CMS
Council
for Medical Schemes

ANNUAL REPORT
2017/2018

A Healthy Industry for all

ANNUAL REPORT
COUNCIL FOR MEDICAL SCHEMES

RP: 111/2018
ISBN:978-0-621-46275-3

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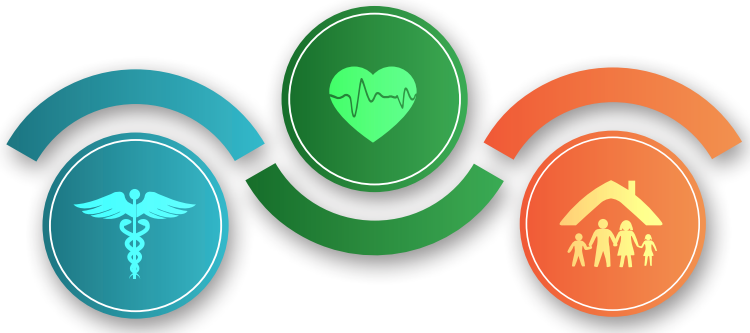

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GENERAL INFORMATION

General information on the Council for Medical Schemes

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
Postal address	Private Bag X34 Hatfield Pretoria 0028 South Africa
Telephone number	012 431 0500
Customer Care Centre	0861 123 267 0861 123 CMS
Fax number	0862 068 260
Email address	information@medicalschemes.com
Website	www.medicalschemes.com
Internal auditors	Nexia-SAB&T
External auditors	Auditor-General of South Africa
Bank	Absa Group Limited
Chairperson of Council	Dr Clarence Mini
Acting Chief Executive & Registrar	Dr Sipho Kabane
Council Secretariat	Mr Khayalethu Mvulo

A | GENERAL INFORMATION

> *It always seems impossible until it's done.*
> *- Nelson Mandela*

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

AC	Appeals Committee
AFS	Annual financial statements
AG	Auditor-General
AGM	Annual general meeting
AGSA	Auditor-General of South Africa
AIDS	Acquired immunodeficiency syndrome
APP	Annual performance plan
ARC	Audit and Risk Committee
ART	Antiretroviral therapy
ASR	Annual Statutory Return
ASAWU	Academic Staff Association of Wits University
BBBEEA	Broad-Based Black Economic Empowerment Act
BEE	Black economic empowerment
Beneficiaries	Principal members + dependants (total membership of medical scheme)
BHF	Board of Healthcare Funders of Southern Africa
BMU	Benefits Management Unit
Board	Board of trustees
BOT	Board of Trustees
CAMAF	Chartered Accountants (SA) Medical Aid Fund
CCMA	Commission for Conciliation, Mediation and Arbitration
CDL	Chronic disease list
CE	Chief Executive
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CISNA	Committee of Insurance, Securities and Non-Banking Financial Authorities
CMS	Council for Medical Schemes
COMMED	Community Medical Aid Scheme
Council	Accounting Authority or the Board of the Council for Medical Schemes
CPI	Consumer Price Index
CT	Computerised Tomography scans
DDDR	Dynamic Database Driven Annual Returns
Dependant	Member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DHMS	Discovery Health Medical Scheme
DRC	Dispute Resolution Committee
NDoH	National Department of Health
DRG	Diagnosis-related group
DRGTAP	DRG Technical Advisory Panel
DSP	Designated service provider
DTPs	Diagnosis and treatment pair
EDO	Efficiency discounted option
EE	Employment equity
EMC	Executive Management Committee
EWS	Early warning system
EXCO	Executive Committee (Council sub-committee)
Executive Authority	Minister of Health
FAIS Act	Financial Advisory and Intermediary Services Act 37 of 2002
FFS	Fee for service
FINCOMM	Finance Committee
FSB	Financial Services Board
FSPs	Financial service providers
FSU	Financial Supervision Unit
GAE	Gross Administration Expenditure
GCI	Gross Contribution Income
GDP	Gross Domestic Product
GEMS	Government Employees Medical Scheme
GP	General practitioner
GRAP	Generally Recognised Accounting Practices
HIV	Human immunodeficiency virus
HMI	Health Market Inquiry
HRSE	Human Resource and Social Ethics Committee
HWSETA	Health and Welfare Sector Education and Training Authority
ICU	Intensive care unit
ICUCD	Intrauterine Contraceptive Implant
ISBN	International Standard Book Number
ITAP	Industry Technical Advisory Panel
KM	Knoweledge Mangement
MCO	Managed care organisation
MMED	Municipal Medical Scheme
MoU	Memorandum of Understanding
MRC	Medical Research Council
MRI (scan)	Magnetic resonance imaging
MSA	Medical Schemes Act
MSO	Medical Services Organisation (Pty) Ltd
NHC	Net Healthcare
NHE	Non-Healthcare Expenditure
NHI	National Health Insurance
Office	Office of the Chief Executive and Registrar (of Medical Schemes)
OOPs	Out of pocket payments
Pab	Per average beneficiary
Pabpa	Per average beneficiary per annum
Pabpm	Per average beneficiary per month
Pampm	Per average member per month
Pasbpm	Pabpm in respect of schemes that had savings transactions
Pb	Per beneficiary
Pbpm	Per beneficiary per month
PCNS	Practice Code Numbering System

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

PET	Position Emission Tomography scans
PFMA	Public Finance Management Act 1 of 1999
PMB	Prescribed minimum benefit
PO	Principal Officer
POPIA	Protection of Personal Information Act
PPPFA	Preferential Procurement Policy Framework
PPPs	Public Private Partnerships
PPS	Professional Provident Society
Principal member	Member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
PSCBC	Public Service Co-ordinating Bargaining Council
Q	Quarter
QR	Quarterly returns
RCI	Risk Contribution Income
Registrar	Registrar of Medical Schemes
R&M	Research and monitoring
RTM	Real Time Monitoring
SADC	Southern African Development Community
SAMA	South African Medical Association
SCA	Supreme Court of Appeal
SRM	Schemes Risk Measurement
Transmed	Transmed Medical Fund
TCF	Treating Customers Fairly
TR	Treasury Regulations
Treasury	National Treasury
VAT	Value Added Tax
WHO	World Health Organization

LEGISLATIVE AND OTHER MANDATES

CONSTITUTIONAL MANDATES

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

LEGISLATED MANDATES

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

Significant problems emerged as a result of the deregulation of the medical schemes industry in 1989, including poor solvency levels, inadequate accountability and a lack of member participation in governance of medical schemes. The situation necessitated the promulgation of the Medical Schemes Act 131 of the 1998, which became fully operational in 2000.

Medical schemes are essentially business entities that are registered with the Council for Medical Schemes, and as such operate in a special legislative environment. This special environment was established in order to balance the rights and interests of the business entity on the one hand, and the rights and interests of the public on the other. The Constitution addresses the limitations of rights and sets clear criteria to be met when any right contained in the Bill of Rights is limited by law. Section 27 of the Constitution describes certain rights with regard to healthcare, food, water and social security, while section 22 of the Constitution guarantees freedom of trade, which may be limited by law.

The MSA imposes certain limitations in the medical schemes environment by confining the business of the schemes to entities that are registered by the CMS and requiring that such entities comply with provision of the Medical Schemes Act.

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

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

POLICY MANDATES

The Council for Medical Schemes (CMS) is obliged to execute its statutory mandate in a way that is coherent and consistent with national policy. The priority areas of the electoral mandate in the SA government's Programme of Action and the Strategic Goals of the National Department of Health (NDoH) are:

Government's Programme of Action electoral mandate priorities for 2014 – 2019:

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

The National Department of Health Strategic Goals

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

PROFILE AND **VISION**

PROFILE

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

VISION

To promote vibrant and affordable healthcare cover for all.

MISSION AND **VALUES**

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 MSA.
- 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 entities in executing our regulatory mandate.

VALUES

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

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

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

STRATEGIC GOALS

STRATEGIC GOAL 1

Access to good quality medical scheme cover is promoted

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

STRATEGIC GOAL 2

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

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

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

STRATEGIC GOAL 3

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

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

STRATEGIC GOAL 4

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

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

OUR LEADERSHIP **THE COUNCIL**

DR CLARENCE MINI
Chairperson

MS SHIVANI RANCHOD
Member

ADV REBAONE GAORAELWE
Member

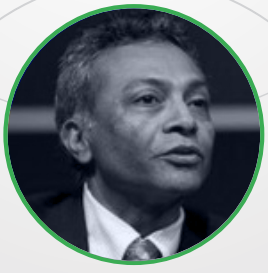
ADV HARSHILA KOOVERJIE (SC)
Vice Chairperson

MS DIANE TERBLANCHE
Member

MR MOERANE MAIMANE
Member

DR STEVEN MABELA
Member

MS MOSIDI MABOYE
Member



DR YOGAN PILLAY
Member

PROF LUNGILE PEPETA
Member

DR AQUINA THULARE
Member

MR JOHAN VAN DER WALT
Member

DR MEMELA MAKIWANE
Member

OUR LEADERSHIP **THE EXECUTIVE**

DR SIPHO KABANE
Senior Strategist and Acting Registrar & Chief Executive

MR DANIEL LEHUTJO
Chief Financial Officer

MR JAAP KÜGEL
Chief Information Officer

MR CRAIG BURTON-DURHAM
General Manager:
Legal Services

THIS POSITION IS CURRENTLY VACANT

VACANT
General Manager:
Stakeholder Relations

THIS POSITION IS CURRENTLY VACANT

VACANT
General Manager:
Research and Monitoring

MR DANIE KOLVER
General Manager:
Accreditation

MS TEBOGO MAZIYA
General Manager:
Financial Supervision

MR STEPHEN MMATLI
General Manager:
Compliance and Investigations

MS LINDELWA NDZIBA
General Manager:
Human Resources

MS THEMBEKILE PHASWANE
General Manager:
Complaints Adjudication

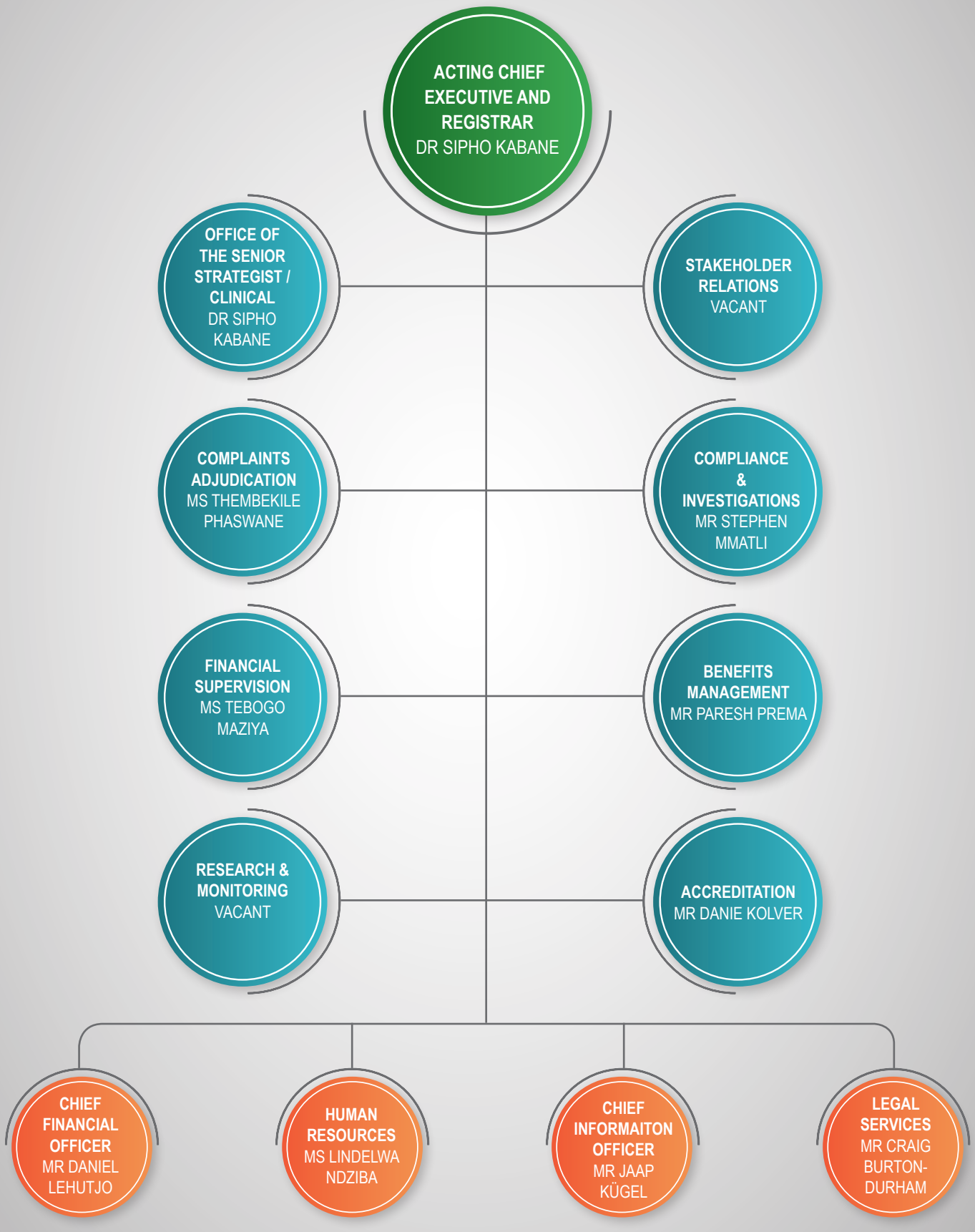
MR PARESH PREMA
General Manager:
Benefits Management

MEDICAL SCHEMES REGISTERED IN TERMS OF THE MEDICAL SCHEMES ACT

AS AT 31 MARCH 2018

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	Community Medical Aid Scheme (Commed)	Open
15	Compcare Wellness Medical Scheme	Open
16	De Beers Benefit Society	Restricted
17	Discovery Health Medical Scheme	Open
18	Engen Medical Benefit Fund	Restricted
19	Fedhealth Medical Scheme	Open
20	Fishing Industry Medical Scheme (FISH-MED)	Restricted
21	Food Workers Medical Benefit Fund	Restricted
22	Genesis Medical Scheme	Open
23	Glencore Medical Scheme	Restricted
24	Golden Arrows Employees' Medical Benefit Fund	Restricted
25	Government Employees Medical Scheme (Gems)	Restricted
26	Grintek Electronics Medical Aid Scheme	Restricted
27	Horizon Medical Scheme	Restricted
28	Hosmed Medical Aid Scheme	Open
29	Impala Medical Plan	Restricted
30	Imperial Group Medical Scheme	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 Health	Open
44	Motohealth Care	Restricted
45	Naspers Medical Fund	Restricted
46	Nedgroup Medical Aid Scheme	Restricted
47	Netcare Medical Scheme	Restricted
48	Old Mutual Staff Medical Aid Fund	Restricted
49	Parmed Medical Aid Scheme	Restricted
50	PG Group Medical Scheme	Restricted
51	Pick n Pay Medical Scheme	Restricted
52	Platinum Health	Restricted
53	Profmed	Restricted
54	Quantum Medical Aid Society	Restricted
55	Rand Water Medical Scheme	Restricted
56	Remedi Medical Aid Scheme	Restricted
57	Resolution Health Medical Scheme	Open
58	Retail Medical Scheme	Restricted
59	Rhodes University Medical Scheme	Restricted
60	SABC Medical Aid Scheme	Restricted
61	SAMWUMED	Restricted
62	Sasolmed	Restricted
63	SEDMED	Restricted
64	Selfmed Medical Scheme	Open
65	Sisonke Health Medical Scheme	Restricted
66	Sizwe Medical Fund	Open
67	South African Breweries Medical Scheme	Restricted
68	South African Police Service Medical Scheme (Polmed)	Restricted
69	Spectramed	Open
70	Suremed Health	Open
71	TFG Medical Aid Scheme	Restricted
72	Thebemed	Open
73	Tiger Brands Medical Scheme	Restricted
74	Topmed Medical Scheme	Open
75	Transmed Medical Fund	Restricted
76	Tsogo Sun Group Medical Scheme	Restricted
77	Umvuzo Health Medical Scheme	Restricted
78	University of KwaZulu-Natal Medical Scheme	Restricted
79	Witbank Coalfields Medical Aid Scheme	Restricted
80	Wooltru Healthcare Fund	Restricted

ORGANISATIONAL STRUCTURE



CHAIRPERSON'S REPORT

Dr Clarence Mini

"I have no doubt in my mind that I am inheriting an entity that has done a reasonable job of regulating the sector in line with the Medical Schemes Act and Regulations"

I, together with my fellow Council members, assumed our responsibilities at the Council for Medical Schemes (CMS) in November 2017. I want to use this opportunity to thank the Minister of Health, Hon. Dr Aaron Motsoaledi for assembling such a formidable team to lead the CMS for the next three years.

The newly appointed Council spent the first three months acquainting itself with the industry and its inner workings, through a series of orientation workshops, meetings and training opportunities.

As a new Council that took over the leadership ropes in the last quarter of the 2017/18 financial year, we accept that we are held accountable for the entire financial year. The Auditor General of South Africa (AGSA) has audited our financial statements and issued an unqualified opinion, with findings on audit of predetermined objectives and compliance. As a governance body we have applied our mind on the issues raised, and adopted a remedial approach aimed at dealing with the issues raised by the AGSA.

Management has been tasked to develop a comprehensive intervention plan to address all the audit findings, and Council will be monitoring its implementation on a quarterly basis. We commit ourselves to clean governance and acknowledge the demarcation between operation and governance structures. As a governing body, we are looking at the strategy that Management has prepared. Once we have approved it and have submitted it to the relevant authorities, it will serve as a basis for performance measurement going forward.

During the last quarter of the financial year I invited a team of managers, led by the Acting Registrar, to go on a roadshow with me and to pay a visit to all the medical schemes, administrators and managed care organisations that we regulate. The purpose of this roadshow was to ensure that we gain a better insight and understanding of the entities we regulate. This was an opportunity for me to share with the industry our vision for the next five years and to open a channel for communication between ourselves and these entities.

The impact of this roadshow was felt through the messages of appreciation and support that were passed on to us as we moved from one entity to the next. There were entities that were completely taken by surprise during these visits and confessed that it was the first time in more than twenty years of their involvement in the industry that they were visited by the CMS, outside the scheduled inspections that we conduct from time to time. This adopted approach is, for us, the beginning of a new era.

I have no doubt in my mind that I am inheriting an entity that has done a reasonable job of regulating the sector in line with the Medical Schemes Act and Regulations. I believe that more still needs to be done. I am acutely aware of the developments in the policy sphere and the responsibilities that the CMS will need to discharge in the next five years, in order to provide effective and efficient regulation of the sector. It is anticipated that the Minister of Health will release the amendments to the Medical Schemes Act and the National Health Insurance Act Bills for public comment, in order to reduce the anxieties and eliminate public speculation regarding their contents and impact, sometime soon.

The Health Market Inquiry is also expected to complete its work and issue a provisional and final report with clear recommendations on how the country should address the harm caused by the anti-competitive behaviour of some key players in the provision of private healthcare services. I am convinced that some of the final recommendations of this inquiry will direct the CMS to implement specific measures in the sector in protection of the beneficiaries of medical schemes. I firmly believe that the CMS should focus its regulatory energy and resources at addressing the following challenges:

- Increase its research and policy development capacity.
- Continue to provide technical support to the National Health Insurance proposals.
- Play a more active role in combating fraud, waste and abuse of scarce resources.
- Prepare and resource itself to implement the recommendations of the Health Market Inquiry.
- Champion the movement towards quality improvement and cost reduction in the private healthcare sector.
- Play a key role in the establishment of a central coding authority.
- Develop skills and competencies in support of Service Benefit and Health Technology Assessment processes.
- Position itself to be the co-ordinator of health funding regulation within the SADC region.

I am satisfied that the CMS utilised the resources that were placed at its disposal in the 2017/18 financial year optimally in order to ensure effective and efficient regulation of the medical schemes, administrators and brokers. Overall, the CMS has performed well against the targets that it had set for itself in the 2017/18 financial year.

I wish to thank the Health Ministry and all the key stakeholders in our sector for the support that they provided to the CMS in its regulatory quest.

Finally, I wish to extend my gratitude to my fellow Council members; the management team and all the CMS personnel led by the Acting Chief Executive & Registrar, Dr Sipho Kabane for a job well done.

Dr Clarence Mini
Chairperson of Council
31 May 2018

OVERVIEW OF THE ACTING CEO & REGISTRAR

Dr Sipho Kabane

"The CMS prides itself on the high-quality skills, competence and experience that its personnel collectively posses."

The Council for Medical Schemes continued to effectively execute its mandate of regulating medical schemes, medical scheme administrators, managed care organisations and brokers, in line with the Medical Schemes Act and its regulations, in the 2017/18 financial year.

This mandate is aimed at the protection of the 8.8 million members who belong to registered medical schemes. The CMS will continue to carry out this mandate for as long as the Medical Schemes Act and its regulations are in place.

The external environment in which the CMS operates was stable in 2017/18 despite the anticipated release of the Health Market Inquiry report, the amendments to the Medical Schemes Act, and National Health Insurance Act Bill. These much-awaited documents have initiated debates in the sector, which were largely based on anxieties by different stakeholders, with respect to their contents and implications. The inferior performance of the South African economy as demonstrated by low Gross Domestic Product (GDP), low employment rates and the negative credit ratings ensured that there was no significant growth in the overall number of medical scheme members. The increase in value added tax (VAT) to 15% created anxiety in the sector, but schemes were able to absorb this without any major consequences.

The financial performance of the sector in the period under consideration was somewhat encouraging. The overall net healthcare result improved from a deficit of R2.4 billion in 2016 to a surplus of R3.4 billion in 2017. The overall reserves retained by schemes also increased to R63.3 billion in 2017, from R52.4 billion in 2016. Scheme members also benefited from lower average contribution increases recommended for 2018 at 7.2% compared to the 11.3% that was recommended in 2017.

The process of standardisation of options and consolidation of schemes is progressing through our regulatory interventions. The total number of schemes that were registered with the CMS as at March 2018

was 80, compared to 82 in March 2017. The total number of scheme options (excluding the Efficiency Discounted Options) registered with the CMS as at March 2018 was 322 compared to 331 in March 2017. This process will be accelerated in the next five years as we approach the full implementation of the National Health Insurance. The CMS has succeeded in achieving 82% of its targets as per our Annual Performance Plan for 2017/18. The organisation received an unqualified audit opinion with matters of emphasis.

The 2017/18 financial year saw the end of term of the Council that was led by Prof Y Veriava and the introduction of a new Council team led by Dr C Mini. This new team started its three-year term in November 2017. The team has been inducted and took over in the new financial year. There were no organisational changes at the CMS that significantly impacted on its overall performance in the reporting period.

The CMS has started to align its annual report with the integrated reporting framework, whilst maintaining the reporting formats as prescribed by the National Treasury. This alignment process will be incremental, and is meant to ensure that the organisation reports on key strategic issues in a more transparent manner.

FINANCIAL CAPITAL

In the 2017/18 financial year, the CMS had a budget of R154 million, derived from a once-off levy on the 3 950 927 principal members, a treasury grant, accreditation, and registration fees. These resources were used to regulate an industry whose collective member contributions were R179.8 billion per annum (in 2016) with aggregated reserves of R59 billion. The detailed financial report of the CMS for the 2017/18 financial year, that details how these resources were transformed to execute the mandate of the CMS is covered in section E of this Annual Report.

HUMAN CAPITAL

In the 2017/18 financial year, CMS carried out its regulatory activities with a staff complement of 113. Our skilled and competent personnel included 22 officials with Masters or PhD degrees; 12 officials with an Honours degree and 36 officials with Bachelor's degrees. The staff complement has aggregated post-graduate experience of more than 127 years. More than 44% of the employees at CMS have been with the regulator for 10 years or more. During this period, the CMS also appointed 15 qualified, but unemployed graduates in order to provide them with experiential learning opportunities in preparation for full time work.

INTELLECTUAL CAPITAL

The intellectual capital that CMS possesses lies mainly with its human resources, stakeholder relationships and its facility. The CMS prides itself on the high-quality skills, competence and experience that its personnel collectively possess. The CMS has, over the years, built strong relationships with the entities we regulate, the National Department of Health, the Parliament Portfolio Committee on Health, our personnel, our suppliers and local communities. The organisation has over the years developed a number of internal operational templates and information systems that are used for data collection, analysis and reporting in order to automate some of its regulatory activities.

In the 2017/18 reporting year, the CMS was engaged in the following strategic projects:

- Development of a framework for standardisation of options.
- Development of a framework for the consolidation of schemes with less than 6000 members.
- Development of a framework for the consolidation of government schemes.
- Development of a framework for the low-cost benefit option.
- Risk based capital solvency framework.
- Prescribed Minimum Benefit Review.
- Beneficiary Registry.
- Medical Schemes Bill.
- Providing inputs to the Health Market Inquiry.

MANUFACTURED CAPITAL

In the 2017/18 financial year, the CMS spent up to R13.7 million on the lease of the building that it currently occupies. The Council also invested an additional amount of R2.9 million into equipment to improve its operations. The total value of the assets as at 31 March 2018 stood at R18.2 million.

NATURAL CAPITAL

We are a minimal impact consumer of natural resources such as water and energy, given the nature of work that we do and our operating hours. Our facility is located in a well-kept and biodiverse environment. We have, wherever possible, reduced the use of paper through the introduction of digital processes in our systems for the sake of the environment.

Energy efficiency and the reduction of the carbon footprint is a priority for the CMS. In 2017, the CMS decided to migrate 32 of its physical servers to virtualised platforms. By implementing virtual servers rather than physical servers, our hardware resources were better used and now require less overall equipment/energy. It is estimated that this virtualisation can lead to approximately 80% energy savings and the elimination of up to four tons of CO2 emissions per virtual server.

We estimate that the environmental impact of these activities has led to a reduction of our carbon footprint from approximately 128 tons of CO2 emissions to 12 tons, while reducing our electricity consumption by approximately 203,000kWh.

SOCIAL AND STAKEHOLDER CAPITAL

In an effort to demonstrate good corporative citizenry, the CMS participated in three main events as part of our Corporate Social Investment programme in 2017/18 financial year.

Rock of Hope Place of Safety

On 6 April 2017 CMS donated groceries to the value of R15 000 to the Rock of Hope Place of Safety in Montana, Pretoria North. About five staff members joined the social responsibility committee representatives to drop off the groceries to the home. The home, which works under the management of Tshwane Place of Safety Association, provides a secure and happy environment for babies and toddlers in crisis.

Cell C Take a Girl Child to Work

The CMS participated in the Cell C Take a Girl Child to Work where 15 staff members hosted for a day 20 Girls from Olievenhoutbosch Secondary School. The event was aimed at motivating and empowering young girls with information on available career opportunities they can pursue at tertiary level. The CMS donated personal hygiene products, books and sanitary towels for the girls who attended the event to the value of R3 000. A national TV & Radio Presenter/News Anchor for eNCA Ms Jenna-Leigh Bilong was the guest speaker for the event.

67 Minutes for Nelson Mandela Day

On 18 July 2017, 10 employees volunteered to participate in serving morning tea, coffee and soup together with the parishioners of St Michael & All Angels Anglican Church in Sunnyside. The church serves soup, tea and bread to almost 100 homeless persons every morning throughout the year. The CMS donated groceries in July and in November to the value of R5 000 to the church. During 67 Minutes for Mandela day, CMS staff members are allowed reported time off in the morning to go and participate in an organisation of their choice.

During the course of executing its regulatory mandate, the CMS has engaged with different stakeholders. There were six broker training sessions that were attended by 1 560 trainees. We also conducted 53 interviews on radio and television and reached an aggregated audience of 65 000.

Southern African Development Community (SADC)

Through active participation and membership of forums such as the Committee of Insurance, Securities and Non-banking Financial Authorities (CISNA), the CMS continued to foster liaison and co-operation with related industry role players within the Southern African Development Community (SADC) region. The Council has now signed Memorandum of Understanding with three (3) countries on the harmonisation of regulatory legal frameworks for medical schemes.

ORGANISATIONAL OUTLOOK:

In the next year, the role and effectiveness of the CMS as a regulator will be determined by the strategic trajectory that will emerge after the release and finalisation of the amendment to the Medical Schemes Act and the National Health Insurance Bills. The recommendations in the final report of the Health Market Inquiry will also play a key role in determining the activities that the CMS will be engaged with in the medium to long term. The CMS will be reviewing its vision, mission and its strategic goals for the next five years in 2018/19. These will give a clear indication of where this regulatory authority sees itself in the next five years (2019-2024)

Dr Sipho Kabane
Acting Chief Executive & Registrar
31 May 2018

B | PERFORMANCE INFORMATION

> *I never lose. I either win or learn.*
> *- Nelson Mandela*

STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

The Acting Chief Executive Officer is responsible for the preparation of the public entity's performance report and for the judgements made in this information.

The Acting Chief Executive Officer is responsible for establishing, and implementing a system of internal control designed to provide reasonable assurance as to the integrity and reliability of performance report.

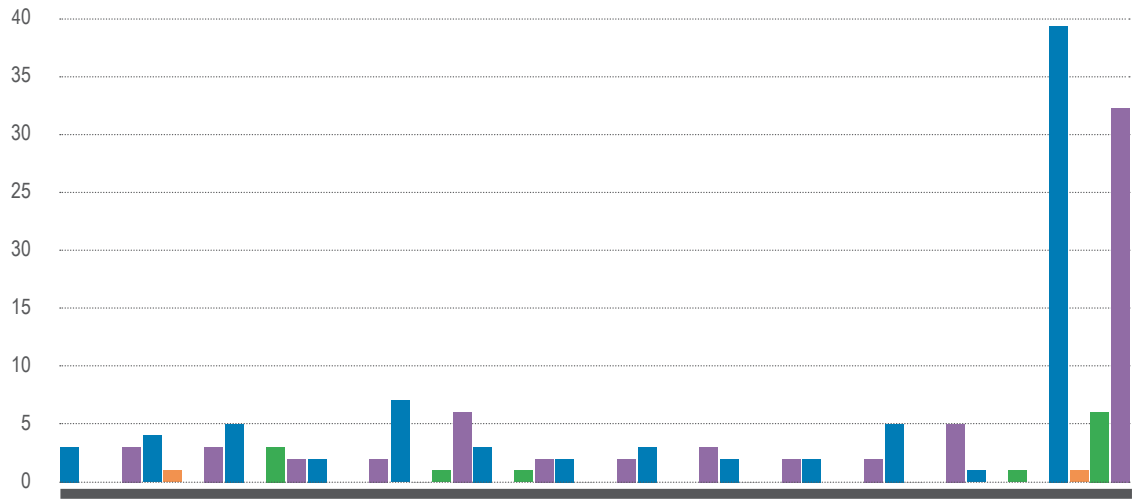
In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned targets which are set out in the annual performance plans of the CMS for the financial year ended 31 March 2018.

The performance report of the CMS for the financial year has been audited by the Auditor-General of South Africa. Its audit is presented on pages 68 to 70.

Dr Sipho Kabane
Acting Chief Executive Officer
Council for Medical Schemes

31 July 2018

Figure 1: Annual performance information report 2017/2018



	Sub-Prog 1.2: Office of CFO	Sub-Prog 1.3: ICT & KM	Sub-Prog 1.4: Huamn Re-sources	Sub-Prog 1.5: Legal Service	Prog 2: Strategy Office	Prog 3: Accredi-tation	Prog 4: Re-search-es & Monitor-ing	Prog 5: Stake-holder Rela-tions	Prog 6: Com-pliance and Investi-gations	Prog 7: Benefit manage-ment	Prog 8: Financial Supervi-sion	Prog 9: Com-pliants Adjudi-cation	Total number of indi-cators
Number of indicator	3	4	5	2	7	3	2	3	2	2	5	1	39
Not Achieved	0	1	0	0	0	0	0	0	0	0	0	0	1
Partially Achieved	0	0	3	0	1	2	0	0	0	0	0	1	7
Achieved	3	3	2	2	6	1	2	3	2	2	5	0	31

The analysis of the performance of the CMS in respect of the four strategic goals that the organisation set for itself in 2014/15, in its five year strategic plan, reveals an over 80% achievement of targets year on year. In 2014/15, there was an overall achievement score of 86% for the 35 indicators that were set for all programmes. In 2015/16, there was an overall achievement score of 85% for the 33 targets set for all programmes. In the year under review 2016/17 there was an overall achievement of 94.44%. For the financial year 2017/18 the CMS had an overall achievement of 97%. The Stakeholder Relations programme included an indicator that was not applicable for the year under review, which was excluded from the calculation.

The Stakeholder Relations programme included an indicator that was not applicable for the year under review, which was excluded from the calculation.

A total of 39 indicators were applicable for the year under review.

Achieved	79%
Partially achieved	18%
Not achieved	3%
TOTAL	**100%**

Performance achievements during 2017/18 include the following:

- Unqualified opinion by the Auditor General on CMS annual financial statements.
- ICT systems up-time were maintained at over 99%.
- There was an increase in PMB definitions published.
- There was an increase in research outputs to address industry challenges and to contribute to policy development.
- There was an increase in stakeholder interactions, training and empowerment, including enhanced publicity initiatives.
- There was an increase in the number of investigations and governance interventions.
- The appeals process was strengthened to reduce the backlog of appeals.

Although the organisation had an overall performance achievement of 97% there were some areas with partial achievement.

In the ICT&KM sub-programme there was security incident that was identified during the period which led to the sub-programme underperforming its indicator. Non-sensitive or proprietary code was shared in violation of CMS policy by an internal staff member. Disciplinary action was taken against the individual.

In the Human Resources sub-programme, one of the 16 vacancies took longer than 120 days to fill. The delay in filling this vacancy was due to internal dispute on how best to fill the position. The appointment of the successful candidate had to be placed on hold until the matter was resolved. The matter was eventually resolved and the position was filled.

The sub-programme also had a challenge in attracting and appointing persons with disabilities. This led to a deviation in CMS achievement of its BBBEEA target of 85%.

Fourteen employees did not have signed performance agreements in place as at 31 May 2017, due to urgent operational matters that required attention. These contracts were finalised in the second quarter of the financial year.

In the Strategy Office programme there was a partial achievement in terms of submission of the draft Prescribed Benefit Package to Council. A review on the PMB package had not been done for a number of years and there was a large volume of work that had to be processed. The project also started late in the year leaving the unit with very little time to develop the draft benefit package framework in time for submission to Council in March 2018. Submission of the draft package to the Council EXCO Sub-Committee was made on 30 May 2018. Now that a significant amount of base-line work has been done on the PMB benefit package, the required biennial review will be less challenging in future.

In the Accreditation programme there was one renewal application that was completed but could not be served at the EXCO meeting due to the there being no Executive Committee meeting scheduled during the last quarter of the financial year. An EXCO meeting is scheduled to take place in the first quarter of the new financial year.

The programme received a qualification due to the system on broker accreditation not being configured to generate a report which illustrated the total number of brokers and broker organisations that were accredited within 21 working days of receipt of the complete application. The identified double reporting on broker accreditation was as a result of 21 applications being handled administratively by the unit, which were double counted by the system. This did not pose a substantial risk as the system prevents any adverse effect on the accreditation status of the brokers involved and what is published on the website. The unit will be enhancing the system to introduce a totally revised and integrated accreditation system.

In the Complaints Adjudication programme there was partial achievement on the resolution of complaints. The programme was faced with capacity constraints during the year caused by the resignation of one staff member as well as another staff going on maternity leave. This resulted in increased workload for the remaining staff which led to a build-up in the complaints backlog. The unit has acquired the services of temporary staff with paralegal qualification in order to assist in resolving non-complex complaints. The temporary staff joined the unit on 10 May 2018 and the contract is for a period of six (6) months.

PROGRAMME 1: ADMINISTRATION

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: CE and Registrar

The CEO is the executive officer of the Council for Medical Schemes delegated with the mandate of exercising overall management of the office, and as Registrar, exercises legislated powers to regulate medical schemes, administrators, brokers, and managed care organisations.

Table 1: Budget of Sub-programme 1.1

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	2 511	1 591	920	1 414	409	1 005
Council Committees	105	89	16	197	142	55
Council Members Fees	1 489	1 270	219	1 595	1 302	293
Courier and Postage	60	63	(3)	64	64	-
Donations	4	-	4	4	-	4
Employee Wellness	1	-	1	1	-	1
International Partnership Program	200	-	200	224	-	224
Refreshments	25	-	25	-	-	-
Staff Training	80	88	(8)	231	83	148
Stationery	44	22	22	47	17	30
Labour Relations	-	-	-	5 000	6 605	(1 605)
Transcription Services	77	63	14	82	134	(52)
Travel	517	336	181	553	1 207	(654)
Venue and catering	234	279	(45)	278	377	(99)
SUB TOTAL	5 347	3 801	1 546	9 690	10 340	(650)
Salaries	5 915	2 699	3 216	6 136	1 932	4 204
TOTAL	11 262	6 500	4 762	15 826	12 272	3 554

Sub-programme 1.2: Office of the CFO

The purpose of the sub-programme is to serve all business units in 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 Internal Finance unit also serves the Audit and Risk Committee, internal auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, we help Council to be a reputable Regulator.

Table 2: Key performance indicators, planned targets and actual achievements of Sub-programme 1.2

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 1.2.3.1: Ensure effective financial management and alignment of budget allocation with strategic priorities							
An unqualified opinion issued by the Auditor-General on the annual financial statements by 31 July each year	1	1	1	1	1	-	
An unqualified opinion issued by the Auditor-General on the annual performance information by 31 July each year	1	1	1	1	1	-	
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risk exposure of the CMS							
Number of strategic risk register reports submitted to Council for monitoring, per year	New indicator	4	4	4	4	-	

1. CMS received an unqualified opinion on its annual financial statements for 2016/2017.
2. CMS received an unqualified opinion on its annual performance information report for 2016/2017.

Achievement of strategic objective

The Council manages its finances under the direction of the Public Finance Management Act, No 1 of 1999 (PFMA). The controls that CMS has put in place for effective and efficient management of its finances need further improvement, especially in the area of Supply Chain Management.

Internal auditors were appointed in December 2017. The Audit and Risk Committee approved a three-year rolling plan of the internal auditors during the year under review.

A strategic risk assessment workshop was held during the year with Council, Audit and Risk Committee, and management. Strategic risks were monitored by all governance structures during the year.

The CMS submitted its Annual Performance Plan for 2018/19 financial year on 31 January 2018. Approval of the plans and budget for 2018/19 was received from the Executive Authority.

The office issued four tenders. Three tenders were awarded in accordance with National Treasury regulations.

Strategy to overcome areas of underperformance

Areas of underperformance in the sub-programme were noted in relation to Supply Chain Management. A remedial approach to strengthen internal controls for supply chain processes will be implemented.

Changes to planned targets

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

Linking performance with budgets

Table 3: Budget of Sub-programme 1.2

	2016/17			2017/18		
Description	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Amortisation	534	498	36	-	646	(646)
Bank Charges	49	100	(51)	138	117	21
Cleaning and Gardening	815	778	37	477	422	55
Consulting Fees	742	789	(47)	195	203	(8)
Courier and Postage	42	15	27	42	3	39
Depreciation	1 890	3 931	(2 041)	-	4 260	(4 260)
Employee Benefits	2 048	2 026	22	2 238	2 405	(167)
Employee Wellness	3	-	3	3	-	3
External Audit Fees	1 034	581	453	886	697	189
General Expenses and Administration	363	300	63	228	256	(28)
Insurance	339	410	(71)	454	481	(27)
Internal Audit Fees	1 167	204	963	700	779	(79)
Operating Costs-Landlord	1 971	1 971	-	2 138	2 138	-
Printing & Publication	75	187	(112)	169	127	42
Refreshments	49	70	(21)	-	-	-
Rent	11 639	11 492	147	11 527	11 625	(98)
Rental Other Assets	13	16	(3)	16	16	-
Repairs and Maintenance Office	150	164	(14)	208	204	4
Staff Training	200	107	93	71	95	(24)
Stationery	84	76	8	95	109	(14)
Subscriptions	12	9	3	20	24	(4)
Travel	6	34	(28)	36	33	3
Venue and Catering	54	19	35	35	65	(30)
Water & Electricity, Rates & Levies	1 185	1 300	(115)	1 398	1 294	104
Workmen's Compensation	151	151	-	160	160	-
SUB TOTAL	24 615	25 228	(613)	21 234	26 159	(4 925)
Salaries	8 479	8 770	(291)	9 540	9 565	(25)
TOTAL	**33 094**	**33 998**	**(904)**	**30 774**	**35 724**	**(4 950)**

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.

Table 4: Key performance indicators, planned targets and actual achievements of Sub-programme 1.3

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 1.3.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected.							
Percentage of network and server uptime, per year	97.05%	99.5%	99.7%	97%	99.45%	2.45%	The positive deviation was due to stability of systems brought about by virtualisation.
Percentage of IT security incidents, per year	New indicator	New indicator	1.1%	0%	0.27%	0.27%	The deviation was due to a single security incident where non-sensitive or proprietary code was shared in violation of policy, leading to disciplinary action and dismissal.
Strategic Objective 1.3.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance							
Percentage of uptime, of all installed application systems where network access exists, per year	98.23%	99%	99.7%	99%	99.47%	0.47%	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 1.3.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing							
Percentage of physical requests for information received and responded to within 30 days, per year	274	350	98% (244/249)	80%	97.5%	17.5%	The target was exceeded as most of the information requested was readily available on online databases which CMS subscribes to.

Achievement of strategic objectives

During the period under review, the CMS ICT and Knowledge Management Unit experienced a single down-time event which caused the mail servers to be down for two days. This, however, did not have an influence on business continuity as our Mimecast solution provided business with uninterrupted access to mail. Besides this single event, no other major server or network downtime was experienced. A stable environment ensured that information was always available and accessible. The environment was further strengthened by successfully concluding several projects such as the successful replacement of old and redundant switches and the addition of equipment such as a new storage area network, as well as by enrolling all staff on the Microsoft Secure Productive Enterprise and by successfully concluding a disaster recovery exercise, and receiving a compliance certificate as a result.

The 0% target for security incidents was not achieved, mainly due to a single security incident where an employee shared non-sensitive or proprietary code on a social media platform in violation of IT policy. This transgression led to a disciplinary process that resulted in the dismissal of the employee. It must be noted that no security breaches occurred during the period and that the security was further strengthened by the successful rollout of data loss prevention to all user workstations as well as new agents for patch deployment.

Software application systems remained stable and the target of 99% was exceeded by achieving a result of 99.5%%. A slight downtime was experienced on the document management system due to a disk space constraint, but this was fixed in a relatively short space of time. The unit succeeded in providing software applications that served all our stakeholders and which contributed to improving operations and performance. Some of these included maintaining and refining existing systems such as the financial, utilisation and auditor returns, while others required developing new systems of strategic importance, such as the National Beneficiary Registry of funded patients.

As far as knowledge management is concerned, the unit achieved a performance target of 97.5%, thereby exceeding the planned target by 17.5%. This was due to the different online databases which the unit subscribes to, which made information more readily accessible within the allotted time frames. Apart from this, the unit also successfully subscribed to additional online databases, ensured full compliance to the Protection of Personal Information Act, No 4 of 2013 (POPI), developed a new Knowledge Management Policy and completed the bureau scanning of documents, thereby further improving knowledge management within the CMS.

Strategy to overcome areas of underperformance

The single IT Security incident reported can mainly be ascribed to a transgression of existing IT Policies. To this effect, a renewed effort will be undertaken to:

a. Refine and rewrite policies where applicable to make them simpler to understand and implement.
b. Undertake a staff awareness and education drive.

To date, the CMS does not have a disaster recovery solution (in the form of a hot or warm site) in place. Having such a solution in place would have averted the downtime experienced with mail servers as well as the downtime experienced on the M-Files ECM solution. A disaster recovery solution system would have been able to serve as a failover, a mechanism to allow for the switch to a standby computer server. It is envisaged that a warm remote site for Disaster Recovery will be established in the 2018/2019 year. A tender process for this purpose was started in 2017, but the tender ended towards the end of 2017 without awarding of the tender to any bidder, mainly due to incomplete proposals having been submitted by bidders. The tender will be re-advertised in early June 2018.

Changes to planned targets

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

Linking performance with budgets

Table 5: Budget of Sub-programme 1.3

	2016/17			2017/18		
Description	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Computer Expenses	86	104	(18)	126	88	38
Consulting Fees	540	222	318	254	89	165
Copy Costs	280	196	84	283	177	106
Employee Wellness	4	-	4	4	-	4
External Storage	360	339	21	431	366	65
Internet Expenses	437	235	202	447	448	(1)
Knowledge Management	733	791	(58)	776	940	(164)
Printing	6	8	(2)	7	7	-
Rental Copiers	402	399	3	424	396	28
Repairs and Maintenance/SLA	799	490	309	845	633	212
Security	441	431	10	602	362	240
SEP System Expenses	-	595	(595)	-	468	(468)
Software License Subscription	2 727	1 606	1 121	4 579	2 841	1 738
Staff Training	180	187	(7)	163	177	(14)
Stationery	5	10	(5)	6	6	-
Subscriptions	-	4	(4)	-	14	(14)
Telephone and Fax	702	407	295	561	424	137
Travel	16	26	(10)	42	37	5
Venue and Catering	5	27	(22)	12	13	(1)
SUB TOTAL	**7 723**	**6 077**	**1 646**	**9 562**	**7 486**	**2 076**
Salaries	9 510	8 295	1 215	10 705	9 866	839
TOTAL	**17 233**	**14 372**	**2 861**	**20 267**	**17 352**	**2 915**

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 vision.

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 CMS remains an employer of choice.

Table 6: Key performance indicators, planned targets and actual achievements of Sub-programme 1.4

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic objective 1.4.3.1: Build competencies and retain skilled employees							
Minimise staff turnover rate to less than 10% per annum	3.88%	9%	4.42%	<10%	7.1%	2.9%	The staff turnover rate remained at less than 10%.
Turnaround time to fill a vacancy (Turnaround time of 120 working days to fill a vacancy that exists during the year)	There were 7 out of 10 positions that took longer than the 90 days to fill	There were 3 out of 9 positions that took longer than the 90 days to fill	There were 5 out of 14 positions that took longer than the 90 days to fill	120 days	There were 16 vacancies during the period under review. 11 were filled within 120 days, recruitment process was underway for 4 posts, and 1 post took longer than 120 days to fill.	1	The selection process for the Senior Developer was placed on hold due to an internal dispute. The appointment was made effective from 1 October 2017.
Senior Compliance Officer 23 January 2017	-	-	-	120 days	66 days	-	
Senior Benefits Analyst 23 January 2017	-	-	-	120 days	88 days	-	
Senior Researcher 1 April 2017	-	-	-	120 days	39 days	-	
Senior Accreditation Analyst 2 May 2017	-	-	-	120 days	43 days	-	
Senior Legal Adjudication Officer 1 June 2017	-	-	-	120 days	21 days	-	
Legal Advisor 1 February 2017	-	-	-	120 days	101 days	-	
Data Management Analyst 1 June 2017	-	-	-	120 days	21 days	-	
Accreditation Analyst 1 June 2017	-	-	-	120 days	46 days	-	
Legal Adjudication Officer 1 April 2017	-	-	-	120 days	85 days	-	
Legal Adjudication Officer 1 July 2017	-	-	-	120 days	43 days	-	

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Labour Relations Officer 1 April 2017	-	-	-	120 days	102 days	-	
Senior Developer 23 January 2017	-	-	-	120 days	172 days	52 days	The selection process was placed on hold after NEHAWU's protest. Incumbent commenced on 1 October 2017.
Supply Chain Management Officer 28 October 2017	-	-	-	120 days	97 days	-	
Junior Developer 15 December 2017	-	-	-	120 days	63 days	-	
GM: Stakeholder Relations 11 December 2017	-	-	-	120 days	67 days	-	
Senior Investigator 2 January 2018	-	-	-	120 days	62 days	-	
Achievement of Employment equity targets (according to BBBEEA targets), annually	88%	94%	91.45%	85%	79.82%	5.18%	Attracting and appointing people with disabilities remains a challenge. Focus will be directed to appointing people with disabilities to align with the BBBEEA scorecard.
Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture							
100% of employee performance agreements are signed by no later than 31 May of each year	New indicator	New indicator	100%	100%	86%	14%	The signing of some performance contracts was delayed due to operational matters.
Percentage of employee performance assessment concluded, bi annually*	New indicator	New indicator	100%	100%	100%	-	

Achievement of strategic objective

Fraud and corruption represents a significant potential risk to CMS assets, service delivery efficiency, reputation and overall sustainability. CMS vetted employees in terms of its fraud and corruption policy. Qualification verifications were conducted on all existing employees and all candidates shortlisted and invited to attend interviews.

The CMS appointed 12 competent personnel in various positions within the organisation during 2017/18. To empower young graduates with experience and assist with temporary workloads, 15 interns were appointed during the same period.

A comprehensive climate survey was conducted. The survey yielded a 65% response rate from the total workforce. The aim was to establish the engagement and motivation levels of employees, highlighting concerns and/or providing positive feedback to allow the office to identify priority areas for improvement.

A staff retention rate of 93% was achieved during the year under review. To ensure that the CMS remains an employer of choice, a comprehensive job evaluation and salary benchmarking exercise was concluded to ensure that all positions are appropriately classified and aligned to achieve internal and external equity.

Strategy to overcome areas of under performance

There was an increase in the staff turnover rate from 4.7% to 7.1% during the

year under review. This was due to death, career advancement and summary dismissals. To reduce the turnover rate, the organisation will review its remuneration philosophy during 2018/19, and review the current training and development framework, with a view to developing a new five-year learning and development strategy for implementation between 2018 and 2023.

Attracting and appointing people with disabilities remains a challenge. Currently, the organisation has a 0% achievement score for this target, missing the national target by 2%. Priority will be given to attract people with disabilities during the new financial year to meet the employment equity target.

The position of the CE & Registrar has been vacant since 22 January 2017. The recruitment process for the appointment of the CE & Registrar resides with the Executive Authority. The CMS awaits this appointment.

Changes to planned targets

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

Linking performance with budgets

Table 7: Budget of Sub-programme 1.4

	2016/17			2017/18		
Description	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	453	286	167	947	568	379
Donations	50	39	11	54	12	42
Employee Wellness	418	326	92	654	379	275
Motor Vehicle -Expenses	51	58	(7)	49	44	5
Recruitment and Relocation	450	503	(53)	415	308	107
Refreshments	-	-	-	132	76	56
Staff Training	100	107	(7)	86	53	33
Stationery	12	11	1	21	15	6
Subscriptions	63	141	(78)	149	162	(13)
Temp Services	222	309	(87)	666	791	(125)
Transcription Services	-	-	-	-	11	(11)
Travel	21	13	8	22	24	(2)
Venue and catering	120	131	(11)	167	118	49
SUB TOTAL	**1 960**	**1 924**	**36**	**3 362**	**2 561**	**801**
Salaries	4 016	4 123	(107)	4 620	4 923	(303)
TOTAL	**5 976**	**6 047**	**(71)**	**7 982**	**7 484**	**498**

Sub-programme 1.5: Legal Services

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

Table 8: Key performance indicators, planned targets and actual achievements of Sub-programme 1.5

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office							
Number of written and verbal legal opinions provided to internal and external stakeholders, per year	New indicator	205	100% (175)	190	267	77	Due to the unpredictable nature of this objective the projected number was exceeded.
Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar							
Percentage of court and tribunal appearances in legal matters received and handled by the unit, per year	24	21	100% (25)	100% (25)	100% (17)	- (8)	The unpredictable nature of this objective resulted in less matters being received than was anticipated.

Achievement of strategic objective

The CMS Legal Services Unit has consistently outperformed and exceeded its set targets. 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 CMS.

The tracking of relevant laws and judgements ensured that current legislative developments and jurisprudence were able to be taken into account when making decisions.

The unit assisted in trustee training workshops. Trustee training created awareness of the need for good corporate governance and by so doing ensured sound compliance with the CMS mandate and the law.

Strong legal capacity has enabled CMS to enforce its statutory mandate with an exemplary success rate. CMS has been able to consistently maintain 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 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 for the sub-programme during the year under review.

Linking performance with budgets

Table 9: Budget of Sub-programme 1.5

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Employee Wellness	1	-	1	1	-	1
Legal Fees	6 922	7 888	(966)	10 110	8 355	1 755
Staff Training	86	74	12	83	69	14
Stationery	4	2	2	5	4	1
Subscriptions	3	6	(3)	4	3	1
Travel	60	79	(19)	31	33	(2)
Venue and Catering	2	1	1	4	2	2
SUB TOTAL	7 078	8 050	(972)	10 238	8 466	1 772
Salaries	3 779	3 575	204	4 041	3 939	102
TOTAL	10 857	11 625	(768)	14 279	12 405	1 874

PROGRAMME 2: STRATEGY OFFICE

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

Table 10: Key performance indicators, planned targets and actual achievements Sub-programme 2

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected							
The number of benefit definitions published, per year	11	12	10 CMS scripts 7 PMB definitions	10	10	-	
Conduct a review of the prescribed minimum benefits (PMB), every two years	New indicator	New indicator	New indicator	Submission of a costed draft PMB benefit package to Council	Draft costed PMB benefit package completed but not submitted to Council	Submission was not made to Council	The draft PMB benefit package was completed during quarter 4 but was not submitted to Council. The package will be presented at the Council meeting in May 2018.
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries							
Percentage of clinical opinions reviewed within 30 working days of receipt from Complaints Adjudication	623	938	40%	90%	98%	8%	The Clinical Unit exceeded targets set for this year for clinical opinions reviewed under 30 working days.
Percentage of clinical opinions reviewed within 60 working days of receipt from Complaints Adjudication	New indicator	New indicator	New indicator	95%	100%	5%	The Clinical Unit exceeded targets set for this year for clinical opinions reviewed under 60 working days.
Percentage of clinical opinions reviewed within 90 working days of receipt from Complaints Adjudication	New indicator	New indicator	New indicator	98%	100%	2%	The Clinical Unit exceeded targets set for this year for clinical opinions reviewed under 90 working days.
Percentage of clinical enquiries received via e-mail or telephone resolved within 7 days	New indicator	New indicator	99%	95%	99%	4%	The Clinical Unit exceeded targets set for this year for clinical enquiries reviewed under 7 working days.
Strategic Objective 2.4.1: Conduct research to inform appropriate national health policy interventions							
Number of research projects and support projects published in support of the National Health Policy, per year	New indicator	New indicator	New indicator	5	11	6	The unit received additional requests for research and support projects.

Achievement of strategic objective

The Prescribed Minimum Benefits (PMB) review is a multi-stakeholder driven process which began late in the financial year due to uncertainty in developments in national health policy. Despite the delays, the unit managed to compile a draft PMB benefit package.

The following PMB benefit definitions were published:

- Appendicitis
- Gastric or intestinal ulcers
- Hepatocellular cancer
- Hernias
- Colorectal cancer (early stage and advanced stage)
- Non-small cell lung cancer
- Small cell lung cancer
- Mesothelioma
- Medical nutrition therapy in palliative care setting for adults

The publication of the above funding guidelines was aimed to clarify scheme members' entitlements while ensuring fewer complaints and enquiries; and the speedy resolution of medical management or payment related issues.

The CMS Clinical Unit also undertook special research projects in support of national health policy so as 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). Between April 2017 and March 2018, the unit published 11 research reports and coordinated the submission of three reports by the Research and Monitoring Unit, as well as seven written responses to questions raised by the Health Market Inquiry (HMI) technical team. These reports were either published on the HMI website, in CMS News or in newspaper articles. All these publications informed policy debates and discussions on risk pool fragmentation, adverse selection, National Health Insurance, designated service provider arrangements, health quality outcomes, regulatory framework for tariff negotiation, the Private Establishment Licensing Framework, or provided input to the contribution increase guideline.

Strategy to overcome areas of underperformance

The review of PMB regulations has been an area of underperformance. CMS has not achieved a successful review in the last 18 years. The current review, which began in 2016, is aimed at addressing the flaws and inadequate protection (associated with the PMB regulation) that medical schemes offer their members. The following activities were undertaken for the 2017/2018 financial year:

- Broad-based stakeholder consultation PMB review committee meetings.
- Framework for revised PMB benefit package.
- Costing of new PMB benefit package.

There was a large volume of work that had to be processed and the project also started later in the year, leaving the unit with very little time to develop the draft benefit package framework in time for submission to Council in March 2018. Submission of the draft package to Council will be made on 31 May 2018. The PMB benefit package should be reviewed every two years; a complete review in the 2017/18 financial year will assist with future updates.

Changes to planned targets

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

Linking performance with budgets

Table 11: Budget of Programme 2

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	336	349	(13)	875	1 070	(195)
Employee Wellness	3	-	3	3	-	3
Staff Training	200	198	2	101	100	1
Stationery	8	9	(1)	7	9	(2)
Subscriptions	-	15	(15)	-	14	(14)
Travel	186	152	34	208	172	36
Venue and Catering	70	30	40	60	81	(21)
SUB TOTAL	**803**	**753**	**50**	**1 254**	**1 446**	**(192)**
Salaries	7 546	7 541	5	9 103	10 017	(914)
TOTAL	**8 349**	**8 294**	**55**	**10 357**	**11 463**	**(1 106)**

PROGRAMME 3: ACCREDITATION

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

Table 12: Key performance indicators, planned targets and actual achievements of Programme 3

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 3.2.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services							
Number of brokers and broker organisations accredited within 21 working days of receipt of complete applications	5 027	5 634	4854	4 045	5500	1455	Partially achieved.
Strategic Objective 3.2.2: Accredit managed care organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined							
Number of managed care organisation applications accredited within 3 months of receipt of all relevant information	26	16	21	15	15	-	
Strategic Objective 3.2.3: Accredit Administrators and issue compliance certificates to self-administered schemes based on their compliance with the accreditation requirements in order to provide administration services							
Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information	9	13	14	8	6	2	One administrator elected not to renew accreditation during the year, the company was deregistered in 2017 and one renewal application had to be carried forward to Q1 of 2018/19 as no Executive Committee (EXCO) meeting took place in Q4 of 2017/18.

Achievement of strategic objective

Third party administrators and self-administered schemes: Applications in respect of five organisations and one self-administered medical scheme were evaluated and finalised during the year. On-site evaluations were conducted in respect of three administrators and one self-administered medical scheme. The CMS 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.

Managed care organisations: Applications were received from three new entrants and 12 existing organisations in respect of renewing their accreditation. On-site evaluations were conducted in respect of three organisations and one self-administered medical scheme. The 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.

Managed Care Theme Project measuring the impact of managed care interventions: This project seeks to effectively demonstrate and evaluate the value of managed care services rendered to beneficiaries of medical schemes. Eleven conditions were finalised in collaboration with stakeholders during the year under review with completed data specifications in respect of entry level criteria, process indicators and health outcomes. Since the start of the project all 25 prescribed chronic diseases as part of the PMBs, have now been completed.

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 collect 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 deviation with regard to accreditation of administrators was due to there being no Executive Committee meeting scheduled during the last quarter of the financial year. An EXCO meeting is scheduled to take place in the first quarter of the new financial year.

The deviation in broker accreditation was due to the system not being configured to generate a report which illustrated the total number of brokers and broker organisations that were accredited within 21 working days of receipt of complete application. The identified double reporting on broker accreditation was as a result of 21 applications being handled administratively by the unit, which were double counted by the system.

This did not pose a substantial risk as the system prevents any adverse effect on the accreditation status of the brokers involved and what is published on the website. The unit will be enhancing the system to introduce a totally revised and integrated accreditation system. An entity that elects not to renew its application falls outside the control of the unit.

Changes to planned targets

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

Linking performance with budgets

Table 13: Budget of Programme 3

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Employee Wellness	3	-	3	3	-	3
Staff Training	200	38	162	100	27	73
Stationery	62	52	10	35	28	7
Subscriptions	78	70	8	166	100	66
Travel	521	246	275	218	51	167
Venue and Catering	6	2	4	73	25	48
SUB TOTAL	**870**	**408**	**462**	**595**	**231**	**364**
Salaries	7 714	7 817	(103)	8 427	9 032	(605)
TOTAL	**8 584**	**8 225**	**359**	**9 022**	**9 263**	**(241)**

PROGRAMME 4: RESEARCH AND MONITORING

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

Table 14: Key performance indicators, planned targets and actual achievements of Programme 4

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions							
Number of research projects and support projects finalised, per year	11	10	10	7	9	2	There was a requirement during the year for additional two projects.
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice							
Non-financial report submitted for inclusion in the annual report	1	1	1	1	1	-	

Achievement of strategic objective

For the period under review, the Research and Monitoring Unit successfully completed nine research and support projects, as follows:

- **Scheme risk measurement:** The report was published and it is clear that schemes do not compete at the same level. There are significant differences in the risk profiles of medical schemes, which confirm the need for a system of risk adjustment.
- **Evaluation of efficiency discount benefit options:** This discussion document could inform future work on the consolidation of benefit options in the industry.
- **Analysis of utilisation statistics:** This database is populated with utilisation data from two different systems per year per discipline. The database has been designed to assist the unit to monitor trends in healthcare utilisation and could support the HMI in its analysis.
- **Measuring patient experience:** The research published in this document was completed and a questionnaire developed to collect data from beneficiaries with diabetes. Patient experience is an important variable in measuring the value proposition of managed care and when finalised, the results could be incorporated in the calculation to measure value. Value is a function of quality over cost.
- **Allocation of healthcare human resources in the medical scheme industry per discipline:** This document could inform the NHI process.
- **Medical scheme inflation:** This discussion document could inform future work and help understand the components of the consolidation of benefit options in the industry.
- **Quality of care in medical schemes:** This report will be useful to medical schemes that require a benchmark to compare the performance of their contracted managed care organisation (MCO) with other MCO's in the industry.
- **Transformation:** The output of the transformation project was a technical situation analysis of transformation among stakeholder institutions operating in the medical schemes industry.
- **Trends in HIV/AIDS and the value of HIV/AIDS management programmes:** The quality of care in medical schemes report gives a detailed overview in the trends of HIV prevalence and treatment, and quality outcomes based on process indicators for the population registered in HIV/AIDS management programmes.

The publication of the 'Prevalence of Chronic Conditions and Evaluation of Cost Increase assumptions' will follow in the first quarter of 2018/19.

The research projects were all relevant and some of the results were shared with the Health Market Inquiry (HMI), while others will be used to inform the consolidation of benefit options moving towards the National Health Insurance (NHI). Important work was also done on the status of transformation in the private medical scheme industry. Going forward the quality of care, or more specific the value proposition of managed care will become more important and, as the regulator, CMS must make sure that all beneficiaries of medicals schemes receive the correct level of care.

The unit was successful in the finalisation of the non-financial section of the annual report and received positive feedback from the industry.

The unit adapted a philosophy of continuous improvement with focus on data quality. The unit held several one-on-one workshops with schemes and administrators to assist them with the Annual Statutory Return (ASR) submissions. The unit is confident that there will be an improvement in the ASR submissions in future.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the programme.

Changes to planned targets

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

Linking performance with budgets

Table 15: Budget of Programme 4

	2016/17			2017/18		
Description	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	27	10	17	94	-	94
Employee Wellness	3	-	3	3	-	3
Staff Training	230	159	71	74	87	(13)
Stationery	3	1	2	3	3	-
Subscriptions	10	13	(3)	11	12	(1)
Travel	45	67	(22)	143	48	95
Venue and Catering	26	44	(18)	28	3	25
SUB TOTAL	**344**	**294**	**50**	**356**	**153**	**203**
Salaries	7 018	6 417	601	6 517	6 261	256
TOTAL	**7 362**	**6 711**	**651**	**6 873**	**6 414**	**459**

PROGRAMME 5: STAKEHOLDER RELATIONS

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

Table 16: Key performance indicators, planned targets and actual achievements of Programme 5

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 5.2.1: Create awareness and provide training in order to enhance the visibility and reputation of CMS							
Percentage of member awareness of CMS resulted from survey, in alternate years	New indicator	New indicator	40.3%	n/a	n/a	n/a	Not applicable for the year under review.
Number of stakeholder training and awareness sessions, per year	New indicator	46	55	20	59	39	The Stakeholder Relations Unit received an increased number of invitations for information sessions from Government departments during the year under review, relating to premiums and benefits issues regarding GEMS.
Strategic Objective 5.2.2: Communication and engagement to inform and empower stakeholders							
Submission of CMS Annual report by 31 August to the Executive Authority	1	1	1	1	1	-	
Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year	72.9%	94%	97%	75%	93%	18%	Stakeholder engagement activities undertaken by the CMS contributed to an increased level of positive/neutral feedback on the CMS reputation.

Achievement of strategic objective

Through education and training initiatives, an increased number of consumers were able to learn about members' rights and obligations relating to medical schemes. The Northern Cape was extensively covered during the period under review. Awareness initiatives were held in all provinces.

The annual report was delivered to the Executive Authority before 31 August 2017, for tabling in Parliament as per statutory requirement. The report is one of CMS' major tools used for sharing information with stakeholders on key industry developments and trends.

Increased media activities regarding some of the initiatives undertaken by CMS has resulted in a higher positive/neutral sentiment towards the CMS brand.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the programme.

Changes to planned targets

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

Linking performance with budgets

Table 17: Budget of Programme 5

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	-	42	(42)	-	-	-
Courier and Postage	10	-	10	11	10	1
Employee Wellness	3	13	(10)	7	8	(1)
Exhibition Costs	100	97	3	100	38	62
Media and Promotion	2 986	3 397	(411)	3 332	3 434	(102)
Printing and Publication	1 524	873	651	820	878	(58)
Staff Training	220	146	74	115	75	40
Stationery	10	6	4	12	11	1
Subscriptions	10	22	(12)	11	11	-
Travel	505	393	112	696	308	388
Venue and Catering	395	330	65	318	340	(22)
SUB TOTAL	**5 763**	**5 319**	**444**	**5 422**	**5 113**	**309**
Salaries	7 112	7 205	(93)	7 893	8 017	(124)
TOTAL	**12 875**	**12 524**	**351**	**13 315**	**13 130**	**185**

PROGRAMME 6: COMPLIANCE AND INVESTIGATION

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

Table 18: Key performance indicators, planned targets and actual achievements of Programme 6

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 6.2.1: Regulated entities comply with Legislation							
Percentage of non-compliance cases against regulated entities undertaken, per year	52	82	100% (39)	100% (35)	100% (72)	100% (37)	All matters that related to non-compliance against regulated entities were attended to.
Strategic Objective 6.2.2: Strengthen and monitor governance systems							
Percentage of governance interventions implemented, per year	88	55	100% (105)	100% (82)	100% (108)	100% (26)	All matters that required enforcement of governance systems were attended to.

Achievement of strategic objective

The primary mandate of the Council for Medical Schemes (CMS) is to protect the beneficiaries of medical schemes. The CMS Compliance and Investigation Unit was able to intervene timeously and appropriately in instances where the rights of members were under threat of being compromised. The enforcement of rulings on members' complaints and other governance irregularities contributed to the attainment of the unit's strategic objective. The strengthening of governance of medical schemes necessitated the institution of routine inspections in order to monitor compliance with the Medical Schemes Act. Where irregularities were identified, the unit instituted commissioned inspections and, where

necessary, appropriate intervention was implemented in a form of remedial action. The unit carried out a total of 23 inspections during the period under review. Of the 23, six were commissioned inspections and 17 were routine inspections.

The Compliance and Investigation Unit Demarcation assessed exemption applications received from insurance entities and their financial services providers (FSPs). The unit could not predict how many submissions it would receive as there were, at the time, no baseline statistics indicating how many insurance entities and FSP were in existence. The unit is still in the process of identifying entities doing the business of a medical scheme.

The unit began monitoring medical scheme annual general meetings (AGMs) in the 2011 financial year after noting an increased number of AGMs that were disrupted by members who were disgruntled with the process that schemes followed in convening general meetings; litigation over the integrity of the election process of trustees and the spiraling cost of holding AGMs. On the other hand, member attendance at AGMs continued to dwindle. The unit has continued to monitor various scheme AGMs with the purpose of ensuring that AGM meeting proceedings are convened according to the rules of the scheme and trustee elections are conducted accordingly. In the past financial year, the unit was able to attend and monitor more AGM's due to the increase in the unit's staff complement.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the programme.

Changes to planned targets

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

Linking performance with budgets

Table 19: Budget of Programme 6

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Cellphone Contracts	9	9	-	-	-	-
Consulting Fees	795	1 957	(1 162)	1 994	11 924	(9 930)
Employee Wellness	3	-	3	3	-	3
Printing	572	12	560	-	3	(3)
Staff Training	160	134	26	85	60	25
Stationery	7	8	(1)	18	9	9
Subscriptions	71	19	52	75	24	51
Travel	154	173	(19)	169	127	42
Venue and Catering	22	-	22	16	3	13
SUB TOTAL	**1 793**	**2 312**	**(519)**	**2 360**	**12 150**	**(9 790)**
Salaries	7 255	6 624	631	7 415	7 477	(62)
TOTAL	9 048	8 936	112	9 775	19 627	(9 852)

PROGRAMME 7: BENEFIT MANAGEMENT

The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. We analyse and approve all other rules to ensure consistency with the Medical Schemes Act This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this we help the Council for Medical Schemes ensure that the rules of medical schemes are fair to beneficiaries and are consistent with legislation the Act.

Table 20: Key performance indicators, planned targets and actual achievements of Programme 7

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objectives 7.2.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act							
Percentage interim rule amendments processed within 14 working days of receipt of all information, per year	New indicator	New indicator	87% (88 out of 101)	80% (129)	96.3% (104/108)	16.3% (4)	104 interim rule amendments were processed within 14 days of receipt. There were 4 submissions that were completed after 14 working days had elapsed.
Percentage of annual rule amendments processed before 31 December of each year	New indicator	New indicator	98.9% (90)	100% (83)	100% (91)	100% (8)	All rule amendments received were processed

Achievement of strategic objective

The registering of rules contributes to the goal of the CMS to ensure that schemes are regulated efficiently and that the rules registered are legally sound and not unfair to members. There are two different sets of rules that are processed by the unit: the first relates to interim rule amendments relating the general rules regarding the operation of the schemes and governance. The second relates to the approval of rules relating the benefit changes and contribution increases that the schemes implement in a new calendar year.

The CMS Benefit Management Unit contributed to the overall objective of the CMS to ensure that medical schemes were governed in a fair and efficient manner. The achievement of the target ensures that medical scheme rule amendments are processed within the timeframes adopted and that schemes receive feedback timeously in order to ensure that they operate effectively.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the programme.

Changes to planned targets

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

Linking performance with budgets

Table 21: Budget of Programme 7

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Employee Wellness	3	-	3	3	-	3
Printing	5	15	(10)	15	5	10
Staff Training	80	48	32	70	56	14
Stationery	11	11	-	9	7	2
Subscriptions	20	17	3	19	19	-
Travel	25	23	2	20	11	9
Venue and Catering	-	-	-	-	2	(2)
SUB TOTAL	**144**	**114**	**30**	**136**	**100**	**36**
Salaries	6 144	5 523	621	6 261	6 421	(160)
TOTAL	**6 288**	**5 637**	**651**	**6 397**	**6 521**	**(124)**

PROGRAMME 8: FINANCIAL SUPERVISION

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

Table 22: Key performance indicators, planned targets and actual achievements of Programme 8

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 8.2.1: Monitor and promote the financial soundness of medical schemes							
Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per year	100%	100%	100%	100%	100%	-	
Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	New indicator	100%	-	100%	100%	-	
Percentage of auditor applications authorized or rejected, per year	New indicator	New indicator	New indicator	100%	100%	-	
Number of Quarterly financial return reports published (excluding quarter 4), per year	3	3	3	3	3	-	
Number of financial sections prepared for the Annual Report	1	1	1	1	1	-	

Achievement of strategic objective

The strategic objective of the CMS Financial Supervision Unit is to monitor and promote the financial soundness of medical schemes. Regulation 29 of the Medical Schemes Act prescribes that the minimum accumulated funds of medical schemes should be at least 25.0% of gross contributions. The unit has a mandate to ensure that it identifies schemes that are below the prescribed solvency ratio and those that have a rapidly reducing solvency 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 ratio 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 unit used the following tools to monitor the financial soundness of medical schemes:

- **Annual financial statements as per section 37 of the Medical Schemes Act**
  These statutory returns reveal the historical financial performance and position of medical schemes; their ability to continue operating into the foreseeable future, as well as 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.

- **Auditor application authorisation**
  The annual financial statements are required to be audited in terms section 37(3). 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 CMS Financial Supervision 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.

Quarterly Return System

- The Quarterly Return System serves as the core of the CMS Early Warning System and enables the continuous monitoring of schemes in between audit cycles. It enables CMS to respond appropriately to changes; to interact with the management of schemes; and to ensure the ongoing protection of members.
  The quarterly reports are the final product of this monitoring phase. The unit publishes quarterly reports to present the consolidated industry data only, as data on an individual level has not been audited and therefore cannot be made available to the public. The primary mandate of the unit is to ensure that the medical schemes industry is financially sound.

During the period under review, the unit identified:

- Schemes falling below the statutory solvency requirement prescribed by Regulation 29;
- Schemes with rapidly reducing solvency levels.

The CMS Financial Supervision Unit engaged with the schemes identified above, provided recommendations and closely monitored these schemes.

Strategy to overcome areas of underperformance

There were no areas of underperformance in the programme.

Changes to planned targets

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

Linking performance with budgets

Table 23: Budget of Programme 8

Description	2016/17			2017/18		
	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Consulting Fees	57	57	-	53	-	53
Employee Wellness	3	-	3	4	-	4
Staff Training	193	105	88	106	64	42
Stationery	10	14	(4)	10	3	7
Subscriptions	20	30	(10)	35	32	3
Travel	36	47	(11)	38	15	23
Venue and Catering	50	14	36	53	21	32
SUB TOTAL	***369***	***267***	***102***	***299***	***135***	***164***
Salaries	10 830	10 831	(1)	11 643	11 749	(106)
TOTAL	**11 199**	**11 098**	**101**	**11 942**	**11 884**	**58**

PROGRAMME 9: COMPLAINTS ADJUDICATION

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

Table 24: Key performance indicators, planned targets and actual achievements of Programme 9

Performance Indicator	Actual Achievement 2014/15	Actual Achievement 2015/16	Actual Achievement 2016/17	Planned Target 2017/18	Actual Achievement 2017/18	Deviation from planned target to Actual Achievement for 2017/18	Comment on deviations
Strategic Objective 9.2.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes							
Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per quarter	73%	75.31%	84%	79%	68%	11%	The Complaints Adjudication Unit experienced a setback with 1 resignation and 2 staff members going on maternity leave. This affected performance against targets.

Achievement of strategic objective

The CMS Complaints Adjudication Unit participated in complaints awareness by conducting educational workshops for beneficiaries of medical schemes in four regions in the Eastern Cape. The regions visited were Kirkwood, Port Elizabeth, Mt Fletcher and Mt Ayliff. The unit presented to the new Board of Trustees of Polmed and to staff of Fedhealth Medical Scheme on complaints resolution processes and the application of certain sections of the Medical Schemes Act. The unit also addressed the GEMS and Metropolitan Health administrative issues after noting their complaints trends. The unit also addressed gaps in their understanding of certain provisions of the Medical Schemes Act.

The capacity constraints experienced, as a result of one resignation and two staff members going on maternity leave, resulted in increased workload which led to the backlog in the resolution of complaints.

The unit handled appeals that were filed in respect of rulings issued by the unit. All appeals were defended before the Council's Appeal Committee.

Strategy to overcome areas of underperformance

The unit has acquired the services of temporary staff with paralegal qualifications in order to assist the unit in resolving non-complex complaints. The temporary staff assisted in addressing the backlog that was created due to vacancies. The legal officers were then freed to focus on resolving overdue complex complaints. Temporary staff were contracted for a period of six months and it is hoped that the backlog be reduced significantly by the time their contract ends.

Changes to planned targets

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

Linking performance with budgets

Table 25: Budget of Programme 9

	2016/17			2017/18		
Description	Budget	Actual Expenditure	(Over)/Under Expenditure	Budget	Actual Expenditure	(Over)/Under Expenditure
Employee Wellness	3	-	3	3	-	3
Staff Training	180	119	61	96	49	47
Stationery	2	4	(2)	2	2	-
Travel	608	87	521	608	61	547
SUB TOTAL	**793**	**210**	**583**	**709**	**112**	**597**
Salaries	5 734	5 746	(12)	6 649	6 387	262
TOTAL	**6 527**	**5 956**	**571**	**7 358**	**6 499**	**859**

C | GOVERNANCE

> *I learned that courage was not the absence of fear, but the triumph over it. The brave man is not he who does not feel afraid, but he who conquers that fear.*
>
> *- Nelson Mandela*

CORPORATE GOVERNANCE REPORT

The Council for Medical Schemes is a body established in terms of the Medical Schemes Act, No 131 of 1998. It is governed by a Council of up to 15 members appointed by the Minister of Health. The Executive Officer of the Council, who is also a Registrar of Medical Schemes, is appointed by the Minister of Health as well. The Council has an appropriate mix of skills, competencies and talents as members are drawn from a cross section of society. The composition of Council displays a clear commitment to transformation and gender diversity.

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

The Council has traditional duties as a governing board over and above the statutory duties and responsibilities These duties 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 has showed consistency on its commitment to good corporate governance for the reporting period. Commitment to good governance has been evidenced by high standards of integrity, accountability and ethical values. Coupled to these is the Council's strong belief in transparency and fairness in the way it conducts its business. Most Council members are leaders in their personal careers and this bodes well for the organisation – it has the advantage of not only tapping the best talent, but also a diversity of cultures, backgrounds and ways of thinking.

The Minister of Health appointed new Council members who came on board in November 2017, when the terms of some of the Council members came to an end. The period of this new Council coincides with the end of the five (5) year strategic planning cycle, the publication of the Health Market Inquiry report, the Medical Schemes Amendment Bill, and the National Health Insurance Bill.

The new Council has the added responsibility of steering the CMS in a new direction as it positions itself to play meaningful role in the changing health sector landscape.

CORPORATE GOVERNANCE

The Council does not view corporate governance as an abstract system of compliance and box ticking, rather as a mechanism through which it expresses its value laden leadership. The Council maintains good corporate governance through the following mechanism:

- A charter and code of conduct which regulates its functions.
- A devolution of its work into six committees which all have charters and defined responsibilities, allows for checks and balances.
- A system for declaration of conflicts of interests and register.
- Regular sittings of up to four times a year as provided for in the Medical Schemes Act and additional special meetings when necessary.
- Full and unfettered access to the organisations information including records of any nature.
- Regular learning and development as well as annual evaluation including that of committees.
- A robust risk management system which is monitored and updated on regular basis.
- Application of the voluntary corporate governance instruments in its business.
- Corporate governance in the Council is audited by internal auditors (external service provider) and the Auditor-General of SA.

