For the **benefit** of the **member**

Annual Report 2019/20

CMS
Council
for Medical Schemes

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The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

The governance of the Council is vested in a board appointed by the Minister of Health, consisting of a Non-executive Chairperson, Deputy Chairperson and 10 members. The Executive Head of the Council is the Registrar, also appointed by the Minister in terms of the Medical Schemes Act. The Council determines overall policy, but day to day decisions and management of staff are the responsibility of the Registrar and the Executive Managers.

The Council for Medical Schemes supervises a massive and very important industry comprising of 76 medical schemes registered in the country.

Annual Report
Council for Medical Schemes
RP: 216/2020
ISBN: 978-0-621-48475-5
Council for Medical Schemes

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Acronyms

ARC	Audit and Risk Committee
AVE	Advertising Value Equivalent
BBBEE	Broad-Based Black Economic Empowerment
BHF	Board of Healthcare Funders
BoT	Board of Trustees
CDL	Chronic Disease List
CISNA	Committee of Insurance, Securities and Non-Banking Financial Authorities
CMS	Council for Medical Schemes
COVID-19	Coronavirus Disease 2019
CPF	Consumer Protection Forum
DDDR	Dynamic Data Driven Return
DES	Demarcation Exemption System
DMP	Disease Management Programme
DRC	Dispute Resolution Committee
DRSaaS	Microsoft Disaster Recovery as a Service
DTP	Diagnosis and Treatment Pairs
EXCO	Executive Committee
FFS	Fee for Service
FPI	Financial Planning Institute
FSCA	Financial Sector Conduct Authority
FSRA	Financial Services Regulatory Authority
GM	General Manager
GP	General Practitioner
HFA	Health Funders Association
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions' Council of South Africa
HR	Human Resources
HRSE	Human Resource, Social & Ethics Committee
HSACF	Health Sector Anti-Corruption Forum
HWSETA	Health and Welfare Sector Education and Training Authority Africa
ICT	Information and Communication Technology
IoDSA	Institute of Directors of Southern Africa
ITAP	Industry Technical Advisory Panel
KM	Knowledge Management
LCBO	Low-Cost Benefit Option
MCO	Managed Care Organisation
MoU	Memorandum of Understanding
MSA	Medical Schemes Act
NDOH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHI	National Health Insurance
NomCom	Nominations Committee
PA	Prudential Authority
PFMA	Public Finance Management Act
PMB	Prescribed Minimum Benefit
POs	Principal Officers
RBC	Risk-Based Capital
SA	South Africa
SABC	South African Broadcasting Cooperation
SADC	Southern African Development Community
SC	Senior Counsel
SCM	Supply Chain Management
SCR	Scheme Community Rate
SIU	Special Investigating Unit
SRM	Scheme Risk Measurement
TB	Tuberculosis
The Act	Medical Schemes Act, No. 131 of 1998

Part A

General Information

Name	Council for Medical Schemes
Physical address	Block A Eco Glades 2 Office Park 420 Witch-Hazel Avenue Eco Park Centurion Pretoria 0157 South Africa
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Telephone number	012 431 0500
Customer Care Centre	0861 123 267 0861 123 CMS
Fax number	0862 068 260
Email address	information@medicalschemes.co.za
Website	www.medicalschemes.co.za
Internal auditors	Nexia-SAB&T
External auditors	Auditor-General of South Africa
Bank	Absa Group Limited
Deputy Chairperson of Council	Adv Harshila Kooverjie SC
Chief Executive & Registrar	Dr Sipho Kabane
Council Secretariat	Mr Khayalethu Mvulo

Foreward by the Deputy Chairperson

Fast fact

At the time of the writing of this Annual Report, the CMS was regulating 76 medical schemes, 19 administrators, 41 managed care organisations, 1 078 broker organisations and 6 053 individual brokers

Introduction

The Council for Medical Schemes (CMS) is the regulatory authority designated in terms of the Medical Schemes Act (131 of 1998) to regulate medical schemes, administration, managed care organisations and brokers. This mandate is being diligently carried out by the CMS through the protection of medical scheme member interests.

At the time of the writing of this Annual Report, the CMS was regulating 76 medical schemes, 19 administrators, 41 managed care organisations, 1 078 broker organisations and 6 053 individual brokers. In the 2019/20 financial reporting year, 8,9 million scheme beneficiaries looked to and received protection from the CMS through its various regulatory activities.

Council for Medical Schemes

The 2019/20 financial year saw the completion of the previous five year planning cycle (2014-2018) and the transition to the new five year planning cycle (2020-2024). As such, the new five year strategic plan was approved by the Council, CMS governance structure, under the leadership of the late chairperson, Dr Clarence Mini. This strategy is premised on a vision that seeks to ensure that as a regulatory entity, the CMS:

- Improves its regulatory effectiveness and efficiency;
- Becomes a significant player in the implementation of the National Health Insurance (NHI).

The Council is confident that this strategic plan is aligned with its mandate that is well articulated in Section 7 of the Act, as well as the developments in the policy landscape of the industry, which include:

- National Health Insurance Bill;
- Medical Schemes Amendment Bill;
- Health Market Inquiry recommendations.

The CMS performed well in relation to its objectives, goals and targets that it set for itself in the 2019/20 financial year. The overall performance score of 92% was attained by the organisation.

In this financial year of significance to note was the Section 59 investigation. CMS was required to intervene when allegations of bully-

Deputy Chairperson's Report

ing, coercion, racial profiling, blacklisting and non-payment of claims were made by black (African, Coloured and Indian) professionals and service providers against medial schemes and administrators. The CMS responded to these allegations by establishing an independent investigation panel to determine their veracity and recommend corrective interventions, in terms of Section 59 of the Act. This investigation panel gave all relevant stakeholders an opportunity to present their case and provide evidence. The compilation of the report from this inquiry is at an advanced stage and will be released in the new financial year.

Strategic relationships

The CMS is a Section 3A entity that reports to parliament through the National Department of Health and, as a result, enjoys a close, collaborative and supportive relationship with it. There are a number of important policy interventions that CMS is engaged with in support of the national policy direction.

The CMS is also dependent on support and collaboration from the entities that it regulates. Information sharing, engagement and consultation have improved the effectiveness and efficiency of the CMS as a regulator. The CMS strengthened its relationship with industry associations through a tripartite agreement with the Board of Healthcare Funders (BHF) and the Health Funders Association (HFA).

When the CMS needed to establish steering committees for the Section 59 Investigation and the Fraud, Waste and Abuse summit, it created a partnership which allowed for inclusive contributions in the quest to improve the image of the medical schemes industry.

The CMS has also established strong links with other regulators in the health sector. Apart from the current collaboration with the Special Investigating Unit (SIU), which is leading the Health Sector Anti- Corruption and Fraud Forum, the CMS has cooperation with National Treasury, the Financial Services Conduct Authority (FSCA) and the Prudential Authority. The CMS is also an active member of the Committee of Insurance Securities and Non-Banking Financial Authorities, which is a SADC regulators forum with support provided by member countries.

Governance structure challenges

The CMS Council as a governance structure appointed by the Minister of Health in November 2017 under the leadership of the late Dr Clarence Mini had a fair number of challenges during the reporting period, one of which was the loss of his leader. Dr Clarence Mini was infected with COVID-19 shortly before the end of March 2020. He later succumbed to complications resulting from the disease. Prof Lungile Pepeta, who replaced Dr Mini, also succumbed to coronavirus soon after this appointment as Chairperson.

Prior to the passing of the chairperson, the Council was conducting business with two members short. To ensure that work continued, members were allocated additional committees, which resulted in an increased frequency of scheduled and special ad hoc meetings. The tenure of the chairperson and an independent non-executive of the Audit and Risk committee came to an end in November 2019, and these vacancies were filled in January 2020.

I sincerely hope that when the term of this Council comes to an end in November 2020, the CMS will again have a full complement of Council members to be able to execute its mandate with great effectiveness.

Moreover a number of CMS executives and managers were suspended with full pay while investigations into allegations of improper and corrupt conduct were undertaken. Once the investigations were completed, four disciplinary hearings were instituted, which yielded a resignation, a termination, and two hearings whose outcomes are still pending. The findings of these investigations have also been referred to the Special Investigations Unit (SIU) for further handling, to ensure that appropriate remedies are implemented to address fraud and corruption in our industry.

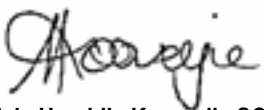
Medium to long-term goals

The CMS is expected to continue with its role as the regulator of the medical schemes industry until this has been changed by legislation and other policy considerations. According to Section 33 of the NHI Bill, at full implementation of the NHI, medical schemes are expected to provide only the cover that is not compensable under the NHI Fund. This complementary cover will be provided by schemes or insurance products, and will be regulated by the CMS using the legislation that is appropriate at the time.

Acknowledgements

The support that we have been provided with by the Honourable Minister of Health, Dr Zwelini Mkhize, and his officials in the course of executing our mandate has been immeasurable. I, together with my fellow Council members have endeavoured to maintain effective governance during these trying times. I am therefore deeply indebted to them.

I would also like to thank the CMS officials, the CMS Secretariat as well as the CMS staff. The CMS has under the leadership of the Chief Executive and Registrar, Dr Sipho Kabane, successfully managed to implement our Annual Performance Plan and maintain effective and efficient regulation of this industry.



Adv Harshila Kooverjie SC
Deputy Chairperson of the Council
31 July 2020

Chief Executive Officer's Overview

Fast fact

The capacity constraints and challenges faced by the CMS have to be understood in the context of the reality that we are allocated a budget of R174m in 2019/20, and yet we regulated entities that collected in excess of R192bn in member contributions that year.

General financial review

The CMS is a Section 3A Public Health entity that is accountable to parliament through the Minister of Health, who is its Executive Authority. It was established through the Medical Schemes Act, 131 of 1998, and has to comply with the provisions of the Public Finance Management Act of 1999 and Treasury regulations.

Funding model

The CMS had a budget of over R186 million to execute its mandate in the 2019/20 financial year. This budget originates from the following funding sources:

- Principal scheme member once-off levies
- Revenues generated through regulatory activities
- Conditional Grant from National Department of Health
- Retained surplus from 2018/19 and other sources

Chief Executive Officer's Overview

Table 1: Funding of the CMS, and its growth in the past three years by source

Description	2020 R'000	2019 R'000	2018 R'000
Levies income	**156 215**	144 980	135 663
Accreditation fees	**8 170**	7 787	8 182
Inspection fees recovered	**2 097**	3 491	9 085
Legal fees recovered	**–**	418	906
Registration fees	**469**	456	402
Government transfers: Department of Health	**6 481**	5 899	5 964
Mandatory transfer: Department of Higher Education and Training	**215**	104	40
Sundry income	**926**	431	549
	174 573	163 566	160 791

Table 2: Funding by source over the past three years

Description	2020 R'000	2019 R'000	2018 R'000
Levies income	**89%**	89%	84%
Accreditation fees	**5%**	5%	5%
Inspection fees recovered	**1%**	2%	6%
Legal fees recovered	**0%**	0%	1%
Registration fees	**0%**	0%	0%
Government transfers: Department of Health	**4%**	4%	4%
Mandatory transfer: Department of Higher Education and Training	**0%**	0%	0%
Sundry income	**1%**	0%	0%
	100%	100%	100%

Principal members of schemes, who number approximately 4 million, are levied a once-off amount each year. It should be noted that only principal members and not all the beneficiaries are subject to this levy. The level of levies imposed each year is subject to the ministers of Health and Treasury concurring with a proposal made by the CMS. The level of the levy imposed on principal members in 2019/20 was R38.67 per member per annum, which represents a modest increase of R2.54 per member per annum. Table 3 shows the levies that have been imposed on principal members over the past three years and their level of contribution to the budget.

Table 3: Levies from principal members

Description	2020	2019	2018
Levy imposed on principal members	**R38.67**	R36.13	R33.99
	R'000	R'000	R'000
Actual levy income	**156 215**	144 980	135 663
Budgeted levy income	**155 336**	144 246	134 276
Contribution to the budget	**83%**	87%	87%

Chief Executive Officer's Overview

The second stream of income that contributes to the budget of the CMS is generated through regulatory activities, which are fees charged for the registration of schemes, registration of new rules and amendments, registration, renewals of and accreditation of administrators, managed care organisations and brokers. The tariffs charged to these entities have not been adjusted regularly and have not kept up with inflation. Table 4 demonstrates the revenue that has been generated by the CMS in the past three years and how this has contributed to its budget.

Table 4: Revenue generated by CMS

Description	2020 R'000	2019 R'000	2018 R'000
Accreditation fees	**8 170**	7 787	8 182
Inspection fees recovered	**2 097**	3 491	9 085
Legal fees recovered	**–**	418	906
Registration fees	**469**	456	402
Total generated income (actual)	**10 736**	12 152	18 575
Total generated income (budget)	**19 281**	9 960	9 681
Contribution to the budget	**11%**	6%	6%

The third stream of income that contributes to the CMS budget is the Conditional Grant from the National Department of Health. This grant funding is for specifically targeted projects that CMS is undertaking in support of the Department of Health initiatives. Table 5 illustrates the allocations by the NDOH for this grant and its growth over the past three years.

Table 5: NDOH allocations over the past three years

Description	2020 R'000	2019 R'000	2018 R'000
Department of Health	**5 987**	5 670	5 496
Growth rate	**6%**	3%	–

The fourth stream of income that makes up the CMS budget is the surplus that is rolled over each year. The surplus is essentially what remains unspent at the end of each financial year and is rolled over to the next financial year to complete the multi-year projects that the CMS is often engaged with. Table 6 demonstrates that this funding has been decreasing over the past three years, which is a clear indication of the pressure that the CMS budget has been under in the recent past.

Table 6: Funding in the past three years

Description	2020 R'000	2019 R'000	2018 R'000
Accumulated surplus/(deficit)	**(19 643)**	6 988	19 643

Expenditure trends

Table 7 illustrates expenditure patterns by the CMS over the past three years. These trends clearly indicate that the entity's expenditure was managed in the 2017/18 and 2018/19 financial years without incurring a deficit. A deficit has been incurred in the 2019/20 financial year. The reducing surpluses and the increased expenditure are a clear indication that the CMS has been faced with an expansionary mandate that has not been matched by its funding stream. This has been identified as an emerging risk that will need to be managed through a comprehensive review of the CMS funding model.

Chief Executive Officer's Overview

Table 7: Expenditure patterns

Description	2020 R'000	2019 R'000	2018 R'000
Administrative expenses	**26 596**	24 254	23 199
Audit fees	**2 715**	2 613	1 476
Operating expenses	**47 740**	35 215	43 783
Staff costs	**122 792**	113 657	101 099
Actual expenditure	**199 843**	175 739	169 557

It is also important to note that the major expenditure is on personnel, followed by goods and services at 35%. Given that the expenditure on personnel is fixed and extremely difficult to manage downwards without collapsing the operations, any cost-containment is only possible on goods and services.

Capacity constraints and challenges

The capacity constraints and challenges faced by the CMS have to be understood in the context of the reality that we are allocated a budget of R186m in 2019/20, and yet we regulated entities that collected in excess of R192bn in member contributions that year. The reserves that schemes held were collectively approximately R60bn in the year in question. This apparent resource mismatch severely constrained the CMS from effectively carrying out its regulatory mandate.

The CMS has been growing organically since it was formally established, however, this growth in resources has not matched the operational and regulatory needs on the ground. This gap, which is primarily a function of the funding model and envelope, has ensured that key posts have not been created and filled, despite the need at the coalface.

The CMS staff complement was 120 permanent employees at the end of the reporting period. The number excludes 16 qualified graduates who were placed in internship programmes, and 16 temporary personnel who were appointed into fixed-term contracts. At the beginning of the financial year, CMS had placed 23 qualified graduates in internship programmes to support the government's call to develop the skills of qualified graduates. The number increased to 32 at the end of the reporting period. In the 2019/20 financial year, CMS had 30 vacant posts, out of which 19 were successfully filled. The remaining 11 vacancies will be filled in the new financial year.

Capacity constraints have also been felt in the unmet need to upgrade and modernise equipment, systems and processes to ensure our operational and regulatory effectiveness. This has led to questions being raised with respect to our ability to regulate this industry effectively and efficiently. The support that we are mandated to provide the National Department of Health in the policy developments and interventions has as a consequence, been limited.

Other regulatory and operational constraints are being addressed through the changes that have been recommended to the Medical Schemes Amendment Act.

The Annual Performance Plan of 2019/20 introduced a number of new activities that signalled our intention to lead and co-ordinate the medical schemes industry in combating Fraud, Waste and Abuse. We have also stepped up our research and policy contributions, and refocused and revamped the industry advice committee, ITAP.

Surplus rollover

CMS incurred an accumulated deficit of R19.6m in the year under review, and as such there will not be a surplus rollover.

Supply chain management

The centralisation of Supply Chain Management (SCM) in the organisation was approved by the Council to address the inefficiencies and non-compliance challenges experienced in previous financial periods. The unit also appointed three officials: a Procurement Manager, a Supply Chain Management Officer and a Supply Chain Management Administrator to implement the centralised SCM function.

SCM processes and systems

- An SCM and Standard Operating Procedure manual was developed to address the roles and responsibilities of the newly appointed officials
- The organisation's SCM policy was reviewed and approved in July 2019 and January 2020 to address shortcomings identified within CMS and to align it with best practice
- A Contract Performance and Monitoring Policy was developed to address the shortcomings in contract management. The policy was submitted to the Audit and Risk Committee for recommendation, pending Council approval
- To ensure effective communication, the unit developed standard emails to improve communication with external and internal stakeholders
- A Loss and Control Committee was established to address and handle non-compliance with the organisation's SCM policies and procedures, and National Treasury Regulations

Chief Executive Officer's Overview

Concluded unsolicited bid proposals for the year

CMS did not entertain, award or conclude any unsolicited bid proposals in the 2019/20 financial year.

Audit report matters

The major audit report matter is the irregular expenditure incurred as a result of a panel of lawyers that were not appointed through a bidding process. However, the newly established Loss Control Committee is addressing these issues of irregular expenditure.

Outlook and future plans

The CMS will continue with its broad plans to become an effective and efficient regulator, while playing a key role in the implementation of the National Health Insurance Fund. The sustained effectiveness and efficiency of the CMS as a regulator is dependent on a number of initiatives that will be undertaken in the near future. These initiatives include:

- Implementing the Health Market Inquiry recommendations
- Supporting the implementation of the NHI Fund Bill
- Implementing amendments that will be accepted to the Medical Schemes Act
- Implementing the revised Business Process Mapping, Service Delivery Model, Operational Business Model and Macrostructure for the CMS
- Revising and implementing a new funding model for the CMS

It is our belief and considered view that the CMS will continue operating as a regulator for this industry for as long as medical schemes exist and there is legislation supporting its regulatory activities, irrespective of the time it takes to fully implement universal health coverage in this country. The CMS continues to be a financially viable entity, despite its stated challenges.

Events after the reporting date

Dr Clarence Mini, the Council Chairperson was infected with COVID-19 shortly before the end of May 2020. He later succumbed to complications resulting from the disease. Prof Lungile Pepeta, who replaced Dr Mini, also succumbed to coronavirus soon after his appointment as Chairperson.

This has been a great loss to the organisation and the industry; we remain indebted to their ethical and effective leadership legacy. The COVID-19 pandemic also resulted in a countrywide lockdown of social and economic activities, which was implemented on 27 March 2020, and which will have a huge impact on the health system and its funding. The full impact of the COVID-19 pandemic on the CMS, on lives of scheme members, on the general public, and on the economy and the entities that we regulate, will be felt for decades to come.

Highlights

- Medical schemes regulated by the CMS have maintained an average solvency ratio of 35.61% compared to the statutory requirement of 25% throughout the period under consideration
- The number of schemes that failed to meet the 25% statutory solvency remained at seven between 2014 and 2018
- The CMS established two advisory committees to address the transition of primary insurance products into the medical schemes environment and the need by medical schemes to provide a low-income option.
- CMS established an independent panel to investigate racial profiling by medical schemes and administrators in relation to Section 59 of the MSA.
- A study on epidemiology and trends in caesarean sections was published to the public.
- A study on the viability of standardising benefit options was published in the South African Health Review 2019.
- The CMS provided secretariat and coordination support on the Presidential Health Compact towards the NHI.
- The CMS is a member of the Health Sector Anti-Corruption Forum, let by the Special Investigating Unit.
- Work on the CMS-led Fraud, Waste and Abuse project has continued with the development of Codes of Good Practice and resolution Tribunal.
- In response to the Health Market Inquiry recommendations, the CMS introduced an integrated development programme for members of boards of trustees (BoT's) of medical schemes in partnership with GIBS pitched at NQF Level 8.

Acknowledgements

The operational and regulatory success that CMS achieved in the 2019/20 financial year would not have been possible without the oversight support from Council and the hard work that was consistently delivered by CMS officials as a collective.

Dr Sipho Kabane
Chief Executive & Registrar
31 July 2020

Statement of responsibility and confirmation of the accuracy of the annual report

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

All information and amounts disclosed throughout the annual report are consistent. 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 the National Treasury. The Annual Financial Statements (Part E) have been prepared in accordance with the n accordance with the South African General Recognised Accounting Practice (SA Grap).

The Accounting Authority is responsible for the preparation of the annual financial statements and for the judgements made in this information.
The Accounting Authority is responsible for establishing and implementing a system of internal control that has been designed to provide reasonable assurance as to the integrity and reliability of the performance information, the human resources information and the annual financial statements. The external auditors are engaged to express an independent opinion on the annual financial statements.

In my opinion, the annual report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the CMS for the financial year ended 31 March 2020.

Yours faithfully,

Dr Sipho Kabane
Chief Executive & Registrar
31 July 2020

Adv Harshila Kooverjie SC
Deputy Chairperson of the Council
31 July 2020

Strategic overview

VISION

To be an agile and transformative Regulator in order to promote affordable and accessible healthcare cover towards universal health coverage.

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
- Ensuring collaboration with other stakeholders in executing its regulatory mandate

Values

The values of the CMS stem from those underpinning the Constitution and its specific vision and mission. Being an organisation that subscribes to a rights-based framework where everyone is equal before the law, where the right of access to healthcare must be protected and enhanced, and where access must be simplified in a transparent manner, the values below are key requirements of all employees:

Regulatory philosophy (external)	Shared values (internal)
Transparent	Accountability
Fair	Ubuntu
Equitable	Professionalism
Consultative	Integrity
Cost-effective	Honesty
Firm	Respect
Proactive	Responsive
Independence	

Legislative and other mandates

Legislative mandates

Section 9 of the Constitution of the Republic of South Africa, 108 of 1996 ("the Constitution"), states that everyone has the right to equality, including access to healthcare services. This means that individuals should not be unfairly excluded in the provision of healthcare.

People also have the right to access information that is held by another person if it is required for the exercise or protection of a right. This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment. This also enables people to exercise their autonomy in decisions related to their own health, which is an important part of the rights to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitution respectively.

Section 27 of the Constitution places the obligation on the state to make reasonable legislation to progressively realise socio-economic rights, including access to healthcare.

The Medical Schemes Act (131 of 1998) (MSA) represents such legislation, which creates the framework for non-discriminatory access to medical schemes. The MSA provides for the regulation of the medical schemes industry to ensure synchrony and consonance with the national health objectives.

Section 27 of Chapter 2 of the Bill of Rights of the Constitution states as follows with regards to healthcare, food, water, and social security:

Everyone has the right to access to:

- Healthcare services, including reproductive healthcare
- Sufficient food and water
- Social security, including appropriate social assistance if they are unable to support themselves and their dependents

The state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights; and no one may be refused emergency medical treatment.

Section 36 of the Constitution deals with the limitation of rights, and spells out strict criteria which must be adhered to whenever rights included in the Bill of Rights are limited by law. Section 22 of the Constitution guarantees the freedom of trade, which may be limited by law.

The Medical Schemes Act limits the business of a medical scheme to those parties that are registered by the Council for Medical Schemes and requires such parties to comply with the provision of the Medical Schemes Act.

The National Health Act, 61 of 2003 (NHA)

The NHA provides the framework for a structured uniform health system for our country, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. A key objective of the NHA is to unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa. Added to this is the intent to promote a spirit of cooperation and shared responsibility among public and private health professionals, providers and other relevant stakeholders within the context of national, provincial and district health plans.

The Charter for the Public and Private Health Sectors of South Africa, 2006

This Health Charter was initiated in support of the NHA. It indicates that the public and private health sectors need to constructively engage each other in discussions and dialogue to create an improved healthcare delivery system for South Africa. Such a system will need to be coherent, efficient, cost-effective and quality driven, and optimize the use of both sectors' resources for the benefit of the entire citizenry.

The Medical Schemes Act, 131 of 1998

The Medical Schemes Act (131 of 1998) established the Council for Medical Schemes. Section 7 of the Act confers the following functions on Council:

- Protect the interests of the beneficiaries at all times
- Control and co-ordinate the functioning of medical schemes in a manner that is complementary to the national health policy
- Make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided 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 the Act for the purpose of the performance of its functions and the exercise of its powers
- Advise the Minister on any matter concerning medical schemes
- Perform any other functions conferred on the Council by the Minister or by the Act

Legislative and other mandates

Related legislation impacting and influencing the functioning of the CMS

Among others, these are:

- Council for Medical Schemes Levy Act, 58 of 2000
- Provides a legal framework for the Council to collect levies from medical schemes
- Public Finance Management Act, 1 of 1999 (PFMA)
- Provides for the effective, efficient and economic financial management in government departments and public entities
- Financial Sector Regulation Act, 9 of 2017 (FSRA)
- To establish a system of financial regulation by establishing the Prudential Authority and the Financial Sector Conduct Authority

Council, as an organ of state, is obliged to discharge its legislated mandate in a coherent manner that is consistent with national policy, as set out in the National Development Plan (NDP) Vision 2030.

The following are key priorities of the Vision 2030 development plan (extract from Chapter 10 of NDP Vision 2030):

1. Raise the life expectancy of South Africans to at least 70 years.
2. Progressively improve TB prevention and cure.
3. Reduce maternal, infant and child mortality.
4. Significantly reduce prevalence of non-communicable diseases.
5. Reduce injury, accidents and violence by 50% from 2010 levels.
6. Complete health system reforms.
7. Primary healthcare teams provide care to families and communities.
8. Universal health coverage.
9. Fill posts with skilled, committed and competent individuals.

Furthermore, the NDP Vision 2030 sets out nine priority areas that highlight the key interventions required to achieve a more effective health system to contribute to the achievement of the desired outcomes. The priority areas are:

1. Address the social determinants that affect health and diseases.
2. Strengthen the health system.
3. Improve health information systems.
4. Prevent and reduce the disease burden and promote health.
5. Finance universal healthcare coverage.
6. Improve human resources in the health sector.
7. Review management positions and appointments and strengthen accountability mechanisms.
8. Improve quality by using evidence.
9. Meaningful public-private partnerships.

Policy mandates

The political environment has been stable for the greater part of this five-year period. The Minister has been consistent in the articulation of policy developments that affect the industry as a whole. The policy mandate and context for the health sector and the medical schemes industry has largely been driven by:

- National Development Plan: 2030
- Sustainable Development Goals
- Strategic Plan of the National Department of Health

These policy mandates remain relevant for the medical schemes industry for the next five years. It is however important to note that these mandates are committing the health sector (both private and public) to the following key deliverables:

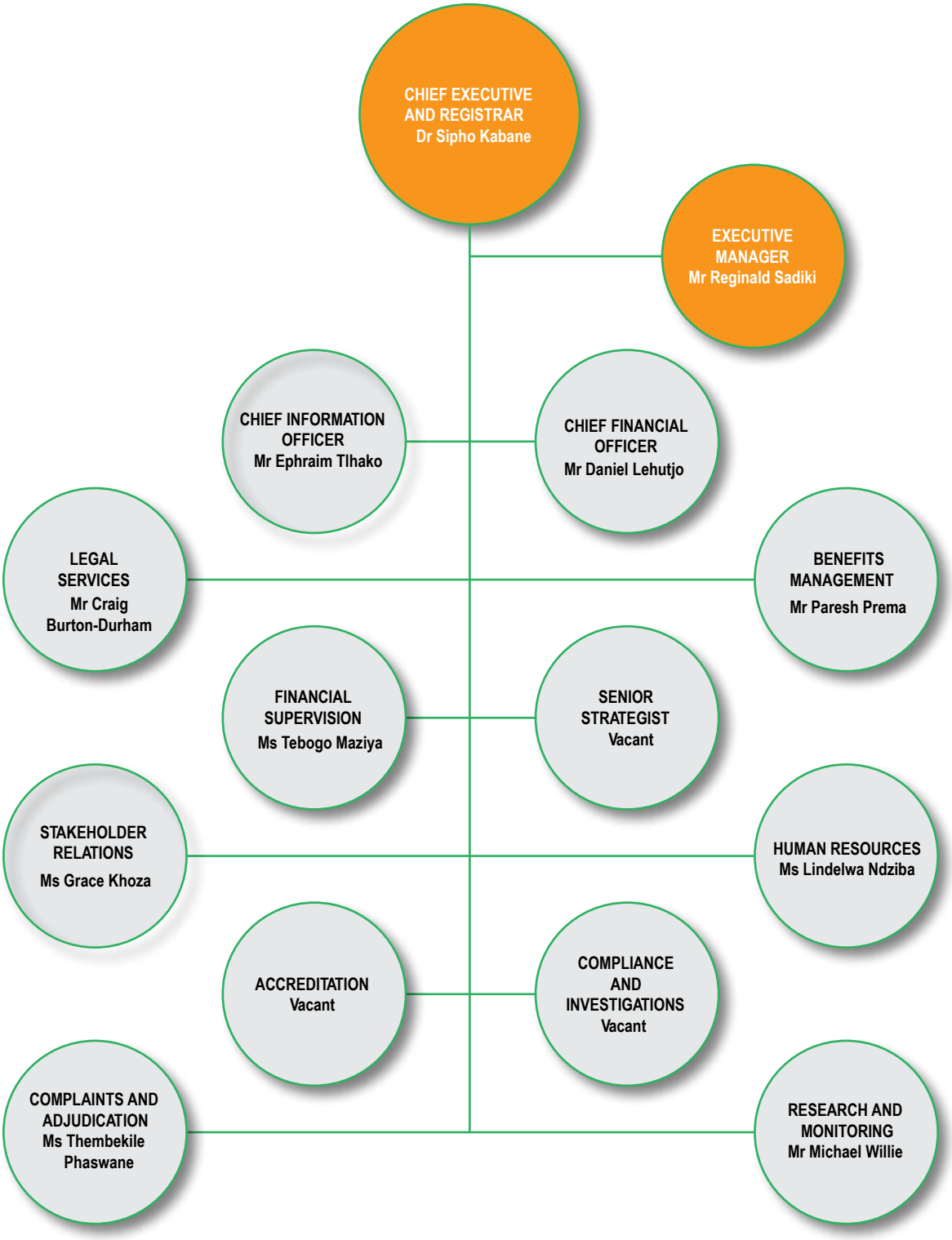
- Increased life expectancy
- Reduction of maternal, infant and child mortality
- Reduction in the burden of HIV and TB
- Reduction in the burden of non-communicable diseases, including violence
- Universal health coverage

Medical schemes registered in terms of the Medical Schemes Act

As at 31 March 2020

	Scheme Name	Type
1.	AECI MEDICAL AID SOCIETY	Restricted
2.	ALLIANCE-MIDMED MEDICAL SCHEME	Restricted
3.	ANGLO MEDICAL SCHEME	Restricted
4.	ANGLOVAAL GROUP MEDICAL SCHEME	Restricted
5.	BANKMED	Restricted
6.	BARLOWORLD MEDICAL SCHEME	Restricted
7.	BESTMED MEDICAL SCHEME	Open
8.	BMW EMPLOYEES MEDICAL AID SOCIETY	Restricted
9	BONITAS MEDICAL FUND	Open
10.	BP MEDICAL AID SOCIETY	Restricted
11.	BUILDING & CONSTRUCTION INDUSTRY MEDICAL AID FUND	Restricted
12.	CAPE MEDICAL PLAN	Open
13	CHARTERED ACCOUNTANTS (SA) MEDICAL AID FUND (CAMAF)	Restricted
14	COMPCARE WELLNESS MEDICAL SCHEME	Open
15	DE BEERS BENEFIT SOCIETY	Restricted
16.	DISCOVERY HEALTH MEDICAL SCHEME	Open
17.	ENGEN MEDICAL BENEFIT FUND	Restricted
18.	FEDHEALTH MEDICAL SCHEME	Open
19.	FISHING INDUSTRY MEDICAL SCHEME (FISH-MED)	Restricted
20.	FOODMED MEDICAL SCHEME	Restricted
21.	GENESIS MEDICAL SCHEME	Open
22.	GLENCORE MEDICAL SCHEME	Restricted
23.	GOLDEN ARROWS EMPLOYEES' MEDICAL BENEFIT FUND	Restricted
24.	GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	Restricted
25.	GRINTEK ELECTRONICS MEDICAL AID SCHEME	Restricted
26.	HEALTH SQUARED MEDICAL SCHEME	Open
27.	HORIZON MEDICAL SCHEME	Restricted
28.	HOSMED MEDICAL AID SCHEME	Open
29.	IMPALA MEDICAL PLAN	Restricted
30.	IMPERIAL AND MOTUS MEDICAL AID	Restricted
31.	KEYHEALTH	Open
32.	LA-HEALTH MEDICAL SCHEME	Restricted
33.	LIBCARE MEDICAL SCHEME	Restricted
34.	LONMIN MEDICAL SCHEME	Restricted
35.	MAKOTI MEDICAL SCHEME	Open
36.	MALCOR MEDICAL SCHEME	Restricted
37.	MASSMART HEALTH PLAN	Restricted
38.	MBMED MEDICAL AID FUND	Restricted
39.	MEDIHELP	Open
40.	MEDIMED MEDICAL SCHEME	Open
41.	MEDIPOS MEDICAL SCHEME	Restricted
42.	MEDSHIELD MEDICAL SCHEME	Open
43.	MOMENTUM MEDICAL SCHEME	Open
44.	MOTOHEALTH CARE	Restricted
45.	NASPERS MEDICAL FUND	Restricted
46.	NEDGROUP MEDICAL AID SCHEME	Restricted
47.	NETCARE MEDICAL SCHEME	Restricted
48.	OLD MUTUAL STAFF MEDICAL AID FUND	Restricted
49.	PARMED MEDICAL AID SCHEME	Restricted
50.	PG GROUP MEDICAL SCHEME	Restricted
51.	PICK N PAY MEDICAL SCHEME	Restricted
52.	PLATINUM HEALTH	Restricted
53.	PROFMED	Restricted
54.	QUANTUM MEDICAL AID SOCIETY	Restricted
55.	RAND WATER MEDICAL SCHEME	Restricted
56.	REMEDI MEDICAL AID SCHEME	Restricted
57.	RETAIL MEDICAL SCHEME	Restricted
58.	RHODES UNIVERSITY MEDICAL SCHEME	Restricted
59.	SABC MEDICAL AID SCHEME	Restricted
60.	SAMWUMED	Restricted
61.	SASOLMED	Restricted
62.	SEDMED	Restricted
63.	SISONKE HEALTH MEDICAL SCHEME	Restricted
64.	SIZWE MEDICAL FUND	Open
65.	SOUTH AFRICAN BREWERIES MEDICAL SCHEME	Restricted
66.	SOUTH AFRICAN POLICE SERVICE MEDICAL SCHEME (POLMED)	Restricted
67.	SUREMED HEALTH	Open
68.	TFG MEDICAL AID SCHEME	Restricted
69.	THEBEMED	Open
70.	TIGER BRANDS MEDICAL SCHEME	Restricted
71.	TRANSMED MEDICAL FUND	Restricted
72.	TSOGO SUN GROUP MEDICAL SCHEME	Restricted
73.	UMVUZO HEALTH MEDICAL SCHEME	Restricted
74.	UNIVERSITY OF KWA-ZULU NATAL MEDICAL SCHEME	Restricted
75.	WITBANK COALFIELDS MEDICAL AID SCHEME	Restricted
76.	WOOLTRU HEALTHCARE FUND	Restricted

Organisational structure



CMS Council

Adv Harshila Kooverjie SC
Deputy Chairperson

Adv Rebaone Gaorelwe

Ms Mosidi Maboye

Mr Moerane Maimane

Dr Steven Mabela

Dr Memela Makiwane

Ms Diane Terblanche

Dr Acquina Thulare

Mr Johan van der Walt

Mr Yogan Pillay

Prof Lungile Pepeta
(1974 - 2020)

Dr Clarence Mini
(1951 - 2020)

CMS Executives

Dr Sipho Kabane
Chief Executive & Registrar

Mr Daniel Lehutjo
Chief Financial Officer

Mr Ephraim Tlhako
Chief Information Officer

Ms Grace Khoza
GM: Stakeholder Relations

Mr Craig Burton-Durham
GM: Legal Services

Ms Lindelwa Ndziba
GM: Human Resources

Mr Paresh Prema
GM: Benefits Management

Mr Michael Willie
GM: Research and Monitoring

Ms Tebogo Maziya
GM: Financial Supervision

Ms Thembekile Phaswane
GM: Complaints and Adjudication

Mr Reginald Sadiki
Executive Manager

Part B

Performance Information

Statement of Responsibility for Performance Information

Statement of Responsibility for Performance Information

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

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

In my opinion, the performance information provided in this report fairly reflects the actual achievement against planed 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 2020.

The performance information of the CMS for the financial year ended 31 March 2020 have been audited by the Auditor-General of South Africa. This information, as contained on pages 33 to 68 has also been approved by Council, which is the Accounting Authority of the CMS.

Yours faithfully,

Dr Sipho Kabane
Chief Executive & Registrar
31 July 2020

Auditor's Report: Predetermined Objectives

The Auditor-General South Africa (AGSA)/auditor currently performs the necessary audit procedures on the performance information to provide a limited assurance conclusion. The audit conclusion on the performance against predetermined objectives is included in the report to management, with material findings being reported under the Predetermined Objectives heading in the Report on other legal and regulatory requirements section of the auditor's report.

Refer to page 90 of the Report of the Auditors Report, published as Part E: Financial Information.

Situational Analysis

Service Delivery Environment

The medical schemes industry regulated by the CMS consists of various key stakeholders with diverse interests and agendas. As at 31 March 2020 the CMS regulated 76 medical schemes, 19 administrators, 41 managed care organisations, 1 078 broker organisations and 6 053 individual brokers. The role of the CMS is to regulate these entities utilising the MSA and Regulations to ensure that the 8.9 million scheme beneficiaries' interests are protected. This means that the CMS should ensure that all the regulated entities are at all times compliant with the MSA and its provisions.

The CMS regulates the medical schemes industry through beneficiary training and education; registering of medical schemes and options; accrediting administrators, brokers and managed care organisations; resolving complaints; conducting inspections; and defending legal challenges. Other important regulatory functions include the collection of key industry data, the review of the beneficiary entitlements in the form of Prescribed Minimum Benefits (PMBs) and the provision of training and support for the regulated entities. The private health industry organically responds to the demand for healthcare, but does not address healthcare needs. For this reason, public policy intervention is necessary to enhance what the private system does well and to minimise those areas where the private system fails. If interventions are well designed and successfully implemented, the private health system is capable of fully supporting the country's broader social goals. Where a coherent strategy for the private health system is absent, however, coverage will invariably diminish in both extent and quality, with knockon effects on the public health system and the quality of life possible in South Africa.

Over the past 100 years, health insurance in various forms has evolved in South Africa along with changes in regulatory instruments. It was, however, not until 1998 that a framework was implemented to modernise and update the system with a view to maximising fair access to medical scheme cover along the lines of developments in Europe and South America. The central aim of these reforms, provided for in the MSA, was to enhance the risk pooling potential of medical schemes and other important regulatory and oversight mechanisms by introducing.

A preferred health insurance vehicle, which required that any person doing the business of a medical scheme must operate in terms of a single legislative framework that incorporates:

- **Open enrolment**, which removed the discriminatory practice of medical schemes to select only good risk beneficiaries for membership (risk selection)
- **Mandatory minimum benefit**, which removed the ability of schemes to discriminate against older and sicker members through the selective non-provision of key benefits
- **Waiting periods and late joiner penalties**, to eliminate any significant application of penalties for member movement between medical schemes and options, while substantially removing opportunities for anti-selection where a member joins only when sick and then leaves, or only joins for the first time later in life
- **Improved governance**, which removed the historical conflicts of interest embedded in the oversight of medical schemes
- **Regulation of intermediaries**, which implemented accreditation and more stringent regulatory oversight of medical scheme, brokers, administrators, and managed care organisations
- **Improved oversight**, through the implementation of a substantially enhanced special-purpose regulator to oversee the Act
- **Member protection**, which includes the complaints resolution mechanisms at scheme level and provides members access to the complaints resolution mechanisms at the Registrar's office and through appeals processes

[1] Note that the term "mandatory minimum benefits" is generic in nature, in our context this refers to the prescribed minimum benefits (PMBs).

Situational Analysis

The original intention of the introduction of the above measures was to ensure that all health funders operate on a level playing field, maximising the advantages and minimising the disadvantages of a competing and highly commercialised multi-fund health industry. However, many facets of the funding and provision of private health services are still not adequately regulated, resulting in systemic shortfalls in coverage, quality of coverage, cost containment, and impact on the public health system.

Certain of these inadequacies pertain to the public health service as well, which contributes to private sector costs, coverage, and unfair access to the health system for low-income groups. Understanding where these gaps are located and how health policy should respond, remains a major challenge for the CMS and government. It is important that all role players respond appropriately to these deficiencies. The regulation of private hospitals is an example of a key policy intervention required to allow for the stabilisation of healthcare costs.

Despite our best intentions with the promulgation of the MSA and its regulations in 2000, the CMS has met with serious challenges in being an effective regulator due to challenges by industry players and certain legislative limitations.

This situation has led to the CMS seeking to amend specific areas of the MSA in order to strengthen its effectiveness and efficiency as a regulator. In the past five years, the CMS has not been successful in effecting the necessary legislative changes due to the long and onerous route that this process has taken. The release of the Medical Schemes Act Amendment Bill (MSAAB) for public comment in June 2018 represents a massive shift towards the legislative empowerment of the CMS, and we wholeheartedly welcome this move.

The CMS has, in the past five years (2014-2019), carried its mandate of regulating medical schemes, administrators, brokers and managed care organisations with great determination and success within the context of limited resources at its disposal. The level of the CMS' effectiveness as a regulator has largely been determined by internal and external environmental factors. These environmental factors can either have a positive or negative impact on the organisation's effectiveness and efficiency as a regulator.

Industry trends

The following section analyses the key industry trends from the CMS perspective, which are mainly driven by the protection of the interests of scheme beneficiaries. The important observed industry trends that have influenced scheme member welfare in the past five years include:

On the positive side

- The schemes have maintained an average solvency ratio of 35.61% compared to the statutory requirement of 25% throughout the period under consideration
- The number of schemes that failed to meet the 25% statutory solvency remained were four between 2014 and 2019
- The number of Efficiency Discounted Options (EDOs) increased from 40 in 2014 to 69 in March 2019

These positive industry trends essentially mean that medical schemes have largely been successful in compliance with the 25% solvency requirements during this period. The scheme beneficiaries are expected to have benefited from an increase in the number of EDO options, through lower annual contribution increases during this period. It is, however, of great concern that the proportion of beneficiaries covered by the EDOs increased to 25.8% in the past five years.

On the negative side

- The number of scheme beneficiaries only grew by 0.8% between 2018 and 2019
- There was a reduction in the number of schemes from 83 in 2014 to 78 in 2019
- The proportion of the beneficiaries covered by the EDOs remained stagnant at 25.8% throughout this period
- Poor governance and financial management of schemes resulted in a number of schemes being placed under curatorship in this period
- The number of accredited administrators decreased from 28 in 2014 to 26 in 2019
- The number of accredited brokers decreased from 10 780 in 2014 to 10 144 in 2019
- The number of accredited managed care organisations increased from 39 in 2014 to 44 in 2019

The main conclusion that can be drawn from these observed trends is that the medical aid industry is faced with serious sustainability challenges. These challenges are characterised by low beneficiary growth, reduction in the number of registered regulated entities, increasing beneficiary dissatisfaction and an increase in the number of non-EDO scheme options. Apart from the trends indicated, other significant developments have characterised the industry in the period under consideration, which are noteworthy.

There have been products and players that have entered the medical schemes market without obtaining the necessary approval by the CMS. The CMS will spend significant time and effort ensuring that these entities are brought under its regulatory umbrella or declaring them illegal in terms of the Medical Schemes Act, as amended.

Situational Analysis

There has also been an increase in the complaints related to diagnostic and procedure codes disputes between schemes and service providers. The CMS will establish a mechanism to address these disputes with the support of other regulators. The disputes between schemes and service providers in the management of alleged fraudulent transactions are of great concern to the CMS. The CMS believes that it can play an active role in developing and implementing interventions to address these disputes. These will however require support by the industry and fellow regulators.

Economic outlook

The outlook of the economy in the past five years has adversely affected the growth in the number of medical scheme memberships. Sluggish economic growth, the country's junk status, increased unemployment and poverty rates have ensured that the number of people that take up medical scheme membership is limited. The growth of scheme membership has also been limited by the number of members leaving schemes and dependents being removed by principal members.

The increase in value added tax from 14% to 15% in the first quarter of 2018 also compounded the ability of members to afford medical scheme membership. The price of goods and services was largely stable in the past five years, and the annual contribution increases were largely in line with the annual Consumer Price Index (CPI), except for a spike in late 2016 and early 2017. This spike was attributed to increased claims by members as a result of a sudden increase in the number of private hospital beds in specific areas of the country. The licensing of private hospitals in the next five years is likely to have this kind of influence on member annual contribution increases.

The consolidation of schemes is supported by the CMS as it ensures risk pooling and encourages social solidarity and affordability of scheme costs to members. The standardisation of scheme options is also supported by the CMS as it will assist members to make rational choices in the purchase of options in schemes. The number of scheme options is currently 271, and this high number adds to the complexities of making rational choices as a scheme member.

The CMS is concerned about the increasing market concentration of the administrators and managed care organisations that has occurred in the past five years. Our concerns are centred around the market failures that will result in market dominance and other anti-competitive behaviour by these entities, which may be at odds with beneficiary interests and welfare. The full implementation plan based on the final recommendations of the HMI report will address these concerns.

Organisational environment

The CEO and Registrar has now been appointed at the CMS, which is expected to contribute to a stable organisational environment. The Council, with the support of the Office of the CEO, undertook an Organisational Diagnostic exercise to address key organisational challenges at the CMS. The key findings and recommendations revealed that there is a need to review the organisation's operational and service models, and conduct a level 1 to 3 business process mapping. This has been communicated to staff members since there is potential to restructure the organisation.

The CMS was faced with a string of allegations against its senior officials indicating that there was corrupt and unethical conduct in the manner that they carried out their functions at the CMS. Seven officials were suspended with full pay, pending the outcome of the comprehensive investigations. One official resigned when faced with charges, the other six officials are still under investigation. The absence of the senior officials at the CMS has created a leadership gap and may affect operations in the medium to long term. The investigations should be completed as soon as possible to address this risk.

There have been a number of disciplinary matters in the organisation and most of them were finalised at CCMA level. We recognise and value our people as our most important asset in achieving the vision of the CMS which is to promote fair and equitable access to healthcare in order to maximise the health of South Africans. The Human Resources sub-programme strategy for the next five years is to improve the culture, leadership, talent management, performance, reward and recognition and personal development within the organisation to ensure that the CMS is able to achieve its strategic goals and that our people have a positive experience at work.

In order to achieve this, the Human Resources sub-programme will embark on the following key strategic projects:

Talent management

Attract, identify, develop and retain high-performing talent across all areas by delivering a clear and sustainable recruitment strategy that encourages and enables the development of internal talent, the identification of external talent and the use of appropriate tools and methods for recruitment.

Situational Analysis

Learning and development

Promote professional development and learning by:

- Assessing the ability of the CMS to deliver on its current mandate, as well as on new health policy initiatives and legislative changes in the regulatory environment
- Identifying the gaps in knowledge and promoting the upskilling and development of relevant skills and competencies
- Focusing on building competencies in leadership, management and coaching

Performance management

Enable the development of a high-performance culture in which staff performance can be supported, rewarded, enhanced and managed effectively by:

- Developing and implementing a performance management framework that minimizes perceptions of bias and is aligned to best practice
- Automate the performance management process

Diversity and inclusion

Foster a values-based culture focused on diversity, inclusivity, wellbeing and positive engagement by:

- Facilitating workshops to address issues raised by employees and identified in an engagement survey conducted in 2016/2017 and to find solutions which will inculcate a positive work experience for employees
- Promoting a culture of communication between managers and employees which is open, honest and supportive
- Building a healthy workplace culture

Remuneration

Develop a remuneration approach which is valued by employees and facilitates organisational objectives by:

- Reviewing the current remuneration structure
- Establishing and implementing a remuneration framework aligned to best practice
- Reviewing titles within the CMS
- Aligning the remuneration framework with relevant markets

Succession planning

Develop a sound strategy for succession planning by:

- Establishing clear career pathways and opportunities for progression
- Describing all key career development and progression pathways across the CMS
- Developing clear approaches to identifying and developing highperforming talent
- Identifying future workforce and talent requirements
- Ensuring clear succession planning and mobility opportunities
- Developing specific policies and procedures to identify and develop and retain high-performing talent

Information technology

Over the next five years, the ICT and KM sub-programme will continue to play a significant role in providing technology enablers that support strategic processes and projects identified by business. The subprogramme will embark on a process to overhaul the entire IT system to keep up with rapid technological changes. This will enable the organisation to become more efficient in its operations.

It has become clear that the CMS cannot continue to fulfill its regulatory mandate effectively without a properly functioning medical scheme member database. This membership database, also called the National Beneficiary Registry (NBR), will enable the CMS to deliver focused services to medical scheme members and will further improve our ability to conduct meaningful research in aid of National Health priorities such as the establishment of the NHI Fund. To this end, all efforts will be directed to operationalise the NBR over the next two years. Other system development efforts will also focus on the renewal of existing key systems such as Financial Statutory Returns, the Complaints System, the Council Website, as well as the Accreditation System.

The sub-programme will further strengthen the organisation's ability to counter cyber-security threats posed by both the internal and external environments. This will be achieved by introducing several additional security measures aimed at strengthening the external and internal vulnerability surface. The sub-programme will also continue with its efforts to ensure that a robust ICT Disaster Recovery solution is established in the form of a HOT Site that will allow real-time replication of data and seamless failover of our critical servers in case of disaster.

Situational Analysis

Financial management

In the area of financial management, the CMS has matured significantly as evidenced by the unqualified audit reports issued by the Auditor-General of South Africa over the years. There are, however, areas that require much improvement. The main area of focus will be strengthening supply chain management. To this end, a proposal has been made to have a dedicated supply chain management unit, which is fully capacitated in line with developing trends. Management must ensure that financial management and internal controls of the CMS are strengthened and policies are reviewed and applied consistently. An area that requires further attention is that of consequence management in cases where there has been non- compliance with policies and regulations. CMS has in place relevant governance structures to oversee the financial environment of the entity. The Audit and Risk Committee operates under an approved charter and oversees the work of the internal auditors.

Key policy developments and legislative changes

The key policy developments that will have a significant influence on the role the CMS has to play in the next five years are:

- Promulgation of the NHI Bill
- Promulgation of the Medical Schemes Act Amendment Bill.
- Health Market Inquiry Report
- Review of the Financial Sector Regulation Act and the COFI Bill
- Presidential Health Compact

The MSAA and the NHI Bills were released on 28 June 2018 for public comment until the middle of September 2018. The release of these bills was preceded by the release of the NHI White Paper (2016), NHI Policy Document (2017) and the Gazette on the NHI Implementation Structures (2017). These documents were aimed at providing a detailed policy direction for the Universal Health Coverage for South Africa in the form of the National Health Insurance.

There is a clear link between these two Bills. The Medical Schemes Act Amendment Bill is aimed at ensuring that in the transition towards the NHI, the CMS remains an effective and efficient regulator of the medical schemes industry. The NHI Bill, on the other hand, provides details on the establishment of the fund, how it will function and related matters. The establishment of the NHI Fund will significantly affect the role of medical schemes as well as the CMS. It is envisaged that at full implementation of the Fund, medical schemes will be permitted to provide only complementary cover.

The HMI Report identified market and regulatory failures in the private health industry. The HMI has made final recommendations in order to address the identified market and regulatory failures. It is patently clear that a significant number of these recommendations will require the CMS to perform specific functions, while the establishment of the proposed Supply-Side Health Regulator (SSHR) is being contemplated.

The Presidential Health Compact is a product of a Presidential Health Summit that convened in October 2018. This committed public-private partnership is aimed at addressing the key challenges that have been identified in both the public and private sectors.

Strategic Outcome Oriented Goals

Goal 1	To promote the improvement of quality and the reduction of costs of in the private healthcare sector
Statement	The high cost of healthcare services in the private sector has been identified as one of the key factors that affects the sustainability of medical schemes in the short to medium term. The CMS is mandated to collect quality data from the private sector and advise the Health Ministry regarding the appropriate policy interventions. The CMS has to collect all the data on both quality and costs to determine if scheme members are getting value-for-money in the many health programmes that they belong to.
Goal 2	To encourage effective risk pooling
Statement	Through the standardisation of scheme options, the consolidation of medical schemes with less than 6000 members, the consolidation of government funded schemes, risk-based capital solvency framework, and the development of a Low-Cost Benefit Option framework, the CMS will ensure effective risk pooling. This work will be done through a consultative approach and by being mindful of the risks to scheme members, employers, trade unions and other key stakeholders.
Goal 3	To ensure that all regulated entities comply with the MSA and Regulations
Statement	Through ensuring that all entities that are doing the business of a medical scheme, are registered or accredited as per the requirements of the Medical Schemes Act and its Regulations. The CMS will provide members of schemes with the protection they need through the approval of scheme rules and options, efficient and expedient management of complaints, conducting of necessary inspections, and examining all schemes to ensure that they are compliant with the financial requirements including solvency and the effective defence and litigation against errant regulated entities.
Goal 4	To be a more effective and efficient organisation
Statement	Through the review, updating, development and implementation of policies, strategies and standard operating procedures for the Office of the CEO, Office of the CFO, Information Communication and Technology (ICT), Human Resources (HR), Finance, and Legal support sub-programmes, the effectiveness and efficiency of the organisation will be improved.
Goal 5	To conduct policy-driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry
Statement	The refocusing of our research efforts and aligning them with policy developments in the public and private health sectors will ensure that this goal is achieved. There will be a need to reprioritise the outputs of the Research and Monitoring, as well as the Strategy office programmes, to gain synergies on the one hand and avoid duplications on the other hand. These research efforts should, through partnership with other research institutions, support both internal and external stakeholders in understanding the strategic trajectory of the CMS.
Goal 6	To collaborate with local, regional and international entities
Statement	The establishment of formalised agreements, attendance of regular meetings and scheduled visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator.

The following section articulates progress on these strategic goals.

Performance by programme

Programme 1: Administration

The administrative programmes of the Council for Medical Schemes focus on the efficient functioning of the office and provide support to the core programmes to efficiently carry out their mandates. The administration programme entails five sub-programmes, namely 1.1 CE and Registrar; 1.2 Office of the CFO; 1.3 Information and Communication Technology and Knowledge Management; 1.4 Human Resources Management; and 1.5 Legal Services.

Sub-programme 1.1: Office of the Chief Executive and Registrar

The CE is the accounting officer exercising overall control over the office of the CMS, and as Registrar, has legislated powers to regulate medical schemes, administrators, brokers and managed care organisations.

The CE and Registrar is responsible for leading the development and execution of the CMS' strategy. The CEO and Registrar is ultimately responsible for all day-to-day management decisions and for implementing the CMS' strategic and annual plans, therefore there are no specific objectives or indicators developed for this sub-programme.

Linking performance with budget

	2019/2020			2018/2019		
Office of the CEO	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**28**	**27**	**1**	50	50	0
Refreshments	**2**	**–**	**2**	2	1	1
Subscriptions	**–**	**27**	**(27)**	–	4	(4)
	30	**54**	**(24)**	52	55	(3)
Operating expenses						
Committee remuneration	**202**	**225**	**(23)**	90	128	(38)
Consulting	**1 500**	**4 624**	**(3 124)**	1 919	1 493	426
Council member fees	**2 738**	**3 232**	**(494)**	2 818	3 530	(712)
Labour relations costs	**1 840**	**2 794**	**(954)**	2 000	1 780	220
Postage and courier	**70**	**44**	**26**	68	66	2
Transcription services	**170**	**520**	**(350)**	113	223	(110)
Travel and subsistence	**1 326**	**1 228**	**98**	1 105	1 495	(390)
Venue and catering	**619**	**520**	**99**	485	754	(269)
	8 465	**13 187**	**(4 722)**	8 598	9 469	(871)
Staff costs						
Salaries	**5 832**	**5 351**	**481**	4 584	2 347	2 237
Staff training	**131**	**148**	**(17)**	349	405	(56)
	5 963	**5 499**	**464**	4 933	2 752	2 181
Total	**14 458**	**18 740**	**(4 282)**	13 583	12 276	1 307

Performance by programme

Sub-programme 1.2: Office of the CFO

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

Key performance indicators, planned targets and actual achievements

Strategic Objective	Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 1.2.1: Ensure effective financial management and alignment of budget allocation with strategic priorities							
1.2.1.1 An unqualified opinion issued by the Auditor-General on the annual financial statements by 31 July each year	1	1	1	**1**	**1**	–	Achieved. The CMS received an unqualified opinion on its annual financial statements for 2018/19
Strategic Objective 1.2.2: Ensure that reported performance information is useful and reliable and in accordance with the Performance Management and reporting framework							
1.2.2.1 Produce an annual performance information report that is reliable, accurate and complete by 31 July each year	1	1	1	**1**	**1**	–	Achieved. The CMS annual performance information report that was reliable, accurate and complete for 2018/19
Strategic Objective 1.2.3: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS							
1.2.3.1 Number of strategic risk register reports submitted to Council for monitoring per year	4	4	4	**4**	**4**	–	Achieved. Strategic risks were monitored during the year by Council

Performance by programme

Achievement of strategic objectives

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

A strategic risk assessment workshop was held during the year with members of Council, the Audit and Risk Committee, and CMS management. Strategic risks were monitored by all governance structures. The CMS submitted its Annual Performance Plan for the 2019/20 financial year on 31 January 2019. Approval from the Executive Authority was received for the plans and budget for 2019/20. In accordance with National Treasury regulations, four tenders were awarded during the year.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the sub-programme.

Changes to planned targets

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

Performance by programme

Linking performance with budget

Office of the CEO	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Bank charges	**83**	**85**	**(2)**	123	112	11
Building expenses	**2 021**	**2 044**	**(23)**	2 053	1 813	240
General administrative expenses	**224**	**807**	**(583)**	216	199	17
Insurance	**458**	**449**	**9**	530	523	7
Printing and stationery	**319**	**328**	**(9)**	194	185	9
Refreshments	**66**	**84**	**(18)**	83	84	(1)
Rent	**12 614**	**11 981**	**633**	11 375	11 690	(315)
Rent: Operating expense	**2 320**	**2 539**	**(219)**	2 320	2 341	(21)
Subscriptions	**18**	**10**	**8**	23	18	5
	18 123	**18 327**	**(204)**	16 917	16 965	(48)
Audit remuneration						
External audit	**903**	**1 123**	**(220)**	900	740	160
Internal audit	**1 375**	**1 592**	**(217)**	1 305	1 873	(568)
	2 278	**2 715**	**(437)**	2 205	2 613	(408)
Operating expenses						
Consulting	**385**	**326**	**58**	156	399	(243)
Postage and courier	**11**	**6**	**5**	44	14	30
Travel and subsistence	**30**	**28**	**2**	30	47	(17)
Venue and catering	**51**	**29**	**22**	35	104	(69)
	477	**389**	**88**	265	564	(299)
Staff costs						
Employee benefits	**3 003**	**3 104**	**(101)**	2 686	2 846	(160)
Salaries	**12 493**	**12 026**	**467**	10 419	10 863	(444)
Staff training	**156**	**94**	**62**	400	283	117
Workmen's compensation	**187**	**187**	**–**	170	170	–
	15 839	**15 411**	**428**	13 675	14 162	(487)
Total	**36 717**	**36 842**	**(125)**	33 062	34 304	(1 242)

Performance by programme

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

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

Key performance indicators, planned targets and actual achievement

Strategic Objective		Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 1.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected								
1.3.3.1	Percentage of network and server uptime, per quarter	97.05%	99.45%	99.41%	**99%**	**100%**	**1%**	The positive deviation was due to stability of systems brought about by server virtualisation
1.3.1.2	Percentage of IT security incidents, per year	1.1%	0.27%	0%	**5%**	**0%**	**5%**	Not experiencing a security incident led to a positive deviation
1.3.1.3	Number of successful IT Disaster Recovery (DR) failover tests, per quarter	New indicator	New indicator	New indicator	**1**	**1**	**0**	
Strategic Objective 1.3.2: Provide software applications that serve both internal and external stakeholders, that improve business operations and performance								
1.3.2.1	Percentage of uptime, of all installed application systems where network access exists, per quarter	99.7%	99.47%	100%	**99%**	**100%**	**1%**	The positive deviation was achieved despite two minor incidents on our document management system during the period which was caused by disk space constraints
Strategic Objective 1.3.3.: Effectively provide information management services and organise and manage organisational knowledge with a view to enhancing knowledge sharing								
1.3.3.1	Percentage of physical requests for information received and finalised to within 30 days, per year	98%	97.5%	98.5% (244/249)	**95%**	**96.6%**	**1.6%**	The target was exceeded, as most of the information requested was readily available on online databases which CMS subscribes to

Performance by programme

Achievement of strategic objectives

In the 2019/20 financial year, the ICT and KM unit achieved 100% of its annual targets, which can be attributed to the team's dedication and commitment to support the CMS in achieving its business objectives. The ICT and KM unit comprises three sub-units which work closely together to deliver business value: Networks, Software Development and Knowledge Management. The Networks sub-unit looks after all ICT infrastructure, Service Desk, Desktop and Networks Support. In the period under review, the team achieved 100% network and server uptime, experienced no security incidents and managed to successfully conduct a disaster recovery failover test. In order to enable collaboration and improve productivity, the Networks team managed to successfully implement video conferencing facilities in our boardrooms and also roll out Microsoft Teams across the organisation.

The Software Development sub-unit is responsible for development of applications in line with business requirements. The team provided ongoing support for stakeholders, ensured maintenance of critical business applications and achieved 100% uptime on all installed applications where network access exists. One of the strategic initiatives undertaken includes groundwork done on the establishment of the Central Beneficiary Register, which is one of the enablers for the successful implementation of the NHI programme. A pilot project was successfully done in collaboration with GEMS, and engagement with other stakeholders, including the DoH and all other medical schemes, are continuing to ensure this project becomes a success.

The Knowledge Management sub-unit is responsible for management of the resource centre, records management and the handling of Promotion of Access to Information Act (PAIA) and other information requests. It aims to create an environment in which the dissemination of information to both internal and external stakeholders becomes more efficient by making available relevant online databases, acquiring resources in support of research and development, and enabling knowledge sharing within the CMS. In the period under review, the sub-unit had achieved its target of responding to received information requests within 30 days, and also submitted the South African Human Rights Commission Section 32 report, as well as ensuring publication of PAIA Section 15 report in the Government Gazette No: 42584.

In order to ensure that the CMS continues to be an effective regulator, the ICT and KM unit will prioritise integration of various legacy and siloed applications to implement an integrated regulatory system that is responsive to the needs of the medical schemes industry. Our ambition is to roll out business capability projects aimed at improving enterprise security, enabling mobility, streamlining of core business processes, deployment of an interactive website and delivery of business insights for effective monitoring and evaluation of business performance. A business continuity plan review will also be conducted to ensure adequate capabilities for online data storage, archiving and disaster recovery. An enterprise information management programme will also be undertaken to scale up bulk scanning and digitisation of organisational records as well as the optimization of our document management system to incorporate the file plan in line with the National Archives and Records Service.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the sub-programme.

Changes to planned targets

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

Performance by programme

Linking performance with budget

Information Technology and Knowledge Management	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
General administrative expenses	**567**	**750**	**(183)**	579	654	(75)
Printing and stationery	**16**	**6**	**10**	18	13	5
Refreshments	**2**	**–**	**2**	2	–	2
Rent: Copiers	**443**	**401**	**42**	399	401	(2)
Security	**506**	**713**	**(207)**	464	409	55
Subscriptions	**5**	**1**	**4**	13	13	–
Telecommunication expenses	**4 886**	**5 578**	**(692)**	6 715	5 146	1 569
SEP system expenses	-	-	-	-	229	(229)
	6 425	**7 449**	**(1 024)**	8 190	6 865	1 325
Operating expenses						
Consulting	**281**	**260**	**21**	230	184	46
Knowledge management	**1 298**	**1 561**	**(263)**	981	1 478	(497)
Travel and subsistence	**57**	**75**	**(18)**	75	89	(14)
Venue and catering	**21**	**15**	**6**	10	11	(1)
	1 657	**1 911**	**(254)**	1 296	1 762	(466)
Staff costs						
Salaries	**12 667**	**11 846**	**821**	11 956	11 426	530
Staff training	**269**	**291**	**(22)**	170	139	31
	12 936	**12 137**	**799**	12 126	11 565	561
Total	**21 018**	**21 497**	**(479)**	21 612	20 192	1 420

Performance by programme

Sub-programme 1.4: Human Resources Management

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support the CMS mission. We fulfil 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

By doing this, we help the CMS by supporting its administration and staff through human resources (HR) management advice and assistance, enabling them to make decisions that maximise its most important asset: its people. We continue working towards ensuring that the CMS remains an employer of choice.

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement 2019/20	Comment on deviations
Strategic objective 1.4.1: Build competencies and retain skilled employees								
1.4.1.1	Minimise staff turnover rate to less than 10% per year	4.42%	7.1%	4.48%	**<10%**	**8.33%**	**1.67%**	The staff turnover rate remained at less than 10%
1.4.1.2	Turnaround time to fill a vacancy (Turnaround time of 120 working days to fill a vacancy that exists during the year) excluding position of CEO	There were 5 out of 14 positions that took longer than the 90 days to fill	There were 16 vacancies during the period, 12 were filled within 120 days, one took longer than the 120 days to fill and the recruitment process was underway for 3	There were 14 vacancies during the period, 9 were filled within 120 days, 3 took longer than 120 days and the recruitment process was underway for 2	**120 days**	**There were 30 vacancies. 27 were advertised. Of the 27, 24 were filled within 120 days turnaround time**	**–**	Selection process for 4 vacancies was postponed due to national lockdown
	Accreditation Analyst: MCO (2/1/2019)	–	–	–	**120 days**	**64 days**	**–**	Incumbent commenced on 1 April 2019
	Legal Adjudication Officer (1/2/2019)	–	–	–	**120 days**	**62 days**	**–**	Incumbent commenced on 2 May 2019
	Client Contact Agent (1/3/2019)	–	–	–	**120 days**	**43 days**	**–**	Incumbent commenced on 2 May 2019
	Executive Assistant (1/4/2019)	–	–	–	**120 days**	**42 days**	**–**	Incumbent commenced on 1 June 2019
	Senior Legal Adjudication Officer (1/4/2019)	–	–	–	**120 days**	**105 days**	**–**	Incumbent commenced on 2 September 2019
	Labour Relations Officer (1/8/2019)	–	–	–	**120 days**	**41 days**	**–**	Incumbent commenced on 1 October 2019
	Procurement Manager (1/7/2019)	–	–	–	**120 days**	**44 days**	**–**	Incumbent commenced on 2 September 2019

Performance by programme

Strategic Objective	Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement 2019/20	Comment on deviations
Supply Chain Administrator (1/7/2019)	–	–	–	**120 days**	**87 days**	–	Incumbent commenced on 1 November 2019
Supply Chain Officer (1/9/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 6 January 2020
Legal Adjudication Officer (1/9/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 2 December 2019
2 x Paralegal Administrators (1/9/2019)	–	–	–	**120 days**	**43 days**	–	Incumbents commenced on 1 November 2019
Administrator: Secretariat (1/9/2019)	–	–	–	**120 days**	**43 days**	–	Incumbent commenced on 1 November 2019
Senior Compliance Officer (1/9/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 6 January 2020
Network Technician (1/9/2019)	–	–	–	**120 days**	**100 days**	–	Incumbent commenced on 1 February 2020
OD Manager Officer (1/10/2019)	–	–	–	**120 days**	**104 days**	–	Incumbent required to serve notice and will join on 4 May 2020
Legal Adjudication Officer (1/10/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 3 February 2020
Legal Adjudication Officer (1/10/2019)	–	–	–	**120 days**	**21 days**	–	Incumbent commenced on 3 December 2019
Medical Advisor (1/10/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 3 February 2020
Senior Researcher (1/10/2019)	–	–	–	**120 days**	**80 days**	–	Incumbent commenced on 2 March 2020
Administrator: Complaints (1/11/2019)	–	–	–	**120 days**	**99 days**	–	Incumbent required to serve notice and will join on 18 May 2020
GM: Accreditation (1/12/2019)	–	–	–	**120 days**	**78 days**	–	Recruitment process currently underway
GM: Compliance (1/12/2019)	–	–	–	**120 days**	**78 days**	–	Recruitment process currently underway

Performance by programme

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement 2019/20	Comment on deviations
	Legal Advisor (6/1/2020)	–	–	–	**120 days**	**62 days**	**–**	Recruitment process currently underway
	Financial Analyst (6/1/2020)	–	–	–	**120 days**	**62 days**	**–**	Incumbent to commence on 1 April 2020
	Chief Information Officer (1/2/2020)	–	–	–	**120 days**	**42 days**	**–**	Incumbent to commence on 1 April 2020
	Helpdesk Technician (1/2/2020)	–	–	–	**120 days**	**42 days**	**–**	Recruitment process currently underway
1.4.1.3	Achievement of employment equity targets (according to BBBEEA targets), annually	79.82%	79.82%	97.12%	**85%**	**100%**	**15%**	Exceeded the BBBEEA scorecard target by 15%
Strategic Objective 1.4.2: Maximise performance to improve organisational efficiency and maintain high performance culture								
1.4.2.1	100% of employee performance agreements are signed by no later than 31 May of each year	100%	86%	100%	**100%**	**93.28%**	**6.72%**	Not all performance contracts were signed due to operational requirements and labour disputes
1.4.2.2	Percentage of employee performance assessment concluded, biannually*	New indicator	New indicator	100%	**100%**	**89.47%**	**10.53%**	Performance assessments were carried out for 102 employees. 17 performance assessments were not completed due to resignations, suspensions and retirement

Performance by programme

Achievement of strategic objectives

For the 2019/2020 reporting year, the CMS had 30 positions made up of 10 newly approved posts and 20 vacancies. Filling of these positions had to be reprioritised due to budget constraints that resulted in some positions not being advertised during the reporting period. The CMS has successfully filled 19 vacancies into permanent positions in line with the CMS recruitment and selection policy. During 2019/2020 reporting period, 4 were filled by internal candidates, 11 by external candidates and 4 were filled by candidates who were on internship programmes. Eleven vacancies remained at the end of the reporting year. There were 17 terminations during the reporting period. The organisation continued to support government's call to develop the skills of qualified graduates. At the beginning of the financial year, CMS had placed 23 qualified graduates into internship programme. The number was increased to 32 at the end of the reporting period.

To ensure that the CMS remains an employer of choice, the Council approved a remuneration philosophy and employment value proposition to benchmark its remuneration against public services and state-owned entities. The State-Owned-Entities (SOE) to be used as comparator market for remuneration benchmarking for the CMS.

Performance management continued to be a high-priority area. At the beginning of the financial year under review, employees signed performance agreements with their supervisors. Two formal performance reviews were concluded in line with Performance Management and Incentive policies. The Moderating Committee, consisting of the executive management and trade union representative will convene in the new financial year and the unit will facilitate the awarding of incentive bonuses to employees for their contribution to the achievement of the CMS overall strategic objectives.

Strategy to overcome areas of underperformance

The unit reviewed the performance management system that lacked detailed evaluation criteria to categorise the allocation of performance scores. An external provider was appointed to assist with the review of the performance management system and will introduce a Balanced Scorecard framework to provide SMART criteria by which performance are monitored and measured.

Attracting and appointing people with disabilities remains a challenge. Currently, the organisation has a 0.42% achievement score for this target, missing the national target by 2% of the BBBEE scorecard. Priority will be given to attract people with disabilities during the new financial year to comply with the scorecard.

Changes to planned targets

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

Performance by programme

Linking performance with budgets

Human Resources	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
General administrative expenses	**31**	**30**	**1**	98	104	(6)
Printing and stationery	**9**	**6**	**3**	22	22	–
Subscriptions	**177**	**161**	**16**	206	164	42
	217	**197**	**20**	326	290	36
Operating expenses						
Consulting	**688**	**805**	**(117)**	990	798	192
Transcription services	**46**	**43**	**(3)**	–	4	(4)
Travel and subsistence	**23**	**40**	**(17)**	27	34	(7)
Venue and catering	**47**	**114**	**(67)**	157	102	55
	804	**1 002**	**(198)**	1 174	938	236
Staff costs						
Employee wellness	**302**	**302**	**0**	318	270	48
Recruitment and relocation	**697**	**1 039**	**(342)**	831	1 009	(178)
Salaries	**6 269**	**5 654**	**615**	4 891	5 114	(223)
Staff training	**95**	**42**	**53**	105	225	(120)
Temporary staff	**3 316**	**3 492**	**(176)**	3 242	2 716	526
	10 679	**10 529**	**126**	9 387	9 334	53
Total	**11 700**	**11 728**	**(28)**	10 887	10 562	325

Performance by programme

Sub-programme 1.5: Legal Services

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

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 1.5.1: Legal advisory and support services for effective regulation of the industry and operations of the office								
1.5.1.1	Number of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days, per year	175	267	279	**210**	**267**	**57**	Due to the volatile and unpredictable nature of this objective, the projected number was exceeded
Strategic Objective 1.5.2: Defending decisions of the Council and the Registrar								
1.5.2.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days, per year	100% (25)	100% (17)	100% (25)	**100% (25)**	**100% (17)**		The unpredictable nature of this objective resulted in fewer matters being received than were anticipated

Achievement of strategic objectives

The CMS Legal Services Unit has consistently outperformed and exceeded its set targets,due to the volatile and unpredictable nature of 1.5.1.1 objective, the projected number was exceeded and the unpredictable nature of 1.5.2.1 objective resulted in fewer matters being received than were anticipated. The deviation in all instances has been a positive one and speaks to the dedication and commitment of the members of the unit in positively contributing to the strategic objectives and overall scorecard of the CMS. As the legal unit, we correctly applied our metrics and monitored them closely all year. We also ensured that our days were specifically spent doing what will make the unit achieve its targets. This enabled the unit to over-achieve on its target, created awareness of the need for good corporate governance and by so doing ensured sound compliance with the CMS mandate and the law. The unit prioritises and completes high revenue/cost saving and strategic commercial agreements for the organisation. The unit continuously and successfully defends and protects the interests of the organisation (litigation, IP, regulatory affairs, compliance).

Strong legal capacity has enabled CMS to enforce its statutory mandate with an exemplary success rate. CMS has consistently maintained legal and regulatory certainty in the medical schemes environment. The unit has also made an important contribution to the Health Market Inquiry currently being undertaken by the Competition Commission. The unit has also made an important contribution to the LCBO processes; it is also playing a significant role in the amendment of the Medical Schemes Act in accordance with the NHI and Health Market Inquiry (HMI). The unit is further engaged with the National Treasury and the FSCA in challenges and plays a role in the alignment of the FRSA and COFI Bill. The CMS' ability to highlight and legally challenge uncompetitive practices by service providers and associations has played a vital role in shaping the behaviour of service providers.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the sub-programme.

Changes to planned targets

There were no changes to planned targets

Performance by programme

Linking performance with budgets

Legal service	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**5**	**4**	**1**	10	–	10
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**–**	**–**	**–**	4	3	1
	7	**4**	**3**	16	3	13
Operating expenses						
Legal fees	**6 400**	**17 958**	**(11 558)**	8 665	6 151	2 514
Travel and subsistence	**73**	**76**	**(3)**	93	83	10
Venue and catering	**–**	**4**	**(4)**	4	2	2
	6 473	**18 038**	**(11 565)**	8 762	6 236	2 526
Staff costs						
Salaries	**5 022**	**4 584**	**438**	4 360	4 489	(129)
Staff training	**86**	**83**	**3**	115	108	7
	5 108	**4 674**	**441**	4 475	4 597	(122)
Total	**11 588**	**22 709**	**(11 121)**	13 253	10 836	2 417

Performance by programme

Programme 2: Strategy Office

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

Key performance indicators, planned targets and actual achievements

	Strategic Objective	Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 2.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected								
2.1.1	The number of benefit definitions published per year	10 CMScripts 7 PMB definitions	10	10	**5**	**5**	**–**	Half of the definitions were not marked final due to lack of industry responses
2.1.2	Develop primary health care package to incorporate into the PMBs	New indicator	Draft costed PMB benefit package completed but not submitted to Council	A service based Preventative and Primary Healthcare package and costing methodology report was submitted to the Executive Authority	**Develop Primary Healthcare package for incorporation into the PMBs**	**Develop Primary Healthcare package for incorporation into the PMBs**	**–**	Primary healthcare package was published during the year under review
Strategic Objective 2.2: Provide clinical opinions with a view to resolve complaints and enquiries								
2.2.1	Percentage of category 1* clinical opinions provided within 30 working days of receipt from Complaints Adjudication Unit	40%	98%	54%	**90%**	**69%**	**(21%)**	The Clinical Unit did not meet the target set for this year for clinical opinions reviewed under 30 working days. This was attributable to an increase in volume of referrals as well as human resource capacity constraints
2.2.2	Percentage of category 2* clinical opinions provided within 60 working days of receipt from Complaints Adjudication Unit	New indicator	100%	99%	**95%**	**100%**	**5%**	The target for this indicator was exceeded as the unit had adequate time within which to complete this category of clinical opinions

Performance by programme

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement for 2019/20	Comment on deviations
2.2.3	Percentage of category 3* clinical opinions provided within 90 working days of receipt from Complaints Adjudication Unit	New indicator	100%	100%	**98%**	**100%**	**2%**	The target for this indicator was exceeded as the unit had adequate time within which to complete this category of clinical opinions
2.2.4	Percentage of clinical enquiries received via email or telephone responded within 7 days	99%	99%	98%	**96%**	**99%**	**3%**	The target was exceeded owing to adequate capacity to attend to these clinical enquiries
Strategic Objective 2.3: Conduct research to inform national health policy interventions								
2.3.1	Number of research projects and support projects published in support of the National Health Policy, per year	New indicator	11	11	**5**	**11**	**6**	The unit received additional requests for research and support projects

Performance by programme

Achievement of strategic objective

The Prescribed Minimum Benefits (PMB) review is a multi-stakeholder driven process that began late in the financial year due to uncertainty in developments in national health policy. Despite the delays, the unit managed to publish a primary healthcare package. The following PMB benefit definitions guidelines were published:

- Follicular lymphoma
- Mantle cell lymphoma
- Diffuse large B-cell lymphoma (DLBCL)
- Marginal zone lymphoma
- Burkitt lymphoma
- Adult T-cell leukaemia/lymphoma
- Nodal and extranodal lymphomas
- Best supportive care for haematology oncology
- Pain management
- Prostate cancer

The publication of the above funding guidelines was aimed at clarifying scheme members' benefits and entitlements while ensuring fewer complaints and enquiries.

The CMS Strategy Office also undertook special research projects in support of national health policy to advise the Minister of Health and other related parties on any matters concerning medical schemes (with the objective of protecting the interests of the beneficiaries).

Strategy to overcome areas of underperformance

The unit is tasked with the provision of high-quality clinical opinions for the resolution of complaints by members and beneficiaries of schemes. This is aimed at ensuring that members' entitlements under the PMB regulations are protected. The increase in volumes and complexities of these opinions has been on the rise in the past few years. The unit has three clinical analysts who are tasked with the synthesis of these clinical opinions amongst many other competing work priorities. This limited capacity had led to a decrease in the capacity of the unit to provide these opinions within 30 working days. A plan to address this through the appointment of additional clinical analysts and improved processes is in place.

Areas where targets were exceeded

Targets for category 2 and 3 clinical opinions were exceeded because despite their complexity, the clinical analysts had more time (60 and 90 working days) to complete them. They therefore were able to analyse, research and complete these categories of opinions before the expiration of the target deadlines.

Performance by programme

Changes to planned targets

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

Linking performance with budgets

Strategy Office	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**3**	**8**	**(5)**	12	7	5
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**13**	**5**	**8**	17	19	(2)
	18	**13**	**5**	31	26	5
Operating expenses						
Consulting	**1 571**	**2 546**	**(975)**	928	2 107	(1 179)
Travel and subsistence	**263**	**341**	**(78)**	250	496	(246)
Venue and catering	**181**	**256**	**(75)**	66	268	(202)
	2 015	**3 143**	**(1 128)**	1 244	2 871	(1 627)
Staff costs						
Salaries	**10 596**	**10 056**	**540**	9 825	10 151	(326)
Staff training	**131**	**121**	**10**	131	150	(19)
	10 727	**10 177**	**550**	9 956	10 301	(345)
Total	**12 760**	**13 333**	**(573)**	11 231	13 198	(1 967)

Performance by programme

Programme 3: Accreditation

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

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement for 2019/20	Comment on deviations
Strategic Objective 3.1: Accredit regulated entities based on their compliance with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation								
3.1.1	Percentage of brokers and broker organisations applications accredited within 30 working days of receipt of complete information	4 854	5 500	5 030	**80%**	**74.3%**	**5.7%**	There were more incomplete applications received due to non-compliance with qualification requirements
3.1.2	Percentage of managed care organisation applications analysis completed within 3 months of receipt of complete information	21	15	22	100%	100%	–	All applications were processed for the period under review
3.1.3	Percentage of administrators and self-administered schemes' applications analysis completed within 3 months of receipt of complete information	14	6	14	100%	100%	–	All applications were processed for the period under review

Performance by programme

Achievement of strategic objectives

Third party administrators and self-administered schemes

- There were five administrator accreditation renewals finalised
- Six self-administered scheme compliance certificate renewal applications were evaluated and finalised during the year
- A full on-site evaluation was completed in one self-administered medical scheme on-site evaluations were conducted during the year
- The Accreditation Unit continued to monitor compliance by accredited entities with conditions imposed and the audited financial statements of administrators annually to ensure their financial soundness

The revised administrator accreditation standards (Version 6) were published during the year with effective date from 1 January 2020.

The unit, in consultation with the Financial Supervision Unit, prepared and published a document to provide clarity regarding the suitable classification of bona fide “accredited” administration and other administration services. Both units continue to monitor compliance with the published circular and to give effect to the second phase of the implementation thereof.

Managed care organisations

- Six new and 14 renewal, managed care accreditation applications were evaluated and accredited during the year. Two new and one renewal self-administered scheme compliance certificate applications were evaluated and the compliance certificates were issued during the same period.
- Four full on-site evaluations and one conditions compliance follow-up on-site evaluation were completed during the year

The Accreditation Unit continued to monitor compliance by accredited entities with conditions imposed and the financial soundness of risk-bearing entities on an annual basis to ensure their financial soundness.
The revised managed care accreditation standards (version 5) were published with effective date from 1 February 2020.

Broker and broker organisations

The unit continued to verify qualifications of individuals applying to be accredited as brokers. The unit amended application forms for accreditation of brokers with a view to collecting details regarding race and gender to measure the extent of transformation in the industry. A guideline for broker agreements and a specimen agreement were completed and published during the year after public comment had been invited and considered.

Strategy to overcome areas of underperformance

The Unit will ensure that the intern is always appointed to assist with processing the incomplete applications received from applicants.
The new online system implemented in January 2020 will not allow applicants to proceed and submit incomplete applications

Changes to planned targets

There were no changes to planned targets for the programme during the year under review. However, the performance indicators were changed to better reflect the unit’s effort and performance.

Performance by programme

Linking performance with budgets

Accreditation Unit	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**22**	**12**	**10**	30	22	8
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**319**	**348**	**(29)**	186	123	63
	343	**360**	**(17)**	218	145	73
Operating expenses						
Consulting	**–**	**–**	**–**	150	102	48
Travel and subsistence	**576**	**615**	**(39)**	311	246	65
Venue and catering	**7**	**4**	**3**	10	7	3
	583	**619**	**(36)**	471	355	116
Staff costs						
Salaries	**9 260**	**8 412**	**848**	8 936	8 445	491
Staff training	**54**	**89**	**(35)**	131	108	23
	9 314	**8 501**	**813**	9 067	8 553	514
Total	**10 240**	**9 480**	**760**	9 756	9 053	703

Performance by programme

Programme 4: Research and Monitoring

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

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 4.1: Conduct research to inform appropriate policy interventions								
4.1.1	Number of research projects finalised, per year	10	9	14	**12**	**15**	**3**	There were additional requests during the year for additional projects
4.1.2	Non-financial report submitted for inclusion in the annual report	1	1	1	**1**	**1**	**–**	

Achievement of strategic objectives

The unit is responsible for collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. This is in support of Section 7(c), (e) and (g) of the Medical Schemes Act. The unit also contributes to helping the CMS to contribute to the development of policy that enhances the protection of the interests of beneficiaries and members of the public.

The unit comprises a staff complement of four senior researchers and one data management analyst to assist the CMS to achieve its mandate of protecting the interest of beneficiaries of medical schemes. Through the analysis of scheme risk profiles, the prevalence of chronic conditions, provider distribution, measurement of quality in medical schemes and utilisation of healthcare services, the unit assists in advocating for key priority areas and intervention that will aid member protection.

The unit has set itself targets for the year including publishing research work in research journals as a method of disseminating policy and research outputs. Some of the research output was also presented at industry conferences, such as HPCSA, BHF and SAMA symposium on NHI. The unit will continue with great performance for greater impact on policy research work.

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Performance by programme

Linking performance with budgets

Research and Monitoring	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**4**	**3**	**1**	9	3	6
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**14**	**12**	**2**	15	13	2
	20	**15**	**5**	26	16	10
Operating expenses						
Consulting	**85**	**–**	**85**	141	207	(66)
Travel and subsistence	**78**	**96**	**(18)**	146	56	90
Venue and catering	**14**	**4**	**10**	29	14	15
	177	**100**	**77**	316	277	39
Staff costs						
Salaries	**6 695**	**8 209**	**(1 514)**	6 864	7 653	(789)
Staff training	**155**	**144**	**11**	192	160	32
	6 850	**8 353**	**(1 503)**	7 056	7 813	(757)
Total	**7 048**	**8 468**	**(1 421)**	7 398	8 106	(708)

Performance by programme

Programme 5: Stakeholder Relations

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

Key performance indicators, planned targets and actual achievements

Strategic Objective	Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement	Management Comments
Strategic objective 5.1: To create awareness and collaboration through with stakeholders, while enhancing the visibility and protecting the reputation of the CMS.							
5.1.1 Number of stakeholder awareness activities conducted, per year	New indicator	New indicator	New indicator	**21**	**36**	**15**	The increased stakeholder engagements were due to public interest issues that led to the prioritisation of projects such as the Section 59 investigation into allegations of racial profiling by medical schemes, the establishment of a working-group working to establish a permanent structure to deal with fraud, waste and abuse, an outcome of the FWA summit and another special project for the unit, the Low-Cost Benefit Option which required constant engagement with the industry.
5.1.2 Percentage of stakeholder awareness of CMS resulted from survey, per year	40.3%	n/a	64%	**50%**	**50%**	**–**	-
Strategic objective 5.2. The CMS must ensure that an Annual Report are submitted to the Executive Authority five months after the end of a financial year							
5.2.1 Submission of Annual report by 31 August to the Executive Authority	1	1	1	**1**	**1**	**–**	–

Performance by programme

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement for 2019/20	Management Comments
Strategic objective 5.3 To enhance knowledge and skills among stakeholders, in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act (1998), through education and training interventions.								
5.3.1	Number of stakeholder education and training sessions, per year	55	59	85	**35**	**70**	**35**	The Education and Training unit introduced the Development Programme for Trustees in partnership with the Gordon Institute of Business Science (GIBS) during the year under review. The sub-unit also took part in World Consumer Rights Celebration activities.

Achievement of strategic objectives

The unit had increased stakeholder awareness activities due to public interest issues that led to the prioritisation of projects such as the Section 59 investigation into allegations of racial profiling by medical schemes; the establishment of a working-group working to establish a permanent structure to deal with fraud, waste and abuse; an outcome of the FWA summit; and another special project for the unit, the Low-Cost Benefit Option, which required constant engagement with the industry. As such, the organisation realised a total Advertising Value Equivalent (AVE) of R181m during the financial year. The CMS Annual Report was submitted to the Executive Authority by 31 August 2019 in line with statutory requirements.

During the year under review, the Education and Training sub-unit conducted a total of 50 education, and awareness sessions to medical scheme members and beneficiaries. The sub-unit was also featured on a radio station in the Western Cape with an estimated listenership of 76 000 covering Paarl Valley, Wellington and surrounding areas of the Cape Metro.

The highlight of the year under review was the introduction of the Trustee Development Programme in partnership with Gordon Institute of Business Science (GIBS). The Education and Training sub-unit trained 100 brokers in Gauteng, Kwa-Zulu Natal and Cape Town. The broker training programme awarded the delegates 6.0 CPD hours as required for Health Services Benefits Class of Business by the FSCA's Board Notice 195. A total of 48 members of the Board of Trustees enrolled for the Induction Trustee Training offered in Cape Town and Gauteng.

