
CMS
Council
for Medical Schemes
ANNUAL REPORT 2016/2017
HEALTH
MATTERS

COUNCIL FOR MEDICAL SCHEMES ANNUAL REPORT 2016/2017

Council for Medical Schemes

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CONTENTS

LIST OF TABLES

Parts A – D

Part F

LIST OF FIGURES

Parts A – D

Part F

LIST OF ANNEXURES

(CD with annexures included at the back of this report)

GENERAL INFORMATION OF THE COUNCIL FOR MEDICAL SCHEMES

Name	Council for Medical Schemes
Physical address	Block A Eco Glades 2 Office Park
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Email address	information@medicalschemes.com
Website	www.medicalschemes.com
Internal auditors	Sekela Xabiso (Pty) Ltd
External auditors	Auditor-General of South Africa
Bank	Absa Group Limited
Chairperson of Council	Professor Yosuf Veriava
Acting Chief Executive & Registrar	Dr Sipho Kabane
Council Secretary	Mr Khayalethu Mvulo

A

GENERAL INFORMATION

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

AFS:	Annual Financial Statements
AGM:	Annual General Meeting
AIDS:	Acquired Immune Deficiency Syndrome
APP:	Annual Performance Plan
ART:	Antiretroviral Therapy
ASR:	Annual Statutory Returns
B-BBEE:	Broad-Based Black Economy Empowerment
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
Bn	Billion
Board:	Board of Trustees
CDL:	Chronic disease list
CHIA:	Clinton Health Access Initiative
CIB:	Chronic illness benefit
CMS:	Council for Medical Schemes
Council:	Accounting Authority or the Board of the Council for Medical Schemes
CPD:	Continuing Professional Development
CPI:	Consumer Price Index
DBG:	Doctor's Billing Guide
DDDR:	Dynamic Database Driven Annual Return
Dependant:	Member not responsible for paying contribution(s) to medical scheme; depends on principal member for membership
DPME:	Department of Planning, Monitoring and Evaluation
DSP:	Designated Service Provider
DTP:	Diagnosis and Treatment Pair
EAP:	Employee Assistance Programme
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
FIA:	Financial Institution Act
FSB:	Financial Services Board
FSU:	Financial Supervision Unit
GAAP:	Generally Accepted Accounting Principles
GAE:	Gross Administration Expenditure
GCI:	Gross Contribution Income
GP:	General Practitioner
GRAP:	Generally Recognised Accounting Practices
HIV:	Human Immunodeficiency Virus
HMI:	Health Market Inquiry
IESBA	International Ethics Standards Board for Accountants
IAS:	International Accounting Standard
INSETA:	Insurance Sector Education and Training Authority
ISBN:	International Standard Book Number
ISA	International Standards on Auditing
ITAG	Information Technology Advisory Group
ITAP:	Industry Technical Advisory Panel
IUCD	Intrauterine Contraceptive Device
M	Million

MAC:	Ministerial Advisory Committee
MCO:	Managed Care Organisation
MSA:	Member Savings Account
NAMFISA:	Namibia Financial Institutions Supervisory Authority
NDoH:	National Department of Health
NDP	National Development Plan
NHC:	Net Healthcare
NHE:	Non-Healthcare Expenditure
NHI:	National Health Insurance
NHISSA:	National Health Information System of South Africa
NHRPL:	National Health Reference Price List
NPA:	National Prosecuting Authority
Office:	Office of the Chief Executive and Registrar (of Medical Schemes)
OOP:	Out of Pocket Payment
PAA:	Public Audit Act
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
Pensioner:	Beneficiary at least 65 years old
PFMA:	Public Finance Management Act 1 of 1999
PMB:	Prescribed minimum benefit
Pmpm:	Per member per month
PMSA:	Personal medical savings account
PO:	Principal Officer
POPIA	Protection of Personal Information Act
PPP:	Public-Private Partnership
PPPFA:	Preferential Procurement Policy Framework Act
PPS:	Professional Provident Society
Principal member:	Member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s
Q:	Quarter
QR:	Quarterly returns
R&M:	Research and Monitoring Unit
RBC:	Risk Based Capital
Registrar:	Registrar of Medical Schemes
REMCO:	Remuneration Committee of Council
RP:	Government Printing Works (report number)
RTM:	Real Time Monitoring
SAMA:	South African Medical Association
SAPA:	South African Pediatric Association
SCA:	Supreme Court of Appeal
SEP	Single exit price
SLA	Service level agreement
SOCTS:	Society of Cardiothoracic Surgeons of South Africa
SRM:	Scheme Risk Measurement
TB:	Tuberculosis
TGPIP:	The Global Platform for Intellectual Property
Treasury:	National Treasury

LEGISLATIVE AND OTHER MANDATES

Constitutional mandates

The state is obliged in terms of section 27 of the Constitution of South Africa, to develop legislation that is geared towards the progressive realisation of the right of access to healthcare by all those living in the country. The Medical Schemes Act, 131 of 1998 (the Act), forms part of the country's legislation aimed at facilitating access to healthcare services. The Act aligns with the spirit and letter of the Constitution through its provision for non-discriminatory access to medical scheme membership.

Legislated mandates

The purpose of the Medical Schemes Act is to promote non-discriminatory access to private healthcare funding and it therefore provides protection to vulnerable members who were previously often assigned to an 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. This situation necessitated the promulgation of the Medical Schemes Act, 131 of 1998, which became fully operational in 2000.

Medical schemes are essentially business entities that are registered with the CMS, and as such, now operate in a special legislative environment. This special environment was established in order to balance the rights and interests of a business entity on the one hand, and the rights and interests of the public on the other.

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

Section 7 of the Medical Schemes Act provided 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 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 NDoH are:

Government's Programme of Action electoral mandate priorities:

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

VISION

To promote vibrant and affordable cover for all.

MISSION

The CMS regulates the medical schemes industry in a fair and transparent manner and achieves this by:

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

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:

- 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**

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 Department of Health (NDoH) and is responsible for the revision of regulations related to PMBs.

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 the Council.
- Undertaking close monitoring of schemes where financial reserves fall below the specified level.

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.

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

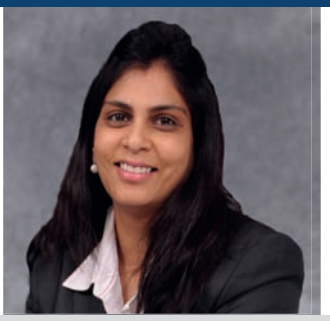
The CMS, with its unique access to detailed information on the private healthcare sector, is able to make an informed contribution to national policy. The data collected by the CMS, through reports submitted by schemes, is supplemented by dedicated research in areas such as the burden of disease and the impact of prescribed minimum benefits 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**

PROF. YOSUF VERIAVA
Chairperson

DR LOYISO MPUNTSHA
Vice Chairperson

PROF BONKE DUMISA
Member



ADV HARSHILA KOOVERJIE
Member

DR STEVEN MABELA
Member

MS MOSIDI MABOYE
Member

PROF SADHASIVAN PERUMAL
Member

MS LUNA SIBANYONI
Member

DR AQUINA THULARE
Member

MR JOHAN VAN DER WALT
Member

OUR LEADERSHIP // **THE EXECUTIVES**

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

DR ELSABÉ CONRADIE
General Manager: Stakeholder Relations

DR ANTON DE VILLIERS
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

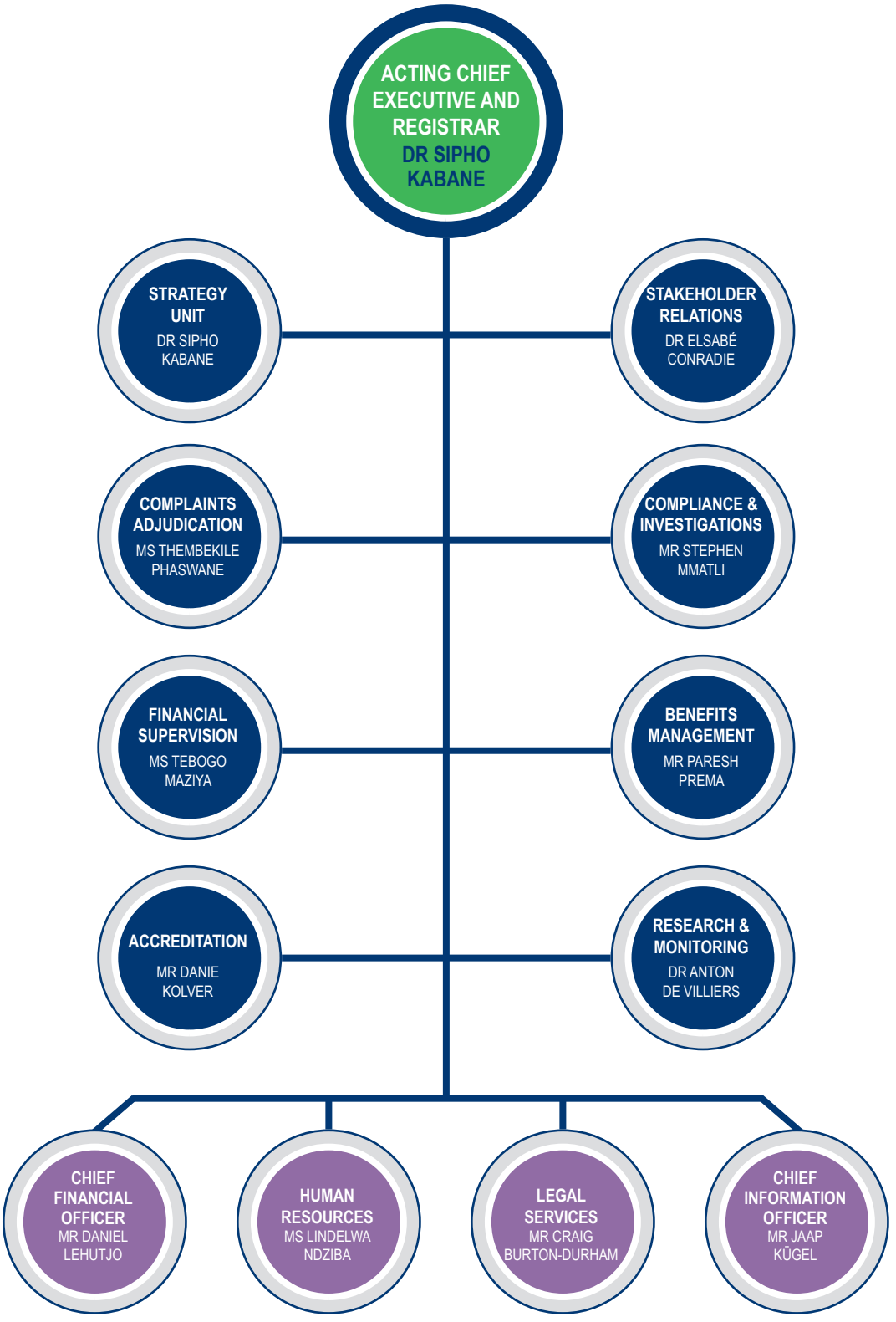
MR PARESH PREMA
General Manager: Benefits Management

MEDICAL SCHEMES REGISTERED IN TERMS OF THE MEDICAL SCHEMES ACT

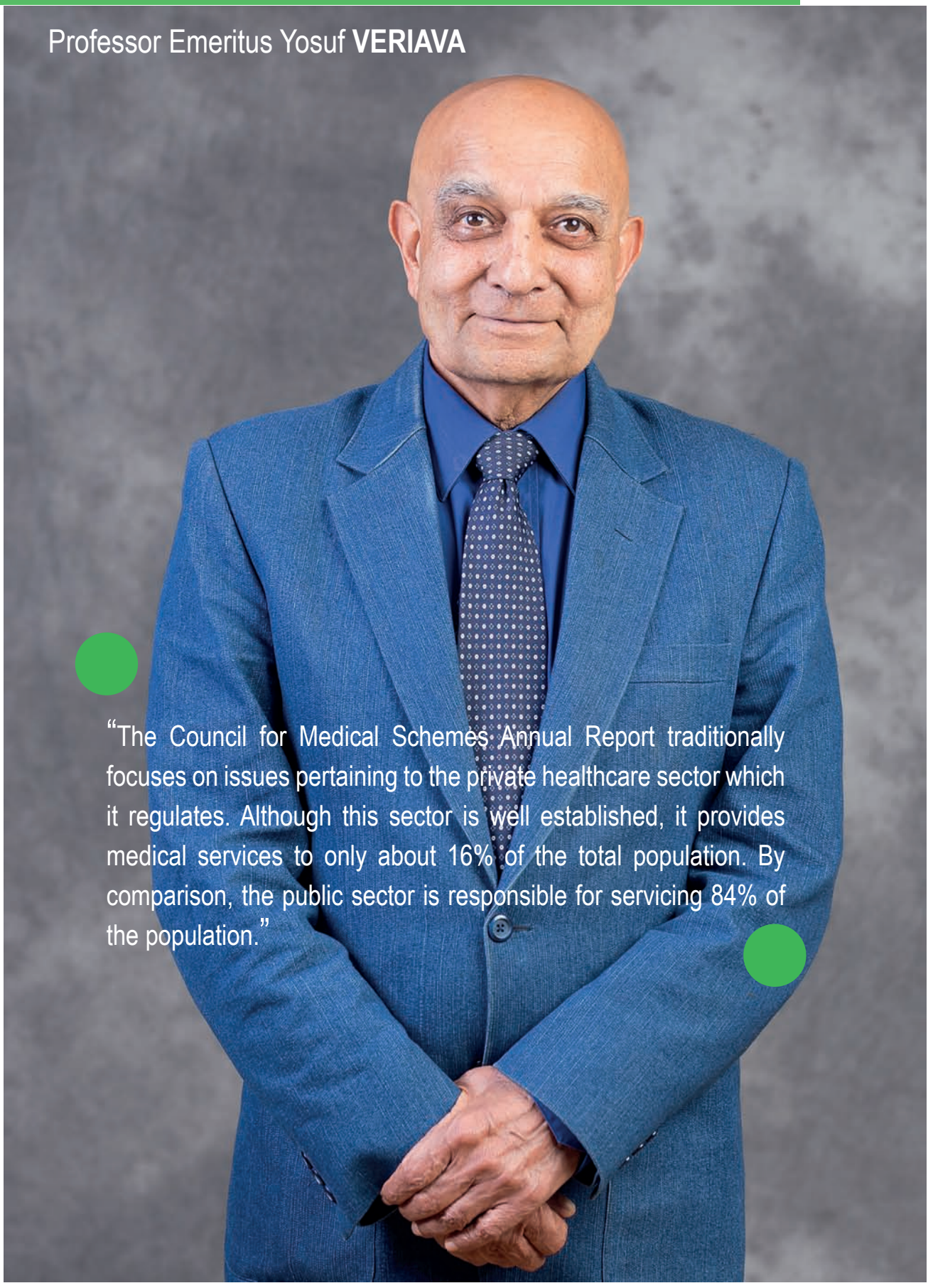
As at 31 March 2017

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	Metropolitan Medical Scheme	Restricted
44	Momentum Health	Open
45	Motohealth Care	Restricted
46	Naspers Medical Fund	Restricted
47	Nedgroup Medical Aid Scheme	Restricted
48	Netcare Medical Scheme	Restricted
49	Old Mutual Staff Medical Aid Fund	Restricted
50	Parmed Medical Aid Scheme	Restricted
51	PG Group Medical Scheme	Restricted
52	Pick n Pay Medical Scheme	Restricted
53	Platinum Health	Restricted
54	Profmed	Restricted
55	Quantum Medical Aid Society	Restricted
56	Rand Water Medical Scheme	Restricted
57	Remedi Medical Aid Scheme	Restricted
58	Resolution Health Medical Scheme	Open
59	Retail Medical Scheme	Restricted
60	Rhodes University Medical Scheme	Restricted
61	SABC Medical Aid Scheme	Restricted
62	Samwumed	Restricted
63	Sasolmed	Restricted
64	Sedmed	Restricted
65	Selfmed Medical Scheme	Open
66	Sisonke Health Medical Scheme	Restricted
67	Sizwe Medical Fund	Open
68	South African Breweries Medical Scheme	Restricted
69	South African Police Service Medical Scheme (Polmed)	Restricted
70	Spectramed	Open
71	Suremed Health	Open
72	TFG Medical Aid Scheme	Restricted
73	Thebemed	Open
74	Tiger Brands Medical Scheme	Restricted
75	Topmed Medical Scheme	Open
76	Transmed Medical Fund	Restricted
77	Tsogo Sun Group Medical Scheme	Restricted
78	Umvuzo Health Medical Scheme	Restricted
79	University of KwaZulu-Natal Medical Scheme	Restricted
80	University of the Witwatersrand Staff Medical Aid Fund	Restricted
81	Witbank Coalfields Medical Aid Scheme	Restricted
82	Wooltru Healthcare Fund	Restricted

ORGANISATIONAL **STRUCTURE**



CHAIRPERSON'S **REPORT**



Inequity between the two sectors in relation to the provision and nature of services, the expenditure involved and more importantly, many of the social and economic determinants of health – such as income and education levels – favour the beneficiaries of the private healthcare sector. These disparities ultimately manifest in the poor health outcomes of the nation and, in particular, of the poor.

As economic inequality in South Africa is marked, so too is inequality in health. The Gini coefficient, a standard metric of income inequality, ranks South Africa as one of the most unequal countries in the world. Poverty in South Africa is still pervasive and the country has made insufficient progress in reducing it. Millions of people remain unemployed and many households live close to the poverty line (NDP). A recent report in the Lancet indicated that such economic inequality is accompanied by increasing disparities in health outcomes as evidenced by the life expectancy of the wealthiest exceeding that of the poorest by 10 to 15 years.

Clear inequities exist within South Africa's dual system of private and public sector of health service provision. Utilisation of the private or public sector is primarily determined by income levels. In 2015, StatsSA stated that 4.5% of the 8.6% of the Gross Domestic Product expenditure on health is spent in the private sector compared to 4.1% in the public sector. This emphasises a disproportionately lower share of the overall health expenditure being directed to the poor.

Additional examples of inequalities between the public and private sectors manifest in a disproportionate distribution of physical health facilities and human professional resources. These inequalities contribute to the poor health outcomes amongst the majority of the population. The problem of poor health outcomes is the responsibility of all sectors and as such, the private sector can no longer turn a blind eye to the serious matter of inequity.

While many of the social determinants of health require interventions by all sectors in South Africa, the healthcare delivery system can only meet the urgent needs of the total population through the establishment of the NHI and the process of universal coverage. In relation to this, a great deal of work is required within both health sectors. It is also noteworthy that South Africa is a signatory of the global United Nations Sustainable Development Programme.

Furthermore, our country has adopted the National Development Plan which has as one of its health sector targets, the establishment of the NHI by 2030. This places on all South Africans the responsibility to work towards its successful implementation. Our only approach should be to find solutions to obstacles that exist, rather than that of perpetual negative criticism.

Another matter of concern is the rising cost of healthcare, particularly in the private sector. This is evident in the insignificant growth of 0.78% of medical scheme membership during the period under review. There are various factors contributing to the increase in healthcare costs, but the main contributors are again private hospitals, specialists and medicines. The expenditure on private hospitals increased to a total of R56.32bn in 2016, while specialists and medicines amounted to R36.32bn and R23.95bn respectively. The prescribed minimum benefits (PMBs) remain a concern in the industry and constituted 54% of the total risk benefits paid.

It is unfortunate that as healthcare costs increase, membership contributions likewise increase, which in the present economic climate and the rising rate of unemployment, poses a major threat to the sustainability of the industry.

Medical schemes should critically review how they contract with managed care organisations (MCOs) to ensure that the scope of healthcare service to be provided is in the best interest of the members of schemes. The preliminary indications of the CMS project to measure quality show that the quality of care in the private medical schemes industry is not as high as one would have expected it to be. Value to members, schemes and MCOs can only be created if the quality delivered exceeds the cost. Medical schemes, therefore, must aim to maximise quality at a reduced cost.

Another major concern is the exorbitant amounts spent on unnecessary litigation. In many cases, schemes use the funds derived from membership to undertake litigation in matters contrary to the basic interest of the beneficiaries. Two examples, which are discussed in more detail in the report, are the Genesis matter referring to PMBs and Regulation 8 and the Genesis case brought to the Constitutional Court. In addition to the wasteful spending of member contributions on legal fees, the impact of rulings on beneficiaries may have huge implications.

Mr Daniel Lehutjo acted as chief executive and registrar during the period under review until 31 October 2016. On 1 November 2016, Dr Humphrey Zokufa commenced his appointment as chief executive and registrar. Dr Zokufa was well known in the private healthcare industry and served in numerous roles in the public, as well as the private health sector. His passion for the implementation of the NHI was discernible as he stressed the importance for the industry to fully understand why the government wants to introduce the NHI policy. It was indeed a great loss to the healthcare industry when Dr Zokufa unexpectedly passed away on 22 January 2017.

In the meantime, the Minister of Health appointed Dr Sipho Kabane as acting chief executive and registrar while Council is in the process of finalising the appointment of a successor to Dr Zokufa.

Finally, as my term is coming to an end, I would like to express my gratitude for the excellent support I received from my Council, the staff of CMS and our executive authority. I wish them all the best with continuous challenges in an incredibly dynamic environment.

Professor Emeritus Yosuf Veriava
Chairperson of Council

May 2017

OVERVIEW OF THE ACTING **CEO & REGISTRAR**

Dr Sipho **KABANE**

"The Council for Medical Schemes continues to make positive strides in its role as a regulatory overseer of the South African medical schemes industry; and it gives me great pleasure to report on our performance during the past year."

We give credit to our dedicated team of employees for the good work highlighted in this report. Anchored by the CMS values, our staff delivered quality service to our diverse stakeholders, encompassing a R163.9bn industry with a subscription of 8 878 081 beneficiaries, spread across 82 registered medical schemes.

Good health matters greatly at both the individual and organisational level of existence. For this reason, we promote a healthy medical scheme industry that adheres to good governance and sound financial management, and that offers value to its beneficiaries in terms of access to good quality healthcare services.

Strategic interventions on healthcare matters

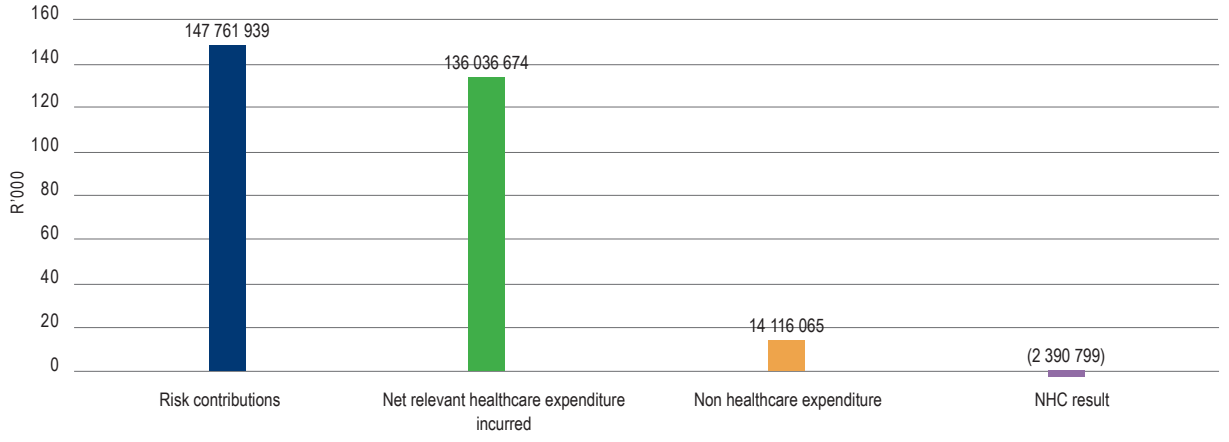
During the past year the CMS carried out several strategic intervention initiatives geared towards delivery on the entity's strategic goals. A synopsis of some of the initiatives is provided below.

Financial viability of medical schemes

For the South African private healthcare system to remain functional, all medical schemes must remain financially viable and able to honour their financial obligations to members.

The figure below depicts how the healthcare rand was distributed. After paying for relevant healthcare services and operational expenses, medical schemes incurred a deficit (net healthcare result) total of R2.4bn before investment income. After investment income and consolidation adjustments, a surplus of R2.0bn was incurred, indicating the reliance on investment income. In other words, R2.0bn from the operations of medical schemes in the 2016 financial year was contributed to general reserves (also known as accumulated funds) of the industry.

Figure 1: Performance of the industry

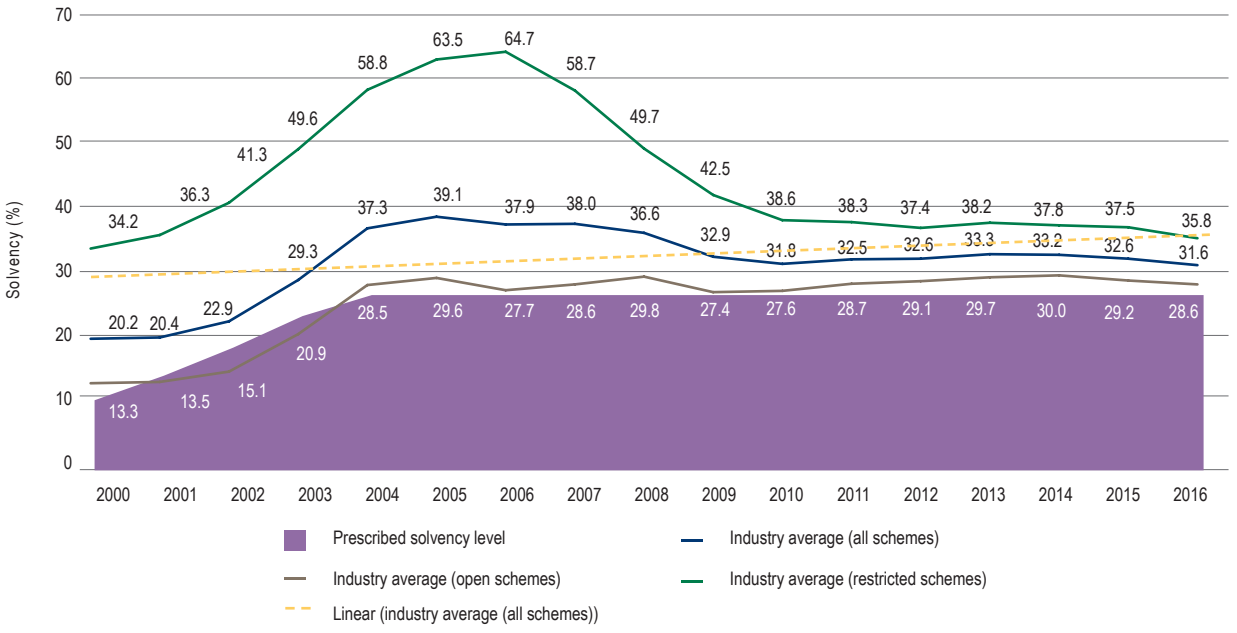


NHC result: net healthcare result

The reserves serve to protect members' interests and to guarantee the continued operation of schemes. They are also a buffer against unforeseen and 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 Medical Schemes Act, No. 131 of 1998, requires all medical schemes to maintain accumulated funds of at least 25.0% of gross annual contributions. For the year ended 31 December 2016, the net assets of all medical schemes amounted to R54.1bn (2015: R52.1bn). The reported solvency level for all medical schemes during the year under review is 31.6%.

Figure 2: Industry solvency for all schemes: 2000 – 2016



Medical schemes that fall short of the statutory minimum solvency level of 25.0% are required to notify the CMS of the underlying causes of failure and the corrective action to be undertaken. Such schemes are then placed under close monitoring by the CMS.

Schemes that have solvency levels above the required level of 25.0%, but have reserves that are rapidly diminishing, are also monitored. Interventions in relation to such schemes may include submission of management accounts, financial review meetings with the board of trustees and even submission of business plans to address the situation. The CMS also closely monitors schemes that have governance problems, are under curatorship, and/or record excessive non-healthcare expenditure.

Schemes under close monitoring

At the end of the 2016 financial year, seven schemes were below the minimum statutory solvency of 25.0% (four open and three restricted schemes). Table 1 below contains a summary of the schemes being monitored by the CMS in terms of Regulation 29(4) of the Medical Schemes Act.

Table 1: Schemes under close monitoring

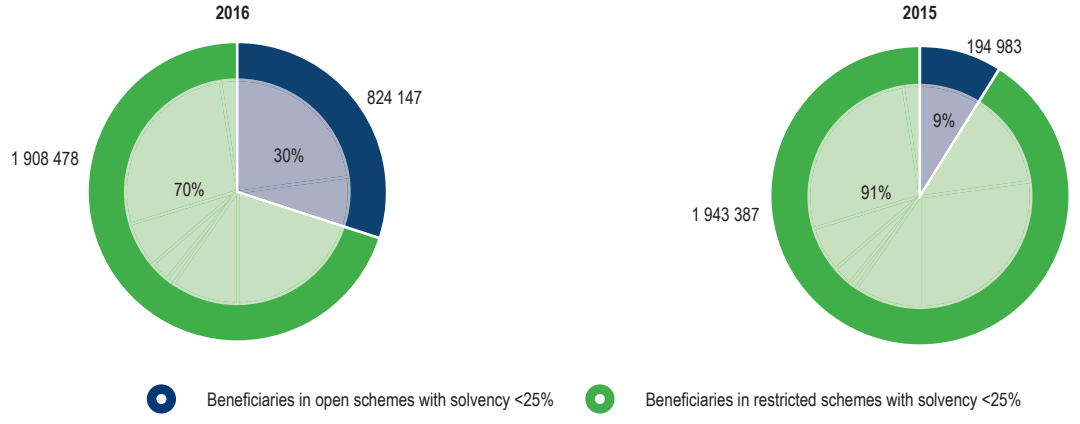
Open schemes			Restricted schemes		
2016	**Number of schemes**	**Name of scheme**	**2016**	**Number of schemes**	**Name of scheme**
Number of schemes below 25.0% at January 2016	4	1. Community Medical Aid Scheme (COMMED)	Number of schemes below 25.0% at January 2016	3	1. Government Employees Medical Scheme (GEMS)
		2. Resolution Health Medical Scheme			2. Transmed Medical Fund
		3. Thebemed			3. Platinum Health
		4. LMS Medical Fund			
Change in number of schemes	+1	5. Bonitas Medical Fund *	Change in number of schemes	-1	Platinum Health reached 25.0% solvency level
Change in number of schemes below 25.0%	-1	* LMS Medical Fund amalgamated with Bonitas Medical Fund on 01 October 2016	Change in number of schemes below 25.0%	+1	Lonmin Medical Scheme
Number of open schemes below 25.0% at 31 December 2016	**4**		**Number of restricted schemes below 25.0% at 31 December 2016**	**3**	

Open schemes			Restricted schemes		
2015	**Number of schemes**	**Name of scheme**	**2015**	**Number of schemes**	**Name of scheme**
Number of schemes below 25.0% at the beginning of 2015	5	1. Liberty Medical Scheme	Number of schemes below 25.0% at the beginning of 2015	2	1. Government Employees Medical Scheme (GEMS)
		2. Thebemed			2. Transmed Medical Fund
		3. Community Medical Aid Scheme (COMMED)			
		4. Suremed			
		5. Resolution Health Medical Scheme			
Change in number of schemes	-1	Suremed reached 25.0% solvency level	Change in number of schemes below 25.0%	+1	Platinum Health
Number of schemes below 25.0% at the end of 2015	**4**		**Number of schemes below 25.0% at the end of 2015**	**3**	

Note: Liberty Medical Scheme changed its name to LMS Medical Fund on 1 August 2016.

The membership coverage of schemes below 25.0% solvency is shown in the graph below.

Figure 3: Comparison of beneficiaries in schemes below 25.0% solvency level



There has been a significant shift in the number of beneficiaries in open schemes that are below the minimum solvency level of 25.0%. This is attributable to Bonitas Medical Fund, as per Table 1.

Bonitas Medical Fund's solvency ratio as at December 2016 was 24.4%, representing a decrease by 6.5% from 26.1% in 2015. The decrease in solvency ratio is mainly due to membership growth, as a result of an amalgamation with LMS Medical Fund with effect from 01 October 2016. A business plan was submitted by the scheme and it was approved by the CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

As at 31 December 2016, GEMS reported a solvency ratio of 7.0%, compared to 9.5% in 2015. The scheme experienced inordinately high claims during the year. Furthermore, the number of GEMS principal members and beneficiaries have increased by 2.9% during the same period. The membership growth is attributable to the new civil servants joining the public sector. GEMS has an approved business plan which includes various cost containment measures and a claims management programme. GEMS submits management accounts and attends monthly monitoring meetings with the CMS.

LMS Medical Fund amalgamated with Bonitas Medical Fund effective from 01 October 2016. The scheme transferred all assets and liabilities to the fund, and disclosed it as such in the annual statutory return.

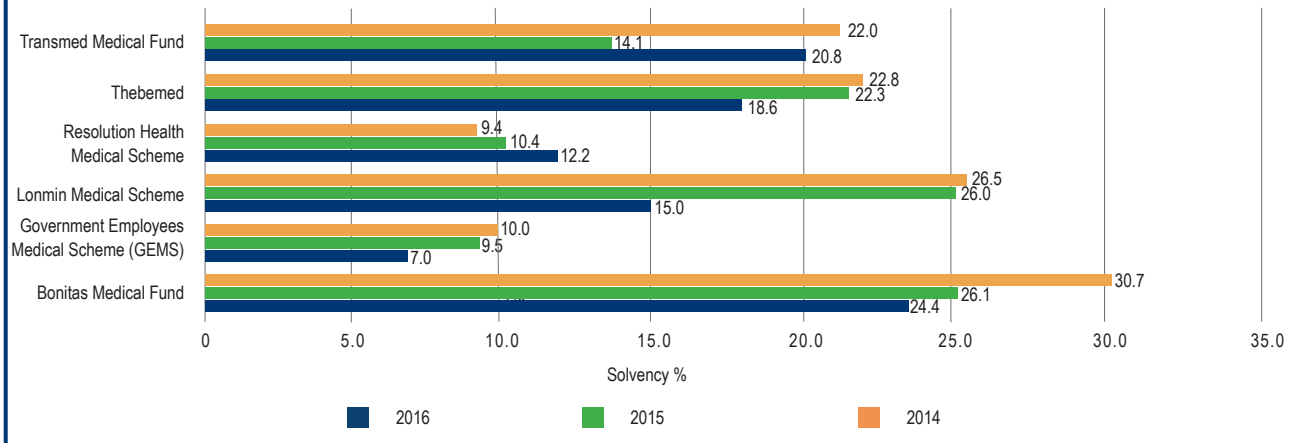
Lonmin Medical Scheme's solvency ratio deteriorated significantly by 42.3% from 26.0% in 2015 to 15.0% in 2016. The significant drop in the scheme's solvency level is attributable to the change in the demographic profile, resulting in the change in the claims profile. A further challenge for the scheme is the unstable nature of the labour environment in which it operates. A business plan was submitted by the scheme and it was approved by the CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

Resolution Health Medical Scheme reported a solvency ratio of 12.2% in 2016, from 10.4% in 2015. The increase in solvency level is mainly due to a significant decline in membership of 16.5% from 2015. The CMS has advised the board to seek sustainable solutions that would safeguard members' interests. A business plan was submitted by the scheme and it was approved by the CMS. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

Thebemed's solvency ratio decreased by 16.6% from 22.3% in 2015 to 18.6% in 2016. The decrease in solvency ratio is mainly due to membership growth and an increase of 15.8% in claims resulting in net healtcare deficits. The scheme submitted a business plan and the CMS approved it. The CMS holds monitoring meetings with the board on a regular basis. The scheme also submits monthly management accounts.

The solvency ratio of Transmed Medical Fund increased significantly by 47.5% from 14.1% in 2015 to 20.8% in 2016. The increase in solvency ratio is mainly due to a decline in membership, and better claims experience. A business plan was submitted by the scheme and it was approved by the CMS. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress.

Figure 4: Solvency trends for all schemes below 25% 2014 – 2016



The graphs below show the distribution of healthcare spend for schemes under close monitoring.

Figure 5: Distribution of healthcare spend for open schemes below 25.0% solvency level 2016

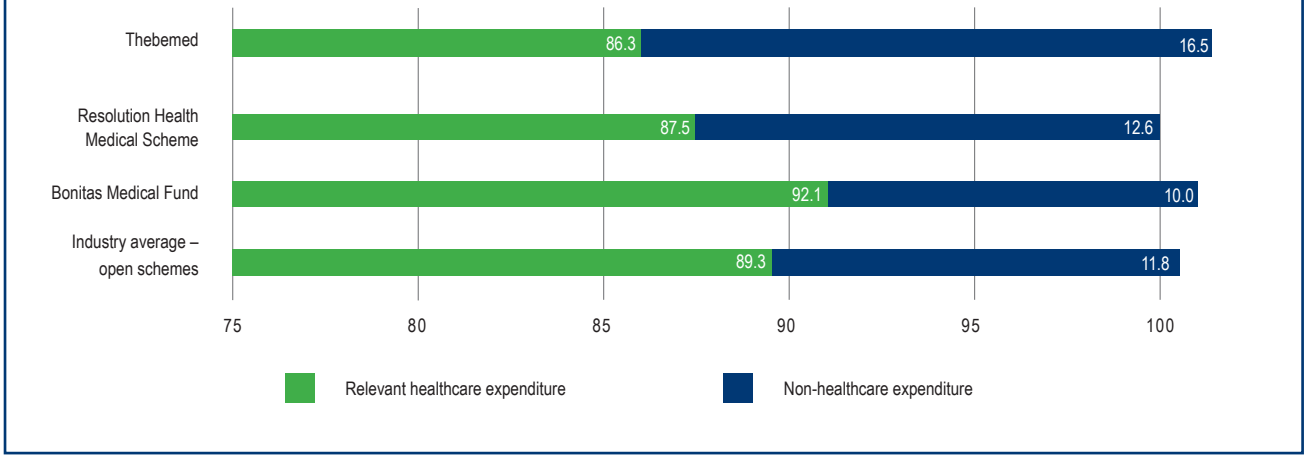
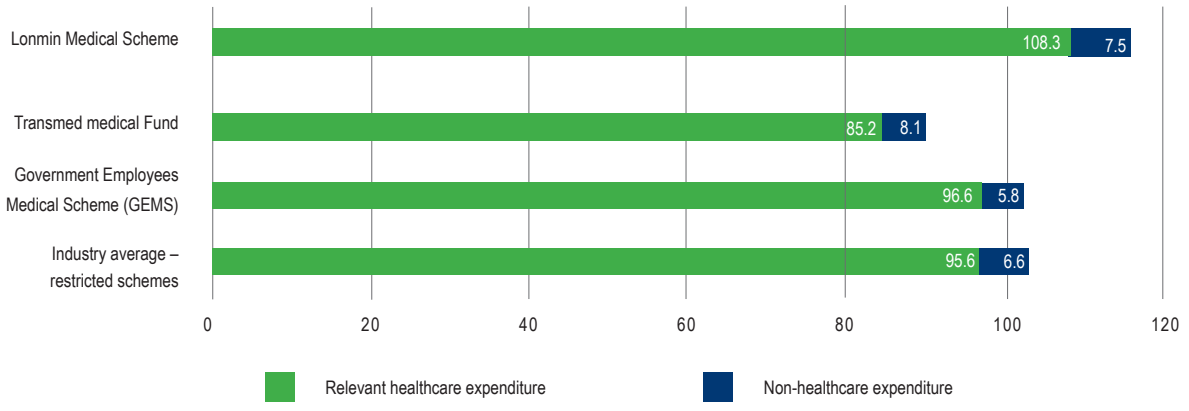


Figure 6: Distribution of healthcare spend for restricted schemes below 25.0% solvency level 2016



Financial supervision tools

The CMS uses the following tools for monitoring schemes:

Annual financial statements (AFS) as per section 37 of the Medical Schemes Act

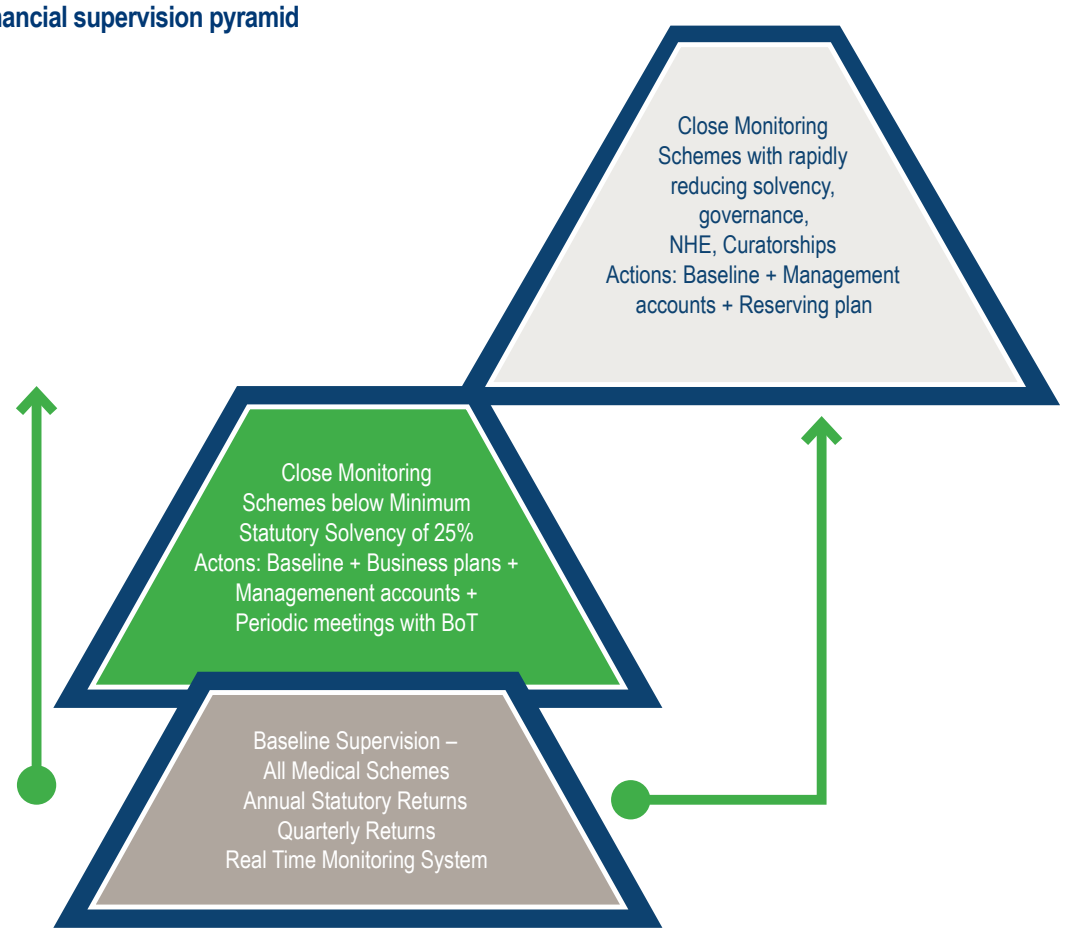
These statutory returns reveal historical financial performance and position of medical schemes; their ability to continue operating into the foreseeable future; and determine trends and emerging issues. Annual financial statements enable more effective decision-making and feed directly into the various regulatory interventions catered for in the Medical Schemes Act and policy formulation. Information contained in the AFS is critical to members in determining their return on investment and value proposition offered by the medical schemes to which they belong.

Early warning system (EWS)

The system signals potential challenges before they happen. It consists of the following:

- The Quarterly Return System serves as the core of our EWS, enabling the continuous monitoring of schemes in between audit cycles. It enables the CMS to institute a suite of interventions/interactions with the management of schemes and ensures the ongoing protection of members.
- The Real-time monitoring (RTM) system collects key data from all schemes monthly, the data informs interactions between the CMS and the schemes. It assists in understanding the profiles of medical schemes and matters that are unique to each scheme.

Figure 7: Financial supervision pyramid



Revision of the solvency framework

Maintaining a strong solvency level is critical to ensure sustainability in the industry. In 2016, the CMS approved research and industry engagement on the proposed risk based capital (RBC) model. Two workshops were conducted with the industry, and four working groups were established to finalise the technical work on each component of the proposed model. Once finalised, the updated proposal will be presented to Council for approval.

Improving the quality of healthcare

Collaborative work with the Industry Technical Advisory Panel (ITAP) has continued to yield positive results. The ITAP's Managed-care Working Group examined a total of 14 CDL conditions and identified minimum process and outcome indicators to be implemented by managed care organisations. It has further recommended that it must be mandatory for managed care organisations to collect information on the process and outcome indicators, and make it available to the CMS. This is one of the key initiatives towards strengthening the quality of managed care services provided to medical scheme beneficiaries.

The CMS adopted the indicators identified by the ITAP as the minimum standards for quality of care in the medical schemes environment. The Utilisation Annual Statutory Return (ASR) data specification documents have been amended accordingly to incorporate these indicators.

The CMS Report on Measuring Quality of Care in Medical Schemes (based on 2014 and 2015 data submissions) was published. The industry was invited to comment on the results and the methodology used. The latest results are reported in Annexure K and a more detailed report will be published in 2017.

Enhancing member benefits

No entity applied to be registered as a new medical scheme during the period under review. The number of medical schemes stood at 82 as at 31 March 2017. In February 2017, the CMS published a list of all registered medical schemes and their contact details in the Government Gazette, as required by section 25 of the Medical Schemes Act.

Rules of medical schemes

The Medical Schemes Act empowers the CMS to oversee and ensure that medical schemes and their rules comply with the legislation. Medical schemes exercise their powers and perform their functions in accordance with set rules. These rules provide for the rights and responsibilities, dos and don'ts for medical schemes and all persons involved, including beneficiaries of the scheme.

The Act stipulates a comprehensive process for the submission of rules by medical schemes, the approval of these as well as the process to be followed by schemes in responding to a rejected submission. Apart from enhancing accountability and promoting trust and fairness, the registered rules help other relevant units within the office of the Registrar in the performance of their daily functions when dealing with medical schemes and/or related parties.

To assist medical schemes, the CMS has compiled a model to follow when drafting rules. This model and the explanatory memorandum were released to industry stakeholders via Circular 39 of 2016. The documents are available on the CMS website. Medical schemes are encouraged to make reference to the model when drafting their rules, and to contact the respective analysts at the CMS where assistance is required.

The CMS processed 101 interim rule amendments and 90 submissions for benefit and contribution changes effective from 1 January 2017 during the year under review.

Benefit options offered to members

The medical schemes industry is currently experiencing a proliferation of benefit options, particularly when efficiency discount benefit options are taken into account. The more benefit options there are, the more complex the process of choosing the right option becomes for beneficiaries. The classification of benefit options project was initiated to standardise and classify benefit options based on the attributes of each option's benefit offerings. The research work is continuing in this regard.

Medical schemes continued to consolidate in 2016/2017, with the number of benefit options available remaining stable over the period under review. There was an increase in the number of efficiency-discounted benefit options (EDOs) registered on 31 March 2017.

The total number of registered benefit options (including EDOs) increased from 323 in March 2016 to 331 in March 2017. Benefit options in open schemes increased from 184 to 185, and restricted schemes registered options increased from 139 to 146.

Table 2: Registered benefit options as at 01 March 2017

Status of option	Open scheme options	Restricted scheme options	Total options
Options registered as at 31 March 2016	**184**	**139**	**323**
Less: efficiency-discounted options	-42	0	-42
Options registered as at 31 March 2016 (excluding efficiency-discounted options)	142	139	281
New options	6	5	11
Discontinued options	0	-1	-1
Discontinued options due to scheme mergers	-7	0	-7
Options registered as at 31 March 2017 (excluding efficiency-discounted options)	141	143	284
Options with efficiency discounts*	44	3	47
Options registered as at 31 March 2017	**185**	**146**	**331**

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

Efficiency-discounted options (EDOs)

There were 11 (nine open and two restricted) schemes offering efficiency-discounted options as at 31 March 2017. The schemes are Momentum Health; Discovery Health Medical Scheme (DHMS); Fedhealth Medical Scheme; Bonitas Medical Scheme; Thebemed; Compcare Wellness Medical Scheme; Medihelp; Bestmed Medical Scheme; Resolution Health; Government Employees Medical Scheme (GEMS) and Motohealth Care.

In terms of section 29(1)(n) of the Medical Schemes Act, a medical scheme can only differentiate contributions on the basis of family size and income. Hence, schemes intending to introduce EDOs must apply and be exempted from section 29(1)(n) before they can operate EDOs. Previously only open medical schemes elected to offer such options, but two restricted medical schemes have applied to register these types of options. Refer to Annexure T for detailed information on the 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.

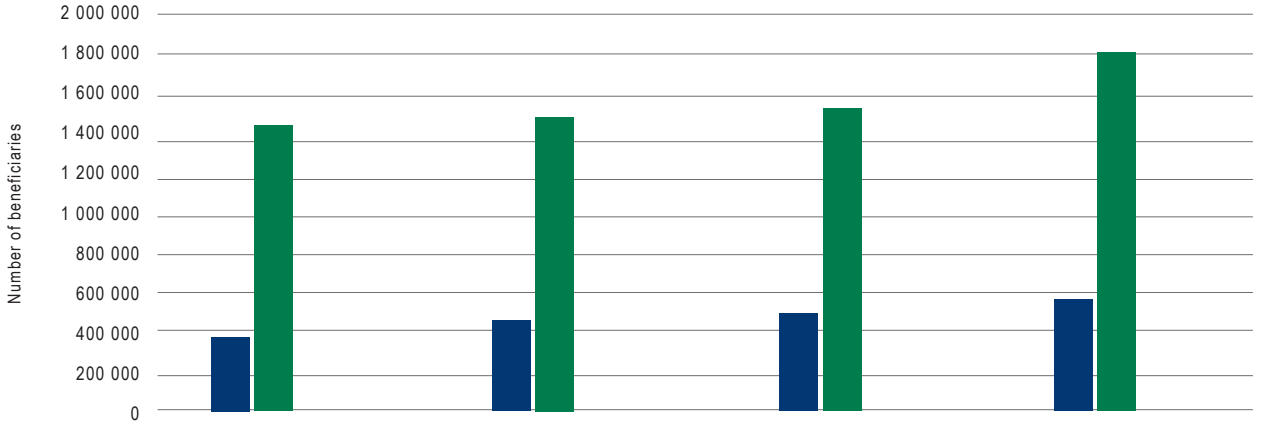
The fact that average age of the membership of EDOs is lower than that of the main option, suggests that members who choose these options are willing to join options with restrictions on provider networks as there is a lower expectation of them needing the benefits in this age cohort. Although experience on these options has been favourable to date, the options with restricted providers should be promoted to the higher age cohort as the choice of the provider network is not only cost effective but also more efficient in providing the healthcare service, resulting in those needing care actually getting access to a better quality of care at a more efficient cost. Members' contributions are fair and non-discriminatory and they retain a measure of choice within the efficiency of the network.

Table 3 reflects the number of beneficiaries on EDOs and non-EDOs since 2013.The EDOs have evidenced consecutive above-average annual membership growth rates over the past three years. During the period under review, membership of EDOs increased by 13.6% per annum across the medical schemes offering EDOs from the beginning of 2016, compared to an increase of 7.1% per annum of the non-EDOs.

Table 3: Beneficiaries on EDO and non-EDO options 2013 – 2016

Type of Options	2013	2014	2015	2016
EDOs	375 448	433 234	487 659	549 787
Non-EDOs	1 460 418	1 482 603	1 527 353	1 796 218
Total	**1 835 866**	**1 915 837**	**2 015 012**	**2 346 005**

Figure 8: Number of Beneficiaries on EDOs and non-EDOs 2013 – 2016



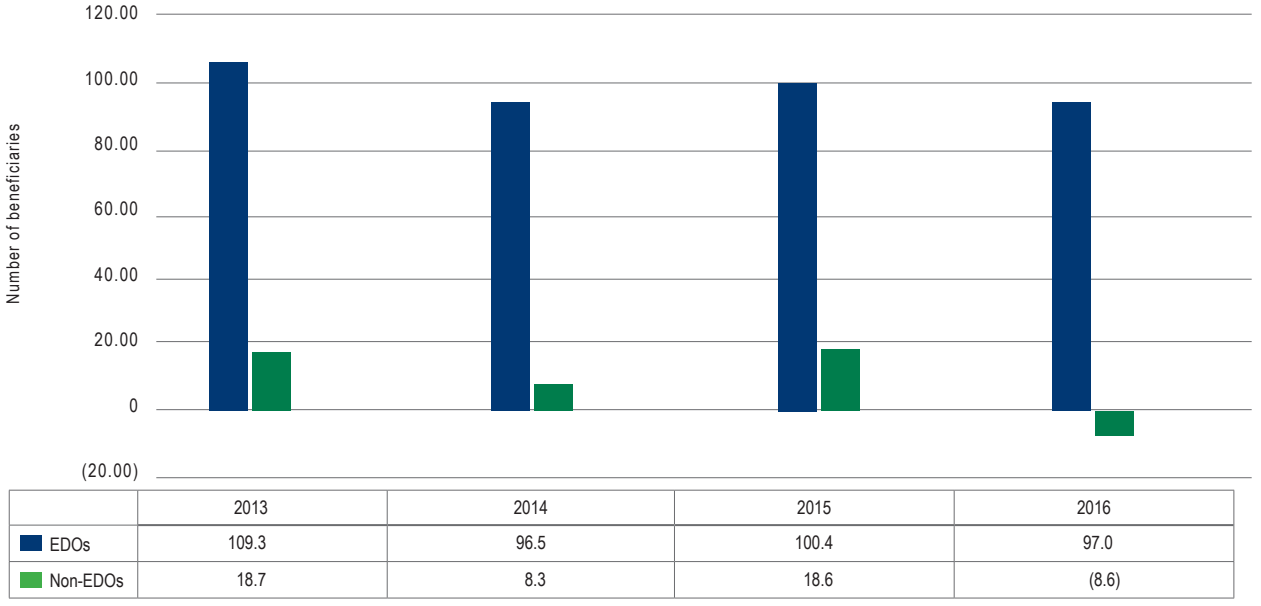
	2013	2014	2015	2016
EDOs	375 448	433 234	487 659	549 787
Non-EDOs	1 460 418	1 482 603	1 527 353	1 796 218

The net healthcare results of the EDOs and non-EDOs is shown in Table 4. Overall, the EDOs continue to report positive net healthcare results. During the period under review, the EDOs collectively contributed up to 139.8% of the total surplus, even though these options accounted for only 23.4% of the total membership.

Table 4: Net healthcare results of EDOs and non-EDOs 2013 – 2016

Table of option	2010 R'000	2011 R'000	2012 R'000	2013 R'000
EDOs	492 198	501 850	587 271	630 314
Non-EDOs	326 786	147 681	341 593	-179 323
Total	**818 984**	**649 531**	**928 864**	**450 991**

Figure 9: Net healthcare results (pbpm) 2013 – 2016



	2013	2014	2015	2016
EDOs	109.3	96.5	100.4	97.0
Non-EDOs	18.7	8.3	18.6	(8.6)

The age profile of the EDOs is compared to the corresponding non-EDOs in Table 4. The membership age profile has been fairly consistent across the nine medical schemes offering EDOs during the period under review. The EDO membership base reflects a favourable age profile with an average age of 31.6. As at 31 December 2016, the average EDO member is 3.6 years younger than the average member on the non-EDO.

Table 5: Membership age profile of EDOs and non-EDOs 2016

	Membership		Average member age	
Scheme Name	EDO	Non-EDOs	EDO	Non-EDOs
Bestmed Medical Scheme	6 042	69 014	30.4	31.6
Bonitas Medical Scheme	12 242	367 084	32.6	33.9
Compcare Wellness Medical Scheme	5 593	19 621	34.9	37.9
Discovery Health Medical Scheme	265 536	1 126 016	31.9	35.6
Fedhealth Medical Scheme	1 399	51 773	33.2	39.3
Medihelp	44 187	106 484	29.1	35.7
Momentum Health	203 985	56 171	31.6	36.1
Thebemed	10 803	55	32.8	30
Total	**549 787**	**1 796 218**	**31.6**	**35.2**

The following table provides a high-level summary of the EDOs currently registered. Refer to Annexure T for detailed information on the EDOs.

Table 6: EDO option summary as at 31 December 2016

Type of option	Members	Beneficiaries	Gross contributions R'000	Net healthcare results pbpm R	Claims ratio %
EDOs	261 820	549 787	7 517 919	97	73.8
Non-EDOs	824,205	1 796 218	42 595 577	-8.6	90
Total	**1 086 025**	**2 346 005**	**50 113 496**	**16.5**	**87.5**

Member contributions to offset benefits

The average gross contribution increase for all medical schemes in 2017 was 11.3%. On average, restricted schemes instituted larger increases in contributions (12.0%) than open schemes (10.8%).

The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. Below is a summary based on medical scheme submissions on benefit changes and contribution increases for 2017.

Table 7: Average gross contribution increases for 2016/2017 benefit and contribution review period

	Principal member %	Adult dependant %	Child dependant %	Family %
Restricted schemes	11.6%	12.6%	12.7%	12.0%
Open schemes	10.7%	11.0%	10.6%	10.8%
All schemes	**11.1%**	**11.6%**	**11.7%**	**11.3%**

Table 8: Average monthly gross contribution for 2017

	Principal member R	Adult dependant R	Child dependant R	Family R
Restricted schemes	2 232	1 826	821	3 841
Open schemes	2 342	2 096	737	3 796
All schemes	**2 298**	**1 988**	**778**	**3 814**

The average risk contribution increase for all medical schemes in 2017 was 11.9%. The comparative increases for open schemes were 11.5% and for restricted schemes 12.5%. The risk contribution is equal to the total contribution paid less the amount that is allocated to a savings account for a beneficiary.

During the review period, the level of contribution to savings accounts as a proportion of the total contribution differed for open and restricted schemes. For all schemes, the average amount contributed to savings accounts amounted to 9.6% of total contributions. In the case of open schemes, this proportion was 13.3%, while for restricted schemes it formed 4.2% of total contributions. This reflects a difference in the benefit structures of open and restricted schemes, particularly in relation to the extent of out-of-hospital benefits and how these are split between members' savings and the risk pool.

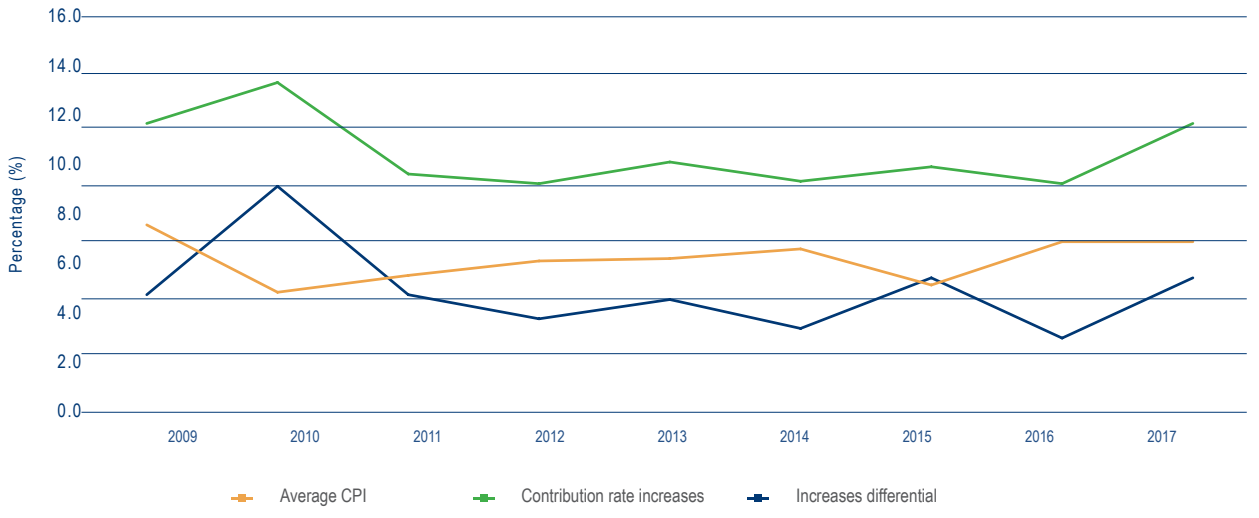
Table 9: Average monthly risk contribution for 2016/2017 benefit and contribution review period

	Principal member %	Adult dependant %	Child dependant %	Family %
Open schemes	11.4%	11.6%	11.6%	11.5%
Restricted schemes	12.1%	13.1%	13.0%	12.5%
All schemes	**11.7%**	**12.3%**	**12.4%**	**11.9%**

Contribution increases for 2017 relative to general price indicators

Figure 10 shows historical and current inflation trends, measured by the Consumer Price Index (CPI), relative to contribution rates of medical schemes between 2009 and 2017. The graph also indicates the percentage by which the average rate of increase in medical scheme contributions exceeded inflation.

Figure 10: Contributions and inflation 2009 – 2017



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

The contribution rate increases shown in the graph above relates to the increase in the contribution rates from the previous year i.e. for 2017 the average increase in contributions of 11.3% relates to the increase in contributions from 2016 to 2017. Similarly, the average CPI is the average CPI experienced in the year the increase was in effect except for 2017 where the projected CPI of 6.4% was based on the National Treasury Forecast for CPI for 2017. The graph also illustrates that the average difference in contribution increases relative to CPI was in the region of 4.4% between 2001 and 2017. This has implications for the long-term affordability of the medical schemes industry as increases in salaries may not keep pace with contribution increases.

Prescribed minimum benefits (PMB) review

The review commenced during the course of the year. The highlight of the review is the proposed transition from the current 270 medical conditions list and 26 chronic conditions to service-based packages. These will be aligned to the NHI comprehensive benefit service. The review will place great emphasis on disease prevention and health promotion. Special attention will be given to maternal, child, adolescent, geriatric and mental health through a comprehensive primary healthcare approach. A consultation process was initiated in this regard, and the CMS is happy with the overall support for the review process.

Benefit definition

The benefit definition project clarifies what benefits members of medical schemes are entitled to under the prescribed minimum benefit regulations. During the year under review, the benefit definitions for early and advanced oesophageal cancer; early and advanced gastric cancer; early and advanced pancreatic cancer, as well as best supportive care, were published. A draft document on colorectal cancer was published for stakeholder comment. This is prospective regulatory work aimed at reducing complaints from members of schemes, while ensuring the sustainability of medical schemes.

PMB Code of Conduct update

The PMB code of conduct is an industry-wide consensus document on the interpretation of the PMB regulation. The current document was agreed upon and published in July 2010, and is now being updated by representatives from various stakeholder groups.

Healthcare utilisation data

Scheme risk measurement

The CMS continued to collect scheme risk measurement data during 2016. This data is useful in understanding the differences in the risk profiles of medical schemes. Unfortunately, the prevalence rates are outdated and will be updated once the project for the revision of the PMBs is finalised. It is evident that medical schemes don't compete at the same level and that there are significant differences between the risk profiles of the various schemes.

The growing burden of chronic disease care

The 2015 retrospective study of the CMS Scheme Risk Measurement (SRM) database was undertaken to establish changes in the frequency of chronic diseases among beneficiaries of medical schemes between 2009 and 2015.

The main finding was that there has been a sustained upward trend in diagnosis and treatment of many conditions on the chronic disease list (CDL). While the study could not isolate specific reasons for this increase in chronic diseases, the trend could generally be attributed to improved data management systems of medical schemes and administrators; the deteriorating disease profile of beneficiaries; increased beneficiary awareness of entitlements; and changes in care-seeking behaviour.

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 an increase in the number of younger, healthier beneficiaries who join medical schemes is critical for the long-term sustainability of the industry. The value proposition of managed healthcare interventions will become increasingly important as we move forward, and schemes have to ensure that the beneficiaries receive value for money.

Third-party accreditation for quality healthcare

Accreditation of entities is undertaken in accordance with the legislative mandate of the CMS. This is to ensure compliance with requirements and accreditation standards that measure capabilities to conduct business as fit and proper entities. Capabilities entail requisite skills, capacity, infrastructure, and ability to remain financially sound.

Third-party administrators and self-administered schemes

The office did not receive any applications from new entrants to be accredited in the 2016/2017 financial year. Prime Med Administrators (Pty) Ltd applied for the renewal of its accreditation, in line with Regulation 26(2) of the Medical Schemes Act, as a result of the changes in control following the acquisition of the entity's shares by another administrator.

Council approved the following renewal applications:

Table 10: Administrators and self-administered schemes accredited

ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES ACCREDITED				
	New applications:	**Renewals:**	**On-site evaluations:**	**On-site compliance evaluations:**
Administrators	None	1. Agility Health (Pty) Ltd 2. Allcare Administrators (Pty) Ltd 3. MMI Health (Pty) Ltd 4. Sanlam Health (Pty) Ltd 5. Sechaba Medical Solutions (Pty) Ltd 6. Sweidan and Company (Pty) Ltd 7. Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd 8. Universal Healthcare Administrators (Pty) Ltd 9. MMI Health (Pty) Ltd	1. Metropolitan Health Corporate (Pty) Ltd 2. MetHealth (Pty) Ltd	1. MMI Health (Pty) Ltd 2. Allcare Administrators (Pty) Ltd
Self-administered Schemes		1. Food Workers Medical Benefit Fund 2. SAMWUMED 3. Rand Water Medical Scheme 4. De Beers Benefit Society 5. Sedmed		1. Bestmed Medical Scheme

Sixteen third-party administrators were accredited and 11 self-administered medical schemes were provided with certificates of compliance with accreditation standards as at 31 March 2017.

Accreditation of managed care organisations

Three new applications for accreditation of managed care organisations (MCOs) were received and evaluated during the period under review. Two organisations were found non-compliant with the conditions for accreditation as the services provided did not meet the definition of "managed healthcare" as defined in the Medical Schemes Act and the Regulations. Accordingly, these organisations did not require to be formally accredited and the applicants were duly notified. Iyeza Health (Pty) Ltd met the requirements and was subsequently accredited.

Council approved the rewewal of accreditation of the following MCOs for a period of two years:

Table 11: Managed care organisations and self-administered schemes accredited

ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES ACCREDITED				
	New applications:	**Renewals:**	**On-site evaluations:**	**On-site compliance evaluations:**
Managed Care	1. Iyeza Health (Pty) Ltd	1. Agility Health (Pty) Ltd 2. Allcare Administrators (Pty) Ltd 3. CareCross Health (Pty) Ltd 4. Discovery Health (Pty) Ltd 5. HIV Managed Care Solutions (Pty) Ltd t/a CareWorks 6. Lifesense Disease Management (Pty) Ltd 7. Mediscor PBM (Pty) Ltd 8. Metropolitan Health Risk Management (Pty) Ltd 9. MMI Health (Pty) Ltd 10. OneCare Health (Pty) Ltd 11. Performance Health (Pty) Ltd 12. Prime Cure Health (Pty) Ltd 13 . Professional Provident Society Healthcare Administrators (Pty) Ltd 14. Providence Healthcare Risk Managers (Pty) Ltd 15. Rx Health (Pty) Ltd 16. Sanlam Health Managed Care (Pty) Ltd 17. Scriptpharm Risk Management (Pty) Ltd 18. South African Oncology Consortium Limited 19. Supplementary Health Services (Pty) Ltd 20. Vmed Administrators (Pty) Ltd	1. ISIMO Health (Pty) Ltd 2. Providence Healthcare Risk Managers (Pty) Ltd 3. Supplementary Health Services (Pty) Ltd 4. Thebe Health Risk Management (Pty) Ltd	1. Allcare Administrators (Pty) Ltd
Self-administered Schemes				1. Bestmed Medical Scheme

The following MCOs elected not to renew their managed care accreditation during the year under review:

- Medicross Healthcare Group (Pty) Ltd
- Managed Healthcare Systems (Pty) Ltd.

A total of 40 accredited managed care organisations and one self-administered scheme were issued with compliance certificates as at 31 March 2017.

Brokers and broker organisations

Table 12: Individual brokers and broker organisations accredited

BROKERS AND BROKERAGES ACCREDITED		
	Individual brokers:	Brokerages:
First time applications received:	648	80
Renewal applications received:	4 253	1 119
Total accredited:	3 816	1 038
Not accredited: disqualified and due to incomplete information	1 085	161

Total number of accredited brokers and broker organisations as at 31 March 2017

A total number of 8 552 Individual brokers and 2 251 organisations were accredited as at 31 March 2017. The accreditation of the following brokers was rejected and withdrawn during the financial year under review:

Table 13: Broker accreditation withdrawn

Broker number	Action	Effective date	Reason
Frans Jacobs (Br35746)	Withdrawn	31/10/2016	Broker passed away
David Harding (Br33828)	Withdrawn	13/04/2016	Broker debarred by FSB
Christopher Swart (Br33828)	Withdrawn	13/04/2016	Broker debarred by FSB
Barry Jamie (Br20102)	Withdrawn	15/11/2016	Broker no longer provides broker services

Table 14: New broker applications rejected

Name of applicants	Action	Effective Date	Reason
Sibusiso Zitha	New application refused	02/03/2017	Failed to comply with the experience requirement for accreditation
Wilhelm Erwee	New application refused	22/02/2017	The applicant is an unrehabilitated insolvent
Janke Olivier	New application refused	21/06/2016	Failed to comply with the qualification requirement for accreditation
Suzanne Croucamp	New application refused	11/04/2016	Names on ID document do not correspond with names on the qualification
Michelle Slater	New application refused	17/08/2016	Failed to comply with the qualification requirement for accreditation
Derek van Zyl	New application refused	14/12/2016	The applicant is an unrehabilitated insolvent
Shane Grant	New application refused	26/01/2017	Failed to disclose material information relating to fit and proper requirement

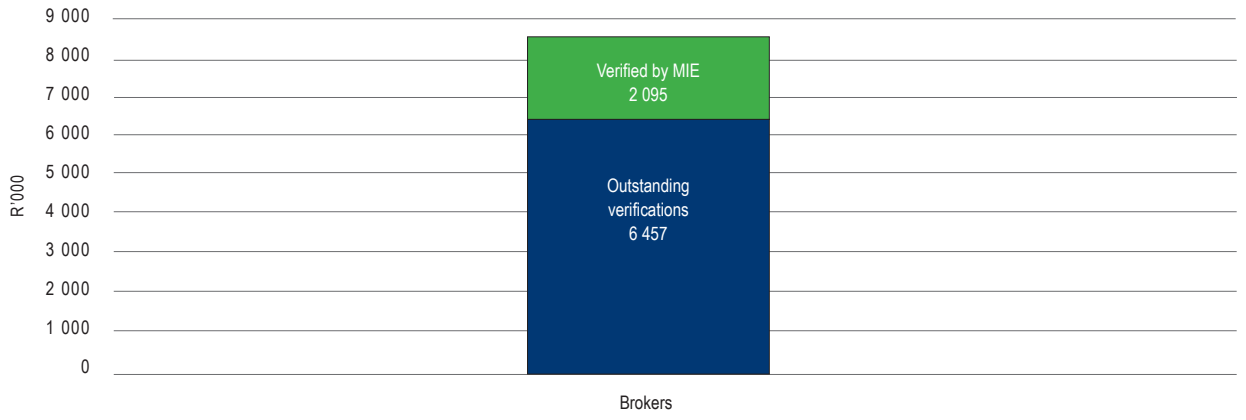
Table 15: Brokerage accreditation withdrawn

Brokerage No.	Action	Effective Date	Reason
Samore CC (ORG165)	Withdrawn	18/05/2016	Requested to be withdrawn
HDM Makelaars CC (ORG 2398)	Withdrawn	18/05/2016	Entity no longer exists
Assure Risk Solutions CC (ORG3371)	Withdrawn	05/07/2016	No longer licensed at FSB

Verification of qualifications

The CMS introduced a system to verify the academic qualifications of individuals applying for accreditation to minimise the risk of accrediting persons who fail the minimum academic qualifications requirement. A total of 1 069 applications were verified in terms of the performance agreement with the service provider during the financial year under review.

Figure 11: Individual broker qualifications verified to date vs total number of individual brokers accredited



Adjustment of broker fees

The Minister of Health announced an increase in the maximum amount payable to brokers by medical schemes in respect of broker clients who are members of medical schemes, in terms of section 65 of the Medical Schemes Act. The amount was increased to R85.00 per member per month, with effect from 01 January 2017.

Complaints

The CMS investigated and resolved three broker related complaints.

Transformation

The CMS initiated a survey to explore the extent to which accredited entities comply with the provisions of the government's Broad Based Black Economic Empowerment (B-BBEE) policy, by requesting submission of B-BBEE certificates by the entities. A total of 30 out of 40 accredited Managed Care Organisations (MCOs); 14 out of 16 Administrators; and 11 out of 23 brokerages responded positively to the request, reporting compliance with B-BBEE status at various levels.

The initiative was in response to a need identified by the Council and the Office of the Registrar to assess the extent to which the medical scheme fraternity responds to the need to transform in terms of gender and race.

Subsequent to the above, processes have since been put in place to collect and report on gender and race information across the entire spectrum of the private sector health insurance environment, to include inter-alia, principal officers; brokers; board of trustees; and medical scheme membership.