The functions of the Council

Section 7 of the Medical Schemes Act 131 of 1998 sets the functions of the Council as follows:

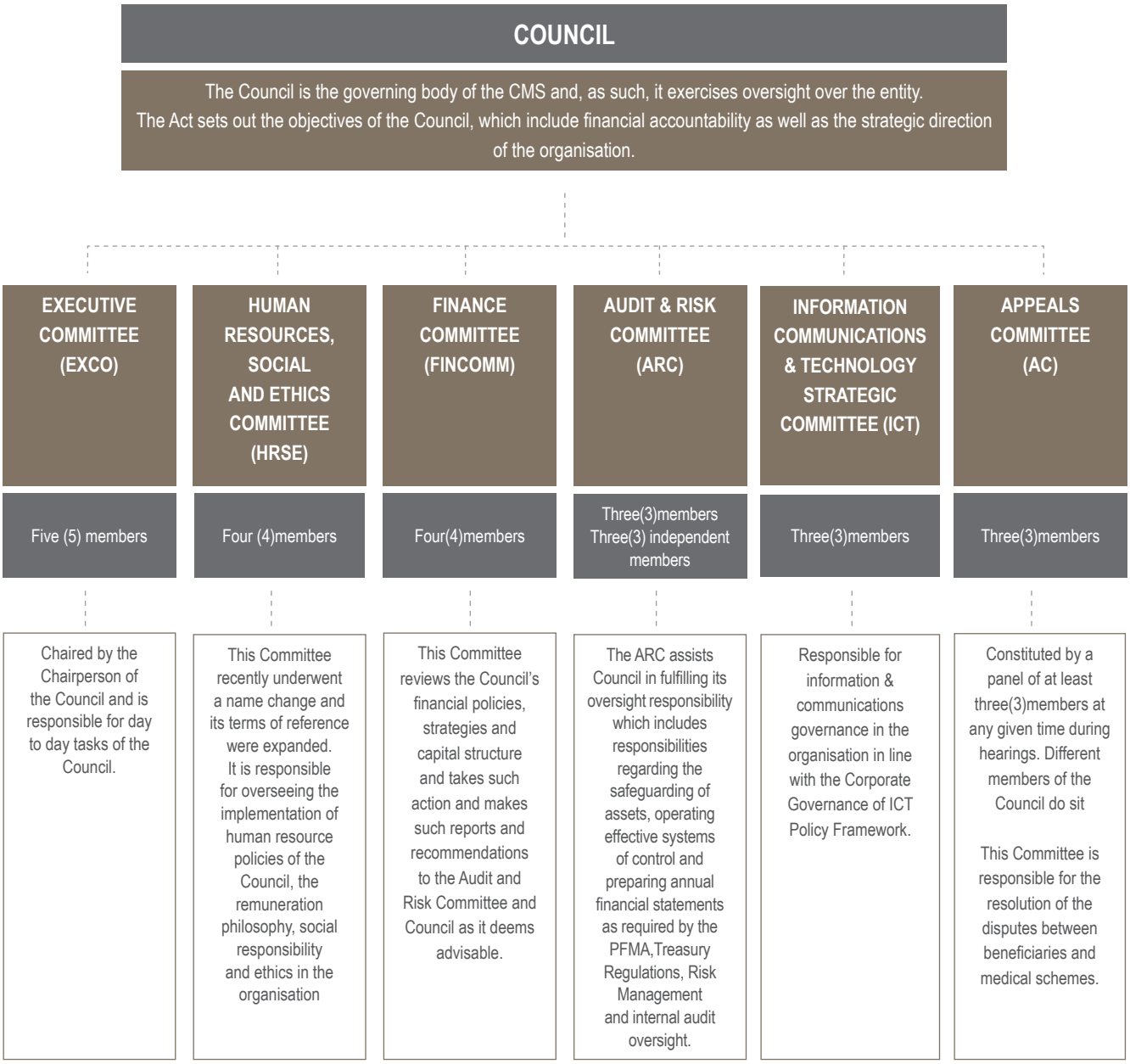
a To protect the interests of beneficiaries at all times.
b To control and coordinate the functioning of medical schemes in a manner that is complementary to national health policy.
c To make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes or relevant healthcare services provided for by medical schemes, and such other services as may be determined from time to time.
d To investigate complaints and settle disputes in relation to the affairs of medical schemes.
e To collect and disseminate information about private healthcare.
f To make rules for the purpose of the performing its functions and the exercise of its powers.
g To advise the Minister of Health on any matter concerning medical schemes.
h To perform any other functions conferred on it by the Minister of Health of the Medical Schemes Act.

Council secretariat

The Council is assisted and supported by the Council Secretariat who offers guidance to members collectively and individually on their duties, responsibilities and powers. The Secretariat apprises the Council on developments in legislation, regulations, good governance, ethics and compliance. The recording of minutes of meetings, resolutions of Council, training and development, induction and annual evaluations are carried out by the Council Secretariat.

Committees of the Council

The Council has delegated its work to six (6) Committees which are chaired by its members and these committee operate with charters to regulate their work.



The Appeal Board

The Appeal Board is established in terms of Section 50 of the Medical Schemes Act. It is not a committee of the Council. Its members are appointed directly by the Minister of Health and its purpose is to hear appeals against decisions of the Appeals Committee of the Council. The Appeal Board comprises three (3) members, with a tenure of three (3) years.

The Registrar and Chief Executive Officer

The Minister of Health appoints the Registrar of Medical Schemes in consultation with the Council. The Registrar is the Executive Officer of the Council and is responsible for the management of the affairs of the Council and the supervision of staff. The Registrar is obligated to act according to the provisions of the Medical Schemes Act and the policy directions of the Council.

The Registrar however, has powers that are distinct and different from those of the Council. In certain instances, the Registrar can only exercise certain powers in concurrence with the Council in terms of the Medical Schemes Act. The Registrar also supervises the staff of the Council for Medical Schemes. The decisions of the Registrar that are performed in terms of the Medical Schemes Act can be appealed to the Council.

Reports to the Portfolio Committee on Health

The Council made presentations to the Portfolio Committee on Health during the financial year under review on the following:

- The Strategic Plan, Annual Performance Plan and Budget for 2017/18 on 3 May 2017.
- The CMS Annual Report 2016/17 on 5 October 2017.

Reports to the Executive Authority

The Accounting Officer approved and submitted four (4) Quarterly Preformation Information Reports to the Executive Authority and National Treasury. The reports were submitted as follows:

- 31 July 2017
- 31 October 2017
- 31 January 2017
- 30 April 2018

Table 26: Composition of Council members as at 31st March 2018

Name of Council Member	Designation	Date Appointed	End date	Qualification	Area of Expertise	Council Committees	Total no. of meetings attended by members
Dr Clarence Mini	Chairperson	15-Nov-17	14-Nov-20	MBChB, PGDip (Palliative care), Advanced Diploma in Negotiations	Health	HRSE, EXCO, Council	2
Adv Harshila Kooverjie (SC)	Deputy Chairperson	15-Nov-17	14-Nov-20	BA, LLB	Law	EXCO, Appeals Committee	22
Dr Yogan Pillay	Member	15-Nov-17	14-Nov-20	PhD	Health	EXCO	1
Dr Steven Mabela	Member	15-Nov-17	14-Nov-20	BSc,MBA,PhD	Economics	EXCO HRSE	17
Adv Rebaone Gaoraelwe	Member	15-Nov-17	14-Nov-20	B Proc, LLB, LLM, Cert. in Public Sector Gov & Strategy, Higher Diploma in Company Law	Law	ICT Appeals Committee	2
Ms Mosidi Maboye	Member	15-Nov-17	14-Nov-20	BA(Nursing), Adv Diploma in Nursing Admin, PG.Certificate in healthcare management	Health	HRSE,Appeals Committe	27
Mr Moerane Maimane	Member	15-Nov-17	14-Nov-20	Diploma in Public Admin BPA(Bachelor of Public Admin), BPA(Hons), MBA	Administration	HRSE, Appeals Committe	2
Mr Johan Van Der Walt	Member	15-Nov-17	14-Nov-20	CA(SA), BCompt(Hons) MCom	Finance Administration	ARC, ICT, FINCOMM	9 excluding ARC and FINCOMM
Dr Memela Makiwane	Member	15-Nov-17	14-Nov-20	MBChB,Dip.HIV Man, PGDip(Pharm Med), FC Clin Pharm, Mmed Clinical Pharmacology	Health	ICT	2
Dr Aquina Thulare	Member	15-Nov-17	14-Nov-20	BScMedSc (Hons) MBA,Master of Management in Public Policy	Health	ICT, ARC, FINCOMM	6 excluding ARC and FINCOMM
Prof Lungile Pepeta	Member	15-Nov-17	14-Nov-20	MBChB, Dip.in Child Care, FC Paed(SA), Certificate in Cardiology, MMED. Paed,FSCAI	Health	Appeals Committee	1
Ms Shivani Ranchod	Member	15-Nov-17	14-Nov-20	MBusSc Actuarial Science	Actuarial Science	ARC and FINCOMM	1 excluding ARC and FINCOMM
Ms Diane Terblanche	Member	15-Nov-17	14-Nov-20	BA Law, LLB, LLM	Law	Appeals Committee, EXCO	1
Ms Angela Drescher	Member	15-Nov-17	Resigned		Activist	HRSE	2

Name of Council Member	Designation	Date Appointed	End date	Qualification	Area of Expertise	Council Committees	Total no. of meetings attended by members
Prof Yosuf Veriava	Chairperson	14-Nov-15	13-Nov-17	MBBCH(Wits), Hons DSc(Wits), FCP(SA), FRCP(London)	Health	EXCO, HRSE	27
Dr Loyiso Mpuntsha	Deputy Chairperson	14-Nov-14	13-Nov-17	MBChB, MPhil	Health	EXCO, Appeals Committee	33
Prof B Dumisa	Member	14-Nov-14	13-Nov-17	LLB, LLM, MBA, MSc, DBA	Law Management	Appeals Committee, ICT Governance	22
Ms L Sibanyoni	Member	14-Nov-14	13-Nov-17	BBuSc, Actuarial Science	Actuarial Science	HRSE, ARC	8 excluding ARC and FINCOMM
Prof S Perumal	Member	14-Nov-14	13-Nov-17	DCom, MSc, BCom	Finance	EXCO, ARC	15 excluding ARC and FINCOMM

Table 27: Membership of Council Committees from 1 April 2017- 14 November 2017

Council Committee	No of Meetings held	No of Members	Names of Members
Executive Committee (EXCO)	8	5	Prof Y Veriava (Chairperson) Dr L Mpuntsha (Deputy Chairperson) Ms M Maboye Dr S Mabela Prof S Perumal
Human Resources Committee (HR)	5	4	Ms M Maboye (Chairperson) Prof Y Veriava Dr S Mabela Ms L Sibanyoni
Appeals Committee (AC)	13	3	Prof B Dumisa Adv H Kooverjie (SC) Dr L Mpuntsha
Information Communication and Technology (ICT)	2	3	Prof B Dumisa (Chairperson) Dr S Mabela Dr A Thulare
Audit & Risk Committee (ARC)	5	7 4 Council members 3 independent members	Prof S Perumal Mr J Van der Walt Dr A Thulare Ms S Ranchod
Finance Committee (FINCOMM)	4	3	Mr J Van der Walt (Chairperson) Dr A Thulare Ms S Ranchod
Full Council	6	10	Prof Y Veriava (Chairperson) Dr L Mpuntsha (Deputy Chairperson) Prof B Dumisa Adv H Kooverjie (SC) Ms M Maboye Dr S Mabela Ms L Sibanyoni Prof S Perumal Mr J Van der Walt Dr A Thulare

Table 28: Membership of Council Committees from 15 November 2017 - 31 March 2018

Council Committee	No of Meetings held	No of Members	Names of Members
Executive Committee (EXCO)	0	5	Dr C Mini (Chairperson) Adv H Kooverjie (SC) Ms D Terblanche Dr S Mabela Dr Y Pillay
Human Resources, Social and Ethics Committee (HRSE)	1	4	Ms M Maboye (Chairperson) Dr C Mini Mr M Moerane Dr S Mabela
Appeals Committee (AC)	2	6	Adv H Kooverjie (SC) (Chairperson) Ms M Maboye Prof L Pepeta Dr M Makiwane Adv R Gaoraelwe Ms D Terblanche
Information Communication and Technology (ICT) Strategic Committee	1	4	Adv R Gaoraelwe (Chairperson) Dr M Makiwane Mr J Van der Walt Dr A Thulare
Audit & Risk Committee (ARC)	2	6 3 Council members 3 independent members	Ms S Ranchod Mr J Van der Walt Dr A Thulare
Finance Committee (FINCOMM)	1	3	Mr J Van der Walt (Chairperson) Ms S Ranchod Dr A Thulare
Full Council	1	13	Dr C Mini (Chairperson) Adv H Kooverjie (SC) (Deputy chairperson) Ms D Terblanche Dr S Mabela Dr Y Pillay Ms M Maboye Mr M Moerane Prof L Pepeta Dr M Makiwane Adv R Gaoraelwe Mr J Van der Walt Dr A Thulare Ms S Ranchod

Table 29: Remuneration of Council members from 1 April 2017 – 31 March 2018

Name of Council member	Remuneration 2018 R'000	Remuneration 2017 R'000
Dr Clarence Mini	64	-
Adv Harshila Kooverjie (SC)	117	109
Ms Diane Terblanche	11	-
Dr Steven Mabela	79	117
Dr Yogan Pillay	-	-
Ms Mosidi Maboye	151	47
Mr Maimane Moerane	18	-
Prof Lungile Pepeta	11	-
Dr Memela Makiwane	18	-
Adv Rebaone Gaoraelwe	18	-
Mr Johan van der Walt	147	113
Ms Shivani Ranchod	21	
Dr Aquina Thulare	-	-
Ms Angela Drescher	13	-
Prof. Yosuf Veriava	173	222
Dr Loyiso Mpuntsha	193	224
Prof. B Dumisa	143	250
Ms L Sibanyoni	47	67
Prof. S Perumal	77	121
Total	**1 301**	**1 270**

INTERNAL CONTROL

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

Budget Management

Section 53 (1) of the PFMA requires public entities to submit a budget of estimated revenue and expenditure for that financial six months before commencement. CMS has complied with this provision by submitting a budget that is in line with its strategic and annual performance plan. The approval of the budget from the Executive Authority was received on 15 April 2017. This approval is important to CMS operations in that it also approves the levy rate at which CMS must charge to medical aid scheme members. During the year the budget is monitored to ensure that expenditure is line with the performance of the organisation.

Financial Management

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

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

Financial management has improved considerably in the organisation. CMS noted instances of financial management regression during the year, mainly due to non-compliance with policies. This area therefore requires much attention in the ensuing financial years. The CMS has received unqualified audit reports from the Auditor-General of South Africa (AGSA) in successive years. In the previous financial year the CMS received a clean audit, the challenge now is to maintain this clean record. While we are satisfied with the systems of internal controls, the supply chain management area has been identified as a component of financial management that requires focused attention. The CMS has taken measures to improve in the area of SCM with a view to establishing a centralised system of SCM and moving to automation of the procurement process.

INTERNAL AUDIT

The internal audit function of the CMS is outsourced. The internal audit function is accountable to the accounting officer under the direction of the Audit and Risk Committee. The purpose of the internal audit function is

to provide an independent, objective assurance and consulting activity designed to add value and improve CMS's operations. It evaluates and provides assurance on the effectiveness of financial management, internal controls, risk management and governance processes at CMS.

The annual internal audit plan and a three-year rolling plan are as approved by the Audit and Risk Committee during the year. A new internal audit service provider was appointed in December 2017 through a tender process.

In line with the combined assurance model the Internal Auditors and External Auditors had meetings during the year.

Scope of Work

The audit scope was based on management's assessment of risks related to the core business of CMS. The audit coverage focussed on high-risk areas identified in consultation with the Audit and Risk Committee, Executive Management and the Risk and Performance Manager.

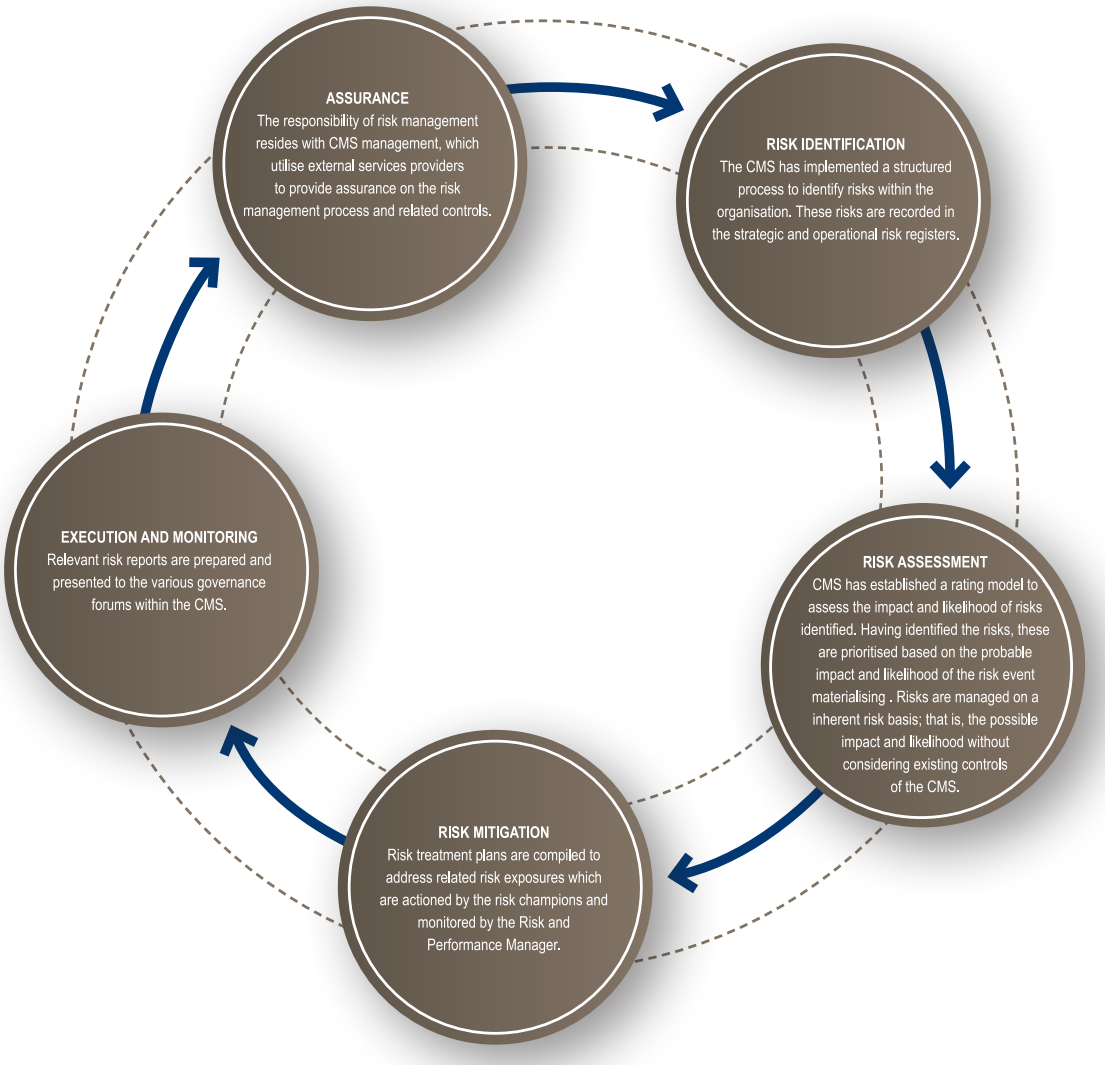
Risk Management

CMS has established a risk management framework which is in line with best practice guidelines. Risk management has been embedded in the CMS's strategy and operations. The Council is ultimately responsible for risk management in CMS and is supported by the Audit and Risk Committee, Executive Management and the Risk and Performance Manager. The Council carries out an annual review of risks as contained in the strategic risk register and this is monitored on a quarterly basis.

CMS Risk Assessment Process during 2017/18

CMS manages all categories of risk associated with its business operations as depicted in the diagram below.

Figure 2: CMS risk assessment process during 2017/2018



MATERIALITY FRAMEWORK

As required by the Treasury Regulations, the Council has developed a materiality and significance framework appropriate to its size and circumstances.

Materiality

The Council has taken into account the following factors in determining the CMS's level of materiality:

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

Having taken these factors into account, the Council has assessed the level of "a material loss" to be:

- Every amount in respect of criminal conduct;
- R30,000 and above for irregular, fruitless and wasteful expenditure involving gross negligence; and
- R1,299,520 and above being about 1% of income to report in terms of Subsection 55 (1)(d) regarding the fair presentation of affairs of the public entity, its business, its financial results, its performance against pre- determined objectives and its financial position as at the end of the financial year concerned.

Significance

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

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

Health, Safety and Environmental issues

A Health and Safety Committee was established and a Health and Safety framework developed with the aim of protecting employees against the hazards of health and safety arising out of activities at work.

The Council considers that reasonable precautions are taken to ensure a safe working environment. CMS conducts its business with due regard for environmental concerns.

Prevention of fraud and corruption

CMS has adopted a Fraud and Corruption prevention strategy. CMS is committed to protect its funds and other assets and as such has adopted a zero tolerance to fraudulent activities emanating from either internal or external sources. Any detected corrupt activities are investigated and, where so required, reported to the law enforcement authorities in accordance with Treasury Regulations 31 and the Fraud and Corruption Prevention Strategy. CMS has an established fraud hot line for the reporting of any suspicious fraudulent activity.

Tip-off Anonymous Hotline

To report suspected fraud against an employee or member of Council for Medical Schemes, please use the e-mail address or numbers provided below:

Toll free number: 0800 867 423
Free Fax: 0800 00 77 88
Email address: cms@tip-offs.com
Free post: KZN 138 Umhlanga Rocks 3240

REPORT OF THE AUDIT AND RISK COMMITTEE

We are pleased to present our report to the Council for Medical Schemes (CMS) Accounting Authority (Council) for the financial year ended 31 March 2018.

This report is provided by the Audit & Risk Committee of Council, appointed in respect of the 2017-2018 financial year of the CMS, in compliance with Section 51(1)(a)(ii) of the Public Finance Management Act 1 of 1999, as amended (PFMA). The Committee's operation is guided by a detailed charter that is informed by the PFMA and approved by Council.

Audit & Risk Committee members and meetings

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

The Committee held four scheduled meetings during the year under review. Meetings and attendance at these meetings was as listed in Table 30.

Table 30: Meetings & attendance of the Audit & Risk Committee in 2017/18

Name of member	Position of member	Date of appointment	Date of reappointment	Term end	Meetings attended						
					12 April 2017 (Special sitting to discuss audit strategy)	25 May 2017 (scheduled)	13 June 2017 (special sitting to evaluate and confirm the status of internal audit tender)	26 July 2017 (scheduled)	07 November 2017 (scheduled)	22 February 2018 (scheduled)	22 March 2018 (special sitting to discuss audit strategy document
Mr. Kariem Hoosain	Independent & non-executive and Chairperson	18 January 2017			√	√	√	√	√	√	√
Mrs. Marianna Strydom	Independent & non-executive	18 November 2016			√	√	√	√	√	√	√
Ms Pumla Mzizi	Independent & non-executive	1 April 2015		Term ended 31 March 2018	√	X	√	X	√	X	X
Dr Aquina Thulare	non-executive council member	May 2017			X	√	X	√	√	X	√
Mr. Johan vd Walt	Non-executive & Council member	14 November 2014			√	√	√	√	√	√	√
Mrs. Shivani Ranchod	non-executive council member	15 November 2017			-	-	-	-	-	√	√
Prof. Sadhasivan Perumal	Non-executive & Council member	14 November 2014		Term ended 13 November 2017	√	X	√	X	X	-	-

√ = attended
X = apology

Other invitees

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

Functions

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

- Evaluation of the effectiveness of risk management, controls, and governance processes
- Oversight of:
  - the financial and performance reporting process
  - the activities of the internal and external audits, and facilitation of a coordinated approach between these functions
- Review of:
  - provisional and year-end financial statements to ensure that they fairly present and are prepared in the manner required by the PFMA and the Medical Schemes Act
  - the external audit plan, budget, and reports on the Annual Financial Statements
  - the internal audit charter, annual audit plan, three-year audit plan, and annual budget
  - internal audit and risk management reports and, where relevant, recommendations made to the Council and Management
- Approval of:
  - the internal audit charter, budget, and three-year audit plan
  - audit fees and engagement terms of the internal auditor are recommended to council
  - engagement terms, plans, and budget for the Auditor-General of South Africa is reviewed and recommended to Council
- Recommendation of the audited Annual Financial Statements and annual performance report to Council for the financial year ended 31 March 2018.

AUDIT & RISK COMMITTEE RESPONSIBILITY

Mandate

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

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

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

Role of the Audit & Risk Committee on CMS governance

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

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

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

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

External audit plan by the Auditor-General of South Africa

The Committee reviewed the external audit plan for the financial year under review as prepared and presented by the Auditor-General of South Africa in terms of the Public Audit Act for the year ended 31 March 2018. The Committee confirms that this plan is in line with Regulations and standards, and that the plan takes into consideration the CMS risk register for the year under review. The Committee believes that the plan and audit fee presented was sufficient and reasonable for completion of the CMS annual audit.

Risk management and internal controls

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

Based on internal audits that were performed during the 2017/18 financial period, the overall control environment of the related processes subject to internal audit was found to be adequate and partially effective. There is a generally sound system of internal controls, designed to meet the

organisation's objectives and are generally being applied consistently. As in the previous financial year, some weakness in relation to the inconsistent application of Supply Chain Management controls put the achievement of Supply Chain Management objectives at risk.

The Committee noted with concern that this has resulted in significant Irregular Expenditure for the 2017/18 financial year. The Committee therefore requested the Council to determine accountability for this continuous breach of Internal Controls and consider and implement appropriate corrective and disciplinary measures, where necessary.

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

Review of legal cases pending at financial year-end

The Committee reviewed progress reports on legal cases involving the CMS as the regulator on a quarterly basis and those pending at the financial year-end so as to assess the adequacy of its disclosure in the Annual Financial Statements as required in terms of the Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. Details in terms of legal cases that warrant noting can be found on page 99 note 23 of the annual financial statements. The Committee also noted with concern, the number of disciplinary matters instituted against Executives of the CMS which resulted in significant additional legal costs being incurred during the 2017/18 financial year.

Evaluation of the Audit & Risk Committee

The Committee is required to have its adequacy and effectiveness evaluated annually. During the year under review a self-evaluation was not carried out by the Committee. Members of the committee changed during the year and a self-evaluation will be carried out during 2018/19.

Evaluation of financial statements and annual performance report

The Committee reviewed the annual financial statements and annual performance report of the CMS for the financial year ended 31 March 2018 and is satisfied that, in all material respects, the financial statements and annual performance report comply with the relevant provisions of the PFMA, GRAP including any interpretations, guidelines and directives issued by the Accounting Standards Board and fairly present the financial position and performance of the CMS at that date and the results of operations and cash flows for the financial year then ended.

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

The Committee recommended the financial statements and performance report for the year ended 31 March 2018 to Council for approval.

OUR COMMITMENT

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

Abdul Kariem Hoosain
Chairperson on behalf of the Audit & Risk Committee
Council for Medical Schemes

31 July 2018

D | HUMAN RESOURCE MANAGEMENT

There can be no greater gift than that of giving one's time and energy to helping others without expecting anything in return.

- Nelson Mandela

The CMS Human Resources (HR) Unit undertook a number of initiatives during the 2017/18 financial year to remain competitive in the industry as an employer of choice. The section below outlines HR strategic objectives and progress made during the year under review.

Workforce planning

The HR unit responded to the organisational needs by addressing internal capacity constraints through increased delegation of some functions to staff and by providing employees with the opportunity to act in senior positions while recruitment processes were underway to support the CMS strategic objectives.

All vacancies were advertised in accordance with the CMS recruitment and selection policy. Twelve (12) permanent positions were filled. The demarcation project undertaken by the Compliance and Investigation Unit required further capacity and this led to the creation of a Senior Compliance Officer position initially placed in the Benefits Management Unit. This position was subsequently transferred to the Compliance and Investigation Unit in the last quarter of the financial year.

To prevent fraud and corruption, in 2017 the CMS introduced a qualification verification process for existing employees and for candidates invited to interviews.

In keeping with government's call for employers to give opportunities to young graduates, CMS appointed fifteen (15) interns and provided them with on-the-job training.

The staff turnover rate has increased to 7.1%. It increased by 2.4% when compared to 4.7% during the previous financial year. A total of eight (8) positions were vacated; three (3) due to misconduct, four (4) due to career advancement and one (1) due to death.

The position of the CE & Registrar has been vacant since 22 January 2017. The CMS awaits finalisation of this appointment process.

A comprehensive climate survey was conducted, which yielded a 65% response rate from the total workforce. The aim of the survey was to establish the engagement and motivation levels of employees, highlighting concerns and/or providing positive feedback to allow the office to identify priority areas for improvement. Leadership and commitment, organisational culture, diversity and change management, shared values and discipline were some of the areas identified as needing improvement. These areas of concern shall be addressed in the next financial year to improve levels of engagement and to improve teamwork.

Performance management

Employees were evaluated against the performance agreements during the financial year under review. The signing of performance agreements for some employees was delayed due to operational matters.

In enhancing service delivery and fine-tuning processes at CMS, the HR Unit coordinated a performance management workshop for the executive management team. The aim of the workshop was to review and improve processes associated with the current performance management system.

Remuneration strategy

A comprehensive job evaluation and salary benchmarking exercise was conducted to ensure that all positions were appropriately classified, market aligned, and achieve internal and external equity. Workshops were facilitated for employees and management explained the job evaluation process that was followe. The recommendations of the exercise were approved by Council on 29 March 2018. It is envisaged that the review will be completed by 31 March 2019.

The HR Unit was further mandated to review the CMS remuneration policy/philosophy and to conduct a benchmark against public service and state-owned entities for proper alignment with similar organisations. Terms of reference for the remuneration policy/philosophy were developed in consultation with the trade union and served before the HR Sub-committee on 20 February 2018. It is envisaged that the review will be completed by 31 March 2019.

Employment equity

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

The CMS is fairly aligned to the BBBEEA scorecard. Although, it has made great progress in attaining employment equity targets, there was regression in retaining people with disabilities during the reporting period. Currently, in this occupational category the CMS scored 0% against the set national target of 2%, as illustrated in the table below. This reflects a decline when compared to 0.44% in the 2016/17 financial year. There was a decline in the overall employment equity target percentage from 93.83% in 2015/16 to 79.82% in 2017/18. When positions are filled in the next financial year, special focus will be on people with disabilities and black women at senior management and professional levels to enable the CMS to meet the requirements of the employment equity scorecard.

Measurement of employment equity criteria

$$A = \frac{B}{C} \times D$$

- **A** is score achieved in respect of any given criteria
- **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 measured

Table 31: Broad-Based Black Economic Empowerment Act (BBBEEA) scorecard

Criteria	A Total no. of employees and score achieved		B % Blacks measured	C % Compliance targets	D Weighing points	%	Achievement /Challenge
Black people with disabilities employed by the entity as a percentage of all full-time employees	0	113	0.00%	4%	2	0.0	2.00
Black people employed by the entity at Senior Management level as a percentage of employees at Senior Management level	7	11	63.64%	60%	2	2.12	-0.12
Black women employed by the entity at Senior Management level as a percentage of employees at Senior Management level	3	11	27.27%	30%	2	1.82	0.18
Black people employed by the entity at Professionally Qualified, Experienced Specialists and Mid-management level as a percentage of employees at Professionally Qualified, Experienced Specialists and Mid-management level	30	38	78.95%	75%	2	2.11	-0.11
Black women employed by the entity at Professionally Qualified, Experienced Specialists and Mid-management level as a percentage of employees at Professionally Qualified, Experienced Specialists and Mid-management level	13	38	34.21	40%	1	0.86	0.14
Black people employed by the entity at Skilled Technical and Academically Qualified Workers, Junior Management, Supervisors, Foremen and Superintendents as a percentage of employees at Skilled Technical and Academically Qualified Workers, Junior Management, Supervisors, Foremen and Superintendents level	45	52	86.54%	80%	1	1.08	-0.08
				Weighting points	10	7.98	2.02
				Employment Equity Target Percentage		79.82%	

Learning and development

Learning and development remains essential as the CMS encourages a culture of high performance. Employees were provided with opportunities to develop new knowledge and skills to improve their capability to meet the CMS objectives. A Workplace Skills Plan and Annual Training Report 2017/18 was submitted to HWSETA on 26 April 2018. The Workplace Skills Plan was implemented successfully and approximately 61% of the planned training has been attended so far.

Employee Wellness, Health and Safety

The CMS provides and maintains a safe working environment for its employees in compliance with the Occupational Health and Safety Act. To ensure commitment to health and safety, the CMS trained sixteen (16) employees in First Aid levels 1 – 3 and Fire Fighting. There were no injuries on duty during the review period.

A fully operational employee wellness programme is in place in the CMS. This programme allows employees and their immediate families to access services such as counselling on work and family matters. The CMS hosted its annual wellness day on 22 September 2017 with 66 employees participating in screening services of cholesterol, body mass index, high blood pressure, glucose and HIV testing.

In support of cancer awareness, the CMS arranged for employees to have mammogram and prostate cancer screenings. There were also wellness talks on men's health issues.

Employee relations

Promoting orderly and constructive relationships with employees remains a key focus area for HR. A number of sessions on employee relations and discipline were facilitated to promote constructive engagement between management, staff and the trade union. The talks on employee relations also underlined the rights and well-being of employees, as well as the role of management in maintaining a positive work ethic.

Currently, 70% of CMS employees are members of the trade union. A wage agreement was signed on 27 March 2018 between the employer and the trade union to increase 2018/19 salaries by 6.7%. Although the CMS does not fall under any bargaining council, it was agreed that the headline percentage agreed in the Public Service Co-ordinating Bargaining Council (PSCBC) will be implemented from 1 April 2018.

Labour relations

There were four (4) Commission for Conciliation, Mediation and Arbitration (CCMA) cases of unfair labour practice and unfair dismissal during the review period. The CCMA ruled in favour of the CMS on one (1) case and settlement agreements were reached in three (3) cases.

Social responsibility

The CMS continues to participate in various activities that empower its employees and community in which it operates. As part of the 2017 Cell C Take A Girl Child To Work campaign, the CMS hosted fifteen (15) girls from Olievenhoutbosch Secondary School and exposed them to different career opportunities.

The CMS also took part in the 67 Minutes for Nelson Mandela Day by donating groceries to the parish of St Michael and All Angels Anglican Church in Sunnyside. Furthermore, the CMS hosted a candlelight ceremony as part of the commemoration of the international World AIDS Day.

HR OVERSIGHT STATISTICS

Table 32: Personnel costs per programme

Business unit	Total expenditure of unit (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees at year end	Average personnel cost per employee (R'000)
Accreditation	9 059	9 032	99.70%	10	903.20
Benefit Management	6 478	6 421	99.12%	7	917.29
CEO and Registrar	2 015	1 931	95.83%	3	643.67
Compliance and Investigation	7 537	7 477	99.20%	8	934.63
Complaints Adjudication	6 436	6 387	99.24%	10	638.70
Financial Supervision	11 813	11 749	99.46%	11	1 068.09
Human Resources	4 975	4 923	98.95%	6	820.50
Internal Finance	9 660	9 565	99.02%	16	597.81
ICT and Knowledge Management	10 043	9 866	98.24%	12	822.17
Legal Services	4 008	3 939	98.28%	4	984.75
Research and Monitoring	6 348	6 261	98.63%	6	1 043.50
Stakeholder Relations	8 092	8 017	99.07%	10	801.70
Strategy Office and Clinical	10 118	10 017	99.00%	10	1 001.70
TOTAL	**96 582**	**95 585**	**98.97%**	**113**	**845.88**

Table 33: Personnel costs per salary band

Level	Personnel expenditure (R'000)	Personnel expenditure as a % of total expenditure	Number of employees at year end	Average personnel cost per employee (R'000)
Top management	-	0.00%	-	-
Senior management	21 940	22.95%	11	1 994.55
Professionals	39 259	41.07%	38	1 033.13
Skilled Technical and Academically Qualified	31 274	32.72%	49	638.24
Semi-skilled labour	2 437	2.55%	7	348.14
Unskilled labour	675	0.71%	8	84.38
TOTAL	**95 585**	**100.00%**	**113**	**845.88**

Note: Skilled Technical and Academically Qualified refers to someone that applies broad knowledge of products, techniques and processes. A person that evaluates procedures and applies previous experience; who can find solutions. Determines own priorities. What must be done is stipulated; but may require initiative in terms of how it should be done

Table 34: Performance rewards

Level	Personnel expenditure (R'000)	Personnel expenditure as a % of total expenditure	Number of employees at year end	Average personnel cost per employee (R'000)
Top management	-	0.0%	-	-
Senior management	1 439	22.1%	11	130.8
Professionals	2 872	44.1%	38	
Skilled Technical and Academically Qualified	2 022	31.1%	49	41.2
Semi-skilled labour	128	1.9%	7	18.2
Unskilled labour	39	0.6%	8	4.8
TOTAL	6 499	100.0%	113	57.5

Note: Skilled Technical and Academically Qualified refers to someone that applies broad knowledge of products, techniques and processes. A person that evaluates procedures and applies previous experience; who can find solutions. Determines own priorities. What must be done is stipulated; but may require initiative in terms of how it should be done.

Table 35: Training costs per programme

Business unit	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel cost	Number of employees	Average training cost per employee (R'000)
Accreditation	9 032	27	2.7%	10	2.7
Benefit Management	6 421	56	5.6%	7	8.0
CEO and Registrar	1 932	83	8.3%	3	27.6
Compliance and Investigation	7 477	60	6.0%	8	7.5
Complaints Adjudication	6 387	49	4.9%	10	4.9
Financial Supervision	11 749	64	6.4%	11	5.8
Human Resources	4 923	53	5.3%	6	8.8
Internal Finance	9 565	95	9.5%	16	5.9
ICT and Knowledge Management	9 866	177	17.7%	12	14.7
Legal Services	3 939	69	6.9%	4	17.2
Research and Monitoring	6 261	87	8.7%	6	14.5
Stakeholder Relations	8 017	75	7.5%	10	7.5
Strategy Office and Clinical	10 017	100	10.0%	10	10.0
TOTAL	95 586	995	100.0%	113	8.8

Table 36: Employment and vacancies per programme

Programme	2016/17 number of employees	Approved posts 2017/18	2017/18 number of employees	2017/18 vacancies	% of vacancies
Accreditation	10	0	10	2	15.3%
Benefit Management	7	1	7	0	0.0%
CEO and Registrar	3	0	3	1	7.6%
Compliance and Investigations	7	3	8	1	7.6%
Complaints Adjudication	9	1	10	2	15.3%
Financial Supervision	11	0	11	0	0.0%
Human Resources	5	1	6	0	0.0%
Internal Finance	18	1	16	2	15.3%
ICT and Knowledge Management	12	1	12	1	7.6%
Legal Services	3	0	4	1	7.6%
Research and Monitoring	7	0	6	2	15.3%
Stakeholder Relations	11	0	10	1	7.6%
Strategy Office and Clinical	10	0	10	0	0.0%
TOTAL	113	8	113	13	100.0%

Table 37: Employent and vacancies per salary band

Level	2016/17 number of employees	Approved posts 2017/18	2017/18 number of employees	2017/18 vacancies	% of vacancies
Top management	0	0	0	1	7.6%
Senior management	12	0	11	1	7.6%
Professionals	36	3	38	4	30.7%
Skilled Technical & Academically qualified	52	4	52	6	46.1%
Semi-skilled labour	5	0	5	0	0.0%
Unskilled labour	8	1	7	1	7.6%
TOTAL	**113**	**8**	**113**	**13**	**100.00%**

Council approved the following new positions in 2017/218 – Senior Analyst: BMU, Senior Compliance Officer, Legal Adjudication Officer, Labour Relations Officer, Senior Developer & two (2) Compliance Officers. Vacancies were due to terminations, resignations, new positions and internal movement.

Table 38: Employment changes per salary band 2017/18

Level	Employment at beginning of period	Appointments	Internal Appointments	Terminations	Employment at end of period
Top management	0	0	0	0	0
Senior management	12	0	0	1	11
Professionals	36	6	1	3	38
Skilled Technical & Academically qualified	52	6	3	3	52
Semi-skilled labour	5	0	0	0	5
Unskilled labour	8	0	0	1	7
TOTAL	**113**	**12**	**4**	**8**	**113**

Vacancies between appointments and terminations were as a result of terminations and newly approved posts.

Table 39: Reasons for staff leaving 2017/18

Reason	Number of employees	% of total number of staff leaving
Death	1	13%
Resignation	4	50%
Dismissal	3	38%
Retirement	0	0%
Ill health	0	0%
Expiry of contract	0	0%
Other	0	0%
TOTAL	8	100%

Table 40: Labour relations: misconduct and disciplinary action 2017/18

Reason	Number of occurrences
Verbal warning	0
Written warning	3
Final written warning	0
Dismissal	3
TOTAL	**6**

E | FINANCIAL INFORMATION

May your choices reflect your hopes, not your fears.

- Nelson Mandela

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 examined by the Auditor-General of South Africa and their report is presented on page 68.

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 2018.

The annual financial statements set out on pages 72 to 103, which have been prepared on the going concern basis, were approved by the Council on 31 May 2018 and were signed on its behalf by:

Dr S Kabane
Acting CEO and Registrar

Dr CM Mini
Chairperson of Council

REPORT OF THE AUDITOR-GENERAL TO PARLIAMENT ON THE 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 72 to 103, which comprise the statement of financial position as at 31 March 2018, the statement of financial performance, statement of changes in net assets and 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 2018, and financial performance and cash flows for the year then ended in accordance with the South African Standards of Generally Recognised Accounting Practice and the requirements of the Public Finance Management Act (Act 1 of 1999).

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 the International Ethics Standards Board for Accountants' Code of ethics for professional accountants (IESBA code) and the ethical requirements that are relevant to my audit in South Africa. I have fulfilled my other ethical responsibilities in accordance with these requirements and the IESBA code.

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

Emphasis of matter

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

Restatement of corresponding figures

7. As disclosed in note 27 to the financial statements, the corresponding figures for 31 March 2017 were restated as a result of an error in the financial statements of the entity at, and for the year ended, 31 March 2018.

Responsibilities of the accounting authority for the financial statements

8. The accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with the South African Standards of Generally Recognised Accounting Practice (SA Standards of GRAP) and the requirements of the Public Finance Management Act, 1999 (Act 1 of 1999) (PFMA), and for such internal control as the accounting authority determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

9. In preparing the financial statements, the accounting authority is responsible for assessing the Council for Medical Schemes' 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 accounting authority either intends to liquidate the entity or to cease operations, or has no realistic alternative but to do so.

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

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

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

Report on the audit of the annual performance report

Introduction and scope

12. In accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA) and the general notice issued in terms thereof, I have a responsibility to report material findings on the reported performance

information against predetermined objectives for selected programmes presented in the annual performance report. I performed procedures to identify findings but not to gather evidence to express assurance.

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

14. I evaluated the usefulness and reliability of the reported performance information in accordance with the criteria developed from the performance management and reporting framework, as defined in the general notice, for the following selected programmes presented in the annual performance report of the entity for the year ended 31 March 2018:

Programmes	Pages in the annual performance report
Programme 2 – strategy office	35 – 36
Programme 3 – accreditation unit	37 – 38
Programme 6 – compliance and investigation	41 – 42
Programme 7 – benefits management unit	43
Programme 8 – financial supervision unit	44 – 45

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

16. The material findings in respect of the usefulness and reliability of the selected programmes are as follows:

Programme 3 - Accreditation unit

Indicator: Number of brokers and broker organisations that comply with accreditation requirements accredited within 21 working days of receipt of complete application

17. The reported achievement of 5 521 for target 4 045 is not reliable as the entity did not have an adequate performance management system to maintain records to enable reliable reporting on achievement of targets. As a result, I was unable to obtain sufficient appropriate audit evidence in some instances while in other cases the supporting evidence provided did not agree to the reported achievement. Based on the supporting evidence that was provided, the achievement was 5 500 but I was unable to further confirm the reported achievement by alternative means. Consequently, I was unable to determine whether any further adjustments were required to the reported achievement.

18. I did not raise any material findings on the usefulness and reliability of the reported performance information for the following programmes:

Other matters

Programmes
Programme 2 – strategy office
Programme 6 – compliance and investigation
Programme 7 – Benefit Management unit
Programme 8 – Financial Supervision unit

19. I draw attention to the matters below.

Achievement of planned targets

20. Refer to the annual performance report on pages 25 to 46 for information on the achievement of planned targets for the year and explanations provided for the under/over achievement of a number of targets. This information should be considered in the context of the material findings on the usefulness and reliability of the reported performance information in paragraph 16 of this report.

Adjustment of material misstatements

21. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were on the reported performance information of Programme 2 - strategic office, compliance and investigation and Programme 3 - accreditation unit. As management subsequently corrected only some of the misstatements, I raised material findings on the usefulness and reliability of the reported performance information. Those that were not corrected are included in the basis for qualified conclusions paragraphs.

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

Report on the audit of compliance with legislation

Introduction and scope

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

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

Annual financial statement

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

25. Material misstatements of current assets and expenditure identified by the auditors in the submitted financial statement were corrected, resulting in the financial statements receiving an unqualified audit opinion.

Expenditure management

26. Effective and appropriate steps were not taken to prevent irregular expenditure of R17 578 000 disclosed in note 25 to the annual financial statements, as required by section 51(1)(b)(ii) of the PFMA. The majority of the irregular expenditure was caused by non-compliance with procurement processes for sourcing consultants.

Procurement and contract management

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

28. The preference point system was not applied in some of the procurement of goods and services above R30 000 as required by section 2(a) of the PPPFA and treasury regulations 16A6.3(b).

Other information

29. 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 the selected programmes presented in the annual performance report that have been specifically reported on in the auditor's report.

30. 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.

31. 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.

32. I did not receive the other information prior to the date of this auditor's report. After I receive and read this information, and if I conclude that there is a material misstatement, I am required to communicate the matter to those charged with governance and request that the other information be corrected. If the other information is not corrected, I may have to retract this auditor's report and re-issue an amended report as appropriate. However, if it is corrected this will not be necessary.

Internal control deficiencies

33. 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 basis for the opinion and the findings on compliance with legislation included in this report.

Financial and performance management

34. The financial statements and annual performance report was not adequately reviewed for accuracy and completeness prior to submission for audit.

35. Significant internal control weaknesses were noted in the accurate and complete recording of irregular expenditure. Adequate controls that will prevent and detect irregular expenditure were not implemented. This resulted in the correction of financial statements.

Auditor - General

Pretoria
31 July 2018

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

ANNEXURE A - AUDITOR GENERAL'S RESPONSIBILITY FOR THE AUDIT

1. As part of an audit in accordance with the ISAs, I exercise professional judgement and maintain professional scepticism throughout my audit of the financial statements, and the procedures performed on reported performance information for selected programmes and on the 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 related to events or conditions that may cast significant doubt on the Council for Medical Schemes' ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements about the material uncertainty or, if such disclosures are inadequate, to modify the opinion on the financial statements. My conclusions are based on the information available to me at the date of this auditor's report. However, future events or conditions may cause an entity to cease continuing as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

Communication with those charged with governance

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

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

STATEMENT OF FINANCIAL POSITION

as at 31 March 2018

	Note(s)	2018 R'000	2017 Restated* R'000
Assets			
Current Assets			
Receivables from exchange transactions	3	10 389	5 847
Cash and cash equivalents	4	32 372	32 470
		42 761	**38 317**
Non-Current Assets			
Property, plant and equipment	5	17 130	18 476
Intangible assets	6	1 084	1 729
		18 214	**20 205**
Total Assets		**60 975**	**58 522**
Liabilities			
Current Liabilities			
Payables from exchange transactions	7	23 261	17 139
Unspent conditional transfers and receipts	12	2 803	3 271
Provisions	8	311	227
		26 375	**20 637**
Non-Current Liabilities			
Operating lease liability	9	9 442	8 231
Provisions	8	1 527	1 464
		10 969	**9 695**
Total Liabilities		**37 344**	**30 332**
Net Assets		**23 631**	**28 190**
Accumulated surplus		23 631	28 190

*See note 27

STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 2018

	Note(s)	2018 R'000	2017 Restated* R'000
Revenue	11	160 605	136 243
Administrative expenses	13	(23 199)	(21 700)
Audit fees	14	(1 476)	(785)
Operating expenses	15	(39 238)	(22 401)
Staff costs	16	(101 099)	(90 599)
Depreciation and amortisation		(4 906)	(4 431)
Gain on disposal of assets	17	9	44
Operating deficit		**(9 304)**	**(3 629)**
Interest received		4 744	4 483
(Deficit)/ surplus for the year		**(4 560)**	**854**

*See note 27

STATEMENT OF CHANGE IN NET ASSETS

for the year ended 31 March 2018

	Accumulated surplus R'000	Total net assets R'000
Opening balance as previously reported	27 337	27 337
Balance at 01 April 2016	**27 337**	**27 337**
Surplus for the year	854	854
Restated* Balance at 01 April 2017	**28 191**	**28 191**
Deficit for the year	(4 560)	(4 560)
Balance at 31 March 2018	**23 631**	**23 631**

CASH FLOW STATEMENT

for the year ended 31 March 2018

	Note(s)	2018 R'000	2017 Restated* R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		145 746	136 499
Transfers		5 536	1 758
Interest received		4 744	4 483
Total receipts		**156 026**	**142 740**
Payments			
Employee costs		(96 263)	(90 599)
Suppliers		(56 956)	(38 826)
Total payments		**(153 219)**	**(129 425)**
Net cash flows from operating activities	20	**2 807**	**13 315**
Cash flows from investing activities			
Purchase of property, plant and equipment	5	(2 941)	(4 284)
Proceeds from sale of property, plant and equipment	5	36	188
Purchase of intangible assets	6	-	(1 436)
Net cash flows from investing activities		**(2 905)**	**(5 532)**
Net increase in cash and cash equivalents		**(98)**	**7 783**
Cash and cash equivalents at the beginning of the year		32 470	24 687
Cash and cash equivalents at the end of the year	4	**32 372**	**32 470**

*See note 27

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2018

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	9 315	-	**9 315**	8 405	**(910)**	
Interest received	2 836	-	**2 836**	4 744	**1 908**	1
Levies income	134 276	-	**134 276**	135 668	**1 392**	2
Other income	1 787	-	**1 787**	1 269	**(518)**	
Other income - proceeds from sale of property, plant and equipment	-	**-**	**-**	36	**36**	
Registration fees	366	-	**366**	402	**36**	
Total revenue from exchange transactions	**148 580**	**-**	**148 580**	**150 524**	**1 944**	
Revenue from non-exchange transactions						
Transfer revenue						
Government transfers - Department of Health	5 496	-	**5 496**	5 536	**40**	
Total revenue	**154 076**	**-**	**154 076**	**156 060**	**1 984**	
Expenditure						
Personnel	(96 049)	(2 900)	**(98 949)**	(93 310)	**5 639**	3
Social contributions	(2 818)	(272)	**(3 090)**	(2 953)	**137**	
Agency and support	(82)	-	**(82)**	(120)	**(38)**	
Audit costs	(2 329)	742	**(1 587)**	(1 182)	**405**	
Bank charges	(52)	(86)	**(138)**	(117)	**21**	
Communication	(1 754)	(2 586)	**(4 340)**	(3 928)	**412**	
Computer services	(6 858)	(183)	**(7 041)**	(5 814)	**1 227**	
Consultants	(6 105)	(388)	**(6 493)**	(8 685)	**(2 192)**	4
Lease payments	(11 837)	(129)	**(11 966)**	(10 016)	**1 950**	5
Legal fees	(8 496)	(1 614)	**(10 110)**	(8 301)	**1 809**	6
Labour relations costs	-	(5 000)	**(5 000)**	(6 153)	**(1 153)**	7
Non-life insurance	(359)	(95)	**(454)**	(504)	**(50)**	
Other	(8 841)	(280)	**(9 121)**	(7 985)	**1 136**	
Other transfers to households	(58)	-	**(58)**	(6)	**52**	
Repairs and maintenace	(159)	(49)	**(208)**	(190)	**18**	
Training and development	(1 129)	(252)	**(1 381)**	(1 119)	**262**	
Travel and subsistence	(2 559)	(451)	**(3 010)**	(1 772)	**1 238**	
Venues and facilities	(1 057)	(86)	**(1 143)**	(1 063)	**80**	
Total expenditure	**(150 542)**	**(13 629)**	**(164 171)**	**(153 218)**	**10 953**	
Surplus/deficit for the year	**3 534**	**(13 629)**	**(10 095)**	**2 842**	**12 937**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2018

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
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	**3 534**	**13 629**	**10 095**	**2 842**	**12 937**	
Reconciliation						
Basis of accounting difference						
Depreciation and amortisation				(4 906)		
Depreciation on sale of property, plant and equipment				(26)		
Movement in operating lease				(1 211)		
Movement in provisions						
Movement in provisions				(147)		
Change in receivables from exchange transactions				4 542		
Change in payables from exchange transactions				(6 122)		
Change in unspent conditional transfer				468		
Actual Amount in the Statement of Financial Performance				**(4 560)**		

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2018

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 Position						
Assets						
Current Assets						
Cash and cash equivalents	-	(17 686)	**(17 686)**	(98)	**17 588**	
Non-Current Assets						
Property, plant and equipment	2 541	785	**3 326**	2 941	**(385)**	
Intangible assets	995	-	**995**	-	**(995)**	
	3 536	**785**	**4 321**	**2 941**	**(1 380)**	
Total Assets	**3 536**	**(16 901)**	**(13 365)**	**2 843**	**16 208**	
Liabilities						
Current Liabilities	-	(3 272)	**(3 272)**	-	**3 272**	
Unspent conditional transfers and receipts						
Total Liabilities	**-**	**(3 272)**	**(3 272)**	**-**	**3 272**	
Net Assets	**3 536**	**(13 629)**	**(10 093)**	**2 843**	**12 936**	
Nets Assets						
Formats and classification difference						
Deficit/(Surplus) for the year	3 536	(13 629)	**(10 093)**	2 842	**12 936**	

Note

Basis of accounting:The approved budget is based on a cash basis, thus recognising transactions and other events only when cash is received or paid. The actual amounts is 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 2017 to 31 March 2018

The approval of budget: The 2017/2018 budget was approved in terms of section 2(4) of the Council for Medical Schemes Levies Act, 2000 (Act no 58 of 2000) by the Minister of Health with the concurrence of the Finance Minister on the 15 April 2017.

Budget adjustments: Approval by the Acting Deputy Director-General: Public Finance was granted on 15 September 2017 CMS to retain cash surplus for the 2016/2017 financial year. Mid-term budget review was also done during October 2017 to reallocate funds between units.

Calculated materiality and significance value as determined in terms of Treasury Regulation 28.3.1 amounts to R 1 299 million. Positive and negative differences above the calculated materiality are explained in this statement below:

1. *Levy on medical schemes is based on a number of principal membership. The actual number of members as furnished by schemes to the Registrar was higher than the estimated number of members at the point of budget planning.*
2. *50% of the levies is received early in the financial year and invested with the South African Reserve bank, CPD account which earns more interest. Budget estimation is prepared on the average interest received in the past three years*
3. *The position of the Registrar is still vacant. Other vacancies were not filled within the prescribed estimated timeframes of 120 days.*
4. *Due to an increased number schemes which needed to be inspected, consulting costs related to this also increased.*
5. *The variance is attributed to straight lining of the lease payments.*
6. *Funds were allocated to this item during budget review in anticipation of possible legal challenges which could arise as a result of the NHI pronouncements made by NDoH and Health Market Inquiry.*
7. *CMS dealt with various labour relations matters during the current financial year which included investigations, disciplinary processes, CCMA appearances and in some instances, there were dismissals.*

ACCOUNTING POLICIES

for the year ended 31 March 2018

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.

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.

ACCOUNTING POLICIES (CONTINUED)

for the year ended 31 March 2018

1.4 Significant judgments and sources of estimation uncertainty (Continued)

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 the preceding reporting date. If any such indication exists, and it is material, 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

Initial recognition

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

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

Initial measurement

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

Subsequent measurement

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

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

Impairment

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

Financial assets measured at amortised cost:

If there is objective evidence that an impairment loss on financial assets measured at amortised cost has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows (excluding future credit losses that have not been incurred) discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced directly OR through the use of an allowance account. The amount of the loss is recognised insurplus ordeficit. If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed directly OR by adjusting an allowance account. The reversal does not result in a carrying amount of the financial asset that exceeds what the amortised cost would have been had the impairment not been recognised at the date the impairment is reversed. The amount of the reversal is recognised insurplus or deficit.

Financial assets measured at cost:

If there is objective evidence that an impairment loss has been incurred on an investment in a residual interest that is not measured at fair value because its fair value cannot be measured reliably, the amount of the impairment loss is measured as the difference between the carrying

amount of the financial asset and the present value of estimated future cash flows discounted at the current market rate of return for a similar financial asset. Such impairment losses are not reversed.

1.6 Property, plant and equipment

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

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

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

Property, plant and equipment is initially measured at cost.

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

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

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

Property, plant and equipment is carried at cost less accumulated depreciation and any impairment losses. Property, plant and equipment are depreciated on the straight line basis over their expected useful lives to their estimated residual value.

Property, plant and equipment is carried at cost less accumulated depreciation and any impairment losses. The useful lives of items of property, plant and equipment have been assessed as follows:

Item	Depreciation method	Average useful life
Furniture and fittings	Straight line	14 years
Motor 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 insurplus 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).

ACCOUNTING POLICIES (CONTINUED)

for the year ended 31 March 2018

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 theentity 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 theentity; 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

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 anintangible assets is included insurplus ordeficit when the asset is derecognised (unless the Standard of GRAP on leases requires otherwise on a sale and leaseback).

1.8 Leases

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

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

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

Finance leases - lessee

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

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

The finance charges resulting from the finance lease are expensed, through the Statement of Financial Performance, as they accrue. The finance cost accrual is determined using the effective interest method. Any contingent rents are expensed in the period in which they are incurred.

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

Operating leases - 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 instatement of financial performance.

Operating leases - lessee

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

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

1.9 Revenue from exchange transactions

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

Recognition

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

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

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

The main sources of revenue from exchange transactions are:

- **Accreditation fees:** Accreditation fees are fixed tariffs paid by administrators, mangaged 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 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.

ACCOUNTING POLICIES (CONTINUED)

for the year ended 31 March 2018

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 an other entity without directly giving approximately equal value in exchange, or gives value to an other 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, theentity 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 theentity and the fair value of the assets can be measured reliably.

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

1.11 Irregular expenditure

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

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

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

Irregular expenditure that was incurred and identified during the current financial year and which was condoned before year end and/or before finalisation of the financial statements must also be recorded appropriately in the irregular expenditure register. In such an instance, no further action is required with the exception of updating the note to the financial statements. Irregular expenditure that was incurred and identified during the current financial year and for which condonement is being awaited at year end must be recorded in the irregular expenditure register. No further action is required with the exception of updating the note to the financial statements. Where irregular expenditure was incurred in the previous financial year and is only condoned in the following financial year, the register and the disclosure note to the financial statements must be updated with the amount condoned. Irregular expenditure that was incurred and identified during the current financial year and which was not condoned by the National Treasury or the relevant authority must be recorded appropriately in the irregular expenditure register. If liability for the irregular expenditure can be attributed to a person, a debt account must be created if such a person is liable in law. Immediate steps must thereafter be taken to recover the amount from the person concerned. If recovery is not possible, the accounting officer or accounting authority may write off the amount as debt impairment and disclose such in the relevant note to the financial statements. The irregular expenditure register must also be updated

accordingly. If the irregular expenditure has not been condoned and no person is liable in law, the expenditure related thereto must remain against the relevant programme/expenditure item, be disclosed as such in the note to the financial statements and updated accordingly in the irregular expenditure register.

1.12 Fruitless and wasteful expenditure

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

1.13 Post-reporting date events

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

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

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

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

1.14 Related parties

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

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

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

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

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

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

The entity is exempt from disclosure requirements in relation to related party transactions if that transaction occurs within normal supplier and/or client/recipient relationships on terms and conditions no more or less favourable than those which it is reasonable to expect the entity to have adopted if dealing with that individual entity or person in

the same circumstances and terms and conditions are within the normal operating parameters established by that reporting entity's legal mandate. Where the entity is exempt from the disclosures in accordance with the above, the entity discloses narrative information about the nature of the transactions and the related outstanding balances, to enable users of the entity's financial statements to understand the effect of related party transactions on its annual financial statements.

1.15 Budget information

Entities 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 01/04/2017 to 31/03/2018.

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.

ACCOUNTING POLICIES (CONTINUED)

for the year ended 31 March 2018

1.16 Provisions and contingencies

Provisions are recognised when:

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

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

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

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

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

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

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

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

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

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note23.

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.

The Council for Medical Schemes (CMS) has only one office based in Centurion.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 31 March 2018

2. New standards and interpretations

2.1 Standards and Interpretations early adopted

The entity has chosen to early adopt the following standards and interpretations:

Standard/ Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 20: Related parties	01 April 2019	Unlikely there will be material impact.

2.2 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 after01 April 2018 or later periods:

Standard/ Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 32: Service Concession Arrangements: Grantor	01 April 2019	Unlikely there will be a material impact
GRAP 108: Statutory Receivables	01 April 2019	Unlikely there will be a material impact
GRAP 109: Accounting by Principals and Agents	01 April 2019	Unlikely there will be a material impact
IGRAP 17: Service Concession Arrangements where a Grantor Controls a Significant Residual Interest in an Asset	01 April 2019	Unlikely there will be a material impact

	2018 R'000	2017 R'000
3. Receivables from exchange transactions		
Accounts receivable	75	83
Sundry debtors	8 808	2 583
Prepaid expenses	1 506	3 181
	10 389	**5 847**
4. Cash and cash equivalents		
Cash and cash equivalents consist of:		
Cash on hand	-	5
Bank balances	4 222	3 827
CPD account	28 150	28 638
	32 372	**32 470**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

5. Property, plant and equipment

Figures in Rand thousand	2018			2017		
	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Computer equipment	12 460	(7 739)	4 721	10 868	(5 790)	5 078
Computer software	2 163	(1 649)	514	2 163	(1 372)	791
Furniture and fittings	7 820	(3 170)	4 650	6 663	(2 652)	4 011
Leasehold improvements	11 980	(5 346)	6 634	11 980	(4 072)	7 908
Motor vehicles	470	(138)	332	470	(44)	426
Other fixed assets	647	(368)	279	585	(323)	262
Total	**35 540**	**(18 410)**	**17 130**	**32 729**	**(14 253)**	**18 476**

Reconciliation of property, plant and equipment - 2018

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

Reconciliation of property, plant and equipment - 2017

	Opening balance	Additions	Disposals	Depreciation	Total
Computer equipment	4 308	2 474	(83)	(1 621)	5 078
Computer software	655	500	-	(364)	791
Furniture and fittings	3 777	836	(45)	(557)	4 011
Leasehold improvements	9 182	-	-	(1 274)	7 908
Motor vehicles	58	443	(8)	(67)	426
Other fixed assets	289	31	(8)	(50)	262
	18 269	**4 284**	**(144)**	**(3 933)**	**18 476**

Figures in Rand thousand	2018			2017		
	Cost / Valuation	Accumulated amortisation and accumulated impairment	Carrying value	Cost / Valuation	Accumulated amortisation and accumulated impairment	Carrying value
6. Intangible assets						
Acquired software	2 424	(1 940)	484	2 452	(1 476)	976
Developed software	1 795	(1 195)	600	1 795	(1 042)	753
Total	**4 219**	**(3 135)**	**1 084**	**4 247**	**(2 518)**	**1 729**

Reconciliation of intangible assets - 2018

	Opening balance	Amortisation	Total
Acquired software	976	(492)	484
Developed software	753	(153)	600
	1 729	**(645)**	**1 084**

Reconciliation of intangible assets - 2017

	Opening balance	Additions	Amortisation	Total
Acquired software	633	787	(444)	976
Developed software	158	649	(54)	753
	791	**1 436**	**(498)**	**1 729**

	2018 R'000	2017 R'000
7. Payables from exchange transactions		
Accounts payable	10 684	8 931
Accruals	8 536	4 986
Accrual for leave pay	2 806	2 208
Income received in advanced	1 235	1 014
	23 261	**17 139**

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

Figures in Rand thousand	Opening balance	Additions	Amortisation	Total
8. Provisions				
Reconciliation of provisions - 2018				
Provision for long service award	1 691	458	(311)	1 838

	Opening balance	Additions	Amortisation	Total
Reconciliation of provisions - 2017				
Provision for long service award	1 185	771	(265)	1 691

	2018 R'000	2017 R'000
Non-current liabilities	1 527	1 464
Current liabilities	311	227
	1 838	**1691**

Employees receive long service awards in intervals of 10 years. The provision for long service award represents management's best estimate of the entity's liability at year end for current employees in service. The calculation is based on the current 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.

9. Operating lease liability

	2018 R'000	2017 R'000
Non-current liabilities	9 442	8 231

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

Figures in Rand thousand	At amortised cost	Total
10. Financial instruments disclosure		
Categories of financial instruments		
2018		
Financial assets		
Trade and other receivables from exchange transactions	8 838	**8 883**
Cash and cash equivalents	32 369	**32 369**
	41 252	**41 252**
Financial liabilities		
Trade and other payables from exchange transactions	23 261	23 261
2017		
Financial assets		
Trade and other receivables from exchange transactions	2 666	2666
Cash and cash equivalents	32 470	32 470
	35 136	**35 136**
Financial liabilities		
Trade and other payables from exchange transactions	17 139	17 139

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

	2018 R'000	2017 R'000
11. Revenue		
Accreditation fees	8 182	6 352
Inspection fees recovered	9 085	168
Government transfers: Department of Health	5 964	595
Legal fees recovered	720	1 543
Levies income	135 663	126 469
Mandatory transfer: Department of Higher Education & Training	40	145
Registration fees	402	431
Sundry income	549	540
	160 605	**136 243**
The amount included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	8 182	6 352
Inspection fees recovered	9 085	168
Legal fees recovered	720	1 543
Levies income	135 663	126 469
Registration fees	402	431
Sundry income	549	540
	154 601	**135 503**
The amount included in revenue arising from non-exchange transactions is as follows:		
Taxation revenue		
Transfer revenue		
Government transfers:Department of Health (Note 12)	5 964	595
Mandatory transfer: Department of Higher Education & Training	40	145
	6 004	**740**
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. CMS does not charge any fee to BHF for the administration of the PCNS. BHF only has to submit quarterly report to CMS for purposes of research work.		

	2018 R'000	2017 R'000
12. Conditional transfer received		
Grant received from Department of Health		
Opening balance	3 272	2 254
Grant received	-	1 613
Utilised during the year	(469)	(595)
	2 803	**3 272**
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 and, b) Development and maintenance of beneficiary registry for medical schemes members.		
13. Administrative expenses		
Bank charges	117	100
Building expenses	1 920	2 242
General administrative expenses	871	949
Insurance	481	410
Printing and stationery	364	448
Refreshments	76	70
Rent	11 625	11 492
Rent - operating expense	2 138	1 971
Rental - copiers	396	399
Security	362	431
Subscriptions	415	345
Telecommunication expenses	4 434	2 843
	23 199	**21 700**
Included in the administrative expenses above is the repairs and maintenance cost with the amount disclosed below:		
Repairs and maintenance		
Repairs and maintenance costs	837	646

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

	2018 R'000	2017 R'000
14. Auditors' remuneration		
External audit	697	581
Internal audit	779	204
	1 476	**785**
15. Operating Expenses		
Committee remuneration	152	89
Consulting	14 105	5 302
Council members' fees	1 302	1 270
Exhibition costs	38	97
Knowledge management	940	791
Labour relations costs	6 618	-
Legal fees	8 355	7 888
Media and promotion	3 434	3 397
Postage and courier	77	78
Printing and publication	878	873
Transcription services	160	63
Travel and subsistence	2 126	1 675
Venue & catering	1 053	878
	39 238	**22 401**
The Human Resource unit dealt with various labour relations matters during the current financial year which included investigations, disciplinary processes, CCMA appearances and in some instances, there were dismissals.		
16. Staff costs		
Employee benefits	2 405	2 026
Employee wellness	387	339
Recruitment and relocation	308	503
Salaries	95 585	85 166
Staff training	995	1 510
Temporary staff	791	309
SEP system expense	468	595
Workmen's compensation	160	151
	101 099	**90 599**
Total number of employees	113	113
Management assessed the operations of the organisation during December 2017 and decided to provide staff members with additional 5 days annual leave.		

	2018 R'000	2017 R'000
17. Gain/ (Loss) on disposal of assets		
Gain/(loss) on disposal of assets	9	44
CMS disposed of some assets which where no longer in use during the year with a gain of R9 000.		
18. Interest received		
Interest earned on investment	4 744	4 483
The entity earns interest from the current account as well as the CPD account.		
19. Taxation		
No provision for taxation is made because the CMS is exempt from income tax in terms of Section 10(1)(cA) of the Income Tax Act 58 of 1962.		
20. Cash generated from operations		
(Deficit) / Surplus	(4 560)	854
Adjustments for:		
Depreciation and amortisation	4 906	4 431
(Gain) / Loss on sale of assets and liabilities	(9)	(44)
Movements in operating lease assets and accruals	1 211	2 026
Movements in provisions	147	506
Changes in working capital:		
Receivables from exchange transactions	(4 542)	1 279
Payables from exchange transactions	6 122	3 246
Unspent conditional transfers and receipts	(468)	1 017
	2 807	**13 315**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

	2018 R'000	2017 R'000
21. Commitments		
Operating leases - as lessee (expense)		
21.1 Photocopier rental		
Minimum lease payments due		
- within one year	369	399
- in second to fifth year inclusive	-	**365**
	369	764
The CMS entered into an operating lease agreement which commenced on 1 March 2016 for the rental of photocopiers up to 28 February 2019, with 0.0% escalation. The existing operating lease was settled in the current financial period.		
21.2 Office rental		
Minimum lease payments due		
- within one year	11 399	10 415
- in second to fifth year inclusive	56 145	51 297
- later than five years	2 678	18 315
	70 222	**80 027**
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.		

22. Related parties

Relationships

Executive authority: The Executive authority as defined in Section 1 of the PFMA, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.

Accounting authority: Council, as defined in Section 49 of the PFMA, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of CMS.

Executive management: Executive management is appointed by the Registrar and the Registrar is appointed by the Minister of Health.

	2018 R'000	2017 R'000
Related party transactions		
Transfer paid to/(received from) related parties		
Department of Health	(5 496)	(1 613)
Council Members		
Prof BC Dumisa	143	250
Ms A Dresher	13	-
Adv R Gaoraelwe	18	-
Adv H Koorverjie (SC)	117	109
Dr MS Mabela	79	117
Ms M Maboye	151	47
Mr M Maimane	18	-
Dr M Makhiwane	18	-
Dr C Mini	64	-
Dr L Mpuntsha	193	224
Ms L Nevhutalu	47	67
Prof L Pepeta	11	-
Prof S. Perumal	77	121
Ms S Ranchod	21	-
Ms D Terblanche	11	-
Mr J van der Walt	147	113
Prof Y Veriava	173	222
	1 301	**1 270**

Ms S Ranchod is a Council Member but she was also performing consultancy work on the consolidation of benefit options for Council for Medical Schemes for which CMS incurred costs of R132 972.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

22. Related parties (continued)

Compensation to executive management	Basic salary	Performance management	Acting allowance & other	Total
2018				
Chief Financial Officer	1 730	159	36	1 925
Chief Information Officer	1 714	-	(3)	1 711
General Manager: Accreditation	1 666	125	39	1 830
General Manager: Benefits Management	1 598	147	32	1 777
General Manager: Compliance and Investigation	1 730	159	48	1 937
General Manager: Complaints and Adjudication	1 415	118	33	1 566
General Manager: Financial Supervision	1 730	159	50	1 939
General Manager: Human Resources	1 730	157	24	1 911
General Manager: Legal Services	1 730	145	66	1 941
General Manager: Research and Monitoring	1 526	140	28	1 694
General Manager: Stakeholder Relations	1 174	-	293	1 467
Senior Strategist/Acting Registrar (April 2017- March 2018)	1 526	140	576	2 242
	19 269	**1 449**	**1 222**	**21 940**

The position of the Chief Executive Officer and Registrar has been vacant for the entire financial year. The Senior Strategist acted in this position. Included in the other benefits for General Manager: Stakeholder relations is R260 985 for termination benefit, with regard to CCMA settlement of two months salary paid to the General Manager who was dismissed during the year. Other benefits include acting allowance, movement in leave provision and movement in long service award.

Compensation to executive management	Basic salary	Performance management	Acting allowance & other	Total
2017				
Chief Executive and Registrar (November 2016- January 2017)	811	-	58	869
Chief Financial Officer/Acting Registrar (April 2016-October 2016 & December 2016)	1 599	148	3 66	2 113
Chief Information Officer	1 584	120	39	1 743
General Manager: Accreditation	1 540	107	28	1 675
General Manager: Benefits Management	1 477	112	28	1 617
General Manager: Compliance and Investigation	1 599	121	59	1 779
General Manager: Financial Supervision	1 599	121	35	1 755
General Manager: Human Resources	1 599	121	44	1 764
General Manager: Legal services	1 599	121	5	1 725
General Manager: Research and Monitoring	1 410	106	34	1 550
General Manager: Stakeholder Relations	1 447	101	40	1 588
Senior Strategist/Acting Registrar (February 2017- March 2017)	1 058	80	178	1 316
Senior Manager: Complaints and Adjudication	1 264	117	32	1 413
	18 586	**1 375**	**946**	**20 907**

Compensation to executive management includes gross remuneration as well as all company contributions. Figures were restated to include other benefits like leave provision and long services awards.

23. Contingencies

Contingent liabilities

On the 1 September 2016, CMS lost an urgent application by Commed in a case of Commed v CMS in the Gauteng High Court. CMS as the respondent was ordered to pay the costs of the application, including the costs of the two counsel. The estimated financial effect is to be determined by the decision of the Tax Master, however the taxed amount is estimated to be equal to or less than R300 000.

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

Contingent assets

The CMS won court cases against the following parties:

- SAMA
- Commed Medical Aid Schemes and CMS (Curatorship/liquidation)
- CMS and SAMWUMED Curatorship application
- Witsmed v CMS and Discovery
- Mr E Sibanda v Registrar and Commed

The CMS, as the successful party in these cases, was awarded costs on the party and party scale. The bills of costs relating to these matters have to date not been approved by the Taxation Master of the court. For these reasons uncertainties exist relating to the amount and timing of the legal fees recovered.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

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. CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account of R28 150 382 as at 31 March 2018.

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 R45 127 or decrease of R45 127 respectively.

25. Irregular expenditure

	2018 R'000	2017 R'000
Opening balance	10 787	9 419
Add: Irregular Expenditure - current year	15 497	1 368
Add: Irregular expenditure incurred in the prior year but identified in the current year	2 081	-
	28 365	**10 787**

The cause of the irrgular expenditure was investigated and the assesment was that the entity did not suffer any loss as the expenditure was incurred in pursuance of the operations of CMS. This irregular expenditure was due to non-comlpiance with procurement processes. The process of application for condonment of this irregular expenditure is still underway.

Analysis of expenditure awaiting condonation per age classification		
Current year	17 578	1 368
Prior years	-	9 419
	17 578	**10 787**

The CMS incurred irregular expenditure during the current year of R1 884 705 due to not inviting written price quotations for procuments up to an estimated value of R500 000 although CMS sourced these services from its legal panel of service providers. CMS also incurred an irregular expenditure of R11 843 285. In establishing a panel of inspectors, CMS did not do that through a bidding process as required for all procurements above R500 000. CMS also incurred an irregular expenditure of R1 769 005 as it 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 year identified during the current year's audit, where CMS did not establish its panel of inspectors through a bidding process as required for all procurements above R500 000.

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

In the prior year's audit, 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, 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 occured in proir years:

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		
Incident		
Bid awarded without following correct procedures	-	303
Bid awarded to the cheapest quote but not to the highest scoring bidder due to system error	-	1 065
	-	**1 368**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS (CONTINUED)

for the year ended 31 March 2018

	2018 R'000	2017 R'000

25. Irregular expenditure (Continued)

In the prior years, CMS incurred irregular expenditure to the amount of R1 094 000 for non comliance 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 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, CMS incurred irregular expenditure of R7 056 000 by acquired 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 & 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.

	2018 R'000	2017 R'000

26. Fruitless and wasteful expenditure

Penalty paid for late cancellation of the venue	7	-

After due consideration, Council decided to cancel the farewell function which was in the best interest of CMS, however the service provider required a 50% cancellation fee.

	2018 R'000	2017 R'000

27. Prior period errors

Management reviewed the treatment of the recoverable inspection costs to be also recognised as consulting fees (expense) and revenue from exchange transactions(inspection costs recoverable) respectively. The adjustments were made retrospectively.

The correction of the error(s) results in adjustments as follows:

Statement of Financial Performance		
Decrease in accumulated surplus (consulting fees) 31 March 2014	-	2 069
(Increase) in accumulated surplus (inspection costs recoverable) 31 March 2014	-	(2 069)
Decrease in accumulated surplus (consulting fees) 31 March 2015		3 231
(Increase) in accumulated surplus (inspection costs recoverable) in 31 March 2015		(3 231)
Decrease in accumulated surplus (consulting fees) 31 March 2016	-	3 351
(Increase in accumulated surplus (inspection costs recoverable) 31 March 2016	-	(3 351)
Increase in consulting fees (expense) 31 March 2017	-	168
in revenue (inspection costs recoverable) 31 March 2017	-	(168)

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 of its core mandate.