Though our Customer Care line we received a total of 39 556 calls during the 2019/20 year under review, and 35 906 (90.77%) calls were dropped by callers due to long waiting periods caused by high volumes.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the sub-programme.

Performance by programme

Changes to planned targets

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

Linking performance with budgets

Stakeholder Relationship	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**10**	**5**	**5**	13	17	(4)
Subscriptions	**18**	**26**	**(8)**	23	11	12
Refreshments	**2**	**-**	**2**	2	-	2
	30	**31**	**(1)**	38	28	10
Operating expenses						
Consulting	**36**	**10**	**26**	328	92	236
Postage and courier	**-**	**-**	**0**	-	3	(3)
Exhibition costs	**86**	**115**	**(28)**	112	103	9
Media and promotion	**1 743**	**1 385**	**358**	1 451	1 606	(155)
Printing and publication	**893**	**935**	**(42)**	812	979	(167)
Travel and subsistence	**550**	**825**	**(275)**	1 108	842	266
Venue and catering	**389**	**702**	**(313)**	1 650	1 875	(225)
	3 697	**3 972**	**(275)**	5 461	5 500	(39)
Staff costs						
Employee wellness	**2**	**–**	**2**	2	–	2
Salaries	**9 296**	**9 524**	**(228)**	8 400	8 404	(4)
Staff training	**122**	**81**	**41**	144	114	30
	9 418	**9 605**	**(187)**	8 544	8 518	26
Total	**13 145**	**13 608**	**(463)**	14 043	14 046	(3)

Performance by programme

Programme 6: Compliance & Investigations

The purpose of the programme is to serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act (1998).

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement for 2019/20	Comment on deviations
Strategic objective 6.1: Inspect regulated entities for routine monitoring of compliance with the prescribed legislation(s).								
6.1.1	Number of routine inspections undertaken, per year	New indicator	New indicator	New indicator	**13**	**13**	**–**	
Strategic objective 6.2: Inspect regulated entities for alleged irregularity or non-compliance with the prescribed legislation(s).								
6.2.1	Number of commissioned inspections undertaken, per year	New indicator	New indicator	New indicator	**4**	**6**	**2**	The unit received more matters that required regulatory intervention
Strategic objective 6.3: Ensure enforcement action is undertaken against regulated entities.								
6.3.1	Number of enforcement actions undertaken to ensure compliance with the Medical Schemes Act (1998), per year	New indicator	New indicator	New indicator	**54**	**93**	**39**	The unit received and uncovered more matters that required regulatory intervention
Strategic objective 6.4: Strengthen and monitor governance systems medical schemes and other regulated entities.								
6.4.1	Number of governance interventions implemented, per year	(105) 100%	(108) 100%	116	**99**	**102**	**3**	The unit uncovered more matters that required regulatory intervention
6.4.2	Number of scheme member meetings attended, per year	New indicator	New indicator	New indicator	**40**	**52**	**12**	The unit observed and attended more AGMs to ensure compliance with the Act

Performance by programme

Achievement of strategic objectives

During the period under review the unit was able to intervene timeously and appropriately in instances where the rights of members were compromised; this is supported by the fact that the unit performed over and above the set targets. The enforcement of rulings on member complaints, observation of annual general meetings and regulatory action of other governance irregularities also contributed to the attainment of the strategic outcomes. Furthermore, the unit divided its performance indicators to enable a clear picture of the unit's activities and performance, thus resulting in five indicators as opposed to two from the previous years.

Annual general meetings

The unit observed 52 annual general meetings to ensure that medical schemes conduct their AGMs in compliance with the Medical Schemes Act as well as scheme rules. The unit's main focus for observing AGMs was to ensure that the scheme's voting and election processes were conducted in a fair and transparent manner, for the benefit of scheme members. The unit made an effort to exceed its planned target to ensure that 74% of medical scheme AGMs have been attended and observed, to ensure compliance with the MS Act.

Enforcement actions

The unit attended to enforcement matters as required and a vetting of scheme officers exercise was initiated where schemes had responded to Circular 44 of 2018. From that exercise the unit issued Section 43 enquiries relating to potential conflict of interest by trustees and scheme officials. In addition, the unit also took action as it relates to enforcements action by schemes funding prescribed minimum benefits from member savings accounts, in violation of regulation 10(6). This led to the unit outperforming its planned targets by 39 matters.

Governance interventions

The unit exceeded its target because it monitored three curatorships for schemes that had been placed under administration due to governance and financial solvency related issues.

Inspections

The unit exceeded its target because it received more information on irregularities and non-compliance that required inspections to be instituted in terms of Section 44(4)(a) of the MS Act.

Strategy to overcome areas of underperformance

It should be noted that the unit did not underperform during the 2019/2020 period. Two errors were identified relating to the submission of performance information, for quarter 1 and quarter 3, and corrections were factored into the final API achieved targets.

To address this, the unit will incorporate a three-tier reviewing process before performance information is submitted to ensure that reporting is free from errors.

Changes to planned targets

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

Performance by programme

Linking performance with budgets

Compliance Investigation	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**16**	**12**	**4**	19	8	11
Subscriptions	**34**	**21**	**13**	19	17	2
Refreshments	**2**	**-**	**2**	2	-	2
	52	**33**	**19**	40	25	15
Operating expenses						
Inspection costs	**6 917**	**4 779**	**2 138**	2 724	6 824	(4 100)
Travel and subsistence	**500**	**500**	**–**	183	277	(94)
Venue and catering	**1**	**2**	**(1)**	20	3	17
	7 418	**5 281**	**2 138**	2 927	7 104	(4 177)
Staff costs						
Salaries	**10 406**	**9 976**	**430**	8 774	9 476	(702)
Staff training	**150**	**80**	**70**	212	159	53
	10 556	**10 056**	**500**	8 986	9 635	(649)
Total	**18 026**	**15 370**	**2 656**	11 953	16 764	(4 811)

Performance by programme

Programme 7: Benefits Management

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

Key performance indicators, planned targets and actual achievements

	Strategic Objective	Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic objective 7.1: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).								
7.1.1	Percentage interim rule amendments processed within 14 working days of receipt of all information, per year	87% (88 out of 101)	96.3% (104/108)	96.2% (101/105)	**80%**	**92.6% (88/95)**	**12.6%**	The unit exceeded its target of analysing 80% of the rule submissions within 14 days by 12.6%. The inclusion of the analyst who has been doing largely administration work for the unit resulted in the unit exceeding this objective
7.1.2	Percentage of annual rule amendments processed before 31 December of each year	98.9% (90)	100% (91)	100% (78/78)	**90%**	**100% (77/77)**	**10% (100%-90%)**	The unit was able to exceed its target of 90% by reviewing 100% of the submissions relating to the changes to benefits and contributions to schemes before 31 December 2019. The inclusion of the analyst who has been largely administration work for the unit resulted in the unit exceeding this objective.

Performance by programme

Achievement of strategic objectives

The unit is responsible for the registration of the rules of medical schemes and as such contributes to the goal of the CMS to ensure that schemes are regulated efficiently based on rules that are fair and compliant with the Medical Schemes Act. The unit comprises six analysts with technical expertise to assist the office of the Registrar and the CMS to achieve its mandate of protecting the interests of beneficiaries of medical schemes.

All the general operations of medical schemes relating to governance, contribution rates and benefits offered are all based on the registered scheme rules. It is therefore important that the targets set annually are met with great precision, consistency and commitment. The unit has included the analyst who has been doing largely administration work, in conducting analyses of amendments, which assisted the unit exceed on in its overall targets The unit set itself high targets for the year and has managed to exceed these targets for the 2019-20 financial reporting period, and with this, the office of the Registrar and the CMS is able to deliver on its mandate successfully. The unit endeavours to continue this stellar performance to ensure the mandate is achieved.

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Linking performance with budgets

	2019/2020			2018/2019		
Stakeholder Relationship	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**19**	**12**	**7**	15	13	2
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**19**	**20**	**(1)**	20	12	8
	40	**32**	**8**	37	25	12
Operating expenses						
Travel and subsistence	**49**	**49**	**–**	25	21	4
Venue and catering	**1**	**4**	**(3)**	–	2	(2)
	50	**53**	**(3)**	25	23	2
Staff costs						
Salaries	**6 701**	**6 968**	**(267)**	7 078	6 436	642
Staff training	**47**	**72**	**(25)**	105	99	6
	6 748	**7 040**	**(292)**	7 183	6 535	648
Total	**6 838**	**7 125**	**(287)**	7 245	6 583	662

Performance by programme

Programme 8: Financial Supervision

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

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achieve-ment 2015/16	Actual Achieve-ment 2016/17	Actual Achieve-ment 2017/18	Actual Achieve-ment 2018/19	Planned Target 2019/20	Actual Achieve-ment 2019/20	Deviation from planned target to Actual Achieve-ment for 2019/20	Comment on deviations
Strategic Objective 8.1: Monitor and promote the financial soundness of medical schemes									
8.1.1	Recommendations in respect of Regula-tion 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar) for 100% of business plan received, per year	100%	100%	100%	88%	**100%**	**100%**	–	Recommendations were done for all business plans received from schemes in respect of Regulation 29
8.1.2	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	100%	–	100%	–	**100%**	**100%**	–	The schemes with rapidly reducing solvency were identified
8.1.3	Percentage of auditor applications analysed, per year	New indicator	New indicator	100%	100%	**100%**	**100%**	–	All schemes that applied for audit approval were approved. All auditor authorization applications received were processed and responded to
8.1.4	Number of Quarterly financial return reports published (excluding quarter 4), per year	3	3	3	3	**3**	**3**	–	3 quarterly returns were published for the period
8.1.5	Number of financial sections prepared for the annual report	1	1	1	1	**1**	**1**	–	Financial sections were prepared for the annual report

Performance by programme

Achievement of strategic objectives

The programme's strategic objective is to monitor and promote the financial soundness of medical schemes. This falls under Strategic Goal 2: Medical schemes and other related entities are properly governed, are responsive to the environment, and beneficiaries are informed and protected.

- Regulation 29 of the Medical Schemes Act prescribes that the minimum accumulated funds of medical schemes should be at least 25% of gross contributions to ensure that members' interests are protected and to guarantee the continued operation of the scheme, ensuring that it is able to pay members' claims when due.
- The prescribed solvency also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations. The schemes that fell below the minimum required statutory solvency level were placed on close monitoring and submitted business plans detailing their turnaround strategies. Regular meetings were also held with the management of these schemes to monitor progress against the submitted plans
- Annual financial statements as per Section 37 of the Medical Schemes Act (MSA). The statutory returns reveal the historical financial performance and position of medical schemes; their ability to continue operating into the foreseeable future; and determine trends and emerging issues. Annual financial statements enable more effective decision-making and feed directly into the various regulatory interventions catered for in the Medical Schemes Act and policy formulation.
- The annual statutory returns form the basis for the financial sections prepared for the annual report. The unit completed the input for 2019/20 timeously. There were no significant analysis findings and the medical schemes industry remained above the statutory solvency requirement of 25% overall
- Auditor application authorization. The MSA requires that the annual financial statements of medical schemes are audited. The reliance that is placed on the information contained in the annual financial statements is high, and it is therefore important to ensure not only the quality of audits, but that auditors are familiar with the very complex medical schemes environment.
- The purpose of the auditor approval process is to assess the capability of the proposed audit firms and audit partners to be engaged in the audit assignment of medical schemes. The unit has to evaluate the quality of both the audit firm and audit partner to ensure that they are fit and proper to conduct an audit of a medical scheme. The unit engaged with applications received for the authorization of statutory auditors and International Financial Reporting Standards as per Section 36 of the MSA during the year. The unit authorized several new applicants with no medical scheme experience with the condition that they utilise an authorized concurrent review partner for at least the first three years of the authorisation cycle
- Quarterly Return System: The Quarterly Return System serves as the core of our Early Warning System and enables the continuous monitoring of schemes in between audit cycles. It enables the CMS to respond timeously and appropriately to changes; to interact with the management of schemes; and to ensure the ongoing protection of members

No deviations occurred during the period under review.

Strategy to overcome areas of underperformance

No underperformance occurred during the period under review.

Changes to planned targets

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

Performance by programme

Linking performance with budgets

Financial Supervision	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**10**	**7**	**3**	16	9	7
Refreshments	**2**	**–**	**2**	2	–	2
Subscriptions	**51**	**68**	**(17)**	37	30	7
	63	**75**	**(12)**	55	39	16
Operating expenses						
Consulting	**30**	**–**	**30**	–	–	–
Travel and subsistence	**42**	**9**	**33**	40	22	18
Venue and catering	**28**	**4**	**24**	56	38	18
	100	**13**	**87**	96	60	36
Staff costs						
Salaries	**13 061**	**13 108**	**(47)**	12 515	12 686	(171)
Staff training	**128**	**65**	**63**	194	168	26
	13 189	**13 173**	**16**	12 709	12 854	(145)
Total	**13 352**	**13 262**	**91**	12 860	12 953	(93)

Performance by programme

Programme 9: Complaints Adjudication

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

Key performance indicators, planned targets and actual achievements

Strategic Objective		Actual Achievement 2016/17	Actual Achievement 2017/18	Actual Achievement 2018/19	Planned Target 2019/20	Actual Achievement 2019/20	Deviation from planned target to Actual Achievement for 2019/20	Comment on deviations
Strategic Objective 9.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes								
9.1.1	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per year	73%	68%	55%	**65%**	**73%**	**8%**	The unit worked overtime hence the target was exceeded

Achievement of strategic objectives

The strategic objectives of the CMS Complaints Adjudication unit are to investigate complaints and settle disputes in relation to the affairs of medical schemes. Section 47 of the Medical Schemes Act prescribes the manner in which complaints should be handled and resolved, and provides that complaints should be referred to the regulated entities for a response within a prescribed period of 30 days. The unit ensures that all complaints referred for responses are responded to and that rulings issues on complaints are complied with by the parties unless appealed.

Through the assessment of all complaints received, the unit identifies trends that shows any unfair treatment of members or contravention of the Medical Schemes Act or the rules of medical schemes, and engages medical schemes and administrators who have failed to protect the interests of members of medical schemes. Such medical schemes and administrators were directed to desist from contravening the Act and were guided on how to ensure compliance.

Continuous engagement with medical schemes on complaints trends also ensures that trends that are identified are addressed sooner with medical schemes to avoid recurrence. This also gives medical schemes the opportunity to do root-cause analysis to curb the increase in the volume of complaints handled internally at medical schemes, and to reduce those that may be referred to the Registrar's Office.

Strategy to overcome areas of underperformance

The unit work overtime and this led to the unit exceeding the target.

Changes to planned targets

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

Performance by programme

Linking performance with budgets

Complaints Adjudication	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Administrative expenses						
Printing and stationery	**3**	**3**	**–**	4	2	2
Refreshments	**2**	**–**	**2**	2	–	2
	5	**3**	**2**	6	2	4
Operating expenses						
Travel and subsistence	**63**	**30**	**33**	109	37	72
Venue and catering	**–**	**2**	**(2)**	–	2	(2)
	63	**32**	**31**	109	39	70
Staff costs						
Salaries	**8 437**	**7 563**	**874**	7 244	6 764	480
Staff training	**115**	**80**	**35**	129	47	82
	8 552	**7 643**	**909**	7 373	6 811	562
Total	**8 620**	**7 678**	**942**	7 488	6 852	636

Revenue collection

Revenue collection	2019/2020			2018/2019		
	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over)/ Under expenditure R'000
Accreditation Fees	**9 536**	**8 170**	**1 366**	8 499	7 787	712
Inspection fees recovered	**9 322**	**2 097**	**7 225**	–	3 491	(3 491)
Government transfers: Department of Health	**5 987**	**6 481**	**(494)**	5 670	5 899	(229)
Legal fees recovered	**–**	**–**	**–**	1 416	418	998
Levies income	**155 336**	**156 215**	**(879)**	144 246	144 980	(734)
Mandatory transfer: Department of Higher Education and Training	**–**	**215**	**(215)**	–	104	(104)
Registration fees	**423**	**469**	**(46)**	45	456	(411)
Sundry income	**790**	**926**	**(136)**	577	431	146
Total	**181 394**	**174 573**	**6 821**	160 453	163 566	(3 113)

Council for Medical Schemes collected 96.2% of the estimated revenue. An under collection in inspection fees occurred in the current year under review. These are investigation fees paid to service providers but recoverable from schemes which were under investigation. It is however foreseen that these recoveries will be collected in the next financial year.

Part C

Governance

Governance

Introduction

The Council for Medical Schemes is a body established in terms of the Medical Schemes Act, 131 of 1998. The organisation is led by a governing body of 12 members appointed by previous Minister of Health, Dr Aaron Motsoaledi, for a period of three years. The governing body is assisted by the Executive Officer, Dr Sipho Kabane, who was appointed by the same Minister for a period of five years.

Portfolio Committees

The CMS presented its Strategic and Annual Performance Plans, as well as the 2018/19 Annual Report to the Portfolio Committee on Health in the second and third quarters respectively. After extensive deliberations with the Portfolio Committee on Health, the presentations were adopted.

Executive Authority

For the period under review, the 2019/20 financial year, all four quarterly performance information reports were reviewed by the Accounting Authority and submitted to the Executive Authority. These reports were submitted as scheduled, which is by the last working day of the month following the quarter.

During the period under review, the CMS underwent a strategic review exercise in line with the Department of Planning, Monitoring and Evaluation's guidelines in the medium-term strategic framework.

Management, in concurrence with the Council, submitted the first draft of the 2020/21 Strategic and Annual Performance Plans to the Executive Authority by end October 2019 as prescribed. Feedback was received from the office of the Executive Authority, the Auditor-General, and National Treasury in late December 2019 and early January 2020 respectively, and was addressed and incorporated into the final draft, which was presented to the Executive Authority by end January 2020 as prescribed.

The Council

Council members emanate from a cross section of the population to ensure a fair representation of our society. The skills and experience of Council members include medicine, law, accounting, management, healthcare, consumer activism, and trade unionism.

The Council is entrusted with the following responsibilities:

- The protection of beneficiaries of medical schemes
- The control and coordination of the functioning of medical schemes
- Advising the Minister of Health on the quality and outcomes of relevant health services provided for by medical schemes
- The investigation of complaints and resolution of disputes
- The collection and dissemination of information about private healthcare

In order to perform these functions, the Council has ensured that management has systems in place that include for complaints resolution, the supervision of the financial performance of the industry, benefits management, research and monitoring, and for compliance, investigations and enforcements functions.

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

- The evaluation and approval of the five-year strategic plan
- The evaluation and approval of the annual performance plan
- The evaluation and approval of financial information and reporting
- The oversight of executive management performance

The Council adheres to principles of good corporate governance. In this regard the Council has a charter and code of conduct in place.

All six committees of Council have charters and clearly defined terms of reference which are reviewed and updated on a regular basis. Furthermore, the arrangement of the governance framework into structures, allows for the devolution of power, responsibility, and accountability, and ensures that Council has checks and balances in place. Council members are required to sign a declaration of interests annually.

The Council is expected to sit four times a year as provided for in the Medical Schemes Act, however meetings often exceed that number due to the volume of work faced by the regulator.

The Council was dealt a double blow of losses. The Chairperson of the Council, Dr Clarence Mini succumbed to corona virus in May. Dr Mini's successor, Prof Lungile Pepeta, who was appointed by the Minister of Health, also succumbed to the virus in August 2020, which resulted in the Deputy Chairperson, Advocate Harshila Kooverjie standing in. There was a resignation from the Council by Dr Yogan Pillay. The term of two independent non-executive members of the Audit and Risk Committee came to an end in January 2020, and the Council appointed Mr Lesetsa Matshekga and Ms Sizo Mzizi as chairperson and member respectively, to fill these vacancies.

The Appeal Board

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

Governance

Composition of Council

Table 8: Composition of Council as at 31 March 2020

council member	Designation	Date appointed	End date	Qualification	Area of expertise	Council committees	No. of meetings attended
Clarence Mini	Dr	14/11/2017	13/11/2020	○ Physician MB Bch ○ Postgraduate diploma in Palliative Medicine ○ Advanced Diploma in Negotiation Skills	Medicine, strategic governance and leadership	EXCO HRSE	32
Harshila Kooverjie	Adv.	14/11/2017	13/11/2020	○ BA ○ LLB ○ Diplomas in ADR ○ Certification in negotiation & leadership	Senior Counsel, ADR, negotiation and leadership, administrative law	EXCO Appeal Committee	18
Moerane Maimane	Mr	14/11/2017	13/11/2020	○ MBA ○ BPA (Hons) ○ Diploma in Public Administration ○ B Admin (Accounting)		HRSE Nominations Appeal Committee	54
Memela Makiwane	Dr	14/11/2017	13/11/2020	○ Master of Medicine ○ MB Bch ○ Diploma in HIV Management ○ Postgraduate Diploma in Pharmaceutical Medicine ○ Fellowship of the College of Clinical Pharmacologists	Medical	Appeal Committee ICT Strategic Committee Audit and Risk Committee	32
Mosidi Maboye	Ms	14/11/2017	13/11/2020	○ PGD in Healthcare Management ○ BA in Nursing Science ○ Occupational Health Nursing ○ Advanced Diploma in Nursing	Healthcare management	Appeals Committee HRSE Nominations	49
Johan van der Walt	Mr	14/11/2017	13/11/2020	○ Master's in Financial Management ○ CA(SA) ○ BCompt	Accounting, auditing, strategic governance and management	ICT Strategic Committee Audit and Risk Committee	23

Governance

Table 9: Composition of Council as at 31 March 2020

Name of council member	Designation	Date appointed	End date	Qualification	Area of expertise	Council committees	No. of meetings attended
Steven Mabela	Dr	14/11/2017	13/11/2020	○ PhD Economics ○ MBA ○ Bachelor of Science		EXCO HRSE	28
Rebaone Gaoraelwe	Adv.	14/11/2017	13/11/2020	○ BProc ○ LLB ○ LLM ○ Higher Diploma ○ Company Law ○ Certificate in Public Sector Governance and Strategy	Law, corporate governance, dispute resolution	Appeal Committee ICT Strategic Committee HRSE	32
Diane Terblanche	Ms	14/11/2017	13/11/2020	○ BA(LAW) ○ LLB ○ LLM	Law	Appeal Committee EXCO Nominations	46
Yogan Pillay	Dr	14/11/2017	13/11/2020	○ BA in physiology, biochemistry and psychology ○ PhD in health policy and planning		EXCO	8
Aquina Thulare	Dr	14/11/2017	13/11/2020	○ MBA ○ BSc Med Sci (Hons) ○ MBChB	Medical	ICT Strategic Committee Audit and Risk Committee	4
Lungile Pepeta	Prof	14/11/2017	13/11/2020	○ MBChB ○ DCH (SA) ○ FC Paed (SA) ○ Cert Cardiology (SA) ○ MMed (Wits) ○ FSCAI	Medical		1

Governance

Committees of the Council

The Council has the following committees:

Table 10: Committees of Council

Executive Committee (EXCO) 5 members	Chaired by the Chairperson of the Council and is responsible for day-to-day tasks of the Council.
Human Resource, Social and Ethics Committee (HRSE) 5 members	Responsible for governance of human resources, remuneration, social and ethics matters
Audit and Risk Committee (ARC) 6 members	The ARC assists Council in fulfilling its oversight responsibility which includes responsibilities regarding the safeguarding of assets, operating effective systems of control and preparing annual financial statements as required by the PFMA, Treasury regulations, risk management and internal audit oversight.
Information Communications and Technology Strategic Committee 4 members	Responsible for ICT governance in the organisation in line with the Corporate Governance of ICT Policy Framework.
Appeals Committee 6 members	Responsible for the resolution of the disputes between beneficiaries and medical schemes.
Nominations Committee (NomCom) 3 members	NomCom monitors the transparent nomination and appointment of members of the committees of Council, ensuring the necessary knowledge, skills, experience, balance of power and diversity of gender and race.

Table 11: Membership of Council Committees as at 31 March 2020

Council committee	No. of meetings held	No. of members of the committee	Names of members of the committee
EXCO	10	5	Dr Clarence Mini Adv. Harshila Kooverjie Dr Steven Mabela Ms Diane Terblanche Dr Yogan Pillay
HRSE	11	5	Dr Clarence Mini Ms Mosidi Maboye Adv. Rebaone Gaoraelwe Dr Steven Mabela Mr Moerane Maimane
Nominations Committee	6	3	Mr Moerane Maimane Ms Diane Terblanche Ms Mosidi Maboye
ICT Strategic Committee	1	4	Mr Johan van der Walt Dr Makiwane Memela Dr Aquina Thulare Adv. Rebaone Gaoraelwe
Appeals Committee	27	6	Adv. Rebaone Gaoraelwe Dr Memela Makiwane Ms Diane Terblanche Mr Moerane Maimane Ms Mosidi Maboye Adv. Harshila Kooverjie
ARC	10	6	Mr Lesetsa Matshekga[1] Mr Kariem Hoosain[2] Ms Marianna Strydom[3] Ms Michelle Pillay Mr Johan van der Walt Dr Memela Makiwane Ms Sizo Mzizi[1] Dr Aquina Thulare

[1] Appointed on 5 February 2020
[2] Term Expired on 31 January 2020
[3] Term Expired on 30 November 2019

Governance

Table 12: Remuneration of Council members from 1 April 2019 – 31 March 2020

Name of Council member	Remuneration – 2020 R'000	Other allowances/ reimbursement/s R'000	Total remuneration 2020 R'000
Adv. R Gaoraelwe	383	–	383
Adv. H Kooverjie	108	–	108
Dr MS Mabela	257	–	257
Ms M Maboye	401	–	401
Mr M Maimane	523	–	523
Dr M Makhiwane	313	–	313
Dr C Mini	537	–	537
Prof L Pepeta	16	–	16
Ms D Terblanche	516	–	516
Mr J van der Walt	179	–	179
Total	**3 233**		**3 233**

Risk Management

The CMS has an Enterprise Risk Management Framework and Policy, which is reviewed on an annual basis. This policy establishes the organisational risk management methodology and risk categorisation.

The CMS enterprise risk management methodology and assessment is maturing, with the maturity level in terms of the enterprise risk management assessment conducted for the financial year under review is level 3 on a scale of 1 to 5.

The CMS Risk Management Committee advises management on the overall system of risk management. The CMS Strategic Risk Register is presented to the Audit and Risk Committee of Council to review and exercise its oversight role towards the independent monitoring and effectiveness of the enterprise system of risk management. The CMS Enterprise Risk Management Framework has enabled the organisation to improve its performance in key functions in relation to legal services, benefits management and complaints adjudication programmes.

Internal Control Unit

In terms of the CMS service delivery model, the internal audit function is outsourced, of which the internal control evaluation and review function falls under the Internal Audit unit.
In consultations with ARC, the Internal Audit unit prepared:

- A rolling three-year strategic Internal Audit Plan based on its assessment of key areas of risk for the CMS, having taken into consideration the regulator's current operations, the operations proposed in its corporate or strategic plan and its risk management strategy.
- An annual Internal Audit Plan.
- Plans indicating the scope, cost and timelines of each audit in the annual internal audit.
- Audit reports directed to ARC detailing its performance against the annual performance plan.

The internal audit function assisted the Accounting Authority to maintain effective controls by evaluating those controls and developing recommendations for enhancement or improvement.

Internal Audit must assist the Accounting Authority to achieve the objectives of the CMS by evaluating and developing recommendations for the enhancement or improvement of the processes, through which:

- Objectives and values are established and communicated
- The accomplishment of strategic objectives is monitored
- Accountability is ensured
- Corporate values are maintained
- The relevance, reliability and integrity of management, financial and operating data and reports are appraised
- The adequacy and effectiveness of the system of internal control are reviewed and appraised
- Systems established to ensure compliance with policies, plans, procedures, statutory requirements and regulations, which could have a significant impact on operations, are reviewed
- Assets are verified
- The adequacy of established systems and procedures are assessed.

Governance

- Other audits that needed to be taken into account at the CMS include:
  - *IT security and systems processes audit*
  - *Conducting special assignments and investigations, on behalf of ARC or the CEO, into any matter or activity affecting the probity, interest and operating efficiency of the CMS*
  - *Audit to detect fraud*

Compliance with laws and regulations

The compliance function, in line with the resolution of the Accounting Authority during the financial year under review, was established in the office of the Accounting Officer. This function is coordinated in line with the risk and performance management functions as planned and reported to the ARC, and full Council sittings, as scheduled.

Fraud and corruption

The CMS has an established Fraud and Corruption Prevention policy that encompasses the Fraud and Corruption Prevention Plan, Fraud and Corruption Response Plan, and the Whistle-blowing Policy. The Policy has been reviewed in line with Council's ethics awareness outlook for the year.

Minimising conflict of interest

The CMS has a Declaration of Interest and Acceptance of Gifts Policy. The policy is reviewed on an annual basis in consultation with all internal stakeholders and reviewed in line with the Council's ethics awareness outlook for the year.

Code of conduct

The CMS has a new Ethics Code of Conduct. The policy culminated from an annual review of the Code of Conduct Policy and the Development of a new Ethics Policy in consultation with all internal stakeholders. This was done in line with the Council's ethics awareness outlook for the year.

Health safety and environmental issues

The Occupational Health and Safety Act requires organisations to provide and maintain a reasonably practical, safe and risk-free working environment for its employees. In compliance with the provisions of the Act, the CMS has established a new health and safety committee on the expiry of the term of the old committee during the reporting period. Training of the committee is scheduled to take place during the first quarter of the new financial year to ensure that the committee performs its mandate in a competent manner. The committee will review the health and safety policy once it has been trained on health and safety in the workplace.

Council secretary

The Council is further assisted by the Company Secretary who provides corporate governance services and administration. His mandate also includes guiding members in their duties, responsibilities and functions. He facilitates full and unfettered access to the organisation's information, including records for the use of Council. The Company Secretary maintains an arm's length relationship with the Council, and the governing body is satisfied that he is fit and able to perform his functions.

Social responsibility

The Stakeholder Relations unit presented a Social Responsibility Policy to Council, which was adopted. The policy aims to build on partnerships with the CMS' regulated entities to do good in their communities.

Audit committee report

Audit committee report

I have pleasure in submitting this report for the financial year ended 31 March 2020, in accordance with the Companies Act 71 of 2008, the Public Finance Management Act (PFMA) and the Medical Schemes Act 131 of 1998.

The Audit and Risk Committee's terms of reference

During the year under review, the committee reviewed and amended its terms of reference to align with changes noted in the business and regulatory environment. A formal and systematic process is in place for determining strategic and operational objectives setting and monitoring performance. Oversight of CMS's risk management and control activities are in place, co-ordinated and continuous improvement monitored.

The Committee is satisfied that it has conducted and discharged its affairs and responsibilities in compliance with its terms of reference, all applicable legal and regulatory requirements.

Audit and Risk Committee members & meeting attendance

This Committee complies with the requirements of the Act pertaining to the composition and functions of an audit committee. The membership of the CMS Audit and Risk Committee consists of three independent members and three council members. The Committee met nine times during the financial year. The Audit and Risk Committee consist of the following members:

Table 13: Members of the Audit and Risk Committee

Members	Number of meetings
Mr Matshekga L (Chairperson)[1]	1
Mr Hoosain K[2]	7
Ms Strydom M	7
Ms Pillay M	7
Mr Van der Walt J	10
Dr Makiwane M	10
Ms Mzizi S[1]	1
Dr Thulare A	2

[1] Appointed on 5 February 2020

[2] Term Expired on 31 January 2020

The Registrar, Chief Financial Officer, Internal Auditors, and External Auditors attend meetings by invitation only.

Audit and Risk Committee roles and responsibilities

The purpose and role of the Audit and Risk Committee are in accordance with the requirements of the Act, PFMA, King IV and additional requirements imposed on the committee by the Council.

In line with its revised terms of reference, King IV, Section 94 (7) (f) of the Companies Act of 2008 and PFMA, the Audit and Risk Committee has:

- Reviewed the company's quarterly performance report and annual financial statements
- Evaluated and considered CMS's risks, as well as measures taken to mitigate those risks
- Reviewed the company's policies and procedures for preventing, detecting and investigating fraud
- Reviewed the effectiveness of the company's policies, systems and procedures
- Reviewed the effectiveness and adequacy of the Internal Audit function
- Reviewed its annual work plan to ensure that it complies with its statutory and governance requirements
- Reviewed the results of the work performed by the Internal Audit function in relation to financial reporting and controls, corporate governance, risk management process, internal controls and any significant investigation and management responses
- Reviewed annual written opinion issued by Internal Audit function on risk management and internal financial controls
- Reviewed and monitored the company's compliance with significant legal and regulatory provisions
- Reviewed and acted on any other relevant matters referred to it by the Council
- Reviewed the validity, accuracy, reliability and completeness of financial information provided by management and other users of such information
- Reviewed the performance of the company and obtained assurance that corrective actions were implemented on adverse performance variances
- Reviewed the accounting and auditing concerns identified by Internal and External Auditors
- Reviewed the annual integrated report and annual financial statements taken as a whole to ensure they present a balanced and understandable assessment of the position, performance and prospects of the company
- Received and considered reports from the external and internal auditors

The internal audit function reports directly to the audit and risk committee. The internal and external auditors attend the committee's quarterly meetings and have unrestricted access to the chairperson of the committee. During the year under review, the audit and risk committee met with Internal and External Auditors in the absence of management to discuss governance, audit and other matters pertaining to the work of the Committee.

Audit committee report

Internal audit

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

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

External audit plan by the Auditor-General of South Africa

The Committee reviewed the external audit plan for the financial year under review as prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act for the year ended 31 March 2020. The Committee confirms that this plan is in line with regulations and standards, and that the plan takes into consideration the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented was sufficient and reasonable for completion of the CMS annual audit.

Performance evaluation

The Audit and Risk Committee conducted a self-performance assessment during the financial year. The result was satisfactory. In addition, the Audit and Risk Committee conducted the effectiveness assessment of Internal Audit and Finance functions. The result of the assessment of the Internal Audit was satisfactory. The Committee satisfied itself regarding the objectivity and independence of the CMS internal audit function and the continued appropriateness of the internal audit charter. Regarding the finance division, the committee is concerned about the expertise and adequacy of the resources within the finance function. The CFO's contract came to an end during the year and an acting CFO was appointed. The Council has started the process to recruit a new CFO, which will be concluded in the new financial year.

Effectiveness of internal controls

The Audit and Risk Committee received and reviewed Internal Audit's written statement on effectiveness of internal controls. Whilst controls are in place and effective in most areas, some weaknesses were identified in in other areas of the business notably Supply Chain Management (SCM) and IT. Remedial actions will be implemented by management, going forward, to address the weaknesses identified. The CMS has taken measures to improve in the area of SCM with a view to establishing a centralised system of SCM and moving to automation of the procurement process.

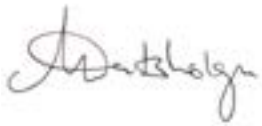
Where irregular and fruitless and wasteful expenditure has been identified, the CMS established an investigating committee in collaboration with internal auditors as required by the SCM Framework. A Chief Information Officer was appointed towards the end of the financial year to provide stability and leadership in the IT department.

Evaluation of financial statements

The Committee reviewed the annual financial statements and annual performance report of the CMS for the financial year ended 31 March 2020 and is satisfied that, in all material respects, the financial statements and annual performance report comply with the relevant provisions of the PFMA, GRAP including any interpretations, guidelines and directives issued by the Accounting Standards Board and fairly present the financial position and performance of the CMS at that date and the results of operations and cash flows for the financial year then ended. The Committee reviewed and discussed the CMS annual financial statements and annual performance report to be included in this Annual Report with the Auditor-General of South Africa and the Accounting Officer of the CMS.

The Committee concurs with and accepts the conclusion of the AuditorGeneral of South Africa on the CMS annual financial statements and annual performance report. The Committee recommended the financial statements and performance report for the year ended 31 March 2020 to Council for approval.

On behalf of the Audit and Risk Committee:



Mr Lesetsa Matshekga
Chairperson of the Audit and Risk Committee
31 July 2020

Part D

Human Resources Management

Human resources management

Introduction

The Human Resources unit, as a strategic partner, provides support to the entire organisation, with overall responsibility for developing and delivering human resource programmes to attract, develop and retain skilled and knowledgeable personnel through effective recruitment and selection processes.

This section captures an overview of the activities of the CMS Human Resources (HR) unit for the 2019/20 reporting period. The information focuses on the implementation of the CMS' Human Resources strategy for the 2019/20 financial year as outlined in the Annual Performance Plan (APP), covering aspects such as remuneration and benefits, talent management and staff retention, performance management, training and development, employment equity (EE), health and safety, as well as personnel and related costs.

Remuneration philosophy

The unit appointed a service provider through a tender process to develop a remuneration philosophy and to benchmark its remuneration against public services and state-owned entities (SOEs). The updated job and competency profiles were used to conduct job evaluations to ensure credibility of the remuneration philosophy project. During the evaluation of jobs, ongoing meetings were held between management and staff to discuss the job evaluation process and possible job title changes. There were challenges in meeting the completion date of 31 May 2019 due to the unavailability of some staff members to attend the planned consultation meetings.

The final remuneration philosophy and employment value proposition reports, as well as contract renewals for senior management, were presented to the Human Resources and Ethics Committee on 28 October 2019, after they had been shared with the trade union.

The remuneration philosophy and employment value proposition policy, which culminated from employee grievances, was approved by Council at a special meeting on 29 November 2019 after the reports were discussed and accepted by the Human Resources and Ethics Committee. The SOEs are to be used as a comparator market for remuneration benchmarking, with the 75th percentile of the SOE circle to be targeted to pay performers with performance rating of at least three.

Workforce planning framework and key strategies to attract and recruit a skilled and capable workforce

To ensure continuity and delivery of the CMS' strategic objectives, the unit facilitated the appointment of employees to act in senior management positions when these became vacant due to resignations, suspensions and retirement.

For the 2019/2020 reporting year, the CMS had 30 positions made up of 10 newly approved posts and 20 vacancies. Filling of these positions had to be reprioritised due to budget constraints that resulted in some positions not being advertised during the reporting period. The CMS has successfully filled 19 vacancies into permanent positions in line with the CMS recruitment and selection policy. During 2019/2020 reporting period, 4 were filled by internal candidates, 11 by external candidates and 4 were filled by candidates who were on internship programmes. Eleven vacancies remained at the end of the reporting year.

There were 17 terminations in the following positions:

- Administrator
- Client Contact Agent
- Executive Assistant
- Finance Officer
- Financial Analyst
- General Managers (3)
- Helpdesk Technician
- Labour Relations Officer
- Legal Adjudication Officers (2)
- Legal Advisor
- Medical Advisor
- Senior Legal Adjudication Officer
- Senior Researcher
- Supply Chain Officer

HR has processes in place to ensure that the CMS' disability target is achieved by March 2020, which include utilizing advertisements, agencies that specialise in the appointment of persons with disabilities, and prioritising the shortlisting and interviewing of persons with disabilities.

The organisation continued to support government's call to develop the skills of qualified graduates. At the beginning of the financial year, CMS had placed 23 qualified graduates into internship programme. The number was increased to 32 at the end of the reporting period.

Human resources management

Skills training

The CMS enrolled six cleaning employees in an Adult Education Training (AET) programme to increase their competencies in numeracy and literacy and for personal development. The Health and Welfare Sector Education and Training Authority (HWSETA) approved bursaries of R1 500 per learner for the year. A notable achievement by one of the cleaning workers was the completion of a bachelor's degree in Public Administration through the University of South Africa (Unisa).

Learning and development

The CMS continued to provide employees with opportunities to develop their knowledge and skills through the Professional Development Programme, which equips them to perform their tasks and contribute to the achievement of organisational objectives. A Workplace Skills Plan has been developed to identify specific training needs related to the skills requirements for the CMS. This is covered in the Annual Training Report 2019/20 submitted to HWSETA on 30 May 2020.

Employee engagement

The unit appointed an external service provider to facilitate Team Dynamics workshops for management and staff during the reporting period, which were based on the results of the climate survey, as well as other issues that were identified as barriers in the employment equity plan. Prior to the workshops, all employees were required to complete the Strengths Assessments Finder, which helped them discover and describe their talents and contribution to the CMS as a team. Following the workshops, debriefing meetings and feedback sessions were held to discuss action plans to effectively manage teams within the organisation.

Employee performance management framework

Performance management continued to be a high priority. At the start of the financial year, employees signed performance agreements with their supervisors, and two formal performance reviews were conducted in line with Performance Management and Incentive policies. The Moderating Committee, consisting of executive management and a trade union representative, will convene in the new financial year and the unit will facilitate the awarding of incentive bonuses to employees for their contributions to the achievement of the CMS' overall strategic objectives.

The performance management system was reviewed by the unit with assistance from an external service provider. The system lacked detailed evaluation criteria to categorise the allocation of performance scores, and a Balanced Scorecard framework to provide SMART criteria by which performance is monitored and measured is being introduced.

Employee relations

To ensure good practices that enable the achievement of organisational objectives compliant with the legislative framework and appropriate to socio-economic conditions, the unit continues to provide a framework for conflict resolution. The HR unit facilitated training for general managers and managers on initiating and chairing disciplinary hearings to empower staff members and to curb costs in appointing external service providers for chairing certain disciplinary hearings.

The CMS had a high number of labour matters during the reporting period. Five unfair labour disputes, six unfair suspension and one case of unfair dismissal were referred and heard at the CCMA.

During the year, four disciplinary hearings and two grievances were held, and four employees referred their matters to the CCMA for arbitration in respect of legitimate expectation of renewal of their employment contracts. The matter has since been cancelled by CCMA due to the COVID-19 pandemic lockdown. An arbitration award against the CMS regarding a senior official's matter is being reviewed at Labour Court. The disciplinary hearings of two suspended senior officials could not proceed further since their five-year term contracts of employment expired on 31 March 2020. All affected senior officials were consulted of Council's intention not to renew the employment contracts. An arbitration award against the CMS in respect of unfair suspension was subjected to rescission application at CCMA; the matter has been cancelled due to COVID-19 lockdown.

The CCMA awarded a ruling against the CMS in the matter involving one employee and instructed the CMS to compensate the employee as part of the separation with effect from 26 March 2020. Three disciplinary hearings are ongoing. Another employee referred a matter to the CCMA in respect of an appointment made in line with the CMS Employment Equity Plan. At the end of the reporting period, a pending matter was referred by an employee to the Labour Court as a form of CCMA review.

The CMS is still awaiting reports from SIU regarding investigations into some of its employees, as well as lifestyle audits of its senior management.

Wage negotiations took place on 24 January 2020 with the Nehawu trade union, which demanded a 6.1% annual salary increase for employees from levels A – D bands. The trade union's demand of 6.1% was matched by the Treasury Guidelines of CPI + 1% translating to 6.1% cost of living adjustment. Council approved a cost of living inflationary annual increase of 5.1% for executive management in line with the Treasury Guidelines. The annual increase will be implemented on 1 April 2020.

Human resources management

Employee wellness programmes

To promote the CMS as an employer of choice, the Council approved a medical aid subsidy for cleaning staff, effective from 1 April 2019.

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

Two employees were referred for occupational health assessment by an independent service provider as part of ongoing performance management, and have been approved for permanent medical boarding. In addition, HR provided the following employee wellness initiatives aimed at assisting employees to manage a healthy and productive lifestyle:

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

Policy review

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

Employment equity

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

The Employment Equity Forum participated in finalising the Employment Equity report and Income Differentials statement, which were submitted on 15 January 2020. An acknowledgement letter of compliance was received from the Department of Labour.

Targeted recruitment aimed at persons with disabilities resulted in persons within this designated group being shortlisted and interviewed for four positions.

The CMS is fairly aligned to the Broad-Based Black Economic Empowerment (BBBEEA) Scorecard. The CMS has made great progress in attaining employment equity targets of 11.33 points when compared to the target of 10 points determined by the BBBEEA scorecard during the reporting period. Attracting and appointing individuals with disabilities remains a challenge. Currently, the organisation is at -0.03% to reach the target of 4% as illustrated in Table 14.

Human resources management

Table 14: BBBEEA Scorecard

Criteria		A*	B*	C*	D*	%	Achieve-ment/ Challenge
Black people with disabilities employed by the entity as a percentage of all full-time employees	1	120	0.83%	4%	2	0.42	-0.03
Black people employed by the entity at senior management level as a percentage of employees at senior management level	8	9	88.89%	60%	2	2.96	0.29
Black women employed by the entity at senior management level as a percentage of employees at senior management level	4	9	44.44%	30%	2	2.96	0.14
Black people employed by the entity at professionally qualified level as a percentage of employees at professionally qualified level	35	37	94.59%	75%	2	2.52	0.20
Black women employed by the entity at professionally qualified level as a percentage of employees at professionally qualified level	18	37	48.65%	40%	1	1.22	0.09
Black people employed by the entity at skilled technical & academically qualified workers as a percentage of employees at skilled technical & academically qualified level	52	52	100.00%	80%	1	1.25	0.20
Weighting points					10	11.33	1.33

*Key
Measurement of the employment equity criteria
The different indicators of employment equity in the scorecard are calculated on the following basis

Formula: A= B/C X D

A is the score achieved in respect of any given criteria as referred to paragraph 5.1.1 to 5.1.

B is the percentage of category of black people being measured

C is the percentage compliance target in respect of that criteria

D is the weighting points allocated to the applicable criteria being measure

Human resources management

Highlights achievements

Wage negotiations were conducted smoothly during the reporting period. Both the union and management agreed on an inflation increase of CPI + 1% effective from 1 April 2020.

A remuneration philosophy and employment value proposition policy was approved following a consultative process.

Challenges faced by the organisation

High staff turnover rate.

No succession in senior positions to ensure continuity.

Future HR plans/goals

Review the Organisational Rights Agreement and train employees on conflict management.

Develop and implement talent management strategy to ensure that talent is developed, and retained within the organisation.

Highlights achievements

Human Resources oversight statistics

Table 15: Personnel costs per programme

Programme	Total expenditure for the entity (R'000)	Personnel expenditure (R'000)	Personnel exp. as a % of total exp.	No. of employees	Average personnel cost per employee (R'000)
Programme 1 – Administration					
Sub–programme 1.1 – Office of the CEO	18 740	5 351	28,6%	6	892
Sub–programme 1.2 – Office of the CFO	36 842	12 026	32,6%	21	573
Sub–programme 1.3 – ICT and Knowledge Mng	21 497	11 846	55,1%	12	987
Sub–programme 1.4 – Human Resources	11 728	5 654	48,2%	6	942
Sub–programme 1.5 – Legal services	22 709	4 584	20,2%	3	1 528
Programme 2 – Strategy Office	13 333	10 056	75,4%	9	1 117
Programme 3 – Accreditation	9 480	8 412	88,7%	8	1 052
Programme 4 – Research and Monitoring	8 468	8 209	96,9%	7	1 173
Programme 5 – Stakeholder Relations	13 608	9 524	70,0%	10	952
Programme 6 – Compliance Investigation	15 370	9 977	64,9%	9	1 109
Programme 7 – Benefit Management	7 125	6 968	97,8%	7	995
Programme 8 – Financial Supervision	13 261	13 108	98,8%	10	1 311
Programme 9 – Complaints Adjudication	7 678	7 563	98,5%	12	630
Total	199 839	113 278	56,7%	120	944

Human Resources oversight statistics

Table 16: Personnel costs per salary level

Level	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	No. of employees at year end	Average personnel cost per employee (R'000)
Top management	1 224	1,1%	1	1 224
Senior management	24 785	21,9%	9	2 754
Professional qualified	41 644	36,8%	35	1 190
Skilled	39 287	34,7%	55	714
Semi–skilled	5 102	4,5%	11	464
Unskilled	1 237	1,1%	9	137
Total	113 278	100,0%	120	944

Table 17: Performance rewards

Level	Performance reward (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure
Top management	271	1 224	22,1%
Senior management	1 020	24 785	4,1%
Professional qualified	2 899	41 644	7,0%
Skilled	3 086	39 287	7,9%
Semi–skilled	343	5 102	6,7%
Unskilled	93	1 237	7,5%
Total	7 712	113 278	6,8%

Performance rewards will be paid once the moratorium on changes to conditions of service and benefits is uplifted.

Human Resources oversight statistics

Table 18: Training costs per programme

Programme	Total expenditure for the entity (R'000)	Training (R'000)	Training expenditure as a % of total expenditure	No. of employees trained	Average training cost per employee (R'000)
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	18 740	148	0,8%	6	25
Sub-programme 1.2 - Office of the CFO	36 842	94	0,3%	21	4
Sub-programme 1.3 - ICT and Knowledge Mng	21 497	291	1,4%	12	24
Sub-programme 1.4 - Human Resources	11 728	42	0,4%	6	7
Sub-programme 1.5 - Legal services	22 709	83	0,4%	3	28
Programme 2 - Strategy Office	13 333	121	0,9%	9	13
Programme 3 - Accreditation	9 480	89	0,9%	8	11
Programme 4 - Research and Monitoring	8 468	144	1,7%	7	21
Programme 5 - Stakeholder Relations	13 608	81	0,6%	10	8
Programme 6 - Compliance Investigation	15 370	80	0,5%	9	9
Programme 7 - Benefit Management	7 125	72	1,0%	7	10
Programme 8 - Financial Supervision	13 261	65	0,5%	10	7
Programme 9 - Complaints Adjudication	7 678	80	1,0%	12	7
Total	199 839	1 390	0,7%	120	174

Human Resources oversight statistics

The following table provides the employment and vacancies per programme and excludes interns and temporary personnel.

Table 19: Employment and vacancies per programme*

Programme	2018/19 number of employees	Approved posts 2019/20	2019/20 number of employees	2019/20 vacancies	% of vacancies
Programme 1 – Administration					
Sub–programme 1.1 – Office of the CEO	4	1	6	0	0.00%
Sub–programme 1.2 – Office of the CFO	19	2	21	2	10.00%
Sub–programme 1.3 – ICT and Knowledge Management	13	1	12	2	10.00%
Sub–programme 1.4 – Human Resources	5	2	6	2	10.00%
Sub–programme 1.5 – Legal Services	4	0	3	2	10.00%
Sub–programme 2 – Strategy Office	10	0	9	1	5.00%
Programme 3 – Accreditation	9	0	8	3	15.00%
Programme 4 – Research & Monitoring	7	0	7	1	5.00%
Sub–programme 5 – Stakeholder Relations	11	0	10	0	0.00%
Sub–programme 6 – Compliance & Investigations	9	1	9	1	5.00%
Sub–programme 7 – Benefits Management	7	0	7	0	0.00%
Sub–programme 8 – Financial Supervision	11	0	10	1	5.00%
Sub–programme 9 – Complaints Adjudication	9	3	12	5	25.00%
Total	118	10	120	20	100.00%

*The CMS had 30 positions made up of 10 newly approved posts and 20 vacancies.

Table 20: Employment and vacancies per salary level 2019/20

Level	2018/19 number of employees	Approved posts 2019/20	2019/20 number of employees	2019/20 vacancies	% of vacancies
Top management	0	0	1	0	0.83%
Senior management	13	0	9	3	7.50%
Professionals	34	3	35	3	29.17%
Skilled labour	54	5	55	11	45.83%
Semi–skilled labour	8	2	11	3	9.17%
Unskilled labour	9	0	9	0	7.50%
Total	118	10	120	20	100.00%

Human Resources oversight statistics

The following new positions were approved by Council for the 2019/20 reporting period: Procurement Manager, Senior Compliance Officer, Manager: Organisational Development, two Paralegal Assistants, Network Technician, Legal Adjudication Officer, OD Officer, and two Administrators. Vacancies resulted from resignations, terminations, internal movements, and approved positions.

Table 21: Employment changes per salary band 2019/20*

Level	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	1	0	0	1
Senior management	12	0	3	9
Professionals	35	4	3	35
Skilled labour	50	11	10	54
Semi–skilled labour	10	4	1	12
Unskilled labour	9	0	0	9
Total	117	19	17	120

*Vacancies between appointments and terminations emanated from new positions and terminations.

Table 22: Reasons for staff leaving 2019/20

Reason	Number of employees	% of total number of staff leaving
Death	0	0%
Resignation	10	59%
Dismissal	0	0%
Retirement	1	6%
Ill health	2	12%
Expiry of contract	0	0%
Other	4	24%
Total	17	100%

Table 23: Labour relations: Misconduct and disciplinary action 2019/20

	Number of occurrences
Verbal warning	0
Written warning	0
Final written warning	3
Dismissal	0
Total	3

Part E

Financial Information

Statement of responsibility and confirmation of accuracy of the annual report

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

All information and amounts disclosed in the annual report are consistent with the annual financial statements audited by the Auditor-General of South Africa.
The annual report is complete, accurate and free from any omissions.
The annual report has been prepared in accordance with the guidelines on the annual report as issued by National Treasury.

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

The annual financial statements are based on appropriate accounting policies, consistently applied and supported by reasonable and prudent judgments and estimates.
The Accounting Authority is responsible for the preparation of the annual financial statements and for the judgments made in this information.

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

The Auditor-General of South Africa is responsible for independently auditing and reporting on the entity's annual financial statements. The annual financial statements have been audited by the Auditor-General of South Africa and their report is presented on page 90.

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 2020.

The annual financial statements set out on pages 93 to 123, which have been prepared on the going concern basis, were approved by the Council on 31 July 2020 and were signed on its behalf by:

Dr S Kabane
Chief Executive Officer and Registrar

Adv H Kooverjie
Deputy Chairperson of Council

Report of the Auditor-General to Parliament on Council for Medical Schemes

Report on the audit of the financial statements

Opinion

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 93 to 123, which comprise the statement of financial position as at 31 March 2020, statement of financial performance, statement of changes in net assets, cash flow statement and the statement of comparison of budget information with actual information for the year then ended, as well as the notes to the financial statements, including a summary of significant accounting policies.
2. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2020, and its financial performance and cash flows for the year then ended in accordance with South African General Recognized Accounting Practice (SA Grap) and the requirements of the Public Finance Management Act, 1999 (Act No. 1 of 1999) (PFMA).

Basis for opinion

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the auditor-general's responsibilities for the audit of the financial statements section of this auditor's report.
4. I am independent of the entity in accordance with sections 290 and 291 of the Code of ethics for professional accountants and parts 1 and 3 of the International Code of Ethics for Professional Accountants (including International Independence Standards) of the International Ethics Standards Board for Accountants (IESBA codes) as well as the ethical requirements that are relevant to my audit in South Africa. I have fulfilled my other ethical responsibilities in accordance with these requirements and the IESBA codes.
5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the accounting authority for the financial statements

6. The accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with SA Grap and the requirements of the Public Finance Management Act of South Africa (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.
7. In preparing the financial statements, the accounting authority is responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless the appropriate governance structure either intends to liquidate the entity or to cease operations, or has no realistic alternative but to do so.

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

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

Report on the audit of the annual performance report

Introduction and scope

10. In accordance with the Public Audit Act of South Africa 2004 (Act No. 25 of 2004) (PAA) and the general notice issued in terms thereof, I have a responsibility to report on the usefulness and reliability of the reported performance information against predetermined objectives for selected programmes presented in the annual performance report. I performed procedures to identify material findings but not to gather evidence to express assurance.
11. My procedures address the usefulness and reliability of the reported performance information, which must be based on the approved performance planning documents of the entity. I have not evaluated the completeness and appropriateness of the performance indicators / measures included in the planning documents. My procedures also do not extend to any disclosures or assertions relating to planned performance strategies and information in respect of future periods that may be included as part of the reported performance information. Accordingly, my findings do not extend to these matters.
12. I evaluated the usefulness and reliability of the reported performance information in accordance with the criteria developed from the performance management and reporting framework, as defined in the general notice, for the following selected programme presented in the annual performance report of the entity for the year ended 31 March 2020:

	Pages in the annual performance report
Programme 2 – Strategy Office	47 - 50

Report of the Auditor-General to Parliament on Council for Medical Schemes

13. I performed procedures to determine whether the reported performance information was properly presented and whether performance was consistent with the approved performance planning documents. I performed further procedures to determine whether the indicators and related targets were measurable and relevant, and assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.
14. I did not identify any material findings on the usefulness and reliability of the reported performance information for this programme.

Other matters

15. I draw attention to the matters below.

Achievement of planned targets

16. Refer to the annual performance report on pages 25 to 68 for information on the achievement of planned targets for the year and explanations provided for the under-/overachievement of a significant number of targets.

Adjustment of material misstatements

17. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were in the reported performance information of Programme 2: strategy office. As management subsequently corrected the misstatements, I did not raise any material findings on the usefulness and reliability of the reported performance information.

Report on the audit of compliance with legislation

Introduction and scope

18. In accordance with the PAA and the general notice issued in terms thereof, I have a responsibility to report material findings on the entity's compliance with specific matters in key legislation. I performed procedures to identify findings but not to gather evidence to express assurance.
19. The material findings on compliance with specific matters in key legislation are as follows:

Expenditure management

20. Effective and appropriate steps were not taken to prevent irregular expenditure amounting to R14 761 000,00 as disclosed in note 25 to the annual financial statements, as required by section 51(1)(b)(ii) of the PFMA. Most of the irregular expenditure was caused by the non-compliance with national treasury practice note 3 of 2003 when establishing a panel of experts.

Procurement and contract management

21. Some of the quotation documentation for procurement of commodities designated for local content and production, did not stipulate the minimum threshold for local production and content as required by the 2017 preferential procurement regulation 8(2). Similar non-compliance was also reported in the prior year.

Other information

22. The accounting authority is responsible for the other information. The other information comprises the information included in the annual report. The other information does not include the financial statements, the auditor's report and those selected programmes presented in the annual performance report that have been specifically reported in this auditor's report.
23. My opinion on the financial statements and findings on the reported performance information and compliance with legislation do not cover the other information and I do not express an audit opinion or any form of assurance conclusion thereon.
24. In connection with my audit, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and the selected programmes presented in the annual performance report, or my knowledge obtained in the audit, or otherwise appears to be materially misstated.
25. If based on the work I have performed, I conclude that there is a material misstatement in this other information, I am required to report that fact. I have nothing to report in this regard.

Internal control deficiencies

26. I considered internal control relevant to my audit of the financial statements, reported performance information and compliance with applicable legislation; however, my objective was not to express any form of assurance on it. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on the annual performance report and the findings on compliance with legislation included in this report.
27. Leadership did not exercise oversight responsibility regarding performance reporting and compliance as well as related internal controls
28. Management did not review and monitor compliance with applicable legislation.
29. Management did not always understand the requirements of the National Treasury Framework for Programme Performance Information (FMPPI) and thus inadequately reviewed compliance with the requirements of the FMPPI.

Auditor - General

Pretoria
30 September 2020

AUDITOR-GENERAL SOUTH AFRICA

Report of the Auditor-General to Parliament on Council for Medical Schemes

Annexure – Auditor-General's responsibility for the audit

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

Financial statements

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

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

Communication with those charged with governance

3. I communicate with the accounting authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.
4. I also confirm to the accounting authority that I have complied with relevant ethical requirements regarding independence, and communicate all relationships and other matters that may reasonably be thought to have a bearing on my independence and, where applicable, actions taken to eliminate threats or safeguards applied.taken to eliminate threats or safeguards applied.

Statement of Financial Position

as at 31 March 2020

	Note(s) R'000	2020 R'000	2019 Restated* R'000
Assets			
Current Assets			
Statutory receivables from exchange transactions	3	**4 903**	3 708
Cash and cash equivalents	4	**4 929**	26 631
		9 832	30 339
Non-Current Assets			
Property, plant and equipment	5	**13 248**	15 225
Intangible assets	6	**1 447**	1 003
		14 695	16 228
Total Assets		**24 527**	46 567
Liabilities			
Current Liabilities			
Payables from exchange transactions	7	**30 740**	25 291
Unspent conditional grants and receipts		**2 080**	2 574
Provisions	8	**257**	179
		33 077	28 044
Non-Current Liabilities			
Operating lease liability	9	**9 345**	9 732
Provisions	8	**1 748**	1 804
		11 093	11 536
Total Liabilities		**44 170**	39 580
Net Assets		**(19 643)**	6 987
Accumulated deficit		**(19 643)**	6 987

Statement of Financial Performance

for the year ended 31 March 2020

	Note(s) R'000	**2020 R'000**	2019 Restated* R'000
Revenue	11	**174 573**	163 566
Administrative expenses	13	**(26 596)**	(24 254)
Audit fees	14	**(2 715)**	(2 613)
Operating expenses	15	**(47 740)**	(35 215)
Staff costs	16	**(122 792)**	(113 657)
Depreciation and amortisation		**(4 576)**	(4 598)
Loss on disposal of assets	17	**(66)**	7
Operating deficit		**(29 912)**	(16 764)
Interest received		**3 281**	4 478
(Deficit)/surplus for the year		**(26 631)**	(12 286)

Statement of Changes in Net Assets

for the year ended 31 March 2020

	Accumulated deficit R'000	Total net assets Restated* R'000
Opening balance as previously reported	**19 273**	19 273
Restated* Balance at 01 April 2018	**19 273**	19 273
Deficit for the year	**(12 286)**	(12 286)
Total recognised income and expenses for the year	**(12 286)**	(12 286)
Balance at 01 April 2019	**6 988**	6 988
Deficit for the year	**(26 631)**	(26 631)
Balance at 31 March 2020	**(19 643)**	(19 643)

Cash Flow Statement

for the year ended 31 March 2020

	Note(s) R'000	2020 R'000	2019 Restated* R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		**168 257**	157 582
Transfers		**6 202**	5 774
Interest received		**3 281**	4 478
Total receipts		**177 740**	167 834
Payments			
Employee costs		**(116 337)**	(104 276)
Suppliers		**(79 999)**	(66 678)
Total payments		**(196 336)**	(170 954)
Net cash flows from operating activities	20	**(18 596)**	(3 120)
Cash flows from investing activities			
Purchase of property, plant and equipment	5	**(2 372)**	(2 305)
Proceeds from sale of property, plant and equipment	5	**26**	12
Purchase of intangible assets	6	**(760)**	(328)
Net cash flows from investing activities		**(3 106)**	(2 621)
Net decrease in cash and cash equivalents		**(21 702)**	(5 741)
Cash and cash equivalents at the beginning of the year		**26 631**	32 372
Cash and cash equivalents at the end of the year	4	**4 929**	26 631

Statement of Comparison of Budget and Actual Amounts

for the year ended 31 March 2020

Budget on Cash Basis	Approved budget R'000	Adjustments R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Reference
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees, registration, appeal fees and inspection fees recovered	**19 281**	–	**19 281**	11 115	**(8 166)**	1
Interest received	**4 996**	–	**4 996**	3 281	**(1 715)**	2
Levies income	**155 336**	–	**155 336**	156 215	**879**	
Other income	**790**	–	**790**	881	**91**	
Fees and penalties		–		45	**45**	
Total revenue from exchange transactions	**180 403**		**180 403**	171 537	**(8 866)**	
Revenue from non-exchange transactions						
Transfer revenue						
Government transfers	**5 987**	–	**5 987**	6 202	**215**	
Total revenue	**186 390**		**186 390**	177 739	**(8 651)**	

Statement of Comparison of Budget and Actual Amounts

for the year ended 31 March 2020

Budget on Cash Basis	Approved budget R'000	Adjustments R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Reference
Expenditure						
Personnel	**(117 404)**	671	**(116 733)**	(113 232)	**3 501**	
Social contributions	**(187)**	–	**(187)**	–	**187**	
Employee benefits	**(3 003)**	–	**(3 003)**	(3 104)	**(101)**	
Advertising	**(1 830)**	–	**(1 830)**	(1 648)	**182**	
Agency and support/outsourced services	**(177)**	(38)	**(215)**	(576)	**(361)**	
Audit costs	**(903)**	–	**(903)**	(1 123)	**(220)**	
Board costs	**(1 519)**	(1 420)	**(2 939)**	(3 627)	**(688)**	3
Bank charges	**(106)**	22	**(84)**	(83)	**1**	
Building expenses	**(2 122)**	376	**(1 746)**	(2 050)	**(304)**	
Communication	**(4 026)**	(165)	**(4 191)**	(4 886)	**(695)**	
Consultants	**(6 683)**	733	**(5 950)**	(10 387)	**(4 437)**	4
Contractors	**(1 053)**	(2 263)	**(3 316)**	(3 628)	**(312)**	
Investigation fees	**(10 585)**	3 667	**(6 918)**	(4 196)	**2 722**	
Legal fees	**(8 240)**	–	**(8 240)**	(13 344)	**(5 104)**	5
Non-life insurance	**(458)**	–	**(458)**	(924)	**(466)**	
Postage	**(94)**	13	**(81)**	(54)	**27**	
Printing and stationary	**(1 326)**	(31)	**(1 357)**	(1 578)	**(221)**	
Rental of buildings and office equipment	**(15 395)**	–	**(15 395)**	(16 623)	**(1 228)**	
Repairs and maintenance	**(946)**	(55)	**(1 001)**	(509)	**492**	
Budget on Cash Basis						
Security costs	**(466)**	(40)	**(506)**	(671)	**(165)**	
Training and development	**(1 382)**	(258)	**(1 640)**	(1 605)	**35**	
Subscription and publication	**(456)**	(212)	**(668)**	(601)	**67**	
Travel and subsistence local	**(2 254)**	(1 377)	**(3 631)**	(4 764)	**(1 133)**	
Venues and facilities	**(1 035)**	(323)	**(1 358)**	(2 072)	**(714)**	
Other unclassified goods and services	**(3 029)**	(131)	**(3 160)**	(5 050)	**(1 890)**	
Total expenditure	**(184 679)**	(831)	**(185 510)**	(196 355)	**(10 825)**	
Surplus/(deficit) for the year	**1 711**	(831)	**880**	(18 596)	**(19 476)**	
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	**1 711**	(831)	**880**	(18 596)	**(19 476)**	

Statement of Comparison of Budget and Actual Amounts

for the year ended 31 March 2020

Budget on Cash Basis	Approved budget R'000	Adjustments R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Reference
Reconciliation						
Basis of accounting difference						
Depreciation and amortisation				(4 576)		
Gain/(loss) on sale of assets				(66)		
Movement in operating lease				387		
Movement in provisions						
Movement in provisions				(22)		
Change in receivables from exchange transactions				1 196		
Change in payables from exchange transactions				(5 448)		
Change in unspent conditional transfer				494		
Actual Amount in the Statement of Financial Performance				(26 631)		
Statement of Financial Position						
Assets						
Current Assets						
Cash and cash equivalents			**(21 701)**	(21 701)		
Non-Current Assets						
Property, plant and equipment	**(3 627)**	332	**(3 295)**	(3 322)	**(27)**	
Total Assets	**(3 627)**	332	**(3 295)**	(25 023)	**(21 728)**	
Liabilities						
Current Liabilities						
Unspent conditional grants and receipts	–	500	**500**	–	**(500)**	
Total Liabilities	–	500	**500**	–	**(500)**	
Net Assets	**(3 627)**	(168)	**(3 795)**	(25 023)	**(21 228)**	
Net Assets						
Net Assets Attributable to Owners of Controlling Entity						
Format and classification difference						
Revised opening balance	**–**	**–**	**–**	(1 485)	(1 485)	
Accumulated deficit	**(1 916)**	(500)	**(2 416)**	2 970	**5 386**	
(1 916)		(500)	**(2 416)**	1 485	**3 901**	
Non-controlling interest	**(1 711)**	332	**(1 379)**	(26 508)	**(25 129)**	
Total Net Assets	**(3 627)**	(168)	**(3 795)**	(25 023)	**(21 228)**	

Notes to the statement of comparison of budget and actual amounts

for the year ended 31 March 2020

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

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

Period of the approved budget: 01 April 2019 to 31 March 2020

The approval of budget: The 2019/2020 budget was approved in terms of section 2(4) of the Council for Medical Schemes Levies Act, 2000 (Act no 58 of 2000) by the Minister of Health with the concurrence of the Finance Minister on 05 April 2019.

Calculated materiality and significance value as determined in terms of Treasury Regulation 28.3.1 amounts to R1.64 million. Positive and negative differences above the calculated materiality are explained in this statement below:

1. Under collection of investigation fees and recoveries, these are investigation fees paid to service providers but recoverable from schemes which were under investigation. It is however foreseen that these recoveries will be collected in the next financial year.
2. Decrease in the cash and cash equivalents contributed in the decrease in the interest received.
3. There have been additional Council meetings and special Council meetings to deliberate and provide strategic guidance on matters affecting the CMS' trajectory and reputation. Some members of Council also serve on the Appeals Committee, hence the increase in board costs.
4. Costs incurred on the various investigations into the maladministration by individuals at the CMS and the medical schemes industry are the main reasons for the overrun.
5. The legal unit incurred legal fees with regard to the Section 59 investigation, payable to the panel members and the represented attorney, which were unforeseen and thus not budgeted for.

Accounting Policies

for the year ended 31 March 2020

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 statement to these annual financial statements.

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

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

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

1.4 Significant judgments and sources of estimation uncertainty

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

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

and applied prospectively.

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

Provisions

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

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

Depreciation and amortisation

At the end of each financial year, management assesses whether there is any indication that the Council for Medical Scheme's expectations about the residual value and the useful life of assets included in the property, plant and equipment have changed since

Accounting Policies

for the year ended 31 March 2020 (continued)

the preceding reporting date. If any such indication exists, the change has been accounted for as a change in accounting estimate in accordance with Standards of GRAP on Accounting Policies, Changes in Accounting Estimates and Errors.

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

Effective interest rate

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

Impairment testing

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

1.5 Financial instruments

Identification

Statutory receivables are receivables that arise from legislation, supporting regulations, or similar means, and require settlement by another entity in cash or another financial asset.

Carrying amount is the amount at which an asset is recognised in the statement of financial position.

The cost method is the method used to account for statutory receivables that requires such receivables to be measured at their transaction amount, plus any accrued interest or other charges (where applicable) and, less any accumulated impairment losses and any amounts derecognised.

Recognition

The entity recognises statutory receivables as follows:

- if the transaction is an exchange transaction, using the policy on Revenue from exchange transactions;

Initial measurement

The entity initially measures statutory receivables at their transaction amount.

Subsequent measurement

The entity measures statutory receivables after initial recognition using the cost method. Under the cost method, the initial measurement of the receivable is changed subsequent to initial recognition to reflect any:

- Interest or other charges that may have accrued on the receivable (where applicable)
- Impairment losses; and
- Amounts derecognised

1.6 Property, plant and equipment

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

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

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

Property, plant and equipment is initially measured at cost.

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

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

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

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

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

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

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

Accounting Policies

for the year ended 31 March 2020 (continued)

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

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

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

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

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

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

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

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

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

1.7 Intangible assets

An asset is identifiable if it either:

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

An intangible asset is recognised when:

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

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

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

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

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

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

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

Item	Useful life
Developed software	7 years
Acquired software	7 years

Accounting Policies

for the year ended 31 March 2020 (continued)

Intangible assets are derecognised:

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

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

Cash-generating assets are assets used with the objective of generating a commercial return. Commercial return means that positive cash flows are expected to be significantly higher than the cost of the asset.

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

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

Carrying amount is the amount at which an asset is recognised in the statement of financial position after deducting any accumulated depreciation and accumulated impairment losses thereon.

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

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

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

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

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

Useful life is either:

- The period of time over which an asset is expected to be used by the entity; or

Impairment of non-financial assets (continued)

- The number of production or similar units expected to be obtained from the asset by the entity

Identification

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

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

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

Recognition and measurement

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

An impairment loss is recognised immediately in surplus or deficit.

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

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

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

Reversal of an impairment loss

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

An impairment loss recognised in prior periods for a non-cash-generating asset is reversed if there has been a change in the estimates used to determine the asset's recoverable service amount since the last impairment loss was recognised. The carrying amount of the asset is increased to its recoverable service amount. The

Accounting Policies

for the year ended 31 March 2020 (continued)

increase is a reversal of an impairment loss. The increased carrying amount of an asset attributable to a reversal of an impairment loss does not exceed the carrying amount that would have been determined (net of depreciation or amortisation) had no impairment loss been recognised for the asset in prior periods.

A reversal of an impairment loss for a non-cash-generating asset is recognised immediately in surplus or deficit.Any reversal of an impairment loss of a revalued non-cash-generating asset is treated as a revaluation increase.

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

1.8 Leases

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

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

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

Finance leases – lessee

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

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

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

Any contingent rents are expensed in the period in which they are incurred.The finance lease liabilities are derecognised when the entity's obligation to settle the liability is extinguished. The assets capitalised under the finance lease are derecognised when the entity no longer expects any economic benefits or service potential to flow from the asset.

Operating leases – lessor

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

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

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

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

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

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

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

1.9 Revenue from exchange transactions

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

Recognition

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

Accounting Policies

for the year ended 31 March 2020 (continued)

- The entity retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold
- The amount of revenue can be measured reliably
- It is probable that the economic benefits or service potential associated with the transaction will flow to the entity and the costs incurred or to be incurred in respect of the transaction can be measured reliably
- Fair value is the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

The main sources of revenue from exchange transactions are:

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

Measurement

Revenue is measured at the fair value of the consideration received or receivable, net of trade discounts and volume rebates. Revenue arising from the use by others of entity assets yielding interest, royalties and dividends or similar distributions is recognised when:

- It is probable that the economic benefits or service potential associated with the transaction will flow to the entity, and
- The amount of the revenue can be measured reliably

Interest is recognised, in surplus or deficit, using the effective interest rate method.

1.10 Revenue from non-exchange transactions

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

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

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

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

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

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

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

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

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

Services in-kind

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

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

Accounting Policies

for the year ended 31 March 2020 (continued)

1.11 Irregular expenditure

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

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

National Treasury Practice Note no. 4 of 2008/09 which was issued in terms of sections 76(1) to 76(4) of the PFMA requires the following (effective from 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 National Treasury or the relevant authority must be recorded appropriately in the irregular expenditure register. If liability for the irregular expenditure can be attributed to a person, a debt account must be created if such a person is liable in law. Immediate steps must thereafter be taken to recover the amount from the person concerned. If recovery is not possible, the accounting officer or accounting authority may write off the amount as debt impairment and disclose such in the relevant note to the financial statements. The irregular expenditure register must also be updated accordingly. If the irregular expenditure has not been condoned and no person is liable in law, the expenditure related thereto must remain against the relevant programme/ expenditure item, be disclosed as such in the note to the financial statements and updated accordingly in the irregular expenditure register.

1.12 Fruitless and wasteful expenditure

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

1.13 Post-reporting date events

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

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

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

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

1.14 Related parties

A related party is a person or an entity with the ability to control or jointly control the other party, or exercise significant influence over the other party, or vice versa, or an entity that is subject to common control, or joint control. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities.

Related party transaction is a transfer of resources, services or obligations between the reporting entity and a related party, regardless of whether a price is charged. Significant influence is the power to participate in the financial and operating policy decisions of an entity, but is not control over those policies.

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

Close members of the family of a person are considered to be those family members who may be expected to influence, or be influenced

Accounting Policies

for the year ended 31 March 2020 (continued)

by, that management in their dealings with the entity.

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

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

1.15 Budget information

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

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

The approved budget is prepared on a cash basis and presented by economic classification linked to performance outcome objectives. The approved budget covers the fiscal period from 01/04/2019 to 31/03/2020.

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

1.16 Provisions and contingencies

Provisions are recognised when:

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

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

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

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

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

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

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

A provision is used only for expenditures for which the provision was originally recognised. Provisions are not recognised for future operating surplus (deficit).

Contingent assets and contingent liabilities are possible assets and liabilities whose occurrence depends on whether some uncertain future event occurs or payment is not probable or amount cannot be measured reliably. Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note 23.

1.17 Segment information

A segment is an activity of an entity:

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

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

2. New standards and interpretations

Standards and interpretations issued, but not yet effective

The entity has not applied the following standards and interpretations, which have been published and are mandatory for the entity's accounting periods beginning on or after 01 April 2020 or later periods:

Standard/Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 34: Separate Financial Statements	01 April 2020	Unlikely there will be a material impact
GRAP 35: Consolidated Financial Statements	01 April 2020	Unlikely there will be a material impact
GRAP 36: Investments in Associates and Joint Ventures	01 April 2020	Unlikely there will be a material impact
GRAP 37: Joint Arrangements	01 April 2020	Unlikely there will be a material impact
GRAP 38: Disclosure of Interests in Other Entities	01 April 2020	Unlikely there will be a material impact
GRAP 110 (as amended 2016): Living and Non–living Resources	01 April 2020	Unlikely there will be a material impact

3. Receivables from exchange transactions

	2020 R'000	2019 R'000
Accounts receivable	**91**	39
Sundry debtors	**1 434**	2 050
Prepaid expenses	**3 378**	1 619
	4 903	3 708

Statutory receivables included in receivables from exchange transactions above are as follows:

	2020 R'000	2019 R'000
Rule Amendments in terms of Regulation 31 of Medical Schemes Act no.131 of 1998	**91**	39
Inspection costs recoverable from inspected schemes in terms of Regulation 4B of Financial Sector Regulation Act No. 9 of 2017	**1 434**	2 050
	1 525	2 089
Other non–financial asset receivables included in receivables from exchange transactions above are as follows:		
Prepaid expenses	**3 378**	1 619
Financial asset receivables included in receivables from exchange transactions above	**–**	–
Total receivables from exchange transactions	**4 903**	3 708

Receivables ageing	Current	30 days	60 days	90 days	120 days	over 120
Accounts receivable	*25*	7	6	–	51	–
Subtotal	*25*	7	6	–	51	–
	25	7	6	–	51	–

Part of the receivables from exchange transactions are the following:
R173 450 is the interest receivable and employee's advances which are both current and R1 260 628 is the sundry debtor of inspection costs recoverable from medical schemes which were under investigation. It is recoverable on the finalisation of the inspection report.

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

4. Cash and cash equivalents

	2020 R'000	2019 R'000
Cash and cash equivalents consist of:		
Cash on hand	**4**	
Bank balances	**4 411**	2 207
CPD account	**514**	24 424
Total	**4 929**	26 631

5. Property, plant and equipment

	2020			2019		
	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000
Furniture and fittings	**8 542**	**(4 304)**	**4 238**	8 369	(3 820)	4 549
Motor vehicles	**470**	**(326)**	**144**	470	(232)	238
Computer equipment	**15 944**	**(11 645)**	**4 299**	14 099	(9 622)	4 477
Computer software	**2 163**	**(2 007)**	**156**	2 163	(1 879)	284
Leasehold improvements	**11 980**	**(7 898)**	**4 082**	11 980	(6 621)	5 359
Other fixed assets	**789**	**(460)**	**329**	731	(413)	318
Total	**39 888**	**(26 640)**	**13 248**	37 812	(22 587)	15 225

Reconciliation of property, plant and equipment – 2020

	Opening balance R'000	Additions R'000	Disposals R'000	Depreciation R'000	Total R'000
Furniture and fittings	**4 549**	**423**	**(75)**	**(659)**	**4 238**
Motor vehicles	**238**	**–**	**–**	**(94)**	**144**
Computer equipment	**4 477**	**1 892**	**(16)**	**(2 054)**	**4 299**
Computer software	**284**	**–**	**–**	**(128)**	**156**
Leasehold improvements	**5 359**	**–**	**–**	**(1 277)**	**4 082**
Other fixed assets	**318**	**57**	**–**	**(46)**	**329**
Total	**15 225**	**2 372**	**(91)**	**(4 258)**	**13 248**

Reconciliation of property, plant and equipment – 2019

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

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

6. Intangible assets

	2020			2019		
	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000	Cost/ Valuation R'000	Accumulated depreciation and accumulated impairment R'000	Carrying value R'000
Developed software	**2 858**	**(1 489)**	**1 369**	2 098	(1 329)	769
Acquired software	**2 449**	**(2 371)**	**78**	2 449	(2 215)	234
Total	**5 307**	**(3 860)**	**1 447**	4 547	(3 544)	1 003

Reconciliation of intangible assets – 2020

	Opening R'000	Additions R'000	Amortisation R'000	Total R'000
Developed software	**769**	760	(160)	1 369
Acquired software	**234**	–	(156)	78
Total	**1 003**	760	(316)	1 447

Reconciliation of intangible assets – 2019

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

7. Payables from exchange transactions

	2020 R'000	2019 R'000
Accounts payable	**8 656**	9 503
Income received in advanced	**1 651**	1 219
Accrual for leave pay	**3 042**	2 214
Accruals	**17 391**	12 355
Total	**30 740**	25 291

Payables ageing	Current	30 days	60 days	90 days	120 days	Over 120
Payables from exchange transactions	4 386	1 397	–	–	–	220
Payables from non-exchange transaction	2 650	–	–	–	–	–
Subtotal	7 036	1 397	–	–	–	220
	7 036	**1 397**	**–**	**–**	**–**	**220**

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 employee up to the reporting date.

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

8. Provisions

Reconciliation of provisions - 2020

	Opening Balance R'000	Additions	Utilised during the year R'000	Reversed during the year R'000	**Total R'000**
Provision for long service award	1 983	464	(180)	(262)	**2 005**

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

Reconciliation of provisions - 2019

	Opening Balance R'000	Additions	Utilised during the year R'000	Reversed during the year R'000	**Total R'000**
Provision for long service award	1 838	497	(311)	(41)	**1 983**
Non-current liabilities Current liabilities				1 748	**1 804**
				257	**179**
				2 005	**1 983**

9. Operating lease liability

	2020 R'000	2018 R'000
Current assets		
Non-current liabilities	**(9 345)**	(9 732)
	(9 345)	(9 732)

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

10. Financial instruments disclosure

Categories of financial instruments

	2020	
	At fair value R'000	Total R'000
Financial assets		
Trade and other receivables from exchange transactions	**1 525**	1 525
Cash and cash equivalents	**4 929**	4 929
	6 454	6 454
Financial liabilities		
Trade and other payables from exchange transactions	**30 740**	30 740

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

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

11. Revenue

	2020 R'000	2019 R'000
Accreditation fees	**8 170**	7 787
Inspection fees recovered	**2 097**	3 491
Government transfers: Department of Health	**6 481**	5 899
Legal fees recovered	**–**	418
Levies income	**156 215**	144 980
Mandatory transfer: Department of Higher Education and Training	**215**	104
Registration fees	**469**	456
Sundry income	**926**	431
	174 573	163 566

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

	2020 R'000	2019 R'000
Accreditation fees	**8 170**	7 787
Inspection fees recovered	**2 097**	3 491
Legal fees recovered	**–**	418
Levies income	**156 215**	144 980
Registration fees	**469**	456
Sundry income	**926**	431
	167 877	157 563

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

	2020 R'000	2019 R'000
Taxation revenue		
Transfer revenue		
Government transfers: Department of Health	**6 481**	5 899
Mandatory transfer: Department of Higher Education and Training	**215**	104
	6 696	6 003

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

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

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

12. Unspent Conditional grants and receipts

	2020 R'000	2019 R'000
Grant received from Department of Health		
Opening balance	**2 574**	2 803
Conditions met transfer to revenue	**(494)**	(229)
Conditions still to be met	**2 080**	2 574

The CMS received a grant to the amount of R2 556 000 in 2015/2016 and R1 613 000 in 2016/2017 financial years with a condition to complete:

a) Development and maintenance of a Medicines Pricing Registry.

b) Development and maintenance of beneficiary registry for medical schemes members.

13. Administrative expenses

	2020 R'000	2019 R'000
Bank charges	**85**	112
Building expenses	**2 044**	1 813
General administrative expenses	**1 587**	957
Insurance	**449**	523
Printing and stationery	**435**	351
Refreshments	**84**	84
Rent	**11 981**	11 690
Rent-operating expense	**2 539**	2 341
Rental-copiers	**401**	401
Security	**713**	409
Subscriptions	**700**	427
Telecommunication expenses	**5 578**	5 146
	26 596	24 254

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

	2020 R'000	2019 R'000
Repairs and maintenance		
Repairs and maintenance costs	**513**	697

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

14. Auditors' remuneration

	2020 R'000	2019 R'000
External audit	**1 123**	740
Internal audit	**1 592**	1 873
	2 715	2 613

15. Operating Expenses

	2020 R'000	2019 R'000
Committee remuneration	**225**	128
Consulting	**8 571**	5 381
Council members' fees	**3 232**	3 530
Exhibition costs	**115**	103
Inspection costs	**4 779**	6 824
Knowledge management	**1 561**	1 498
Labour relations costs	**2 794**	1 780
Legal fees	**17 958**	6 151
Media and promotion	**1 385**	1 606
Postage and courier	**50**	83
Printing and publication	**935**	979
Transcription services	**563**	226
Travel and subsistence	**3 896**	3 744
Venue and catering	**1 659**	3 182
	47 740	35 215

16. Staff costs

	2020 R'000	2019 R'000
Employee benefits	**3 104**	2 846
Employee wellness	**302**	270
Recruitment and relocation	**1 039**	1 009
Salaries	**113 278**	113 657
Staff training	**1 390**	2 165
Temporary staff	**3 492**	2 716
SEP system expense	**–**	229
Workmen's compensation	**187**	170
	122 792	113 657
Total number of employees	**120**	118

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

17. Gain/(loss) on disposal of assets

	2020 R'000	2019 R'000
Gain/(loss) on disposal of assets	**(66)**	7

The CMS disposed of some assets which where no longer in use during the year with a loss of R66 000.

18. Interest received

	2020 R'000	2019 R'000
Interest earned on investment	**3 281**	4 478

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

19. Taxation

No provision for taxation has been made for 2020 tax year because the CMS is exempt from income tax in terms of Section 10(1)(cA) of the Income Tax Act (Act No. 58 of 19192)

20. Cash used in operations

	2020 R'000	2019 R'000
(Deficit)/surplus	**(26 631)**	(12 286)
Adjustments for:		
Depreciation and amortisation	**4 576**	4 598
(Gain)/loss on sale of assets and liabilities	**66**	(7)
Movements in operating lease assets and accruals	**(387)**	290
Movements in provisions	**22**	145
Changes in working capital:		
Statutory receivables from exchange transactions	**(1 196)**	6 884
Payables from exchange transactions	**5 448**	(2 515)
Unspent conditional grants and receipts	**(494)**	(229)
	(18 596)	(3 120)

21. Commitments

Operating leases – as lessee (expense)

20.1 Office rental

	2020 R'000	2019 R'000
Minimum lease payments due		
– within one year	**13 419**	12 368
– in second to fifth year inclusive	**33 035**	46 455
	46 454	58 823

The CMS entered into a renewable 10-year lease agreement which commenced on 1 June 2013 and will terminate on 31 May 2023 and which provides for an escalation of 8.5% per annum. In conjunction with the first lease, a second lease was entered into to start in June 2014 for additional space in the existing building with the same terms as the first lease agreement. In conjunction with the first lease, a third lease was entered into to start in October 2015 for additional space in the existing building with the same terms as the first lease agreement. The CMS also contracted to have the option to purchase the office building.

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

22. Related parties

Relationships

Executive authority:	The Executive authority as defined in Section 1 of the PFMA, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.
Accounting authority:	Council, as defined in Section 49 of the PFMA, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.
Executive management:	In terms of section 8(a) of Medical Schemes Act, Council shall appoint such staff as the Council may deem necessary to employ to assist Council in the performance of its functions and execution of its duties.

Related party transactions

	2020 R'000	2019 R'000
Transfer paid to (received from) related parties		
Department of Health	**(5 987)**	(5 670)
Council Members' remuneration		
Adv. R Gaoraelwe	**383**	268
Adv. H Kooverjie	**108**	376
Dr MS Mabela	**257**	137
Ms M Maboye	**401**	579
Mr M Maimane	**523**	650
Dr M Makhiwane	**313**	230
Dr C Mini	**537**	557
Prof L Pepeta	**16**	47
Ms S Ranchod (resigned in 2018/19 financial year)	**–**	47
Ms D Terblanche	**516**	461
Mr J van der Walt	**179**	178
	3 233	3 530

Council is the governing body of the CMS and as such it exercises oversight over the entity. Council members' fees decreased by 8% in the current financial year due to a decrease in the number of meetings. Refer to Refer to Part C (Governance) for detailed report on Council's activities.

Independent Audit and Risk committee members' remuneration		
Mr H Kariem	**94 190**	82 042
Mr L Matshekga	**10 460**	–
Ms S Mzizi	**7 776**	–
Ms EM Pillay	**62 208**	11 664
Ms M Strydom	**50 544**	34 180
	225 178	127 886

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

	2020			
	Basic salary	Performance management	Acting allowance and other	Total
Compensation to Executive Management				
Chief Executive and Registrar - Dr S. Kabane (from 20 February 2019)	2 517	**271**	49	**2 837**
Chief Financial Officer - Mr D. Lehutjo	1 885	**–**	87	**1 972**
Chief Information Officer (Resigned: 31 January 2020) - Mr J. Kugel	1 546	**–**	(103)	**1 443**
General Manager: Accreditation (Retirement: 31 December 2019) - Mr D. Kolver	1 450	**–**	(139)	**1 311**
General Manager: Benefit Management - Mr P. Prema	1 885	**172**	(44)	**2 013**
General Manager: Compliance and Investigation (Resigned: 15 September 2019) - Mr S. Mmatli	934	**–**	(53)	**881**
General Manger: Complaints and Adjudication - Ms T. Phaswane	1 548	**152**	15	**1 715**
General Manager: Financial Supervision - Ms T. Maziya	1 891	**–**	96	**1 987**
General Manager: Human Resources - Ms L. Ndziba	1 887	**–**	73	**1 960**
General Manager: Legal Services - Mr C. Burton-Durham	1 891	**168**	113	**2 172**
General Manager: Research and Monitoring - Mr M. Willie	1 633	**177**	39	**1 849**
General Manager: Stakeholder Relations - Ms G. Khoza	2 225	**198**	88	**2 511**
Executive Manager: Office of the Chief Executive and Registrar - Mr R. Sadiki	1 540	**152**	53	**1 745**
	22 832	**1 290**	274	**24 396**

Other benefits include acting allowance, movement in leave provision and movement in long service award.