Compliance matters for proper governance

As part of its mandate to investigate and enforce compliance with the provisions of the Medical Schemes Act, the CMS conducts various regulatory activities to ensure that the Act is upheld by all entities carrying out "the business of a medical scheme", and to reduce non-compliance and fraud within the private healthcare sphere.

In the quest to find multi-dimensional approaches to dealing with governance concerns, the CMS has collaborated with The Global Platform for Intellectual Property (TGPIP) to develop the Governance Compliance Instrument for medical schemes. The instrument is intended to serve as a comprehensive, credible, and standardised process that will facilitate better governance and compliance management by medical schemes' members of the board of trustees, including the promotion of transparency and accountability towards the schemes beneficiaries and the Council for Medical Schemes. A total of 39 schemes have come on board so far. Medical schemes that have not yet subscribed to the platform are targeted for participation.

AGMs

The CMS identified and attended 41 schemes' annual general meetings (AGMs) as an observer. Irregularities were identified in 19 meetings, and these have been addressed with the schemes' principal officers. From observation of the AGM proceedings, it was noted that most of the issues raised by members related to complaints regarding partial payment of hospital bills; the schemes' appointment of service providers such as auditors; and salary increases for board of trustees without prior consultation with scheme members; scheduling of AGMs at inconvenient times; and the late delivery of meeting packs to members. Some of the AGM observations are indicated below.

SAMWUMED Medical Scheme

Pursuant to the scheme's AGM on 30 June 2016, which was not quorate, the CMS Compliance and Investigations Unit prepared a report to alert the Council.

The Council issued a directive to the scheme to respond to the AGM findings and upon receipt of the scheme's response, a final determination was made by the Acting Registrar for the scheme's AGM to be reconvened. The scheme has filed a section 49 appeal, and the date for the hearing is still pending.

POLMED Medical Fund

The South African Policing Union (SAPU) interdicted the 2016 AGM. The scheme and SAPU convened a meeting during which it was resolved that the scheme would prepare a disclosure document that would be included in the AGM pack, and thereafter the AGM would proceed. The disclosure to members would include the inspection findings, directives and the implementation thereof. The scheme subsequently made a proposal to the Registrar, requesting that instead of a disclosure document being sent to members, a special general meeting (SGM) be held to address the matters contained in the disclosure document. The scheme's SGM was scheduled for 26 April 2017.

Routine inspections

Great strides were made in overseeing routine monitoring of compliance by schemes in terms of section 44(4)(b) inspections. During the year under review, a total of 13 routine inspections were conducted on the following schemes:

- Anglovaal Medical Scheme
- BMW Employees Medical Scheme
- Engen Medical Scheme
- Imperial Medical Scheme
- De Beers Medical Scheme
- Fishmed Medical Scheme
- Golden Arrows Medical Scheme
- Grintek Medical Scheme
- UKZN Medical Scheme
- Commed Medical Scheme
- Foodworkers Medical Scheme
- Sedmed Medical Scheme
- Genesis Medical Scheme

Probes into allegations

In instances where allegations of fraudulent or improper conduct were received, the allegations were looked into; and section 44(4) (a) inspections commissioned as follows:

Bonitas Medical Scheme

The CMS instituted an inspection into the affairs of the scheme based on information obtained with regard to allegations of governance irregularities.

Bestmed Medical Scheme

The CMS instituted an inspection into the affairs of the scheme to investigate allegations of nepotism, contracting based on favouritism, doing business outside of South Africa, remuneration of non-brokers for introduction and admission of members, and payment of loyalty programme fees by the scheme.

Removal of trustees

In instances where trustees of a scheme were found to be unfit and improper, the removal of trustees in terms of section 46(1) was effected.

Bestmed Medical Scheme

On 13 October 2016, the Appeal Board heard the arguments with regard to the removal of 10 board of trustee members. The matter set down for hearing on 03 March 2017 was argued on preliminary issues, and the Appeal Board found in favour of the CMS. The scheme has 180 days to respond.

Medshield Medical Scheme

The Medshield Medical Scheme informed the CMS of its decision to remove its former chairperson Mr T. Mphela, due to allegations made by the Chairperson of the Thebemed medical scheme Mr V. Mazibuko, alleging that Mr Mphela had attempted to merge the two schemes in order to personally gain from the transaction. The CMS conducted an investigation into the allegations to determine if Mr Mphela was fit and proper to remain as a trustee. Council resolved to issue section 46 notices to Messrs Mphela and Mazibuko, who duly responded to the notices. At its discretion, the Medshield Board of Trustees took a decision to demote Mr Mphela from the position of Chairperson to an ordinary member of the board, as a result of the allegations made by Mr Mazibuko. Mr Mphela subsequently resigned from his role as a trustee member of the scheme. Council resolved not to remove Mr Mazibuko as a trustee, but to issue him with a stern warning.

Another section 46 notice was issued against Mr C. Parsons, a member of the Medshield Board of Trustees, pertaining to allegations of non-disclosure when he was nominated and elected as a trustee of the scheme. After careful consideration of Mr Parsons' submissions on the allegations made against him, Council took a resolution to remove him as trustee member of the scheme.

Complaints adjudicated

The CMS received 4 823 new complaints during 2016, this signifies a decrease of 266 complaints compared to the 5 089 complaints received in 2015.

Table 16: Number of complaints received and resolved

	Dec 2016	Dec 2015
Complaints carried forward from the previous year	1 457	2 162
Complaints received during current year	4 823	5 089
Total complaints	6 280	7 251
Total complaints resolved during the year	(4 526)	(5 794)
Closing balance as at 31 Dec	1 754	1 457

Some complaints were not resolved timeously and rolled-over to the next reporting period due to their complexity, while others could not be resolved due to delayed submission of further particulars which were required for adjudication. In addition to this, two (2) staff members resigned and the unit was short-staffed.

Table 17: Resolution turnaround times for complaints in 2016

	Resolution turnaround time in days					
Complaints resolved	0 – 30	31 – 60	61 – 90	91 – 120	>120	Total
Number of complaints resolved	1 813	904	682	420	707	4 526
% of complaints resolved	40.0	20.0	15.1	9.3	15.6	100.0

Table 18: Rulings on resolved complaints against regulated entities in 2016

Entity Type	Number of complaints	Ruled in favour of the complainant	Ruled in favour of both complainant and the regulated entity	Ruled in favour of the regulated entity	Invalid / Enquiries
Open medical schemes	2 676	968	254	1 014	440
Restricted medical schemes	1 844	794	47	485	518
Brokers	3	3 (2 referred)			
Administrators	3	2		1	
Total	**4 526**	**1 767**	**301**	**1 500**	**958**

* *In respect of the broker complaints, two (2) were referred to FIAS Ombuds and FSB as they related to alleged improper conduct.*

Table 19: Number of complaints resolved in 2016, by category

Main categories	Number of complaints resolved
Valid complaints: Clinical	1 229
Valid complaints: Administrative	2 051
Valid complaints: Legal / Compliance	288
Sub-total	3 568
Inquiries / Invalid	958
Total	**4 526**

Table 20: Number of complaints resolved by category (2015 and 2016)

	2015	2016
Clinical complaints	**1 524**	**1 229**
Short-payment of PMB accounts	**1 050**	**839**
Paid at scheme tariff	387	327
Designated service provider	257	187
Protocols	166	111
Sub-limits in options	50	54
Incorrect coding	42	45
Outstanding information	63	38
Formularies	36	34
Paid from savings account	41	29
Service provider irregular billing	8	14
Non-payment of PMB accounts	**322**	**278**
Protocols	128	98
Sub-limit in options	37	47
Scheme exclusion	26	30
Outstanding information	44	27
Designated service provider	37	26
Incorrect coding	21	26
Formularies	21	23
3rd party claim	1	1
Paid at scheme tariff	2	0
Service provider irregular billing	5	0

	2015	2016
Short-payment of non-PMB accounts	**128**	**96**
Sub-limits in options	56	49
Network provider	20	19
Outstanding information	12	11
Protocols	28	8
Incorrect coding	9	6
Formularies	2	2
Provider irregular billing	1	1
Non-payment of non-PMB accounts	**24**	**16**
Administrative complaints	**1 767**	**2 051**
Benefits paid incorrectly	923	1 058
Pre-authorisation	300	341
General customer service	241	328
Medical savings account	144	162
Contribution increases	118	139
Benefit option changes	24	21
Information / brochures not received	15	2
Inaccessible networks	2	0
Legal/Compliance	**348**	**288**
Suspension/termination of membership	200	169
Waiting periods	81	69
Late joiner penalty	33	27
Rejection of application for membership (discrimination)	15	13 (eligibility)
Governance	10	6
Broker conduct	6	3
Unethical conduct	3	1

Internal dispute resolution

The CMS collected data on internal dispute resolution processes applied by the various schemes, with a view to determine whether the dispute resolution procedures stated in the registered rules of the schemes are being implemented. The analysis revealed a worrisome trend indicating that alternative dispute resolution mechanisms are not being implemented by most medical schemes. The implication is that some of the schemes are not escalating members' complaints to their internal dispute committees and members are also not being afforded the opportunity to refer disputes to the schemes' dispute resolution committees. This resulted in some members approaching the CMS for the resolution of their complaints.

Table 21: Internal dispute resolution activities for open medical schemes with most complaints per 1 000 beneficiaries

Open schemes	2015 complaints per 1 000 beneficiaries	2016 complaints per 1 000 beneficiaries	Dispute Resolution Committee (DRC) Yes/No	Number of matters served before the DRC
Spectramed	5.4	5.5	Yes	Nil
Resolution Health	2.9	3.4	Yes	Nil
Commed	0.8	2.3	Yes	Nil
Genesis	1.2	1.5	Yes	Nil
Topmed	0.8	1.4	No	Nil
Medihelp	0.9	1.3	Yes	Nil
Selfmed	0.6	1.0	Yes	Nil
Fedhealth	0.9	0.9	No	Nil
Cape Medical Plan	0.7	0.9	Yes	Nil
Liberty Health	0.7	0.8	No	Nil

* *This table shows the number of complaints received per 1000 beneficiaries, and does not imply that rulings were issued against the medical schemes listed.*

Table 22: Internal dispute resolution activities for closed medical schemes with most complaints per 1 000 beneficiaries

Restricted schemes	2015 complaints per 1 000 beneficiaries	2016 complaints per 1 000 beneficiaries	Dispute Resolution Committee (DRC) Yes/No	Number of matters served before the DRC
Metropolitan Health	0.4	0.9	Yes	Nil
Grintek	0.0	1.1	No	Nil
BP	0.2	1.0	No	Nil
Bankmed	0.4	0.8	Yes	Nil
Golden Arrows	0.0	0.8	No	Nil
Polmed	0.6	0.7	Yes	Nil
Motohealth	0.5	0.7	Yes	Nil
Netcare	0.9	0.7	Yes	Nil
Parmed	0.2	0.6	No	Nil
Transmed	0.5	0.5	Yes	Nil

* *The table above shows the number of complaints received per 1000 beneficiaries and does not imply that rulings were issued against the medical schemes listed.*

Clinical opinions

The Clinical Unit provided a total of 410 clinical opinions out of 404 cases referred by the Complaints Adjudication Unit. The six additional cases were carried over from the previous financial year. An overall completion rate of 100% of all referred clinical opinions was achieved for the 2016/2017 financial year.

Topical court rulings

During the period under review the Legal Services Unit was involved in a number of High Court applications and tribunal hearings to ensure that the interests of beneficiaries are protected at all times and to ensure that medical schemes complied with the legislated principles of fiduciary responsibility and good corporate governance enshrined in the Medical Schemes Act. The unit exceeded the targets set in achieving its key objectives during the period and positively contributed to upholding the regulatory mandate of the CMS.

CMS v COMMED

COMMED's financial statements were blanked out in the 2015/2016 annual report due to a dispute concerning the scheme's rejected and restated audited financial statements that had not been resolved at the time. The dispute is not yet finalised and has been referred for external adjudication.

The CMS lodged an urgent application for an order placing this medical scheme under curatorship as a result of a number of serious adverse findings emanating from a commissioned inspection into the affairs of the scheme, during the year under review. These related to a significant failure of governance resulting in the financial stability of the medical scheme being seriously compromised.

CMS v South African Medical Association

Competition Commission: South African Medical Association v CMS (Modifiers)

This longstanding matter relates to a complaint lodged with the Competition Tribunal by the CMS against the South African Medical Association (SAMA) and the South African Paediatric Association (SAPA) on the one hand and SAMA and the Society of Cardiothoracic Surgeons of South Africa (SOCTS) on the other hand. In the complaint referrals, the CMS alleges that these parties are involved in indirect price-fixing by way of the publication of certain codes in the doctor's billing guide (DBG) issued by SAMA, which are not provided for in the National Health Reference Price List (NHRPL).

The effect of these publications means that paediatricians and neonatologists are allowed to charge a 50% surcharge by charging a new code, Modifier 0019(b) on certain intensive care items; and cardiothoracic surgeons are allowed to use a formula in terms of which they can charge a separate fee under code 1348 for each saphenous vein graft performed under a single anaesthetic, subject to the application of Modifier 0005. As a result of this conduct, members and consumers in general are required to pay more for these health services while medical schemes are not obliged to fund these codes.

There has been a number of interlocutory disputes ranging from the right of the CMS to lodge the complaint in its capacity as a regulatory body, to an application to strike out our case due to allegations by SAMA that it is too vague. These matters have now been adjudicated by the Competition Appeal Court and the Competition Tribunal respectively – both ruled in favour of the CMS in both instances. The pleadings have been consolidated by the CMS and the merits of the matter can now be dealt with by the Competition Tribunal.

Genesis

Genesis v CMS (Defamation)

The matter was heard in the Gauteng Division of the High Court (Pretoria) on 16 March 2017. Genesis Medical Scheme (Genesis) lodged an urgent application against the CMS and the Registrar requesting an order by the court to direct the CMS and the Registrar to remove a number of statements from its website which stated that the scheme persists in not paying prescribed minimum benefits (PMBs) in full despite a ruling by the Supreme Court of Appeal that it do so. Genesis and the CMS differed on the application and interpretation of the relevant judgment. The matter was heard by Judge Davis who dismissed the case on the basis that the publications by the CMS were both true and in the public interest. A cost order was also awarded against Genesis.

Genesis v Registrar (Rule amendment)

The Registrar rejected a rule submitted by the scheme in terms of which it sought to summarily select all state hospitals as its designated service provider (DSP). The reason for the rejection was based on the Registrar's interpretation of the Supreme Court of Appeals' judgment in the matter of Genesis v the CMS and Joubert, wherein the court said that the appointment of the public sector as a DSP would not have been offensive if the Registrar was satisfied that there was a clear agreement in place.

The Registrar found that the proposed rule amendment would not be in the best interests of members of the medical scheme, as a mere selection of the state as a DSP fails to ensure that the relevant state facilities indeed have the capacity and resources required to service all the members of the scheme. The scheme appealed the rule rejection on the basis that the statement made by the Supreme Court of Appeal was simply made in passing and was therefore not part of the judgment.

The matter was heard by the Appeals Committee which dismissed the appeal and directed the scheme to withdraw within seven days, a publication sent to its members on 11 March 2016 advising them that every public hospital has been selected as a DSP for the treatment of prescribed minimum benefits. The scheme is expected to lodge a further appeal, but this falls outside the scope of this annual report.

Genesis v CMS (Savings)

Following a ruling by the Gauteng Division of the High Court regarding the accounting treatment to be accorded to personal medical savings accounts, a dispute arose between Genesis and the CMS when the scheme failed to submit financial statements in line with the judgment (by not separately accounting for the funds in members' savings accounts).

The scheme lodged an application in the Western Cape High Court, which found in favour of the scheme. The CMS then successfully appealed the matter in the Supreme Court of Appeal, after which the scheme appealed to the Constitutional Court. The matter was heard before the Constitutional Court on 07 February 2017 and we await the outcome that will clarify how savings accounts should be accounted for by medical schemes.

The view of the CMS is that the funds in a member's personal savings account are trust funds belonging to members and should not be accounted for in the same way as the other assets of a medical scheme. We will report further on this matter in our next annual report.

Bonitas v CMS

The Registrar ordered a commissioned inspection into the affairs of the Bonitas Medical Fund and appointed an inspector in terms of section 44(4)(a) of the Medical Schemes Act and section 2 of the Inspection of Financial Institutions Act 80 of 1998 (FIA). The scheme appealed the Registrar's decision to order the inspection in terms of section 49. The effect of the appeal was that the decision being appealed against was suspended and the inspection could not proceed. A dispute arose between the Registrar and the scheme regarding whether the Registrar's decision to order the inspection could be appealed. The CMS approached the High Court for a declaratory order to resolve the dispute. Judge Tuchten of the Gauteng Division of the High Court ruled in favour of the position adopted by the CMS, namely that this was not a decision which could be subjected to an appeal.

The scheme then appealed the decision to the Supreme Court of Appeal, which dismissed the scheme's appeal with costs. The court agreed with the CMS that inspections formed part of its regulatory functions and promoted the objective in section 7(a) of the Medical Schemes Act which requires the Council to protect the interests of members at all times. The court also stated that inspections are intended to be an effective regulatory mechanism which will be undermined if a scheme can obstruct the CMS by way of an appeal. The court stated that it was in the public interest that such inspections be performed without notice and with expedition so that errant schemes would not have the opportunity to hide or destroy evidence. This interest outweighs the right of a scheme to receive notice.

An inspector who conducts the inspection merely gathers evidence and does not determine or affect any rights of a medical scheme. Once directives are issued against a scheme, a scheme was entitled to lodge an appeal against such directive.

Strata v CMS

Strata was previously accredited as an administrator and managed healthcare organisation to render services to Medihelp. These services were previously performed by Medihelp on an in-house basis. When Strata submitted a renewal application for its accreditation as an administrator at the end of December 2015, it came to the attention of the Registrar that there were irregularities in the process in terms of which Medihelp's administration component had been sold and outsourced to Strata.

Some of the concerns related to the contravention of an undesirable business practice declaration in terms of which the employees of Strata were prohibited from benefiting from this transaction. Furthermore the business was sold to Strata, despite a higher offer being made by a competitor. The question of Strata's renewal of its accreditation was considered by the CMS and was turned down on the basis that Strata was not fit and proper to render administration services. Strata appealed the decision to the Appeal Board. At the same time, a process of negotiating the reintegration of the administration services and staff back into the Medihelp Medical Scheme was commenced with. This process was completed in June 2016. The appeal was heard in November 2016 as Strata indicated that the only purpose for proceeding with the appeal was to clear the names of the directors. The Appeal Board dismissed the appeal and confirmed the decision of the CMS.

Medical Schemes Amendment Bill

The Department of Planning, Monitoring and Evaluation (DPME) approved the socio-economic impact assessment on the Bill after it was reviewed and approved by the state law advisors. The Bill is en route to Parliament for further processing.

Health Market Inquiry

The CMS continued to participate in the Health Market Inquiry (HMI) processes; and has engaged with various stakeholders in an effort to clarify certain issues raised during the inquiry.

National Health Insurance

The CMS contributed to the National Health Insurance policy process throughout 2016. Several engagements were conducted with the Clinton Health Access Initiative (CHIA) in an effort to support their research and recommendations for various work-streams within the NHI Committee. This included sharing of data as well as discussions on the PMB revision service package framework.

Provider distribution

The CMS conducted an analysis of the geographic distribution of healthcare providers, with specific focus on healthcare providers that claimed from medical schemes in 2016/2017. The analysis revealed that providers are concentrated in specific centres in each province. The unequal distribution has negative implications on beneficiaries' access to healthcare, as well as the distribution of healthcare expenditure within provinces. This finding has bearing on the NHI in as far as the issue of public-private partnerships is concerned.

Designated service provider and preferred provider arrangements

Work-stream 3 of the NHI White Paper and phase 2 of the NHI implementation focuses on purchase-provider splits, strategic purchasing and value based selective contracting. In line with this approach, the CMS conducted a study on medical schemes' existing designated service provider (DSP) and preferred provider arrangements.

In order to gain a better insight into the importance of DSPs as examples of value added contracting, it is recommended that the Annual Statutory Return Data Specification needs to be expanded to include data requirements on the use of state facilities as DSPs, since the current reporting is limited. A special focus needs to be placed on collecting quality data on remuneration methods and rates. This information can be triangulated to the CMS Scheme Rule Registration data for prospective and concurrent regulatory purposes.

Demarcation between health insurance policies and medical schemes

During the period under review, the CMS received concurrence from the ministers of health and of finance on final demarcation regulations. The Demarcation Regulations were gazetted on 23 December 2016, following several years of extensive consultation with the Financial Services Board, the National Treasury and other key stakeholders.

The Demarcation Regulations provide a distinction between medical scheme cover, which is governed by the Medical Schemes Act, and other types of health insurance that are 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 these regulations, any insurer providing indemnity products such as primary healthcare cover and hospital indemnity cover as of 01 April 2017, is regarded as conducting 'the business of a medical scheme' and falls within the ambit of the Medical Schemes Act.

With effect from 01 April 2017, primary healthcare insurance policies and hospital indemnity products can only be provided by providers that successfully apply for exemption from the CMS.

Reaching out to our stakeholders

During the year under review, the CMS continued to reach out to stakeholders through various platforms such as the Principal Officers' Forum, the Marketing Forum, the Administrators' Forum, as well as the Indaba sessions. The visit to the CMS by members from the Namibia Financial Institutions Supervisory Authority (NAMFISA) and the Financial Services Regulatory Authority of Swaziland, marked a significant step towards strengthening international relations with similar organisations from neighbouring countries.

Education and training

Stakeholder training and awareness sessions conducted during the year under review included continuing professional development (CPD) induction broker training sessions in Gauteng, Eastern Cape, Western Cape and KwaZulu-Natal. The compulsory two-day induction sessions for newly appointed trustees were held in Gauteng and the Western Cape. Focused two-day induction trustee training session was also conducted for HOSMED. Employees from three schemes as well as from the CMS, registered for the accredited skills programme, which is quality assured by the Insurance Sector Education and Training Authority (INSETA).

Table 23: Total number of trustees who attended training sessions during 2016/2017

Training	Number	Percentage
Trained by the CMS	50	5.5%
Trained by others in the industry	125	13.7%
Trained on POPI Act, governance, ethics, King IV	43	4.7%
No training attended	676	74%
Resigned	1	0.2%
Not indicated	1	0.2%
Contradictory information (invalid)	14	1.6%

Notes: 4 trustees attended a combination of training (organised by the CMS & others in the industry).

The figures indicated are not audited and may not reflect all training events attended by trustees.

Table 24: Consumer education and awareness sessions

Province	No. of sessions	No. of sessions in rural areas	No. of sessions in non-rural areas	Total no. of Consumers reached	No. of Consumers reached in rural areas	Rural areas covered	Main languages spoken in the covered rural areas
Eastern Cape	2	–	2	63	–	–	–
Free State	1	1		250	250	Kroonstad	SeSotho and English
Gauteng	27	–	27	2 909	–	–	–
KwaZulu-Natal	3	1	2	542	250	Pongola	IsiZulu
Limpopo	3	3	–	750	–	Modimolle Mokgophong Bela Bela	Sepedi and Setswana
North West	3	2	1	300	300	Swarttruggens Tigane Hartbeesfontein	Setswana
Western Cape	8	3	5	1 547	422	Oudtshoorn Riversdale	IsiXhosa and Afrikaans
Total	47	10	37	6 361	1 222		

Raising awareness among beneficiaries

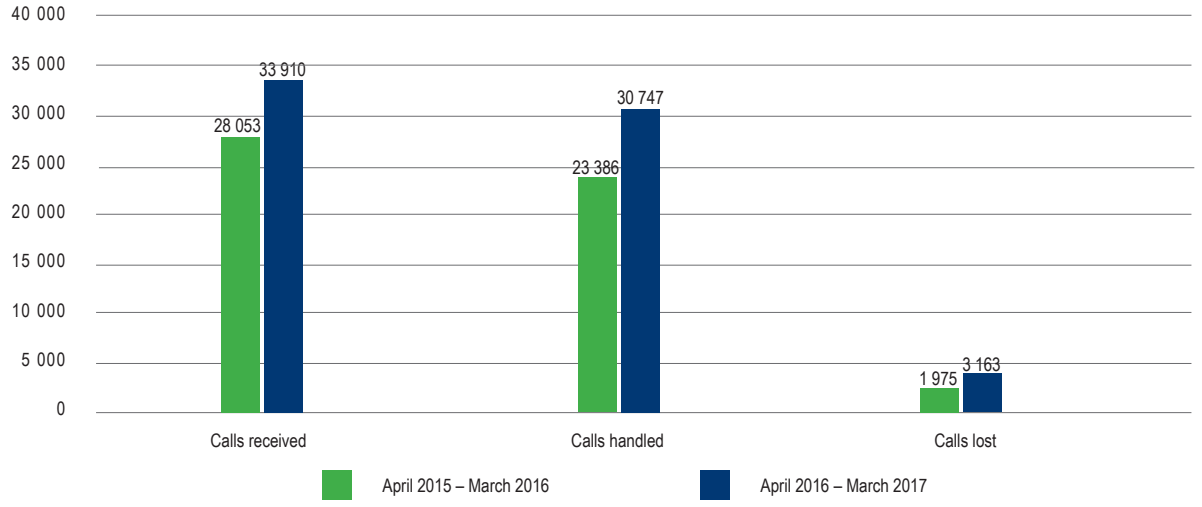
A campaign to raise awareness among beneficiaries regarding services offered by the CMS was successfully rolled out through various media platforms across the country. The campaign was carried out through various advertisements in the national broadcaster's television and radio stations; billboards around Gauteng; taxi advertising; as well as newspaper inserts. A total amount of R3m was allocated for this initiative, which constituted a significant step to enhance scheme members' awareness of their rights and obligations.

Taking care of our customers

Through the customer care centre, we continued to provide information and guidance to assist members of medical schemes and other stakeholders to resolve medical schemes related enquiries and complaints.

During the period under review, the CMS received a total of 33 910 calls, of which 30 747 (90.7%) were handled. The call-handling rate was more than the global metric standard of 80.0%. Compared to the previous financial year, the total number of calls has increased by 5 857 (17.2%). The number of lost calls recorded was 3 148 (9.2%) for 2016/2017 compared to 2 813 (10.0%) for 2015/2016. The global metric standard for the rate of calls abandoned by a call centre is 5.0% – 8.0%.

Figure 12: Number of incoming calls, 2016/2017 compared to 2015/2016



Note: Calls outside working hours not included.

Concluding remarks

The release and publication of this annual report almost coincided with the publication of the NHI White Paper and the related implementation structures. The NHI White Paper and these aforementioned documents provide a clear direction for the industry with respect to the specific policy interventions, who will be responsible for their implementation, and how these will affect the medical scheme industry as a whole.

The key NHI policy interventions directed at the industry include, but are not limited to the following:

- Consolidation of schemes and options to improve risk pooling, cross subsidisation, affordability and sustainability;
- Alignment of the PMBs with the NHI Single Service Benefit Framework;
- Price regulation of services including removal of balance billing and co-payments as well as diagnosis based pricing;
- Defining a clear framework around scheme solvency requirements;
- Reform of governance and implementation of all the necessary legislation changes including the Medical Schemes Act.

The smooth implementation of these policy interventions will require extensive, frequent and meaningful consultation between the Ministry, the CMS and key industry role players. The CMS pledges to play an active role in collaboration with the National Department of Health to ensure that these consultative platforms are created and supported.

On behalf of the CMS, I would like to thank all the stakeholders that have contributed towards the organisation's success in its regulatory role. We would like to acknowledge and appreciate the support as well as the oversight role played by the Council. We wish those members of Council whose term is expiring later this year, every success in their future endeavours.

Finally, we wish to acknowledge the support and stewardship role that the Ministry has played in ensuring that the CMS delivers on its mandate of protecting the interest of scheme members.

We look forward to a fruitful year as we continue to work together in pursuit of sustainable solutions for the healthcare industry.

Dr Sipho Kabane
Acting Chief Executive & Registrar

May 2017

PERFORMANCE INFORMATION

PART B: PERFORMANCE INFORMATION

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.

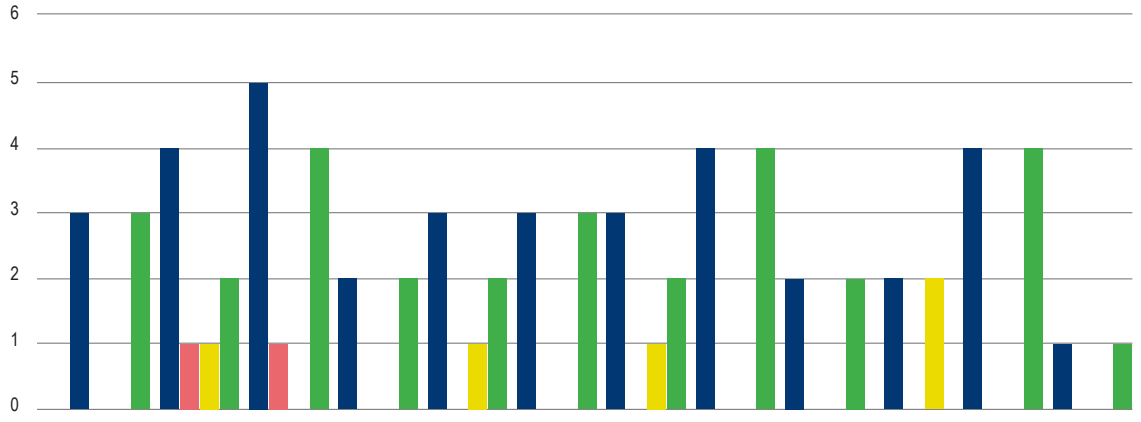
In my opinion, the performance information provided in this report fairly reflects the actual achievements against planned targets which are set out in the annual performance plans of the CMS for the financial year ended 31 March 2017.

The performance report of the CMS for the financial year has been audited by the Auditor-General of South Africa. Its audit report is presented on pages 97 to 99.

Dr Sipho Kabane
Acting Chief Executive Officer
Council for Medical Schemes

31 July 2017

Figure 13: Overview of CMS performance per programme 2016/2017



	Sub-Prog 1.2: Office of CFO	Sub-Prog 1.3: ICT & KM	Sub-Prog 1.4: Human Resources	Sub-Prog 1.5: Legal Services	Prog 2: Strategy Office	Prog 3: Accreditation	Prog 4: Research & Monitoring	Prog 5: Stakeholder Relations	Prog 6: Compiance and Investiga-tions	Prog 7: Benefit Management	Prog 8: Financial Supervision	Prog 9: Complaints Adjudication
Number of indicators	3	4	5	2	3	3	3	4	2	2	4	1
Not achieved	0	1	1	0	0	0	0	0	0	0	0	0
Partially achieved	0	1	0	0	1	0	1	0	0	2	0	0
Achieved	3	2	4	2	2	3	2	4	2	0	4	1

Overview of CMS performance per programme 2016/2017

The analysis of the performance of the CMS in respect of the four strategic goals that the organisation set for itself in 2014/2015, in its five-year strategic plan, reveals an achievement of over 80% of targets year on year. In 2014/2015, there was an overall achievement score of 86% for the 35 indicators that were set for all programmes. In 2015/2016, there was an overall achievement score of 85% for the 33 targets set for all programmes. In the year under review 2016/2017, there has been an overall achievement of 94.44%. This incorporates those indicators that were partially achieved.

Concerted effort was made to improve the performance per programme during the review period. Improved planning, co-ordination and better liaison between the National Health Ministry and the CMS led to improved performance results across the different programmes.

Performance achievements during 2016/2017 include the following:

- Unqualified report by the Auditor-General
- ICT systems up-time were maintained at over 99%
- There was an increase in PMB definitions published
- Increased research outputs to address industry challenges and contribute to policy development
- Increased stakeholder interactions, training and empowerment, including enhanced publicity initiatives
- Increase in the number of investigations and governance interventions undertaken
- The appeals process was strengthened to reduce the backlog of appeals
- Improvement in the resolution of complaints during the year

Although the organisation had an overall performance achievement of 94.44%, there are some areas that require improvement. Two programmes had negative deviations. In the Human Resources programme there were five out of 14 positions that took longer than 90 days to fill. This was due to the fact that these positions required scarce or critical skills which are normally harder to attract. This resulted in the affected positions not being filled within the 90-day period.

In the ICT&KM programme there was one security incident that occurred during the period under review. The CMS monitoring systems picked up that unauthorised access had been gained to an executive's mailbox. Disciplinary action followed, leading to the dismissal of the offender.

In the Strategy office there was partial achievement with regard to clinical opinions. The human resource constraints experienced by the unit had a negative impact on the unit's ability to deliver on its targets of providing clinical opinions within the set timeframes. These constraints have been remedied, turnaround strategies are now in place and the unit is better positioned for the next performance cycle.

In the Benefit Management programme the partial achievement relating to rule amendments was due to the complexity level of the rule amendments that were received. The activity required more than the set 14 working days to complete. The revised target of 80% for this indicator is reflective of the complexity and nature of the process.

Annual performance report by programme

Programme 1: Administration

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

- Sub-programme 1.1: CEO & Registrar
- Sub-programme 1.2: Office of CFO
- Sub-programme 1.3: Information and Communication Technology and Knowledge Management
- Sub-programme 1.4: Human Resources Management
- Sub-programme 1.5: Legal Services

Sub-programme 1.1: CEO & Registrar

Purpose

The CEO is the executive officer of 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.

Sub-programme 1.2: Office of the CFO

Purpose

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.

Key performance indicators, planned targets and actual achievements

Table 25: Key performance indicators, planned targets and actual achievements of Sub-programme 1.2

Sub-Programme 1.2: Office of the CFO

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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	New indicator	1	1	1	1	–	CMS received an unqualified opinion on its annual financial statements for 2015/2016.
An unqualified opinion issued by the Auditor General on the annual performance information by 31 July each year	New indicator	1	1	1	1	–	CMS received an unqualified opinion on its annual performance information report for 2015/2016.
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS							
Number of strategic risk register reports submitted to Council for monitoring, per year	New indicator	New indicator	4	4	4	–	Strategic risks were monitored during the year by Council.

Achievement of strategic objectives

The CMS received an unqualified audit opinion on both its annual financial statements and annual performance information report for 2015/2016 from the Auditor-General. The Office of the CEO strived to strengthen the area of supply chain management during the year.

The office ensured that performance information reports for each quarter were completed and submitted according to the strategic planning framework timelines. The annual performance plans for 2017/2018 were finalised and submitted to the Executive Authority and the National Treasury on 31 January 2017.

A strategic risk assessment workshop was held with members of the Council, Audit and Risk Committee, and executive management on 23 September 2016. There was continuous monitoring of operational and strategic risks during the year.

Strategy to overcome areas of under performance

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

Changes to planned targets

There were no changes to planned targets for the sub-programme.

Linking performance with budgets

Table 26: Budget of Sub-programme 1.2

	2015/2016			2016/2017		
Description	Budget	Actual Expenditure	(Over)/under Expenditure	Budget	Actual Expenditure	(Over)/under Expenditure
Amortisation	765	737	28	534	498	36
Bank Charges	50	55	(5)	49	100	(51)
Cleaning and Gardening	1 016	946	69	815	778	37
Consulting Fees	254	135	120	742	789	(47)
Courier and Postage	42	15	27	42	15	27
Depreciation	3 007	3 118	(112)	1 890	3 931	(2 041)
Employee Benefits	1 808	1 794	15	2 048	2 026	22
Employee Wellness	–	–	–	3	–	3
External Audit Fees	977	969	8	1 034	581	453
General Expense Admin	223	138	85	363	300	63
Insurance	333	333	–	339	410	(71)
Internal Audit Fees	1 103	983	120	1 167	204	963
Operating costs – Land Lord	1 715	1 687	28	1 971	1 971	–
Printing & publication	60	61	(1)	75	187	(112)
Refreshments	–	–	–	49	70	(21)
Rent	11 049	10 655	394	11 639	11 492	147
Rental Other Assets	11	14	(3)	13	16	(3)
Repairs and Maintenance Office	150	136	14	150	164	(14)
Salaries	7 361	7 833	(472)	8 479	8 770	(291)
Staff Training	200	234	(34)	200	107	93
Stationary	82	93	(11)	84	76	8
Subscriptions	8	9	(1)	12	9	3
Travel	15	15	–	6	34	(28)
Venue and catering	15	15	–	54	19	35
Water & Electricity, Rates & levies	1 185	1 300	(115)	1 185	1 300	(115)
Workmen's compensation	155	167	(12)	151	151	–
Total	**31 584**	**31 442**	**142**	**33 094**	**33 998**	**(904)**

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

Purpose

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

Key performance indicators, planned targets and actual achievements

Table 27: Key performance indicators, planned targets and actual achievements of Sub-programme 1.3

Sub-Programme 1.3: ICT&KM

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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	New indicator	97.05%	99.5%	95%	99.7%	+4.7%	The unit exceeded its planned target mainly due to the fact that we have successfully virtualised our server environment and upgraded our core switching infrastructure, thus creating a highly redundant and stable production environment.
Percentage of IT security incidents, per year	New indicator	New indicator	New indicator	0%	1.1%	-1.1%	There was one security incident that occurred during the period under review. Our monitoring systems picked up that an unauthorised access had been gained to an executive's mailbox. Disciplinary action followed.
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	96%	98.23%	99%	99%	99.7%	+0.7%	CMS existing software applications have matured over time and new applications are being developed using sound software development methodologies as well as rigorous pilot testing.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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 successfully responded to within 30 days, per year	279	274	350	100% (300)	98% (244/249)	-2%	There was an ongoing trend of receiving less physical requests for information than targeted, mainly due to the positive effect of our ongoing scanning of organisational records, which makes it possible for records to be easily accessible on our electronic portal, thus negating the need for making any formal physical information requests

Achievement of strategic objectives

ICT Infrastructure and Support

The unit succeeded in successfully virtualising its production server environment as well as upgrading its core switching infrastructure. This led to improved redundancy as well as failover capability in the production environment and a resultant exceeding of the target of maintaining a 95% server uptime by 4.7%. The unit improved its helpdesk application by automating the existing ICT procedures as web based service requests and linking them with SLA's.

The unit replaced all photocopiers with bigger units and introduced improved print management software, which resulted in cost savings across the organisation.

A new wireless network was installed during the reporting period. This resulted in CMS employees being able to securely connect to the CMS domain and consume services without the need for a wired connection, whilst allowing visitors to the CMS to access the internet securely. This intervention increased the efficiency and effectiveness of staff in servicing visitors to our premises.

The period under review also saw the upgrading of the CMS perimeter firewall by the addition of several security modules or "blades" in order to ensure that the CMS stay abreast with the latest security requirements, and is compliant with legislation such as the Protection of Personal Information Act (POPIA).

Software Development

The unit refined the Annual and Quarterly Financial Returns system and completely revamped the Auditor Approval System, while making important changes to the complaints adjudication system. This resulted in the CMS being able to improve our service to stakeholders. Improvements in the current system led to an increase in system stability and we exceeded our target of 99% uptime by 0.7%.

The unit also introduced electronic signatures to our electronic document management system and rolled the signatures out so schemes as part of the online financial returns system, thus improving efficiencies in return submissions while enhancing the security of signing documents.

The period under review saw the establishment of the Information Technology Advisory Group (ITAG), an advisory group of medical schemes IT personnel chaired by the CMS. This came about as a result of the CMS embarking on developing a Beneficiary Register as directed by the Minister of Health. The establishment of ITAG led to improved cooperation between the CMS and schemes' IT staff. The group is expected to play a vital role in future where systems are developed, that impact industry stakeholders.

The software development team enhanced the dynamic database driven return system for submission of utilisation data. This led to the submission of critical utilisation data which assisted the CMS to better understand issues such as quality of managed care interventions.

Finally, the team also developed a case management system as well as a system for electronic submission and comparison of Rules during the reporting period. These will be implemented fully during 2017 and it is hoped that both systems will improve the efficiency of the office in dealing with new case files as well as rule submissions.

Knowledge Management

The Knowledge Management Sub-unit continued its drive to digitise or scan paper-based organisational records kept by our archive / storage provider. This drive is yielding rewards, as we have seen a reduction in the number of physical requests for information received by the Knowledge Management officer, as people are now able to access the material directly from our EDMS system in digitised format.

Strategy to overcome areas of under performance

ICT Infrastructure and Support

During the period under review, it became clear that the CMS was in need of a proper business continuity and disaster recovery solution as the existing online backup solution proved to be ineffective. A new "hot site" could however not be established due to the high costs involved.

The CMS will embark on tender process to secure the necessary infrastructure and hosting services for the establishment of a "hot site" for business continuity and disaster recovery.

Software Development

With the assistance and cooperation of ITAG, the CMS will work toward a mutual understanding and adoption of the Beneficiary Register by all stakeholders. The CMS will also investigate the possibility of establishing a switching mechanism to aid state facilities in the identification of medical schemes members.

The new Single Exit Price System (SEP) for Medicines being developed for the National Department of Health was further delayed due to issues experienced with the enrolment module. The system will now be delivered during 2017.

Resistance to the development of the Beneficiary Register was experienced from certain industry stakeholders, as well as from the main opposition party in Parliament. The legality and legislative mandate of the CMS was challenged. This resulted in the matter being referred to the state law advisors and the development suspended until a final opinion is obtained.

A developer will be seconded to the CMS by the National Department of Health to assimilate knowledge on maintaining the newly developed SEP system while a hosting environment will be secured for the system. Arrangements are already in place to ensure that the system can be tested.

Knowledge Management

The handling of less than expected physical requests for information is seen as a positive deviation as it indicates that the digitisation of paper-based records, and making them available on the CMS EDMS system, is having a positive effect. The unit deviated on the turnaround time in responding to requests for information, mainly because certain requests required a legal opinion which extended beyond the turnaround time.

Changes to planned targets

There were no changes to planned targets for the sub-programme.

Linking performance with budgets

Table 28: Budget of Sub-programme 1.3

	2015/2016			2016/2017		
Description	Budget	Actual Expenditure	(Over)/under expenditure	Budget	Actual Expenditure	(Over)/under Expenditure
Computer Expenses	92	46	46	86	104	(18)
Consulting Fees	263	286	(24)	540	222	318
Copy Costs	252	305	(53)	280	196	84
Employee Wellness	–	–	–	4	–	4
External Storage	278	311	(33)	360	339	21
Internet Expenses	176	197	(21)	437	235	202
Knowledge Management	686	544	142	733	791	(58)
Printing	6	5	1	6	8	(2)
Rental Copiers	264	194	70	402	399	3
Repairs and Maintenance/SLA	554	607	(53)	799	490	309
Salaries	8 352	7 699	652	9 510	8 295	1 215
Security	919	864	55	441	431	10
SEP system expenses	496	302	194	–	595	(595)
Software License Subscription	1 400	1 462	(62)	2 727	1 606	1 121
Staff Training	180	41	139	180	187	(7)
Stationery	5	5	–	5	10	(5)
Subscriptions	–	–	–	–	4	(4)
Telephone and Fax	452	472	(20)	702	407	295
Travel	51	50	1	16	26	(10)
Venue and catering	20	13	7	5	27	(22)
Total	**14 446**	**13 403**	**1 041**	**17 233**	**14 372**	**2 861**

Sub-programme 1.4: Human Resources Management

Purpose

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 Council's vision.

We will 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 to maximise its most important asset, and to position the organisation as an employer of choice.

Key performance indicators, planned targets and actual achievements

Table 29: Key performance indicators, planned targets and actual achievements of Sub-programme 1.4

Sub-Programme 1.4: Human Resource Management

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic objective 1.4.3.1: Build competencies and retain skilled employees							
Minimise staff turnover rate to less than 5% per annum	6.12%	3.88%	9%	<5%	4.42%	–	Staff turnover rate was minimised.
Average turnaround time to fill a vacancy (Average turnaround time of 90 working days to fill a vacancy that exists during the year)	New Indicator	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	90 days	There were 5 out of 14 positions that took longer than the 90 days to fill		Some positions were challenging to fill within the stipulated turn–around period as they required scarce or critical skills.
CE & Registrar 01/04/2016	–	–	–	90 days	150 days	60 days	The position was approved by the Minister for re-advertising in April 2016. The position was filled on 1 November 2016.
Senior Strategist 3/11/2014	–	–	–	90 days	404 days	314 days	The position was filled with effect from 1 July 2016. Delays were due to a labour dispute with the terminated employee as well as the position requiring scarce and critical skills.
Health Economist 4/01/2016	–	–	–	90 days	102 days	12 days	Position was filled on 1 June 2016. The delay in filling the position was due to the position requiring scarce and critical skills.
Senior Manager: Clinical 12/01/2016	–	–	–	90 days	96 days	6 days	Position was filled by an internal candidate on 1 June 2016. The delays in filling the position was due to the position requiring scarce and critical skills.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Accountant 1/4/2016	–	–	–	90 days	0 days	–	The position was filled within 90 days.
Communications Manager 1/04/2016	–	–	–	90 days	52 days	–	The position was filled within 90 days.
Junior Developer 1/02/2016	–	–	–	90 days	61 days	–	The position was filled within 90 days.
Medical Advisor 1/06/2016	–	–	–	90 days	106 days	16 days	Position was filled by an internal candidate on 1 November 2016. The delays in filling the position was due to the position requiring scarce and critical skills.
Senior Legal Adjudication Officer 1/3/2016	–	–	–	90 days	40 days	–	The position was filled within 90 days.
Legal Adjudication Officer 1/05/2016	–	–	–	90 days	21 days	–	The position was filled within 90 days.
Legal Adjudication Officer 1/07/2016	–	–	–	90 days	42 days	–	The position was filled within 90 days.
Clinical Analyst 1/09/2016	–	–	–	90 days	65 days	–	The position was filled within 90 days.
Executive Assistant: FSU 23/09/2016	–	–	–	90 days	49 days	–	The position was filled within 90 days.
Executive Assistant: CEO 1/11/2016	–	–	–	90 days	10 days	–	The position was filled within 90 days.
Legal Advisor 19/01/2017	–	–	–	90 days	51 days	–	The position was filled within 90 days.
Senior Compliance Officer 23/01/2017	–	–	–	90 days	49 days	n/a	Recruitment process currently underway.
Senior Analyst: BMU 23/01/2017	–	–	–	90 days	49 days	n/a	Recruitment process currently underway.
Senior Developer 22/01/2017	–	–	–	90 days	49 days	n/a	Recruitment process currently underway.
CE & Registrar 22/01/2017	–	–	–	90 days	49 days	n/a	Recruitment process currently underway.
Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually	New indicator	88%	94%	85%	91.45%	6.45%	Exceeded the planned target.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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	New indicator	100%	100%	–	
Percentage of employee performance assessment concluded, bi annually	New indicator	New indicator	New indicator	100%	100%	–	

Achievement of strategic objectives

The Human Resources (HR) unit's strategic objectives address the broader strategic goal of the CMS, to be responsive to the environment by being a fair, transparent, effective and efficient organisation. During the period under review, talented personnel were sourced in line with our recruitment policies and procedures. The selection process which was adopted in recruiting for both existing and new positions was to ensure that the best and most appropriately qualified personnel were appointed in various positions within the organisation.

In filling all vacant positions, we ensured that the organisation is adequately resourced to deliver on its key strategic objectives. Efforts were made to minimise the period between a termination and a new appointment to minimise operational disruptions. HR utilised unorthodox recruitment methods within policy to attract the appropriate skills and talent which were difficult to source due to their critical and scarce nature. We were able to meet our employment targets, as well as exceed the national employment equity targets.

While other organisations struggle to remain below the benchmark of 10% staff turnover rate, the CMS achieved a staff turnover rate of 4.42% in 2016/2017 financial year, which is a significant reduction from 9% in the previous year.

The CMS was able to successfully measure the performance of its employees against the overall strategic objectives set for the 2016/2017 financial year by ensuring that performance agreements for all employees were concluded on time. This laid the foundation for the successful bi-annual staff performance review, culminating in the positive final performance assessment in March 2017.

Strategy to overcome areas of under performance

The CMS has seen growth over the years, with each year posing an increase in the number of positions to be filled either due to resignations or newly created positions. Some positions were challenging to fill within the stipulated turnaround time as they require scarce or critical skills. Five (5) positions required several attempts to attract the most appropriate talent to enable the organisation to meet its mandate.

Enhancements to the recruitment and selection policy were made in response to the challenges experienced in the recruitment process, particularly with regard to attracting and retaining scarce and critical skills. These enhancements included developing a set of procedures for the attraction of scarce and critical skills which would make it easier to attract the right talent within the prescribed timeframe.

In addition, the HR unit identified capacity gaps and deployed additional resources to strengthen HR capacity in general, and specifically to respond to the human capital requirements for the organisation.

Changes to planned targets

There were no changes to planned targets for the sub-programme.

Linking performance with budgets

Table 30: Budget of Sub-programme 1.4

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Consulting Fees	513	531	(18)	453	286	167
Donations	48	45	3	50	39	11
Employee Wellness	577	313	264	418	326	92
Motor Vehicle – Expenses	29	27	2	51	58	(7)
Recruitment and Relocation	784	786	(3)	450	503	(53)
Refreshments	48	48	–	–	–	–
Salaries	3 716	3 836	(121)	4 016	4 123	(107)
Staff Training	100	80	20	100	107	(7)
Stationery	12	15	(3)	12	11	1
Subscriptions	105	117	(11)	63	141	(78)
Temp Services	282	207	75	222	309	(87)
Transcription Services	6	6	–	–	–	–
Travel	30	23	7	21	13	8
Venue and catering	133	108	25	120	131	(11)
Total	**6 383**	**6 142**	**240**	**5 976**	**6 047**	**(71)**

Sub-programme 1.5: Legal Services Unit

Purpose

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

Key performance indicators, planned targets and actual achievements

Table 31: Key performance indicators, planned targets and actual achievements of Sub-programme 1.5

Sub-Programme 1.5: Legal Services

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office							
Percentage of written and verbal legal opinions generated internally to internal and external stakeholders, per year	New indicator	New indicator	205	85% (180)	100% (175)	+15%	All opinions received were attended to within the time frames set by the unit.
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	17	24	21	100% (23)	100% (25)	–	All legal matters were attended to by the unit.

Achievement of strategic objectives

The legal advice dispensed by the unit to the CMS and business units during the period under review, ensured adherence to the relevant principles of administrative law and natural justice. This resulted in the integrity of regulatory decisions falling within the scope and ambit of the law, thereby avoiding regulatory decisions being successfully challenged on judicial review.

As all written and verbal legal opinions were responded to and furnished within the prescribed time period; the deviation is insignificant.

Strategy to overcome areas of under performance

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

Changes to planned targets

There were no changes to planned targets for the sub-programme.

Linking performance with budgets

Table 32: Budget of Sub-programme 1.5

Description	2015/2016			2016/2017		
	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Employee Wellness	–	–	–	1	–	1
Legal Fees	7 970	7 459	511	6 922	7 888	(966)
Salaries	3 503	3 529	(26)	3 779	3 575	204
Staff Training	75	66	9	86	74	12
Stationery	8	6	2	4	2	2
Subscriptions	5	2	3	3	6	(3)
Travel	90	93	(3)	60	79	(19)
Venue and catering	4	2	1	2	1	1
Total	**11 655**	**11 157**	**497**	**10 857**	**11 625**	**(768)**

Programme 2: Strategy Office

Purpose

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

Key performance indicators, planned targets and actual achievements

Table 33: Key performance indicators, planned targets and actual achievements of Programme 2

Programme 2: Strategy Office

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected							
The number of benefit definitions and CMS scripts published, per year	New indicator	11	12	14 (10 CMScripts 4 PMB definitions)	10 CMScripts 7 PMB definitions	3 PMB definitions	The unit was able to publish 3 more benefit definitions during the year than was initially anticipated.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries							
Percentage of clinical opinions reviewed within 30 days of receipt from Complaints Adjudication	839	623	938	90%	40%	-50%	The human resource constraints experienced by the unit played a major role in the backlog on poor performance on this indicator. The unit has since implemented a turnaround strategy to address this, and this has begun to produce results.
Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	New indicator	New indicator	New indicator	90%	99%	+9%	The timeous resolution of enquiries is ongoing and targets were exceeded.

Achievement of strategic objectives

The clinical unit contributed to the CMS strategic objective by enhancing the protection of members and beneficiaries through the provision of clinical opinions, responses to enquiries, and the resolution and adjudication of complaints. However, resource constraints impaired the unit's ability to deliver clinical opinions within the set timeframes. The unit has put in place turnaround strategies to address this.

The benefit definition clarifies what benefits members of medical schemes are entitled to under the PMB regulations. The basket of care of each PMB diagnosis is developed as part of funding guidelines for schemes to adhere to, consistent with best scientific evidence and principles of affordability. This is prospective regulatory work that is aimed at reducing complaints from members of schemes while ensuring the sustainability of schemes.

Strategy to overcome areas of under performance

The turnaround strategies for the provision of clinical opinions include:

A motivation for an additional permanent clinical analyst post is being considered, subject to availability of funding. This will strengthen the human resource capacity of the unit.

The indicator for clinical opinions has been revised to reflect the complexity of clinical opinions and turnaround times for the new financial year.

An improved workflow process has been implemented to promote efficiency and effectiveness by allocating opinions to individual clinical analysts as soon as they are received and validated.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 34: Budget of Programme 2

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Consulting Fees	330	220	110	336	349	(13)
Employee Wellness	–	–	–	3	–	3
Salaries	6 145	4 322	1 823	7 546	7 541	5
Staff Training	180	39	141	200	198	2
Stationery	10	9	1	8	9	(1)
Subscriptions	–	–	–	–	15	(15)
Travel	171	21	150	186	152	34
Venue and catering	–	–	–	70	30	40
Total	**6 836**	**4 611**	**2 225**	**8 349**	**8 294**	**55**

Programme 3: Accreditation Unit

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

Key performance indicators, planned targets and actual achievements

Table 35: Key performance indicators, planned targets and actual achievements of Programme 3

Programme 3: Accreditation unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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 that comply with the accreditation requirements accredited within 21 working days of receipt of complete applications	5 564	5 027	5 634	3 980	4 854	874	There were more applications received than anticipated.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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	14	26	16	26	21	5	Two renewal applications which were scheduled to be finalised in the first quarter of 2016/2017 were finalised in the last quarter of 2015/2016. Two MCOs elected not to renew their accreditation. One renewal application was moved to the first quarter of 2017/18 due to a rescheduling of an EXCO meeting.
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	16	9	13	15	14	1	One self-administered scheme's application was approved by Council in last quarter of 2015/2016, earlier than expected.

Achievement of strategic objectives

Third-Party Administrators and Self-administered Schemes:
Applications in respect of eight (8) organisations and five (5) self-administered schemes were conducted and finalised during the year. On-site evaluations were conducted in respect of four (4) administrators and one (1) self-administered scheme.

Managed Care Organisations:
A number of new applications for MCOs accreditations were received and evaluated during the period under review. Some of them were found not to be valid as the services provided by these organisations could not be defined as managed healthcare within the definitions of the Medical Schemes Act and Regulations. Accordingly, these organisations did not require to be formally accredited and applicants were notified as such. On-site evaluations for compliance were conducted on five (5) organisations and one (1) self-administered scheme. The Accreditation unit continues to monitor the financial soundness of risk-bearing entities based on their Annual Financial Statements to ensure their financial soundness.

Managed care theme project, measuring the impact of managed care interventions:
The project seeks to effectively demonstrate the value of managed care rendered to beneficiaries of medical schemes. Four (4) PMB conditions were finalised in collaboration with stakeholders during the year under review with completed data specifications in respect of entry level criteria, process indicators and health outcomes having been introduced.

Brokers and Broker Organisations:
The Accreditation unit started verifying qualifications of brokers that applied for renewal of accreditation. The unit's efforts resulted in the Minister of Health announcing an increase in the maximum amount payable to brokers by medical schemes.

Strategy to overcome areas of under performance

There were no areas of under performance in the programme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 36: Budget of Programme 3

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Employee Wellness	–	–	–	3	–	3
Salaries	7 238	7 121	117	7 714	7 817	(103)
Staff Training	100	23	77	200	38	162
Stationery	50	40	10	62	52	10
Subscriptions	85	67	18	78	70	8
Travel	499	438	61	521	246	275
Venue and catering	6	4	2	6	2	4
Total	**7 978**	**7 693**	**285**	**8 584**	**8 225**	**359**

Programme 4: Research and Monitoring Unit

Purpose

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. The unit also undertakes work to measure the risks in medical schemes and make 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.

Key performance indicators, planned targets and actual achievements

Table 37: Key performance indicators, planned targets and actual achievements of Programme 4

Programme 4: Research and Monitoring unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning							
Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per year	4	4	4	4	3	1	The quarterly report January to March 2017 was still outstanding.

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions							
Number of research projects and support projects finalised, per year	13	11	10	8	10	2	The unit received additional ad-hoc research project requests from Council.
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice							
Non-financial report submitted for inclusion in the annual report, per year	1	1	1	1	1	–	A non-financial report was submitted for inclusion into the annual report.

Achievement of strategic objectives

The Research and Monitoring unit completed the non-financial section of the annual report on time. This enabled the CMS and the NDoH to monitor healthcare utilisation trends in the industry, including changes in the demographic profile of beneficiaries and the cost of private healthcare. Research on the distribution of healthcare providers and the classification of benefit options was also concluded and submitted to the senior strategist for discussion with the NDoH for possible policy interventions. Significant progress was also made with the revision of the solvency framework and engagement with the industry will continue in 2017/18. The target of eight research and technical support projects was exceeded.

The relationship between the CMS and the Board of Healthcare Funders (BHF) negatively affected the submission of the quarterly PCNS reports by BHF. This issue was discussed with the acting chief executive and registrar, as well as the Legal unit and after intervention by the acting chief executive and registrar, all four reports were submitted by BHF (unfortunately not within the quarterly and annual time frames).

Strategy to overcome areas of under performance

The acting Chief Executive and Registrar had meetings with the BHF at the highest level to improve communication and ultimately the relationship between the entities.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 38: Budget of Programme 4

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Consulting Fees	65	–	65	27	10	17
Employee Wellness	–	–	–	3	–	3
Salaries	6 409	6 609	(201)	7 018	6 417	601
Staff Training	160	122	38	230	159	71
Stationery	3	2	1	3	1	2
Subscriptions	10	10	–	10	13	(3)
Travel	43	36	6	45	67	(22)
Venue and catering	25	14	11	26	44	(18)
Total	**6 715**	**6 793**	**(80)**	**7 362**	**6 711**	**651**

Programme 5: Stakeholder Relations Unit

Purpose

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

Key performance indicators, planned targets and actual achievements

Table 39: Key performance indicators, planned targets and actual achievements of Programme 5

Programme 5: Stakeholder Relations unit

Performance indicator	Actual achievement 201320/14	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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	New indicator	New indicator	New indicator	30%	40.3%	+10.3%	The survey results indicated a higher percentage of members being aware of the CMS than expected.
Number of stakeholder training and awareness sessions, per year	New indicator	New indicator	46	18	55	+37	The unit held additional training and awareness sessions during the year

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 5.2.2: Communication and engagement to inform and empower stakeholders							
Publication of CMS Annual Report by 31 August	1	1	1	1	1	–	A pending court case about COMMED's financial statements caused the publication of the annual report to be postponed to 14 October 2016.
Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year	New indicator	72.9%	94%	75%	97%	+22%	The initiatives taken by the unit led to an increase in the positive or neutral feedback on the CMS reputation.

Achievement of strategic objectives

For the first time, the Stakeholder Relations unit conducted research to determine the percentage of CMS awareness among members of medical schemes. Although the percentage of awareness was higher than expected, an awareness campaign commenced in September 2016 to improve public awareness of the CMS.

Stakeholder training and awareness sessions included continuing professional development (CPD) and broker training sessions conducted in Gauteng, Eastern Cape, Western Cape and KwaZulu-Natal. A compulsory two-day induction training session for newly appointed trustees were held in Gauteng and the Western Cape. Eleven people attended the INSETA-accredited skills development programme, of which four submitted their portfolios of evidence.

Consumer education activities for general consumers and medical scheme members were conducted in the urban and semi-urban areas, covering eight provinces, three more than the previous year. Of the total 6 147 consumers reached, 3 472 were from rural areas. The CMS was invited to take part in a isiZulu TV programme called "Ilungelo Lakho" which can loosely be translated as "Your Rights" This is a programme with a viewership of about 300 000 in both urban and rural areas.

The CMS participated in several radio and television interviews, and talk shows in various languages. Several opinion pieces were published, resulting in the continued positive reputation of the CMS for the year under review.

The annual report was delivered to the minister's office before 31 August 2016 as required by the PFMA. Under instruction from the minister, the CMS annual report had to first be tabled in Parliament and presented to the Health Portfolio Committee before it could be released to the public.

Strategy to overcome areas of under performance

There were no areas of under performance in the programme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 40: Budget of Programme 5

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Consulting Fees	40	33	7	–	42	(42)
Courier and postage	10	–	10	10	–	10
Employee Wellness	3	6	(3)	3	13	(10)
Exhibition costs	100	56	44	100	97	3
Media and Promotion	981	843	138	2 986	3 397	(411)
Printing and Publication	549	571	(22)	1 524	873	651
Salaries	6 589	6 729	(141)	7 112	7 205	(93)
Staff Training	100	88	12	220	146	74
Stationery	10	6	4	10	6	4
Subscriptions	10	7	3	10	22	(12)
Travel	388	331	57	505	393	112
Venue and catering	324	337	(13)	395	330	65
Total	**9 104**	**9 007**	**96**	**12 875**	**12 524**	**351**

Programme 6: Compliance and Investigation Unit

Purpose

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

Key performance indicators, planned targets and actual achievements

Table 41: Key performance indicators, planned targets and actual achievements of Programme 6

Programme 6: Compliance and Investigation unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/205	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
Strategic Objective 6.2.1: Regulated entities comply with Legislation							
Percentage of non-compliance cases against regulated entities undertaken, per year	New indicator	52	82	100% (40)	100% (39)	–	The Compliance and Investigations unit attended to all matters that related to non-compliance against regulated entities.
Strategic Objective 6.2.2:Strengthen and monitor governance systems							
Percentage of governance interventions implemented, per year	New indicator	88	55	100% (75)	100% (105)	–	The Compliance and Investigations unit attended to all the matters that required enforcement of governance systems.

Achievement of strategic objectives

During the reporting period, the Compliance Investigation unit collected R5 376 227.84 in inspections fees from medical schemes. The unit obtained a judgment in the Bonitas vs CMS matter, which confirmed that an order to inspect may be not appealed and as such in September 2016, the unit commenced the Bonitas inspection, which had been hindered by the scheme through legal processes.

To monitor and enforce governance systems, the unit attended 41 scheme annual general meetings (AGMS) wherein we monitored the meeting proceedings.

The office further received concurrence from the Minister of Health and the Minister of Finance on the publication of the final Demarcation Regulations by 01 April 2017. A circular was issued to the industry informing them of the promulgation of the Demarcation Regulations into law and requested all affected parties to apply for the demarcation exemption which would be granted for a period of two (2) years until such time that the entities which are doing “a business of a medical scheme” have registered under section 24 of the Medical Schemes Act as a medical scheme.

The unit implemented section 46 proceedings on Spectramed, Medshield and Thebemed medical schemes and removed trustees that had been deemed to be unfit and improper to hold office.

Strategy to overcome areas of under performance

There were no areas of under performance in the programme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 42: Budget of Programme 6

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Cell phone contracts	48	34	15	9	9	–
Consulting Fees	500	110	390	795	1 789	(994)
Employee Wellness	–	–	–	3	–	3
Printing	2	1	1	572	12	560
Salaries	6 426	6 069	357	7 255	6 624	631
Staff Training	160	60	100	160	134	26
Stationery	50	9	41	7	8	(1)
Subscriptions	64	11	53	71	19	52
Travel	158	211	(53)	154	173	(19)
Venue and catering	20	–	20	22	–	22
Total	**7 428**	**6 505**	**924**	**9 048**	**8 768**	**280**

Programme 7: Benefits Management Unit

Purpose

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 the Medical Schemes Act.

Key performance indicators, planned targets and actual achievements

Table 43: Key performance indicators, planned targets and actual achievements of Programme 7

Programme 7: Benefit Management unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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 days of receipt of all information, per year	New indicator	New indicator	New indicator	100% (129)	87% (88 out of 101)	13%	The deviation was due to the complexity of some of the amendments received.
Percentage of annual rule amendments processed before 31 December of each year	New indicator	New indicator	New indicator	100% (83)	98.9% (90)	1.1%	The deviation was due to one amendment that was processed in January 2017 due to it being a replacement page received on 15 December 2016. As the finalisation of processing was priority, this rule was prioritised for January 2017.

Achievement of strategic objectives

The registering of rules contributed 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. The two targets relate to the different sets of rules that are processed by the unit. The first one relates to interim rule amendments of the general rules regarding the operation of the schemes and governance. The second target relates to the approval of rules affecting the benefit changes and contribution increases that the schemes implement in a new calendar year.

The deviation in the first target was due to the complexity of rules amendments received, and it requiring more than 14 working days to complete. The revised target of 80% for this indicator is reflective of the complexity and nature of the process. The deviation on the second target was due to date of receipt of the amendment and prioritisation of amendments.

Strategy to overcome areas of under performance

The target for goal "Percentage interim rule amendments processed within 14 days of receipt of all information, per quarter" has been revised to 80% as the experience of the unit is that some of the amendments' complexity and the prioritisation of the workload, requires the revision of the target to 80%. This target revision makes allowance for sufficient time for the review of complex amendments to ensure that the rules registered are compliant with the Act and not unfair to members of a medical scheme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 44: Budget of Programme 7

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Employee Wellness	–	–	–	3	–	3
Printing	5	4	1	5	15	(10)
Salaries	5 402	5 069	333	6 144	5 523	621
Staff Training	132	19	113	80	48	32
Stationery	9	8	1	11	11	–
Subscriptions	17	10	7	20	17	3
Travel	15	14	1	25	23	2
Venue and catering	2	1	1	–	–	–
Total	**5 582**	**5 125**	**457**	**6 288**	**5 637**	**651**

Programme 8: Financial Supervision Unit

Purpose

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 Medical Schemes 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.

Key performance indicators, planned targets and actual achievements

Table 45: Key performance indicators, planned targets and actual achievements of Programme 8

Programme 8: Financial Supervision unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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 were done for all business plans received from schemes in respect of Regulation 29.
Performance indicator	**Actual achievement 2013/2014**	**Actual achievement 2014/2015**	**Actual achievement 2015/2016**	**Planned Target 2016/2017**	**Actual achievement 2016/2017**	**Deviation from planned target to Actual Achievement for 2016/2017**	**Comments on deviation**
Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	New indicator	New indicator	100%	100%	–	–	No schemes were identified with rapidly reducing solvency during the period under review.
Number of Quarterly financial return reports published (excluding quarter 4), per year	3	3	3	3	3	–	Quarter 1 and 2 financial returns reports were published in November 2016. The quarter 1 report was delayed due to the late publication of Annual report.
Number of financial sections prepared for the Annual Report	1	1	1	1	1	–	Financial sections were prepared for the annual report.

Achievement of strategic objectives

The financial supervision unit is responsible for ensuring that all registered medical schemes remain financially sound and sustainable. The unit's activities for the period under review; such as ongoing monitoring of schemes; financial review meetings and the analysis of financial information, are all geared towards achieving this objective.

Strategy to overcome areas of under performance

There were no areas of under performance in the programme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 46: Budget of Programme 8

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Consulting Fees	–	–	–	57	57	–
Employee Wellness	–	–	–	3	–	3
Salaries	10 008	10 035	(27)	10 830	10 831	(1)
Staff Training	188	151	37	193	105	88
Stationery	10	7	4	10	14	(4)
Subscriptions	20	28	(8)	20	30	(10)
Travel	25	23	2	36	47	(11)
Venue and catering	50	34	16	50	14	36
Total	**10 301**	**10 278**	**24**	**11 199**	**11 098**	**101**

Programme 9: Complaints Adjudication Unit

Purpose:

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

Key performance indicators, planned targets and actual achievements

Table 47: Key performance indicators, planned targets and actual achievements of Programme 9

Programme 9: Complaints Adjudication unit

Performance indicator	Actual achievement 2013/2014	Actual achievement 2014/2015	Actual achievement 2015/2016	Planned Target 2016/2017	Actual achievement 2016/2017	Deviation from planned target to Actual Achievement for 2016/2017	Comments on deviation
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 year	63%	73%	75.31%	76%	84%	+8%	The positive deviation was as a result of the services of the Complaints Administrator who assisted in resolving non-complex complaints.

Achievement of strategic objectives

The performance of the Complaints Adjudication unit enabled the organisation to meet its statutory objective of resolving complaints submitted to it by the public. This ensured that the beneficiaries of medical schemes were protected and treated fairly by the regulated entities. The unit will continue making use of the services of the administrator as it helps the unit to exceed its targets.

Strategy to overcome areas of under performance

There were no areas of under performance in the programme.

Changes to planned targets

There were no changes to planned targets for the programme.

Linking performance with budgets

Table 48: Budget of Programme 9

	2015/2016			2016/2017		
Description	Budget	Actual	(Over)/under expenditure	Budget	Actual	(Over)/under expenditure
Employee Wellness	–	–	–	3	–	3
Salaries	5 262	5 179	83	5 734	5 746	(12)
Staff Training	150	36	114	180	119	61
Stationery	2	2	–	2	4	(2)
Travel	8	11	(3)	608	87	521
Total	**5 422**	**5 228**	**194**	**6 527**	**5 956**	**571**

GOVERNANCE

PART C: GOVERNANCE

Corporate governance report

The Council for Medical Schemes is an entity that was established in terms of the Medical Schemes Act, 131 of 1998 (the Act). The Minister of Health appoints the governing body (the Council) which may consist of up to 15 members to exercise political oversight over the Council for Medical Schemes. The Council has adopted a charter and code of conduct to which all members serving in the Council are committed.

The CMS complies with the Public Finance Management Act (PFMA) and Treasury Regulations as a Schedule 3A entity, as well as all other relevant legislation applicable to the CMS.

The Accounting Authority, the Executive Authority and Parliament ensure that the CMS embraces good corporate governance practices.

Accounting Authority: Council

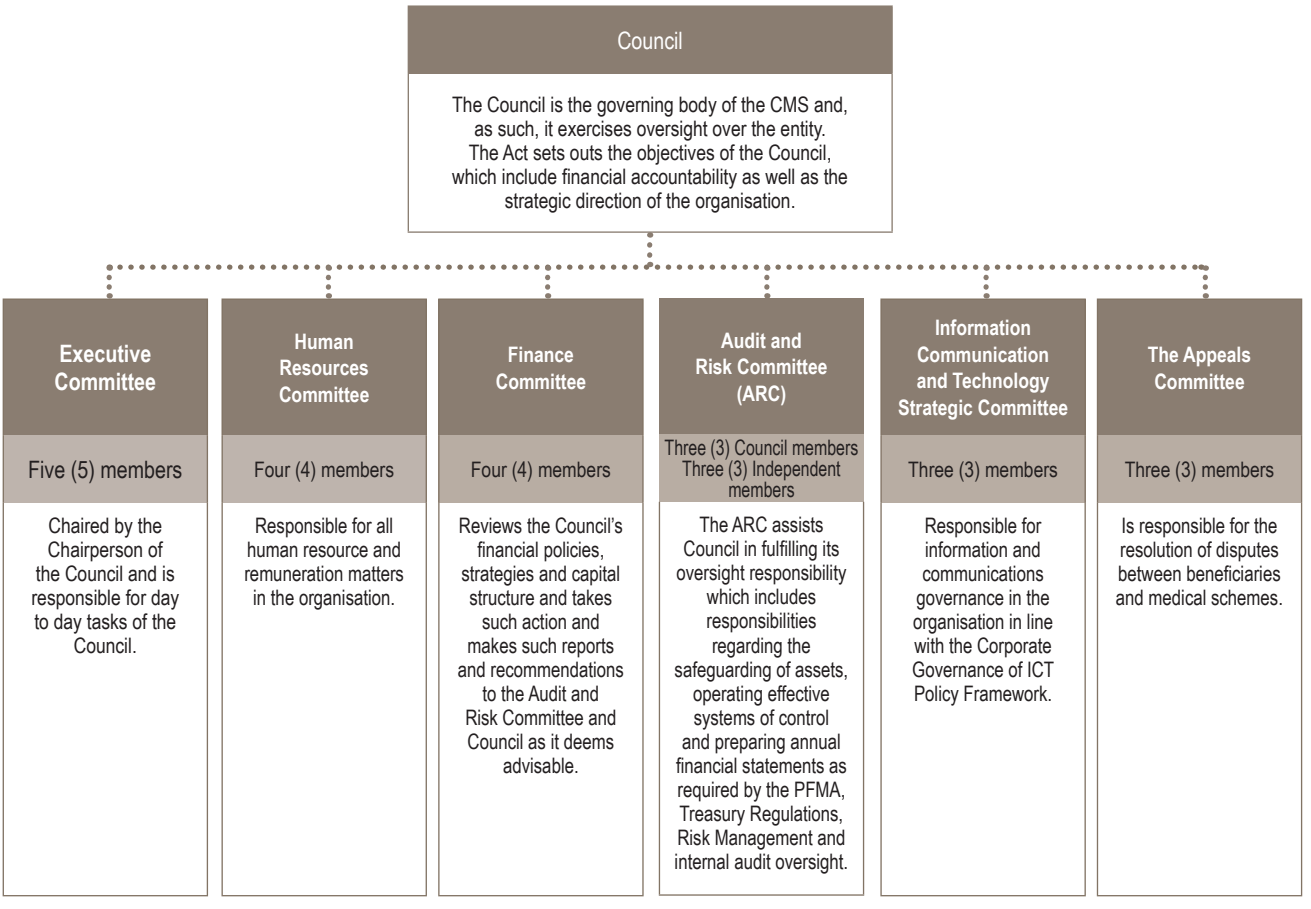
The role of Council

The Council is responsible for the following functions:

- Protection of the interests of beneficiaries;
- Control and coordination of the functioning of medical schemes in a manner that is complementary to national health policy;
- 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;
- Investigation of complaints and settlement of disputes in relation to the affairs of medical schemes;
- Collection and dissemination of information about private healthcare;
- Making rules for the purpose of performing its functions and the exercise of its powers;
- Advising of the Minister of Health on any matter concerning medical schemes; and
- Performance of any other functions conferred on it by the Minister of Health in terms of the Medical Schemes Act.