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

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

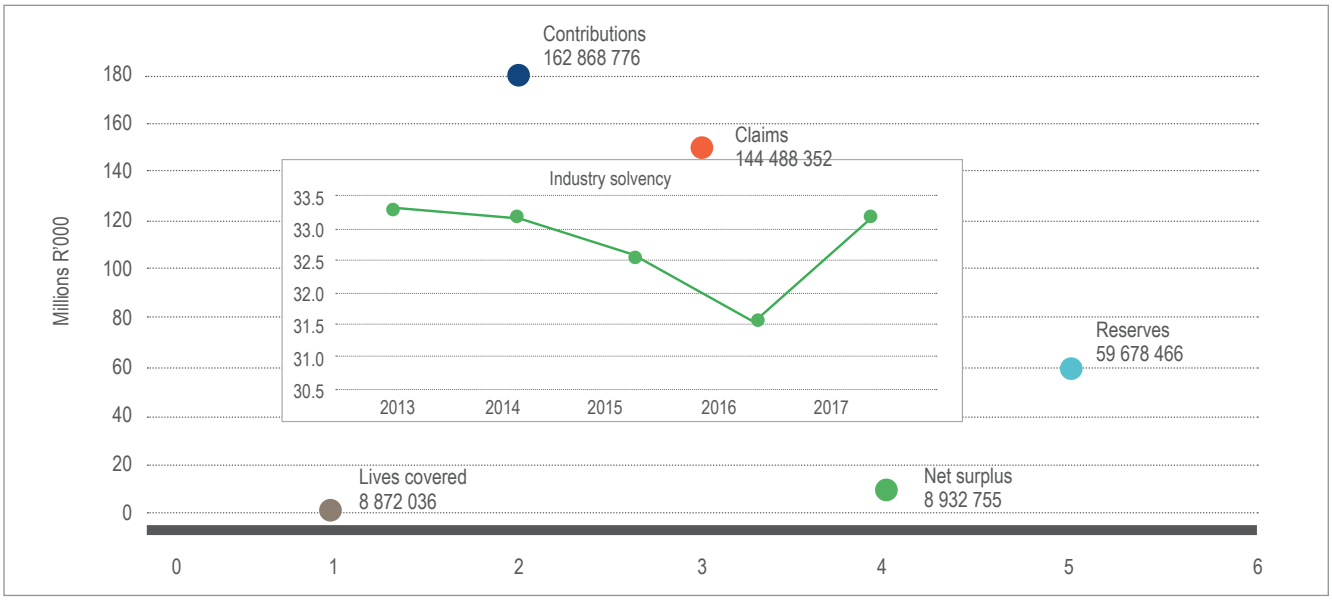
F | OVERVIEW OF ACTIVITIES DURING THE 2017/2018 REPORTING PERIOD

> *We can change the world and make it a better place. It is in your hands to make a difference. - Nelson Mandela*

OVERVIEW OF ACTIVITIES DURING THE 2017/2018 REPORTING PERIOD

The CMS promotes a healthy medical schemes industry that adheres to good governance and sound financial management. A key objective is to ensure that medical schemes offer good value to all beneficiaries of different ages, income groups and health status.

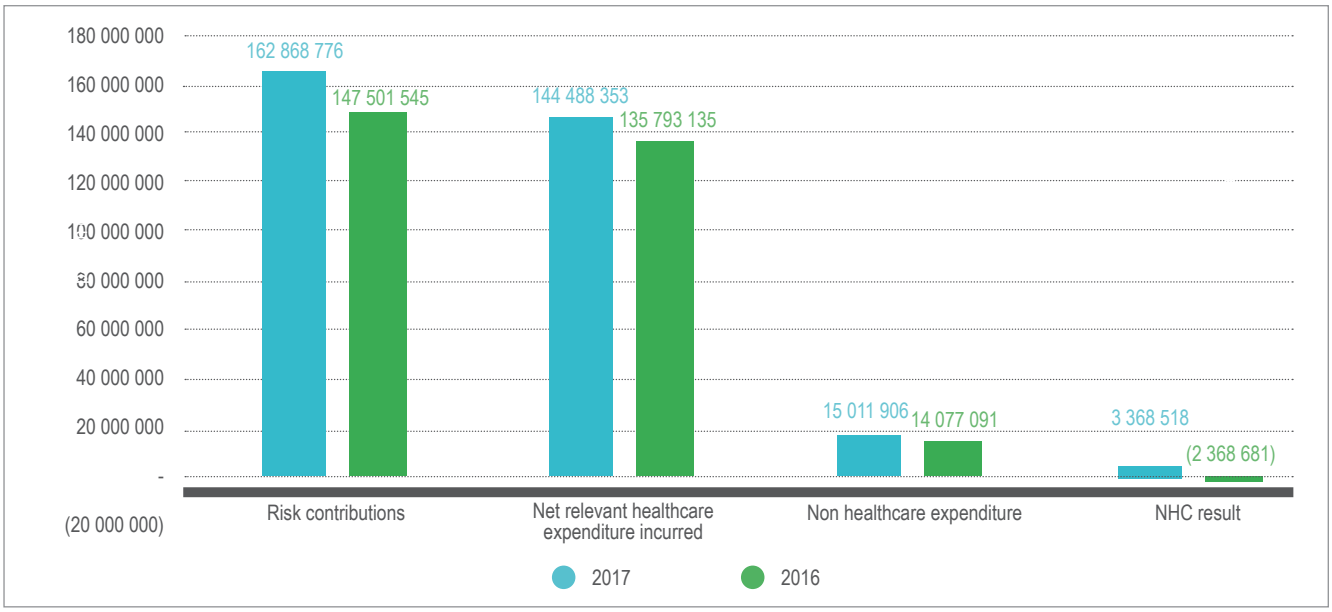
Figure 3: A snapshot of the industry



Financial soundness of medical schemes

The financial soundness of medical schemes can generally be measured by their operational results, the performance of their investments and the level of reserves. Medical schemes are required to remain financially viable, while meeting their legal obligations to members, as expressed by the Medical Schemes Act 131 of 1998 (MSA).

Figure 4: Performance of the industry



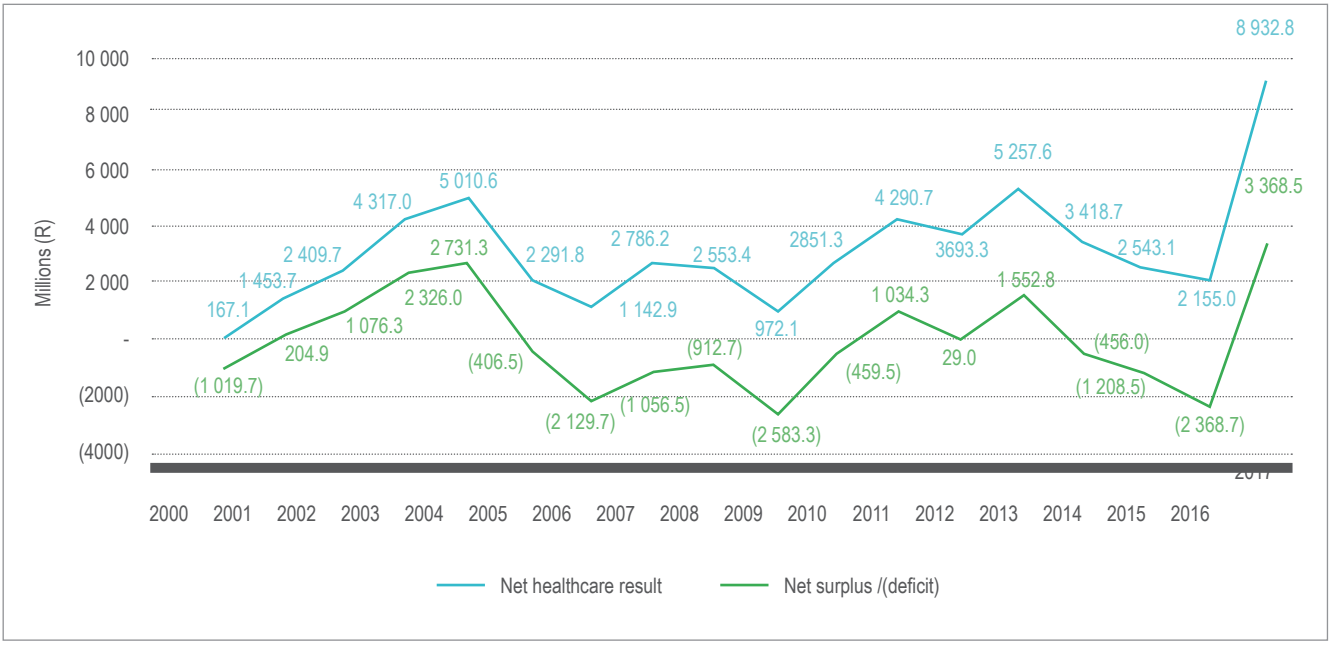
Note: NHC result: net healthcare results

The figure above shows how the total healthcare contribution paid by members was spent by medical schemes. In 2017, a total of R163.0 billion was collected in risk contributions[1] from members (2016: R148.0 billion) and expenditure on relevant healthcare services increased by 6.4% to R144.5 billion (2016: R136.0 billion). A total of R15.0 billion was spent on non-healthcare expenses, compared to R14.1 billion in 2016, an increase of 6.6%.

The 2017 financial year was a good year for most medical schemes, as many schemes over-provided for increased utilisation in their pricing following the poor industry-average operational results in 2016 experience. Actual claims were better than budgeted for and this resulted in a lower claims ratio of 88.7% for all medical schemes in 2017 compared to 92.1% in 2016.

After paying for relevant healthcare services and operational expenses, medical schemes reported a surplus of R3.4 billion before investment income in 2017, compared to a deficit of R2.4 billion in 2016.

Figure 5: Net healthcare results and the net results (after investment income and consolidation adjustments): 2000 – 2017



The net healthcare result for all medical schemes in 2017 was reported at R3.4 billion. After investment income and consolidation adjustments, a surplus of R8.9 billion was reported, (2016: R2.2 billion). This was an increase of 314.5% and meant that R8.9 billion of member contributions were contributed to general reserves (also known as accumulated funds) of the industry.

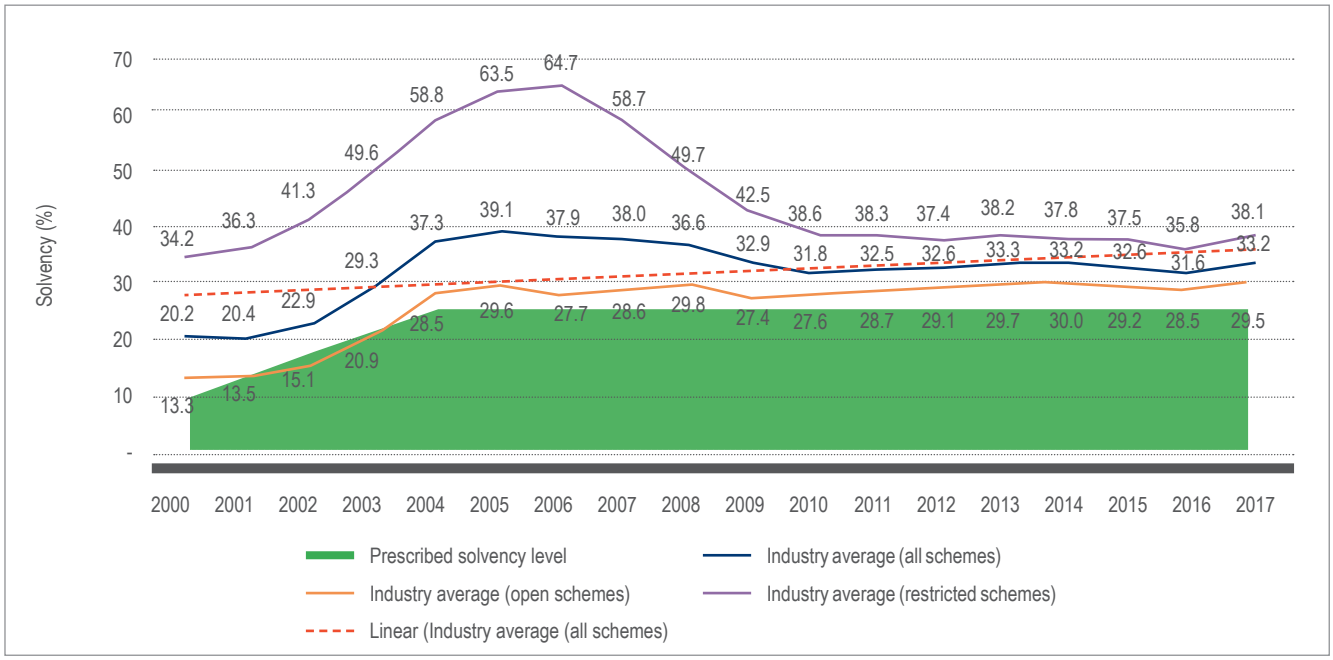
Reserves of medical schemes

Reserves serve to protect members' interests and to guarantee the continued operation of schemes. They also serve as a buffer against unforeseen, large-scale health events or the adverse performance of medical schemes. Accumulated funds, when expressed as a percentage of gross annual contributions translate into the solvency ratio.

Regulation 29 of the MSA requires all medical schemes to maintain accumulated funds of at least 25% of gross annual contributions. For the year ended 31 December 2017, the net assets of all medical schemes amounted to R63.6 billion (2016: R54.0 billion). The reported solvency level for all medical schemes for the year under review was 33.2%.

1 Risk contributions: Gross contributions less savings contributions

Figure 6: Industry solvency level for all schemes: 2000 – 2017



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.

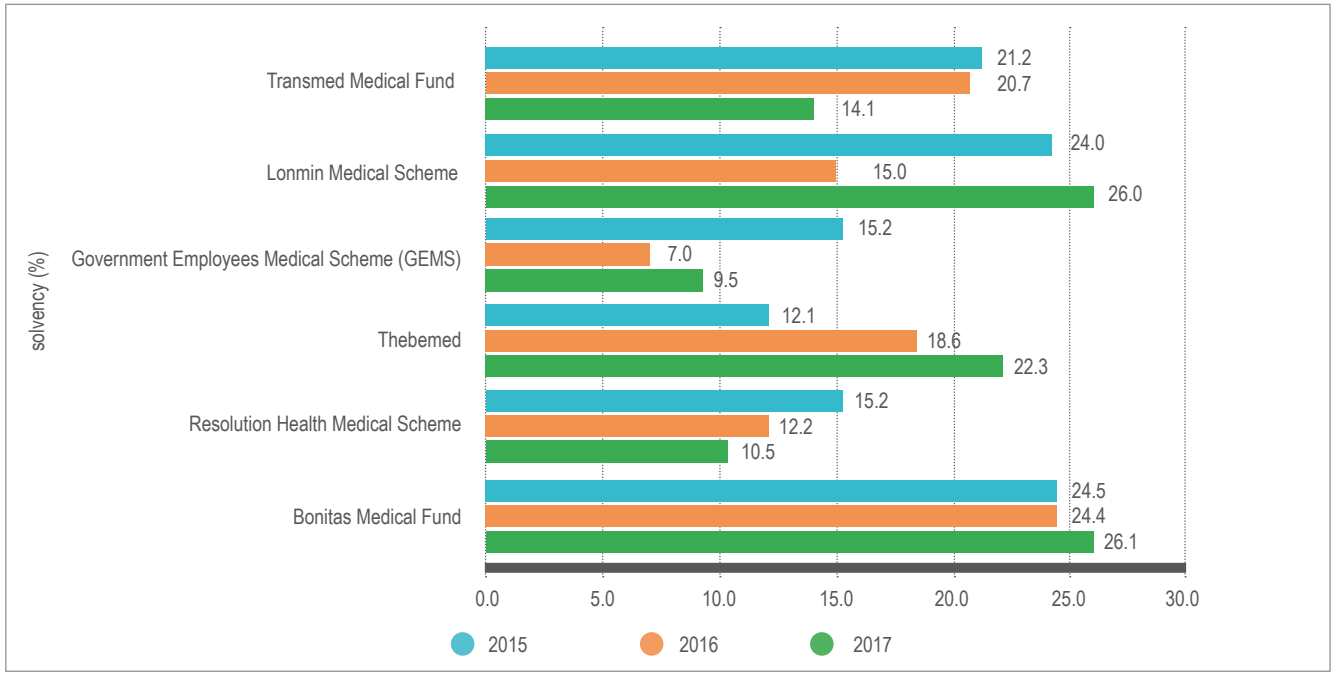
Such schemes are then placed on close monitoring by the CMS. During the period under review, six medical schemes, including one that is currently undergoing liquidation, failed to meet statutory solvency levels.

There were 779 925 lives covered in open schemes that were below 25% solvency in 2017, compared to 824 147 lives in 2016.

There were 1 876 641 lives covered in restricted schemes that were below 25% solvency in 2017, compared to 1 908 478 in 2016.

Other reasons for schemes to be subjected to close monitoring could include governance-related concerns or the fact that the scheme has high non-health expenditure levels. The figure below shows solvency trends for the last three years, for schemes below 25% as at 31 December 2017.

Figure 7: Schemes with solvency level below 25% from 2015 to 2017



- Community Medical Aid Scheme (COMMED) is not listed as it is currently undergoing liquidation.
- The Government Employees Medical Scheme (GEMS) reported a solvency level of 15.2% in 2017, up from 7.0% in 2016. The scheme introduced various initiatives in respect of claims management as well as cost containment, which are beginning to yield positive results.
- Lonmin Medical Scheme experienced a small decrease in its membership, as well as lower claims than anticipated. A business plan was submitted by the scheme and it was approved by CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.
- Resolution Health Medical Scheme's increase in solvency was mainly due to continued loss of membership. A business plan was submitted by the scheme and it was approved by CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.
- Thebemed's solvency ratio decrease was mainly due to membership growth and worse than anticipated claims experience. A business plan was submitted by the scheme and it was approved by CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.
- Transmed Medical Fund's (Transmed) increase in solvency was largely due to a steady decline in membership. The scheme's demographic profile has worsened over the years. A business plan was submitted by the scheme and it was approved by 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.

Member contribution increases for 2018

The average gross contribution increase for all medical schemes in 2018 was 7.2%. On average, restricted schemes instituted a 6.1% increase in contributions, while open schemes increased contributions by 8%.

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. Table 41 shows a summary based on medical scheme submissions on benefit changes and contribution increases for the 2018 calendar year.

Table 41: Average gross contribution increases for 2018

	Principal member %	Adult dependent %	Child dependent %	Family %
Restricted schemes	5.9%	6.8%	5.9%	6.1%
Open schemes	7.9%	8.1%	8.0%	8.0%
All schemes	7.1%	7.6%	6.9%	7.2%

Table 42: Average monthly gross contribution for 2018, as measured in Rands

	Principal member R	Adult dependent R	Child dependent R	Family R
Restricted schemes	2 371.1	2 015.8	855.4	4 067.0
Open schemes	2 480.8	2 219.1	790.3	4 009.4
All schemes	2 436.0	2 136.6	822.5	4 032.9

The average risk contribution increase for all medical schemes in 2018 was 7.4%. The comparative increases for open schemes were 8.0% and for restricted schemes 6.6%. The risk contribution is equal to the total contribution paid less the amount that is allocated to a savings account for a beneficiary.

Table 43: Average risk contribution increases for 2017/2018 benefit and contribution review period

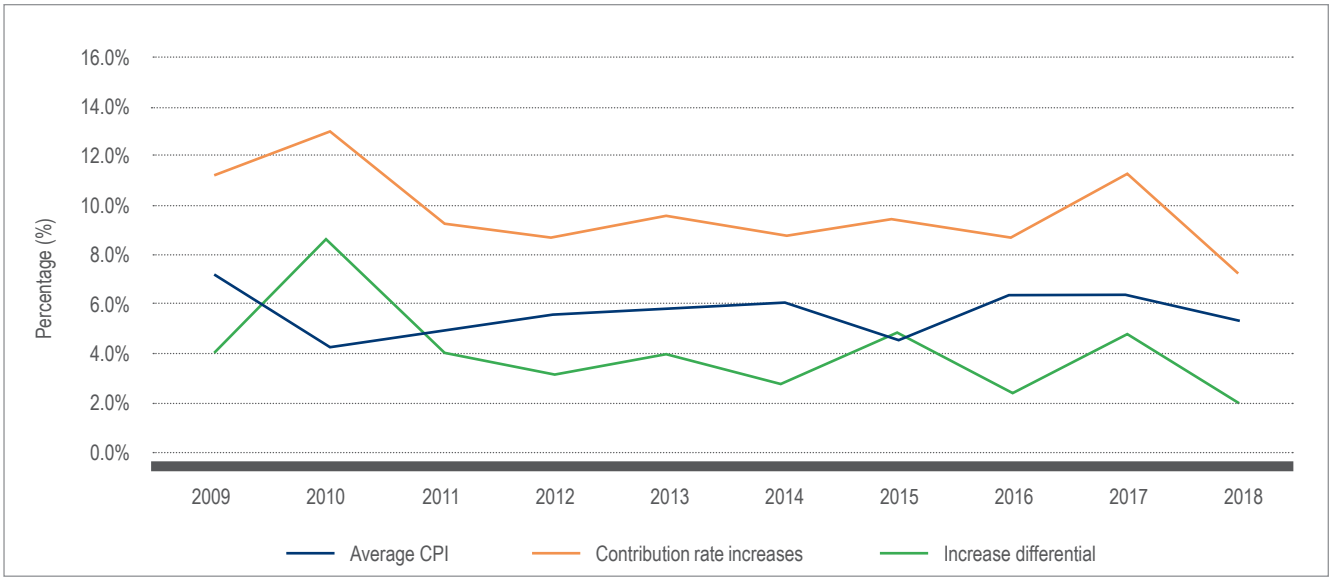
	Principal member %	Adult dependent %	Child dependent %	Family %
Open schemes	7.9%	8.1%	8.0%	8.2%
Restricted schemes	6.5%	7.4%	6.1%	6.6%
All schemes	7.3%	7.8%	6.9%	7.4%

Medical scheme contribution increases relative to inflation

The average contribution rate increase across the industry was 11.3% between 2016 and 2017 and 7.2% between 2017 and 2018. The average Consumer Price Index (CPI) increase during 2017 was 6.4%, as calculated by Statistics South Africa and 5.7% for the 2018 period as forecast by National Treasury.

The figure below illustrates that the average difference in contribution increases relative to CPI was in the region of 4.1% between 2009 and 2018. The difference between medical scheme contribution rate increases and the average CPI increase has implications for the long-term affordability of the medical schemes industry as increases in salaries may not necessarily keep pace with contribution increases.

Figure 8: Medical scheme contribution increases and inflation: 2009 – 2018



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

Medical schemes, benefit options and consolidation trends

In February 2018, the CMS published a list of all 80 registered medical schemes and their contact details in the Government Gazette, as required by section 25 of the MSA. No new medical schemes were registered during the period under review.

To ensure compliance with provisions of the MSA, the CMS compiled model scheme rules with an explanatory memorandum released to industry stakeholders via Circular 39 of 2016, which medical schemes were encouraged to follow. As at 31 March 2018, the CMS had processed 104 interim rule amendments and 91 submissions for benefit and contribution changes effective 1 January 2018, during 2017/18.

Benefit options

The total number of registered benefit options decreased from 331 in March 2017 to 324 in March 2018. Benefit options in open schemes decreased from 185 to 181 and restricted schemes registered options decreased from 146 to 143. However there was an increase in the number of efficiency-discounted benefit options (EDOs) registered on 31 March 2018. The total number of registered EDOs increased from 47 in March 2017 to 51 in March 2018.

Table 44: Registered benefit options as of March 2018

Classification of medical scheme	Open scheme options	Restricted scheme options	Total options
Options registered as at 31 March 2017	185	146	331
Less: efficiency-discounted options	-44	-3	-47
Options registered as at 31 March 2017 (excluding efficiency-discounted options)	141	143	284
New options	1	0	1
Discontinued options	-2	-2	-41
Discontinued options due to scheme mergers	0	-4	-4
Discontinued options due to scheme liquidations	-4	0	-4
Options registered as at 31 March 2018 (excluding efficiency-discounted options)	136	137	273
Efficiency-discounted options*	46	6	51
Options registered as at 31 March 2018	181	143	324

* Efficiency Discounted Options have similar benefit offerings to the main options but they have discounted contribution tables based on the restricted provider network.

Efficiency-discounted options (EDOs)

In terms of section 29(1)(n) of the MSA, 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 MSA before they can operate EDOs. EDOs operate primarily by providing members the choice of a tighter network of service providers that offers advantages to both members and medical schemes. By electing to be on these options members receive a discount on the contribution rate based on the pre-negotiated discounts the scheme has arranged with a selected provider network.

There were 12 (nine open and three restricted) schemes offering efficiency-discounted options as at 31 March 2018. The schemes included Momentum Health, Discovery Health Medical Scheme (DHMS), Fedhealth Medical Scheme, Bonitas Medical Fund, Thebemed, Compcare Wellness Medical Aid Scheme, Medihelp, Bestmed Medical Scheme, Resolution Health Medical Scheme, Government Employees Medical Scheme (GEMS), MotoHealth Care and Old Mutual Staff Medical Aid Fund.

The proportion of beneficiaries on EDOs remained largely unchanged between 2013 and 2017, at 20.45% and 20.39% of the total number of beneficiaries covered by options that offer an EDO, respectively.

This trend is disappointing seeing that an analysis of the net healthcare results shows that EDOs continue to report positive results. The net healthcare result of the EDOs and non-EDOs is shown in the table that follows. During the period under review, the EDOs collectively contributed up to 32.3% of the total surplus, even though these options accounted for only 20.4% of the total membership.

Table 45 : Net healthcare results of EDOs and non-EDOs: 2013 - 2017

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

One of the reasons for the better operating results of EDOs could be that the average age of beneficiaries of EDOs is lower than the average age of the scheme membership. As of December 2017, the average age of EDO beneficiaries was 30.9 compared to 34.9 for non-EDOs. The claims ratio for EDOs was 76% compared to 88.4% for non-EDOs. Refer to Annexure V for detailed information on the EDOs.

Consolidation of medical schemes and benefit options

Over the last 20 years there has been a natural consolidation of schemes, and more recently, benefit options. The National Health Insurance (NHI) White Paper raised the prospect of medical schemes and benefit options consolidating by 2025 in the gazetted NHI Implementation structures.

The Council for Medical Schemes attended and organised several industry engagements on the issue of risk pool consolidation. Discussions were also held with the Health Market Inquiry panel to explore possible policy and regulatory instruments to address risk pool fragmentation in the interim phase, in anticipation of amendments to the Medical Schemes Act and establishment of the NHI fund. The key concern for the CMS is the risk pools with less than 2500 members at a benefit option level, where such benefit options are experiencing operational deficient, low reserves as well as low beneficiary numbers. Affected schemes have been cautioned and requested to submit a detailed turnaround strategy to address the situation, in protection of the beneficiaries' interests. Some of the measures implemented by schemes in response to CMS regulatory interventions include: reviewing of the benefit design to measure appropriateness in line with provisions of Section 33 of the MSA; tightening of contractual agreements with service providers to improve cost containment while protecting access to benefits; implementation of medical insurance risk management policies; as well as strengthening of the fraud prevention and detection strategy by schemes.

Burden of disease and use of healthcare services in medical schemes

Monitoring and analysis of clinical data

Accurate, high quality healthcare data is vital for any healthcare planning and evaluating process, but is especially necessary for a healthcare system aimed at achieving healthy outcomes for all. The utilisation of healthcare services paid for by medical schemes has to be monitored by the CMS in order to evaluate the effectiveness of medical schemes as a financing mechanism for the delivery of healthcare to members. Where necessary, CMS should be in a position to recommend legislative reforms based on the data collected for this purpose.

CMS implemented the Dynamic Database Driven Annual Returns (DDDR) to collect the Healthcare Utilisation Returns during the 2012/13 financial year. The introduction of the DDDR system was accompanied by continuous improvements in the data specification guidelines.

Over the past four years, CMS has noticed an improvement in the quality of the healthcare utilisation data supplied by medical schemes, but there are schemes that still find it difficult to submit quality data and do not have their data audited. In future, CMS may have to consider introducing initiatives aimed at improving the quality of data provided by schemes; such as requiring schemes to provide verification of the number of beneficiaries registered on chronic disease management programmes.

Scheme risk measurement

The CMS continued to collect scheme risk measurement (SRM) data to measure and report on the risk profiles of medical schemes and benefit options. It has become difficult to assess the quality of chronic disease list (CDL) data submitted by medical schemes because the 2009 weighting and count tables have become outdated. Nevertheless, the SRM analysis results remain useful as a standard in comparing differences in risk profiles between medical schemes. The SRM analysis results will play an integral part in the future consolidation of benefit options.

Figure 9 demonstrates the impact of risk factor variables and probable changes in the utilisation behaviour when prices are kept constant. The industry community rate, the indirect measure for prescribed minimum benefit (PMB) costs, increased by 70% from R457 in 2006 to R805 in 2017. This large increase can be attributed to changing scheme demographic profiles (e.g. aging), increased utilisation of healthcare services (e.g. hospitals and specialists) and improved identification of beneficiaries with SRM risk factors.

Further studies are needed to understand the contribution of each of these factors to the changes observed in estimated costs between 2006 and 2017. The industry community rate is expected to continue to increase at levels above inflation as risk profiles of medical schemes continue to deteriorate. The increase from 2016 to 2017 amounted to 2.6% above inflation.

Figure 9: Industry community rate, 2017 prices

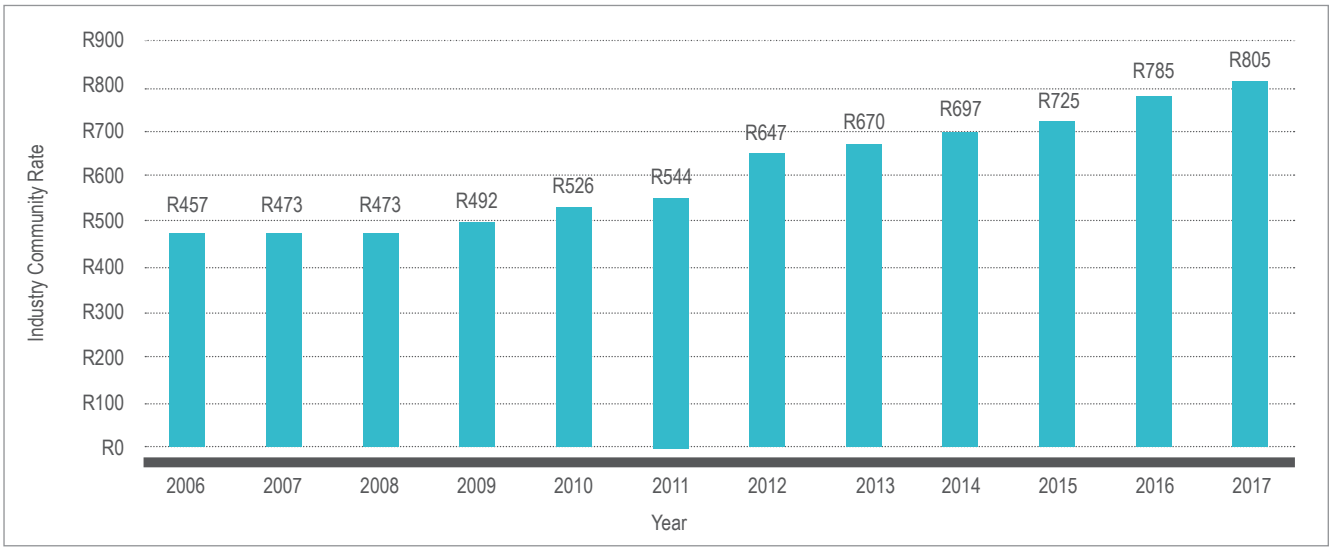


Figure 10 below illustrates the variation in the medical schemes' community rate for 2017. The scheme community rate of the most unfavourable age structure was R1 094 above industry community rate (R805), whereas the cost for a scheme with the most favourable age structure was R536 below industry community rate.

The variation in the observed scheme community rate is a clear indication that some schemes attract younger and healthier beneficiaries. This leaves other schemes with older and less healthy beneficiaries and with a higher community rate for the PMB package. The widening variation in risk profiles between medical schemes and options, and the limited income and risk cross subisdy is a threat to the goal of a healthy industry for all.

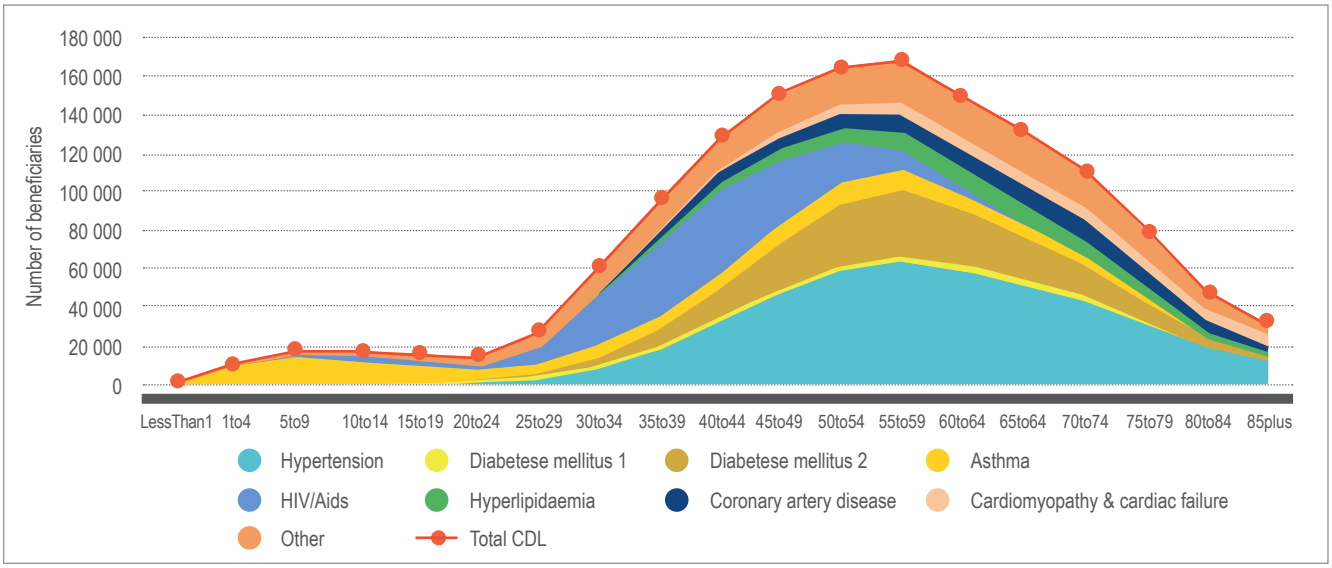
Figure 10: Scheme community rate variation

The growing burden of disease

The burden of cardiac associated conditions (hypertension, cardiac failure and cardiomyopathy, and coronary artery disease) and diabetes mellitus type 2 highlights the huge impact of lifestyle diseases on medical schemes and their beneficiaries.

The higher prevalence of beneficiaries with chronic diseases translates to an increase in visits to general practitioners and specialists, a growth in the use of medicines, and a possible rise in hospital admissions. Without population-wide interventions to address the root cause of these chronic diseases, the upward trend is expected to continue, with increasingly severe negative impact on schemes. The protection of the risk pools and a substantial growth in the number of medical scheme beneficiaries is critical for the long-term sustainability of the industry.

Figure 11: Distribution of chronic disease by age: 2017

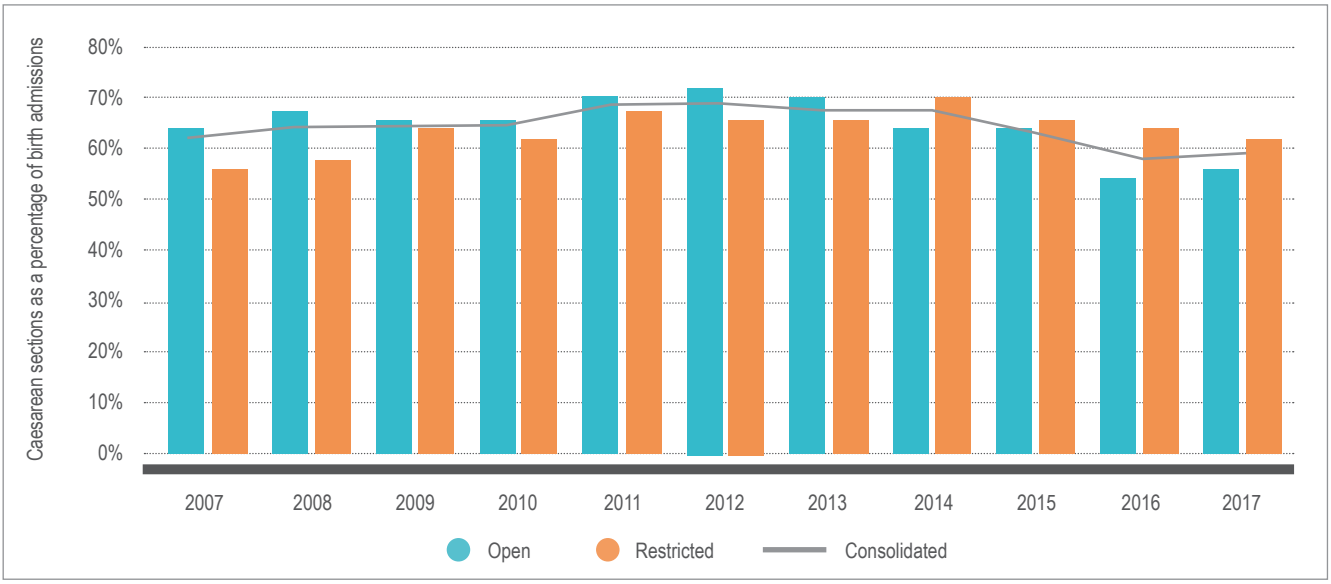


Equity in service utilisation

Equitable use of services refers to the use of healthcare services based on need rather than on the ability to pay. Variations in the use of healthcare services is usually explained by differences in age, gender, ethnic group, urban versus rural residence, medical scheme membership and ability to pay, among other factors.

Delivery by caesarean section in the insured population is significantly above the South African public sector average and the international average. The World Health Organisation (WHO) recommends a maximum of between 10-15% caesareans per country (WHO, 2015). The rates observed in the medical scheme environment are not likely to be explained by differences in clinical risk factors for assisted delivery; they are more likely explained by the ability of patients to pay. Inefficient use of healthcare services, such as caesarean section deliveries, contributes to inequalities in health.

Figure 12: Caesarean sections performed in the medical schemes population: 2007 – 2017



Process and outcome indicators for improved managed care interventions

During the year under review, the working group of the Industry Technical Advisory Panel (ITAP) made good progress discussing the 26 CDL conditions. As in the previous year, this panel identified minimum process and outcome indicators that are expected of managed care organisations when they manage these conditions.

ITAP also recommended that managed care organisations should collect the process and outcome indicators and have these available on request by CMS. The CMS adopted the same indicators identified through ITAP as the minimum standards acceptable for quality of care in the medical schemes environment.

The Utilisation Annual Statutory Return (ASR) data specification documents were amended to incorporate these indicators. Schemes are required to ensure that all beneficiaries have access to quality healthcare and that they receive the appropriate care, especially if they are registered on a chronic disease management programme.

Managed Care Theme Project

This project seeks to effectively demonstrate and evaluate the value of managed care services rendered to beneficiaries of medical schemes. Eleven conditions were finalised in collaboration with stakeholders during the year under review, with completed data specifications in respect of entry level criteria, process indicators and health outcomes having been introduced. All prescribed chronic diseases have now been allocated data specifications to be analysed in terms of this participatory process.

Prescribed minimum benefits review

It is a key responsibility of the CMS to ensure that the prescribed minimum benefits (PMBs) provide adequate health cover for members of schemes. In line with this responsibility, one of the strategic projects identified by the CMS for the 2017/18 financial year was the review of PMBs.

PMBs are a list of minimum benefits that medical schemes must provide to members irrespective of the benefit option chosen by the member. Over the past few years, many stakeholders have commented that the current PMBs are not responsive enough to the changes in healthcare needs of the population, current health technology and best clinical practice, burden of disease, health policy, or the financial impact on medical schemes.

Consultative meetings between the CMS and different stakeholders is continuing in this regard. The following committees were established during 2017:

- The benefit package advisory committee.
- The costing committee.
- The legal and regulatory committee.
- The joint steering committee.
- The priority setting technical subcommittee.

During 2017, a draft PMB benefit package framework was published by CMS for stakeholder comments. The CMS is proposing a service benefit framework for a revised PMB package with a departure from the current package, which is a disease/condition/diagnosis based list. The proposal is that the recommended health service package will serve as a basis for a maximum set of services available to medical scheme members, at primary care and hospital settings.

Several submissions were received and are being collated into the proposed draft framework. These consolidated submissions will be submitted to the benefit package advisory committee for consideration. The service benefits will describe the detailed services that should be covered, including the level of healthcare setting and provider where the services could be accessed by scheme members. Costing of the revised PMB benefit package will be undertaken to ensure affordability and sustainability.

In addition, the following PMB benefit definitions were published as funding guidelines during the 2017/18 financial year:

- Appendicitis
- Gastric or intestinal ulcers
- Hepatocellular cancer
- Hernias
- Colorectal cancer (early stage and advanced stage)
- Non - small cell lung cancer small cell lung cancer
- Small cell lung cancer
- Mesothelioma
- Medical nutrition therapy in palliative care setting in adults

Demarcation Regulations

The final Demarcation Regulations came into effect on 1 April 2017. The Regulations provide a distinction between medical scheme cover, which is governed by the MSA and other types of health insurance governed by the two insurance Acts, namely the Long Term Insurance Act 52 of 1998 and the Short Term Insurance Act 53 of 1998. In terms of the regulations, any insurer selling indemnity products such as primary healthcare cover or hospital indemnity cover was, with effect from 1 April 2017, regarded as conducting 'the business of a medical scheme' and was therefore subject to regulation under by the MSA.

However, a two-year exemption to sellers of primary healthcare insurance products, subject to certain conditions, was agreed upon. This was to ensure that existing policy holders were covered while research was conducted by the National Department of Health and the CMS into the viability of substitute health insurance products. It is envisaged that in due course this research will contribute to the development of a Low Cost Benefit Option designed for entry-level workers.

The exemption process for eligible insurers was published in the Demarcation Exemption Framework in March 2017, and described the two-stage exemption process that insurers were obliged to follow in order

to continue to sell primary health products with full exemption from the provisions of the MSA.

The CMS received 38 applications, representing 171 insurance products. These applications were reviewed by the Compliance & Investigations Unit and submitted to Council for approval. Council approved 36 exemption applications. In the second leg of this process, insurers and their respective financial service providers were required to submit Stage 2 exemption applications within 30 days after formal notification was received by the CMS.

In the second round, exemptions were granted to the 18 insurers that had met the terms and conditions set by the CMS. Exemption was refused to the remaining 18 insurers, due to a wide range of factors. The factors considered by the CMS included those listed for quality for granting exemption, included:

- Consumer warning and awareness.
- Discrimination.
- Application of unfair waiting periods.
- Compliance with Financial Sector Conduct Authority prudential requirements.
- Treating Customers Fairly (TCF).
- Policy Protection rules.

Promoting a healthy industry through stakeholder engagement

External, internal and international liaison

Through active participation in forums such as the Committee of Insurance, Securities and Non-banking Financial Authorities (CISNA), the CMS continued to foster liaison and co-operation with related industry role players within the Southern African Development Community (SADC) region.

The Stakeholder Relations Unit hosted several stakeholder events which served as a valuable platform for continued engagement and sharing information on industry developments, with key stakeholders. These included the Principal Officers and Board of Trustees Forum, the Medical Schemes Stakeholder Indaba sessions, the Marketing Forum and the Customer Care Manager's Forum. The unit also participated in some of the exhibitions hosted by key industry role players during the year.

During the last quarter of the financial year, the unit coordinated the introduction of a roadshow initiative to visit schemes and other entities at their premises for one-on-one meetings. Spearheaded by the Chairperson of Council and the Acting Registrar, the meetings form part of the CMS' aim to deepen the level of engagement with medical schemes and other entities over which the CMS exercises supervisory oversight, in line with its broader goal of positioning the private healthcare industry as a resourceful role player in the country's envisaged NHI environment.

The engagements provided valuable insight into some of the unique challenges that schemes grapple with. The meetings continue to serve as a catalyst for schemes to make inputs on possible solutions for implementation in the NHI environment, based on their experiences in managing diverse variables in the provision of healthcare services for their members.

Member education

A significant number of members were reached as a result of increased outreach activities conducted across the country during the period under review. Information brochures written in various official languages were distributed to members as part of the outreach activities. The outreach initiatives also included consumer information sessions and community radio interviews conducted as part of the Provincial Consumer Protection initiative.

A billboard campaign was rolled out in the last quarter of the financial year under review, as part of reaching members in some of the townships in the rural areas of the country. The unit also introduced an advanced broker training programme, with sessions conducted in Gauteng, Western Cape, Eastern Cape, and KwaZulu-Natal provinces.

Member support

The CMS continued to offer support to members and beneficiaries who engaged with the organisation through the Customer Care Centre care line. Staff members based in the Customer Care Centre handled a total of 34 023 calls during the year under review. This amounted to 92.2 % of the 36 892 calls received during that period. A total of 2 869 (7.8%) were abandoned calls, including calls received outside working hours.

Enforcing and encouraging compliance for a healthy industry

Enforcing compliance in medical schemes

The CMS uses a number of mechanisms and tools to enforce and encourage compliance in medical schemes in line with the provisions of the MSA. A tiered monitoring system, which starts with baseline supervision and routine inspections, and moves through to a 'close monitoring' regime, has also been designed. The CMS regularly attends annual general meetings (AGMs) of medical schemes, follows up with complaints or allegations, assists with the vetting of trustees, and if necessary, the removal of conflicted trustees.

Baseline supervision

All medical schemes are subject to baseline financial supervision, which requires the submission of Annual Statutory Returns, the submission of Quarterly Returns and scrutiny from the Real Time Monitoring System.

The Annual Financial Statements (AFS) as per section 37 of the MSA:
The statutory returns are an important tool for reporting on historical financial performance and position of medical schemes, their ability to

continue operating into the foreseeable future, as well as determining trends and any emerging issues. Access to such data enables more effective decision making and feeds directly into the various regulatory interventions catered for in the MSA and policy formulation. The information contained in the AFS is useful to various stakeholders, in particular members whose monies are being managed by medical schemes on their behalf. This information contained in the AFS is critical to members in determining their return on investment and value proposition offered by medical schemes to which they belong.

Early Warning System (EWS): The EWS is mainly used as an alarm bell mechanism to signal potential challenges that schemes could be facing. It comprises several statutory tools namely:

- *Quarterly Return System:* This system serves as the core of our EWS, enabling the continuous monitoring of schemes in between audit cycles. The Council for Medical Schemes is then able to institute a suite of interventions/ interactions with the management of schemes, thus ensuring the ongoing protection of members.

- *Real Time Monitoring (RTM) System:* Over the last financial year, the CMS has made significant progress in the implementation and utilisation of the RTM by the industry. The data received through this system focuses on a few key indicators which are collected from all schemes monthly, based on which there will be interaction with the scheme. It seeks to assist in better understanding the profiles of medical schemes, and any other matters that are unique to the respective schemes.

Routine inspections

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

By conducting these inspections on medical schemes, medical scheme members can find comfort in the knowledge that schemes are being monitored for overall good governance and compliance with relevant legislation as well as scheme rules. During 2017/18, routine inspections were conducted on the following schemes and directives issued:

- Fishmed: After the routine inspection, the scheme was directed to remove two of its trustees.
- Golden Arrows: After the routine inspection, the scheme was directed to remove one trustee and to terminate one of its profit sharing agreements.
- Resolution Health Medical Scheme: The routine inspection exposed allegations of irregularities that were beyond the scope of a routine inspection, which will subsequently be investigated in terms of a commissioned inspection.
- Pick n Pay Medical Scheme: Directives were issued to the scheme regarding in-house matters that needed attention.

The following routine inspections are in the process of being conducted:

- PG Group Medical Scheme
- Witbank Coalfields Medical Aid Scheme
- Libcare medical scheme
- Medshield medical scheme

Where there is a lack of good governance, the CMS issues directives instructing the relevant scheme to rectify non-compliance. In cases where the overall non-compliance or lack of good corporate governance are identified, action is taken to protect the interest of members of the scheme, and this is done by the removal of a principal officer / trustee (s) or, in certain cases, placing the scheme under curatorship.

Inspections following complaints or allegations

Both commissioned and routine inspections are crucial, as non-compliance and irregularities have a major impact on scheme members. Irregularities can have a major impact on schemes' healthcare and non-healthcare expenditure, which can lead to members paying higher membership contributions; and/or receiving very limited benefits.

In May 2017, a forensic inspection was commissioned into the affairs of COMMED after complaints by members regarding the scheme's failure to pay claims. The scheme was subsequently placed under curatorship on 2 June 2017.

Inspections following allegations of irregularities:

- Discovery Health Medical Scheme: Scheme inspected following allegations of irregularities.
- Bonitas Medical Fund: Scheme inspected following allegations of irregularities.
- Government Employees Medical Scheme: Scheme inspected following allegations of irregularities.
- Resolution Health Medical Scheme: Scheme inspected following allegations of irregularities.

Declaration of undesirable business practices

The Compliance and Investigation unit continuously identifies frequent and common contraventions of the MSA for the purpose of having it declared undesirable conduct. Practices that are undesirable often impact on the trustee election process, fitness and propriety of the board, unfair practices towards members, marketing and branding practices or the unfair influence by scheme service providers.

Monitoring Annual General Meetings (AGMs)

All schemes are required to call for annual general meetings during which the audited financial statements of the schemes as well as the appointment of external auditors are approved.

It is crucial for the CMS to attend annual general meetings (AGMs) as observers in order to monitor compliance with scheme rules, which are aligned with the MSA. It is also important to observe that proper protocols are followed in terms of member eligibility to vote and that the meetings are conducted without bias and or influence from any other parties, meeting manipulation or vote rigging.

The audited statements should be laid out to the members who should approve the audited financial statements and the appointment of the external auditors.

Areas of concern that are identified at AGMs are directed to the schemes to rectify. Examples of previously identified concerns included the following:

- Construction of rules.
- Compliance with rules at the meetings on matters of quorum, nominations and attendance registers.
- Member complaints regarding the payment of claims in contravention of the Act and relevant medical scheme rules.
- Member complaints on service delivery.

During the period under review, CMS attended and monitored the AGMs of 31 medical schemes. In addition, the special general meetings held by Bonitas Medical Scheme and Polmed Medical Scheme were observed.

Trustee vetting

The vetting of trustees and principal officers is conducted by the Compliance & Investigations Unit from time to time. Vetting is done to determine the fitness and propriety of scheme officials and to ensure that schemes follow a proper, independent and objective vetting process.

Trustees and principal officers are appointed on the basis that they are fit and proper to manage the business of schemes. It is possible that trustees that are not fit and proper might pursue their own interests, financial or any other gain. Such officials are unlikely to be objective and their actions may result in decisions or initiatives that are not in the best interest of members. It is therefore crucial to follow a trustee vetting process in order to protect members from trustees who may want to put their own interests above the interests of scheme members.

Removal of trustees

Trustees who are not fit and proper to manage a medical scheme are removed in terms of section 46 of the Act. Trustees that act for personal financial gain pose a major threat to members' interests as well as to the sustainability of medical schemes. It is therefore crucial to remove them from office.

Exemption applications

Schemes should comply with all the provisions of the MSA. In cases where they are not compliant, a formal exemption application should be submitted for approval by Council.

The Compliance & Investigations Unit, in conjunction with other CMS units, reviews exemption applications to ensure that such applications are in the best interest of members and for the ultimate protection of beneficiaries.

During 2017, the majority of the 62 exemption applications received related to the exemption from the provisions of section 35(8) relating to investments of scheme assets or the granting of loans.

Accreditation of medical scheme administrators and self-administered schemes

Regulatory oversight applicable to administrators and managed care organisations is centred on measuring the performance of entities to comply with standards applicable to accreditation. The process of accreditation aims to ensure that all organisations are fit and proper to render services; are based in South Africa; are financially sound; and have the requisite skills, resources, systems and capacity in place.

There are currently 12 administrators accredited in terms of 230 standards and 11 self-administered schemes which are furnished with certificates of compliance with adjusted standards.

Applications in respect of five organisations and one self-administered medical scheme were evaluated and finalised during the year. On-site evaluations were conducted in respect of three administrators and one self-administered medical scheme.

Administrators pay statutory fees when they apply for accreditation and contributed R126 000 towards the Council's income during the 2017 financial year.

Table 46: Administrators and self-administered schemes accredited during 2017/2018

ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES ACCREDITED				
	New applications	Renewals	On-site evaluations	On-site compliance evaluations
Administrators		Professional Provident Society Healthcare Administrators (Pty) Ltd	Sechaba Medical Solutions (Pty) Ltd	Allcare Administrators (Pty) Ltd
		V Med Administrators (Pty) Ltd		Discovery Health (Pty) Ltd
		Discovery Health (Pty) Ltd		
		Medscheme Holdings (Pty) Ltd		
		Metropolitan Health Corporate (Pty) Ltd		
Self-administered Schemes		Selfmed Medical Scheme	Bestmed Medical Scheme	

Accreditation of managed care organisations

There are currently 37 accredited managed care organisations which comply with 144 managed care standards and render a combination or hybrid of one or more of seven basic categories of managed care services. Eleven organisations are accredited to accept risk transfer arrangements from client schemes, and ensure that services are rendered to beneficiaries, with an alternative reimbursement business model approach. This approach is often supported by designated or preferred provider networks to ensure favourable remuneration terms.

Alternative reimbursement models will no doubt form the basis of a future dispensation for remunerating healthcare providers, given the perception that the fee-for-service model is becoming less attractive among medical schemes and some providers. In addition, the capitation or fixed-fee-per-patient remuneration model has been identified as the preferred remuneration structure in the NHI rollout.

The application of managed care strategies in both the private and public sector is relevant when healthcare costs are under pressure and healthcare funders have to ensure that healthcare services are clinically appropriate and cost effective.

An ongoing priority is to improve the evaluation of managed care organisations to ensure that they continue to render services that offer value for money.

Managed care organisations pay statutory fees when they apply for accreditation and contributed R168 000 towards the Council's income during the year under review.

Table 47: Managed care organisations and self-administered schemes accredited during 2017/18:

ACCREDITED MANAGED CARE ORGANISATIONS AND SELF-ADMINISTERED SCHEMES				
	New applications	Renewals	On-site evaluations	On-site compliance evaluations
Managed Care Organisations	Managed Healthcare Systems (Pty) Ltd	Dental Risk Company (Pty) Ltd	Sechaba Medical Solutions (Pty) Ltd	Allcare Administrators (Pty) Ltd
	MMI Dental Risk Management (Pty) Ltd	ISIMO Health (Pty) Ltd		Discovery Health (Pty) Ltd
	HaloCare (Pty) Ltd	Medical Services Organisation (Pty) Ltd		
		Centre for Diabetes and Endocrinology (Pty) Ltd		
		Medscheme Holdings (Pty) Ltd		
		Dental Information Systems (Pty) Ltd		
		Knowledge Objects Solutions (Pty) Ltd		
		Knowledge Objects Healthcare (Pty) Ltd		
		Enablemed (Pty) Ltd		
		Universal Care (Pty) Ltd		
		Private Health Administrators (Pty) Ltd		
		Thebe Risk Managers (Pty) Ltd		
Self-administered Schemes			Bestmed Medical Scheme	

Accreditation of brokers and broker organisations

There were 8 418 individuals and 2 237 broker organisations accredited at the end of the 2017/18 financial year. Accreditation is subject to brokers having been licensed as Financial Services Providers in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS Act). Registered brokers are subject to fit and proper requirements determined by relevant laws, Board Notices and codes of conduct.

Close co-operation between the CMS and the Financial Sector Conduct Authority ensures that timeous action is taken against brokers who are in breach of regulations. Brokers are required to demonstrate their value-add to clients and medical schemes through actively engaging with clients, analysing their healthcare needs, rendering professional advice and educating them on the functioning of medical schemes and benefit options.

Medical schemes, on the other hand, should conduct member surveys to evaluate the performance of brokers as provided for in service level agreements. Underperformance of registered brokers should be monitored. Registered brokers contribute substantially towards the income of the CMS and paid R7.8 million in accreditation fees during the 2017 financial year.

Table 48: Individual brokers and broker organisations accredited

BROKERS AND BROKERAGES ACCREDITED		
	Individual brokers	Brokerages
First time applications received:	975	140
Renewal applications received	4 597	1 159
Total Accredited	4 369	1 152
Not accredited: disqualified and due to incomplete information.	1 203	147

Table 49: Broker accreditation suspended/withdrawn

Broker number	Action	Effective date	Reason
Daniel Strydom (Br4103)	Withdrawn	06/06/2017	Requested to be withdrawn
Jacobus Henning(Br1977)	Suspended	06/06/2017	Suspended by FSCA
Susanna Le Roux (Br1345)	Suspended	03/05/2017	Suspended by FSCA
Catherina Viljoen (Br24640)	Withdrawn	01/05/2017	Broker passed away
Jennifer Maseko (Br27097)	Withdrawn	10/07/2017	Requested to be withdrawn
Linda Makupula (Br35306)	Withdrawn	10/07/2017	Requested to be withdrawn
Hendrik Van Den Ordel (Br1654)	Withdrawn	19/07/2017	Broker passed away
David Smith (Br27244)	Withdrawn	28/11/2017	Broker no longer provides broker services

Table 50: New broker applications rejected

Name of applicants	Action	Effective date	Reason
Lionel Joe (Br26401)	New application refused	21/07/2017	No longer provides broker services
Christien Van Staden (Br38627)	New application refused	24/10/2017	Failed to comply with the qualification requirement for accreditation.
Sandra Redman (Br38514)	New application refused	17/10/2017	The applicant is an unrehabilitated insolvent
Fouche Meyers (Br38769)	New application refused	06/12/2017	The applicant is an unrehabilitated insolvent

Table 51: Brokerage accreditation withdrawn

Brokerage number	Action	Effective date	Reason
Watterson Agencies CC (ORG178)	Withdrawn	08/08/2017	No longer licensed at FSCA
D.F Strydom Makelaars en Eiendomme BK (ORG2647)	Withdrawn	06/06/2017	Requested to be withdrawn
Haven Independent Financial CC (ORG2708)	Withdrawn	07/06/2017	Requested to be withdrawn

The Accreditation Unit continued to verify qualifications of individuals applying to be accredited as brokers. A total number of 3 910 accredited broker qualifications were verified independently since commencing with the initiative. During the period under review, 1 936 individual broker qualification were verified.

During 2017, the Accreditation Unit amended the application form for the accreditation of brokers with a view to collecting details regarding race and gender in order to measure the extent of transformation in the industry. A guideline for broker agreements and a specimen agreement were completed and published after public comments were invited and considered.

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 MSA. The amount was increased to R90.0 per member per month with effect from 1 January 2018.

Broker Complaints

The CMS investigated and resolved two complaints relating to broker conduct.

Adjudication of complaints

Investigation and adjudication of complaints remains one of the core functions through which the CMS ensures protection of medical scheme members.

A total of 4 667 new complaints were received in 2017, compared to 4 823 received in 2016. The CMS resolved 3 578 complaints and responded to 456 enquiries. Complaints were either resolved in favour of complainants or respondents respectively. However, in certain instances, complaints were resolved in favour of both parties.

Capacity constraints within the Complaints Unit resulted in a backlog of complaints, which required the team to work under extreme pressure. Backlog reduction measures were implemented, resulting in a significant improvement.

Despite delayed resolution of certain complaints, priority was given to clinically urgent complaints and those relating to oncology treatment, which were resolved within 5 working days from receipt.

Table 52: Number of complaints received and resolved

	December 2016	December 2017
Complaints carried forward from the previous year	1 457	1 754
Complaints received during current year	4 823	4 667
Total complaints	6 280	6 421
Total complaints resolved during the year	(4 526)	(3 579)
Closing balance as at 31 December	1 754	2 842

There were 0.53 complaints per 1000 beneficiaries in 2017 (0.54 in 2016), a decrease of 1%.

Table 53: Resolution turnaround times for complaints in 2017

Resolution turnaround time in days						
Complaints resolved	**0 – 30**	**31 – 60**	**61 – 90**	**91 – 120**	**>120**	**Total**
Number of complaints resolved	1 245	702	423	263	946	3 579
% of complaints resolved	34.7%	19.6%	11.8%	7.3%	26.4%	100%

Table 54: Rulings on resolved complaints against regulated entities in 2017

Entity Type	Number of complaints	Ruled in favour of the complainant	Ruled in favour of both	Ruled in favour of the regulated entity	Invalid / Enquiries
Open Medical Schemes	2 190	989	131	771	299
Restricted Medical Schemes	1 373	794	98	324	157
Brokers	5	2 (FAIS Ombud)		3	
Administrators	9			9	
Managed care organisation	2	1		1	
Total	**3 579**	**1 786**	**229**	**1 108**	**456**

Table 55: Number of complaints resolved in 2017, by category

Main categories	Number of complaints resolved
Valid complaints: Administrative	1 855
Valid complaints: Clinical	995
Valid complaints: Legal / Compliance	273
Sub-total	**3 123**
Inquiries / Invalid	456
Total	**3 579**

Out of the 3 579 complaints resolved, 3 123 (87% of total complaints) were found to be valid complaints and 456 included enquiries and invalid complaints. Enquiries and invalid complaints amounted, therefore, to 13% of the total.

Table 56: Categories of resolved complaints in detail (2016 and 2017)

	2017	2016	% Increase / Decrease
Administrative complaints	**1 855**	**2 051**	**-9.6%**
Benefits paid incorrectly	1 086	1 058	**2.6%**
Pre-authorisation	320	341	**-6.2%**
General customer service	244	328	**-25.6%**
Medical savings account	120	162	**-25.9%**
Contribution increases	69	139	**-50.4%**
Benefit option changes	16	21	**-23.8%**
Information / brochures not received	0	2	**-10.0%**
Clinical Complaints	**995**	**1 229**	**-19.0%**
Short-payment of PMB accounts	669	839	**-20.3%**
Paid at scheme tariff	195	327	**-40.4%**
Designated Service Provider	154	187	**-17.6%**
Protocols	101	111	**-9.0%**
Sub-limits in options	59	54	**9.3%**
Incorrect coding	49	45	**8.9%**
Outstanding information	49	38	**28.9%**
Formularies	31	34	**-8.8%**
Paid from savings account	22	29	**-24.1%**
Service provider irregular billing	9	14	**-35.7%**
Non-payment of PMB accounts	**220**	**278**	**-20.9%**
Protocols	68	98	**-30.6%**
Sub-limit in options	36	47	**-23.4%**
Scheme exclusion	19	30	**-36.7%**
Outstanding information	19	27	**-29.6%**
Designated Service Provider	29	26	**11.5%**
Incorrect coding	33	26	**26.9%**
Formularies	16	23	**-30.4%**
3rd party claim	0	1	**-100.0%**

	2017	2016	% Increase / Decrease
Short-payment of non-PMB accounts	**92**	**96**	**-4.2%**
Sub-limits in options	38	49	**-22.4%**
Network provider	19	19	**0.0%**
Outstanding information	7	11	**-36.4%**
Protocols	14	8	**75.0%**
Incorrect coding	13	6	**116.7%**
Formularies	0	2	**-100.0%**
Provider irregular billing	1	1	**0.0%**
Non-payment of non-PMB accounts	**14**	**16**	**-12.5%**
Legal / Compliance	**273**	**288**	**-5.2%**
Suspension / termination of membership	148	169	**-12.4%**
Waiting periods	61	69	**-11.6%**
Late joiner penalty	31	27	**14.8%**
Rejection of application for membership (eligibility)	10	13	**-23.1%**
Governance	20	6	**233.3%**
Broker conduct	3	3	**0.0%**
Unethical conduct	0	1	**-100.0%**

Internal dispute resolution

The CMS collected data on internal dispute resolution processes applied by various medical schemes with a view to determining whether the dispute resolution procedures stated in the rules of medical schemes were being implemented or not. The CMS found that alternative dispute resolution procedures were not being implemented by most medical schemes and this resulted in members referring their complaints to the CMS.

The CMS benchmarked the number of complaints received per medical scheme to establish which medical schemes received the most complaints compared to schemes of the same or similar size.

Table 57: Internal dispute resolution activities for the Top 10 open medical schemes with most complaints per 1 000 beneficiaries

Open schemes	2016 complaints per 1 000 beneficiaries	2017 complaints per 1 000 beneficiaries	Dispute Resolution committee (DRC) (Yes/No)	Numbers of matters served before the DRC
Spectramed	5.5	4.4	Yes	None
COMMED	2.3	2.8	Yes	None
Resolution Health	3.4	2.6	Yes	None
Genesis	1.5	2.1	Yes	None
Suremed	0.4	1.6	Yes	None
Fedhealth	0.9	1.4	No	None
Sizwe	0.8	1.2	Yes	None
Keyhealth	0.6	1.1	Yes	None
Medihelp	1.3	1.1	Yes	None
Hosmed	0.7	0.9	Yes	1

Table 58: Internal dispute resolution activities for the Top 10 restricted medical schemes with most complaints per 1 000 beneficiaries

Restricted schemes	2016 complaints per 1 000 beneficiaries	2017 complaints per 1 000 beneficiaries	Dispute Resolution committee (DRC) (Yes/No)	Numbers of matters served before the DRC
Metropolitan Health Medical Scheme	0.9	2.2	Yes	None
Transmed	0.5	1.2	Yes	None
BP Medical Scheme	1.0	1.0	Yes	None
Parmed	0.6	1.0	No	None
Rhodes University	0.4	0.8	Yes	None
Government Employees Medical Scheme	0.5	0.6	Yes	None
PG Group Medical Scheme	0.0	0.6	Yes	None
TFG Medical Scheme	0.3	0.6	Yes	None
University of Witwatersrand	0.2	0.6	Yes	None
Malcor Medical Scheme	0.3	0.5	No	None

Based on adjudicated complaints, the CMS detected a number of administrative inefficiencies in the processing and funding of claims for members of GEMS, which is administered by Metropolitan Health Administrators. The trends observed in these complaints included the following:

- Short-payment of accounts without valid reasons and subsequent referral of accounts for reprocessing, however accounts were never reprocessed.
- Failure to correct payment errors in claims which were escalated by healthcare providers and/or members due to incorrect processing.
- In certain instances, members were advised that their accounts would be referred to the claims department for investigation, after which they were informed that their disputed accounts could not be funded as they were regarded as “stale”. In these cases, GEMS had misinterpreted regulations 6(1) and 6(3) in that it declined to reprocess accounts which had been short paid or incorrectly processed on the basis that providers and members did not query said accounts within 60 days. The Scheme held the incorrect view that it had no obligation to reprocess accounts where administrative errors were made by its administrator.
- Short-payment or rejection of accounts for PMB related treatments, with reasons ranging from “personal overall limit exceeded” to “paid at scheme rate”. When queries relating to these short-payments were raised with GEMS or its administrator, no feedback was provided.
- The CMS noted instances where Metropolitan Health Risk Services had approved accounts to pay at cost, but Metropolitan Health had not processed the approval.
- Corrective action was only taken to reprocess accounts after intervention from the CMS.

In addition to rulings issued against GEMS, the trends noted were raised officially with GEMS, Metropolitan Health Administrators and Metropolitan Health Risk Services in a joint meeting. The monitoring of these entities continues.

Court Rulings

The Legal Services Unit provided support to the CMS on a range of legal issues, and a high success rate was achieved.

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

CMS v Community Medical Aid Scheme (COMMED)

The matter was heard before the North Gauteng High Court on 29 and 30 May 2017 and on 2 June 2017. Judgement was handed down on 2 June 2017 in favour of the CMS.

COMMED was placed under provisional curatorship on 2 June 2017 after the CMS approached the Gauteng High Court in Pretoria on an urgent basis. The application was necessitated after an inspection into the affairs of the scheme indicated a number of material irregularities and that the scheme’s financial position was in a precarious state.

The scheme opposed the application, after which the Board of Trustees (BOT) also applied to join the proceedings in their individual capacities as the 2nd to 10th respondents. The curatorship was confirmed in February 2018 with Adv Deon van Wyk being appointed by the court as the curator to take over the management and governance of the scheme.

The presiding judge referred to certain serious allegations against the scheme which constituted criminal offences in terms of the MSA. He mentioned that the fact that the scheme was at loggerheads with its regulator supported the notion that the board was not fit and proper. The improper influence by the administrator on the board of the scheme, the illegal contracts entered into by the scheme to the detriment of members, the salary increase of the Principal Officer and the lack of financial prudency on the part of the scheme, amongst other things, persuaded the court that it was in the best interests of members that a curator be appointed.

The true financial position of the scheme only became apparent after the curator commenced with further investigations. It emerged that the scheme had been trading while insolvent. The curator and the CMS subsequently applied for the provisional winding up of the scheme simultaneously with the curatorship of the scheme being lifted. The order was granted.

Genesis Medical Scheme v Registrar of the CMS (Classification of personal savings account assets)

The Constitutional Court brought finality to a long-standing dispute between the Genesis Medical Scheme and the CMS regarding the correct accounting treatment to be accorded to personal savings accounts. The dispute arose when the Registrar rejected the financial statements of the scheme following a High Court judgment in 2007 which determined that the personal savings accounts of members constituted trust property which must be kept separately.

The Supreme Court of Appeal in a majority judgment upheld this view. The Constitutional Court, however, overturned the majority judgement of the Supreme Court of Appeal on 6 June 2017 in favour of the scheme and held that savings funds should be treated in the same manner as would the other liabilities of a scheme, but that these monies could however only be treated as trust property in the event that the scheme rules provide for this.

SAMWUMED v Registrar of the CMS

This matter concerned an appeal against the Registrar's refusal to approve an application by the scheme for a change of name. In terms of Rule 1 of the Scheme Rules, the name of the scheme is the South African Municipal Workers Union National Medical Scheme. The scheme proposed that the name be changed to "Municipal Medical Scheme" (MMED).

The application was refused by the Registrar together with reasons for the rejection. The SAMWUMED's contention was that the Registrar's powers to refuse an amendment of this nature were limited by the Medical Schemes Act and that he had exceeded the scope of his powers. The Registrar's concerns about the proper composition of the BOT and the resultant invalidity of the BOT resolution resulted in various exchanges of correspondence with the scheme between May and November 2016. The matter was ultimately heard by the Council Appeal Committee on 22 September 2017 and the application for a rule change was dismissed.

Genesis v Registrar of the CMS (Designated Service Provider matter)

After the Supreme Court of Appeal (SCA) rendered a judgment in favour of the CMS in the case of Genesis v Joubert and the CMS, the Registrar rejected a rule amendment from the scheme on the basis that the scheme had selected the state hospital sector as the scheme's Designated Service Provider (DSP).

The scheme sought to rely on the reference in Regulation 7 to the selection of a DSP, but the CMS differed on the basis that the SCA judgement specifically referred to contracts with state facilities. In addition, the Registrar considered it unfair towards members for a scheme to default members to an already overburdened state sector without confirming that the relevant facilities had the capacity and service offerings to accommodate the members of the scheme.

The matter was heard by the Appeal Board on 11 August 2017. The Appeal Board per Judge Bernard Ngoepe agreed with the Registrar and dismissed the scheme's appeal. The scheme has subsequently taken the decision on review to the High Court.

Sibanda v CMS

This was an urgent application to the High Court for the setting aside of the decision of the Registrar to postpone consideration of the 2016 application by Mr Sibanda for authorisation to act as an auditor of medical schemes.

The matter concerns the proper interpretation of section 36(2) and section 38 of the MSA read together with clause 6.4 of the Standards for the Authorisation of Auditors. The Registrar opposed this application on the basis that the applicant held the view that the Registrar had a discretion with respect to considering the authorisation of an auditor, a view which the Registrar differed with. The matter was heard in the Pretoria High Court on 31 October 2017 and was struck off the roll with the costs of two counsel, due to lack of urgency.

Witsmed vs CMS and Discovery Health Medical Scheme

This matter concerned an urgent application by the Academic Staff Association of Wits University (ASAWU) to the High Court against a proposed amalgamation of the Witsmed Medical Scheme with the Discovery Health Medical Scheme. The CMS defended its decision that the schemes be amalgamated and the case was dismissed by the Gauteng High Court for lack of urgency.

The Registrar duly approved the amalgamation between Witsmed and the Discovery Health Medical Scheme towards the end of 2017.

G | THE MEDICAL SCHEMES INDUSTRY IN 2017

What counts is not the mere fact that we have lived. It is what difference we have made to the lives of others that will determine the significance of the life we lead.

- Nelson Mandela

THE MEDICAL SCHEMES **INDUSTRY IN 2017**

This section of the CMS Annual Report 2017/18 is based on the 2017 annual healthcare utilisation statutory returns of all registered medical schemes operating in the country. The analysis of this data provides insights into the state of the industry in 2017. Combined with comparable historical data, it affords an appreciation of trends and changes in the functioning of medical schemes.

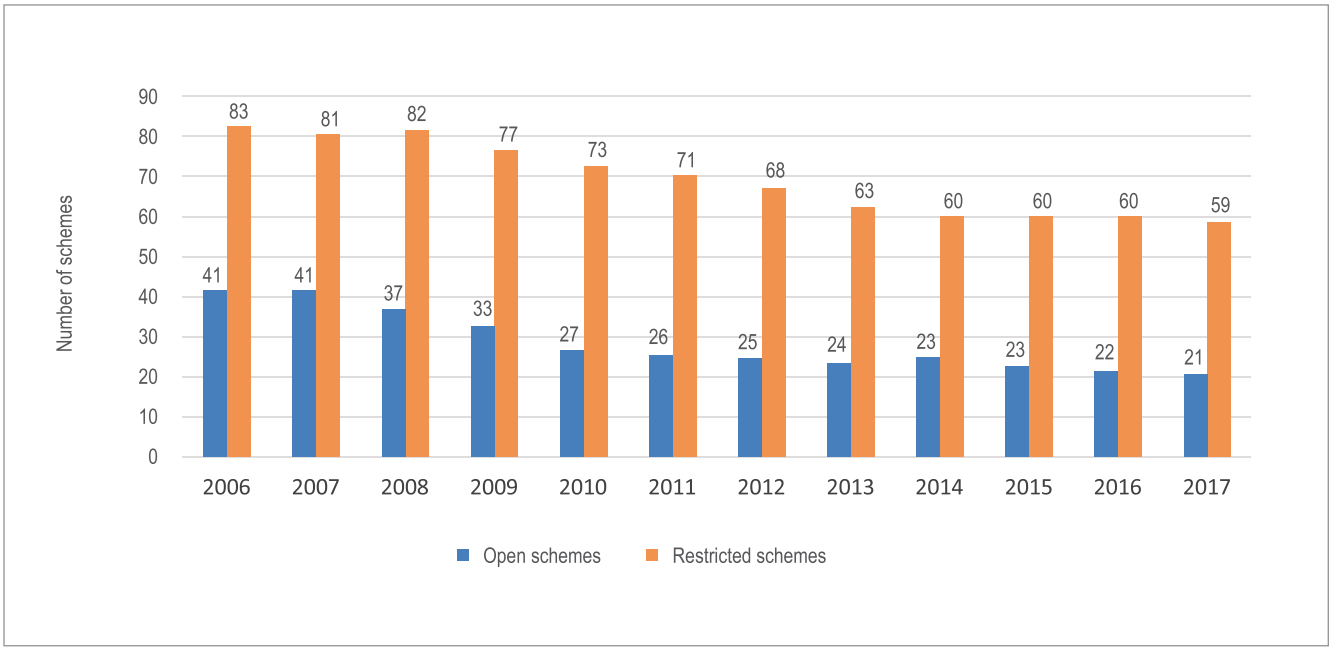
Gross benefits paid (benefits paid from risk pool and savings) reported in the utilisation section of this report (pages 125 to 157 and Annexures C to M) differ slightly from the gross benefits reported in the financial statutory returns section. This is as a result of definitional issues and the application of accounting principles. Note that all figures reported in the utilisation section of this report (pages 125 to 157 and Annexures C to M) for the financial year of 2017 have been revised and as a result may differ from the amounts reported in the previous year's annual report.

DEMOGRAPHIC INFORMATION

Number of schemes and benefit options

The statistics illustrated below show the trends in the consolidation of medical schemes that are mainly driven by liquidations (Community Medical Aid Scheme, 2017) and voluntary amalgamations (Metropolitan Medical Scheme and Momentum Health, 2017). The number of schemes dropped to 80, consisting of 21 open schemes and 59 restricted schemes by the end of 2017.

Figure 1: Number of schemes 2006-2017



Information on the distribution of schemes by size is depicted in Table 1. Schemes classified as "very large" or "small" remained unchanged between 2015 and 2017. The number of schemes classified as "medium" dropped to 28 in 2017, from 30 in 2016, while the number of "large" schemes remained unchanged at 13 between 2016 and 2017. The open and restricted grouping of schemes lost one scheme each during the period under review.

