PROTECTING THE INTERESTS OF MEMBERS

PROMOTING AN ACCOUNTABLE INDUSTRY

CMS

Council for Medical Schemes

ANNUAL REPORT
2013/14

ANNUAL REPORT
COUNCIL FOR MEDICAL SCHEMES

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GENERAL INFORMATION OF THE COUNCIL FOR MEDICAL SCHEMES

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Bank	Absa Group Limited
Chairperson of Council	Professor Yosuf Veriava
Acting Chief Executive & Registrar	Mr Daniel Lehutjo
Council Secretariat	Mr Khayalethu Mvulo

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

ADSL:	Asymmetric digital subscriber line
AFS:	Annual financial statements
A-G:	Auditor-General
AGM:	Annual general meeting
AGSA:	Auditor-General of South Africa
AIDS:	Acquired immune deficiency syndrome
Altron:	Altron Medical Aid Scheme
APP:	Annual performance plan
Barloworld:	Barloworld Medical Scheme
BEE:	Black economic empowerment
Beneficiaries:	Principal members + dependants (total membership of medical scheme)
Bestmed:	Bestmed Medical Scheme
BHF:	Board of Healthcare Funders of Southern Africa
BHP:	Broken Hill Proprietary Company (Australia)
BMU:	Benefits Management Unit
BMW:	Bayerische Motoren Werke AG (Germany)
Board:	Board of trustees
Bonitas:	Bonitas Medical Fund
BP:	British Petroleum (United Kingdom)
Bpk:	Beperk
CAMAF:	Chartered Accountants (SA) Medical Aid Fund
CAS:	Current Awareness Services
CC:	Closed Corporation
CDL:	Chronic disease list
CIB:	Chronic illness benefit
CMS:	Council for Medical Schemes
COMMED:	Community Medical Aid Scheme
Compcare:	Compcare Wellness Medical Scheme
Council:	Accounting Authority or the board of the Council for Medical Schemes
CPI:	Consumer Price Index
CPIX:	CPI excluding interest rates on mortgage bonds
CRC:	Clinical Review Committee
DENOSA:	Democratic Nursing Organisation of South Africa
Dependant:	Member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DHMS:	Discovery Health Medical Scheme
DoH:	Department of Health
DRG:	Diagnosis-related group
DRGTAP:	DRG Technical Advisory Panel
DSP:	Designated service provider

DTP:	Diagnosis and treatment pair
EDO:	Efficiency discounted option
ECIPA:	East Cape Medical Business Systems (Pty) Ltd
Edms:	Eiendoms
EE:	Employment equity
EWS:	Early warning system
Excl:	Excluding
EXCO:	Executive Committee (Council sub-committee)
Executive Authority:	Minister of Health
FAIS Act:	Financial Advisory and Intermediary Services Act 37 of 2002
Fedhealth:	Fedhealth Medical Scheme
Fishmed:	Fishing Industry Medical Scheme
FSB:	Financial Services Board
FSU:	Financial Supervision Unit
GAAP:	Generally Accepted Accounting Principles
GAE:	Gross Administration Expenditure
GCI:	Gross Contribution Income
GEMS:	Government Employees Medical Scheme
Genesis:	Genesis Medical Scheme
Golden Arrow:	Golden Arrow Employees' Medical Benefit Fund
GP:	General practitioner
GRAP:	Generally Recognised Accounting Practices
HIV:	Human immunodeficiency virus
Hosmed:	Hosmed Medical Aid Scheme
HPCSA:	Health Professions Council of South Africa
HWSETA:	Health and Welfare Sector Education and Training Authority
IAS:	International Accounting Standard
IBM:	International Business Machines Company (USA)
ICD-10:	International Classification of Diseases – 10th Revision
ICON:	Independent Clinical Oncology Network (Pty) Ltd
ICT:	Information and communication technology
ICU:	Intensive care unit
IFRS:	International Financial Reporting Standards
Inc:	Incorporated
Incl:	Including
INSETA:	Insurance Sector Education and Training Authority
IRBA:	Independent Regulatory Board of Auditors
IS:	Information systems
ISBN:	International Standard Book Number

ACRONYMS, ABBREVIATIONS AND DEFINITIONS (CONTINUED)

IT:	Information technology
ITAP:	Industry Technical Advisory Panel
KM:	Knowledge management
KZN:	KwaZulu-Natal
LAN:	Local area network
LCS:	Live communications server
Liberty:	Liberty Medical Scheme
Lonmin:	Lonmin Medical Scheme
MAC:	Ministerial Advisory Committee
MCO:	Managed care organisation
Medipos:	Medipos Medical Scheme
Medscheme:	Medscheme Holdings (Pty) Ltd
Medshield:	Medshield Medical Scheme
Metropolitan:	Metropolitan Health Corporate (Pty) Ltd
Minemed:	Minemed Medical Scheme
MOSS:	Microsoft Office SharePoint
MoU:	Memorandum of Understanding
MPR:	Medicine Price Registry
MRC:	Medical Research Council
MRI (scan):	Magnetic resonance imaging
MSO:	Medical Services Organisation (Pty) Ltd
Naspers:	Naspers Medical Fund
NC:	Not comparable
NHC:	Net Healthcare
NHE:	Non-Health Expenditure
NHI:	National Health Insurance
NHISSA:	National Health Information System of South Africa
NHRPL:	National Health Reference Price List
NPA:	National Prosecuting Authority
Office:	Office of the Chief Executive and Registrar (of Medical Schemes)
Pab:	Per average beneficiary
Pabpa:	Per average beneficiary per annum
Pabpm:	Per average beneficiary per month
Pampm:	Per average member per month
Pasbpm:	pabpm in respect of schemes that had savings transactions
Pb:	Per beneficiary
Pbpm:	Per beneficiary per month
PC:	Personal computer
PCNS:	Practice Code Numbering System
Pensioner:	Beneficiary at least 65 years old
PFMA:	Public Finance Management Act 1 of 1999

Pharos:	Pharos Medical Plan
PMB:	Prescribed minimum benefit
Pmpm:	Per member per month
PMSA:	Personal medical savings account
PO:	Principal officer
POLMED:	South African Police Service Medical Scheme
PPS:	Professional Provident Society
Principal member:	Member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Pro Sano:	Pro Sano Medical Scheme
Pty:	Proprietary
Q:	Quarter
QR:	Quarterly returns
R:	Rand (South African currency)
RAF:	Risk Assessment Framework
RCI:	Risk Contribution Income
RDC:	Regulatory Decisions Committee
Ref:	Reference
REF:	Risk Equalisation Fund
Registrar:	Registrar of Medical Schemes
REMCO:	Remuneration Committee of Council
Remedi:	Remedi Medical Aid Scheme
Resolution Health:	Resolution Health Medical Scheme
RETAP:	Risk Equalisation Technical Advisory Panel
R&M:	Research and monitoring
RMA:	Rand Mutual Association
RP:	Government Printing Works (number)
RPL:	Reference Price List
SABC:	South African Broadcasting Corporation
SABINET:	Southern African Bibliographic Information Network
SAHRC:	South Africa Human Rights Commission
SAICA:	South African Institute of Chartered Accountants
SAMA:	South African Medical Association
SAMWUMed:	South African Municipal Workers Union Medical Scheme
SAN:	Storage area network
SAPS:	South African Police Service
SCA:	Supreme Court of Appeal
Selfmed:	Selfmed Medical Scheme
SEP:	Single exit price
Sizwe:	Sizwe Medical Fund
SLA:	Service level agreement

ACRONYMS, ABBREVIATIONS AND DEFINITIONS (CONTINUED)

SMM:	Strategic Management Meeting
SOP:	Standard operating procedure
SPU:	Strategic Projects Unit
T/a:	trading as
TAU:	Technical Advisory Unit
TB:	Tuberculosis
Thebe Ya Bophelo:	Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd
Topmed:	Topmed Medical Scheme
Transmed:	Transmed Medical Fund
Treasury:	National Treasury
Umvuzo:	Umvuzo Health Medical Scheme
V:	Versus
V Med:	V Med Administrators (Pty) Ltd
WHO:	World Health Organisation
Witbank Coalfields:	Witbank Coalfields Medical Aid Scheme

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PROFILE

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

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 Medical Schemes 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.

VISION

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

VALUES

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

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

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

Strategic GOALS

STRATEGIC GOAL 1

Access to good quality medical scheme cover is maximised

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

STRATEGIC GOAL 2

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

STRATEGIC GOAL 3

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

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

STRATEGIC GOAL 4

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

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

OUR LEADERSHIP
THE COUNCIL

1 2 3 4

1. **Prof Cyril Jack van Gelderen**
Member

2. **Prof Yosuf Veriava**
Chairperson

3. **Dr Loyiso Mpuntsha**
Member

4. **Prof Bonke Clayton Dumisa**
Member

Missing in the picture:
Mr T Phadu, Mr T Zulu, Ms L Nevhutalu, Adv JC Weapond, Dr A Pillay and Mr Z Fihlani

5 6 7 8

5. Ms Mokgadi Olga Morata Member	6. Mr Kariem Hoosain Member	7. Mr Trevor Bailey Vice-Chairperson	8. Ms Ashleigh Theophanides Member

OUR LEADERSHIP
THE EXECUTIVES

1 2 3 4 5 6

1. **Mr Daniel Lehutjo**
   Chief Financial Officer and Acting Chief Executive & Registrar
2. **Dr Anton de Villiers**
   Head of Research and Monitoring
3. **Mr Stephen Mmatli**
   Head of Compliance and Investigations
4. **Ms Lindelwa Ndziba**
   Head of Human Resources
5. **Mr Craig Burton-Durham**
   Head of Legal Services
6. **Ms Thembekile Phaswane**
   Senior Manager: Complaints Adjudication

7 8 9 10 11 12

7. **Ms Tebogo Maziya**
Head of Financial Supervision

8. **Mr Jaap Kugel**
Head of ICT and KM

9. **Dr Elsabé Conradie**
Head of Stakeholder Relations

10. **Dr Faruk Mahomed**
Senior Strategist

11. **Mr Paresh Prema**
Head of Benefits Management Unit

12. **Mr Danie Kolver**
Head of Accreditation

LEGISLATIVE AND OTHER MANDATES

Constitutional mandates

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

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

Legislated mandates

The CMS has been established in terms of the Medical Schemes Act, Section 7 of which sets out the following functions for Council, which is the accounting authority or board of the CMS:

- 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 this Act.
- Collect and disseminate information about private healthcare.
- Make rules, not inconsistent with the provisions of this Act, for the purpose of the performance of its functions and the exercise of its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on Council by the Minister of Health or by this Act.

Policy mandates

The CMS is obliged to discharge its statutory mandate in a manner which is consistent with national policy, particularly as it affects the health sector. In 2013/14 the following were of particular significance:

The 10 priority areas in government's Programme of Action for 2009 – 2014

- Speed up economic growth and transform the economy to create decent work.
- Introduce a massive programme to build economic and social infrastructure.
- Develop and implement a comprehensive rural development strategy linked to land and agrarian reform and food security.
- Strengthen skills and the country's human resource base.
- Improve the health profile of all South Africans.
- Intensify the fight against crime and corruption.
- Build cohesive, caring and sustainable communities.
- Pursue African advancement and enhanced international co-operation.
- Ensure sustainable resource management and use.
- Build a developmental state, improve public services and strengthen democratic institutions.

The 10-Point Plan of the Department of Health for 2009 – 2014

- Provide strategic leadership and create a social compact for better health outcomes.
- Implement a national health insurance (NHI) plan.
- Improve the quality of healthcare services.
- Overhaul the healthcare system and improve its management.
- Improve human resources planning, development and management.
- Revitalise healthcare infrastructure.
- Accelerate the implementation of the HIV/AIDS and STIs National Strategic Plan and increase the focus on TB and other communicable diseases.
- Undertake mass mobilisation in support of better health across the population.
- Review the drug policy.
- Strengthen research and development.

Developments in relation to the National Health Insurance (NHI)

Government remains committed to the development of NHI as a means of reducing inequities in access to healthcare and achieving universal access to essential services. The introduction of NHI will have a fundamental effect on public and private healthcare providers and on the medical schemes industry.

At the time of the publication of the Green Paper on National Health Insurance in August 2011, Minister of Health Dr Aaron Motsoaledi indicated there were two major preconditions that needed to be achieved for the introduction of NHI:

- A major improvement in the quality of care in the public healthcare sector.
- Containment of the cost of care in the private healthcare sector.

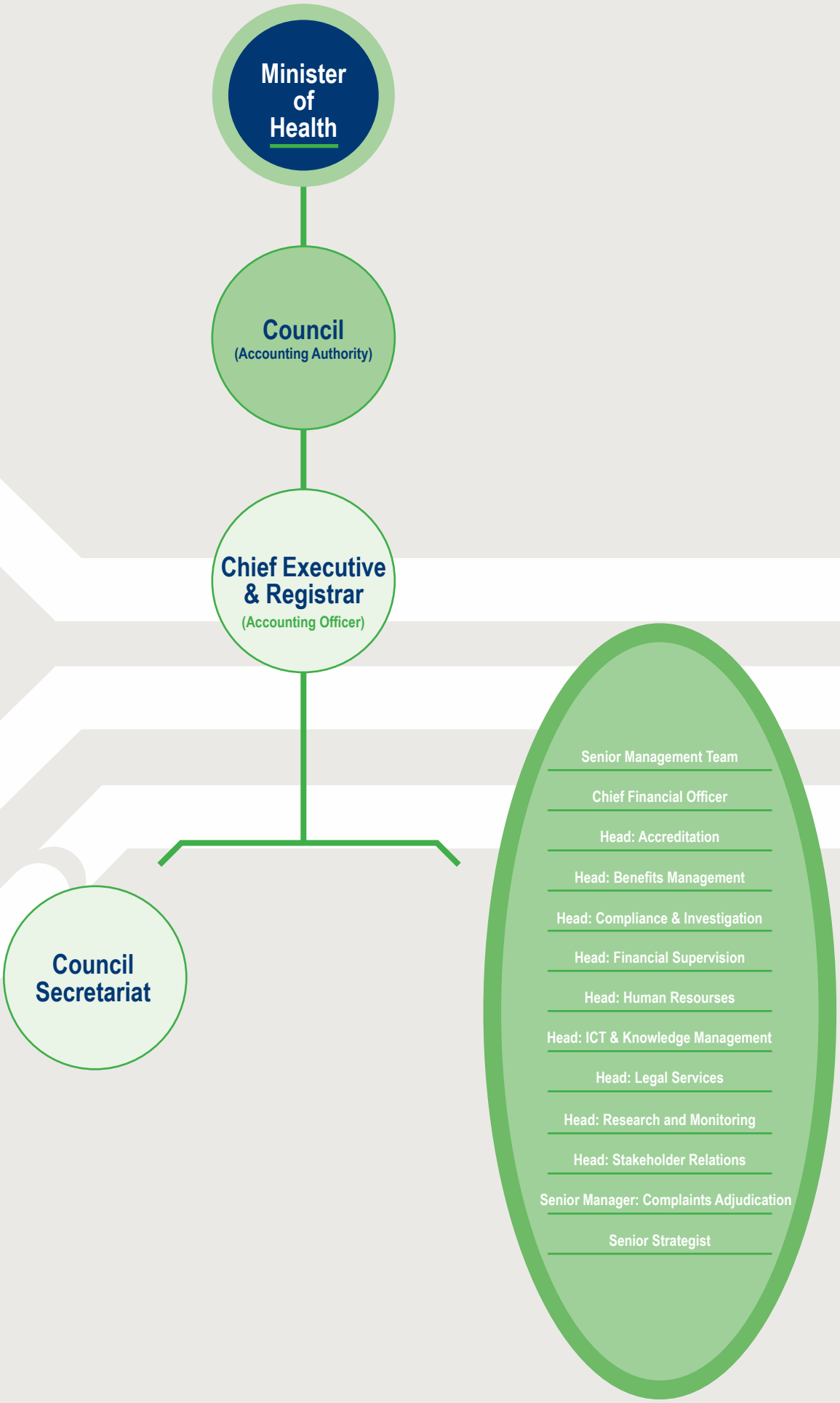
He also stated that the nation's approach to primary healthcare – including health promotion and the prevention of disease – needed to be much more robust and rooted in communities.

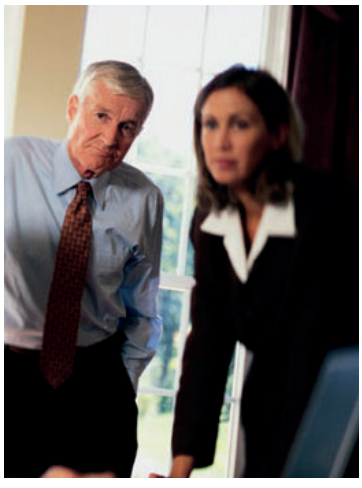
While the White Paper on NHI is still awaited and no major restructuring of the financing of healthcare will proceed before the adoption of a clear policy, preparatory work in the priority areas indicated by the Minister continued throughout 2013/14.

- NHI pilot projects in 10 health districts continued for the second year. The pilot interventions seek to address certain quality of care and management shortcomings in the public health sector, to develop new models of community-based care and to test certain approaches that could be incorporated into the NHI policy.
- The Office of Health Standards Compliance (OHSC) was created as a new regulator of healthcare establishments by an amendment to the National Health Act and the board of the OHSC was appointed by the Minister of Health early in 2014.
- The Competition Commission prepared to launch an extensive investigation into the operation of the private healthcare market, an investigation that will extend to the end of 2015 at least.

Since the CMS's mandate is to work in a manner that complements national health policy, the Council remained alert to all these developments and looks forward to the publication of the White Paper on NHI.

ORGANISATIONAL STRUCTURE





Chairperson's **REPORT**

Chairperson's REPORT

Professor Yosuf VERIAVA

It gives me great pleasure to introduce the Annual Report of the Council for Medical Schemes (CMS) for the financial year 1 April 2013 to 31 March 2014. As the report indicates, this was a period in which the CMS made considerable progress towards the fulfilment of its various mandates. I would like to thank the members of Council, Executives and the dedicated staff of the organisation whose vision and hard work have made these positive developments possible.

Just what is the role of the CMS? I think many people do not realise how extensive and weighty the organisation's responsibilities actually are. The CMS's most important mandate, as stated in the Medical Schemes Act 131 of 1998, is to protect the interests of beneficiaries of medical schemes in South Africa. Although that sounds simple it means that the CMS must guide, support, co-ordinate and, if necessary, control the functioning of medical schemes. This entails a highly complex set of tasks. The CMS also acts as the industry's ombudsman, assisting in resolving issues that arise between schemes, healthcare providers and scheme beneficiaries.

Another important responsibility of the CMS is to provide support for the development of national health policy and strengthening of the healthcare delivery system. One way that the CMS does this is by providing information and data on strategic health reforms that may contribute to equitable and sustainable healthcare financing and promote universal access to healthcare in South Africa.

The provision of quality healthcare and how this is best achieved remain complex challenges. All citizens, regardless of whether they are serviced by the public or the private healthcare sector, deserve good quality care. The right to access healthcare, in its preventive and curative forms, is enshrined in our constitution. An essential question is whether healthcare funders are fulfilling their responsibilities in ensuring that service providers are offering good quality care by monitoring outcomes and evaluating patient experiences. In order to protect the interests of scheme beneficiaries, the CMS is presently investigating how best to monitor the quality of care that beneficiaries receive.

The need to provide all South Africans with quality care goes beyond the moral imperative, important though this may be. It also touches the very stability and economic vigour of our nation. People who are unhealthy are less productive and contribute less to the growth of our communities. It follows that if we want a thriving nation, we need to keep it healthy.

As an institution that strives to strengthen the healthcare delivery system for all citizens, the CMS supports the process of establishing a system of national health insurance (NHI) and views its successful implementation as a crucial stepping stone to a sustainable future. With extensive experience of the healthcare funding sector, the CMS has been able to provide critical expertise, advice and data to assist with the implementation of NHI. A member of the CMS Strategic Management Team on NHI continues to serve on a technical sub-committee of the Ministerial Advisory Committee (MAC) on NHI.

NHI has been widely misunderstood and it is evident that many view it as a threatening development. I do not believe that the introduction of NHI will mean the end of the private healthcare sector or medical schemes. Medical schemes will continue to play an important role for those individuals who wish to have healthcare cover over and above that which NHI will offer. The NHI process will bring about a greater degree of co-operation between the public and private healthcare sectors. The challenge is to develop innovative approaches to promote such collaboration and enable it to flourish.

On the subject of co-operation, it was most encouraging to see the CMS and medical schemes working closely together on a number of member advocacy projects during the financial year. For example, a marketing initiative of the CMS highlighted the fact that medical schemes exist for the purpose of serving their beneficiaries and encouraged members to participate actively in the running of their medical schemes. Many schemes reported a high degree of involvement by members in their annual general meetings and other activities as a result of this initiative.

Some medical schemes have raised concerns and even criticised the implementation of statutory provisions on prescribed minimum benefits (PMBs), claiming that these have placed an onerous financial burden on medical schemes and even threatened their financial viability. However, these claims are not borne out by the data at the disposal of the CMS. In fact, all evidence suggests that the medical schemes industry remains financially solid. PMBs are certainly playing a critical role by providing beneficiaries with a minimum level of cover, protecting them from financial disaster in the event of a healthcare crisis, and offering them a measure of social security.

While some medical schemes continued to struggle with solvency issues during 2013/14, overall solvency ratios remained highly satisfactory. Those schemes facing solvency challenges made good progress in tackling this issue. The medical schemes industry continued to contract, with five mergers occurring during the year. Although the amalgamation of schemes has reduced the number of entities it has also tended to result in stronger and more viable medical schemes and may be seen in a positive light. Non-healthcare expenditure by schemes has remained stable over the past few years pointing to better control in this area.

A matter of considerable concern is the increasing number of medical scheme beneficiaries who require treatment for chronic conditions. This is in large part due to the increasing average age of members, as older people tend to require more healthcare than younger people. However, it is also clear that increasingly unhealthy lifestyle choices made by many South Africans are contributing to the increase in chronic conditions. This is a worrying development and one that needs to be urgently addressed by all roleplayers within the funding industry.

Our response as medical schemes should be to place greater emphasis on preventive medicine and health education. It is considerably more cost-effective and beneficial to prevent disease than to be compelled to treat it. The early detection and treatment of many medical conditions, including HIV and high blood pressure, are of critical importance because these chronic diseases can usually be successfully managed if they are tackled before they progress or cause complications that seriously compromise the individual's health.

It is gratifying to see so many schemes according higher priority to educational and pro-active screening programmes that identify health

risks. However, even more needs to be done in this area and I reiterate my belief that funders and service providers need to work together to tackle the scourge of chronic diseases.

The CMS has continued to work toward the strengthening of the Medical Schemes Act in order to bolster the sector and improve access to quality medical cover. A subject that has been in the headlines recently is the demarcation regulations which differentiate medical scheme cover from health insurance. In our view it remains critical to clarify the role of insurance products and protect the sustainability of the medical schemes industry, which provides a vital social service to millions of South Africans. The CMS has put considerable effort into shaping legislation that clearly defines the roles that insurance products should play in the future healthcare landscape.

Another of the CMS's roles is to collect data and undertake meaningful research on the funding sector in order to inform broader healthcare policy. One of the more fascinating research projects currently underway seeks to measure the impact of managed care interventions in South Africa. This is a collaborative project involving the Research and Monitoring Unit and the Industry Technical Advisory Panel (ITAP) Managed Care Working Group. The significance of this research, which has now entered its second phase, is that it will investigate various models of service provision in order to determine which models are most cost-effective and could be adopted in the future.

Those entities within the healthcare funding sector that have shown commitment and devoted considerable resources to finding creative solutions should be congratulated. Many of these interventions are highly innovative and in some cases seem to offer real funding alternatives. We urge the sector to take this promising work forward.

Recently, in response to serious allegations levelled against the Registrar of the CMS by the former provisional curator of Medshield, an independent forensic investigation into these allegations was instituted and the Registrar was suspended. It is gratifying that the staff of the CMS, under the guidance of Acting Registrar Mr Daniel Lehutjo, have continued to perform their duties efficiently in the absence of the Registrar.

In closing, I must express my gratitude to all my colleagues on Council for their unstinting support and guidance over the past year, to the staff of the CMS for their active commitment to fulfilling the mandate of the CMS, and to those in the industry who continue to sustain the vital role expected of the private sector in the national health system.

Professor Yosuf Veriava
Chairperson of Council
Council for Medical Schemes
May 2014

Overview of the Acting **CHIEF EXECUTIVE & REGISTRAR**

Acting Chief Executive & REGISTRAR

Daniel **LEHUTJO**

I am pleased to present the Annual Report of the Council for Medical Schemes (CMS) for the financial year 1 April 2013 to 31 March 2014.

This overview of the organisation's performance speaks to the continued commitment of Council – that is, the governing board and Executive Authority of the CMS – and its employees to fulfilling the organisation's mandate, as set out in the Medical Schemes Act 131 of 1998.

The main function of CMS, stated very simply in the Act, is to protect the interests of beneficiaries of medical schemes. Other major functions include controlling and co-ordinating the functioning of medical schemes "in a manner that is complementary with national health policy" (Section 7(b) Medical Schemes Act) and making recommendations to government on measuring the quality and outcomes of health services secured through medical scheme cover.

Therefore this overview not only considers the CMS's activities in key regulatory areas – such as registration of medical schemes, accreditation of administrators, brokers and managed care organisations, enforcing compliance with statutory provisions and investigation and adjudication of complaints – but also describes the CMS's engagement with the development of national health policy and measures to improve the quality and impact of healthcare.

Strategic focus areas and interventions

The CMS made progress in strategic focus areas during the course of the financial year, implementing interventions to increase access to good quality medical scheme cover and extend its support for and protection of beneficiaries. Several projects were initiated to improve the organisation's outputs and performance and strengthen its striving for service excellence.

Strategic planning processes of the CMS

The annual planning process commenced in June 2013, after the Auditor-General of South Africa had presented his report to Council, with a series of internal meetings. These led to the development of a draft strategic plan, annual performance plan and budget for the 2014/15 financial year. These were presented to Council in August 2013.

In accordance with Council's guidance, the Office of the Chief Executive and Registrar amended the plans and related budget for 2014/15 and these were approved by Council in October 2013. The Minister of Health approved the 2014/15 plans on 15 March 2014.

Strategic Management Team on National Health Insurance

The CMS has a contribution to make to strengthening the overall healthcare delivery system and making services accessible to all citizens of our country. The CMS is, therefore, fully supportive of the process of establishing a national health insurance (NHI) system for South Africa. Through participation in a technical sub-committee of the Ministerial Advisory Committee (MAC) on NHI, the CMS has contributed its understanding of healthcare funding to this initiative to transform healthcare in South Africa.

Review of the Medical Schemes Act

The Medical Schemes Act was promulgated in 1998 and the CMS was established about two years later. The effectiveness of the CMS depends largely on the extent to which the enabling legislation allows it to fulfil its mandate.

The CMS has found it necessary to strengthen certain provisions of the Medical Schemes Act, including provisions on the governance of medical schemes and prescribed minimum benefits (PMBs). Proposed amendments were approved by Council in 2012/13 and the draft amendment bill was submitted to the Department of Health (DoH) in October 2013.

PMB review processes

The provision that entitles all members and beneficiaries of medical schemes to a set of PMBs is arguably the most striking feature of the Medical Schemes Act. This guarantee protects members against health events which could otherwise result in financial ruin.

PMBs are the minimum benefits that every medical scheme is required to provide by law, regardless of the benefit option. PMB conditions are diagnosis-driven, which means that it is irrelevant how a beneficiary acquired a PMB condition. They cover the diagnosis, treatment, and care of roughly 300 of the most serious and most expensive health conditions, including emergency conditions, 25 chronic conditions and diseases such as cancer and tuberculosis.

Schemes must pay for PMB conditions in full, according to the healthcare provider's invoice, from their risk pools. Schemes are not allowed to use members' personal medical savings accounts to pay for PMB conditions.

PMBs go hand-in-hand with the system of designated service providers (DSPs). These are doctors, pharmacists, hospitals and other healthcare providers that medical schemes select as the first option for beneficiaries when they need care for PMB conditions. Beneficiaries are entitled to use non-DSPs but may have to pay a portion of the bill as a co-payment should they do so.

The Medical Schemes Act makes provision for the review of PMB regulations every two years. Draft regulations reviewing PMBs were submitted to the Ministry of Health in 2010 and were expected to be published in the Government Gazette in 2012/13. This had not happened by March 2014. The CMS has further undertaken to review the definition of various PMBs.

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

The growing burden of chronic disease care

The 2014 retrospective study of the CMS's Scheme Risk Measurement Database was undertaken to establish changes in the frequency of chronic diseases among beneficiaries of medical schemes between 2007 and 2012. The study compared trends for open and restricted schemes, schemes of various sizes, and a range of benefit options.

The main finding was that there has been a sustained upward trend in diagnosis and treatment of many conditions on the chronic disease list (CDL). While the study could not isolate specific reasons for this increase

in chronic diseases, the trend could be generally attributed to improved data management systems of medical schemes and administrators, the deteriorating disease profile and higher average age of beneficiaries, increased beneficiary awareness of entitlements and changes in care-seeking behaviour.

The findings of the 2014 prevalence study are summarised in Table 1.

Table 1: Prevalence of chronic conditions among medical scheme beneficiaries 2011 and 2012

Condition (SRM code)	Type of medical scheme	Prevalence 2011 (Cases/1 000 beneficiaries)	Prevalence 2012 (Cases/1 000 beneficiaries)	Trends
Hypertension (HYP)	All schemes	82.6	86.2	Overall increase of approximately 4% between 2011 and 2012, with increase more marked in restricted schemes (8%) than open schemes (2%)
	Open	85.5	86.9	
	Restricted	79.1	85.3	
Hyperlipidaemia (HYL)	All schemes	34.4	35.6	Moderate increase across all schemes, with higher prevalence in open schemes
	Open	39.2	40.5	
	Restricted	28.8	30.0	
Diabetes mellitus type 2 (DM2)	All schemes	23.3	25.7	Overall increase of almost 10% across all schemes. Both prevalence and rate of increase were slightly higher in restricted schemes
	Open	21.2	23.0	
	Restricted	25.7	28.6	
Asthma (AST)	All schemes	15.4	15.8	Moderate increase across all schemes and similar prevalence rates in open and restricted schemes
	Open	15.5	15.8	
	Restricted	15.20	15.8	
Hyperthyroidism (TDH)	All schemes	14.3	14.7	Overall increase of 3% across all schemes. In restricted schemes the increase was 7% while open schemes showed no significant increase
	Open	15.3	15.2	
	Restricted	13.1	14.1	
HIV/AIDS (Receiving ARVs)	All schemes	9.4	14.6	Largest increase of any condition, with 55% rise in prevalence across all schemes. Prevalence and rate of increase (60%) were higher in restricted schemes
	Open	6.0	8.5	
	Restricted	13.4	21.4	
Ischaemic heart disease (IHD)	All schemes	7.3	7.3	Prevalence across the total number of schemes remained steady with higher prevalence in open schemes and a minor rise in restricted schemes
	Open	8.6	8.3	
	Restricted	5.7	6.1	
Epilepsy (EPL)	All schemes	4.1	4.2	No significant increase and prevalence rate of about 4 per 1 000 beneficiaries remained steady across all types of schemes
	Open	4.4	4.4	
	Restricted	3.8	4.0	
Cardiomyopathy and cardiac failure (CMY and CHF)	All schemes	4.1	4.2	Minor increases appear insignificant and similar prevalence occurs in all categories of schemes
	Open	4.3	4.0	
	Restricted	3.9	4.3	
Dysrhythmias (DYS)	All schemes	3.4	3.6	Overall increase of 5% between 2011 and 2012 across all schemes, with higher prevalence in open schemes
	Open	4.5	4.5	
	Restricted	2.9	2.6	

Figure 1 depicts the trends in the 10 most commonly diagnosed and treated conditions from 2007 to 2012. The ranking of these conditions has remained mostly unchanged over this period. Hypertension, hyperlipidaemia and diabetes mellitus type 2 have shown the greatest increase. Other conditions, though increasing, have remained at rates below 20 per 1 000 beneficiaries.

Figure 1: Top 10 diagnosed and treated chronic conditions 2007 – 2012

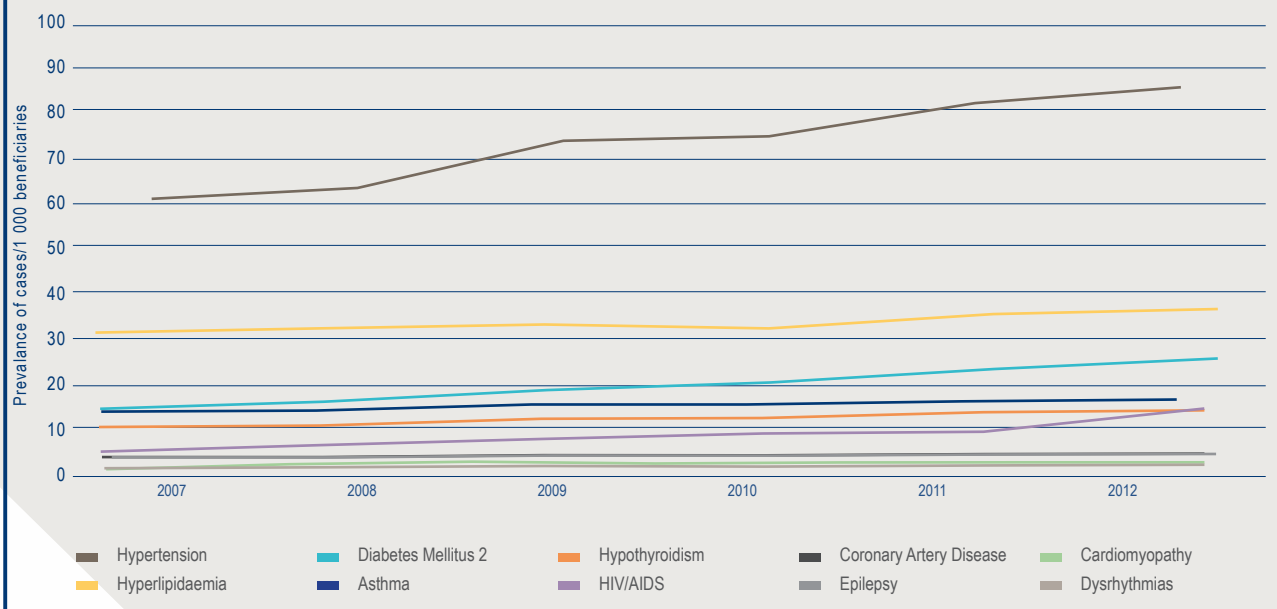
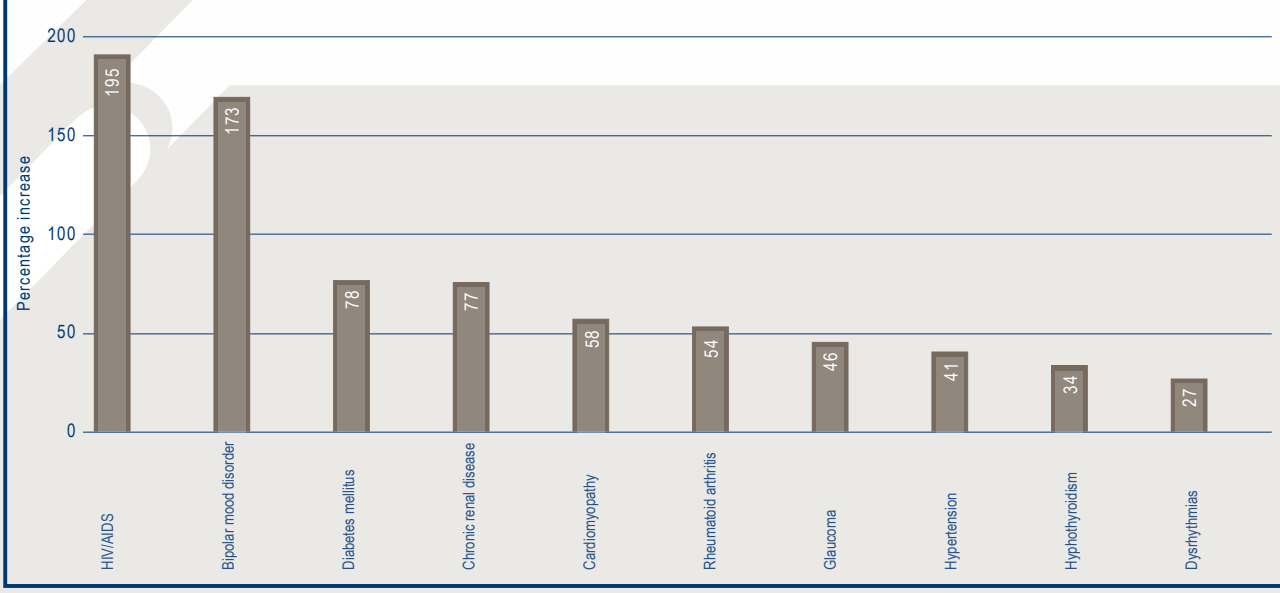


Figure 2 shows the rate of increase in the diagnosis and treatment of some chronic conditions. The number of beneficiaries on antiretroviral treatment for HIV increased by 195% between 2007 and 2012. This sharp increase may be attributable to a reduction in the stigma related to HIV. The number of beneficiaries treated for bipolar mood disorder increased 173% over the same period. There were also substantial and sustained increases in chronic conditions that may be partly attributable to lifestyle choices: diabetes mellitus type 2 (78%), cardiomyopathy (58%) and hypertension (41%).

Figure 2: Percentage increase in prevalence of chronic conditions 2007 – 2012



The higher prevalence of beneficiaries with chronic diseases translates to an increase in visits to general practitioners and specialists, a growth in the use of medicines, and a possible rise in hospital events. Without population-wide interventions to address the root causes of these chronic diseases the upward trend is expected to continue with increasingly severe impacts on schemes. Protection of risk pools and growth in younger, healthier beneficiaries are critical for long-term sustainability of the industry.

Medical schemes vs health insurance products

In 2013/14, the Office of the Registrar interacted continually with Treasury, the DoH and the Financial Services Board (FSB) to finalise the draft regulations to demarcate health insurance policies and medical schemes. Health insurance policies are regulated through insurance laws by the FSB, whereas medical schemes are regulated through the Medical Schemes Act by the CMS.

Council supports demarcation regulations which would prevent harmful health insurance products from operating and would not in any way undermine the principles and provisions of the Medical Schemes Act.

The Medical Schemes Act establishes a unique social security framework which offers members of schemes protection that is unavailable through other means. Only the Medical Schemes Act contains provisions on open enrolment, community rating and PMBs, as well as establishing strict governance requirements and oversight by the CMS. Commercially driven health insurance products, purporting to do the business of medical schemes, are not subject to the same regulatory oversight and some conduct themselves in ways which undermine the social protection offered by the Medical Schemes Act and medical schemes themselves.

Escalating costs in the private healthcare sector

Since 2010 discussions have been held between the CMS and officials of the DoH, the Health Professions Council of SA (HPCSA) and, more recently, the Competition Commission (CC) on the crucial matter of price escalation in the private healthcare sector and the determination of prices. A dedicated CMS task team continued to provide support to the Market Inquiry Committee of the CC. This wide-ranging inquiry into the healthcare market finalised its terms of reference in November 2013 and commenced engagement with the industry in 2014. The inquiry is expected to be concluded by the end of 2015.

Guiding trustee remuneration

The CMS appointed Ernst and Young (Ltd) to conduct a survey on current remuneration practices in relation to trustees of medical schemes. The objectives were to:

- Undertake a detailed analysis of current practices in relation to the remuneration of trustees and sub-committee members of medical schemes.
- Review the range of remuneration philosophies and procedures.
- Propose a benchmark and guideline for the industry on remuneration of trustees and sub-committee members.

The study involved key informant interviews with a sample of principal officers (POs) as well as an online survey aimed at all medical schemes. The sampling framework used to select POs for interviews took account of:

- Scheme type (open and restricted).
- Scheme size (small, medium and large).
- Remuneration structure of trustees (level of payment).

A total of 17 POs, whose schemes covered more than 70% of beneficiaries in the industry, were selected for interviews but only 15 POs eventually participated. The online survey was completed by 52 out of 92 medical schemes (57%). The schemes that chose to respond represented more than 75% of beneficiaries in the industry. Results obtained from the two streams of research were combined to inform the development of guidelines. Both the survey results and the guidelines will be published once the process is completed.

Making out-of-pocket spending visible

An exploratory study on out-of-pocket expenditure on healthcare was undertaken in order to assess the suitability of available data sources for inclusion in future annual reports. The study comprised a review of literature containing relevant data and an analysis of data collected by the CMS but currently not made public.

The review of literature focused mainly on Income and Expenditure Surveys published by Statistics South Africa (StatsSA). They indicated that medicine expenditure was the main cost driver of out-of-pocket expenditure, but that there were different patterns of out-of-pocket spending for medical scheme beneficiaries and individuals who were not covered by schemes.

The data collected through annual statutory returns to the CMS revealed that expenditure on medical specialists alone absorbed more than a third of reported out-of-pocket spending, while a quarter was paid to pharmacies for the purchase of medicines.

Further analysis, based on scheme rules for major medical plans offering comprehensive ambulatory care cover, provided a framework for:

- Estimating the total amount paid out-of-pocket.
- Evaluating and monitoring the real costs of co-payments, including their impact on community rating and scheme enrolment.

The recommendations of the study were that the annual report data specification should be reviewed to reflect both the actual amount

charged by healthcare providers and the actual benefits paid by schemes at option level. While these data would still be under-reported, they would give an indication of the extent to which co-payments impact on benefit offerings.

The study also recommended that the CMS seek the collaboration of agencies such as StatsSA so that the latter clearly distinguish between medical scheme members and non-members when designing data collection tools to measure out-of-pocket spending on healthcare.

Value-add of managed care

Strategic planning and research are necessary to ensure that the CMS stays abreast of developments in the managed healthcare industry, which assumes particular significance in the context of South Africa's complex and expanding burden of disease.

The chronic disease profile described earlier in this report is only one aspect of the quadruple burden of disease that South Africa experiences. This disease burden includes a wide range of communicable diseases – such as tuberculosis and other respiratory infections – as well as trauma and high rates of infant and maternal mortality and morbidity. In addition to the heavy disease burden, factors such as provider behaviour and increased utilisation of services contribute to the documented rise in the cost of private healthcare.

Against this background, effective and value-based managed care interventions become increasingly important.

During 2013/14 a multi-year project on measuring the impact of managed care interventions gained significant momentum. The project is a collaborative initiative involving the CMS and the Managed Care Working Group of the Industry Technical Advisory Panel (ITAP).

Phase 1 was completed in December 2013 and it showed challenges faced by the industry in terms of data collection and recording, particularly in respect of indicators which would demonstrate the value of managed care.

Phase 2 of the project, which aims to develop the required indicators and minimum data specifications for managed care organisations and/or medical schemes, commenced in February 2014 with the establishment of three ITAP task teams:

- Task Team 1 will identify and/or develop outcomes indicators and minimum data specifications for 25 chronic conditions. This team will initially focus on five conditions (including HIV/AIDS) and later expand to cover the rest.
- Task Team 2 will investigate the possibility of developing beneficiary registries for high-cost interventions and/or events, focusing initially on the top three high-cost interventions and/or events and expanding later. This team's work will resolve a challenge identified during Phase 1, namely, that it is difficult to measure the effectiveness of a particular managed care programme in the absence of the history of each patient, as patients may change medical schemes, benefit options or managed care programmes.
- Task Team 3 will undertake a review of utilisation management, examining interventions that are applied to minimise or eliminate wastage and unnecessary expenditure, such as managing the level of care or length of stay in hospital.

The work of all three task teams is significant and the industry is encouraged to participate and make resources available to fast track this work.

International managed care practice

In 2013, a study reviewing international best practice models on managed healthcare was undertaken by the Office of the Registrar.

This project involved a review of literature from selected countries such as the United Kingdom, United States, Germany and Australia. This review was triangulated with qualitative information and quantitative data to better understand managed healthcare in the South African context. A secondary analysis of cost drivers, reimbursement models and risk transfer arrangements within the medical schemes industry was also undertaken.

The qualitative assessment included a review of the managed care basket of services as regulated through the Medical Schemes Act. To gain an in-depth understanding of relationship between medical schemes and managed care organisations (MCOs), a few medical schemes were selected for interviews on managed care services, managed care arrangements and the use of reimbursement models.

Key findings from this report included the following:

- For most countries, the common objective of managed care models is to influence both the demand side and supply side of the market. The Australian experience showed that managed care can be extended to include elements of member education.
- Measuring health outcomes appears to be relatively uncomplicated when such measurement is undertaken within the broader framework of a review of the overall performance of the health system.
- Assessing the quality of healthcare outcomes requires tracking individual patients over time. Some patients will be lost to follow-up and it is possible that their characteristics and outcomes may differ substantially from those for whom data are available. Many measures of outcomes, such as information on health status and readmissions, require collection of data directly from patients. Lack of such information may limit the analysis and findings.
- Regulation of both the supply and demand sides of the healthcare market facilitates access to data that can be utilised during a comprehensive review of health quality outcomes.

The South African medical schemes market has a long way to go in documenting health outcomes within managed healthcare. In future the CMS will make changes to the annual data specification in order to start collecting more process indicators and information on health outcomes.

The establishment of the Office of Health Standards Compliance (OHSC) and the tightening private hospital licensing processes will contribute to the measurement of quality of care. In addition, strategic partnerships with various organisations – including the HPCSA, the CC, the Medical Research Council (MRC) and StatsSA – under the oversight of the DoH, will go a long way towards facilitating comprehensive regulation and the review of quality health outcomes across different domains.

State of the industry: schemes, benefits, contributions and costs

No entity applied to be registered as a new medical scheme during the period under review and the number of medical schemes dropped from 90 in March 2013 to 85 in March 2014.

In February 2014 the CMS published a list of all registered medical schemes and their contact details in the Government Gazette, as required by Section 25 of the Medical Schemes Act.

Scheme amalgamations and liquidations

In the year under review, medical schemes continued to merge. Such developments are an expected response to market forces and are not necessarily a negative development or an indication of instability in the South African medical schemes environment. The mergers listed in Table 2 involved the absorption of schemes into larger entities and resulted in greater risk pooling.

Table 2: Amalgamations of medical schemes

Scheme name	Scheme amalgamated/merger with	Date
Sappi Medical Scheme	Bestmed Medical Scheme	1 April 2013
IBM Medical Scheme	Discovery Health Medical Scheme	1 July 2013
Minemed	Bestmed Medical Scheme	1 September 2013
Altron Medical Scheme	Discovery Health Medical Scheme	1 January 2014
Pharos Medical Plan	Topmed Medical Scheme	1 January 2014

No schemes were liquidated in the period under review.

Benefit options: offerings to members

Medical schemes continued to consolidate in 2013/14, and this process resulted in a reduction in the overall number of benefit options available. There was, however, an increase in efficiency-discounted benefit options (EDOs), from 37 such options on 31 March 2013 to 40 a year later.

The total number of registered benefit options (including EDOs) decreased from 323 in March 2013 to 317 in March 2014. The drop in benefit options in open schemes was from 178 to 177, while the decrease in restricted schemes was from 145 to 140.

Table 3: Benefit options available as at 1 March 2014

Status of option	Open scheme options	Restricted scheme options	Total
Total options registered as at 31 March 2013	**178**	**145**	**323**
Less: efficiency-discounted options (EDOs)	-37	0	-37
Options excluding EDOs registered as at 31 March 2013	141	145	286
New options	+5	+2	+7
Discontinued options	-4	0	-4
Discontinued options due to scheme mergers	-5	-7	-12
Discontinued options due to scheme liquidations	0	0	0
Options excluding EDOs registered as at 31 March 2014	**137**	**140**	**277**
Options with efficiency discounts*	+40	0	+40
Total options registered as at 31 March 2014	**177**	**140**	**317**

* *These options are registered as one option but they have differing contribution tables based on the provider choice offered to members. The total number of registered options for open schemes is therefore 137.*

Efficiency-discounted options

EDOs are benefit options with network arrangements for healthcare provision. They were introduced in 2008 and allow monthly medical scheme contributions to be differentiated on the basis of the healthcare providers that are utilised to provide benefits. This practice is in conflict with the statutory principle that contributions may be differentiated only on the basis of income or family size, or both. Schemes must therefore be exempted from section 29(1)(n) of the Medical Schemes Act before they can operate EDOs.

In the year under review, Council allowed Hosmed Medical Aid Scheme to introduce EDOs, bringing the total number of schemes offering such options to eight at the end of March 2014. The other seven are: Momentum Health, Discovery Health Medical Scheme (DHMS), Fedhealth Medical Scheme, Liberty Medical Scheme, Thebemed, Compcare Wellness Medical Scheme and Medihelp.

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

Benefit options with network arrangements offer advantages to both members and medical schemes. Members receive discounts because the scheme is able to obtain efficiency from a selected provider network. Members' contributions are fair and non-discriminatory and they retain a measure of choice within the efficiency of the network. Medical schemes also achieve cost savings because network arrangements allow schemes to negotiate better reimbursement and healthcare delivery terms.

The high level of interest in options with network arrangements among medical schemes, members and the industry at large is illustrated by the 8.1% growth in such options from 37 in March 2013 to 40 in March 2014. Demand for such options is expected to continue growing as schemes and members continue to benefit from such arrangements.

Momentum Health's and DHMS's EDOs were the first to be introduced and have been operating long enough to allow performance comparisons with other options in the same schemes.

DHMS EDOs continue to experience above-average growth, with an increase in membership of 408.8% and 145 337 new beneficiaries since 2009. Non-EDO options in the same scheme had a 6.4% membership growth over the same period and acquired 67 988 new beneficiaries.

Momentum Health EDOs have increased membership but not to the same extent as Discovery. Figures submitted to the CMS show a membership increase of 36.6% in Momentum Health's EDOs since 2009. Although there was a dip in membership between 2009 and 2012, this was compensated for by an increase of 38.1% between 2012 and 2013. Momentum Health's non-EDO options, in comparison, have experienced a 15% decrease in membership since 2009.

Table 4 reflects the number of beneficiaries covered by EDO and non-EDO options of the Momentum Health Scheme and DHMS since 2009.

Table 4: Number of beneficiaries on EDO and non-EDO options: DHMS and Momentum 2009 – 2013

Beneficiaries	2009	2010	2011	2012	2013
DHMS Non-EDO	1 063 446	1 088 217	1 095 683	1 112 879	1 131 434
DHMS EDO	35 551	83 319	119 017	145 374	180 888
DHMS total	**1 098 997**	**1 171 536**	**1 214 700**	**1 258 253**	**1 312 322**
Momentum Non-EDO	44 982	45 440	43 129	41 838	38 231
Momentum EDO	120 046	104 469	108 413	118 711	163 969
Momentum total	**165 028**	**149 909**	**151 542**	**160 549**	**202 200**

The net healthcare performance of the DHMS EDOs is shown in Table 5. These indicate that DHMS's EDOs contributed up to 26% of the scheme's surplus in 2013 although they service on 13.8% of the scheme's total membership.

Table 5: Net healthcare performance of DHMS EDOs 2009 – 2013

	2009 R'000	2010 R'000	2011 R'000	2012 R'000	2013 R'000
EDOs	30 820	70 779	110 068	159 410	223 141
Non-EDOs	178 941	198 558	149 859	332 515	365 488
Total	**209 761**	**269 337**	**259 927**	**491 925**	**858 629**

Similar results have been observed in Momentum Health's EDOs. Table 6 shows that EDOs have enabled the scheme as a whole to achieve positive net healthcare results. The majority of its members (81.1%) are on EDOs.

Table 6: Net healthcare performance of Momentum Health EDOs 2009 – 2013

	2009 R'000	2010 R'000	2011 R'000	2012 R'000	2013 R'000
EDOs	63 771	108 907	136 411	154 762	179 863
Non-EDOs	(111 018)	(80 929)	(63 689)	(50 517)	(80 170)
Total	**(47 247)**	**27 978**	**72 722**	**104 245**	**99 693**

EDOs that were registered as early as 2009 have consistently made a positive contribution to the combined performance of all options offered within their schemes. It is too early to analyse the performance trends of EDOs that were established more recently.

Table 7 provides a high-level summary of the EDO options currently registered.

Table 7: Summary of EDOs and non-EDOs as at 31 December 2013

	Members	Beneficiaries	Gross contributions R'000	Net healthcare results pbpm	Claims ratio	Number of options
EDOs	186 559	375 448	4 177 897	109.25	66.1%	39
Non-EDOs	648 557	1 460 418	27 792 515	18.64	84.2%	24
Total	**835 116**	**1 835 866**	**31 970 412**	**37.17**	**81.7%**	**24**

Annexure V provides detailed information on EDOs that are currently registered.

Registration of rule amendments

Section 32 of the Medical Schemes Act ensures that the rules of schemes are binding on the schemes and relevant stakeholders.

The CMS processed 212 rule amendments submitted by schemes in 2013/14. These included changes to contributions and benefits, the registration of new benefit options, and the registration of new EDOs.

Both the Appeals Committee and the Appeal Board agreed with the decision by the Office of the Registrar to reject the eligibility criteria that restricted medical schemes were proposing in an effort to avoid admitting higher-risk groups as members. It is unfortunate that restricted medical schemes persisted in their efforts to discriminate against older and sicker individuals by trying to limit, and even deny, their access to the schemes.

Model rules

By developing model rules, the CMS aims to provide best practice guidance for complying with the Medical Schemes Act in order to nurture an industry-wide culture of compliance. The rules also aim to foster co-operation among medical schemes and other regulated entities by standardising submissions to the CMS on matters such as governance, contributions and benefits.

The revision of the model rules was necessitated to a large extent by the promulgation of the Consumer Protection Act 68 of 2008, Circular 28 of 2011 and Circular 5 of 2012 (on personal medical savings accounts), Circular 48 of 2011 (the King III Report on governance and integrated sustainability reporting), extensive amendments being proposed to the Medical Schemes Act, and related legislation.

Marketing materials and application forms

The CMS evaluated the marketing materials and application forms of 51 medical schemes in the 2013/14 financial year. This activity revealed some issues relating to asymmetry of information in the industry, a matter of ongoing concern to the CMS.

Some materials analysed lacked the key information that PMBs are available to all beneficiaries and payable in full in terms of the Medical Schemes Act. Another concern was the identification of state facilities as designated service providers without any reference to the fact that this arrangement was subject to Regulation 8(3). Some schemes indicated that forms and information were accessible only on their websites and/or by e-mail. This would prejudice members who do not have access to these technologies.

The brochures of some schemes did not indicate the tariffs applicable or the tariff level at which various benefits are payable. In these instances, schemes were required to correct inaccuracies or provide outstanding information in their marketing materials and application forms to ensure that members are properly informed of their benefit entitlements, as required by the legislation.

The CMS will continue to monitor the marketing material and application forms of schemes to ensure that they comply with their registered rules and the Medical Schemes Act (which always takes precedence over scheme rules if there are inconsistencies).

Guidance on contribution increases

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

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

In Circular 33 of 2013, the CMS provided guidance on contribution increases for the 2014 calendar year. Medical schemes were advised that they should limit their cost increase assumptions for 2014 to 6.0% for each individual healthcare cost driver, including private hospital fees, specialist costs and administration fees. The circular also informed medical schemes of the key considerations that the CMS would take into account in assessing cost increases for 2014.

Schemes were requested to submit analyses of demographic indicators and healthcare utilisation in motivating for their cost increase assumptions for 2014.

Cost assumption data was submitted by 81 medical schemes. Data from 76 medical schemes, representing 8 272 390 beneficiaries (approximately 95% of all beneficiaries in the industry), was found to be of adequate quality for inclusion in the analysis of industry trends.

The weighted average total assumed increase for 2014 across all medical schemes was 9.2%, slightly lower than the 2013 increase of 9.6%.

The weighted average assumed impact of utilisation and demographic changes on contribution increases across all schemes was 2.3%.

The results of the analysis were published in Circular 14 of 2014 and presented at an ITAP meeting in 2014.

The average gross contribution increase for all medical schemes in 2014 was 8.9%.

Open schemes instituted larger increases in contributions than restricted schemes. The increases for open and restricted schemes were 9.2% and 8.4% respectively.

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. The information in this section is a summary based on medical scheme submissions on benefit changes and contribution increases for 2014.

Table 8: Average gross contribution increases for 2013/14 benefit and contribution review period

Increase in gross contributions in 2014	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.2%	9.2%	9.3%	9.2%
Restricted schemes	8.4%	8.4%	8.7%	8.4%
All schemes	**8.9%**	**8.9%**	**9.0%**	**8.9%**

Table 9: Average monthly gross contribution for 2014

Monthly gross contribution in 2014	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 874	R1 683	R569	R3 065
Restricted schemes	R1 752	R1 452	R644	R3 042
All schemes	**R1 825**	**R1 593**	**R607**	**R3 056**

Table 10: Average monthly risk contribution for 2013/14 benefit and contribution review period

Monthly risk contribution in 2014	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 636	R1 440	R495	R2 661
Restricted schemes	R1 678	R1 392	R624	R2 922
All schemes	**R1 653**	**R1 421**	**R560**	**R2 767**

The risk contribution is equal to the total contribution paid less the amount that is allocated to the beneficiary's savings account. The average risk contribution increase for all medical schemes in 2014 was 8.9%. The increases for open and restricted schemes were 9.2% and 8.5% respectively.

Data analysed during the review period showed that contributions to savings accounts as a proportion of total contributions differed between open and restricted schemes. Across both categories of schemes savings account contributions constituted an average of 9.5% of total contributions. However, in the case of open schemes this figures rose to 13.2% of total contributions, while in restricted schemes it averaged 3.9%.

This difference is due to different benefit structures in open and restricted schemes, particularly in relation to out-of-hospital benefits and the extent to which these are provided from the overall risk pool or savings accounts.