Committees

The Council, like any board, has delegated its work to various committees that each have a specific focus area.



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 Council Secretariat

The Council appoints the CMS Council Secretariat whose role is to support corporate governance and ethics in the Council. The Council Secretariat services the Council and its committees by providing guidance to members on their fiduciary responsibilities. The promotion of compliance, induction and training of Council members as well as the formulation of agendas are some of the responsibilities of the Council Secretariat.

The Registrar and CEO

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. The Registrar is obligated to act according to the provisions of the Medical Schemes Act and the policy and directions of the Council. The Registrar also supervises the staff of the Council for Medical Schemes.

Reports to the Portfolio Committee on Health

The Council made presentations to the Portfolio Committee on Health during the year under review as follows:

- The Strategic Plan, Annual Performance Plan and Budget for 2016/2017 presentation to the Portfolio Committee took place on 20 May 2016.
- The Annual Report briefing to the Portfolio Committee took place on 12 October 2016.

Reports to the Executive Authority

The Minister of Health is the Executive Authority.

The Council approved and submitted four (4) Quarterly Performance Information Reports to the Executive Authority. The reports were submitted as follows:

- 29 July 2016
- 31 October 2016
- 30 January 2017
- 26 April 2017

Table 49: Composition of new council as at 31 March 2017

Name of Council Member	Designation	Date appointed	Date resigned	Qualification	Area of expertise	Council committee	No. of Meetings attended
Prof. Y Veriava	Chairperson	14 Nov 2014	N/A	MBBCH (Wits), Hon DSc(Wits) FCP(SA), FRCP (London)	Clinical Medicine	EXCO, HR	13
Dr L Mpuntsha	Vice Chairperson	14 Nov 2014	N/A	MBChB, MPhil	Medicine	EXCO, Appeals Committee	18
Prof. BC Dumisa	Member	14 Nov 2014	N/A	LLB, LLM, MBA, MSc, DBA	Law Management	Appeals Committee ICT Governance	16
Ms L Sibanyoni	Member	14 Nov 2014	N/A	BBusSC (Actuarial Sciences)	Actuarial Sciences	HR, Audit and Risk Committee	8
Dr S Mabela	Member	14 Nov 2014	N/A	Bsc, MBA, PhD (Economics)		EXCO, HR, ICT Governance	13
Ms M Maboye	Member	14 Nov 2014	N/A	BA, Adv. Dip, Dip	Healthcare Management	EXCO, HR	9
Mr J Van der Walt	Member	14 Nov 2014	N/A	CA (SA) BCompt (Hons) MComm	Accounting Management	Audit and Risk committee	9
Mr M Nkosi	Member	14 Nov 2014	31 Dec 2016	MPH, PGD, BA	Healthcare Management	ICT Governance Audit & Risk Committee	3
Prof. S Perumal	Member	14 Nov 2014	N/A	DComm, MSc BComm	Finance	EXCO, Audit & Risk Committee	17
Adv H Kooverjie	Member	14 Nov 2014	N/A	BA, LLB,	Law	Appeals Committee	12
Dr A Thulare	Member	14 Feb 2017	N/A	BSc, MBChB, MM, MBA	Healthcare	ICT Governance	3

Table 50: Membership of Council Committees as at 31 March 2017

Council Members	No. of meetings held	No. of members	Names of members
Executive Committee (EXCO)	3	5	Prof. Y Veriava
			Dr L Mpuntsha
			Prof. S Perumal
			Dr S Mabela
			Ms M Maboye
Human Resources Committee	3	4	Prof. Y Veriava
			Dr S Mabela
			Ms M Maboye
			Ms L Sibanyoni
Audit & Risk Committee	4	6	Mr R Nicholls (Independent non-executive member)
			Mrs J Naicker (Independent non-executive member)
			Ms P Mzizi (Independent non-executive member)
			Prof. S Perumal
			Dr A Thulare
			Mr J Van der Walt
Finance Committee	6	4	Prof. S Perumal
			Mr M Nkosi (resigned)
			Ms L Sibanyoni
			Mr J Van der Walt
Full Council	5	10	Prof. Y Veriava
			Dr L Mpuntsha
			Prof. B Dumisa
			Prof. S Perumal
			Dr S Mabela
			Adv H Kooverjie
			Dr A Thulare
			Ms L Sibanyoni
			Ms M Maboye
			Mr J van der Walt
HEARINGS			
Appeals Committee	12	3	Dr L Mpuntsha
			Prof. B Dumisa
			Adv H Kooverjie

Table 51: Remuneration of council members 2016/2017

Name of Council member	Remuneration R'000	Total R'000
Prof. Y Veriava	222	222
Prof. BC Dumisa	250	250
Adv H Koovertjie SC	109	109
Dr MS Mabela	117	117
Ms M Maboye	47	47
Dr L Mpuntsha	224	224
Ms L Nevhutalu	67	67
Prof. S Perumal	121	121
Mr J van der Walt	113	113
Total	1 270	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.

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 14 June 2016. This approval is important to CMS operations in that it also approves the levy rate at which CMS must charge to medical 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 and efficiency of operations
- 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. The CMS has received unqualified audit reports from the Auditor-General of South Africa 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.

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 operations. It evaluates and provides assurance on the effectiveness of financial management, internal controls, risk management and governance processes at the CMS.

The annual internal audit plan and a three-year rolling plan was approved by the Audit and Risk Committee during the year. The internal audit service contract expired in June 2016 and was extended while a tender process was in progress.

In line with the combined assurance model, the internal auditors and external auditors had several 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 focused on high-risk areas identified in consultation with the Audit and Risk Committee, Executive Management and the Risk and Performance Manager.

Risk management

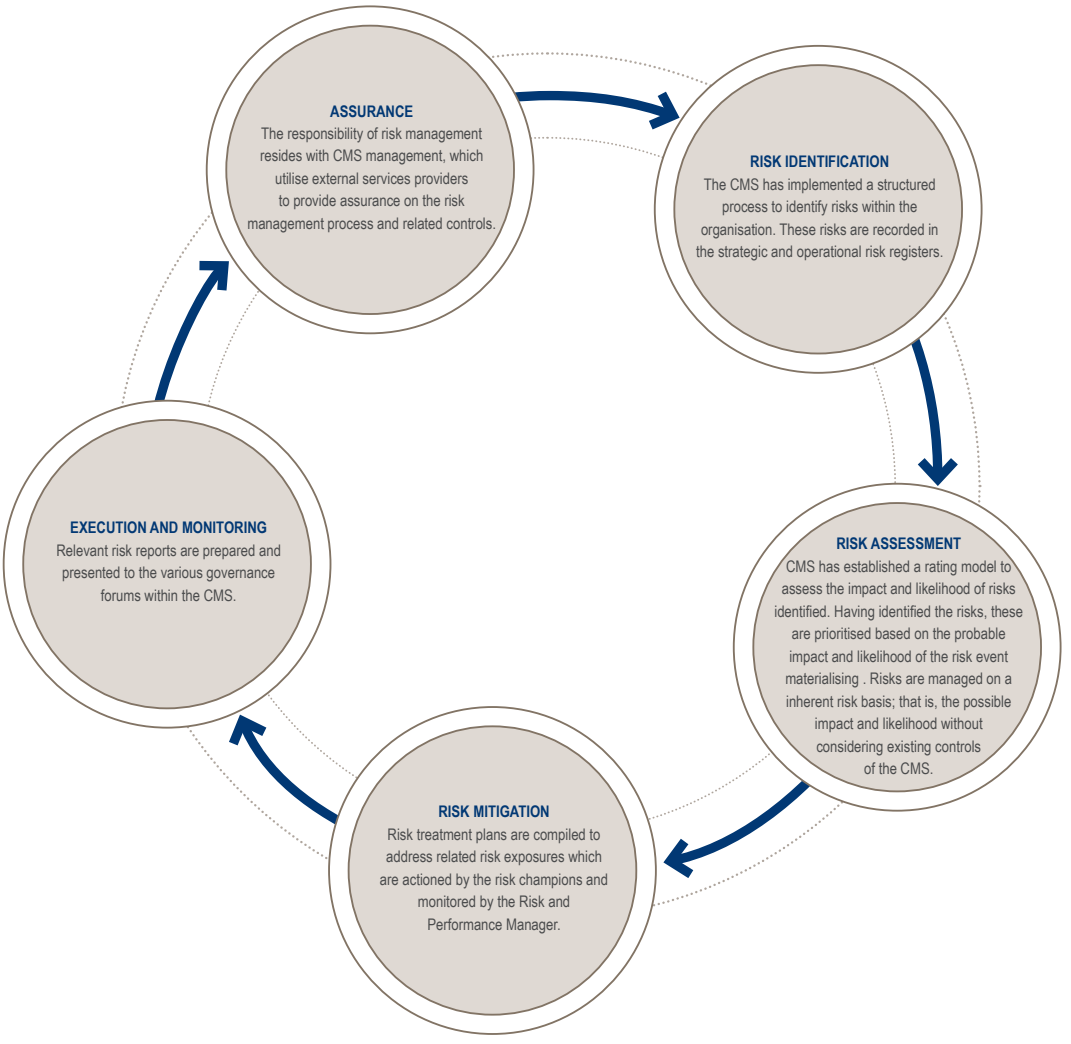
The CMS has established a risk management framework which is in line with best practice guidelines and is working towards attaining a higher level of risk maturity. Risk management is gradually being embedded in the strategy and operations of the CMS. In order for risk management to be embraced by the organisation, the CMS must adopt a top-down approach.

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

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

Figure 14: CMS risk assessment process during 2016/2017



Materiality and significance framework

Framework 2016/2017 financial year

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 200 950.00 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 predetermined objectives and its financial position as at the end of the financial year concerned.

Significance

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

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

Health, safety and environmental issues

Reasonable precautions are taken to ensure a safe working environment. The CMS conducts its business with due regard for environmental concerns. As a safety measure, CMS conducts routine fire drills and keeps employees informed about health and safety measures.

Our health and safety activities for the 2016/2017 financial year included ensuring compliance with the Occupational Health and Safety Act, 85 of 1995 and other relevant legislation, and ensuring that safety measures are adhered to and appropriate safety equipment is put in place.

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.

Preventing 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 Regulation 31 and the fraud and corruption prevention strategy. CMS has an established fraud hot line for the reporting of any suspicious fraudulent activity.

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 2017.

This report is provided by the Audit and Risk Committee of Council, appointed in respect of the 2016/2017 financial year of the CMS, in compliance with Section S51(1)(a)(ii) of the Public Finance Management Act 1 of 1999, as amended (PFMA). The Committee's operation is guided by a detailed charter that 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 follows in Table 52.

Table 52: Meetings & attendance of the Audit and Risk Committee in 2016/2017

Name of member	Position of member	Date of appointment	Date of re-appointment	Term end	Meetings attended			
					24 July 2013 (special)	27 July 2016 (scheduled)	23 November 2016 (scheduled)	16 February 2017 (scheduled)
Mr Rowan Nicholls	Independent & non-executive and Chairperson	1 October 2009	1 November 2012	Term ended 16 February 2017	√	√	√	√
Mrs Josephine Naicker	Independent & non-executive	1 October 2009	1 November 2012	Term ended October 2016	√	√	√	term ended
Ms Pumla Mzizi	Independent & non-executive	1 April 2015			√	X	√	√
Mr Johan vd Walt	Non-executive & Council member	14 November 2014			√	√	√	√
Mr Moremi Nkosi	Non-executive & Council member	14 November 2014	Resigned as Council member		X	√	X	resigned
Prof. Sadhasivan Perumal	Non-executive & Council member	14 November 2014			√	√	√	√
Mr Kariem Hoosain	Independent & non-executive and Chairperson	18 January 2017			–	–	–	√
Mrs Marianna Strydom	Independent & non-executive	18 November 2016			–	–	√	√

** Dr Aquina Thulare joined the Audit and Risk Committee as a non-executive council member in May 2017.*
√ = 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 unaudited and audited Annual Financial Statements and annual performance report to Council for the financial year ended 31 March 2017

Audit & Risk Committee responsibility

Mandate

The mandate of the Committee is derived from section S51(1)(a)(ii) of the PFMA and Treasury Regulations 27.

The Committee reports that it has discharged its responsibilities arising from section S51(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, among 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, 25 of 2004 for the year ended 31 March 2017. 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.

The Committee is satisfied that areas of improvement within the CMS risk management and internal control practices have been adequately identified and entity-wide risk management within the CMS has now been fully implemented.

Based on internal audits that were performed during the 2016/2017 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. However, some weakness in relation to the inconsistent application of Supply Chain Management controls put the achievement of Supply Chain Management objectives at risk.

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 against 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 South African Generally Recognised Accounting Practice (GRAP) and Treasury Regulations. Details in terms of legal cases that warrant noting can be found on page 123 note 23 of the annual financial statements.

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 2017/18.

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 2017 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 2017 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.

A.K. Hoosain

A.K. Hoosain
Chairperson on behalf of the Audit & Risk Committee
Council for Medical Schemes

31 July 2017

HUMAN RESOURCES MANAGEMENT

PART D: HUMAN RESOURCES MANAGEMENT

The Human Resource (HR) unit continues to maintain its competitive advantage in the industry by providing quality service to the CMS and its internal stakeholders. The information below highlights key HR strategic objectives for the financial year 2016/2017 as implemented through the Annual Performance Plan (APP). Outlined hereunder are the key HR strategic objectives achieved during the period under review.

Resources utilisation and talent management

The HR unit undertook a wide range of activities over the period 2016/2017 financial year to ensure that the CMS is adequately resourced and capacitated, with emphasis placed on retaining key talent to be able to respond to our mandate of promoting vibrant and affordable healthcare cover for all.

The HR strategic objectives address the broader strategic goal of the CMS to be responsive to the environment by being a fair, transparent, effective and efficient organisation. During the period under review, talented personnel were sourced in line with the recruitment policies and procedures. The selection process adopted in recruiting for both existing and new positions was to ensure that the best and most appropriately qualified personnel were appointed in various positions within the organisation.

In filling all vacant positions we ensured that the organisation was adequately resourced to deliver on its key strategic objectives. Efforts were made to minimise the period between termination and new appointments so that there was minimal disruptions to the operations. HR utilised unorthodox recruitment methods, within policy, to attract the appropriate skills and talent which were difficult to source due to their critical and scarce nature.

While other organisations struggle to remain below the benchmark 10% staff turnover rate, the CMS continues to strive to minimise the staff turnover rate. In 2016/2017 we successfully achieved a staff turnover rate of 4.42%, which is a significant reduction from 9% for the 2015/2016 financial year.

Orientation, induction, training and development

The HR unit ensured that staff joining the CMS were equipped and adequately resourced to carry out their duties by providing a comprehensive induction and orientation programme. In addition to the on-boarding of new employees, we provided additional training and development opportunities through our professional development programme and on-the-job training at unit level. The training opportunities are aimed at keeping employees up to date with industry trends in their respective fields.

Remuneration and staff benefits

The salary benchmarking survey is undertaken every three years to ensure that the salaries offered by the CMS are market related. During the year under review, the HR unit reviewed remuneration and job profiles, and identified appropriate compensation through role-based benchmarking. The services of an independent contractor were procured to provide remuneration benchmarking services. The recommendations from the market survey will be submitted to the Council for consideration and approval.

Performance management

In line with the HR policy on performance management, two formal performance reviews were conducted. This was preceded by the conclusion of signed performance agreements for all employees. Incentive bonuses were awarded to employees who exceeded performance expectations.

In enhancing performance management processes, the newly formed union was afforded representation at the moderating committee to further promote transparency and fairness in line with the Labour Relations Act 66, of 1995.

Employee wellness and health and safety

The CMS appointed Careways as the new service provider for the employee assistance programme (EAP). The service covers both family and work-related matters. In addition, HR offered the following wellness initiatives to assist employees to maintain a healthy work-life balance:

- subsidy to gym membership;
- health screening for chronic conditions such as diabetes, cholesterol, BMI as well as counselling and testing for HIV/AIDS; and
- on-site administration of flu vaccinations.

The HR unit commemorated World AIDS Day on 1 December 2016 and hosted Ms Seabelo Kgarosi-Atemlefac from Khanya Consultants as a guest speaker.

Employee relations

Employee relations involved protecting employee rights, coordinating with unions, and mediating disagreements between the organisation and employees. During the reporting period, HR was involved in the following activities:

- mediating disagreements between employees and employers;
- mediating disagreements among employees;
- attending to claims of harassment and other workplace grievances;
- attending to employee complaints submitted by union representatives, management, and other stakeholders; and
- acting as the voice of the organisation and/or employees on any broader organisational issues pertaining to employee welfare.

Social responsibility

The CMS continues to play a support role in serving the community. During the reporting period, the CMS partnered with the St Michaels Church and the All Angels Anglican Church to feed the homeless. Groceries were donated to the Rock of Hope Children's Home and the Compass Children's Home.

We also supported initiatives such as the *Cell C Take a Girl Child to Work* and the *Men in the Making* initiative. This entailed hosting school learners for career guidance and giving them the opportunity to visit a place of work and and gain an experience of the world of work.

Employment equity

The CMS continued to exceed its employment equity target in all of the designated categories, with the exception of persons with disabilities. However, we consciously strive to bridge the gap in this designated category by specifically inviting candidates that would fill the gap.

Future HR plans

The HR unit will continue to ensure adequate human resources to meet the strategic goals and operational plans of the CMS. Embedded within the culture of our recruitment strategy is an ethos of 'the right people with the right skills at the right time'.

HR oversight statistics

Table 53: Personnel costs per programme

Programme	Total expenditure of unit (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees	Average personnel cost per employee (R'000)
Accreditation	8 225	7 817	95.04%	10	781.70
Benefits Management	5 637	5 523	97.98%	7	789.00
CEO & Registrar's Office	6 499	2 699	41.53%	3	899.67
Compliance & Investigations	8 768	6 624	75.55%	7	946.29
Complaints Adjudication	5 956	5 746	96.47%	9	638.44
Financial Supervision	11 098	10 831	97.59%	11	984.64
Human Resources	6 047	4 123	68.18%	5	824.60
Internal Finance	33 998	8 770	25.80%	18	487.22
ICT & KM	14 372	8 295	57.72%	12	691.25
Legal Services	11 625	3 575	30.75%	3	1 191.67
Research & Monitoring	6 711	6 417	95.62%	7	916.71
Stakeholder Relations	12 524	7 205	57.53%	11	655.00
Strategy Office & Clinical unit	8 293	7 541	90.93%	10	754.10
Total	**139 753**	**85 166**	**60.94%**	**113**	**753.68**

Table 54: 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	869	1.02%	0	0
Senior management	20 043	23.53%	12	1 670
Professionals	33 346	39.15%	36	926
Skilled labour	29 265	34.36%	52	563
Semi-skilled labour	1 377	1.62%	5	275
Unskilled labour	265	0.31%	8	33
Total	**85 166**	**100.00%**	**113**	**754**

The Registrar's employment ceased on 22 January 2017 before year end thus zero occupancy in top management

Table 55: Performance rewards

Level	Performance rewards (R'000)	Personnel expenditure (R'000)	% of performance rewards to total personnel expenditure per occupational level
Top management	0	869	0.00%
Senior management	1 386	20 043	6.92%
Professionals	2 365	33 346	7.09%
Skilled labour	1 984	29 265	6.78%
Semi-skilled labour	93	1 377	6.78%
Unskilled labour	0	265	0.00%
Total	**5 828**	**85 166**	**6.84%**

Note: 56.84% is the percentage of performance rewards to total personnel cost, whereas, 27.56% is the percentage of total rewards to personnel expenditure per occupational level.

Table 56: Training costs per programme

Programme	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel cost	Number of employees t	Average training cost per employee (R'000)
Accreditation	7 817	38	0.49%	10	3.84
Benefits Management	5 523	48	0.87%	7	6.83
CEO & Registrar's Office	2 699	88	3.26%	3	29.33
Compliance & Investigations	6 624	134	2.02%	7	19.11
Complaints Adjudication	5 746	119	2.07%	9	13.22
Financial Supervision	10 831	105	0.97%	11	9.53
Human Resources	4 123	107	2.58%	5	21.31
Internal Finance	8 770	107	1.22%	18	5.94
ICT & KM	8 295	187	2.26%	12	15.59
Legal Services	3 575	74	2.06%	3	24.54
Research & Monitoring	6 417	159	2.48%	7	22.71
Stakeholder Relations	7 205	146	2.03%	11	13.31
Strategy Office & Clinical unit	7 541	198	2.63%	10	19.80
Total	**85 166**	**1 510**	**1.77%**	**113**	**13.36**

Table 57: Employment and vacancies per programme

Programme (Unit)	2015/2016 number of employees	Approved posts 2016/2017	2016/2017 number of employees	2016/2017 vacancies	% of vacancies
Accreditation	10	0	10	0	0.00%
Benefits Management	7	1	7	0	0.00%
CEO & Registrar's Office	3	0	3	2	10.00%
Compliance & Investigations	7	1	7	1	5.00%
Complaints Adjudication	8	1	9	2	10.00%
Financial Supervision	11	0	11	1	5.00%
Human Resources	5	0	5	0	0.00%
Internal Finance	9	8	18	8	40.00%
ICT & KM	11	1	12	2	10.00%
Legal Services	4	0	3	1	5.00%
Research & Monitoring	8	0	7	1	5.00%
Stakeholder Relations	11	0	11	1	5.00%
Strategy Office & Clinical unit	6	0	10	1	5.00%
Total	**100**	**12**	**113**	**20**	**100.00%**

Table 58: Employment and vacancies per salary band

Level	2015/16 number of employees	Approved posts 2016/2017	2016/2017 number of employees	2016/2017 vacancies	% of vacancies
Top management	0	0	0	1	5.00%
Senior management	10	0	11	1	5.00%
Professionals	36	3	37	5	25.00%
Skilled labour	50	1	52	4	20.00%
Semi-skilled labour	4	0	5	1	5.00%
Unskilled labour	0	8	8	8	40.00%
Total	**100**	**12**	**113**	**20**	**100.00%**

Note: Council approved the following new positions in 2016/2017: Senior Analyst: Benefits Management, Senior Compliance Officer, Senior Developer, and eight Cleaners. Vacancies were due to resignations, new positions and internal movement.

Table 59: Employment changes per salary band 2016/2017

Level	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	0	1	1	0
Senior management	10	1	0	11
Professionals	35	5	2	37
Skilled labour	50	4	3	52
Semi-skilled labour	4	1	0	5
Unskilled labour	0	8	0	8
Total	**99**	**20**	**6**	**113**

The movement between the closing balance 2015/2016 and the opening balance 2016/2017 is due to employee serving notice of resignation during the month of March 2016.

Vacancies between appointments and terminations were due to resignations and internal alignment of jobs within Patterson grading system.

Table 60: Reasons for staff leaving 2016/2017

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

Table 61: Labour relations: misconduct and disciplinary action 2016/2017

Reason	Number of occurrences
Verbal warning	0
Written warning	0
Final written warning	0
Dismissal	0
Total	**0**

Table 62: Employment equity – current status and targets (Male) 2016/2017

	Male							
	African		Coloured		Indian		White	
Levels	Current	Target	Current	Target	Current	Target	Current	Target
Top management	0	0	0	0	0	0	0	0
Senior management	3	0	0	1	1	0	4	0
Professional qualified	15	0	0	0	1	0	2	0
Skilled	7	2	2	0	0	0	1	0
Semi-skilled	2	0	0	0	0	0	0	0
Unskilled	0	0	0	0	0	0	0	0
Total	**27**	**2**	**2**	**1**	**2**	**0**	**7**	**0**

Table 63: Employment equity – current status and targets (Female) 2016/2017

	Female							
	African		Coloured		Indian		White	
Levels	Current	Target	Current	Target	Current	Target	Current	Target
Top management	0	0	0	0	0	0	0	0
Senior management	3	2	0	1	0	1	1	0
Professional qualified	10	1	1	0	1	0	6	0
Skilled	31	1	3	0	1	0	6	1
Semi-skilled	3	0	0	0	0	0	0	0
Unskilled	8	0	0	0	0	0	0	0
Total	**55**	**4**	**4**	**1**	**2**	**1**	**13**	**1**

Table 64: Employment equity – current status and targets (Disabled) 2016/2017

	Disabled staff			
	Male		Female	
Levels	Current	Target	Current	Target
Top management	0	0	0	0
Senior management	0	0	0	0
Professional qualified	0	0	0	0
Skilled	1	0	0	0
Semi-skilled	0	0	0	0
Unskilled	0	0	0	0
Total	**1**	**0**	**0**	**0**


E
FINANCIAL INFORMATION

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY FOR 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 responsible for independently reviewing 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 97.

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 2017.

The annual financial statements set out on pages 96 to 126, which have been prepared on the going concern basis, were approved by the Council on 31 May 2017 and were signed on its behalf by:

Dr S Kabane
Acting CEO and Registrar

Prof. Y Veriava
Chairperson of Council

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

Report on the financial statements

Opinion

1. I have audited the annual financial statements of the Council for Medical Schemes set out on pages 101 to 126, which comprise the statement of financial position as at 31 March 2017, and the statement of financial performance, statement of changes in net assets and statement of cash flows and the statement of comparison of budget information with actual information for the year then ended, as well as the notes to the financial statements, including a summary of significant accounting policies.

2. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March 2017, 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 of South Africa, 1999 (Act No. 1 of 1999) (PFMA). 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 my report.

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 my report.

4. I am independent of the public entity in accordance with the International Ethics Standards Board for Accountants' Code of ethics for professional accountants (IESBA code) together with 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.

Other matter

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

7. The supplementary information set out on pages 128 to 233 does not form part of the financial statements and is presented as additional information. I have not audited these schedules and, accordingly, I do not express an opinion on them.

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 SA Standards of GRAP and the requirements of the 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 there is an intention to liquidate the public entity or to cease operations, or there is no realistic alternative but to do so.

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

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

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

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

Report on the audit of the annual performance report

Introduction and scope

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

13. My procedures address the reported performance information, which must be based on the approved performance planning documents of the public 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 public entity for the year ended 31 March 2017:

Programmes	Pages in the annual performance report
Programme 3 – accreditation unit	63 – 65
Programme 4 – research and monitoring unit	65 – 66
Programme 6 – compliance investigations unit	69 – 70
Programme 7 – benefit management unit	71 – 72
Programme 8 – financial supervision unit	73 – 74
Programme 9 – complaints adjudication unit	75 – 76

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

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

Other matters

17. I draw attention to the matters below.

Achievement of planned targets

18. Refer to the annual performance report on pages 48 to 76 for information on the achievement of planned targets for the year and explanations provided for the under or over achievement of a significant number of targets.

Adjustment of material misstatements

19. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were on the reported performance information of programme 8 – financial supervision unit. As management subsequently corrected the misstatements, I did not raise material findings on the usefulness and reliability of the reported performance information.

Report on audit of compliance with legislation

Introduction and scope

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

21. I did not identify any instances of material non-compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA.

Other information

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

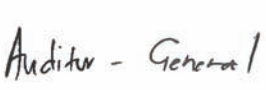
23. My opinion on the financial statements and findings on the reported performance information and compliance with legislation do not cover the other information and I do not express an audit opinion or any form of assurance conclusion thereon.

24. In connection with my audit, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and the selected programmes presented in the annual performance report, or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work I have performed on the other information obtained prior to the date of this auditor's report, I conclude that there is a material misstatement of this other information, I am required to report that fact.

25. I did not identify any material inconsistencies between other information and the financial statements and the selected programmes presented in the annual performance report.

Internal control deficiencies

26. I considered internal control relevant to my audit of the financial statements, reported performance information and compliance with applicable legislation; however, my objective was not to express any form of assurance thereon. I did not identify any significant deficiencies in internal control.



Auditor General
Pretoria
31 July 2017

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 public entity's compliance with respect to the selected subject matters.

Financial statements

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

    - identify and assess the risks of material misstatement of the financial statements whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control
    - obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the public entity's internal control
    - evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the accounting authority
    - conclude on the appropriateness of the accounting authority's use of the going concern basis of accounting in the preparation of the financial statements. I also conclude, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Council for Medical Scheme's 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 the auditor's report. However, future events or conditions may cause a public entity to cease operating 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 here applicable, related safeguards.

STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2017

	Note(s)	2017 R'000	2016 R'000
Assets			
Current Assets			
Receivables from exchange transactions	3	**5 853**	7 132
Cash and cash equivalents	4	**32 470**	24 687
		38 323	31 819
Non-current Assets			
Property, plant and equipment	5	**18 476**	18 269
Intangible assets	6	**1 729**	791
		20 205	19 060
Total Assets		**58 528**	50 879
Liabilities			
Current Liabilities			
Payables from exchange transactions	7	**17 139**	13 893
Unspent conditional grants and receipts	12	**3 271**	2 254
Provisions	8	**227**	257
		20 637	16 404
Non-current Liabilities			
Operating lease liability	9	**8 231**	6 205
Provisions	8	**1 464**	928
		9 695	7 133
Total Liabilities		**30 332**	23 537
Net Assets		**28 196**	27 342
Accumulated surplus		**28 196**	27 342

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 31 MARCH 2017

	Note(s)	**2017 R'000**	2016 R'000
Revenue	11	**136 075**	129 952
Administrative expenses	13	**(21 700)**	(20 448)
Audit fees	14	**(785)**	(1 952)
Operating expenses	15	**(22 233)**	(15 862)
Staff cost	16	**(90 599)**	(80 689)
Depreciation and amortisation		**(4 431)**	(4 106)
Gain/(Loss) on disposal of assets	17	**44**	(254)
Operating (deficit)/surplus		**(3 629)**	6 641
Investment revenue	18	**4 483**	2 836
Surplus for the year		**854**	9 477

STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED 31 MARCH 2017

	Accumulated surplus R'000	Total net assets R'000
Opening balance as previously reported	17 072	17 072
Correction of errors	793	793
Balance at 01 April 2015 as restated*	**17 865**	**17 865**
Surplus for the year	9 477	9 477
Opening balance as previously reported	9 564	9 564
Correction of errors	(87)	(87)
Balance at 01 April 2016	**27 342**	**27 342**
Surplus for the year	854	854
Balance at 31 March 2017	**28 196**	**28 196**

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2017

	Note(s)	2017 R'000	2016 R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		**136 499**	129 205
Grants		**1 758**	2 710
Interest income		**4 483**	2 836
		142 740	134 751
Payments			
Employee costs		**(90 599)**	(80 689)
Suppliers		**(38 826)**	(34 778)
		(129 425)	(115 467)
Net cash flows from operating activities	20	**13 315**	19 284
Cash flows from investing activities			
Purchase of property, plant and equipment	5	**(4 284)**	(5 135)
Proceeds from sale of property, plant and equipment	5	**188**	(33)
Purchase of other intangible assets	6	**(1 436)**	(12)
Proceeds from sale of intangible assets	6		68
Net cash flows from investing activities		**(5 532)**	(5 112)
Net Increase in cash and cash equivalents		**7 783**	14 172
Cash and cash equivalents at the beginning of the year		**24 687**	10 515
Cash and cash equivalents at the end of the year	4	**32 470**	24 687

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2017

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	6 352	(2 963)	1
Appeal fees	–	–	–	10	10	
Gains on disposal of assets	–	–	–	44	44	
Interest received - investment	2 345	–	2 345	4 483	2 138	2
Legal fees recovered	–	–	–	1 543	1 543	3
Levies income	127 527	2 039	129 566	126 469	(3 097)	
Registration fees	356	–	356	431	75	
Sundry income	–	–	–	530	530	
Total revenue from exchange transactions	**139 543**	**2 039**	**141 582**	**139 862**	**(1 720)**	
Revenue from non-exchange transactions						
Transfer revenue						
Government transfers – Department of Health	1 613	–	1 613	595	(1 018)	4
Mandatory transfer – Department of Higher Education and Training	–	–	–	145	145	
Total revenue from non-exchange transactions	**1 613**	**–**	**1 613**	**740**	**(873)**	
Total revenue	**141 156**	**2 039**	**143 195**	**140 602**	**(2 593)**	
Expenditure						
Personnel	(93 682)	(2 800)	(96 482)	(90 599)	5 883	
Administrative expenses	(23 446)	(704)	(24 150)	(21 700)	2 450	5
Operating expenses	(18 673)	(4 520)	(23 193)	(22 233)	960	
Depreciation and amortisation	(2 424)	–	(2 424)	(4 431)	(2 007)	
Auditors' remuneration	(2 201)	–	(2 201)	(785)	1 416	6
Total expenditure	**(140 426)**	**(8 024)**	**(148 450)**	**(139 748)**	**8 702**	
Surplus for the year	**730**	**(5 985)**	**(5 255)**	**854**	**6 109**	
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	**730**	**(5 985)**	**(5 255)**	**854**	**6 109**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2017

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						
Receivables from exchange transactions	–	–	–	(1 279)	**(1 279)**	
Cash and cash equivalents	–	–	–	7 783	**7 783**	
	–	–	–	6 504	**6 504**	
Non-current Assets						
Property, plant and equipment	2 945	1 855	4 800	207	**(4 593)**	7
Intangible assets	–	–	–	938	**938**	
	2 945	**1 855**	**4 800**	**1 145**	**(3 655)**	
Total Assets	**2 945**	**1 855**	**4 800**	**7 649**	**2 849**	
Liabilities						
Current Liabilities						
Payables from exchange transactions	–	–	–	3 246	**3 246**	8
Non-current Liabilities						
Operating lease liability	–	–	–	2 026	**2 026**	9
Unspent conditional grants and receipts	–	–	–	1 017	**1 017**	
Provisions	–	–	–	506	**506**	
	–	**–**	**–**	**3 549**	**3 549**	
Total Liabilities	**–**	**–**	**–**	**6 795**	**6 795**	
Net Assets	**2 945**	**1 855**	**4 800**	**854**	**(3 946)**	
Net Assets						
Net Assets attributable to Owners of Controlling Entity						
Reserves						
Accumulated surplus	2 945	1 855	4 800	854	**(3 946)**	

Note

1. *32% under-collection on Accreditation fees was due to amendments to Regulation 31 which was effective in September 2016 while impact on budget was planned for the entire year.*
2. *91% over-collection on interest received was due to surplus funds used in the later part of the year resulting on interest earned on higher bank balance.*
3. *100% over-collection on legal fees recovered was due to timing of the income being unknown. Only after receiving the Tax Masters' account can income be reliably estimated.*
4. *63% under- expenditure on the grant received from Department of Health was due to the grant being conditional and only R595 000 was utilised on the projects.*
5. *10% under-expenditure on administrative expenses was due to Microsoft License agreement which was cancelled due to revised licensing arrangements.*
6. *64% under-expenditure on the auditors' remuneration (external auditors) was due to costs incurred according to audit plan while the contract for internal auditors had expired and the awarding of tender is still underway.*
7. *Only capital expenditure acquisitions are budgeted for, in particular Property Plant and equipment.*
8. *100% over-expenditure on payables from exchange transactions was due to inadequate budgeting for the line item.*
9. *100% over-expenditure on the operating lease liability was due to inadequate budgeting for the line item.*

ACCOUNTING POLICIES

FOR THE YEAR ENDED 31 MARCH 2017

1. Presentation of Annual Financial Statements

The annual financial statements have been prepared in accordance with the Standards of Generally Recognised Accounting Practice (GRAP), issued by the Accounting Standards Board in accordance with Section 55 of the Public Finance Management Act (Act 1 of 1999).

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

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

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

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

1.1 Presentation currency

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

1.2 Going concern assumption

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

1.3 Comparative figures

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

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

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

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

1.4 Significant judgements and sources of estimation uncertainty

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

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

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

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

Provisions

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

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

1.4 Significant judgements 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, the change has been accounted for as a change in accounting estimate in accordance with Standards of GRAP on Accounting Policies, Changes in Accounting Estimates and Errors.

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

Effective interest rate

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

Impairment testing

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

1.5 Financial instruments

Classification

The entity classifies financial assets and financial liabilities into the following categories:

Classification depends on the purpose for which the financial instruments were obtained / incurred and takes place at initial recognition. Classification is re-assessed on an annual basis, except for derivatives and financial assets designated as at fair value through surplus or deficit, which shall not be classified out of the fair value through surplus or deficit category.

Initial recognition and measurement

Financial instruments are recognised initially when the entity becomes a party to the contractual provisions of the instruments.

The entity classifies financial instruments, or their component parts, on initial recognition as a financial asset, a financial liability or an equity instrument in accordance with the substance of the contractual arrangement.

Financial instruments are measured initially at fair value, except for equity investments for which a fair value is not determinable, which are measured at cost and are classified as available-for-sale financial assets.

For financial instruments which are not at fair value through surplus or deficit, transaction costs are included in the initial measurement of the instrument.

Subsequent measurement

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

Gains and losses arising from changes in fair value are recognised in equity until the asset is disposed of or determined to be impaired. Interest on available-for-sale financial assets calculated using the effective interest method is recognised in surplus or deficit as part of other income. Dividends or similar distributions received on available-for-sale equity instruments are recognised in surplus or deficit as part of other income when the entity's right to receive payment is established.

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

Impairment of financial assets

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

Impairment losses are recognised in surplus or deficit.

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.

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

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 residual value, and the useful life and depreciation method of each asset are reviewed at the end of each reporting date.

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

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 charge for each period is recognised in surplus or deficit unless it is included in the carrying amount of another asset.

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

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

1.7 Intangible assets

An asset is identifiable if it either:

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

An intangible asset is recognised when:

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

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

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

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

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

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

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

Item	Useful life
Developed software	7 years
Acquired software	7 years

Intangible assets are derecognised:

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

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

1.8 Impairment of non-financial assets

Cash-generating assets are assets managed with the objective of generating a commercial return. An asset generates a commercial return when it is deployed in a manner consistent with that adopted by a profit-oriented entity.

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

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

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

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

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

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

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

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

Useful life is either:
(a) the period of time over which an asset is expected to be used by the entity; or
(b) the number of production or similar units expected to be obtained from the asset by the entity.

Identification

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

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

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

Recognition and measurement

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

An impairment loss is recognised immediately in surplus or deficit.

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

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

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

Reversal of impairment loss

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

An impairment loss recognised in prior periods for a non-cash-generating asset is reversed if there has been a change in the estimates used to determine the asset's recoverable service amount since the last impairment loss was recognised. The carrying amount of the asset is increased to its recoverable service amount. The increase is a reversal of an impairment loss. The increased carrying amount of an asset attributable to a reversal of an impairment loss does not exceed the carrying amount that would have been determined (net of depreciation or amortisation) had no impairment loss been recognised for the asset in prior periods.

A reversal of an impairment loss for a non-cash-generating asset is recognised immediately in surplus or deficit.

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

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

1.9 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.

1.9 Leases (continued)

Finance leases – lessee

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

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

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

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

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

Operating leases – lessee

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

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

1.10 Revenue from exchange transactions

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

Recognition

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

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

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

The main sources of revenue from exchange transactions are:

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

1.11 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.

Expenses paid through the tax system are amounts that are available to beneficiaries regardless of whether or not they pay taxes.

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 lal/t/S or regulations.

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

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

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

Tax expenditures are preferential provisions of the tax law that provide certain taxpayers with concessions that are not available to others.

The taxable event is the event that the government, legislature or other authority has determined will be subject to taxation.

Taxes are economic benefits or service potential compulsorily paid or payable to entities, in accordance with laws and or regulations, established to provide revenue to government. Taxes do not include fines or other penalties imposed for breaches of the law.

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

1.12 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.

1.13 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.

1.14 Post-reporting date events

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

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

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

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

1.15 Related parties

The entity has processes and controls in place to aid in the identification of related parties. A related party is a person or an entity with the ability to control or jointly control the other party, or exercise significant influence over the other party, or vice versa,or an entity that is subject to common control, or joint control. Related party relationships where control exists are disclosed regardless of whether any transactions took place between the parties during the reporting period.

Where transactions occurred between the entity any one or more related parties, and those transactions were not within:

- Normal supplier and/or client/recipient relationships on terms and conditions no more or less favourable than those which it is reasonable to expect the entity to have adopted if dealing with that individual entity or person in the same circumstances.
- Terms and conditions within the normal operating parameters established by the reporting entity's legal mandate;

Further details about those transactions are disclosed in the notes to the financial statements.

Only transactions with related parties not at arm's length or not in the ordinary course of business are disclosed

1.16 Budget information

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

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

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

The approved budget covers the fiscal period from 01/04/2016 to 31/03/2017.

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

1.17 Segment information

A segment is an activity of an entity:

- that generates service potential (induding 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 2017

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	1 April 2017	The impact of the amendment is not material.

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 after 01 Aprll 2017 or later periods:

Standard/Interpretation:	Effective date: Years beginning on or after	Impact on current year
GRAP 34: Separate Financial Statements	01 April 2017	Unlikely there will be a material impact
GRAP 35: Consolidated Financial Statements	01 April 2017	Unlikely there will be a material impact
GRAP 36: Investments in Associates and Joint Ventures	01 April 2017	Unlikely there will be a material impact
GRAP 37:Joint Arrangements	01 April 2017	Unlikely there will be a material impact
GRAP 38: Disclosure of Interests in Other Entities	01 April 2017	Unlikely there will be a material impact
GRAP 110:Living and Non-living Resources	01 April 2017	Unlikely there will be a material impact
GRAP 12 (as amended 2016): Inventories	01 April 2017	Unlikely there will be a material impact
GRAP 27 (as amended 2016): Agriculture	01 April 2017	Unlikely there will be a material impact
GRAP 31 (as amended 2016): Intangible Assets	01 April 2017	Unlikely there will be a material impact
GRAP 103 (as amended 2016):Heritage Assets	01 April 2017	Unlikely there will be a material impact
GRAP 110 (as amended 2016):Living and Non-living resources	01 April 2017	Unlikely there will be a material impact
IGRAP 18: Interpretation of the Standard of GRAP on Recognition and Derecogntion of Land	01 April 2017	Unlikely there will be a material impact
Directive 12: The Selection of an Appropriate Reporting Framework by Public Entities	01 April 2018	Unlikely there will be a material impact
GRAP 109: Accounting by Principals and Agents	01 April 2017	Unlikely there will be a material impact

	2017 R'000	2016 R'000
3. Receivables from exchange transactions		
Accounts receivable	**89**	158
Sundry debtors	**2 583**	4 359
Prepaid expenses	**3 181**	2 615
	5 853	7 132
4. Cash and cash equivalents		
Cash and cash equivalents consist of:		
Cash on hand	**5**	7
Bank balances	**3 827**	1 274
CPD account	**28 638**	23 406
	32 470	24 687

5. Property, plant and equipment

	2017			2016		
	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Computer equipment	**10 868**	**(5 790)**	**5 078**	9 779	(5 471)	4 308
Computer software	**2 163**	**(1 372)**	**791**	1 697	(1 042)	655
Furniture and fittings	**6 663**	**(2 652)**	**4 011**	6 106	(2 329)	3 777
Leasehold improvements	**11 980**	**(4 072)**	**7 908**	11 980	(2 798)	9 182
Motor vehicles	**470**	**(44)**	**426**	249	(191)	58
Other fixed assets	**585**	**(323)**	**262**	581	(292)	289
Total	**32 729**	**(14 253)**	**18 476**	30 392	(12 123)	18 269

Reconciliation of property, plant and equipment – 2017

	Opening balance	Additions	Disposals	Other changes movements	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**

Reconciliation of property, plant and equipment – 2016

	Opening balance	Additions	Disposals	Depreciation	Total
Computer equipment	3 296	2 282	(43)	(1 227)	4 308
Computer software	1 011	–	(17)	(339)	655
Furniture and fittings	3 088	1 324	(145)	(490)	3 777
Leasehold improvements	8 883	1 488	–	(1 189)	9 182
Motor vehicles	80	27	–	(49)	58
Other fixed assets	341	14	(16)	(50)	289
	16 699	5 135	(221)	(3 344)	18 269

6. Intangible assets

	2017			2016		
	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value	Cost/ Valuation	Accumulated amortisation and accumulated impairment	Carrying value
Acquired software	**2 452**	**(1 476)**	**976**	1 703	(1 070)	633
Developed software	**1 795**	**(1 042)**	**753**	1 145	(987)	158
Total	**4 247**	**(2 518)**	**1 729**	2 848	(2 057)	791

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**

Reconciliation of intangible assets – 2016

	Opening balance	Additions	Disposals	Amortisation	Total
Acquired software	1 187	12	(64)	(502)	633
Developed software	427	–	(4)	(265)	158
	1 614	12	(68)	(767)	791

7. Payables from exchange transactions

	2017 R'000	2016 R'000
Accounts payable	**8 931**	5 697
Accruals	**4 986**	5 786
Accrual for leave pay	**2 208**	1 753
Income received in advance	**1 014**	657
	17 139	13 893

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

8. Provisions

	Opening Balance	Additions	Utilised during the year	Total
Reconciliation of provisions – 2017				
Provision for long service award	**1 185**	**771**	**(265)**	**1 691**

Reconciliation of provisions – 2016

	Opening Balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	1 028	308	(151)	–	1 185

	2017 R'000	2016 R'000
Non-current liabilities	**1 464**	928
Current liabilities	**227**	257
	1 691	1 185

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

	2017 R'000	2016 R'000
Non-current liabilities	**8 231**	6 205

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

10. Financial instruments disclosure

	At amortised cost	Total
Categories of financial instruments		
2017		
Financial assets		
Trade and other receivables from exchange transactions	**2 666**	**2 666**
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**
2016		
Financial assets		
Trade and other receivables from exchange transactions	4 516	4 516
Cash and cash equivalents	24 687	24 687
	29 203	29 203
Financial liabilities		
Trade and other payables from exchange transactions	13 893	13 893

	2017 R'000	2016 R'000
11. Revenue		
Accreditation fees	**6 352**	6 228
Appeal fees	**10**	10
Government transfers: Department of Health	**595**	302
Legal fees recovered	**1 543**	1 551
Levies income	**126 469**	120 107
Mandatory transfer: Department of Higher Education & Training	**145**	154
Registration fees	**431**	370
Sundry income	**530**	1 230
	136 075	129 952
The amounts included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	**6 352**	6 228
Appeal fees	**10**	10
Legal fees recovered	**1 543**	1 551
Levies income	**126 469**	120 107
Registration fees	**431**	370
Sundry income	**530**	1 230
	135 335	129 496
The amount included in revenue arising from non-exchange transactions is as follows:		
Transfer revenue		
Government transfers: Department of Health (note 12)	**595**	302
Mandatory transfer: Department of Higher Education & Training	**145**	154
	740	456
Nature and type of services in-kind are as follows:		
The CMS awarded Board of Healthcare Funders (BHF) a contract 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.		
12. Conditional grant received		
Grant received from Department of Health		
Opening balance	**2 254**	–
Grant received	**1 613**	2 556
Utilised during the year	**(595)**	(302)
	3 272	2 254
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.		

	2017 R'000	2016 R'000
13. Administrative expenses		
Bank charges	**100**	55
Building expenses	**2 242**	2 382
General administrative expenses	**949**	840
Insurance	**410**	333
Printing and stationery	**448**	311
Refreshments	**70**	48
Rent	**11 492**	10 655
Rent – operating expense	**1 971**	1 687
Rental – copiers	**399**	194
Security	**431**	864
Subscriptions	**345**	261
Telecommunication expenses	**2 843**	2 818
	21 700	20 448
14. Auditors' remuneration		
External audit	**581**	969
Internal audit	**204**	983
	785	1 952
15. Operating expenses		
Committee remuneration	**89**	54
Consulting	**5 134**	3 054
Council members' fees (see note 23)	**1 270**	741
Courier and postage	**78**	66
Exhibition costs	**97**	56
Knowledge management	**791**	544
Legal fees	**7 888**	7 459
Media and promotion	**3 397**	843
Printing and publication	**873**	571
Transcription services	**63**	48
Travel and subsistence	**1 675**	1 714
Venue and catering	**878**	712
	22 233	15 862
16. Staff costs		
Employee benefits	**2 026**	1 794
Employee wellness	**339**	319
Recruitment and relocation	**503**	786
Salaries	**85 166**	76 101
Staff training	**1 510**	1 013
Temporary staff	**309**	207
SEP system expense	**595**	302
Workmen's compensation	**151**	167
	90 599	80 689
Total number of employees	**113**	100

	2017 R'000	2016 R'000
17. Gain/(loss) on disposal of assets		
Gain/(loss) on disposal of assets	**44**	(254)
CMS disposed of some assets which where no longer in use during the year with a gain of R44 000.		
18. Investment revenue		
Interest earned on investment	**4 483**	2 836
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	**854**	9 477
Adjustments for:		
Depreciation and amortisation	**4 431**	4 106
(Gain)/Loss on sale of assets and liabilities	**(44)**	254
Movements in operating lease assets and accruals	**2 026**	2 524
Movements in provisions	**506**	157
Changes in working capital:		
Receivables from exchange transactions	**1 279**	(291)
Payables from exchange transactions	**3 246**	803
Unspent conditional grants and receipts	**1 017**	2 254
	13 315	19 284
21. Commitments		
Operating leases – as lessee (expense)		
21.1 Photocopier rental		
Minimum lease payments due		
– within one year	**399**	399
– in second to fifth year inclusive	**365**	764
	764	1 163
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	**10 415**	9 599
– in second to fifth year inclusive	**51 297**	47 278
– later than five years	**18 315**	32 748
	80 027	89 625
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.

	2017 R'000	2016 R'000
Related party transactions		
Transfer paid to/(received from) related parties		
Department of Health	**(1 613)**	(2 556)
Prof. BC Dumisa	**250**	96
Adv H Kooverjie SC	**109**	78
Dr MS Mabela	**117**	88
Ms M Maboye	**47**	25
Dr L Mpuntsha	**224**	131
Ms L Nevhutalu	**67**	28
Prof. S Perumal	**121**	108
Mr J van der Walt	**113**	77
Prof. Y Veriava	**222**	110
	1 270	741

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 - 0ctober 2016 & December 2016)	**1 599**	**148**	**366**	**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: Comlpiance 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**
Geral Manager: Research & 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 Adjudication	**1 264**	**117**	**32**	**1 413**
	18 586	**1 375**	**946**	**20 907**

22. Related parties (continued)

Compensation to executive management:	Basic salary	Performance management	Acting allowance & other	Total
2016				
Chief Executive and Registrar (Until 30 June 2015)	520	–	(29)	491
Chief Financial Officer/Acting Registrar (April 2015 – March 2016)	1 494	119	625	2 238
Chief Information Officer	1 480	96	(5)	1 571
General Manager: Accreditation	1 439	94	64	1 597
General Manager: Benefits Management	1 368	89	4	1 461
General Manager: Comliance and Investigation	1 494	108	12	1 614
General Manager: Financial Supervision	1 494	108	39	1 641
General Manager: Human Resources	1 494	119	42	1 655
General Manager: Legal Services	1 494	108	(20)	1 582
General Manager: Research & Monitoring	1 363	100	31	1 494
General Manager: Stakeholder Relations	1 321	97	11	1 429
Senior Manager: Complaints Adjudication	1 123	81	25	1 229
	16 084	1 119	799	18 002

Compensation to executive management includes gross remuneration as well as all company contribution. 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 or less than R300 000.

Genesis v Registrar of Medical Schemes and CMS case:

On the 6 of June 2017, the CMS lost an appeal in the Constitutional Court from the Supreme Court of Appeal in the case of Genesis v Registrar of Medical Schemes and CMS. The CMS is liable for the applicants legal costs, including where applicable the costs of the two Council. The estimated financial effect is to be determined by the Tax Master however the taxed amount is estimated to be equal or less than R600 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:

- Genesis vs CMS and Du Toit
- Genesis vs CMS and Joubert
- Government Employees Medical Fund/Mokoditoa & CMS
- SAMA
- Commed Medical Aid Schemes and CMS

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

24. Risk management

Financial risk management

The entity's activities expose it to a variety of financial risks: liquidity risk, credit risk and market risk (including cashflow 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 637 663 as at 31 March 2017.

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 R42 116 or decrease of R42 116 respectively.

	2017 R'000	2016 R'000
25. Irregular expenditure		
Opening balance	**9 419**	8 436
Add: Irregular Expenditure – current year	**1 368**	983
Less: Amounts not recoverable (not condoned)	**–**	–
	10 787	9 419
Analysis of expenditure awaiting condonation per age classification		
Current year	**1 368**	983

The irregular expenditure for the current year of R1 064 915, was identified and it is 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).

During the current years 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. During the current 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: See below.

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

	2017 R'000	2016 R'000
Details of irregular expenditure		
Incident		
Bid awarded without following correct procedures	**303**	983
Bid awarded to the cheapest qoute but not to the highest scoring bidder due to system error	**1 065**	–
	1 368	983

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 diversionary 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.

	2017 R'000	2016 R'000
26. Reconciliation between budget and statement of financial performance		
Reconciliation of budget surplus/deficit with the surplus/deficit in the statement of financial performance:		
Net surplus per the statement of financial performance	**854**	9 477
Adjusted for:		
(Gain)/loss on the sale of assets	**(44)**	254
(Over)/ under collection of revenue	**2 637**	(923)
(Over)/under budget expenditure	**(8 702)**	(9 029)
Net surplus per approved budget	**(5 255)**	(221)

27. Budget differences

Differences between budget and actual amounts basis of preparation and presentation

The budget and the accounting bases differ. The annual financial statements are prepared on the accrual basis using a classification based on the nature of expenses in the statement of financial performance. The annual financial statements differ from the budget, which is approved on the cash basis.

	2017 R'000	2016 R'000
28. Change in estimate		
Property, plant and equipment		
Management reviewed the expected useful life of Property, plant and equipment and intangible assets at year end. Useful life of assets with carrying values at the beginning of the financial year were corrected prospectively, thus in the current year and future years. The change in the estimated useful life of these assets resulted in a decrease in amortisation and depreciation in the current year and an increase in amortisation and depreciation in the future years.		
The effect of the changes in estimate on the current and future periods can be summarised as follows:		
Amortisation expense still to be written-off in future years on acquired software	**47**	–
Amortisation expense still to be written-off in future years on developed software	**50**	–
Depreciation expense still to be written-off in future years on computer equipment	**36**	–
Depreciation expense still to be written-off in future years on computer software	**7**	–
	140	–
29. Prior period errors		
Management reviewed the expected usefullife of Property, Plant and Equipment and Intangible assets at year end. Useful lives of asstes fully depreciated at the beginning of the financial year were retrospectively adjusted.		
The correction of the error(s) results in adjustments as follows:		
(Decrease) in accumulated depreciation 31 March 2015	–	(684)
(Decrease) in accumulated amortisation 31 March 2015	–	(109)
Increase in accumulated surplus 31 March 2015	–	793
(Decrease) in depreciation and amortisation	–	(57)
(Decrease) in accumulated depreciation 31 March 2016	–	(586)
(Decrease) in accumulated amortisation 31 March 2016	–	(119)
Increase in accumulated surplus 31 March 2016	–	705
Increase in depreciation and amortisation	–	87

30. 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 management views the entity as a single segment to which adequate disclosure has been made in these Annual Financial Statement.

THE MEDICAL SCHEMES INDUSTRY IN 2016

THE MEDICAL SCHEMES INDUSTRY IN 2016

The CMS is in the third year of using the new Dynamic Database Driven Annual Returns System (DDDR) to collect the Healthcare Utilisation Returns (ASR). The aim of the new system is to ensure that healthcare utilisation measures in the Healthcare Utilisation Annual Statutory Returns (ASR) are adequately defined and not open to varying interpretations by medical schemes.

In order to accommodate all administration systems, the guidelines and specification documents are deliberately targeted at the lowest common denominator. The standards in the specification documents will be gradually raised to allow for the collection of healthcare indicators that are currently not available from all medical schemes. The updated guidelines and specification documents are not meant to change the definitions of healthcare utilisation indicators, but rather to strengthen these definitions and improve consistency.

The CMS will continue to work on improving the system and will consult with all stakeholders in this process. The CMS will also investigate the option of having certain sections of the healthcare utilisation data audited in the future. The submission of quality data is very important for monitoring, research projects and ultimately health policy recommendations to the National Department of Health (NDoH).

Gross benefits paid (benefits paid from risk pool plus savings) reported in the utilisation section of this report (pages 128 to 173 and annexures C to K) differ slightly from gross benefits reported in the financial statutory returns section. This is a result of definitional issues and the application of accounting principles.

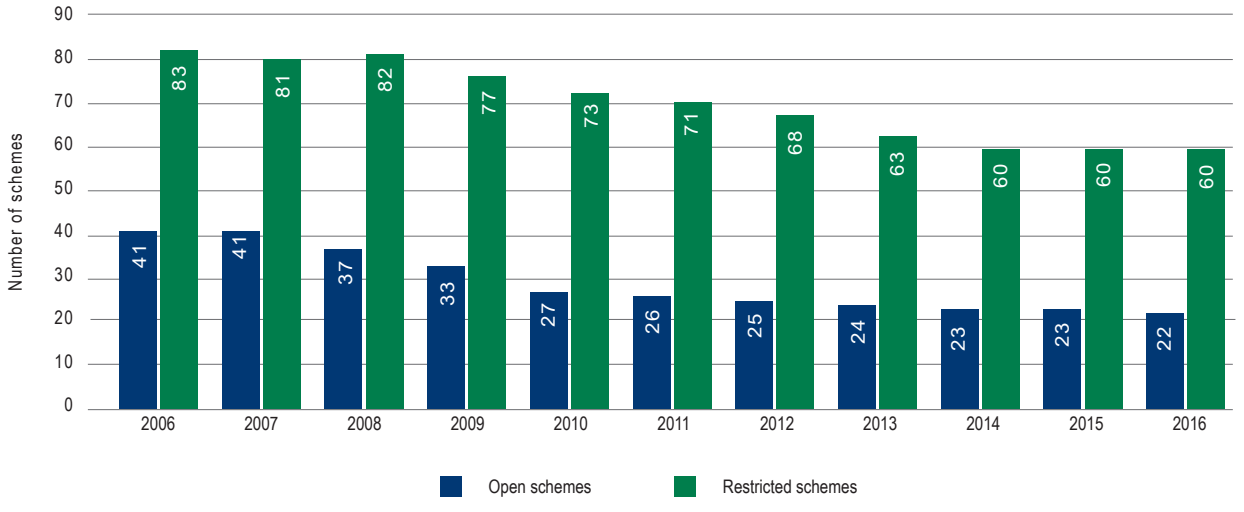
Note that all figures reported in the utilisation section of this report for the financial year 2015 have been revised and as a result may differ with the amounts reported in the previous year's annual report.

Demographic information

Number of schemes and benefit options

The number of medical schemes has decreased due to the amalgamation of LMS Medical Fund and Bonitas Medical Scheme on 1 October 2016. At the end of 2016, there were 82 medical schemes, consisting of 22 open schemes and 60 restricted schemes. The decline in the number of schemes from 2006 to 2016 is illustrated in Figure 1 below.

Figure 1: Number of schemes 2006 – 2016



The classification of schemes by size has remained largely unchanged between 2015 and 2016, as shown in Table 1. Small sized medical schemes are more prevalent in restricted schemes compared to open schemes. High fragmentation of risk pools is a barrier to re-distributional capacity and are likely to increase costs due to administrative duplication. The continued existence of small and fragmented risk pools remains a concern to the Office of the Registrar.

Table 1: Number of schemes by size and type as at 31 December 2016

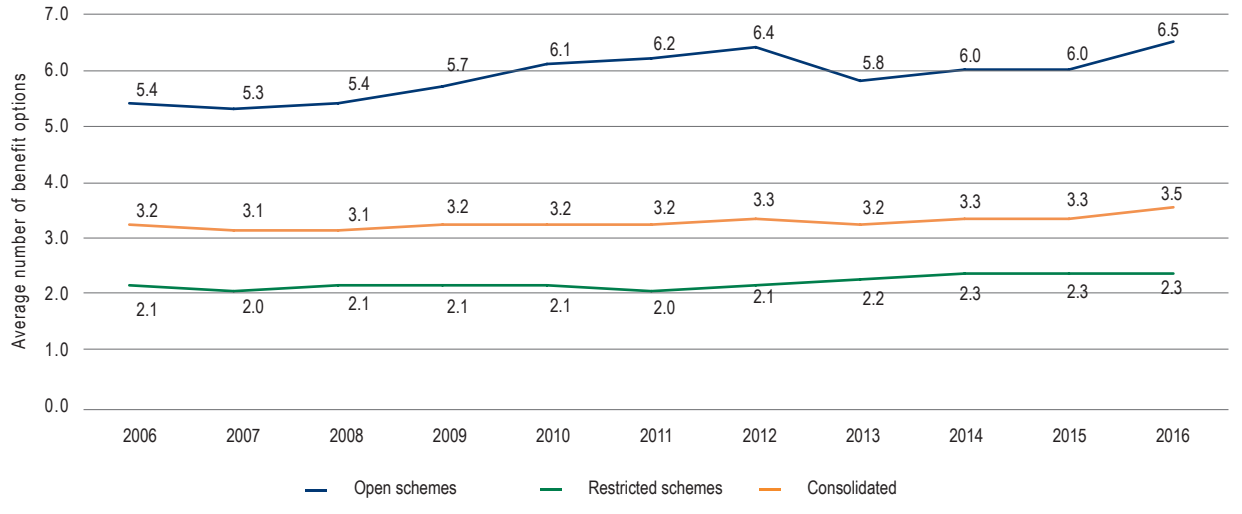
Type of scheme	Size of scheme	2014	2015	2016
Open schemes	Very Large	4	3	3
	Large	7	8	7
	Medium	6	7	7
	Small	6	5	5
Restricted schemes	Very Large	2	2	2
	Large	7	6	6
	Medium	21	23	23
	Small	30	29	29
All schemes	Very Large	6	5	5
	Large	14	14	13
	Medium	27	30	30
	Small	36	34	34
	Total	**83**	**83**	**82**

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

Trend in average number of options

In 2016, open medical schemes had on average 6.5 benefit options per scheme, compared to approximately two benefit options for the restricted schemes. For the industry as a whole, the average number of benefit options was about 3.5. Over time, there has been a slight increase in the average number of benefit options for open schemes. The difference in the average number of benefit options between open and restricted schemes is due to differences in competition dynamics. Open medical schemes generally use benefit design as a mechanisms to achieve any one of the following objectives: i) marketability and competiveness of benefit options; ii) effective risk-pooling and iii) the mechanism through which healthcare benefits are rationed and delivered.

Figure 2: Average number of options 2006 – 2016



Efficiency Discount Options reported at parent option level.

Membership of medical schemes

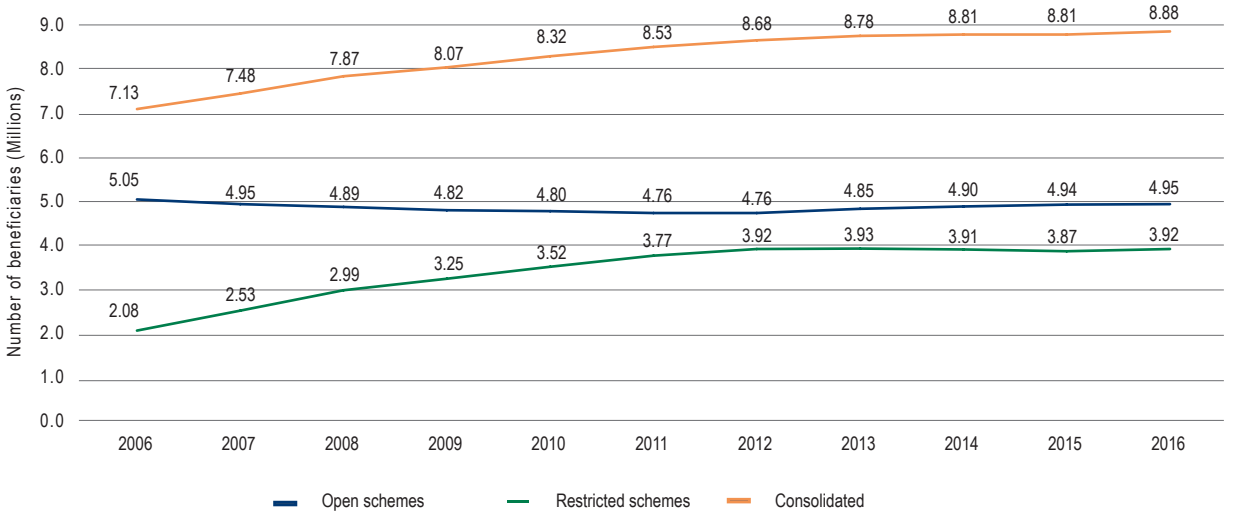
There was a year-on-year increase of 0.78% in the total number of medical scheme beneficiaries, from 8.809 million in December 2015 to 8.879 million in December 2016. The total number of beneficiaries of restricted schemes increased by 1.39% compared to a 0.30% increase in the beneficiaries of open schemes.

Table 2: Membership of schemes 2015 and 2016

Type of scheme	Year	Members	Dependants	Beneficiaries	% change
Open schemes	2015	2 327 137	2 611 316	4 938 453	
	2016	2 347 757	2 605 423	4 953 180	0.30%
Restricted schemes	2015	1 623 790	2 247 280	3 871 070	
	2016	1 644 345	2 280 556	3 924 901	1.39%
All schemes	2015	3 950 927	4 858 596	8 809 523	
	2016	3 992 102	4 885 979	8 878 081	0.78%

Figure 3 depicts the trend in medical scheme coverage for the past 11 years. The number of beneficiaries increased from 8.809 million in 2015 to 8.878 million in 2016. This represents an increase of 0.78%. Beneficiaries belonging to open schemes constituted 55.8% of the total number of beneficiaries at the end of 2016.

Figure 3: Number of beneficiaries 2006 – 2016



Average age, pensioner ratio and gender distribution

Table 3 shows the average age of beneficiaries and the proportion of pensioners (beneficiaries aged 65 years and older) by scheme type and gender. The average age of medical scheme beneficiaries in 2016 was 32.5 years, which is slightly older than the 32.3 reported in 2015. Female beneficiaries were generally older than male beneficiaries. The average age of female medical scheme beneficiaries was 33.4 years in 2016 and that of males was 31.5 years. The pensioner ratio increased slightly to 7.9% for the industry, with pensioner ratios for both male and female beneficiaries rising.

Table 3: Average age of beneficiaries and pensioner ratio 2014, 2015 and 2016

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

Figure 4 shows the age and gender distribution of medical scheme beneficiaries for 2006, 2015 and 2016. A bimodal distribution is evident, for both male and female beneficiaries. Age bands under 1 to 15–19 years featured more male beneficiaries while female beneficiaries outnumbered males in the age groups 20 years and older.

Figure 4: Age and gender distribution of beneficiaries 2006, 2015 and 2016

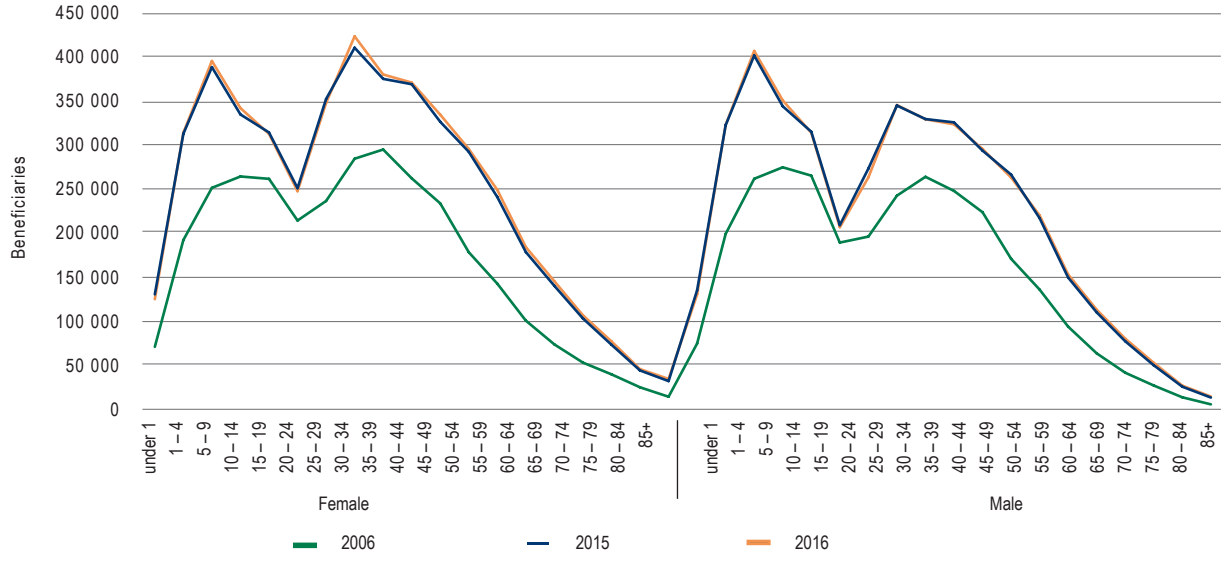
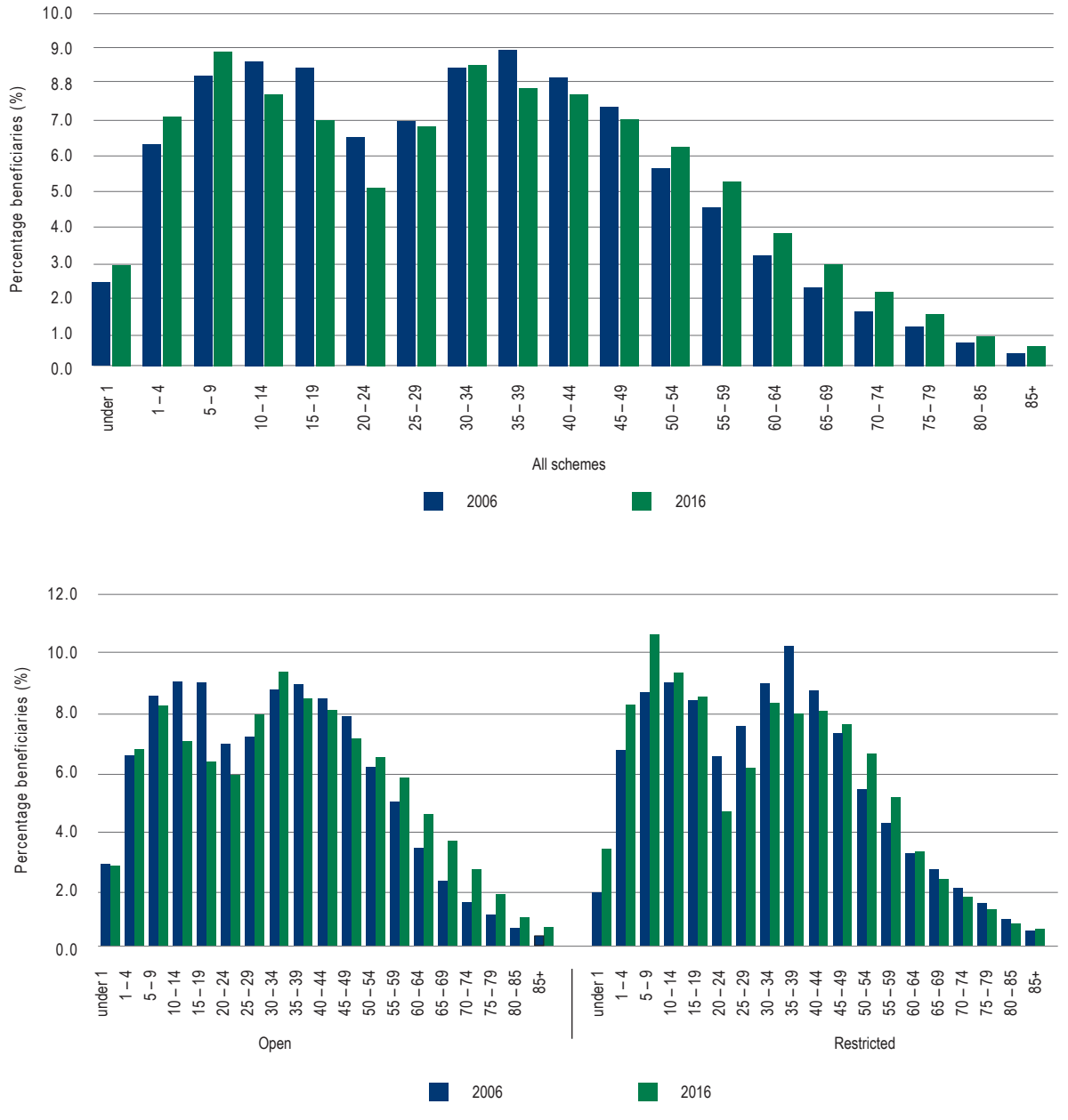


Figure 5 illustrates how the proportion of beneficiaries by age band has changed over time, from 2006 to 2016. There were proportionally more beneficiaries in the ages between 10 and 24 years, as well as between 35 and 49 years, for 2006 compared to 2016. In 2006, there were proportionally less beneficiaries under 9 years of age as well as 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 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 5: Proportion of beneficiaries per age band 2006 vs 2016



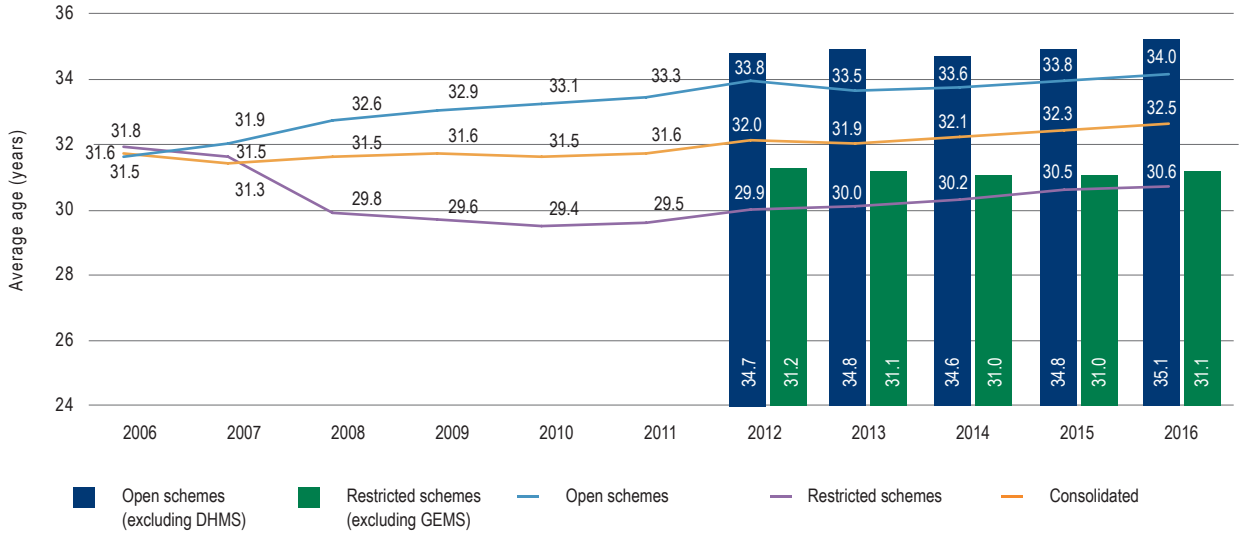
Trend in the average age of beneficiaries

Figure 6 shows the trend in the average age of beneficiaries from 2006 to 2016. Beneficiaries of restricted medical schemes were older than those of open schemes until 2006. This changed in 2007, primarily due to the introduction of GEMS, when the average age of beneficiaries in restricted schemes became lower than that of open schemes. On the other hand open schemes have shown a gradual increase in the average age.