Table 1: Number of schemes by size and type as at 31 December 2017

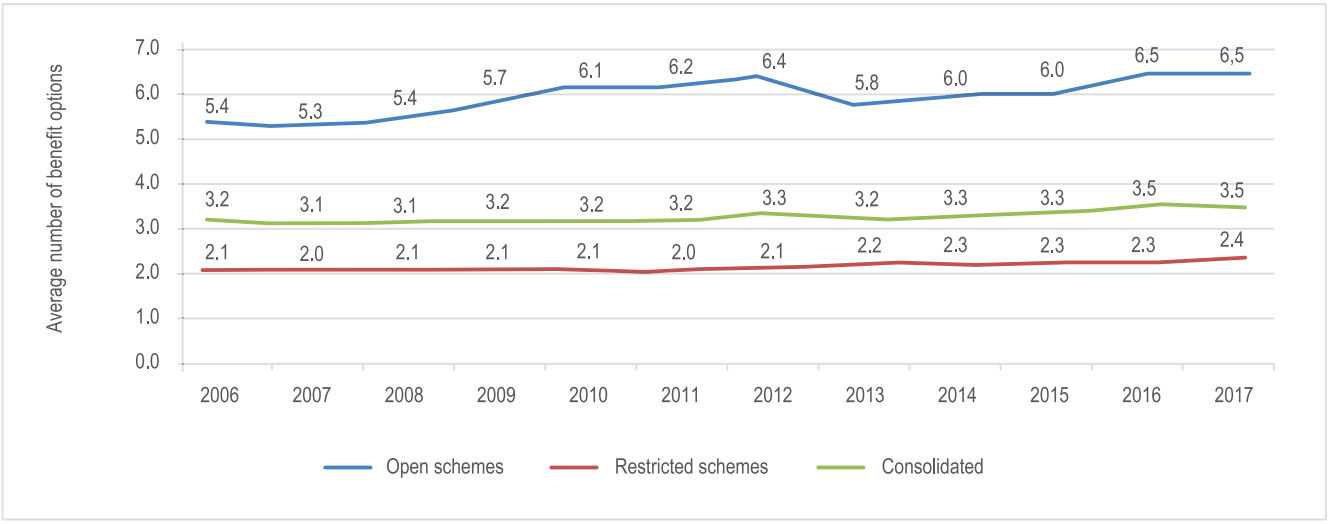
Type of scheme	Scheme size	2015	2016	2017
Open schemes	Very large	3	3	3
	Large	8	7	7
	Medium	7	7	7
	Small	5	5	4
Total open schemes		**23**	**22**	**21**
Restricted schemes	Very large	2	2	2
	Large	6	6	6
	Medium	23	23	21
	Small	29	29	30
Total restricted schemes		**60**	**60**	**59**
All schemes	Very large	5	5	5
	Large	14	13	13
	Medium	30	30	28
	Small	34	34	34
Total		**83**	**82**	**80**

Very Large => 220 000 beneficiaries
Large => 65 000, but < 220 000 beneficiaries
Medium > 15 000, but < 65 000 beneficiaries
Small < 15 000 beneficiaries

Trend in average number of options

The industry average number of options for 2017 remained unchanged from the 2016 average of 3.5 options per scheme. The average number of options in open schemes is consistently above the industry average, while restricted schemes have remained well below the industry average for the period under review. In 2017, the average number of options per scheme in restricted medical schemes increased to 2.4 from 2.3 options per scheme in 2016. The average for the open schemes remained unchanged at 6.5 options per scheme during the period under review.

Figure 2: Average number of optons 2006 - 2017



Membership of medical schemes

The number of beneficiaries covered by medical schemes declined by a negligible 0.07% to 8.872 million by December 2017, from 8.878 million at the end of December 2016, as shown in Table 2. The decrease in the number of beneficiaries is mainly explained by the 0.3% (13 320) decrease in the number of beneficiaries covered by restricted schemes.

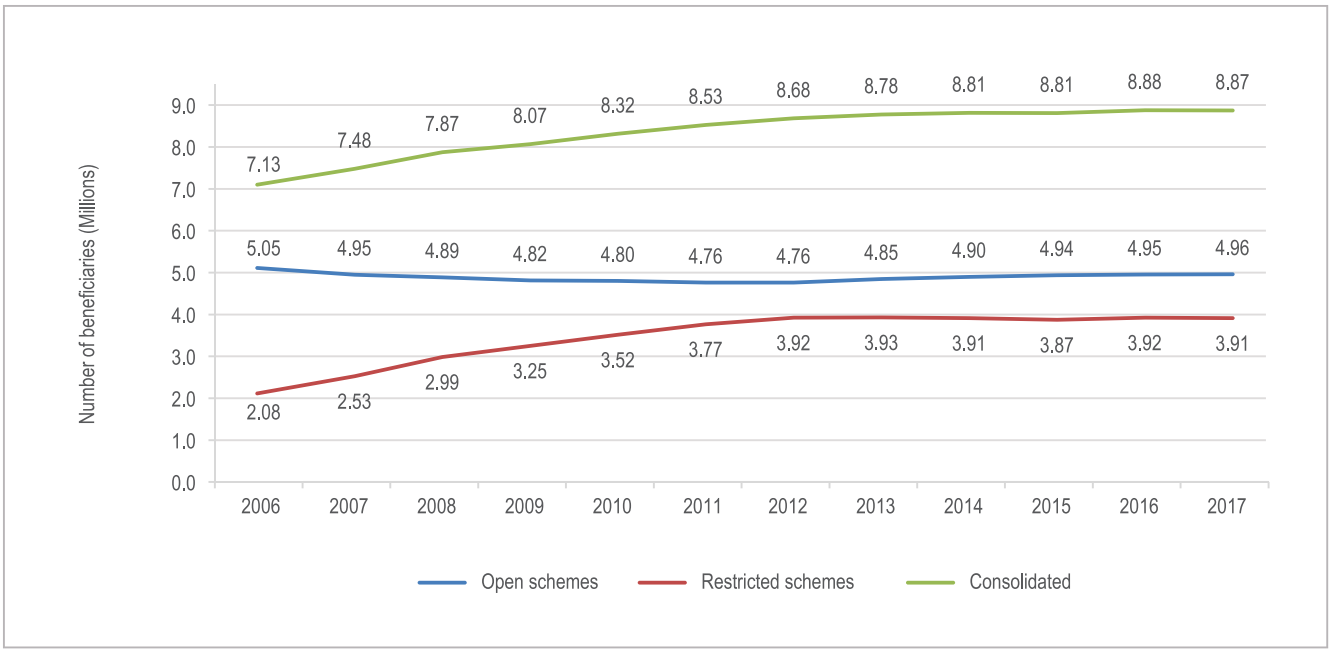
Open medical schemes continue to cover a larger proportion of all medical schemes beneficiaries.

Table 2: Membership of schemes in 2016 and 2017

Type of scheme	Year	Members	Dependants	Beneficiaries	% Change
Open schemes	2016	2 347 757	2 605 423	4 953 180	0.15%
	2017	2 366 197	2 594 258	4 960 455	
Restricted schemes	2016	1 644 345	2 280 556	3 924 901	-0.34%
	2017	1 646 525	2 265 056	3 911 581	
All schemes	2016	3 992 102	4 885 979	8 878 081	-0.07%
	2017	4 012 722	4 859 314	8 872 036	

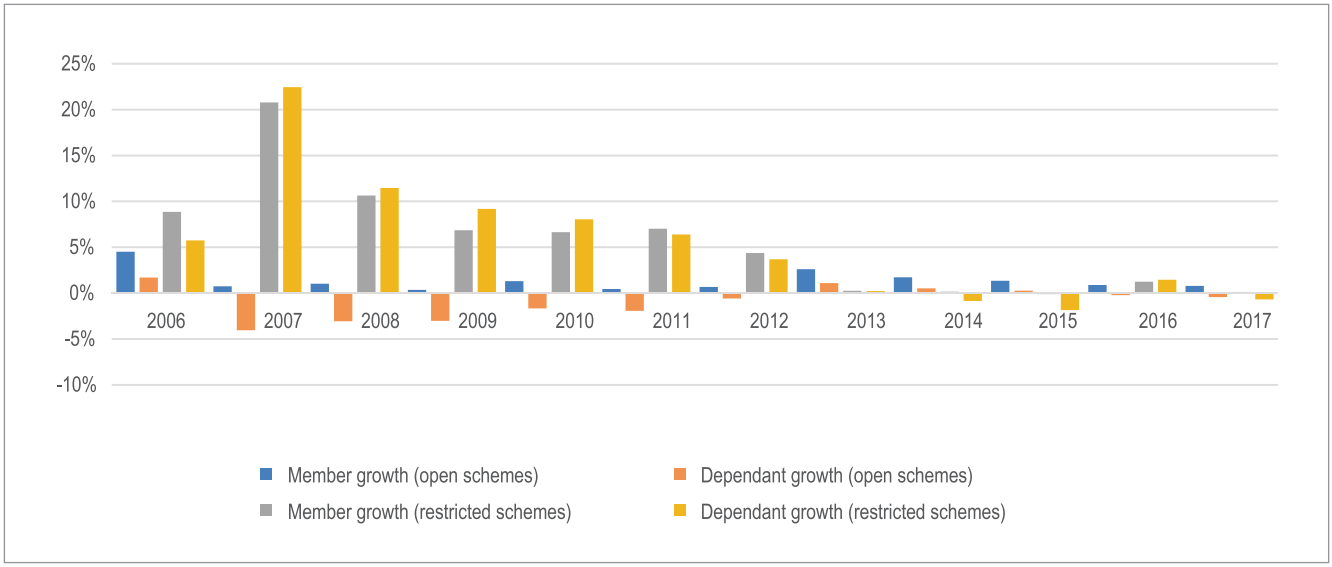
The number of beneficiaries increased significantly over the period spanning 2006 to 2017, as shown in Figure 3. Medical schemes beneficiaries increased by 24.5% during this period, with an annualised growth of 2.0%. The growth in the industry seems to have been mainly due to the uptake of new beneficiaries by restricted medical schemes, mainly fuelled by the growth in the Government Employees Medical Scheme. The positive growth in the number of medical scheme beneficiaries appears to have ended, with the industry experiencing its second negative growth figure in 2017, after many years of sustained growth (the only other negative growth figure was in 2015).

Figure 3: Number of beneficiaries 2006-2017



As noted in Figure 3, the growth in the industry was mainly fuelled by the growth in the restricted schemes. Figure 4 shows that restricted schemes experienced the highest rates in the uptake of new members and beneficiaries between 2007 and 2012. On the other hand, open schemes have been losing dependant beneficiaries during the corresponding period. The growth in the number of beneficiaries covered by medical schemes has stagnated since 2014. The marginal growth in principal members have been accompanied by a slight drop in dependant beneficiaries during this period.

Figure 4: Membership changes by beneficiary type in open and restricted schemes



Average age, pensioner ratio, and gender distribution

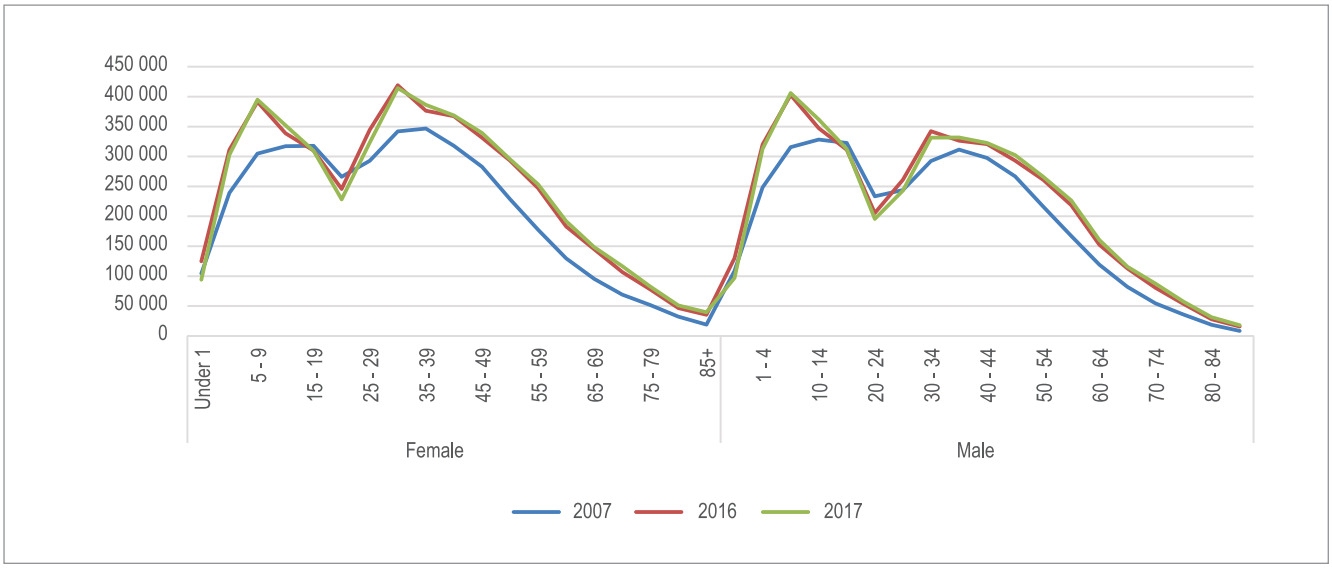
Table 3 shows the average age of the beneficiaries and the proportion of pensioners (beneficiaries aged 65 years and older) by scheme type, and gender. The industry average age in 2017 increased by 0.7 years to 33.2 from 32.5 in 2016. The proportion of pensioners increased to 8.4% in 2017 from 7.9% in 2016. Female beneficiaries were on average older than male beneficiaries, recording an average age of 34.1 years, compared to 32.1 for males in 2017.

Table 3: Average age, pensioner ratio, and gender distribution

Type of scheme	Gender	Average age (years) and pensioner ratio (%)	2014	2015	2016	2017
Open schemes	Female	Average age	34.2	34.5	34.7	35.6
		Pensioner ratio	9.3%	9.7%	10.1%	10.9%
	Male	Average age	32.8	33.0	33.2	34.0
		Pensioner ratio	7.6%	7.9%	8.2%	8.9%
	Total	**Average age**	**33.6**	**33.8**	**34.0**	**34.8**
		Pensioner ratio	**8.5%**	**8.8%**	**9.2%**	**10.0%**
Restricted schemes	Female	Average age	31.3	31.6	31.9	32.2
		Pensioner ratio	6.8%	7.0%	7.1%	7.4%
	Male	Average age	28.9	29.1	29.1	29.5
		Pensioner ratio	4.9%	5.1%	5.2%	5.4%
	Total	**Average age**	**30.2**	**30.5**	**30.6**	**31.0**
		Pensioner ratio	**5.9%**	**6.1%**	**6.3%**	**6.5%**
All schemes	Female	Average age	32.9	33.2	33.4	34.1
		Pensioner ratio	8.2%	8.5%	8.8%	9.3%
	Male	Average age	31.1	31.3	31.5	32.1
		Pensioner ratio	6.4%	6.7%	7.0%	7.4%
	Total	**Average age**	**32.1**	**32.3**	**32.5**	**33.2**
		Pensioner ratio	**7.3%**	**7.7%**	**7.9%**	**8.4%**

Figure 5 illustrates the demographic patterns of beneficiaries for 2007, 2016, and 2017. A bimodal distribution is evident, for both male and female beneficiaries. The age bands under 1 and 15–19 years had more male beneficiaries, while female beneficiaries outnumbered males in the age bands 20 years and older.

Figure 5: Age and gender distribution of beneficiaries 2007, 2016 and 2017



Figures 6 and 7 illustrate how the proportion of beneficiaries by age band has changed over time, from 2007 to 2017. There were proportionally more beneficiaries in the ages between 10 and 24 years, as well as between 35 and 49 years, for 2007 compared to 2017. In 2007 there were proportionally less beneficiaries under 9 years of age and over 50 years of age. The increase of members in the age bands over 50 years has greater cost implications, as beneficiaries in the older age bands have higher average healthcare costs. This trend is more prominent in the open schemes, and a negative change in the age distribution can have a significant impact on the cost of healthcare.

Figure 6: Proportion of beneficiaries per age band 2007 vs 2017

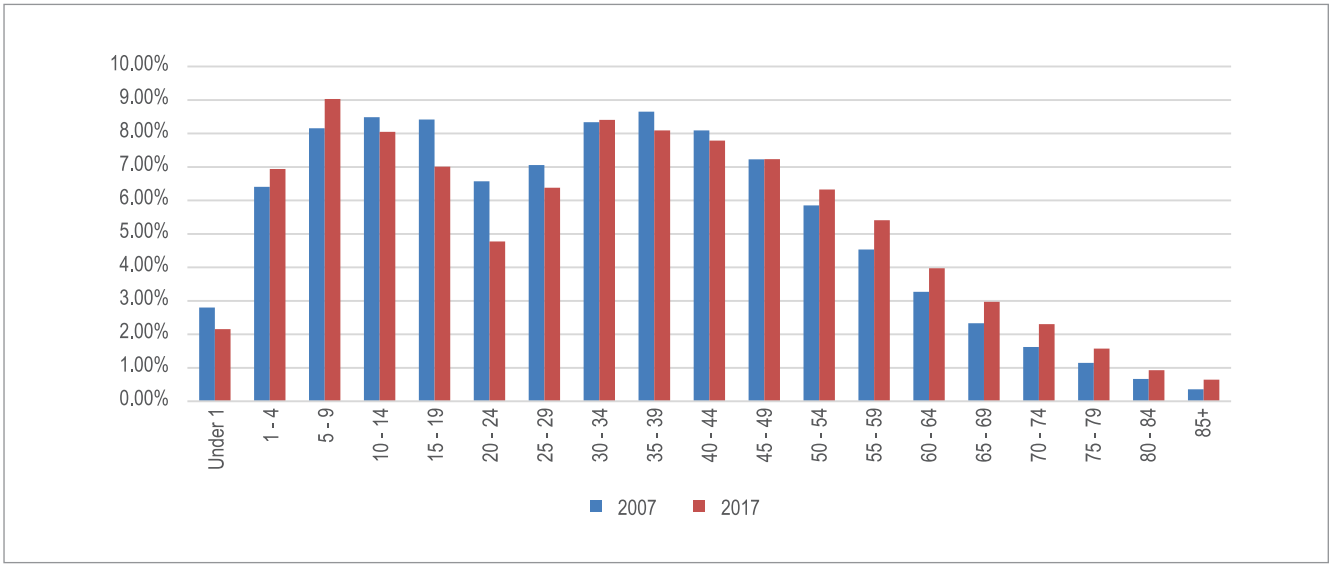
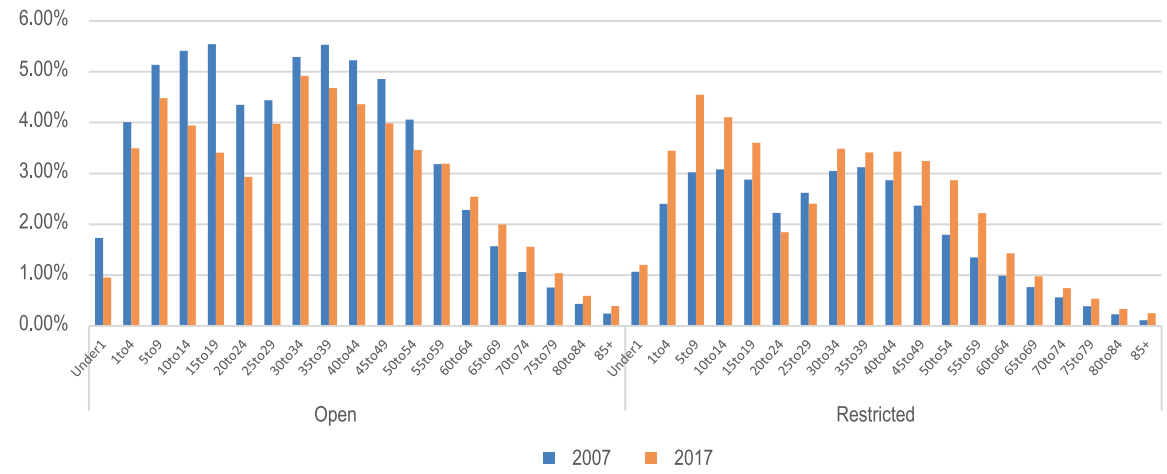


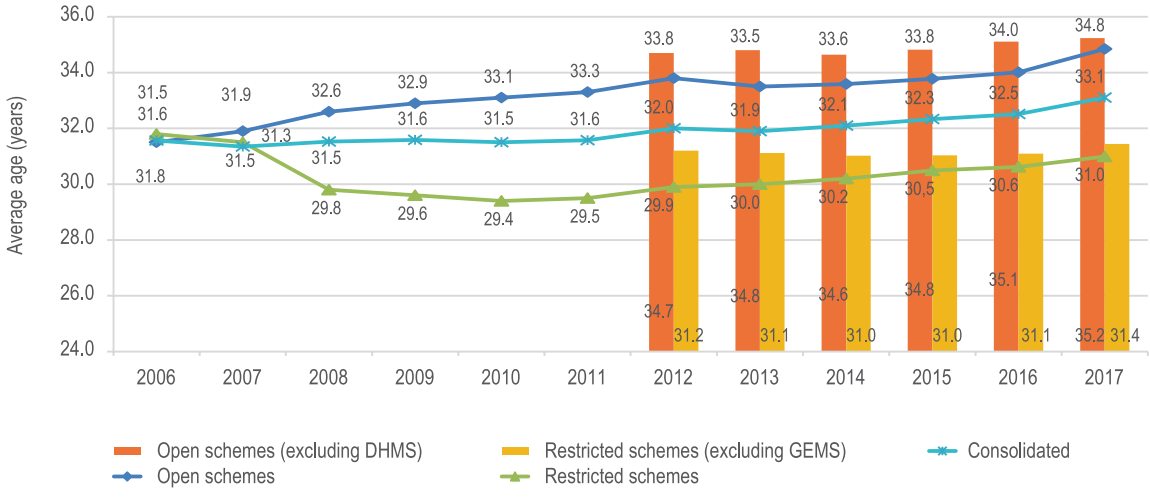
Figure 7: Proportion of beneficiaries per age band 2007 vs 2017



Trend in the average age of beneficiaries

Figure 8 depicts trends in the average age of the beneficiaries from 2006 to 2017. The beneficiaries of open medical schemes were older than those of restricted medical schemes except for the year 2006 where the average age was 31.5 years for open schemes and 31.8 years for restricted schemes. The average age of beneficiaries of open schemes in 2017 was 34.8 years – and 35.3 years if Discovery Health Medical Scheme (DHMS) is excluded. On the other hand, the average age of beneficiaries of restricted schemes was 31.0 years, and 31.4 if the Government Employees Medical Scheme (GEMS) is excluded. This analysis shows the impact of GEMS and DHMS on the demographics of the medical schemes population.

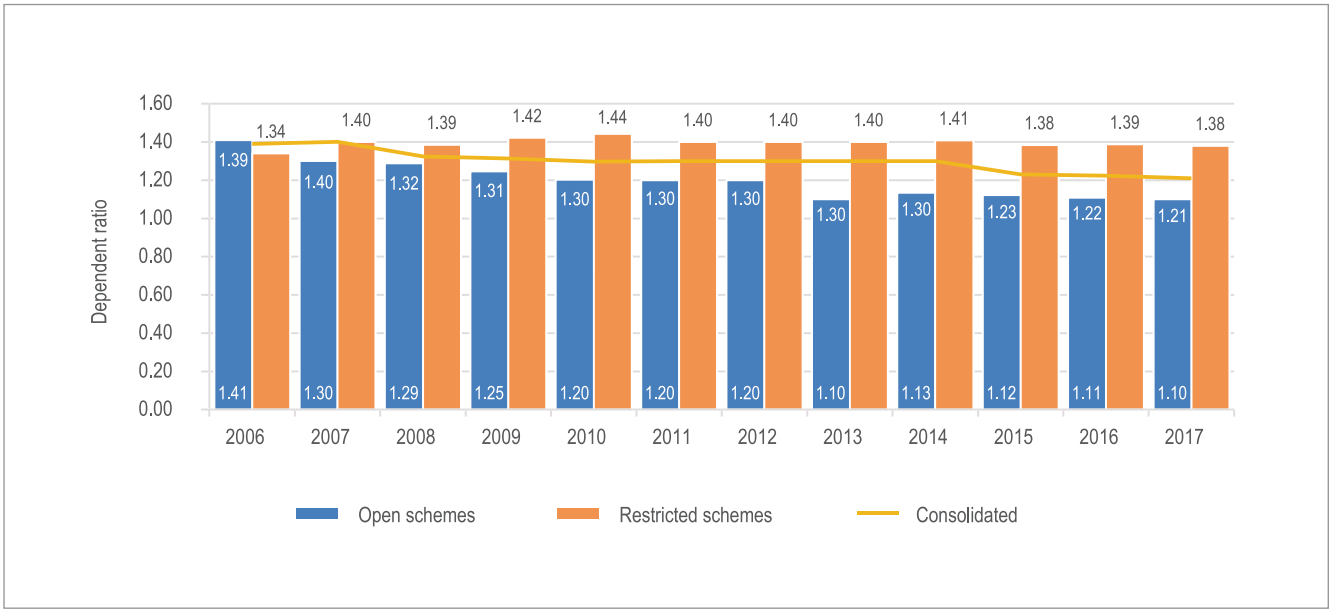
Figure 8: Age of beneficiaries 2006 - 2017



Dependant ratio in schemes for 2006-2017

Figure 9 below depicts the dependant ratio in medical schemes from 2006 to 2017. The dependant ratio measures the average number of dependants per principal member. The industry dependant ratio declined from 1.3 in 2006 to 1.2 in 2017. This indicates a decrease in the size of families covered, or a possible choice by members to only cover a few members of the family over time. The dependant ratio decreased by a margin of 0.01 between 2016 to 2017 for both restricted and open schemes.

Figure 9: Dependent ratio in schemes: 2006 - 2017



Coverage by province

Figure 10 and Table 4 demonstrate the distribution of beneficiaries by province. The province of residence data is collected primarily on the basis of the principal member's address. The largest proportion of beneficiaries covered by medical schemes resided in Gauteng (40%), followed by the Western Cape (15%) and KwaZulu-Natal (14%). The other provinces each made up less than 10% of the covered beneficiaries. The disparities in coverage by province are likely to be explained by the urban-rural divide, and employment opportunities (medical scheme membership is strongly linked to employment). Although membership declined in the other provinces, Gauteng, Mpumalanga, and the Northern Cape recorded an increase of 1.4%, 1.1%, and 1.0% in the proportion of beneficiaries covered, respectively.

Figure 10: Provincial distribution of beneficiaries

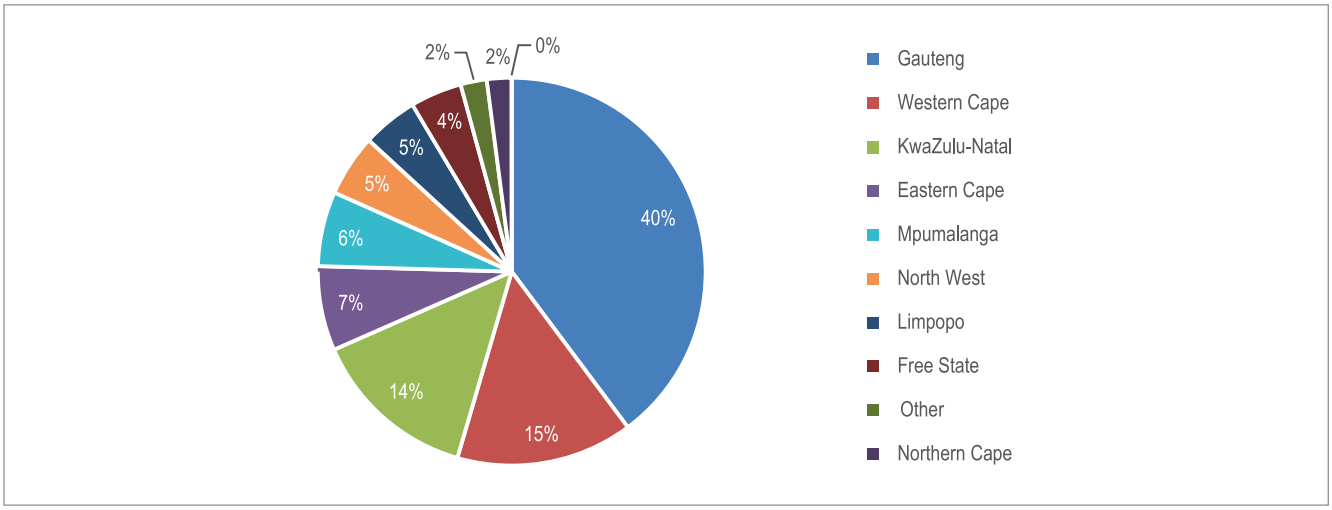


Table 4: Provincial changes in beneficiaries for 2016-2017

Province	2016	2017	%Change
Gauteng	3 479 810	3 530 204	1.4%
Western Cape	1 309 134	1 307 019	-0.1%
KwaZulu-Natal	1 253 144	1 232 181	-1.6%
Eastern Cape	638 434	625 276	-2.0%
Mpumalanga	545 595	551 688	1.1%
North West	461 237	457 333	-0.8%
Limpopo	412 936	410 439	-0.6%
Free State	387 739	381 721	-1.5%
Northern Cape	179 595	181 511	1.0%
Other	207 996	193 045	-7.1%
Outside the republic	2 461	1 619	-34.2%
All provinces	**8 878 081**	**8 872 036**	**-0.07%**

HEALTHCARE BENEFITS

Total healthcare benefits paid

The gross benefits paid (benefits paid from risk pool and 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 the notes in Annexures C to M. All values in this section are stated in nominal terms, unless stated otherwise. Total healthcare expenditure includes both benefits paid from risk pools of medical schemes and the medical savings accounts of members. This expenditure totalled R160.5 billion in 2017, showing an increase of 6.1% from the expenditure on healthcare benefits in 2016 that totalled R151.2 billion.

The average amount spent per beneficiary per annum (pbpa) increased by 6.0%, from R17 157.7 in 2016 to R18 172.4 in 2017. Figure 11 depicts the proportions of benefit expenditure paid to various categories of healthcare services for the period between 2015 and 2017.

Total hospital expenditure amounted to R59.0 billion of the R160.6 billion (36.8%) that medical schemes paid to all healthcare providers in 2017. This proportion is slightly lower, by 0.6 percentage points, than the 37.4% of the previous year.

Expenditure on private hospitals increased by 4.1% to R58.7 billion in 2017, from R56.3 billion in 2016. Overnight admissions constituted about 87.5% of the R58.7 billion paid to private hospitals in 2017 (same-day admissions constituted 12.4%). The average amount of pbpa paid to private hospitals increased by 4.1%, from R6 390.5 in 2016 to R6 653.3 in 2017.

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals amounted to R25.81 billion or 16.1% of total healthcare benefits paid. This represents an increase of 7.74% compared to the R23.9 billion spent in 2016.

The amount paid to supplementary and allied health professionals increased by 7.1% from R10.9 billion in 2016 to R11.7 billion in 2017. This category accounted for 7.3% of all benefits paid by schemes in 2017.

Expenditure on general practitioners (GPs) amounted to R9.1 billion or 5.6% of healthcare benefits paid, representing an increase of 1.9% on the 2016 figure of R8.9 billion. Only 11.2% of the R9.1 billion paid to GPs in 2017 was paid to GPs operating in hospitals.

Payments to all specialists (anaesthetists, medical specialists, pathology services, radiology services and surgical specialists) amounted to R38.5 billion or 23.9% of total healthcare benefits paid in 2017. This amount increased by 6.0% from the R36.3 billion paid in 2016.

Payments to medical specialists amounted to R10.9 billion or 6.8% of total healthcare benefits paid in 2017. About 60.8% of the total paid to medical specialists in 2017 was paid to medical specialists operating in hospitals. Expenditure on pathology amounted to R8.7 billion, or 5.4% of healthcare benefits paid, while expenditure on surgical specialists and radiology services amounted to R8.5 billion and R6.9 billion respectively.

Figure 11: Distribution of healthcare benefits paid 2015,2016 and 2017

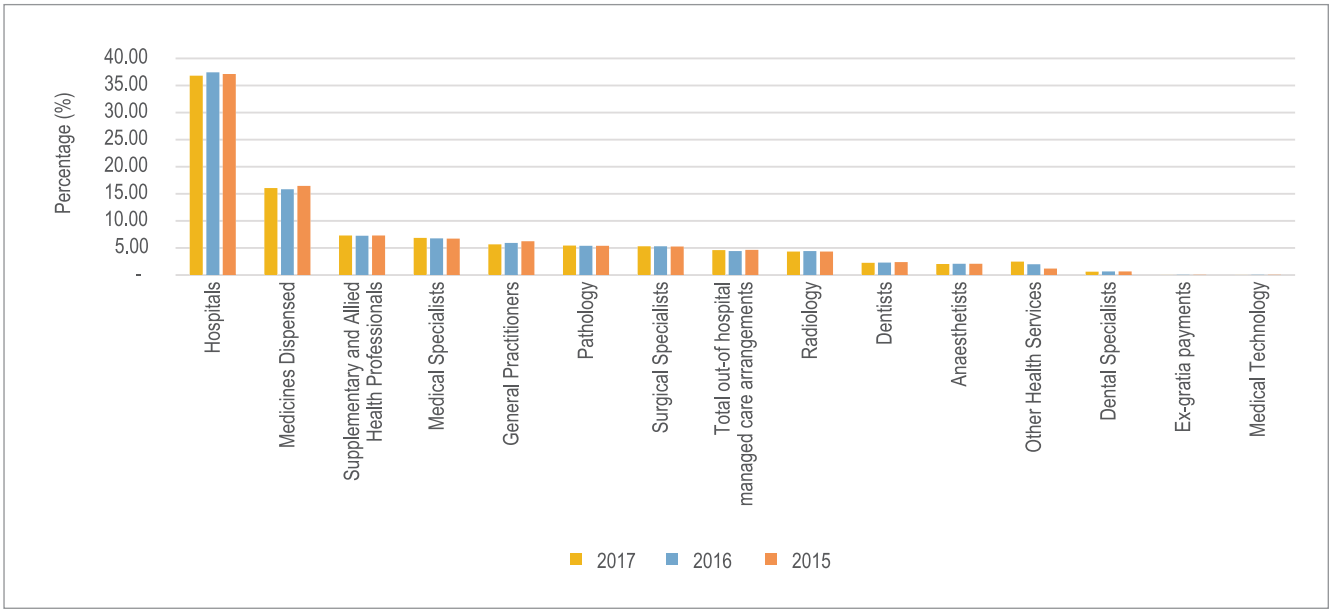
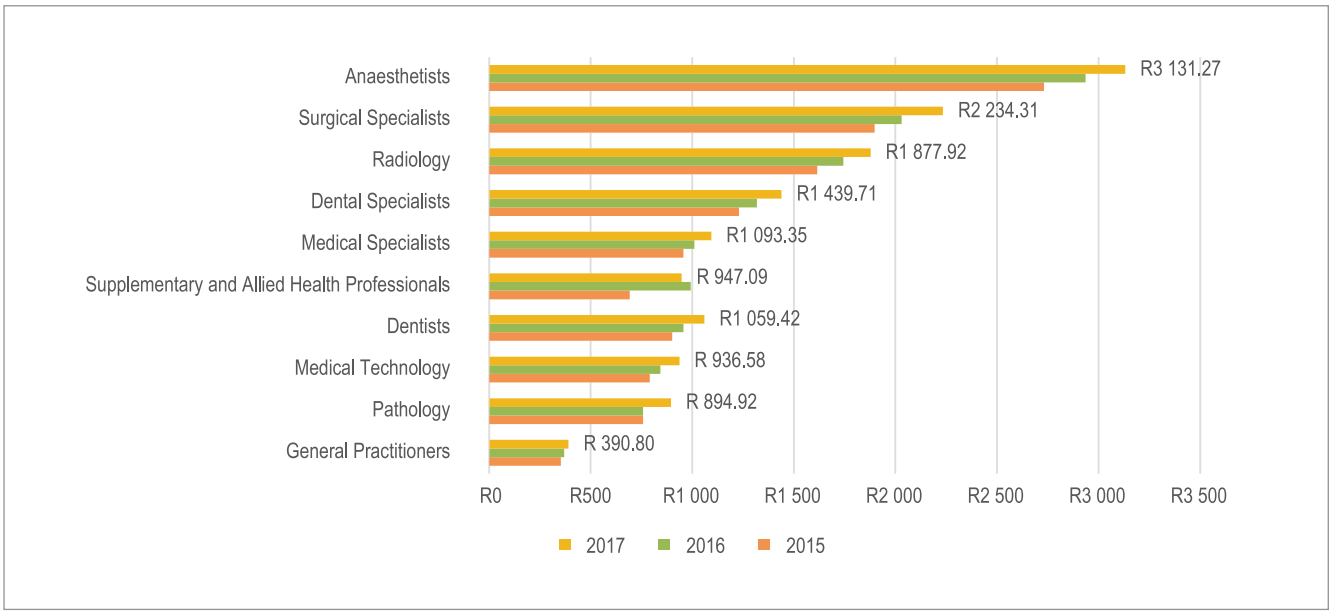


Figure 12 shows benefits paid to different disciplines per event (visit). Total benefits paid per event are calculated as total benefits paid (from risk pool and savings) divided by the number of visits to a provider. Notice that the cost (or benefits paid) per event must be interpreted with caution, as the calculation does not take other factors into account – such as the number of hours spent per event. In 2017, benefits paid to anaesthetists averaged R3 131.2 per event (visit). This represented an increase of 10.0% from the 2016 figure of R2 935.6, with anaesthetist events staying in place as the events with the highest average paid per event in the industry. The amount paid to surgical specialists was R2 234.3 per event.

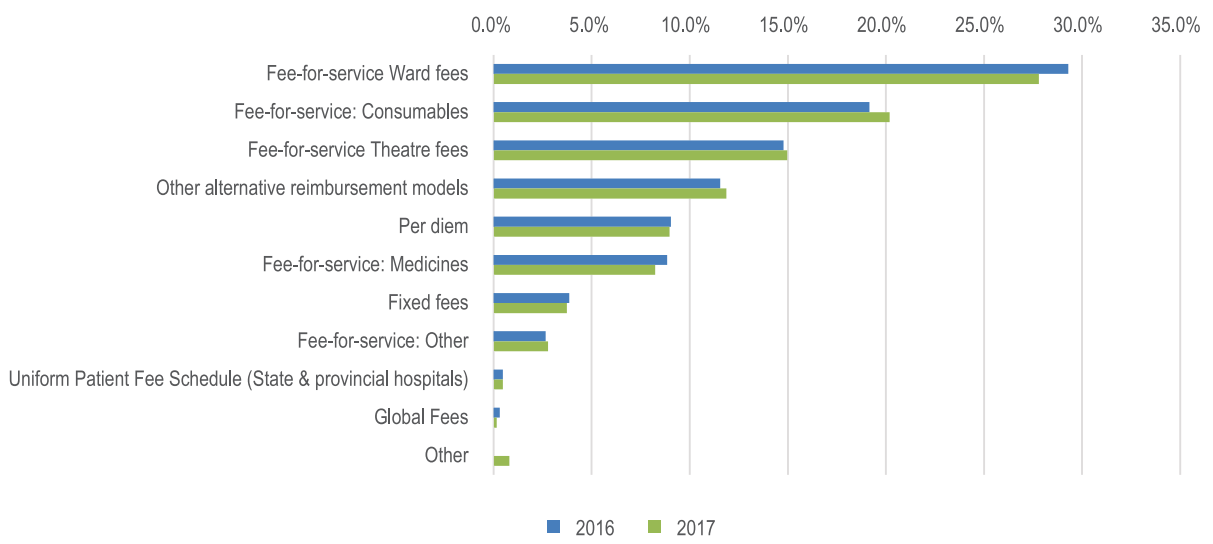
GPs were paid the lowest amount, at an average of R390.8 per event. This represented an increase of 5.8% from the 2016 figure of R369.2. The average amount paid to GPs per event in 2017 for in-hospital consultations was R861.7 – more than twice the average amount paid for out-of-hospital consultations (R365.5).

Figure 12: Total benefits paid per event (visit)



Total expenditure on hospitals in 2017 amounted to R59.1 billion. Figure 13 below presents the proportion of hospital expenditure paid per cost type and reimbursement method. Approximately 28% of the total expenditure was paid towards Fee-For-Service (FFS) ward fees, which amounted to R16.4 billion in 2017. Twenty percent of the expenditure went toward FFS consumables and around 15% towards FFS theatre fees, and only R4.8 billion was paid towards FFS medicine expenditure. All in all, the FFS payment arrangement amounted to 74.6% or R44.2 billion for hospital services in 2017. The 2016 values were restated, due to changes in the data specification guidelines for the reimbursement methods.

Figure 13: Reimbursement methods for hospital services

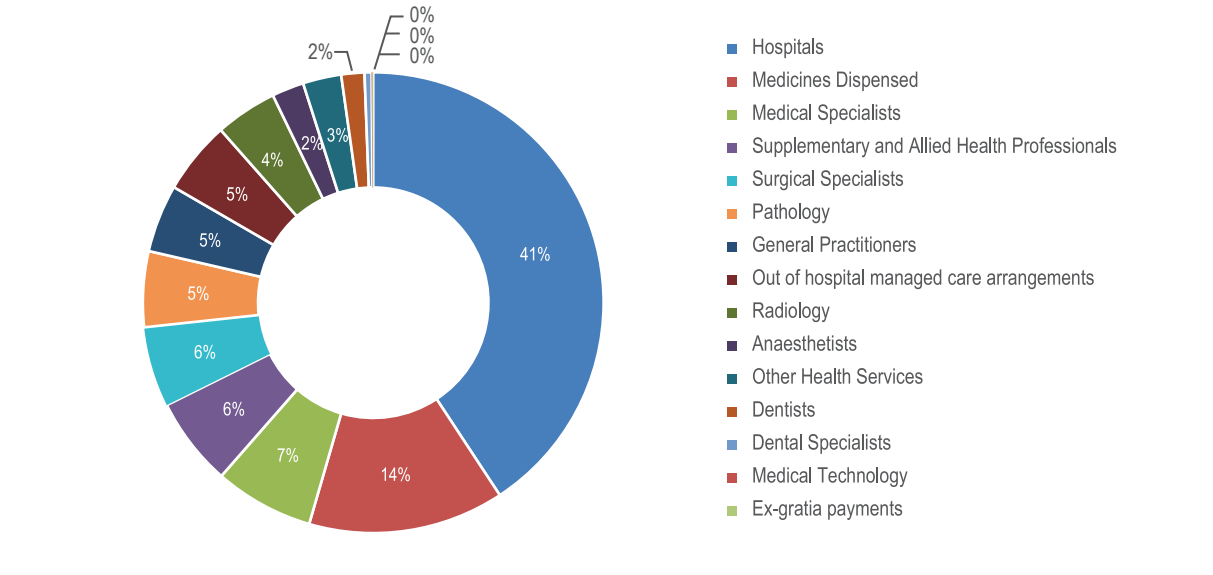


Healthcare benefits paid from risk pools

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 14. Healthcare benefits that medical schemes covered from their risk pools amounted to R144.44 billion in 2017, compared to R135.98 billion in 2016 – which is an increase of 6.2%. The average risk amount pabpa increased by 6.09% to R16 348.7 in 2017, compared to R15 429.3 in 2016.

Hospital expenditure accounted for 40.7% of risk benefits paid in 2017. Expenditure on medicines dispensed accounted for 13.7% of total risk pool benefits. Medical specialists consumed 6.9% of the pie, while risk pool expenditure on GPs was R6.8 billion or 4.7% of total risk pool benefits.

Figure 14: Distribution of healthcare benefits paid from risk pool in 2017

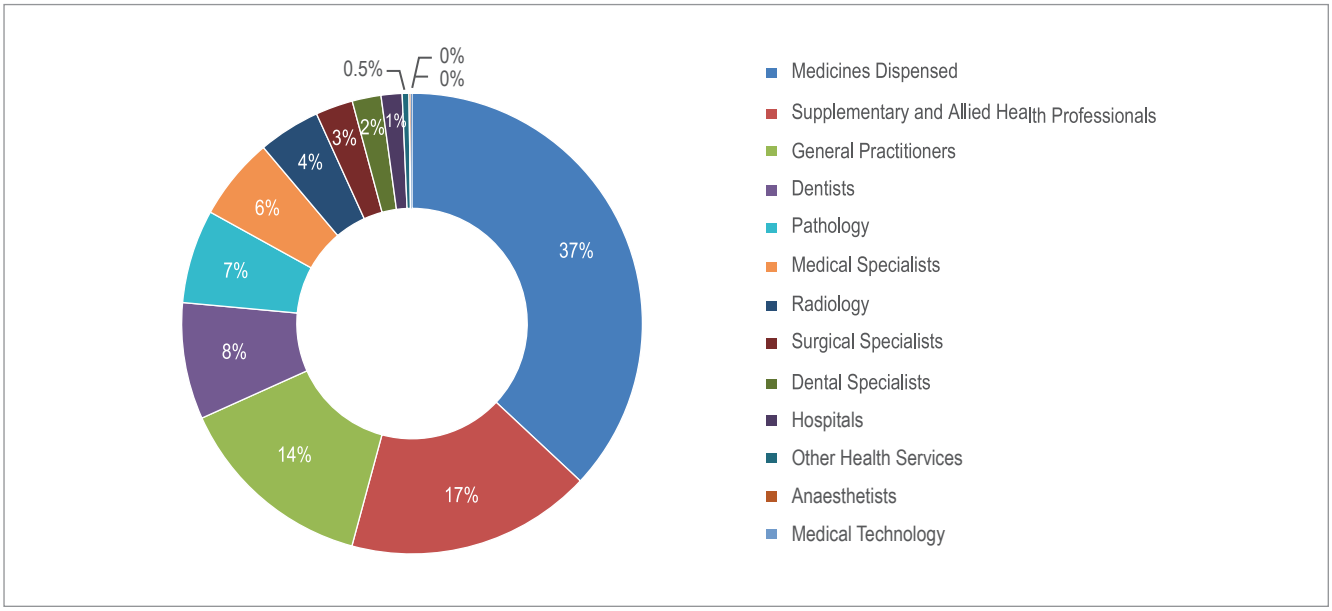


Healthcare benefits paid from savings

Of the total healthcare benefits paid, medical schemes paid R16.1 billion (10.0%) from beneficiaries' personal medical savings accounts in 2017. Figure 15 shows that medicines absorbed the largest share of savings accounts expenditure in 2017 (36.9%). Supplementary and allied health professionals took up 17.2% of the healthcare benefits paid from savings accounts.

GPs accounted for 14.0% and dentists for 8.1%, while pathology services and medical specialists absorbed 6.5% and 5.8% of healthcare benefits paid from savings accounts respectively.

Figure 15: Distribution of healthcare benefits paid from savings in 2017



Trends in total healthcare benefits paid[1]

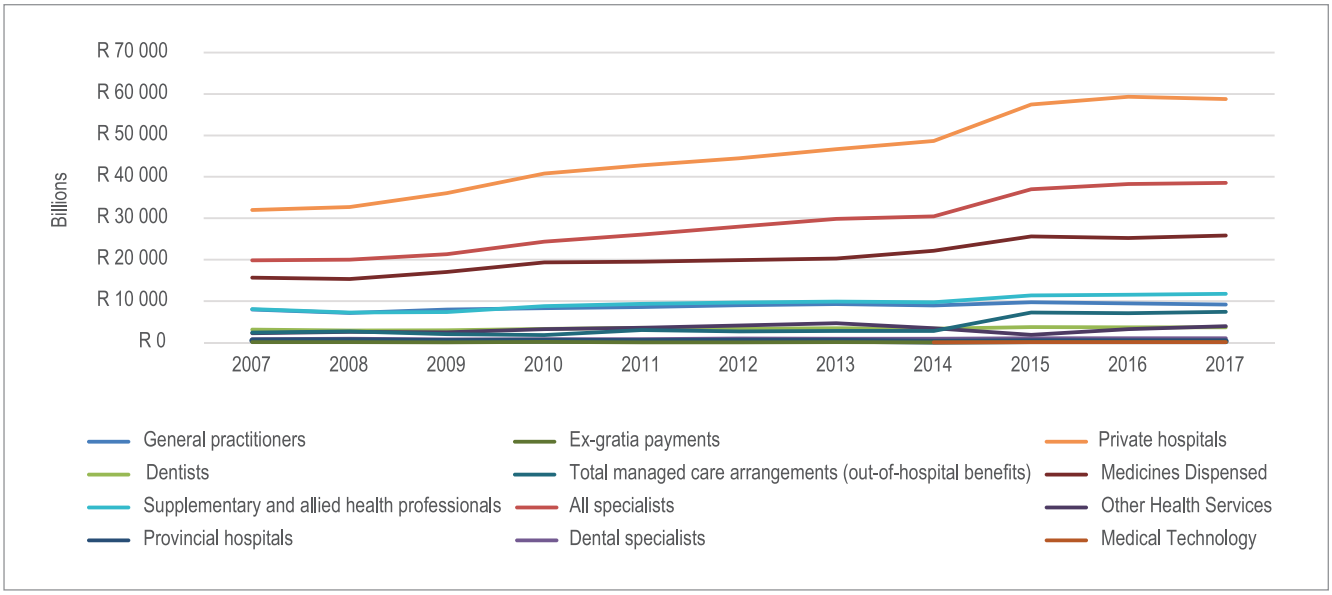
Figure 16 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2007. These figures have been adjusted for inflation, with 2017 used as the base year. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2017 prices.

Medical schemes' expenditure on private hospitals decreased slightly – in real terms by 0.8% to R58.7 billion in 2017 – compared to R59.3 billion in 2016. The increasing trend in expenditure on private hospitals, rising from R31.9 billion in 2007 to R58.7 billion in 2017, is illustrated in Figure 16.

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2017 amounted to R38.5 billion in real terms, an increase of 0.7% in real terms when compared to the R38.2 billion spent on this item in 2016.

It should be noted that the annual growth in membership must be taken into account when considering changes in the total expenditure of medical schemes.

Figure 16: Total healthcare benefits paid 2007-2017: 2017 prices*



* All values are adjusted for inflation using the Consumer Price Index (CPI) for 2017 as a base period.

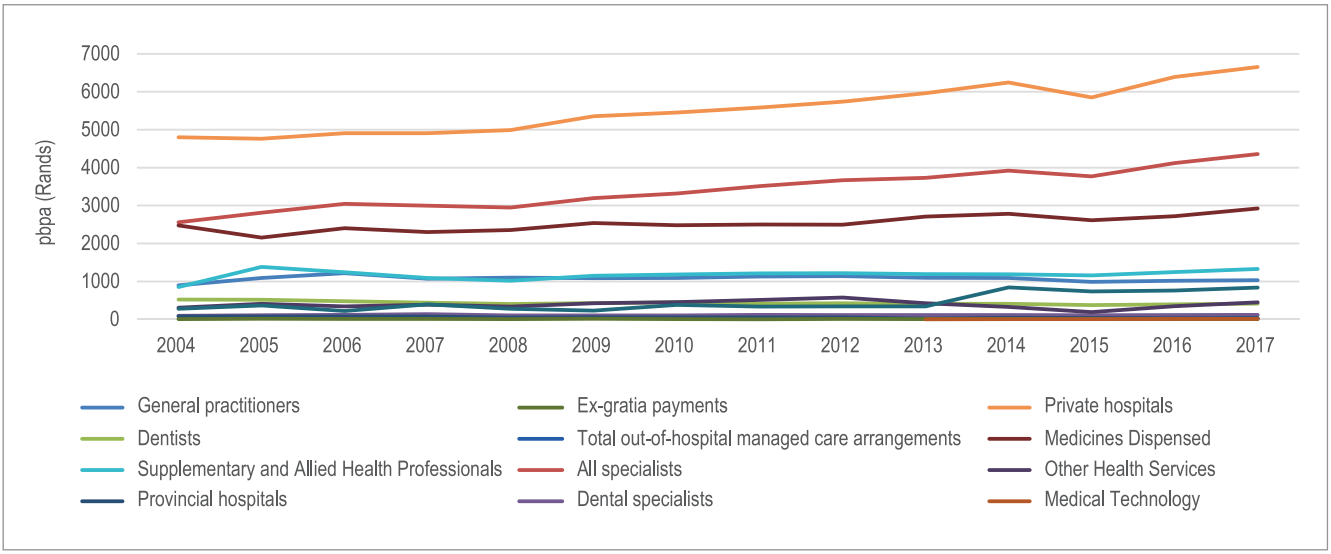
** Historical values are revised when the base period changes and will not correspond to the values reported in the 2015 annual report.

[1] 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.

Healthcare benefits paid per beneficiary

Figure 17 shows the changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2007 to 2017 in real terms (at 2017 prices). The amount paid in real terms towards private hospitals increased by 4.1% from R6 390.5 pabpa in 2016 to R6 653.3 pabpa in 2017. The amount spent on specialists increased in real terms from R4 121.3 pabpa in 2016 to R4 359.4 pabpa in 2017 – an annual increase of 5.7%. There was an increase of 7.4% in real terms in the benefits paid for medicines dispensed.

Figure 17: Total health benefits paid pabpa 2007-2017: 2017 prices*



* All values are adjusted for inflation using the Consumer Price Index (CPI) for 2017 as a base period.

** Historical values are revised when the base period changes and will not correspond to the values reported in the 2015 annual report.

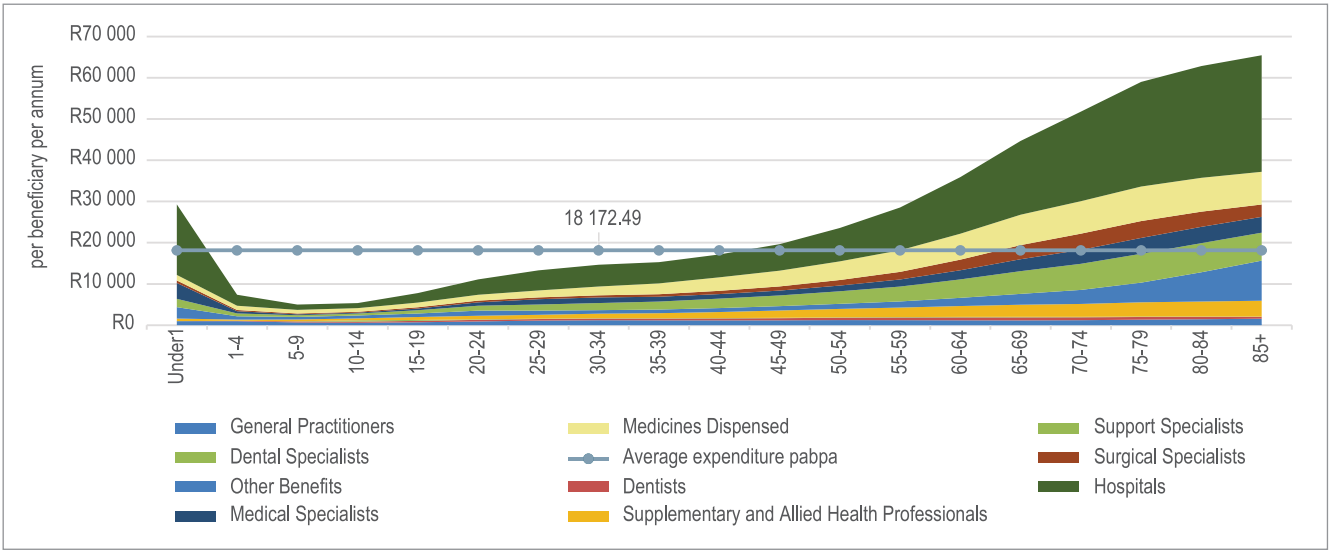
Healthcare benefits paid per age band

Figure 18 shows the per capita healthcare expenditure across healthcare services by age group. The expenditure for beneficiaries under the age of one year is 1.5 times the average expenditure pabpa of R18 172.4. Per capita expenditure decreases for beneficiaries over the age of one year and increases rapidly after the age of 45 years. Expenditure for beneficiaries in the 80-84 years age group is 3.2 times higher than the average per capita expenditure.

Expenditure on primary healthcare providers, general medical practitioners, and dentists is overshadowed by the expenditure on specialists. Hospitals, medicines, and specialist consultations constitute a large portion of the healthcare services expenditure in the older age bands.

This analysis shows the positive effect of the principle of community rating, one of the social solidarity pillars of the medical schemes legislation, without which healthcare would be unaffordable and inaccessible for older and sickly beneficiaries.

Figure 18: Expenditure per capita by age band (2017)



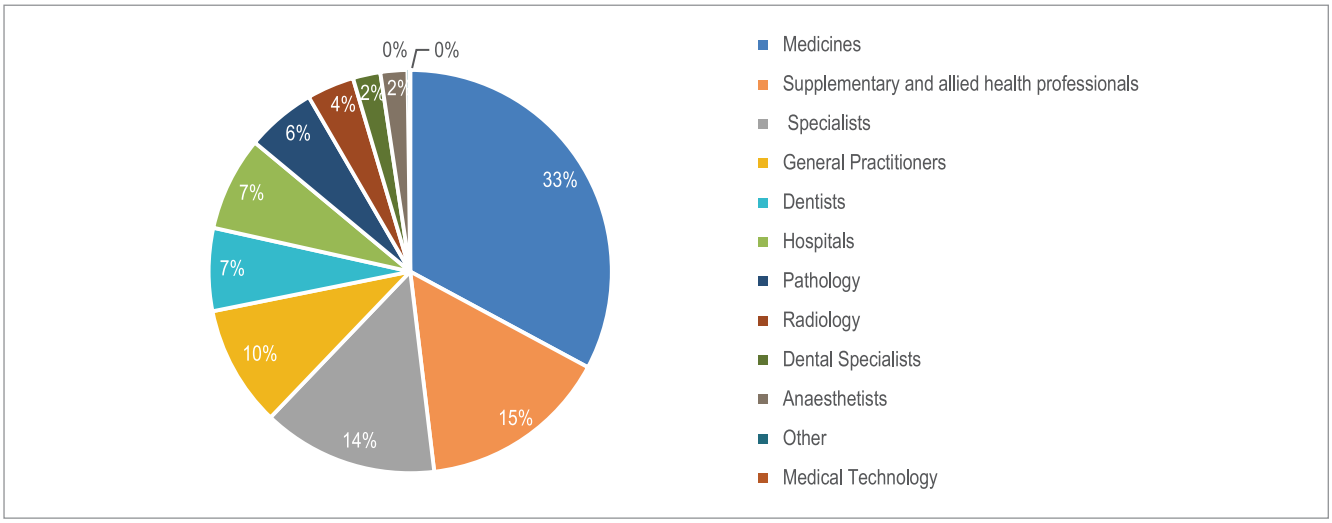
Out-of-pocket payments

The total for out-of-pocket payments (OOPs) has been calculated as the difference between the total amounts claimed less the total risk benefits paid by medical schemes. This may understate the actual level of OOPs as medical scheme beneficiaries don't always submit a claim for healthcare services when they run out of benefits. OOPs expenditure cannot be recorded when no claims are submitted.

In 2016, the level of OOPs expenditure was at least 19.1% of the total healthcare expenditure among medical scheme beneficiaries. This amounted to approximately R28.9 billion in nominal terms. In nominal terms, OOPs expenditure grew by 10.4% to R31.8 billion in 2017 compared to 2016. This represents 19.8% of total healthcare expenditure for beneficiaries.

The bulk of OOPs were for out-of-hospital medicine claims, which constituted 33% of all OOPs expenditure. The next highest expenditure was for supplementary and allied health professionals, which amounted to 15% of total OOPs expenditure. A similar trend was observed last year.

Figure 19: Out of Pocket Payments (OOPs)



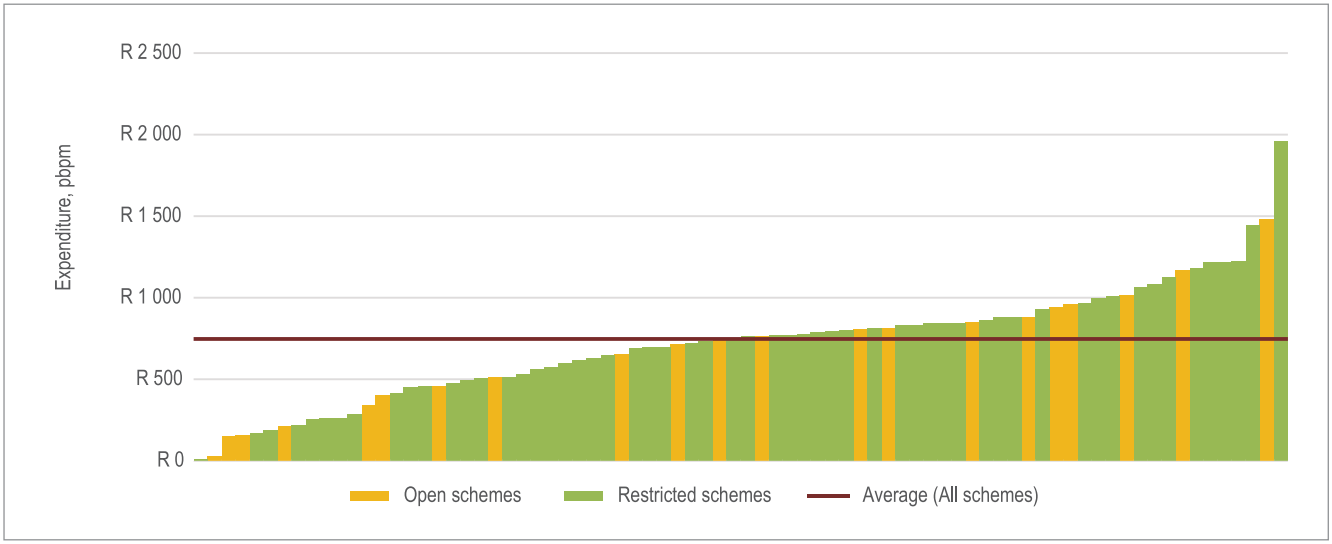
Prescribed Minimum Benefits (PMBs)

The total expenditure on prescribed minimum benefits (PMBs) by medical schemes amounted to R79.2 billion in 2017. The total risk benefits paid in 2017 was R160.6 billion. Therefore, the PMBs constituted 49% of total risk benefits paid. In 2016, PMBs constituted 47% of total risk benefits paid.

The expenditure on PMBs for 2017 was R746 per beneficiary per month (pbpm), representing a 9.5% increase from the recalculated figure of R681 for the 2016 financial year.

The expenditure on PMBs varies from scheme to scheme, and these differences can be seen in Figure 20. The variation is due to a number of factors, such as different risk profiles and efficiency within the schemes. The other reason for variation, which is of concern to the CMS, could be noncompliance in terms of either payment of PMBs or improper reporting on the level of PMBs.

Figure 20: PMB expenditure by scheme for 2017



Twelve (12) schemes reported PMB expenditure below R300 per beneficiary per month (pbpm) – of which four are open schemes and eight are restricted schemes. In 2017, the average PMB expenditure per beneficiary is higher on open schemes than on restricted schemes, unlike previous years. This may be indicative of a worsening risk profile in open schemes.

The medical schemes' expenditure on PMBs is monitored from year to year. The expenditure on PMBs is mainly driven by a combination of the following:

- the beneficiary profile, which speaks to the level of cross subsidisation between the young and the old, or the sick and the healthy,
- the prevalence of chronic conditions and disease burden, and
- expenditure on treatment, which is strongly linked to contracting between schemes and providers.

Figure 21 depicts the relationship between medical schemes' expenditure on PMBs and proportions of beneficiaries by age group. The expenditure on PMBs generally increases with age. In ages above 45, the expenditure on PMBs is higher than the industry average of R746 pbpm.

The PMB expenditure for beneficiaries aged one year or less is significantly higher than that of the industry average. The ages from one to 44 years have PMB expenditure below the industry average. To maintain a reasonable PMB expenditure increase from year to year, the membership growth in the age groups encompassing 1 to 44-year olds should be higher than the growth in age ranges with PMB costs above the average of R746 pbpm (beneficiaries aged one year or less, and those older than 45).

Figure 21: PMB Expenditure by age band for 2016 and 2017

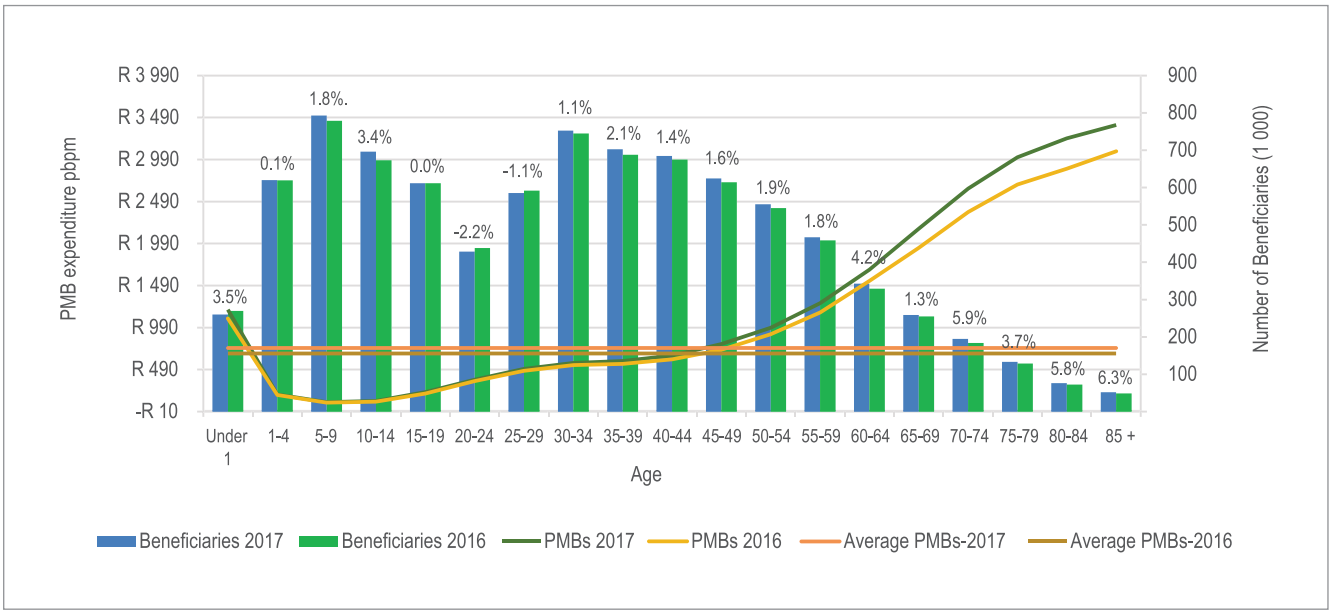


Figure 22 shows the medical schemes expenditure and prevalence of conditions on the Chronic Disease List (CDL). Generally, the more prevalent a condition is, the more a medical scheme would spend on a pbpm basis. Hypertension remains the most prevalent CDL condition among medical scheme beneficiaries. In 2017, the prevalence of hypertension was 138.2 per 1 000 beneficiaries, compared to 133.30 per 1 000 beneficiaries in 2016. This CDL is the most expensive on a pbpm basis. In 2017, medical schemes spent R23.8 pbpm, up from R22.9 pbpm in 2016. Hyperlipidaemia is the second most prevalent condition, with a prevalence of 74.4 per 1 000 beneficiaries, followed by Diabetes Mellitus Type 2 – with a prevalence of 46.3 per 1 000 beneficiaries.

Figure 22: Expenditure and prevalence of chronic conditions

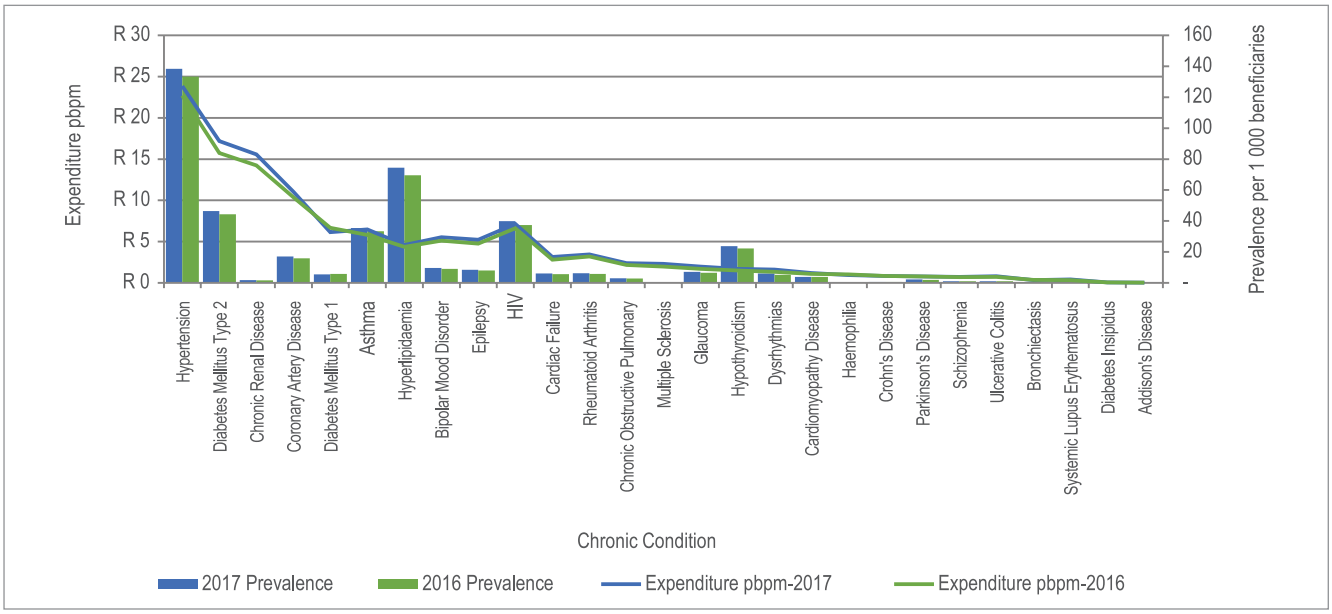


Figure 23 shows the expenditure on chronic conditions in 2016 and 2017 per patient per month (pppm). Haemophilia had the highest expenditure per patient registered, followed by chronic renal disease and Multiple Sclerosis.

In 2017, schemes spent R23 955 pppm on Haemophilia compared to R25 860 pppm in 2016. The 2016 amounts have been restated due to the reclassification of the data. For most conditions, the increase in the number of registered patients from 2016 to 2017 was greater than the increase in expenditure, resulting in a decrease in the average pppm costs.

The pppm expenditure is much lower than the SRM estimated cost per patient for most of the CDLs. This may be due to either under-reporting of PMB expenditure by schemes, or a reflection of the quality of care provided by the medical schemes. The latter possibility is consistent with the data submitted on the quality of care.

Figure 23: Expenditure on chronic conditions in 2016 and 2017

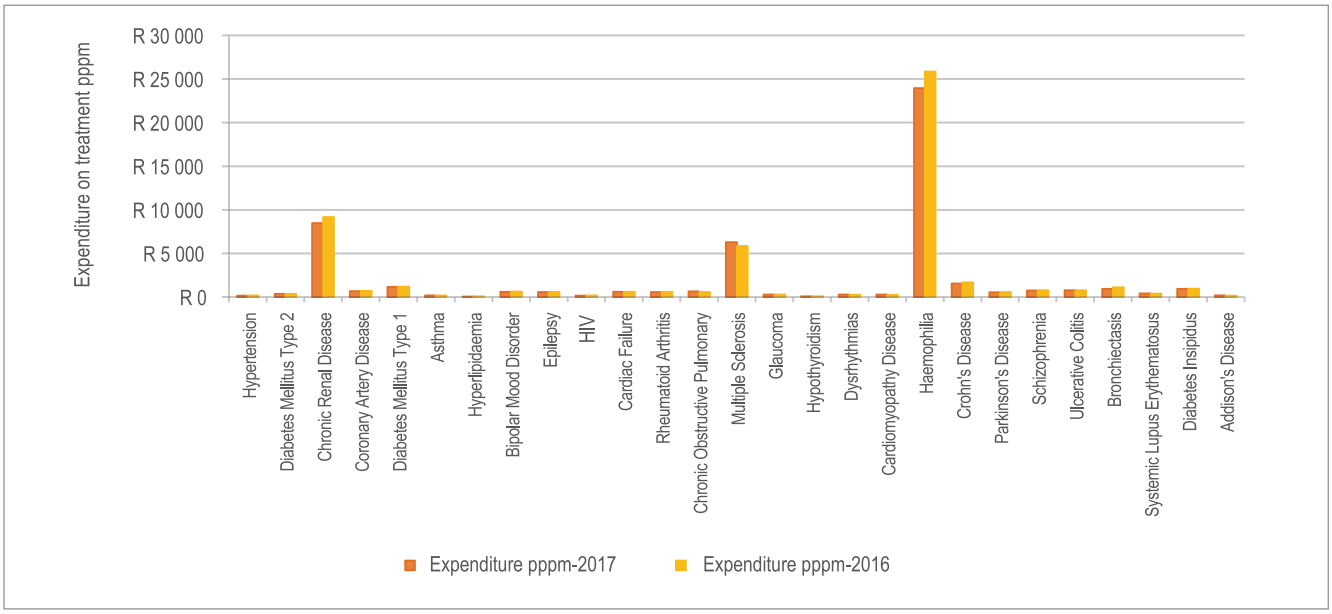


Figure 24 depicts the medical schemes' expenditure on Disease Treatment Pairs (DTPs) conditions for 2017 and 2016. Most of the DTP expenditure is in-hospital. Default emergency conditions was the most expensive DTP in 2017, with schemes spending R36 pbpm. The composition of the top 10 DTP conditions has not changed significantly since 2016. Treatable breast cancer and major affective disorders (including unipolar and bipolar depression) had the highest expenditure outside hospital, amounting to R7.4 and R5.6 pbpm respectively.

Figure 24: Top 10 DTPs by expenditure pbpm

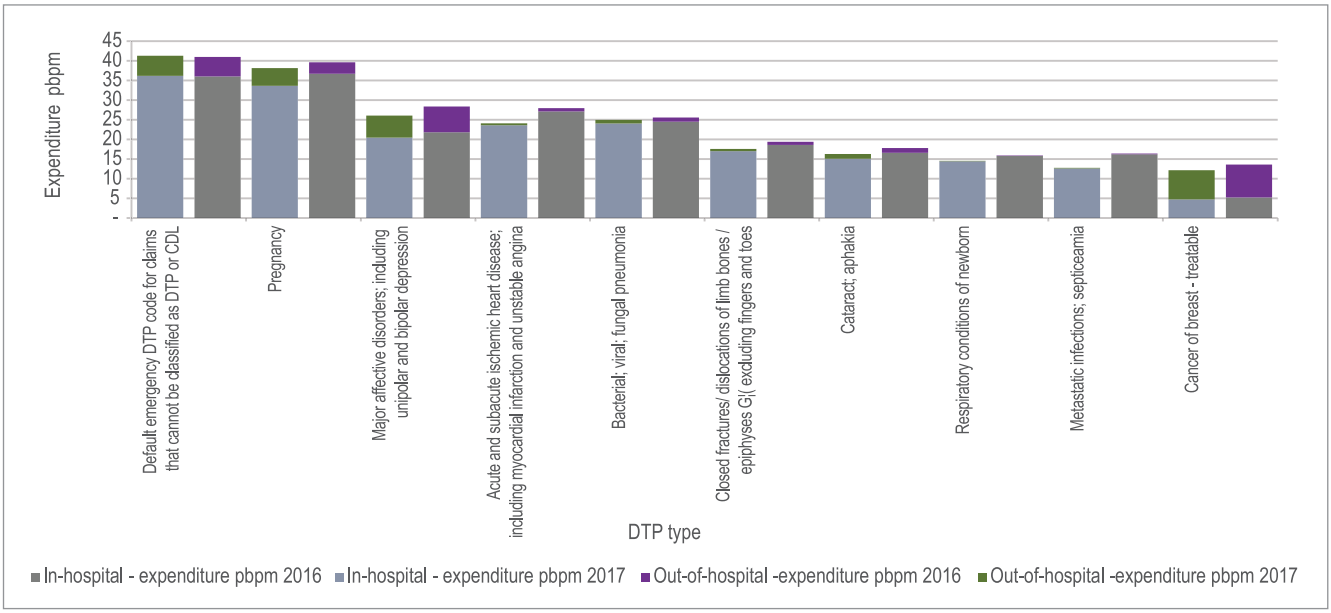


Table 5 shows expenditure on the top 10 disease treatment pairs (DTP) conditions, with the highest cost by expenditure and occurrence. The expenditure on the top 10 DTP conditions amounted to R26 billion in 2017, compared to R23.9 billion in 2016.

Table 5: Top 10 Disease Treatment Pairs (DTP) conditions

DTP diagnosis	Total expenditure on DTP conditions (R million)
Default emergency DTP code for claims that cannot be classified as DTP or CDL	4 344
Pregnancy	4 203
Major affective disorders; including unipolar and bipolar depression	3 010
Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina	2 965
Bacterial; viral; fungal pneumonia	2 714
Closed fractures/ dislocations of limb bones / epiphyses (excluding fingers and toes)	2 057
Cataract; aphakia	1 889
Respiratory conditions of new-born	1 687
Metastatic infections; septicaemia	1 740
Cancer of breast - treatable	1 440
Total Cost	**26 050**

Quality of Care

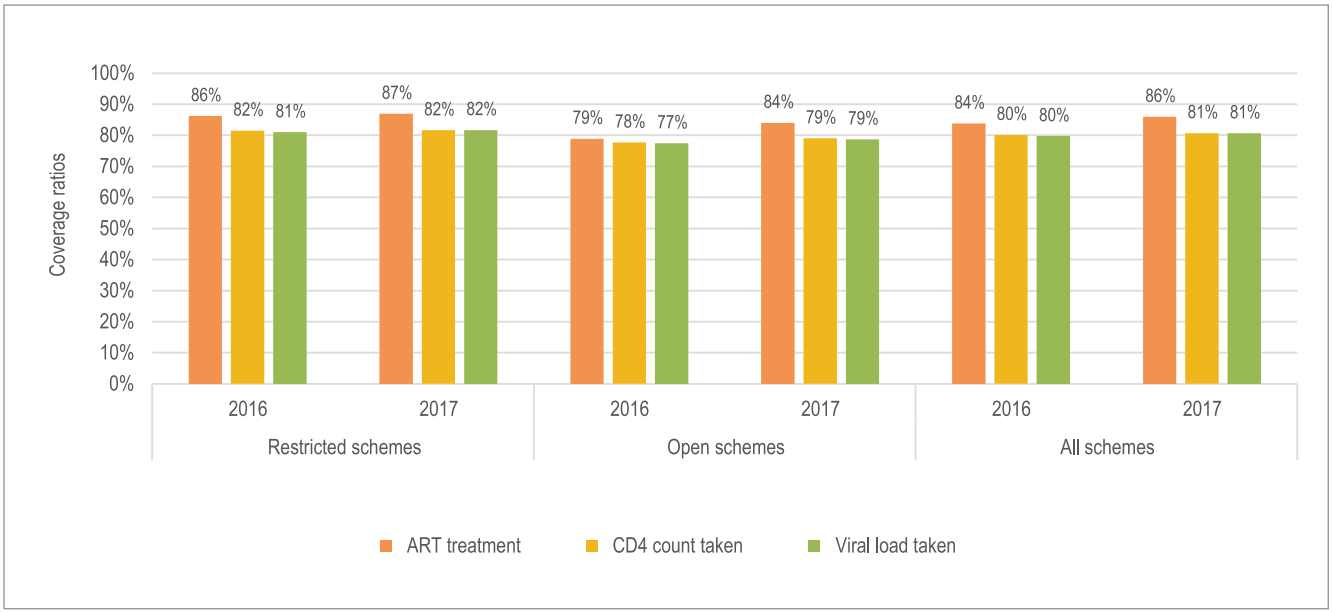
The CMS embarked on an industry-wide, ongoing consultative process to establish the best standard of care that is clinically appropriate and cost effective for medical schemes. The process identified appropriate process and outcome indicators for the management of CDL conditions. So far, 14 of the CDL conditions have gone through this process. The CMS has collected data on these 14 CDL conditions, and more CDLs will be included in the future. The data collected includes the number of chronic patients receiving appropriate care per CDL condition. The coverage ratios for these conditions are listed in Annexure L by scheme and benefit option.