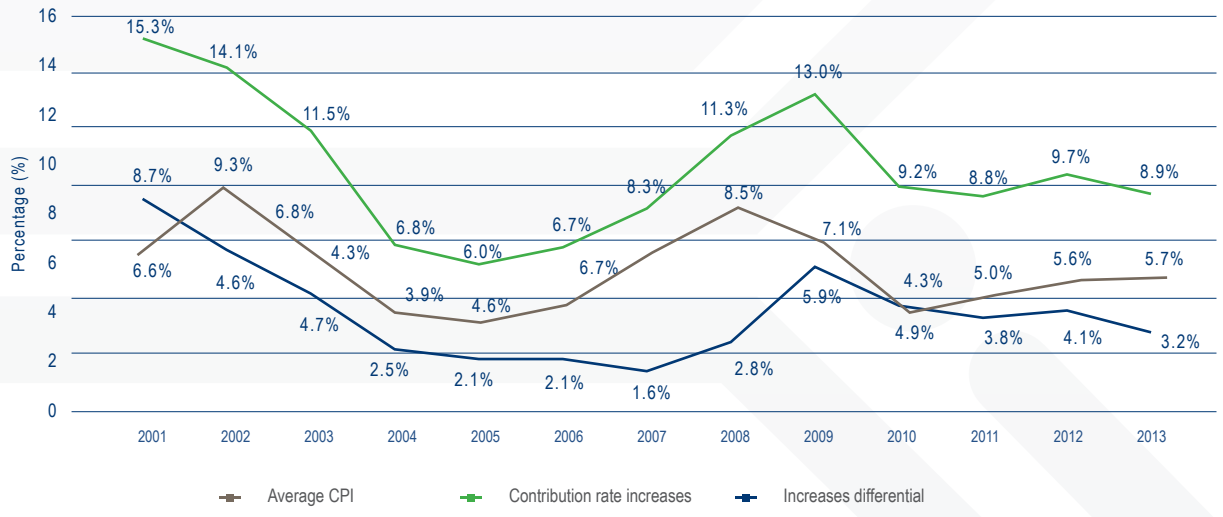
Table 11: Average risk contribution increases for 2013/14 benefit and contribution review period

	Principal member	Adult dependant	Child dependant	Family
Open schemes	9.2%	9.2%	9.4%	9.2%
Restricted schemes	8.4%	8.4%	8.7%	8.5%
All schemes	**8.9%**	**8.9%**	**9.0%**	**8.9%**

Contribution rates relative to general price indicators

Figure 3 shows historical and current inflation trends, measured by the Consumer Price Index (CPI), relative to medical scheme contribution rates between 2001 and 2013. The graph also indicates the percentage by which the average rate of medical scheme contributions increases exceeded inflation.

Figure 3: Medical scheme contributions and inflation 2001 – 2013



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

The data show that, since the year 2002, medical scheme contributions have followed a similar trend to inflation. However, average annual increases in medical scheme contributions have consistently been higher than CPI increases. The average difference over the period 2001 to 2013 is in the region of 4.0%. This has implications for the long-term affordability of the medical schemes industry as increases in salaries may not necessarily be able to keep pace with contribution increases.

Ensuring schemes remain financially viable

The CMS is tasked with ensuring the financial soundness of medical schemes and that they maintain the minimum statutory solvency level. Regulation 29, promulgated under the Medical Schemes Act 131 of 1998, requires medical schemes to maintain accumulated funds amounting to at least 25% of gross annual contributions. This is commonly referred to as the "solvency level".

The regulation further sets out processes to be followed by those schemes that fail to meet solvency requirements. These schemes are required to submit business plans and, where necessary, action plans to address the situation. These plans are analysed by the CMS and, if they are found to be satisfactory, approved. However, the schemes are still closely monitored to ensure that solvency levels improve and schemes remain sustainable.

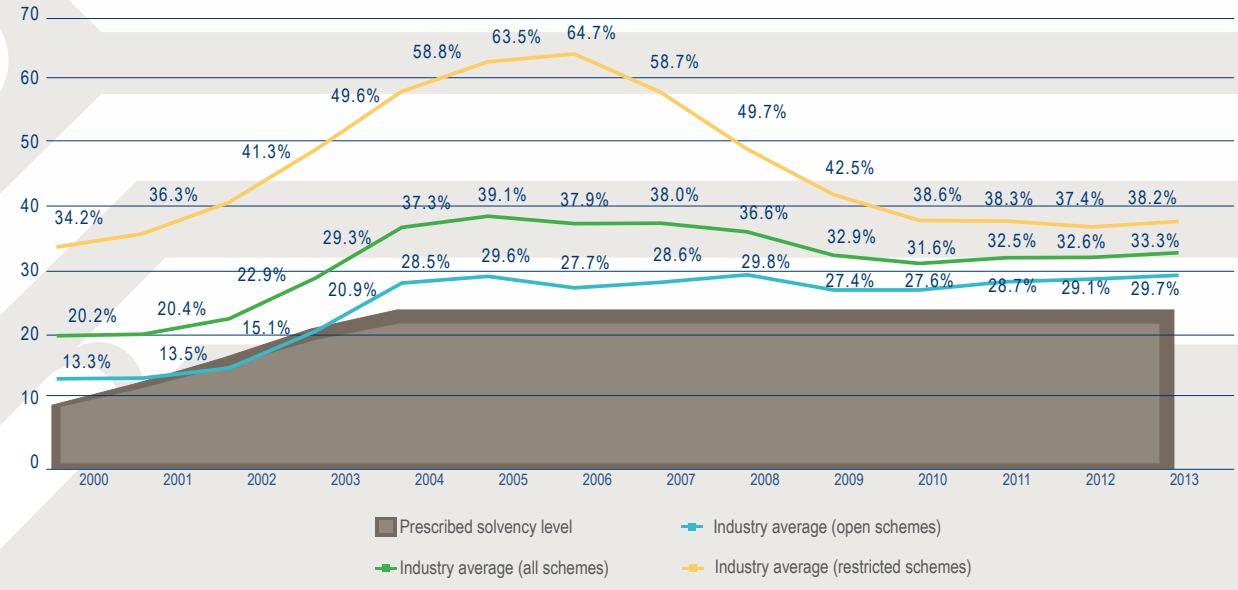
While some schemes continued to face solvency challenges in 2013, the industry as a whole remained fairly stable. Some medical schemes that were previously on close monitoring significantly improved their solvency ratios. The ongoing endeavours of the management of these schemes are noteworthy. The CMS maintains regular interaction with boards of trustees and management of schemes faced with challenges in order to ensure that members' interests are protected.

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

Overall, in real terms, non-healthcare expenditure of medical schemes has remained stable in recent years, in contrast to the double-digit increases experienced over a decade ago.

Boards of trustees and the management of medical schemes need to continually manage non-healthcare expenditure in such a manner that it is reduced and maintained at acceptable levels. This will ensure that members of schemes derive maximum value from every healthcare rand that they spend.

Figure 4: Industry solvency trends 2000 – 2013



As at 31 December 2013 there were nine medical schemes (six open and three restricted) that were below the statutory solvency requirement. The comparable figures at the end of 2012 were 11 schemes, seven of which were open schemes and four restricted.

Three schemes that had been on close monitoring, no longer required "intensive care" by 31 December 2013. Altron Medical Aid Scheme and Keyhealth Medical Scheme improved their reserves and achieved the statutory solvency level of 25%, while Prosano Medical Scheme amalgamated with Bonitas Medical Fund with effect from 1 January 2013.

Table 12 contains a summary of schemes subject to close monitoring in terms of Regulation 29(4) of the Medical Schemes Act.

Table 12: Schemes with reserves below statutory minimum as at December 2013

Solvency level	Open schemes	Restricted schemes	Name of scheme
Below 10%	1	0	Resolution Health Medical Scheme
From 10% – 13,5%	0	1	Government Employees Medical Scheme
From 13,5% – 17,5%	2	0	Thebemed, Pharos Medical Plan
From 17,5% – 22%	0	2	Transmed Medical Fund, Umvuzo Health Medical Scheme
From 22% – 25%	3	0	Discovery Health Medical Scheme, Liberty Medical Scheme, Hosmed Medical Aid Scheme
Total number with solvency below 25%	**6**	**3**	

Figures 5 and 6 indicate that a high proportion of beneficiaries belong to schemes that do not meet the minimum statutory solvency level and that this position has remained much the same over the last two years.

Figure 5: Beneficiaries by solvency level of their medical schemes 2013

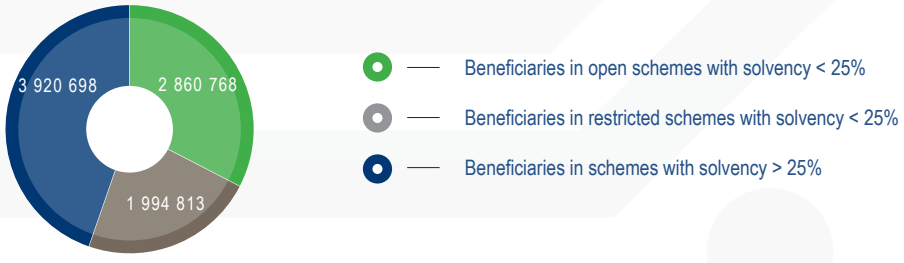
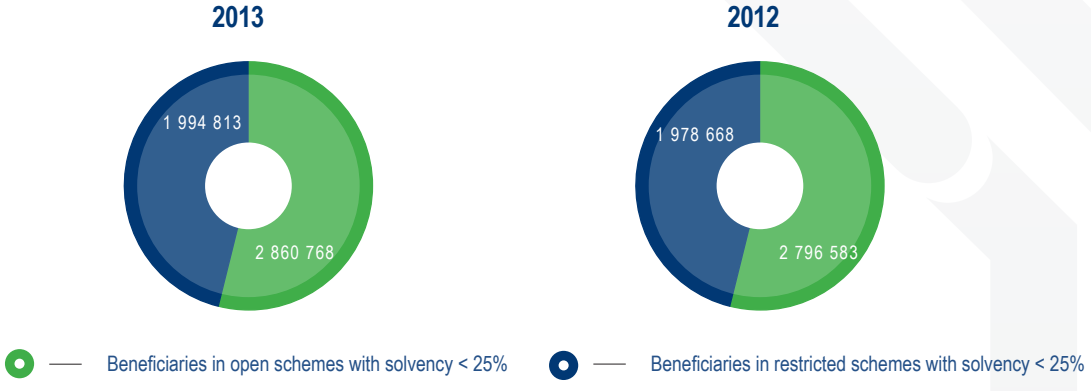


Figure 6: Comparison of beneficiaries in schemes below 25% solvency level: 2012 and 2013



On 31 December 2013 there were 87 registered medical schemes, of which 24 were open and 63 restricted. These schemes had a total of 8 776 279 beneficiaries, comprising 3 878 267 principal members and 4 898 012 dependants.

At the end of 2013 the open scheme market encompassed 4 846 909 beneficiaries (4 759 994 in December 2012) and 59.0% of them belonged to schemes that failed to meet the prescribed minimum solvency level. The restricted scheme market covered 3 929 370 beneficiaries (3 919 479 in 31 December 2012), 50.8% of whom were in schemes that did not meet the minimum solvency requirement.

The percentage of beneficiaries in open schemes with lower-than-required solvency levels would be only 6.1% without Discovery Health Medical Scheme (DHMS) which accounts for 52.9% of beneficiaries in the open market. Similarly, in the restricted schemes market only 3.6% of beneficiaries would belong to schemes that fail to meet solvency requirements if it weren't for the Government Employees Medical Scheme (GEMS) which represents 47.2% of all beneficiaries in the restricted market.

Interactions with schemes in 'intensive care'

The restricted Altron Medical Aid Scheme was below the statutory solvency level in 2012. As at 31 December 2013, the scheme had a solvency level of 25.9%, which is an improvement on the figure of 21.1% reported in December 2012. The reversal of the employer's decision to allow employees to join other medical schemes was successful in attracting younger and healthier members to the company scheme. However, the increased size of the risk pool resulted in increasing claims volatility which caused the scheme to pursue a merger with another scheme.

Discovery Health Medical Scheme ended 2013 with a solvency ratio of 24.3%, which represented a 3.8% increase on the 2012 ratio of 23.4%. The scheme continued to experience growth in its membership base. Further, management of the scheme and its board of trustees implemented interventions including adjustments to contributions, benefits and non-healthcare expenditure, and forensic and fraud management measures. All of these boosted the scheme's savings in 2013. The scheme is still on close monitoring and has an approved business plan against which progress is tracked. Its trustees attend regular monitoring meetings with the CMS.

The Government Employees Medical Scheme (GEMS) had a solvency ratio of 11.7% at the end of 2013, which represented an increase of 47.4% on the ratio of 7.9% reported in December 2012. The number of GEMS beneficiaries continued to increase, placing pressure on the scheme's reserves. Initiatives to stabilise the scheme and grow its reserves included the enhancement of its provider networks to manage costs and more stringent risk management processes. As required by the regulations, GEMS has an approved business plan detailing the turnaround strategies to be implemented in order to improve the solvency level. GEMS submit monthly management accounts and quarterly financial updates for monitoring purposes.

A solvency ratio of 24.5% was reported by Hosmed Medical Aid Scheme at the end of 2013, compared to 23.0% in 2012. The scheme continued to experience significant governance challenges, coupled with membership loss and substantial increases in non-healthcare expenditure. A curator has been appointed to address the challenges experienced by the scheme and protect the interests of members.

Liberty Medical Scheme had a lower solvency ratio at the end of 2013 of 24.4% as compared to 2012 (26.2%). The decline in solvency was partly due to a drop in membership, higher than expected claims and increasing non-healthcare expenditure. Management of the scheme has submitted a business plan. New product offerings and an adjustment to contributions and benefits are some of the interventions to be implemented. Trustees attend regular monitoring meetings with the CMS.

Keyhealth Medical Scheme had a solvency ratio of 29.5% in 2013, a substantial increase on the ratio of 23.1% reported in 2012. The scheme continued to improve its financial performance due to mitigating measures introduced in recent years, including a reduction in scheme expenses and interventions in the areas of managed care and chronic medicine. But the scheme still faced challenges posed by an increasingly unfavourable demographic profile. Its trustees attended monitoring meetings to discuss progress against the approved business plan.

Minemed Medical Scheme amalgamated with Bestmed Medical Scheme in September 2013.

The 2013 year-end solvency ratio of 17.3% for Pharos Medical Plan was a slight improvement on the previous year's ratio of 16.6%. A small, declining and ageing risk pool continued to be the scheme's main difficulty, ultimately resulting in a merger with another scheme in 2014.

Resolution Health Medical Scheme had a solvency ratio of 8.1% for 2013; the solvency ratio in December 2012 was 6.1%. The scheme adjusted its contributions in an attempt to address previous pricing issues. While this resulted in an increase in reserves, the scheme also experienced a decline in membership coupled with an ageing profile. The CMS has advised the board to seek sustainable solutions which would safeguard members' interests.

A solvency ratio of 15.1% was reported in 2013 for Thebemed, which is higher than the 2012 figure of 10.6%. The improvement was due to measures ranging from tighter management of utilisation to conclusion of a reinsurance contract in order to protect the risk pool. A business plan was submitted by the scheme and the CMS holds monitoring meetings with the board on a regular basis. Thebemed also submits monthly management accounts.

At the end of 2013 the solvency ratio of Transmed Medical Fund (Transmed) had improved by 28.5%, from 16.3% to 20.9%. The scheme continued to struggle with an ageing pool of beneficiaries.

However, adjustments to the benefit configuration and introduction of managed care interventions a few years ago seem to be bearing fruit. Transmed submitted a business plan and continues to submit monthly management reports. It remained under close monitoring and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

Umvuzo Health Medical Scheme had a solvency level of 21.3% at 2013 year-end. The growth in its reserves was attributable to lower than anticipated claims. The scheme has an approved business plan and submits monthly management accounts.

Preserving and growing schemes' reserves

Investments by medical schemes are regulated by Annexure B, read in conjunction with Regulation 30. The objective of regulation is to ensure that the spread of investments is aligned with the nature of the medical scheme's liabilities. As medical schemes continue to face costs that are significantly higher than inflation, it is important that boards of trustees make appropriate investment decisions to ensure growth and preservation of reserves so that schemes are able to carry out their obligations in the future.

The conceptual framework underlying these legislative provisions on investments is under consideration by Council. The intention is to improve both the regulation and management of investments. The industry will be engaged in due course to provide comments on possible changes.

Quality control through accreditation

The CMS is responsible for the accreditation and monitoring of administrators of medical schemes, managed care organisations (MCOs) and brokers operating in the industry. It is also tasked with ensuring that self-administered medical schemes comply with statutory requirements.

Administrators and self-administered schemes

A total of 17 third-party administrators were accredited and 10 self-administered medical schemes were in possession of compliance certificates as at 31 March 2014.

Table 13: Accreditation of administrators and compliance certification of schemes 2013/14

Third-party administrators		Self-administered schemes		On-site compliance evaluation*
New	Renewed	Certified compliant	Compliance renewed	
Strata Healthcare Management (Pty) Ltd	Discovery Health (Pty) Ltd	Food Workers Medical Benefit Fund	De Beers Benefit Society	PrimeMed Administrators (Pty) Ltd, a new company
PrimeMed Administrators (Pty) Ltd	Medscheme Holdings (Pty) Ltd	Sedmed	Rand Water Medical Scheme	Professional Medical Scheme Administrators (Pty) Ltd, which changed its administration system
	MetHealth (Pty) Ltd		SAMWUMED	Sedmed, a self-administered scheme
	Metropolitan Health Corporate (Pty) Ltd		Witbank Coalfields Medical Aid Scheme	
	Professional Medical Scheme Administrators (Pty) Ltd			
	Providence Healthcare Risk Managers (Pty) Ltd			
	V Med Administrators (Pty) Ltd			

* *Applicable to both third-party administrators and self-administered schemes*

Managed care organisations

There were 40 accredited MCOs as at 31 March 2014. A number of new applications for accreditation as MCOs were received and evaluated during the period under review. Some of these were found to be invalid as the proposed services did not fall within the legislated definition of "managed healthcare". These applicants were advised that they did not require formal accreditation.

A document setting out the types of managed care services that require accreditation and correct naming conventions was published in March 2014. Schemes, MCOs and administrators are now required to use these universal naming conventions for the purposes of contracting and reporting.

Table 14: Accreditation of managed care organisations (MCOs) 2013/14

Newly accredited	Accreditation renewed	On-site compliance evaluations	De-activated MCOs
Knowledge Objects Healthcare (Pty) Ltd	Centre for Degenerative Joint Diseases (Pty) Ltd	Aid for Aids Management (Pty) Ltd	Dentpro (Pty) Ltd elected not to renew accreditation
Knowledge Objects Solutions (Pty) Ltd	Centre for Diabetes and Endocrinology (Pty) Ltd	Enablemed (Pty) Ltd	Resilience Health Services (Pty) Ltd elected not to renew accreditation
My Care Health Solutions (Pty) Ltd	Dental Information Systems (Pty) Ltd	Eternity Healthcare (Pty) Ltd	KwaZulu Natal Managed Care Coalition Ltd which did not require accreditation as its services did not constitute managed care as defined in law
Strata Healthcare Management (Pty) Ltd	Dental Risk Company (Pty) Ltd	Medscheme Holdings (Pty) Ltd	
	Enablemed (Pty) Ltd	Managed Healthcare Systems (Pty) Ltd	
	Independent Clinical Oncology Network (Pty) Ltd	Performance Health (Pty) Ltd	
	Medical Services Organisation SA (Pty) Ltd	Universal Care (Pty) Ltd	
	Medscheme Holdings (Pty) Ltd	Uno Healthcare (Pty), trading as One Health Managed Care	
	Private Health Administrators (Pty) Ltd		
	Sechaba Medical Solutions (Pty) Ltd		
	Universal Care (Pty) Ltd		
	Uno Healthcare (Pty) Ltd, trading as One Health Managed Care		

Brokers and broker organisations

The Accreditation Unit processed applications from 1 117 new brokers and 104 new broker organisations and renewal applications from 4 664 brokers and 1 120 broker organisations.

As at 31 March 2014, the total number of accredited brokers was 8 757 and the total number of broker organisations was 2 146.

Tables 15, 16 and 17 provide details of individuals and organisations where broker accreditation was rejected, suspended or withdrawn during the financial year under review.

Table 15: Broker accreditation applications rejected 2013/14

Broker number	Action	Effective date	Reason
PR Sangweni (BR 9347)	Rejected	28.06.2013	The applicant has been debarred by the Financial Services Board
DS van Zyl (BR 33062)	Rejected	25.04.2013	The applicant has been sequestrated
EH Barnard (BR 34000)	Rejected	02.08.2013	The applicant has been sequestrated

Table 16: Broker accreditations suspended and withdrawn 2013/14

Broker number	Action	Effective date	Reason
AS Louter (BR 22116)	Withdrawn	22.01.2014	The broker no longer provides broker services
RB Skene (BR 33563)	Withdrawn	31.07.2013	The broker no longer provides broker services

Table 17: Brokerage accreditations suspended and withdrawn 2013/14

Brokerage number	Action	Effective date	Reason
Masthead Trade and Invest 3 (Pty) Ltd (ORG 3686)	Withdrawn	30.04.2013	The entity no longer provides broker services

Support for broker accreditation

The CMS has published a document on the accreditation procedure to assist applicants to comply with accreditation requirements. In addition, the brokerage and the broker portals have been upgraded to allow successful applicants to print copies of their accreditation certificates.

Monitoring providers of healthcare services

The sound administration of medical schemes rests partly on healthcare institutions and professionals playing their part in providing clear and verifiable information to medical schemes. The CMS facilitates the submission of this information and monitors the extent to which healthcare service providers adhere to the standards required.

Practice code numbering system

The Medical Schemes Act requires all providers of healthcare services to include a practice code number (PCN) on each account submitted to a medical scheme for payment. The CMS is responsible for ensuring that there is a system for issuing such numbers and has fulfilled this requirement through outsourcing.

In 2012, the CMS awarded the tender for the administration of the practice code numbering system (PCNS) to a new service provider. The Board of Healthcare Funders (BHF), which had previously managed the PCNS, challenged the decision by lodging a review application in the North Gauteng High Court. The CMS brought a counter application in order to obtain a court pronouncement on the question of ownership of the PCNS. The BHF contract – which was due to expire on 31 December 2013 – has been extended until these court proceedings have been finalised. The CMS will keep the industry informed on the outcome of the court action.

Monitoring of diagnosis coding (ICD-10)

It is a statutory requirement that all healthcare providers – including doctors, hospitals, and allied professionals – use the International Classification of Diseases – 10th Revision (ICD-10) codes when diagnosing patients and submitting claims to medical schemes. The Research and Monitoring Unit of the CMS continued to provide ICD-10 compliance data to the DoH's Health Information Systems Chief Directorate.

Data specifications for quarterly submissions from medical schemes were revised in the year under review and selected administrators have already begun submitting returns using the new format. These quarterly submissions enable the CMS to monitor the extent to which healthcare providers comply with the legal requirement to include a valid ICD-10 code when they submit their claims to medical schemes.

Investigation and resolution of complaints

The CMS received 5 609 complaints in the year 2013 compared to 6 290 in the previous year. This represented a decline of 10.9%.

The decrease in the number of complaints dealt with is largely due to a procedural change by the Complaints Adjudication Unit. This was necessitated by the practices of certain medical practitioners who submitted complaints, merely indicating that medical schemes were not paying their accounts on time or in full and attaching copies of the relevant accounts without providing further details. These complaints used to be logged on the system. The unit has since engaged with medical schemes and medical practitioners requesting schemes to respond to the complainants directly. As a result, these complaints are no longer logged on the system and medical practitioners have been encouraged to exhaust internal avenues available at medical schemes before approaching the CMS. This initiative has been welcomed by most medical schemes and practitioners alike.

Further, the reporting of complaints statistics was rebased in the period under review – aligning it with the financial year of medical schemes rather than that of the CMS. Therefore, complaints data contained in this report cover the period from 1 January 2013 to 31 December 2013 and are not comparable with figures in the previous annual report.

For the year under review, 5 473 complaints were resolved. The resolution rate is reflected in Table 18 below. However, of the 5 473 resolved complaints, 2 029 were carried over from 2012.

In 2013, 5 473 complaints and inquiries were resolved. It should be noted that 2 029 of these resolved matters were carried over from 2012.

Figure 7: Number of complaints received per 1 000 beneficiaries 2013

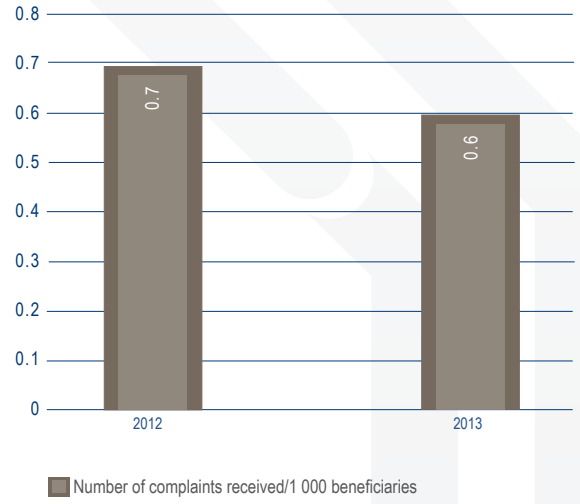
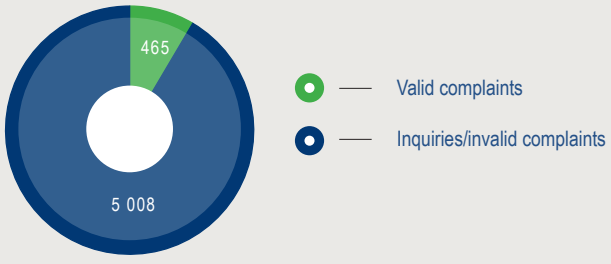


Table 18: Resolution time for complaints in 2013

	Resolution time in days 2013					
Complaints resolved	0-30	>30-60	>60-90	>90-120	>120	Total
Total complaints resolved	1 575	1 019	506	422	1 951	5 473
% of total resolved	28.8	18.6	9.2	7.7	35.6	100

Figure 8 indicates that the majority of matters resolved where valid complaints, while a relatively small number were either invalid complaints or simple inquiries.

Figure 8: Number of resolved complaints: valid and invalid/inquiries 2013



The 5 008 (91.5%) complaints which were classified as valid were referred to medical schemes, administrators and brokers for comment and were resolved after receipt of responses from the parties against which the complaints were made. The inquiries and invalid complaints, which comprised 8% of the total number of matters resolved, were not referred to the medical schemes for comment but were handled internally.

The rulings made in relation to complaints are summarised in Table 19.

Table 19: Rulings on complaints resolved in 2013

Type of scheme	Number of complaints	Ruled in favour of the complainant	Ruled in favour of both complainant and scheme	Ruled in favour of the scheme	Invalid/ inquiries
Open	3 496	1 669	255	1 332	240
Restricted	1 977	1 094	145	513	225
Total	**5 473**	**2 763**	**400**	**1 845**	**465**

The resolution of complaints by category is reflected in Table 20.

Table 20: Number of complaints resolved in 2013 by category

Main categories	Number of complaints resolved
Valid complaints: Clinical	3 078
Valid complaints: Administrative	1 521
Valid complaints: Legal/compliance	409
Subtotal	**5 008**
Inquiries and invalid complaints	465
Total	**5 473**

Table 21: Reasons for valid complaints resolved in 2013

Clinical	Total received per category	
Clinical complaints		**3 078**
Sub-total: Short-payment on PMB accounts		2 116
	3rd party claim	5
	Designated service provider	416
	Exclusion of condition	2
	Formulary	82
	Incorrect coding	114
	Outstanding information	50
	Paid at scheme tariff	1 027
	Paid from savings account	68
	Protocols	223
	Provider irregular billing	22
	Sub-limits in options	107
Sub-total: Non-payment of PMB accounts		620
	3rd party claim	11
	Designated service provider	43
	Exclusion of condition	45
	Formulary	64
	Incorrect coding	63
	Outstanding information	67
	Paid at scheme tariff	42
	Paid from savings account	14
	Protocols	200
	Provider irregular billing	1
	Sub-limits in options	68
	Reversal (erroneous payment)	2
Sub-total: Short payment on non-PMB accounts		179
	Network provider	30
	Exclusion of condition	3
	Formulary	1
	Incorrect coding	25
	Outstanding information	11
	Protocols	25
	Provider irregular billing	5
	Sub-limits in options	79
Sub-total: Non-payment of non-PMBs		163
Administrative complaints		**1 521**
	Benefits paid incorrectly	960
	Contributions increases	122
	General customer service	74
	Inaccessible networks	10
	Information/brochures not received	73
	Medical savings account	70
	Rejection of application for membership (due to legibility)	16
	Pre-authorisation	196
Legal/compliance		**409**
	Broker conduct	8
	Incorrect advice	6
	Governance	14
	Rejection of application for membership (discrimination)	22
	Waiting periods	74
	Late joiner penalty	39
	Suspension and/or termination of membership	246

Scheme-specific performance

Figure 9 and Table 22 indicate the 10 open medical schemes that had the highest rates of complaints in 2013. The fact that medical schemes appear on the list below does not necessarily mean that their members face bigger risks or that these medical schemes are likely to fail.

Figure 9: Ten open schemes with most valid complaints per 1 000 beneficiaries 2013

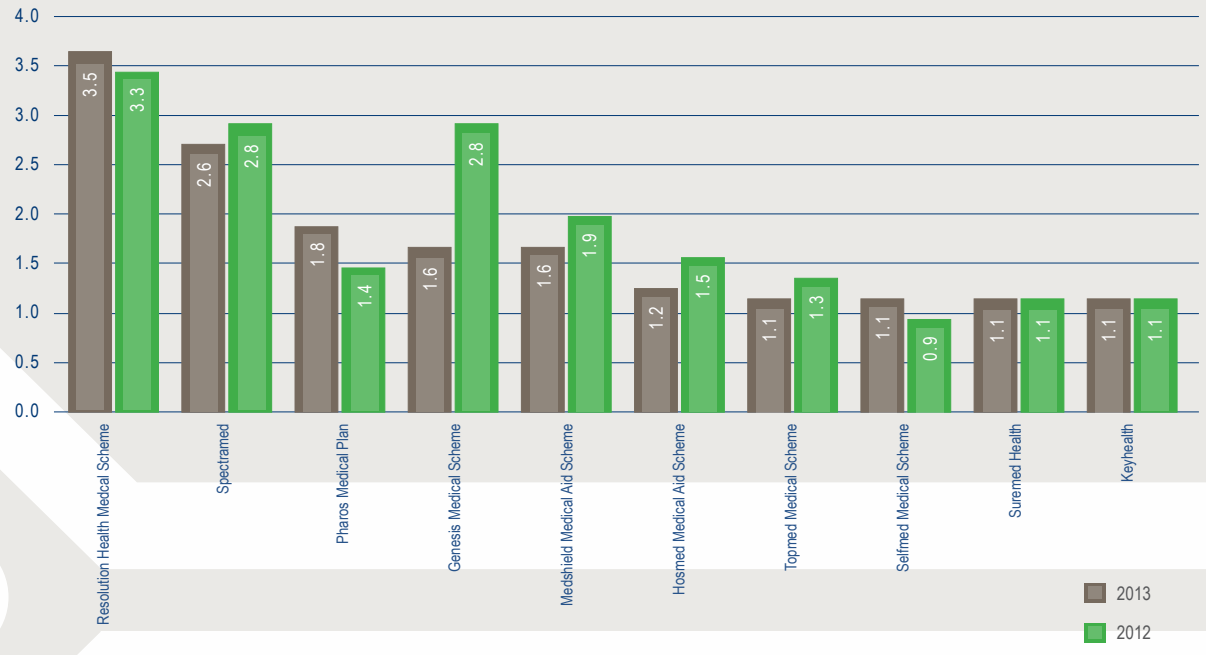


Table 22: Ten open schemes with highest number of valid complaints per 1 000 beneficiaries 2013

Open Schemes	2013 Complaints/ 1000 beneficiaries	2012 Complaints/ 1 000 beneficiaries	Dispute resolution committee (DRC)	Matters that served before DRC
Resolution Health Medical Scheme	3.5	3.3	Yes	None
Spectramed	2.6	2.8	Yes	None
Pharos Medical Plan	1.8	1.4	No	None
Genesis Medical Scheme	1.6	2.8	Yes	None
Medshield Medical Scheme	1.6	1.9	No	None
Hosmed Medical Aid Scheme	1.2	1.5	No	None
Topmed Medical Scheme	1.1	1.3	No	None
Selfmed Medical Scheme	1.1	0.9	Yes	None
Suremed Health	1.1	1.1	Yes	None
Keyhealth Medical Scheme	1.1	1.1	Yes	None

In both the open and restricted scheme categories, there were no matters that served before the dispute resolution committees of the 10 medical schemes with highest complaints ratios. It appears that the dispute resolution committees were not effective in adjudicating complaints.

Figure 10: Ten restricted schemes with highest number of valid complaints per 1 000 beneficiaries 2013

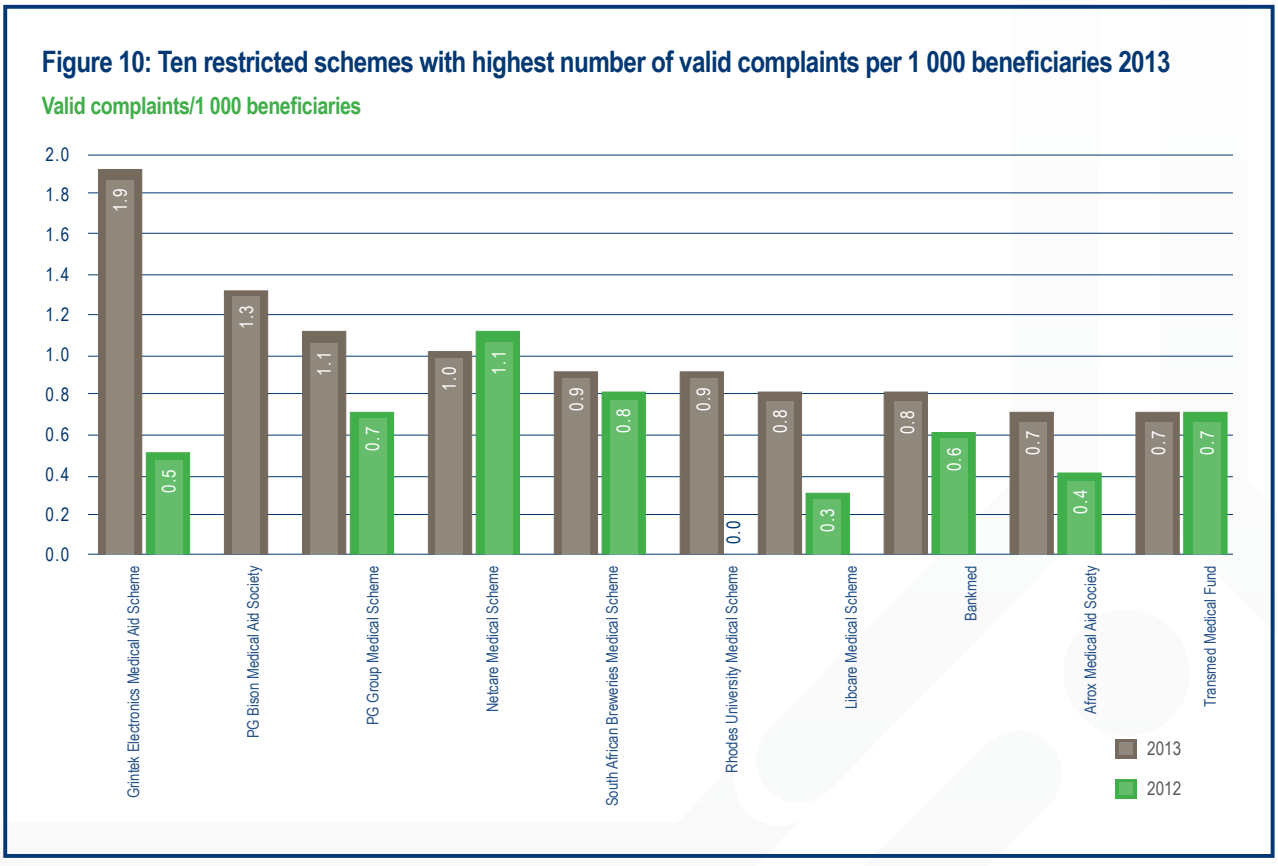


Table 23: Ten restricted medical schemes with highest number of complaints per 1 000 beneficiaries 2013

	2013 Complaints/ 1 000 beneficiaries	2012 Complaints/ 1 000 beneficiaries	Dispute resolution committee (DRC)	Matters that served before DRC
Grintek Electronics Medical Aid Scheme	1.9	0.5	No	None
PG Bison Medical Aid Society	1.3	0.0	Yes	None
PG Group Medical Scheme	1.1	0.7	Yes	None
Netcare Medical Scheme	1.0	1.1	Yes	None
South African Breweries Medical Scheme	0.9	0.8	Yes	None
Rhodes University Medical Scheme	0.9	0.0	Yes	None
Libcare Medical Scheme	0.8	0.3	No	None
Bankmed	0.8	0.6	No	None
Afrox Medical Aid Society	0.7	0.4	Yes	None
Transmed Medical Fund	0.7	0.7	Yes	None

Topical rulings

Liberty Health Medical Scheme vs the Registrar and NCK

Mr N was diagnosed with end stage renal disease during 2007 and had undergone a kidney transplant during October 2011 after receiving authorisation from his medical scheme. However, neither his hospitalisation accounts nor the cost of harvesting the organ from the cadaver were funded by his scheme. The reason for declining payment was that the deceased donor was not a member of Liberty Health Medical Scheme (LHMS).

The scheme did not dispute that the member suffered from a PMB condition, listed under code 901L in the relevant regulation as "Dialysis and renal transplant where Department of Health criteria are met". However, it disputed liability on the following grounds:

- The cost of harvesting organs from a donor who was not a beneficiary of the scheme at the time of death was excluded from benefits.
- The donor in this case had not been a LHMS beneficiary at the time of death.
- The scheme's rules provide cover for the costs of organ transplant only if both the donor and the recipient were members of the scheme.
- The transplant did not qualify as PMB care because it was performed at a private hospital.

A ruling against the medical scheme was appealed by the scheme which maintained that the transplantation did not qualify as PMB care since the procedure was performed at a private hospital.

The Appeals Committee held that it would be unreasonable to require a member to have a kidney transplant performed at a public hospital when the donor kidney, the expertise, the equipment and the capacity to perform the operation were available at a private hospital at a particular time and were not available at a public hospital.

The scheme was obliged in terms of the Medical Schemes Act to fund all costs relating to the harvesting and transplant of the organ in full. By refusing to fund the harvesting of the organ, the scheme was found to be in contravention of Regulation 8(1) to the Act. The provisions of the Medical Schemes Act prevailed over the rule that specified both recipient and donor should belong to the medical scheme.

Medshield Medical Scheme v the Registrar and TE

The member in this matter suffers from multiple sclerosis (MS). Her treatment provider stated that the member had experienced two disabling relapses, with the MRI results showing dissemination in space. Medshield declined funding for treatment stating that it was unable to confirm from the information available that the member had both secondary progression of MS plus remitting relapses.

This Office ruled that the member met the criteria for Rebif, as defined in the MS algorithm. The member had:

- An MRI scan that showed dissemination in space.
- Experienced two disabling recent relapses.
- Distinctive neurological symptoms.

Medshield appealed this ruling on the basis that the CMS had applied the MS algorithm incorrectly. The issue in dispute was whether the member was entitled to receive beta-interferon as a PMB for the diagnosis of RRMS with "Frequent relapse" or whether beta-interferon is only a PMB for SPMS with "Frequent relapse".

The Appeals Committee found that, since the terms begin with a capital letter and the use of a capital letter in punctuation is to separate sentences and phrases, the words "Frequent relapse Secondary progressive" are intended to be two separate terms. There was no basis for reading an ungrammatical "and" into the algorithm to deny the member the PMB where her neurologist prescribed beta-interferon as the appropriate treatment.

GEMS v the Registrar and N MKD

The complaint was lodged by the main member against GEMS for unlawfully terminating the membership of her husband who was registered as her adult dependant. This action followed allegations by the scheme that the husband, who was a pharmacist by profession, had (through his practice) submitted fraudulent claims to GEMS for services rendered to his patients who were members of the scheme. The termination was therefore based on the conduct of the dependant in his capacity as a service provider and not his conduct as a dependant and beneficiary of the medical scheme.

The scheme argued that its decision was based on its right to cancel membership in terms of Section 29(2) of the Medical Schemes Act and its rules. According to the scheme, the Act does not prescribe a procedure to be followed in terminating membership in terms of the above provisions, save to say the member or beneficiary must have been found guilty of submitting fraudulent claims or committing a fraudulent act. The member contested the allegations of fraudulent claims and subsequent termination, arguing that the termination was unlawful and based on incorrect information.

The Office found in favour of the member, deeming the decision to terminate the membership of the dependant on the basis of his dealings as a service provider was both unfounded and invalid. The scheme was directed to reinstate the membership of the dependant.

The scheme then appealed the Office's ruling but its appeal was dismissed by the Appeals Committee which rejected the appellant's contention that Section 29(2) of the Act includes the conduct of beneficiaries outside the scope of membership. The committee held that the Act cannot be interpreted to include the conduct of a service provider if that service provider also happens to be a member of the scheme. The scheme then lodged a further appeal to the Appeal Board which was also dismissed.

H and T v Profmed

Mr H and Mr T were members of the board of trustees of Profmed. Following a majority vote by the board, they were removed as trustees. They filed a complaint in this regard.

The Registrar, in his ruling, indicated that the removal of the former board members was unfair in the light of rule 20.4.1 of the scheme's registered rules which did not afford Mr H and Mr T the opportunity to make

submissions prior to their removal. The Registrar found this rule to be inconsistent with Section 46 of the Medical Schemes Act. The Registrar declined to deal with the grounds the board relied on for the removal of the two members, indicating that it was not for the Registrar's Office to deal with the merits of the matter and contending that it was sufficient to rely on the board minutes and e-mail exchanges between members of the board and the chairperson. The Registrar took the view that he was not in a position to judge the alleged conduct of the two board members and made a determination based purely on the rules of the medical scheme.

In its appeal, the board argued that it was incorrect for the Registrar to rule on whether due process was followed in removing the members since the members had not raised procedural fairness in their complaint. The board contended that the question that should have been answered was whether the members were removed without justifiable cause and, if so, whether the Registrar should reinstate them. The board further submitted that the Registrar incorrectly characterised the issues for consideration and had incorrectly found that rules 20.4.1.3 and 20.4.1.4 were in conflict with Section 46 of the Medical Schemes Act. It was further averred that the Registrar had a duty to resolve the issues in dispute between the parties.

In its ruling, the Appeals Committee noted that the removed board members had asked the Registrar to consider whether their removal complied with the rules of the scheme which called for removal of trustees to be carried out in a procedurally fair manner. The Appeals Committee took the view that the chairman was bound to address a complaint about the conduct of the trustees but only after considering what the affected trustees had to say in response to the complaint. The affected trustees should have been given adequate notice of complaints against them and an opportunity to be heard prior to any decision being taken.

The Appeals Committee held that the board had failed to ensure the rules were complied with: a majority of board members had simply voted for the removal of the two board members after a motion for their removal was tabled. Since procedural fairness was required by the rules, the removal was found to be unfair and thus unlawful and should be set aside.

The board subsequently appealed the decision of the Appeals Committee to the Appeal Board in terms of Section 50 of the Act and the matter will be heard in the new financial year.

Discovery Health Medical Scheme v J

Discovery Health Medical Scheme (DHMS) made an appeal to the Appeal Board following the disposal of a complaint filed by a broker (Mr J) when DHMS refused membership to Mrs M.

Mrs M had been a member of Transmed's restricted medical scheme. When Transmed closed down the benefit option she was on, Mrs M and other former members of Transmed decided to apply to DHMS. They were assisted by a broker, Mr J. DHMS declined to take Mrs M and her colleagues as members on the basis that they posed a systematic risk to the open medical scheme industry.

The Registrar found that DHMS's refusal of membership to Mrs M was inconsistent with the provisions of the Medical Schemes Act read together with the rules of DHMS. The Registrar held that a former member of Transmed was entitled to apply for membership to an open medical scheme and that the open enrolment provisions of the Act would be contravened if DHMS refused to accept the application for membership.

The Appeal Board subsequently made an order that Mrs M was entitled to apply for membership of DHMS and that the open enrolment provisions of the Medical Schemes Act would be breached if the scheme refused to accept her application.

DHMS had requested the Registrar to pend rulings in respect of approximately 60 similar complaints against it until the Appeals Committee and Appeal Board decisions were handed down.

Promoting sound management of schemes

The CMS continued to safeguard members' interests by monitoring medical schemes and enforcing compliance with the Medical Schemes Act. In instances where trustees of schemes were found to be unfit and improper, the removal of trustees in terms of section 46(1) was effected.

Removal of trustees

The trustees of Hosmed Medical Aid Scheme were removed by Council and they took the matter on appeal to the Appeal Board. The allegations which led to their removal included making false statements under oath, having poor credit records and showing bias in favour of the employer. The Appeal Board confirmed Council's ruling, stating that Rule 20 imposed on a trustee the duty to *"ensure proper and sound management of Hosmed (Rule 20.1); to act with care and diligence, skill, and good faith (Rule 20.2), to avoid conflicts of interest and to declare interests (Rule 20.3); to apply sound business principles and ensure financial soundness of the scheme (Rule 20.4) and to make sure that proper control systems are employed (Rule 20.8). For its part, Section 57(6) [of the Medical Schemes Act] requires of a trustee to at all times protect the interests of beneficiaries; to act with due diligence, skill and good faith, to take all reasonable steps to avoid conflicts of interest and to act with impartiality in respect of all beneficiaries. Accordingly, the appeal by the trustees against their removal by the Council was dismissed."*

The CMS's intention to place Selfmed Medical Scheme under curatorship led to a settlement order between Selfmed and the CMS, made by the Western Cape High Court on 16 April 2013. The order directed the scheme to constitute a new board of trustees. The rules of the scheme provide that the board shall consist of a minimum of four trustees - 50% elected and 50% appointed. In June 2013 two member-elected trustees were chosen at the Selfmed AGM and during July 2013 two new trustees were appointed, completing the reconstitution of the board. The new board has set up an independent audit committee as well as an investment committee which will manage the scheme's finances. The irregularities identified by CMS inspectors continue to be investigated.

Curatorships

Sizwe Medical Fund was placed under provisional curatorship by the South Gauteng High Court on 4 September 2012 on the basis of material irregularities of a governance nature which had come to the attention of

the Chief Executive and Registrar. Dr Khaya Gobinca was subsequently appointed curator. An application for leave to appeal the judgment was heard in the North Gauteng High Court on 8 May 2013 and was dismissed with costs. Subsequently concerns about the manner in which the curator of Sizwe Medical Fund was executing his mandate prompted the Registrar to approach the North Gauteng High Court on 10 September 2013 for the removal of Dr Gobinca. This application was granted and a new curator, Mr Joe Seoloane, was subsequently appointed.

Medshield Medical Scheme was placed under provisional curatorship by the North Gauteng High Court on 2 October 2012 as a result of material concerns over the governance of the scheme. Mr Themba Langa was appointed curator and charged with addressing and rectifying the concerns. The former trustees applied for leave to appeal the judgment in the Supreme Court of Appeal and this was granted.

The Registrar subsequently approached the North Gauteng High Court with an application for the removal of Mr Langa as the provisional curator of the scheme because of concerns about his management of the scheme. Dr Tebogo Phaleng was duly appointed as the new provisional curator of the scheme.

General meetings and trustee elections

The CMS attended 32 annual general meetings of medical schemes as observers. Where irregularities were identified at the meetings, the CMS addressed these with principal officers.

The CMS received complaints pertaining to the refusal by Liberty Health Medical Scheme to accept motions for tabling at its AGM. The CMS declared the elections unfair and issued a directive that the scheme must hold new elections in 2014. The scheme has taken steps to comply with the directive and a representative of the CMS serves as an observer on the steering committee to oversee the election process. Terms of reference for the steering committee were set jointly by the Registrar and the scheme.

Board Notice 73 of 2004

The CMS was about to investigate whether the Netcare Medical Scheme had complied with Board Notice No 73 when it changed its administrator from Metropolitan Health to PrimeMed as from January 2013. Board Notice 73 requires schemes to engage in fair and reasonable evaluation of a range of potential service providers when selecting an administrator. Before the investigation commenced, it became apparent that PrimeMed was not accredited as an administrator by the CMS but was in the process of obtaining accreditation. The scheme was then directed to terminate its administration contract with PrimeMed and given three months to commence a new process of evaluating potential administrators.

Within this three-month period PrimeMed obtained CMS accreditation. The scheme completed a new process of evaluation as directed by the CMS and once again considered PrimeMed to be the most suitable administrator. The CMS confirmed that the scheme had complied with requirements. PrimeMed was then placed on CMS records as the legitimate administrator of Netcare Medical Scheme.

Undesirable business practices

In the matter of the Trustees of Topmed v Registrar, which involved Section 61(3) on undesirable business practices in the Medical Schemes Act, the appeal against the directive was heard and a favourable ruling was issued. The scheme recommenced the process of appointing an administrator and made the appointment according to required procedure.

Inspection of regulated entities

The CMS is entitled to undertake inspections in terms of the Medical Schemes Act. Section 44(4)(a) inspections are undertaken where the CMS is of the opinion that there may be evidence of irregularities or non-compliance. Section 44(4)(b) inspections are of a more routine nature.

The CMS instituted Section 44(4)(a) inspections of the following schemes:

- Hosmed: The inspection found irregular payments were made to consultants. It also found that trustees who had been removed spent R27 million to fight their removal and, during the time that they were appealing their removal, the three trustees remunerated themselves to the extent of R1.8 million.
- Discovery Health: Allegations of BOT elections irregularities. Investigation pending.
- Samwumed: Complaints and allegations pertaining to the commission of fraud, misconduct and other irregularities.
- Minemed: Interference by employer into scheme affairs. Investigation pending.
- Spectramed: A complaint was received concerning the circumstances of the dissolution of the audit and risk committee and, subsequently, the audit committee. The inspection also looked into other aspects of governance of the scheme. The inspection has not been finalised almost a year after commencement due to the scheme's refusal to co-operate with investigators. The matter has been referred to the High Court for resolution.

The CMS instituted section 44(4)(b) inspections of the following schemes:

- Parmed: Investigation pending.
- Polmed: Investigation pending.
- Momentum: Investigation pending.
- Tigerbrands: The scheme was found to have good corporate governance.
- Foodworkers: Governance of the scheme is satisfied but the CMS has requested the scheme to review the remuneration of some trustees.
- Fedhealth: Investigation pending.
- Medipos: Investigation finalised. The CMS established that the scheme's administrator paid for the Cape Town Jazz Festival tickets for trustees and the principal officer. The board of trustees was directed to cease such practices and develop a policy on receipt of gifts.
- Thebemed: The CMS issued a directive to the scheme to cancel a contract for a non-healthcare item that was captured as a healthcare expense and the scheme complied.

Litigation and the Appeals Committee

The Legal Services Unit assumes responsibility for litigation in instances where recourse to the courts is needed to discharge the regulatory

mandate of the CMS and is responsible for initiatives to improve the efficiency and procedural fairness of the Appeals Committee.

The nature and extent of litigation against both the Chief Executive and Registrar and Council are unpredictable. The year under review saw an increase in demand on the Legal Services Unit, primarily in the area of litigation. This can be attributed mainly to the increasing ability of the Compliance and Investigations Unit to conduct in-depth investigations into the functioning and governance of medical schemes.

The following cases were dealt with in the period under review:

The Registrar of Medical Schemes v Hosmed

The Registrar instituted action in the North Gauteng High Court against Hosmed Medical Scheme, its principal officer and trustees for the recovery of penalties levied in terms of Section 66(3) of the Medical Schemes Act. The defendants argued that the particulars of the Registrar's claim failed to show the cause of action. The defendants' case was dismissed with costs on 27 November 2013. The scheme elected not to pursue its defence and instead made an offer to pay the penalties and legal costs.

Genesis v CMS and Joubert

The dependant of a member of Genesis Medical Scheme was involved in a motor vehicle accident in 2008 during which she sustained a broken leg. The scheme appealed a ruling of the Registrar which directed it to pay for three external prostheses which were fitted to the dependant's leg. The matter was appealed by the scheme to the level of the Appeal Board. The Appeal Board ruled that the scheme was liable to fund the medical expenses up to the amount that would be paid to a public hospital. The scheme subsequently lodged a review application in the Western Cape High Court. The court ruled in favour of Genesis and CMS was granted leave to appeal. The matter will be heard by the Supreme Court of Appeal in the next financial year.

Genesis v CMS and du Toit

This matter related to a member's surgical procedure following a back injury in 2007. The scheme did not fund the claims in full because the services were not provided by a state hospital. The decision was appealed to the Appeals Committee which postponed its ruling to allow the scheme to submit further documents. When these documents were not submitted, the Appeals Committee ruled that the scheme must fund the outstanding claims. The scheme lodged a review application in the North Gauteng High Court and requested exemption from the provision in the Promotion of Administrative Justice Act which would require the scheme first to exhaust internal remedies – an Appeal Board hearing – before resorting to court action. In November 2013 the court dismissed Genesis's application with costs, ruling that the Appeal Board had wide powers to hear the matter and remedy alleged irregularities by the Appeals Committee. The scheme applied for leave to appeal and this was rejected by the same court. The scheme petitioned to the Supreme Court of Appeal and the application was dismissed.

Cost-effective dispute resolution

The CMS has initiated a process to resolve appeals in a more cost effective and expedient manner through the alternative dispute resolution method of mediation. A pilot project was launched to test the effectiveness of introducing mediation after a ruling has been made by the Registrar and before the matter is set down for hearing by the Appeals Committee.

Mediation is engaged in voluntarily by the parties and is a confidential, without-prejudice process in which legal representation is not allowed. It creates a safe setting in which parties attempt to settle their dispute outside of a tribunal or court of law. There are no cost implications for the parties and it provides an opportunity to resolve the dispute while the parties await a hearing date.

The pilot ran from 25 March to 31 July 2013 during which members and schemes voluntarily participated in mediation conducted by an accredited third-party service provider. Of the 21 matters that were referred for mediation, 15 were settled between the parties. This indicates that mediation is a meaningful way to save costs and time while serving the interests of the parties.

Mediation is now being used regularly. However, only those matters which are considered as suitable for mediation will be referred to independent mediators for intervention. Should settlement not be reached, the matter is referred to the Appeals Committee for a formal hearing.

Pro bono assistance for members

The CMS is pleased to announce that it has joined hands with the non-governmental organisation, ProBono.Org, to launch a pro bono panel of attorneys and a law clinic to assist members of medical schemes who are unable to afford their own legal representation. The fact that medical schemes are often represented by attorneys and counsel at appeal hearings means that members who cannot afford the same legal services are at a disadvantage. Although the Appeals Committee and Appeal Board provide assistance to such members, they are nevertheless in a more advantageous position when professionally represented.

Section 34 of the Constitution affords every citizen the right to have disputes resolved by the application of law in a fair public hearing. ProBono.Org is an NGO that ensures that this right is upheld for those who cannot afford legal representation through the facilitation of free legal services provided by lawyers who sign up as volunteers.

The CMS conducted training for volunteer lawyers at ProBono.Org on the Medical Schemes Act and processes of the CMS. CMS looks forward to seeing how legal representation for members at appeal forums will assist vulnerable members.

Improving efficiency of Appeals Committee

The Appeals Committee of the CMS has drafted rules to ensure that appeal hearings are conducted in an effective and efficient manner. The rules provide guidance on how appeals should be conducted, from the initial lodging of an appeal to the issuing of a ruling by the Appeals Committee and compliance with such ruling. Stakeholders were invited

to comment on the draft rules before the end of November 2013 and comments were considered and incorporated where relevant into the final version of the rules. These were approved by Council and are available on the CMS website.

Interface with stakeholders, beneficiaries and the industry

The CMS continued to build relationships with stakeholders through indabas and forums, such as the Boards of Trustees Forum and the Principal Officers Forum. An Administrators Forum was also established to further enhance relationships with stakeholders.

An indication of the co-operation that exists is the inclusion of the CMS logo on the membership cards of some medical schemes. The CMS appreciates the support of these schemes and encourages others to adopt this practice.

The move to the new premises in Centurion provided another opportunity to engage with stakeholders during the opening of the building and the launch of the 2012/13 Annual Report. Media engagement occurred regularly by way of press releases, a press conference, media breakfasts and interactions prompted by media inquiries. The CMS enjoyed good coverage in both print and online media, and increased its presence on radio and television.

A billboard campaign, as well as a series of radio and television talk shows, were undertaken to enhance awareness of the role of the CMS in protecting beneficiaries and the public in general. The focus of advertising campaigns on the rights of members of medical schemes resulted in higher numbers of members attending the annual general meetings of their schemes.

There was a reduction in calls received by the contact centre, with 2 477 fewer calls than in the previous financial year. A reason for this was a clear reduction in callers asking basic questions about the role of the CMS. This could be attributed to advertising campaigns which appear to have increased public awareness of the CMS.

The CMS conducted two general induction sessions for trustees as well as in-depth trustee training in Gauteng and Cape Town in the year under review. These sessions, attended by more than 200 trustees, were designed to educate new and existing trustees about their fiduciary responsibilities and empower them to play their roles effectively. The CMS also conducted scheme-specific trustee training on request. The Education and Training Sub-unit initiated discussions with the Insurance Sector Training Authority (INSETA) to obtain accreditation for the CMS as a training provider offering approved programmes. The accreditation process will commence once the CMS has both the physical and human resource requirements to pursue such an endeavour. The CMS also introduced broker training in the year under review and attracted 50 brokers from Gauteng. The training focused on basic issues relating to members and prospective members of medical schemes and was conducted as a pilot project to guide future broker training sessions.