The impact of GEMS and Discovery Health Medical Scheme (DHMS) on restricted and open schemes is also reflected in Figure 6.

Figure 6 further illustrates that the average age of beneficiaries of open schemes in 2016 was 34.0 years (and is 35.1 years if DHMS is excluded) while the average age of beneficiaries of restricted schemes in 2016 was 30.6 years (and is 31.1 years if GEMS is excluded).

Figure 6: Age of beneficiaries 2006 – 2016



Dependant ratio

The dependant ratio measures the average number of dependants per principal member. The dependant ratio for the industry decreased slightly from 1.23 in 2015 to 1.22 in 2016. The dependant ratio changed slightly for open medical scheme from 1.12 to 1.11 and restricted medical schemes from 1.38 to 1.39. See Figure 7 for more detail.

Figure 7: Dependant ratio in schemes 2006 – 2016

Coverage by province

Figure 8 shows the distribution of beneficiaries by province during 2016. This data is collected primarily on the basis of the location of principal members. Approximately 39% of beneficiaries were located in Gauteng. The Western Cape and KwaZulu-Natal accounted collectively for approximately 2.56 million beneficiaries, comprising 29% of the total number. Table 4 and Figure 8 provide further detailed information.

Figure 8: Provincial distribution of beneficiaries 2016

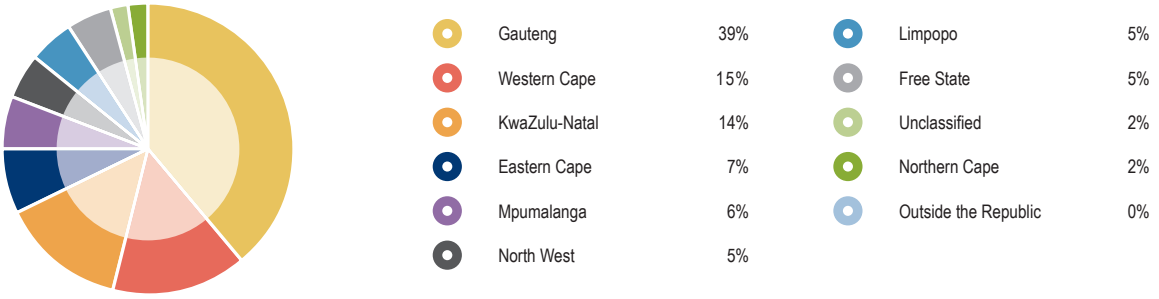


Table 4: Provincial changes in beneficiaries 2015 – 2016

Province	2016	2015	% Growth
Gauteng	3 479 810	3 381 051	2.92%
Western Cape	1 309 134	1 297 359	0.91%
KwaZulu-Natal	1 253 144	1 244 568	0.69%
Eastern Cape	638 434	643 620	-0.81%
Mpumalanga	545 595	559 573	-2.50%
North West	461 237	480 496	-4.01%
Limpopo	412 936	405 353	1.87%
Free State	387 739	385 224	0.65%
Unclassified	207 996	227 824	-8.70%
Northern Cape	179 595	181 608	-1.11%
Outside the Republic	2 461	2 847	-13.56%
All provinces	**8 878 081**	**8 809 523**	**0.78%**

Healthcare benefits

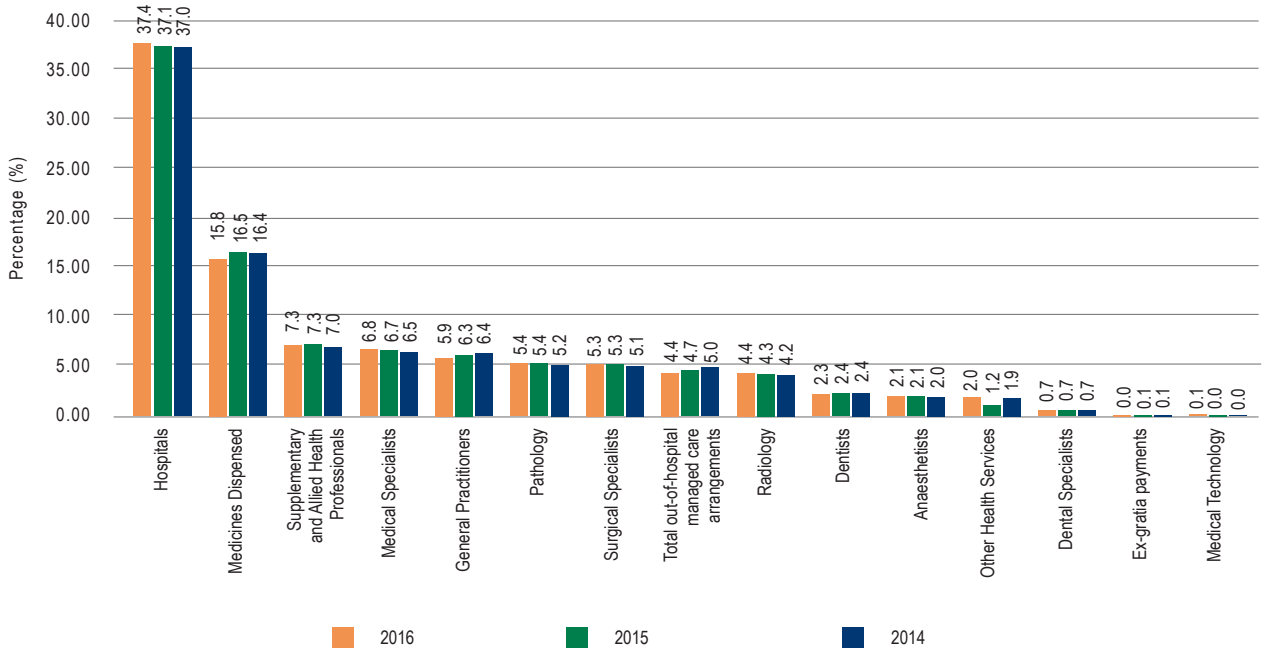
Total healthcare benefits paid

The total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members. Expenditure on healthcare benefits increased (in nominal terms) by 8.87% from R138.89 billion in 2015 to R151.21 billion in 2016.

The average amount spent per beneficiary per annum (pabpa) went up by 8.30% in 2016, from R15 843.35 to R17 157.77.

Figure 9 shows the proportions of benefit expenditure paid by medical schemes to various categories of healthcare providers for the period between 2014 and 2016.

Figure 9: Distribution of healthcare benefits paid 2014, 2015 and 2016



Total hospital expenditure by medical schemes comprised R56.61 billion or 37.44% of the R151.21 billion that medical schemes paid to all healthcare providers in 2016.

Total medical scheme expenditure on private hospitals increased by 9.80% to R56.32 billion in 2016 from R51.29 billion in 2015. Inpatient admissions constituted about 87.75% of the R56.32 billion paid to private hospitals in 2016 (same-day inpatient admissions constituted 12.25%). The average amount pabpa paid to private hospitals increased by 9.22%, from R5 850.85 in 2015 to R6 390.53 in 2016.

Medicines (and consumables) dispensed by pharmacists and providers other than hospitals, amounted to R23.95 billion or 15.84% of total healthcare benefits paid. This represents an increase of 4.65% compared to the R22.89 billion spent in 2015.

The amount paid to supplementary and allied health professionals in 2016 increased by 8.01%, from R10.15 billion in 2015 to R10.97 billion in 2016. This category accounted for 7.25% of all benefits paid by schemes in 2016.

Expenditure on general practitioners (GPs) amounted to R8.96 billion or 5.93% of healthcare benefits paid, representing an increase of 3.25% on the 2015 figure of R8.68 billion. Only 9.92% of the R8.96 billion paid to general practitioners in 2016 was paid to general practitioners operating in hospitals.

Payments to all specialists (anaesthetists, medical specialists, pathology services, radiology services and surgical specialists) amounted to R36.32 billion or 24.02% of total healthcare benefits paid in 2016. This amount increased by 9.92% from R33.04 billion paid in 2015.

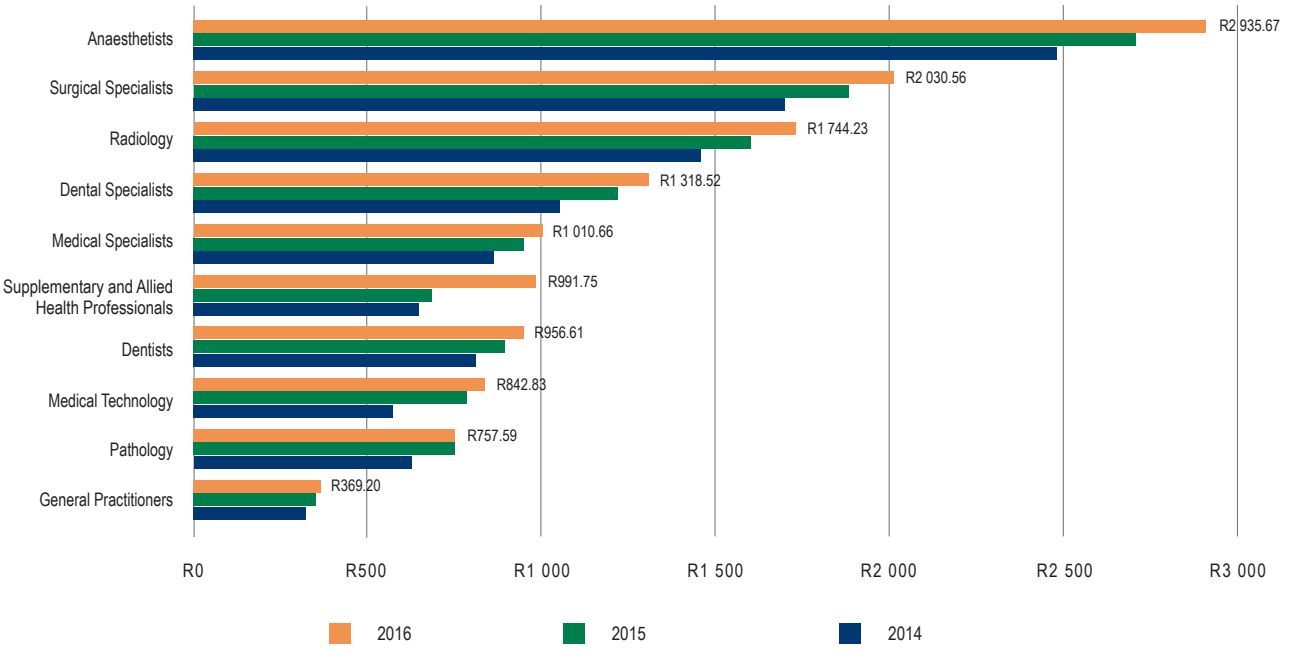
Payments to medical specialists amounted to R10.24 billion or 6.78% of total healthcare benefits paid in 2016. About 51.33% of the R10.16 billion paid to medical specialists in 2016 was paid to medical specialists operating in hospitals. Expenditure on pathology amounted to R8.16 billion or 5.40% of healthcare benefits paid. Expenditure on surgical specialists and radiology services amounted to R8.04 billion and R6.69 billion respectively.

Figure 10 shows benefits paid to different disciplines per event (visit). Total benefits paid per event is calculated as total benefits paid (from risk + savings) divided by the number of visits to a provider. Notice that the cost (or benefits paid) per event must be interpreted with caution as the calculation does not take into account other factors such as the number of hours spent per event.

In 2016, benefits paid to anaesthetists averaged at R2 935.67 per event (visit). This represented an increase of 7.47% from the 2015 figure of R2 731.53 and was the highest average paid per event in the industry, but in total, anaesthetists consumed less than 3% of all benefits paid. The amount paid to surgical specialists was R2 030.56 per event.

General practitioners (GPs) were paid the lowest amount at an average of R369.20 per event. This represented an increase of 4.42% from the 2015 figure of R353.56. The average amount paid to GPs per event in 2016 for in-hospital consultations was R861.45. This is more than twice the average amount paid for out-of-hospital consultations, the average being R328.00.

Figure 10: Total benefits paid per event (visit) 2016



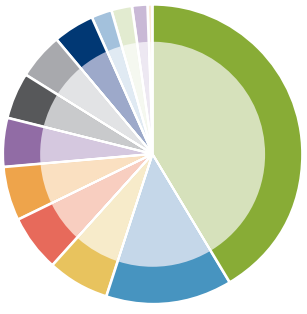
Healthcare benefits paid from risk pool

A detailed breakdown of how medical schemes used their risk pools to cover healthcare benefits is provided in Figure 11.

Healthcare benefits that medical schemes covered from their risk pools, amounted to R135.98 billion in 2016 compared to R124.54 billion in 2015, which is an increase of 9.18%. The average risk amount pabpa increased by 8.87% to R15 429.36 in 2016 compared to R14 172.56 in 2015.

Hospital expenditure accounted for 41.46% of risk benefits paid in 2016. Expenditure on medicines dispensed accounted for 13.52% of total risk pool benefits. Medical specialists consumed 6.86% of the pie, while risk pool expenditure on GPs was R6.81 billion or 5.01% of total risk pool benefits.

Figure 11: Distribution of healthcare benefits paid from risk pool 2016



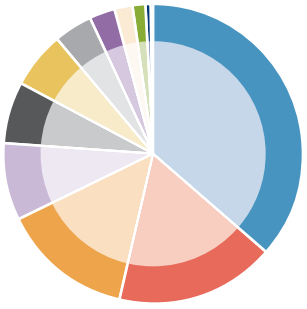
Hospitals	41.46%	Radiology	4.45%
Medicines dispensed	13.52%	Anaesthetists	2.32%
Medical specialists	6.86%	Other Health Services	2.18%
Supplementary and allied health professionals	6.14%	Dentists	1.62%
Surgical specialists	5.61%	Dental specialists	0.51%
Pathology	5.27%	Medical technology	0.06%
General Practitioners	5.01%	Ex-gratia payments	0.05%
Out-of-hospital managed care arrangements	4.94%		

Healthcare benefits paid from savings

Of total healthcare benefits paid, medical schemes paid R15.23 billion (10.07%) from beneficiaries' personal medical savings accounts in 2016. Figure 12 shows that medicines absorbed the largest share of savings accounts expenditure in 2016 (36.57%). Supplementary and allied health professionals took up 17.21% of healthcare benefits paid from savings accounts.

General practitioners accounted for 14.11% and dentists for 8.39%, while pathology services absorbed 6.61% and medical specialists took 6.05% of healthcare benefits paid from savings accounts.

Figure 12: Distribution of healthcare benefits paid from savings 2016



Medicines Dispensed	36.57%	Surgical Specialists	2.7%
Supplementary And Allied Health Professionals	17.21%	Dental Specialists	1.98%
General Practitioners	14.11%	Hospitals	1.52%
Dentists	8.39%	Other Health Services	0.48%
Pathology	6.61%	Anaesthetists	0.13%
Medical Specialists	6.05%	Medical Technology	0.07%
Radiology	4.18%		

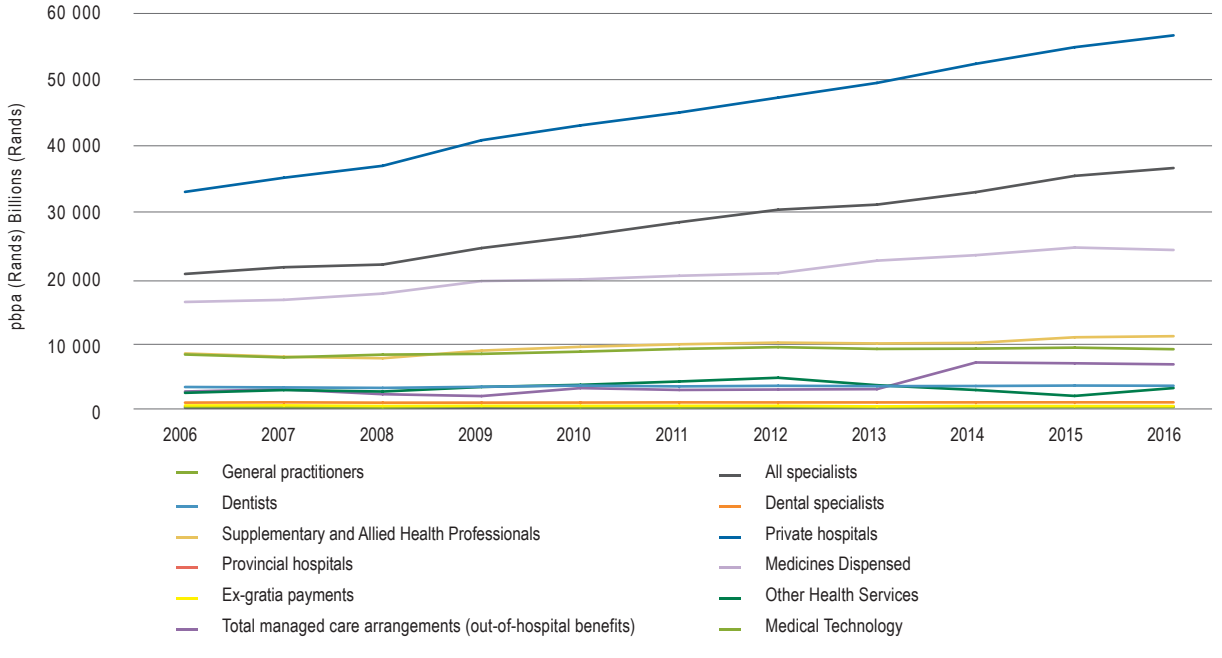
Trends in total healthcare benefits paid

Figure 13 shows trends in the distribution of healthcare benefits that medical schemes have paid to various categories of service providers since 2006. These figures have been adjusted for inflation, with 2016 used as the base year.

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.

Historical values are revised when the base period changes and will not correspond to the values reported in the 2015 annual report. The figures are reported in real (or constant) terms, implying that the historical data has been adjusted to 2016 prices, using the Consumer Price Index (CPI).

Figure 13: Total healthcare benefits paid 2006 – 2016 (2016 prices)



In 2016, medical schemes' expenditure on private hospitals increased in real terms by 9.80%, which amounts to a total of R56.32 billion. In 2015, it totalled R51.29 billion. The sustained increase in expenditure on private hospitals, rising from R30.5 billion in 2006 to R56.32 billion in 2016, is illustrated in Figure 13.

The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists. Benefits paid to specialists in 2016 amounted to R36.32 billion in real terms, an increase of 9.92% in real terms when compared to the R33.04 billion spent on this item in 2015.

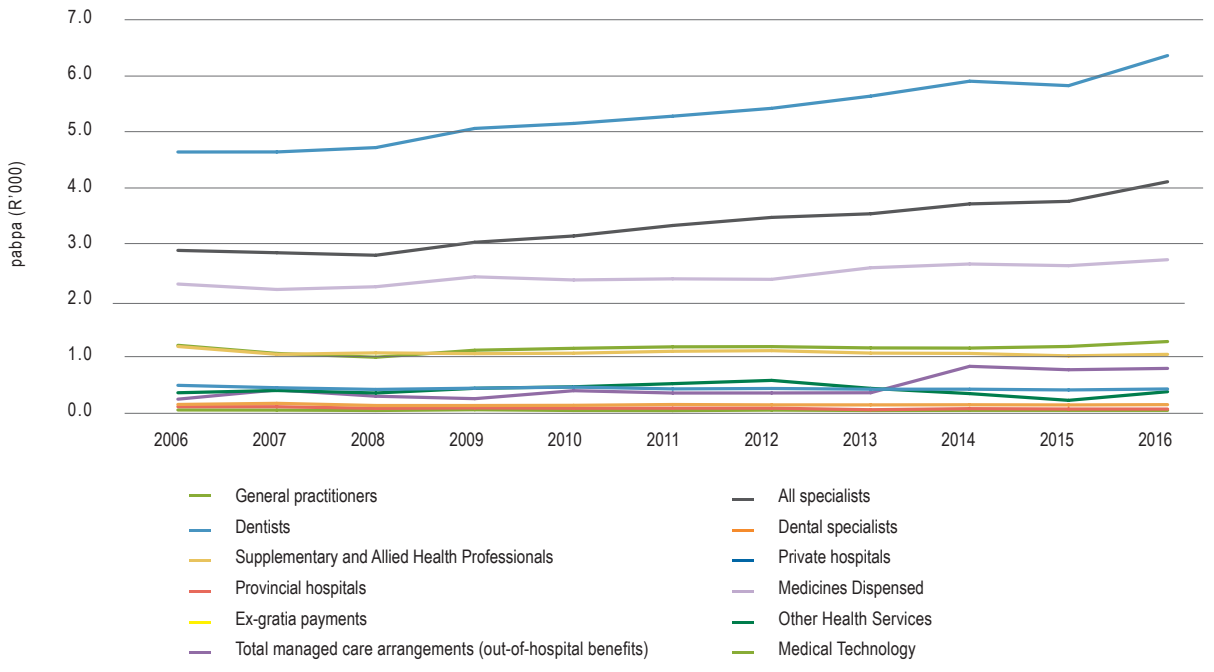
It should be noted that the annual growth in membership must be taken into account when considering changes in the total expenditure of medical schemes.

Healthcare benefits paid per beneficiary

Figure 14 shows the changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2006 to 2016 in real terms (at 2016 prices). The amount paid in real terms on private hospitals increased by 9.22%, from R5 850.85 pabpa in 2015 to R6 390.53 pabpa in 2016.

The amount spent on specialists increased in real terms from R3 769.11 pabpa in 2015 to R4 121.31 pabpa in 2016, an annual increase of 9.34%. There was an increase of 4.10% in real terms for the benefits paid medicines dispensed.

Figure 14: Total healthcare benefits paid pabpa 2006 – 2016 (2016 prices*)



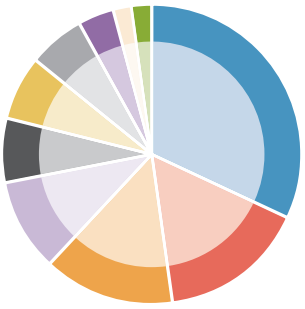
Out of pocket payments

The total 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 OOP as medical scheme beneficiaries don't always submit a claim for healthcare services when they run out of benefits. OOP expenditure cannot be recorded when no claims are submitted.

In 2015, the level of OOP was at least 18.6% of total healthcare expenditure among medical scheme beneficiaries. This amounted to approximately R27.2 billion in nominal terms. In nominal terms, OOP grew by 13.4% to R29.7 billion in 2016 compared to 2015. This represents 18.6% of total healthcare expenditure for beneficiaries.

The bulk of OOP was for out-of-hospital medicine claims, which constituted 32% of all OOP expenditure in 2016. The next highest expenditure was for Supplementary and Allied Health Professionals, which amounted to 16% of total OOP expenditure. A similar trend was observed in the previous financial year.

Figure 15: Out of Pocket Payments (OOPs) for 2016



Medicines	32%		Radiology	4%
Supplementary And Allied Health Professionals	16%		Dental Specialists	2%
Specialists	14%		Anaesthetists	2%
General Practitioners	10%		Other	0%
Dentists	7%		Medical Technology	0%
Hospitals	7%			
Pathology	6%			

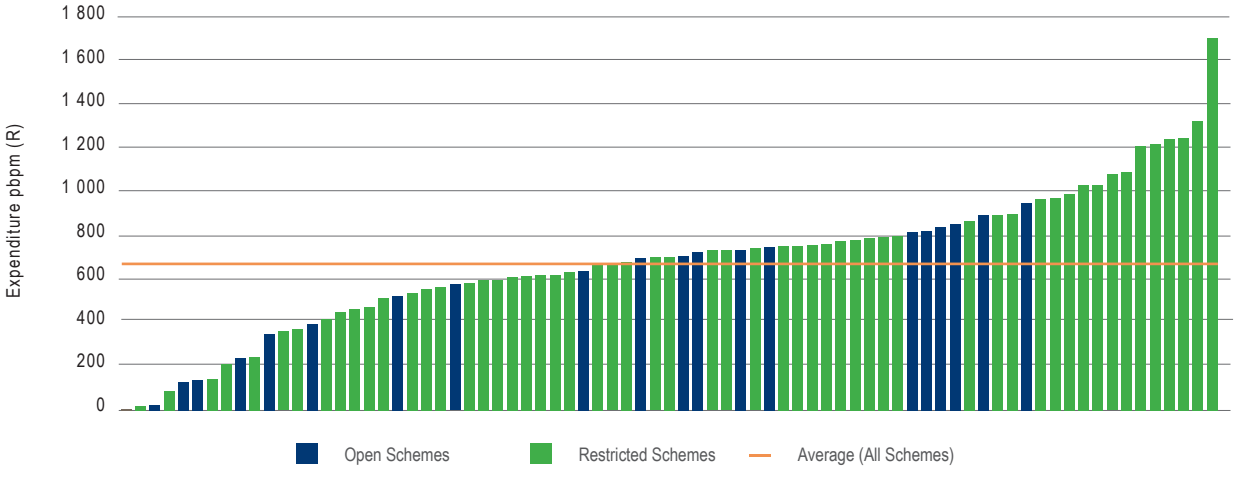
Prescribed Minimum Benefits (PMBs)

The total expenditure on prescribed minimum benefits (PMBs) by medical schemes amounted to R73.1 billion in 2016. The total risk benefits paid in 2016 was R136 billion. Therefore, the PMBs constituted 54% of total risk benefits paid. In 2015, PMBs constituted 51% of total risk benefits paid.

The expenditure on PMBs for 2016 was R680 per beneficiary per month (pbpm), representing a 7.6% increase from the recalculated figure of R632 for the 2015 financial year.

The expenditure on PMBs varies from scheme to scheme and the differences can be seen in Figure 16. 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 non-compliance in terms of either payment of PMBs or improper reporting on the level of PMBs.

Figure 16: PMB expenditure by scheme for 2016



Ten (10) schemes reported PMB expenditure below R250 pbpm – equally split between open and restricted schemes. The open schemes seem to have lower costs of PMBs on average.

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:

- Beneficiary profile, which speaks to the level of cross subsidisation between the young and the old; the sick and the healthy.
- Prevalence of chronic conditions and disease burden
- Expenditure on treatment, which is strongly linked to contracting between schemes and providers

Figure 17: PMB expenditure and change in beneficiaries by age band

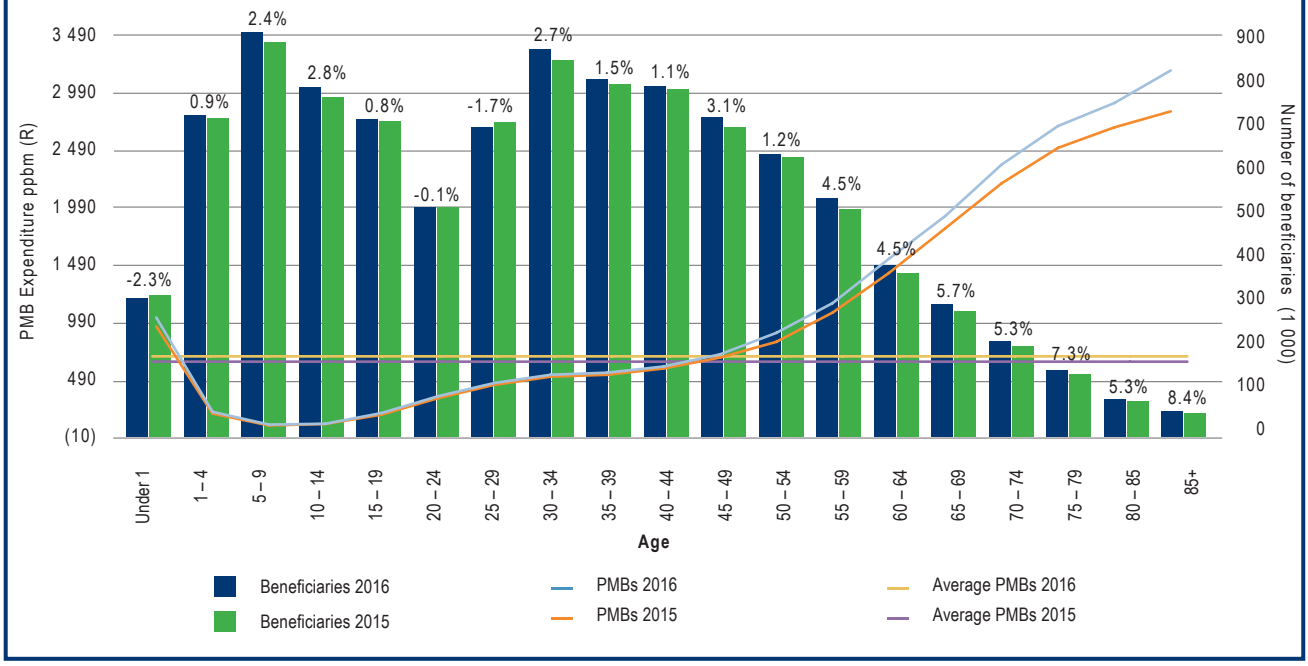
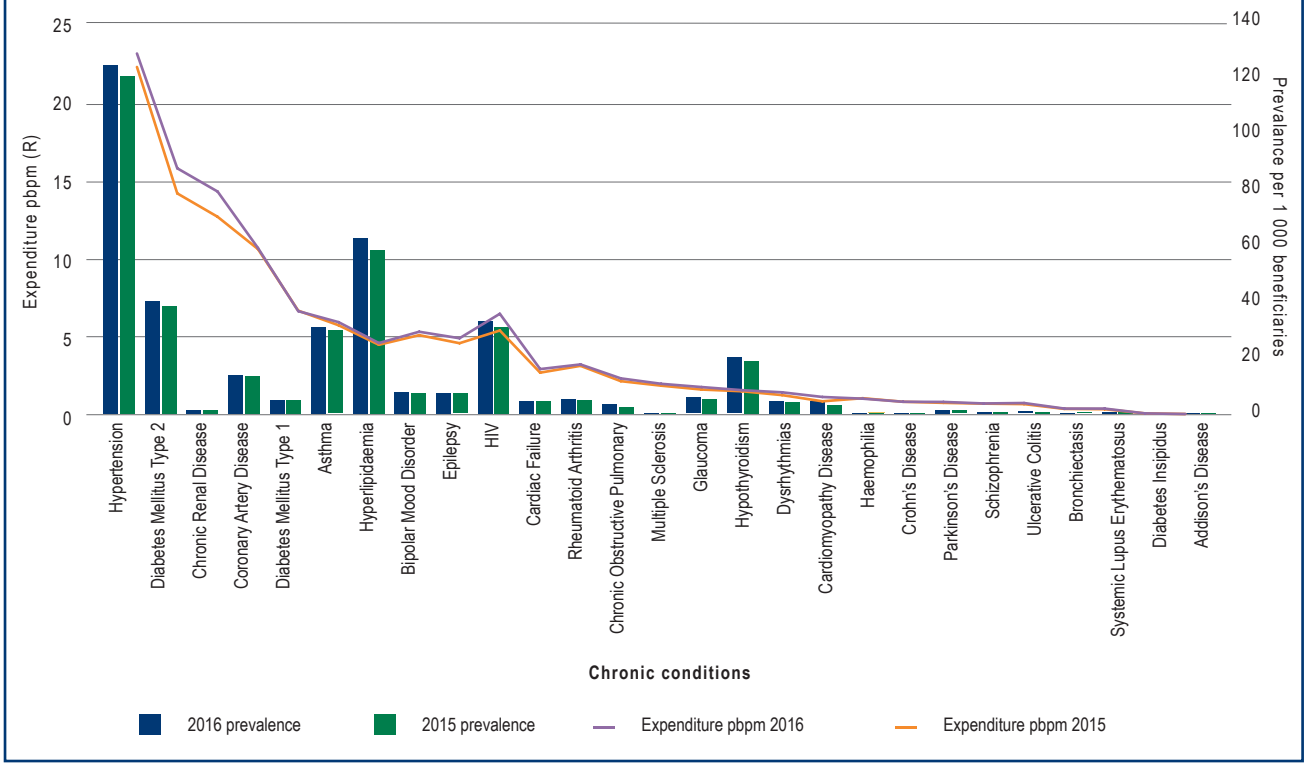


Figure 17 depicts the relationship between medical schemes' expenditure on PMBs, the beneficiary profile and the change in beneficiary age profile. The expenditure on PMBs generally increases with age. In ages above 45, the expenditure on PMBs is higher than the industry average of R680 pbpm. The PMB expenditure for beneficiaries aged one year or less is significantly more than the industry average. The ages from one to 44 years have PMB expenditure below the industry average. To maintain a reasonable PMB expenditure increases 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 R680 pbpm (beneficiaries aged one year or less, and those older than 45). As shown by figure 17, this has not been the case. There is negative growth in age ranges 20 to 29 years, while growth rates are relatively low in the age ranges 1 to 19 years.

The graphs of PMB expenditure for 2015 vs 2016 by age band, reflect almost no increases in expenditure in the ages under 44 years. However, from age 45, there is an increase in costs from 2015 to 2016. This age range experiences the greatest growth in membership, yet it experiences the greatest increase in PMB expenditure as well. From age 65 onwards, the growth in membership is in excess of 5%.

Figure 18 shows the medical schemes expenditure and prevalence of the Chronic Conditions List (CDL) conditions. Generally, the more prevalent a condition is, the more medical schemes would spend on it pbpm.

Figure 18: Expenditure and prevalence of chronic conditions



Hypertension remains the most prevalent CDL condition among medical scheme beneficiaries. In 2016, the prevalence of hypertension was 134,21 per 1 000 beneficiaries compared to 130,05 per 1 000 beneficiaries in 2015. This CDL is the most expensive on a per-beneficiary-per-month basis. In 2016, medical schemes spent R23,27 pbpm up from R22,42 pbpm in 2015.

Cardiovascular diseases recorded significant increases in prevalence. The prevalence of cardiomyopathy increased by 33%, chronic renal disease by 13% and Diabetes Mellitus Type 2 increased by 12%.

Figure 19: Expenditure on chronic conditions in 2015 and 2016

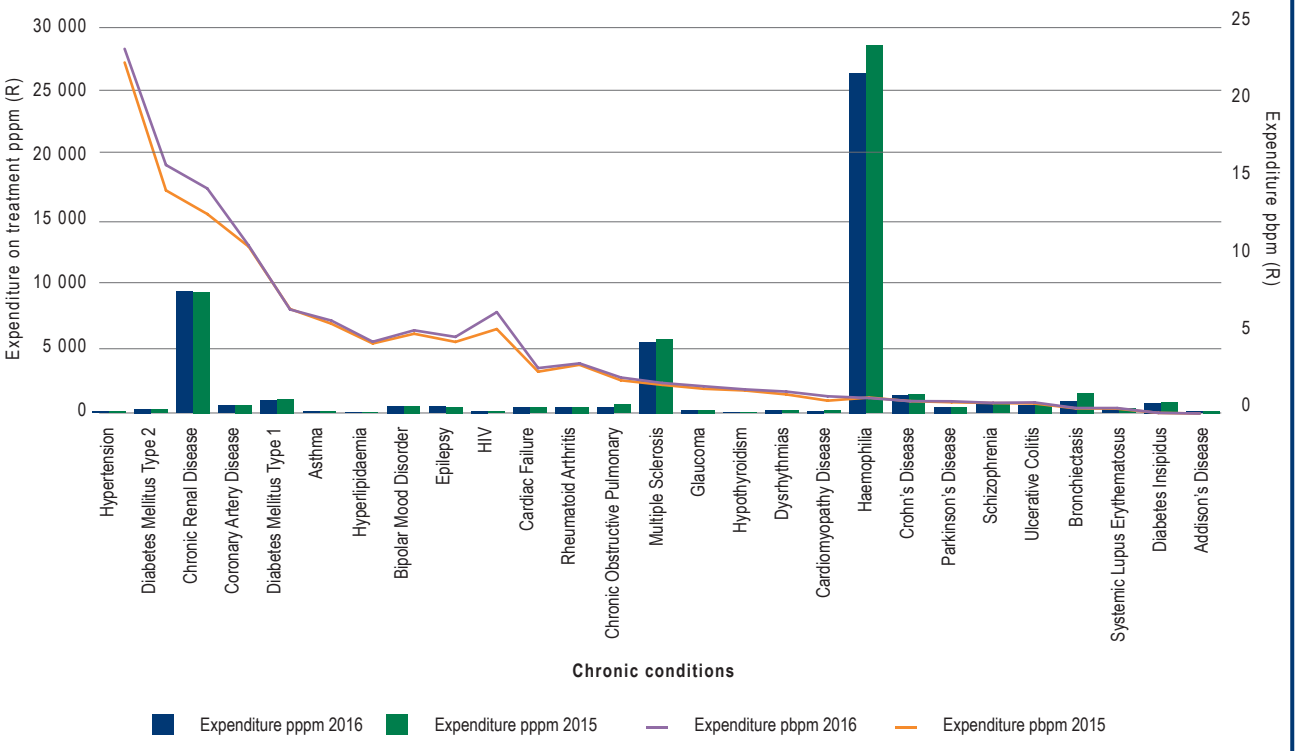


Figure 19 shows the prevalence of CDL conditions and medical schemes expenditure on CDLs per patient per month (pppm).

The average expenditure on each CDL per patient registered on each scheme's chronic program is monitored from year to year. Haemophilia had the highest expenditure per patient registered, compared to other CDLs. In 2016, schemes spent R26 479 pppm compared to R28 393 pppm in 2015.

Chronic renal disease and multiple sclerosis had significantly higher expenditure on a per-patient-per-month basis compared to the remaining CDLs.

The pppm expenditure is much lower than the Scheme Risk Management estimated cost per patient for most of the CDLs. This may be due to either under-reporting of the 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 20: Top 10 Disease Treatment Pairs (DTPs) by expenditure pbpm

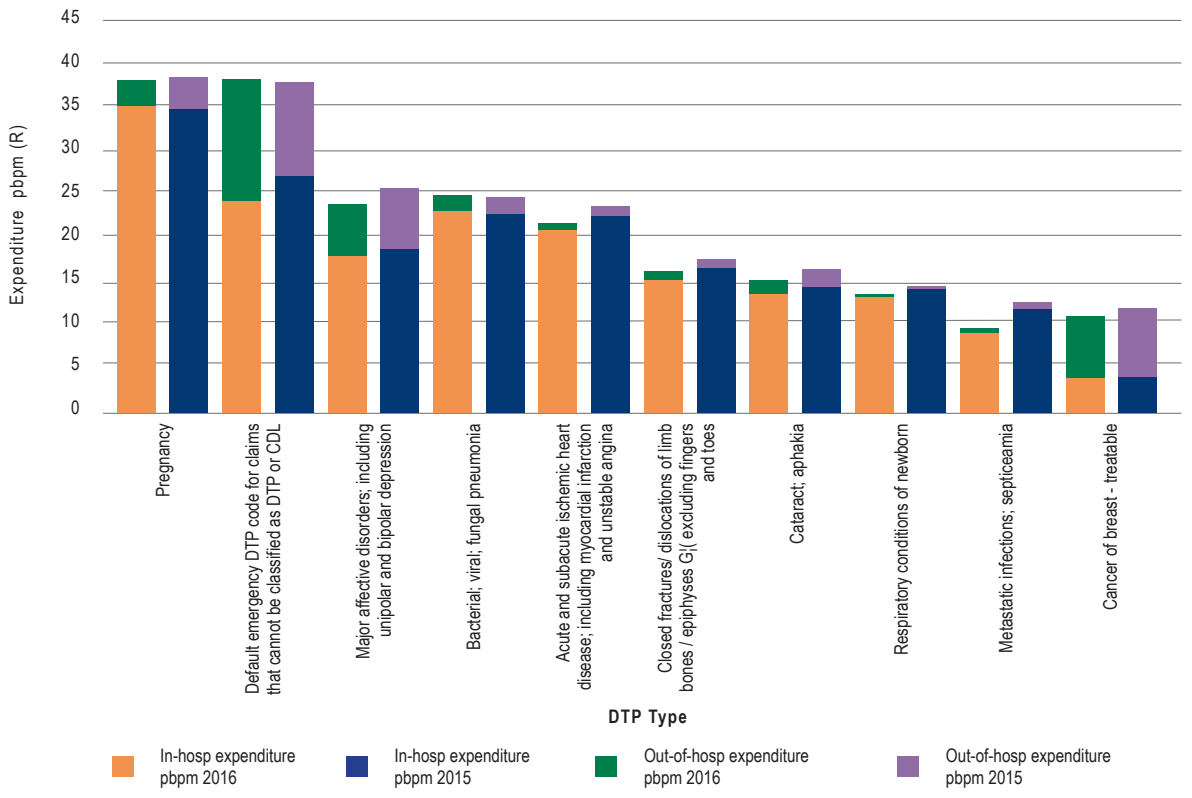


Figure 20 depicts the medical schemes' expenditure on Disease Treatment Pairs (DTPs) conditions for 2016 and 2015. Most of the DTP expenditure is in hospital.

Pregnancy was the most expensive DTP in 2016, with schemes spending R38 pbpm. The composition of the top 10 DTP conditions has not changed significantly since 2015.

Default emergency conditions and treatable breast cancer had the highest expenditure outside hospital, amounting to R10.74 and R7.86 pbpm respectively.

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

DTP Diagnosis	Total expenditure on DTP conditions (R billion)
Pregnancy	4 123
Default emergency DTP code for claims that cannot be classified as DTP or CDL	4 058
Major affective disorders; including unipolar and bipolar depression	2 759
Bacterial; viral; fungal pneumonia	2 658
Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina	2 538
Closed fractures / dislocations of limb bones / epiphyses (excluding fingers and toes)	1 885
Cataract; aphakia	1 763
Respiratory conditions of newborn	1 553
Metastatic infections; septicaemia	1 359
Cancer of breast – treatable	1 282
Total Cost	**23 980**

The top 10 DTP conditions cost R20.6 billion in 2015 compared to R23.9 billion in 2016.

Quality of care

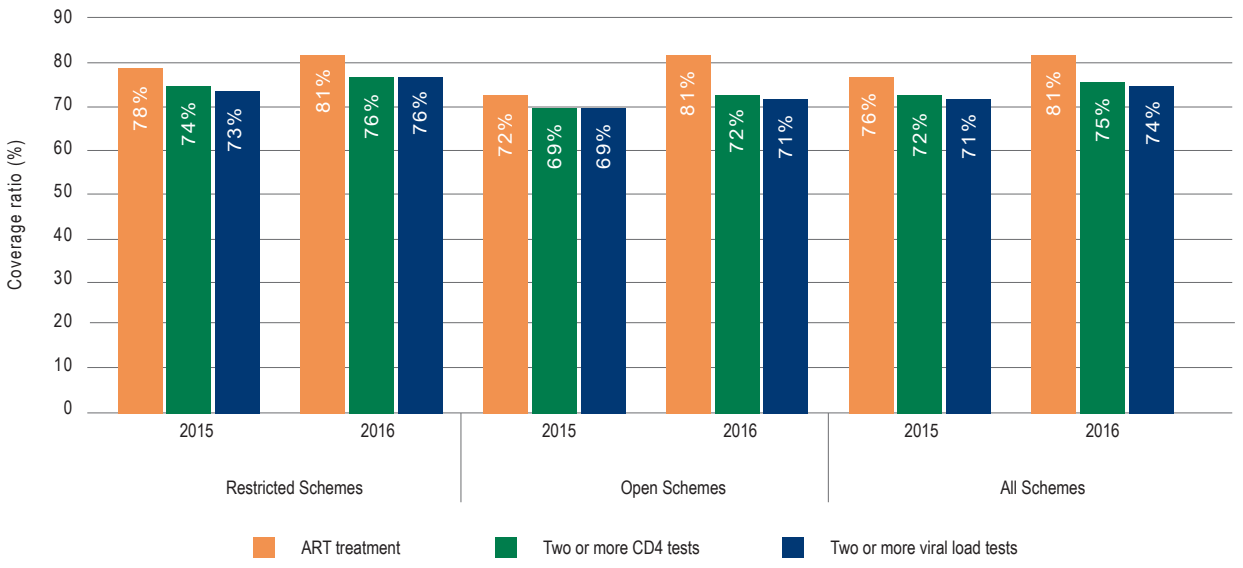
The CMS embarked on an industry-wide, ongoing consultative process to establish the best standard of care that is clinically appropriate and cost effective in medical schemes. The process identified appropriate process indicators and outcome indicators for the management of CDL conditions. So far, 14 of the CDL conditions have gone through the 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 K by scheme and benefit option.

HIV is the best managed CDL condition with coverage ratios as high as 75%. The coverage ratios are disappointing for other chronic conditions. There is also wide variation of coverage ratios, if one compares benefit options and ultimately the managed care organisations. The 2015 figures have been restated.

The CMS is to publish a separate comprehensive on the coverage ratios for each of the 14 CDL conditions. The outcome indicators will be included in this report.

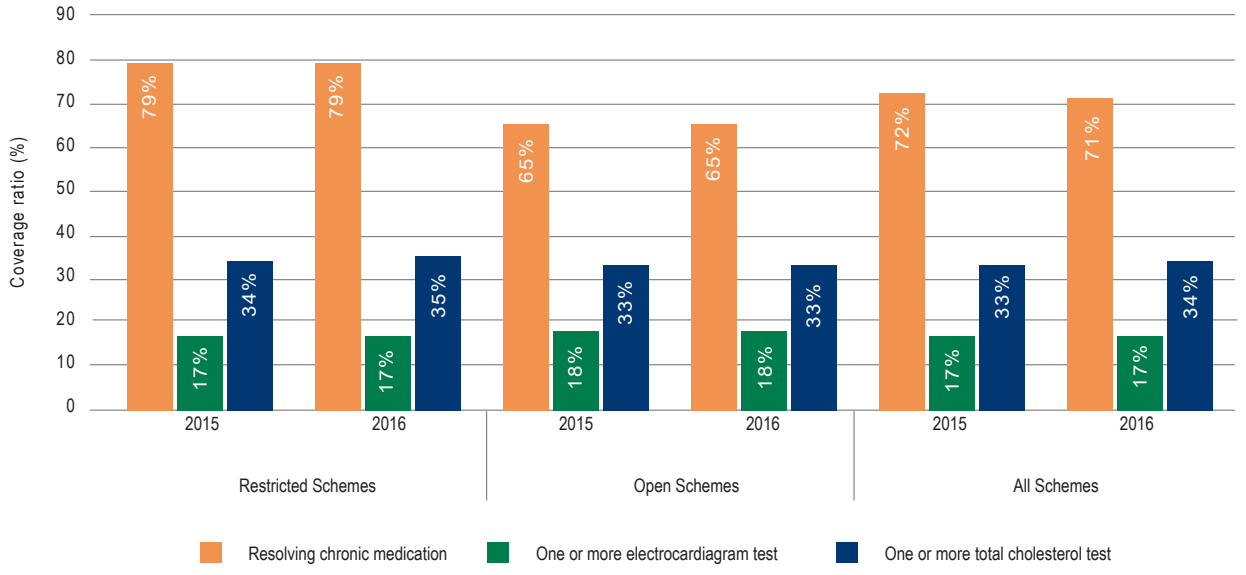
Figure 21: HIV coverage ratios



The proportion of beneficiaries receiving antiretroviral therapy (ART) is 81% in 2016, which is up from 76% in 2015. The coverage of HIV monitoring tests has also increased, with increases from about 71% in 2015 to 74% in 2016 and 72% in 2015 to 75% in 2016 for viral load tests and the CD4 counts respectively.

Restricted schemes had higher coverage of the CD4 tests and the viral load tests, about 76% for both tests in 2016 compared to 72% for the CD4 test and 71% for viral load test on open scheme beneficiaries.

Figure 22: Hypertension coverage ratios

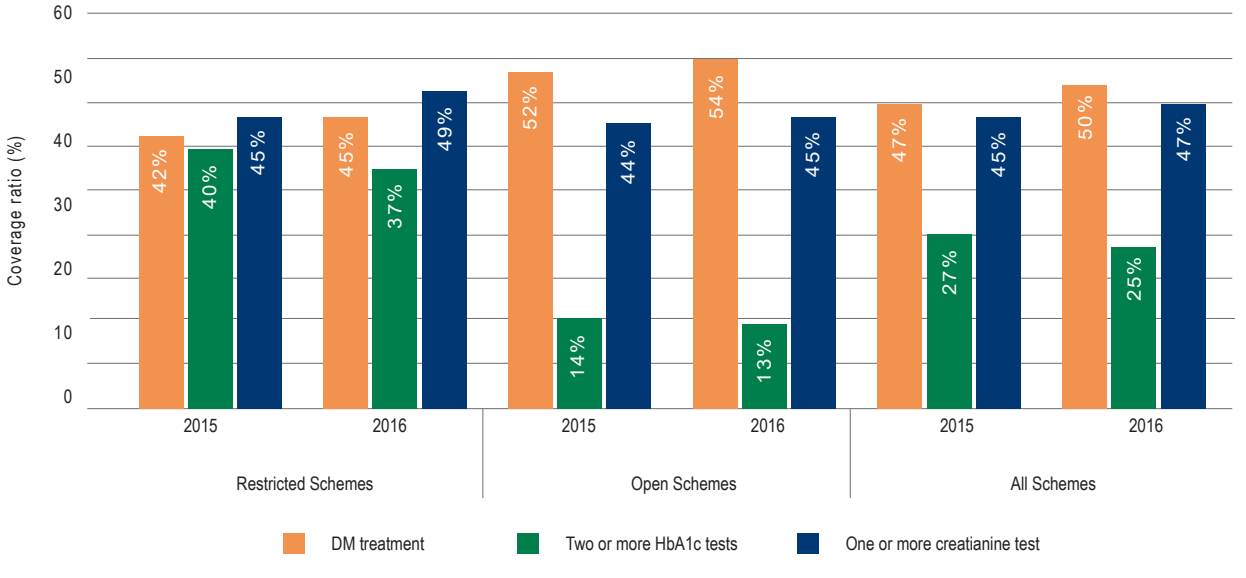


Hypertension is the most prevalent chronic condition across medical scheme beneficiaries. The coverage ratios of hypertension are very low. About 71% of hypertensive patients receive hypertension treatment. The coverage ratios of monitoring tests to help with patient management. The coverage for the electrocardiogram test was unchanged at 17.0% for 2015 and 2016. The coverage of the total cholesterol test was higher – 33% in 2015, increasing marginally to 34% in 2016.

The coverage ratios of hypertension monitoring tests was similar between open and restricted schemes, though a greater number of hypertensive beneficiaries were on treatment on the restricted schemes.

Considering this data alone, it appears the registration of hypertensive patients on the CDL management program is presently aimed at giving patients access to drugs rather than at managing the condition.

Figure 23: Diabetes Mellitus Type 2 coverage ratios



Diabetes Mellitus is becoming more prevalent. The coverage ratios in Figure 23 are for Diabetes Mellitus Type 2. The coverage ratios are low, with monitoring tests such as the creatinine test being 47% in 2015 while the HbA1c test was 25%. Restricted schemes had considerable higher coverage for the HbA1c test, 37% compared to open schemes which had only 13%.

The proportion of DM2 patients receiving DM2 treatment was 50% in 2016, increasing by 3% when compared to 2015.

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 secondary care that the patient may need. This is not always the case in the South African medical scheme environment. Patients are free to enter the healthcare system at any point in the system.

Table 6 and Table 7 show patterns in the out-of-hospital utilisation of primary healthcare providers by type of scheme.

The number of medical schemes beneficiaries visiting general practitioners (GPs) at least once a year was 737.25 and 730.96 per 1 000 beneficiaries for 2015 and 2016 respectively. The overall rate of general practitioner consultations has shown a slight reduction of 6.29 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 2016 and 2015 financial years when compared to open schemes.

Visits to general dental practitioners showed a slight decrease between 2015 and 2016, at 214.88 and 212.46 per 1 000 beneficiaries respectively. More beneficiaries in restricted schemes (237.82 per 1 000) had at least one dentist consultation in 2016 compared to those in open schemes (192.33 per 1 000). Similar trends were observed during 2015.

Visits to registered nurses increased from a revised 12.59 per 1 000 beneficiaries in 2015 to 17.96 per 1 000 beneficiaries in the 2016 financial year. The number of consultations with a nurse was higher in restricted schemes than in open schemes, during the period under review.

The frequency of average GP visits per patient increased from 3.59 in 2015 to 3.75 in 2016, while visits to dentists remained largely unchanged at about 1.94 visits per patient. On the other hand, nurse visits per patient showed a minor reduction from 2.53 to 2.17 per patient, during the period under review.

A visit in this report is defined as an actual valid beneficiary consultation with a service provider or an event leading to a submission of a valid claim.

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.

Table 6: Utilisation of primary healthcare services in 2015 and 2016

	2016			2015*		
Discipline	Open	Restricted	All	Open	Restricted	All
Provider utilisation per 1 000 beneficiaries						
General medical practice	689.58	783.11	730.96	681.43	807.87	737.25
General dental practice	192.33	237.82	212.46	193.4	242.06	214.88
Registered nurses	15.58	20.97	17.96	11.97	13.37	12.59
Provider utilisation per patient						
General medical practice	3.46	3.75	3.6	3.44	3.75	3.59
General dental practice	1.97	1.89	1.93	1.96	1.91	1.94
Registered nurses	2.1	2.23	2.17	2.31	2.79	2.53
Average amount paid to provider per visit (Risk benefit)						
General medical practice	R204.49	R307.22	R255.31	R186.42	R298.78	R243.21
General dental practice	R356.82	R859.27	R601.07	R351.29	R785.25	R564.23
Registered nurses	R239.11	R310.09	R276.82	R237.01	R337.91	R289.14
Average amount paid to provider per visit (MSA)						
General medical practice	R140.42	R43.92	R92.68	R142.14	R42.08	R91.57
General dental practice	R615.53	R72.35	R351.48	R584.84	R73.65	R334.01
Registered nurses	R137.26	R18.44	R74.13	R139.66	R19.31	R77.49
Average amount paid to provider per visit (Total)						
General medical practice	R351.14	R348.00	R328.56	R340.87	R334.78	R351.14
General dental practice	R931.62	R952.55	R936.13	R858.90	R898.24	R931.62
Registered nurses	R328.53	R350.95	R376.68	R357.22	R366.62	R328.53

* *The 2015 figures have been restated.*

Table 7 demonstrates the statistical distribution of the number of beneficiaries utilising healthcare services and amounts paid to primary health providers in 2016. The large variation in the utilisation statistics is indicative of varying levels of benefit depth between medical schemes and benefit options. This is largely a function of benefit design, demographic profile of risk pools and the associated burden of disease.

The amount paid for a small number of events or visits is likely to be influenced by reversals or claim rejection in the year subsequent to the date of event or visit. Therefore, the minimum amounts paid are likely not to be the actual amounts paid by the scheme, per visit.

Table 7: Statistical distribution of the number of beneficiaries, visits and amounts paid to primary health providers 2016

Discipline	Indicator	Minimum	25th percentile	50th percentile	75th percentile	Maximum
General medical practice						
	Utilisation per 1 000 beneficiaries	0	549.01	742.67	823.74	954.85
	Utilisation per patient	1.89	3.03	3.49	4.13	30.91
	Risk amount paid per visit	R0.00	R174.23	R288.77	R346.91	R967.00
	MSA amount paid per visit	R0.00	R0.00	R30.11	R171.42	R344.55
	Total amount paid per visit	R0.00	R332.04	R348.57	R375.72	R967.00
General dental practice						
	Utilisation per 1 000 beneficiaries	0	147.38	236.55	309.98	481.3
	Utilisation per patient	1	1.7	1.91	2.06	29.31
	Risk amount paid per visit	R0.00	R278.48	R754.00	R945.69	R1 486.97
	MSA amount paid per visit	R0.00	R0.00	R18.51	R413.51	R803.69
	Total amount paid per visit	R0.00	R788.83	R895.35	R1 058.83	R1 486.97
Registered nurses						
	Utilisation per 1 000 beneficiaries	0	4.45	9.15	15.71	82.08
	Utilisation per patient	1.21	2.07	2.72	4.32	11.33
	Risk amount paid per visit	R0.00	R217.47	R285.45	R349.54	R1 515.39
	MSA amount paid per visit	R0.00	R0.00	R3.43	R83.99	R334.79
	Total amount paid per visit	R0.00	R268.75	R316.65	R430.84	R1 515.39

Utilisation of specialist healthcare services

Table 8 depicts the utilisation and average cost of specialist healthcare services by scheme type for 2016 and 2015 financial years, in- and out-of-hospital combined. Medical specialists are used more frequently than all the other specialities. The utilisation of anaesthetists, pathology and radiology services and all support specialists, are to a large extent dependent on the activity of medical and surgical specialists.

The number of medical schemes beneficiaries visiting any medical specialist at least once a year was 331.00 and 333.75 per 1 000 beneficiaries for 2015 and 2016, respectively. The number of beneficiaries visiting medical specialists was higher in the open schemes for both 2016 and 2015 financial years compared to restricted schemes.

Beneficiary consultations with surgical specialists have remained largely unchanged at 226.22 and 226.02 per 1 000 beneficiaries in 2015 and 2016, respectively. As noted with medical specialists, the utilisation of surgical specialists was higher in open schemes compared to restricted schemes.

The utilisation of dental specialists showed a very small reduction from 42.10 per 1 000 beneficiaries in 2015 to 41.88 per 1 000 beneficiaries in 2016. The number of beneficiaries visiting dental specialists was higher in the restricted schemes for both 2016 and 2015 financial years compared to open schemes.

The beneficiary utilisation of anaesthetists remained largely unchanged at about 87 per 1 000 beneficiaries for the period under review. The utilisation of anaesthetists was higher in open schemes than in restricted schemes.

The claims submitted by pathologists per patient increased slightly from 430.51 per 1 000 beneficiaries in 2015 to 433.05 per 1 000 beneficiaries in 2016. The proportion of pathology claims per beneficiary was high in open schemes when compared to restricted schemes.

The claims submitted by radiologists per patient increased slightly from 254.18 per 1 000 beneficiaries in 2015 to 258.02 per 1 000 beneficiaries in 2016. The proportion of radiology claims was higher in open schemes than in restricted schemes.

Medical specialists registered the highest per patient visits (3.32 in 2015 and 3.38 in 2016) compared to other specialist groups.

The frequency of consultations with surgical specialists and dental specialists was about 2 per patient for the period under review.

The rate of consultations with anaesthetists was about 1.4 per patient for the period under review.

Claims submitted on behalf of patients utilising the services of pathologists and radiologists was about 2.8 and 1.7 per patient respectively for the period under review.

Overall, anaesthetists attracted the largest average per patient expenditure, at R2 935.67 in 2016, followed by surgical specialists at R2 030.56 in the second position. The 2016 expenditure for radiologists came third at about R1 744.23 per patient. The expenditure on medical specialists and pathology services came fourth and fifth at R1 010.66 and R757.59 per patient in 2016, respectively.

The average expenditures reported here are for a group of specialists, with large inter- and intra-group variations. Table 9 on page 150 demonstrates the statistical distribution of the number of beneficiaries utilising healthcare services and amounts paid to specialists primary health providers in 2016. The large spread in the utilisation statistics is indicative of varying levels of benefit depth between benefit options and variation in the utilisation of individual specialist types. This is largely a function of benefit design, demographic profile of risk pools and the burden of disease. Hospital plans will mostly have very low utilisation of primary healthcare services while the opposite is true for comprehensive plans.

Table 8: Utilisation of specialist healthcare services in 2015 and 2016

	2016			2015*		
Specialist Group	**Open**	**Restricted**	**All**	**Open**	**Restricted**	**All**
Utilisation per 1 000 beneficiaries						
Medical Specialists	344.82	319.80	333.75	337.67	322.56	331.00
Surgical Specialists	246.28	200.50	226.02	244.78	202.73	226.22
Dental Specialists	32.06	54.25	41.88	31.60	55.59	42.19
Anaesthetists	98.63	73.05	87.31	97.49	73.03	86.69
Pathology	446.43	416.18	433.05	438.07	420.94	430.51
Radiology	267.12	246.55	258.02	261.97	244.34	254.18
Utilisation per patient						
Medical Specialists	3.27	3.54	3.38	3.22	3.44	3.32
Surgical Specialists	1.92	1.98	1.94	1.88	1.93	1.90
Dental Specialists	2.34	1.78	2.02	2.35	1.84	2.05
Anaesthetists	1.37	1.38	1.37	1.36	1.37	1.37
Pathology	2.84	2.76	2.81	2.57	2.66	2.61
Radiology	1.65	1.68	1.66	1.64	1.68	1.65
Risk amount paid per visit / event						
Medical Specialists	R923.92	R911.91	R918.59	R871.80	R859.68	R866.39
Surgical Specialists	R2 041.06	R1 751.20	R1 925.16	R1 911.05	R1 622.83	R1 795.09
Dental Specialists	R839.66	R992.29	R916.68	R810.65	R907.38	R861.11
Anaesthetists	R3 081.99	R2 638.03	R2 916.91	R2 878.56	R2 430.26	R2 711.00
Pathology	R586.60	R770.99	R663.67	R597.82	R744.59	R662.45
Radiology	R1 570.17	R1 584.15	R1 576.13	R1 464.23	R1 446.29	R1 456.50
MSA amount paid per visit / event						
Medical Specialists	R138.29	R34.08	R92.07	R136.26	R31.68	R89.58
Surgical Specialists	R149.24	R39.62	R105.40	R144.76	R40.57	R102.84
Dental Specialists	R730.93	R78.76	R401.83	R685.17	R79.46	R369.18
Anaesthetists	R25.16	R7.96	R18.77	R23.84	R14.99	R20.53
Pathology	R138.87	R31.33	R93.92	R145.41	R31.54	R95.26
Radiology	R263.57	R39.71	R168.10	R252.47	R36.02	R159.23
Total amount paid per visit / event						
Medical Specialists	R1 062.20	R945.99	R1 010.66	R0.00	R891.36	R955.97
Surgical Specialists	R2 190.30	R1 790.82	R2 030.56	R2 055.81	R1 663.40	R1 897.94
Dental Specialists	R1 570.59	R1 071.06	R1 318.52	R1 495.82	R986.83	R1 230.29
Anaesthetists	R3 107.14	R2 645.99	R2 935.67	R2 902.40	R2 445.25	R2 731.53
Pathology	R725.47	R802.32	R757.59	R743.23	R776.13	R757.72
Radiology	R1 833.75	R1 623.86	R1 744.23	R1 716.69	R1 482.30	R1 615.72

* *The 2015 figures have been restated.*

Table 9: Statistical distribution of the number of beneficiaries, visits and amounts paid to specialist providers in 2016

Specialist Group	Indicator	Minimum	25th percentile	50th percentile	75th percentile	Maximum
Medical Specialists						
	Utilisation per 1 000 beneficiaries	9.42	197.20	340.93	418.29	786.13
	Utilisation per patient	1.77	2.97	3.24	3.50	7.22
	Risk amount paid per visit	R0.00	R840.02	R931.25	R1 019.27	R2 285.85
	MSA amount paid per visit	R0.00	R0.00	R21.63	R96.44	R233.35
	Total amount paid per visit	R0.00	R899.08	R992.63	R1 071.06	R2 491.59
Surgical Specialists						
	Utilisation per 1 000 beneficiaries	5.88	162.50	217.82	294.56	645.50
	Utilisation per patient	1.45	1.76	1.92	2.02	3.85
	Risk amount paid per visit	R0.00	R1 575.09	R1 787.24	R2 094.05	R4 781.15
	MSA amount paid per visit	R0.00	R0.00	R30.66	R117.42	R242.38
	Total amount paid per visit	R0.00	R1 654.19	R1 864.25	R2 198.95	R4 781.15
Dental Specialists						
	Utilisation per 1 000 beneficiaries	0.00	24.76	39.74	59.67	98.38
	Utilisation per patient	1.00	1.72	2.08	2.44	8.81
	Risk amount paid per visit	R0.00	R750.51	R985.62	R1 150.54	R4 131.60
	MSA amount paid per visit	R0.00	R0.00	R102.42	R422.95	R994.12
	Total amount paid per visit	R0.00	R1 043.59	R1 166.95	R1 404.17	R4 701.76
Anaesthetists						
	Utilisation per 1 000 beneficiaries	0.18	55.14	88.55	112.18	258.70
	Utilisation per patient	1.09	1.28	1.35	1.44	4.46
	Risk amount paid per visit	R0.00	R2 364.33	R2 636.38	R3 037.15	R4 720.62
	MSA amount paid per visit	R0.00	R0.00	R2.78	R25.91	R124.51
	Total amount paid per visit	R0.00	R2 373.74	R2 649.24	R3 042.86	R4 720.62
Pathology						
	Utilisation per 1 000 beneficiaries	0.12	302.12	435.76	513.54	778.97
	Utilisation per patient	1.00	2.33	2.54	2.79	5.37
	Risk amount paid per visit	R0.00	R630.19	R779.22	R877.33	R2 004.93
	MSA amount paid per visit	R0.00	R0.00	R0.74	R97.00	R352.34
	Total amount paid per visit	R0.00	R756.87	R839.27	R925.82	R2 004.93
Radiology						
	Utilisation per 1 000 beneficiaries	7.06	185.92	265.45	322.23	538.60
	Utilisation per patient	1.10	1.55	1.63	1.80	7.58
	Risk amount paid per visit	R0.00	R1 462.71	R1 591.57	R1 807.49	R2 723.15
	MSA amount paid per visit	R0.00	R0.00	R2.99	R120.40	R403.42
	Total amount paid per visit	R0.00	R1 532.21	R1 701.46	R1 854.00	R2 723.15

* *The 2015 figures have been restated.*

Utilisation of hospital services

Table 10 provides details of the utilisation of private hospital services for same day and inpatient admissions by hospital category. Same-day cases in the report refer to hospital confinement that ends within 24 hours, while inpatient admission refers to a hospital confinement longer than 24 hours. Work with the industry is ongoing in order to improve the definitions and coding of hospital data. Inpatient admissions have largely remained unchanged during the period under review. Most hospital admission statistics were higher for open schemes, except for maternity admissions. Admissions to provincial hospitals were significantly lower than the admissions 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.

The number of same-day admissions at private hospitals ('A' & 'B' - status) decreased to 91.62 per 1 000 in 2016 from 99.95 in 2015. On the other hand, same-day admissions to provincial hospitals decreased to 12.90 per 1 000 in 2016 beneficiaries from 14.09 per 1 000 beneficiaries in 2015.

The number of inpatient admissions at private hospitals increased to 179.67 per 1 000 beneficiaries in 2016 from 176.83 per 1 000 beneficiaries in 2015. Inpatient admissions to provincial hospitals were 2.03 and 2.50 per 1 000 beneficiaries in 2016 and 2015, respectively.

Table 10: Utilisation of hospital facilities in 2015 and 2016: Admission Rates

Admission Type	2016			2015*		
Hospital Category	Open	Restricted	All	Open	Restricted	All
Same-day inpatient admissions per 1 000 beneficiaries						
Sub-Acute Facilities	0.21	0.26	0.23	0.21	0.23	0.22
Provincial Hospitals	1.39	26.42	12.46	1.61	31.75	14.92
Private Hospitals ('A' – Status)	10.52	15.90	12.90	10.87	18.16	14.09
Private Hospitals ('A' & 'B' – Status)	83.65	101.66	91.62	84.58	119.39	99.95
Private Hospitals ('B' – Status)	73.13	85.76	78.72	73.71	101.23	85.87
Approved Day Clinics	15.15	9.08	12.46	12.80	7.78	10.58
Drug & Alcohol Rehab	0.03	0.03	0.03	0.03	0.08	0.05
Hospices	0.23	0.07	0.16	0.24	0.13	0.19
Mental Health Institutions	0.23	0.13	0.18	0.21	0.13	0.18
Private Rehab Hospital (Acute)	0.03	0.01	0.02	0.04	0.02	0.03
Inpatient admissions per 1 000 beneficiaries						
Sub-Acute Facilities	2.65	3.26	2.92	2.50	3.30	2.86
Provincial Hospitals	0.98	3.36	2.03	1.09	4.29	2.50
Private Hospitals ('A' – Status)	20.28	28.63	23.98	19.72	29.08	23.86
Private Hospitals ('A' & 'B' – Status)	186.25	171.39	179.67	181.92	170.40	176.83
Private Hospitals ('B' – Status)	165.97	142.76	155.70	162.19	141.32	152.98
Approved Day Clinics	0.83	0.64	0.75	0.80	0.62	0.72
Drug & Alcohol Rehab	1.05	0.75	0.92	1.08	0.77	0.94
Hospices	0.12	0.14	0.13	0.13	0.13	0.13
Mental Health Institutions	4.61	4.54	4.58	4.32	4.04	4.20
Private Rehab Hospital (Acute)	0.36	0.27	0.32	0.35	0.31	0.33
Unattached Operating Theatres	0.01	0.00	0.00	0.01	0.01	0.01

* *The 2015 figures have been restated.*

Table 11 illustrates the mean number of hospital days per year for different categories of hospital facilities. The average length of stay for inpatient admissions in private hospitals ('A' & 'B' – Status) decreased to 4.17 days in 2016 from 4.22 in 2015. Provincial hospitals recorded a high average length of stay per admission, 6.51 days in 2016 from 11.2 days in 2015. This is likely to be more of a data quality issue that the actual practice. The provincial hospitals' admissions data should therefore be interpreted with caution.