Human Immune Defeficiency Virus (HIV) is the best managed CDL condition with coverage ratios of 80% and above. The coverage ratios are disappointing for other chronic conditions. There is also a wide variation in coverage ratios, if one compares benefit options and ultimately the managed care organisations.

Human Immunodeficiency Virus (HIV)

The proportion of beneficiaries receiving antiretroviral therapy (ART) is 86% in 2017 – slightly higher than the 84% in 2016. The coverage of HIV monitoring tests has also increased slightly, with coverage ratios of 80% in 2016 and 81% in 2017 for both viral load tests and the CD4 counts. In 2017, restricted schemes had approximately 3% higher coverage than open schemes – for ART treatment as well as the CD4 tests and the viral load tests.

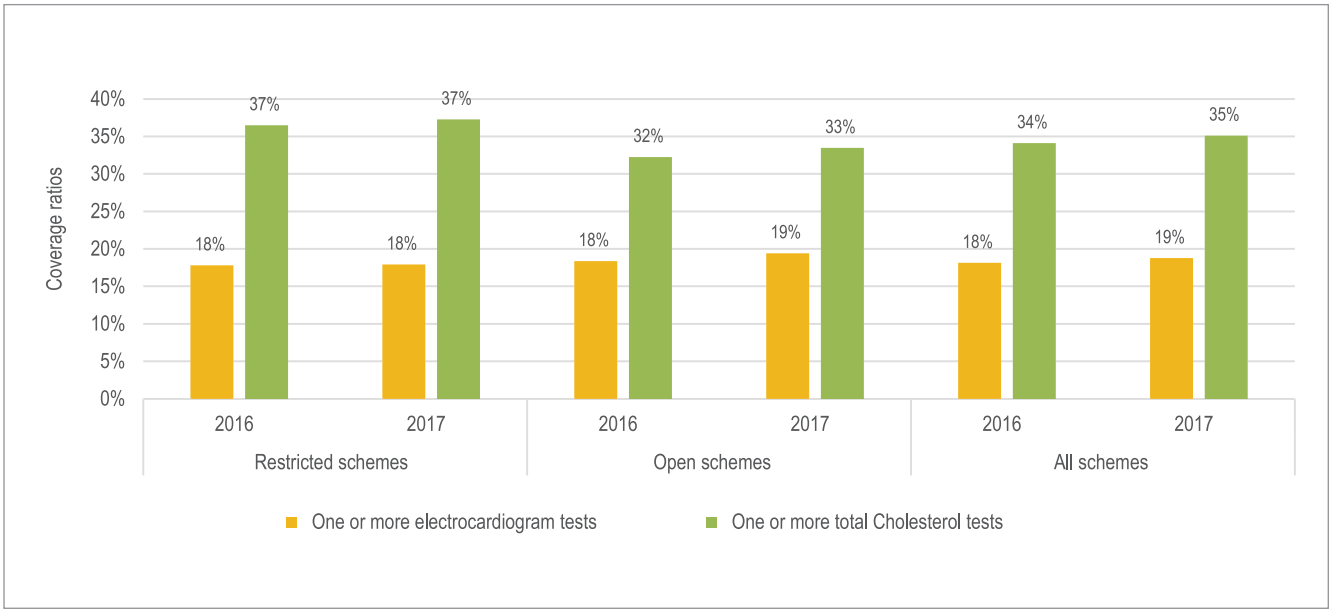
Figure 25: HIV - coverage ratios



Hypertension

Hypertension is the most prevalent chronic condition across medical scheme beneficiaries, yet the coverage ratios of monitoring tests to help with patient management are very low. The coverage for the electrocardiogram test was 18% and 19% for 2016 and 2017, respectively. The coverage of the total cholesterol test was higher – at 34% in 2016, and increasing marginally to 35% in 2017.

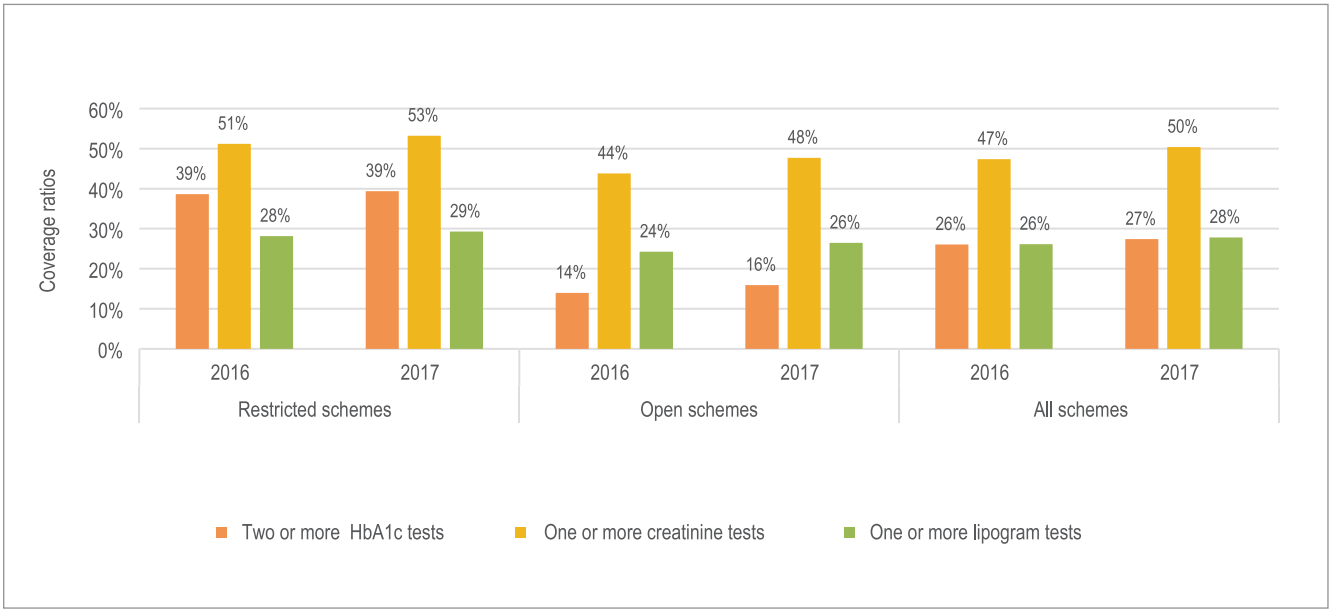
Figure 26: Hypertension - coverage ratios



Diabetes Mellitus Type 2

Diabetes mellitus type 2 is becoming more prevalent. The coverage ratios in Figure 26 are for diabetes mellitus type 2. The coverage ratios are low, with monitoring tests such as the creatinine test being 50% in 2017 while the HbA1c test was 27%. Restricted schemes had considerably higher coverage for the HbA1c test, with 39% compared to open schemes that had only 16%.

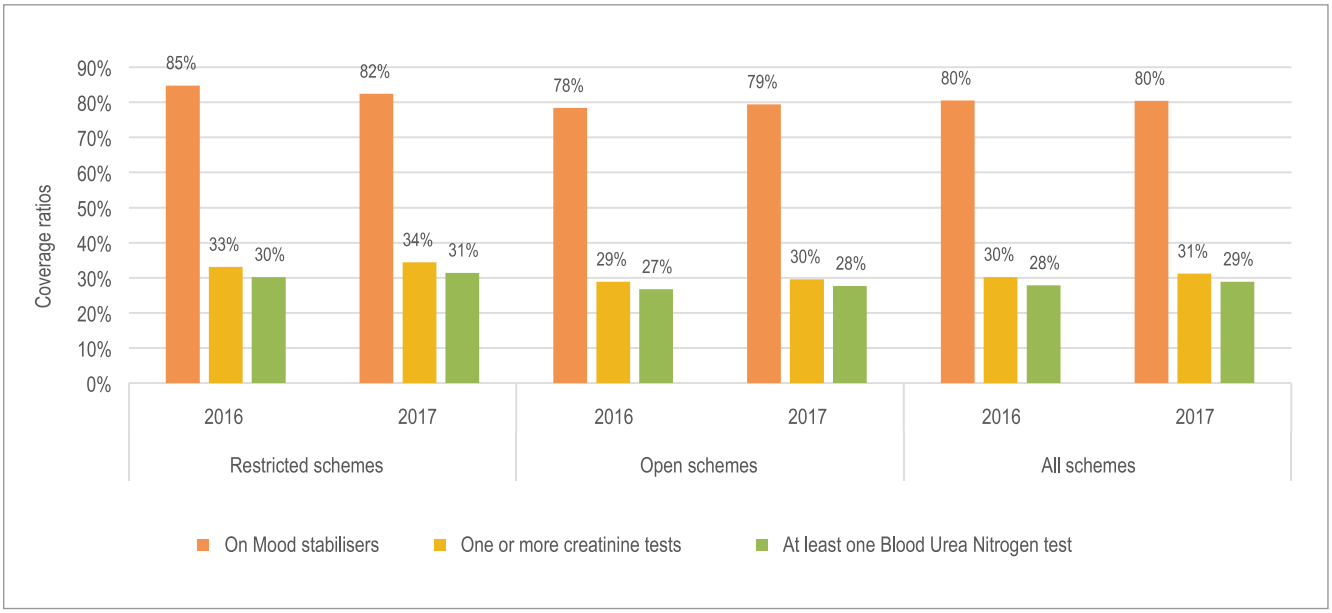
Figure 27: Diabetes Mellitus Type 2 - coverage ratios



Bipolar Mood Disorder

Bipolar mood disorder is another condition that is becoming more prevalent, but the high coverage ratio of those on mood stabilisers suggests that the condition is being well-managed.

Figure 28: Bipolar Mood Disorder - coverage ratios



UTILISATION OF HEALTHCARE SERVICES

Primary healthcare services

Primary healthcare providers act as a first point of contact, and are responsible for patients' continuing care. Ideally, the primary healthcare providers (medical, dental, or nurse practitioner) should also be responsible for the coordination of any secondary care that the patient may need. This is not always the case in the South African medical Schemes environment.

The number of medical schemes beneficiaries visiting general practitioners (GPs) at least once a year was 745.3 and 738.7 per 1 000 beneficiaries for 2016 and 2017, respectively. The overall rate of GP consultations has shown a slight reduction of 6.6 per 1 000 beneficiaries or 0.9% during the period under review. The number of beneficiaries visiting GPs was higher in the restricted schemes for both the 2017 and 2016 financial years when compared to open schemes.

Visits to general dental practitioners remained largely unchanged between 2016 and 2017, at 216.1 and 216.6 per 1 000 beneficiaries respectively. Significantly more beneficiaries in restricted schemes (240.1 per 1 000 beneficiaries) had at least one dentist consultation in 2017 compared to those in open schemes (197.9 per 1 000 beneficiaries).

Visits to registered nurses increased from 18.3 per 1 000 beneficiaries in 2016 to 20.2 per 1 000 beneficiaries in the 2017 financial year. The number of consultations with a nurse was higher in restricted schemes than in open schemes during the period under review.

The average frequency of GP visits per patient decreased slightly from 3.5 in 2016 to 3.4 in 2017, while visits to dentists remained largely unchanged at about 1.8 visits per patient. On the other hand, nurse visits per patient showed a minor reduction from 1.9 to 1.9 per patient during the period under review.

The amount paid to primary healthcare providers is higher for dentists compared to both GPs and nurses. Moreover, a large portion of dental care is paid for from the member savings account (MSA). It must be noted that the unexpectedly large per-beneficiary expenditure on dentists may be attributed to associated services such as laboratory fees and consumables. The potential out-of-pocket payment (OOPs) related to the respective primary care providers per patient was highest for dentists (R231 per patient), followed by nurses (R79.1). GPs had the lowest OOPs (R32.2).

Table 6: Utilisation of primary healthcare services (out-of-hospital) in 2016 and 2017

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
General Medical Practice (014)				
Number of patients per 1 000 beneficiaries	699.6	788.1	738.7	745.3
Number of visits per patient	3.2	3.6	3.4	3.5
Total amount claimed per patient	R 400.9	R 394.6	R 397.7	R 374.9
Risk amount paid per patient	R 207.0	R 321.5	R 264.1	R 255.5
Medical savings account amount paid per patient	R 153.3	R 49.1	R 101.4	R 92.2
General Dental Practice (054)				
Number of patients per 1 000 beneficiaries	197.9	240.1	216.6	216.1
Number of visits per patient	1.8	1.7	1.7	1.8
Total amount claimed per patient	R 1 384.4	R 1 138.3	R 1 265.5	R 1 201.0
Risk amount paid per patient	R 384.3	R 937.3	R 651.5	R 609.3
Medical savings account amount paid per patient	R 670.8	R 75.0	R 383.0	R 372.5
Registered nurses (88)				
Number of patients per 1 000 beneficiaries	17.0	24.3	20.2	18.3
Number of visits per patient	1.8	1.9	1.9	1.9
Total amount claimed per patient	R 540.8	R 386.7	R 457.4	R 429.0
Risk amount paid per patient	R 276.3	R 321.5	R 300.8	R 261.8
Medical savings account amount paid per patient	R 141.3	R 23.2	R 77.4	R 82.4

Utilisation of specialist healthcare services

Table 7 depicts the in-hospital healthcare services utilisation and average expenditure for the top five most frequently used medical specialists in the 2016 and 2017 financial years. Specialists registered in the category 'specialist medicine' are used more frequently than all of the other medical specialists. This category is followed closely by obstetrics and gynaecology, and paediatric specialists. The number of beneficiaries consulting with specialist medicine practitioners and neurologists increased by 4 and 2% respectively for the period under review. A slight decrease was observed in the number of patients consulting with specialists in the category of obstetrics and gynaecology (-2%), paediatrics (-2%), and psychiatry (-1%). On the other hand, a significant year-to-year increase in the amount claimed per patient by providers was observed across all medical specialists. The largest increase (R802.44 for 2016 to R900.82 for 2017or 12%) was reported for specialist medicine practitioners in independent practices. The amount claimed for the in-hospital services of obstetrics and gynaecology specialists grew by 9% between 2016 (R3 252.49) to 2016 (R3 536.14) . Paediatric, psychiatry, and neurology specialists' in-hospital claims grew by 8%, 7%, and 7% respectively for the period under review.

It must also be noted that the bulk of the amount claimed for in-hospital use of medical specialists was paid from risk benefits. Only a negligible amount was paid from savings. This is not the case for out-of-hospital use of the same specialists, where a significant amount claimed for patient consultations was paid from members' medical savings accounts. Members of medical schemes are also more likely to experience large OOPs for the out-of-hospital services delivered by medical specialists.

Table 7: Utilisation of medical specialists' in-hospital healthcare services in 2016 and 2017

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Independent Practice Specialist Medicine (18)				
Number of patients per 1 000 beneficiaries	53.3	51.9	52.7	50.7
Number of visits per patient	6.8	7.1	6.9	7.0
Total amount claimed per patient	R 941.2	R 852.6	R 900.8	R 802.4
Risk amount paid per patient	R 877.7	R 788.1	R 836.8	R 752.6
Medical savings account amount paid per patient	R 0.7	R 0.4	R 0.6	R 0.4
Independent Practice Specialist Obstetrics and Gynaecology (16)				
Number of patients per 1 000 female beneficiaries	50.5	47.3	49.1	50.1
Number of visits per patient	1.7	1.9	1.8	1.8
Total amount claimed per patient	R 3 928.4	R 3 093.9	R 3 536.1	R 3 252.4
Risk amount paid per patient	R 2 932.9	R 2 748.5	R 2 846.2	R 2 662.2
Medical savings account amount paid per patient	R 4.2	R 3.8	R 4.0	R 3.4
Paediatrics Independent Practice Specialist (32)				
Number of patients per 1 000 beneficiaries	26.2	9	24.4	25.0
Number of visits per patient	4.8	5.3	5.0	5.0
Total amount claimed per patient	R 967.1	R 901.7	R 938.6	R 868.4
Risk amount paid per patient	R 903.8	R 865.3	R 887.0	R 823.6
Medical savings account amount paid per patient	R 0.3	R 2.7	R 1.3	R 1.0
Psychiatry (22)				
Number of patients per 1 000 beneficiaries	8.2	9.5	8.8	8.7
Number of visits per patient	7.5	7.8	7.6	7.7
Total amount claimed per patient	R 1 177.8	R 1 067.8	R 1 123.2	R 1 046.2
Risk amount paid per patient	R 1 161.6	R 1 034.8	R 1 098.6	R 1 025.9
Medical savings account amount paid per patient	R 0.2	R 5.0	R 2.6	R 1.6
Neurology (20)				
Number of patients per 1 000 beneficiaries	7.4	5.2	6.4	6.3
Number of visits per patient	4.8	5.2	4.9	4.9
Total amount claimed per patient	R 1 219.0	R 1 038.3	R 1 149.3	R 1 078.8
Risk amount paid per patient	R 1 175.3	R 1 002.1	R 1 108.5	R 1 030.1
Medical savings account amount paid per patient	R 0.4	R 0.7	R 0.5	R 0.3

Table 8 summarises the use of surgical specialists by members of medical schemes for the period under review. All surgical specialists experienced a decrease of 1% in the volume of patients using their services, except for ophthalmologists – who recorded an increase of 4%. On the other hand, increases above inflation in the amount claimed by surgical specialists for in-hospital services was experienced for orthopaedics (11%), paediatric surgeons (9%), and urologists (8%). The amount claimed per patient by otorhinolaryngologist and ophthalmologists for in-hospital services increased by 4% for the period under review. As is the case with medical specialists, the amount paid by beneficiaries from their savings accounts in the in-hospital setting is very small compared to that in the out-of-hospital setting for the same providers.

Table 8: Utilisation of surgical specialists' in-hospital healthcare services in 2016 and 2017

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Surgery/Paediatric surgery Independent Practice Specialist (42)				
Number of patients per 1 000 beneficiaries	41.5	31.6	37.0	37.3
Number of visits per patient	2.7	2.9	2.8	2.8
Total amount claimed per patient	R 2 384.4	R 1 912.2	R 2 192.1	R 2 006.0
Risk amount paid per patient	R 2 050.5	R 1 659.6	R 1 891.3	R 1 743.6
Medical savings account amount paid per patient	R 3.9	R 1.6	R 3.0	R 2.3
Orthopaedics (28)				
Number of patients per 1 000 beneficiaries	24.7	18.7	22.0	22.1
Number of visits per patient	1.6	1.8	1.7	1.7
Total amount claimed per patient	R 8 481.4	R 6 492.8	R 7 671.1	R 6 898.3
Risk amount paid per patient	R 6 927.4	R 5 218.9	R 6 231.2	R 5 632.2
Medical savings account amount paid per patient	R 18.2	R 5.8	R 13.2	R 9.3
Urology (46)				
Number of patients per 1 000 beneficiaries	14.5	10.4	12.7	12.8
Number of visits per patient	2.1	2.1	2.1	2.1
Total amount claimed per patient	R 2 778.3	R 2 436.0	R 2 652.9	R 2 452.2
Risk amount paid per patient	R 2 463.3	R 2 114.5	R 2 335.6	R 2 196.6
Medical savings account amount paid per patient	R 3.3	R 3.0	R 3.2	R 2.0
Otorhinolaryngology (30)				
Number of patients per 1 000 beneficiaries	13.9	10.1	12.2	12.3
Number of visits per patient	1.5	1.6	1.5	1.5
Total amount claimed per patient	R 3 112.5	R 2 507.8	R 2 878.0	R 2 761.4
Risk amount paid per patient	R 2 538.7	R 2 094.2	R 2 366.3	R 2 252.0
Medical savings account amount paid per patient	R 9.8	R 6.8	R 8.6	R 6.1
Ophthalmology (26)				
Number of patients per 1 000 beneficiaries	13.8	9.4	11.8	11.4
Number of visits per patient	1.7	1.6	1.7	1.7
Total amount claimed per patient	R 6 415.9	R 5 517.5	R 6 100.8	R 5 864.1
Risk amount paid per patient	R 6 015.5	R 5 092.1	R 5 691.6	R 5 461.4
Medical savings account amount paid per patient	R 3.8	R 3.0	R 3.5	R 3.8

There was a negligible change in the number of patients using the hospital-based services of support specialist practitioners, except for radiographers – where the number of patients using radiography services grew by 10%, as shown in Table 9. Radiographers recorded a significant increase in the number of patient consultations and the lowest increase in the amount claimed per patient for the period under review. A seven to eight percent increase in the amount claimed per patient in the hospital setting was recorded for pathologists, anaesthetists, diagnostic radiologists, and nuclear medicine specialists. The difference between the reported amount claimed and paid from risk was insignificant, ensuring full cover for patients for the healthcare services delivered by support specialists.

More details on the utilisation of medical, surgical, and support specialists' healthcare services can be found in Annexure G.

Table 9: Utilisation of support specialists' in-hospital healthcare services in 2016 and 2017

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Pathology Independent Practice Specialist (52)				
Number of patients per 1 000 beneficiaries	142.1	124.3	134.1	133.7
Number of visits per patient	3.6	4.0	3.7	3.7
Total amount claimed per patient	R 1 045.0	R 999.5	R 1 024.8	R 950.1
Risk amount paid per patient	R 1 038.7	R 989.7	R 1 016.9	R 939.1
Medical savings account amount paid per patient	R 0.8	R 1.7	R 1.2	R 0.7
Anaesthetists (10)				
Number of patients per 1 000 beneficiaries	90.9	68.0	80.6	81.8
Number of visits per patient	1.3	1.3	1.3	1.4
Total amount claimed per patient	R 3 964.0	R 3 482.9	R 3 782.1	R 3 486.5
Risk amount paid per patient	R 3 360.0	R 2 827.4	R 3 158.7	R 2 957.6
Medical savings account amount paid per patient	R 10.3	R 4.5	R 8.1	R 6.2
Diagnostic Radiology (38)				
Number of patients per 1 000 beneficiaries	83.1	75.0	79.5	80.8
Number of visits per patient	2.0	2.1	2.0	2.0
Total amount claimed per patient	R 2 561.9	R 2 200.0	R 2 401.3	R 2 251.0
Risk amount paid per patient	R 2 450.1	R 2 164.9	R 2 323.6	R 2 192.3
Medical savings account amount paid per patient	R 6.1	R 4.5	R 5.4	R 2.7
Radiography (39)				
Number of patients per 1 000 beneficiaries	14.7	10.3	12.7	11.5
Number of visits per patient	1.1	1.1	1.1	1.1
Total amount claimed per patient	R 1 160.3	R 1 140.3	R 1 153.0	R 1 117.7
Risk amount paid per patient	R 1 146.3	R 1 109.6	R 1 132.9	R 1 101.7
Medical savings account amount paid per patient	R 0.6	R 1.4	R 0.9	R 0.6
Nuclear Medicine (25)				
Number of patients per 1 000 beneficiaries	1.9	1.3	1.6	1.7
Number of visits per patient	1.0	1.0	1.0	1.0
Total amount claimed per patient	R 6 664.6	R 5 391.0	R 6 195.8	R 5 752.8
Risk amount paid per patient	R 6 524.7	R 5 304.3	R 6 075.5	R 5 642.8
Medical savings account amount paid per patient	R 9.8	R 1.1	R 6.6	R 2.0

Utilisation of supplementary and allied health professionals' healthcare services

Table 10 gives a summary on the use of supplementary and allied health professionals' healthcare out-of-hospital services for the period under review. Optometrists, psychologists, and chiropractors recorded a negative growth in the number of patients using their services. The number of patients using the services of physiotherapists, orthotists, and prosthetists in the out-of-hospital setting grew by 1% for the period under review. The highest increase in the amount claimed per patient for the selected supplementary and allied health professionals was recorded by the chiropractic practitioners, at 9%. Orthotists, prosthetists, and physiotherapists followed closely at 7%, while the amount claimed by psychologists and optometrists grew by 5 and 3%, respectively.

It must also be noted that the bulk of the amount claimed for the use of supplementary and allied health professional healthcare services was paid from the members' savings accounts. In addition, patients using the services of supplementary and allied health professionals are likely to be exposed to larger OOPs when accessing service in the out-of-hospital setting. More details on the utilisation of supplementary and allied health professionals' healthcare services can be found in Annexure G.

Table 10: Utilisation of supplementary and allied health professionals' in-hospital healthcare services in 2016 and 2017

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Optometrists (70)				
Number of patients per 1 000 beneficiaries	116.7	158.2	135.0	141.8
Number of visits per patient	1.2	1.0	1.1	1.1
Total amount claimed per patient	R 2 993.7	R 2 388.6	R 2 700.2	R 2 615.5
Risk amount paid per patient	R 443.6	R 1 453.9	R 933.5	R 907.6
Medical savings account amount paid per patient	R 1 866.6	R 531.7	R 1 219.3	R 1 150.3
Physiotherapists (72)				
Number of patients per 1 000 beneficiaries	59.3	59.2	59.3	58.8
Number of visits per patient	4.2	3.2	3.7	3.8
Total amount claimed per patient	R 557.1	R 551.2	R 554.9	R 518.4
Risk amount paid per patient	R 223.6	R 401.3	R 289.6	R 263.6
Medical savings account amount paid per patient	R 223.7	R 63.8	R 164.2	R 157.2
Psychologists (86)				
Number of patients per 1 000 beneficiaries	26.0	25.8	25.9	26.5
Number of visits per patient	4.7	3.3	4.1	4.0
Total amount claimed per patient	R 1 011.7	R 1 019.6	R 1 014.5	R 969.4
Risk amount paid per patient	R 556.6	R 834.6	R 655.0	R 615.1
Medical savings account amount paid per patient	R 275.6	R 67.2	R 201.8	R 193.6
Orthotists & Prosthetists (87)				
Number of patients per 1 000 beneficiaries	16.5	18.1	17.2	16.9
Number of visits per patient	1.1	1.1	1.1	1.1
Total amount claimed per patient	R 2 779.6	R 2 583.0	R 2 690.5	R 2 519.2
Risk amount paid per patient	R 1 336.4	R 2 136.1	R 1 698.9	R 1 534.4
Medical savings account amount paid per patient	R 737.4	R 64.1	R 432.2	R 417.7
Chiropractors (4)				
Number of patients per 1 000 beneficiaries	17.1	9.1	13.7	13.9
Number of visits per patient	3.1	2.6	2.9	3.0
Total amount claimed per patient	R 545.9	R 517.0	R 538.5	R 496.1
Risk amount paid per patient	R 130.7	R 337.7	R 183.8	R 173.8
Medical savings account amount paid per patient	R 312.6	R 113.3	R 261.5	R 235.3

Utilisation of hospital services

Table 11 provides details of the utilisation of private hospital services for same-day and overnight admissions by hospital category. 'Same-day' cases in the report refer to hospital confinement that ends within 24 hours, while 'overnight' admission refers to a hospital confinement longer than 24 hours.

Same-day and overnight admissions in the A-status (PCNS=057) private hospitals have largely remained unchanged during the period under review.

Same-day and overnight admissions in the B-status (PCNS=058) private hospitals recorded a negative growth during the period under review. The same-day admissions decreased by 5% from 79.0 per 1 000 beneficiaries in 2016 to 75.3 per 1 000 beneficiaries in 2017.There was a slight decrease (2%), from 153.0 per 1 000 beneficiaries in 2016 to 150.2 per 1 000 beneficiaries in 2017, in the number of patients admitted on an overnight basis.

Most hospital admission statistics were higher for open schemes, except for maternity admissions. Maternity admissions to provincial hospitals were significantly lower than the same to private hospitals. This may be due to benefit design, patient choice, or the difficulty experienced by provincial hospitals in successfully submitting claims for payment to medical schemes or administrators. The analysis also shows the low usage of sub-acute facilities and day clinics – facilities that could possibly reduce hospital costs.

More details on hospital admissions can be found in Annexure H.

Table 11: Utilisation of hospital facilities in 2016 and 2017, admission rates per 1 000 beneficiaries

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Private Hospitals ('A' - Status) (057)				
Same-day admissions	11.3	16.2	13.4	13.3
Overnight admissions	22.5	24.4	23.4	23.3
Private Hospitals ('B' - Status) (058)				
Same-day admissions	72.4	78.9	75.3	79.0
Overnight admissions	160.1	137.7	150.2	153.0
Provincial Hospitals (056)				
Same-day admissions	1.4	27.2	12.8	13.9
Overnight admissions	0.9	3.5	2.1	2.1
Sub-Acute Facilities (049)				
Same-day admissions	0.2	0.1	0.2	0.2
Overnight admissions	2.8	3.1	2.9	2.9
Unattached operating theatres / Day clinics (076)				
Same-day admissions	0.06	0.04	0.05	0.06
Overnight admissions	0.00	0.04	0.01	0.01
Approved U O T U / Day clinics (077)				
Same-day admissions	17.3	10.7	14.4	12.8
Overnight admissions	1.2	0.6	0.9	0.6
Drug & Alcohol Rehab (047)				
Same-day admissions	0.04	0.05	0.05	0.07
Overnight admissions	1.0	0.7	0.9	0.9
Hospices (079)				
Same-day admissions	0.6	0.1	0.2	0.2
Overnight admissions	0.1	0.1	0.1	0.1
All admissions	0.7	0.2	0.4	0.3
Mental Health Institutions (055)				
Same-day admissions	0.1	0.2	0.2	0.2
Overnight admissions	5.0	4.5	4.8	4.6
Private Rehab Hospital (Acute) (059)				
Same-day admissions	0.00	0.01	0.01	0.02
Overnight admissions	0.4	0.4	0.4	0.4

Table 12 illustrates the average number of hospital days per year for different categories of hospital facilities. The average length of stay in this report is defined as the difference between date of discharge and date of admission divided by the total number of admissions. The average length of stay for inpatient admissions in private hospitals, with A and B status decreased to 3.8 and 4.2 days in 2017, from 4.0 and 4.3 days in 2016, respectively. Provincial hospitals recorded a high average length of stay per admission – with 9.8 days in 2017 and 11.3 days in 2016. The average length of stay for insured beneficiaries is lower than the international norm. The lower average length of stay is likely to be related to the organisation of care in the private health sector, where specialists work independently. Weak controls over admissions have implications on costs, quality of care, and health outcomes.

Table 12: Utilisation of hospital facilities in 2016 and 2017, average length of stay (ALOS)

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Hospital category				
Private Hospitals ('A' - Status) (057)	3.6	3.8	3.7	4.0
Private Hospitals ('B' - Status) (058)	4.1	4.4	4.2	4.3
Provincial Hospitals (056)	5.0	11.4	9.8	11.3
Sub-Acute Facilities (049)	10.7	10.1	10.4	10.0
Unattached operating theatres / Day clinics (076)	1.1	1.3	1.2	1.1
Approved U O T U / Day clinics (077)	2.2	3.6	2.6	3.4
Drug & Alcohol Rehab (047)	12.1	15.7	13.3	13.3
Hospices (079)	17.0	24.5	20.0	29.2
Mental Health Institutions (055)	11.0	11.7	11.3	11.5
Private Rehab Hospital (Acute) (059)	28.3	25.9	27.7	27.7

Figure 29 illustrates admission rates and the average length of stay per year for different admission categories across hospital facilities. Overnight admissions for medical cases remained largely unchanged between 2016 (127.8 per 1 000 beneficiaries) and 2017 (127.0 per 1 000 beneficiaries).

On the other hand, same day admissions of medical cases decreased by 5%, from 86.8 per 1 000 beneficiaries in 2016 to 82.4 per 1 000 beneficiaries in 2017. The average length of stay for medical cases decreased from 5.5 days in 2016 to 5.1 days in 2017.

The overnight admissions for surgical cases recorded a 10% increase during the period under review, with 55.4 and 60.8 beneficiaries per 1 000 beneficiaries in 2016 and 2017, respectively. Like medical cases, a reduction of 9% was observed in the admission of same-day surgical cases during the period under review. The average length of stay for surgical cases decreased from 3.7 days in 2016 to 3.5 days in 2017.

Marginally fewer overnight maternity admissions were recorded in 2017 (32.2 per 1000 female beneficiaries) compared to 2016 (32.7 per 1000 female beneficiaries). A very small number of same-day admissions were attributable to maternity cases in both 2017 (3.2 per 1000 female beneficiaries) and 2016 (2.7 per 1000 female beneficiaries). The average length of stay for inpatient maternity cases remained largely unchanged at about 3 days for the period under review.

Ambulatory admissions increased by 44% to 5.9 per 1 000 beneficiaries, while on the other hand a 6% reduction (6.3 to 5.9 beneficiaries per 1 000 beneficiaries) in the number of emergency room visits was recorded.

Figure 29: Hospital admission categories in 2016 and 2017

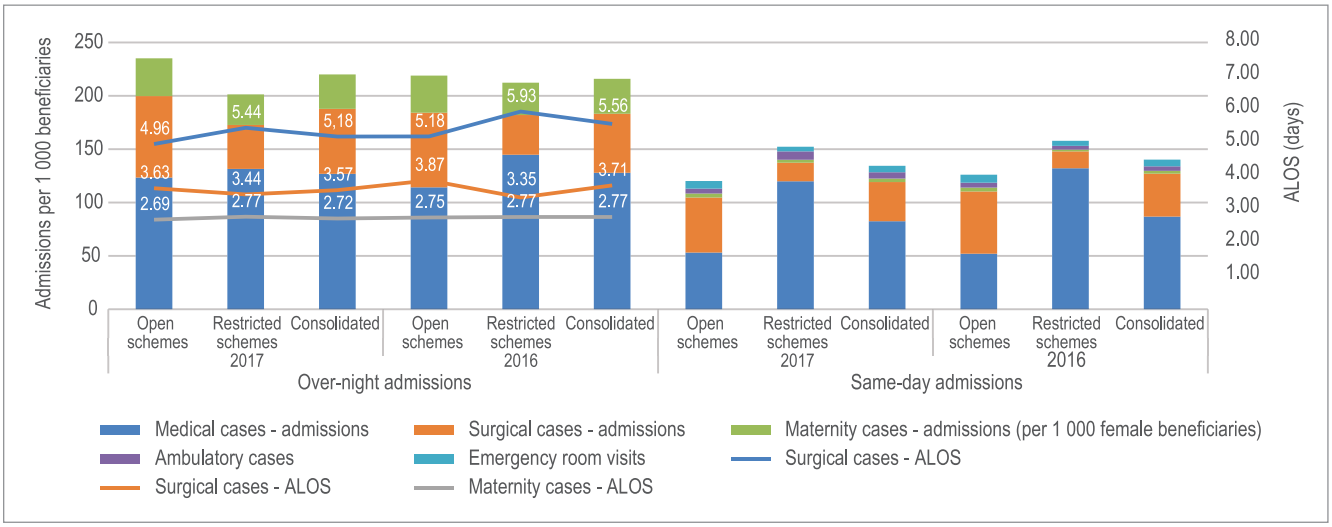


Table 13 illustrates the average length of stay and admission rates per year by level of care across hospital facilities. General ward admissions decreased by 5% between 2016 (188.7 per 1 000 beneficiaries) and 2017 (178.9 per 1 000 beneficiaries). The number of inpatient days per general ward admission remained largely unchanged at 3.3 days in 2016 and 3.44 days in 2017.

Admissions to the high care unit decreased by 4% from 26.5 per 1 000 beneficiaries in 2017 to 25.3 in 2017. The length of stay in high care units increased slightly from 3.01 days in 2016 to 3.2 days in 2017.

Admissions to the intensive care unit (ICU) decreased by 12% from 12.3 per 1 000 beneficiaries in 2016 to 11.1 per 1000 beneficiaries in 2017. The length of stay in ICU increased slightly from 3.0 days in 2016 to 3.2 days in 2017.

The average number of hospital admissions in respect of PMB conditions remained unchanged between 2016 and 2017 at 73.8 and 72.4 per 1 000 beneficiaries, respectively. The accuracy of PMB admissions data is a major challenge as scheme rules and systems are not set up to separate PMB from non-PMB admissions. The logic generally advanced by medical schemes is that there is no business incentive to identify claims related to PMBs when the rules of the scheme provide for the payment of all authorised hospital admissions – PMB or not. Work to improve the quality of PMB admissions data is ongoing.

Repeat admissions decreased to 40.0 per 1 000 admissions in 2017, from the restated 46.1 per 1 000 admissions in 2016. A re-admission to hospital within 90 days of the first admission is not necessarily related to the first admission. Repeat admission rate is an important indicator of quality in hospital care services.

Table 13: Hospital admissions by level of care and other outcomes in 2016 and 2017

	2017			2016
Level of care	Open schemes	Restricted schemes	Consolidated	Consolidated
General Ward				
Number of admissions per 1 000 beneficiaries	177.0	181.2	178.9	188.7
Average length of stay (days)	3.2	3.6	3.4	3.3
High Care Unit				
Number of admissions per 1 000 beneficiaries	26.1	24.2	25.3	26.5
Average length of stay (days)	3.0	3.5	3.2	3.0
Intensive Care Unit				
Number of admissions per 1 000 beneficiaries	11.2	10.9	11.1	12.3
Average length of stay (days)	4.8	4.9	4.8	4.1
Prescribed Minimum Benefits				
Number of admissions per 1 000 beneficiaries	53.1	97.0	72.4	73.8
Repeat admissions (within 90 days)				
Number of admissions per 1 000 inpatient admissions	46.4	32.3	40.0	46.1
Outpatient				
Number of admissions per 1 000 beneficiaries	162.5	134.3	149.9	149.4
Inpatient deaths				
Number of known deaths per 1 000 admissions	2.0	1.5	1.8	2.0

Utilisation of medical technology

Table 14 provides an overview of the utilisation of medical technology, which remained largely unchanged during the period under review. The utilisation of MRI scans, angiograms, bone density scans, and dialysis services are generally higher in open medical schemes than in restricted schemes.

Table 14: Utilisation of medical technology in 2016 and 2017

	2017			2016
Healthcare Technology	Open schemes	Restricted schemes	Consolidated	Consolidated
Number of procedures performed				
Angiograms	14 754	6 308	21 062	21 261
Bone density scans	15 436	13 906	29 342	32 140
CT (Computerised Tomography) scans	282 372	156 644	439 016	413 471
MRI (Magnetic Resonance Imaging) scans	165 123	85 359	250 482	236 018
PET (Positron Emission Tomography) scans	4 739	3 348	8 087	8 017
Renal dialysis services	64 466	20 370	84 836	62 238

Utilisation of screening, preventative, child, maternal, and reproductive healthcare services

This section gives an account of the utilisation of screening, child, maternal, and reproductive health services. Most of the indicators in this section were introduced as a new data part for the first time in the 2016 Healthcare Utilisation Annual Statutory Returns. This data therefore has many data quality shortcomings as some of the data elements are simply not collected by medical schemes. Data quality continues to be a concern in 2017. These results must therefore be interpreted with caution. The aim of the data part is to align indicators collected by the CMS with those collected by the National Department of Health.

This will allow for benchmarking in the level of access and quality of care received by beneficiaries of medical schemes. Table 15 illustrates preventive services for selected health services.

Table 15: Coverage for selected health services

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Contraception Coverage (per 1 000 female beneficiaries aged 15-49 years)				
Women using contraceptives	193.2	415.8	293.2	293.6
Intrauterine contraceptive device (IUCD)	7.0	9.8	8.3	22.7
Subdermal contraceptive implant	0.8	69.7	59.9	54.6
Child Health Coverage (per 1 000 beneficiaries aged under 5 years)				
Number of children (6-59 months) receiving Vitamin A supplementation	2.3	2.2	2.3	2.2
Children (0 -59 months) with diarrhoea receiving oral rehydration solution (ORS)	34.2	215.5	123.3	144.4
Children aged 6–59 months with malaria	3.6	2.5	2.8	1.8
Cancer Care coverage				
Beneficiaries with breast cancer (per 1 000 female beneficiaries)	18.7	27.3	22.6	22.7
Number screened for cervical cancer (per 1 000 females aged 30-49 years)	31.3	80.4	53.3	60.3
Cervical cancer (per 1 000 female beneficiaries)	6.8	4.0	5.6	5.8
Colon cancer (per 1 000 beneficiaries)	1.9	2.7	2.3	2.3
Liver cancer (per 1 000 beneficiaries)	0.2	2.4	1.2	1.2
Lung cancer (per 1 000 beneficiaries)	1,0	1.8	1.3	1.4
Prostate cancer (per 1 000 male beneficiaries aged 40 years and older)	11.6	18.2	14.2	13.6
Eye Care Coverage				
Cataract surgeries (per 1 000 beneficiaries)	9.5	17.1	12.8	13.2
Mental Health Coverage				
Depression (per 1 000 beneficiaries)	63.9	149.2	101.3	104.3
Psychosis (per 1 000 beneficiaries)	6.4	10.7	8.3	8.2
HIV (Human Immunodeficiency Virus)				
Circumcisions in 15 – 49-year-old males (per 1 000 male beneficiaries aged 15-49)	6.3	11.8	8.6	8.8
Beneficiaries tested for HIV (per 1 000 beneficiaries)	29.0	47.8	37.7	38.5

Table 16 illustrates preventive services for female beneficiaries. The number of birth admissions reduced slightly from the restated 32.7 per 1 000 female beneficiaries in 2016 to 32.2 per 1 000 female beneficiaries in 2017. Birth admissions were higher in open schemes when compared to restricted schemes during the period under review. The number of live births increased from 970.5 per 1 000 birth admissions in 2016 to 976.0 per 1 000 birth admissions in 2017.

Caesarean sections increased from the restated 575.8 in 2016 to 590.0 per 1 000 birth admissions in 2017. The number of caesarean section procedures performed was slightly higher in restricted schemes than in open schemes. The number of births to female beneficiaries under 15 years of age has decreased from the restated 10.2 per 1 000 female beneficiaries under the age of 15 to 6.8 per 1 000 female beneficiaries under the age of 15.

The number of births to female beneficiaries 15–19 years of age decreased from 33.1 per 1 000 female beneficiaries aged 15–19 years in 2016 to 26.0 in 2017. There were 18.8 and 29.9 births per 1 000 female beneficiaries aged between 15–19 years in restricted and open schemes respectively for 2017.

The number of pap smear procedures paid for in 2017 was 161.2 per 1 000 female beneficiaries aged 15–69 years, compared to 171.4 in the previous year. Open schemes reported higher rates of utilisation for pap smear procedures than restricted schemes.

Table 16: Maternal health coverage

	2017			2016
	Open schemes	Restricted schemes	Consolidated	Consolidated
Maternal health indicators				
Birth admissions (per 1 000 female beneficiaries)	35.3	28.5	32.2	32.7
Birth admissions to women 15–19 years (per 1 000 females aged 15-19 years)	18.8	29.9	26.0	33.1
Birth admissions to women under 15 years (per 1 000 females under 15 years)	2.0	8.7	6.8	10.2
Caesarean sections performed (per 1 000 birth admissions)	568.5	621.7	590.0	575.8
Mammograms paid for per 1 000 female beneficiaries aged 50-69 years)	336.9	267.3	308.1	346.4
Pap smears paid for (per 1 000 female beneficiaries aged 15-69 years)	172.2	146.9	161.2	171.4
Surgical procedure to prevent a man from being fertile (per 1 000 males 15-49)	7.8	2.7	5.8	5.5
Surgical procedure to protect a woman from pregnancy (per 1 000 females 15-49)	3.5	0.7	2.5	2.5
Termination of pregnancy (TOP) (per 1 000 female beneficiaries 18-59 years)	1.6	1.9	1.7	1.7
TOP at 13-20 weeks of pregnancy (per 1 000 terminations)	444.0	165.7	277.2	269.7
TOP in the first 12 weeks of pregnancy (per 1 000 terminations)	466.2	609.4	553.3	577.7
Live births (per 1 000 birth admissions)	964.5	993.7	976.0	970.5

PROVIDER DISTRIBUTION: POLICY CONTEXT & SITUATIONAL ANALYSIS

The roll out of the National Health Insurance (NHI), and the current Health Market Inquiry (HMI) into competition in the private health sector, will most likely bring the distribution of health care providers under the policy limelight. The policy relevance is informed by:

- the current initiatives to implement public-private partnerships (PPPs) with general practitioners;
- ever since the Constitutional Court set aside the Certificate of Need regulation, the policy impasse on licensing healthcare facilities has not been breached.
- the need to enable a market structure that makes healthcare equally accessible across all South African geographic markets.

The provisional recommendation made by the HMI is to implement a coordinated effort in licensing healthcare providers, among private-public sector regulators and administrators. The licensing of healthcare facilities should be based on a needs assessment that considers both the: i) healthcare needs and resources; and ii) accessibility to healthcare.

Significant observations

The data describing the private healthcare delivery system for general practitioners (GPs) and the distribution of medical scheme beneficiaries reveals outcomes that are pertinent to ensuing policy interventions. The most salient of all observations show that there are geographic markets which are: i) underserved areas, and ii) potentially with excess capacity.

Therefore, future health policy interventions in the private funding environment should focus on efforts to expand GP networks in underserved markets. In terms of innovative interventions, efficiency discount option (EDO) networks should offer integrated solutions that are designed around GP networks, particularly for underserved geographic areas. Such initiatives in the private sector will be valuable for implementing PPPs. More specifically, this will enable PPPs to leverage the resources in the private sector – to achieve the greater good envisaged within an NHI purchaser-provider split policy framework.

Policy research at the Council for Medical Schemes

A redistribution of healthcare resources will have to be informed by a needs assessment that identifies markets that are overserved, or have excess capacity. This would require an efficiency analysis that optimises healthcare benefits relative to healthcare resources or inputs. The analysis should be conducted in terms of healthcare discipline and geographic healthcare market.

The outcome of such analysis may be meaningful for: i) market definition exercises that consider scale economies in making market power determinations; and ii) human resources for health planning – i.e. taking resources from areas with low efficiency returns to underserved areas with high efficiency returns.

Such analysis should point to whether each of the healthcare delivery markets provide increasing efficiency, or decreasing efficiency. This item should be at the centre of market efficiency discussions and policy recommendations. The CMS' Research and Monitoring has analysed this policy question during the 2017/18 financial year.

Situational analysis

The CMS has been collecting data on the distribution of medical scheme beneficiaries, and healthcare providers claiming from medical schemes – for all nine provinces. This section gives an overview of the private sector financing and healthcare delivery with the following intentions: i) to describe the structure of the healthcare provider market across geographic spaces; ii) to understand the state of healthcare equality across these geographic markets; and iii) to distinguish between underserved areas and markets with excess capacity.

The overview covers four of the largest provinces, in terms of medical scheme beneficiary enrolments. This has been done due to space constraints. The synopsis uses data collected through the healthcare utilisation statutory return system for the 2017 financial year. The collection of this data is a recent initiative by the CMS, and therefore the accuracy of it is subject to the gradual process of improving data collection, capturing, and completeness over time.

The figures below describe the equality of access to general practitioners (GPs) in four provinces. The provinces that are described follow the order of: i) the Eastern Cape; ii) Gauteng; iii) KwaZulu-Natal; and iv) the Western Cape.

The geographic markets contained in each province are generated by summarising beneficiaries' per capita expenditure by postal code. The postal codes' per capita expenditures are then ranked by size (lowest to highest), and then assigned one of five groups. The lowest per capita expenditures are assigned the designation of Group 1, and the highest per capita expenditures are assigned the designation of Group 5. The distribution of medical scheme beneficiaries in each group are of equal weight (they are of equal number).

Figures 30, 32, 34, and 36 show the distribution of GP patient loads (primary y-axis), GPs, and patient visits (secondary y-axis) across postal codes group designations (x-axis) – remembering that the groups are based on ranking medical scheme beneficiaries by the per capita healthcare expenditure on GP visits.

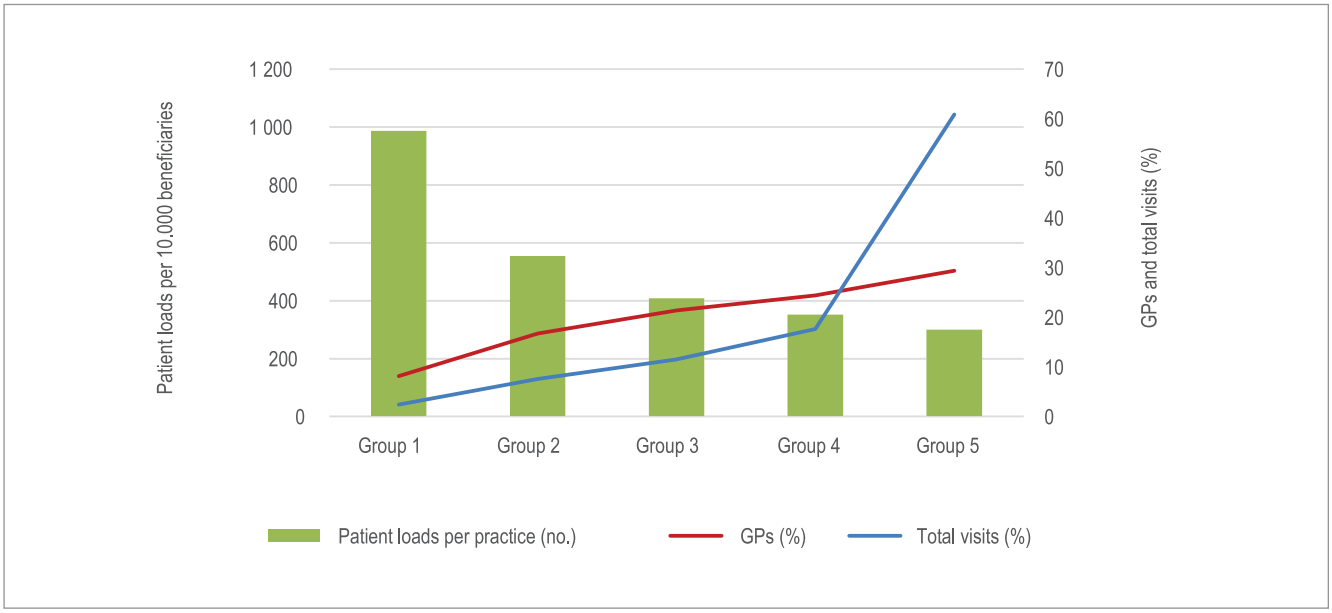
Figures 31, 33, 35, and 37 describe the inequality using the Lorenz curve. The Lorenz curves compare the cumulative distribution of medical scheme beneficiaries (x-axis), against the cumulative distribution of medical scheme expenditure on GPs (y-axis). The orange line reflects the equal distribution of healthcare expenditure, and the blue curve shows the actual distribution of healthcare expenditure.

The larger (smaller) the area between the orange line (equity line) and the blue curve, the larger (smaller) the concentration of inequality is across postal codes in which medical scheme beneficiaries live. The Gini coefficient it used to summarise the overall concentration index of inequality. The index ranges from 0 (no inequality) to 1 (highest inequality possible). By convention, an index of 0.5 is deemed to be extremely high.

Figure 30 gives a high-level account of the Eastern Cape's private GP healthcare delivery system's capacity, and utilisation outcomes. It describes (fig. 30) the state of resource allocation and utilisation in areas with high GP practice patient loads (e.g. Group 1), compared to areas with relatively lower GP practice patient loads (e.g. Group 5). The groups with relatively higher patient loads, such as Groups 1 and 2, are relatively less endowed with GPs than Groups 4 and 5. Groups 1 and 2 also have far less patient visits than Groups 4 and 5.

The relatively higher patient loads in Groups 1 and 2 means that there are relatively fewer GPs per 10,000 beneficiaries than in Groups 4 and 5. Groups 1 and 2 could be underserved areas, relative to Groups 4 and 5 (fig. 30).

Figure 30: Distribution of patient loads, GPs, and GP visits in Eastern Cape (Dec. 2017)



Note: The data is not adjusted for morbidity.

Figure 31 describes the inequality related to medical scheme beneficiaries' expenditure on GP visits, in the Eastern Cape. The Gini coefficient for expenditure on GP visits in the Eastern Cape is 0.51. This is because medical scheme beneficiaries that are ranked:

- In the lowest 20% of per capita expenditure on GPs spend 2% of total expenditure on GP visits; and
- that are ranked in the highest 80% of per capita expenditure on GPs spend 60% of the total expenditure on GP visits.

Beneficiaries ranked in the highest 80% of expenditure on GP visits pay nine rand for every one rand spent by beneficiaries ranked in the lowest 20%.

The inequality in spending diminishes when comparing beneficiaries ranked at the lowest 40% and highest 60% of expenditure on GP visits. The highest 60% pay six rand for every one rand spent by beneficiaries at the lowest 40% (fig. 31).

Figure 31: Lorenz curve showing inequality of access to GPs in the Eastern Cape (Dec. 2017)

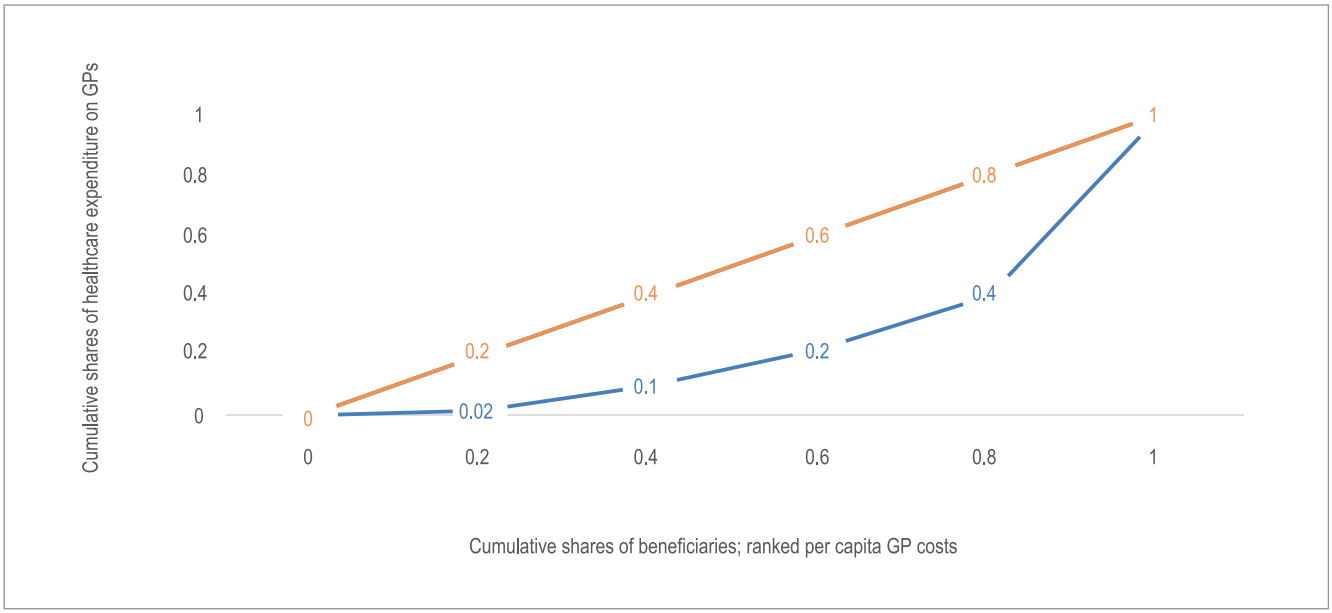
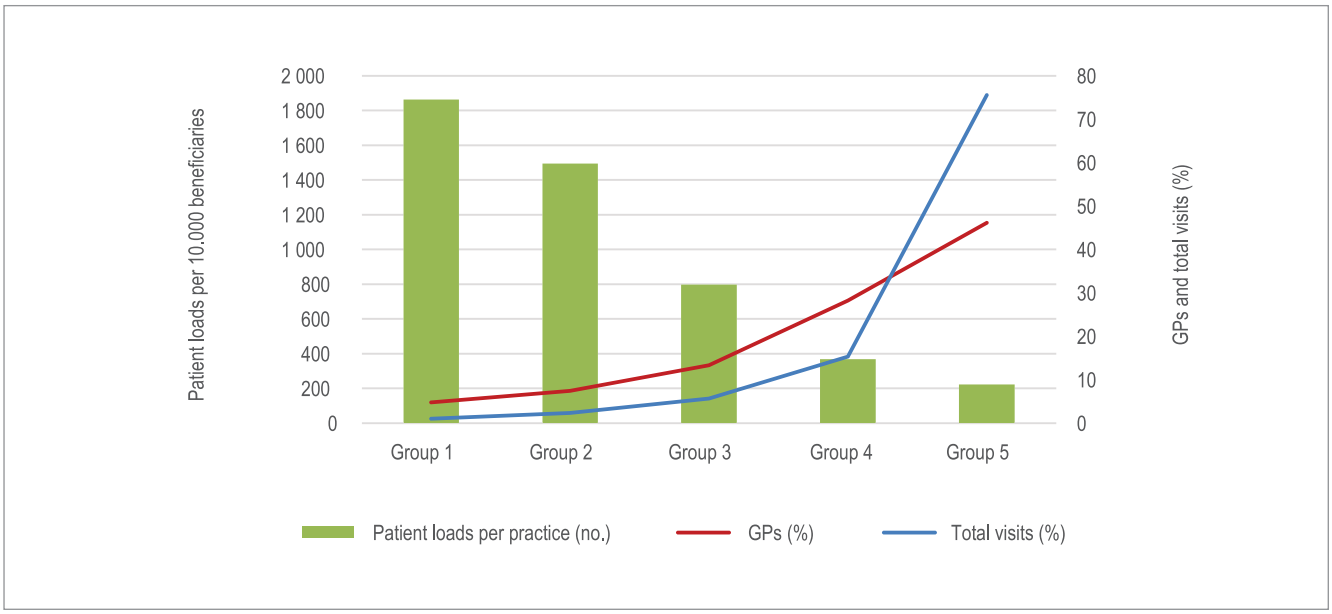


Figure 32 describes the relative patient loads per GP practice, total GP visits paid by medical schemes, and distribution of GPs in Gauteng. The patterns are like those observed in the Eastern Cape. That said, the differences between the groups are greater in Gauteng (fig. 32) than in the Eastern Cape (fig. 30).

Figure 32: Distribution of patient loads, GPs, and GP visits in Gauteng (Dec. 2017)



Note: The data is not adjusted for morbidity.

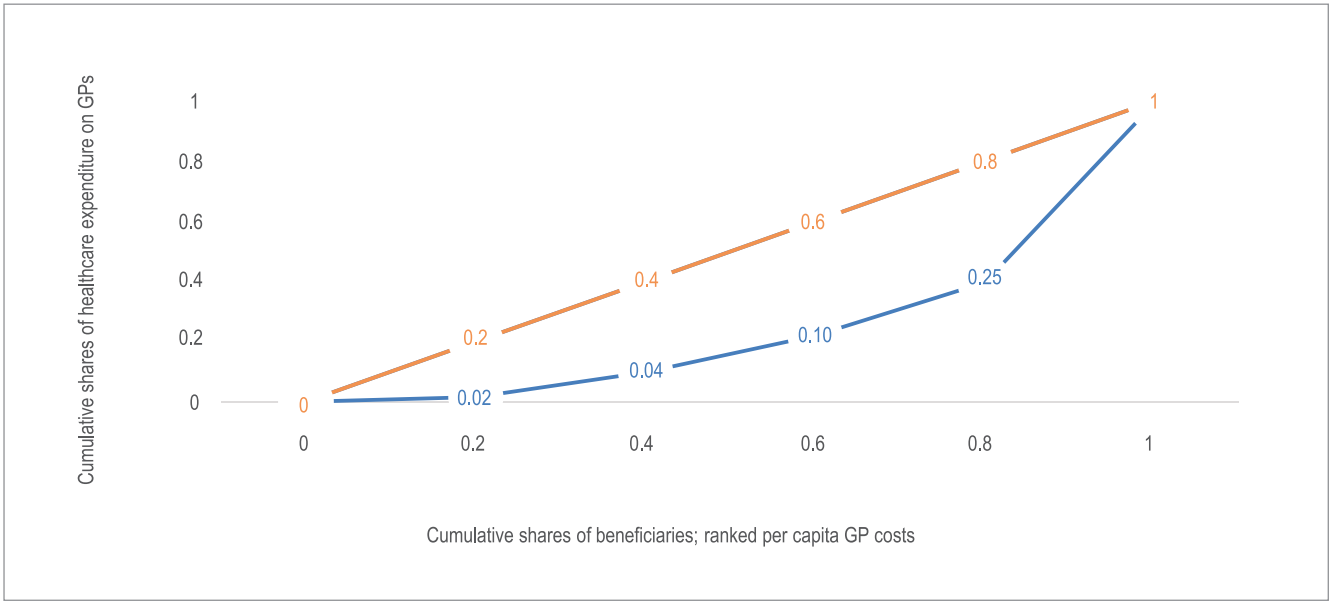
Figure 33 illustrates inequality in the allocation of total healthcare expenditure on GPs in Gauteng. The area between the equality line (orange line) and the true allocation of total expenditure on GP visits (blue curve) is large. In fact, it is the largest out of the four provincial healthcare markets that are included in this overview.

The Gini coefficient for expenditure on GP visits in Gauteng is 0.6 (fig. 33). This is because medical scheme beneficiaries that:

- are ranked in the lowest 20% of per capita expenditure on GPs spend to 2% of total expenditure on GP visits; and
- medical scheme beneficiaries that are ranked in the highest 80% of per capita expenditure on GPs spend 75% of the total expenditure on GP visits.

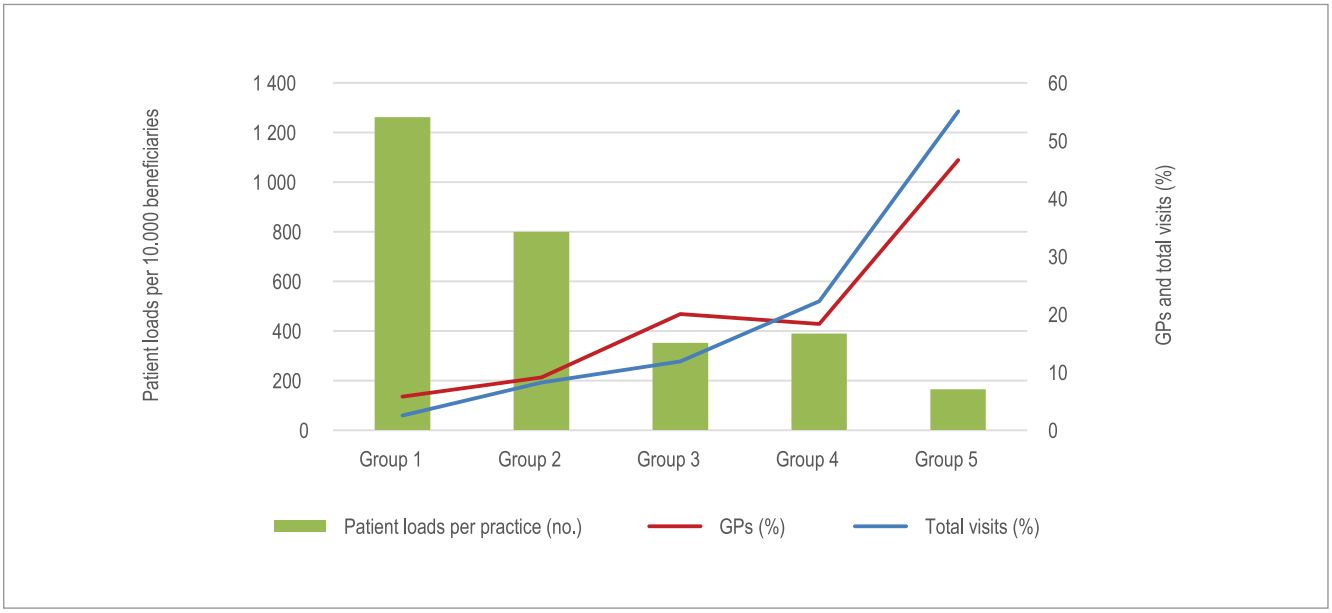
Beneficiaries ranked in the highest 80% of expenditure on GP visits pay R36 for every one rand spent by beneficiaries ranked in the lowest 20%. The inequality in spending diminishes when comparing beneficiaries ranked at the lowest 40% and highest 60% of expenditure on GP visits. The highest 60% pay R16 for every one rand spent by beneficiaries in the lowest 40% (fig. 33).

Figure 33: Lorenz curve showing inequality of access to GPs in Gauteng (Dec. 2017)



Figures 34 to 37 in the rest of the overview can be interpreted with the same logic used to describe the state of inequality that was illustrated by the foregoing figures. We therefore merely present the figures for KwaZulu-Natal and the Western Cape without discussing the results.

Figure 34: Distribution of patient loads, GPs, and GP visits in KwaZulu-Natal (Dec. 2017)



Note: The data is not adjusted for morbidity.

Figure 35: Lorenz curve showing inequality of access to GPs in KwaZulu-Natal (Dec. 2017)

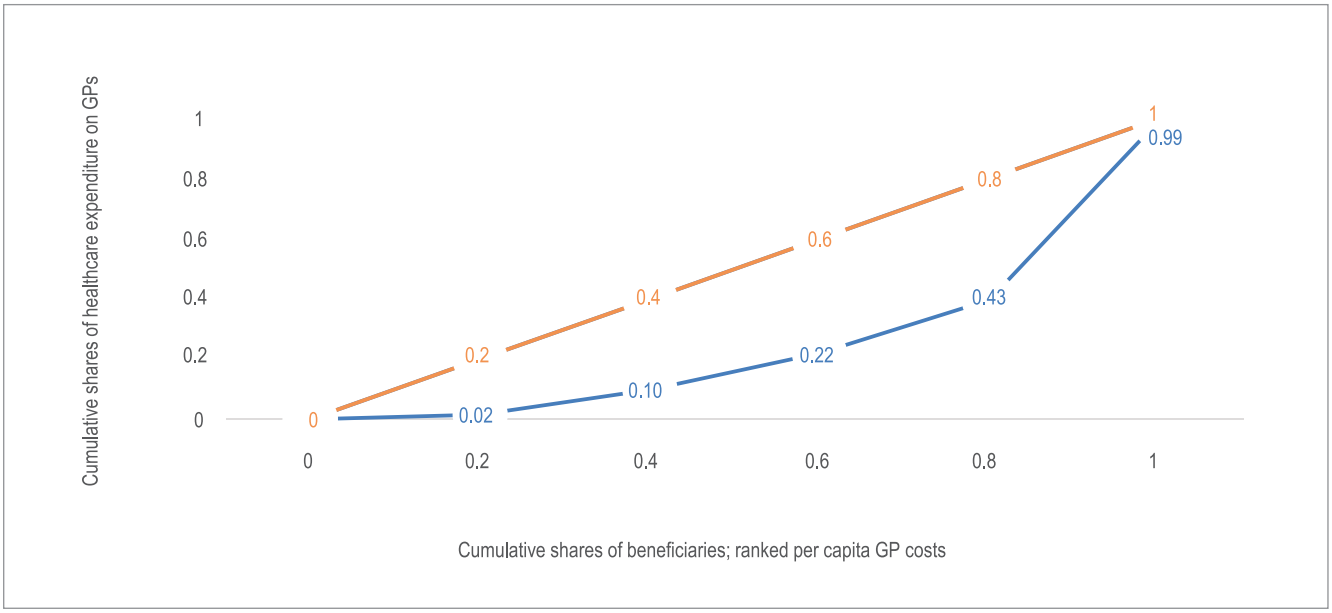
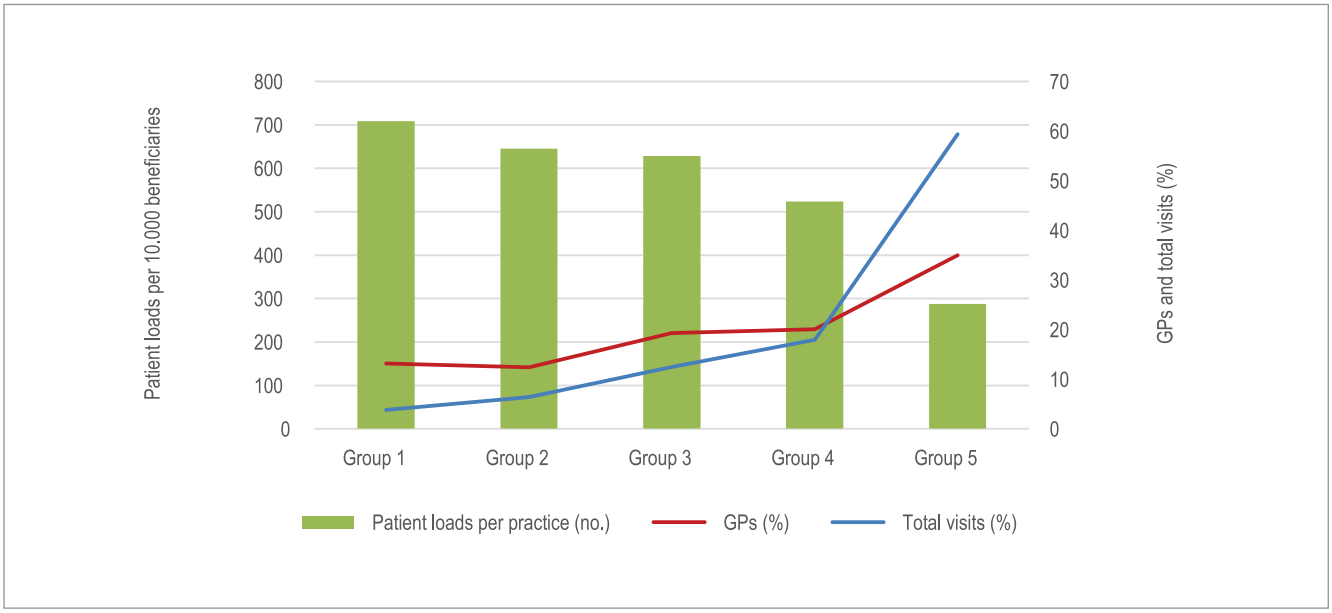
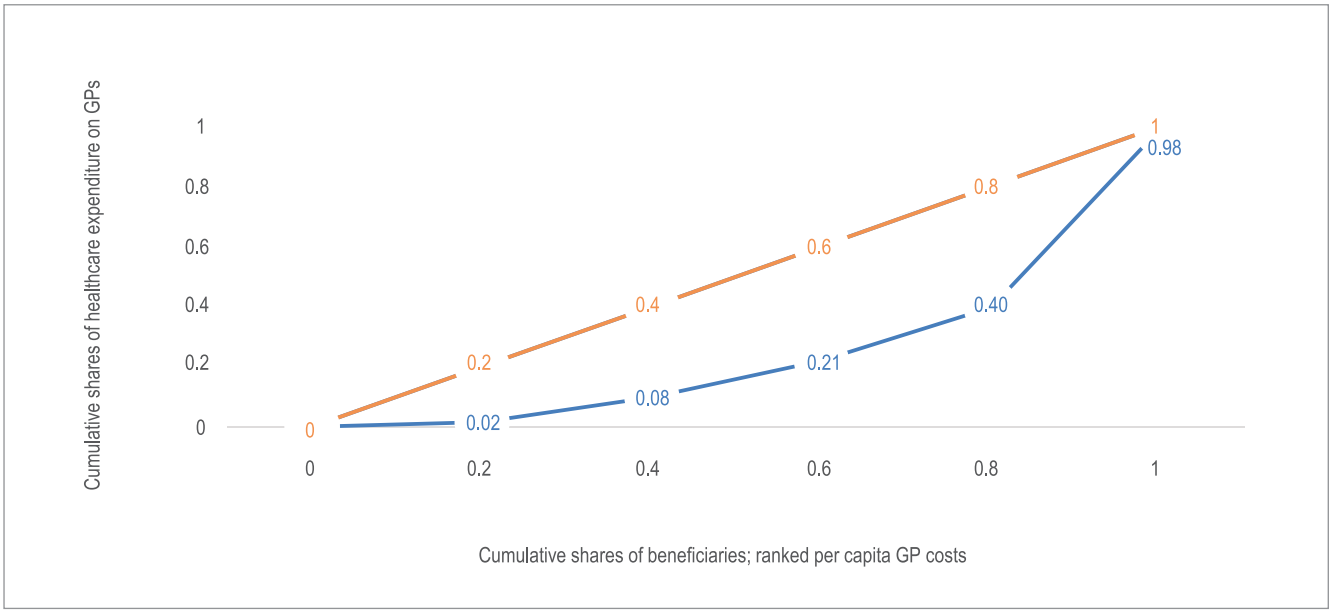


Figure 36: Distribution of patient loads, GPs, and GP visits in the Western Cape (Dec. 2017)



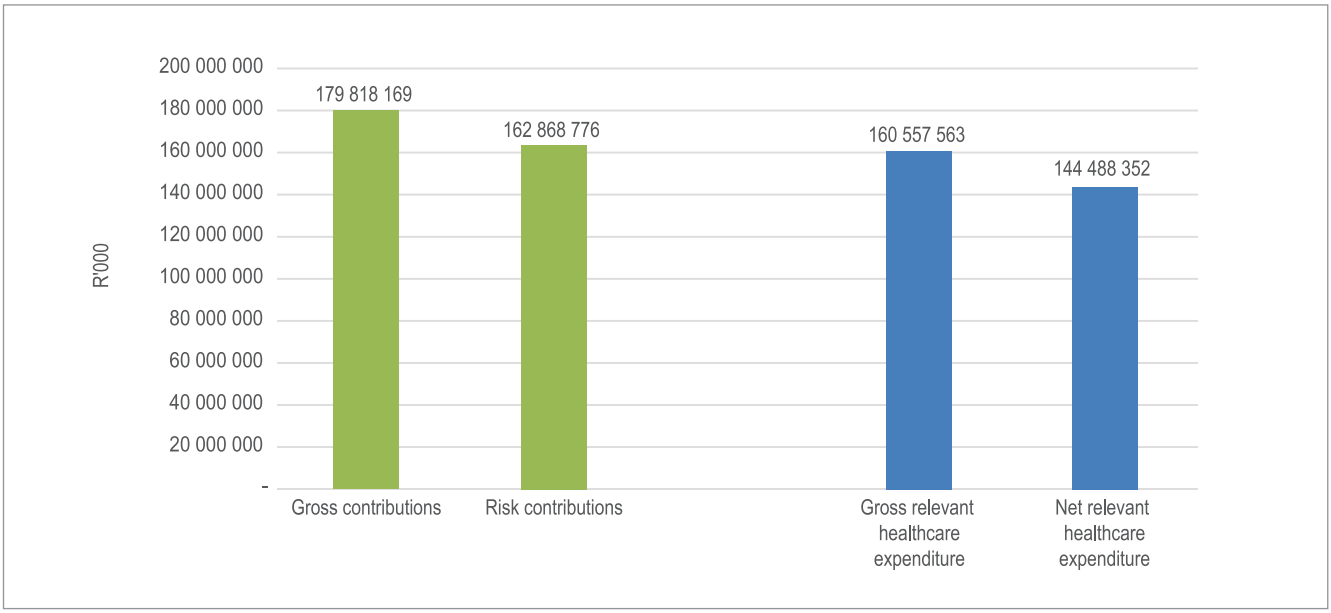
Note: The data is not adjusted for morbidity.

Figure 37: Lorenz curve showing inequality of access to GPs in the Western Cape (Dec. 2017)



CONTRIBUTIONS, RELEVANT HEALTHCARE EXPENDITURE, AND TRENDS

Figure 38:Contributions, relevant healthcare expenditure and trends

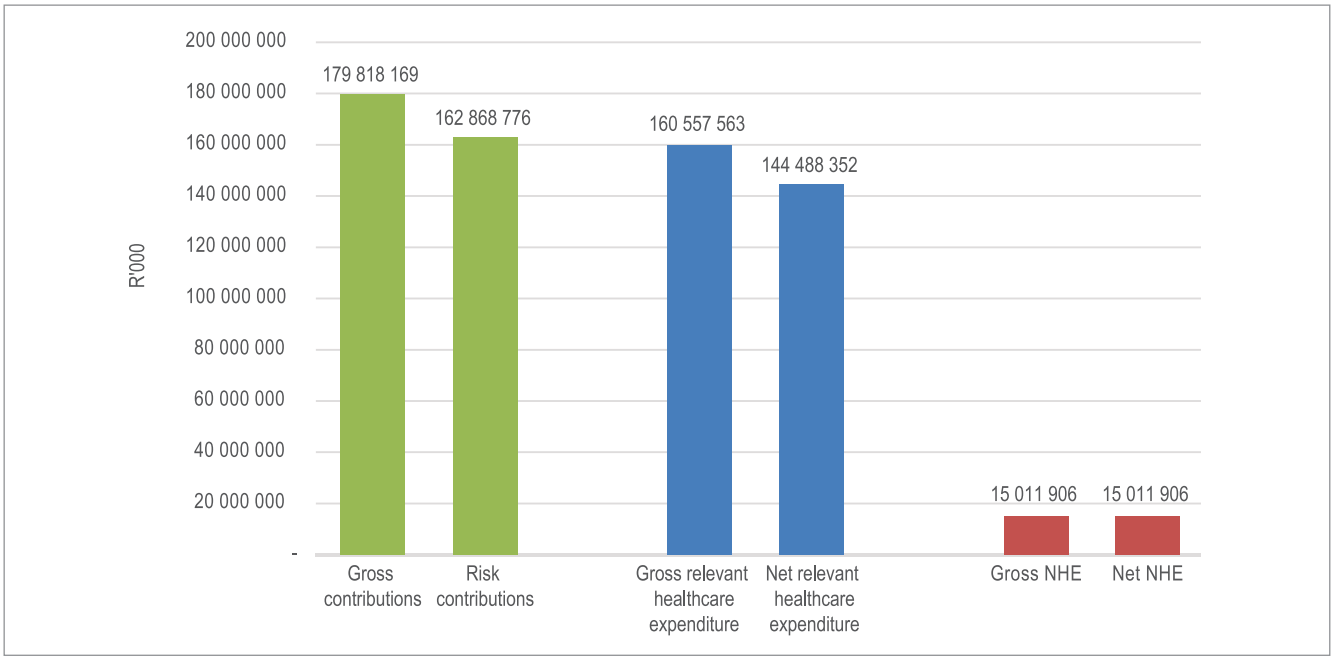


Contributions

The figure below shows total contributions collected from members, before (gross) and after (risk) savings.