	2019			
	Basic salary	Performance management	Acting allowance and other	Total
Compensation to Executive Management				
Chief Executive and Registrar - Dr S. Kabane (from 20 February 2019) (Acting from April 2018 - 19 February 2019)	1 973	**197**	355	**2 525**
Chief Financial Officer - Mr D. Lehutjo	1 846	**203**	(27)	**2 022**
Chief Information Officer - Mr J. Kugel	1 811	**163**	45	**2 019**
General Manager: Accreditation - Mr D. Kolver	1 778	**178**	4	**1 960**
General Manager: Benefits Management - Mr P. Prema	1 704	**188**	4	**1 896**
General Manager: Compliance and Investigation - Mr S. Mmatli	1 846	**–**	5	**1 851**
General Manager: Complaints and Adjudication - Ms T. Phaswane	1 510	**125**	(22)	**1 613**
General Manager: Financial Supervision - Ms T. Maziya	1 846	**185**	5	**2 036**
General Manager: Human Resources - Ms L. Ndziba	1 846	**166**	(43)	**1 969**
General Manager: Legal services - Mr C. Burton-Durham	1 846	**185**	5	**2 036**
General Manager: Research and Monitoring - Mr M. Willie	810	**–**	32	**842**
General Manager: Stakeholder Relations (from 13 August 2018) - Ms G. Khoza	1 284	**–**	(6)	**1 278**
Executive Manager: Office of the Chief Executive and Registrar - Mr R. Sadiki	237	**–**	–	**237**
	20 337	**1 590**	357	**22 284**

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

23. Contingencies

Contingent liabilities

Dr MA Mazibuko v the CMS and Government Employees Medical Schemes case:

On 30 May 2017, the CMS was ordered by the High Court of South Africa Gauteng Division, Pretoria to provide Dr MA Mazibuko with the ruling and/or decision of the complaint lodged with the CMS in terms of the Medical Schemes Act, 131 of 1998, by Friday 2 June 2017. The costs of this application are reserved. The estimated taxed amount of costs on this case is equal or less than R180 000.

Bonitas Medical Aid Scheme vs the CMS:

On 18 March 2020, the CMS lost an urgent interdict application by Bonitas Medical Aid scheme in the Gauteng High Court. The CMS as the respondent was ordered to pay the costs of the application. The estimated financial effect is to be determined by the decision of the Tax Master.

Four General Managers and the CFO whose contracts with the CMS expired on 31 March 2020 and were not renewed referred a dispute of legitimate expectation of renewal of their fixed term contracts to CCMA.

Communication Manager and Risk and Performance Manager referred an unfair dismissal dispute against them to CCMA.

Network Manager referred an unfair labour practice dispute regarding a grading exercise which he lost at CCMA to the Labour Court for review.

A Compliance Officer referred an unfair labour practice dispute to CCMA regarding the CMS recruitment processes.

Contingent assets

The CMS won a court case against the following party:

- CMS vs Polmed Curatorship

The CMS, as the successful party in this case, was awarded costs on the party and party scale. The bill of costs relating to these matters have to date not been approved by the Taxation Master of the Court due to uncertainties relating to the amount and timing of the legal fees recovered.

The following cases are still ongoing in courts of which judgments are still pending:

- The CMS vs National Health Care Professionals S59(2) challenge
- City Hospital vs the CMS and others
- W. Alberts and others vs the CMS S46 challenge
- Compcare vs Registrar and the CMS name change
- Reed vs Keyhealth Medical Scheme and Registrar of Medical Schemes
- The CMS vs Medihelp inspection challenge
- The CMS vs Polmed immovable property sale challenge
- The CMS vs Sizwe Medical Scheme curatorship
- The CMS vs Keyhealth curatorship
- The CMS vs Mokoditoa S59 challenge

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

24. Risk management

Financial risk management

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

Liquidity risk

The entity's risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. The CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account of R4 929 348 as at 31 March 2020.

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

The entity invests surplus funds in the CPD account. The interest rates on this account fluctuate in line with movements in money market rates. The impact on investment revenue of a percentage shift would be a maximum increase of R30 906 or decrease of R30 906 respectively.

25. Irregular expenditure

	2020 R'000	2019 R'000
Opening balance	**44 423**	28 255
Add: Irregular Expenditure – current year	**14 761**	16 168
	59 184	44 423

The CMS established a Loss Control Committee in terms of National Treasury Irregular Expenditure Framework at the beginning of 2020/2021 financial year. This committee has started its work to deal with the irregular expenditure as required by National Treasury Irregular Expenditure Framework.

Analysis of expenditure awaiting condonation per age classification

	2020 R'000	2019 R'000
Current year	**14 060**	16 168
Prior years	**701**	28 255
	14 761	44 423

The CMS incurred irregular expenditure during the year of R579 556 due to extending the scope of work by more than 15% without prior approval from National Treasury. The CMS also incurred an irregular expenditure of R12 655 586. In establishing a panel of lawyers in the prior years, the CMS did go through a bidding process as required for all procurements above R500 000.

The CMS incurred irregular expenditure in the prior years which was identified in the current year of R700 613 due to not maintaining an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective in terms of section 51 (1)(a)(iii) of PFMA.

The CMS incurred irregular expenditure during the year of R825 036 due to not maintaining an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective in terms of s 51 (1)(a)(iii) of PFMA.

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

25. Irregular expenditure (continued)

The CMS incurred irregular expenditure in the prior year of R781 441 due to extending the scope of work by more than 15% without prior approval from National Treasury. The CMS also incurred an irregular expenditure of R10 320 009. In establishing a panel of inspectors, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS also incurred an irregular expenditure of R4 654 279. In establishing a panel of lawyers, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS incurred an irregular expenditure of R367 804 as the CMS did not apply the preference point system in awarding the bid. The CMS incurred irregular expenditure of R44 194 by sourcing services without going through a competitive quotation process.

In the prior years, the CMS incurred irregular expenditure of R1 884 705 due to not inviting written price quotations for procurements up to an estimated value of R500 000 although the CMS sourced these services from its legal panel of service providers. The CMS also incurred an irregular expenditure of R11 843 285, in establishing a panel of inspectors, the CMS did not do that through a bidding process as required for all procurements above R500 000. The CMS also incurred an irregular expenditure of R1 769 005 as the CMS did not apply the preference point system correctly as in some cases bids were not awarded to service providers with highest points.

The CMS incurred irregular expenditure of R2 081 317 in the prior financial years identified during the prior years audit, where the CMS did not establish its panel of inspectors through a bidding process as required for all procurements above R500 000.

In the prior years, the CMS incurred irregular expenditure of R1 064 915, which was as a result of a calculation error on the application of the 80/20 preferential point system on procurement of transactions above R30 000 but below R500 000, however bids were awarded to the cheapest quotation but not the highest scoring bidder. This resulted in non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA).

In the prior years, the CMS incurred irregular expenditure of R99 326 without following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/2008. In the prior year, the CMS also incurred an irregular expenditure of R204 000 due to non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) for not awarding the contract to the bidder who scored the highest points which occurred in prior years: See below.

In the prior years, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified to the amount of R982 906 for not awarding the contract to the bidder who scored the highest points.

Details of irregular expenditure

	2020 R'000	2019 R'000
Incident		
Bid awarded without following correct procedures	**1 526**	412
Bid awarded to inspectors whose panel was not established through bidding process	**–**	10 321
More than 15% extension of the scope of work without prior National Treasury approval.	**579**	781
Bid awarded to lawyers whose panel was not established through bidding process	**12 656**	4 654
	14 761	**16 168**

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

In the prior years, the CMS incurred irregular expenditure to the amount of R1 094 000 for non-compliance with the Preferential Procurement Policy Framework Act (PPPFA), 2000 (Act No.5 of 2000) for not awarding the contract to the tenderer who scored the highest points.

In the prior financial years the CMS incurred irregular expenditure to the amount of R31 863 for staff training and temporary staffing without following the proper legislative procurement process prescribed by National Treasury in terms of paragraph 3.3.1 to 3.3.3 of Practice Note 8 of 2007/08.

In the prior years, non-compliance to National Treasury Instruction 01 of 2013/14 regarding Cost Containment Measures relating to catering was identified and was classified as irregular expenditure to the amount of R3 000.

In the prior years, the CMS incurred irregular expenditure of R7 056 000 by acquiring services without going through a competitive quotation process or without going through a competitive bidding process to appoint a service provider. However, the reasons for this deviation were recorded and approved by the Acting Chief Executive and Registrar for the quotations, and the deviation for the bidding process were recorded and approved by the Council. In both instances, the reasons advanced did not meet the requirements of paragraph 3.4.3 of Practice Note 8 of 2007/08 of National Treasury, which allows for deviation from a competitive quotation and bidding process. Also in the prior years, non-compliance with the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA) was identified for not indicating the weighting of the criterion used to evaluate functionality on a request for quotation which amounted to R251 000. All the irregular expenditure incurred by the CMS has been submitted to National Treasury for condonation.

26. Fruitless and wasteful expenditure

	2020 R'000	2019 R'000
Opening balance as previously reported	**37**	7
Incurred during the year	**571**	30
Opening balance as restated	**608**	37
Closing balance	**608**	37

During the year, an expenditure of R14 950 was incurred for a conference that one of the delegates did not attend. Expenditure of R2 971 was incurred for accommodation booked but not utilised. A penalty of R553 516 was paid to SARS for a late PAYE payment for the months of June and August 2019.

Notes to the Annual Financial Statements

for the year ended 31 March 2020 (continued)

27. Prior period errors

A prior period error was identified in relation to invoices received during the current year of which activities occurred in the 2019/2020 financial year.

	2020 R'000	2019 R'000
Increase in legal fees 31 March 2019	–	129
Increase in venue and catering 31 March 2019	–	7
Increase in stationery 31 March 2019	–	5
Increase in consulting 31 March 2019	–	12
Increase in salaries 31 March 2019	–	1 285
Increase in accruals 31 March 2019	–	(1 438)

28. Segment information

General information

Identification of segments

The entity is organised and reports to management on the basis of its core mandated business as set out in the Medical Schemes Act, Act 131 of 1998. The function of the mandate is to regulate the medical schemes industry. Due to the nature and service of the organisation, management reviews and evaluates the entity as a whole, as all risks, resources and financial matters of the entity are directed to deliver its core mandate.

The entity's operations are located in Centurion, as its only office in the country. Although the office services the public of South Africa, its risk and financial costs are limited to this single location.

It is on this basis that management views the entity as a single segment to which adequate disclosure has been made in these Annual Financial Statement.

Part F

Overview of activities during the 2019/20 reporting period

Overview of activities during the 2019/20 reporting period

Financial overview

A snapshot of the industry

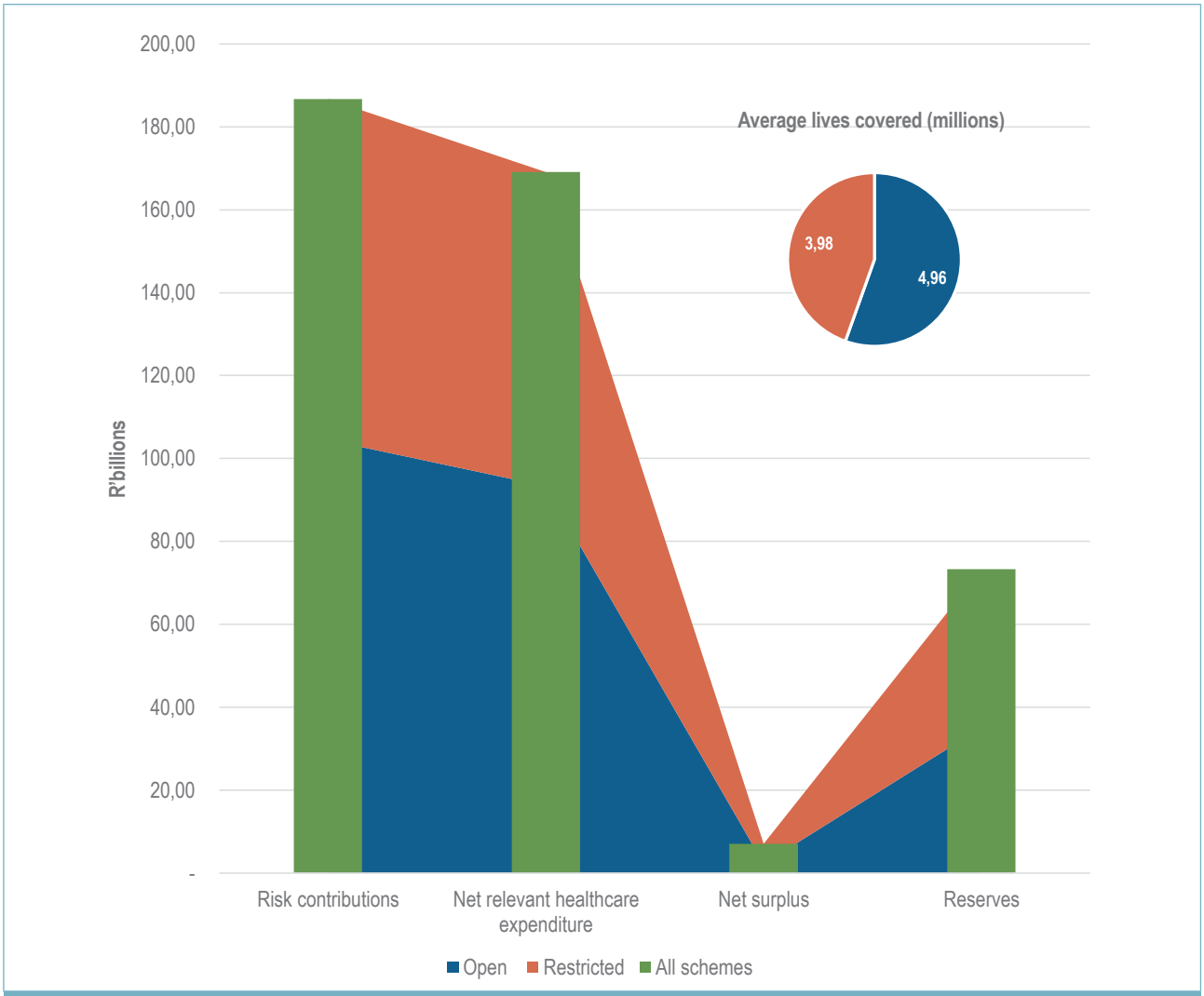


Figure 1: A snapshot of the industry – financial performance

Medical scheme membership remained stable during 2019.

In 2019, a total of R186.66 billion was collected in risk contributions from members (2018: R173.95 billion) and expenditure on relevant healthcare services was reported at R169.07 billion (2018: R156.94 billion).

On average, medical schemes incurred a similar claims experience compared with 2018. The claims ratio increased marginally from 2018's 90.23% to 2019's 90.58%, which resulted in a net healthcare result of R1.03 billion (2018: R1.21 billion).

Overview of activities during the 2019/20 reporting period

Figure 2 illustrates the reliance placed by medical schemes on investment income to maintain and grow their reserves.

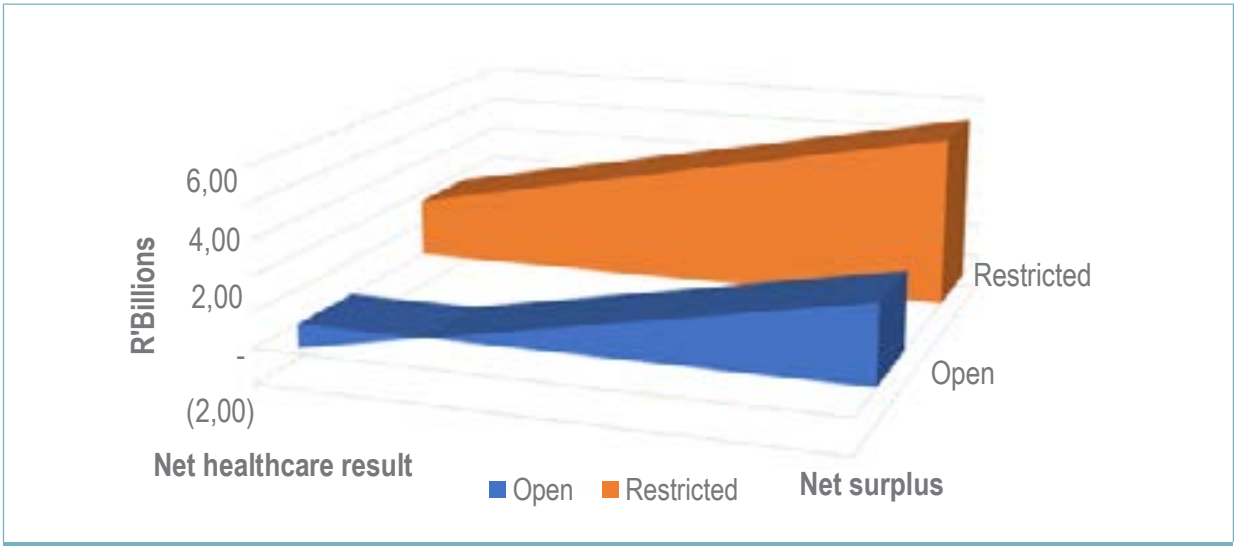


Figure 2: Reliance on investment income

Investment income grew substantially from 2018's low levels, ensuring a net surplus of R7.07 billion in 2019 (compared with 2018's R5.01 billion).The higher investment yields had a positive effect on the overall reserving of medical schemes – the Regulation 29 reserves increased by 10.37% and the solvency by 3.10% to 2019's R73.29 billion and 35.61% respectively.

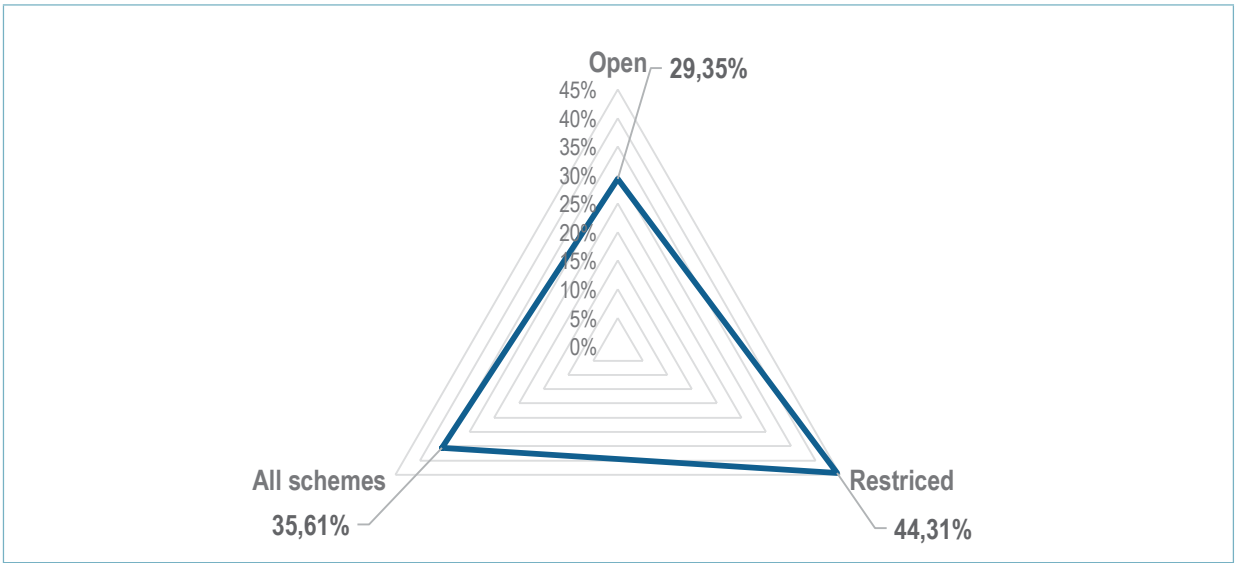


Figure 3: A snapshot of the industry – solvency

Overview of activities during the 2019/20 reporting period

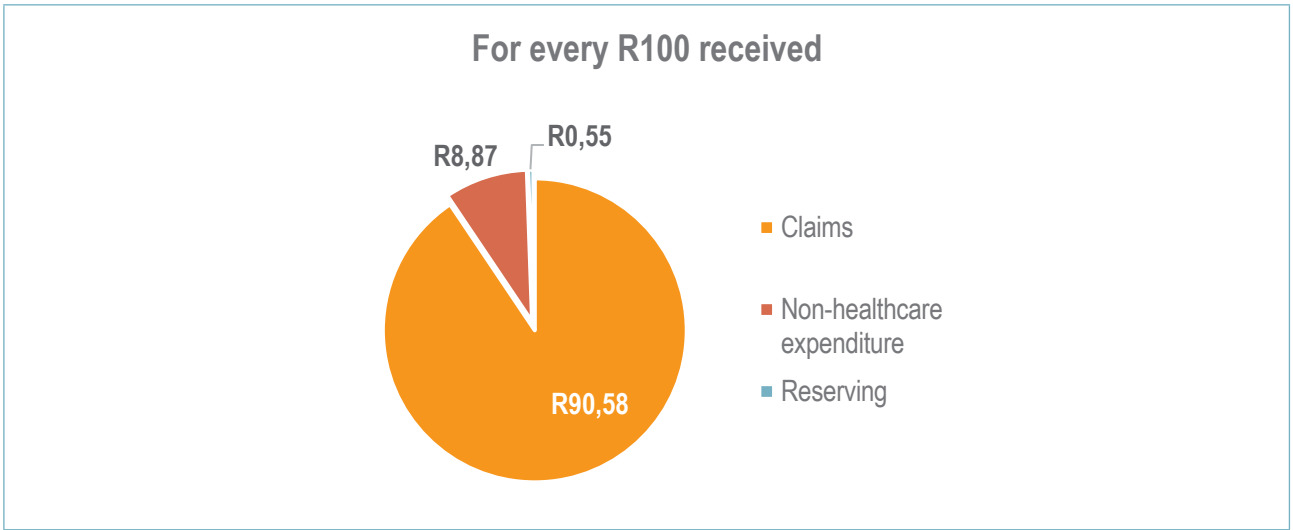


Figure 4: A snapshot of the industry – for every R100 received

Figure 4 illustrates that for every R100 received in 2019, R90.58 was spent on claims, R8.87 was spent on non-healthcare expenditure, and R0.55 was allocated towards reserving. Medical schemes generally price to break even on a net healthcare result level; this pricing objective was achieved in 2019.

Reserves of medical schemes in 2019

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

Figure 5 shows that the medical schemes industry is financially sound; the industry solvency of 35.61%, which exceeds the minimum required solvency level of 25%.

The open scheme industry's solvency level has been stable over the past decade; reaching a solvency level of 29.35% at the end of 2019.

The restricted industry's solvency level reached a peak in 2006 and declined from 2007 onwards, which is mostly due to the denominator used in the solvency calculation (gross contributions), which in turn is affected by membership growth. The Government Employees Medical Scheme (GEMS), which is the largest restricted scheme, has shown exceptional membership growth following its registration, which resulted in an overall deterioration in the solvency level of the restricted schemes industry. The restricted scheme solvency level subsequently improved between 2016 and 2019, largely due to the turnaround in the financial performance of GEMS, which reported an increase in solvency levels from 6.98% in 2016 to 31.53% in 2019. As such, the overall restricted scheme market reported an improved solvency of 44.31% in 2019 from 35.80% in 2016.

Overview of activities during the 2019/20 reporting period

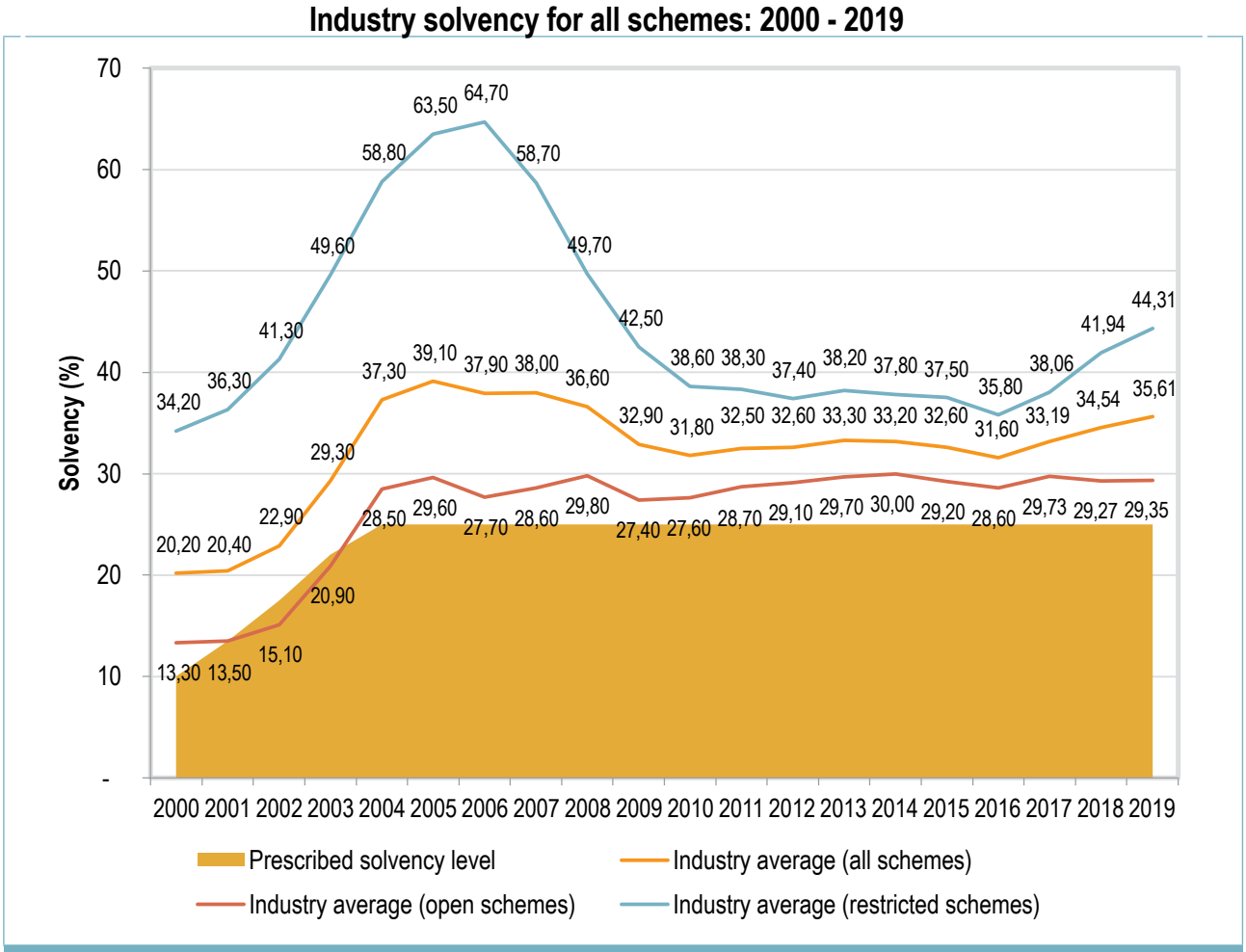


Figure 5: Industry solvency level for all medical schemes: 2000 – 2019

Schemes under close monitoring

Medical schemes that fall short of the statutory minimum solvency level of 25% are required to notify the CMS of the underlying causes of failure and corrective action to be undertaken. Such schemes are then closely monitored by the CMS. As at 31 December 2019, four medical schemes were below the minimum statutory solvency requirement of 25% (ICU schemes) – three open and one restricted scheme.

Open medical schemes experienced a marginal increase in solvency from 29.27% at the end of December 2018 to 29.35% at the end of December 2019. In total, of 4 936 896 beneficiaries in the open scheme market (4 969 621: December 2018), 15.94% (768 919) were in schemes not meeting the prescribed minimum solvency requirement (7.36%: 365 535 in December 2018).

The solvency ratio for all restricted schemes increased by 5.65%, from 41.94% as at 31 December 2018 to 44.31% as at 31 December 2019. The restricted scheme market had 4 016 180 beneficiaries (3 947 074: 31 December 2018) of which 0.86% (34 703) were in schemes not meeting the prescribed minimum solvency requirement (48.16%: 1 900 775 in December 2018). Other reasons for schemes being subjected to close monitoring could include governance-related concerns or the fact that the scheme has high non-healthcare expenditure levels.

Figure 5 depicts solvency trends for the last three years for schemes below 25%, as at 31 December of the relevant year.

Overview of activities during the 2019/20 reporting period

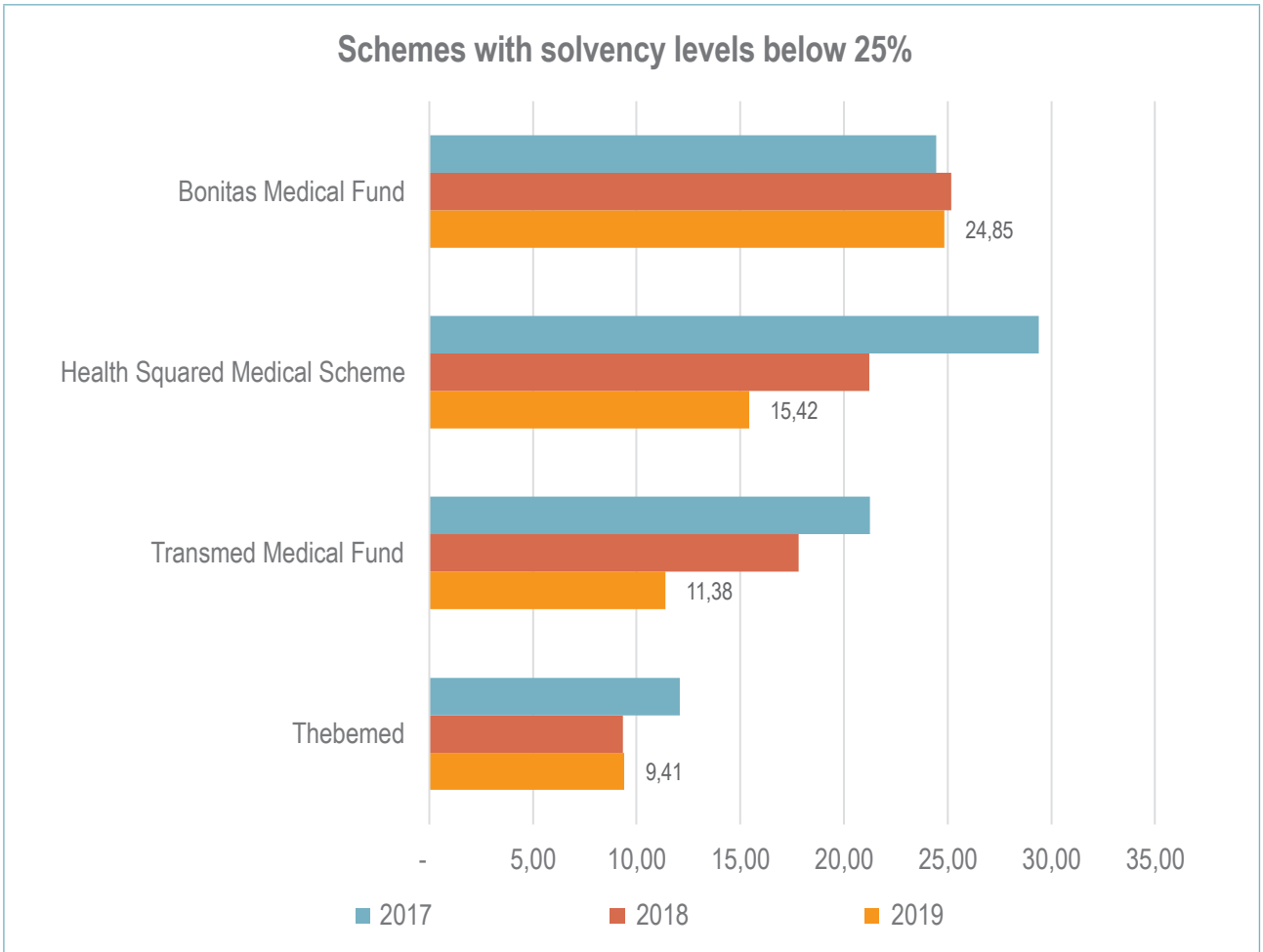


Figure 6: Schemes with solvency levels below 25%

Bonitas Medical Fund again fell below the required minimum solvency level in 2019 with a solvency level of 24.85% (compared to 2018's 25.16% and 2017's 24.46%).

Spectramed fell below the minimum statutory solvency level of 25% in 2018. The scheme amalgamated with Resolution Health Medical Scheme, effective 1 January 2019. The amalgamated entity is known as Health Squared Medical Scheme. The scheme reported a solvency level of 15.42%, a decrease from 21.23% in 2018. The CMS holds monitoring meetings with the board on a regular basis and the scheme submits monthly management accounts.

Thebemed's solvency ratio increased marginally from 9.34% in 2018 to 9.41% at the end of 2019. The scheme has a reinsurance contract in place to mitigate some of the risk of high claims costs. The scheme was placed under curatorship during the year.

Transmed Medical Fund (Transmed) reported a solvency ratio of 11.38%, a decrease from 17.81% in the previous year. This decrease is attributable to, among other things, a steady decline in membership coupled with a worsening demographic profile. A business plan was submitted by the scheme and approved by the CMS. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

Overview of activities during the 2019/20 reporting period

Interventions to strengthen financial supervision of medical schemes

During the 2018 financial year, the CMS carried out a non-healthcare expenditure review project. One of the key findings was that the cost structure across medical schemes is not directly comparable due to differences in the classification of what are deemed to be core administration and other administration services. The industry was engaged on the proposed classification of services, which culminated in the publication of Circular 77 of 2019. This circular standardised and outlined the required contracting and reporting of accredited administration services and other administration services, which will ensure a greater level of transparency and will allow for more efficient monitoring and comparability across the industry of the individual services contracted in the future.

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

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

Member contribution increases for 2020

The average gross contribution increase for all medical schemes in 2020 was 7.6%. On average, restricted schemes instituted a 6.9% increase in contributions, while open schemes increased contributions by 8.1%.

The gross contribution increase is based on the actual number of principal members, as well as adult and child dependents. Table 24 shows a summary based on medical scheme submissions on benefit changes and contribution increases for the 2020 calendar year.

Table 24: Average gross contribution increases for 2020

	Principal member %	Adult dependent %	Child dependent %	Family %
Restricted schemes	8.0%	1.6%	9.9%	6.9%
Open schemes	8.2%	8.0%	8.2%	8.1%
All schemes	8.1%	5.4%	9.0%	7.6%

Table 25: Average monthly gross contribution for 2020, as measured in Rands

	Principal member R	Adult dependent R	Child dependent R	Family R
Restricted schemes	2 691.85	2 068.97	997.62	4 574.10
Open schemes	2 898.04	2 467.30	918.17	4 487.78
All schemes	2 817.03	2 302.36	958.11	4 521.69

The average risk contribution increase for all medical schemes in 2020 was 7.6%. The comparative increase for open schemes was 8.0% and for restricted schemes 7.0%. The risk contribution is equal to the total contribution paid less the amount that is allocated to a savings account for a beneficiary.

Table 26: Average risk contribution increases for 2019/2020 benefit and contribution review period

	Principal member %	Adult dependent %	Child dependent %	Family %
Open schemes	8.1%	7.8%	8.0%	8.0%
Restricted schemes	8.1%	1.3%	10.1%	7.0%
All schemes	8.1%	5.1%	9.2%	7.6%

Overview of activities during the 2019/20 reporting period

Medical scheme contribution increases relative to consumer inflation

The contribution rate increases reflected in Figure 7 show that on average contribution rates across the industry, increased by 8.2% in 2019 and 7.6% in 2020. During the same period, the average consumer price index (CPI) for 2019 was 4.1%, as reported by Statistics South Africa, while according to National Treasury's Economic Outlook, CPI is projected to average 3.0% in 2020.

It is evident from the graph that the medical scheme contribution increase rate has consistently surpassed the CPI. The actual average contribution increase rate of 7.6% for 2020 is 4.6% higher than the projected average CPI of 3.0%. The difference between the medical scheme contribution rate increase and the average CPI increase has implications for the long-term affordability of the medical schemes industry, as increases in salaries may not keep pace with contribution increases.

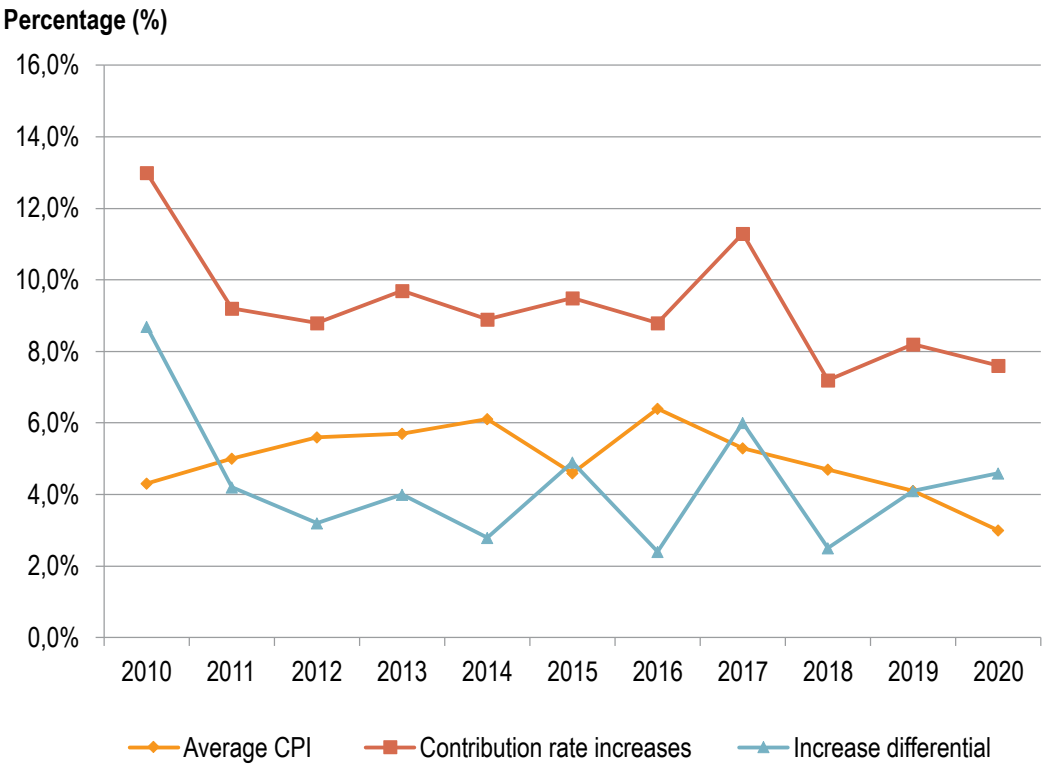


Figure 7: Medical scheme contribution increases and inflation: 2010 – 2020

Note: Average CPI: Average change in the Consumer Price Index year-on-year

Overview of activities during the 2019/20 reporting period

Medical schemes, benefit options and consolidation trends

In February 2020, the CMS published a list of all 76 registered medical schemes and their contact details in the Government Gazette, as required by Section 25 of the Medical Schemes Act. No new medical schemes were registered during the period under review.

Amalgamated schemes

During the period under review, there were two amalgamations of medical schemes. Fedhealth Medical Scheme merged with Topmed Medical Scheme with effect from 1 August 2019. Similarly, CompCare Wellness Medical Scheme merged with Selfmed Medical Scheme with effect from 1 September 2019.

Benefit options

The total number of registered benefit options decreased from 264 in March 2019 to 246 in March 2020. These options exclude the 69 efficiency-discounted options (EDOs) as at March 2020 that are part of the individual options registered. The number of EDOs increased from 65 as at March 2019 to 69 as at March 2020. Benefit options in open schemes decreased from 129 to 113 while restricted schemes' registered options decreased from 135 to 133.

Table 27: Registered benefit options as of March 2020

Classification of medical scheme	Open scheme options	Restricted scheme options	Total options
Options registered as at 31 March 2019	182	147	329
Less: efficiency-discounted options	-53	-12	-65
Options registered as at 31 March 2019 (excluding EDOs)	129	135	264
New options	6	0	6
Discontinued options	-12	0	-12
Discontinued options due to scheme mergers	-12	0	-12
Discontinued options due to scheme liquidations	0	0	0
Options registered as at 31 March 2020 (excluding EDOs)	113	133	246
Efficiency-discounted options*	57	12	69
Options registered as at 31 March 2020	170	145	315

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

Efficiency-discounted options (EDOs)

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

As at 31 March 2020, there were 15 (10 open and five restricted) schemes offering efficiency-discounted options. The schemes include Bestmed Medical Scheme, Bonitas Medical Fund, CompCare Wellness Medical Aid Scheme, Discovery Health Medical Scheme (DHMS), FedHealth Medical Scheme, Government Employees Medical Scheme (GEMS), Health Squared Medical Scheme, Medihelp, Momentum Medical Scheme, Moto Health Care, Old Mutual Staff Medical Aid Fund, Profmed, Sizwe Medical Fund, Thebemed and Umvuzo Health Medical Scheme. The percentage of members with EDO options, measured as a percentage of members with all options has increased marginally from 23.5% in 2018 to 25.8% in 2019.

Overview of activities during the 2019/20 reporting period

The net healthcare results show that EDOs continue to report positive results. The net healthcare result of the EDOs and non-EDOs is shown in Table 28. During the period under review, EDOs collectively contributed up to 27.9% of the total surplus, even though these options accounted for a mere 25.8% of the total membership.

Table 28: Net healthcare results of EDOs and non-EDOs: 2014 – 2019

Type of option	2014 R'000	2015 R'000	2016 R'000	2017 R'000	2018 R'000	2019 R'000
EDOs	501 850	587 271	630 314	1 054 804	983 335	1 772 484
Non-EDOs	147 681	341 593	-179 323	2 202 764	1 632 130	4 585 935
Total	649 531	928 864	450 991	3 257 568	2 615 465	6 358 442

One of the reasons for the better operating results of EDOs can be attributed to the fact that the average age of beneficiaries of EDOs is younger than the average age of the scheme. As at December 2019, the average age of EDOs beneficiaries was 32.1 compared to 34.8 for non-EDOs. Similarly, the claims ratio for EDOs was 81.9% compared to 90.8% for non-EDOs. Refer to Annexure U for detailed information on the EDOs.

Table 29: Schemes exempted from PMBs

Name of scheme	Benefit options
Building & Construction Industry Medical Scheme	Basic option
Fishing Industry Medical Scheme (Fishmed)	Primary Standard
Foodmed Medical Benefit Fund	Foodmed Medical Benefit Fund
Golden Arrows Employees Medical Benefit Fund	Advance Primary Standard
Moto Health Care	Custom option Essential option

Schemes exempted from the provisions of PMBs are Bargain Council's schemes and the exemptions are granted on the proviso that these benefits will be gradually incorporated into the benefits offerings overtime.

Overview of activities during the 2019/20 reporting period

Accreditation of medical scheme administrators & self-administered schemes

Table 30: Administrators and self-administered schemes accredited 2019/2020:

	Administrators and self-administered schemes accredited			
	New applications	Renewals	On-site evaluations completed	Conditions compliance on-site evaluations
Administrators	None	Discovery Health (Pty) Ltd		3Sixty Health (Pty) Ltd
		Liberty Health Administration (Pty) Ltd		Discovery Health (Pty) Ltd
		Medscheme Holdings (Pty) Ltd		
		Metropolitan Health Corporate (Pty) Ltd		
		Professional Provident Society Healthcare Administrators (Pty) Ltd		
Self-administered schemes	None	Foodmed Medical Benefit Fund	Medshield Medical Scheme	
		De Beers Benefit Society		
		Rand Water Medical Scheme		
		SAMWUMED		
		Sedmed		
		Witbank Coalfields Medical Aid Scheme		

Third-party administrators and self-administered schemes:

Five administrator accreditations and six self-administered scheme compliance certificate renewal applications were evaluated and finalised during the year. A full on-site evaluation was completed in respect of one self-administered medical scheme, and two conditions compliance follow-up on-site evaluations were conducted during the year. The Accreditation unit continued to monitor compliance by accredited entities with conditions imposed and with the audited financial statements of administrators annually to ensure their financial soundness.

The revised administrator accreditation standards (version 6) were published during the year, effective from 1 January 2020.

The unit, in consultation with the Financial Supervision unit, prepared and published a document to provide clarity regarding the suitable classification of bona fide accredited administration and other administration services. Both units continue to monitor compliance with the published circular and to give effect to the second phase of the implementation thereof.

Overview of activities during the 2019/20 reporting period

	Managed care organisations and self-administered schemes accredited:			
	New applications	Renewals	On-site evaluations completed	Conditions compliance on-site evaluations
Managed care organisations	Alignd (Pty) Ltd	Centre for Diabetes and Endocrinology (Pty) Ltd	Dental Information Systems (Pty) Ltd	Discovery Health (Pty) Ltd
	Integrated Clinical Managed Care Services (Pty) Ltd t/a Khula Clinical Care Services	Dental Information Systems (Pty) Ltd	Momentum Dental Risk Management (Pty) Ltd	
	Metropolitan Health Corporate (Pty) Ltd	Dental Risk Company (Pty) Ltd	Momentum Health Solutions (Pty) Ltd	
	Optimal Spinal Care (Pty) Ltd	Enablemed (Pty) Ltd	South African Oncology Consortium Limited	
	Professional Provider Organisation Services (Pty) Ltd	Halo Care (Pty) Ltd		
	Supplementary Health Services (Pty) Ltd	ISIMO Health (Pty) Ltd Knowledge Objects		
		Healthcare (Pty) Ltd		
		Knowledge Objects Solutions (Pty) Ltd		
		Medscheme Holdings (Pty) Ltd		
		Medical Services Organisation SA (Pty) Ltd*		
		Momentum Dental Risk Management (Pty) Ltd		
		Private Health Administrators (Pty) Ltd		
		Thebe Health Risk Management (Pty) Ltd		
		Universal Care (Pty) Ltd		
Self-administered schemes	Cape Medical Plan	Bestmed Medical Scheme		
	Selfmed Medical Scheme**			

* The organisation ceased to operate as a managed care organisation during the latter half of 2019 (subsequent to granting renewal of accreditation).
** The scheme merged with the CompCare Wellness Medical Scheme with effect from 1 July 2019 (subsequent to issuing the compliance certificate).

Overview of activities during the 2019/20 reporting period

Managed care organisations

Six new and 14 renewal managed care accreditation applications were evaluated and accredited during the year. Two new and one renewal self-administered scheme compliance certificate applications were evaluated and compliance certificates issued during the same period. Four full on-site evaluations and one condition compliance follow-up on-site evaluation were completed during the year.

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

The revised managed care accreditation standards (version 5) was published with effective date from 1 February 2020.

Table 31: Brokers and broker organisations

Individual brokers and broker organisations accredited: (New and Renewal)	
Total number of broker and broker organisation applications received	5 787
Total number of broker and broker organisation applications accredited within 30 working days of receipt of complete information	4 308
Percentage pf broker and broker organisation applications accredited within 30 working days of receipt of complete information	74.3%
Total number of accredited brokers and broker organisations as at 31 March 2020	8 276

Table 32: Brokers accreditation withdrawn

Broker numbers	Action	Effective date	Reason
Mr. CG Esprey (Br176)	Withdrawn	20/08/2018	Broker retired
Mr. R Greeff (1457)	Withdrawn	27/01/2020	Broker passed away
Mr. MR Neubert (Br2109)	Withdrawn	5/03/2020	Broker is the director for an accredited Administrator
Ms. MA Jansen van Vuuren (Br31952)	Withdrawn	16/05/2019	Broker no longer fit and proper to be accredited

Table 33: Brokerage accreditation withdrawn

Broker numbers	Action	Effective date	Reason
Direct Axis Financial Services (ORG3060)	Withdrawn	03/07/2019	Requested to be withdrawn

Overview of activities during the 2019/20 reporting period

Verification of academic qualifications

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

Exemptions granted to broker applicants

The Registrar approved exemption to 22 individual broker applicants from complying with Regulation 28B(2), for not complying with the qualification requirement for accreditation as a healthcare broker, in terms of Section 8 of the Medical Schemes Act, 131 of 1998.

Adjustments of broker fees

The Minister of Health announced an increase in the maximum amount payable to brokers by medical schemes in respect of broker clients who are members of medical schemes, in terms of Section 65 of the Medical Schemes Act. The amount was increased to R98.85 per member per month, with effect from 1 January 2020.

Online application portal for brokers and broker organisations

The Accreditation unit had implemented an advanced online application portal for brokers and broker organisations, effective 20 January 2020. The system is designed to allow all applicants to complete and submit broker applications for accreditation safely and securely.

Enforcing and encouraging compliance for a healthy industry

Routine monitoring of compliance

The CMS is permitted to conduct commissioned inspections into the affairs of medical schemes in terms of Section 44(4)(a) of the Medical Schemes Act and routine inspections in terms of Section 44(4)(b) of the Medical Schemes Act if the Registrar is of the opinion that an inspection will provide evidence of irregularity or non-compliance with the Act, respectively. Routine inspections are conducted to ensure that medical schemes comply with the provisions of the MS Act, registered scheme rules, internal policies and procedures and the overall fitness and propriety of the board of trustees (BoT).

During the year under review, the CMS conducted 13 routine inspections to monitor compliance with the MS Act. A risk-based approach was used to select schemes to be subjected to a routine inspection.

The following schemes were inspected for routine monitoring during the period under review:

1.	Barloworld Medical Scheme
2.	Capemed Medical Scheme
3.	Naspers Medical Scheme
4.	Retail Medical Scheme
5.	Umvuzo Medical Scheme
6.	Building & Construction Industry Medical Scheme
7.	CAMAF Medical Scheme
8.	Profmed Medical Scheme
9.	Anglo Medical Scheme
10.	Suremed Medical Scheme
11.	Medipos Medical Scheme
12.	Tiger Brands Medical Scheme
13.	Remedi Medical Scheme

The Registrar instituted six Commissioned Inspection during the period under review. The following entities were inspected:

1.	Bonitas Medical Scheme
2.	Medihelp Medical Scheme
3.	Keyhealth Medical Scheme
4.	Genesis Medical Scheme
5.	Optivest Health Solutions (brokerage)
6.	Medshield Medical Scheme

Proactive approach to monitoring conflict of interest

Towards the end of 2018/19 financial year, the CMS commenced with its project to vet members of the board of trustees and principal officers (POs) of medical schemes. In this regard, the CMS issued Circular 49 of 2019 wherein medical schemes were requested to furnish the office with their details and supporting documents to enable the CMS to conduct background checks. In addition, medical schemes were requested to provide the CMS with completed and signed vetting forms.

During the year under review, all completed and signed forms were vetted and where issues pertaining to conflict of interest were identified, the affected schemes were subjected to a Section 43 enquiry. The project is ongoing.

Curatorships

During the period under review, two medical schemes (Foodmed and Thebemed) were placed under curatorship.

Foodmed was placed under curatorship in July 2019 primarily because the board was not properly constituted in terms of the scheme rules.

Overview of activities during the 2019/20 reporting period

A new board was eventually constituted following a successful special general members' meeting convened by the curator on 26 October 2019 to elect a new board, which includes an independent governance specialist. The curatorship was duly lifted in February 2020.

Thebemed was placed under curatorship in August 2019 due to the continuing financial difficulties of the scheme and its persistent failure to maintain the minimum statutory solvency ratio of 25% as set out in Regulation 29(2) of the regulations of the Medical Schemes Act. The scheme remains under curatorship.

During the same period, the curatorship of SAMWUMED was lifted following the successful appointment of a new board. SAMWUMED was placed under curatorship in 2018 based on the fact that the board of trustees was not properly composed and constituted, which posed a serious risk in terms of proper corporate governance. This corporate governance risk stemmed from factional battles that befell the South African Municipal Workers' Union (SAMWU) and spilled over to governance of the medical scheme.

Demarcation regulations

On 23 December 2016, the Final Demarcation Regulations were published (effective 1 April 2017) to facilitate a clear demarcation between what constitutes insurance business and the business of a medical scheme in instance where there is ambiguity and uncertainty in legislative framework. The Demarcation Exemption Renewal Framework was prepared in consultation with the NDOH, National Treasury and the Financial Sector Conduct Authority (FSCA), and was approved by Council on 28 March 2019. The industry was informed that renewal applications would be due for submission by 29 March 2019.

During the period under review, renewal applications were evaluated based on information submitted, and concerns were identified relating to the healthcare benefits provided to policyholders and the high non-healthcare on products.

In this regard, Circulars 80 and 82 were issued in December 2019 which set out the findings of the renewal applications and concerns raised by the CMS regarding lack of proper benefits to policyholders.

The CMS received appeals from affected parties stating dissatisfaction with the circulars and the possibility that exemptions application will not be allowed post 31 March 2020 if the current products do not convert into the medical schemes' environment. The industry also enquired about engagements with the CMS to discuss the circulars.

Action post the renewal applications and Circulars 80 and 82

During January 2020, the CMS hosted various forums and workshops to address the renewal applications findings as highlighted in the two circulars.

- Workshop with insurers, financial service providers, medical schemes and administrators were held on:
  - 23 January 2020 in Johannesburg
  - 29 January 2020 in Cape Town
- A workshop with National Treasury, the Reserve Bank and the FSCA
- A meeting with the Minister of Health in February 2020

Two LCBO advisory committees established

To address the issues identified in Circulars 80 and 82, the CMS established two advisory task teams: one for the insurance stream, chaired by Ms Avril Jacobs, and the other for funders and administrators, chaired by Mr Michael Willie.
The purposes of the advisory committees are to:

- Address the challenges faced by different stakeholders concerning insurance products conducting the business of a medical scheme, which were granted exemption in terms of Section 8(h) from the provisions of Section 20 of the Medical Schemes Act
- Develop a road-map leading to the exemption expiry period of 31 March 2021
- Serve as a platform for engagement on the draft low-cost benefit option (LCBO) framework that the CMS developed

Development of a draft conversion guideline and LCBO framework

The CMS developed a draft conversion guideline that sets out the conversion process to be undertaken by insurers conducting the business of a medical scheme into the medical schemes' environment.

In addition, a draft LCBO guideline was also prepared that will deal with the application and exemption process to be followed by medical schemes intending to offer low-cost benefit options. These two documents will form a crucial part of the discussions to be undertaken by the two advisory committees.

Overview of activities during the 2019/20 reporting period

CISNA – solving the SADC student issue

The CMS is a member of the Committee of Insurance, Securities and Non-Banking Financial Authorities (CISNA), a sub-committee of SADC charged with the harmonisation of legislation of the various SADC member states in the sectors of insurance, finance and securities related laws. In the past few years, the CMS has been made aware of the difficulties faced by SADC students in meeting the requirement in the Immigration Regulation to provide proof of membership with a medical scheme registered in the Republic of South Africa when applying for a study visa. These include, inter alia, 12 months upfront payment of contributions and dual membership.

In collaboration with relevant (local and SADC) stakeholders, CMS developed a framework to allow for the recognition of appropriate medical scheme benefit options registered with member authorities within the SADC region, for the purpose of satisfying the requirement in the Immigration Regulation for obtaining a study visa. The project is ongoing.

Burden of disease and use of healthcare services in medical schemes

Healthcare utilisation annual statutory returns data collection system

Section 7(e) of the Medical Schemes Act depicts that one of the key functions of the Council is to collect and disseminate information about private healthcare, which includes utilisation of healthcare services. Through the Dynamic Data Driven Return (DDDR) system, which was implemented recently coupled with continuous improvement of utilisation statistics indicators and data specification guidelines, the CMS continues to see an improvement in the quality of healthcare data.

Analysis of scheme risk measurement returns

The CMS continued to collect scheme risk measurement (SRM) data to measure and report on the risk profiles of medical schemes and benefit options. This allows schemes to better understand the impact of age and chronic disease on the beneficiaries covered by medical schemes. Medical schemes are further categorised into risk categories measuring the degree of difference from the industry community rate (ICR) at both scheme and option level. Furthermore, measuring schemes' deviation from their expected community rate gives an indication of worsening or improving risk profiles over time. Individual scheme reports are shared with schemes and aggregated information is shared in the industry report.

There was a noticeable increase in the variation between schemes' risk profiles, evident by the increase in the risk rate measured from the ICR. Schemes with favourable risk profiles (young and healthy beneficiaries) recorded at rates of R498.67 below the ICR and schemes with unfavourable risk profiles recorded rates at over R1 200 above the ICR. The findings continue to depict that a large degree of variation in risk between medical schemes is directly attributable to the true differences in the risk profiles of individual medical schemes. The observed increase in the industry community rate is possibly a result of a change in the risk profile of medical schemes' beneficiaries.

Scheme-specific reports detailing the scheme community rate (SCR) by benefit option

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

Prevalence of chronic diseases in the medical schemes' population

The CMS continues to monitor the prevalence of chronic conditions in the medical schemes' population. Hypertension, hyperlipidaemia and diabetes mellitus type 2 are the most prevalent chronic conditions. These are also ranked highest in beneficiaries who are 60 years and older, as well as in the entire industry. Analysis of the PMB coverage for beneficiaries with chronic conditions revealed that 7.52% was admitted to hospital. Close to 21% of beneficiaries admitted to hospital received treatment for hypertension, 11.5% for coronary artery disease and 11.4% for diabetes mellitus 2. General prevalence, which is defined as beneficiaries having at least one claim for a chronic condition, rates over 1.8 times higher than the strict prevalence, set by the entry and verification criteria. Considering the current COVID-19 pandemic, all beneficiaries with underlying conditions are at higher risk for severe COVID-19 infection. This analysis has assessed the prevalence of conditions in the specific vulnerable sectors of the population, such as beneficiaries 60 years and over, beneficiaries with hypertension, diabetes, respiratory conditions, cardiac conditions and chronic renal disease, as indicated by the Ministry of Health.

Overview of activities during the 2019/20 reporting period

Policy research areas

Epidemiology and trends of caesarean section births among medical scheme beneficiaries, 2015 – 2018

The unit conducted a study that focused on assessing the epidemiology and trends in caesarean section births in the medical schemes' population. The objective was to evaluate trends in the utilisation and expenditure on caesarean deliveries in the population covered by medical schemes between 2015 and 2018. The study population included births of more than 100 000 over the review period, and the study revealed a significantly high frequency of C-section deliveries in the private sector compared to the public sector and developed countries.

The 2018 rate of caesarean deliveries of 76.9% in the population covered by medical schemes is among the highest in the world. Our analysis showed an annualised increase of 0.6% for caesarean deliveries, a trend that is expected to continue in the absence of appropriate interventions. As expected, maternal age was a risk factor for caesarean deliveries. Benefit design did not show a strong association with caesarean deliveries, though odds of a caesarean delivery were significantly low in comprehensive plans compared with hospital plans. The study showed that the average cost of caesarean deliveries (R37 596.19 ± R548.11) was at least 75% higher than that of normal deliveries (R21 545.37 ± R311.18).

The high frequency of caesarean deliveries in the private sector may be indicative of inefficient use of healthcare resources, supplier induced demand, lack of coordinated maternal care and poor choices by members of medical schemes. Caesarean deliveries attract higher healthcare costs for hospital, specialists, pharmaceuticals and other healthcare services compared with normal vaginal deliveries. Urgent steps must be taken to reduce what is likely to be high levels of medically unnecessary caesarean delivery rates in the medical schemes population. Future studies must investigate the health outcomes of associated with caesarean deliveries in the medical schemes' population. Factors for investigation may include, but not be limited to, gestational age at the time of caesarean delivery, post-delivery hospital admission of baby or mother, birth weight and maternal clinical co-morbidities.

Patient experience survey: beneficiaries living with diabetes

The Research & Monitoring (R&M) unit conducted a pilot patient reported experience measure (PREM) survey in the previous financial year. The purpose of PREMs is to assess whether the interpersonal interactions between patient and health professional result in treatment adherence and patient satisfaction. Internationally, PREM surveys have been found to be essential policy tools for policy responsiveness of health authorities that seek to strengthen the health system through engaging with user experiences.

A major finding in the survey was that out of the four dimensions that were measured for assessing how patients experience diabetes management programmes, one performed relatively poorer than others. Medical scheme beneficiaries living with diabetes reported relatively good experiences for: i) waiting times and access to services; ii) respect and inclusive decisions; and iii) management of diabetes. That said, the dimension of emotional and psychological support performed relatively worse than the other three. This outcome suggests medical schemes and managed care companies (MCOs) should invest in interventions that seek to address the impact of psychosocial self-efficacy in disease management programmes for beneficiaries living with diabetes.

The benefit of improving the psychosocial dimension of those registered on diabetes disease management programmes, is that by their nature, chronic conditions require self-management on a daily basis. If patients are activated through optimal education programmes, they will tend to be self-motivated to stick with treatment protocols. This approach to disease management programmes is called the patient empowerment approach. The practical policy implication of this finding is that patient empowerment as an approach to treating chronic conditions has better outcomes than the traditional purely clinical approach to treating chronic conditions. Regulatory interventions should enable the monitoring of experiences of patients with chronic conditions because patient activation leads to better self-management outcomes. Registration of disease management programmes should require ongoing monitoring of patient-centred disease management approaches. In fact, international research finds that non-effectiveness of networks in managed care is due to patients not being activated. The activation of consumers is central to demand management in healthcare markets that implement managed care.

Overview of activities during the 2019/20 reporting period

Provider distribution

The unit also conducted an analysis and distribution of general practitioners (GPs) relative to the geographic location of medical scheme beneficiaries' postal codes. The analysis found that the province with the highest utilisation levels was Gauteng, and the lowest utilisation was Northern Cape. The key supply and demand indicators behind the utilisation levels were:

- Gauteng had the highest number of GPs and medical schemes beneficiaries
- Northern Cape had the lowest number of GPs and medical schemes beneficiaries

Therefore, the utilisation of GP services at provincial level seems to be positively associated with beneficiary and GP numbers.

The analysis found that the province with the second lowest level of utilisation was North West, and the third lowest was Limpopo. The key supply and demand indicators behind the utilisation levels were:

- North West had the highest patient loads and the lowest density ratios
- Limpopo had the lowest patient loads and the highest density ratios

It would therefore seem that there are no direct positive associations between patient loads or density ratios with the utilisation of GP healthcare services.

Although these findings are meaningful, they are hardly useful for resolving allocation problems. For example, sparsely populated areas such as Northern Cape might be potentially under served areas. However, as has been observed, patient loads on their own do not seem to be positively associated with utilisation. Therefore, some other criteria will be required to resolve resource allocation problems. The other key findings of the study in respect of supply and demand underlying resource allocation indicators, which also included an analysis of district distribution of healthcare services, were that:

- There is a positive relationship between the number of GPs available and expenditure of GP healthcare services
- The number of covered beneficiaries has a positive association with patient loads, and a negative association with density ratios
- Some districts seem to be sparsely populated, with no signs of being under served areas. These districts show relatively low proportional shares of available GPs in a province, while having the lowest proportional share of covered medical schemes' beneficiaries. These districts show a high concentration of GPs, and thus yield low patient loads. These findings are meaningful for identifying potential gaps regarding supply and demand for GP health services, however, they do nothing to explain whether high patient loads (low coverage ratios) are signs of a district being an under served area. Furthermore, the associations drawn from the descriptive analysis do not explain a justified cause for suspecting inequality in the allocation of GP services, nor whether efficiency or productivity should support a re-allocation of healthcare resources.

Benefit option classification: standardisation and simplification

The Research & Monitoring (R&M) unit has been conducting research on the viability of standardising benefit options in order to make benefit option decisions easier for medical scheme beneficiaries. The research culminated in the publishing of Research Brief 4 of 2019. Over the current financial year, the unit was successful in publishing the work in the South African Health Review 2019.

The importance of this work is that it seeks to meet the Health Market Inquiry's (HMI) recommendation. The HMI recommendation is that the CMS should develop a framework for the standardisation of a supplementary benefit package (SBP). The rationale of the recommendation is that the HMI found members confused by a proliferation of benefit options in the medical schemes industry, which compounds impediments to the operation of market competition, ultimately leaving beneficiaries in the periphery of the private healthcare market. The R&M unit would like to conduct a market segmentation survey to collect additional variables that explain beneficiaries' choice preference when choosing a benefit option. This work should yield better benefit design clusters as a basis to engaging the industry on potential solutions to simplifying benefit option offerings.

The practical policy implication of this research is that medical schemes will have a standardised framework to make benefit option registrations (model rules framework). More importantly, beneficiaries with chronic conditions will be able to make informed and easier benefit option comparisons based on information being supplemented by performance or clinical quality information by benefit design. This is crucial as that experience shows that a large proportion of health utilisation is by those living with chronic conditions. Therefore, those most at risk will have the power to discipline the supply-side through simplified benefit option decisions.

Overview of activities during the 2019/20 reporting period

Risk-based capital solvency framework

On 24 June 2019, the CMS published an update on the review of the solvency framework (Circular 44 of 2019). Continued monitoring and reporting of results to individual schemes will be populated on a quarterly basis to assess impact. These reports will assess the impact through engagement with respective schemes.

Research publications

The unit also published a number research papers in both in peer-review and non-peer-review journals, which include South African Health Review (Optimising beneficiary choices: Standardisation of Medical Scheme Benefit Options), World Medical Journal (Identifying Training Needs for Health Care Organisations), Medical Health Review (On The Median Cost of a General Practitioner Visit: Medical Schemes Cross-Sectional Study 2017 – 2018) and the International Journal of Medical and Surgical Sciences (General Practitioner as A Gatekeeper and Scheme Benefit Design In South Africa).

National Health Insurance

Medical schemes risk pool consolidation

On 26 July 2019, the Minister of Health released the National Health Insurance (NHI) Bill, which was tabled in parliament in August 2019. Written submissions were called for between September and November 2019. The Portfolio Committee on Health held public hearings on the NHI Bill across different provinces.

The NHI policy states that progress towards universal health coverage requires transformation and reconfiguration of institutions for pooling of funds and purchasing of services within both public and private healthcare to achieve income and risk cross-subsidisation, while improving efficiency and effectiveness in purchasing of personal health services.

The NHI Bill and the Medical Schemes Amendment Bill further indicated that once the NHI Fund is fully implemented, medical schemes will not be allowed to provide duplicative cover, but will only offer complementary cover.

Considering these factors, the CMS initiated the following projects on risk pool consolidation:

- Standardisation of benefit options
- Review of secondary data including working papers, circulars and other published reports on NHI and low-cost benefit options
- Risk-based solvency framework
- Public sector consolidation forum

Presidential NHI war room and the health compact

The CMS continued to provide support to the Presidential NHI war room and the Presidential Health Compact activities. The purpose of the war room is to support the NHI implementation through coordination; communication; mobilising for adequate allocation of resources; and unblocking barriers where they may exist.

The Presidential Health Compact was finalised and signed by all social partners, including government and the President on 25 July 2019. The CMS has provided secretariat and coordination support on health compact activities, including coordination of Pillar 9 implementation of the action plan, while working closely with the Social Policy Advisor and the Department of Planning, Monitoring and Evaluation in the Presidency, to monitor and evaluate 324 interventions and detailed action plans consisting of 52 themes, 433 actions (including subactions) and 105 responsible stakeholders.

The Compact places the accountability on all stakeholders who are signatories to the Compact to meet the commitments made within the allocated time frame, and achieve the primary goal, which is to strengthen and improve universal access to health and healthcare in South Africa.

Health Sector Anti-Corruption Forum (HSACF)

On 1 October 2019, the President officiated the launch of the Health Sector Anti-Corruption Forum (HSACF) at the Union Buildings in Pretoria. The CMS is a member of the HSACF and the Forum is led by SIU. The Forum was established following the signing of the Presidential Health Compact which mandated government and social partners to work together to reform the healthcare system. As South Africa prepares to implement universal health coverage through the National Health Insurance Bill, proactive measures through the HSACF will serve as a deterrent to ensure appropriate standards of governance and accountability leading to the full roll-out of NHI.

This forum also appreciates that in the health sector, both public and private healthcare markets are vulnerable to fraud and corruption because of large and varied numbers of transactions on goods and services, including fraudulent orders, tender irregularities, fiscal dumping by government departments through non-governmental organisations, bribery, over-pricing, poor governance, transfer of liabilities to the state, and bogus and fraudulent qualifications.

Prescribed minimum benefits review

The unit was established as an offshoot of the Risk Equalisation Fund subunit about eight years ago with the pioneer staff

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consisting of a clinical analyst and a medical advisor/doctor. They were tasked with the provision of clinical opinions for the adjudication of complaints lodged with the office by members and beneficiaries of medical schemes.

The complaints requiring clinical opinions have over the years increased in volume and complexity, and are more contentious than ever. The complaints are around the interpretation of the prescribed minimum benefits, scheme rules as well as clinical protocols, guidelines and formularies used in funding decisions by medical schemes.

The unit has also undertaken the development and publication of the prescribed minimum benefit guidelines. These guidelines are aimed at prospectively clarifying members' PMB entitlements under the regulations using the best available clinical evidence, taking cost effectiveness and affordability into consideration. They are aimed at protecting scheme members and beneficiaries.

In the last two years the Clinical unit has undertaken a review of the prescribed minimum benefit package in conjunction with stakeholders. A comprehensive preventative and primary healthcare package has been developed for incorporation into PMB regulations.

Court rulings

The Legal Services unit was instrumental in implementing the mandate and protecting the regulatory powers of the CMS. The unit engaged in several key interventions, which included giving effect to the Registrar's decision to reject a rule by a scheme to change to that of its administrator, which would have incrementally disadvantaged members of schemes.

CMS//SAMWUMED

The Registrar successfully placed SAMWUMED under curatorship due to lack of adherence to corporate governance rules and policies. This also included infighting with the scheme, and as such, a legitimate board of trustees (BoT) could not be nominated. After months of rebuilding the rules and appointing a new BoT under the supervision of the Registrar, the scheme now has a new legitimate BoT and a PO who are steering the scheme to a stable future. The Registrar has since agreed to upliftment of the curatorship as a result.

CMS//THEBEMED

The Registrar successfully placed Thebemed under curatorship due to low solvency in the scheme. The appointed turnaround strategist is the curator, who is working with the CMS to restore the financial stability of the scheme and ensure that members of the scheme continue to access services.

CMS//FOODMED

The Registrar successfully placed Foodmed under curatorship as the term of the BoT expired because of the scheme's inability to hold an AGM. The Registrar acted to protect the scheme and its members. A BoT has since been appointed and the said curatorship has been lifted.

CMS//COMPCARE

The Registrar successfully rejected a rule amendment to change the name of the scheme to that of Universal (Administrator). This request was to ensure that the scheme shared the name with its administrator. The Registrar found that this arrangement would be misleading to the public and the amendment rejection would protect members.

Adjudication of complaints

DHMS trends

1. 24-hour emergency admission protocol

Based on adjudicated complaints, the CMS detected what seemed to be a growing trend in the processing and funding of PMB-related claims submitted by members of DHMS. The Complaints Adjudication unit noted that DHMS had a tendency to only approve the first 24 hours of an emergency admission as involuntary use of non-DSP (with full costs paid for claims incurred during those 24 hours), while the rest of the admission was classified as voluntary use of non-DSP (with claims partially paid).

The difficulty with this arrangement is that it left beneficiaries with high claim shortfalls as every healthcare provider attending to the beneficiary post the 24 hours would be short-paid, despite the reason for admission being acknowledged as an 'emergency medical condition'.

A number of rulings were issued against DHMS, directing the scheme to desist from this practice and directing full reimbursement in respect of all claims associated with such emergency admissions.

DHMS was also engaged through bilateral meetings and ultimately accepted that the protocol was incorrect, and undertakings were made that it would abide by the issued rulings. The office will continue to monitor incoming complaints to ensure that there is no recurrence.

2. Unclear communication of benefits and funding limitations

Another noted trend was in relation to false representation of non-PMB procedure co-payments.

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A number of DHMS complaints were received wherein beneficiaries were dissatisfied with the scheme's marketing of procedure co-payments as a form of shared liability with DHMS, whereas in reality, these were ostensibly used by DHMS to completely avoid liability. In these matters, we found that the scheme had standard co-payments in respect of certain endoscopic procedures that were priced above the actual procedure costs. Although DHMS had registered a rule that exonerated it from liability if the cost of service was equal to or less than the co-payment, the Registrar found that the scheme's communication of these benefits was ambiguous, and funding restrictions were unfairly hidden from beneficiaries. This resulted in beneficiaries unknowingly incurring more liability than they would have anticipated, in that they became liable for the entire procedure as the co-payments paid would exceed the amounts charged.

In M v DHMS, the complainant and his son underwent in-hospital gastroscopies, for which he was advised that there would be a specified co-payment for each of them, which he accepted. Following the two procedures, he learned that the entire hospital account was his responsibility due to the fact that the hospital account amounted to less than the co-payments. The complainant was therefore aggrieved by what he saw as a manipulated marketing strategy sold as a co-payment when in fact members were expected to pay in full, out of pocket.

Following investigation by the Complaints Adjudication unit, an unfairness in the practical implementation of the scheme rules and in the way the scheme communicated and marketed some of the procedure co-payments was found to be the case. While the relevant rule was registered and binding, it was not made clear to beneficiaries that should the cost of the procedure be equivalent to or less than the co-payment, the scheme will not pay anything towards that service unless a PMB diagnosis was made.

This was equivalent to no benefit at all and it was misleading to market these endoscopic procedures as covered benefits when they were not. Although the scheme had acted within its rules, its conduct was found to have been in bad faith by failing to disclose upfront that no funding will be made if the cost of the procedure was equal to or less than the co-payment charged. Beneficiaries were essentially being deceived into believing that they were co-paying a service.

The scheme was directed to revise all benefit brochures and preauthorisation communication to include clear and accurate outline of the extent of cover available to members whose procedures are subject to co-payments. The scheme was further directed to ensure that all benefits and preauthorisation correspondence contained clear and precise communication regarding the exclusions, particularly those involving deductibles / co-payments. The CMS' view remains that rules and restrictions which may result in adverse financial impact must be clearly and visibly communicated. DHMS eventually acknowledged this shortcoming and undertook to revise its benefits and preauthorisation communication accordingly.

3. Non-disclosure of the details of non-DSPs at the time of calling for authorisation

Another trend noted relates to instances where the details of DSPs or network providers are not disclosed to members at the time of calling for authorisation or receiving preauthorisation requests from members for planned procedures.

Some members who requested details of the of the doctors who had agreement with medical schemes were simply referred to the scheme's or administrator's website to navigate the information themselves or to call a different telephone number. We recommended to schemes that they must disclose the details upon request as they should be in possession of such information instead of requesting members to call different numbers or being directed to the website.

4. Termination of membership due to non-disclosure of health conditions and backdating termination to five or eight years of joining

Like most non-disclosure investigations, preauthorisation requests for hospital admission trigger investigation into whether the member disclosed in full medical conditions and treatments received within 12 months of date of applying for membership. Section 29(7) of the Medical Schemes Act 131 of 1998 allows medical schemes to request disclosure of medical conditions for which medical advice, diagnosis, care or treatment was received or recommended within the 12-month period ending on the date of making an application for membership. However, we have noted instances where medical schemes requested members to disclose and provide medical reports for conditions that fell outside the legislated 12-month period.

As a reason to justify terminated membership for non-disclosure of health conditions, medical schemes would rely on the contents of their application form which specifically stated "Have you ever experienced symptoms or received treatment, been diagnosed with…" and terminate membership of members who received treatment for conditions that were present outside the statutory time frame and not pre-existing. In such cases, it was clear that Section 29(7) was not being applied correctly as the legislature intended medical schemes to impose waiting period on all conditions for which diagnosis, medical advice, care

Overview of activities during the 2019/20 reporting period

or treatment was received or recommended within 12 months preceding the date of applying for membership.

5. Unreasonable delays in investigation non-disclosure material information

Medical schemes were cautioned to inform members of the investigation of possible non-disclosure of material information and to speed up the investigations, especially where the delays were not attributed to information awaited from healthcare providers or members. This is important in order to avoid any surprises once a decision to terminate membership has been made. The schemes' delay of non-disclosure investigations for high cost cases (NICU admissions) for unreasonable periods resulted in members incurring exorbitant amounts of debt. The delays were caused by the scheme's lack of urgency of these investigations.

In instances where members were informed of investigation of material non-disclosure and declined authorisation for medical intervention, members were not informed of the outcome of the investigation until they filed complaints with the Registrar's office. Members only learned after the investigation of complaints that there was no non-disclosure of material information found against them. This failure to communicate the outcome of investigation was tantamount to denial of funding insured benefits as members could not be treated while waiting for the investigation to be concluded.

6. Appointment of state hospitals as a designated service provider to treat PMBs

Genesis Medical Scheme appointed the state healthcare facilities as its designated service provide and has concluded a contract with Western Cape and Gauteng only, despite having members in other provinces. It is advisable that contracts are concluded with other members where the scheme has footprint to ensure consistency of funding for treatment for conditions listed under the PMBs.

7. Monetary limit imposed for funding treatment of PMBs

According to Genesis Medical Scheme, the funding of a specified lump sum for treatment of PMBs is based on its registered rules. The lump sum amount is then presented as a full and final settlement offer to the member, despite the Medical Schemes Act stipulating that funding for PMBs should be made at cost. This is despite numerous rulings issued against the scheme, including by the Supreme Court of Appeal.

When challenged for its blatant incorrect interpretation of the Act and the defiance of the SCA judgment, the scheme advises members and the Registrar's office that it does not provide treatment to its members and that the disputes that arise on complaints submitted in terms of Section 47(1) of the Act do not mean that members are prevented from obtaining treatment. This argument fails to appreciate that members need to be certain of the amount of funding that will be provided by their medical scheme, and the dispute certainly affects the commencement of treatment and/or funding ongoing treatment.

8. Poorly drafted letters of authorisation

Polmed's and GEMS' letters of authorisation contain a lot of irrelevant information not closely related to the procedure or reason requested for authorisation. To illustrate: authorisation for oncology benefits will include information about funding breast reduction. In other words, the important facts for the purposes of complaints investigation are clouded by irrelevant information in authorisation letters.

GEMS failed to provide members with adequate information at preauthorisation stage regarding skin lesion removal. GEMS would approve the procedure but fail to inform the member that there is a limitation on the number of lesions removed at a time, for example, that it authorizes 10 lesions at a time. A member would then have 70 lesions removed and the scheme would fund only 10 removed lesions. The Office of the Registrar ruled in favour of the complainants as the scheme failed to provide members with the full extent of cover, despite having knowledge of the number of lesions that were planned to be removed surgically.

9. Failure to disclose a Rand amount despite quotations with specified amounts sent to scheme

Another notable trend relates to quotations that are sent to medical schemes prior to members obtaining treatment for various medical conditions. Instead of providing the Rand amount that would be funded per code listed in the quotation, some medical schemes would only state the overall limit that would be funded for the specified procedure, and not the amount that would be funded for each code. This tended to happen with requests for dental procedures where medical schemes would ask for a quotation that discloses all codes upfront, but the subsequent letters of authorisation would contain technical information relating to approval. It appeared that medical schemes deliberately used technical language during pre-approval stage to escape full liabilities, with language that at times members found difficult to understand.

Medical schemes were advised to communicate better with members of the actual amount their medical schemes would fund, to enable members to make informed decisions before undergoing treatment.

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10. Incorrect advice by medical practitioners

Another concerning conduct relates to incorrect advice received by members from their medical providers. Deliberate and incorrect medical advice to members was noted, relating to the extent of funding by medical schemes for treatment of conditions listed as PMBs. Members have been left with huge medical bills that need to be paid from their pockets due to incorrect advice from medical practitioners who inform members that medical schemes are obliged to fund the costs of planned treatment in full, despite their being non-DSPs of those medical schemes. The members rely on the strength of information given to them and insist that their medical scheme is liable for the accounts. In certain instances, the conditions themselves are non-PMBs, but members are incorrectly informed that their conditions are PMBs. This practice amounts to abuse of trust by medical practitioners.

11. Interest charged on accounts due to late payment

Even where there was overwhelming evidence that medical schemes had delayed in settling accounts, some schemes resisted paying interest accumulated if the member had been handed over to debt collectors. The issue of interest levied on unpaid accounts was reviewed against the schemes' rules, which exclude payments of interest on accounts, but payment had to be made due to late payment by medical schemes.

12. Retrospective payment of PMBs

It is common cause that an ICD-10 code on its own does not validate PMB status of an account. It is also generally acceptable for medical schemes to structure PMBs in the form of a basket of care (BoC) considering its protocols and formularies. However, there is a tendency to short-fund even clear-cut PMB/emergency claims in the medical schemes industry across the board, which contradicts the provisions as prescribed by the Medical Schemes Act 131 of 1998.

Medical schemes and their administrators neglect to act in the best interests of members in taking the time to investigate internal complaints received, or to explain, when contacted for clarity by members or healthcare providers, which clinical records/letters of motivation are required for them to review and correctly fund the claims. They rarely go the extra mile to satisfy themselves that they have complied with their own PMB funding obligations in terms of the Act, and payment of the balance on the accounts was only triggered by complaints from the CMS.

Table 34: Complaints ratio per 1 000 beneficiaries

2017	2018	2019	% change (18/19)
4 667 (new complaints)	3 808 (new complaints)	2 829 (new complaints)	(34.60%)
0.53	0.43	0.32	(27.0%)

Table 35: Number of complaints received and resolved

	2018	2019
Complaints carried forward from the previous year	2 842	*1 902
Complaints received during the year	3 808	2 829
Total complaints	6 650	4 731
Total complaints resolved during the year	-4 758	(3 006)
Closing balance as at 31 December	1 892	1 725

* Previously the Age Analysis report used for complaints started counting the resolution days from the date of analysis of complaints but this has been changed to the date of receipt of responses from regulated entities. The changes in the reporting method resulted in the change in number of complaints that were carried over to the new financial year hence the 1 902 reflected above.

Table 36: Resolution turnaround times

Resolution turnaround times in days						
Complaints resolved in days	0 – 30	31 – 60	61 – 90	91 – 120	+ 120	Total
Total number of complaints resolved	901	534	322	309	940	3 006
% of complaints resolved	29.97%	17.76%	10.71%	10.28%	31.27%	100%

Overview of activities during the 2019/20 reporting period

Table 37: Number of complaints resolved by category

Main category	Number of complaints resolved
Administrative	1 839
Clinical	749
Legal/compliance	246
Sub-total	2 834
Inquiries/Unjustifiable complaints	172
Total	3 006

Table 38: Rulings on resolved complaints per regulated entities in 2019

Entity Type	Number of complaints	Ruled in favour of complainant	Ruled in favour of regulated entity	Ruled in favour of both	Inquiries/ Unjustifiable complaints
Open medical schemes	1 898	826	789	168	115
Restricted medical schemes	1 077	566	355	100	56
Administrators	25	5	14	5	1
Managed healthcare organisation	6	1	3	2	—
Total	3 006	1 398	1 161	275	172

Table 39: Availability of internal dispute resolution mechanism for top 10 open medical schemes with most complaints

Name of medical scheme	2018 complaints per 1000 beneficiaries	2019 complaints per 1000 beneficiaries	Dispute Resolution committee	Number of matters served before the Dispute Resolution committee
Health Squared Medical Scheme	2.8	2.1	Yes	—
Genesis Medical Scheme	1.8	1.3	Yes	1
Fedhealth Medical Scheme	1.4	1.2	No	—
Medihelp	0.9	0.8	Yes	—
Hosmed Medical Aid Scheme	1.0	0.8	Yes	2
Medshield Medical Scheme	0.8	0.7	Yes	113
Keyhealth	0.7	0.5	Yes	2
Bestmed Medical Scheme	0.5	0.4	Yes	—
*Selfmed Medical Aid	1.2	0.4	—	—
Bonitas Medical Fund	0.5	0.4	No	—

* Selfmed merged with Compcare Medical Scheme with effect from 1 September 2019 therefore the data was for the period from 01 January 2019 until the date of merger.

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Table 40: Availability of internal dispute resolution mechanism for top 10 restricted medical schemes with most complaints

Name of medical scheme	2018 complaints per 1000 beneficiaries	2019 complaints per 1000 beneficiaries	Dispute Resolution committee	Number of matters served before the Dispute Resolution committee
Grintek Electronics Medical Aid Scheme	0.9	0.9	No	-
Old Mutual Staff Medical Aid Fund	0.3	0.5	No	-
TFG Medical Aid Scheme	0.2	0.4	Yes	-
AECI Medical Aid Society	0.2	0.4	Yes	-
Nedgroup Medical Aid Scheme	0.4	0.3	No	-
Golden Arrows Employees' Medical Benefit Fund	0.5	0.3	Yes	-
Motohealth Care	0.3	0.3	Yes	-
Bankmed	0.4	0.3	No	-
Profmed	0.5	0.3	Yes	-
PG Group Medical Scheme	–	0.3	Yes	-

Promoting a healthy industry through stakeholder engagement

The Stakeholder Relations unit approached stakeholder management with vigour in the past reporting year. In supporting the trajectory of the CMS as a regulator who is responsive and consultative, a number of ad hoc strategic projects were undertaken by the unit, in addition to its communications, education and training, and customer care activities.

Stakeholder Engagement

Section 59 Investigation

When the CMS caught wind of public allegations of medical schemes and administrators making use of Section 59 of the Medical Schemes Act (131 of 1998) to target Black and Indian health practitioners to run them out of business, a multi-disciplinary steering committee was swiftly constituted.

The steering committee recommended the establishment of an independent investigation to conduct an enquiry into the allegations. An investigation panel constituted by three advocates was appointed to investigate the complaints and make recommendations on the appropriate administrative, legal or policy interventions required.

Led by Advocates Tembeka Ngcukaitobi, Kelly Williams and Adila Hassim, the Section 59 Investigation held five hearing sessions over 22 days. The investigation was live streamed on social media platforms and on the inquiry's website, www.cmsinvestigation.org.za. This website, run by the unit, is also a repository of information for the terms of reference, transcriptions and related documents.

The preliminary and final report by the panel is due to be released in the 2020/21 financial year.

Fraud, waste and abuse

The CMS has, since 2019, hosted a Fraud, Waste and Abuse (FWA) Summit, which aims to deal with fraud, waste and abuse for industry sustainability.

1. FWA Charter

The FWA Charter attains industry commitment with all stakeholders pledging to contribute to combating fraud, waste and abuse, in line with set standards. The charter was signed at the inaugural summit in 2019 and will be reviewed every two years.

2. Codes of Good Practice (including arbitration process and resolution tribunal)

The FWA Summit planned for 2020 was planned to set the scene for the adoption of codes of good practice for industry, while unpacking a framework on a resolution tribunal aimed at protecting and empowering members. Due to the outbreak of COVID-19 and the subsequent lockdown, the 2020 summit did not take place. Work on the industry codes of good practice and the resolution tribunal is continuing in earnest.

3. Fraud, waste and abuse structure

The 2021 summit will start the work of establishing this as a

Overview of activities during the 2019/20 reporting period

permanent structure to continuously deal with FWA in the industry.

The FWA Summit's mandate and progress are constantly updated on the summit's website www.fwasummit.co.za, run by the unit. The summit's steering committee is comprised of key stakeholders and meets regularly.

Low-cost benefit options

The CMS issued Circulars 80 and 82 of 2019 to the medical schemes industry in December 2019, announcing its plans for low-cost benefit options (LCBOs) and the demarcation exemption framework, going forward.

These circulars were published as concerns were highlighted during the analysis and review of renewal exemption applications, submitted by insurers conducting the business of a medical scheme. The CMS could not perpetually regulate by exemption.

In January and February 2020, the CMS held several engagements on the report findings and the two circulars in Cape Town and Pretoria with key stakeholders including the Minister of Health, National Treasury, the FSCA, Prudential Authority (PA), medical schemes, administrators, managed care organisations, insurers, brokers and related service providers.

These discussions paved the way for the establishment of advisory committees grouped into two streams for insurance, and administrator and funders. These streams would be tasked with addressing the challenges faced by primary health insurance providers in complying with the Medical Schemes Act, and with the need by medical schemes to develop options for low-income earners. They would also develop a road-map leading to the end of March 2021.

Enhancing visibility and protecting the reputation of the CMS

The unit's activities inclusive of 84 industry circulars and 11 press releases have resulted in a total advertising value equivalent (AVE) of over R63 million for print, R35 million for broadcast and R82 million for online media. The CMS' sentiment movement increased from 89.7% to 95% in the 2019/20 financial year, signalling that the majority of media coverage was positive (92%) and neutral (3,1%).

In its quest to drive the CMS' mandate through enhanced information sharing, simpler complaints lodging, and appeals tracking, the unit undertook a project to redesign the CMS website to a faster, easier and more responsive portal. The website will be launched in the new financial year.

Education and Training

Education and Training conducted a total of 50 education and awareness sessions to medical scheme members and beneficiaries. The subunit also featured in a radio station in the Western Cape with an estimated listenership of 76 000 covering Paarl Valley, Wellington and surrounding areas of the Cape Metro.

Consumer education

The 50 sessions for consumers were conducted in seven provinces. Members in those provinces were educated in the predominant languages of the provinces, with information booklets provided in the relevant official languages.

A total of 16 908 consumers were reached, 3 656 of whom were from rural areas in Limpopo, North West, Mpumalanga, Eastern Cape and KwaZulu-Natal.