Table 11: Utilisation of hospital facilities in 2015 and 2016: Average Length of Stay (ALOS)

	2016			2015*		
Hospital Category	Open	Restricted	All	Open	Restricted	All
Sub-Acute Facilities	10.16	10.00	10.08	9.87	9.76	9.81
Provincial Hospitals	5.17	7.37	6.51	6.13	12.86	11.12
Private Hospitals ('A' - Status)	3.74	3.91	3.83	3.72	3.92	3.83
Private Hospitals ('B' - Status)	4.10	4.41	4.22	4.11	4.57	4.29
Private Hospitals ('A' & 'B' - Status)	4.06	4.33	4.17	4.07	4.45	4.22
Approved Day Clinics	0.00	0.00	0.00	0.00	0.00	0.00
Drug & Alcohol Rehab	11.83	15.71	13.21	11.94	16.31	13.48
Hospices	11.74	24.84	17.38	11.60	34.94	20.65
Mental Health Institutions	11.23	12.01	11.57	11.45	12.08	11.72
Private Rehab Hospital (Acute)	27.89	29.20	28.38	28.21	28.65	28.39
Unattached Operating Theatres	0.00	0.00	0.00	0.0	0.00	0.00

* *The 2015 figures have been restated.*

Table 12 illustrates admission rates and the average length of stay per year for different admission categories across hospital facilities. Ambulatory and emergency room admissions remained largely unchanged during the period under review. The data for medical and surgical same-day admissions seems to be irregular and should therefore be interpreted with caution. Same-day admissions for maternity cases decreased to 2.63 per 1 000 beneficiaries in 2016 from 4.13 in 2015.

The inpatient admissions for surgical cases recorded the highest proportion of inpatient admissions but decreased to 142.67 per 1 000 beneficiaries in 2016 from 149.94 in 2015. Inpatient surgical cases increased to 57.90 per 1 000 beneficiaries in 2016 from 48.83 per 1 000 beneficiaries in 2015. Inpatient maternity cases remained largely unchanged for the period under review, at 33.8 in 2016 and 31.94 in 2015.

The average length of stay for medical cases (6.44 in 2016 and 6.77 in 2015) was longer than the length of stay for surgical cases (3.79 in 2016 and 4.00 in 2015). The average length of stay for inpatient maternity cases remained largely unchanged at about 3 days for the period under review.

Table 12: Inpatient (≥ 24 hours) across all hospital types by admission category in 2015 and 2016

	2016			2015*		
Hospital Admission Category	Open	Restricted	All	Open	Restricted	All
Same day inpatient (< 24 hours) across all hospital types						
Admission rate per 1 000 beneficiaries						
Ambulatory cases	3.08	2.57	2.85	2.89	2.06	2.52
Emergency room visits	7.77	9.73	8.64	7.35	10.14	8.58
Medical cases	41.42	106.18	70.08	35.46	141.39	82.23
Surgical cases	50.50	13.91	34.31	53.65	10.76	34.71
Maternity cases	3.44	1.64	2.63	3.38	5.05	4.13
Inpatient (≥ 24 hours) across all hospital types by admission category						
Admission rate per 1 000 beneficiaries						
Medical cases	147.48	136.62	142.67	148.68	151.53	149.94
Surgical cases	72.77	39.17	57.90	69.41	22.79	48.83
Maternity cases	36.47	29.64	33.38	33.97	29.46	31.94
Average length of stay						
Medical cases	7.11	5.52	6.44	6.26	7.40	6.77
Surgical cases	3.99	3.32	3.79	3.69	5.18	4.00
Maternity cases	2.76	2.77	2.76	2.78	2.86	2.82

* *The 2015 figures have been restated.*

Table 13 illustrates the average length of stay and admission rates per year by level of care across hospital facilities. As expected, admissions to the general ward were the highest, remaining largely unchanged between 2015 and 2016, at 173.93 and 172.95 per 1 000 beneficiaries respectively.

The median number of hospital admissions in respect of PMB conditions remained unchanged between 2015 and 2016 at about 105 per 1 000 beneficiaries. 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 increased to 203.16 per 1 000 beneficiaries in 2016 from the restated 191.34 per 1 000 beneficiaries in 2015. The 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: 2015 and 2016

	2016			2015*		
	Open	Restricted	All	Open	Restricted	All
Average number of General Ward admissions (per 1 000 beneficiaries)	166.67	180.99	172.95	170.74	177.98	173.93
Average length of stay for General Ward admissions	4.45	3.89	4.19	3.57	4.09	3.80
Average number of High Care admissions (per 1 000 beneficiaries)	23.63	21.54	22.72	23.96	20.62	22.49
Average length of stay for High Care admissions	3.45	4.02	3.69	3.42	4.07	3.69
Average number of ICU admissions (per 1 000 beneficiaries)	9.97	8.74	9.43	10.35	9.35	9.91
Average length of stay for ICU admissions	5.18	5.47	5.30	5.07	5.12	5.09
Average number of hospital outpatient visits (per 1 000 beneficiaries)	122.54	93.30	109.73	122.56	95.41	110.59
Median number of PMB related admissions (per 1 000 beneficiaries)	116.64	102.42	104.96	108.24	102.00	104.51
Average number of repeat admissions (90 days) (per 1 000 beneficiaries)	249.46	141.80	203.16	253.37	110.23	191.34
Number of hospital deaths (per 1 000 beneficiaries)	11.80	10.28	11.14	13.89	12.99	13.50

* *The 2015 figures have been restated.*

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 2015 and 2016

	2016			2015*		
	Open	Restricted	All	Open	Restricted	All
Number of utilising beneficiaries per 1 000 beneficiaries						
Angiograms	1.09	1.82	1.51	0.51	2.15	1.40
Bone density scans	5.35	5.65	6.92	4.36	7.24	4.62
CT (Computerised Tomography) scans	40.69	43.60	45.53	34.40	48.74	37.16
MRI (Magnetic Resonance Imaging) scans	24.25	25.96	27.94	19.46	29.94	20.97
PET (Positron Emission Tomography) scans	0.35	0.81	0.46	0.22	0.67	1.02
Renal dialysis services	6.53	7.50	8.66	3.73	9.28	5.19

* *The 2015 figures have been restated.*

Utilisation of screening, preventative, child, maternal and reproductive healthcare services

This sections 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 a significant number of schemes were not able to adjust their systems to submit this data to the CMS by the due date. Data quality continues to be a concern in 2016. These results must 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 the benchmarking in the level of access and quality of care received by beneficiaries of medical schemes.

Table 15 illustrates preventive services for female beneficiaries. The number of birth admissions dropped from the restated 34.31 per 1 000 female beneficiaries in 2015 to 33.93 per 1 000 female beneficiaries in 2016. Birth admissions were higher in open schemes when compared to restricted schemes during the period under review.

The number of live births showed a marginal drop in 2016 but remains relatively high at about 923.48 per 1 000 birth admissions.

Caesarean sections increased from the restated 613.46 in 2015 to 629.05 per 1 000 birth admissions in 2016. 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 continued to increase, and stands at 2.57 per 1 000 female beneficiaries in 2016 from 0.29 per 1 000 female beneficiaries in 2015.

The number of births to female beneficiaries 15 – 19 years of age decreased from 6.67 per 1 000 female beneficiaries aged 15 – 19 years in 2015 to 4.56 in 2016. There were 3.58 and 6.66 births per 1 000 female beneficiaries aged between 15 – 19 years in restricted and open schemes respectively for 2016.

The number of pap smear procedures paid for in 2016 was 174.77 per 1 000 female beneficiaries aged 15 – 69 years compared to 176.48 in the previous year. Open schemes reported higher rates of utilisation for pap smear procedures than restricted schemes.

Table 15: Maternal health coverage

	2016			2015*		
	Open	Restricted	All	Open	Restricted	All
Number of birth admissions (per 1 000 female beneficiaries)	38.55	28.26	33.93	38.90	28.73	34.31
Total number of live births (per 1 000 births)	915.02	949.26	923.48	924.90	906.70	920.49
Number of caesarean sections performed (per 1 000 female beneficiaries)	600.11	654.14	613.46	619.07	660.21	629.05
Number of birth admissions to women under 15 years	3.45	4.02	3.69	3.42	4.07	3.69
(per 1 000 female beneficiaries aged under 15 years)	3.75	0.21	2.57	0.25	0.36	0.29
Number of birth admissions to women between 15 – 19 years (per 1 000 female beneficiaries aged 15 – 19 years)	3.58	6.66	4.56	3.54	13.30	6.67
Number of pap smears paid for (per 1 000 female beneficiaries aged 15 – 69 years)	181.08	158.08	174.77	184.99	154.47	176.48
Number of women using contraceptives (per 1 000 female beneficiaries aged 15 – 49 years)	71.61	57.53	67.47	67.60	49.28	62.15
Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15 – 49 years (per 1 000 female beneficiaries aged 15 – 49 years)	6.78	69.69	25.30	7.05	7.25	7.11
Surgical procedure to protect a woman from further pregnancy (count)	3 645	661	4 306	3 325	1 009	4 334
Surgical procedure to prevent a man from being fertile (count)	8 725	1 517	10 242	8 623	1 430	10 053
Subdermal contraceptive implant inserted just under the skin of a woman aged 15 – 49 years upper arm (per 1 000 female beneficiaries aged 15 – 49 years)	0.05	65.08	19.20	0.07	0.30	0.14

* *The 2015 figures have been restated.*

Resources

Policy context

One of the policy issues identified in the National Department of Health's NHI Policy Paper, is the unequal distribution of healthcare resources between the public and private sector. As phases of the National Health Insurance (NHI) implementation are rolled-out, there will be opportunities for private health providers to enter into public-private partnership (PPP) contracts with the NHI.

This prerogative was amplified in the Minister of Finance's Budget speech for the 2017 tax year. It was announced that contracts with general practitioners will be a priority in the current phase of implementing NHI. This is perhaps just one of the interventions which will help reduce the gap of human resources for health between the public and private health sectors.

The NHI will establish a comprehensive list of essential health services. This section describes the structure of the private healthcare provider sector. This is followed by an overview of the number of healthcare providers and healthcare service utilisation per 10 000 medical scheme beneficiaries. The overview summarises provider distribution at the provincial level.

The data presented below is sourced from annual healthcare utilisation statutory returns. The data on private sector providers are based on providers who have claimed from medical schemes in 2016. The data does not reflect the availability of providers in the public sector.

The first year of collecting information on the provider disciplines was 2015. It is expected that the quality of the data provided by medical schemes, on unique identifiers of healthcare providers, will improve over time. The Board of Health Funders' discipline codes were used to count unique providers.

Private sector

Structure of human resources for the private health sector

The pie chart in figure 24 describes the relative percentage distribution of provider disciplines in 2016. The highest proportion of providers were general practitioners (GPs), followed by medical specialists. Audiologists and speech therapists, followed by radiologists were the lowest proportion of healthcare providers.

Figure 24: Percentage distribution of healthcare providers (2016)

General Practitioners	25.0%	Surgical Specialists	7.8%
Medical Specialists	14.4%	Occupational Therapists	4.3%
Pathology	11.5%	Dental Specialists	3.6%
Psychologists	11.5%	Audiologist & Speech Therapy	3.4%
Dentists	8.7%	Radiology	1.6%
Optometrists	8.1%		

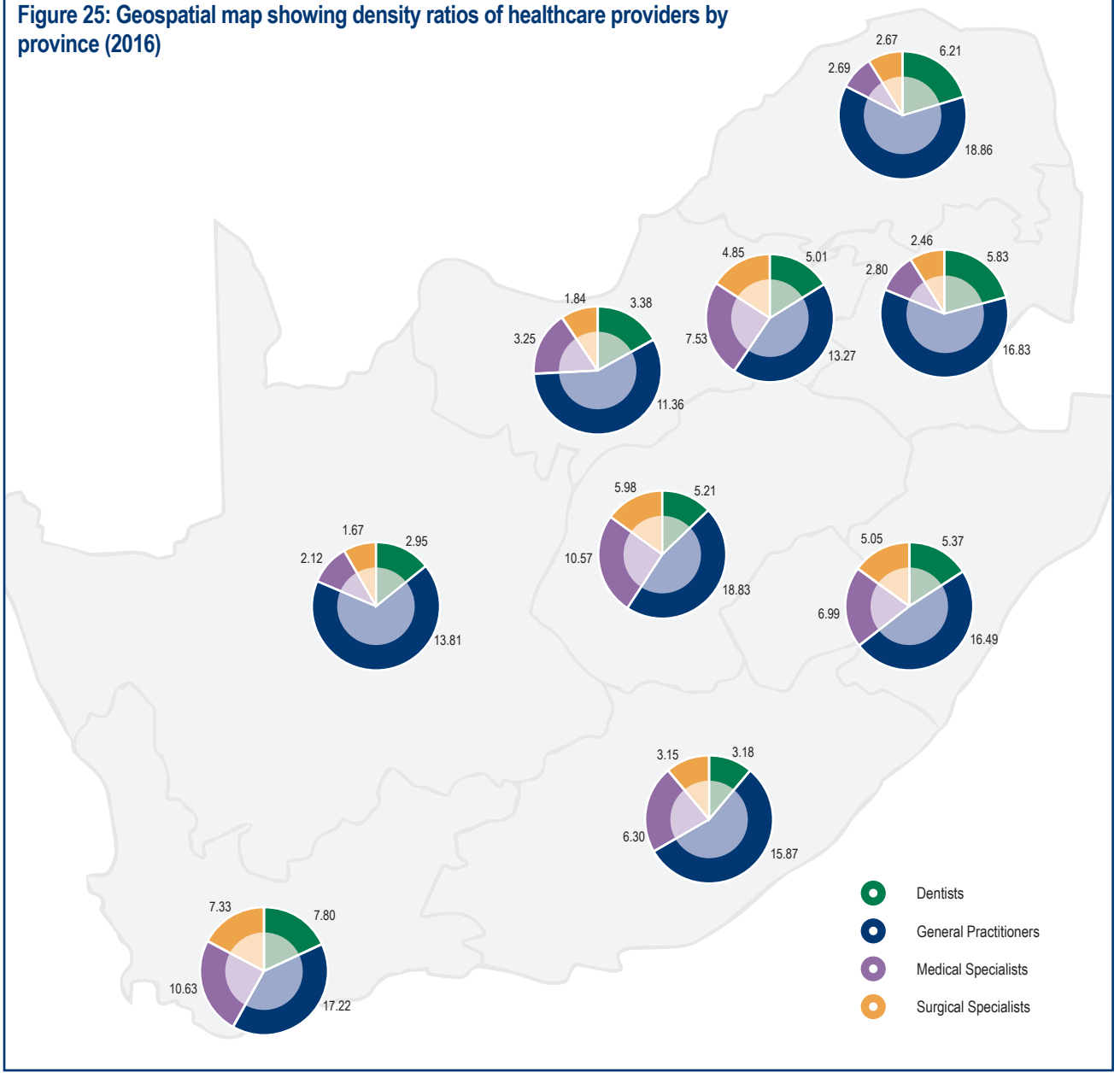
Figure 25 is a geospatial map that describes the availability of healthcare providers per 10 000 beneficiaries (density ratios), across the nine provinces in South Africa. It reports these ratios for GPs, dentists, medical specialist and surgical specialists, respectively.

According to Figure 25, the Free State and Limpopo have the highest number of general practitioners per 10 000 beneficiaries. The density ratios were 18 GPs per 10 000 beneficiaries, respectively. The lowest availability of GPs was in the Northern Cape and in the North West, where the density ratios were 13 and 11 respectively.

Figure 25 also describes the density ratios of medical specialists in South African provinces. The density ratios are significantly lower in the Northern Cape, the North West, Limpopo and Mpumalanga. The provinces with relatively higher density ratios are Western Cape, Free State and Gauteng.

The density ratios of surgical specialists are the lowest of the reported densities ratios. The density ratios for surgical specialists are highest in Western Cape, Gauteng, KwaZulu-Natal and Free State. The density ratios for the other provinces are significantly lower.

Figure 25: Geospatial map showing density ratios of healthcare providers by province (2016)



Note: The density ratios are based on private providers who have claimed from Medical Schemes.

Private providers by NHI healthcare services

The section will report on healthcare providers that provide services that may be in line with the comprehensive essential services to be provided under NHI. The NHI's essential list of healthcare services are:

- Primary health services, and progressively include opportunities for secondary and tertiary level private healthcare providers to participate in NHI
- Oral health services
- Maternal health services
- Diagnostic radiology and pathology
- Optometry services
- Speech and hearing services
- Mental health services
- Rehabilitative care
- Paediatric and child health services.

Figure 26 describes key indicators associated with GPs in the primary health system. Panel 1 shows the proportional percentage distribution of GPs, patient visits and beneficiaries across the nine provinces.

Panel 2 shows scatter-plot diagrams. The scatter-plots describe the demand for healthcare services using visits per 10 000 beneficiaries, relative to the supply of healthcare services (density ratios).

Primary healthcare services

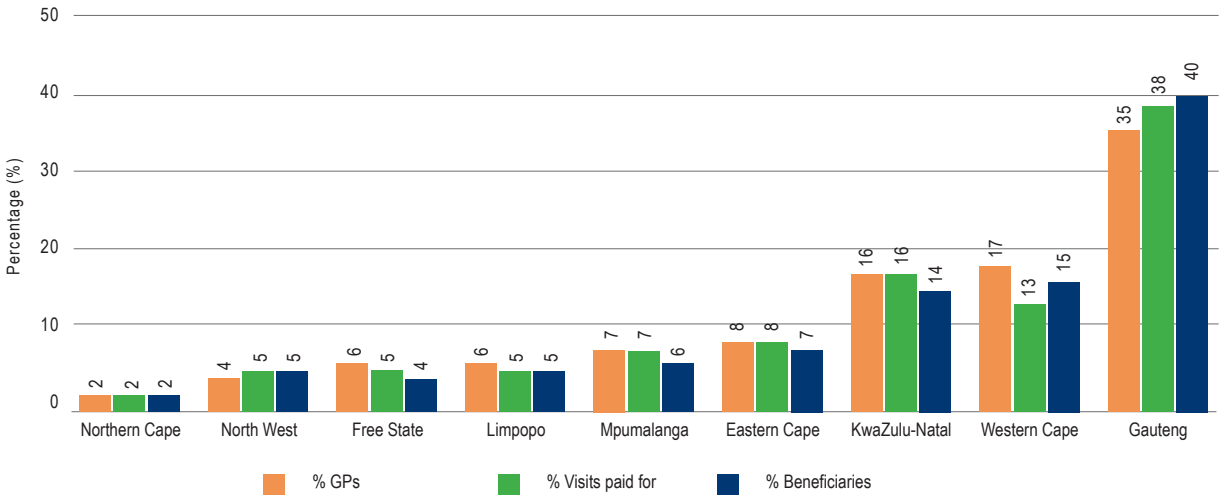
The NHI will restructure the system of healthcare provision. The system will be transformed from a hospital-centric to a primary healthcare orientation. The finance minister's budget for the current fiscal year has made provisions to implement this health policy initiative. The national budget has identified contracting with private sector general practitioners as a priority area in the current NHI implementation phase.

Panel 1 of Figure 26 describes the relative percentage distribution GPs, patient visits and medical scheme beneficiaries, across the nine provinces. The distribution of these variables are highest in Gauteng, KwaZulu-Natal and Western Cape. The number of patient visits are higher than the number of beneficiaries in KwaZulu-Natal. Patient visits are lower than the relative distribution of GPs and medical schemes beneficiaries in the Western Cape. In Gauteng, patient visits are relatively higher than the number of GPs.

Panel 2 shows that the availability of GPs per 10 000 beneficiaries (supply) is higher than that of Gauteng in six provinces (Free State is superimposed by Limpopo). That said; these provinces' utilisation of GPs (demand) is much lower than Gauteng's.

Figure 26: Access and utilisation of general practitioners (2016)

Panel 1: Relative distribution of GPs, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and GPs per 10 000 beneficiaries by Province (2016)

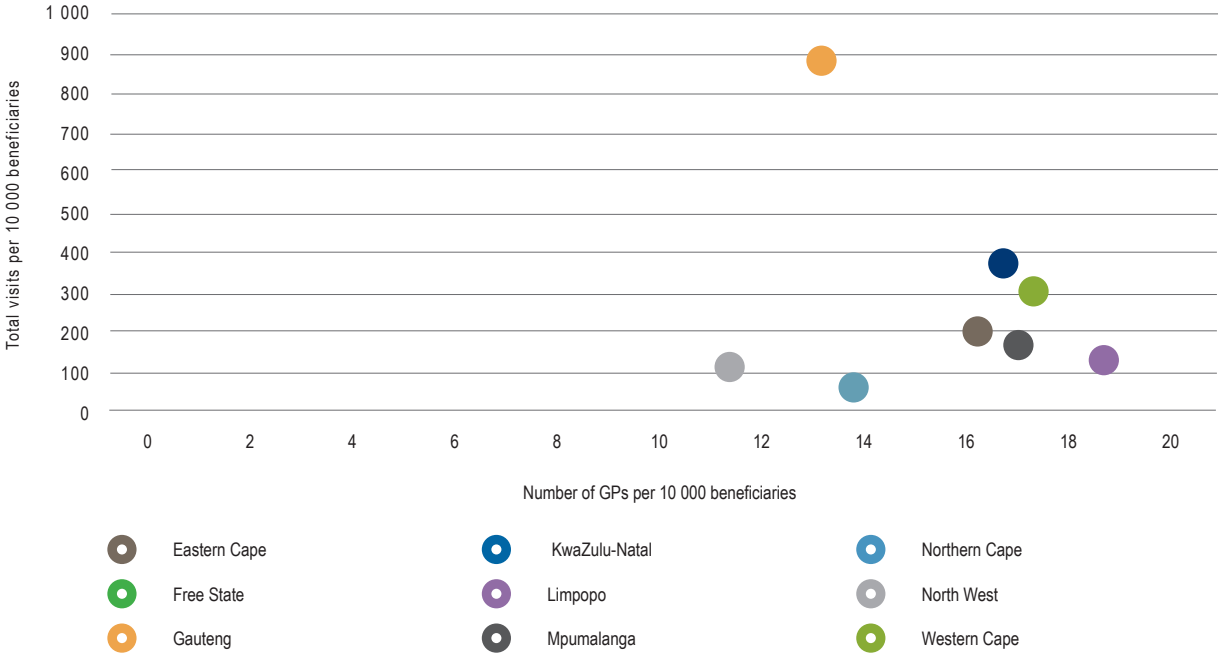


Table 16 reports the number of GPs and density ratios across provinces. The highest number of GPs are in Gauteng, KwaZulu-Natal and the Western Cape. That said; the highest density ratios are in the Free State and Limpopo.

Table 16: General practitioners per 10 000 beneficiaries by province (2016)

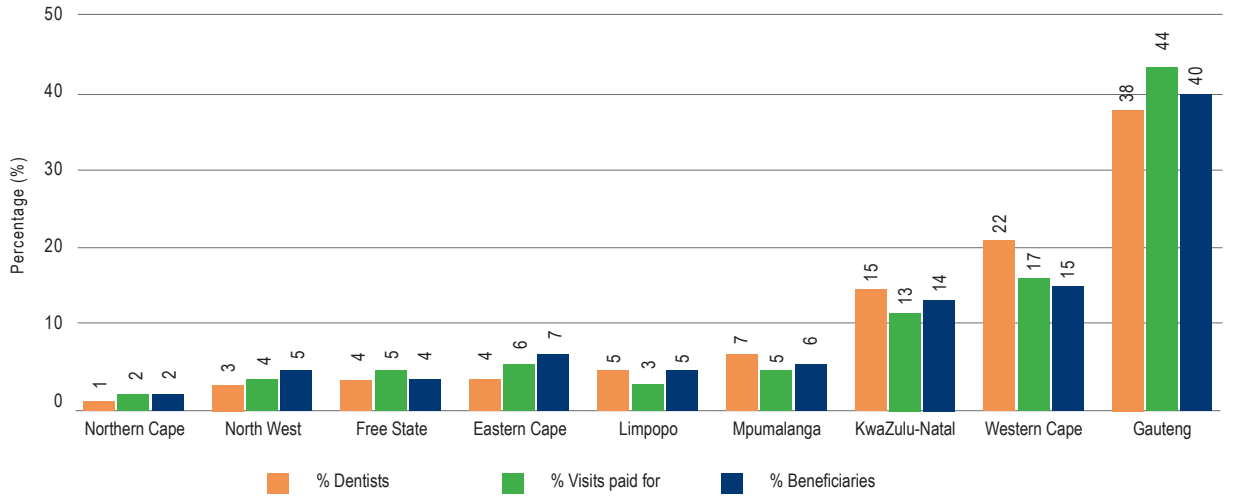
Province	GP headcount	GPs per 10 000 beneficiaries
Eastern Cape	1 013	15.9
Free State	730	18.8
Gauteng	4 621	13.3
KwaZulu-Natal	2 067	16.5
Limpopo	779	18.9
Mpumalanga	918	16.8
Northern Cape	248	13.8
North West	524	11.4
Western Cape	2 255	17.2
Total	**13 155**	**15.2**

Oral healthcare services

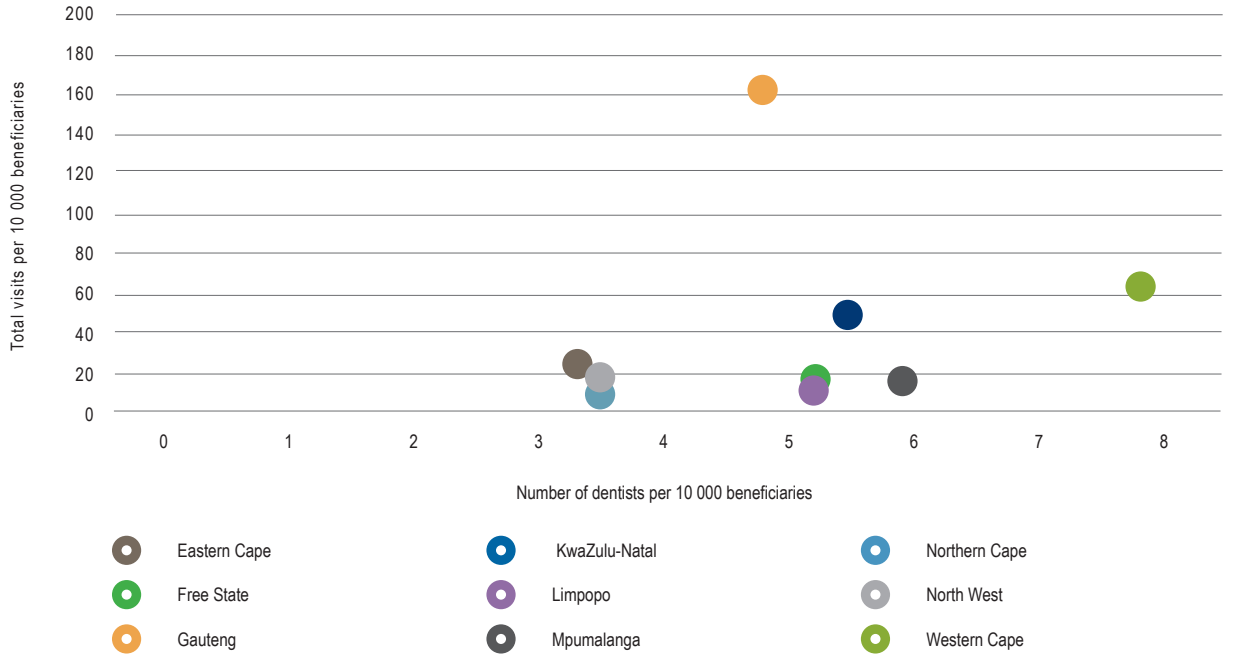
Figure 27 shows that the relative provincial distribution of patient visits to dentists is highest in Gauteng (panel 1). Panel 2 shows that, although the utilisation of dentists' per 10 000 beneficiaries is highest in Gauteng, the number of available dentists per 10 000 beneficiaries is highest in the Western Cape.

Figure 27: Access and utilisation of dentists (2016)

Panel 1: Relative distribution of Dentists, Patient visits and beneficiaries by Province (2016)



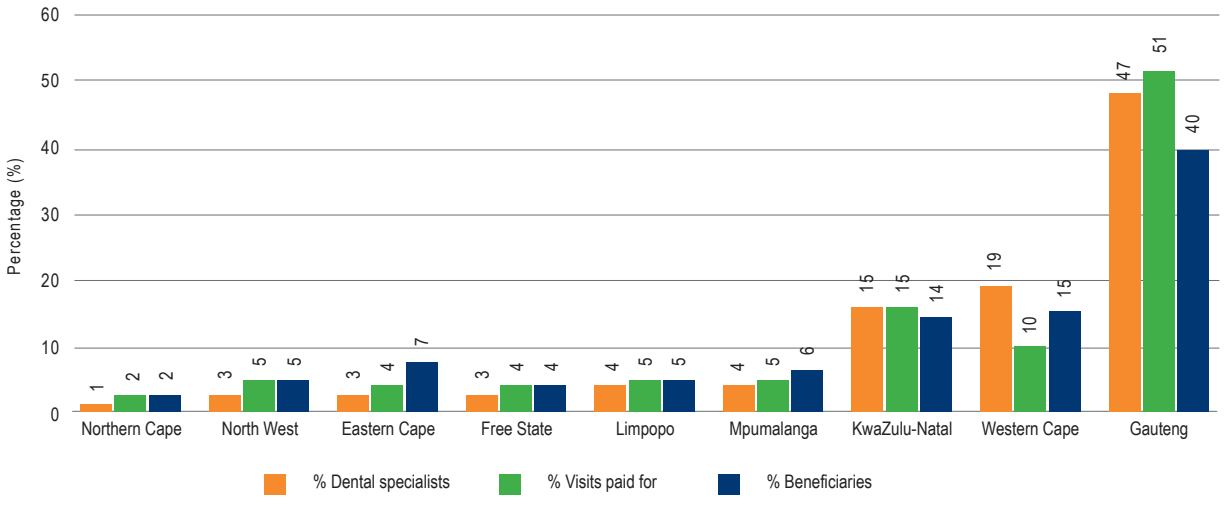
Panel 2: Scatter Plot Diagram – Patient Visits and Dentists per 10 000 beneficiaries by Province (2016)



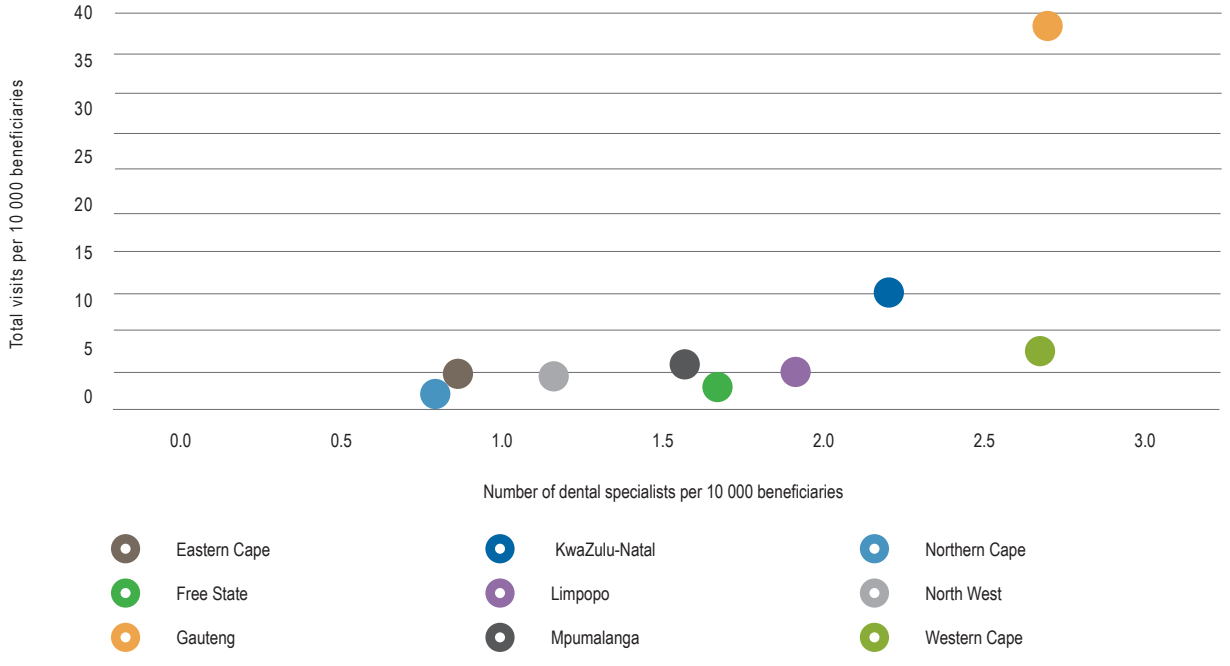
Panel 1 in figure 28 shows that the relative distribution of patient visits in Western Cape is lower than the relative distribution of dental specialists and beneficiaries. In contrast, the relative distribution of patient visits in Gauteng is greater than that of dental specialists and beneficiaries.

Figure 28: Access and utilisation of dental specialists (2016)

Panel 1: Relative distribution of Dental Specialists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Dental Specialists per 10 000 beneficiaries by Province (2016)



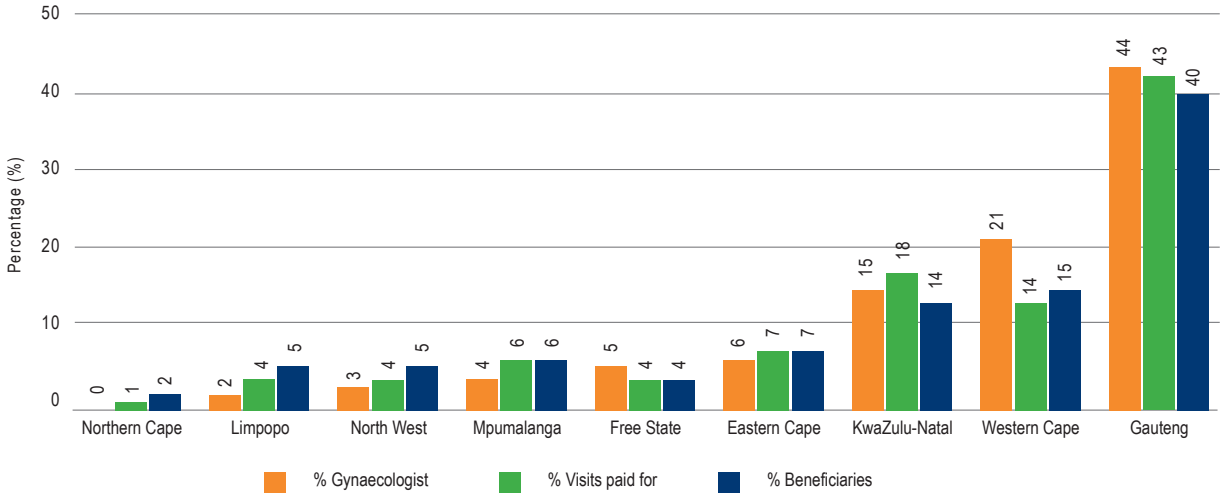
Maternal health services

Maternal health services have been identified as a priority area in the implementation of the current phase of the NHI roll-out. Figure 29 describes gynaecological providers in terms utilisation, availability and access to gynaecologists by medical scheme beneficiaries, at provincial level.

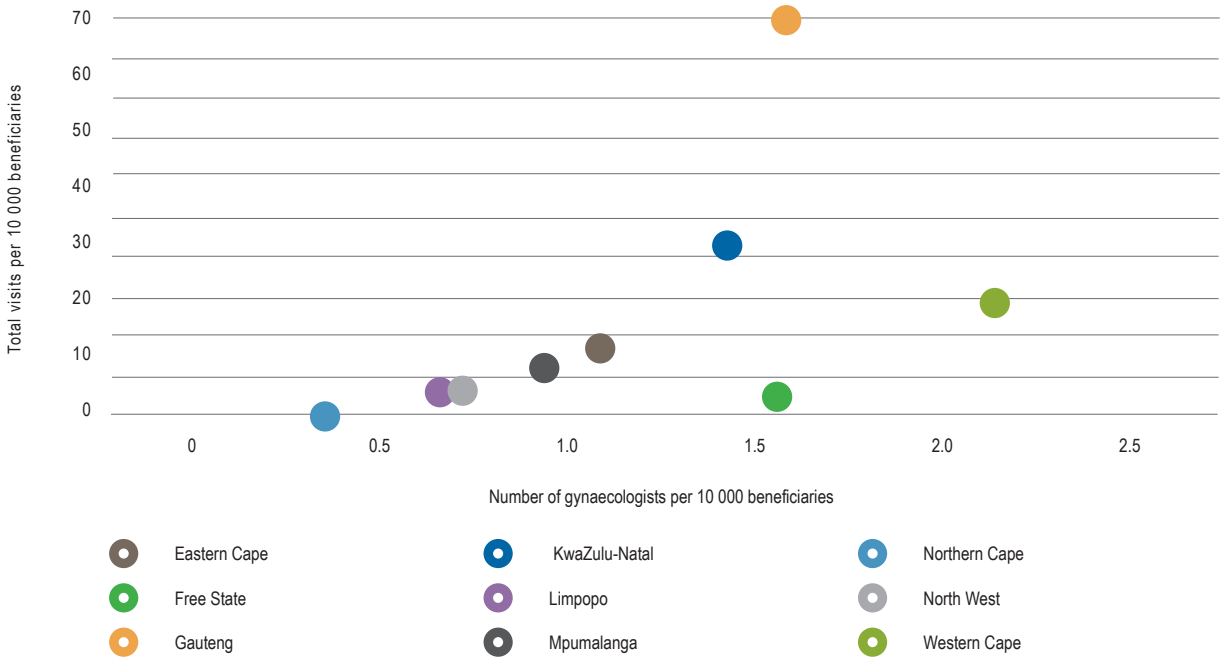
In Figure 29 below, the relative distribution of patient visits is greater than the distribution of gynaecologists and beneficiaries in KwaZulu-Natal. Panel 2 shows that this has translated into a higher utilisation per 10 000 beneficiaries in KwaZulu-Natal than in the Western Cape. However, the relative availability of gynaecologists (per 10 000 beneficiaries) is greater in the Western Cape than in KwaZulu-Natal.

Figure 29: Access and utilisation of gynaecologists (2016)

Panel 1: Relative distribution of Gynaecologists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Gynaecologists per 10 000 beneficiaries by Province (2016)

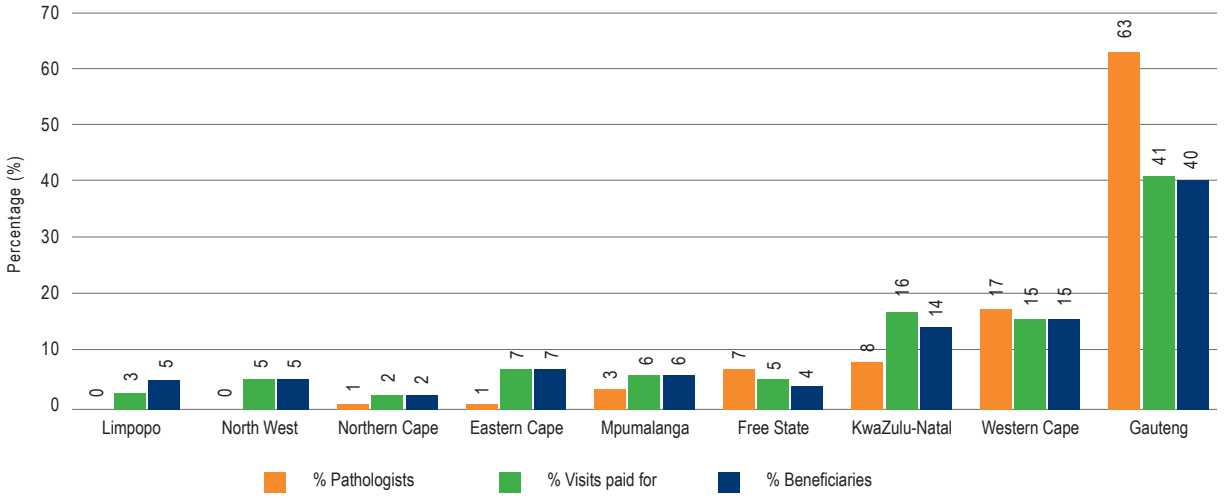


Diagnostic radiology and pathology

Figure 30 describes pathology with respect to variables which explain the distribution of utilisation, access and availability. The relative distribution of providers and patient visits is significantly higher in Gauteng, relative to other provinces, as can be seen in Panel 1. This had an impact on utilisation and availability of healthcare services per 10 000 medical scheme beneficiaries. Utilisation and availability was highest in Gauteng.

Figure 30: Access and utilisation of pathologists (2016)

Panel 1: Relative distribution of Pathologists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Pathologists per 10 000 beneficiaries by Province (2016)

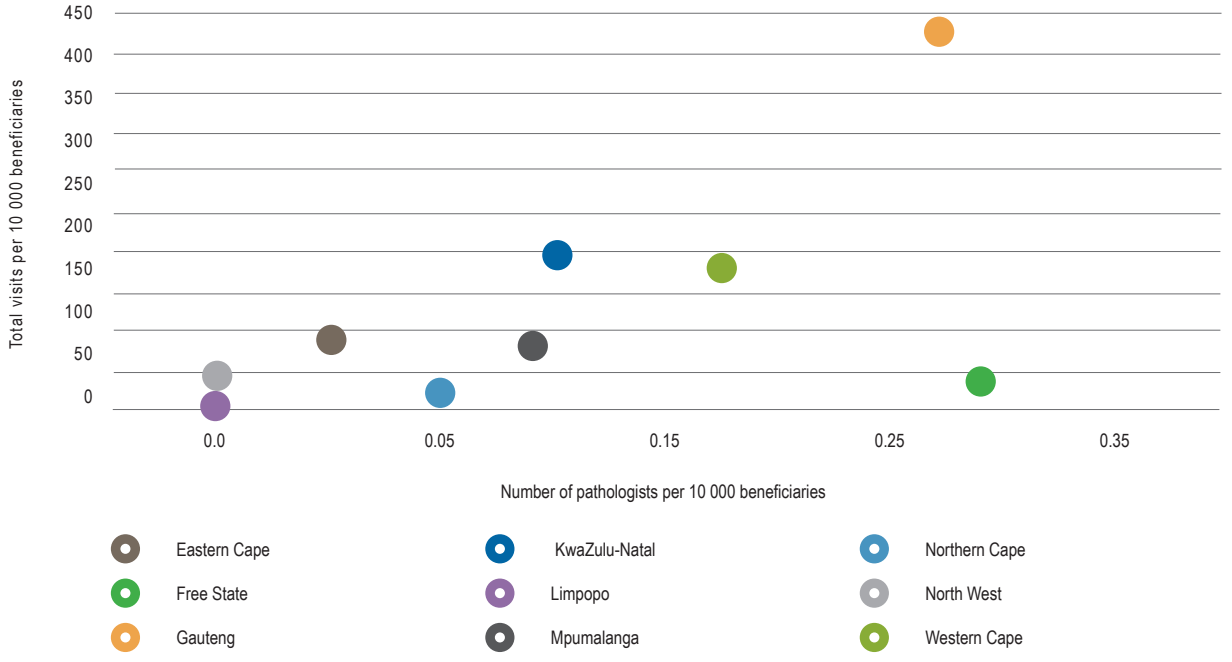
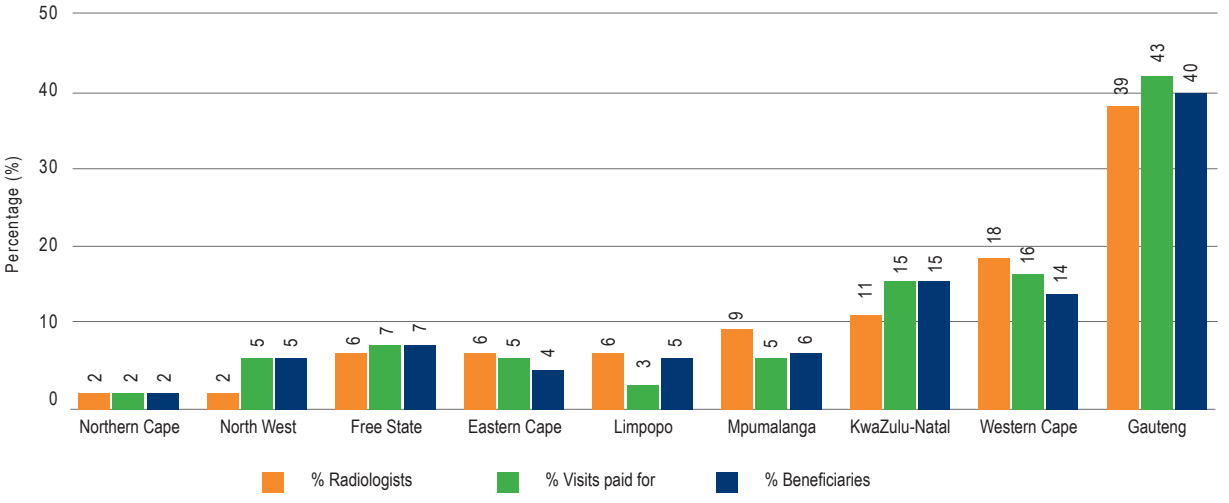


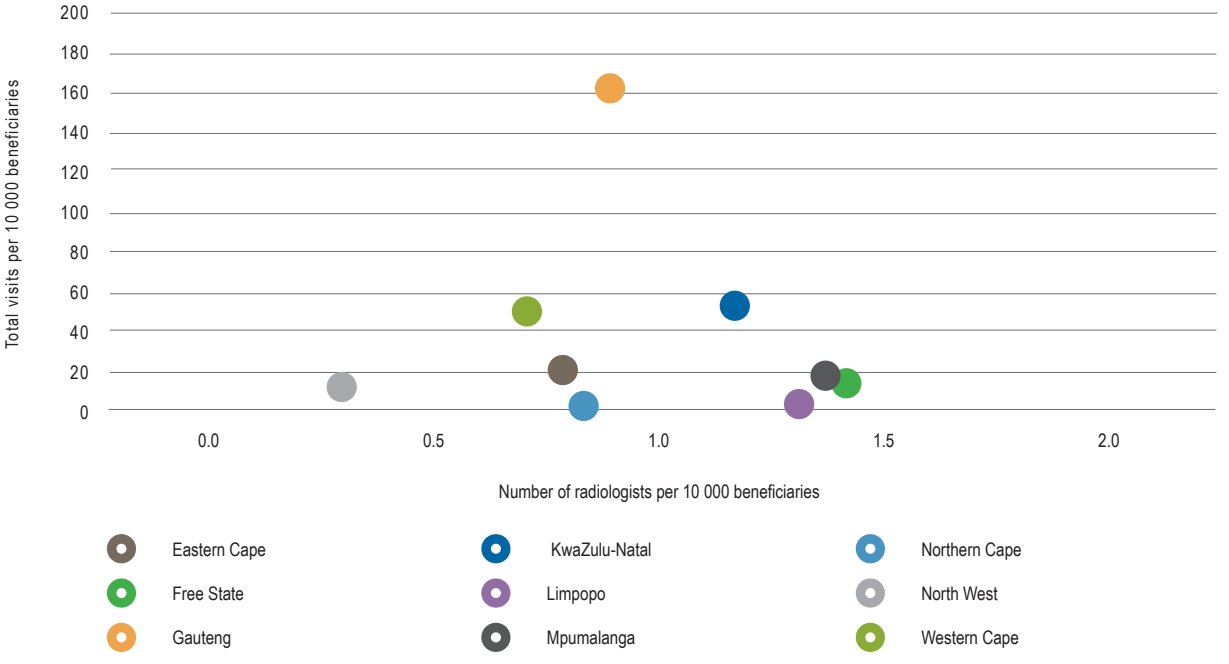
Figure 31 shows that the utilisation of radiologists is highest in Gauteng. The availability of radiologists per 10 000 beneficiaries is relatively higher in Gauteng, than the availability in KwaZulu-Natal, the Western Cape and Mpumalanga.

Figure 31: Access and utilisation of radiologists (2016)

Panel 1: Relative distribution of Radiologists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Radiologists per 10 000 beneficiaries by Province (2016)

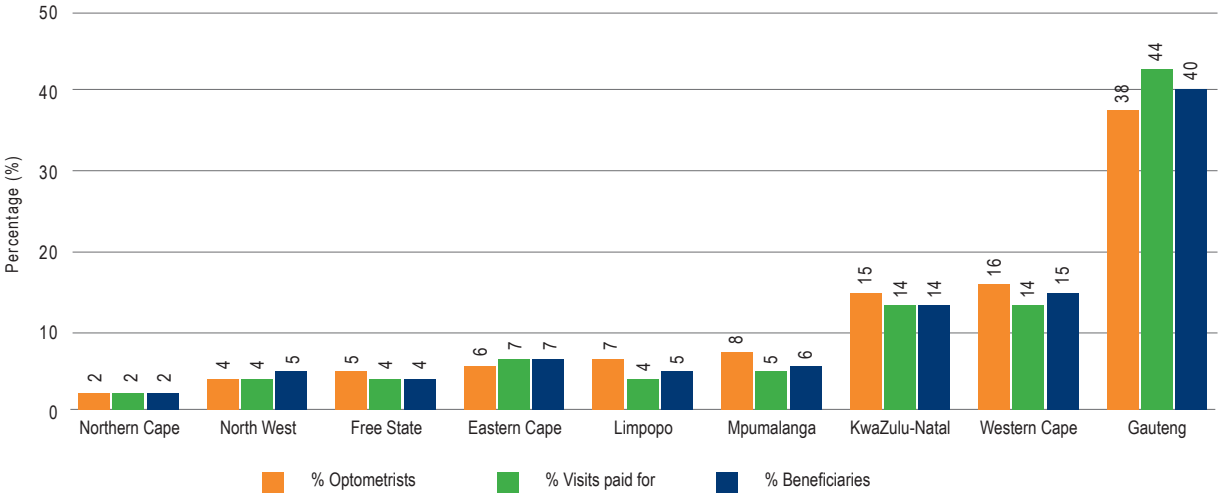


Optometry services

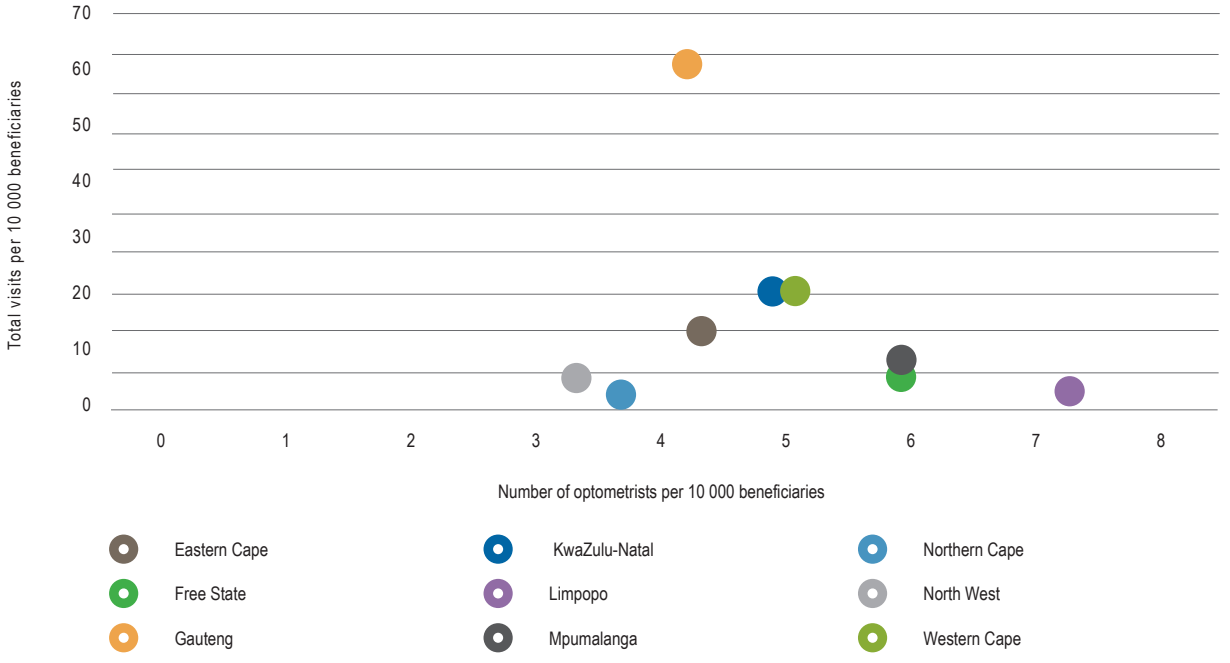
Figure 32 shows that the relative distribution of optometrists and patient visits are similar in KwaZulu-Natal and the Western Cape. The number of optometrist per 10 000 medical schemes beneficiaries is highest in Mpumalanga, the Free State and Limpopo.

Figure 32: Access and utilisation of optometrists (2016)

Panel 1: Relative distribution of Optometrists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Optometrists per 10 000 beneficiaries by Province (2016)

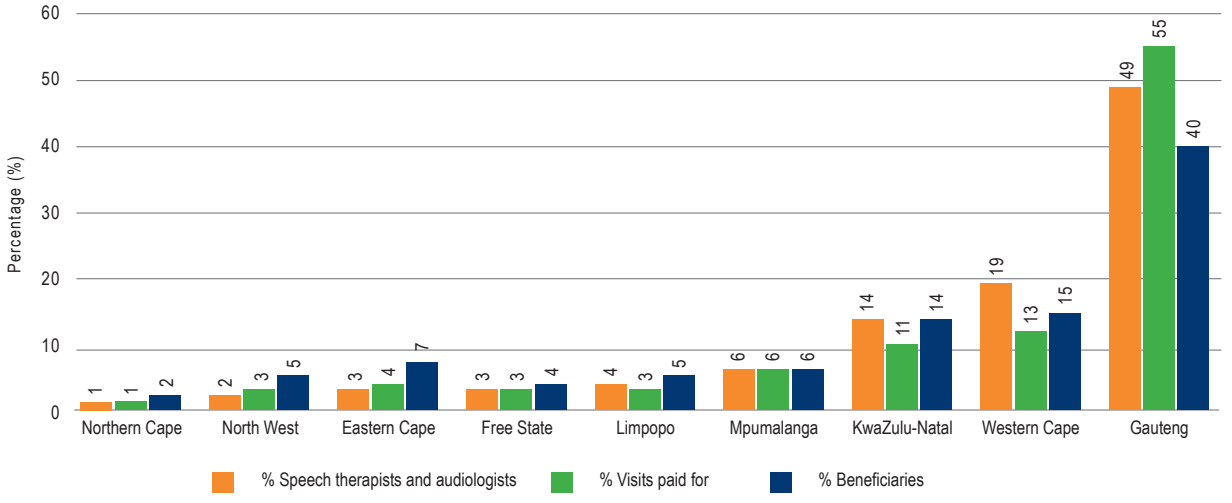


Speech and hearing services

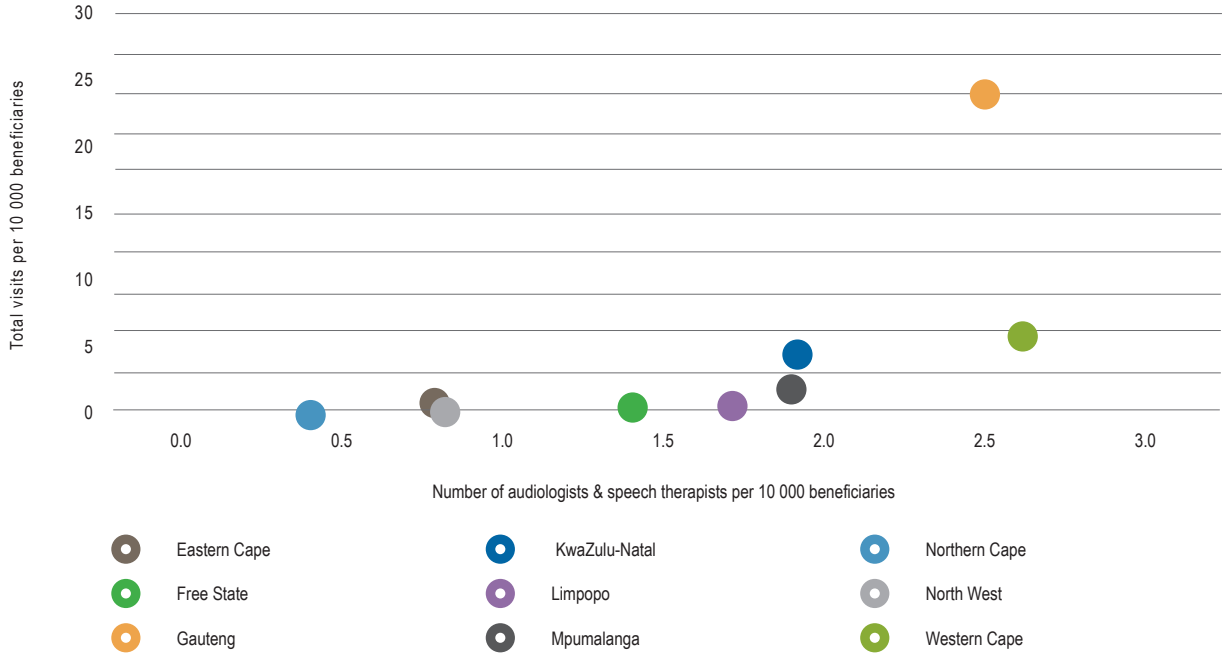
Figure 33 shows that the distribution of patient visits to audiologists and speech therapists is relatively higher than that of available providers and medical scheme beneficiaries. The utilisation per 10 000 beneficiaries is far greater in Gauteng than the other provinces. Western Cape is the only provinces with more providers per 10 000 beneficiaries than Gauteng.

Figure 33: Access and utilisation of audiologists and speech therapists

Panel 1: Relative distribution of Audiologists and Speech Therapists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits & Audiology & Speech Therapists per 10 000 beneficiaries by Province (2016)

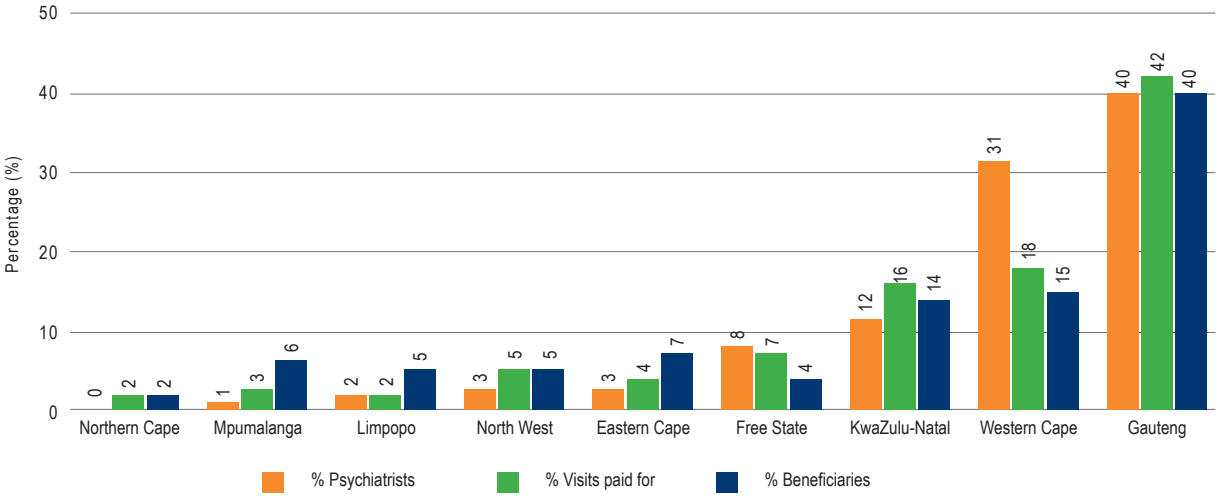


Mental health services

The NHI will prioritise access to mental health services in its initial implementation phases. Figures 34 and 35 describe access and utilisation of mental health services in the private healthcare sector. Both figures describe similar patterns associated with psychiatrists and psychologists.

Figure 34: Access and utilisation of psychiatrists (2016)

Panel 1: Relative distribution of Psychiatrists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Psychiatrists per 10 000 beneficiaries by Province (2016)

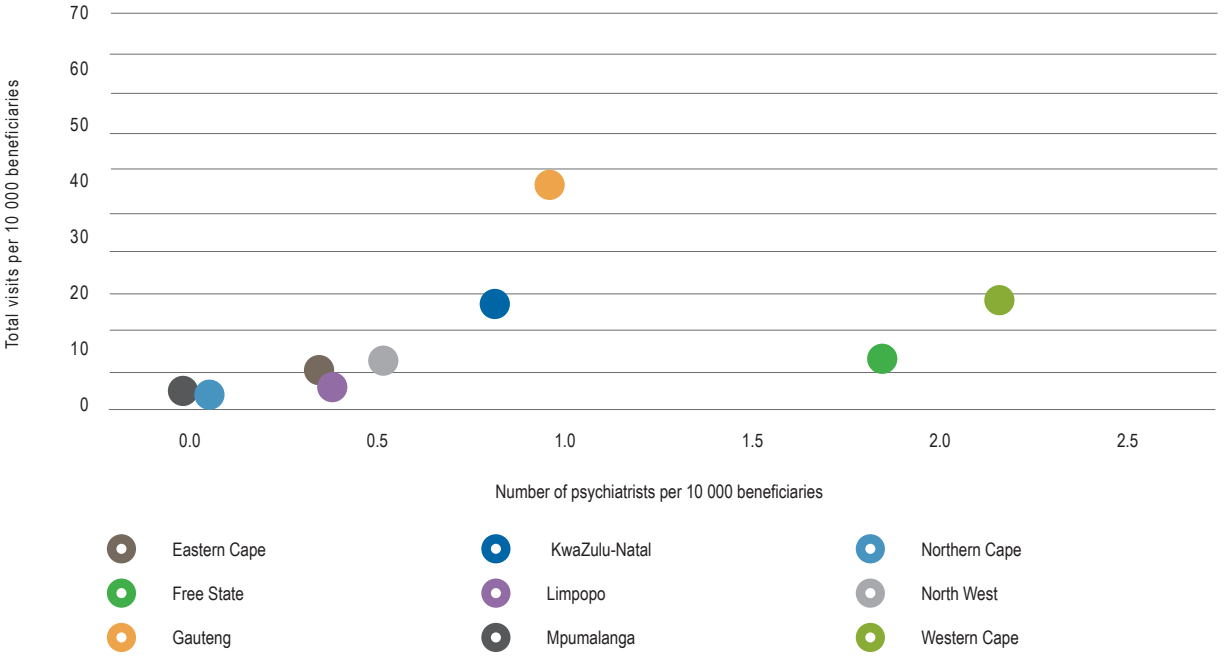
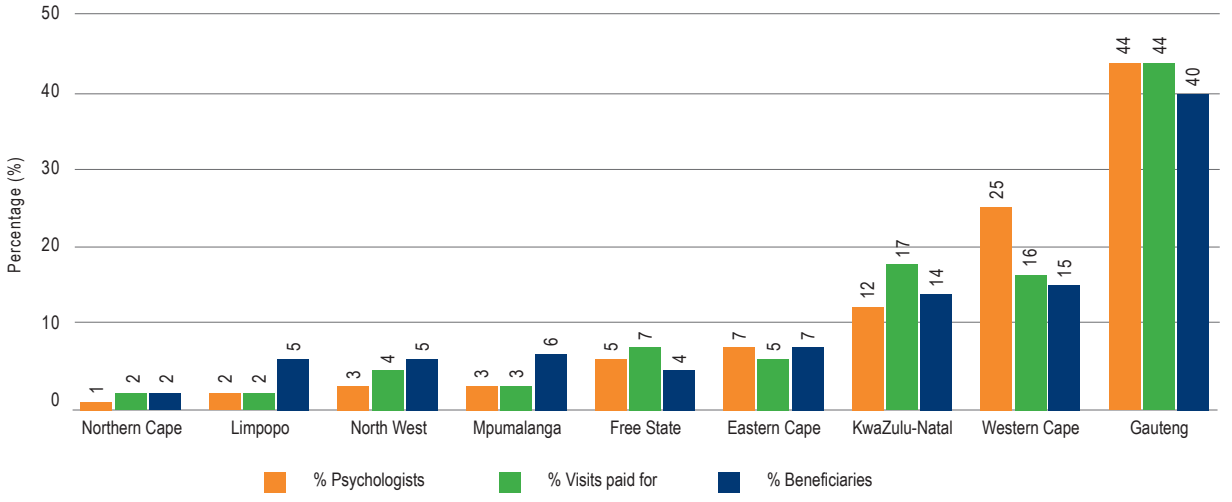
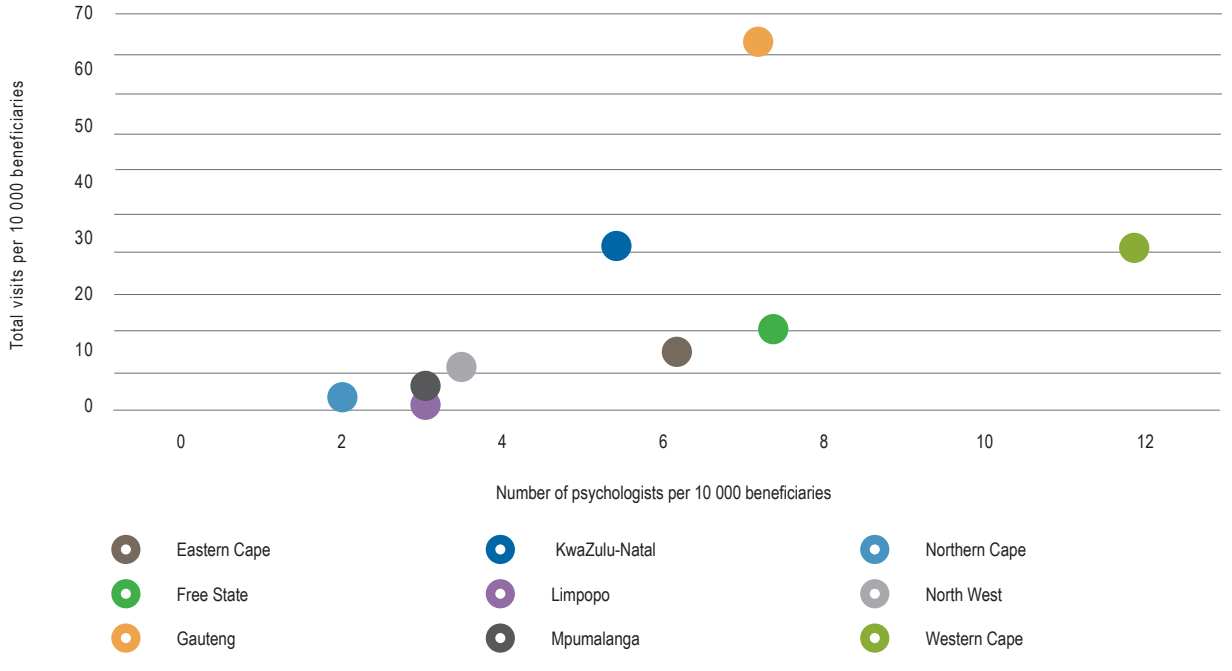


Figure 35: Access and utilisation of psychologists (2016)

Panel 1: Relative distribution of Psychologists , Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits and Psychologists per 10 000 beneficiaries by Province (2016)

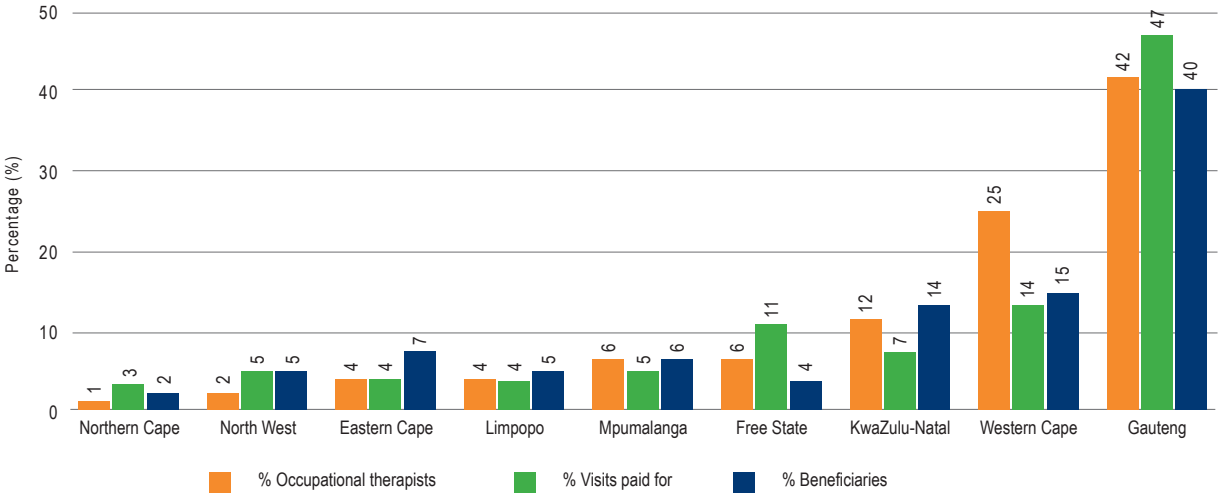


Rehabilitative care

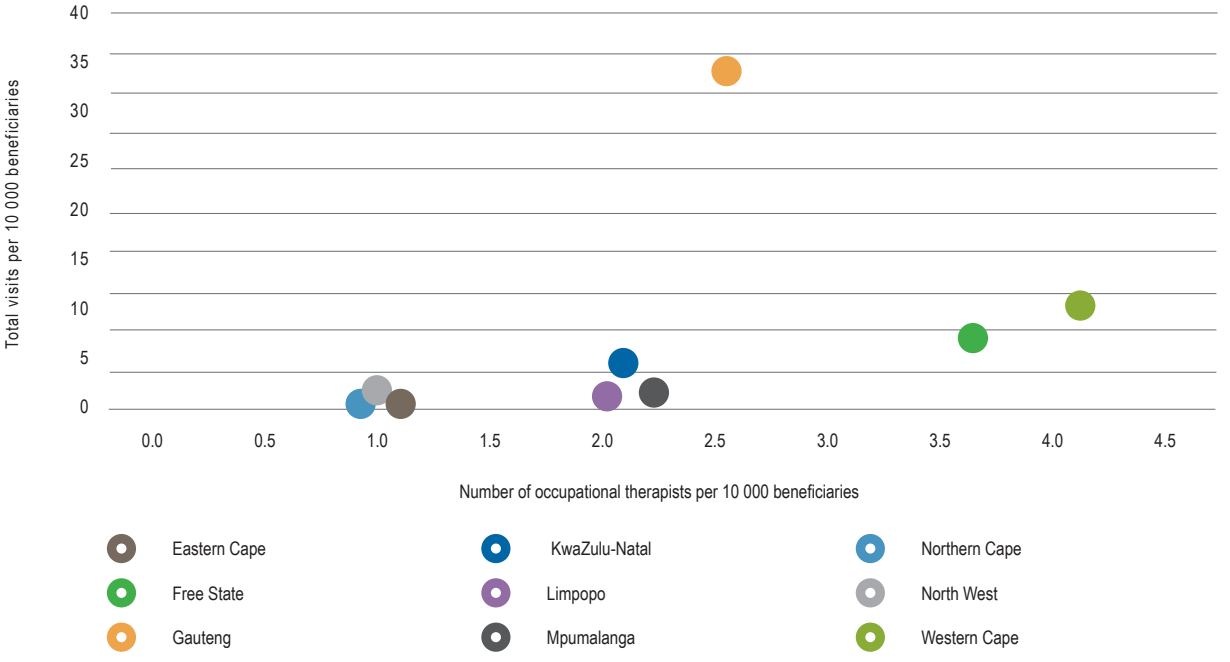
Figure 36 shows that the number of occupational therapists per 10 000 beneficiaries is highest in the Western Cape, followed by the Free State and Gauteng.