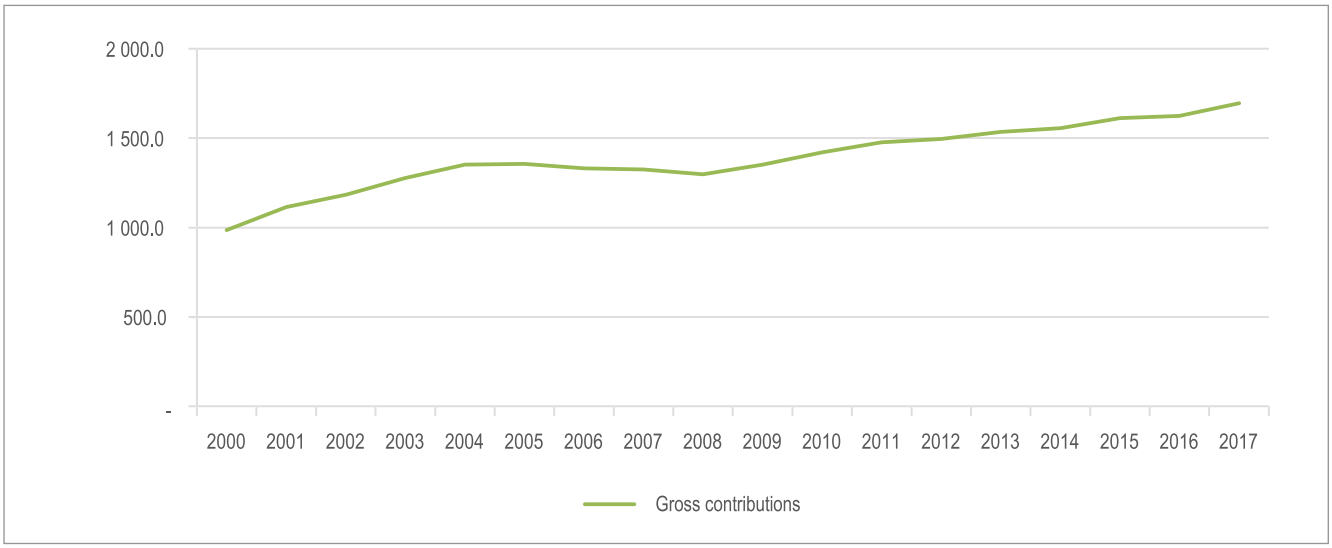
Gross contributions increased by 9.9% to R179.8 billion as at December 2017, from R163.7 billion in December 2016. Risk contributions (excluding medical savings accounts contributions) increased by 10.4% to R162.9 billion from R147.5 billion in 2016. The equivalent increase from 2015 to 2016 was 8.1%.

Figure 39: Gross contributions 2017



[1]All references to claims and benefits indicate relevant healthcare expenditure.

Figure 40: Gross contributions per average beneficiary per month for 2000 - 2017 (2017 prices)



pabpm = per average beneficiary per month

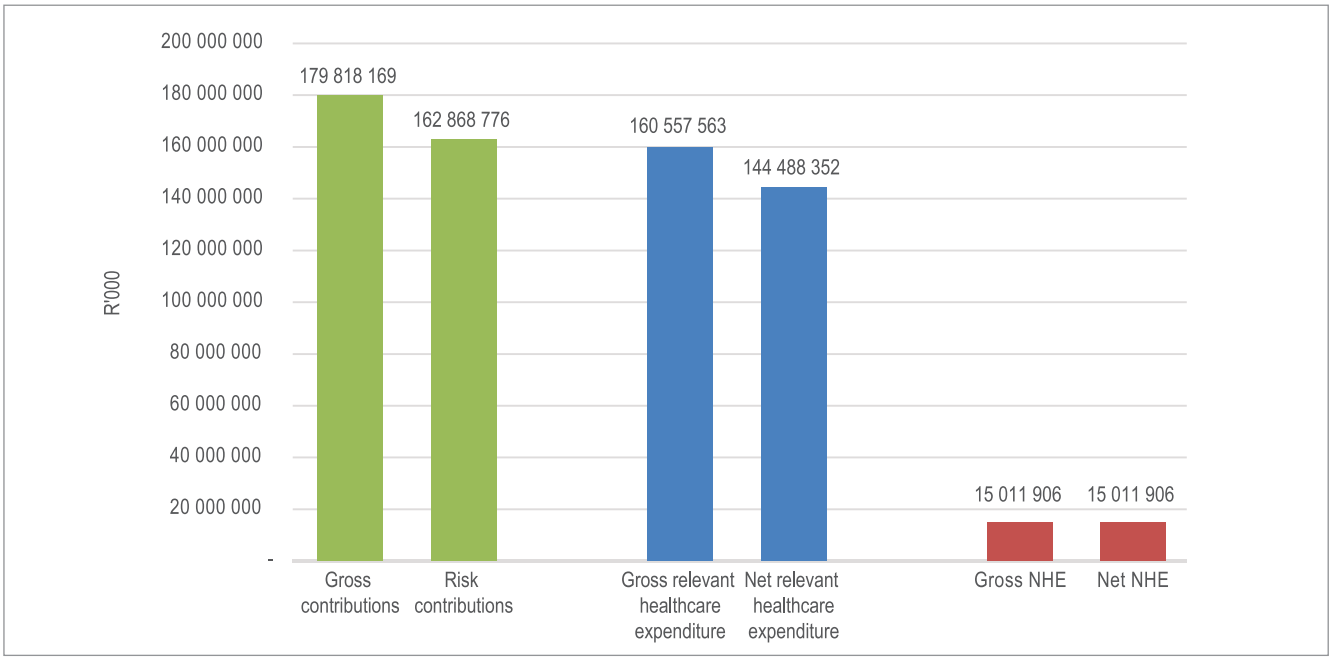
Gross contributions per average beneficiary per month[2] (pabpm) have increased by 72.0% between 2000 and 2017, while gross relevant healthcare expenditure increased by 72.1% (see Figure 42).

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.

Gross contributions pabpm rose by 9.9% to R1 695.1, from R1 543.1 in 2016. After adjusting for inflation this growth was 4.3%. The increase in risk contributions pabpm was 10.4%, rising to R1 535.4 from R1 390.8. The 2016 increase was 7.1%.

Contributions to medical savings accounts increased by 4.9% to R16.9 billion from R16.2 billion (2016: 8.6% increase). When measured on a pabpm basis in respect of only those schemes that use medical savings accounts, the increase was 8.1% – from R177.3 to R191.7. The increase was 7.3% during 2016.

Figure 41: Relevant healthcare expenditure in 2017

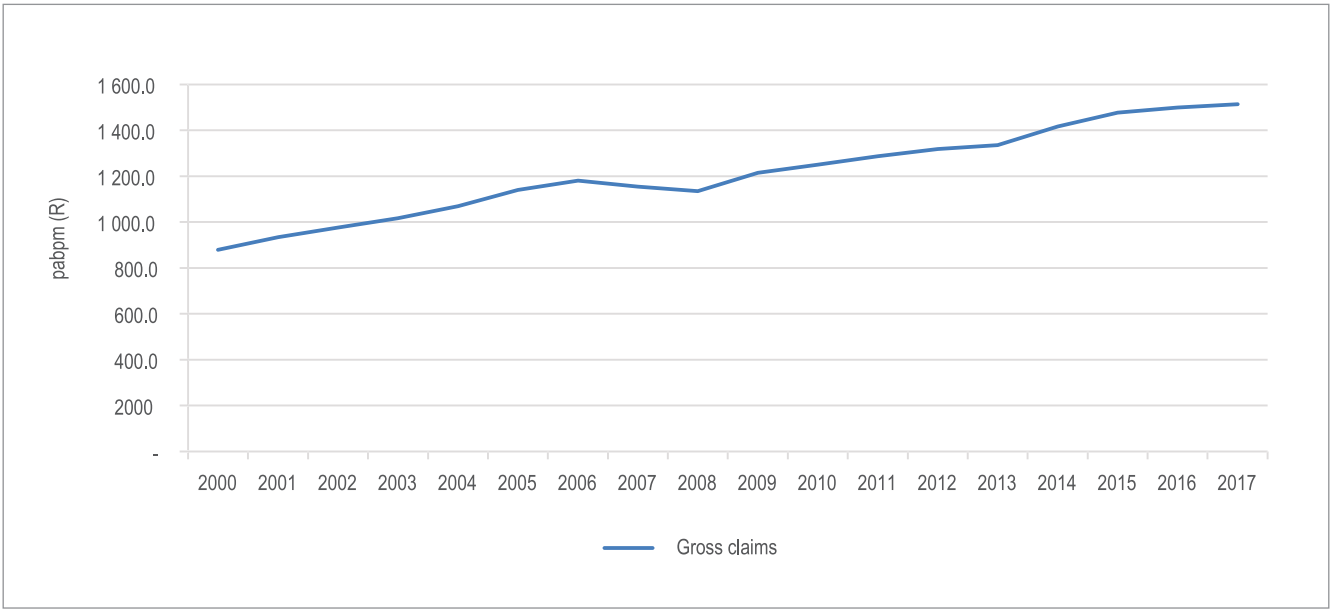


The total gross relevant healthcare expenditure incurred by medical schemes increased by 6.4% to R160.6 billion[3], from R151.0 billion in 2016. Risk claims increased by 6.4% to R144.5 billion, from R135.8 billion in 2016.

[2] Adjusted for inflation using 2017 prices.

[3] This number differs from the R144.4 billion reported above as "benefits paid" due to the inclusion of IBNR and the results of risk transfer arrangements.

Figure 42: Gross relevant healthcare expenditure for 2000-2017 (2017 prices)



pabpm = per average beneficiary per month

The total gross relevant healthcare expenditure incurred pabpm increased by 6.3% to R1 513.6 from R1 423.4 in 2016. Risk claims pabpm rose by 6.4% to R1 362.1 from R1 280.4.

Several factors have impacted on the claims experience of medical schemes – such as changing benefit design, demographic profiles, and in some cases increased utilisation of benefits. Some medical schemes were also affected by widespread fraud and abuse of benefits, as well as wastage. The trend in claims experience improved in 2017, compared to 2016. Based on the 2016 claims experience, medical schemes had over-provided for increased utilisation of benefits in their pricing in 2017.

Figure 43 and 44 below show the medical schemes that had the highest increases in claims ratios, from 2016 to 2017.

Figure 43: Open schemes with a claims ratio increase greater than 4%

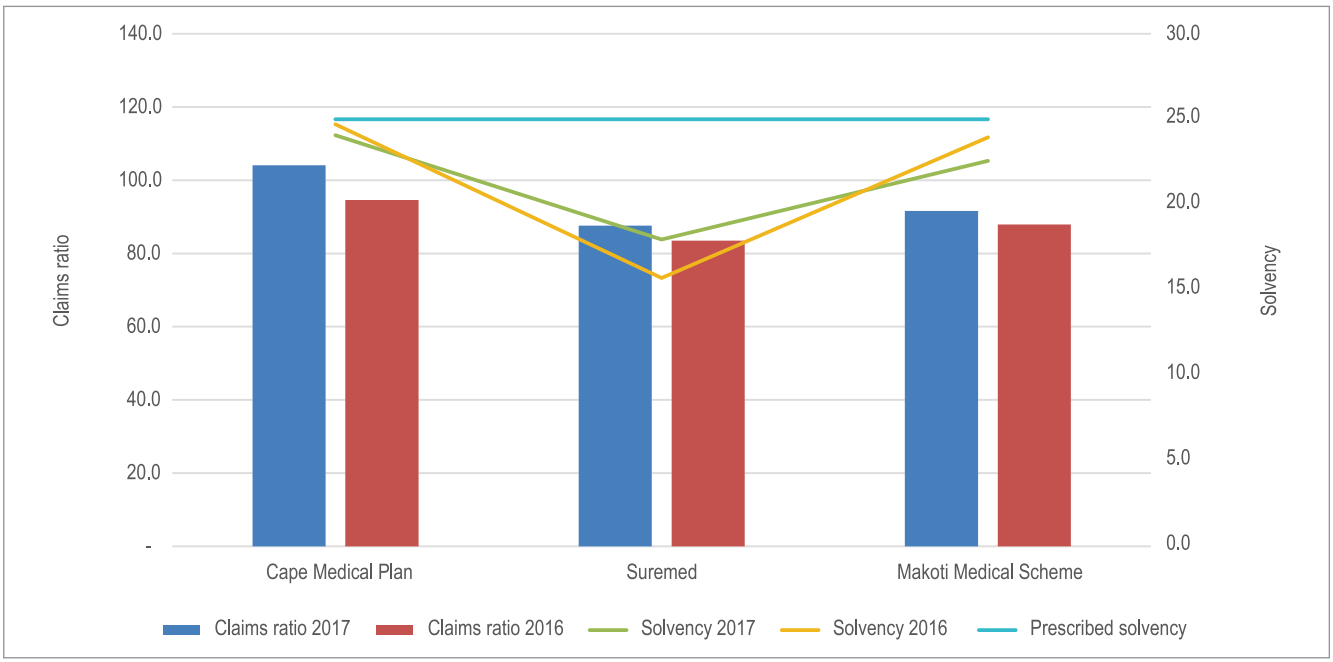
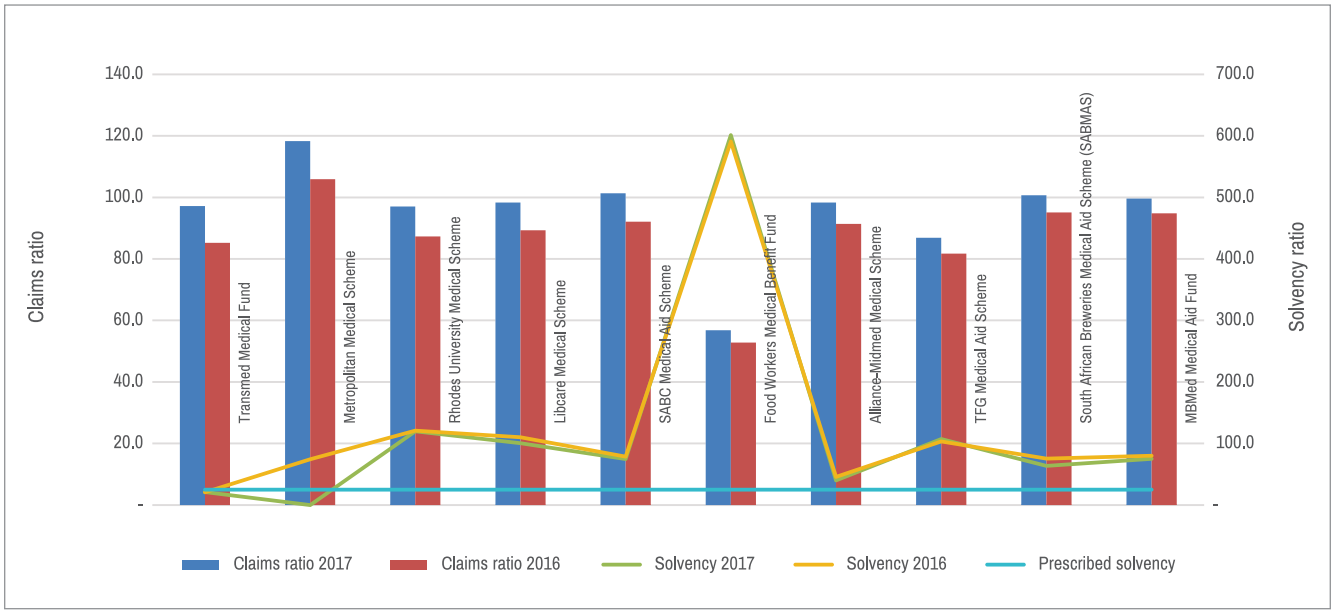


Figure 44: Restricted schemes with a claims ratio increase greater than 4%



All the open schemes and most restricted schemes where claims ratios increased by more than 4% have solvency ratios that are above the minimum required statutory level of 25%, suggesting that they could be utilising reserves to cushion members from high contribution increases.

Table 17: Open scheme deviation from industry average in 2017 and 2016

Ref. no.	Name of medical scheme	% change in claims ratio	% deviation from average claims ratio of 87.2% 2017	% deviation from average claims ratio of 89.3% 2016
1034	Cape Medical Plan	10.0	19.4%	5.9%
1464	Suremed	4.9	0.5%	-6.5%
1466	Makoti Medical Scheme	4.2	5.0%	-1.6%

The table above shows the percentage deviation of the open schemes, with a claims ratio increase greater than 4% from 2016 to 2017, from the industry average of 87.2% and 89.3% for 2017 and 2016 respectively.

Table 18: Restricted scheme deviation from industry average in 2017 and 2016

Ref. no.	Name of medical scheme	% change in claims ratio	% deviation from average claims ratio of 90.6% 2017	% deviation from average claims ratio of 95.6% 2016
1582	Transmed Medical Fund	14.1	7.3%	-10.9%
1105	Metropolitan Medical Scheme	11.7	30.6%	10.8%
1013	Rhodes University Medical Scheme	11.1	7.1%	-8.7%
1197	Libcare Medical Scheme	10.1	8.5%	-6.6%
1424	SABC Medical Aid Scheme	10.0	11.8%	-3.7%
1086	Food Workers Medical Benefit Fund	7.6	-37.3%	-44.8%
1465	Alliance-Midmed Medical Scheme	7.5	8.5%	-4.4%
1578	TFG Medical Aid Scheme	6.4	-4.1%	-14.5%
1209	South African Breweries Medical Aid Scheme (SABMAS)	5.9	11.1%	-0.5%
1039	MBMed Medical Aid Fund	5.1	9.9%	-0.8%

Table 18 shows the percentage deviation of the restricted schemes, with a claims ratio increase of 4% and more from 2016 to 2017, from the industry average of 90.6% and 95.6% for 2017 and 2016 respectively.

When compared to open schemes, a greater number of restricted schemes had higher increases in their claims ratios (restricted schemes have significantly larger reserves and are better able to absorb these increases).

Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Claims paid from medical savings accounts increased by 5.9% to R16.1 billion from R15.2 billion (2016: 8.7% increase). On a pabpm basis for schemes that offer medical savings accounts, medical savings accounts claims increased by 9.2% to R181.7 from R166.5 (2016: 7.4% increase).

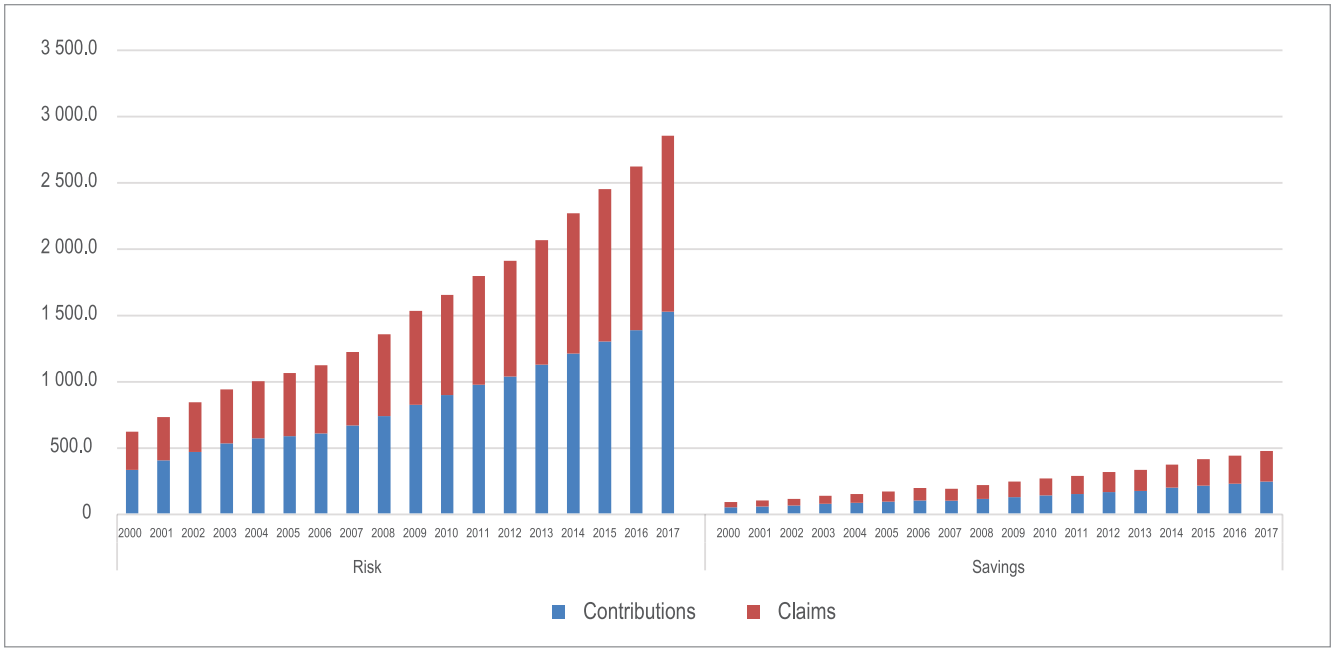
Table 19 and Figures 45 and 46 show contributions and claims for open and restricted schemes pabpm.

Table 19: Contributions and relevant healthcare expenditure pabpm for 2000-2017

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
Open schemes								
2000	333.6		46.1		292.4		41.3	
2001	406.4	21.8	52.6	14.1	331.4	13.3	46.6	12.8
2002	470.6	15.8	59.9	13.9	379.3	14.5	51.6	10.7
2003	535.5	13.8	73.8	23.2	413.9	9.1	61.0	18.2
2004	574.0	7.2	80.2	8.7	437.2	5.6	68.2	11.8
2005	590.7	2.9	90.6	13.0	484.2	10.8	77.5	13.6
2006	611.6	3.5	98.9	9.2	522.9	8.0	95.9	23.7
2007	673.0	10.0	96.6	-2.3	562.1	7.5	91.6	-4.5
2008	745.1	10.7	110.5	14.4	626.6	11.5	105.9	15.6
2009	831.1	11.5	123.7	11.9	719.4	14.8	119.5	12.8
2010	905.6	9.0	137.2	10.9	767.2	6.6	130.8	9.5
2011	985.0	8.8	147.4	7.4	831.8	8.4	139.8	6.9
2012	1 047.8	6.4	163.4	10.9	884.9	6.4	153.6	9.9
2013	1 138.1	8.6	172.0	5.3	953.2	7.7	160.5	4.5
2014	1 223.1	7.5	197.0	14.5	1 073.5	12.6	175.8	9.5
2015	1 315.7	7.6	212.7	8.0	1 166.9	8.7	202.4	15.1
2016	1 402.4	14.7	226.8	15.1	1 252.3	16.7	215.6	6.5
2017	1 544.2	10.1	243.9	7.5	1 347.2	7.6	233.3	15.3
Restricted schemes								
2000	360.8		66.7		333.1		58.8	
2001	415.0	15.0	64.0	-4.0	360.9	8.3	57.9	-1.5
2002	489.0	17.8	69.8	9.1	417.9	15.8	60.3	4.1
2003	545.7	11.6	78.4	12.3	455.9	9.1	66.6	10.4
2004	581.3	6.5	86.8	10.7	490.0	7.5	69.7	4.7
2005	594.5	2.3	95.5	10.0	531.4	8.4	77.2	10.8
2006	617.9	3.9	103.7	8.6	582.1	9.5	92.8	20.2
2007	641.8	3.9	86.3	-16.8	595.7	2.3	75.7	-18.4
2008	693.8	8.1	75.7	-12.3	638.0	7.1	66.2	-12.5
2009	774.4	11.6	66.7	-11.9	727.3	14.0	61.7	-6.8
2010	860.3	11.1	62.6	-6.1	785.1	7.9	57.5	-6.8
2011	942.8	9.6	61.6	-1.6	842.0	7.2	55.6	-3.3
2012	1 016.1	7.8	60.0	-2.6	932.8	10.8	53.6	-3.6
2013	1 100.1	8.3	45.5	-24.2	988.8	6.0	40.6	-24.3
2014	1 180.1	7.3	71.3	56.7	1 118.3	13.1	43.8	7.9
2015	1 276.8	8.2	80.9	13.5	1 211.4	8.3	70.9	61.9
2016	1 375.9	16.6	90.9	27.5	1 316.0	17.7	80.0	12.8
2017	1 524.2	10.8	99.5	9.5	1 380.9	4.9	90.5	27.6

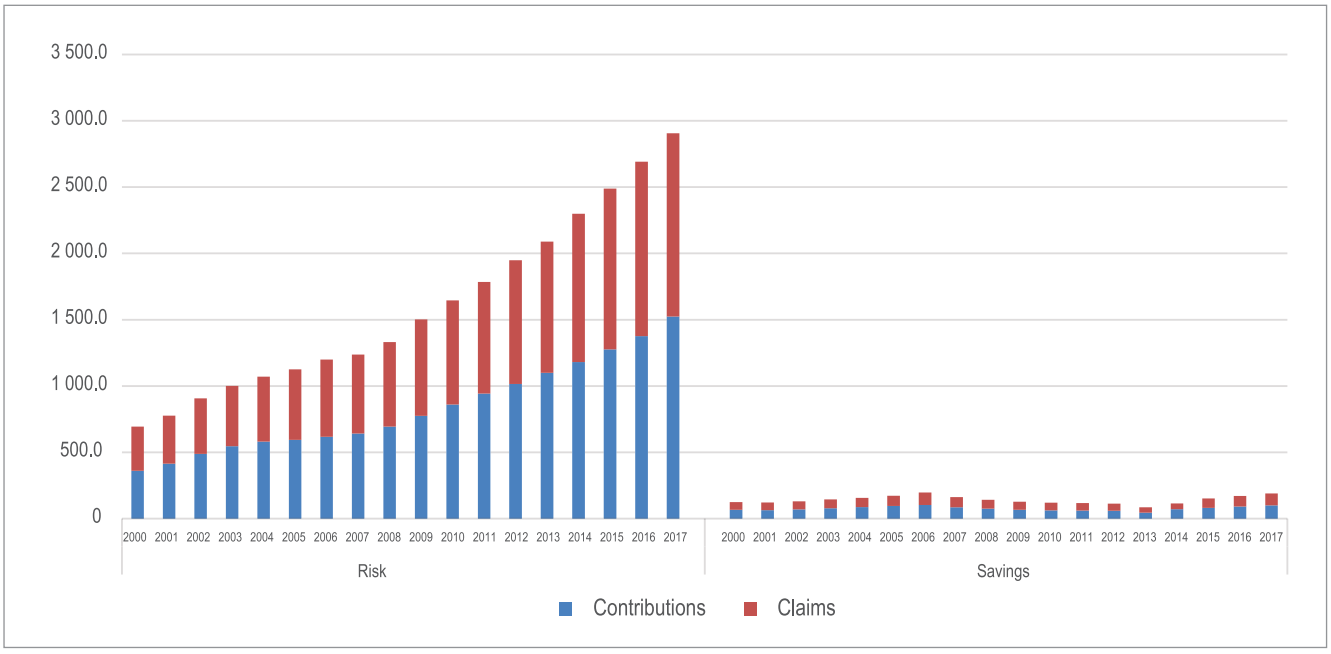
pabpm = per average beneficiary per month
pasbpm = pabpm in respect of schemes which had savings transactions

Figure 45: Risk and savings contributions and claims pabpm for 2000-2017 in open schemes



pabpm = per average beneficiary per month

Figure 46: Risk and savings contributions and claims pabpm for 2000-2017 in restricted schemes

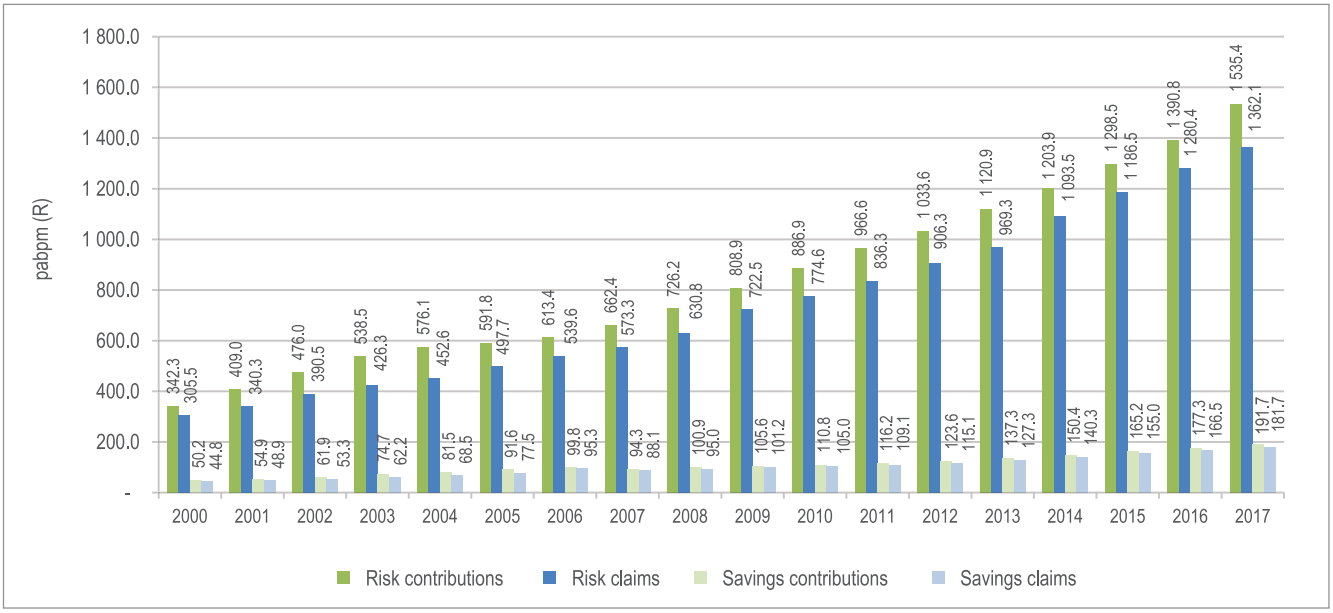


pabpm = per average beneficiary per month

Figure 45 and 46 above 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 for both open and restricted schemes has come down in 2017 from 2016, recorded at 87.2% and 90.6% for open and restricted schemes respectively. For the savings pool, 95.7% of contributions received from members of open schemes was paid out in claims – compared with 91.0% for restricted schemes.

The contributions and expenditure on savings in open schemes is much higher than it is in restricted schemes. This could be partially due to the nature of benefit design. Restricted schemes generally have more traditional and richer options.

Figure 47: Risk and medical savings accounts contributions and claims pabpm for 2000-2017



pabpm = per average beneficiary per month

Figure 47 and Table 20 show that between 2003 and 2006 medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components.

But the figures for the period 2007-2012 appear to reflect a change in this trend. In 2000, savings contributions made up 12.8% of gross contributions. At the end of 2012, savings had declined to 10.7% of gross contributions. The decrease is partly attributable to a decision by the CMS not to allow variable savings rates on an option, which resulted in a number of medical schemes no longer offering savings plan accounts.

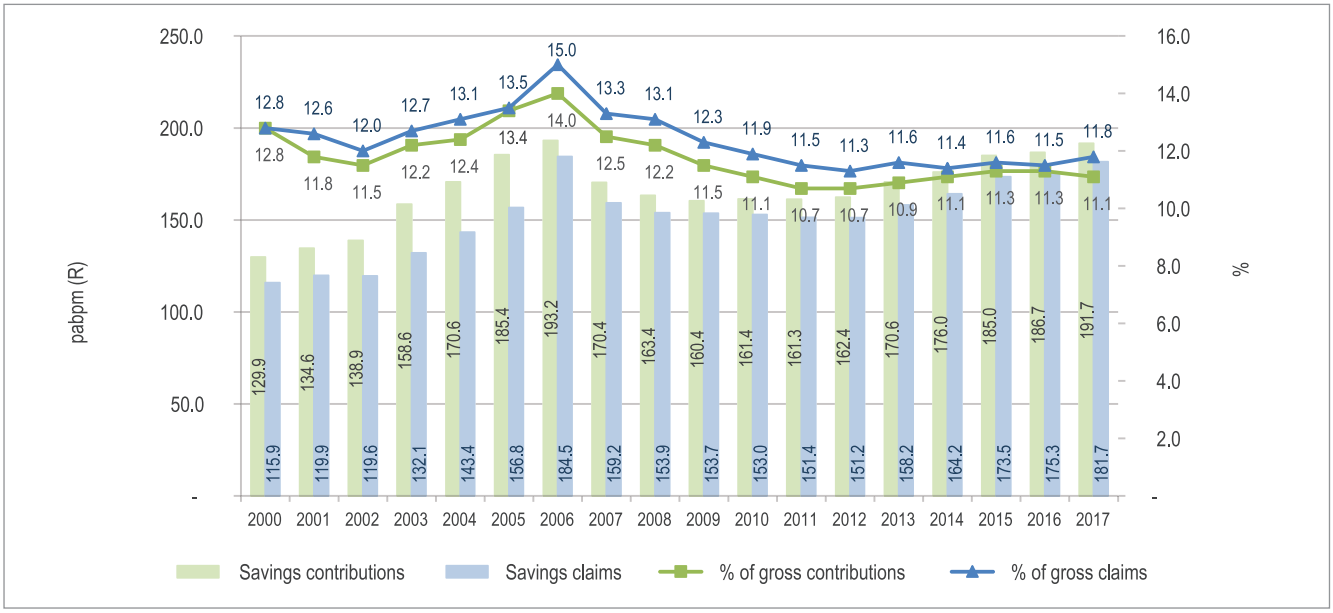
The subsequently higher increases in the savings components are partly due to a number of schemes introducing savings on existing options, and is indicative of a move towards benefit designs that require a greater proportion of benefits to be funded out of members' personal savings accounts than from the general risk pool of the scheme.

Table 20: Contributions and relevant healthcare expenditure pabpm for 2000-2017 (2017 prices)

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
2000	885.9		129.9		790.6		115.9	
2001	1 003.0	13.2	134.6	3.6	834.5	5.6	119.9	3.5
2002	1 068.1	6.5	138.9	3.2	876.3	5.0	119.6	-0.3
2003	1 143.6	7.1	158.6	14.2	905.3	3.3	132.1	10.5
2004	1 206.1	5.5	170.6	7.6	947.5	4.7	143.4	8.6
2005	1 197.6	-0.7	185.4	8.7	1 007.1	6.3	156.8	9.3
2006		-0.8	193.2	4.2	1 044.7	3.7	184.5	17.7
2007	1 197.0	0.8	170.4	-11.8	1 036.0	-0.8	159.2	-13.7
2008	1 176.1	-1.7	163.4	-4.1	1 021.6	-1.4	153.9	-3.3
2009	1 228.9	4.5	160.4	-1.8	1 097.6	7.4	153.7	-0.1
2010	1 292.1	5.1	161.4	0.6	1 128.5	2.8	153.0	-0.5
2011	1 341.8	3.8	161.3	-0.1	1 160.9	2.9	151.4	-1.0
2012	1 357.9	1.2	162.4	0.7	1 190.7	2.6	151.2	-0.1
2013	1 392.7	2.6	170.6	5.0	1 204.3	1.1	158.2	4.6
2014	1 409.1	1.2	176.0	3.2	1 279.9	6.3	164.2	3.8
2015	1 453.8	4.4	185.0	8.4	1 328.4	10.3	173.5	9.7
2016	1 464.7	3.9	186.7	6.1	1 348.5	5.4	175.3	6.8
2017	1 535.4	4.8	191.7	2.7	1 362.1	1.0	181.7	3.7

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

Figure 48: Medical savings accounts contributions and claims pabpm for 2000-2017 (2017 prices)



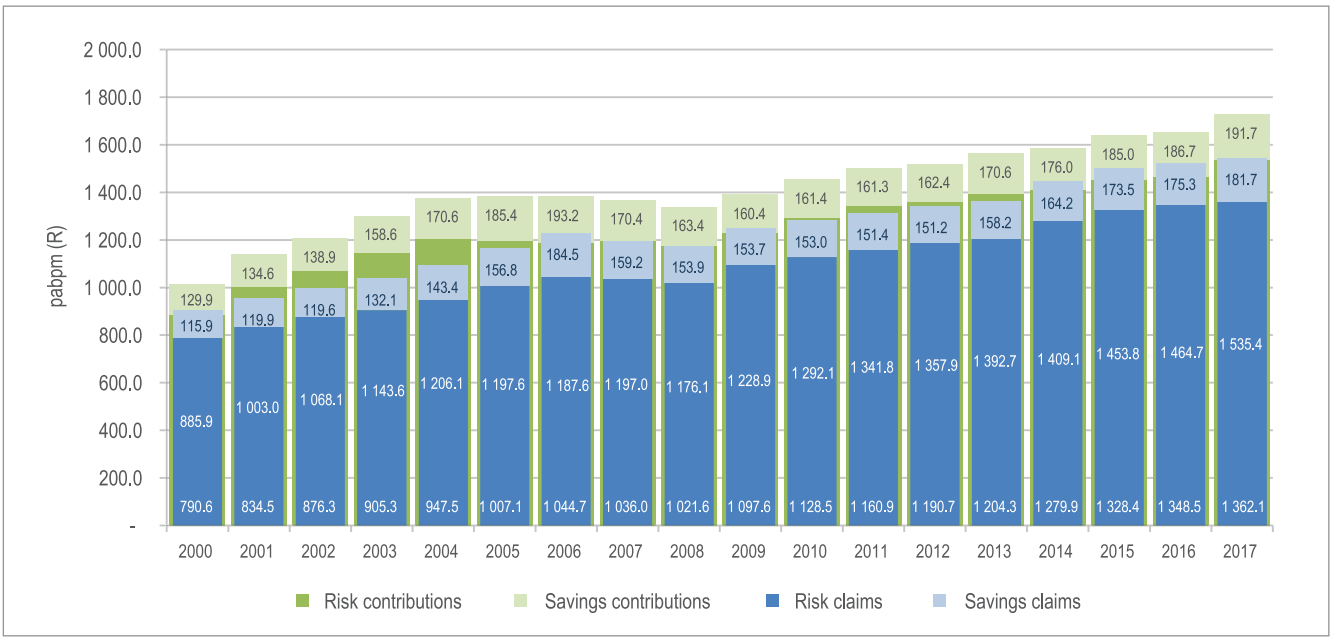
pabpm = per average beneficiary per month

The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure decreased slightly to 11.5% in 2016, but increased again to 11.8% in 2017 – as shown in Figure 48.

For open schemes, the proportion of claims paid from medical savings accounts decreased from 14.7% in 2016 to 14.8% in 2017. The medical savings accounts claims ratio increased to 95.7% from 95.1% in 2016. For restricted schemes, the proportion of claims paid from medical savings accounts increased from 5.7% in 2016 to 6.2% in 2017. The medical savings accounts claims ratio increased to 91.0% from 88.0% in 2016.

Figure 49 shows the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 73.3% and 72.3% respectively on a pabpm basis. Medical savings account contributions and claims have risen by 47.6% and 56.8% respectively.

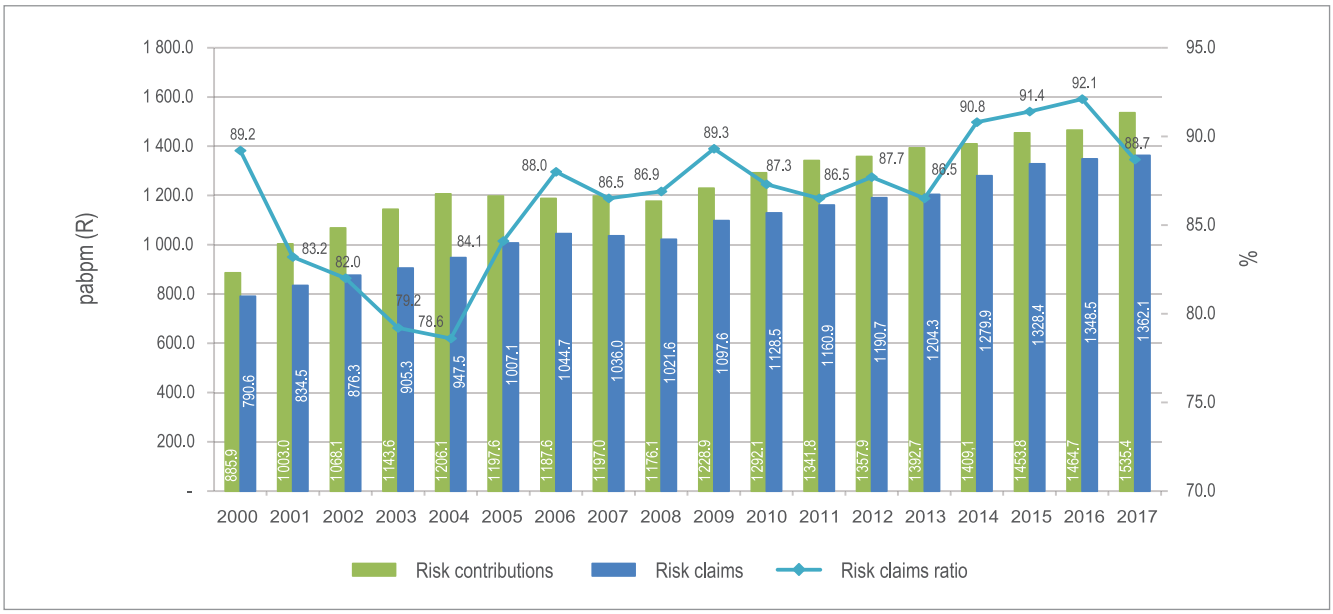
Figure 49: Risk and medical savings accounts contributions and claims pabpm for 2000-2017 (2017 prices)



pabpm = per average beneficiary per month

Figure 50 shows the relationship between risk contributions and claims paid over the past decade. All figures have been adjusted for inflation.

Figure 50: Risk claims ratio for all schemes for 2000-2017 (2017 prices)



pabpm = per average beneficiary per month

After an initial decline, the claims ratio increased to 88.0% in 2006 and stabilised at 86.9% in 2008. There was an increase in 2009, followed by a decrease over the next two years to 86.5% in 2011. In 2012, there was a slight increase from the previous year, with medical schemes paying out 87.7% of risk contributions in benefits. In 2013, the claims ratio decreased to 86.5%, and had then risen again to 92.1% in 2016. There was a decrease in the claims ratio in 2017 to 88.7%.

Figure 51: Seasonality of claims per month in 2017

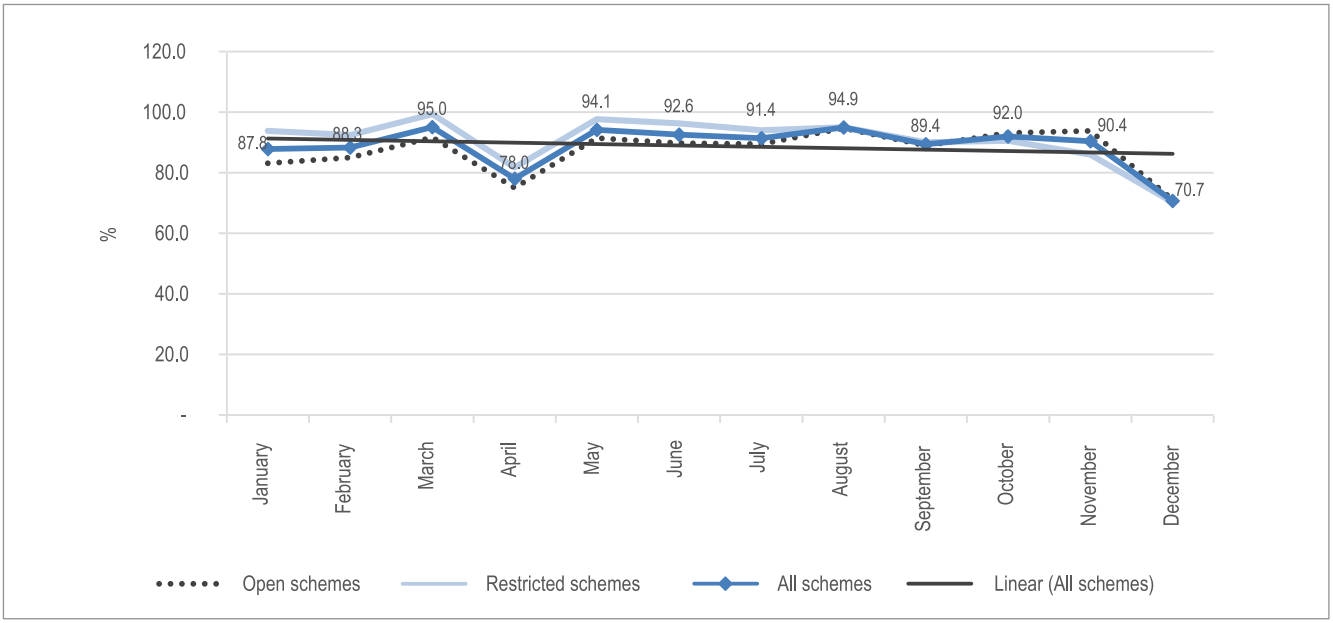


Figure 52: Seasonality of claims per month in 2016

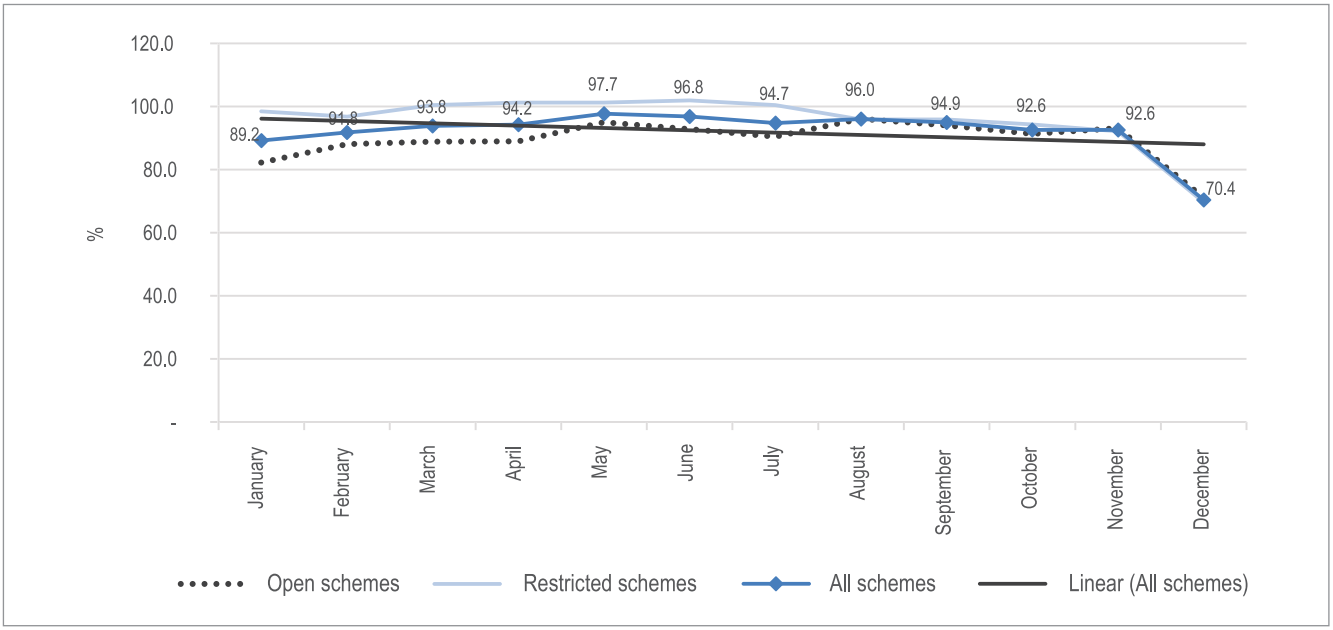


Figure 51 shows the seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2017, whilst Figure 52 depicts that of 2016.

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.

The biggest variance in the year on year seasonality is the downward trend in April 2017; a claims ratio of 94.2% was incurred in 2016 compared to the 78.0% in 2017.

Risk transfer arrangements

Over the last few years, medical schemes have increasingly undertaken risk transfer arrangements to manage their insurance risks. Table 21 reflects the main components of such arrangements:

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

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

Table 21: Significant risk transfer arrangements for 2016 and 2017

	Capitation fees			Estimated recoveries			Net income/(expense)*		
	2017 R'000	2016 R'000	% growth	2017 R'000	2016 R'000	% growth	2017 R'000	2016 R'000	% growth
Open schemes	2 169 892	2 094 267	3.6	2 006 246	1 851 873	8.3	(160 057)	(240 876)	33.6
Restricted schemes	1 190 139	1 096 380	8.6	1 380 131	1 187 932	16.2	196 101	97 335	101.5
All	**3 360 031**	**3 190 648**	**5.3**	**3 386 377**	**3 039 805**	**11.4**	**36 044**	**(143 541)**	**125.1**

** The net income/(expense) on risk transfer arrangements includes an amount of R9.7 million in respect of profit- and loss-sharing agreements.*

Table 22 lists the ten schemes that incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 23 details the ten benefit options that reported the greatest losses.

Table 22: Schemes with highest risk transfer arrangement losses in 2017

Ref. no.	Name of medical scheme	Beneficiaries 31 Dec 2017	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	728 943	821 156	667 122	(154 034)	-18.8
1167	Momentum Health	293 787	377 962	319 788	(57 590)	-15.2
1486	Sizwe Medical Fund	112 910	63 715	55 885	(7 830)	-12.3
1039	MBMed Medical Aid Fund	9 952	7 384	3 826	(3 558)	-48.2
1087	Keyhealth	71 935	76 401	73 141	(3 200)	-4.2
1575	Resolution Health Medical Scheme	27 241	6 900	4 051	(2 850)	-41.3
1584	Netcare Medical Scheme	38 185	4 999	3 644	(1 356)	-27.1
1422	Topmed Medical Scheme	40 469	13 526	12 443	(1 083)	-8.0
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	46 466	9 214	8 151	(1 063)	-11.5
1506	Medimed Medical Scheme	15 188	8 813	7 891	(922)	-10.5

Table 23: Options with highest risk transfer arrangement losses in 2017

Ref. no.	Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2017	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	147 728	31.4	147 448	65 777	223	(81 448)	-55.2
1512	Bonitas Medical Fund	Standard	298 173	34.3	470 808	399 419	-	(71 389)	-15.2
1512	Bonitas Medical Fund	Primary	172 796	28.4	168 491	133 420	-	(35 071)	-20.8
1512	Bonitas Medical Fund	Bonsave	81 908	29.5	76 526	51 368	-	(25 158)	-32.9
1167	Momentum Health	Ingwe	53 405	27.5	116 180	100 793	167	(15 220)	-13.1
1125	Discovery Health Medical Scheme	Classic Comprehensive	320 053	41.3	138 893	125 940	-	(12 953)	-9.3
1512	Bonitas Medical Fund	Boncap	68 496	32.2	29 046	17 895	-	(11 151)	-38.4
1486	Sizwe Medical Fund	Gomomo Care Option	11 300	29.0	63 715	55 885	-	(7 830)	-12.3
1469	Nedgroup Medical Aid Scheme	Savings	26 515	26.7	35 286	28 405	1 409	(5 473)	-15.5
1512	Bonitas Medical Fund	BonClassic	21 649	47.7	35 739	31 937	-	(3 802)	-10.6

Bonitas Medical Fund is listed in both Tables 22 and 23 as the biggest lossmaker.

The Momentum Health Custom option suffered the biggest loss in terms of the percentage of capitation fees paid (55.2%), followed by the BonCap option from Bonitas Medical Fund (38.4%), as shown in Table 23.

Accredited managed healthcare services (no transfer of risk)

Accredited managed healthcare services increased by 35.7% to R4.0 billion in 2017, from R3.0 billion* in 2016. In 2017, 8 760 217 beneficiaries (or 98.7% of beneficiaries) were covered by these managed healthcare arrangements.

*Note: This figure differs from the 2016 annual report due to the data issues on some schemes.

Table 24: Accredited managed healthcare service fees (no transfer of risk) for options with a claims ratio above 100% in 2017

	Accredited managed healthcare services fees (no transfer of risk)		Risk claims		Beneficiaries	Number of options
	R'000	pmpm	R'000	% of RCI		
Open schemes	279 243	91.9	15 332 235	105.3	512 557	24
Restricted schemes	229 514	77.5	12 573 908	111.5	537 607	45
All schemes	508 758	84.8	27 906 144	108.0	1 050 164	69

pmpm = per member per month
RCI = risk contribution income

Table 24 shows the number of benefit options with claims ratios greater than 100.0% and their expenditure on managed healthcare services. There were 69 options in this category, and they accounted for 12.0% of beneficiaries in respect of whom such expenditure was incurred.

Table 25: Accredited managed healthcare services (no transfer of risk) of the 10 largest schemes in 2017

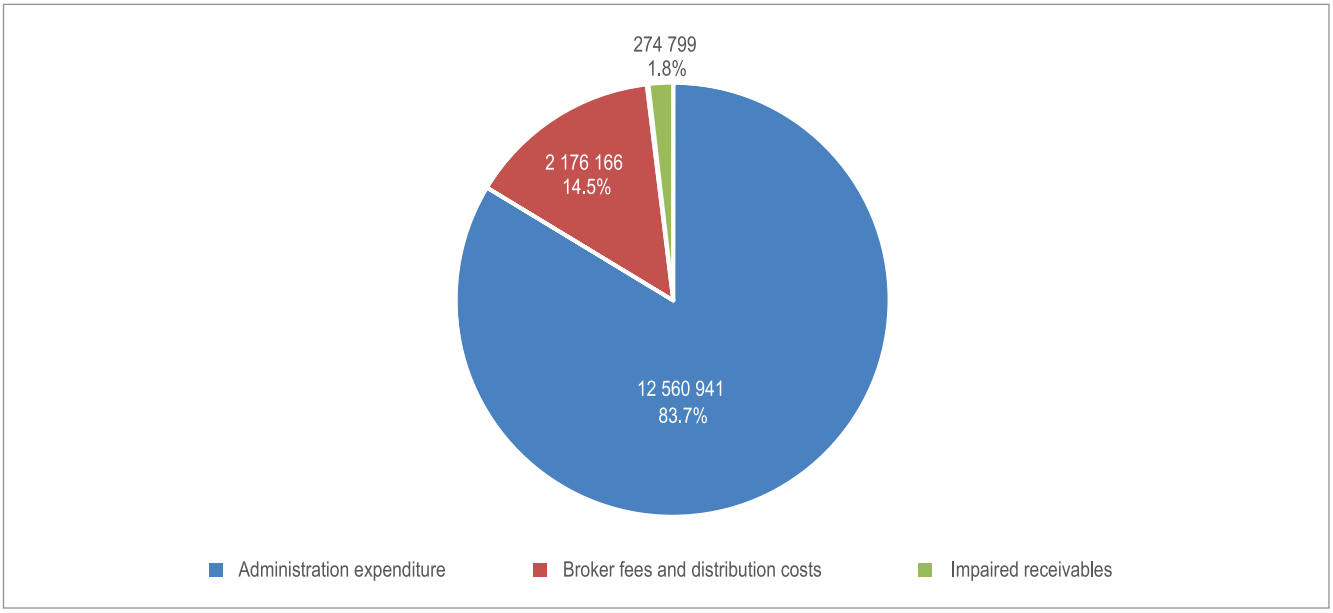
Ref. no.	Name of medical scheme	Type	Average beneficiaries	Claims ratio	Accredited managed healthcare services as % of RCI
1125	Discovery Health Medical Scheme	Open	2 747 898	85.7	3.2
1598	Government Employees Medical Scheme (GEMS)	Restricted	1 805 268	86.0	2.0
1512	Bonitas Medical Fund	Open	731 494	88.3	3.0
1580	South African Police Service Medical Scheme (POLMED)	Restricted	493 755	99.9	1.5
1167	Momentum Health	Open	284 411	86.0	2.7
1279	Bankmed	Restricted	216 776	95.3	2.7
1252	Bestmed Medical Scheme	Open	199 613	87.2	2.5
1149	Medihelp	Open	198 712	90.7	1.8
1145	LA-Health Medical Scheme	Restricted	160 991	81.3	2.3
1140	Medshield Medical Scheme	Open	158 259	97.8	1.7

Table 25 depicts the ten largest schemes (by number of average beneficiaries), and shows their total expenditure on accredited managed healthcare services. The industry average was 2.5% of risk contribution income.

Non-healthcare expenditure

The non-healthcare expenditure of medical schemes consists mainly of administration expenditure, broker costs, and impaired receivables. Affordability of medical schemes has increasingly become an important consideration in the private healthcare sector. When medical schemes determine contributions, factors such as the claims experience of the scheme, operational costs, and level of reserving required are taken into consideration. It is therefore essential to ensure that monies collected from members are directed at the appropriate interventions and expenditure, and that non-healthcare expenditure is managed judiciously.

Figure 53: Distribution of non-healthcare expenditure of medical schemes



The total gross non-healthcare expenditure for all medical schemes at the end of 2017 was reported at R15.0 billion, an increase of 6.6% from R14.1 billion in 2016. The net non-healthcare expenditure increased by 6.6% from 2016.

Figure 54: Gross non-healthcare expenditure in 2017

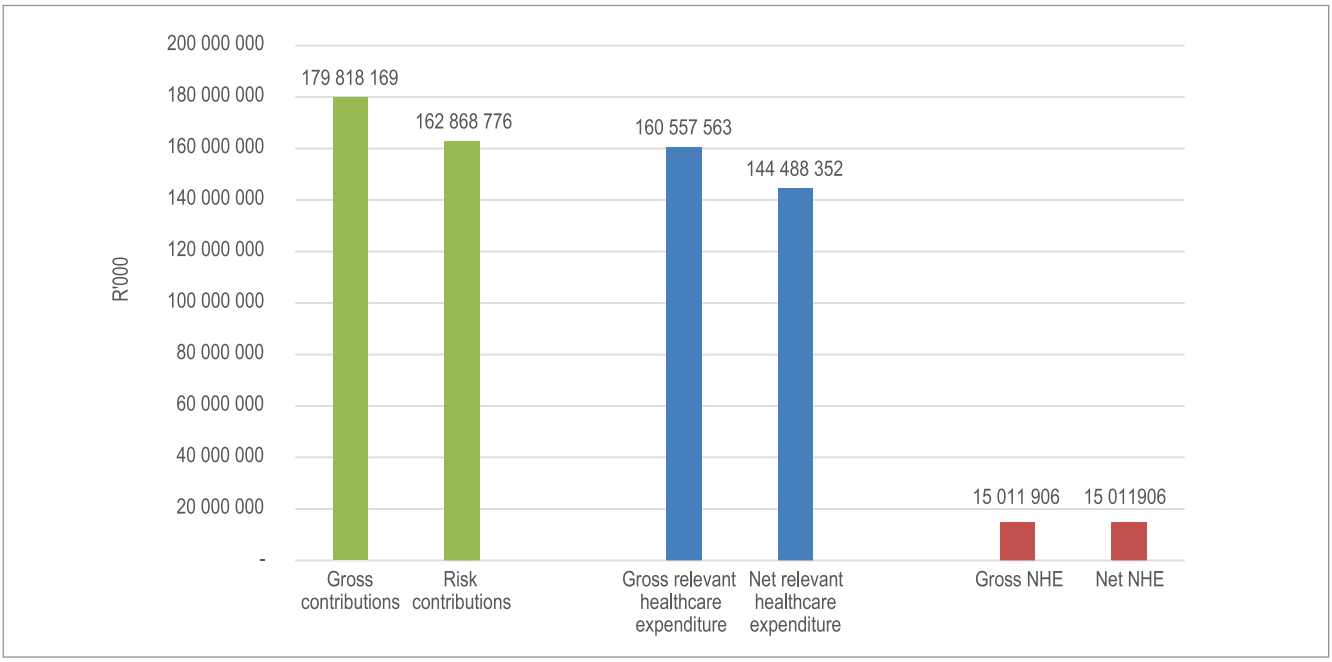
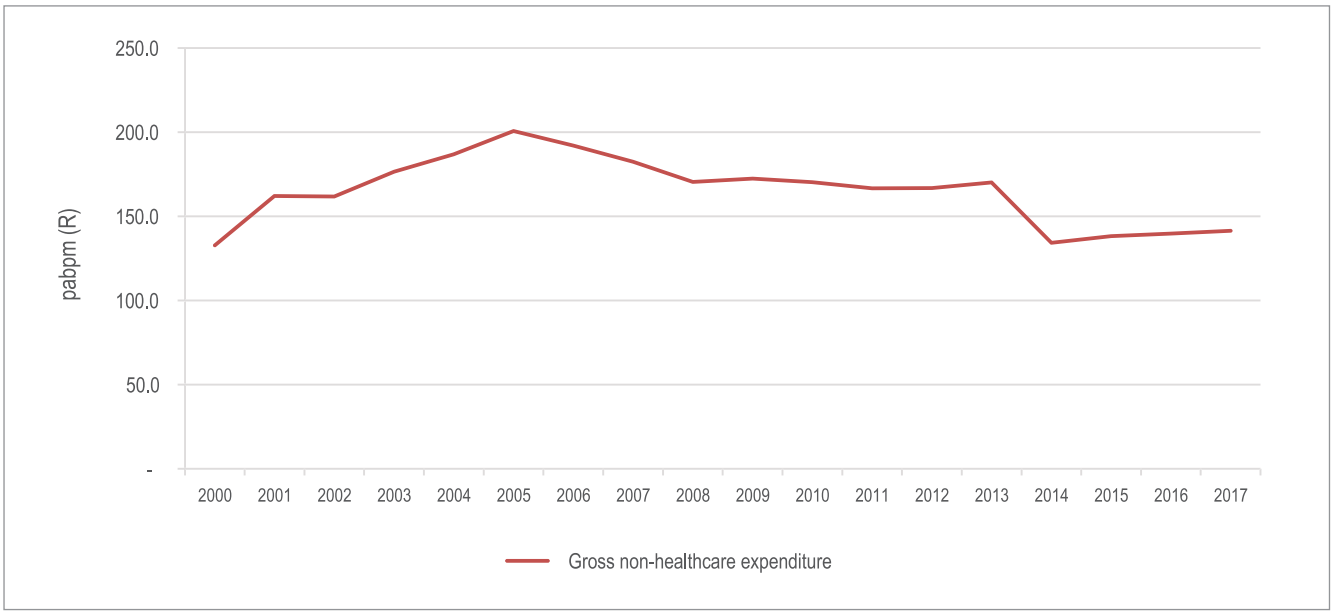


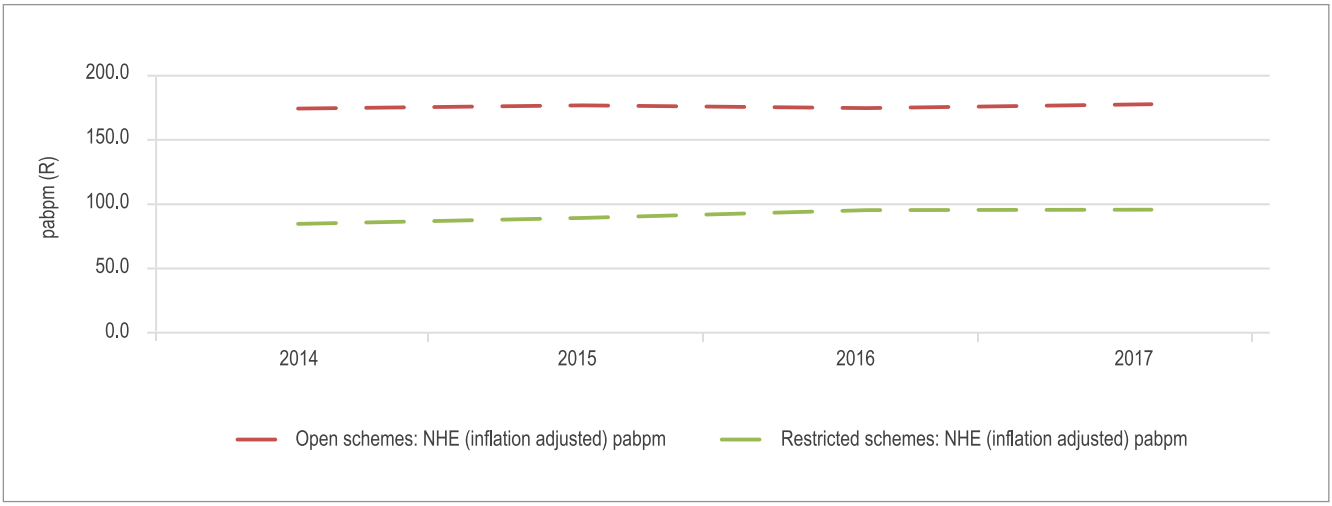
Figure 55: Gross non-healthcare expenditure: 2017 prices



pabpm = per average beneficiary per month

The real rate of increase in non-healthcare expenditure has displayed a downward trend between 2000 and 2017, and more so in recent years – particularly given that this expenditure was increasing at rates that exceeded the rate of increase in contributions in the earlier years. In real terms, non-healthcare expenditure has reduced compared to earlier periods. There are, however, still individual schemes and components of non-healthcare expenditure – such as advertising and marketing, consulting and legal fees, and trustee remuneration – that continue to show marked increases at higher levels than inflation, and therefore require attention. In recent years, the remuneration of trustees and Principal Officers of medical schemes, as well as the expenditure on Annual General Meeting (AGM) costs, have come under the spotlight. 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 for 2014-2017 (2017 prices)



Based on Figure 56 above, which shows a comparison of non-healthcare expenditure between open and restricted schemes, it is evident that expenditure in restricted schemes is much lower than in open schemes on a pabpm basis. This is partly because restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry. However, the rate of change in restricted schemes is steeper than it is for open schemes.

Administration expenditure

Administration expenditure, being the largest component of non-healthcare expenditure in all medical schemes, grew by 6.0% from R11.9 billion to R12.6 billion between December 2016 and December 2017. Open schemes increased their administration expenditure by 5.9% to R8.3 billion, from R7.8 billion in 2016. Administration expenditure in restricted schemes increased by 6.2% from R4.0 billion in 2016 to R4.3 billion in 2017. Ten open schemes (representing 5.5% of all average beneficiaries) and seven restricted schemes (representing 3.5% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of Gross Contribution Income (GCI) in 2017.

Tables 26 and 28 show ten open and restricted schemes respectively, with the highest administration expenditure pabpm. A high cost per life covered is sometimes the function of low average beneficiaries rather than high absolute administration costs. Schemes need to be operating with a certain number of lives in order for the average operational costs to be lower and make the business more profitable and sustainable in the long term.

Table 26: The ten open schemes with the highest administration expenditure above the industry average of R140.3 pabpm (2017)

Ref. no.	Name of Scheme	Name of administrator	Average beneficiaries	Administration expenditure R'000	Administration expenditure pabpm R	Administration expenditure % of GCI
1141	Spectramed	Agility Health (Pty) Ltd	22 777	69 479	254.2	11.2
1446	Selfmed Medical Scheme	Self-Administered	13 805	37 881	228.7	11.9
1575	Resolution Health Medical Scheme	Agility Health (Pty) Ltd	28 839	66 058	190.9	10.1
1464	Suremed Health	Providence Healthcare Risk Managers (Pty) Ltd	2 600	5 551	177.9	10.2
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	73 312	155 867	177.2	7.4
1486	Sizwe Medical Fund	Sechaba Medical Solutions (Pty) Ltd	116 283	245 450	175.9	10.4
1491	Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	24 080	50 767	175.7	10.1
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	143 511	298 803	173.5	8.8
1034	Cape Medical Plan	Self-Administered	11 045	21 240	160.3	11.9
1537	Hosmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	67 020	124 383	154.7	8.7

GCI = Gross Contribution Income
pabpm = per average beneficiary per month

Table 27: Ten open schemes with the highest administration fees pampm (2017)

Name of Scheme	Name of Administrator	Average members	Admin fee pampm
Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 305 219	288.0
Sizwe Medical Fund	Sechaba Medical Solutions (Pty) Ltd	48 489	274.4
Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	72 203	261.7
Hosmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	24 403	245.8
Resolution Health Medical Scheme	Agility Health (Pty) Ltd	14 758	240.0
Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	35 102	215.5
Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	15 014	211.8
Momentum Health	MMI Health (Pty) Ltd	149 816	203.2
Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	339 003	191.5
Suremed Health	Providence Healthcare Risk Managers (Pty) Ltd	1 310	183.4

Table 28: The ten restricted schemes with the highest administration expenditure above the industry average of R90.8 pabpm (2017)

Ref. no.	Name of Scheme	Name of administrator	Average beneficiaries	Administration expenditure R'000	Administration expenditure pabpm R	Administration expenditure % of GCI
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Sanlam Health Administrators (Pty) Ltd	46 812	116 353	207.1	9.9
1194	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	70 342	174 375	206.6	11.4
1105	Metropolitan Medical Scheme	MMI Health (Pty) Ltd	4 254	4 730	185.3	9.1
1068	De Beers Benefit Society	Self-Administered	10 456	19 663	156.7	6.6
1441	Parmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	4 803	9 010	156.3	4.0
1523	Grintek Electronics Medical Aid Scheme	Universal Healthcare Administrators (Pty) Ltd	1 714	3 123	151.8	8.1
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund	Discovery Health (Pty) Ltd	4 964	8 819	148.0	5.7
1571	Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	7 506	12 403	137.7	6.9
1012	Anglo Medical Scheme	Discovery Health (Pty) Ltd	18 849	29 724	131.4	5.9
1241	Naspers Medical Fund	Discovery Health (Pty) Ltd	15 495	24 346	130.9	7.7

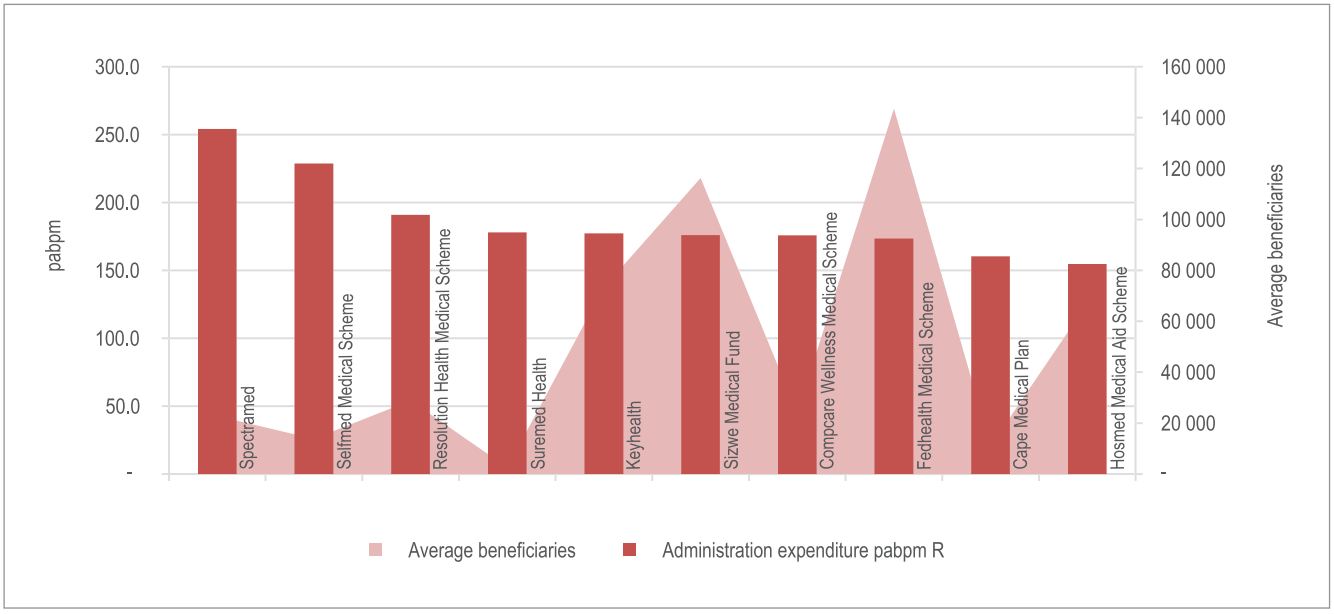
GCI = Gross Contribution Income
pabpm = per average beneficiary per month

Relative to the open and restricted schemes industry average, some of these schemes have high administration costs – both as a percentage of GCI and on a pabpm basis.

Table 29: The ten restricted schemes with the highest administration fees pampm in 2017

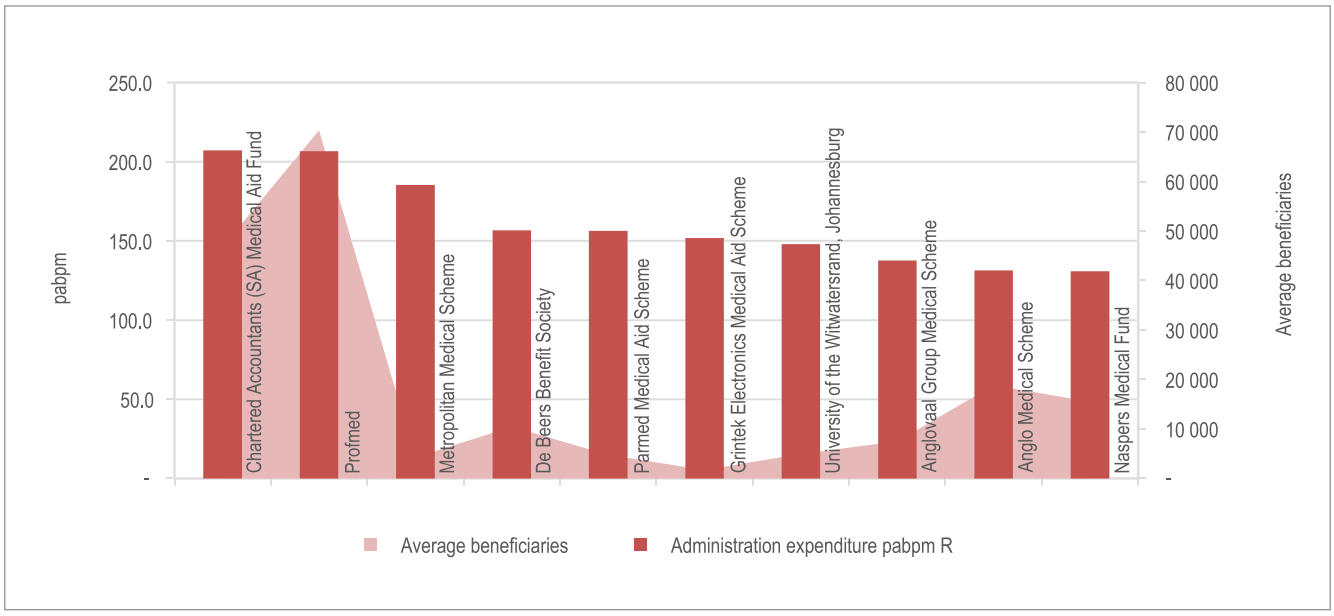
Name of Scheme	Name of Administrator	Average members	Admin fee pampm
Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Sanlam Health Administrators (Pty) Ltd	25 409	303.6
LA-Health Medical Scheme	Discovery Health (Pty) Ltd	66 079	274.1
Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	32 665	272.5
Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	3 704	240.9
Metropolitan Medical Scheme	MMI Health (Pty) Ltd	2 091	238.7
Grintek Electronics Medical Aid Scheme	Universal Healthcare Administrators (Pty) Ltd	760	235.3
Parmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	2 394	229.6
University of Kwa-Zulu Natal Medical Scheme	Discovery Health (Pty) Ltd	3 410	221.2
Naspers Medical Fund	Discovery Health (Pty) Ltd	8 066	210.9

Figure 57: The ten open schemes with the highest administration expenditure above the industry average of R140.3 pabpm in 2017



pabpm = per average beneficiary per month

Figure 58: The ten restricted schemes with the highest administration expenditure above the industry average of R90.8 pabpm in 2017



pabpm = per average beneficiary per month

Based on the data submitted, it was noted that whilst 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 any correlation between the scheme size and the administration fees charged in the restricted scheme environment.

Table 30 shows the gross administration fees paid to third-party administrators as well as administration fees paid by self-administered medical schemes. These fees are the sum of administration fees, co-administration fees, and other indirect fees paid to the administrator.

Table 30: Administration fees paid to third-party administrators pabpm in 2016 and 2017

	Open schemes			Restricted schemes		
	2017 pabpm R	2016 pabpm R	% variance	2017 pabpm R	2016 pabpm R	% Variance
Third party						
Administration fees	123.2	114.7	7.4	53.6	52.7	1.7
Co-administration fees	-	-	-	18.5	17.1	8.2
Total	**123.2**	**114.7**	**7.4**	**62.9**	**61.3**	**2.6**
Self administered						
Administration fees*	-	57.8	-100.0	-	-	-
Co-administration fees	-	-	-	-	-	-
Total	**-**	**57.8**	**-100.0**	**-**	**-**	**-**

pabpm = per average beneficiary per month
Medihelp became self-administered after Strata Healthcare Management (Pty) Ltd's accreditation expired on 5 December 2016. The scheme still incurred administration fees for 5 months during 2017.

Governance-related expenditure

Remuneration and other considerations of trustees and principal officers accounted for 0.7% and 0.9% of GAE respectively. In 2017, the fees of principal officers amounted to 0.7% of GAE in open schemes (2016: 0.7%), and 1.4% in restricted schemes (2016: 1.4%). Table 31 and Figure 59(a) show the 10 schemes with the highest average fees for trustees. More details are contained in Annexure X. Figure 59(b) then shows the breakdown of trustee remuneration for the 10 schemes with the highest remuneration.

Table 31 shows the ten schemes with the highest principal officer fees. More details are contained in Annexure X.