Broker training

Education and Training trained 100 brokers in Gauteng, KwaZulu-Natal and Cape Town. The broker training programme awarded the delegates 6.0 CPD hours as required for the health services benefits class of business by the FSCA's Board Notice 194.

Induction Trustee Training

During the year under review, 48 members of boards of trustees enrolled for the induction trustee training offered in Cape Town and Gauteng. The training enrolled 20 schemes in total, and was used as a prerequisite for the trustee development programme offered in partnership with the Gordon Institute of Business Science (GIBS).

Trustee development programme

The highlight of the year was the introduction of the trustee development programme in partnership with GIBS. The programme is pitched at an NQF level 8 level of complexity. A total of 48 representatives of the following medical schemes completed the training: Bonitas Medical Fund, Discovery Health Medical Scheme, GEMS, Massmart Health Plan, Nedbank Limited Medical Scheme, POLMED, Remedi Medical Aid Scheme, SAMWUMED, Sisonke Health Medical Scheme, Sizwe Medical Fund, Umvuzo Health Medical Scheme, and Witbank Coalfield Medical Aid Scheme.

Customer care

The CMS continued to service its stakeholders through the customer care centre frontline offering advice and guidance. A total of 39 556 calls were received, 35 906 (90.77%) of these calls were handled, and 3650 (9.22%) were dropped by callers due to high call volumes.

The unit's 2019/20 customer care centre trends included: late joiner penalties; waiting periods; prescribed minimum benefits (PMBs); designated service providers (DSPs); medical savings accounts (MSAs); formularies and protocols.

Part G

The Medical Schemes Industry in 2019

The Medical Schemes Industry Overview in 2019

Number of schemes and benefit options

The downward trend in the total number of registered medical schemes over the past years continued in 2019, when the number decreased due to a merger between Resolution Health Medical Scheme and Spectramed to form Health Squared Medical Scheme. Figure 8 shows that the number of medical schemes reduced from 144 in 2000 to 78 in 2019, and indicates that the highest decline was between 2008 and 2010. The trend in the consolidation of medical schemes is mainly driven by liquidations and voluntary amalgamations. In 2019, the number was 78, consisting of 20 open schemes and 58 restricted schemes.

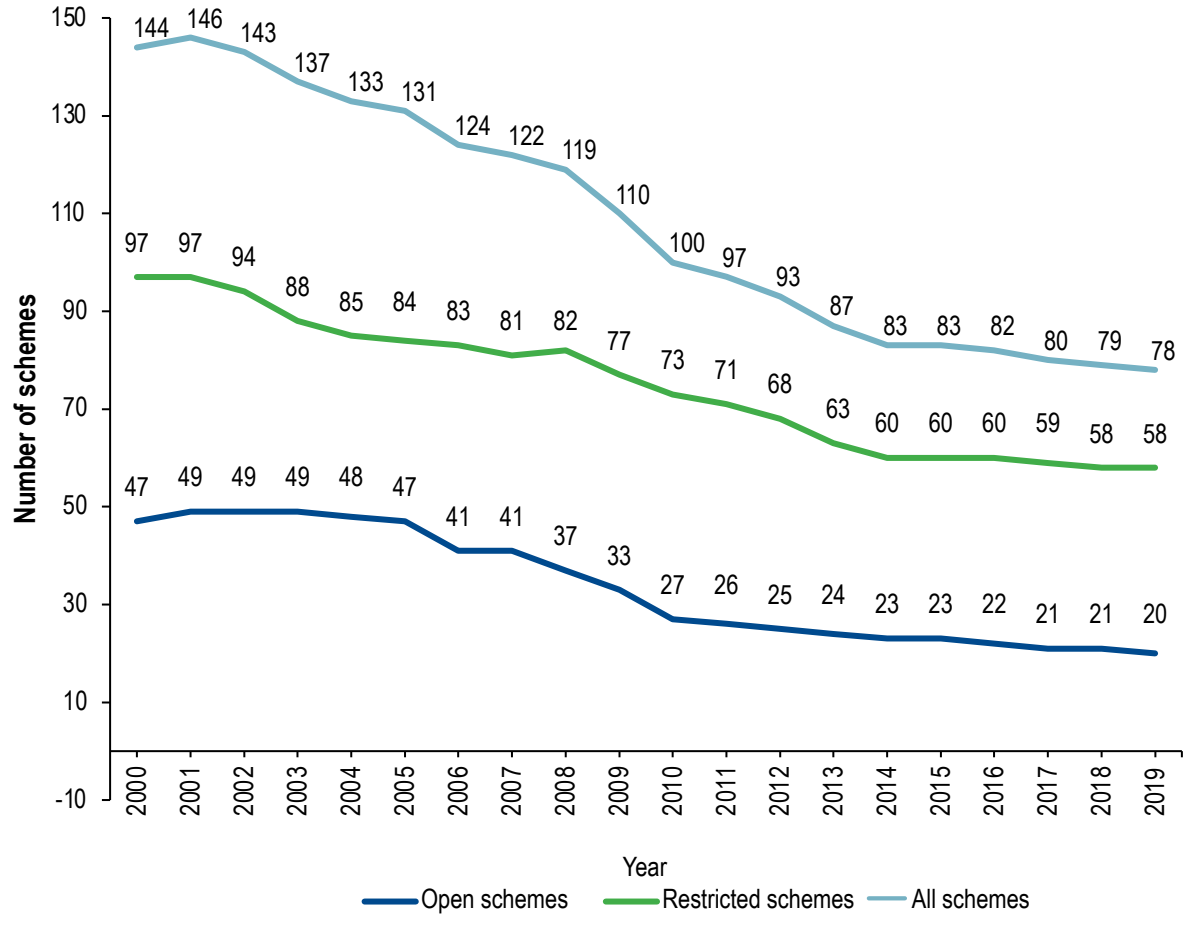

Figure 8: Number of schemes 2000-2019

The Medical Schemes Industry Overview in 2019

Figure 9 shows the trends in the distribution of medical schemes in the industry by size from 2002 to 2019, with small schemes outnumbering large and medium schemes from 2002 to 2013. In general, the industry experienced a decrease in the number of medical schemes, with small schemes contributing significantly to this deterioration. Small schemes remained stable between 2014 and 2019. In 2019, the number of small schemes remained unchanged while schemes classified as medium declined and large schemes increased.

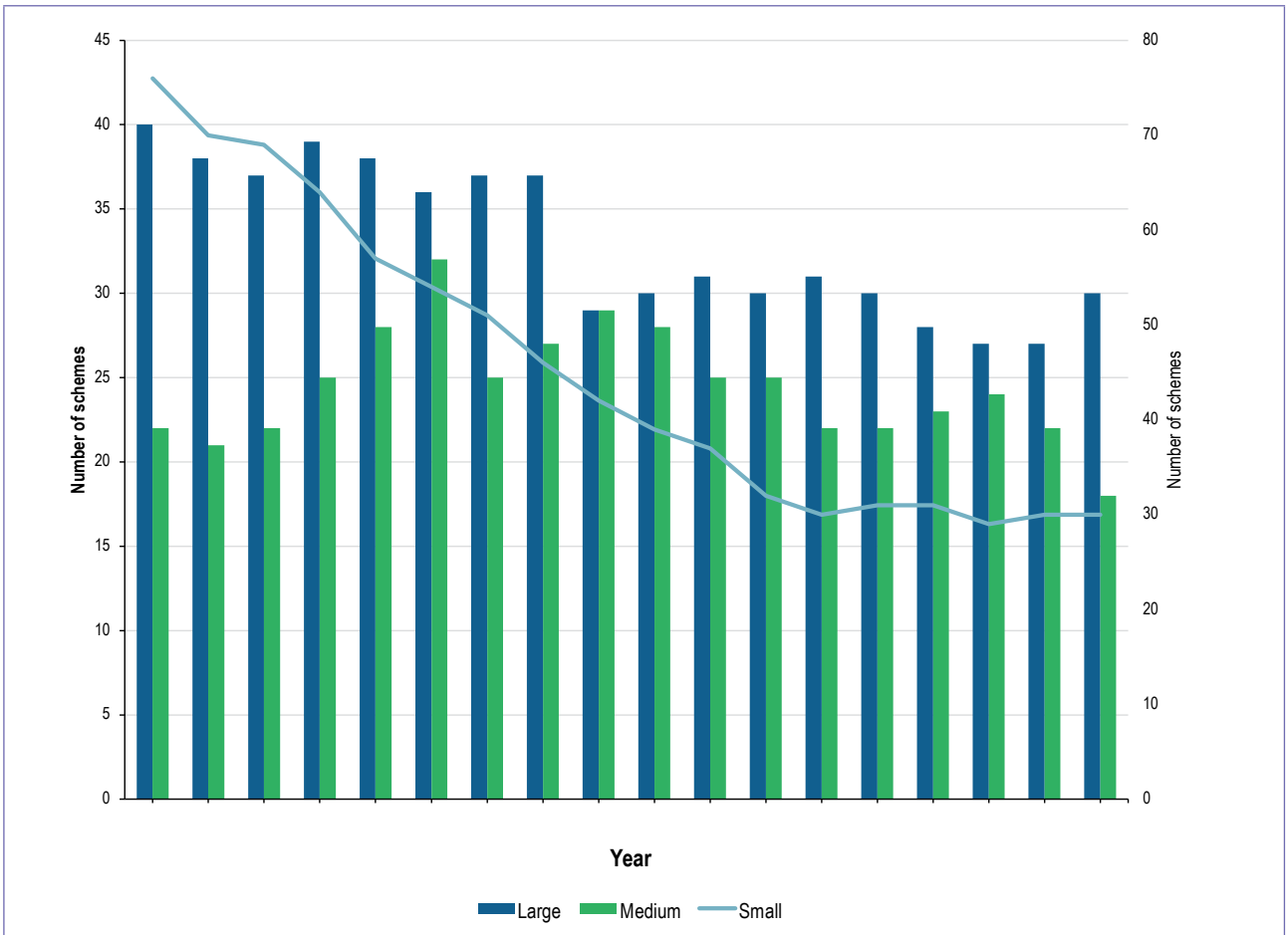

Figure 9: Number of schemes by size 2002-2019

The Medical Schemes Industry Overview in 2019

Figure 10 illustrates the trends from 2002 to 2019 in the number of schemes restricted by size, with the decrease in the number of small schemes showing similar trends to the industry. Small schemes had a significant drop in numbers in 2003 and 2007. The gap between medium and large schemes was large between 2004 and 2007, while the number of medium schemes remained higher than large schemes. The gap was again observed between 2009 and 2011, followed by little variation in the number of schemes from 2012 to 2018. In 2019 the number of large schemes increased and the number of medium schemes declined.

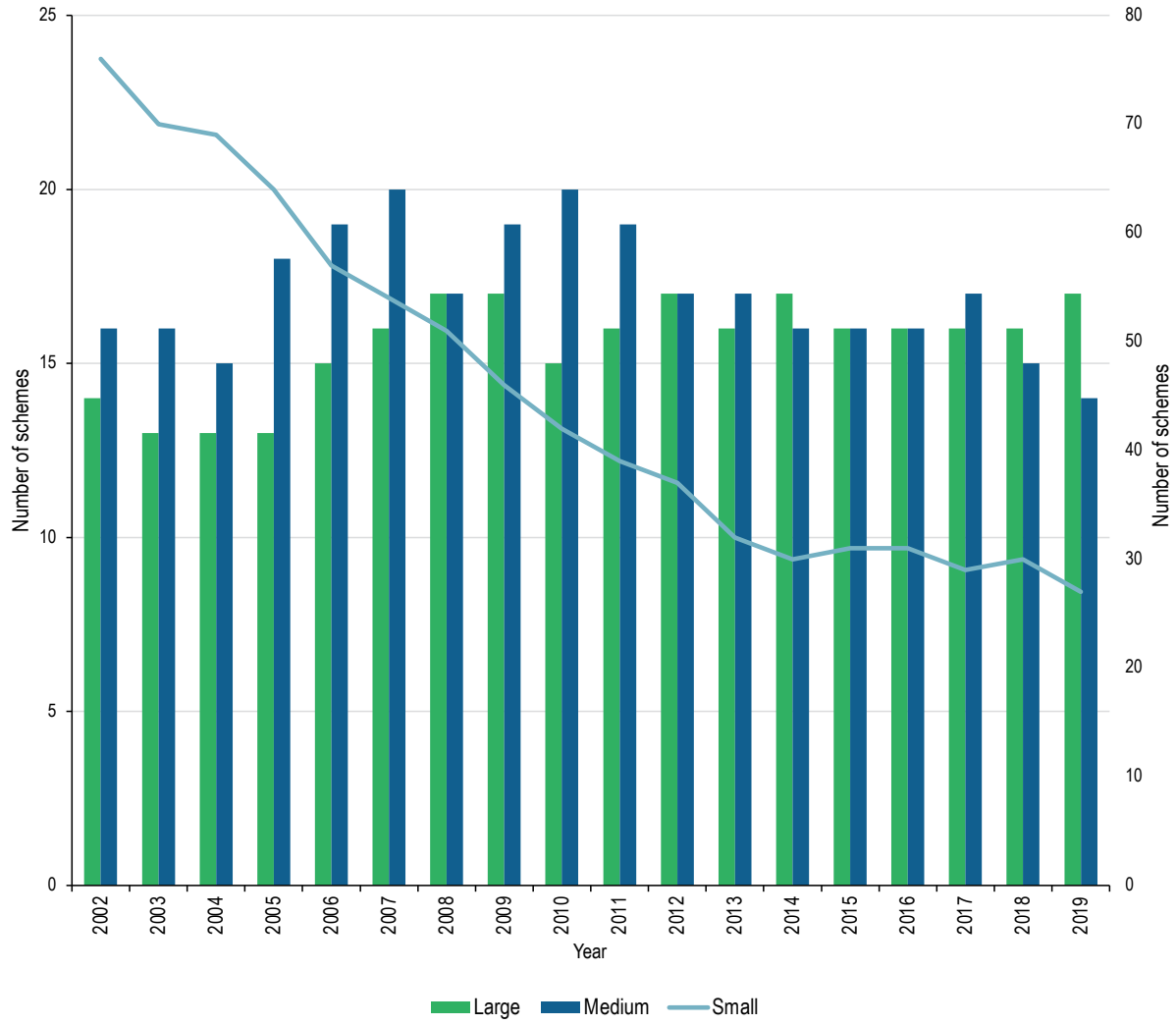

Figure 10: Number of restricted schemes by size 2002-2019

The Medical Schemes Industry Overview in 2019

Figure 11 illustrates the contribution of open schemes in the consolidation of medical schemes by size between 2002 and 2019. Among open schemes, large schemes outnumbered both small and medium schemes for the entire period. There is an upward trend in medium schemes from 2005 to 2007 and a downward trend in large schemes in the same period. In 2019, large schemes increased, while small and medium schemes remained unchanged.

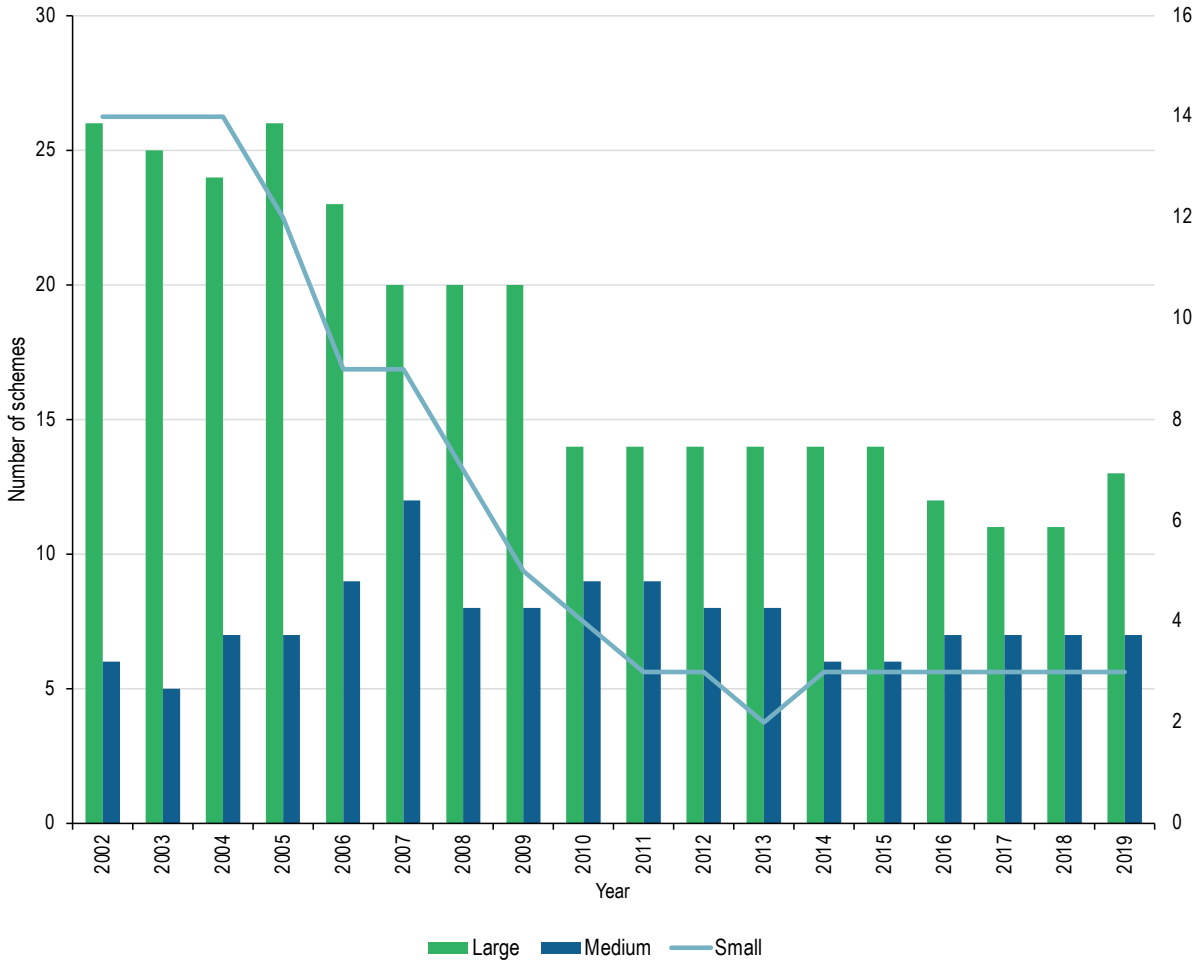

Figure 11: Number of open schemes by size 2002-2019

The Medical Schemes Industry Overview in 2019

Figure 12 depicts the average number of benefit options per scheme from 2002 to 2019. In 2019, open schemes had an average of 6.45 options per scheme as compared with 2.34 options in restriction schemes. The average number of benefit options declined slightly with a margin of 0.03. The number of benefit options available in open schemes has remained consistently above the industry average, while those in restricted schemes have remained below average.

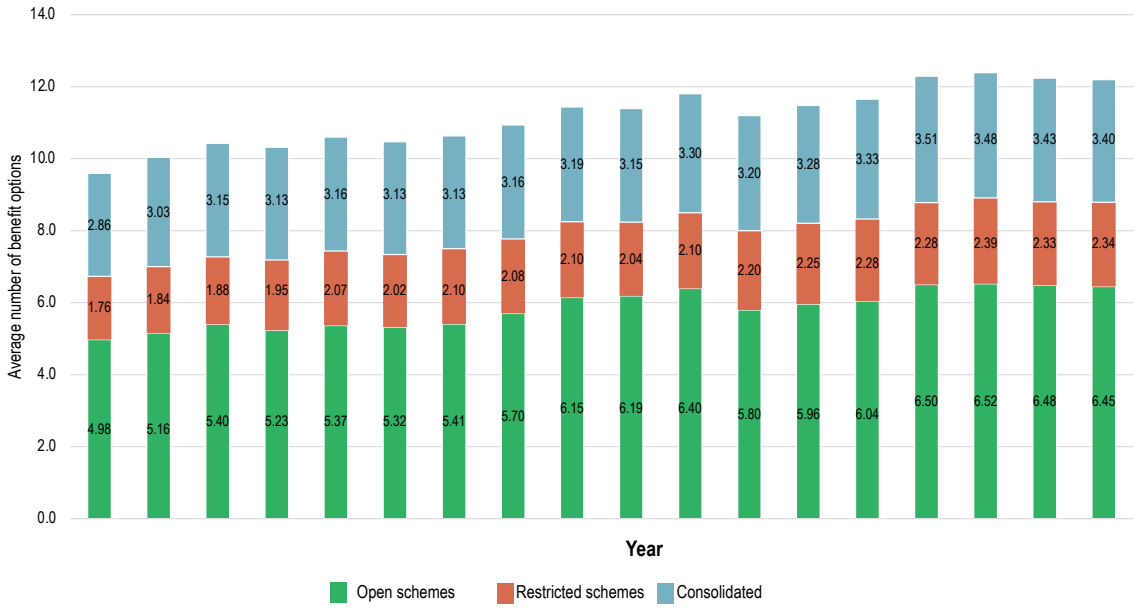

Figure 12: Average number of benefit options 2002-2019

The Medical Schemes Industry Overview in 2019

Demographic information

The number of beneficiaries covered by medical schemes has remained stagnant in the past decade. The proportion of beneficiaries covered by medical schemes expressed as a proportion of the population in the country, declined during the period under review from 16.5% in 2000 to 15.08% in 2019. Restricted schemes grew by 64 172 beneficiaries and open schemes added only 9 293 beneficiaries between 2018 and 2019. This represents an insignificant 0.82% in the year-on-year increase in the absolute number of beneficiaries covered by medical schemes. The largest number of beneficiaries is covered by open medical schemes (55.38% in 2019). The year-on-year increase in beneficiaries was attributed to the significant growth of Sisonke Health (73.57%), Compcare Wellness (65.21%), Thebemed (23.55%), LA-Health (11.21%), and Umvuzo Health (19.56%). Government Employees Medical Scheme (GEMS) contributed significantly with the highest increase of 53 102 beneficiaries, with less than 5% year-on-year growth (2.89%).

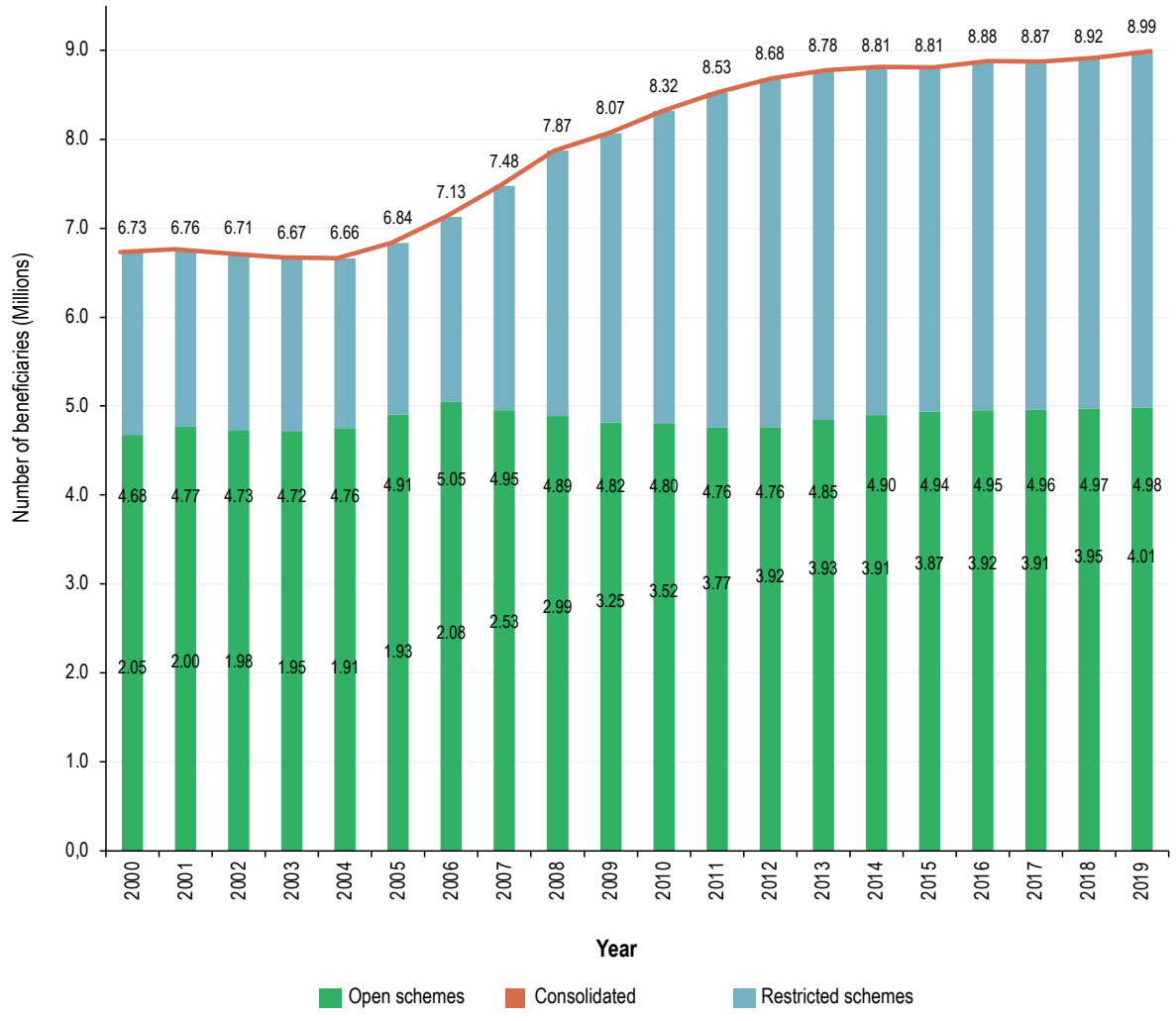

Figure 13: Number of beneficiaries 2000-2019

The Medical Schemes Industry Overview in 2019

Figure 14 illustrates the number of beneficiaries as disaggregated by principal member and dependants. Restricted schemes covered more dependents per principal member compared with open schemes. The number of principal members grew at a faster rate compared with dependant beneficiaries, 1.1% versus 0.6% between 2018 and 2019.

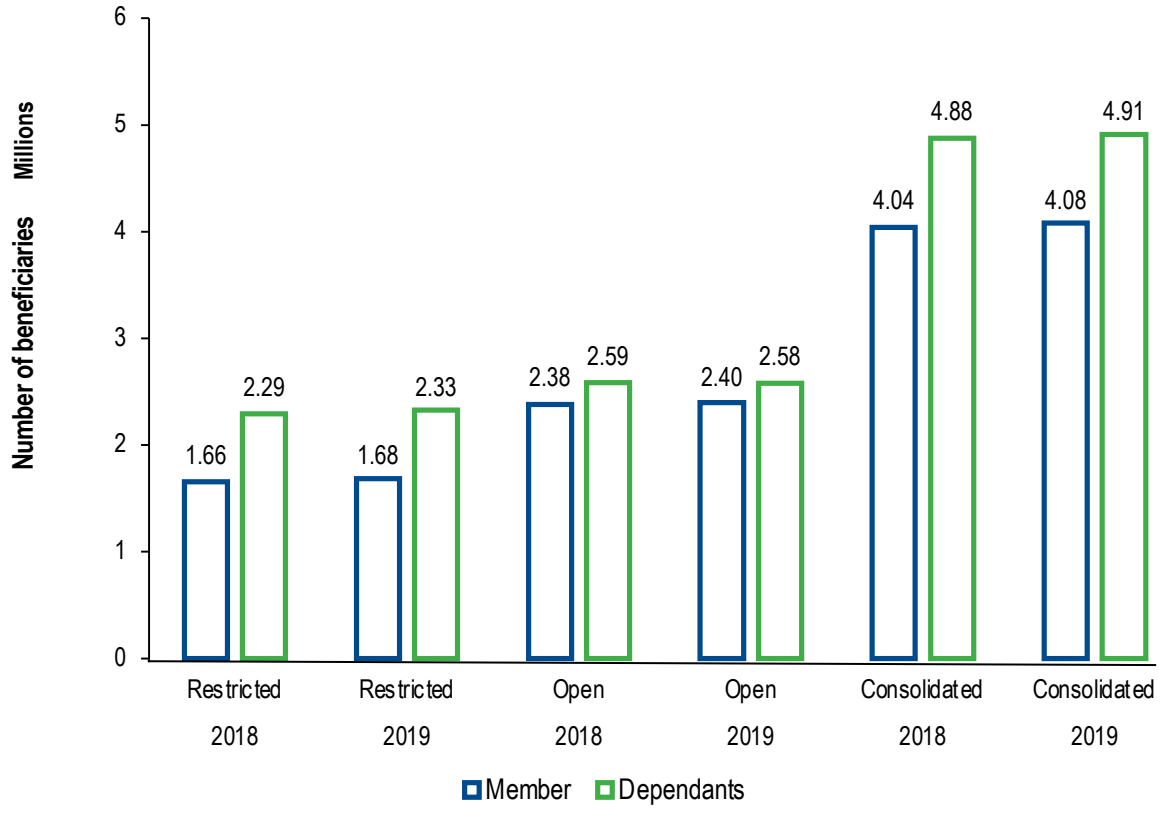

Figure 14: Number of beneficiaries by type

The Medical Schemes Industry Overview in 2019

Figure 15 shows year-on-year growth in the number of beneficiaries between 2008 and 2019. The medical scheme industry experienced positive growth in the number of members and dependents from 2008 to 2013. In 2008, the proportion of beneficiaries increased significantly compared with other years. The negative growth was more pronounced between 2014 and 2017, with a significant decline of 0.71% in 2015. In 2019, both the number of dependants and members increased slightly by 1.1% and 0.63% respectively.

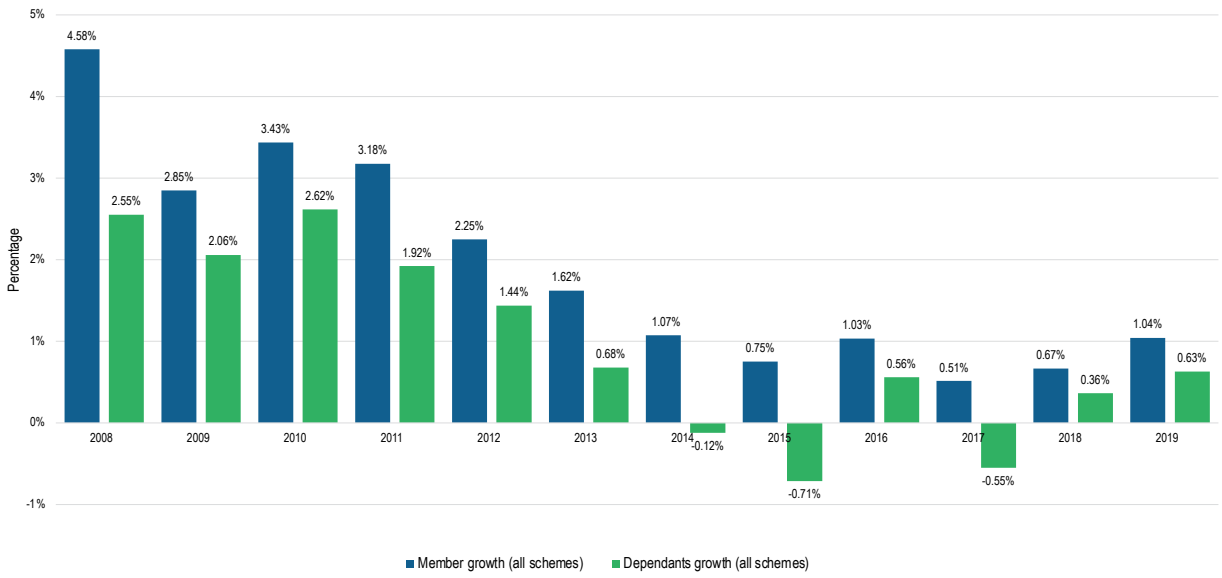

Figure 15: Membership % changes by beneficiary type

The Medical Schemes Industry Overview in 2019

Figure 16 illustrates the year-on-year growth in the number of beneficiaries per scheme type. There has been a consistent decline in the number of dependants in open schemes between 2008 and 2012. The dependants of restricted schemes showed a decline in 2014, 2015 and 2017. In 2019, beneficiaries in both settings increased slightly, but with a decline of 0.30% of dependants in open schemes.

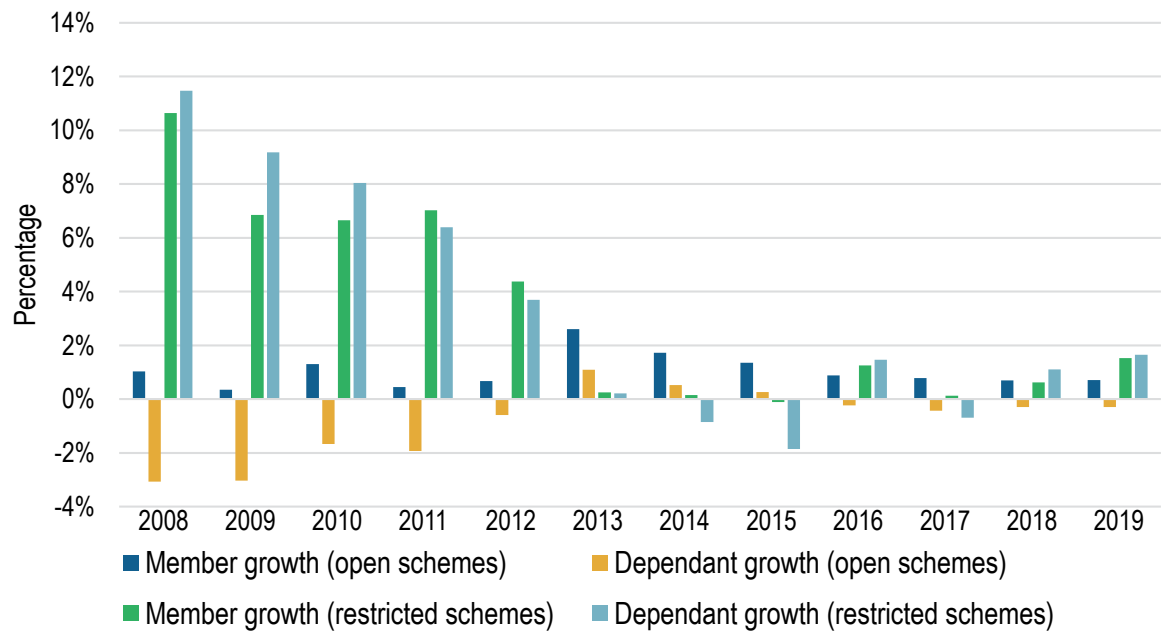

Figure 16: Membership % changes by beneficiary type in open and restricted schemes

The Medical Schemes Industry Overview in 2019

Figure 17 depicts the dependant ratio in medical schemes from 2008 to 2019, measuring the average number of dependants per principal member. The ratio declined from 1.32 in 2008 to 1.20 in 2019. It remained unchanged for restricted schemes between 2018 and 2019 at 1:1.38 while in open schemes the ratio declined by 0.02.

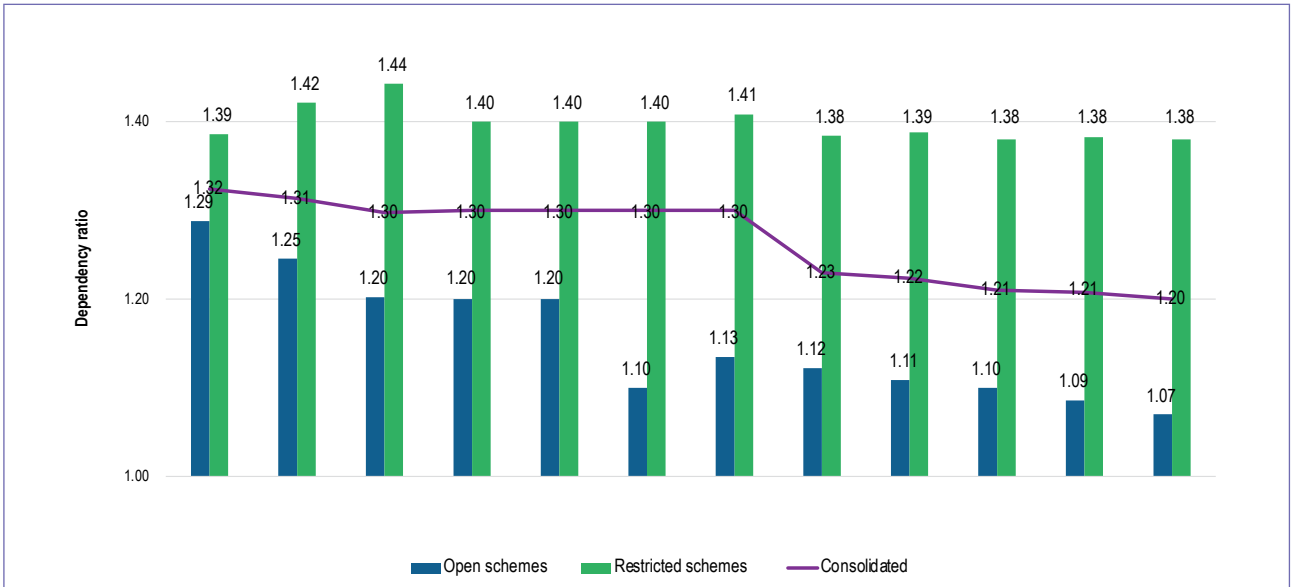

Figure 17: Dependant ratio in schemes 2008-2019

The Medical Schemes Industry Overview in 2019

Figure 18 depicts the age and gender distribution of medical scheme beneficiaries for 2015, 2018 and 2019. A bimodal distribution is evident for both male and female beneficiaries. There were more young beneficiaries and fewer beneficiaries for 85 years plus. The figure shows a downward slope between age 5-9 years and 20-24 years, and the trend is similar across all the years.

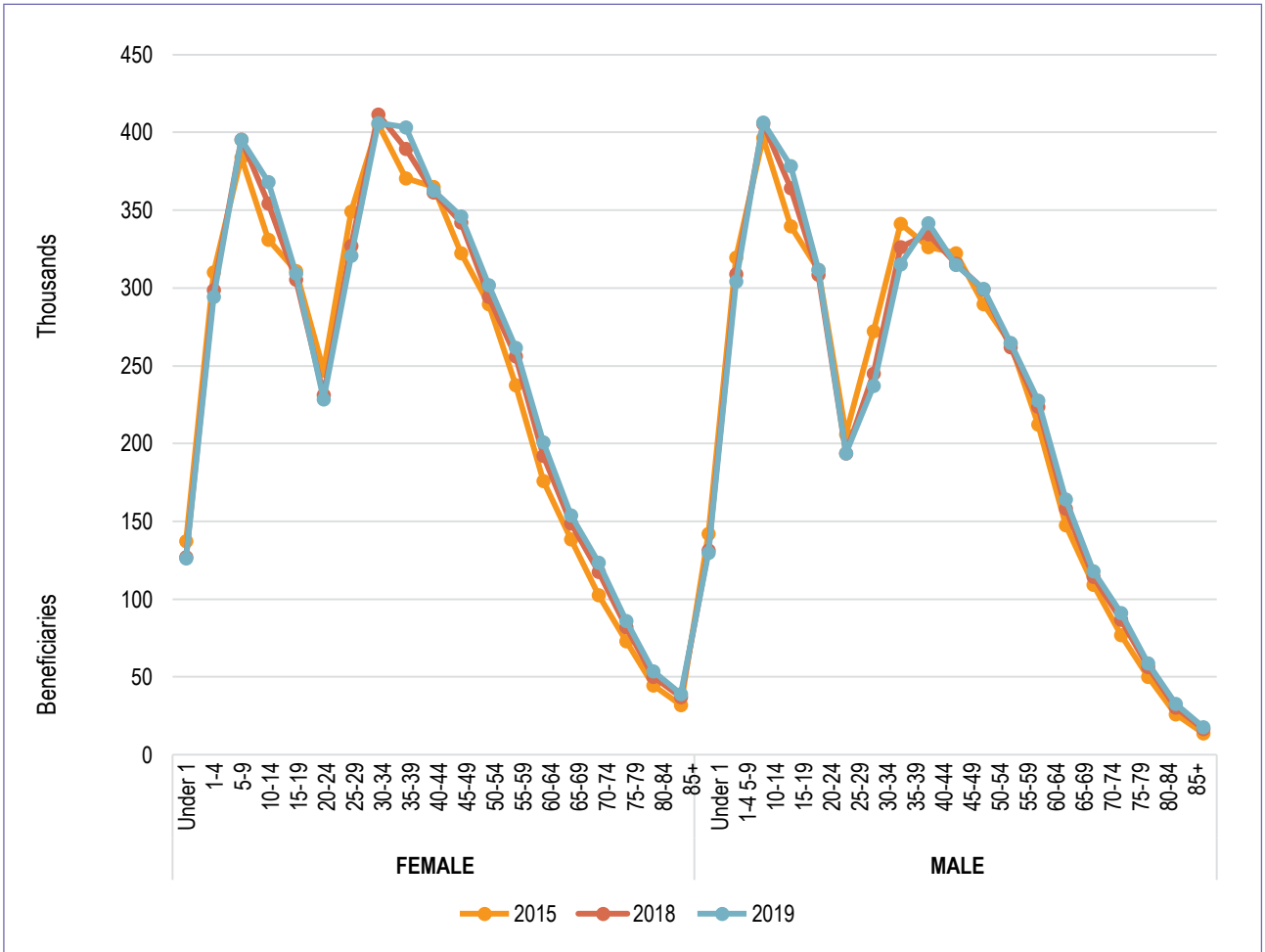

Figure 18: Age and gender distribution of beneficiaries 2015, 2018, 2019

The Medical Schemes Industry Overview in 2019

Table 41 illustrates the average age of beneficiaries and the proportion of pensioners by scheme type and gender from 2016 to 2019. The industry average age of beneficiaries increased slightly by 0.2 for two consecutive periods (2017/18 and 2018/19). The average age of female beneficiaries was greater than that of male beneficiaries from 2015 to 2018. In 2019, the proportion of pensioners (beneficiaries aged 65 and older) declined to 8.6% from 9.0% in 2018. The average age and pensioner ratio of male beneficiaries were lower than that of female beneficiaries. The average age of 34.9 years in open schemes was higher than the industry average of 33.0 years in 2019, while in restricted schemes it was lower at 31.1 years.

Table 41: Average age, pensioner ratio, and distribution

	Gender	Average age (years) and pensioner ratio (%)	2016	2017	2018	2019
Open schemes	Female	Average age	34.7	34.9	35.2	35.6
		Pensioner ratio	10.1	10.9	11.6	11.3
	Male	Average age	33.2	33.3	33.5	33.8
		Pensioner ratio	8.2	8.9	9.6	9.2
	Total	Average age	34.0	34.1	34.4	34.9
		Pensioner ratio	9.2	10.0	10.7	10.3
Restricted schemes	Female	Average age	31.9	31.8	32.1	32.2
		Pensioner ratio	7.1	7.4	7.9	7.4
	Male	Average age	29.1	28.9	29.3	29.3
		Pensioner ratio	5.2	5.4	5.8	5.3
	Total	Average age	30.6	30.5	30.8	31.1
		Pensioner ratio	6.3	6.5	6.9	6.5
All schemes	Female	Average age	33.4	33.5	33.8	34.1
		Pensioner ratio	8.8	9.3	9.9	9.5
	Male	Average age	31.5	31.4	31.7	31.9
		Pensioner ratio	7.0	7.4	7.9	7.6
	Total	Average age	32.5	32.6	32.8	33.0
		Pensioner ratio	7.9	8.4	9.0	8.6

The Medical Schemes Industry Overview in 2019

Figure 19 depicts the geographic distribution of beneficiaries per province in 2019, with the data primarily based on the principal member's address. Approximately 40% of medical scheme beneficiaries were in Gauteng, followed by Western Cape and KwaZulu-Natal with 15% and 14%, respectively. The lowest number of beneficiaries were in Northern Cape, which had 2% of the total.

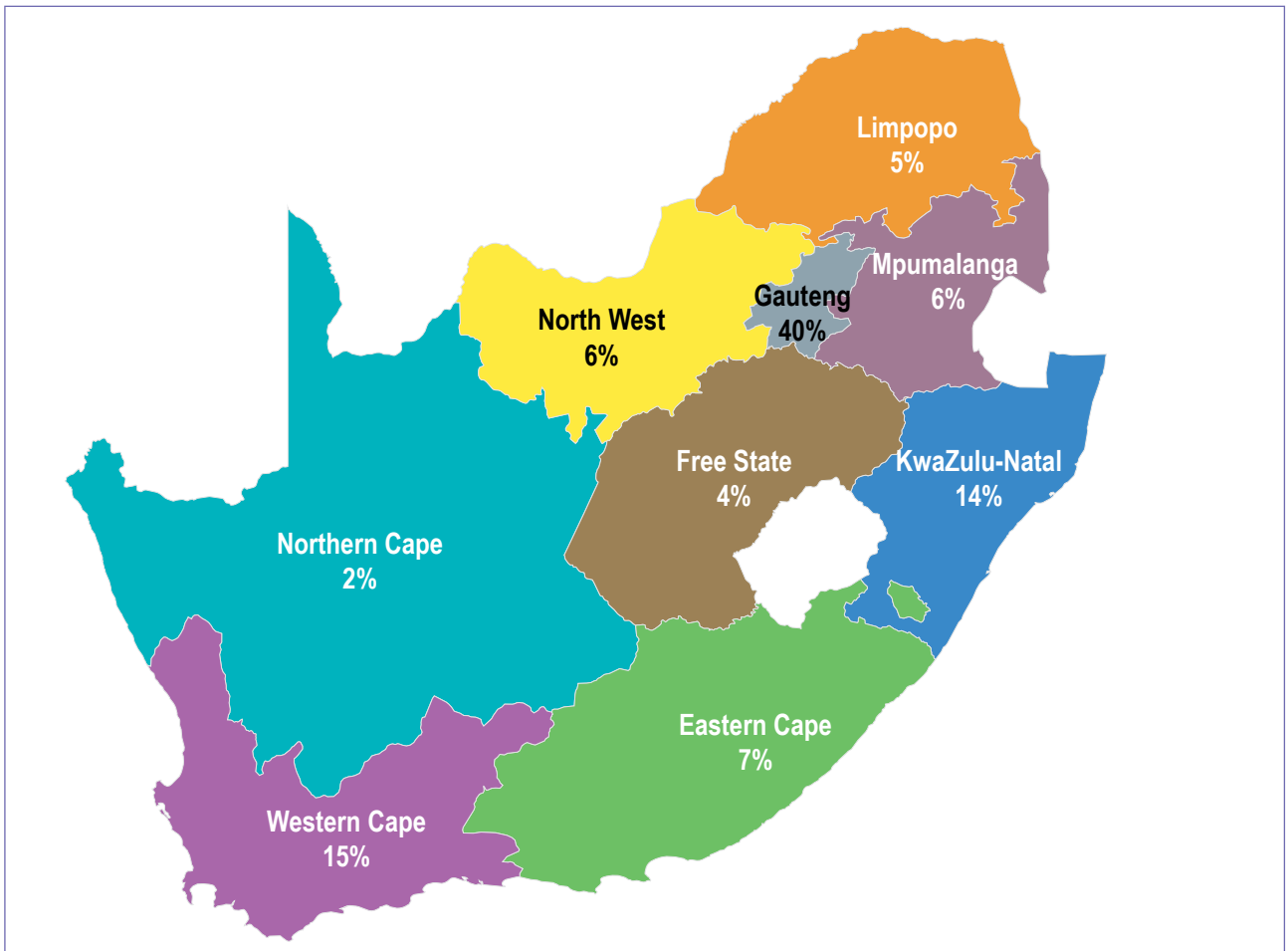

Figure 19: Distribution of beneficiaries by province

The Medical Schemes Industry Overview in 2019

Table 42 shows the number of beneficiaries per province in 2018 and 2019. North West and Northern Cape experienced a year-on-year decline in the number of beneficiaries by 1.7% and 5.6% respectively. Limpopo had the largest growth, with 6.1% increase between 2018 and 2019. Overall, the industry grew by 0.8% in 2019, a slight improvement from 0.05% in 2018. The number of beneficiaries outside South Africa decreased significantly by 20.2% between 2018 and 2019. There was more than a fifth improvement in the classification of beneficiaries by province, which is seen in the significant decline in the unclassified category.

Table 42: Distribution of beneficiaries by province 2018 and 2019

Province	2018	2019	% change
Gauteng	3 543 351	3 598 421	1.6
Western Cape	1 327 573	1 333 363	0.4
KwaZulu-Natal	1 256 360	1,265 694	0.7
Eastern Cape	637 847	653,755	2.5
Mpumalanga	547 402	550 360	0.5
North West	485 044	476 557	-1.7
Limpopo	433 881	460 369	6.1
Free State	389 600	390 841	0.3
Northern Cape	187 573	177 151	-5.6
Unclassified	103 296	79 789	-22.8
Outside South Africa	4 768	3 806	-20.2
All provinces	8 916 695	8 990 106	0.8

Table 43 shows the number of beneficiaries by scheme type and province in 2018 and 2019. Among the restricted schemes, Mpumalanga recorded the largest increase (0.7%) in the proportion of beneficiaries, followed by Eastern Cape and Gauteng with 4.9% and 4.5% respectively. Restricted schemes gained membership in all provinces except North West and Northern Cape. In open schemes, six provinces recorded a decline in the number of beneficiaries between 2018 and 2019, while Limpopo grew by 11.2%.

Table 43: Beneficiary growth per province

Province	2018		2019		% change		
	Open	Restricted	Open	Restricted	Open	Restricted	All
Eastern Cape	290 877	346 970	289 663	364 092	-0.4	4.9	2.5
Free State	159 008	230 592	156 328	234 513	-1.7	1.7	0.3
Gauteng	2 389 006	1 154 345	2 392 004	1 206 417	0.1	4.5	1.6
KwaZulu-Natal	675 327	581 033	663 031	602 663	-1.8	3.7	0.7
Limpopo	125 947	307 934	140 099	320 270	11.2	4.0	6.1
Mpumalanga	261 231	286 171	242 252	308 108	-7.3	7.7	0.5
North West	161 027	324 017	170 996	305 561	6.2	-5.7	-1.7
Northern Cape	74 379	113 194	68 403	108 748	-8.0	-3.9	-5.6
Western Cape	800 876	526 697	795 039	53 8324	-0.7	2.2	0.4

The Medical Schemes Industry Overview in 2019

Table 44 shows medical schemes with fewer than 6 000 members. Among 10 medical schemes, nine were restricted and one was open. About 70% of the schemes presented had an average age above industry average of 33.0. There was a minimum of one option and a maximum of four options among the schemes.

Table 44: Medical schemes with fewer than 6 000 members

Medical schemes	Scheme type	Beneficiaries	Members	Average age	Number of benefit option
Grintek Electronics Medical Aid Scheme	Restricted	1 202	539	38.3	1
Sedmed	Restricted	2 371	1 082	42.6	1
Suremed Health	Open	2 275	1 145	38.4	4
Rhodes University Medical Scheme	Restricted	2 414	1 189	39.5	1
PG Group Medical Scheme	Restricted	3 050	1 440	32.0	1
Alliance-Midmed Medical Scheme	Restricted	3 928	1 680	32.6	1
Bp Medical Aid Society	Restricted	3 532	1 750	45.0	1
Fishing Industry Medical Scheme (Fishmed)	Restricted	4 347	1 892	25.8	2
Anglovaal Group Medical Scheme	Restricted	5 035	2 506	39.7	1
Golden Arrows Employees' Medical Benefit Fund	Restricted	5 635	2 786	33.9	3

The Medical Schemes Industry Overview in 2019

Healthcare Benefits[1]

Total healthcare benefits paid

Total healthcare expenditure on benefits paid in 2019 increased to R185.9 billion, higher by 8.0% from the 2018 reported amount of R172.2 billion. Risk benefits paid remained 90% of total benefits paid with medical savings accounts at 10%. The claims paid per average beneficiary per annum (pabpa) increased by 8.0% from R19 485.26 in 2018 to R20 854.40 in 2019. Risk benefits paid per beneficiary increased by 8.33% from R17 534.91 in 2018 to R18 824.78 in 2019, and the average spent from medical savings accounts pabpa, increased by 5.01% to R2 029.63.

The proportion of healthcare expenditure on hospital services was 37.17%, with expenditure on all specialists accounting for 25.52%, followed by medicine dispensed at 15.32%, and supplementary and allied health professionals at 7.6%. Slightly more than 41% of risk benefits paid was on hospital services, with 26.17% on all specialists, medicine dispensed at 12.94%, and supplementary and allied health professionals at 6.48%.

Medicines dispensed accounted for 37.44% of expenditure from medical savings accounts, followed by expenditure on specialists at 19.46%, supplementary and allied health professionals at 17.96%, and general practitioners at 13.95%. Expenditure from medical savings accounts toward hospital services remained at 1.57%. These proportions highlight how benefit options are designed and are presented in Figure 20.

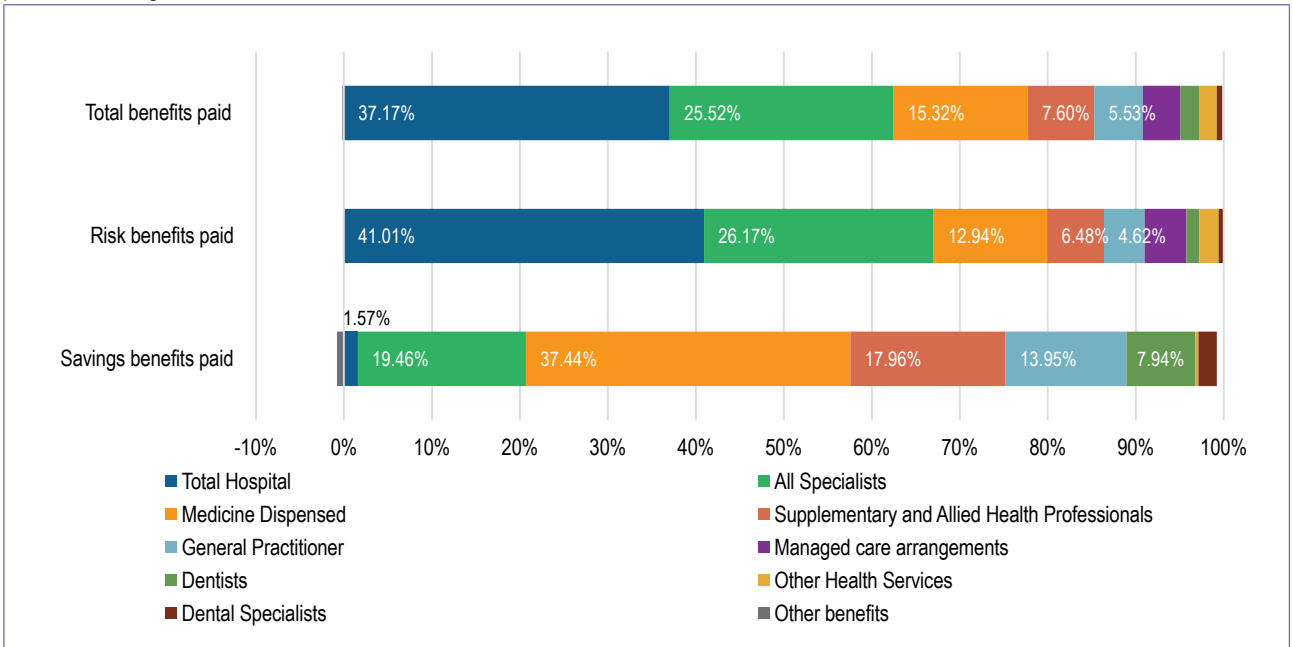

Figure 20: Distribution of healthcare benefits paid 2019 by type of benefit and discipline

* Other consists of Anaesthetists. Other health services. Dental specialists. Ex-gratia payments and other unspecified benefits

[1] Note that gross benefits paid (benefits paid from risk pool plus savings) reported in the utilisation section of this report differ slightly from gross benefits reported in the financial statutory returns section. For more information, read notes in Annexures C to K. All values in this section is stated in nominal terms unless stated otherwise. Prior year figures have been restated.

The Medical Schemes Industry Overview in 2019

The distribution of benefits paid between open and restricted medical schemes varied only slightly, with open medical schemes having paid 1.39% more benefits towards hospital services and 2.59% towards specialists than restricted medical schemes, which paid more benefits towards medicines dispensed, supplementary and allied health professionals, general practitioners than open schemes. Open schemes paid 0.94% more benefits toward managed care arrangements than restricted schemes. Figure 21 highlights these differences.

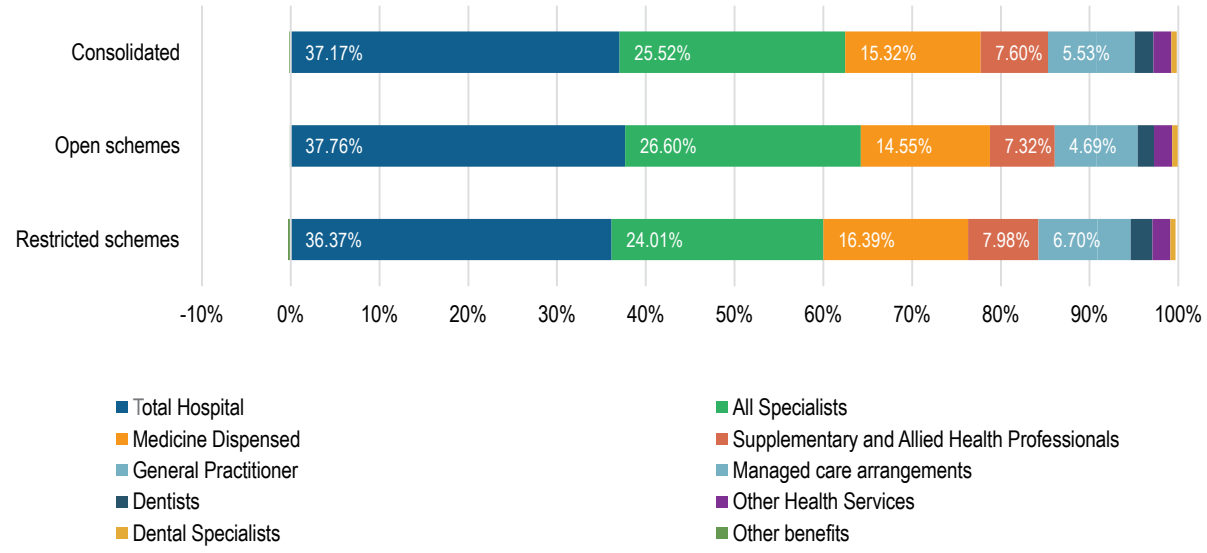

Figure 21: Distribution of healthcare benefits paid 2019 by scheme type and discipline

* Other consists of Dentists. Anaesthetists. Other health services. Dental specialists. Ex-gratia payments and other unspecified benefits

The Medical Schemes Industry Overview in 2019

Total hospital expenditure amounted to R69.1 billion in 2019, an increase of 7.9% from 2018. A larger percentage of benefits paid towards hospital services is spent in open schemes at 58.89% compared with 41.11% in restricted schemes. The average amount paid per beneficiary for hospital services increased by 6.93% to R7 752.49. Ninety-three percent of total expenditure towards hospital services was paid to private hospitals.

Expenditure on hospital services paid on a fee-for-service (FFS) basis amounted to R51.4 billion in 2019, an increase of 7.36% from R46.9 billion in 2018. Close to 86% of this is attributed to ward fees, theatre fees and consumables, with expenditure on medicines accounting for only 10.3% at R5.3 billion. These values are presented in Figure 22.

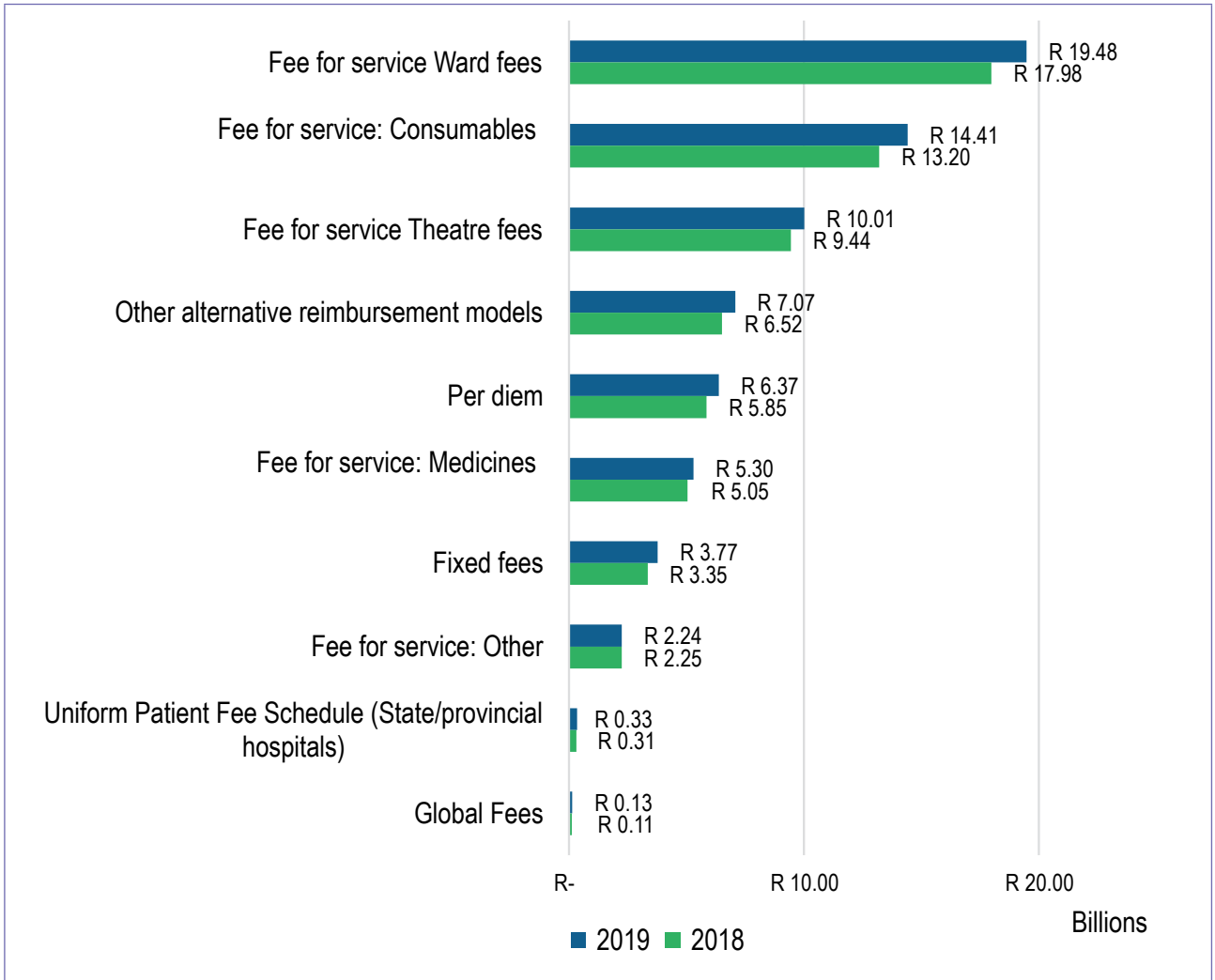

Figure 22: Reimbursement methods for hospital services 2018 - 2019

The Medical Schemes Industry Overview in 2019

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals amounted to approximately R27.3 billion, representing an increase of 5.67% compared with R25.8 billion in 2018. Pharmacies were paid R25.1 billion of all benefits paid towards medicines dispensed in 2019. General practitioners accounted for 4.5% of medicines dispensed, with all other providers making up 3.5%. The most significant year-on-year increase was for Speech therapy and Audiology, which increased by over 80%, followed by blood transfusion services, which increased by over 60%. Table 45 lists the top 10 dispensing providers.

Table 45: Benefits paid for medicines dispensed – top 10 disciplines

Discipline 2	2019		2018		
	R	% of total	R	% of total	% change
Pharmacies (60)	25 106 139.64	92.02	23 831 189.47	92.30	5.35
General Medical Practice (014)	1 226 596.83	4.50	1 245 554.54	4.82	-1.52
Clinical services (90)	575 613.74	2.11	455 035.02	1.76	26.50
Speech therapy and Audiology (82)	117 547.56	0.43	62 295.02	0.24	88.69
Registered nurses (88)	86 618.86	0.32	70 787.52	0.27	22.36
Clinical technology (75)	42 731.60	0.16	46 127.42	0.18	-7.36
Group practices (50)	36 393.05	0.13	44 997.53	0.17	-19.12
Blood transfusion services (78)	46 769.58	0.17	27 774.48	0.11	68.39
Hearing Aid Acoustician (83)	20 983.69	0.08	14 183.10	0.05	47.95
Orthotists & Prosthetists (87)	13 516.94	0.05	11 510.20	0.04	17.43
Other	11 083.98	0.04	10 592.88	0.04	4.64
Grand Total	27 283 995.48	100.00	25 820 047.18	100.00	5.67

Total expenditure on pathology services amounted to R10.5 billion in 2019, an increase of 10.9% from R9.5 billion in 2018. Slightly more than 55.1% of this expenditure was spent in-hospital at an average of R4 674 per event, and R4 049 per event out-of-hospital. Restricted schemes paid on average higher fees per event compared with open schemes, presented in Figure 23.

Expenditure on surgical specialists amounted to R10.7 billion in 2019, an increase of 11.7% from R9.6 billion in 2018, with an average of R4131.03 per event in-hospital and R1 368.98 out-of-hospital. Expenditure on anaesthetists increased by 10.7% from R3.7 billion in 2018 to R4.1 billion in 2019, with an average R3 667.48 per event in hospital, compared with R2 062.73 per event out-of-hospital. Restricted schemes paid slightly higher fees in-hospital per event than open schemes, with the opposite result for events out-of-hospital.

The amount paid to supplementary and allied health professionals in 2019 increased by 9.25% from R12.9 billion in 2018 to R14.1 billion in 2019, of which open medical schemes spent R7.9 billion, and restricted medical schemes spent just over R6.2 billion. The average expenditure per event in-hospital was higher in restricted schemes at R2 851 compared with R1 478 for open schemes.

Expenditure on general practitioners (GPs) amounted to R10.3 billion, an increase of 7.55% from R9.6 billion in 2018. Hospital visits accounted for 13.4% of expenditure on GPs, with an average of R1 073 per event. Visits out-of-hospital averaged R408. Restricted schemes paid higher fees per event compared with open schemes.

Payments to medical specialists amounted to R13.5 billion or 7.26% of total healthcare benefits paid in 2019. Around 62% of expenditure related to treatment in-hospital at an average of R1 621 per event, and R1 243 per event out-of-hospital.

The Medical Schemes Industry Overview in 2019

Figure 23 shows benefits paid to different disciplines per event (visit) for both in and out-of-hospital. Total benefits paid per event is calculated as total benefits paid (from risk + savings) divided by the number of visits to a provider. Notice that the cost (or benefits paid) per event must be interpreted with caution as the calculation does not consider other factors such as the number of hours spent per event, etc. Events paid in-hospital from medical savings accounts of beneficiaries make up a very small part of the expenditure and relate to mainly dentist visits and dental specialist visits.

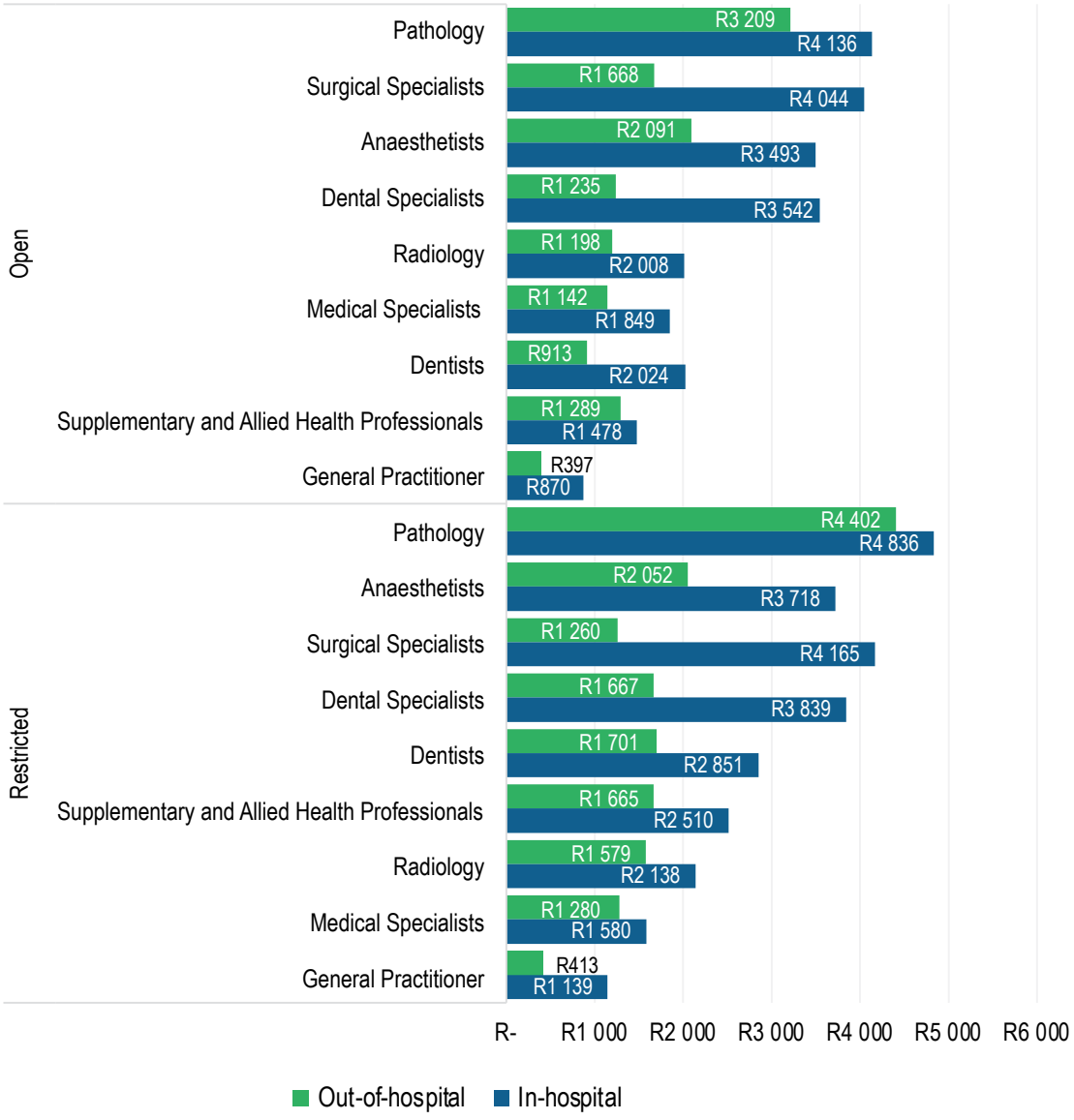

Figure 23: Benefits paid per event (visit) 2019

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Table 46 compares the year-on-year % change of average expenditure per event. Surgical specialist visits out-of-hospital increased by over 22% to R1 369 per event/visit in 2019 compared with R1 116 per event in 2018, out-of-hospital pathology increased by over 19% to R4 049 per event, similarly supplementary and allied health professionals visits increased by over 15% to R1 527 per event.

The average in-hospital expenditure per event for radiology increased by over 13% to R2 109 compared with R1 852 in 2018, with average events for pathology in-hospital increasing by over 10% to R4 674.

Table 46: Year-on-year % change of average expenditure per event

Setting	Discipline Group	2019 R	2018 R	% change
In-hospital	Pathology	4 674.00	4 248.00	10
	Surgical Specialists	4 131.00	3 870.00	7
	Anaesthetists	3 667.00	3 408.00	8
	Dental Specialists	3 442.00	4 484.00	-23
	Dentists	2 661.00	2 488.00	7
	Radiology	2 109.00	1 852.00	14
	Supplementary and Allied Health Professionals	2 068.00	2 411.00	-14
	Medical Specialists	1 621.00	1 524.00	6
	General Practitioner	1 073.00	1 030.00	4
Out-of-hospital	Pathology	4 049.00	3 390.00	19
	Anaesthetists	2 063.00	1 840.00	12
	Dental Specialists	1 559.00	1 477.00	6
	Supplementary and Allied Health Professionals	1 527.00	1 321.00	16
	Dentists	1 494.00	1 545.00	-3
	Radiology	1 475.00	1 463.00	1
	Surgical Specialists	1 369.00	1 116.00	23
	Medical Specialists	1 243.00	1 389.00	-11
	General Practitioner	408.00	393.00	4

The Medical Schemes Industry Overview in 2019

Trends in total healthcare benefits paid at constant prices

Figure 24 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2007. These figures have been adjusted for inflation with 2019 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2019 prices.

Expenditure on private hospitals increased by 3.3% in real terms from R66.3 billion in 2018 to R68.8 billion in 2019. The annual average increase from R39.3 billion in 2009 to R68.8 billion in 2019, was 6.07% and is illustrated in Figure 24. The proportion of benefits paid toward private hospitals has averaged around 36.3% between 2009 and 2019. The proportions of expenditure on all specialist and medicines dispensed displayed greater fluctuation over the period.

[2] Note that historical (pre-2014) provider classifications have been used in order to create continuity and preserve historical data. The groupings differ slightly with provider classifications used in other sections of the report.

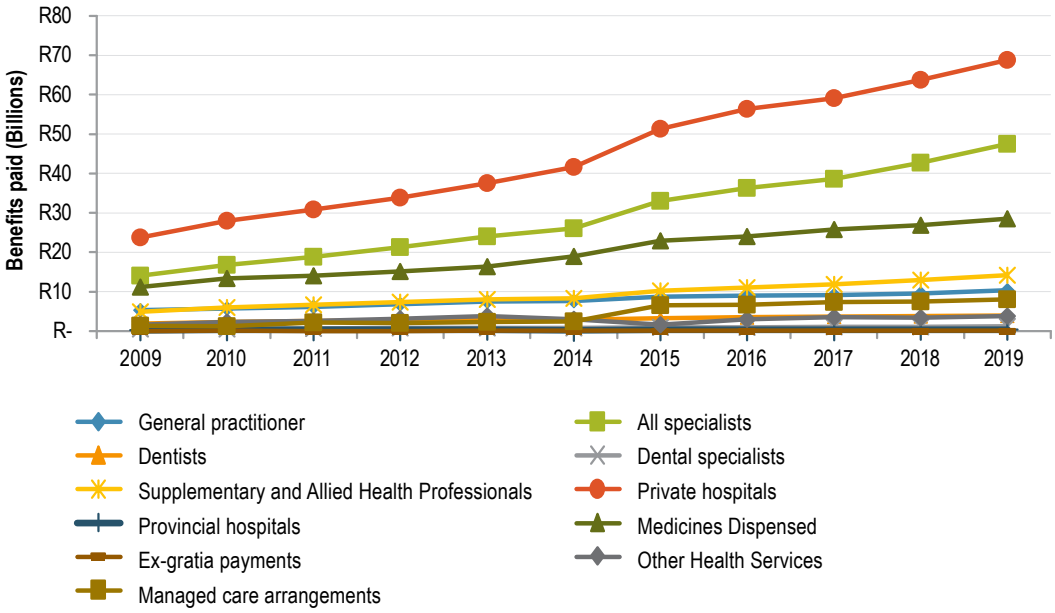

Figure 24: Total healthcare benefits paid 2009-2019 (2019 Prices*)

* All values are adjusted for inflation using the Consumer Price Index (CPI) for 2019 as a base period.
** Historical values are revised when the base period % changes and will not correspond to the values reported in the previous annual reports.

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2019 amounted to R47.4 billion in real terms, an increase of 6.6% in real terms when compared with 2018 and a 7.4% annualised increase from R23.2 billion in 2009.

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Healthcare benefits paid per beneficiary

Figure 25 shows the % changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2009 to 2019 in real terms (at 2019 prices). The amount paid in real terms on private hospitals increased by 2.76% from R7 503 pabpa in 2018 to R7 710 pabpa in 2019, the annual average increase from R5 833 pabpa in 2009 was 2.8%.

The amount spent on specialists increased in real terms from R3 483 pabpa in 2009 to R5 321 pabpa in 2019, an annual average increase of 4.33%. Expenditure on GPs decreased with an annual average of 0.24% from R1 182 pabpa in 2009 to R1 154 in 2019. Similarly expenditure on dentists decreased with an annual average of 0.57% from R444 pabpa in 2009.

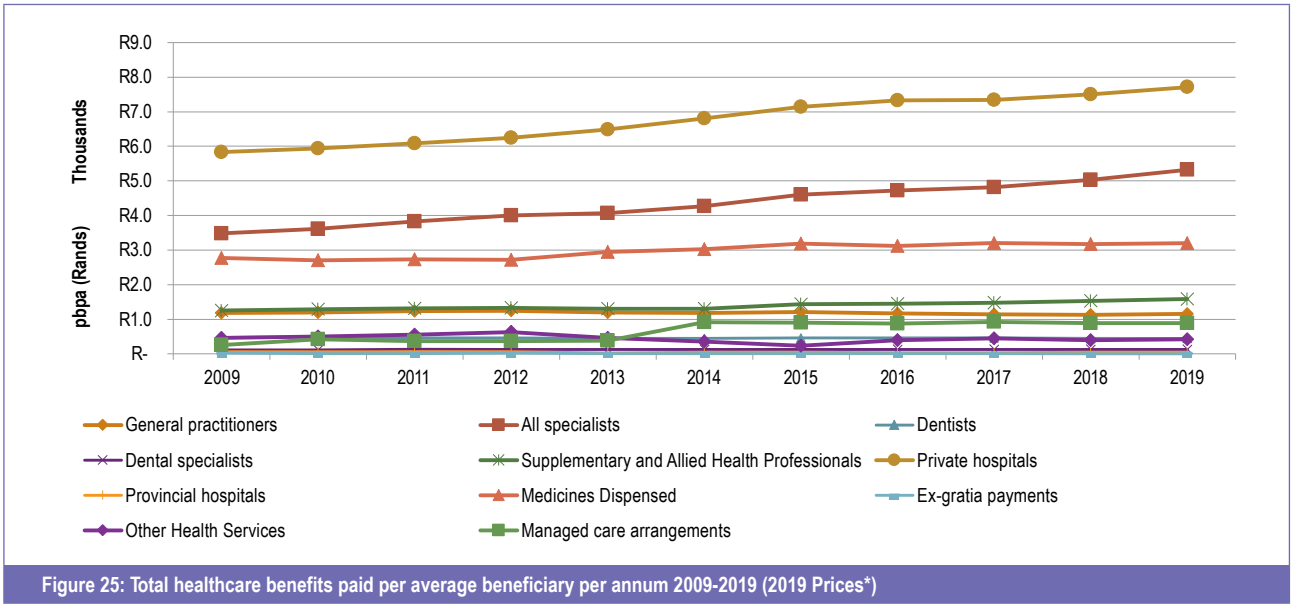

Figure 25: Total healthcare benefits paid per average beneficiary per annum 2009-2019 (2019 Prices*)

* All values are adjusted for inflation using the Consumer Price Index (CPI) for 2019 as a base period.
** Historical values are revised when the base period % changes and will not correspond to the values reported in the previous annual reports.

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Healthcare benefits paid per age-band

Figure 26 shows the per capita healthcare expenditure across healthcare services by age group. Expenditure for beneficiaries over the age of 44 years rises above the average cost per beneficiary of R19 999, and peaks for beneficiaries in the age band 80 to 84 years at R68 944 per average beneficiary.

Expenditure on primary healthcare providers, general medical practitioners and dentists continue to be overshadowed by the expenditure on specialists, hospitals and medicines dispensed, which combined consists of over 80% of the cost per age band.

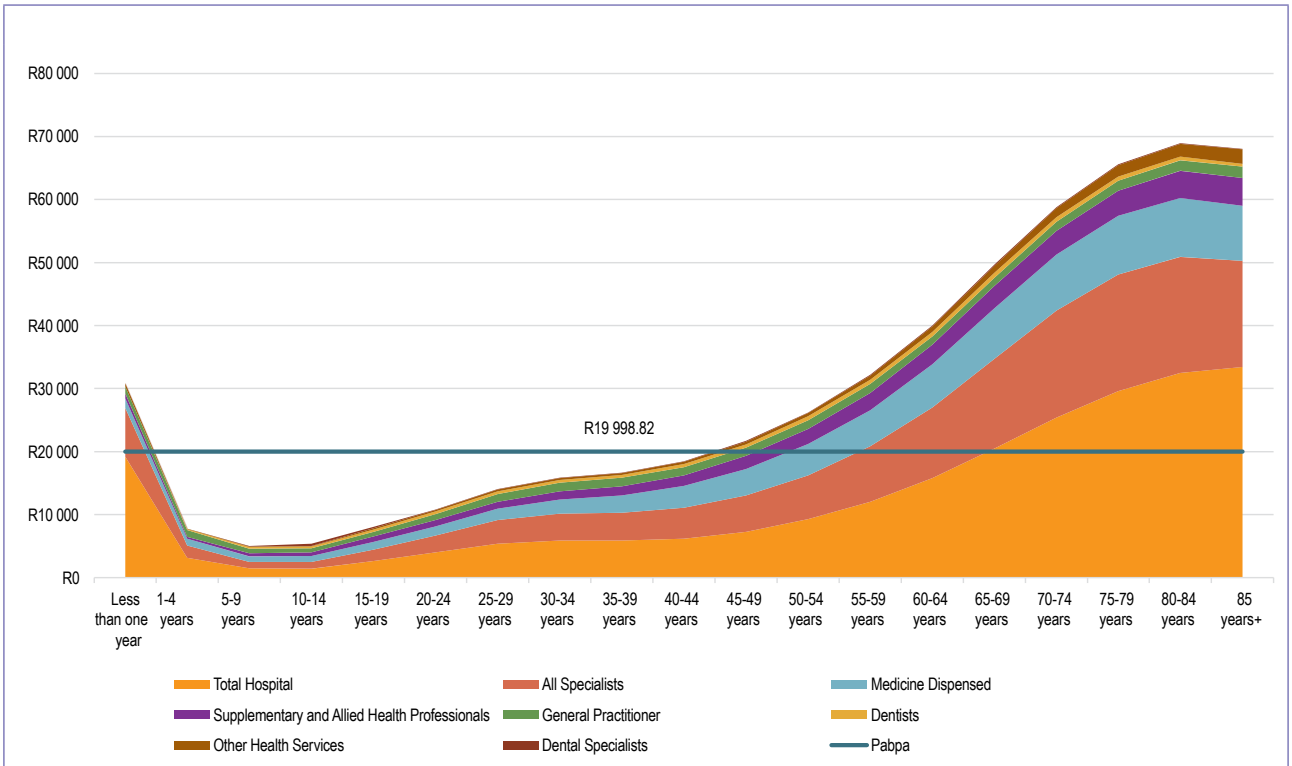

Figure 26: Expenditure per capita by age band 2019

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Figure 27 highlights the differences observed in the expenditure of benefits paid by age band. Expenditure for beneficiaries over the age of 59 increase significantly between 2018 and 2019 ranging from 10.28% to 15.04% increase. The most distinct % change was for the beneficiaries in the age band, 80-84-year category, with the average benefits paid per beneficiary increasing by 7.66%. Figure 28 depicts the number of beneficiaries in 2018 and 2019 against the average amount paid for benefits for each of the age bands.

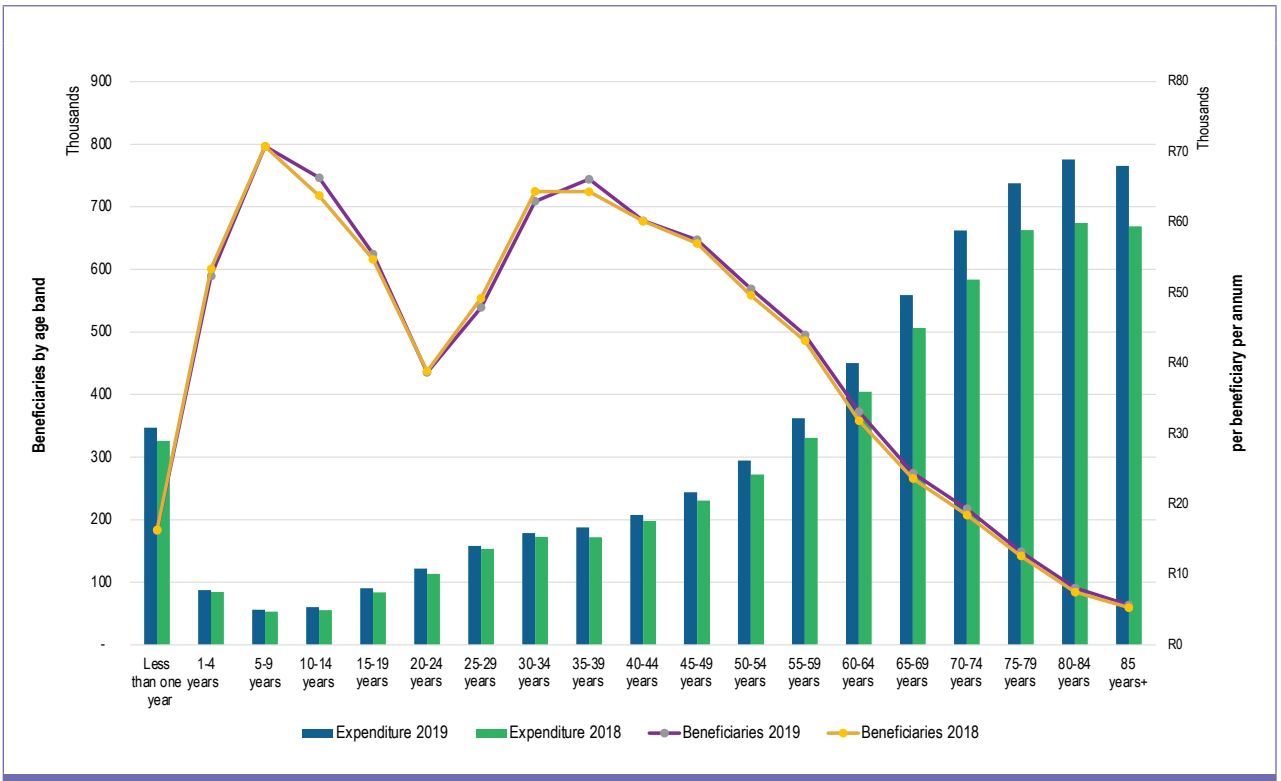

Figure 27: Expenditure by age band 2018 and 2019

Proportionally more benefits are paid towards beneficiaries in the age bands above 44 years, with 65 and older beneficiaries consisting of 8.91% of the population consuming over 26% of healthcare benefits, and beneficiaries between 45 and 64 years consisting of 23.4% of the medical schemes population consuming 34% of healthcare benefits. This translates to a total of 33% of the medical schemes' population consuming close to 60% of the healthcare benefits provided in 2019, demonstrating the cross-subsidisation between the young and healthy and the older and sicker beneficiaries.

The Medical Schemes Industry Overview in 2019

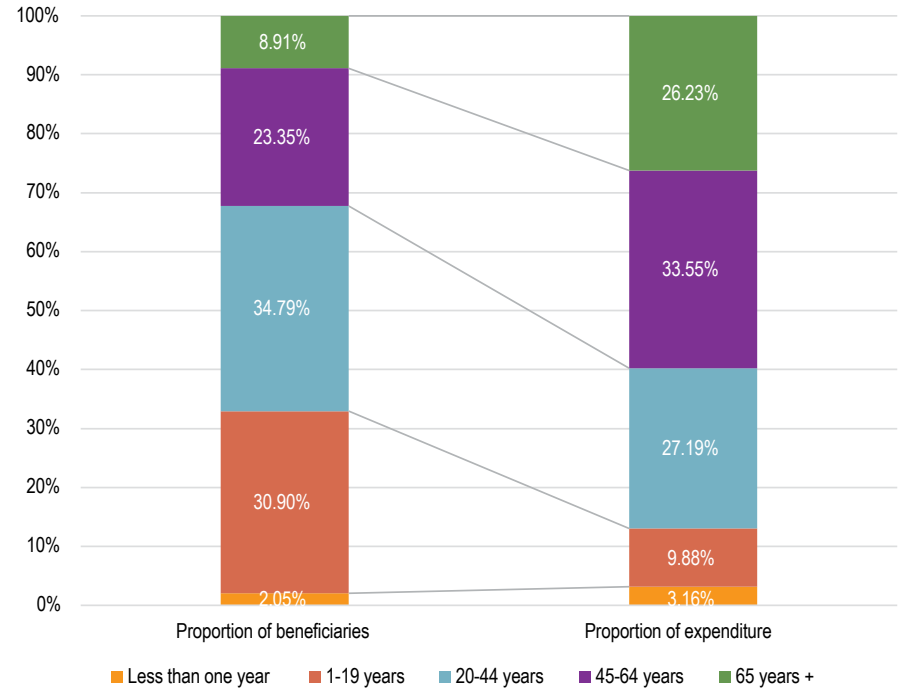

Figure 28: Proportion of total healthcare expenditure by age group

The Medical Schemes Industry Overview in 2019

Out-of-pocket payments

Out-of-pocket payments (OOPs) are calculated as the difference between the claimed amount and the amount that was paid from the medical scheme risk. This is an understatement of the true OOPs that members incur as it is likely that medical schemes do not fully capture and submit all costs associated with seeking healthcare.