Figure 36: Access and utilisation of occupational therapists (2016)

Panel 1: Relative distribution of Occupational Therapists , Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits & Occupational therapists per 10 000 beneficiaries by Province (2016)

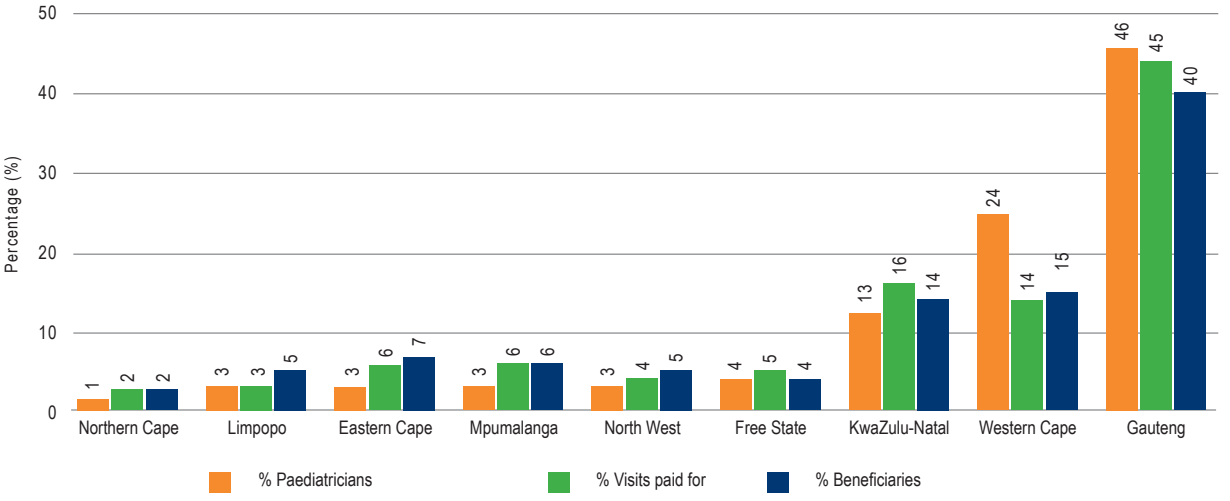


Paediatric and child services

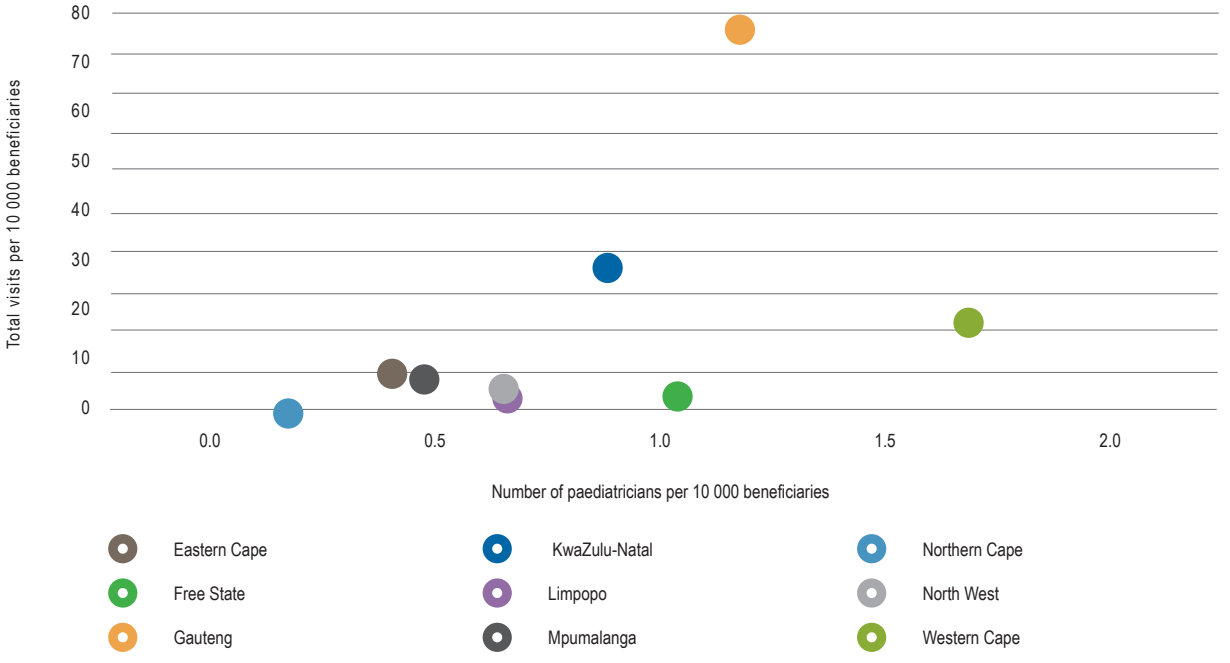
Access to healthcare services for children is also a priority area for NHI. Figure 37 describes the access and utilisation of paediatricians in the nine provinces.

Figure 37: Access and utilisation of paediatricians

Panel 1: Relative distribution of Paediatricians, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits & Paediatricians per 10 000 beneficiaries by Province (2016)

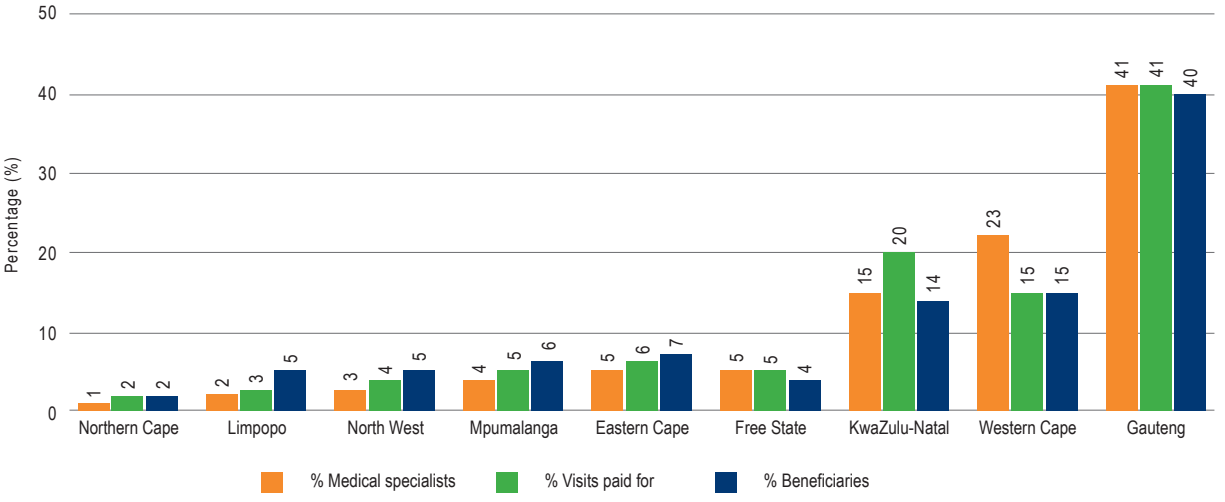


Medical and surgical specialist healthcare services

The NHI will contract private healthcare providers in the secondary level of healthcare services during the latter stages of implementing NHI. Figure 38 describes the access and utilisation of medical specialists in the private healthcare sector. Figure 39 describes the scenario for surgical specialists.

Figure 38: Access and utilisation of medical specialists (2016)

Panel 1: Relative distribution of Medical Specialists , Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits & Medical Specialists per 10 000 beneficiaries by Province (2016)

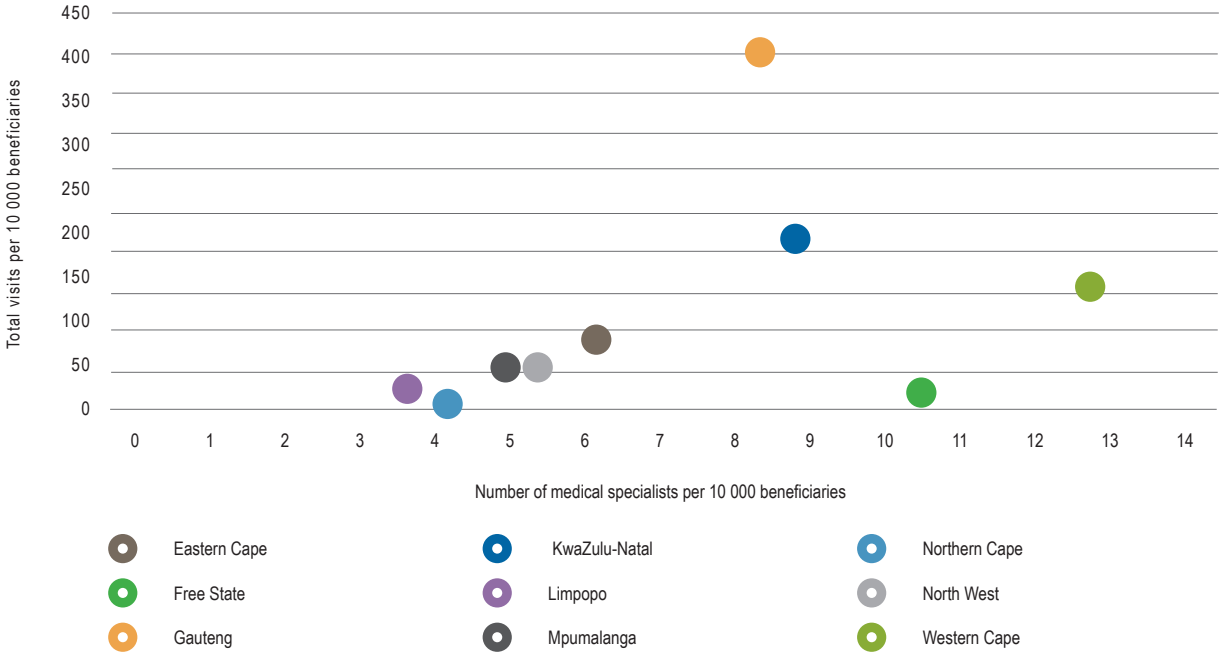
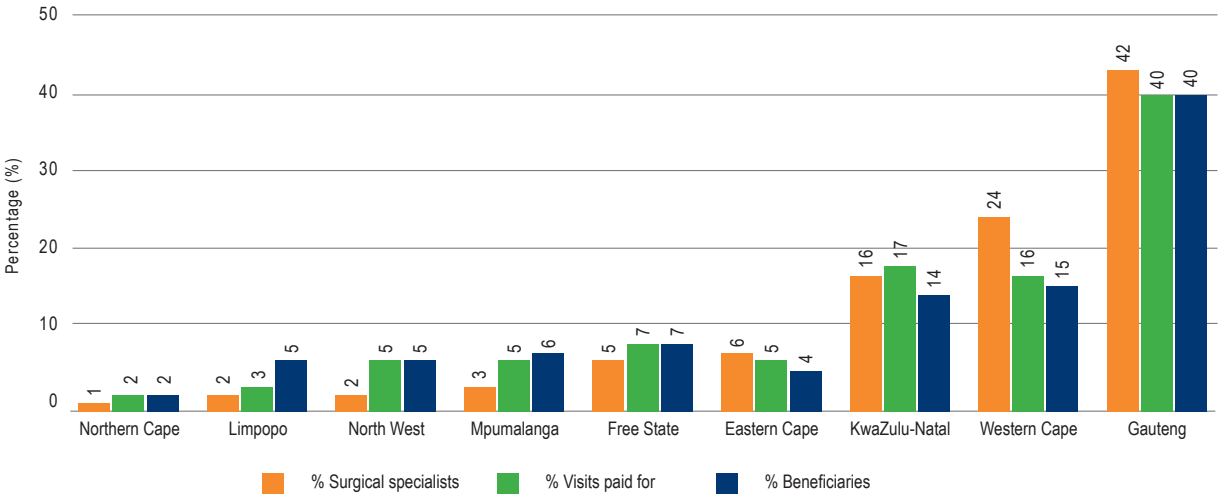
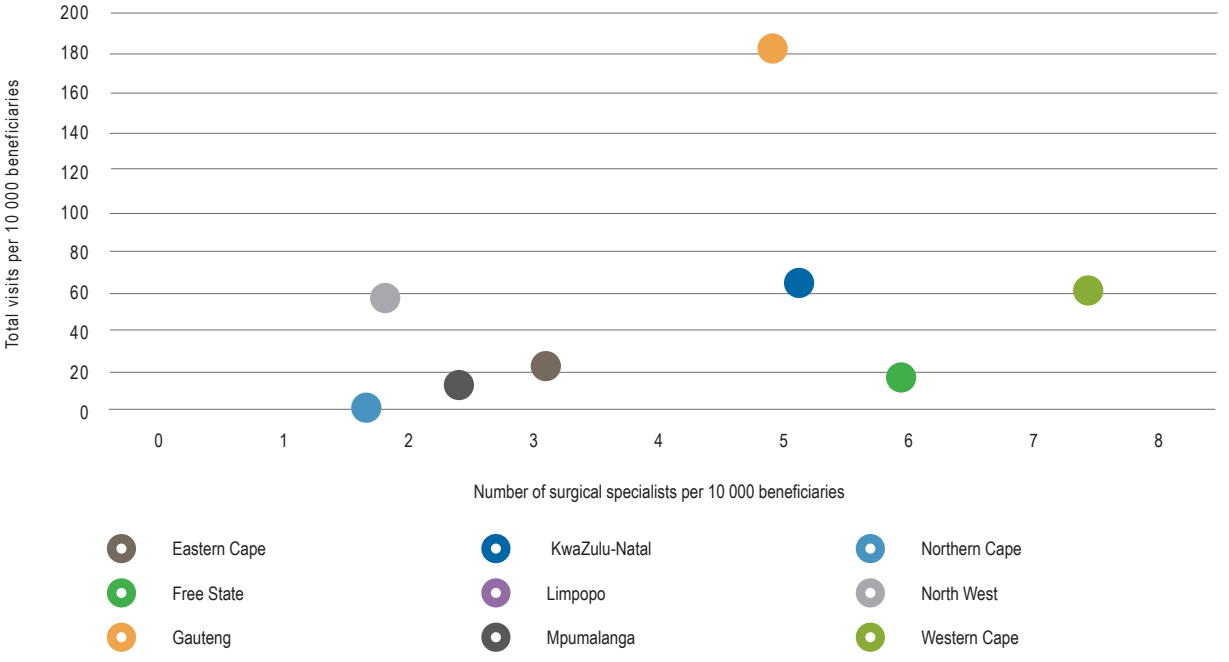


Figure 39: Access and utilisation of surgical specialists (2016)

Panel 1: Relative distribution of Surgical Specialists, Patient visits and beneficiaries by Province (2016)



Panel 2: Scatter Plot Diagram – Patient Visits & Surgical Specialists per 10 000 beneficiaries by Province (2016)



The global picture

The global level of density ratios for physicians is 12 physicians per 10 000 beneficiaries. Figures in Brazil and China are higher than this benchmark. South Africa, like some other BRICS countries, has a figure lower than the global level.

Table 17: Global comparison of physicians per 10 000 population

Domaine	Physicians per 10 000 population
Global	**12.3**
Upper middle income countries	Not available
BRICS:	
Brazil	18.5
Russia	Not available
India	7.3
China	14.9
South Africa	7.7
Africa	**2.4**

Source: Universal Health Coverage data Portal (WHO)

Significant observations

The relative distribution of providers, health visits and beneficiaries is the highest in Gauteng, followed by the Western Cape. Mpumalanga, Northern Cape, West Cape and Limpopo consistently have lower proportions.

There is a consistent pattern in the levels of healthcare demand (visits per 10 000 beneficiaries), relative to the supply of healthcare providers (density ratios). The level of healthcare provider demand is significantly higher in Gauteng than the other provinces. That said; some provinces may have higher levels of healthcare providers, yet much lower utilisation demand. These provinces are KwaZulu-Natal, Free-State and Western Cape. Mpumalanga, Northern Cape, Limpopo and North West, have relatively lower utilisation.

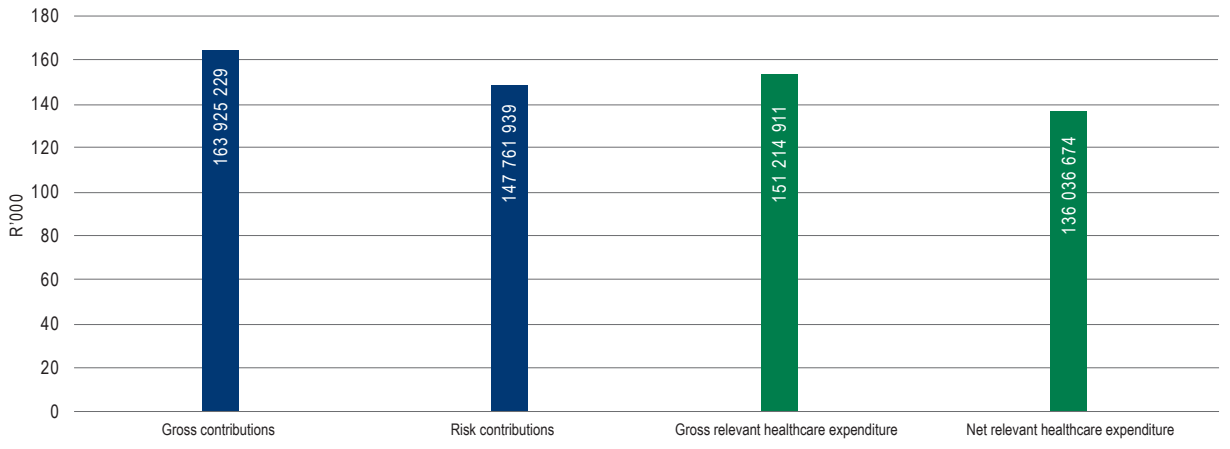
All these trends may be more associated with the size of beneficiaries per province than healthcare demand. In some provinces, this phenomenon may be linked to the inequalities across the respective provinces. In the latter case, greater effort in engaging the private sector may be required.

The level of physician density ratios at national level is relatively lower compared to the global level. The level of physicians in the public sector may have contributed to pulling the physician density ratio down. The private sector could augment health resource capacity, for rolling-out NHI. The White Paper on the NHI recommends engagement with the private sector for implementing the NHI.

Contributions, relevant healthcare expenditure and trends

All references to claims and benefits indicate relevant healthcare expenditure.

Figure 40a: Contributions, relevant healthcare expenditure and trends



Contributions

The figure below shows total contributions collected from members, before (gross) and after savings (risk).

Gross contributions increased by 8.1% to R163.9 billion as at December 2016, from R151.6 billion in December 2015. Risk contributions (excluding medical savings accounts contributions) increased by 8.1% to R147.8 billion from R136.7 billion in 2015. The equivalent increase from 2014 to 2015 was 7.7%.

Figure 40b: Gross contributions 2016

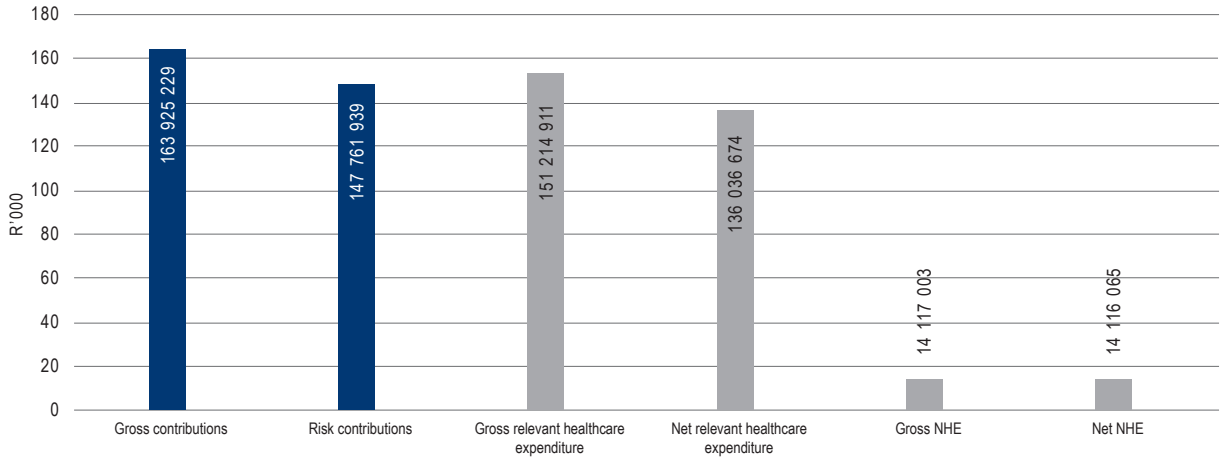
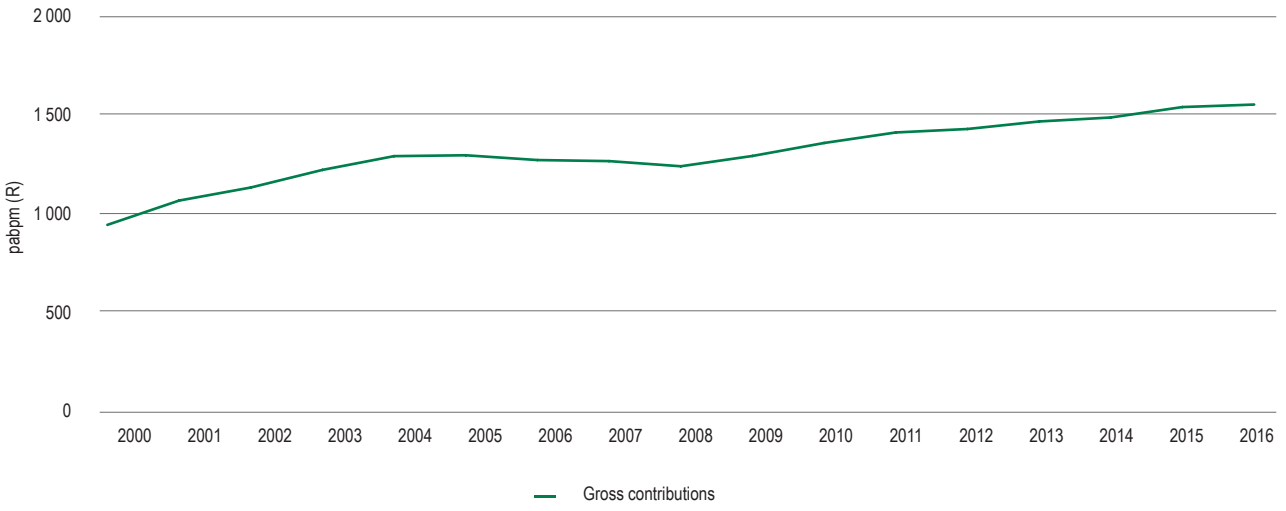


Figure 41: Gross contributions per average beneficiary per month 2000 – 2016 (2016 prices)



Gross contributions per average beneficiary per month (pabpm), adjusted for inflation using 2016 prices, have increased by 64.9% between 2000 and 2016, while gross relevant healthcare expenditure increased by 70.5%, as can be seen in Figure 42.

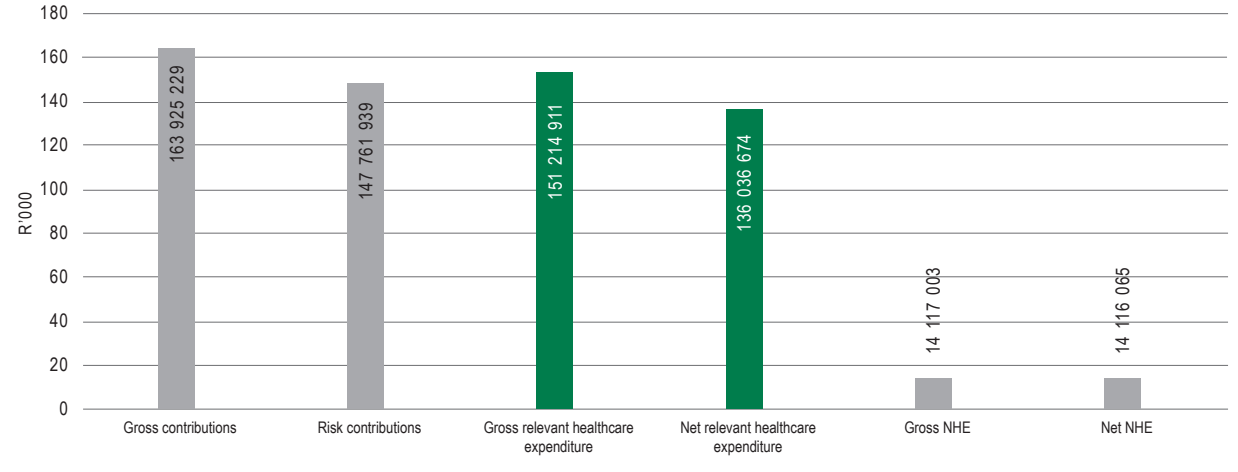
Investment income and reserves have somewhat assisted the industry to cover increasing healthcare costs, maintain reserves and retain members. Factors such as increasing healthcare inflation as well as utilisation have also had an impact on the affordability of medical schemes.

Gross contributions pabpm rose by 7.2% to R1 543.2 from R1 439.8 in 2015. After adjusting for inflation, this growth was 0.8%.

The increase in risk contributions pabpm was 7.1%, rising to R1 391.1 from R1 298.5. The 2015 increase was 7.9%.

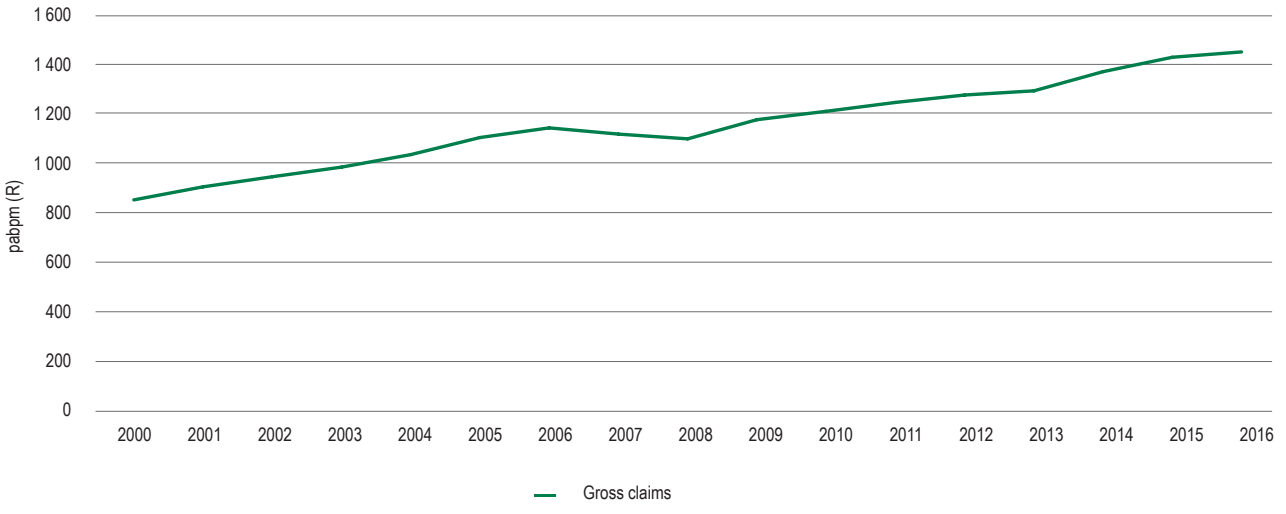
Contributions to medical savings accounts increased by 8.6% to R16.2 billion from R14.9 billion (12.1% increase in 2015). When measured on a pabpm basis in respect of only those schemes which use medical savings accounts, the increase was 7.3%, from R165.2 to R177.3. The increase in 2015 was 9.8%.

Figure 42: Relevant healthcare expenditure 2016



The total gross relevant healthcare expenditure incurred by medical schemes increased by 8.9% to R151.2 billion from R138.9 billion in 2015. Please note that this figure differs from the R136.0 billion reported as benefits paid, due to the inclusion of IBNR and the results of risk transfer arrangements. Risk claims increased by 8.9% to R136.0 billion from R124.9 billion in 2015.

Figure 43: Gross relevant healthcare expenditure per average beneficiary per month 2000 – 2016 (2016 prices)



The total gross relevant healthcare expenditure incurred pabpm increased by 7.9% to R1 423.6 from R1 319.1 in 2015. Risk claims pabpm rose by 7.9% to R1 280.7 from R1 186.5.

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.

Figures 44 and 45 show medical schemes that had the highest increases in claims ratio, from 2015 to 2016.

Figure 44: Open schemes with a claims ratio increase of greater than 4%

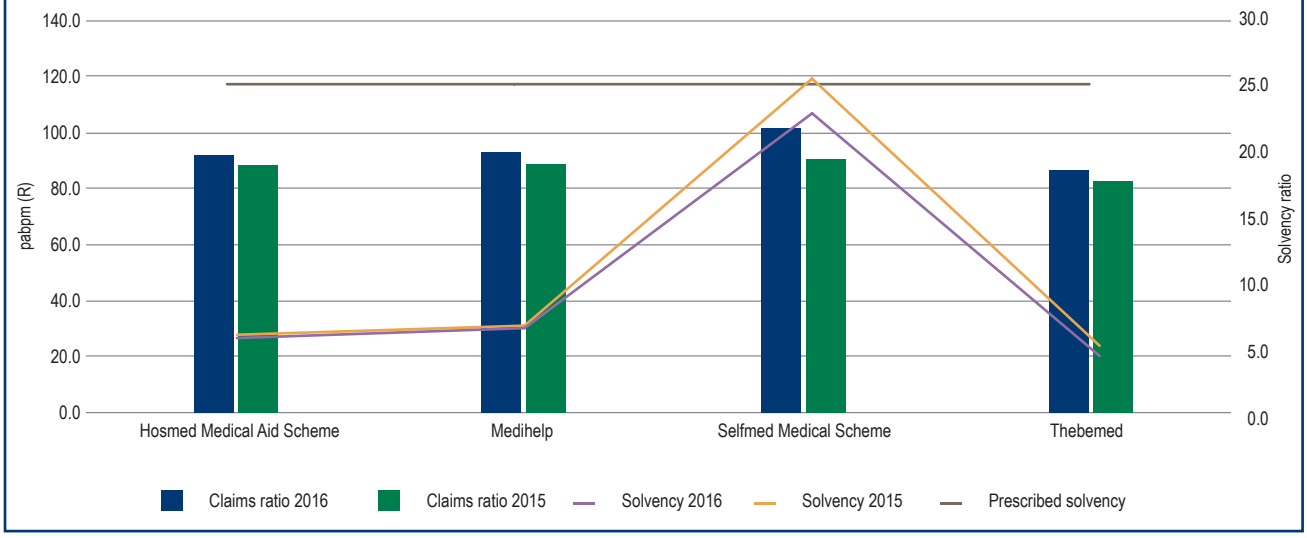
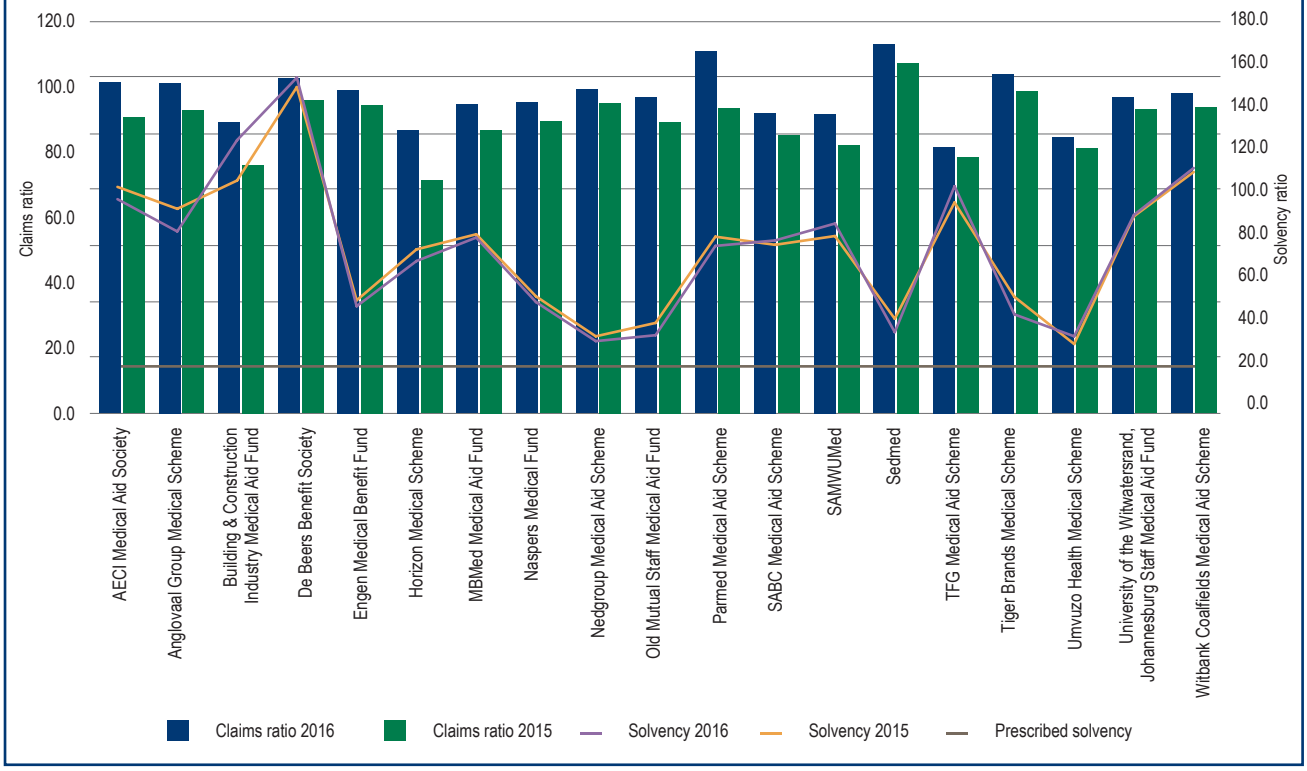


Figure 45: Restricted schemes with a claims ratio increase of greater than 4%



The majority of 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 18: Open scheme deviation from industry average 2015 and 2016

Ref.	Scheme name	% deviation from average of 89.3% 2016	% deviation from average of 88.7% 2015
1537	Hosmed Medical Aid Scheme	2.8%	-0.6%
1149	Medihelp	4.0%	-0.2%
1446	Selfmed Medical Scheme	13.5%	1.8%
1592	Thebemed	-3.4%	-7.1%

Table 18 shows the percentage deviation of the open schemes, with a claims ratio increase greater than 4% 2015 to 2016, from the industry average of 89.3% and 88.7% for 2016 and 2015 respectively.

Table 19: Restricted scheme deviation from industry average 2015 and 2016

Ref.	Scheme name	% deviation from average of 95.6% 2016	% deviation from average of 94.9% 2015
1005	AECI Medical Aid Society	6.1%	-4.3%
1571	Anglovaal Group Medical Scheme	6.0%	-2.2%
1590	Building & Construction Industry Medical Aid Fund	-6.8%	-19.8%
1068	De Beers Benefit Society	7.3%	1.1%
1572	Engen Medical Benefit Fund	3.8%	-0.3%
1566	Horizon Medical Scheme	-9.1%	-24.8%
1039	MBMed Medical Aid Fund	-0.8%	-8.4%
1241	Naspers Medical Fund	-0.3%	-5.7%
1469	Nedgroup Medical Aid Scheme	4.0%	0.3%
1214	Old Mutual Staff Medical Aid Fund	1.4%	-5.9%
1441	Parmed Medical Aid Scheme	16.0%	-1.4%
1424	SABC Medical Aid Scheme	-3.7%	-10.1%
1038	SAMWUMed	-4.0%	-13.5%
1531	Sedmed	18.3%	13.3%
1578	TFG Medical Aid Scheme	-14.5%	-17.4%
1544	Tiger Brands Medical Scheme	8.9%	4.2%
1597	Umvuzo Health Medical Scheme	-11.5%	-14.4%
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund	1.5%	-1.8%
1291	Witbank Coalfields Medical Aid Scheme	2.5%	-1.2%

Table 19 shows the percentage deviation of the restricted schemes, with a claims ratio increase of 4% and more from 2015 to 2016, from the industry average of 95.6% and 94.9% for 2016 and 2015 respectively.

Claims paid from medical savings accounts increased by 8.7% to R15.2 billion from R14.0 billion (13.4% increase in 2015). On a pabpm basis for schemes which offer medical savings accounts, medical savings accounts claims increased by 6.5% to R215.6 from R202.4 (15.1% increase in 2015). The higher increase, together with the increases in contributions to savings accounts, seem to suggest a move towards benefit designs which requires a greater proportion of benefits to be funded out of members' personal medical savings accounts rather than from the general risk pool of their scheme.

Relationship between contributions and relevant healthcare expenditure from risk pool and savings

Table 20 and Figures 46 and 47 show contributions and claims for open and restricted schemes pabpm.

Table 20: Contributions and relevant healthcare expenditure pabpm 2000 – 2016

	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	1 403.0	6.6	226.3	6.4	1 252.9	7.4	215.6	6.5
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	7.8	90.9	12.4	1 316.0	8.6	80.0	12.8

pabpm = per average beneficiary per month
pasbpm = pabpm in respect of those schemes that had savings contributions

Figure 46: Risk and savings contributions pabpm: 2000 – 2016

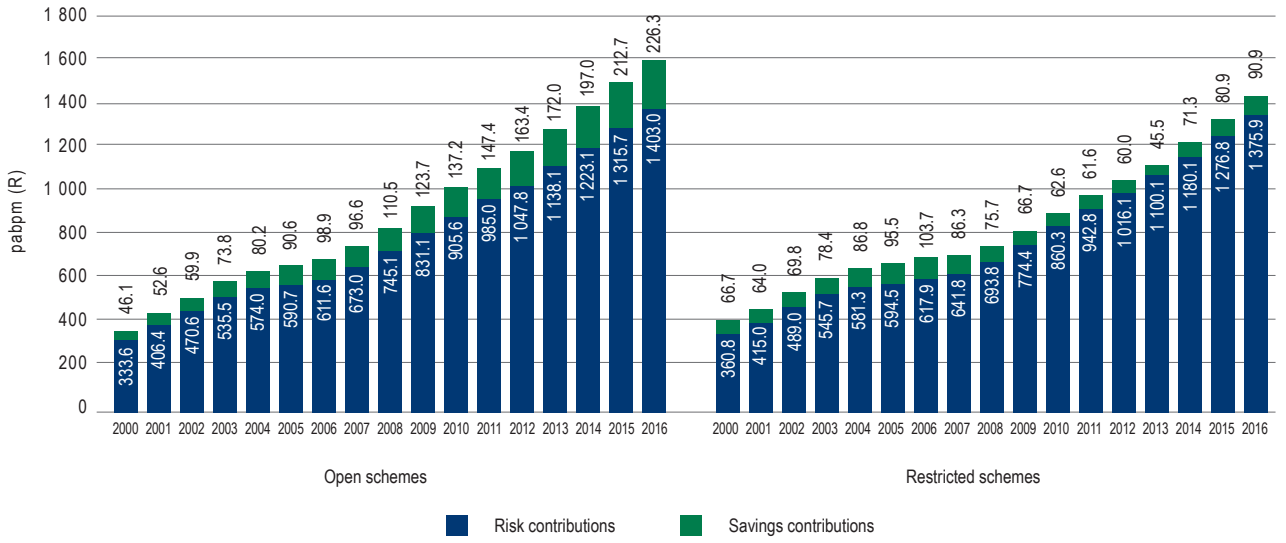
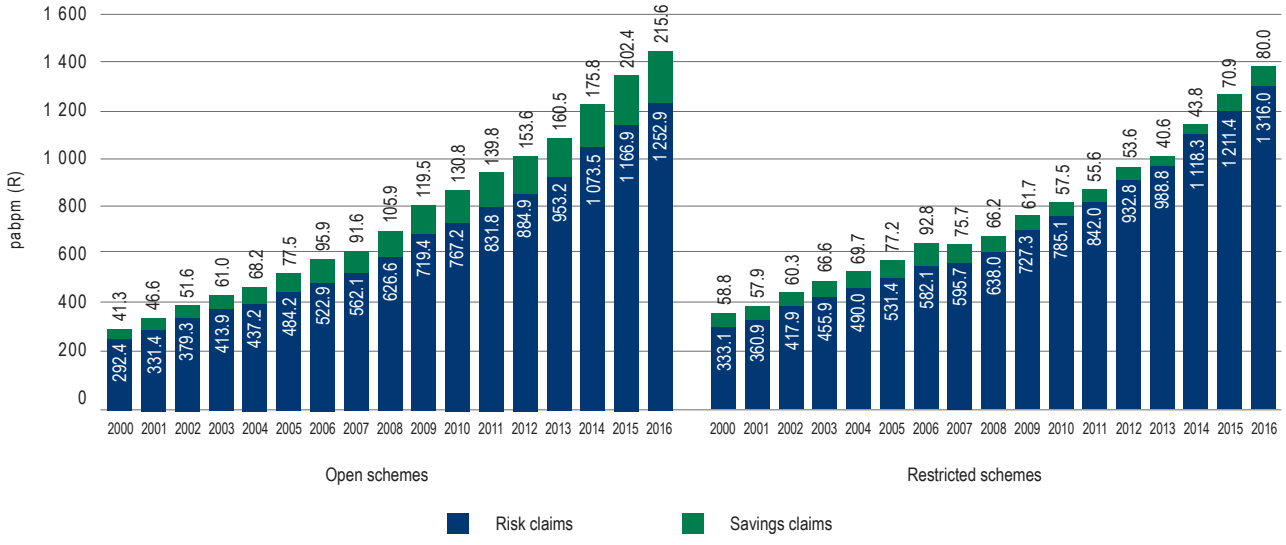


Figure 47: Risk and savings claims pabpm: 2000 – 2016



pabpm = per average beneficiary per month

On average, increases in risk contributions and claims pabpm were slightly lower in restricted schemes than in open schemes over the last 16 years. This is partly because restricted schemes generally have higher reserve levels compared to open schemes, thus availing resources for cushioning of increasing healthcare costs. The risk claims ratio in open schemes increased to 89.3% in 2016 from 88.7% in 2015; in restricted schemes it increased to 95.6% from 94.9% in 2015.

Figure 48: Risk and medical savings account contributions and claims pabpm: 2000 – 2016

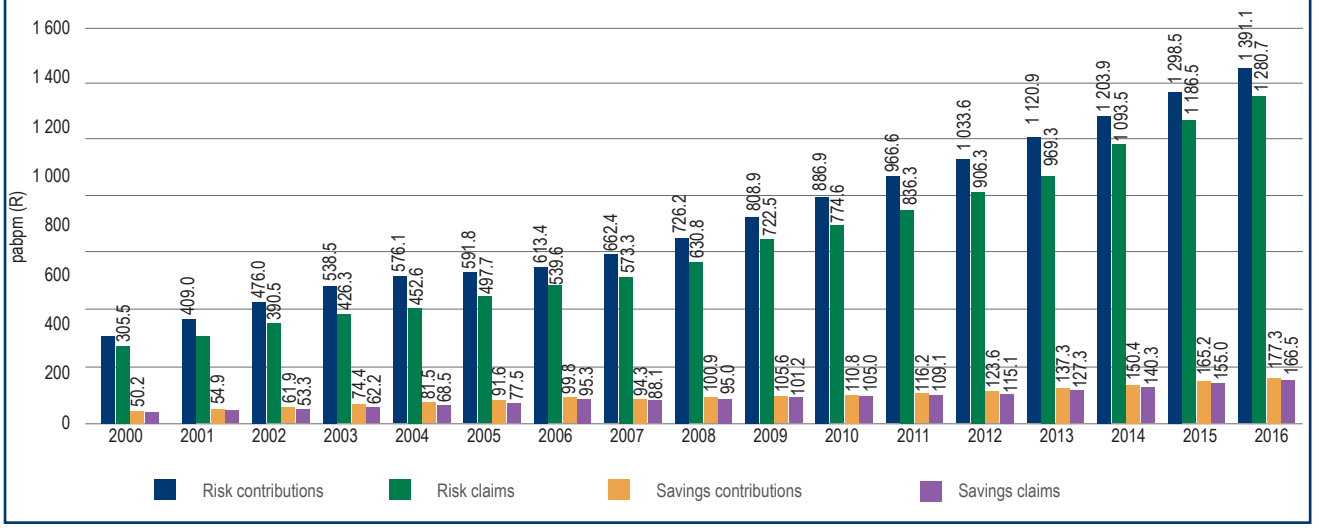


Figure 48 and Table 21 show that between 2003 and 2006 medical savings accounts contributions and claims increased at greater rates than those recorded for the risk components.

But the figures for the period 2007 to 2013 appear to reflect a change in this trend. In 2000, savings contributions made up 12.8% of gross contributions. At the end of 2013, savings had declined to 9.3% of gross contributions. The decrease is partly attributable to a decision taken 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.

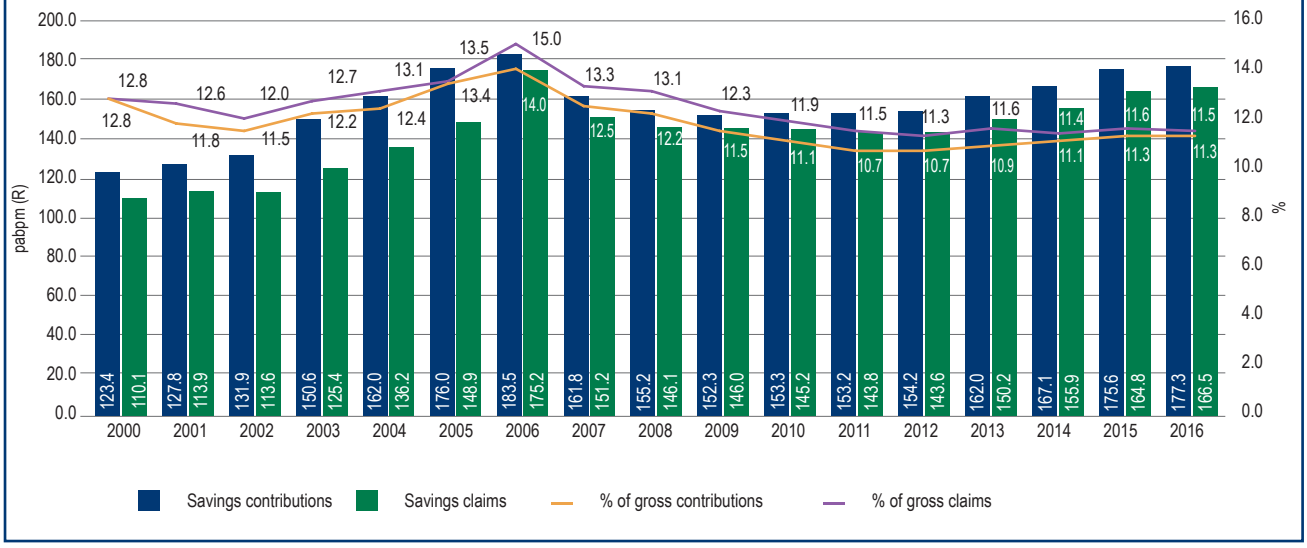
The subsequently higher increases in the savings components are partly due to a number of schemes introducing savings on existing options, and is indicative of a move towards benefit designs which require a greater proportion of benefits to be funded out of members' personal savings accounts than from the general risk pool of the scheme.

Table 21: Contributions and relevant healthcare expenditure per average beneficiary per month 2000 – 2016 (2016 prices)

	Risk contributions		Savings contributions		Risk claims		Savings claims	
	pabpm R	% change	pasbpm R	% change	pabpm R	% change	pasbpm R	% change
2000	841.1		123.4		750.7		110.1	
2001	952.4	13.2	127.8	3.6	792.4	5.6	113.9	3.5
2002	1 014.2	6.5	131.9	3.2	832.0	5.0	113.6	-0.3
2003	1 085.9	7.1	150.6	14.2	859.6	3.3	125.4	10.4
2004	1 145.2	5.5	162.0	7.6	899.7	4.7	136.2	8.6
2005	1 137.1	-0.7	176.0	8.6	956.3	6.3	148.9	9.3
2006	1 127.6	-0.8	183.5	4.3	992.0	3.7	175.2	17.7
2007	1 136.5	0.8	161.8	-11.8	983.7	-0.8	151.2	-13.7
2008	1 116.7	-1.7	155.2	-4.1	970.0	-1.4	146.1	-3.4
2009	1 166.8	4.5	152.3	-1.9	1 042.2	7.4	146.0	-0.1
2010	1 226.9	5.2	153.3	0.7	1 071.5	2.8	145.2	-0.5
2011	1 274.0	3.8	153.2	-0.1	1 102.3	2.9	143.8	-1.0
2012	1 289.4	1.2	154.2	0.7	1 130.6	2.6	143.6	-0.1
2013	1 322.4	2.6	162.0	5.1	1 143.5	1.1	150.2	4.6
2014	1 338.0	1.2	167.1	3.1	1 215.3	6.3	155.9	3.8
2015	1 380.4	3.2	175.6	5.1	1 261.3	3.8	164.8	5.7
2016	1 391.1	0.8	177.3	1.0	1 280.7	1.5	166.5	1.0

pasbpm = pabpm in respect of schemes which had savings transactions

Figure 49: Medical savings accounts contributions and claims pabpm: 2004 – 2016 (2016 prices)



pabpm = per average beneficiary per month

The proportion of claims paid from medical savings accounts as a percentage of gross healthcare expenditure increased to 11.6% in 2015 but decreased slightly to 11.5% in 2016, as shown in Figure 49.

For open schemes, the proportion of claims paid from medical savings accounts decreased from 14.8% in 2015 to 14.7% in 2016; the medical savings accounts claims ratio increased to 95.3% from 95.2% in 2015.

For restricted schemes, the proportion of claims paid from medical savings accounts increased from 5.5% in 2015 to 5.7% in 2016. The medical savings accounts claims ratio increased to 88.5% from 87.6% in 2015.

Figure 50 shows the use of medical savings accounts in the benefit designs of medical schemes since 2000. When adjusted for inflation, risk contributions and claims have increased by 65.4% and 70.6% respectively on a pabpm basis; medical savings account contributions and claims have risen by 43.7% and 51.2% respectively.

Figure 50: Risk and medical savings accounts contributions and claims pabpm: 2000 – 2016 (2016 prices)

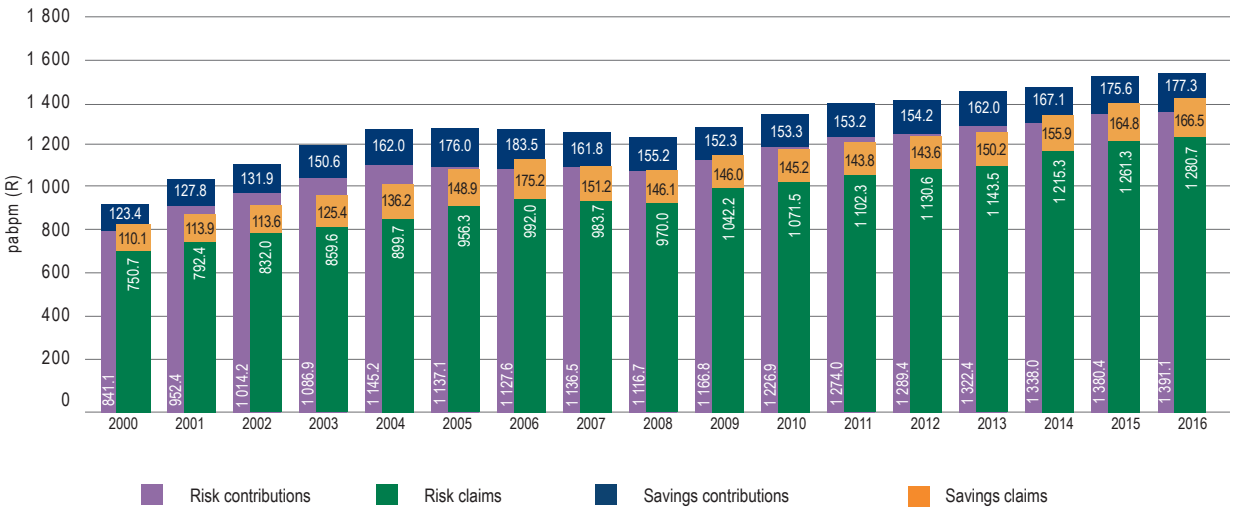
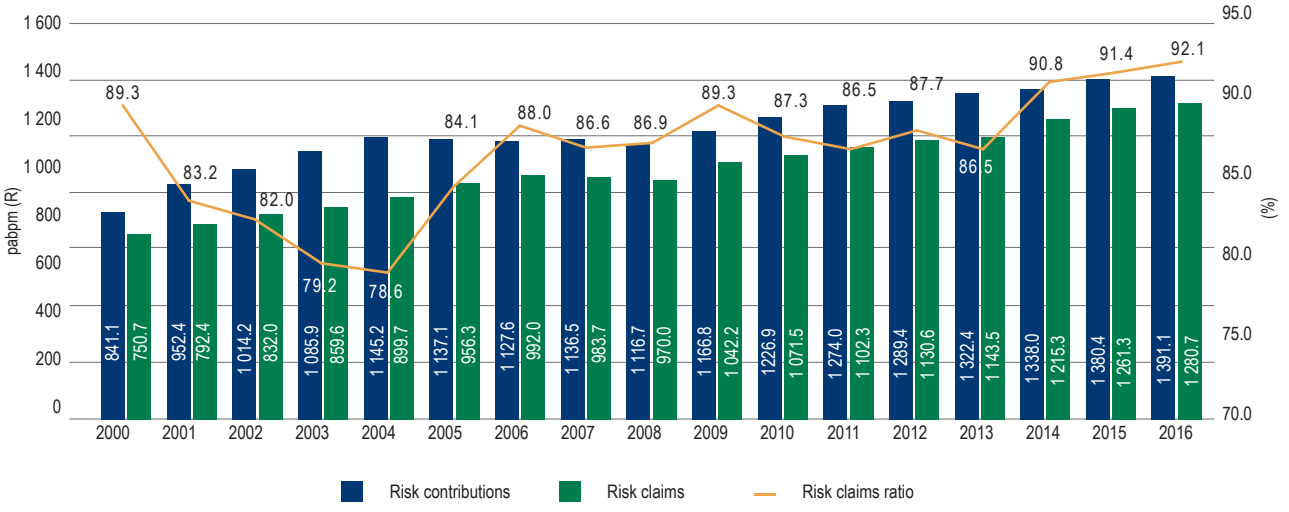


Figure 51 shows the relationship between risk contributions and claims paid over the past decade. All figures have been adjusted for inflation.

Figure 51: Risk claims ratio for all schemes per average beneficiary per month 2000 – 2016 (2016 prices)



After an initial decline, the claims ratio increased to 88.0% in 2006 from 84.1% in 2005, and stabilised at 86.6% in 2007 and 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. There was a slight increase in 2012 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 has since risen again in 2014 to 90.8%, in 2015 to 91.4%, and in 2016 to 92.1%.

Figure 52: Seasonality of claims per month in 2016

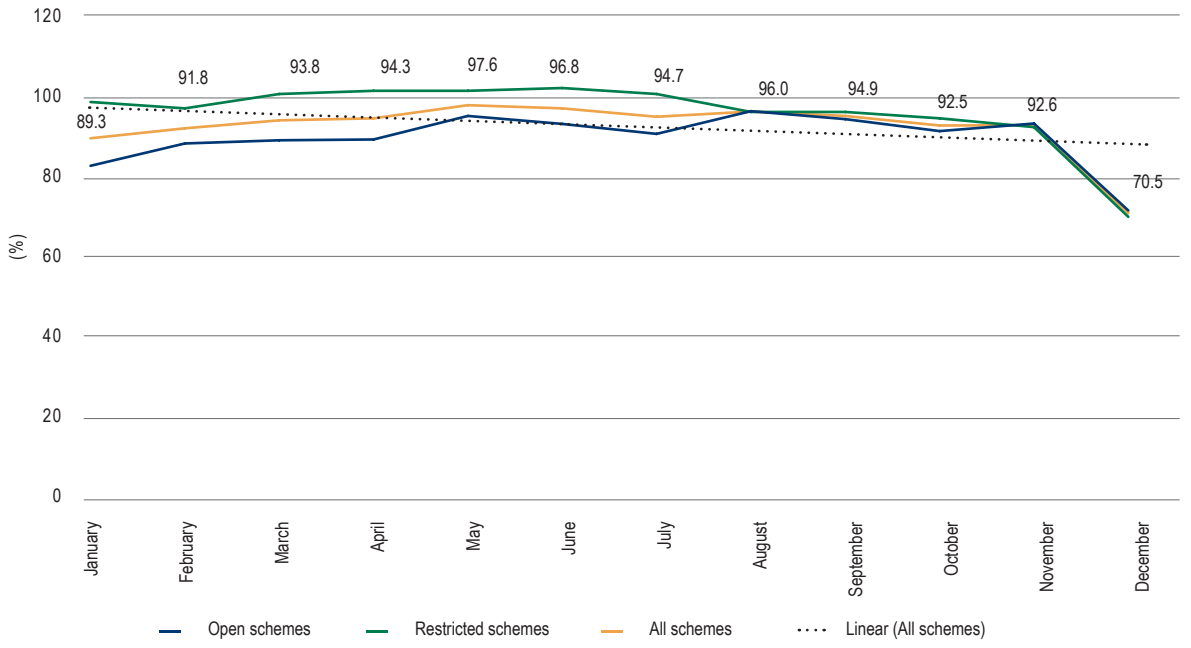


Figure 52 shows the seasonal pattern in monthly claims (as a percentage of monthly contributions) during 2016. Both open and restricted schemes follow the same general trend: an increase in claims in the first quarter of the year as members gain access to new benefits, increases in claims over the winter months, and a downward trend in the last quarter of the year.

Risk transfer arrangements

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

Table 22 reflects the main components of such arrangements: The capitation fees which schemes paid to third parties to manage their risks, the estimated costs which schemes would have incurred had they not used risk transfer arrangements, and the net effect thereof.

The net income/(expense) column in Table 22 reflects the value derived from the risk transfer arrangement. (Annexure Z provides further details.)

Table 22: Significant risk transfer arrangements 2015 and 2016

	Capitation fees			Estimated recoveries			Net income/(expense)*		
	2016 R'000	2015 R'000	% growth	2016 R'000	2015 R'000	% growth	2016 R'000	2015 R'000	% growth
Open schemes	2 095 581	2 035 516	3.0	1 852 388	1 805 918	2.6	(241 674)	(228 051)	-6.0
Restricted schemes	1 096 380	1 040 302	5.4	1 187 932	1 180 012	0.7	97 335	145 371	-33.0
All	**3 191 961**	**3 075 818**	**3.8**	**3 040 320**	**2 985 930**	**1.8**	**(144 339)**	**(82 680)**	**-74.6**

* *The net income/(expense) on risk transfer arrangements includes an amount of R7.3 million in respect of profit- and loss-sharing agreements.*

Table 23 lists the ten schemes which incurred the biggest losses in respect of their significant risk transfer arrangements, and Table 24 details the ten benefit options which reported the greatest losses.

Table 23: Schemes with highest risk transfer arrangement losses: 2016

Ref. no.	Name of medical scheme	Beneficiaries 31 Dec 2016	Capitation fees R'000	Estimated recoveries R'000	Net income/ (expense) R'000	Net income/ (expense) as % of capitation fees %
1512	Bonitas Medical Fund	753 514	774 585	614 134	(160 451)	-20.7
1486	Sizwe Medical Fund	122 938	65 010	10 825	(54 185)	-83.3
1167	Momentum Health	266 206	322 300	274 377	(50 154)	-15.6
1125	Discovery Health Medical Scheme	2 735 191	366 344	350 923	(15 421)	-4.2
1580	South African Police Service Medical Scheme (POLMED)	498 152	195 825	181 808	(14 017)	-7.2
1270	Golden Arrow Employees' Medical Benefit Fund	5 942	24 574	19 529	(4 876)	-19.8
1087	Keyhealth	75 038	74 391	69 876	(4 539)	-6.1
1039	MBMed Medical Aid Fund	9 764	9 939	6 125	(3 814)	-38.4
1575	Resolution Health Medical Scheme	35 317	7 724	3 994	(3 730)	-48.3
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	46 373	23 782	20 920	(2 862)	-12.0

Table 24: Options with highest risk transfer arrangement losses: 2016

Ref. No.	Name of medical scheme	Name of benefit option	Beneficiaries 31 Dec 2016	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 %
1512	Bonitas Medical Fund	Standard	307 443	33.5	491 103	400 260	–	(90 844)	-18.5
1167	Momentum Health	Custom	124 349	31.2	117 319	52 172	(895)	(66 042)	-56.3
1486	Sizwe Medical Fund	Gomomo Care Option	13 046	30.5	65 010	10 825	–	(54 185)	-83.3
1125	Discovery Health Medical Scheme	Classic Comprehensive	349 237	38.9	131 485	95 836	–	(35 649)	-27.1
1512	Bonitas Medical Fund	Primary	163 426	27.6	148 565	118 889	–	(29 676)	-20.0
1512	Bonitas Medical Fund	Bonsave	71 964	27.7	63 034	39 886	–	(23 149)	-36.7
1167	Momentum Health	Ingwe	46 245	27.1	91 817	79 945	(621)	(12 493)	-13.6
1580	South African Police Service Medical Scheme (POLMED)	Aquarium	142 639	21.8	32 985	23 094	–	(9 891)	-30.0
1512	Bonitas Medical Fund	Boncap	61 703	32.3	23 591	14 677	–	(8 914)	-37.8
1270	Golden Arrow Employees' Medical Benefit Fund	Standard	5 104	31.3	18 920	13 012	147	(5 761)	-30.4

Bonitas Medical Fund is listed in both Tables 23 and 24 as the biggest loss-maker.

The Sizwe Medical Fund Gomomo Care option suffered the biggest loss in terms of the percentage of capitation fees paid (83.3%) followed by the Custom option from Momentum Health (56.3%), as shown in Table 24.

Accredited managed healthcare services (no transfer of risk)

Accredited managed healthcare services increased by 7.8% to R3.8 billion in 2016 from R3.5 billion in 2015. In 2016, 8 768 950 beneficiaries (or 98.8% of beneficiaries) were covered by these managed healthcare arrangements.

Table 25: Accredited managed healthcare service fees (no transfer of risk) for options with a claims ratio above 100%: 2016

	Accredited managed healthcare services fees (no transfer of risk)		Risk claims		Beneficiaries	Number of options
	R'000	pmpm	R'000	% of RCI		
Open schemes	277 735	86.5	14 779 057	105.2	549 162	26
Restricted schemes	181 672	75.9	10 542 663	114.4	390 949	42
All schemes	**459 406**	**82.0**	**25 321 720**	**108.8**	**940 111**	**68**

pmpm = per member per month
RCI = risk contribution income

Table 26: Accredited managed healthcare services (no transfer of risk) of 10 largest schemes: 2016

Ref. no.	Name of medical scheme	Type	Average beneficiaries	Claims ratio	Accredited managed healthcare services as % of RCI
1125	Discovery Health Medical Scheme	Open	2 707 913	87.2	3.2
1598	Government Employees Medical Scheme (GEMS)	Restricted	1 801 999	96.6	2.3
1512	Bonitas Medical Fund	Open	676 785	92.1	2.9
1580	South African Police Service Medical Scheme (POLMED)	Restricted	497 129	97.0	1.7
1167	Momentum Health	Open	257 371	88.1	2.7
1279	Bankmed	Restricted	214 305	96.5	2.8
1252	Bestmed Medical Scheme	Open	200 400	88.0	2.6
1149	Medihelp	Open	195 858	92.9	1.9
1140	Medshield Medical Scheme	Open	153 415	94.8	1.7
1145	LA-Health Medical Scheme	Restricted	147 778	82.9	2.3

RCI = Risk Contribution Income

Table 26 depicts the 10 largest schemes by number of average beneficiaries and shows their total expenditure on accredited managed healthcare services. The industry average was 2.6% of risk contribution income.

Non-healthcare expenditure

The total gross non-healthcare expenditure for all medical schemes at the end of 2016 was reported at R14.1 billion, an increase of 8.5% from R13.0 billion in 2015. The net non-healthcare expenditure increased by 8.5% from 2015.

Figure 53: Gross non-healthcare expenditure 2016

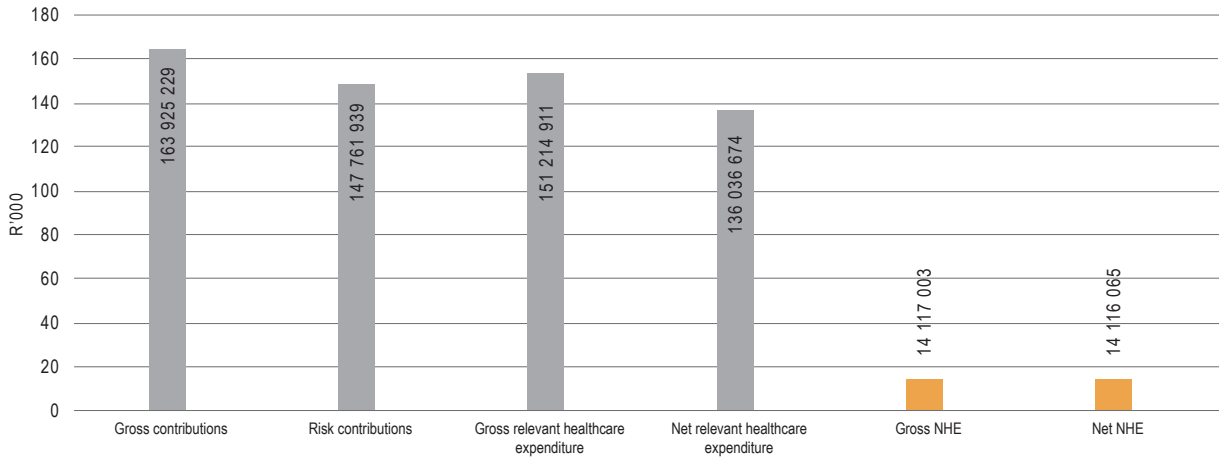
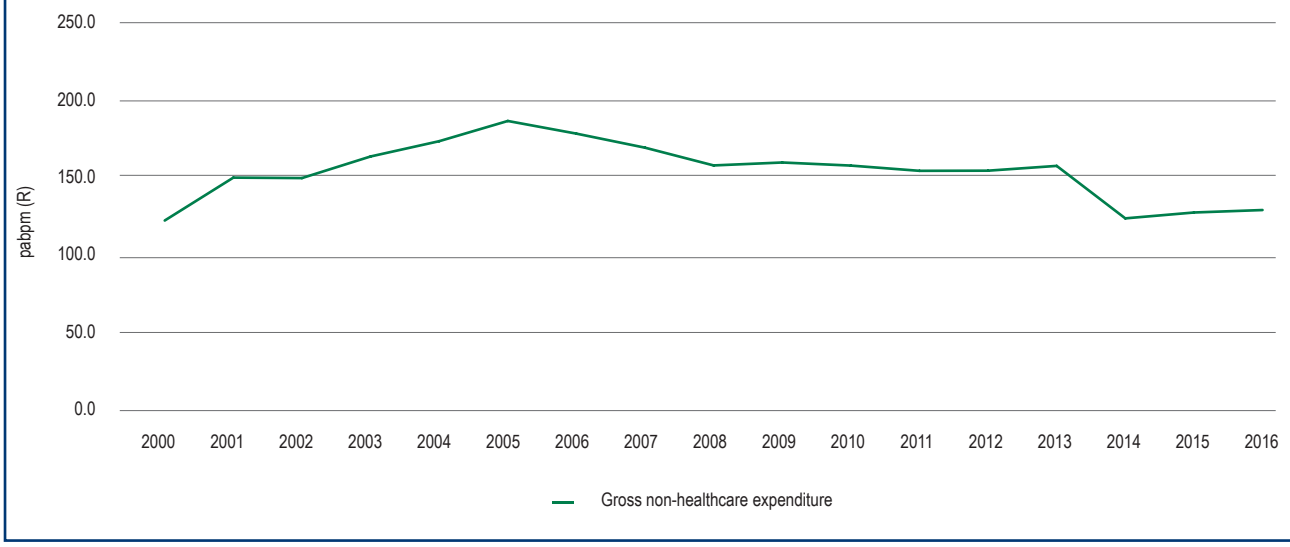


Figure 54: Gross non-healthcare expenditure: 2016 prices



pabpm = per average beneficiary per month

The non-healthcare expenditure of medical schemes consists mainly of administration expenditure, commissions and service fees paid to brokers, other distribution costs and impaired receivables.

Affordability of medical schemes has increasingly become an important consideration in the private healthcare sector. When medical schemes determine premiums, 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.

The rate of increase in non-healthcare expenditure has decreased substantially between 2000 and 2016, 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.

Non-healthcare expenditure has in fact reduced in real terms over the period. There are, however, still individual schemes and particular non-healthcare items (such as advertising and marketing, consulting and legal fees, and trustee remuneration) that continue to show upward trends and thus require attention. In recent years, the remuneration of trustees and Principal Officers of medical schemes, has come under the spotlight, with increases being significantly higher than inflation, as well as the expenditure on Annual General Meeting costs. In the interest of members' protection, it is important that such expenditure is associated with a discernible value proposition.

Administration expenditure

Administration expenditure, being the largest component of non-healthcare expenditure in all medical schemes, grew by 8.1% to R11.9 billion between December 2015 (when it stood at R11.0 billion) and December 2016. Open schemes increased their administration expenditure by 5.8% to R7.9 billion from R7.4 billion in 2015. Administration expenditure in restricted schemes increased by 12.8% from R3.6 billion in 2015 to R4.0 billion in 2016.

Eight open schemes (representing 5.4% of all average beneficiaries) and eight restricted schemes (representing 4.6% of all average beneficiaries) had an overall administration expenditure greater than 10.0% of gross contribution income (GCI) in 2016.

Tables 27 and 28 show the ten open and restricted schemes respectively, with the highest administration expenditure pabpm.

A high cost per life is sometimes the function of a low average of beneficiaries rather than high absolute administration costs. Schemes need to be operating with a certain number of lives in order for the average operational costs to be lower and make the business more profitable and sustainable in the long term.

Table 27: Ten open schemes with the highest administration expenditure above industry average of R132.4 pabpm (2016)

Ref. No.	Type	Name of scheme	Name of administrator	Average number of beneficiaries	GAE R'000	GAE pabpm	GAE % of GCI
1141	Open	Spectramed	Agility Health (Pty) Ltd	27 599	74 395	224.6	11.3
1446	Open	Selfmed Medical Scheme	Self-Administered	13 896	34 050	204.2	11.3
1202	Open	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	144 167	290 996	168.2	9.3
1486	Open	Sizwe Medical Fund	Sechaba Medical Solutions (Pty) Ltd	121 692	245 414	168.1	10.7
1575	Open	Resolution Health Medical Scheme	Agility Health (Pty) Ltd	37 546	75 572	167.7	10.3
1087	Open	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	75 506	146 041	161.2	7.3
1464	Open	Suremed Health	Providence Healthcare Risk Managers (Pty) Ltd	2 772	5 314	159.8	9.8
1491	Open	Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	26 593	49 093	153.8	9.9
1149	Open	Medihelp	Self-Administered	195 858	340 613	144.9	8.6
1034	Open	Cape Medical Plan	Self-Administered	11 676	19 992	142.7	11.6

GAE = Gross Administration Expenditure

GCI = Gross Contribution Income

pabpm = per average beneficiary per month

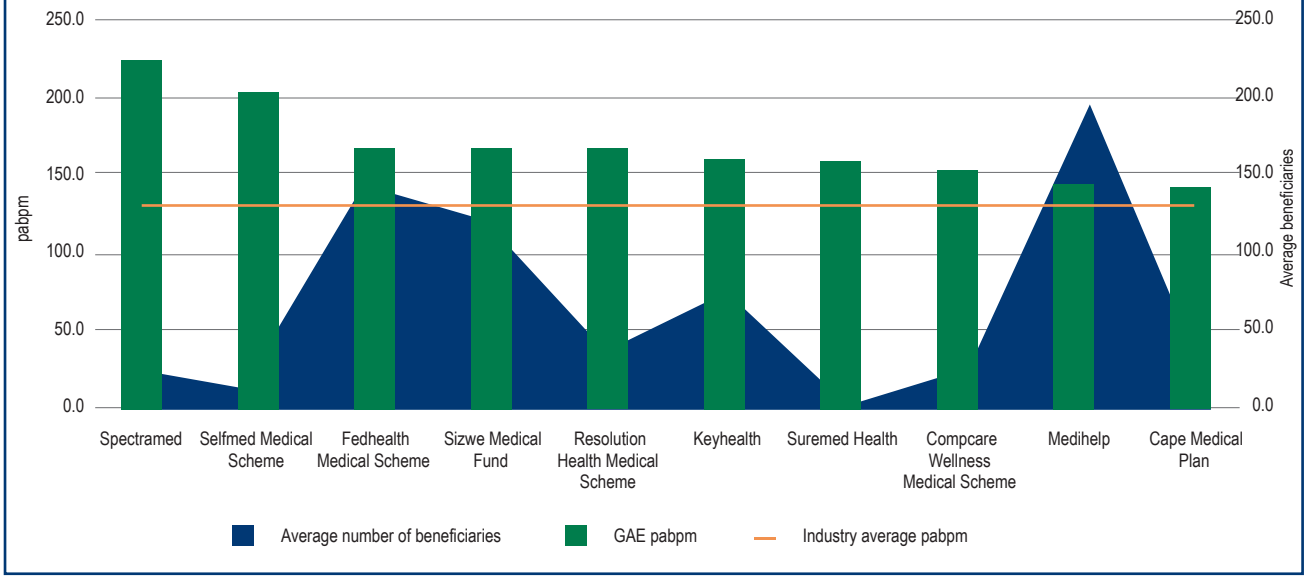
Table 28: Ten restricted schemes with the highest administration expenditure above industry average of R85.9 pabpm (2016)

Ref. No.	Type	Name of scheme	Name of administrator	Average number of beneficiaries	GAE R'000	GAE pabpm	GAE % of GCI
1194	Restricted	Profmed	Professional Provident Society Healthcare Administrators (Pty) Ltd	68 637	162 630	197.5	11.9
1043	Restricted	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Sanlam Health Administrators (Pty) Ltd	46 946	109 023	193.5	10.2
1441	Restricted	Parmed Medical Aid Scheme	Medscheme Holdings (Pty) Ltd	4 896	8 874	151	4.3
1068	Restricted	De Beers Benefit Society	Self-Administered	11 145	18 556	138.7	6.4
1523	Restricted	Grintek Electronics Medical Aid Scheme	Universal Healthcare Administrators (Pty) Ltd	1 678	2 734	135.8	8.1
1571	Restricted	Anglovaal Group Medical Scheme	Discovery Health (Pty) Ltd	7 503	11 586	128.7	7.0
1012	Restricted	Anglo Medical Scheme	Discovery Health (Pty) Ltd	18 984	28 489	125.1	6.1
1105	Restricted	Metropolitan Medical Scheme	METHEALTH (Pty) Ltd	7 322	10 888	123.9	7.2
1241	Restricted	Naspers Medical Fund	Discovery Health (Pty) Ltd	16 315	23 959	122.4	7.7
1566	Restricted	Horizon Medical Scheme	Medscheme Holdings (Pty) Ltd	4 527	6 468	119.1	13.7

GAE = Gross Administration Expenditure
GCI = Gross Contribution Income
pabpm = per average beneficiary per month

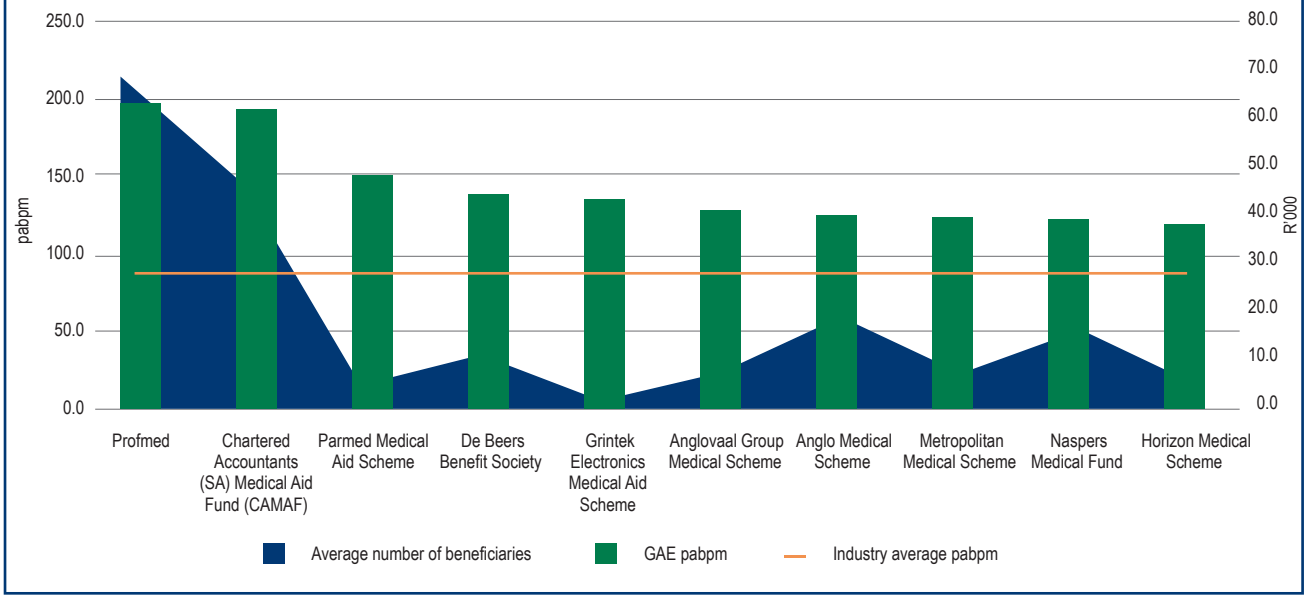
Relative to the open and restricted schemes' industry average, some of these schemes have high administration costs both as a percentage of GCI and on a pabpm basis.