Table 31: The ten schemes with highest trustee fees in 2017

			Trustee remuneration & other considerations		No. of trustees		Average fee per trustee	
Ref. no.	Name of medical scheme	Type	2017 R'000	2016 R'000	2017	2016	2017 R'000	2016 R'000
1598	Government Employees Medical Scheme (GEMS)	Restricted	8 729	7 543	12	13	727	580
1125	Discovery Health Medical Scheme	Open	7 834	5 430	10	9	783	603
1580	South African Police Service Medical Scheme (POLMED)	Restricted	5 982	4 931	19	14	315	352
1512	Bonitas Medical Fund	Open	4 495	4 596	13	14	346	328
1140	Medshield Medical Scheme	Open	4 269	4 615	13	9	328	513
1486	Sizwe Medical Fund	Open	4 259	3 857	16	10	266	386
1194	Profmed	Restricted	3 870	3 394	13	10	298	339
1202	Fedhealth Medical Scheme	Open	3 637	3 678	10	10	364	368
1537	Hosmed Medical Aid Scheme	Open	3 622	2 791	11	11	329	254
1087	Keyhealth	Open	3 303	2 695	11	11	300	245

Figure 59(a): Average trustee fees: Ten schemes with the highest trustee fees for 2016 and 2017

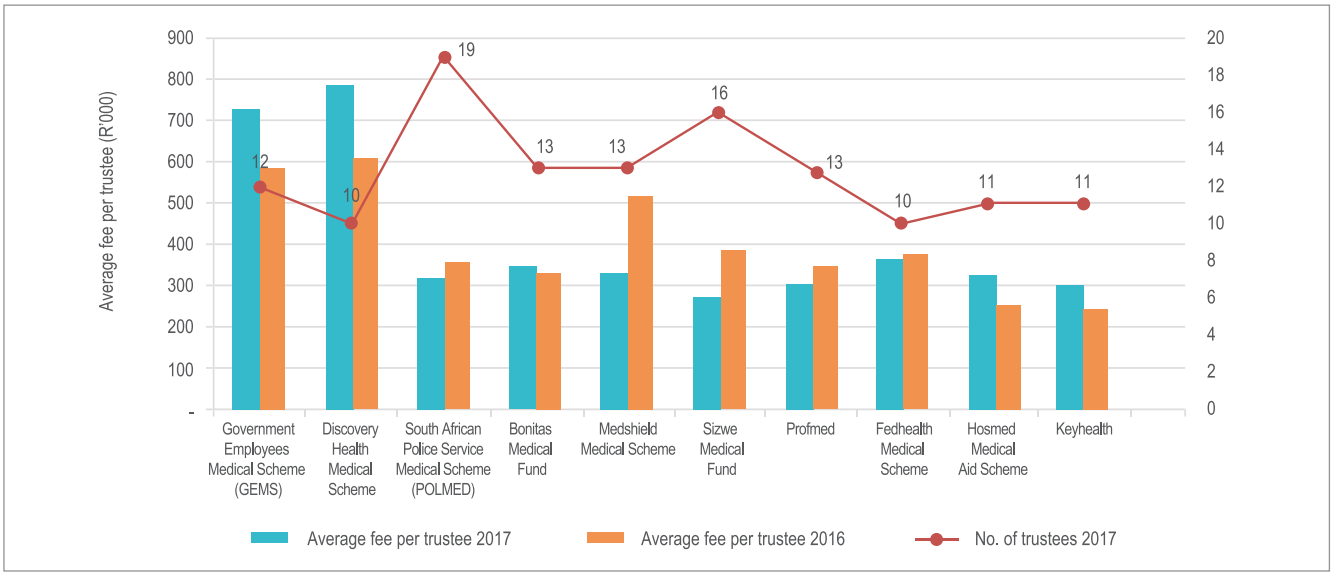


Figure 59(b): Composition of trustee remuneration for 10 schemes with the highest remuneration in 2017

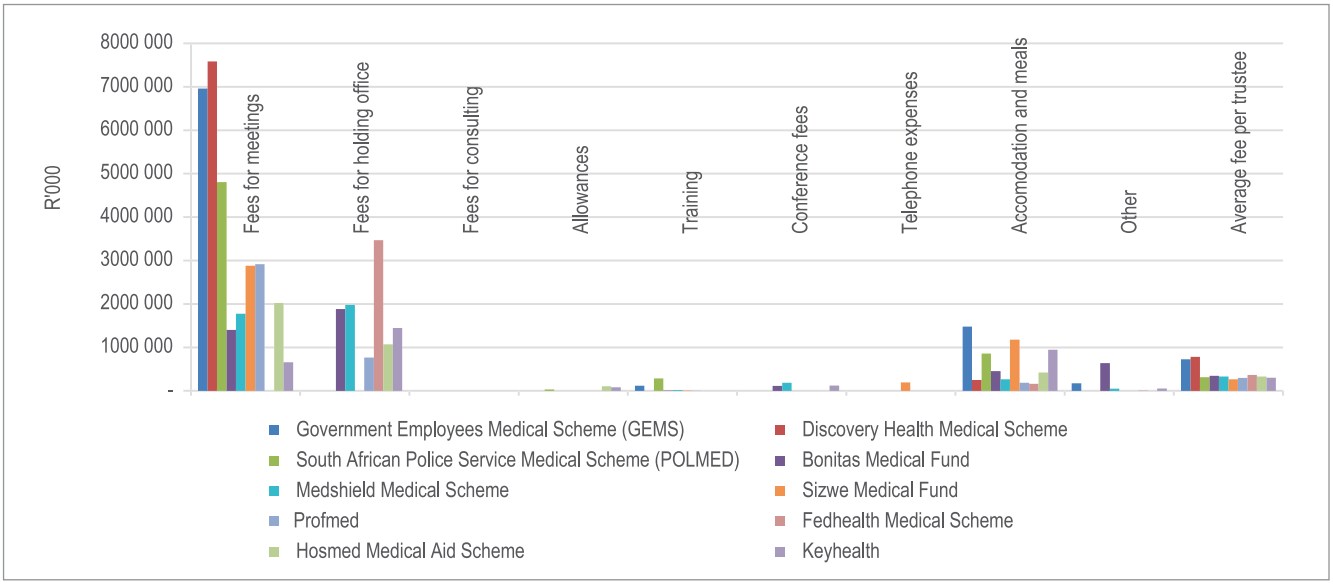


Table 32: The ten schemes with the highest remuneration for principal officers in 2017

Ref. no.	Name of medical scheme	Average beneficiaries	Principal Officer remuneration		
			2017 R'000	2016 R'000	% change
1252	Bestmed Medical Scheme	199 613	11 907	4 657	155.6
1125	Discovery Health Medical Scheme	2 747 898	5 128	5 706	-10.1
1512	Bonitas Medical Fund	731 494	4 993	3 116	60.2
1140	Medshield Medical Scheme	158 259	4 506	4 349	3.6
1598	Government Employees Medical Scheme (GEMS)	1 805 268	4 258	4 223	0.8
1580	South African Police Service Medical Scheme (POLMED)	493 755	4 254	9 417	-54.8
1582	Transmed Medical Fund	49 165	3 931	3 607	9
1597	Umvuzo Health Medical Scheme	58 501	3 705	3 495	6
1145	LA-Health Medical Scheme	160 991	3 418	2 351	45.4
1194	Profmed	70 342	3 269	3 074	6.3

**Principal Officer remuneration includes curator fees*

Table 33: The top ten open schemes with the highest governance-related expenditure*

Ref. no.	Name of medical scheme	Average beneficiaries	PO fees	Legal fees	Consulting fees	Trustee remuneration	Investigation fees	Total governance related expenditure
			R'000	R'000	R'000	R'000	R'000	pabpa
1464	Suremed Health	2 600	563	-	-	986	-	595.7
1446	Selfmed Medical Scheme	13 805	1 604	1 634	-	1 231	-	323.7
1554	Genesis Medical Scheme	22 333	2 253	3 614	12	702	-	294.7
1141	Spectramed	22 777	2 440	1 977	345	1 528	-	276.1
1466	Makoti Medical Scheme	4 937	322	-	-	589	-	184.5
1575	Resolution Health Medical Scheme	28 839	2 361	74	729	1 647	-	166.8
1491	Compcare Wellness Medical Scheme	24 080	864	126	-	2 691	-	152.9
1537	Hosmed Medical Aid Scheme	67 020	2 738	1 313	2 499	3 622	-	151.8
1034	Cape Medical Plan	11 045	1 147	1	161	273	-	143.3
1252	Bestmed Medical Scheme	199 613	11 907	4 712	6 317	2 111	-	125.5

For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in "governance related" expenditure.

Table 34: The top ten restricted schemes with the highest governance-related expenditure*

Ref. no.	Name of medical scheme	Average beneficiaries	PO fees	Legal fees	Consulting fees	Trustee remuneration	Investigation fees	Total governance related expenditure
			R'000	R'000	R'000	R'000	R'000	pabpa
1012	Anglo Medical Scheme	18 849	2 150	25	1 867	884	-	261.4
1237	BP Medical Aid Society	3 819	461	-	64	352	-	229.8
1186	PG Group Medical Scheme	3 072	500	-	145	-	-	210.0
1441	Parmed Medical Aid Scheme	4 803	871	-	-	15	103	206.1
1068	De Beers Benefit Society	10 456	1 437	27	138	388	-	190.3
1568	Sisonke Health Medical Scheme	18 536	1 937	-	1 339	34	-	178.5
1547	Malcor Medical Scheme	12 152	554	-	1 598	12	-	178.1
1523	Grintek Electronics Medical Aid Scheme	1 714	181	65	-	-	52	173.9
1579	Tsogo Sun Group Medical Scheme	10 969	-	-	1 813	-	-	165.2
1571	Anglovaal Group Medical Scheme	7 506	-	156	969	-	-	149.8

For purposes of this report, any expenditure on structures related to the governance of medical schemes is included in "governance related" expenditure.

Table 35: The ten schemes with the highest Annual General Meeting costs in 2017

Ref. no.	Name of medical scheme	Average members		Annual General Meeting Costs			
		2017	2016	2017 R'000	2016 R'000	2017 pampm R	2016 pampm R
1125	Discovery Health Medical Scheme	1 305 219	1 280 494	9 989	8 986	0.6	0.6
1486	Sizwe Medical Fund	48 489	50 784	4 632	3 194	8.0	5.2
1140	Medshield Medical Scheme	77 008	74 058	2 245	271	2.4	0.3
1512	Bonitas Medical Fund	339 003	308 262	1 772	1 859	0.4	0.5
1038	SAMWUMed	36 396	37 129	997	1 107	2.3	2.5
1580	South African Police Service Medical Scheme (POLMED)	175 609	174 480	950	575	0.5	0.3
1252	Bestmed Medical Scheme	94 751	94 998	893	975	0.8	0.9
1149	Medihelp	91 665	90 676	623	501	0.6	0.5
1537	Hosmed Medical Aid Scheme	24 403	25 778	528	-	1.8	-
1590	Building & Construction Industry Medical Aid Fund	4 643	4 449	173	160	3.1	3.0

Broker costs

Broker costs includes all broker service fees (or broker commissions) and other distribution costs. Broker costs increased by 9.6% from R2.0 billion in 2016 to R2.2 billion in 2017 (2016: 10.1%).

Broker costs represented 14.5% of total non-healthcare expenditure in 2017, while they accounted for 14.1% in 2016.

For schemes that pay broker service fees, the amounts paid on a per average member per month (pampm) basis increased to R68.1 pampm in 2017, from R62.4 pampm in 2016 – representing an increase of 9.1%.

Broker service fees as a percentage of GCI remained constant at 1.2% in both 2016 and 2017.

Figure 60 shows annual broker service fees paid by open schemes since 2000, as well as their percentage of total non-healthcare expenditure.

Figure 60: Broker service fees (open schemes) for 2000-2017

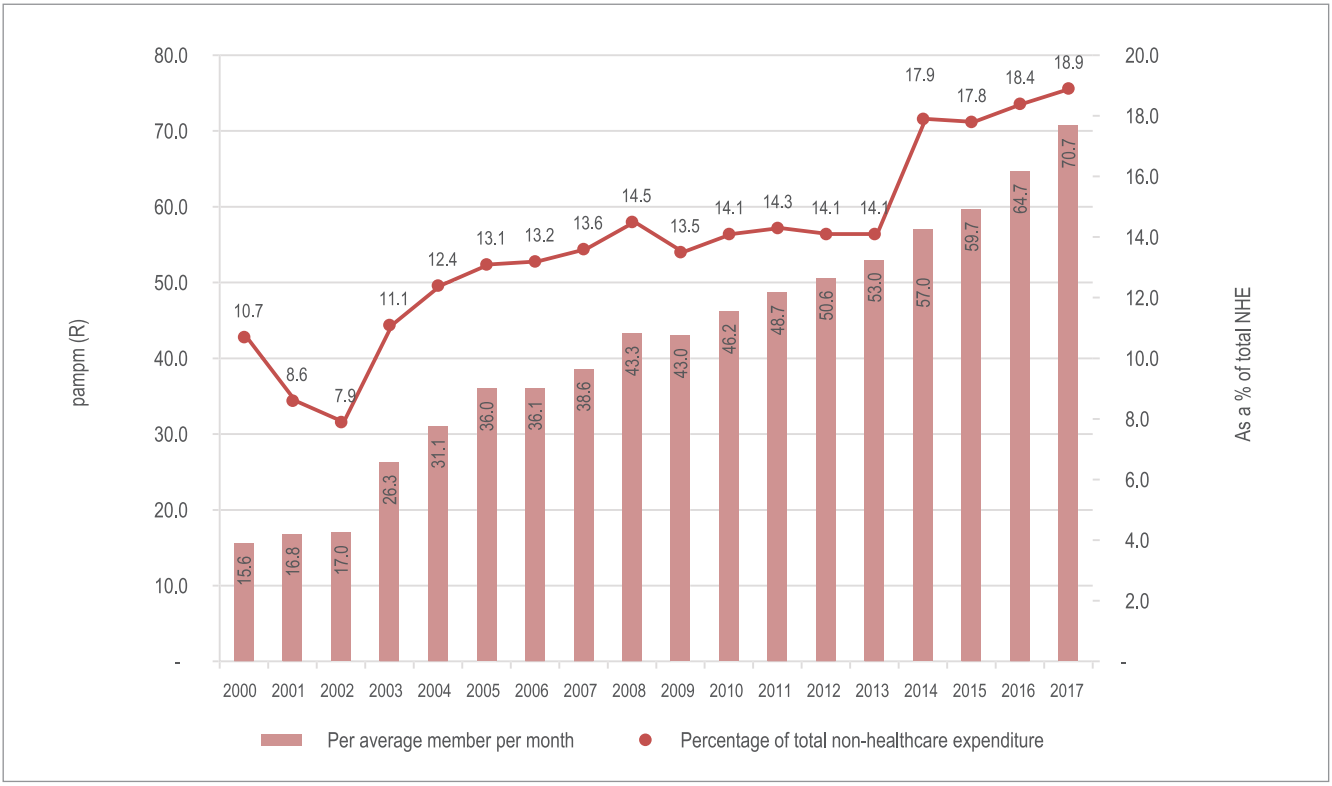


Figure 61 illustrates the increase in broker service fees relative to the number of members of schemes that pay brokers.

Figure 61: Broker service fees and scheme membership for 2000-2017

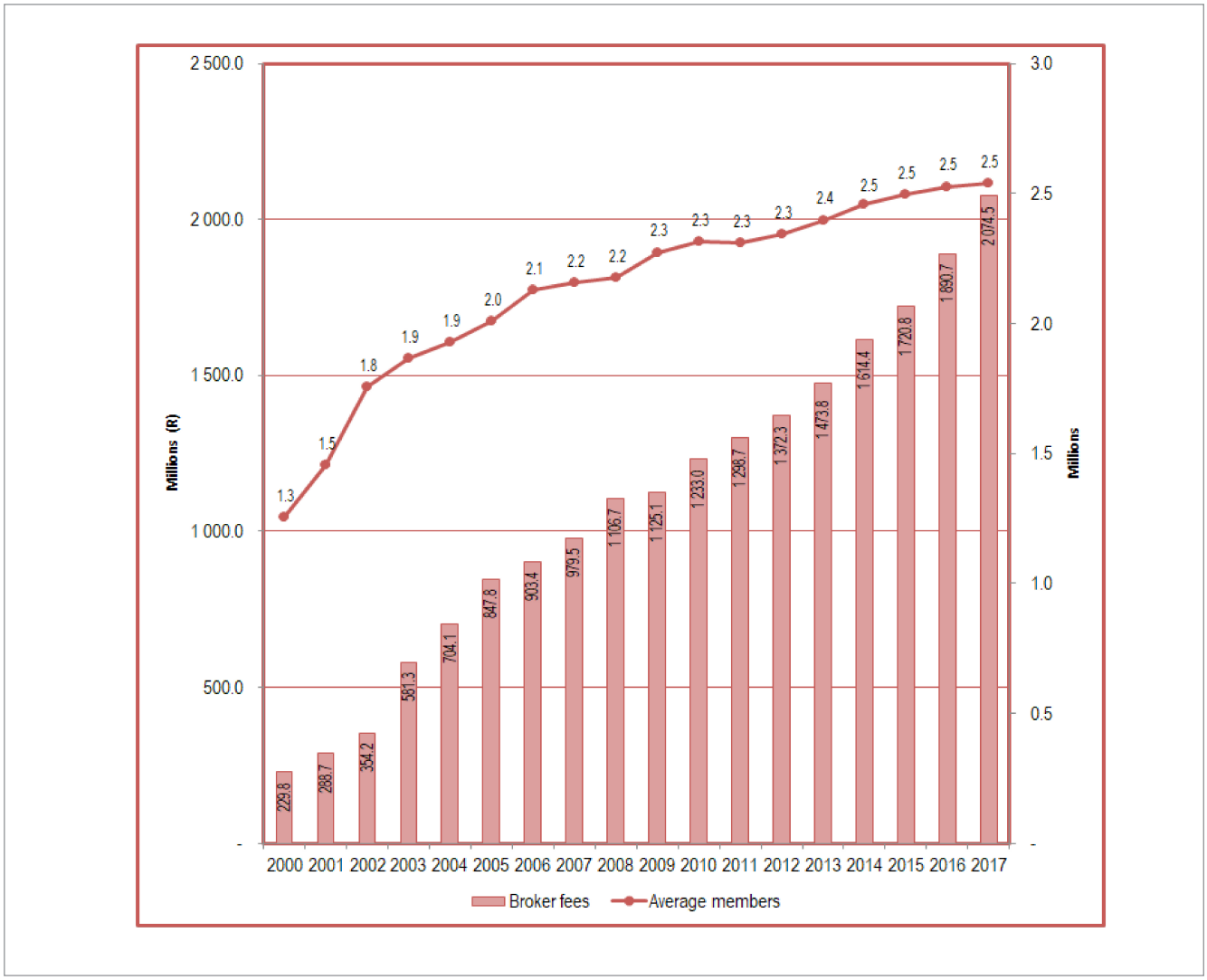


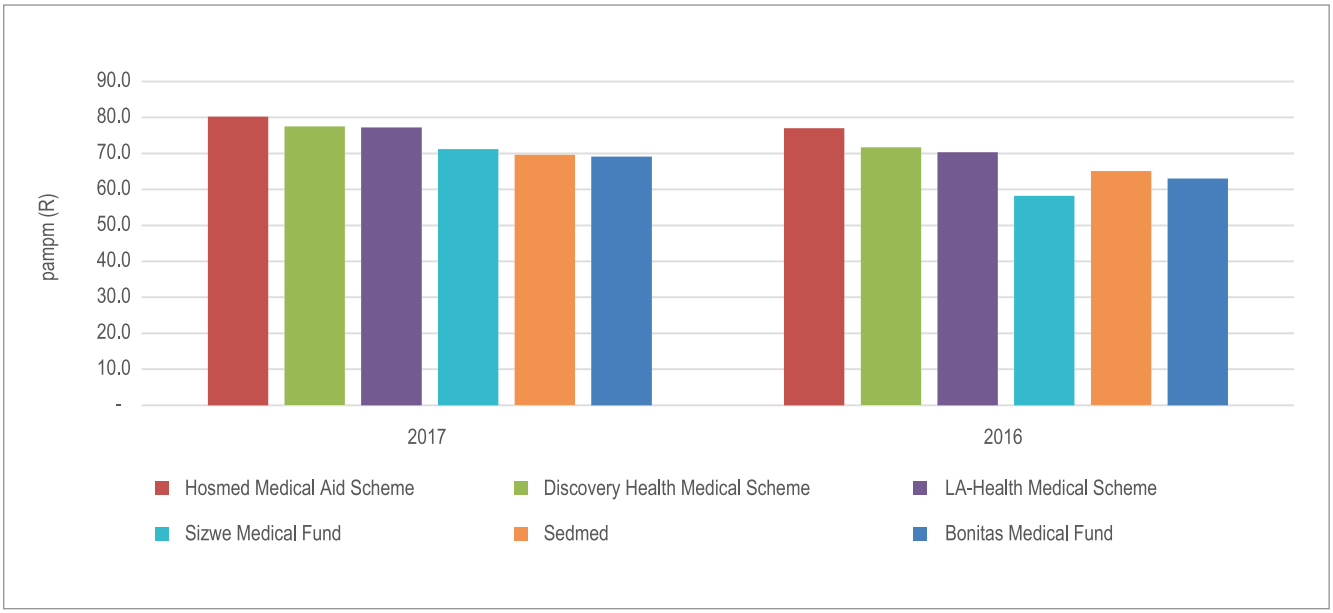
Table 36 illustrates the schemes that had broker service fees that were higher than the industry average of R68.1 pampm during 2017 (2016: R62.4 pampm). These six schemes (2016: 6) represented 70.3% (2016: 69.3%) of total membership that paid for broker service fees, and 78.2% (2016: 77.6%) of total broker service fees paid. One of these schemes paid at a level of 17.8% greater than the industry average.

Table 36: Schemes with broker fees above the industry average in 2016 and 2017

Ref. no.	Name of medical scheme	Type	Broker service fees*			Other distribution fees		
			2017 pampm R	2016 pampm R	% change	2017 pampm R	2016 pampm R	% change
1537	Hosmed Medical Aid Scheme	Open	80.2	77.0	4.2	-	-	
1125	Discovery Health Medical Scheme	Open	77.5	71.7	8.1	-	-	-
1145	LA-Health Medical Scheme	Restricted	77.2	70.3	9.8	-	-	-
1486	Sizwe Medical Fund	Open	71.2	58.2	22.3	-	-	-
1531	Sedmed	Restricted	69.6	65.1	6.9	-	-	-
1512	Bonitas Medical Fund	Open	69.1	63.0	9.7	-	-	-

pampm = per average member per month
**excluding distribution costs*

Figure 62: Schemes with broker fees above the industry average of R 68.1 pampm in 2016 and 2017



pampm = per average member per month

Reinsurance results

There were no schemes with reinsurance contracts in place in both 2016 and 2017.

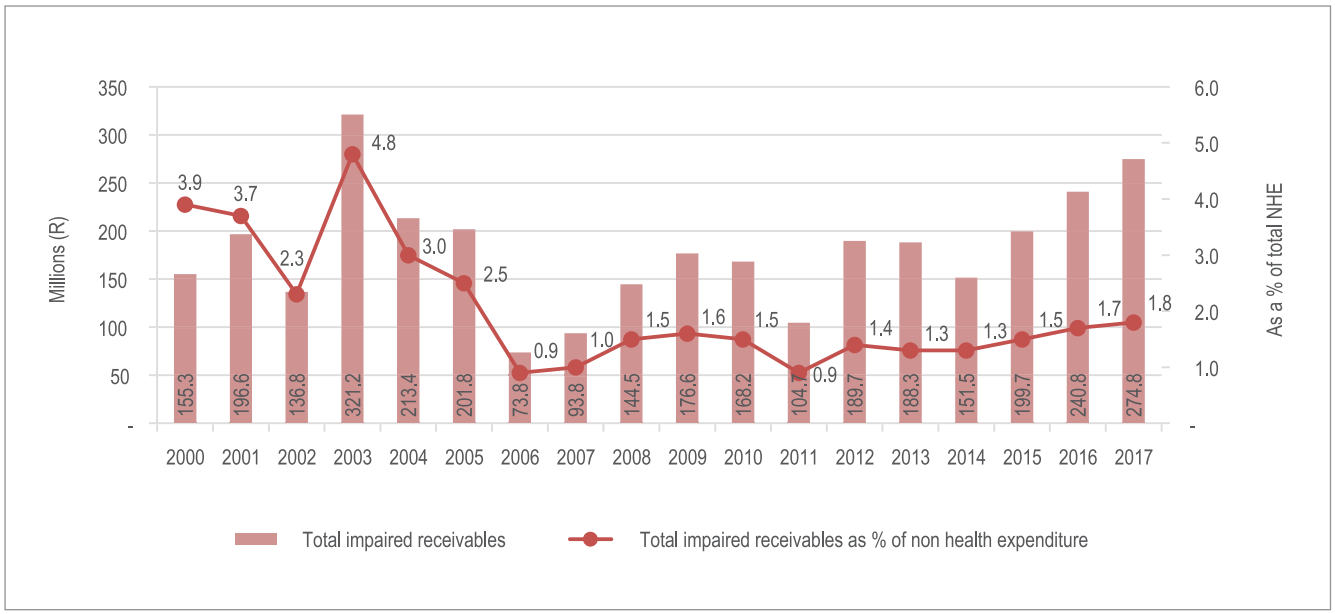
Impaired receivables

Impaired receivables increased by 14.1% to R274.8 million for the year under review, from R240.8million in 2016. They represented 1.8% of total non-healthcare expenditure (1.7% in 2016).

It took schemes an average of 8 days to collect debts (contributions from their members) in 2017. This improved by 24.5% from 10.6 days in 2016. This collection period falls well outside the legal provision requiring 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 63 shows the trend in impaired receivables over the past 17 years – also expressed as a percentage of total non-healthcare expenditure.

Figure 63: Impaired receivables for 2000-2017



Trends in non-healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2017 at 83.7% (2016: 84.2%).

Administration expenditure accounted for 7.0% of GCI in 2017 (2016: 7.2%).

Table 37 shows administration expenditure by type of scheme administration.

Table 37: Gross Administration Expenditure (GAE) for 2000-2017

	Open schemes				Restricted schemes			
	Self -administered		Third party		Self -administered		Third party	
	pabpm R	% change	pabpm R	% change	pabpm R	% change	pabpm R	% change
2000	31.5		37.1		22.1		26.2	
2001	51.8	64.4	49.5	33.4	26.5	19.9	30.4	16.0
2002	48.1	-7.1	56.5	14.1	33.5	26.4	38.7	27.3
2003	59.6	23.9	63.1	11.7	30.2	-9.9	43.3	11.9
2004	65.3	9.6	69.0	9.4	37.4	23.8	45.3	4.6
2005	68.7	5.2	75.0	8.7	35.9	-4.0	53.6	18.3
2006	70.4	2.5	78.8	5.1	32.5	-9.5	52.9	-1.3
2007	76.0	8.0	82.1	4.2	36.1	11.1	51.7	-2.3
2008	81.1	6.7	88.0	7.2	33.3	-7.8	49.6	-4.1
2009	90.4	11.5	96.0	9.1	37.9	13.8	53.6	8.1
2010	87.3	-3.4	97.8	1.9	46.0	21.4	54.8	2.2
2011	86.0	-1.5	103.6	5.9	47.7	3.7	55.6	1.5
2012	99.6	15.8	108.8	5.0	53.7	12.6	58.2	4.7
2013	108.7	9.1	113.5	4.3	55.9	4.1	62.4	7.2
2014	111.0	2.1	120.2	5.9	71.0	27.0	68.8	10.3
2015	128.3	15.6	126.1	4.9	67.6	-4.8	77.5	12.6
2016	134.2	4.6	132.0	4.7	75.1	11.1	86.7	11.9
2017	137.9	2.8	140.6	6.5	82.8	10.3	91.5	5.5

pabpm = per average beneficiary per month

Table 37 also shows that self-administered open schemes paid 66.5% (2016: 78.7%) more pabpm for administration expenditure than self-administered restricted schemes. Third-party administered open schemes paid 53.7% (2016: 52.2%) more pabpm for administration expenditure than third-party administered restricted schemes.

The variance in the GAE pabpm incurred by third-party and self-administered schemes is not significant in the open scheme industry. Third party administered restricted schemes however incurred 10.5% more GAE pabpm than their self-administered counterparts in 2017.

During 2017 there were six self-administered open schemes (2016: six), representing 603 767 average beneficiaries (2016: 596 826), and 15 third-party administered open schemes (2016: 16), representing 4 327 146 average beneficiaries (2016: 4 346 942).

Self-administered open schemes experienced an increase of 2.8% in spending on administration expenditure (from R134.2 pabpm in 2016 to R137.9 pabpm in 2017) while third-party administered open schemes increased their expenditure by 6.5% to R140.6 pabpm, from R132.0 pabpm in 2016. Third-party administered open schemes paid 2.0% more for administration expenditure than self-administered open schemes. The figure was 1.6% less in 2016.

During 2017, there were eight self-administered restricted schemes (2016: eight), representing 300 591 average beneficiaries (2016: 299 373), and 52 third-party administered restricted schemes (2016: 52), representing 3 608 388 average beneficiaries (2016: 3 595 107).

Third-party administered restricted schemes spent 10.5% on average more on administration expenditure at R91.5 pabpm ,compared to the R82.8 pabpm of self-administered restricted schemes (2016: 15.4%).

The GAE pabpm in the open scheme industry is however significantly higher than that of the restricted scheme industry. This is also reflected in the comparison between third-party administered and self-administered schemes in the two industries. This is partly due to the fact that restricted schemes do not incur the same level of marketing (including advertising) expenditure and broker fees as the open scheme industry.

Table 38 indicates the ten schemes with the highest marketing, advertising, and broker costs. The majority of these are open medical schemes. The table shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 1.1 % from 2016 to 2017 (2015 to 2016: 1.0%). 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.

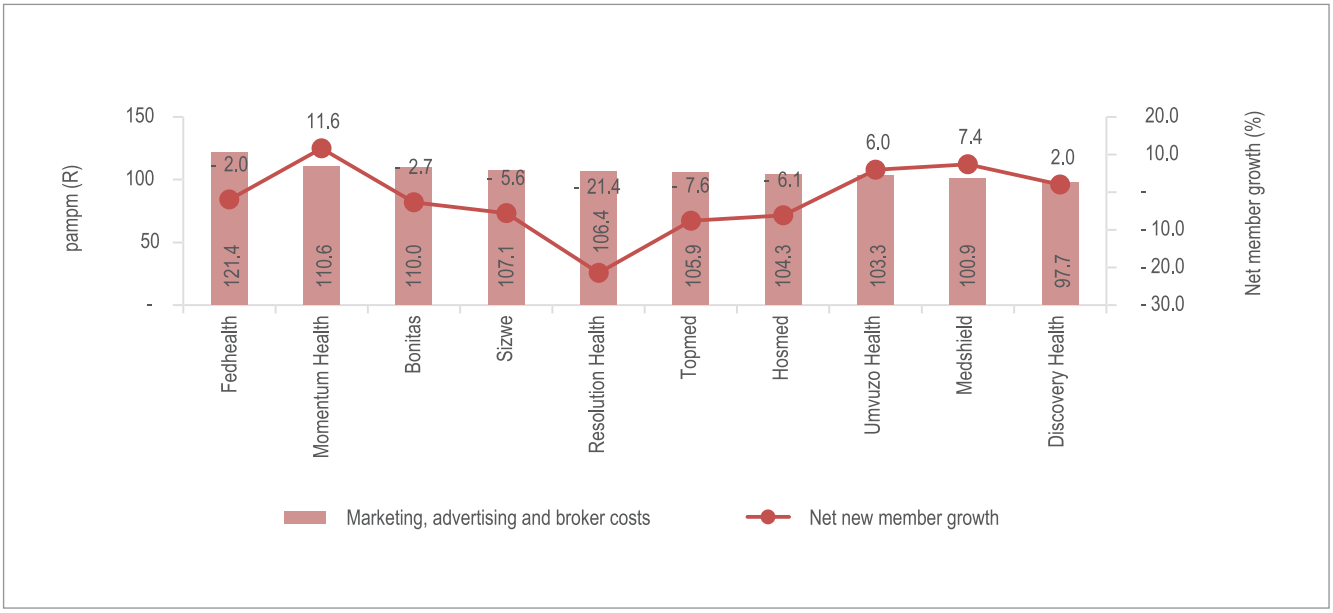
Figure 64 illustrates the information contained in Table 38.

Table 38: The ten schemes with the highest marketing, advertising, and broker costs in 2017

Ref. no.	Name of medical scheme	Marketing, advertising and broker costs pampm	Net new member growth %
1202	Fedhealth Medical Scheme	121.4	-2.0
1167	Momentum Health	110.6	11.6
1512	Bonitas Medical Fund	110.0	-2.7
1486	Sizwe Medical Fund	107.1	-5.6
1575	Resolution Health Medical Scheme	106.4	-21.4
1422	Topmed Medical Scheme	105.9	-7.6
1537	Hosmed Medical Aid Scheme	104.3	-6.1
1597	Umvuzo Health Medical Scheme	103.3	6.0
1140	Medshield Medical Scheme	100.9	7.4
1125	Discovery Health Medical Scheme	97.7	2.0

pampm = per average member per month

Figure 64: The ten schemes with the highest marketing, advertising and broker costs in 2017



pampm = per average member per month

Tables 39 and 40 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 39: Open schemes with the highest marketing and advertising expenditure in 2017*

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
		2017 pampm	2016 pampm	% change	2017 pampm	2016 pampm	% change	2017	2016	% change			
1202	Fedhealth Medical Scheme	56.2	55.2	1.8	65.1	58.4	11.5	72 203	72 315	-0.2	The Cheese Has Moved (Pty) Ltd	48 725	100.0
1167	Momentum Health	-	-	-	110.6	103.7	6.7	149 816	134 214	11.6	Not applicable	-	-
1512	Bonitas Medical Fund	40.8	40.3	1.2	69.1	63.0	9.7	339 003	308 262	10.0	Afrocentric Distribution Services (Pty) Ltd	166 048	100.0
1486	Sizwe Medical Fund	35.8	38.8	-7.7	71.2	58.2	22.3	48 489	50 784	-4.5	Ad-hoc expenditure	16 833	80.8
											Sechaba Medical Solutions Pty Ltd	3 000	14.4
											Ingenious Marketing	1 006	4.8
1575	Resolution Health Medical Scheme	45.2	35.7	26.6	61.2	56.1	9.1	14 758	18 959	-22.2	Agility Channel	6 966	87.0
											Ad-hoc expenditure	842	10.5
											Martina Nicholson	171	2.1
											National Positions	27	0.3
1422	Topmed Medical Scheme	40.2	39.0	3.1	65.7	61.5	6.8	21 093	23 384	-9.8	FastPulse	4 839	47.6
											Ad-hoc expenditure	2 597	25.5
											Jellyfish Online Marketing SA (Pty) Ltd	1 121	11.0
											Digital Comparison Services (Pty) Ltd	1 002	9.9
											Med Aid Quote (Pty) Ltd	466	4.6
											Intelligent Internet Solutions CC	143	1.4
1537	Hosmed Medical Aid Scheme	24.1	9.9	143.4	80.2	77.0	4.2	24 403	25 778	-5.3	Skyvue communication	1 823	25.9
											Print Joint	1 819	25.8
											Jet Printers	1 664	23.6
											MBE Maternity Bags	789	11.2
											Travel with flair	376	5.3
											Kashan Advertising	208	3.0
											Salga	91	1.3
											B2B Marketing	89	1.3
											Time Media-Adverts	60	0.9
											Tiso Blackstar	53	0.7
											Independent newspaper	35	0.5
											Kaqala Media	34	0.5
											Mail and Guardian	26	0.4
											Periwinkle Marketing T/A Perie	21	0.3
											Media 24	12	0.2
											Makro	6	0.1
											Umtata member retention campaign	(60)	-0.9

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
		2017 pampm	2016 pampm	% change	2017 pampm	2016 pampm	% change	2017	2016	% change			
1140	Medshield Medical Scheme	34.4	31.2	10.3	66.5	63.3	5.1	77 008	74 058	4.0	Spacegrow Media	9 339	29.3
											Hi Performance Supplies	6 031	19.0
											Kaizer Chiefs	4 031	12.7
											Ntsumi Telecommunications	3 283	10.3
											Specialist Research	2 389	7.5
											Saints Brand and Design	1 924	6.0
											Bakubung (SABC Healthtalk)	1 656	5.2
											Wellness Odyssey	1 552	4.9
											Kaya FM	672	2.1
											Wink Promotions	516	1.6
											Ad-hoc expenditure	404	1.3
											Maverick Digital Labs	25	0.1
1125	Discovery Health Medical Scheme	20.2	18.9	6.9	77.5	71.7	8.1	1 305 219	1 280 494	1.9	Discovery Health (Pty) Ltd - all inclusive administration agreement	315 812	100.0
1466	Makoti Medical Scheme	52.5	30.1	74.4	40.9	43.1	-5.1	2 760	2 429	13.6	Ad-hoc expenditure	1 738	100.0
1141	Spectramed	61.6	57.8	6.6	26.2	23.0	13.9	12 468	14 703	-15.2	Agility Chanel (Pty) Ltd	8 470	91.8
											Ad-hoc expenditure	753	8.2
Open scheme industry average**		**24.9**	**23.9**	**4.2**	**74.3**	**68.1**	**9.1**	**2 333 866**	**2 333 174**	**0.0**			

pampm = per average member per month
** Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*
*** The industry averages are based only on those schemes that incurred the specific type of expenditure.*

Table 40: Restricted schemes with the highest marketing and advertising expenditure in 2017

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
		2017 pampm	2016 pampm	% change	2017 pampm	2016 pampm	% change	2017	2016	% change			
1597	Umvuzo Health Medical Scheme	55.5	52.6	5.5	47.8	45.9	4.1	27 666	26 110	6.0	Ad-hoc expenditure	18 437	100.0
1145	LA-Health Medical Scheme	9.1	1.1	727.3	77.2	70.3	9.8	66 079	60 832	8.6	Discovery Health (Pty) Ltd	6 520	90.6
											Ad-hoc expenditure	675	9.4
1194	Profmed	46.2	50.8	-9.1	25.7	23.7	8.4	32 665	31 488	3.7	Ebony and Ivory	12 824	70.9
											Cyberkinetics	2 489	13.8
											Ad-hoc expenditure	1 119	6.2
											StorkBrands (Pty) Ltd	768	4.2
											Epic Communications	468	2.6
											YKnot Online	258	1.4
											ROI Africa	169	0.9
1531	Sedmed	0.9	2.2	-59.1	69.6	65.1	6.9	1 004	982	2.2	Ad hoc expenditure	11	100.0
1291	Witbank Coalfields Medical Aid Scheme	20.9	18.9	10.6	0.7	0.6	16.7	8 437	9 393	-10.2	Amadwala Group Benefits	2 111	100.0

Ref. no.	Name of medical scheme	Marketing expenditure (including advertising)			Broker costs paid			Average members			Name of main advertising and marketing provider(s)	Expenditure per provider R'000	% of total fees
		2017 pampm	2016 pampm	% change	2017 pampm	2016 pampm	% change	2017	2016	% change			
1598	Government Employees Medical Scheme (GEMS)	20.3	21.1	-3.8	-	-	-	690 072	683 286	1.0	Healthi Choices (Pty) Ltd	57 996	34.5
											Other (Advertising and marketing)	46 407	27.6
											EOH Advisory Services (Pty) Ltd	41 895	24.9
											Ad-hoc expenditure	21 827	13.0
1038	SAMWUMed	8.4	26.9	-68.8	9.9	6.2	59.7	36 396	37 129	-2.0	Ad-hoc expenditure	3 686	100.0
1568	Sisonke Health Medical Scheme	17.6	13.5	30.4	-	-	-	8 503	8 389	1.4	Ad-hoc expenditure	1 220	68.0
											Twynne	574	32.0
1590	Building & Construction Industry Medical Aid Fund	15.1	8.1	86.4	0.7	0.6	16.7	4 643	4 449	4.4	Various suppliers	839	100.0
1600	Motohealth Care	7.8	11.2	-30.4	7.5	13.5	-44.4	22 993	24 441	-5.9	Various Other Companies	2 001	93.4
											Dimage	141	6.6
	Restricted scheme industry average**	**15.2**	**16.2**	**-6.2**	**38.7**	**33.7**	**14.8**	**1 312 316**	**1 245 356**	**5.4**			

pampm = per average member per month
** Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*
***The industry averages are based only in respect of those schemes that incurred the specific expenditure.*

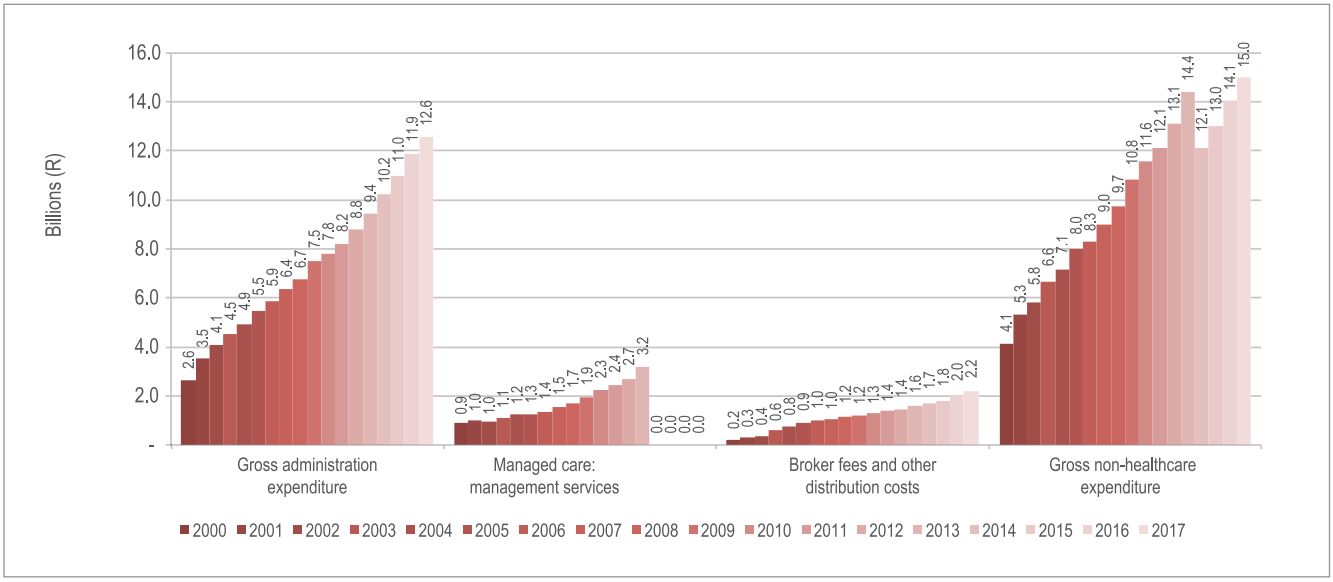
Table 41: The top two schemes paying marketing fees to administrators

Ref. no.	Name of medical scheme	Marketing component of administration fee		Total marketing, advertising and broker costs
		%	pampm	pampm
1125	Discovery Health Medical Scheme	7.0	20.2	97.7
1599	Lonmin Medical Scheme	3.0	1.8	1.8

pampm = per average member per month

Figure 65 shows the changes in the major categories of non-healthcare expenditure for the past 18 years. Total net non-healthcare expenditure rose by 6.6 % from R14.1 billion in 2016 to R15.0 billion in 2017.

Figure 65: Changes in main components of non-healthcare expenditure for 2000-2017



Total gross non-healthcare expenditure has increased by 264.0% since 2000. This was driven by a 374.4% upswing in administration expenditure, and an increase of 847.0% in broker costs.

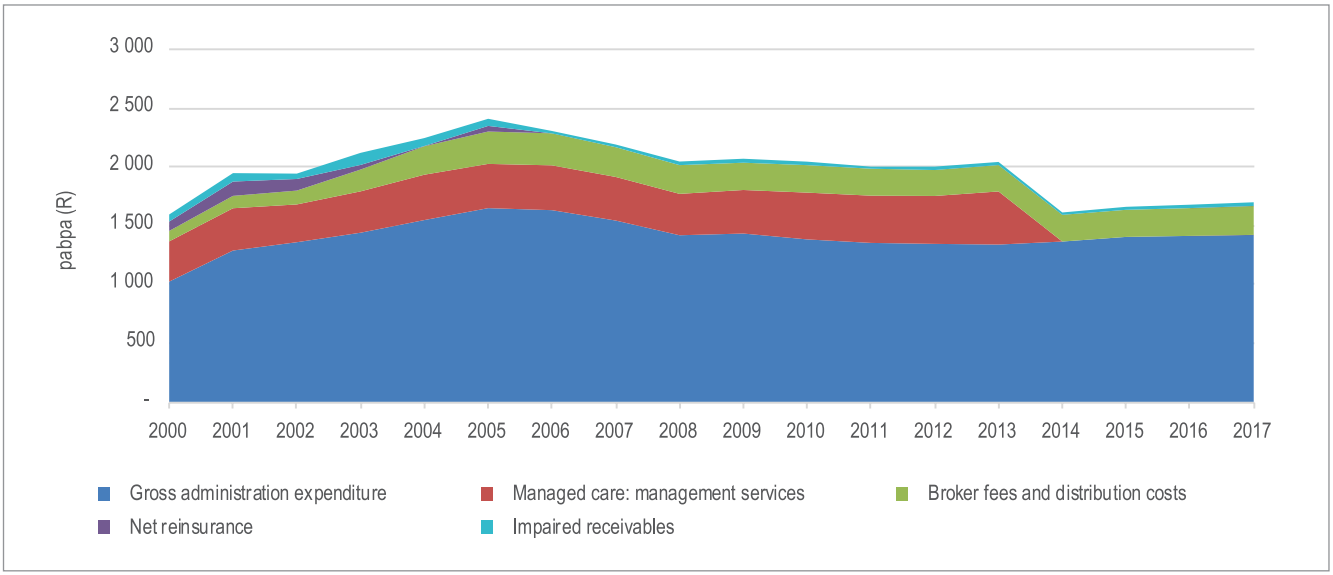
By comparison, gross claims have risen by 488.0% (not adjusted for inflation) since 2000.

As illustrated in Figure 65 and 66 together with Table 42, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI) prior to 2006. The rate of increase was reversed in 2006[4] and since then there has been a real decrease[5] in non-healthcare expenditure, from R2 408.1 pabpa in 2005 to R1 698.2 pabpa in 2017 (prices adjusted to 2017 prices).

Circular 56 of 2016 resulted in the 2014 non-healthcare expenditure decreasing by 21.5% from R2 052.3 pabpa to R1 611.1pabpa (in real terms). This can be clearly observed in Figure 66.

Non-healthcare expenditure increased marginally (by 1.2%) to R1 698.2 pabpa in 2017, from R1 677.4 pabpa in 2016. The non-healthcare ratio (as percent of RCI) also decreased, to 9.2% in 2017 from 9.5% in 2016

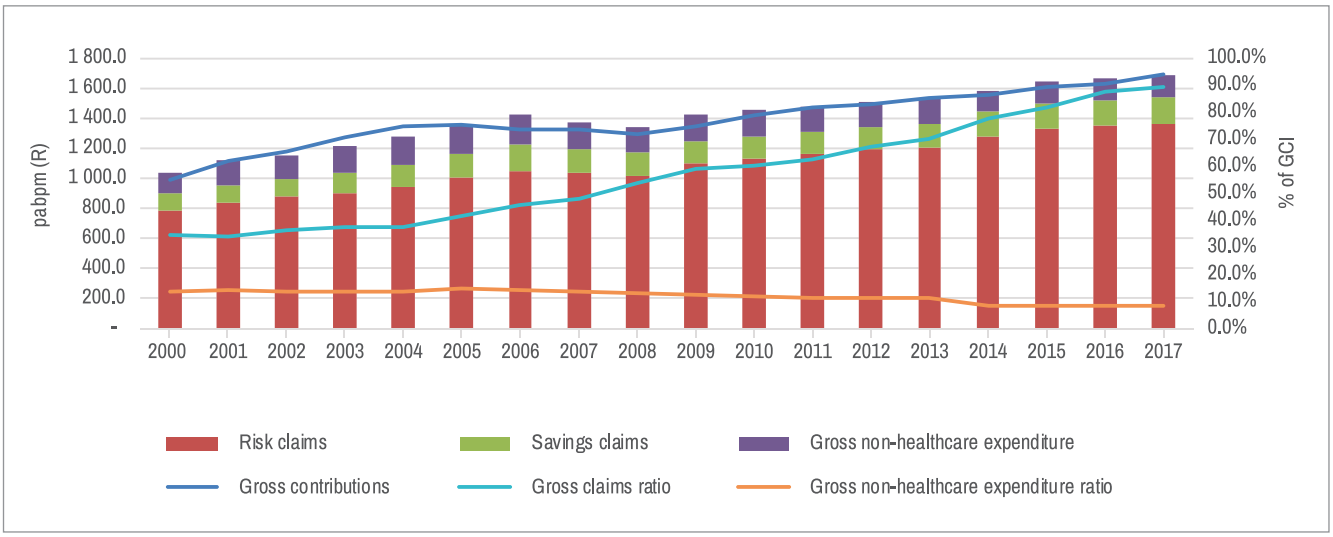
Figure 66: Non-healthcare expenditure pabpa for 2000-2017 (2017 prices)



pabpa = per average beneficiary per annum

No significant changes were observed in the composition of NHE over the last three years. Administration expenditure is the biggest component of NHE (83.7%), followed by broker fees and other distribution costs (14.5%), and impaired receivables (1.8%).

Figure 67: Claims and non-healthcare expenditure pabpm for 2000-2017 (2017 prices)



pabpm = per average beneficiary per month
GCI = Gross Contribution Income

[4] The decrease between 2013 and 2014 is partially due to the reclassification of accredited managed healthcare services.
[5] The decrease between 2013 and 2014 is partially due to the reclassification of accredited managed healthcare services.

Table 42: Trends in contributions, claims, and non-healthcare expenditure for 2000-2017 (2017 prices)*

	Gross contributions		Gross claims		Gross non-healthcare expenditure	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	11 827.8		10 555.6		1 594.4	
2001	13 377.8	13.1	9 964.1	-5.6	1 946.3	22.1
2002	14 210.6	6.2	11 717.9	17.6	1 941.9	-0.2
2003	15 334.2	7.9	12 202.0	4.1	2 118.4	9.1
2004	16 211.6	5.7	12 830.5	5.2	2 244.4	5.9
2005	16 267.4	0.3	13 688.9	6.7	2 408.3	7.3
2006	15 963.7	-1.9	14 172.9	3.5	2 304.6	-4.3
2007	15 895.5	-0.4	13 861.1	-2.2	2 189.4	-5.0
2008	15 566.6	-2.1	13 622.6	-1.7	2 044.8	-6.6
2009	16 222.9	4.2	14 585.9	7.1	2 068.5	1.2
2010	17 051.0	5.1	15 006.3	2.9	2 043.8	-1.2
2011	17 722.9	3.9	15 452.5	3.0	2 001.1	-2.1
2012	17 943.9	1.2	15 825.4	2.4	2 001.5	-
2013	18 424.0	2.7	16 035.0	1.3	2 041.3	2.0
2014	18 677.9	1.4	16 999.9	6.0	1 611.3	-21.1
2015	19 343.9	3.6	17 721.8	10.5	1 659.6	3.0
2016	19 501.5	0.8	17 989.0	5.8	1 677.5	1.1
2017	20 341.7	4.3	18 162.8	1.0	1 698.2	1.2
since 2000		**72.0**		**72.1**		**6.5**

pabpa = per average beneficiary per annum
** The values were adjusted for CPI for 2000-2016.*

Table 42 also shows how non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.0% per annum from 2000 to 2001 before stabilising.

Table 43 shows the ten open schemes with non-healthcare expenditure greater than both the industry average of R177.8 pabpm and the open schemes average of 11.5% when expressed as a percentage of Risk Contribution Income (RCI).

Table 44 shows the ten restricted schemes with non-healthcare expenditure greater than both the industry average of R95.7 pabpm and the restricted schemes average of 6.3% when expressed as a percentage of Risk Contribution Income (RCI).

Table 43: Trends in claims, non-healthcare expenditure, and reserve-building as a percentage of contributions among open schemes in 2016 and 2017

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2017 pabpm	2016 pabpm	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	% change
1141	Spectramed	239.9	234.2	95.1	95.7	12.5	14.3	-7.6	-9.9	23.2
1446	Selfmed Medical Scheme	235.7	210.7	103.7	101.4	12.3	11.7	-15.9	-13.0	-22.3
1575	Resolution Health Medical Scheme	234.0	196.1	86.9	87.5	12.8	12.6	0.3	-0.1	400.0
1202	Fedhealth Medical Scheme	209.6	199.7	86.9	93.5	12.2	12.0	0.9	-5.6	116.1
1486	Sizwe Medical Fund	206.1	192.6	88.0	88.8	12.2	12.3	-0.2	-1.1	81.8
1087	Keyhealth	203.1	185.9	86.8	91.4	9.1	9.0	4.1	-0.5	920.0
1464	Suremed Health	199.4	181.5	87.6	83.5	12.3	12.0	0.1	4.5	-97.8
1537	Hosmed Medical Aid Scheme	198.3	161.8	86.2	91.8	11.2	10.5	2.6	-2.3	213.0

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2017 pabpm	2016 pabpm	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	% change
1491	Compcare Wellness Medical Scheme	196.8	177.0	90.3	93.9	12.5	12.2	-2.8	-6.1	54.1
1125	Discovery Health Medical Scheme	181.5	168.9	85.7	87.2	12.3	12.6	2.0	0.2	900.0
1167	Momentum Health	171.9	160.1	86.0	88.1	14.4	14.4	-0.5	-2.6	80.8
Industry average - open schemes		177.8	165.9	87.2	89.3	11.5	11.8	1.2	-1.1	209.1

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

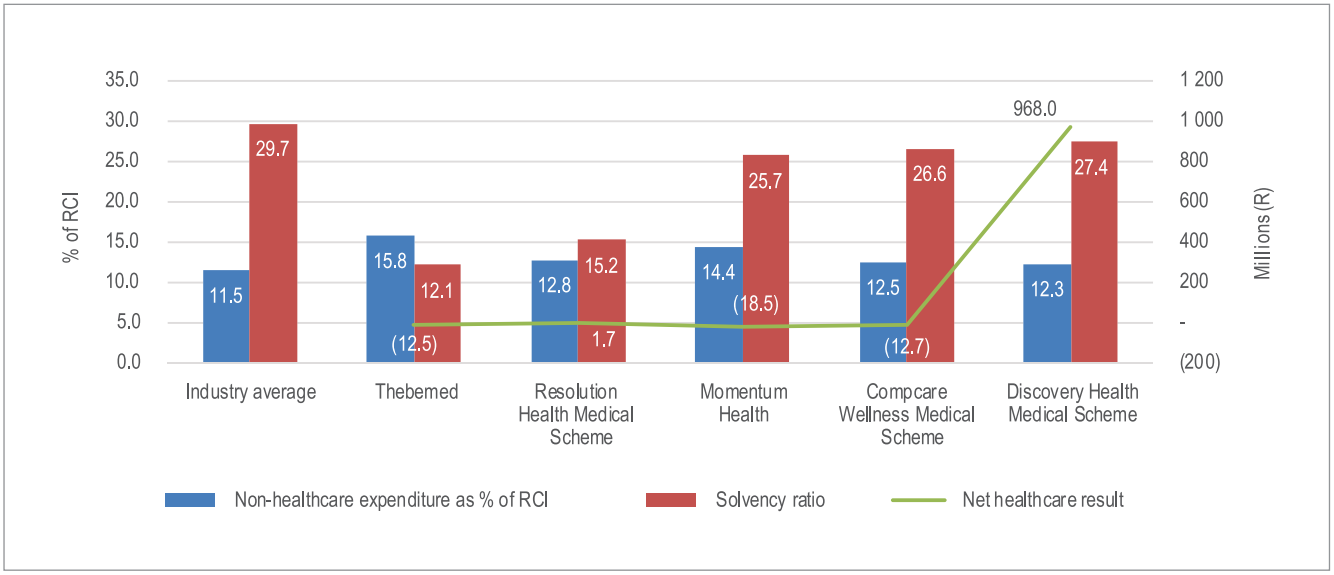
Table 44: Trends in claims, non-healthcare expenditure, and reserve-building as a percentage of contributions among restricted schemes in 2016 and 2017

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2017 pabpm	2016 pabpm	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	2017 As % of RCI	2016 As % of RCI	% change
1105	Metropolitan Medical Scheme	234.5	149.2	118.3	105.9	11.6	8.7	-29.8	-14.6	-104.1
1194	Profmed	218.4	208.3	90.9	90.6	12.0	12.6	-2.9	-3.1	6.5
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	207.5	194.2	88.1	92.3	10.8	11.2	1.2	-3.5	134.3
1441	Parmed Medical Aid Scheme	160.7	156.0	107.5	110.9	4.2	4.5	-11.7	-15.3	23.5
1068	De Beers Benefit Society	156.8	139.0	105.6	102.6	6.6	6.4	-12.2	-9.1	-34.1
1145	LA-Health Medical Scheme	156.2	146.8	81.3	82.9	11.9	11.9	6.8	5.2	30.8
1282	University of the Witwaters-rand, Johannesburg Staff Medical Aid Fund	155.3	124.6	98.5	97.0	6.0	5.3	-4.5	-2.3	-95.7
1523	Grintek Electronics Medical Aid Scheme	151.2	136.5	99.5	100.4	8.1	8.2	-7.6	-8.5	10.6
1571	Anglovaal Group Medical Scheme	139.9	129.2	97.9	101.3	8.7	8.8	-6.7	-10.1	33.7
1237	BP Medical Aid Society	136.5	114.2	115.7	112.3	6.4	5.7	-22.0	-18.0	-22.2
Industry average - restricted schemes		**95.7**	**90.6**	**90.6**	**95.6**	**6.3**	**6.6**	**3.1**	**-2.2**	**240.9**

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

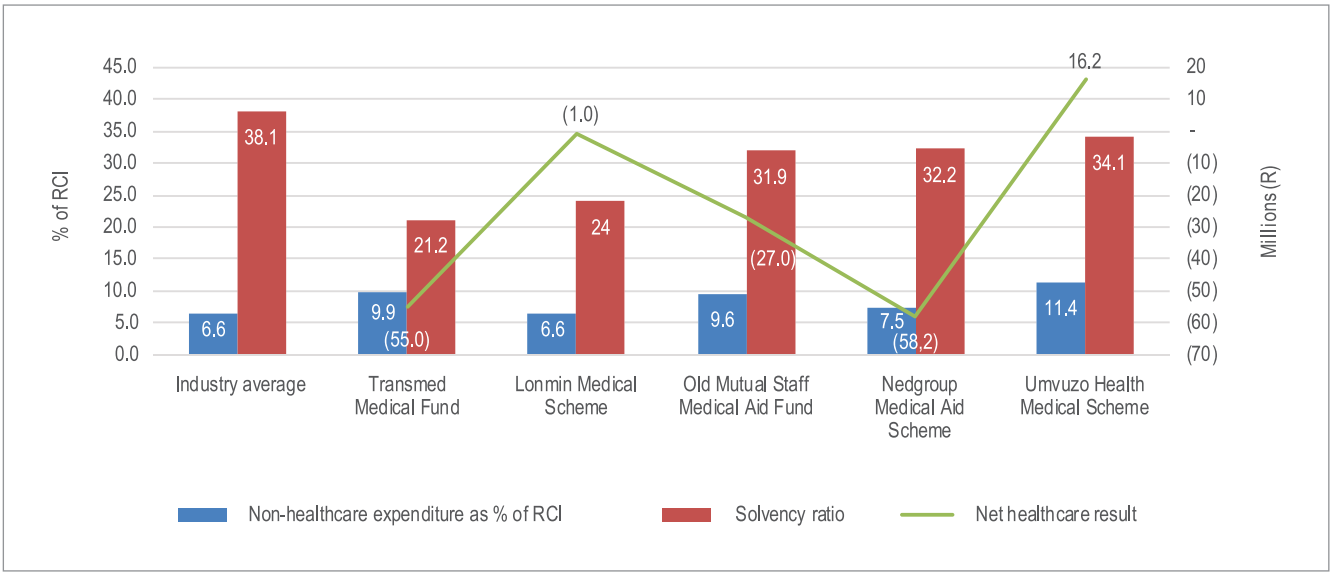
Figure 68 shows the open schemes in Table 43 that had a solvency ratio below the open schemes average of 29.7%. Figure 69 shows the restricted schemes in Table 44 that had a solvency ratio below the restricted schemes average of 38.1%. It is concerning that some of these medical schemes fall below the 25.0% solvency target, yet exhibit very high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies.

Figure 68: Open schemes with high non-healthcare expenditure and a solvency ratio below average in 2017



RCI = Risk Contribution Income

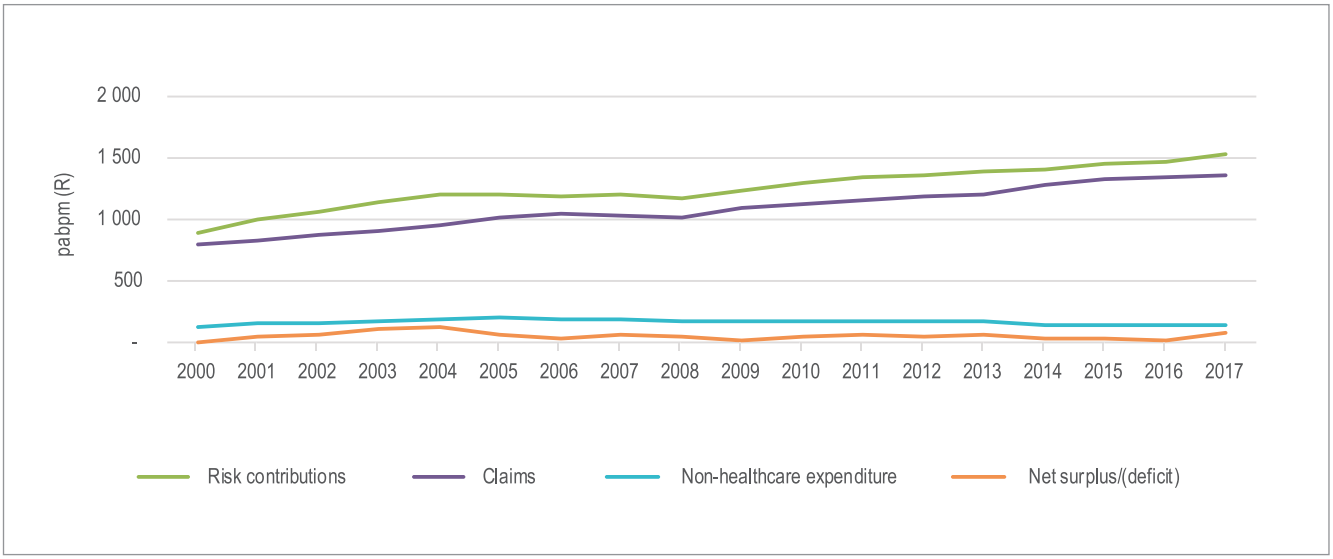
Figure 69: Restricted schemes with high non-healthcare expenditure and a solvency ratio below average in 2017



RCI = Risk Contribution Income

Figure 70 depicts information on contributions, benefits, non-healthcare expenditure, and operating surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm had been growing since 2000 but decreased in 2003, almost levelling out in 2004. Although this gap has since grown wider, it seems to have stabilised in the last few years.

Figure 70: Risk contributions, claims, non-healthcare expenditure, and net surpluses for 2000-2017 (2017 prices)*



pabpm = per average beneficiary per month
** The values were adjusted for CPI for 2000-2016.*

Benefit options

During 2017 there were 278 registered benefit options (2016: 276) operating in 81 medical schemes (2016: 82).

Open schemes accounted for 49.3% or 137 of the registered benefit options during 2017 (2016: 50.0% or 138 options). Restricted schemes had 141 options during the year, representing 50.7% of all options (2016: 138 options or 50.0%).

On average, open schemes had 6.5 options per scheme (2016: 6.3), and an average of 17 272 members per option at year-end (2016: 16 955). Restricted schemes had an average of 2.4 options per scheme (2016: 2.3), with an average of 11 677 members per option as at 31 December 2017 (2016: 11 916).

Of the 278 benefit options during the year, 104 (37.4%) had fewer than 2 500 members per option (2016: 100 or 36.2%). Of these 104 options, 68 (65.4%) incurred net healthcare losses in 2017. In 2016, 56 of these options (56.0%) incurred losses.

The remaining 174 options (2016: 176) had more than 2 500 members per option. Of these, 44.3% or 77 options incurred net healthcare losses (2016: 57.4% or 101 options).

Table 45: Results of benefit options in 2017

	Open schemes	% representing	Restricted schemes	% representing	Total
All options					
Number of options	137	49.3	141	50.7	278
Members represented	2 366 197	59.0	1 646 525	41.0	4 012 722
Number of schemes	21	25.9	60	74.1	81
Net healthcare result (R'000)	1 134 679		2 233 839		3 368 518
Gross non-healthcare as % of GCI	10.0		6.0		8.3
Gross claims ratio (%)	88.3		90.6		89.3
Gross claims incurred pbpm	1 560.5		1 441.6		1 508.1
GCI pbpm	1 766.3		1 590.9		1 689.0

	Open schemes	% representing	Restricted schemes	% representing	Total
Options with members >= 2 500					
Number of options	89	51.1	85	48.9	174
Members represented	2 314 411	59.3	1 588 130	40.7	3 902 541
Net healthcare result (R'000)	1 242 957		2 516 984		3 759 941
Gross non-healthcare as % of GCI	10.0		6.0		8.4
Gross claims ratio (%)	88.2		90.1		89.0
Gross claims incurred pbpm	1 552.4		1 419.4		1 494.1
GCI pbpm	1 760.4		1 575.1		1 679.2
Options with members < 2 500					
Number of options	48	46.2	56	53.8	104
Members represented	51 786	47.0	58 395	53.0	110 181
Net healthcare result (R'000)	(108 379)		(283 145)		(391 524)
Gross non-healthcare as % of GCI	8.5		6.4		7.3
Gross claims ratio (%)	95.3		103.0		99.5
Gross claims incurred pbpm	1 969.3		2 174.3		2 080.7
GCI pbpm	2 067.3		2 036.9		2 091.5

GCI = Gross Contribution Income
pbpm = per beneficiary per month

At the end of 2017, there were 48 options in open schemes with fewer than 2 500 members (2016: 48). They had an average of 1 078.9 members per option (2016: 1 153.5) and represented 35.0% (2016: 34.8%) of all open schemes options.

Restricted schemes had 56 options with fewer than 2 500 members (2016: 52). The average number of members per option was 1 042.8 (2016: 1 141.8), and these options represented 39.7% (2016: 37.7%) of all restricted schemes options.

Table 46: Results of loss-making benefit options in 2017

	Open schemes	% representing	Restricted schemes	% representing	Total
Total loss-making options					
% of total options	52.6		51.8		52.2
Number of options	72	49.7	73	50.3	145
Members represented	822 370	62.8	487 870	37.2	1 310 240
Net healthcare result (R'000)	(2 964 370)		(2 281 996)		(5 246 366)
Gross non-healthcare as % of GCI	8.5		5.3		7.2
Gross claims ratio (%)	98.7		103.8		100.8
Gross claims incurred pbpm	1 953.8		1 878.5		1 922.6
GCI pbpm	1 978.5		1 809.0		1 908.2
Loss-making options with members > =2 500					
Number of options	39	50.6	38	49.4	77
Members represented	784 116	63.6	449 440	36.4	1 233 556
Net healthcare result (R'000)	(2 809 002)		(1 935 988)		(4 744 989)
Gross non-healthcare as % of GCI	8.5		5.3		7.2
Gross claims ratio (%)	98.7		103.3		100.5
Gross claims incurred pbpm	1 942.5		1 813.2		1 889.6
GCI pbpm	1 967.3		1 755.0		1 880.5

	Open schemes	% representing	Restricted schemes	% representing	Total
Loss-making options with members < 2 500					
Number of options	33	48.5	35	51.5	68
Members represented	38 254	49.9	38 430	50.1	76 684
Net healthcare result (R'000)	(155 368)		(346 008)		(501 376)
Gross non-healthcare as % of GCI	8.5		5.9		7.1
Gross claims ratio (%)	99.0		108.8		104.4
Gross claims incurred pbpm	2 192.6		2 782.1		2 495.7
GCI pbpm	2 214.8		2 556.5		2 390.4

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 278 benefit options registered and operating during 2017 (2016: 276), 145 (52.2%) incurred net healthcare losses. In 2016, 157 options (56.9%) incurred net healthcare losses. In the year under review, 72 options (2016: 84), representing 49.7% of loss-making options (2016: 53.5%), were in open schemes and 73 (2016: 73), representing 50.3% of loss-making options (2016: 46.5%), were in restricted schemes. Net healthcare losses pmpm for options with fewer than 2 500 members were 1.7 times greater (2016: 2.4) than those for options with more than 2 500 members – an average of R-544.9 pmpm compared to R-320.5 pmpm (2016: R-531.6 pmpm and R-217.8 pmpm respectively).

Benefit options with fewer than 2 500 members generally have higher contributions and claims than other options and also attract higher non-healthcare costs as they are shared across a smaller base.

Table 47 shows option results by demographics.

Table 47: Demographics of registered options at year-end in 2017

	Open	Restricted	Total
Average age pb	**34.9**	**31.0**	
Net healthcare result pb	**19.1**	**47.6**	
Number of options with average age greater than or equal to the industry average	**86**	**71**	**157**
Number of options incurring net healthcare results better or equal to the industry average	25	12	37
Number of options incurring net healthcare results worse than the industry average	61	59	120
Number of options with average age below the industry average	**51**	**70**	**112**
Number of options incurring net healthcare results better or equal to the industry average	34	28	62
Number of options incurring net healthcare results worse than the industry average	17	42	59

pb = per beneficiary

There were 86 options with an average age above the 34.9 years in open schemes, and 51 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 71 benefit options had beneficiaries with an average age higher than the 31.0 years. A total of 70 options had younger beneficiaries. As expected, options covering older and sicker lives incurred greater deficits.

Net healthcare results and trends

The net healthcare result of a medical scheme indicates its position after benefits, and non-healthcare expenditure are deducted from contribution income. The net healthcare result for all medical schemes combined reflected a surplus of R3.4 billion in 2017 (2016: R 2.4 billion deficit). Open schemes incurred a total surplus of R1.1 billion (2016: R0.9 billion deficit), and restricted schemes generated a combined surplus of R2.2 billion (2016: R1.4 billion deficit). This improvement is mainly due to the improved claims ratios of all schemes from 92.1% in 2016 to 88.7% in 2017.

Figure 71: Net healthcare results for 2000-2017

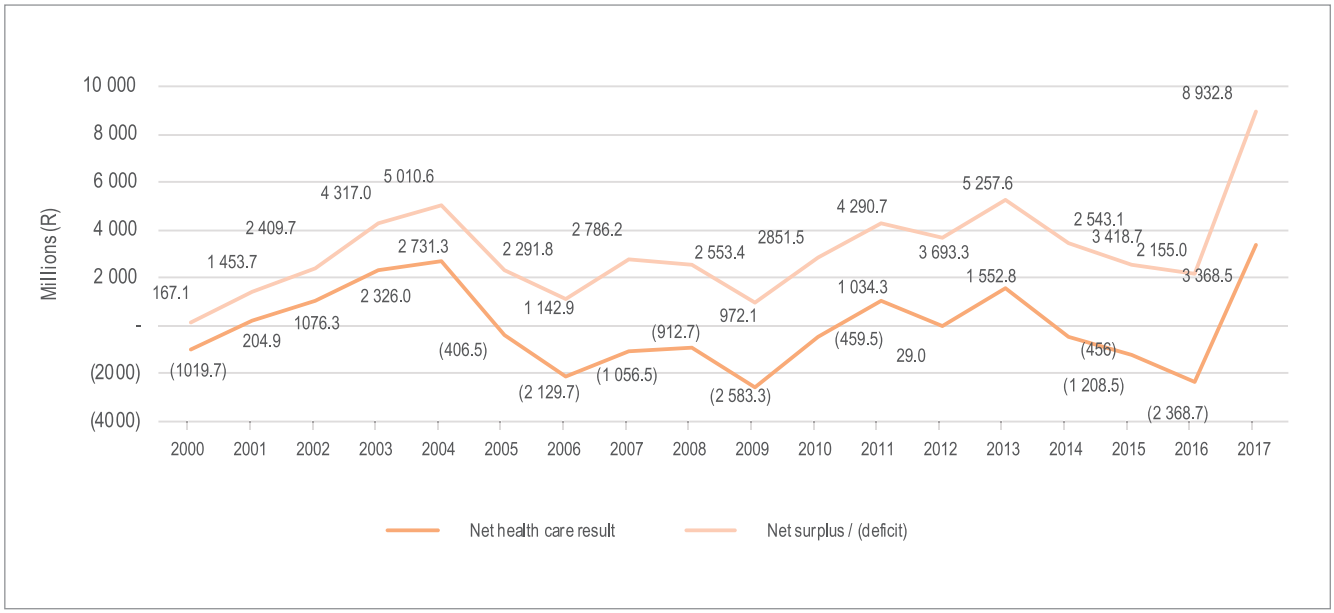


Table 48 shows the 20 schemes with the largest net healthcare deficits, representing 41.7% of all beneficiaries of schemes that suffered operating deficits. (Annexure X has more details on this.) Investment income has boosted the performance of a number of these schemes, and therefore they have not experienced major drops in their solvency levels.

Table 48: 20 schemes with the largest net healthcare deficits in 2016 and 2017

Ref. no.	Name of medical scheme	Type	Net healthcare result			Solvency ratio	
			2017 R'000	2016 R'000	% growth	2017 %	2016 %
1580	South African Police Service Medical Scheme (POLMED)	Restricted	(344 192)	(190 798)	-80.4	46.4	50.4
1140	Medshield Medical Scheme	Open	(256 764)	(139 693)	-83.8	44.6	52.1
1012	Anglo Medical Scheme	Restricted	(108 375)	(135 311)	19.9	487.1	529.2
1422	Topmed Medical Scheme	Open	(81 161)	(82 107)	1.2	72.6	77.9
1469	Nedgroup Medical Aid Scheme	Restricted	(58 227)	(67 832)	14.2	32.2	32.9
1600	Motohealth Care	Restricted	(58 087)	(36 443)	-59.4	49.0	51.6
1582	Transmed Medical Fund	Restricted	(54 991)	64 351	-185.5	21.2	20.7
1446	Selfmed Medical Scheme	Open	(50 649)	(39 317)	-28.8	92.4	106.8
1194	Profmed	Restricted	(44 574)	(42 628)	-4.6	52.5	57.3
1548	Medipos Medical Scheme	Restricted	(43 503)	(47 104)	7.6	95.7	111.9
1141	Spectramed	Open	(39 754)	(53 941)	26.3	29.4	30.2
1279	Bankmed	Restricted	(36 381)	(128 822)	71.8	38.8	40.1
1068	De Beers Benefit Society	Restricted	(36 227)	(26 232)	-38.1	152.6	153.0
1209	South African Breweries Medical Aid Scheme (SABMAS)	Restricted	(33 552)	(9 608)	-249.2	63.6	75.3
1034	Cape Medical Plan	Open	(27 925)	(11 552)	-141.7	112.3	115.3
1214	Old Mutual Staff Medical Aid Fund	Restricted	(26 967)	(32 481)	17.0	31.9	35.6
1441	Parmed Medical Aid Scheme	Restricted	(26 070)	(31 359)	16.9	72.3	76.3
1291	Witbank Coalfields Medical Aid Scheme	Restricted	(24 682)	(18 209)	-35.6	121.6	111.8
1507	Barloworld Medical Scheme	Restricted	(23 552)	(19 885)	-18.4	82.5	83.6
1270	Golden Arrow Employees' Medical Benefit Fund	Restricted	(22 221)	(21 438)	-3.7	183.4	163.0

A total of 47.6% (10 of 21) of open schemes and 60.0% (36 of 60) of restricted schemes showed net healthcare deficits during the year.

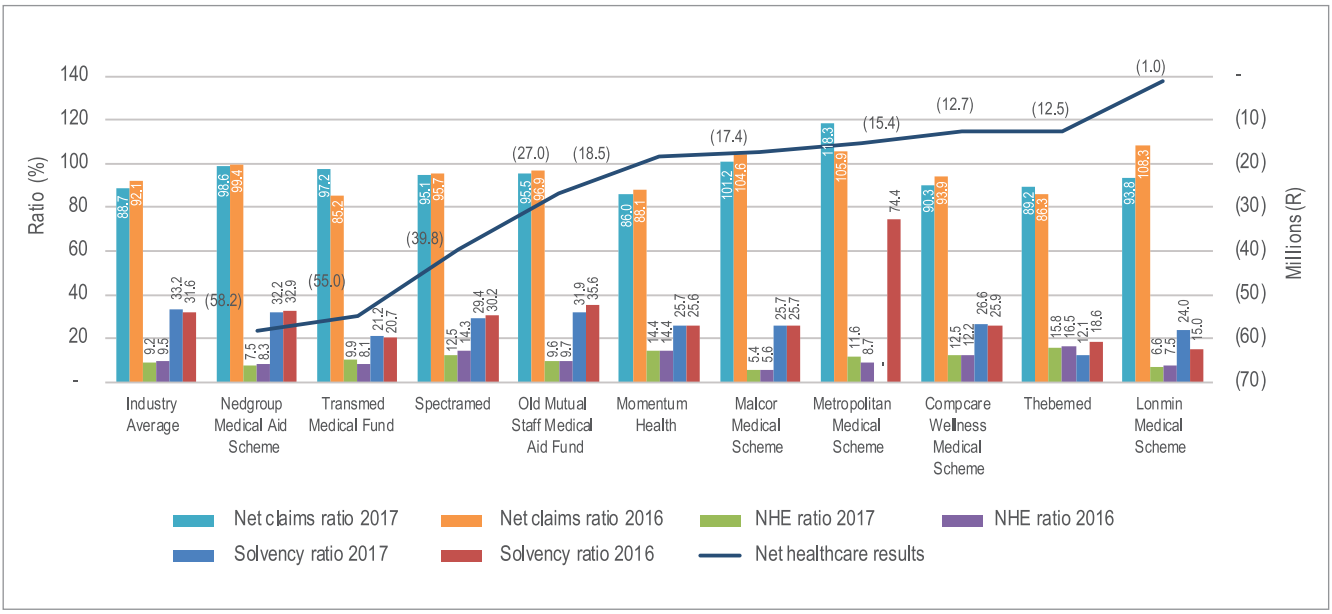
The net surplus of all schemes combined, after investment income and consolidation adjustments, was R8.9 billion (2016: R2.2 billion). Net investment and other income as well as expenditure increased by 23.0% to R5.6 billion. Open schemes made a R4.0 billion (2016: R1.4 billion) surplus, and restricted schemes a surplus of R4.9 billion (2016: R0.7 billion).

Figures 71 and 72 show the impact of the increases in claims costs and non-healthcare expenditure on the NHC result.

The net healthcare and net results of all schemes since 2000 are reflected in Figure 71.

Figure 72 shows the schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 33.2%. (Annexure Y provides more details.)