Figure 29 shows the split of OOPs in 2019. The largest component remains that of medicines dispensed which constituted 33% of OOPs expenditure in both 2018 and 2019.

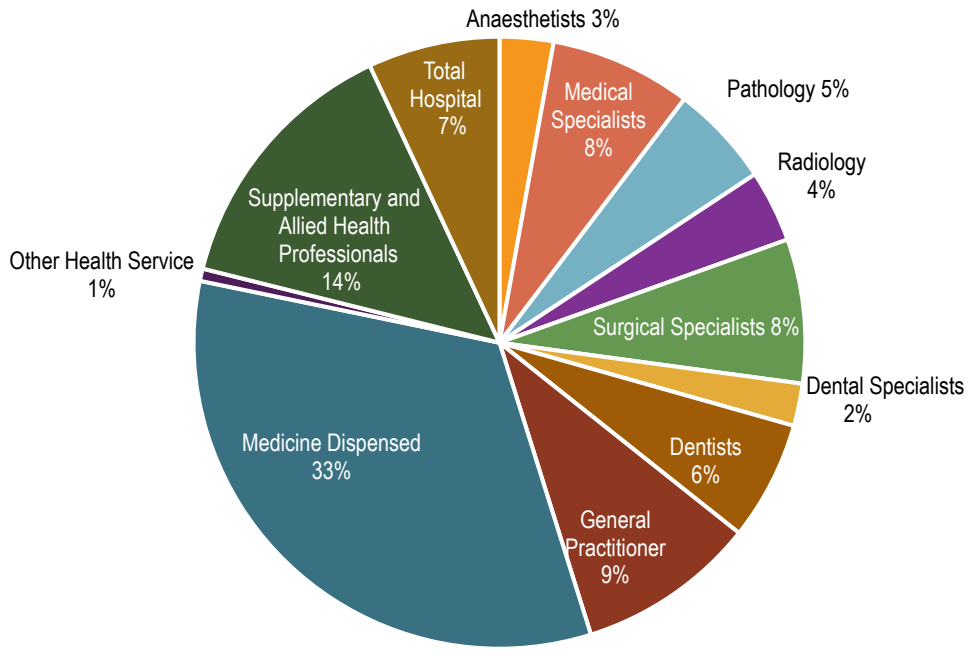

Figure 29: Out-of-pocket payments by type, 2019

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Figure 30 offers a closer look into OOPs by splitting the expenditure into the proportion from the medical saving account (MSA) and that paid by the member. This reveals that Anaesthetics, Surgical Specialists and Total Hospitals constitute that largest proportions of expenditure paid by members while GPs, pathology and supplementary and allied works constitute the largest expenditure from the MSA.

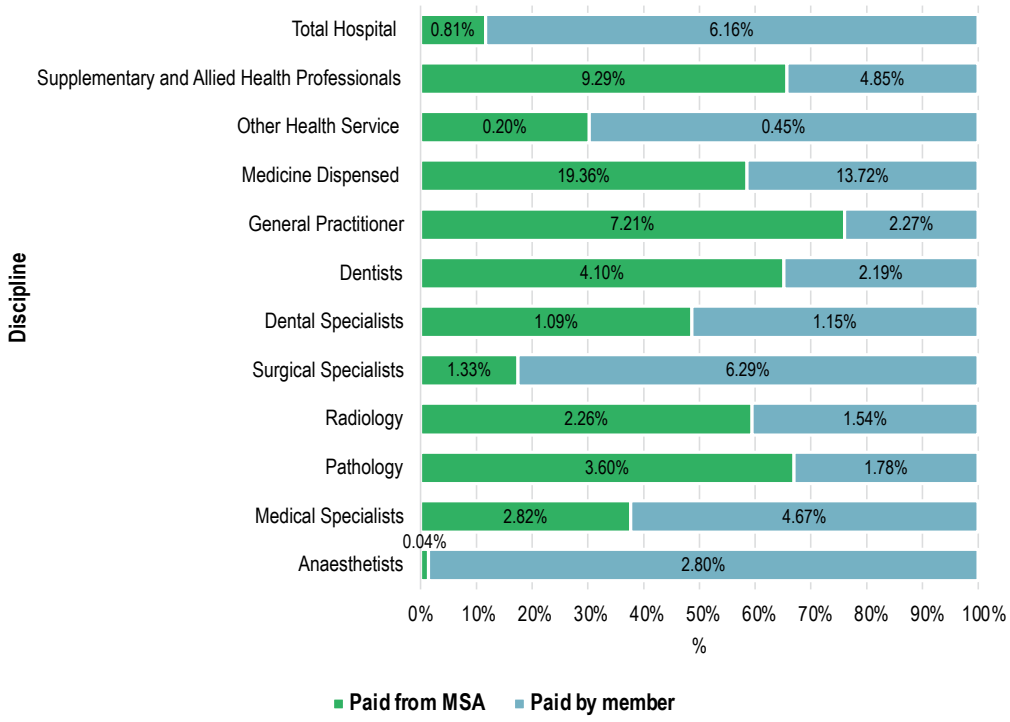

Figure 30: Out-of-pocket payments by source, 2019

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Figure 31 shows the trend in OOPs from 2014 to 2019. Over time, there has been an increasing upward trend in out-of-pocket payments across the industry. Generally, OOPs are lower in restricted schemes which by design tend to be more comprehensive. However, a worrying trend is that payments by members are significantly higher for surgical specialists, total hospitalisation and anaesthetists compared with the other categories.

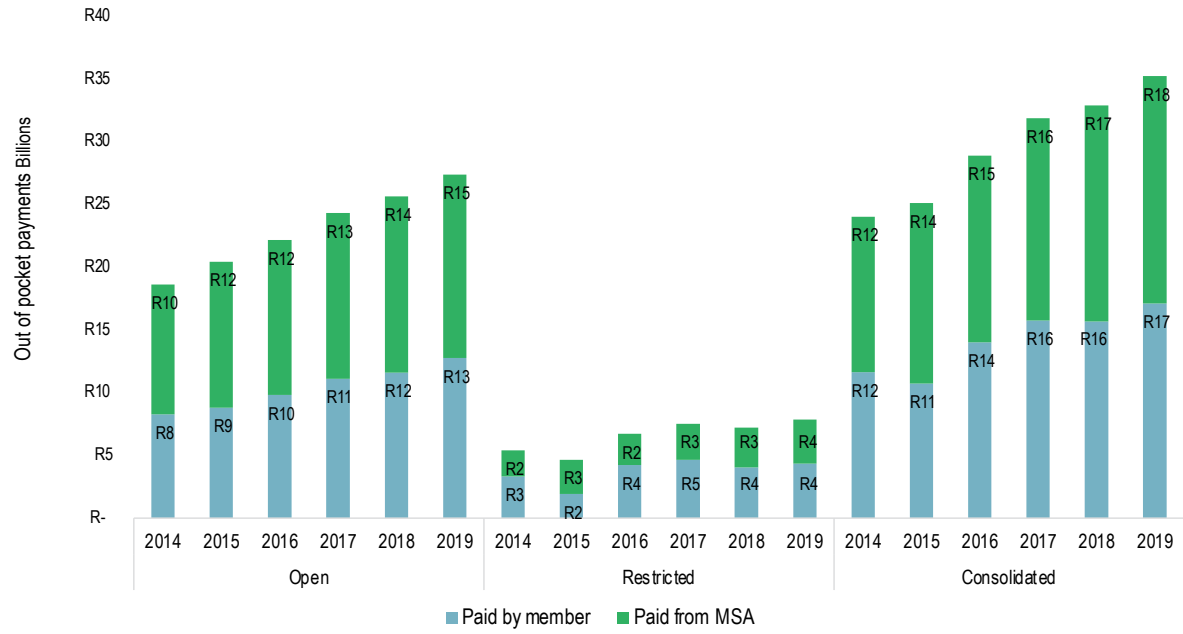

Figure 31: Out-of-pocket payments by scheme type

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Prescribed minimum benefits

Expenditure on Prescribed Minimum Benefits (PMB) is mainly driven by beneficiary profile, the prevalence of chronic conditions and cost of treatment. Beneficiary profile refers to the level of cross-subsidisation between the young and old and the sick and healthy. In order to remain sustainable, medical schemes need membership growth in young and healthier populations.

Figure 32 depicts the relationship between medical schemes expenditure on PMB and beneficiary profiles. Expenditure generally increases with age, particularly beyond the ages of 45-49 years, where it surpasses the average expenditure pbpm. Furthermore, beyond this point membership growth drops rapidly.

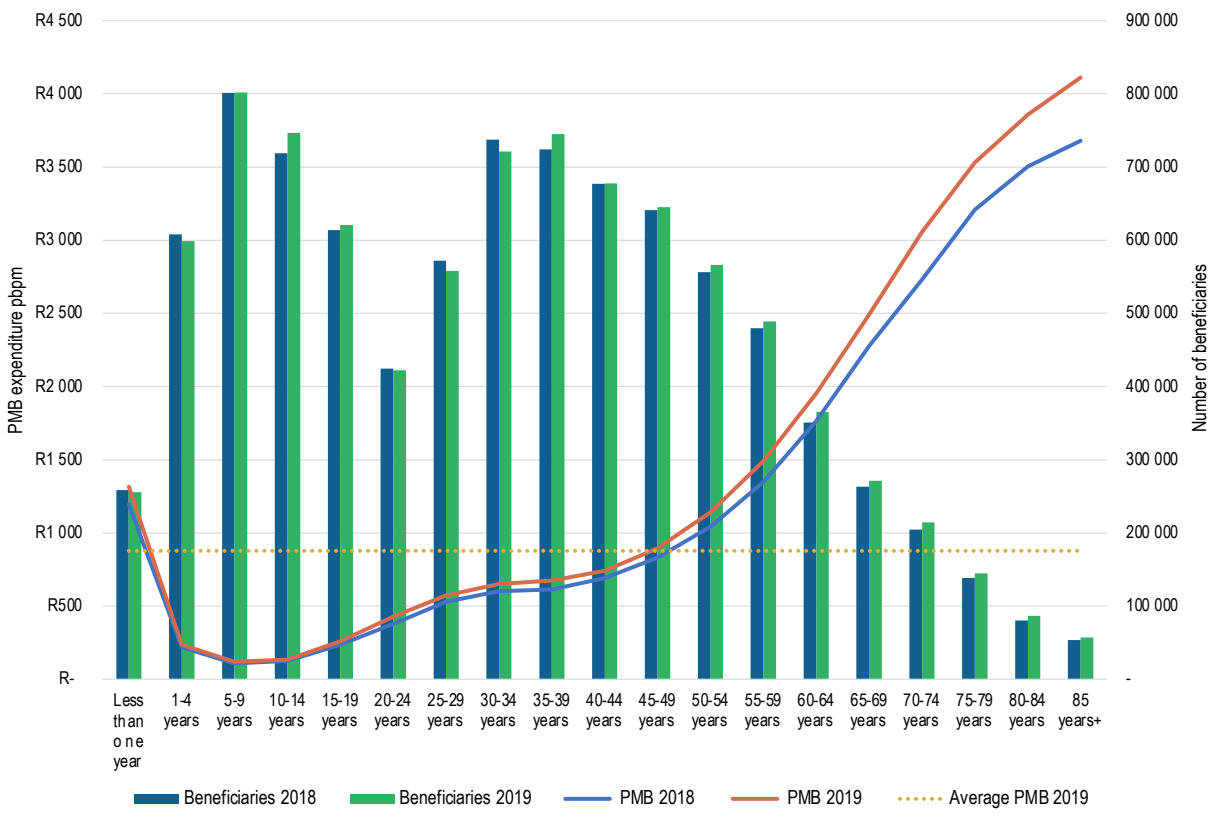

Figure 32: PMB expenditure by age bands for 2018 and 2019

The Medical Schemes Industry Overview in 2019

Chronic condition benefits

Figure 33 shows the proportion of beneficiaries registered on schemes' disease management programmes. Hypertension, hyperlipidaemia and diabetes mellitus type 2 remain the most prevalent conditions on the CDL of medical schemes.

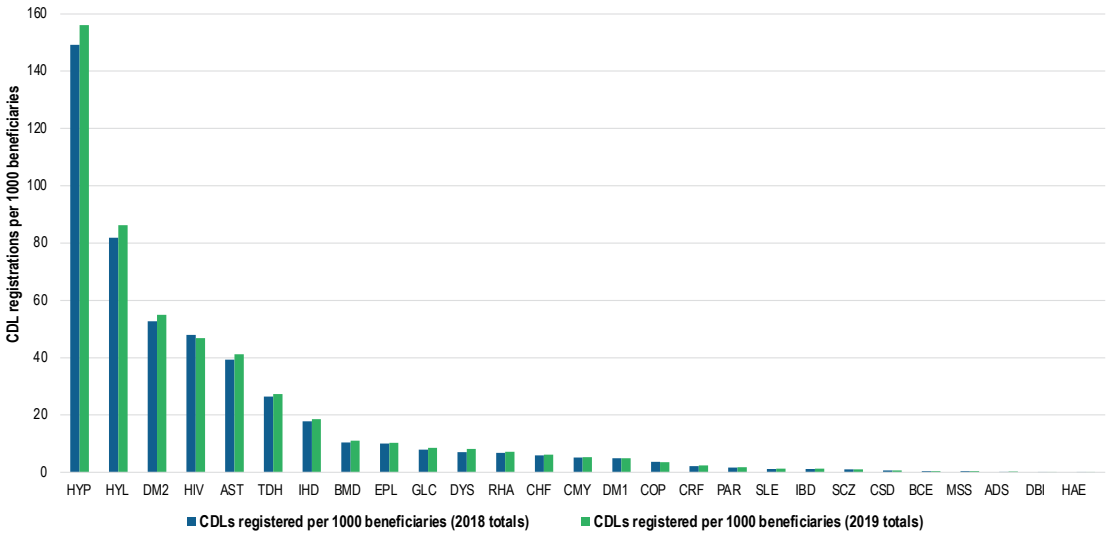

Figure 33: Proportion of beneficiaries registered on a chronic disease management programme in 2018 and 2019

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Figure 34 shows the prevalence of chronic conditions against the expenditure per patient per month (pppm). Haemophilia had the highest expenditure per patient registered of R25 974 (although it has the lowest prevalence), followed by multiple sclerosis and chronic renal failure at R4 927 and R4 272 pppm respectively.

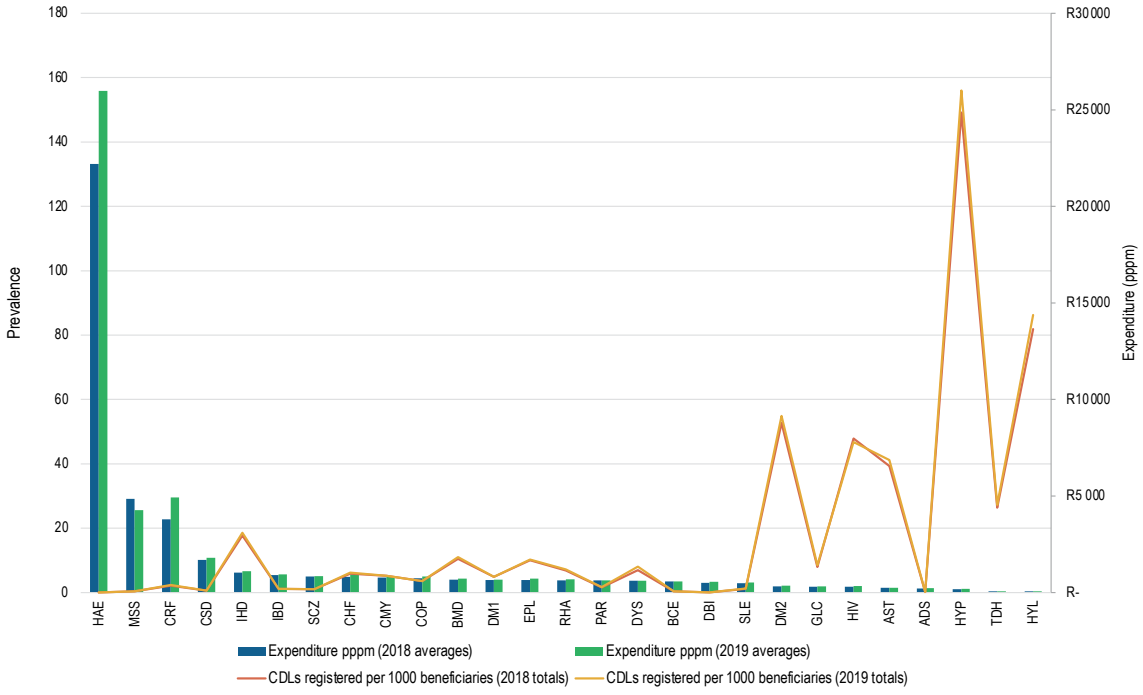

Figure 34: Expenditure pppm on chronic conditions in 2018 and 2019 compared with the prevalence

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Diagnosis and treatment pairs (DTPs) are a set of procedures and treatments linked to certain PMB conditions. Figure 35 depicts expenditure by medical schemes on DTPs for 2018 and 2019. Default emergencies remain the most expensive, with schemes spending R45.74 pbpm for 2019. On comparing in and out-of-hospital expenditure, default emergencies are the most expensive to treat in-hospital while breast cancer is the most expensive to treat out-of-hospital at R42.47 and R9.35 respectively.

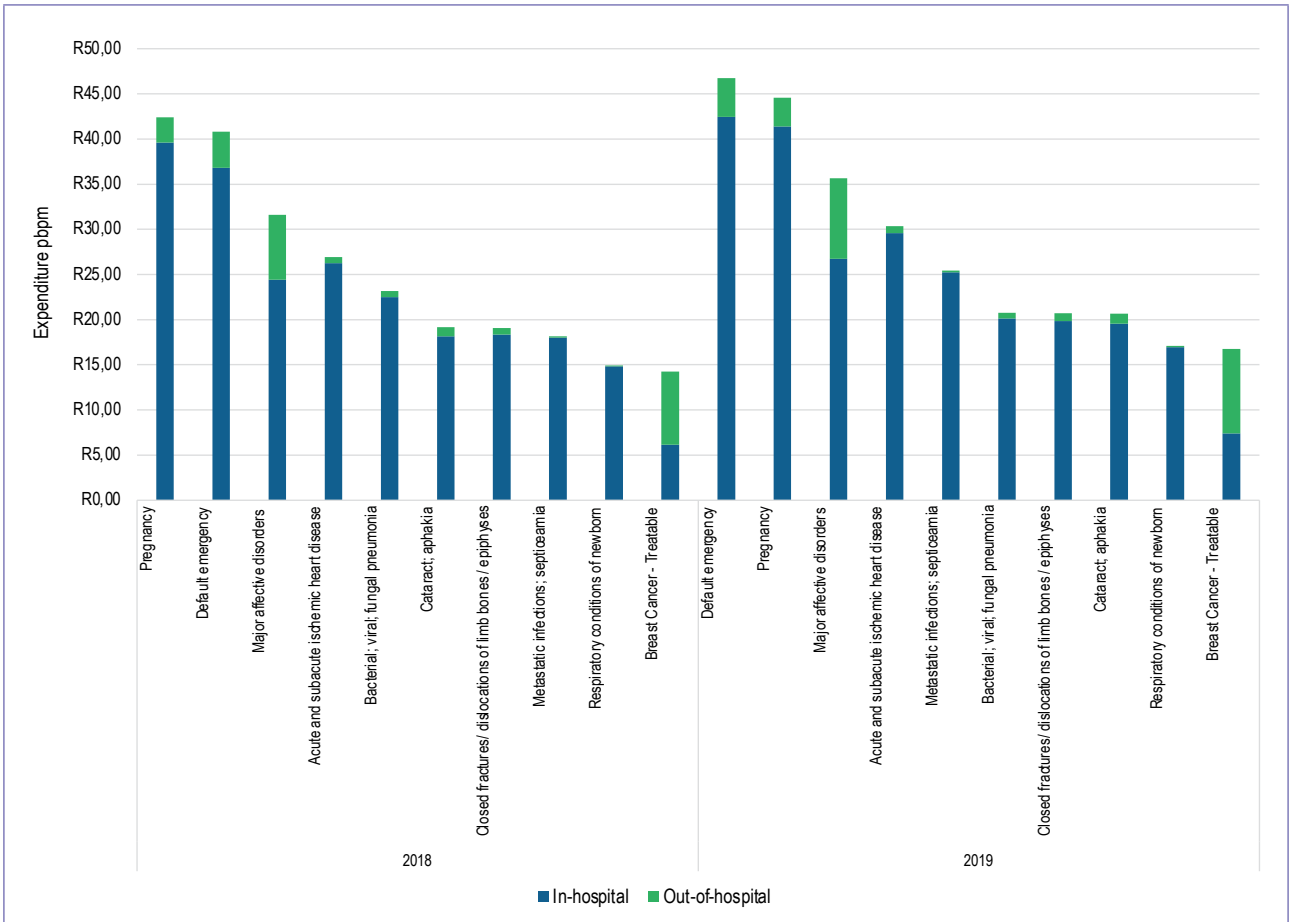

Figure 35: Top 10 DTPs by expenditure

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Table 47: Top 10 diagnosis and treatment pair (DTP) conditions

DTP conditions	Total expenditure R
Default emergency	5 005 199 335
Pregnancy	4 775 247 707
Major affective disorders	3 253 045 771
Acute and subacute ischaemic heart disease	3 818 221 908
Metastatic infections; septicaemia	2 723 870 413
Bacterial; viral; fungal pneumonia	2 222 132 521
Closed fractures/ dislocations of limb bones/epiphyses	2 218 227 022
Cataract; aphakia	2 213 134 993
Respiratory conditions of the newborn	1 828 884 869
Breast cancer – treatable	1 309 997 523
	29 367 962 062

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Quality of care

Access to quality of care has increasingly become more important in predicting the health outcomes of various healthcare interventions beyond the realm of access to healthcare services. Figure 36 and Figure 37 depict coverage ratios for hypertension and diabetes mellitus type 2, both of which are among the top three most prevalent chronic conditions. Although hypertension is the most prevalent, the coverage ratios for its various tests continue to remain low (Figure 36). There was possible under-reporting by some schemes in 2019 compared with 2018, which means a declining trend might not necessarily be explained by lower utilisation of services.

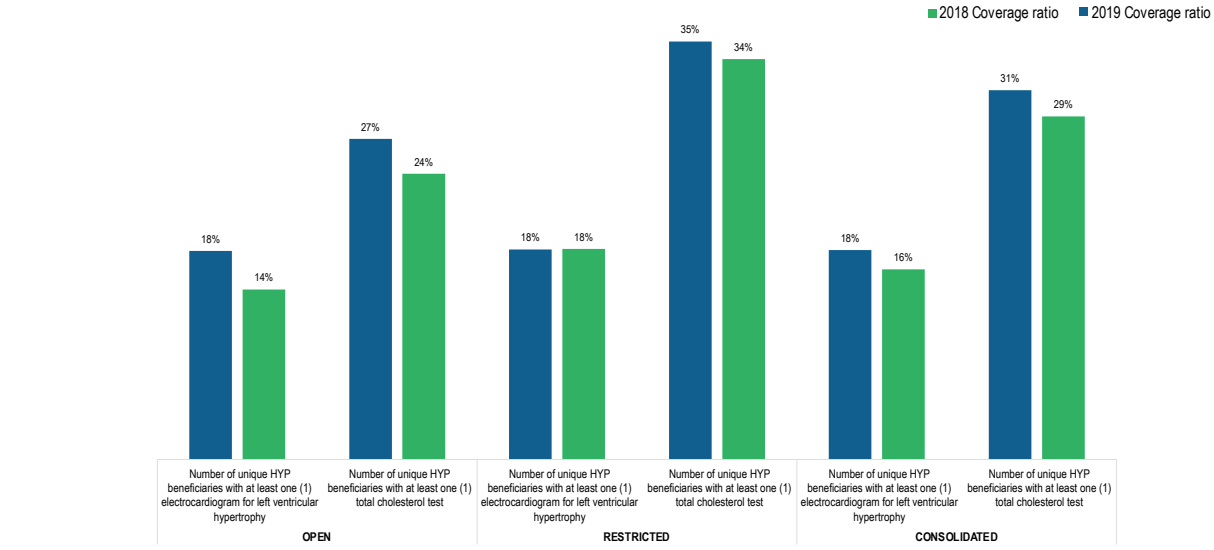

Figure 36: Hypertension coverage ratios

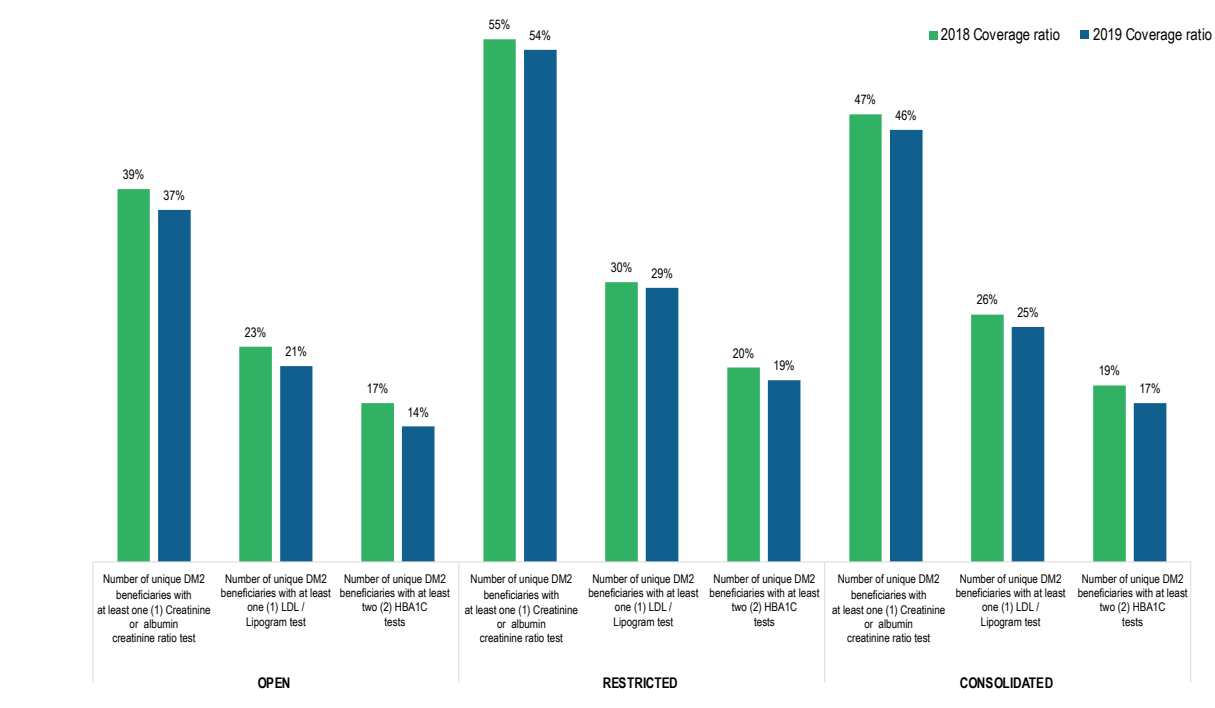

Figure 37: Diabetes Mellitus Type 2 coverage ratios

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Utilisation of healthcare services

Utilisation of GP health services

The utilisation of general practitioner services by medical scheme beneficiaries in 2018 and 2019 is reported in Table 48. The number of beneficiaries visiting a medical GP at least once during the year increased by 1.15% from 7.21 million in 2018 to 7.29 million in 2019. The increase was not significant when adjusted for the population covered by medical schemes (816.64 to 816.73 per 1 000 beneficiaries). In 2019 more beneficiaries covered by restricted schemes (889.48 per 1 000) visited a GP against open scheme beneficiaries (758.17 per 1 000). Open and restricted medical schemes recorded 90.34% and 88.11% GP out-of-hospital visits respectively. The average number of GP visits per patient remained unchanged at 3.19 for 2018 and 2019. The average number of visits to the GP in open schemes decreased slightly from 3.07 to 3.05 visits per patient for the period under review, while restricted schemes reported an increase from 3.33 in 2018 to 3.34 in 2019.

The amount claimed by GPs increased by about 6% between 2018 and 2019 (R449.76 to 475.89). Overall, medical schemes increased payments from risk pool to GPs by 7.13%. The increase was higher for open (8.43%) compared with restricted schemes (5.83%). Members in open schemes rely more on medical savings accounts than members in restricted schemes to fund GP consultations.

The amount claimed and not paid by medical schemes increased by 1.27% in open schemes, while beneficiaries in restricted schemes saw a 3.62% reduction in out-of-pocket payments for GPs in 2019. Overall, out-of-pocket payments for GPs decreased by 0.77%.

Table 48: Utilisation of general medical practitioner health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	3 750 721	3 742 924	0.21	3 542 194	3 466 912	2.17	7 292 915	7 209 836	1.15
Number of patients per 1 000 beneficiaries	758.17	761.28	-0.41	889.48	886.21	0.37	816.73	816.64	0.01
Out-of-hospital utilisation	90.34%	90.16%	0.20	88.11%	88.19%	-0.09	89.26%	89.21%	0.05
In-hospital utilisation	9.66%	9.84%	-1.79	11.89%	11.81%	0.64	10.74%	10.79%	-0.41
Number of visits per patient	3.05	3.07	-0.46	3.34	3.33	0.31	3.19	3.19	-0.03
Amount claimed per patient	R489.70	R461.80	6.04	R462.53	R437.79	5.65	R475.89	R449.76	5.81
Risk amount paid per patient	R279.21	R257.50	8.43	R385.72	R364.48	5.83	R333.32	R311.12	7.13
MSA amount paid per patient	R161.72	R156.15	3.57	R56.82	R52.57	8.08	R108.43	R104.23	4.03
Total amount paid per patient	R440.93	R413.64	6.60	R442.54	R417.05	6.11	R441.75	R415.35	6.36
Amount not paid per patient	R48.77	R48.16	1.27	R19.99	R20.74	-3.62	R34.15	R34.41	-0.77

The Medical Schemes Industry Overview in 2019

Utilisation of general dental practitioner health services

The utilisation of general dental practitioner services by medical scheme beneficiaries in 2018 and 2019 is reported in Table 48. About 1.94 million beneficiaries visited a dentist at least once during 2019, representing a 1.17% increase in the absolute number of visits to the dentist. The % change between 2018 and 2019 was mainly driven by a significant increase (2.65%) in the number of dentist visits by beneficiaries covered by restricted schemes. More beneficiaries in restricted schemes (246.69 per 1 000) had at least one dentist consultation in 2019 compared with those in open schemes (193.95 per 1 000). Similar trends were observed in 2018. The average number of visits to dental practitioners remained largely unchanged at about 1.8 visits per patient in both open and restricted schemes. About 99% all dental practitioner consultations took place in out-of-hospital settings.

The amount claimed per patient increased by 4.14% (R1 324.81 to R1 379.72) for open and restricted schemes combined. Patients in open schemes rely more on medical savings accounts than risk benefits to fund dental consultations compared with restricted schemes. In addition, the out-ofpocket payment for dental consultations was very high for beneficiaries covered by open schemes. Beneficiaries in restricted schemes enjoyed more coverage from risk benefits and lower out-of-pocket payments for dental procedures, which explains the higher utilisation of dentist services by restricted scheme beneficiaries. The large out-of-pocket and MSA payments are likely to disincentivise beneficiaries in open schemes from using dentist services.

Table 49: Utilisation of general dental practitioner health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	959 480	962 424	-0.31	981 354	956 042	2.65	1 940 834	1 918 466	1.17%
Number of patients per 1 000 beneficiaries	193.95	195.75	-0.92	246.69	244.64	0.84	217.46	217.40	0.03
Out-of-hospital utilisation	99.38%	99.53%	-0.15	97.73%	97.64%	0.09	98.55%	98.59%	-0.04
In-hospital utilisation	0.62%	0.47%	31.67	2.27%	2.36%	-3.72	1.45%	1.41%	3.02
Number of visits per patient	1.79	1.82	-1.34	1.73	1.74	-0.85	1.76	1.78	-1.12
Amount claimed per patient	R1 519.53	R1 459.61	4.10	R1 238.13	R1 183.54	4.61	R1 379.72	R1 324.81	4.14
Risk amount paid per patient	R405.67	R399.87	1.45	R1 066.53	R1 018.80	4.68	R734.00	R702.08	4.55
MSA amount paid per patient	R752.99	R717.77	4.91	R84.24	R79.59	5.84	R420.74	R406.16	3.59
Total amount paid per patient	R1 158.67	R1 117.64	3.67	R1 150.77	R1 098.39	4.77	R1 154.74	R1 108.24	4.20
Amount not paid per patient	R360.86	R341.97	5.52	R87.36	R85.15	2.60	R224.98	R216.57	3.88

The Medical Schemes Industry Overview in 2019

Utilisation of medical specialist health services

The utilisation of medical specialist services by medical scheme beneficiaries in 2018 and 2019 is reported in Table 50. The number of beneficiaries visiting a general specialist at least once during the year increased by 2.79% from 3.10 million in 2018 to 3.19 million in 2019. A higher proportion of beneficiaries in open schemes (367.91 per 1 000) consulted with a medical specialist compared with restricted schemes (346.13 per 1 000) in 2019. During the period under review, about 38% of beneficiary consultations with medical specialists occurred in in-hospital settings and 62% in out-ofhospital settings. The average annual number of consultations per patient increased by 1.11% (3.33 to 3.37 visits) between 2018 and 2019.

The amount claimed by medical specialists increased by about 7.11% (R1 314.59 to R1 408.01) between 2018 and 2019. Overall, medical schemes increased payments from risk benefits to medical specialists by 7.78%. A portion of claims not paid by medical schemes increased by 7.39% and 9.49% for open and restricted schemes respectively. Beneficiaries in open schemes utilising medical specialists' services experienced higher outof-pocket payments compared with those in restricted schemes. Detailed utilisation and expenditure analysis for medical specialist is reported in Annexure G.

Table 50: Utilisation of medical specialist health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	1 820 098	1 791 976	1.57	1 370 333	1 311 760	4.47	3 190 431	3 103 736	2.79
Number of patients per 1 000 beneficiaries	367.91	364.47	0.94	346.13	337.37	2.60	358.23	352.50	1.63
Out-of-hospital utilisation	62.59%	62.13%	0.74	62.42%	62.38%	0.06	62.52%	62.24%	0.45
In-hospital utilisation	37.41%	37.87%	-1.21	37.58%	37.62%	-0.11	37.48%	37.76%	-0.74
Number of visits per patient	3.30	3.28	0.56	3.46	3.40	1.76	3.37	3.33	1.11
Amount claimed per patient	R1 524.10	R1 424.02	7.03	R1 261.15	R1 170.53	7.74	R1 408.01	R1 314.59	7.11
Risk amount paid per patient	R1 185.04	R1 100.34	7.70	R1 137.62	R1 053.47	7.99	R1 164.10	R1 080.10	7.78
MSA amount paid per patient	R135.03	R133.70	0.99	R37.35	R38.35	-2.59	R91.91	R92.54	-0.68
Total amount paid per patient	R1 320.08	R1 234.04	6.97	R1 174.97	R1 091.81	7.62	R1 256.01	R1 172.64	7.11
Amount not paid per patient	R204.03	R189.98	7.39	R86.18	R78.72	9.49	R152.00	R141.95	7.08

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Utilisation of surgical specialist health services

The utilisation of medical specialist services by beneficiaries of medical schemes in 2018 and 2019 is reported in Table 51. The average amount claimed by surgical specialists was R3 257.40 per patient in 2019, which represents an increase of 10.14% between 2018 and 2019. Overall, medical schemes increased payments from risk benefits to GPs by 10.21%. As observed for other healthcare practitioner services, members in open schemes rely more on medical savings accounts than restricted scheme members to fund surgical specialist consultations.

The amount claimed and not paid by medical schemes increased by 9.96% in open schemes, while beneficiaries in restricted schemes saw a 15.39% escalation in the out-of-pocket payment for surgical specialist consultations between 2018 and 2019. Overall, the out-of-pocket payment for surgical specialist consultations decreased by 11.19%. Detailed utilisation and expenditure analysis for surgical specialists is reported in Annexure G.

The number of medical scheme beneficiaries consulting with a surgical specialist at least once a year increased by 1.70% from 2.07 million in 2018 to 2.10 million in 2019. The proportion of surgical specialist consultations was higher in open schemes (252.66 and 253.45 per 1 000) in both the 2019 and 2018 financial years when compared with restricted schemes (213.78 and 210.67 per 1 000). The annual average number of repeat consultations per patient was around 1.9 across the medical scheme industry during the period under review. Overall, the percentage of patients consulting with a surgical specialist in a hospital setting remained largely unchanged at 47.35% in 2018 and 47.30% in 2019. The in-hospital surgical specialist visits were higher in open medical schemes than in restricted schemes.

The average amount claimed by surgical specialists was R3 257.40 per patient in 2019. This represents an increase of 10.14% between 2018 and 2019. Overall, medical schemes increased payments from risk benefits to GPs by 10.21%. As observed for other healthcare practitioner services, open scheme members rely more on medical savings accounts to fund surgical specialist consultations than restricted scheme members.

The amount claimed and not paid by medical schemes increased by 9.96% in open schemes, while beneficiaries in restricted schemes saw a 15.39% escalation in the out-of-pocket payment for surgical specialist consultations between 2018 and 2019. Overall, the out-of-pocket payment for surgical specialist consultations decreased by 11.19%. Detailed utilisation and expenditure analysis for surgical specialists is reported in Annexure G.

Table 51: Utilisation of surgical specialist health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	1 249 938	1 246 132	0.31	850 421	819 115	3.82	2 100 359	2 065 247	1.70
Number of patients per 1 000 beneficiaries	252.66	253.45	-0.31	213.78	210.67	1.48	235.33	234.56	0.33
Out-of-hospital utilisation	50.89%	50.69%	0.40	55.35%	55.62%	-0.48	52.70%	52.65%	0.10
In-hospital utilisation	49.11%	49.31%	-0.41	44.65%	44.38%	0.61	47.30%	47.35%	-0.11
Number of visits per patient	1.87	1.87	-0.13	1.90	1.90	-0.08	1.88	1.88	-0.10
Amount claimed per patient	R3 593.08	R3 278.22	9.60	R2 772.29	R2 477.58	11.89	R3 257.40	R2 957.52	10.14
Risk amount paid per patient	R2 776.76	R2 529.65	9.77	R2 301.59	R2 063.91	11.52	R2 582.43	R2 343.10	10.21
MSA amount paid per patient	R168.27	R159.19	5.70	R44.62	R44.43	0.42	R117.70	R113.23	3.95
Total amount paid per patient	R2 945.03	R2 688.84	9.53	R2 346.21	R2 108.34	11.28	R2 700.13	R2 456.32	9.93
Amount not paid per patient	R648.06	R589.38	9.96	R426.08	R369.24	15.39	R557.27	R501.20	11.19

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Utilisation of dental specialist health services

The utilisation of dental specialist services by medical scheme beneficiaries in 2018 and 2019 are reported in Table 52. The number of beneficiaries visiting dental specialists increased by 1.88% from 378 332 in 2018 to 385 446 in 2019. The increase between 2018 and 2019 was mainly driven by a significant increase (3.23%) in the number of dental specialist visits by beneficiaries covered by restricted schemes. More beneficiaries in restricted schemes (56.10% and 56.88% per 1 000) had at least one dentist consultation in 2018 and 2019 compared with those in open schemes (32.62 and 32.39% per 1 000). The average number of visits per patient to dental specialists reduced slightly from 1.88 to 1.83. About 95% all dental specialist consultations took place in out-of-hospital settings.

The amount claimed per patient increased by 8.17% (R2 036.69 to R2 203.05) for all medical schemes during the period under review. The amount paid from risk benefits by medical schemes to dental specialists accounted for nearly 50% of the amount claimed and increased by 5.67% (R1 036.68 to R1 095.43) between 2018 and 2019. Patients in open schemes rely more on medical savings accounts to fund dental specialist consultations compared with restricted scheme beneficiaries. In addition, out-of-pocket payments for dental consultations were very high for beneficiaries covered by open schemes. Beneficiaries in restricted schemes enjoyed more coverage from risk benefits and lower out-of-pocket payments for dental procedures. Patients covered in both restricted and open schemes experienced a higher-than-inflation increase in out-of-pocket payments.

Table 52: Utilisation of dental specialist health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	160 246	160 185	0.04	225 200	218 147	3.23	385 446	378 332	1.88
Number of patients per 1 000 beneficiaries	32.39	32.62	-0.71	56.88	56.10	1.39	43.28	43.00	0.65
Out-of-hospital utilisation	96.26%	96.30%	-0.05	94.23%	94.16%	0.07	95.07%	95.07%	0.00
In-hospital utilisation	3.74%	3.70%	1.31	5.77%	5.84%	-1.11	4.93%	4.93%	-0.02
Number of visits per patient	2.13	2.18	-2.53	1.62	1.66	-2.19	1.83	1.88	-2.56
Amount claimed per patient	R2 847.18	R2 639.25	7.88	R1 602.97	R1 455.35	10.14	R2 203.05	R2 036.69	8.17
Risk amount paid per patient	R976.67	R935.45	4.41	R1 206.06	R1 134.35	6.32	R1 095.43	R1 036.68	5.67
MSA amount paid per patient	R998.12	R913.62	9.25	R110.63	R101.24	9.28	R538.67	R500.15	7.70
Total amount paid per patient	R1 974.80	R1 849.07	6.80	R1 316.69	R1 235.59	6.56	R1 634.09	R1 536.83	6.33
Amount not paid per patient	R872.38	R790.19	10.40	R286.28	R219.76	30.27	R568.96	R499.86	13.82

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Utilisation of support specialists' health services

The utilisation of support specialists' services by beneficiaries of medical schemes in 2018 and 2019 is reported in Table 53. Support specialists include anaesthetists, radiologists, and pathologists. The number of beneficiaries visiting support specialists at least once during the year increased by 2.30% from 7.20 million in 2018 to 7.83 million in 2019. A higher proportion of beneficiaries in open schemes (851.86 per 1 000) consulted with a support specialist compared with restricted schemes (796.76 per 1 000) in 2019. The average annual number of consultations remained largely unchanged at about two per patient in 2018 and 2019.

The amount claimed by medical specialists increased by about 7.11% (R1 536.86 to R1 651.18) between 2018 and 2019. Overall, medical schemes increased payments from risk benefits to medical specialists by 7.78%. A portion of claims not paid by medical schemes increased by 8.79% and 11.20% for open and restricted schemes respectively. Beneficiaries in open schemes utilising medical specialists' services experienced higher out-of pocket-payments compared with those covered in restricted schemes. Detailed utilisation and expenditure analysis for support specialists is reported in Annexure G.

Table 53: Utilisation of support specialist health services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	4 214 226	4 182 992	0.75	3 169 584	3 034 801	4.44	7 383 810	7 217 793	2.30
Number of patients per 1 000 beneficiaries	851.86	850.78	0.13	796.76	776.56	2.60	827.30	817.91	1.15
Out-of-hospital utilisation	60.37%	60.05%	0.53	61.22%	60.56%	1.09	60.74%	60.26%	0.78
In-hospital utilisation	39.63%	39.95%	-0.80	38.78%	39.44%	-1.68	39.26%	39.74%	-1.19
Number of visits per patient	2.07	2.05	1.03	2.10	2.10	0.01	2.08	2.07	0.61
Amount claimed per patient	R1 774.53	R1 649.94	7.55	R1 489.55	R1 384.82	7.56	R1 651.18	R1 536.86	7.44
Risk amount paid per patient	R1 387.11	R1 284.56	7.98	R1 364.83	R1 270.26	7.44	R1 377.47	R1 278.46	7.74
MSA amount paid per patient	R202.52	R195.42	3.63	R45.20	R43.04	5.01	R134.42	R130.43	3.06
Total amount paid per patient	R1 589.64	R1 479.98	7.41	R1 410.03	R1 313.30	7.36	R1 511.89	R1 408.89	7.31
Amount not paid per patient	R184.89	R169.96	8.79	R79.53	R71.51	11.20	R139.29	R127.97	8.84

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Utilisation of supplementary and allied health professional services

The utilisation of supplementary and allied health practitioner services by beneficiaries of medical schemes in 2018 and 2019 is reported in Table 54. The number of beneficiaries visiting any one of the supplementary and allied health professionals at least once during the year increased by 3.86 from 4.41 million in 2018 to 4.58 million in 2019. The increase was not significant when adjusted for the population covered by all medical schemes (500.04 to 513.53 per 1 000 beneficiaries). The average number of consultations with supplementary and allied health professionals was about three visits per patient for the period under review.

The amount claimed by supplementary and allied health professionals increased by about 6 between 2018 and 2019 (R1 107.36 to R1 164.15). Overall, medical schemes increased payments from risk pool to supplementary and allied health professionals by 5.73. The increase was higher for open (6.05) compared with restricted schemes (4.83). Members in open schemes rely more on medical savings accounts to fund supplementary and allied health professionals' consultations than members in restricted schemes.

The amount claimed and not paid by medical schemes increased by 2.73 in open schemes, while beneficiaries in restricted schemes saw a 23.21 increase in out-of-pocket payments for supplementary and allied health professionals in 2019. Overall, the out-of-pocket payment for supplementary and allied health professional increased by 6.70. Detailed expenditure analysis per supplementary and allied health professional provider is reported in Annexure G.

Table 54: Utilisation of supplementary and allied health professional services in 2019 and 2018

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Total number of visits to the provider	2 518 065	2 484 616	1.35	2 058 464	1 921 806	7.11	4 576 529	4 406 422	3.86
Number of patients per 1 000 beneficiaries	509.00	505.35	0.72	519.18	493.35	5.24	513.53	500.04	2.70
Out-of-hospital utilisation	78.86	79.51	-0.82	80.77	80.67	0.11	79.72	80.02	-0.38
In-hospital utilisation	21.14	20.49	3.18	19.23	19.33	-0.47	20.28	19.98	1.51
Number of visits per patient	3.13	3.08	1.46	2.78	2.81	-1.11	2.97	2.96	0.23
Amount claimed per patient	R1 161.66	R1 109.06	4.74	R1 167.58	R1 104.95	5.67	R1 164.15	R1 107.36	5.13
Risk amount paid per patient	R667.01	R628.95	6.05	R983.57	R938.24	4.83	R800.14	R756.79	5.73
MSA amount paid per patient	R334.53	R324.25	3.17	R107.62	R104.71	2.78	R239.10	R233.50	2.40
Total amount paid per patient	R1 001.54	R953.20	5.07	R1 091.19	R1 042.95	4.63	R1 039.24	R990.30	4.94
Amount not paid per patient	R160.13	R155.86	2.73	R76.39	R62.00	23.21	R124.91	R117.07	6.70

The Medical Schemes Industry Overview in 2019

Analysis of admissions to hospitals

Private hospitals

The details of the utilisation of hospital services for all inpatient admissions by facility type is reported in tables 55 and 56. Table 57 provides details for overnight and same-day inpatient stays.

There was a negligible reduction (0.04) in the number of inpatient admissions to private acute hospitals between 2018 (2 388 528) and 2019 (2 387 471) across all schemes. In 2019, proportionally more beneficiaries covered by restricted schemes (276.82 per 1 000) compared with open schemes (259.77 per 1 000) were admitted to private acute hospitals. Over all schemes, the share of beneficiaries to private acute hospital reduced by 1.11, from 270.03 per 1 000 in 2018 to 267.37 per 1 000 in 2019.

The average number of times a beneficiary was admitted to private acute hospitals was 1.32 for the total population during the period under review. The average length of stay was around three days for private acute hospitals (calculations include same-day inpatient admissions) during the period under review.

The average age of admitted beneficiaries increased slightly from 38.28 years in 2018 to 39.79 in 2019. The average age of admitted patients was significantly high for open schemes (41.29 and 42.00 years) compared with restricted scheme (36.84 and 37.22 years) for 2018 and 2019 respectively.

Provincial hospitals

Admissions to provincial hospitals were less common in open schemes (2.15 per 1 000) when compared with restricted schemes (34.28 per 1000) in 2019. Open schemes accounted for only 10 651 admissions compared with 136 503 for restricted schemes in 2019. Similar trends were observed for 2018.

Restricted schemes recorded higher repeat admissions compared with open schemes. In 2019, provincial hospitals (2.21 time per year) experienced higher repeat admission compared with private acute hospitals (1.32 times per year).

Provincial hospital recorded unusually low length of stay compared with previous years. The low average length of stay may be attributable to poor data quality.

The average age of beneficiaries admitted to provincial hospitals was between 41 and 42 years for the period under review.

Day clinics

The number of admissions to day clinics increased by 11.09 between 2018 (145 863) and 2019 (164 052). Open schemes had proportionally more beneficiaries admitted to day clinics when compared with restricted schemes in 2019, 22.42 versus 13.34. The number of admissions per patient was about 1.2 for 2018 and 2019. The average age of beneficiaries admitted to day clinics, 40.06 years in 2019, was in the same range as that of beneficiaries admitted to acute private and provincial hospitals.

Subacute facilities

About 24 000 beneficiaries were admitted to subacute facilities in 2019. The proportion of beneficiaries, about three per 1 000, was the same between open and restricted schemes. Significantly older beneficiaries were admitted to subacute facilities.

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Mental institutions

The number of admissions to mental health institutions showed an increase of 7.62 from 49 746 in 2018 to 53 849 in 2019. The average length of stay for all inpatient admissions (including same-day admissions) was 11.43 and 11.01 days in 2018 and 2019, respectively. The average age of beneficiaries admitted to mental institutions decreased slightly from 38.14 in 2018 to 37.91 in 2019. There was a significant increase in the number of beneficiaries admitted as same-day cases in mental institutions.

Rehabilitation hospitals and hospices

Rehabilitation hospitals and hospices recorded 15 245 admissions for 10 700 beneficiaries of medical schemes in 2019. This translated to about 1.4 admissions per patient with an average stay of about 17 days. The proportion of admissions between open and restricted schemes was nearly the same. The average age of admitted beneficiaries was 48.36 and 45.50 for open and restricted schemes respectively.

Table 55: Analysis of all (same-day and overnight inpatient) admissions to hospitals in 2019 and 2018

Hospital group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Private hospital (57/58)									
Number of admissions	1 285 095	1 308 479	-1.79	1 102 376	1 080 049	2.07	2 387 471	2 388 528	-0.04
Number of beneficiaries admitted	970 855	993 188	-2.25	832 787	816 685	1.97	1 803 642	1 809 873	-0.34
Number of admissions per 1 000 beneficiaries	259.77	266.13	-2.39	276.82	275.60	0.44	267.37	270.33	-1.09
Number of admissions per patient	1.32	1.32	0.47	1.32	1.32	0.09	1.32	1.32	0.30
Average length of stay (days)	2.89	2.97	-2.66	2.85	2.95	-3.38	2.87	2.96	-2.99
Average age (years)	42.00	41.29	1.72	37.22	36.84	1.03	39.79	39.28	1.30
Provincial hospitals (56)									
Number of admissions	10 651	9 912	7.46	136 503	140 010	-2.50	147 154	149 922	-1.85
Number of beneficiaries admitted	7 369	7 090	3.94	59 247	61 276	-3.31	66 616	68 366	-2.56
Number of admissions per 1 000 beneficiaries	2.15	2.02	6.79	34.28	35.73	-4.06	16.48	16.97	-2.88
Number of admissions per patient	1.45	1.40	3.39	2.30	2.28	0.83	2.21	2.19	0.73
Average length of stay (days)	2.62	2.87	-8.73	0.60	0.62	-4.35	0.74	0.77	-3.78
Average age (years)	41.04	41.17	-0.31	41.70	42.09	-0.91	41.63	41.99	-0.86
Day clinics (76/77)									
Number of admissions	110 916	99 406	11.58	53 136	46 457	14.38	164 052	145 863	12.47
Number of beneficiaries admitted	92 343	82 481	11.96	43 997	38 529	14.19	136 340	121 010	12.67
Number of admissions per 1 000 beneficiaries	22.42	20.22	10.89	13.34	11.85	12.56	18.37	16.51	11.29
Number of admissions per patient	1.20	1.21	-0.34	1.21	1.21	0.16	1.20	1.21	-0.18
Average length of stay (days)	0.16	0.17	-6.22	0.29	0.24	18.72	0.20	0.19	4.06
Average age (years)	40.10	39.78	0.80	39.98	39.83	0.38	40.06	39.80	0.66

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Table 56: Analysis of all (same-day and overnight inpatient) admissions to hospitals in 2019 and 2018

Hospital group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Subacute facilities (49)									
Number of admissions	16 085	15 619	2.98	11 955	12 945	-7.65	28 040	28 564	-1.83
Number of beneficiaries admitted	13 722	13 144	4.40	10 070	10 783	-6.61	23 792	23 927	-0.56
Number of admissions per 1 000 beneficiaries	3.25	3.18	2.35	3.00	3.30	-9.12	3.14	3.23	-2.87
Number of admissions per patient	1.17	1.19	-1.35	1.19	1.20	-1.11	1.18	1.19	-1.28
Average length of stay (days)	11.28	11.00	2.54	10.49	10.34	1.44	10.94	10.70	2.25
Average age (years)	65.46	64.48	1.52	58.04	56.16	3.36	62.32	60.73	2.62
Mental health institutions (55)									
Number of admissions	29 804	27 545	8.20	24 045	22 201	8.31	53 849	49 746	8.25
Number of beneficiaries admitted	24 799	22 864	8.46	21 308	19 587	8.79	46 107	42 451	8.61
Number of admissions per 1 000 beneficiaries	6.02	5.60	7.54	6.04	5.67	6.58	6.03	5.63	7.11
Number of admissions per patient	1.20	1.20	-0.24	1.13	1.13	-0.44	1.17	1.17	-0.34
Average length of stay (days)	10.78	10.87	-0.80	11.29	12.14	-6.97	11.01	11.43	-3.72
Average age (years)	37.88	38.01	-0.36	37.96	38.30	-0.89	37.91	38.14	-0.61
Rehabilitation hospitals and hospices (47/59/79)									
Number of admissions	9 804	9 527	2.91	5 441	5 706	-4.64	15 245	15 233	0.08
Number of beneficiaries admitted	6 407	6 339	1.07	4 328	4 433	-2.37	10 735	10 772	-0.34
Number of admissions per 1 000 beneficiaries	1.98	1.94	2.27	1.37	1.46	-6.16	1.71	1.72	-0.97
Number of admissions per patient	1.53	1.50	1.82	1.26	1.29	-2.33	1.42	1.41	0.42
Average length of stay (days)	15.35	17.45	-12.04	19.31	18.64	3.60	16.76	17.90	-6.33
Average age (years)	48.36	49.03	-1.37	45.50	44.62	1.98	47.21	47.22	-0.02

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Table 57: Analysis of overnight inpatient admissions to hospitals in 2019 and 2018

Hospital group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Private hospital (57/58)									
Number of admissions	891 402	897 814	-0.71	692 138	680 990	1.64	1 583 540	1 578 804	0.30
Number of beneficiaries admitted	645 694	653 160	-1.14	495 719	489 121	1.35	1 141 413	1 142 281	-0.08
Number of admissions per 1 000 beneficiaries	180.19	182.61	-1.33	173.80	173.77	0.02	177.34	178.69	-0.75
Number of admissions per patient	1.38	1.37	0.43	1.40	1.39	0.28	1.39	1.38	0.38
Average length of stay (days)	4.17	4.33	-3.71	4.54	4.68	-2.99	4.33	4.48	-3.34
Average age (years)	42.64	41.84	1.91	38.92	38.42	1.30	41.02	40.37	1.61
Provincial hospitals (56)									
Number of admissions	4 339	4 313	0.60	13 227	15 237	-13.19	17 566	19 550	-10.15
Number of beneficiaries admitted	3 176	3 021	5.13	9 366	10 321	-9.25	12 542	13 342	-6.00
Number of admissions per 1 000 beneficiaries	0.88	0.88	-0.02	3.32	3.89	-14.57	1.97	2.21	-11.09
Number of admissions per patient	1.37	1.43	-4.31	1.41	1.48	-4.34	1.40	1.47	-4.42
Average length of stay (days)	6.42	6.59	-2.51	6.13	5.72	7.18	6.20	5.91	4.93
Average age (years)	38.93	39.60	-1.69	43.80	45.59	-3.94	42.56	44.24	-3.78
Day clinics (76/77)									
Number of admissions	5 512	4 958	11.17	4 931	3 943	25.06	10 443	8 901	17.32
Number of beneficiaries admitted	4 850	4 362	11.19	4 135	3 234	27.86	8 985	7 596	18.29
Number of admissions per 1 000 beneficiaries	1.11	1.01	10.49	1.24	1.01	23.07	1.17	1.01	16.09
Number of admissions per patient	1.14	1.14	-0.01	1.19	1.22	-2.19	1.16	1.17	-0.81
Average length of stay (days)	3.21	3.41	-5.88	3.08	2.83	8.55	3.15	3.16	-0.26
Average age (years)	53.87	53.18	1.29	43.39	43.88	-1.12	49.05	49.22	-0.36

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Table 58: Analysis of overnight inpatient admissions to hospitals in 2019 and 2018

group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Subacute facilities (49)									
Number of admissions	15 234	14 668	3.86	10 828	11 575	-6.45	26 062	26 243	-0.69
Number of beneficiaries admitted	12 950	12 228	5.90	9 185	9 711	-5.42	22 135	21 939	0.89
Number of admissions per 1 000 beneficiaries	3.08	2.98	3.22	2.72	2.95	-7.94	2.92	2.97	-1.73
Number of admissions per patient	1.18	1.20	-1.93	1.18	1.19	-1.10	1.18	1.20	-1.57
Average length of stay (days)	11.91	11.71	1.67	11.58	11.57	0.14	11.77	11.65	1.07
Average age (years)	65.40	64.64	1.19	58.88	57.13	3.07	62.70	61.31	2.26
Mental health institutions (55)									
Number of admissions	28 362	26 431	7.31	22 671	21 944	3.31	51 033	48 375	5.49
Number of beneficiaries admitted	23 924	22 211	7.71	20 031	19 390	3.31	43 955	41 601	5.66
Number of admissions per 1 000 beneficiaries	5.73	5.38	6.65	5.69	5.60	1.67	5.72	5.48	4.39
Number of admissions per patient	1.19	1.19	-0.38	1.13	1.13	0.01	1.16	1.16	-0.16
Average length of stay (days)	11.33	11.32	0.03	11.98	12.28	-2.47	11.62	11.76	-1.21
Average age (years)	37.78	37.97	-0.50	37.83	38.30	-1.21	37.80	38.12	-0.83
Rehabilitation hospitals and hospices (47/59/79)									
Number of admissions	8 805	8 531	3.21	4 751	4 887	-2.78	13 556	13 418	1.03
Number of beneficiaries admitted	5 927	5 808	2.05	3 792	3 803	-0.29	9 719	9 611	1.12
Number of admissions per 1 000 beneficiaries	1.78	1.74	2.58	1.19	1.25	-4.33	1.52	1.52	-0.03
Number of admissions per patient	1.49	1.47	1.14	1.25	1.29	-2.50	1.39	1.40	-0.09
Average length of stay (days)	17.10	19.49	-12.29	22.11	21.76	1.61	18.85	20.32	-7.21
Average age (years)	47.08	47.68	-1.26	44.88	43.79	2.48	46.22	46.14	0.17

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Table 59: Analysis of same-day inpatient admissions to hospitals in 2019 and 2018

group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Private hospital (57/58)									
Number of admissions	393 693	410 665	-4.13	410 238	399 059	2.80	803 931	809 724	-0.72
Number of beneficiaries admitted	325 161	340 028	-4.37	337 068	327 564	2.90	662 229	667 592	-0.80
Number of admissions per 1 000 beneficiaries	79.58	83.53	-4.72	103.01	101.83	1.16	90.03	91.64	-1.76
Number of admissions per patient	1.21	1.21	0.25	1.22	1.22	-0.10	1.21	1.21	0.09
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	40.75	40.25	1.23	34.71	34.48	0.68	37.67	37.42	0.69
Provincial hospitals (56)									
Number of admissions	6 312	5 599	12.73	123 276	124 773	-1.20	129 588	130 372	-0.60
Number of beneficiaries admitted	4 193	4 069	3.05	49 881	50 955	-2.11	54 074	55 024	-1.73
Number of admissions per 1 000 beneficiaries	1.28	1.14	12.04	30.96	31.84	-2.77	14.51	14.76	-1.65
Number of admissions per patient	1.51	1.38	9.40	2.47	2.45	0.93	2.40	2.37	1.14
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	42.64	42.34	0.72	41.31	41.38	-0.16	41.42	41.45	-0.08
Day clinics (76/77)									
Number of admissions	105 404	94 448	11.60	48 205	42 514	13.39	153 609	136 962	12.15
Number of beneficiaries admitted	87 493	78 119	12.00	39 862	35 295	12.94	127 355	113 414	12.29
Number of admissions per 1 000 beneficiaries	21.31	19.21	10.91	12.10	10.85	11.58	17.20	15.50	10.98
Number of admissions per patient	1.20	1.21	-0.36	1.21	1.20	0.40	1.21	1.21	-0.12
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	39.33	39.03	0.77	39.63	39.46	0.43	39.43	39.17	0.67

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Table 60: Analysis of same-day inpatient admissions to hospitals in 2019 and 2018

Hospital group (PCNS Number)	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Subacute facilities (49)									
Number of admissions	851	951	-10.52	1 127	1 370	-17.74	1 978	2 321	-14.78
Number of beneficiaries admitted	772	916	-15.72	885	1 072	-17.44	1 657	1 988	-16.65
Number of admissions per 1 000 beneficiaries	0.17	0.19	-11.07	0.28	0.35	-19.05	0.22	0.26	-15.67
Number of admissions per patient	1.10	1.04	6.18	1.27	1.28	-0.36	1.19	1.17	2.25
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	66.47	62.43	6.46	49.29	47.35	4.10	57.29	54.30	5.51
Mental health institutions (55)									
Number of admissions	1 442	1 114	29.44	1 374	257	434.63	2 816	1 371	105.40
Number of beneficiaries admitted	875	653	34.00	1 277	197	548.22	2 152	850	153.18
Number of admissions per 1 000 beneficiaries	0.29	0.23	28.65	0.35	0.07	426.12	0.32	0.16	103.24
Number of admissions per patient	1.65	1.71	-3.40	1.08	1.30	-17.52	1.31	1.61	-18.87
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	40.60	39.63	2.45	39.92	38.42	3.90	40.20	39.35	2.15
Rehabilitation hospitals and hospices (47/59/79)									
Number of admissions	999	996	0.30	690	819	-15.75	1 689	1 815	-6.94
Number of beneficiaries admitted	480	531	-9.60	536	630	-14.92	1 016	1 161	-12.49
Number of admissions per 1 000 beneficiaries	0.20	0.20	-0.32	0.17	0.21	-17.09	0.19	0.21	-7.92
Number of admissions per patient	2w.08	1.88	10.96	1.29	1.30	-0.98	1.66	1.56	6.34
Average length of stay (days)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Average age (years)	64.20	63.84	0.55	49.95	49.63	0.64	56.68	56.13	0.98

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Analysis of admissions to private hospitals

Figure 38 demonstrates admission rates by age for different hospital groups. Private acute hospitals show an expected pattern with high admission rates for infants, high admission rates for female beneficiaries in the reproductive age range and very high admission rates for elderly beneficiaries. The increase in the utilisation in the 20 to 40 years may be explained by an increase in the utilisation of maternal health services by female beneficiaries.

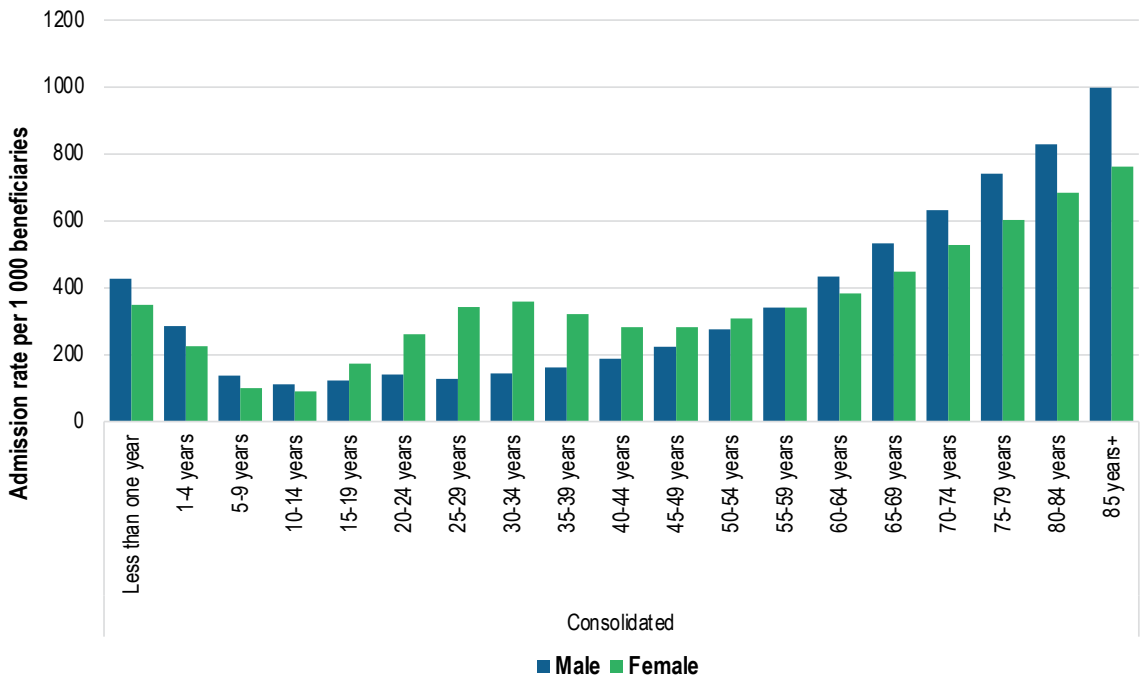

Figure 38: Admission rates (per 1 000 beneficiaries) for private hospitals

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Analysis of admissions to public hospitals

Age analysis of public hospitals shows that, in addition to lower admission rates, older beneficiaries in benefit options that have the state facility as the designated service provider are far more likely to be admitted to hospital as overnight inpatient cases than younger beneficiaries in the same plan, as demonstrated in Figure 39. Like private hospitals, an increase in the utilisation of hospital services by female beneficiaries in the 20-40-year age bracket was observed, which may also explain the increase in the utilisation of maternal health services by female beneficiaries. Additionally, more male compared with female beneficiaries in the older age bands (> 55 years) were admitted to public hospitals.

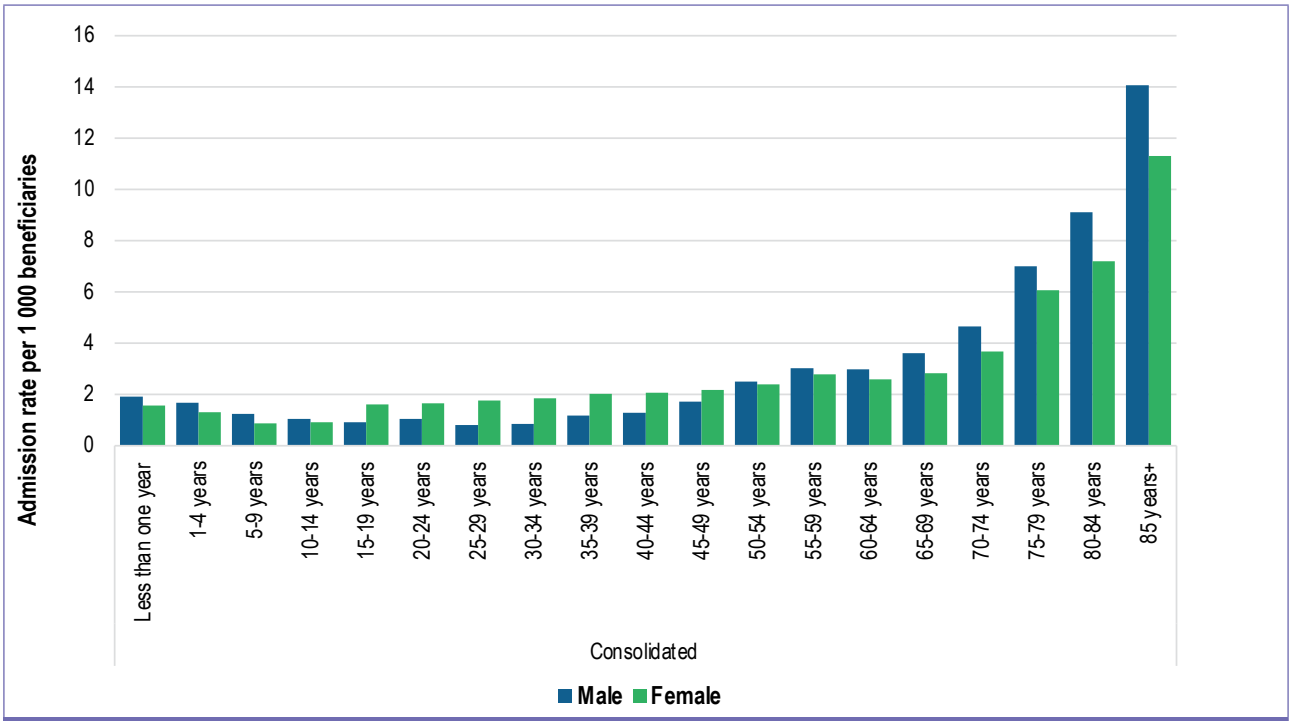

Figure 39: Admission rates (per 1 000 beneficiaries) for provincial hospitals

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Analysis of admissions to day clinics

Figure 40 depicts the analysis of beneficiary admissions to day clinics. Day hospitals offer opportunities to improve the efficiency of the private hospital sector. The use of day hospitals has cost benefits for both beneficiaries and medical schemes. Less than 30 in 1 000 beneficiaries in the one to fouryear age band were admitted to day clinics. The decline ping to levels around 10 in 1 000 beneficiaries between the five to 59 years age band and then rising to steadily to 70 in 1 000 in the 75 to 79 years age band, before declining to under 60 in 1 000 beneficiaries in 2018.

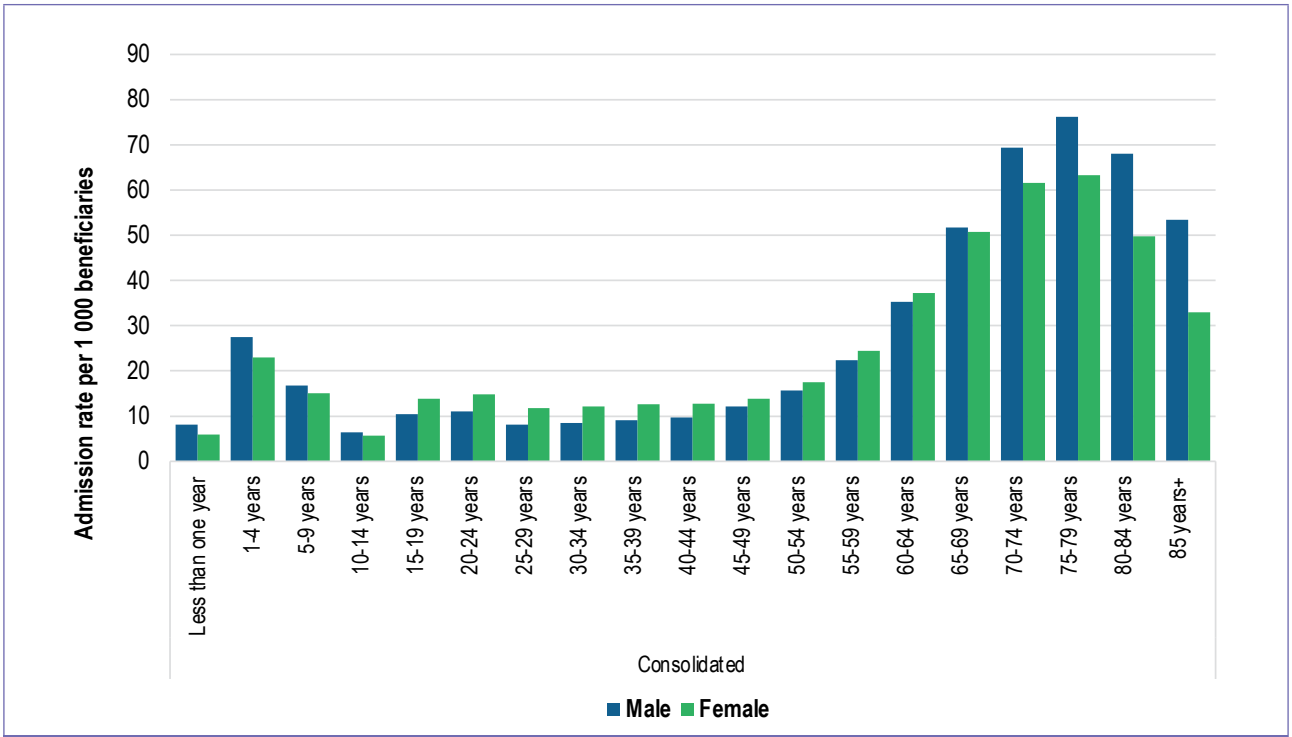

Figure 40: Admission rates (per 1 000 beneficiaries) for day clinics

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Analysis of admissions to mental health institutions

Figure 41 demonstrates the admission of beneficiaries to mental health institutions by age. Proportionally more female compared with male beneficiaries were admitted to mental health institutions across all age groups. The excess of female mental health institution admissions is consistent with the high prevalence of psychiatric in the female medical schemes' population.

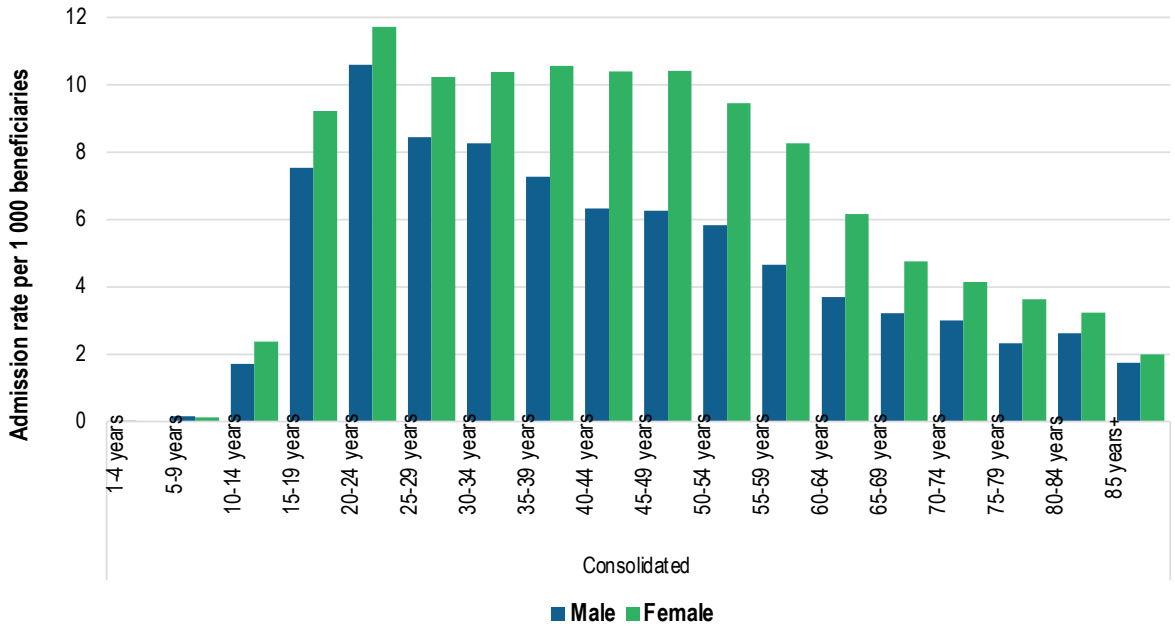

Figure 41: Admission rates (per 1 000 beneficiaries) for mental health institutions

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Hospital admissions by level of care

General ward admissions decreased by 3.4 to 171.32 per 1 000 beneficiaries in 2018 from 177.30 per 1 000 beneficiaries in 2017. The number of inpatient days per general ward admission was 3.27 days in 2018 and 3.19 days in 2017.

Admissions to the high care unit declined by 3.9 from 26.91 per 1 000 beneficiaries in 2017 to 25.86 in 2018. The length of stay in high care units increased slightly from 3.08 days in 2016 to 3.29 days in 2018.

Admissions to the intensive care unit (ICU) decreased by 9.3 from 12.10 per 1 000 beneficiaries in 2017 to 11.12 per 1000 beneficiaries in 2018. The length of stay in ICU increased slightly from 4.52 days in 2017 to 4.95 days in 2018.

The average number of hospital admissions in respect of PMB conditions remained unchanged between 2019 and 2018 at 64.43 and 64.03 per 1 000 beneficiaries respectively. The accuracy of PMB admissions data is a major challenge as scheme rules and systems are not set up to separate PMB from non-PMB admissions. The logic generally advanced by medical schemes is that there is no business incentive to identify claims related to PMB when the rules of the scheme provide for the payment of all authorised hospital admissions, PMB or not.

Table 61: Hospital admissions by level of care

	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
General Ward									
Number of admissions per 1 000 beneficiaries	165.10	165.88	-0.47	206.98	207.80	-0.39	183.78	184.47	-0.37
Average length of stay (days)	3.42	3.45	-0.98	3.66	4.55	-19.47	3.54	4.00	-11.47
High Care									
Number of admissions per 1 000 beneficiaries	28.31	25.58	10.65	27.14	25.48	6.51	27.79	25.54	8.81
Average length of stay (days)	3.03	3.20	-5.30	3.55	4.37	-18.71	3.26	3.72	-12.37
ICU									
Number of admissions per 1 000 beneficiaries	11.82	10.97	7.68	12.62	11.31	11.60	12.18	11.12	9.47
Average length of stay (days)	4.87	5.00	-2.70	4.86	6.27	-22.53	4.86	5.57	-12.76
PMB									
Number of admissions per 1 000 beneficiaries	61.07	57.75	5.76	93.40	93.13	0.29	75.49	73.44	2.79

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Analysis of admissions by selected case types

Table 62 and Table 63 show admission rates, average length of stay and expenditure across the 32 selected case types, and the rate of % change between 2018 and 2019. Data quality issues led to the exclusion of many schemes' data. Reason for exclusion included highly unlikely admission rates, average length of stay and expenditure data.

Medical – inpatient admissions

Of the reported medical inpatient admissions, pneumonia was the most common reason for admissions. The proportion of beneficiaries admitted for pneumonia was 75.22 per 10 000. Schemes recorded a reduction in the number of beneficiaries admitted for pneumonia. The reduction was about 10 for open schemes, 20 for restricted schemes and 15 overall. A decline in the admissions for pneumonia may represent progress towards the reduction of the infectious diseases associated burden. The limited data reported on immunisation coverage (Annexure M) shows very low rates for influenza vaccinations. Health failure was the only case type to show an increase during the period under review. Beneficiaries admitted for heart failure increased by 5.16 between 2018 and 2019. The increase was more pronounced in open schemes, which recorded an increase of 7.51, while restricted schemes increased by 2.32. The average length of stay for inpatient medical case types showed insignificant % changes for the period under review. Expenditure by cost types, disaggregated by hospital claims and related fees, is shown in Table 65. The medical inpatient case types with the highest average amount paid in 2019 were acute myocardial infarction with an average cost of R132 008.17. The hospital competent of the admission account forms the significant portion of the total expenditure for all the medical case types.

Surgical – inpatient admission rates

Surgical inpatient admissions showed an increase in the number of selected case types. The proportion of beneficiaries admitted for caesarean section procedures decreased by 0.49 during the period under review. In 2019, with 88.17 per 10 000 beneficiaries being admitted for caesarean section births compared with 88.61 per 10 000 beneficiaries in 2018. Large average length of stay % changes from 2018 and 2019 may be attributable to data quality issues. The reported figures must therefore be interpreted with caution. Surgical case types with the significant average amount paid in 2019 are coronary artery bypass graft (R157 589.50), endarterectomy (R141 972.82), discectomy (R141 621.49), hip replacement (R139 283.63) and knee replacement (132 521.18).

Day surgery admission rates

More lens and cataract procedures were performed on the same day (85.14 per 1 000) compared with the inpatient setting (46.43 per 10 000). The average expenditure for each of the selected case types was significantly lower when treated in day-surgery cases compared with inpatient-surgery cases. This strengthens the evidence that suggests that healthcare costs can be reduced significantly when treatment is delivered in appropriate settings.

The Medical Schemes Industry Overview in 2019

Table 62: Admission rates (per 10 000 beneficiaries) and average rate of % change by case type

Case type	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Medical – Inpatient									
M01 Acute Myocardial Infarction	15.95	15.38	3.71	8.42	8.76	-3.79	11.05	11.06	-0.04
M02 Angina Pectoris	68.77	68.94	-0.25	39.16	39.72	-1.40	49.85	50.29	-0.86
M03 Cholelitiasis	6.44	6.89	-6.53	3.66	3.80	-3.61	5.23	5.56	-5.86
M04 Heart Failure	33.91	31.54	7.51	32.33	31.60	2.32	33.19	31.56	5.16
M05 Malignant Neoplasm	4.18	3.96	5.52	2.77	3.16	-12.24	3.56	3.61	-1.42
M06 Normal Deliveries	26.69	27.82	-4.05	22.54	24.80	-9.13	24.80	26.45	-6.24
M07 Pneumonia	77.57	86.05	-9.86	72.46	90.41	-19.85	75.22	88.04	-14.56
Surgical – Inpatient									
S01 Appendectomy	14.45	14.58	-0.88	8.93	9.90	-9.73	12.00	12.51	-4.13
S02 Caesarean section	97.02	97.24	-0.23	77.49	78.07	-0.74	88.17	88.61	-0.49
S03 Cholecystectomy	16.68	16.69	-0.01	13.00	13.31	-2.39	15.01	15.17	-1.02
S04 Colorectal resection	1.75	1.78	-2.11	1.05	1.36	-22.43	1.60	1.69	-5.63
S05 Coronary artery bypass graft	5.12	4.94	3.60	0.91	0.95	-3.93	2.17	2.14	1.67
S06 Discectomy	0.93	1.09	-14.75	1.98	1.91	3.54	1.33	1.40	-5.13
S07 Endarterectomy	0.53	0.46	16.70	0.36	0.38	-3.91	0.45	0.42	7.91
S08 Hip replacement: total and partial	13.72	12.65	8.48	7.92	8.09	-2.05	11.15	10.65	4.78
S09 Hysterectomy: abdominal or vaginal	15.82	15.25	3.79	16.55	17.00	-2.67	16.14	16.01	0.82
S10 Knee replacement	17.26	16.31	5.81	14.04	13.87	1.24	15.84	15.25	3.93
S11 Mastectomy	2.94	2.85	2.94	2.97	2.87	3.40	2.95	2.86	3.14
S12 Open prostatectomy	0.74	0.72	3.04	0.71	1.01	-29.60	0.73	0.84	-13.16
S13 Percutaneous transluminal coronary angioplasty				11.91	10.58	12.58	11.91	10.58	12.58
S14 Peripheral vascular bypass	0.48	0.53	-8.32	0.83	0.81	2.39	0.52	0.56	-6.54
S15 Repair of inguinal hernia	11.40	11.28	1.09	5.26	5.24	0.41	8.73	8.67	0.63
S16 Thyroidectomy	3.31	3.36	-1.40	2.37	2.11	12.65	2.90	2.82	2.94
S17 Transurethral resection of prostate	4.10	4.26	-3.58	4.89	5.14	-4.84	4.41	4.60	-4.05
S18 Arthroscopic excision of meniscus of knee	9.78	9.18	6.59	4.55	4.58	-0.78	7.47	7.16	4.28

The Medical Schemes Industry Overview in 2019

Table 63: Admission rates (per 10 000 beneficiaries) and average rate of % change by case type

Case type	Open			Restricted			Restricted		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
S19 Lens and cataract procedures	68.99	66.58	3.63	18.34	17.77	3.16	46.43	45.08	3.00
S20 Litigation and stripping of varicose veins - lower limb	2.15	2.13	0.87	1.13	1.31	-13.47	1.72	1.78	-3.82
S21 Tonsillectomy and/or adenoidectomy	30.88	31.26	-1.24	13.95	14.02	-0.51	23.45	23.78	-1.36
Day surgery									
S18 Arthroscopic excision of meniscus of knee	5.18	5.62	-7.76	4.58	4.11	11.64	4.78	4.59	3.99
S19 Lens and cataract procedures	104.91	108.63	-3.43	75.41	72.84	3.53	85.45	84.97	0.56
S20 Litigation and stripping of varicose veins - lower limb	0.57	0.64	-10.99	0.57	0.84	-32.16	0.57	0.65	-11.68
S21 Tonsillectomy and/or adenoidectomy	33.69	37.85	-11.00	28.44	28.89	-1.56	30.26	31.98	-5.40

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Table 64: Average length of stay by medical case type

	Open			Restricted			Restricted		
Case type	2019	2018	% change	2019	2018	% change	2019	2018	% change
Medical – Inpatient									
M01 Acute Myocardial Infarction	4.92	5.14	-4.28	5.32	4.96	7.26	5.12	5.05	1.39
M02 Angina Pectoris	2.71	3.01	-9.97	3.02	3.11	-2.89	2.87	3.06	-6.21
M03 Cholelitiasis	2.91	3.08	-5.52	3.38	3.28	3.05	3.05	3.14	-2.87
M04 Heart Failure	5.98	5.98	0.00	6.04	5.87	2.90	6.01	5.93	1.35
M05 Malignant Neoplasm	5.13	5.40	-5.00	6	6.24	-3.85	5.43	5.72	-5.07
M06 Normal Deliveries	1.96	1.97	-0.51	2.19	2.25	-2.67	2.05	2.09	-1.91
M07 Pneumonia	4.71	4.67	0.86	5.05	4.9	3.06	4.86	4.78	1.67
Surgical – Inpatient									
S01 Appendectomy	2.55	2.56	-0.39	3.4	3.3	3.03	2.83	2.82	0.35
S02 Caesarean section	2.92	2.89	1.04	3.21	3.43	-6.41	3.03	3.1	-2.26
S03 Cholecystectomy	2.92	3.16	-7.59	3.69	3.62	1.93	3.22	3.34	-3.59
S04 Colorectal resection	7.96	7.50	6.13	7.1	7.57	-6.21	7.83	7.51	4.26
S05 Coronary artery bypass graft	4.69	7.24	-35.22	5.77	7.09	-18.62	5.00	7.19	-30.46
S06 Discectomy	5.07	5.28	-3.98	4.4	4.32	1.85	4.69	4.79	-2.09
S07 Endarterectomy	5.94	5.62	5.69	7.04	7.61	-7.49	6.35	6.44	-1.40
S08 Hip replacement: total and partial	5.46	5.64	-3.19	5.36	6	-10.67	5.43	5.76	-5.73
S09 Hysterectomy: abdominal or vaginal	2.91	2.90	0.34	3.43	3.4	0.88	3.14	3.13	0.32
S10 Knee replacement	4.02	4.27	-5.85	5.15	5.39	-4.45	4.46	4.72	-5.51
S11 Mastectomy	2.65	2.62	1.15	3.43	3.59	-4.46	2.99	3.04	-1.64
S12 Open prostatectomy	5.35	5.33	0.38	5.68	5.52	2.90	5.48	5.43	0.92
S13 Percutaneous transluminal coronary angioplasty				2.82	2.21	27.60	2.82	2.21	27.60
S14 Peripheral vascular bypass	6.04	6.29	-3.97	4.82	4.95	-2.63	5.83	6.09	-4.27
S15 Repair of inguinal hernia	1.52	1.50	1.33	1.52	1.73	-12.14	1.52	1.56	-2.56
S16 Thyroidectomy	2.30	2.29	0.44	2.98	3.02	-1.32	2.54	2.52	0.79
S17 Transurethral resection of prostate	3.20	3.05	4.92	3.35	3.45	-2.90	3.27	3.23	1.24
S18 Arthroscopic excision of meniscus of knee	1.07	1.23	-13.01	1.5	1.43	4.90	1.18	1.29	-8.53
S19 Lens and cataract procedures	0.99	0.97	2.06	1.01	1.01	0.00	0.99	0.98	1.02
S20 Litigation and stripping of varicose veins - lower limb	1.19	1.28	-7.03	1.69	1.8	-6.11	1.33	1.44	-7.64
S21 Tonsillectomy and/or adenoidectomy	1.07	1.07	0.00	1.3	1.25	4.00	1.13	1.11	1.80

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Table 65: Average hospital expenditure (in Rand) by case type, 2019

Case type	Hospital fees paid per admission	Radiology fees paid per admission	Pathology fees paid per admission	Professional fees paid per admission	Medicines fees paid per admission	Other fees paid per admission	Total claims paid per admission
Medical – inpatient							
M01 Acute Myocardial Infarction	R95 517.08	R1 358.55	R20 786.40	R3 846.32	R3 847.49	R6 652.33	R132 008.17
M02 Angina Pectoris	R44 563.59	R1 020.87	R11 325.83	R1 908.75	R1 909.64	R2 765.04	R63 493.72
M03 Cholelitiasis	R20 534.50	R1 838.76	R5 499.42	R1 295.78	R1 295.30	R1 153.32	R31 617.08
M04 Heart Failure	R37 679.18	R1 801.71	R7 641.90	R995.58	R995.81	R3 863.44	R52 977.62
M05 Malignant Neoplasm	R26 573.83	R2 428.34	R5 579.01	R1 160.55	R1 162.96	R3 530.35	R40 435.03
M06 Normal Deliveries	R17 582.90	R55.09	R5 816.45	R106.03	R97.18	R476.81	R24 134.46
M07 Pneumonia	R24 507.57	R1 258.76	R4 689.82	R702.23	R701.92	R2 840.94	R34 701.25
Surgical – inpatient							
S01 Appendectomy	R27 068.48	R2 123.10	R10 320.12	R411.39	R409.37	R849.23	R41 181.70
S02 Caesarean section	R28 480.21	R136.67	R10 886.17	R187.89	R171.51	R1 007.22	R40 869.68
S03 Cholecystectomy	R38 238.76	R1 197.32	R12 353.61	R420.06	R406.97	R1 171.85	R53 788.56
S04 Colorectal resection	R85 664.47	R2 094.40	R19 654.17	R848.16	R808.45	R5 631.57	R114 701.21
S05 Coronary artery bypass graft	R127 182.11	R196.48	R8 219.08	R9 902.22	R9 902.22	R2 187.37	R157 589.50
S06 Discectomy	R97 315.40	R2 511.35	R35 252.56	R826.04	R805.75	R4 910.38	R141 621.49
S07 Endarterectomy	R93 407.04	R3 874.56	R34 758.08	R1 874.82	R1 873.97	R6 184.35	R141 972.82
S08 Hip replacement: total and partial	R99 257.21	R1 582.24	R27 893.76	R2 624.28	R2 611.87	R5 314.27	R139 283.63
S09 Hysterectomy: abdominal or vaginal	R35 934.14	R345.61	R10 695.24	R456.98	R449.34	R1 872.05	R49 753.36
S10 Knee replacement	R96 872.87	R903.63	R25 997.94	R2 625.47	R2 609.62	R3 511.66	R132 521.18
S11 Mastectomy	R32 302.02	R1 476.14	R13 386.41	R1 042.01	R1 038.77	R887.10	R50 132.44
S12 Open prostatectomy	R64 769.33	R861.64	R19 833.64	R1 580.42	R1 584.56	R4 304.20	R92 933.78
S13 Percutaneous transluminal coronary angioplasty	R108 738.03	R346.00	R27 155.10	R8.29	R16.77	R2 920.07	R139 184.25
S14 Peripheral vascular bypass	R83 933.06	R1 328.03	R22 296.50	R5 308.97	R5 308.64	R5 362.67	R123 537.87
S15 Repair of inguinal hernia	R27 811.34	R239.81	R8 069.12	R660.54	R643.14	R562.48	R37 986.44
S16 Thyroidectomy	R36 413.11	R560.54	R11 463.53	R348.25	R316.62	R1 015.24	R50 117.28
S17 Transurethral resection of prostate	R29 833.28	R664.49	R10 240.13	R758.00	R757.76	R849.62	R43 103.29
S18 Arthroscopic excision of meniscus of knee	R22 540.50	R283.68	R11 653.28	R120.15	R105.88	R815.45	R35 518.94
S19 Lens and cataract procedures	R12 009.24	R7.30	R15 377.36	R685.84	R629.92	R33.09	R28 742.75
S20 Litigation and stripping of varicose veins - lower limb	R23 161.94	R289.95	R9 263.84	R161.83	R142.36	R461.26	R33 481.17
S21 Tonsillectomy and/or adenoidectomy	R10 575.32	R56.50	R5 200.52	R132.43	R122.12	R114.45	R16 201.34
Day surgery							
S18 Arthroscopic excision of meniscus of knee	R17 333.43	R31.03	R7 727.06	R144.97	R118.70	R566.28	R25 921.46
S19 Lens and cataract procedures	R12 814.66	R1.66	R11 402.96	R196.81	R194.10	R179.30	R24 789.49
S20 Litigation and stripping of varicose veins - lower limb	R16 335.92	R64.52	R4 454.06	R197.77	R148.72	R266.39	R21 467.37
S21 Tonsillectomy and/or adenoidectomy	R7 956.21	R2.45	R2 510.84	R181.59	R183.57	R240.82	R11 075.49

The Medical Schemes Industry Overview in 2019

Utilisation of medical technology

Table 61 provides an overview of the utilisation of medical technology, which remained largely unchanged during the period under review. The utilisation of magnetic resonance imaging (MRI) scans, angiograms, bone density scans, and dialysis services are generally higher in open medical schemes than in restricted schemes. The % changes observed may be explained by % changes in the demographic characteristics of beneficiaries over time.