Figure 55: Ten open schemes with the highest administration expenditure above industry average of R132.4 pabpm (2016)



pabpm = per average beneficiary per month

Figure 56: Ten restricted schemes with the highest administration expenditure above industry average of R85.9 pabpm (2016)



pabpm = per average beneficiary per month

Table 29 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 29: Administration fees paid to third-party administrators per average beneficiary per month: 2015 and 2016

	Open schemes			Restricted schemes		
	2016 pabpm R'000	2015 pabpm R'000	% variance	2016 pabpm R'000	2015 pabpm R'000	% variance
Third party						
Administration fees	114.8	109.8	4.6	52.7	50.1	5.2
Co-administration fees	–	–	–	17.1	8.2	108.5
Total	**114.8**	**109.8**	**4.6**	**61.3**	**54.2**	**13.1**
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 the Strata Healthcare Management (Pty) Ltd accreditation expired on 5 December 2015. The scheme still incurred administration fees for 5 months during 2016.

On average, third-party-administered open schemes spent 87.3% more per beneficiary on administration fees than third-party-administered restricted schemes In 2015, open schemes spent 102.6% more per beneficiary.

Administration and co-administration fees paid to third-party administrators were the main component of Gross Administration Expenditure (GAE). They grew by 4.4% to R8.6 billion in 2016 from R8.3 billion in the previous year. These fees represented 80.9 % of GAE in 2016, compared to 80.9 % in 2015.

Fees of trustees and principal officers

Remuneration and other considerations of trustees and principal officers accounted for 0.7% and 0.9% of GAE respectively. In 2016, the fees of principal officers amounted to 0.7% of GAE in open schemes (0.6% in 2015) and 1.4% in restricted schemes (unchanged from 2015).

Table 30 and Figure 57 show the 10 schemes with the highest average fees for trustees. More details are contained in Annexure V. Figure 58 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 V.

Table 30: Ten schemes with highest trustee fees: 2015 and 2016

Ref no	Name of medical scheme	Type	Trustee remuneration and other considerations		Number of trustees		Average fee per trustee	
			2016 R'000	2015 R'000	2016	2015	2016 R'000	2015 R'000
1598	Government Employees Medical Scheme (GEMS)	Restricted	7 543	7 161	13	12	580	597
1125	Discovery Health Medical Scheme	Open	5 430	4 037	9	6	603	673
1580	South African Police Service Medical Scheme (POLMED)	Restricted	4 931	2 251	14	16	352	141
1140	Medshield Medical Scheme	Open	4 615	3 810	9	7	513	544
1512	Bonitas Medical Fund	Open	4 596	3 524	14	10	328	352
1486	Sizwe Medical Fund	Open	3 857	3 431	10	11	386	312
1202	Fedhealth Medical Scheme	Open	3 678	3 457	10	11	368	314
1194	Profmed	Restricted	3 394	2 861	10	10	339	286
1145	LA-Health Medical Scheme	Restricted	3 038	2 492	16	19	190	131
1537	Hosmed Medical Aid Scheme	Open	2 791	152	11	11	254	14

Figure 57: Ten schemes with highest average trustee fees 2015 and 2016

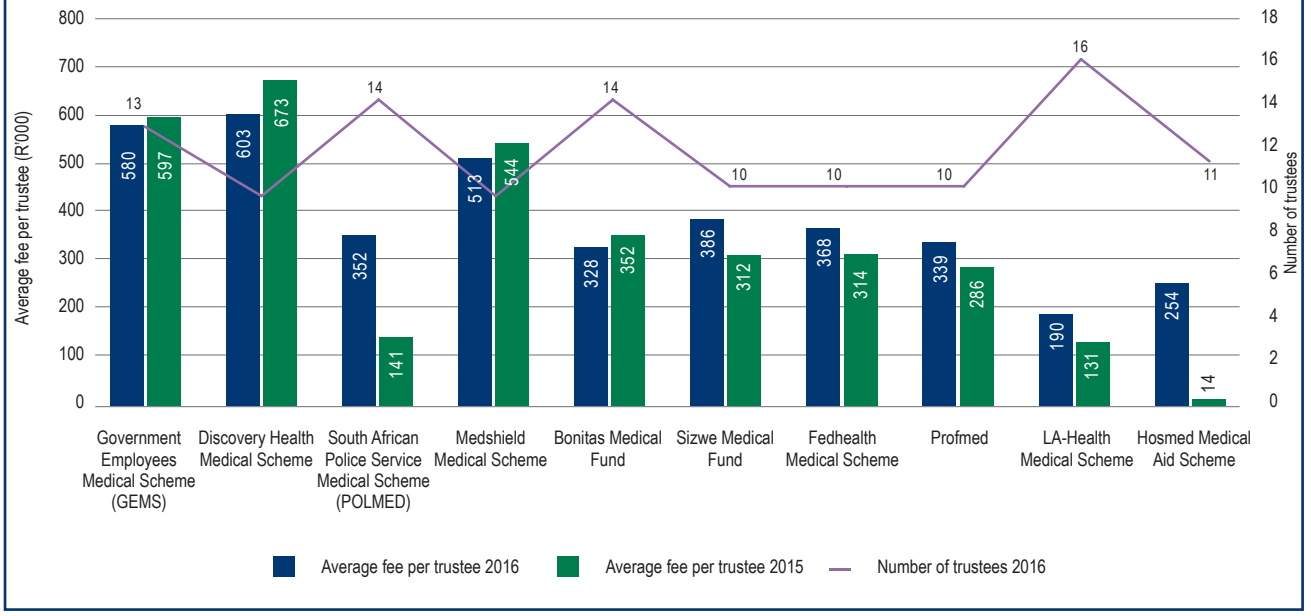


Figure 58: Composition of trustee remuneration for 10 schemes with highest remuneration in 2016

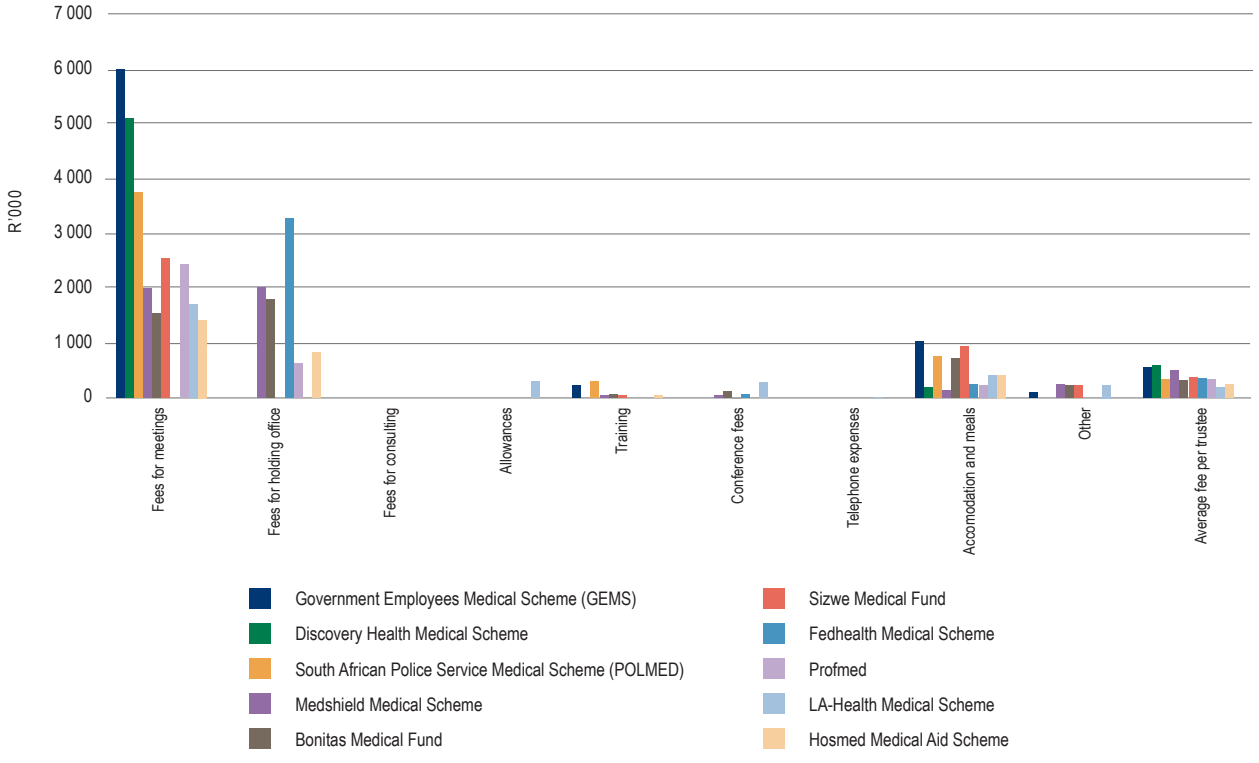


Table 31: Ten schemes with highest remuneration for Principal Officers: 2016

Ref. No.	Name of medical scheme	Average beneficiaries	Principal Officer remuneration		
			2016 R'000	2015 R'000	% change
1576	LMS Medical Fund	110 019	9 733	3 484	179.4
1580	South African Police Service Medical Scheme (POLMED)	497 129	9 417	5 744	63.9
1125	Discovery Health Medical Scheme	2 707 913	5 706	5 126	11.3
1252	Bestmed Medical Scheme	200 400	4 657	3 752	24.1
1140	Medshield Medical Scheme	153 415	4 349	2 837	53.3
1598	Government Employees Medical Scheme (GEMS)	1 801 999	4 223	4 223	0
1582	Transmed Medical Fund	57 137	3 607	3 345	7.8
1597	Umvuzo Health Medical Scheme	54 821	3 495	3 267	7
1512	Bonitas Medical Fund	676 785	3 116	3 523	-11.6
1194	Profmed	68 637	3 074	2 749	11.8

* *Principal Officer remuneration includes curator fees.*

Table 32: Top ten open schemes with the highest advisory* services fees

Ref. No.	Scheme name	Average beneficiaries	PO fees R'000	Legal fees R'000	Consulting fees R'000	Total legal fees and consulting R'000
1512	Bonitas Medical Fund	676 785	3 116	7 326	3 478	10 803
1140	Medshield Medical Scheme	153 415	4 349	6 926	2 716	9 642
1252	Bestmed Medical Scheme	200 400	4 657	2 123	6 842	8 965
1486	Sizwe Medical Fund	121 692	2 316	2 513	5 658	8 171
1149	Medihelp	195 858	1 807	6 803	1 028	7 830
1537	Hosmed Medical Aid Scheme	70 606	2 800	1 172	2 581	3 753
1576	LMS Medical Fund **	110 019	9 733	963	1 610	2 573
1554	Genesis Medical Scheme	21 581	1 669	2 239	–	2 239
1141	Spectramed	27 599	2 286	1 736	227	1 962
1034	Cape Medical Plan	11 676	840	938	152	1 090

* *Advisory fees refers to the combination of legal and consulting fees.*

** *LMS Medical Fund amalgamated with Bonitas Medical Fund on 1 October 2016.*

Table 33: Top ten restricted schemes with the highest advisory* services fees

Ref. No.	Name of medical scheme	Average beneficiaries	PO fees R'000	Legal fees R'000	Consulting fees R'000	Total legal fees and consulting R'000
1598	Government Employees Medical Scheme (GEMS)	1 801 999	4 223	7 703	90 611	98 314
1580	South African Police Service Medical Scheme (POLMED)	497 129	9 417	4 687	5 432	10 119
1279	Bankmed	214 305	2 425	1 378	1 248	2 626
1038	SAMWUMed	83 523	2 487	1 176	1 323	2 499
1086	Food Workers Medical Benefit Fund	18 314	1 273	1 816	–	1 816
1579	Tsogo Sun Group Medical Scheme	10 556	–	–	1 710	1 710
1012	Anglo Medical Scheme	18 984	2 028	–	1 670	1 670
1547	Malcor Medical Scheme	12 084	470	–	1 468	1 468
1209	South African Breweries Medical Aid Scheme (SABMAS)	21 905	–	182	1 229	1 411
1600	Motohealth Care	53 168	2 009	934	385	1 319

* *Advisory fees refers to the combination of legal and consulting fees.*

Table 34: Ten schemes with highest Annual General Meeting costs: 2016

Ref. No.	Name of medical scheme	Average members		Annual General Meeting Costs			
		2016	2015	2016 R'000	2015 R'000	2016 pampb R	2015 pampb R
1125	Discovery Health Medical Scheme	1 280 494	1 250 194	8 986	3 218	0.6	0.2
1486	Sizwe Medical Fund	50 784	52 767	3 194	770	5.2	1.2
1512	Bonitas Medical Fund	308 262	295 462	1 859	2 477	0.5	0.7
1038	SAMWUMed	37 129	38 664	1 107	1 632	2.5	3.5
1252	Bestmed Medical Scheme	94 998	93 066	975	1 149	0.9	1.0
1580	South African Police Service Medical Scheme (POLMED)	174 480	172 039	575	277	0.3	0.1
1149	Medihelp	90 676	94 316	501	691	0.5	0.6
1140	Medshield Medical Scheme	74 058	75 679	271	253	0.3	0.3
1590	Building & Construction Industry Medical Aid Fund	4 449	5 255	160	121	3.0	1.9
1592	Thebemed	10 115	9 319	95 853	79 200	0.8	0.7

Broker costs

Broker costs, which include all commissions, service fees and other distribution costs, increased by 10.0% from R1.8 billion in 2015 to R2.0 billion in 2016, compared to 5.8% in 2015.

Broker costs represented 14.1% of total non-healthcare expenditure in 2016, while they accounted for 13.9% in 2015.

For schemes that pay broker commissions, the amounts paid on a per average member per month (pampm) basis increased to R62.2 pampm in 2016 from R57.4 pampm in 2015, representing an increase of 8.4%.

Broker commissions as a percentage of GCI remained constant at 1.2% in both 2015 and 2016.

Figure 59 shows annual broker service fees paid by open schemes since 2000, as well as their percentage of total non-healthcare expenditure.

Figure 59: Broker service fees for open schemes: 2000 – 2016

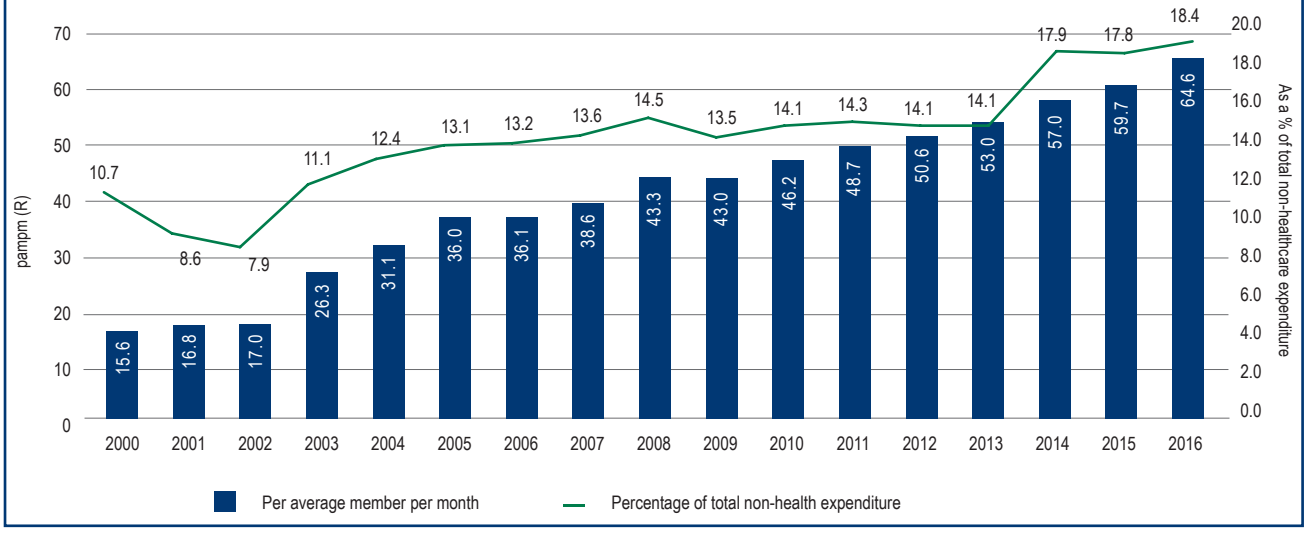


Figure 60 illustrates the increase in broker fees relative to the number of members of schemes that pay brokers.

Figure 60: Broker fees and scheme membership: 2000 – 2016

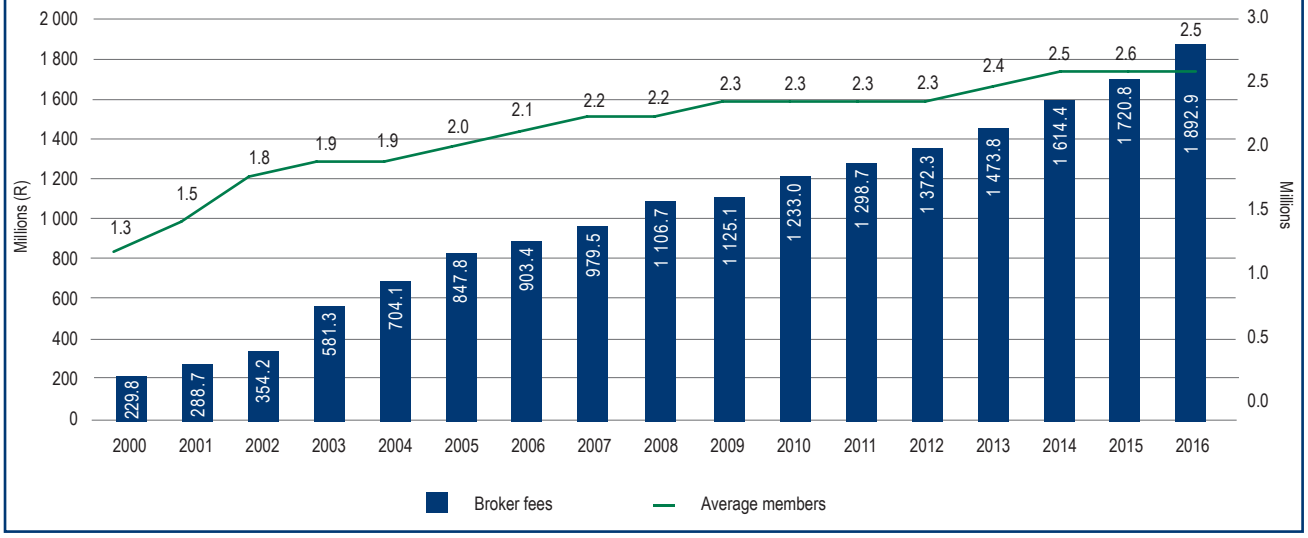


Table 35 illustrates the schemes which had broker service fees that were higher than the industry average of R62.2 pampm during 2016 (The average in 2015 was R57.4 pampm). These six schemes (2015: six) represented 78.6% (2015: 60.8%) of total membership that paid for broker service fees, and 86.4% (2015: 68.8%) of total broker service fees paid. One of these schemes paid at a level of 20.0% greater than the industry average.

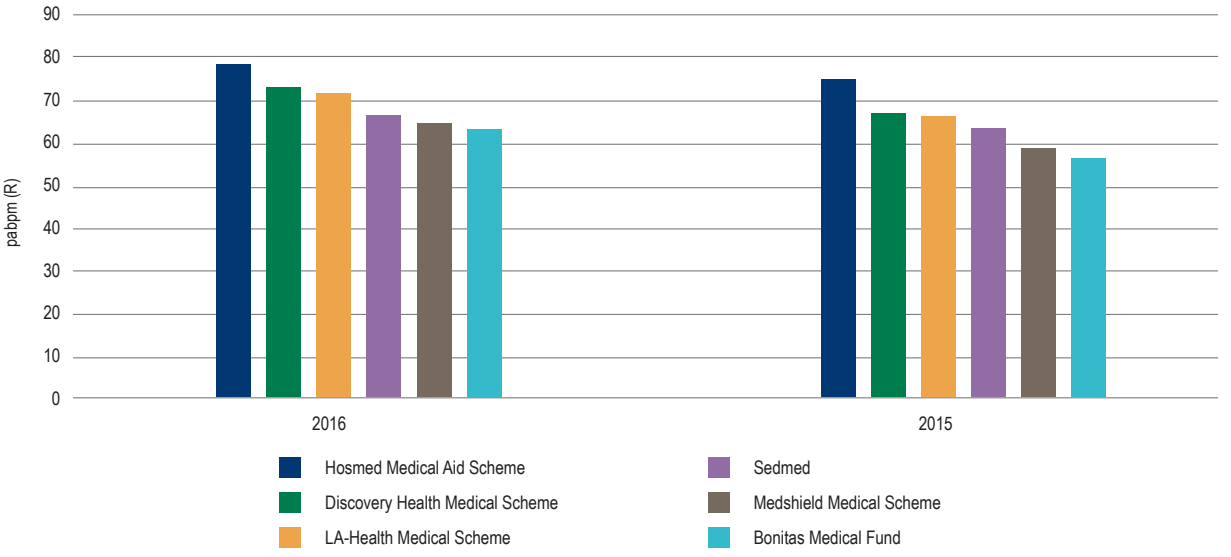
Table 35: Schemes with broker fees above the industry average per average member per month 2015 and 2016

Ref. No.	Name of medical scheme	Type	Broker fees*			Other distribution fees		
			2016 pampm R	2015 pampm R	% change	2016 pampm R	2015 pampm R	% change
1537	Hosmed Medical Aid Scheme	Open	77.0	73.5	4.8	–	–	–
1125	Discovery Health Medical Scheme	Open	71.7	65.5	9.5	–	–	–
1145	LA-Health Medical Scheme	Restricted	70.3	64.8	8.5	–	–	–
1531	Sedmed	Restricted	65.1	62.1	4.8	–	–	–
1140	Medshield Medical Scheme	Open	63.3	59.6	6.2	–	–	–
1512	Bonitas Medical Fund	Open	63.0	57.2	10.1	–	–	–

pampm = per average member per month

* *Excluding distribution costs.*

Figure 61: Schemes with broker fees above the industry average of R62.2 per average member per month 2015 and 2016



Reinsurance results

There were no schemes with reinsurance contracts in place in either 2015 or 2016.

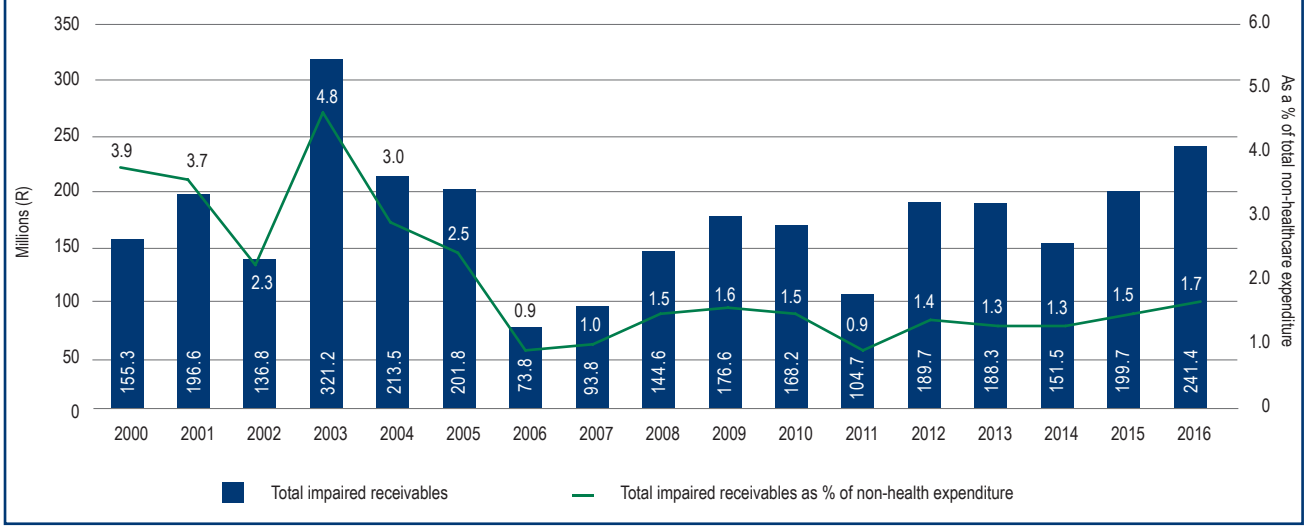
Impaired receivables

Impaired receivables increased by 20.9% to R241.4 million for the year under review from R199.7 million in 2015. They represented 1.7% of total non-healthcare expenditure, up from 1.5% in 2015.

It took schemes an average of 10.6 days to collect debts (contributions from their members) in 2016. This worsened by -9.3% from 9.7 days in 2015. This collection period falls well outside the legal provisions which require that members pay all contributions to their medical scheme not later than three days after the payment is due. The associated risks of not paying and collecting contributions timeously are the possible impairment of the debtor and paying claims when contributions have not been received.

Figure 62 shows the trend in impaired receivables over the past 17 years, also expressed as a percentage of total non-healthcare expenditure.

Figure 62: Impaired receivables: 2000 – 2016



Trends in non-healthcare expenditure

Administration expenditure was the main component of non-healthcare expenditure in 2016 at 84.2%, down from 84.6% in 2015.

Administration expenditure accounted for 7.3% of GCI in 2016, unchanged from 2015.

Table 36 shows administration expenditure by type of scheme administration.

Table 36: Gross administration expenditure (GAE) per average beneficiary per month 2000 – 2016

	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	132.1	4.8	75.1	11.1	86.7	11.9

pabpm = per average beneficiary per month

Table 36 also shows that self-administered open schemes paid 78.7% (2015: 89.8%) more pabpm for administration expenditure than self-administered restricted schemes. Third-party-administered open schemes paid 52.4% (2015: 62.7%) more pabpm for administration expenditure than third-party-administered restricted schemes.

During 2016, there were six self-administered open schemes (five in 2015), representing 596 826 average beneficiaries (2015: 403 016), and 17 third-party-administered open schemes (18 in 2015), representing 4 360 490 average beneficiaries (2015: 4 509 467).

Self-administered open schemes experienced an increase of 4.6% in spending on administration expenditure (from R128.3 pabpm in 2015 to R134.2 pabpm in 2016) while third-party-administered open schemes increased their expenditure by 4.8% to R132.1 pabpm from R126.1 pabpm in 2015. Third-party-administered open schemes paid 1.6% less for administration expenditure than self-administered open schemes, compared to the 1.7% in 2015.

During 2016, there were eight self-administered restricted schemes, unchanged from the previous year, representing 299 373 average beneficiaries (2015: 308 300), and 53 third-party-administered restricted schemes (2015: 52), representing 5 397 106 average beneficiaries (2015: 5 326 621).

Third-party-administered restricted schemes spent on average 15.4% more on administration expenditure at R86.7 pabpm compared to the R75.1 pabpm of self-administered restricted schemes, up from 14.6% in 2015.

Table 37 indicates the ten schemes with the highest marketing, advertising, and broker costs. The majority of these are open medical schemes. The table also shows the expenditure incurred by schemes when recruiting new members. The membership statistics show that the number of principal members in open schemes increased by 0.9% from 2015 to 2016 (1.4% from 2014 to 2015). 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.

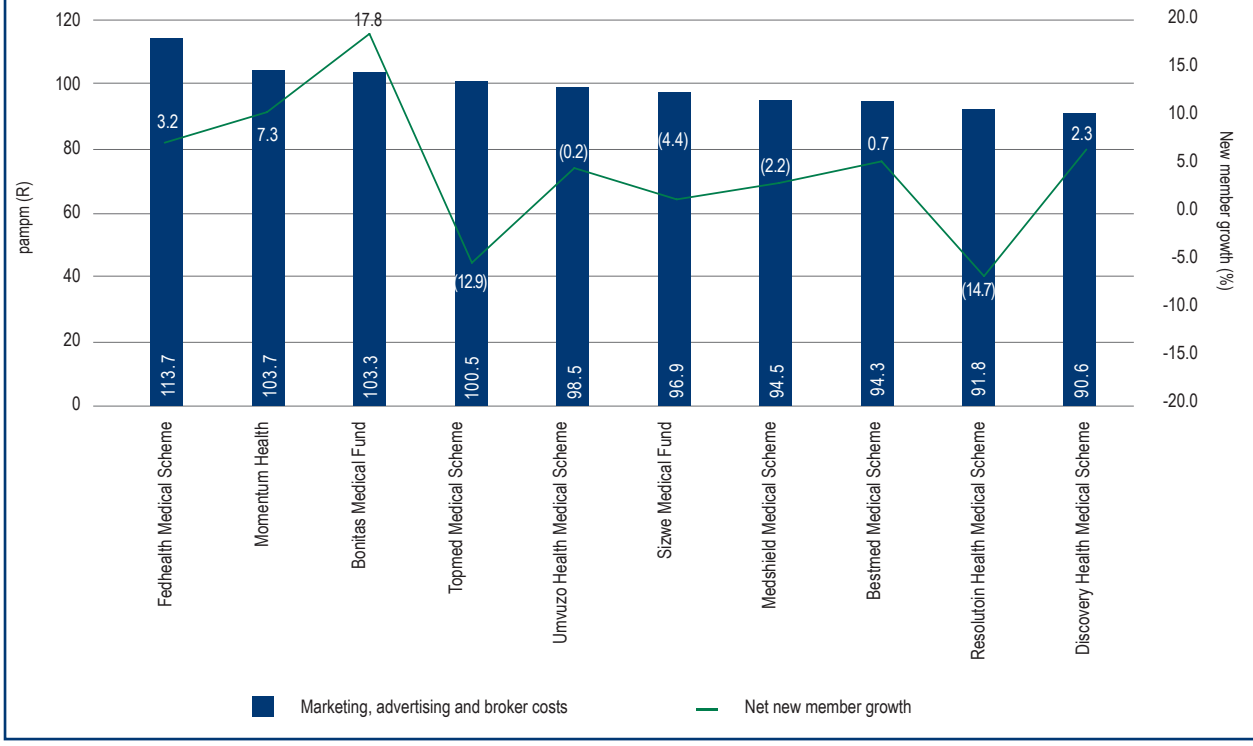
Figure 63 illustrates the information contained in Table 37.

Table 37: Ten schemes with highest marketing, advertising and broker costs per average member per month 2016

Ref. No.	Name of medical scheme	Marketing, advertising and broker costs	Net new member growth
1202	Fedhealth Medical Scheme	113.7	3.2
1167	Momentum Health	103.7	7.3
1512	Bonitas Medical Fund	103.3	17.8
1422	Topmed Medical Scheme	100.5	-12.9
1597	Umvuzo Health Medical Scheme	98.5	-0.2
1486	Sizwe Medical Fund	96.9	-4.4
1140	Medshield Medical Scheme	94.5	-2.2
1252	Bestmed Medical Scheme	94.3	0.7
1575	Resolution Health Medical Scheme	91.8	-14.7
1125	Discovery Health Medical Scheme	90.6	2.3

pampm = per average member per month

Figure 63: Ten schemes with highest marketing, advertising and broker costs per average member per month 2016



Tables 38 and 39 show open and restricted schemes with the highest marketing and advertising expenditure.

Table 38: Open schemes with the highest marketing and advertising expenditure per average member per month 2016

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
		2016 pampm	2015 pampm	% change	2016 pampm	2015 pampm	% change	2016	2015	% change			
1202	Fedhealth Medical Scheme	55.2	43.2	27.8	58.4	53.2	9.8	72 315	71 900	0.6	The Cheese Has Moved (Pty) Ltd	47 931	100.0
1167	Momentum Health	–	–	–	103.7	97.1	6.8	134 214	126 070	6.5	Not applicable	–	–
1512	Bonitas Medical Fund	40.3	43.4	-7.1	63.0	57.2	10.1	308 262	295 462	4.3	Afrocentric Distribution Services (Pty) Ltd	149 172	100.0
1422	Topmed Medical Scheme	39.0	39.1	-0.3	61.5	55.2	11.4	23 384	24 088	-2.9	FastPulse	4 543	41.5
											Ad hoc expenditure	6 396	58.5
1486	Sizwe Medical Fund	38.8	20.9	85.6	58.2	60.5	-3.8	50 784	52 767	-3.8	Ad hoc Marketing Advertising Sponsorships and promotions	16 860	71.4
											Bakone Strategic Concepts	6 758	28.6
1140	Medshield Medical Scheme	31.2	25.3	23.3	63.3	59.6	6.2	74 058	75 679	-2.1	Spacegrow Media	10 682	38.5
											Wellness Odyssey	1 265	4.6
											Wink Promotions	965	3.5
											Risk SA	155	0.6
											Other Marketing	3 236	11.7
											Ntsumi Telecommunications	3 283	11.8
											Saints Brand and Design	5 628	20.3
											Maverick Digital Labs	23	0.1
											Hi Performance Supplies	1 259	4.5
											Peakin Blu Staff Marketing	108	0.4
											Specialist Research	345	1.2
											Kaya FM	774	2.8

THE MEDICAL SCHEMES INDUSTRY IN 2016 (CONTINUED)

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
		2016 pampm	2015 pampm	% change	2016 pampm	2015 pampm	% change	2016	2015	% change			
1252	Bestmed Medical Scheme	28.5	28.2	1.1	65.7	62.7	4.8	94 998	93 066	2.1	The Old Shanghai Fire Cracker Factory	3 478	10.7
											Cycle Labuschagne Brothers	1 244	3.8
											Bluestream Research CC	274	0.8
											Tukssport (Pty) Ltd (HPC)	1 512	4.6
											Tukssport Borgskap	46	0.1
											Tukssport Study Centre	333	1.0
											Two The Core Events (Pty) Ltd	891	2.7
											Urban Event Lab	741	2.3
											LJ van Zyl	297	0.9
											Tukssport University of Pretoria	2 772	8.5
											ASG Event Solutions (Pty) Ltd	3 020	9.3
											Nelson Mandela Metropolitan University	1 094	3.4
											Brandman Business Development	529	1.6
											AGE Business Solutions	285	0.9
											Inkonde Projects	1 452	4.5
											De Villiers Cycling Events	217	0.7
											Ad hoc expenditure	14 349	44.1
1575	Resolution Health Medical Scheme	35.7	29.8	19.8	56.1	51.7	8.5	18 959	22 525	-15.8	National Positions	173	2.1
											Agility Channel	6 572	80.9
											Jean de Villiers	61	0.8
											Ad hoc expenditure	1 043	12.8
											Martina Nicholson	274	3.4
1125	Discovery Health Medical Scheme	18.9	18.1	4.4	71.7	65.5	9.5	1 280 494	1 250 194	2.4	Discovery Health (Pty) Ltd - all inclusive administration agreement	290 514	100.0
1576	LMS Medical Fund	17.0	47.9	-64.5	48.3	61.3	-21.2	55 276	55 995	-1.3	V Medical Solutions (Pty) Ltd	7 526	66.6
											Afrocentric Distribution services (Pty) Ltd.	2 301	20.4
											Ad hoc expenditure	1 467	13.0
	Open scheme industry average**	**24.1**	**24.3**	**-0.8**	**68.0**	**62.8**	**8.3**	**2 341 617**	**2 304 852**	**1.6**			

pampm = per average member per month

* *Due to data limitations this table does not reflect schemes in which this expenditure is included in administration fees.*

** *The industry averages are based only on those schemes which incurred the specific type of expenditure.*

Table 39: Restricted schemes with the highest marketing and advertising expenditure per average member per month 2016

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
		2016 pampm	2015 pampm	% change	2016 pampm	2015 pampm	% change	2016	2015	% change			
1597	Umvuzo Health Medical Scheme	52.6	47.5	10.7	45.9	44.8	2.5	26 110	27 113	-3.7	Ad hoc expenditure	16,490	100.0
1194	Profmed	50.8	36.2	40.3	23.7	22.3	6.3	31 488	29 982	5.0	Ebony and Ivory	14,229	74.1
											Cyberkinetics	2,518	13.1
											Newsclip	133	0.7
											Epic Communications	448	2.3
											Other	1,871	9.7
1145	LA-Health Medical Scheme	1.1	0.8	37.5	70.3	64.8	8.5	60 832	55 712	9.2	Ad hoc expenditure	770	100.0
1531	Sedmed	2.2	0.9	144.4	65.1	62.1	4.8	982	930	5.6	Ad hoc expenditure	26	100.0
1038	SAMWUMed	26.9	14.2	89.4	6.2	6.8	-8.8	37 129	38 664	-4.0	Ad hoc expenditure	5,349	44.7
											Epic Communications (Pty) Ltd	6,620	55.3
1600	Motohealth Care	11.2	9.5	17.9	13.5	10.7	26.2	24 441	25 677	-4.8	Dimage	607	18.5
											Various Other Companies	931	28.4
											Multiply	1,742	53.1
1598	Government Employees Medical Scheme (GEMS)	21.1	21.3	-0.9	–	–	–	683 286	671 215	1.8	Healthi Choices (Pty) Ltd	31,126	18.0
											Other (Advertising and marketing)	52,438	30.3
											Pinnacle Health Solutions (Pty) Ltd	37,419	21.7
											Teledirect (Pty) Ltd	51,837	30.0
1578	TFG Medical Aid Scheme	20.6	1.9	984.2	–	–	–	2 937	2 873	2.2	Discovery Health (Pty) Ltd	697	95.9
											Ad hoc expenditure	30	4.1
1291	Witbank Coalfields Medical Aid Scheme	18.9	17.9	5.6	0.6	0.7	-14.3	9 393	9 898	-5.1	Amadwala Group Benefits	2,128	100.0
1568	Sisonke Health Medical Scheme	13.5	7.3	84.9	–	–	–	8 389	8 201	2.3	Ad hoc expenditure	1,359	100.0
	Restricted scheme industry average**	**14.3**	**13.2**	**8.3**	**34.6**	**30.7**	**12.7**	**1 419 836**	**1 412 268**	**0.5**			

** *Due to data limitations the industry averages are based only in respect of those schemes which incurred the specific expenditure.*
pampm = per average member per month

Table 40: Top five schemes paying marketing fees to administrators per average member per month 2016

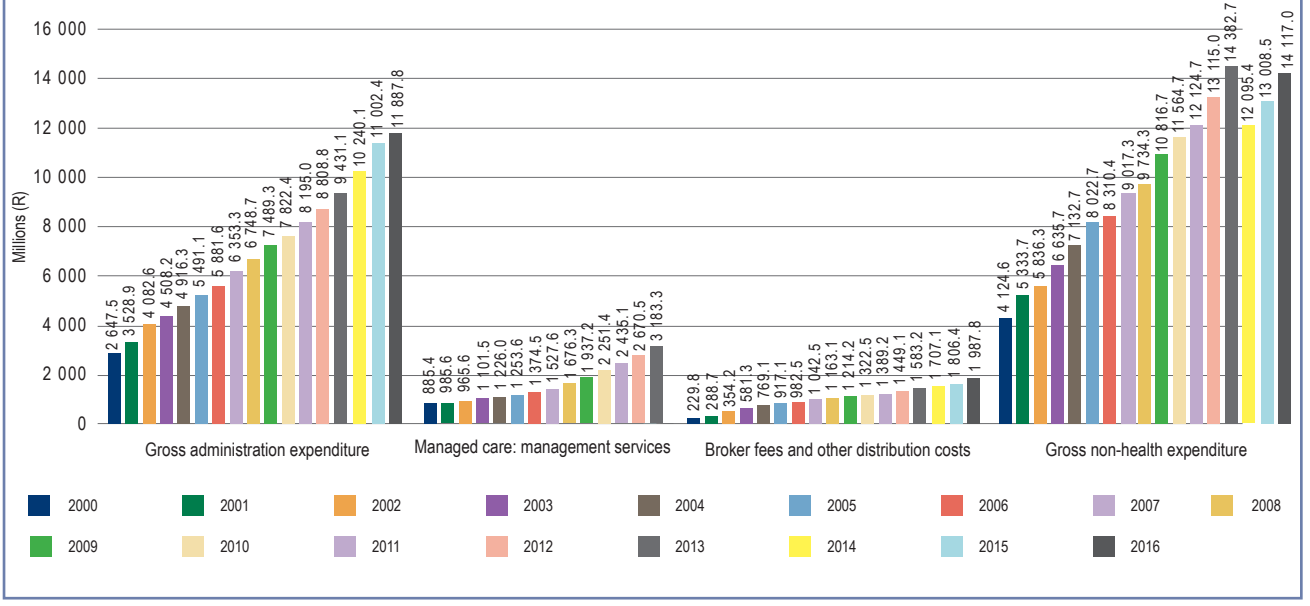
Ref. No.	Name of medical scheme	Marketing component of administration fee		Total marketing, advertising and broker costs
		%	pampm	pampm
1599	Lonmin Medical Scheme	11.0	6.2	6.2
1578	TFG Medical Aid Scheme	10.0	19.8	20.6
1149	Medihelp	7.7	9.6	78.7
1125	Discovery Health Medical Scheme	7.0	18.9	90.6
1279	Bankmed	1.1	1.8	1.9

pampm = per average member per month

Figure 64 shows the changes in the major categories of non-healthcare expenditure for the past 17 years.

Total net non-healthcare expenditure rose by 8.5% from R13.0 billion in 2015 to R14.1 billion in 2016.

Figure 64: Changes in non-healthcare expenditure 2000 – 2016



Total gross non-healthcare expenditure has increased by 242.3% since 2000. This was driven by a 349.0% upswing in administration expenditure and an increase of 765.0% in broker costs.

By comparison, gross claims have risen by 453.8% (not adjusted for inflation) since 2000.

As illustrated in Figures 65 and 66 along with Table 41, 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. This can partly be explained by GEMS starting to operate in 2006. Since then there has been a real decrease in non-healthcare expenditure, from R2 286.5 pabpa in 2005 to R1 594.7 pabpa 2016 (prices adjusted to 2016 prices).

The decrease between 2013 and 2014 is partially due to the reclassification of accredited managed healthcare services. Circular 56 of 2015 resulted in the 2014 non-healthcare expenditure decreasing by 21.5% from R1 948.7 pabpa to R1 529.8 pabpa (in real terms). This can be clearly observed in Figure 66.

Non-healthcare expenditure increased marginally (by 1.2%) to R1 594.7 in 2016 from R1 575.6 in 2015. The non-healthcare ratio (as % of RCI) also increased, to 9.6% in 2016 from 9.5% in 2015.

Figure 65: Non-healthcare expenditure per average beneficiary per annum 2000 – 2016 (2016 prices)

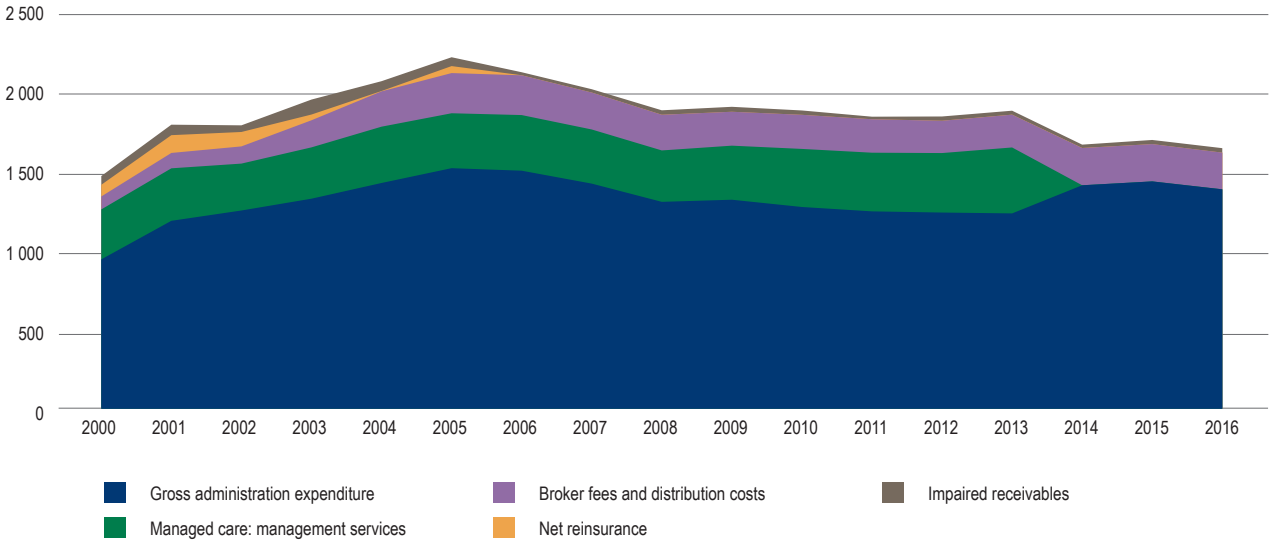


Figure 66: Claims and non-healthcare expenditure per average beneficiary per month 2000 – 2016 (2016 prices)

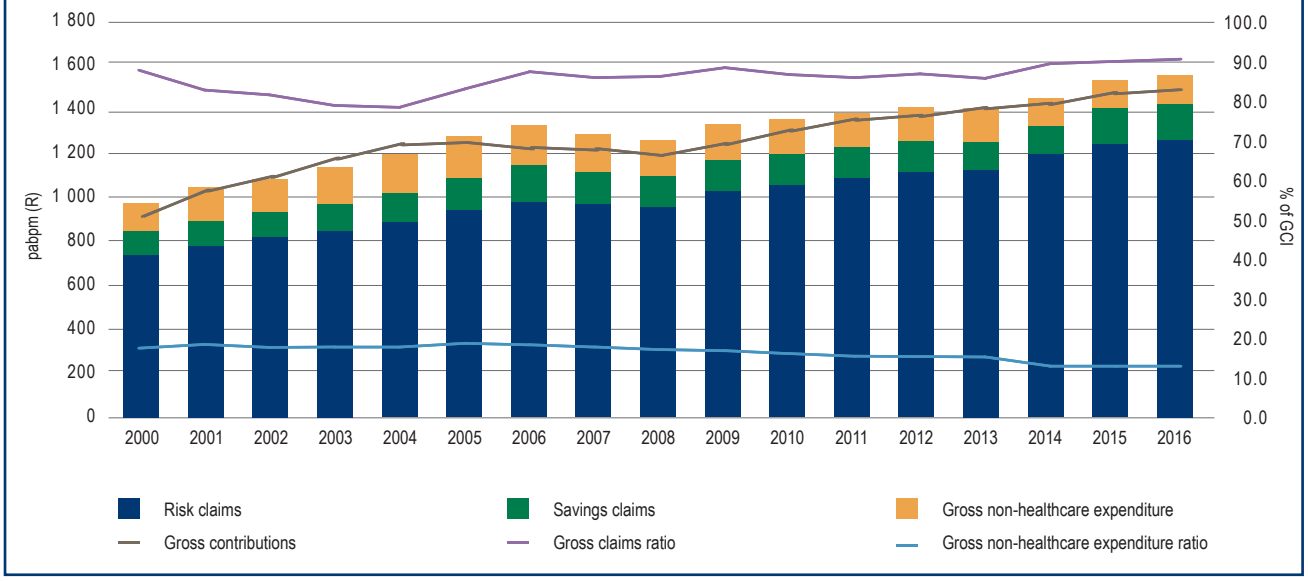


Figure 67: Claims and non-healthcare expenditure per average beneficiary per annum 2000 – 2016 (2016 prices)

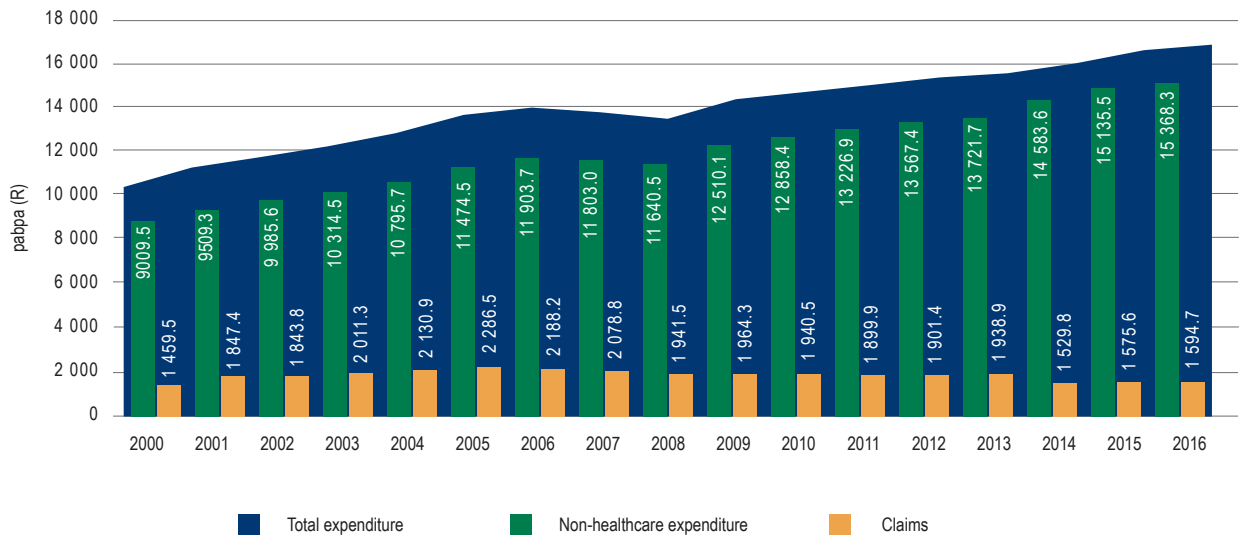


Table 41: Trends in contributions, claims and non-healthcare expenditure 2000 – 2016 (2016 prices*)

	Gross contributions		Gross claims		Gross non-healthcare expenditure	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	11 230.6	13.1	10 022.7	6.2	1 513.9	22.1
2001	12 702.4		10 645.6		1 848.0	
2002	13 493.1	6.2	11 126.3	4.5	1 843.9	-0.2
2003	14 560.0	7.9	11 586.0	4.1	2 011.5	9.1
2004	15 393.2	5.7	12 182.7	5.2	2 131.0	5.9
2005	15 446.2	0.3	12 997.8	6.7	2 286.7	7.3
2006	15 157.8	-1.9	13 457.4	3.5	2 188.2	-4.3
2007	15 093.0	-0.4	13 161.3	-2.2	2 078.8	-5.0
2008	14 780.7	-2.1	12 934.8	-1.7	1 941.5	-6.6
2009	15 403.9	4.2	13 849.5	7.1	1 964.0	1.2
2010	16 190.2	5.1	14 248.7	2.9	1 940.6	-1.2
2011	16 828.1	3.9	14 672.4	3.0	1 900.1	-2.1
2012	17 038.0	1.2	15 026.4	2.4	1 900.5	–
2013	17 493.8	2.7	15 225.4	1.3	1 938.2	2.0
2014	17 734.9	1.4	16 141.6	6.0	1 530.0	-21.1
2015	18 367.3	3.6	16 827.1	4.2	1 575.8	3.0
2016	18 518.9	0.8	17 083.0	1.5	1 594.8	1.2
since 2000		**64.9**		**70.4**		**5.3**

pabpa = per average beneficiary per annum

* *The values were adjusted for CPI for 2000 – 2015.*

Figure 67 and Table 41 also show how non-healthcare expenditure outpaced contributions and claims in most years until 2005. Total non-healthcare expenditure grew at more than 20.0% per annum from 1999 to 2001 before stabilising.

Table 42 shows the 10 open schemes with non-healthcare expenditure greater than both the industry average of R166.1 pabpm and the open schemes average of 11.8% when expressed as a percentage of risk contribution income (RCI).

Table 43 shows the 10 restricted schemes with non-healthcare expenditure greater than both the industry average of R90.6 pabpm and the restricted schemes average of 6.6% when expressed as a percentage of RCI.

Table 42: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions among open schemes (2015 and 2016)

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2016 pabpm	2015 pabpm	2016 As % of RCI	2015 As % of RCI	2016 As % of RCI	2015 As % of RCI	2016 As % of RCI	2015 As % of RCI	% change
1141	Spectramed	234.2	288.0	95.7	98.0	14.3	19.9	-9.9	-17.8	44.4
1446	Selfmed Medical Scheme	210.7	198.2	101.4	90.3	11.7	11.2	-13.0	-1.4	-828.6
1202	Fedhealth Medical Scheme	199.7	179.9	93.5	91.2	12.0	11.3	-5.6	-2.5	-124.0
1575	Resolution Health Medical Scheme	196.1	178.7	87.5	87.2	12.6	12.9	-0.1	-0.1	-
1486	Sizwe Medical Fund	192.6	167.6	88.4	88.3	12.3	11.1	-0.7	0.6	-216.7
1087	Keyhealth	185.9	176.0	91.4	93.9	9.0	9.2	-0.5	-3.1	83.9
1464	Suremed Health	181.5	182.2	83.5	84.7	12.0	13.4	4.5	1.9	136.8
1491	Compcare Wellness Medical Scheme	177.0	180.9	93.9	92.7	12.2	13.6	-6.1	-6.3	3.2
1149	Medihelp	171.1	181.0	92.9	88.5	10.4	11.6	-3.3	-	-100.0
1576	LMS Medical Fund	169.0	174.0	95.3	93.2	10.6	11.8	-5.9	-5.0	-18.0
	Industry average – open schemes	**166.1**	**157.9**	**89.3**	**88.7**	**11.8**	**12.0**	**-1.1**	**-0.7**	**-57.1**

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

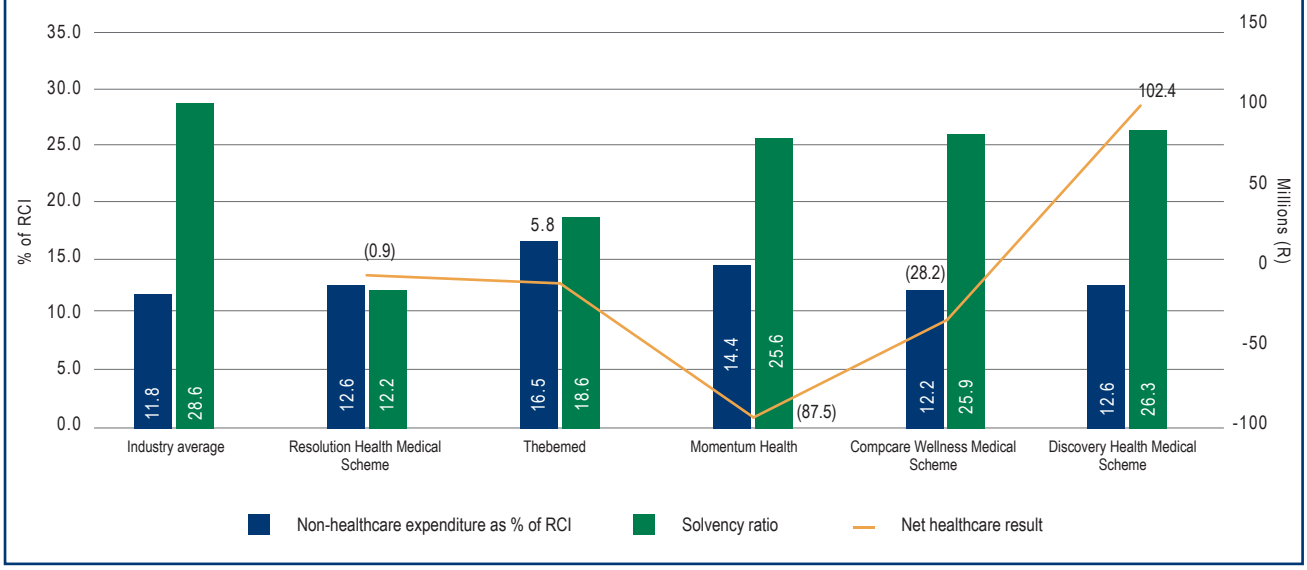
Table 43: Trends in claims, non-healthcare expenditure, and reserve-building as percentage of contributions among restricted schemes (2015 and 2016)

Ref. no.	Name of medical scheme	Net non-healthcare expenditure		Net claims incurred		Net non-healthcare expenditure		Reserve-building		
		2016 pabpm	2015 pabpm	2016 As % of RCI	2015 As % of RCI	2016 As % of RCI	2015 As % of RCI	2016 As % of RCI	2015 As % of RCI	% change
1194	Profmed	208.3	191.5	90.6	90.0	12.6	12.6	-3.1	-2.6	-19.2
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	194.2	183.8	92.3	94.5	11.2	11.6	-3.5	-6.1	42.6
1441	Parmed Medical Aid Scheme	156.0	152.7	110.9	93.6	4.5	4.3	-15.3	2.1	-828.6
1105	Metropolitan Medical Scheme	149.2	105.5	105.9	105.1	8.7	7.6	-14.6	-12.7	-15.0
1145	LA-Health Medical Scheme	146.8	138.3	82.9	82.6	11.9	11.7	5.2	5.7	-8.8
1068	De Beers Benefit Society	139.0	150.0	102.6	95.9	6.4	7.6	-9.1	-3.4	-167.6
1523	Grintek Electronics Medical Aid Scheme	136.5	127.6	100.4	103.9	8.2	8.4	-8.5	-12.3	30.9
1571	Anglovaal Group Medical Scheme	129.2	122.6	101.3	92.8	8.8	8.7	-10.1	-1.5	-573.3
1012	Anglo Medical Scheme	127.3	122.7	127.5	124.6	7.5	7.7	-35.0	-32.4	-8.0
1241	Naspers Medical Fund	125.8	117.3	95.3	89.5	9.8	9.6	-5.1	0.9	-666.7
	Industry average – restricted schemes	**90.6**	**79.8**	**95.6**	**94.9**	**6.6**	**6.3**	**-2.2**	**-1.1**	**-100.0**

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

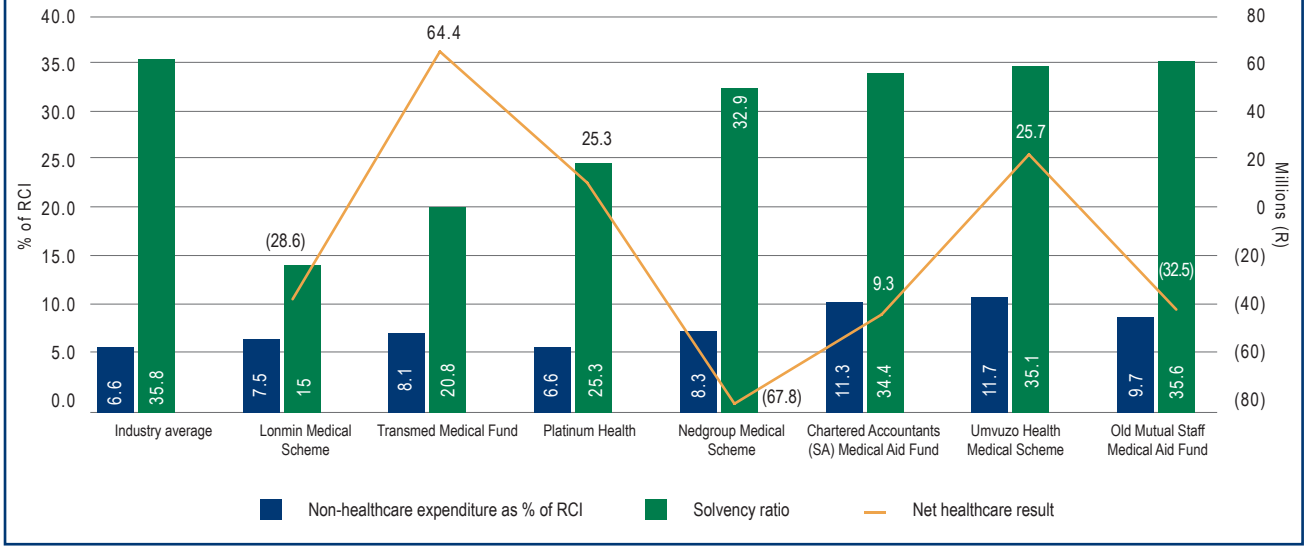
Figure 68 shows the open schemes in Tables 42 and 43 that had a solvency ratio below the open schemes average of 28.6%. Figure 69 shows the restricted schemes in Table 42 and 43 that had a solvency ratio below the restricted schemes average of 35.8%. It is concerning that some of these medical schemes 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 solvency ratio below average: 2016



RCI = Risk Contribution Income

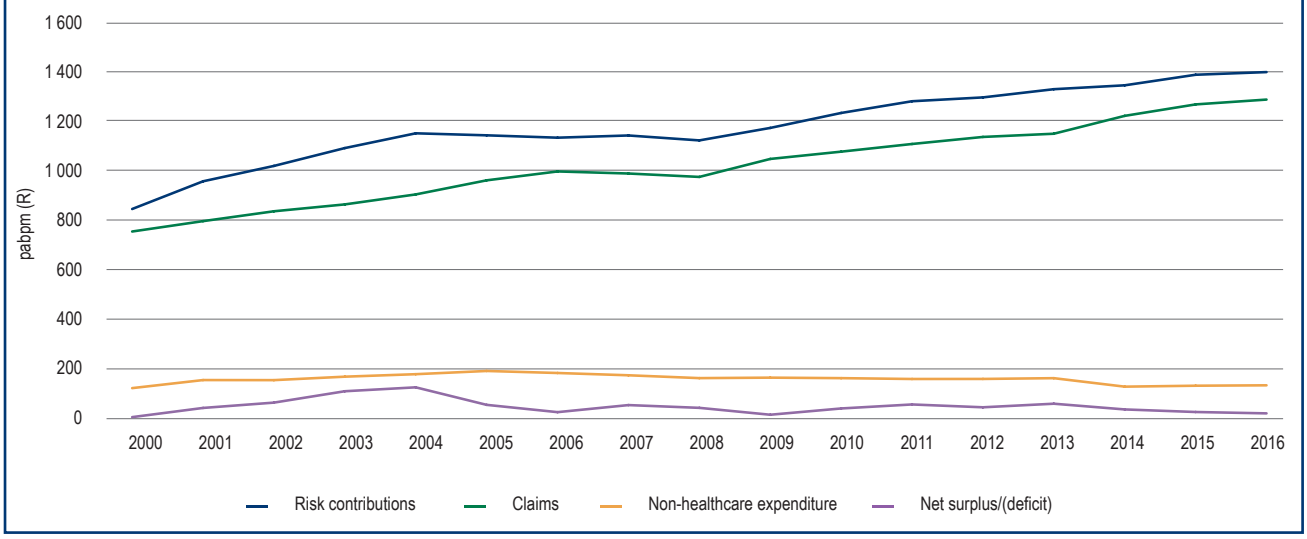
Figure 69: Restricted schemes with high non-healthcare expenditure and solvency ratio below average: 2016



RCI = Risk Contribution Income

Figure 70 depicts information on risk contributions, benefits, non-healthcare expenditure, and net surpluses pabpm. The trade-off between non-healthcare expenditure and annual surpluses pabpm grew between 2000 and 2003, then started decreasing and almost levelled 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 2000 – 2016 (2016 prices*)



pabpm = per average beneficiary per month
* *The values were adjusted for CPI for 2000-2015.*

Benefit options

During 2016, there were 280 registered benefit options (2015: 276) operating in 83 medical schemes.

Open schemes accounted for 50.7% or 142 of the registered benefit options at the end of 2016 (2015: 50.4% or 139 options). Restricted schemes had 138 options at year end, representing 49.3% of all options (2015: 137 options or 49.6%).

On average, open schemes had 6.2 options per scheme (2015: 6.0) and an average of 16 534 members per option at year-end (2015: 16 742). Restricted schemes had an average of 2.3 options per scheme (2015: 2.3), with an average of 11 916 members per option as at 31 December 2016 (2015: 11 852).

Of the 280 benefit options at year end, 103 (36.8%) had fewer than 2 500 members per option (2015: 95 or 34.4%). Of these 103 options, 56 (54.4%) incurred net healthcare losses in 2016. In 2015, 49 options (51.6%) incurred losses.

The remaining 177 options (2015: 181) had more than 2 500 members per option. Of these, 57.6% or 102 options incurred net healthcare losses (2015: 55.8% or 101 options).

Table 44: Results of benefit options 2016

	Open schemes	% representing	Restricted schemes	% representing	Total
All options					
Number of options	142	50.7	138	49.3	280
Members represented	2 347 757	58.8	1 644 345	41.2	3 992 102
Number of schemes	23	27.7	60	72.3	83
Net healthcare result (R'000)	(955 717)		(1 435 083)		(2 390 800)
Gross non-healthcare as % of GCI	10.2		6.3		8.6
Gross claims ratio (%)	90.1		95.3		92.2
Gross claims incurred pbpm	1 464.9		1 361.9		1 419.4
GCI pbpm	1 625.6		1 429.0		1 538.7
Options with members >= 2 500					
Number of options	91	51.4	86	48.6	177
Members represented	2 289 304	59.1	1 584 974	40.9	3 874 278
Net healthcare result (R'000)	(904 197)		(1 228 418)		(2 132 615)
Gross non-healthcare as % of GCI	10.3		6.3		8.7
Gross claims ratio (%)	90.0		95.1		92.1
Gross claims incurred pbpm	1 457.2		1 346.3		1 408.4
GCI pbpm	1 618.4		1 416.2		1 529.3
Options with members < 2 500					
Number of options	51	49.5	52	50.5	103
Members represented	58 453	49.6	59 371	50.4	117 824
Net healthcare result (R'000)	(51 512)		(206 664)		(258 176)
Gross non-healthcare as % of GCI	8.3		6.4		7.3
Gross claims ratio (%)	92.7		101.2		97.0
Gross claims incurred pbpm	1 790.6		1 868.2		1 829.9
GCI pbpm	1 930.7		1 845.1		1 887.3

GCI = Gross Contribution Income
pbpm = per beneficiary per month

At the end of 2016, there were 51 options in open schemes with fewer than 2 500 members (2015: 45). They had an average of 1 146.1 members per option (2015: 1 076.2) and represented 35.9% (2015: 32.4%) of all open schemes options.

Restricted schemes had 52 options with fewer than 2 500 members (2015: 50). The average number of members per option was 1 141.8 (2015: 1 123.6) and these options represented 37.7% (2015: 36.5%) of all restricted schemes options.

Table 45: Results of loss-making benefit options 2016

	Open schemes	% representing	Restricted schemes	% representing	Total
Total loss making options					
% of total options	59.9		52.9		56.4
Number of options	85	53.8	73	46.2	158
Members represented	1 337 792	56.1	1 048 570	43.9	2 386 362
Net healthcare result (R'000)	(3 536 919)		(2 966 537)		(6 503 457)
Gross non-healthcare as % of GCI	9.7		5.7		7.8
Gross claims ratio (%)	96.0		100.2		97.9
Gross claims incurred pbpm	1 652.7		1 584.2		1 619.6
GCI pbpm	1 722.2		1 581.8		1 654.2
Loss making options with members > =2 500					
Number of options	59	57.8	43	42.2	102
Members represented	1 308 678	56.4	1 013 155	43.6	2 321 833
Net healthcare result (R'000)	(3 409 286)		(2 682 514)		(6 091 799)
Gross non-healthcare as % of GCI	9.8		5.7		7.9
Gross claims ratio (%)	95.8		99.8		97.6
Gross claims incurred pbpm	1 647.5		1 560.5		1 605.6
GCI pbpm	1 720.3		1 563.8		1 644.8
Loss making options with members < 2 500					
Number of options	26	46.4	30	53.6	56
Members represented	29 114	45.1	35 415	54.9	64 529
Net healthcare result (R'000)	(127 626)		(284 024)		(411 650)
Gross non-healthcare as % of GCI	7.3		5.7		6.4
Gross claims ratio (%)	100.1		109.3		105.2
Gross claims incurred pbpm	2 320.7		2 435.2		2 385.1
GCI pbpm	2 317.6		2 228.1		2 267.3

GCI = Gross Contribution Income
pbpm = per beneficiary per month

Of the 280 benefit options registered and operating at the end of 2016 (2015: 276), 158 (56.4%) incurred net healthcare losses. In 2015, 150 options (54.7%) incurred net healthcare losses. In the year under review, 85 options (2015: 80), representing 53.8% of loss-making options (2015: 53.6%), were in open schemes and 73 (2015: 70), representing 46.2% of loss-making options (2015: 46.4%), were in restricted schemes.

Net healthcare losses pmpm in options with fewer than 2 500 members were 2.4 times greater (2015: 3.1) than those for options with more than 2 500 members – an average of R-531.6 pmpm compared to R-218.6 pmpm (2015: R568.6 pmpm and R181.0 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 46 shows option results by demographics.

Table 46: Demographics of registered options at year-end 2016

	Open	Restricted	Total
Average age pb	**34.0**	**30.6**	
Net healthcare result pb	**-16.1**	**-30.5**	
Number of options with average age greater than or equal to the industry average	**92**	**77**	**169**
Number of options incurring net healthcare results better or equal to the industry average	39	25	64
Number of options incurring net healthcare results worse than the industry average	53	52	105
Number of options with average age below the industry average	**50**	**61**	**111**
Number of options incurring net healthcare results better or equal to the industry average	28	50	78
Number of options incurring net healthcare results worse than the industry average	22	11	33

pb = per beneficiary

There were 92 options with an average age above the 34.0 years for options in open schemes, and 50 benefit options with beneficiaries younger than the average in open schemes.

In the restricted schemes market, 77 benefit options had beneficiaries with an average age higher than the 30.6 years for all options in restricted schemes. A total of 61 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 deficit of R2 390.8m in 2016 (2015: R1 208.5m deficit). Open schemes incurred a total deficit of R955.7m (2015: R539.6m deficit), and restricted schemes generated a combined deficit of R1 435.1m (2015: R668.9m deficit). This deterioration is mainly due to the worsening claims ratios of all schemes from 91.4% in 2015 to 92.1% in 2016.

