the technical efficiency of GP allocations*

Research literature states that small and underserved geographic areas, especially rural areas, have difficulties in realising economies of scale. The empirical evidence in this analysis confirms that underserved areas show increasing returns to scale but are far from achieving their optimal scale.

Noteworthy observations of this study include:

- The number of GP visits increases as the concentration of GPs increases along the quintiles of the provinces in the analysis; and
- The returns to scale decrease the higher the number of GP visits in quintiles.

### *Recommendations and Implications for Fraud, Waste and Abuse*

- GPs should be re-allocated to areas that are underserved and moved from areas where there are diminishing benefits from added resources. This should reduce transactions in areas where the concentration of GPs is high and have a positive impact on reducing potential SID or fraud, waste and abuse.
- Re-imbursement mechanisms should be used to incentivise the re-allocation of healthcare resources.

# NOTES

# NOTES

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# ANNEXURES

Included on the attached USB are all Annexures in PDF and Excel formats.


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