The use of computerised tomography (CT) scans increased by 4.44, from 45.13 in 2018 to 47.13 per 1 000 beneficiaries in 2019 as shown in Table 61. The number of beneficiaries receiving CT scans was high in open schemes when compared with restricted schemes. The number of beneficiaries utilising MRI scans increased by 3.76 during the period under review. About 27 in 1 000 beneficiaries received an MRI scan during the 2018 financial year. Proportionally more beneficiaries received MRI scans compared with restricted schemes. The number of beneficiaries receiving renal dialysis increased significantly by 11.95 between 2018 and 2019. Overall, 13.03 patients per 1 000 beneficiaries received renal dialysis in 2019. Proportionally more beneficiaries in restricted schemes received renal dialysis compared with open schemes. The number of bone density scans increased by 3.4 from 5.65 in 2018 to 5.84 per 1 000 beneficiaries in 2019. A small number of beneficiaries received an angiogram during the 2018 and 2019 financial years (1.95 in 2018 and 2.23 per 1 000 beneficiaries in 2019). Positron resonance tomography (PET) scans were performed on about 1 per 1 000 beneficiaries in both 2018 and 2019. The difference in the use of PET scans in the open and restricted schemes was not significant.

Table 66: Utilisation of medical technology

Healthcare technology	Open			Restricted			Consolidated		
	2019	2018	% change	2019	2018	% change	2019	2018	% change
Number of patients utilising CT scan per 1 000 beneficiaries	51.82	50.19	3.24	41.31	38.80	6.47	47.13	45.13	4.44
Number of patients utilising MRI scans per 1 000 beneficiaries	32.48	31.64	2.65	23.60	22.29	5.88	28.52	27.48	3.76
Number of patients receiving renal dialysis per 1 000 beneficiaries	10.01	9.30	7.60	16.62	15.25	9.01	13.03	11.95	9.05
Number of patients utilising bone density scans per 1 000 beneficiaries	7.03	6.77	3.79	4.36	4.24	2.96	5.84	5.65	3.40
Number of patients utilising angiograms per 1 000 beneficiaries	2.46	2.31	6.64	1.94	1.50	29.14	2.23	1.95	14.29
Number of patients utilising positron emission tomography (PET) scan per 1 000 beneficiaries	1.11	0.93	19.94	1.31	0.84	55.79	1.20	0.89	35.03

The Medical Schemes Industry Overview in 2019

Utilisation of maternal, and reproductive healthcare services

This section accounts for the utilisation of screening, child, maternal, and reproductive health services. The utilisation of maternal, and reproductive healthcare services was stable during the period under review. The % changes observed may be explained by % changes in the demographic characteristics of beneficiaries and improvements in the quality of data over time. The number of caesarean sections performed per 1 000 birth admissions was significant. According to the data received from medical schemes, more than 75 of all births were by caesarean in 2019. The true rate is likely to be significantly higher than the reported figures. Efforts to improve maternal health data will continue in the current financial year.

Table 67: Utilisation of maternal and reproductive healthcare services

Selected health services	Open	Restricted	Consolidated		
	2019	2019	2019	2018	% change
Baby born alive in health facility who weighs less than 2500g (per 1 000 live births)	11.80	23.36	16.44	18.32	-10.22
Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15-49 years (per 1 000 female beneficiaries aged 15-49 years)	14.49	10.69	12.78	12.68	0.78
Number of birth admissions (per 1 000 female beneficiaries)	31.00	26.70	29.06	30.15	-3.59
Number of birth admissions to women between 15 – 19 years (per 1 000 female beneficiaries aged 15-19 years)	9.72	17.89	15.13	15.72	-3.80
Number of birth admissions to women under 15 years (per 1 000 female beneficiaries aged under 15 years)	0.56	3.58	2.60	4.43	-41.33
Number of caesarean sections performed (per 1 000 birth admissions)	786.20	770.13	779.85	771.13	1.13
Number of mammograms paid for (per 1 000 female beneficiaries aged 50-69 years)	360.64	277.14	325.03	324.61	0.13
Number of pap smears paid for (per 1 000 female beneficiaries aged 15-69 years)	168.77	139.43	155.81	159.06	-2.04
Subdermal contraceptive implant inserted just under the skin of a woman aged 15-49 years upper arm (per 1 000 female beneficiaries aged 15-49 years)	0.92	1.00	0.98	1.04	-5.57
Surgical procedure to prevent a man from being fertile (per 1 000 male beneficiaries aged 15-49 years)	8.06	2.94	5.95	5.86	1.61
Surgical procedure to protect a woman from further pregnancy (per 1 000 female beneficiaries aged 15-49 years)	5.92	3.72	4.96	5.14	-3.42
Termination of Pregnancy at 13-20 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations)	516.19	173.91	319.06	279.41	14.19
Termination of Pregnancy in the first 12 weeks of pregnancy performed under safe conditions in a health facility (per 1 000 terminations)	369.52	767.51	598.87	490.45	22.11
Total number of live births (per 1 000 birth admissions)	976.42	968.87	973.38	977.91	-0.46
Number of women using contraceptives (per 1 000 female beneficiaries aged 15-49 years)	213.31	205.45	209.72	201.50	4.08

The Medical Schemes Industry Overview in 2019

The medical schemes industry in 2019

Trends in contributions received and claims paid on behalf of members

Contributions

The gross contribution received from medical scheme members in 2019 was R205.83 billion compared with R192.28 billion in December 2018, which is an increase of 7.05%.

Risk contributions (gross contributions excluding medical savings accounts contributions) increased by 7.31% to R186.66 billion from R173.95 billion in 2018. The equivalent increase from 2017 to 2018 was 6.81%.

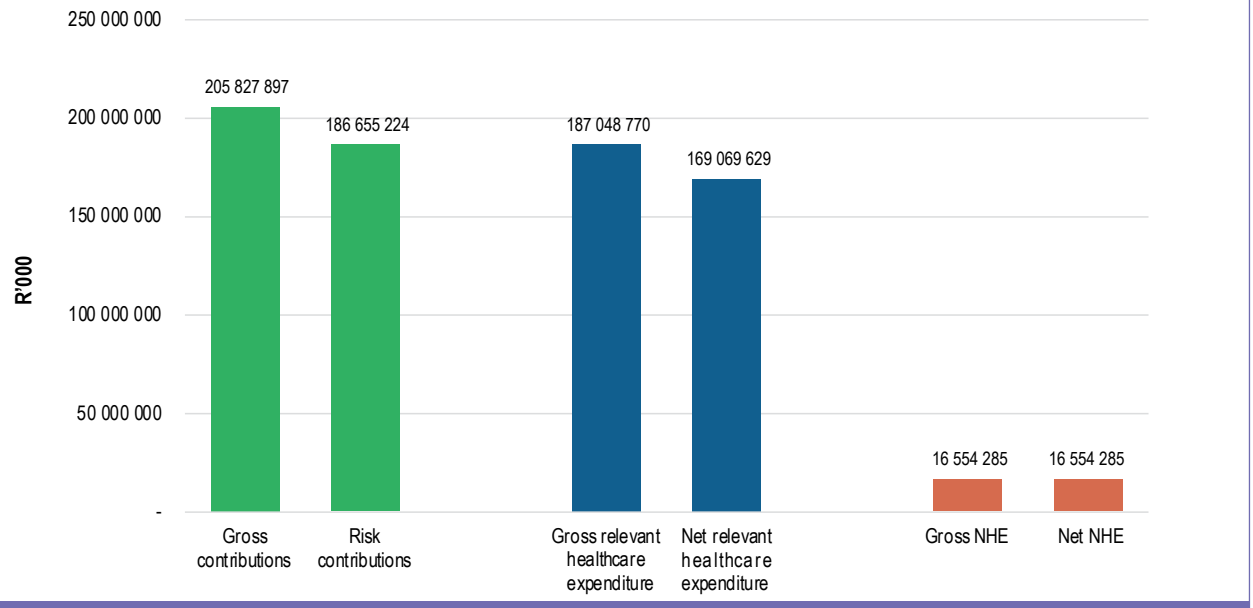

Figure 42 : Contributions, relevant healthcare expenditure and non-healthcare expenditure (NHE) 2019

The Medical Schemes Industry Overview in 2019

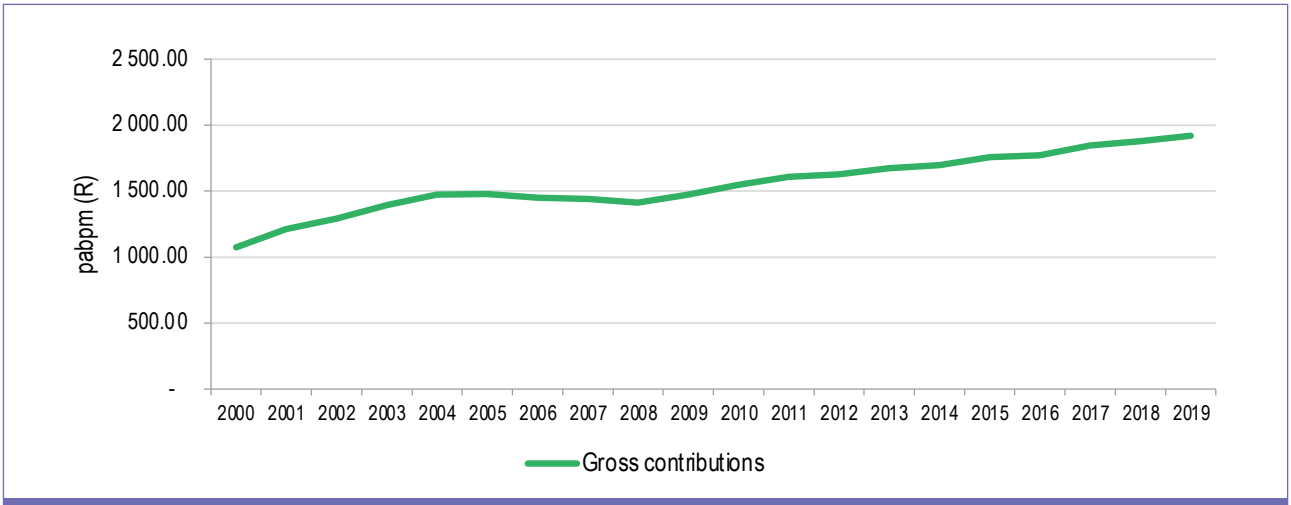

Figure 43: Gross contributions per average beneficiary per month (2000 – 2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

Gross contributions, adjusted for lives covered (per average beneficiary per month)[3] (pabpm) have increased by 78.78% between 2000 and 2019, while gross relevant healthcare expenditure increased by 82.05%. See Figure 43.

Gross contributions pabpm rose by 6.29% to R1 919.57 from R1 805.98 in 2018. After adjusting for inflation, this growth was 2.12%.

The increase in risk contributions pabpm was 6.55%, rising to R1 740.77 from R1 633.83. After adjusting for inflation, this growth was 2.37%.

Contributions to personal medical savings accounts increased by 4.61% to R19.17 billion from R18.33 billion (2018: 8.13% increase). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 2.25% from R203.05 to R207.61. After adjusting for inflation, a decrease of 1.76% was noted.

Investment income and reserves have assisted medical schemes to reduce the burden of increasing healthcare costs, maintain reserves and retain members. Factors such as increasing claims, technology costs, members getting sicker and older, and stagnant growth in members, have had a collective negative impact on available resources.

The total gross relevant healthcare expenditure incurred by medical schemes increased by 7.43% to R187.05 billion from R174.12 billion in 2018. Risk claims increased by 7.73% to R169.07 billion from R156.94 billion in 2018.

[3] Reflected in 2019 prices.

The Medical Schemes Industry Overview in 2019

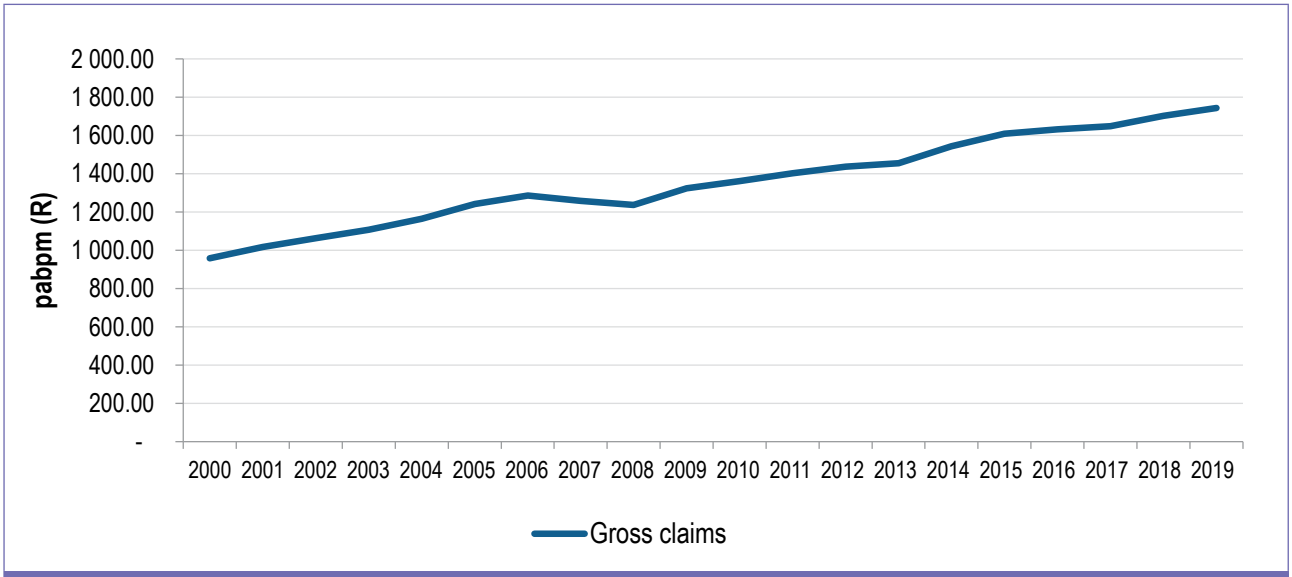

Figure 44: Gross relevant healthcare expenditure (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
*The values were adjusted for CPI for 2000 – 2018

The total gross relevant healthcare expenditure incurred pabpm increased by 6.66% to R1 744.44 from R1 635.46 in 2018. Risk claims pabpm rose by 6.96% to R1 576.76 from R1 474.13 in 2018; after adjusting for inflation, this growth was 2.80%.

A combination of factors has impacted on the claims experience of medical schemes over time, more so in later years. These include changing benefit design, demographic profiles, increased utilisation of benefits and a higher number of high cost cases. Some medical schemes were also affected by widespread fraud and abuse of benefits, as well as wastage of resources. The change in VAT on 1 April 2018 also had an impact on claims costs.

The Medical Schemes Industry Overview in 2019

Figure 45 and 46 depict medical schemes that had the highest increases in claims ratios, from 2018 to 2019.

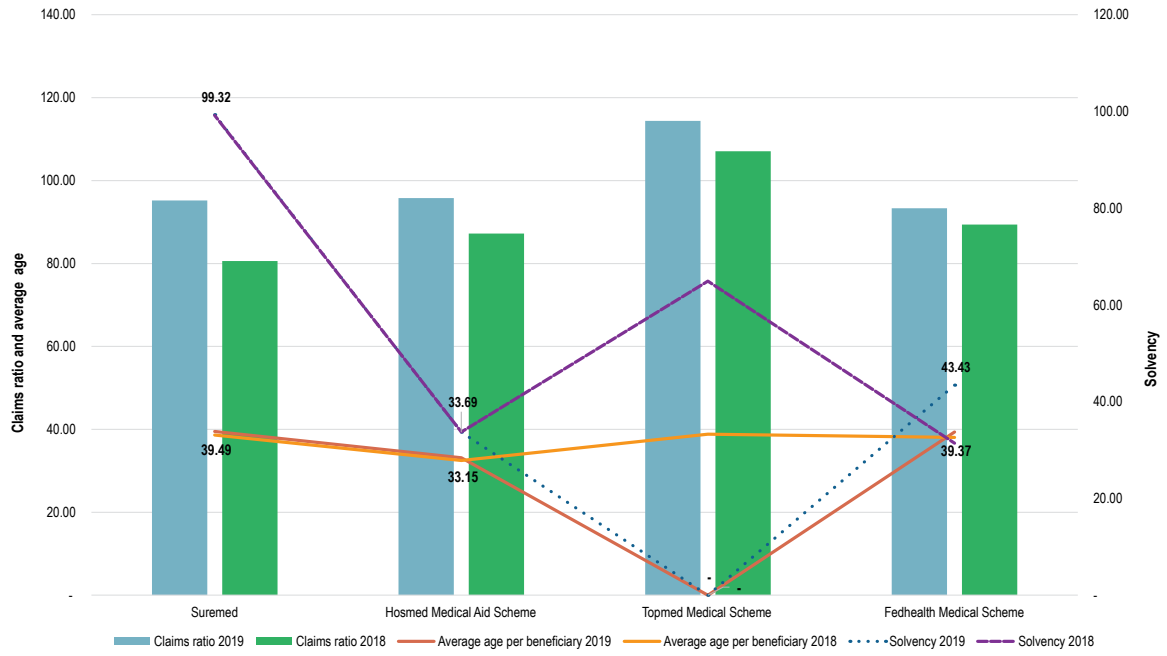

Figure 45 : Open schemes with a claims ratio increase greater than 4%

The Medical Schemes Industry in 2019

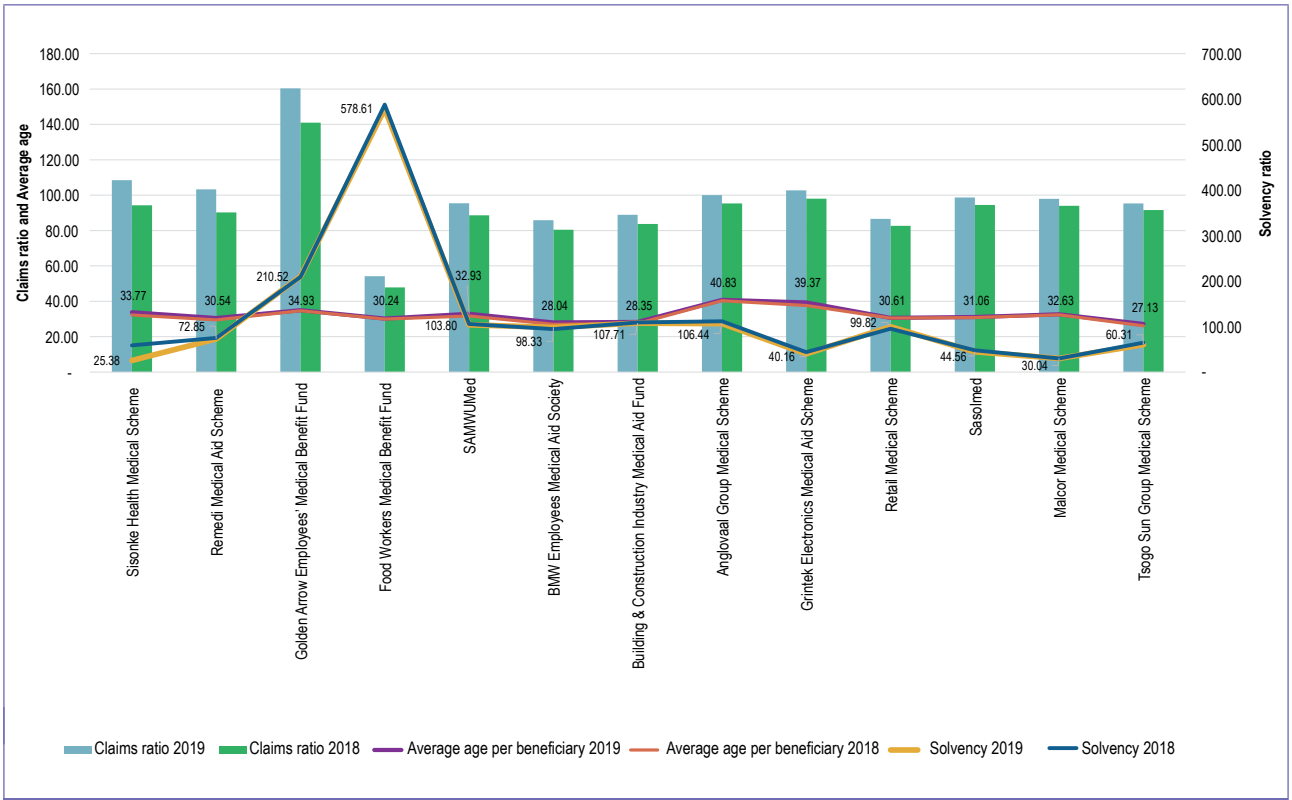

Figure 46: Restricted schemes with a claims ratio increase greater than 4.00%

The majority of open schemes and all restricted schemes where claims ratios increased by more than 4.00% have solvency ratios that are above the minimum required statutory level of 25.00% suggest that they could be utilising reserves to cushion members from high contribution increases. While the utilisation of reserves to cushion members against increasing costs is an appropriate strategy for medical schemes, there are schemes that appear to be deliberately under-pricing, some with poorer than average risk profiles. In those cases, caution should be exercised to ensure that financial sustainability is maintained.

Table 68: Open scheme deviation from industry average – 2019 and 2018

Ref. no.	Name of medical scheme	% change in claims ratio	% deviation from average claims ratio of 89.34 2019	% deviation from average claims ratio of 89.85 2018
1464	Suremed	18.16	6.57	-10.32
1537	Hosmed Medical Aid Scheme	9.82	7.20	-2.94
1422	Topmed Medical Scheme	6.81	28.03	19.19
1202	Fedhealth Medical Scheme	4.40	4.47	-0.50

The table shows the percentage deviation of the open schemes with a claims ratio increase greater than 4.00% from 2018 to 2019, from the industry average of 89.34% and 89.85% for 2019 and 2018 respectively.

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Table 69: Restricted scheme deviation from industry average – 2019 and 2018

Ref. no.	Name of medical scheme	% change in claims ratio	% deviation from average claims ratio of 92.15 2019	% deviation from average claims ratio of 90.71 2018
1568	Sisonke Health Medical Scheme	15.05	17.70	3.92
1430	Remedi Medical Aid Scheme	14.47	12.10	-0.52
1270	Golden Arrow Employees' Medical Benefit Fund	13.69	73.97	55.45
1086	Food Workers Medical Benefit Fund	13.16	-41.20	-47.22
1038	SAMWUMed	7.66	3.52	-2.33
1526	BMW Employees Medical Aid Society	6.76	-6.83	-11.34
1590	Building & Construction Industry Medical Aid Fund	6.21	-3.49	-7.69
1571	Anglovaal Group Medical Scheme	4.92	8.49	5.04
1523	Grintek Electronics Medical Aid Scheme	4.81	11.44	8.01
1176	Retail Medical Scheme	4.78	-6.02	-8.89
1234	Sasolmed	4.42	7.06	4.16
1547	Malcor Medical Scheme	4.26	6.27	3.55
1579	Tsogo Sun Group Medical Scheme	4.14	3.45	0.92

Table 69 shows the percentage deviation of restricted schemes with a claims ratio increase of 4.00% and more from 2018 to 2019 from the industry average of 92.15% and 90.71% for 2019 and 2018 respectively. When compared with open schemes, a greater number of restricted schemes had higher increases in their claims ratios; restricted schemes have significantly larger reserves and are better able to absorb these increases.

The Medical Schemes Industry in 2019

The top 10 schemes with the highest claims ratios for both open and restricted schemes in 2019 are shown in Table 70 and Table 71.

Table 70: Top 10 claims ratios open schemes – 2019 and 2018

Ref. no.	Name of medical scheme	Claims ratio 2019	Claims ratio 2018	Average age per beneficiary 2019	Average age per beneficiary 2018	Solvency 2019	Solvency 2018
1422	Topmed Medical Scheme	114.38	107.09	–	38.83	–	64.92
1446	Selfmed Medical Scheme	100.24	103.58	–	46.32	–	80.77
1486	Sizwe Medical Fund	100.17	98.16	33.07	34.23	36.48	46.95
1034	Cape Medical Plan	100.02	103.69	40.54	39.57	94.42	99.82
1537	Hosmed Medical Aid Scheme	95.77	87.21	33.15	32.50	33.69	33.75
1464	Suremed Health	95.21	80.58	39.49	38.65	99.32	99.19
1202	Fedhealth Medical Scheme	93.33	89.40	39.37	38.07	43.43	31.42
1149	Medihelp	93.01	93.25	37.04	37.03	27.68	28.65
1141	Health Squared Medical Scheme	92.61	101.50	46.78	50.27	15.42	21.23
1512	Bonitas Medical Fund	92.26	91.12	33.77	34.60	24.85	25.16

Table 71: Top 10 claims ratios restricted schemes – 2019 and 2018

Ref. no.	Name of medical scheme	Claims ratio 2019	Claims ratio 2018	Average age per beneficiary 2019	Average age per beneficiary 2018	Solvency 2019	Solvency 2018
1270	Golden Arrow Employees' Medical Benefit Fund	160.31	141.01	34.93	34.67	210.52	209.18
1237	BP Medical Aid Society	130.50	126.26	46.24	46.35	129.60	142.09
1012	Anglo Medical Scheme	122.28	123.89	42.94	42.19	433.63	473.01
1068	De Beers Benefit Society	109.42	112.73	49.20	48.22	162.43	144.39
1568	Sisonke Health Medical Scheme	108.46	94.27	33.77	32.27	25.38	58.83
1430	Remedi Medical Aid Scheme	103.30	90.24	30.54	29.49	72.85	75.23
1523	Grintek Electronics Medical Aid Scheme	102.69	97.98	39.37	37.63	40.16	43.88
1507	Barloworld Medical Scheme	102.03	105.82	32.88	32.90	67.58	74.64
1241	Naspers Medical Fund	101.60	99.19	26.28	24.83	91.55	91.41
1580	South African Police Service Medical Scheme (POLMED)	100.33	102.12	27.88	27.60	40.45	43.15

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Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Claims paid from medical savings accounts increased by 4.68% to R17.98 billion (2018: R17.18 billion and 6.88% increase). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 2.32% to R194.69 (2018: R190.28 and 4.70% increase).

Table 72, 73 and figure 47 and 48 show contributions and claims for open and restricted schemes pabpm.

Table 72: Contributions and relevant healthcare expenditure in open schemes pabpm (2000-2019) in 2019 prices*

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	940.45		129.96		824.30		116.43	
2001	1 085.67	15.44	140.52	8.13	885.31	7.40	124.49	6.92
2002	1 150.36	5.96	146.42	4.20	927.18	4.73	126.13	1.32
2003	1 238.83	7.69	170.73	16.60	957.52	3.27	141.12	11.88
2004	1 309.00	5.66	182.90	7.13	997.03	4.13	155.53	10.21
2005	1 302.09	-0.53	199.71	9.19	1 067.33	7.05	170.83	9.84
2006	1 289.88	-0.94	208.58	4.44	1 102.81	3.32	202.26	18.40
2007	1 324.75	2.70	190.15	-8.84	1 106.45	0.33	180.31	-10.85
2008	1 314.47	-0.78	194.94	2.52	1 105.42	-0.09	186.82	3.61
2009	1 375.36	4.63	204.71	5.01	1 190.51	7.70	197.76	5.86
2010	1 437.18	4.49	217.73	6.36	1 217.54	2.27	207.58	4.97
2011	1 489.45	3.64	222.89	2.37	1 257.79	3.31	211.40	1.84
2012	1 499.53	0.68	233.85	4.92	1 266.40	0.68	219.82	3.98
2013	1 540.35	2.72	232.79	-0.45	1 290.10	1.87	217.23	-1.18
2014	1 559.45	1.24	251.18	7.90	1 368.71	6.09	224.15	3.19
2015	1 604.58	2.89	259.40	3.27	1 423.11	3.97	246.84	10.12
2016	1 608.89	0.27	260.19	0.30	1 436.69	0.95	247.34	0.20
2017	1 682.12	4.55	265.69	2.11	1 466.78	2.09	254.14	2.75
2018	1 708.92	1.59	265.10	-0.22	1 535.39	4.68	251.65	-0.98
2019	1 757.52	2.84	256.70	-3.17	1 570.23	2.27	244.35	-2.90

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions
* The values were adjusted for CPI for 2000 – 2018

The Medical Schemes Industry in 2019

Table 73: Contributions and relevant healthcare expenditure in restricted schemes pabpm (2000-2019) in 2019 prices*

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Restricted schemes								
2000	1 017.13		188.03		939.04		165.76	
2001	1 108.64	9.00	170.97	-9.07	964.12	2.67	154.68	-6.68
2002	1 195.33	7.82	170.62	-0.20	1 021.53	5.95	147.40	-4.71
2003	1 262.42	5.61	181.37	6.30	1 054.68	3.25	154.07	4.53
2004	1 325.65	5.01	197.95	9.14	1 117.44	5.95	158.95	3.17
2005	1 310.47	-1.15	210.51	6.35	1 171.38	4.83	170.17	7.06
2006	1 303.17	-0.56	218.71	3.90	1 227.66	4.80	195.72	15.01
2007	1 263.33	-3.06	169.87	-22.33	1 172.59	-4.49	149.01	-23.87
2008	1 223.97	-3.12	133.55	-21.38	1 125.53	-4.01	116.79	-21.62
2009	1 281.53	4.70	110.38	-17.35	1 203.58	6.93	102.11	-12.57
2010	1 365.29	6.54	99.35	-9.99	1 245.94	3.52	91.25	-10.64
2011	1 425.64	4.42	93.15	-6.24	1 273.21	2.19	84.07	-7.87
2012	1 454.16	2.00	85.87	-7.82	1 334.95	4.85	76.71	-8.75
2013	1 488.92	2.39	61.58	-28.29	1 338.28	0.25	54.95	-28.37
2014	1 504.63	1.06	90.91	47.63	1 425.83	6.54	55.85	1.64
2015	1 557.14	3.49	98.66	8.52	1 477.38	3.62	86.47	54.83
2016	1 578.49	1.37	104.28	5.70	1 509.77	2.19	91.78	6.14
2017	1 660.36	5.19	108.39	3.94	1 504.58	-0.34	98.58	7.41
2018	1 689.90	1.78	115.43	6.50	1 532.92	1.88	102.35	3.82
2019	1 719.91	1.78	120.00	3.96	1 584.89	3.39	105.92	3.49

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions
* The values were adjusted for CPI for 2000 – 2018

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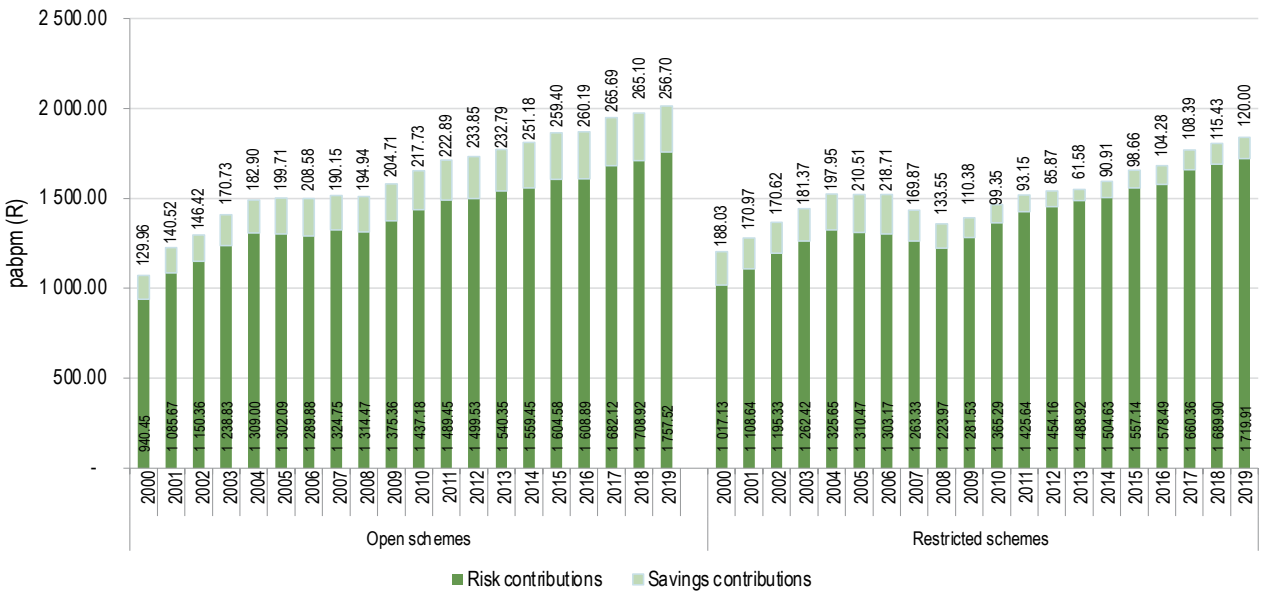

Figure 47: Risk and savings contributions and contributions pabpm (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

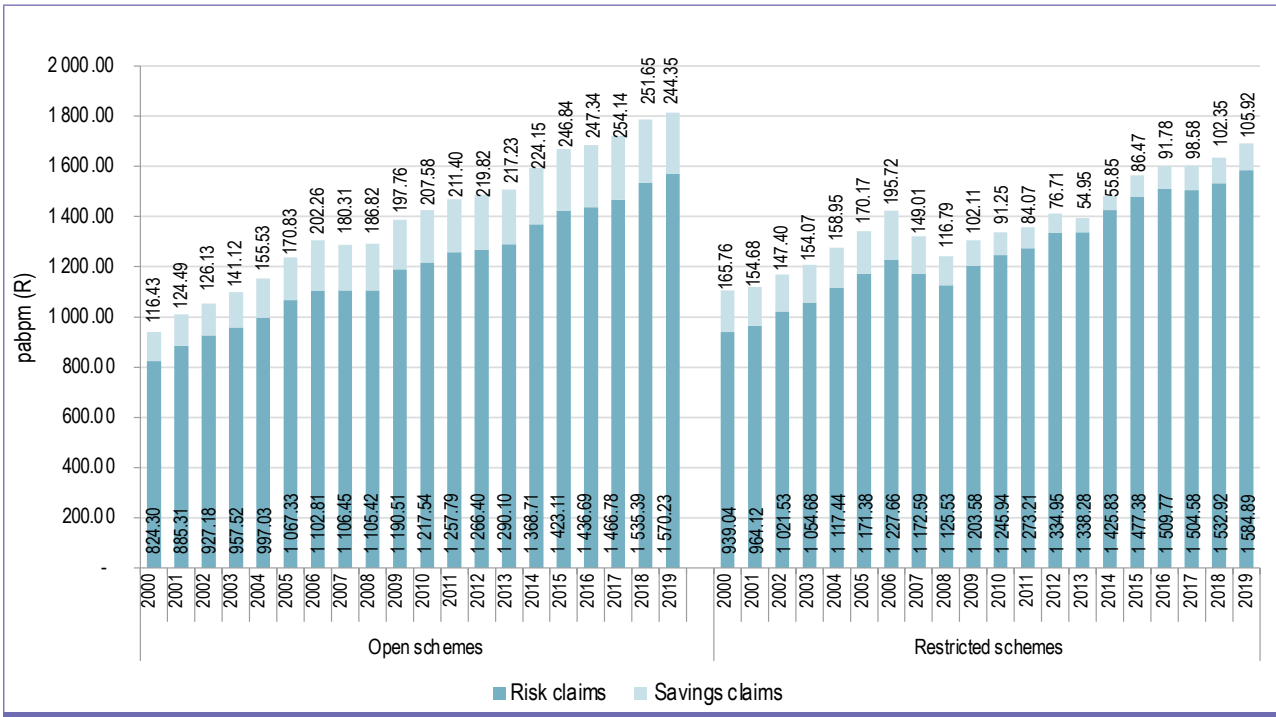

Figure 48: Risk and savings claims and claims pabpm (2000-2019) in 2019 prices*

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Figures 47 and 48 show the relationship between contributions and claims for both the risk and savings pool in the open and restricted schemes respectively. The risk claims ratio decreased in 2019 from 2018 for open schemes to 89.34%, while it increased to 92.15% in restricted schemes. For the savings pool, 95.19% of contributions received from members of open schemes was paid out in claims, compared with 88.27% for restricted schemes.

The contributions and expenditure on savings in open schemes is much higher than in restricted schemes. This could partially be due to the nature of benefit design. Restricted schemes generally have more traditional and richer options.

Table 74 shows that between 2003 and 2006 medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components. The figures for the period 2007 to 2012 appears to reflect a change in this trend. In 2000, savings contributions made up 12.79% of gross contributions. At the end of 2012, savings had declined to 10.68% of gross contributions. The decrease is partly attributable to a decision by the CMS not to allow variable savings rates on an option, which resulted in a number of medical schemes no longer offering savings plan accounts.

The subsequently higher increase in the savings components is partly due to a number of schemes introducing savings on existing options, and is indicative of a move towards benefit designs which requires a greater proportion of benefits to be funded out of members' personal savings accounts than from the general risk pool of the scheme.

Table 74: Contributions and relevant healthcare expenditure pabpm (2000-2019) in 2019 prices*

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
2000	964.98		141.52		861.23		126.30	
2001	1 092.61	13.23	146.66	3.63	909.09	5.60	130.63	3.43
2002	1 163.56	6.49	151.31	3.17	954.56	5.00	130.29	-0.26
2003	1 245.77	7.07	172.81	14.21	986.20	3.30	143.89	10.44
2004	1 313.79	5.46	185.86	7.55	1 032.15	4.70	156.21	8.56
2005	1 304.52	-0.71	201.92	8.64	1 097.09	6.30	170.83	9.36
2006	1 293.67	-0.83	210.48	4.24	1 138.03	3.70	200.99	17.65
2007	1 303.88	0.79	185.62	-11.81	1 128.50	-0.80	173.42	-13.72
2008	1 281.13	-1.74	178.00	-4.11	1 112.83	-1.40	167.59	-3.36
2009	1 338.62	4.49	174.75	-1.83	1 195.64	7.40	167.47	-0.07
2010	1 407.50	5.15	175.84	0.62	1 229.28	2.80	166.63	-0.50
2011	1 461.62	3.85	175.71	-0.07	1 264.59	2.90	164.97	-1.00
2012	1 479.21	1.20	176.89	0.67	1 297.03	2.60	164.72	-0.15
2013	1 517.07	2.56	185.83	5.05	1 311.89	1.10	172.29	4.60
2014	1 534.97	1.18	191.76	3.19	1 394.21	6.30	178.88	3.82
2015	1 583.61	3.17	201.47	5.06	1 447.01	3.80	189.05	5.69
2016	1 595.58	0.76	203.41	0.96	1 468.93	1.50	191.00	1.03
2017	1 672.50	4.82	208.82	2.66	1 483.50	1.00	197.97	3.65
2018	1 700.52	1.68	211.34	1.21	1 534.30	3.40	198.04	0.04
2019	1 740.77	2.37	207.61	-1.76	1 576.76	2.80	194.69	-1.69

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions
* The values were adjusted for CPI for 2000 – 2018

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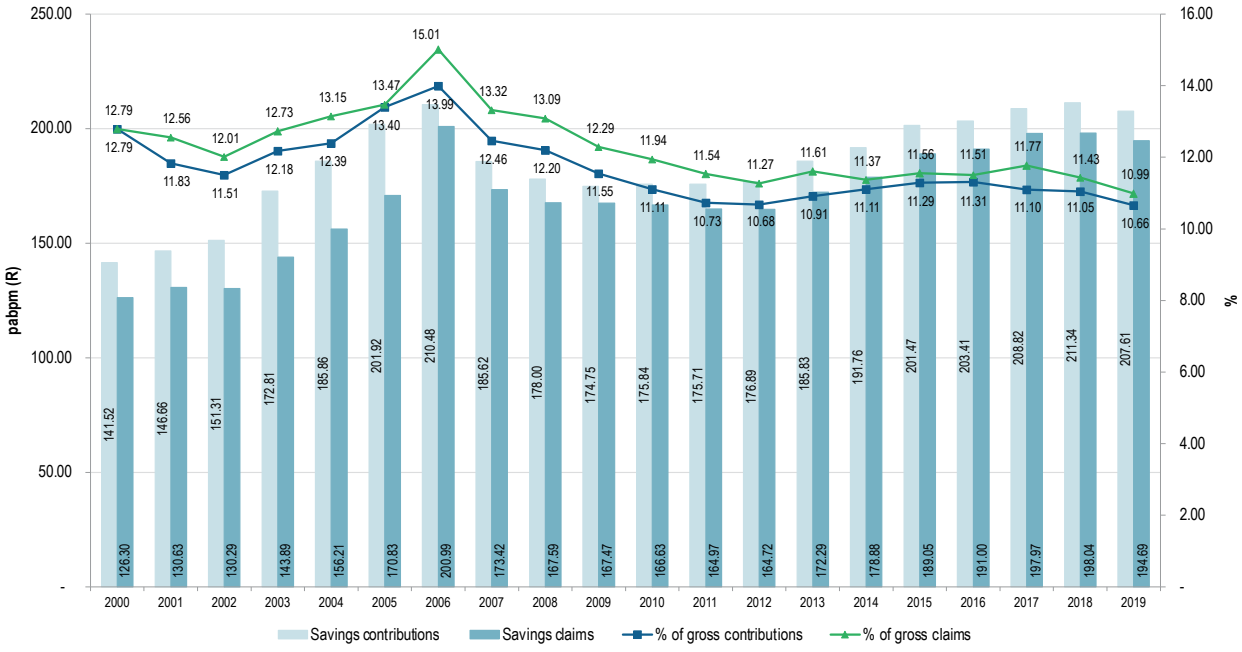

Figure 49: Medical savings account contributions and claims pabpm (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure decreased slightly to 11.51% in 2016 but increased again to 11.77% in 2017, as shown in Figure 49. This decreased again in 2018 and 2019 to 11.43% and 10.99% respectively.

For open schemes, the proportion of claims paid from medical savings accounts decreased from 14.08% in 2018 to 13.47% in 2019; the medical savings accounts claims ratio increased to 95.19% from 94.93% in 2018.

For restricted schemes, the proportion of claims paid from medical savings accounts increased from 6.26% in 2018 to 6.26% in 2019. The medical savings accounts claims ratio decreased to 88.27% from 88.67% in 2018.

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Figure 50 shows the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims increased by 80.39% and 83.08% respectively on a pabpm basis, and medical savings account contributions and claims rose by 46.70% and 54.15% respectively.

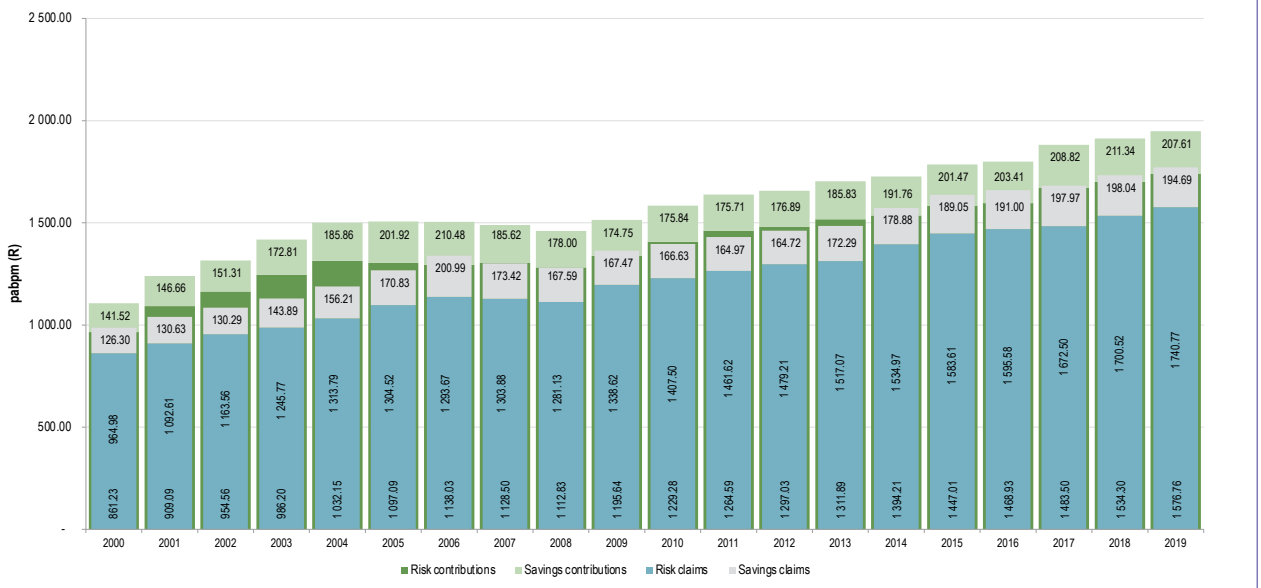

Figure 50: Risk and medical savings accounts contributions and claims pabpm (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

The Medical Schemes Industry Overview in 2019

Figure 51 shows the relationship between risk contributions and claims paid over the last 20 years. All figures have been adjusted for inflation.

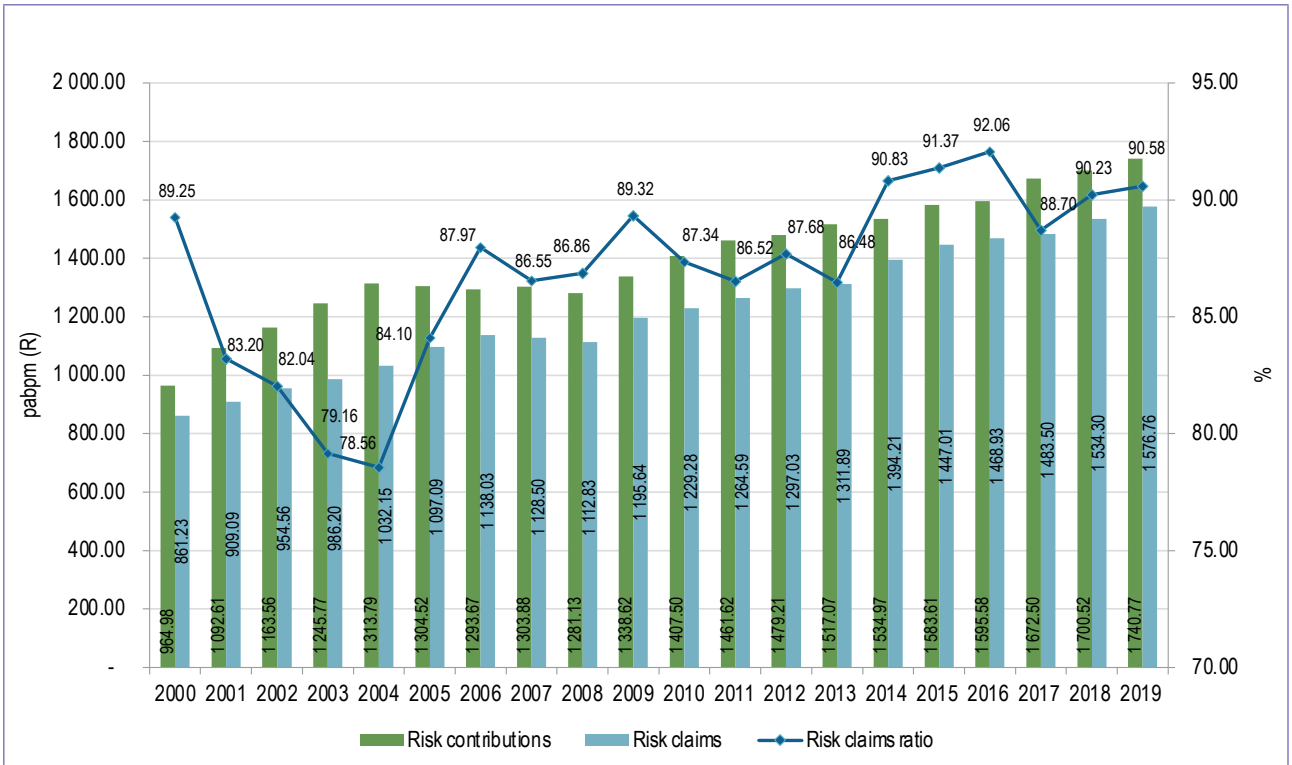

Figure 51: Risk claims ratio for all schemes (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

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After an initial decline, the claims ratio increased to 87.97% in 2006 and stabilised to 86.86% in 2008. There was an increase in 2009 followed by a decrease over the next two years to 86.52% in 2011. In 2012, there was a slight increase from the previous year, with medical schemes paying out 87.68% of risk contributions in benefits. In 2013, the claims ratio decreased to 86.48% and rose again to 92.06% in 2016. There was a further increase in the claims ratio in 2019 to 90.58% from 88.7% in 2017.

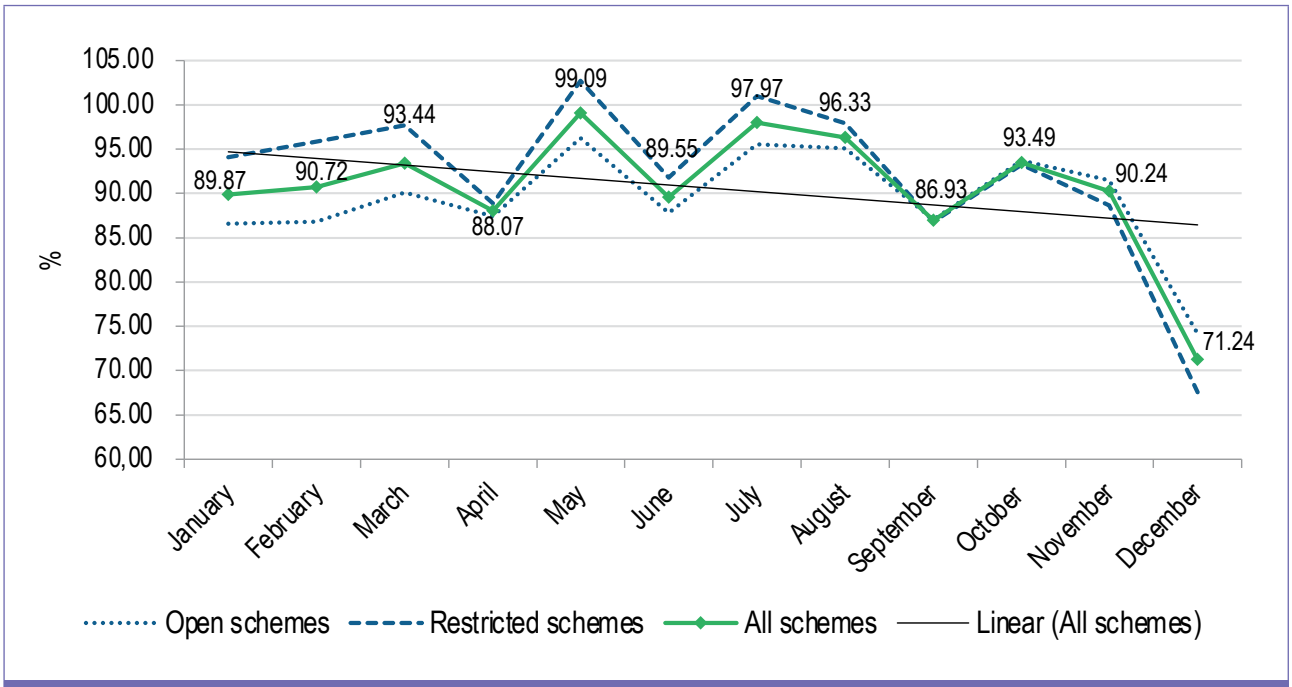

Figure 52: Seasonality of claims per month in 2019

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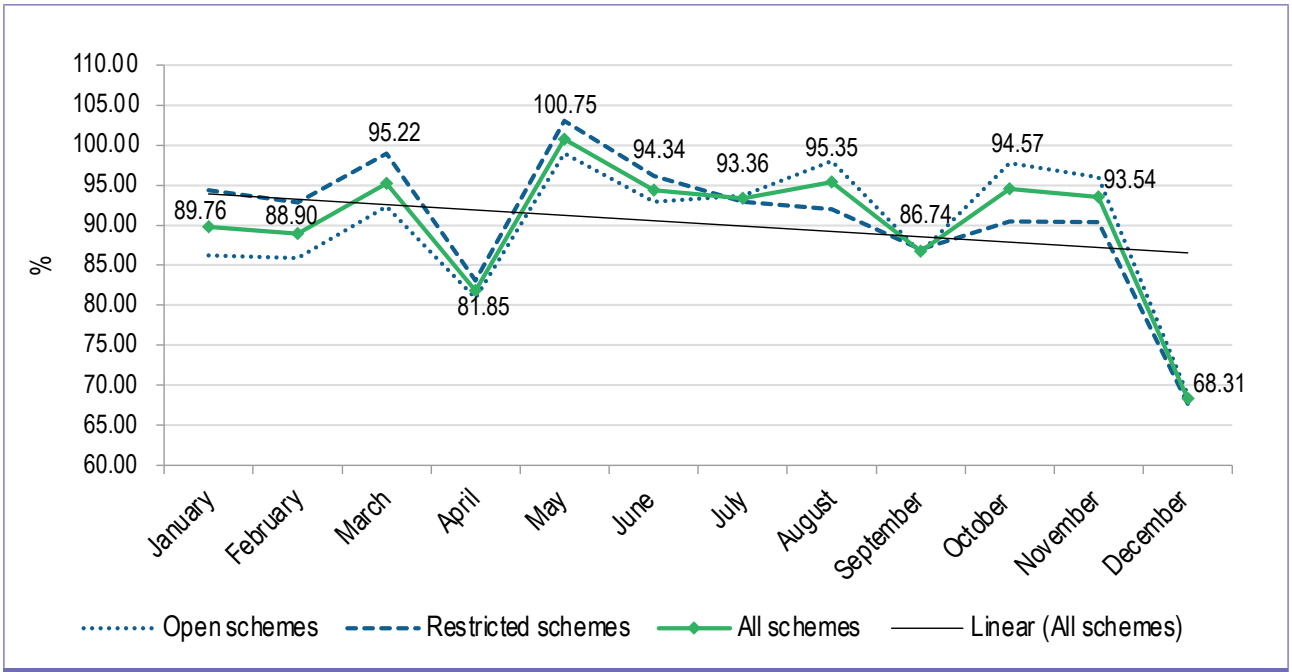

Figure 53: Seasonality of claims per month in 2018

Figure 52 and Figure 53 show the seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2019 and 2018 respectively. Both open and restricted schemes follow the same general trend: an increase in claims in the first quarter of the year as members gain access to new benefits. increases in claims over the winter months. and a downward trend in the last quarter of the year.

Risk transfer arrangements

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

Table 75 reflects the main components of such arrangements:

- The capitation fees which schemes paid to third parties to manage their risks.
- The estimated costs which schemes would have incurred had they not used risk transfer arrangements.
- The net effect thereof. The net income/(expense) column reflects the value derived from the risk transfer arrangement. (Annexure Z provides further details.)

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Table 75: Significant risk transfer arrangements in 2018 and 2019

	Capitation fees			Estimated recoveries			Net income/(expense)*		
	2019 R'000	2018 R'000	% growth	2019 R'000	2018 R'000	% growth	2019 R'000	2018 R'000	% growth
Open schemes	2 185 255	2 155 736	1.37	2 328 975	2 231 470	4.37	148 618	79 442	87.08
Restricted schemes	1 821 185	1 307 398	39.30	1 860 337	1 406 941	32.23	46 868	101 184	-53.68
All	4 006 440	3 463 134	15.69	4 189 312	3 638 411	15.14	195 486	180 627	8.23

* The net income/(expense) on risk transfer arrangements includes an amount of R12.6 million in respect of profit- and loss-sharing agreements.

Table 76 lists the 10 schemes that incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 77 details the 10 benefit options that reported the greatest losses.

Table 76: Schemes with highest risk transfer arrangement losses 2019

Ref. no.	Name of medical scheme	Beneficiaries 31 Dec 2019	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1167	Momentum Health	298 852	440 383	360 168	(80 215)	-18.21
1580	POLMED	507 764	701 746	651 036	(43 149)	-6.15
1486	Sizwe Medical Fund	111 409	74 923	60 705	(14 217)	-18.98
1591	Impala Medical Plan	26 005	174 649	163 339	(11 310)	-6.48
1537	Hosmed Medical Aid Scheme	54 502	25 776	20 496	(5 280)	-20.48
1039	MBMed Medical Aid Fund	10 150	7 307	3 415	(3 892)	-53.26
1271	Fishmed	4 347	17 757	14 153	(3 604)	-20.30
1141	Health Squared Medical Scheme	34 936	10 115	6 944	(3 171)	-31.35
1469	Nedgroup Medical Aid Scheme	49 403	71 437	65 667	(2 860)	-4.00
1145	LA-Health Medical Scheme	208 258	23 563	20 736	(2 827)	-12.00

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Table 77: Options with highest risk transfer arrangement losses 2019

Ref. no.	Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2019	Average age per beneficiary Years	Capitation fees R'000	Estimated recoveries R'000	Profit/ (loss) sharing R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1167	Momentum Health	Custom	161 696	32.27	184 690	85 421	–	(99 269)	-53.75
1580	POLMED	Aquarium	168 426	22.33	196 430	60 744	93 736	(41 949)	-21.36
1167	Momentum Health	Ingwe	55 795	27.15	144 617	122 828	–	(21 789)	-15.07
1512	Bonitas Medical Fund	Bonsave	83 540	30.22	83 180	68 049	–	(15 131)	-18.19
1486	Sizwe Medical Fund	Gomomo Care Option	13 655	30.37	74 923	60 705	–	(14 217)	-18.98
1591	Impala Medical Plan	Impala Medical Plan	26 005	30.90	174 649	163 339	–	(11 310)	-6.48
1149	Medihelp	Prime 1	59 718	32.76	12 013	5 339	–	(6 674)	-55.56
1466	Makoti Medical Scheme	Makoti Primary	5 206	33.11	21 383	15 114	–	(6 269)	-29.32
1125	Discovery Health Medical Scheme	Essential Smart	35 704	33.19	6 012	1 609	–	(4 403)	-73.24
1537	Hosmed Medical Aid Scheme	Value	40 807	31.69	18 542	14 173	–	(4 368)	-23.56

Momentum Health is listed in both Tables 76 and 77 as the biggest loss-maker.

The Essential Smart option of Discovery Health Medical Scheme suffered the biggest loss in terms of the percentage of capitation fees paid (73.24%) followed by the Prime 1 option of Medihelp (55.56%), as shown in Table 77.

Table 78 lists the 10 contracts on which schemes incurred the biggest losses in respect of their significant risk transfer arrangements, with comparative 2018 figures. Two Momentum Health Solutions (Pty) Ltd contracts features on this list, as well as three Preferred Provider Negotiators (Pty) Ltd.

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Table 78: Contracts with the highest risk transfer losses: 2018 and 2019

			2019					2018				
Ref. no.	Name of medical scheme	Contract name	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 %	Capitation fees R'000	Estimated recoveries R'000	Profit/ (loss) sharing R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1167	Momentum Health	Momentum Health Solutions (Pty) Ltd	418 051	(333 132)	–	(84 919)	-20.31	408 686	(329 407)	–	(79 279)	-19.40
1580	South African Police Service Medical Scheme (POLMED)	Scriptpharm Risk Management (Pty) Ltd	494 500	(469 075)	(700)	(24 725)	-5.00	–	–	–	–	–
1580	South African Police Service Medical Scheme (POLMED)	Preferred Provider Negotiators (Pty) Ltd	207 041	(183 231)	(6 860)	(16 950)	-8.19	201 541	(204 536)	–	2 995	1.49
1486	Sizwe Medical Fund	InteliHealth Africa Managed Care Organisation (Pty) Ltd	52 795	(41 462)	–	(11 333)	-21.47	40 527	(34 577)	–	(5 950)	-14.68
1591	Impala Medical Plan	Impala Medical Services	174 649	(163 339)	–	(11 310)	-6.48	163 614	(158 620)	–	(4 994)	-3.05
1537	Hosmed Medical Aid Scheme	Preferred Provider Negotiators (Pty) Ltd	25 776	(20 496)	–	(5 280)	-20.48	27 613	(24 148)	–	(3 466)	-12.55
1039	MBMed Medical Aid Fund	Preferred Provider Negotiators (Pty) Ltd	5 382	(1 155)	–	(4 227)	-78.54	5 639	(970)	–	(4 669)	-82.80
1145	LA-Health Medical Scheme	Dental Risk Company (Pty) Ltd	16 018	(12 313)	–	(3 705)	-23.13	13 611	(9 875)	–	(3 735)	-27.44
1271	Fishing Industry Medical Scheme (Fishmed)	Momentum Health Solutions (Pty) Ltd	17 757	(14 153)	–	(3 604)	-20.30	15 828	(12 894)	(99)	(2 835)	-17.91
1512	Bonitas Medical Fund	Bryte Insurance Company Limited	16 018	(12 850)	–	(3 168)	-19.78	6 776	(7 431)	–	655	9.66

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Accredited managed healthcare services (no transfer of risk)

Accredited managed healthcare services increased by 8.38% to R4.69 billion in 2019 from R4.33 billion in 2018. In 2019, 8 857 408 average beneficiaries (or 99.13% of beneficiaries) were covered by these managed healthcare arrangements.

Table 79: Accredited managed healthcare service fees (no transfer of risk) for options with a claims ratio above 100.00%: 2019

	Accredited managed healthcare services fees (no transfer of risk)		Risk claims		Beneficiaries	Number of options
	R'000	pmpm	R'000	% of RCI		
Open schemes	327 011	107.84	17 889 197	107.19	494 232	37
Restricted schemes	254 343	87.91	13 786 822	111.37	527 914	43
All schemes	581 354	98.11	31 676 019	108.97	1 022 146	80

pmpm = per member per month
RCI = risk contribution income

Table 79 shows the number of benefit options with claims ratios greater than 100.00% and their expenditure on managed healthcare services. There were 80 options in this category, which accounted for 11.53% of beneficiaries in respect of whom such expenditure was incurred.

Table 80: Accredited managed healthcare services (no transfer of risk) of the 10 largest schemes: 2019

Ref. no.	Name of medical scheme	Type	Average beneficiaries	Claims ratio	Accredited managed healthcare services as % of RCI
1125	Discovery Health Medical Scheme	Open	2 795 107	87.73	3.09
1598	Government Employees Medical Scheme (GEMS)	Restricted	1 856 491	88.77	2.03
1512	Bonitas Medical Fund	Open	718 919	92.26	3.09
1580	South African Police Service Medical Scheme (POLMED)	Restricted	507 217	100.33	1.50
1167	Momentum Health	Open	298 829	84.23	3.03
1279	Bankmed	Restricted	221 009	95.53	2.73
1149	Medihelp	Open	205 438	93.01	1.31
1145	LA-Health Medical Scheme	Restricted	202 860	84.33	2.30
1252	Bestmed Medical Scheme	Open	197 956	86.83	2.47
1140	Medshield Medical Scheme	Open	160 886	89.77	1.67

Table 80 depicts the 10 largest schemes (by number of average beneficiaries) and shows their total expenditure on accredited managed healthcare services. The industry accredited managed healthcare services average was 2.52% of RCI.

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Non-healthcare expenditure

Non-healthcare expenditure refers to all other expenditure incurred by medical schemes that is not related to relevant healthcare services, i.e. claims. It consists mainly of administration expenditure, broker costs and impaired receivables.

The curbing of increasing costs, the elimination of fraud, waste and abuse, as well as the affordability of medical schemes have increasingly become important considerations in the private healthcare sector. When medical schemes determine contributions, factors such as the claims experience of the scheme, operational costs and level of reserving required, are taken into consideration. It is therefore essential to ensure that monies collected from members are directed at appropriate interventions and expenditure, and that NHE is managed judiciously.

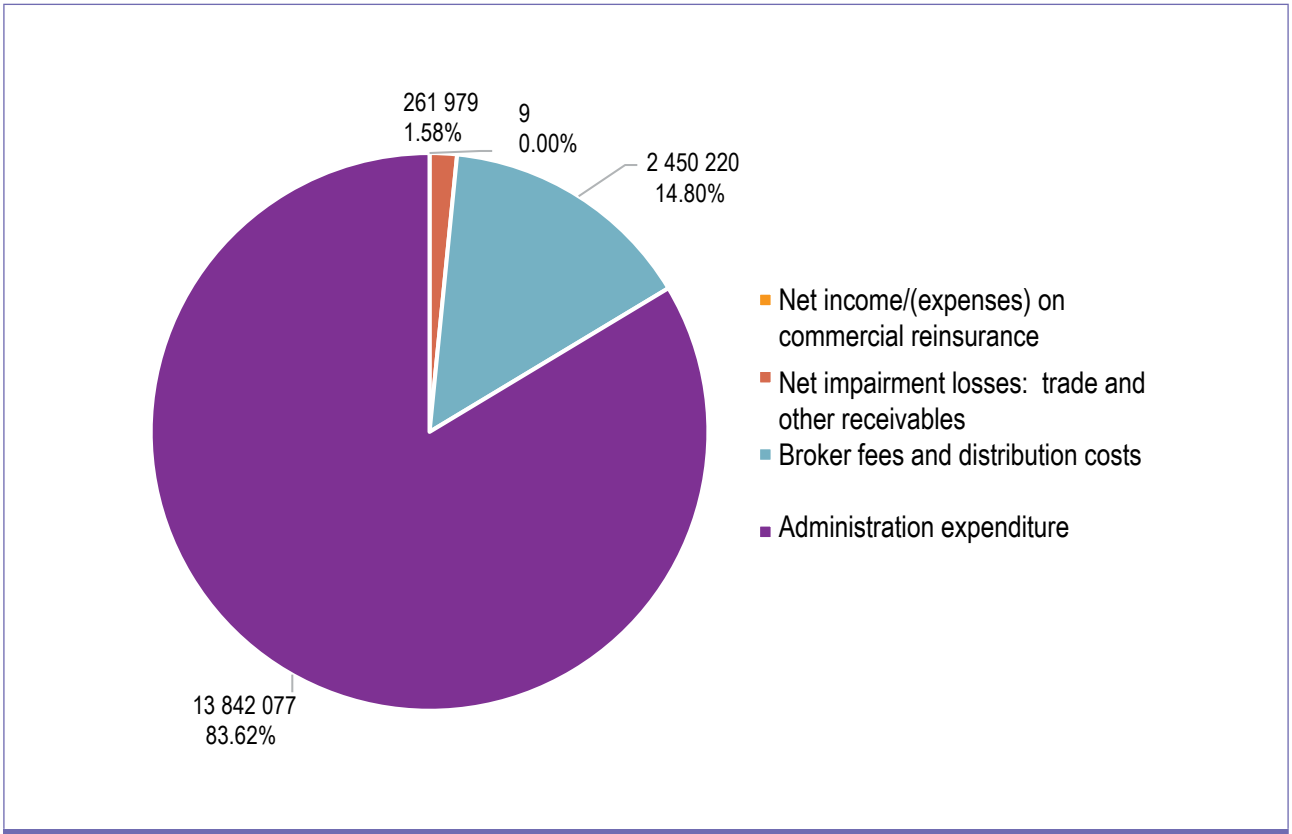

Figure 54: Distribution of non-healthcare expenditure of medical schemes

The gross NHE for all medical schemes at the end of 2019 was reported at R16.55 billion, an increase of 4.84% from R15.79 billion in 2018.

The Medical Schemes Industry Overview in 2019

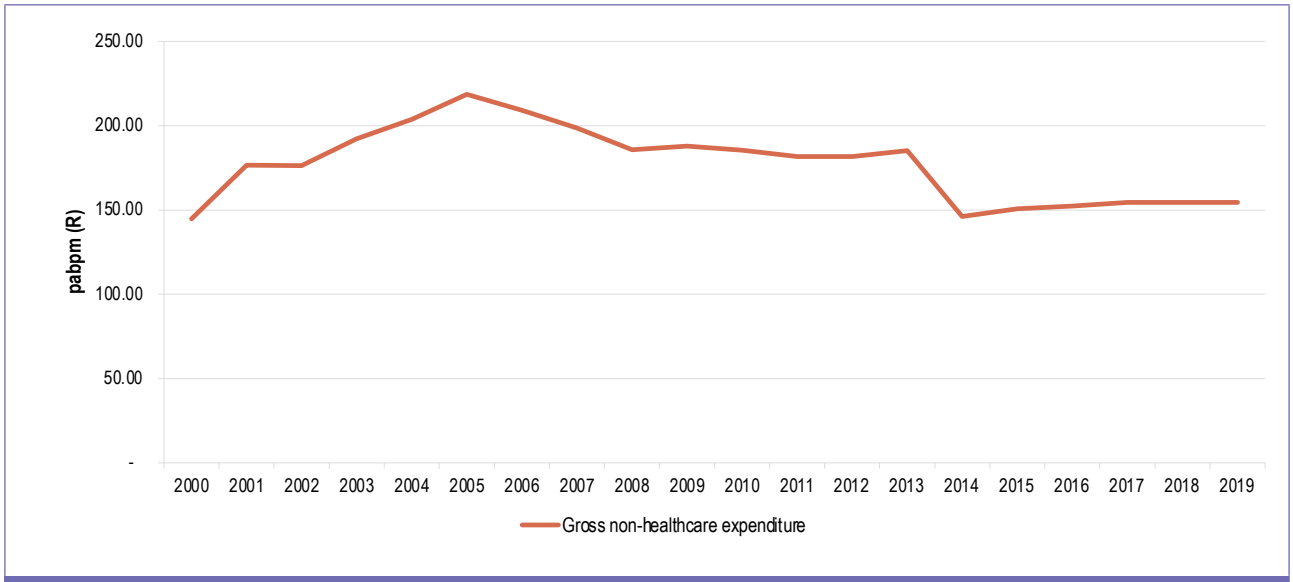

Figure 55: Gross non-healthcare expenditure (2000 – 2019) in 2019 prices*

pabpm = per average beneficiary per month
*The values were adjusted for CPI for 2000 – 2018

The rate of increase in NHE has displayed a downward trend since 2005. In earlier years, this expenditure was increasing at rates that exceeded the rate of increase in contributions. In real terms, NHE has reduced compared with earlier periods. In recent years, the remuneration of trustees and principal officers of medical schemes has come under the spotlight, as well as the expenditure on AGM costs. There are instances where such expenditure can be deemed to be wastage of resources. In the interests of member protection, it is important that such expenditure is associated with a discernible value proposition.

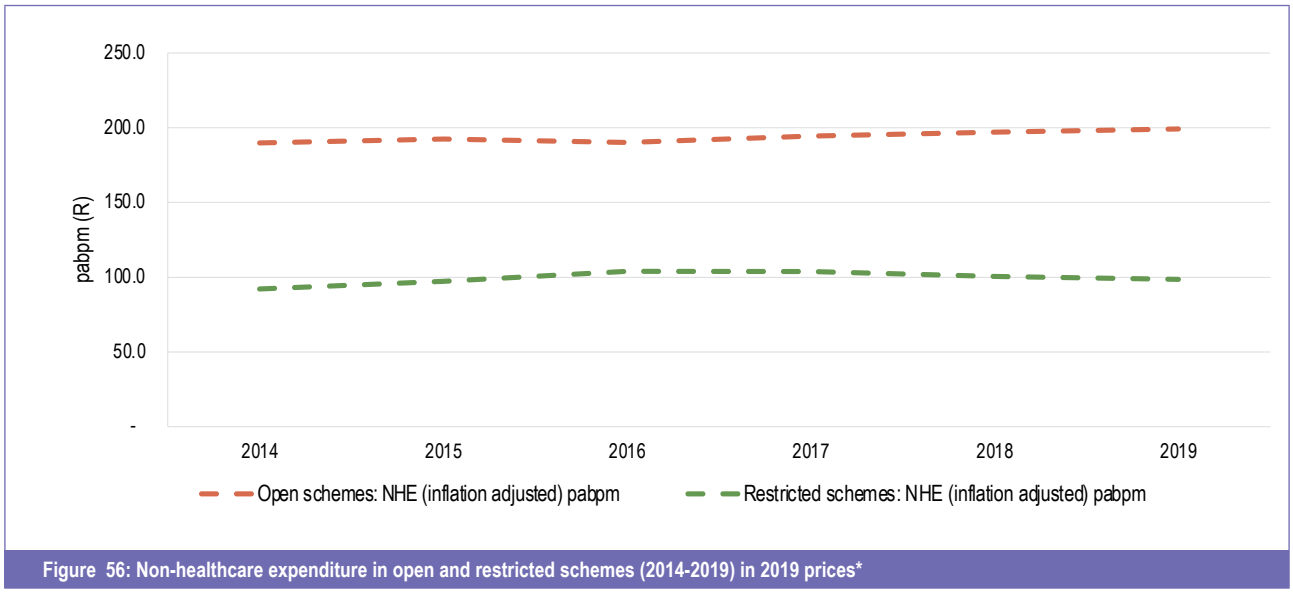

Figure 56: Non-healthcare expenditure in open and restricted schemes (2014-2019) in 2019 prices*

*The values were adjusted for CPI for 2000 – 2018

The Medical Schemes Industry Overview in 2019

Based on the Figure 56, which shows a comparison of NHE between open and restricted schemes, it is evident that expenditure in restricted schemes is much lower than in open schemes on a pabpm basis. This is partly because restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

Administration expenditure

Administration expenditure, being the largest component of NHE in all medical schemes, grew by 4.59% to R13.84 billion from R13.23 billion between 2018 and 2019. Open schemes increased their administration expenditure by 4.63% to R9.35 billion from R8.94 billion in 2018. Administration expenditure in restricted schemes increased by 4.50% from R4.29 billion in 2018 to R4.49 billion in 2019.

Nine open schemes (representing 11.22% of all average beneficiaries) and eight restricted schemes (representing 3.65% of all average beneficiaries) had an overall administration expenditure greater than 10.00% of Gross Contribution Income (GCI) in 2019.

Tables 81 and 82 show the 10 open schemes with the highest administration expenditure pabpm and pampm. A high cost per life covered is sometimes the function of a low average beneficiaries rather than high absolute administration costs. Schemes need to operate with a certain number of lives for average operational costs to be lower and make the business more profitable and sustainable into the long term.

Table 81: Ten open schemes with the highest administration expenditure above industry average of R157.31 pabpm (2019)

Ref. no.	Name of scheme	Name of administrator	Average beneficiaries	Admin-istration expenditure R'000	Admin-istration expenditure pabpm R	Admin-istration expenditure % of GCI
1446	Selfmed Medical Scheme	Self-administered	12 720	32 868	323.00	14.33
1141	Health Squared Medical Scheme	Agility Health (Pty) Ltd	37 604	110 715	245.35	9.78
1491	Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	26 209	73 626	234.10	11.48
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	2 253	5 842	216.08	10.38
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	146 961	361 013	204.71	10.69
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	66 931	153 792	191.48	7.09
1486	Sizwe Medical Fund	3Sixty Health (Pty) Ltd	112 661	243 453	180.08	9.90
1034	Cape Medical Plan	Self-administered	9 477	19 611	172.44	10.25
1167	Momentum Health	Momentum Health Solutions (Pty) Ltd	298 829	597 101	166.51	11.56
1554	Genesis Medical Scheme	Self-administered	21 421	42 538	165.48	12.31

GCI = Gross Contribution Income
pabpm = per average beneficiary per month

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Table 82: Ten open schemes with the highest administration fees pampm (2019)

Ref. no.	Name of scheme	Name of administrator	Average members	Administration fee pampm R
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 342 758	320.05
1167	Momentum Health	Momentum Health Solutions (Pty) Ltd	156 841	305.95
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	74 613	304.31
1491	Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	16 691	252.13
1141	Health Squared Medical Scheme	Agility Health (Pty) Ltd	21 272	235.97
1486	Sizwe Medical Fund	3Sixty Health (Pty) Ltd	47 321	227.57
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	1 122	223.34
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	32 450	212.16
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	336 651	210.07
1422	Topmed Medical Scheme	Private Health Administrators (Pty) Ltd	16 360	196.15

pampm = per average member per month

Tables 83 and 84 show the 10 restricted schemes with the highest administration expenditure pabpm and pampm.

Table 83: Ten restricted schemes with the highest administration expenditure above industry average of R93.96 pabpm (2019)

Ref. no.	Name of scheme	Name of administrator	Average beneficiaries	Administration expenditure R'000	Administration expenditure pabpm R	Administration expenditure % of GCI
1237	BP Medical Aid Society	Momentum Health Solutions (Pty) Ltd	3 564	12 376	289.38	12.53
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	72 649	207 869	238.44	11.46
1068	De Beers Benefit Society	Self-administered	9 492	21 986	193.02	6.92
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Self-administered	47 380	107 343	188.80	7.91
1523	Grintek Electronics Medical Aid Scheme	Universal Healthcare Administrators (Pty) Ltd	1 342	2 927	181.76	7.42
1441	Parmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	4 742	10 092	177.35	3.60
1571	Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	5 069	9 426	154.96	6.92
1582	Transmed Medical Fund	Momentum Health Solutions (Pty) Ltd	36 498	66 209	151.17	9.89
1012	Anglo Medical Scheme	Discovery Health (Pty) Ltd	18 308	32 476	147.82	5.77
1520	University of Kwa-Zulu Natal Medical Scheme	Discovery Health (Pty) Ltd	6 888	11 717	141.76	5.83

GCI = Gross Contribution Income
pabpm = per average beneficiary per month

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Table 84: Ten restricted schemes with the highest administration fees pampm (2019)

Ref. no.	Name of scheme	Name of administrator	Average members	Admin-istration fee pampm R
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	34 344	309.73
1145	LA-Health Medical Scheme	Discovery Health (Pty) Ltd	81 753	306.15
1571	Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	2 528	263.71
1441	Parmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	2 456	254.65
1523	Grintek Electronics Medical Aid Scheme	Universal Healthcare Administrators (Pty) Ltd	605	251.79
1520	University of Kwa-Zulu Natal Medical Scheme	Discovery Health (Pty) Ltd	3 457	248.77
1241	Naspers Medical Fund	Discovery Health (Pty) Ltd	3 725	236.26
1578	TFG Medical Aid Scheme	Discovery Health (Pty) Ltd	2 968	235.12
1572	Engen Medical Benefit Fund	Discovery Health (Pty) Ltd	3 455	234.23
1590	Building & Construction Industry Medical Aid Fund	Universal Healthcare Administrators (Pty) Ltd	4 836	233.94

pampm = per average member per month

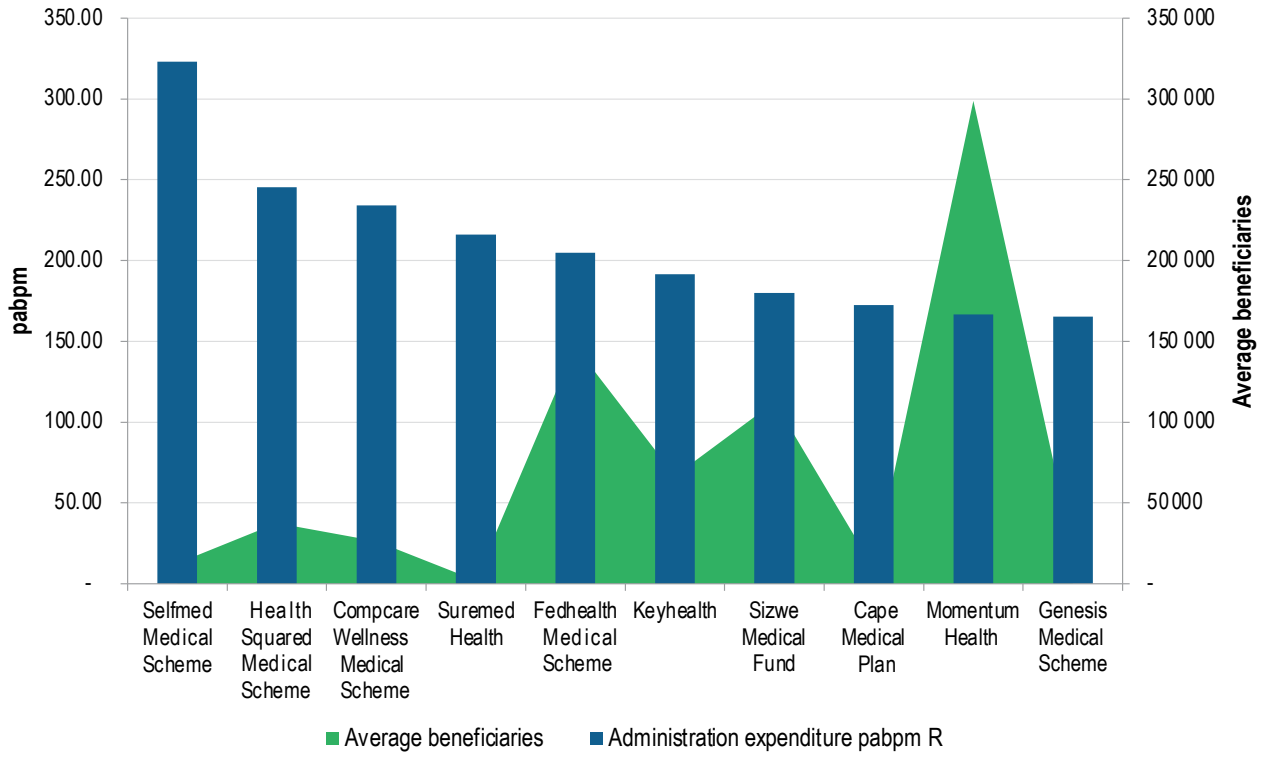

Figure 57: Ten open schemes with the highest administration expenditure above industry average of R157.31 pabpm (2019)

pabpm = per average beneficiary per month

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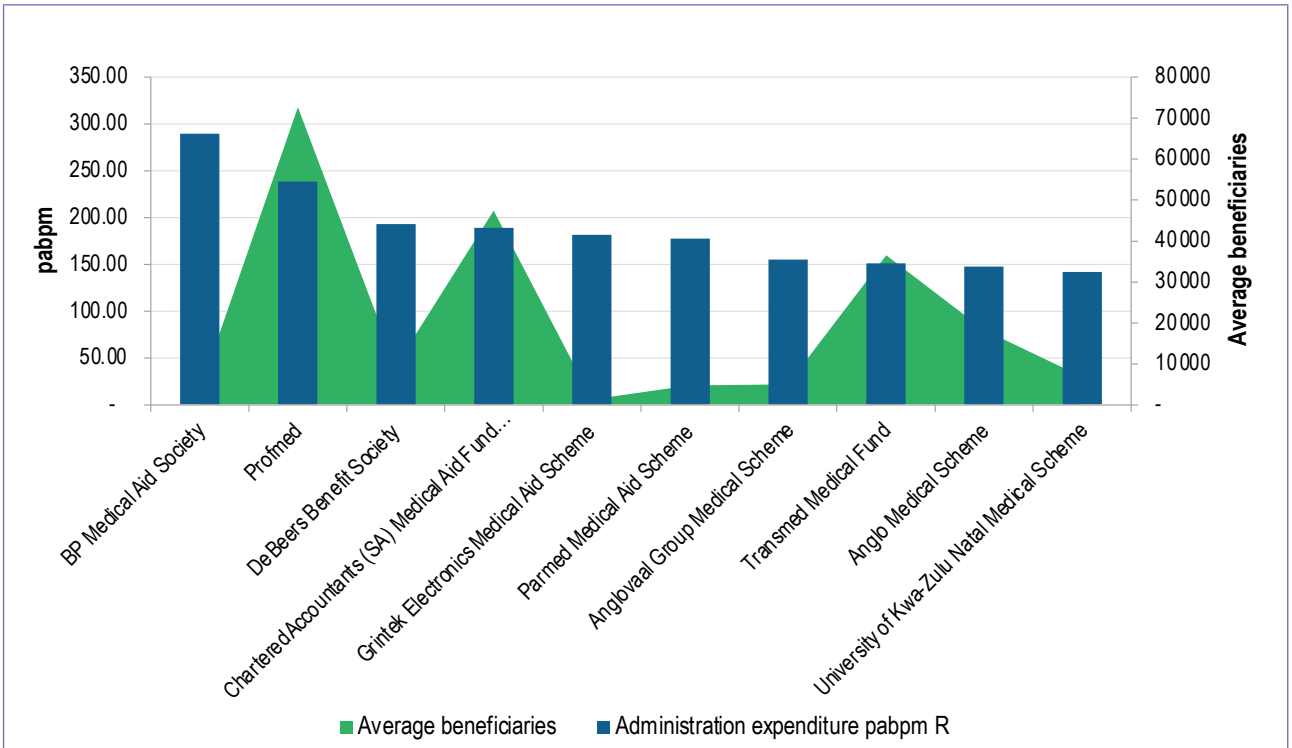

Figure 58: Ten restricted schemes with the highest administration expenditure above industry average of R93.96 pabpm (2019)

pabpm = per average beneficiary per month

A current complexity in the environment is that the definition of services provided by medical scheme administrators is not standardised. The bouquet of services offered by the administrators as both core and non-core administration and related cost structures differs across entities. As such, these are not directly comparable. Circular 6 of 2019, published by the CMS, was an initial attempt to address this issue. Circular 77 of 2019 was subsequently issued to standardise the contracting and reporting of accredited administration services and other administration services, thereby ensuring transparency that would allow more efficient monitoring and comparability across the industry of the individual services contracted.