Figure 71: Net healthcare results: 2000 – 2016

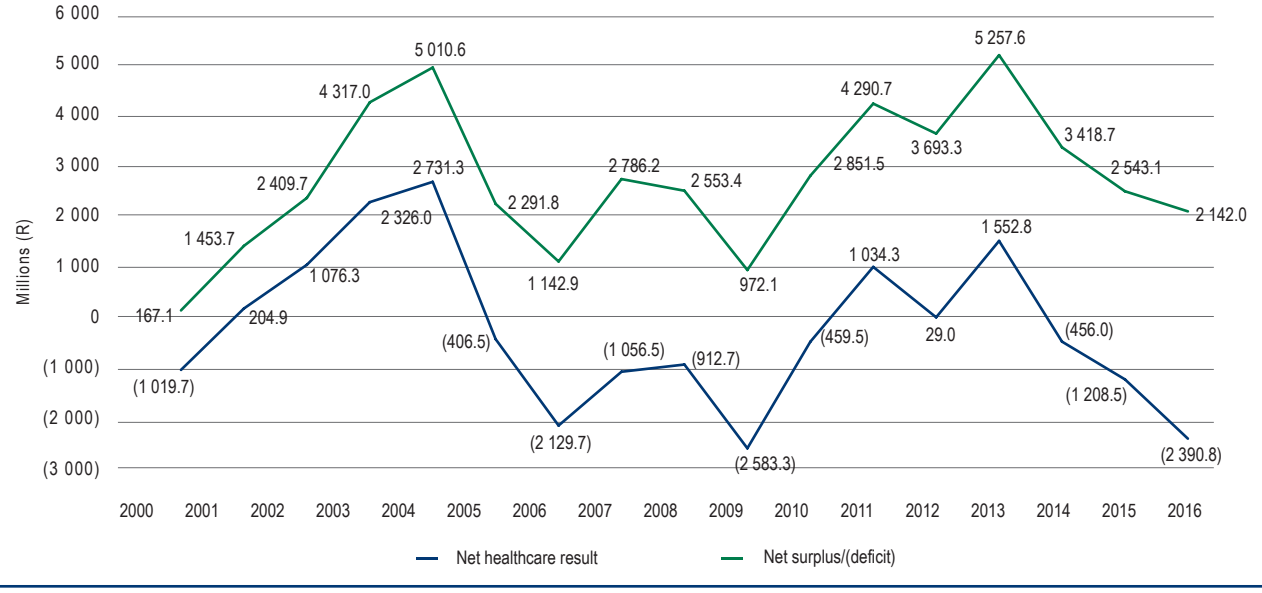


Table 47 shows the 20 schemes with the largest net healthcare deficits; they represent 82.3% of all beneficiaries of schemes that suffered operating deficits. (Annexure W has more details on this.) Investment income has boosted the performance of a number of these schemes, thus not experiencing major drops in their solvency levels.

Table 47: Twenty schemes with largest net healthcare deficits 2015 and 2016

Ref. no.	Name of medical scheme	Type	Net healthcare result 2016 R'000	Net healthcare result 2015 R'000	Net healthcare result % growth	Solvency ratio 2016 %	Solvency ratio 2015 %
1598	Government Employees Medical Scheme (GEMS)	Restricted	(723 160)	(205 108)	-252.6	7.0	9.5
1512	Bonitas Medical Fund	Open	(257 997)	(494 277)	47.8	24.4	26.1
1580	South African Police Service Medical Scheme (POLMED)	Restricted	(190 798)	(8 868)	-2 051.5	50.4	51.1
1202	Fedhealth Medical Scheme	Open	(159 782)	(67 785)	-135.7	31.5	35.7
1140	Medshield Medical Scheme	Open	(143 197)	(113 897)	-25.7	52.1	53.2
1012	Anglo Medical Scheme	Restricted	(135 311)	(119 407)	-13.3	529.2	505.2
1279	Bankmed	Restricted	(128 822)	(150 265)	14.3	40.1	42.5
1149	Medihelp	Open	(126 569)	(1 127)	-11 132.5	28.7	29.6
1576	LMS Medical Fund	Open	(93 036)	(99 825)	6.8	–	12.6
1167	Momentum Health	Open	(87 527)	(12 221)	-616.2	25.6	29.3
1422	Topmed Medical Scheme	Open	(82 107)	(66 291)	-23.9	77.9	86.4
1469	Nedgroup Medical Aid Scheme	Restricted	(67 832)	(28 441)	-138.5	32.9	35.1
1141	Spectramed	Open	(53 941)	(102 555)	47.4	30.2	37.0
1548	Medipos Medical Scheme	Restricted	(47 104)	(29 818)	-58.0	111.9	120.6
1194	Profmed	Restricted	(42 628)	(31 404)	-35.7	57.3	53.0
1446	Selfmed Medical Scheme	Open	(39 317)	(4 126)	-852.8	106.8	119.4
1600	Motohealth Care	Restricted	(36 443)	(26 379)	-38.2	51.6	54.4
1043	Chartered Accountants (SA) Medical Aid Fund (CAMAF)	Restricted	(34 329)	(53 343)	35.6	34.4	36.8
1214	Old Mutual Staff Medical Aid Fund	Restricted	(32 481)	6 607	-591.6	35.6	41.2
1441	Parmed Medical Aid Scheme	Restricted	(31 359)	4 473	-801.1	76.3	80.5

A total of 78.3% (or 18 of 23) of open schemes and 61.7% (37 of 60) of restricted schemes showed net healthcare deficits during the year.

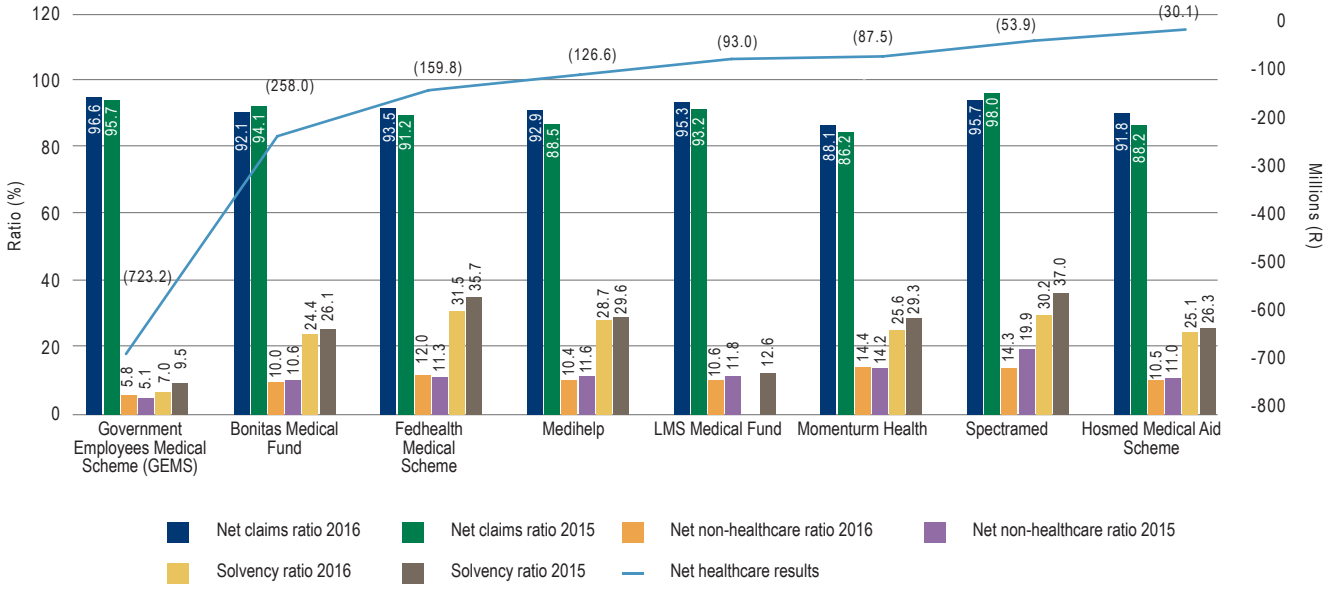
The net surplus of all schemes combined, after investment income and consolidation adjustments, was R2.1bn (2015: R2.5bn). Net investment and other income as well as expenditure decreased by 20.8% to R4.5bn. Open schemes made a R1.4bn (2015: R1.4 bn) surplus and restricted schemes a surplus of R.8bn (2015: R1.2bn).

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 72.

Figure 72 shows the schemes with the largest net healthcare deficits and whose solvency levels are below the industry average of 31.6%. (Annexure W provides more details.)

Figure 72: Schemes with largest net healthcare deficits and solvency levels below the industry average of 31.6% in 2016



Accumulated funds, solvency and solvency trends

Figure 73 below shows that all medical schemes incurred a surplus of R2.1bn compared to R2.5bn in 2015, representing a decline of 15.7%. The net assets, in terms of regulation 29 of the Medical Schemes Act, increased by 4.6% from R49.4bn in 2015 to a reported R51.7bn in 2016.

Figure 73: Net surplus and net assets per Regulation 29 of the Medical Schemes Act

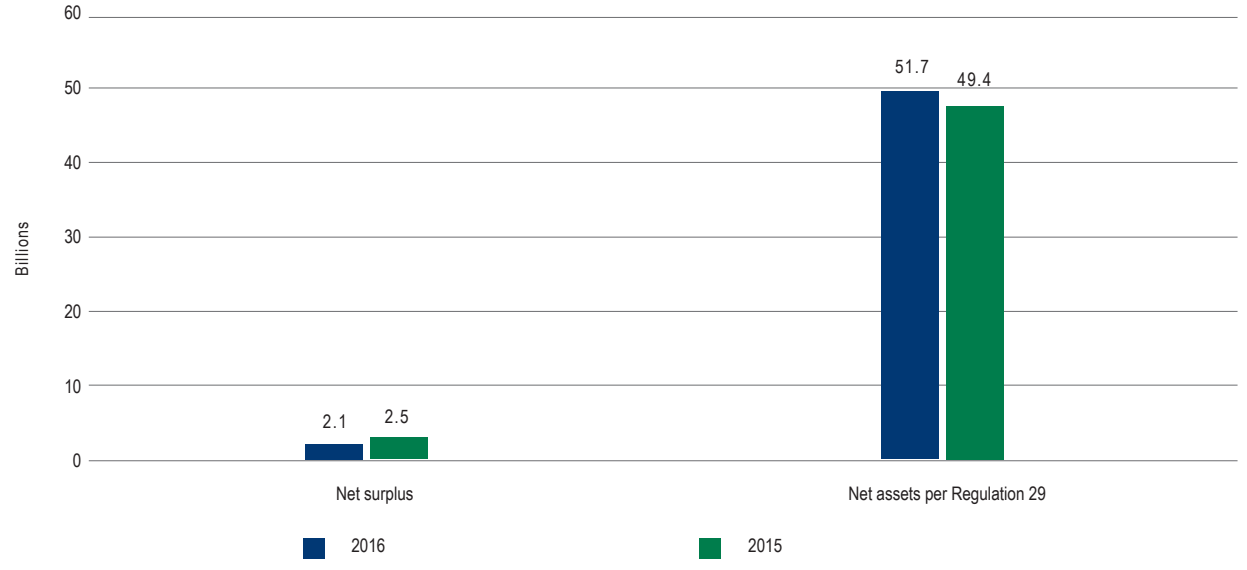
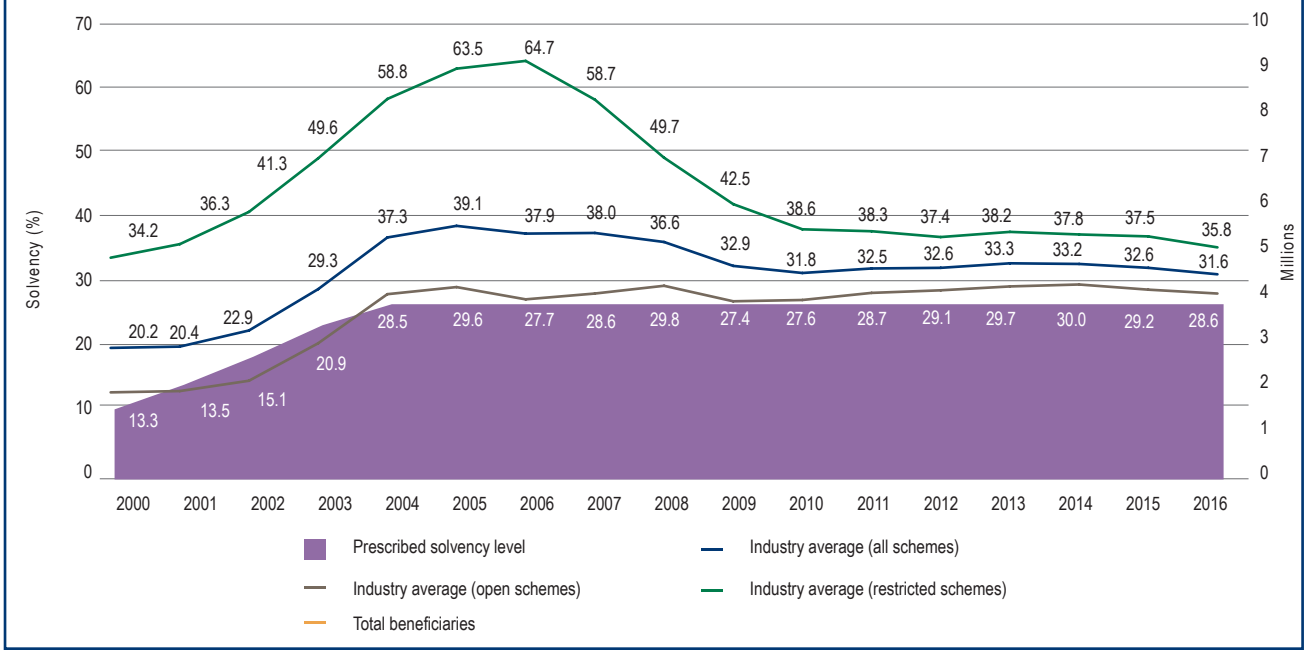


Figure 74: Industry solvency for all schemes: 2000 – 2016



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 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 to both protect members' interests and to guarantee the continued operation of the scheme, ensuring that it is able to meet members' claims as they arise. It also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio this serves as a warning of a medical scheme's possible inability to meet its obligations.

The size of a medical scheme plays a crucial role in terms of its ability to absorb adverse claims fluctuations and meet its obligations. Therefore, non-compliance with Regulation 29 does not necessarily mean that the scheme is in financial difficulties.

Factors that affect solvency

The most important factors affecting solvency are, inter alia:

- Membership growth
- The performance of the medical scheme (including claims and non-healthcare expenditure)
- Investment income

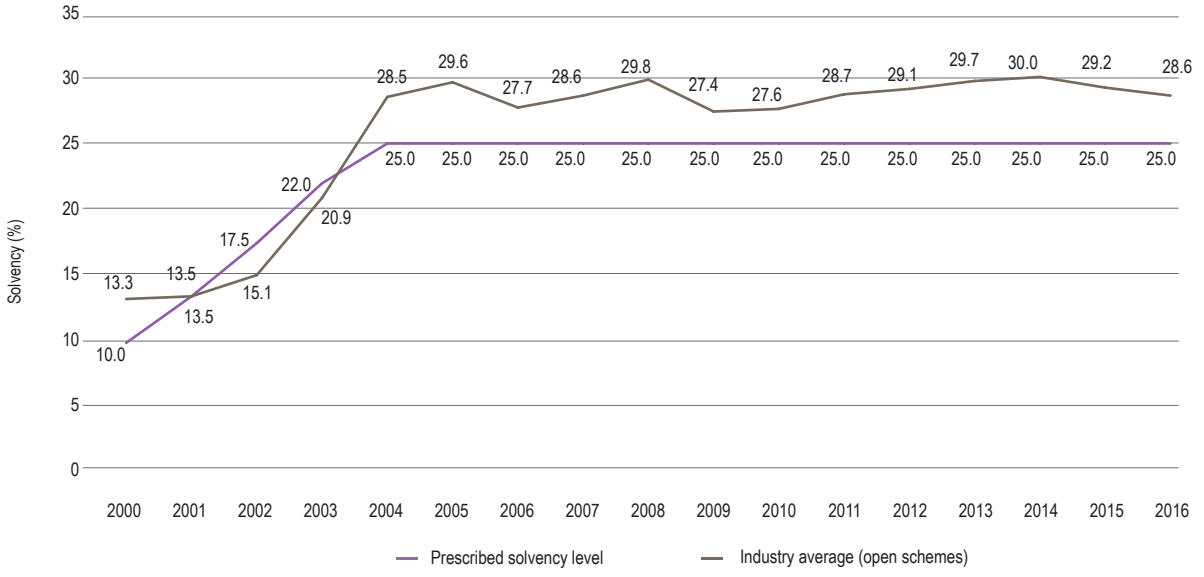
The membership profile of a medical scheme further affects its solvency. Membership includes variables such as the average age of beneficiaries, the proportion of pensioners, the relative number of male and female dependants, and the dependant ratio. All of these affect the frequency and extent of claims.

Net assets or members' funds (total assets minus total liabilities) rose by 3.8% to end 2016 at R54.1bn. Accumulated funds grew by 4.5% to R52.6bn from the R50.3bn recorded in 2015. The industry average solvency ratio decreased to 31.6% in 2016 from 32.6% in 2015.

The solvency ratio of open schemes decreased by (2.1)% to 28.6% in 2016 (2015: 29.2%). Restricted schemes experienced a decrease of (4.5)% in their solvency ratio, 35.8% from 37.5% in 2015. 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 schemes industry remained fairly constant between 2004 and 2016, slightly above the 25.0% solvency ratio prescribed by the Medical Schemes Act.

Figure 75: Industry solvency for open schemes: 2000 – 2016



As indicated in Figure 76, the restricted schemes 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: 2000 – 2016

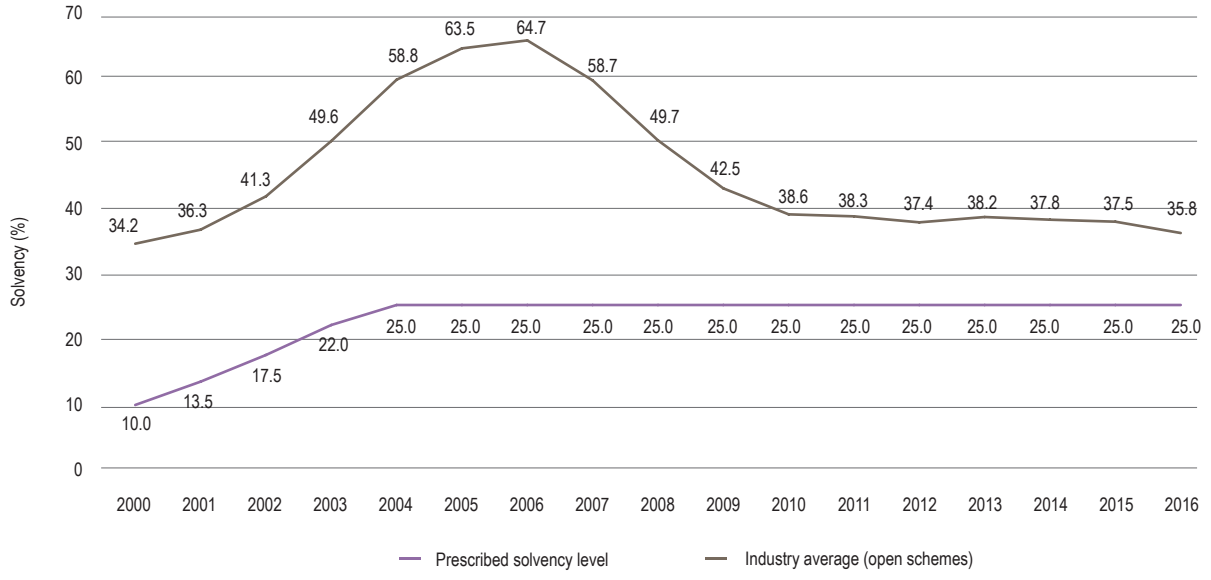


Table 48: Risk claims, non-healthcare expenditure and reserve-building as a percentage of contributions 1999 – 2016

	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	9.6	-1.6

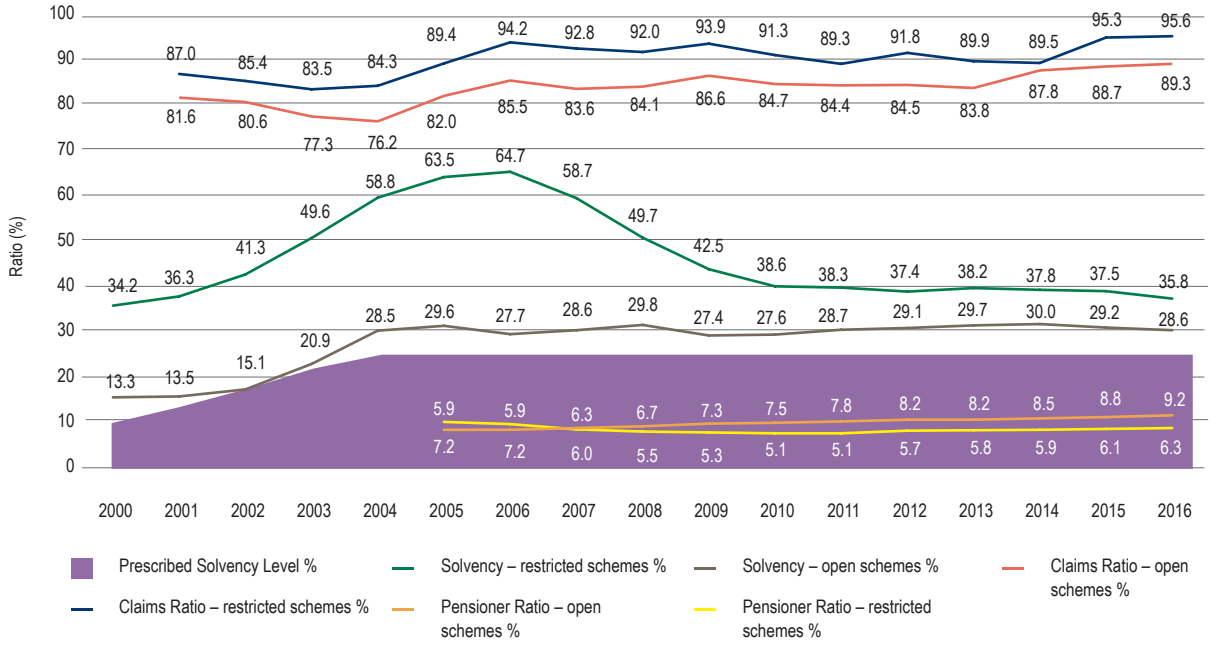
RCI = risk contribution income

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. During periods of 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 2015; while 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. The maintenance of reserves as a protection for members should be considered against the backdrop of increasing claim costs, changing demographic profiles and 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 started with operations only on 1 January 2006.

Figure 77: Impact of GEMS: 2006 – 2016

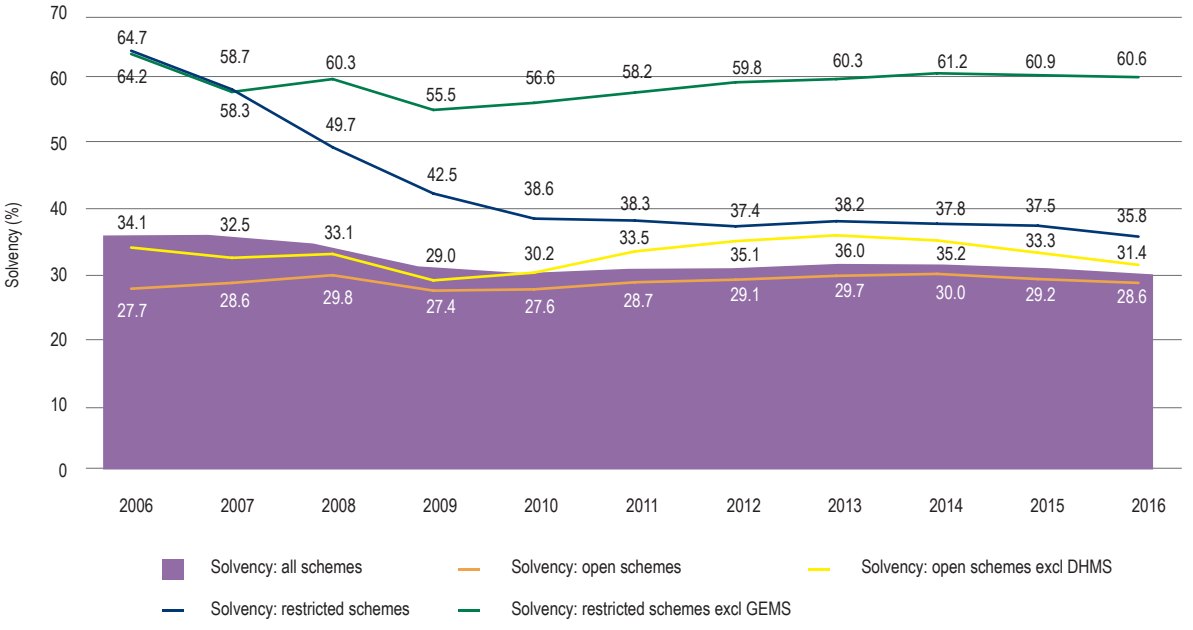


Claims data per industry was available only from 2001 onwards and pensioner ratios from 2005 onwards.

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 since then, 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: 2006 – 2016



Excluding GEMS, the restricted industry solvency ratio decreased in 2009 to 55.5% and then increased from 2010 onwards to 60.6% in 2016. 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 2016 open industry solvency ratio increases to 31.4% (from 28.6%).

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 which failed to reach the 25.0% solvency

Table 49 and Figure 79 show both the number of medical schemes that have yet to attain the prescribed solvency ratio of 25.0%, and the number of beneficiaries in those schemes.

Table 49: Prescribed solvency and number of beneficiaries 2000 – 2016

Year	Number of open schemes		Number of restricted schemes	
	Below prescribed level	Above prescribed level	Below prescribed level	Above prescribed level
2000	15	33	15	86
2001	19	29	11	83
2002	24	25	7	86
2003	19	29	7	80
2004	18	30	4	81
2005	17	29	4	79
2006	18	23	4	79
2007	18	23	7	74
2008	14	21	8	71
2009	16	17	3	71
2010	12	15	7	66
2011	9	17	5	66
2012	7	18	4	63
2013	6	18	3	60
2014	5	18	2	58
2015	4	19	3	57
2016	4	18	3	57

Year	Number of beneficiaries in open schemes			Number of beneficiaries in restricted schemes		
	Below prescribed level		Above prescribed level	Below prescribed level		Above prescribed level
	At end	%	At end	At end	%	At end
2000	2 385 051	51.0	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	194 983	3.9	4 743 470	1 943 387	50.2	1 927 683
2016	824 147	16.6	4 129 033	1 908 478	48.6	2 016 423

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 only due to amalgamation, but also due to schemes attaining the minimum solvency ratio.

Figure 79: Prescribed solvency and number of beneficiaries: 2015 and 2016

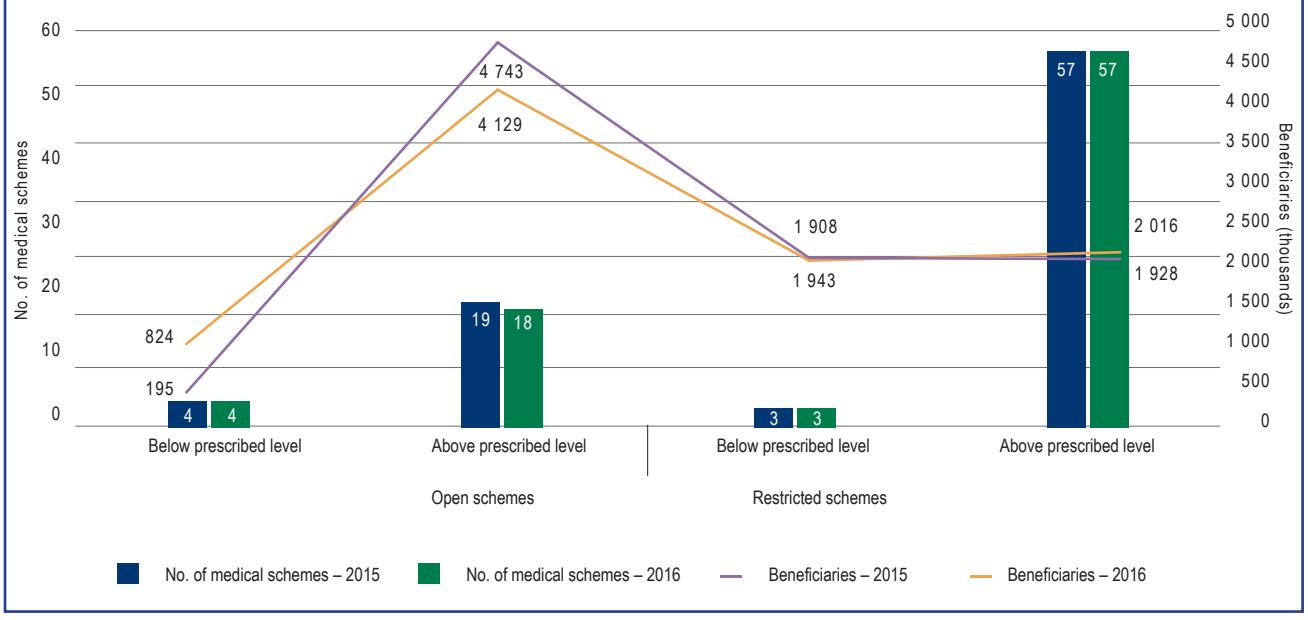


Table 50: Schemes on close monitoring in the last six years

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments
2010	12				7			
2011	9	-3	0	Protea Medical Aid Society liquidated Pro Sano Medical Scheme reached 25% Spectramed reached 25%	5	-1	-1	Lonmin Medical Scheme reached 25% Built Environment Professional Associations Medical Scheme (BEPS) amalgamated with Topmed Medical Scheme
2012	7	-1	-1	National Independent Medical Aid Society (NIMAS) amalgamated with Resolution Health Medical Scheme Community Medical Aid Scheme (COMMED) reached 25% Momentum Health reached 25% Pro Sano Medical Scheme fell below 25%	4	-1	0	Minemed Medical Scheme reached 25%

	Open schemes				Restricted schemes			
	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments	Number of schemes below 25%	Change in number of schemes below 25%	Changes due to amalgamations	Comments
2013	6	0	-1	Pro Sano Medical Scheme amalgamated with Bonitas Medical Fund	3	-1	0	Altron Medical Aid Scheme reached 25%
				Keyhealth reached 25%				
				Liberty Medical Scheme dropped below 25%				
2014	5	0	-1	Pharos Medical Plan amalgamated with Topmed Medical Scheme	2	-1	0	Umvuzo Health Medical Scheme reached 25%
				Discovery Health Medical Scheme reached 25%				
				Hosmed Medical Aid Scheme reached 25%				
				Community Medical Aid Scheme (COMMED) fell below 25%				
				Suremed Health fell below 25%				
2015	4	-1	0	Suremed Health reached 25%	3	1	0	Platinum Health dropped below 25%
2016	4	1	- 1	Bonitas Medical Fund dropped below 25%	3	0	0	Platinum Health reached 25%
				Liberty Medical Scheme amalgamated with Bonitas Medical Fund				Lonmin Medical Scheme dropped below 25%

A total of 16.6% beneficiaries in open schemes (2015: 3.9%) were covered by the four open schemes (2015: 4) which failed to meet the prescribed solvency level in 2016. The remaining beneficiaries belonged to the other 18 open schemes (2015: 19) which had attained the prescribed solvency level of 25%.

In the period after 2000, a high proportion of beneficiaries in the open industry were 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 and 2016 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015, this figure was a mere 3.9% compared to 59.0% in 2013. In 2016, Bonitas Medical Fund fell below 25%, increasing the percentage again to 16.6 %.

Of the 60 restricted schemes, only three had solvency ratios below 25%. These three, however, accounted for 48.6% of all beneficiaries in restricted schemes. GEMS still finds itself below the statutory solvency level of 25% and this accounts for 96.1% of beneficiaries in schemes which have yet to achieve the prescribed solvency ratio. The table below provides a summary of performance of schemes that were below the required statutory minimum solvency of 25% as at 31 December 2016.

Table 51: Summary of performance of schemes below 25% solvency in 2016

Ref. No.	Name of scheme	Average beneficiaries	Average age pb (years)	Pensioners ratio (%)	Net claims ratio (%)		Net surplus/deficit		Solvency ratio (%)	
		2016	2016	2016	2016	2015	2016	2015	2016	2015
1512	Bonitas Medical Fund	676 785	32.8	7.7	92.1	94.1	-16 908	-205 559	24.4	26.1
1598	Government Employees Medical Scheme (GEMS)	1 801 999	30.1	5.7	96.6	95.7	-484 650	5 314	7.0	9.5
1599	Lonmin Medical Scheme	21 531	35.9	0.0	108.3	106.0	-11 787	-4 900	15.0	26.0
1575	Resolution Health Medical Scheme	37 546	40.0	15.2	87.5	87.2	6 342	2 468	12.2	10.4
1592	Thebemed	22 018	27.1	0.5	86.3	82.4	-3 256	4 651	18.6	22.3
1582	Transmed Medical Fund	57 137	52.5	39.7	85.2	105.3	80 053	-117 286	20.8	14.1

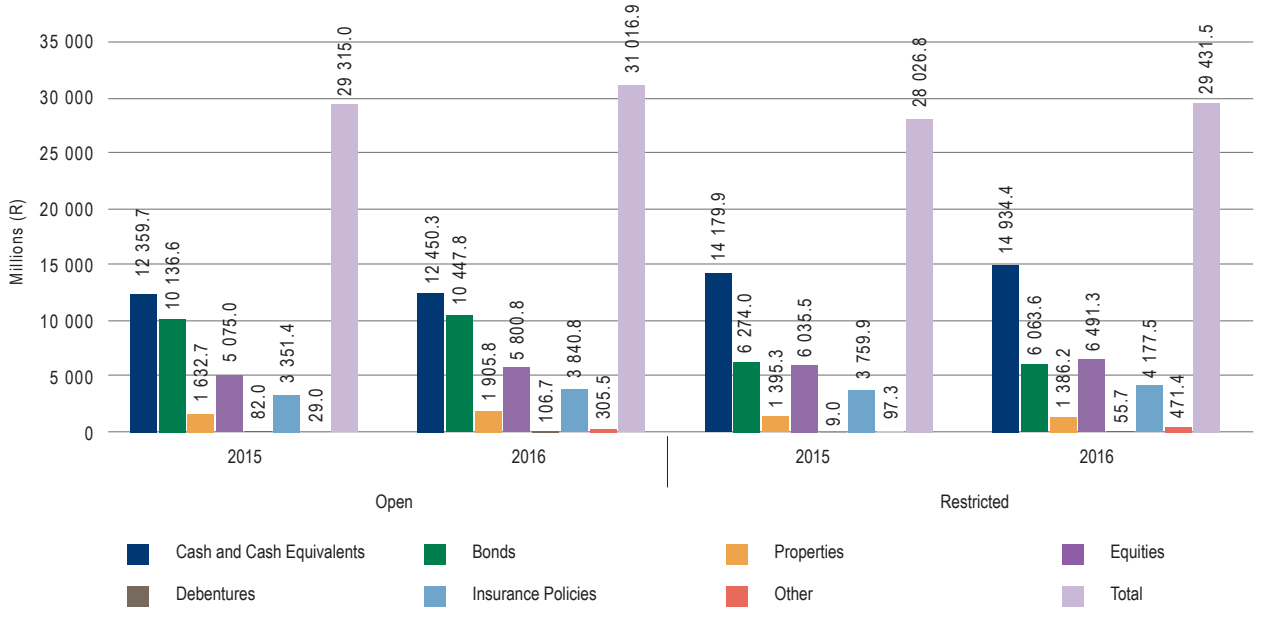
pb = per beneficiary

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 thus far in moving towards the prescribed solvency levels. Much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

Investments

Figure 80 provides information on the investments of medical schemes as at the end of the years 2015 and 2016.

Figure 80: Scheme investments: 2015 and 2016



In open schemes, 40.1% of investments (2015: 42.2%) were held in cash or cash equivalents. Bonds accounted for 33.7% (2015: 34.6%), debentures for 0.3% (2015: 0.3%), equities for 18.7% (2015: 17.3%), non-linked insurance policies for 0.0% (2015: 0.0%), properties for 6.1% (2015: 5.6%), and other investments for 1.0% (2015: 0.1%).

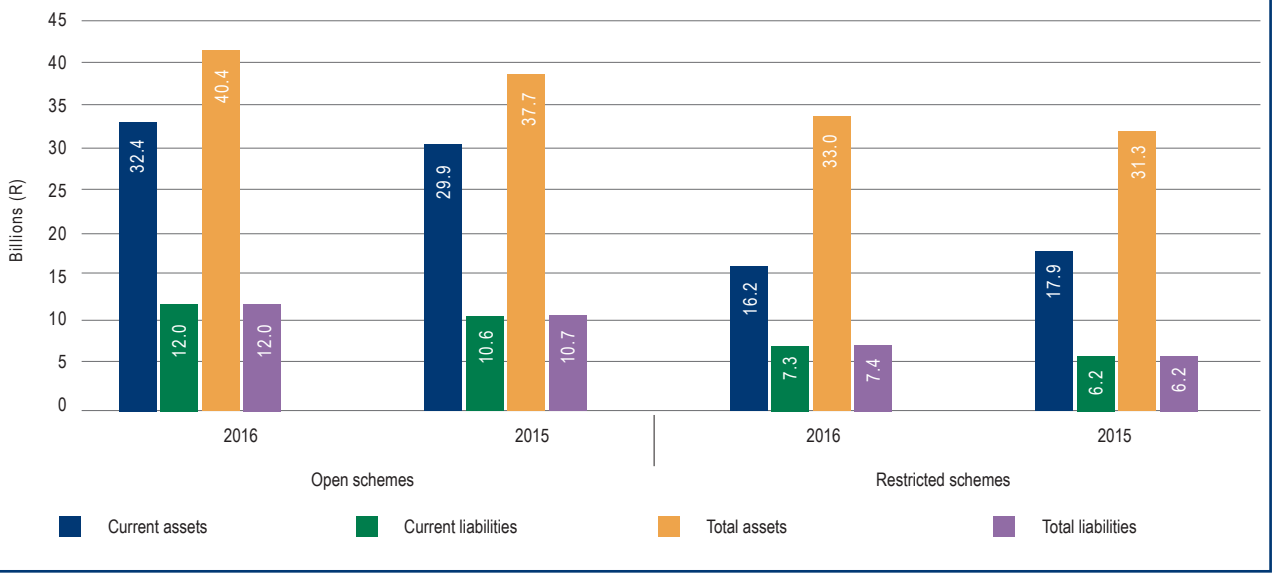
Restricted schemes also held a large proportion of their investments (50.7%) in cash or cash equivalents (2015: 50.6%). Their bonds accounted for 20.6% (2015: 22.4%) and debentures for 0.2% (2015: 0.0%). Equities made up 22.1% (2015: 21.5%), non-linked insurance policies 0.1% (2015: 0.1%), properties 4.7% (2015: 5.0%), and other investments 1.6% (2015: 0.3%).

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

Figure 81: Matching of assets and liabilities: 2015 and 2016



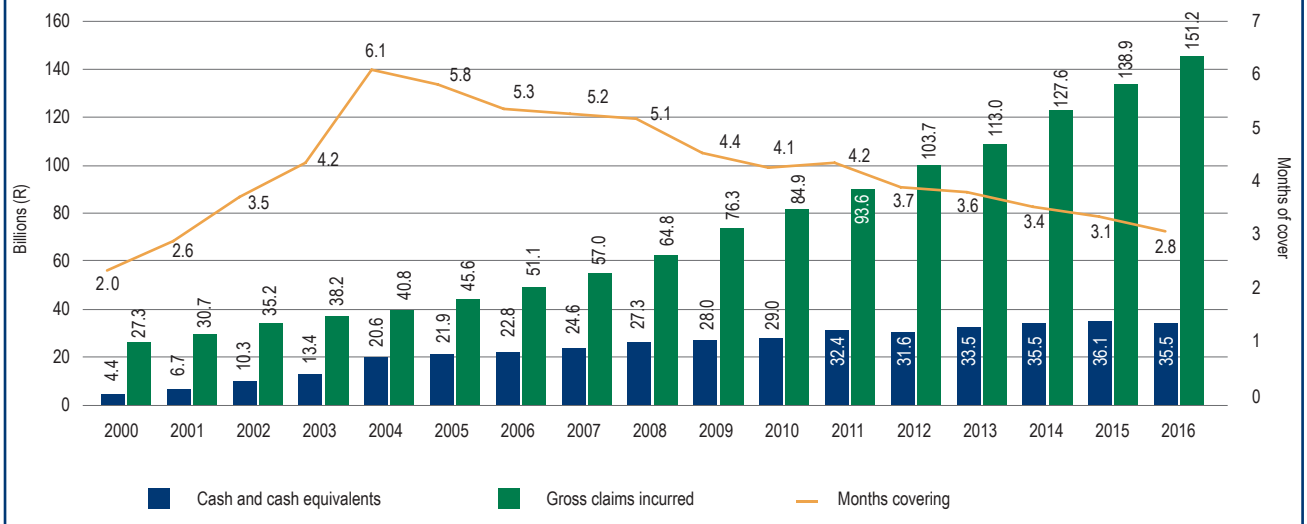
The current-assets-to-current-liabilities ratio in open schemes was 2.7:1 in 2016 (2.8:1 in 2015) and it was 2.2:1 (2015: 2.9:1) in restricted schemes. The total-asset-to-total-liability ratio for open and restricted schemes in 2016 was 3.4:1 (2015: 3.5:1) and 4.5:1 (2015: 5.0:1) respectively.

The principle of matching assets with liabilities is particularly important in the context of liquidity. Where the claims-paying ability of medical schemes with low liquidity (that is, a quick ratio below 2.0) is lower than the industry average of 2.8 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 82 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 82: Average gross claims covered by cash and cash equivalents: 2000 – 2016

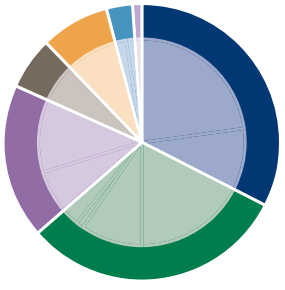


The length of cash coverage declined from 3.1 months in 2015 to 2.8 months in December 2016. Payment cycles of medical schemes in 2016 were an average of 14.0 days compared with the 23.3 days in 2015.

Administrator market

Figure 83 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 2016[1].

Figure 83: Administrator market share at the end of 2016

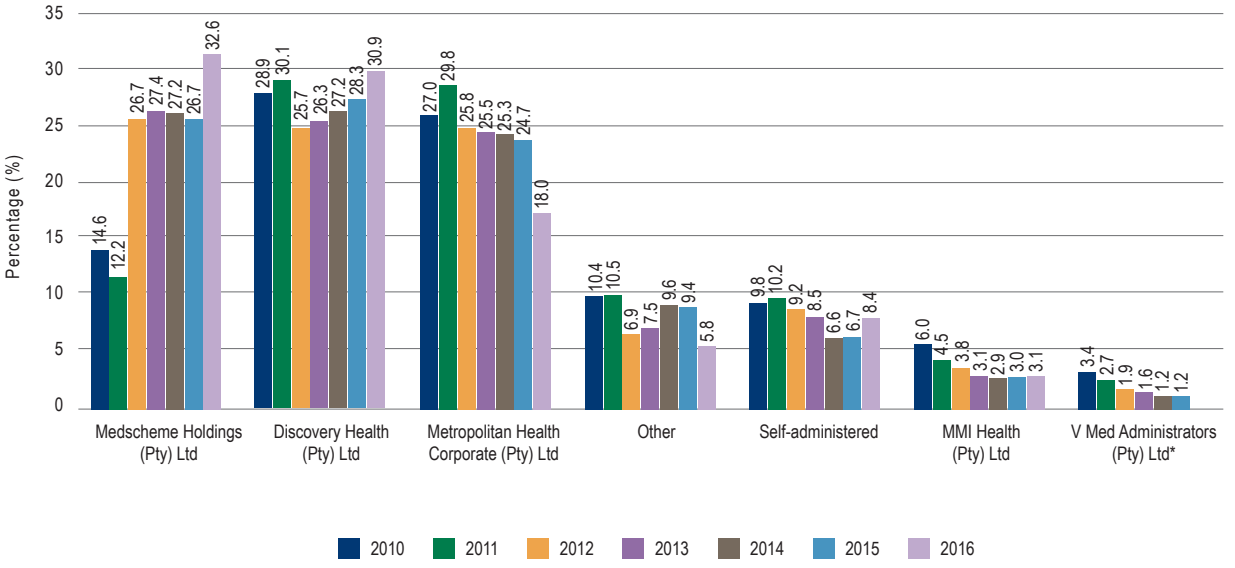


Medscheme Holdings (Prty) Ltd	32.6%	Self-administered	8.4%
Discovery Health (Pty) Ltd	30.9%	MMI Health (Pty) Ltd	3.1%
Metropolitan Health Corporate (Pty) Ltd	18.0%	V Med Administrators (Pty) Ltd	1.2%
Other	5.8%		

[1] *The data that is presented here differs from Annexure FSU17 which is based on the average membership administered during the year.*

Figure 84 depicts the changes in market share of all medical schemes over the last seven years, based on the average number of beneficiaries administered by the various parties at the end of each year.

Figure 84: Market share of largest administrators based on average number of beneficiaries 2010 – 2016*



* *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 AC).*

Five third-party administrators continued to dominate the market in 2016, namely:

- Discovery Health (Pty) Ltd.
- Metropolitan Health Corporate (Pty) Ltd.
- Medscheme Holdings (Pty) Ltd.
- MMI Health (Pty) Ltd.
- V Med Administrators (Pty) Ltd.

Collectively the above companies administer 85.8% of the market (excluding self-administered medical schemes)[2]. Table 52 indicates the change in administrator market share between 2010 and 2016.

Figure 85 shows the change in market share for the administrators with the largest share of the market for all schemes, between 2010 and 2016. Overall, Medscheme Holdings (Pty) Ltd grew by 123.3% and is now the largest administrator, with a market share of 32.6%.

[2] *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.*

Figure 85: Percentage change in administrators with largest market share for all schemes: 2010 – 2016

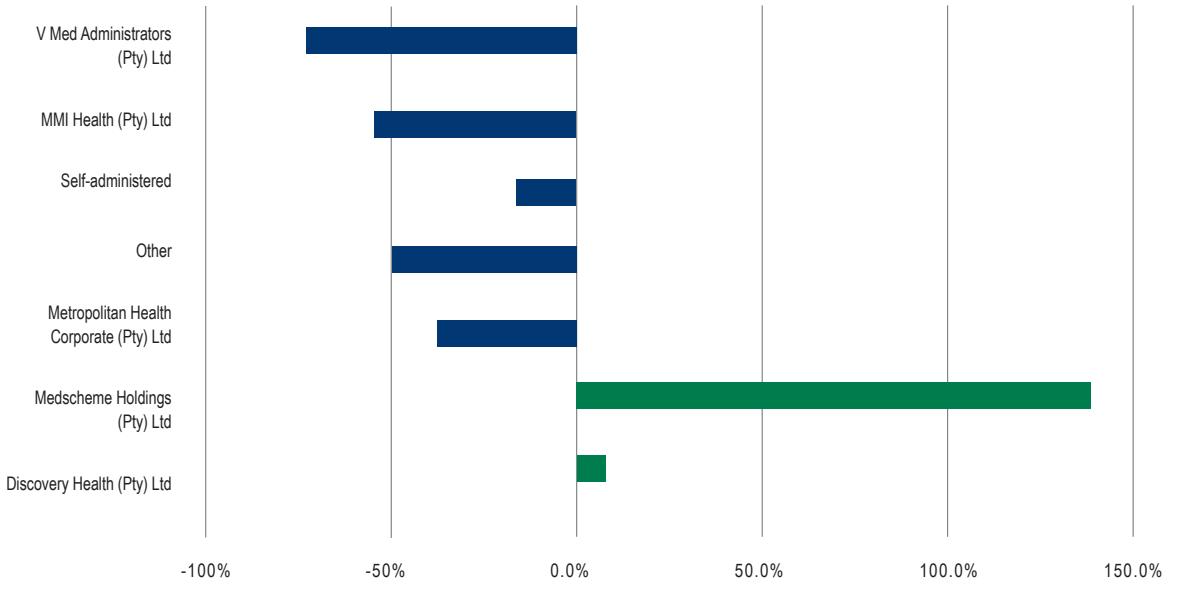
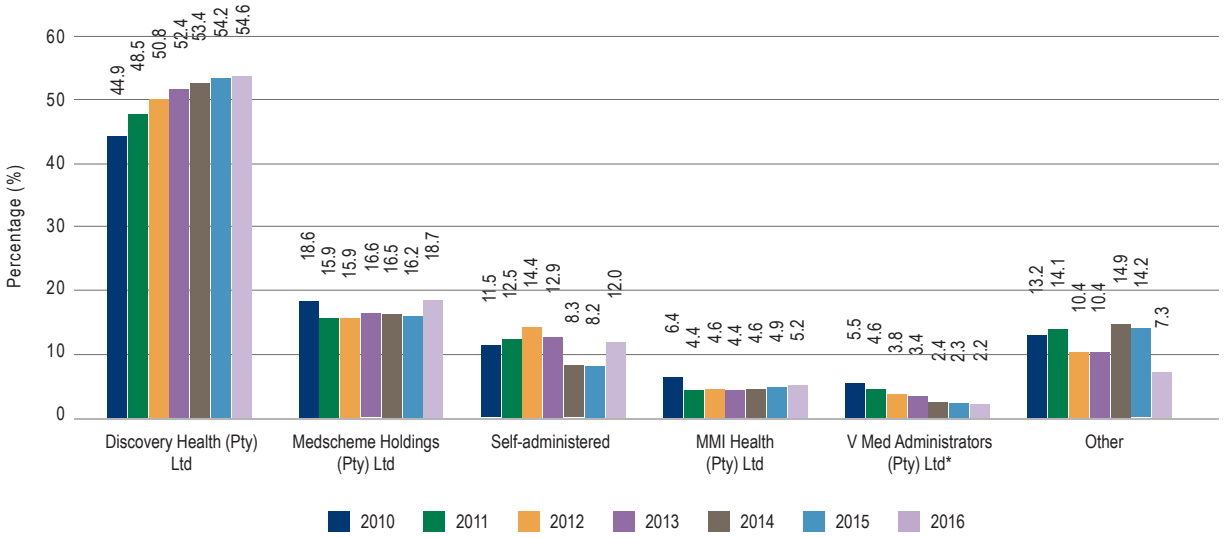


Table 52: Administrator market share 2010 – 2016

Largest market share – all schemes	2010	2011	2012	2013	2014	2015	2016	% change: 2010 – 2016
Medscheme Holdings (Pty) Ltd	14.6%	12.2%	26.7%	27.4%	27.2%	26.7%	32.6%	123.3%
Discovery Health (Pty) Ltd	28.9%	30.1%	25.7%	26.3%	27.2%	28.3%	30.9%	6.9%
Metropolitan Health Corporate (Pty) Ltd	27.0%	29.8%	25.8%	25.5%	25.3%	24.7%	18.0%	-33.3%
Other	10.4%	10.5%	6.9%	7.5%	9.6%	9.4%	5.8%	-44.2%
Self-administered	9.8%	10.2%	9.2%	8.5%	6.6%	6.7%	8.4%	-14.3%
MMI Health (Pty) Ltd	6.0%	4.5%	3.8%	3.1%	2.9%	3.0%	3.1%	-48.3%
V Med Administrators (Pty) Ltd	3.4%	2.7%	1.9%	1.6%	1.2%	1.2%	1.2%	-64.7%
Total	**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%	54.6%	21.6%
Medscheme Holdings (Pty) Ltd	18.6%	15.9%	15.9%	16.6%	16.5%	16.2%	18.7%	0.5%
Self-administered	11.5%	12.5%	14.4%	12.9%	8.3%	8.2%	12.0%	4.3%
MMI Health (Pty) Ltd	6.4%	4.4%	4.6%	4.4%	4.6%	4.9%	5.2%	-18.8%
V Med Administrators (Pty) Ltd	5.5%	4.6%	3.8%	3.4%	2.4%	2.3%	2.2%	-60.0%
Other	13.2%	14.1%	10.4%	10.4%	14.9%	14.2%	7.3%	-44.7%
Total	**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%	44.2%	396.6%
Metropolitan Health Corporate (Pty) Ltd	64.9%	67.8%	47.4%	46.7%	46.6%	46.2%	33.7%	-48.1%
Discovery Health (Pty) Ltd	6.2%	6.4%	4.4%	4.6%	5.1%	5.7%	10.2%	64.5%
Self-administered	7.3%	7.1%	4.8%	4.9%	5.1%	5.5%	5.3%	-27.4%
MMI Health (Pty) Ltd	5.4%	4.7%	3.0%	2.1%	1.4%	1.4%	1.4%	-74.1%
Other	7.4%	6.7%	4.4%	5.4%	5.4%	5.3%	5.2%	-29.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Figures 86 and 88 indicate the changes in administrator market share over the last seven years for open and restricted medical schemes.

Figure 86: Open schemes market share of largest administrators based on average number of beneficiaries 2010 – 2016*



* *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 AC).*

Figures 87 and 89 indicate the percentage growth or decline in market share between 2010 and 2016 for open and restricted medical schemes respectively.

Figure 87: Percentage change in administrators with largest market share for open schemes: 2010 – 2016

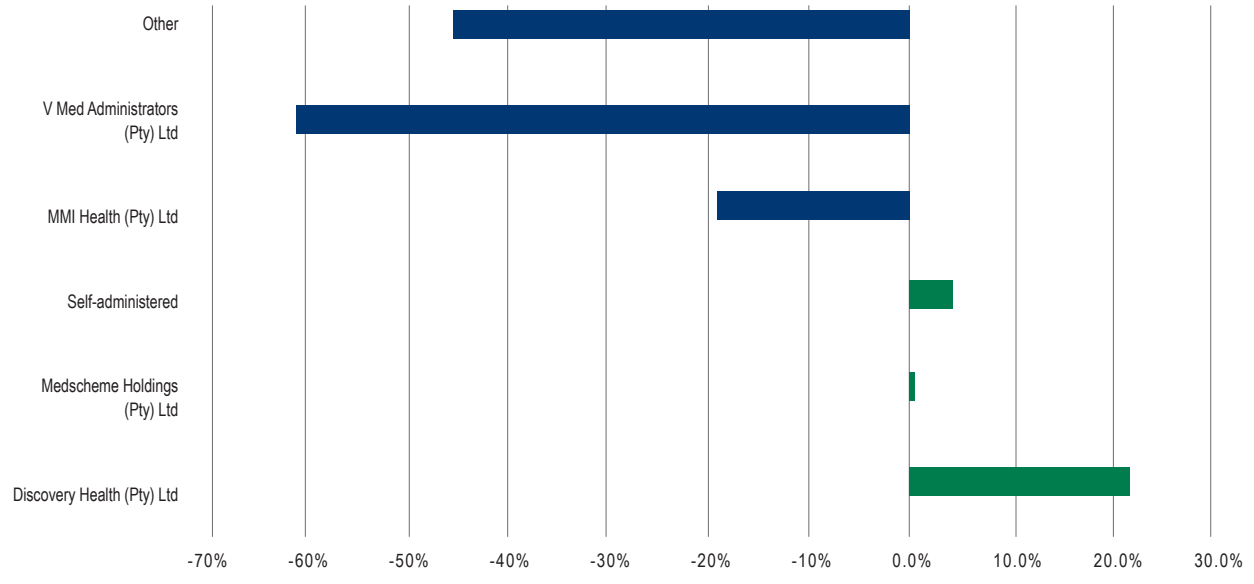
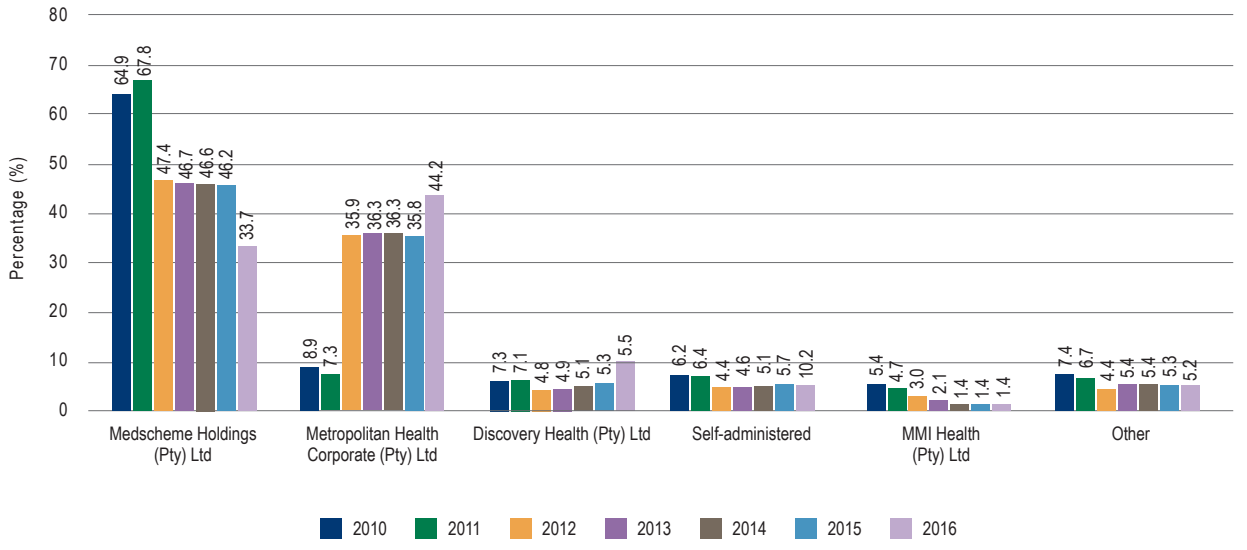


Figure 88: Restricted schemes market share of largest administrators based on average number of beneficiaries 2010 – 2016*



* *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 AC).*

Discovery Health (Pty) Ltd share of the open schemes market increased to 54.6% (2015: 54.2%) and its share in the restricted schemes market increased to 10.2% (2015: 5.7%).

Medscheme Holdings (Pty) Ltd has the second biggest share in the open schemes administration market at 18.7% (2015: 16.2%) and the biggest share in the restricted schemes administration market at 44.2% (2015: 35.8%). Medscheme Holdings (Pty) Ltd has been responsible for GEMS's contribution and debt management as well as correspondence services since 1 January 2012.

Metropolitan Health Corporate (Pty) Ltd has the second biggest share of the restricted schemes market at 33.7% (2015: 46.2%).

Table 53 shows the five administrators who had higher administration costs and fees than the industry average of administrators handling open schemes.

Figure 89: Percentage change in administrators with largest market share for restricted schemes: 2010 – 2016

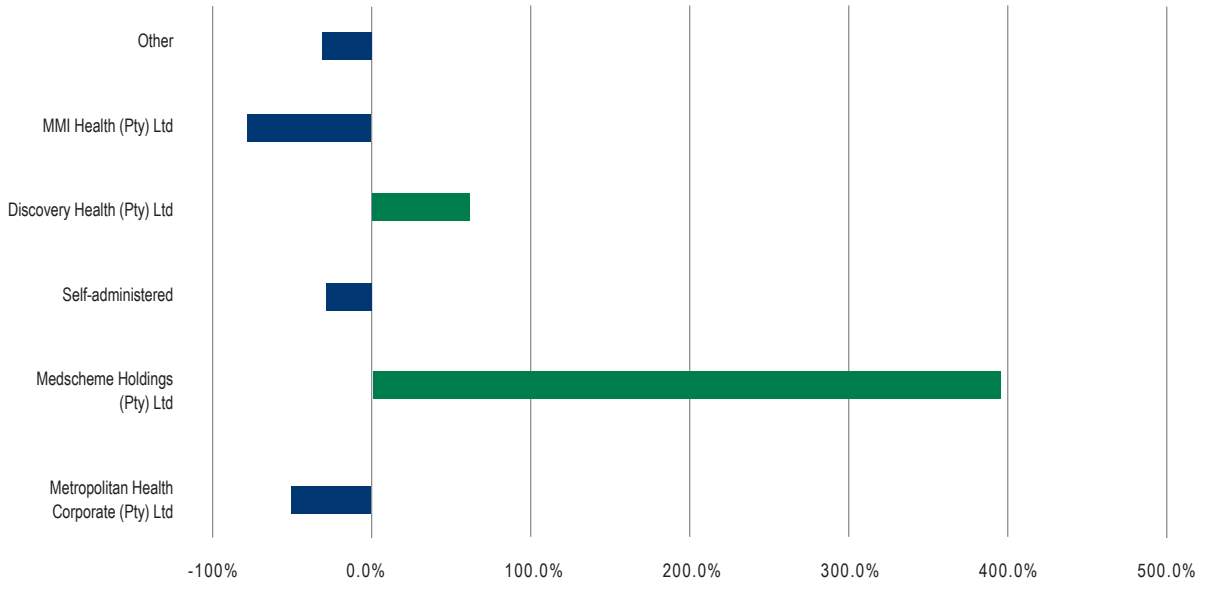


Table 53: Percentage deviation from industry average: open schemes

	Gross administration costs	Administration fees paid*	Fees paid to administrators
	%	%	%
Allcare Administrators (Pty) Ltd	113.8	35.7	35.7
Discovery Health (Pty) Ltd	0.2	24.5	24.5
Universal Healthcare Administrators (Pty) Ltd	8.5	6.4	6.4
Sechaba Medical Solutions (Pty) Ltd	27.0	3.2	3.2
Agility Health (Pty) Ltd	44.9	1.1	1.1

* *Excluding co-administration fees*

Table 54 shows the two administrators of restricted schemes with higher administration costs and fees than the industry average for restricted schemes.

Table 54: Percentage deviation from industry average: restricted schemes

	Gross administration costs	Administration fees paid*	Fees paid to administrators
	%	%	%
Sanlam Health Administrators (Pty) Ltd	79.2	72.6	72.6
Professional Provident Society Healthcare Administrators (Pty) Ltd	82.9	28.7	28.7

* *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 55 and 56 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 AC.)

Table 55: Administrator market share 2016: open schemes

Name of administrator	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Agility Health (Pty) Ltd	2	1.3	191.8	10.8	103.7	5.8	103.7	5.8	1,782.3	91.1
Allcare Administrators (Pty) Ltd	1	0.3	283.1	17.8	139.2	8.8	139.2	8.8	1,588.8	91.9
Discovery Health (Pty) Ltd	1	54.6	132.7	8.0	127.7	7.7	127.7	7.7	1,663.5	87.2
Medscheme Holdings (Pty) Ltd	3	18.7	117.3	8.0	80.7	5.5	80.7	5.5	1,463.5	92.5
MMI Health (Pty) Ltd	1	5.2	105.4	8.8	99.7	8.3	99.7	8.3	1,195.9	88.1
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.5	161.2	7.3	96.2	4.4	96.2	4.4	2,196.6	91.4
Providence Healthcare Risk Managers (Pty) Ltd	2	0.4	87.5	7.5	67.0	5.8	67.0	5.8	1,164.5	89.1
Sechaba Medical Solutions (Pty) Ltd	1	2.5	168.1	10.7	105.9	6.7	105.9	6.7	1,571.8	88.4
Self-Administered	6	12.0	134.2	7.9	19.0	1.1	19.0	1.1	1,694.2	91.5
Sweidan and Company (Pty) Ltd	1	0.9	119.8	8.2	84.5	5.8	84.5	5.8	1,451.8	99.4
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	1.9	126.5	9.2	79.4	5.8	79.4	5.8	1,368.3	91.1
Universal Healthcare Administrators (Pty) Ltd	2	0.6	143.6	9.9	109.2	7.5	109.2	7.5	1,368.3	91.1
V Med Administrators (Pty) Ltd	1	2.2	78.1	7.5	56.4	5.5	56.4	5.5	1,034.8	93.9
Average	**24**	**102.1**	**132.4**	**8.2**	**102.6**	**6.3**	**102.6**	**6.3**	**1,624.2**	**89.3**

LMS Medical Fund changed its administrator from V Med Administrators (Pty) Ltd to Medscheme Holdings (Pty) Ltd with effect from 1 August 2016. 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

Table 56: Administrator market share 2016: restricted schemes

Name of administrator	No of schemes	Beneficiaries	Gross administration costs		Administration fees paid*		Total fees paid to administrators		Gross contributions	Risk claims ratio
		Market share %	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	As % of GCI	pabpm R	%
Discovery Health (Pty) Ltd	16	10.2	98.6	6.5	84.6	5.6	84.6	5.6	1,510.4	93.6
Medscheme Holdings (Pty) Ltd**	12	44.2	34.3	2.4	54.6	1.1	27.8	1.9	1,453.8	96.8
METHEALTH (Pty) Ltd	4	0.8	112.9	7.3	88.7	5.8	88.7	5.8	1,541.6	97.1
Metropolitan Health Corporate (Pty) Ltd	7	33.7	63.4	71.6	34.7	39.2	34.7	39.2	1,449.5	96.4
MMI Health (Pty) Ltd	3	1.4	98.6	7.1	78.0	5.6	78.0	5.6	1,383.0	96.0
Prime Med Administrators (Pty) Ltd	1	0.7	71.4	4.1	64.9	3.7	64.9	3.7	1,755.0	96.8
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1.2	197.5	11.9	117.1	7.1	117.1	7.1	1,657.0	90.6
Providence Healthcare Risk Managers (Pty) Ltd	3	0.8	58.7	6.6	41.7	4.7	41.7	4.7	884.0	94.6
Sanlam Health Administrators (Pty) Ltd	1	0.8	193.5	10.2	157.1	8.3	157.1	8.3	1,890.3	92.3
Self-Administered	8	5.3	75.1	6.8	-	-	-	-	1,105.6	91.8
Sweidan and Company (Pty) Ltd	1	0.1	107.7	6.5	69.0	4.2	69.0	4.2	1,655.0	91.4
Universal Healthcare Administrators (Pty) Ltd	4	0.7	93.0	7.1	79.8	6.1	79.8	6.1	1,312.1	95.4
V Med Administrators (Pty) Ltd	1	0.2	108.0	6.1	91.0	5.1	91.0	5.1	1,780.1	89.3
Average	**62**	**100.0**	**58.7**	**6.0**	**33.3**	**3.4**	**38.7**	**3.9**	**984.6**	**95.6**

* *Excluding co-administration fees.*
** *The GEMS co-administration fee was included in the cash flows under administration; the GEMS average beneficiaries were included.*
pabpm = per average beneficiary per month
GCI = Gross Contribution Income

Table 57 indicates the total fees paid to the top four third party administrators in terms of market share for all schemes, as well as the schemes falling under their administration.

Table 58 shows market share of administrators, including accredited managed healthcare services.

Table 59 shows the two administrators that had the highest deviation from the 2016 industry average of R96.10 pabpm in respect of total fees received by administrators.

Table 57: Total fees paid to administrators (excluding accredited managed healthcare services) deviation from average per administrator in 2016

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	As % of	pampm	
				R	GAE	R	%
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 280 494	270.1	96.3	254.3	6.2
1145	LA-Health Medical Scheme		60 832	257.2	92.4		1.1
1571	Anglovaal Group Medical Scheme		3 707	226.3	86.9		-11.0
1520	University of Kwa-Zulu Natal Medical Scheme		3 369	206.8	85.9		-18.7
1241	Naspers Medical Fund		8 576	199.0	85.5		-21.7
1578	TFG Medical Aid Scheme		2 937	197.7	89.5		-22.3
1282	University of the Witwatersrand, Johannesburg Staff Medical Aid Fund		2 779	193.7	86.5		-23.8
1516	Quantum Medical Aid Society		4 869	191.2	84.9		-24.8
1579	Tsogo Sun Group Medical Scheme		4 812	183.6	81.0		-27.8
1430	Remedi Medical Aid Scheme		20 994	179.8	91.6		-29.3
1176	Retail Medical Scheme		11 340	176.7	94.7		-30.5
1547	Malcor Medical Scheme		5 085	165.9	78.9		-34.8
1012	Anglo Medical Scheme		9 081	163.7	62.6		-35.6
1526	BMW Employees Medical Aid Society		3 218	162.2	91.5		-36.2
1279	Bankmed		106 461	159.7	80.9		-37.2
1253	Glencore Medical Scheme		9 093	140.3	42.8		-44.8
1599	Lonmin Medical Scheme		17 864	56.3	89.4		-77.9
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	72 315	246.8	73.6	85.1	190.0
1441	Parmed Medical Aid Scheme		2 406	229.7	74.7		169.9
1507	Barloworld Medical Scheme		5 609	198.1	86.2		132.8
1005	AECI Medical Aid Society		7 089	189.7	86.2		122.9
1424	SABC Medical Aid Scheme		4 833	182.4	76.0		114.3
1469	Nedgroup Medical Aid Scheme		28 829	181.9	86.4		113.7
1214	Old Mutual Staff Medical Aid Fund		18 424	180.8	85.9		112.5
1512	Bonitas Medical Fund		308 262	180.5	67.8		112.1
1234	Sasolmed		28 715	174.8	85.5		105.4
1039	MBMed Medical Aid Fund		4 021	172.8	80.3		103.1
1576	LMS Medical Fund		55 276	153.9	12.7		80.8
1566	Horizon Medical Scheme		2 793	153.5	79.5		80.4
1580	South African Police Service Medical Scheme (POLMED)		174 480	113.1	60.2		32.9
1598	Government Employees Medical Scheme (GEMS)		683 286	45.2	21.9		-46.9

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	As % of	pampm	
				R	GAE	R	%
1572	Engen Medical Benefit Fund	Metropolitan Health Corporate (Pty) Ltd	3 592	163.1	81.4	130.7	24.8
1548	Medipos Medical Scheme		12 435	151.4	87.8		15.8
1582	Transmed Medical Fund		35 125	142.4	76.8		9.0
1559	Imperial Group Medical Scheme		7 740	140.0	58.5		7.1
1270	Golden Arrow Employees' Medical Benefit Fund		2 791	137.8	86.1		5.4
1598	Government Employees Medical Scheme (GEMS)		683 286	84.3	41.0		-35.5
1271	Fishing Industry Medical Scheme (Fishmed)		1 535	73.3	62.0		-43.9
1167	Momentum Health	MMI Health (Pty) Ltd	134 214	191.2	94.6	187.0	2.2
1209	South African Breweries Medical Aid Scheme (SABMAS)		9 727	190.7	82.5		2.0
1186	PG Group Medical Scheme		1 360	184.1	87.8		-1.6
1600	Motohealth Care		24 441	162.5	77.1		-13.1

GAE = Gross Administration Expenditure

Table 58: Market share of administrators (including accredited managed healthcare services) 2016

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	0.6	103.7	1 451.0	43.3	–	147.0
Allcare Administrators (Pty) Ltd	1	0.1	139.2	1 416.0	6.9	–	146.2
Discovery Health (Pty) Ltd	17	30.9	120.3	1 180.8	41.7	38.8	164.2
Medscheme Holdings (Pty) Ltd**	15	32.6	34.4	1 322.3	33.7	–	50.4
METHEALTH (Pty) Ltd	4	0.4	88.7	1 390.1	38.8	103.5	141.2
Metropolitan Health Corporate (Pty) Ltd	7	18.0	50.8	1 351.2	17.7	333.6	69.0
MMI Health (Pty) Ltd	4	3.1	94.7	1 023.2	23.8	99.1	194.6
Prime Med Administrators (Pty) Ltd	1	0.4	64.9	1 444.7	–	–	64.9
Professional Provident Society Healthcare Administrators (Pty) Ltd	2	1.4	106.1	1 699.1	21.2	–	127.3
Providence Healthcare Risk Managers (Pty) Ltd	5	0.6	49.0	847.6	28.1	–	66.5
Sanlam Health Administrators (Pty) Ltd	1	0.4	157.1	1 594.8	38.9	–	196.0
Sechaba Medical Solutions (Pty) Ltd	1	1.1	105.9	1 389.1	27.7	–	133.7
Self-Administered	14	8.4	12.6	1 283.6	15.4	–	19.4
Sweidan and Company (Pty) Ltd	2	0.5	83.1	1 272.3	27.0	21.2	129.5
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	2	0.9	79.4	1 246.2	–	–	79.4
Universal Healthcare Administrators (Pty) Ltd	6	0.7	92.6	1 217.4	31.0	3.1	122.7
V Med Administrators (Pty) Ltd	2	1.2	9.4	919.8	40.4	–	13.6
Average	**86**	**101.3**	**89.4**	**1 280.7**	**31.6**	**68.2**	**96.1**

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 59: Total fees paid to administrators (including accredited managed healthcare services) – deviation from industry average in 2016

Name of administrator	Total fees paid to administrators (various services)*	Accredited managed healthcare services (no transfer of risk) received *	Accredited managed healthcare services (risk transfer arrangement): capitation fee received	Total fees received*
	%	%	%	%
Sanlam Health Administrators (Pty) Ltd	75.7	23.1	-100.0	104.0
MMI Health (Pty) Ltd	5.9	-24.7	45.3	102.5

* *Excluding co-administration fees*

NOTES

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