Meetings with other relevant regulators have laid the foundation for formalising collaboration through the signing of memorandums of understanding (MOUs) between the CMS and these regulators. Regulators that have agreed to conclude MOUs include the Consumer Protection Commission, the CC, the Public Protector and the FSB. A memorandum of understanding was also discussed with the University of the Witwatersrand's School of Public Health.

Relations were established with medical insurance regulators of various African countries, including Swaziland, Ghana and Mozambique, as well as the Netherlands and China. The purpose of these engagements was not only to strengthen relationships, but also to learn from each other's experiences.

Collaboration with the industry

The CMS takes the view that its regulatory mandate is enhanced and in no way compromised by clearly defined collaboration with the industry on matters of mutual interest.

Industry Technical Advisory Panel

The Industry Technical Advisory Panel (ITAP) brings together the CMS and industry stakeholders to collaborate on projects which have strategic implications for the entire industry. Participation in the ITAP is voluntary and open to any stakeholder in the medical scheme industry with an interest in an identified research project. During the year under review, various sub-committees of the ITAP made significant progress.

The Utilisation and Inflation Sub-committee expanded its terms of reference to address inconsistencies in definitions used in the collection of data for CMS annual statutory returns. Major hospital groups, schemes and administrators will work together to ensure that utilisation indicators are clear and consistent. The sub-committee will focus initially on hospital-related utilisation indicators and then address other utilisation definitions.

The Scheme Risk Measurement (SRM) Sub-committee provided input on the Entry and Verification Guidelines for identifying beneficiaries with risk factors and the weighting and count tables were updated and published. Participation from the industry was excellent and only two schemes did not submit their SRM data on time.

Following phase one of the project focused on measuring the impact of managed care interventions, the Managed Care Sub-committee expanded its terms of reference to help the CMS define outcomes for all chronic conditions. The committee will also develop a minimum data specification for measuring and testing the health quality outcomes of treatment for each chronic condition.

ITAP is an active and significant forum and the CMS appreciates the valuable participation of all stakeholders from the industry.

Protection of Personal Information Act

The Protection of Personal Information Act (POPI) has been signed into law by President Jacob Zuma. However, the Act is not yet in force as the

Information Regulator has still to be established and regulations must be promulgated by the Minister of Justice. The CMS has requested the medical schemes industry to submit comments on a code of conduct for the industry, as contemplated in Chapter 7 of the POPI Act. Council was reviewing those comments at the close of the financial year and will revert to the industry with a draft code of conduct which will be further refined and ultimately submitted to the Information Regulator.

Improving the quality of reporting by schemes

The CMS collaborated with the medical schemes project group of the SA Institute of Chartered Accountants (SAICA) to produce the SAICA Accounting Guide for Medical Schemes, which was published in September 2013. The CMS also engaged with Independent Regulatory Board for Auditors (IRBA) on several matters during the year under review. Relationships with these bodies are critical in ensuring that the quality of data submitted by medical schemes is of the highest standard and complies with relevant accounting and auditing standards.

ICT and Knowledge Management

The year under review saw the CMS enter an exciting phase as it relocated from Hatfield to its new premises in Eco Park, Centurion. This meant that the existing ICT infrastructure, which includes a data centre, network infrastructure, internet and telephony support equipment as well as end-user computers and printers, needed to be relocated. The aim was to achieve this with minimal interruption of service and ICT systems were only down for two days over a long weekend. CMS stakeholders experienced virtually no interruption in accessing the systems.

Apart from building a new data centre and local area network infrastructure, the CMS upgraded its storage area network and improved business continuity by implementing a new online backup and failover solution, based on the latest virtualisation technology.

In terms of software development, the CMS strengthened its internally focused products by configuring and implementing an enterprise content management and document management system and integrating this with the complaints and accreditation systems. This initiative was combined with the development and rollout of a new intranet site.

Other internally focused systems which the CMS developed and deployed included an appeals rulings database and a new business intelligence tool. These new internal systems will assist in improving staff productivity and effectiveness and ultimately translate into better service for stakeholders.

In terms of externally focused software products, the CMS:

- Undertook extensive work on the development of a Medicine Pricing Registry for the DoH.
- Maintained and further refined the annual and quarterly financial returns.

These new systems, in conjunction with those already available, should improve the experience of CMS stakeholders.

The Knowledge and Records Management Unit successfully scanned and digitised all paper-based files and documents held on-site and commenced the process for paper-based files stored at the external service provider's premises. The successful conclusion of this project will see the CMS moving to a paperless working environment.

The unit also oversaw adherence to the requirements of the Promotion of Access to Information Act and ensured that information was made available to internal and external stakeholders in a timeous and transparent manner.

Regulatory tools

As part of its legislated mandate, the CMS collects data from medical schemes on a regular basis for monitoring purposes, as well as to inform policy development. The tools used include the following:

- Annual and quarterly statutory returns: These are audited by the CMS, as required by the Act. The quarterly returns also form the base of our early warning system used to track performance of medical schemes in the period between audits and ensure that appropriate regulatory interventions are made timeously.
- Complaints lodged by members and other interested parties: The CMS analyses trends in complaints received in order to identify where there is non-compliance with legislation.

In the last two years the CMS has worked hard to implement the real-time monitoring (RTM) system, which will allow for specific, timely and suitable regulatory interventions by the CMS, in conjunction with the trustees of schemes where indicated. In 2013, significant progress was made in the roll-out and collection of data from schemes. But the project has posed significant challenges. The CMS has engaged with various scheme administrators and self-administered schemes in order to obtain insight into the architecture of information technology systems used in the industry.

Concluding thoughts

I would like to thank all CMS employees for their hard work and dedication in the period under review, especially during the extremely difficult period towards the end of the year. I am constantly aware that the CMS is only as effective and efficient as its people. I would also like to extend a special word of thanks to our Council members for their support and guidance during trying circumstances.

The CMS looks forward to another year of success in 2014/15, as we continue to fulfil our mandate to protect members, guide medical schemes and contribute to the attainment of a more equitable national health system.

Mr Daniel Lehutjo
Acting Chief Executive & Registrar
29 May 2014

Performance **INFORMATION**

PART B: PERFORMANCE INFORMATION

Statement of responsibility for performance information for the year ended 31 March 2014

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

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

In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned objectives, indicators and targets which are set out in the strategic plan and annual performance plan of the CMS for the financial year ended 31 March 2014.

The performance information of the CMS for the financial year ended 31 March 2014 has been audited by the Auditor-General of South Africa. This information, as contained on pages 63 to 92, has also been approved by Council, which is the Accounting Authority of the CMS.

Daniel Lehutjo

Acting Chief Executive & Registrar

Council for Medical Schemes

31 July 2014

Programme 1: Office of the CEO & Registrar

Programme 1 – the Office of the CEO & Registrar – comprises three sub-programmes:

- The CEO & Registrar.
- The Strategy Office.
- Complaints Adjudication Unit.

Details of the annual performance of each of these sub-programmes are presented together with their budgets.

Sub-programme 1.1: CEO & Registrar

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Comments on deviation
Strategic objective 1.1.4.1 – Develop strategic international relationships with other regulators					
1.1.4.1	Number of meetings with regulators from other countries	1	1	–	No deviation
Strategic objective 1.1.3.1 – Secretarial support service					
1.1.3.1	Number of Council meetings supported per year	4	6	2	**Deviation** Two additional meetings were required during the year by Council to deal with urgent matters.
	Number of EXCO meetings supported per year	12	7	5	**Deviation** EXCO was scheduled to sit three times per quarter but due to the nature of the work dealt with by the committee, fewer meetings were required during the year.
	Number of Appeals Committee meetings supported per year	12	15	3	**Deviation** Due to the volume of complaints received and the ensuing number of appeals by parties dissatisfied with decisions of medical schemes, there was a need to schedule additional Appeals Committee meetings.
	Number of Appeal Board hearings supported per year	6	10	4	**Deviation** In order to clear the backlog of cases before the Appeal Board, more hearings had to be scheduled.
	Number of Strategic Management meetings supported per year	22	21	1	**Deviation** One Strategic Management meeting had to be cancelled, due to the relocation of the office.
	Number of Regulatory Decisions Committee (RDC) meetings supported per year	6	9	3	**Deviation** Additional committee meetings had to be set up to deal with the large number of exemption applications received.
	Number of Remuneration Committee (REMCO) meetings supported per year	3	1	2	**Deviation** Council took a decision during the year to amalgamate REMCO with the HR Sub-committee.
	Number of HR Sub-committee meetings supported per year	4	5	1	**Deviation** An additional meeting had to be scheduled to deal with urgent HR matters.

Purpose

The CEO is the Accounting Officer of the organisation and exercises overall control over the office of the CMS. As Registrar, he exercises legislated powers to regulate medical schemes, administrators, brokers and managed care organisations.

Achievement of strategic objectives

During the period under review, the Office of the CEO & Registrar executed its mandate in terms of specified objectives. Together with Stakeholder Relations Unit, it facilitated the CEO's study tour to China. The CEO was accompanied by the Chairperson of Council and the Chief Financial Officer. The purpose of the tour was to visit the China Insurance Regulatory Commission (CIRC) in order to draw lessons from the Chinese private healthcare system. This in turn assisted Council in fulfilling its advisory duties to the Minister of Health.

In order to serve beneficiaries of medical schemes and to ensure prompt resolution of disputes, the unit scheduled extra hearings for both the Appeals Committee and the Appeal Board. The extra hearings served to reduce the backlog of cases.

The unit has functioned well as a link between executive management and the Council. It has facilitated the business of Council and ensured that feedback is provided to executive management in order to enable the organisation to function effectively.

Changes to planned targets

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

Unit budget

Office of the CEO	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**143**	**138**	**5**	**125**	**121**	**4**
Stationery	117	126	(9)	100	89	11
Refreshments	26	12	14	25	33	(8)
Operating expenses	**5 040**	**5 934**	**(894)**	**3 982**	**5 133**	**(1 151)**
Committee remuneration	63	100	(37)	274	261	13
Consulting fees	1 545	1 623	(78)	1 149	1 134	15
Council members' fees	1 800	2 317	(517)	1 033	2 420	(1 387)
Courier and postage	83	124	(41)	87	110	(23)
Printing and publication	–	–	–	52	32	20
Transcription services	69	109	(40)	–	–	–
Travel and subsistence	756	860	(104)	937	899	38
Venues and catering	724	801	(77)	450	277	173
Staff costs	**3 446**	**3 447**	**(1)**	**8 527**	**6 030**	**2 497**
Salaries	3 308	3 255	53	8 287	5 829	2 458
Staff training	138	192	(54)	240	201	39
Total	**8 629**	**9 519**	**(890)**	**12 634**	**11 284**	**1 350**

Sub-programme 1.2: Strategy Office

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 1.2.1.1 – Support the prescribed minimum benefits review conducted by the DoH					
1.2.1.1	At least one submission to the DoH on amendments to prescribed minimum benefits (PMB) regulations every two years	1	–	1	**Deviation** A submission on PMB amendments was made to the DoH in 2010. A workshop between the CMS and DoH has been scheduled for 2014/15 to drive this process forward.
Strategic objective 1.2.2.1 – The prescribed minimum benefits code of conduct is updated					
1.2.2.1	Number of prescribed minimum benefits code of conduct reports released per year	1	–	1	**Deviation** The report was not completed due to staff constraints and because PMB amendments were expected.
Strategic objective 1.2.2.2 – Prescribed minimum benefit definitions					
1.2.2.2	Minimum number of final benefit definitions published per year	10	–	10	**Deviation** Due to staff constraints, during the year the benefit definitions could not be published. This work is now in progress and will be completed during 2014/15. The unit will improve business continuity planning to ensure that this type of situation does not recur.
Strategic objective 1.2.2.3 – Provide clinical opinions					
1.2.2.3	Number of clinical matters reviewed by the CRC per year	890	839	51	**Deviation** The deviation was due to staff constraints experienced in the Clinical Unit. An intervention was introduced in the final quarter of the financial year to help reduce the backlog in clinical opinions.
Strategic objective 1.2.3.1 – Strategic plan and annual performance plan					
1.2.3.1	Annual submission of the draft and final annual performance plans	2	2	–	No deviation
Strategic objective 1.2.4.1 – Support universal access through recommendations made to Ministerial Advisory Committee (MAC) on National Health Insurance					
1.2.4.1	Number of written reports submitted to National Health Insurance (NHI) Ministerial Advisory Committee (MAC) per year	1	–	1	**Deviation** The office made a set of proposals addressing issues in the NHI Green Paper in 2012. The office is awaiting the release of the NHI White Paper.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 1.2.4.2 – Policy recommendations made to the Department of Health					
1.2.4.2	Number of policy recommendations made to the Department of Health per year	1	–	1	**Deviation** No policy recommendations were made due to staff constraints arising from the Senior Strategist post being vacant for about half the year. The position of the Senior Strategist was filled in December 2013.
Strategic objective 1.2.4.3 – The Medical Schemes Act is reviewed to protect the legislated framework					
1.2.4.3	At least one recommendation made to amend the Medical Schemes Act every two years	1	1	–	No deviation

Purpose

The purpose of the Strategy Office is to engage in projects to provide information on strategic health reform to the Ministry of Health in order to contribute to government's objective of an equitable and sustainable healthcare financing system in support of universal access, and to support the CMS in relation to strategic and operational planning and clinical matters.

Achievement of strategic objectives

The Strategy Office plays a pivotal role in coordinating the planning cycle of the CMS. This entails the formulation of the strategic plan, the annual performance plan and the budget. In 2013, the post of Senior Strategist was vacant for some months, and the CEO was involved in coordinating the planning process together with the Office of the Chief Financial Officer and the Financial Supervision Unit.

The Strategy Office interacted with a range of ad hoc committees and task teams of the CMS on significant projects and issues that cut across various units. The matters dealt with by these committees and task teams included the following:

- Strategic Management Team on National Health Insurance (NHI): Members of the CMS's Strategic Management Team on NHI, who serve on the technical sub-committee of the MAC on NHI, met with a delegation from DoH in early 2014 to discuss matters of common interest including a report back on developments relating to NHI. The White Paper on NHI is still awaited.
- Medical Schemes Amendment Bill Review: Proposed amendments to the Act were approved by Council in 2012/13 and the draft Amendment Bill was submitted to the DoH in October 2013. A workshop on this draft, involving the CMS and DoH, is planned for June 2014.
- PMB Review Task Team: Draft regulations reviewing PMBs were submitted to the DoH in 2010 and were expected to be published in the Government Gazette in 2012/13. This had not happened by March 2014 and this matter, too, will be discussed at the workshop with DoH in June 2014.
- The Demarcation Process Task Team: Following interactions involving CMS, DoH, National Treasury and the Financial Services Board (FSB), draft regulations to formally demarcate health insurance products from medical schemes benefits were in the process of being tabled and published for public comment. The draft regulations would prevent harmful health insurance products from operating in South Africa and would in no way undermine the principles and provisions of the Medical Schemes Act. The Strategy Office played a role in co-ordinating some of the meetings involved.
- The CMS participated through the Strategy Office in a range of other committees including:
  - The Independent Community Pharmacy Association (ICPA) Task Team where the focus of interaction was the issue of contractual agreements between designated service providers and medical schemes.
  - The Market Inquiry Committee of the Competition Commission (CC) which deals with the forthcoming inquiry into the healthcare market. The CMS is collaborating with the CC on this inquiry which was due to commence in early 2014 and was expected to conclude by the end of 2015.

Changes to planned targets

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

Unit budget

Strategy Office	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**6**	**4**	**2**	**6**	**0**	**6**
Stationery	3	2	1	3	–	3
Refreshments	3	2	1	3	–	3
Operating expenses	**70**	**25**	**45**	**6**	**2**	**4**
Travel and subsistence	70	25	45	6	2	4
Staff costs	**4 799**	**3 793**	**1 006**	**75**	**51**	**24**
Salaries	4 611	3 645	966	–	–	–
Staff training	188	148	40	75	51	24
Total	**4 875**	**3 822**	**1 053**	**87**	**53**	**34**

Sub-programme 1.3: Complaints Adjudication Unit

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 1.3.2.1 – Complaints resolution					
1.3.2.1	Estimated number of complaints received per year	7 700	5 264	2 436	**Deviation** The reduction in complaints was due to measures taken in the second quarter of the year to reduce the flood of complaints by service providers and to ensure that medical schemes take responsibility for dealing with complaints lodged against them by service providers. This intervention was made after the CMS noted a trend of service providers merely referring copies of unpaid accounts to the CMS, alleging non-payment on the part of medical schemes. The CMS decided to refer these matters to medical schemes for direct resolution between the parties.
	Estimated number of complaints resolved per year	6 562	5 651	911	**Deviation** The unit resolved more complaints than the number received as some complaints were carried forward from 2012/13. Also refer to comments above.

Purpose

The unit serves beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, the CMS ensures that beneficiaries are treated fairly by their medical schemes.

Achievement of strategic objectives

The unit resolved more complaints than those received during the course of the year because some complaints lodged in 2012/13 were finalised in 2013/14.

The unit participated in a number of appeal hearings and provided input to the Appeals Committee in respect of cases that were adjudicated by the Council. Most rulings of the Registrar's Office were confirmed by the Appeals Committee. Issues in dispute included the application of benefits as per the scheme's registered rules, co-payments imposed, requirements for pre-authorisation and the use of formularies.

The unit conducted educational workshops with the following medical schemes and administrators: Polmed, Spectramed, Metropolitan Health Risk Management, Private Health Administrators and Metropolitan Health Administrators. It also participated in consumer education on the role of the CMS and the Complaints Adjudication Unit and undertook radio interviews with Power FM and XK FM, which allowed for listeners to pose questions and interact with the CMS.

The unit participated in the CMS's first training session for brokers and broker organisations which was held in Centurion. This allowed the unit to explain complaints procedures and discuss common broker-related complaints with a view to assisting brokers to understand the concerns of their clients.

Changes to planned targets

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

Unit budget

Complaints Adjudication	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**11**	**7**	**4**	**11**	**5**	**6**
Printing and stationery	6	2	4	6	2	4
Refreshments	5	5	–	5	3	2
Operating expenses	**27**	**15**	**12**	**40**	**36**	**4**
Travel and subsistence	22	12	10	33	30	3
Venues and catering	5	3	2	7	6	1
Staff costs	**4 568**	**4 414**	**154**	**4 022**	**4 004**	**18**
Salaries	4 496	4 388	108	3 938	3 959	(21)
Staff training	72	26	46	84	45	39
Total	**4 606**	**4 436**	**170**	**4 073**	**4 045**	**28**

Programme 2: Corporate Services

Programme 2 – Corporate Services – comprises three sub-programmes:

- Internal Finance.
- Information and Communication Technology and Knowledge Management.
- Human Resources Management.

Details of the annual performance of each of these sub-programmes are presented together with their budgets.

Sub-programme 2.1: Internal Finance Unit

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 2.1.3.1 – Annual financial statements					
2.1.3.1	Number of GRAP- compliant annual financial statements submitted by 31 May each year	1	1	–	No deviation
Strategic objective 2.1.3.2 – Budget management					
2.1.3.2	Number of budget reports and management accounts produced to ensure budgeted resources allocated to the strategic objectives are utilised for the intended purposes	12	12	–	No deviation
Strategic objective 2.1.3.3 – Revenue management					
2.1.3.3	Percentage of levy income collected per year	100%	100%	–	No deviation
Strategic objective 2.1.3.4 – Supply chain management					
2.1.3.4	Number of demand management plans submitted to National Treasury by 30 April	1	1	–	No deviation
	Percentage of creditors paid within 30 days of approval, per year	100%	99%	0.01%	**Deviation** There were instances where queries on invoices needed to be cleared before payment could be made. There were also instances where credit notes were outstanding.
	A supplier database is updated annually	1	1	–	No deviation
Strategic objective 2.1.3.5 – Cash management					
2.1.3.5	Number of cash flow projections produced per year to meet operational requirements	12	12	–	No deviation
Strategic objective 2.1.3.6 – Asset management					
2.1.3.6	Number of asset register updates per year	12	12	–	No deviation
	Percentage of assets insured during the year	100%	100%	–	No deviation
Strategic objective 2.1.3.7 – Payroll management					
2.1.3.7	Number of payrolls produced in a financial year	13	13	–	No deviation

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 2.1.3.8 – Internal controls					
2.1.3.8	Number of Audit & Risk Committee meetings held in a year	4	4	–	No deviation
	Number of Finance Committee meetings held in a year	5	5	–	No deviation
	An approved internal audit plan is in place annually	1	1	–	No deviation
Strategic objective 2.1.3.9 – Risk management					
2.1.3.9	Number of risk register updates per year	4	4	–	No deviation
Strategic objective 2.1.3.10 – Planning and budgeting					
2.1.3.10	Annual performance report submitted to Executive Authority by 31 May	1	1	–	No deviation
	Number of performance information reports submitted to Executive Authority per year	4	4	–	No deviation
Strategic objective 2.1.3.11 – Office management					
2.1.3.11	Percentage of employees having allocated office space which is properly resourced and well maintained per year	100%	100%	–	No deviation

Purpose

This programme serves all business units in the CMS, the senior management team and Council by maintaining an efficient, effective and transparent system of financial management that complies with the applicable legislation. The programme also serves the Audit and Risk Committee, Internal Auditors, DoH, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the unit enhances Council's standing as a reputable Regulator.

Achievement of strategic objectives

The unit achieved an unqualified audit opinion for the CMS, which confirms that the organisation has proper internal controls and functioning management systems. This also means that the financial resources of the CMS are used in a cost-effective and efficient manner, as required by the Public Finance Management Act.

The five-year strategic plan and annual performance plans were submitted to the Executive Authority within the stipulated time frames.

For the effective monitoring of performance, quarterly performance information reports were submitted to the Executive Authority as per the deadlines.

During the year under review, the unit enhanced its risk management processes by developing a new risk management framework and policy, which were adopted by Council. "Top-down" and "bottom-up" risk reviews were carried out in each area of the business, involving Council, executive management and staff. As the responsibility of reducing risk lies with all employees, workshops on the risk management process were held with executive management and all staff in order to ensure that there was a common understanding of the process. Risk champions were appointed in each unit to help co-ordinate all risk management activity. A special workshop was presented for risk champions to assist them to understand their roles and responsibilities.

Changes to planned targets

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

Unit budget

Internal Finance	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**11 449**	**11 875**	**(430)**	**9 782**	**8 631**	**1 151**
Bank charges	50	41	9	43	40	3
Cleaning and gardening	657	741	(84)	677	606	71
External audit fees	680	806	(126)	630	627	3
General expense admin	475	471	4	165	167	(2)
Insurance	159	274	(115)	150	176	(26)
Internal audit fees	850	795	55	788	1 052	(264)
Printing and stationery	31	24	7	31	45	(14)
Refreshments	13	8	5	10	17	(7)
Rent	6 420	6 319	101	5 234	4 485	749
Rent – operating costs	948	948	–	–	–	–
Rental other assets	25	6	18	14	12	2
Repairs and maintenance	227	285	(58)	1 041	274	767
Subscriptions	6	5	1	7	5	2
Water and electricity, rates and levies	908	1 152	(244)	992	1 125	(133)
Operating expenses	**486**	**522**	**(36)**	**146**	**182**	**(36)**
Consulting fees	353	405	(52)	72	112	(40)
Courier and postage	44	48	(4)	50	34	16
Travel	26	17	9	24	36	(12)
Venues and catering	63	52	11	–	–	–
Amortisation	**1 205**	**895**	**310**	**848**	**942**	**(94)**
Depreciation	**1 206**	**1 742**	**(535)**	**1 191**	**1 861**	**(670)**
Debt waived	**–**	**310**	**(310)**	**–**	**–**	**–**
Loss on disposal of assets	**–**	**176**	**(176)**	**–**	**–**	**–**
Staff costs	**7 972**	**7 779**	**193**	**8 096**	**7 899**	**197**
Employee benefits	1 587	1 462	125	1 328	1 349	(21)
Salaries	6 146	6 072	74	6 318	6 069	249
Staff training	115	125	(10)	250	341	(91)
Workmen's Compensation Fund	124	120	4	200	140	60
Total	**22 318**	**23 299**	**(961)**	**20 063**	**19 515**	**550**

Sub-programme 2.2: Information and Communication Technology and Knowledge Management

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 2.2.3.1 – Training and support					
2.2.3.1	Number of desktop support incidents/cases concluded during year	300	655	355	**Deviation** A high number of hardware- and software-related helpdesk calls were attended to during the year.
	Number of CMS staff trained in the use of various ICT systems in use at CMS per year	70	65	5	**Deviation** Slightly fewer staff members were trained than planned despite concerted efforts to "market" the unit's quarterly "Chalk & Talk" training sessions. In future, the unit will hold only two such sessions a year in the hope of attracting more staff.
Strategic objective 2.2.3.2 – Operations					
2.2.3.2	Percentage of network uptime per year	99%	96%	3%	**Deviation** The network was down several times during the year mainly due to the municipality cutting power to the precinct, load-shedding and the city council accidentally switching electrical phases on the electrical supply. Teething problems with CMS's generator and UPS configurations and their subsequent failure during these outages had a ripple effect on the network. These teething problems have now been resolved and a repeat of the above is unlikely.
	Percentage of server uptime per year	99%	96%	3%	**Deviation** The CMS data centre and servers were affected by the power outages referred to above.
	Maximum percentage of security incidents per year	2%	–	2%	**Deviation** No security incidents were detected during the year.
2.2.3.3	Maximum number of custom software application "bugs" or incidents reported per year	200	178	22	**Deviation** Due to the maturity of the software development methodologies followed on internally developed software systems, these systems were more stable and fewer bugs were reported during the year.
	Percentage uptime, of custom-developed systems during working days, where full network access exists	99%	97.7%	1.25%	**Deviation** Several power outages during the year, where the backup electrical supply did not perform as designed, caused the underlying server infrastructure to go down. This had a roll-on effect on the uptime of the custom-developed applications. The impact was less severe than on the network and servers as most outages occurred outside of working hours.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
2.2.3.4	Estimated number of requests for information responded to and successfully dealt with per year	320	279	41	**Deviation** Slightly fewer requests for information than expected were received and processed.
	Number of records electronically captured (scanned) per year	4 000	1 299	2 701	**Deviation** Substantially fewer records were scanned in-house than targeted. The reasons for this were: (1) The relocation of the office and the establishment of the registry office in the new premises. (2) The fact that most registry files were scanned externally by a bureau, leaving fewer files to capture internally. (3) The fact that most documents are now received in electronic form and there are fewer paper-based source documents to scan.

Purpose

The unit services other business units of the CMS by providing technology enablers and making information available to stakeholders.

Achievement of strategic objectives

During the year under review, the Information and Communication Technology and Knowledge Management (ICT & KM) Unit assisted the re-location of the CMS from Hatfield to its new premises in Eco Park, Centurion. The moving of the ICT infrastructure, which includes a data centre, network infrastructure, internet and telephony support infrastructure as well as end-user computers and printers, was a major part of the operation. The unit undertook to accomplish this task with minimal interruption of service. Although some network, server and application outages were experienced, our stakeholders experienced virtually no interruption in accessing our systems.

Apart from building a new data centre and local area network infrastructure, the unit also expanded the CMS's storage capacity by upgrading the storage area network. To improve business continuity, the unit implemented a new online backup and failover solution, based on the latest virtualisation technology.

In terms of internally focused software products, the unit successfully configured and implemented an enterprise content management and document management system. The complaints and accreditation systems were integrated with this new system and all of this was combined with the development and rollout of a new intranet site. Other internally focused systems included the development of an appeals rulings database, a new supplier database, and a new business intelligence tool. Minimal bugs were reported on these systems, as the software development methodology and change control measures provided a high level of maturity.

The Knowledge and Records Management Sub-unit scanned and digitised all paper-based files and documents in the CMS's on-site filing facility and commenced scanning of paper-based files stored at an external service provider. The conclusion of this project will see the CMS moving to a paperless working environment.

This sub-unit also oversaw adherence to the requirements of the Promotion of Access to Information Act and ensured that information was made available to internal and external stakeholders in a timeous and transparent manner. Fewer requests for information were received during the first quarter of the year, mainly due to our office relocation, while requests shot up sharply during the fourth quarter, mainly due to requests for schemes' rules and information in the annual report.

Changes to planned targets

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

Unit budget

Information and Communication Technology (ICT) and Knowledge Management (KM)	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenditure	**3 099**	**3 244**	**(146)**	**2 540**	**2 278**	**262**
Computer expenses	120	79	41	114	103	11
Copy cost	159	236	(77)	159	247	(88)
External storage	228	275	(47)	228	242	(14)
Internet expenses	151	330	(180)	357	342	15
Printing and stationery	20	9	11	20	6	14
Refreshments	18	6	12	18	12	6
Rental: copiers	280	244	36	180	120	60
Security	290	368	(78)	295	52	243
Software licence subscriptions	898	815	83	485	341	144
Telephone and fax	935	882	54	684	813	(129)
Operating expenses	**697**	**583**	**115**	**713**	**514**	**200**
Consulting fees	150	51	99	210	56	154
Knowledge management	531	527	4	487	446	41
Travel and subsistence	16	5	11	16	10	6
Venues and catering	–	–	–	–	2	(2)
Staff costs	**8 198**	**7 416**	**782**	**6 749**	**7 136**	**(387)**
Salaries	6 858	6 960	(102)	6 559	6 562	(3)
SEP system expenses	1 200	308	892	–	478	(478)
Staff training	140	148	(8)	190	96	94
Total	**11 994**	**11 243**	**751**	**10 002**	**9 928**	**75**

Sub-programme 2.3: Human Resources Management

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 2.3.3.1 – Talent management and staff retention					
2.3.3.1	Maximum staff turnover rate per year	5%	6.12%	1.25%	**Deviation** There were six resignations during the year, five due to career advancement and one to ill health.
	Number of high-potential individuals engaged and developed for strategic positions per year	21	–	21	**Deviation** Council approved the Succession Framework and Strategy in February 2014. Implementation of the succession strategy will commence in April 2014.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 2.3.3.2 – Performance is maximised					
2.3.3.2	Percentage of performance reviews conducted per year	100%	99.45%	0.55%	**Deviation** The deviation is due to one employee choosing not to be assessed as she had resigned during second review period.
	Percentage of employees undergoing training annually in accordance with a personal development plan	68%	82%	14%	**Deviation** A higher number of employees than anticipated (80 out of 98) participated in the personal development programme.
Strategic objective 2.3.3.3 – A productive work environment					
2.3.3.3	Number of health days held per year	1	2	1	**Deviation** The SA National Blood Service approached the CMS about staff donating blood on a regular basis. The resulting blood drive yielded an additional health day.
	Percentage of employees attending cultural awareness session per year	100%	100%	–	No deviation
	Number of workshops on values and work ethics per year	1	1	–	No deviation
Strategic objective 2.3.3.4 – Human resource management systems and processes					
2.3.3.4	Percentage of employees surveyed in respect of HR customer service per year	100%	–	100%	**Deviation** The unit was occupied with implementing recommendations for service improvement made in the previous financial year. Due to budgetary and capacity constraints, it was not possible to finalise this process as well as conduct a survey in 2013/14.

Purpose

The HR Unit is committed to providing high quality service to internal and external customers by assessing their needs and proactively addressing these by developing, delivering and continually improving human resources programmes that promote and support CMS's vision.

The unit fulfils this mission with professionalism, integrity and responsiveness by:

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

The HR Unit assists managers of various other units to make decisions that strengthen their most important assets – their people.

Achievement of strategic objectives

Succession and retention strategy: The unit formulated a succession strategy and framework aligned with the organisation's long-term strategy for developing and retaining the right people for the right positions. This involved consultation with relevant internal parties. The strategy and framework were completed on 30 November 2013 and subsequently approved by Council for implementation from 1 April 2014.

Performance management: In line with HR policies, two formal performance reviews were conducted in the 2013/14 reporting period. Through the Moderating Committee, HR facilitated the awarding of incentive bonuses to those employees who excelled. Employees were recognised for their contribution to the CMS meeting its strategic goals and delivering on its mandate.

Employment equity: The CMS achieved its 2013/14 targets in terms of the Employment Equity Plan by appointing four candidates from designated groups for the positions of Manager: Education & Training, Senior Manager: Clinical, Senior Financial Analyst and Senior Strategist. A suitably qualified candidate was identified to fill the vacant position of Customer Relations Officer.

Health and Safety: The office participated in a successful joint emergency evacuation drill with other tenants on 11 March 2014.

Employee wellness: In the year under review, HR Unit proactively addressed various health and social issues, pre-empting their development into bigger, costly problems for the CMS. ICAS Southern Africa was again contracted to provide interested employees with access to confidential professional assistance programmes. Other wellness activities included:

- The promotion of fitness through subsidised health club membership for staff.
- A wellness day for the screening of HIV, diabetes, high cholesterol and risk factors relating to weight.
- Annual on-site flu vaccinations.
- A cancer awareness campaign.
- A health promotion day, which again focused on counselling and testing for cancer, diabetes and HIV.
- The commemoration of World AIDS Day.
- Participation in the CANSA Relay for Life.
- Talks on mental health and breast cancer and vision testing.

Teambuilding

HR facilitated management engagement and leadership workshops for the senior management and motivational talks for all staff on self-awareness, emotional intelligence, gender inequity and group dynamics.

Social Responsibility

In the organisation's continued support to the less fortunate, the CMS donated soccer goalposts nets to Vukani Mawethu High School soccer team in Mamelodi West. Due to budget constraints, the Make a Difference Day Project was not completed during the reporting period but will be finalised early in the new financial year.

Changes to planned targets

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

Unit budget

Human Resources Management	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**177**	**194**	**(17)**	**165**	**160**	**5**
Donations	7	7	–	6	4	2
Motor vehicle expenses	22	23	(1)	21	20	1
Printing and stationery	10	10	–	8	11	(3)
Refreshments	90	111	(21)	85	84	1
Subscriptions	48	43	5	45	41	4
Operating expenses	**1 015**	**1 090**	**(75)**	**1 012**	**1 180**	**(168)**
Consulting fees	546	596	(50)	525	665	(140)
Legal fees	91	111	(20)	–	–	–
Travel and subsistence	17	14	3	208	193	15
Venue and catering	361	369	(8)	279	322	(43)
Staff costs	**5 245**	**5 243**	**2**	**4 717**	**4 575**	**142**
Employee wellness	446	480	(34)	421	442	(21)
Recruitment and relocation	1 070	1 092	(22)	718	580	138
Salaries	3 350	3 243	107	3 062	3 177	(115)
Staff training	125	127	(2)	162	167	(5)
Temp services	254	301	(47)	354	209	145
Total	**6 437**	**6 527**	**(90)**	**5 894**	**5 915**	**(21)**

Programme 3: Accreditation

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 3.2.1 – Broker accreditation applications processed					
3.2.1	Total number of broker accreditation applications processed during the year, within 30 days of receipt of all relevant information	5 470	7 007	1 537	**Deviation** The unit processed more applications than anticipated.
	Number of new individual broker accreditation applications processed during the year, within 30 days of receipt of all relevant information	850	1 117	267	**Deviation** The unit processed more applications than anticipated.
	Number of new individual broker accreditation applications resulting in accreditation during the year, within 30 days of receipt of all relevant information	480	843	363	**Deviation** The unit granted accreditation for more applications than anticipated.
	Number of individual broker renewal applications processed during the year, within 30 days of receipt of all relevant information	3 700	4 664	964	**Deviation** The unit processed more applications than anticipated due to a number of late applications received in respect of expired accreditation from brokers who should have applied in the previous financial year.
	Number of individual broker renewal accreditation applications accredited during the year, within 30 days of receipt of all relevant information	3 650	3 628	22	**Deviation** The unit accredited fewer applications than anticipated due to the fact that applicants did not comply with "fit and proper" requirements as required by the FAIS Act.
	Number of new broker organisation applications processed during the year, within 30 days of receipt of all relevant information	130	104	26	**Deviation** The unit processed all applications received and these were fewer than initially estimated.
	Number of new broker organisation applications accredited during the year, within 30 days of receipt of all relevant information	85	56	29	**Deviation** The unit accredited fewer applications than anticipated as many applications did not comply with accreditation requirements.
	Number of broker organisation renewal applications processed during the year, within 30 days of receipt of all relevant information	1 100	1 120	20	**Deviation** The unit processed more applications than anticipated due to a number of late applications received in respect of expired accreditation from organisations that should have applied in the previous year.

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
	Number of broker organisation renewal applications accredited during the year, within 30 days of receipt of all relevant information	990	1 037	47	**Deviation** The unit accredited more applications than anticipated due to a number of late applications received in respect of expired accreditation. Applicants who were due to apply for renewal during the previous financial year failed to do so during that period.
Strategic objective 3.2.2 – Managed care organisation (MCO) accreditation applications processed					
3.2.2	Number of MCO applications processed during the year, within two months of receipt of all relevant information and upon conclusion of on-site evaluations as determined	12	14	2	**Deviation** Accreditation applications from two new MCOs were received and processed during the year.
	Number of MCO applications accredited during the year, within three months of receipt of all relevant information and upon conclusion of on-site evaluations as determined	13	14	1	**Deviation** One MCO accreditation application was completed and accreditation granted ahead of schedule, in Q4 of 2013/14 instead of Q1 of 2014/15.
Strategic objective 3.2.3 – Administrator accreditation applications processed					
3.2.3	Number of applications by administrators and self-administered schemes processed during the year, within two months of receipt of all relevant information and upon conclusion of on-site evaluations as determined	14	13	1	**Deviation** One administrator had not lodged a renewal application by the end of Q4 and therefore the expected number was not met.
	Number of applications by administrators and self-administered schemes accredited during the year, within three months of receipt of all relevant information and upon conclusion of on-site evaluations as determined	14	16	2	**Deviation** Two applications were received from new administrators and processed during the year.

Purpose

The unit ensures that brokers, administrators and managed care organisations (MCOs) are assessed and accredited if they meet the accreditation requirements as set out in the Medical Schemes Act. These requirements include applicants showing that they are fit and proper, financially sound and have the necessary resources, skills, capacity and infrastructure.

Achievement of strategic objectives

Accreditation of MCOs

A number of new applications for accreditation as MCOs were received and evaluated. Some applications were invalid or unnecessary as the service offering they proposed could not be regarded as "managed healthcare" as defined by the Medical Schemes Act and relevant regulations. These organisations were informed that they did not require formal accreditation.

During the course of the year:

- Four new applications were processed and the MCOs were accredited by Council for two years.
- Renewal applications from 12 MCOs were processed and accreditation was granted by Council.
- On-site evaluations were conducted in eight instances to establish compliance with the managed care accreditation standards.
- Two MCOs were de-activated on the CMS website – one elected not to renew its accreditation, and the other organisation's services were found not to constitute managed care as defined by statute.

Accreditation of third-party administrators and self-administered schemes

- Two new third-party administrators' applications were processed and the relevant administrators were accredited.
- Two self-administered schemes were issued with compliance certificates following completion of their first on-site evaluations.
- Council approved two-year accreditation of seven third-party administrators who had applied for renewal of accreditation.
- Council approved the renewal of compliance certificates for a period of three years in respect of four self-administered schemes.
- Two on-site evaluations of third-party administrators and one evaluation of a self-administered medical scheme were completed during the year.

Accreditation of brokers is undertaken in accordance with dual regulatory provisions by the CMS and the FSB. The CMS ensures that brokers who fail to comply with both sets of regulatory provisions are refused accreditation. Since the publication of a document on the accreditation procedure on the CMS website, there has been an improvement in the number of applications that have been properly completed and comply with the accreditation requirements.

Changes to planned targets

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

Unit budget

Accreditation	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**78**	**63**	**14**	**70**	**65**	**5**
Stationery	70	60	10	65	58	7
Refreshments	8	3	5	5	7	(2)
Operating expenses	**406**	**245**	**161**	**401**	**289**	**112**
Travel	398	240	158	401	289	112
Venues and catering	8	5	3	–	–	–
Staff costs	**5 313**	**5 807**	**(494)**	**5 563**	**5 439**	**124**
Salaries	5 156	5 751	(595)	5 501	5 397	104
Staff training	157	56	101	62	42	20
Total	**5 797**	**6 115**	**(319)**	**6 034**	**5 793**	**241**

Programme 4: Research and Monitoring

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 4.1.1 – Maintain the scheme risk measurement process					
4.1.1	Minimum number of articles on risk adjustment published per year	1	–	1	**Deviation** The Risk Equalisation Fund (REF) Project was discontinued by Council. It was no longer appropriate to publish an article on this topic.
	Percentage of scheme-specific risk measurement reports published per year	100%	100%	–	No Deviation

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
	Number of scheme risk measurement research reports published for the year	1	1	–	No Deviation
Strategic objective 4.2.2 – Monitor ICD-10 compliance					
4.2.2	Number of ICD-10 compliance reports produced per year	4	4	–	No Deviation
	Number of Ministerial Task Team meetings attended per year	8	2	6	**Deviation** Participation in the Ministerial Task Team meetings is by appointment of the Minister of Health. This unit no longer attends these meetings. Clinical Analyst Ronelle Smit of the Strategy Office is currently a member of the Ministerial Task Team.
Strategic objective 4.2.3 – Practice Code Numbering System (PCNS)					
4.2.3	Ensure that an approved entity is contracted to manage the PCNS at all times	Yes	Yes	–	No Deviation
	Receipt of quarterly reports of statistics on providers registered on the PCNS	4	4	–	No Deviation
	Annual review of performance of approved entity	1	1	–	No Deviation
Strategic objective 4.4.1 – Research					
4.4.1	Number of research projects finalised per year	4	4	–	No Deviation
Strategic objective 4.4.2 – Specialised technical support					
4.4.2	Number of support projects finalised per year	4	9	5	**Deviation** The unit received more support project requests than anticipated.
Strategic objective 3.4.3 – Annual report					
4.4.3	Number of inputs provided on the Registrar's review, review of operations sections completed and analysis of data done on an annual basis	1	1	–	No Deviation

Purpose

The unit serves beneficiaries of medical schemes and members of the public by collecting and analysing data in order to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes, and develop recommendations to improve regulatory policy and practice.

Achievement of strategic objectives

The Research and Monitoring Unit continued to provide ICD-10 compliance data to the DoH's Health Information Systems Chief Directorate.

Data specifications for quarterly submissions from medical schemes were revised and selected administrators have begun using the new specifications.

The Practice Code Numbering System (PCNS) contract with BHF was extended until such time as court proceedings relating to the tender for a service provider are finalised.

Ernst and Young (Ltd) conducted a survey on current remuneration practices in relation to trustees of medical schemes and the results will inform the development of guidelines on trustees' fees.

The CMS undertook research on international best practice in managed healthcare. This involved a review of literature from selected countries. This information was triangulated with qualitative information and quantitative data from South Africa to better understand managed healthcare in the domestic context.

The unit also conducted a literature review of available data on out-of-pocket payments by medical scheme members. Among the recommendations of the study was the identification of additional data sources on out-of-pocket payments.

The unit arranged and participated in a full Industry Technical Advisory Panel (ITAP) meeting that was held on 20 March 2014 to provide feedback to the industry on all ITAP-related projects. An ITAP sub-committee was established to define and measure health quality outcomes, starting with selected chronic conditions. Participation from the industry in ITAP is excellent.

The unit has identified shortcomings in data collection processes within the CMS (utilisation statistics, PMB data and managed care data) and these will be addressed in the new financial year.

The unit also published results of a prevalence study on chronic conditions among beneficiaries of medical schemes.

Changes to planned targets

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

Unit budget

Research and Monitoring	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**10**	**7**	**2**	**7**	**7**	**–**
Stationery	3	2	1	3	3	–
Refreshments	5	5	–	4	4	–
Subscriptions	2	–	2	–	–	–
Operating expenses	**474**	**420**	**54**	**165**	**152**	**14**
Consulting fees	400	397	3	125	115	10
Travel and substance	55	18	37	34	31	3
Venues and catering	19	5	14	6	6	–
Staff costs	**5 972**	**5 256**	**716**	**5 545**	**5 495**	**50**
Salaries	5 788	5 085	704	5 429	5 364	65
Staff training	184	171	12	116	131	(15)
Total	**6 456**	**5 683**	**772**	**5 717**	**5 654**	**64**

Programme 5: Stakeholder Relations

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 5.2.1 – Trustee training					
5.2.1	Number of trustees trained per year	100	187	87	**Deviation** Stakeholder relations introduced in-depth training for trustees, hence the increased number of trustees who were trained.
Strategic objective 5.2.2 – Consumer education					
5.2.2	Number of consumer education and awareness sessions conducted by CMS per year	130	57	73	**Deviation** The unit received fewer requests for training from consumer education groups than anticipated.
Strategic objective 5.2.3 – Co-ordinate external training undertaken by other CMS units					
5.2.3	Number of training sessions co-ordinated per year	2	2	–	No Deviation
Strategic objective 5.2.4 – Communication with stakeholders					
5.2.4	Number of editions of *CMS News* published per year	2	1	1	**Deviation** Due to the resignations of the manager and officer in the Communication Unit, the second *CMSNews* was published in April 2014 instead of March 2014. The Communication Officer post was filled within the year and the Communication Manager was due to commence work in the first quarter of 2014/15.
	Number of editions of *CMScript* published per year	8	7	1	**Deviation** Due to a lack of resources in the Communication Unit with both the officer's and manager's resignations, the *CMScript* missed one issue. The Communication officer position was filled within the year while a new Communication Manager was due to commence work in the first quarter of 2014/15.
	Number of editions of *Masihambisane* published per year	12	8	4	**Deviation** Due to a lack of resources in the Communication Unit with both the officer's and the manager's resignations and the move during May, fewer issues of the *Masihambisane* were published than planned. The Communication Officer position was filled within the year and the new Communication Manager due to commence work in the first quarter of 2014/15.

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
	Number of press conferences held per year	2	3	1	**Deviation** One additional press conference took place to accommodate the demand from Cape Town journalists.
	Number of press releases published per year	12	18	6	**Deviation** Due to important developments in the CMS more press releases were required than expected.
	Percentage of media enquiries handled per year	100%	100%	–	No deviation
Strategic objective 5.2.5 – Publication of and engagement with stakeholders on Council's annual report					
5.2.5	Publication of Council's annual report	1	1	–	No Deviation
	Launch of Council's annual report (press conference)	1	1	–	No Deviation
	Number of road shows on Council's annual report per year	2	2	–	No Deviation
Strategic objective 5.2.6 – Support for other units					
5.2.6	Estimated number of circulars to be drafted and edited per year	52	61	9	**Deviation** The frequent need to make announcements to stakeholders entailed an increase in the number of circulars issued.
Strategic objective 5.2.7 – Customer Care Service Centre					
5.2.7	Estimated number of calls handled per year	44 000	29 227	14 773	**Deviation** Awareness of the CMS has increased and this has resulted in fewer calls being received. More stakeholders know how to lodge complaints and consequently the call centre received fewer inquiries.
	Number of calls abandoned per year	2 750	2 875	125	**Deviation** The majority of abandoned calls are due to the out-dated telephone system. A new system is being procured for the new financial year.
	Average talk time per call	3:00 minutes	3:08 minutes	0:08 minutes	**Deviation** Calls often involved technical explanations which required time. Sometimes information had to be verified and this also extended call time.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 5.2.8 – Stakeholder relations					
5.2.8	Number of stakeholder interactions per year	4	11	7	**Deviation** Additional interactions with stakeholders took place in response to a demand from the industry to engage more often.
	Number of advertisements per year	2	5	3	**Deviation** In order to create more awareness of the CMS and its role, more advertisements were placed.

Purpose

Create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, members of schemes and the general public, the media, Council members and staff through communication, education, training and customer care interventions.

Achievement of strategic objectives

The Education and Training Section of the unit serves members of medical schemes and the public in general by providing training and educational interventions in order to increase understanding of medical schemes by consumers and to promote good corporate governance among trustees.

A well-attended broker training session was held and feedback indicated a need to continue such training.

Council approved a proposal for the CMS to seek accreditation as a training facility by the Insurance Sector Education and Training Authority (INSETA) and also to have its trustee training programme accredited. The unit is working closely with INSETA to achieve accreditation.

The Communication Section is responsible for editing, proofreading and production of all publications, as well as marketing and communication to stakeholders. A Customer Relations Officer was appointed to fill the post previously allocated to a Communication Officer and inputs and outcomes quickly improved. Work also commenced on the annual report.

The new look and feel of *Masihambisane* was positively received by staff. The backlog on production of *CMScript* was cleared and the unit managed to publish seven editions during the year. The unit exceeded the targeted number of press releases, circulars and editing/proofreading projects, thereby providing excellent support to other units.

The Contact Centre is responsible for receiving all incoming inquiries and aims to respond quickly and efficiently to all calls. These relate mostly to brokers, administrators, schemes and members. The process of determining the requirements for a new call centre system was completed during the year and the new system will be operational early in 2014/15. This new digital system has greater capacity and will reduce call redundancy and enhance interaction with stakeholders.

The unit continued to plan and organise stakeholder engagements, including the Administrator Forum and two sittings of the Trustee and Principal Officer forums. It also hosted delegations from Mozambique and the Netherlands and assisted in arranging a trip to China by the CMS.

Media engagement continued throughout the year. The allegations made against the Registrar posed a major reputational risk to the Office.

The media monitoring report was well received as a measurement tool and an aid to determining actions required to protect and improve the CMS's image and reputation.

Changes to planned targets

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

Unit budget

Stakeholder Relations	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**17**	**16**	**–**	**8**	**7**	**1**
Printing and stationery	8	8	–	5	4	1
Refreshments	8	8	–	2	2	–
Subscriptions	1	–	1	1	1	–
Operating expenses	**2 396**	**2 435**	**(40)**	**1 887**	**1 898**	**(12)**
Consulting fees	82	82	–	–	–	–
Courier and postage	10	10	–	14	14	–
Exhibition cost	252	251	1	290	302	(12)
Media and promotion	416	455	(39)	212	171	41
Printing and publication	842	835	7	491	438	53
Travel and subsistence	546	551	(5)	622	718	(96)
Venues and catering	248	251	(3)	258	255	3
Staff costs	**5 873**	**5 219**	**654**	**5 361**	**5 149**	**211**
Salaries	5 713	5 089	624	5 199	5 029	169
Staff training	160	130	30	162	120	42
Total	**8 286**	**7 670**	**614**	**7 256**	**7 054**	**200**

Programme 6: Compliance

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 6.2.1 – Enforcement of rulings and directives					
6.2.1	Estimated number of rulings and directives enforced to ensure compliance per year	20	13	7	**Deviation** Fewer matters requiring enforcement were received.
Strategic objective 6.2.2 – Inspection of regulated entities					
6.2.2	Number of inspections or investigations instituted per year	12	11	1	**Deviation** A few section 44(4)(b) inspections were carried over from 2012/13 to 2013/14 and these had to be completed before commencing inspections for the year under review. This affected targets negatively.
Strategic objective 6.2.3 – Exemption applications					
6.2.3	Estimated number of exemption applications prepared for adjudication by the Council per year	12	14	2	**Deviation** More exemption applications requiring adjudication by Council were received than estimated.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 6.2.4 – Strengthen and monitor governance systems					
6.2.4	Number of Annual general meetings (AGMs) or Special general meetings (SGMs) and trustee elections attended and monitored per year	25	32	7	**Deviation** Initially the plan was to attend meetings at 25 identified schemes. It was then decided to attend AGMs of schemes which were to undergo section 44(4) (b) routine inspections.
	Number of officers of regulated entities vetted per year	25	32	7	**Deviation** The unit vetted more officers of schemes than targeted, as some were vetted as part of the routine inspection process.
	Number of section 46 proceedings instituted per year	5	1	4	**Deviation** There were fewer schemes that required section 46 interventions during the reporting period.
	Number of curatorships, liquidations and compliance officers overseen and monitored per year	5	3	2	**Deviation** There were only three schemes that continued to be under curatorship during the reporting period.

Purpose

The unit serves members of medical schemes and the public by analysing, reviewing and investigating information on possible transgressions of the Medical Schemes Act and taking appropriate action to enforce compliance with the Act.

Achievement of strategic objectives

The trustees of Hosmed challenged their removal by Council by appealing to the Appeal Board presided over by retired Judge BM Ngoepe. The allegations for which the trustees were removed included making false statements under oath, having poor credit records and showing bias in favour of their employer. The Appeal Board confirmed Council's ruling and the trustees were removed.

The unit identified and attended 33 annual general meetings of medical schemes as observers and addressed irregularities that were identified at these meetings with the schemes' principal officers.

During 2013, Selfmed reconstituted its board, starting with two new member-elected trustees and then appointing two additional trustees. The scheme's board is now duly constituted and the scheme is in its hands. The board has set up an independent audit committee as well as an investment committee.

Changes to planned targets

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

Unit budget

Compliance	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**108**	**70**	**38**	**16**	**22**	**(5)**
Cell phone contracts	30	19	11	–	–	–
Printing and stationery	22	12	10	10	11	(1)
Refreshments	4	4	–	4	3	1
Subscriptions	52	35	17	2	8	(6)
Operating expenses	**639**	**385**	**254**	**655**	**322**	**333**
Consulting fees	322	218	104	288	126	162
Travel and subsistence	197	147	50	367	196	171
Venues and catering	120	20	100	–	–	–
Staff costs	**5 402**	**4 853**	**549**	**4 556**	**4 636**	**(80)**
Salaries	5 282	4 747	535	4 431	4 538	(107)
Staff training	120	106	14	125	98	27
Total	**6 149**	**5 308**	**841**	**5 227**	**4 980**	**248**

Programme 7: Benefits Management

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objectives 7.2.1 – Scheme rule amendments					
7.2.1	Estimated number of rule amendments processed per year	275	212	63	**Deviation** The rule amendments submitted to the CMS are based on decisions made by the boards of the schemes. The number received is not within the unit's control.
Strategic objective 7.2.2 – Monitor scheme marketing material					
7.2.2	Number of schemes marketing material reviewed per year	45	51	6	**Deviation** The objective of this activity is to analyse marketing material in conjunction with the registered rules of the scheme to establish whether there are any inconsistencies. During the year under review, the unit exceeded its target by analysing materials of 51 schemes.

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 7.2.3 – Registration of new schemes					
7.2.3	Estimated number of applications for new schemes considered per year	1	–	1	**Deviation** No applications for registration were received from new medical schemes.
Strategic objective 7.2.4 – Management of scheme amalgamations					
7.2.4	Number of amalgamations managed per year	3	6	3	**Deviation** The unit managed a larger number of scheme amalgamations during the year than expected. The incidence of amalgamations is not within the control of the unit.

Purpose

The unit serves beneficiaries of medical schemes and the general public by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The unit analyses and approves all rules made by schemes to ensure consistency with the Medical Schemes Act. This contributes to beneficiaries having access to affordable and appropriate quality healthcare and schemes with fair rules that meet statutory requirements.

Achievement of strategic objectives

The unit has continued to ensure that medical schemes are properly governed and responsive to the socio-economic and healthcare environment. The unit achieves this partly by systematically analysing all rule amendments to ensure that they are fair and consistent with the Medical Schemes Act.

The unit also scrutinises the marketing materials of medical schemes to ensure that beneficiaries are being properly informed and not misled by these materials.

The unit's responsibility for managing the amalgamation of schemes also contributes to the protection of beneficiaries.

Changes to planned targets

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

Budget

Benefits Management Unit	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**50**	**36**	**14**	**54**	**38**	**16**
Printing and stationery	25	19	6	24	19	5
Refreshments	5	2	3	10	6	4
Subscriptions	20	15	5	20	13	7
Operating expenses	**26**	**1**	**25**	**12**	**–**	**12**
Consulting fees	20	–	20	–	–	–
Travel and subsistence	6	1	5	12	–	12
Staff costs	**4 819**	**4 537**	**282**	**4 695**	**4 325**	**370**
Salaries	4 659	4 373	286	4 545	4 178	367
Staff training	160	164	(4)	150	147	3
Total	**4 895**	**4 574**	**321**	**4 761**	**4 363**	**398**

Programme 8: Legal Services

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

Performance indicator		Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 8.2.1 – Legal advisory service					
8.2.1.	Estimated number of written and verbal legal opinions provided to the CMS or business units per year	60	167	107	**Deviation** The projected targets were exceeded due to unexpected demand for legal advice. The unit continued to provide well-researched legal advice to both internal and external stakeholders as required.
Strategic objective 8.2.2 – Legal support service					
8.2.2	Estimated number of court cases where court papers are filed per year	30	17	13	**Deviation** In an effort to save costs, the unit endeavoured to settle matters without resorting to litigation where possible.

Purpose

The unit provides legal advice to the CMS and its business units to ensure the integrity of regulatory decisions and also represents the organisation in various court/tribunal proceedings.

Achievement of strategic objectives

The Legal Services Unit continued to provide legal support, ranging from legal advice on day-to-day matters through to High Court litigation, to the various operational units of the CMS and to Council. Close co-operation between this unit and the Compliance & Investigations Unit was maintained throughout the year in order to ensure that regulatory interventions initiated by the latter had the necessary legal support.

The unit successfully defended a number of matters in the High Court, including cases involving: Selfmed Medical Scheme, Sizwe Medical Fund, Medshield Medical Scheme, Genesis and Hosmed.

The unit provided well-researched legal advice to internal and external stakeholders as and when required. Matters addressed included:

- Late joiner penalties: A number of members and brokers sought legal advice on late joiner penalties. The unit provided an explanation of why these penalties are necessary to the industry along with the relevant regulations and correct method of calculating penalties.
- Third party claims: The CMS received a number of queries on third party claims in cases where schemes failed to pay PMB claims if the member failed to lodge a claim with the relevant organisation, for example the Road Accident Fund. The CMS informed members and the media that schemes had to fund PMB claims in full, but could include in their rules a provision that the member must refund the scheme if s/he received payment in respect of the same claim by another organisation.