However, based on the data submitted, while the services provided by the various administrators of schemes, as well as the benefit option design may be variable, there does not seem to be correlation between the scheme size and the administration fees charged in the restricted scheme environment.

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Table 85 shows the gross administration fees paid to third-party administrators. These fees are the sum of administration fees, co-administration fees, and other indirect fees paid to the administrator.

Table 85: Administration fees paid to third-party administrators pabpm 2018 and 2019

	Open schemes			Restricted schemes		
	2019	2018	%	2019	2018	%
	pabpm R	pabpm R	variance	pabpm R	pabpm R	variance
Third party						
Administration fees	140.15	133.49	4.99	58.20	55.41	5.04
Co-administration fees	–	–	–	6.65	15.41	-56.85
Total	**140.15**	**133.49**	**4.99**	**61.59**	**63.14**	**-2.45**

pabpm = per average beneficiary per month

On average, third-party-administered open schemes spent 127.55% more per beneficiary on administration fees than third-party-administered restricted schemes (2018: 111.42%).

Administration and co-administration fees paid to third-party administrators were the main component of gross administration expenditure (GAE). They grew by 2.93% to R9.97 billion in 2019 from R9.69 billion in the previous year. These fees represented 81.06% of the GAE of schemes which incurred this expenditure in 2019 (2018: 81.46%).

Governance-related expenditure

Remuneration and other considerations of trustees accounted for 0.64% of GAE. Table 86 and Figure 59 show the 10 schemes with the highest average trustee fees. Figure 60 shows the breakdown of trustee remuneration for the 10 schemes with the highest remuneration. More details are contained in Annexure V.

Table 86: Ten schemes with highest trustee fees (2019)

			Trustee remuneration & other considerations		No. of trustees		Average fee per trustee R	
Ref. no.	Name of medical scheme	Type	2019 R'000	2018 R'000	2019	2018	2019	2018
1125	Discovery Health Medical Scheme	Open	9 720	9 756	8	8	1 215	1 220
1598	Government Employees Medical Scheme (GEMS)	Restricted	7 682	7 271	15	14	512	519
1580	South African Police Service Medical Scheme (POLMED)	Restricted	5 148	5 617	15	20	343	281
1202	Fedhealth Medical Scheme	Open	4 980	3 958	13	9	383	440
1537	Hosmed Medical Aid Scheme	Open	4 953	4 394	15	11	330	399
1486	Sizwe Medical Fund	Open	4 731	4 945	12	10	394	495
1512	Bonitas Medical Fund	Open	4 634	4 079	12	10	386	408
1140	Medshield Medical Scheme	Open	4 437	4 517	8	10	555	452
1194	Profmed	Restricted	3 929	4 298	11	14	357	307
1491	Compcare Wellness Medical Scheme	Open	3 557	2 676	11	9	323	297

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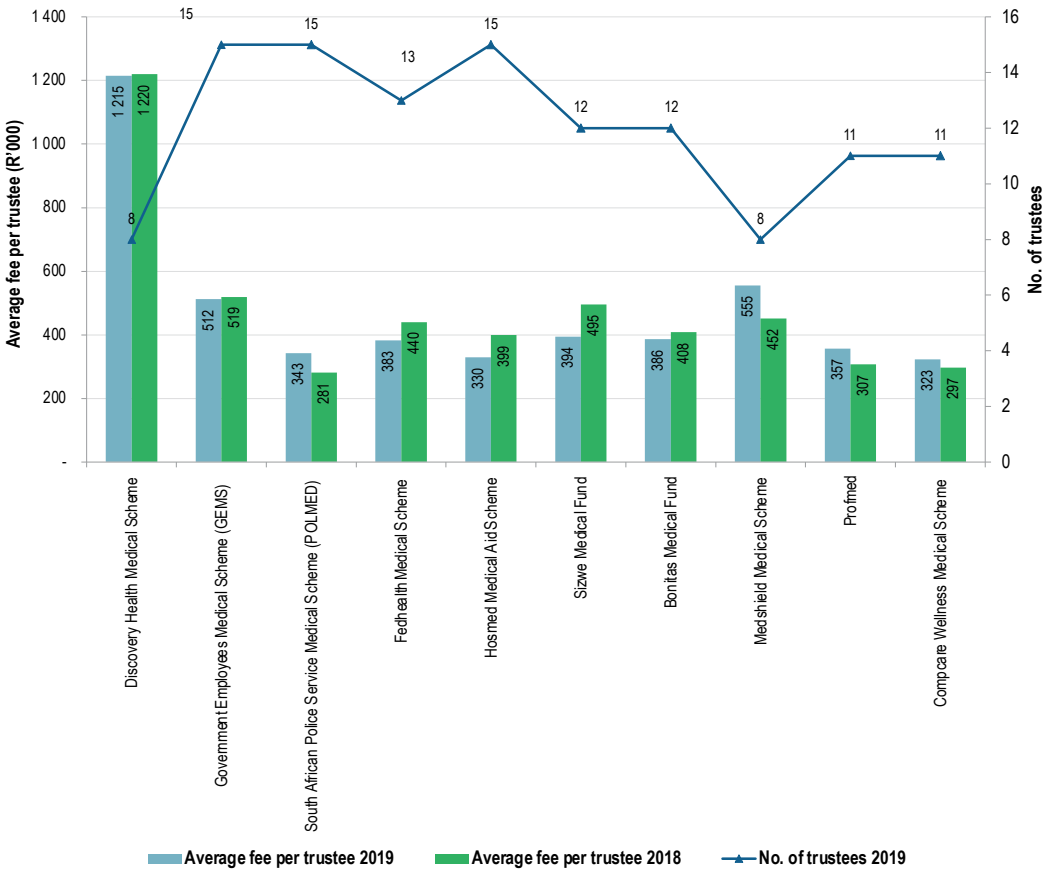

Figure 59: Average trustee fees: 10 schemes with highest trustee fees 2018 and 2019

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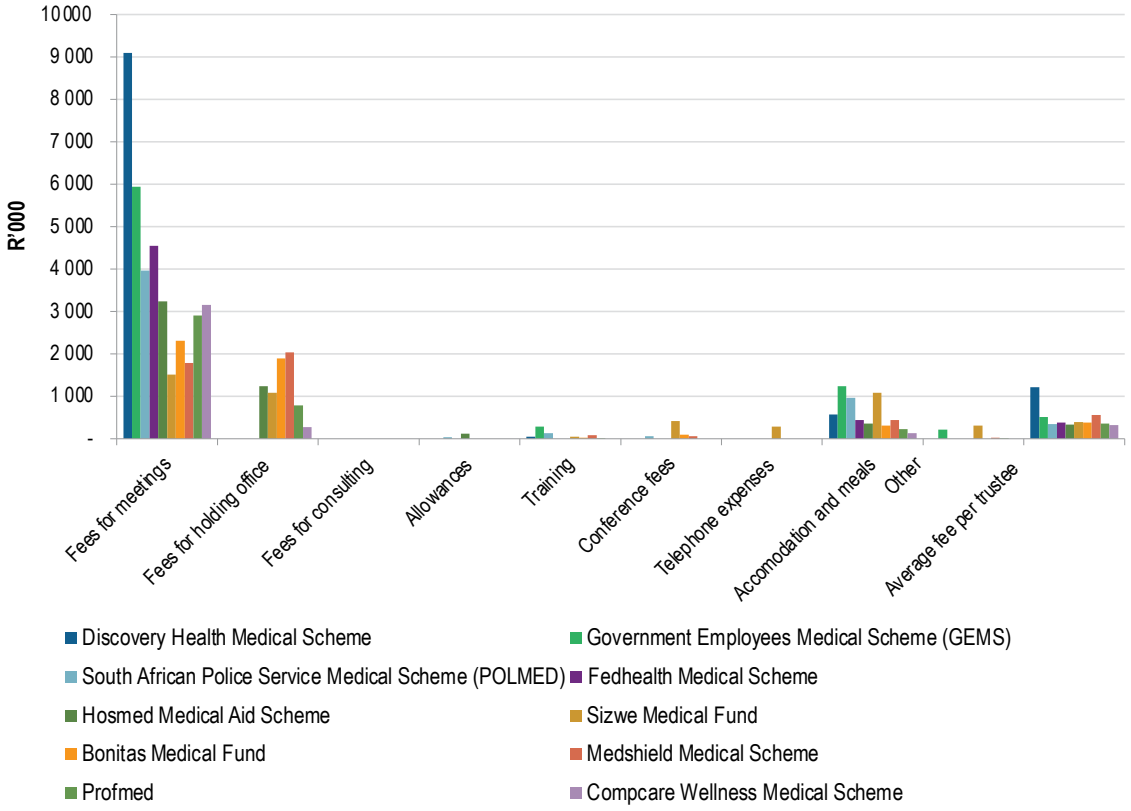

Figure 60: Composition of trustee remuneration for 10 schemes with highest remuneration in 2019

The remuneration of principal officers of medical schemes amounted to 0.93% of GAE in 2019. The fees of principal officers in 2019 amounted to 0.57% of GAE in open schemes (2018: 0.58%) and 1.70% in restricted schemes (2018: 1.58%).

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Table 87: Ten schemes with highest remuneration of principal officers in 2019

Ref. no.	Name of medical scheme		Principal Officer remuneration		
		Average beneficiaries	2019 R'000	2018 R'000	% change
1125	Discovery Health Medical Scheme	2 795 107	8 888	7 639	16.35
1512	Bonitas Medical Fund	718 919	6 103	5 113	19.36
1598	Government Employees Medical Scheme (GEMS)	1 856 491	6 053	5 820	4.00
1140	Medshield Medical Scheme	160 886	5 914	2 366	149.96
1580	South African Police Service Medical Scheme (POLMED)	507 217	5 282	5 193	1.71
1038	SAMWUMed	73 776	4 776	4 412	8.25
1582	Transmed Medical Fund	36 498	4 651	4 113	13.08
1145	LA-Health Medical Scheme	202 860	4 228	3 721	13.63
1597	Umvuzo Health Medical Scheme	75 049	4 143	3 927	5.50
1291	Witbank Coalfields Medical Aid Scheme	24 037	4 027	2 299	75.16

* Principal Officer remuneration includes curator fees

Table 88: Top 10 open schemes with the highest governance-related* expenditure (pabpm)

Ref. no.	Name of medical scheme	Average beneficiaries	PO fees R'000	Legal fees R'000	Consulting fees R'000	Trustee remuneration R'000	Investigation fees (fraud and other) R'000	Total governance related expenditure pabpm
1464	Suremed Health	2 253	635	35	–	1 088	–	65.01
1446	Selfmed Medical Scheme	12 720	1 438	–	2 089	1 151	–	30.65
1554	Genesis Medical Scheme	21 421	2 836	14	1 741	534	–	19.94
1491	Compcare Wellness Medical Scheme	26 209	2 074	–	520	3 557	–	19.56
1537	Hosmed Medical Aid Scheme	56 046	3 009	3 091	841	4 953	–	17.69
1141	Health Squared Medical Scheme	37 604	2 171	1 679	401	2 674	–	15.35
1140	Medshield Medical Scheme	160 886	5 914	6 331	3 759	4 437	3 792	12.55
1466	Makoti Medical Scheme	7 698	331	–	–	608	–	10.16
1486	Sizwe Medical Fund	112 661	3 438	2 994	1 017	4 731	127	9.10
1034	Cape Medical Plan	9 477	253	340	33	384	–	8.88

pabpm = per average beneficiary per month
** For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in "governance-related expenditure".

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Table 89: Top 10 restricted schemes with the highest governance-related* expenditure (pabpm)

Ref. no.	Name of medical scheme	Average beneficiaries	PO fees	Legal fees	Consulting fees	Trustee remuneration	Investigation fees (fraud and other)	Total governance related expenditure
1237	BP Medical Aid Society	3 564	1 578	3 126	–	954	–	132.29
1012	Anglo Medical Scheme	18 308	2 304	1 919	–	1 142	–	24.42
1291	Witbank Coalfields Medical Aid Scheme	24 037	4 027	2 836	–	126	–	24.23
1441	Parmed Medical Aid Scheme	4 742	973	–	–	20	41	18.17
1186	PG Group Medical Scheme	3 084	662	–	–	–	–	17.89
1547	Malcor Medical Scheme	11 472	587	1 734	–	75	–	17.40
1523	Grintek Electronics Medical Aid Scheme	1 342	204	–	–	–	44	15.41
1579	Tsogo Sun Group Medical Scheme	11 376	–	2 033	–	–	–	14.89
1068	De Beers Benefit Society	9 492	1 209	–	29	373	–	14.14
1582	Transmed Medical Fund	36 498	4 651	19	–	1 463	–	14.00

pabpm = per average beneficiary per month
** For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in “governance-related expenditure”.

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Table 90: Ten schemes with highest AGM costs in 2019

Ref. no.	Name of medical scheme	Average members		AGM costs			
		2019	2018	2019 R'000	2018 R'000	2019 pampm R	2018 pampm R
1125	Discovery Health Medical Scheme	1 342 758	1 335 093	6 375	4 271	0.40	0.27
1537	Hosmed Medical Aid Scheme	21 444	23 052	4 799	7 653	18.65	27.67
1038	SAMWUMed	33 421	33 644	3 902	1 037	9.73	2.57
1512	Bonitas Medical Fund	336 651	331 955	2 946	3 547	0.73	0.89
1486	Sizwe Medical Fund	47 321	46 850	2 304	2 349	4.06	4.18
1598	GEMS	713 646	695 531	988	1 026	0.12	0.12
1252	Bestmed Medical Scheme	94 527	93 635	508	731	0.45	0.65
1149	Medihelp	94 084	92 884	504	544	0.45	0.49
1580	POLMED	177 430	175 954	414	669	0.19	0.32
1086	Food Workers Medical Benefit Fund	11 358	11 965	354	147	2.60	1.02

pampm = per average member per month

Broker costs

Broker costs include all broker service fees (or broker commissions) and other distribution costs. Broker costs increased by 9.19% from R2.24 billion in 2019 to R2.45 billion in 2019 (2018: 8.17%).

Broker costs represented 14.80% of total NHE in 2019, while accounting for 14.21% in 2018.

For schemes that pay broker service fees, the amounts paid on a per average member per month (pampm) basis increased to R78.53 pampm in 2019 from R72.75 pampm in 2018, representing an increase of 7.95%.

Broker service fees as a percentage of GCI increased slightly from 1.17% in 2018 to 1.19% in 2019.

The Medical Schemes Industry Overview in 2019

Figure 61 illustrates the increase in broker service fees relative to the number of members of schemes that pay brokers.

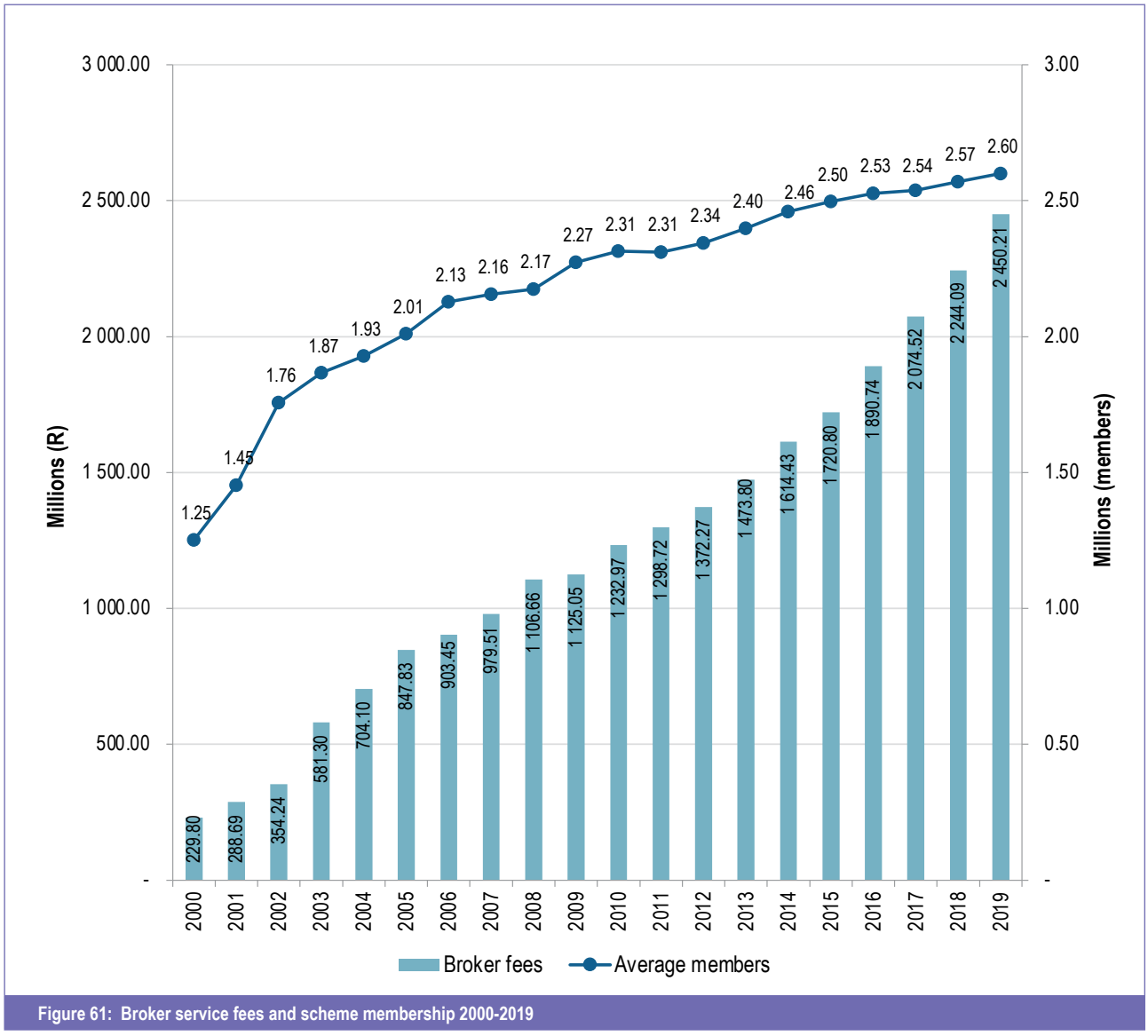

Figure 61: Broker service fees and scheme membership 2000-2019

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Figure 62 pampm illustrates the increase in broker service fees pampm in those schemes that incurred this expenditure (the data is limited to the extent that it is based on full scheme membership and not restricted to members who incurred this expenditure), relative to the statutory limit impose.

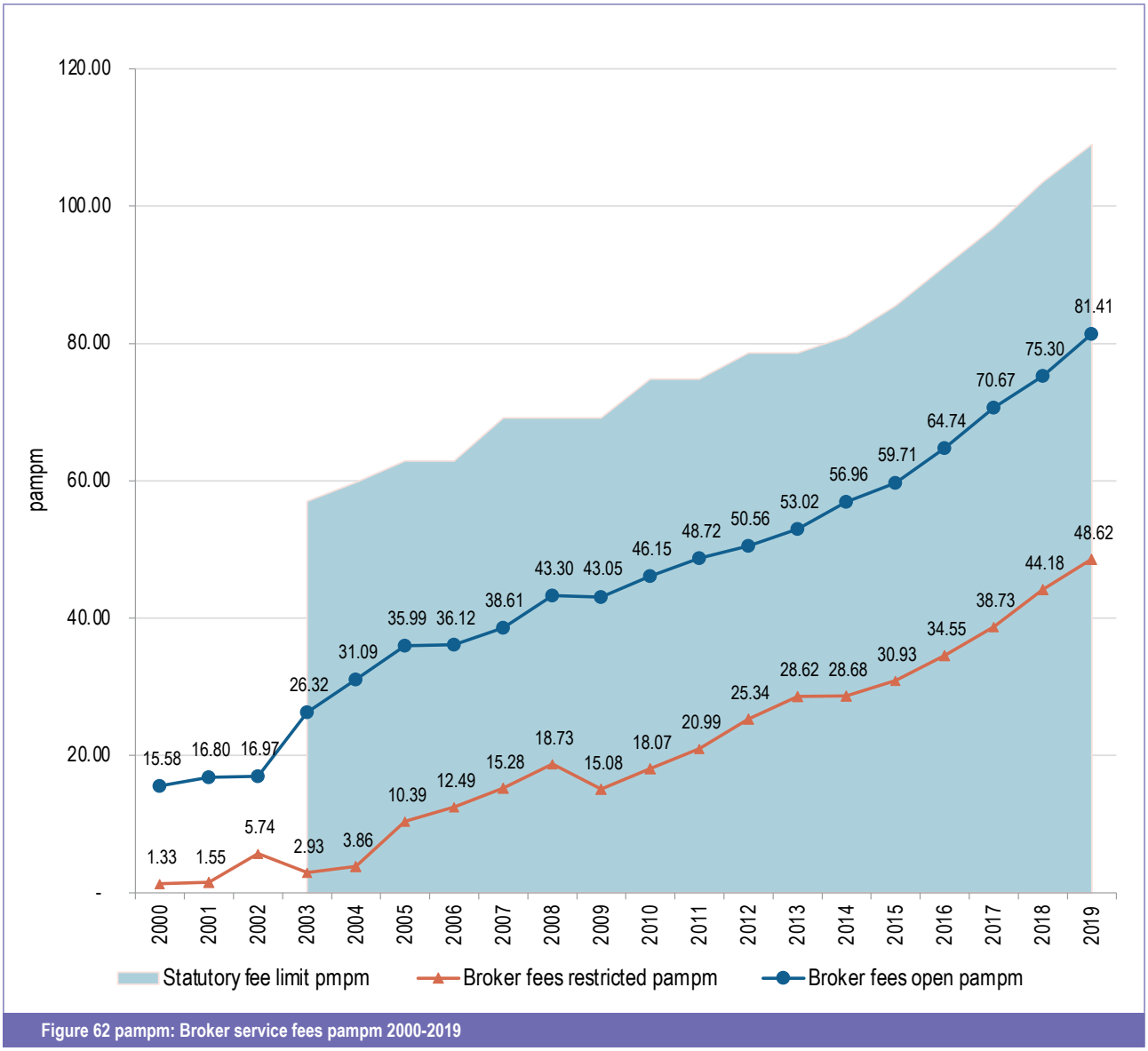

Figure 62 pampm: Broker service fees pampm 2000-2019

The Medical Schemes Industry in 2019

Table 91 illustrates the schemes that had broker service fees higher than the industry average of R78.53 pampm during 2019 (2018: R72.75 pampm). These five schemes (2018: 5) represented 70.38% (2018: 70.46%) of total membership that paid for broker service fees, and 78.41% (2018: 77.99%) of total broker service fees paid. One of these schemes paid at a level of 25.10% greater than the industry average.

Table 91: Schemes with broker fees above the industry average of R78.53 pampm (2019 and 2018)

Ref. no.	Name of medical scheme	Type	Broker service fees*			Other distribution fees		
			2019 pampm R	2018 pampm R	% change	2019 pampm R	2018 pampm R	% change
1537	Hosmed Medical Aid Scheme	Open	98.24	88.39	11.14	–	–	–
1125	Discovery Health Medical Scheme	Open	89.65	82.00	9.33	–	–	–
1145	LA-Health Medical Scheme	Restricted	88.27	82.86	6.53	–	–	–
1486	Sizwe Medical Fund	Open	80.82	75.96	6.40	–	–	–
1512	Bonitas Medical Fund	Open	78.93	74.21	6.36	–	–	–

pampm = per average member per month
* excluding distribution costs

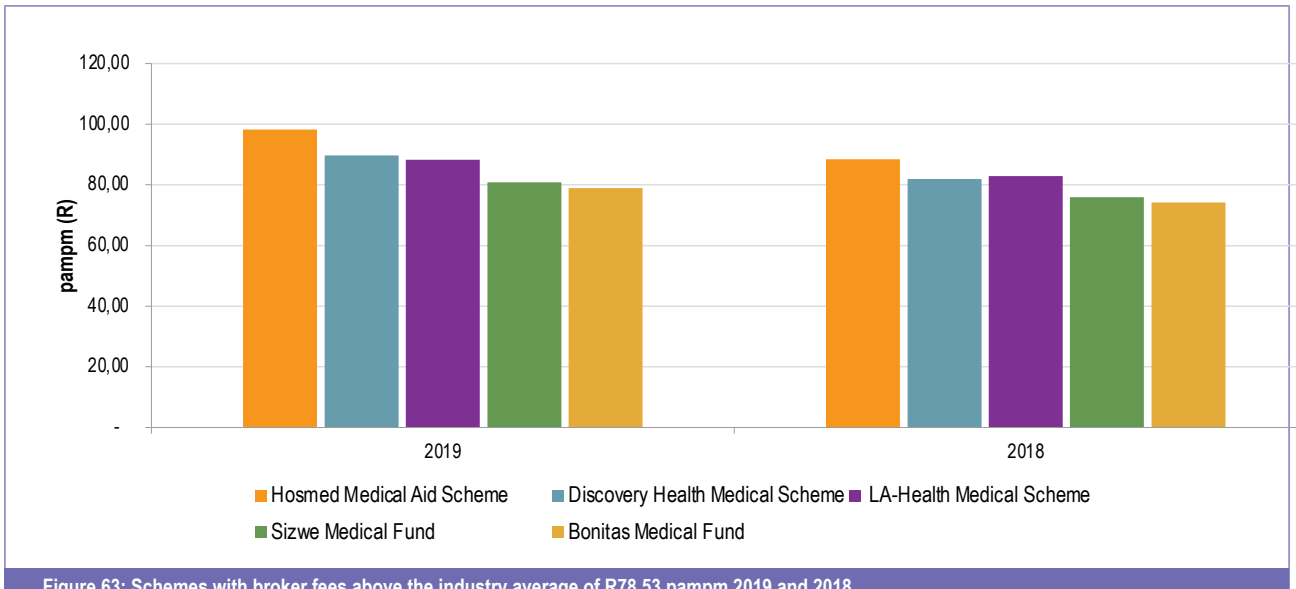

Figure 63: Schemes with broker fees above the industry average of R78.53 pampm 2019 and 2018

pampm = per average member per month

The Medical Schemes Industry in 2019

Reinsurance results

Thebemed has had a reinsurance contract in place since 1 July 2018. The scheme incurred a net expense on commercial reinsurance of R9 000 (2018: R626 000).

Impaired receivables

Impaired receivables increased by 15.89% to R261.98 million for the year under review from R311.48 million in 2018. This represents 1.58% of total NHE (1.97% in 2018).

It took schemes an average of 10.39 days to collect debts (contributions from their members) in 2019, a deterioration of 0.87% from 10.30 days in 2018. This collection period falls well outside the legal provisions which require that members pay all contributions to their medical scheme not later than three days after the payment is due. The associated risks of not paying and collecting contributions timeously are the possible impairment of the debtor and paying claims when contributions have not been received.

Figure 64 shows the trend in impaired receivables over the past 20 years, also expressed as a percentage of total NHE.

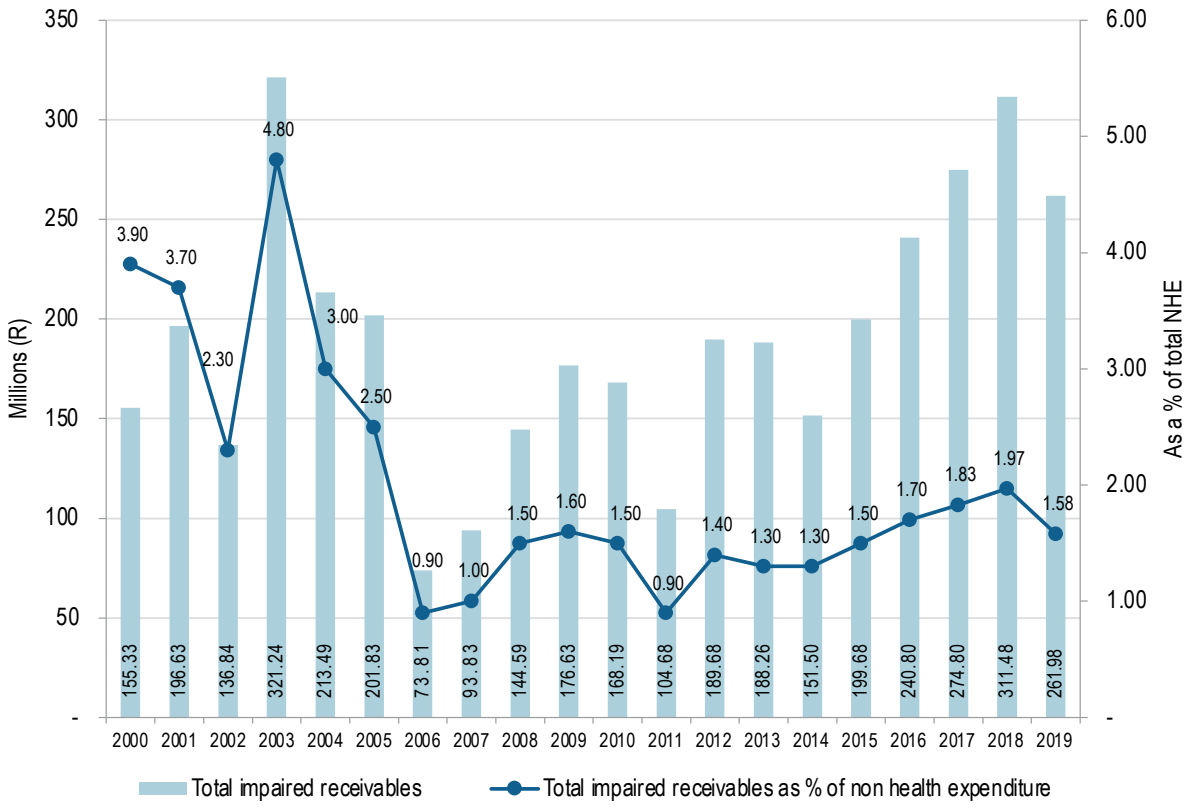

Figure 64: Impaired receivables 2000-2019

The Medical Schemes Industry in 2019

Fraud detection and prevention

Fraud, waste and abuse of resources is a perennial challenge in many sectors, including the healthcare sector. It is an area that has recently come under the spotlight, particularly against the backdrop of increasing costs.

Table 92 depicts monies spent by open and restricted schemes in respect of their fraud interventions, including investigating and identifying fraudulent claims, recoveries, and recovery administration fees paid to third parties. It should be noted that a significant number of medical schemes have such fees included in the composite administration fee paid to third-party administrators.

Table 92: Expenditure on fraud detection and prevention (2019)

	Investigation fees (fraud) R'000	Forensic recoveries R'000	Third-party recovery administration fees R'000
Open schemes	(12 951)	114 272	(46 135)
Restricted schemes	(11 372)	138 039	(7 667)
All schemes	(24 323)	252 311	(53 802)

Trends in non-healthcare expenditure

Administration expenditure, which includes administration fees, trustee fees, principal officer fees and other operational expenditure incurred by medical schemes, was the main component of NHE in 2019 at 83.62% (2018: 83.81%).

Administration expenditure accounted for 6.73% of GCI in 2018 (2018: 6.88%).

The Medical Schemes Industry in 2019

Table 93 shows administration expenditure by type of scheme administration.

Table 93: GAE (2000-2019) in 2019 prices*

	Open schemes				Restricted schemes			
	Self-administered		Third party		Self-administered		Third party	
	pabpm R	% change	pabpm R	pabpm R	% change	pabpm R	pabpm R	% change
2000	88.80	55.83	104.59	26.43	62.30	13.63	73.86	9.95
2001	138.38		132.24		70.79		81.21	
2002	117.58	-15.03	138.11	4.44	81.89	15.67	94.60	16.49
2003	137.88	17.27	145.98	5.69	69.86	-14.68	100.17	5.89
2004	148.92	8.00	157.35	7.79	85.29	22.08	103.31	3.13
2005	151.44	1.69	165.32	5.07	79.14	-7.22	118.15	14.37
2006	148.48	-1.96	166.19	0.52	68.54	-13.38	111.57	-5.57
2007	149.60	0.76	161.61	-2.76	71.06	3.67	101.77	-8.78
2008	143.07	-4.36	155.25	-3.94	58.75	-17.33	87.50	-14.02
2009	149.60	4.56	158.87	2.33	62.72	6.76	88.70	1.37
2010	138.54	-7.39	155.21	-2.30	73.00	16.39	86.97	-1.95
2011	130.04	-6.14	156.66	0.93	72.13	-1.20	84.07	-3.33
2012	142.54	9.61	155.71	-0.61	76.85	6.55	83.29	-0.93
2013	147.12	3.21	153.62	-1.34	75.66	-1.55	84.45	1.40
2014	141.53	-3.80	153.26	-0.23	90.53	19.65	87.72	3.87
2015	156.47	10.56	153.79	0.35	82.44	-8.93	94.52	7.75
2016	153.96	-1.60	151.44	-1.53	86.16	4.51	99.47	5.24
2017	150.18	-2.45	154.23	1.84	85.44	-0.84	99.66	0.20
2018	144.98	-3.47	158.39	2.70	112.90	32.14	93.34	-6.34
2019	143.96	-0.70	159.18	0.50	117.52	4.09	91.72	-1.74

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000 – 2018

The Medical Schemes Industry in 2019

Open schemes

During 2019, there were six self-administered open schemes (2018: 6), representing 607 898 average beneficiaries (2018: 609 682), and 14 thirdparty-administered open schemes (2018: 15), representing 4 347 162 average beneficiaries (2018: 4 343 974).

Self-administered open schemes experienced a real decrease of 0.70% in spending on administration expenditure (from R144.98 pabpm in 2018 to R143.96 pabpm in 2019) while third-party-administered open schemes increased their expenditure by 0.50% in real terms to R159.18 pabpm from R158.39 pabpm in 2018. Third-party-administered open schemes paid 10.57% more for administration expenditure than self-administered open schemes. The figure was 9.25% higher in 2018.

Restricted schemes

During 2019, there were nine self-administered restricted schemes (2018: 9), representing 345 886 average beneficiaries (2018: 346 358) and 49 third-party-administered restricted schemes (2018: 49), representing 3 634 550 average beneficiaries (2018: 3 572 135).

Self-administered restricted schemes spent on average, 28.13% more on administration expenditure at R117.52 pabpm compared with the R91.72 pabpm of third-party administered restricted schemes (2018: 20.95%).

The GAE pabpm in the open scheme industry is significantly higher than that of the restricted scheme industry. This is also reflected in the comparison between third-party-administered and self-administered schemes in the two industries. This is partly due to the fact that restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

Table 94 indicates the 10 schemes with the highest marketing, advertising, and broker costs. The majority of which are open schemes. The table shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 0.36% from 2018 to 2019 (2017 to 2018: 0.71%) in respect of those schemes that incurred broker fees, marketing and advertising expenditure. Member growth in this instance is not confined to new members who were not previously covered by a scheme as it includes members who moved from other schemes. Figure 65 illustrates the information contained in Table 91.

Table 94: Ten schemes with highest marketing, advertising and broker costs (2019)

Ref. no.	Name of medical scheme	Marketing, advertising and broker costs pampm	Net new member growth* %
	Industry average	R 78.11	0.97
1486	Sizwe Medical Fund	R 159.09	0.70
1141	Health Squared Medical Scheme***	R 144.93	98.40
1537	Hosmed Medical Aid Scheme	R 142.71	-5.40
1202	Fedhealth Medical Scheme**	R 141.20	9.60
1145	LA-Health Medical Scheme	R 134.79	10.30
1422	Topmed Medical Scheme	R 131.38	-100.00
1167	Momentum Health	R 130.64	0.10
1512	Bonitas Medical Fund	R 125.28	2.30
1597	Umvuzo Health Medical Scheme	R 112.35	31.70
1125	Discovery Health Medical Scheme	R 112.06	0.10

* Net new member growth is calculated as the number of members at year-end compared with that of the previous year
** Topmed Medical Scheme amalgamated with Fedhealth Medical Scheme on 1 August 2019.
*** There was a merger during the year.
pampm = per average member per month

The Medical Schemes Industry in 2019

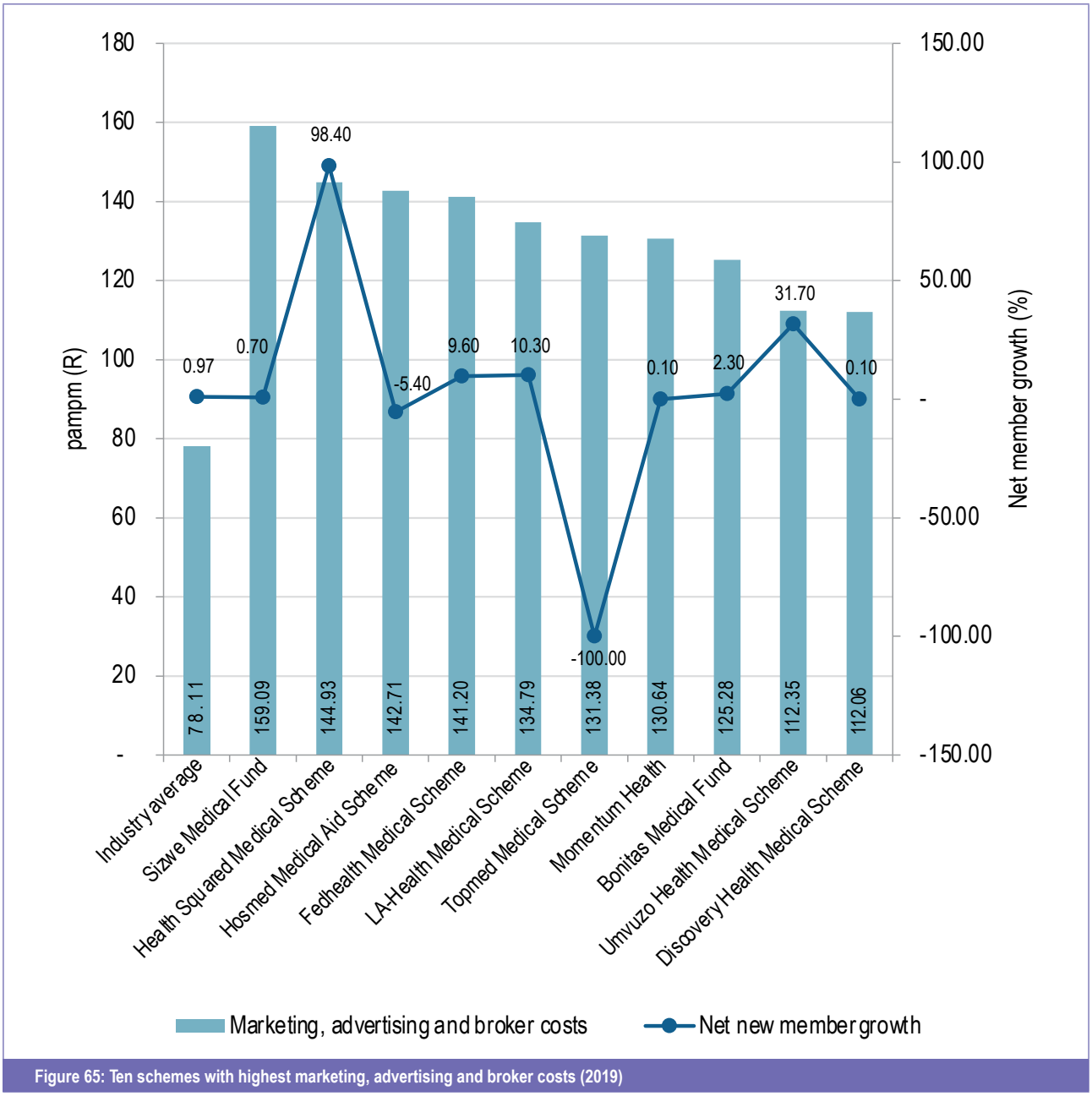

Figure 65: Ten schemes with highest marketing, advertising and broker costs (2019)

pampm = per average member per month

The Medical Schemes Industry in 2019

Tables 95 and 96 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 95: Open schemes with highest marketing and advertising expenditure (2019)

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising) R			Broker costs paid R			Average members R			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	% of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1486	Sizwe Medical Fund	78.27	56.09	39.54	80.82	75.96	6.40	47 321	46 850	1.01	Ad hoc expenditure	7 073	15.91
											3Sixty Marketing (Pty) Ltd	20 125	45.28
											3Sixty Health (Pty) Ltd	17 250	38.81
1141	Health Squared Medical Scheme	93.18	77.24	20.64	51.75	29.64	74.60	21 272	10 646	99.81	Ad hoc expenditure	10 318	43.38
											Agility Channel (Pty) Ltd	13 468	56.62
1537	Hosmed Medical Aid Scheme	44.46	19.94	122.97	98.24	88.39	11.14	21 444	23 052	-6.98	Ad hoc expenditure	5 116	44.72
											Moralo Business Enterprise	2 907	25.41
											Print Joint	2 533	22.14
											On Aucklands (Pty) Ltd	725	6.33
											Ideas Wise and Wonderful	152	1.33
											Mail and Guardian	9	0.08
1202	Fedhealth Medical Scheme	66.92	78.30	-14.53	74.28	71.39	4.05	74 613	72 286	3.22	Ad hoc expenditure	–	0.00
											The Cheesed Has Moved (Pty) Ltd	59 916	100.00
1422	Topmed Medical Scheme	29.77	50.36	-40.89	46.86	68.34	-31.43	16 360	19 414	-15.73	Ad hoc expenditure	310	5.31

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising) R			Broker costs paid R			Average members R			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1422	Topmed Medical Scheme										Fastpulse	3 172	54.27
											Hippo Comparative Services (Pty) Ltd – name % changed from Digital Comparision Services	1 492	25.53
											Jellyfish Online Marketing SA (Pty) Ltd	748	12.79
											Intellegent Internet Solutions	108	1.84
											Med Aid Quote (Pty) Ltd	16	0.27
1167	Momentum Health	67.60	62.93	7.42	63.04	58.23	8.26	156 841	156 761	0.05	Ad hoc expenditure	–	0.00
											Momentum Health Solutions (Pty) Ltd	127 233	100.00
1512	Bonitas Medical Fund	46.35	41.76	10.99	78.93	74.21	6.36	336 651	331 955	1.41	Ad hoc expenditure	4 986	2.66
											Afrocentric Distribution Services (Pty) Ltd	182 244	97.34

The Medical Schemes Industry in 2019

Tables 95 and 96 show open and restricted schemes with the highest marketing and advertising expenditure.

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising) R			Broker costs paid R			Average members R			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	% of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1125	Discovery Health Medical Scheme	22.41	21.30	5.21	89.65	82.00	9.33	1 342 758	1 335 093	0.57	Ad hoc expenditure	–	0.00
											Discovery Health (Pty) Ltd	361 014	100.00
1087	Keyhealth	49.66	34.10	45.63	56.21	54.55	3.04	32 450	33 503	-3.14	Ad hoc expenditure	1 437	7.43
											Brand ET AL	9 350	48.36
											Blou Bulle Maatskappy (Pty) Ltd	2 933	15.17
											Asem School Sport	2 286	11.82
											I Lead ET AL	1 328	6.87
											Varsity Cup Club	903	4.67
											Sports for U	522	2.70
											Nevarest	500	2.59
											Irene Country Club	77	0.40
1592	Thebemed	35.65	44.49	-19.87	67.69	60.06	12.70	13 854	11 549	19.96	Ad hoc expenditure	2 483	41.90
											Momentum Thebe Ya Bophelo (Pty) Ltd	3 443	58.10
1252	Bestmed Medical Scheme	31.26	31.15	0.35	71.04	66.60	6.67	94 527	93 635	0.95	Ad hoc expenditure	6 550	18.47

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising) R			Broker costs paid R			Average members R			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1252	Bestmed Medical Scheme										Onimcom Media	12 683	35.76
											Promise Brand Specialists	5 325	15.02
											University Of Pretoria	3 597	10.14
											Acco-mmodation Options Events	2 327	6.56
											Hectic Promotions	1 450	4.09
											Nelson Mandela Metro-politan Uni-versity	1 400	3.95
											Promo Distri-butors	1 131	3.19
											PHD	1 000	2.82
	Open scheme industry average*	32.88	31.05	5.89	81.41	75.30	8.11	2 378 345	2 360 008	0.78			

pampm = per average member per month
* *The industry averages are based only on those schemes which incurred the specific type of expenditure.*

Table 96: Restricted schemes with highest marketing and advertising expenditure (2019)

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1145	LA-Health Medical Scheme	46.51	44.25	5.11	88.27	82.86	6.53	81 753	74 124	10.29	Ad hoc expenditure	575	1.26
											Discovery Health (Pty) Ltd	45 056	98.74
1597	Umvuzo Health Medical Scheme	55.09	60.53	-8.99	57.25	58.52	-2.17	39 422	29 391	34.13	Ad hoc expenditure	–	0.00
											Rain Catchers	26 062	100.00
1194	Profmed	54.22	55.55	-2.39	29.02	26.63	8.97	34 344	33 221	3.38	Ad hoc expenditure	769	3.44
											Ebony and Ivory	10 949	49.00
											Faith and Fear	7 543	33.76
											Condriac Digital	1 258	5.63
											MSL	885	3.96
											StorkBrands	684	3.06
											YKnot Online	168	0.75
											Novus Group	89	0.40
1590	Building & Construc-tion Industry Medical Aid Fund	18.27	19.93	-8.33	6.91	3.06	125.82	4 836	4 846	-0.21	Ad hoc expenditure	1 060	100.00
1038	SAMWUMed	16.62	11.60	43.28	7.43	5.15	44.27	33 421	33 644	-0.66	Ad hoc expenditure	6 667	100.00

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expen-diture per provider R'000	of total fees
		2019 pampm	2018 pampm	% change	2019 pampm	2018 pampm	% change	2019	2018	% change			
1291	Witbank Coalfields Medical Aid Scheme	23.28	23.52	-1.02	0.29	0.83	-65.06	9 389	8 975	4.61	Ad hoc expenditure	2 623	100.00
1568	Sisonke Health Medical Scheme	22.53	12.55	79.52	–	–	–	16 131	8 371	92.70	Ad hoc expenditure	3 766	86.33
											Brandcode	596	13.67
1598	GEMS	18.64	18.10	2.98	–	–	–	713 646	695 531	2.60	Ad hoc expenditure	33 779	21.16
											Healthi Choices (Pty) Ltd	74 430	46.63
											Assegai Strategic Investments (Pty) Ltd	51 425	32.21
1600	Motohealth Care	3.22	2.76	16.67	13.14	13.10	0.31	20 030	21 530	-6.97	Ad hoc expenditure	775	100.00
1547	Malcor Medical Scheme	1.98	1.87	5.88	13.77	16.04	-14.15	4 768	4 758	0.21	Ad hoc expenditure	113	100.00
	Restricted scheme industry average*	15.48	14.35	7.87	48.62	40.80	19.17	1 542 399	1 515 418	1.78			

pampm = per average member per month
** The industry averages are based only in respect of those schemes which incurred the specific expenditure.*

The Medical Schemes Industry in 2019

Table 97: Schemes paying marketing fees to administrator: five largest percentages

Ref. no.	Name of medical scheme	Marketing component of administration fee		Total marketing, advertising and broker costs
		%	pampm	pampm
1167	Momentum Health	22.10	67.61	130.64
1145	LA-Health Medical Scheme	15.00	45.92	134.79
1486	Sizwe Medical Fund	13.35	30.38	159.09
1125	Discovery Health Medical Scheme	7.00	22.40	112.06
1599	Lonmin Medical Scheme	3.00	2.01	2.01

pampm = per average member per month

Figure 66 shows the % changes in the major categories of NHE for the past 20 years. Total net NHE rose by 4.84% from R15.79 billion in 2018 to R16.55 billion in 2019.

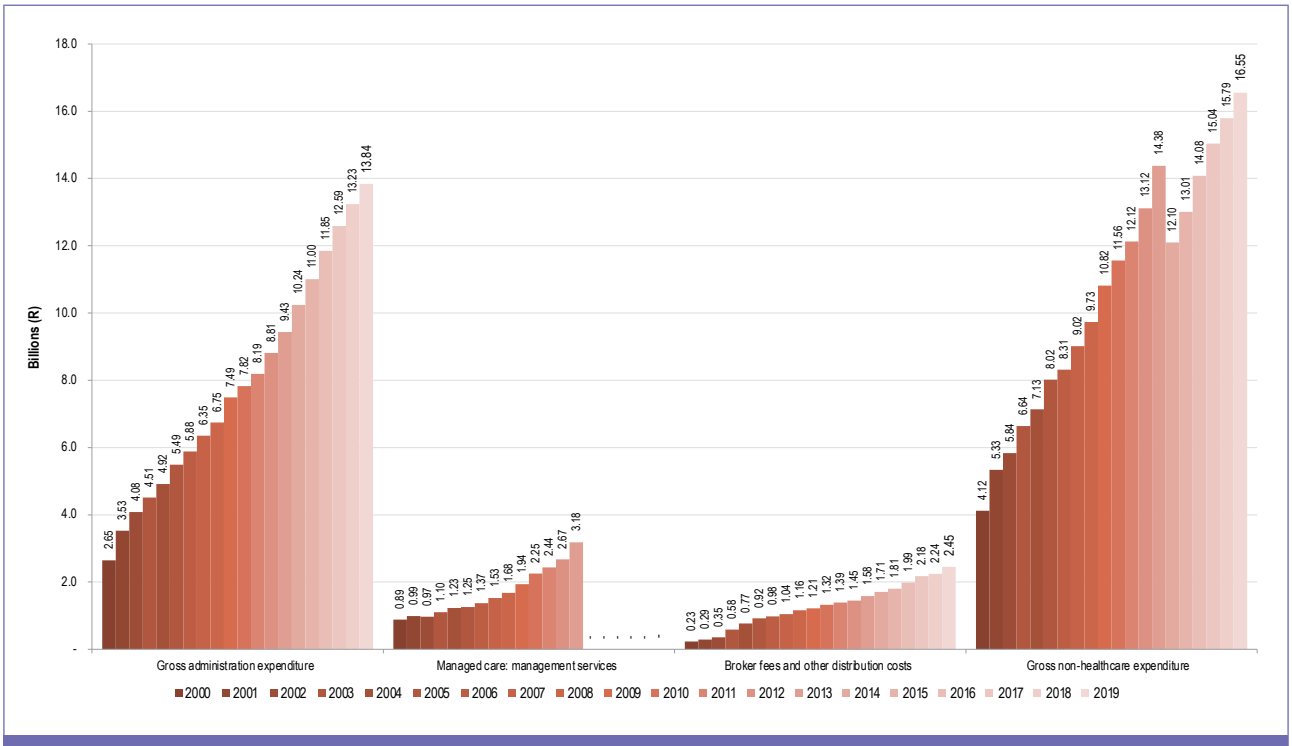

Figure 66: % changes in main components of non-healthcare expenditure 2000-2019

The Medical Schemes Industry in 2019

Total gross NHE (not adjusted for inflation) has increased by 301.35% since 2000, which was driven by a 422.84% upswing in administration expenditure and an increase of 966.25% in broker costs. By comparison, gross claims have risen by 585.01% (not adjusted for inflation) since 2000.

As illustrated in Figure 67 and 68 together with Table 97, the increase in NHE was consistently higher than the CPI prior to 2006[1]. The rate of increase was reversed in 2006 and since then there has been a real decrease in NHE, from R2 623.15 pabpa in 2005 to R2 224.36 pabpa in 2013 (prices adjusted to 2019 prices).

Circular 56 of 2015 was issued by the CMS in respect of reclassification of managed care, i.e. all managed care services, with and without risk transfer, were reclassified as part of claims. Only the benefit management services of a non-healthcare nature are included in NHE. This had the effect of the reducing NHE (2014 non-healthcare expenditure pabpa figure was downward adjusted with 21.49%). This can be clearly observed in Figure 67: NHE pabpa decreased from 2013's R2 224.36 to 2014's R1 755.05. Thereafter a marginal increase in NHE occurred, from 2014's R1 755.05 pabpa to 2019's R1 852.64 pabpa.The non-healthcare ratio (as % of RCI) decreased from 9.08% in 2018 to 8.87% in 2019.

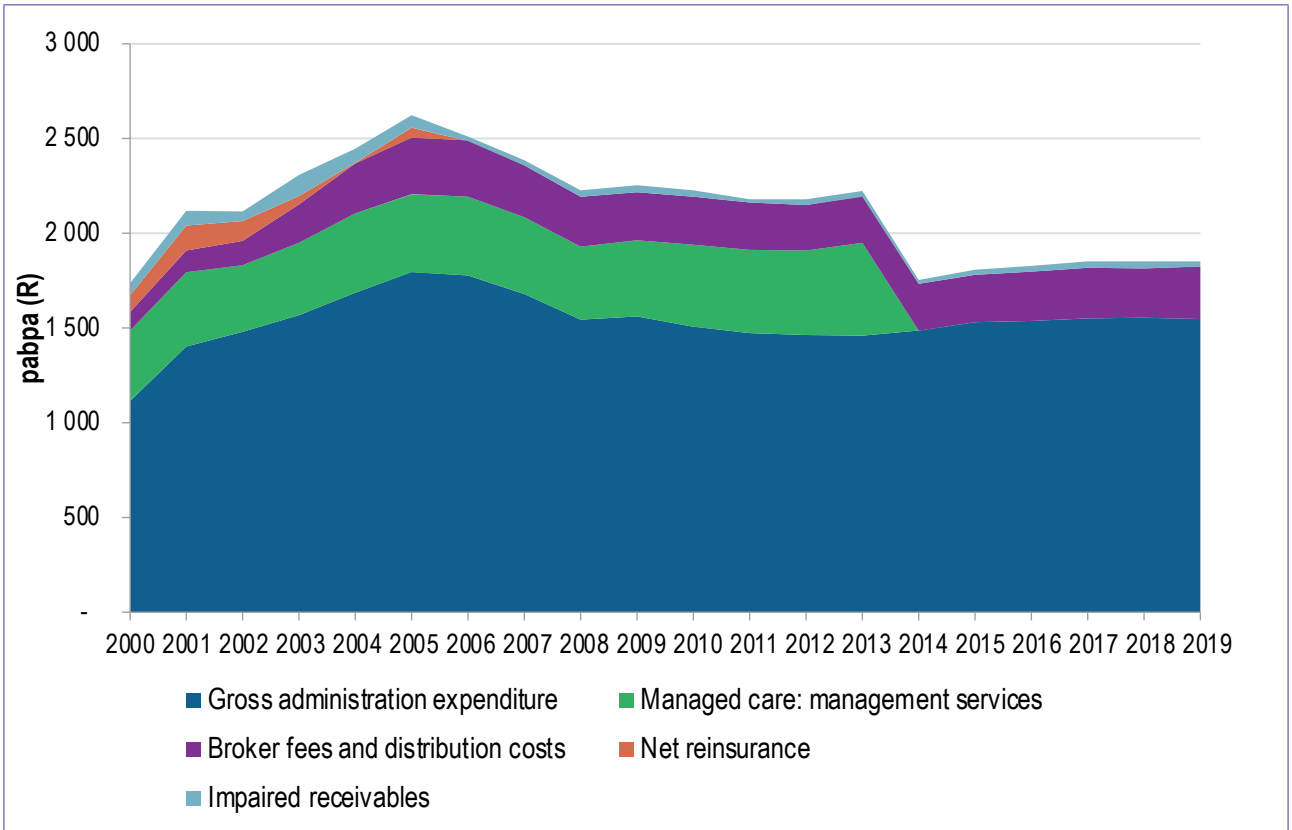

Figure 67: Non-healthcare expenditure pabpa (2000-2019) in 2019 prices*

pabpa = per average beneficiary per annum
* The values were adjusted for CPI for 2000 – 2018

No significant % changes were observed in the composition of NHE over the last few years. Administration expenditure is the biggest component of NHE (83.62%), followed by broker fees and other distribution costs (14.80%) and impaired receivables (1.58%).

[1] This can partly be explained by GEMS starting to operate in 2006.

The Medical Schemes Industry in 2019

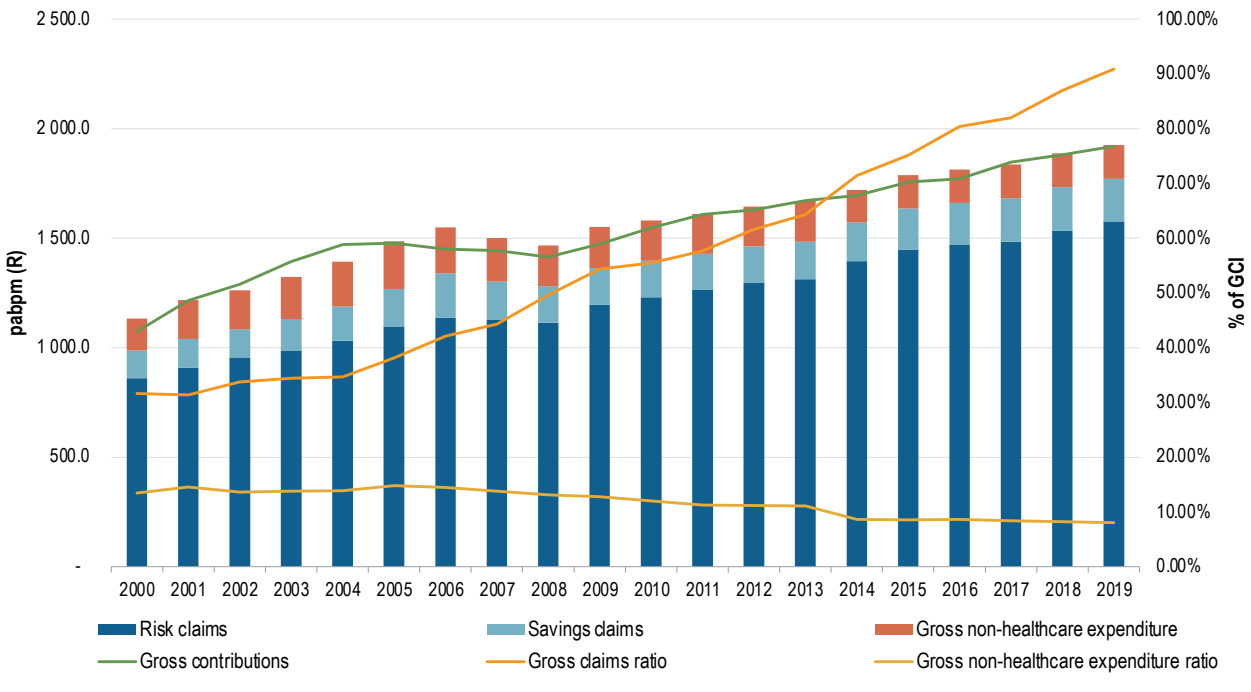

Figure 68: Claims and non-healthcare expenditure pabpm (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
GCI = Gross Contribution Income
* The values were adjusted for CPI for 2000 – 2018

The Medical Schemes Industry in 2019

Table 98: Trends in contributions, claims and non-healthcare expenditure (2000-2019) in 2019 prices*

	Gross contributions		Gross claims		Gross NHE	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	12 884.21	13.11	11 498.38	-5.60	1 736.85	22.07
2001	14 572.70		10 854.07		2 120.12	
2002	15 479.84	6.22	12 764.49	17.60	2 115.34	-0.23
2003	16 703.81	7.91	13 291.88	4.13	2 307.67	9.09
2004	17 659.64	5.72	13 976.47	5.15	2 444.82	5.94
2005	17 720.46	0.34	14 911.58	6.69	2 623.36	7.30
2006	17 389.62	-1.87	15 438.86	3.54	2 510.40	-4.31
2007	17 315.24	-0.43	15 099.16	-2.20	2 384.92	-5.00
2008	16 957.01	-2.07	14 839.33	-1.72	2 227.41	-6.60
2009	17 671.97	4.22	15 888.74	7.07	2 253.22	1.16
2010	18 573.98	5.10	16 346.72	2.88	2 226.35	-1.19
2011	19 305.91	3.94	16 832.75	2.97	2 179.84	-2.09
2012	19 546.62	1.25	17 238.89	2.41	2 180.29	0.02
2013	20 069.61	2.68	17 467.22	1.32	2 223.60	1.99
2014	20 346.19	1.38	18 518.32	6.02	1 755.25	-21.06
2015	21 071.70	3.57	19 304.74	4.25	1 807.81	2.99
2016	21 243.33	0.81	19 595.78	1.51	1 827.38	1.08
2017	22 158.60	4.31	19 782.18	0.95	1 853.07	1.41
2018	22 556.35	1.80	20 426.51	3.26	1 852.46	-0.03
2019	23 034.86	2.12	20 933.23	2.48	1 852.64	0.01
since 2000	78.78	82.05	6.67			

pabpa = per average beneficiary per annum
* The values were adjusted for CPI for 2000-2018.

The Medical Schemes Industry in 2019

Table 99 shows how NHE outpaced contributions and claims in most years until 2005. Total NHE has increased marginally over the past four years. Table 93 shows the 10 open schemes with NHE greater than the industry average of R199.15 pabpm and highlighted those schemes exceeding the open schemes average of 11.33% when expressed as a percentage of RCI.

Table 99: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions among open schemes (2018 and 2019)

		Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
Ref. no.	Name of medical scheme	2019 pabpm	2018 pabpm	2019 As % of RCI	2018 As % of RCI	2019 As % of RCI	2018 As % of RCI	2019 As % of RCI	2018 As % of RCI	% change
1446	Selfmed Medical Scheme	331.47	260.98	100.24	103.58	14.70	12.93	-14.94	-16.51	9.51
1141	Health Squared Medical Scheme	302.29	330.90	92.61	101.50	12.94	15.30	-5.54	-16.80	67.02
1491	Compcare Wellness Medical Scheme	256.51	202.35	87.91	93.16	13.91	11.95	-1.82	-5.11	64.38
1202	Fedhealth Medical Scheme	252.09	240.44	93.33	89.40	13.53	13.29	-6.86	-2.68	-155.97
1464	Suremed Health	247.45	214.17	95.21	80.58	12.87	12.29	-8.08	7.13	-213.32
1087	Keyhealth	219.79	206.54	89.91	88.88	8.70	8.65	1.40	2.47	-43.32
1486	Sizwe Medical Fund	215.12	242.81	100.17	98.16	11.83	14.05	-12.00	-12.21	1.72
1422	Topmed Medical Scheme	205.93	175.07	114.38	107.09	12.14	11.48	-26.51	-18.58	-42.68
1125	Discovery Health Medical Scheme	205.35	192.85	87.73	88.43	12.04	12.23	0.24	-0.67	135.82
1167	Momentum Health	199.85	185.09	84.23	87.32	14.68	14.72	1.09	-2.05	153.17
	Industry average – open schemes	199.15	189.23	89.34	89.85	11.33	11.53	-0.67	-1.37	51.09

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

The Medical Schemes Industry in 2019

Table100 shows the 10 restricted schemes with NHE greater than the industry average of R98.67 pabpm and highlighted those schemes exceeding the restricted schemes average of 5.74% when expressed as a percentage of RCI.

Table 100: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions among restricted schemes (2018 and 2019)

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2019 pabpm	2018 pabpm	2019 As % of RCI	2018 As % of RCI	2019 As % of RCI	2018 As % of RCI	2019 As % of RCI	2018 As % of RCI	% change
1237	BP Medical Aid Society	288.44	151.59	130.50	126.26	12.49	7.07	-42.99	-33.33	-28.98
1194	Profmed	252.28	238.37	93.07	89.86	12.12	12.18	-5.20	-2.04	-154.90
1441	Parmed Medical Aid Scheme	200.30	173.40	92.86	101.35	4.06	3.90	3.07	-5.25	158.48
1068	De Beers Benefit Society	192.42	182.61	109.42	112.73	6.90	7.11	-16.32	-19.84	17.74
1043	CAMAF	189.33	236.72	85.83	92.02	8.54	11.63	5.63	-3.64	254.67
1523	Grintek Electronics Medical Aid Scheme	188.46	162.34	102.69	97.98	7.70	7.74	-10.39	-5.73	-81.33
1145	LA-Health Medical Scheme	170.55	167.54	84.33	82.68	12.20	12.51	3.47	4.82	-28.01
1197	Libcare Medical Scheme	156.91	111.36	93.09	100.74	8.35	6.55	-1.44	-7.29	80.25
1582	Transmed Medical Fund	151.41	140.94	100.20	97.19	9.91	9.47	-10.11	-6.65	-52.03
1571	Anglovaal Group Medical Scheme	149.42	151.26	99.97	95.28	8.33	8.86	-8.30	-4.13	-100.97
	Industry average – restricted schemes	98.67	96.60	92.15	90.71	5.74	5.95	2.11	3.34	-36.83

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

The Medical Schemes Industry in 2019

Non-healthcare expenditure for open schemes with a solvency ratio below the open schemes average of 29.35% is shown in Figure 69, while Figure 70 shows the NHE for restricted schemes with a solvency ratio below the restricted schemes average of 44.31%. It is concerning that some of these medical schemes fall below the 25.0% solvency target yet exhibit high levels of NHE. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

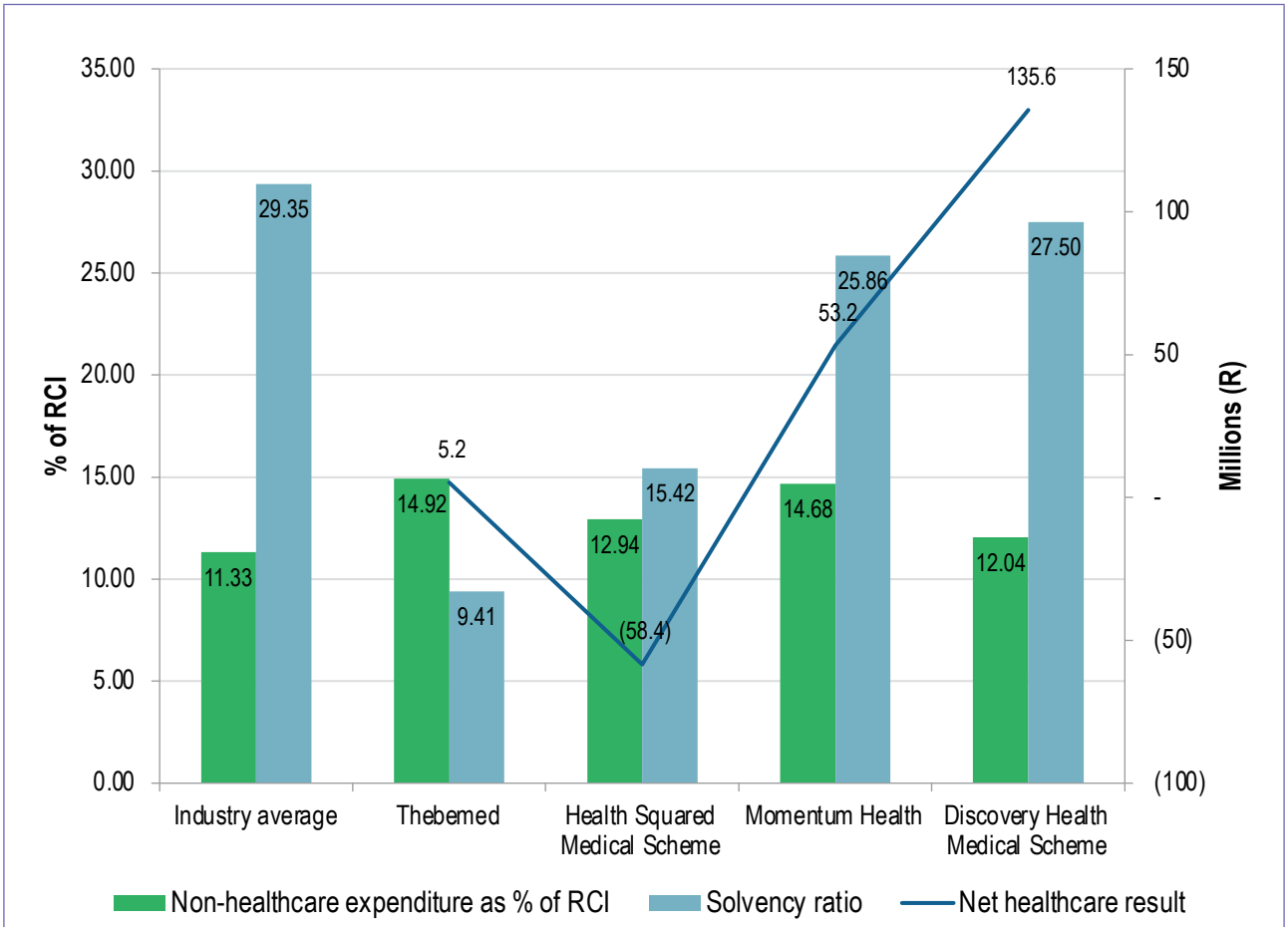

Figure 69: Open schemes with high non-healthcare expenditure and solvency ratio below average (2019)

RCI = Risk Contribution Income

The Medical Schemes Industry in 2019

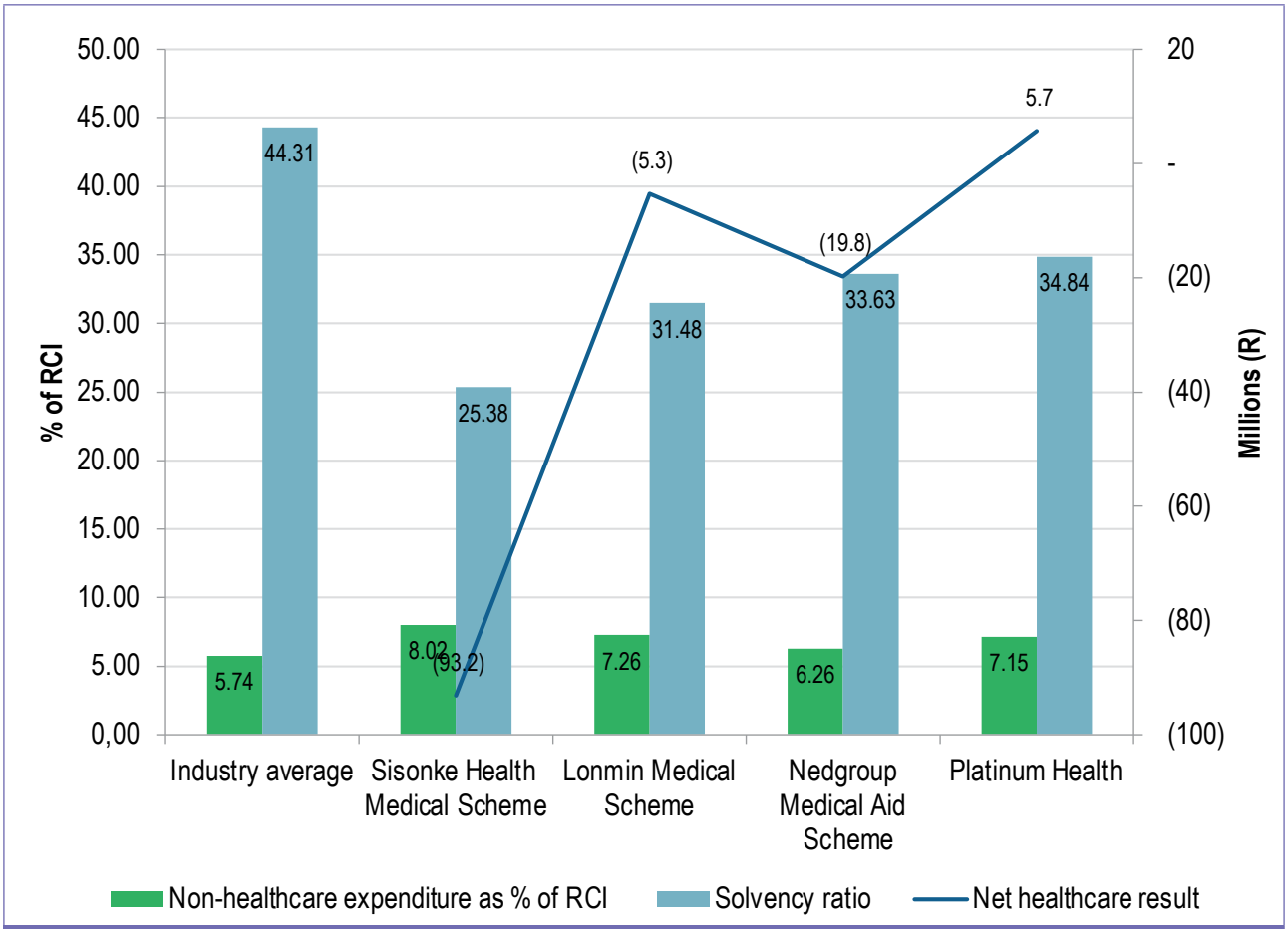

Figure 70: Restricted schemes with high non-healthcare expenditure and solvency ratio below average (2019)

RCI = Risk Contribution Income

The Medical Schemes Industry in 2019

Figure 71 depicts information on contributions, benefits, NHE, and operating surpluses pabpm. The trade-off between NHE and annual surpluses pabpm had been growing since 2000 but decreased in 2003, almost levelling out in 2004. Although this gap has since grown wider, it seems to have stabilised in the last few years.

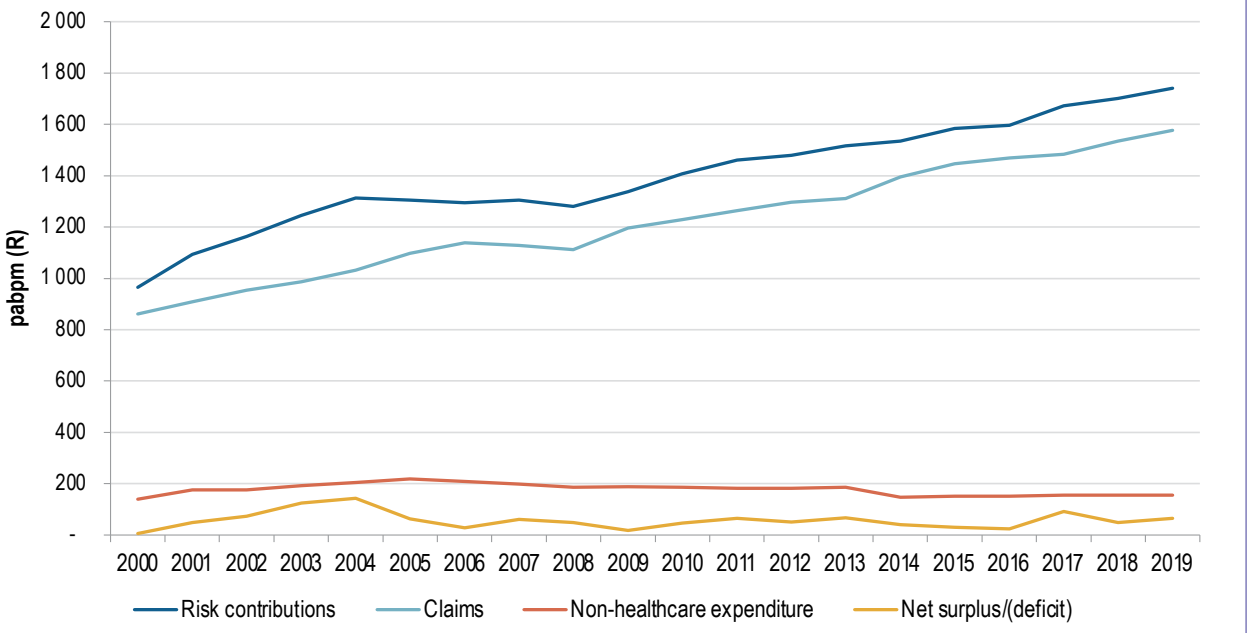

Figure 71: Risk contributions, claims, non-healthcare expenditure, and net surpluses (2000-2019) in 2019 prices*

pabpm = per average beneficiary per month
* The values were adjusted for CPI for 2000-2018.

The Medical Schemes Industry in 2019

Benefit options

During 2019 there were 271 registered benefit options (2018: 271) operating in 78 medical schemes (2018: 79).

Open schemes accounted for 49.82% or 135 of the registered benefit options during 2019 (excluding Resolution Health Medical Scheme which amalgamated with Spectramed on 1 January 2019) (2018: 50.18% or 136 options). On average, open schemes had 6.75 options per scheme (2018: 6.48) and an average of 17 611 members per option at year-end (2018: 17 522).

Restricted schemes had 136 options during the year, representing 50.18% of all options (2018: 135 options or 49.82% – excluding University of the Witwatersrand, Johannesburg Staff Medical Aid Fund which amalgamated on 1 January 2018 with Discovery Health Medical Scheme). Restricted schemes had an average of 2.34 options per scheme (2018: 2.29), with an average of 12 389 members per option as at 31 December 2019 (2018: 12 272).

Table 101: Results of benefit options 2019

	Open schemes	% representing	Restricted schemes	% representing	Total
All options					
Number of options	135	49.82	136	50.18	271
Members represented	2 377 444	58.52	1 684 969	41.48	4 062 413
Number of schemes	20	25.64	58	74.36	78
Net healthcare result (R'000)	(705 239)		1 736 549		1 031 310
Gross non-healthcare as % of GCI	9.89		5.47		8.04
Gross claims ratio (%)	90.09		91.97		90.88
Gross claims incurred pbpm	1 820.25		1 643.60		1 741.01
GCI pbpm	2 020.53		1 787.07		1 915.80
Options with members >= 2 500					
Number of options	77	47.53	85	52.47	162
Members represented	2 323 633	58.75	1 631 218	41.25	3 954 851
Net healthcare result (R'000)	(423 886)		1 948 910		1 525 024
Gross non-healthcare as % of GCI	9.90		5.44		8.04
Gross claims ratio (%)	89.83		91.69		90.61
Gross claims incurred pbpm	1 794.94		1 629.97		1 721.20
GCI pbpm	1 998.04		1 777.70		1 899.55
Options with members < 2 500					
Number of options	58	53.21	51	46.79	109
Members represented	53 811	50.03	53 751	49.97	107 562
Net healthcare result (R'000)	(281 388)		(212 366)		(493 754)
Gross non-healthcare as % of GCI	9.51		6.48		7.79
Gross claims ratio (%)	97.96		100.61		97.71
Gross claims incurred pbpm	3 045.38		2 144.27		2 279.08
GCI pbpm	3 108.73		2 131.28		2 332.53

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 271 benefit options during the year, 109 (40.22%) had fewer than 2 500 members per option (2018: 101 or 37.27%). Of these 109 options, 69 (63.30%) incurred net healthcare losses in 2019, compared with 63 of these options (62.38%) incurring losses in 2018.

The Medical Schemes Industry in 2019

At the end of 2019, there were 58 options in open schemes with fewer than 2 500 members (2018: 50). They had an average of 927.78. members per option (2018: 1 117.16) and represented 42.96% (2018: 36.76%) of all open scheme options.

Restricted schemes had 51 options with fewer than 2 500 members (2018: 51). The average number of members per option was 1 053.94 (2018: 1 069.71) and these options represented 37.50% (2018: 37.78%) of all restricted scheme options. The remaining 162 options (2018: 170) had more than 2 500 members per option. Of these, 55.56% or 90 options incurred net healthcare losses (2018: 55.29% or 94 options).

Table 102: Results of loss-making benefit options 2019

	Open schemes	% representing	Restricted schemes	% representing	Total
Total loss-making options					
% of total options	64.44		52.94		58.67
Number of options	87	54.72	72	45.28	159
Members represented	1 243 626	66.58	624 108	33.42	1 867 734
Net healthcare result (R'000)	(4 161 639)		(2 638 759)		(6 800 398)
Gross non-healthcare as % of GCI	9.66		5.10		8.05
Gross claims ratio (%)	96.68		102.37		98.69
Gross claims incurred pbpm	1 934.32		2 007.54		1 960.51
GCI pbpm	2 000.82		1 960.97		1 986.57
Loss-making options with members > =2 500					
Number of options	45	50.00	45	50.00	90
Members represented	1 208 062	66.98	595 425	33.02	1 803 487
Net healthcare result (R'000)	(3 816 106)		(2 329 937)		(6 146 043)
Gross non-healthcare as % of GCI	9.68		5.05		8.05
Gross claims ratio (%)	96.35		101.95		98.31
Gross claims incurred pbpm	1 890.46		1 961.70		1 915.72
GCI pbpm	1 962.08		1 924.19		1 948.64
Loss-making options with members < 2 500					
Number of options	42	60.87	27	39.13	69
Members represented	35 564	55.36	28 683	44.64	64 247
Net healthcare result (R'000)	(345 533)		(308 822)		(654 355)
Gross non-healthcare as % of GCI	9.39		5.95		7.98
Gross claims ratio (%)	103.63		109.40		105.99
Gross claims incurred pbpm	3 577.47		3 136.95		3 376.99
GCI pbpm	3 452.13		2 867.36		3 186.01

GCI = Gross Contribution Income
pbpm = per beneficiary per month

The Medical Schemes Industry in 2019

Of the 271 benefit options registered and operating during 2019 (2018: 271), 159 (58.67%) incurred net healthcare losses. In 2018, 157 options (57.93%) incurred net healthcare losses.

In the year under review, 87 options (2018: 85), representing 54.72% of loss-making options (2018: 54.14%), were in open schemes and 72 (2018: 72), representing 45.28% of loss-making options (2018: 45.86%), were in restricted schemes.

Net healthcare losses pbpm in options with fewer than 2 500 members were 2.99 times greater (2018: 2.29) than those for options with more than 2 500 members – an average of R-848.75 pbpm compared with R-283.99 pbpm (2018: R-717.02 pbpm and R-313.06 pbpm respectively).

Benefit options with fewer than 2 500 members generally have higher contributions and claims than other options as they are shared across a smaller base. Table 103 shows option results by demographics.

Table 103: Demographics of registered options at year-end: 2019

	Open	Restricted	Total
Average age pb	34.88	31.29	
Net healthcare result pb	-11.90	36.03	
Number of options with average age greater than or equal to the industry average	76	76	152
Number of options incurring net healthcare results better or equal to the industry average	25	17	42
Number of options incurring net healthcare results worse than the industry average	51	59	110
Number of options with average age below the industry average	59	60	119
Number of options incurring net healthcare results better or equal to the industry average	27	35	62
Number of options incurring net healthcare results worse than the industry average	23	25	48

pb = per beneficiary

There were 76 options with an average age above the 34.88 years for options in open schemes, and 59 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 76 benefit options had beneficiaries with an average age higher than the 31.29 years for all options in restricted schemes. A total of 60 options had younger beneficiaries. As expected, options covering older and sicker lives incurred greater deficits.

The Medical Schemes Industry in 2019

Net healthcare results and trends

The net healthcare result of a medical scheme indicates its position after benefits and NHE are deducted from contribution income.

The net healthcare result for all medical schemes combined reflected a surplus of R1.03 billion in 2019 (2018: R1.21 billion surplus). Open schemes incurred a net healthcare deficit of R0.71 billion (2018: R1.34 billion deficit), and restricted schemes generated a combined net healthcare surplus of R1.74 billion (2018: R2.55 billion surplus). The deterioration is mainly due to the higher claims ratios of restricted schemes from 90.71% in 2018 to 92.15% in 2019. Open schemes experienced a slight decrease in the claims ratio.

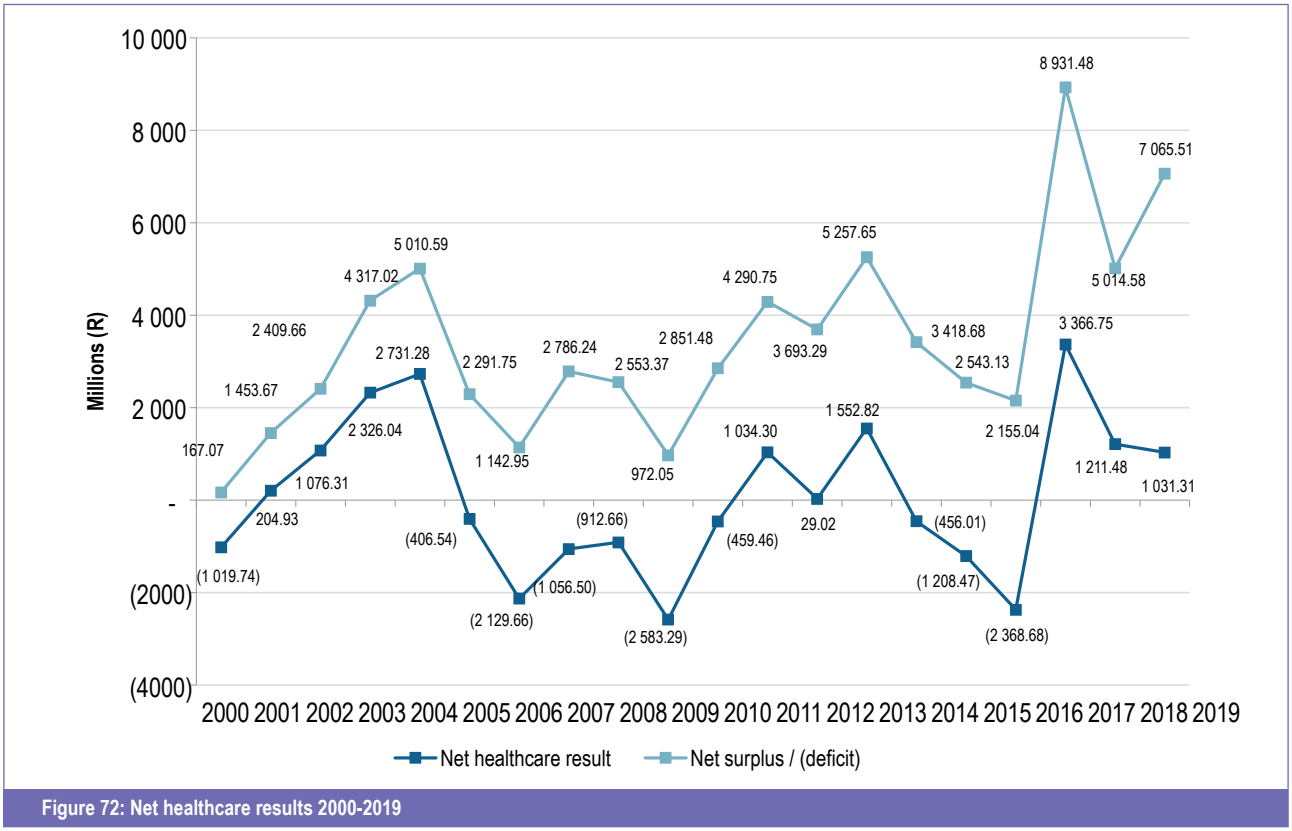

Figure 72: Net healthcare results 2000-2019

RCI = Risk Contribution Income

The Medical Schemes Industry in 2019

Table 104 shows the 20 schemes with the largest net healthcare deficits; representing 80.93% of all beneficiaries of schemes that suffered operating deficits. Annexure W has more details on this. Investment income has generally boosted the performance of schemes.

Table 104: 20 schemes with largest net healthcare deficits 2018 and 2019

Ref. no.	Name of medical scheme	Type	Net healthcare result			Solvency ratio	
			2019 R'000	2018 R'000	% growth	2019 %	2018 %
1580	South African Police Service Medical Scheme (POLMED)	Restricted	(390 209)	(548 191)	28.82	40.45	43.15
1486	Sizwe Medical Fund	Open	(295 019)	(284 136)	-3.83	36.48	46.95
1512	Bonitas Medical Fund	Open	(249 493)	(71 662)	-248.15	24.85	25.16
1202	Fedhealth Medical Scheme	Open	(225 397)	(83 477)	-170.01	43.43	31.42
1012	Anglo Medical Scheme	Restricted	(138 058)	(139 008)	0.68	433.63	473.01
1422	Topmed Medical Scheme	Open	(102 210)	(127 248)	19.68	–	64.92
1194	Profmed	Restricted	(94 317)	(34 003)	-177.38	43.47	49.36
1430	Remedi Medical Aid Scheme	Restricted	(93 906)	40 189	-333.66	72.85	75.23
1568	Sisonke Health Medical Scheme	Restricted	(93 154)	(7 796)	-1 094.89	25.38	58.83
1149	Medihelp	Open	(76 437)	(99 206)	22.95	27.68	28.65
1537	Hosmed Medical Aid Scheme	Open	(69 089)	48 727	-241.79	33.69	33.75
1582	Transmed Medical Fund	Restricted	(67 663)	(49 430)	-36.89	11.38	17.81
1234	Sasolmed	Restricted	(66 927)	12 970	-616.01	44.56	48.01
1141	Health Squared Medical Scheme	Open	(58 442)	(82 517)	29.18	15.42	21.23
1068	De Beers Benefit Society	Restricted	(51 831)	(60 977)	15.00	162.43	144.39
1279	Bankmed	Restricted	(48 498)	(19 950)	-143.10	40.46	41.73
1237	BP Medical Aid Society	Restricted	(42 457)	(31 459)	-34.96	129.60	142.09
1291	Witbank Coalfields Medical Aid Scheme	Restricted	(40 517)	(29 553)	-37.10	96.85	110.03
1038	SAMWUMed	Restricted	(35 047)	68 664	-151.04	103.80	105.69
1446	Selfmed Medical Scheme	Open	(34 285)	(54 434)	37.02	–	80.77

The Medical Schemes Industry in 2019

A total of 65.00% (13 of 20) of open schemes and 65.52% (38 of 58) of restricted schemes showed net healthcare deficits during the year.

The net surplus of all schemes combined after investment income and consolidation adjustments was R7.07 billion (2018: R5.01 billion). Net investment and other income, as well as expenditure, increased by 58.67% from R3.80 billion in 2018 to R6.03 billion in 2019. Open schemes made a R2.24 billion surplus (2018: R0.82 billion) and restricted schemes had a surplus of R4.83 billion (2018: R4.20 billion).