Figure 72: Schemes with the largest net healthcare deficits and solvency levels below the industry average of 33.2% in 2017



Accumulated funds, solvency, and solvency trends

Figure 73 below shows that overall, medical schemes experienced a surplus of R8.9 billion, compared to R2.2 billion in 2016 – representing an increase of 314.5%. The net assets in terms of Regulation 29 of the Medical Schemes Act increased by 15.5% from R51.7 billion in 2016 to a reported R59.7 billion in 2017.

Figure 73: Net surplus and net assets as per Regulation 29

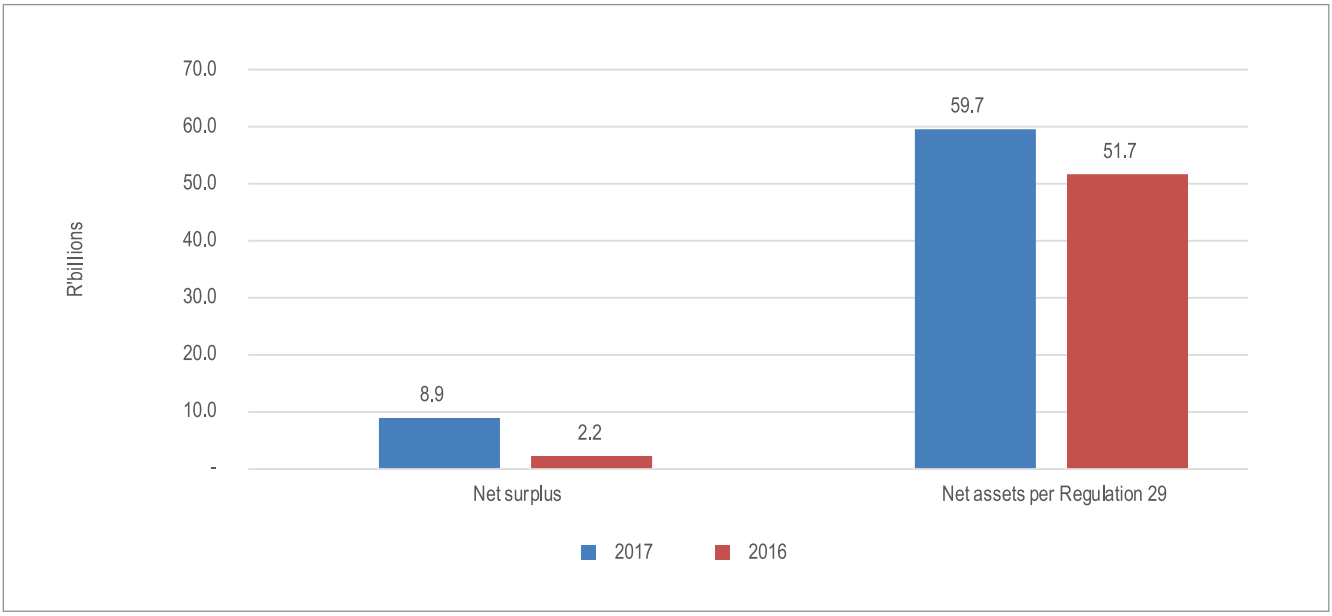
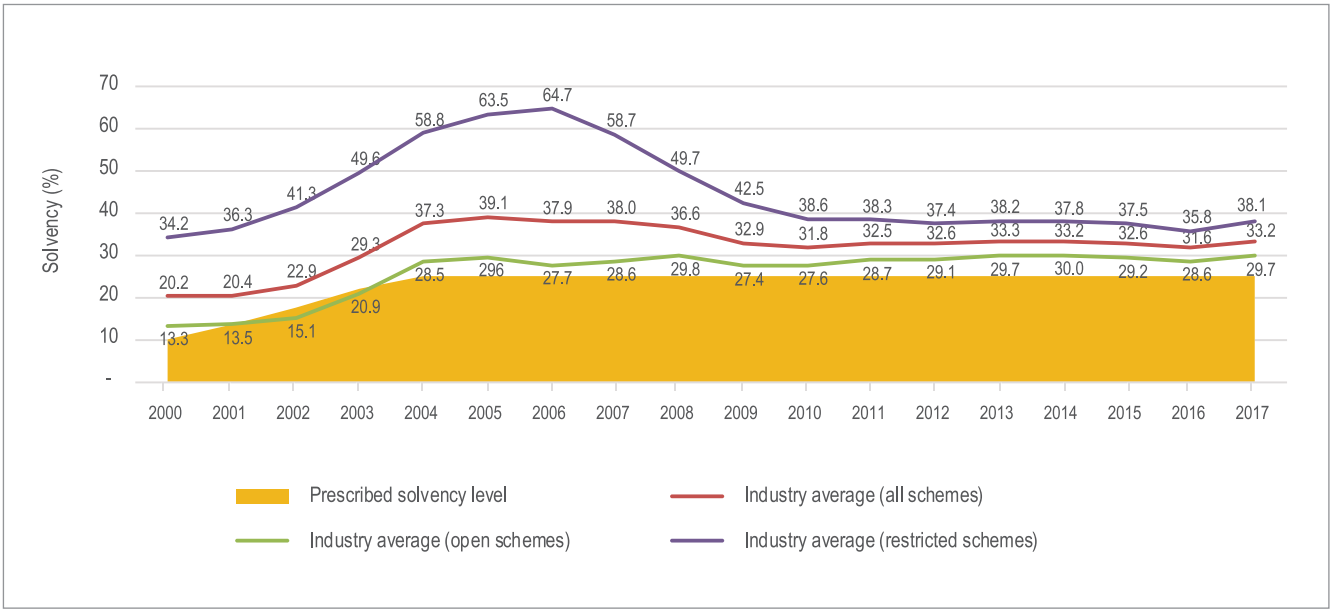


Figure 74: Industry solvency for all schemes for 2000-2017



Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds 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 25.0% of gross contributions, except for new medical schemes in which case phase-in solvency ratios will apply. The phase-in solvency ratio is 10% during the first year of operation, 13.5% during the second year, 17.5% during the third year, and not less than 22% during the fourth year.

These minimum accumulated funds are more commonly called the 'reserves' of a scheme. When expressed as a percentage of gross contributions, they become known as the 'solvency ratio' of a scheme.

A prescribed solvency ratio serves both to protect members' interests and to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities, or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations.

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, 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 are, inter alia:

- membership growth;
- the performance of the medical scheme (claims and non-healthcare expenditure);
- utilisation of benefits; and
- 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 or members' funds (total assets minus total liabilities) rose by 17.6% to end 2017 at R63.6 billion. Accumulated funds grew by 17.2 % to R61.5 billion from the R52.5 billion recorded in 2016.

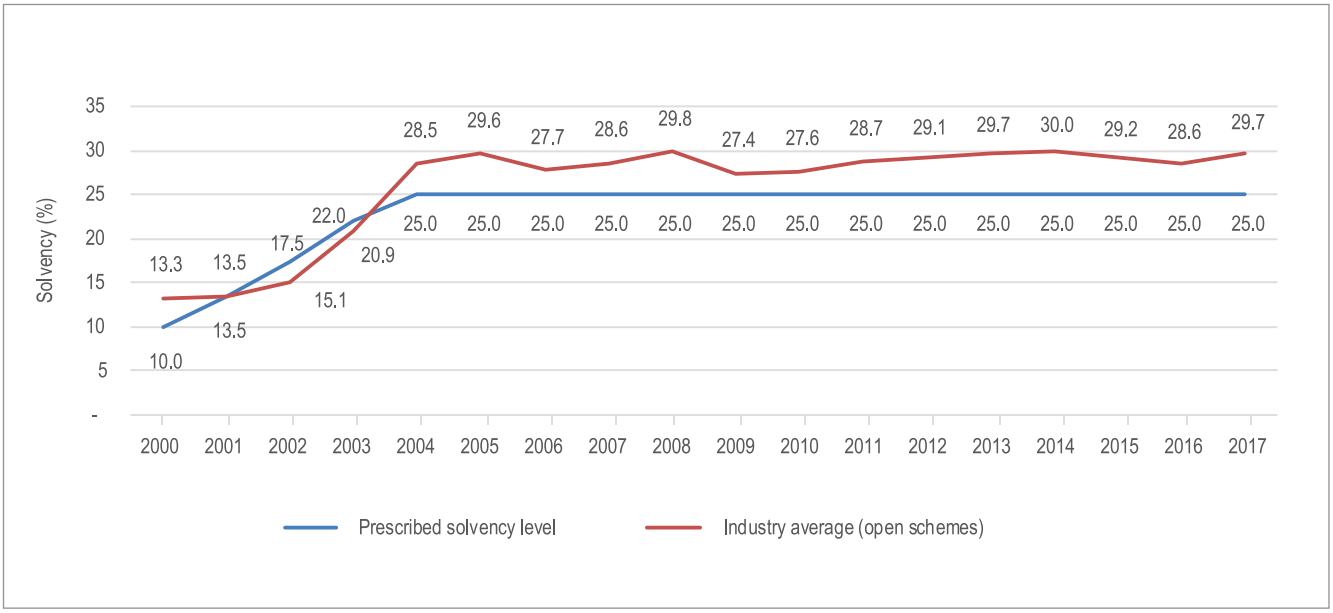
The industry average solvency ratio increased to 33.2% in 2017 from 31.6% in 2016.

The solvency ratio of open schemes increased by 3.8% to 29.7% in 2017 (2016: 28.6%) . Restricted schemes experienced an increase of 6.4% in their solvency ratio – 38.1% from 35.8% in 2016 .

The overall industry average solvency ratio increased consistently from 2000 to 2005. Schemes were required to have reached the 25% solvency ratio in 2005.

As indicated in Figure 75, the open industry remained fairly constant between 2004 and 2017, – at slightly above the 25.0% solvency ratio prescribed by the Medical Schemes Act.

Figure 75: Industry solvency for open schemes for 2000-2017



As indicated in figure 76 the restricted scheme industry was at its peak in 2006 and declined from 2007 onwards. This is mostly due to the denominator that is used in the solvency calculation (gross contributions), which is affected by membership growth. The Government Employee Medical Scheme (GEMS), which is the largest restricted scheme, has shown exceptional membership growth since registration, and this resulted in deterioration in the solvency level of the restricted schemes industry. The growth in GEMS has since slowed down, as much of its target market is covered.

Figure 76: Industry solvency for restricted schemes for 2000-2017

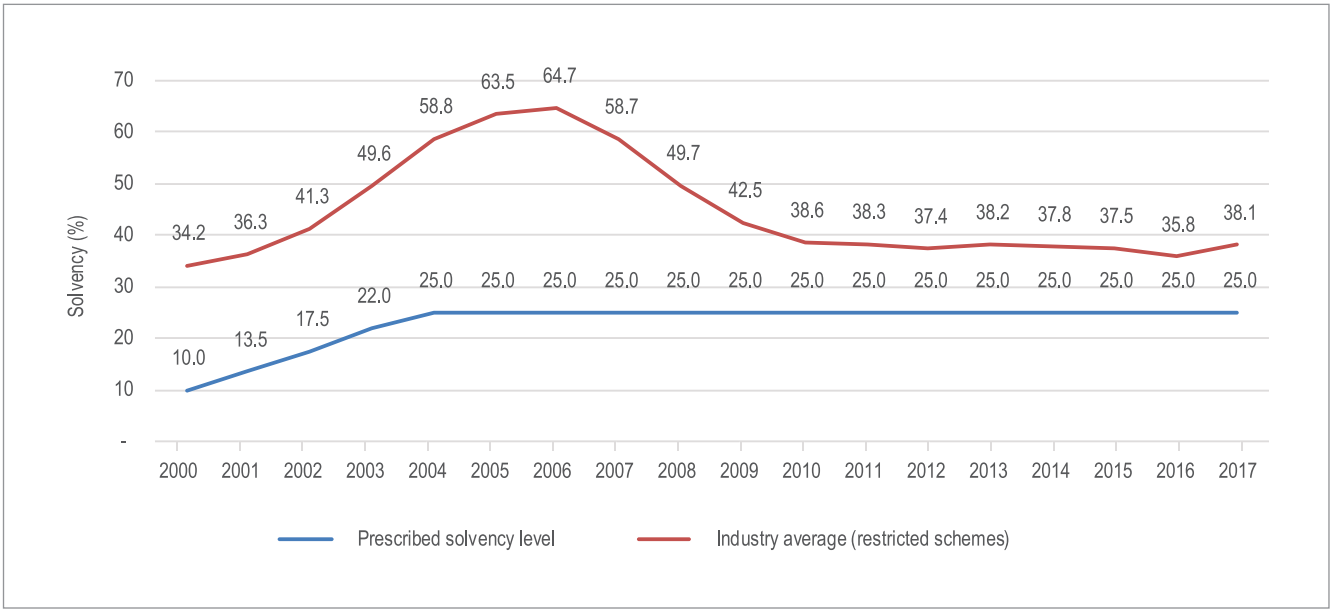


Table 49: Risk claims, non-healthcare expenditure, and reserve-building as a percentage of contributions for 1999-2017

	Risk claims % of RCI	Non-healthcare expenditure % of RCI	Reserve-building % of RCI
1999	91.5	12.7	-4.2
2000	89.3	14.5	-3.7
2001	83.2	16.2	0.6
2002	82.1	15.2	2.8
2003	79.2	15.4	5.4
2004	78.6	15.5	5.9
2005	84.1	16.8	-
2006	88.0	16.2	-4.1
2007	86.5	15.2	-1.8
2008	86.9	14.5	-1.4
2009	89.3	14.0	-3.3
2010	87.3	13.2	-0.5
2011	86.5	12.4	1.1
2012	87.7	12.3	-
2013	86.5	12.2	1.3
2014	90.8	9.5	-0.4
2015	91.4	9.5	-0.9
2016	92.1	9.5	-1.6
2017	88.7	9.2	2.1

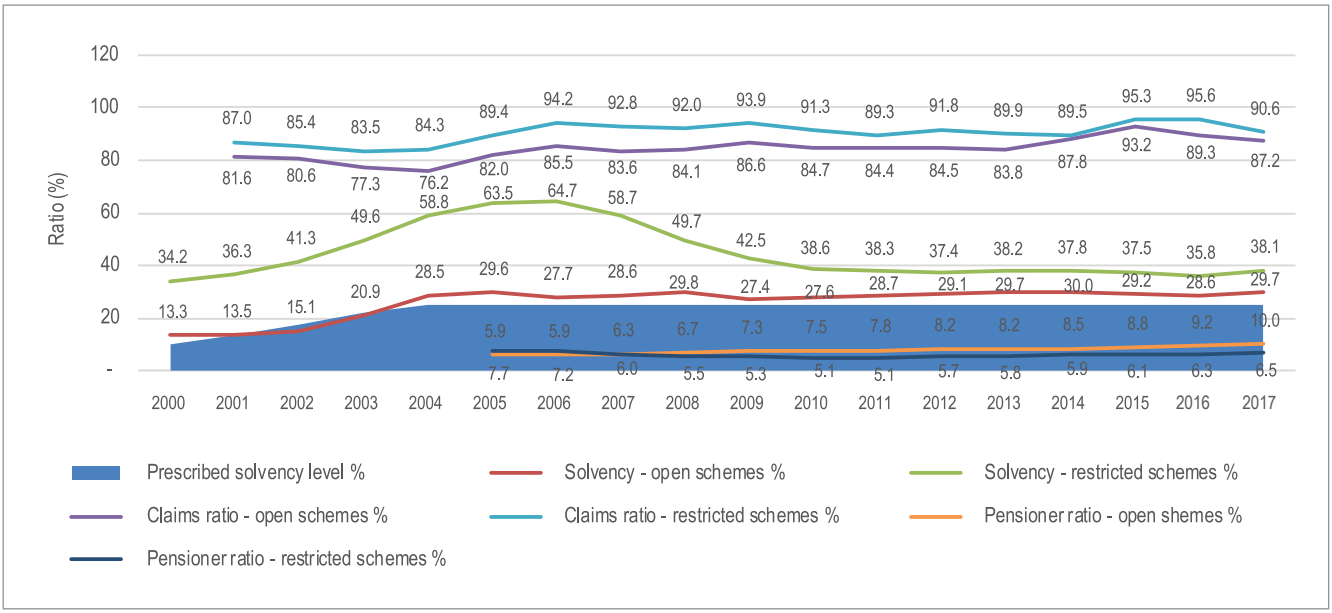
RCI = Risk Contribution Income

The table above illustrates the relationship between risk claims, non-healthcare expenditure, and reserve building. Risk claims appear to have more of an impact on reserve building than non-healthcare expenditure. 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 91.5% and reserves decreased by 4.2%, while in 2004 risk claims amounted to 78.6% and reserves increased by 5.9%.

Total risk claims fell between 2000 and 2004, and the ratio of contributions to reserves improved during this period from -3.7% to 5.9%. Non-healthcare expenditure grew during this period, largely at the expense of claims. Risk claims were at their lowest in 2004, and then started to increase in 2005 – reaching 92.1% in 2016. In this respect, it is important to note that the 2014 and 2015 risk claims ratios have been restated to include accredited managed healthcare services as per the requirements of Circular 56 of 2016; whilst it had been excluded from the non-healthcare expenditure ratio. Contributions to reserves were negative during this time, which was consistent with the fact that most medical schemes had attained the prescribed solvency ratio of 25.0% and did not need to grow their reserves any further. 2017 saw a reduction in the claims ratio to 88.7%, whilst positive reserve building of 2.1% 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.

Figure 77 illustrates the impact of GEMS on all medical schemes. This restricted scheme was registered on 1 January 2005, but only started with operations on the 1st of January 2006.

Figure 77: The impact of GEMS for 2006-2017*

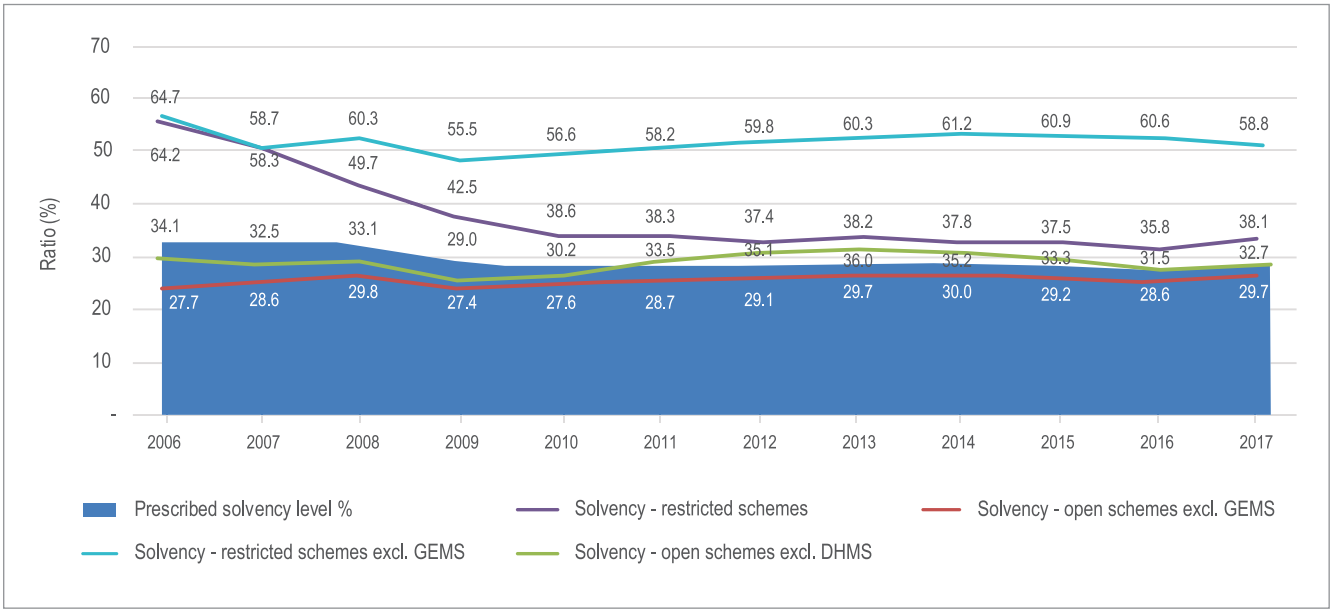


** Claims data per industry was available only from 2001 onwards, and pensioner ratios from 2005 onwards.*

GEMS initially had a positive effect on the solvency levels of open schemes. Many of these schemes had previously structured their benefits specifically for government employees who have steadily left them to join GEMS. The reserves that these members had accumulated over the years in open schemes were not transferred to GEMS.

A negative impact was subsequently experienced on some of these open schemes' claiming patterns, as the members who left them to join GEMS tended to be young and healthy, and they were not necessarily replaced by members of a similar profile.

Figure 78: Industry solvency ratios, excluding GEMS and DHMS



Excluding GEMS, the restricted industry solvency ratio decreased in 2009 to 55.5%, and then increased from 2010 onwards to 60.6% in 2016 – with a subsequent reduction to 58.8% in 2017. The solvency ratio of the restricted scheme industry is much lower when GEMS results are included. This indicates the significant impact of GEMS on the restricted schemes industry.

In comparison, Discovery Health Medical Scheme (DHMS) has a lesser impact on the open scheme industry. Excluding DHMS, the 2017 open industry solvency ratio increases to 32.7% (from 29.7%). 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 being highly priced, causing the younger and lower-claiming members to move to other, less expensive options – or even other medical schemes. This results in the scheme losing the cross-subsidy provided by these younger members and therefore to an increase in losses, resulting in even higher contribution increases and/or reductions in benefits.

Beneficiaries of schemes that failed to reach the 25.0% solvency

Table 49 and Figure 78 show both the number of medical schemes which have yet to attain the prescribed solvency ratio of 25.0% and the number of beneficiaries in those schemes.

Table 50: Prescribed solvency and number of beneficiaries for 2000-2017

	Number of open schemes		Number of restricted schemes	
Year	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
2000	15	33	15	86
2001	19	29	11	83
2002	24	25	7	86
2003	19	29	7	80
2004	18	30	4	81
2005	17	29	4	79
2006	18	23	4	79
2007	18	23	7	74
2008	14	21	8	71
2009	16	17	3	71
2010	12	15	7	66
2011	9	17	5	66
2012	7	18	4	63
2013	6	18	3	60
2014	5	18	2	58
2015*	3	19	3	57
2016*	3	18	3	57
2017*	3	18	3	56

	Number of beneficiaries in open schemes			Number of beneficiaries in restricted schemes		
	Below prescribed level		Above prescribed level	Below prescribed level		Above prescribed level
Year	At end	%	At end	At end	%	At end
2000	2 385 051	51.0	2 291 048	839 029	40.9	1 214 412
2001	2 650 934	55.6	2 117 142	576 462	28.9	1 419 862
2002	3 519 329	74.4	1 211 882	251 050	12.7	1 731 873
2003	3 426 988	72.6	1 291 809	222 430	11.4	1 730 574
2004	2 534 273	53.3	2 221 030	80 160	4.2	1 827 100
2005	2 783 108	56.7	2 122 444	36 359	1.9	1 893 710
2006	3 218 382	63.7	1 832 056	145 369	7.0	1 931 536
2007	3 139 176	63.4	1 812 141	689 865	26.0	1 964 054
2008	1 076 450	22.0	3 812 456	981 977	32.9	2 003 943
2009	992 523	20.6	3 822 811	1 254 151	38.6	1 999 020
2010	2 918 055	60.8	1 881 860	1 684 682	47.9	1 831 121
2011	2 855 072	60.0	1 905 042	1 865 313	49.5	1 900 982
2012	2 796 583	58.8	1 963 411	1 978 668	50.4	1 943 538
2013	2 860 768	59.0	1 986 141	1 994 813	50.7	1 936 586
2014	212 169	4.3	4 687 806	1 914 481	48.9	2 000 002
2015	177 807	3.6	4 743 470	1 943 387	50.2	1 927 683
2016	811 038	16.4	4 129 033	1 908 478	48.6	2 016 423
2017	779 925	15.7	4 180 530	1 876 641	48.0	2 034 940

**Community Medical Aid Scheme (COMMED) was excluded from this table for the 2015 – 2017 period.*

The total number of schemes below 25% has declined since 2001. Although there have been numerous amalgamations, the reduction in schemes below 25% was not mainly due to amalgamation but also due to schemes attaining the minimum solvency ratio

Figure 79: Prescribed solvency and number of beneficiaries in 2016 and 2017

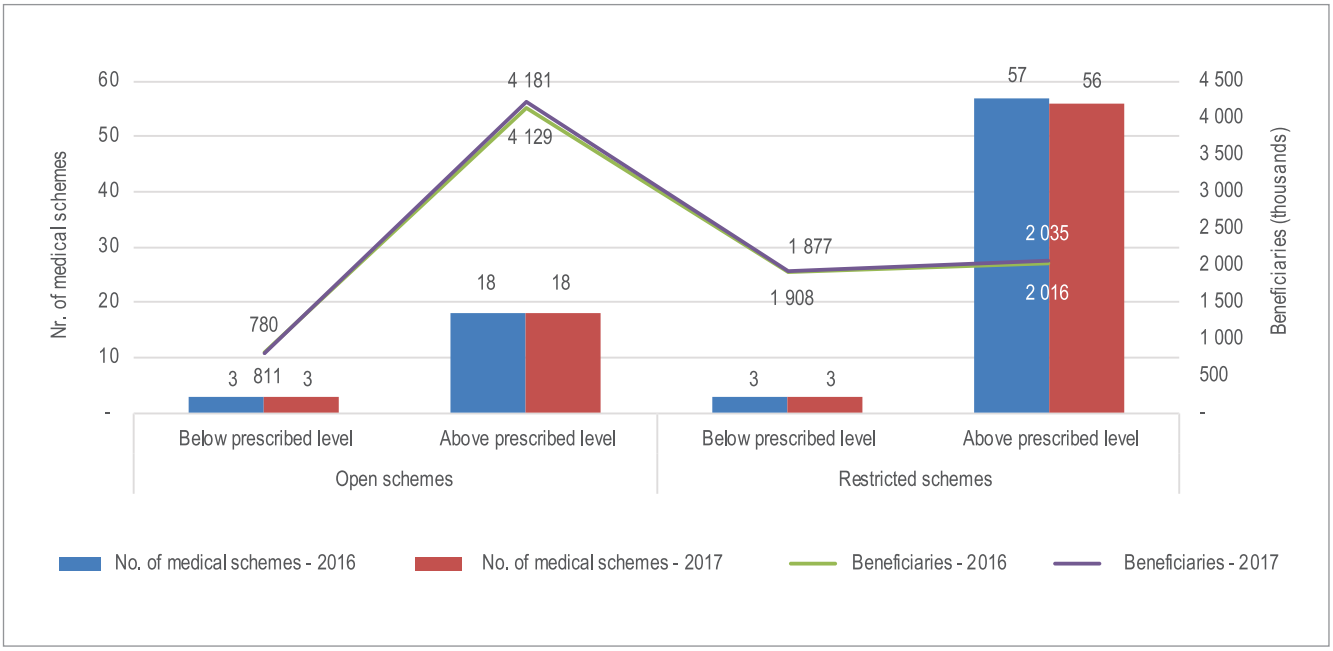
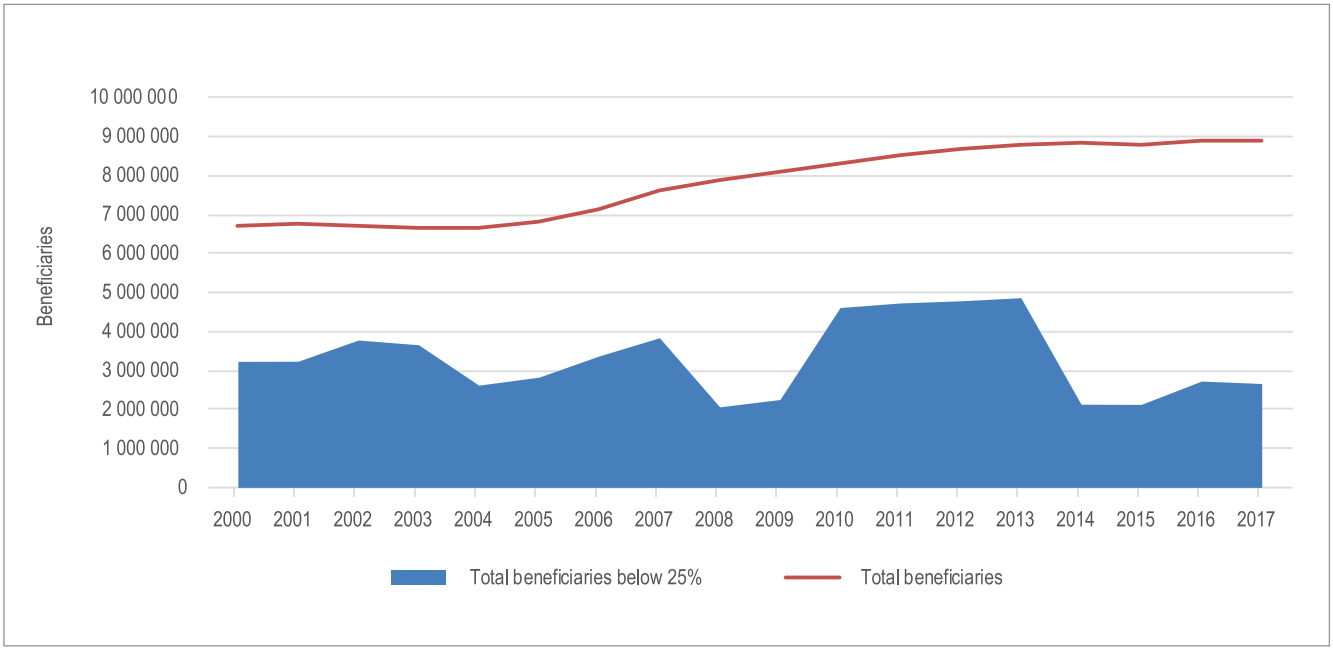


Figure 80: Schemes on close monitoring for 2000 - 2017



A total of 15.7% of beneficiaries in open schemes (2016: 16.4%) were covered by the three open schemes (2016: 3) that failed to meet the prescribed solvency level in 2017. The remaining beneficiaries belonged to the other 18 open schemes (2016: 18) that had attained the prescribed solvency level of 25%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25%. 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% – in 2008, 2009, 2014, 2015, 2016, and 2017 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015 this figure was a mere 3.6% compared to 59.0 % in 2013. In 2016, Bonitas Medical Fund fell below 25%, increasing the percentage again to 16.4%.

Of the 59 restricted schemes at the end of 2017, only three had solvency ratios below 25%. These three, however, accounted for 48.0% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory solvency level of 25%, and this accounts for 96.3% of beneficiaries in schemes that have yet to achieve the prescribed solvency ratio.

Table 51 below provides a summary of the performance of schemes that were below the required statutory minimum solvency of 25% as at 31 December 2017.

Table 51: Summary of performance of schemes below 25% solvency in 2017

Ref. no.	Name of scheme	Average beneficiaries	Average age pb years	Pensioner ratio %	Net claims ratio %		Net surplus/(deficit) R'000		Solvency ratio %	
		2017	2017	2017	2017	2016	2017	2016	2017	2016
1592	Thebemed	23 511	28.3	0.5	89.2	86.3	(12 496)	(5 849)	12.1	18.6
1598	Government Employees Medical Scheme (GEMS)	1 805 268	30.5	6.0	86.0	96.6	2 877 730	(723 160)	15.2	7.0
1575	Resolution Health Medical Scheme	28 839	42.0	17.7	86.9	87.5	1 682	(898)	15.2	12.2
1582	Transmed Medical Fund	49 165	53.6	42.4	97.2	85.2	(54 991)	64 351	21.2	20.7
1599	Lonmin Medical Scheme	23 065	37.0	0.1	93.8	108.3	(969)	(28 597)	24.0	15.0
1512	Bonitas Medical Fund	731 494	33.3	8.3	88.3	92.1	345 854	(257 997)	24.5	24.4

pb = per beneficiary

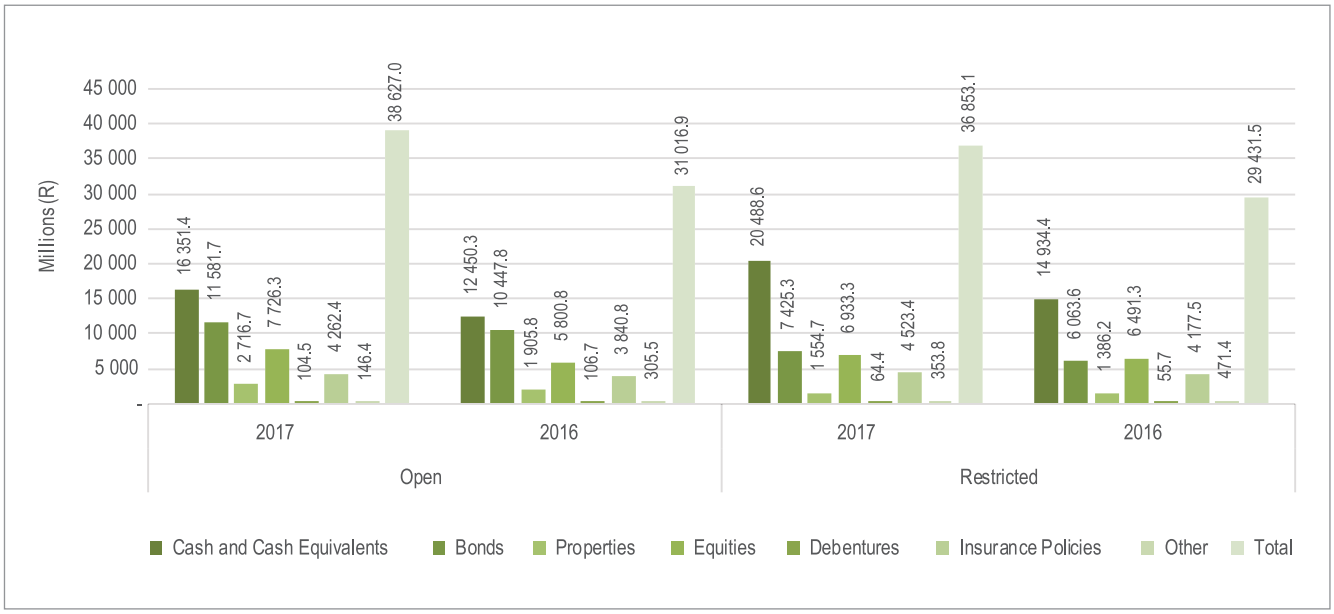
The CMS closely monitors schemes below the 25% solvency ratio, by having regular meetings with them in order to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes environment, and the progress that schemes have made so far in moving towards the prescribed solvency levels – but much remains to be done in ensuring that all medical schemes comply with this requirement of the Medical Schemes Act.

Investments

Figure 81 provides information on the investments of medical schemes as at the end of the years 2016 and 2017. Investments

Figure 81: Scheme investments in 2016 and 2017



In open schemes, 41.7% of investments (2016: 40.1%) were held in cash or cash equivalents. Bonds accounted for 29.6% (2016: 33.7%), debentures for 0.3% (2016: 0.3%), equities for 19.7% (2016: 18.7%), non-linked insurance policies for 1.4% (2016: 0.0%), properties for 6.9% (2016: 6.1%), and other investments for 0.4% (2016: 1.0%).

Restricted schemes also held a large proportion of their investments (55.6%) in cash or cash equivalents (2016: 50.7%). Their bonds accounted for 20.1% (2016: 20.6%) and debentures for 0.2% (2016: 0.2%). Equities made up 18.8% (2016: 22.1%), non-linked insurance policies 0.1% (2016: 0.1%), properties 4.2% (2016: 4.7%), and other investments 1.0% (2016: 1.6%).

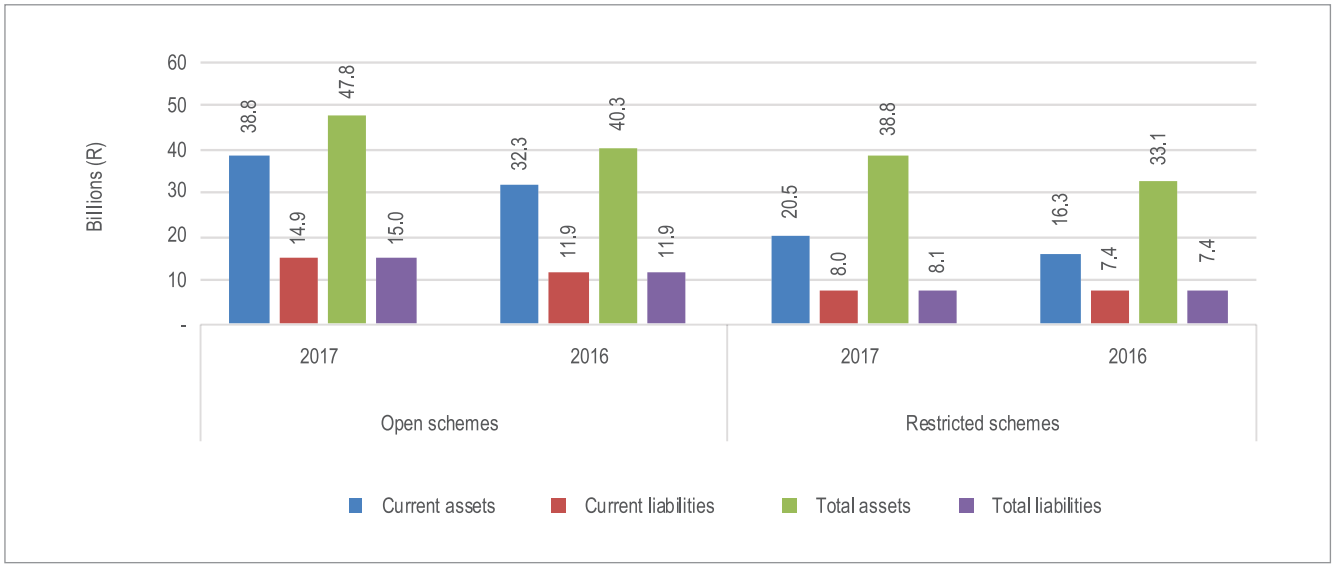
The primary obligation of a medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries when those benefits fall due. The management of its assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities. The assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately.

The difference between the total assets of a scheme and its total liabilities represents the liquidity gap. A positive number indicates that the scheme has sufficient assets to meet its liabilities. A negative number, on the other hand, indicates that the scheme has greater liabilities than assets and is therefore technically insolvent and in breach of section 35(3) of the Medical Schemes Act.

Schemes should pay attention to more than just their total asset and liability positions; they should also consider the periods in which liabilities must be paid and in which assets can be converted into cash flows.

Figure 82 compares the matching of assets and liabilities in open and restricted schemes.

Figure 82: Matching of assets and liabilities in 2016 and 2017



The current assets to current liabilities ratio in open schemes was 2.6:1 in 2017 (2.7:1 in 2016) and it was 2.6:1 (2016: 2.2:1) in restricted schemes. The total asset to total liability ratio for open and restricted schemes in 2017 was 3.2:1 (2016: 3.4:1) and 4.8:1 (2016: 4.5:1) 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 3.6 months, boards of trustees must guard against longer-term, riskier investments.

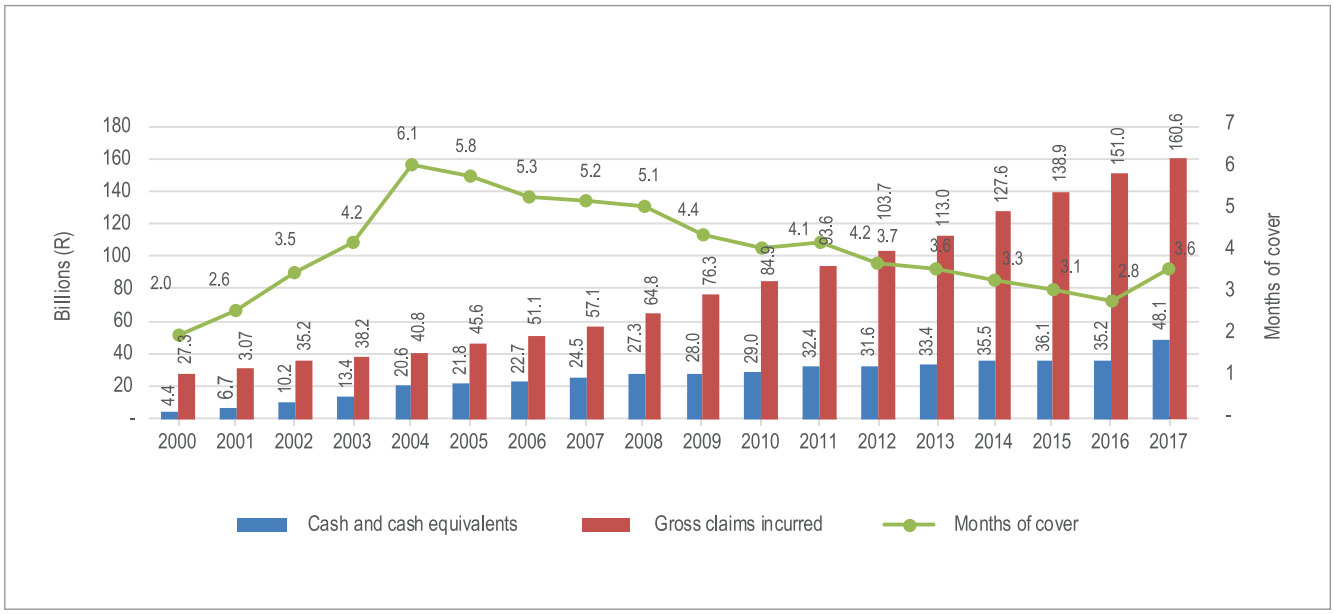
Although such investments may offer the prospect of higher returns, they may prove detrimental to the scheme should it experience a liquidity crunch.

Claims-paying ability of schemes

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

Figure 83 depicts the claims-paying ability of schemes measured in months of cover. This is the number of months for which the scheme can pay claims from its existing cash and cash equivalents.

Figure 83: Average gross claims covered by cash and cash equivalents for 2000-2017

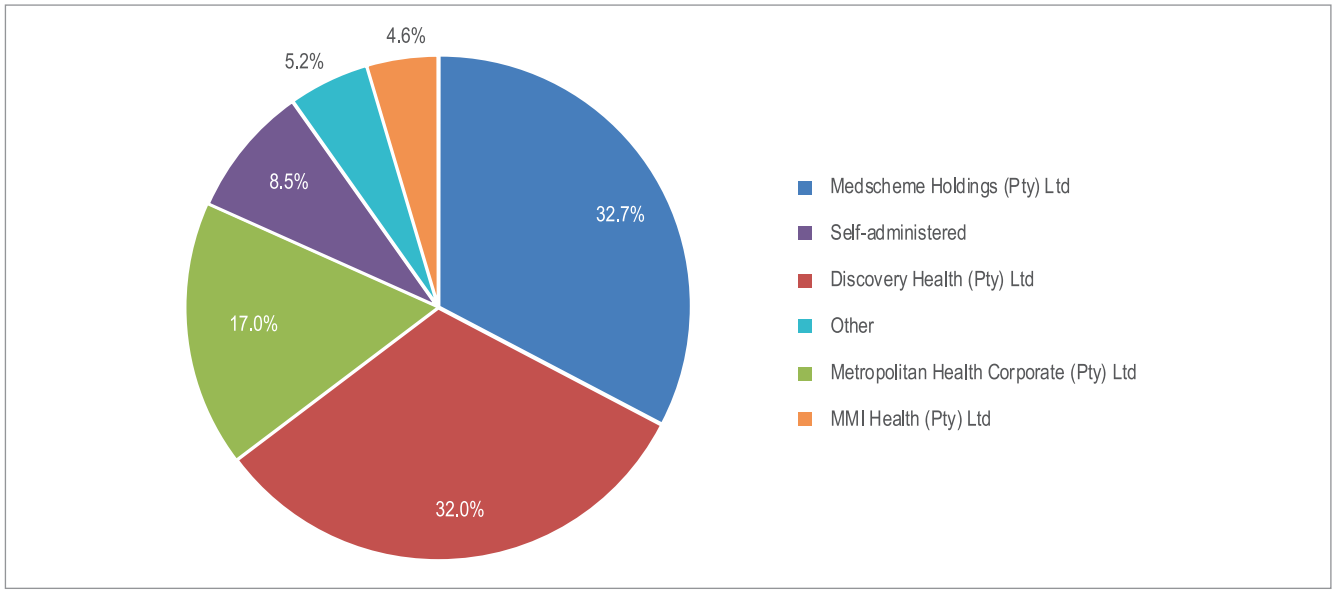


The length of cash coverage improved from 2.8 months in 2016 to 3.6 months in December 2017. Payment cycles of medical schemes in 2017 were an average of 18.3 days compared with 14.0 days in 2016.

Administrator market

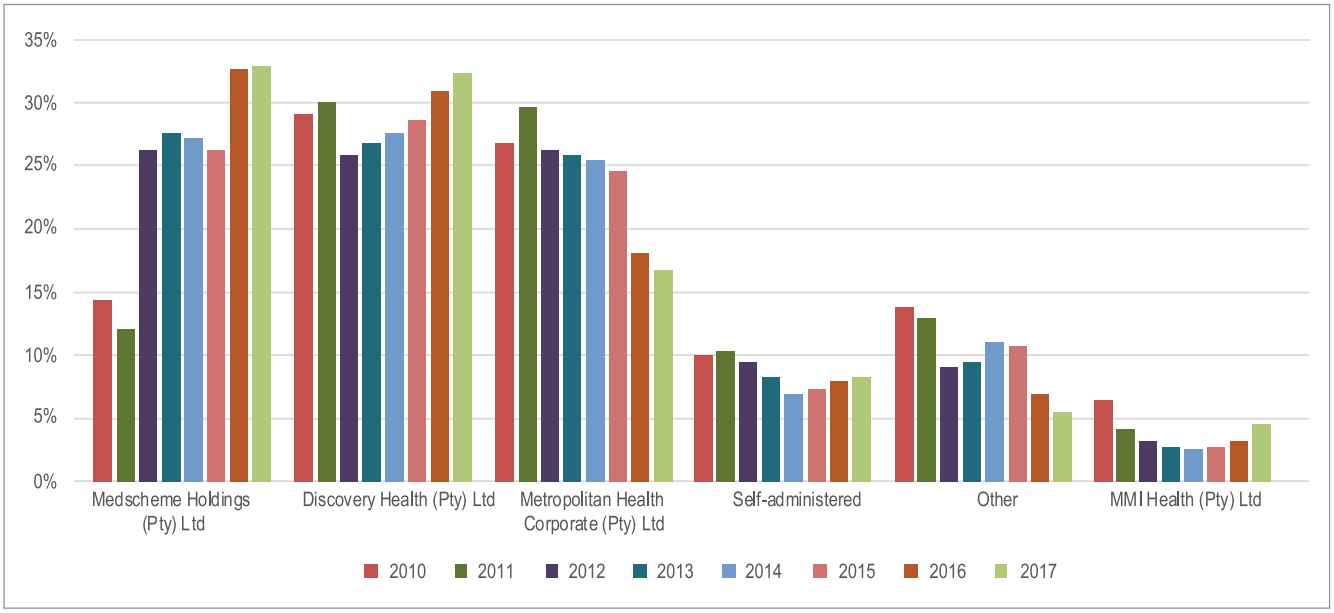
Figure 84 shows the market share of medical scheme administrators as well as self-administered medical schemes, based on the average number of beneficiaries administered at the end of 2017[6].

Figure 84: Administrator market share at the end of 2017



[6]The data that is presented here differs from Annexure AE that is based on the average membership administered during the year.

Figure 85: Market share of largest administrators based on average number of beneficiaries for 2010-2017*



** 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 AE).*

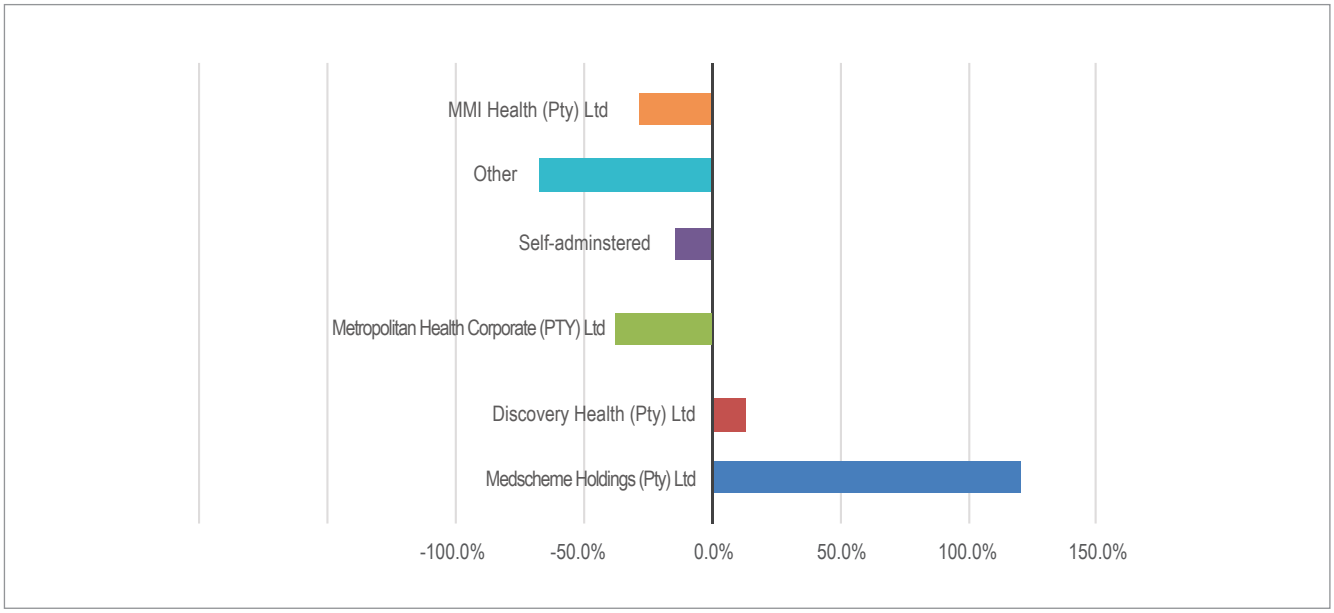
Four third-party administrators continued to dominate the market in 2017, namely (in order of market share):

- Medscheme Holdings (Pty) Ltd
- Discovery Health (Pty) Ltd
- Metropolitan Health Corporate (Pty) Ltd
- MMI Health (Pty) Ltd.

Collectively, the above companies administer 86.3% of the market (excluding self-administered medical schemes).[7] Figure 86 indicates the change in administrator market share between 2010 and 2017.

Figure 86 below shows the change in market share for the administrators with the largest share of the market for all schemes, between 2010 and 2017. Overall, Medscheme Holdings (Pty) Ltd grew by 124.0% and is now the largest administrator, with a market share of 32.7%.

Figure 86: Percentage change in administrators with largest market share for all schemes for 2010 -2017



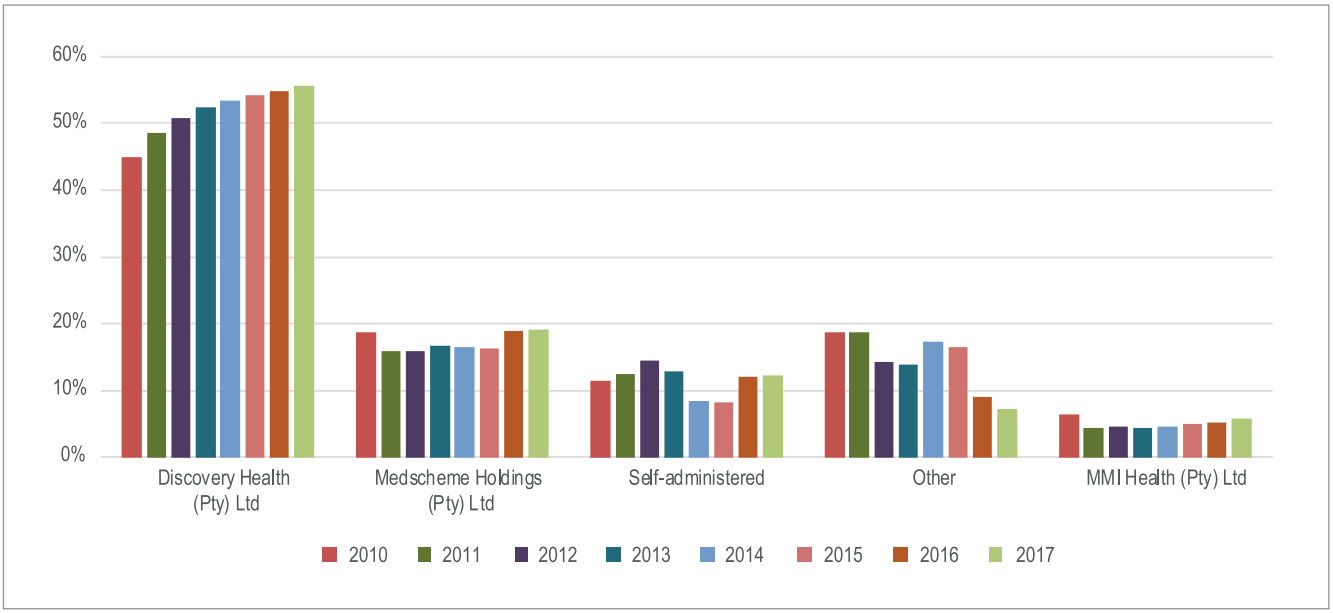
[7]The Government Employees Medical Scheme (GEMS) had a joint administrator contract in place since 2012. Medscheme Holdings (Pty) Ltd was responsible for its contribution and debt management as well as correspondence services, and Metropolitan Health Corporate (Pty) Ltd was responsible for member and claims management services as well as the provision of financial and operational information. The membership was included for both administrators.

Table 52: Administrator market share for 2010-2017

Largest market share – all schemes	2010	2011	2012	2013	2014	2015	2016	2017	% change: 2010 - 2017
Medscheme Holdings (Pty) Ltd	14.6%	12.2%	26.7%	27.4%	27.2%	26.7%	32.6%	32.7%	124.0%
Discovery Health (Pty) Ltd	28.9%	30.1%	25.7%	26.3%	27.2%	28.3%	30.9%	32.0%	10.7%
Metropolitan Health Corporate (Pty) Ltd	27.0%	29.8%	25.8%	25.5%	25.3%	24.7%	18.0%	17.0%	-37.0%
Self-administered	9.8%	10.2%	9.2%	8.5%	6.6%	6.7%	8.4%	8.5%	-13.3%
Other	13.8%	13.2%	8.8%	9.1%	10.8%	10.6%	6.9%	5.2%	-62.3%
MMI Health (Pty) Ltd	6.0%	4.5%	3.8%	3.1%	2.9%	3.0%	3.2%	4.6%	-23.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Largest market share – open schemes									
Discovery Health (Pty) Ltd	44.9%	48.5%	50.8%	52.4%	53.4%	54.2%	54.8%	55.7%	24.1%
Medscheme Holdings (Pty) Ltd	18.6%	15.9%	15.9%	16.6%	16.5%	16.2%	18.8%	19.1%	2.7%
Self-administered	11.5%	12.5%	14.4%	12.9%	8.3%	8.2%	12.1%	12.2%	6.1%
Other	18.7%	18.7%	14.2%	13.8%	17.3%	16.5%	9.1%	7.2%	-61.5%
MMI Health (Pty) Ltd	6.4%	4.4%	4.6%	4.4%	4.6%	4.9%	5.2%	5.8%	-9.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Largest market share – restricted schemes									
Medscheme Holdings (Pty) Ltd	8.9%	7.3%	35.9%	36.3%	36.3%	35.8%	44.7%	44.4%	398.9%
Metropolitan Health Corporate (Pty) Ltd	64.9%	67.8%	47.4%	46.7%	46.6%	46.2%	33.7%	31.6%	-51.3%
Discovery Health (Pty) Ltd	6.2%	6.4%	4.4%	4.6%	5.1%	5.7%	10.2%	11.5%	85.5%
Self-administered	7.3%	7.1%	4.8%	4.9%	5.1%	5.5%	5.3%	5.3%	-27.4%
Other	7.4%	6.7%	4.4%	5.4%	5.4%	5.3%	4.7%	3.6%	-51.4%
MMI Health (Pty) Ltd	5.4%	4.7%	3.0%	2.1%	1.4%	1.4%	1.4%	3.6%	-33.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Figures 87 and 89 indicate the changes in administrator market share over the last eight years for open and restricted medical schemes respectively.

Figure 87: Open schemes' market share of largest administrators based on average number of beneficiaries for 2010-2017*



** 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 AE)*

Figure 86 and 88 indicate the percentage of growth or decline in market share between 2010 and 2017, for open and restricted medical schemes respectively.

Figure 88: Percentage change in administrators with largest market share for open schemes for 2010 -2017

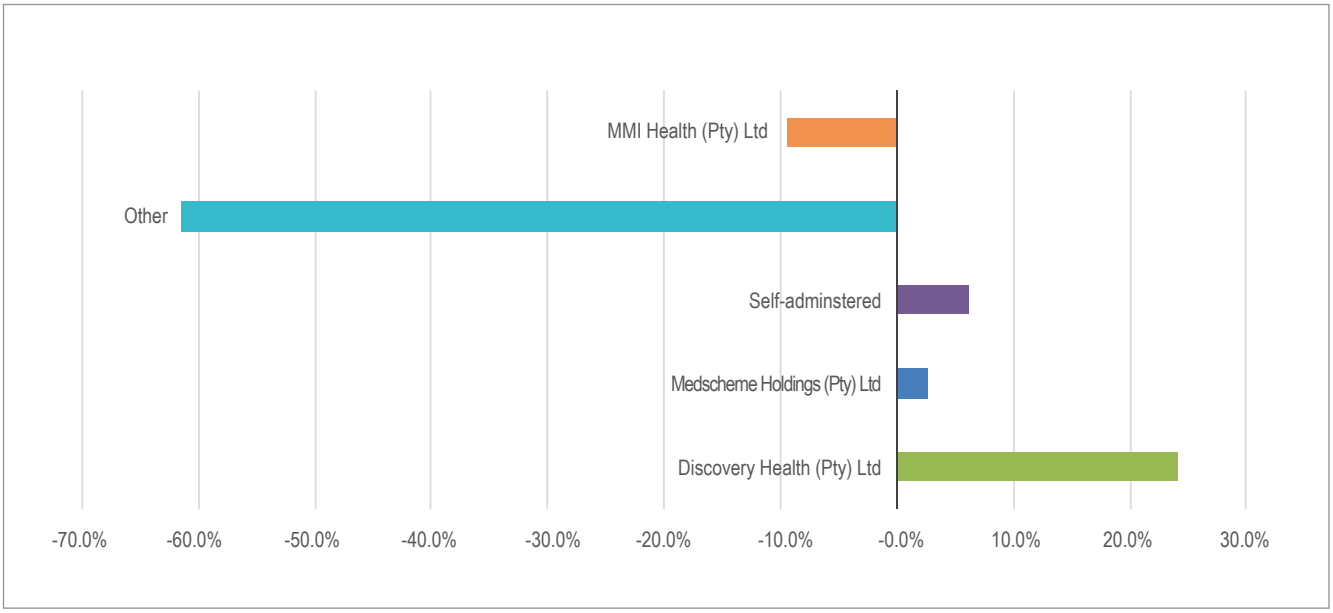
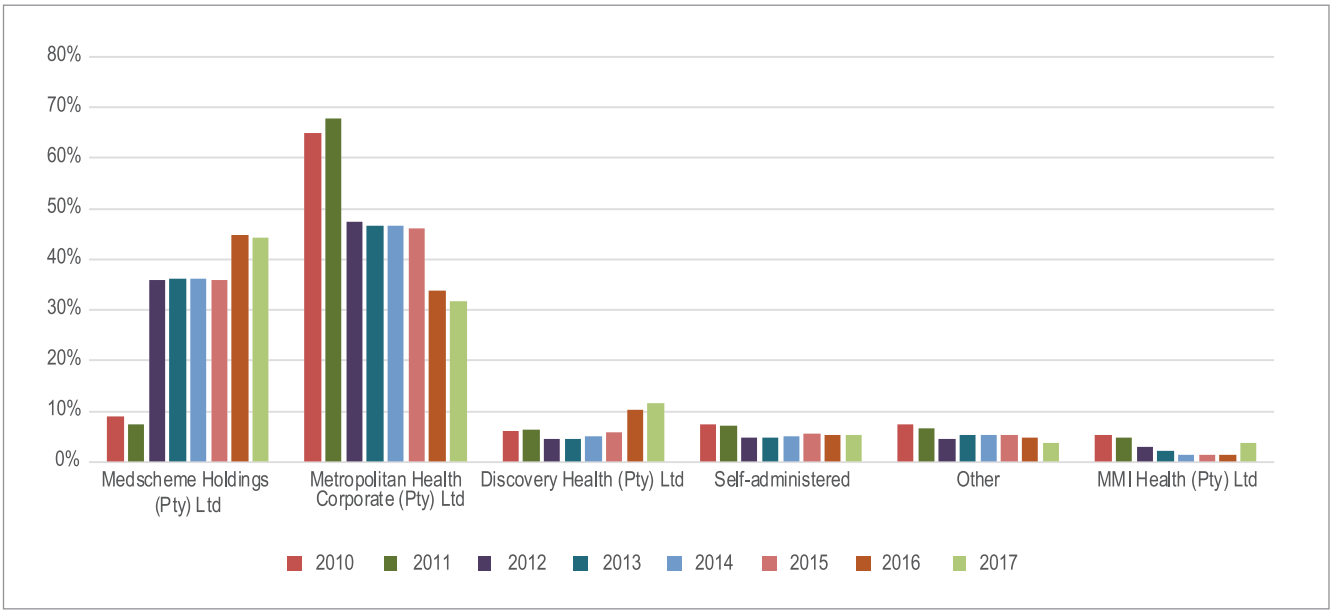


Figure 89: Restricted schemes' market share of largest administrators based on average number of beneficiaries for 2010-2017*



** 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 AE).*

Discovery Health (Pty) Ltd's share of the open schemes market increased to 55.7% (2016: 54.8%), and its share in the restricted schemes market increased to 11.5% (2016: 10.2%).

Medscheme Holdings (Pty) Ltd has the second-biggest share in the open schemes administration market at 19.1% (2016: 18.8%) and the biggest share in the restricted schemes administration market at 44.4% (2016: 44.7%). Medscheme Holdings (Pty) Ltd has been responsible for GEMS's contribution and debt management as well as correspondence services since the 1st of January 2012.

Metropolitan Health Corporate (Pty) Ltd has the second-biggest share of the restricted schemes market at 31.6% (2016: 33.7%).

Figure 90: Percentage change in administrators with largest market share for restricted schemes for 2010 -2017

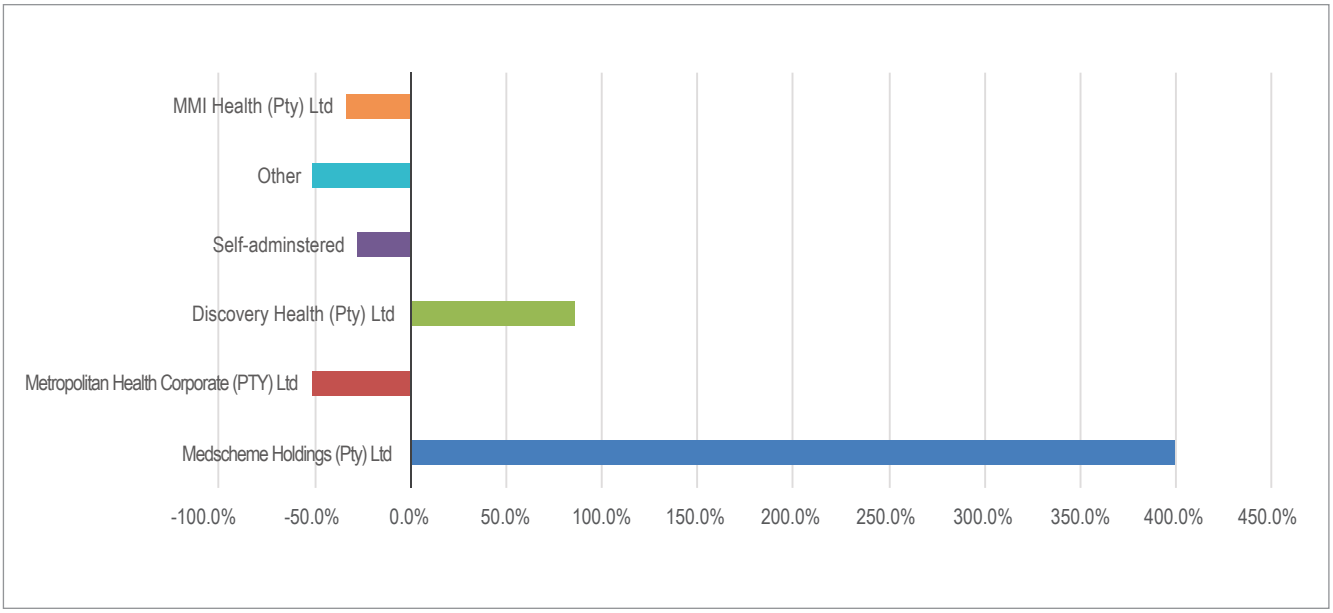


Table 53 shows the five administrators who had higher administration costs and fees than the industry average for administrators handling open schemes.

Table 53: Percentage deviation from industry average for open schemes

	Market share %	Gross administration costs %	Administration fees paid* %	Fees paid to administrators %
Discovery Health (Pty) Ltd	55.7	1.3	26.5	26.5
Universal Healthcare Administrators (Pty) Ltd	0.6	16.8	9.2	9.2
Sechaba Medical Solutions (Pty) Ltd	2.4	25.4	5.8	5.8
Agility Health (Pty) Ltd	1.0	56.0	3.9	3.9
Professional Provident Society Healthcare Administrators (Pty) Ltd	1.5	26.3	-4.5	-4.5

** Excluding co-administration fees*

Table 54 shows the three administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

Table 54: Percentage deviation from industry average for restricted schemes

	Market share %	Gross administration costs %	Administration fees paid* %	Fees paid to administrators %
Sanlam Health Administrators (Pty) Ltd	0.8	91.2	82.1	82.1
Professional Provident Society Healthcare Administrators (Pty) Ltd	1.2	90.8	39.8	39.8
MMI Health (Pty) Ltd	3.6	7.7	-3.0	-8.2

** 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.

Tables 56 and 57 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 AE).

Table 55: Administrators with administration fees higher than the average for all administrators of R213.9 pampm

Name of Administrator	No. of medical schemes	Average members	Average beneficiaries	Market share %	Administration fees pampm
Sanlam Health Administrators (Pty) Ltd	1	25 409	46 812	0.4	303.6
Sechaba Medical Solutions (Pty) Ltd	1	48 489	116 283	1.1	274.4
Discovery Health (Pty) Ltd	19	1 614 758	3 405 610	32.0	266.6
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	67 767	143 654	1.3	243.0
Agility Health (Pty) Ltd	2	27 226	51 616	0.5	213.0

Table 56: Administrator market share 2017 for open schemes

Name of administrator	Nr. of schemes	Beneficiaries	Gross admininistration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Agility Health (Pty) Ltd	2	1.0	218.8	10.6	112.3	5.4	112.3	5.4	2 062.7	90.6
Discovery Health (Pty) Ltd	1	55.7	142.1	7.8	136.8	7.6	136.8	7.6	1 810.8	85.7
Medscheme Holdings (Pty) Ltd	3	19.1	134.6	7.5	95.3	5.3	95.3	5.3	1 796.4	87.9
MMI Health (Pty) Ltd	1	5.8	113.1	8.9	107.0	8.4	107.0	8.4	1 270.9	86.0
Private Health Administrators (Pty) Ltd	1	0.8	129.2	8.0	91.3	5.6	91.3	5.6	1 625.0	99.8
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.5	177.2	7.4	103.2	4.3	103.2	4.3	2 385.5	86.8
Providence Healthcare Risk Managers (Pty) Ltd	2	0.4	93.6	7.5	71.1	5.7	71.1	5.7	1 251.2	87.7
Sechaba Medical Solutions (Pty) Ltd	1	2.4	175.9	10.4	114.4	6.8	114.4	6.8	1 688.8	88.0
Self-Administered	6	12.2	137.9	7.6	-	-	-	-	1 817.9	91.4
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	1	0.5	115.1	12.8	79.9	8.9	79.9	8.9	896.8	89.2
Universal Healthcare Administrators (Pty) Ltd	2	0.6	163.9	10.2	118.0	7.4	118.0	7.4	896.8	89.2
Average	**21**	**100.0**	**140.3**	**7.9**	**108.1**	**6.1**	**108.1**	**6.1**	**1 776.9**	**87.2**

**Excluding co-administration fees*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Table 57: Administrators' market share in 2017 for restricted schemes

Name of administrator	Nr. of schemes	Beneficiaries	Gross admininistration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Discovery Health (Pty) Ltd	18	11.5	96.5	5.9	82.8	5.1	82.8	5.1	1 635.9	92.4
Medscheme Holdings (Pty) Ltd**	11	44.4	32.9	2.0	47.3	0.8	27.2	1.7	1 612.5	89.6
Metropolitan Health Corporate (Pty) Ltd***	1	31.6	69.5	4.2	34.4	2.1	34.4	-	1 638.6	86.0
MMI Health (Pty) Ltd	13	3.6	116.6	7.4	87.8	5.6	83.1	5.3	1 568.7	96.7
Private Health Administrators (Pty) Ltd	1	0.1	112.8	6.3	73.9	4.1	-	-	1 782.5	98.3
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.2	206.6	11.4	126.5	7.0	126.5	7.0	1 816.1	90.9
Providence Healthcare Risk Managers (Pty) Ltd	3	0.8	61.1	6.5	42.5	4.5	42.5	4.5	935.4	94.8
Sanlam Health Administrators (Pty) Ltd	1	0.8	207.1	9.9	164.8	7.9	164.8	7.9	2 088.9	88.1
Self-Administered	8	5.3	82.8	6.9	-	-	-	-	1 207.6	90.7
Universal Healthcare Administrators (Pty) Ltd	4	0.8	99.3	7.2	85.2	6.1	85.2	6.1	1 385.5	90.6
V Med Administrators (Pty) Ltd	1	0.2	108.3	5.6	90.5	4.7	90.5	4.7	1 924.2	98.3
Average	**62**	**100.0**	**62.1**	**5.7**	**33.9**	**3.1**	**39.7**	**3.6**	**1 089.0**	**90.6**

South African Breweries Medical Scheme changed its administrator from MMI Health (Pty) Ltd to Discovery Health (Pty) Ltd, with effect from the 1st of July 2017. Its membership was included in both administrators to represent the market share during the year.

**Excluding 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.*

Table 58 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 58: Total fees paid to administrators (excluding accredited managed healthcare services) and the deviation from average per administrator in 2017

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	1 305 219	288.0	96.3	266.6	8.0
1145	LA-Health Medical Scheme		66 079	274.1	93.1		2.8
1571	Anglovaal Group Medical Scheme		3 704	240.9	86.3		-9.6
1520	University of Kwa-Zulu Natal Medical Scheme		3 410	221.2	85.5		-17.0
1241	Naspers Medical Fund		8 066	210.9	83.8		-20.9
1578	TFG Medical Aid Scheme		2 936	209.8	89.9		-21.3
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund		2 624	207.2	74.0		-22.3
1516	Quantum Medical Aid Society		4 468	203.8	84.6		-23.6
1209	South African Breweries Medical Aid Scheme (SABMAS)		9 795	198.9	76.5		-25.4
1579	Tsogo Sun Group Medical Scheme		5 009	195.5	80.4		-26.7
1430	Remedi Medical Aid Scheme		21 119	190.8	91.6		-28.4
1176	Retail Medical Scheme		11 813	188.9	95.1		-29.1
1547	Malcor Medical Scheme		5 078	176.3	78.8		-33.9
1526	BMW Employees Medical Aid Society		3 250	174.1	91.8		-34.7
1012	Anglo Medical Scheme		9 089	172.6	63.3		-35.3
1253	Glencore Medical Scheme		9 185	148.6	93.2		-44.3
1584	Netcare Medical Scheme		17 680	145.1	91.4		-45.6
1279	Bankmed		107 498	136.5	79.1		-48.8
1599	Lonmin Medical Scheme		18 602	59.7	89.8		-77.6
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	72 203	261.7	75.9	111.6	134.5
1537	Hosmed Medical Aid Scheme		24 403	245.8	57.9		120.3
1441	Parmed Medical Aid Scheme		2 394	229.6	73.2		105.7
1507	Barloworld Medical Scheme		5 474	210.0	82.7		88.2
1424	SABC Medical Aid Scheme		4 724	192.9	77.5		72.8
1214	Old Mutual Staff Medical Aid Fund		18 339	192.0	85.7		72.0
1512	Bonitas Medical Fund		339 003	191.5	70.9		71.6
1005	AECI Medical Aid Society		6 946	189.7	85.2		70.0
1234	Sasolmed		29 260	185.3	86.0		66.0
1039	MBMed Medical Aid Fund		4 040	183.2	81.4		64.2
1469	Nedgroup Medical Aid Scheme		28 918	173.0	85.0		55.0
1566	Horizon Medical Scheme		3 226	163.2	80.6		46.2
1466	Makoti Medical Scheme		2 760	88.7	46.7		-20.5
1598	Government Employees Medical Scheme (GEMS)		690 072	90.1	39.2		-19.3

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	%
1598	Government Employees Medical Scheme (GEMS)	Metropolitan Health Corporate (Pty) Ltd	690 072	90.1	39.2	90.1	-
1105	Metropolitan Medical Scheme	MMI Health (Pty) Ltd	2 091	238.7	63.3	190.2	25.5
1167	Momentum Health		149 816	203.2	94.6		6.8
1563	Pick n Pay Medical Scheme		7 274	194.4	78.1		2.2
1293	Wooltru Healthcare Fund		9 899	189.3	80.4		-0.5
1186	PG Group Medical Scheme		1 428	183.5	75.2		-3.5
1600	Motohealth Care		22 993	173.1	75.8		-9.0
1572	Engen Medical Benefit Fund		3 494	171.8	84.0		-9.7
1548	Medipos Medical Scheme		13 512	160.6	87.8		-15.6
1582	Transmed Medical Fund		30 785	151.3	72.7		-20.5
1559	Imperial Group Medical Scheme		7 896	149.8	59.7		-21.2
1270	Golden Arrow Employees' Medical Benefit Fund		2 813	146.7	85.3		-22.9
1237	BP Medical Aid Society		1 867	143.9	55.1		-24.3
1271	Fishing Industry Medical Scheme (Fishmed)		1 752	79.0	64.8		-58.5
1548	Medipos Medical Scheme		13 512	160.6	87.8		-15.6
1582	Transmed Medical Fund		30 785	151.3	72.7		-20.5
1559	Imperial Group Medical Scheme		7 896	149.8	59.7		-21.2
1270	Golden Arrow Employees' Medical Benefit Fund		2 813	146.7	85.3		-22.9
1237	BP Medical Aid Society		1 867	143.9	55.1		-24.3
1271	Fishing Industry Medical Scheme (Fishmed)		1 752	79.0	64.8		-58.5
1548	Medipos Medical Scheme		13 512	160.6	87.8		-15.6
1582	Transmed Medical Fund		30 785	151.3	72.7		-20.5
1559	Imperial Group Medical Scheme		7 896	149.8	59.7		-21.2
1270	Golden Arrow Employees' Medical Benefit Fund		2 813	146.7	85.3		-22.9
1237	BP Medical Aid Society		1 867	143.9	55.1		-24.3
1271	Fishing Industry Medical Scheme (Fishmed)		1 752	79.0	64.8		-58.5

GAE = Gross Administration Expenditure

Table 59 shows the market share of administrators, including accredited managed healthcare services.

Table 59: Market share of administrators, including accredited managed healthcare services

Name of administrator	Nr. of schemes	Beneficiaries	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*
		Market share %	pabpm R	pabpm R	pabpm R	pabpm R	pabpm R
Agility Health (Pty) Ltd	2	0.5	112.3	1 692.9	48.0	-	160.3
Discovery Health (Pty) Ltd	19	32.0	126.4	1 275.8	44.4	42.7	173.5
Medscheme Holdings (Pty) Ltd**	14	32.7	45.3	1 504.4	27.2	-	71.8
Metropolitan Health Corporate (Pty) Ltd	1	17.0	34.4	1 377.7	1.6	-	36.1
MMI Health (Pty) Ltd	14	4.6	98.9	1 197.6	28.4	108.0	196.7
Private Health Administrators (Pty) Ltd	2	0.4	89.7	1 442.2	28.4	19.1	135.3
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	1.3	114.6	1 796.5	22.8	-	137.4
Providence Healthcare Risk Managers (Pty) Ltd	5	0.6	50.3	897.2	29.7	-	68.1
Sanlam Health Administrators (Pty) Ltd	1	0.4	164.8	1 699.0	51.3	-	216.1
Sechaba Medical Solutions (Pty) Ltd	1	1.1	114.4	1 485.6	29.9	-	144.3
Self-Administered	14	8.5	-	1 378.6	22.1	-	9.7
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	1	0.2	79.9	799.5	-	-	79.9
Universal Healthcare Administrators (Pty) Ltd	6	0.7	98.2	1 236.4	32.7	-	128.7
V Med Administrators (Pty) Ltd	1	0.1	90.5	1 543.4	40.1	-	130.6
Average	**83**	**100.0**	**95.8**	**1 362.1**	**34.9**	**77.6**	**102.4**

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.*

Table 60 shows the six administrators who had the highest deviation from the 2017 industry average of R102.4 pabpm in respect of total fees received by administrators.

Table 60: Total fees paid to administrators (including accredited managed healthcare services) and the deviation from the industry average in 2017

	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*
	%	%		%
Sanlam Health Administrators (Pty) Ltd	72.0	47.0	-100.0	111.0
MMI Health (Pty) Ltd	3.2	-18.6	39.2	92.1
Discovery Health (Pty) Ltd	31.9	27.2	-45.0	69.4
Agility Health (Pty) Ltd	17.2	37.5	-100.0	56.5
Sechaba Medical Solutions (Pty) Ltd	19.4	-14.3	-100.0	40.9
Professional Provident Society Healthcare Administrators (Pty) Ltd	19.6	-34.7	-100.0	34.2

** Excluding co-administration fees*

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RP111/2018
ISBN: 978-0-621-46275-3

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