While the unit responded effectively to almost every request for support, the lack of an adequate budget – especially for litigation – remains a challenge. Attention is drawn to the fact that medical schemes seeking to challenge the CMS are able to utilise extensive funds belonging to members for litigation purposes.

Changes to planned targets

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

Unit budget

Legal Services	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**17**	**14**	**3**	**23**	**21**	**2**
Printing and stationery	11	8	3	17	15	2
Refreshments	6	6	–	6	6	–
Operating expenses	**7 987**	**9 476**	**(1 489)**	**5 360**	**9 499**	**(4 141)**
Consulting fees	–	–	–	372	89	283
Courier and postage	–	–	–	10	9	1
Legal fees	7 950	9 438	(1 488)	4 793	9 305	(4 512)
Transcription services	1	–	1	59	46	13
Travel	36	38	(2)	113	47	66
Venue and catering	–	–	–	13	3	10
Staff costs	**3 122**	**3 210**	**(88)**	**3 091**	**3 286**	**(195)**
Salaries	3 027	3 097	(70)	3 002	3 211	(209)
Staff training	95	113	(18)	89	75	14
Total	**11 126**	**12 700**	**(1 574)**	**8 474**	**12 806**	**(4 334)**

Programme 9: Financial Supervision Unit

Legend: ***Positive deviation*** ***Negative deviation*** ***No deviation***

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
Strategic objective 9.2.1 – Improve statutory returns as tools for monitoring and reporting and publish reports on findings					
9.2.1	Number of IT specifications produced in respect of quarterly returns per year	1	1	–	No Deviation
	Number of IT specifications produced in respect of annual return per year	1	1	–	No Deviation
	Number of quarterly reports published per year	3	3	–	No Deviation
	Number of financial sections prepared for the annual report per year	1	1	–	No Deviation
Strategic Objective 9.2.2 – Improve reporting by medical schemes (data quality)					
9.2.2	Number of training sessions held on reporting of financial information per year	1	1	–	No Deviation
	Rejection of all statutory returns received that do not meet quality specifications as identified per year	100%	100%	–	No Deviation

	Performance indicator	Planned target 2013/14	Actual achievement 2013/14	Deviation of actual achievement from target 2013/14	Management comments
	Rejection of all AFS received that do not meet quality specifications as identified per year	100%	100%	–	No Deviation
	Number of accounting guidelines published per year	6	6	–	No Deviation
	Number of inputs prepared for SA Institute of Chartered Accountants (SAICA) guide per year	1	1	–	No Deviation
	Number of inputs prepared for Independent Regulatory Board of Auditors (IRBA) guide per year	1	1	–	No Deviation
Strategic objective 9.2.3 – Provide specialised financial advice					
9.2.3	Processing of all requests for specialised advice received per year	100%	100%	–	No Deviation
Strategic objective 9.2.4 – Provide financial oversight/close monitoring of medical schemes					
9.2.4	Recommendations related to Regulation 29 (schemes below solvency) provided for all business plan submissions received per year	100%	100%	–	No Deviation
	Recommendations on action plans for schemes with rapidly reducing schemes solvency but above statutory minimum for 100% of schemes identified per year	100%	100%	–	No Deviation
Strategic objective 9.2.5 – Governance and independence					
9.2.5	Number of online auditor approval questionnaires per year	1	1	–	No Deviation
	Audit approval letters drafted to ensure that 100% of applications received are responded to annually	100%	100%	–	No Deviation
	Responses to 100% of schemes that submitted reinsurance applications per year	100%	–	–	**Deviation** No applications for reinsurance were received during the period under review.

Purpose

The unit serves the beneficiaries of medical schemes, trustees of schemes, Council and the Registrar's Office by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. This assists the CMS to monitor and promote the financial performance of schemes in order to achieve a financially sound industry.

Achievement of strategic objectives

The unit's main objective is to provide oversight of medical schemes in relation to their financial soundness to ensure they are able to honour their obligations and their reporting is in line with international accounting and reporting standards as well as legislative requirements.

During the year under review, the unit prepared IT specifications for statutory annual returns by schemes as well as quarterly returns. These constitute the CMS's key data collection tools. The online returns were developed by the IT & KM Unit and were made available for completion by medical scheme users. The resultant reports were published during the course of the year.

The unit introduced comprehensive changes to the annual statutory return specifications, which for the first time included data in respect of PMBs and other utilisation statistics.

In order to ensure that the quality of data submitted by medical schemes continues to improve, the unit held its annual administrator workshop in March 2014 and published six guidelines for the industry. The unit also continued to engage and collaborate with SAICA and IRBA to ensure that reporting by medical schemes is aligned with accounting and auditing standards.

The unit engaged frequently with schemes placed on close monitoring to ensure that they were financially sound and members' interests were protected.

The unit fulfilled its responsibility of approving the auditors appointed by medical schemes, in accordance with section 36 of the Medical Schemes Act.

Further, the Annual Report 2012/13 was published timeously in September 2013, despite IT challenges impacting on analysis of the data submitted in annual statutory returns.

The unit was faced with staff shortages due to the resignation of one member and two taking maternity leave. This resulted in remaining individuals working under immense pressure throughout the year.

The unit also experienced significant delay in the roll out of the annual statutory return due to IT challenges, which impacted on the timeline of the entire project.

Changes to planned targets

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

Unit budget

Financial Supervision Unit	Budget 2013/14 R'000	Actual 2013/14 R'000	(Over)/under expenditure R'000	Budget 2012/13 R'000	Actual 2012/13 R'000	(Over)/under expenditure R'000
Administrative expenses	**56**	**38**	**18**	**44**	**32**	**12**
Printing and stationery	19	13	6	19	16	3
Refreshments	7	7	–	5	4	1
Subscriptions	30	18	12	20	12	8
Operating expenses	**200**	**83**	**117**	**70**	**42**	**28**
Consulting fees	20	–	20	20	7	13
Travel and subsistence	55	19	36	50	35	15
Venues and catering	145	64	81	–	–	–
Staff costs	**9 471**	**8 695**	**777**	**8 082**	**8 015**	**67**
Salaries	9 209	8 431	778	7 788	7 817	(29)
Staff training	262	264	(2)	294	198	96
Total	**9 747**	**8 816**	**931**	**8 196**	**8 089**	**107**

GOVERNANCE

PART C: GOVERNANCE

Responsibility for governance of the CMS is vested in the Council of the organisation which fulfils the roles and duties of a board of directors. In the execution of its governance responsibilities, Council is guided by the Medical Schemes Act 131 of 1998 (as amended), the Public Finance Management Act 1 of 1999 (as amended), Treasury Regulations and the principles of good corporate governance set out in the King III Report, as well as other relevant laws.

Members of Council are appointed by the Minister of Health who also appoints the Chairperson of Council. Members hold office for a three-year term.

Council has delegated aspects of its work to various sub-committees in order to ensure efficiency and effectiveness in the conduct of its business.

Portfolio Committee on Health

The CMS made two presentations to the parliamentary Portfolio Committee on Health.

Subject of presentation	Date
The CMS strategic plan, annual performance plan and budget for 2013/14	20 March 2013
Annual Report 2011/12	11 October 2013

The Portfolio Committee acknowledged the challenges presented by the current Medical Schemes Act and appreciated the urgent need for changes to be incorporated in the Medical Schemes Amendment Bill.

Executive Authority: the Minister of Health

In compliance with guidelines published by National Treasury, the CMS submitted performance information reports to the Minister of Health on a quarterly basis. The exact dates are indicated below.

Quarterly performance information reports submitted to the Minister of Health	
Quarter 1 (April – June 2013)	30 July 2013
Quarter 2 (July – September 2013)	30 October 2013
Quarter 3 (October – December 2013)	30 January 2013
Quarter 4 (January – March 2014)	24 April 2014

The CMS submitted its Strategic Plan 2011/12 to 2014/15, the Annual Performance Plan 2013/14 and budget for the financial year to the Minister of Health on 9 November 2012.

Accounting Authority: Council

Section 4 of the Medical Schemes Act empowers the Minister of Health to appoint a Council consisting of a maximum of 15 members. Council sits at least four times a year and the Chairperson presides at all such meetings. As at 31 March 2014, Council consisted of 14 members.

Council is responsible for the strategic direction of the organisation and reports to the Minister of Health and Parliament in respect of its financial performance and service delivery.

Council has the following sub-committees:

- Human Resources Committee.
- Finance Committee.
- Audit & Risk Committee, which is chaired by an independent member.
- Appeals Committee, which is mandated to execute duties conferred on Council by Sections 48 and 49 of the Medical Schemes Act.

Council envisages appointing a sub-committee for ICT governance in the near future.

All sub-committees of Council play an important role in ensuring the sound governance of the CMS.

The role of Council

The role of Council is captured in Section 7 of the Medical Schemes Act 131 of 1998. This provides that "the functions of the Council shall be to:

(a) protect the interests of the [medical schemes] beneficiaries at all times;

(b) control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy;

(c) make recommendations to the Minister [of Health] on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;

(d) investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act;

(e) collect and disseminate information about private healthcare;

(f) make rules, not inconsistent with the provisions of this Act, for the purpose of the performance of its functions and the exercise of its powers;

(g) advise the Minister [of Health] on any matter concerning medical schemes; and

(h) perform any other functions conferred on the Council by the Minister [of Health] or by this Act."

Table 24: Composition of Council as at 31 March 2014

Name and designation	Date appointed	Date resigned	Qualifications	Area of expertise	Council committees	Number of meetings attended
Prof Y Veriava Chairperson	28 Nov 2012	N/A	MBBCh (Wits), Hon DSc (Wits), FCP (SA), FRCP (London)	Clinical medicine	EXCO and HR	16
Mr T Bailey Vice-Chairperson	28 Oct 2011	N/A	BA, LLB, LLM	Law	EXCO and Appeals Committee	18
Prof BC Dumisa Member	28 Oct 2011	N/A	LLB, LLM, MBA, MSc, DBA	Law and management	Appeals Committee	15
Mr ZL Fihlani Member	28 Oct 2011	N/A	CA (SA), MComm (Tax)	Tax	Finance and Audit & Risk	2
Mr K Hoosain Member	28 Oct 2011	N/A	CA (SA), MBA	Accounting and management	EXCO, Finance and Audit & Risk	4
Ms MO Morata Member	28 Oct 2011	N/A	BProc, PostGradDip (Drafting of Contracts)	Law	Remuneration and Appeals Committee	6
Dr L Mpuntsha Member	28 Oct 2011	N/A	MBChB, MPhil	Medicine	HR and Appeals Committee	13
Ms L Nevhutalu Member	28 Oct 2011	N/A	BBusSc (Actuarial Sciences)	Actuarial sciences	HR	2
Mr T Phadu Member	28 Oct 2011	N/A	MSc (London), Senior Diploma (Political Economy) (Moscow)	Policy	HR and Remuneration	10
Dr A Pillay* Member	28 Oct 2011	N/A	BPharm, MSc, PhD (Australia)	Medicine and management	EXCO	6
Ms A Theophanides Member	28 Oct 2011	N/A	BCom Hons (Actuarial Sciences)	Actuarial sciences	EXCO, HR and Remuneration	9
Prof CJ van Gelderen Member	28 Oct 2011	N/A	MBChB, Dip Mid COG (SA), MRCOG, FRCOG, FCOG (SA)	Medicine	HR and Appeals Committee	21
Adv CJ Weapond Member	28 Oct 2011	N/A	BIuris, BPol, LLB, MTech	Law	Appeals Committee	17
Mr T Zulu Member	28 Oct 2011	N/A	CA (SA)	Accounting	Finance and Audit & Risk	3

* *Non-remunerated Council member*

Table 25: Membership of Council committees as at 31 March 2014

Council Committee	Number of meetings held	Number of members	Names of members
Executive Committee (EXCO)	7	6	Prof Y Veriava
			Mr T Bailey
			Mr K Hoosain
			Dr A Pillay*
			Ms A Theophanides
			Mr T Phadu
Human Resources Committee	5	6	Prof Y Veriava
			Dr L Mpuntsha
			Ms L Nevhutalu
			Mr T Phadu
			Ms A Theophanides
			Prof CJ van Gelderen
Finance Committee	5	3	Mr ZL Fihlani
			Mr K Hoosain
			Mr T Zulu
Audit & Risk Committee	4 scheduled 3 ad hoc	6	Mr ZL Fihlani
			Mr K Hoosain
			Mr T Zulu
			Mr C Mazhindu
			Ms J Naicker
			Mr R Nicholls
Appeals Committee	13	8	Mr T Bailey
			Prof BC Dumisa
			Adv H Maenetje (external alternate Chairperson of the Appeals Committee)
			Ms MO Morata
			Dr L Mpuntsha
			Adv V Ngalwana (external alternate Chairperson of the Appeals Committee)
			Prof CJ van Gelderen
			Adv CJ Weapond

* *Non-remunerated Council member*

Table 26: Remuneration of Council members in 2013/14

Name of Council member	Remuneration	Other allowance/s	Other reimbursement/s	Total
Prof Y Veriava	R264 798	N/A	N/A	R264 798
Mr T Bailey	R355 429	N/A	N/A	R355 429
Prof BC Dumisa	R292 509	N/A	N/A	R292 509
Mr ZL Fihlani	R44 390	N/A	N/A	R44 390
Mr K Hoosain	R164 528	N/A	N/A	R164 528
Ms MO Morata	R196 282	N/A	N/A	R196 282
Dr L Mpuntsha	R170 901	N/A	N/A	R170 901
Ms L Nevhutalu	R15 054	N/A	N/A	R15 054
Mr T Phadu	R109 431	N/A	N/A	R109 431
Dr A Pillay*	N/A	N/A	N/A	N/A
Ms A Theophanides	R125 257	N/A	N/A	R125 257
Prof CJ van Gelderen	R245 507	N/A	N/A	R245 507
Adv CJ Weapond	R281 799	N/A	N/A	R281 799
Mr T Zulu	R51 531	N/A	N/A	R51 531

* *Non-remunerated Council member*

Council Secretariat

The Council Secretariat is responsible for providing support and advice in relation to good governance to Council and its committees. The Council Secretariat endeavours to provide guidance to Council members on their rights, responsibilities, duties and powers, both on an individual level and collectively. The Council Secretary also ensures that Council complies with all laws and regulations which have a bearing on the CMS and the industry which it regulates. In addition to this, the Council Secretary services Council meetings, attending to the logistical arrangements and ensuring that proper minutes are taken and kept. Council resolutions are communicated by the Council Secretary to all affected parties.

Internal Finance Unit and internal controls

The CMS has an Internal Finance Unit which takes responsibility for internal controls and is central to the efficient management of CMS resources. The Internal Finance Policies and Procedures Manual was revised and approved by Council during the year under review.

Internal audit

The scope of the annual internal audit of the CMS is based on management's assessment of the risks facing the organisation. The internal audits conducted during 2013/14 focused on high-risk areas identified jointly by management and the Audit & Risk Committee.

The contract of the internal auditors expired in May 2013, and the newly appointed internal auditors commenced work in June 2013.

The internal auditors performed risk assessments of the following during the period under review:

- Follow-up report on all audit findings from the previous financial year.
- Audit of strategic planning documents for 2014/15.
- Audit of predetermined objectives (for quarters 1 and 2 of 2013/14).
- Supply chain management.
- Financial management.
- Stakeholder relations.
- Audit on predetermined objectives (for quarters 3 and 4 of 2013/14).

Compliance with laws and regulations

The CMS reviews its internal policies on an annual basis to ensure compliance with relevant legislation and policies are signed off by Council.

Risk management

Council has an integrated approach to risk management and ensures that its review of risk is used to inform the internal audit process and the design of internal controls. The risk management process, which was developed during the year under review, identifies, evaluates, manages and monitors the risks facing CMS. Where risks are identified

as significant, they are not only subject to mitigating controls but are also reviewed regularly by the Executive Committee and Council. The Audit & Risk Committee regularly reviews the effectiveness of the risk identification process and the methodology used to evaluate and quantify the risks.

"Top-down" and "bottom-up" risk reviews were carried out in all areas of the business, involving Council, executive management and staff, as appropriate. All executive managers are responsible for managing and monitoring risks in their area of work and recording information in the risk register. It is mandatory for this process to take place quarterly. For each risk identified, management assesses the root causes, consequences and mitigating controls. An assessment is then made of the maximum risk exposure, taking into account the probability of the risk occurring and its possible impact before application of mitigating controls. Each of the business units is supported by a risk champion who co-ordinates risk management activities in that unit and ensures that actions are implemented appropriately. This process ensures all risks are measured, monitored and reported on a consistent basis.

Risk tolerance

Risk tolerance is an indication of the amount of risk an entity is willing to accept in order to meet its strategic objectives. This is reflected in its capacity to sustain losses and its ability to continue to meet its obligations. CMS has a matrix scoring system which rates risks in terms of the likelihood of them occurring and their potential severity. The severity of the risk can be measured using financial, health and safety, environmental, stakeholder or legal criteria. These scores inform decisions to escalate risks within the organisation and institute mitigating actions.

Prevention of fraud and corruption

The CMS has a fraud and corruption prevention strategy in place which includes a whistle-blowing policy.

In compliance with the Protected Disclosures Act 26 of 2000, the CMS is committed to the protection of employees who disclose information in good faith, using the appropriate channels. The CMS recognises that it can be difficult for an employee to make the decision to report a concern.

The CMS has a dedicated Tip-offs Anonymous hotline in place. Employees who may wish to make confidential disclosures about suspected fraud and/or corruption at the CMS are able – and in fact encouraged – to call the tip-offs hotline anonymously.

Users of the Tip-offs Anonymous service can report their disclosures using any of the following:

- A dedicated FreeCall number: 0800 867 423.
- A unique e-mail address: cms@tip-offs.com.
- A FreePost address: KZN 138, Umhlanga Rocks, 4320.
- A FreeFacsimile number: 0800 00 77 88.

Cases involving CMS employees are reported directly to the organisation's internal auditors as well as the chairperson of Audit & Risk Committee for further investigation.

To ensure that the strategy remains sustainable, articles on fraud and corruption are featured monthly in the internal newsletter of the CMS, Masihambisane. Information on the Tip-offs Anonymous hotline was also published on the CMS intranet and website together with the strategy and policy document.

Social responsibility

The HR Unit facilitated the mentorship of 10 girls from the Vukani-Mawethu High School in Mamelodi in Pretoria in an effort to contribute to the development and empowerment of young women. The CMS also donated sanitary towels to the school and sponsored school uniforms for 123 underprivileged learners, who were taken to the Moretele Park Recreation Resort for a day of fun and laughter. The CMS participated in the annual Nelson Mandela 67 Minutes Campaign in 2013 by donating 85 pairs of school shoes to the same school.

Report of the Audit & Risk Committee

The Audit & Risk Committee is pleased to present its report for the financial year ended 31 March 2014 to the Council (or Accounting Authority) of the Council for Medical Schemes (CMS).

The Audit & Risk Committee holding office during the 2013/14 financial year was appointed in compliance with Section S51(1)(a)(ii) of the Public Finance Management Act 1 of 1999, as amended (PFMA). The Committee's operation is guided by a detailed charter that was informed by the PFMA and approved by Council.

Audit & Risk Committee members and meetings

The Committee, consisting of three independent non-Council members and three non-executive members of Council, held three scheduled meetings and one special meeting during the year under review. The dates of these meetings and attendance at them are recorded in Table A.

Table A: Meetings of the Audit & Risk Committee in 2013/14 and attendance of members

Name of member	Position of member	Date of appointment	Date of re-appointment	Meetings attended			
				23 May 2013 (scheduled)	24 July 2013 (special)	3 December 2013 (scheduled)	20 February 2014 (scheduled)
Charles Mazhindu	Chairperson. Independent and non-executive	1 October 2009	1 November 2012	√	√	X	√
Rowan Nicholls	Independent and non-executive	1 October 2009	1 November 2012	√	√	√	√
Josephine Naicker	Independent and non-executive	1 October 2009	1 November 2012	√	X	X	X
Kariem A Hoosain	Non-executive and Council member	28 May 2009	28 October 2011	√	√	√	√
Thabani F Zulu	Non-executive and Council member	1 November 2011	N/A	√	X	√	√
Zola L Fihlani	Non-executive and Council member	1 November 2011	N/A	X	X	√	√

√ = attended
X = apology

The Committee had a further three ad hoc meetings during the year:

- 11 April 2013 – meeting of the Committee with internal and external auditors;
- 4 September 2013 – meeting of the Committee with internal auditors; and
- 5 March 2014 – meeting of the Committee to discuss allegations against the Registrar

Other invitees

The CMS's internal and external auditors attended all the above meetings of the Committee as invitees. The Chief Executive & Registrar and the Chief Financial Officer also attended meetings by invitation and other senior managers attended when there were agenda items relevant to them.

Functions

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

- Evaluation of the effectiveness of risk management, controls and governance processes.
- Oversight of:
  - The financial and performance reporting processes.
  - The activities of the internal and external audits and facilitation of a co-ordinated approach to these functions.
- Review of:
  - Provisional and year-end financial statements to ensure that they were fairly presented and 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.
  - The internal audit and risk management reports and, where relevant, recommendations made to Council and management.
- Approval of:
  - The internal audit charter, budget and three-year audit plan.
  - Audit fees and terms of engagement of the internal auditor.
  - Terms of engagement, plans and budget for the Auditor-General of South Africa.
- Recommendation of the unaudited and audited annual financial statements for the year ended 31 March 2014 to Council.

Audit & Risk Committee responsibility

Mandate

The mandate of the Committee is derived from Section S51(1)(a)(ii) of the PFMA and paragraph 3.1 of Treasury Regulations.

The Committee reports that it has discharged its responsibilities arising from Section S51(1)(a)(ii) of the PFMA and Treasury Regulation 3.1.13.

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

Role of the Audit & Risk Committee on CMS governance

As part of the CMS governance structures, the Committee continued to discharge its mandate and performed its oversight function as indicated below.

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

The outsourced internal auditor of the CMS compiled and presented a three-year rolling strategic plan for the review and approval of the Committee. The plan was approved after the Committee was satisfied that it was in line with Treasury Regulations and risk-based, as required by Internal Auditing Standards.

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

External audit plan by the Auditor-General of South Africa

The Committee reviewed and approved the external audit plan for the year under review as prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act. The Committee confirms that this plan is in line with regulations and standards and takes into account the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented were adequate for completion of the CMS annual audit.

Risk management and internal controls

The Committee continued to review and report on CMS risk management practices, internal policies and procedures in order to ensure that they are effective and adequate for safeguarding the CMS's resources and promoting the achievement of its mission. The Committee continued to report on the establishment of effective internal controls, which requires periodic identification and assessment of external and internal risks faced by the CMS.

The Committee is satisfied that improvements to CMS risk management and internal control practices are being adequately identified and entity-wide risk management within the CMS has now been formalised. The Committee acknowledges that an effective internal audit function is central to the proper operation of the Committee.

Both internal and external audits identified information technology as an area requiring enhancement for greater efficacy and control. The audit by the Auditor-General also identified weaknesses relating to supply chain management. The Committee noted a year-on-year increase in the number of audit findings and encouraged management to improve the organisation's internal controls. The CMS responded by formulating an enhancement plan which is currently being implemented.

Review of legal cases pending at financial year-end

The Committee reviewed progress reports on legal cases taken against the CMS (in its capacity as regulator) that were pending at the financial year-end. This was to ensure adequate disclosure was made in the annual financial statements as required by the South African Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. No cases warranted any further mention in this report.

Evaluation of the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually. During the year under review, the Committee was not evaluated by Council.

Evaluation of financial statements

The Committee reviewed the annual financial statements of the CMS for the year ended 31 March 2014 and is satisfied that, in all material respects, the financial statements comply with the relevant provisions of the PFMA, GRAP, and fairly present the financial position of the CMS at that date and the results of operations and cash flows for the year.

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

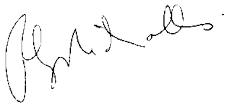
The Committee recommended the financial statements and performance information report for the year ended 31 March 2014 to Council for approval.

Other matters

Subsequent to the year under review the Executive Authority suspended the Chief Executive Officer. An external forensic investigation is currently in progress relating to allegations of corruption. The allegations did not relate to any internal financial irregularities.

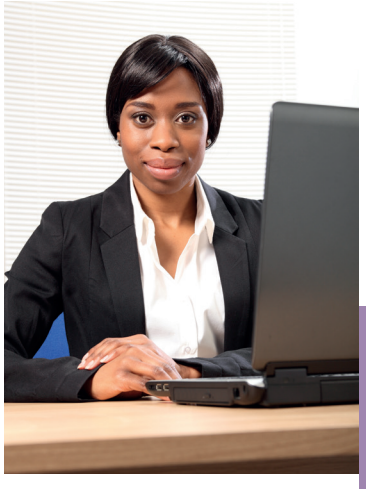
Our commitment

The Committee remains committed to working 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.



Rowan Nicholls
Acting Chairperson*
Audit & Risk Committee
Council for Medical Schemes
30 July 2014

* *The Chairperson, Mr Charles Mazhindu, resigned from the Committee on 20 July 2014. The Committee appointed Mr Rowan Nicholls as Acting Chairperson until Council appoints a new Chairperson.*



HUMAN RESOURCES **MANAGEMENT**

PART D: HUMAN RESOURCES MANAGEMENT

The information in this section focuses on the implementation of the CMS's Human Resources Strategy for the 2013/14 financial year through the Annual Performance Plan (APP) as it relates to matters such as remuneration and benefits, talent management and staff retention, performance management, training and development, employment equity and personnel-related costs.

The Human Resources (HR) Unit's strategic objectives support the broader strategic goals of the CMS by maintaining an effective and efficient organisation.

Succession planning framework and strategy

During the period under review, the process of developing a succession strategy was initiated in order to ensure continuity in delivery and provide opportunities for growth and promotion to CMS employees who are willing and able to take up more senior positions. The process involved the development of a promotion strategy and the identification of key positions that require a succession plan. Through input from management and staff, a strategy was developed which provides for:

- Guidance on recruitment.
- Continuous development and increased readiness of CMS employees for senior positions.
- A development plan for all employees, with a focus on leadership development for identified successors.

Remuneration and benefits

The CMS implemented the recommendations of a comprehensive job grading and evaluation exercise by reviewing all existing positions to ensure that the respective roles were clearly defined and appropriately graded.

Talent management and staff retention

Attracting and retaining talent remains a key priority for the CMS. The aim of its talent acquisition strategy is to identify and hire the best talent available. The HR Unit manages and participates in the recruitment, interviewing, testing, selection, orientation and evaluation of all employees.

During the period under review, talented personnel were sourced, in line with our recruitment policies and processes. Their performance was monitored during the probation period to ensure that they met their performance targets.

Appointments

Thirteen appointments were made in the financial year under review:

1. Head: Research & Monitoring.
2. Senior Strategist.
3. Education and Training Manager.
4. Senior Manager: Clinical.
5. Clinical Health Researcher.
6. Financial Analyst.
7. Senior Financial Analyst.
8. Legal Adjudication Officers x 2.
9. Messenger/driver.
10. Executive Assistant and Administrator.
11. Administrator: Complaints Adjudication.
12. Customer Relations Officer.

Orientation and induction

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

Probation

Nine of the 13 new employees completed the mandatory probation period of six months and were confirmed as permanent employees of the CMS after the successful conclusion of their probation reviews.

Resignations

The following resignations were received in the reporting period:

- Senior Strategist.
- Education and Training Manager.
- Assistant Senior Financial Analyst.
- Communications Manager.
- Communications Officer.
- Messenger/driver.

Employer of Choice survey

Issues that were raised in the *Employer of Choice* employee engagement survey were addressed by management.

Performance management

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

In line with HR policies, two formal performance reviews were conducted in the 2013/14 reporting period. Through the Moderating Committee, the HR Unit facilitated the awarding of incentive bonuses to recognise those employees who excelled in their performance.

Training and development

Staff undertook various training programmes identified in their personal development plans or professional development programmes. The HR Unit completed a workplace skills plan and annual training report and submitted these to the Health and Welfare Sector Education and Training Authority (HWSETA).

The unit takes pride in encouraging a culture of learning among all CMS employees. A number of employees achieved academic success by completing certificate, diploma and degree programmes. Two employees are currently undertaking PhD studies.

New employees were offered career development opportunities through the professional development programme.

Employment equity

At the end of the financial year, the CMS employed 98 employees, of whom 78.57% were black and 62.24% female. The CMS has been relatively successful in recruiting and appointing employees from previously disadvantaged groups.

The CMS submitted its employment equity (EE) report for the year under review to the Department of Labour.

The EE Forum continued to monitor the implementation of equity targets when new appointments were made, and held awareness and feedback sessions for both management and staff during the period under review.

The CMS has a diverse workforce, but the number of coloured employees and those of Indian origin as well as persons with disabilities remained below the nationally defined benchmark for designated groups. The CMS will continue to use available opportunities to ensure equitable representation of all designated groups.

Employee wellness

Employee wellness remained a priority for the HR Unit and a key strategy for ensuring staff retention and improving productivity. The CMS has undertaken a number of employee wellness initiatives aimed at assisting employees to manage their health proactively. It helped employees address various health and social issues, pre-empting their development into bigger and costlier problems. ICAS Southern Africa – a leading international provider of employee assistance, wellness and wellbeing programmes – was again contracted to provide employees access to professional assistance that is both private and confidential.

Wellness initiatives included:

- The promotion of fitness and healthy habits through subsidised health club membership.
- The organisation of a wellness day for screening for chronic conditions and associated risk factors.
- The provision of annual on-site flu vaccinations.
- The conduct of a cancer awareness campaign.
- The organisation of a health promotion day which included counselling and testing opportunities for cancer, diabetes and HIV.
- The commemoration of World AIDS Day.
- The participation in the CANSA Relay for Life to recognise cancer survivors and commemorate those who died from cancer.
- Wellness talks on mental health, breast cancer and eye health.

The Wellness Committee partnered with South African National Blood Service (SANBS) to organise the CMS's second blood donation drive on 6 February 2014.

Social responsibility

The CMS donated goal posts and nets to Vukani Mawethu High School soccer team in Mamelodi.

Policy reviews

The code of conduct for CMS employees was reviewed during 2013/14.

Team-building, culture and diversity

The HR Unit facilitated management engagement workshops, cross-functional team-building sessions and cultural awareness presentations for all the CMS units during the period under review.

HR Oversight Statistics

Table 27: Personnel costs by programme/unit 2013/14

Programme (Unit)	Total expenditure of unit (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees	Average personnel cost per employee (R'000)
Accreditation	6 115	5 751	94.05%	9	639
Benefits Management	4 574	4 373	95.61%	7	625
Complaints Adjudication	4 436	4 388	98.92%	9	488
Compliance & Investigations	5 308	4 747	89.43%	6	791
Financial Supervision	8 816	8 431	95.63%	11	766
Human Resources	6 527	3 243	49.69%	5	649
ICT & KM	11 243	6 960	61.91%	11	633
Internal Finance	23 303	6 072	26.06%	9	675
Legal Services	12 700	3 097	24.39%	4	774
Office of Chief Executive & Registrar	9 519	3 255	34.19%	4	814
Office of Senior Strategist (including Clinical Unit)	3 822	3 645	95.37%	6	–
Research & Monitoring	5 683	5 085	89.48%	7	726
Stakeholder Relations	7 670	5 089	66.35%	10	509
Total	**109 716**	**64 136**	**58.46%**	**98**	**654**

Table 28: Personnel costs by salary band 2013/14

Level	Personnel expenditure (R'000)	% of personnel expenditure to total personnel cost	Number of employees	Average personnel cost per employee (R'000)
Top management	1 820	2.84%	1	1 820
Senior management	13 142	20.49%	11	1 195
Professionals	23 618	36.82%	33	716
Skilled labour	19 428	30.29%	40	486
Semi-skilled labour	6 128	9.55%	13	471
Unskilled labour	N/A	N/A	0	N/A
Total	**64 136**	**100.00%**	**98**	**654**

Table 29: Performance rewards by salary band 2013/14

Level	Performance rewards (R'000)	Personnel expenditure (R'000)	% of performance rewards to total personnel cost
Top management	120	1 820	6,59%
Senior management	656	13 142	4,99%
Professionals	1 193	23 618	5,05%
Skilled labour	827	19 428	4,26%
Semi-skilled labour	204	6 128	3,33%
Unskilled labour	N/A	N/A	N/A
Total	**3 000**	**64 136**	**4,68%**

Table 30: Training costs by programme/unit 2013/14

Programme (Unit)	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel cost	Number of employees trained	Average training cost per employee (R'000)
Accreditation	5 751	56	0.97%	9	6
Benefits Management	4 373	164	3.75%	7	23
Complaints Adjudication	4 388	26	0.59%	9	3
Compliance & Investigations	4 747	106	2.23%	6	18
Financial Supervision	8 431	264	3.13%	11	24
Human Resources	3 243	127	3.92%	5	25
ICT & KM	6 960	148	2.13%	11	13
Internal Finance	6 072	125	2.06%	9	14
Legal Services	3 097	113	3.65%	4	28
Office of Chief Executive & Registrar	3 255	192	5.90%	4	48
Office of Senior Strategist (including Clinical Unit)	3 645	148	4.06%	6	25
Research & Monitoring	5 085	171	3.36%	7	24
Stakeholder Relations	5 089	130	2.55%	10	13
Total	**64 136**	**1 770**	**38.31%**	**98**	**265**

Table 31: Employment and vacancies by programme/unit 2013/14

Programme (Unit)	2012/2013 number of employees	2013/2014 Approved	2013/2014 Vacancies	Appointments	2013/2014 number of employees	2013/2014 % number of employees
Accreditation	9	0	0	0	9	0%
Benefits Management	7	0	0	0	7	0%
Complaints Adjudication	8	1	0	0	9	0%
Compliance & Investigations	6	0	0	0	6	0%
Financial Supervision	10	1	0	0	11	25%
Human Resources	5	0	0	0	5	0%
ICT & KM	11	0	0	0	11	0%
Internal Finance	9	0	0	0	9	0%
Legal Services	4	0	0	0	4	0%
Office of the CE & Registrar	2	1	1	0	4	0%
Office of the Senior Strategist (including Clinical units)	4	1	1	0	6	25%
Research & Monitoring*	8	0	0	1	7	25%
Stakeholder Relations	11	0	1	2	10	25%
Total	**94**	**4**	**3**	**3**	**98**	**100%**

* *Research & Monitoring : An incumbent was transferred to the Office of the Senior Strategist.*
* *The vacancy of Head: Research & Monitoring was filled from within the unit*

Table 32: Employment and vacancies by salary level 2013/14

Programme (level)	2012/13 number of employees	2013/14 approved posts	2013/14 number of employees	2013/14 vacancies	% of vacancies
Top management	1	0	1	0	0,00%
Senior management	10	0	11	0	0,00%
Professionals	28	1	33	2	66,67%
Skilled labour	37	2	40	1	33,33%
Semi-skilled labour	18	1	13	0	0,00%
Unskilled labour	0	0	0	0	0,00%
Total	**94**	**4**	**98**	**3**	**100%**

Council approved the following new positions in 2013/14: Clinical Research Analyst, Executive Assistant and Administrator, Legal Adjudication Officer and Senior Financial Analyst.

Vacancies were due to resignations, ill-health and internal movement of employees.

Table 33: Employment changes by salary band 2013/14

Employment change by salary band	Employment at beginning of period	Appointments	Reclassification of salary band	Terminations	Transfer/ promotion	Employment at end of period
Top management	1	0	0	0	0	1
Senior management	10	2	0	1	0	11
Professionals	28	3	6	2	2	33
Skilled labour	37	5	0	2	0	40
Semi-skilled labour	18	3	(6)	1	1	13
Unskilled labour	0	0	0	0	0	0
Total	**94**	**13**	**0**	**6**	**3**	**98**

Thirteen vacancies were filled in the year under review and nine of these appointments were to replace staff that had resigned or changed positions, within the CMS. Four new positions were created and filled within the reporting period.

Table 34: Reasons for staff leaving 2013/14

Reason	Number of employees	% of total number of staff leaving
Death	0	–
Resignation	5	83%
Dismissal	0	–
Retirement	0	–
Ill health	1	17%
Expiry of contract	0	–
Other	0	–
Total	**6**	**100%**

Table 35: Labour relations: misconduct and disciplinary action 2013/14

Nature of disciplinary action	Number of occurrences
Verbal warning	1
Written warning	0
Final written warning	0
Dismissal	0
Total	**1**

Tables 36, 37 and 38 indicate the planned or targeted increases in CMS employees at various levels of the organisation in order to improve representation of designated groups.

Table 36: Employment equity – current status and targets for male employees 2013/14

	Male							
	African		Coloured		Indian		White	
Level	Current	Target	Current	Target	Current	Target	Current	Target
Top management	1	0	0	0	0	0	0	0
Senior management	2	0	0	0	2	0	4	0
Professionals	10	0	0	1	1	0	4	0
Skilled labour	8	0	2	0	1	0	1	0
Semi-skilled labour	1	0	0	0	0	0	0	0
Unskilled labour	0	0	0	0	0	0	0	0
Total	**22**	**0**	**2**	**1**	**4**	**0**	**9**	**0**

Table 37: Employment equity – current status and targets for female employees 2013/14

	Female							
	African		Coloured		Indian		White	
Level	Current	Target	Current	Target	Current	Target	Current	Target
Top management	0	0	0	0	0	0	0	0
Senior management	2	0	0	0	0	0	1	0
Professionals	11	0	1	+1	1	+1	5	0
Skilled labour	14	0	1		1	0	6	0
Semi-skilled labour	16	0	2	0	0	0	0	0
Unskilled labour	0	0	0	0	0	0	0	0
Total	**43**	**0**	**4**	**1**	**2**	**1**	**12**	**0**

Table 38: Employment equity – current status and targets for employees with disabilities 2013/14

	Disabled staff			
	Male		Female	
Level	Current	Target	Current	Target
Top management	0	–	0	–
Senior management	0	–	0	–
Professionals	0	+1	0	–
Skilled labour	1	–	0	+1
Semi-skilled labour	0	–	0	–
Unskilled labour	0	–	0	–
Total	**1**	**1**	**0**	**1**

Financial
INFORMATION

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY FOR THE ANNUAL REPORT

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

All information and amounts disclosed in the annual report are consistent with the annual financial statements audited by the Auditor-General.

The annual report is complete, accurate and free from any omissions.

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

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

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

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

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

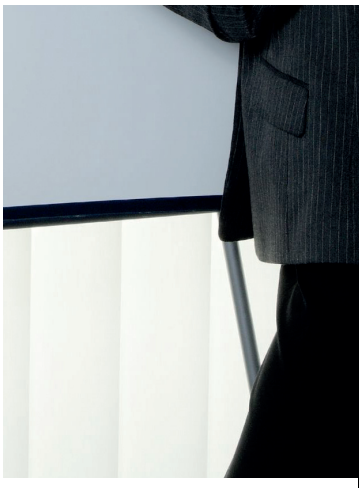
The external auditors are responsible for independently reviewing and reporting on the entity's annual financial statements. The annual financial statements have been examined by the entity's external auditors and their report is presented on pages 112 to 114.

In our opinion, the annual report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the entity for the financial year ended 31 March 2014.

The annual financial statements set out on pages 116 to 142, which have been prepared on the going concern basis, were approved by the Council on 30 July 2014 and were signed on its behalf by:

Mr MD Lehutjo
Acting Registrar

Prof Y Veriava
Chairperson of Council



Report of the AUDITOR GENERAL

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

Report on the financial statements

Introduction

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 116 to 142 which comprise the statement of financial position as at 31 March 2014, the statement of financial performance, statement of changes in net assets, cash flow statement and the statement of comparison of budget and actual amounts for the year then ended, as well as the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting Authority's responsibility for the financial statements

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

Auditor-General's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No 25 of 2004) (PAA), the general notice issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements, and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2014 and its financial performance and cash flows for the year then ended, in accordance with SA Standards of GRAP and the requirements of the PFMA.

Report on other legal and regulatory requirements

7. In accordance with the PAA and the general notice issued in terms thereof, I report the following findings on the reported performance information against predetermined objectives for selected objective presented in the annual performance report, non-compliance with legislation as well as internal control. The objective of my tests was to identify reportable findings as described under each sub-heading but not to gather evidence to express assurance on these matters. Accordingly, I do not express an opinion or conclusion on these matters.

Predetermined objectives

I performed procedures to obtain evidence about the usefulness and reliability of the reported performance information for the following selected programmes presented in the annual performance report of the public entity for the year ended 31 March 2014:

- Programme 3 : Accreditation on pages 77 to 79
- Programme 4 : Research and Monitoring on pages 79 to 81
- Programme 5: Stakeholder Relations on pages 82 to 85
- Programme 6: Compliance on pages 85 to 87
- Programme 7: Benefits Management on pages 87 to 88
- Programme 8: Legal Support on pages 89 to 90
- Programme 9: Financial Supervision on pages 90 to 92

8. I evaluated the reported performance information against the overall criteria of usefulness and reliability.

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

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

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

Achievement of planned targets

12. Refer to the annual performance report on pages 62 to 92 for information on the achievement of planned targets for the year.

Compliance with legislation

13. I performed procedures to obtain evidence that the public entity had complied with applicable legislation regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA, are as follows:

Procurement and contract management

14. 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.

15. Quotations were awarded to bidders who did not submit a declaration on whether they are employed by the state or connected to any person employed by the state, which is prescribed in order to comply with Treasury regulation 16A8.3.

Expenditure management

16. The accounting authority did not take effective steps to prevent irregular expenditure as required by section 51(1)(b)(ii) of the PFMA.

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

Internal control

17. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with legislation. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on non-compliance with legislation included in this report.

Financial and performance management

18. The internal control systems designed and implemented by management did not prevent or detect irregular expenditure, in certain instances, due to a lack of dedicated resources for the supply chain function.

Other reports

Investigations

19. Subsequent to the year under review the Executive Authority suspended the Chief Executive Officer. An external forensic investigation relating to allegations of corruption is currently in progress.

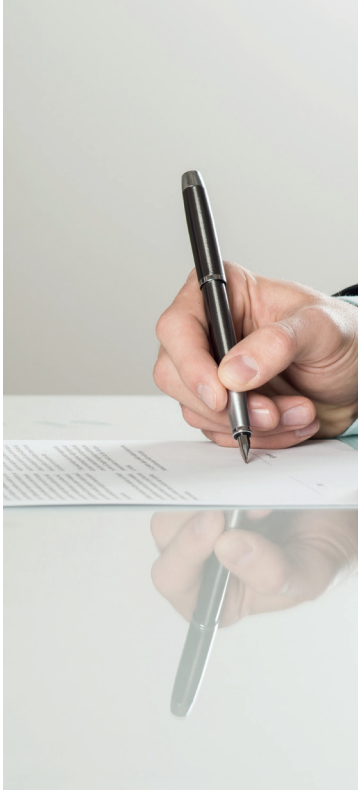
Auditor - General

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

Pretoria

31 July 2014



Annual financial STATEMENTS

STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2014

	Note(s)	2014 R	2013 R
Assets			
Current assets			
Receivables from exchange transactions	4	**5 627 741**	3 737 447
Cash and cash equivalents	5	**15 086 669**	16 901 496
		20 714 410	20 638 943
Non-current assets			
Property, plant and equipment	6	**12 096 183**	12 285 804
Intangible assets	7	**1 640 187**	2 379 473
		13 736 370	14 665 277
Total assets		**34 450 780**	35 304 220
Liabilities			
Current liabilities			
Operating lease liability	10	**–**	66 795
Payables from exchange transactions	8	**12 040 077**	19 451 684
Provisions	9	**362 414**	303 719
		12 402 491	19 822 198
Non-current liabilities			
Operating lease liability	10	**1 107 411**	–
Provisions	9	**794 047**	660 112
		1 901 458	660 112
Total liabilities		**14 303 949**	20 482 310
Net assets		**20 146 831**	14 821 910
Accumulated surplus		**20 146 831**	14 821 910

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 31 MARCH 2014

	Note(s)	2014 R	2013 R
Revenue	12	**113 076 058**	102 282 273
Other income		**–**	17 482
Expenditure			
Administrative expenditure	13	**(14 108 313)**	(9 706 744)
Audit fees	14	**(1 600 961)**	(1 678 369)
Operating expenses	15	**(21 214 868)**	(19 250 207)
Staff cost	16	**(69 668 676)**	(66 038 683)
Depreciation and amortisation		**(2 637 058)**	(2 802 866)
Penalties waived	17	**(310 000)**	–
Loss on disposal of asset		**(176 423)**	–
Operating surplus		**3 359 759**	2 822 886
Investment revenue		**1 965 162**	1 439 807
Surplus for the year		**5 324 921**	4 262 693

STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED 31 MARCH 2014

	Accumulated surplus R	Total net assets R
Opening balance as previously reported	11 298 092	11 298 092
Adjustments		
Prior year adjustments	(738 875)	(738 875)
Balance at 01 April 2012 as restated*	**10 559 217**	**10 559 217**
Changes in net assets		
Surplus for the year	4 262 693	4 262 693
Total changes	4 262 693	4 262 693
Opening balance as previously reported	15 785 741	15 785 741
Adjustments		
Prior year adjustments	(963 831)	(963 831)
Balance at 01 April 2013 as restated*	**14 821 910**	**14 821 910**
Changes in net assets		
Surplus for the year	5 324 921	5 324 921
Total changes	5 324 921	5 324 921
Balance at 31 March 2014	**20 146 831**	**20 146 831**

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2014

	Note(s)	2014 R	2013 R
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		**105 805 755**	97 826 145
Grants		**4 935 285**	4 340 569
Interest income		**1 965 162**	1 439 807
		112 706 202	103 606 521
Payments			
Employee costs		**(69 666 937)**	(66 038 683)
Suppliers		**(42 969 517)**	(22 877 150)
		(112 636 454)	(88 915 833)
Net cash flows from operating activities	19	**69 748**	14 690 688
Cash flows from investing activities			
Purchase of property, plant and equipment	6	**(1 772 974)**	(8 030 567)
Proceeds from sale of property, plant and equipment	6	**73 745**	48 505
Purchase of other intangible assets	7	**(185 346)**	(827 084)
Net cash flows from investing activities		**(1 884 575)**	(8 809 146)
Net increase/(decrease) in cash and cash equivalents		**(1 814 827)**	5 881 542
Cash and cash equivalents at the beginning of the year		**16 901 496**	11 019 954
Cash and cash equivalents at the end of the year	5	**15 086 669**	16 901 496

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2014

Budget on Cash Basis

	Approved budget R	Adjustments R	Final Budget R	Actual amounts on comparable basis R	Variance R	Note
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees	5 700 000	–	5 700 000	6 263 716	563 716	
Appeal fees	–	–	–	2 000	2 000	
Interest received	840 000	–	840 000	1 965 162	1 125 162	1
Legal fees recovered	–	–	–	2 057 805	2 057 805	
Levies income	100 138 321	–	100 138 321	99 176 566	(961 755)	2
Registration fees	370 000	–	370 000	393 750	23 750	
Sundry income	–	–	–	246 936	246 936	
Total revenue from exchange transactions	**107 048 321**	**–**	**107 048 321**	**110 105 935**	**3 057 614**	
Revenue from non-exchange transactions						
Government transfers – Department of Health	4 525 000	–	4 525 000	4 525 000	–	
Mandatory transfer – Department of Higher Education and Training	–	–	–	410 285	410 285	
Total revenue from non-exchange transactions	4 525 000	–	4 525 000	4 935 285	410 285	
Total revenue	**111 573 321**	**–**	**111 573 321**	**115 041 220**	**3 467 899**	
Expenditure						
Personnel	(74 202 282)	–	(74 202 282)	(69 668 676)	4 533 606	3
Depreciation and amortisation	(2 411 178)	–	(2 411 178)	(2 637 058)	(225 880)	
Penalties waived	–	–	–	(310 000)	(310 000)	
Loss on disposal of assets	–	–	–	(176 423)	(176 423)	
General expenses	(11 377 869)	–	(11 377 869)	(11 640 275)	(262 406)	
Legal fees	(8 040 900)	–	(8 040 900)	(9 549 049)	(1 508 149)	4
Rent	(6 419 693)	–	(6 419 693)	(6 319 243)	100 450	
Council members' fees	(1 800 000)	–	(1 800 000)	(2 317 418)	(517 418)	5
Consulting	(3 397 453)	–	(3 397 453)	(3 371 306)	26 147	
Auditors' remuneration	(1 529 905)	–	(1 529 905)	(1 600 961)	(71 056)	
Telecommunication expenses	(2 134 570)	–	(2 134 570)	(2 125 890)	8 680	
Total expenditure	**(111 313 850)**	**–**	**(111 313 850)**	**(109 716 299)**	**1 597 551**	
Surplus	**259 471**	**–**	**259 471**	**5 324 921**	**5 065 450**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2014

Budget on Cash Basis

	Approved budget R	Adjustments R	Final Budget R	Actual amounts on comparable basis R	Variance R	Note
Statement of financial position						
Assets						
Non-current assets						
Property, plant and equipment	2 672 000	–	2 672 000	1 772 974	(899 026)	6
Intangible assets	–	–	–	185 346	185 346	6
	2 672 000	**–**	**2 672 000**	**1 958 320**	**(713 680)**	
Total assets	**2 672 000**	**–**	**2 672 000**	**1 958 320**	**(713 680)**	
Liabilities						
Current liabilities						
Payables from exchange transactions	1 350 042	–	1 350 042	1 450 030	99 988	
Total liabilities	**1 350 042**	**–**	**1 350 042**	**1 450 030**	**99 988**	
Net assets	**1 321 958**	**–**	**1 321 958**	**508 290**	**(813 668)**	
Net assets						
Net assets attributable to owners of controlling entity						
Reserves						
Accumulated surplus	1 321 958	–	1 321 958	508 290	(813 668)	7

Note

1. *133.9% Over-collection on interest due to the prudent investment of cash surpluses in the CPD account.*
2. *-0.9% Under-collection on levies income due to the budgeted principal members were based on a higher projection than the actual principal members on 31 December 2013.*
3. *6.1% Under-expenditure on salaries was due to the delay in filling of new positions, as well as resignations during the year.*
4. *18.7% Over-expenditure on legal fees was due to the increased number of legal matters. The legal fees recovered for the current year exceeds this over-expenditure.*
5. *28.7% Over-expenditure on council members' fees is attributed to a number of special meetings held during the year.*
6. *26.7% Under-expenditure on the capital budget was due to the late approval of the current year's budget.*
7. *61.6% Overall under-expenditure of surplus funds allocated to the current year's budget was due to saving, as well as additional income.*

ACCOUNTING POLICIES

FOR THE YEAR ENDED 31 MARCH 2014

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 1 of 1999).

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

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

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

The principal accounting policies, applied in the preparation of these annual financial statements, are set out below.

These accounting policies are consistent with those applied in the preparation of the prior year annual financial statements, unless specified otherwise.

1.1 Presentation currency

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

1.2 Going concern assumption

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

1.3 Comparative figures

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

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

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

Where there has been a change in accounting policy in the current year, the adjustment is made retrospectively as far as is practicable and the prior year comparatives are restated accordingly.

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

1.4 Significant judgements and sources of estimation uncertainty

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

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

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

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

Provisions

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

Additional disclosure of these estimates of provisions are included in note 9 – Provisions.

Depreciation and amortisation

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

Effective interest rate

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

flows. The entity used the prime interest rate to discount future cash flows.

Impairment testing

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

1.5 Financial instruments

Initial recognition

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

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

Initial measurement

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

Subsequent measurement

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

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

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

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

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

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

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

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

Gains and losses

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

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

Impairment

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

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

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

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

Derecognition

Financial assets

A financial asset is derecognised at trade date, when:

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

Financial liabilities

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

Policies relating to specific financial instruments

Investments

Investments, which include fixed deposits and short-term deposits invested in registered commercial banks, are categorised as financial instruments at amortised cost and are subsequently measured at amortised cost.

Where investments have been impaired, the carrying value is adjusted by the impairment loss, which is recognised as an expense in the period that the impairment is identified.

On disposal of an investment, the difference between the net disposal proceeds and the carrying amount is charged or credited to the Statement of Financial Performance.

Cash and cash equivalents

Cash and cash equivalents are measured at amortised cost. Cash includes cash on hand and cash with banks. Cash equivalents are short-term highly liquid investments that are held with registered banking institutions with maturities of three months or less and are subject to an insignificant risk of change in value.

For the purposes of the Cash Flow Statement, cash and cash equivalents comprise cash on hand and deposits held on call with banks.

Trade and other receivables

Trade and other receivables are initially recognised at fair value plus transaction costs that are directly attributable to the acquisition and subsequently stated at amortised cost, less provision for impairment. All trade and other receivables are assessed at least annually for possible impairment. Impairments of trade and other receivables are determined in accordance with the accounting policy for impairments. Impairment adjustments are made through the use of an allowance account.

Bad debts are written off in the year in which they are identified as irrecoverable. Amounts receivable within 12 months from the reporting date are classified as current.

Trade payables

Trade payables are initially measured at fair value plus transaction costs that are directly attributable to the acquisition and are subsequently measured at amortised cost using the effective interest rate method.

1.6 Property, plant and equipment

Initial recognition and measurement

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 for longer than one year.

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.
- The cost of the item can be measured reliably.

Items of property, plant and equipment are initially recognised as assets on acquisition date and are initially recorded at cost where acquired through exchange transactions. However, when items of property, plant and equipment are acquired through non-exchange transactions, those items are initially measured at their fair values as at the date of acquisition.

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, its deemed cost is the carrying amount of the asset(s) given up.

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

Subsequent to initial recognition, items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses.

Deprecation

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	Average useful life
Furniture and fittings	14 years
Motor vehicles	5 years
Computer equipment	7 years
Computer software	7 years
Leasehold improvements	10 years
Other fixed assets	16 years

Impairments

The entity tests for impairment where there is an indication that an asset may be impaired. An assessment of whether there is an indication of possible impairment is done at each reporting date. Where the carrying amount of an item of property, plant and equipment is greater than the estimated recoverable amount (or recoverable service amount), it is written down immediately to its recoverable amount (or recoverable service amount) and an impairment loss is charged to the Statement of Financial Performance.

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

An impairment is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined had no impairment been recognised. A reversal of the impairment is recognised in the Statement of Financial Performance.

Derecognition

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 on the disposal or retirement of an item of property, plant and equipment is determined as the difference between the sales proceeds and the carrying value and is recognised in the Statement of Financial Performance.

1.7 Intangible assets

Initial recognition and measurement

An intangible asset is an identifiable non-monetary asset without physical substance. The entity recognises an intangible asset in its Statement of Financial Position only 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.

Internally generated intangible assets are subject to strict recognition criteria before they are capitalised. Research expenditure is never capitalised, while development expenditure is only capitalised to the extent that:

- The entity intends to complete the intangible asset for use or sale.
- It is technically feasible to complete the intangible asset.
- The entity has the resources to complete the project.
- It is probable that the entity will receive future economic benefits or service potential.
- The entity has the ability to measure reliably the expenditure during development.

Intangible assets are initially recognised at cost.

Where an intangible asset is acquired by the entity for no or nominal consideration (i.e. a non-exchange transaction), the cost is deemed to be equal to the fair value of that asset on the date acquired.

Where an intangible asset 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 is not determinable, its deemed cost is the carrying amount of the asset(s) given up.

Subsequent measurement

Intangible assets are subsequently carried at cost less accumulated amortisation and impairments.

The cost of an intangible asset is amortised over the useful life where that useful life is finite. The amortisation expense on intangible assets with finite lives is recognised in the Statement of Financial Performance in the expense category consistent with the function of the intangible asset.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually, either individually or at the cash generating unit level. The assessment of indefinite life is reviewed annually to determine whether the indefinite life assumption continues to be supportable. If not, the change in useful life from indefinite to finite is made on a prospective basis.

Following initial recognition of the development expenditure as an asset, the cost model is applied requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses. Amortisation of the asset begins when development is complete and the asset is available for use. It is amortised over the period of expected future benefit. Amortisation is recorded in Statement of Financial Performance in the expense category consistent with the function of the intangible asset. During the period of development, the asset is tested for impairment annually.

Amortisation and impairment

Amortisation is charged to write off the cost of intangible assets over their estimated useful lives using the straight-line method.

Item	Useful life
Developed software	7 years
Acquired software	7 years

The amortisation period, the amortisation method and residual value for intangible assets with finite useful lives are reviewed at each reporting date and any changes are recognised as a change in accounting estimate in the Statement of Financial Performance.

Impairments

The entity tests intangible assets with finite useful lives for impairment where there is an indication that an asset may be impaired. An assessment of whether there is an indication of possible impairment is performed at each reporting date. Where the carrying amount of an item of an intangible asset is greater than the estimated recoverable amount (or recoverable service amount), it is written down immediately to its recoverable amount (or recoverable service amount) and an impairment loss is charged to the Statement of Financial Performance.

Derecognition

Intangible assets are derecognised when the asset is disposed of or when there are no further economic benefits or service potential expected from the asset. The gain or loss arising on the disposal or retirement of an intangible asset is determined as the difference between the sales proceeds and the carrying value and is recognised in the Statement of Financial Performance.

1.8 Impairment of non-financial assets

Recognition

The entity assesses at each reporting date whether there is an indication that an asset may be impaired. Where the carrying amount of an asset exceeds its recoverable amount (or recoverable service amount in the case of non cash-generating assets), the asset is considered impaired and is written down to its recoverable amount (or recoverable service amount). An asset's recoverable amount (or recoverable service amount) is the higher of the fair value less costs to sell, and the value-in-use of the asset.

Measurement

An asset's recoverable amount (or recoverable service amount) is the higher of an asset's or cash-generating unit's fair value less costs to sell and its value-in-use. This recoverable amount (or recoverable service amount) is determined for individual assets, unless those individual assets are part of a larger cash generating unit, in which case the recoverable amount (or recoverable service amount) is determined for the whole cash generating unit.