Figure 72 and 74 show the impact of the increases in claims costs and NHE on the NHC result. The net healthcare and net results of all schemes since 2000 are reflected in Figure 73.

Figure 73 shows the schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 35.61%. (Annexure W provides more details.)

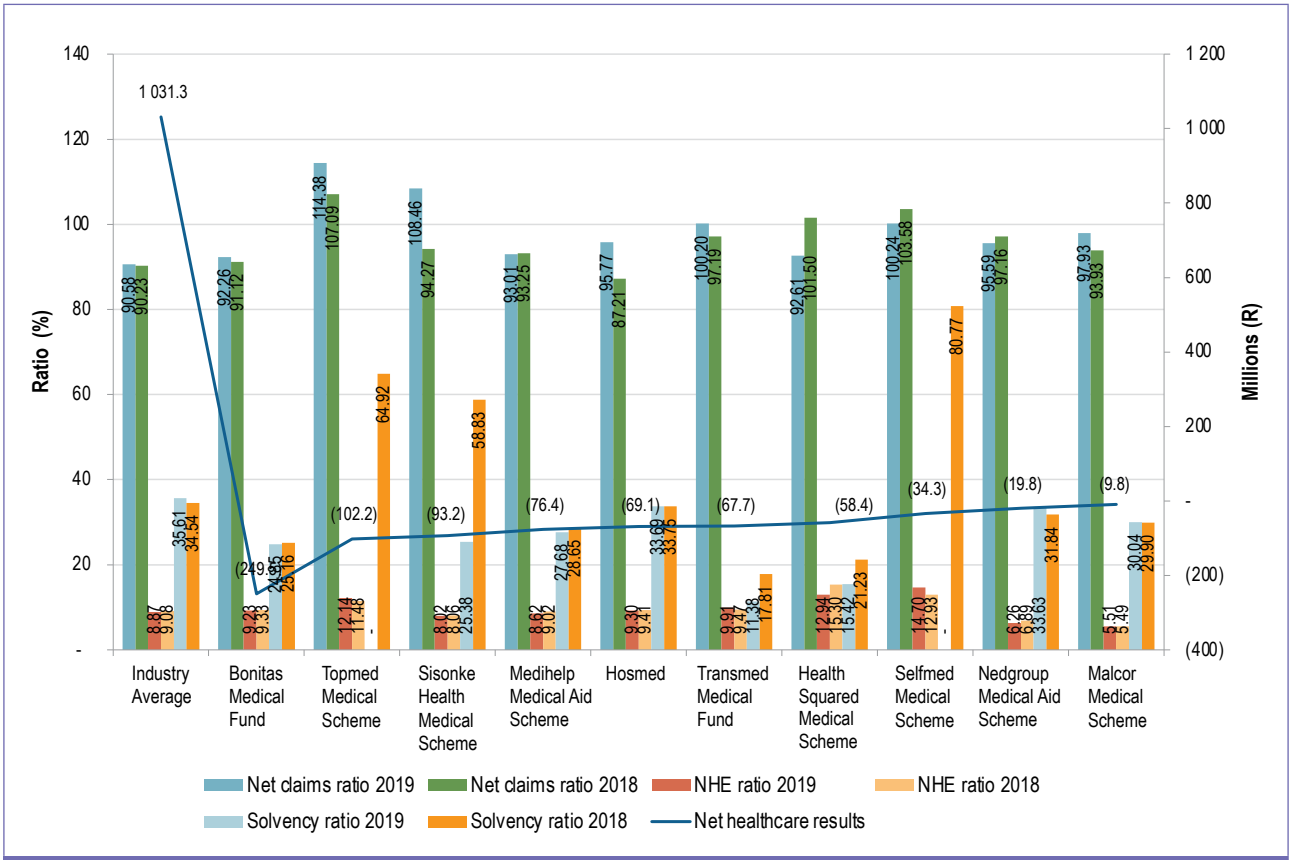

Figure 73: Schemes with largest net healthcare deficits and solvency levels below the industry average of 35.61% (2019)

The Medical Schemes Industry in 2019

Accumulated funds, solvency and solvency trends

Figure 74 shows that all medical schemes incurred a surplus of R7.07 billion compared with R5.01 billion in 2018, representing an increase of 40.90%. The net assets in terms of Regulation 29 of the Medical Schemes Act increased by 10.37% from R66.41 billion in 2018 to a reported R73.29 billion in 2019.

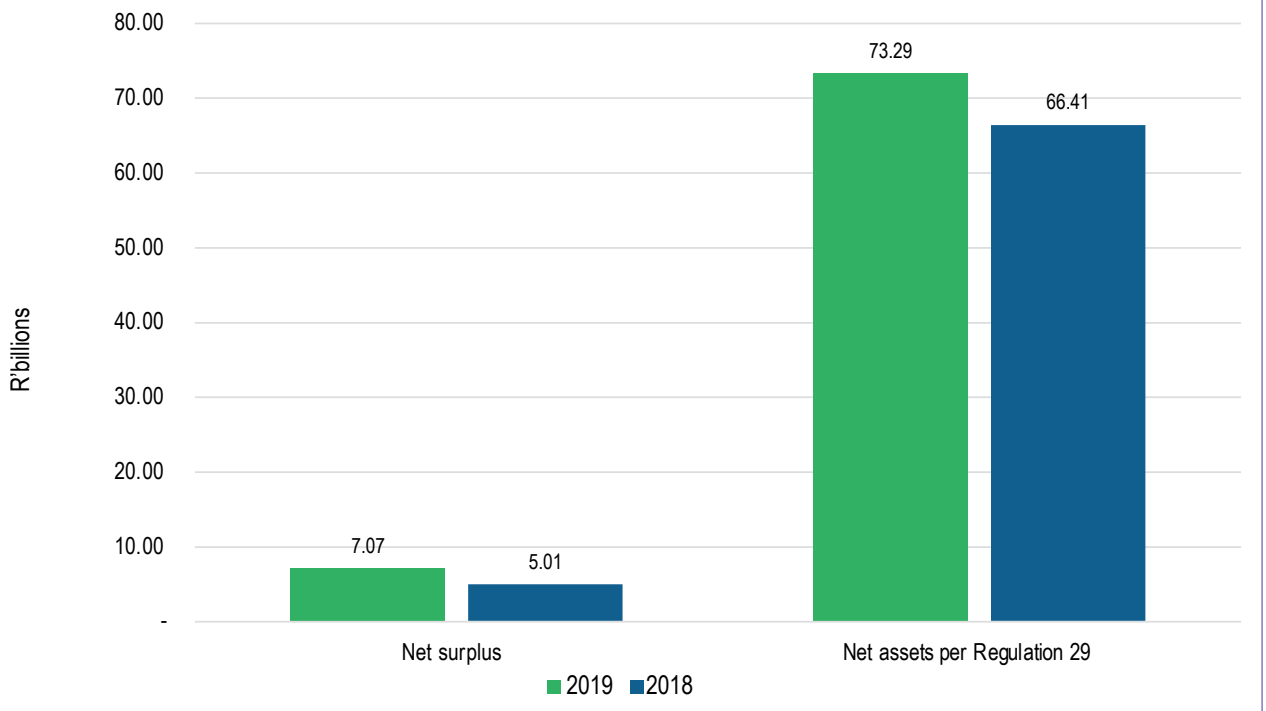

Figure 74: Net surplus and net assets per Regulation 29

The Medical Schemes Industry in 2019

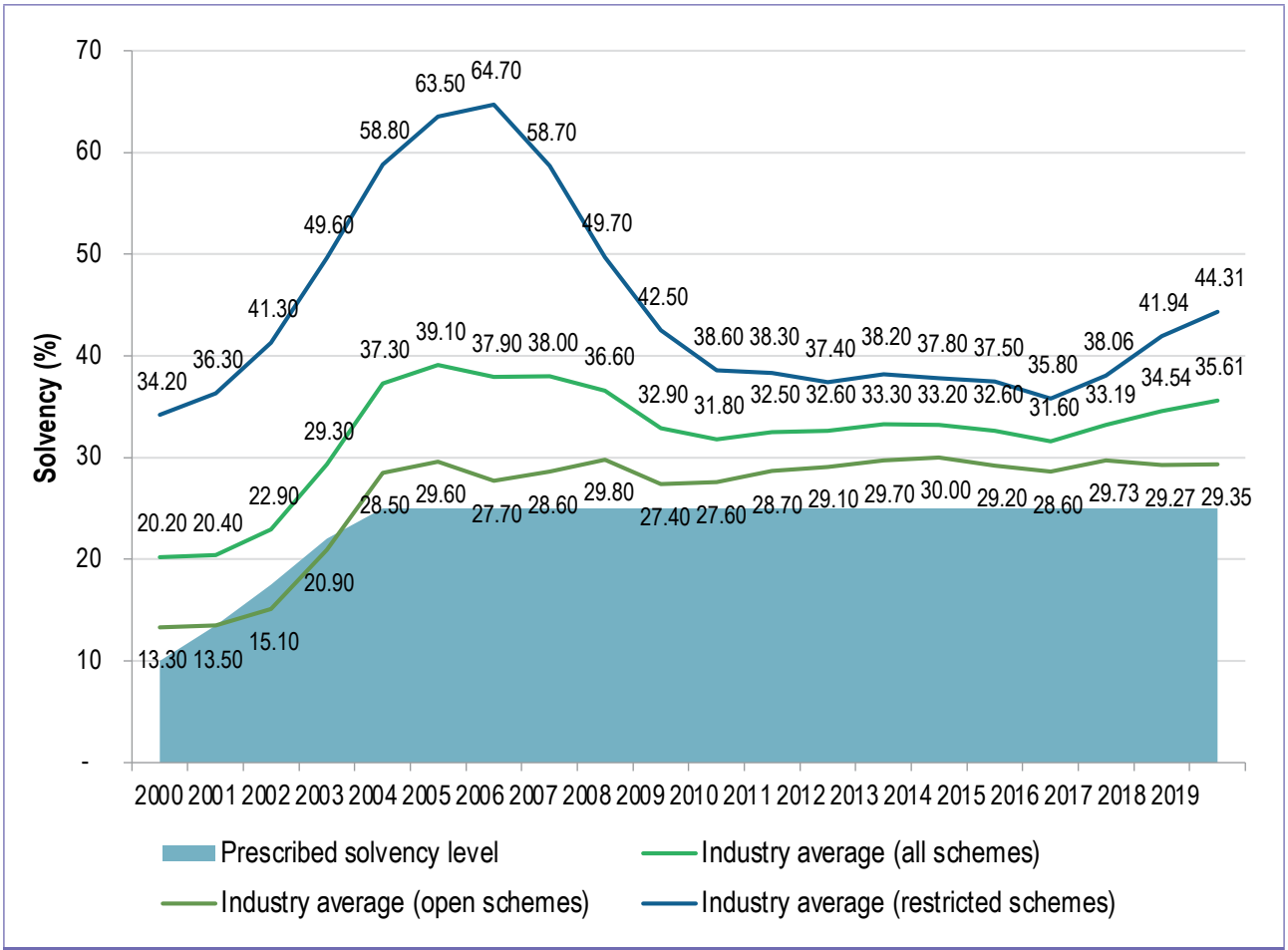

Figure 75: Industry solvency for all schemes (2000-2019)

Regulation 29 of the Medical Schemes Act prescribes a minimum accumulated funds is to be maintained by medical schemes.

Accumulated funds means the net asset value of the medical scheme excluding funds set aside for specific purposes and unrealised non-distributable profits. The accumulated funds must at all times be maintained at a minimum level of 25.00% of gross contributions except in the case of new medical schemes where phase-in solvency ratios apply.

These minimum accumulated funds are more commonly called the 'reserves' of a scheme. When expressed as a percentage of gross contributions, they become known as the 'solvency ratio' of a scheme.

A prescribed solvency ratio serves both to protect members' interests and to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations.

The Medical Schemes Industry in 2019

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, noncompliance with Regulation 29 does not necessarily mean that the scheme is in financial difficulties.

Factors that affect solvency

The most important factors affecting solvency include:

- Membership growth
- The performance of the medical scheme, that is, claims and NHE
- Utilisation of benefits
- Investment income

The membership profile of a medical scheme further affects its solvency. Membership profile includes variables such as the average age of beneficiaries, the proportion of pensioners, the relative number of male and female dependants, and the dependant ratio. All of these affect the frequency and extent of claims.

Net assets per Regulation 29 rose by 10.37% to end 2019 at R73.29 billion. Accumulated funds grew by 10.53% to R74.79 billion from the R67.66 billion recorded in 2018.

The industry average solvency ratio increased to 35.61% in 2019 from 34.54% in 2018.

The solvency ratio of open schemes increased by 0.27% to 29.35% in 2019 (2018: 29.27%). Restricted schemes experienced an increase of 5.65% in their solvency ratio, 44.31% from 41.94% in 2018.

Overall industry average solvency ratio increased consistently from 2000 to 2005. Schemes were required to have reached the 25.00% minimum solvency ratio in 2005.

As indicated in Figure 76, the open industry remained fairly constant between 2004 and 2019, slightly above the 25.00% solvency ratio prescribed by the Medical Schemes Act.

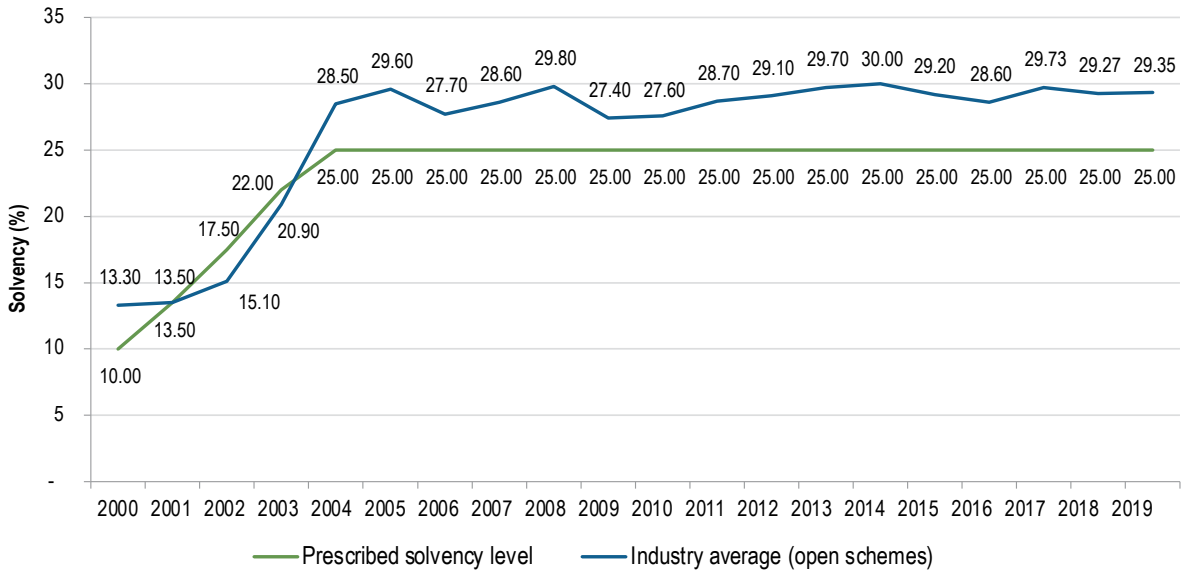

Figure 76: Industry solvency for open schemes (2000-2019)

The Medical Schemes Industry in 2019

As indicated in Figure 77, the restricted industry was at its peak in 2006 and declined from 2007 onwards. This is mostly due to the denominator that is used in the solvency calculation (gross contributions), which is affected by membership growth. GEMS, which is the largest restricted scheme, has shown exceptional membership growth following its registration and this resulted in an overall deterioration in the solvency level of the restricted schemes industry. This subsequently improved between 2016 and 2019, largely due to the turnaround in financial performance of GEMS, which reported an increase in solvency levels, from 6.98% in 2016 to 31.53% in 2019. As such, the overall restricted scheme market reported an improved solvency of 44.31% in 2019, from 35.80% in 2016.

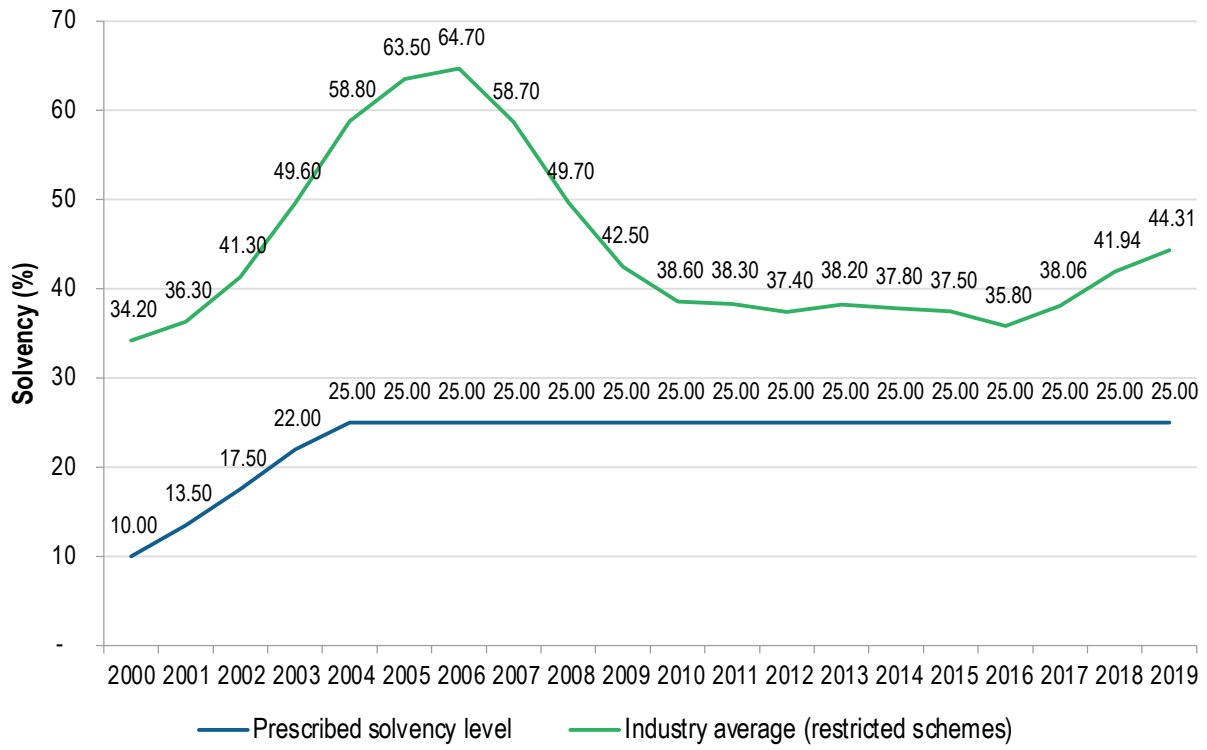

Figure 77: Industry solvency for restricted schemes (2000-2019)

The Medical Schemes Industry in 2019

Table 105: Risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions (1999-2019)

	Risk claims % of RCI	Non-healthcare expenditure % of RCI	Reserve-building % of RCI
1999	91.50	12.70	-4.20
2000	89.30	14.50	-3.70
2001	83.20	16.20	0.60
2002	82.10	15.20	2.80
2003	79.20	15.40	5.40
2004	78.60	15.50	5.90
2005	84.10	16.80	–
2006	88.00	16.20	-4.10
2007	86.50	15.20	-1.80
2008	86.90	14.50	-1.40
2009	89.30	14.00	-3.30
2010	87.30	13.20	-0.50
2011	86.50	12.40	1.10
2012	87.70	12.30	–
2013	86.50	12.20	1.30
2014	90.80	9.50	-0.40
2015	91.40	9.50	-0.90
2016	92.10	9.50	-1.60
2017	88.70	9.23	2.07
2018	90.23	9.08	0.70
2019	90.58	8.87	0.55

RCI = Risk Contribution Income

Table 105 illustrates the relationship between risk claims, NHE and reserve-building. Risk claims appear to have more of an impact on reserve-building than NHE. During periods of high claims the industry experienced a reduction in reserves while in periods with lower claims the reserves increased. In 1999, the industry experienced risk claims of 91.50% expressed as a percentage of contributions, and reserves decreased by 4.20%, while in 2004 risk claims amounted to 78.60% and reserves increased by 5.90%.

Total risk claims fell between 2000 and 2004 and the ratio of contributions to reserves improved during this period from -3.70% to 5.90%. NHE grew during this period, largely at the expense of claims. Risk claims were at their lowest in 2004 and then started to increase in 2005, reaching 92.10% in 2016. It is important to note that the 2014 and 2015 risk claims ratios have been restated to include accredited managed healthcare services as per the requirements of Circular 56 of 2015; while it had been excluded from the NHE ratio. Contributions to reserves were negative during this time, which was consistent with the fact that most medical schemes had attained the prescribed solvency ratio of 25.00% and did not need to grow their reserves any further. 2017 saw a reduction in the claims ratio to 88.70%, while positive reserve-building of 2.07% occurred. The maintenance of reserves as a protection for members should be considered against the backdrop of increasing claim costs, changing demographic profiles and the increasing burden of disease. In 2019, reserve-building was positive, however it declined in comparison to 2017 and 2018 due to the claims ratios increasing to 90.58%.

The Medical Schemes Industry in 2019

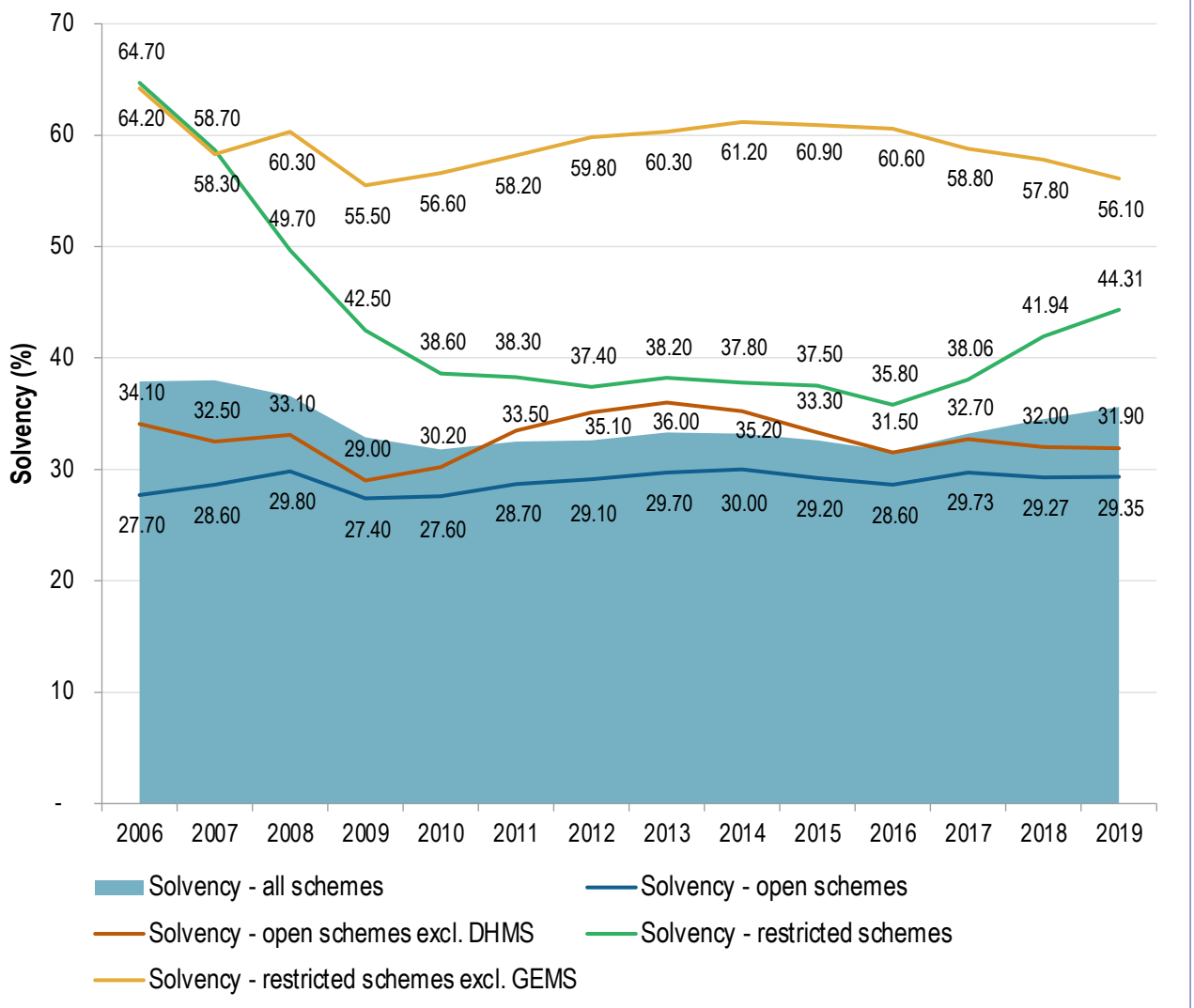

Figure 78: Industry solvency ratios excluding GEMS and DHMS

Excluding GEMS, the restricted industry solvency ratio decreased in 2009 to 55.50% and then increased from 2010 onwards to 60.60% in 2016, with a subsequent reduction to 56.10% in 2019. The solvency ratio of the restricted scheme industry is much lower when GEMS results are included (44.31%). This indicates the significant impact of GEMS on the restricted schemes industry.

In comparison, Discovery Health Medical Scheme (DHMS) has a lesser impact on the open scheme industry. Excluding DHMS, the 2019 open industry solvency ratio increases to 31.90% (from 29.35%).

Medical schemes should be careful of the so-called 'death spiral'. A scheme with a disadvantageous, high-claiming membership profile may need to adjust its contributions and/or benefits. This can result in options with older and sicker members, that are highly priced, which may cause the younger and lower-claiming members to move to other less expensive options, or even other medical schemes.

The Medical Schemes Industry in 2019

This results in the scheme losing the cross-subsidy provided by these younger members and leads to an increase in losses, resulting in even higher contribution increases and/or reductions in benefits.

Beneficiaries of schemes which failed to reach the 25.00% solvency

Table 106, Solvency graph and Figure 81 show both the number of medical schemes that have yet to attain the prescribed solvency ratio of 25.00% and the number of beneficiaries in those schemes.

Table 106: Prescribed solvency and number of beneficiaries 2000-2019

Year	Number of open schemes		Number of restricted schemes	
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
2000	15	33	15	86
2001	19	29	11	83
2002	24	25	7	86
2003	19	29	7	80
2004	18	30	4	81
2005	17	29	4	79
2006	18	23	4	79
2007	18	23	7	74
2008	14	21	8	71
2009	16	17	3	71
2010	12	15	7	66
2011	9	17	5	66
2012	7	18	4	63
2013	6	18	3	60
2014	5	18	2	58
2015	3	19	3	57
2016	3	18	3	57
2017	3	18	3	56
2018	4	17	3	55
2019	3	15	1	57

The Medical Schemes Industry in 2019

Table 106: Prescribed solvency and number of beneficiaries 2000-2019

Year	Number of beneficiaries in open schemes			Number of beneficiaries in restricted schemes		
	Below prescribed level		Above prescribed level	Below prescribed level		Above prescribed level
	At end	%	At end	At end	%	At end
2000	2 385 051	51.01	2 291 048	839 029	40.86	1 214 412
2001	2 650 934	55.60	2 117 142	576 462	28.88	1 419 862
2002	3 519 329	74.39	1 211 882	251 050	12.66	1 731 873
2003	3 426 988	72.62	1 291 809	222 430	11.39	1 730 574
2004	2 534 273	53.29	2 221 030	80 160	4.20	1 827 100
2005	2 783 108	56.73	2 122 444	36 359	1.88	1 893 710
2006	3 218 382	63.72	1 832 056	145 369	7.00	1 931 536
2007	3 139 176	63.40	1 812 141	689 865	25.99	1 964 054
2008	1 076 450	22.02	3 812 456	981 977	32.89	2 003 943
2009	992 523	20.61	3 822 811	1 254 151	38.55	1 999 020
2010	2 918 055	60.79	1 881 860	1 684 682	47.92	1 831 121
2011	2 855 072	59.98	1 905 042	1 865 313	49.53	1 900 982
2012	2 796 583	58.75	1 963 411	1 978 668	50.45	1 943 538
2013	2 860 768	59.02	1 986 141	1 994 813	50.74	1 936 586
2014	212 169	4.33	4 687 806	1 914 481	48.91	2 000 002
2015	177 807	3.61	4 743 470	1 943 387	50.20	1 927 683
2016	811 038	16.42	4 129 033	1 908 478	48.62	2 016 423
2017	779 925	15.72	4 180 530	1 876 641	47.98	2 034 940
2018	365 535	7.36	4 604 086	1 900 775	48.16	2 046 299
2019	786 919	15.94	4 149 977	34 703	0.86	3 981 477

*Community Medical Aid Scheme (COMMED) was excluded from this table for the 2015 – 2017 years.

The total number of schemes below 25.00% has declined since 2003. Although there have been numerous amalgamations, the reduction in schemes below 25.00% was not only due to amalgamation but also due to schemes attaining the minimum solvency ratio.

The Medical Schemes Industry in 2019

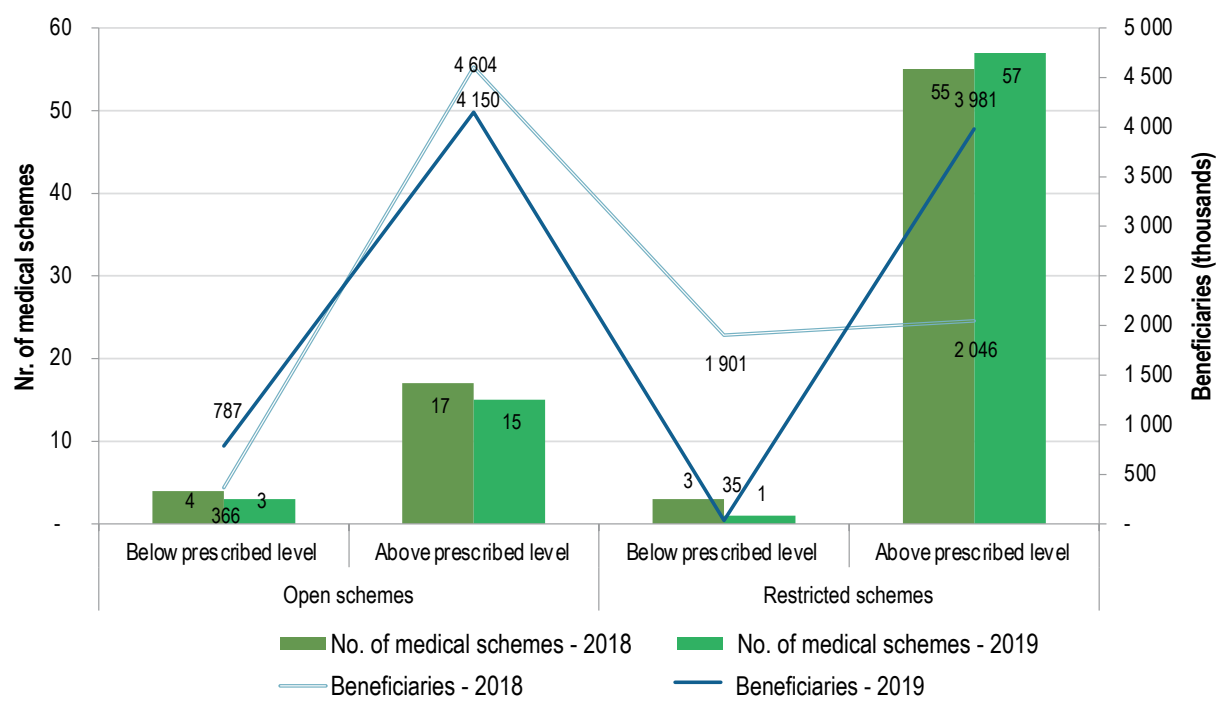

Figure 79: Prescribed solvency and number of beneficiaries 2018 and 2019

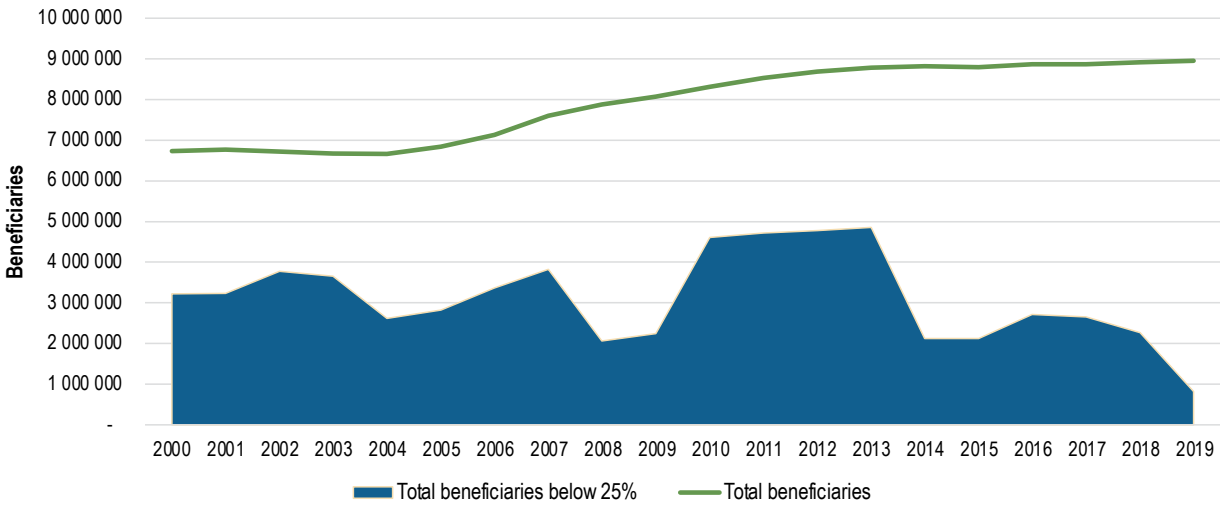

Figure 80: Beneficiaries in schemes with solvency below 25.00% (2000 – 2019)

The Medical Schemes Industry in 2019

A total of 15.94% of beneficiaries in open schemes (2018: 7.36%) was covered by the three open schemes (2018: four) which failed to meet the prescribed solvency level in 2019. The remaining beneficiaries belonged to the other 15 open schemes (2018: 17) which had attained the prescribed solvency level of 25.00%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25.00%. This was mainly due to DHMS, the biggest scheme in South Africa, failing to attain the minimum prescribed solvency ratio. When DHMS reached the solvency ratio of 25.00% in 2008, 2009, 2014 to 2019 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015 this figure was a mere 3.61% compared with 59.02 % in 2013. In 2016 and 2019, Bonitas Medical Fund fell below 25.00%, increasing the percentages again to 16.42% and 15.94% respectively.

Of the 58 restricted schemes at the end of 2019, only one had a solvency ratio below 25.00%. This scheme accounted for only 0.86% of all beneficiaries in restricted schemes.

Table 107 provides a summary of performance of schemes that were below the required statutory minimum solvency of 25.00% as at 31 December 2019.

Table 107: Summary of performance of schemes below 25% solvency – 2019

Ref. no.	Name of scheme	Average beneficiaries 2019	Average age pb 2019 years	Pensioner ratio 2019 %	Net claims ratio 2019 %	Net claims ratio 2018 %	Net healthcare result 2019 R'000	Net healthcare result 2018 R'000	Solvency ratio 2019 %	Solvency ratio 2018 %
1592	Thebemed	30 230	27.46	0.49	83.64	86.43	5 190	(6 091)	9.41	9.34
1582	Transmed Medical Fund	36 498	55.22	45.58	100.20	97.19	(67 663)	(49 430)	11.38	17.81
1141	Health Squared Medical Scheme	37 604	46.78	25.93	92.61	101.50	(58 442)	(82 517)	15.42	21.23
1512	Bonitas Medical Fund	718 919	33.77	9.00	92.26	91.12	(249 493)	(71 662)	24.85	25.16

pb = per beneficiary

The CMS closely monitors schemes below the 25.00% solvency ratio by having regular meetings with them to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes environment and the progress that schemes have made thus far in moving towards the prescribed solvency levels, but much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

The Medical Schemes Industry in 2019

Investments

Figure 81 provides information on the investments of medical schemes as at the end of the years 2018 and 2019.

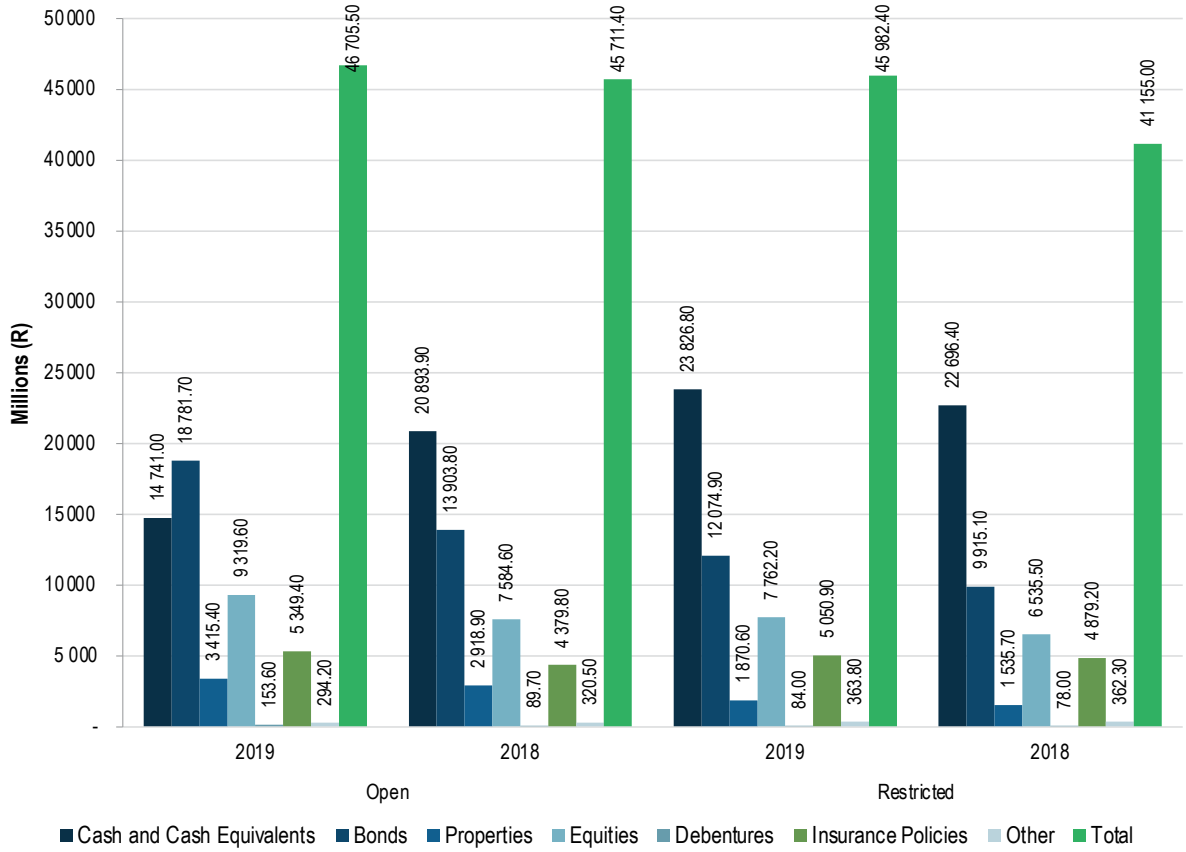

Figure 81: Scheme investments 2018 and 2019

In open schemes, 31.56% of investments (2018: 45.71%) were held in cash or cash equivalents. Bonds accounted for 40.21% (2018: 30.42%), debentures for 0.33% (2018: 0.20%), equities for 19.95% (2018: 16.59%), non-linked insurance policies for 0.00% (2018: 0.00%), properties for 7.31% (2018: 6.39%), and other investments for 0.63% (2018: 0.70%).

Restricted schemes also held a large proportion of their investments (51.82%) in cash or cash equivalents (2018: 55.15%). Their bonds accounted for 26.26% (2018: 24.09%) and debentures for 0.18% (2018: 0.19%). Equities made up 16.88% (2018: 15.88%), non-linked insurance policies 0.00% (2018: 0.08%), properties 4.07% (2018: 3.73%), and other investments 0.79% (2018: 0.88%).

The Medical Schemes Industry in 2019

The following tables list the asset distribution of the 10 largest schemes by asset base per asset category listed under Annexure B of the Regulations, as well split by local and foreign, and investment income:

Table 108: Asset distribution of the 10 largest schemes by asset base 2019

Ref. no.	Name of medical scheme	Average beneficiaries	Total investable assets* R'millions	Category*** 1 %	2 %	3 %	4 %	5 %	6** %	7 %
1125	Discovery Health Medical Scheme	2 795 107	25 261.65	25.23	48.82	8.94	16.18	0.47	3.50	0.35
1598	Government Employees Medical Scheme (GEMS)	1 856 491	15 682.95	64.30	21.21	4.15	9.49	0.00	0.00	0.85
1512	Bonitas Medical Fund	718 919	5 710.99	24.24	41.78	7.50	26.15	0.04	4.57	0.29
1580	South African Police Service Medical Scheme (POLMED)	507 217	4 631.37	41.06	41.84	4.67	12.04	0.18	0.00	0.21
1279	Bankmed	221 009	3 169.45	41.27	25.94	5.81	25.87	0.39	0.00	0.71
1012	Anglo Medical Scheme	18 308	3 072.75	20.39	40.56	1.82	36.85	0.00	21.77	0.38
1252	Bestmed Medical Scheme	197 956	2 397.23	43.29	32.63	4.69	15.82	0.29	32.28	3.27
1140	Medshield Medical Scheme	160 886	2 097.74	33.25	30.60	4.42	29.14	0.47	28.76	2.15
1167	Momentum Health	298 829	2 009.73	46.93	23.39	5.21	24.17	0.00	68.88	0.30
1149	Medihelp	205 438	1 833.39	62.79	10.38	1.83	24.19	0.00	13.28	0.81

* Total investable assets represents the total amount available for investment, excluding encumbered assets.
** Category 6 investments' underlying assets were also included in the relevant categories.
*** Categories are referred to in Annexure B of the Act, read in conjunction with Regulation 30.

The Medical Schemes Industry in 2019

Table 109: Local and foreign asset distribution of largest 10 schemes by asset base: 2019

Ref. no.	Name of medical scheme	Average beneficiaries	Total investable assets* R'millions	Local** %	Foreign** %
1125	Discovery Health Medical Scheme	2 795 107	25 261.65	96.45	3.55
1598	Government Employees Medical Scheme (GEMS)	1 856 491	15 682.95	96.75	3.25
1512	Bonitas Medical Fund	718 919	5 710.99	99.86	0.14
1580	South African Police Service Medical Scheme (POLMED)	507 217	4 631.37	99.84	0.16
1279	Bankmed	221 009	3 169.45	97.87	2.13
1012	Anglo Medical Scheme	18 308	3 072.75	97.00	3.00
1252	Bestmed Medical Scheme	197 956	2 397.23	95.94	4.06
1140	Medshield Medical Scheme	160 886	2 097.74	93.18	6.86
1167	Momentum Health	298 829	2 009.73	95.54	4.46
1149	Medihelp	205 438	1 833.39	100.00	0.00

* Total investable assets represents the total amount available for investment, excluding encumbered assets.
** The definitions of local and foreign assets make reference to investments made within the Republic and outside the Republic as referred to in Annexure B of the Act, read in conjunction with Regulation 30.

Table 110: Investment income of largest 10 schemes by asset base: 2019

Ref. no.	Name of medical scheme	Average beneficiaries	Total investable assets* R'millions	Net investment income** R'millions	Net investment income** % of investable assets
1125	Discovery Health Medical Scheme	2 795 107	25 261.65	1 665.47	6.59
1598	Government Employees Medical Scheme (GEMS)	1 856 491	15 682.95	909.91	5.80
1512	Bonitas Medical Fund	718 919	5 710.99	405.58	7.10
1580	South African Police Service Medical Scheme (POLMED)	507 217	4 631.37	391.09	8.44
1279	Bankmed	221 009	3 169.45	218.69	6.90
1012	Anglo Medical Scheme	18 308	3 072.75	199.41	6.49
1252	Bestmed Medical Scheme	197 956	2 397.23	206.58	8.62
1140	Medshield Medical Scheme	160 886	2 097.74	124.55	5.94
1167	Momentum Health	298 829	2 009.73	157.79	7.85
1149	Medihelp	205 438	1 833.39	133.39	7.28

* Total investable assets represents the total amount available for investment, excluding encumbered assets.
** Net investment income represents investment income after taking into account asset management fees

The Medical Schemes Industry in 2019

The following table illustrates the total net investment income of the industry split between open and restricted scheme:

Table 111: Asset base and investment income: 2018 and 2019

	Total investable assets*			Net investment income**			Net investment income as % of total investable assets		
	2019 R'millions	2018 R'millions	% growth	2019 R'millions	2018 R'millions	% growth	2019 %	2018 %	% growth
Open schemes	46 705.50	45 711.40	2.17	3 192.43	2 253.03	41.70	6.84	4.93	38.74
Restricted schemes	45 982.40	41 155.00	11.73	3 046.28	1 584.74	92.23	6.62	3.85	71.95
All schemes	**92 687.90**	**86 866.40**	**6.70**	**6 238.71**	**3 837.77**	**62.56**	**6.73**	**4.42**	**52.26**

* Total investable assets represents the total amount available for investment, excluding encumbered assets.
** Net investment income represents investment income after taking into account asset management fees

As can be seen from the Table 111, overall net investment income increased significantly from 2018, and its impact on scheme reserving can be noted. The JSE All-Share Index grew by 8.24% during 2019 (2018: the decline of more than 11.00% was due to values of listed equity and property depreciating).

The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number, on the other hand, indicates that the scheme has greater liabilities than assets and is therefore technically insolvent and in breach of Section 35(3) of the Medical Schemes Act.

Schemes should pay attention to more than just their total asset and liability positions; they should also consider the periods in which liabilities must be paid and in which assets can be converted into cash flows.

The Medical Schemes Industry in 2019

Figure 82 compares the matching of assets and liabilities in open and restricted schemes.

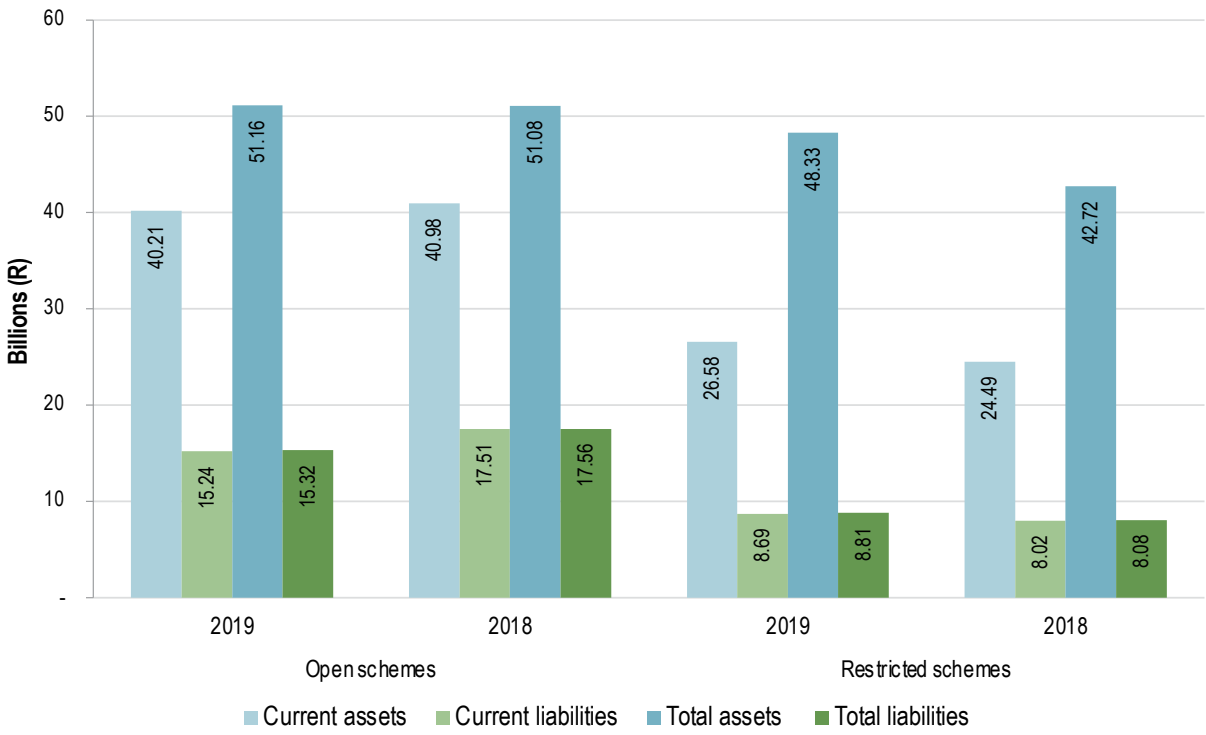

Figure 82: Matching of assets and liabilities 2018 and 2019

The current-assets-to-current-liabilities ratio in open schemes was 2.6:1 in 2019 (2.3:1 in 2018). It was 3.1:1 (2018: 3.1:1) in restricted schemes in 2019. The total-asset-to-total-liability ratio for open and restricted schemes in 2019 was 3.3:1 (2018: 2.9:1) and 5.5:1 (2018: 5.3:1) respectively.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, a quick ratio below 2.0) is lower than the industry average of 3.80 months, boards of trustees must guard against longerterm, 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.

The Medical Schemes Industry in 2019

Claims-paying ability of schemes

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

Figure 83 depicts the claims-paying ability of schemes measured in months of cover, which is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

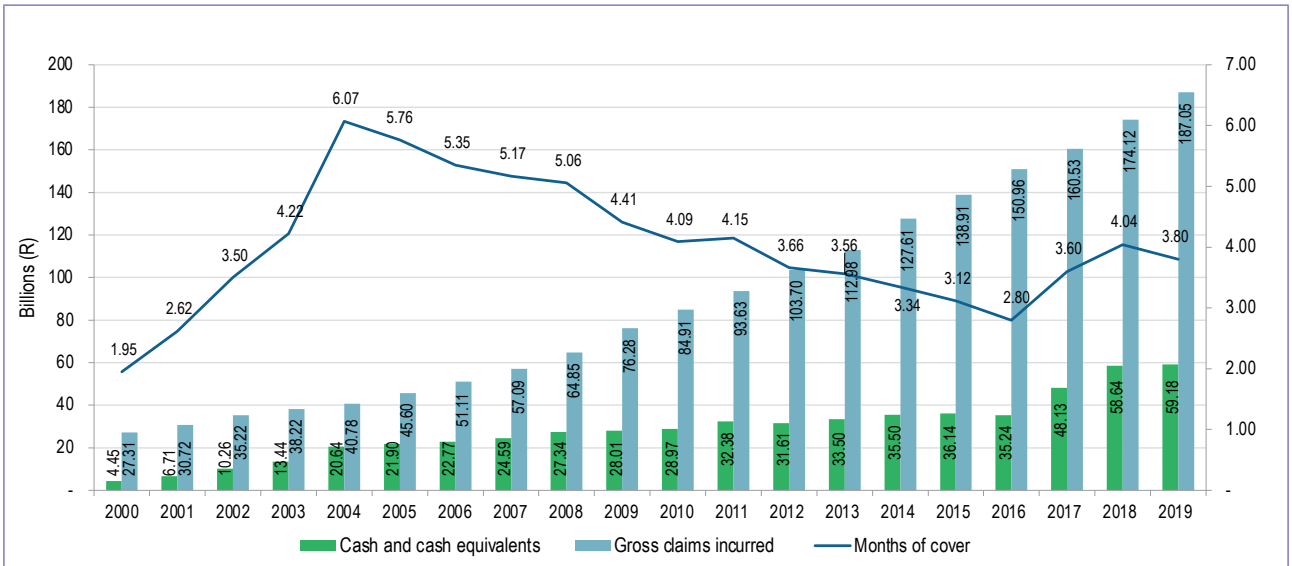

Figure 83 : Average gross claims covered by cash and cash equivalents 2000 - 2019

The length of cash coverage declined from 4.04 months in 2018 to 3.80 months in December 2019. Payment cycles of medical schemes in 2019 were an average of 11.84 days compared with the 19.14 days in 2018.

The Medical Schemes Industry in 2019

Administrator market

Figure 84 shows the market share of medical scheme administrators and self-administered medical schemes based on the average number of beneficiaries administered at the end of 2019.[5]

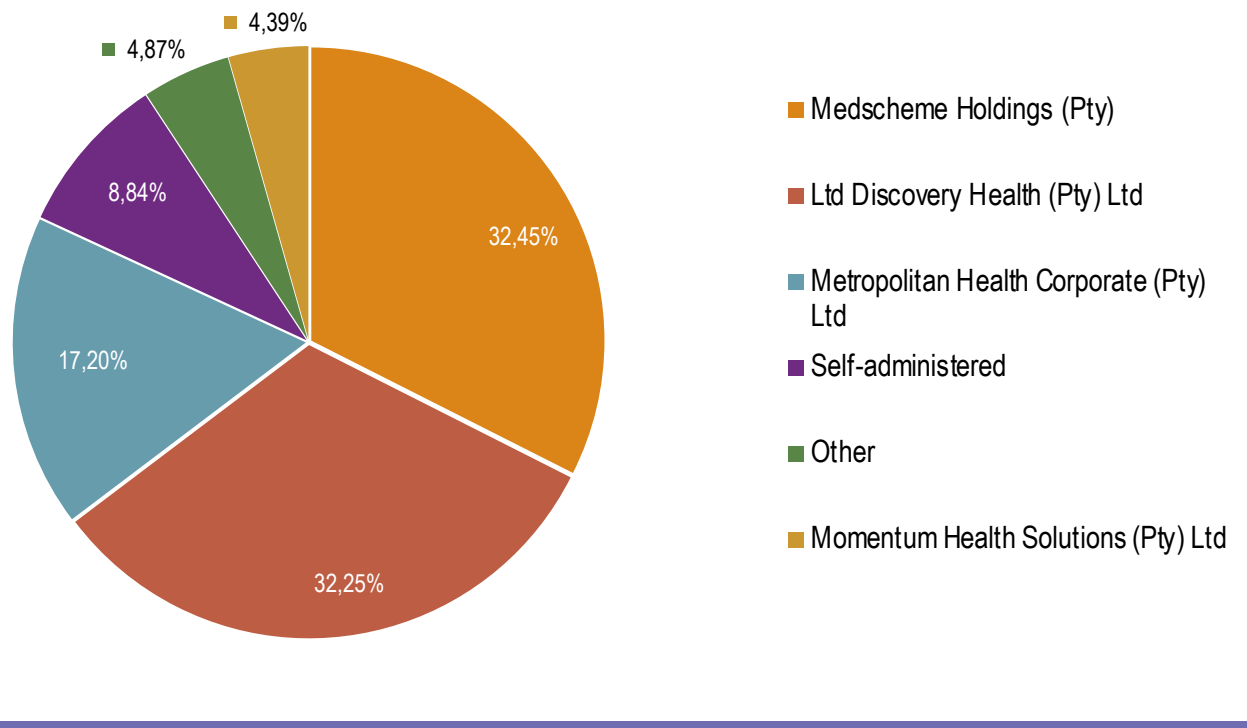

Figure 84: Administrator market share at the end of 2019

[5] The data that is presented here differs from Annexure AD which is based on the average membership administered during the year.

The Medical Schemes Industry in 2019

Figure 85 depicts the changes in market share of all medical schemes over the last 10 years, based on the average number of beneficiaries administered by the various parties at the end of each year. Table 112 indicates the change in administrator market share between 2010 and 2019.

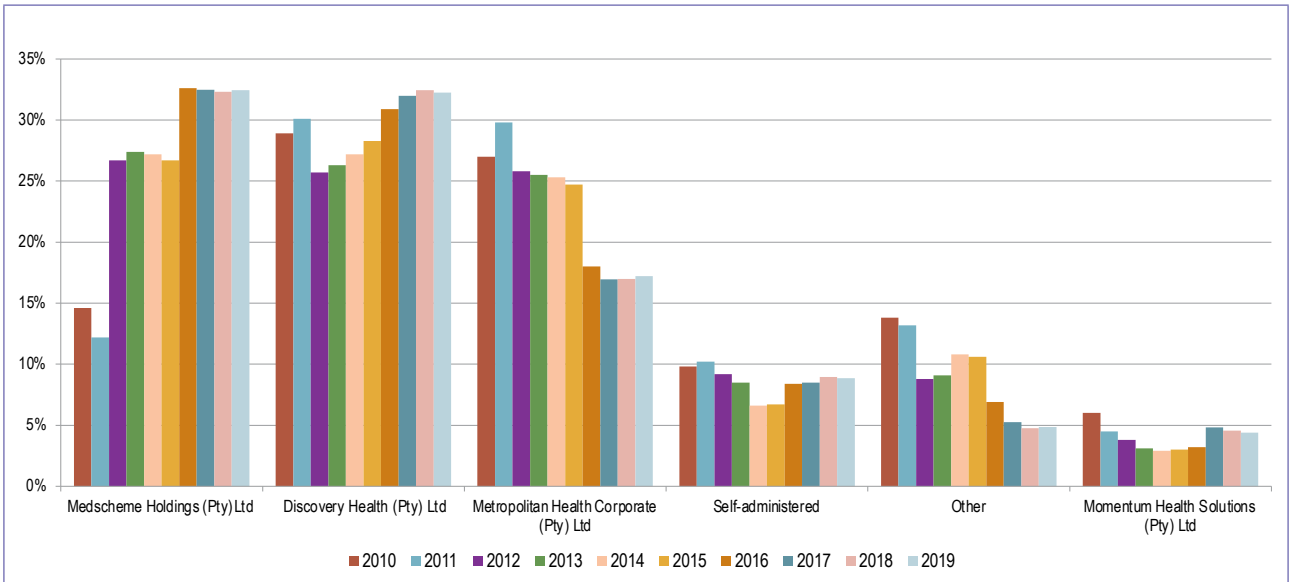

Figure 85: Market share of largest administrators based on average number of beneficiaries 2010-2019*

* 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 AD).

Four third-party administrators continued to dominate the market in 2019, namely (in order of market share):

- Medscheme Holdings (Pty) Ltd
- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- Momentum Health Solutions (Pty) Ltd

Collectively these companies administer 86.29% of the market (excluding self-administered medical schemes).

[4] The Government Employees Medical Scheme (GEMS) had a joint administration contract in place since 2012. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The membership was included for both administrators.

The Medical Schemes Industry in 2019

Figure 86 shows the change in market share for the administrators with the largest share of the market for all schemes, between 2010 and 2019. The administrator with the highest growth in market share is Medscheme Holdings (Pty) Ltd which grew by 122.26% over that period with a market share of 32.45% and is currently the largest administrator, followed by Discovery Health (Pty) Ltd with a market share of 32.25%

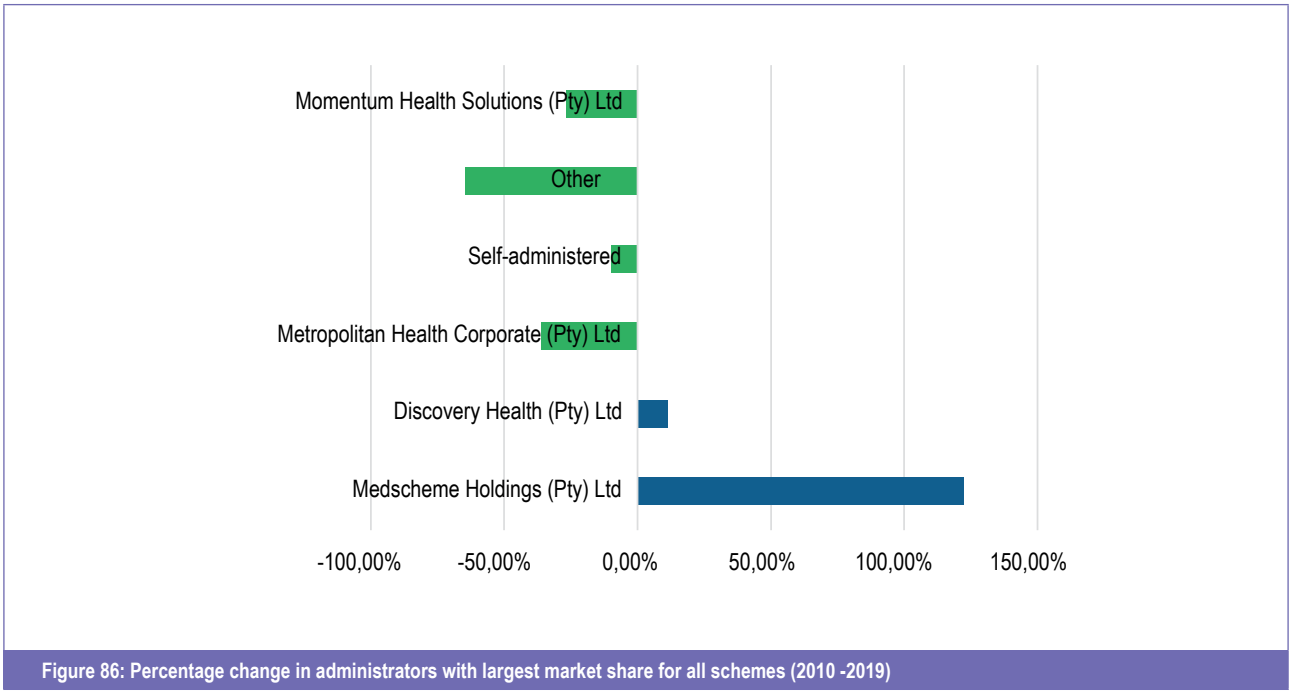

Figure 86: Percentage change in administrators with largest market share for all schemes (2010 -2019)

The Medical Schemes Industry in 2019

Table 112: Administrator market share (2010-2019)

Largest market share - open schemes	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Change: 2010-19
Discovery Health (Pty) Ltd	44.90%	48.50%	50.80%	52.40%	53.40%	54.20%	54.80%	55.73%	56.37%	56.41%	25.63%
Medscheme Holdings (Pty) Ltd	18.60%	15.90%	15.90%	16.60%	16.50%	16.20%	18.80%	19.08%	18.53%	18.61%	0.05%
Self-administered	11.50%	12.50%	14.40%	12.90%	8.30%	8.20%	12.10%	12.24%	12.31%	12.27%	6.70%
Other	18.70%	18.70%	14.20%	13.80%	17.30%	16.50%	9.10%	7.18%	6.77%	6.68%	-64.28%
Momentum Health Solutions (Pty) Ltd	6.40%	4.40%	4.60%	4.40%	4.60%	4.90%	5.20%	5.77%	6.02%	6.03%	-5.78%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	
Largest market share - restricted schemes											
Medscheme Holdings (Pty) Ltd	8.90%	7.30%	35.90%	36.30%	36.30%	35.80%	44.70%	44.06%	44.21%	44.20%	396.63%
Metropolitan Health Corporate (Pty) Ltd	64.90%	67.80%	47.40%	46.70%	46.60%	46.20%	33.70%	31.59%	31.64%	31.81%	-50.99%
Discovery Health (Pty) Ltd	6.20%	6.40%	4.40%	4.60%	5.10%	5.70%	10.20%	11.51%	11.77%	11.75%	89.52%
Self-administered	7.30%	7.10%	4.80%	4.90%	5.10%	5.50%	5.30%	5.26%	6.04%	5.93%	-18.77%
Other	7.40%	6.70%	4.40%	5.40%	5.40%	5.32%	4.70%	3.58%	3.02%	3.31%	-55.27%
Momentum Health Solutions (Pty) Ltd	5.40%	4.70%	3.00%	2.10%	1.40%	1.40%	1.40%	4.00%	3.32%	3.00%	-44.44%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	
Largest market share - all schemes											
Medscheme Holdings (Pty) Ltd	14.60%	12.20%	26.70%	27.40%	27.20%	26.70%	32.60%	32.49%	32.30%	32.45%	122.26%
Discovery Health (Pty) Ltd	28.90%	30.10%	25.70%	26.30%	27.20%	28.30%	30.90%	31.99%	32.45%	32.25%	11.59%
Metropolitan Health Corporate (Pty) Ltd	27.00%	29.80%	25.80%	25.50%	25.30%	24.70%	18.00%	16.96%	16.97%	17.20%	-36.30%
Self-administered	9.80%	10.20%	9.20%	8.50%	6.60%	6.70%	8.40%	8.50%	8.95%	8.84%	-9.80%
Other	13.80%	13.20%	8.80%	9.10%	10.80%	10.60%	6.90%	5.24%	4.76%	4.87%	-64.71%
Momentum Health Solutions (Pty) Ltd	6.00%	4.50%	3.80%	3.10%	2.90%	3.00%	3.20%	4.82%	4.57%	4.39%	-26.83%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	

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Figure 87 and 88 indicate the changes in administrator market share over the last 10 years for open and restricted medical schemes respectively. Discovery Health (Pty) Ltd's share of the open schemes market increased to 56.41% (2018: 56.37%) and its share in the restricted schemes market decreased to 11.75% (2018: 11.77%).

Medscheme Holdings (Pty) Ltd has the second-biggest share in the open schemes administration market at 18.61% (2018: 18.53%) and the biggest share in the restricted schemes administration market at 44.20% (2018: 44.21%). Medscheme Holdings (Pty) Ltd has been responsible for GEMS's contribution and debt management, as well as correspondence services since 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the second-biggest share of the restricted schemes market at 31.81% (2018: 31.64%).

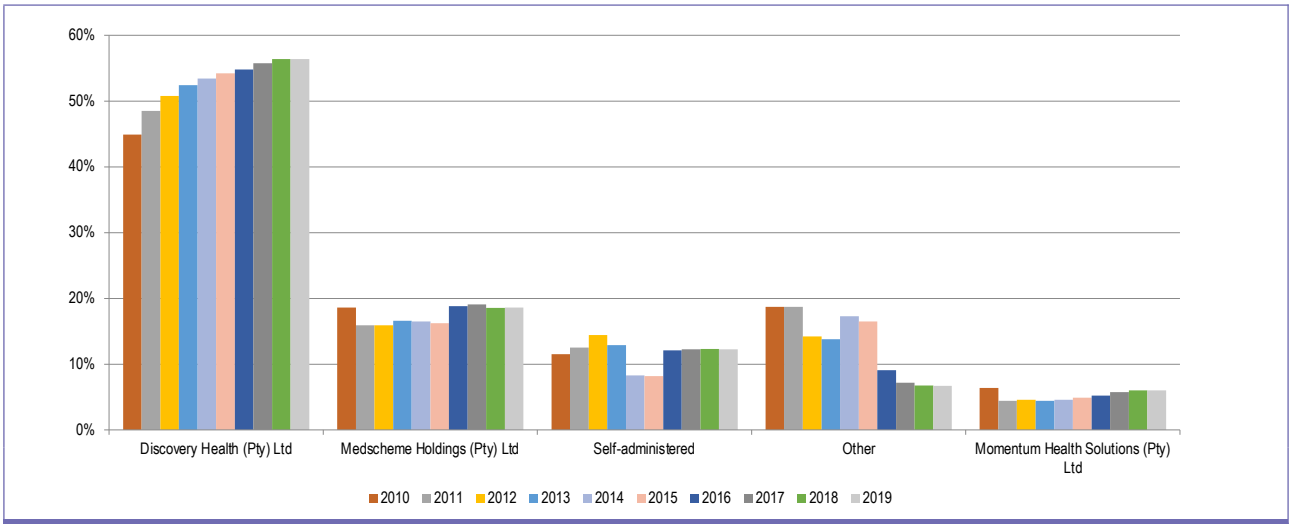

Figure 87: Open schemes market share of largest administrators based on average number of beneficiaries (2010-2019)*

* 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 AD).

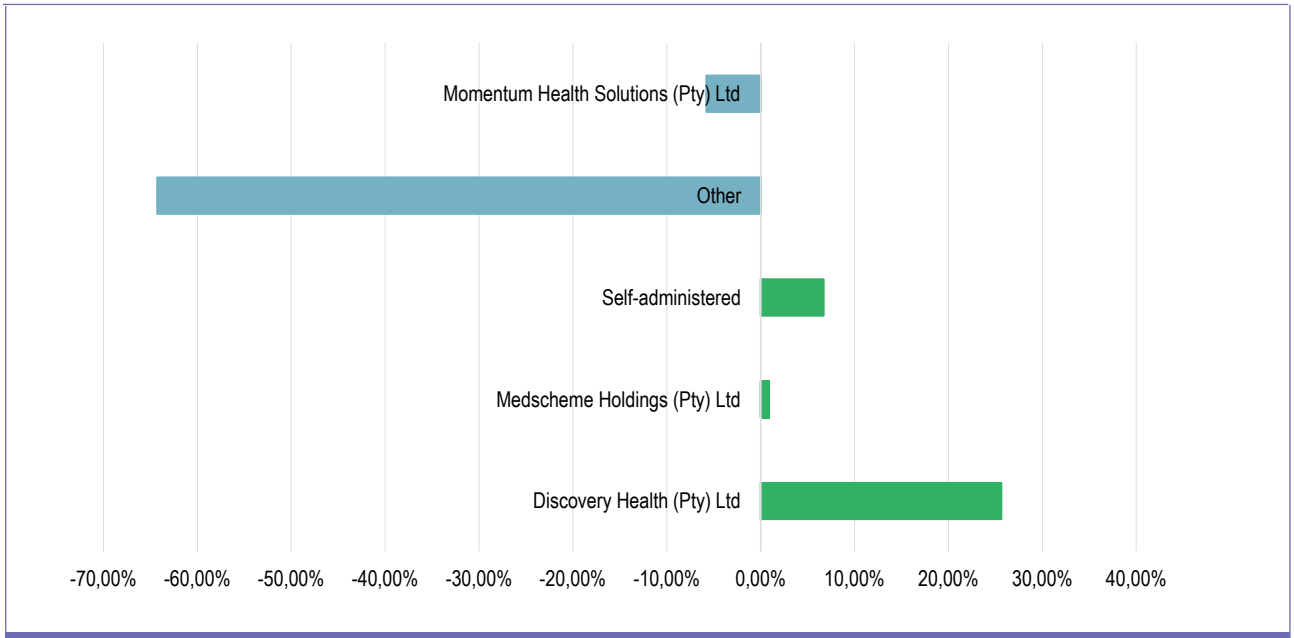

Figure 88: Percentage % change in administrators with largest market share for open schemes (2010 – 2019)

The Medical Schemes Industry in 2019

Figure 89 and 90 indicate the percentage growth or decline in market share between 2010 and 2019 for open and restricted medical schemes respectively.

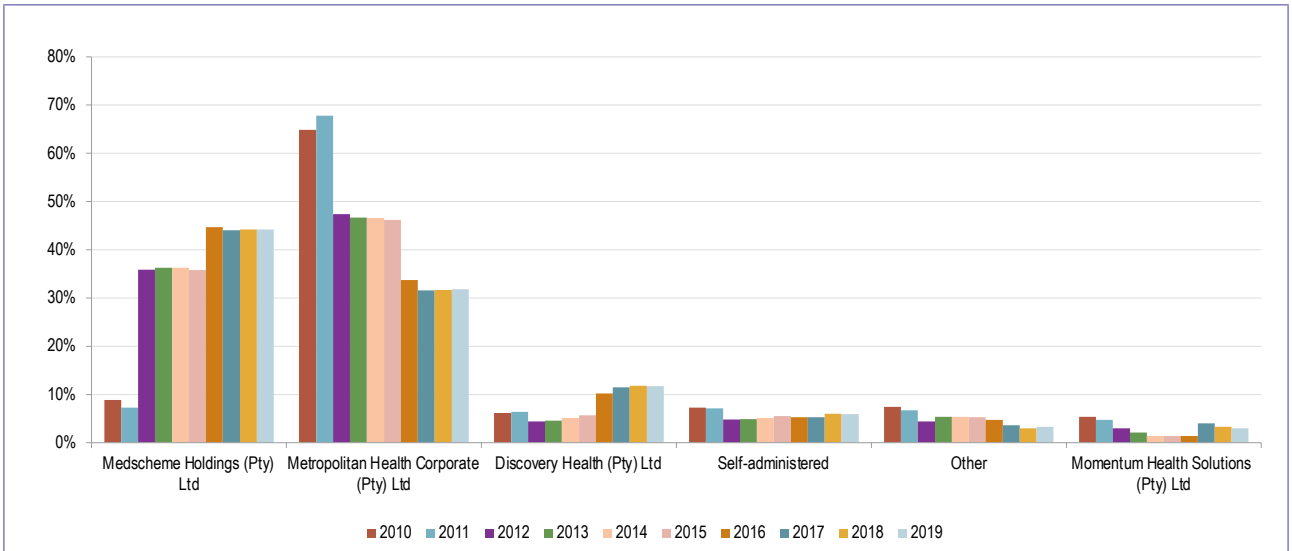

Figure 89: Restricted schemes market share of largest administrators based on average number of beneficiaries (2010-2019)*

* 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 AD).

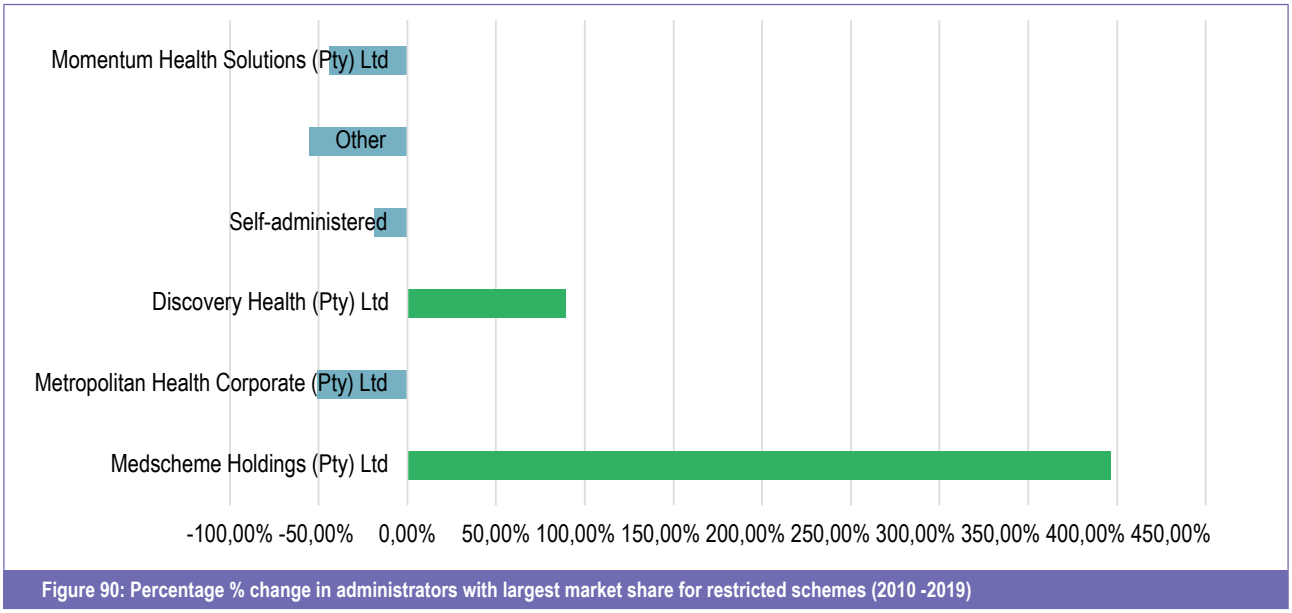

Figure 90: Percentage % change in administrators with largest market share for restricted schemes (2010 -2019)

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Table 113 shows the four administrators who had higher administration costs and fees than the industry average of R122.57 pabpm of administrators handling open schemes.

Table 113: Percentage deviation from industry average: open schemes

	Market share %	Gross admin istration costs %	Admin-istration fees paid* %	Fees paid to admin-istrators %
Momentum Health Solutions (Pty) Ltd	6.03	5.85	31.01	31.01
Discovery Health (Pty) Ltd	56.41	1.14	25.44	25.44
Universal Healthcare Administrators (Pty) Ltd	0.68	29.61	13.01	13.01
Agility Health (Pty) Ltd	0.76	55.97	8.90	8.90

* Excluding co-administration fees

Table 114 shows the seven administrators of restricted schemes with higher administration costs and fees than the industry average of R38.35 pabpm for restricted schemes.

Table 114: Percentage deviation from industry average: restricted schemes

	Market share %	Gross admin istration costs %	Admin-istration fees paid* %	Fees paid to admin istrators %
Professional Provident Society Healthcare Administrators (Pty) Ltd	1.24	272.10	304.03	281.80
Liberty Health Administration (Pty) Ltd	0.21	89.40	176.96	161.72
Discovery Health (Pty) Ltd	11.75	71.85	163.58	149.07
Momentum Health Solutions (Pty) Ltd	3	98.06	158.69	144.46
Universal Healthcare Administrators (Pty) Ltd	1.32	44.09	109.55	98.02
Momentum Thebe Ya Bophelo (Pty) Ltd	1.03	16.95	48.59	40.42
Metropolitan Health Corporate (Pty) Ltd	31.81	18.54	8.58	2.61

* Excluding co-administration fees

Administrators often provide other services, such as call centre fees and marketing expenditure. They were included in the 'fees paid to administrators' figures.

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Tables 115 and 116 show administrator market share based on the average number of beneficiaries to whom services are being delivered by third-party administrators and medical schemes under self-administration. The tables also show the average cost of administration. Gross administration costs are costs charged to both risk pools and savings accounts. (Details per individual administrator are outlined in Annexure AD.)

Table 115: Highest admin fee: Administrators with administration fees higher than the average for all administrators of R232.16 pampm

Administrator	No. of medical schemes	Average members	Average beneficiaries	Market share %	Admini-stration fees % pampm
Discovery Health (Pty) Ltd	19	1 659 247	3 480 943	32.25	298.48
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	66 794	139 580	1.29	262.33
Momentum Health Solutions (Pty) Ltd	11	247 168	473 752	4.39	260.49
Agility Health (Pty) Ltd	1	21 272	37 604	0.35	235.97

pampm = per average member per month

Table 116: Administrator market share 2019: open schemes

Name of administrator	No. of schemes	Bene-ficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators**		Gross contri-butions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI
3Sixty Health (Pty) Ltd	1	2.27	180.08	9.90	95.59	5.25	95.59	5.25	1 819.33	100.17
Agility Health (Pty) Ltd	1	0.76	245.35	9.78	133.48	5.32	133.48	5.32	2 508.40	92.61
Discovery Health (Pty) Ltd	1	56.41	159.11	7.64	153.75	7.38	153.75	7.38	2 082.66	87.73
Medscheme Holdings (Pty) Ltd	3	18.61	151.69	7.58	104.81	5.24	104.81	5.24	2 000.33	92.65
Momentum Health Solutions (Pty) Ltd	1	6.03	166.51	11.56	160.58	11.15	160.58	11.15	1 440.02	84.23
Momentum Thebe Ya Bophelo (Pty) Ltd	3	0.96	112.57	9.60	78.31	6.68	78.31	6.68	1 173.14	86.84
Private Health Administrators (Pty) Ltd	1	0.65	92.96	8.18	57.68	5.07	57.68	5.07	1 137.03	114.38
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.35	191.48	7.09	102.86	3.81	102.86	3.81	2 702.47	89.91
Self-administered	6	12.27	143.96	7.02	–	–	–	–	2 050.84	89.94
Universal Healthcare Administrators (Pty) Ltd	2	0.68	203.89	11.60	138.52	7.88	138.52	7.88	1 757.84	88.26
Average	**20**	**100.00**	**157.31**	**7.81**	**122.57**	**6.09**	**122.57**	**6.09**	**2 013.12**	**89.34**

* Excluding co-administration fees
** Administration fees including co-administration fees
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

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Table 117: Administrator market share 2019: restricted schemes

Name of administrator	No. of schemes	Bene-ficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators**		Gross contri-butions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI
Discovery Health (Pty) Ltd	18	11.75	110.12	5.91	95.52	5.13	95.52	5.13	1 861.82	93.74
Liberty Health Administration (Pty) Ltd	1	0.21	121.37	5.43	100.37	4.49	100.37	4.49	2 234.64	93.09
Medscheme Holdings (Pty) Ltd**	11	44.20	24.71	1.35	48.77	0.75	18.45	1.01	1 827.10	91.55
Metropolitan Health Corporate (Pty) Ltd***	1	31.81	75.96	4.09	39.35	2.12	39.35	–	1 857.98	88.77
Momentum Health Solutions (Pty) Ltd	10	3.00	126.92	7.42	93.75	5.48	93.75	5.48	1 710.39	92.67
Momentum Thebe Ya Bophelo (Pty) Ltd	3	1.03	74.94	6.72	53.85	4.83	53.85	4.83	1 115.68	104.80
Private Health Administrators (Pty) Ltd	1	0.07	115.63	5.28	85.44	3.90	–	–	2 191.07	97.43
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.24	238.44	11.46	146.42	7.04	146.42	7.04	2 080.74	93.07
Self-administered	9	5.93	117.52	7.65	–	–	–	–	1 535.95	92.02
Universal Healthcare Administrators (Pty) Ltd	5	1.32	92.33	6.96	75.94	5.73	75.94	5.73	1 325.93	90.69
Average	**60**	**100.00**	**64.08**	**5.21**	**36.24**	**2.95**	**38.35**	**3.12**	**1 229.62**	**92.15**

Old Mutual Staff Medical Aid Fund % changed its administrator from Medscheme Holdings (Pty) Ltd to Universal Healthcare Administrators (Pty) Ltd on 1 July 2019. (The % change to Universal Healthcare Administrators (Pty) Ltd was phased from 1 July 2018.) Its membership was included in both administrators to represent the market share during the year.

* Excluding co-administration fees
** Administration fees including co-administration fees
pabpm = per average beneficiary per month
GCI = Gross Contribution Income
** The GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included.
*** The GEMS administration fee was included in the cash flows under administration; the GEMS GCI was included

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Table 118 indicates the total fees paid to the top four administrators in terms of market share for all schemes, as well as the schemes falling under their administration.

Table 118: Total fees paid to the four largest administrators (excluding accredited managed healthcare services) - deviation from average per administrator: 2019.

Ref. no.	Name of medical scheme	Name of administrator	Average members	Total fees paid to administrators		Average per administrator	Deviation from average per administrator
				pampm R	As % of GAE	pampm R	%
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 342 758	320.05	96.63	298.48	7.23
1145	LA-Health Medical Scheme		81 753	306.15	94.20		2.57
1571	Anglovaal Group Medical Scheme		2 528	263.71	84.87		-11.65
1520	University of Kwa-Zulu Natal Medical Scheme		3 457	248.77	88.08		-16.65
1241	Naspers Medical Fund		3 725	236.26	85.34		-20.85
1578	TFG Medical Aid Scheme		2 968	235.12	86.60		-21.23
1572	Engen Medical Benefit Fund		3 455	234.23	84.22		-21.53
1516	Quantum Medical Aid Society		3 897	227.87	86.08		-23.66
1579	Tsogo Sun Group Medical Scheme		5 171	219.43	82.00		-26.48
1430	Remedi Medical Aid Scheme		21 016	213.81	92.53		-28.37
1176	Retail Medical Scheme		12 449	210.49	95.34		-29.48
1547	Malcor Medical Scheme		4 768	197.50	77.34		-33.83
1526	BMW Employees Medical Aid Society		3 488	194.07	92.50		-34.98
1209	South African Breweries Medical Aid Scheme (SABMAS)		11 159	191.15	79.06		-35.96
1012	Anglo Medical Scheme		8 914	188.00	61.92		-37.01
1253	Glencore Medical Scheme		8 263	166.58	93.32		-44.19
1584	Netcare Medical Scheme		17 843	162.20	92.31		-45.66
1279	Bankmed		109 392	154.61	78.86		-48.20
1599	Lonmin Medical Scheme		12 243	66.85	85.26		-77.60

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Ref. no.	Name of medical scheme	Name of administrator	Average members	Total fees paid to administrators		Average per administrator	Deviation from average per administrator
				pampm R	As % of GAE	pampm R	%
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	74 613	304.31	75.47	101.16	200.82
1441	Parmed Medical Aid Scheme		2 456	254.65	74.37		151.73
1507	Barloworld Medical Scheme		5 134	232.92	83.47		130.25
1424	SABC Medical Aid Scheme		4 447	216.21	74.44		113.73
1005	AECI Medical Aid Society		6 542	213.19	81.66		110.75
1512	Bonitas Medical Fund		336 651	210.07	69.69		107.66
1039	MBMed Medical Aid Fund		4 057	205.22	80.77		102.87
1234	Sasolmed		29 419	197.80	82.24		95.53
1566	Horizon Medical Scheme		3 692	183.66	82.37		81.55
1469	Nedgroup Medical Aid Scheme		28 157	161.98	83.09		60.12
1537	Hosmed Medical Aid Scheme		21 444	149.37	38.71		47.66
1580	South African Police Service Medical Scheme (POLMED)		177 430	97.60	58.77		-3.52
1598	Government Employees Medical Scheme (GEMS)		713 646	102.35	47.63		1.18
1598	Government Employees Medical Scheme (GEMS)	Metropolitan Health Corporate (Pty) Ltd	713 646	102.35	47.63	102.35 –	
1167	Momentum Health	Momentum Health Solutions (Pty) Ltd	156 841	305.95	96.44	260.49	17.45
1563	Pick n Pay Medical Scheme		7 575	214.51	79.44		-17.65
1186	PG Group Medical Scheme		1 450	214.37	72.94		-17.71
1293	Wooltru Healthcare Fund		9 831	206.78	81.94		-20.62
1600	Motohealth Care		20 030	196.83	79.90		-24.44
1548	Medipos Medical Scheme		13 903	177.85	85.68		-31.72
1559	Imperial Group Medical Scheme		7 642	167.33	61.59		-35.76
1237	BP Medical Aid Society		1 767	166.57	28.54		-36.06
1270	Golden Arrow Employees' Medical Benefit Fund		2 820	163.77	86.65		-37.13
1582	Transmed Medical Fund		23 456	162.72	69.18		-37.53
1271	Fishing Industry Medical Scheme (Fishmed)		1 853	88.28	60.36		-66.11

GAE = Gross Administration Expenditure
pampm = per average member per month

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Table 119 shows the market share of administrators including accredited managed healthcare services.

Table 119: Market share of administrators: including accredited managed healthcare services

Name of administrator	No. of schemes	Beneficiaries Market share %	Total fees paid to administrators (various services)*	Net relevant healthcare expenditure incurred	Accredited managed healthcare services (no transfer of risk) received *	Accredited managed healthcare services (risk transfer arrangement): capitation fee received *	Total fees received*
3Sixty Health (Pty) Ltd	1	1.04	95.59	1 821.40	83.31	–	178.89
Agility Health (Pty) Ltd	1	0.35	133.49	2 163.70	56.81	–	190.30
Discovery Health (Pty) Ltd	19	32.25	142.28	1 499.96	50.04	60.27	196.15
Liberty Health Administration (Pty) Ltd	1	0.12	100.37	1 748.85	44.49	–	144.86
Medscheme Holdings (Pty) Ltd**	14	32.45	41.19	1 753.80	30.36	–	71.27
Metropolitan Health Corporate (Pty) Ltd	1	17.20	39.35	1 604.68	1.90	–	41.25
Momentum Health Solutions (Pty) Ltd	11	4.39	135.90	1 270.35	34.61	125.19	270.15
Momentum Thebe Ya Bophelo (Pty) Ltd	6	1.00	64.70	1 059.45	38.81	–	83.20
Private Health Administrators (Pty) Ltd	2	0.34	60.66	1 228.28	20.42	6.07	86.50
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	1.29	125.53	2 097.65	36.85	–	162.39
Self-administered	15	8.84	–	1 581.65	25.16	–	12.48
Universal Healthcare Administrators (Pty) Ltd	7	1.03	95.08	1 202.60	34.74	–	127.42
Average	**80**	**100.00**	**104.31**	**1 576.76**	**39.93**	**96.69**	**113.68**

pabpm = per average beneficiary per month
The above table reflect market share based on the number of beneficiaries administered during the year (i.e. includes mid-year administrator % changes)
* Excluding co-administration fees
** Only the GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included.

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Table 120 shows the six administrators who had the highest deviation from the 2019 industry average of R104.31 pabpm in respect of total fees received by administrators.

Table 120: Total fees paid to administrators (including accredited managed healthcare services) – deviation from industry average: 2019

	Total fees paid to administrators (various services)* %	Accredited managed healthcare services (no transfer of risk) received * %	Accredited managed healthcare services (risk transfer arrangement): capitation fee received * %	Total fees received* %
Momentum Health Solutions (Pty) Ltd	30.28	-13.32	29.48	137.64
Discovery Health (Pty) Ltd	36.40	25.32	-37.67	72.55
Agility Health (Pty) Ltd	27.97	42.27	-100.00	67.40
Professional Provident Society Healthcare Administrators (Pty) Ltd	20.34	-7.71	-100.00	42.85
Liberty Health Administration (Pty) Ltd	-3.78	11.42	-100.00	27.43
Universal Healthcare Administrators (Pty) Ltd	-8.85	-13.00	-100.00	12.09

* Excluding co-administration fees

Annual Report
Council for Medical Schemes RP: 216/2020
ISBN: 978-0-621-48475-5 Council for Medical Schemes

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