An asset is part of a cash generating unit where that asset does not generate cash inflows that are largely independent of those from other assets or group of assets.

In determining the recoverable amount (or recoverable service amount) of an asset, the entity evaluates the assets to determine whether the assets are cash-generating assets or non cash-generating assets.

For cash-generating assets, the value in use is determined as a function of the discounted future cash flows from the asset.

Where the asset is a non cash-generating asset, the value in use is determined through one of the following approaches:

- Depreciated replacement cost approach: The current replacement cost of the asset is used as the basis for this value. This current replacement cost is depreciated for a period equal to the period that the asset has been in use so that the final depreciated replacement cost is representative of the age of the asset.
- Restoration cost approach: Under this approach, the present value of the remaining service potential of the asset is determined by subtracting the estimated restoration cost of the asset from the current cost of replacing the remaining service potential of the asset before impairment.
- Service units approach: The present value of the remaining service potential of the asset is determined by reducing the current cost of the remaining service potential of the asset before impairment, to conform with the reduced number of service units expected from the asset in its impaired state.

The decision as to which approach to use is dependent on the nature of the identified impairment.

In assessing value-in-use for cash-generating assets, the estimated future cash flows are discounted to their present value using a discount rate that reflects current market assessments of the time value of money and the risks specific to the asset. In determining fair value less costs to sell, other fair value indicators are used.

Impairment losses of continuing operations are recognised in the Statement of Financial Performance in those expense categories consistent with the function of the impaired asset.

An assessment is made at each reporting date as to whether there is any indication that previously recognised impairment losses may no longer exist or may have decreased. If such indication exists, the entity makes an estimate of the assets or cash-generating unit's recoverable amount.

Reversal of impairment losses

A previously recognised impairment loss is reversed only if there has been a change in the assumptions used to determine the asset's recoverable amount since the last impairment loss was recognised. The reversal is limited so that the carrying amount of the asset does not exceed its recoverable amount, nor exceed the carrying amount that would have been determined, net of depreciation, had no impairment loss been recognised for the asset in prior years. Such reversal is recognised in the Statement of Financial Performance unless the asset is carried at a revalued amount, in which case the reversal is treated as a revaluation increase.

1.9 Employee benefits

Short term employee benefits

Short-term employee benefits encompass all those benefits that become payable in the short term, i.e. within a financial year or within 12 months after the financial year. Therefore, short-term employee benefits include remuneration, compensated absences and bonuses.

Short-term employee benefits are recognised in the Statement of Financial Performance as services are rendered, except for non-accumulating benefits, which are recognised when the specific event occurs. These short-term employee benefits are measured at their undiscounted costs in the period the employee renders the related service or the specific event occurs.

Defined contribution plans

Contributions made towards the fund are recognised as an expense in the Statement of Financial Performance in the period that such contributions become payable. This contribution expense is measured at the undiscounted amount of the contribution paid or payable to the fund. A liability is recognised to the extent that any of the contributions have not yet been paid. Conversely an asset is recognised to the extent that any contributions have been paid in advance.

1.10 Leases

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

Assets subject to operating leases, i.e. 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 fulfillment of the arrangement is dependent on the use of a specific asset or assets or the arrangement conveys a right to use the asset.

Finance leases – lessee

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

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

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

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

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

Operating leases – lessee

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

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

1.11 Revenue from exchange transactions

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

Recognition

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

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

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

The main sources of revenue from exchange transactions are:

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

Measurement

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

1.12 Revenue from non-exchange transactions

Non-exchange transactions are transactions that are not exchange transactions.

Revenue from non-exchange transaction arises when the 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.

Revenue from non-exchange transactions is generally recognised to the extent that the related receipt or receivable qualifies for recognition as an asset and there is no liability to repay the amount.

Grants, transfers and donations received or receivable are recognised when the resources that have been transferred meet the criteria for recognition as an asset and there is not a corresponding liability in respect of related conditions.

An asset that is recognised as a result of a non-exchange transaction is recognised at its fair value at the date of the transfer. Consequently, revenue arising from a non-exchange transaction is measured at the fair value of the asset received, less the amount of any liabilities that are also recognised due to conditions that must still be satisfied.

Where there are conditions attached to a grant, transfer or donation that give rise to a liability at initial recognition, that liability is transferred to revenue as and when the conditions attached to the grant are met.

Grants without any conditions attached are recognised as revenue in full when the asset is recognised, at an amount equalling the fair value of the asset received.

1.13 Borrowing costs

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

1.14 Translation of foreign currencies

Foreign currency transactions

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

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

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

1.15 Unauthorised expenditure

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

1.16 Irregular expenditure

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

(a) This Act.

(b) The State Tender Board Act, 1968 (Act No. 86 of 1968), or any regulations made in terms of the Act.

(c) Any provincial legislation providing for procurement procedures in that provincial government.

National Treasury practice note no. 4 of 2008/2009 which was issued in terms of sections 76(1) to 76(4) of the PFMA requires the following (effective from 1 April 2008):

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

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

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

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

1.17 Fruitless and wasteful expenditure

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

1.18 Post-reporting date events

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

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

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

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

1.19 Related parties

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

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

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

Further details about those transactions are disclosed in the notes to the financial statements.

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

1.20 Transfer of functions

Between entities under common control:

Recognition

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

Derecognition

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

Measurement

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

Between entities that are not under common control:

Recognition

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

Derecognition

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

Measurement

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

1.21 Budget information

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

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

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

The approved budget covers the fiscal period from 2013/04/01 to 2014/03/31.

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

2. New standards and interpretations

2.1 Standards and interpretations effective and adopted in the current year

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

Standard/Interpretation:	Effective date: Years beginning on or after	Impact on current year
GRAP 25: Employee benefits	1 April 2013	Refer to note 3 – Changes in accounting policy
GRAP 1 (as revised 2012): Presentation of Financial Statements	1 April 2013	Minimal and immaterial
GRAP 3 (as revised 2012): Accounting Policies, Change in Accounting Estimates and Errors	1 April 2013	Minimal and immaterial
GRAP 9 (as revised 2012): Revenue from Exchange Transactions	1 April 2013	Minimal and immaterial
GRAP 13 (as revised 2012): Leases	1 April 2013	Minimal and immaterial
GRAP 17 (as revised 2012): Property, Plant and Equipment	1 April 2013	Minimal and immaterial
GRAP 31 (as revised 2012): Intangible Assets (replaces GRAP 102)	1 April 2013	Minimal and immaterial
IGRAP 16: Intangible assets website costs	1 April 2013	Minimal and immaterial
IGRAP 1 (as revised 2012): Applying the probability test on initial recognition of revenue	1 April 2013	Minimal and immaterial

2.2 Standards and Interpretations early adopted

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

Standard/Interpretation:	Effective date: Years beginning on or after	Impact on current year
GRAP 105: Transfers of functions between entities under common control	1 April 2014	Minimal and immaterial
GRAP 106: Transfers of functions between entities not under common control	1 April 2014	Minimal and immaterial

3. Changes in accounting policy

The annual financial statements have been prepared in accordance with Standards of Generally Recognised Accounting Practice on a basis consistent with the prior year except for the adoption of the following new or revised standards.

GRAP 25: Employee benefits

During the year, the entity changed its accounting policy with respect to the treatment of long service awards, in order to conform with the benchmark treatment of GRAP 25. The entity now accounts for a provision regarding long service award in the year that the service is rendered, and not in the year the award is paid out to employees.

Employees receive long service awards in intervals of 10 years. The provision for long service award represents management's best estimate of the entity's liability at year-end for current employees.

The aggregate effect of the changes in accounting policy on the annual financial statements for the year ended 31 March 2013 is as follows:

	2014 R	2013 R
Statement of financial position		
Provisions		
Previously stated	–	–
Adjustment	–	963 831
	–	963 831
Accumulated surplus		
Previously stated	–	15 785 741
Adjustment	–	(963 831)
	–	14 821 910
Statement of Financial Performance		
Staff cost		
Previously stated	–	65 813 727
Adjustment	–	224 956
	–	66 038 683
Surplus for the year		
Previously stated	–	4 487 649
Adjustment	–	(224 956)
	–	4 262 693

4. Receivables from exchange transactions

Accounts receivable	**401 249**	683 608
Prepaid expenses	**2 057 165**	872 016
Sundry debtors	**3 169 327**	2 181 823
	5 627 741	3 737 447

5. Cash and cash equivalents

Cash and cash equivalents consist of:		
Cash on hand	**5 758**	3 103
Bank balances	**3 277 496**	5 707 777
CPD account	**11 803 415**	11 190 616
	15 086 669	16 901 496

6. Property, plant and equipment

	2014			2013		
	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Computer equipment	**6 332 929**	**(3 865 242)**	**2 467 687**	6 547 918	(4 377 863)	2 170 055
Computer software	**1 717 728**	**(1 401 467)**	**316 261**	2 236 618	(1 562 787)	673 831
Furniture and fittings	**4 106 902**	**(1 695 731)**	**2 411 171**	3 873 259	(2 343 030)	1 530 229
Leasehold improvements WIP	**7 071 416**	**(584 447)**	**6 486 969**	7 421 064	–	7 421 064
Motor vehicles	**221 871**	**(97 137)**	**124 734**	221 871	(52 763)	169 108
Other fixed assets	**571 256**	**(281 895)**	**289 361**	661 914	(340 397)	321 517
Total	**20 022 102**	**(7 925 919)**	**12 096 183**	20 962 644	(8 676 840)	12 285 804

Reconciliation of property, plant and equipment – 2014

	Opening balance	Additions	Disposals	Reclassification of leasehold improvement	Depreciation	Total
Furniture and fittings	**1 530 229**	**646 393**	**(126 746)**	**438 951**	**(77 656)**	**2 411 171**
Motor vehicles	**169 108**	**–**	**–**	**–**	**(44 374)**	**124 734**
Computer equipment	**2 170 055**	**947 190**	**(37 800)**	**18 094**	**(629 852)**	**2 467 687**
Computer software	**673 831**	**–**	**(5 506)**	**–**	**(352 064)**	**316 261**
Leasehold improvements	**7 421 064**	**107 397**	**–**	**(457 045)**	**(584 447)**	**6 486 969**
Other fixed assets	**321 517**	**71 994**	**(50 794)**	**–**	**(53 356)**	**289 361**
	12 285 804	**1 772 974**	**(220 846)**	**–**	**(1 741 749)**	**12 096 183**

Reconciliation of property, plant and equipment – 2013

	Opening balance	Additions	Disposals	Depreciation	Total
Computer equipment	2 617 519	428 613	(10 098)	(865 979)	2 170 055
Computer software	955 263	3 330	–	(284 762)	673 831
Furniture and fittings	2 026 336	96 296	(20 895)	(571 508)	1 530 229
Leasehold improvements WIP	–	7 421 064	–	–	7 421 064
Motor vehicles	213 482	–	–	(44 374)	169 108
Other fixed assets	334 715	81 264	(30)	(94 432)	321 517
	6 147 315	8 030 567	(31 023)	(1 861 055)	12 285 804

7. Intangible assets

	2014			2013		
	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value
Acquired software	**4 389 806**	**(3 395 153)**	**994 653**	4 922 466	(3 477 432)	1 445 034
Developed software	**1 571 274**	**(925 740)**	**645 534**	1 642 615	(708 176)	934 439
Total	**5 961 080**	**(4 320 893)**	**1 640 187**	6 565 081	(4 185 608)	2 379 473

Reconciliation of intangible assets – 2014

	Opening balance	Additions	Disposals	Amortisation	Total
Acquired software	**1 445 034**	**185 346**	**(23 409)**	**(612 318)**	**994 653**
Developed software	**934 439**	**–**	**(5 913)**	**(282 992)**	**645 534**
	2 379 473	**185 346**	**(29 322)**	**(895 310)**	**1 640 187**

Reconciliation of intangible assets – 2013

	Opening balance	Additions	Amortisation	Total
Acquired software	1 964 744	161 626	(681 336)	1 445 034
Developed software	529 456	665 458	(260 475)	934 439
	2 494 200	827 084	(941 811)	2 379 473

8. Payables from exchange transactions

	2014 R	2013 R
Accounts payable	**5 526 664**	4 349 361
Accruals	**4 025 008**	5 356 303
Accrual for leasehold improvement	**270 008**	7 421 064
Accrual for leave pay	**1 440 065**	1 523 579
Income received in advance	**778 332**	801 377
	12 040 077	19 451 684

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.

9. Provisions

	Opening Balance	Additions	Utilised during the year	Total
Reconciliation of provisions – 2014				
Provision for long service award	**963 831**	**375 973**	**(303 719)**	**1 036 085**
Provision for performance bonus	**–**	**120 376**	**–**	**120 376**
	963 831	**496 349**	**(303 719)**	**1 156 461**

Reconciliation of provisions – 2013

	Opening Balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	738 875	472 163	(247 207)	–	963 831
Other	16 360	–	–	(16 360)	–
	755 235	472 163	(247 207)	(16 360)	963 831

	2014 R	2013 R
Non-current liabilities	**794 047**	660 112
Current liabilities	**362 414**	303 719
	1 156 461	963 831

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

10. Operating lease asset (accrual)

	2014 R	2013 R
Non-current liabilities	**(1 107 411)**	–
Current liabilities	**–**	(66 795)
	(1 107 411)	(66 795)

CMS entered into an office rental 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.

11. Financial instruments disclosure

	At amortised cost	Total
Categories of financial instruments		
2014		
Financial assets		
Trade and other receivables from exchange transactions	**3 570 576**	**3 570 576**
Cash and cash equivalents	**15 086 669**	**15 086 669**
	18 657 245	**18 657 245**
Financial liabilities		
Trade and other payables from exchange transactions	**12 040 077**	**12 040 077**
2013		
Financial assets		
Trade and other receivables from exchange transactions	2 865 431	2 865 431
Cash and cash equivalents	16 901 496	16 901 496
	19 766 927	19 766 927
Financial liabilities		
Trade and other payables from exchange transactions	19 451 688	19 451 688

12. Revenue

	2014 R	2013 R
Accreditation fees	**6 263 716**	5 497 000
Appeal fees	**2 000**	10 000
Government transfers: Department of Health	**4 525 000**	4 310 000
Legal fees recovered	**2 057 805**	763 389
Levies income	**99 176 566**	90 775 193
Mandatory transfer: Department of Higher Education & Training	**410 285**	30 569
Registration fees	**393 750**	376 650
Sundry income	**246 936**	519 472
	113 076 058	102 282 273
The amounts included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	**6 263 716**	5 497 000
Appeal fees	**2 000**	10 000
Legal fees recovered	**2 057 805**	763 389
Levies income	**99 176 566**	90 775 193
Registration fees	**393 750**	376 650
Sundry income	**246 936**	519 472
	108 140 773	97 941 704
The amount included in revenue arising from non-exchange transactions is as follows:		
Transfer revenue		
Government transfers: Department of Health	**4 525 000**	4 310 000
Mandatory transfer: Department of Higher Education & Training	**410 285**	30 569
	4 935 285	4 340 569

	2014 R	2013 R
13. Administrative expenses		
Bank charges	**41 012**	39 545
Building expenses	**2 178 341**	2 005 050
General administrative expenses	**1 017 944**	690 623
Insurance	**274 398**	176 368
Printing and stationery	**297 371**	279 098
Refreshments	**178 014**	180 552
Rent	**6 319 243**	4 484 853
Rent - operating expense	**947 768**	–
Rental - copiers	**243 655**	119 702
Security	**368 070**	51 604
Subscriptions	**116 607**	80 366
Telecommunication expenses	**2 125 890**	1 598 983
	14 108 313	9 706 744
14. Auditors' remuneration		
External audit	**805 980**	626 578
Internal audit	**794 981**	1 051 791
	1 600 961	1 678 369
15. Operating expenses		
Committee remuneration	**100 475**	261 211
Consulting	**3 371 306**	2 303 159
Council members' fees (see note 21)	**2 317 416**	2 420 396
Courier and postage	**181 784**	167 113
Exhibition costs	**251 265**	302 496
Knowledge management	**527 447**	446 382
Legal fees	**9 549 049**	9 304 908
Media and promotion	**454 737**	170 976
Printing and publication	**834 549**	470 412
Transcription services	**109 406**	45 657
Travel and subsistence	**1 948 464**	2 486 647
Venue and catering	**1 568 970**	870 850
	21 214 868	19 250 207

	2014 R	2013 R
16. Staff costs		
Employee benefits	**1 462 222**	1 349 136
Employee wellness	**480 133**	441 881
Recruitment and relocation	**1 091 942**	580 164
Salaries	**64 135 532**	61 130 718
Staff training	**1 770 455**	1 710 148
Temporary staff	**300 682**	208 606
Temporary staff – SEP system	**307 554**	478 075
Workmen's compensation	**120 156**	139 955
	69 668 676	66 038 683
Total number of employees	**98**	94
17. Penalties waived		
Penalties waived	**310 000**	–
The Registrar imposed a penalty on a medical scheme in December 2011 for non-compliance with Regulation(8) of the Medical Schemes Act. The medical scheme finally settled the member's PMB claim on which the penalty was imposed. The Registrar decided to waive this penalty.		
18. 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 58 of 1962.		
19. Cash generated from operations		
Surplus	**5 324 921**	4 262 693
Adjustments for:		
Depreciation and amortisation	**2 637 058**	2 802 866
Gain (loss) on sale of assets and liabilities	**176 423**	(17 482)
Debt impairment	**310 000**	–
Movements in operating lease assets and accruals	**1 040 616**	(332 084)
Movements in provisions	**192 630**	(3 863 393)
Changes in working capital:		
Receivables from exchange transactions	**(1 890 294)**	(115 558)
Sundry debtors	**(310 000)**	–
Payables from exchange transactions	**(7 411 606)**	11 953 646
	69 748	14 690 688

	2014 R	2013 R
20. Commitments		
Operating leases – as lessee (expense)		
20.1 Photocopier rental		
Minimum lease payments due		
– within one year	**249 595**	239 404
– in second to fifth year inclusive	**136 688**	359 105
	386 283	598 509
The CMS has operating leases for the rental of photocopiers up to 30 November 2016, with 0,0% escalation. The first operating lease's terms have been adjusted as the photocopiers were only delivered in October 2012 and not in August 2012 as initially agreed upon. The second operating lease commenced in December 2013.		
20.2 Office rental		
Minimum lease payments due		
– within one year	**7 121 828**	6 746 559
– in second to fifth year inclusive	**34 643 169**	27 366 772
– later than five years	**50 291 788**	50 983 898
	92 056 785	85 097 229
The CMS entered into a renewable 10 year lease agreement which commenced on 1 June 2013 and will terminate on 31 May 2023, 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.The CMS also contracted to have the option to purchase the office building.		

21. Related parties

Relationships

Executive authority: The Executive Authority as defined in Section 1 of the Public Finance Management Act 1 of 1999, 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 Public Finance Management Act, 1 of 1999 is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.

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

	2014 R	2013 R
Related party transactions		
Transfer paid to (received from) related parties		
Department of Health	**(4 525 000)**	(4 310 000)
Compensation to accounting authority/non-executive council members:		
Mr T Bailey	**355 429**	384 030
Prof BC Dumisa	**292 509**	278 894
Mr ZL Fihlani	**44 390**	102 934
Mr AK Hoosain	**164 528**	244 604
Ms MO Morata	**196 282**	253 023
Dr L Mpuntsha	**170 901**	63 690
Ms L Nevhutalu	**15 054**	80 288
Mr T Phadu	**109 431**	174 279
Dr RV Simelane	**–**	16 368
Ms A Theophanides	**125 257**	148 996
Prof CJ van Gelderen	**245 507**	257 462
Prof Y Veriava	**264 798**	102 782
Adv CJ Weapond	**281 799**	196 088
Mr TF Zulu	**51 531**	116 958
	2 317 416	2 420 396

21. Related parties (continued)

Compensation to executive management:	Basic salary	Performance bonus	Long service award	Total
2014				
Chief Executive & Registrar	**1 817 886**	**120 376**	**–**	**1 938 262**
Chief Financial Officer	**1 354 369**	**84 986**	**–**	**1 439 355**
Head: Accreditation	**1 301 891**	**–**	**–**	**1 301 891**
Head: Benefits management	**1 206 014**	**70 414**	**–**	**1 276 428**
Head: Compliance and investigation	**1 305 809**	**77 260**	**–**	**1 383 069**
Head: Financial supervision	**1 326 029**	**77 260**	**–**	**1 403 289**
Head: Human resources	**1 341 491**	**77 260**	**108 851**	**1 527 602**
Head: ICT & KM	**1 293 936**	**68 890**	**–**	**1 362 826**
Head: Legal services	**1 328 362**	**84 986**	**–**	**1 413 348**
Acting Head: Research & monitoring – replaced 30/09/2013	**436 445**	**–**	**–**	**436 445**
Head: Research & monitoring – appointed 01/10/2013	**595 597**	**53 992**	**–**	**649 589**
Head: Stakeholder relations	**1 175 502**	**60 782**	**–**	**1 236 284**
Senior strategist – resigned 31/07/2013	**467 759**	**–**	**–**	**467 759**
Senior strategist – appointed 01/12/2013	**372 168**	**–**	**–**	**372 168**
Senior manager: Complaints adjudication	**982 021**	**58 085**	**–**	**1 040 106**
	16 305 279	**834 291**	**108 851**	**17 248 421**
2013				
Chief Executive & Registrar	1 640 536	183 191	–	1 823 727
Chief Financial Officer	1 201 233	133 040	100 788	1 435 061
Head: Accreditation	1 216 179	–	–	1 216 179
Head: Benefits management	1 061 595	119 953	–	1 181 548
Head: Compliance and investigation	1 302 019	120 946	–	1 422 965
Head: Financial supervision	1 229 206	120 946	–	1 350 152
Head: Human resources	1 194 172	108 850	–	1 303 022
Head: ICT & KM	1 220 910	100 385	–	1 321 295
Head: Legal services	1 221 964	133 040	–	1 355 004
Head: Research & monitoring – resigned 31/08/2012	546 911	77 478	–	624 389
Acting Head: Research & monitoring – appointed 01/09/2012	552 343	–	–	552 343
Head: Stakeholder relations – appointed 01/08/2012	684 411	–	–	684 411
Senior strategist	1 163 691	100 385	–	1 264 076
Senior manager: Complaints adjudication	916 647	81 836	–	998 483
	15 151 817	1 280 050	100 788	16 532 655

22. Contingencies

Contingent assets

The CMS won court cases against the following parties:

- Medshield
- Genesis vs CMS and du Toit
- Genesis vs CMS and Joubert

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

23. Risk management

Financial risk management

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

Liquidity risk

The entity's risk of liquidity is a result of payment of its payables. These payables are all due within the short-term. CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account.

Credit risk

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

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

Market risk:

Interest rate risk

As the entity invests surplus funds in the CPD account, the interest rates on this account fluctuate in line with movements on the money market rates.

24. Events after the reporting date

Disclose for each material category of non-adjusting events after the reporting date:

- Nature of the event.
- Estimation of its financial effect or a statement that such an estimation cannot be made.

25. Irregular expenditure

	2014 R	2013 R
Opening balance	**3 825 506**	3 472 451
Current year	**1 416 707**	353 055
Prior years	**1 273 622**	–
Less: amounts condoned	**–**	–
	6 515 835	3 825 506
Analysis of expenditure awaiting condonation per age classification		
Current year	**1 416 707**	353 055
Prior years	**5 099 128**	3 472 451
	6 515 835	3 825 506

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

CMS has applied for condonation from National Treasury but it has not yet been granted. This matter was also discussed at the Standing Committee on Public Accounts (SCOPA) in February 2012.

The CMS incurred irregular expenditure of R353 055 in the prior financial year identified during the previous year's audit of the financial year under review, that it had acquired goods with invalid deviation motivations. The reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/2008 of National Treasury, which allows for deviation from competitive bidding process.

During the audit of the financial year under review, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not applying the preference points for procurements above R30 000 but below R500 000. Management has investigated the extent of the possible irregular expenditure and reports R206 314 expenditure for 2013/14 and R885 753 for prior year.

During the audit of the financial year under review, CMS incurred irregular expenditure of R415 412, and R387 869 for the previous year. It applied to services for staff training and temporary staffing without following the proper legislative procurement process as prescribed by National Treasury, paragraphs 3.3.1 to 3.3.3 of Practice Note 8 of 2007/2008.

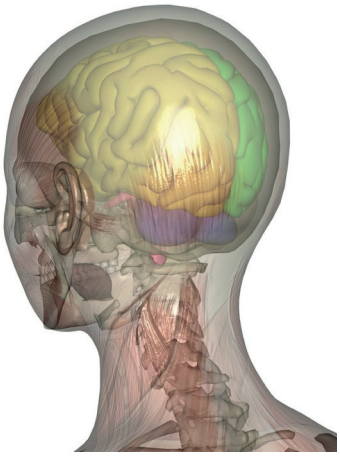
In the current financial year under review, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified to the amount of R794 981 for not awarding the contract to the tenderer who scored the highest points. The tender was awarded to an entity deemed to be an SMME to promote objectives of Government regarding SMMEs, but the goal was not specifically advertised nor was it included in the bid documents.

26. Reconciliation between budget and statement of financial performance

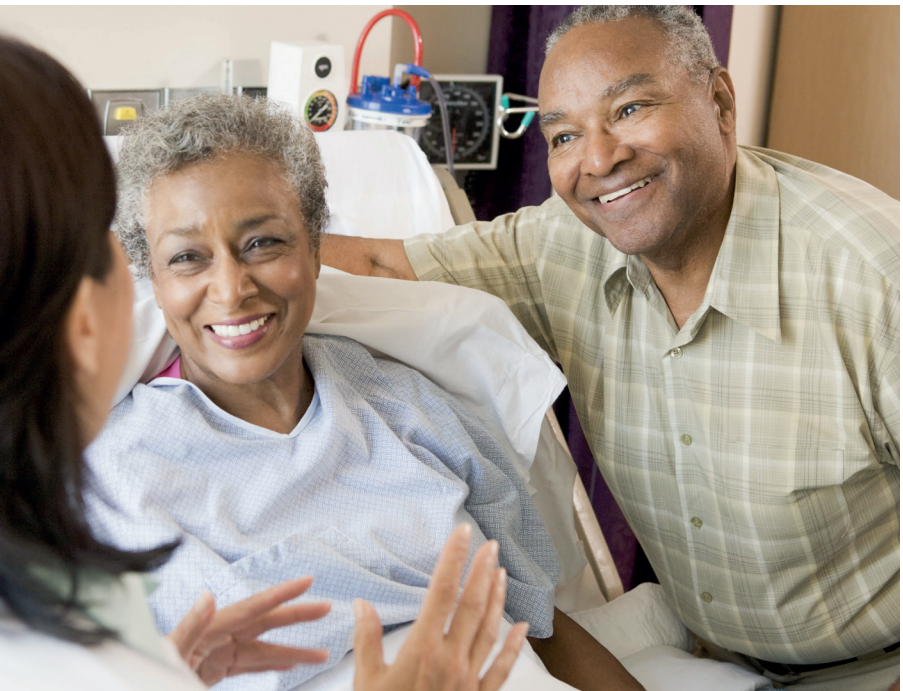
	2014 R	2013 R
Reconciliation of budget surplus/deficit with the surplus/deficit in the statement of financial performance:		
Net surplus per the statement of financial performance	**5 324 921**	4 262 693
Adjusted for:		
Impairments recognised/reversed	**310 000**	–
Loss/(gain) on the sale of assets	**176 423**	(17 482)
Over-collection of revenue	**(3 467 899)**	(4 734 671)
Under/(over) budget expenditure	**(2 083 972)**	1 059 087
Net surplus per approved budget	**259 473**	569 627

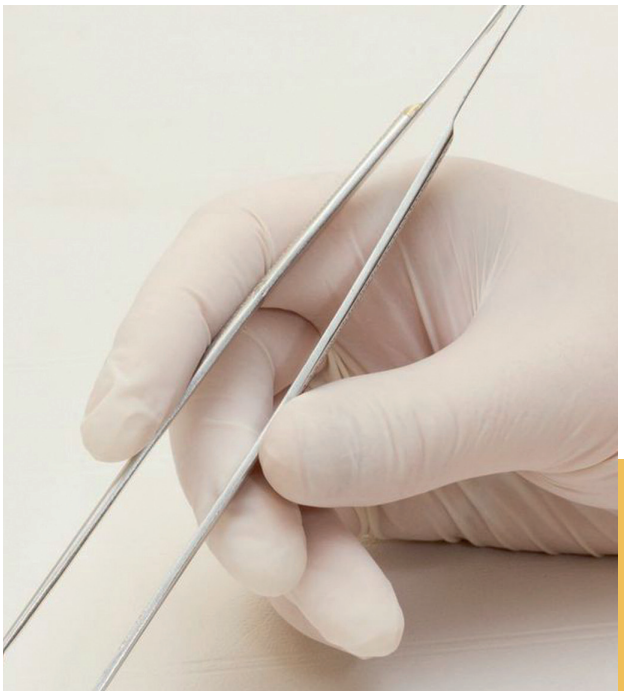
27. Budget differences

The budget and the accounting bases differ. The annual financial statements are prepared on the accrual basis using a classification based on the nature of expenses in the statement of financial performance. The annual financial statements differ from the budget, which is approved on the cash basis.



The medical schemes **INDUSTRY IN 2013**





CHAPTER 2: THE MEDICAL SCHEMES INDUSTRY IN 2013

This section of the CMS Annual Report 2013/14 is based on the 2013 annual statutory returns of all medical schemes operating in the country. The analysis of this data provides insight into the state of the industry in 2013. Combined with comparable data submitted over the past decade, it affords an appreciation of trends and changes in the functioning of medical schemes.

Number of schemes and options

The downward trend in the total number of medical schemes that has been noted for several years continued in 2013. It was most pronounced among small restricted schemes. At the end of 2013, there were 87 medical schemes registered in South Africa, compared to 93 at the end of 2012.

In 2013, the number of open schemes decreased by one to 24 and the number of restricted schemes declined by five to 63. The sustained reduction in the number of schemes for the past 10 years can be seen in Figures 11 and 12.

Table 39: Number of schemes by size and type as at 31 December 2012 and 2013

Type of scheme	Size of scheme	2012	2013
Open schemes	Large*	14	14
	Medium**	8	8
	Small***	3	2
Restricted schemes	Large*	17	16
	Medium**	17	17
	Small***	34	30
All schemes	**Large***	**31**	**30**
	Medium**	**25**	**25**
	Small***	**37**	**32**

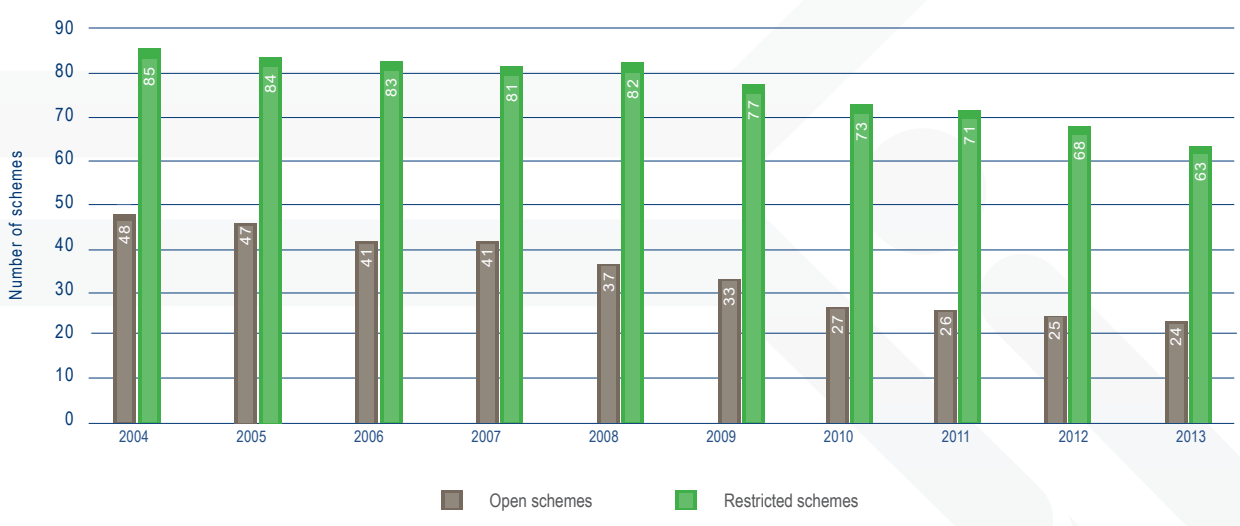
* *Large scheme = ≥ 30 000 beneficiaries*
** *Medium scheme = ≥ 6 000 members but < 30 000 beneficiaries*
*** *Small scheme = < 6 000 members*

The 2012 figures have been restated.

Trend in average number of options

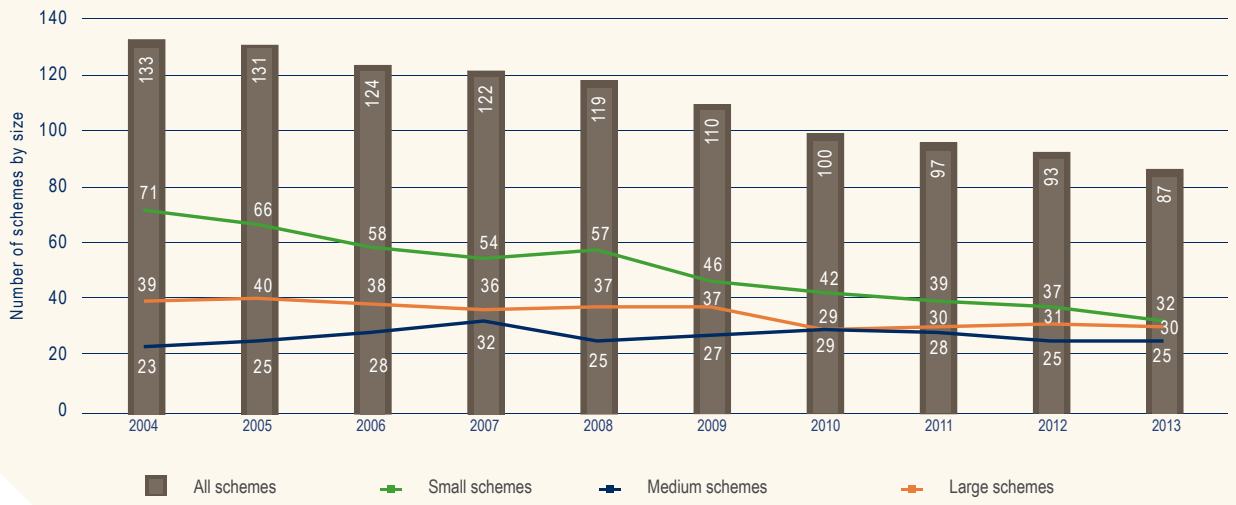
The average number of options per medical scheme has consolidated at between five and six options in the open scheme market and at two in the restricted scheme market. The trend in the average number of options per scheme for the past 10 years is illustrated in Figure 13.

Figure 11: Number of schemes 2004 – 2013



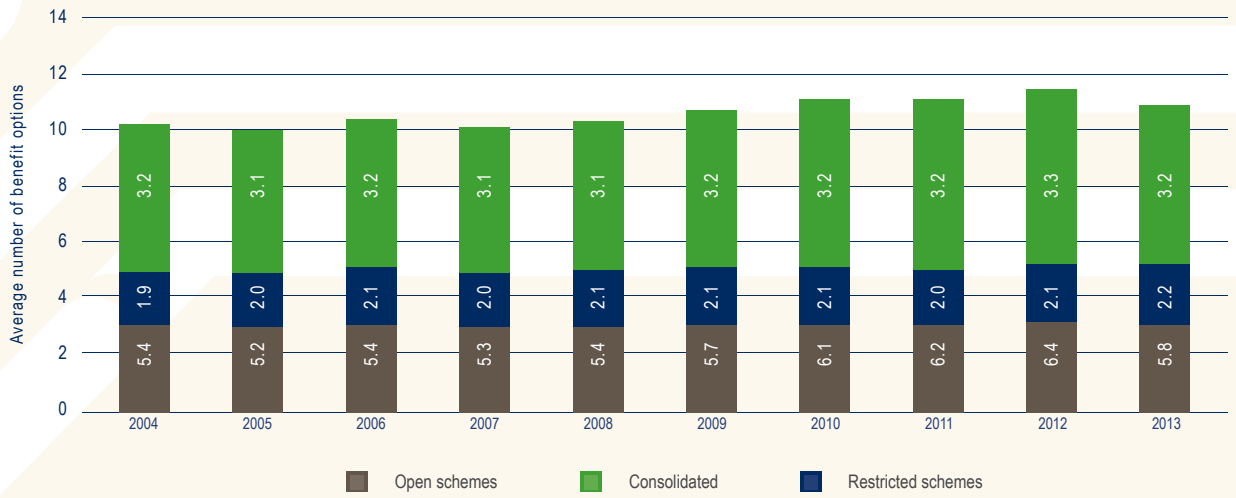
* *The 2012 figures have been restated.*

Figure 12: Number of schemes by size 2004 – 2013



* *The 2012 figures have been restated.*

Figure 13: Average number of options 2004 – 2013



Membership of medical schemes

There was a year-on-year increase of 1.1% in the total number of medical scheme beneficiaries from 31 December 2012 to 31 December 2013. The total number of medical scheme beneficiaries increased from 8 682 200 to 8 776 279 in the 2013 benefit year. The average beneficiary increase from 2012 to 2013, taken across all months and allowing for fluctuations, was 1.7%.

On a year-on-year basis, there was virtually no increase in the membership of restricted schemes, while an increase of 1.8% was registered for open schemes. See Table 40 for more detail.

Table 40: Membership of schemes 2012 and 2013

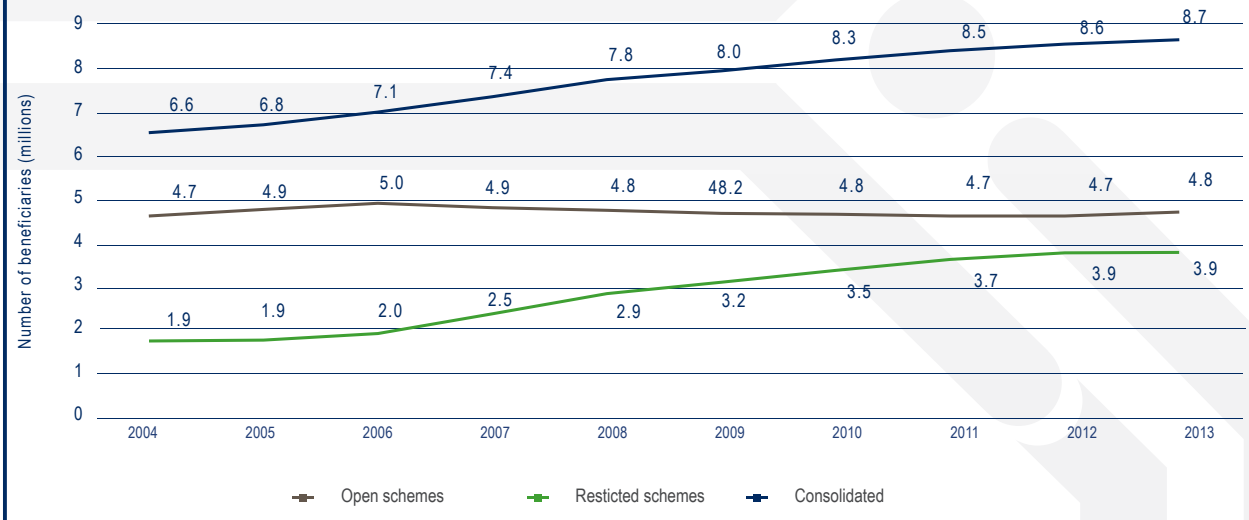
Type of scheme	Year (December)	Members	Dependants	Beneficiaries	% change
Open schemes	2012	2 197 454	2 562 540	4 759 994	
	2013	2 256 168	2 590 741	4 846 909	1.8
Restricted schemes	2012	1 618 884	2 303 322	3 922 206	
	2013	1 622 099	2 307 271	3 929 370	0.2
All schemes	**2012**	**3 816 338**	**4 865 862**	**8 682 200**	
	2013	**3 878 267**	**4 898 012**	**8 776 279**	**1.1**

Trends in the number of beneficiaries

Figure 14 depicts the trend in medical scheme coverage for the past 10 years. The number of beneficiaries increased to 8.78 million in 2013 from 6.66 million in 2004. This represents an increase of 31.7% over the course of a decade. Beneficiaries belonging to open schemes constitute 55.2% of the total number of beneficiaries with those in restricted schemes accounting for the remaining 44.8%.

There is a noticeable increase in beneficiaries of restricted schemes from 2006/7, but this is off a low base relative to open schemes. The growth in beneficiaries belonging to restricted schemes really started with the inception of the Government Employees Medical Scheme (GEMS), but it appears that membership of GEMS has started to stabilise and this reflects in slower growth for the restricted scheme market as a whole.

Figure 14: Number of beneficiaries 2004 – 2013



Average age, pensioner ratio and gender distribution

Table 41 shows the average age of beneficiaries and proportion of pensioners (beneficiaries aged 65 years and older) by scheme type and gender. The average age of male beneficiaries is much lower than that of females. The pensioner ratio remains constant at 7.1% for the industry, but the pensioner ratio is higher for females than males.

Table 41: Average age of beneficiaries and pensioner ratio 2012 and 2013 (%)

Type of scheme	Gender	Average age of beneficiaries and pensioner ratio	2013	2012
Open schemes	Female	Average age in years	34.2	34.4
		Pensioner ratio (%)	9.0	8.9
	Male	Average age in years	32.8	33.2
		Pensioner ratio (%)	7.3	7.5
	Total	**Average age in years**	**33.5**	**33.8**
		Pensioner ratio (%)	**8.2**	**8.2**
Restricted schemes	Female	Average age in years	31.1	30.9
		Pensioner ratio (%)	6.6	6.5
	Male	Average age in years	28.8	28.8
		Pensioner ratio (%)	4.8	4.7
	Total	**Average age in years**	**30.0**	**29.9**
		Pensioner ratio (%)	**5.8**	**5.7**
All schemes	Female	Average age in years	32.8	32.8
		Pensioner ratio (%)	7.9	7.8
	Male	Average age in years	31.0	31.2
		Pensioner ratio (%)	6.2	6.3
	Total	**Average age in years**	**31.9**	**32.0**
		Pensioner ratio (%)	**7.1**	**7.1**

Figure 15 shows the age and gender distribution of medical scheme beneficiaries for 2012 and 2013. A bimodal distribution is again evident, for both male and female beneficiaries. Age bands <1 to 15 – 19 years featured more male beneficiaries while female beneficiaries outnumbered males in the age groups 20 years and older. Over all age groups, in 2013, 52.4% of all beneficiaries were female and 47.6% male.

The average age of medical scheme beneficiaries in 2013 was 31.9 years, slightly younger than the 32 years reported in 2012. Female beneficiaries were generally older than male beneficiaries. The average age of female medical scheme beneficiaries was 32.8 years in 2013 and that of males 31.0 years.

Trend in the average age of beneficiaries

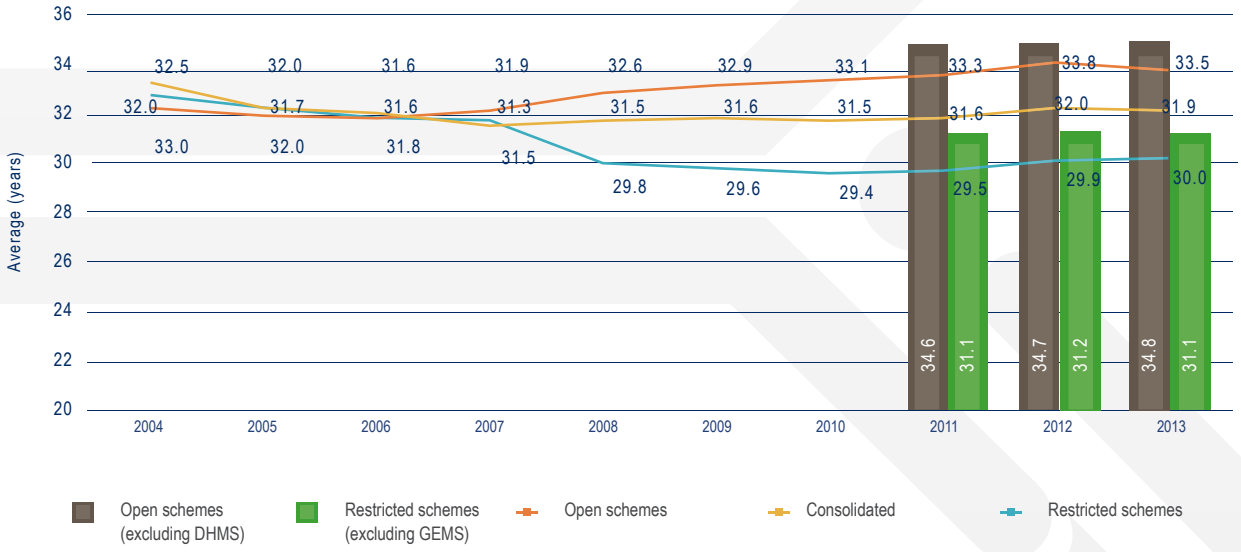
Figure 16 shows the trend in the average age of beneficiaries from 2004 to 2013. It indicates that members of restricted medical schemes were older than those of open schemes until 2006. This changed in 2007, primarily due to the introduction of GEMS, when beneficiaries of restricted schemes were suddenly younger than open schemes.

The impact of GEMS and Discovery Health Medical Scheme (DHMS) on restricted and open schemes respectively is also reflected in Figure 16.

Figure 16 further illustrates that the average age of beneficiaries of open schemes in 2013 was 33.5 years (and would be 34.8 years if DHMS was excluded) while the average age of beneficiaries of restricted schemes in 2013 was 30.0 years (and would have been 31.1 years without GEMS).

Figure 15: Age and gender distribution of beneficiaries 2012 and 2013

Figure 16: Age of beneficiaries 2004 – 2013

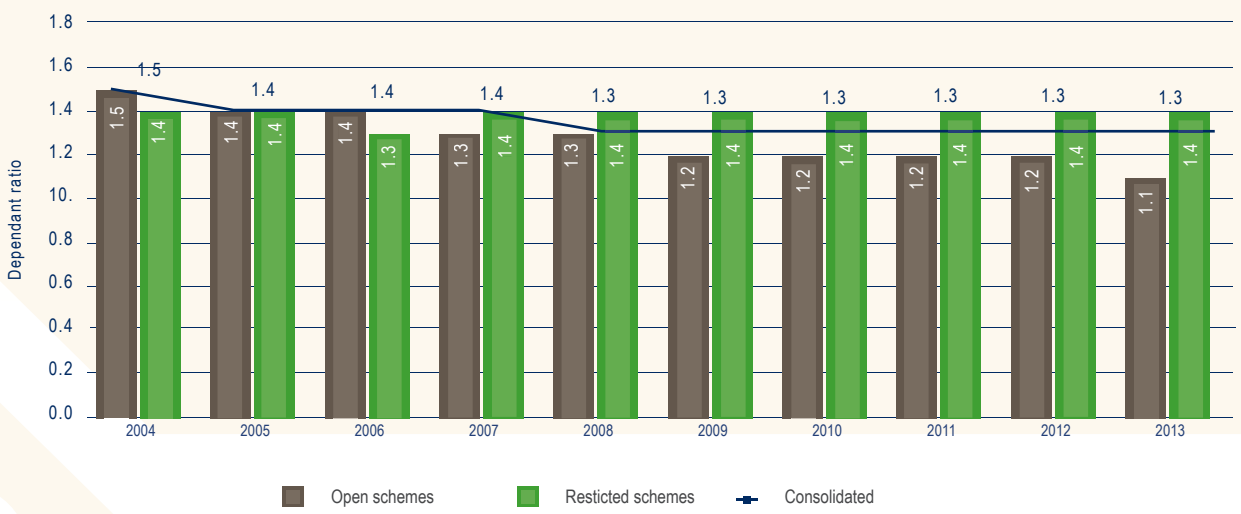


Dependant ratio

The dependant ratio measures the average number of dependants per principal member. It remained unchanged across the entire industry in 2013, at 1.3. The dependant ratio for restricted schemes also remained unchanged, but for open schemes there was a fractional decrease.

Figure 17 illustrates that the overall dependant ratio has declined steadily between 2004 and 2013.

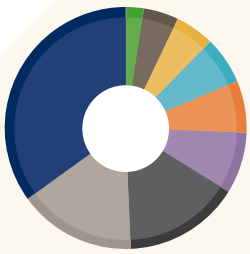
Figure 17: Dependant ratio in schemes 2004 – 2013



Coverage by province

Figure 18 shows the distribution of beneficiaries by province. This data was collected primarily on the basis of the location of principal members. More than one-third of beneficiaries (34.96%) were located in Gauteng. This translates to slightly more than 3 million beneficiaries. KwaZulu-Natal accounted for 1.37 million beneficiaries (15.71% of the total) and the Western Cape had 1.35 million beneficiaries (15.49%).

Figure 18: Proportional distribution of beneficiaries by province in 2013



- Northern Cape – 2.31%
- Free State – 4.67%
- Limpopo – 5.27%
- North West – 6.32%
- Mpumalanga – 6.96%
- Eastern Cape – 8.20%
- Western Cape – 15.49%
- KwaZulu-Natal – 15.71%
- Gauteng – 34.96%
- Outside the Republic – 0.11%

Table 42: Provincial changes in membership between 2012 and 2013

Province	2013	2012	Growth (%)
Outside South Africa	9 653	7 959	21.3
Northern Cape	202 853	198 857	2.0
Free State	410 114	407 891	0.5
Limpopo	462 137	452 987	2.0
North West	555 033	533 463	4.0
Mpumalanga	611 226	625 779	-2.3
Eastern Cape	719 282	709 197	1.4
Western Cape	1 359 220	1 348 318	0.8
KwaZulu-Natal	1 378 996	1 366 161	0.9
Gauteng	3 067 765	3 031 588	1.2
Total	**8 776 279**	**8 682 200**	**1.1**

The provincial distribution of membership for 2013 is very similar to 2012. The biggest percentage increase was outside of South Africa, but the numbers involved are small.

Healthcare benefits

Total healthcare benefits paid

The total healthcare benefits paid is the sum of the benefits paid from the risk pools of medical schemes and the savings accounts of the members. Medical schemes spent 8.9% more on healthcare benefits in 2013 than in 2012. This expenditure increased (in nominal terms) to R112.5 billion in 2013 from R103.3 billion in 2012.

The average amount spent per beneficiary per annum (pbpa) went up by 7.1% in 2013, from R12 008 to R12 859.

Figure 19 shows the proportions of benefit expenditure paid by medical schemes to various categories of healthcare providers in 2013.

Figure 19: Distribution of total healthcare benefits paid 2013

Total hospital expenditure by medical schemes – which includes ward fees, theatre fees, consumables, medicines and per diem arrangements – consumed R39.7 billion or 35.3% of the R112.5 billion that medical schemes paid to all healthcare providers in 2013.

Total medical scheme expenditure on private hospitals increased by 4.9% to R39.4 billion from R37.5 billion in 2012. The average amount pbpa increased by 3.1%, from R4 367.20 in 2012 to R4 503.90 in 2013.

Payments to medical specialists amounted to R27.5 billion or 24.5% of total healthcare benefits paid in 2013. This was an increase of 14.6% on 2012. Healthcare benefits which medical schemes paid for medicines dispensed by pharmacists and providers other than hospitals amounted to R18 billion or 16% of total healthcare benefits paid. This was an increase of 10.4% compared to the R16.3 billion spent in 2012. Expenditure on general practitioners (GPs) amounted to R7.8 billion or 7% of healthcare benefits paid, representing an increase of 4.8% on the 2012 figure of R7.4 billion.

The most significant increase in benefits paid in 2013 was in respect of support and allied health professionals. The amount increased by 19% from R7.9 billion in 2012 to R9.4 billion in 2013. This category accounted for 8.4% of all benefits paid by schemes in 2013.

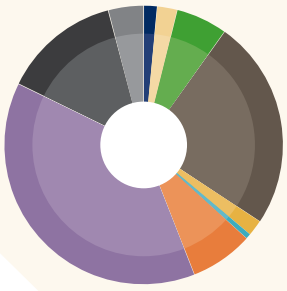
Healthcare benefits paid from risk pools

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 20.

Healthcare benefits which medical schemes covered from their risk pools amounted to R101.3 billion in 2013 compared to R93.3 billion in 2012, an increase of 8.7%. The average risk amount pbpa increased by 6.9% to R11 583.70 in 2013 compared to R10 838.60 in 2012.

Hospital expenditure accounted for 39.1% of risk benefits paid in 2013. Expenditure on medical specialists accounted for 25% of total risk pool benefits. Medicines consumed 14% of the pie, while risk pool expenditure on GPs was R6.2 billion or 6.1% of total risk pool benefits.

Figure 20: Healthcare benefits paid from risk pool 2013

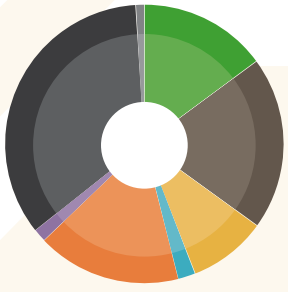


- General practitioners – 6.1%
- Medical specialists – 25.0%
- Dentists – 1.9%
- Dental specialists – 0.6%
- Support and allied health professionals – 7.5%
- Total hospitals – 39.1%
- Total medicines – 14.0%
- Other benefits – 4.2%
- Managed care arrangements (out-of-hospital benefits) – 2.4%
- Ex gratia payments – 1.6%

Healthcare benefits paid from personal medical savings accounts

Of total healthcare benefits paid, medical schemes paid R11.1 billion (9.9%) from beneficiaries' personal medical savings accounts in 2013. Figure 21 shows that medicines absorbed the largest share of savings accounts expenditure in 2013 (34.7%). Medical specialists accounted for 20.1% and GPs for 14.9%. Support and allied health professionals took up 16.8% of healthcare benefits paid from savings accounts.

Figure 21: Healthcare benefits paid from savings accounts 2013



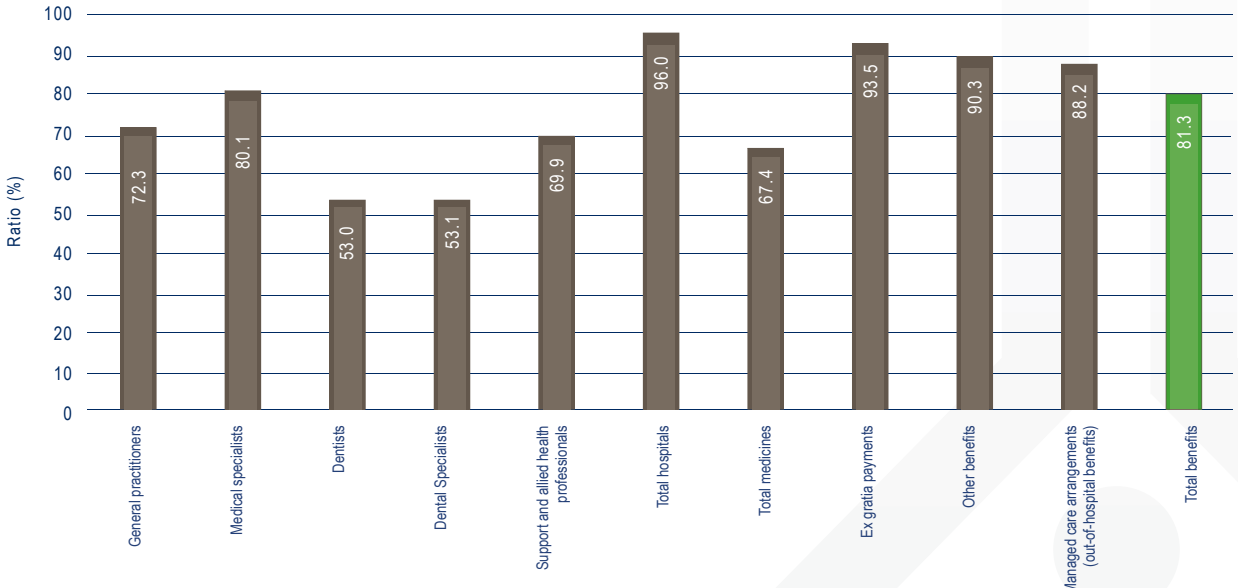
- General practitioners – 14.9%
- Medical specialists – 20.1%
- Dentists – 9.1%
- Dental specialists – 2.0%
- Support and allied health professionals – 16.8%
- Total hospitals – 1.5%
- Total medicines – 34.7%
- Other benefits – 1.0%
- Managed care arrangements (out-of-hospital benefits) – 0.0%
- Ex gratia payments – 0.0%

Healthcare benefits paid out-of-pocket

Collection of data on out-of-pocket payment is a challenge due to under-reporting by both members and medical schemes. Figure 23 should therefore be interpreted with caution.

The percentages shown in Figure 22 are a ratio of the risk amount paid by the schemes to the amount invoiced by healthcare providers. In total, 81.3% of all benefits charged by the providers were paid by schemes from their risk pools and 18.7% of the total was paid out-of-pocket by members. In restricted schemes, members paid a total of 11.8% out-of-pocket, compared to 23.8% in the open scheme industry. The out-of-pocket amount included payments from the personal medical savings accounts of beneficiaries.

Figure 22: Proportion of amounts charged for healthcare paid from risk pool in 2013

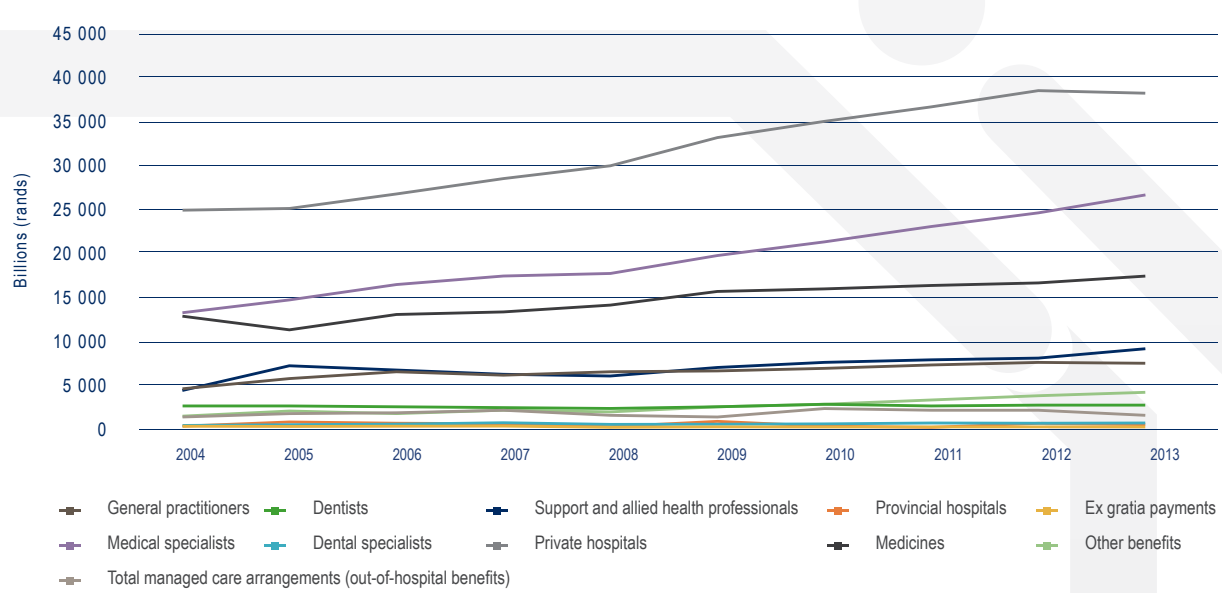


Medical scheme members paid 47% of the amounts charged by dentists out-of-pocket and 46.9% of the charges of dental specialists.

Trends in total healthcare benefits paid

Figure 23 shows trends in the distribution of healthcare benefits that medical schemes paid to various categories of service providers since 2004. These figures have been adjusted for inflation with 2013 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2013 prices.

Figure 23: Total healthcare benefits paid 2004 – 2013: 2013 prices*



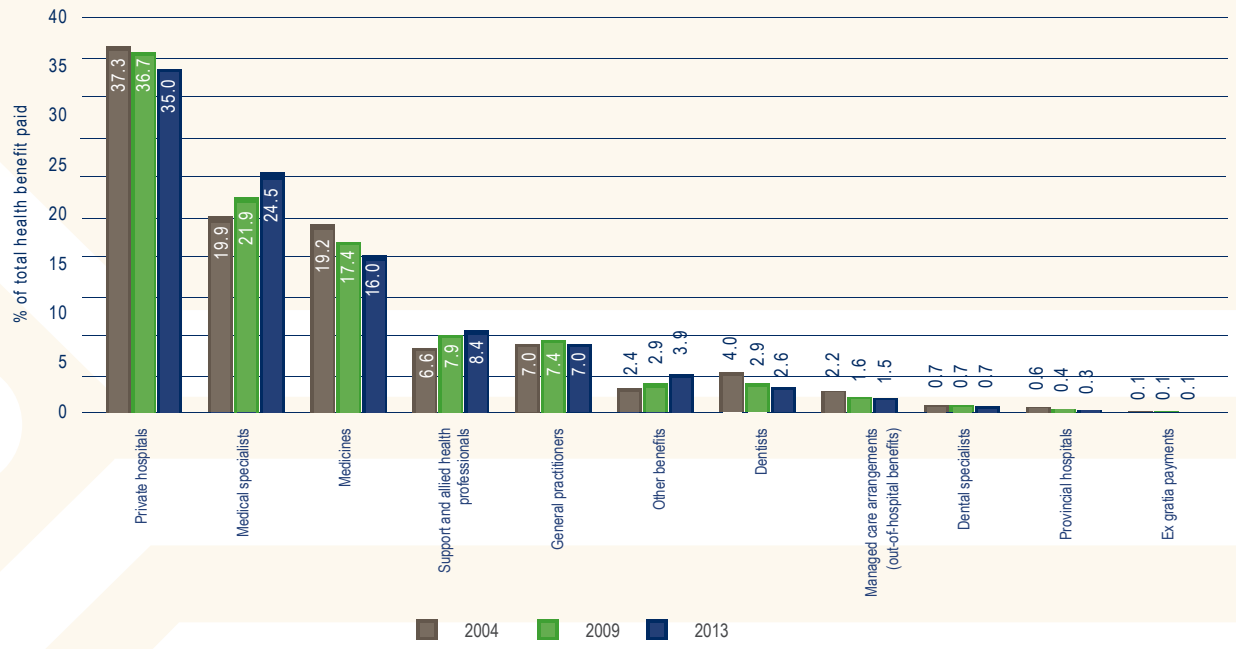
* *All values are adjusted for inflation using the Consumer Price Index (CPI) for 2013 as a base period.*
** *Historical values are revised when the base period changes and will not correspond to the values reported in the 2012 annual report.*

Medical schemes' expenditure on private hospitals decreased slightly in real terms by -0.8% to R39.4 billion in 2013, compared to R39.7 billion in 2012. However, Figure 23 illustrates the sustained increase in expenditure on private hospitals, rising from R25.7 billion in 2004 to R39.4 billion in 2013. 2013 was the first year since 2005 in which there was no significant increase in expenditure paid to hospitals. However, the bulk of medical schemes' total expenditure was still being paid to hospitals and medical specialists.

Benefits paid to medical specialists in 2013 amounted to R27.5 billion in real terms, an increase of 8.4% in real terms when compared to the R25.4 billion spent on this item in 2012.

Figure 24 shows the proportion of healthcare benefits that medical schemes paid to various categories of service providers in the periods 2004, 2009 and 2013.

Figure 24: Proportional distribution of healthcare benefits in 2004, 2009 and 2013: nominal terms



Private hospital expenditure accounted for 37.3% of all healthcare benefits paid by medical schemes in 2004; the comparative figure in 2009 was 36.7% which decreased further to 35% in 2013. Despite this downward trend, the bulk of total benefit expenditure by schemes was still allocated to private hospitals.

Expenditure on medical specialists has increased from 19.9% of the total expenditure in 2004 to 24.5% in 2013. Medical specialists and private hospitals constitute the bulk of the expenditure with a combined share of 59.5% of the total in 2013.

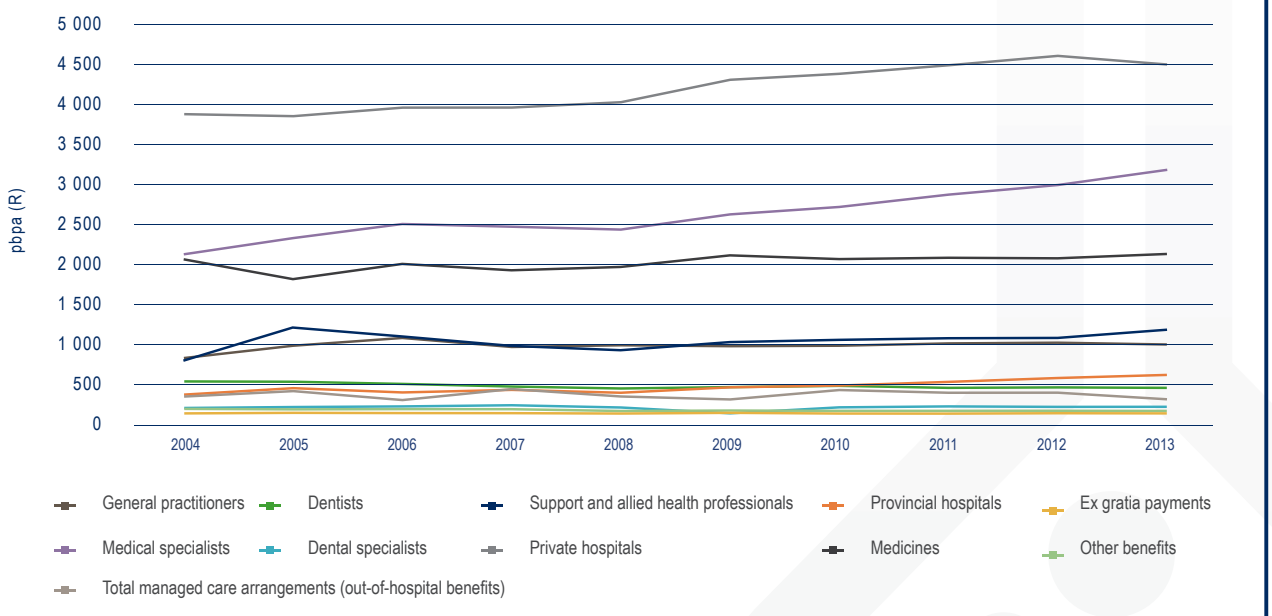
Healthcare benefits paid per beneficiary

Figure 25 shows the changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2004 to 2013 in real terms (at 2013 prices). For the first time since 2005, the amount spent per average beneficiary per annum on private hospitals has decreased. The amount paid in real terms on private hospitals decreased by 2.4% from R4 615 pabpa in 2012 to R4 504 pabpa in 2013.

The amount spent on medical specialists increased in real terms from R2 951 pabpa in 2012 to R3 147 pabpa in 2013, an annual increase of 6.6%. There was an increase of 10.8% in real terms for the benefits paid for support and allied health professionals from 2012 to 2013.

It should be noted that the annual growth in membership must always be taken into account when considering changes in the total expenditure of schemes.

Figure 25: Total healthcare benefits paid papba 2000 – 2013: 2013 prices*



* *All values are adjusted for inflation using the Consumer Price Index (CPI) for 2013 as a base period.*
** *Historical values are revised when the base period changes and will not correspond to the values in the 2012 annual report.*

Utilisation of healthcare services

Preventive services

The CMS is aware that matters of definition may lead to inconsistent extraction and interpretation of utilisation data. The Industry Technical Advisory Panel (ITAP) is currently engaged in a project to define indicators and this will improve data quality on utilisation across the industry. Schemes will be consulted in the course of the project. There is also a possibility that utilisation data will be collected through a new statutory portal in future.

Table 43 illustrates preventive benefits for female beneficiaries. The number of mammograms that medical schemes paid for in respect of female beneficiaries aged 50 to 69 years increased from 92 per 1 000 female beneficiaries in 2012 to 217 in 2013. More mammograms were paid for in open schemes than in restricted schemes, at 300 per 1 000 female beneficiaries and 91 per 1 000 female beneficiaries respectively.

The number of pap smears paid for in 2013 was 111 per 1 000 female beneficiaries in the age band 15 – 69 years, compared to 42 in the previous year. Open schemes again reported higher utilisation rates than restricted schemes.

Table 43: Utilisation of preventive services by female beneficiaries 2012 and 2013

	2013			2012*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of mammograms paid for (per 1 000 female beneficiaries aged 50 – 69 years)	300	91	217	92
Number of pap smears paid for (per 1 000 female beneficiaries aged 15 – 69 years)	166	42	111	42

* *The 2012 figures have been restated.*

Primary healthcare services: visits to GPs and dentists

The average number of visits to a GP in 2013 was almost three visits per 1 000 beneficiaries and there were no increases in the number of GP, dentist and nurse visits from 2012 to 2013. It appears that members of restricted schemes visit their GPs on a more regular basis.

Table 44: Utilisation of primary healthcare services 2012 and 2013 (per 1 000 beneficiaries)

	2013			2012*
	Open schemes	Restricted schemes	All schemes	All schemes
Number of GP visits (per 1 000 beneficiaries)	2.6	3.3	2.9	2.9
Number of dentist visits (per 1 000 beneficiaries)	0.4	0.4	0.4	0.4
Number of nurse visits (per 1 000 beneficiaries)	0.0	0.1	0.1	0.1

* *The 2012 figures have been restated.*

Private hospital services

Table 45 illustrates the utilisation of private hospital services. The most significant year-on-year increase was for inpatient admissions for medical cases and it was much higher for open schemes than restricted schemes. Most hospital admission statistics were higher for open schemes, except for maternity admissions. There were 64.4 maternity admissions per 1 000 female inpatient admissions for open schemes compared to 88.3 for restricted schemes in 2013.

Table 45: Utilisation of private hospital services 2012 and 2013

	2013			2012*
	Open schemes	Restricted schemes	All schemes	All schemes
Total number of outpatient visits (per 1 000 beneficiaries)	79.1	43.3	63.1	66.6
Number of inpatient admissions (per 1 000 beneficiaries)	216.8	188.5	204.1	195.7
Number of same-day inpatients (per 1 000 beneficiaries)	65.6	59.1	62.7	59.5
Total number of inpatient admissions for medical cases (per 1 000 inpatient admissions)	436.4	141.5	314.5	289.6
Total number of inpatient admissions for surgical cases (per 1 000 inpatient admissions)	396.7	373.8	387.2	396.8
Total number of inpatient admissions for maternity cases (per 1 000 female inpatient admissions)	64.4	88.3	74.3	76.8
Total number of inpatient admissions for cathlab cases (per 1 000 inpatient admissions)	24.5	19.7	22.5	22.6

* *The 2012 figures have been restated.*

Burden of disease

Figure 26 shows the prevalence of the prescribed minimum benefit (PMB) chronic conditions which medical schemes are required by law to cover in full on all their benefit options.

The analysis for 2013 showed that the most prevalent PMB chronic condition among medical scheme beneficiaries was hypertension at 118.2 cases per 1 000 beneficiaries (117.1 in 2012), followed by hyperlipidaemia at 53.6 (53.4 in 2012), diabetes mellitus type 2 at 34.5 (34.4 in 2012), and asthma at 28.1 (28.0 in 2012).

The prevalence of PMB chronic conditions was generally higher in open schemes, but cardiac failure and HIV were more prevalent in restricted schemes.

Figure 26: PMB chronic conditions among beneficiaries 2012 and 2013

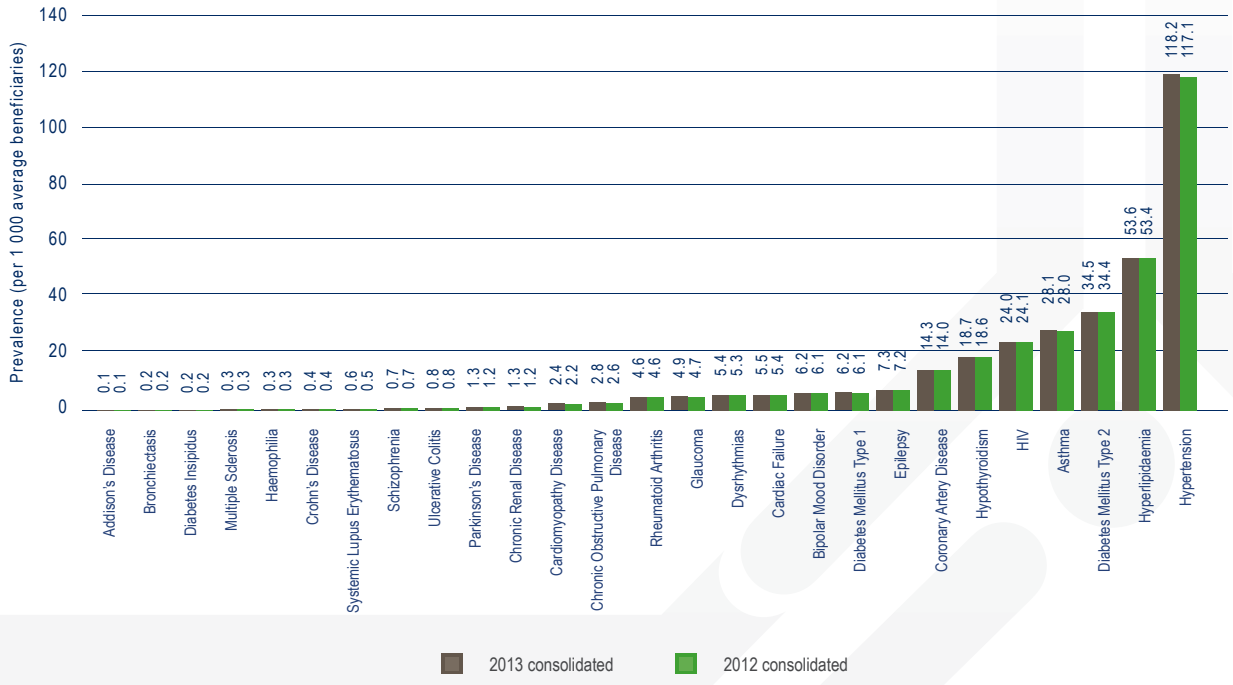
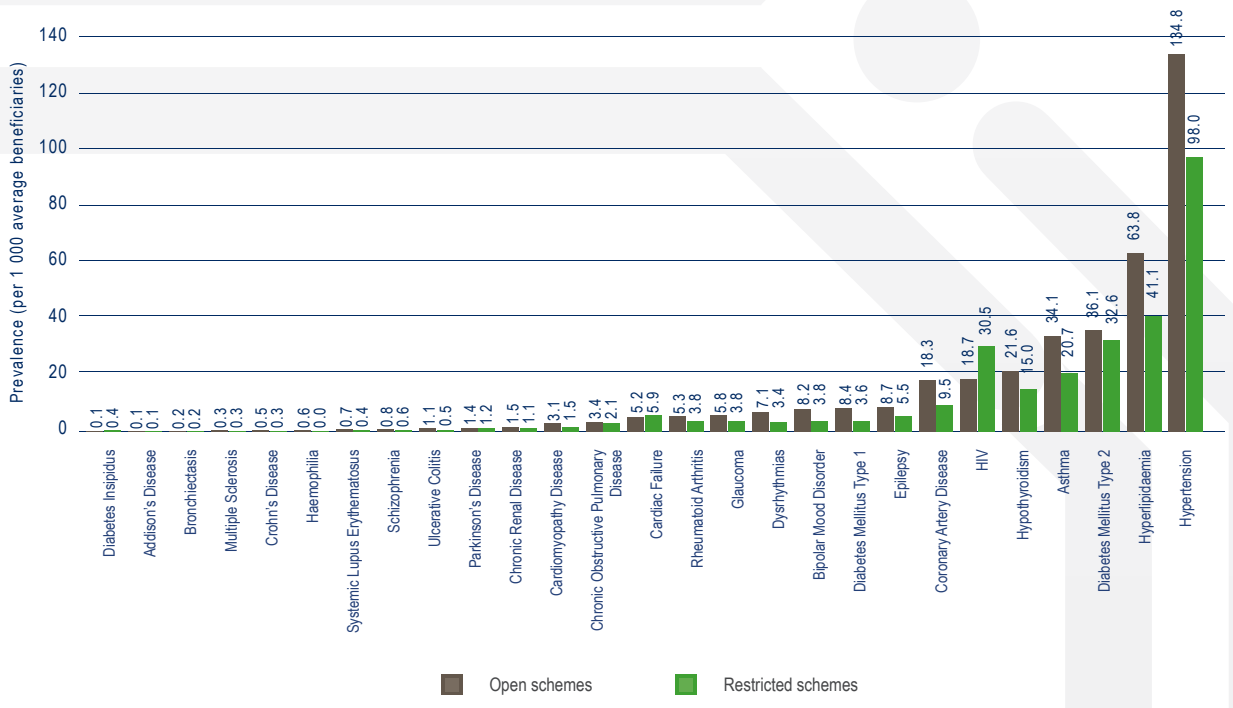


Figure 27: PMB chronic conditions in open and restricted schemes 2013



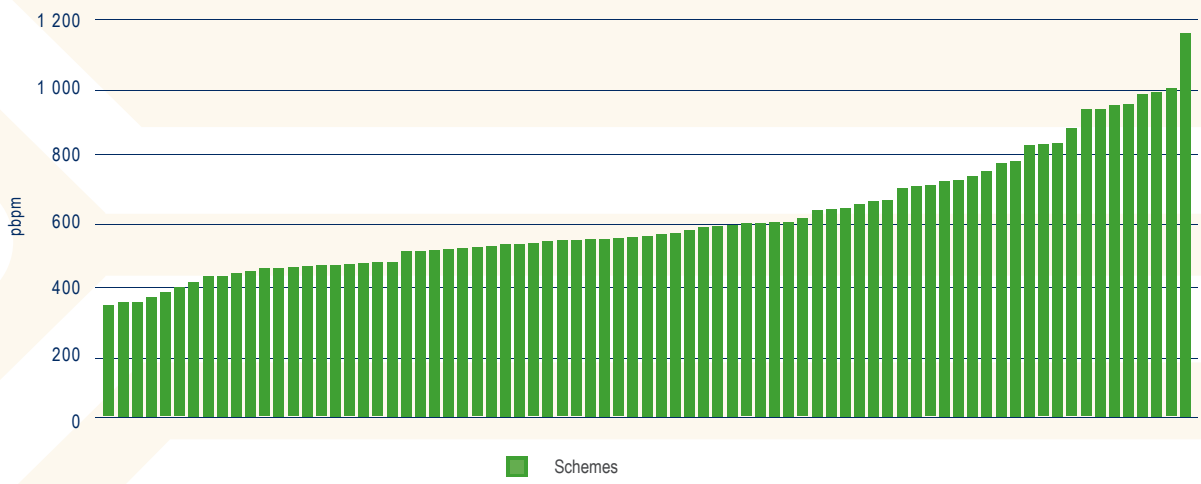
Prescribed minimum benefits and risk profiles of schemes

The CMS continues to collect risk profile data from medical schemes in the same format used for the Risk Equalisation Fund (REF) shadow process. It is now called the Scheme Risk Measure (SRM) process and it is one of the ITAP-related projects. The CMS used the data to analyse the risk profiles of medical schemes, including trends in the prevalence of chronic conditions in the industry. Participation from the industry in the SRM process is excellent and more than 80 schemes submitted their 2013 data on time. The submissions represent approximately 8.5 million beneficiaries or 96% of those covered by the industry.

The purpose of this section is to highlight the variations in risk that medical schemes experience. Risk is measured in terms of the expected PMB cost per beneficiary per month (pbpm). A comprehensive report on the SRM returns will be released and will include further details on participation, methods, the data collection process and data quality as well as a full set of results.

The 2013 difference among schemes in relation to the scheme community rate can be seen in Figure 29 which clearly shows that schemes do not compete at the same level. Competition among schemes is not fair and a system of risk adjustment that was proposed previously could equalise the cost of providing benefits to members across medical schemes. This would encourage schemes to compete in terms of efficiency rather than on their membership profile.

Figure 28: Scheme community rate for December 2013

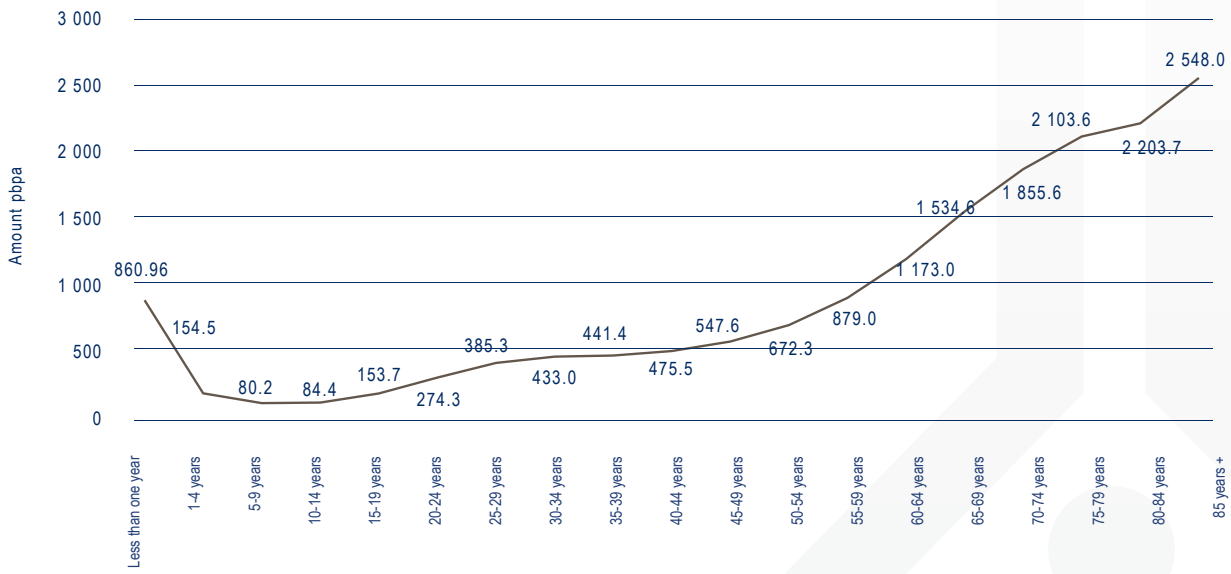


Note: The PMB exempted schemes were excluded in the graph above.

The scheme community rate varied between R332.3 and R1 150.4 per beneficiary per month (pbpm) for December 2013. The amounts and variation were very similar for the other months of 2013. The expected industry community rate for 2013 was R508.2 pbpm, which is an estimate of the cost of the PMB benefit package for 2013.

The CMS also expanded the statutory data specification to collect more information on PMBs. Figure 29 shows the average cost of PMBs pbpm. For babies under one year of age, the average cost per month was R860.96 and for a beneficiary 85 years or older, the average monthly cost was R2 548.0.

Figure 29: The average cost of PMBs by age band for 2013



The average cost across all age groups is R512.8 pbpm which correlates very well with the SRM estimate of R508.2. The total amount paid for the PMBs was R54 010 279 052 and this amounted to 53% of all risk benefits paid for 2013. The top 10 Diagnosis and Treatment Pairs (DTPs) are shown in Table 46.

Table 46: Amounts paid for top 10 diagnosis and treatment pairs in 2013

DTP Code	Diagnosis	Amount paid
52N	Pregnancy	R3 713 619 943
903D	Bacterial, viral and fungal pneumonia	R2 338 525 879
902T	Major affective disorders, including unipolar and bipolar depression	R2 006 185 759
907E	Acute and sub-acute ischaemic heart disease, including myocardial infarction and unstable angina	R1 562 840 966
902H	Closed fractures/dislocations of limb bones/epiphyses (excluding fingers and toes)	R1 371 905 389
901B	Cataract or aphakia	R1 359 419 320
56N	Respiratory conditions of new-born babies	R1 244 807 848
950J	Cancer of breast (treatable)	R1 057 744 932
941A	Spinal cord compression, ischaemia or degenerative disease NOS	R1 000 854 542
904S	Metastatic infections or septicaemia	R752 710 912

The top 10 DTPs listed in Table 46 constitute 40.5% of all the benefits paid for DTPs. Unfortunately there are currently no entry and verification criteria for the DTPs and the results should therefore be interpreted with caution.

Contributions, relevant healthcare expenditure[1] and trends

Scheme contributions increased by 10.4% over the course of 2013, standing at R129.8 billion as at December 2013. Contributions for the whole of 2012 amounted to R117.6 billion. The total gross relevant healthcare expenditure by medical schemes increased by 8.9% to R112.9 billion[2] from R103.7 billion in 2012.

1. *All references to claims and benefits indicate relevant healthcare expenditure.*
2. *This number differs from the R101.4 billion reported above as "benefits paid" it includes IBNR and the results of risk transfer arrangements in this section.*

Gross contributions pabpm grew by 8.6% to R1 235.8 from R1 138.2 in 2012. The total gross relevant healthcare expenditure incurred per average beneficiary per month (pabpm) increased by 7.1% to R1 075.3 from R1 003.8 in 2012.

Risk contribution and relevant healthcare expenditure

Risk contributions (net of medical savings accounts contributions) increased by 10.3% to R117.7 billion from R106.8 billion in 2012. The increase from 2011 to 2012 was 9.4%.

In 2013, the increase in risk contributions pabpm was 8.5%, rising to R1 121.0 from R1 033.6 in 2012. The rate of increase for 2012 was 6.9%.

Risk claims increased by 8.7% to R101.8 billion from R93.6 billion in 2013 (2012: 10.9%). Risk claims pabpm rose by 6.9% to R969.1 from R906.3 (2012: 8.4%).

Medical savings accounts contributions and relevant healthcare expenditure

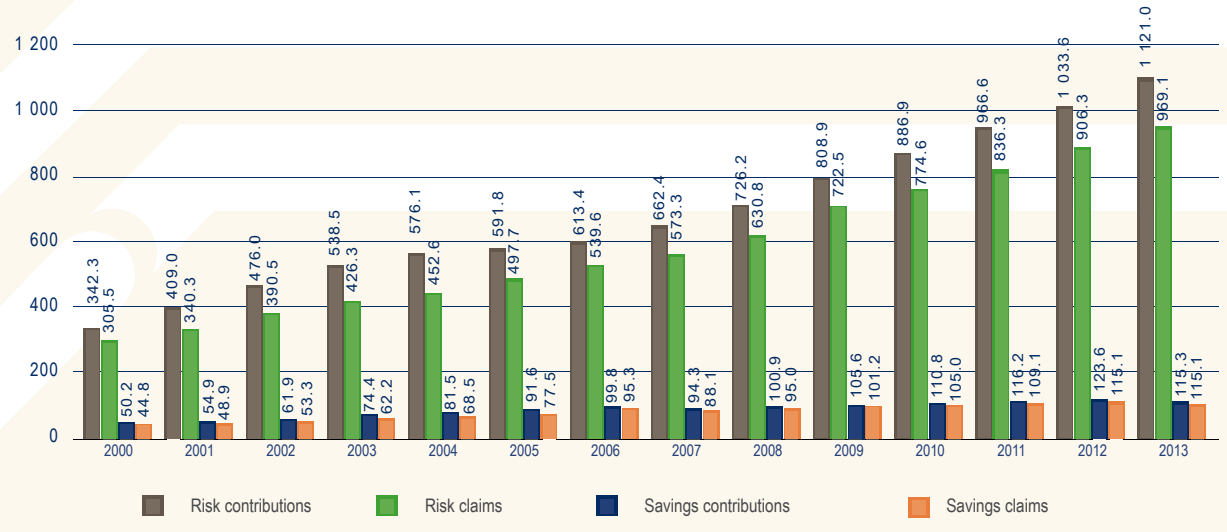
Contributions to medical savings accounts increased by 11.6% in 2013 to R12.1 billion from R10.8 billion (2012: 10.0% increase). When measured on a pabpm basis only for those schemes which use medical savings accounts, the increase was 11.4% – from R123.3 to R137.3 (2012: 6.1% increase).

Claims paid from medical savings accounts increased by 10.8% to R11.2 billion from R10.1 billion (2012: 9.1% increase). On a pabpm basis for schemes offering medical savings accounts, medical savings accounts claims decreased by 7.4% to R106.7 from R115.1 (2012: 5.5% increase).

Figure 30 and Table 47 show that between 2003 and 2006, medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components. This indicates a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

But the lower figures for 2007 – 2013 appear to reflect a change in this trend. The decrease is partly attributable to a decision of the CMS not to allow variable savings rates on an option, which resulted in several medical schemes ceasing savings plan accounts.

Figure 30: Risk and medical savings accounts contributions and claims pbpm 2000 – 2013



Contributions and relevant healthcare expenditure by type of scheme

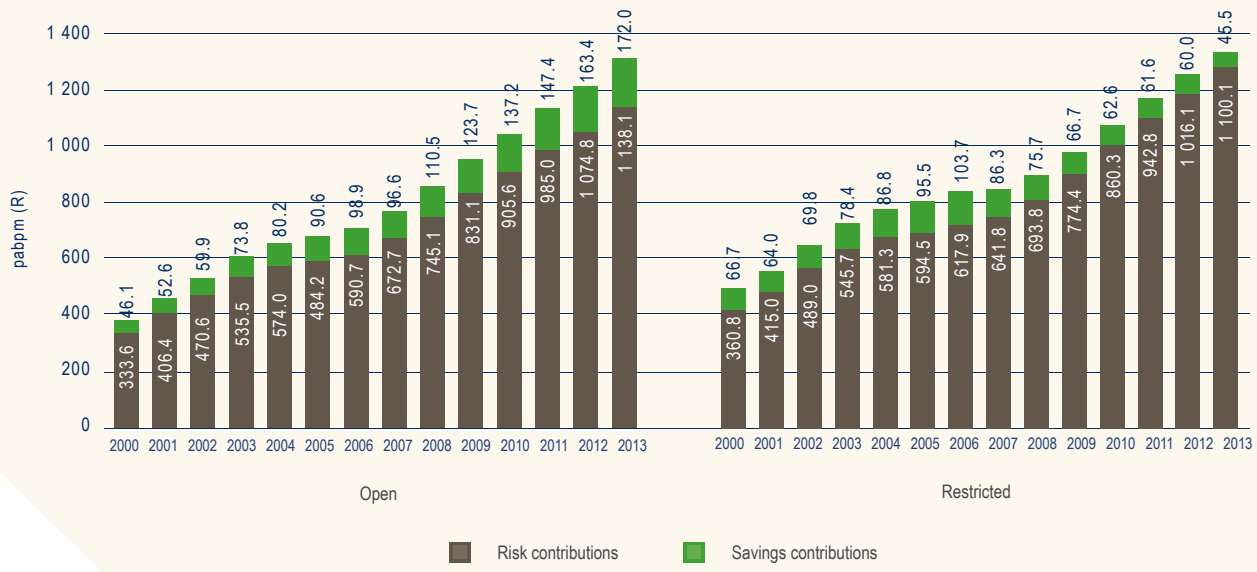
Table 47 and Figures 31 and 32 show contributions and claims for open and restricted schemes pabpm.

Table 47: Contributions and relevant healthcare expenditure pabpm 2000 – 2013

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% Change	pasbpm R	% Change	pabpm R	% Change	pasbpm R	% Change
Open								
2000	333.6		46.1		292.4		41.3	
2001	406.4	21.8	52.6	13.9	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	14.0	379.3	14.4	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.7	77.5	13.6
2006	611.6	3.5	98.9	9.1	522.9	8.0	95.9	23.6
2007	672.7	10.0	96.6	(2.3)	562.1	7.5	91.6	(4.4)
2008	745.1	10.8	110.5	14.3	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
2011	985.0	8.8	147.4	7.5	831.8	8.4	139.8	6.8
2012	1 047.8	6.4	163.4	10.8	884.9	6.4	153.6	9.9
2013	1 138.1	8.6	172.0	5.3	952.8	7.7	160.5	4.5
Restricted								
2000	360.8		66.7		333.1		58.8	
2001	415.0	15.0	64.0	(4.0)	360.9	8.3	57.9	(1.5)
2002	489.0	17.8	69.8	9.0	417.9	15.8	60.3	4.2
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.5
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.6
2005	594.5	2.3	95.5	10.1	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.3
2007	641.8	3.9	86.3	(16.8)	595.7	2.3	75.7	(18.4)
2008	693.8	8.1	75.7	(12.3)	638.0	7.1	66.2	(12.5)
2009	774.4	11.6	66.7	(11.9)	727.3	14.0	61.7	(6.9)
2010	860.3	11.1	62.6	(6.1)	785.1	8.0	57.5	(6.7)
2011	942.8	9.6	61.6	(1.7)	842.0	7.2	55.6	(3.4)
2012	1 016.1	7.8	60.0	(2.7)	932.8	10.8	53.6	(3.5)
2013	1 100.1	8.3	45.5	(24.0)	988.8	6.0	40.6	(24.3)

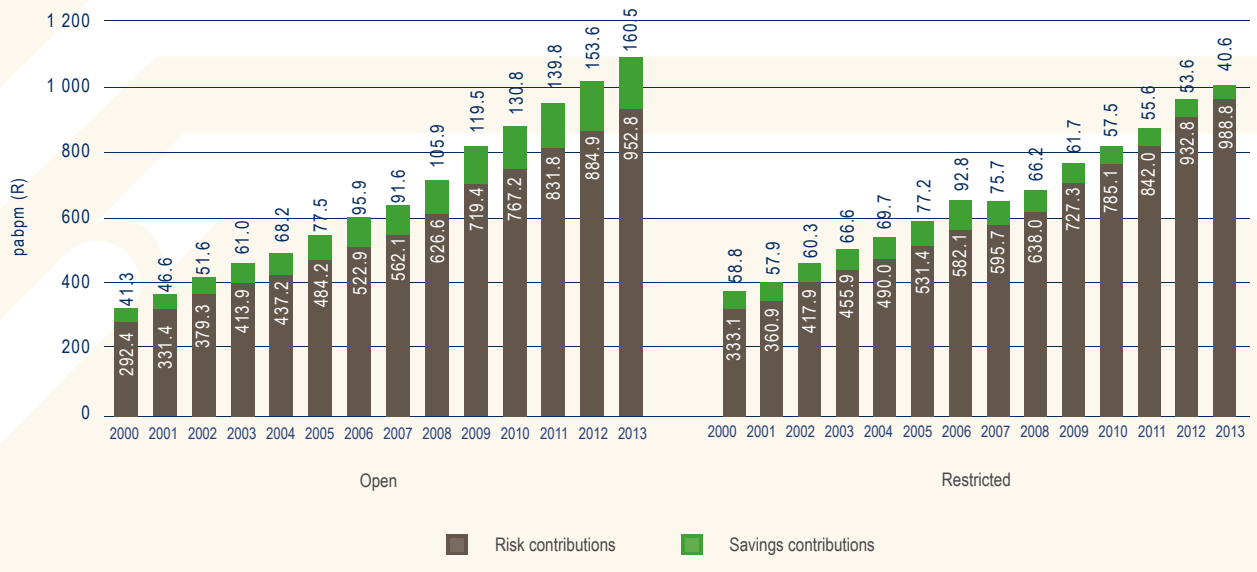
pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

Figure 31: Risk and savings contributions pabpm 2000 – 2013



pabpm = per average beneficiary per month

Figure 32: Risk and savings claims pabpm 2000 – 2013



pabpm = per average beneficiary per month

On average, increases in risk claims and contributions pabpm were slightly lower in restricted schemes than in open schemes over the last 10 years. From 2008 onwards, restricted schemes experienced a decrease in claims from members' medical savings accounts while open schemes reflected an increase. The risk claims ratio in open schemes decreased to 83.7% in 2013 from 84.5% in 2012; in restricted schemes it decreased to 89.9% from 91.8% in 2012.

Table 48: Contributions and relevant healthcare expenditure pabpm 2000 – 2013: 2013 prices

All schemes	Risk contributions pabpm R	% change	Savings contributions pasbpm R	% change	Risk claims pabpm R	% change	Savings claims pasbpm R	% change
2000	713.7		104.6		636.9		93.3	
2001	807.0	13.1	108.3	3.5	671.5	5.4	96.5	3.5
2002	860.4	6.6	111.8	3.3	706.0	5.1	96.4	(0.1)
2003	920.4	7.0	127.7	14.2	728.5	3.2	106.2	10.2
2004	970.2	5.4	137.3	7.5	762.2	4.6	115.4	8.6
2005	965.2	(0.5)	149.3	8.8	811.6	6.5	126.3	9.5
2006	955.2	(1.0)	155.4	4.0	840.3	3.5	148.4	17.5
2007	963.3	0.9	137.2	(11.7)	833.7	(0.8)	128.1	(13.7)
2008	946.9	(1.7)	131.5	(4.1)	822.5	(1.3)	123.9	(3.3)
2009	988.6	4.4	129.1	(1.9)	883.0	7.4	123.6	(0.2)
2010	1 039.7	5.2	129.9	0.7	908.1	2.8	123.1	(0.5)
2011	1 079.4	3.8	129.7	(0.2)	933.8	2.8	121.8	(1.0)
2012	1 092.8	1.2	130.7	0.7	958.2	2.6	121.7	(0.1)
2013	1 121.0	2.6	115.3	(11.8)	969.1	1.1	106.7	(12.4)

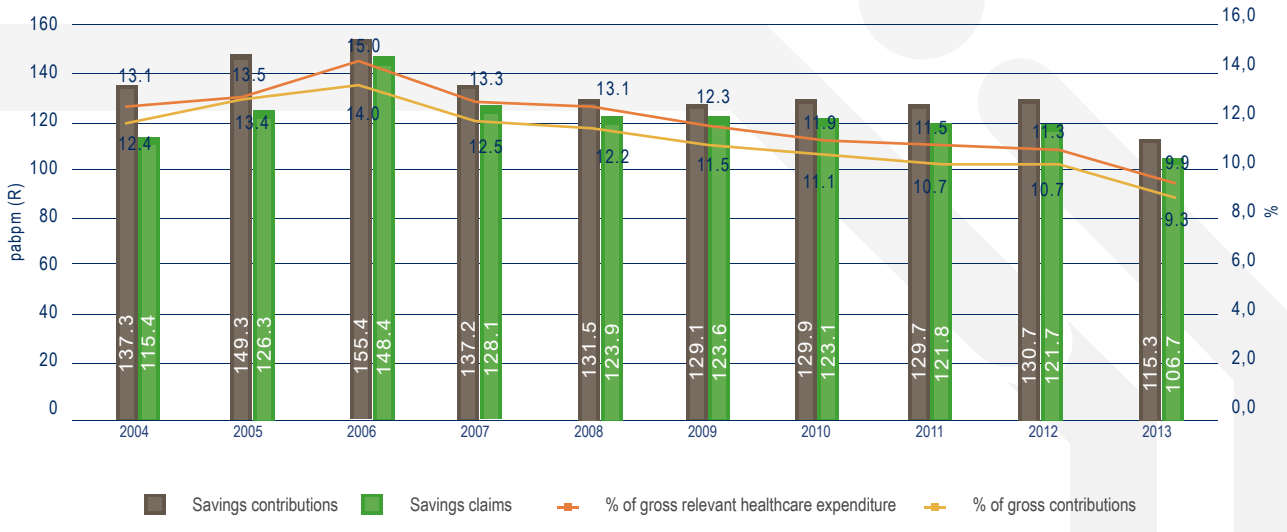
pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

Table 48 indicates the changes in contributions and claims after adjusting for inflation.

Over the last few years, medical schemes have generally experienced increases in risk contributions and claims pabpm, and a noted decrease in savings contributions and claims.

Savings contributions and claims have shown a downward trend since 2007. There was a sharp decline in 2013 due to a number of schemes no longer utilising personal medical savings accounts in their benefit designs.

Figure 33: Medical savings accounts contributions and claims pabpm 2004 – 2013: 2013 prices



The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure decreased to 9.9% during the review period, from 11.3% in 2012, as shown in Figure 33.

For open schemes, the proportion of claims paid from medical savings accounts decreased from 14.8% in 2012 to 14.4% in 2013. The medical savings accounts' claims ratio decreased from 94.0% in 2012 to 93.3%.

For restricted schemes, the proportion of claims paid from medical savings accounts decreased from 5.4% in 2012 to 3.9% in 2013. The medical savings accounts' claims ratio decreased from 89.5% in 2012 to 89.1%.

Contributions and relevant healthcare expenditure since 2000

Figure 34 tracks the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims pabpm have increased by 57.1% and 52.1% respectively. Medical savings accounts contributions and claims have risen by 10.2% and 14.3% respectively on a pabpm basis.

Figure 34: Risk and medical savings accounts contributions and claims pabpm 2000 – 2013: 2013 prices

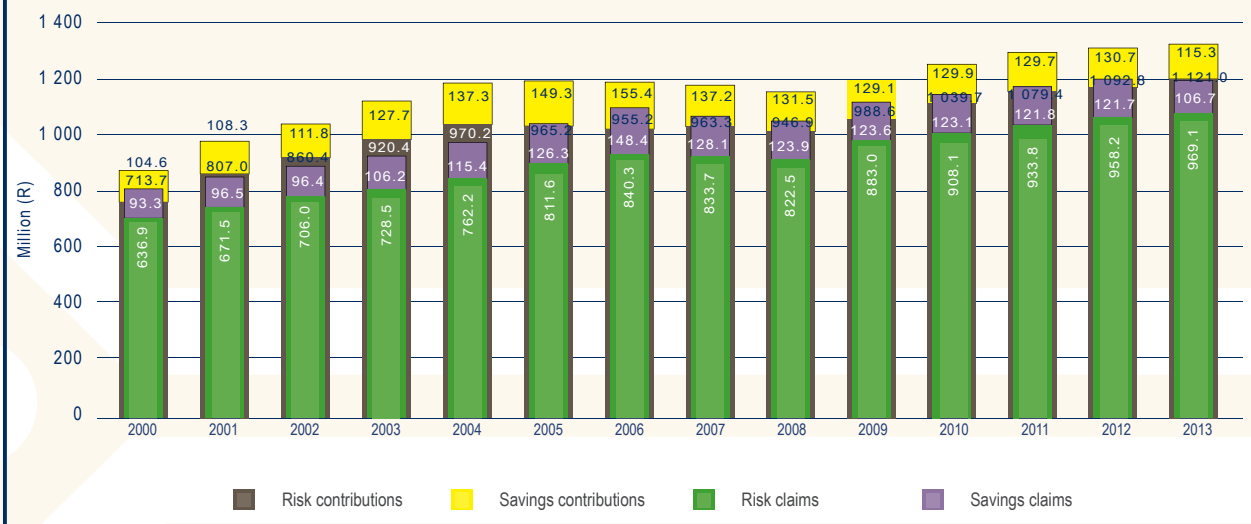
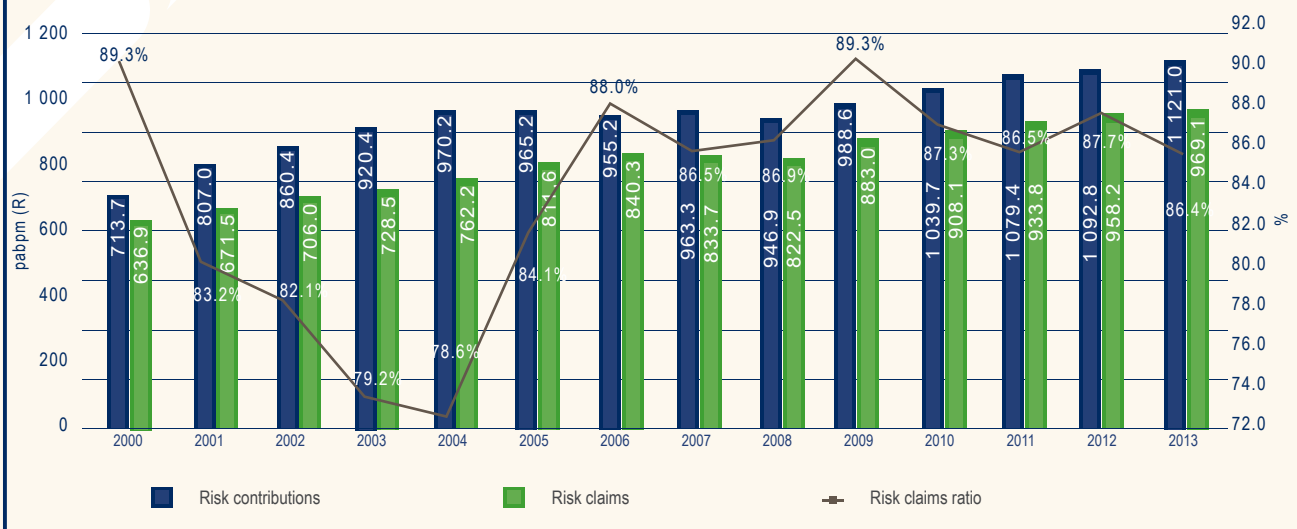


Figure 35 shows the relationship between risk contributions and claims paid over the past decade, after adjusting for inflation.

Figure 35: Risk claims ratio for all schemes 2000 – 2013: 2013 prices



After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised at 86.5% in 2007 and 86.9% in 2008. There was an increase in 2009, followed by a decrease over the next two years to 86.5% in 2011. For the year ended 31 December 2012, there was a slight increase from the previous year, with medical schemes paying out 87.7% of risk contributions in benefits. In 2013, the claims ratio has decreased to 86.4%. Thus between 2006 and 2013, claims ratios remained in a range between 86% and 88%, with the exception of 2009 when the figure rose to 89.3%.

Figure 36: Claims seasonality per month 2013

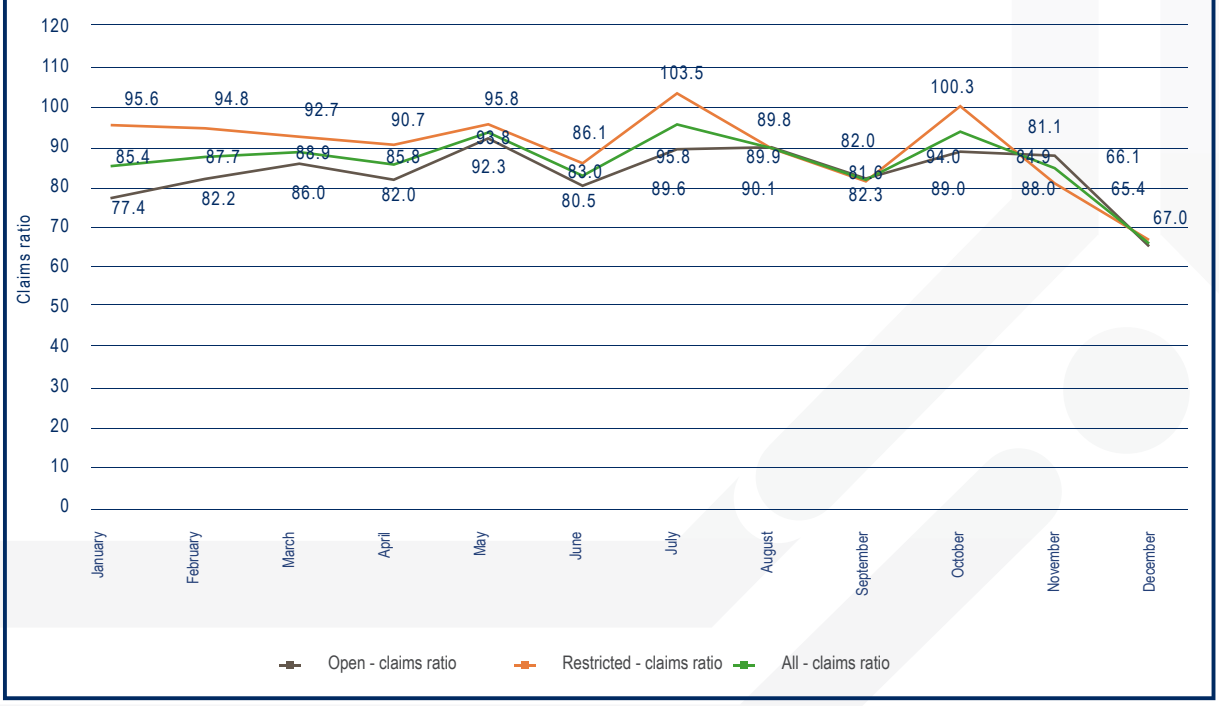


Figure 36 shows the seasonality of claims in 2013.

Both open and restricted schemes followed the same general trend. There was an increase in claims in the first quarter of the year as members gained access to new benefits. There were also increases in claims as a proportion of contributions during the winter months, followed by a general downward trend in the last quarter of the year.

Risk transfer arrangements

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

Table 49 reflects the main components of such arrangements:

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

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

Table 49: Significant risk transfer arrangements 2012 and 2013

	Capitation fees			Estimated recoveries			Net income/(expense)*		
Scheme category	2013 R'000	2012 R'000	% growth	2013 R'000	2012 R'000	% growth	2013 R'000	2012 R'000	% growth
Open	1 859 642	2 192 757	(15.2)	1 705 147	2 102 196	(18.9)	(152 246)	(86 905)	75.2
Restricted	1 056 858	1 051 761	0.5	1 213 541	1 097 887	10.5	158 270	48 854	224.0
All	**2 916 499**	**3 244 518**	**(10.1)**	**2 918 688**	**3 200 083**	**(8.8)**	**6 024**	**(38 051)**	**115.8**

* *The net income/(expense) on risk transfer arrangements also includes an amount of R3.8 million in respect of profit- and loss-sharing agreements.*

Table 50 lists the 10 schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 51 details the 10 benefit options that incurred the largest losses in relation to risk transfer arrangements.

Table 50: Schemes with highest risk transfer arrangement losses 2013

Ref no	Name of medical scheme	Beneficiaries 31 Dec 2013	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	650 600	664 408	513 947	(150 460)	(22.6)
1167	Momentum Health	212 378	244 271	211 946	(33 257)	(13.6)
1149	Medihelp	220 710	265 511	247 837	(14 724)	(5.5)
1087	Keyhealth Medical Scheme	76 738	67 100	60 705	(7 630)	(11.4)
1293	Wooltru Healthcare Fund	18 123	21 106	16 331	(3 900)	(18.5)
1209	South African Breweries Medical Scheme	22 323	18 513	14 713	(3 800)	(20.5)
1486	Sizwe Medical Fund	135 417	8 661	5 300	(3 361)	(38.8)
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	47 143	17 764	14 612	(3 152)	(17.7)
1252	Bestmed Medical Scheme	185 750	117 901	114 775	(3 126)	(2.7)
1552	Community Medical Aid Scheme (COMMED)	11 618	16 249	13 701	(2 548)	(15.7)

Table 51: Options with highest risk transfer arrangement losses 2013

Ref No	Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2013	Average age pb 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 %
1894	Bonitas Medical Fund	Standard	341 435	33.3	491 941	388 318	–	(103 623)	(21.1)
1790	Discovery Health Medical Scheme	Classic Comprehensive	421 848	37.2	109 498	80 305	–	(29 193)	(26.7)
1896	Bonitas Medical Fund	Primary	141 325	28.2	93 040	69 949	–	(23 091)	(24.8)
2294	Medihelp	Unify	9 967	26.0	54 104	37 966	(999)	(17 137)	(31.7)
1895	Bonitas Medical Fund	Bonsave	68 099	27.8	43 558	29 650	–	(13 908)	(31.9)
2263	Momentum Health	Ingwe	31 852	27.4	59 315	50 159	(256)	(9 412)	(15.9)
2049	Momentum Health	Custom	77 399	30.5	36 208	27 685	(271)	(8 794)	(24.3)
2053	Momentum Health	Incentive	75 726	36.1	75 648	68 770	(289)	(7 167)	(9.5)
2081	South African Police Service Medical Scheme (Polmed)	Lower Plan	146 135	21.5	33 863	28 183	–	(5 680)	(16.8)
6070	Bonitas Medical Fund	BonClassic	28 013	45.6	22 403	17 280	–	(5 124)	(22.9)

pb = per beneficiary

Bonitas Medical Fund is listed in both Table 50 and 51 as the biggest loss-maker.

The Bonitas Bonsave option suffered the biggest loss in terms of the percentage of capitation fees paid (31.9%) followed by the Unify option from Medihelp (31.7%), as shown in Table 51.

Non-healthcare expenditure

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

- Administration expenditure.
- Managed healthcare: management services (fees for managing health benefits).
- Commissions and service fees paid to brokers.
- Other distribution costs.
- Impaired receivables.

Administration expenditure

Administration expenditure for all medical schemes grew by 7.1% to R9.4 billion at the end of December 2013 from R8.8 billion in 2012. Open schemes increased their administration expenditure by 6.3% to R6.5 billion from R6.1 billion in 2012. There was an 8.9% increase in the administration spending of restricted schemes (from R2.7 billion in 2012 to R2.9 billion in 2013) as their membership expanded during the year under review. GEMS alone experienced a 4.8% increase in beneficiaries.

There were 10 open schemes (representing 3.8% of the average number of beneficiaries for 2013) and 10 restricted schemes (representing 2.1% of the average number of beneficiaries for 2013) that had an overall administration expenditure greater than 10% of Gross Contribution Income (GCI) in 2013.

Table 52 shows "high-impact"[3] open schemes with administration expenditure greater than 10% of GCI. A high administration percentage is sometimes a function of low average contribution rates rather than high absolute administration costs.

Table 52: High-impact open schemes with administration expenditure above 10% of GCI (2013)

Name of scheme	Average number of beneficiaries	Administration expenditure as % of GCI
Spectramed	43 034	12.4
Selfmed Medical Scheme	15 175	12.2
Liberty Medical Scheme	118 163	11.0
Resolution Health Medical Scheme	73 917	10.9

GCI = Gross Contribution Income

3. *Refer to the section on the Risk Assessment Framework (RAF) on page 189).*

Table 53 shows high-impact open schemes with administration expenditure above the open schemes industry average of R113.0 pabpm. (When excluding self-administered schemes, this average increases to R113.6 pabpm.) In some instances high percentage increases may be the result of low average contributions. Relative to the open schemes industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

Table 53: High-impact open schemes with administration expenditure above the open schemes industry average of R113.0 pabpm (2013)

Name of scheme	Average number of beneficiaries	Administration expenditure pabpm R
Spectramed	43 034	186.0
Selfmed Medical Scheme	15 175	181.9
Liberty Medical Scheme	118 163	149.9
Fedhealth Medical Scheme	148 650	133.6
Medihelp	218 991	122.8
Resolution Health Medical Scheme	73 917	119.7
Keyhealth	76 842	119.1
Bestmed Medical Scheme	172 984	114.1
Discovery Health Medical Scheme	2 519 743	113.8

pabpm = per average beneficiary per month

Table 54 shows the gross administration fees paid to third-party administrators as well as administration fees paid by self-administered medical schemes. These fees are the sum of administration fees, co-administration fees and other indirect fees paid to the administrator.

Table 54: Gross administration fees paid pabpm to third-party administrators 2012 and 2013

	Open schemes			Restricted schemes		
	2013 R pabpm	2012 R pabpm	% variance	2013 R pabpm	2012 R pabpm	% variance
Third party						
Administration fees	97.8	92.9	5.2	43.6	44.5	(1.9)
Co-administration fees	–	2.1	(100.0)	5.8	–	100.0
Total – third party	**97.8**	**93.0**	**5.1**	**46.5**	**44.5**	**4.6**
Self-administered						
Administration fees	–	–	–	–	–	–
Co-administration fees	–	1.7	(100.0)	–	–	–
Total – self-administered	**–**	**1.7**	**(100.0)**	**–**	**–**	**–**

pabpm = per average beneficiary per month

On average, third party-administered open schemes spent 110.3% more on gross administration fees than third party-administered restricted schemes (2012: 109.0%).

Administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE), representing 82.3% of GAE in 2013 and 82.6% in 2012. They grew by 6.4% to R6.9 billion in 2013 from R6.5 billion in the previous year.

Expenditure on benefits management: managed healthcare fees

Managed healthcare management fees increased significantly by 19.9% to R3.2 billion in 2013 from R2.7 billion in 2012. In 2013, the number of beneficiaries covered by these managed healthcare interventions increased by 1.8% to 8 684 439 beneficiaries (or 99% of all beneficiaries).

Table 55 shows the number of benefit options with claims ratios greater than 100% and their expenditure on managed healthcare management fees. There were 46 options in this category, and they accounted for 4.4% of beneficiaries in respect of whom such expenditure was incurred.

Table 55: Managed healthcare management fees in respect of options with a claims ratio above 100% (2013)

	Managed care costs R'000	Managed care costs pbpm R	Gross healthcare result* R'000	Gross healthcare result pbpm* R	Number of beneficiaries	Number of options
Open schemes	87 756	36.3	(430 981)	(178.1)	201 624	24
Restricted schemes	78 635	35.8	(713 585)	(325.2)	182 841	22
All schemes	166 391	36.1	(1 144 566)	(248.1)	384 465	46

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

Fees of trustees and principal officers

Remuneration and other considerations of trustees and principal officers accounted for 0.7% and 1.0% of GAE respectively. In 2013, the fees of principal officers absorbed 0.7% of GAE in open schemes (2012: 0.7%) and 1.5% in restricted schemes (2012: 1.5%).

Table 56 shows the 10 schemes with the highest average trustee fees. More details are contained in Annexure P.

Table 57 shows the 10 schemes with the highest principal officer fees. More details are contained in Annexure P.

Table 56: Ten schemes with highest trustee fees (2013)

	Trustee remuneration and other considerations		
Name of medical scheme	R'000	No of trustees	Average fee per trustee R'000
Government Employees Medical Scheme (GEMS)	7 951	14	568
Bonitas Medical Fund	3 730	10	373
Fedhealth Medical Scheme	3 703	12	309
Hosmed Medical Aid Scheme	3 685	12	307
Discovery Health Medical Scheme	3 178	8	397
Liberty Medical Scheme	2 774	9	308
Profmed	2 705	12	225
LA-Health Medical Scheme	2 459	16	154
Bestmed Medical Scheme	2 170	13	167
Spectramed	2 135	6	356

Table 57: Ten schemes with highest paid principal officers (2013)

		Principal officer remuneration R'000		
Name of medical scheme	Number of beneficiaries	2013	2012	% change
Medihelp	218 991	6 070	3 373	80.0
Bestmed Medical Scheme	172 984	5 684	4 336	31.1
Discovery Health Medical Scheme	2 519 743	5 399	4 029	34.0
South African Police Service Medical Scheme (POLMED)	496 817	5 204	3 416	52.4
Liberty Medical Scheme	118 163	3 993	3 466	15.2
Government Employees Medical Scheme (GEMS)	1 835 733	2 989	1 751	70.7
Transmed Medical Fund	95 868	2 916	2 640	10.5
Bonitas Medical Fund	650 291	2 863	4 870	-41.2
Umvuzo Health Medical Scheme	52 507	2 706	2 246	20.5
Bankmed	200 827	2 683	2 975	-9.8

Trends in administration and managed healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2013 at 65.5% (2012: 67.2%). Managed healthcare management fees comprised 22.2% of non-healthcare expenditure (2012: 20.4%).

Administration expenditure and managed healthcare management fees effectively accounted for 9.7% of Gross Contribution Income (GCI) in 2013 (2012: 9.8 %).

Table 58 shows administration and managed healthcare expenditure by type of scheme administration.

Table 58: Gross Administration Expenditure (GAE) and managed healthcare expenditure 2000 – 2013

	Open schemes				Restricted schemes			
	Self-administered		Third party		Self-administered		Third party	
	Pabpm Rand	% change	Pabpm Rand	% change	Pabpm Rand	% change	Pabpm Rand	% change
2000	37.5	–	48.7	–	24.7	–	38.3	–
2001	62.8	67.5	62.7	28.9	31.3	26.6	41.5	8.4
2002	55.8	(11.2)	69.8	11.3	37.3	19.4	49.3	18.8
2003	69.2	24.0	78.4	12.3	33.0	(11.7)	55.8	13.2
2004	75.9	9.8	86.1	9.8	43.3	31.4	59.1	6.1
2005	80.8	6.4	91.9	6.8	41.8	(3.5)	67.8	14.7
2006	84.1	4.1	96.9	5.4	39.0	(6.7)	67.2	(0.9)
2007	89.8	6.8	101.8	5.0	41.3	6.0	65.8	(2.0)
2008	96.5	7.5	108.5	6.6	41.8	1.3	65.5	(0.5)
2009	109.8	13.8	118.6	9.3	45.1	7.8	71.9	9.7
2010	106.2	(3.3)	124.4	4.9	54.6	21.0	74.2	3.3
2011	107.1	0.8	132.5	6.5	56.3	3.1	75.6	1.9
2012	128.4	19.9	139.0	4.9	62.8	11.5	79.9	5.7
2013	132.2	3.0	148.4	6.8	65.9	4.9	90.4	13.1

pabpm = per average beneficiary per month

During 2013, there were 6 self-administered open schemes (2012: 7), representing an average of 617 791 beneficiaries (2012: 682 449), and 18 third party-administered open schemes (2012: 19), representing an average of 4 187 671 beneficiaries (2012: 4 068 533).

In 2013, self-administered open schemes experienced an increase of 3.0% in the cost of administration and managed healthcare services (from R128.4 pabpm in 2012 to R132.2 pabpm) while third party-administered open schemes saw a 6.8% increase on these items (from R139.0 in 2012 to R148.4 pabpm in 2013). Third party-administered open schemes paid 12.3% more for administration and managed healthcare services than self-administered open schemes. The difference was 8.3% in 2012.[4]

During 2013, there were eight self-administered restricted schemes (2012: 8), representing an average of 281 489 beneficiaries for the year (2012: 270 921), and 59 third party-administered restricted schemes (2012: 61), representing an average of 3 665 319 beneficiaries (2012: 3 586 673). Third party-administered restricted schemes spent an average of 37.2% more on administration and managed healthcare management fees than their self-administered counterparts (2012: 27.2%). The respective figures were R90.4 pabpm and R65.9 pabpm.

Table 58 also shows that self-administered open schemes paid 100.6% (2012: 104.5%) more pabpm for administration and managed healthcare expenditure than self-administered restricted schemes. Third party-administered open schemes paid 64.2% (2012: 74.0%) more pabpm for administration and managed healthcare expenditure than third party-administered restricted schemes.

Table 59 takes the 10 largest schemes by average number of beneficiaries and shows their total expenditure on administration and managed healthcare management fees. The industry averages were 7.3% for gross administration and 9.7% for gross administration plus managed healthcare as a percentage of GCI (2012: 7.5% and 9.8%).

4. Bestmed Medical Scheme became self-administered with effect from 1 July 2012.

Table 59: Gross Administration Expenditure (GAE) and managed healthcare expenditure of the 10 largest schemes (2013)

Name of medical scheme	Type	Average number of beneficiaries	GAE as % of GCI	GAE + managed healthcare expenditure as % of GCI
Discovery Health Medical Scheme	Open	2 519 743	8.5	11.2
Government Employees Medical Scheme (GEMS)	Restricted	1 835 733	4.2	6.9
Bonitas Medical Fund	Open	650 291	8.5	11.5
South African Police Service Medical Scheme (POLMED)	Restricted	496 817	4.5	6.4
Medihelp	Open	218 991	9.3	11.3
Momentum Health	Open	210 275	8.4	10.6
Bankmed	Restricted	200 827	6.4	8.9
Medshield Medical Scheme	Open	177 153	6.6	8.5
Bestmed Medical Scheme	Open	172 984	7.2	8.8
Fedhealth Medical Scheme	Open	148 650	9.1	11.5

GAE = Gross Administration Expenditure
GCI = Gross Contribution Income

Table 60 indicates the 10 schemes with the highest marketing, advertising and broker costs. The majority of these are open medical schemes and, in large measure, the table reflects expenditure incurred when recruiting new members. The table reflects only those marketing, advertising and broker expenses that were paid directly by the scheme. It does not apportion these costs where they have been included in administration fees. Membership statistics show that the number of principal members in open schemes increased by 2.7% from 2012 to 2013 (2011 to 2012: 0.7%). The membership growth shown in the table is not confined to new members who were previously not covered but includes those who moved from other schemes.

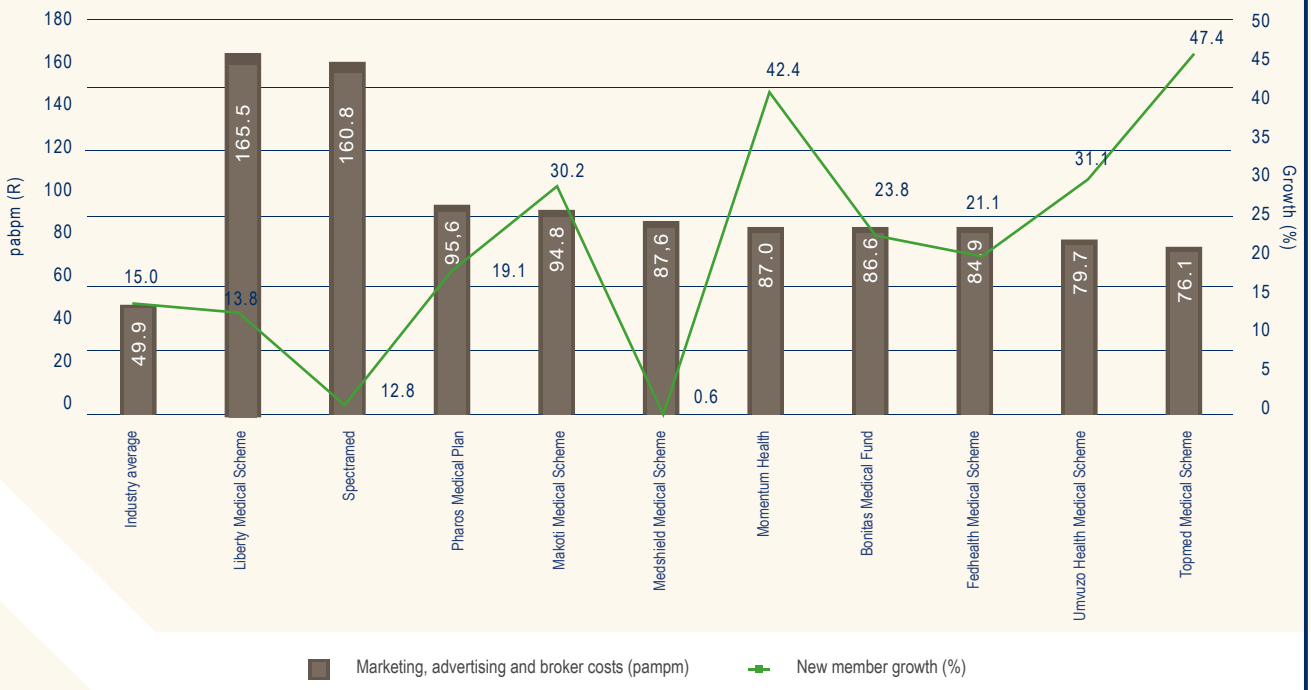
Figure 37 depicts the data in Table 52.

Table 60: Ten schemes with highest marketing, advertising and broker costs (2013)

Name of medical scheme	Marketing, advertising and broker costs pampm Rand	New member growth %
Industry average	49.9	15.0
Liberty Medical Scheme	165.5	13.8
Spectramed	160.8	12.8
Pharos Medical Plan	95.6	19.1
Makoti Medical Scheme	94.8	30.2
Medshield Medical Scheme	87.6	0.6
Momentum Health	87.0	42.4
Bonitas Medical Fund	86.6	23.8
Fedhealth Medical Scheme	84.9	21.1
Umvuzo Health Medical Scheme	79.7	31.1
Topmed Medical Scheme	76.1	47.4

pampm = per average member per month

Figure 37: Ten schemes with highest marketing, advertising and broker costs (2013)



Tables 61 and 62 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 61: Open schemes with the highest marketing and advertising expenditure (2013)*

Name of scheme	2013 Advertising & marketing pampm R	2012 Advertising & marketing pampm R	% change	2013 Broker fees paid pampm R	2012 Broker fees paid pampm R	% change	2013 Average members	2012 Average members	% change	Name of main advertising and marketing provider(s)	Marketing and advertising expenditure per provider	% of total fees
Liberty Medical Scheme	113.8	78.4	45.2	51.7	48.4	6.7	55 882	58 780	(4.9)	LMS Management and Auxillary Services (Pty) Ltd	76 220	99.9
										V Medical Solutions (Pty) Ltd	101	0.1
Makoti Medical Scheme	54.7	63.9	(14.4)	40.1	36.1	11.2	2 512	2 525	(0.5)	Various suppliers	401	24.3
										SuperSport United Football Club (Pty) Ltd	1 248	75.7
Community Medical Aid Scheme (COMMED)	49.6	43.9	13.0	17.3	13.3	30.0	7 207	7 535	(4.4)	Allcare Administrators (Pty) Ltd	4 290	100.0
Spectramed	41.4	13.2	213.9	119.4	17.1	599.4	21 857	26 203	(16.6)	In-house advertising and marketing expenses using third party suppliers on an ad hoc basis	10 860	100.0
Bonitas Medical Fund	38.1	39.1	(2.6)	48.5	47.5	2.0	294 329	273 285	7.7	Bonitas Marketing (Pty) Ltd	134 458	100.0
Open scheme industry average**	**31.4**	**28.6**	**10.0**	**57.1**	**53.5**	**6.8**	**2 232 727**	**2 190 872**	**1.9**			

pampm = per average member per month

* *Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*

** *The industry averages are based only in respect of those schemes which incurred the specific expenditure.*

Table 62: Restricted schemes with the highest marketing and advertising expenditure (2013)*

Name of scheme	2013 Advertising & marketing pampm R	2012 Advertising & marketing pampm R	% change	2013 Broker fees paid pampm R	2012 Broker fees paid pampm R	% change	2013 Average members	2012 Average members	% change	Name of main advertising and marketing provider(s)	Marketing and advertising expenditure per provider R'000	% of total fees
Umvuzo Health Medical Scheme	38.2	34.1	11.9	41.5	40.0	3.6	26 193	23 738	10.3	Rain Catchers (Pty) Ltd	12 005	100.0
Motohealth Care	26.9	47.5	(43.4)	13.8	3.3	322.0	28 099	28 745	(2.2)	Various other companies	6 914	76.3
										Dimage	2 147	23.7
Profmed	26.0	25.8	0.6	21.5	19.7	9.4	27 270	26 565	2.7	Ebony and Ivory	7 373	86.8
										Cyberkinetics	440	5.2
										Newsclip	9	0.1
										Epic Communications	343	4.0
										Other	330	3.9
Government Employees Medical Scheme (GEMS)	14.3	13.8	3.4	–	–	–	676 068	638 353	5.9	Pinnacle Health Solutions	25 803	22.3
										Other (advertising and marketing)	90 049	77.7
Restricted scheme industry average**	**10.3**	**11.0**	**(7.0)**	**28.6**	**25.3**	**12.9**	**1 630 520**	**1 593 108**	**2.3**			

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.*

Broker costs

Broker costs, which include all commissions, service fees and other distribution costs, increased by 9.3% in 2013, from R1 449.1 million in 2012 to R1 583.2 million (2012: 4.3%).

Broker costs represented 11.0% of total non-healthcare expenditure in 2013 as in 2012.

For schemes that pay broker commissions, the amounts paid pampm increased to R51.2 from R48.8 pampm in 2012, representing an increase of 5.0%. Broker commissions as a percentage of GCI decreased from 1.2% in 2012 to 1.1% in 2013.

Figure 38 shows annual broker service fees paid by open schemes since 2000, as well as their percentage share of total non-healthcare expenditure.

Figure 38: Broker service fees (open schemes) 2000 – 2013

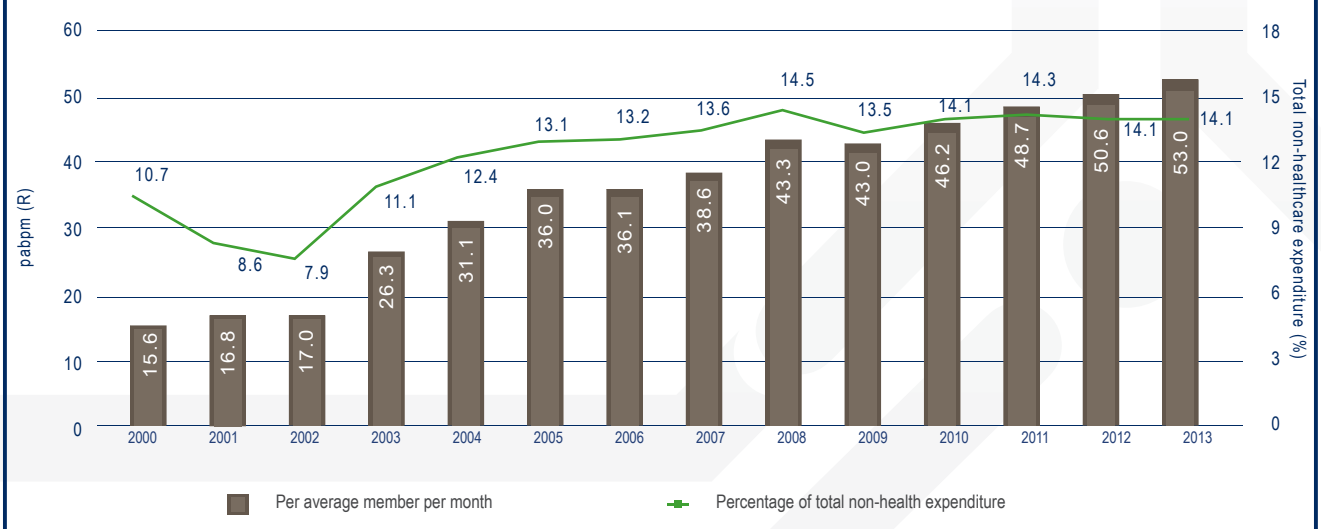


Figure 39 illustrates the increase in broker fees relative to membership of schemes that pay brokers.

Figure 39: Broker fees and scheme membership 2000 – 2013

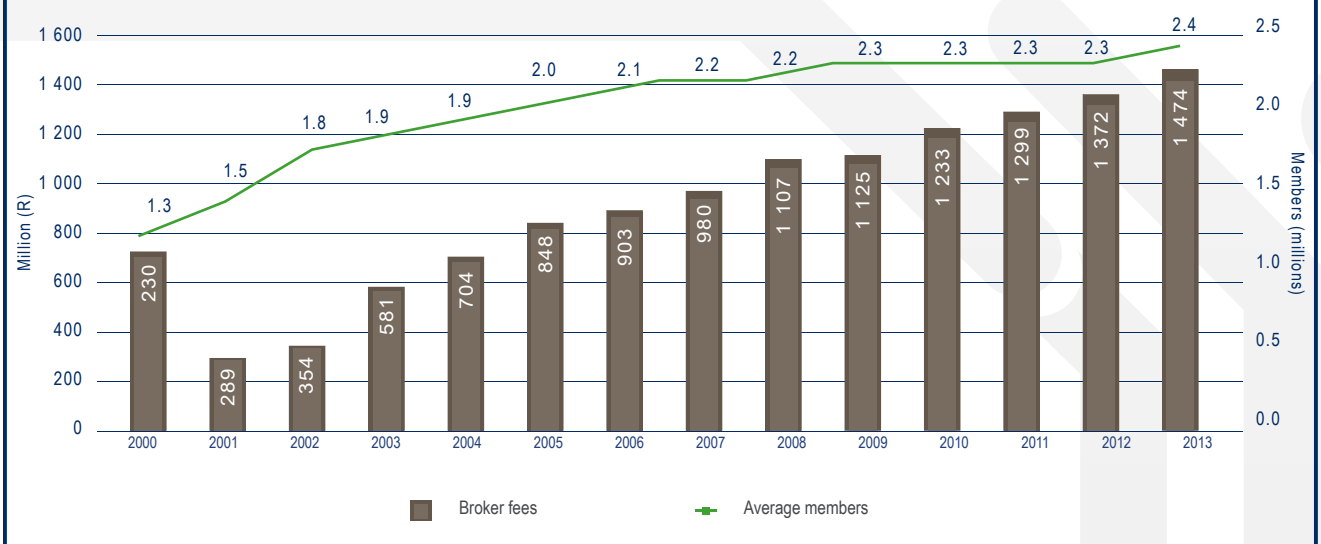


Table 63 illustrates the schemes which had broker service fees at levels higher than the industry average of R51.2 pampm (2012: R48.8 pampm). These eight schemes (2012: 10) represented 60.8% (2012: 62.5%) of total membership that paid for broker service fees, and 69.1% (2012: 71.2%) of total broker service fees paid. Four of these schemes paid at levels 15.0% greater than the industry average.

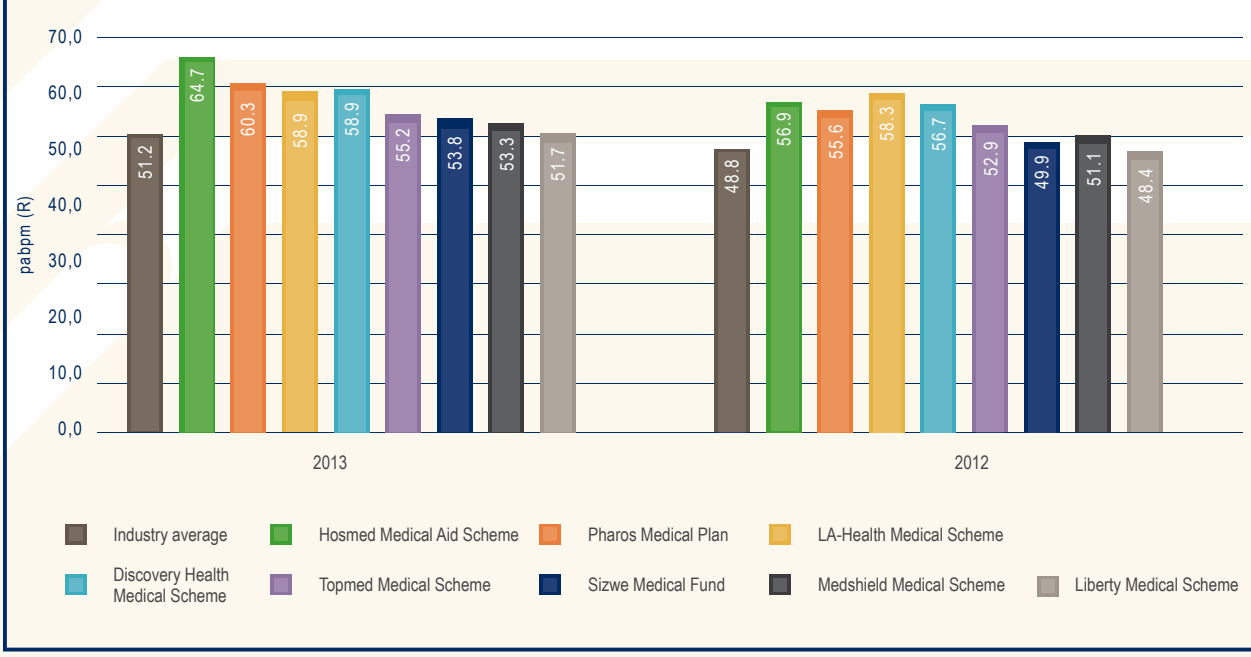
It is of concern that in addition to these schemes exceeding the industry average for broker commissions, they incurred additional distribution fees in respect of their broker network.

Table 63: Schemes with broker fees above the industry average for 2012 and 2013

		Broker fees			Other distribution fees		
Name of medical scheme	Type	2013 pampm R	2012 pampm R	% change	2013 pampm R	2012 pampm R	% change
Hosmed Medical Aid Scheme	Open	64.7	56.9	13.7%	–	–	–
Pharos Medical Plan	Open	60.3	55.6	8.5%	–	–	–
LA-Health Medical Scheme	Restricted	58.9	58.3	1.0%	–	–	–
Discovery Health Medical Scheme	Open	58.9	56.7	3.9%	–	–	–
Topmed Medical Scheme	Open	55.2	52.9	4.3%	13.7	13.0	5.7
Sizwe Medical Fund	Open	53.8	49.9	7.9%	–	–	–
Medshield Medical Scheme	Open	53.3	51.1	4.3%	17.4	22.9	(23.9)
Liberty Medical Scheme	Open	51.7	48.4	6.7%	–	–	–

pampm = per average member per month

Figure 40: Schemes with broker fees above the industry average for 2012 and 2013



pampm = per average member per month

Re-insurance results

Only one medical scheme had re-insurance contracts in 2013 (2012: 2). The scheme made a net healthcare surplus of R5.7 million with a net re-insurance surplus of R3.2 million.

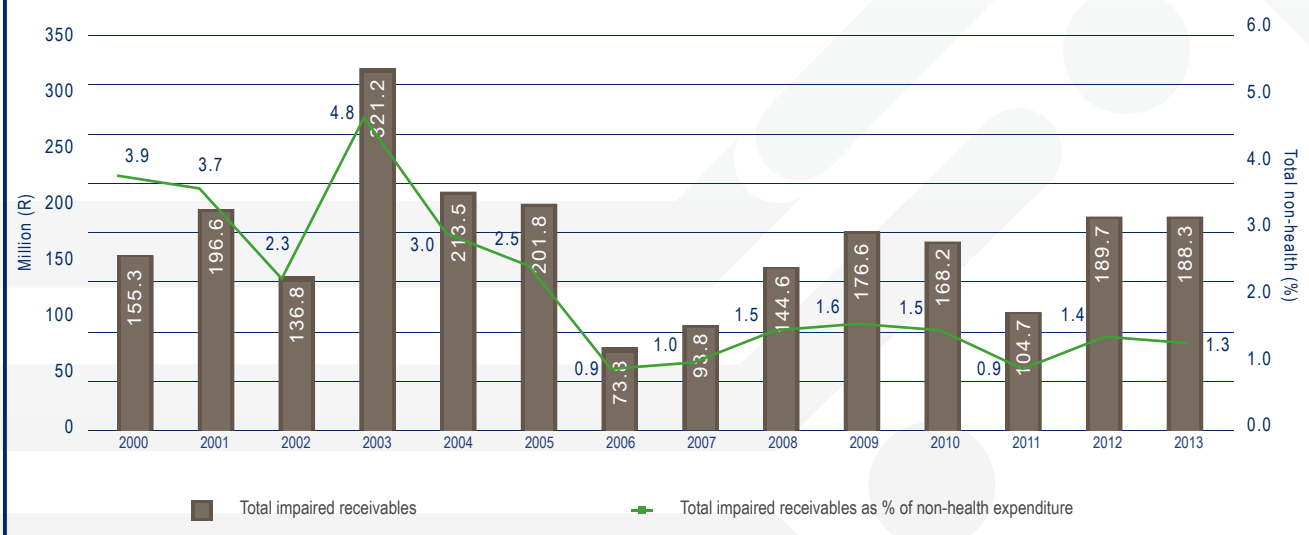
Impaired receivables

Impaired receivables decreased by 0.7% to R188.3 million for the year under review from R189.7 million in 2012. They represented 1.3% of total non-healthcare expenditure (1.4% in 2012).

It took schemes an average of 10.6 days to collect debts (contributions from their members) in 2013. This is an improvement of 2.8% from 10.9 days in 2012. However, this collection period still falls well outside the statutory provision which requires that members pay all contributions to their medical scheme not later than three days after the payment is due. The risks of not collecting contributions timeously are the possible impairment of the debtor and paying claims when contributions have not been received.

Figure 41 shows the trend in impaired receivables over the past 14 years and includes impaired receivables as a percentage of total non-healthcare expenditure.

Figure 41: Impaired receivables 2000 – 2013



Trends in non-healthcare expenditure

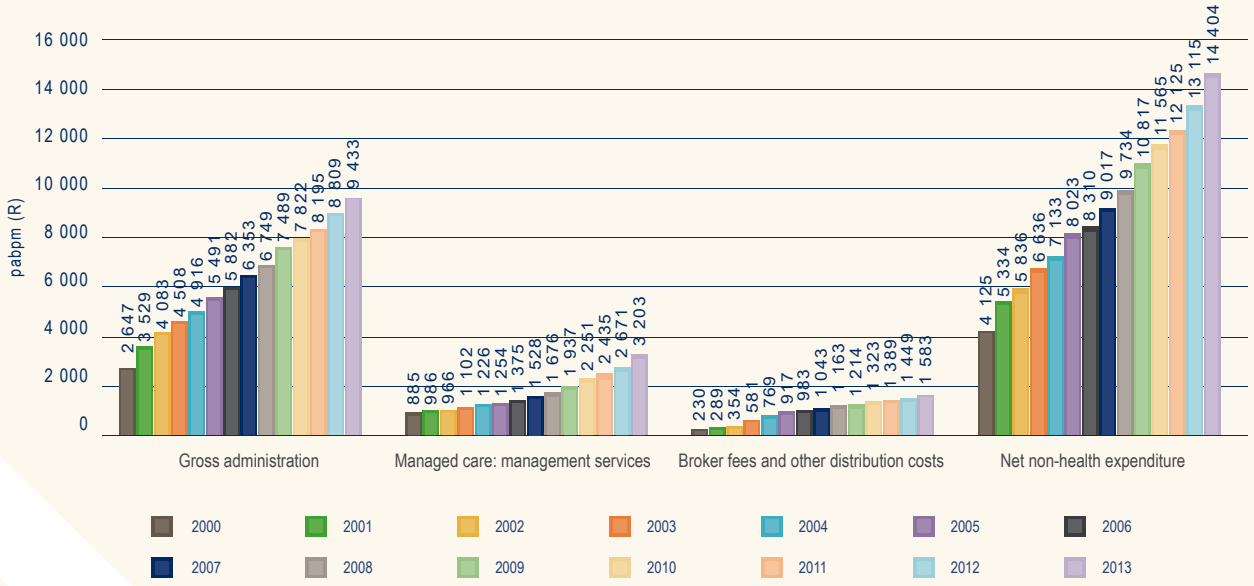
Total net non-healthcare expenditure rose by 9.8% from R13.1 billion in 2012 to R14.4 billion in 2013.

Before 2006, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI). The rate of increase was reversed in 2006[5] and since then there has been a real decrease in non-healthcare expenditure, from R1 940.9 in 2005 to R1 645.8 per average beneficiary per annum (pabpa) in 2013 (prices adjusted to 2013 prices).

5. This can partly be explained by GEMS starting to operate in 2006.

Figure 42 shows the changes in the major categories of non-healthcare expenditure for the past 14 years.

Figure 42: Changes in non-healthcare expenditure 2000 – 2013



Total gross non-healthcare expenditure has increased by 249.2% since 2000. This was driven by a 256.3% upswing in administration expenditure, a 261.8% rise in fees paid for managed healthcare, and an increase of 588.9% in broker costs.

By comparison, gross claims have risen by 313.6% (not adjusted for inflation) since 2000.

Figures 43 and 44 together with Table 64 show that, after adjusting for inflation, gross non-healthcare expenditure pabpa decreased in real terms since 2005. It increased marginally (by 2.2%) to R1 645.8 in 2013 from R1 610.7 in 2012. The net claims ratio (risk claims expressed as a percentage of risk contributions) also decreased, to 86.4% in 2013 from 87.7% in 2012.

Figure 43: Non-healthcare expenditure pabpa 1998 – 2013: 2013 prices

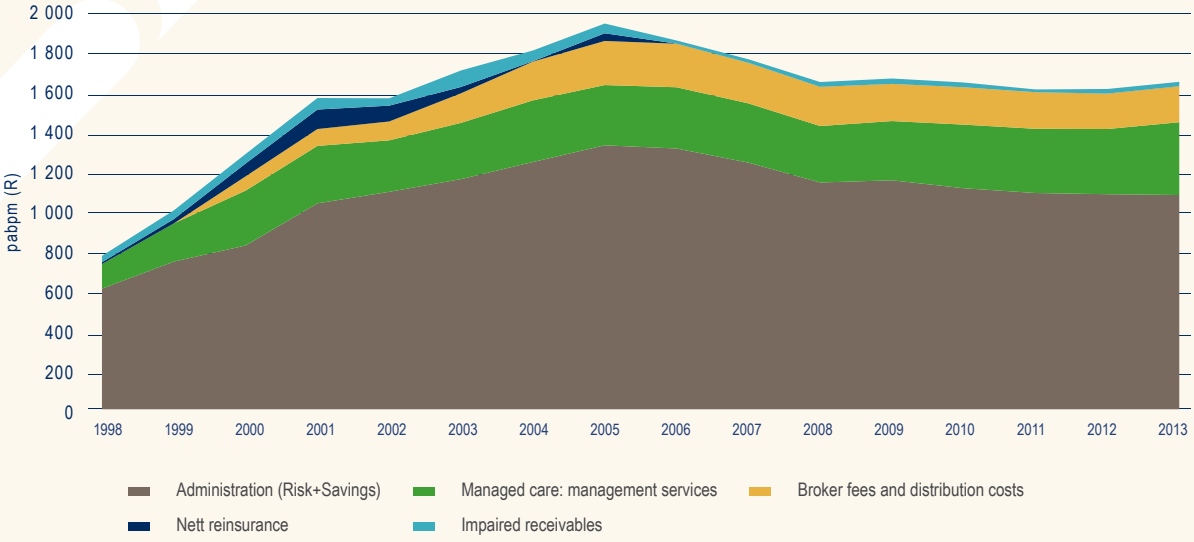
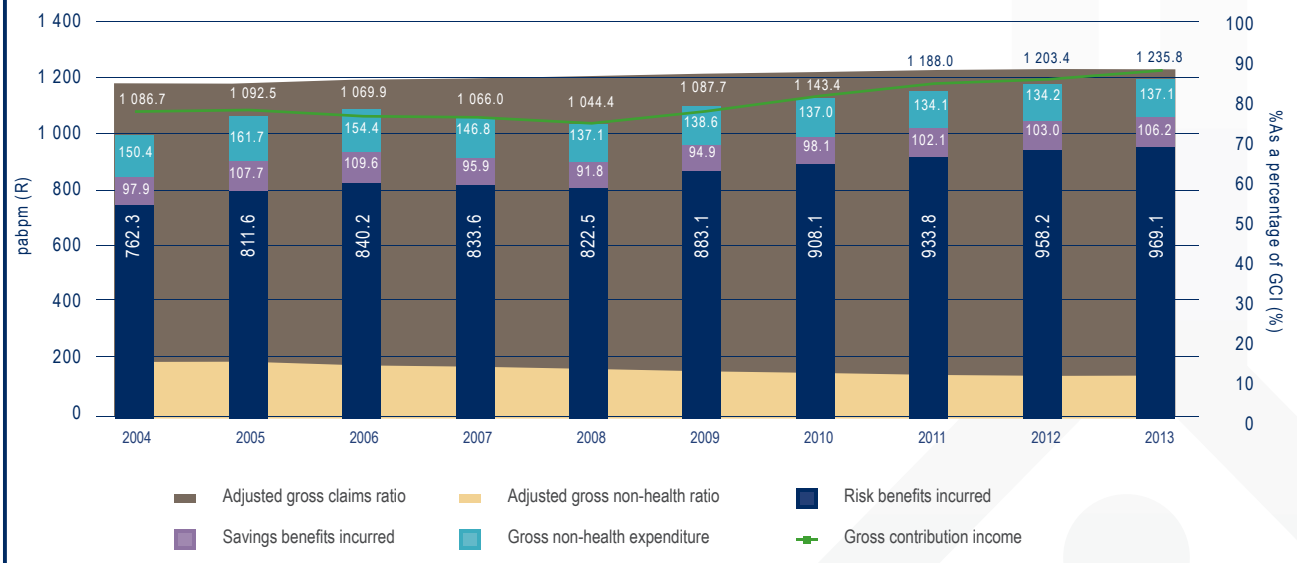


Figure 44: Claims and non-healthcare expenditure pabpm 2004 – 2013: 2013 prices



pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Figure 45: Claims and non-healthcare expenditure pabpa 1998 – 2013: 2013 prices

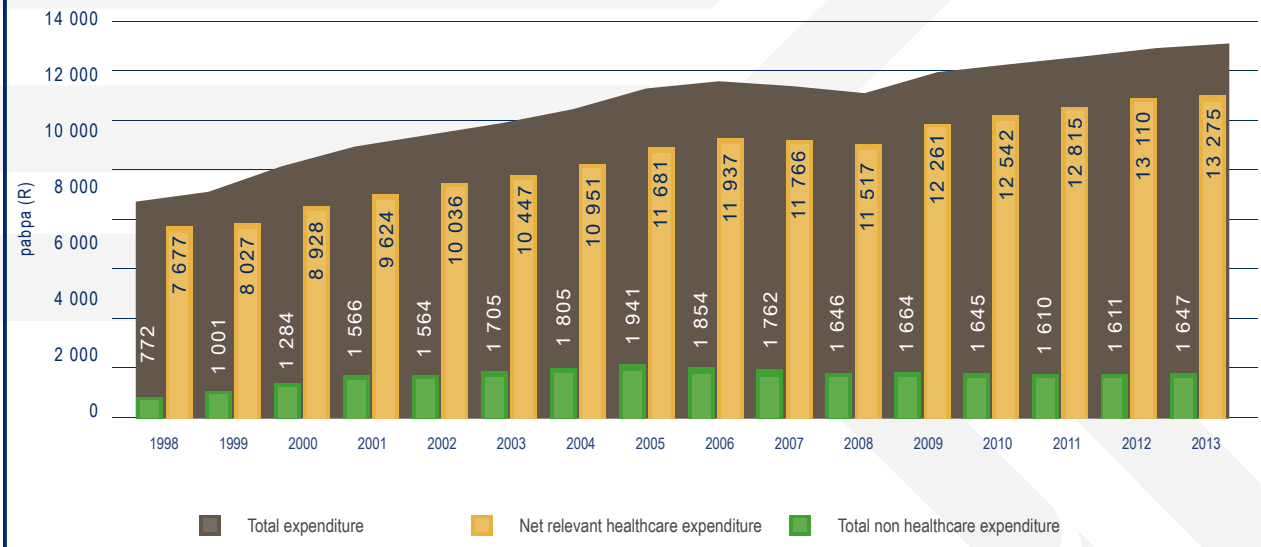


Table 64: Trends in contributions, claims and non-healthcare expenditure 2000 – 2013: 2013 prices*

	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa		pabpa		pabpa	
Expenditure	R	% growth	R	% growth	R	% growth
2000	9 527.7	6.4%	8 502.9	6.1%	1 284.4	28.2%
2001	10 764.3	13.0%	9 021.3	6.1%	1 566.1	21.9%
2002	11 447.5	6.3%	9 439.5	4.6%	1 564.3	-0.1%
2003	12 340.4	7.8%	9 819.8	4.0%	1 704.9	9.0%
2004	13 040.9	5.7%	10 321.0	5.1%	1 805.4	5.9%
2005	13 110.9	0.5%	11 032.7	6.9%	1 940.9	7.5%
2006	12 839.9	-2.1%	11 399.5	3.3%	1 853.6	-4.5%
2007	12 792.7	-0.4%	11 155.4	-2.1%	1 762.0	-4.9%
2008	12 533.2	-2.0%	10 972.8	-1.6%	1 646.3	-6.6%
2009	13 053.0	4.1%	11 736.4	7.0%	1 663.7	1.1%
2010	13 720.9	5.1%	12 075.6	2.9%	1 644.6	-1.1%
2011	14 256.4	3.9%	12 430.1	2.9%	1 609.7	-2.1%
2012	14 440.3	1.3%	12 735.4	2.5%	1 610.7	0.1%
2013	14 829.2	2.7%	12 903.6	1.3%	1 645.8	2.2%
Since 2000		**55.6%**		**51.8%**		**28.1%**

pabpa = per average beneficiary per annum
** The values were adjusted for CPI for 2000-2013.*

Figure 44 and Table 64 show that non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.0% per annum from 1999 to 2001 before stabilising.

Table 65 shows the six open schemes with non-healthcare expenditure greater than the industry averages of R174.4 pabpm and 15.3% of Risk Contribution Income (RCI).

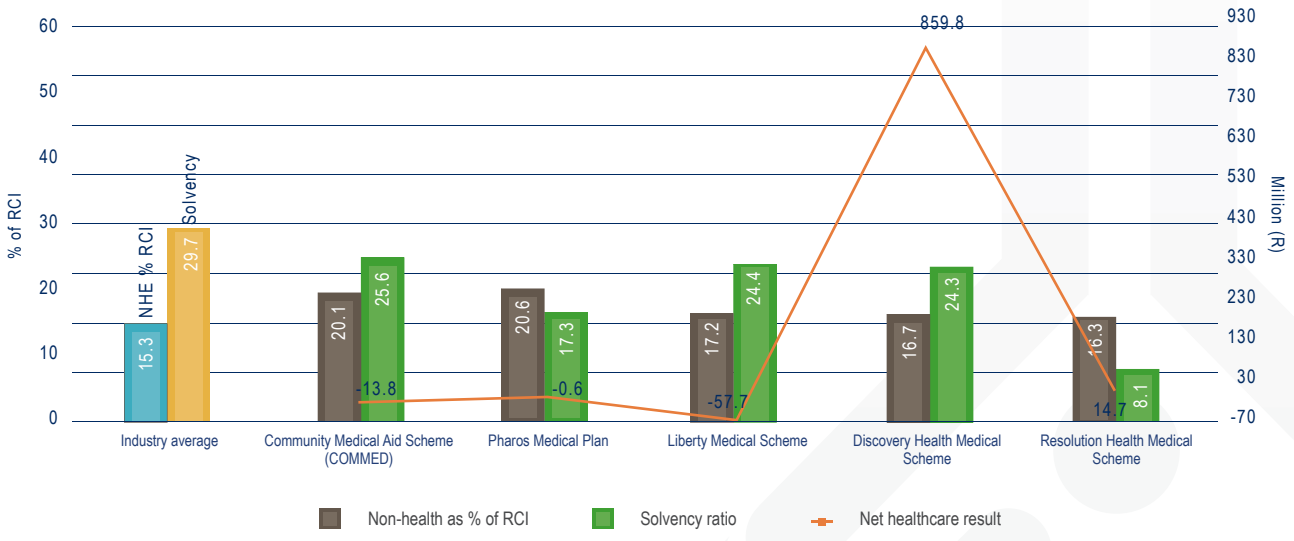
Table 65: Net non-healthcare expenses, claims and reserve-building of open schemes with above average non-healthcare 2012 and 2013

	Net non-healthcare expenses – pabpm		Net claims incurred as % of RCI		Net non-healthcare expenses as % of RCI		Reserve-building as % of RCI	
Name of open medical scheme	2013	2012	2013	2012	2013	2012	2013	2012
Community Medical Aid Scheme (COMMED)	323.5	287.9	85.4	82.3	20.1	18.6	(5.5)	(0.9)
Spectramed	276.7	193.6	82.3	80.0	22.5	17.3	(4.8)	2.7
Pharos Medical Plan	272.6	238.3	79.7	81.3	20.6	18.6	(0.3)	0.1
Compcare Wellness Medical Scheme	217.3	202.3	87.8	80.9	16.9	16.2	(4.7)	2.9
Liberty Medical Scheme	210.7	180.2	86.1	88.8	17.2	16.4	(3.3)	(5.1)
Discovery Health Medical Scheme	179.2	170.7	80.7	81.8	16.7	17.5	2.6	0.7
Industry average for open schemes	**174.4**	**164.0**	**83.7**	**84.5**	**15.3**	**15.6**	**1.0**	**(0.1)**

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

Figure 46 shows which schemes listed in Table 65 had a solvency ratio below the open schemes' average of 29.7%. It is concerning that some of these medical schemes fall below the statutory target of 25% yet exhibit very high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

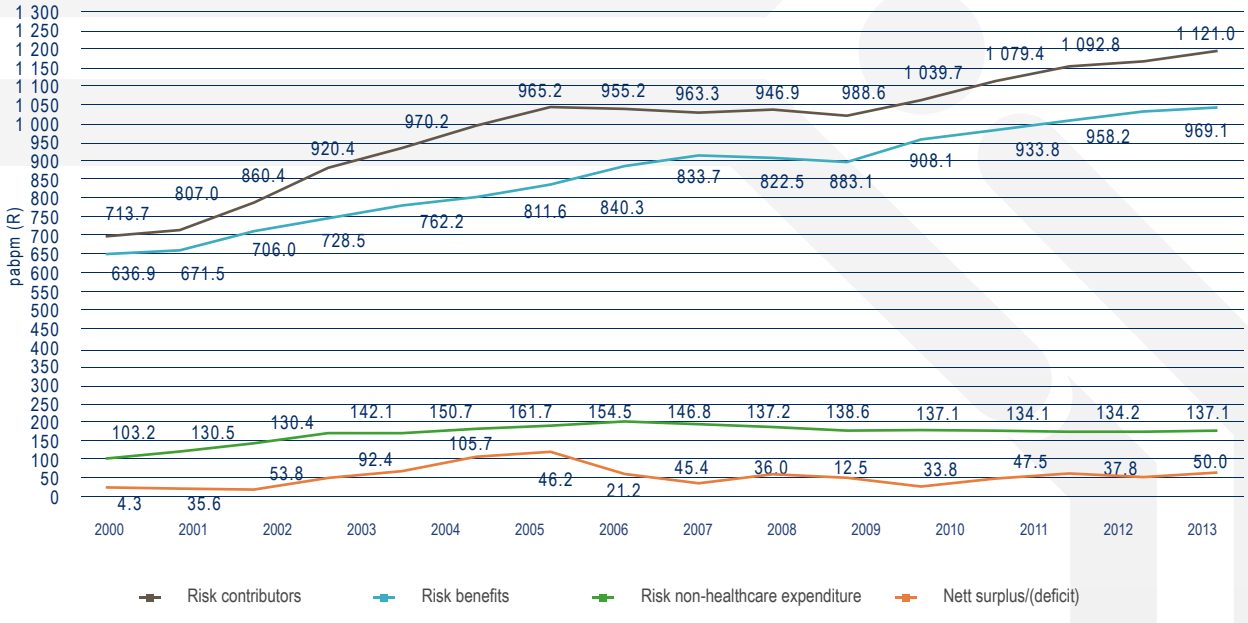
Figure 46: Open schemes with high non-healthcare expenditure and solvency ratio below average (2013)



RCI = Risk Contribution Income

Figure 47 depicts information on contributions, benefits, non-healthcare expenditure and operating surpluses pabpm. Unlike in earlier years, where both the non-healthcare expenditure and surpluses pabpm were volatile, the situation seems to have stabilised in recent years.

Figure 47: Risk contributions, benefits, non-healthcare expenditure and operating surpluses 2000 – 2013: 2013 prices*



pabpm = per average beneficiary per month
** The values were adjusted for CPI for 2000-2013.*

Net healthcare results and trends

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

The net healthcare result for all medical schemes combined was a surplus of R1 551.8 million in 2013 (2012: R29.0 million surplus). Open schemes incurred surpluses of R626.5 million (2012: R61.1 million deficit), and restricted schemes generated surpluses of R925.2 million (2012: R90.1 million surplus). This improvement is mainly due to the reduced claims ratios of all schemes from 87.7% in 2012 to 86.4%.

Figure 48: Net healthcare results 2000 – 2013

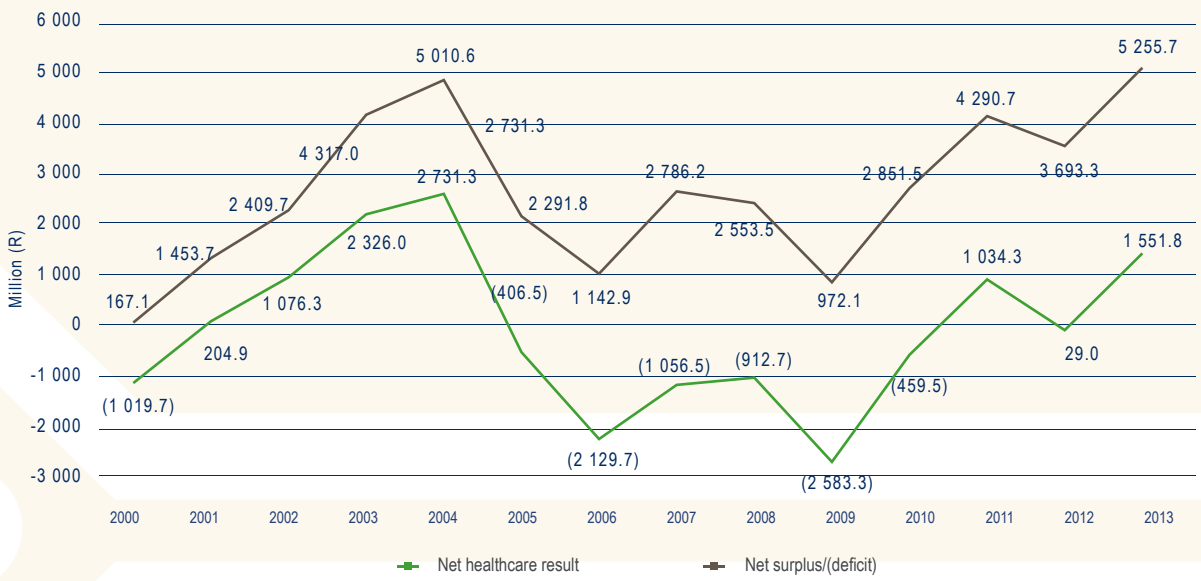


Table 66 lists the 20 schemes with the highest net healthcare deficits. Investment income has protected a number of these schemes from experiencing major drops in their solvency levels.

Table 66: Twenty schemes with largest net healthcare deficits 2012 and 2013

Name of medical scheme	Type	Net healthcare result 2013 R'000	2012 R'000	% growth	Solvency ratio 2013 %	Solvency ratio 2012 %
Medihelp	Open	(143 090)	(164 123)	12.8	30.4	32.4
Bonitas Medical Fund	Open	(115 219)	(184 477)	37.5	33.3	35.5
Topmed Medical Scheme	Open	(68 389)	(49 300)	(38.7)	123.8	152.3
Anglo Medical Scheme	Restricted	(58 559)	(52 435)	(11.7)	526.3	472.3
Liberty Medical Scheme	Open	(57 728)	(86 040)	32.9	24.4	26.2
Fedhealth Medical Scheme	Open	(54 858)	91 295	(160.1)	40.2	40.9
Platinum Health	Restricted	(38 389)	(16 934)	(126.7)	33.5	34.7
Nedgroup Medical Aid Scheme	Restricted	(35 022)	(29 137)	(20.2)	35.6	36.1
Spectramed	Open	(30 498)	19 216	(258.7)	48.5	44.9
Bestmed Medical Scheme	Open	(28 008)	(21 049)	(33.1)	29.2	28.5
Cape Medical Plan	Open	(26 408)	(10 826)	(143.9)	133.1	140.3
Malcor Medical Scheme	Restricted	(21 415)	(19 525)	(9.7)	25.0	26.1
Quantum Medical Aid Society	Restricted	(21 403)	(25 755)	16.9	87.7	98.5
Bankmed	Restricted	(20 942)	(78 546)	73.3	49.7	48.4
Selfmed Medical Scheme	Open	(20 654)	(21 065)	2.0	111.2	116.2
SAMWUMed	Restricted	(20 363)	(7 569)	(169.0)	59.9	72.0
Golden Arrow Employees Medical Benefit Fund	Restricted	(18 877)	(16 258)	(16.1)	128.5	112.1
Compcare Wellness Medical Scheme	Open	(16 952)	10 050	(268.7)	42.1	45.1
Transmed Medical Fund	Restricted	(14 810)	84 168	(117.6)	20.9	16.3
Community Medical Aid Scheme (COMMED)	Open	(13 814)	(2 375)	(481.6)	25.6	25.5

A total of 66.7% (or 16 of 24) of open schemes and 41.3% (26 of 63)[6] of restricted schemes recorded net healthcare deficits in 2013.

The net surplus of all schemes combined, after investment income and consolidation adjustments, was R5.3 billion (2012: R3.7 billion). Net investment and other income as well as expenditure increased by 1% to R3.7 billion. Open schemes made a R2.3 billion (2012: R1.6 billion) surplus and restricted schemes a surplus of R2.9 billion (2012: R2.1 billion).

Figures 47 and 48 show the impact of increases in claims costs on the net healthcare result.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 48.

Table 67 shows the 20 schemes with the largest net healthcare deficits according to the Risk Assessment Framework (RAF) classification in 2013. These schemes represent 83.2% of the total number beneficiaries belonging to schemes that recorded operating deficits. (Annexure L provides more detail on this.)

6. Sedmed did not submit any financial information and were therefore omitted from this analysis.

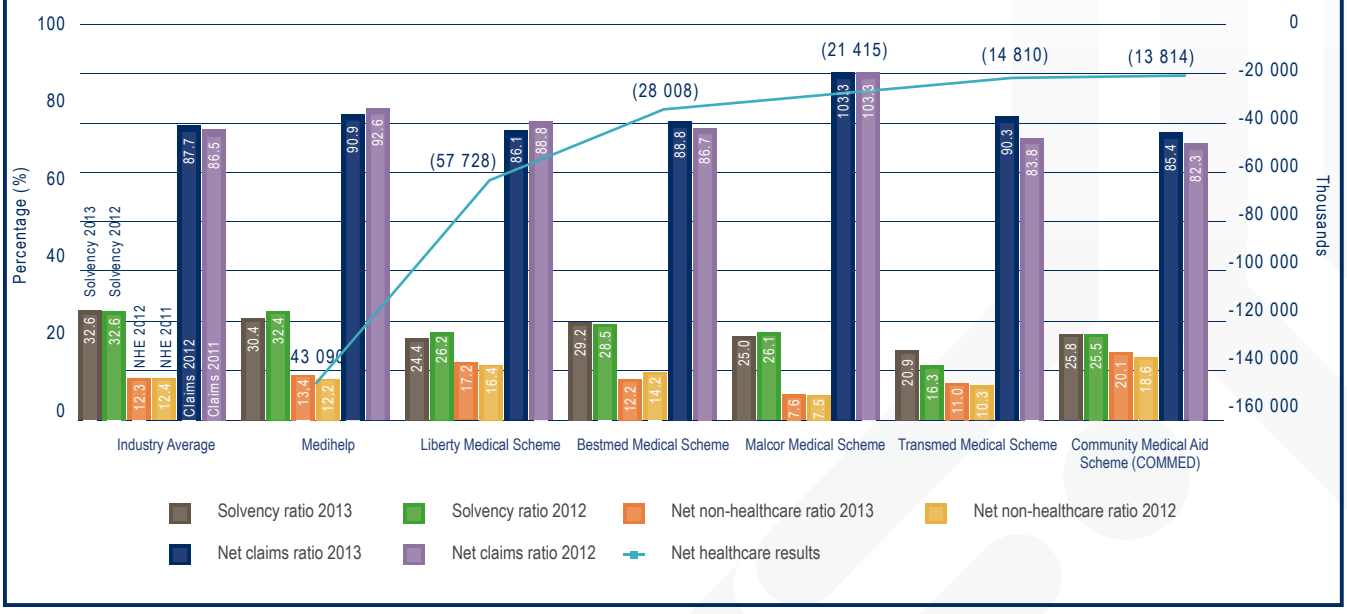
Table 67: Twenty schemes with largest net healthcare deficits by RAF classification 2012 and 2013

Name of medical scheme	Type	Net healthcare result 2013 R'000	2012 R'000	% growth	RAF classification
Medihelp	Open	**(143 090)**	(164 123)	12.8	High
Bonitas Medical Fund	Open	**(115 219)**	(184 477)	37.5	High
Topmed Medical Scheme	Open	**(68 389)**	(49 300)	(38.7)	Medium
Anglo Medical Scheme	Open	**(58 559)**	(52 435)	(11.7)	Medium
Liberty Medical Scheme	Restricted	**(57 728)**	(86 040)	32.9	High
Fedhealth Medical Scheme	Restricted	**(54 858)**	91 295	(160.1)	High
Platinum Health	Open	**(38 389)**	(16 934)	(126.7)	High
Nedgroup Medical Aid Scheme	Open	**(35 022)**	(29 137)	(20.2)	High
Spectramed	Restricted	**(30 498)**	19 216	(258.7)	High
Bestmed Medical Scheme	Open	**(28 008)**	(21 049)	(33.1)	High
Cape Medical Plan	Restricted	**(26 408)**	(10 826)	(143.9)	Medium
Malcor Medical Scheme	Restricted	**(21 415)**	(19 525)	(9.7)	Medium
Quantum Medical Aid Society	Restricted	**(21 403)**	(25 755)	16.9	Medium
Bankmed	Restricted	**(20 942)**	(78 546)	73.3	High
Selfmed Medical Scheme	Open	**(20 654)**	(21 065)	2.0	High
SAMWUMed	Open	**(20 363)**	(7 569)	(169.0)	High
Golden Arrow Employees Medical Benefit Fund	Restricted	**(18 877)**	(16 258)	(16.1)	Medium
Compcare Wellness Medical Scheme	Restricted	**(16 952)**	10 050	(268.7)	Medium
Transmed Medical Fund	Open	**(14 810)**	84 168	(117.6)	High
Community Medical Aid Scheme (COMMED)	Restricted	**(13 814)**	(2 375)	(481.6)	Medium

RAF = Risk Assessment Framework

Figure 49 shows the high-impact schemes with the largest net healthcare deficits and with solvency levels below the industry average of 33.3%. (Annexure M provides more details.)

Figure 49: High impact schemes with the largest net healtcare deficits and solvency levels below industry average 2012 and 2013



Accumulated funds, solvency and solvency trends

Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes.

Accumulated funds – that is, the net asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable profits – must at all times be maintained at a minimum level of 25% of gross contributions. These minimum accumulated funds are more commonly called the "reserves" of a scheme. When expressed as a percentage of gross contributions, they become known as the "solvency ratio" of a scheme.

The purpose of a prescribed solvency level is to have warning of a medical scheme's possible inability to meet its obligations. A solvency margin serves both to protect members' interests as well as to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse events, whether from claims, assets, liabilities or expenses.

Net assets or members' funds (total assets minus total liabilities) rose by 13.3% to R46.3 billion at the end of 2013. Accumulated funds grew by 13.4% to R44.3 billion from R39.1 billion recorded at the end of 2012.

The industry average solvency ratio increased by 2.1% to 33.3% from 32.6% in 2012.

The solvency ratio of open schemes increased by 2.1% to 29.7% in 2013 (2012: 29.1%). Restricted schemes experienced an increase of 2.1% in solvency ratio, which increased to 38.2% (2012: 37.4%)

Table 66 lists the schemes which experienced the largest net healthcare deficits. Full details of the solvency ratios of all medical schemes are contained in Annexures J, K, and L.

Figures 50, 51 and 52 show changes in solvency ratios since 2000 in all schemes, open schemes and restricted schemes respectively. The average solvency of restricted schemes has been declining since 2006. This is mostly due to the fact that the denominator used in calculating solvency is affected by membership growth. GEMS, which is the largest restricted scheme, has shown exceptional membership growth since registration, and this resulted in a deterioration in the solvency level of the restricted schemes industry.

Figure 50: Industry solvency trends 2000 – 2013

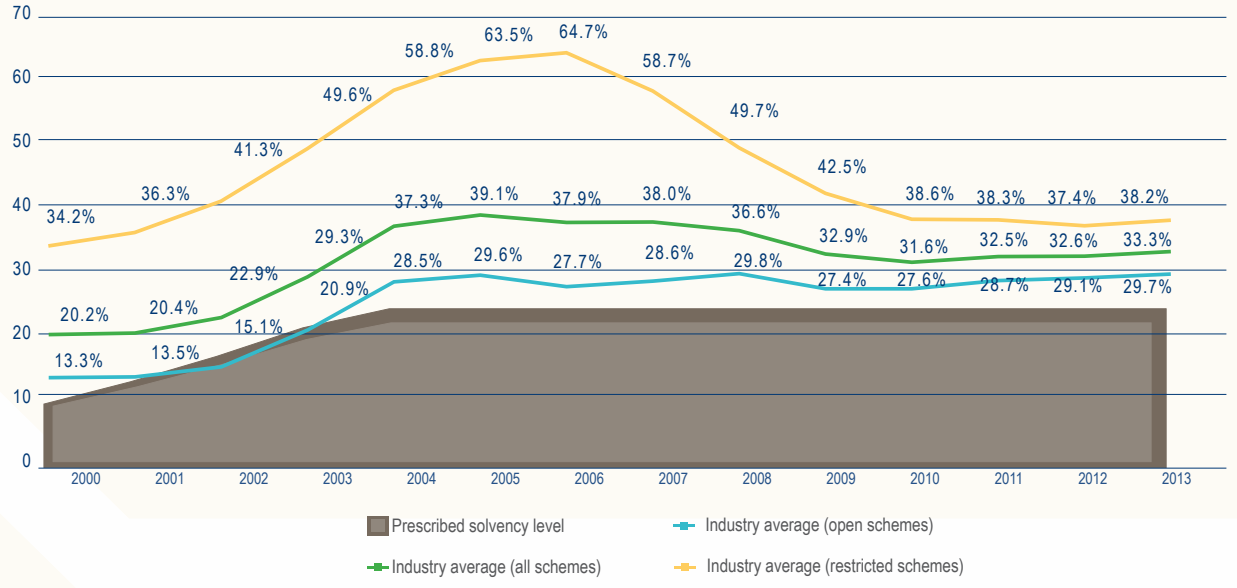


Figure 51: Industry solvency for open schemes 2000 – 2013

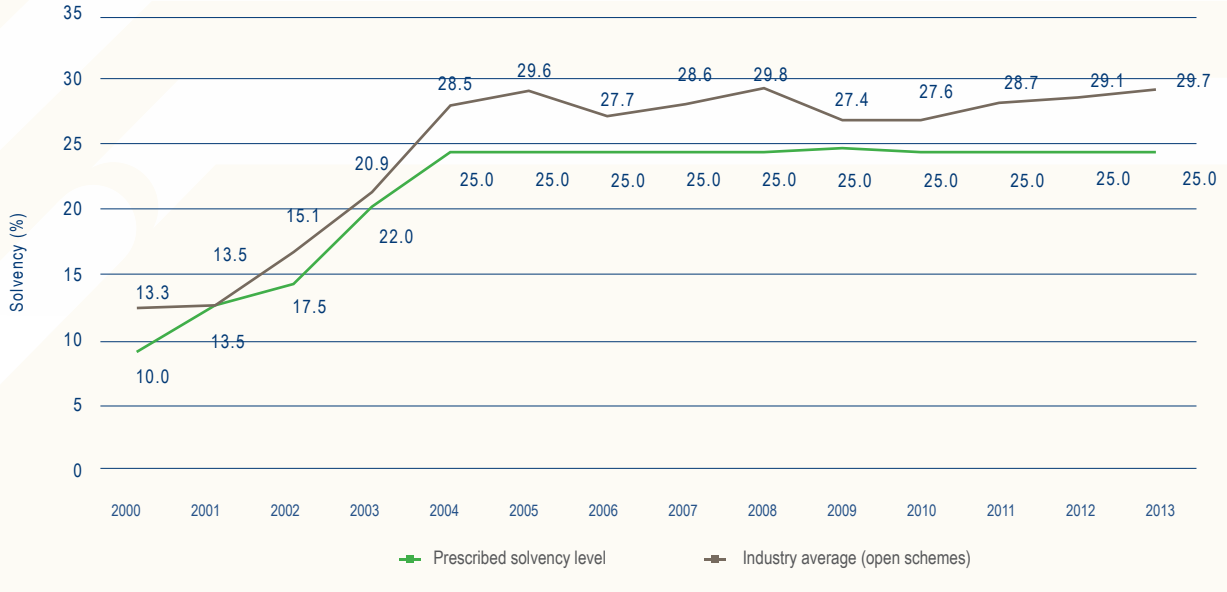
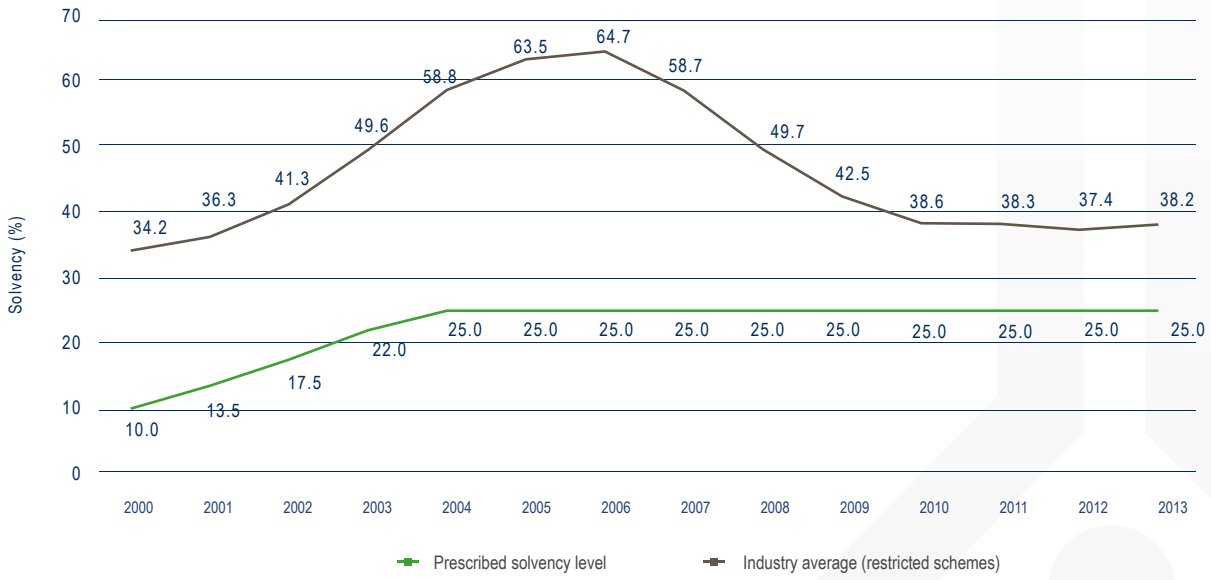


Figure 52: Industry solvency for restricted schemes 2000 – 2013



Factors that affect solvency

The most important factors impacting on solvency are:

- The pricing of contributions relative to benefits provided, including whether such benefits are provided from the risk pool of the scheme or from members' savings accounts.
- Non-healthcare expenditure.
- Investment income.
- Membership growth.

The membership profile of a medical scheme further affects its solvency. The membership profile includes variables such as the average age of the scheme's beneficiaries, its pensioner ratio, the number of male versus female dependants, and the dependant ratio. All of these impact on the frequency and extent of claims.

Table 68 looks at risk claims, non-healthcare expenditure and contributions relative to reserves between 1999 and 2013.

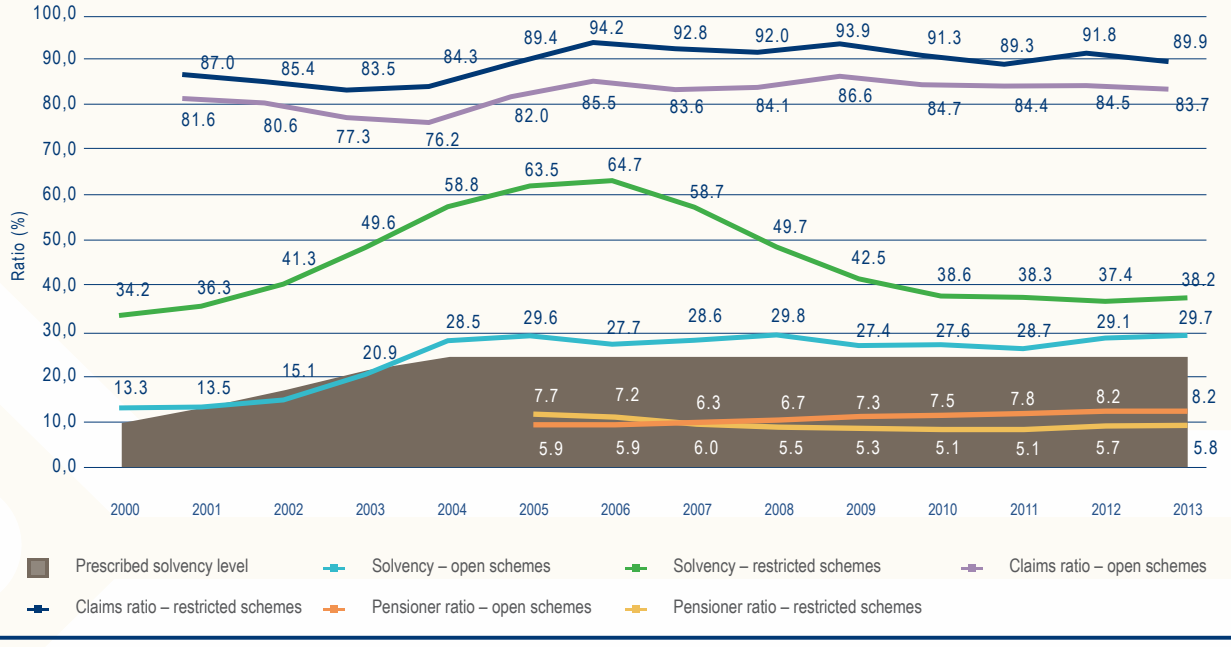
Table 68: Risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions 1999 – 2013

	Risk claims %	Non- healthcare expenditure %	Reserve-building %
1999	91.5	12.7	(4.2)
2000	89.3	14.5	(3.7)
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	(0.0)
2006	88.0	16.2	(4.1)
2007	86.5	15.2	(1.8)
2008	86.9	14.5	(1.4)
2009	89.3	14.0	(3.3)
2010	87.3	13.2	(0.5)
2011	86.5	12.4	1.1
2012	87.7	12.3	–
2013	86.4	12.2	1.4

Total risk claims fell between 2000 and 2004 and the ratio of contributions to reserves improved during this period from a negative 4.2% to a positive 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. The claims ratio then started to increase in 2005 and reached 86.4% in 2013. Contributions to reserves were generally negative during this period. This is consistent with the fact that most medical schemes have attained the prescribed solvency ratio of 25.0% and do not need to grow their reserves any further. The maintenance of reserves should be considered against the backdrop of increasing claim costs to ensure that members are protected at all times.

Figure 53 illustrates the impact of GEMS on all medical schemes. GEMS is a restricted scheme that was registered on 1 January 2005 and started operating on 1 January 2006.

Figure 53: Impact of GEMS on medical schemes industry 2006 – 2013*



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

GEMS initially had a positive effect on the solvency levels of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who have been steadily leaving them to join GEMS. The reserves which these members had accumulated over the years of their membership of these open schemes were not transferred to GEMS.

A negative impact was subsequently experienced on the claiming patterns of some of these open schemes as members who left them to join GEMS tended to be young and healthy, and they were not necessarily replaced by members of a similar profile.

Medical schemes need to be careful of the so-called "death spiral". A scheme with an adverse, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members being over-priced, causing younger and lower-claiming members to move to less expensive options or even to other medical schemes. This leads to the scheme losing the cross-subsidy provided by younger members and therefore its losses increase and it becomes necessary to increase contributions or reduce benefits even further.

Beneficiaries of schemes failing to reach the 25% solvency

Table 69 shows the number of medical schemes which have yet to attain the prescribed solvency ratio of 25% and the number of beneficiaries in those schemes. The data for 2012 and 2013 are depicted in Figure 54.

Table 69: Prescribed solvency and number of beneficiaries 2000 – 2013

		Open schemes		Restricted schemes	
		Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
Number of schemes	2000	15	33	15	86
	2001	19	29	11	83
	2002	24	25	7	86
	2003	19	29	7	80
	2004	18	30	4	81
	2005	17	29	4	79
	2006	18	23	4	79
	2007	18	23	7	74
	2008	14	21	8	71
	2009	16	17	4	71
	2010	12	15	7	66
	2011	9	17	5	66
	2012	7	18	4	63
	2013	6	18	3	59

		At end of year	% of total	At end of year	At end of year	% of total	At end of year
Beneficiaries	2000	2 385 051	51.0	2 291 048	839 029	40.9	1 214 412
	2001	2 650 934	55.6	2 117 142	576 462	28.9	1 419 862
	2002	3 519 329	74.4	1 211 882	251 050	12.7	1 731 873
	2003	3 426 988	72.6	1 291 809	222 430	11.4	1 730 574
	2004	2 534 273	53.3	2 221 030	80 160	4.2	1 827 100
	2005	2 783 108	56.7	2 122 444	36 359	1.9	1 893 710
	2006	3 218 382	63.7	1 832 056	145 369	7.0	1 931 536
	2007	3 139 176	63.4	1 812 141	689 865	26.0	1 964 054
	2008	1 076 450	22.0	3 812 456	981 977	32.9	2 003 943
	2009	992 523	20.6	3 822 811	1 254 151	38.6	1 999 020
	2010	2 918 055	60.8	1 881 860	1 684 682	47.9	1 831 121
	2011	2 855 072	60.0	1 905 042	1 865 313	49.5	1 900 982
	2012	2 796 583	58.8	1 963 411	1 978 668	50.4	1 943 538
	2013	2 860 768	59.0	1 986 141	1 994 813	50.8	1 934 557

Figure 54: Prescribed solvency and number of beneficiaries 2012 and 2013

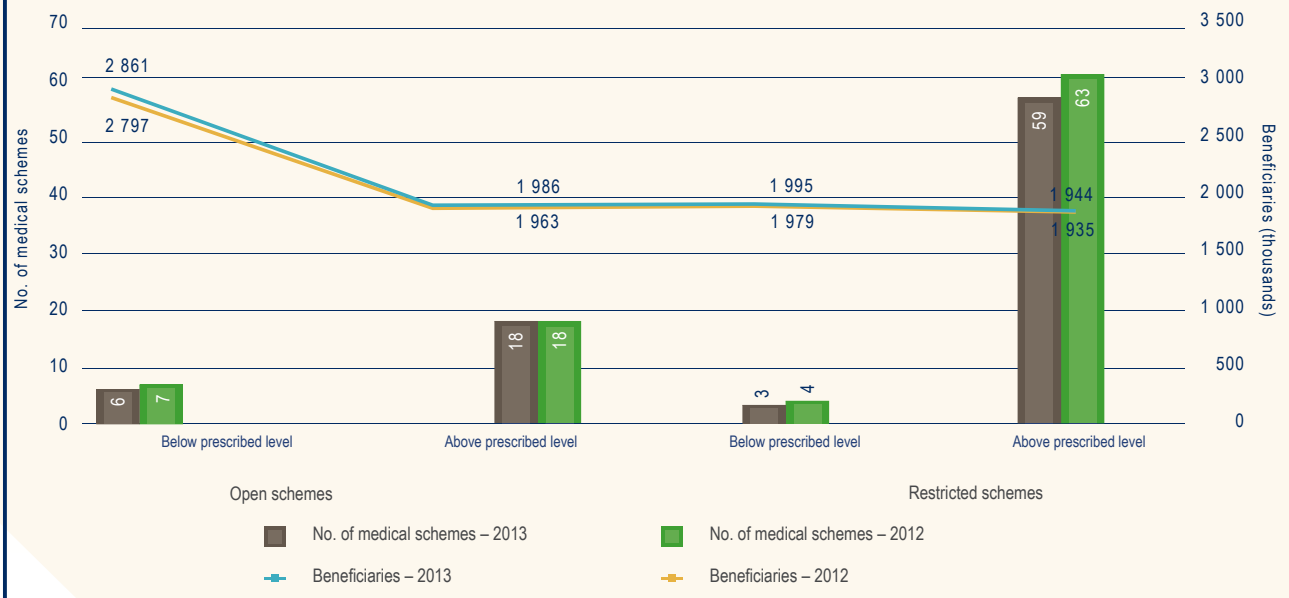


Table 69 and Figure 54 show the number of schemes meeting the prescribed solvency level and the number of beneficiaries represented by falling above and below the prescribed solvency level.

In 2013, a total of 59.0% of beneficiaries in open schemes (2012: 58.8%) were covered by the six schemes (2012: seven) which failed to meet the prescribed solvency level. The remaining beneficiaries belonged to the 18 open schemes (2012: 18) which had attained the prescribed solvency level of 25%.

Most beneficiaries of open schemes which have yet to achieve the prescribed solvency belong to Discovery Health Medical Scheme (DHMS), which was the largest open scheme in South Africa as at December 2013. DHMS had a solvency of 24.3% as at 31 December 2013.

Of the 63 restricted schemes, only three recorded solvency ratios lower than 25%. These three, however, account for 50.8% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory phase-in solvency level of 25% and this scheme accounts for 92.9% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio.

The CMS is cognisant of the structural challenges facing the medical schemes environment and the progress that schemes have made in moving towards the prescribed solvency levels. However, much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

Risk Assessment Framework and high-impact schemes

The Risk Assessment Framework (RAF) is a regulatory tool adopted by the CMS to identify both scheme-specific and cross-cutting risks related to the medical schemes environment. It assists in identifying those medical schemes which may have a major systemic impact on the goals of the CMS and industry if they were to fail. The classification as a "high-impact scheme" does not necessarily mean that the identified scheme is a major-risk scheme or that it is experiencing problems.

Of the 27 schemes classified as high impact in 2013 (2012: 28), one (2012: two) had a solvency ratio below 10%, one (2012: zero) had a solvency ratio in the 10 – 15% range, none (2012: one) in the 15 – 20% range, and four (2012: four) in the 20 – 25% range. The remaining 21 high-impact schemes (2012: 21) had met the prescribed solvency of 25% by the end of 2013.

Table 72 shows that the average contributions of high-impact open schemes were 3.5% higher than those of high-impact restricted schemes. High-impact open schemes had a claims ratio that was 7.2% lower than that of high-impact restricted schemes. The net non-healthcare expenditure expressed as a percentage of Risk Contribution Income (RCI) of these open schemes exceeds the net non-healthcare expenditure of high-impact restricted schemes by 91.8%.

Table 70: High-impact schemes by type 2012 and 2013

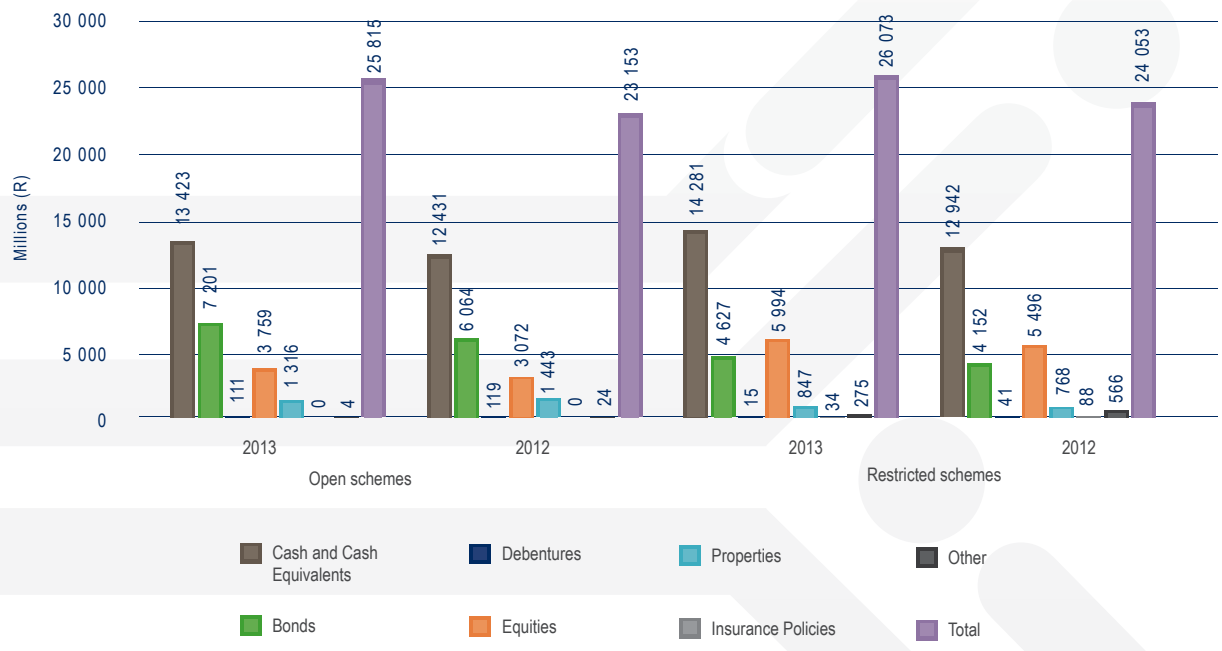
	Average number of beneficiaries		Net contributions pabpm		Net claims ratio		Net non-healthcare ratio		Solvency ratio	
			2013	2012	2013	2012	2013	2012	2013	2012
	2013	2012	R	R	%	%	%	%	%	%
Open	4 641 548	4 580 290	1 143.3	1 051.6	83.6	84.4	15.3	15.6	28.5	27.8
Restricted	3 182 705	3 098 959	1 104.7	1 008.7	90.1	92.4	8.0	7.6	26.6	24.8
Total	**7 824 253**	**7 679 249**	**1 127.6**	**1 034.3**	**86.2**	**87.5**	**12.4**	**12.5**	**27.8**	**26.7**

pabpm = per average beneficiary per month

Investments

Figure 55 provides information on the investments of medical schemes as at the end of the years 2012 and 2013.

Figure 55: Scheme investments 2012 and 2013



In open schemes, 52.0% of investments (2012: 53.7%) were held in cash or cash equivalents. Bonds accounted for 27.9% (2012: 26.2%), debentures for 0.4% (2012: 0.5%), equities for 14.6% (2012: 13.3%), non-linked insurance policies for 0.0% (2012: 0.0%), properties for 5.1% (2012: 6.2%), and other investments for 0.0% (2012: 0.1%).

Restricted schemes also held a large proportion of their investments (54.8%) in cash or cash equivalents (2012: 53.8%). Bonds accounted for 17.8% of total investments (2012: 17.3%) and debentures for 0.1% (2012: 0.2%). Equities made up 23.0% (2012: 22.9%), non-linked insurance policies 0.1% (2012: 0.4%), properties 3.3% (2012: 3.2%), and other investments 1.1% (2012: 2.4%).

The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when these benefits fall due. The management of its assets must therefore be structured to cope with the magnitude, nature and timing of its expected liabilities. The assets of a scheme

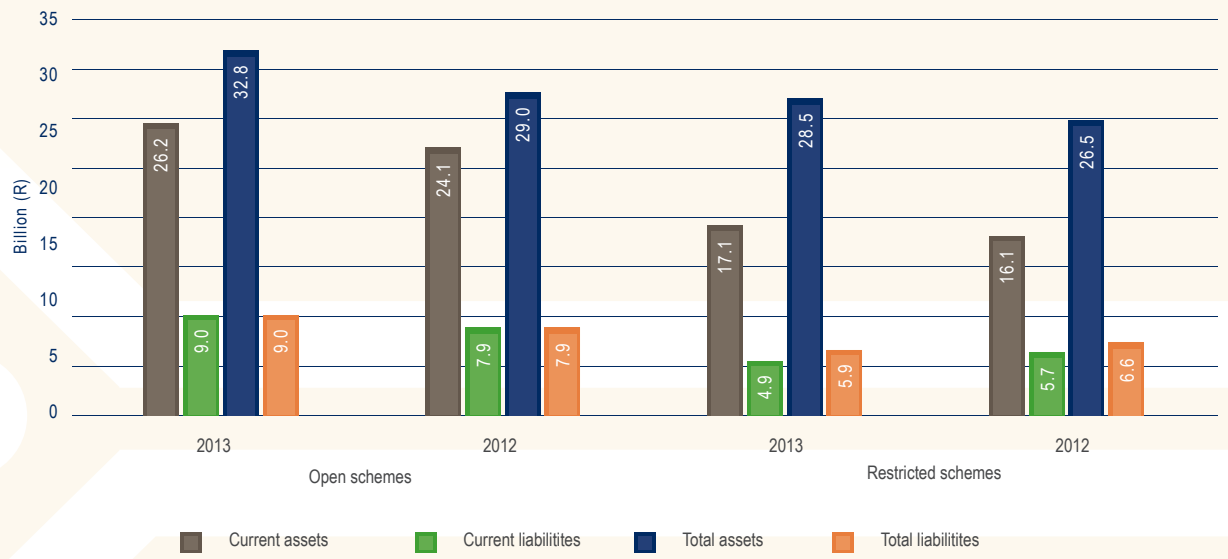
should be spread in such a manner that they meet its liabilities and minimum accumulated fund requirements (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities constitutes 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 need to pay attention to more than their total asset and liability positions. They need to consider the periods in which liabilities must be paid and which assets can be converted into cash flows.

Figure 56 compares the matching of assets and liabilities in open and restricted schemes.

Figure 56: Matching assets and liabilities 2012 and 2013



The current-assets-to-current-liabilities ratio in open schemes was 2.9:1 in 2013 (3:0 in 2012). The corresponding figure for restricted schemes was 3.5:1 (2012: 2.8:1). The total-asset-to-total-liability ratios for open and restricted schemes were 3.6:1 (2012: 3.6:1) and 4.8:1 (2012: 4.0:1) respectively.

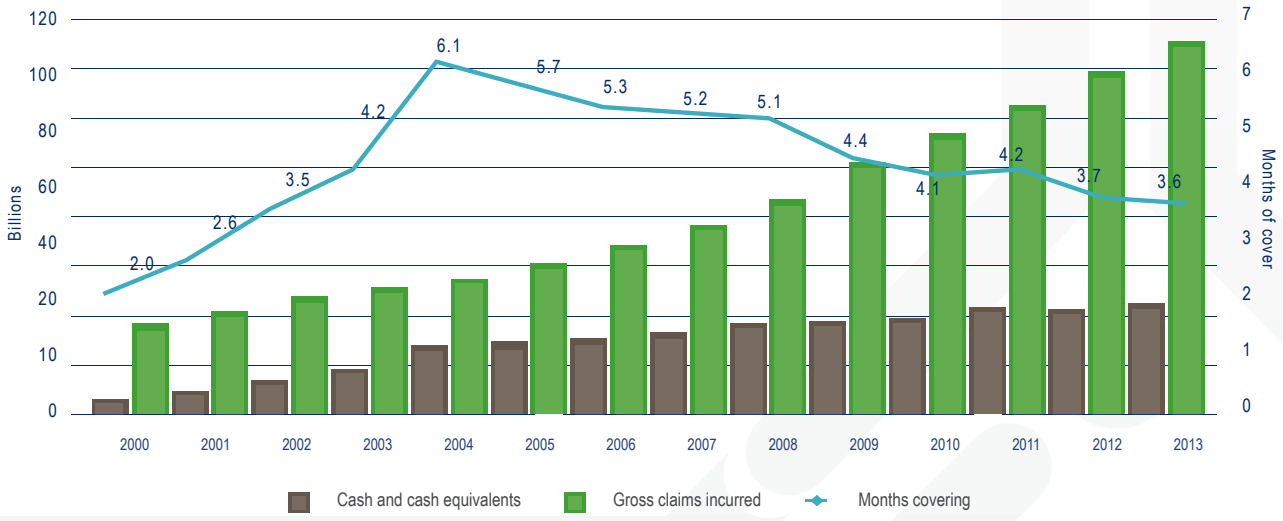
The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, with a quick ratio below 2.0) falls below the industry average of 3.6 months, boards of trustees must guard against longer-term (and 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 partly measured by its ability to pay claims from cash and cash equivalents.

Figure 57 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 57: Average gross claims covered by cash and cash equivalents 2000 – 2013



The cash coverage of schemes declined from 3.7 months in 2012 to 3.6 months as at December 2013. The payment cycles of medical schemes reflected an average of 12.4 days compared with the 15.3 days reported in 2012.

Benefit options

At the end of 2013, there were 278 registered benefit options (2012: 303) operating in 87 medical schemes.

It should be noted that for the purposes of this report, the benefit options of Sedmed were excluded as the scheme submitted no data for the 2013 year.

Open schemes accounted for 50.4% or 140 of the registered benefit options at the end of 2013 (2012: 52.1% or 158 options). Restricted schemes had 138 options at year end representing 49.6% of all options (2012: 145 options or 47.9%).

On average, in December 2013, open schemes had 5.8 options per scheme (2012: 6.3) and 16 115 members per option (2012: 13 908). Restricted schemes had an average of 2.2 options per scheme (2012: 2.2), with an average of 11 754 members per option as at December 2013 (2012: 11 165).

Of the 278 benefit options at year end, 96 (34.5%) had fewer than 2 500 members per option (2012: 117 or 38.6%). Of these 96 options, 58 (60.4%) incurred net healthcare losses in 2013. In 2012, 61 of these options (52.1%) incurred losses.

The remaining 182 options (2012: 186) had more than 2 500 members per option. Of these, 40.7% or 74 options incurred net healthcare losses (2012: 43.5% or 81 options).

Table 71: Results of benefit options 2013

	Open schemes	Share of total %	Restricted schemes	Share of total %	Total
All options					
Number of options	140	50.4	138	49.6	278
Membership represented	2 256 168	58.2	1 622 099	41.8	3 878 267
Number of schemes	24	27.6	63	72.4	87
Net healthcare result (R'000)	626 362		923 839		1 550 201
Gross non-healthcare as % of GCI	13.3		8.0		11.1
Gross claims ratio (%)	85.0		89.9		87.0
Gross claims incurred pbpm	1 103.8		1 028.7		1 070.1
GCI pbpm	1 298.9		1 144.8		1 229.9
Options with members >= 2 500					
Number of options	95	52.2	87	47.8	182
Membership represented	2 207 203	58.5	1 566 368	41.5	3 773 571
Net healthcare result (R'000)	768 319		1 022 298		1 790 617
Gross non-healthcare as % of GCI	13.4		8.0		11.1
Gross claims ratio (%)	84.7		89.6		86.7
Gross claims incurred pbpm	1 095.2		1 013.5		1 058.8
GCI pbpm	1 292.8		1 131.3		1 220.9
Options with members < 2 500					
Number of options	45	46.9	51	53.1	96
Membership represented	48 965	46.8	55 731	53.2	104 696
Net healthcare result (R'000)	(141 957)		(98 459)		(240 416)
Gross non-healthcare as % of GCI	11.6		8.0		9.6
Gross claims ratio (%)	95.2		96.2		95.8
Gross claims incurred pbpm	1 522.1		1 535.0		1 529.1
GCI pbpm	1 598.9		1 595.0		1 596.8

GCI = Gross Contribution Income
pbpm = per beneficiary per month

At the end of 2013, there were 45 options in open schemes with fewer than 2 500 members (2012: 62). These had an average of 1 088.1 members per option (2012: 1 133.2) and represented 32.1% (2012: 39.2%) of all open schemes options.

Restricted schemes had 51 options with fewer than 2 500 members (2012: 55). These options had an average membership of 1 092.8 (2012: 1 151.6) and they represented 37.0% (2012: 37.9%) of all options in restricted schemes.

Table 72: Results of loss-making benefit options 2013

	Open schemes	Share of total %	Restricted schemes	Share of total %	Total
Total loss making options					
Loss-making options as % of total options	53.6		41.3		47.5
Number of loss-making options	75	56.8	57	43.2	132
Membership represented	1 026 382	72.8	384 267	27.2	1 410 649
Net healthcare result (R'000)	(1 912 121)		(1 372 023)		(3 284 145)
Gross non-healthcare spending as % of GCI	12.7		8.1		11.5
Gross claims ratio (%)	91.6		102.2		94.4
Gross claims incurred pbpm (R)	1 227.5		1 403.3		1 273.8
GCI pbpm (R)	1 340.3		1 373.6		1 349.1
Loss making options with members > =2 500					
Number of loss-making options	44	59.5	30	40.5	74
Membership represented	992 133	73.7	353 789	26.3	1 345 922
Net healthcare result (R'000)	(1 731 808)		(1 208 406)		(2 940 214)
Gross non-healthcare as % of GCI	12.8		8.2		11.6
Gross claims ratio (%)	91.2		101.8		93.9
Gross claims incurred pbpm (R)	1 213.0		1 359.1		1 250.0
GCI pbpm (R)	1 330.1		1 334.5		1 331.2
Loss making options with members < 2 500					
Number of loss-making options	31	53.4	27	46.6	58
Membership represented	34 249	52.9	30 478	47.1	64 727
Net healthcare result (R'000)	(180 314)		(163 617)		(343 931)
Gross non-healthcare as % of GCI	11.5		6.8		9.1
Gross claims ratio (%)	101.3		104.8		103.1
Gross claims incurred pbpm (R)	1 688.2		1 902.5		1 793.0
GCI pbpm (R)	1 666.5		1 815.6		1 739.4

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 278 benefit options registered and operating at the end of 2013 (2012: 303), 132 (47.5%) incurred net healthcare losses. In 2012, 142 options (46.9%) incurred net healthcare losses. In the year under review, 75 of these options (2012: 77), representing 56.8% (2012: 54.2%) of loss-making options, were in open schemes and 57 (2012: 65), representing 43.2% (2012: 45.8%), were in restricted schemes.

Net healthcare losses per member per month (pmpm) in options with fewer than 2 500 members amounted to R442.8 compared to R182.0 for options with more than 2 500 members. In other words, net healthcare losses in the smaller options were 2.4 times greater (2012: 3.1) than in options with more than 2 500 members.

Benefit options with fewer than 2 500 members generally had higher contributions and claims than other options and also attracted higher non-healthcare costs as they were spread across a smaller base.

Table 73 shows option results by the age demographic.

In open schemes, there were 87 options where the average age of beneficiaries was above 33.5 years (the average beneficiary age for all options in open schemes) and 53 benefit options with the average age of beneficiaries falling below the industry average.

Table 73: Net healthcare result of options in 2013 by age demographic

	Options with average member age above or equal to average for industry* 2013			Options with average member age below average for industry* 2013		
	Open	Restricted	Total	Open	Restricted	Total
NHC results pbpm above or equal to industry average (R10.8 for open schemes and R19.6 for restricted schemes)	30	30	60	23	35	58
NHC results pbpm below industry average (R10.8 for open schemes and R19.6 for restricted schemes)	57	47	104	30	26	56
Total number of options	**87**	**77**	**164**	**53**	**61**	**114**

* *Average age for open schemes = 33.5 years in 2013 and for restricted schemes = 30.0 years*
NHC = Net healthcare
pbpm = per beneficiary per month

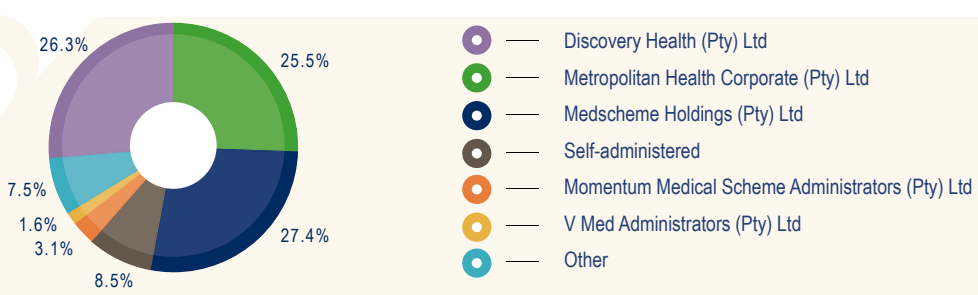
In the restricted schemes market, 77 benefit options had beneficiaries with an average age higher than 30.0 years (the average beneficiary age for all options in restricted schemes) and a total of 61 options had beneficiaries with an average age below 30.0 years.

As expected, options covering older beneficiaries who experience more illness incurred greater deficits.

Administrator market

Figure 58 shows the market shares of medical scheme administrators and self-administered medical schemes respectively based on the number of beneficiaries administered as at December 2013[7].

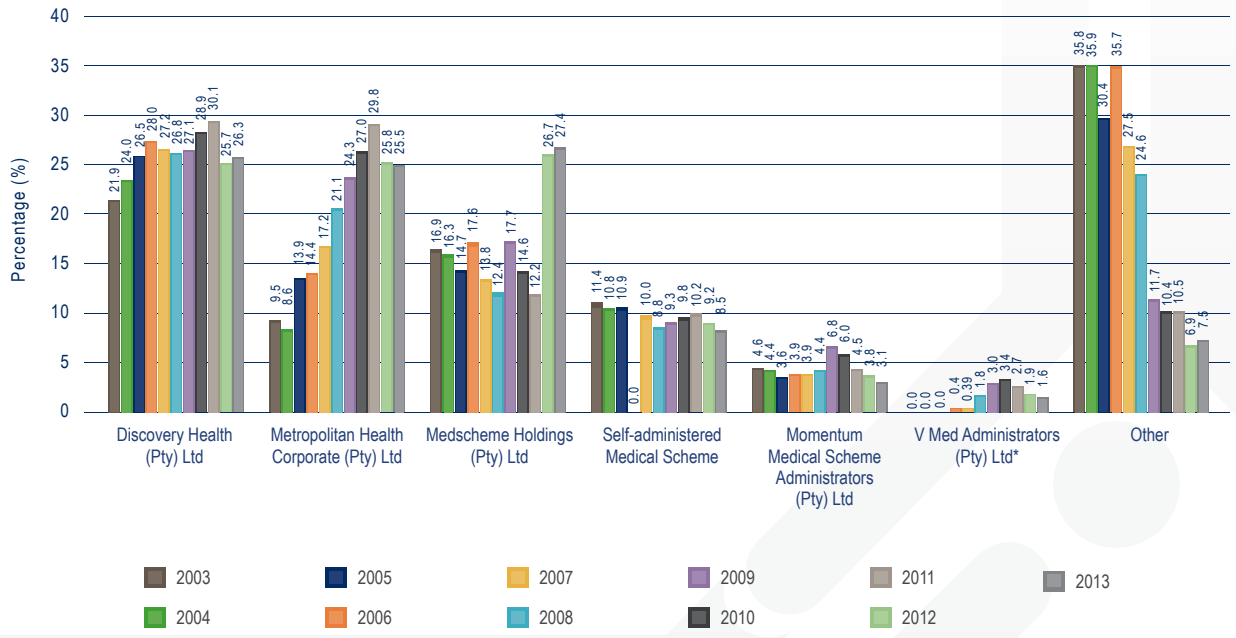
Figure 58: Administrator market share at the end of 2013



7. The data that is presented here differs from Annexure U which is based on the average membership administered during the year.

Figure 59 depicts the changes in market share of all medical schemes over the last 10 years based on the number of beneficiaries administered by the various parties at the end of each year.

Figure 59: Market share of largest administrators based on average number of beneficiaries 2003 – 2013*



* *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 U).*

Five third-party administrators continued to dominate the market in 2013, namely:

- Discovery Health (Pty) Ltd.
- Metropolitan Health Corporate (Pty) Ltd.
- Medscheme Holdings (Pty) Ltd.
- Momentum Medical Scheme Administrators (Pty) Ltd.
- V Med Administrators (Pty) Ltd.

Together they administered 84.0% of the market (excluding the self-administered medical schemes).[8]

Table 74 indicates the change in administrator market share between 2009 and 2013.

Table 74: Administrator market share 2009 – 2013

Largest market share – all schemes	2009	2010	2011	2012	2013	% change over five years
Discovery Health (Pty) Ltd	27.1%	28.9%	30.1%	25.7%	26.3%	(2.9%)
Metropolitan Health Corporate (Pty) Ltd	24.3%	27.0%	29.8%	25.8%	25.5%	5.1%
Medscheme Holdings (Pty) Ltd	17.7%	14.6%	12.2%	26.7%	27.4%	54.6%
Self-administered Medical Schemes	9.3%	9.8%	10.2%	9.2%	8.5%	(8.9%)
Momentum Medical Scheme Administrators (Pty) Ltd	6.8%	6.0%	4.5%	3.8%	3.1%	(54.5%)
V Med Administrators (Pty) Ltd	3.0%	3.4%	2.7%	1.9%	1.6%	(46.1%)
Other	11.7%	10.4%	10.5%	6.9%	7.5%	(35.5%)
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

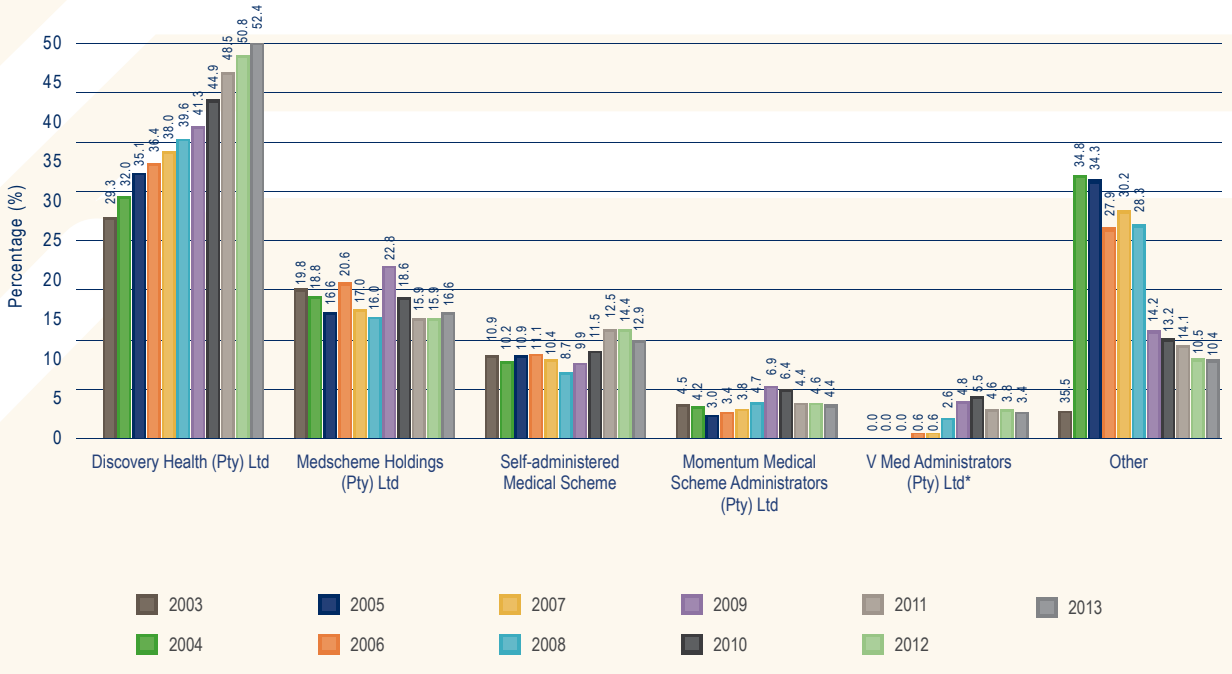
8. *The Government Employees Medical Scheme (GEMS) had a joint administrator contract in place in 2013. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The membership was included for both administrators.*

Largest market share – all schemes	2009	2010	2011	2012	2013	% change over five years
Largest market share in open medical schemes						
Discovery Health (Pty) Ltd	41.3%	44.9%	48.5%	50.8%	52.4%	26.8%
Medscheme Holdings (Pty) Ltd	22.8%	18.6%	15.9%	15.9%	16.6%	(27.1%)
Self-administered Medical Scheme	9.9%	11.5%	12.5%	14.4%	12.9%	29.4%
Momentum Medical Scheme Administrators (Pty) Ltd	6.9%	6.4%	4.4%	4.6%	4.4%	(36.9%)
V Med Administrators (Pty) Ltd*	4.8%	5.5%	4.6%	3.8%	3.4%	(29.4%)
Other	14.2%	13.2%	14.1%	10.5%	10.4%	(27.3%)
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Largest market share in restricted medical schemes						
Metropolitan Health Corporate (Pty) Ltd	60.9%	64.9%	67.8%	47.4%	46.7%	(23.3%)
Medscheme Holdings (Pty) Ltd	9.8%	8.9%	7.3%	35.9%	36.3%	269.2%
Self-administered	8.4%	7.3%	7.1%	4.8%	4.9%	(41.8%)
Discovery Health (Pty) Ltd	5.1%	6.2%	6.4%	4.4%	4.6%	(8.6%)
Momentum Medical Scheme Administrators (Pty) Ltd	6.7%	5.4%	4.7%	3.0%	2.1%	(69.2%)
Other	9.1%	7.4%	6.7%	4.4%	5.4%	(40.7%)
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

* *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 U).*

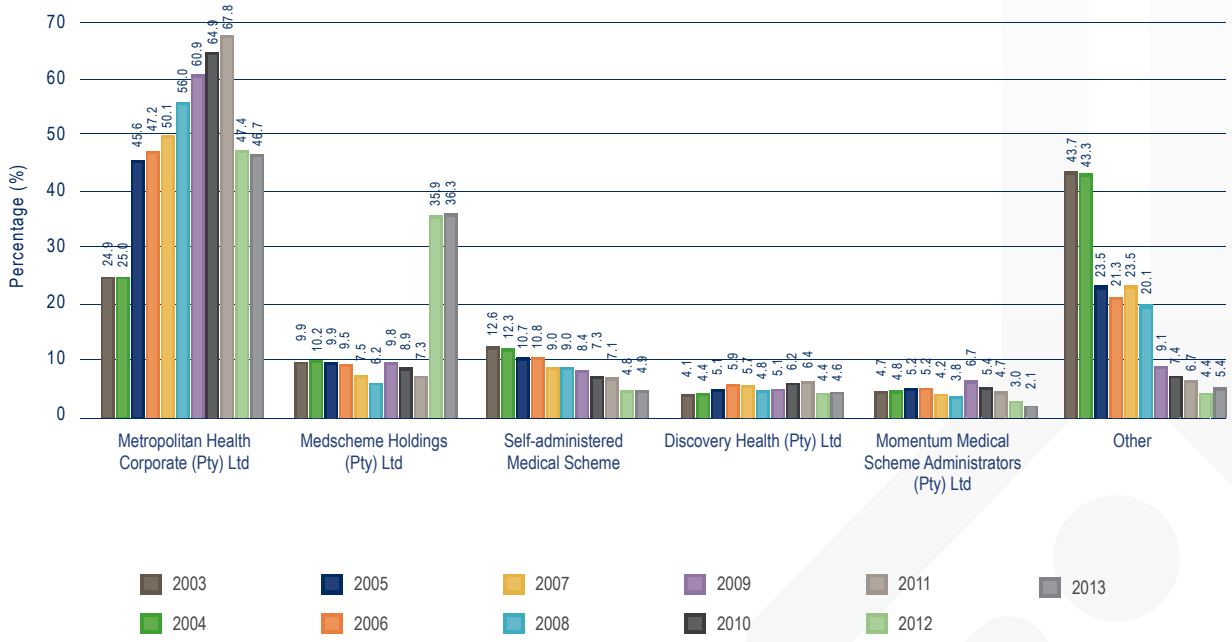
Figures 60 and 61 indicate the changes in administrator market share over the last 11 years for open and restricted medical schemes respectively.

Figure 60: Share of largest administrators in open scheme market based on average number of beneficiaries 2003 – 2013*



* *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 U).*

Figure 61: Share of largest administrators in restricted scheme market based on average number of beneficiaries 2003 – 2013*



* *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 U).*

The share of administrator Discovery Health (Pty) Ltd of the open schemes market increased to 52.4% (2012: 50.8%) and its share in the restricted schemes market increased to 4.6% (2012: 4.4%).

Medscheme Holdings (Pty) Ltd has the second-biggest share of administration in both the open and restricted schemes markets at 16.6% (2012: also 15.9%) and 36.3% (2012: 35.9%) respectively. The significant change in ranking of Medscheme Holdings (Pty) Ltd in the restricted scheme market was because it assumed responsibility for GEMS's contribution, debt management and correspondence services from 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the biggest share of the restricted schemes market at 46.7% (2012: 47.4%).

Despite their market dominance and the inherent benefits of economies of scale, the larger administrators do not appear to offer any cost advantages over their smaller rivals. It is possible that their size makes them less efficient and less responsive to clients' needs.

Table 75 shows the three administrators that had higher administration costs and fees than the industry average for administrators of open schemes.

Table 75: Open scheme administrators with higher than average costs and fees 2013

	Gross administration costs % deviation	Administration fees paid* % deviation	Fees paid to administrators (administration + managed care)* % deviation
Allcare Administrators (Pty) Ltd	155.7	57.9	40.9
Discovery Health (Pty) Ltd	0.7	13.0	21.5
Universal Healthcare Administrators (Pty) Ltd	17.2	(0.1)	1.3

* *Excluding co-administration fees*

Table 76 shows the five administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

Table 76: Restricted scheme administrators with higher than average costs and fees

	Gross administration costs % deviation	Administration fees paid* % deviation	Fees paid to administrators (administration + managed care)* % deviation
Eternity Private Health Fund Administrators (Pty) Ltd	136.8	162.6	129.2
Allcare Administrators (Pty) Ltd	146.0	159.4	89.3
V Med Administrators (Pty) Ltd	53.2	71.2	80.4
Discovery Health (Pty) Ltd	45.6	71.8	70.8
Professional Medical Scheme Administrators (Pty) Ltd	119.1	88.4	61.2

* *Excluding co-administration fees*

Administrators and the businesses associated with administrators often provide managed healthcare services. In some instances, the value proposition of such services to members is less than demonstrable, and these services could merely be additional layers of administration costs. The CMS has included them in the "fees paid to administrators" figures in instances where they were paid to the administrator or to any company in the administrator group.

Tables 77 and 78 show market share (based on the average number of beneficiaries served) of third-party administrators and self-administered medical schemes. They also provide the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure U.)

Table 77: Administrator market share 2013: open schemes

Name of administrator	No of schemes	Beneficiaries % market share	Gross administration costs Pabpm Rand	Gross administration costs As % of GCI	Administration fees paid Pabpm Rand	Administration fees paid As % of GCI	Total fees paid to administrators Pabpm Rand	Total fees paid to administrators As % of GCI	Gross contributions pabpm Rand	Risk claims ratio %
Agility Global Health Solutions Africa (Pty) Ltd	1	1.5	119.7	10.9	91.6	8.4	117.6	10.7	1 096.2	82.2
Allcare Administrators (Pty) Ltd	1	0.3	288.9	17.2	154.4	9.2	170.3	10.2	1 676.6	85.4
Discovery Health (Pty) Ltd	1	52.4	113.8	8.5	110.5	8.3	146.9	11.0	1 338.2	80.7
Eternity Private Health Fund Administrators (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Medscheme Holdings (Pty) Ltd	2	16.6	107.0	8.6	75.4	6.1	110.9	8.9	1 245.1	87.5
Methealth (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Metropolitan Health Corporate (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Momentum Medical Scheme Administrators (Pty) Ltd	1	4.4	89.7	8.4	85.4	8.0	102.5	9.6	1 069.5	79.5
Old Mutual Healthcare (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Prime Med Administrators (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Private Health Administrators (Pty) Ltd	2	0.9	138.1	11.1	93.1	7.5	117.6	9.5	1 243.2	93.8
Professional Medical Scheme Administrators (Pty) Ltd	1	1.6	119.1	6.4	76.2	4.1	93.9	5.0	1 867.5	84.6
Providence Healthcare Risk Managers (Pty) Ltd	2	0.5	73.5	8.5	58.0	6.7	72.1	8.3	864.2	91.0
Sanlam Healthcare Management (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Sechaba Medical Solutions (Pty) Ltd	1	2.9	111.9	8.5	87.3	6.6	111.7	8.4	1 323.5	82.4
Self-administered Medical Schemes	6	12.9	108.7	8.1	–	–	19.9	1.4	1 340.8	89.5
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	2.0	102.4	9.4	60.3	5.5	62.9	5.8	1 087.3	85.8
Universal Healthcare Administrators (Pty) Ltd	2	0.6	132.4	10.0	97.7	7.3	122.5	9.2	1 329.8	88.1
V Med Administrators (Pty) Ltd	2	3.4	159.5	11.4	73.3	5.2	95.9	6.9	1 398.0	85.1
Total or average	**24**	**100.0**	**113.0**	**8.6**	**97.8**	**7.5**	**120.9**	**9.2**	**113.0**	**83.7**

Table 78: Administrator market share 2013: restricted schemes

Name of administrator	No of schemes	Market share % of beneficiaries	Gross administration costs Pabpm Rand	Gross administration costs As % of GCI	Administration fees paid Pabpm Rand	Administration fees paid As % of GCI	Total fees paid to administrators Pabpm Rand	Total fees paid to administrators As % of GCI	Gross contributions pabpm Rand	Risk claims ratio %
Agility Global Health Solutions Africa (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Allcare Administrators (Pty) Ltd	1	0.0	151.6	9.5	120.6	7.6	120.6	7.6	1 587.4	113.0
Discovery Health (Pty) Ltd	11	4.6	89.7	7.6	79.9	6.7	108.8	9.2	1 186.1	84.1
Eternity Private Health Fund Administrators (Pty) Ltd	2	1.0	145.9	9.4	122.1	7.9	146.0	9.5	1 544.5	88.9
Medscheme Holdings (Pty) Ltd	14	36.3	32.8	2.8	13.7	1.2	28.8	2.5	1 153.3	89.9
Methealth (Pty) Ltd	4	0.9	89.2	7.6	72.2	6.2	86.4	7.4	1 171.2	92.3
Metropolitan Health Corporate (Pty) Ltd	10	46.7	34.6	9.2	32.7	8.7	41.8	11.2	374.5	90.4
Momentum Medical Scheme Administrators (Pty) Ltd	4	2.1	86.2	7.5	62.5	5.4	81.8	7.1	1 155.0	93.9
Prime Med Administrators (Pty) Ltd	1	0.7	58.1	4.0	48.0	3.3	77.5	5.4	1 437.5	88.4
Private Health Administrators (Pty) Ltd	1	0.1	73.3	5.6	53.9	4.1	66.2	5.0	1 313.1	85.7
Professional Medical Scheme Administrators (Pty) Ltd	1	1.1	135.0	10.2	87.6	6.6	102.7	7.8	1 323.0	85.6
Providence Healthcare Risk Managers (Pty) Ltd	3	0.9	57.0	7.0	41.6	5.1	56.9	6.9	818.6	88.3
Sanlam Healthcare Management (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Sechaba Medical Solutions (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Self-administered Medical Schemes	8	4.9	55.8	6.6	–	–	8.1	0.9	849.1	90.9
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	–	–	–	–	–	–	–	–	–	–
Universal Healthcare Administrators (Pty) Ltd	3	0.4	73.1	7.0	62.4	5.9	75.3	7.2	1 050.5	86.3
V Med Administrators (Pty) Ltd	1	0.2	94.4	6.2	79.6	5.2	114.9	7.6	1 519.6	79.2
Total average	**64**	**100.0**	**62.0**	**5.4**	**46.5**	**4.0**	**63.7**	**5.5**	**1 145.2**	**89.9**

* *Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

ANNEXURES

All the Annexures can be found on the provided disc

Please note that all the Annexures are available on the disc at the back of this Annual Report, in Excel format and printable PDFs.


CMS
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